2009 Health Disparities Initiatives Self-Assessment Survey Report

Office of Minority and Multicultural Health, New Jersey Department of Health & Senior Services

Center for State Health Policy, Rutgers University

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Executive Summary

The Office of Minority & Multicultural Health (OMMH) conducted the 2009 Health Disparities Initiatives Self-Assessment Survey among New Jersey Department of Health and Senior Services (DHSS) professional staff in collaboration with the Rutgers University Center for State Health Policy (CSHP). The purpose of the survey was to assess existing health disparities initiatives and their strategies with respect to data collection, outcomes and program evaluation, promotion of health literacy and cultural competency, and community outreach.

Methods

An electronic survey was emailed to DHSS staff. The questionnaire consisted of twenty-one questions. Respondents were asked to complete one questionnaire per program. Thirty-nine completed surveys were collected and analyzed by the CSHP.

Findings

DHSS programs are aware of and engaging in essential activities required to properly identify, evaluate, and plan for reducing health disparities statewide. More than 70% of the programs evaluated collect client-level information by racial/ethnic population and nearly half also collect data on the primary language spoken in the home. More than half of the programs conduct cultural competency training or assess the diversity of staff delivering services regularly. With respect to health literacy - while more than 60 percent of the programs translate health materials into other languages only slightly more than a third assess the reading level of translated materials or provide interpretation services. Too few programs track measurable outcomes by race/ethnicity considering that nearly half target interventions and activities to specific racial/ethnic groups. Program evaluation strategies are limited within DHSS. The most frequently cited evaluation method is a review of the number of referrals or provider linkages made. Changes in medical care seeking behaviors or differences in health comes which result from DHSS program activities are only minimally tracked.

Community outreach is conducted within a majority of the programs assessed. Several programs were nominated for Best Practice procedures in delivering health care services throughout the state.

Conclusion

OMMH will continue raising awareness on the topic of health disparities throughout DHSS and statewide. Assessment of data collection and reporting strategies, communication of best practices among programs, enhancing community outreach, and evaluation of program effectiveness are all key components of the DHSS Strategic Plan to Eliminate Health Disparities. DHSS will continue to integrate this Plan in the regular planning of all program activities.

Introduction

New Jersey is one of the nation's most racially and ethnically diverse states. More than one-third of the total New Jersey population belongs to a racial/ethnic minority group. Consistent with nationwide statistics, New Jersey minorities experience health disparities in almost all of the major chronic disease areas among the leading causes of death and morbidity statewide. An overarching goal of the New Jersey Department of Health and Senior Services' (DHSS) Healthy New Jersey agenda is to eliminate health disparities. All DHSS programs are obligated to evaluate health disparities and implement policies, procedures and activities that are intended to close gaps in health access and outcomes. The Office of Minority and Multicultural Health (OMMH) is committed to facilitating DHSS' objectives toward this goal.

Through the 2009 Health Disparities Initiatives Self Assessment Survey (Self-Assessment Survey), OMMH strives to conduct surveillance of existing DHSS health disparities initiatives, gather information on best practice strategies, and maintain the elimination of health disparities as a guiding principle for all DHSS activities. Self-assessment is key to DHSS' ability to evaluate progress in reaching racial/ethnic minorities, and to conduct essential health promotion and disease prevention activities within these communities.

Background

OMMH developed and implemented the *New Jersey Initiative to Reduce Health Disparities in 2005*. Funded by the U.S. Department of Health and Human Services' Office of Minority Health, this project encompasses four main objectives: (1) to increase the number of state health disparities initiatives meeting a "Best Practice" standard; (2) to develop standardized tools and resources that result in increased access to language services; (3) to increase the number of minorities in the health professions and management positions ; and (4) to standardize race and ethnic data collection tools in an effort to better track targeted program outcomes.

In partnership with Rutgers University- Center for State Health Policy (CSHP), OMMH developed the 2005 Self-Assessment Survey within DHSS. Its purpose was to begin monitoring DHSS initiatives and evaluate the strategies employed. In developing that survey, six content areas were deemed imperative in appropriately addressing health disparities. These areas included race/ethnicity data collection and reporting methods, cultural competency strategies, health care access, and quality of care, community partnerships and evaluation.

The 2005 survey identified 27 DHSS programs which implemented health disparities initiatives. Within the specified content areas, more than three quarters of the programs reported tracking progress and outcomes by race/ethnicity, and the implementation of cultural competency activities. A majority reported conducting outreach efforts among hard-to-reach populations or having established partnerships with community based organizations. The analysis of whether the initiative included efforts to improve quality of care proved difficult because phrasing of the questionnaire made it impossible for responders to distinguish clinical from programmatic activities. As a result, questions relating to this topic were removed from the 2009 survey.

