2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Englewood Hospital Service Area

Prepared for
Englewood Hospital

ENGLEWOOD HEALTH

2024-0741-02

Prepared by
www.PRCExcellence.com

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INTRODUCTION

PROJECT OVERVIEW

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 Community Health Needs Assessment — a follow-up to similar studies conducted in 2016 and 2022 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Englewood Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This assessment for Englewood Hospital is part of a regional project conducted by Professional Research Consultants, Inc. (PRC) for the Community Health *Improvement* Partnership (CH*I*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.

CHIP Community Health *Improvement* Partnership OF BERGEN COUNTY

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey, the PRC Online Key Informant Survey, focus groups, and community leader interviews), 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.

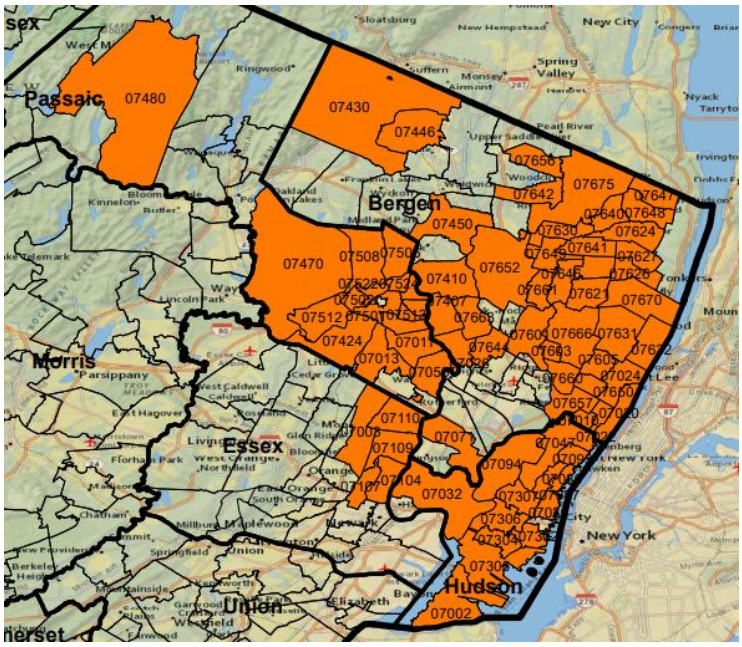
PRC Community Health Survey

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 the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

For Englewood Hospital, the community of focus (referred to as the "service area" in this report) is defined as each of the residential ZIP Codes comprising the service area of the hospital. This community definition, determined based on the ZIP Codes of residence of most recent patients, is illustrated in the adjacent 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 (landline and cell phone) 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 1,381 surveys throughout the service area.

OVERSAMPLE SURVEYS (PRC) ► In addition to the random sampling, PRC oversampled Hispanic, Asian, and Black/African American respondents to bolster representation among these populations.

COMMUNITY OUTREACH SURVEYS (The Partnership) ► 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 453 surveys to the overall sample.

In all, 1,834 surveys were completed through these mechanisms. The total sample included 381 interviews among Hispanic residents (in Spanish or English), 190 interviews among Asian residents (in Korean or English), and 235 interviews among Black/African American residents, who were reached through either random sampling or oversampling efforts.

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.

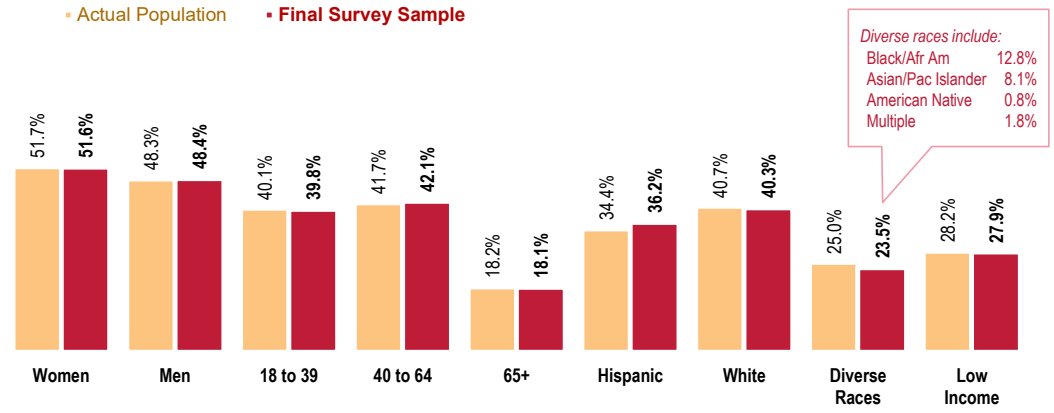
For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 1,834 respondents is ±2.3% at the 95 percent confidence level.

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 Hospital Service Area, 2025)



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2025 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% FPL (federal poverty level, based on guidelines established by the US Department of Health & Human Services).
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

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.

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 was also 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 asked about health throughout Bergen County and were predominantly local, but also included some who work regionally or statewide.

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. In all, 124 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	16
Public Health Representatives	12
Other Health Providers	25
Social Services Providers	16
Other Community Leaders	55

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- AARP
- ACO Director of Clinical Operations
- Age Friendly Englewood
- Age Friendly Teaneck
- Asian Women's Christian Association
- Bergen Community College
- Bergen County Department of Health Services
- Bergen County Department of Human Services
- Bergen County Division of Senior Services
- Bergen County School Nurse Association
- Bergen New Bridge Medical Center
- Bergen Volunteer Medical Initiative
- Bogota Middle School
- Bogota Schools
- Calvary Baptist Church
- Center for Food Action
- CFA
- Children's Aid and Family Services
- Christian Health
- Community Chest
- Comprehensive Behavioral Health Care
- Different Breed Sports Academy
- Don Bosco High School
- Eastwick College
- Ebeneezer Church, BFC seniors
- El Especialito
- Elmwood Park Homeowners Association
- Elmwood Park Paterson Elks Lodge
- Englewood Health
- Englewood Health Department
- Englewood Health Physician Network
- Family Promise of Ridgewood
- Family Success Center
- Felician College
- First Baptist Church of Teaneck
- Food Brigade
- Former President Diversity Publishing
- Fort Lee High School
- Franciscan Community Development Center
- Gym Guyz
- Hackensack Early Childhood Development Center
- Hackensack Health Department
- Hackensack Police Department
- HealthBarn USA
- Hillsdale Health Department
- Holy Name
- HUMC Allergy, Asthma & Immune Disorders
- HUMC Smoking Cessation
- JCC on the Palisades
- Korean American senior citizens association of NJ
- Leonia Senior Center
- LPM Strategies LLC
- Mahwah High School
- Maywood Health Dept/Wellness
- Meadowlands Area YMCA
- Metro Community Center/ Church
- Mid Bergen Regional Health Commission
- Midland Park Senior Center and Age Friendly Ridgewood
- Mt. Bethel Church
- NAACP, Bergen County Chapter
- New Hope Pregnancy Resource Center
- New Jersey Buddies
- North Hudson Community Action Corporation
- Nutrition Outreach Manager
- Office of Concern Food Pantry
- Pascack Valley Medical Center
- Pilgrim Church
- Presbyterian Church of Teaneck
- Ramapo College
- Ridgecrest Apartments
- Ridgewood Board of Health

- Ridgewood High School
- River Vale Farmers Market
- Share, Inc
- Shirvan Family Live Well Center
- ShopRite Hackensack
- ShopRite New Milford
- Sodexo
- The Bright Side Family
- The Center for Alcohol and Drug Resources
- Township of Washington
- Transition Professionals
- Valley Hospital
- Valley Medical Group
- Wallington Jr/Sr High School
- Westwood Health Department
- WFM Project & Construction

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 Bergen County among those representing the following populations:

- African American Community Leaders
- Elder Care Providers
- EMT/First Responders
- Korean Providers
- Latinx Community Leaders
- LGBTQ+ Community Leaders
- Mental Health and Substance Use Providers
- Public Health Leaders (Health Officers/Health Educators/CHWs)
- 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 35th 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 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)
- 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, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles

- 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 the entirety of Bergen County, New Jersey.

Benchmark Data

Trending

Similar surveys were administered in the service area in 2016 and 2022 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 geographic service area definition has changed slightly over time). Historical data for secondary data indicators 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 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. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 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 findings (from various existing resources) 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.

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 US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, “significance” of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

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, Spanish, or Korean — 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 — while included in the overall findings, 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 Hospital 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 Hospital 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 Hospital 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 nonprofit 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	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	31
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	132
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	12
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	14
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	145

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 key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access ○ Inconvenient Office Hours ○ Cost of Prescriptions ○ Appointment Availability ○ Difficulty Finding a Physician ○ Lack of Transportation ▪ Skipping/Stretching Prescriptions ▪ Emergency Room Utilization
CANCER	▪ Leading Cause of Death ▪ Prostate Cancer Incidence
DIABETES	▪ Diabetes Prevalence ▪ Prevalence of Borderline/Pre-Diabetes ▪ Key Informants: *Diabetes* ranked as a top concern.
DISABLING CONDITIONS	▪ Key Informants: *Disabling Conditions* ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Prevalence ▪ Taking Action to Control High Blood Pressure ▪ High Blood Cholesterol Prevalence ▪ Overall Cardiovascular Risk
HOUSING	▪ Housing Insecurity ▪ Key Informants: *Social Determinants of Health (including Housing)* ranked as a top concern.
INFANT HEALTH & FAMILY PLANNING	▪ Infant Deaths
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ▪ Violent Crime Experience
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: *Mental Health* ranked as a top concern.

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AREAS OF OPPORTUNITY (continued)	
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Use of Food Pantries/Free Meals ▪ Difficulty Accessing Fresh Produce ▪ Overweight & Obesity [Adults] ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
RESPIRATORY DISEASE	▪ Asthma Prevalence [Adults]
SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Unintentional Drug-Induced Deaths ▪ Marijuana/THC Use ▪ Family Member Treated for Prescription Drug Addiction ▪ Personally Impacted by Substance Use
TOBACCO USE	▪ Cigarette Smoking ▪ Cigarette Smoking in the Home ▪ Use of Vaping Products

Other Qualitative Input

In the focus groups and one-on-one interviews conducted, several common themes emerged that were consistent in all conversations:

1. Collaboration and advocacy
2. People are being left behind
3. Caregivers need support
4. Creativity and safe spaces

Prioritization of Health Needs

On October 14, 2025, 13 people representing all the partner agencies of Bergen County Community Health *Improvement* Partnership (Bergen New Bridge Medical Center, Christian Health, Hackensack University Medical Center, Englewood Health, Holy Name Medical Center, Pascack Valley Medical Center, Valley Health System, and Bergen County Department of Health Services) held an in-person meeting with consultants from 35th Street Consulting. The purpose of the meeting was to use the data collected for the 2025 CHNA to identify priority areas for collective action in the coming years. 35th Street Consulting facilitated a consensus-building process to help determine the following priority areas:

HEALTHY MINDS

- Address stress, worry, fear
- Support caregivers and caregiving
- Mental health for all ages
- Substance use as a coping mechanism (including alcohol, gambling, tobacco, vape)

HEALTHY BODIES

- Heart health and cardiovascular disease
- Diabetes and GLP-1 medications
- Build on successes in cancer outcomes
- Healthy living for all ages (healthy eating and healthy food access, high-impact chronic pain, ambulatory limitations, understanding senior living community needs, supporting youth)

LEVERAGE COLLABORATION

- Maximize partnership impact (by strengthening and continuing to build bridges)
- Link and support existing services
- Build local capacity to identify and respond to changing needs
- Leverage connections to expand access to care and services for all

The above would be addressed with the **overarching goal** to expand healthcare reach and outcomes.

Hospital Implementation Strategy

Englewood Hospital will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community.

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

Summary Tables: Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, Englewood Hospital service area results are shown in the larger, gray column.

The columns to the right of the service area column provide trending, as well as comparisons between service area data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the service area compares favorably (), unfavorably (), or comparably () to these external data.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2016 (or earliest available data). Note that survey data reflect the ZIP Code-defined 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). Local secondary data reflect county-level data for Bergen County.

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.

SOCIAL DETERMINANTS	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	**6.9** [County-Level Data]		6.3	3.9		
Population in Poverty (Percent)	**6.7** [County-Level Data]		9.8	12.4	8.0	
Children in Poverty (Percent)	**7.5** [County-Level Data]		13.3	16.3	8.0	
No High School Diploma (Age 25+, Percent)	**7.1** [County-Level Data]		9.3	10.6		
Unemployment Rate (Age 16+, Percent)	**3.5** [County-Level Data]		4.2	4.0		
% Unable to Pay for a $400 Emergency Expense	**23.6**	18.5		34.0		23.3
% Worry/Stress Over Rent/Mortgage in Past Year	**41.4**	38.0		45.8		37.0
% Unhealthy/Unsafe Housing Conditions	**13.8**	12.4		16.4		19.3
Population With Low (Geographic) Food Access (Percent)	**10.3** [County-Level Data]		23.8	22.2		
% Food Insecure	**38.3**	26.6		43.3		26.0
% Used Food Pantry/Free Meals in the Past Year	**13.3**	7.4				9.9

better similar worse

OVERALL HEALTH	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	15.0	14.6	17.0	15.7		13.3
			better	similar	worse	

ACCESS TO HEALTH CARE	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	6.9	6.7	11.4	8.1	7.6	6.5
% Difficulty Accessing Health Care in Past Year (Composite)	53.7	51.2		52.5		42.0
% Cost Prevented Physician Visit in Past Year	20.2	18.8	10.8	21.6		18.7
% Cost Prevented Getting Prescription in Past Year	19.4	16.1		20.2		11.7
% Difficulty Getting Appointment in Past Year	28.9	29.0		33.4		19.4
% Inconvenient Hrs Prevented Dr Visit in Past Year	29.1	25.3		22.9		18.9
% Difficulty Finding Physician in Past Year	21.7	18.3		22.0		13.8
% Transportation Hindered Dr Visit in Past Year	15.6	10.3		18.3		7.3

ACCESS TO HEALTH CARE (continued)	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% Language/Culture Prevented Care in Past Year	**4.9**	2.4		5.0		3.3
% Stretched Prescription to Save Cost in Past Year	**18.0**	13.7		19.4		11.5
% Difficulty Getting Child's Health Care in Past Year	**12.9**	9.0		11.1		12.1
Primary Care Doctors per 100,000	**113.4** [County-Level Data]		78.2	74.9		
% Routine Checkup in Past Year	**76.3**	76.4	79.2	65.3		73.8
% [Child 0-17] Routine Checkup in Past Year	**90.1**	90.2		77.5		81.7
% Two or More ER Visits in Past Year	**17.1**	11.2		15.6		9.9
% Eye Exam in Past 2 Years	**59.7**	63.9		55.5	57.4	63.5
% Health Affected by Missed Medical Care During COVID-19 Pandemic	**10.8**	8.8				
% Resuming Preventive Health Care After COVID-19 Pandemic	**78.9**	79.7				
% "Seldom/Never" Understand Written Health Information	**10.6**	8.0		10.0		11.5

ACCESS TO HEALTH CARE (continued)	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% "Seldom/Never" Understand Spoken Health Information	6.4	6.8		7.5		10.7
% Rate Local Health Care "Fair/Poor"	11.5	10.7		11.5		12.2
			better	similar	worse	

CANCER	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000	158.9 [County-Level Data]		166.1	182.5	122.7	181.7
Lung Cancer Deaths per 100,000	28.8 [County-Level Data]		32.8	39.8	25.1	
Female Breast Cancer Deaths per 100,000	24.7 [County-Level Data]		25.7	25.1	15.3	
Prostate Cancer Deaths per 100,000	15.6 [County-Level Data]		17.0	20.1	16.9	
Colorectal Cancer Deaths per 100,000	14.9 [County-Level Data]		15.0	16.3	8.9	
Cancer Incidence per 100,000	465.8 [County-Level Data]		481.9	442.3		
Lung Cancer Incidence per 100,000	45.4 [County-Level Data]		51.3	54.0		

CANCER (continued)	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
Female Breast Cancer Incidence per 100,000	**144.0** [County-Level Data]		137.1	127.0		
Prostate Cancer Incidence per 100,000	**137.3** [County-Level Data]		143.3	110.5		
Colorectal Cancer Incidence per 100,000	**37.3** [County-Level Data]		38.7	36.5		
% Cancer	**7.8**	9.2	9.5	7.4		6.5
% [Women 40-74] Breast Cancer Screening	**76.3**	82.6		64.0	80.5	74.4
% [Women 21-65] Cervical Cancer Screening	**79.3**	80.6		75.4	84.3	74.4
% [Age 45-75] Colorectal Cancer Screening	**74.9**	77.5		71.5	74.4	73.6
% [Men 40+] Prostate Cancer Screening in Past 2 Years	**62.8**	61.9				53.0
			better	similar	worse	

DIABETES	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000	**16.3** [County-Level Data]		22.2	30.5		17.4

DIABETES (continued)	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% Diabetes/High Blood Sugar	**13.9**	10.8	10.5	12.8		9.3
% Borderline/Pre-Diabetes	**17.3**	19.6		15.0		10.9
Kidney Disease Deaths per 100,000	**15.0** [County-Level Data]		18.4	16.9		16.6

better similar worse

DISABLING CONDITIONS	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	**34.1**	31.6		38.0		35.9
% Activity Limitations	**23.6**	23.7		27.5		21.6
% High-Impact Chronic Pain	**15.4**	14.4		19.6	6.4	17.5
Alzheimer's Disease Deaths per 100,000	**31.6** [County-Level Data]		25.3	35.8		29.9
% Caregiver to a Friend/Family Member	**22.3**	22.2		22.8		22.5

better similar worse

GAMBLING	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% Negatively Affected by Gambling in Past Year	6.1	4.6				

better similar worse

HEART DISEASE & STROKE	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000	176.1 [County-Level Data]		199.8	209.5	127.4	197.5
% Heart Disease	8.9	8.4	5.0	10.3		5.4
Stroke Deaths per 100,000	36.5 [County-Level Data]		39.6	49.3	33.4	37.9
% Stroke	4.0	2.8	2.4	5.4		3.9
% High Blood Pressure	39.9	37.8	33.4	40.4	42.6	37.3
% [HBP] Taking Action to Control High Blood Pressure	84.5	86.8				90.1
% High Cholesterol	41.7	43.7		32.4		38.0
% [HBC] Taking Action to Control High Blood Cholesterol	85.0	82.6				82.2

HEART DISEASE & STROKE (continued)	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% 1+ Cardiovascular Risk Factor	**87.6**	86.2		87.8		82.6
			better	similar	worse	

INFANT HEALTH & FAMILY PLANNING	Service Area	SERVICE AREA vs. BENCHMARKS vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent of Births)	**15.2** [County-Level Data]		23.5	22.3		
Teen Births per 1,000 Females 15-19	**3.2** [County-Level Data]		9.6	16.6		
Low Birthweight (Percent of Births)	**7.5** [County-Level Data]		7.9	8.3		
Infant Deaths per 1,000 Births	**3.2** [County-Level Data]		4.2	5.6	5.0	2.4
			better	similar	worse	

INJURY & VIOLENCE	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000	37.1 [County-Level Data]		53.8	67.8	43.2	27.5
Motor Vehicle Crash Deaths per 100,000	4.7 [County-Level Data]		7.3	13.3	10.1	
Homicide Deaths per 100,000	1.5 [County-Level Data]		3.9	7.6	5.5	1.6
% Victim of Violent Crime in Past 5 Years	4.0	2.5		7.0		1.9
% Victim of Intimate Partner Violence	13.1	12.1		20.3		11.0

better similar worse

MENTAL HEALTH	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	19.4	21.1		24.4		11.4
% Diagnosed Depression	24.8	23.1	13.9	30.8		11.3
% Symptoms of Chronic Depression	41.8	37.1		46.7		30.6
% Typical Day Is "Extremely/Very" Stressful	16.4	17.4		21.1		13.3

MENTAL HEALTH (continued)	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
Suicide Deaths per 100,000	7.1 [County-Level Data]		7.8	14.7	12.8	8.1
Mental Health Providers per 100,000	307.0 [County-Level Data]		291.2	313.6		
% Receiving Mental Health Treatment	16.9	19.5		21.9		13.1
% Unable to Get Mental Health Services in Past Year	9.4	8.8		13.2		6.2
% [Child 5-17] Diagnosed w/Mental Health Issue	17.6	20.3				19.4
			better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	25.4	23.6		30.0		20.1
% Use Food Labels to Make Purchasing Decisions	80.9	76.8				74.0
% No Leisure-Time Physical Activity	23.7	22.2	24.2	30.2	21.8	26.2
% Meet Physical Activity Guidelines	29.3	30.8	31.3	30.3	29.7	25.1

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% [Child 2-17] Physically Active 1+ Hours per Day	**40.5**	32.5		27.4		43.1
Recreation/Fitness Facilities per 100,000	**20.7** [County-Level Data]		15.8	12.3		
% Overweight (BMI 25+)	**65.1**	65.0	64.8	63.3		58.6
% Obese (BMI 30+)	**30.5**	30.3	28.9	33.9	36.0	22.0
% Currently Taking GLP-1 Agonist	**10.9**	10.5				
% [Child 5-17] Overweight (85th Percentile)	**31.6**	29.6		31.8		35.9
% [Child 5-17] Obese (95th Percentile)	**19.0**	18.4		19.5	15.5	22.7
			better	similar	worse	

ORAL HEALTH	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% Have Dental Insurance	**79.4**	80.3		72.7	75.0	68.5
% Dental Visit in Past Year	**64.6**	71.5	68.3	56.5	45.0	68.6
% [Child 2-17] Dental Visit in Past Year	**86.0**	86.3		77.8	45.0	67.5
			better	similar	worse	

RESPIRATORY DISEASE	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000	**21.0** [County-Level Data]		27.7	43.5		27.4
Pneumonia/Influenza Deaths per 100,000	**9.8** [County-Level Data]		12.4	13.4		16.7
% Asthma	**13.0**	10.7	8.6	17.9		9.8
% [Child 0-17] Asthma	**10.9**	9.6		16.7		7.8
% COPD (Lung Disease)	**6.7**	5.9	4.4	11.0		8.7
			better	similar	worse	

SEXUAL HEALTH	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	**232.3** [County-Level Data]		449.7	386.6		
Chlamydia Incidence per 100,000	**221.8** [County-Level Data]		357.9	495.0		
Gonorrhea Incidence per 100,000	**56.3** [County-Level Data]		100.7	194.4		
			better	similar	worse	

SUBSTANCE USE	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000	**7.7** [County-Level Data]		8.5	15.7		4.9
Cirrhosis/Liver Disease Deaths per 100,000	**7.2** [County-Level Data]		10.6	16.4	10.9	
% Excessive Drinking	**21.4**	19.4	15.7	34.3		27.1
Unintentional Drug-Induced Deaths per 100,000	**15.8** [County-Level Data]		30.8	29.7		9.4
% Used an Illicit Drug in Past Month	**4.2**	2.8		8.4		4.0
% Used Marijuana/THC in the Past Year	**21.2**	20.1				7.5

SUBSTANCE USE (continued)	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% Used a Prescription Opioid in Past Year	9.8	9.2		15.1		8.0
% Family Member Treated for Rx Addiction	10.4	7.8				8.4
% Ever Sought Help for Alcohol or Drug Problem	5.6	3.8		6.8		2.7
% Personally Impacted by Substance Use	34.5	32.8		45.4		29.0
			better	similar	worse	

TOBACCO USE	Service Area	SERVICE AREA vs. BENCHMARKS				
		vs. Bergen County	vs. NJ	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	18.3	9.2	9.1	23.9	6.1	10.9
% Someone Smokes at Home	15.2	10.3		17.7		11.9
% Use Vaping Products	15.1	11.2	6.3	18.5		8.5
			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]

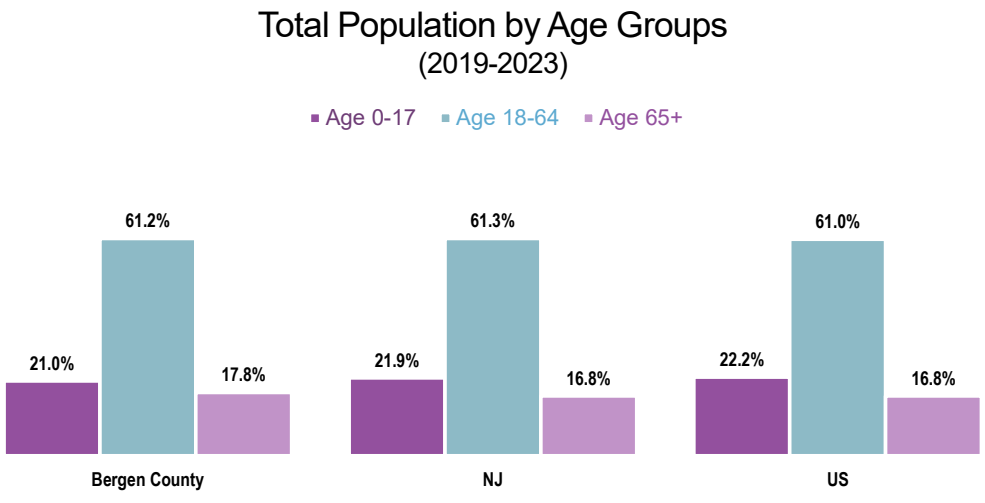
Total Population
(Estimated Population, 2019-2023)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Bergen County	954,717	232.79	4,101
New Jersey	9,267,014	7,354.93	1,260
United States	332,387,540	3,533,298.58	94

Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 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]



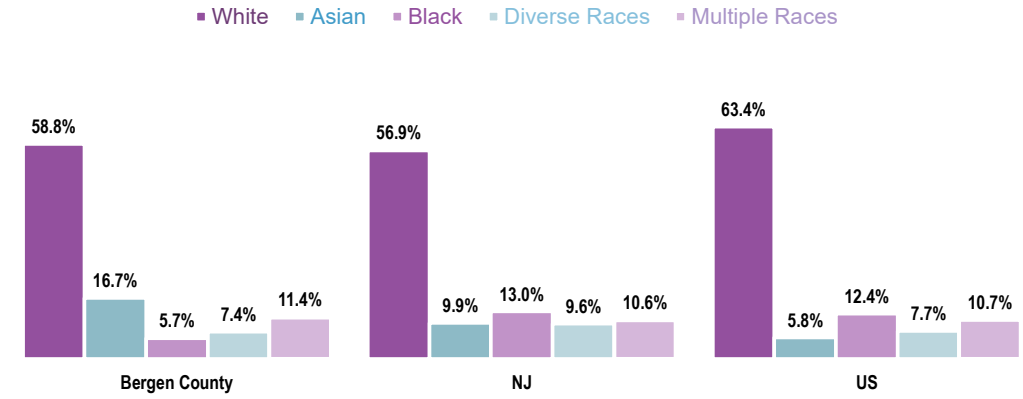
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Race & Ethnicity

Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

The following charts illustrate the racial and ethnic makeup of our community. [COUNTY-LEVEL DATA]

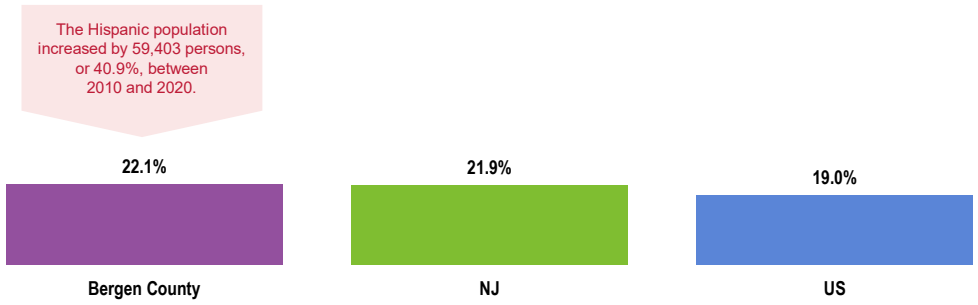
Total Population by Race Alone
(2019-2023)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.

Hispanic Population
(2019-2023)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- 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.

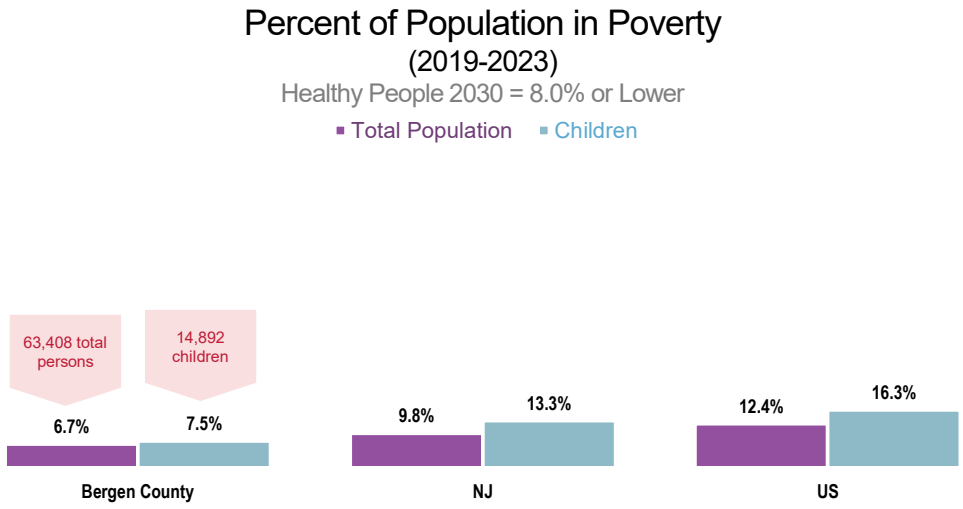
– Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

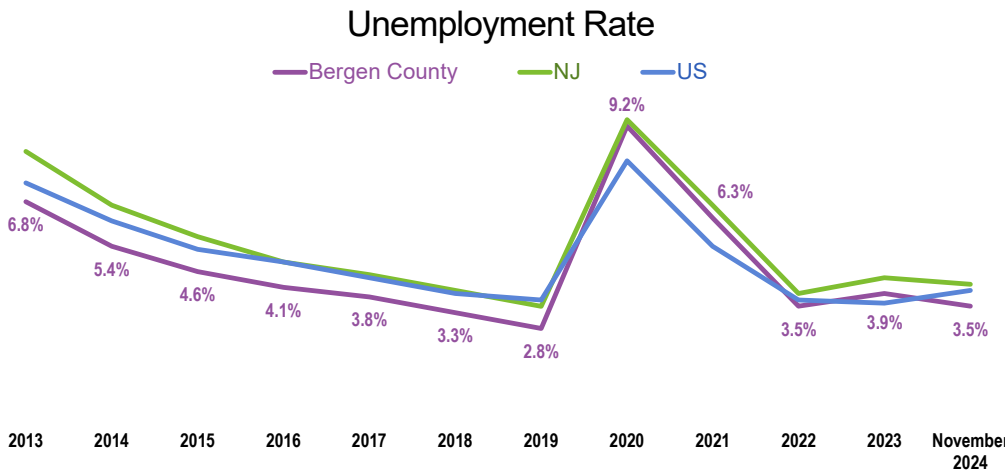
The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Employment

Note the following trends in unemployment data derived from the US Department of Labor. [COUNTY-LEVEL DATA]



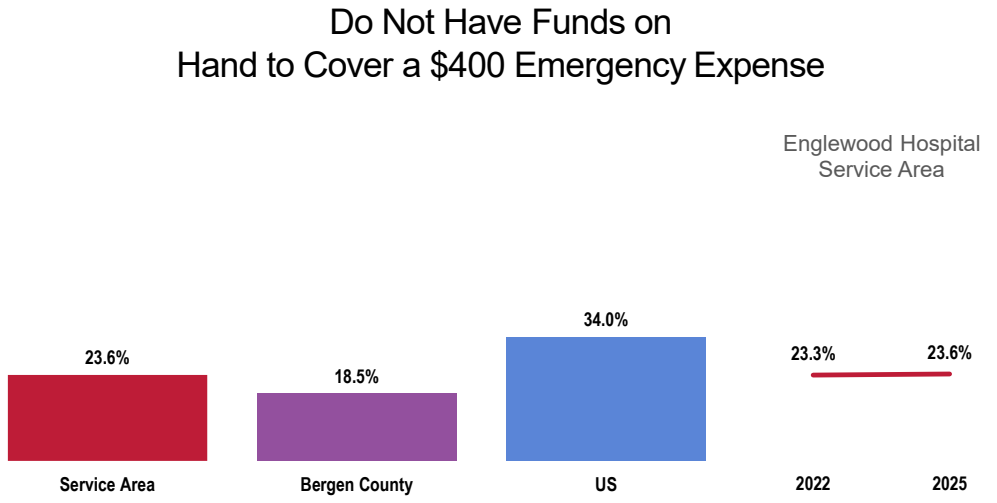
Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Financial Resilience

PRC SURVEY ► "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?"

