



# 2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Englewood Health Service Area

Prepared for  
Englewood Health



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# INTRODUCTION

# PROJECT OVERVIEW

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Englewood Health. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment for Englewood Health is part of a regional project conducted by Professional Research Consultants, Inc. (PRC) for the Community Health *Improvement* Partnership (CH/P) of Bergen County (“the Partnership”). PRC is a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

## Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

## PRC Community Health Survey

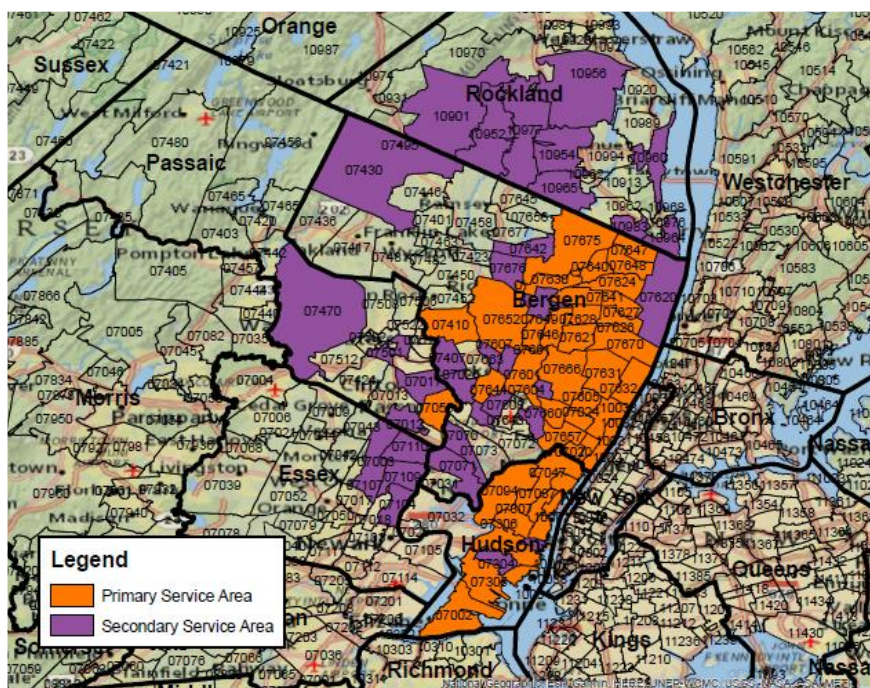
### Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by the Partnership and PRC and is similar to a previous survey used in the region in 2016, allowing for data trending.

### Community Defined for This Assessment

For Englewood Health, the community of focus (referred to as “service area” in this report) is defined as each of the residential ZIP Codes comprising the primary and secondary service areas of Englewood Health. This community definition, determined based on the ZIP Codes of residence of most recent patients, is illustrated in the following map.





## Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included targeted surveys conducted by PRC via telephone (cell phone and landline) or through online questionnaires, as well as a community outreach component promoted by the study sponsors through social media posting and other communications.

**RANDOM-SAMPLE SURVEYS (PRC)** ► For the targeted administration, PRC administered 1,156 surveys at random throughout the hospital service area.

**COMMUNITY OUTREACH SURVEYS** (Community Health *Improvement* Partnership of Bergen County)  
 ► PRC also created a link to an online version of the survey, and the Partnership promoted this link throughout the various communities in order to drive additional participation and bolster overall samples. This yielded an additional 640 surveys to the overall sample.

**In all, 1,796 surveys were completed through these mechanisms.** Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the service area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 1,796 respondents is  $\pm 2.3\%$  at the 95 percent confidence level.

## Sample Characteristics

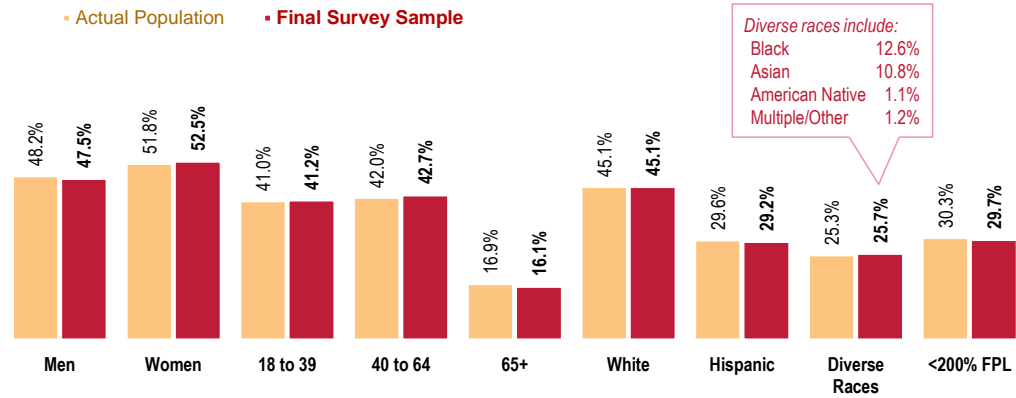
To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the service area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted



solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]

## Population & Survey Sample Characteristics (Englewood Health Service Area, 2022)



Sources: • US Census Bureau, 2011-2015 American Community Survey.  
 • 2022 PRC Community Health Survey, PRC, Inc.  
 Notes: • FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

### INCOME & RACE/ETHNICITY

**INCOME** ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2021 guidelines place the poverty threshold for a family of four at \$26,500 annual household income or lower). In sample segmentation: “very low income” refers to community members living in a household with defined poverty status; “low income” refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

**RACE & ETHNICITY** ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any race group. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).



## Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by the Community Health *Improvement* Partnership of Bergen County; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. Local stakeholders were asked to provide input about communities in Bergen County; the input also included stakeholders who work more regionally or statewide. In all, 146 community stakeholders in Bergen County took part in the Online Key Informant Survey, as outlined below:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	17
Public Health Representatives	15
Other Health Providers	39
Social Services Providers	26
Other Community Leaders	49

Final participation included representatives of the organizations outlined below.

- Academic Medical Practice
- Age-Friendly Englewood
- Age-Friendly Teaneck
- ALL Thingz AP
- Annie Clyde Holt Food Pantry
- Asian Women's Christian Association
- Balance and Thrive Counseling Center
- BC Special Services School District
- Becton Dickinson/private practice/CHIP
- Behavioral Health
- Bergen Community College
- Bergen County
- Bergen County Commissioner
- Bergen County Department of Health Services
- Bergen County Department of Health Services-Drug Prevention Alliance
- Bergen County Division of Senior Services
- Bergen Family Center
- Bergen Family Center, Southeast Senior Center for Independent Living
- Bergen New Bridge Medical Center
- Bergen Volunteer Medical Initiative
- Bergen's Promise
- Borough of Westwood
- Boys & Girls Club
- Carlstadt Health Department
- Center for Food Action
- Christian Health
- Church of the Tabernacle North Bergen
- Community Chest
- Community Health
- Community Outreach
- Comprehensive Behavioral Health Care
- Digital Voice Network





- Dwight Morrow HS
- Eastwick College
- Ebenezer Church
- Embody Wellness
- Englewood Health
- Englewood Health Department
- EZ Ride–Bike & Pedestrian
- Family Promise of Ridgewood
- Family Success Center
- Food Pantry–Fairlawn
- Franklin Lakes Recreation
- Fusion Muslim Community Center of NJ
- Galilee Church
- Garfield Public School
- Generations Counseling & Care Management
- Greater Bergen Community Action
- Hackensack Meridian
- Hackensack Meridian Health–Pascack Valley Medical Center
- Hackensack Public Schools
- Hackensack University Medical Center
- HealthBarn USA
- Holy Name
- Holy Name Cancer Community
- Holy Name Fitness
- Jewish Family and Children's Services
- Korean American Senior Citizens Association of NJ
- Korean Community Center
- K-Radio, Esther Ha Foundation
- LPM Strategies, LLC
- Maywood Health Department/Wellness
- Meadowlands Area YMCA
- Meals on Wheels Northern Jersey
- Metro Community Center/Church
- Midland Park Senior Center and Age Friendly Ridgewood
- Mount Bethel Church
- NAACP, Bergen County Chapter
- New Jersey Buddies
- Office of Concern Food Pantry
- Pascack Medical Group
- Pascack Valley Medical Center
- Pascack Valley Medical Group
- Pediatric Emergency Department
- Physicians' Practice Enhancement
- Pilgrim Church
- Presbyterian Church of Teaneck
- Renfrew Center for Eating Disorders
- Ridgecrest Apartments
- Ridgewood Public Schools
- Russell Berrie Foundation
- Saddle Brook Public Schools
- ShopRite
- Sodexo
- Teaneck Health Department
- Teaneck Recreation Department
- Teaneck Recreation Center
- The Center for Alcohol and Drug Resources
- Township of Teaneck
- Valley Home Care
- Valley Hospital
- Vantage Health System
- West Bergen Mental Healthcare
- Westwood for All Ages
- WFM Project & Construction
- Young Men's Christian Association Northern New Jersey

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.



## Focus Groups & Key Informant Interviews

To complement the survey and other findings, multiple focus groups were held throughout the county among those representing the following populations:

- African American Community Leaders
- Elder Care Providers
- EMT/First Responders
- Health Officers from Bergen County Communities
- Korean Language Speakers
- LGBTQ+ Community Members
- Mental Health and Substance Use Providers
- Latinx Community Leaders
- Youth Service Providers

In addition, a series of one-on-one interviews was also conducted with a variety of key informants.

These focus groups and interviews were conducted by 35<sup>th</sup> Street Consulting, LLC, and a summary of the findings from these research activities can be found as an appendix to this report.

## Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the service area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap ([sparkmap.org](http://sparkmap.org))
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services



- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data for the service area reflect county-level data for Bergen County, New Jersey.

## Benchmark Data

### Trending

A similar survey was administered in the service area in 2016 by PRC on behalf of the Partnership. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available (however, note that the hospital's geographic service area definition has changed slightly since the 2016 survey data were collected). Historical data for secondary data indicators in Bergen County are also included for the purposes of trending.

### Bergen County Data

Because this assessment was part of a broader, regional project conducted by the Partnership, a Bergen County benchmark for survey indicators is also available.

### New Jersey Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

### Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

### Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.



Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.



The Healthy People 2030 framework was based on recommendations made by the Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

## Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community’s health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

## Public Comment

Englewood Health made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Englewood Health had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Englewood Health will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.



# IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)		See Report Page
<b>Part V Section B Line 3a</b> A definition of the community served by the hospital facility		5
<b>Part V Section B Line 3b</b> Demographics of the community		36
<b>Part V Section B Line 3c</b> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		145
<b>Part V Section B Line 3d</b> How data was obtained		5
<b>Part V Section B Line 3e</b> The significant health needs of the community		14
<b>Part V Section B Line 3f</b> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		Addressed Throughout
<b>Part V Section B Line 3g</b> The process for identifying and prioritizing community health needs and services to meet the community health needs		15
<b>Part V Section B Line 3h</b> The process for consulting with persons representing the community's interests		7
<b>Part V Section B Line 3i</b> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		163



# SUMMARY OF FINDINGS

## Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	<ul style="list-style-type: none"> <li>▪ Barriers to Access               <ul style="list-style-type: none"> <li>– Inconvenient Office Hours</li> <li>– Cost of Physician Visits</li> <li>– Cost of Prescriptions</li> <li>– Appointment Availability</li> <li>– Finding a Physician</li> <li>– Lack of Transportation</li> </ul> </li> <li>▪ Skipping/Stretching Prescriptions</li> <li>▪ Specific Source of Ongoing Medical Care</li> </ul>
CANCER	<ul style="list-style-type: none"> <li>▪ Leading Cause of Death</li> <li>▪ Cancer Incidence               <ul style="list-style-type: none"> <li>– Including Prostate Cancer</li> </ul> </li> <li>▪ Cancer Prevalence</li> </ul>
DIABETES	<ul style="list-style-type: none"> <li>▪ Prevalence of Borderline/Pre-Diabetes</li> </ul>
HEART DISEASE & STROKE	<ul style="list-style-type: none"> <li>▪ Leading Cause of Death</li> <li>▪ High Blood Cholesterol Prevalence</li> </ul>
HOUSING	<ul style="list-style-type: none"> <li>▪ Stress About Rent/Mortgage</li> <li>▪ Housing Conditions</li> </ul>
INJURY & VIOLENCE	<ul style="list-style-type: none"> <li>▪ Unintentional Injury Deaths</li> <li>▪ Violent Crime Experience</li> <li>▪ Intimate Partner Violence</li> </ul>
MENTAL HEALTH	<ul style="list-style-type: none"> <li>▪ “Fair/Poor” Mental Health</li> <li>▪ Diagnosed Depression</li> <li>▪ Symptoms of Chronic Depression</li> <li>▪ Stress</li> <li>▪ Difficulty Obtaining Mental Health Services</li> <li>▪ Key Informants: Mental health ranked as a top concern.</li> </ul>

—continued on the following page—



## AREAS OF OPPORTUNITY (continued)

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	<ul style="list-style-type: none"> <li>▪ Food Insecurity</li> <li>▪ Difficulty Accessing Fresh Produce</li> <li>▪ Overweight &amp; Obesity [Adults]</li> <li>▪ Overweight &amp; Obesity [Children]</li> <li>▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.</li> </ul>
ORAL HEALTH	<ul style="list-style-type: none"> <li>▪ Regular Dental Care [Adults]</li> </ul>
POTENTIALLY DISABLING CONDITIONS	<ul style="list-style-type: none"> <li>▪ High-Impact Chronic Pain</li> <li>▪ Alzheimer’s Disease Deaths</li> </ul>
RESPIRATORY DISEASE	<ul style="list-style-type: none"> <li>▪ COVID-19 Deaths</li> <li>▪ Asthma Prevalence [Adults]</li> <li>▪ Asthma Prevalence [Children]</li> <li>▪ Chronic Obstructive Pulmonary Disease (COPD) Prevalence</li> </ul>
SUBSTANCE USE	<ul style="list-style-type: none"> <li>▪ Cirrhosis/Liver Disease Deaths</li> <li>▪ Unintentional Drug-Related Deaths</li> <li>▪ Illicit Drug Use</li> <li>▪ Use of Marijuana</li> <li>▪ Personally Impacted by Substance Use (Self or Other’s)</li> <li>▪ Key Informants: Substance use ranked as a top concern.</li> </ul>

### Prioritization of Health Needs

#### Key Informant Input

Prioritization of the health needs identified in this assessment (“Areas of Opportunity” above) was initially determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Substance Use
3. Nutrition, Physical Activity & Weight
4. Diabetes
5. Respiratory Diseases (including COVID-19)
6. Heart Disease & Stroke
7. Potentially Disabling Conditions
8. Cancer
9. Access to Healthcare Services
10. Oral Health
11. Injury & Violence



Not prioritized within the list above is **Housing**, which potentially impacts outcomes for all of the above.

### **Community Feedback**

On October 19, 2022, the Partnership convened an online meeting with community partners to review and discuss the findings of this assessment. At that time, it was determined to address the issues identified above within the reframed priority areas as follows, each examined for health disparities and social determinants, viewed through the lens of health equity, and addressed using a whole-person approach:

- **Healthy Minds** (e.g., behavioral health, mental health, substance use, stress)
- **Healthy Bodies** (e.g., chronic disease, prevention, and awareness)
- **Building Bridges** (e.g., housing, food insecurity, barriers to health care access)

### Hospital Implementation Strategy

Englewood Health will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.





## Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Englewood Health service area, as well as trend data. These data are grouped by health topic.

### Reading the Summary Tables

- In the following tables, service area results are shown in the larger, gray column.
- The columns to the left of the service area column provide comparisons between the two subareas, identifying differences for each as “better than” (☀️), “worse than” (🌧️), or “similar to” (☁️) the opposing area.
- The columns to the right of the service area column provide trending, as well as comparisons between local data and any available regional, state, and national findings, and Healthy People 2030 objectives. Symbols indicate whether the service area compares favorably (☀️), unfavorably (🌧️), or comparably (☁️) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

#### TREND SUMMARY

(Current vs. Baseline Data)

#### SURVEY DATA INDICATORS:













Trends for survey-derived indicators represent significant changes since 2016. Note that survey data reflect the ZIP Code-defined Englewood Health service area.























#### OTHER (SECONDARY) DATA INDICATORS:



Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).


Note that secondary data reflect county-level data.









SOCIAL DETERMINANTS	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
Linguistically Isolated Population (Percent)		
Population in Poverty (Percent)		
Children in Poverty (Percent)		
No High School Diploma (Age 25+, Percent)		
Unemployment Rate (Age 16+, Percent)		
% Unable to Pay Cash for a \$400 Emergency Expense	 24.9	 20.5
% HH Member Lost Job, Wages, Insurance Due to Pandemic	 34.7	 34.3
% Worry/Stress Over Rent/Mortgage in Past Year	 40.1	 42.3
% Unhealthy/Unsafe Housing Conditions	 20.0	 18.2
% Food Insecure	 39.7	 42.1
% Used Food Pantry/Free Meals in the Past Year	 11.4	 7.4

Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
<b>7.2</b> [County Data]		 6.3	 4.3		
<b>6.7</b> [County Data]		 10.0	 13.4	 8.0	
<b>7.4</b> [County Data]		 14.0	 18.5	 8.0	
<b>7.5</b> [County Data]		 10.2	 12.0		
<b>3.5</b> [County Data]		 3.7	 3.8		 7.7
<b>23.3</b>	 19.7		 24.6		
<b>34.6</b>	 28.5				
<b>40.8</b>	 34.2		 32.2		 37.0
<b>19.3</b>	 16.3		 12.2		
<b>40.6</b>	 28.5		 34.1		 26.0
<b>9.9</b>	 8.7				

SOCIAL DETERMINANTS (continued)	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% Have Access to High-Speed Internet Sufficient for Daily Needs	 91.2	 87.4





Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
89.8	 94.1				













OVERALL HEALTH	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% "Fair/Poor" Overall Health	 17.5	 13.2

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
15.9	 11.8	 11.7	 12.6		 13.3

Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.















 better       similar       worse

ACCESS TO HEALTH CARE	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% [Age 18-64] Lack Health Insurance	 8.9	 5.9
% Difficulty Accessing Health Care in Past Year (Composite)	 52.9	 52.4
% Cost Prevented Physician Visit in Past Year	 17.7	 17.9





















Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
7.8	 6.4	 14.1	 8.7	 7.9	 6.5
52.7	 52.2		 35.0		 42.0
17.7	 16.9	 10.5	 12.9		 18.7

ACCESS TO HEALTH CARE (continued)	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% Cost Prevented Getting Prescription in Past Year	16.1	16.8
% Difficulty Getting Appointment in Past Year	28.8	33.7
% Inconvenient Hrs Prevented Dr Visit in Past Year	26.2	30.2
% Difficulty Finding Physician in Past Year	20.0	22.6
% Transportation Hindered Dr Visit in Past Year	15.8	8.8
% Language/Culture Prevented Care in Past Year	4.4	3.0
% Skipped Prescription Doses to Save Costs	15.9	19.0
% Difficulty Getting Child's Health Care in Past Year	7.8	12.0
Primary Care Doctors per 100,000		
% Have a Specific Source of Ongoing Care	67.4	70.2
% Have Had Routine Checkup in Past Year	70.8	70.0



Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
<b>16.4</b>	13.6		12.8		11.7
<b>30.6</b>	30.7		14.5		19.4
<b>27.7</b>	23.5		12.5		18.9
<b>20.9</b>	19.8		9.4		13.8
<b>13.2</b>	10.5		8.9		7.3
<b>3.9</b>	2.5		2.8		3.3
<b>17.0</b>	15.2		12.7		11.5
<b>9.4</b>	8.8		8.0		12.1
<b>115.5</b> [County Data]		105.2	102.3		
<b>68.5</b>	71.8		74.2	84.0	69.1
<b>70.5</b>	71.4	74.4	70.5		73.8































ACCESS TO HEALTH CARE (continued)	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% Child Has Had Checkup in Past Year	 79.1	 73.2
% Two or More ER Visits in Past Year	 11.1	 11.5
% Eye Exam in Past 2 Years	 58.2	 61.1
% Have Foregone Medical Care Due to Pandemic	 29.3	 37.6
% "Seldom/Never" Understand Written Health Information	 12.7	 9.5
% "Seldom/Never" Understand Spoken Health Information	 10.7	 10.8
% Rate Local Health Care "Fair/Poor"	 11.3	 7.4

Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
<b>76.9</b>	 86.7		 77.4		 81.7
<b>11.3</b>	 9.0		 10.1		 9.9
<b>59.3</b>	 63.0		 61.0	 61.1	 63.5
<b>32.4</b>	 31.7				
<b>11.5</b>	 12.5		 13.4		 13.5
<b>10.7</b>	 8.6		 10.7		 12.8
<b>9.9</b>	 8.4		 8.0		 12.2

 better    
  similar    
  worse

CANCER	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
Cancer (Age-Adjusted Death Rate)		
Lung Cancer (Age-Adjusted Death Rate)		
Prostate Cancer (Age-Adjusted Death Rate)		
Female Breast Cancer (Age-Adjusted Death Rate)		
Colorectal Cancer (Age-Adjusted Death Rate)		
Cancer Incidence Rate (All Sites)		
Female Breast Cancer Incidence Rate		
Prostate Cancer Incidence Rate		
Lung Cancer Incidence Rate		
Colorectal Cancer Incidence Rate		
% Cancer	 10.0	 10.6

Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
<b>123.8</b> [County Data]		 137.1	 146.5	 122.7	 144.6
<b>24.4</b> [County Data]		 28.6	 33.4	 25.1	
<b>12.8</b> [County Data]		 16.2	 18.5	 16.9	
<b>17.2</b> [County Data]		 20.1	 19.4	 15.3	
<b>11.8</b> [County Data]		 12.6	 13.1	 8.9	
<b>472.8</b> [County Data]		 486.7	 448.6		
<b>142.1</b> [County Data]		 137.2	 126.8		
<b>131.1</b> [County Data]		 134.4	 106.2		
<b>48.4</b> [County Data]		 54.5	 57.3		
<b>38.3</b> [County Data]		 40.1	 38.0		
<b>10.2</b>	 10.4	 9.9	 10.0		 6.5

CANCER (continued)	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% [Women 50-74] Mammogram in Past 2 Years	75.8	85.5
% [Women 21-65] Cervical Cancer Screening	71.3	81.9
% [Age 50-75] Colorectal Cancer Screening	77.7	75.1
% [Men 40+] PSA Test in Past 2 Years	49.3	59.1

Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
79.2	82.0	78.9	76.1	77.1	74.4
75.3	76.3	80.1	73.8	84.3	74.4
76.8	77.5	71.9	77.4	74.4	73.6
53.0	64.7	33.9			





better      similar      worse

DIABETES	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
Diabetes (Age-Adjusted Death Rate)		
% Diabetes/High Blood Sugar	11.4	12.0
% Borderline/Pre-Diabetes	18.4	18.1
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	45.3	47.4



Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
13.3 [County Data]		18.2	22.6		14.9
11.6	10.9	10.0	13.8		9.3
18.3	15.6		9.7		10.9
46.1	47.4		43.3		49.7









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GAMBLING	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% Gambled in the Past Year	 31.4	 32.5
% [Those Who Gamble] Negatively Affected by Time Spent Gambling	 10.8	 4.9

Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.







Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
31.8	 27.9				
8.6	 10.7				

 better     similar     worse

HEART DISEASE & STROKE	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
Diseases of the Heart (Age-Adjusted Death Rate)		
% Heart Disease (Heart Attack, Angina, Coronary Disease)	 6.6	 7.8
Stroke (Age-Adjusted Death Rate)		
% Stroke	 5.0	 2.8
% Told Have High Blood Pressure	 37.9	 39.0
% [HBP] Taking Action to Control High Blood Pressure	 89.1	 83.8

Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
132.3 [County Data]		 162.4	 164.4	 127.4	 145.9
7.1	 7.7	 6.2	 6.1		 5.4
24.0 [County Data]		 30.6	 37.6	 33.4	 27.6
4.2	 3.0	 2.7	 4.3		 3.9
38.3	 38.3	 33.0	 36.9	 27.7	 37.3
87.1	 86.3		 84.2		 90.1












HEART DISEASE & STROKE (continued)	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% Told Have High Cholesterol	 39.2	 36.9
% [HBC] Taking Action to Control High Blood Cholesterol	 78.5	 81.6
% 1+ Cardiovascular Risk Factor	 83.7	 84.2












Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

INFANT HEALTH & FAMILY PLANNING	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
No Prenatal Care in First Trimester (Percent)		
Low Birthweight Births (Percent)		
Infant Death Rate		
Births to Adolescents Age 15 to 19 (Rate per 1,000)		





Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
38.4	 41.5		 32.7		 38.0
79.6	 83.9		 83.2		 82.2
83.9	 83.6		 84.6		 82.6


























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Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
15.2 [County Data]		 23.5	 22.3		 15.3
7.7 [County Data]		 8.0	 8.2		
3.2 [County Data]		 4.0	 5.5	 5.0	 3.9
3.8 [County Data]		 11.7	 20.9		

 better       similar       worse

INJURY & VIOLENCE	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
Unintentional Injury (Age-Adjusted Death Rate)		
Motor Vehicle Crashes (Age-Adjusted Death Rate)		
[65+] Falls (Age-Adjusted Death Rate)		
Firearm-Related Deaths (Age-Adjusted Death Rate)		
Homicide (Age-Adjusted Death Rate)		
Violent Crime Rate		
% Victim of Violent Crime in Past 5 Years	 5.2	 2.4
% Victim of Intimate Partner Violence	 13.2	 19.8



Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
<b>33.2</b> [County Data]		 49.9	 51.6	 43.2	 22.4
<b>4.4</b> [County Data]		 6.3	 11.4	 10.1	
<b>37.2</b> [County Data]		 32.1	 67.1	 63.4	
<b>2.0</b> [County Data]		 4.6	 12.5	 10.7	
<b>1.1</b> [County Data]		 3.8	 6.1	 5.5	 1.1
<b>79.9</b> [County Data]		 242.0	 416.0		
<b>4.1</b>	 3.0		 6.2		 1.9
<b>15.7</b>	 12.1		 13.7		 11.0











  
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KIDNEY DISEASE	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
Kidney Disease (Age-Adjusted Death Rate)		
% Kidney Disease	 3.7	 2.9

Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.










MENTAL HEALTH	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% "Fair/Poor" Mental Health	 21.0	 27.0
% Diagnosed Depression	 20.5	 25.2
% Symptoms of Chronic Depression (2+ Years)	 37.8	 44.8
% Typical Day Is "Extremely/Very" Stressful	 17.0	 21.1
% Mental Health Has Worsened During Pandemic	 22.8	 24.2
Suicide (Age-Adjusted Death Rate)		

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
11.2 [County Data]		 14.3	 12.8		 11.8
3.4	 2.7	 2.6	 5.0		 3.1
					
	better	similar	worse		







Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
23.3	 21.9		 13.4		 11.4
22.2	 23.2	 15.2	 20.6		 11.3
40.4	 38.4		 30.3		 30.6
18.5	 18.0		 16.1		 13.3
23.3	 27.7				
7.9 [County Data]		 7.8	 13.9	 12.8	 6.9










MENTAL HEALTH (continued)	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
Mental Health Providers per 100,000		
% Taking Rx/Receiving Mental Health Trtmt	 13.6	 16.4
% Unable to Get Mental Health Svcs in Past Yr	 9.4	 12.8
% [Age 5-17] Child Has Been Diagnosed w/ Mental Issue	 17.0	 23.5

















Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
<b>118.8</b> [County Data]		 103.9	 124.9		
<b>14.6</b>	 19.1		 16.8		 13.1
<b>10.6</b>	 9.7		 7.8		 6.2
<b>19.4</b>	 22.9				

































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NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
Population With Low Food Access (Percent)		
% "Very/Somewhat" Difficult to Buy Fresh Produce	 24.1	 26.5
% 5+ Servings of Fruits/Vegetables per Day	 27.7	 32.4
% Use Food Labels to Make Purchasing Decisions	 71.9	 77.6

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
<b>10.3</b> [County Data]		 23.8	 22.2		
<b>25.1</b>	 22.0		 21.1		 20.1
<b>29.5</b>	 28.1		 32.7		 26.4
<b>74.0</b>	 71.3				

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% No Leisure-Time Physical Activity	 26.7	 27.7
% Meeting Physical Activity Guidelines	 23.2	 30.6
3+ Hours of Screen Time for Entertainment	 60.4	 55.4
% Child [Age 2-17] Physically Active 1+ Hours per Day	 31.4	 40.1
Recreation/Fitness Facilities per 100,000		
% Overweight (BMI 25+)	 63.2	 59.2
% Obese (BMI 30+)	 33.6	 28.4
% Children [Age 5-17] Overweight (85th Percentile)	 39.0	 25.5
% Children [Age 5-17] Obese (95th Percentile)	 29.2	 18.3

Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
27.1	 23.0	 21.0	 31.3	 21.2	 26.2
26.0	 28.5	 21.9	 21.4	 28.4	 25.1
58.5	 57.9				
34.7	 36.5		 33.0		 43.1
24.6 [County Data]		 17.7	 12.2		
61.7	 60.9	 64.6	 61.0		 58.6
31.6	 27.7	 27.7	 31.3	 36.0	 22.0
33.8	 32.4		 32.3		 35.9
25.0	 19.8		 16.0	 15.5	 22.7



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similar



worse

ORAL HEALTH	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% Have Dental Insurance	73.6	70.9
% [Age 18+] Dental Visit in Past Year	60.7	59.0
% Child [Age 2-17] Dental Visit in Past Year	73.4	68.9

Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
72.6	73.2		68.7	59.8	68.5
60.1	68.3	68.1	62.0	45.0	68.6
71.7	83.8		72.1	45.0	67.5











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POTENTIALLY DISABLING CONDITIONS	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% 3+ Chronic Conditions	34.7	37.8
% Activity Limitations	23.5	24.0
% With High-Impact Chronic Pain	18.0	16.5
Alzheimer's Disease (Age-Adjusted Death Rate)		
% Caregiver to a Friend/Family Member	23.0	26.4

























Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
35.9	35.6		32.5		
23.7	23.2		24.0		21.6
17.5	14.7		14.1	7.0	
22.8 [County Data]		22.2	30.9		14.2
24.3	25.8		22.6		22.5

better      similar      worse

RESPIRATORY DISEASE	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
CLRD (Age-Adjusted Death Rate)		
Pneumonia/Influenza (Age-Adjusted Death Rate)		
% [Age 65+] Flu Vaccine in Past Year	 85.0	 78.0
COVID-19 (Age-Adjusted Death Rate)		
% Vaccinated for COVID-19	 85.6	 78.3
% [Adult] Asthma	 12.7	 15.0
% [Child 0-17] Asthma	 7.7	 10.8
% COPD (Lung Disease)	 9.8	 8.0





Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.









Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
<b>20.1</b> [County Data]		 26.4	 38.1		 22.6
<b>10.4</b> [County Data]		 12.5	 13.4		 11.3
<b>82.3</b>	 85.0	 64.5	 71.0		 53.5
<b>146.3</b> [County Data]		 141.6	 85.0		
<b>82.9</b>	 88.1				
<b>13.6</b>	 11.3	 8.7	 12.9		 9.8
<b>8.9</b>	 10.1		 7.8		 3.5
<b>9.1</b>	 7.6	 4.9	 6.4		 8.7

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  similar     
  worse















SEXUAL HEALTH	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
HIV/AIDS (Age-Adjusted Death Rate)		
HIV Prevalence Rate		
Chlamydia Incidence Rate		
Gonorrhea Incidence Rate		

Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.











SUBSTANCE USE	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)		
% Excessive Drinker	 23.9	 17.0
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)		
% Illicit Drug Use in Past Month	 4.5	 3.1

Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
<b>0.7</b> [County Data]		 2.3	 1.8		
<b>220.8</b> [County Data]		 464.4	 372.8		
<b>246.4</b> [County Data]		 405.5	 539.9		
<b>46.8</b> [County Data]		 100.7	 179.1		












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Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
<b>6.2</b> [County Data]		 8.4	 11.9	 10.9	 5.0
<b>21.3</b>	 21.7	 17.6	 27.2		 27.1
<b>17.1</b> [County Data]		 31.0	 21.0		 7.6
<b>4.0</b>	 3.8		 2.0	 12.0	




















SUBSTANCE USE (continued)	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% Used Marijuana in the Past Year	 17.3	 20.6
% Used a Prescription Opioid in Past Year	 8.6	 7.2
% Member of HH Treated for Rx Addiction	 6.6	 11.5
% Ever Sought Help for Alcohol or Drug Problem	 5.9	 3.8
% Personally Impacted by Substance Use	 34.2	 34.9



Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
18.5	 17.8				 7.5
8.0	 10.0		 12.9		
8.4	 7.8				
5.1	 4.0		 5.4		 2.7
34.9	 35.2		 35.8		 29.0








 better     similar     worse

TOBACCO USE	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% Current Smoker	 11.7	 10.3
% Someone Smokes at Home	 12.2	 11.5
% [Household With Children] Someone Smokes in the Home	 16.7	 11.4

Service Area	SERVICE AREA vs. BENCHMARKS				TREND
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	
11.2	 11.6	 10.8	 17.4	 5.0	 10.9
11.9	 10.4		 14.6		 11.9
14.7	 12.5		 17.4		 12.3

TOBACCO USE (continued)	DISPARITY BETWEEN SUBAREAS	
	PSA	SSA
% [Smokers] Received Advice to Quit Smoking	71.9	72.1
% Currently Use Vaping Products	 9.5	 6.8

Note: In the section above, each subarea is compared against the opposing area. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Service Area	SERVICE AREA vs. BENCHMARKS				
	vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
72.0	 64.6		 59.6	 66.6	 81.1
8.5	 8.0	 5.0	 8.9		

 better     
  similar     
  worse



# DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

# COMMUNITY CHARACTERISTICS

## Population Characteristics

### Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density. [COUNTY-LEVEL DATA]

**Total Population**  
(Estimated Population, 2016-2020)

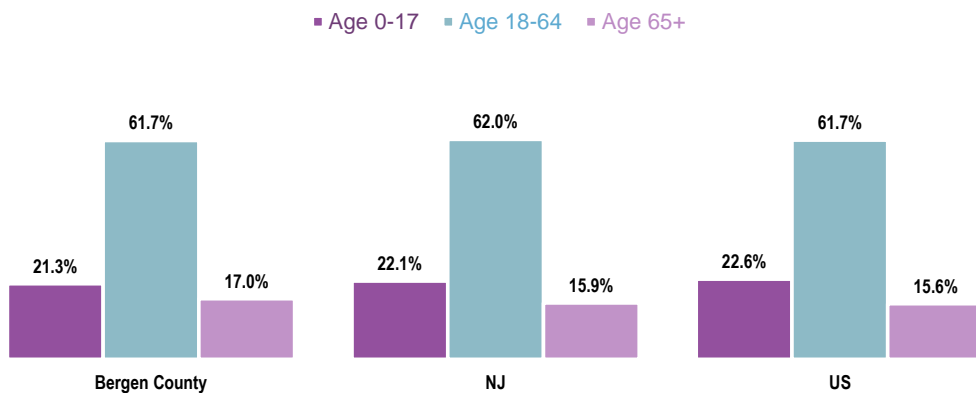
	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Bergen County	930,390	232.79	3,997
NJ	8,885,418	7,354.76	1,208
US	326,569,308	3,533,038.14	92

Sources:   
 • US Census Bureau American Community Survey 5-year estimates.   
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved June 2022 via SparkMap (sparkmap.org).

### Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum. [COUNTY-LEVEL DATA]

**Total Population by Age Groups**  
(2015-2019)



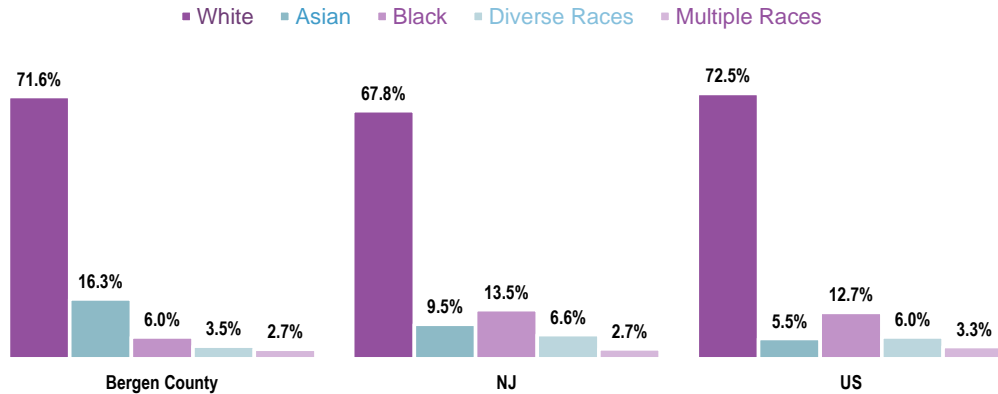
Sources:   
 • US Census Bureau American Community Survey 5-year estimates.   
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).



## Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race. [COUNTY-LEVEL DATA]

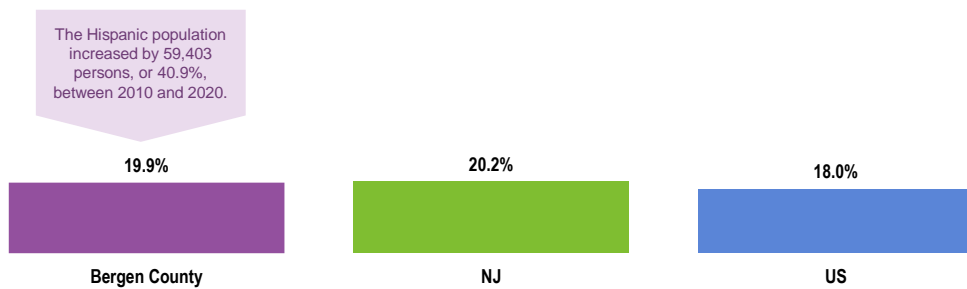
### Total Population by Race Alone (2015-2019)



Sources: 

- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

### Hispanic Population (2015-2019)



Sources: 

- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).

  
 Notes: 

- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.



# Social Determinants of Health

## ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (<https://health.gov/healthypeople>)

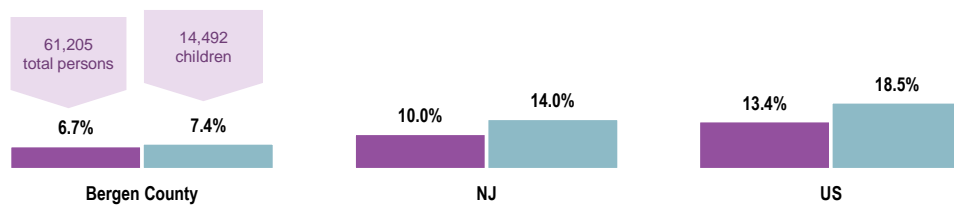
## Income & Poverty

### Poverty

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]

**Population in Poverty**  
(Populations Living Below the Poverty Level; 2015-2019)  
Healthy People 2030 = 8.0% or Lower

■ Total Population ■ Children



Sources: 

- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap ([sparkmap.org](http://sparkmap.org)).
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: 

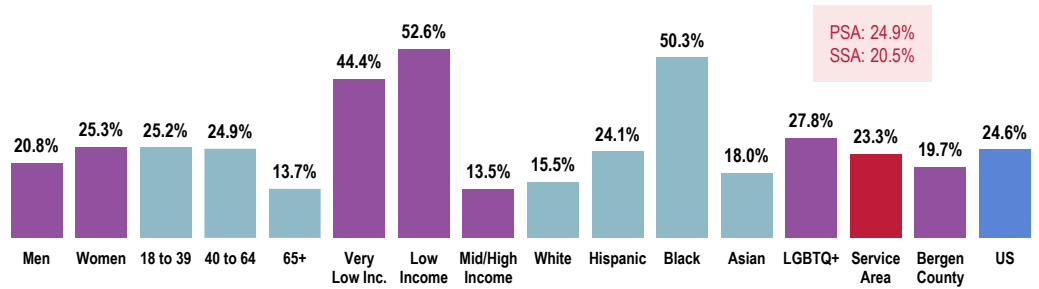
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.



## Financial Resilience

“Suppose that you have an emergency expense that costs \$400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?”

### Do Not Have Cash on Hand to Cover a \$400 Emergency Expense (Englewood Health Service Area, 2022)



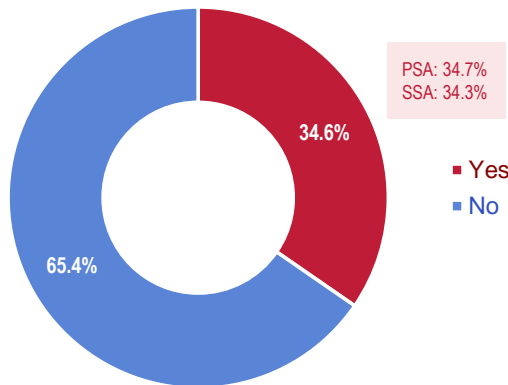
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 63]  
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.  
• Includes respondents who say they would not be able to pay for a \$400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

## Pandemic Impact

“Has the coronavirus pandemic cause you or any other adult in your household to lose a job, work fewer hours than wanted or needed, or led to a loss of health insurance coverage?”

### Household Member has Lost a Job, Hours/Wages, or Health Insurance as a Result of the Pandemic (Englewood Health Service Area, 2022)



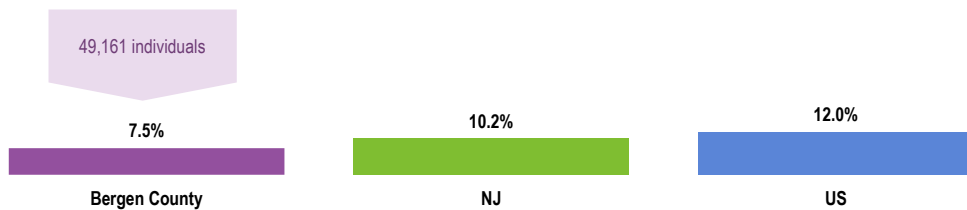
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 315]  
Notes: • Asked of all respondents.



## Education

Education levels are reflected in the proportion of our population without a high school diploma. [COUNTY-LEVEL DATA]

### Population With No High School Diploma (Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



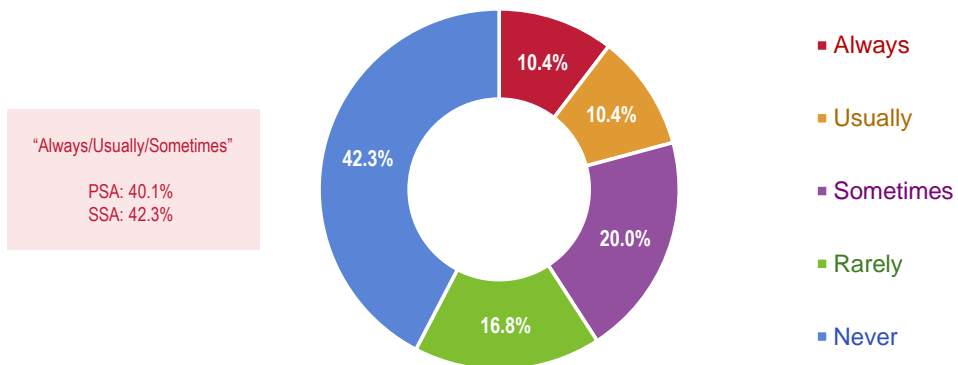
Sources: • US Census Bureau American Community Survey 5-year estimates.  
 • Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).  
 Notes: • This indicator is relevant because educational attainment is linked to positive health outcomes.

## Housing

### Housing Insecurity

**“In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?”**

### Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year (Englewood Health Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 66]  
 Notes: • Asked of all respondents.

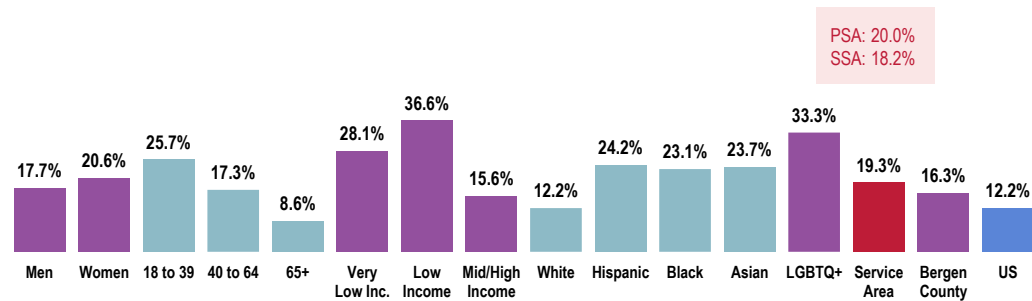




## Unhealthy or Unsafe Housing

“Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?”

### Unhealthy or Unsafe Housing Conditions in the Past Year (Englewood Health Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 65]  
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.  
• Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

## Food Insecurity

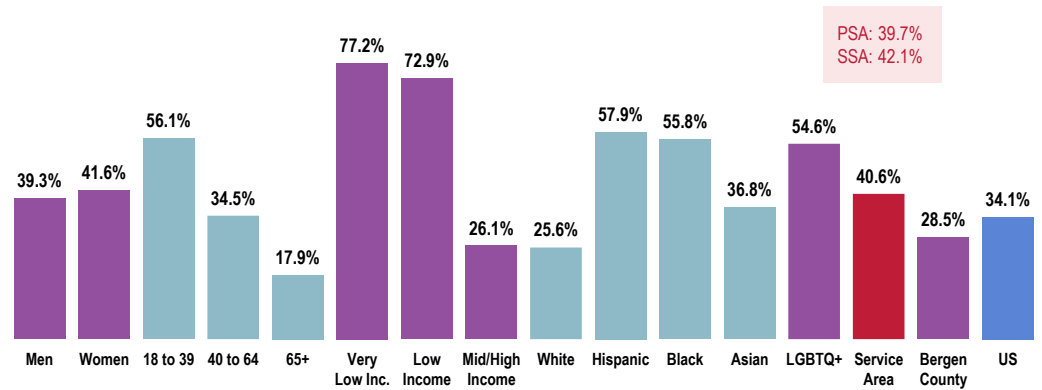
“Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was ‘often true,’ ‘sometimes true,’ or ‘never true’ for you in the past 12 months.

- ‘I worried about whether our food would run out before we got money to buy more.’
- ‘The food that we bought just did not last, and we did not have money to get more.’”

Agreement with either or both of these statements (“often true” or “sometimes true”) defines food insecurity for respondents.



## Food Insecurity (Englewood Health Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 112]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 • Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

### Use of Food Pantries and Free Meals

**“During the past 12 months, have you gone to a food pantry or received free meals provided by a charitable organization?”**

### Visited a Food Pantry or Received Free Meals in the Past Year



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 309]  
 Notes: • Asked of all respondents.



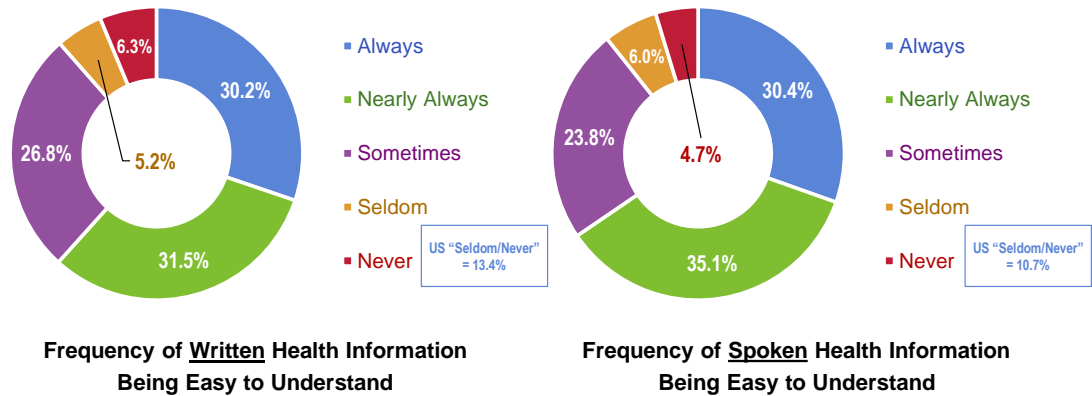
## Health Literacy

Health information is on the internet, in newspapers and magazines, at the doctor's office, in clinics, and many other places.

“How often is health information written in a way that is easy for you to understand?”

“How often is health information spoken in a way that is easy for you to understand?”

### Health Literacy (Englewood Health Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 305-306]  
• 2020 PRC National Health Survey, PRC, Inc.

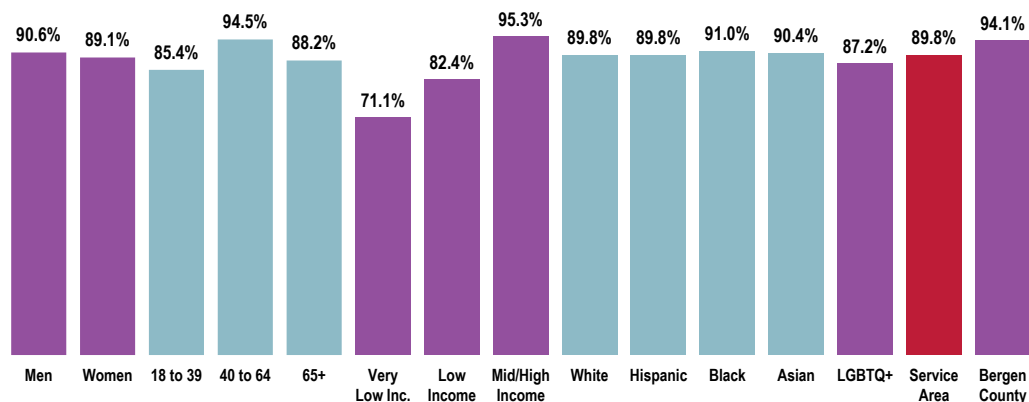
Notes: • Asked of all respondents.