The 2009 Self-Assessment Survey was redesigned to primarily examine to what extent each program had established an infrastructure for reducing disparities on particular health indicators. Infrastructure is measured by assessing the programs' activities in essential areas:

- Collecting and reporting race/ethnicity data;
- Tracking measurable outcomes that include racial/ethnic identifiers;
- Promoting cultural competency among staff and clients;
- Promoting health literacy among staff and clients;
- Enhancing community outreach; and
- Evaluating the effectiveness of program strategies.

The survey was distributed to the DHSS Health Disparities Work Group, which was established in 2007 to gather DHSS Senior Staff in a continuous discussion about strategies required to reduce the persistent health disparities statewide. Thirty-nine programs were evaluated (See Appendix 1), by 36 staff members who completed the survey.

This analysis provides an overview of the disparities initiatives currently in progress within DHSS programs. Overall, a majority collect client-level information on race/ethnicity, engage in activities that promote heath literacy, conduct outreach activities, and also demonstrate specific ways that they measure their programs' effectiveness. More than half of the programs also provide cultural competency training initiatives. Nearly half target one or more specific racial/ethnic or social/economic groups when providing services.

Survey Methods

The survey was designed by OMMH and Rutgers Center for State Health Policy (CSHP). Thirty-nine programs represented by 36 staff members from 9 divisions participated in this assessment. Three staff members each represented two programs in this assessment. A combination of direct service and surveillance programs were evaluated. Direct Service programs serve clients through face-to-face interactions which might include providing clinical services, implementing interventions, or disseminating health information. Surveillance programs do not work directly with clients and have mainly a monitoring and reporting function. Table 1 below lists the DHSS divisions and programs which participated in the survey.

Table 1. NJDHSS Divisions and Programs Participating in the 2009 Self Assessment Survey	
Division	**Number of Programs**
Aging and Community Service	5
Epidemiology, Environmental and Occupational Health Service	8
Family Health Services	16
Health Infrastructure Preparedness and Emergency Response	1
HIV/AIDS Services	3
Management and Administration	1
Office of the Commissioner	2
Public Health Services	1
Senior Benefits and Utilization Management	2

The questionnaire was forwarded to Senior Staff identified by members of DHSS Health Disparities Work Group. Senior Staff then forwarded the survey to appropriate program level staff to complete in an electronic PDF form. Respondents were asked to complete and return the form within three weeks. There were approximately 20 questions which were intended to assess the infrastructure of the program regarding the core measures in addressing health disparities described above. CSHP analyzed the responses and reported the findings.

Findings

CSHP evaluated survey responses and compiled summary statistics within each of the infrastructure areas: client level data availability, tracking measurable outcomes, promoting cultural competency and health literacy, targeting disparate populations, conducting community outreach and measuring program effectives.

Collecting Client-Level Information

Collecting client level information is essential in identifying the population served as well as documenting differences in outcomes. Twenty-eight programs (72%) collect client-level information on race/ethnicity overall, and 11 programs (28%) do not (Table 2).
Among the programs collecting the racial/ethnic data, 46% also collect information on primary language spoken. In addition, more than a quarter of them collect information on the percentage of the population that speaks a primary language other than English. However, only 3 programs publicly report this information. Data on English proficiency are becoming increasingly important as more evidence shows that patients are suffering the consequences of limited ability to communicate with health care providers. In this state, where nearly one-fifth of the population reports speaking a language other than English at home, understanding the health challenges faced by this population is critical to providing health care services to these New Jersey residents (US Census Bureau, American Community Survey data, 2006-2008).

Tracking Measurable Outcomes

The ability to track measurable outcomes by race/ethnicity is fundamental to measuring health disparities and identifying high risk populations. Fewer than half of the programs (38.5%) reported tracking measurable outcomes. Among those that do track outcomes by race/ethnicity 53% do so based on Healthy New Jersey 2010 Objectives, and 73% track measurable outcomes based on program specific objectives.

Promoting Cultural Competency

Cultural competency initiatives are promoted to create health care environments which are conducive to reducing health disparities by addressing health concerns that may be impacted by health behaviors or attitudes. Twenty-two programs (56%) provide some type of cultural competency initiatives. Nearly two-thirds of the programs (64%) offer cultural competency training and 41% assess the diversity of staff delivering services. Six programs engage in both these types of activities.

A number of *other* methods promoting cultural competency were described through the survey. Other activities included provision of sign language interpreters and CART services /TTY phone line to assist deaf/hard of hearing individuals; increasing cultural competency training opportunities for outreach staff; providing additional funding for grantees that provide immunization services to various racial/ethnic groups; and issuing comprehensive cultural competency standards.

Promoting Health Literacy

Research reveals that health literacy among many patients is below a level that allows the appropriate communication of vital information such as how to administer medication or accurately follow providers' instructions. At DHSS nearly 70% of the programs surveyed engage in one or more activities that promote health literacy. Specifically, 63 % of programs translate materials for clients. More than a third assess the reading level of translated materials (33%) and provide interpretation services (37%). Slightly more than a fifth of the programs provide educational materials to clients (22%).

About 15% of the programs reported *other* health literacy initiatives including Spanish translation of web pages and all forms, adding bilingual customer service representatives to hotlines, provision of health literacy training to program coordinators, and funding grantee initiatives that promote health literacy.

