

COMMUNITY NEED INDEX

Overview

Not-for-profit and community-based health systems have long considered community need a core component of their mission of service to local communities. While specific initiatives designed to address health disparities vary across local communities (outreach to migrant farm workers, asthma programs for inner city children, etc), the **need to prioritize and effectively distribute hospital resources** is a common thread among all providers.

Given the increased transparency of hospital operations (quality report cards, financial disclosures, etc), **community-benefit efforts need to become increasingly strategic and targeted** in order to illustrate to a variety of audiences how specific programs have been designed and developed. While local community-needs assessments will always play a central role in this process, they are often voluminous, difficult to communicate, and may lack necessary qualitative and statistical justification for choosing specific communities as having the “greatest need.”

Because of such challenges, the **Community Need Index (or CNI) was developed to assist in the process of gathering vital socio-economic factors in the community. The CNI is strongly linked to variations in community health-care needs and is a strong indicator of a community’s demand for various health-care services.**

Based on a wide array of demographic and economic statistics, the CNI provides a score for every ZIP code in the United States on a scale of 1.0 to 5.0. A score of **1.0 indicates a ZIP code with the least need, while a score of 5.0 represents a ZIP code with the most need.** The CNI should be used as part of the larger community-needs assessment to pinpoint specific areas that have greater need than others. The CNI should be shared with community partners and used to justify grants or resource allocations for community initiatives. (Data sources: 2003 Demographic Data, Claritas, Inc.; and 2003 Insurance Coverage Estimates, Solucient)

Methodology

The CNI score is an average of five different barrier scores that measure various socio-economic indicators of each community. The five barriers are listed below along with the individual statistics that are analyzed for each barrier. These barriers, and the statistics that comprise them, were carefully chosen and tested individually.

1. Income Barrier

- Percentage of households over age 65 below poverty line
- Percentage of families with children under 18 below poverty line
- Percentage of single-female families with children below poverty line

2. Cultural Barrier

- Percentage of population that is minority (including Hispanic ethnicity)
- Percentage of population over age five that speaks English poorly or not at all

3. Education Barrier

- Percentage of population over 18 without a high-school diploma

4. Insurance Barrier

- Percentage of population in the labor force without employment
- Percentage of population without health insurance

5. Housing Barrier

- Percentage of households renting their home

Every populated ZIP code in the United States is assigned a barrier score of 1, 2, 3, 4 or 5 depending upon the ZIP code's national rank (quintile). A score of **1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally**. For example, ZIP codes that score a 1 for the Education Barrier contain highly educated populations; ZIP codes with a score of 5 have a very small percentage of high-school graduates.

Lodi Memorial Hospital

Market Name: **Primary Market Area**

Market 2003 Population: **88,690**

Market Summary (average of all ZIPs)

3.50	3.41	4.21	3.17	3.53	3.19	9%	16%	32%	27%	36%	9%	8%	21%	39%
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ZIP Codes	Post Office Box Name	County	State	CNI Score	Income Rank	Education Rank	Culture Rank	Insurance Rank	Housing Rank	Poverty 65+	Poverty Children	Poverty Single w/kids	No High School Diploma	Minority	Limited English	Unemployed	Uninsured	Renting	2003 Population
95240	Lodi	San Joaquin	CA	4.2	4	5	4	4	4	10%	22%	37%	34%	45%	13%	9%	25%	48%	48,132
95242	Lodi	San Joaquin	CA	2.8	3	3	2	3	3	9%	10%	30%	18%	25%	5%	5%	17%	33%	25,051
95220	Acampo	San Joaquin	CA	2.4	2	4	2	3	1	12%	8%	20%	22%	24%	4%	8%	17%	20%	7,817
95237	Lockeford	San Joaquin	CA	3.0	3	4	3	4	1	2%	16%	35%	24%	31%	7%	18%	25%	21%	3,462
95258	Woodbridge	San Joaquin	CA	2.2	2	3	3	2	1	0%	7%	16%	19%	28%	3%	6%	9%	19%	4,228

1 = Lowest 5 = Highest

Lodi Memorial Hospital

Market Name: **Secondary Market Area**

Market 2003 Population: **296,762**

Market Summary (average of all ZIPs)