## Internet Access

“Do you currently have access to high-speed internet that is sufficient for your daily needs?”

**RELATED ISSUE**  
See *Physical Activity* in the **Modifiable Health Risks** section of this report for data on Screen Time for Entertainment among adults.

### Have High-Speed Internet Sufficient for Daily Needs (Englewood Health Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 311]  
Notes: • Asked of all respondents.

PSA: 91.2%  
SSA: 87.4%



## Key Informant Input: Social Determinants of Health

The following quote was in response to an online question about problems in the community:

### Lack of Affordable Housing

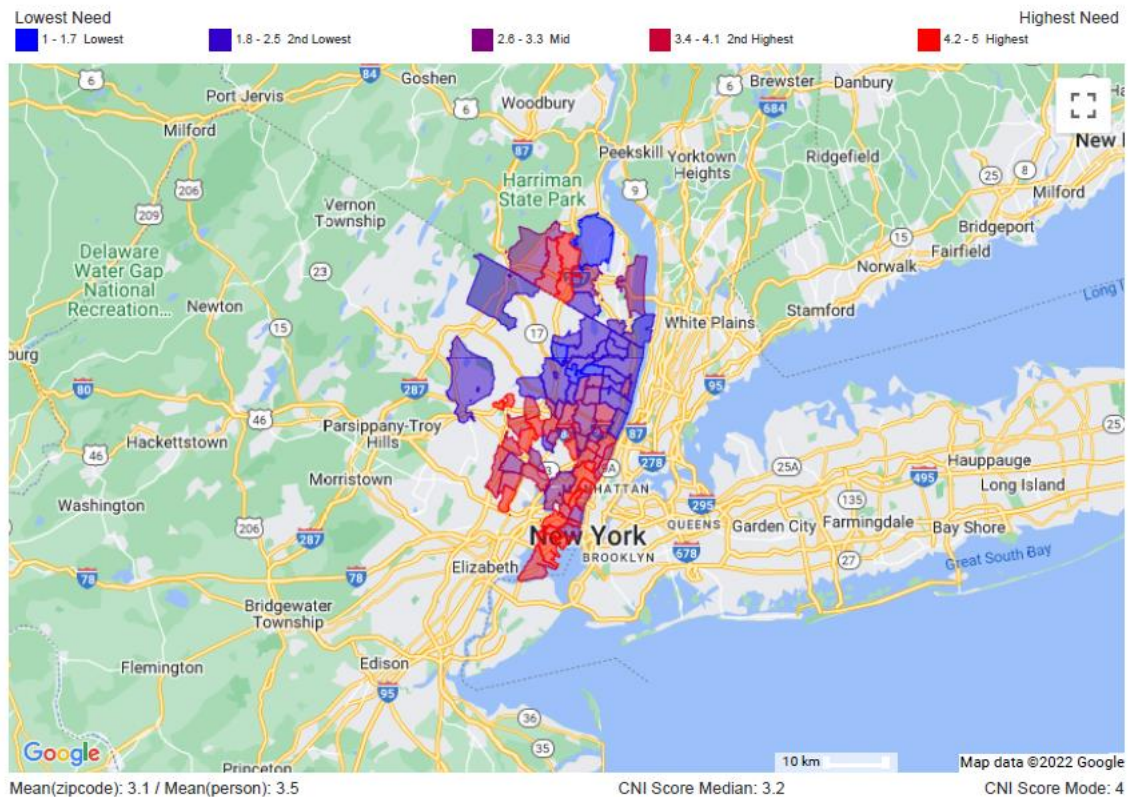
Lack of affordable housing. Having a stable place to live is imperative for good mental and physical health. – Social Services Provider

## High-Need Areas

In 2004, Dignity Health and IBM Watson Health™ jointly developed a Community Need Index (“CNI”) to assist in the process of gathering vital socio-economic factors in the community.

Based on demographic and economic statistics, the CNI provides a score for every populated ZIP code in the United States on a scale of 1.0 to 5.0. The CNI score is an average of five different barrier scores that measure various socio-economic indicators. 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 compared to the US national average (score of 3.0).

The CNI is strongly linked to variations in community healthcare needs and is a good indicator of a community’s demand for a range of healthcare services.



ZIP Code-specific CNI scores are outlined below.

Zip Code	CNI Score	Population	City	County	State
07002	4	64658	Bayonne	Hudson	New Jersey
07003	3.4	48223	Bloomfield	Essex	New Jersey
07010	3.8	25043	Cliffside Park	Bergen	New Jersey
07011	4	39836	Clifton	Passaic	New Jersey
07012	3.6	11283	Clifton	Passaic	New Jersey
07020	3.6	14526	Edgewater	Bergen	New Jersey
07022	4.4	14364	Fairview	Bergen	New Jersey
07024	3.6	37438	Fort Lee	Bergen	New Jersey
07026	4.2	30631	Garfield	Bergen	New Jersey
07030	3	56105	Hoboken	Hudson	New Jersey
07047	4.4	64011	North Bergen	Hudson	New Jersey
07055	4.8	69729	Passaic	Passaic	New Jersey
07070	2.6	18313	Rutherford	Bergen	New Jersey
07071	3.4	21641	Lyndhurst	Bergen	New Jersey
07075	2.4	9571	Wood Ridge	Bergen	New Jersey
07086	4	13762	Weehawken	Hudson	New Jersey
07087	4.6	67916	Union City	Hudson	New Jersey
07093	4.6	63844	West New York	Hudson	New Jersey
07094	3.2	19430	Secaucus	Hudson	New Jersey
07104	4.8	52981	Newark	Essex	New Jersey
07109	3.8	35410	Belleville	Essex	New Jersey
07110	3	29217	Nutley	Essex	New Jersey
07302	3.2	47099	Jersey City	Hudson	New Jersey
07304	4.6	44249	Jersey City	Hudson	New Jersey
07305	4.4	62895	Jersey City	Hudson	New Jersey
07306	4.4	54165	Jersey City	Hudson	New Jersey
07307	4	43724	Jersey City	Hudson	New Jersey
07310	3.8	15247	Jersey City	Hudson	New Jersey
07407	3.6	20161	Elmwood Park	Bergen	New Jersey
07410	2	33289	Fair Lawn	Bergen	New Jersey
07430	2.2	26781	Mahwah	Bergen	New Jersey
07470	2	51164	Wayne	Passaic	New Jersey
07501	4.8	33864	Paterson	Passaic	New Jersey
07601	4	45606	Hackensack	Bergen	New Jersey
07603	3.6	7897	Bogota	Bergen	New Jersey
07604	2.6	11926	Hasbrouck Heights	Bergen	New Jersey
07605	3.2	9034	Leonia	Bergen	New Jersey
07607	2.8	9642	Maywood	Bergen	New Jersey
07620	2.6	1605	Alpine	Bergen	New Jersey
07621	3.2	27862	Bergenfield	Bergen	New Jersey
07624	2.2	8624	Closter	Bergen	New Jersey
07626	2.2	9353	Cresskill	Bergen	New Jersey
07627	1.8	5052	Demarest	Bergen	New Jersey
07628	3	17049	Dumont	Bergen	New Jersey
07630	2.2	7615	Emerson	Bergen	New Jersey
07631	4	27718	Englewood	Bergen	New Jersey
07632	1.8	5214	Englewood Cliffs	Bergen	New Jersey
07640	2	4688	Harrington Park	Bergen	New Jersey
07641	1.6	3383	Haworth	Bergen	New Jersey
07642	1.8	10293	Hillsdale	Bergen	New Jersey
07643	4.2	10650	Little Ferry	Bergen	New Jersey
07644	4	24780	Lodi	Bergen	New Jersey
07646	2.8	16519	New Milford	Bergen	New Jersey
07647	2.4	5581	Northvale	Bergen	New Jersey
07648	2.2	5602	Norwood	Bergen	New Jersey
07649	1.6	7998	Oradell	Bergen	New Jersey
07650	3.8	20605	Palisades Park	Bergen	New Jersey
07652	1.8	27556	Paramus	Bergen	New Jersey
07657	3.4	11631	Ridgefield	Bergen	New Jersey
07660	3.2	12640	Ridgefield Park	Bergen	New Jersey
07661	2.4	11312	River Edge	Bergen	New Jersey
07662	3	5638	Rochelle Park	Bergen	New Jersey
07666	2.6	41105	Teaneck	Bergen	New Jersey
07670	2.2	14720	Tenafly	Bergen	New Jersey
07675	2	26807	Westwood	Bergen	New Jersey
07676	1.4	9108	Township Of Washington	Bergen	New Jersey
10901	2.6	24305	Suffern	Rockland	New York
10952	3.4	43634	Monsey	Rockland	New York
10954	2.8	23496	Nanuet	Rockland	New York
10956	1.6	31350	New City	Rockland	New York
10960	2.6	15120	Nyack	Rockland	New York
10964	2.4	1378	Palisades	Rockland	New York
10965	2	15180	Pearl River	Rockland	New York
10977	4.4	65780	Spring Valley	Rockland	New York
10983	2	5605	Tappan	Rockland	New York

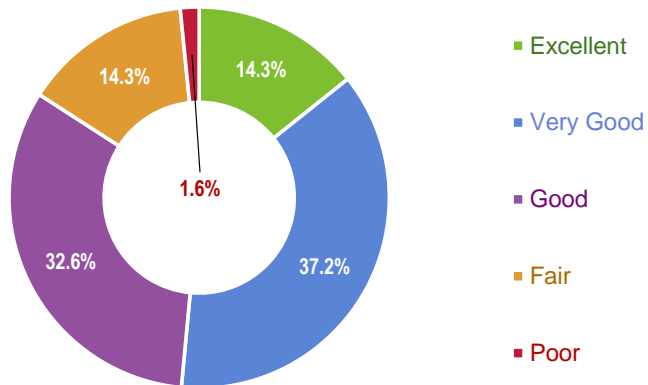


# HEALTH STATUS

## Overall Health

“Would you say that in general your health is: excellent, very good, good, fair, or poor?”

Self-Reported Health Status  
(Englewood Health Service Area, 2022)

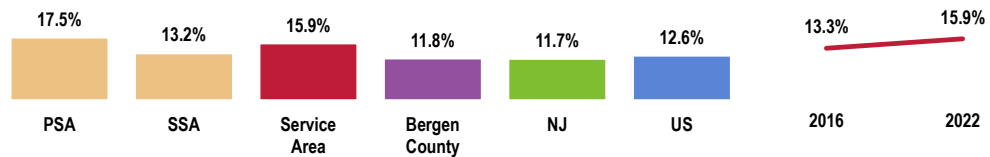


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]  
Notes: • Asked of all respondents.

The following charts further detail “fair/poor” overall health responses in the service area in comparison to benchmark data, as well as by basic demographic characteristics (namely by sex, age groupings, income [based on poverty status], race/ethnicity, and LGBTQ+ identity).

## Experience “Fair” or “Poor” Overall Health

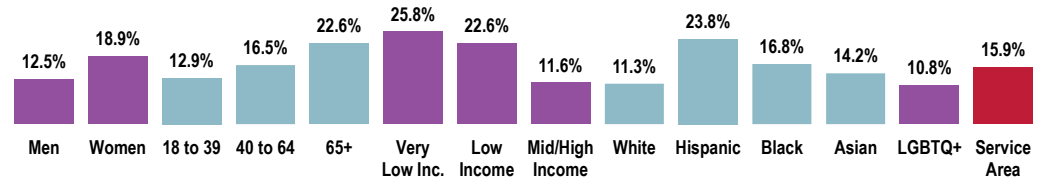
Englewood Health Service Area



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2021 New Jersey data.  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.



## Experience “Fair” or “Poor” Overall Health (Englewood Health Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]  
 Notes: • Asked of all respondents.



# Mental Health

## ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. ...Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

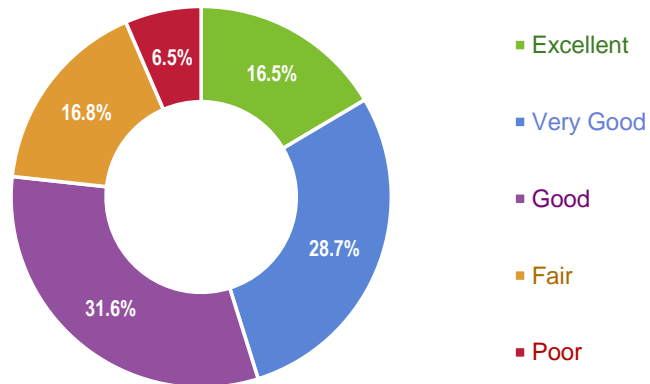
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Mental Health Status

### Self-Reported Mental Health Status

**“Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?”**

Self-Reported Mental Health Status  
(Englewood Health Service Area, 2022)



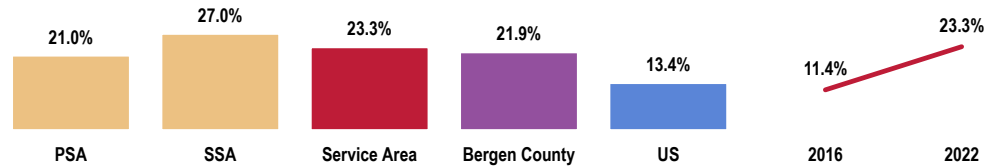
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 90]  
Notes: • Asked of all respondents.





## Experience “Fair” or “Poor” Mental Health

Englewood Health Service Area

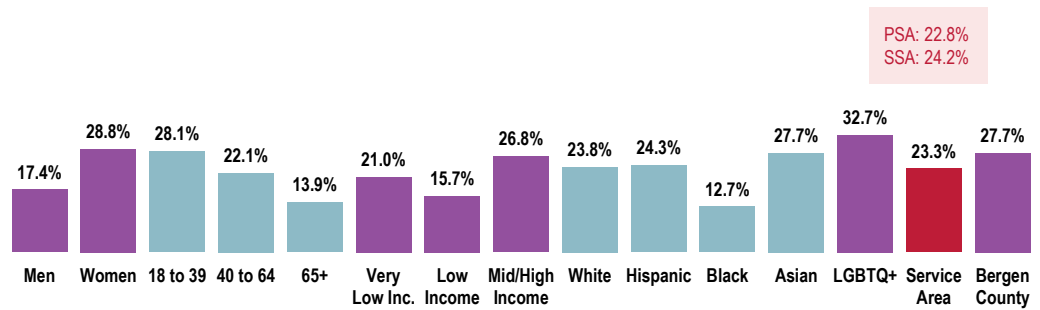


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 90]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.

## Impact of the Pandemic on Mental Health

“Since the start of the pandemic, would you say or mental health has: improved, stayed about the same, or become worse?”

### Mental Health Has Gotten Worse Since the Beginning of the Pandemic (Englewood Health Service Area, 2022)



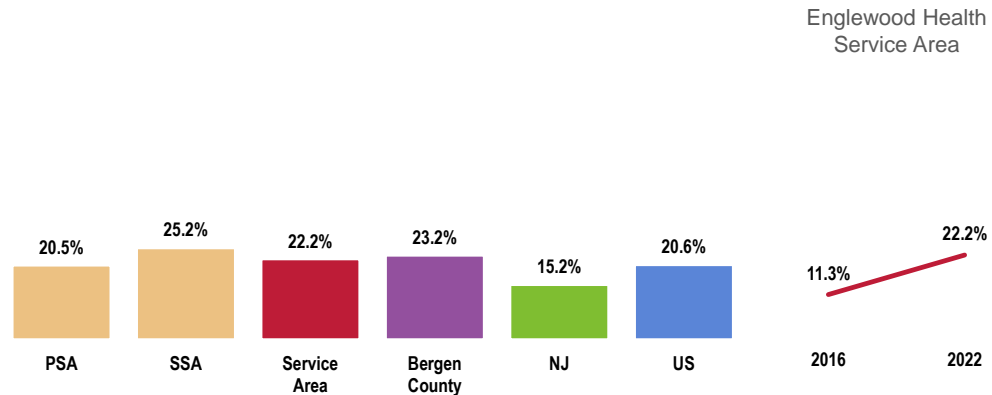
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 314]  
 Notes: • Asked of all respondents.  
 • Beginning of pandemic specified as March 2020.



## Depression

**DIAGNOSED DEPRESSION** ▶ “Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

### Have Been Diagnosed With a Depressive Disorder

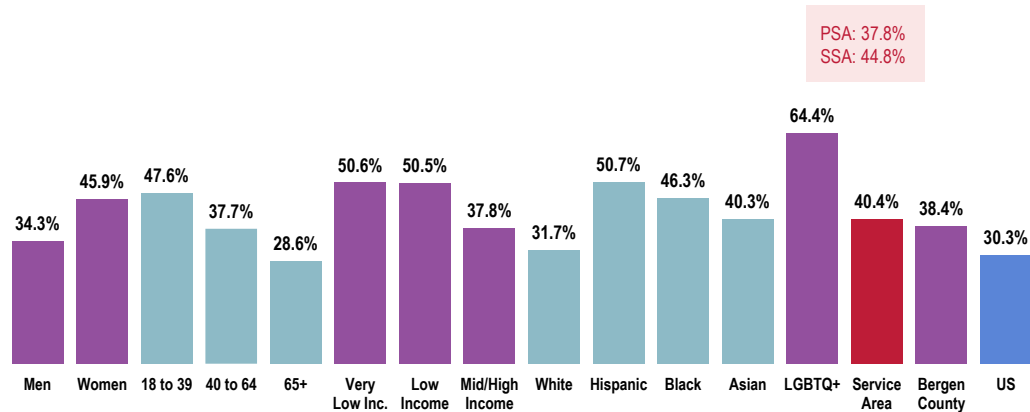


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 93]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.  
 • Depressive disorders include depression, major depression, dysthymia, or minor depression.

**SYMPTOMS OF CHRONIC DEPRESSION** ▶ “Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?”

### Have Experienced Symptoms of Chronic Depression (Englewood Health Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 91]  
 • 2020 PRC National Health Survey, PRC, Inc.

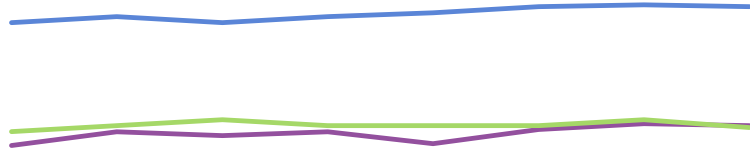
Notes: • Asked of all respondents.  
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.



## Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population (refer to “Leading Causes of Death” for an explanation of the use of age-adjusting for these rates). [COUNTY-LEVEL DATA]

**Suicide: Age-Adjusted Mortality Trends**  
(Annual Average Deaths per 100,000 Population)  
Healthy People 2030 = 12.8 or Lower



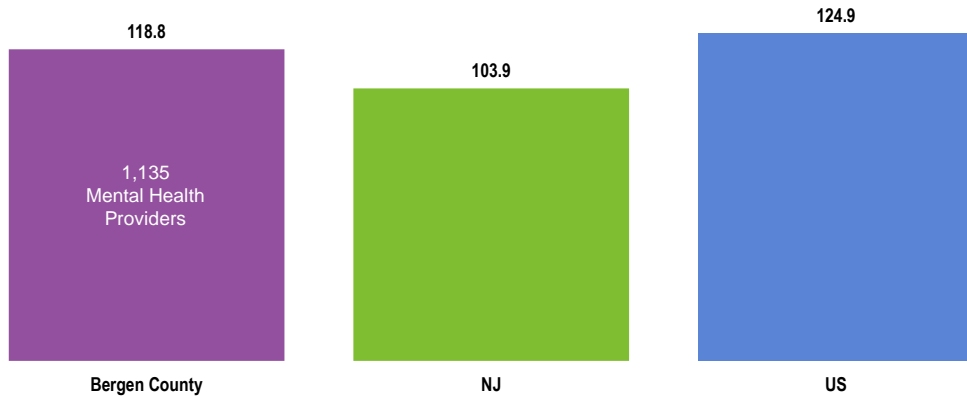
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Bergen County	6.9	7.6	7.4	7.6	7.0	7.7	8.0	7.9
NJ	7.6	7.9	8.2	7.9	7.9	7.9	8.2	7.8
US	13.1	13.4	13.1	13.4	13.6	13.9	14.0	13.9

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

## Mental Health Treatment

The following chart outlines access to mental health providers, expressed as the number of providers per 100,000 residents. [COUNTY-LEVEL DATA]

**Access to Mental Health Providers**  
(Number of Mental Health Providers per 100,000 Population, 2021)



Sources: • University of Wisconsin Population Health Institute, County Health Rankings.  
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap ([sparkmap.org](http://sparkmap.org)).  
Notes: • This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Here, “mental health providers” includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in and residents living within Bergen County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

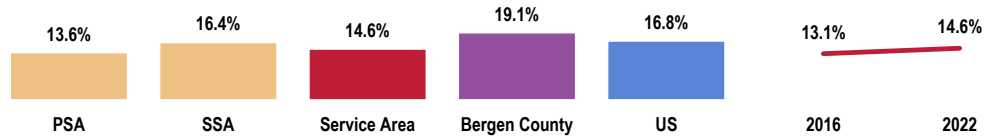


“Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?”

### Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 52.5% are currently receiving treatment.

Englewood Health Service Area

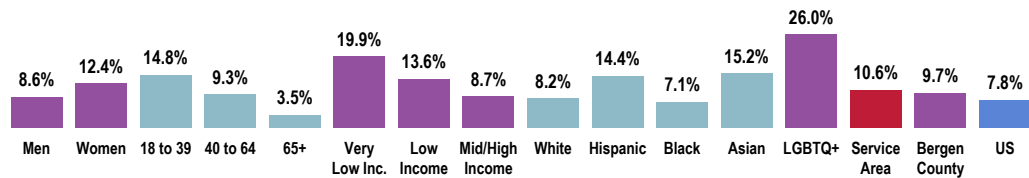


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 93-94]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 • “Treatment” can include taking medications for mental health.

“Was there a time in the past 12 months when you needed mental health services but were not able to get them?”

### Unable to Get Mental Health Services When Needed in the Past Year (Englewood Health Service Area, 2022)

PSA: 9.4%  
 SSA: 12.8%



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 95]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.



## Child’s Mental, Emotional, and Behavioral Health

[Age 5-17] “Has this child ever suffered from or been diagnosed with any type of mental, emotional, or behavioral health issue, such as depression, anxiety, ADHD, etc.?”

### Child Has Been Diagnosed with a Mental, Emotional, or Behavioral Issue (Parents of a Child Age 5-17)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 319]  
Notes: • Asked of all respondents.

## Key Informant Input: Mental Health

The following chart outlines key informants’ perceptions of the severity of *Mental Health* as a problem in the community:

### Perceptions of Mental Health as a Problem in the Community (Key Informants, 2022)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, PRC, Inc.  
Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

#### Access to Care/Services

Services for youth 3-17 with special needs and/or co-occurring medical conditions, organizations/agencies not accepting insurance coverage. Private, Medicaid, availability of culturally competent practitioners, transportation challenges. – Social Services Provider

Access, health literacy. – Community/Business Leader

They are not adequate services for victims of trauma and abuse... Complex PTSD is prevalent but kept secret. Not enough knowledge that they are trained therapist to deal with trauma and PTSD it’s not every therapist is qualified or trained... They need to refer and not just take on patience to make money – Other Healthcare Provider



Just not enough resources in an emergency. Hard to access help, many insurances do not cover. Stigma. – Social Services Provider

Access to care, stigma, diagnosis. – Community/Business Leader

Lack of resources and poor post diagnostic follow up. COVID-19 has exacerbated behavioral and mental health issues. Lack of resources. – Community/Business Leader

Access to services to manage their mental health and to learn coping strategies. – Other Healthcare Provider

Access to care. Stigma associated with the illness. Lack of mental health literacy – people experiencing challenges lack the awareness of mental health signs and symptoms therefore don't associate their challenges with mental health hence do not seek support/treatment. Suicide – the # of lives lost to suicide and people who attempt suicide warrant a public health crisis just like COVID. The Dept of Ed's policies need to be transformed to incorporate mental health education into every subject from K-12: 1x only education 1x/year is ineffective. Lack of awareness of resources – the 2-1-1 system that is funded by the state with the intent of serving as a single point of access to resources has not been and continues to be ineffective. Mental health program names are confusing/unclear. Family/child mental health urgent care/resource center is needed. Specialized supportive housing is needed. Seamless connections and coordination of care is lacking=people don't get coordinated care – Social Services Provider

Lack of access to mental health supports. Every long wait times for mental health supports. Mental health staff shortages. Not enough culturally competent practitioners/inability to provide services in other languages. Cost. – Social Services Provider

Access to counseling and treatment, education. – Public Health Representative

Access and stigma of gaining access. – Community/Business Leader

Accessing and finding appropriate resources. Waiting time to be seen by professionals. – Other Healthcare Provider

Access to care that's not a clinic setting. It seems any doctor that you would want to bring your family to are generally out of network and don't take health insurance. Other options are more clinic situation which seem to be a volume practice. – Physician

Lack of services and affordability. – Community/Business Leader

Inadequate mental health inpatient & outpatient facilities, insufficient psychologists, long waiting lists. Insufficient child/adolescent psychiatrist & neuropsychiatrists. Inadequate housing for people with combined mental health & housing issues. Inadequate mental health services for people without housing. Inadequate addiction services. – Physician

There are not enough IOP's or long-term involuntary beds for people in crisis, especially children. There are not enough therapists that take insurance. – Other Healthcare Provider

Lack of Mental Health services at the local Health Departments. – Public Health Representative

Lack of mental health facilities for the I/DD population. Lack of services for eating disorders, especially for youth. – Social Services Provider

Access to care for both psychotherapy and psychiatric care. – Physician

Hard to find services to support adults and pediatric mental health concerns. – Other Healthcare Provider

Waitlists for treatment as long as eight months. Psychiatrists who don't take insurance. Lack of Medicaid providers. The entire system is backlogged, from Outpatient to Day Programs to hospitals. – Social Services Provider

Access. – Community/Business Leader

Lack of timely access and coverage. – Other Healthcare Provider

Access to care. – Public Health Representative

## Denial/Stigma

The stigma surrounding mental health outreach. As an African American many sad misconceptions about mental health issues keep many in the black and brown communities from seeking the much-needed help they should be receiving. More seminars and educational info is needed to educate those communities to let them know mental health is nothing to be ashamed of and certainly getting help is a courageous and respectable thing to do. – Community/Business Leader

There is still a huge stigma about getting help. And not enough resources. – Other Healthcare Provider

Discrimination, Denial, Lack of education, Lack of support services for clients and family members. People with mental illnesses should receive treatment and support and should not become part of the penal system. Family members often find it exhausting and frustrating to deal with a family member with a mental illness. If there are financial issues, it is even less likely that the person in need of treatment will be able to receive that treatment. Sometimes families move away leaving their family member on his own out of frustration. – Community/Business Leader



Mental health has become a large issue not just in Bergen County but across the nation. I believe the biggest challenge for people is overcoming the stigma that is attached to mental health issues. Someone that is suffering from mental issues can be perceived as "crazy" or unstable causing them to not receive a job offer or be socially accepted. There are also limited therapists that accept insurance or are affordable to those that do not have insurance. Because of the limited covered services, many people go untreated which causes their issues to escalate and become so overwhelming, they are not able to function in society. – Other Healthcare Provider

Acknowledgement that there is an issue, access to care and support, stigma. The pandemic has markedly increased mental health issues. – Other Healthcare Provider

Stigma with reaching out for supports and the lack of supports out there. – Social Services Provider

The stigma of having mental health issues and the accessibility of mental health services. – Community/Business Leader

Shame and discomfort around asking for help. – Social Services Provider

One of the biggest challenges continues to be the stigma, talking about mental health, admitting one is struggling or has a family member who is, and accepting it as an illness that needs attention and often one from which someone can recover or at least live with. – Social Services Provider

Even before COVID, there are an overwhelming amount of mental health issues not only in adults but more so in youth. The stigma attached to acknowledging there is an issue with yourself or a loved one is the first hurdle to jump over. Many are not ready to do that because of the fear of judgement. With the pandemic, youth are experiencing high levels of anxiety. They cannot express themselves and are holding it all in. – Public Health Representative

The stigma that you are weak if you need help, especially among males. – Community/Business Leader

I see stigma associated with issues of mental health to be the biggest issue facing people today. This is especially true in minority communities. In addition, too many people do not realize or accept that positive life events can also lead to a mental health crisis--such as postpartum depression or anxiety. – Community/Business Leader

I think people try to hide their mental health issues. They also try to avoid taking medication due to stigma or due to side effects. – Physician

## Affordable Care/Services

Affordable providers, most are out of pocket payments. Education and prevention programs needed at a younger age. – Other Healthcare Provider

Complete lack of affordable resources, lack of resources in general. Available resources overburdened. Lack of inpatient beds. Deficiencies in pediatric and adolescent care and lack of resources. – Other Healthcare Provider

Access to affordable mental health services. – Other Healthcare Provider

Access to professionals can be costly and finding the right doctor can be challenging. I'm concerned that people with depression may give up trying to find the right doctor. – Public Health Representative

Access to affordable quality care. – Community/Business Leader

## Due to COVID-19

COVID caused significant mental health problems with people of all ages, especially teens and children. – Community/Business Leader

COVID 19 and the severe isolation that brought on among residents in the community. – Social Services Provider

The COVID-19 pandemic has had a tremendous impact on the mental-wellness of NJ residents of all ages. Though the physical health impact seen during the past two + years is widely known and continues to be experienced by many, the long-term outcome of the pandemic will certainly show that the impact on mental health is even greater. Statistics already show increased and steadily increasing levels of anxiety, depression, and substance misuse, especially including among those without a prior history of these symptoms. We expect to see that impact continue to manifest itself and increase for years to come. That view is already widely held among health-care providers in NJ and beyond. – Community/Business Leader

I think the pandemic has had a significant impact on the mental health of many, but in particular older residents who may be suffering from social isolation and loneliness. For the past two years many have had to be isolated, particularly if they were at high-risk for COVID and even now many do not feel comfortable being out in public even if they are fully vaccinated and boosted. There is also a stigma still attached to mental illness which may be inhibiting many from being able to seek support or counseling services. – Community/Business Leader

## Incidence/Prevalence

Depression and anxiety are frequently diagnosed within our facility as well as others. Data shows it has increased in terms of primary diagnosis within the last six years. – Other Healthcare Provider

High rates of depression, psychosis, and suicidality. – Physician



This is a really big issue in my community. As with other diseases, especially for mental health, language is very important, but there are very few psychiatrists who can speak Korean. A professional with a medical background is absolutely necessary, not a social worker or counselor. Currently, many people are suffering from this mental health in the Korean community. – Community/Business Leader

## Lack of Providers

Scarcity of mental health providers. Overuse of Emergency Departments for non-emergency mental health needs. Gaps in insurance coverage; exceptional scarcity of providers who accept Medicaid. – Other Healthcare Provider

Not enough providers, especially prescribers. Not enough housing and resource options. Difficult to access services, especially if you're working poor. – Social Services Provider

Lack of providers, wait lists, lack of specialists. Neuropsychology, substance abuse counseling, marriage, and family. – Other Healthcare Provider

## Access to Care for Uninsured/Underinsured

Accessing service if uninsured. Appointments can be expensive, requiring multiple visits. Less reimbursement for mental health related appointments as they are "out of network". Looking for drugs to deal with issues. Drug dependency. – Other Healthcare Provider

Access to services when they do not have private insurance. – Community/Business Leader

## Diagnosis/Treatment

Seeking help/insurance/financial. – Other Healthcare Provider

Those with mental health issues are not given real therapy and services. Mental health in this country is ignored until someone acts out and the answer is to throw them in jail, which does not help either. – Other Healthcare Provider

## Insurance Issues

Insurance limitations often restrict length of stay. New Bridge Medical has the most beds, but Holy Name and Hackensack have Psychiatric Units. However, housing, and intermediate support are sorely lacking. – Community/Business Leader

Developing a therapeutic alliance with an outpatient psychiatrist, especially so for children and adolescents. The biggest barriers are high deductibles, copays, burdensome arbitrary managed care requirements and shady practices by insurance companies purposely designed to stop individuals from getting treatment (i.e. costing the insurance company money this quarter). I myself was sued sent to collections by the hospital that my own family member works for, for a bill that I didn't know existed before the collectors started calling. Why? Because somebody, somewhere misspelled my name by one letter and my insurance provider denied payment. Am I expected to believe that with all my insurance information, my social security number and entire medical record, the insurance company or hospital could not possibly have connected those dots? Fraud has been institutionalized in health care and instead of going after the perpetrators we are putting pressure on physicians. – Physician

## Alcohol/Drug Use

Substance abuse and depression and anxiety. – Community/Business Leader

Drugs, functional alcoholism, depression, child suicide attempts. – Other Healthcare Provider

## Co-Occurrences

Significant increase in mental health conditions as a result of COVID. – Other Healthcare Provider

Anxiety and depression. – Community/Business Leader

## Suicide Rates

Suicide, anxiety, and depression are very high and the backlog for students and adults to access services is extremely long. – Community/Business Leader

Suicidal ideation. Post-Pandemic trauma depression and anxiety. – Social Services Provider

## Isolation

Many are faced with isolation, depression, loneliness, and anxiety. It has been a challenge to get services with the lack of available clinicians. – Social Services Provider

Isolation and loneliness is a major cause of depression and other mental health issues. – Community/Business Leader





## Awareness/Education

Lack of basic knowledge on mental health. What, why and how to cope with the disease, in addition to social stigma against the disease. – Community/Business Leader

## Access for Medicare/Medicaid Patients

Lack of providers taking Medicaid and uninsured patients to address mental health care. – Social Services Provider

## Follow-Up/Support

Finding support and a consistent provider. For the uninsured or the underinsured, finding counseling or psychiatric services can be difficult to navigate, even when an individual is ready to come forward and seek help. – Public Health Representative

## Funding

Lack of funding for programs that do provide help. Barriers to programs, accessible housing, mental health advocacy. – Social Services Provider

## Impact on Families

When people have mental health issues, the caregiver needs to take care the client for 24 hours a day. It means that the caregiver's quality of living can be dropped due to the client's health issues. – Community/Business Leader

## Impact on Quality of Life

They have an issue dealing with everyday problems. – Other Healthcare Provider  
Time, energy, finances, stigma. – Other Healthcare Provider

## Language Barrier

Little or no access to care especially for patients with limited English proficiency. – Physician

## Prevention/Screenings

Mental health should be screened at every medical visit and attended to. Most patients do not know resources unless they present with an extreme condition. – Physician

## Social Isolation

Social Isolation. – Social Services Provider

## Stress

Stress and anxiety are big issues. – Social Services Provider

## Anxiety

Anxiety. – Physician

## Geriatric Care

Geriatric mental health. – Physician

## Lack of Sleep

Lack of sleep. – Community/Business Leader



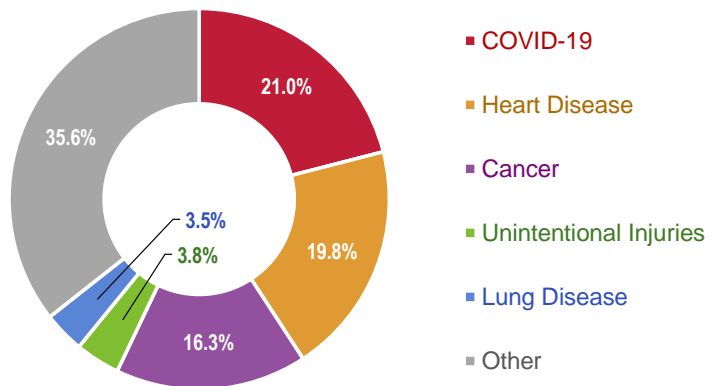
# DEATH, DISEASE & CHRONIC CONDITIONS

## Leading Causes of Death

### Distribution of Deaths by Cause

COVID-19, heart disease, and cancers are the leading causes of death in the community. [COUNTY-LEVEL DATA]

Leading Causes of Death  
(Bergen County, 2018-2020)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.  
Notes: • Lung disease is CLRD, or chronic lower respiratory disease.

## Age-Adjusted Death Rates for Selected Causes

### AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, New Jersey and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.



For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the service area. [COUNTY-LEVEL DATA]

### Age-Adjusted Death Rates for Selected Causes (2018-2020 Deaths per 100,000 Population)

	Bergen County	NJ	US	HP2030
<b>COVID-19 [2020]</b>	146.3	141.6	85.0	—
<b>Diseases of the Heart</b>	132.3	162.4	164.4	127.4*
<b>Malignant Neoplasms (Cancers)</b>	123.8	137.1	146.5	122.7
<b>Falls [Age 65+]</b>	37.2	32.1	67.1	63.4
<b>Unintentional Injuries</b>	33.2	49.9	51.6	43.2
<b>Cerebrovascular Disease (Stroke)</b>	24.0	30.6	37.6	33.4
<b>Alzheimer's Disease</b>	22.8	22.2	30.9	—
<b>Chronic Lower Respiratory Disease (CLRD)</b>	20.1	26.4	38.1	—
<b>Unintentional Drug-Related Deaths</b>	17.1	31.0	21.0	—
<b>Diabetes</b>	13.3	18.2	22.6	—
<b>Kidney Disease</b>	11.2	14.3	12.8	—
<b>Pneumonia/Influenza</b>	10.4	12.5	13.4	—
<b>Intentional Self-Harm (Suicide)</b>	7.9	7.8	13.9	12.8
<b>Cirrhosis/Liver Disease</b>	6.2	8.4	11.9	10.9
<b>Motor Vehicle Deaths</b>	4.4	6.3	11.4	10.1
<b>Firearm-Related</b>	2.0	4.6	12.5	10.7
<b>Homicide/Legal Intervention</b>	1.1	3.8	6.1	5.5
<b>HIV/AIDS [2011-2020]</b>	0.7	2.3	1.8	—

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>.

Note: • \*The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.



# Cardiovascular Disease

## ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. ...Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (<https://health.gov/healthypeople>)

## Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]

### Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
— Bergen County	145.9	143.9	143.0	139.7	138.2	135.3	133.7	132.3
— NJ	172.2	169.3	167.7	165.9	164.6	163.3	161.1	162.4
— US	190.6	188.9	168.9	167.5	166.3	164.7	163.4	164.4

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

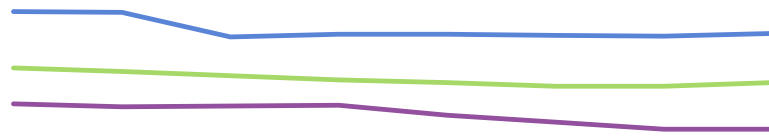
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: • The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.



## Stroke: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Bergen County	27.6	27.2	27.3	27.4	26.0	25.0	24.0	24.0
NJ	32.7	32.2	31.6	31.0	30.6	30.1	30.1	30.6
US	40.7	40.6	37.1	37.5	37.5	37.3	37.2	37.6

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.  
● US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

## Prevalence of Heart Disease & Stroke

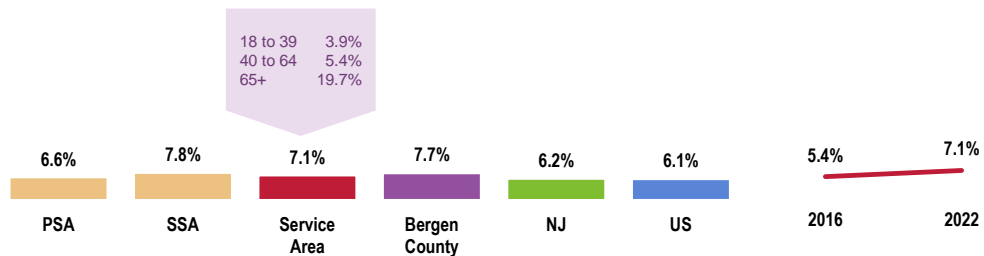
“Has a doctor, nurse, or other health professional ever told you that you had:

- A heart attack, also called a myocardial infarction?
- Angina or coronary heart disease?”

Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.

## Prevalence of Heart Disease

Englewood Health  
Service Area



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 114]  
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
● 2020 PRC National Health Survey, PRC, Inc.

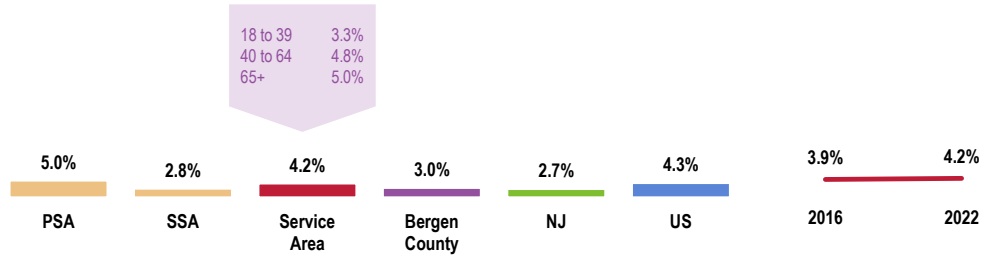
Notes: ● Asked of all respondents.  
● Includes diagnoses of heart attack, angina, or coronary heart disease.



“Has a doctor, nurse, or other health professional ever told you that you had a stroke?”

## Prevalence of Stroke

Englewood Health  
Service Area



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 29]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

## Cardiovascular Risk Factors

### Blood Pressure & Cholesterol

“Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?”

[Adults with high blood pressure] “Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?”

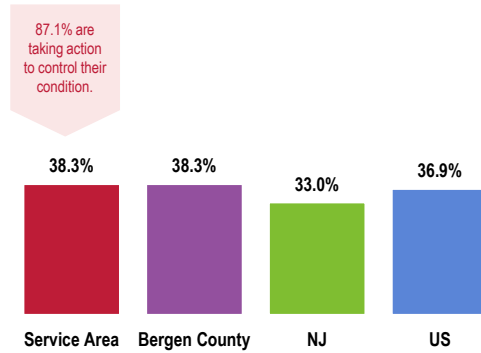
“Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?”

[Adults with high cholesterol] “Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?”

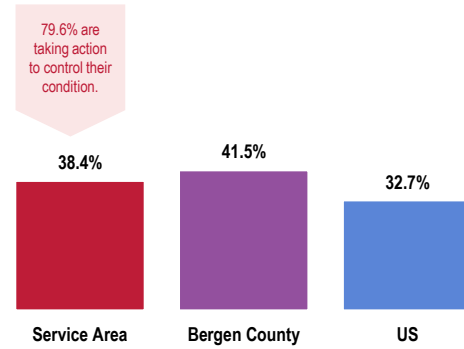


## Prevalence of High Blood Pressure

Healthy People 2030 = 27.7% or Lower



## Prevalence of High Blood Cholesterol

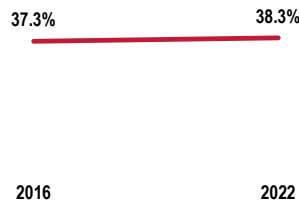


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36, 301-302]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

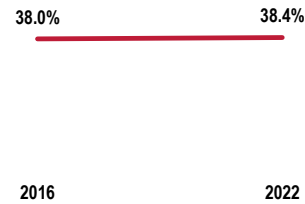
Notes: • Asked of all respondents.

## Prevalence of High Blood Pressure (Englewood Health Service Area)

Healthy People 2030 = 27.7% or Lower



## Prevalence of High Blood Cholesterol (Englewood Health Service Area)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36]  
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.



## Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

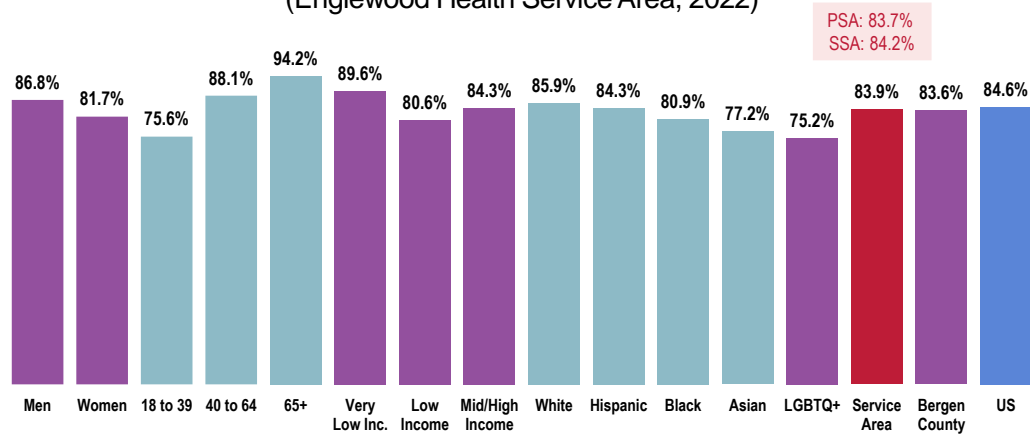
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

The following chart reflects the percentage of adults in the service area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

**RELATED ISSUE**  
See also *Nutrition, Physical Activity & Weight and Tobacco Use* in the **Modifiable Health Risks** section of this report.

**Present One or More Cardiovascular Risks or Behaviors**  
(Englewood Health Service Area, 2022)

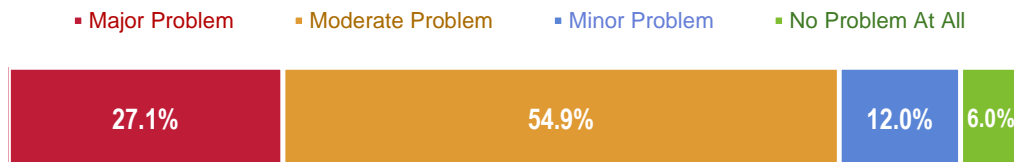


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 115]  
Notes: • Reflects all respondents.  
• Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

## Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

**Perceptions of Heart Disease and Stroke**  
**as a Problem in the Community**  
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.  
Notes: • Asked of all respondents.





Among those rating this issue as a “major problem,” reasons related to the following:

### Incidence/Prevalence

- High prevalence of stroke diagnoses. – Physician
- Women's risk of heart disease is increasing, and the aftermath of a stroke can leave a person disabled. – Public Health Representative
- Hearing more about it lately and know a few people who have died recently in the community. – Community/Business Leader
- Still so many patients have CAD and PVD. It is sometimes shocking how bad the leg swelling is on patients and how far they will let it go without getting care. – Physician
- Common diagnosis. – Community/Business Leader
- There are pockets of spaces in our community where heart disease and stroke are still of great concern. – Other Healthcare Provider
- Many clients that I sit down with for nutrition counseling suffer from hypertension and high cholesterol. – Other Healthcare Provider
- Prevalence rate is very high. – Community/Business Leader
- Cases of hypertension are high in number. – Public Health Representative
- The increased incidence proves that these are major problems. – Other Healthcare Provider

### Awareness/Education

- Awareness of lifestyle choices. – Other Healthcare Provider
- Lack of information about how to prevent and address. – Community/Business Leader
- High blood pressure. People in my community are under educated about the side effects of high blood pressure. – Community/Business Leader
- Because people do not pay attention to warning signs. We don't pay enough attention to nutrition and exercise. – Community/Business Leader
- Lack of awareness and lack of affordable lifestyle programs. – Other Healthcare Provider

### Nutrition

- Lack ongoing Outpatient Nutrition care to support lifestyle changes to improve outcomes. – Public Health Representative
- Access to heart healthy diet, education, exercise, transportation to doctor's visits. – Public Health Representative

### Lifestyle

- Heart attack is a major cause of death. Lifestyle choices make heart disease and/or stroke a probability. – Community/Business Leader
- It's a problem in all communities. Our lifestyles lend itself to developing these issues. – Social Services Provider

### Obesity

- The community in general are overweight and not active as much as other areas of the country. – Community/Business Leader
- I see a major increase in obesity and sedentary lifestyle and heart disease is a natural byproduct of that. – Physician

### Vulnerable Populations

- BC has a number of historically underserved populations. These groups were disproportionately challenged by heart disease. – Community/Business Leader
- There are specific population such as the Latin X and Black communities that have increase numbers of people who are not aware of their risks for heart disease and stroke. Lack of education, lifestyle, medication compliant, and altogether lack resources. – Community/Business Leader

### Access to Care/Services

- When they have heart disease and stroke as their major problems, they have less access to the daily activity than normal healthy adults. It could be the major issue that the patience have less access to daily living activity. – Community/Business Leader



## Comorbidities

More than 50% of our residents have diabetes that is not well controlled which leads to heart disease and stroke. Not having access to healthy food options and not being able to afford gym memberships. – Social Services Provider

## Co-Occurrences

These are complications of uncontrolled chronic diseases and downstream effects of poor access to health care earlier in life. – Physician

## Diagnosis/Treatment

For underserved populations, high blood pressure and hypertension are under diagnosed and under treated making the likelihood of a stroke higher. Despite taking medication, there is not enough focus on shifting lifestyle thus making treatment less effective for underserved populations taking medications. Obesity and under activity are issues across black, Hispanic and the elderly. – Social Services Provider

## Disease Management

These chronic conditions require ongoing care and monitoring. People who are uninsured don't have access to care. – Other Healthcare Provider

# Cancer

## ABOUT CANCER

Cancer is the second leading cause of death in the United States. ...The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (<https://health.gov/healthypeople>)



## Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in the service area. [COUNTY-LEVEL DATA]

**Cancer: Age-Adjusted Mortality Trends**  
(Annual Average Deaths per 100,000 Population)  
Healthy People 2030 = 122.7 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
— Bergen County	144.6	142.3	139.6	138.5	135.5	133.0	128.0	123.8
— NJ	160.8	157.5	154.4	152.2	148.4	145.2	140.8	137.1
— US	171.5	168.0	160.1	157.6	155.6	152.5	149.3	146.5

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Lung cancer is the leading cause of cancer deaths in the service area. [COUNTY-LEVEL DATA]

**Age-Adjusted Cancer Death Rates by Site**  
(2018-2020 Annual Average Deaths per 100,000 Population)

	Bergen County	New Jersey	US	HP2030
<b>ALL CANCERS</b>	<b>123.8</b>	<b>137.1</b>	<b>146.5</b>	<b>122.7</b>
<b>Lung Cancer</b>	<b>24.4</b>	<b>28.6</b>	<b>33.4</b>	<b>25.1</b>
<b>Female Breast Cancer</b>	<b>17.2</b>	<b>20.1</b>	<b>19.4</b>	<b>15.3</b>
<b>Prostate Cancer</b>	<b>12.8</b>	<b>16.2</b>	<b>18.5</b>	<b>16.9</b>
<b>Colorectal Cancer</b>	<b>11.8</b>	<b>12.6</b>	<b>13.1</b>	<b>8.9</b>

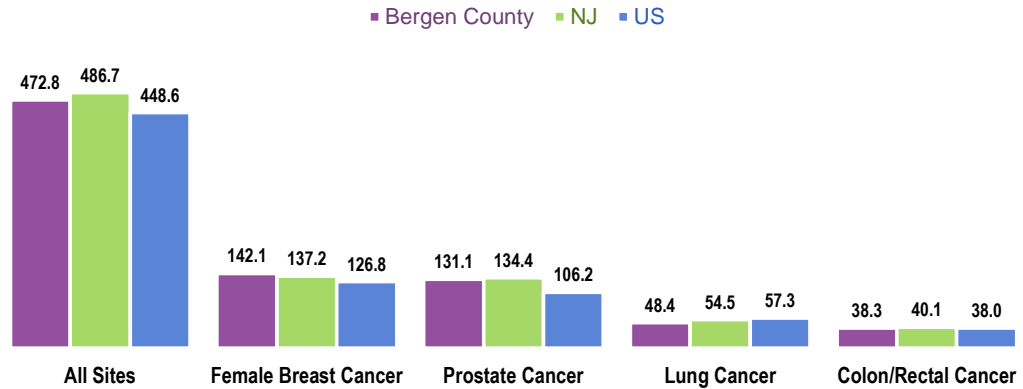
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>



## Cancer Incidence

“Incidence rate” or “case rate” is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]

**Cancer Incidence Rates by Site**  
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2014-2018)



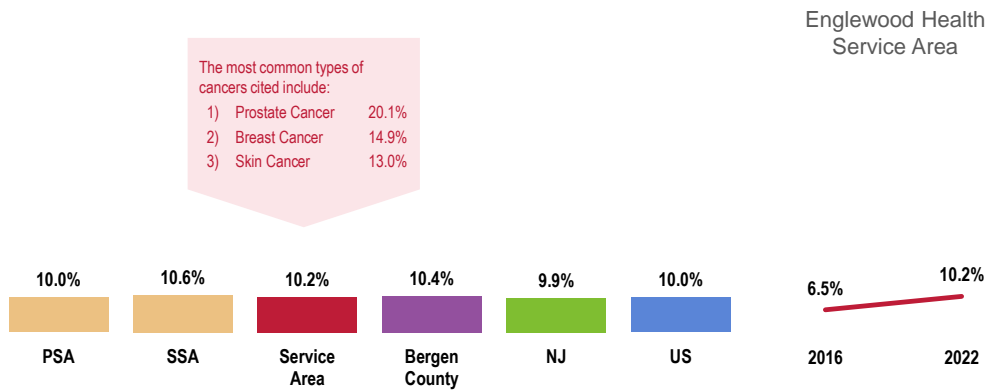
Sources: • State Cancer Profiles.  
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).  
Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

## Prevalence of Cancer

“Have you ever suffered from or been diagnosed with cancer?”