Table 2. NJDHSS Health Disparities Initiatives Self Assessment Survey Major Areas of Evaluation, 2009		
Program Evaluation Measure	Yes (N)	No (N)
Collect client level information	28	11
Track measurable outcomes by race/ethnicity	14	25
Track measurable outcomes based on Healthy NJ 2010 Objectives	8	31
Track measurable outcomes based on other objectives	11	28
Track measurable outcomes based on both Healthy New Jersey 2010 objectives and other objectives	4	35
Familiarity with NJDHSS Strategic Plan	36	3
Very familiar	8	28
Somewhat familiar	24	12
Not at all familiar	4	32
Promote Cultural Competency	22	17
Offer cultural competency training initiatives	14	16
Assesses the diversity of the staff delivering services	9	21
Other	6	24
Promote Health Literacy	27	12
Assesses the reading level of translated materials	9	18
Provide interpretation services	10	17
Translate materials for clients	18	10
Provide educational materials to clients	6	21
Other	3	23
Target Specific Group	19	20
Make Outreach Efforts	26	13
800 numbers/hotlines	18	8
Educational brochures/materials	21	5
Messaging through radio and television	8	18
Billboards	4	22
Face to face outreach	18	8
Other	14	12
Measure Program Effectiveness	30	9
Number of referrals or linkages made to health care providers	15	15
Reduce the number of unnecessary or excess provider visits	2	6.7
Reduce the number of visits to emergency rooms	4	13.3
Evaluate cost impacts or savings	3	10.0
Other	19	63.3

Targeting Specific Groups

As health disparities are identified and documented, programs are better able to assess which groups are essential to target for services and public health interventions. Nearly half of the DHSS programs (49%) target one or more specific racial/ethnic or social/economic groups when providing services. Of these programs, 58% target Hispanics/Latinos, 53% target Blacks/African Americans, and 53% target persons who are uninsured (See Table 3.)

Table 3. DHSS Program Target Groups (N=20)	
Target Group	
Race/Ethnicity	Number of Programs
White	9
Black/African American	16
Hispanic/Latino	11
Asian	6
American Indian/Alaskan Native	6
Native Hawaiian/Pacific Islander	3
Other	4
Income or Poverty Level	
Up to 300% Supplemental Security Income	1
Insurance	
Uninsured	10
Privately insured	6
Medicaid	7
NJ Family Care	7
Medicare	7
Undocumented immigrants	7
Other	14

Making Outreach Efforts

Historically, those most heavily impacted by poverty, and racial/ethnic minority groups have had problems using mainstream methods of communication. To effectively reach these populations, a combination of strategies must be employed to ensure every individual has the health information required to make important decisions about their lifestyle and overall well-being, and gain access to health care. Over two-thirds (67%) of DHSS programs use outreach efforts to increase access to health services among hard-to-reach populations. The methods used include but are not limited to 800 numbers/hotlines (69%), educational brochures/materials (81%), radio and television advertisements (31%), billboards (15%), and face-to-face outreach (70%).

Some programs have also used outreach efforts by funding or subcontracting with community-based organizations (CBOs) or faith-based organizations (FBOs). A description of a subset of DHSS' grantee or collaborating CBOs and FBOs and key activities is provided in Appendix 3.

Measuring Program Effectiveness

Evaluation of program methods and their impact on the community served is essential in determining whether tactics are effective and should be continued or whether they should be revised to better meet the needs of the at risk population served. A majority of DHSS programs (77%) utilize specific methods to measure program effectiveness. The indicators used to evaluate program methods vary significantly according to individual program goals, approaches, and targeted populations. However, one method frequently used (by more than half of DHSS programs) is counting the number of referrals or linkages made to health care providers. Less frequently used strategies include reviewing the reduction in the number of unnecessary or excess provider visits (7%), looking at the reduction in the number of visits to emergency rooms (13%), and evaluating cost impacts or savings (10%).

Familiarity with the DHSS Strategic Plan to Eliminate Health Disparities

The DHSS Strategic Plan to Eliminate Health Disparities (Disparity Plan) in New Jersey was released in 2007. The Disparity Plan examines medical priority areas where disparities have persisted statewide for decades, and outlines an action plan for reducing them. OMMH assessed DHSS staff familiarity with the plan, in order to evaluate and raise awareness of its goals and objectives, as well as if and how it drives or supports program initiatives. Of the staff surveyed, few were very familiar with the plan (22%), however, more than two-thirds (67%) were "somewhat familiar" with the Plan. A small percentage (11%) were "not at all familiar" with it.

Table 4. Number and Percent of Staff Who Are Familiar with NJDHSS Strategic Plan

Familiarity with NJDHSS Strategic Plan	N	Percent
Very familiar	8	22.2
Somewhat familiar	24	66.7
Not at all familiar	4	11.1

Limitations

The Self-Assessment Survey does not provide a complete evaluation of DHSS programs, as it was conducted solely among a subset of key DHSS staff. While the respondents are considered DHSS experts, an assessment of a larger subset of DHSS employees would better inform on how well the elimination of health disparities is integrated department wide. Given the small sample size, it is possible that not all eligible programs were evaluated.