2.47	2.41	2.71	3.28	2.17	1.80	7%	10%	25%	17%	42%	5%	6%	13%	24%
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94571	Rio Vista	Solano	CA	3.0	4	3	2	3	3	3%	13%	52%	18%	21%	4%	5%	19%	30%	6,708
95209	Stockton	San Joaquin	CA	3.0	4	3	4	2	2	5%	17%	39%	18%	52%	6%	6%	14%	28%	33,142
95210	Stockton	San Joaquin	CA	4.4	4	5	5	4	4	12%	27%	43%	35%	79%	14%	10%	25%	45%	43,889
95212	Stockton	San Joaquin	CA	2.4	2	3	3	3	1	5%	10%	19%	20%	33%	4%	6%	20%	11%	7,725
95219	Stockton	San Joaquin	CA	3.0	3	2	3	3	4	3%	12%	28%	10%	41%	4%	5%	16%	43%	21,027
95222	Angels Camp	Calaveras	CA	2.8	4	3	1	4	2	11%	13%	38%	15%	13%	1%	10%	24%	29%	4,427
95236	Linden	San Joaquin	CA	3.0	4	3	3	3	2	10%	11%	47%	21%	35%	9%	12%	14%	28%	3,582
95249	San Andreas	Calaveras	CA	3.0	4	2	1	4	4	7%	22%	38%	13%	13%	1%	11%	29%	38%	3,541
95252	Valley Springs	Calaveras	CA	2.0	2	3	2	2	1	7%	9%	19%	16%	17%	1%	8%	13%	14%	12,815
95624	Elk Grove	Sacramento	CA	1.6	1	2	3	1	1	3%	3%	11%	11%	35%	2%	4%	7%	15%	46,220
95632	Galt	Sacramento	CA	2.8	3	4	3	3	1	10%	11%	30%	24%	38%	6%	9%	16%	20%	27,481
95638	Herald	Sacramento	CA	1.6	2	2	2	1	1	0%	3%	16%	12%	17%	2%	6%	5%	13%	1,723
95640	Ione	Amador	CA	3.0	3	4	3	3	2	12%	14%	26%	27%	40%	2%	3%	16%	29%	10,062
95641	Isleton	Sacramento	CA	3.8	5	4	3	4	3	6%	14%	56%	25%	38%	8%	10%	28%	29%	2,024
95642	Jackson	Amador	CA	2.2	2	2	1	3	3	10%	6%	18%	13%	11%	1%	4%	18%	33%	6,953
95690	Walnut Grove	Sacramento	CA	3.8	3	4	4	4	4	4%	17%	33%	31%	56%	16%	12%	22%	46%	2,562
95693	Wilton	Sacramento	CA	1.6	3	1	2	1	1	6%	5%	34%	8%	21%	1%	5%	7%	12%	6,150
95758	Elk Grove	Sacramento	CA	1.6	1	1	4	1	1	7%	4%	11%	8%	49%	3%	4%	7%	16%	56,731

OPPORTUNITIES

Access

Overall, in the past decade, **Lodi Memorial Hospital has done an extraordinary job of increasing access to primary-care services** on a regular basis for residents of its service area and especially for those in the area identified by the needs index as the most in need. Initially when the hospital conducted its first needs assessment in 1995, nearly five of each 10 individuals presenting themselves to the hospital emergency room reported they had no access to primary-care services on a regular basis. Now, following the hospital's opening of its network of clinics – mostly for the low and no-income residents of the hospital service area – only about one out of 10 people who present themselves to the hospital emergency room report they do not have regular access to primary-care services.

A similar pattern has developed when the hospital conducts or participates in health fairs for the uninsured and underinsured. Twelve years ago nearly 100 percent of those seeking care and information at health fairs had no access to health-care services. Today that number has been greatly reduced to about one in 10.

Cultural diversity

Increasing diversity of the U.S. population requires hospitals to address different language needs, varying cultural norms and preferences, even medical requirements. There is an opportunity for Lodi Memorial Hospital and all US hospitals to better **accommodate diversity** according to the gaps in quality care outlined in the Institute of Medicine (IOM) report Crossing the Quality Chasm (2001). A staff that reflects the ethnic makeup of its patient population is therefore a **core issue in improving quality of care**. In the 2003 IOM report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, further underscores these gaps. Race, ethnicity and language-based barriers are also related to **medical errors and patient satisfaction**. Studies have documented that adverse medical events often occur in connection with patient-provider communication problems, especially with minority patients.

Currently, the clinical staff at Lodi Memorial Hospital does not reflect the population served, and findings from the hospital's patient-satisfaction surveys (monthly telephone survey, follow-up call survey, PEP-C and needs assessment survey) reflect that via patient comments.

2003 LMH Report to EEOC

Professional staff	Female	Male	Total %
White	208	19	80%
Black	3	0	1%
Hispanic	9	3	4%
Asian	39	4	15%

Ethnicity by department, unofficial estimation by department director

	<u>Patients</u>	<u>Staff</u>
OB	White – 35% Hispanic – 50% Pakistani – 15%	White – 100%
Med/Surg	White – 75% Hispanic – 15% Pakistani – 10%	White – 90 % Asian – 10%
ICU	White – 75% Hispanic – 15% Pakistani – 10%	White – 100%
PRU	White – 70% Hispanic – 25% Pakistani – .5% Other – 4.5%	White – 89% Hispanic – 7% Pakistani – 0 Indian – 4%

Possible step to closing one gap:

1. The hospital service area’s minority populations continue to grow, while it staff does not grow in its diversity. In the hospital telephone survey conducted of inpatients and outpatients, telephone follow up calls, the PEP-C survey and in the need- assessment study, those minorities surveyed often comment that they felt their care would have been better had the hospital had care givers who spoke their language and better understood their cultural needs.

Develop a plan to **recruit and retain Spanish-speaking and Urdu-speaking nurses** and other staff.

Work with school districts and community groups to establish nursing and other clinical scholarships for students wishing to pursue medical careers at LMH.

The full 2004 Lodi Memorial Hospital Community Needs Assessment can be found on the hospital's web site, www.lodihealth.org, or by contacting the Lodi Memorial Hospital Community Development Department, 339-7535.