“Which type of cancer were you diagnosed with?” (If more than one past diagnosis, respondent was asked about the most recent.)

### Prevalence of Cancer



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 25-26]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Reflects all respondents.



RELATED ISSUE  
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

## ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
  - According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

## Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

### FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

### CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

### PROSTATE CANCER

The US Preventive Services Task Force (USPSTF) recommends that the decision to be screened for prostate cancer should be an individual one for men age 55 to 69 years. The USPSTF recommends against PSA-based screening in men age 70 and older.

### COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.



Screening levels in the community were measured in the PRC Community Health Survey relative to four cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); colorectal cancer (sigmoidoscopy and fecal occult blood testing); and prostate cancer (PSA).

**BREAST CANCER SCREENING** ▶ “A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?”

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

**CERVICAL CANCER SCREENING** ▶ “A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?”

“Appropriate cervical cancer screening” includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.

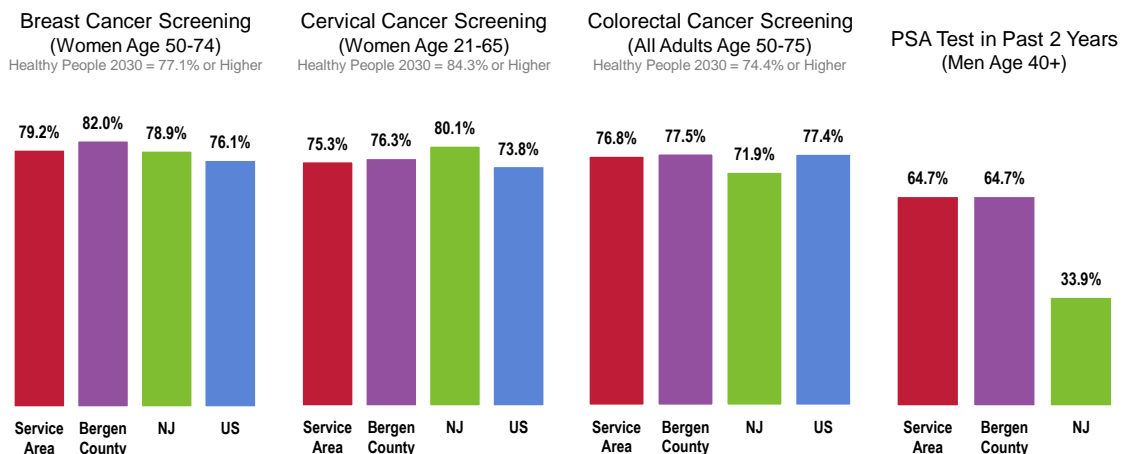
**COLORECTAL CANCER SCREENING** ▶ “Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?”

“A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?”

“Appropriate colorectal cancer screening” is calculated here among men and women age 50 to 75 years who have had a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

**PROSTATE CANCER SCREENING** ▶ “A prostate-specific antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. How long has it been since you had your last PSA test?”

“Prostate cancer screening” is calculated here among men age 40 and older who indicate screening within the past 2 years.



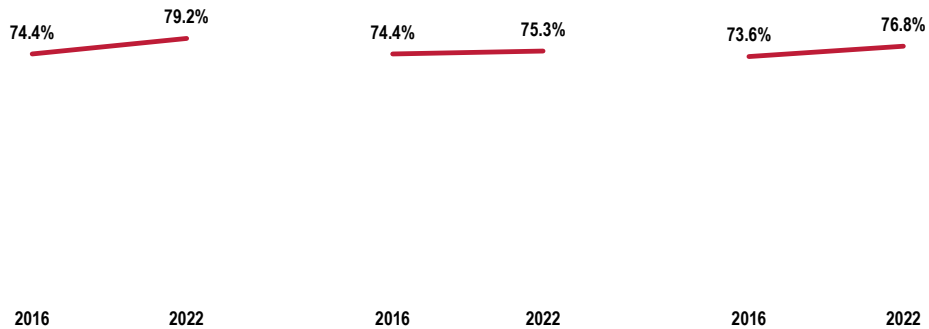
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 116-118, 157]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>  
 Notes: • Each indicator is shown among the gender and/or age group specified.



**Breast Cancer Screening**  
(Women Age 50-74)  
Healthy People 2030 = 77.1% or Higher

**Cervical Cancer Screening**  
(Women Age 21-65)  
Healthy People 2030 = 84.3% or Higher

**Colorectal Cancer Screening**  
(All Adults Age 50-75)  
Healthy People 2030 = 74.4% or Higher

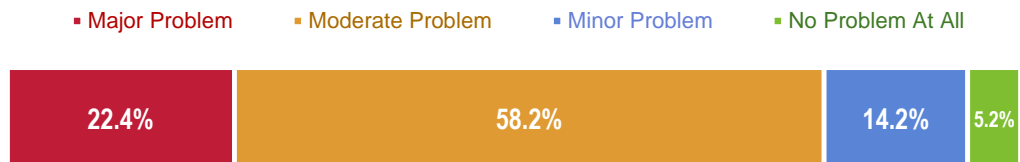


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 116-118]  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>  
Notes: • Each indicator is shown among the gender and/or age group specified.

## Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:

### Perceptions of Cancer as a Problem in the Community (Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.  
Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

#### Incidence/Prevalence

The number of people reporting Cancer and navigating treatment options. The lack of compassionate responsiveness to older adults with Cancer. Responsiveness to needs to understand treatment options, transportation, and supported care along the treatment path. – Social Services Provider

The prevalence of the disease alone makes it a major problem. Healthcare is so expensive, and many physicians do not accept insurance, so people put off seeking treatment. – Social Services Provider

Rates of cancer diagnosis are going up and probably under diagnosed secondary to the pandemic. Residents are still not as knowledgeable about cancer risks as they should be. – Other Healthcare Provider

Our Cancer Center and other hospitals in the area serve 1000's of patients. – Other Healthcare Provider

Based on patients submitted to hospital. – Other Healthcare Provider

There is not only a prevalence of cancer, but also the access to and ability to pay for medications to treat it. – Community/Business Leader

The high incidence of cancer in Bergen County plus limited access to care for the uninsured, underinsured. Large immigrant population. Low HPV vaccine rates. – Other Healthcare Provider

Incidence increasing, diagnosis essential, the earlier the better. Vigilance is key. – Other Healthcare Provider

Everyone has someone that is touched by it. – Social Services Provider



High prevalence of many different types of cancer in children and adults. This may be due to exposure. – Physician

So many people have cancer of various types. Lifestyles make cancer a probability in the future for many people. – Community/Business Leader

There are just so many types of cancer and so many afflicted. – Community/Business Leader

Cancer is on the rise and more and more patients present with cancer. – Other Healthcare Provider

Cancer seems to affect almost every family in some way. It is rare to find a local family that has not been affected by cancer. – Public Health Representative

It seems as though everyone I know and people that they know have some type of cancer. It seems to be of great proportions and although I believe that the treatments are excellent, I think that's what makes it palatable would prefer to see and understand why people get it in the first place. It seems to me a major increase since my childhood which is only 40 years ago – Physician

Disease prevalence. – Other Healthcare Provider

The prevalence of all types of cancer seems to be higher. I'm also very concerned at how much younger people are when they are being diagnosed. – Community/Business Leader

## Prevention/Screenings

Due to COVID cancer screening appointments have not been where they should be. – Other Healthcare Provider

Lack of early Cancer screening opportunities. Lack of cancer specialists who can help patients with language and cultural challenges. Lack of insurance for cancer treatments. – Community/Business Leader

Underutilized screening, access, language, and health literacy. – Community/Business Leader

## Aging Population

Aging population with cancer as a common diagnosis. – Community/Business Leader

In Bergen there is great longevity which contributes to cancer burden. – Other Healthcare Provider

## Awareness/Education

Lack of education and screening availability for those who do not have insurance. – Community/Business Leader

Again, lack of knowledge to resources. – Community/Business Leader

## Access to Care/Services

It is pervasive in that so many families are grappling with the challenges of finding the right treatment and care. In addition to the mental health impact, it has on all the family members around it. – Public Health Representative

## Affordable Care/Services

Cost of treatment for those with high deductible insurance plans, or uninsured and limited ability to investigate resources. – Physician





# Respiratory Disease (Including COVID-19)

## ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. ...More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

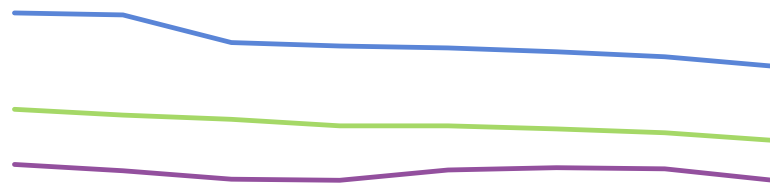
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.

Pneumonia and influenza mortality is also illustrated. [COUNTY-LEVEL DATA]

**CLRD: Age-Adjusted Mortality Trends**  
(Annual Average Deaths per 100,000 Population)

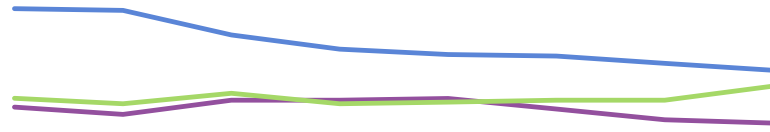


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

Notes: • CLRD is chronic lower respiratory disease.



## Pneumonia/Influenza: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Bergen County	11.3	10.9	11.7	11.7	11.8	11.2	10.6	10.4
NJ	11.8	11.5	12.1	11.5	11.6	11.7	11.7	12.5
US	16.9	16.8	15.4	14.6	14.3	14.2	13.8	13.4

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

## Prevalence of Respiratory Disease

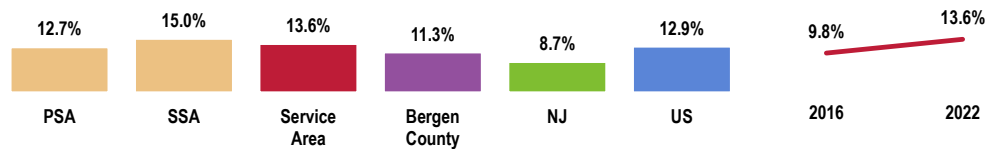
### Asthma

**ADULTS** ▶ “Have you ever been told by a doctor, nurse, or other health professional that you had asthma?” and “Do you still have asthma?” (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

**CHILDREN** ▶ “Has a doctor, nurse, or other health professional ever told you that this child had asthma?” and “Does this child still have asthma?” (Calculated here as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma.)

## Prevalence of Asthma

Englewood Health  
Service Area



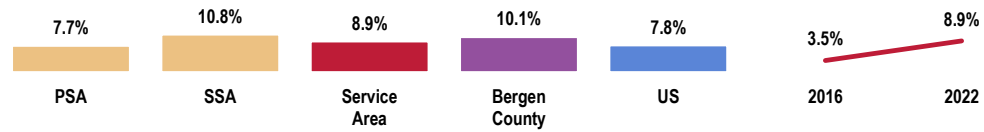
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 119]  
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
● 2020 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.  
● Includes those who have ever been diagnosed with asthma and report that they still have asthma.



## Prevalence of Asthma in Children (Parents of Children Age 0-17)

Englewood Health  
Service Area



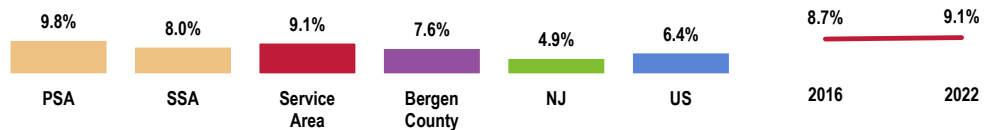
- Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 120]
  - 2020 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents with children 0 to 17 in the household.
  - Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

## Chronic Obstructive Pulmonary Disease (COPD)

**“Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?”**

## Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

Englewood Health  
Service Area

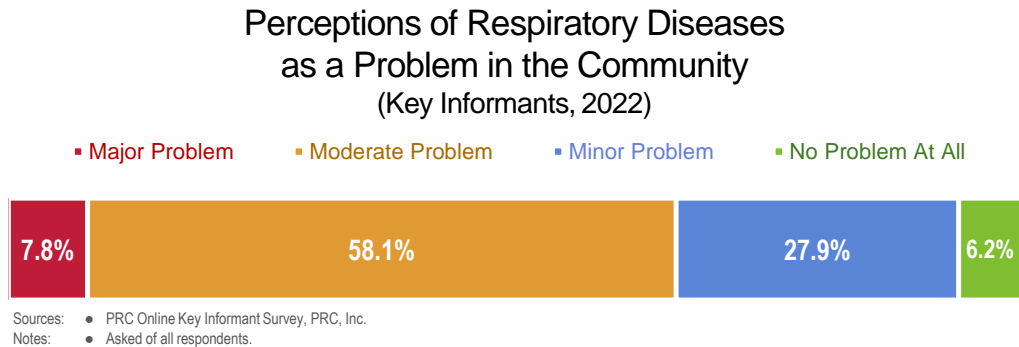


- Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 23]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.
  - 2020 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.
  - Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.



## Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:



Among those rating this issue as a “major problem,” reasons related to the following:

### Incidence/Prevalence

High prevalence of asthma and bronchitis. High tobacco use. – Physician

We have seen an increase in respiratory concerns in patients. – Other Healthcare Provider

Lung cancer is prevalent... As well as other respiratory diseases. There needs to be a team approach and again public service announcements to make those aware of how important it is to maintain lung health. It's vital as adults age to maintain Optimum lung function in lung health and to have screenings at a regular basis to diagnose lung cancer and other diseases at the onset – Other Healthcare Provider

### Environmental Contributors

Asthma and air pollution from traffic, airports, idling. – Social Services Provider

Pollution contributes to pulmonary disease and vehicle traffic in this area is high. – Public Health Representative

Pollution. Constant construction in our area, allergies. – Social Services Provider

### Aging Population

Many of our older adults are on oxygen due to hear or lung issues. – Social Services Provider

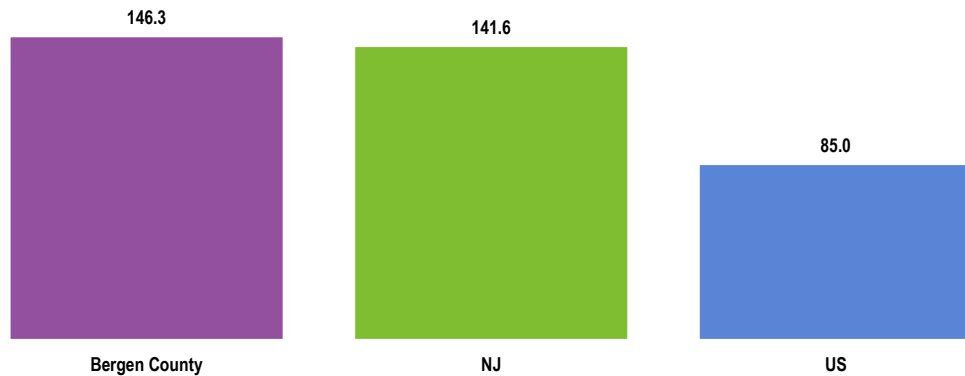


## Coronavirus Disease (COVID-19)

### Age-Adjusted Coronavirus Disease/COVID-19 Deaths

The 2020 age-adjusted mortality rate for coronavirus disease/COVID-19 is illustrated in the following chart. [COUNTY-LEVEL DATA]

**COVID-19: Age-Adjusted Mortality**  
(2020 Annual Average Deaths per 100,000 Population)



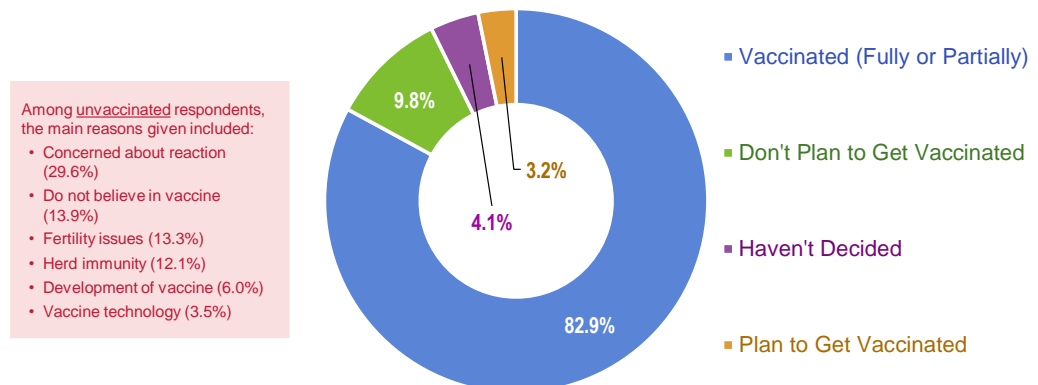
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

### COVID-19 Vaccination

**“Would you please tell me which of the following statements best describes you: I am vaccinated for COVID-19; I plan to receive the vaccine; I do not plan to receive the vaccine; I haven’t decided whether or not to receive the vaccine.”**

[If unvaccinated] **“What is the main reason you have NOT received the COVID-19 vaccine?”**

**Prevalence of COVID-19 Vaccination**  
(Englewood Health Service Area, 2022)

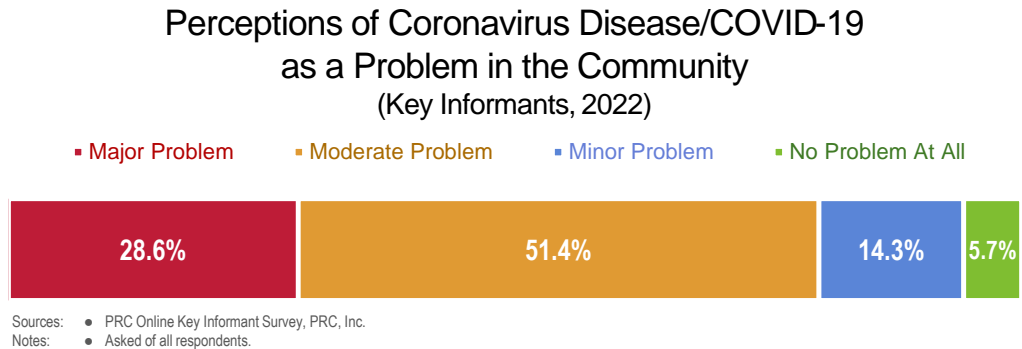


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 317-318]  
Notes: • Asked of all respondents.



## Key Informant Input: Coronavirus Disease/COVID-19

The following chart outlines key informants' perceptions of the severity of *Coronavirus Disease/COVID-19* as a problem in the community:



Among those rating this issue as a “major problem,” reasons related to the following:

### Incidence/Prevalence

- Significant number of cases since March 2020. – Public Health Representative
- The community had more cases than others in the area. – Community/Business Leader
- Depending on the time of year and strain there has been an increase in COVID positive patients. – Other Healthcare Provider
- Bergen County has high rates of infection since March 2020. Lack of strong leadership and guidance in navigating the pandemic. – Other Healthcare Provider
- The number of cases in Bergen County have been high during most of the pandemic. – Other Healthcare Provider
- High disease burden. – Public Health Representative
- High rate of transmission and hospitalization. – Physician
- Bergen County alone has had 245 thousand cases. Affecting people of all ages, race, and ethnicity. COVID continues to be an issue as cases have begun to arise once again. – Community/Business Leader
- Major regional area of infection, especially in early stages of pandemic. – Physician

### Impact on Quality of Life

- Health. – Community/Business Leader
- COVID-19 has caused a sudden and unexpected change in the environments of children who are in crucial windows of development. We are currently in a National State of Emergency for children's mental health and COVID was an accelerant that set that fire ablaze. – Physician
- High anxiety among families and seniors. – Community/Business Leader
- Holy Name Hospital was an epicenter. Trauma for staff and patients, numerous COVID widows in the county now facing grief and financial hardship. Isolation of children and seniors contributing to significant mental health problems. – Social Services Provider
- COVID-19 shut down our area in 2020 and continues to affect our residents. – Public Health Representative

### Vaccination Rates

- There are still many who refuse to get vaccinated. Further, recent variants of COVID-19 seem to be immune to vaccinations. – Social Services Provider
- Still large numbers of unvaccinated people. Spread continues in communities. – Other Healthcare Provider
- I've come across many types of people, some of which have expressed their resistance to getting vaccinated. I do know that COVID-19 is still spreading, and a lot of people are also not wearing masks. – Other Healthcare Provider
- There are still people who have not yet been vaccinated. – Other Healthcare Provider



## Awareness/Education

The uncertainty and changing health guidelines. – Community/Business Leader

Lack of knowledge within the underserved communities. Reluctance to accept vaccines. – Other Healthcare Provider

So much confusion and misinformation. – Community/Business Leader

## Densely Populated Area

Densely populated community. – Social Services Provider

Dense population number going up. – Other Healthcare Provider

## Government/Policy

Even though COVID numbers are manageable right now, the fact that the government is no longer covering the cost of testing or vaccines for people who are uninsured is a problem. These are the people who are most likely to interact with other people in their jobs – grocery store cashier, day care workers, Uber/Lyft drivers – all the people who make the lives of people who do have financial resources easier. – Other Healthcare Provider

## Lack of Adherence to Safety Measures

Britain county had a very high incidence. Different communities were not wearing masks and also its proximity to New York City when was a high incidence. There are still many communities for people to not believe in vaccinations. This is unfortunate. – Other Healthcare Provider

Many people have now let their guard down and our COVID numbers are going up in the schools. Where there are large group gatherings, I feel masks should be in use again. – Other Healthcare Provider

## Co-Occurrences

Mental health, substance misuse and addiction and trauma. – Community/Business Leader

## Diagnosis/Treatment

While the number of deaths and hospitalizations have decreased, we are still in a pandemic. We are acting as if it does not exist and trying to go back to pre-covid life instead of remembering that this is a disease that is potentially life-threatening and may cause long term damage. There is also a pervasive idea that people feel they don't have to worry because it only really affects those with co-morbidities as if their lives don't matter. – Public Health Representative

## Isolation

The isolation triggers loneliness and feelings of past trauma. Everyone in general is more stressed and less likely to help a neighbor or friend. – Other Healthcare Provider

## Prevention/Screenings

Masks can only prevent so much, and even with a vaccine and booster, people are still getting COVID and spreading it. Symptoms more recently seem very minor so that is good to see. – Other Healthcare Provider

## Access to Care/Services

At the beginning of COVID-19, the lack of hospital access and racism was very prevalent. This was caused by underlying conditions, lack of insurance, being put to the back of the line at hospitals, hesitancy to go to the hospital, etc. – Community/Business Leader

## Vulnerable Populations

BC has a number of historically underserved populations. These groups were disproportionately challenged by COVID 19, vaccinations, testing, information, and other care. – Community/Business Leader



# Injury & Violence

## ABOUT INJURY & VIOLENCE

**INJURY** ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. ...Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

**VIOLENCE** ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. ...Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (<https://health.gov/healthypeople>)

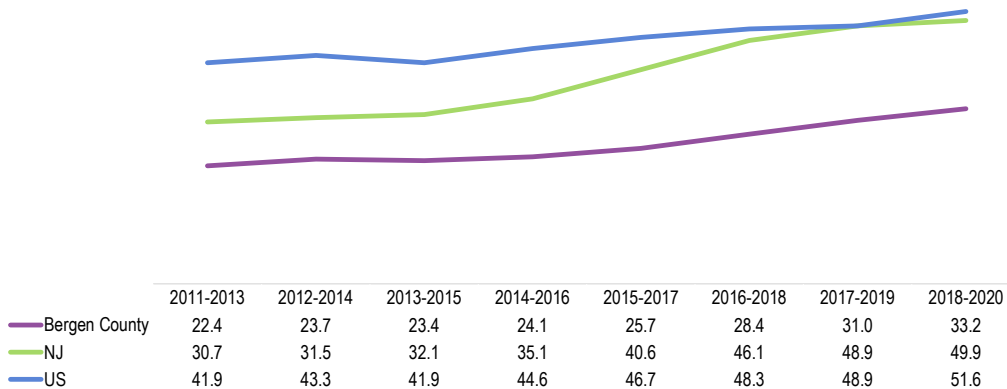
**RELATED ISSUE**  
For more information about unintentional drug-related deaths, see also *Substance Use* in the **Modifiable Health Risks** section of this report.

## Unintentional Injury

### Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area. [COUNTY-LEVEL DATA]

**Unintentional Injuries: Age-Adjusted Mortality Trends**  
(Annual Average Deaths per 100,000 Population)  
Healthy People 2030 = 43.2 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

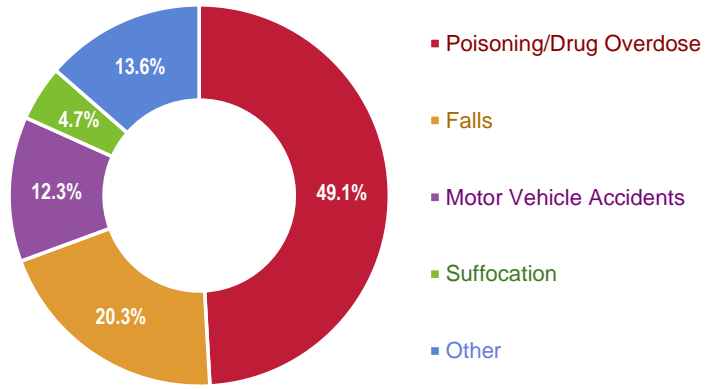




## Leading Causes of Unintentional Injury Deaths

Leading causes of accidental death in the area include the following: [COUNTY-LEVEL DATA]

### Leading Causes of Unintentional Injury Deaths (Bergen County, 2018-2020)



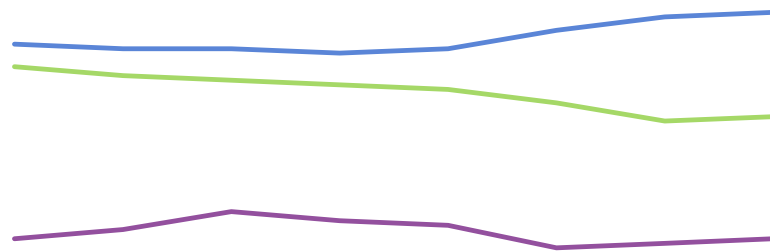
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

## Intentional Injury (Violence)

### Age-Adjusted Homicide Deaths

Age-adjusted mortality attributed to homicide is shown in the following chart. [COUNTY-LEVEL DATA]

### Homicide: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2030 = 5.5 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Bergen County	1.1	1.3	1.7	1.5	1.4	0.9	1.0	1.1
NJ	4.9	4.7	4.6	4.5	4.4	4.1	3.7	3.8
US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

RELATED ISSUE  
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

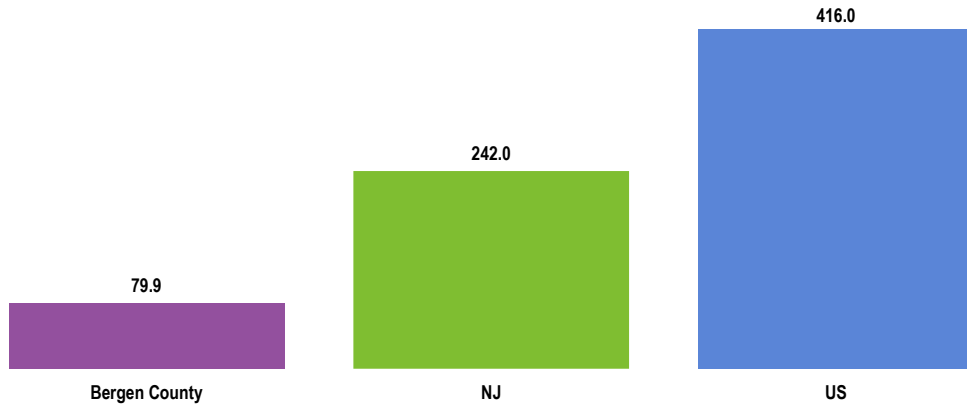


## Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions. [COUNTY-LEVEL DATA]

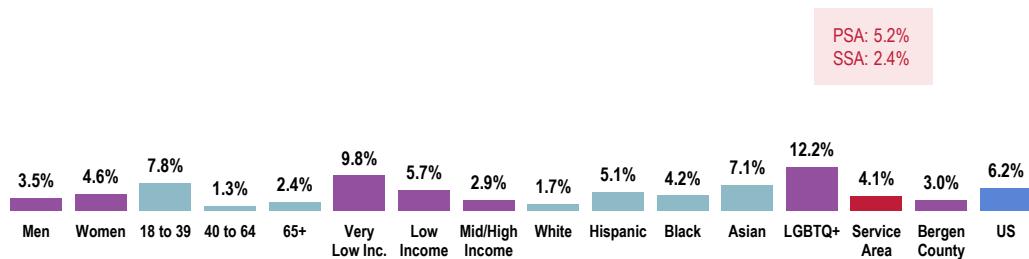
**Violent Crime**  
(Rate per 100,000 Population, 2014-2016)



- Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
- Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
  - Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

## VIOLENT CRIME EXPERIENCE ► “Have you been the victim of a violent crime in your area in the past 5 years?”

**Victim of a Violent Crime in the Past Five Years**  
(Englewood Health Service Area, 2022)



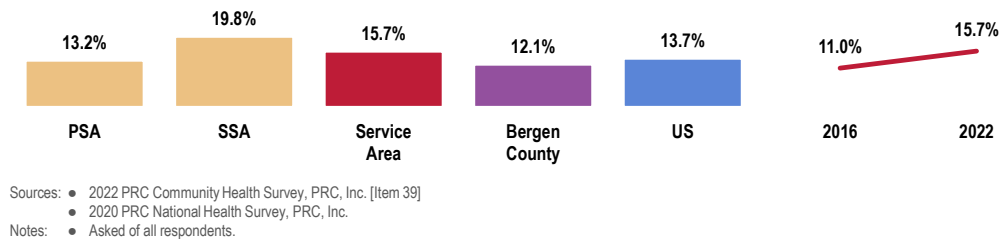
- Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
  - 2020 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.



**INTIMATE PARTNER VIOLENCE** ▶ “The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?”

### Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

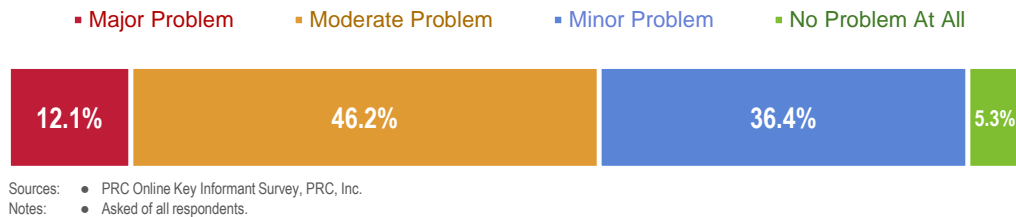
Englewood Health Service Area



### Key Informant Input: Injury & Violence

The following chart outlines key informants’ perceptions of the severity of *Injury & Violence* as a problem in the community:

#### Perceptions of Injury and Violence as a Problem in the Community (Key Informants, 2022)



Among those rating this issue as a “major problem,” reasons related to the following:

#### Incidence/Prevalence

- There is an increase in cutting and violence in the home. – Other Healthcare Provider
- Violence is hard for us to deal with as a whole. – Social Services Provider
- Increased number of violent attacks. – Other Healthcare Provider
- Seems that violence is increasing, guns too accessible, gang problems in larger cities. – Community/Business Leader



I believe injury and violence have become major problems in our society, and our community is a microcosm of the nation. Guns are too easily available and are used by people in engaged in physical disputes, assaults, drive-by shootings. Domestic violence is a continuing, if not a growing, problem. The pandemic has exacerbated inequities in income and racial and religious discrimination and prejudice. Fewer people are members of faith-based institutions or attend religious services. There is no longer a functioning Teaneck Clergy Council. – Community/Business Leader

## Domestic/Family Violence

Domestic violence is an issue. – Social Services Provider

High rate of domestic violence. – Physician

Domestic violence. – Community/Business Leader

Specifically domestic violence, which includes childhood abuse, spousal or partner abuse and definitely elder abuse. – Other Healthcare Provider

## Stigma

Domestic violence is specifically a major issue in our community because it often occurs behind closed doors. Victims are often afraid to come forward, and/or are not aware of resources available. – Public Health Representative

## Accountability

There is no accountability for acts of violence. Most violence begins with threats that are ignored. – Other Healthcare Provider

## Vulnerable Populations

Domestic violence and victims of violence, many times are scared to speak out because of their legal status or dependence on perpetrator. – Social Services Provider

## Government/Policy

These are problems since there is lack of gun control and people can get guns, machine guns etc. In the 1960-1980-time frame, differences were resulted without guns and violence. The police are hampered to fight crime effectively and efficiently. – Social Services Provider

## Teen/Young Adults

Recently there have been many fights in the middle school age group. – Other Healthcare Provider

# Diabetes

## ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. ...Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

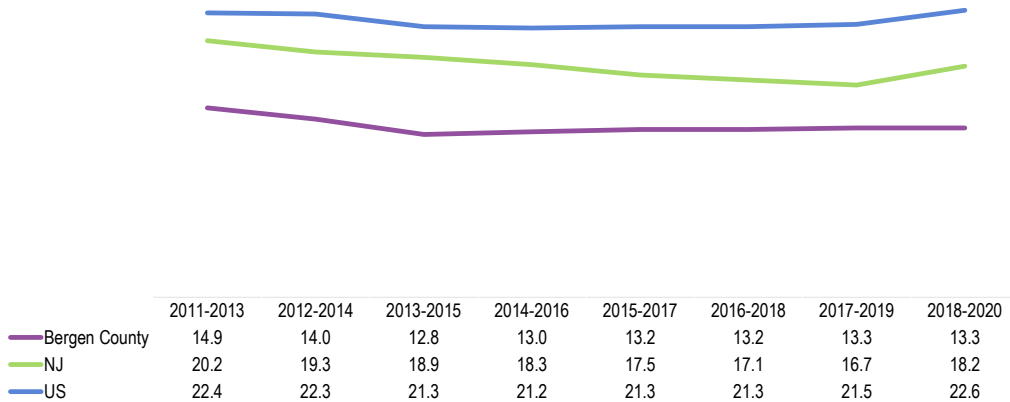
– Healthy People 2030 (<https://health.gov/healthypeople>)



## Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]

**Diabetes: Age-Adjusted Mortality Trends**  
(Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

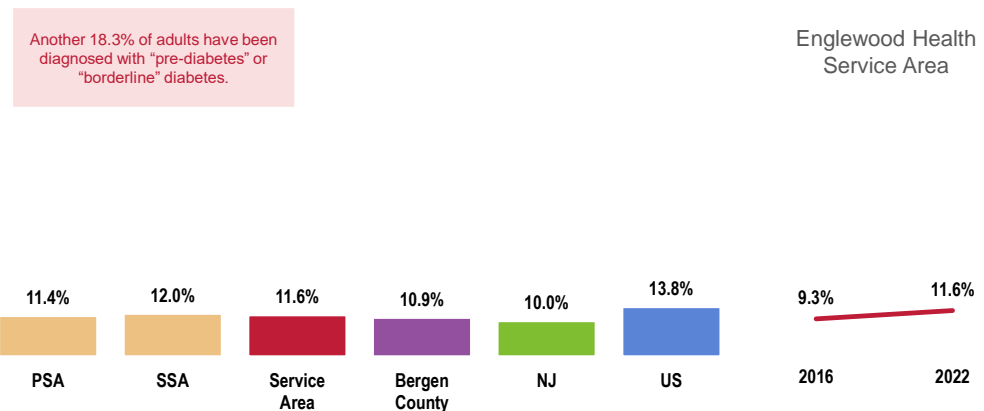
## Prevalence of Diabetes

**“Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)”**

**“Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)”**

[Adults who do not have diabetes] **“Have you had a test for high blood sugar or diabetes within the past three years?”**

## Prevalence of Diabetes



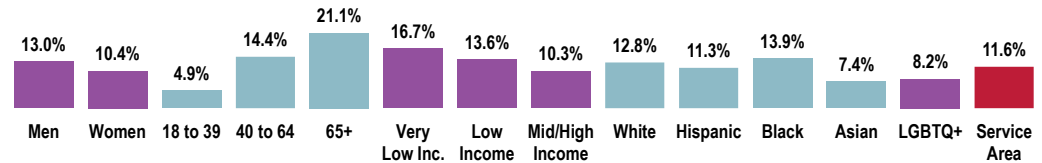
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 121]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.  
• Excludes gestational diabetes (occurring only during pregnancy).



## Prevalence of Diabetes (Englewood Health Service Area, 2022)

Note that among adults who have not been diagnosed with diabetes, 46.1% report having had their blood sugar level tested within the past three years.



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 33, 121]  
 Notes: ● Asked of all respondents.  
 ● Excludes gestational diabetes (occurring only during pregnancy).

### Key Informant Input: Diabetes

The following chart outlines key informants’ perceptions of the severity of *Diabetes* as a problem in the community:

### Perceptions of Diabetes as a Problem in the Community (Key Informants, 2022)

■ Major Problem    ■ Moderate Problem    ■ Minor Problem    ■ No Problem At All



Sources: ● PRC Online Key Informant Survey, PRC, Inc.  
 Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

#### Awareness/Education

Lack of educational resources and financial resources to make healthier choices. – Social Services Provider  
 Education, healthy eating, access to care, knowledge. – Community/Business Leader

Low health literacy, high cost of medication, lack of available appointments for follow up. – Physician

Providing the families with knowledge of the long-term effect of not eating healthy nutritious foods. – Social Services Provider

Information, access to supplies, healthy lifestyle ability. – Social Services Provider

The problem that concerns me most is the ambiguity of the word Diabetes in itself. The average person doesn't fully understand how awful this disease really is until too late compared to say the diagnosis and the word cancer! There must be more definitive education about the Vass symptoms of diabetes and its devastating effects and toll on the body. Education and information regarding a patient's diagnosis of diabetes has to be available to the public but in simple layman's terms. Teaching proper diet made simple is a challenge too. I am pre-diabetic and those instruction from my specialist are good, but many times need to be clearer and more patient friendly. I'm suspicious many people with diabetes continue to eat improperly is because a meal plan is confusing and expensive. Make diabetes education more understandable and the ugly monster that it can be if ignored due to ignorance and complicated directions – Community/Business Leader



Lock of knowledge and no health insurance. – Other Healthcare Provider  
Information about the severity of the disease, and steps that can be taken to ameliorate the negative effects. – Social Services Provider  
Nutritional guidance. – Other Healthcare Provider  
Understanding how food and drinks can affect their glucose levels. Having access to healthy food choices. – Social Services Provider  
The biggest issue around diabetes I see is education on what diabetes is. How to take care of yourself if you are diagnosed with the disease and many people do not recognize the signs and symptoms of diabetes onset. – Other Healthcare Provider  
Early diagnosis and weight management support. Education and access to newer medications. – Physician

## Access to Care/Services

Availability of preventative care/education on chronic diseases and availability of certified diabetes care and education specialists is very limited. Long wait times for Endocrinologist appointments and Health Centers closing Diabetes Centers. Limited number of experts in Diabetes Management and Technology. – Other Healthcare Provider  
Lack of access to provider and medication. Poor health literacy. Limited use of technology. Poor family and community support. – Physician  
Access to quality health foods. The inability to afford quality healthy food. Lack of nutritional education to youth and families. – Social Services Provider  
Lack of access to providers. Lack of insurance for certain individuals. – Other Healthcare Provider  
Access to nutritionist, especially for pre diabetics, access to healthy foods. Access to other lifestyle modifications like exercise programs, counseling. – Public Health Representative  
Finding the appropriate amount of care. – Other Healthcare Provider  
Lack of prediabetes programs, lack of outreach to the underserved. – Other Healthcare Provider  
Lack of community locations to provide literature, testing and dietary solutions. – Community/Business Leader  
Subpar healthcare (PCPs who watched their clients enter the pre-diabetes range and didn't recommend that they see a dietitian or make any changes); misinformation – some of the nutrition guidance that people receive from their doctors is false (i.e., "bananas make you fat"); the food industry – the food industry engineers processed foods to be extremely palatable, affordable and overall, very tempting. It is difficult for many people to resist; physical inactivity – many people are unable to find the time to exercise – Other Healthcare Provider  
Access to Outpatient Nutrition care. – Public Health Representative

## Nutrition

Lack of healthy fast food, cost of fresh produce. Lack of understanding of best diet. Willpower to eat healthy food. – Social Services Provider  
Food insecurity leads to poor food choices. – Social Services Provider  
Proper eating habits, lifestyle changes. – Community/Business Leader  
Food desserts and low income. – Social Services Provider  
Poor diet and not willing to change their eating habits. – Public Health Representative

## Access to Affordable Healthy Food

Cost of nutritional meals is very expensive. – Social Services Provider  
The cost of eating healthy. Fruits and vegetables are expensive. – Other Healthcare Provider  
Access to healthy food issue. – Social Services Provider  
Maintaining a healthy diet and lifestyle with rising food costs. – Other Healthcare Provider

## Disease Management

Patients are sometimes resistant to checking their glucose levels and to the dietary modifications recommended. Everyone is so focused on big is beautiful and that physicians shouldn't "fat shame" that physicians have gotten scared to bring it up with patients. This has led to a void in very important care. – Physician  
Rigorous disease management by doctors and patients. Not following doctor's instructions for following exercise and food intake. – Community/Business Leader  
Diabetes management and screening. – Community/Business Leader

## Incidence/Prevalence

The increasing number of young diabetic patients. Bad lifestyles of people with diabetes. There are many people with diabetes, so they share information about diabetes with each other. Misjudging that they are managing their diabetes well. – Community/Business Leader



The number of people diagnosed with diabetes is increasing and the cost of insulin is enormous. – Public Health Representative

Trending higher – type 2 diabetes. Nutritional needs, quality educational programs about nutrition needed. Primary care physicians should work closely with nutritionists also with exercise programs offered at low to no cost at senior centers and Y. Medicare should cover exercise and nutritional programs for older adults. – Social Services Provider

### Affordable Medications/Supplies

Out of pocket expenses for supplies not covered by insurance, limited outpatient resources that are covered by insurance. Patients not really understanding resources that are available to them such as outpatient diabetes centers. Physicians follow up post discharge of a diagnosis of diabetes and management- – Community/Business Leader

Medication access and affordability. – Community/Business Leader

### Lifestyle

Support services for their entire lifestyle. – Community/Business Leader

Making the necessary lifestyle changes to properly manage the disease. – Community/Business Leader

### Access to Care for Uninsured/Underinsured

Again, for the uninsured, lack of access to ongoing care, low health literacy/can't manage their disease. Cost of insulin and other diabetes medications. – Other Healthcare Provider

### Affordable Care/Services

Access to affordable treatments. – Social Services Provider

### Follow-Up/Support

Apathy and lack of healthy lifestyle by choice or by other. – Physician

### Insurance Issues

Lack of coverage for nutrition for dietitian sessions. These can be very costly. – Other Healthcare Provider

### Lifestyle

Weight and exercise. – Community/Business Leader





# Kidney Disease

## ABOUT KIDNEY DISEASE

More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. ...People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (<https://health.gov/healthypeople>)

## Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart. [COUNTY-LEVEL DATA]

**Kidney Disease: Age-Adjusted Mortality Trends**  
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Bergen County	11.8	12.1	12.5	11.9	11.7	10.8	11.6	11.2
NJ	13.7	13.5	13.8	14.0	14.0	14.1	14.1	14.3
US	15.3	15.3	13.3	13.3	13.2	13.0	12.9	12.8

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

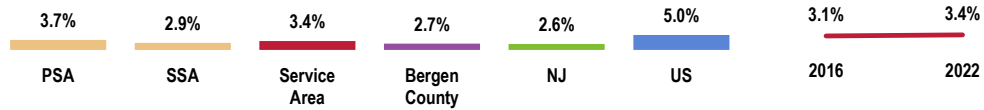


## Prevalence of Kidney Disease

“Have you ever suffered from or been diagnosed with kidney disease?”

### Prevalence of Kidney Disease

Englewood Health  
Service Area



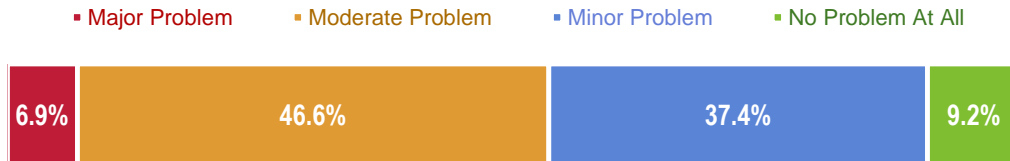
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 24]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

## Key Informant Input: Kidney Disease

The following chart outlines key informants’ perceptions of the severity of *Kidney Disease* as a problem in the community:

### Perceptions of Kidney Disease as a Problem in the Community (Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.  
 Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

#### Incidence/Prevalence

Kidney disease and failure seem to be increasing and dialysis is a temporary treatment. – Public Health Representative

I am not aware that it’s a major problem that is neglected. From what I have heard, there are many who suffer kidney disease, many who are in need of kidneys, but kidneys are not readily available in this area. – Other Healthcare Provider

#### Access to Care for Uninsured/Underinsured

Specifically end-stage renal disease – people who are uninsured have absolutely no way to get dialysis. They can go to the emergency room once, but after that, they’re on their own. Many other states cover the cost of dialysis for patients with ESRD, but not New Jersey. – Other Healthcare Provider

#### Awareness/Education

Access to knowledge. – Community/Business Leader



## Co-Occurrences

Patients with uncontrolled hypertension and diabetes which result in kidney failure. Lack of preventive measures to prevent progression of kidney failure. – Physician

## Nutrition

Food insecurity leads to poor food choices. Many people ignore symptoms or do not manage the disease properly. – Social Services Provider

# Potentially Disabling Conditions

## Multiple Chronic Conditions

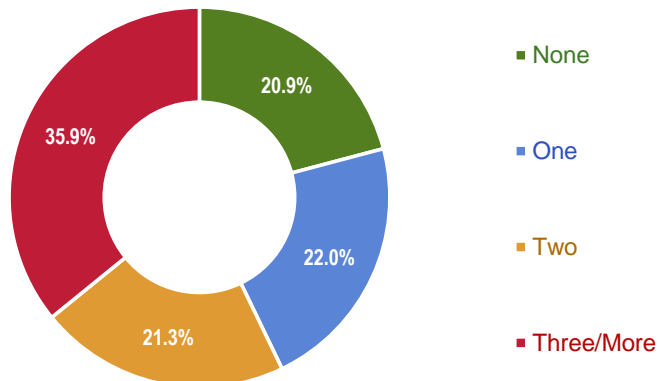
The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.