Data from the survey provide only a snapshot of the initiatives undertaken by DHSS programs in meeting best practice standards with respect to addressing health disparities. At the time of the survey, activities may have been in early stages of development (and unknown to the respondent) or recently discontinued and not captured among the survey results.

Another limitation is that the results from this survey can not be compared with the first Health Disparities Initiative Assessment Survey, conducted in 2005 because the questions were revised considerably in the 2009 version.

Conclusion

The 2009 Health Disparities Initiative Assessment Survey demonstrates that DHSS programs are conducting activities required to identify, measure and address health disparities. Information gathered from staff identified by DHSS senior staff as most knowledgeable on health disparities initiatives describes a Department that has much of the infrastructure, which is required to appropriately address health disparities statewide, already in place.

Raising awareness about existing health disparities is key to effectively implementing strategies to reduce them. Overall, this survey shows that DHSS programs are familiar with the DHSS' Strategic Plan to Eliminate Health Disparities which was released in March 2007. The fact that nearly 90% of those surveyed were either very or somewhat familiar with the Disparities Plan is encouraging.

Regarding some of the Disparity Plan's core recommendations on infrastructure, the survey suggests that DHSS programs are conducting essential activities which promote cultural competency and health literacy, and conduct outreach among minority communities. More than half of the programs promote cultural competency through training initiatives (64%) and a smaller portion also assess the diversity of staff delivering services in their program planning. More than two-thirds of the programs promote health literacy through translating materials in different languages for clients (63%), or providing interpretation services (37%). Outreach efforts among racial/ethnic minority groups are also conducted among more than two-thirds of the programs surveyed. The major outreach activities include the distribution of educational information, face-to-face encounters, and provision of 800 numbers and hotlines for the public to access.

The survey also revealed that a majority of programs, more than 75%, have mechanisms in place to evaluate their program's effectiveness overall. With such measures in place, programs can regularly assess the effectiveness of the programs they fund and make improvements accordingly. However, increasing the percentage of programs that measure health outcomes specific to interventions executed, and evaluate benefits of the strategies employed toward closing disparities gaps and improving health access and outcomes is critical to achieving set goals.

A majority of programs surveyed collect client level data by race/ethnicity. Nearly half of them also collect data on primary language spoken at home. The ability to conduct analyses on the status of health disparities is only possible when the data are available.

With the goal of incorporating these methods in all DHSS program activities, there is still work to be done in the Department and statewide to perform in a manner that will surely achieve a reduction in health disparities. Continued attention to the quality of racial/ethnic data that is collected, following through on and maintaining set guidelines, and making cultural competency, health literacy and outreach to hard-to-reach populations a priority for all population based interventions are key strategies in achieving both the Disparity Plan and Healthy New Jersey goals to eliminate health disparities.

Recommendations/Next Steps

DHSS programs are encouraged to keep the reduction of health disparities at the forefront of all public health planning. OMMH priorities in continuing this work require the following objectives be accomplished:

1. Follow up with DHSS programs to assess their progress in achieving the standards outlined in DHSS' Race/Ethnicity Coding Guidelines.

2. Conduct in-depth interviews with select programs to identify problem areas with respect to collecting and reporting racial/ethnic data. Trouble shoot ways to resolve problems identified.

3. Ensure that Healthy New Jersey 2020 includes the minimum six racial/ethnic categories for all population based objectives as well as a commitment to examine the social determinants of health and how to develop strategies that review and correct social, physical, economic, and environmental barriers to racial/ethnic minorities achieving optimal health.

4. Increase program evaluation methods which are focused on ensuring appropriate and cost effective strategies are used to affect improvements in health access and outcomes which are essential for closing health disparities gaps.

5. Increase the percent of programs engaging in best practices to eliminate health disparities to 100% in all essential areas, through communicating successful initiatives, collaboration between programs, and overall dedication to reducing health disparities statewide.

APPENDICES

Appendix 1.