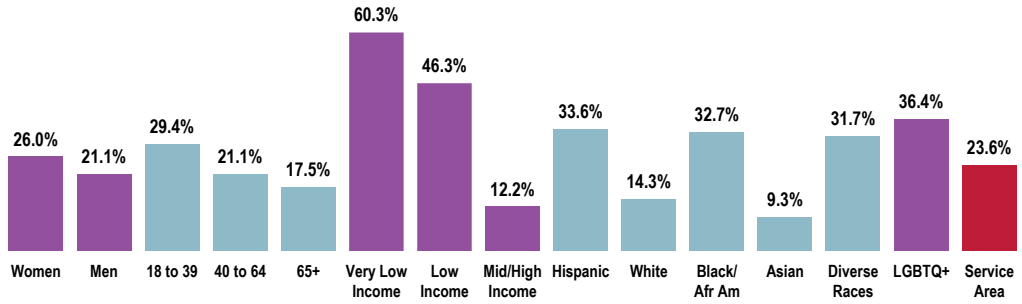
The following details "no" responses in the service area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], race/ethnicity, and LGBTQ+ identification).



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 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.

Do Not Have Funds on Hand to Cover a $400 Emergency Expense
(Englewood Hospital Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
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.

INCOME & RACE/ETHNICITY

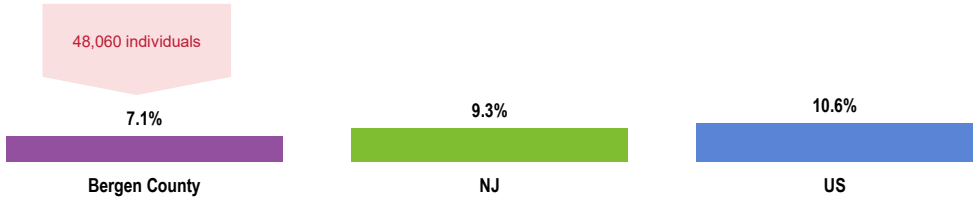
INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2024 guidelines place the poverty threshold for a family of four at $30,700 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 other race group. Other race categories are non-Hispanic categorizations (e.g., “White” reflects those who identify as White alone, without Hispanic origin). “Diverse Races” includes those who identify as American Indian or Alaska Native, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes. [COUNTY-LEVEL DATA]

Population With No High School Diploma
(Adults Age 25 and Older; 2019-2023)



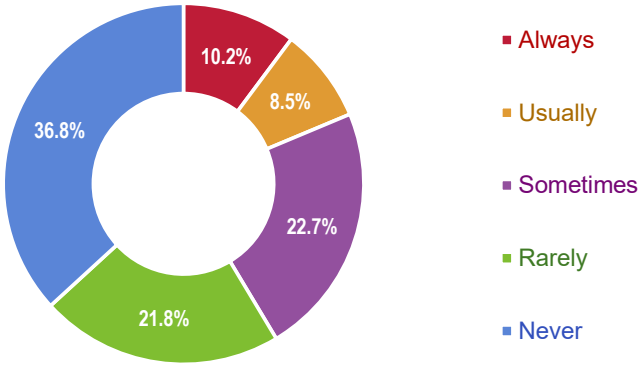
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Housing

Housing Insecurity

PRC SURVEY ► "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?"

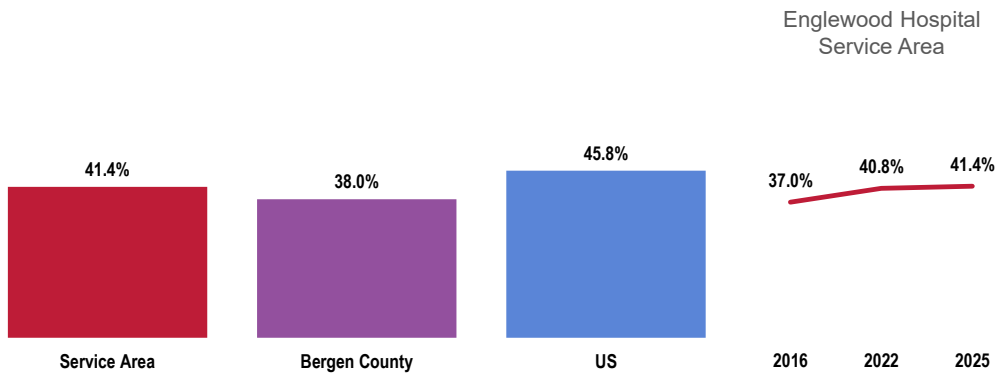
Frequency of Worry or Stress About Paying Rent or Mortgage in the Past Year
(Englewood Hospital Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 56]

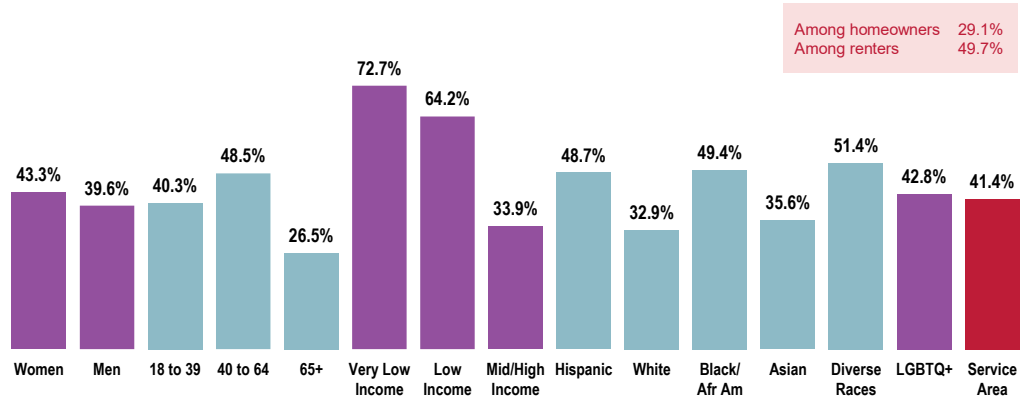
Notes:
- Asked of all respondents.

“Always/Usually/Sometimes” Worried About Paying Rent or Mortgage in the Past Year



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

“Always/Usually/Sometimes” Worried About Paying Rent or Mortgage in the Past Year
(Englewood Hospital Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

PRC SURVEY ► "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

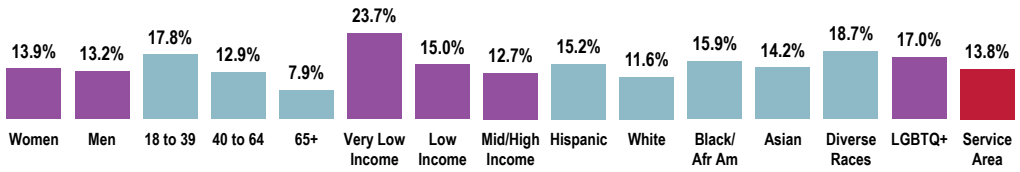
Englewood Hospital Service Area

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 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.

Unhealthy or Unsafe Housing Conditions in the Past Year
(Englewood Hospital Service Area, 2025)

Among homeowners	9.9%
Among renters	16.0%



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 55]

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.

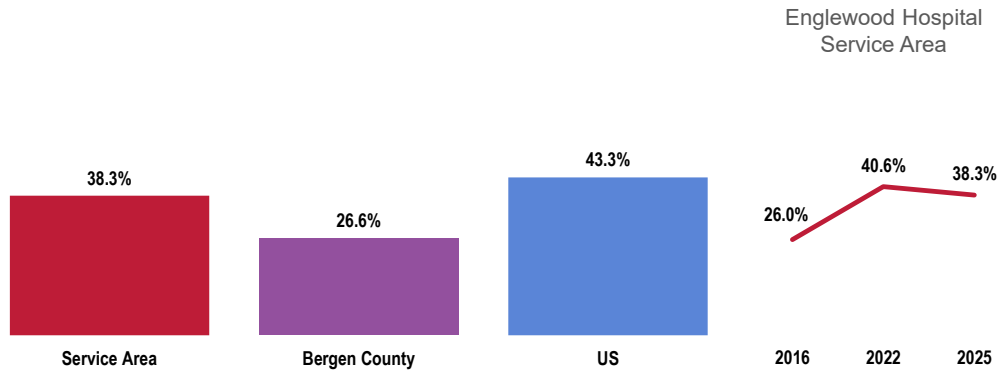
Food Insecurity

PRC SURVEY ► "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.'"

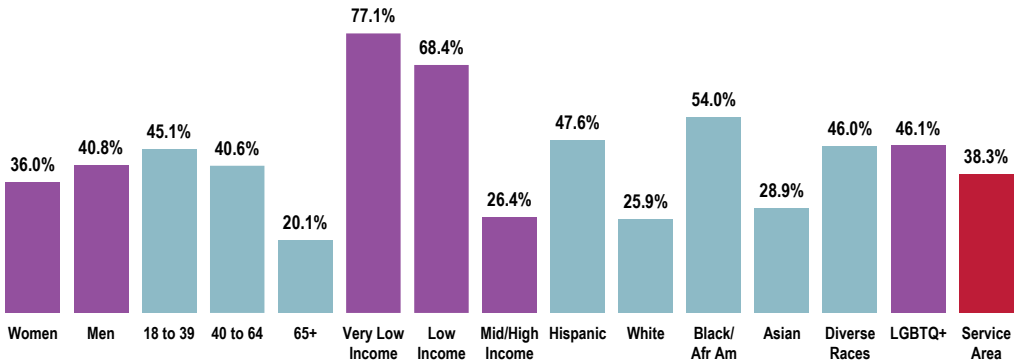
Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity for respondents.

Food Insecurity



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 98]
● 2023 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.

Food Insecurity
(Englewood Hospital Service Area, 2025)

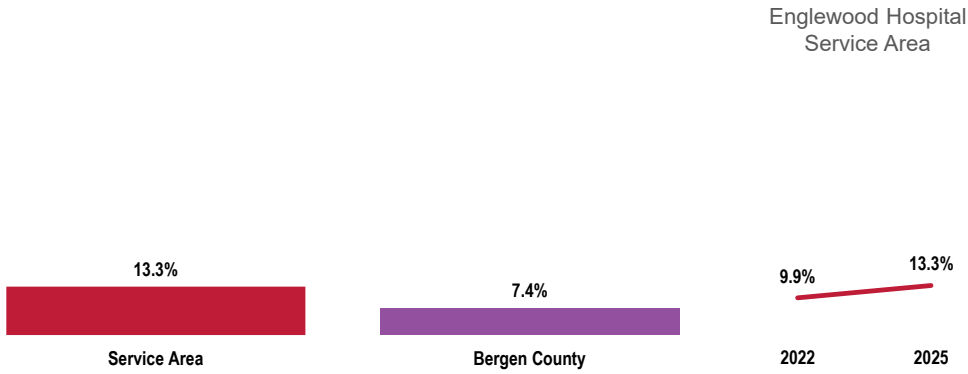


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 98]
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Use of Food Pantries and Free Meals

PRC SURVEY ► "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: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 312]
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.

PRC SURVEY ► "How often is health information written in a way that is easy for you to understand?"

PRC SURVEY ► "How often is health information spoken in a way that is easy for you to understand?"

"Seldom/Never" Understand Written Health Information
(Englewood Hospital Service Area)

US "Seldom/Never" = 10.0%

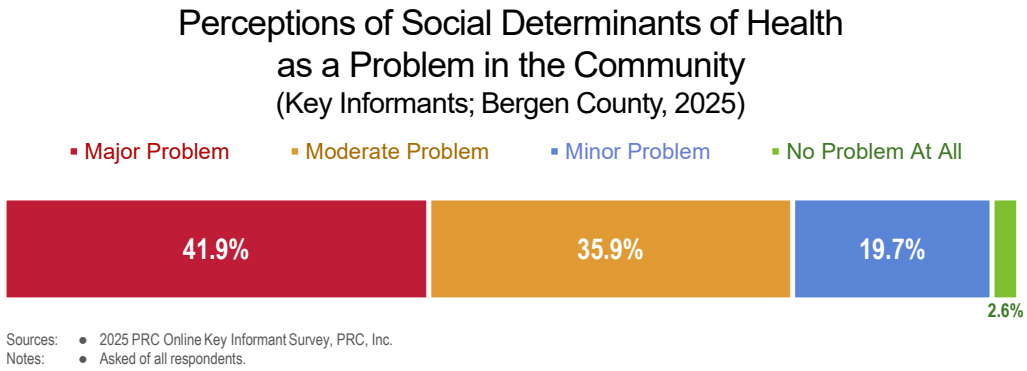
"Seldom/Never" Understand Spoken Health Information
(Englewood Hospital Service Area)

US "Seldom/Never" = 7.5%

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 308-309]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Social Determinants of Health

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



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

Housing

> Housing, especially for lower income individuals and families, are in many cases environmentally unsafe, with lead contamination, mold, and other airborne pathogens. Income severely limits access to healthcare. Without insurance treating even a minor condition can bankrupt a family. Even with insurance, there can be devastating expenses as insurers deny legitimate claims. Education for health problems is very spotty, witness the current nonsense over vaccination and treatments such has horse pills, bleach, etc. Environmental issues such as air pollution, questionable safety of public water supply, microplastics in food, food born illnesses, etc. Discrimination: why is the mortality among minority child bearers much higher than other classes? Why are women less likely to have accurate heart attack diagnoses? – Community Leader
>
> Bergen County is considered a high income, high cost of living area. Yet many older adults and low-income earners are struggling to find affordable housing and high housing costs and high taxes cut into their household budgets, leaving them without adequate resources to pay for health care, education, food, etc. Lack of adequate public transportation makes it difficult to access jobs, health care, etc. without owning a car which is another expense that cuts into monthly budgets. – Community Leader
>
> So many people are having difficulty finding affordable housing. There is so much construction taking place, but it is all luxury housing. Huge disparities exist between the haves and the have nots. Environmental protections and protections for workers are being cut by the president. The president's attitude and actions has given rise to visible, active hate against anyone perceived as different. He has given people permission to express what was festering below the surface. – Social Services Provider
>
> Housing, income, education, environment, discrimination, etc. present challenges to accessing health care. Health literacy is an issue as well. The cost of housing and care are also determinants that present challenges. – Community Leader
>
> The issues I see most are housing and income problems. Housing for low-income people is our mission. We turn a lot of people away who cannot afford our all-inclusive $1800/month rate. We receive multiple calls a day from people throughout Bergen County looking for a room for under $1000/month. Almost all of our residents and all the people who call us fall in the very-low-income bracket, but they have not been able to qualify for HUD or state funded public housing. Many of these people are sleeping on friends and relative's couches or in their cars. Our residents are intelligent, kind people who just exhausted their life's savings before they died. Their last decade is very insecure and depressing. – Social Services Provider
>
> Affordable housing -- there is not enough low income and affordable housing options for people to stay within their communities or to move nearby. Low-income housing has a 3 to 5 year wait. Affordable housing applications normally need to be filed online, disqualifying those without technology. The norm is for applications to be submitted online for a lottery system to then have the applicant be put on a wait list, if picked in the lottery, with no understanding of the wait time. An ongoing concern are escalating property taxes for older adults who can be priced out of their homes when they have utilized their savings to subsidize the cost of their home taxes and maintenance. Although NJ is trying to help with the tax burden through ANCHOR, Senior Freeze, and Stay NJ, these programs are dependent on the state identifying money in the budget to pay the costs. Climate change, increased flooding events, outdated sewer systems, PFAS filled water are all of concern. – Social Services Provider
>
> Without access to housing and nutrition, you can't have good health. – Health Care Provider

Housing is a huge problem in Englewood. There is no available affordable, low income or even moderate-income housing. The cost of living in this area is extremely high which makes it difficult for native Englewood residents to remain. Young adults cannot purchase homes. Rental apartments are all luxury priced and there are no condo/coop options to allow people to purchase. Because of the high incomes of those on the East Hill, it prevents people from seeing the true disparity in the city. There are many who are struggling financially. Many are just barely making ends meet. While they work, housing, food and medical costs are high. The school system in Englewood is abysmal. Children are not receiving what they need from the school district. Students are underperforming on all state tests and are not graduating with the skills they need to succeed after high school. It is a gross injustice. – Community Leader

Cost of living increased, with the high cost of housing in the area, low income or loss of income, lack of access to education and insurance coverage. – Community Leader

Housing is an issue since we can use more affordable housing in this area. – Social Services Provider

The lack of affordable housing in Bergen County is a major problem and source of stress. Income and education also contribute to health concerns. – Community Leader

If the cost of housing is not affordable financially, it can lead to an unhealthy state. – Community Leader

Cost of living is way up, especially in Bergen County. – Public Health Representative

I just want to emphasize the importance of safe, affordable housing for every adult at every stage of their life. – Community Leader

As a SDOH, lack of housing resources for Bergen County Residents in need either for unhoused or low income. – Health Care Provider

Income/Poverty

Although Bergen County is extraordinarily wealthy, it does have pockets of poverty. For low-income people, getting access to critical resources can be difficult and require working with many different organizations. Food security continues to be a challenge, as is access to affordable housing, educational opportunities, transportation, childcare and other critical needs. Accessing these resources does indeed depend on your zip code. – Community Leader

Economic instability, unemployment, rent prices. – Social Services Provider

Low Income and unemployment can lead to food insecurity, housing instability, and difficulty affording healthcare or medications. This increases the risk of chronic diseases and poor health outcomes. – Health Care Provider

Income, education, discrimination and environmental play major roles in people's health in Bergen County. Having Income and not being discriminated against gives you a better advantage for elite health services. Starting from basic types of food you can afford. – Community Leader

Due to limited incomes and education, many older adults do not have access to medical professionals due to lack of insurance and transportation. Medicare and Medicaid have severe limitations. Older adults that are unable to afford secondary insurance suffer greatly. – Social Services Provider

Awareness/Education

Lack of knowledge where resources are. – Community Leader

Patients lack understanding of the documents they need to apply for assistance, and this can extend the process of gaining access to resources. There is a large gap due to language and literacy. There is a lack of comfort in patients seeking care by providers who do not speak their language. – Health Care Provider

Limited knowledge of the impact of SDOH. – Health Care Provider

Lack of understanding of this important issue by local hospitals and no interest in learning about it. – Physician

Impact on Quality of Life

Prevent individuals from seeking care they truly need and deserve to have access to. – Community Leader

They shape the conditions in which people live, work, learn, and play affecting health outcomes and quality of life. Communities with poor SDOH often experience higher rates of chronic diseases, infant mortality, and lower life expectancy. Disparities are often tied to systemic issues like poverty, racism, and underinvestment in certain neighborhoods. Poor social conditions lead to poor health, which can then limit educational and job opportunities—creating a cycle that keeps individuals/communities trapped in disadvantage. Poor health outcomes lead to increased healthcare costs and lost productivity. When communities are unhealthy, local economies suffer due to a less capable workforce and higher public spending on emergency care rather than preventive services. Inadequate housing, food insecurity, and violence are linked to poor social determinants and can increase crime rates, stress-related illness, and reduce overall community well-being.
– Social Services Provider

Because the social determinants have significant impact on health. – Community Leader

Access to Care/Services

They are a major problem given that the population of patients we serve are from underserved communities, who usually are not able to receive/ have access to medical care. – Physician

> Lack of gas pod nods with adequate health care, lack of affordable healthcare, housing and the cost of groceries, clothing, etc. – Community Leader

Aging Population

> Many seniors are lonely and need engagement with others. – Community Leader
>
> Many seniors over 65 years are suffering from food insecurity, home care services, transportation support and social isolation. – Community Leader

Nutrition

> Please socialize over food. Lots of food means abundance. Sweets are considered a "treat" or special event food. – Social Services Provider
>
> We are a food pantry, so we see issues around food insecurity - housing, income, etc. – Community Leader

Environmental Issues

> Environmental issues and technology. Overbuilding is causing congestion and loss of green space. Communities are experiencing separation between residents who rent in buildings and all others as new construction has been created to be independent of community amenities and residents. Isolation and loneliness, loss of social connections, reliance on technology and devices impede social connections and increase isolation and loneliness and compromise meaningful relationships - across all populations and ages.
> – Social Services Provider

Discrimination

> It is the basis for all health-related issues - the societal structures that exist prevent many people from accessing the services they need. For example, discrimination may lead to incarceration which may lead to issues related to housing, employment, safety, education... each issue feeds into the other. – Community Leader

Politics

> Polarity could actually be a health issue today. The present social-political climate of polarity is triggering tension, division, assumptions and overreactions which in turn cause more fear, anxiety, isolation and stress to what we already had. – Social Services Provider

Foreign-Born

> Non legal immigrants have fear to find medical assistance because of their unstable status. – Community Leader

Funding

> Access to services since the reduction of federal funding in this space. – Health Care Provider

Affordable Care/Services

> Lack of low-income health programs. – Community Leader

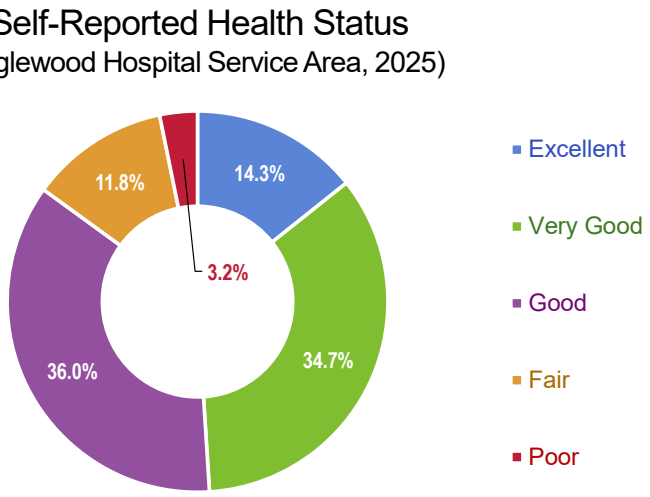
Incidence/Prevalence

> They affect everybody in some way. – Community Leader

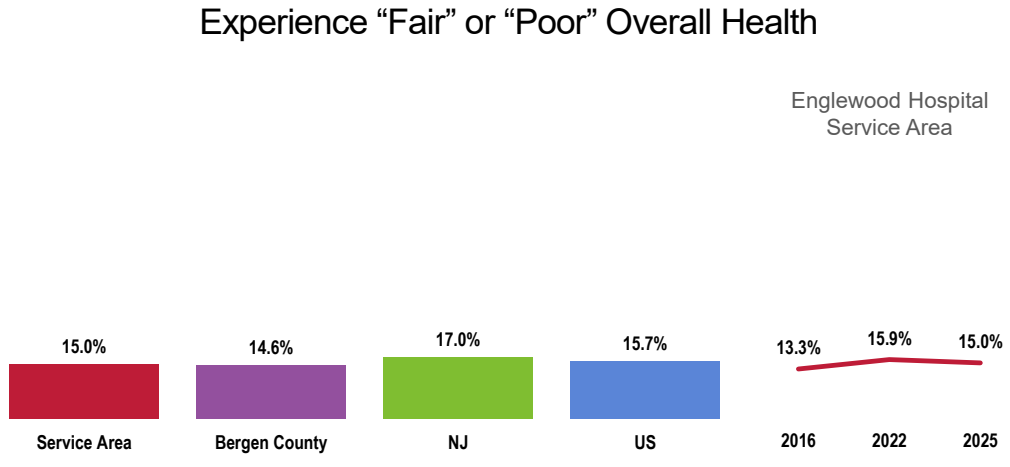
HEALTH STATUS

Overall Health

PRC SURVEY ► "Would you say that, in general, your health is: excellent, very good, good, fair, or poor?"

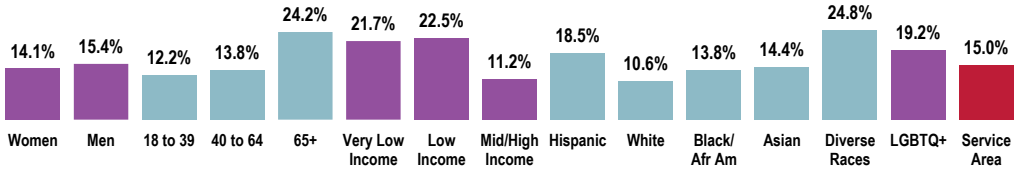


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Englewood Hospital Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

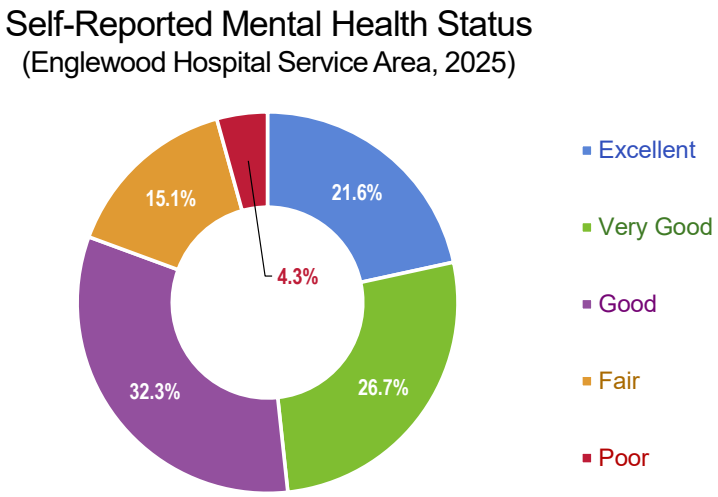
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

PRC SURVEY ► "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?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

Englewood Hospital Service Area

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

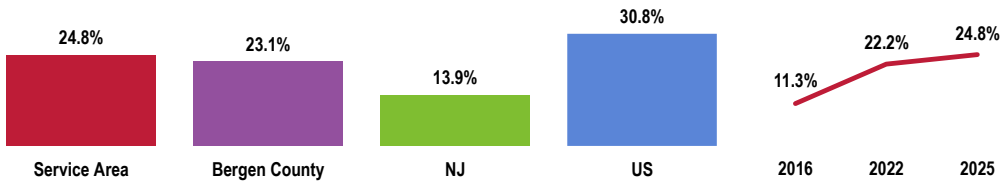
Depression

Diagnosed Depression

PRC SURVEY ► “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

Englewood Hospital Service Area



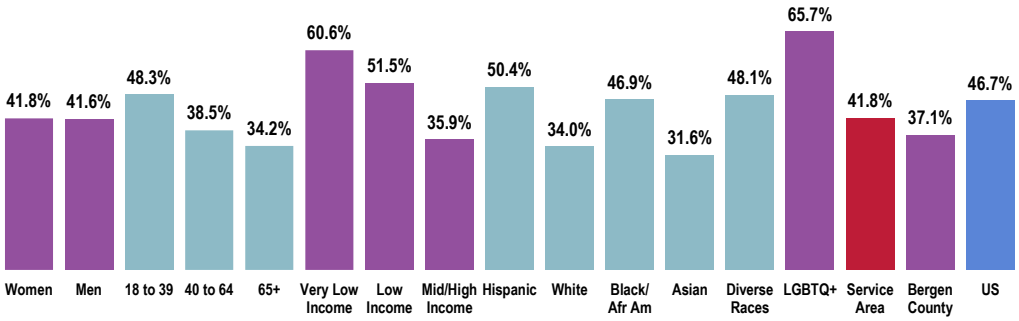
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Symptoms of Chronic Depression

PRC SURVEY ► "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 Hospital Service Area, 2025)



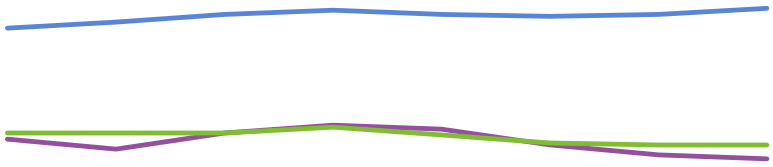
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

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 mortality rates attributed to suicide in our population. [COUNTY-LEVEL DATA]

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



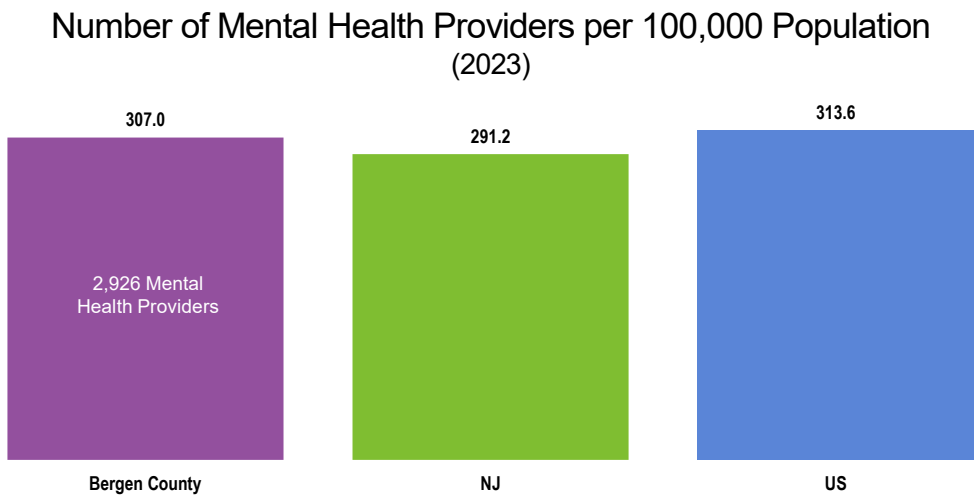
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	8.1	7.6	8.4	8.8	8.6	7.8	7.3	7.1
NJ	8.4	8.4	8.4	8.7	8.3	7.9	7.8	7.8
US	13.7	14.0	14.4	14.6	14.4	14.3	14.4	14.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Mental Health Treatment

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

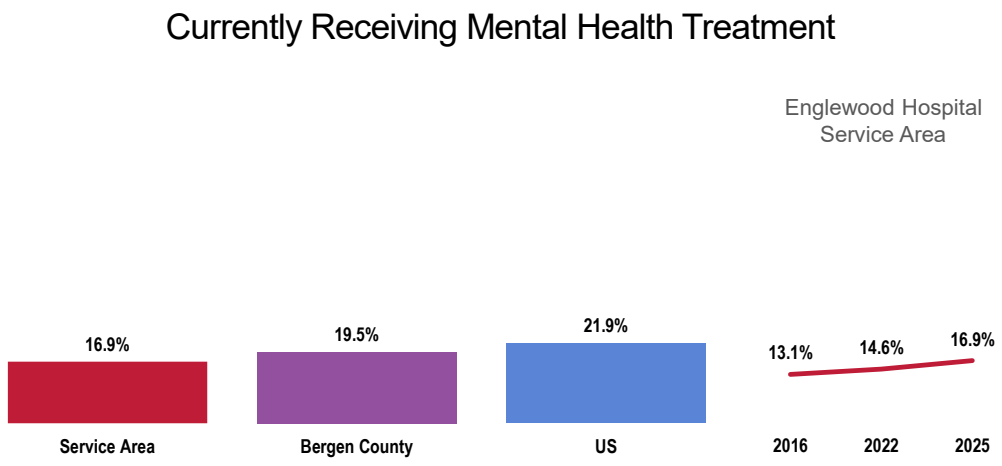
The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]



Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (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 counselors that specialize in mental health care.

PRC SURVEY ► "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?"