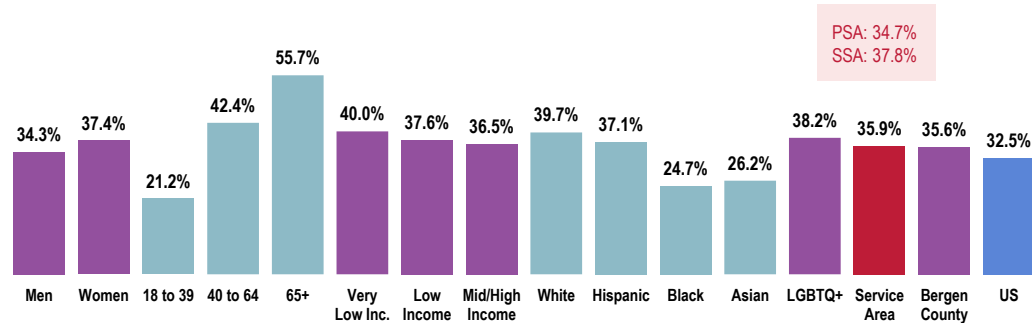
Number of Current Chronic Conditions  
(Englewood Health Service Area, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 123]  
Notes: ● Asked of all respondents.  
● In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.



## Currently Have Three or More Chronic Conditions (Englewood Health Service Area, 2022)



PSA: 34.7%  
SSA: 37.8%

- Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
  - 2020 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.
  - In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

## Activity Limitations

### ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

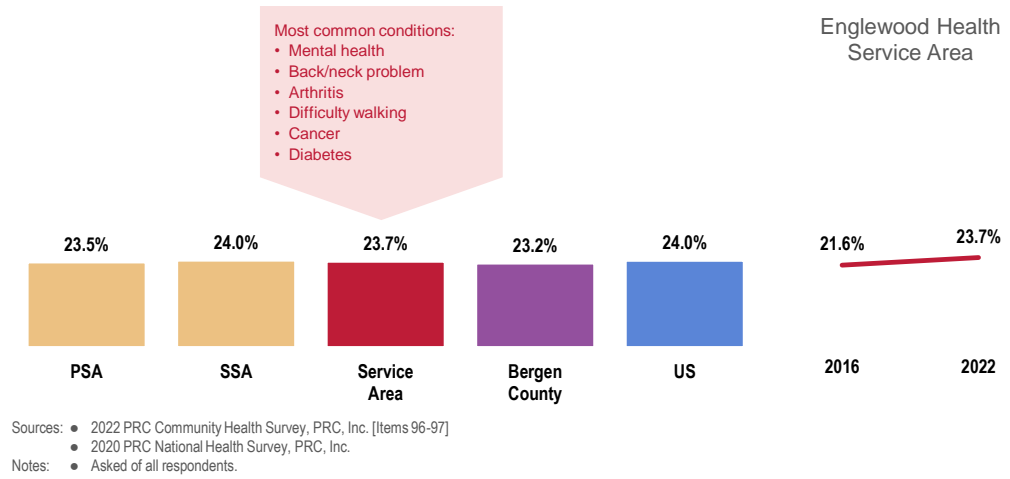
– Healthy People 2030 (<https://health.gov/healthypeople>)

**“Are you limited in any way in any activities because of physical, mental, or emotional problems?”**

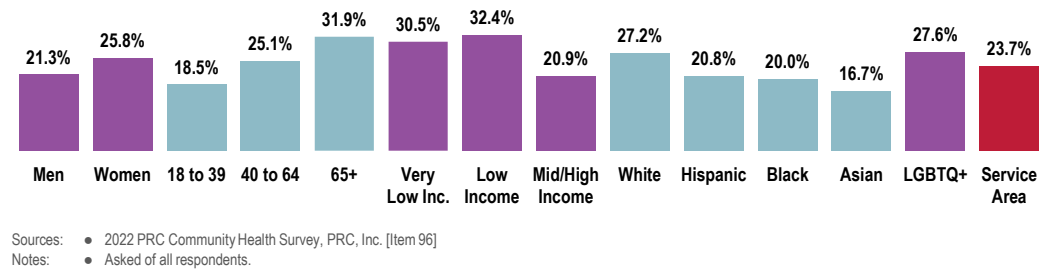
[Adults with activity limitations] **“What is the major impairment or health problem that limits you?”**



## Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem



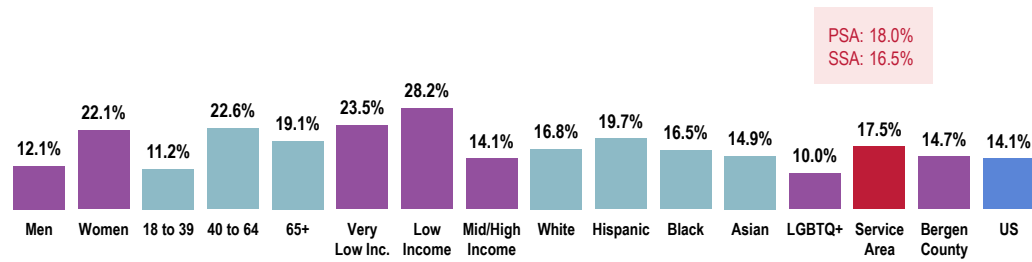
## Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem (Englewood Health Service Area, 2022)



## High-Impact Chronic Pain

“Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?” (Reported here among those responding “most days” or “every day.”)

### Experience High-Impact Chronic Pain (Englewood Health Service Area, 2022) Healthy People 2030 = 7.0% or Lower

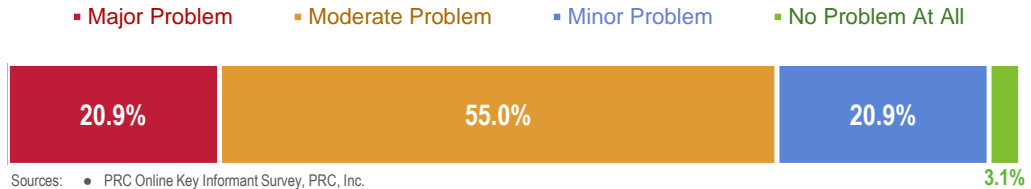


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 37]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030, August 2030. <http://www.healthypeople.gov>  
 Notes: • Asked of all respondents.  
 • High-impact chronic pain includes physical pain that limits life or work activities on “most days” or “every day” of the past six months.

## Key Informant Input: Disability & Chronic Pain

The following chart outlines key informants’ perceptions of the severity of *Disability & Chronic Pain* as a problem in the community:

### Perceptions of Disability & Chronic Pain as a Problem in the Community (Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.  
 Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

#### Incidence/Prevalence

- Many people have chronic and debilitating pain. They need more options and education on how to make it manageable. – Social Services Provider
- High prevalence among population. – Physician
- Many of our residents have severe arthritis that significantly affects their quality of life. – Social Services Provider



Increase in hip replacements, increase in obesity, Increased patients in pain, this is visible on any given day and any of the local superstores watching people struggle. Be it walking or just getting around, plus my patient population seems to suffer greatly from pain and disability – Physician

Many people suffering and cost of treatments that are out of the mainstream AKA medication. – Community/Business Leader

There is an entire community of people who are wheelchair bound or homebound. I've recently become more aware of this community. They usually order groceries online. – Other Healthcare Provider

Previously I worked in a medical clinic where all the patients we saw had some sort of chronic pain. Whether it was low back pain, carpal tunnel or arthritis, almost every person had some sort of long-lasting issue that was affecting them. In many cases, it was so extreme that they were unable to work or complete activities of daily living because of their pain. Arthritis effects almost everyone at some point in their life and there are more people that live with pain and do report it or see a physician. – Other Healthcare Provider

## Aging Population

Seems to be a complaint among seniors. – Community/Business Leader

We have an older population, and a significant population that physically work hard. – Social Services Provider

In the work I do with older residents and people who are food insecure, most suffer from sort of chronic pain and/or disability issue that impacts their daily quality of life. I think in many cases they just accept their circumstances and do not always know how to find the right kind of care to address the issue. In many cases there is little awareness of self-care strategies for managing these conditions as they are not offered in most primary care settings. – Community/Business Leader

Many of the senior population experience severe arthritis and chronic pain on a daily basis. – Social Services Provider

## Access to Care

Limited resources for people with disability, dangerous obstructed and broke sidewalks. No exercise facilities for people with disability, insufficient adapted affordable housing for people with disabilities. – Physician

They have still lack of social services such as aide services, assistance for caregivers. – Community/Business Leader

Services/supports for individuals living with intellectual and/or developmental disabilities and their families through the age continuum and including those with co-occurring medical conditions. There are not enough practitioners and/or services that are culturally appropriate/competent, accept private insurance, Medicaid, offer sliding scale and offer transportation assistance. – Social Services Provider

More assistance is needed to help adults with their dental, eye, and hearing issues. There is a need for low cost and accessible dental services. Low cost and available hearing aids. Low cost and affordable eye care and eyeglasses. Older adults often neglect their dental needs -- a high quality dental clinic that operates with a sliding scale or is covered by NJ Assistance is a necessity. – Social Services Provider

Access to diagnostic resources like MRI to make accurate diagnosis. Cost of physical therapy to aid in recovery. Proper pain management. – Physician

## Affordable Medications/Supplies

Lack of access to non-narcotic pain management. – Other Healthcare Provider

People with disabilities often require support that they can't afford or is not available. Chronic pain contributes to depression and substance abuse if not managed well. Often chronic pain sufferers are unable work impacting all aspects of their life. – Other Healthcare Provider

## Diagnosis/Treatment

More and more people are suffering from chronic pain as well as those who have disabilities. There's a lack of knowledge by physicians and especially pain management doctors. Or education is needed to assist those with disabilities and chronic pain be with Physical therapy language speech therapy and integrative medicine modalities such as breathing and meditation which are valuable tools... A more round in education is needed for those serving those patients with disabilities and chronic pain. As a speech pathologist I had excellent training worked with the team and have also trained in mind-body and other tools and techniques to assist those with disabilities and chronic pain. To know they're not learning to change thinking, to change attitudes and behaviors... Patients need to be heard in believed not just administer drugs... Rehabilitation is essential and mind-body techniques are essential – Other Healthcare Provider

## Co-Occurrences

Disability can lead to many other problems. Immobility made it difficult to get a covid test, to get a vaccine. Transportation can be an issue. Chronic pain can lead to drug dependency, and other hazards of immobility. it is a great financial and emotional stressor. – Other Healthcare Provider



## Disease Management

Many suffer from chronic pain and tend to ignore or take medications that do not help the root of the problem. – Social Services Provider

## Due to COVID-19

People with disability are disproportionately affected by COVID-19 Pandemic. There is a great need to scale up disability to be included in all levels of the healthcare systems especially primary care. – Community/Business Leader

## Isolation

When someone becomes disabled, their access to the world changes leaving them isolated. People suffering from chronic pain, particularly women, are not recognized. Doctors are often suspicious that they may be drug seeking. – Public Health Representative

## Lack of Providers

Not enough physical medicine and rehab specialists and challenging payment models for physical therapy and occupational therapy, and pain and palliative care. – Physician

## Youth

Assistance to children with learning disabilities and diseases. Multiple sclerosis, etc. and programs once they finish high school. – Social Services Provider

## Culture

Many first-generation Koreans living here are self-employed. They work more than 10 hours a day and usually eat out two or more meals a day. As a result, eat a lot of fast foods that contain a lot of salt, sugar and fat. Also, because they do not have time, they neglect to exercise or take care of their health. – Community/Business Leader

## Alzheimer's Disease

### ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.<sup>1</sup> Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (<https://health.gov/healthypeople>)

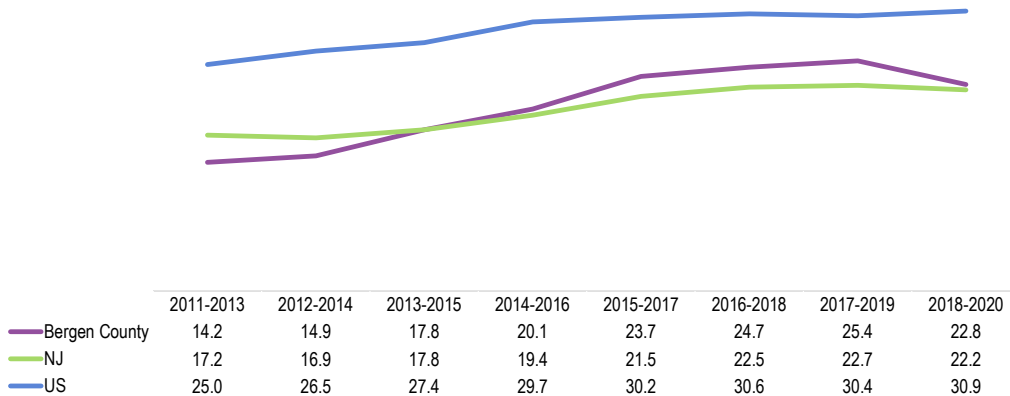




## Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined in the following chart. [COUNTY-LEVEL DATA]

Alzheimer's Disease: Age-Adjusted Mortality Trends  
(Annual Average Deaths per 100,000 Population)

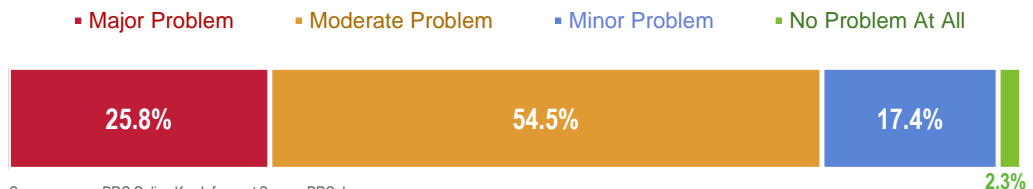


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

## Key Informant Input: Dementia/Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementia, Including Alzheimer's Disease* as a problem in the community:

Perceptions of Dementia/Alzheimer's Disease  
as a Problem in the Community  
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.  
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

### Incidence/Prevalence

Alzheimer's disease is the fifth most common cause of death for Americans age sixty-five years and older. By 2060, the researchers estimate there will be 3.2 million Hispanics and 2.2 million African Americans with Alzheimer's disease and related dementias. – Community/Business Leader

Alzheimer's is prevalent among community seniors who are not getting the support they need. They are mostly relying on their family members or spouse who is frail as well. – Community/Business Leader

Increasing numbers of older adults, and people with diagnosis of dementia. – Public Health Representative



As people live longer there is a greater chance of Alzheimer's Disease. At a recent program for older adults, 75% of the audience present raised their hand when asked if they had been touched by Alzheimer's Disease within their family. Lack of Geriatricians practicing in the area. General Internists don't seem to have specific training in identifying and caring for people with dementia. Respite and homecare services are not easily accessible or affordable. Day care program at CHCC closed creating a void in day care services for people needing such services in NW Bergen County. – Social Services Provider

## Aging Population

As the population ages, the rate of dementia increases. Care is expensive limiting the choices families have to help care for the person with dementia. – Social Services Provider

As the population is aging and living longer, this is a problem. EBP tells us that 6.2 million Americans are living with Alzheimer's. – Community/Business Leader

Serving seniors, we notice issues comparable to this disease, but the individual does not realize this, nor do they have family to assist. – Social Services Provider

The population is aging. I know more and more friends who struggle with parents that have dementia. – Other Healthcare Provider

Aged community. – Social Services Provider

## Vulnerable Populations

BC has a number of historically underserved populations. These groups were disproportionately challenged by dementia, including caregivers. There is a lack of programming in the community. – Community/Business Leader

There are many elderly immigrants in this area. Of course, old people are those aged 80-90 years old, but there are a lot of people at 65 who are now eligible for Medicare. I mean A LOT! Many of them are lonely elderly people with few friends or hobbies. However, there is very little dementia prevention education or related facilities conducted in their language. A related program, seminar, or group meeting is necessary at a hospital trusted by the community rather than a non-profit organization. – Community/Business Leader

## Awareness/Education

Lack of knowledge, stigma attached. But Holy Name Medical Center Tina teachers eight is very active in promoting and giving classes and diagnosis treatment and caregivers. – Other Healthcare Provider

Lack of knowledge and accessibility. – Community/Business Leader

## Access to Care/Services

Limited long-term-care facilities that will care for this population. – Public Health Representative

Difficult to access Neurology care. No good treatment. – Physician

## Affordable Care/Services

All too common and very expensive to provide care. – Community/Business Leader

Difficult to access services, especially if you're working poor. – Social Services Provider

## Diagnosis/Treatment

Many people being diagnosed. – Community/Business Leader

Dementia and Alzheimer's is a major problem in the community because it is challenging to screen for when individuals are not under constant care/supervision. It is also challenging to treat because of the level of care that is required, and the expense that comes along with it. – Public Health Representative

## Impact on Families

Alzheimer's is a family disease. Many families are not educated on resources, the disease and future planning. – Social Services Provider

I do not think there is enough support for caregivers or enough money to help those families. – Other Healthcare Provider

## Impact on Quality of Life

Dementia is a crippling condition that gradually robs the identity of an individual and this has a tremendous effect not just on the individual but perhaps more so on their families. Assisted living facilities are often perceived to provide sub-standard care and there seems to be a frequent back and forth of individuals with dementia between these facilities and hospitals. Patients often arrive in a state of delirium which causes trauma to the patient, their family members and their medical providers. – Physician

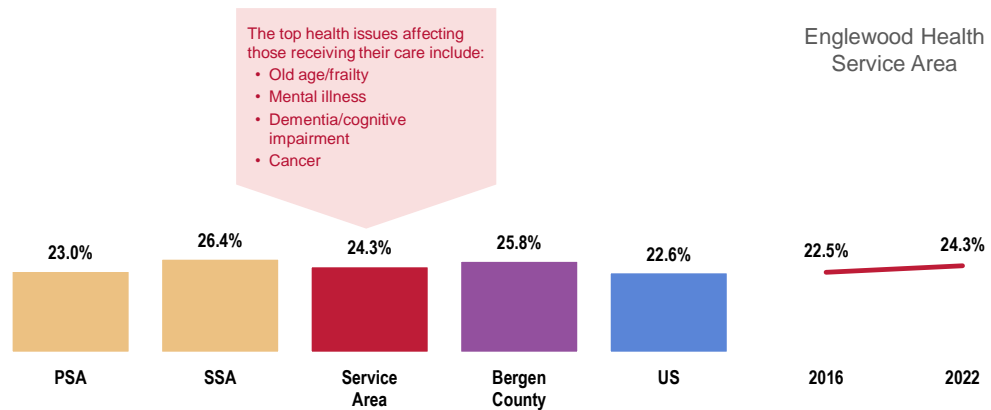


## Caregiving

“People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?”

[Among those providing care] “What is the main health problem, long-term illness, or disability that the person you care for has?”

### Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 98-99]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.



# BIRTHS

## ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women’s health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants’ health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

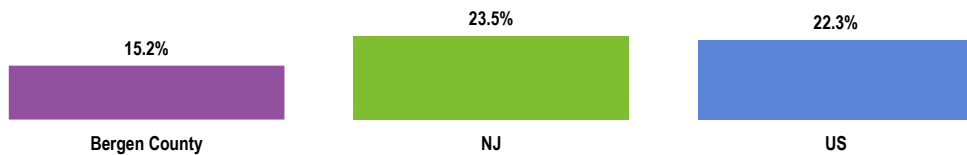
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (<https://health.gov/healthypeople>)

## Prenatal Care

Early and continuous prenatal care is the best assurance of infant health. Lack of timely prenatal care (care initiated during the first trimester of pregnancy) is outlined in the following chart. [COUNTY-LEVEL DATA]

Lack of Prenatal Care During First Trimester  
(Percentage of Live Births, 2018-2020)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.

Note: • This indicator reports the percentage of women who do not obtain prenatal care until the seventh month of pregnancy or later, if at all. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.



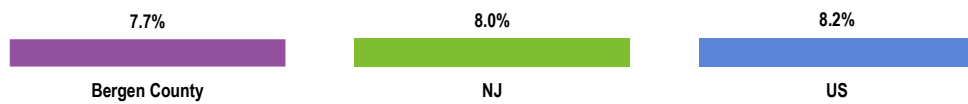
# Birth Outcomes & Risks

## Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. [COUNTY-LEVEL DATA]

Low-Weight Births  
(Percent of Live Births, 2013-2019)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.

Note: • This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

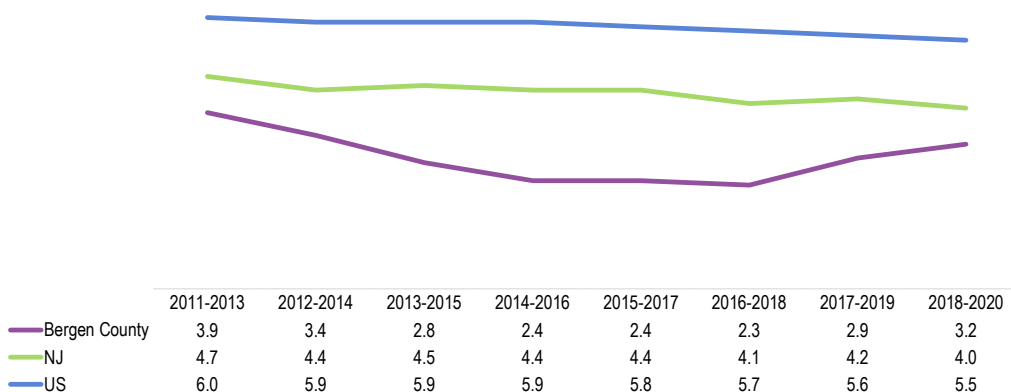
## Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart. [COUNTY-LEVEL DATA]



## Infant Mortality Trends (Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2030 = 5.0 or Lower



Sources: 

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2022.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>

Notes: 

- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

## Family Planning

### ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. ...Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

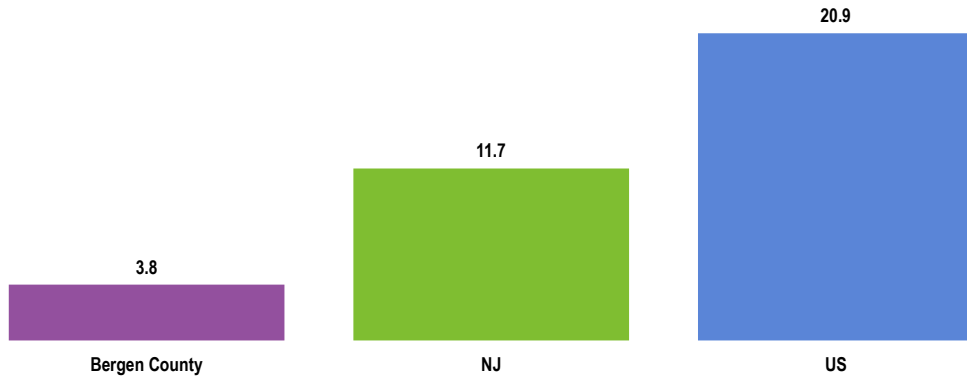
– Healthy People 2030 (<https://health.gov/healthypeople>)



## Births to Adolescent Mothers

The following chart describes births to adolescent mothers under the age of 20 years. [COUNTY-LEVEL DATA]

**Teen Birth Rate**  
(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2013-2019)

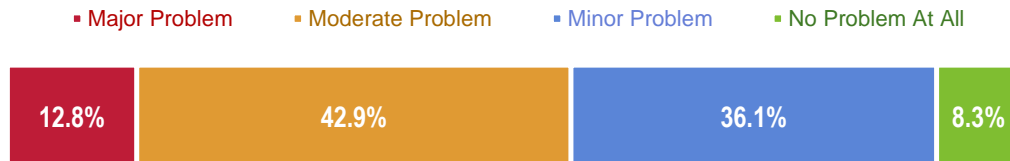


- Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
- Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

## Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health and Family Planning* as a problem in the community:

**Perceptions of Infant Health and Family Planning as a Problem in the Community**  
(Key Informants, 2022)



- Sources:
- PRC Online Key Informant Survey, PRC, Inc.
- Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

### Maternal and Infant Mortality Rates

- Mortality rate for black babies. – Community/Business Leader
- Maternal mortality especially among women from health disparate groups. – Physician
- Maternal and child health morbidity and mortality. – Other Healthcare Provider
- New Jersey practically leads the nation in maternal death. True of Bergen as well. – Social Services Provider
- I keep hearing about infant mortality in the news, especially as it pertains to people of color. – Social Services Provider



## Access to Care/Services

Women's Health and Reproductive Health for Women. There is not enough resources devoted to woman's health until the issues become a matter of disease maintenance and/or treatment. Many of the issues effecting women can be address as prevention and/or early detection. In addition, non-english speaking women are often being left out of the conversations/services on education and prevention. – Community/Business Leader

I believe it is not intuitive or easy for someone to navigate the system when needed. – Social Services Provider

Lack of access to providers. Potential to restrict or limit abortions. – Other Healthcare Provider

Prenatal care for underserved communities. – Physician

Hard to find different services. – Other Healthcare Provider

## Awareness/Education

Most clients I have seen are not aware of information related to infant health and family care. – Other Healthcare Provider

In certain communities' early education in pregnancy is not available and attention is only highlighted if a problem arises. – Physician

## Stigma

For undocumented folks. Stigma to obtain WIC service or fear of applying for this service will affect legal status in the future. – Social Services Provider

I think it's a hidden problem in my community. I think families are often embarrassed to reach out to seek help. – Other Healthcare Provider

## Lack of Trust in Providers

Lack of trust in doctors and health care institutions. Too many times doctors do not believe what the patient is telling them. – Community/Business Leader

## Government/Policy

Home-based family planning services and childcare are not included as a mandatory program at the Health Department level. – Public Health Representative

## Family Planning

Every baby born is a new concern. Family planning is needed so babies that are not intended are not born and so that families can plan for children to be born when they can afford it. – Community/Business Leader





# MODIFIABLE HEALTH RISKS

## Nutrition

### ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. ...People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (<https://health.gov/healthypeople>)

### Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents in the service area were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

**“For the following questions, please think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?”**

**“How many servings of vegetables did you have yesterday?”**

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.

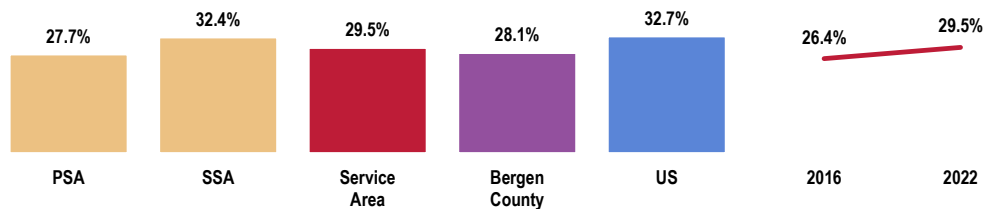
Respondents were also asked about food labels:

**“Generally speaking, do you read food labels to help you make decisions about which food to select?”**

### Consume Five or More Servings of Fruits/Vegetables Per Day

74.0% of respondents report that they generally read food labels when selecting what foods to buy.

Englewood Health Service Area



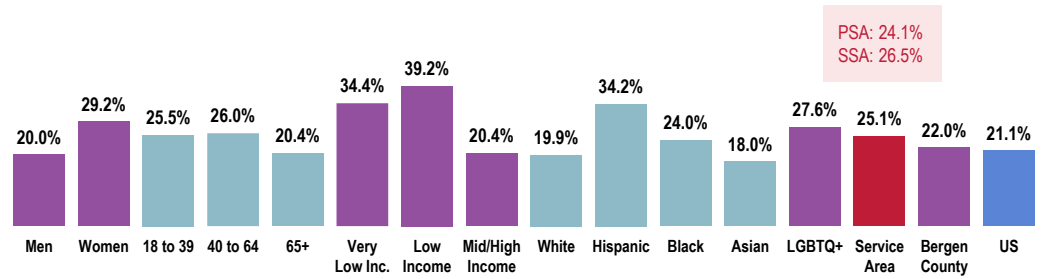
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 125, 308]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.  
• For this issue, respondents were asked to recall their food intake on the previous day.



## Access to Fresh Produce

“How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?”

### Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (Englewood Health Service Area, 2022)

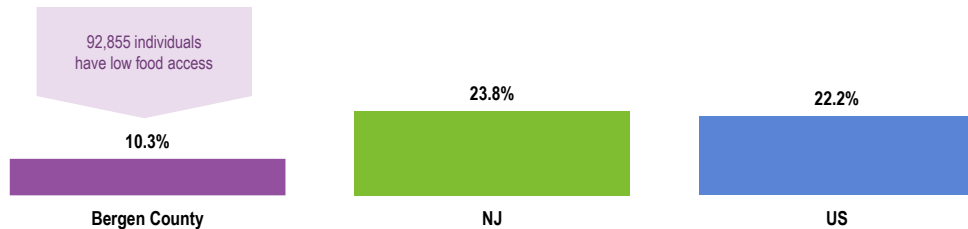


PSA: 24.1%  
SSA: 26.5%

Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 79]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This related chart is based on US Department of Agriculture data. [COUNTY-LEVEL DATA]

### Population With Low Food Access (Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



Sources: • US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).  
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).  
Notes: • This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.



# Physical Activity

## ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

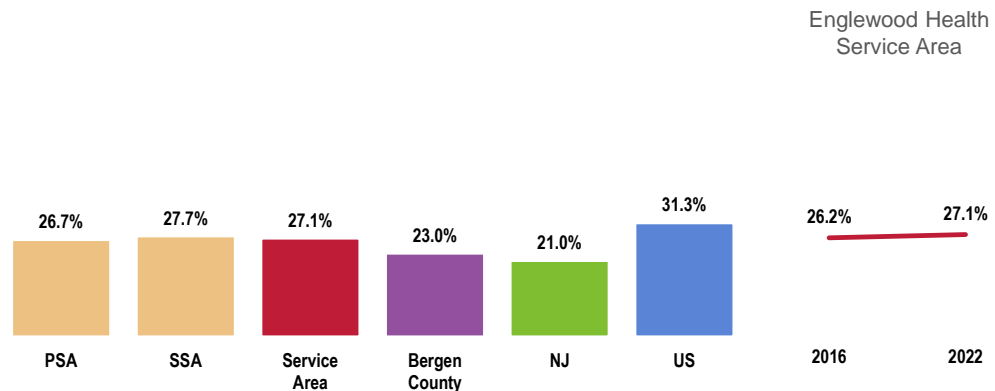
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Leisure-Time Physical Activity

**“During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?”**

### No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 82]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
• 2020 PRC National Health Survey, PRC, Inc.  
• US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.



## Meeting Physical Activity Recommendations

### ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services.  
[www.cdc.gov/physicalactivity](http://www.cdc.gov/physicalactivity)

To measure physical activity frequency, duration, and intensity, respondents were asked:

**“During the past month, what type of physical activity or exercise did you spend the most time doing?”**

**“And during the past month, how many times per week or per month did you take part in this activity?”**

**“And when you took part in this activity, for how many minutes or hours did you usually keep at it?”**

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

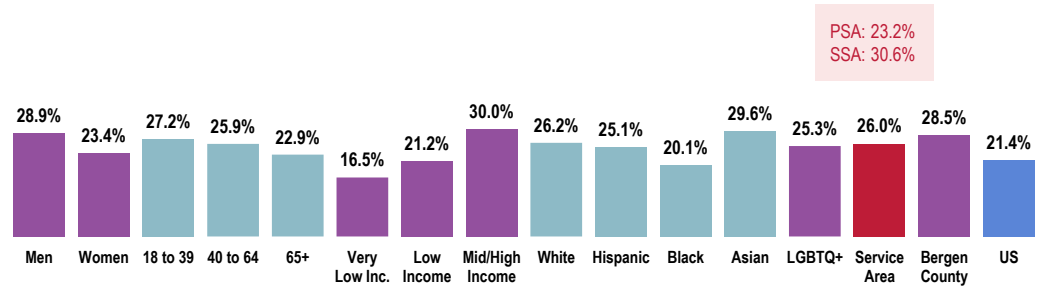
**“During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands.”**

“Meeting physical activity recommendations” includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.



## Meets Physical Activity Recommendations (Englewood Health Service Area, 2022) Healthy People 2030 = 28.4% or Higher



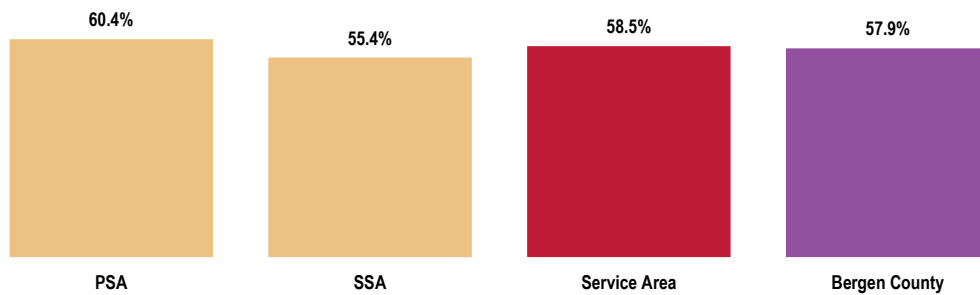
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 126]  
• US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.  
• Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

## Screen Time for Entertainment

[Adults] “Including television, video games, computers, phones, tablets, and the internet, on an average day, about how many hours or minutes of screen time do you use for entertainment?”

### Three or More Hours of Screen Time for Entertainment (Adults)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 158, 311]  
Notes: • Asked of all respondents.



## Children's Physical Activity

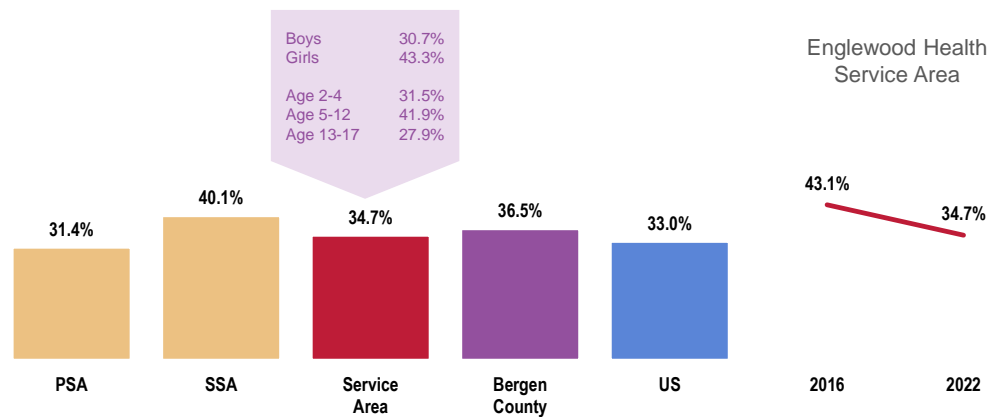
### CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services.  
www.cdc.gov/physicalactivity

**“During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?”**

### Child Is Physically Active for One or More Hours per Day (Parents of Children Age 2-17)



- Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 109]
  - 2020 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents with children age 2-17 at home.
  - Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.



## Weight Status

### ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (<https://health.gov/healthypeople>)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared ( $m^2$ ). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches<sup>2</sup>)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9  $kg/m^2$  and obesity as a BMI  $\geq 30 kg/m^2$ . The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25  $kg/m^2$ . The increase in mortality, however, tends to be modest until a BMI of 30  $kg/m^2$  is reached. For persons with a BMI  $\geq 30 kg/m^2$ , mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25  $kg/m^2$ .

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

### Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI ( $kg/m^2$ )
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	$\geq 30.0$

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

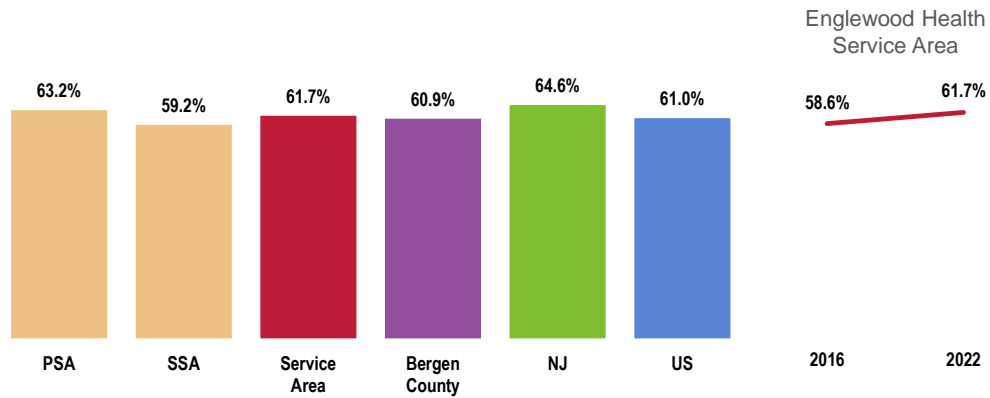
**“About how much do you weigh without shoes?”**

**“About how tall are you without shoes?”**

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).



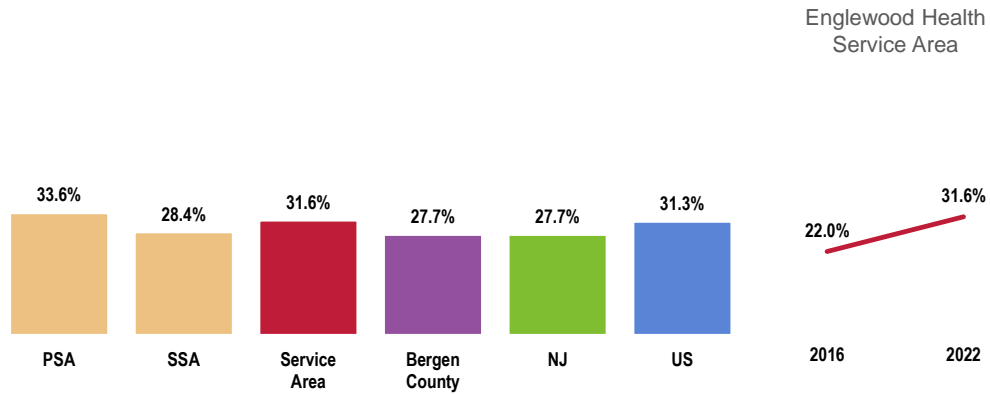
## Prevalence of Total Overweight (Overweight and Obese)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 128]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Based on reported heights and weights, asked of all respondents.  
 • The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

## Prevalence of Obesity Healthy People 2030 = 36.0% or Lower



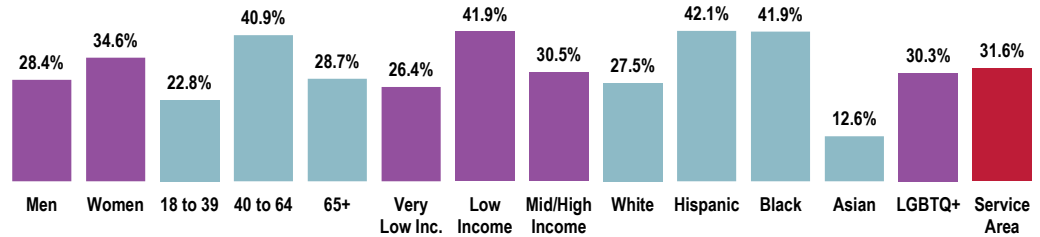
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 128]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

Notes: • Based on reported heights and weights, asked of all respondents.  
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.





## Prevalence of Obesity (Englewood Health Service Area, 2022) Healthy People 2030 = 36.0% or Lower



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 128]  
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>  
 Notes: • Based on reported heights and weights, asked of all respondents.  
 • The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

## Children’s Weight Status

### ABOUT WEIGHT STATUS IN CHILDREN & TEENS

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child’s BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5<sup>th</sup> percentile
- Healthy Weight ≥5<sup>th</sup> and <85<sup>th</sup> percentile
- Overweight ≥85<sup>th</sup> and <95<sup>th</sup> percentile
- Obese ≥95<sup>th</sup> percentile

– Centers for Disease Control and Prevention

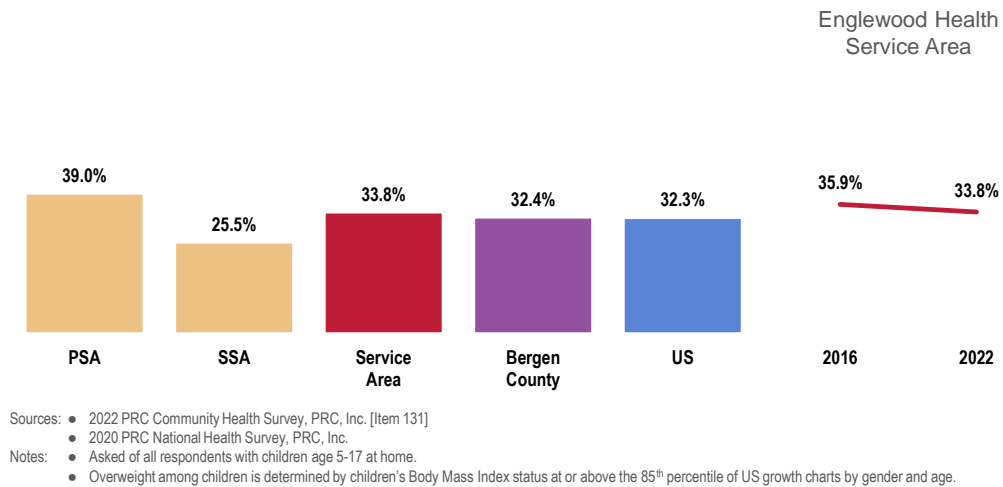
The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

**“How much does this child weigh without shoes?”**

**“About how tall is this child?”**



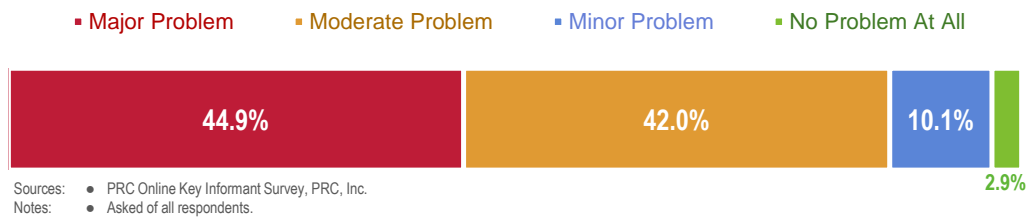
## Prevalence of Overweight in Children (Parents of Children Age 5-17)



## Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

### Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community (Key Informants, 2022)



Among those rating this issue as a “major problem,” reasons related to the following:

#### Awareness/Education

- The understanding of its importance, not individually, but as a whole. – Community/Business Leader
- Lack of education, and lack of exercise. – Community/Business Leader
- Inadequate health behavior/nutrition education in primary and secondary education. Inadequate access to affordable organic food. Poor quality water supply in parts of Bergen County. Density of fast-food restaurants. – Physician
- Lack of education, lack of access to healthier experiences, affordable gyms. The high costs to healthier options. – Social Services Provider
- Knowledge, access to food. – Community/Business Leader
- People are not aware of good nutritional health. They do not avail themselves to physical activities that would reduce weight issues. – Community/Business Leader



Many people are unaware how to go about making lasting changes in diet and lifestyle. Also, there are many people with a "fad diet" mentality who have unrealistic expectations about effort and results and how quickly results should come. Mental health is another challenge because it's an integral piece of making lifestyle changes. – Other Healthcare Provider

Lack of information about healthy eating. Lack of exercise. – Community/Business Leader

We are a sedentary nation. As people age, they are not educated on the food and budgets they can work with. People are not walking or exercising because they may not feel safe and exercise buddies for homebound older adults does not exist. Fixed incomes make it hard to buy enough food. Cheap food is unhealthy food and healthy food is expensive food. – Social Services Provider

## Insufficient Physical Activity

As a society, we are becoming more sedentary. Fast food and processed food are typical food choices. Healthy foods are expensive. – Public Health Representative

We don't exercise enough and don't pay attention enough to nutrition. – Community/Business Leader

To me, a huge challenge is the normalization of little physical activity, of reliance on poor food choices due to the pressures of lifestyle. And weight gain that too many people interpret as unavoidable. – Community/Business Leader

Lack of exercise. – Social Services Provider

Lack of better physical activity in schools. More knowledge of nutrition and weight to school age children. – Social Services Provider

Lack of physical activity and lack of information about nutrition lead to increased weight, which is a health issue. – Community/Business Leader

## Nutrition

Ongoing Outpatient nutrition services for obesity. – Public Health Representative

Nutrition, physical activity, and mental health issues are our biggest problems in the community. – Physician

Food insecurity, i.e., those living in food deserts or who do not have the resources to access a steady source of fresh, nutritious foods. – Public Health Representative

Food insecurity. – Community/Business Leader

Without being directly connected to a program, many are not receiving adequate nutritional meals and exercise. Day program at least provide lunch (some breakfast) to seniors Mon-Fri. However, without this connection, many lack a standard 3 meals and physical exercise. – Social Services Provider

Overeating and now with businesses closing, so many new restaurants, and take out places are moving in. Coupons and promotions may make them affordable but whether or not, the food is properly prepared, high in fat, calories may not be considered by the customer. Obesity is linked to many chronic diseases. High cost of foods especially healthier foods may limit choices for some families. More people rely on Uber. Lyft instead of walking – Other Healthcare Provider

Fast food, busy lifestyles, and apathy. – Physician

## Access to Affordable Healthy Food

Access to healthy food that is easy to prepare. Food prices have skyrocketed, and many have difficult affording healthy options. – Physician

Poor access to affordable food options, low health literacy, high stress jobs. – Physician

Affordable health food. Affordable weight loss and exercise programs and transportation. – Other Healthcare Provider

Low income/poverty level, not enough access to healthy food items and unable to afford gym memberships. – Social Services Provider

For nutrition, is the lack of income to afford healthy food. Lack of free or low-cost wellness programs in our local neighborhoods. – Social Services Provider

Access to affordable, healthy food. The quality of food and presentation of said food that is served to students in schools is subpar. Schools have sent the message that physical activity is not important hence it was cut/reduced from daily schedules. Businesses do not incorporate physical activity but allow smoking breaks. Weight issues are linked with inadequate access to natural food, high consumption of processed foods, poor portion control and lack of awareness of shifts in nutritional needs as people age. These issues become even more complex and profound when they are applied to special needs populations like those who live with chronic health conditions (inc physical, mental and substance disorders). – Social Services Provider

## Lifestyle

I think the stay at homework has increased the sedentary lifestyle and increased daily snacking. I see it all day in my office. Back pain from sitting around all day. Weight gain from snacking while at home all day. Drinking more due to stress and isolation – Physician



Busy, stressful lifestyles and low priority. – Other Healthcare Provider

Many people are too busy for self-care. – Other Healthcare Provider

## Affordable Care/Services

The expense of working with a nutritionist she's not covered certainly by Medicare and other medical insurance plans. This needs to be widely available and insurance needs to be accepted Nutrition is key physical activity nutrition and weight loss community programs and programs for nutrition weight loss and physical activity within a hospital setting need to be affordable and offered on a continual basis – Other Healthcare Provider

In my community there are not enough resources and appropriate education on obesity and weight management and how it can be directly influence by proper nutrition and proper physical activity. In specific communities of social economic challenges and non-English speaking communities, the ability to seek educational and/or medical services as preventative services is lacking. The overall importance of preventive medicine (i.e., holistic nutrition, proper/safe physical exercise and weight loss/management, etc.) is not heavily emphasized. – Community/Business Leader

Affordable gyms, places to workout, willpower to exercise. Dangerous streets for those want to walk, run and bike as low-cost ways to exercise. – Social Services Provider

## Obesity

People are overweight and obese because of poor nutrition and no exercise. They don't know about healthy eating and exercise. Many immigrants come to the US and want to "fit in" so they start eating all the bad stuff so they fit in. Low-income people don't always have access to healthy foods or safe places to exercise. – Other Healthcare Provider

High rate of obesity, poor eating habits, lack of exercise. Use of medications such as steroids which augment weight gain. – Physician

High rate of obesity, poor eating habits, lack of exercise. Use of medications such as steroids which augment weight gain. – Physician

## Aging Population

Isolated older adults may lack access transportation to shop for food and may not know how to access or afford food delivery services. They may also suffer from loss of appetite. Lower-income residents may not be able to afford fresh food to have a balanced diet. The pandemic exacerbated these problems as well as contributing to greater obesity, as people at home consumed more food and may have had less opportunity for exercise. Those who were able to afford to visit a fitness center or gym have been unable to do so for the last two years, – Community/Business Leader

People in my community very much mirror state average on these indexes. For older, low-income residents we see many subsisting on low-quality nutrition foods that are the least expensive to purchase and do not engage in regular physical activity. We have also seen that as food prices continue to increase people who are already food insecure are priced out of buying fresh produce, lean meats, and dairy, etc. Obesity continues to be an issue for those who are living at or below the poverty line. This then leads to a host of comorbidities such as diabetes, heart disease, and inflammation. – Community/Business Leader

## Built Environment

Not enough spaces/parks for residents to utilize. Not enough affordable recreational activities for residents. High cost of nutritional foods. Poor quality/unhealthy school breakfast and lunch. – Social Services Provider

In the summer access to transportation to access plenty of the Bergen County parks. Access is only possible by car. Bike lanes not clearly delineated for cyclist including young children and elderly, people with disabilities in wheelchair or other forms of pedestrian transportation. In the winter: low-cost facilities available for indoor sports for adults and the elderly. Lack of awareness of other feeding programs to help stretch family food budgets.