DHSS Programs/Program Areas Assessed	
DHSS Program (N=39)	Health Areas/Conditions Addressed by the Program
Aging and Community Service	
Alzheimer's Adult Day Services Program	Alzheimer's Disease
Community Education and Wellness	Cardiovascular Disease, Nutrition, Physical Activity, Immunizations, Injuries
Congregate Housing Services Program	Nutrition
Title III OAA	Activities of Daily Living
Statewide Respite Care Program	Chronic Conditions
Epidemiology, Environmental and Occupational Health Services	
Hazardous Site Health Evaluation/Environmental PH Tracking	Asthma, Cancer/Cancer Screening, Cardiovascular Disease, Maternal and Child Health, Injuries or Injury Prevention, Occupational Health, Birth Defects, Poisonings
Infectious and Zoonotic Disease Program	Hepatitis C, Infectious Diseases, Zoonotic Diseases
Occupational Health Surveillance	Asthma, Injuries or Injury Prevention, Occupational Health, Other Chronic Diseases
Public Employees Occupational Safety and Health Program	Occupational Health
Right to Know Program	Occupational Health
Sexually Transmitted Disease Program	Sexually Transmitted Diseases
Tuberculosis Program	Infectious Disease
Vaccine Preventable Disease Program	Immunizations
Family Health Services	
Child and Adolescent Health Program	Lead Poisoning
Children's Oral Health Education Program	Children's Oral Health Education
Comprehensive Tobacco Control Program-Community Partnership Program	Tobacco Control and Tobacco Related Diseases
Comprehensive Tobacco Control Program-Treatment and Cessation Program	Tobacco Control and Tobacco Related Diseases
Early Identification and Monitoring Program	Birth Defect Conditions, Hearing Screening, Autism
Family Centered HIV Care Program	HIV/AIDS
Governor's Council for Medical Research & Treatment of Autism Program	Autism
Infant Mortality Reduction Program	Maternal and Child Health
MCH Epidemiology Program	Maternal and Child Health, Injuries or Injury Prevention
New Born Screening and Genetic Services Program	Chronic Diseases (Metabolic Disorders, Hematologic Disorders, Endocrine Disorders, Cystic Fibrosis, Hemophilia
New Jersey Early Intervention System	Developmental Delays/Disabilities
Office of Primary Care & Rural Health	Asthma, Cancer/Cancer Screening, Cardiovascular Diseases, Diabetes, Hepatitis C, Nutrition, Physical Activity, HIV/AIDS, Immunizations, Maternal and

DHSS Programs/Program Areas Assessed	
DHSS Program (N=39)	Health Areas/Conditions Addressed by the Program
	Child Health, Kidney Diseases, Sexually Transmitted Diseases
Special Child Health and Early Intervention Program-Case Management	Asthma, Cardiovascular Diseases, Diabetes, HIV/AIDS, Kidney Diseases
Special Child Health and Early Intervention Program-Specialized Pediatric	Asthma, Diabetes, Immunizations, Kidney Disease, Infectious Diseases
Tobacco Age of Sale Enforcement Program	Tobacco Control
Wellness Promotion & Chronic Disease Prevention Program	Asthma, Cancer/Cancer Screening, Cardiovascular Diseases, Diabetes, Nutrition, Physical Activity, Kidney Disease, Tobacco Control, Other Chronic Diseases
Health Infrastructure Preparedness and Emergency Response	
Emergency Medical Services	Hepatitis C, Injuries or Injury Prevention, Sexually Transmitted Diseases, Infectious Diseases
HIV/AIDS Services	
Care and Treatment	HIV/AIDS
Epidemiologic Services	HIV/AIDS
Prevention and Education	HIV/AIDS
Management and Administration	
Bureau of Vital Statistics	Data Collection on Birth, Death, Cause of Death, Congenital Anomalies
Office of the Commissioner	
Health Care Quality Assessment	Cardiovascular Diseases
OMMH Community Grants Program	Asthma, Diabetes
Public Health Services	
Office of Cancer Control and Prevention	Cancer/Cancer Screening, Nutrition, Physical Activity, Tobacco Control
Senior Benefits and Utilization Management	
Rate Setting	None
Support Services	Monetary Assistance to Beneficiaries for Prescription Drugs, Hearing Aids, and Utilities

Appendix 2: DHSS Data Collection Standards for Race and Ethnicity

Ethnicity	Definition
Hispanic or Latino ("Spanish origin")	Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin
Not Hispanic or Latino ("Not of Spanish origin")	
Race	**Definition**
American Indian or Alaska Native:	Origins in any of the original peoples of Northland South America (including Central America), and tribal affiliation or community attachment.
Asian:	Original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
Black or African American:	Origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander:	Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
White:	Origins in any of the original peoples of Europe, the Middle East, or North Africa.
Other Race:	Persons who identify as a race outside of the minimum standard racial categories.

Recommended racial/ethnic sub-group categories

Race/Ethnicity category	Definition
Hispanic/Latino	Mexican/Mexican American/Chicano, Puerto Rican, Cuban, Central or South American, Dominican, Other Spanish or Latino
Asian	Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian
Pacific Islander	Native Hawaiian, Guamian or Chamorro, Samoan, Other Pacific Islander

The White, Black, Asian and Pacific Islander categories include those who answered “Yes” for one of the respective race groups and who also answered No to or did not answer (Unknown) the Hispanic ethnicity question. All responders answering “Yes” to the Hispanic or Latino ethnicity question should be coded as Hispanic, regardless of the race response chosen. To avoid confusion about whether the data published for each racial group includes or excludes persons of Hispanic descent, the following footnote should be used:

*Data for White, Black, and Asian, and Pacific Islander do not include Hispanics.
Hispanic ethnicity includes persons of any race.

Appendix 3.