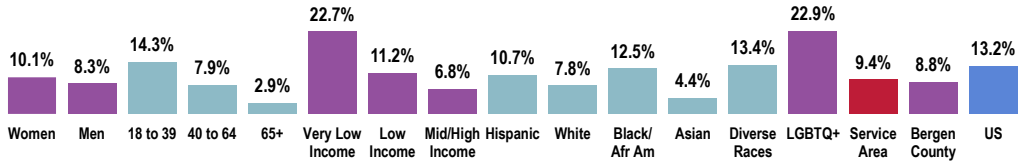


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC SURVEY ▶ "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 Hospital Service Area, 2025)

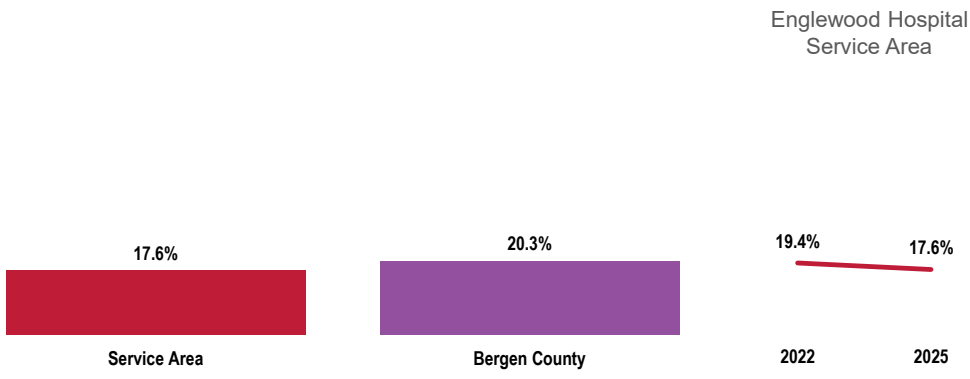


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 82]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Child's Mental, Emotional, and Behavioral Health

PRC SURVEY ▶ [About children age 5 to 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.?"**

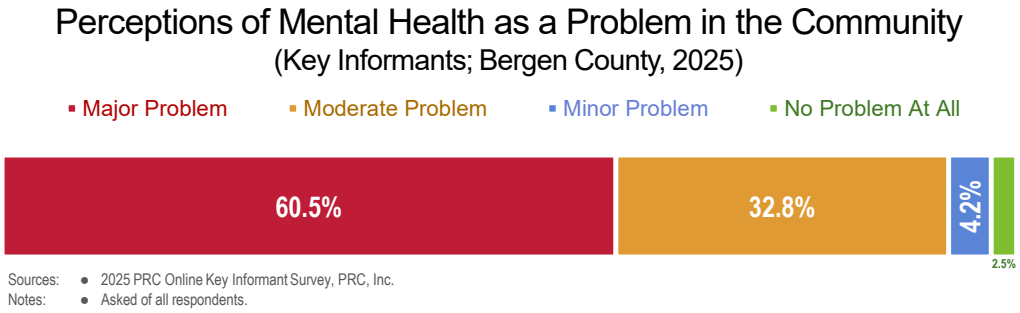
Child Has Been Diagnosed with a Mental, Emotional, or Behavioral Issue (Depression, Anxiety, ADHD, etc.)
(Englewood Hospital Service Area Children 5-17)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 318]
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:



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

Access to Care/Services

> Access to care, stigma. – Community Leader
>
> Access to care in a timely fashion and comfort of management by primary providers. – Health Care Provider
>
> The biggest challenge is access and feasibility of care as well as willingness of the patient to accept the care they need. – Physician
>
> No access to help or no mandatory requirements. – Community Leader
>
> Access to mental health, limited resources. – Physician
>
> Lack of access. – Health Care Provider
>
> Access to care in a timely manner and frequent appointment. – Health Care Provider
>
> Access to care. Waiting times are very long to get in to see someone. Bilingual therapists, especially Spanish, wait is even longer. – Community Leader
>
> Getting help, you call a place, for example they don't call back, you leave a message, two, if you do get a person on the phone, they have limited hours available and are not willing to help, work with people. There are not enough places in general for people to turn too. – Community Leader
>
> Lack of resources. – Social Services Provider
>
> Navigating resources to get help, admitting that they need help – Community Leader
>
> Access to programs that address and counsel patients on mental health. – Health Care Provider
>
> Access to care and providers. – Physician
>
> Addressing mental health issues requires comprehensive, culturally competent, and accessible systems of care — alongside broader efforts to reduce stigma and build mental health literacy. The local mental health system of care is fractured and broken; what's left standing is paralyzed by in silos impeding access to comprehensive, seamless care. COVID shined a long overdue spotlight on mental health but that resulted in a high demand and low access to care and labeling of every challenge as mental issue. Publicly funded non-profits that provide care to Medicaid/care, uninsured, etc., experience great difficulties retaining/attracting staff as salaries pale in comparison to private industry. Special funding to address issues among youth, like NJ4S and CSOC, do not operate/deliver services in accordance with funding visions. No awareness of resources/confusing names. No strategic plan to break silos/build a collaborative to create a one-door, seamless system from any touch point. – Social Services Provider
>
> Not enough programs to address those suffering with mental health. – Social Services Provider
>
> Lack of access to care, difficulty with insurance reimbursement and long wait times. – Health Care Provider
>
> Access to care, removal of stigma, access to affordable care. Severe shortage of voluntary beds. – Community Leader
>
> Access to resources. Cost of treatment. – Community Leader
>
> There are not enough health care services to address mental health in general. The services that do exists are unaffordable to most residents of Bergen County. – Physician
>
> I know someone who had a mental health issue and reached out to many providers to try and get an appointment. They did not have much luck, and their insurance was pretty good. – Community Leader
>
> Access to mental health care. – Physician
>
> Access to care and stable housing for those with dual diagnosis. – Public Health Representative

> One of the primary issues experienced by those with mental health issues in our community is accessibility to services. More specifically the length of time in which services are sought out by an individual, and intake appointments for psychiatric medication management and/or individual psychotherapy are obtained. It is frequently reported by patients that inpatient psychiatric hospitalizations could have been prevented if seen by a provider sooner. The delay in services often leads to significant decompensation in an individual's symptomology. An additional issue is a lack of awareness of the mental health services available within the community. Individuals often report coming to the hospital solely to obtain more community supports and coordinate mental health services faster than they would if not hospitalized. – Social Services Provider

Denial/Stigma

> Stigma, access to services, lack of understanding within the community. Sadly, there was a police shooting of a man who was undergoing a mental health crisis. He was killed. The fear of that happening to a loved one creates fear for people to seek help for family members and friends. – Community Leader
>
> Stigma of traditional family about mental health. – Community Leader
>
> Stigma. – Public Health Representative
>
> The biggest challenge is to get beyond negative backlash when seeking help. – Community Leader
>
> The biggest challenge for people with mental health in BC are stigma, despite significant efforts by the BC stigma free campaign, limited in network providers, long waiting time for specialists, and cultural barriers.
> – Public Health Representative
>
> Stigma. Lack of quality services. Major hospitals not devoting resources to mental health and not interested in developing quality programs. – Physician
>
> Stigma, identification, accessing services, denial, shame. Many of my young employees ages 22 - 30 suffer from severe anxiety. – Social Services Provider
>
> Stigma, not wanting to get help because of stigma associated with mental health. Medications, many people do not want to take the medications needed for MH due to side effects. Wait time in getting an appointment for counseling. – Social Services Provider

Awareness/Education

> Having information to help identify when someone is in crisis, steps that should be taken to assist someone with mental health issues, contact information for additional supports. – Public Health Representative
>
> There is a huge lack of understanding and education around mental health which adds to the stigma. Cultural beliefs often hinder one's ability to get help. It is very hard to find mental health professionals that are bilingual in other languages, especially Spanish. If you do find one, it takes a long time to get an appointment.
> – Social Services Provider
>
> Knowing that there are resources. – Community Leader
>
> In my community, there are numerous mental health providers available to meet the needs of residents. I feel that social service organizations and community recreation groups can do a better job of incorporating mental health awareness training in regular meetings. For example, in little league or similar groups, incorporate brief mental health awareness talks for the adults who work with children (what to look for, warning signs, etc.).
> – Community Leader

Incidence/Prevalence

> Increase stress and anxiety daily living. – Community Leader
>
> Suicide, anxiety and depression are much more common and heard about. – Public Health Representative
>
> Personal witness in community and within my family and friend network. – Community Leader
>
> Depression and anxiety disorders prevalence rate is pretty high. In addition, stigma prevent many people from seeing help which is a big problem. – Community Leader

Affordable Care/Services

> Many resources are not free, and folks don't want to pay out of pocket for clinic visits. Some communities still don't put much stock in things like depression or anxiety which are very common. Many people don't seek help.
> – Community Leader
>
> Cost and access. Among older adults, the access may be related to available and flexible transportation. Mental health issues also exacerbated by unavailable affordable housing, hording issues, medical conditions not attended to, etc. – Social Services Provider
>
> Finding an affordable and available psychiatrist is one of the biggest challenges in northern NJ. Finding an available psychiatrist with or without insurance is a challenge in and of itself regardless the cost.
> – Social Services Provider

Isolation/Loneliness

> Isolation. – Social Services Provider

> Lack of connection with others/isolation from others. Many residents I work with are widows/widowers, their grief weighs heavily on them (which totally makes sense) and this impacts their ability to socialize and resume "normal life" after such a huge loss. Many live alone after this and their children may not be close by...which only exacerbates the issue. – Community Leader
>
> Depression, isolation, anxiety, misuse of medication leading to confusion or decline in health. Also, overuse of prescriptions or alcohol to avoid feeling depressed and anxious. – Social Services Provider

Diagnosis/Treatment

> Taking the step(s) to seek mental health assistance. – Community Leader
>
> Undiagnosed mental illness, stigma stopping people from seeking treatment or therapy, bullying of people/children that may need help with an issue, or someone with an issue doing the bullying and not realizing the distress they cause, general population not knowing how to react to or interact with those with mental illnesses needing accommodations and/or those currently in crisis, resources existing in our affluent community, but because we also tend to be "green" in our way of marketing such resources, people don't tend to see or come across the flyers or information... it takes someone "pulling information and looking in the right places to find it" - when really, I think pushing out the information so that those who need it and their friends/family and loved ones can see it. The more it's put out there, the more chances it will get in the right hands at the time that it's needed. – Community Leader

Funding

> Access to services since the reduction of federal funding in this space. – Health Care Provider
>
> Lack of funding for behavioral health conditions. Lack of parity. – Health Care Provider

Housing

> Housing and financial resources. – Community Leader
>
> Housing, food, clothing and adequate facilities to accommodate those in my community that need it. – Community Leader

Social Media

> Social media, lack of communication, financial struggles. – Social Services Provider
>
> Social media and isolation. – Community Leader

Access to Care for Uninsured/Underinsured

> Access to therapy and medication that is covered by their insurance. – Community Leader
>
> Lack of access for those without private insurance. Many providers out of network. High copay, extensive waiting list. Very limited provers for Medicaid, Medicare populations. – Health Care Provider

Teens/Young Adults

> This is becoming more of an issue with children and now noticeable with parents. – Community Leader
>
> Mental issues with teens. – Community Leader

Lack of Providers

> The mental health challenges faced are increasing. There are few psychiatrists available to provide support - especially for children and teens therefore access is a major issue. Wait lists for community mental health centers. Decreases in funding to provide services for youth attending school. – Community Leader

Due to Covid-19

> Young Adults are ill-prepared to deal with situations due to the pandemic. Many parents feel that social media has become toxic to their children, their children's ability to learn and to socialize. Aged individuals tend to feel isolated. The biggest challenge of people with mental health issues is that they have difficulty finding resources and do not know how to get the help they need. – Public Health Representative

Alcohol/Drug Use

> Substance use, depression, anxiety, affordability of services. – Health Care Provider

Disease Management

> Seeking services. – Health Care Provider

Language Barrier

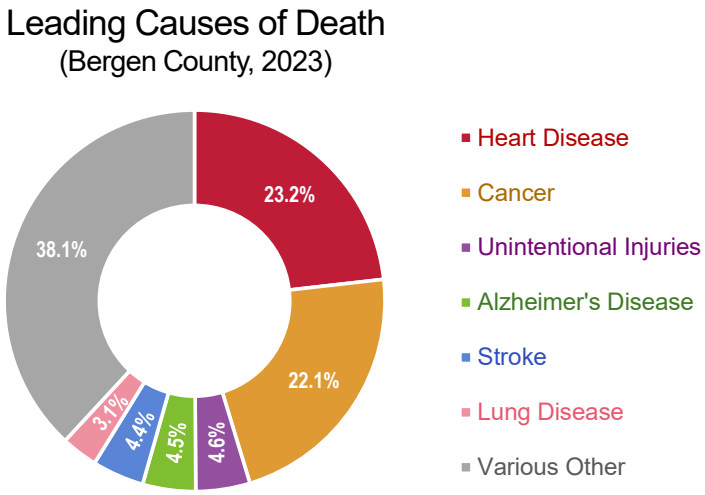
> Resources in Spanish and other languages. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines leading causes of death in the community. [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 February 2025.

Notes: ● Lung disease includes deaths classified as chronic lower respiratory disease (CLRD).

Death Rates for Selected Causes

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

Here, deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population.

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

Death Rates for Selected Causes
(2021-2023 Deaths per 100,000 Population)

	Bergen County	NJ	US	Healthy People 2030
Heart Disease	176.1	199.8	209.5	127.4*
Cancers (Malignant Neoplasms)	158.9	166.1	182.5	122.7
Unintentional Injuries	37.1	53.8	67.8	43.2
Stroke (Cerebrovascular Disease)	36.5	39.6	49.3	33.4
Alzheimer's Disease	31.6	25.3	35.8	—
Lung Disease (Chronic Lower Respiratory Disease)	21.0	27.7	43.5	—
Diabetes	16.3	22.2	30.5	—
Unintentional Drug-Induced Deaths	15.8	30.8	29.7	—
Kidney Disease	15.0	18.4	16.9	—
Pneumonia/Influenza	9.8	12.4	13.4	—
Alcohol-Induced Deaths	7.7	8.5	15.7	—
Cirrhosis/Liver Disease	7.2	10.6	16.4	10.9
Suicide	7.1	7.8	14.7	12.8
Motor Vehicle Crashes	4.7	7.3	13.3	10.1
Homicide	1.5	3.9	7.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople.

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

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)

Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

The following charts outline mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]

Heart Disease Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	197.5	197.5	196.0	198.2	198.2	195.3	187.2	176.1
NJ	207.0	208.4	210.3	211.2	215.6	210.9	208.0	199.8
US	195.5	197.5	198.6	200.0	204.2	207.3	210.7	209.5

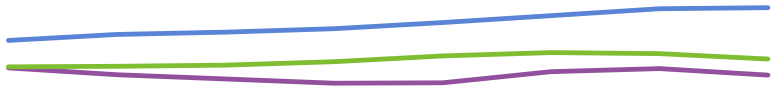
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.

Stroke Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	37.9	36.6	35.8	35.0	35.1	37.2	37.8	36.5
NJ	38.1	38.2	38.4	39.1	40.2	40.8	40.6	39.6
US	43.1	44.2	44.7	45.3	46.5	47.8	49.1	49.3

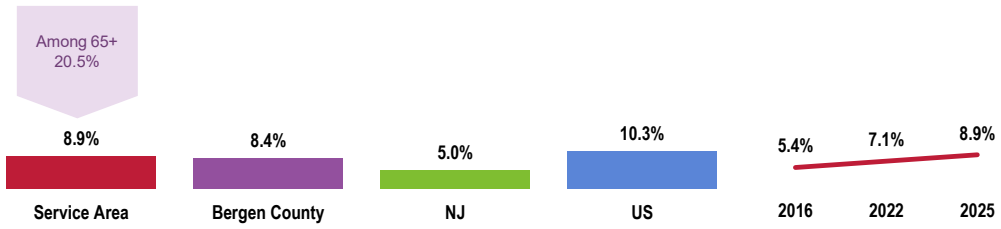
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Prevalence of Heart Disease & Stroke

PRC SURVEY ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of Heart Disease

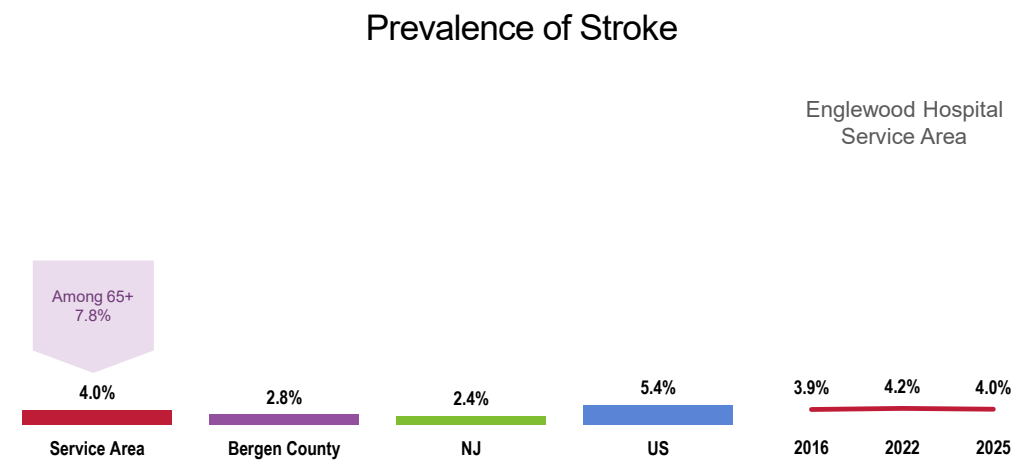
Englewood Hospital Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

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

PRC SURVEY ► "Have you ever suffered from or been diagnosed with a stroke?"



Sources:
- 2025 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): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

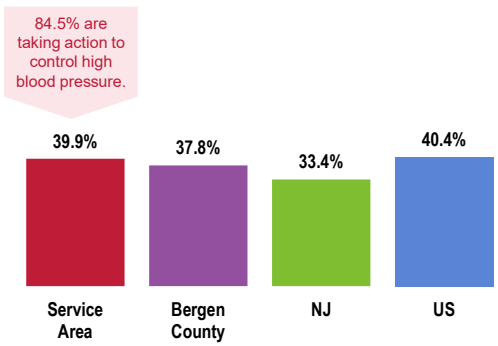
PRC SURVEY ► [Those with high blood pressure] **"Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"**

PRC SURVEY ► "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?"

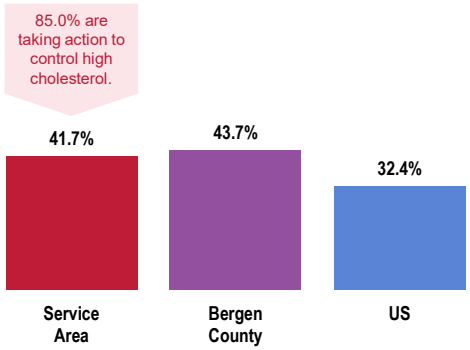
PRC SURVEY ► [Those with high cholesterol] **"Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?"**

Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower



Prevalence of High Blood Cholesterol

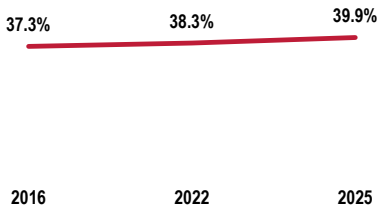


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30, 304-305]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

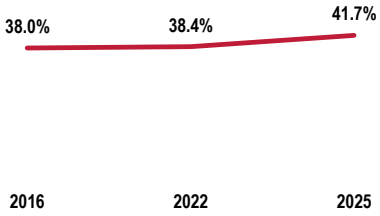
Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure (Englewood Hospital Service Area)

Healthy People 2030 = 42.6% or Lower



Prevalence of High Blood Cholesterol (Englewood Hospital Service Area)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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:

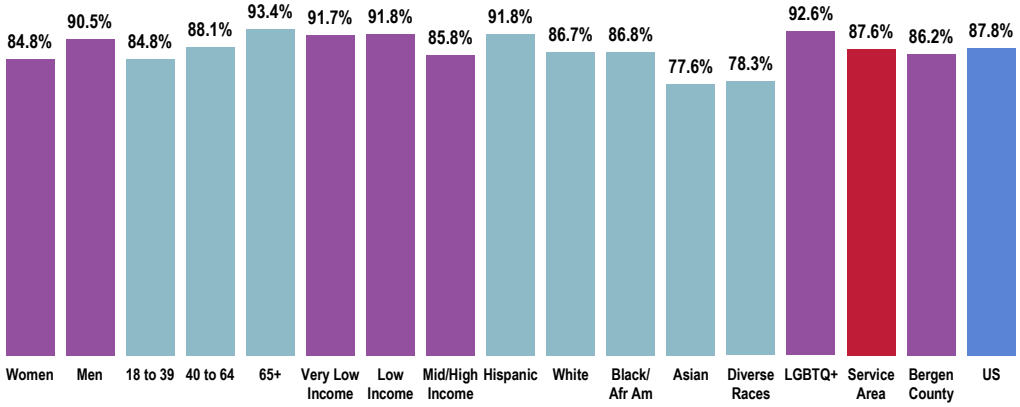
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

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

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

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.

Exhibit One or More Cardiovascular Risks or Behaviors
(Englewood Hospital Service Area, 2025)

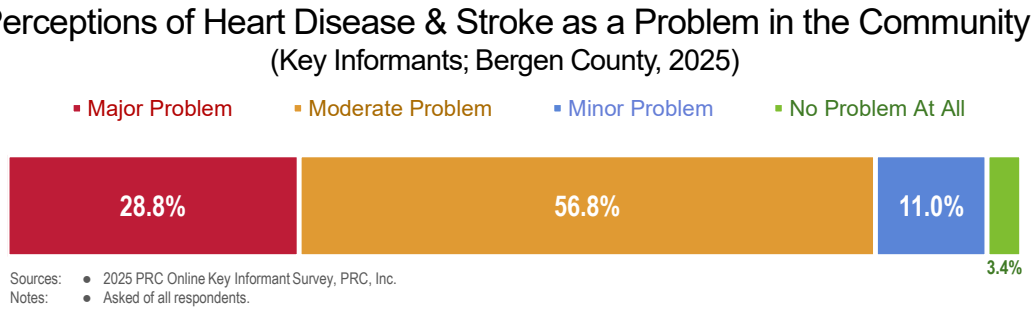


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

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:



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

Incidence/Prevalence

> Number one leading cause of death. – Public Health Representative
>
> Another major cause of death. – Community Leader
>
> High risk factors. – Community Leader
>
> This is not affected in my community but may affect various individuals in minority areas. – Social Services Provider
>
> Heart disease is a leading killer, so I know it is here too. The last community survey asked about this as well. We have high rates of diabetes and obesity, so I guess that they all go together. Stroke likely is also high because of those same reasons. – Community Leader
>
> Risk factors. – Community Leader
>
> High rate of heart disease. – Health Care Provider
>
> Many community members are experiencing heart disease and strokes. – Community Leader
>
> Conversations with different people and some reading. – Community Leader
>
> Experienced within my family and friend network – Community Leader

Aging Population

> Due to an aging population, poor diet and lack of exercise, heart disease and stroke appear to be on the rise. I also am a health care provider and see this as well in patients and friends. – Public Health Representative
>
> As people age, they are moving less and eating poorly, this is exacerbating heart disease and stroke issues. – Community Leader
>
> Aging population: chronic diseases are more prevalent in an aging population; current societal norms (food choices, physical activity patterns, sleep habits, stress management habits - or lack thereof) are contributing to poor lifestyle choices that aggravate / contribute to risk factors of these chronic diseases. – Physician
>
> We have an older population that experiences stroke and heart disease. – Community Leader

Lifestyle

> Lack of exercise and poor diet. – Public Health Representative
>
> Our lifestyles, sedentary, poor eating habits and stress, lend themselves to the conditions. – Social Services Provider
>
> Poor food choices and lack of exercise. – Public Health Representative
>
> People do not always eat as healthy as they should, nor do they exercise or move as often as they should. – Community Leader

Hypertension

> Hypertension among youth. The number of young men (especially) and women between 20 and 40 who are stroke victims is climbing. Too many of them have unchecked and untreated problems with high blood pressure and they either are unaware of it or don't believe they can have a stroke. – Community Leader

Access to Care/Services

> Long wait times in the emergency departments with these diagnoses. Poor eating habits and lack of exercise. – Health Care Provider

Awareness/Education

> Lack of education about how to live heart healthy. Lack of financial resources to eat heart healthy food. – Social Services Provider

Diagnosis/Treatment

> Similar to those listed for diabetes. Many people are unaware of having heart disease or any conditions associated with it, until it becomes a serious matter. Willingness to begin medication or compliance with medication. – Health Care Provider

Impact on Quality of Life

> The effect of cardiovascular disease and stroke can cause physical limitation that makes the affected individual increasingly dependent on other. Cardiovascular condition and stroke can cause premature death. – Health Care Provider

Obesity

> Obesity leads to many secondary issues. Poor management of chronic conditions also lead to high risk of stroke and ACS. Patients secondary to these events can struggle to return to normal ADLs and work which impacts their resources and access. – Health Care Provider

Prevention/Screenings

> The providers are not providing enough preventive care and early detection. Also, the residents are not prioritizing regular checkups, or they are not aware of the risk of factors like high blood pressure, high cholesterol, diabetes until a major event occurs. – Public Health Representative

Language Barrier

> Language barriers, lack of access to exercise and lack of access to healthy foods, barriers to preventative care or health education. – Community Leader

Teens/Young Adults

> Affects young population, high lethality and debilitation consequences especially after CVA with long rehab, which is very costly. – Physician

Income/Poverty

> Low socioeconomic background - 60% of the underserved are overweight. – Social Services 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)

Cancer Deaths

The following chart illustrates cancer mortality (all types). [COUNTY-LEVEL DATA]

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	181.7	180.5	180.2	175.7	171.9	165.6	161.2	158.9
NJ	183.4	181.8	181.1	179.0	177.3	173.1	169.3	166.1
US	185.4	184.8	184.1	183.3	182.9	182.6	182.6	182.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

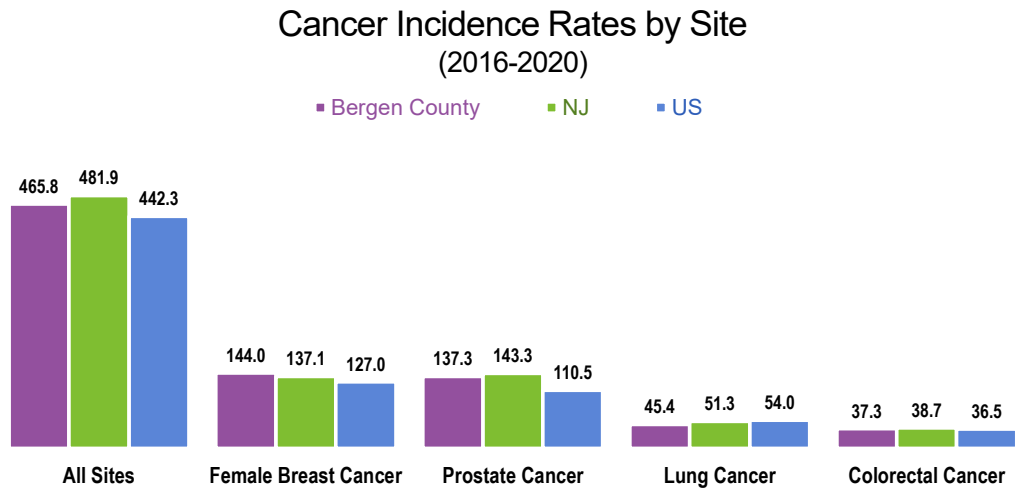
Cancer Death Rates by Site
(2021-2023 Annual Average Deaths per 100,000 Population)

	Bergen County	NJ	US	HP2030
ALL CANCERS	158.9	166.1	182.5	122.7
Lung Cancer	28.8	32.8	39.8	25.1
Female Breast Cancer	24.7	25.7	25.1	15.3
Prostate Cancer	15.6	17.0	20.1	16.9
Colorectal Cancer	14.9	15.0	16.3	8.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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. It is usually expressed as cases per 100,000 population per year.
[COUNTY-LEVEL DATA]



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

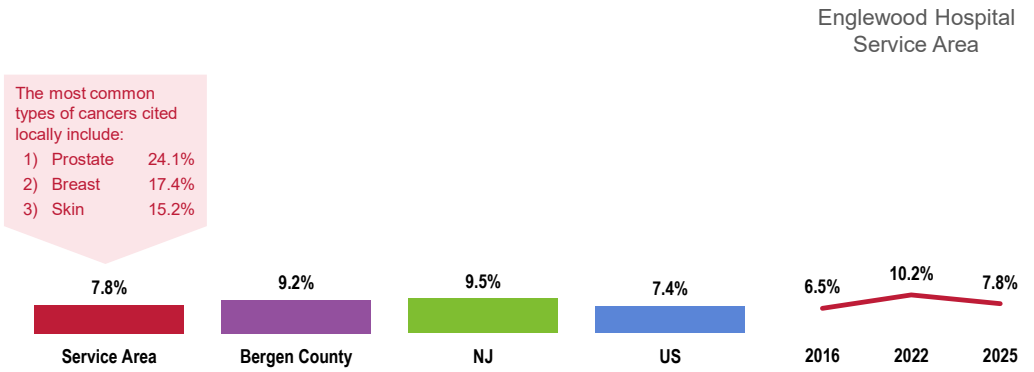
Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Prevalence of Cancer

PRC SURVEY ► "Have you ever suffered from or been diagnosed with cancer?"

PRC SURVEY ► "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:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 24-25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 40 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 age 21 to 29 years. For women age 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.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

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.

– 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 the following cancer sites:

Breast Cancer Screening

PRC SURVEY ► "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 40 to 74 who indicate mammography within the past 2 years.

Cervical Cancer Screening

PRC SURVEY ► "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 65.

Colorectal Cancer Screening

PRC SURVEY ► "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?"

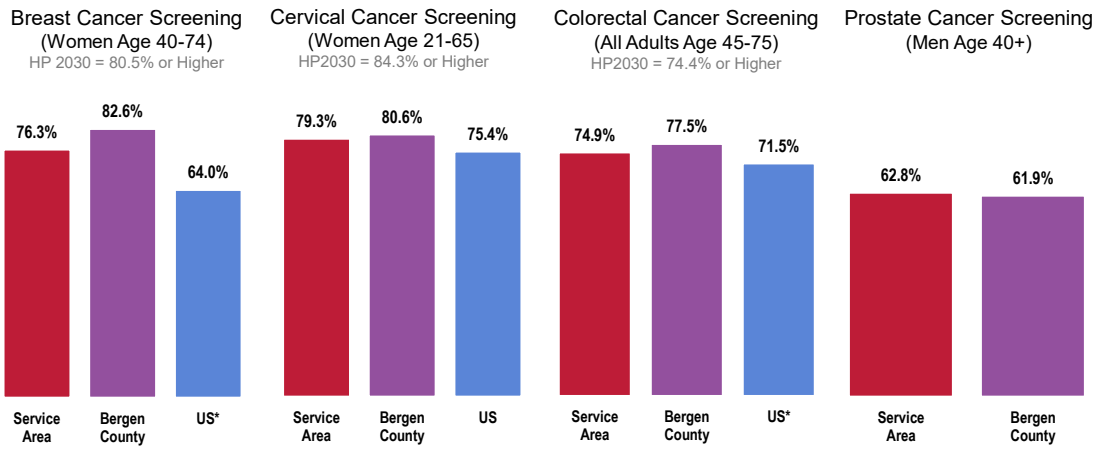
PRC SURVEY ► "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" includes a fecal occult blood test among adults age 45 to 75 within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

Prostate Cancer

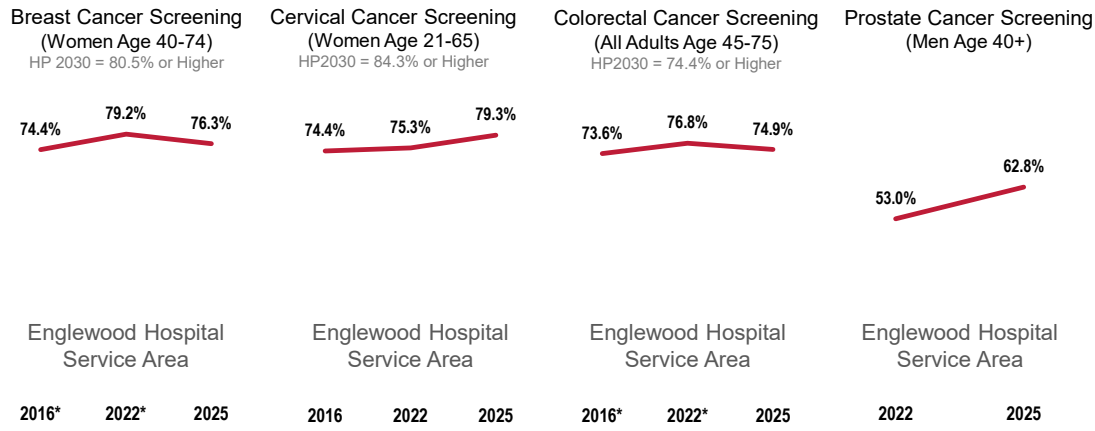
PRC SURVEY ► "A prostate-specific antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. How long has it been since you had your last PSA test?"

Prostate cancer screening reflects men age 40 and older who indicate a prostate-specific antigen test within the past two years.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103, 327]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- *Note that national data for breast cancer screening reflect women age 50 to 74. National data for colorectal cancer screening reflect adults age 50 to 75.