Minimal availability of nutrition education resources for non-English speakers. Underutilization of SNAP and SNAP ed programs. Lack of park adaptations in urban towns to make park more readily available for people with disabilities. – Social Services Provider

## Lack of Time

People are so busy working that they don't have time to exercise and eat right. – Social Services Provider

Lack of priority, not enough time for cooking, lack of nutrition knowledge. No time for physical activities, and choosing unhealthy food on the daily menu. – Other Healthcare Provider

## Due to COVID-19

COVID increased the community lockdown and restriction to movement. It also increased the mental health and behavioral issues both in the community and in schools. These issues increased the sedentary nature of our community. – Community/Business Leader



## Eating Disorders

| Access to eating disorder treatment without private insurance. – Community/Business Leader

## Incidence/Prevalence

| Metabolic syndrome X is rampant and being treated as five to ten different medical conditions by five to ten different providers. – Physician



# Substance Use

## ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. ...Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

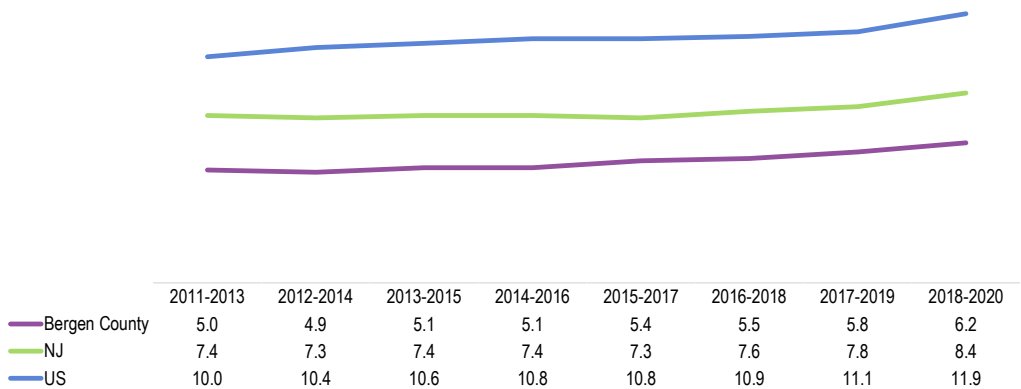
– Healthy People 2030 (<https://health.gov/healthypeople>)

## Alcohol

### Age-Adjusted Cirrhosis/Liver Disease Deaths

Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in the area. [COUNTY-LEVEL DATA]

**Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends**  
(Annual Average Deaths per 100,000 Population)  
Healthy People 2030 = 10.9 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.  
• US Department of Health and Human Services. Healthy People 2030. August 2020. <http://www.healthypeople.gov>



## Excessive Drinking

“During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?”

“On the day(s) when you drank, about how many drinks did you have on the average?”

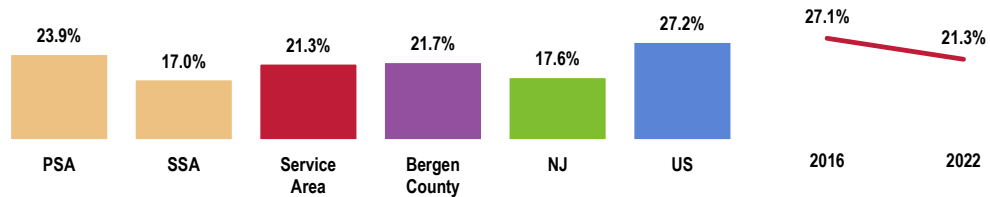
“Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?”

Excessive drinking includes heavy and/or binge drinkers:

- **HEAVY DRINKERS** ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- **BINGE DRINKERS** ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

## Excessive Drinkers

Englewood Health Service Area



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 136]  
• 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2021 New Jersey data.  
• Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

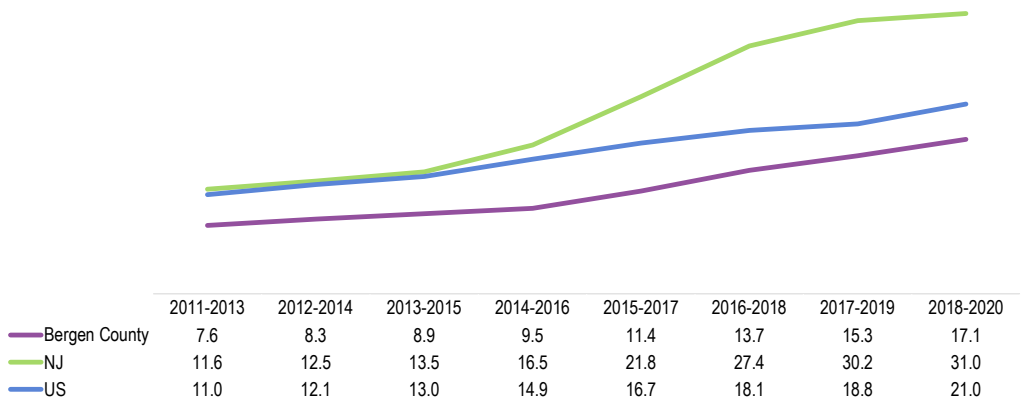
## Drugs

### Age-Adjusted Unintentional Drug-Related Deaths

Unintentional drug-related deaths include all deaths, other than suicide, for which drugs are the underlying cause. A “drug” includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-related deaths. [COUNTY-LEVEL DATA]



## Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.

### Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

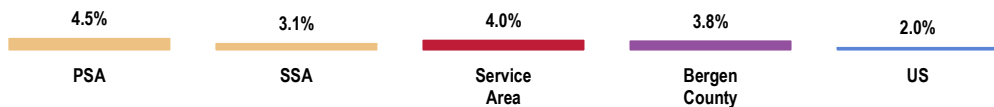
**“During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?”**

**“Have you ever sought professional help for an alcohol or drug-related problem?”**

### Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower

5.1% of respondents report that they have sought professional help for an alcohol or drug-related problem at some point in their lives.



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 49, 51]  
 ● 2020 PRC National Health Survey, PRC, Inc.  
 ● US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>  
 Notes: ● Asked of all respondents.



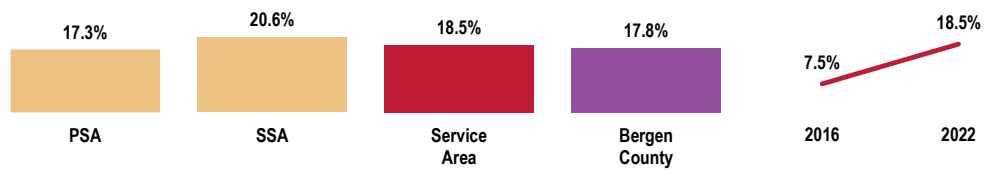


## Use of Marijuana/THC

“During the past 12 months, have you used marijuana or products containing THC in any form? This includes use of traditional marijuana, hashish, edibles, and concentrates like hash oil, wax, or shatter. It does not include use of CBD oils.”

### Used Marijuana or THC-Containing Products in the Past Year

Englewood Health Service Area



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 303]  
Notes: • Asked of all respondents.

## Use of Prescription Opioids

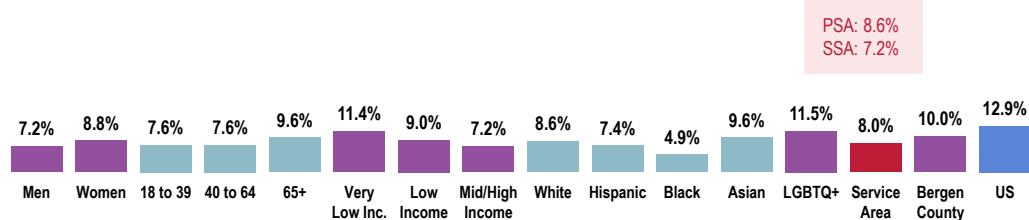
“Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?”

“Have you or has a member of your family ever received treatment for addiction to a prescription medication or been referred by a doctor, nurse, or other health professional for this type of care?”

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

### Used a Prescription Opioid in the Past Year (Englewood Health Service Area, 2022)

8.4% of respondents report that they or a member of their household have been referred to or treated for an addiction to prescription medications.



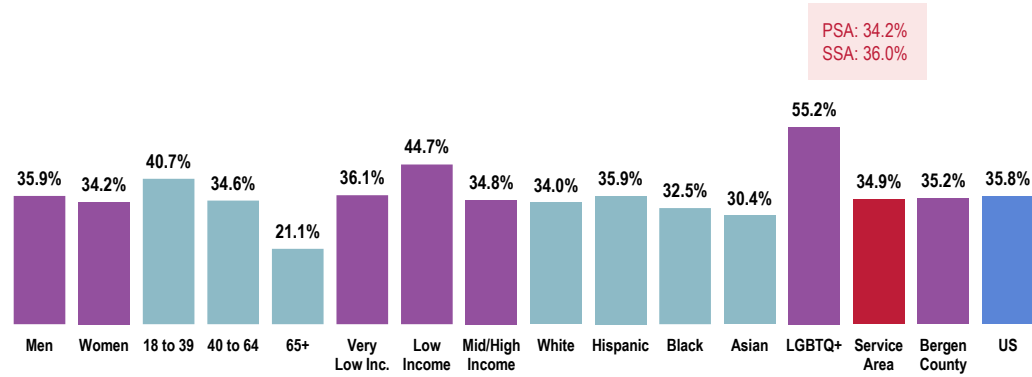
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 50, 304]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.



## Personal Impact From Substance Use

“Including alcohol, prescription, and other drugs, to what degree has your life been negatively affected by your own or someone else’s substance use issues? Would you say: a great deal, somewhat, a little, or not at all?”

Life Has Been Negatively Affected by Substance Use (by Self or Someone Else)  
(Englewood Health Service Area, 2022)



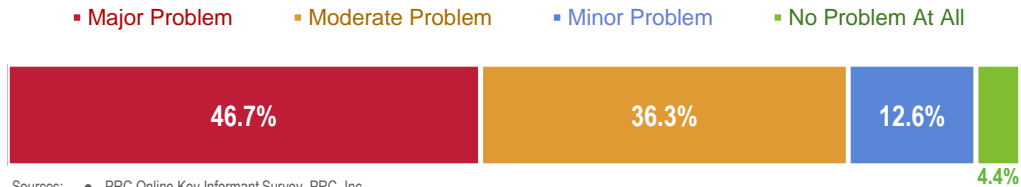
PSA: 34.2%  
SSA: 36.0%

Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 52]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents.  
• Includes response of "a great deal," "somewhat," and "a little."

## Key Informant Input: Substance Use

The following chart outlines key informants’ perceptions of the severity of *Substance Use* as a problem in the community:

Perceptions of Substance Use as a Problem in the Community  
(Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.  
Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

### Denial/Stigma

- Stigma. – Community/Business Leader
- The stigma. – Social Services Provider
- People who are substance abusers don't realize they have a problem. – Other Healthcare Provider
- Shame in asking for help. – Social Services Provider
- Stigma attached to asking for help, willingness to quit. Need to get the education piece out there. – Public Health Representative



Stigma, lack of understanding of the detox process. – Other Healthcare Provider

Stigma, criminalization of addiction, and now a prevailing attitude about cannabis being safe. Adolescents are presenting to hospitals with psychosis and delirium secondary to high potency THC intoxication as well as intoxication with synthetic cannabinoids. This is a brewing, unrecognized epidemic. – Physician

Shame- avoidance- awareness – education- substance-abuse, needs to be looked at not as a stigma but as a disease. From law-enforcement schools and doctors screening for substance-abuse... Pharmacies on the lookout...I noticed from a professional standpoint not personal... But Alcoholics Anonymous narcotics anonymous and programs for families and friends of the alcoholic or drug addict such as Al-Anon Naranon Alateen all can provide a wealth of information support recovery. Doctors, schools, workplace, houses of worship, need to be vigilant as well – Other Healthcare Provider

The stigma associated with substance abuse is still high even though efforts to address this have been taking place. That aside, just knowing where to look for treatment can be overwhelming. There are a good number of people who think that New Bridge Medical is the only place to provide this sort of treatment and frankly they still have a questionable reputation in the minds of people who may have had experiences with this facility when it was under a different name. We also don't do enough to assist families living with substance abusers in getting help for themselves as well as their loved ones. – Community/Business Leader

Denial. Prevalence of drugs in the community and ease of access. The problem may increase with the loss of restrictions on recreational marijuana, which can be a gateway drug. Addiction is a very difficult condition to treat. Family shame may prevent recognition of problem and treatment of the problem. Not enough treatment options – Community/Business Leader

Stigma and bias. Too few providers with expertise in addiction medicine. – Physician

Lack of desire, financial status, and lack of resources. – Other Healthcare Provider

Shame and lack of awareness. – Community/Business Leader

Stigma. Lack of knowledge by medical providers who are not specialists in this area. Lack of meaningful referrals when a problem is identified. – Social Services Provider

## Access to Care/Services

Places that people can access easy and long waits to get in a program. – Other Healthcare Provider

The lack of fear if a person is caught with an illegal substance. Once a person gets out of rehab, provide a program or support group so the person is not back again into the same physical environment as previously. – Social Services Provider

Inadequate safe injection facilities for IV drug users. Inadequate Inpatient/Outpatient treatment facilities. Continue iatrogenic supply of habit-forming drugs in ETC's and by PCP's and other MD's. – Physician

Spaces and available beds. Easy access to Outpatient follow up transportation. – Social Services Provider

Lack of resources in the community addressing the issue. Not enough evidence-based education to youth and families. Outdated educational resources in schools. – Social Services Provider

Lack of programs. – Community/Business Leader

There is a lack of appropriate resources in this area of need. – Social Services Provider

Quality care. – Community/Business Leader

Need to be able to access treatment at the point of readiness, so more open accessibility to engage in treatment. More awareness about the local resource availability. – Public Health Representative

The greatest barrier for those that are suffering from substance abuse are resources that are available right away. When someone that has an addiction problem decides they want to get help, we only have a short window of opportunity to react and get the patient the help they need. There are many times, where a facility does not have a bed available until a few days later which causes a person to relapse or runaway from help. – Other Healthcare Provider

Availability and cost of treatment. – Other Healthcare Provider

Access to supportive programs, especially in low-income areas such as Newark. Lack of infrastructure in low-income areas. Lack of educational infrastructure on availability of substance abuse treatment in low-income areas. – Other Healthcare Provider

Not enough long-term beds, especially for those without insurance, as well as the stigma that comes with addiction. – Public Health Representative

## Affordable Care/Services

Cost. – Community/Business Leader

Money, rehab is expensive. A 30-day detox doesn't work. – Other Healthcare Provider

The greatest barrier to accessing substance abuse treatment is cost and whether insurance will cover the cost. – Community/Business Leader

Difficult to access services, especially if you're working poor. – Social Services Provider

Affordable treatment services. – Community/Business Leader



- Cost. – Public Health Representative
- Cost, staff, and providers needed. – Other Healthcare Provider

## Insurance Issues

- Getting treatment in many cases depends on insurance coverage. There needs to be more walk-in facilities for substance abusers with or without insurance coverage. – Community/Business Leader
- Insurance payments do not correlate to patient outcomes and encourage patient visits to increase revenue. All forms of FDA approved MAT should be encouraged. Greater access to LAI to encourage successful recovery without revenue incentives where daily methadone treatments are the business model to make money. – Community/Business Leader
- Insurance coverage, stigma, and awareness. – Community/Business Leader
- Lack of health coverage and can't afford the costs. Stigma, they don't want to ask for help/denial. – Social Services Provider

## Lack of Providers

- Providers and insurance. – Other Healthcare Provider
- Lack of providers. – Other Healthcare Provider
- Not enough providers educated to treatment for different substance issues. – Physician

## Awareness/Education

- Lack of awareness. – Other Healthcare Provider
- Lack of education on what constitutes substance abuse, especially alcohol and tobacco abuse. Stigma associated with getting treatments. – Community/Business Leader
- Lack of awareness of resources. Stigma associated with substance use disorders. Fractures in the system of care --- lack of coordinated care (refer to the comments offered in the mental health section regarding creation of unique client ID, QR code, etc.). Lack of housing (parent and child housing; sober living; supportive housing) and employment options to support people in recovery. Resistance of school systems to address the issue every day through comprehensive education rather than a 1x/yr assembly. Absence of comprehensive and coordinated effort to tackle the issue (i.e. – every one of the 70 towns in BC operate independently of each other. Imagine the difference that could be made and # of lives saved if every one of the 70 towns "loaned" one officer to Paterson (the main artery of the drugs flowing into BC?!!) Coordinated care management for individuals living with SA / working towards recovery is non-existent but needed. Awareness of Family support/ed is lacking. – Social Services Provider

## Access to Care for Uninsured/Underinsured

- Access to long term recovery services for under insured and uninsured. – Social Services Provider

## Alcohol

- Alcohol is a big issue. – Social Services Provider

## Co-Occurrences

- Due to the overwhelming concern of mental health, it has led to an increase in substance abuse. – Other Healthcare Provider

## Diagnosis/Treatment

- Engaging people in treatment and then continuity of care. – Other Healthcare Provider

## Family Support

- Family members are often reluctant to confront the substance abuser thus do not seek treatment. – Community/Business Leader

## Incidence/Prevalence

- Over 107,000 deaths due to opioid overdoses. – Other Healthcare Provider

## Peer Pressure

- Peer pressure. – Community/Business Leader

## Marijuana

- Mid-level providers practicing as physicians. The confusion amongst the patient population about what level of training their provider has is astonishing. – Physician



# Tobacco Use

## ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

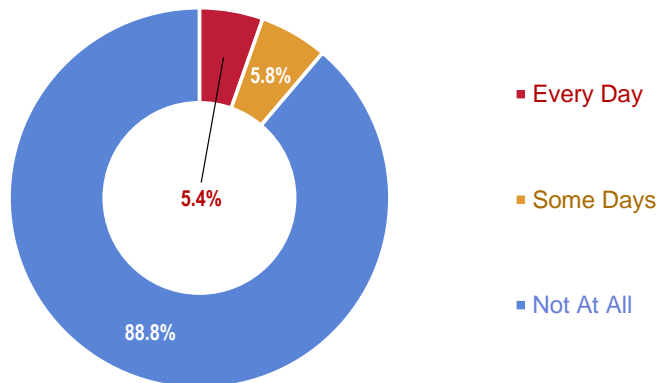
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (<https://health.gov/healthypeople>)

## Cigarette Smoking

**“Do you currently smoke cigarettes every day, some days, or not at all?”** (“Current smokers” include those smoking “every day” or on “some days.”)

Cigarette Smoking Prevalence  
(Englewood Health Service Area, 2022)



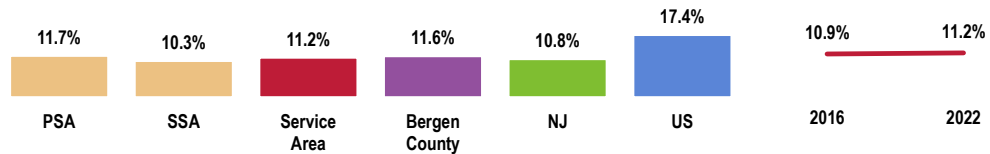
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 40]  
Notes: • Asked of all respondents.



# Cigarette Smoking Prevalence

Healthy People 2030 = 5.0% or Lower

Englewood Health Service Area



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 40]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.  
 • Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

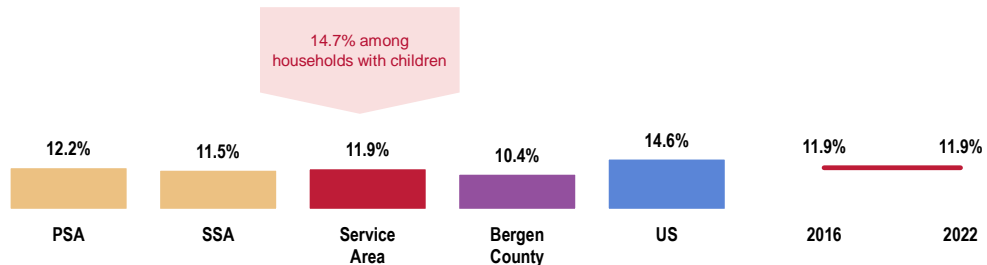
## Environmental Tobacco Smoke

**“In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?”**

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

### Member of Household Smokes at Home

Englewood Health Service Area



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 43, 134]  
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.  
 • “Smokes at home” refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.



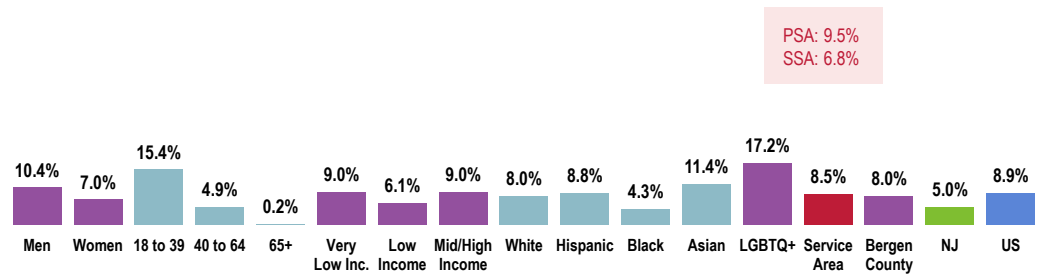
## Use of Vaping Products

“The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?”

“Do you now use electronic vaping products, such as e-cigarettes, ‘every day,’ ‘some days,’ or ‘not at all’?”

“Current use” includes use “every day” or on “some days.”

### Currently Use Vaping Products (Englewood Health Service Area, 2022)



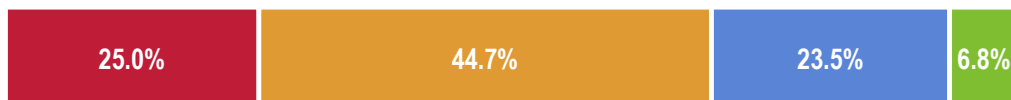
- Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 135]
  - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.
  - 2020 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.
  - Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

## Key Informant Input: Tobacco Use

The following chart outlines key informants’ perceptions of the severity of *Tobacco Use* as a problem in the community:

### Perceptions of Tobacco Use as a Problem in the Community (Key Informants, 2022)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



- Sources:
- PRC Online Key Informant Survey, PRC, Inc.
- Notes:
- Asked of all respondents.



Among those rating this issue as a “major problem,” reasons related to the following:

### Incidence/Prevalence

My opinion is formed from conversations and observations. – Community/Business Leader

We are seeing a larger number of tobacco use in our families. – Other Healthcare Provider

Still high numbers considering what we know about how it impacts health. – Community/Business Leader

People still smoke knowing the risks. – Other Healthcare Provider

High use. – Physician

Rate of smoking among Korean population and underserved communities is high. Vapor smoking among teens and young adults continues to be on the rise. – Social Services Provider

### Impact on Quality of Life

Although smoking has been eliminated from public buildings and some outdoor venues, tobacco causes cancer. – Community/Business Leader

It causes cancer, lung disease, diabetes, and strokes. – Social Services Provider

Increased incidence of lung cancer in both smokers and non-smokers. Probably due to secondhand smoke, relative to neighboring counties. – Other Healthcare Provider

Tobacco use causes cancer and contributes to pulmonary and heart disease. – Public Health Representative

Tobacco continues to have major implications on overall health. – Social Services Provider

### Youth

Tobacco use is starting at a young age and used as acceptance into the cool crowds. – Social Services Provider

The use of tobacco has changed in the recent years causing a younger generation to smoke tobacco more than before. I believe that many people have moved away from your ordinary cigarettes and are now using electronic vapes which has caused the increase in tobacco use. The smell and taste are in a variety of flavors which makes it more appealing and since the flavors are exotic it also prevents people from smelling of cigarette smoke. This is what causes not only an older population to be using tobacco but younger kids as well. I also don't believe there is enough awareness of how harmful electronic vape pens can be and what other diseases they cause. – Other Healthcare Provider

Because cigarettes are accessible to younger people and cause health problems. – Community/Business Leader

Youth are able to get tobacco easier than any other substance. With vaping being one of the biggest problems across the state, tobacco use has skyrocketed. – Public Health Representative

### Access to Care/Services

Inadequate tobacco cessation programs. – Physician

There are not enough programs to help people quit, and lack of education. – Community/Business Leader

### Co-Occurrences

Heart disease. Stroke and cancers high prevalence. – Public Health Representative

### Awareness/Education

It is overlooked as newer misused substances are given more attention. – Community/Business Leader

### E-Cigarettes

Vaping is so easy and convenient. – Other Healthcare Provider

### Social Norms/Community Attitude

Many people used to smoke actively in Korea while growing up through their adulthoods. Smoking was expected and accepted as part of effective social activities at work and at community setting. – Community/Business Leader





# Sexual Health

## ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

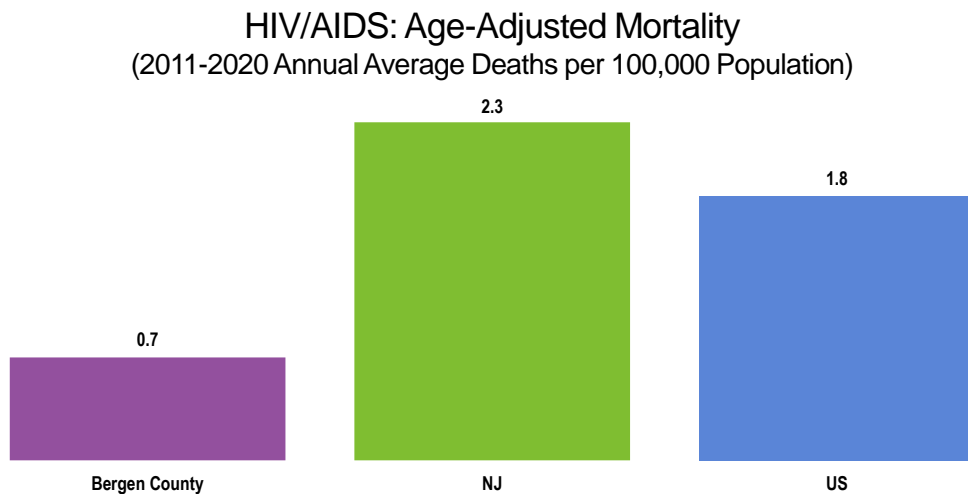
Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (<https://health.gov/healthypeople>)

## HIV

### Age-Adjusted HIV/AIDS Deaths

The following chart outlines local age-adjusted mortality for HIV/AIDS deaths. [COUNTY-LEVEL DATA]

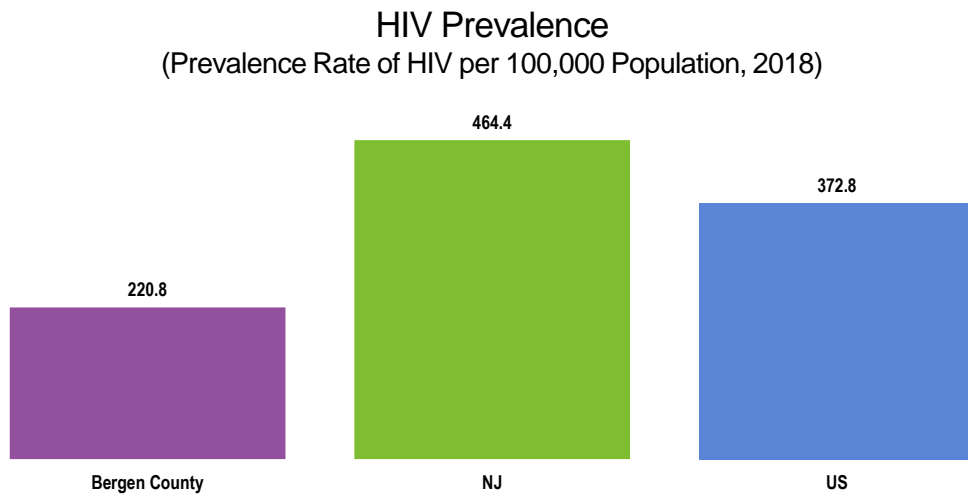


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2022.



## HIV Prevalence

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area. [COUNTY-LEVEL DATA]



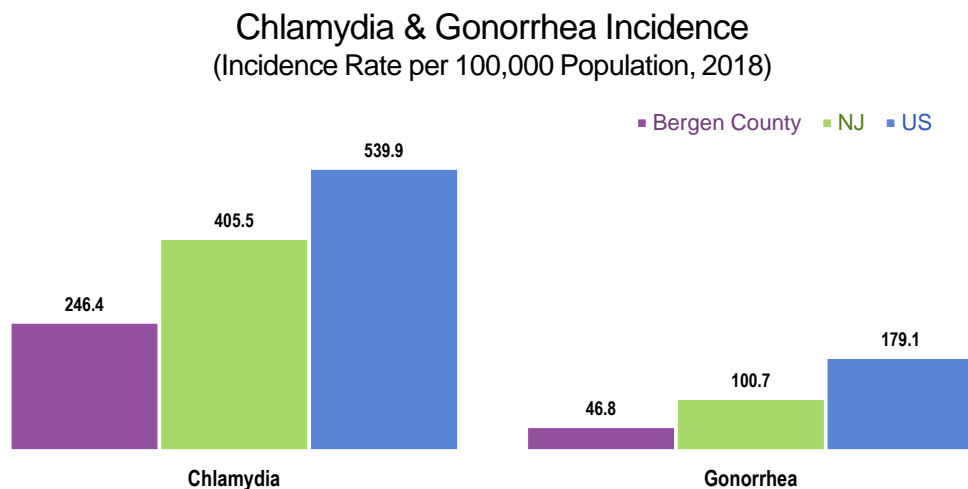
- Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
- Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

## Sexually Transmitted Infections (STIs)

**CHLAMYDIA** ► Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

**GONORRHEA** ► Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]



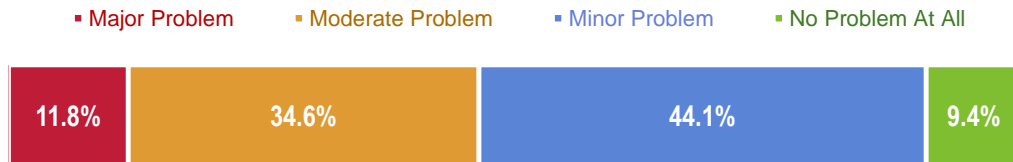
- Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
  - Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap (sparkmap.org).
- Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.



## Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:

### Perceptions of Sexual Health as a Problem in the Community (Key Informants, 2022)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.  
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

#### Awareness/Education

Confusing information leading to apathy. – Other Healthcare Provider

Lack of education. – Social Services Provider

I believe it's very important that Planned Parenthood is available to those young women who need education and examinations. Schools need to teach about sexual health concerns. TV is so widely prevalent as we read those vaccinations are available so there needs to be again constant community public health service announcements schools need to educate parents from junior high school age on up... – Other Healthcare Provider

A lack of recreational activities for youth has led to unhealthy sexual engagement and substance use. HIV is on the rise in Bergen County and not enough education around it. Lack of knowledge and access to testing. Cost of testing. – Social Services Provider

Not openly discussed. – Community/Business Leader

No identified providers knowledgeable about the needs of the LGBTQIA+ community. Inadequate sex education in schools. – Physician

#### Incidence/Prevalence

High incidence of STD's. – Public Health Representative

AIDS and other STD's still prevalent among communities. – Other Healthcare Provider

#### Access to Care/Services

I believe that most of the health systems are challenged to effectively and accurately deal with sexual health in our community. – Social Services Provider

#### Affordable Insurance

Health insurance is expensive. – Public Health Representative

#### Testing

Not enough safe, nonjudgmental, affordable testing locations. – Social Services Provider

#### Teen/Young Adult Usage

Young teens are having sex recklessly and access to social media is the culprit. – Other Healthcare Provider

#### Infectious Disease

Infectious Disease. – Public Health Representative

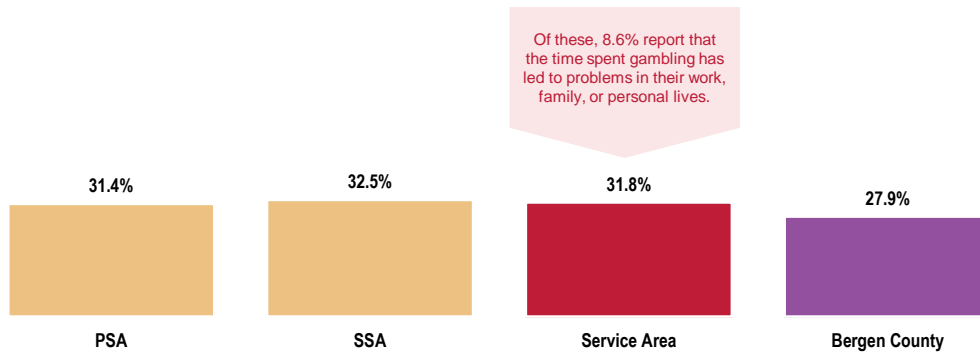


# Gambling

**“In the past 12 months, have you bet money or possessions on any of the following activities: casino games, including slot machines and table games; the lottery, including scratch tickets, pull tabs, and lotto; sports betting; internet gambling; bingo; or any other type of wagering?”**

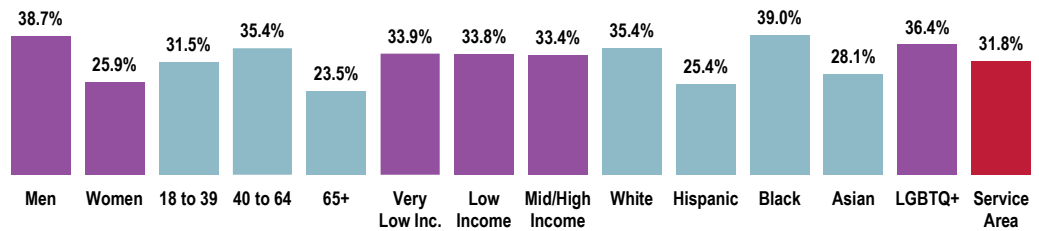
[Those who gamble] **“Has the time you spent on gambling led to problems in your work, family, or personal life?”**

## Gambled in the Past 12 Months



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 312-313]  
 Notes: • Asked of all respondents.  
 • For this issue, gambling refers to betting money or possessions on any of these activities: casino games (including slot machines and table games); the lottery (including scratch tickets, pull tabs, and lotto); sports betting; internet gambling; bingo; or any other type of wagering.

## Gambled in the Past 12 Months (Englewood Health Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 312]  
 Notes: • Asked of all respondents.  
 • For this issue, gambling refers to betting money or possessions on any of these activities: casino games (including slot machines and table games); the lottery (including scratch tickets, pull tabs, and lotto); sports betting; internet gambling; bingo; or any other type of wagering.



# ACCESS TO HEALTH CARE

## ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. ...About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (<https://health.gov/healthypeople>)

## Lack of Health Insurance Coverage

Survey respondents in the Englewood Health service area were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

**“Do you have any government-assisted health care coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?”**

**“Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay for health care entirely on your own?”**

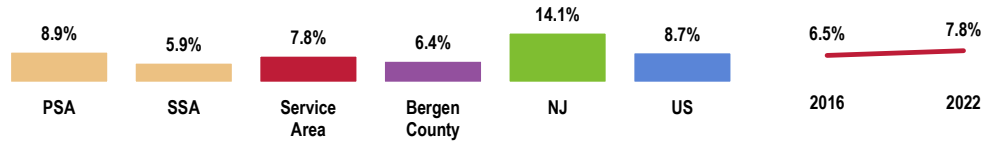
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).



## Lack of Health Care Insurance Coverage (Adults Age 18-64)

Healthy People 2030 = 7.9% or Lower

Englewood Health  
Service Area

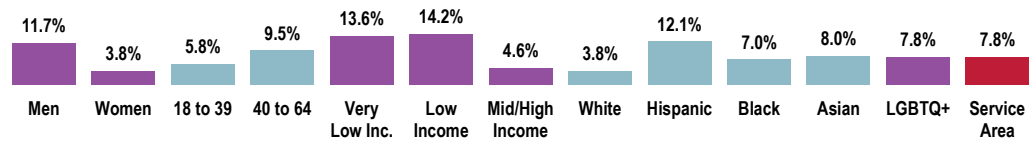


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 137]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

Notes: • Asked of all respondents under the age of 65.

## Lack of Health Care Insurance Coverage (Adults Age 18-64; Englewood Health Service Area, 2022)

Healthy People 2030 = 7.9% or Lower



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 137]  
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov> [Objective AHS-1]

Notes: • Asked of all respondents under the age of 65.



# Difficulties Accessing Health Care

## Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

“Was there a time in the past 12 months when you needed medical care, but had **difficulty finding a doctor?**”

“Was there a time in the past 12 months when you had **difficulty getting an appointment to see a doctor?**”

“Was there a time in the past 12 months when you **needed to see a doctor, but could not because of the cost?**”

“Was there a time in the past 12 months when a **lack of transportation** made it difficult or prevented you from seeing a doctor or making a medical appointment?”

“Was there a time in the past 12 months when you were not able to see a doctor because the **office hours were not convenient?**”

“Was there a time in the past 12 months when you **needed a prescription medicine, but did not get it because you could not afford it?**”

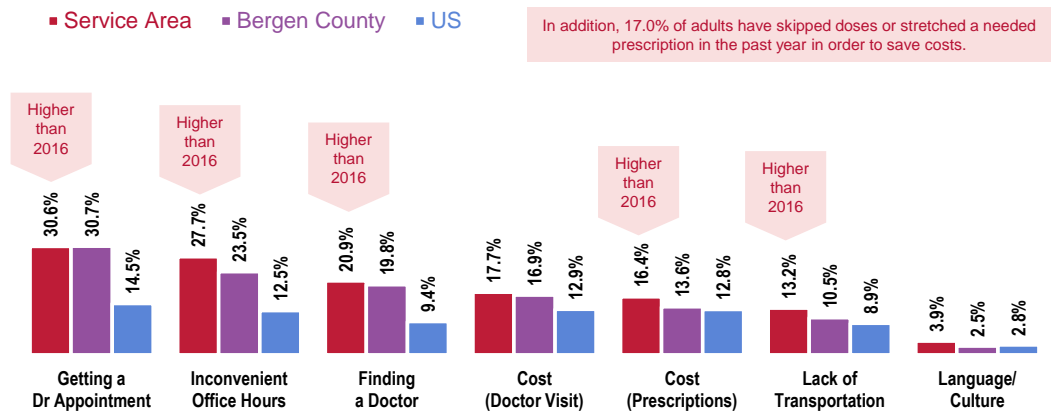
“Was there a time in the past 12 months when you were not able to see a doctor due to **language or cultural differences?**”

Also:

“Was there a time in the past 12 months when you **skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?**”

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

### Barriers to Access Have Prevented Medical Care in the Past Year



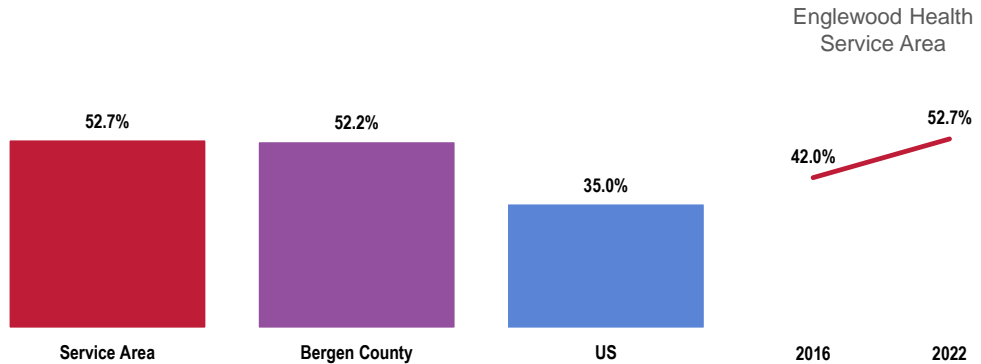
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 7-14]  
● 2020 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.



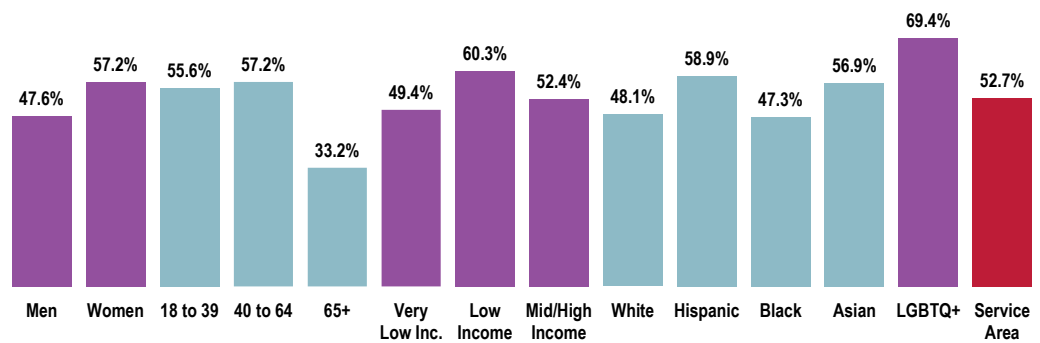
The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

### Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 140]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 Notes: • Asked of all respondents.  
 • Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

### Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year (Englewood Health Service Area, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 140]  
 Notes: • Asked of all respondents.  
 • Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

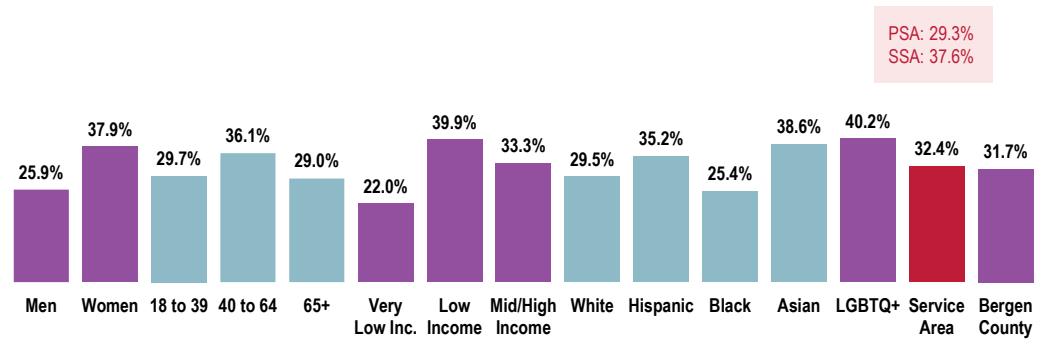




## Care Avoidance Due to the Pandemic

“Has there been a time since the start of the pandemic when you needed medical care or had a medical appointment scheduled, but you chose to avoid receiving care due to concerns about coronavirus?”

### Went Without Needed or Planned Medical Care Due to the Pandemic (Englewood Health Service Area, 2022)



PSA: 29.3%  
SSA: 37.6%

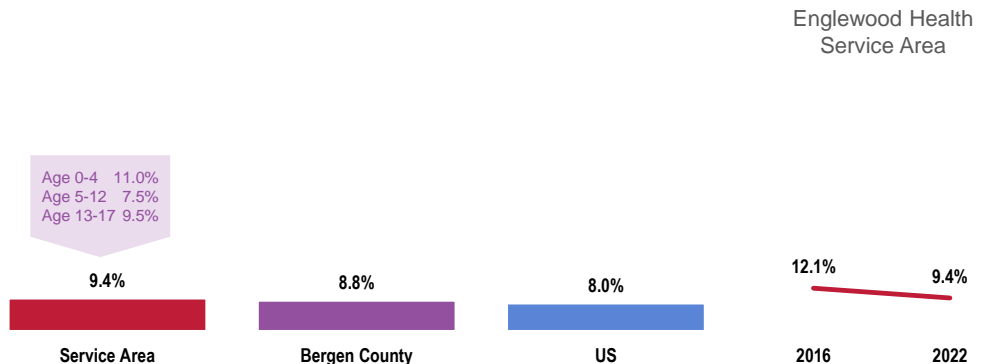
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 316]  
Notes: • Asked of all respondents.  
• Beginning of pandemic specified as March 2020.

## Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

“Was there a time in the past 12 months when you needed medical care for this child, but could not get it?”

### Had Trouble Obtaining Medical Care for Child in the Past Year (Parents of Children 0-17)



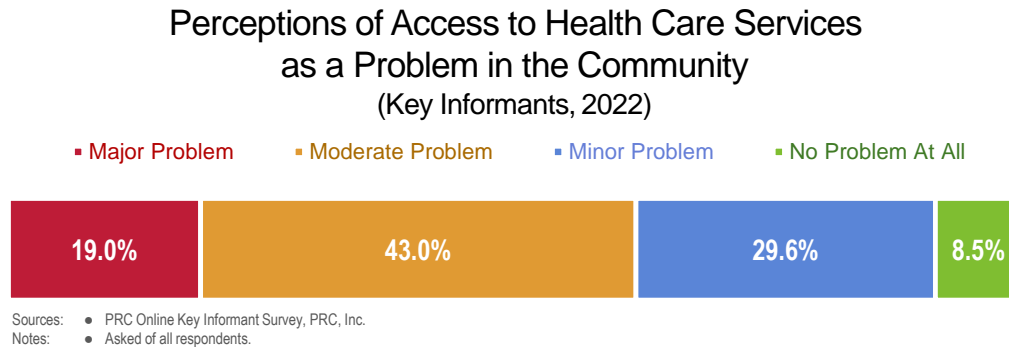
Englewood Health Service Area



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 104]  
• 2020 PRC National Health Survey, PRC, Inc.  
Notes: • Asked of all respondents with children 0 to 17 in the household.

## Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:



Among those rating this issue as a “major problem,” reasons related to the following:

### Access to Care/Services

Accessing health care and many other services/programs is a major problem particularly for low-income older adults, who may not be able to visit even a primary care physician due to lack of transportation. Many older and low-income residents may not be aware of resources available to them in the community. There needs to be more and more effective methods used to disseminate information to older, isolated adults and other low-income residents. – Community/Business Leader

Accessing health care services for youth with I/DD ages 3-18 with co-occurring medical conditions for intensive outpatient, in patient crisis services, respite programs, psychiatric and developmental assessments, dental services, transportation challenges for this population, culturally competent/appropriate services etc. – Social Services Provider

Access. – Social Services Provider

Higher demand for mental health/substance use services than system capacity can meet. Community/safety net providers need to be reimbursed at more adequate rates in order to hire and retain qualified staff. Health care providers have been limiting hours of operation to be more traditional office hours. This is difficult for adults who work and unable to take off for an appointment. Need solutions for greater accessibility to care for all. – Public Health Representative

Medical office have become a business. Seems to have been a major shift from the old-world doctors who got to know their patients due to the need for an increased administrative process. – Physician

Most of the clients I treat have told me that the major problem with finding a health care provider is that providers do not call them back. I believe there is a problem with coordination of care. Drugs, alcohol, and lack of self-care are major problems that I see often – Other Healthcare Provider

It is difficult to find and establish a therapeutic alliance with a psychiatrist. Managed care forcefully dictates the delivery of substandard care by for example focusing on superfluous and time-consuming paperwork that directly interferes with the therapeutic alliance or attempting to prevent psychiatrist from practicing psychotherapy or even spending any significant amount of time understanding their patients. The model that is pushed on psychiatrists is a non-evidence-based fantasy and the vigor with which is enforced is an atrocity and directly causing harm to patients. Insurance companies often seem to try to sabotage patient care at every turn in the name of profits. Psychiatrists would be able to help many more people if they were free to practice psychiatry. – Physician

The cost of health care is the biggest challenge related to accessing services. – Public Health Representative

Easy to access information for physician specialists available on the web. – Other Healthcare Provider

### Affordable Care/Services

Cost and availability of providers, hours of service for those who work full time. Need evening and weekend appointments. – Social Services Provider

Cost and access to affordable health care. Undocumented folks. The time spent to get charity care is lengthy and the language barrier is also another barrier. – Social Services Provider

Cost of health care and medications. Insurance issues. – Other Healthcare Provider



Access among low-income, racial/ethnic minority populations, and to some extent older adults and those living in suburban or rural areas with limited transportation is a problem. Long waiting lists for specialty care. Limited availability of endocrinologists and specialty care specialists that serve this population. – Social Services Provider

Cost to the individual. Cost to the company. – Community/Business Leader

## Vulnerable Populations

People who are low-income, uninsured, and undocumented have limited access to healthcare because they can't afford to pay for services or are afraid to apply for assistance. They use the emergency room for primary care and to deal with results of chronic disease. – Other Healthcare Provider

Access to health care for underserved communities, as defined by ethnicity, socioeconomic status, sexual orientation/gender identity and immigrants seeking status. – Physician

Families who are undocumented do not qualify for health insurance limiting their access to a primary physician and preventive care. Also, many families documented and undocumented have little to no dental health insurance. Major issues. – Social Services Provider

Resources for the LGBTQA+ community. – Social Services Provider

The language barrier and finding a good doctor. – Community/Business Leader

## Awareness/Education

Health literacy, language barrier, transportation, comprehensive insurance. – Community/Business Leader

Lack of knowledge to where to go for certain services. – Community/Business Leader

Lack of health literacy and understanding of preventive medicine. – Other Healthcare Provider

## Transportation Issues

Transportation is a huge barrier. Access for the uninsured and underinsured is also significant. Accurate and trusted information in multiple languages is always needed. – Social Services Provider

Transportation, language barriers, payment sources. – Social Services Provider

Transportation, availability of appointments, knowledge. – Community/Business Leader

## Insurance Issues

Access to insurance. – Community/Business Leader

Mental health insurance coverage. – Community/Business Leader

Gaps in insurance coverage; insurance plans limit the providers that a patient can see; hospitals (such as Hackensack) have specific insurances that are accepted--meaning that a patient often has to be sent away for specialty care; generally, health care literacy underlies a lot of the issues. – Other Healthcare Provider

## Access to Care for Uninsured/Underinsured

Big issue is health care for the uninsured. – Social Services Provider

There is a high percentage of person in Bergen County who do not have insurance or access to much needed medications. Which ultimately contributes to poor long-term care. – Physician

## Culturally Competent Healthcare

Lack of culturally competent healthcare among health care providers in hospital or physician office settings. Many of our community people are not able to speak and understand English. In addition, healthcare providers need to understand cultural norms and values of patients. – Community/Business Leader

## Poverty

Poverty. It limits access to medical care, healthy nutrition. – Community/Business Leader

## Lack of Collaboration

Collaboration among providers of healthcare and social services is lacking. – Social Services Provider



# Primary Care Services

## ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

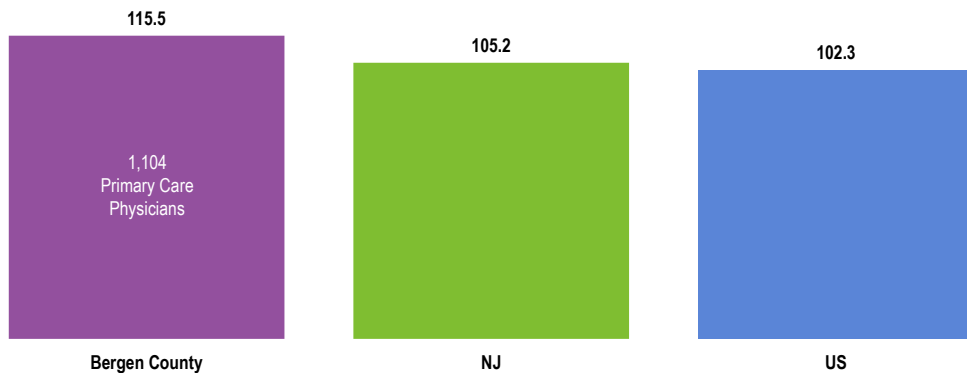
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (<https://health.gov/healthypeople>)

## Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

**Access to Primary Care**  
(Number of Primary Care Physicians per 100,000 Population, 2021)



Sources: 

- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2022 via SparkMap ([sparkmap.org](http://sparkmap.org)).