Program Infrastructure Assessment on Reducing Health Disparities								
Program	**Collect Client-Level Information**	**Track Measurable Outcomes that Include Race/Ethnic Identifiers**	**Interviewed Staff Familiar with DHSS Strategic Plan**	**Promote Cultural Competency**	**Promote Health Literacy**	**Target Specific Groups**	**Make Outreach Efforts**	**Measure Effectiveness of Program**
DACS - Alzheimer's Adult Day Services	✓							
DACS - Community Education and Wellness	✓		✓	✓	✓	✓	✓	✓
DACS - Congregate Housing Services Program	✓				✓	✓		✓
DACS - Statewide Respite Care Program				✓	✓	✓		
DACS - Title III OAA	✓		✓	✓	✓	✓	✓	
EEOH - Hazardous Site Health Evaluation/Environmental PH Tracking	✓	✓	✓					
EEOH - Infectious and Zoonotic Disease Program	✓		✓	✓	✓			
EEOH - Occupational Health Surveillance	✓	✓	✓		✓		✓	✓
EEOH - Public Employees Occupational Safety and Health Program			✓		✓		✓	✓
EEOH - Right to Know Program			✓		✓			
EEOH - Sexually Transmitted Disease Program	✓	✓	✓	✓	✓	✓	✓	✓
EEOH - Tuberculosis	✓	✓		✓	✓		✓	✓
EEOH - Vaccine Preventable Disease Program	✓		✓	✓		✓	✓	✓
FHS - Child and Adolescent Health	✓				✓		✓	✓
FHS - Children's Oral Health Education			✓		✓	✓	✓	
FHS - Comprehensive Tobacco Control Program-Community Partnership	✓		✓	✓	✓	✓	✓	✓
FHS - Comprehensive Tobacco Control Program-Treatment and Cessation	✓		✓	✓	✓	✓	✓	✓
FHS - Early Identification and Monitoring	✓		✓	✓	✓			✓

Program Infrastructure Assessment on Reducing Health Disparities								
Program	**Collect Client-Level Information**	**Track Measurable Outcomes that Include Race/Ethnic Identifiers**	**Interviewed Staff Familiar with DHSS Strategic Plan**	**Promote Cultural Competency**	**Promote Health Literacy**	**Target Specific Groups**	**Make Outreach Efforts**	**Measure Effectiveness of Program**
FHS - Family Centered HIV Care	✓	✓	✓	✓	✓	✓	✓	✓
FHS - Governor's Council for Medical Research & Treatment of Autism	✓		✓			✓	✓	✓
FHS - Infant Mortality Reduction		✓	✓	✓			✓	✓
FHS - MCH Epidemiology Program		✓	✓					✓
FHS - New Born Screening and Genetic Services	✓	✓	✓	✓	✓		✓	✓
FHS - New Jersey Early Intervention System	✓	✓	✓	✓	✓	✓	✓	✓
FHS - Office of Primary Care & Rural Health			✓			✓	✓	✓
FHS - Special Child Health and Early Intervention-Case Management	✓		✓	✓	✓		✓	
FHS - Special Child Health and Early Intervention-Specialized Pediatric	✓		✓	✓	✓		✓	✓
FHS - Tobacco Age of Sale Enforcement	✓		✓			✓	✓	✓
FHS - Wellness Promotion & Chronic Disease Prevention	✓	✓	✓	✓	✓	✓	✓	✓
HIPER - Emergency Medical Services			✓	✓				
HIV/AIDS - Care and Treatment	✓		✓	✓			✓	✓
HIV/AIDS - Epidemiologic Services	✓		✓		✓			✓
HIV/AIDS - Prevention and Education	✓		✓	✓	✓	✓	✓	✓
MA - Bureau of Vital Statistics	✓	✓	✓		✓		✓	✓
OC - Health Care Quality Assessment	✓	✓	✓					✓
OC - OMMH Community Grants Program	✓	✓	✓	✓	✓	✓		✓
PHS - Office of Cancer Control and Prevention		✓	✓	✓	✓	✓	✓	✓
SBUM - Rate Setting			✓					✓
SBUM - Support Services			✓		✓	✓	✓	✓

Appendix 4.