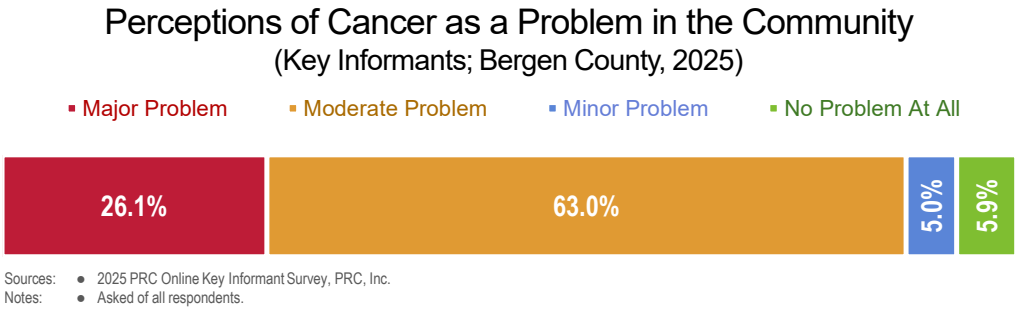


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103, 327]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- *Note that trend data for breast cancer screening reflect the age group (50 to 74) of the previous recommendation. Trend data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

Key Informant Input: Cancer

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



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

Incidence/Prevalence

Every day I hear more about people having cancer. A good part of them are people I know. – Community Leader

One of the largest causes of death and we have an aging population. – Community Leader

We heard about those who have cancer or are in the process of fighting. – Community Leader

Many people have cancer. – Physician

Cancer prevalence rate seems to be going up each year among Asian and Korean American population. – Community Leader

There seems to be a high number of people we serve that are receiving a cancer diagnosis as well as a high amount of people I personally know. There has been more tolerable treatment, yet people are still dying. – Social Services Provider

Abundance of diagnoses and intensity of the impact of the impairment. – Community Leader

Increasing prevalence and in young patients. – Physician

Seen it on rise within my family and friends' network – Community Leader

Many diagnoses of different types of cancers. – Community Leader

I know of many people that have been stricken with several kinds of cancer. – Community Leader

The incidence of cancer has progressively increased since COVID-19. More people are being diagnosed with cancer and at younger ages than before. – Health Care Provider

In the past year alone, I have personally known over 20 people diagnosed with cancer. After speaking with friends and coworkers, our collective knowledge is closer to 50. That is the largest number we have experienced in our lives. – Social Services Provider

I know several people in our community that have cancer including our Borough Administrator and Chief of Police. – Community Leader

Cancer treatment and predictive risk are problems for certain demographics in Bergen County--mostly for those who are also facing issues such as food security. maternal health challenges and housing loss. Even though this is the 33rd richest county in the US, our organization. supports 1000s of families/households each month as the largest food pantry in Bergen County. Also extremely important is nutrition for Cancer patients. An important source would be to provide them with Medically Tailored Meals (MTMs), but we do not have access to Medicaid Waivers to pay for them. CFA needs the help of local medical centers. – Community Leader

High rate of clients. – Social Services Provider

Cancer is a major problem overall. – Social Services Provider

Hearing a lot about people being diagnosed with it in our community. – Community Leader

Many in my community suffer from cancer. The research for living with cancer and treatment are respectable but preventive research is needed too. Until professionals in the medical field stop shoving medicine down our throats and learn more positive alternatives, we are going around in circles with diseases such as cancers... that's a major problem! – Community Leader

The number of people diagnosed with some type of cancer seems to be increasing as well as the age of diagnosis lowering. – Community Leader

Cancer rates are rising all over the country. – Public Health Representative

There seems to be more people diagnosed with a variety of different cancers and they are in end stages at younger ages. – Community Leader

Affordable Care/Services

> Anecdotally, we have heard of numerous cancer cases in the community. The reason I believe it is a major problem is that those who have the disease, generally lack affordable caregiving resources and/or feel as though they pose a burden to their family. – Public Health Representative

Environmental Contributors

> Too many toxins in the environment here - pollution, so many people with cancer! – Community Leader

Access to Care/Services

> Lack of healthcare accessibility and environmental toxins. – Community Leader

Diagnosis/Treatment

> Late diagnosis, poor treatment options, low survival rate. – Physician

Prevention/Screenings

> People do not get early-enough screenings. – Health Care Provider

Respiratory Disease

ABOUT RESPIRATORY DISEASE

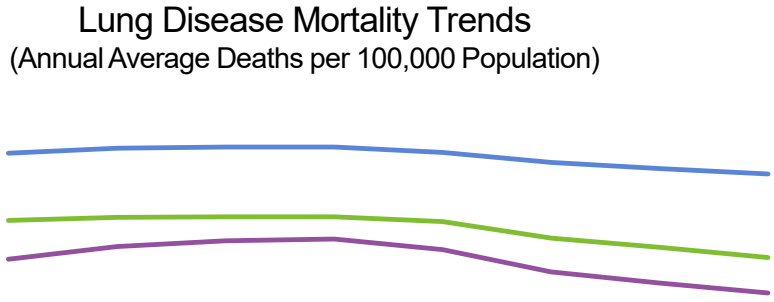
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million 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.

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

Respiratory Disease Deaths

Lung 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 lung disease is illustrated in the charts that follow. [COUNTY-LEVEL DATA]



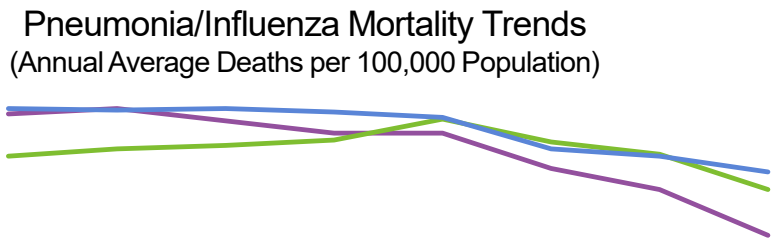
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	27.4	29.8	30.9	31.2	29.2	25.0	22.9	21.0
NJ	34.7	35.3	35.4	35.4	34.5	31.4	29.6	27.7
US	47.4	48.4	48.6	48.6	47.6	45.7	44.5	43.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Pneumonia/Influenza Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	16.7	17.0	16.3	15.6	15.6	13.6	12.4	9.8
NJ	14.3	14.7	14.9	15.2	16.4	15.1	14.4	12.4
US	17.0	16.9	17.0	16.8	16.5	14.7	14.3	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 February 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

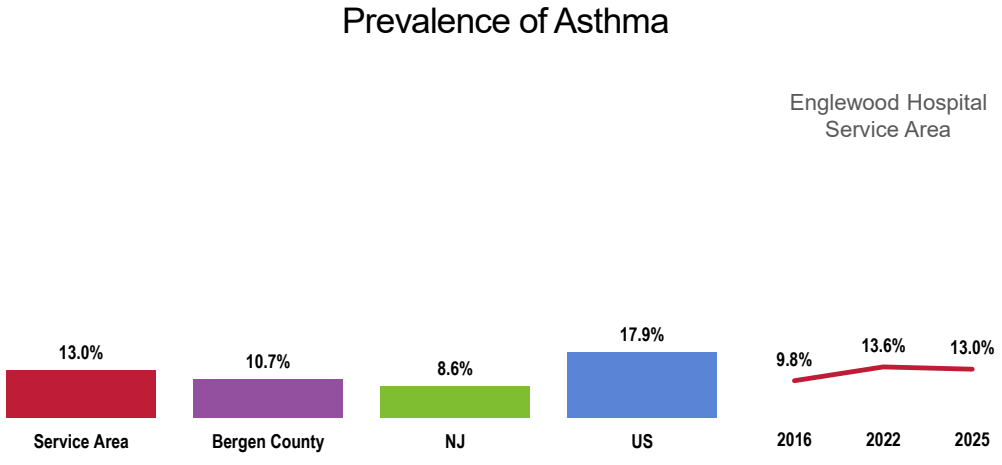
Prevalence of Respiratory Disease

Asthma

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you had asthma?"

PRC SURVEY ► [Those who have been told they had asthma] **"Do you currently have asthma?"**

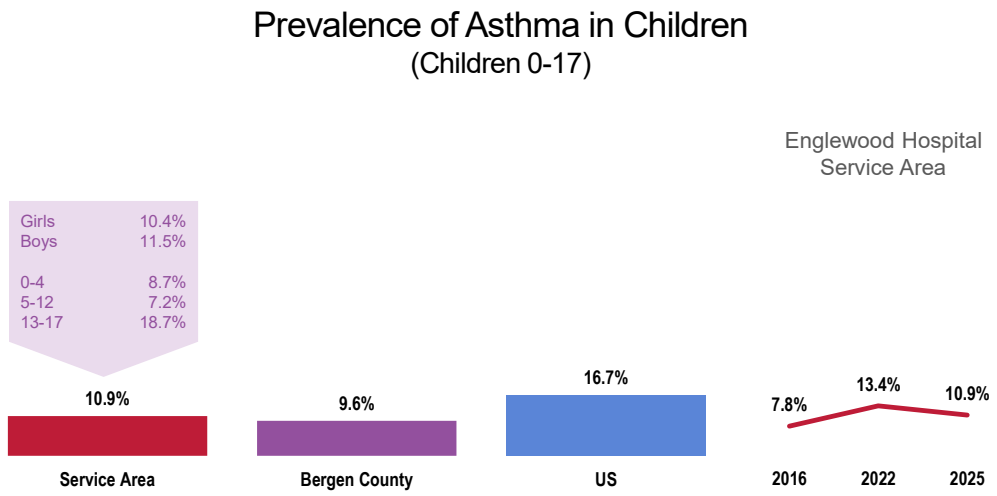
Current prevalence reflects those with a past diagnosis who state that they currently have the condition, as a proportion of the total population.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 104]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 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.

PRC SURVEY ► [Among parents of children age 0-17] **"Has a doctor, nurse, or other health professional ever told you that this child had asthma?"**

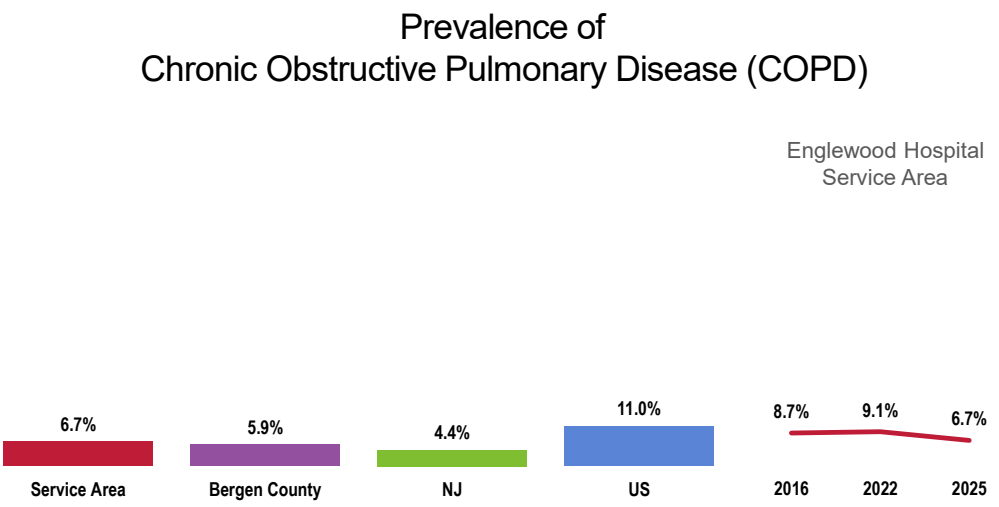


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 92]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 0 to 17 in the household.

Chronic Obstructive Pulmonary Disease (COPD)

PRC SURVEY ► **"Have you ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including chronic bronchitis or emphysema?"**

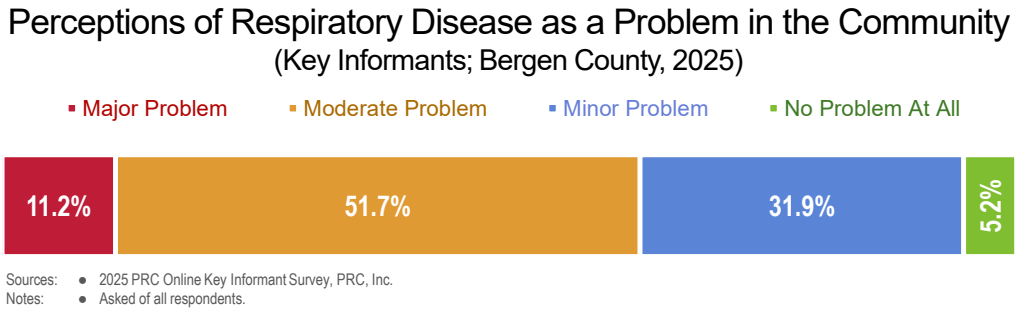


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and 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:

Due to COVID-19

> COVID was scary and raised awareness of our vulnerability. Vaping is also a huge issue especially among young people. – Social Services Provider
>
> Including COVID-19 the examples are obvious, there were somewhere in the neighborhood of 1 million unnecessary deaths because of poor governmental guidance. More general, smoking related disabilities and deaths are omnipresent; personally, I have lost 8 close family members or friends to smoking related illnesses. – Community Leader
>
> As a result of the pandemic many individuals have been identified to have respiratory disease or ailments that impact daily life. It seems that more people describe breathing difficulties due to allergies, viruses, etc. – Public Health Representative

Incidence/Prevalence

> COVID. Pneumonia. COPD. – Health Care Provider
>
> Many people seem to have cough or bronchitis often. – Community Leader

Prevention/Screenings

> Not enough prevention and lack of resources. – Physician
>
> Lack of masking, people live close together, high population of older adults more susceptible. – Health Care Provider

Impact on Quality of Life

> Respiratory disease can be disabling in the later stages. – Health Care Provider

Obesity

> Overweight men smokers. – Social Services Provider

Environmental Contributors

> Bad air quality. – Community 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.

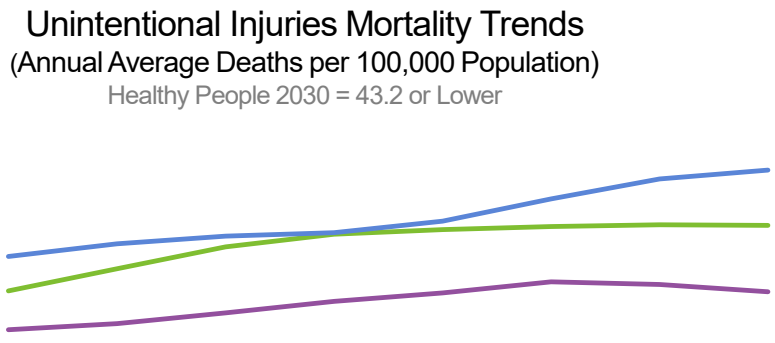
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Unintentional Injury Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	27.5	29.0	31.8	34.7	36.8	39.6	38.9	37.1
NJ	37.3	42.9	48.4	51.6	52.8	53.6	54.0	53.8
US	46.0	49.2	51.1	52.0	54.9	60.5	65.6	67.8

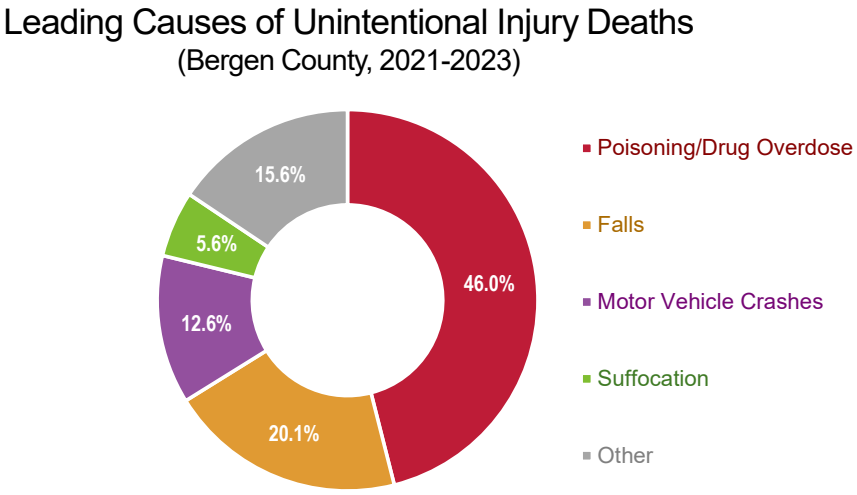
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Leading Causes of Unintentional Injury Deaths

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

The following outlines leading causes of accidental death in the area. [COUNTY-LEVEL DATA]



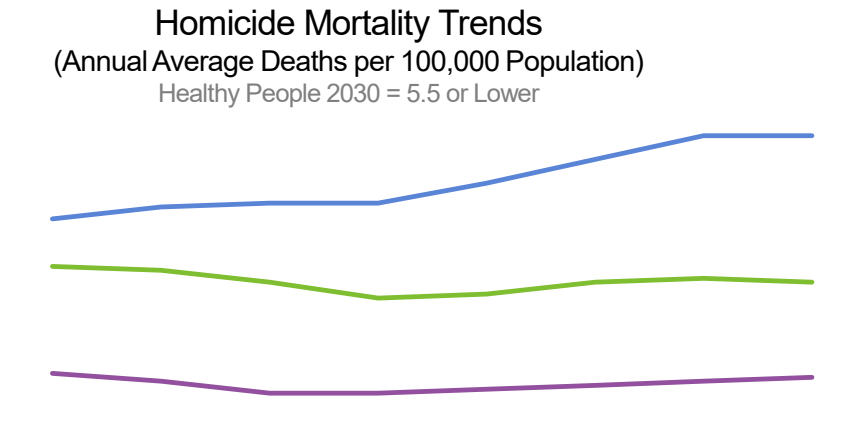
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Intentional Injury (Violence)

Homicide Deaths

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

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	1.6	1.4	1.1	1.1	1.2	1.3	1.4	1.5
NJ	4.3	4.2	3.9	3.5	3.6	3.9	4.0	3.9
US	5.5	5.8	5.9	5.9	6.4	7.0	7.6	7.6

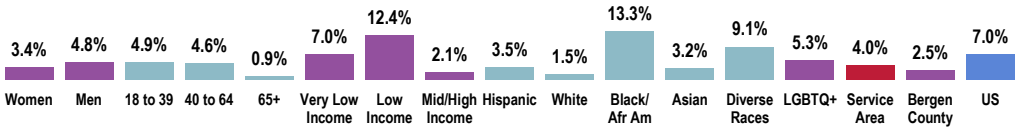
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Violent Crime Experience

PRC SURVEY ► "Thinking about your own personal safety, 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 Hospital Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

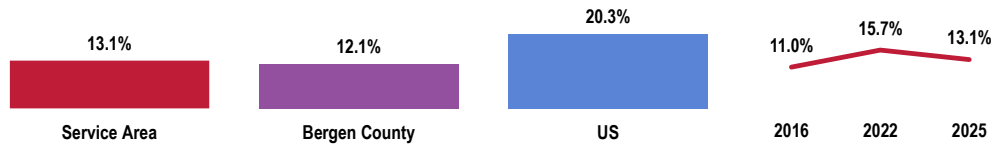
Intimate Partner Violence

An intimate partner may include any current or former spouse, boyfriend, or girlfriend. A person someone is dating, or romantically or sexually intimate with, would also be considered an intimate partner.

PRC SURVEY ► "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

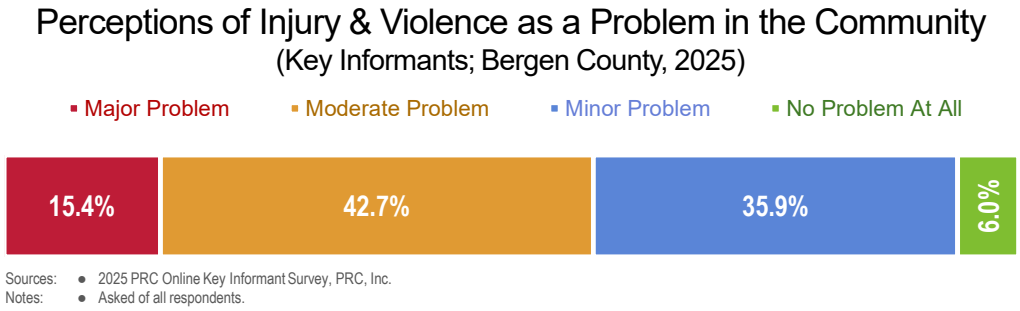
Englewood Hospital Service Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 33]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

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



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

Law Enforcement

> This is an issue in every community, certainly close by. Police do not have the support they should and when anyone is arrested, they are released in a short period of time. – Social Services Provider
>
> The police do not have the power to work efficiently. Guns are not outlawed. – Community Leader

Parental Influence

> Parents do not keep track of their children's whereabouts. Parents do not punish children for things they do wrong, talking only goes so far, you must at some point act. Parents are too busy about themselves and neglect the children. There are not enough different opportunities and programs for kids of all ages in this area and the ones are too expensive. – Community Leader

Awareness/Education

> Most older adults do not have the education on how to be physically active to help prevent injury. They also lack the financial resources to join a gym or work with a trainer. – Social Services Provider

Co-Occurrences

> Injury and violence lead to vulnerability of the individual in the community which could lead to mental health and substance use disorders. – Physician

Due to COVID-19

> People are so angry, and the incidence of violence has risen since the pandemic. – Social Services Provider

Foreign-Born

> Injury. Most folks are undocumented and uninsured, they take jobs that nobody else wants and are at high risk for low. – Social Services Provider

Government/Politics

> It's a chronic problem in the community and getting worse with the political environment. – Health Care Provider

Unhoused Populations

> I usually walk during my lunch; I can see on the street, indigents on the street sleeping or searching for clothes on containers on the street. – Community Leader

Incidence/Prevalence

> Hear/see it reported on the news every day like the world has gone crazy. – Social Services Provider

Income/Poverty

> Increase population in the community with various socioeconomic statuses, mental health issues, unemployment, cost of living. – Community Leader

Prevention/Screenings

> Not enough preventive measures or access to care. – Physician

Traffic

> Heavy traffic, frequent MVA, subsequently traumas and TBI. – Physician

Diabetes

ABOUT DIABETES

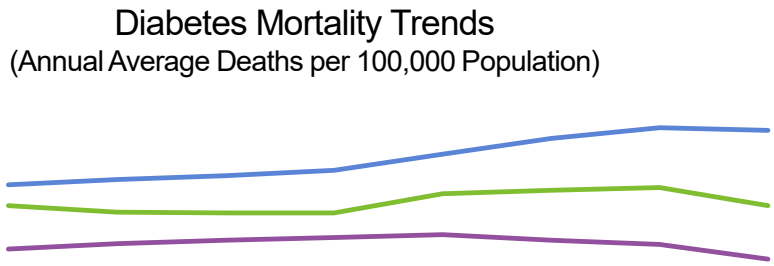
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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)

Diabetes Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	17.4	18.0	18.4	18.7	19.0	18.4	17.9	16.3
NJ	22.2	21.5	21.4	21.4	23.5	23.9	24.2	22.2
US	24.5	25.1	25.5	26.1	27.9	29.6	30.8	30.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Diabetes

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

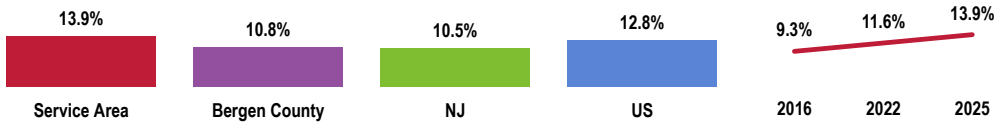
PRC SURVEY ► "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

PRC SURVEY ► "Are you currently taking any type of GLP-1 medication?"

Prevalence of Diabetes

Another 17.3% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

Englewood Hospital Service Area



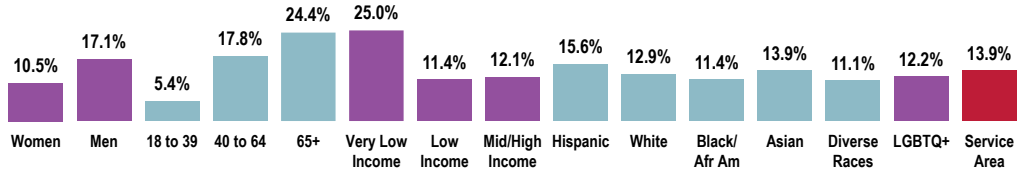
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

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

A class of new prescription drugs called GLP-1 agonists are being prescribed to treat diabetes and/or for weight loss. These often involve giving oneself daily or weekly injections. Common brand names include Trulicity, Ozempic, Mounjaro, Zepbound, and Wegovy.

Prevalence of Diabetes
(Englewood Hospital Service Area, 2025)

Note that 36.1% of respondents with diabetes are taking GLP-1 agonist medications.

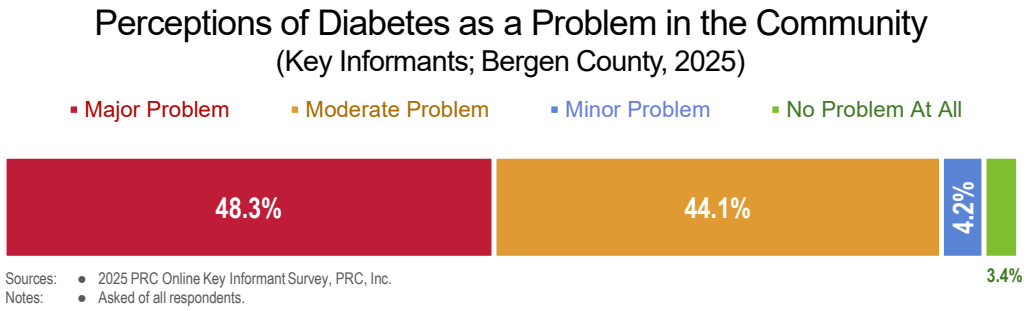


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 106, 303]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).
- GLP-1 agonists defined for respondents as a class of drugs prescribed to treat diabetes and/or weight loss that can involve daily or weekly injections. Common brand names mentioned were Trulicity, Ozempic, Mounjaro, and Wegovy.

Key Informant Input: Diabetes

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



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

Awareness/Education

> Lack of information, lack of knowledge. Bad diet. – Health Care Provider
>
> Education for self-care. – Public Health Representative
>
> Lack of education from doctors on nutrition. – Public Health Representative
>
> Access to diabetes education and continuous care. – Community Leader
>
> Education and focus on nutrition. – Community Leader
>
> Lack of access to education regarding food choices and free or reduced cost exercise options for adults. Food costs are also high. – Community Leader
>
> Understanding how to care and reduce the risk of blood sugar levels. – Community Leader
>
> Lack of correct information, people unwillingness or inability to stay true to treatments; disbelief about treatments including things like cholesterol medicine; preferences for cultural and food therapies over medications. – Community Leader
>
> Need more health classes that explain how serious an issue it is. – Community Leader
>
> Being educated about what foods to eat or avoid to improve their blood sugar levels. Access to healthy foods that are appropriate for reducing or maintaining healthy blood sugar levels. Education about lifestyle changes that can positively impact blood sugar levels. – Public Health Representative
>
> In my opinion the biggest challenge is lack of proper education. While there are educational programs available, people are too busy with everyday tasks that they do not understand the complex of self-management strategies, like healthy eating and importance of using insulin, can be difficult for many, particularly if there are language barriers or health literacy issues. – Public Health Representative
>
> Clear instructions from healthcare providers. Affordability of medications or hesitancy to begin medications. Patient's feelings that once blood work comes to a better range that compliance is no longer needed. – Health Care Provider
>
> Defining what Diabetes is in the simplest terms and educate those who have it and those who don't on the graveness of the disease but how it can be managed. When someone is told by their doctor you may have cancer. Most people will respond by adhering to all of the medical advice that's out there. Not so, with diabetes. It's so abstract it doesn't hit home like the gravity of diabetes as cancer does. – Community Leader
>
> Diabetes education. – Social Services Provider

Affordable Medications/Supplies

> Some of the biggest challenges for people with Diabetes in Bergen County are access to medication and supplies, transportation to appointments and getting appointments at times that are convenient with the rest of their daily life and activities. Nutrition and food security is another challenge as many people who are facing diabetes management have food insecurity and have a hard time maintaining proper nutrition. – Health Care Provider
>
> 1. Access to continuous glucose monitoring -blood testing is essential in an effort to control the HbA1C. 2. Access to affordable weight loss drugs. 3. Ancillary staff support teams-nutritionists, dietitians, fitness instructors, etc. 4. Food insecure households having access to low glucose, low sodium meals--also can be addressed by access to MTMs. – Community Leader
>
> Cost of medication and consistent care. – Community Leader

> Affordability of diabetic medications. Availability and accessibility of diabetic education that is not out of pocket cost to the community. Better and more frequent follow up care that is no cost to the community. – Health Care Provider
>
> Medications and smarter options for monitoring are too expensive. – Community Leader
>
> The biggest challenges for people living with diabetes are probably access to affordable medications, food, and referral to outpatient diabetes centers in the community. – Health Care Provider
>
> Insulin coverage, compliance with medication adherence, understanding the illness and importance of taking medications for management. – Health Care Provider
>
> Cost of medication. – Public Health Representative

Access to Affordable Healthy Food

> Good quality food is too expensive. Most food sold in grocery stores is highly processed as companies work to produce more of their product at a reduced cost. What we sell in the USA is often times banned in Europe. – Community Leader
>
> Price of food. – Public Health Representative
>
> Nutrition and affordable healthy foods – Community Leader
>
> Access to healthy foods. Cost of medication. Knowledge about improving their lifestyle to manage diabetes. – Community Leader
>
> Access to healthy food, proximity, cost. Education and support for diabetes management. – Community Leader
>
> Being able to afford healthy alternatives to the standard American diet as well as education about the condition. – Social Services Provider

Access to Care/Services

> Access to appointments, access to affordable medications and supplies. – Health Care Provider
>
> Access to care; adequate support regarding appropriate lifestyle modifications that should be part of treatment plan; sufficient understanding of the board impact diabetes has on other chronic diseases and overall quality of life and overall morbidity and mortality. – Physician
>
> Finding treatment and affordable cost options for medication. – Health Care Provider
>
> Lack of access to doctors, transportation as a barrier, lack of supportive follow up to help maintain necessary lifestyle and dietary changes in the environment. – Health Care Provider
>
> Accessibility healthcare, increase of fast-food restaurants. – Community Leader
>
> Access to care, early detection and monitoring. – Physician

Incidence/Prevalence

> It seems like there were some clusters of diabetes popping up, especially in children. – Health Care Provider
>
> There seems to be an increase in newly diagnosed diabetics. – Public Health Representative
>
> Prevalence rate is very high, 40-50% people are either diabetic or pre diabetic. – Community Leader
>
> We can easily meet people with diabetes. – Community Leader

Diagnosis/Treatment

> Care and treatment for pre-diabetes including support, exercise/walking groups, meal planning coverage. Lack of accessible endocrinologists. – Social Services Provider
>
> Diagnosis and treatment especially for the very obese. – Community Leader

Prevention/Screenings

> Access to preventative care such as ophthalmology. Clear understanding of management. Lack of information provided at appropriate literacy level in native language and lack of resources to support those who have literacy issues. – Health Care Provider
>
> Screening, cost for medications particularly the drugs that are associated with weigh loss like Mounjaro that PAAD won't cover because it is a weight loss drug, but valuable with pre diabetic and diabetic clients to lower A1C. Access to a dietician to evaluate nutrition and diet. – Social Services Provider

Lifestyle

> This is linked to lifestyle that are not active and poor dietary habits. – Community Leader
>
> Support in lifestyle changes, education and access to healthy food choices. Cost. – Health Care Provider

Affordable Care/Services

> Access to affordable resources. – Health Care Provider

Disease Management

> Learning to control their sugar on their own. – Community Leader

Nutrition

> Poor diet. – Public Health Representative

Obesity

> Overweight, poor diets and low income. – Social Services Provider

Disabling Conditions

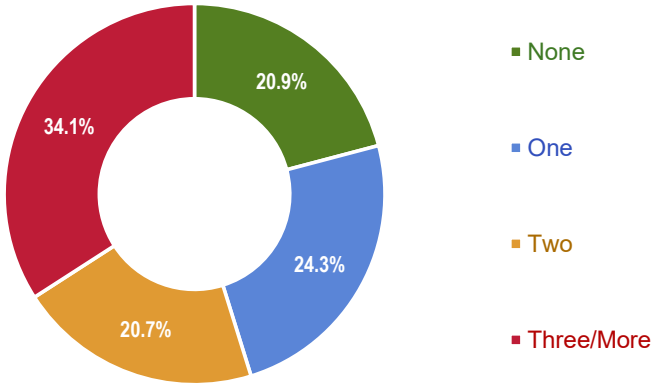
Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

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

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.

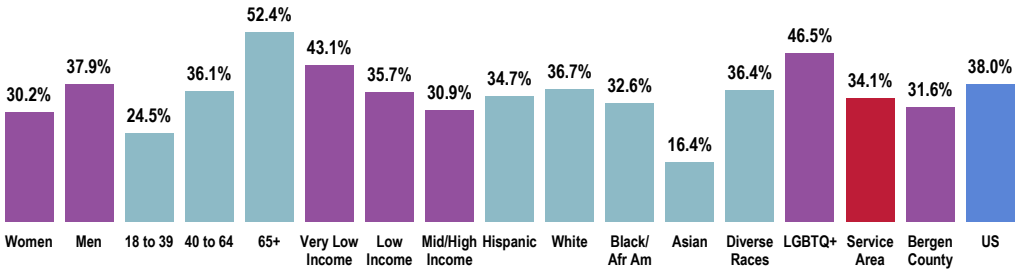
Number of Chronic Conditions
(Englewood Hospital Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.