Notes: 

- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

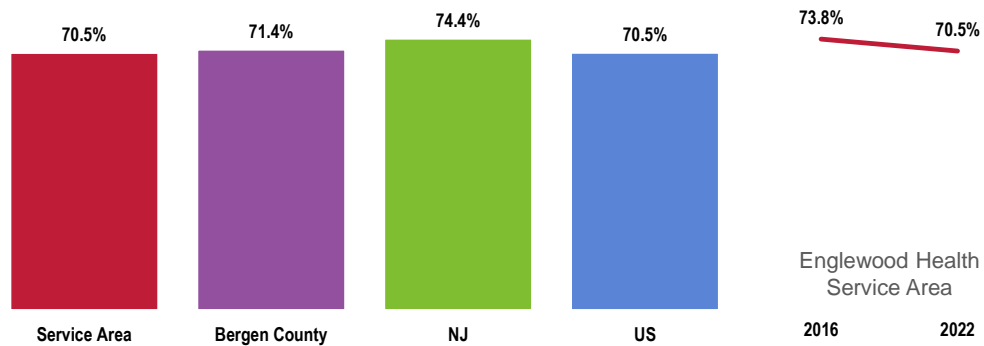


## Utilization of Primary Care Services

**ADULTS** ▶ “A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?”

**CHILDREN** ▶ “About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?”

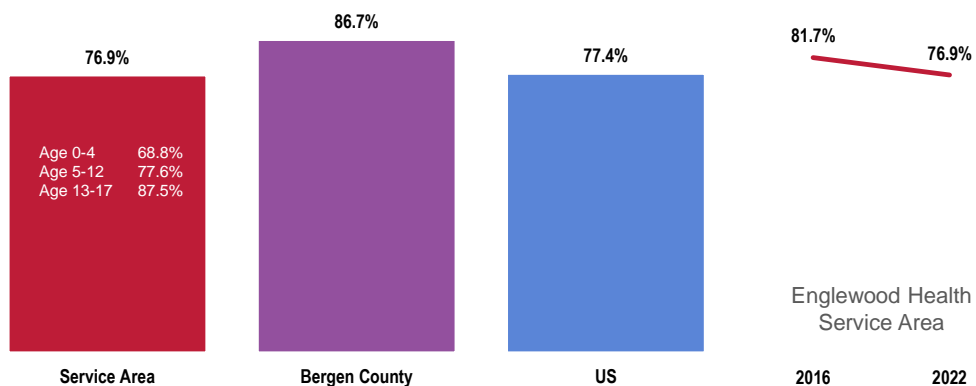
### Have Visited a Physician for a Checkup in the Past Year



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 18]  
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

### Child Has Visited a Physician for a Routine Checkup in the Past Year (Parents of Children 0-17)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 105]  
 • 2020 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents with children 0 to 17 in the household.



# Oral Health

## ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. ...Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (<https://health.gov/healthypeople>)

## Dental Care

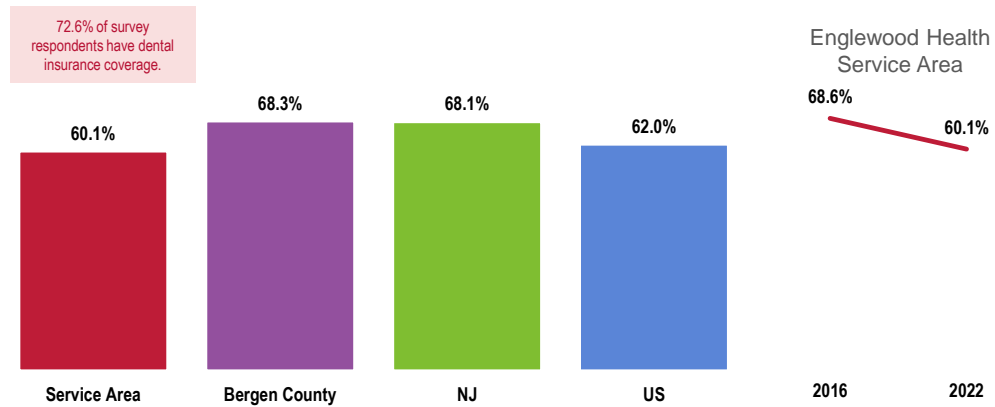
**ADULTS** ▶ “About how long has it been since you last visited a dentist or a dental clinic for any reason?”

**"Do you currently have any health insurance coverage that pays for at least part of your dental care?"**

**CHILDREN AGE 2-17** ▶ “About how long has it been since this child visited a dentist or dental clinic?”

### Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



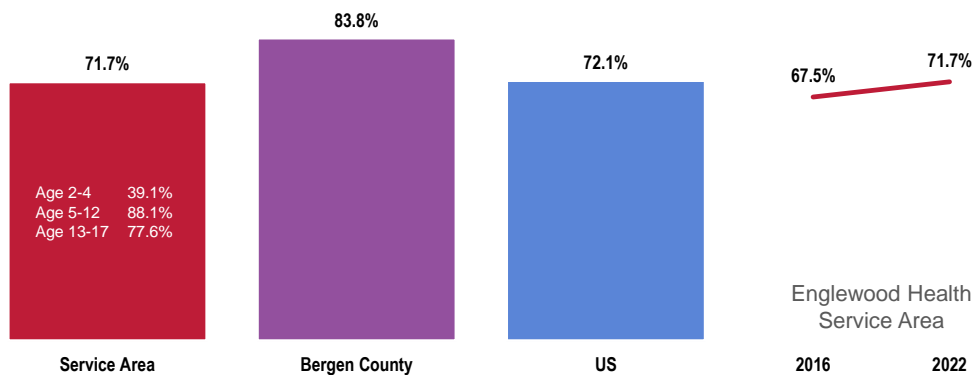
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 20-21]  
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2021 New Jersey data.  
• 2020 PRC National Health Survey, PRC, Inc.  
• US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>

Notes: • Asked of all respondents.



## Child Has Visited a Dentist or Dental Clinic Within the Past Year (Parents of Children Age 2-17)

Healthy People 2030 = 45.0% or Higher

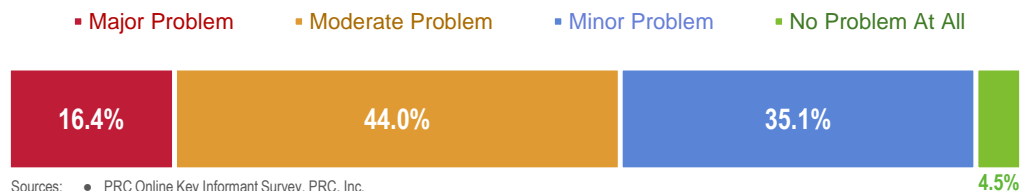


Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 108]  
 • 2020 PRC National Health Survey, PRC, Inc.  
 • US Department of Health and Human Services. Healthy People 2030. August 2030. <http://www.healthypeople.gov>  
 Notes: • Asked of all respondents with children age 2 through 17.

## Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:

### Perceptions of Oral Health as a Problem in the Community (Key Informants, 2022)



Sources: • PRC Online Key Informant Survey, PRC, Inc.  
 Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

#### Affordable Care/Services

- Dental health is not covered by most insurance, not required by schools. – Social Services Provider
- People need more affordable dental care. Why is oral healthcare so expensive and hard to get? Why doesn't Medicare include it in their basic membership. – Community/Business Leader
- Dental care is not affordable. – Physician
- Dental care is too expensive for the majority of the community. – Other Healthcare Provider
- Too expensive, not enough insurance coverage. – Social Services Provider
- I notice seniors have limited access to dental care because of financial challenges. There was an affordable dentist in the past in Englewood; however, has since retired. Several seniors indicated they do not receive care because it is not covered 100% by insurance. – Social Services Provider

#### Awareness/Education

- Not nearly enough focus on oral health, and people don't understand how connected oral health is to physical health. Few people have dental insurance. Dentists are expensive. People who don't take care of their teeth often have issues that will cost thousands to fix. – Other Healthcare Provider



People do not understand the correlation to your mental and physical health and how important it is. – Community/Business Leader

A lot of people don't realize the relationship between oral health and general physical health. – Community/Business Leader

Health literacy, access, insurance coverage. – Community/Business Leader

### Access to Care for Uninsured/Underinsured

Dental insurance is not always offered by employers, so regular visits are expensive. – Public Health Representative

Oral health is not available to uninsured children. Oral health is not available to the underserved community. – Other Healthcare Provider

No dental insurance. Low to very low-income families. No non-profit dental clinics. – Social Services Provider

### Access for Medicare/Medicaid Patients

There are no private practitioners or comprehensive dental clinics that accept Medicaid/care in Bergen County. Oral health is connected to all other aspects of health. This gap in the continuum of care profoundly impacts those who depend upon public benefits and those who live with a chronic health condition, like mental illness. – Social Services Provider

Medicare does not cover dental care. Many older adults will go preventative care until they are forced to deal with oral health issues. – Social Services Provider

### Affordable Insurance

Dental insurance premiums are high, and public have cost concerns for dental services. – Public Health Representative

### Fear

Many people are scared of going to the dentist. Oral health is vital to general health. My PSA's need to be made to discuss the importance of maintaining good oral health. From young children to seniors- Especially due to COVID people are scared to see their dentists – Other Healthcare Provider

### Income/Poverty

Finances. – Other Healthcare Provider

### Nutrition

Poor oral health due to poor nutrition. – Social Services Provider



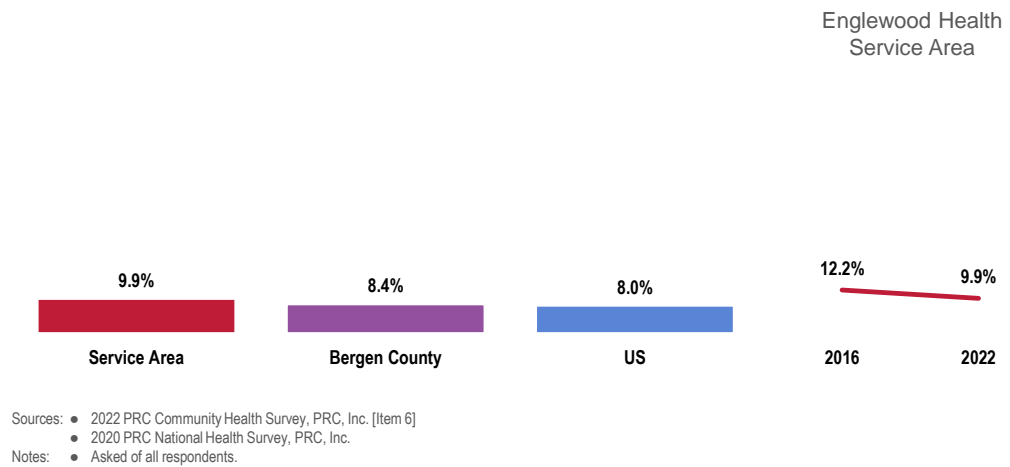


# LOCAL RESOURCES

## Perceptions of Local Health Care Services

“How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?”

### Perceive Local Health Care Services as “Fair/Poor”



# Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

## Access to Health Care Services

- Alzheimer's Organizations
- Bergen County Division of Mental Health and Addiction
- Bergen County Health Department
- Bergen County Social Services
- Bergen New Bridge Medical Center
- Bergen Volunteer Medical Initiative
- Cancer Education and Early Detection
- CarePlus New Jersey
- Carlstadt Civic Center
- Center for Independent Living
- Charity Care
- Children's Aid and Family Services
- Churches
- Community Transportation
- Comprehensive Behavioral Health Care
- Diabetes Foundation
- Doctor's Offices
- Englewood Health
- Englewood Health Department
- Faith Based Partnership Initiatives
- Federally Qualified Health Centers
- Government
- Greater Bergen Community Action
- Hackensack Meridian Health Center
- Hackensack University Medical Center
- Health Department
- Holy Name Medical Center
- Hospitals
- Hudson Clinic
- Jewish Family and Children's Services of Northern NJ
- Mental Health Centers
- National MS Society
- New Jersey Children's System of Care
- North Hudson Clinic
- North Hudson Community Action Corporation
- North Hudson Community Action Program
- Outreach Programs
- Pharmacies
- Private Practice Psychiatrists
- Urgent Care Centers

- Vantage Health

- West Bergen Mental Health Center
- Young Men's Christian Association/Young Women's Christian Association

## Cancer

- American Cancer Association
- American Cancer Society
- Bergen County Health Department
- Bergen Volunteer Medical Initiative
- Breast Cancer Organizations
- Cancer Care
- Cancer Education
- Cancer Education and Early Detection
- Cancer Support Community
- Churches
- Community Social Service Organizations
- Doctor's Offices
- Englewood Health
- Englewood Hospital
- Hackensack Hospital
- Hackensack Meridian Health Center
- Hackensack Meridian John Theurer Cancer Center
- Hackensack University Medical Center
- Holy Name Medical Center
- Hospitals
- Insurance
- Melanoma Organizations
- Memorial Sloan Kettering Hospital
- Online Resources
- Outpatient Service
- Sloan Kettering
- Valley Health
- Valley Hospital
- Wellness Center
- Young Men's Christian Association/Young Women's Christian Association



## Coronavirus Disease/COVID-19

Act Now Foundation  
Alzheimer's New Jersey  
Bergen County  
Bergen County Department of Health Services  
Bergen County Department of Human Services  
Bergen County Health Department  
Bergen County Senior Services  
Bergen National Association for the Advancement of Colored People  
Bergen New Bridge Medical Center  
BMBMC  
CarePlus New Jersey  
Case Investigation  
City MD  
County Sites  
CVS Pharmacy  
Division on Aging  
Doctor's Offices  
Education  
Englewood Hospital  
Federally Qualified Health Centers  
Hackensack Hospital  
Hackensack Meridian Health Center  
Hackensack University Medical Center  
Health Department  
Highlighting and Assessing Referral Program Participation  
Holy Name Medical Center  
Hospitals  
Jewish Family and Children's Services of Northern NJ  
Mobile Pop-Ups  
Office of Aging  
Pharmacies  
Riverside Medical Group  
School System  
Social Media  
Surveillance  
Testing  
The Center for Alcohol and Drug Resources  
Vaccinations  
Valley Community Care  
Valley Health  
Valley Hospital  
Walk in Clinic  
West Bergen Mental Health Center

## Dementia/Alzheimer's Disease

Act Now Foundation  
Allendale Community Living Center  
Allied World Assurance Company  
Alzheimer's Association  
Alzheimer's New Jersey  
Alzheimer's Organizations  
Bergen County Respite Care  
Bergen County Senior Help Line  
Bergen County Senior Services  
Bergen County Social Services  
Bergen New Bridge Medical Center  
Care2Care  
Care2Caregivers  
Caregiver Education Program  
Case Management  
Christian Health  
Churches  
Classes  
Community Health Centers  
Community Social Service Organizations  
Comprehensive Services On Aging  
Day Away Programs  
Doctor's Offices  
Dumont Senior Center  
Englewood Hospital  
Friends/Family  
Hackensack Meridian Health Center  
Hackensack University Medical Center  
Harmony Village  
Holland House  
Holy Name Medical Center  
Hospitals  
Informal Support Networks  
Jewish Family and Children's Services of Northern NJ  
Jewish Home  
Korean Community Center KCC  
Long-Term Care Facilities  
Memory Care Centers  
North Hudson Community Action Corporation  
Nursing Homes  
Ramapo Ridge Behavioral Health Hospital  
Senior Centers  
Senior Source  
Social Workers  
Sunrise Living  
Sunshine Adult Daycare  
Valley Hospital  
Van Dyk's  
Vantage Health  
Young Men's Christian Association/Young Women's Christian Association



## Diabetes

340B Prescription Program  
Allied World Assurance Company  
American Diabetes Association  
Bariatric Surgery Team  
Bergen Family Center  
Bergen New Bridge Medical Center  
Bergen Volunteer Medical Initiative  
Center for Diabetes Excellence  
Classes  
Community Centers  
Community Social Service Organizations  
Diabetes Association  
Diabetes Foundation  
Diabetes Organizations  
Diabetes Support Groups  
Division of Senior Services  
DM Educator  
Doctor's Offices  
Englewood Health  
Englewood Hospital  
Food Banks  
Food Pantries  
Friends/Family  
Hackensack Hospital  
Hackensack Meridian Health Center  
Hackensack University Medical Center  
Highlighting and Assessing Referral Program Participation  
Holy Name Medical Center  
Hospitals  
Korean Community Center KCC  
Life Time Gym  
Meals on Wheels  
Molly Diabetic Center  
North Hudson Community Action Corporation  
Online Resources  
Optavia  
Parks and Recreation  
Pharmacies  
School System  
ShopRite  
Town-Wide Wellness Challenges  
Valley Health  
Valley Hospital  
Women's Right Information Center  
Young Men's Christian Association/Young Women's Christian Association

## Disability & Chronic Pain

Acupuncture  
ARC of New Jersey  
Bergen County Community Health Improvement Partnership  
Bergen County Department of Health Services  
Bergen New Bridge Medical Center  
Bergen Pain Management  
Bergen-Hudson Chronic Disease Coalition  
Case Management  
Center for Independent Living  
Commission for the Blind  
Doctor's Offices  
Employee Insurance Policies  
Englewood Hospital  
Fitness Centers/Gyms  
Hackensack Hospital  
Hackensack University Medical Center  
Holy Name Medical Center  
Meals on Wheels  
New Jersey State Department Division of Disability Svcs  
Online Resources  
Pain Management Centers  
Parks and Recreation  
Physical Therapy  
PingPong Parkinson  
ShopRite  
Telehealth  
The Pain, Spine & Sports Institute  
Valley Hospital  
Veterans' Health Services

## Heart Disease & Stroke

340B Prescription Program  
Adler Aphasia Center  
American Heart Association  
American Stroke Association  
Bergen Volunteer Medical Initiative  
Cardiac Centers  
Community Service Organizations  
Diabetes Foundation  
Doctor's Offices  
Education  
Englewood Health  
Englewood Hospital  
Food Banks  
Hackensack Hospital  
Hackensack Meridian Health Center  
Hackensack University Medical Center  
Highlighting and Assessing Referral Program Participation



- Holy Name Medical Center
- Hospitals
- Mayor's Wellness Campaign
- Medications
- Paramedic Units
- Pharmacies
- Police and Ambulance Units
- Post Stroke and Disabled Program - Bergen County
- Saint Joseph's Medical Center
- Screenings
- ShopRite
- Social Media
- The Center for Physical Rehabilitation
- Valley Community Care
- Valley Health
- Valley Home Care
- Valley Hospital
- Young Men's Christian Association/Young Women's Christian Association

- Never Alone Again Resource Center
- Police Department
- Prosecutor's Office
- School System
- Township of Teaneck Community Policing Bureau
- Vantage Health
- Women's Right Information Center

### Kidney Disease

- American Kidney Fund
- Englewood Hospital
- Hackensack University Medical Center
- Holy Name Medical Center
- National Kidney Foundation
- Young Men's Christian Association/Young Women's Christian Association

### Mental Health

- 201-262-HELP
- 340B Prescription Program
- Act Now Foundation
- Allied World Assurance Company
- Alzheimer's New Jersey
- Bergen County Center for Educational and Psych Svcs
- Bergen County Department of Health Services
- Bergen County Division of Mental Health and Addiction
- Bergen County Family Guidance
- Bergen County Health Department
- Bergen County Therapy
- Bergen Family Center
- Bergen Family Promise
- Bergen New Bridge Medical Center
- Bergen Promise
- Bergen Regional Hospital
- Buddies of New Jersey, Inc
- Cancer Care
- CarePlus New Jersey
- CBH Care
- Children's Aid and Family Services
- Christian Health
- Churches
- Community Centers
- Community Health Law Project
- Community Mental Health
- Community Social Service Organizations
- Community Support Groups
- Comprehensive Behavioral Health Care
- County and Local Elected Leaders

### Infant Health & Family Planning

- Bergen Family Center
- Bergen Volunteer Medical Initiative
- Community-Based MCH Initiatives
- Doctor's Offices
- Englewood Health
- Health Department
- Holy Name Medical Center
- Hospitals
- Literature
- Maternal Child Health Consortium
- Maternal High Risk Clinics
- Medicaid
- New Jersey Buddies
- North Hudson Community Action Corporation
- North Hudson Community Action Program
- Partnership for Maternal and Child Health
- Planned Parenthood
- Women, Infants, and Children

### Injury & Violence

- Alternatives to Domestic Violence Hackensack
- Bergen County Alternatives to Domestic Violence
- Center for Hope and Safety
- County of Bergen Police
- Healing SPACE
- Jewish Family and Children's Services of Northern NJ
- National Association for the Advancement of Colored People



County Mental Health Board  
 County Sites  
 Defining Moments Foundation  
 Doctor's Offices  
 Education  
 Employer EAP Programs  
 Englewood Health  
 Englewood Hospital  
 First Aid Mental Health Training Referral  
 Friends/Family  
 Hackensack Hospital  
 Hackensack Meridian Carrier Clinic  
 Hackensack Meridian Health Center  
 Hackensack Meridian Health Network 6 St. John Unit  
 Hackensack University Medical Center  
 Healing SPACE  
 High Focus  
 Highlighting and Assessing Referral Program Participation  
 Holy Name Medical Center  
 Hospitals  
 Jewish Family and Children's Services of Northern NJ  
 Korean Community Center KCC  
 Local Health Departments  
 Meals on Wheels  
 Mental Health Centers  
 Mental Health Providers  
 National Alliance on Mental Illness  
 New Jersey Children's System of Care  
 New Jersey Protection & Advocacy  
 North Hudson Community Action Corporation  
 Online Meditation Events  
 Online Resources  
 Partnership for Maternal and Child Health  
 Pascack Mental Health Care  
 PerformCare  
 School System  
 Senior Centers  
 Spectrum for Living  
 Stigma Free Care  
 Stigma-Free  
 Suicide Prevention Lifeline  
 Telehealth  
 Trauma Informed Care  
 Trusted Facilities in the Community  
 Urgent Care Centers  
 Valley Health  
 Valley Hospital  
 Vantage Health  
 Wellness Center  
 West Bergen Mental Health Center  
 Westwood

Women's Right Information Center  
[www.betterhelp.com](http://www.betterhelp.com)  
 Young Men's Christian Association/Young Women's Christian Association  
 Zoom Programs

### Nutrition, Physical Activity & Weight

Amerigroup  
 Bergen County Department of Health Services  
 Bergen County Food Insecurity Task Force  
 Bergen Family Center  
 Bergen New Bridge Medical Center  
 Bergen Volunteer Medical Initiative  
 Children's Health Insurance Program  
 Classes  
 Community Centers  
 Cooking Clinics  
 County Parks  
 DM Educator  
 Doctor's Offices  
 Employer Resources  
 Englewood Health  
 Englewood Health Department  
 Englewood Population Health  
 Fitness Centers/Gyms  
 Food Banks  
 Food Pantries  
 Hackensack Meridian Health Center  
 Health Department  
 Healthy Food Options  
 Helping Hands Food Pantry  
 Holy Name Medical Center  
 Hospitals  
 Insurance  
 Jewish Family and Children's Services of Northern NJ  
 Mayor's Challenges  
 Mayor's Wellness Campaign  
 Meals on Wheels  
 Online Resources  
 Parks and Recreation  
 Partnership for Healthy Eating  
 Richard Rodda Center  
 School System  
 Senior Centers  
 ShopRite  
 SNAP Program  
 Social Media  
 Supermarkets  
 Valley Health  
 Valley Hospital  
 Vantage Health



Weight Watchers  
Young Men's Christian Association/Young  
Women's Christian Association

### Oral Health

Bergen Community College  
Dental Lifeline Network  
Dentist's Offices  
Federally Qualified Health Centers  
Hackensack Meridian Health Dental Clinic  
Hackensack University Medical Center  
Health Department  
North Hudson Community Action Corporation  
North Hudson Community Action Program  
Saint Joseph's Medical Center  
Southeast Senior Center for Independent  
Living  
Young Men's Christian Association/Young  
Women's Christian Association

### Respiratory Disease

American Lung Association  
Holy Name Medical Center  
North Hudson Clinic

### Sexual Health

Buddies of New Jersey, Inc  
Doctor's Offices  
Englewood Health  
Hospitals  
New Jersey Buddies  
Planned Parenthood  
The Zone

### Substance Use

Addiction Counseling and Treatment Centers  
Addiction Recovery Program  
Alumni in Recovery  
Bergen County  
Bergen County Center for Alcohol and  
Substance Use  
Bergen County Division of Mental Health and  
Addiction  
Bergen County Office of Alcohol and Drug  
Dependency  
Bergen New Bridge Medical Center  
Bergen Regional Hospital  
Bergen Regional Inpatient Detox

BlueCrest Recovery Center  
Care One  
CarePlus New Jersey  
Carrier Clinic  
CBH Care  
Center for Alcohol and Drug Resources  
Children's Aid and Family Services  
Christian Health  
Churches  
Community Countermeasures  
Community Mental Health  
Community Social Service Organizations  
Comprehensive Behavioral Health Care  
Doctor's Offices  
Drug Court  
Dumont Mental Health  
Eva's Village  
Faith Based Organizations  
Hackensack Hospital  
Hackensack Meridian Health Network 6 St.  
John Unit  
Hackensack University Medical Center  
High Focus  
Holy Name Medical Center  
Hospitals  
Informal Networks  
Integrity House  
Jewish Family and Children's Services of  
Northern NJ  
Ladder Project  
Peer and Advocate Lead Initiatives  
School System  
Social Workers  
Spring House  
The Center for Alcohol and Drug Resources  
Turning Point  
Vantage Health  
Wellness Center  
West Bergen Mental Health Center

### Tobacco Use

Bergen New Bridge Medical Center  
Counseling  
Doctor's Offices  
Education  
Faith Based Organizations  
Hackensack University Medical Center  
Highlighting and Assessing Referral Program  
Participation  
Hospitals  
New Jersey Quits  
Nicotine Patches



Non-Profit Advocacy Groups  
Over-the-Counter Stop Smoking Patches  
Partnership for Drug Free New Jersey  
Peer Groups  
Policies/Penalties Against Selling Tobacco to  
Minors  
School System  
Sports  
The Center for Alcohol and Drug Resources







# APPENDICES

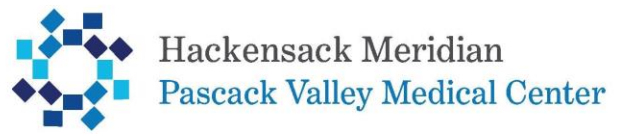
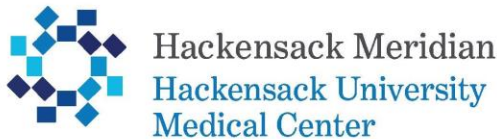
# FINDINGS FROM FOCUS GROUPS & KEY INFORMANT INTERVIEWS

## Themes from Focus Groups and Interviews with Strategic Leaders: *Bergen County, New Jersey*

The Bergen County Community Health Improvement Partnership (CHIP) comprises representatives from Bergen County Health Department, Christian Health Care NJ-Ramapo Ridge Behavioral Health, Englewood Hospital and Medical Center, Hackensack Meridian Health, Holy Name Medical Center, and Valley Health. We work together to improve the health and wellbeing of all people living in Bergen County.



**Community Health  
Improvement Partnership**  
OF BERGEN COUNTY



Every three years, these partners conduct a collaborative Community Health Needs Assessment (CHNA) to document the health status of our community, demonstrate health trends and disparities, and create a community-wide resource for Bergen County. This information is used to evaluate our collective efforts toward health improvement and formulate strategies to advance health equity.

Part of this process is talking with real people about their perceptions and experiences in Bergen County. 35<sup>th</sup> Street Consulting, a New Jersey-based, woman-owned business, was engaged by the Bergen County CHIP to conduct interviews with community leaders and facilitate focus groups with people from all walks of life in Bergen County. Including the voices of people who live and work in our community helps contextualize statistical data and glean insights into disparities. These conversations help create practical, place-based solutions to improve the quality of life for all people in Bergen County, New Jersey.

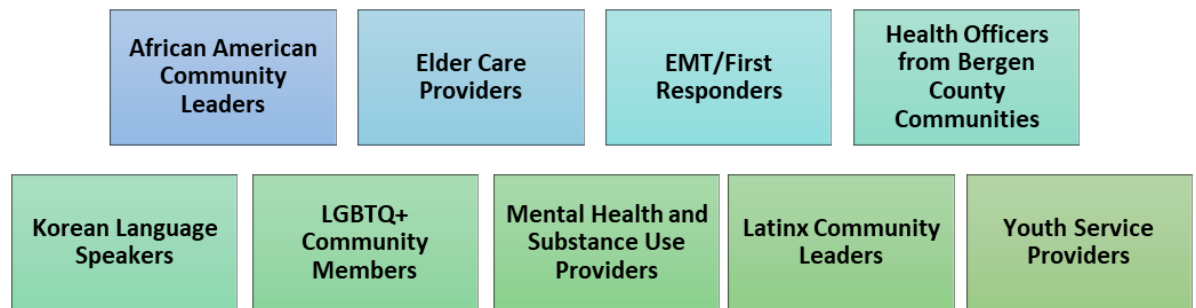


The participants in both the focus groups and the one-on-one interviews were asked a similar array of questions. The following questions were included in the focus groups and interviews.

- What stands out to you as a significant accomplishment in recent years that has most impacted the community?
- What challenges brought about by COVID do you think will take our community the longest time to recover from?
- What are the most pressing concerns you are seeing among the people you serve now?
  - How is that different than it was before COVID?
  - What are the biggest barriers you have in connecting people with what they need now?
- How is the way your institution operates the same or different now than before COVID?
  - What works better?
  - What is harder?
- In your experience, what do you think should be the top 3 priorities the Bergen County Health Improvement Partnership should tackle to improve the health and quality of life of the people you serve?
- What should health care and public health do differently to address the priority areas you identified?
- In the future, when you think back to this time, what do you think you will remember most?
- If you had a magic wand that could fix one problem you see, what would you fix?

From June through September 2022, 35<sup>th</sup> Street Consulting conducted nine focus groups with individuals representing segments of the Bergen County population whose perspectives are often underrepresented in planning and decision-making. Focus groups provide an environment in which in-depth discussions lead to greater understanding of the “whys” behind research findings, as well as creating space to solicit candid feedback on experiences and attitudes. These insights are essential to crafting relevant, actionable plans that engage the enthusiasm, resources, and interest of the partner agencies. Some focus groups were conducted in person, while others were conducted virtually. Discussions were conducted in English and Korean languages.

The focus groups included people representing the following populations:



In addition to the nine focus groups, 35<sup>th</sup> Street conducted 13 interviews with select strategic leaders representing a wide range of expertise across Bergen County. These one-to-one conversations were valuable in diving deeply into the experiences of stakeholder groups, capturing unique perspectives, gathering input on priority needs, and mining recommendations for problem-solving at a systems level.

The following individuals participated in virtual interviews between June and September 2022.

- Lynn Algrant, Greater Bergen Community Action
- Helen Archontou, YWCA Northern NJ
- Dr. Hillary Cohen, CME Englewood Health
- Liz Corsini, Bergen Family Center
- Dr. Mohammed Elrafei, Christian Health Ramapo Ridge Psychiatric Hospital
- Sofia Magnifico, Christian Health
- Michael McCann, FORGE Health
- Commissioner Germaine Ortiz
- Kristine Pendency, Bergen New Bridge Health
- Vito Veneruso, North Hudson Community Action
- Deborah Visconi, Bergen New Bridge Medical Center
- EJ Vizzi, Age Friendly Teaneck
- Chairwoman, Commissioner Tracy Zur

A summary of the themes that emerged from analysis of the data gathered from the focus groups and the interviews is listed here. Key elements impacting these themes will be explored in the following pages.

## Key Themes from Community Conversations



## Bergen County bore the brunt of COVID-19 at the very beginning of the pandemic

Bergen County experienced the devastating impact of COVID-19 infection and death earlier than most other places in the world. On March 13, 2020, the US declared COVID-19 a global pandemic triggering a nationwide shut down beginning March 15, 2020. On March 28, 2020, the Centers for Disease Control issued a domestic travel advisory for New York, New Jersey and Connecticut due to high community transmission of COVID-19 through that area. Within the state of New Jersey, the northern counties closest to New York City including Bergen County, were the most dramatically impacted by COVID-19 infection, transmission and death at that time. While unprecedented efforts were occurring worldwide to identify processes to stop the spread of COVID-19, there were very few known strategies to protect from, treat, and stop the virus during the early months of 2020. By April 10, 2020, the New York City area, including Bergen County, had more COVID-19 cases and deaths than any other country in the world, elevating COVID-19 as the leading cause of death for all people in 2020 in Bergen County.

***“We [Bergen County] were the guinea pigs... we shared our learning, and we saved other people.”***

- The lessons learned in Bergen County saved lives worldwide, but at a cost.
- The early onset of a new and deadly virus impacted **individuals** and **families**, but also **took a toll on the capacity of health care** providers, social services providers for vulnerable populations to continue to provide care.
- The **physical toll** on people in these professions combined with **restrictions required for educational institutions, economic hardships**, and other factors **reduced the pipeline of newly trained workers in these fields.**

***“There were about 25 of us here every day [at work], scared to death. We watched people die, really quite a remarkable time. A bunch got really sick with Delta at the beginning, long haul COVID and anxiety... we couldn’t get the vaccine because we were not considered essential, so lots of us got really sick.”***

***“People don’t want to work in the [health care/social service/first responder] industry anymore. For the salaries we offer, people can work at Foot Locker and make the same money and not risk their lives.”***

***“We don’t have the workforce to meet the need. We saw a big hit to the nursing staff, a lot retired through COVID ...Hoping the healthcare industry gets that influx of college students and graduates who want to come here right now we don’t have enough ...Everybody has upped their salaries – baristas make the same as entry level mental health specialists. We can’t keep up.”***



## Mental Health: The pandemic period negatively impacted mental health, especially for already vulnerable populations and frontline workers.

People in Bergen County struggle with **trauma stemming from the COVID-19 pandemic period** from myriad sources including:

- Living in **unsafe households** during the pandemic quarantine period
- **Grief and loss** from COVID-19 period
- **Financial crisis**
- Fear, exhaustion, illness, stress, **and burnout among frontline workers** including:
  - Healthcare workers
  - EMTs and first responders
  - Social services providers
  - Educators at all levels
  - Elder care workers
  - Essential services workers
- **Extended isolation**, especially among:
  - Children/adolescents
  - Seniors
  - People with disabling conditions
  - People in recovery
- Need for Mental Health Support exceeds current capacity, especially for:
  - **Anxiety** and Depression
  - Substance Use, **especially alcohol**
  - **Young people**

*“So much teen mental health need now. The pandemic was an earthquake and now a tsunami is coming. The levels of anxiety and depression is troublesome.”*

*“Healthcare providers have been traumatized and have PTSD. Many didn’t go home in order to try and save their families. They had separate silverware, etc. to try and keep their family safe.”*

*“Staff are at their wits end – anything that is difficult becomes personal. It’s easier to stick yourself in someone else’s shoes when you have the mental space to be able to do that.”*

*“There is a lot of PTSD from what we all endured as a society.”*



***“There are two Bergen Counties” – Bergen County is a very expensive place to live.***

Even though the percentage of people in poverty is relatively low, it still **represents a large number of individuals and families.**

- There are more **people in need** than it seems
- The cost and availability of the internet is a huge barrier for many
- Many **front-line staff do not make a living wage** based on Bergen County’s cost of living
- **Housing costs** are very high for renters and homeowners; emergency housing and affordable housing does not meet demand
- **Inflation** is impacting families, seniors, small businesses as resources from COVID are diminishing
- **Food Security** continues to be a wide-reaching concern throughout the pandemic including today
- **Small business** owners have not recovered financially

*“Bergen County is considered so wealthy. When we think about fed and state standards of living, \$50,000 is great in North Carolina, but it’s nothing in Bergen County.”*

*“This is one of the wealthiest counties in the nation. How can children go to bed hungry here?”*

*“Living here is impossible for normal people.”*

*“[The fact that] young people can’t afford to live here is a huge problem.”*

*“Internet should be a public utility like water and electricity are. Should not be an optional thing in this society. If you don’t have internet or means to pay for it or understanding of speed etc. is a big barrier.”*



## Breaking down silos: Care and services in Bergen County are many, but seem disconnected, complicated, and limited by resources.

Because Bergen County is largely affluent, **the resources that do exist to help are less apparent** than in other communities.

- There are resources but **people don't know about them**
- Disconnected care makes it hard for people in need to find an **"on ramp" to access services**
- Long **wait times** can exacerbate existing problems, erode trust
- **No common source or location to share or gather information** about resources
  - **Lack of available data to identify disparities** based on demographic characteristics
  - **Disconnected services** reduce the availability of support for people, and impacts the investment of money and resources for care services
  - Many individuals and community agencies **do not have consistent access to the internet**

*"Our people are not keeping up with the pace – our people are not able to navigate online."*

*"Everyone is really desperate in their own little nook. We need to come together to work on systemic issues that have always been there. COVID blew that wide open."*

*"There are lots of silos, secrecy and competition even within the helping communities because dollars are so scarce."*

*"Social safety net has more holes than string around here."*

*"Why does it have to be so hard? I can't even share my food with other organizations, even if they have need. There's so much red tape."*





## Inclusion is important: Work needs to be done to rebuild trust in health care.

COVID-19 revealed and **highlighted existing inequities**, which, combined with fear and widespread misinformation during the pandemic, **exacerbated mistrust**.

- **Representation matters:** patients willing to discuss discrimination (racism, LGBTQ+ discrimination, language and country of origin) when they feel welcome, understood, and able to use their preferred language
- **Language/culture barriers** including lack of **LGBTQ+ affirming care** and messaging
- **Continuity of Care:** not having a primary care provider **relationship** negatively impacts health outcomes and trust in health care
  - **Lower income** people in Bergen are less likely to have a primary care provider
  - Disconnected care creates **opportunities for misinformation**
- **Fear based delay** in routine care appointments since the pandemic started negatively impacts health outcomes and trust
- There are many CBO's who are willing to share what they know but are **not being connected to the conversation**
- Sense that **race/ethnicity/language/income/education impacted** what care was provided
  - **Essential workers from fields beyond health care and first responders**, especially frontline workers of color and people with limited income **felt they were not prioritized for safety measures** vaccines to the beginning for

*“Early on [in the pandemic, there] was fear, and the sense that systems didn’t care for people of color same way as white folks.”*

*“[Regarding COVID-19 vaccines] We didn’t have hesitancy problems, we had access problems in communities of color. Once we had access then we didn’t have hesitancy.”*

Rise in race-based hate instills fear, isolation

*“We have a lot of work to do. Racial justice is the most important issue. A lot of this could have been prevented.”*

from PPE to information from the pandemic community-wide

*“NA/AA/ and other Anonymous meetings are few and far between in New Jersey. And there are lots of LGBTQ people who are not willing to go to a church.”*

*“It was so awful to see racism play out in who didn’t get care, and who lost people, who didn’t know if their families were going to make it.”*

*“We are in a public health crisis with racism. Not mitigate, we need to eliminate systems of oppression, especially those that impact black and brown.”*



Data collected from these conversations will be used to develop collaborative action planning to advance the health and well-being of all people in Bergen County.



This report has been prepared on behalf of the Community Health *Improvement* Partnership (CHIP) of Bergen County.

**Our Research Partner:**



A New Jersey certified Small Business Enterprise (SBE) and Women Owned Business Enterprise (WBE), 35th Street Consulting specializes in transforming data into action that advances health and social equity through practical and impactful strategies. Our interdisciplinary team of community development experts, health planners, researchers, and data analysts have worked with hundreds of healthcare providers, payors, public health departments, government agencies, health and human service providers, and other community-based organizations to direct action and funding to reimagine policies and achieve realistic, measurable social impact.

We use quantitative and qualitative research methods to conduct studies and develop solutions to address community health, housing, socioeconomic disparities, capacity-building, population health management, and similar challenges. We specialize in transforming research into action through strategic planning, policy change, and collective impact.

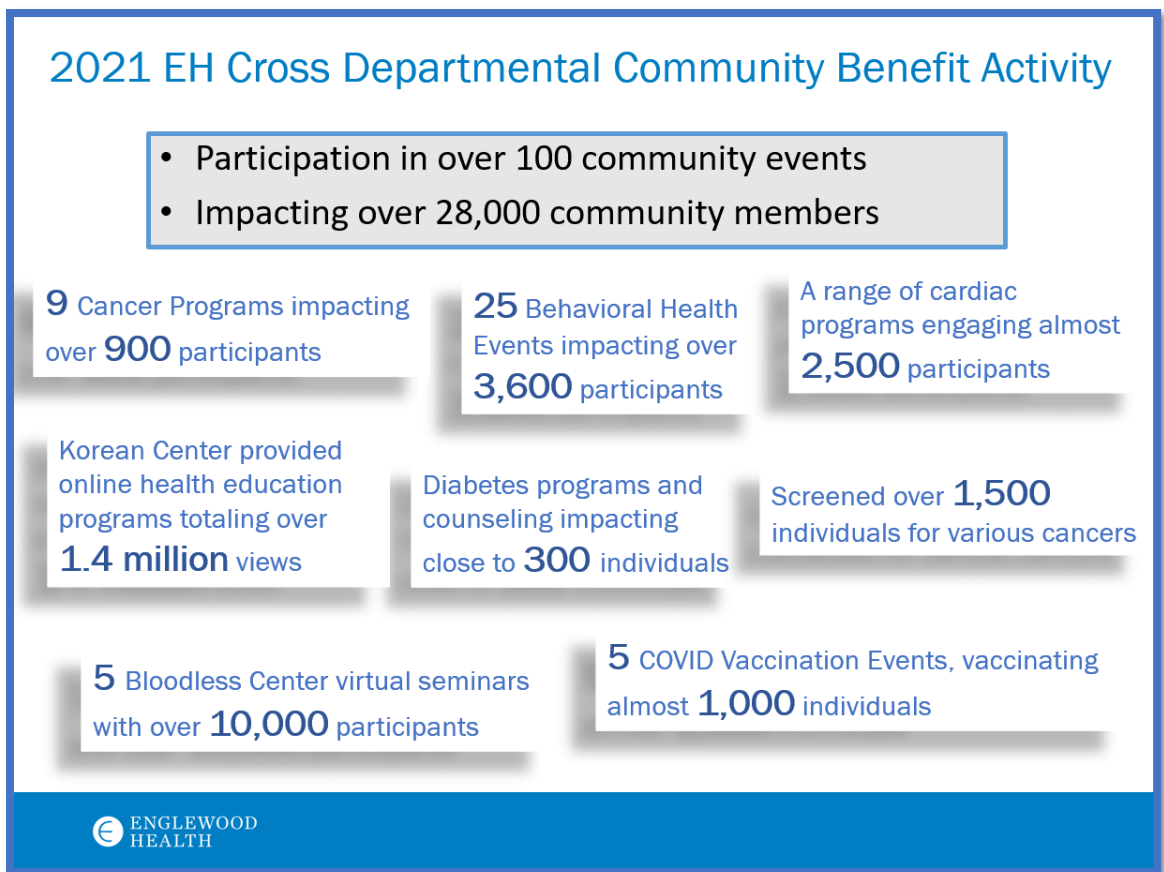


# EVALUATION OF PAST ACTIVITIES

## Year End Report 2021: 2020-2022 Community Health Needs Assessment

### OVERVIEW

This 2021 Community Health Needs Assessment Year End Report contains highlights of key initiatives and a full overview of the community activities provided by Englewood Health to support the health of the populations we serve. While continuing to manage the ongoing COVID-19 pandemic, Englewood Health engaged our patients and community members in a wide range of impactful educational opportunities, prevention programs, and wellness efforts. The majority of programs and activities detailed below reflect the use of a successful virtual engagement platform.



The selection and criteria for the Englewood Health (EH) community health initiatives are guided by the hospital's implementation strategy, updated in 2019 based on the most recent results and analysis identified in the 2019 Community Health Needs Assessment.

The process for generating this annual report includes the Population Health team meeting with respective service lines and departments to discuss and capture the 2021 goals, objectives, strategies and accomplishments.

For purposes of review, below are the 2020 – 2022 EH goals and objectives.



### Goal 1: Increase Access to Health Education, Screening and Prevention Services

- **Objective 1**
  - Provide education and intervention regarding wellness, health promotion, prevention efforts, risk factors, and healthy behaviors (nutritional, physical, and emotional health / wellness)
- **Objective 2**
  - Conduct screenings for chronic disease risk factors (e.g., cancer, high blood pressure, cholesterol, BMI) and provide referrals to appropriate treatment or services
- **Objective 3**
  - Implement programs and events with local and regional collaboratives that address issues related to wellness, prevention, and risk factors
- **Objective 4**
  - Expand upon our system-wide care management program

### Goal 2: Improve Health Status Through Chronic Disease and Care Management

- **Objective 1**
  - Provide programs that promote education and awareness of chronic and complex conditions
- **Objective 2**
  - Promote chronic disease management programs (diabetes, cardiovascular, stroke and cancer)
- **Objective 3**
  - Provide linkage to care, with increased access to providers and navigation within physician network
- **Objective 4**
  - Create customized care plans to manage patients with complex conditions

### Goal 3: Promote Positive Mental, Social, and Emotional Health

- **Objective 1**
  - Expand efforts to reduce stigma
- **Objective 2**
  - Continue to offer behavioral health educational programs and screenings in community-based settings, with a focus on priority populations
- **Objective 3**
  - Expand behavioral health care services in the Englewood Health Physician Network
- **Objective 4**
  - Improve access to behavioral health treatment
- **Objective 5**
  - Collaborate with local and regional partners to address behavioral health issues

### Goal 4: Address Issues That Prevent or Delay Individuals from Accessing Care and Resources

- **Objective 1**
  - Develop innovative solutions for improving access to care, for the community at-large and patients attributed to the Englewood Health Physician Network
- **Objective 2**
  - Implement navigation services that remove barriers to care (language, age/transportation)
- **Objective 3**
  - Expand program and policies that screen for and address social determinants of health, with a focus on nutrition and food security
- **Objective 4**
  - Implement local and regional efforts to address social determinants of health and access to care issues

## KEY HIGHLIGHTS

Significant community benefit activity occurred as Englewood Health continued to manage the ongoing COVID-19 pandemic and provide educational opportunities and programming to the community.

In an effort to expand access to the COVID-19 vaccine, EH opened a dedicated vaccination facility in Englewood Cliffs, as well as conducted 5 highly promoted community vaccination events, providing nearly 1,000 vaccines for vulnerable populations in the Englewood area.

EH remained actively committed to efforts around cancer care and detection during the pandemic. EH promoted several programs to educate community members around the importance of receiving regular cancer screenings. EH's Cancer Education and Early Detection



(CEED) Program, funded through the New Jersey Department of Health, Division of Family Health Services, screened 88 patients for breast and cervical cancers in 2021. Lung cancer screenings continued to increase in 2021, with over 770 screenings completed. In addition, cancer care patient navigators aided in connecting over 120 uninsured patients with charity care.

EH continued its strong focus on the Diabetes Education program, once again obtaining recognition by the American Diabetes Association for meeting the national standards of Diabetes self-management education, which it has held for over 20 years. EH also offered free Diabetes testing supplies for uninsured women with Gestational Diabetes and worked in conjunction with the North Hudson Community Action Corporation Englewood Health Center to provide needed Diabetes support to its patient population. In addition, dietary counseling and education were provided for pregnant patients referred by the North Hudson Community Corporation.

The EH Korean Center's team successfully pivoted during COVID and took on a large-scale virtual health programming effort to engage the Korean population on important health issues and COVID safety information. This effort resulted in over 1.4 million views of this virtual content, covering various chronic conditions and providing consistent and timely medical information.

EH promoted the cardiac health and wellness of community members through trainings and educational programming. In 2021, over 2,300 individuals were trained in various CPR courses, including advanced cardiac life support, pediatric advanced life support, pediatric emergency assessment recognition and stabilization, and basic life support.