Programs, Funded or Subcontracted Organizations and Activities		
Program	**Funded or Subcontracted Organization**	**Activities**
Comprehensive Tobacco Control Program-Community Partnership	Seven funded quit centers receive the same amount of funding	Provide in-person and telephonic counseling & for individuals and in groups
Congregate Housing Services Program	Jewish Community Housing, Jewish Federation Housing	Housing with supportive services
	Hudson Lutheran Housing	
	Presbyterian Homes and Services	
Infant Mortality Reduction	Isaiah House	Healthy Start
Office of Primary Care & Rural Health	All federally qualified health centers	Reimbursement for uninsured/underinsured primary medical and dental services
OMMH Community Mobilization Grants Program	Catholic Charities of Camden	Diabetes screening, education and referral targeting African Americans and Latinos
	Henry J. Austin Community Health Center	Pediatric Asthma screening, education, referral and treatment for African American & Latino children & families
	Friends of Grace, Inc.	Diabetes screening, education and referral targeting Korean Americans
Sexually Transmitted Disease Program	NJ Community Research Initiative	Syphilis screening, STD education in Newark
	EL Club Del Barrio	STD educational outreach to Hispanic populations in Newark
	Area Health Education Centers	Syphilis screening and STD education in Camden
Title III OAA	Essex AAA	Provide services directly or subcontract with community and faith based organizations to provide information, care management, home, and community based services.
	Hudson AAA	
	Bergen AAA	
Vaccine Preventable Disease Program	Lakewood Resource & Referral Community, Inc.	Provide services directly or subcontract with community and faith based organizations to provide information, care management, home, and community based services.
	Tri-County Community Center	Provide immunizations to migrant workers and their families, outreach and immunization education to clients
	Monmouth City Health Department	Expanded immunization coverage in the community, outreach/immunization education to Hispanic Community in Spanish
Epidemiologic Services	North Jersey Community Research Initiative	Survey administration, needs assessment and HIV testing
Prevention and Education	NJ Human Development Corporation	HIV prevention
	Hyacinth AIDS Foundation	HIV prevention
	South Jersey AIDS Alliance	HIV prevention

Appendix 5: DHSS Health Disparities Initiatives Self-Assessment Survey

Instructions: One survey should be completed for each program. Answer questions in reference to the program's current activities and practices.

1. Division_____

2. Program name _____

a. Contact person _____

b. Telephone number _____

c. Email address_____

3. Does this program collect client-specific information (e.g., demographics)?

☐ **Yes**

☐ **No – SKIP TO Question #8**

4. Does your program collect client-level information on languages spoken?

☐ **No, Program does NOT collect information on languages spoken on a per client basis.**

☐ **Yes (Please specify what questions are asked):**

☐ Primary language spoken at home?

☐ English fluency?

☐ Other (Specify);

_____

5. Does the program collect the percent of the population that has a primary language other than English?

☐ **Yes** ☐ **No**

6. Does the program publicly report the percent of the population that has a primary language other than English?

☐ **Yes** ☐ **No**

7. Please indicate the specific race/ethnic data categories used to collect client level information (Check all that apply).

☐ **Program does NOT collect race/ethnic data on a per client basis.**

☐ **White non-Hispanic** ☐ **White**

☐ **Hispanic/Latino**

☐ **Black non-Hispanic** ☐ **Black**
☐ **Asian (non-Hispanic)**

☐ **American Indian or Alaskan Native**
☐ **Native Hawaiian/Pacific Islander**

☐ **Other (Please describe):**

_____

8. Please indicate which health condition(s) this program addresses (Check all that apply).

☐ **Asthma**

☐ **Cancer/Cancer screening**

☐ Lung ☐ Breast ☐ Cervical
☐ Colorectal ☐ Prostate

☐ Other

☐ **Cardiovascular diseases**

☐ **Diabetes**

☐ **Hepatitis C**

☐ **Nutrition**

☐ **Child** ☐ **Adult**

☐ **Physical activity**

☐ **Child** ☐ **Adult**

☐ **HIV/AIDS**

☐ **Immunizations**

☐ Child ☐ Adult

☐ **Maternal and Child Health**

☐ **Infant mortality** ☐**SIDS**
☐ **Prenatal Care**

☐ **Low Birth Weight**

☐ **Teenage Pregnancy**

☐ **Injuries or Injury Prevention**

☐ Unintentional (e.g., accidents)

☐ Intentional (e.g., suicide, assault, homicide)

☐ **Kidney disease**

☐ **Occupational health**

☐ Work-related injuries

☐ Exposure to hazardous substances

☐ **Sexually transmitted diseases**

☐ **Tobacco control**

☐ **Infectious diseases**

☐ **Other chronic diseases (not included above – Please specify)**

☐ **Other (Please specify)**

9. DHSS has a strategic plan to eliminate racial and ethnic disparities in New Jersey. How familiar are you with this strategic plan?

☐ **Very familiar**

☐ **Somewhat familiar**

☐ **Not at all familiar**

1. Does your program track any measurable outcomes that include racial/ethnic identifiers based on Healthy NJ 21 objectives?

☐ **No**
☐ **Yes (Please specify)**

11. Does your program track any measurable outcomes that include racial/ethnic identifiers that are NOT based on Healthy NJ 21 objectives?