Have Three or More Chronic Conditions
(Englewood Hospital Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.

Activity Limitations

ABOUT DISABILITY & HEALTH

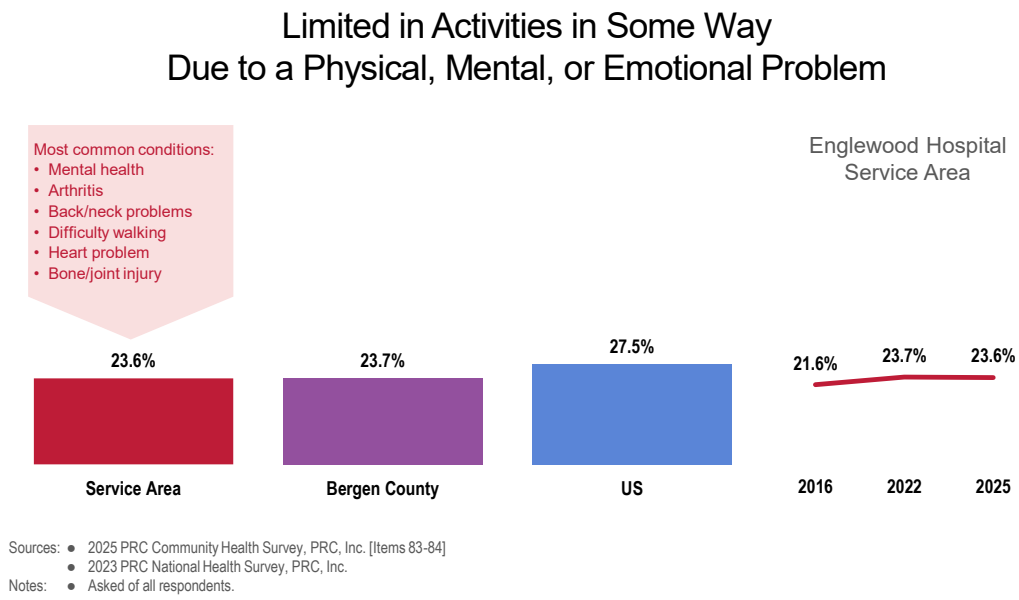
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

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)

PRC SURVEY ► "Are you limited in any way in any activities because of physical, mental, or emotional problems?"

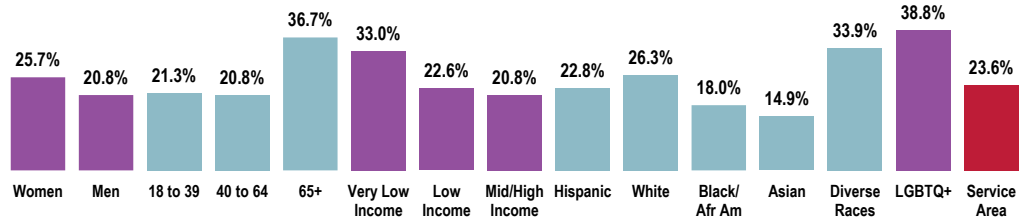
PRC SURVEY ► [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

(Englewood Hospital Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: ● Asked of all respondents.

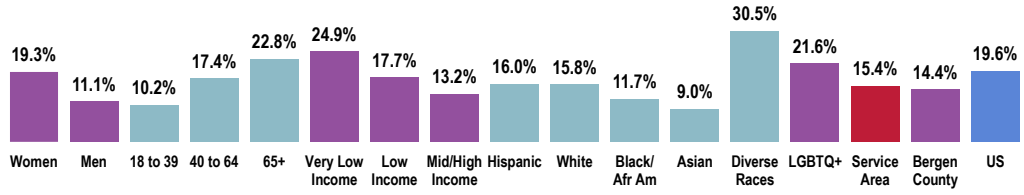
High-Impact Chronic Pain

PRC SURVEY ► "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 Hospital Service Area, 2025)

Healthy People 2030 = 6.4% or Lower



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 31]
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
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.

Alzheimer's Disease

ABOUT DEMENTIA

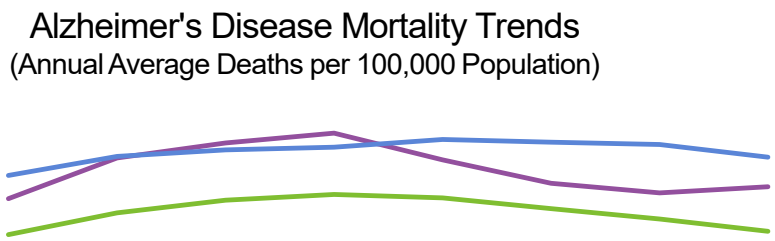
Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

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)

Alzheimer's Disease Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	29.9	35.7	37.8	39.2	35.4	32.1	30.7	31.6
NJ	24.8	27.9	29.7	30.5	30.0	28.5	27.0	25.3
US	33.2	35.9	36.8	37.2	38.3	37.9	37.6	35.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

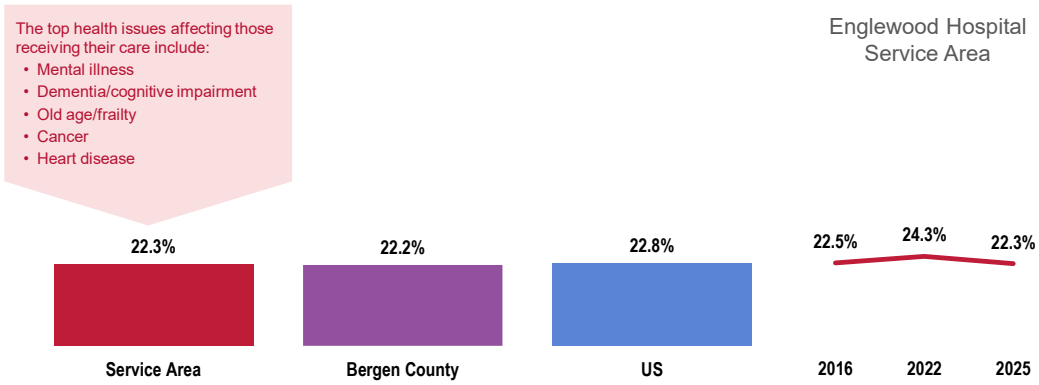
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Caregiving

PRC SURVEY ▶ "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?"

PRC SURVEY ▶ [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: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 85-86]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Disabling Conditions

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

Perceptions of Disabling Conditions as a Problem in the Community
(Key Informants; Bergen County, 2025)

Sources: ● 2025 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:

Aging Population

> Aging population and lack of resources. – Social Services Provider
>
> Elderly, chronic debilitating illness affecting gait, lack of support to drive patients to health care and patients live alone. – Health Care Provider
>
> The community is aging. There are increases of chronic disease. – Public Health Representative
>
> Our population is getting older, and people are becoming weaker. – Community Leader
>
> Aging populations. – Health Care Provider

> The community has a large number of individuals, many elderly, who need extended care. Frequently this care is provided by a family caregiver, who has nowhere to go for support, time off, assistance, or loss of income. Getting professional caregivers is a bewildering array of poorly supported and understood procedures to be followed, and that doesn't always succeed. There are many individuals in nursing homes solely because they can't get appropriate care at home. This is a social and financial challenge that needs to be addressed. – Community Leader
>
> Pops. Population is growing older and growing old with these conditions. – Community Leader
>
> Seniors are complaining of chronic pain, many are getting steroid shots, and getting operations that do not improve their quality of life. – Community Leader
>
> We have an extensive senior population and as they age, more disabling conditions emerge. Lack of quality and affordable healthcare makes it challenging for people to always get the help they need. – Community Leader
>
> With the older adult population representing a growing, larger percentage of the overall population, there is a growing number of adults living with disabilities including mobility impairments, vision and hearing loss. Likewise, dementia is a huge and growing problem and puts tremendous financial and caregiving burdens on families. Much of our housing stock is not accessible for people with mobility impairments. – Community Leader
>
> Increasing geriatric population, limited family support and inability to provide care for self, need for structural setting and assisted living. – Physician

Incidence/Prevalence

> There are so many people suffering from these conditions it is truly a major health issue. I personally know many people who suffer from these conditions. Treatment is either unavailable or too expensive to access. – Social Services Provider
>
> Many people are walking with canes or walkers. – Community Leader
>
> Conversations with people. – Community Leader
>
> Chronic pain is a common complaint by patients including things like arthritis. They are sometimes unable to unwilling to go to physical therapy. – Community Leader
>
> We see many clients here that are physically or mentally disabled or impaired. – Community Leader
>
> I see many people with mobility issues. Some work at it, some don't. – Social Services Provider
>
> We meet people who have activity limitations, hearing problems, and dementia. – Community Leader

Access to Care/Services

> They can prevent sufferers from being able to access essential services needed for a basic standard of living. – Community Leader
>
> Accessibility to follow up care, lack of awareness and education, stigma with accents and cultural stigmas, and stereotypes, lack of support. – Community Leader
>
> Not enough services to address these issues. – Physician
>
> Not enough resources to help individuals with disabling conditions for day to day. – Public Health Representative
>
> Lack of access. – Social Services Provider

Access to Care for Uninsured/Underinsured

> Many people lack insurance coverage and transportation to see the proper medical professionals. Social isolation for older adults causes dementia, loss of vision and hearing to go unnoticed by others. – Social Services Provider
>
> Eye care and glasses, hearing aids, dental treatments are not covered by Medicare. Older adults will usually go to the eye doctor and pay the $75 for refraction that is not covered by Medicare. However, the expense for new glasses can be prohibitive. Lower income older adults whose income is slightly over Medicaid eligibility delay routine dental care and are often unable to pay the expense for crowns, implants, or dentures. The dental clinics are crowded and often have long waits and provide limited services. The donated dental services can have waits along as 6 months to a year and my experience with clients using this service have not been positive. Hearing aids at $5,000+ a pair are unaffordable for many. The Hearing Aid project is available and the refurbished hearing aids are better than nothing, but not ideal. In addition, many are unaware of this program. The HAAD program provides $1,000 grant for hearing aids, but one must be on PAAD to qualify. – Social Services Provider

Diagnosis/Treatment

> Lack of long-term cures. – Public Health Representative
>
> Because I have chronic pain and once again my doctors want to solve all things with a pill. That's a major problem. – Community Leader

Income/Poverty

> See and hear many people complaining of an array of health complaints and lack of money to get help – Community Leader

> Lack of financial resources and caretakers. – Community Leader

Affordable Care/Services

> I personally know many people suffering with such conditions and all of them spend their last dollar trying to find help. – Social Services Provider

Awareness/Education

> Health literacy, access to health education in alternative languages. Obesity and mental health remain disabling and limiting. – Health Care Provider

Built Environment

> We do not live in a disability friendly community. It does not have reliable accessible transportation and services. – Health Care Provider

Discrimination

> There is still an unconscious bias and lack of cultural competency that exists between healthcare providers and patients, impacting the ability to receive adequate and quality care. – Social Services Provider

Impact on Quality of Life

> The disease progression of every chronic condition leads to disabling conditions that limits participating in activities that could improve healthcare outcomes. – Health Care Provider

Transportation

> Lack of access including transportation issues, having caregivers needing to go to appointments, online access for people with limited digital literacy. – Health Care Provider

Isolation/Loneliness

> They prevent residents from leaving their homes, leading to social isolation and loneliness. – Community Leader

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.

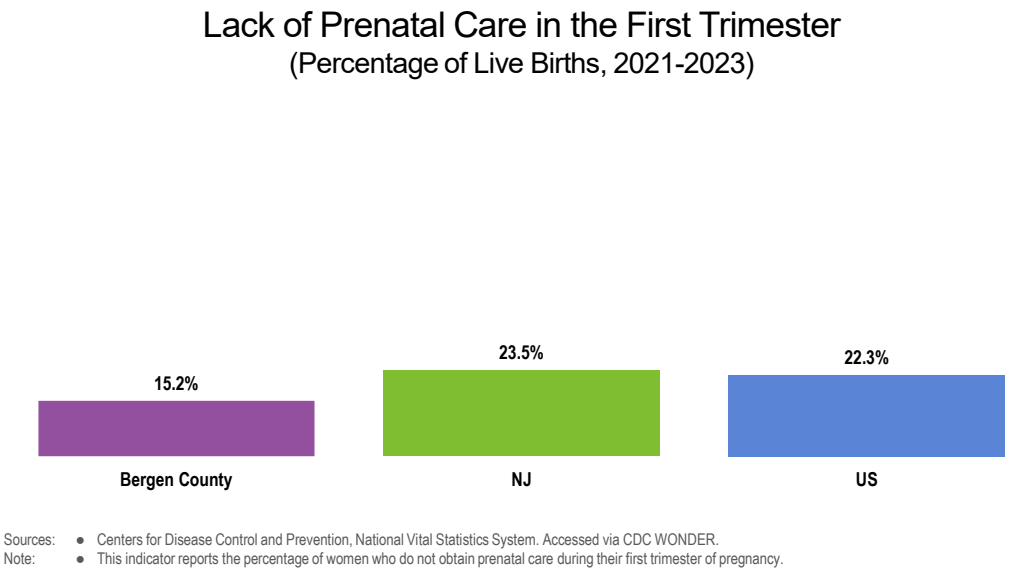
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

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

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health.

This indicator reports the percentage of women who did not receive prenatal care during their first trimester of pregnancy. This indicator can signify a lack of access to preventive care, a lack of health knowledge, or other barriers to services. [COUNTY-LEVEL DATA]



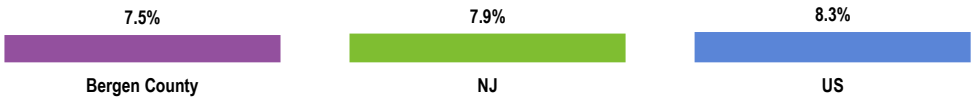
Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Note: • This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy.

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, 2016-2022)



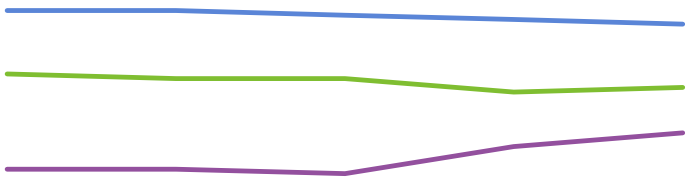
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than 1 year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health.
[COUNTY-LEVEL DATA]

Infant Mortality Trends
(Annual Average Infant Deaths per 1,000 Live Births)
Healthy People 2030 = 5.0 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Bergen County	2.4	2.4	2.3	2.9	3.2
NJ	4.5	4.4	4.4	4.1	4.2
US	5.9	5.9	5.8	5.7	5.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2025.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- This indicator reports 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.

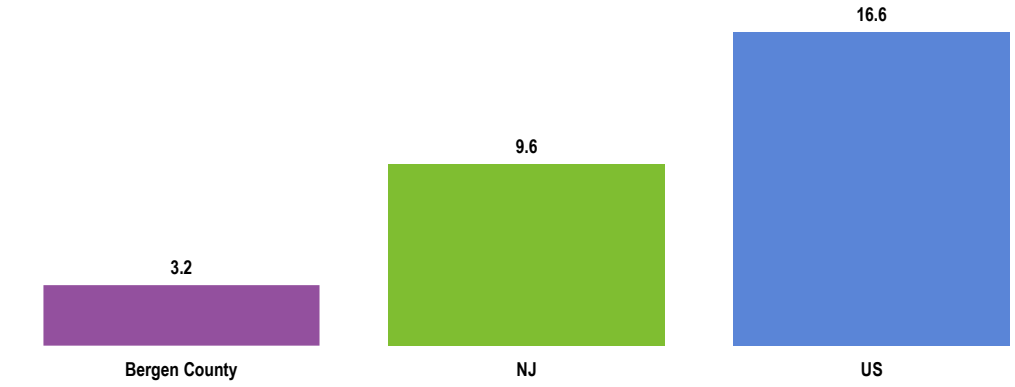
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

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

Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior. [COUNTY-LEVEL DATA]

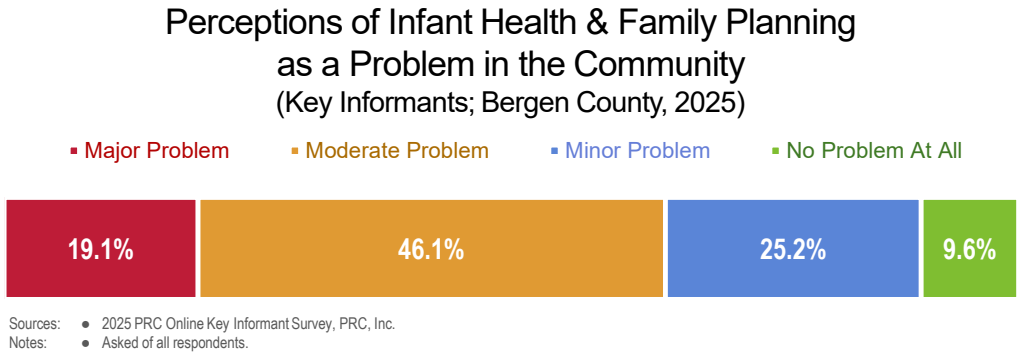


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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.

Key Informant Input: Infant Health & Family Planning

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



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

Awareness/Education

> Information shared at some community information sessions and a conference at Bergen Community College. – Community Leader
>
> Access to education. – Community Leader
>
> Working in the preschool program, I see a lot of parents having questions regarding behaviors – Health Care Provider
>
> I believe women are released from the hospital too soon after giving birth to a baby, especially their first baby. More instructions should be given before releasing a mom as to how to feed an infant, bath, and keep a schedule. Family planning is something that should be discussed as part of a high school program. Boys need to take more responsibility and held accountable if they are involved with someone and she becomes pregnant. He should be held accountable to help support the child he brings into the world. – Social Services Provider

Access to Care/Services

> I work with students with special needs, and I strongly believe that parents are in need of more services like, free insurance, healthy food, safety in the community. Workshops for educating parents in how to deal with children with special needs. – Community Leader
>
> Limited resources. – Community Leader
>
> Inadequate services overall. Even harder for minorities. – Physician

Infant Mortality

> Infant health and family planning are country-wide problems. The US has the highest infant mortality rate and maternal mortality and morbidity than any other developed country. This is truly a disgrace. – Community Leader
>
> NJ has one of the lowest scores for infant mortality in the nation and we are facing issues around maternal hypertension. – Community Leader

Access to Care for Uninsured/Underinsured

> Most folks are uninsured. – Social Services Provider
>
> Lack of health insurance, doctors not understanding black women's issues. – Community Leader

Income/Poverty

> Access to family planning and infant health depends on socioeconomic factors. – Community Leader
>
> Financial resources. – Social Services Provider

Incidence/Prevalence

> The United States has an extremely low maternal and fetal health outcome. – Public Health Representative

Language Barrier

> Multilingual in community resources. – Health Care Provider

Infant Safe Sleep

> Infant safe sleep. – Community 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.

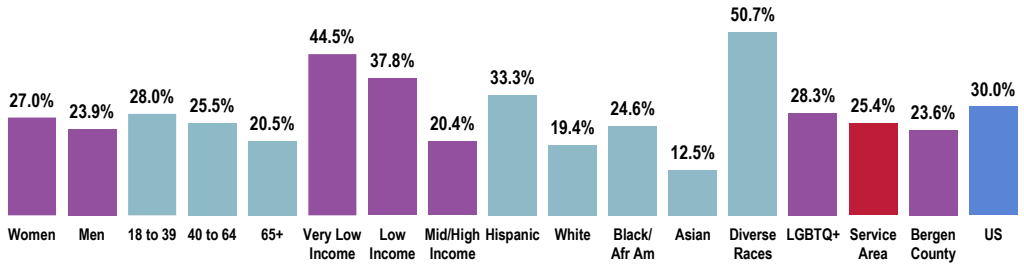
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Access to Fresh Produce

PRC SURVEY ► "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 Hospital Service Area, 2025)



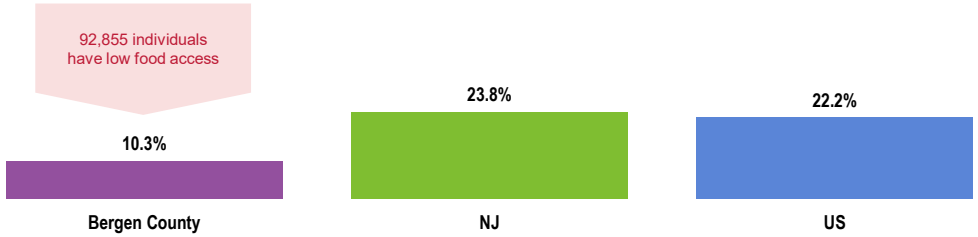
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Low (Geographic) Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data. [COUNTY-LEVEL DATA]

Population With Low (Geographic) Food Access
(2019)



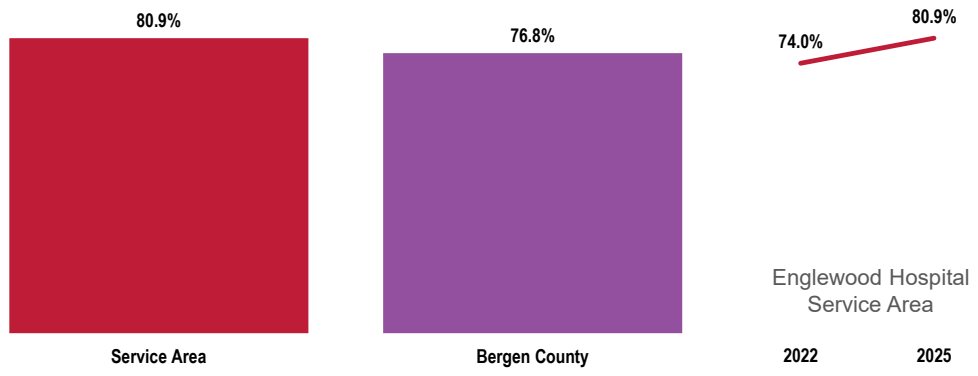
Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living far (more than 1 mile in urban areas, more than 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

Reading Food Labels

PRC SURVEY ► "Generally speaking, do you read food labels to help you make decisions about which food to select?"

Generally Use Food Labels to Make Purchasing Decisions



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 311]

Notes:
- Asked of all respondents.

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.

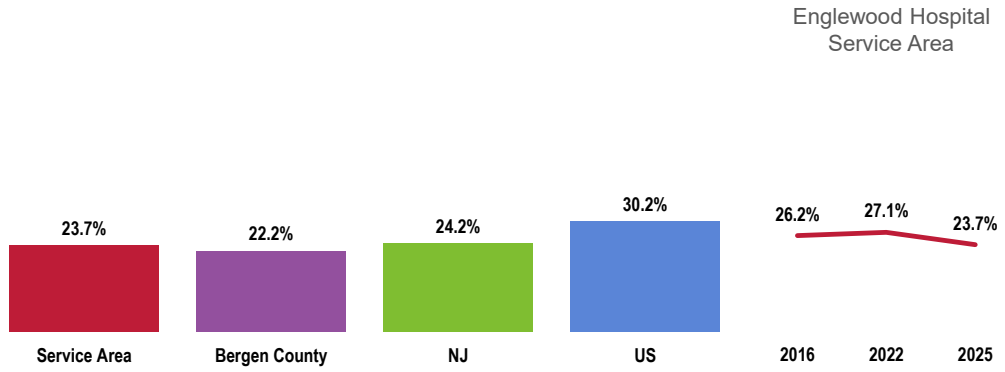
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

PRC SURVEY ► "During the past month, 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 = 21.8% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

"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.

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

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

Respondents could answer this 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.

PRC SURVEY ► "During the past month, what type of physical activity or exercise did you spend the most time doing?"

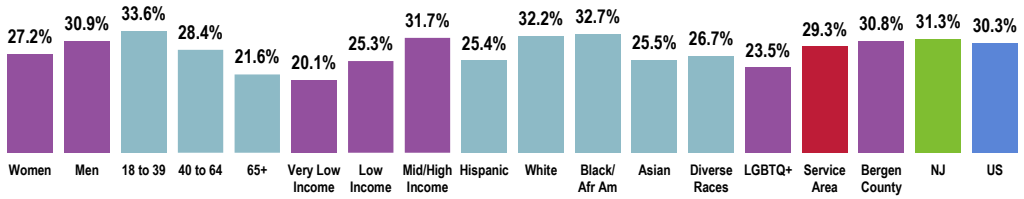
PRC SURVEY ► "And during the past month, how many times per week or per month did you take part in this activity?"

PRC SURVEY ► "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents were also asked about strengthening exercises:

PRC SURVEY ► "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."

Meets Physical Activity Recommendations
(Englewood Hospital Service Area, 2025)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

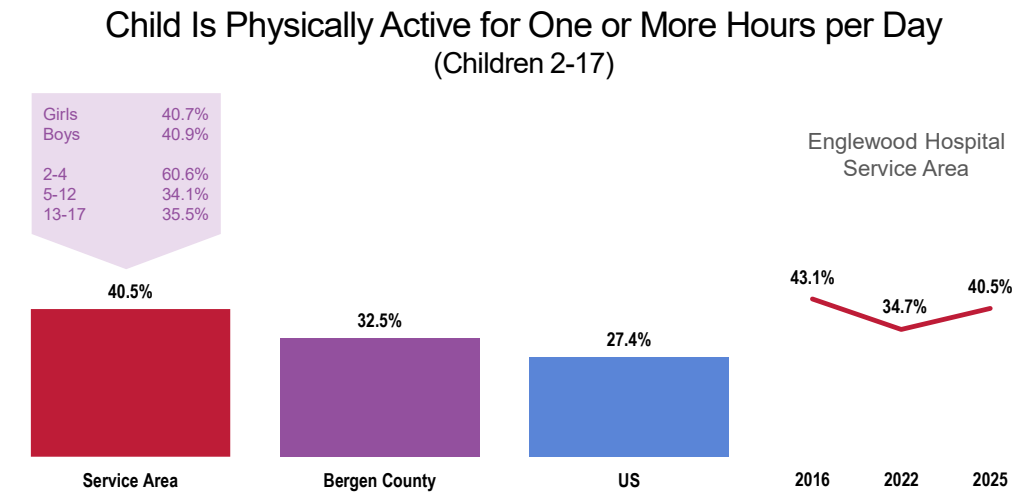
Children's Physical Activity

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

PRC SURVEY ► [Among parents of children age 2-17] **"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"**



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 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 ($inches^2$)] 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 ≥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 ≥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
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

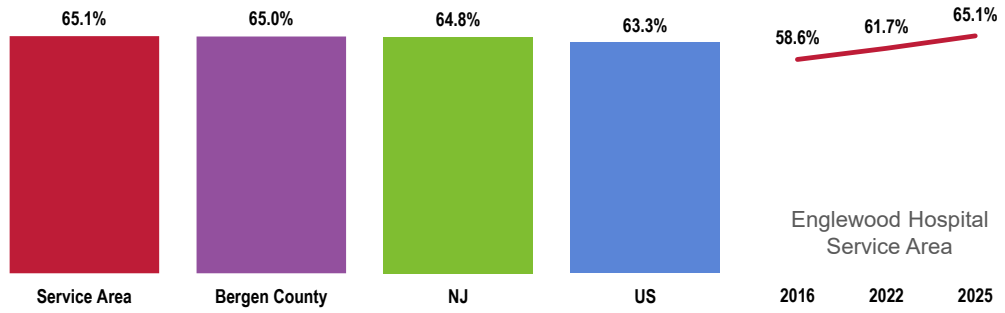
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

PRC SURVEY ► "About how much do you weigh without shoes?"

PRC SURVEY ► "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 preceding table).

Prevalence of Total Overweight (Overweight and Obese)

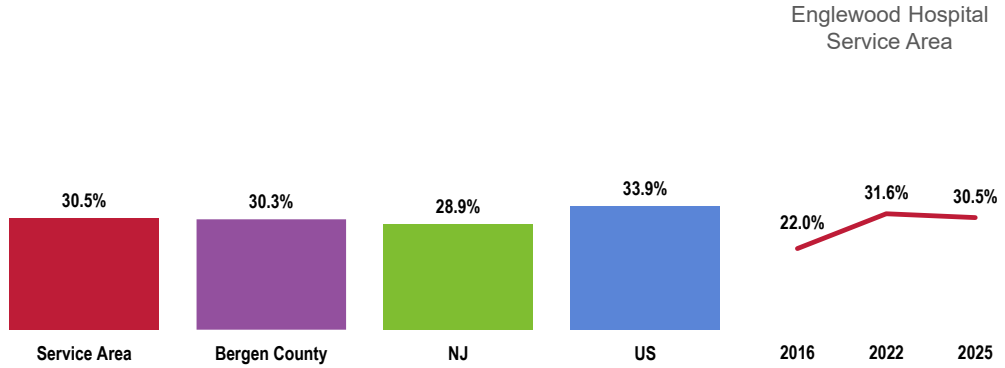


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, 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. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

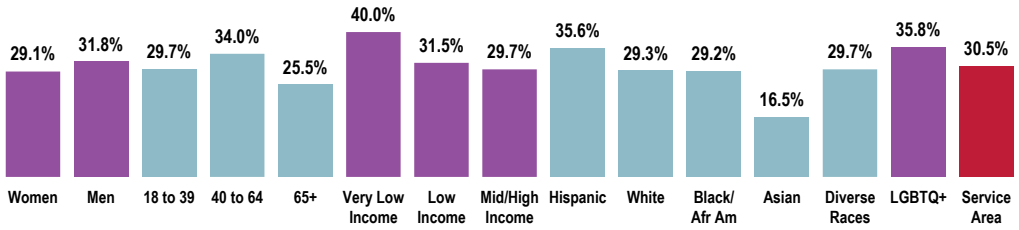
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.

Prevalence of Obesity
(Englewood Hospital Service Area, 2025)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

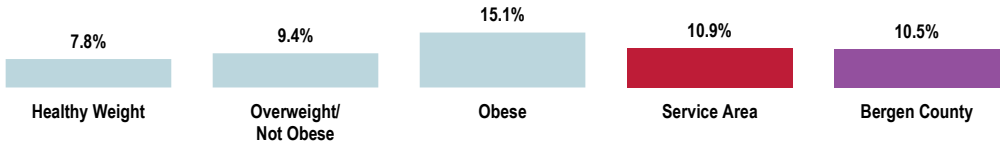
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Use of GLP-1 Agonists

PRC SURVEY ► "Are you currently taking any type of GLP-1 medication?"

Respondents were provided with the following description: A class of new prescription drugs called GLP-1 agonists are being prescribed to treat diabetes and/or for weight loss. These often involve giving oneself daily or weekly injections. Common brand names include Trulicity, Ozempic, Mounjaro, Zepbound, and Wegovy.

Currently Taking GLP-1 Agonist



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 303]

Notes:
- Asked of all respondents.
- GLP-1 agonists defined for respondents as a class of drugs prescribed to treat diabetes and/or weight loss that can involve daily or weekly injections. Common brand names mentioned were Trulicity, Ozempic, Mounjaro, and Wegovy.
- The definition of healthy weight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), of 18.5 to less than 25.0. The definition of overweight but not obese is a BMI of 25.0 to less than 30.0. The definition for obesity is a BMI greater than or equal to 30.0.