The Bloodless Medicine and Surgery Department continued hosting virtual education seminars for the community; these seminar topics included ways to better care for your health and lifestyle choices, understanding bloodless medicine, the future of the bloodless program at Englewood Health. 5 virtual seminars were held, reaching approximately 10,000 participants.

The Population Health Care Management Team held a second very successful free 12-week Diabetes management virtual program for EHPN (Englewood Health Physician Network) patients with the goal of effectively managing their diabetes through education and behavior modification. This program built upon the success of the first series held in 2020. Patients participated in a skills-based program around exercise, healthy eating, effectively managing medication and testing blood sugar levels, and developing emotional skills to manage stress while dealing with a chronic condition.

EH supported the Population Health Department's community outreach by maintaining and expanding a series of strategic community partnerships, allowing EH to bring meaningful programming and content to the community. These included the continuation of the Healthy Eating Partnership, which provided free meals, nutritional education, and interventional tools presented by EH Diabetes Educators. In 2021, the program expanded its virtual engagement and reached new partners in the community through contact-free meal pick-up and virtual nutrition education presentations. EH continued its focus on the Social Determinants of Health by growing the Food Insecurity Response Initiative (FIRI), which screens patients for food insecurity and seamlessly connects them to on-going food resources. In 2021, FIRI expanded to include the North Hudson Community Action Corporation and the Englewood Health emergency department, both of which are areas with defined needs.

EH also actively supported wellness in community youth through programming addressing emotional, physical and nutritional wellness. In response to the impact of the ongoing pandemic, Englewood Health has pivoted to include crucial programming, both virtual and in-person, to support the youth population. This includes a virtual rotation of the Discovery Program, a 4-week health and wellness series educating youth on practical life skills surrounding emotional, physical and nutritional health. EH also continued to provide emotional support to youth through yoga, art therapy and stress management and coping skills workshops.

EH further invested in the behavioral health of the community, as the ongoing pandemic has resulted in an even greater demand for support and services. EH has held more than 25 emotional wellness events, impacting more than 3,600 community members. EH continued the behavioral health partnership with the Bergen Family Center to provide individual therapy, youth art therapy workshops, youth wellness presentations and virtual yoga that reached a combined 230 youth. In addition, emotional wellness programming was provided to adults through a partnership with the Bergen Family Center, reaching over 75 adults and parents in the



community. Overall, EH provided a range of very timely virtual behavioral health programming to a wide range of ages from youth to seniors, as well as an ethnically diverse audience. EH also held a large education and skill-building workshop supporting caregivers of individuals with dementia, to teach how to effectively cope and manage during this unprecedented time of solitude. Additionally, in response to the pandemic and the increase in depression, isolation, and anxiety, EH increased the number of virtual yoga and meditation classes provided to our community partner agencies, as well as the community at large. These programs were conducted in multiple languages.

EH maintained its focus on the fundamentals of wellness and through partnerships with local agencies (Women’s Rights and Information Center as well as local churches and the local North Hudson Community Action Corporation), providing multiple skills-based, month-long health and wellness workshops for adults from vulnerable populations.

A detailed account of all programming that occurred during 2021 for each of the hospital’s four goals can be found in the following **PROGRESS REPORT** section.

#### Methodology

The review and assessment process includes:

- Submission, review of the outcomes and impact data that was tracked and reported during the last fiscal year.
- Discussion of the accomplishments and next steps identified during review meetings held with EH hospital representatives throughout Q1 2022.

A total of **28** hospital staff participated in the evaluation process through a series of review meetings. The review meetings included representation from the following EH areas: Heart Disease and Stroke, Immunizations and Infectious Diseases, Behavioral Health, Access to Healthcare, Bloodless Medicine and Surgery, Cancer , EMS, Diabetes, Integrative Medicine, Population Health and the Korean Center. The participants included:

Name	Title
Debra Albanese	VP of Development
Andrew Brunnuell	Behavioral Health Assistant, Population Health
Michael Chananie	Director, Public Affairs and Marketing
Ramon Correa	Manager, Bloodless Medicine and Surgery
Melisa Damcevaska	Population Health Coordinator
Dr. Alexandra Gottdiener	Chief of Medicine, Department of Medicine
Barbara Grygotis	Administrative Director, Cardiac Surgery
Christine Hamel	Manager, Special Projects
Sooyun Lee	Public Relations Specialist
Linda Leighton	Nurse Manager, Behavioral Health
Jamie Ketas	VP of Population Health
Cynthia Lewis-Kroning	Program Manager, Center for Integrative Medicine
Danielle Lambert	Manager Behavioral Health, Population Health
Elizabeth Manfredo	Administrative Director, Cancer Center
Lauren Menkes	Director of Social Work, Population Health
Mary O'Connor	Director, Diabetes Education Program
Alicia Park	VP Communications
Dr. Dipal Patel	Associate Program Director, Internal Medicine Residency Program
Dr. Natasha Rastogi	Associate Director of Ambulatory Care
Claire Rizzo	Senior Director of Risk and Quality Assessment
Richard Sposa	Director, Emergency Medical Services



Diana Torres	Manager, Infection Prevention
JoAnn Venezia	Program Director of Behavioral Health
Deborah Weinstein	Director, Ambulatory Quality Programs
Christina Weiselberg	Administrative Director, Breast Care Center
Jennifer Yanowitz	Manager of Strategic Programming
Ethan Yoon	Public Relations Specialist
Christine Young	Manager, Ambulatory Care Management

## PROGRESS REPORT

### Priority Area: Wellness & Prevention

#### Goal 1: Increase Access to Health Education, Screening and Prevention Services

##### **Objective 1: Provide education and interventions regarding wellness, health promotion, prevention efforts, risk factors, and healthy behaviors (nutritional, physical and emotional).**

- EH produced ongoing social media campaigns to educate the public regarding COVID-19 prevention, social distancing, and the importance of vaccination.
- EH and community partner agencies mobilized and continued having weekly community calls to identify unmet needs of local residents and to strategize and implement solutions such as food access and emotional support programming.
- Through the efforts of the GRAF Center, EH held over 10 meditation workshops for the community with over 2,800 participants. Meditations were held in both English and Spanish for several community agencies and available for community members to stream from home.
- The EH Infection Prevention team promoted the importance of hand washing and hand hygiene, as well as the importance of mask mandates given the ongoing COVID-19 pandemic.
- EH held 5 vaccination clinics in the community throughout 2021 that succeeded in vaccinating nearly 1,000 community members.
- Bloodless Medicine hosted 5 virtual health seminars in 2021. The topics included information on ways to better care for your health and lifestyle choices, understanding bloodless medicine, the future of the bloodless program at Englewood Health. The seminars were attended by over 10,000 individuals.
- Through its digital platform EH provided daily COVID information updates and delivered important medical information to the Korean population. EH recorded over 30 podcasts and videos detailing information about COVID-19 and the vaccine. The combined informational materials, videos, articles, and physician podcasts resulted in over 1.4 million views.
- In 4Q of 2021, EH received a grant from Screen NJ to screen eligible Korean community individuals for lung and colon cancers.
  - The grant will be executed in 2022.
- In 2021 EH opened a new urgent care center located in downtown Englewood providing increased access to convenient care for the underserved population in the area.
  - An additional urgent care center will open in Jersey City to support Hudson County patients and community members.



General Health			
Date	Activity/Topic	Program Purpose	Results
1/5/2021	Healthy Labels & Nutrition	Education & Awareness	20 attendees/session
1/7/2021	Hot Cocoa and Self-Care	Education & Awareness	30 attendees
1/11/2021	Fad Diets: The Reality	Education & Awareness	173 attendees
1/13/2021 - 5/26/2021	Youth Yoga	Education & Awareness	6 attendees/session
1/20/2021 - 2/10/2021	Health E Englewood	Education & Awareness	19 attendees
1/26/2021	Youth Advisory Board (High School)	Research	18 attendees
1/27/2021	Using Food Pantry Ingredients to Eat Healthier	Education & Awareness	19 attendees
2/8/2021 - 3/8/2021	Winter Art Therapy	Education & Awareness	12 attendees
2/9/2021	Parent Art Workshop	Education & Awareness	10 attendees
2/10/2021 - 1/22/2022	Yoga for Addiction Recovery	Education & Awareness	15 attendees/session
2/10/2021 - 3/10/2021	Parent Series Workshops	Education & Awareness	8 attendees
3/7/2021	Emerging from the Darkness: Health Care in 2021	Education & Awareness	2,000 attendees
3/7/2021	We're Not Getting Older - We're Only Getting Better!	Education & Awareness	60 attendees
3/13/2021	Community Vaccine Clinic	Vaccination	126 individuals vaccinated
3/14/2021	Community Vaccine Clinic	Vaccination	162 individuals vaccinated
3/25/2021	Be Inspired, Be Phenomenal	Education & Awareness	4 attendees
3/31/2021	Yoga for Parents	Education & Awareness	4 attendees
4/6/2021 - 4/27/2021	Get Fit for Seniors	Education & Awareness	5 attendees
4/8/2021	Healthy Talk: A Conversation with Community Health Leaders About Ways to Stay Healthy	Education & Awareness	50 attendees
4/28/2021	Yoga for Parents	Education & Awareness	8 attendees
4/29/2021	Lunch & Learn with Tenafly Rotary: Pain Management	Education & Awareness	11 attendees
4/29/2021	Youth Sexual Assault Awareness Event	Education & Awareness	2 attendees
5/11/2021 - 6/1/2021	Discovery Program	Education & Awareness	4-week health and wellness youth workshop, 15 attendees
5/25/2021	Community Vaccine Clinic	Vaccination	113 individuals vaccinated
5/27/2021	Community Vaccine Clinic	Vaccination	123 individuals vaccinated
5/13/2021	Massage for TMJ	Education & Awareness	7 attendees





5/19/2021	Bite Size Mindfulness for the Classroom	Education & Awareness	200 attendees
5/25/2021	COVID Parenting	Education & Awareness	10 attendees
5/26/2021	BFC Older Adult Program: It's Our Time	Education & Awareness	22 attendees
6/8/2021 - 6/29/2021	Summer Art Therapy	Education & Awareness	20 attendees
6/9/2021	Community Vaccine Clinic	Vaccination	402 individuals vaccinated
6/17/2021	Summer After COVID: Identifying Your Child's Transition Struggles and Learning Ways to Respond	Education & Awareness	3 attendees
7/1/2021 - 7/28/2021	Health E Englewood	Education & Awareness	4-week health and wellness workshop, 40 attendees
7/12/2021	Acupuncture for Golf/Tennis Injuries	Education & Awareness	5 attendees
7/15/2021 - 8/5/2021	Summer Art Therapy Series II	Education & Awareness	20 attendees
7/15/2021 - 8/5/2021	Exercise and Movement Series for Youth	Education & Awareness	17 attendees
8/17/2021	Plant-Based Diet: Information Session	Education & Awareness	10 attendees
8/9/2021	Summer Celebration	Education & Awareness	30 attendees
9/11/2021	Community Health Fair at the Faith Reformed Church	Education & Awareness	200 attendees
10/27/2021 - 11/17/2021	Health E Englewood	Education & Awareness	4-week health and wellness workshop, 40 attendees

**Objective 2: Screenings for chronic disease risk factors and provide referrals to appropriate treatment services.**

- The Cancer Center conducted an increased number of lung cancer screenings in 2021. Over 770 individuals participated and were screened.
- The North Hudson Community Action Corporation Englewood Health Center screened over 700 individuals for colon cancer in 2021.

**Objective 3: Implement programs and events with local and regional collaboratives that address issues related to wellness, prevention and risk factors.**

- EH has created a branded educational approach to the health of the community named "Live Well". The approach is focused on the 3 tenets of good health: emotional, nutritional and physical wellness. A program that supports the concept of Live Well is the ongoing "Health E Englewood" series, a 4-week long wellness workshop that highlights education and the skill-building surrounding physical activity, healthy cooking, eating on a budget, and coping with stress. The series is implemented in collaboration with local agencies in the community and is conducted in multiple languages (evolved to virtual). Over 120 individuals participated in Health E Englewood in 2021.
- EH has continued to collaborate with the Partnership for Healthy Eating and pivoted to host virtual presentations and dinners for local churches.
  - 4 virtual dinners were held in 2021 with nearly 60 community members participating. Participants received an informational packet, a portion plate, cookbook, and a prepackaged healthy meal.



- EH has developed a nutritional education workshop teaching the clients of food pantries how to eat healthier using food pantry items and some supplemental supermarket groceries. In addition, EH developed a booklet titled “A Guide to Healthy Eating with Food Pantry Ingredients” to support the nutritional health and wellness of community members utilizing food pantries.
  - The guide will be formally distributed starting in Q1 2022.
  - Events and cooking demonstrations will also be scheduled in Q1 2021 on site at local food pantries to enhance the education and excitement around the importance of good nutrition for all.
- EH continued to build a partnership with the Center for Food Action to connect patients screened and identified as food insecure to food access and resources through the Food Insecurity Response Initiative (FIRI) Food Access program (Priority Area: Social Determinants of Health and Access to Care, Goal 4).
  - EH expanded the network of food resources to include the Salvation Armies of Jersey City and Union City, respectively.
- EH collaborated with the Englewood Health Department to provide the first-dose of the COVID-19 vaccine to community members.
- EH collaborated with local agencies (Bergen County NAACP, Mocha Moms, Inc. Bergen County Chapter, National Coalition of 100 Black Women Bergen/Passaic Chapter) to host a Healthy Talk about the importance of vaccination, early cancer detection and screening, maternal health and diabetes. 4 participants were eligible to receive a home health kit.
- In an effort to address addiction related issues in the community, EH partnered with the Children’s Aid and Family Services and the Center for Alcohol and Drug Resources for September’s National Recovery Month. A screening of the documentary “The First Day” was shown, followed by an expert panel discussion.

#### **Objective 4: Expand upon our system wide care management program**

- EH implemented and expanded upon the Food Insecurity Response Initiative (FIRI) Food Access pilot program to screen and link identified food insecure patients to community resources in the Mother/Baby and Bariatric Departments, as well as all Englewood Health Physicians’ offices. In 2021 the program was expanded to the Emergency Department and the North Hudson Community Action Corporation Englewood Health Center (see Priority Area: Social Determinants of Health and Access to Care, Goal 4).
- In 2021, EH had 11 Care Coordinators spread across 16 EHPN practices focused on supporting patient needs and navigating their medical care.

### **Priority Area: Chronic and Complex Conditions**

#### **Goal 2: Improve health status through chronic disease and care management**

##### **Objective 1: Provide programs that promote education and awareness of chronic and complex conditions**

###### **Improve health status of patients with cardiovascular/heart disease and stroke**

- The Korean Center outreach to the community included a focus on cardiovascular and blood clot-related articles and podcasts aimed to discussing COVID-19’s impact on cardiovascular-related disease. These social media sources had over 200,000 views.
- The GRAF Center hosted 2 events targeting heart health through nutrition and acupuncture, reaching 15 community members.
- CPR courses were held, focusing on ACLS (advanced cardiac life support), PALS (pediatric advanced life support), PEARS (pediatric emergency assessment recognition and stabilization) and BLS (basic life support). Over 2,300 individuals were trained.



Cardio			
Date	Activity/Topic	Program Purpose	Results
1/30/2021	Bloodless Medicine and Surgery at Englewood Health	Education & Awareness	2,000 attendees
2/9/2021	Heart Health: Nutrition	Education & Awareness	10 attendees
2/9/2021	Heart Health: Acupuncture	Education & Awareness	5 attendees
3/3/2021	Heart Health Seminar	Education & Awareness	60 attendees
3/7/2021	Emerging from the Darkness: Health Care in 2021	Education & Awareness	2,000 attendees
5/1/2021	Important Healthcare Choices for Bloodless Patients	Education & Awareness	2,000 attendees
8/14/2021	The Bright Future of Bloodless Medicine at Englewood Health	Education & Awareness	2,000 attendees
11/20/2021	Caring for Your Health: The Role of Bloodless Medicine	Education & Awareness	2,000 attendees
1/2021 - 12/2021	CPR Classes	Education & Awareness	2,368 attendees

**Objective 2: Promote chronic disease management programs (diabetes, cardiovascular, stroke, and cancer)**

**Improve health status of patients with cancer**

- The Cancer Center’s Cancer Education and Early Detection (CEED) program screened 88 patients over the course of 2021.
- The Cancer Center screened over 770 individuals for lung cancer (See Priority Area: Wellness & Prevention, Goal 1).

Cancer			
Date	Activity/Topic	Program Purpose	Results
3/23/2021	Feeding Your Gut: Colorectal Cancer	Education & Awareness	2 attendees
6/7/2021	Acupuncture for Cancer Care	Education & Awareness	12 attendees
6/8/2021	Nutrition for Cancer Care	Education & Awareness	14 attendees
6/14/2021 - 12/2021	Yoga for Breast Cancer	Education & Awareness	5 attendees
6/29/2021	Survivor's Event	Education & Awareness	200 attendees
10/11/2021	Acupuncture for Cancer Care & Women's Health	Education & Awareness	5 attendees
10/12/2021 - 10/19/2021	Eat Right: Cancer Care	Education & Awareness	9 attendees
10/24/2021	Walk for Awareness	Education & Awareness	640 attendees
11/12/2021	Cancer Center Annual Symposium: Multidisciplinary Care in Lung Cancer	Education & Awareness	50 attendees

**Improve health status of patients with Diabetes**

- EH held a 12-week Live Well Diabetes Management Program that aided patients in behavior modification around exercise, healthier eating, medication management, losing weight, and emotional wellness while living with a chronic condition. 11 participants completed the program.



- 2022 goals entail expanding program to all patients with diabetes and provide diabetic and nutrition counseling.
- The Diabetes Program supports the Partnership for Healthy Eating by providing education presentations and materials at the free dinner and offers consultation with attendees as needed (See Priority Area: Wellness & Prevention, Goal 1).
- EH continued to screen for Gestational Diabetes among the uninsured women in the community. 83 women were screened for gestational diabetes in 2021. In addition, 22 women were provided with nutrition and dietary counseling related to their pregnancies.

Diabetes			
Date	Activity/Topic	Program Purpose	Results
4/23/2021	Partnership for Healthy Eating Dinner	Education & Awareness	14 attendees
6/8/2021	Partnership for Healthy Eating Dinner	Education & Awareness	20 attendees
9/23/2021	Partnership for Healthy Eating Dinner	Education & Awareness	11 attendees
9/28/2021 - 12/14/2021	Live Well Diabetes Series	Education & Awareness	11 attendees
11/4/2021	Partnership for Healthy Eating Dinner	Education & Awareness	14 attendees

**Objective 3: Provide linkage to care, with increased access to providers and navigation within physician network**

- As previously stated in Priority Area: Wellness and Prevention, Goal 1, the FIRI Food Access program is available to all EHPN offices, allowing EHPN to connect patients with food resources. 94 patients were identified as food insecure through the EHPN offices and linked to resources.
- 2 additional EHPN Care Coordinators were hired in 2022 to support the patient population within the physician network.

**Objective 4: Create customized care plans to manage patients with complex conditions**

- EHPN Care Coordinators continued to create patient-centered care plans for patients identified as “high-risk” by providers. These care plans address a variety of complex conditions and are focused on the patient’s health needs, including addressing dementia, asthma, hypertension, diabetes, obesity, and smoking cessation.
  - EHPN Care Coordinators created care plans for 120 patients.
- EHPN Care Coordinators provided approximately 1,100 patients with home monitoring care for patients diagnosed with COVID-19. In addition, care coordinators contacted over 1,000 patients providing notice of positive cases and other COVID-19 information.

**Priority Area: Behavioral Health**

**Goal 3: Promote positive mental, social and emotional health**

**Objective 1: Expand efforts to reduce stigma**

- EH remains committed to supporting the social and emotional health of all ages and groups in the community. Presentations and workshops are continually being held for a range of audiences including; youth, parents, Hispanic/Latino, AA/Black, seniors, and other minority populations, in the community to meet the emotional challenges exacerbated by COVID.



- Several behavioral health social media campaigns were conducted in 2021. These campaigns covered Mental Health Awareness Month in May and opioid abuse prevention in October.
- EH hosted a screening of the social media documentary “LIKE” followed by an expert panel discussion to help educate youth, parents and educators on the impact of social media, its use, addictive properties and the resulting impact on mental health (110 community members viewing the film).
- EH recognized the importance of caring for the emotional health of EH Team Members during a turbulent year. A confidential phone line was set up in 2020 to connect EH Team Members to EH clinical social workers and psychiatrists and EH has continued to provide this support in 2021.
- EH educated all employees on what it means to be “Stigma Free” and 100% of employees signed a pledge to be Stigma Free.

**Objective 2: Continue to offer behavioral health educational programs and screenings in community-based settings, with a focus on priority populations**

- EH has recognized the increase need of behavioral health services due to the impact of COVID. In 2020, over 25 behavioral health programs, including mindfulness, meditation, anxiety management, and emotional support were held. These events impacted over 3,600 community members.
- EH conducted 17 behavioral and emotional education and support programs to provide a resource to parents, youth and families during COVID with a focus on coping with anxiety and stress and the family experience. These programs reached over 200 parents and youth.
- The senior population remains a priority for EH behavioral health programming. An educational training program was held for caregivers of a local senior living facility with 12 community members positively impacted.
- The annual Behavioral Health Conference was held virtually with 82 behavioral health professionals in attendance. The topic was “Universality of Trauma”.
- EH continued to effectively integrate mental health screenings into the primary care visits. The results help physicians identify depression, anxiety, and stress, thus allowing them to refer patients for behavioral health care proactively.
- In 2021 EH began to implement the C-SSRS (Columbia-Suicide Severity Rating Scale) to provide mental health screening services and appropriate care for community members admitted to the Emergency Department.
- As stated above, EH continues to support the behavioral health of the community by creating convenient and affordable access to licensed clinical professionals including psychiatrists, licensed clinical social workers, addiction specialists, and other healthcare professionals.

**Objective 3: Expand behavioral health care services in the Englewood Physician Network**

- EH transitioned to telehealth for behavioral health care to continue to deliver services to patients despite the implications of COVID.
- EH continued to operate a centralized line for referrals to the Social Work team to better support the needs of patients during COVID. EH also began offering group therapy and hired one LCSW and a part-time psychiatrist who specialize in working with youth.

**Objective 4: Improve Access to Behavioral Health Treatment**

- EH is providing psycho-educational support to youth through a partnership at Bergen Family Center middle school Zone program. Additionally, EH is also supporting coping skills in the youth by teaching yoga to this at risk population.



- In an effort to address addiction related issues in the community, EH has hired a physician who specializes in addiction medicine to provide support through EHPN (Englewood Health Physician Network).

**Objective 5: Collaborate with local and regional partners to address behavioral health issues.**

- EH has collaborated with the Bergen Family Center to address behavioral and emotional health issues in local youth through behavioral health group programming for students and parent workshops.
- EH partnered with Age-Friendly Englewood to provide a program titled “Pandemic-Related Anxiety, Stress and Social Isolation” with 14 community members positively impacted.
- EH partnered with the Women’s Rights and Information Center to provide a 4- week emotional health skill building series with 8 community members attending.

Behavioral Health			
Date	Activity/Topic	Program Purpose	Results
1/4/2021 - 1/24/2022	Storytime: Guided Meditation	Education & Awareness	5 attendees/session
1/4/2021 - 1/24/2022	Meditation for Depression, Anxiety and Stress	Education & Awareness	15 attendees/session
1/5/2021 - 1/22/2022	Meditation	Education & Awareness	20 attendees/session
1/5/2021 - 1/22/2022	Meditation (Spanish)	Education & Awareness	20 attendees/session
1/7/2021	Hot Cocoa and Self-Care	Education & Awareness	30 attendees
1/11/2021	Meditation & Vision Boards	Education & Awareness	12 attendees
1/13/2021 - 5/26/2021	Youth Yoga	Education & Awareness	6 attendees
1/20/2021 - 2/10/2021	Health E Englewood	Education & Awareness	4-week health and wellness workshop, 19 attendees
2/8/2021 - 3/8/2021	Winter Art Therapy	Education & Awareness	12 attendees
2/10/2021 - 1/22/2022	Yoga for Addiction Recovery	Education & Awareness	15 attendees/session
2/10/2021 - 3/10/2021	Parent Series Workshops	Education & Awareness	8 attendees
2/15/2021	Meditation for Caretakers	Education & Awareness	8 attendees
2/19/2021	Managing the Unknown	Education & Awareness	22 attendees
2/25/2021	Healthy Teen Relationships	Education & Awareness	5 attendees
3/3/2021	One Year Later: Webinar with Englewood Library around Emotional Health	Education & Awareness	5 attendees
3/4/2021 - 3/25/2021	Live Well - Emotional Wellness Series	Education & Awareness	4-week emotional health workshop, 8 attendees
3/10/2021	LIKE Screening	Education & Awareness	110 attendees
3/11, 6/21, 10/23, 12/9/2021	Stress Management: Tools	Education & Awareness	session held quarterly, 46 attendees
3/25/2021	Power of Aromatherapy: Caregivers	Education & Awareness	25 attendees
3/31/2021	Yoga for Parents	Education & Awareness	4 attendees
4/2/2021	Meditation & Journaling	Education & Awareness	25 attendees



4/14/2021	Pandemic-Related Anxiety, Stress and Social Isolation	Education & Awareness	14 attendees
4/22/2021	Integrative Medicine and Stress	Education & Awareness	30 attendees
4/28/2021	Yoga for Parents	Education & Awareness	8 attendees
5/3/2021	Aromatherapy: What Is It?	Education & Awareness	15 attendees
5/6/2021	Youth Mental Health Round Table: Congressman Gottheimer	Education & Awareness	16 attendees
5/19/2021	Bite Size Mindfulness for the Classroom	Education & Awareness	200 attendees
5/20/2021	Dementia Care Training	Education & Awareness	12 attendees
6/8/2021 - 6/29/2021	Summer Art Therapy	Education & Awareness	20 attendees
6/17/2021	Summer After COVID: Identifying Your Child's Transition Struggles and Learning Ways to Respond	Education & Awareness	3 attendees
7/1/2021 - 7/28/2021	Health E Englewood	Education & Awareness	4-week health and wellness workshop, 40 attendees
7/5/2021 - 8/7/2021	Meditation and Movement (ages 7-13)	Education & Awareness	25 attendees
7/8/2021 - 8/18/2021	Storytime for Families: Ages 0-5 Years	Education & Awareness	10 attendees
7/8/2021 - 8/18/2021	Meditation and Choreography (Ages 14-24)	Education & Awareness	25 attendees
8/9/2021	Summer Celebration	Education & Awareness	30 attendees
9/29/2021	The Journey of Recovery (National Recovery Month)	Education & Awareness	57 attendees
9/30/2021	2021 Annual Behavioral Health Conference: Universality of Trauma	Education & Awareness	82 attendees
10/11/2021	Mindfulness Program	Education & Awareness	10 attendees
10/14/2021	Managing Stress: Fear of the Unknown	Education & Awareness	16 attendees
10/27/2021 - 11/17/2021	Health E Englewood	Education & Awareness	4-week health and wellness workshop, 40 attendees
11/9/2021	ZZZ-Care: Self-Care & Nutrition	Education & Awareness	7 attendees
11/10/2021	Guided Meditation & Breathing for Cresskill Parents	Education & Awareness	20 attendees

## Priority Area: Social Determinants of Health and Access to Care

EH has been actively engaging in expanding its relationships and partnerships with local community agencies including the Community Chest, Jewish Community Center, Bergen Family Center, The Family Success Center, Metro Community Center, and various senior programs in the community, local religious organizations and the North Hudson Community Action Corporation Englewood Health Center. We will continue to make this a priority for 2022 and maintain a strategic focus on a selection of partner agencies to help engage and support health equity in the EH service area community.



Goal 4: Address issues that prevent or delay individuals from accessing care and resources

**Objective 1: Develop innovative solutions for improving access to care, for the community at large and patients attributed to the Englewood Physician Network**

- The Food Insecurity Response Initiative (FIRI) Food Access program continues to be available to EHPN physician's offices to address food insecurity. Identified patients are directly connected to local food resources through the Center for Food Action and other food pantries. 94 EHPN patients were identified as food insecure. EHPN Care Coordinators follow up with patients to link to services. Monthly follow-up is conducted with the Center for Food Action to ensure patients are receiving services.
- 2022 Goals will involve implementing Unite Us (formally Now Pow), a community referral management platform for addressing the social determinants of health (SDOH), chronic health and social conditions. This will allow EHPN Care Coordinators to provide comprehensive, closed-loop referrals and general resources to better support patients and the community at large.

**Objective 2: Implement navigation services that remove barriers to care (language, age / transportation)**

- EH patients identified as food insecure through the FIRI Food Access Program (See Goal 4 Objective 1) are able to receive food packages delivered directly to their home once every two weeks.
- All EH material is translated in to multiple languages to remove barriers to patients and community members. All FIRI materials are translated into Spanish and Korean to support the linguistic needs of EH patients and community members in need of food access.
- EH offers the Uber Health program; patients in need are able to utilize the service to receive free transportation both to and from any EH appointment or office to make EH health services more accessible. This program also helped patients and community members overcome transportation barriers to attending COVID-19 vaccination appointments. EH provided nearly 30,000 rides.

**Objective 3: Expand programs and policies that screen for and address the social determinants of health, with a focus on nutrition and food security.**

- The Food Insecurity Response Initiative (FIRI) Food Access continued to screen patients for food insecurity in the Mother/Baby and Bariatrics Departments and all offices in the Englewood Health Physician's Network (EHPN) for food insecurity.
- In 2021 the FIRI program expanded to include the Emergency Department and the North Hudson Community Action Corporation.
  - Nearly 26,000 patients were screened for food insecurity in 2021.
  - Over 200 patients were connected with local resources.
- In 2021, additional Hudson County food partners were provided to better connect patients and community members to food resources.
- Goals for 2022 include the distribution of the "A Guide to Healthy Eating with Food Pantry Ingredients" booklets to local food pantry clients. Additionally EH will provide educational workshops to the community on nutrition and healthy eating using the food provided by a food pantry.

**Objective 4: Implement local and regional efforts to address social determinants of health and access to care issues.**

- Goal to begin implementation of Unite Us (formerly Now Pow) (see Goal 4 Objective 1) in 2022 throughout the EH network.
- EH will open the Shirvan Family Live Well Center in 2022 to engage and educate at-risk populations on preventative health and wellness measures. The center will be located at 55 W. Palisade Ave in downtown Englewood and all services provided will be free.





# Year End Report 2020: 2020-2022 Community Health Needs Assessment

## EXECUTIVE SUMMARY

The Community Health Needs Assessment Year End report reflects both highlights and a summary of the events, programs, and activities Englewood Health has engaged in throughout 2020.

The intended plans and activities that were committed to for 2020 were universally upended (in March of 2020) due to the resources and restrictions required to manage the COVID-19 pandemic. Englewood Health was able to quickly pivot and, in addition to meeting the medical needs surrounding COVID-19 care, create impactful educational opportunities and programs for our community and our patients during this time of crisis.

The selection and criteria for the Englewood Health (EH) community health initiatives are guided by the hospital's strategic plan, updated in 2019 based on the most recent results and analysis identified in the 2019 Community Health Needs Assessment.

The process for generating this report includes the Population Health Team meeting with respective service lines and departments to discuss and capture the 2020 goals, objectives, strategies and accomplishments.

For purposes of review, below are the EH goals and objectives.

### Goal 1: Increase Access to Health Education, Screening, and Prevention Services

- **Objective 1**
  - Provide education and intervention regarding wellness, health promotion, prevention efforts, risk factors, and healthy behaviors (nutritional, physical, and emotional health / wellness)
- **Objective 2**
  - Conduct screenings for chronic disease risk factors (e.g., cancer, high blood pressure, cholesterol, BMI) and provide referrals to appropriate treatment or services
- **Objective 3**
  - Implement programs and events with local and regional collaboratives that address issues related to wellness, prevention, and risk factors
- **Objective 4**
  - Expand upon our system-wide care management program

### Goal 2: Improve Health Status Through Chronic Disease and Care Management

- **Objective 1**
  - Provide programs that promote education and awareness of chronic and complex conditions
- **Objective 2**
  - Promote chronic disease management programs (diabetes, cardiovascular, stroke and cancer)
- **Objective 3**
  - Provide linkage to care, with increased access to providers and navigation within physician network
- **Objective 4**
  - Create customized care plans to manage patients with complex conditions



### Goal 3: Promote Positive Mental, Social, and Emotional Health

- **Objective 1**
  - Expand efforts to reduce stigma
- **Objective 2**
  - Continue to offer behavioral health educational programs and screenings in community-based settings, with a focus on priority populations
- **Objective 3**
  - Expand behavioral health care services in the Englewood Health Physician Network
- **Objective 4**
  - Improve access to behavioral health treatment
- **Objective 5**
  - Collaborate with local and regional partners to address behavioral health issues

### Goal 4: Address Issues That Prevent or Delay Individuals from Accessing Care and Resources

- **Objective 1**
  - Develop innovative solutions for improving access to care, for the community at-large and patients attributed to the Englewood Health Physician Network
- **Objective 2**
  - Implement navigation services that remove barriers to care (language, age/transportation)
- **Objective 3**
  - Expand program and policies that screen for and address social determinants of health, with a focus on nutrition and food security
- **Objective 4**
  - Implement local and regional efforts to address social determinants of health and access to care issues

Significant accomplishments occurred in a year that was unprecedented in our history. In-person activities from March 2020 through the balance of the year were significantly reduced, requiring a new virtual path forward for much of our community benefit programming. Our assessment of participation thus, for the most part, reflects a virtual engagement.

EH participated in over 50 community events allowing the hospital to impact more than 10,000 community members.

EH continues to strongly support the Population Health Department's community outreach by maintaining and expanding a series of strategic community partnerships, allowing EH to bring meaningful programs and content to the community. These include the continuation of the Healthy Eating Partnership with the local food banks, the Community Chest, and the North Hudson Community Action Corporation Englewood Health Center. The Partnership continues to provide free meals, nutritional education, and interventional tools presented by EH Diabetes Educators. In the fall of 2020, the program was able to evolve to allow for contact-free food pick-up and virtual education presentations of the material. Additionally, EH increased its dedicated focus on the Social Determinants of Health and launched a new comprehensive program titled the Food Insecurity Response Initiative (FIRI), which includes EH screening of patients for food insecurity and seamlessly connecting them to on-going food resources.

EH also actively supported wellness in the schools, teaching emotional and nutritional wellness in the freshmen health classes at Dwight Morrow High School. This included a focus on two goals: one, teaching an understanding of diabetes prevention and nutrition awareness with the goal of fostering behavioral changes to prevent the development of diabetes. Secondly, the program focuses on increasing awareness around emotional challenges like stress and anxiety to help the students cultivate tools to better manage these challenges in their daily lives. The program is delivered by EH Diabetes Educators and Social Workers. However, the program was interrupted by COVID and due to the challenges faced by the local school system, the decision was made to place the program on hold.



EH continues to aggressively support the behavioral health needs of the community, as the pandemic has resulted in an even greater demand for support and services. In response to this burgeoning situation, EH held more than 30 emotional wellness events, impacting more than 3,300 community members. EH launched a new behavioral health partnership with the Bergen Family Center to provide individual youth therapy, youth art therapy workshops, youth wellness presentations and virtual yoga that reached a combined 150 youth.

Overall, EH provided a range of very timely virtual behavioral health programming to the community at large, which engaged a wide range of ages from youth to seniors, as well as an ethnically diverse audience. Due to COVID, many of the programming topics centered on how to cope with the stress and challenge of living through a pandemic, how to parent during a pandemic, and how young people can manage and cope successfully with the stress and anxiety of the current crisis. EH also held a large education and skill-building webinar supporting caregivers of individuals with dementia, to teach how to effectively cope and manage during this unprecedented time of solitude. Additionally, in response to the pandemic and the depression, isolation, and anxiety it brought, EH increased the number of virtual yoga and meditation classes provided to our community partner agencies, as well as the community at large. These were run in multiple languages.

EH maintained its focus on the fundamentals of wellness and through partnerships with local agencies (Women's Rights and Information Center as well as local churches), providing multiple skills-based month-long health and wellness workshops for adults from vulnerable populations (youth postponed to 2021). The workshops focused on nutrition, healthy cooking, exercise and emotional wellness, all grounded in developing practical skills for a healthy life.

In an effort to expand access to the flu vaccine, EH partnered with the Englewood Health Department to create a free drive-thru flu vaccine event for the community, providing over 150 vaccines for vulnerable populations in the Englewood area.

EH has remained actively committed to its efforts around cancer care and detection during the pandemic. Despite in-person screening and educational sessions being put on hold, EH continued to care for patients via virtual telemedicine visits and oral treatments. Oncologists and nurse practitioners were redeployed to support the intensive care unit (ICU) and were assigned to care teams to communicate and dialogue with families about a patient's condition related to COVID. EH's Cancer Education and Early Detection (CEED) Program, funded through the New Jersey Department of Health, Division of Family Health Services, was limited due to COVID guidelines, but screened 36 patients for breast and cervical cancers in 2020. Lung cancer screenings increased in 2020, with approximately 450 screenings completed.

EH continues to be strongly focused on the Diabetes Education Program, once again supporting its recognition by the American Diabetes Association for meeting the national standards for Diabetes self-management education, which it has held for over 20 years. EH also offered free Diabetes testing supplies for uninsured women with Gestational Diabetes and worked in conjunction with the North Hudson Community Action Corporation

Englewood Health Center to provide needed Diabetes support to its patient population.

The Population Health Quality Care Team launched a very successful free 12-week Diabetes management virtual program with EHPN (Englewood Health Physician Network) patients with the goal of effectively managing their diabetes through education and behavior modification. Patients participated in a skills-based program around exercise, healthy eating, effectively managing medication and testing blood sugar levels, and developing emotional skills to manage stress while dealing with a chronic condition.

The EH Korean Center's team successfully pivoted during COVID and took on a large scale virtual health programming effort to engage the Korean population on important health issues and COVID safety information. This effort resulted in over 30,000 views of this virtual content, covering various chronic conditions and providing consistent and timely medical information.

A detailed account of programming that occurred during 2020 for each of the hospital's four goals can be found in the following Progress Report section.

### **Methodology**

The review and assessment process includes:



- Submission, review of the outcomes and impact data that was tracked and reported during the last fiscal year.
- Discussion of the accomplishments and next steps identified during review meetings held with EH hospital representatives throughout Q1 2021.

A total of **27** hospital staff participated in the evaluation process through a series of review meetings. The review meetings included representation from the following EH areas: Heart Disease and Stroke, Immunizations and Infectious Diseases, Behavioral Health, Access to Healthcare, Cancer, EMS, Diabetes, Integrative Medicine and the Korean Center. The participants included:

Name	Title
Debra Albanese	VP of Development
Andrew Brunnuell	Behavioral Health Assistant, Population Health
Michael Chananie	Director, Public Affairs and Marketing
Bettyann Cifu	Director of Quality Development and Accreditation
Ramon Correa	Manager, Bloodless Medicine and Surgery
Melisa Damcevka	Population Health Coordinator
Dr. Alexandra Gottdiener	Chief of Medicine, Department of Medicine
Barbara Grygotis	Administrative Director, Cardiac Surgery
Christina Laird	Administrative Director, Cancer Center
Sooyun Lee	Public Relations Specialist
Linda Leighton	Nurse Manager, Behavioral Health
Jamie Ketas	VP of Quality
Cynthia Lewis-Kroning	Program Manager, Center for Integrative Medicine
Danielle Lambert	Manager Behavioral Health, Population Health
Lauren Menkes	Director of Social Work, Population Health
Mary O'Connor	Director, Diabetes Education Program
Alicia Park	VP Communications
Dr. Natasha Rastogi	Associate Director of Ambulatory Care
Claire Rizzo	Senior Director of Risk and Quality Assessment
Richard Sposa	Director, Emergency Medical Services
Diana Torres	Manager, Infection Prevention
JoAnn Venezia	Program Director of Behavioral Health
Deborah Weinstein	Director, Ambulatory Quality Programs
Christina Weiselberg	Administrative Director, Breast Care Center
Jennifer Yanowitz	Manager of Strategic Programming
Ethan Yoon	Public Relations Specialist
Christine Young	Manager, Ambulatory Care Management

## PROGRESS REPORT

### Priority Area: Wellness & Prevention

Goal 1: Increase Access to Health Education, Screening and Prevention Services

**Objective 1: Provide education and interventions regarding wellness, health promotion, prevention efforts, risk factors, and healthy behaviors (nutritional, physical and emotional).**



- EH has offered a multitude of virtual programming, podcasts, resources, and blog posts surrounding mental health care. This virtual engagement has resulted in over 21,000 views and downloads.
- EH produced social media campaigns to educate the public regarding COVID-19 prevention and social distancing.
- EH and community partner agencies mobilized and began weekly community calls to identify unmet needs of local residents and to strategize and implement solutions such as food access and emotional support programming.
- Through the efforts of the GRAF Center, EH held over 10 meditation workshops for the community with over 2,500 participants. Meditations were held in both English and Spanish for several community agencies including the Bergen Family Center and the Women’s Rights and Information Center. EH and the GRAF Center held a nutritional workshop for a local Black sorority chapter with 50 attendees.
- EH Infection Prevention emphasized the importance of hand washing and hand hygiene, as well as the importance of mask mandates given the COVID-19 pandemic.
- EH provided 1,000 masks to the NAACP of Bergen County to prevent the spread of COVID.
- EH hosted a Heart Health event where patients and community members were given the opportunity to receive healthy recipes and free blood pressure screenings. 100 participants received blood pressure screenings.
- Bloodless Medicine hosted 2 virtual seminars in 2020 titled “Wise Healthcare Choices for Bloodless Patients in the Times of Coronavirus”. The seminars were viewed by over 14,000 people in over 30 different countries.
- EH provided daily COVID information and delivered important medical information to the Korean population and increased involvement in Korean social platforms to over 3,000 members. EH also organized a medical podcast interviewing physicians about health and COVID information. The combined informational materials, videos, articles, and physician podcasts resulted in over 30,000 views. In addition, the Korean Center’s social media platforms have resulted in over 430,000 clicks to various health and hospital resources.

General Health			
Date	Activity/Topic	Program Purpose	Results
1/8/2020 – 1/28/2020	Health E Englewood, Women’s Rights and Information Center	Education & Awareness	4-week health and wellness workshop, 29 attendees
1/10/2020	Live Well – Youth Education	Education & Awareness	3 sessions, 24 attendees
1/11/2020	KCC Health and Wellness Event	Education & Awareness	50 attendees
1/13/2020	JCC Nutrition Quarterly Event	Education & Awareness	25 attendees
1/13/2020	Why Am I So Sleepy?	Education & Awareness	20 attendees
1/14/2020	Dementia presentation for family members	Education & Awareness	25 attendees
1/25/2020	Korean Wellness Seminar	Education & Awareness	200 attendees
1/28/2020	JCC Education Monthly Event	Education & Awareness	25 attendees
1/29/2020	Memory Matters	Education & Awareness	10 attendees
2/3/2020	JCC Pulmonary Quarterly Event	Education & Awareness	25 attendees
2/5/2020	Memory Matters	Education & Awareness	10 attendees
2/20/2020	Cliffside Park Senior Center Speaking Event	Education & Awareness	50 attendees
10/24/2020	Flu Clinic at Englewood Health Department	Screening	150 attendees



4/2/2020	The Good Enough Parent in a Time of Disruption	Education & Awareness	40 attendees
4/23/2020	Metro Community Youth Wellness: When Your World Feels Upside Down	Education & Awareness	30 attendees
4/30/2020 – 5/21/2020	Spring Youth Art Therapy: Express Yourself Art Series	Education & Awareness	4-week art therapy sessions for youth, 40 attendees
6/25/2020	How to Have a Successful Summer During Challenging Times (English)	Education & Awareness	30 attendees
6/25/2020	How to Have a Successful Summer During Challenging Times (Spanish)	Education & Awareness	40 attendees
6/2020 – 12/2020	Yoga for Addiction Recovery	Education & Awareness	2,500 attendees (average of 10/session)
7/6/2020 – 8/28/2020	Summer Youth Yoga	Education & Awareness	10 attendees
7/22/2020	Virtual Youth Career Day	Education & Awareness	15 attendees
8/19/2020 – 9/9/2020	Health E Englewood, Galilee United Methodist Church	Education & Awareness	4-week health and wellness workshop, 30 attendees
8/26/2020	Families Dealing with Dementia and Alzheimer's Disease	Education & Awareness	10 attendees
9/30/2020 – 12/16/2020	Fall Youth Yoga	Education & Awareness	4 attendees
10/1/2020	Balancing Family Life During COVID (English)	Education & Awareness	25 attendees
10/1/2020	Balancing Family Life During COVID (Spanish)	Education & Awareness	20 attendees
10/22/2020 – 12/17/2020	Fall Youth Art Therapy Series	Education & Awareness	Weekly art therapy sessions for youth, 11 attendees
10/27/2020	Setting Yourself Up for Success	Education & Awareness	15 attendees
11/11/2020 – 12/16/2020	Navigating the Parenting Experience	Education & Awareness	Weekly parent series, 15 attendees
11/12/2020	Youth Advisory Board	Research	15 attendees
11/17/2020 – 12/8/2020	Winter Youth Art Therapy Series	Education & Awareness	10 attendees
12/15/2020	Wrapping up 2020: Making This Season Stress Free	Education & Awareness	10 attendees

**Objective 2: Screenings for chronic disease risk factors and provide referrals to appropriate treatment services.**

- The Cancer Center conducted an increased number of lung cancer screenings in 2020. Approximately 450 individuals were screened.
- EH Emergency Medical Services (EMS) screened 100 individuals in a blood pressure screening clinic hosted prior to COVID.

**Objective 3: Implement programs and events with local and regional collaboratives that address issues related to wellness, prevention and risk factors**

- EH has created a branded educational approach to the health of the community named “Live Well”. The approach is focused on the 3 tenets of good health: emotional, nutritional and physical wellness. A program that supports the concept of Live Well is the ongoing “Health E Englewood” series, a 4-week long wellness workshop that highlights education and skill-building of physical activity, healthy cooking, eating on a budget, and coping with stress. The series is being rolled out at local partner agencies in the community in multiple languages (evolved to virtual). Nearly 100 individuals participated in Health E Englewood in 2020.



- EH has continued to collaborate with the Partnership for Healthy Eating and pivoted to host virtual presentations and dinners for local churches.
  - The first virtual dinner was held in November 2020, with 14 attendees. Participants received an informational packet, a portion plate, cookbook, and a prepackaged healthy meal.
- EH has developed a nutritional education workshop targeted towards teaching the clients of food pantries on how to use food pantry items and supplement groceries to eat healthier on a budget.
- EH partnered with the Office of Concern food pantry and provided chicken for distribution. This addressed the COVID-related challenge of the meat and poultry shortage caused by disruption to the supply chain.
- EH created a partnership with the Center for Food Action to connect patients screened and identified as food insecure to food access and resources through the Food Insecurity Response Initiative (FIRI) Food Access program (Priority Area: Social Determinants of Health and Access to Care, Goal 4).
  - In 2021 EH will partner with the Salvation Armies of Jersey City and Union City to serve food insecure patients residing in Hudson County.
- EH collaborated with the Englewood Health Department to host a Flu Clinic for Englewood residents in October 2020. The Flu Clinic successfully vaccinated 152 community members.
- In an effort to address addiction related issues in the community, EH is providing addiction education seminars for the community, which include training on how to administer naloxone and provide free Narcan® kits (in partnership with Children's Aid and Family Services and the Center for Alcohol and Drug Resources).

**Objective 4: Expand upon our system wide care management program**

- EH implemented and expanded upon the Food Insecurity Response Initiative (FIRI) Food Access pilot program to screen and link identified food insecure patients to community resources in the Mother/Baby and Bariatric Departments, as well as all Englewood Health Physicians' offices (see Priority Area: Social Determinants of Health and Access to Care, Goal 4).
  - In 2020, EH had 9 Care Coordinators spread across 16 EHPN practices.

**Priority Area: Chronic and Complex Conditions**

**Goal 2: Improve health status through chronic disease and care management**

**Objective 1: Provide programs that promote education and awareness of chronic and complex conditions**

Improve health status of patients with cardiovascular/heart disease and stroke

- The Korean Center outreach to the community with vein screening awareness materials, articles and podcasts aimed to discussing COVID-19's impact on cardiovascular-related disease. These social media sources reached over 2,000 community members.
- EH Emergency Medical Services (EMS) screened 100 individuals in a blood pressure screening clinic hosted prior to COVID.
- Despite COVID limitations, 7 CPR training classes were held with a total of 37 individuals trained.



Cardio			
Date	Activity/Topic	Program Purpose	Results
2/3/2020	JCC Pulmonary Quarterly Event	Education & Awareness	25 attendees
2/7/2020	CNBC Heart Health Event and Blood Pressure Screenings	Education & Awareness	100 attendees
2/10/2020	CPR education program	Education & Awareness	6 attendees
2/11/2020	CPR education program	Education & Awareness	5 attendees
2/11/2020	CPR education program	Education & Awareness	8 attendees
3/13/2020	CPR education program	Education & Awareness	8 attendees
3/28/2020	Bloodless Wellness and Lifestyle	Education & Awareness	600 attendees
5/16/2020	Bloodless Wellness and Lifestyle (Spanish)	Education & Awareness	600 attendees
8/11/2020	CPR education program	Education & Awareness	2 attendees
8/14/2020	CPR education program	Education & Awareness	4 attendees
8/17/2020	CPR education program	Education & Awareness	4 attendees
10/15/2020	EMS Overview for Leonia Women's Club	Education & Awareness	40 attendees
10/24/2020	Bloodless Wellness and Lifestyle	Education & Awareness	400 attendees
2020	Korean Center Cardio Materials	Education & Awareness	2,000 individuals reached virtually

**Objective 2: Promote Chronic disease management programs (diabetes, cardiovascular, stroke, and cancer)**

**Improve health status of patients with cancer**

- Despite limited in-person screening programs and events, the Cancer Center's Cancer Education and Early Detection (CEED) program screened 36 patients over the course of 2020.
- The Cancer Center screened 450 individuals for lung cancer (See Priority Area: Wellness & Prevention, Goal 1).