☐ **No**
☐ **Yes (Please specify)**

12. Does this program report data/information on services by clients' race/ethnicity?

☐ **Yes**

☐ **No – SKIP TO Question 13**

12a. Does the program report this information to:

☐ **Commissioner of DHSS**
☐ **Funder/Sponsor**
☐ **Public/website**
☐ **Other (Please specify):**

13. Please indicate the activities that this program uses to promote cultural competency, if any (Check all that apply):

☐ **Does NOT engage in activities to promote cultural competency for clients or staff**

☐ **Offers cultural competency training initiatives**

☐ **Assesses the diversity of the staff delivering services**

☐ **Other (Please specify)**

14. Please indicate the activities that this program uses to promote health literacy, if

any (Check all that apply):

☐ **Does NOT engage in activities to promote health literacy for clients or staff**

☐ **Assesses the reading level of translated materials**

☐ **Provides interpretation services (e.g., 8 phone numbers, in-person)**

☐ **Translates materials for clients (if yes, what languages?)**

☐ **Other (Please specify)**

15. Have you or has someone from your office attended any training session on health literacy?

☐ **Yes**

☐ **No – SKIP TO Question #16**

15a. If yes, has your office been able to revise your materials to reflect health literacy guidelines that were discussed?

☐ **Yes**

☐ **No**

15b. If no, what are the barriers preventing your office from making revisions?

16. What specific groups does this program target (Check all that apply)?

☐ **Does NOT target specific groups (Skip to Question 17)**

RACE/ETHNICITY:

☐ **White** ☐ **White non-Hispanic**

☐ **Hispanic/Latino**

☐ **Black** ☐ **Black non-Hispanic**

☐ **American Indian or Alaskan Native**

☐ **Native Hawaiian/Pacific Islander**

☐ **Other (Please describe)**

INCOME OR POVERTY LEVEL:

Specify income or federal poverty level thresholds: _____

INSURANCE:

☐ **Uninsured**

☐ **Privately insured**
☐ **Medicaid**

☐ **New Jersey FamilyCare**
☐ **Medicare**

☐ **Other (Please specify):**

_____

OTHER TARGETED GROUPS:

☐ **Undocumented immigrants**

☐ **Other immigrants**

☐ **Other (Please specify)**

17. How do you measure the effectiveness of your health program? (Check all that apply)

☐ **Number of referrals or linkages made to health care providers**

☐ **Reducing the number of unnecessary or excess provider visits**

☐ **Reducing the number of visits to emergency rooms**

☐ **Cost impacts or savings**

☐ **Other (Please specify):_____**

18. Do you think there should be additional measures of the effectiveness of your health program?

☐ **Yes**
☐ **No – SKIP TO Question 19**

18a. If yes, what would be measured? (Please specify):

19. Please indicate the current specific outreach efforts this program utilizes to increase access to health services for hard to reach populations (check all that apply):

☐ **Does NOT engage in efforts to increase access for hard to reach populations**

☐ **8 numbers/hotlines**

☐ **Educational brochures/materials**

☐ **Messaging through radio and television**

☐ **Billboards**

☐ **Face to face outreach**

☐ **Other (Please describe):**

We would like to know more about your work with community and faith based organizations (organizations where both the leadership and the membership reflect the communities that they seek to serve).

2. Does your program provide funds or subcontracts to any of these kinds of organizations?

☐ **Yes**

☐ **No – SKIP TO Question 21**

2a. How many of the organizations do you fund/subcontract with to target racial/ethnic groups most likely to suffer from health disparities? _____

2b. Please provide the names and activities of the 3 organizations which receive the largest amount of funding.

Names of Minority Community/Faith-based organizations	Activities

21. If you would like, please nominate a model initiative in your program or in a grantee program that has made significant contributions in eliminating health disparities in different racial and ethnic groups.

a. Which initiative in your program or grantee would you like to nominate

Initiative or Grantee Name:

_____

Contact information for initiative or grantee:

_____

b. Which of the following criteria does this model initiative fulfill (check all that apply)?

☐ **Collecting client level data using race/ethnicity categories**

☐ **Promote cultural competency and health literacy**

☐ **Promoting language access**

☐ **Establishing collaboration with community based organizations**

☐ **Targeting specific race/ethnicity communities**

☐ **Other (Please specify)**_____

c. A brief description of the achievements of the initiative

22. Date survey completed: _____

Self-Assessment Feedback Form

In an effort to develop this self- assessment, we would appreciate your feedback about the form itself.

1. **On a scale of 1-5 with 5 being the most clear, how clear were the questions?**

   1 2 3 4 5

   Least Clear Most Clear

   1a. If your response is less than 3, please indicate questions which were unclear:_____

2. **On a scale of 1-5 with 5 being too time consuming, how much time did it take to complete the form?**

   1 2 3 4 5

   Did not take much time Took too much time

   2a. If your response is more than 3, please indicate questions which were too time consuming: _____

3. **On a scale of 1-5 with 5 being most complete, how sufficient were these questions in gaining a clear understanding about this program's efforts in addressing race/ethnic disparities?**

   1 2 3 4 5

   Not sufficient Completely captures programs' efforts

   3a. If your response is less than 3, please indicate what we should include to make the assessment more complete:

4. **On a scale of 1-5 with 5 being the most relevant, how relevant were the questions?**

   1 2 3 4 5

   Not relevant Very relevant

   4a. If your response is less than 3, please indicate questions which were not relevant:

Thank you for your time and consideration