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:

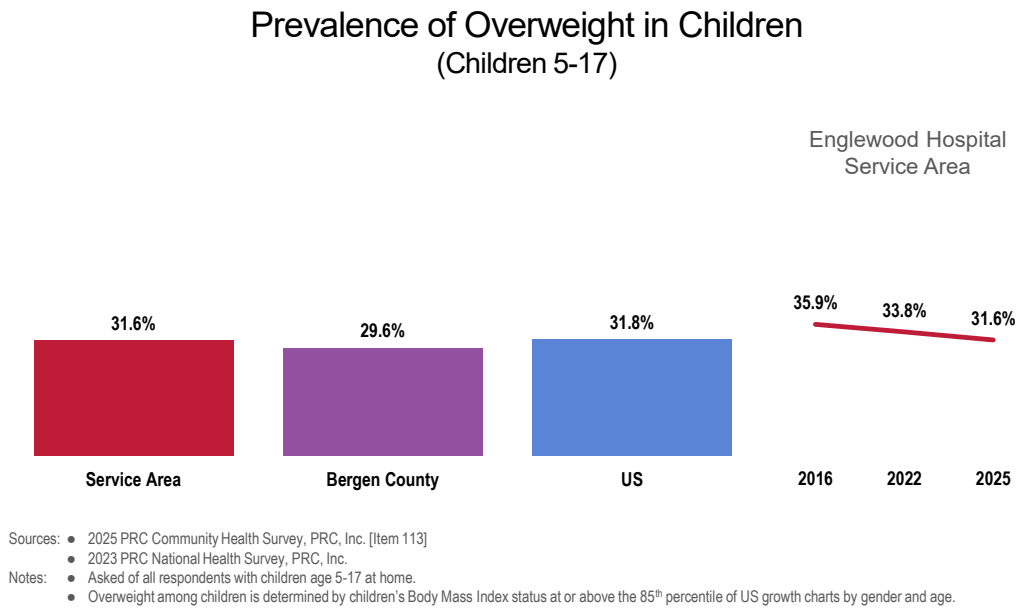
- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– 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:

PRC SURVEY ► [Among parents of children age 5-17] **"How much does this child weigh without shoes?"**

PRC SURVEY ► [Among parents of children age 5-17] **"About how tall is this child?"**

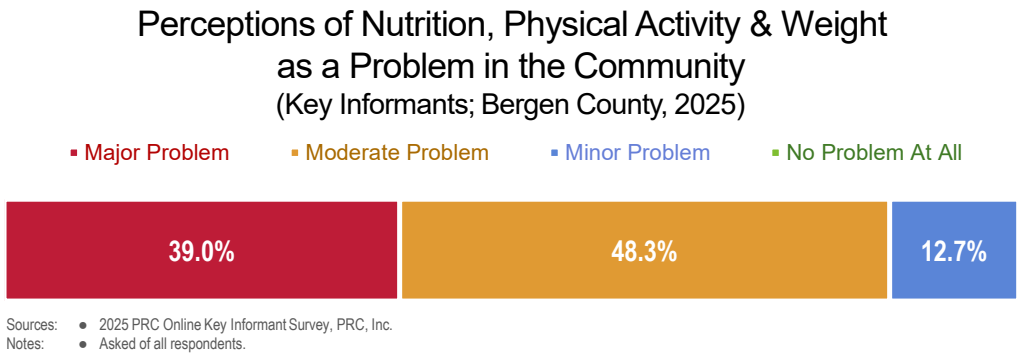


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

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:



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

Access to Affordable Healthy Food

> Access to healthy food and the finances to afford it. – Community Leader
>
> Lack of affordable food, affordable gyms. time and commitment. – Social Services Provider
>
> Cost of nutritious meals and cost of weight loss drugs. – Community Leader
>
> Lack of healthy foods offered, and cost associated with healthy eating. It is easier to eat fattening fast foods because of convenience and lower cost. – Social Services Provider
>
> Keeping motivation. Perception that eating healthy is expensive. Lack of time for people to focus on these three aspects of their life. Making meals that are healthy and taste good, that their whole household will enjoy. – Health Care Provider
>
> Access to healthy and affordable food options, affordable gyms, and access to nutritionists accepting insurance plans like Medicaid. – Health Care Provider
>
> Areas that have limited access to healthy, unprocessed foods. Needing to work multiple jobs to make ends meet so there's less time to exercise, eat at optimal times to manage weight, etc. – Public Health Representative
>
> Access to nutritious and affordable foods, time for exercise. – Community Leader
>
> Good food is expensive, people do not prioritize their own health. – Community Leader

Awareness/Education

> Education around healthy eating and exercise. Access to healthy food, proximity and cost. – Community Leader
>
> Lack of guidance and insurance reimbursement for preventative medicine and treatment plans. – Health Care Provider
>
> Nutrition education access is challenging. Social media misinformation. – Health Care Provider
>
> Education of healthy food. – Physician
>
> Advertising and a lifestyle that is dependent on fast food. – Community Leader
>
> This should be addressed while students are still in high school. This should be part of the health program instead of the programs that are being taught regarding sexuality. – Social Services Provider
>
> Education and the ability to buy nutritious foods due to financial constraints. Difficult for some to get to free facilities that offer physical activity. – Community Leader
>
> Lack of education around nutrition and physical activity. Lack of personal finances to eat healthy and work with a trainer on proper exercise. – Social Services Provider

Obesity

> Obesity seems to be an issue with more reliance on taking medication such as Ozempic, and less effort with healthy diet and exercise. Motivation may also be a challenge, as well as such easy access to junk food and unhealthy snacks. – Public Health Representative
>
> Excess weight and lack of activity. – Community Leader
>
> Obesity is a significant challenge, overeating and limited physical activity. – Physician
>
> Obesity in kids and adults. The main reasons are dietary habits, physical inactivity. – Public Health Representative

> Obesity and its associated co morbid conditions. – Physician
>
> Obesity and the new profusion of quick weight loss potions available on the market. – Social Services Provider

Nutrition

> Increase fast food restaurants, lack of reading nutritional information labels, social media advertisements of sweets and other unhealthy items. – Community Leader
>
> Many people don't have a good grasp of healthy eating especially in regard to weight loss. Wide availability of cheap junk food and high grocery store prices makes it tough to make best choices for food. – Community Leader
>
> Eating well, on a budget and food security. – Community Leader
>
> Poor nutrition and obesity. – Community Leader

Lifestyle

> Free diet, walking, exercise and wellness groups. – Social Services Provider
>
> Eating worse food, decrease in physical activity are leading to increase weight. Ozempic is now a running problem for a quick fix to lose weight. – Public Health Representative
>
> Bad habits. – Health Care Provider
>
> Time. – Public Health Representative

Insufficient Physical Activity

> Finding active physical activities for preschoolers and families to find. – Health Care Provider
>
> There are very few free or low-cost opportunities for adults to engage in physical activity within the city. The recreation dept offers nothing for adults (tennis lessons, swim lessons, Zumba, boxing, etc...) There are none for kids outside of sports teams. – Community Leader
>
> Finding the time to exercise throughout our busy days. – Social Services Provider
>
> Spending too much time on screens and lack of exercise. – Health Care Provider

Denial/Stigma

> Getting people in a comfortable space so they can begin their journey away from judgement. – Community Leader
>
> Admitting that you need help with nutrition, physical activity and weight. – Community Leader

Built Environment

> Over dependence on cars for travel, communities that aren't walkable, food insecurity and lack of nutrition education. – Community Leader

Access to Care/Services

> No available quality programs. Local hospitals not interested in this topic. No interest in preventive medicine from major hospitals. – Physician

Foreign-Born

> Undocumented, no papers to work, low income, extremely vulnerable, living in the food desert, and having no access to healthy nutritious food. – Social Services Provider

Hunger/Malnutrition

> Food insufficiency since these effects the ability of children to learn and people to remain healthy. – Community Leader

Funding

> Access to services since the reduction of federal funding in this space. – Health Care Provider

Aging Population

> Many seniors are craving exercise and any movement daily. – Community Leader

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.

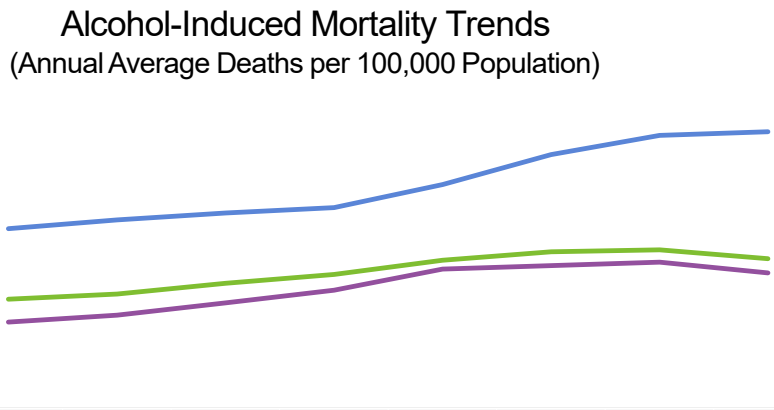
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

Alcohol

Alcohol-Induced Deaths

The following chart outlines alcohol-induced mortality in the area. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	4.9	5.3	6.0	6.7	7.9	8.1	8.3	7.7
NJ	6.2	6.5	7.1	7.6	8.4	8.9	9.0	8.5
US	10.2	10.7	11.1	11.4	12.7	14.4	15.5	15.7

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

Excessive Drinking

PRC SURVEY ► "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?"

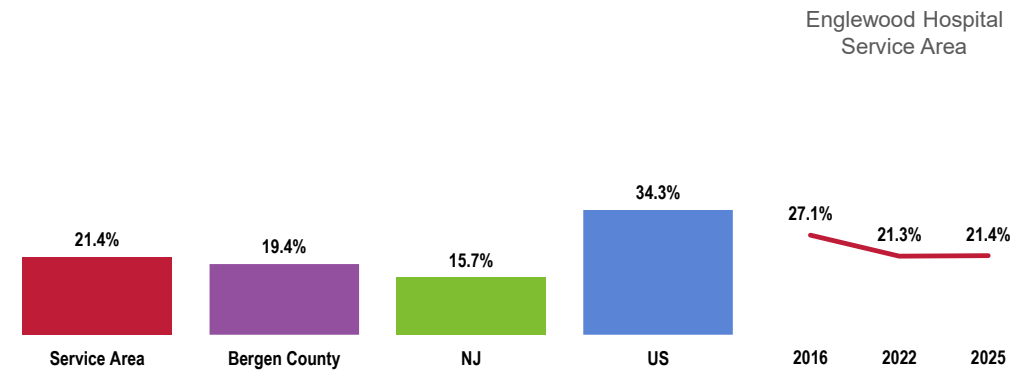
PRC SURVEY ► "On the day(s) when you drank, about how many drinks did you have on average?"

PRC SURVEY ► "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 DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Engage in Excessive Drinking



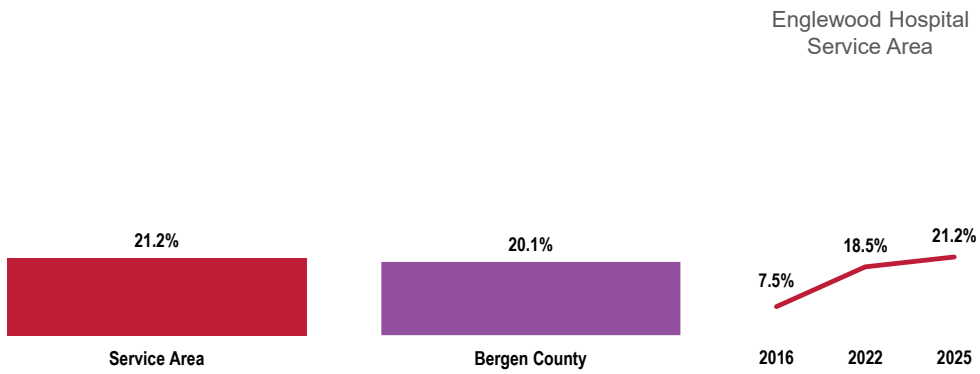
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 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.

Marijuana/THC

PRC SURVEY ► "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/THC in the Past Year



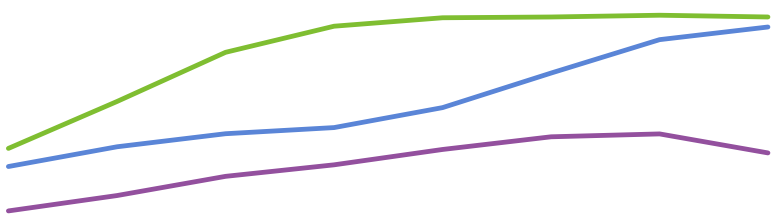
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.
● Use of marijuana or products containing THC in any form, including traditional marijuana, hashish, edibles, and concentrates like hash oil, wax, or shatter. Does not include use of CBD oils.

Other Drugs

Unintentional Drug-Induced Deaths

Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an 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 mortality for unintentional drug-induced deaths. [COUNTY-LEVEL DATA]

Unintentional Drug-Induced Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
Bergen County	9.4	11.1	13.2	14.5	16.2	17.6	17.9	15.8
NJ	16.3	21.5	26.9	29.8	30.7	30.8	31.0	30.8
US	14.3	16.5	17.9	18.6	20.8	24.6	28.3	29.7

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted February 2025.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population.

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.

PRC SURVEY ► "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month

Englewood Hospital Service Area

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Use of Prescription Opioids

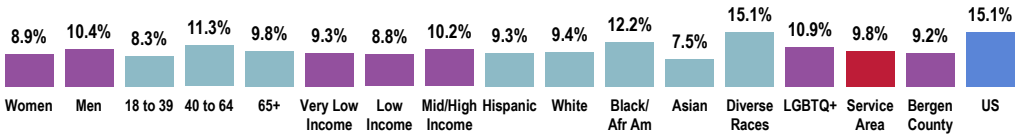
Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

PRC SURVEY ► "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?"

PRC SURVEY ► "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?"

Used a Prescription Opioid in the Past Year
(Englewood Hospital Service Area, 2025)

10.4% of respondents report that they or a member of their household have been referred to or treated for an addiction to prescription medications.



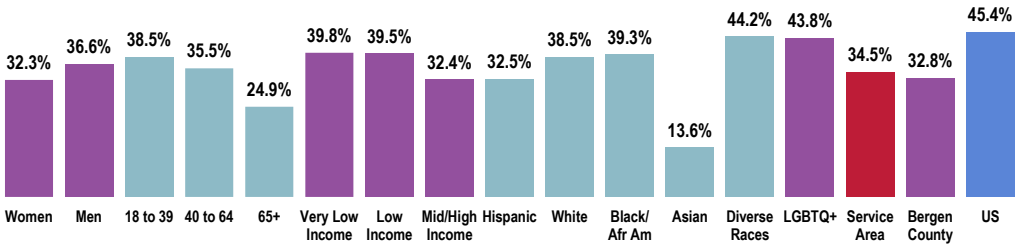
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 41, 307]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Use

PRC SURVEY ► "To what degree has your life been negatively affected by your own or someone else's substance use issues, including alcohol, prescription, and other drugs? 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 Hospital Service Area, 2025)



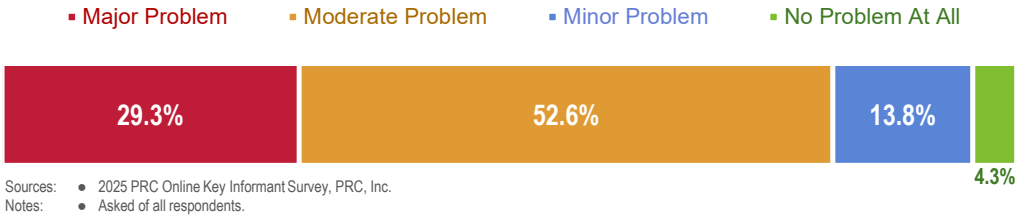
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," or "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; Bergen County, 2025)



Sources:
- 2025 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

> Good treatment programming for those without Commercial insurance, stigma and its effects on individuals and families, lack of available services (Methadone treatment is not available in Bergen County), lack of treatment that is not abstinence-based, only community-based recovery support center is not community-based as it is located on the grounds of Bergen New Bridge Medical Center, a location that is difficult to get to - people don't want to go to - and is inside the hospital requiring a pass from security and having a whole lot of people know where a person is going. – Community Leader
>
> Access to drug rehab facilities. – Health Care Provider
>
> Available facilities. Education on available resources. – Community Leader
>
> Hospitals not allocating resources to this problem. – Physician
>
> Wait time for treatment. – Health Care Provider
>
> Limited sober living and long-term rehab. – Physician
>
> There are not enough places in the area, there are not enough people to help the places that are in the areas have limited hours available to help and are always crying they have no money. – Community Leader

Awareness/Education

> Awareness of available resources, like the 24-hour crisis hotline that could offer individuals and families guidance and support. Increasing awareness of and utilization of the 24-hour line could alleviate the burden on people trying to find resources in times of need. The absence of an involuntary commitment law, specific to matters related to substance use, adds to the trauma and burden of the disease. Specifically, voices of family members have been heard loudly over the years pleading for the system to allow them to access needed care for their loved one whose decision-making skills have been severely impacted by substances. Family members believe that having the ability to commit their loved one to detox/treatment would save lives. The allowable length of stays in detox/treatment etc. are counterproductive to addiction science. Opportunities to have save housing & meaningful employment must be increased to support individuals' recovery. – Social Services Provider
>
> The lack of knowledge in the resources available and how to initiate care. – Physician
>
> Where to go, admitting there is a problem to need help. – Public Health Representative
>
> High schools are not doing enough. More programs are needed for the teenagers. – Social Services Provider

Denial/Stigma

> The stigma around getting help. – Community Leader
>
> Stigma and lack of walk-in sites. – Social Services Provider
>
> Shame and people not wanting to admit they have a problem. – Community Leader
>
> In my opinion the greatest barrier related to access substance use treatment in BC community are stigma, shortage of qualified addiction treatment professionals, co-occurring disorders, high cost of treatment. – Public Health Representative

Affordable Care/Services

> Money. – Community Leader
>
> I am not very familiar with substance use treatment options, but I believe barriers would include cost of care, stigma and denial around seeking out treatment, other stressors that make seeking out treatment a low priority. – Community Leader

Insurance Issues

> Access to substance use treatment is often obstructed due to lack of accepted insurances by most substance use programs. Substance use programs that accept Medicare and Medicaid plans are extremely challenging to find, for both inpatient and outpatient levels of care in our community. Lack of transportation to and from substance use programs in our community also significantly impacts this population's ability to participate in services. – Social Services Provider

Law Enforcement

> Fear of the law. Space availability in programs. Oh yes and the cost of an effective rehabilitation program. There is also no crystal meth specific treatment available in Bergen County to my knowledge. – Social Services Provider

Narcan

> Narcan---many people do not understand its purpose and automatically associate it with drug use. There are many other situations that require Narcan (i.e. a child who finds a pill on the floor, eats it thinking that its candy & it ends up being an opioid, etc). – Community Leader

Funding

> Access to services since the reduction of federal funding in this space. Lack of interest in providers willing to work together, county shows preference to Care Plus. – Health Care Provider

Incidence/Prevalence

> People are still dying from overdoses. Fentanyl is a huge problem for our communities. – Health Care Provider

Prevention/Screenings

> More resources are needed for programs to not only help substance misuse but also prevention too. – Community Leader

Social Media

> Increase in social media advertisements, accessibility to smoking stores and liquor stores, accessibility to vapes. – Community Leader

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.

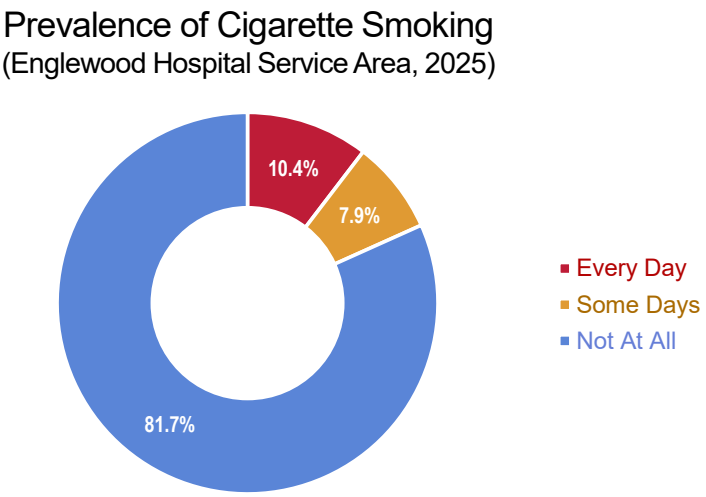
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including 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

PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")

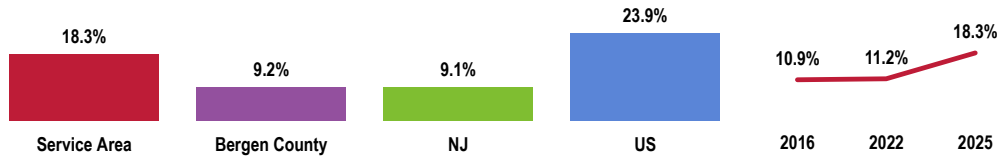


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

Englewood Hospital Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

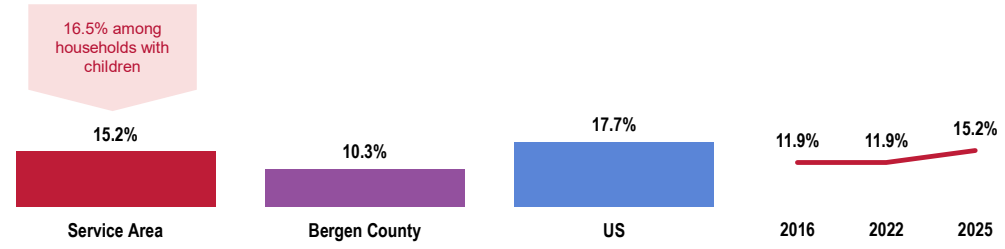
Environmental Tobacco Smoke

PRC SURVEY ► "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 Hospital Service Area



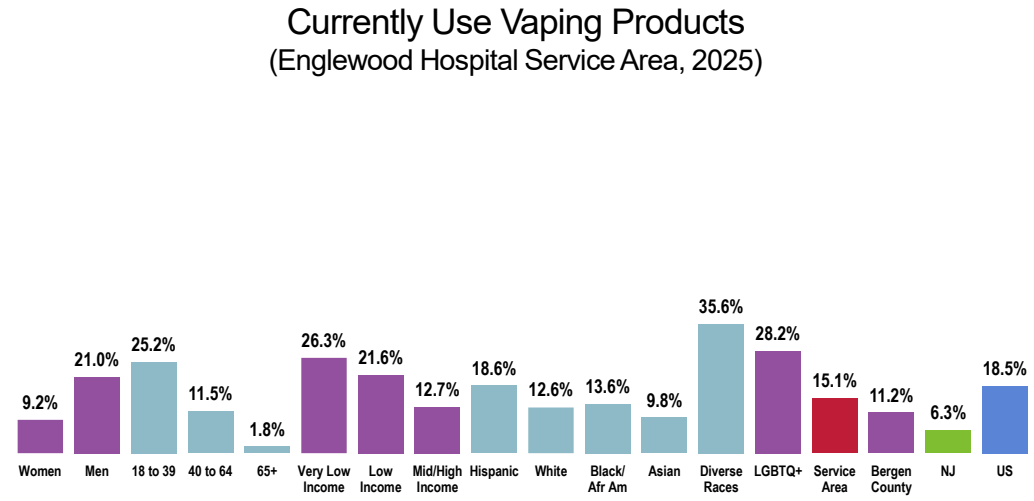
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

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

PRC SURVEY ► "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

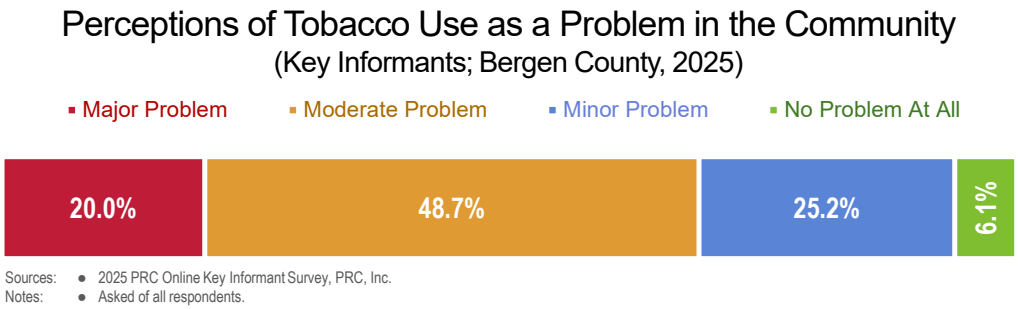


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who use vaping products 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:



Sources:
- 2025 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:

E-Cigarettes

> Tobacco and vaping. A lot of schools have had to put in vaping detectors in schools in schools we are always finding vaping and tobacco products. – Community Leader
>
> Vaping devices have increase access and appeal around tobacco products. The large amount of nicotine included makes it more addicting. Devices are designed to attract kids: video game vapes (vapes you actually play games on), solar powered devices, collectable devices, etc. – Health Care Provider
>
> Vaping is common in younger individuals. – Public Health Representative

> It is nicotine not tobacco related to vaping. There are so many people, especially young people who begin and are addicted to vaping. – Community Leader

Impact on Quality of Life

> Tobacco has major effects on your long-term health. – Community Leader
>
> It's not healthy. – Community Leader
>
> Tobacco use leads to a number of health issues, and it is very prevalent. – Community Leader
>
> Many people still smoke even though the health risks are better communicated because the nicotine is addictive. – Public Health Representative

Social Norms/Community Attitude

> Acculturation and the accessibility to tobacco, social media influence. – Community Leader
>
> It has been socially acceptable for so long. – Community Leader
>
> It is a major problem given that tobacco use is not considered by most people as an addiction and is a social norm in some communities. – Physician

Awareness/Education

> Not enough is taught in the high schools about the addiction to tobacco. – Social Services Provider
>
> With all the information we have today, I find it hard to understand why so many people still smoke and why anyone vapes. – Social Services Provider

Incidence/Prevalence

> High incidence and prevalence of its use. – Physician
>
> We don't see as much smoking as vaping. Smoking seems to have drastically downsized. Yet, there is still not enough available for people who have been addicted for many years. – Social Services Provider

Easy Access

> Easy accessibility to nicotine vapes has caused dependence with individuals starting at a very young age. This causes significant increase in anxiety and panic related disorders, a decreased ability to try healthier ways of coping. – Social Services Provider

Addiction

> It is addictive and expensive. – Social Services Provider

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).

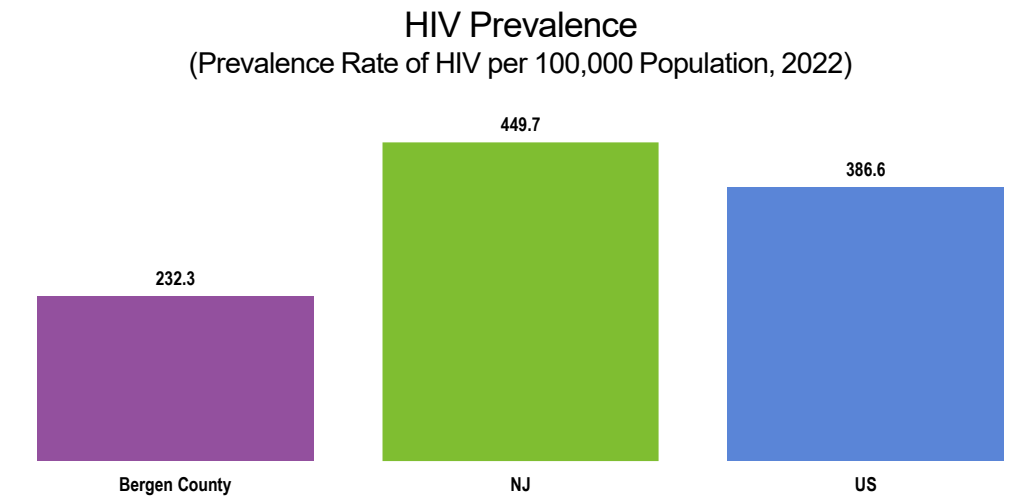
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

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

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 February 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

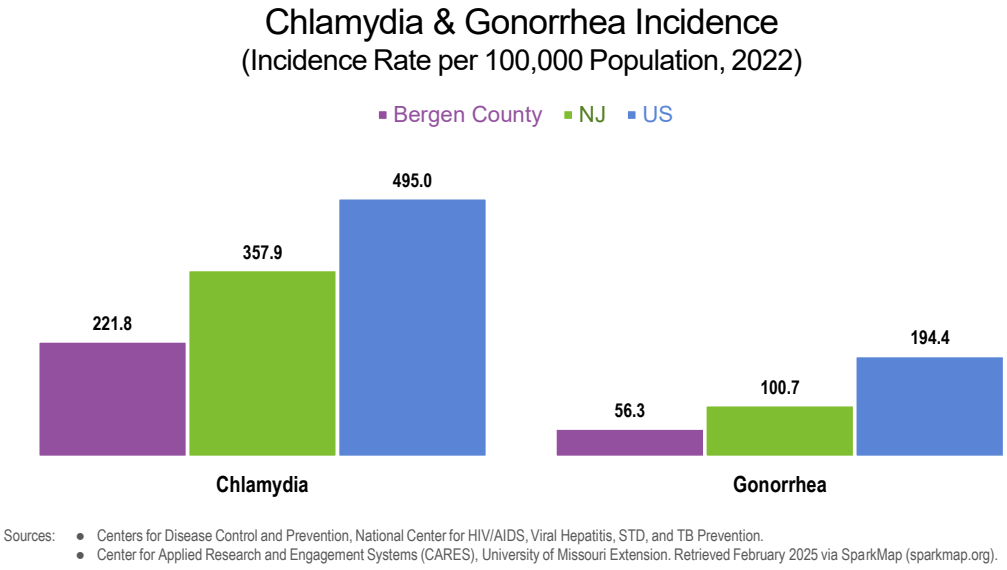
Chlamydia

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.

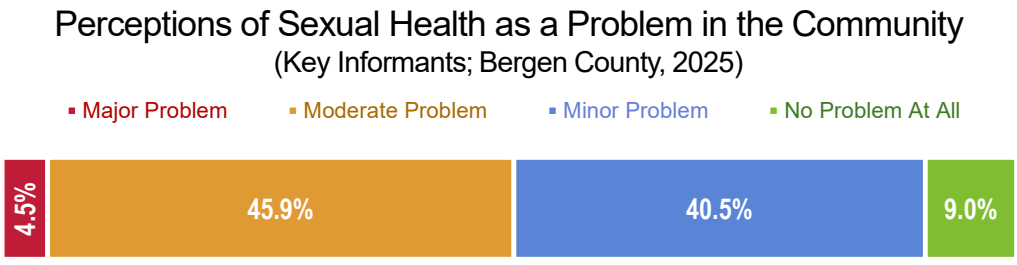
The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]



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 February 2025 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

The following outlines key informants' perceptions of *Sexual Health* as a problem in the community:



Sources: 2025 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

> Sexual Health should be addressed as part of the high school programs and how to prevent getting these diseases. – Social Services Provider

Prevention/Screenings

> No interest from major hospitals in this area. No preventive measures available. – Physician

Incidence/Prevalence

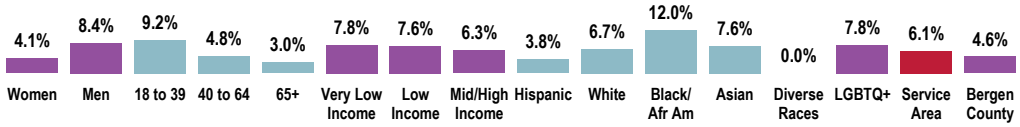
> STDs are on the rise. – Public Health Representative

Gambling

Here, respondents were asked about gambling, which involves betting 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.

PRC SURVEY ► "In the past 12 months, has gambling — by you or someone close to you — led to problems in your work, family, or personal life?"

Negatively Affected by Gambling (by Self or Someone Else) in the Past Year
(Englewood Hospital Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 315]

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

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.

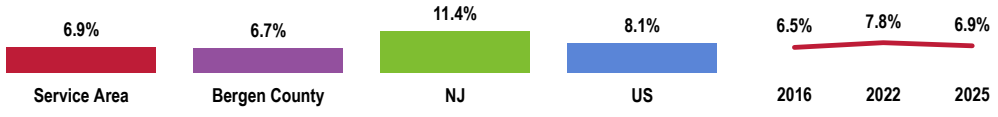
Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?"

PRC SURVEY ► "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?"

Lack of Health Care Insurance Coverage
(Adults 18-64)
Healthy People 2030 = 7.6% or Lower

Englewood Hospital Service Area



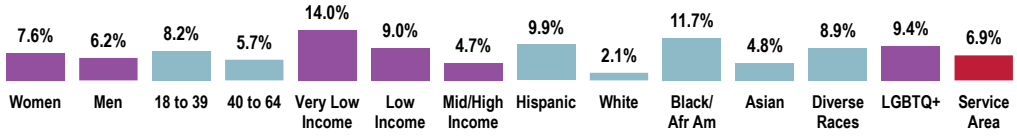
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage

(Adults 18-64; Englewood Hospital Service Area, 2025)

Healthy People 2030 = 7.6% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

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.

PRC SURVEY ► "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"

PRC SURVEY ► "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?"

PRC SURVEY ► "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?"