Cancer			
Date	Activity/Topic	Program Purpose	Results
1/11/2020	KCC Health and Wellness Event	Education & Awareness	50 attendees
1/2020 – 12/2020	2020 Lung Cancer screenings	Screening	450 attendees
Jan – Dec 2020	CEEDS Cancer screenings	Screening	36 patients

**Improve health status of patients with Diabetes**

- EH piloted a 12-week Live Well Diabetes Management Program that aided patients in behavior modification around exercise, healthier eating, managing medication effectively, and losing weight, and emotional wellness while living with a chronic condition. 6 participants completed the program.
  - 2021 goals entail expanding the program to 2 other EHPN practices and opening the program to all those diagnosed with diabetes versus just high risk.





- The Diabetes Program supports the Partnership for Healthy Eating by providing education presentations and materials at the free dinner and offers consultation with attendees as needed (See Priority Area: Wellness & Prevention, Goal 1).
- EH continues to screen for Gestational Diabetes among the uninsured women in the community. 47 women were screened for gestational diabetes in 2020.
- Prior to COVID, EH was holding diabetes support groups run by Diabetes Educators; the groups are currently on hold.

Diabetes			
Date	Activity/Topic	Program Purpose	Results
1/13/2020	JCC Nutrition Quarterly Event	Education & Awareness	25 attendees
1/15/2020	Partnership for Healthy Eating Dinner	Education & Awareness	33 attendees
11/12/2020	Partnership for Healthy Eating Dinner (Virtual)	Education & Awareness	14 attendees
4 <sup>th</sup> Quarter 2020	Live Well Diabetes Management Program	Education & Awareness	6 attendees

**Objective 3: Provide linkage to care, with increased access to providers and navigation within physician network**

- Care Coordinators pivoted to create care management plans for COVID patients discharged from the hospital for short-term follow-up. Care Coordinators outreached to over 4,000 patients regarding COVID results and referred COVID discharges to follow-up care.
  - Patients who were uninsured were referred to the North Hudson Community Action Corporation for services. 177 appointments were referred. Care coordinators continued to follow up with patients after the referral.
- EH rapidly evolved to telehealth services in response to COVID and providers were able to utilize this technology to see almost 78,000 patients. Barriers such as transportation were therefore removed.
- As previously stated in Priority Area: Wellness and Prevention, Goal 1, the FIRI Food Access program is available to all EHPN offices, allowing EHPN to connect patients with food resources. 54 patients were identified as food insecure through the EHPN offices and linked to resources.

**Objective 4: Create customized care plans to manage patients with complex conditions**

- EHPN Care Coordinators continued to create patient-centered care plans for patients identified as “high-risk” by providers. These care plans focus on a variety of complex conditions and are focused on the patient’s health needs, including addressing dementia, asthma, hypertension, diabetes, obesity, and smoking cessation.

**Priority Area: Behavioral Health**

**Goal 3: Promote positive mental, social and emotional health**

**Objective 1: Expand efforts to reduce stigma**

- EH remains committed to supporting the mental, social and emotional health of all ages and groups and our overall community and reduce stigma. Ongoing presentations are continually being held for youth, parents, Hispanic/Latino, Black populations and other minority populations, and seniors in the community to meet the emotional challenges exacerbated by COVID.



- EH hosted a screening of the social media documentary “LIKE” to educate and reduce stigma around social media use and its impact on mental health, with 300 community members viewing the film. (See Objective 5).
- EH recognized the importance of caring for the emotional health of Team Members during a turbulent year to help better support our patients and community. A confidential line was set up to connect EH Team Members to EH clinical social workers and psychiatrists.
- EH educated all employees on what it means to be “Stigma Free” and 100% of employees signed a pledge to be Stigma Free.

**Objective 2: Continue to offer behavioral health educational programs and screenings in community-based settings, with a focus on priority populations**

- EH has recognized the increase need of behavioral health services due to the impact of COVID. In 2020, over 33 behavioral health programs, including mindfulness, meditation, anxiety management, and emotional support were held. These events impacted over 3,300 community members.
- EH ran 7 behavioral and emotional education presentations to support parents, youth and families during COVID with a focus on navigating new challenges and the family experience. These presentations reached over 200 parents and youth.
- The senior population remains a priority for EH behavioral health programming. An educational program was held for families who have a loved one with dementia, with 25 community members positively impacted. In addition, a virtual program for “Families Dealing with Dementia and Alzheimer’s Disease” reached 10 community members.
- The annual Behavioral Health Conference was held virtually with 140 behavioral health professionals in attendance. The topic was “Practical and Realistic Strategies for Dementia Care During a Pandemic”.
- EH continues to effectively integrate mental health screenings into the primary care visits. Each patient receives a screener to be completed. The results help physicians identify depression, anxiety, and stress, thus allowing them to refer patients for behavioral health care earlier, when more treatment options are available, and treatment is usually more effective.
- As stated above EH continues to support the behavioral health of the community by creating convenient and affordable access to licensed clinical professionals including psychiatrists, licensed clinical social workers, addiction specialists, and other healthcare professionals.
- EH continues to grow the number of embedded therapists in the primary care setting so they are easily accessed either by appointment or in the moment when needed. One additional LCSW was hired in 2020.
- 2021 will focus on running a third annual conference aimed towards cognitive behavioral therapy (CBT) and anxiety management, offering program around Post-Traumatic Stress Disorder (PTSD), and supporting EH Team Members from the long-term emotional impacts of the pandemic.

**Objective 3: Expand behavioral health care services in the Englewood Physician Network**

- EH transitioned to telehealth for behavioral health care to continue to deliver services to patients despite the implications of COVID.
- EH developed a centralized line for referrals to the Social Work team to better support the needs of patients during COVID. EH also began offering group therapy and hired one LCSW and a part-time psychiatrist who specialize in working with youth.



#### Objective 4: Improve Access to Behavioral Health Treatment

- EH is providing psycho-educational support to youth through a partnership at Bergen Family Center middle school Zone program. Additionally, EH is also supporting coping skills in the youth by teaching yoga to this at risk population.
- In an effort to address addiction related issues in the community, EH is providing addiction education seminars for the community, which include training on how to administer naloxone and providing free Narcan® kits (in partnership with Children's Aid and Family Services and the Center for Alcohol and Drug Resources).
- 54% of EHPN patients were screened for depression in 2020.
- To expand upon treatment for major depression, EH will work on marketing its ECT (electroconvulsive therapy) program in 2021. EH is the only hospital in Bergen County to offer this treatment.

#### Objective 5: Collaborate with local and regional partners to address behavioral health issues.

- EH has collaborated with the Bergen Family Center to address behavioral and emotional health issues in local youth through providing one-on-one therapy.
- EH has worked collaboratively with the Jewish Federation of Northern New Jersey to host a screening of the social media documentary "LIKE" aimed to educate youth and families about the impacts of social media use on students emotional well-being. The LIKE program featured an expert-led panel including social workers, educators, and students.
  - 2021 will include a second screening for the Englewood community.
- EH partnered with Strive Health to host an alcohol education event, "Alcohol Awareness: COVID-19 and the Winter Months". 50 individuals participated.
- Goals for 2021 include piloting an emotional wellness series workshop with the Women's Rights and Information Center to support the emotional health of community members.

Behavioral Health			
Date	Activity/Topic	Program Purpose	Results
1/8/2020 – 1/28/2020	Health E Englewood, Women's Rights and Information Center	Education & Awareness	4-week health and wellness workshop, 29 attendees
1/10/2020 – 1/23/2020	Live Well – Youth Education	Education & Awareness	3 sessions, 34 attendees
1/13/2020	Why Am I So Sleepy?	Education & Awareness	20 attendees
1/14/2020	Dementia presentation for family members	Education & Awareness	25 attendees
1/15/2020 – 2/5/2020	Live Well Discovery Program	Education & Awareness	4-week youth workshops, 22 attendees
3/20/2020	Anxiety Management Presentation	Education & Awareness	15 attendees
4/2/2020	The Good Enough Parent in a Time of Disruption	Education & Awareness	40 attendees
4/14/2020 - 4/21/2020	Meditation for Bergen Family Center (English)	Education & Awareness	200 attendees
4/15/2020 – 6/30/2020	Meditation for Bergen Family Center (Spanish)	Education & Awareness	2,000 attendees
4/21/2020 – 5/5/2020	Meditation for Women's Rights and Information Center (English)	Education & Awareness	3 sessions, 400 attendees
4/23/2020	Metro Community Youth Wellness: When Your World Feels Upside Down	Education & Awareness	30 attendees
4/29/2020 – 5/20/2020	Online Meditation for Community Members	Education & Awareness	400 attendees



4/30/2020 – 5/21/2020	Spring Youth Art Therapy: Express Yourself Art Series	Education & Awareness	4-week art therapy sessions for youth, 40 attendees
6/25/2020	How to Have a Successful Summer During Challenging Times (English)	Education & Awareness	30 attendees
6/25/2020	How to Have a Successful Summer During Challenging Times (Spanish)	Education & Awareness	40 attendees
6/2020 – 12/2020	Yoga for Addiction Recovery	Education & Awareness	2,500 attendees (average of 10/session)
7/6/2020 – 8/28/2020	Summer Youth Yoga	Education & Awareness	10 attendees
7/22/2020	Virtual Youth Career Day	Education & Awareness	15 attendees
8/19/2020 – 9/9/2020	Health E Englewood, Galilee United Methodist Church	Education & Awareness	4-week health and wellness workshop, 30 attendees
8/26/2020	Families Dealing with Dementia and Alzheimer's Disease	Education & Awareness	10 attendees
8/31/2020	Narcan Training	Education & Awareness	15 attendees, distributed Narcan kits to participants
9/15/2020	Annual Behavioral Health Conference: Practical and Realistic Strategies for Dementia Care during a Pandemic	Education & Awareness	140 attendees
9/30/2020 – 12/16/2020	Fall Youth Yoga	Education & Awareness	4 attendees
10/1/2020	Balancing Family Life During COVID (English)	Education & Awareness	25 attendees
10/1/2020	Balancing Family Life During COVID (Spanish)	Education & Awareness	20 attendees
10/22/2020 – 12/17/2020	Fall Youth Art Therapy Series	Education & Awareness	Weekly art therapy sessions for youth, 11 attendees
10/27/2020	Setting Yourself Up for Success	Education & Awareness	15 attendees
11/11/2020 – 12/16/2020	Navigating the Parenting Experience	Education & Awareness	Weekly parent series, 15 attendees
11/12/2020	Youth Advisory Board	Research	15 attendees
11/17/2020 – 12/8/2020	Winter Youth Art Therapy Series	Education & Awareness	10 attendees
11/18/2020	LIKE Screening with the Jewish Federation of Northern NJ	Education & Awareness	Screened film with expert panel, 300 attendees
11/19/2020	Youth Advisory Board	Research	10 attendees
12/8/2020	Alcohol Awareness: COVID-19 and the Winter Months	Education & Awareness	50 attendees
12/15/2020	Wrapping up 2020: Making This Season Stress Free	Education & Awareness	10 attendees



## Priority Area: Social Determinants of Health and Access to Care

EH has been actively engaging in expanding its relationships and partnerships with local community agencies including the Community Chest, Jewish Community Center, Bergen Family Center, The Family Success Center, Metro Community Center, and various senior programs in the community, local religious organizations and the North Hudson Community Action Corporation Englewood Health Center. We will continue to make this a priority for 2021 and maintain a focus on a selection of partners to help engage and support health equity in the Englewood Community.

Goal 4: Address issues that prevent or delay individuals from accessing care and resources

### **Objective 1: Develop innovative solutions for improving access to care, for the community at large and patients attributed to the Englewood Physician Network**

- In October of 2020, The Food Insecurity Response Initiative (FIRI) Food Access program was made available to EHPN physicians' offices for food insecurity. Identified patients are directly connected to local food resources through the Center for Food Action and other food pantries. 54 EHPN patients were identified as food insecure. EHPN Care Coordinators follow up with patients to link to services. Quarterly follow-up is conducted with the Center for Food Action to ensure patients are receiving services.
- EHPN Care Coordinators provided follow up to patients regarding COVID results and referred discharged patients who were uninsured to the North Hudson Community Action Corporation (See Priority Area: Chronic and Complex Conditions, Goal 2).
- EH has increased access to telehealth services to continue to care for patients in light of COVID (See Priority Area: Chronic and Complex Conditions, Goal 2).
- EH established the Diversity, Inclusion, and Equity Council (DIEC) to promote and address health equity and diversity within our community and our EH team.
- 2021 Goals will involve potentially utilizing Now Pow, a community referral management platform for addressing social determinants of health (SDOH), chronic health and social conditions. This will allow EHPN Care Coordinators to provide comprehensive, closed-loop referrals to better support patients in the EHPN network.

### **Objective 2: Implement navigation services that remove barriers to care (language, age / transportation)**

- EH patients identified as food insecure through the FIRI Food Access Program (See Goal 4 Objective 1) are able to receive food packages delivered directly to their home once every two weeks.
- All EH material is translated to remove language barriers to patients and community members. All FIRI materials are translated into Spanish and Korean to support the linguistic needs of EH patients and community members in need of food access.
- EH offers the Uber Health program; patients are able to utilize the service to receive free transportation both to and from any EH appointment or office to make EH health services more accessible and provided over 20,000 Uber Health rides.

### **Objective 3: Expand programs and policies that screen for and address the social determinants of health, with a focus on nutrition and food security.**

- The Food Insecurity Response Initiative (FIRI) Food Access program began screening patients in the Mother/Baby and Bariatrics Departments and all offices in the Englewood Health Physicians Network (EHPN) for food insecurity.
  - 60 patients were identified and linked to local food resources from September to December 2020.
  - 2021 looks to expand to the Emergency Department as well as to the North Hudson Community Action Corporation. Program will also expand geographically



connecting Hudson County patients to food resources in Hudson County through a new partnership with the Salvation Army food pantries.

- In 2021, EH will expand the FIRI program to include educational workshops for food pantry clients.
  - EH will pilot a program for food pantry clients from the Norwood Food Pantry to educate participants on how to eat healthy on a budget using what is provided by the food pantry and supplemented from the grocery store.

**Objective 4: Implement local and regional efforts to address social determinants of health and access to care issues**

- Goal to potentially implement Now Pow (See Goal 4 Objective 1) in 2021.
- EH will aim to hire Community Health Workers in 2021 to support the initiatives of addressing social determinants of health and promote community wellness.
- In 2021, EH will explore the opening of a wellness center located in downtown Englewood to engage and educate at risk populations on preventative health measures.



# Year End Report 2019: 2017-2019 Community Health Needs Assessment

## EXECUTIVE SUMMARY

The Community Health Needs Assessment report reflects both highlights and a summary of the events, programs, and activities that Englewood Health has engaged in throughout 2019.

The selection and criteria for the Englewood Health (EH) initiatives are guided by the continued implementation of the hospital's strategic action plan, initially developed in 2016.

The process for generating the report includes the Population Health group meeting with the respective service lines and departments to discuss and capture the 2019 goals, objectives, strategies and accomplishments.

For purposes of review below are the EH goals and objectives.

### Goal 1: Increase Access to Health Care through Population Health Management

- **Objective 1**  
Expand primary and preventative care to meet the community needs
- **Objective 2**  
Enhance access and convenience to meet consumer expectations
- **Objective 3**  
Develop a system-wide care management program
- **Objective 4**  
Develop population-specific programs to ensure access to care through screening and health fairs
- **Objective 5**  
Partner with local communities, providers, and agencies to provide resources and expertise in achieving healthy populations

### Goal 2: Promote Behavioral Health

- **Objective 1**  
Continue to offer behavioral health education and screenings to the community
- **Objective 2**  
Integrate behavioral health into the primary care setting
- **Objective 3**  
Increase population-specific programs and services
- **Objective 4**  
Collaborate with other providers in cross continuum initiatives



### Goal 3: Improve Health Status through Chronic Disease and Care Management across the Continuum

- **Objective 1**  
Improve health status of patients with cardiovascular/heart disease and stroke
- **Objective 2**  
Improve health status of patients with cancer
- **Objective 3**  
Improve health status of patients with Diabetes
- **Objective 4**  
Improve health status of patients with nutrition, physical activity weight

### Goal 4: Increase Access to Immunizations and Reduce Infectious Diseases

- **Objective 1**  
Increase preventative measures in primary care setting

Significant accomplishments have occurred over the last year including EH participation in over 200 community events allowing the hospital to impact close to 25,000 community members.

EH continues to strongly support the Population Health Department's community outreach by creating a series of strategic community partnerships, allowing EH to bring meaningful programs and content to the community. These include the continuation of the Healthy Eating Partnership with the local food banks, the Community Chest, and the North Hudson Community Action Corporation Englewood Health Center. The Partnership continues to provide free meals and nutritional education, presented by EH Diabetes Educators, for families at the local churches and senior living facilities. EH has written and developed a Healthy Eating on a Budget cookbook that provides education and awareness of how individuals and families can eat healthy and nutritious meals with very little money. Each meal per person is \$4.25 or less. The cookbooks are provided to the low-income population in the community along with portion correct plates that families can use to better understand meal composition and proper portion sizes.

EH continues to actively support wellness in the schools and teaches emotional and nutritional wellness in the freshmen health classes at Dwight Morrow High School. This includes a focus on two goals; one, teaching an understanding of diabetes prevention and nutrition awareness with the goal of fostering behavioral changes in an effort to prevent the development of diabetes. Secondly, the program focuses on increasing awareness around emotional challenges like stress and anxiety and helps the students to cultivate tools to better manage challenges in their daily lives. The program is delivered by EH Diabetes Educators and Social Workers.





EH continues to aggressively support the behavioral health of the community by developing and running offsite programming that supports a wide range of ages and demographics in the community. This includes a focus on the aging population, as well as families, including parents and students in relevant topics including how to cope with the stress and challenges of aging, and stress and anxiety in young people. Additionally, educational materials have been created and are distributed on these topics throughout the community.

EH has continued to offer free (in conjunction with the Bergen County Health Department) Mental Health First Aid Workshops for the community at large, including both adults and youth.

Through partnerships with local agencies EH has launched multiple health and wellness month long workshops for both adults and youth targeting more at-risk populations and their unique wellness challenges. The workshops focus on nutrition, healthy cooking, exercise and emotional wellness all grounded in developing practical skills for a healthy life. The programs are run in multiple languages.

EH is actively committed to its efforts around cancer care and detection. EH has participated in over 21 community outreach events including screenings and educational sessions impacting close to 5,000 community members. This includes 3 three screening events where 145 people were screened for various cancers.

EH continues to be strongly focused on the Diabetes Education Program, once again supporting its recognition by the American Diabetes Association for meeting the national standards for Diabetes self-management education, which it has held for over 20 years. EH also offered free Diabetes testing supplies for uninsured women with Gestational Diabetes and worked in-conjunction with the North Hudson Community Action Corporation

Englewood Health Center to provide needed support to its patient population.

The hospital also works closely with the Englewood Health Department and provides funding for a Youth Educator for the Reach and Teach program in the Englewood school system, who works with students on an array of issues ranging from nutrition and wellness to sexually transmitted diseases to drug and alcohol addiction.

A detailed account of programming that occurred during 2019 for each of the hospital's four goals can be found in the following Progress Report section.

### **Methodology**

The review and assessment process includes:

- Submission, review of the outcomes and impact data that was tracked and reported during the last fiscal year.
- Discussion of the accomplishments and next steps identified during review meetings held with EH hospital representatives throughout the Q1 2020.

A total of 20 hospital staff participated in the Year 2 evaluation process through a series of review meetings. The review meetings included representation from the following EH areas: Heart Disease and Stroke, Immunizations and Infectious Diseases, Behavioral Health, Access to Healthcare, Diabetes, Integrative Medicine and the Korean Center. The participants included:



Name	Title
Debra Albanese	VP of Development
Andrew Brunnquell	Research Assistant, Population Health
Michael Chananie	Director, Public Affairs and Marketing
Bettyann Cifu	Director of Quality Development and Accreditation
Dr. Alexandra Gottdiener	Chief of Medicine, Department of Medicine
Christina Laird	Administrative Director, Cancer Center
Sooyun Lee	Public Relations Specialist
Linda Leighton	Nurse Manager, Behavioral Health
Jamie Ketas	VP of Quality
Cynthia Lewis-Kroning	Program Manager, Center for Integrative Medicine
Lauren Menkes	Director of Social Work
Mary O'Connor	Director, Diabetes Education Program
Alicia Park	VP Communications
Dr. Natasha Rastogi	Associate Director of Ambulatory Care
Claire Rizzo	Senior Director of Risk and Quality Assessment
Richard Sposa	Director, Emergency Medical Services
Diana Torres	Manager, Infection Prevention
JoAnn Venezia	Program Director of Behavioral Health
Deborah Weinstein	Director, Ambulatory Quality Programs
Christina Weiselberg	Administrative Director, Breast Care Center
Jennifer Yanowitz	Population Health Community Specialist
Ethan Yoon	Public Relations Specialist
Christine Young	Manager, Ambulatory Care Management

## PROGRESS REPORT

### Goal 1: Increase Access to Health Care through Population Health Management

#### Objective 1: Expand primary and preventative care to meet the community needs

- EH hired two Diabetes Educators, embedded in the Primary Care Setting, to expand services offered to patients, thus allowing for more individual consultations and added care efforts.
- EH increased the presence of Social Workers including hiring 3 additional therapists, embedded in the practices, taking all insurance. This expanded model of care has proven successful and allows for our health care offices to care for the patients' emotional and physical needs.
  - 2020 will include a focus on the creation of behavioral health group work in response to the driving issues impacting patients including bereavement and the



emotional processing of a new diagnosis. A range of therapeutic techniques will be applied ranging from more traditional talk-therapy to DBT.

- EH has continued to expand its Physician Network in order to provide more services to meet the community needs. In 2019, EH added 89 providers and 10 group practices to their Network.

**Objective 2: Enhance access and convenience to meet consumer expectations**

- EH physician offices continue to operate extended hours in order to accommodate patient needs/ demands.
- EH physician offices will be exploring telemedicine opportunities moving forward to further meet the needs of the community.

**OBJECTIVE 3 removed because of duplication of effort**

**Objective 4: Develop a system-wide care management program**

- In an effort to address high utilizers in the Emergency Department, EH created a task force led by the ED social workers to identify, on a monthly basis, a list of patients who are high ED utilizers. Care plans are continuously developed, and serve as the patients' link to follow up and appropriate support. The team then tracks and monitors the patients.
- EHPN expanded targeted patient conditioned focused care plans to include the diabetic and hypertensive patient populations. Additionally, food insecurity screening was introduced along with a link to support services.

**Objective 5: Develop population-specific programs to ensure access to care through screenings and health fairs**

- Participated in over 200 population-specific community events and health fairs in 2019, reaching over 25,000 community members.

General Health			
Date	Activity/Topic	Program Purpose	Result
1/7/2019	JCC: Nutrition Education Program (Veggication)	Education & Awareness	25 attendees
1/9/2019	25 anniversary of Bloodless Program award dinner	Education & Awareness	250 attendees
1/10/2019	Crunchi Workshop	Education & Awareness	7 attendees
1/11/2019	Englewood Idol	Education & Awareness	1000 attendees
1/16/2019	MLK Donations: Community Service Project	Education & Awareness	1500 attendees
1/26/2019	Physician Speaking Engagement	Education & Awareness	35 attendees
1/29/2019	JCC: Education Program (Guide to Winter Skin Care)	Education & Awareness	25 attendees
2/11/2019	Crunchi Workshop	Education & Awareness	7 attendees
2/26/2019	JCC: Nutrition Education Program	Education & Awareness	25 attendees
2/28/2019	MOM 101: Infant CPR, Car Seat and Safe Sleep	Education & Awareness	35 attendees
3/9/2019	Chinese Health Event	Education & Awareness	210 attendees
3/26/2019	JCC: Education Program- Aging: How to Cope	Education & Awareness	25 attendees
3/27/2019	MOM 101: Total Pre/Post Pregnancy Wellness: Health, Nutrition & Fitness	Education & Awareness	35 attendees
4/1/2019	Community Health Week	Screening	150 attendees
4/4/2019	EHPN Office Ribbon Cutting	Education & Awareness	150 attendees
4/8/2019-5/27/2019	Gentle Yoga	Education & Awareness	20 attendees



4/10/2019	MOM 101: The Preschool Years: Surviving & Thriving	Education & Awareness	35 attendees
4/13/2019	Birthing In Communities of Color	Education & Awareness	50 attendees
4/14/2019	EMS Family Fitness Fun Day 5K	Education & Awareness	200 attendees
4/18/2019	Chronic Conditions Support Group	Education & Awareness	16 attendees
4/25/2019	Chronic Conditions Support Group	Education & Awareness	14 attendees
4/27/2019	Korean Wellness Seminar	Education & Awareness	300 attendees
4/27/2019	Fort Lee Youth Event	Education & Awareness	200 attendees
5/2/2019	Chronic Conditions Support Group	Education & Awareness	12 attendees
5/7/2019	Health Fair	Education & Awareness	85 attendees
5/9/2019	Chronic Conditions Support Group	Education & Awareness	17 attendees
5/10/2019	Summer Concert Series	Education & Awareness	150 attendees
5/12/2019	Rubin Run JCC	Education & Awareness	1,000 attendees
5/16/2019	Chronic Conditions Support Group	Education & Awareness	16 attendees
5/19/2019	Demarest 5k Run	Education & Awareness	500 attendees
5/22/2019	CHNA Group Research Interview	Education & Awareness	20 attendees
5/23/2019	Chronic Conditions Support Group	Education & Awareness	17 attendees
5/28/2019	JCC: Education Program	Education & Awareness	25 attendees
6/1/2019	Summer Concert Series	Education & Awareness	100 attendees
6/1/2019	Community Health Fair	Screening	16 attendees
6/2/2019	George Washington Bridge 5k/10k	Education & Awareness	1000 attendees
6/7/2019	Basic Hospital Access Guide	Education & Awareness	25 attendees
6/7/2019	McCloud School Field Day	Education & Awareness	50 attendees
6/13/2019	Junteenth Celebration	Education & Awareness	500 attendees
6/14/2019	Englewood Cliffs Community Night Out	Education & Awareness	300 attendees
6/18/2019	Parkinson's Event	Education & Awareness	200 attendees
6/19/2019	Parkinson's Lecture w/ Jewish Home	Education & Awareness	200 attendees
6/21/2019	Summer Concert Series	Education & Awareness	100 attendees
6/22/2019	Korean Wellness Seminar	Education & Awareness	320 attendees
6/23/2019	Jewish Family and Children Services of Northern New Jersey Bike Ride	Education & Awareness	300 attendees
6/25/2019	JCC: Education Program	Education & Awareness	25 attendees
6/26/2019	Demonstration Englewood Cliffs Junior Police Academy	Education & Awareness	50 attendees
7/2/2019-7/6/2019	Leonia Sports Booster Carnival	Education & Awareness	5,000 attendees
7/3/2019	Youth Yoga	Education & Awareness	10 attendees
7/3/2019	Why am I so sleepy?	Education & Awareness	35 attendees
7/8/2019-7/29/2019	Meditation	Education & Awareness	20 attendees
7/13/2019	Bloodless Documentary Premiere	Education & Awareness	1200 attendees
7/13/2019	Summer Concert Series	Education & Awareness	100 attendees
7/16/2019	Crunchi Workshop	Education & Awareness	7 attendees
7/27/2019	Korean Wellness Seminar	Education & Awareness	340 attendees
7/31/2019	Summer Apprenticship Youth Tour	Education & Awareness	45 attendees
8/1/2019	Summer Concert Series	Education & Awareness	100 attendees



8/4/2019	Flat Rock Brook 5k	Education & Awareness	200 attendees
8/6/2019	National Night Out	Education & Awareness	200 attendees
8/7/2019	Bogota Police Emergency Services Youth Academy	Education & Awareness	50 attendees
8/9/2019	Englewood Summer Apprenticeship Ceremony	Education & Awareness	100 attendees
8/31/2019	Korean Wellness Seminar	Education & Awareness	170 attendees
9/8/2019	Save Latin America	Education & Awareness	900 attendees
9/11/2019	Gentle Yoga	Education & Awareness	20 attendees
9/14/2019	Chinese Brain Olympics (Dementia)	Education & Awareness	60 attendees
9/14/2019	Summer Concert Series	Education & Awareness	100 attendees
9/26/2019	Aroma Therapy	Education & Awareness	6 attendees
9/28/2019	Korean Wellness Seminar	Education & Awareness	230 attendees
10/2/2019	Fort Lee Health Fair	Education & Awareness	1,000 attendees
10/13/2019	Englewood Cliffs PTA Fall Festival	Education & Awareness	300 attendees
10/16/2019	Aroma Therapy	Education & Awareness	6 attendees
10/26/2019	Korean Healing Concert	Education & Awareness	400 attendees
10/26/2019	Korean Wellness Seminar		180 attendees
10/29/2019	JCC: Education Program	Education & Awareness	25 attendees
10/30/2019	At Risk Youth Yoga	Education & Awareness	10 attendees /week
11/7/2019	Art of Healing Exhibit	Education & Awareness	150 attendees
11/23/2019	Korean Wellness Seminar	Education & Awareness	350 attendees
11/26/2019	JCC: Education Program	Education & Awareness	25 attendees
12/28/2019	Korean Wellness Seminar	Education & Awareness	280 attendees
12/31/2019	JCC: Education Program	Education & Awareness	25 attendees

**Objective 6: Partner with local communities, providers, and agencies to provide resources and expertise in achieving healthy populations**

EH has been actively engaging in expanding its relationships and partnerships with local community agencies including the Community Chest, JCC, Bergen Family Center, The Family Success Center, and various senior programs in the community, local religious organizations and the North Hudson Community Action Corporation Englewood Health Center. They will continue to make this a priority for 2020 and maintain a focus on a selection of partners to help engage and support health equity in the Englewood Community.

- The JCC Cardiac Wellness Heart Health Program. The program is an 8 class series (3 sessions have been conducted) combining education, prevention, life style change modification particularly on the topics of nutrition, exercise and heart health. Experts in Cardiology, physiology and nutrition work with the participants.
- JCC Senior Programs. The bi-monthly special education program held at the JCC is an interactive based and wellness focused program covering topics including aging skin, nutrition, a range of medical conditions and more.
- JCC Special Needs programming. 8 week long cognitively appropriate special needs students cooking and nutrition class. Cultivating the educational and technical skills to teach this students how to navigate the kitchen and prepare meals for themselves (approximately 15 students ages 16-24).

**Local Agencies**

- Continued to partner with the Community Chest, the Englewood Health Department, the local Englewood food banks and the North Hudson Community Action Corporation Englewood Health Center to provide families with a free healthy dinner and healthy



eating presentation led by the EH Diabetes Educators. Attendees also received a bag of ingredients to prepare their next healthy meal, as well as recipes and helpful hints for meal prep, cooking and grocery shopping. The dinners were held on site at local churches monthly in the community. Blood pressure was also taken and a link to a high blood pressure support group was established.

## Goal 2: Promote Behavioral Health

### Objective 1: Continue to offer behavior health education and screenings to the community

- To address the burgeoning youth behavioral health crisis, EH continues to engage the community in the youth anxiety and depression program. In 2019, the program rolled out to the Dumont school system, the Englewood Health community at large and the Jewish Federation of Northern Jersey in engaging close over 800 educators, parents and students. The education includes the provision of a screener for parents and youth to screen for an overabundance of anxiety, therefore identifying when more focused support / help is needed
  - 2020 will include the continued rollout of the program to schools and community centers
- EH continued to offer speaker outreach and educational series to the broader community on a range of behavioral health topics.
- EH has worked collaboratively with many community agencies, including a strong emphasis on the senior population and their respective age-related issues (isolation, depression, caregiving, dementia support, and connections to care).
- EH participates in Stigma Free Englewood town hall events and hosted a Stigma Free event on gambling and addiction. Additionally, EH has held behavioral health seminars.
- Continue to ensure ED protocol of ED RN's administering a depression screening every time a patient is brought in.
- EH educated all employees on what it means to be "Stigma Free" and 100% of employees signed a pledge to be Stigma Free

### Objective 2: Integrate behavioral health into the primary care setting

- EH continues to effectively integrate mental health screenings into the primary care visits. Each patient receives a screener to be completed. The results help physicians identify depression, anxiety, and stress, thus allowing them to refer patients for behavioral health care earlier, when more treatment options are available, and treatment is usually more effective.
- In 2019 over 50,000 EHPN patients received a depression screening and follow-up – prescriptions, referral, linkage to community services.
- As stated above EH continues to support the behavioral health of the community by creating convenient and affordable access to licensed clinical professionals including psychiatrists, licensed clinical social workers, addiction specialists, and other healthcare professionals.
- EH continues to grow the number of embedded therapists in the primary care setting so they are easily accessed either by appointment or in the moment when needed.
- 2020 will look towards the creation of behavioral health group work focused on some of the driving issues impacting patients including bereavement and emotional processing of new diagnosis. A range of therapeutic techniques will be applied ranging from more traditional talk-therapy to DBT.

### Objective 3: Increase population-specific programs and services

- As stated above, EH continues to run a community wide youth anxiety and depression program. In 2019, the program rolled out to over 800 local community members through a myriad of community partner relationships.



- Provided several local community workshops on Mental Health First Aid for adults and youth on how to assess a mental health crisis, select interventions, provide initial help, and connect people with care. This is particularly relevant for those such as educators, coaches, and program coordinators, who are in close contact with the community's youth.
- EH providing psycho-educational support to youth through a partnership at Bergen Family Center middle school Zone program. Additionally, EH also supporting coping skills in the youth by teaching this at risk youth population yoga.
- EH is provided education on emotional wellness, stress and coping tools to the freshmen health classes in the Englewood Public School system. This effort will continue in 2020.

**Objective 4: Collaborate with other providers in cross continuum initiatives**

- In an effort to address addiction related issues in the community, EH is providing addiction education seminars for the community, which include training on how to administer naloxone and provide free Narcan® kits (in partnership with Children's Aid and Family Services and the Center for Alcohol and Drug Resources).
- EH continues to develop Opioid Partnerships and ways to work with other agencies to support the community.
- EH continues to partner with local Opioid Overdose Recovery Program (OORP) to send out recovery specialist for patients who are rescued after receiving Narcan.

Behavioral Health			
Date	Activity/Topic	Program Purpose	Result
2/13/2019	Mind, Body and SOLE	Education & Awareness	200 attendees, 8 fit kits distributed
2/13/2019	JCC Women's Expo	Education & Awareness	250 attendees
2/27/2019	Angst for Bergen Family Center Parents	Education & Awareness	20 attendees
2/28/2019	Angst for Bergen Family Center school kids	Education & Awareness	50 attendees
3/4/2019	Angst Screening for Teaching Staff	Education & Awareness	120 attendees
3/5/2019	Angst Screening for Students & Teachers	Education & Awareness	80 attendees
3/26/2019	JCC: Education Program- Aging: How to Cope	Education & Awareness	25 attendees
3/30/2019	Annual Behavioral Health Conference	Education & Awareness	55 attendees
4/3/2019	Internal & External (6:30) Screening Angst	Education & Awareness	130 attendees
4/4/2019	Internal Screening Angst	Education & Awareness	25 attendees
4/9/2019	Stigma Free Town Hall Meeting	Education & Awareness	50 attendees
4/13/2019	Birthing In Communities of Color	Education & Awareness	50 attendees
4/23/2019	Supporting Families After a Perinatal Loss	Education & Awareness	20 attendees
5/15/2019	Stigma Free Walk	Education & Awareness	CANCELLED
5/17/2019	RENT Performance	Education & Awareness	700 attendees
5/29/2019	Power of Age	Education & Awareness	200 attendees
6/11/2019	Narcan Training	Education & Awareness	75 attendees
6/25/2019	JCC: Education Program	Education & Awareness	25 attendees
7/3/2019	Youth Yoga	Education & Awareness	10 attendees
7/3/2019	Why am I so sleepy?	Education & Awareness	35 attendees
7/10/2019	Stress Management	Education & Awareness	70 attendees
7/30/2019	JCC: Education Program	Education & Awareness	25 attendees
7/31/2019	CHNA Korean Community Focus Group	Education & Awareness	10 attendees



8/18/2019	Englewood Day	Education & Awareness	500 attendees
9/7/2019	Englewood Community Fest	Education & Awareness	200 attendees
9/11/2019	Normal and Successful Aging	Education & Awareness	80 attendees
9/15/2019	Englewood Wellness Fest	Education & Awareness	500, attendees, 6 Mammo appts booked, 14 fit kits distributed
9/19/2019	Anxiety and Depression	Education & Awareness	20 attendees
9/24/2019	JCC: Education Program	Education & Awareness	25 attendees
10/10/2019	Opioid Event (3 Part Event)	Education & Awareness	30 attendees
10/22/2019	PsychoEducation At Risk Youth - BFC	Education & Awareness	10 attendees
10/28/2019	Angst	Education & Awareness	300 attendees
10/30/2019	At Risk Youth Yoga	Education & Awareness	10 attendees
11/6/2019	Individual Treatment Approaches to Working with Trauma	Education & Awareness	25 attendees
12/11/2019	Opioid Overdose Recovery Program (OORP)	Education & Awareness	40 attendees
12/17/2019	JCC: Education Program	Education & Awareness	25 attendees

### Goal 3: Improve Health Status through Chronic Disease and Care Management across the Continuum

#### Objective 1: Improve health status of patients with cardiovascular/heart disease and stroke

- EH staff have participated in 80 community events, impacting over 6,000 community members.
- EH continues to offer monthly medical seminars and lab testing through the Korean Health and Wellness Center
- EH distributes cardiovascular educational materials to community.
- EH continues to deliver its Cardiac Wellness Heart Health Program held at the JCC. The program is an 8 class series (3 sessions have been conducted) combining education, prevention, life style change modification particularly on the topics of nutrition, exercise and heart health. Experts in Cardiology, physiology and nutrition work with the participants.

Cardio			
Date	Activity/Topic	Program Purpose	Result
1/9/2019	CPR education program	Education & Awareness	7 attendees
1/15/2019	CPR education program	Education & Awareness	38 attendees
1/16/2019	CPR education program	Education & Awareness	12 attendees
1/21/2019	CPR education program	Education & Awareness	12 attendees
1/26/2019	Physician Speaking Engagement	Education & Awareness	35 attendees
1/26/2019	Korean Wellness Seminar	Education & Awareness	240 attendees
1/27/2019	CPR education program	Education & Awareness	1 attendee
1/28/2019	CPR education program	Education & Awareness	7 attendees
1/30/2019	CPR education program	Education & Awareness	9 attendees
2/4/2019	JCC - Pulmonary Education Program	Education & Awareness	25 attendees
2/5/2019	CPR education program	Education & Awareness	5 attendees





2/10/2019	Healthy Heart Tour	Education & Awareness	10 attendees
2/23/2019	Korean Wellness Seminar	Education & Awareness	130 attendees
3/6/2019	CPR education program	Education & Awareness	12 attendees
3/6/2019	CPR education program	Education & Awareness	13 attendees
3/7/2019	CPR education program	Education & Awareness	18 attendees
3/19/2019	CPR education program	Education & Awareness	16 attendees
3/20/2019	CPR education program	Education & Awareness	8 attendees
3/23/2019	CPR education program	Education & Awareness	18 attendees
4/1/2019	Community Health Week	Education & Awareness	150 attendees
4/7/2019	CPR education program	Education & Awareness	15 attendees
4/22/2019	CPR education program	Education & Awareness	12 attendees
5/4/2019	CPR education program	Education & Awareness	10 attendees
5/6/2019	JCC - Pulmonary Education Program	Education & Awareness	25 attendees
5/7/2019	CPR education program	Education & Awareness	3 attendees
5/10/2019	CPR education program	Education & Awareness	2 attendees
5/18/2019	CPR education program	Education & Awareness	8 attendees
5/20/2019	CPR education program	Education & Awareness	6 attendees
5/30/2019	CPR education program	Education & Awareness	13 attendees
6/1/2019	Community Health Fair	Screening	16 attendees, blood pressures recorded
6/1/2019	CPR education program	Education & Awareness	10 attendees
6/12/2019	CPR education program	Education & Awareness	19 attendees
6/13/2019	CPR education program	Education & Awareness	22 attendees
6/15/2019	CPR education program	Education & Awareness	11 attendees
8/5/2019	JCC: Pulmonary Education	Education & Awareness	25 attendees
8/12/2019	CPR education program	Education & Awareness	10 attendees
8/15/2019	CPR education program	Education & Awareness	10 attendees
9/3/2019	CPR education program	Education & Awareness	7 attendees
9/4/2019	CPR education program	Education & Awareness	3 attendees
9/20/2019	CPR education program	Education & Awareness	8 attendees
9/22/2019	CPR education program	Education & Awareness	7 attendees
9/23/2019	CPR education program	Education & Awareness	30 attendees
10/3/2019	CPR education program	Education & Awareness	5 attendees
10/6/2019	AHA Bergen-Passaic Heart Walk	Education & Awareness	500 attendees
10/9/2019	CPR education program	Education & Awareness	25 attendees
10/14/2019	CPR education program	Education & Awareness	18 attendees
10/14/2019	CPR education program	Education & Awareness	5 attendees
10/15/2019	CPR education program	Education & Awareness	16 attendees
10/18/2019	CPR education program	Education & Awareness	1 attendee
10/28/2019	CPR education program	Education & Awareness	11 attendees
11/4/2019	CPR education program	Education & Awareness	12 attendees
11/5/2019	CPR education program	Education & Awareness	9 attendees
11/5/2019	CPR education program	Education & Awareness	9 attendees
11/7/2019	CPR education program	Education & Awareness	4 attendees
11/8/2019	CPR education program	Education & Awareness	4 attendees



11/11/2019	JCC - Pulmonary Education Program	Education & Awareness	25 attendees
11/13/2019	CPR education program	Education & Awareness	4 attendees
11/14/2019	CPR education program	Education & Awareness	6 attendees
12/5/2019	CPR education program	Education & Awareness	13 attendees
12/5/2019	CPR education program	Education & Awareness	2 attendees

## Objective 2: Improve health status of patients with cancer

In 2019, The Cancer Center made the following accomplishments:

- The Cancer Center has participated in over 25 community outreach events including screenings and educational sessions for the community, impacting over 6000 community members.
- The Cancer Center has successfully performed an increased number of cancer screenings this year totaling over 1000 participants.
- The screenings and educational emphasis have been on colorectal, lung, breast, and prostate cancers.
- The Cancer Center received \$26,000 grant from the Susan G. Komen Cancer to screen African American Women for breast cancer – an event was held at a church in Hackensack where over 70 women attended and received relevant health information.
- The Cancer Center continues to provide cancer screenings through CEED funding for patients in need.
- In 2020 the Cancer Center will have two physicians be conducting endoscopic ultrasounds for patients in need who cannot afford it.
- In 2020 the Cancer Center will also focus on smoking cessation particularly with certain target populations who are reporting smoking numbers that are higher than normal.

Cancer			
Date	Activity/Topic	Program Purpose	Result
2/13/2019	JCC Women's Expo	Education & Awareness	250 attendees
2/13/2019	Mind, Body and SOLE	Education & Awareness	200 attendees, 8 fit kits distributed
3/19/2019	Sisters Checking In	Education & Awareness	47, attendees, 1 diagnosed Breast Cancer
4/7/2019	New Residents Day	Education & Awareness	100 attendees
5/25/2019	Korean Wellness Seminar	Education & Awareness	130 attendees
6/2/2019	George Washington Bridge 5k/10k	Education & Awareness	1000 attendees
6/5/2019	Cancer Survivors Day	Education & Awareness	100 attendees
7/31/2019	Skin Cancer Screenings	Screening	17 attendees
7/31/2019	CHNA Korean Community Focus Group	Education & Awareness	10 attendees
9/15/2019	Englewood Wellness Fest	Education & Awareness	500, attendees, 6 Mammo appts booked, 14 fit kits distributed



9/26/2019	Prostate Cancer Screenings	Screening	112, attendees, 17 elevated PSAs, 12 follow-up appts
10/3/2019	Bergen Wine & Food Experience	Education & Awareness	700 attendees
10/12/2019	Women of Color Event	Education & Awareness	200 attendees
10/12/2019	Fort Lee Health Fair	Education & Awareness	500, attendees, 11 fit kits distributed
10/25/2019	Passaic County Vicinage Cancer Awareness Program	Education & Awareness	200 attendees
10/25/2019	JCC Breast Cancer Expo	Education & Awareness	100 attendees
10/26/2019	Korean Wellness Seminar	Education & Awareness	180, attendees, 6 fit kits distributed, 2 physician consultations
10/27/2019	Walk for Awareness	Education & Awareness	250 attendees
10/29/2019	City of Englewood Meeting - honoring Dr. McIntosh	Education & Awareness	75 attendees
11/21/2019	Lung Cancer Screenings	Screening	16 attendees
11/22/2019	CME /Community Bloodless Oncology Conference	Education & Awareness	200 attendees

### Objective 3: Improve health status of patients with Diabetes

- The EH Diabetes Educators have participated in over 20 community outreach events including support groups and educational seminars for the community, impacting almost 3,000 community members.
- In conjunction with the Diabetes Foundation, EH continues to provide education sessions to their clients.
- The Diabetes Program continues to be instrumental in its collaboration with the EH Population Health Department to service youth in the community. The Diabetes Educators engage the local freshmen health class students in education and awareness on health and wellness subjects including; diabetes, basic nutrition and healthier eating options.
- The Diabetes Program supports the Partnership for Healthy Eating by providing education presentations and materials at the free dinner and offers consultation with attendees as needed.

EH routinely offers several free support groups for diabetics and continues to support the North Hudson Community Action Corporation Englewood Health Center by accepting patients for diabetes education and supporting persons in need.

- The EH Diabetes Education Program maintains its status as the American Diabetes Association recognition for meeting the national standards for Diabetes self-management education.
- EH continues to screen for Gestational Diabetes among the uninsured women in the community.



Diabetes			
Date	Activity/Topic	Program Purpose	Result
1/5/2019	Weight loss options for the bloodless patient	Education & Awareness	600 attendees
1/7/2019	JCC: Nutrition Education Program (Veggication)	Education & Awareness	25 attendees
1/29/2019	Veggication and Nutrition (Healthy Eating Habits for a healthy life)	Education & Awareness	20 attendees
3/28/2019	Healthy Eating Church Dinner	Education & Awareness	70 attendees
3/30/2019	Diabetes and Heart Health for the Bloodless Patient	Education & Awareness	600 attendees
4/11/2019	Healthy Eating Church Dinner	Education & Awareness	110 attendees
4/15/2019	JCC: Nutrition Education Program	Education & Awareness	25 attendees
5/15/2019	Healthy Eating Church Dinner	Education & Awareness	30 attendees
5/28/2019	Social Worker attends Diabetes Group / Stress Mangement	Education & Awareness	20 attendees
6/13/2019	Healthy Eating Church Dinner	Education & Awareness	100 attendees
7/1/2019	JCC: Nutrition Program	Education & Awareness	25 attendees
8/31/2019	Bloodless: Diabetes and heart health	Education & Awareness	500 attendees
10/7/2019	JCC: Nutrition Program	Education & Awareness	25 attendees
10/20/2019	Juvenile Diabetes Fundraiser Walk	Education & Awareness	250 attendees
10/26/2019	Diabetes and Heart Health for the Bloodless Patient	Education & Awareness	600 attendees
11/17/2019	Be the Healthiest You	Education & Awareness	20 attendees
11/20/2019	Healthy Eating Dinner	Education & Awareness	100 attendees
Nov-Dec	Dwight Morrow Youth Education	Education & Awareness	35 attendees

**Objective 4: Improve health status of patients with nutrition, physical activity and weight**

- EH has created a branded educational approach to the health of the community named “Live Well”. The approach is focused on the 3 tenets of good health; emotionally, nutritionally and physically. Educational materials have been created to support the concept and are routinely distributed at a range of engagement opportunities.
- EH has launched the “Health E Englewood” wellness workshop series. The workshop is a series that brings the Live Well concept to life and is being rolled out at local partner agency sites in the community in multiple languages.
- See information on funding Youth Educator for the Reach and Teach program in the Englewood school system.
- See information on Live Well Program at Dwight Morrow High School
- In 2020 the Live Well program will be adapted and piloted with EHPN.
- In 2020 the Live Well program will be adapted into a youth healthy workshop series and will be launched at local community agencies.



#### Goal 4: Increase Access to Immunizations and Reduce Infectious Diseases

##### Objective 1: Increase preventative measures in primary care setting

2019

- The EH focus remains strongly centered on education and awareness around sepsis (on site for EH employees) and hand hygiene (both for EH and community at large). Clear, concise messages have displayed throughout the hospital and educational materials have been distributed throughout the community.
- EH has developed and executed an Antibiotic Stewardship Program: engaging patients in understanding the importance of finishing courses of meds and not requesting antibiotics.
- EH has supported the distribution of flu information to EHPN practices and to the Englewood Health Department to be circulated throughout the community.
- EH has participated in 5 community events, impacting over 150 community members. EH remains strongly committed to educating and supporting the community in preventative infectious disease measures using a wide range of interventions.

Infectious Disease			
Date	Activity/Topic	Program Purpose	Result
2/4/2019	JCC - Pulmonary Education Program	Education & Awareness	25 attendees
3/19/2019	Early Childhood Development	Education & Awareness	35 attendees
5/6/2019	JCC - Pulmonary Education Program	Education & Awareness	25 attendees
8/5/2019	JCC - Pulmonary Education Program	Education & Awareness	25 attendees
11/11/2019	JCC - Pulmonary Education Program	Education & Awareness	25 attendees