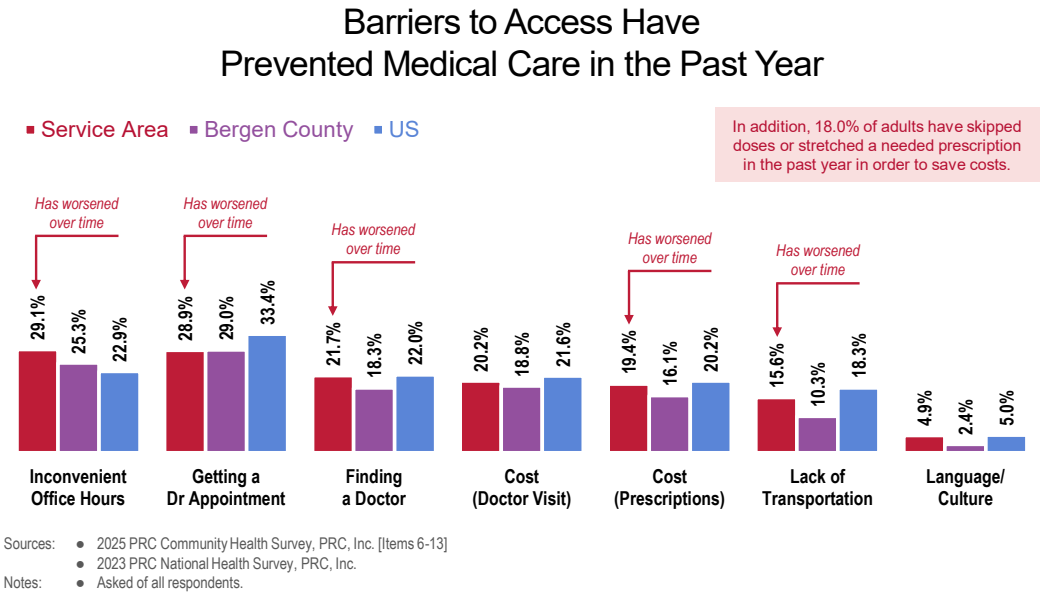
PRC SURVEY ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

PRC SURVEY ► "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:

PRC SURVEY ► "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.

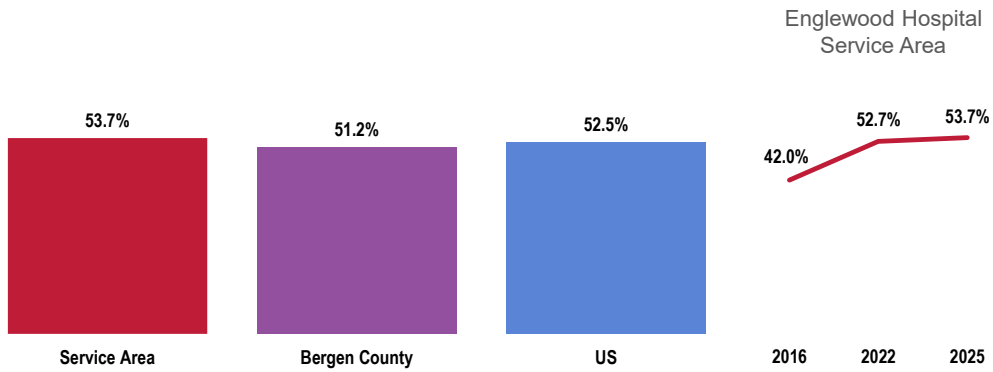


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

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), again regardless of whether they needed or sought care.

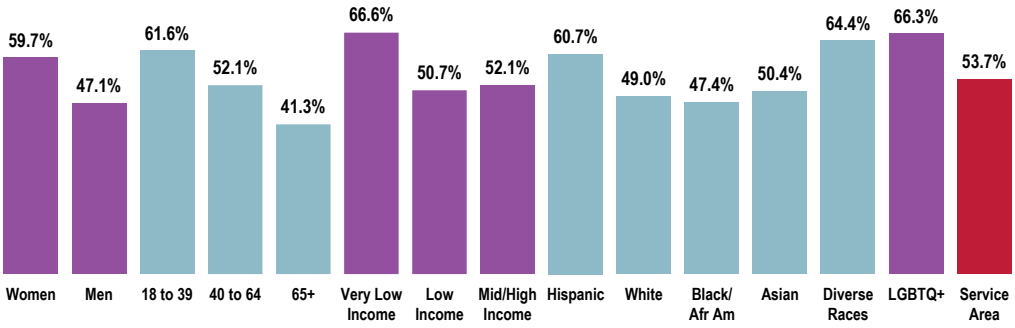
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]
- 2023 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 Hospital Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]

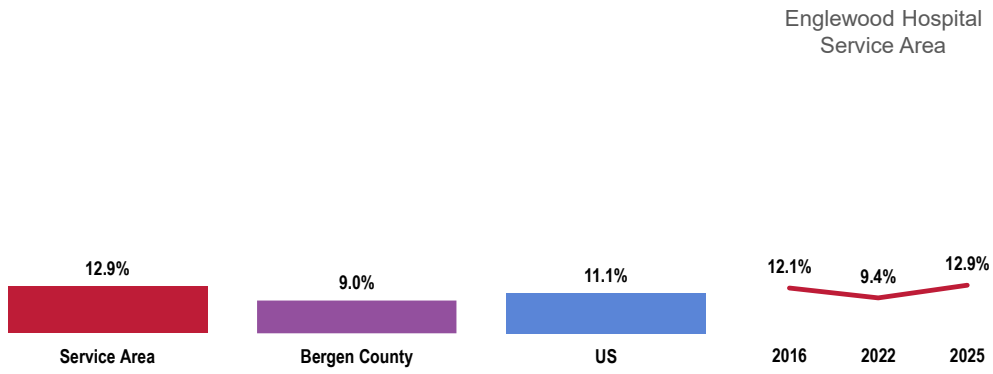
Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

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.

PRC SURVEY ▶ [Among parents of children age 0-17] **"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
(Children 0-17)

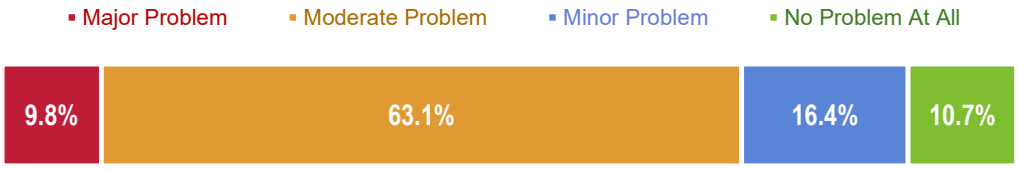


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 90]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 0 to 17 in the household.

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:

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants; Bergen County, 2025)



Sources: ● 2025 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

> Financial accessibility, even with insurance co-pays and deductibles are too expensive and burdensome on individuals and families. – Community Leader
>
> Cost. Discrimination to racial and financial minorities. Stigma of mental illness. Limited services for mental health. – Physician
>
> Affordability and location. – Social Services Provider
>
> High cost to see doctor and emergency for limited resource population. – Community Leader

Access to Care/Services

> As a community nurse, I deal with a lot of families who do not have access to the health system. Students with special needs are more vulnerable to get services like dental and get free visits to the ophthalmologist or the waiting list is too long. – Community Leader
>
> Getting an appointment when you need one, not being told next appointment is three weeks. That does not help when you are ill. – Community Leader
>
> Getting to see a primary care doctor or specialist within a reasonable timeframe. – Physician

Access to Care for Uninsured/Underinsured

> There is plenty of healthcare to be had in Bergen County, with five hospitals within the county's borders, and many more hospitals and doctors in NYC. There is a problem of access, though, for people who are uninsured or underinsured. For them, the ER is often the only option they have for care because of cost. – Community Leader
>
> Lack of insurance, limited funding for Charity Care programs. Most importantly, with the mass deportations, many families do not want to leave their homes unless it's only for work. – Public Health Representative

Affordable Insurance

> High cost of health insurance for middle class working population. – Health Care Provider
>
> Although it's an indirect issue, the cost of medical insurance including prescription drugs. People's budgets are being strained, and they should not have to choose between health care and other basic needs.
> – Community Leader

Focus on Prevention

> Focus on prevention and healthy lifestyles. Invest time and resources and access to folks who can teach the community and motivate. – Health Care Provider

Language Barrier

> Spanish speakers don't know where to find/understand where to find resources. – Health Care Provider

Awareness/Education

> Lack of awareness where they can receive care. – Community Leader

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.

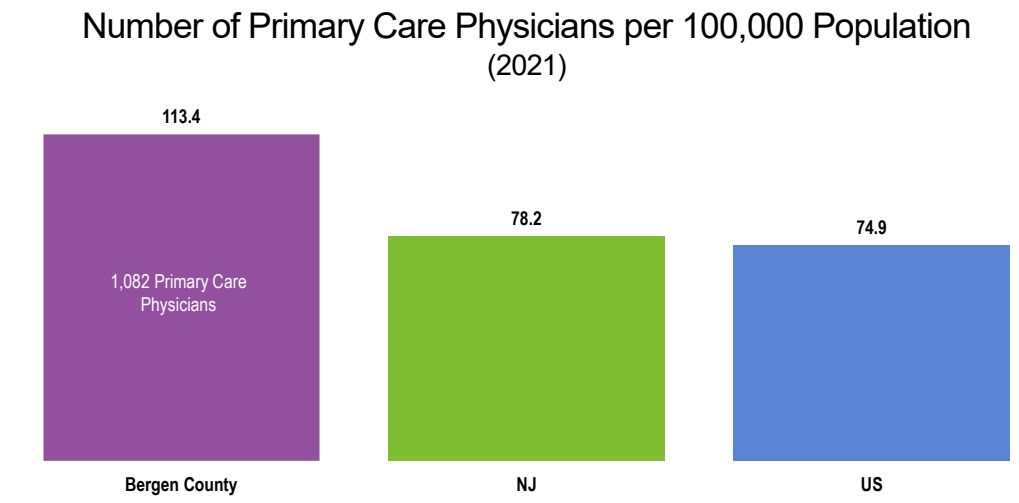
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

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

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. [COUNTY-LEVEL DATA]

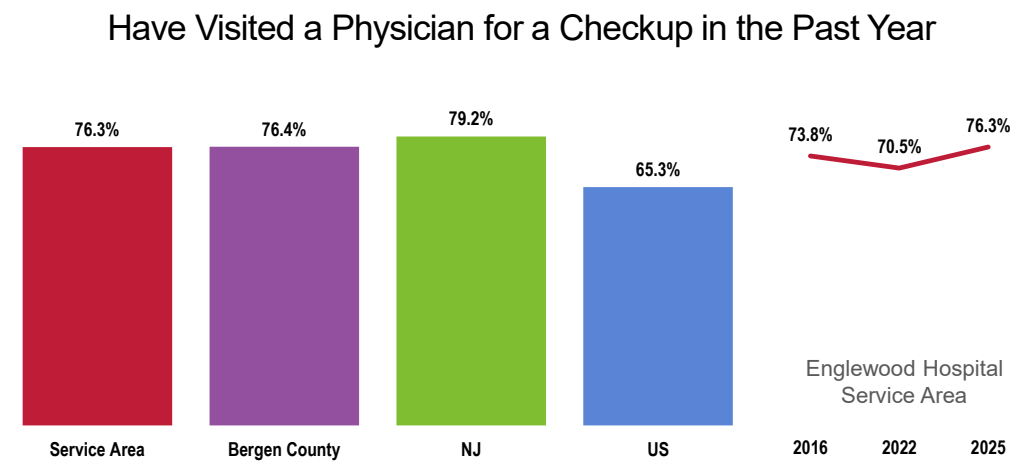


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved February 2025 via SparkMap (sparkmap.org).

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.

Utilization of Primary Care Services

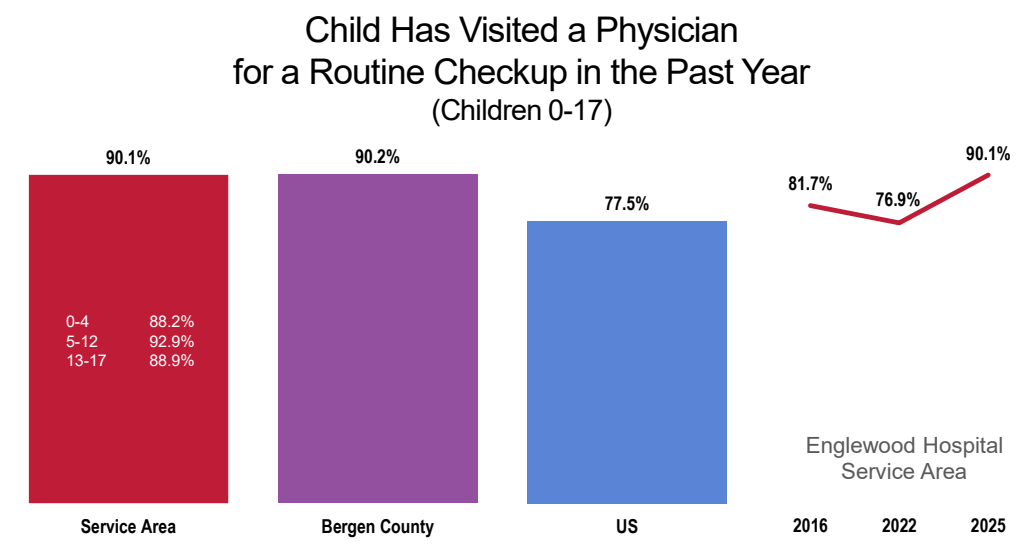
PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► [Among parents of children age 0-17] **"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?"**



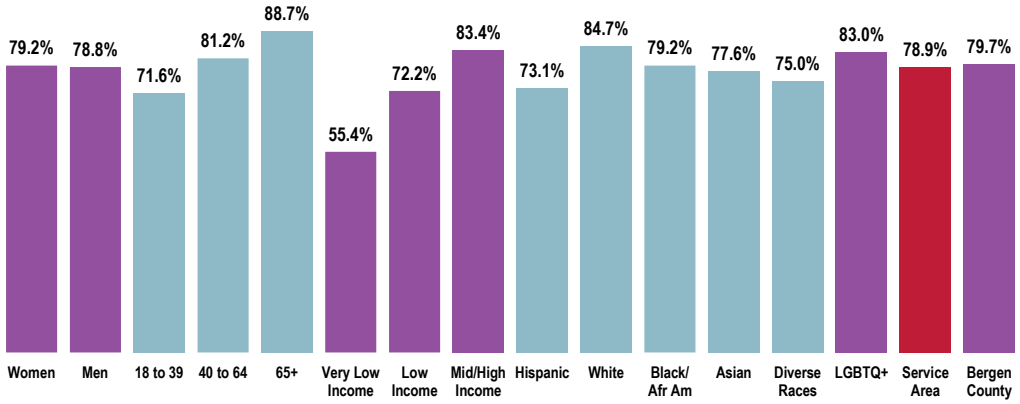
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 0 to 17 in the household.

Post-Pandemic Health Care

PRC SURVEY ► "Since the COVID-19 pandemic, do you feel that you are back on track for getting preventive health care services, such as routine medical checkups, health screenings, and dental care?"

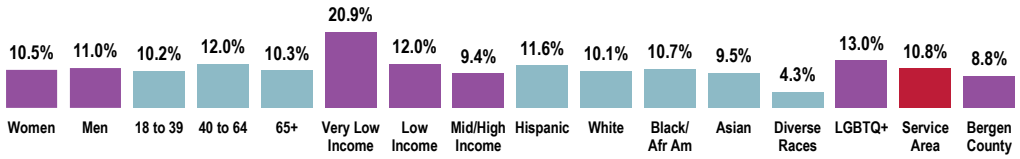
Feel "Back on Track" for Receiving
Preventive Health Care After COVID-19 Pandemic
(Englewood Hospital Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 317]
Notes: ● Asked of all respondents.
● Preventive health care defined for respondents as services like routine medical checkups, health screenings, and dental care.

PRC SURVEY ► "Have you experienced any adverse health effects as a result of health care that was missed or delayed during the COVID-19 pandemic?"

Have Experienced Adverse Health Effects from
Missed/Delayed Medical Care During COVID-19 Pandemic
(Englewood Hospital Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 316]
Notes: ● Asked of all respondents.

Oral Health

ABOUT ORAL HEALTH

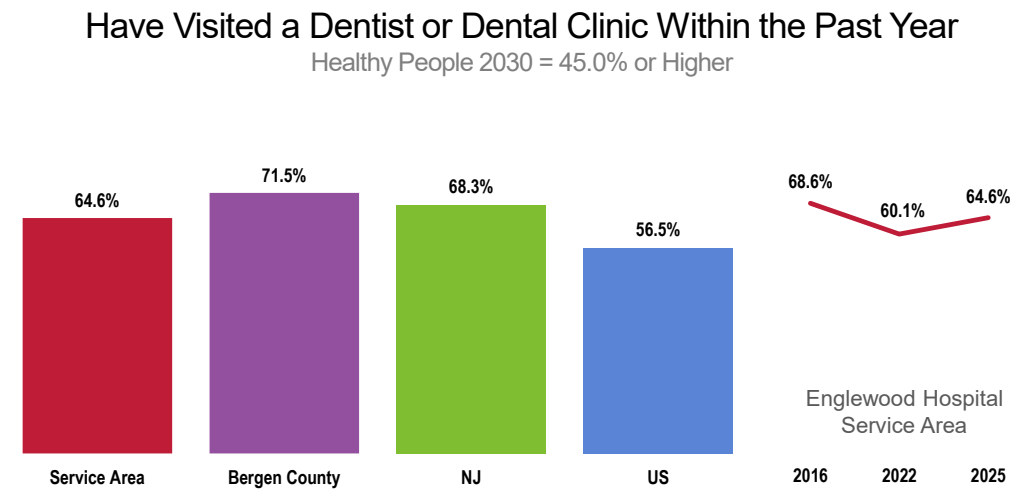
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems 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

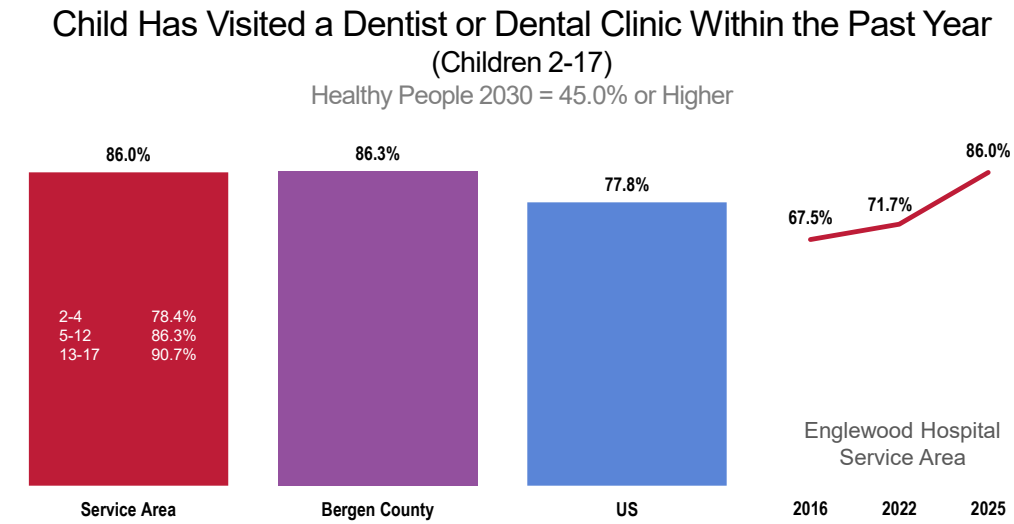
PRC SURVEY ► "About how long has it been since you last visited a dentist or a dental clinic for any reason?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

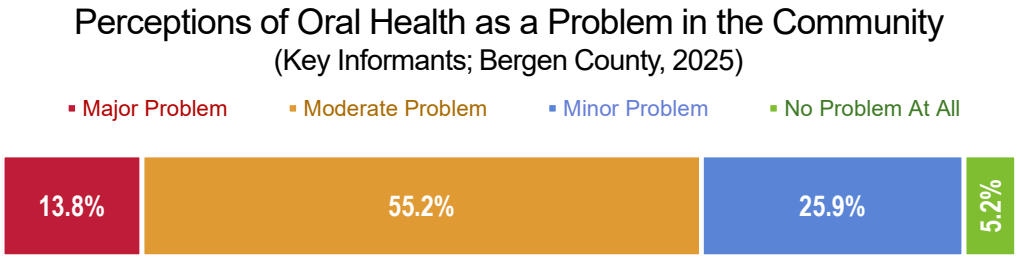
PRC SURVEY ▶ [Among parents of children age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 93]
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
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:



Sources: ● 2025 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 for Uninsured/Underinsured

> Lack of dental insurance. – Community Leader
>
> Very few people, especially low-income, have dental insurance or the means to pay for care, so oral health is far down the list of priorities. Poor oral health is tied to poor medical outcomes. Access is a problem for those with low incomes. – Community Leader
>
> Not all residents have dental health coverage which makes it too costly for them to get preventive and corrective care. – Public Health Representative

Affordable Care/Services

> Cost and insurance covering minimum. – Community Leader
>
> For older adults, affordability. – Social Services Provider

> The cost is astronomical. A simple root canal is thousands of dollars... even if insured, 1 tooth can put someone in debt; that is only if you can find a dentist who will do it without payment up front. Oh yeah, and should we discuss implants? We all know the importance to oral health care and how it affects healthcare in general. The cosmetic side of dentistry is also essential in today's society where your employment can and is often based on physical appearance. – Social Services Provider

Access to Care/Services

> Access to dental care for children. – Health Care Provider
>
> Access to care, lack of insurance coverage. – Community Leader
>
> Not having access to healthcare. – Community Leader

Nutrition

> Food items, expensive dental services. – Community Leader
>
> Oral health is horrible due to lack of nutrition. – Social Services Provider

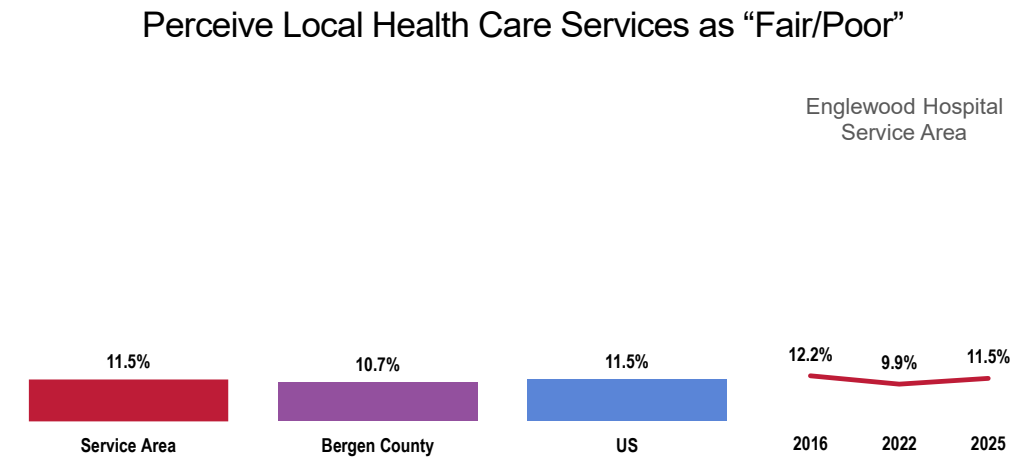
Awareness/Education

> I do believe this should be part of the high school programs and students should be taught hygiene in health classes. – Social Services Provider

LOCAL RESOURCES

Perceptions of Local Health Care Services

PRC SURVEY ► "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Resources Available to Address 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

- Bergen Volunteer Medical Initiative
- Bergen's Promise
- Earl Wheaton Family Care Center
- Englewood Health
- Hackensack Health Department
- Hackensack Meridian
- Holy Name Hospital
- Hospitals
- Little Ferry Family Success Center
- Neighbor Plus
- North Hudson Community Action
- Urgent Care Facilities
- YMCA/YWCA

Cancer

- Cancer Centers
- CancerCare
- Cancer Education and Early Detection Program
- Chemotherapy and Radiation
- Chilton Hospital
- Churches
- Community Focus on Prevention/Healthy Lifestyles
- Community Support Groups
- Community-Based Health Centers
- Doctors' Offices
- Elmwood Park Homeowners Association
- Englewood Health
- Englewood Hospital
- Faith-Based Organizations
- Federally Qualified Health Center
- Hackensack Hospital
- Hackensack Medical Health Network
- Hackensack Meridian
- Hackensack Meridian Health-John Theurer Cancer Center
- Health Screening Vans
- Health Screenings
- Holy Name Hospital
- Hospice Care
- Hospitals
- JayFund
- Library
- Media
- Memorial Sloan
- Mental Health Resources
- MSK Satellite
- New Jersey Cancer Education
- Pain Management
- Personal Meeting
- Regional Cancer Care Associates
- Sloan Kettering
- Tomorrows Children's Fund
- Town Hall
- Town Van
- Valley - Mount Sinai Comprehensive Cancer Care
- Valley Health Community Benefit Department
- Valley Health Robert and Audrey Luckow Pavilion
- Valley Hospital System

Diabetes

- 24 Hour Glucose Monitoring
- Bergen County Department of Health Services
- Bergen County Support Center
- Bergen Family Center
- Bergen New Bridge Medical Center
- Bergen Volunteer Medical Initiative
- Center for Diabetes Ridgewood
- Chilton Hospital
- Churches
- Community Chest
- Community-Based Education Programs
- Community-Based Health Centers
- Community-Based Organizations
- Diabetes Association
- Diabetes Foundation
- Diabetes Prevention Programs
- Dietitians
- Discount Grocery Stores
- Doctors' Offices

- Englewood Diabetes Center
- Englewood Health
- Englewood Health Department
- Englewood Hospital
- Farmers' Markets
- Federally Qualified Health Center
- Food Bank/Food Pantry
- Fresh Food Markets
- Hackensack Diabetes Center
- Hackensack Hospital
- Handouts
- Health Care Facilities
- Health Screening Vans
- Holy Name Hospital
- Hospital Zooms
- Hospitals
- Live Well Center
- ManKave Black Men's Health Fair
- Medication Assistance Programs
- Medication Management
- Molly Diabetes Education and Management Center
- NAACP
- North Hudson Community Action
- Nurse Teaching
- Nutrition Centers
- Nutritionists
- Pharmacy
- Shelter
- Shirvan Family Live Well Center
- ShopRite
- Social Services
- Transportation Options
- Urgent Care Facilities
- Valley Health Community Benefit Department
- Valley Home Care
- Valley Hospital System
- Women, Infants and Children
- YMCA/YWCA

Disabling Conditions

- AARP
- Access Transport
- ADA Organizations
- Adler Aphasia Center
- Alzheimer's Association
- Bergen County Transportation
- Bergen Family Center
- Bright Side Family
- Children's Aid and Family Services
- Churches
- Community-Based Education Programs
- Community-Based Organizations
- Day Programs for Mentally Ill/Substance Misusers
- Dispatch Health
- Doctors' Offices
- Elevators
- Englewood Health Department
- Federally Qualified Health Center
- Hackensack Hospital
- Hackensack Meridian
- Hackensack University Medical Center
- Health Screenings
- Heightened Independence and Program Center
- High Focus
- Holy Name Day Away Program
- Holy Name Hospital
- Hospitals
- Leonia Senior and Rec Center
- Lifetime Fitness
- Local Boards of Health
- Long-Term Care Facilities
- Meals on Wheels
- Northwest Bergen Regional Health Commission
- Office for Disabled
- Online Government Resources/Programs
- Physical Therapy
- Private Dementia Care Facilities
- Private Hearing Aid Dealers
- Public Transportation
- Rebuilding Together
- Residential Facility
- Senior Centers
- Senior Citizen Programs
- Senior Transportation Services
- ShopRite
- Skilled Nursing Facilities
- Supportive/Neurocognitive Programs for Elderly
- Town Van
- Universities
- Urgent Care Facilities
- Valley Health Community Benefit Department
- Valley Hospital System
- Vocational Therapy
- Wheelchair Ramps
- Women, Infants and Children

Heart Disease & Stroke

- Bergen County Department of Health Services
- Bergen County Health Department
- Bergen New Bridge Medical Center

- Bergen Volunteer Medical Initiative
- Bilingual Services
- Blood Pressure Monitors
- Charity Care Clinics
- Chilton Hospital
- Community Fairs
- Community Outreach
- Community-Based Education Programs
- Community-Based Health Centers
- Congestive Heart Failure Clinic
- Doctors' Offices
- Educational Programs
- EMS Systems
- Englewood Health Department
- Englewood Hospital
- Federally Qualified Health Center
- Fitness Centers/Gyms
- Hackensack Hospital
- Hackensack Meridian
- Hackensack University Medical Center
- Health Care Facilities
- Heart Association
- Holy Name Hospital
- Hospitals
- Local Boards of Health
- Long-Term Care Facilities
- Medication Assistance Programs
- Mobile Clinics
- Northwest Bergen Regional Health Commission
- Online Multi-Language Information
- Parks and Recreation
- Physical Therapy
- Rehabs for Recovery
- Senior Citizen Programs
- Shirvan Family Live Well Center
- ShopRite
- Skilled Nursing Facilities
- Stroke Centers
- Urgent Care Facilities
- Valley Health Community Benefit Department
- Valley Hospital System
- Walking Groups
- Wellness Centers
- Women, Infants and Children
- YMCA/YWCA

Infant Health & Family Planning

- Baby Basics
- Bergen County Family Planning
- Bergen Volunteer Medical Initiative
- Birthright
- Community Outreach
- Community-Based Health Centers
- Doctors' Offices
- Englewood Hospital
- HAARP
- Hackensack Health Department
- Hackensack Meridian
- Holy Name Hospital
- Hospitals
- Lifenet
- Lighthouse
- Maternal Child Health
- New Hope Infant Resource Center
- North Hudson Community Action
- Planned Parenthood
- Shirvan Family Live Well Center
- Valley Hospital System

Injury & Violence

- 211
- Behavioral Health Services
- Bergen County Jail
- Center for Hope and Safety
- Charity Care Clinics
- Community Policing
- Community Safety Events
- Community-Based Programs for Shelter/Food
- County Resources
- Division of Child Protection and Permanency
- Hospitals
- Medical Care
- Neighborhood Watch
- Physical Therapy
- Police
- School System
- Self-Care

Mental Health

- 988
- Anti-Drug Programs
- Apps
- Arrive Together Initiative
- Behavioral Health Services
- Bergen County Department of Health Services
- Bergen County Division of Mental Health and Addiction
- Bergen Family Center
- Bergen New Bridge Medical Center
- Bergen Volunteer Medical Initiative
- Bergen's Promise
- Body Positive Works

- Bridgeway
- Buddies of NJ
- Care Plus
- Center for Alcohol and Drug Resources
- Children's Aid and Family Services
- Children's Mobile Crisis Response and Stabilization
- Christian Healthcare Center
- Collaborative Support Programs of New Jersey
- Community Mental Health Organizations
- Community Outreach
- Community Support Groups
- Community-Based Education Programs
- Community-Based Health Centers
- Community-Based Programs for Shelter/Food
- Comprehensive Behavioral Health Care
- Counseling
- Defining Moment Foundation
- Department of Community Affairs
- Division of Child Protection and Permanency
- Doctors' Offices
- Employee Assistance Programs
- Englewood Health
- Food Bank/Food Pantry
- Hackensack Hospital
- Hackensack University Medical Center
- Health Department
- High Focus
- Holy Name Hospital
- Home Health Visits
- Hospitals
- Insurance Companies
- Intensive Outpatient Treatment
- Library
- Lukin Center
- Medical Care
- Medicare
- Mental Health Association of New Jersey
- Mental Health Center
- Mental Health Literacy
- National Alliance on Mental Illness
- National Institute of Mental Health
- New Jersey Help Lines
- North Hudson
- Pascack Mental Health Center
- Perform Care
- Pines Bergen Health
- Police
- Private Mental Health Services
- Project Hope
- Ridgewood Community Center
- School System
- Sober Living
- Spring House for Women
- Substance Use Treatment/Partial Program
- Supreme Consultants
- Team Management 2K
- Telehealth Services
- The Counseling Center at Fair Lawn
- Town Hall
- Valley Health Community Benefit Department
- Valley Hospital System
- Valley Psychiatry
- Vantage Health
- Virtual Therapy Providers
- Wellspring
- West Bergen Mental Health
- Westwood Walk-In Center

Nutrition, Physical Activity & Weight

- Bergen County Health Department
- Bergen Family Center
- Bergen Volunteer Medical Initiative
- Center for Food Action
- Children's Health Insurance Program
- Dietitians
- Doctors' Offices
- Englewood Health
- Englewood Health Department
- Englewood Hospital
- Faith-Based Organizations
- Federally Qualified Health Center
- Fitness Centers/Gyms
- Food Bank/Food Pantry
- Hackensack Hospital
- Health Department
- HealthBarn
- Holy Name Hospital
- Hospitals
- Lifetime Fitness
- Live Well Center
- Nonprofits
- North Hudson Community Action
- Nutrition Centers
- Nutritionists
- Parks and Recreation
- Pilates Programs
- Rodda Center
- Safe/Well Lit Place to Walk
- School System
- Shirvan Family Live Well Center
- ShopRite
- Telehealth Services
- Town or Country Free Exercise Classes

Valley Health Community Benefit Department
Valley Hospital System
Wellness Events
YMCA/YWCA

Oral Health

Bergen Community College
Board of Education Dental Health Program
Community Support Groups
Dental Offices
Federally Qualified Health Center
Hackensack Meridian
Hackensack University Medical Center
Health Screenings
Hospitals
North Hudson Community Action
School System

Respiratory Diseases

American Lung Association
Bergen County Health Department
Bergen New Bridge Medical Center
Community Outreach
Community-Based Education Programs
Doctors' Offices
Englewood Health
Englewood Hospital
Hackensack Hospital
Hackensack Meridian
Hackensack University Medical Center
Holy Name Hospital
Hospitals
Pulmonary Rehab
Quit Centers
Smoke Enders
Stop Smoking Resources
Valley Hospital System
Walgreens

Sexual Health

Doctors' Offices

Social Determinants of Health

211
Behavioral Health Services
Bergen Community College
Bergen County Center for Food Action
Bergen County Community Action
Bergen County Department of Health Services
Bergen County Department of Human Services
Bergen County Department of Social Services
Bergen County Division of Senior Services
Bergen County Housing Authority
Bergen Family Center
Bergen New Bridge Medical Center
Bergen Volunteer Medical Initiative
Board of Social Services
Breast Cancer Center
Bright Side Family
Cancer Education and Early Detection Program
Center for Food Action
Children's Aid and Family Services
Children's Health Insurance Program
Community Chest
Community Development Block Grants
Community Health Nurses
Community-Based Organizations
Education Through Science-Based Programs
Englewood Health
Environmental Programs
Fair Housing
Faith-Based Organizations
Family Promise
Family Support Organization
Federally Qualified Health Center
Food Bank/Food Pantry
Greater Bergen Community Action
Hackensack Hospital
Health and Human Services Center
Health Department
Hearts
HHH Center
Hospitals
Housing
In the Meantime
Jewish Family and Children's Services of Northern NJ
Library
Lighthouse
Making-It-Home
Media
Medical Care
Medicare
Metro Community Center
NAACP
Parks and Recreation
Police
Quit Centers
School System
Social Services

State/County Senior Services Department
Town Boroughs
Transition Professionals
Valley Hospital System
Women, Infants and Children
Women's Right Information Center
YMCA/YWCA

Substance Use

AA/NA
Absolute Awakenings
Behavioral Health Services
Bergen County Adolescent Substance Misuse Program
Bergen County Department of Health Services
Bergen County Prosecutor's Office
Bergen New Bridge Medical Center
Black Poster Project
Buddies of NJ
Care Plus
Center for Alcohol and Drug Resources
Children's Aid and Family Services
ChoicePoint
Community-Based Organizations
Court House
Defining Moment Foundation
Englewood Health
Eva's Village
Evergreen
Faith-Based Organizations
Hackensack Hospital
High Focus
Holy Name Hospital
Hospitals
Inpatient Rehab
Inpatient Unit for Substance Misuse
Integrity House
Intensive Outpatient Treatment
Medical Care
Narcan
Police
Ridgewood Community Center
School System
Social Services
Spring House for Women
Stop Smoking Resources
Team Management 2K
The Counseling Center at Fair Lawn
Urgent Care Facilities
Vantage Health
West Bergen Mental Health

Tobacco Use

Behavioral Health Services
Bergen County Prevention Coalition
Bergen New Bridge Medical Center
Center for Alcohol and Drug Resources
Community-Based Organizations
County Resources
Doctors' Offices
Faith-Based Organizations
Hackensack Meridian
Health Department
Holy Name Hospital
Hospitals
Medical Care
New Jersey Help Lines
Public Service Announcements
Quit Centers
Quitline
School System
State Resources
Stop Smoking Resources
Youth Tobacco Action Group

APPENDICES

APPENDIX I: DEMOGRAPHIC SAMPLE COMPARISONS

The following table compares the results for select indicators in the service area in comparison to benchmark data, as well as by select demographic characteristics. The highlighted cells reflect responses that are significantly higher than those of one or more opposing groups, as determined by statistical testing.

ENGLEWOOD HOSPITAL	Very Low Income	Low Income	Mid/High Income	White	Hispanic	Asian	Black/AA	LGBTQ+	Service Area	Bergen County	NJ	US
Health Literacy												
"Seldom/Never" understand written health information	17.4%	9.9%	10.2%	9.7%	12.0%	10.1%	11.8%	11.9%	**10.6%**	8.0%	—	10.0%
"Seldom/Never" understand spoken health information	13.0%	9.1%	4.9%	3.6%	9.9%	5.4%	7.0%	9.8%	**6.4%**	6.8%	—	7.5%
Wellness & Prevention: Access												
No health insurance (age 18-64)	14.0%	9.0%	4.7%	2.1%	9.9%	4.8%	11.7%	9.4%	**6.9%**	6.7%	11.4%	8.1%
Difficulty accessing health care in past year	66.6%	50.7%	52.1%	49.0%	60.7%	50.4%	47.4%	66.3%	**53.7%**	51.2%	—	52.5%
No routine checkup in past year	22.7%	27.1%	25.1%	21.3%	27.2%	23.2%	25.3%	19.8%	**23.7%**	23.6%	20.8%	34.7%
Did not have Pap smear in past 2 years (women 21-65)	29.0%	26.2%	16.4%	15.2%	23.3%	29.5%	17.8%	35.3%	**20.7%**	19.4%	—	24.6%
Wellness & Prevention: Nutrition & Exercise												
Overweight or obese (BMI≥25)	62.9%	73.0%	64.6%	63.1%	72.6%	39.7%	65.8%	70.1%	**65.1%**	65.0%	64.8%	63.3%
Do not meet physical activity recommendations	79.8%	74.7%	68.3%	67.8%	74.6%	74.6%	67.3%	76.5%	**70.7%**	69.2%	68.7%	69.7%
Food insecure	77.1%	68.4%	26.4%	25.9%	47.6%	28.9%	54.0%	46.1%	**38.3%**	26.6%	—	43.3%
Difficult to find fresh produce	44.5%	37.8%	20.4%	19.4%	33.3%	12.5%	24.6%	28.3%	**25.4%**	23.6%	—	30.0%
Chronic & Complex Conditions												
Ever told have high blood pressure	42.3%	41.2%	38.5%	45.0%	37.3%	27.0%	40.9%	42.8%	**39.9%**	37.8%	33.4%	40.4%
Ever told have diabetes	25.0%	11.4%	12.1%	12.9%	15.6%	13.9%	11.4%	12.2%	**13.9%**	10.8%	10.5%	12.8%
Ever told have borderline/pre-diabetes	12.3%	14.3%	17.6%	15.5%	22.4%	15.8%	11.9%	23.6%	**17.3%**	19.6%	—	15.0%
Currently have asthma	20.0%	17.4%	11.2%	10.6%	15.4%	8.2%	13.6%	11.1%	**13.0%**	10.7%	8.6%	17.9%
[Child] Ever told has asthma	15.5%	18.5%	8.3%	6.3%	12.2%	11.8%	19.4%	25.8%	**10.9%**	9.6%	—	16.7%
Behavioral Health												
Symptoms of chronic depression	60.6%	51.5%	35.9%	34.0%	50.4%	31.6%	46.9%	65.7%	**41.8%**	37.1%	—	46.7%
Unable to get MH services in past year	22.7%	11.2%	6.8%	7.8%	10.7%	4.4%	12.5%	22.9%	**9.4%**	8.8%	—	13.2%
Adults who smoke cigarettes	36.8%	25.6%	14.8%	17.6%	19.5%	9.1%	24.1%	25.3%	**18.3%**	9.2%	9.1%	23.9%
Adults who use vaping products	26.3%	21.6%	12.7%	12.6%	18.6%	9.8%	13.6%	28.2%	**15.1%**	11.2%	6.3%	18.5%
Adults with heavy/binge drinking	19.6%	25.7%	22.5%	25.4%	19.4%	15.5%	21.2%	28.7%	**21.4%**	19.4%	15.7%	34.3%
Life impacted by own or someone else's substance use	39.8%	39.5%	32.4%	38.5%	32.5%	13.6%	39.3%	43.8%	**34.5%**	32.8%	—	45.4%
Adults who use THC products	24.6%	27.3%	19.2%	18.3%	22.6%	13.3%	32.7%	48.9%	**21.2%**	20.1%	—	n/a

Note: Highlighted cells reflect a high prevalence in comparison to one or more opposing groups, based on tests for statistical significance.

APPENDIX II: FINDINGS FROM FOCUS GROUPS & KEY INFORMANT INTERVIEWS

Methods

Including the voices of residents, community leaders, and health and social services providers in our community enriches our understanding of statistical data, revealing insights into the gaps in care that individuals face and how service providers can collaborate to address these issues. These conversations are essential for developing practical, localized solutions designed to improve the quality of life for everyone in Bergen County, New Jersey, as part of the CHNA process.

35th Street Consulting, a New Jersey-based, woman-owned business, has been hired by the Bergen County Community Health Improvement Partnership (CHIP) to conduct interviews with community leaders and facilitate focus groups comprising individuals from various backgrounds within Bergen County. In 2025, 35th Street Consulting conducted one-on-one interviews with fourteen community leaders and held nine focus groups, totaling 48 individuals. All interviewees and focus group participants were selected by members of Bergen County CHIP.

Aligned with best practices, 35th Street Consulting employs Community-Based Participatory Research (CBPR) methods to engage stakeholders and gather diverse perspectives, defining and solving challenges alongside the individuals who experience them. CBPR is a partnership approach to research that involves stakeholders, organizational representatives, and researchers in the research process and honors participants' expertise and input in co-developing solutions.

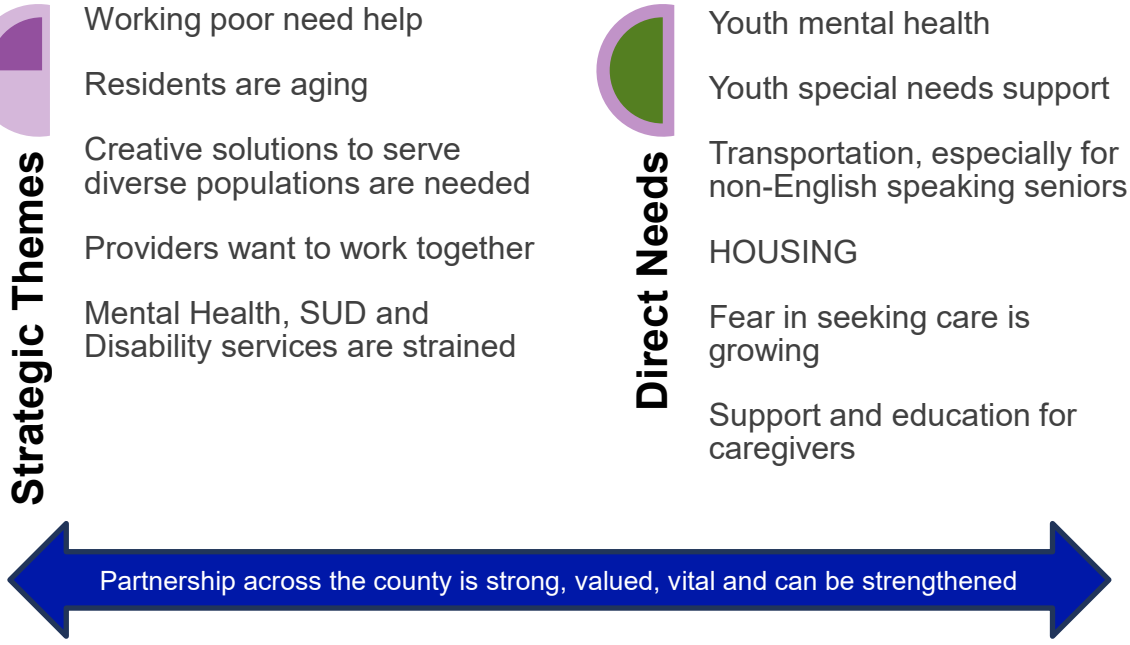
Key Informant Interviews

Incorporating viewpoints from various community leaders through one-on-one, in-depth conversations provides a broad and high-level community perspective on different segments of the population. In-depth interviews offer an opportunity to engage leaders from traditional partners, as well as hard-to-reach and historically underrepresented groups, at the beginning of the Community Health Needs Assessment (CHNA) process. This approach helps to gain insight into local strategic thinking and fosters connections with leaders from segments of the population where there is an interest in exploring solutions to address existing needs.

35th Street Consulting conducted fourteen interviews with selected strategic leaders identified by the Bergen County Community Health Improvement Partnership (CHIP) partners. These leaders represent a wide range of leadership expertise from across Bergen County. The one-on-one conversations proved invaluable for delving deeply into the experiences of different stakeholder groups, capturing unique perspectives, gathering input on priority needs, and generating recommendations for addressing issues at a systemic level.

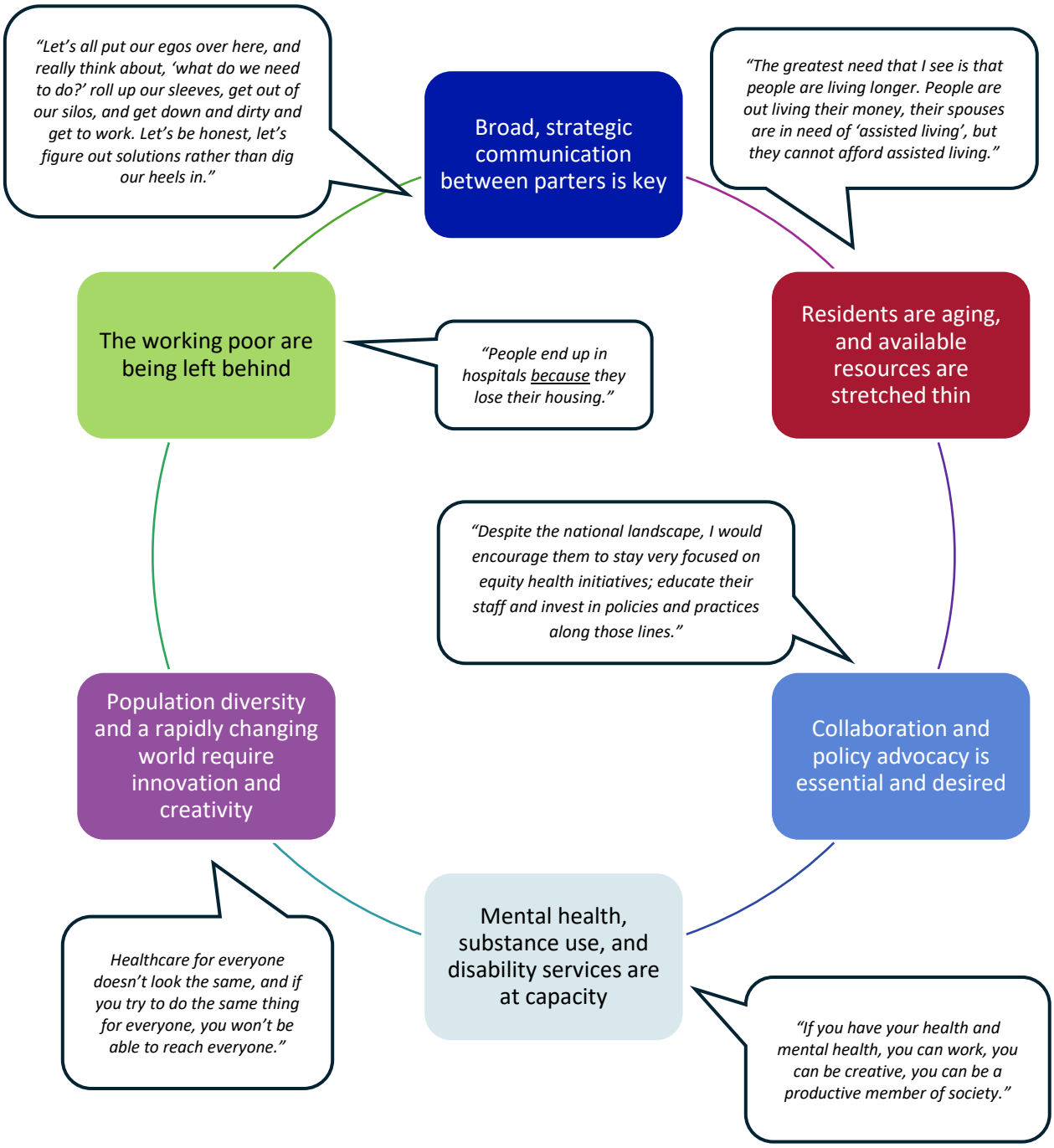
Key informants participated in one-hour interviews via Zoom with qualitative researchers from 35th Street Consulting between January and March 2025. The discussions focused on perceptions of community strengths and needs, as well as observations of emerging trends at the organizational, local, regional, state, and national levels. Respondents had the opportunity to share their priorities and concerns regarding their organizations and the communities they serve. Each interviewee was also asked to describe the actions and initiatives they would most like to support through their participation.

The analysis of the data from the interviews yielded both strategic themes and direct needs.



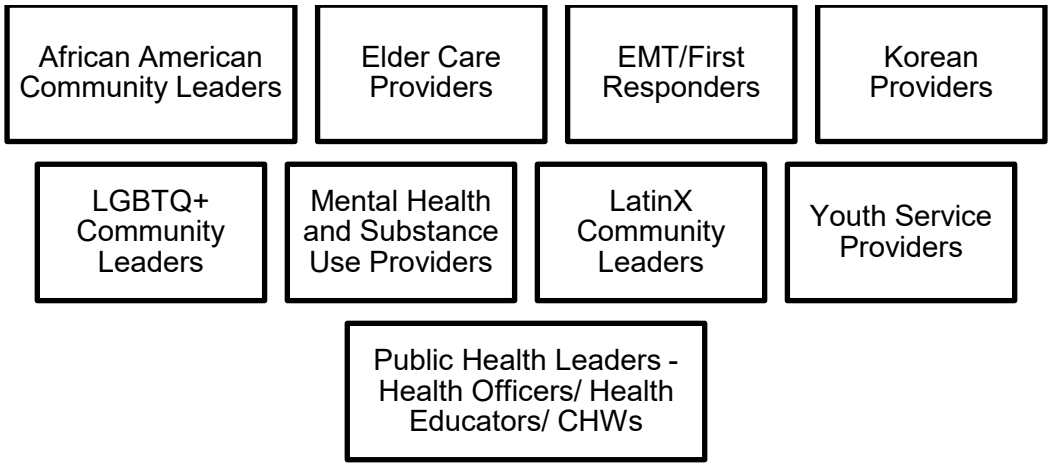
Key Informant Interview Summary

The following graphic details the sentiments and specific statements from the Key Informant Interviews.



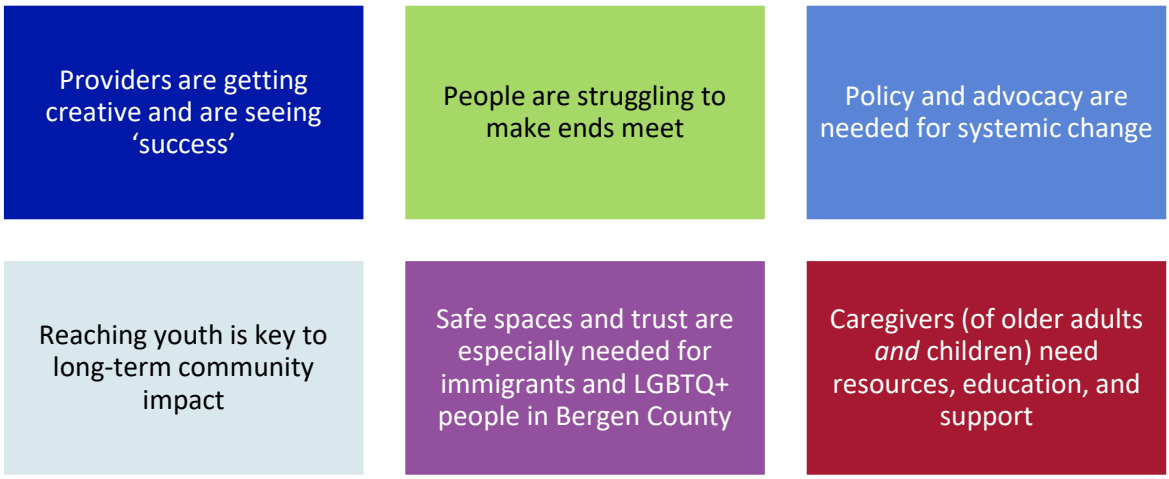
Focus Groups

Focus groups offer an opportunity to uncover the "why" behind differences revealed through quantitative data. Through in-depth discussions in small groups, facilitators gather candid feedback on participants' experiences, attitudes, awareness, and ideas regarding their experiences and quality of life living in Bergen County, New Jersey. These insights are crucial for developing relevant and actionable plans that engage the enthusiasm, resources, and interests of the community being served. From April to June 2025, 35th Street Consulting conducted nine focus groups with 48 individuals representing or directly serving populations that have historically been underrepresented in community planning and decision-making. Focus groups included people representing the following populations in Bergen County:



Focus Group Summary

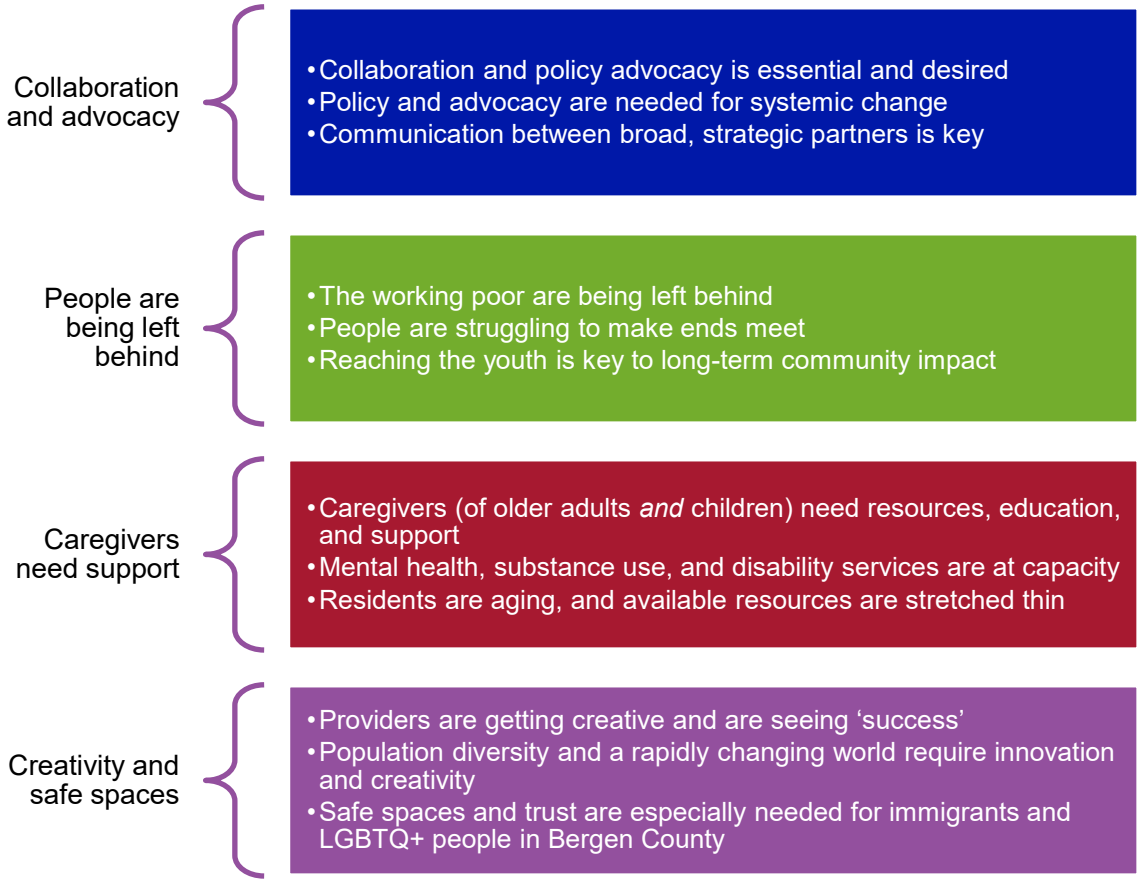
The nine focus group conversations explored strengths, challenges, barriers, and useful tools that participants utilize in their lives and in their work. Participants were also asked to identify priorities that they believe would have the greatest impact on the well-being of themselves and the people they serve. Analysis of the conversations with all the groups yielded the following themes, many of which are consistent with the Key Informant Interview themes:



Aligning Qualitative Themes

Overarching themes: Bergen County CHIP Key Informant Interviews and Focus Groups, 2025

Two key qualitative research methods – one-on-one interviews and focus groups - were used to gather insights and ideas about the strengths, needs and barriers, and solutions experienced by diverse people throughout Bergen County. Sixty-two individuals from Bergen County, representing a wide range of perspectives, participated in the Key Informant Interviews and Focus Groups between January and June 2025. While details and nuances varied, several common themes emerged from the discussions. The following concepts reflect the consistent sentiments revealed in all the conversations.



APPENDIX III: EVALUATION OF PAST ACTIVITIES

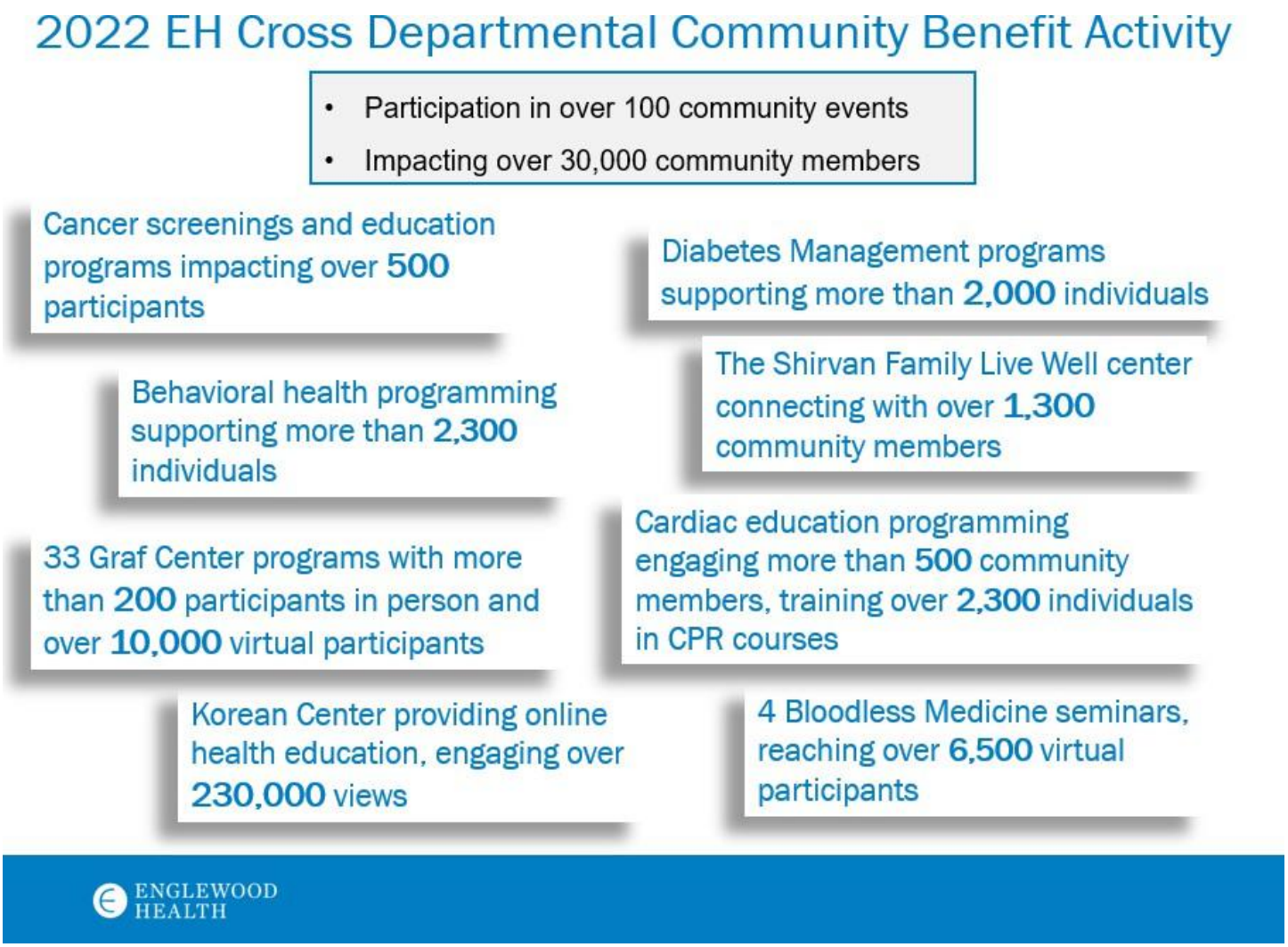
ENGLEWOOD HEALTH

Year End Report 2022

2020-2022 Community Health Needs Assessment

OVERVIEW

This 2022 Community Health Needs Assessment Year End Report contains highlights of key initiatives, as well as 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 lingering impact of the COVID-19 pandemic, Englewood Health engaged our patients and community members in a wide range of impactful educational opportunities, prevention programs, and wellness efforts. A portion 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 our 2020 – 2022 implementation strategy, based on the results of 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 their contributions towards our 2022 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

Englewood Health (EH) remained actively committed to efforts around cancer care and detection. EH promoted and led several programs to educate community members on the importance of receiving regular cancer screenings and early detection. EH's Cancer Education and Early Detection (CEED) Program, funded through the New Jersey Department of Health, Division of Family Health Services, screened more than 240 patients for breast and cervical cancers in 2022. The Screen NJ Grant supported an EH initiative to provide colonoscopies and lung CT screenings for 43 patients, in collaboration with Rutgers and the Korean Health and Wellness team.

EH continued its strong focus on the Diabetes Education and Support 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 worked in conjunction with the North Hudson Community Action Corporation to provide needed diabetes support and education to its patient population. This included providing free diabetes testing supplies for uninsured women with gestational diabetes as well as dietary counseling and education. Lastly, the Diabetes Program also connected patients in need to discount prescription programs to obtain insulin and other necessary medications.

The EH Korean Health and Wellness Center continues to successfully engage the Korean population with their large-scale virtual health platform, which supports health education programming efforts. The team has provided education to the Korean population on a wide range of important health issues including neurology, pain management, and COVID safety information. This digital effort resulted in over 233,000 views in 2022 alone. These videos have informed millions of viewers over the years with timely medical information on various chronic conditions. As we resume in-person programs, three members of the Korean Team have been certified as health education facilitators and will be able to bring additional free health

programs to the community in 2023. Additionally, this year the Korean Team connected members of the community to important cancer resources, including free lung cancer screenings and free smoking cessation programs.

EH promoted the cardiac health and wellness of community members through training and educational programming. In 2022, over 200 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.

For stroke health, EH urgent care centers held heart screenings by taking blood pressure and BMI assessments. EH also sponsored the American Heart Association's Tri-County Cycle Nation event, which focused on stroke awareness. The American Heart Association Heart Walk promoting stroke awareness was also sponsored by Englewood Health.

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, lifestyle choices and understanding bloodless medicine. Four virtual seminars were held, reaching approximately 7,300 participants.

The Population Health Care Management Team led a chronic care management program for 440 patients with the goal of more effectively managing chronic conditions and medication adherence. Additionally, the team developed and piloted a Cardiac Care program focused on engaging cardiac patients in a skills-based program around exercise, healthy eating, stress management, and effective medication management while dealing with a chronic condition.

The EH Population Health Department's Live Well Center team has had a significant impact on our community through its integration with community agencies and engagement of their respective audiences. The diverse programming, frequently produced in English and Spanish, engages middle school and high school youth, adults and seniors. The programming provides education and hands-on interactive experiences building skills to support emotional, physical,

and nutritional wellness. This specifically includes yoga, art therapy, and stress management resources, as well as the development of healthy culinary skills in the kitchen and working with fitness experts to get in better shape and build new habits.

EH expanded its focus on the social determinants of health. In 2022, EH screened more than 40,000 patients for food insecurity and connected those who screened positive to local food resources. As a result of additional screenings through EH Inpatient Care Coordination, North Hudson Community Action Corporation Clinic, and more physician practices, in total almost 500 patients were identified as food insecure. Continuing its Food Insecurity Response Initiative (FIRI), EH partnered with the Bergen County Food Security task force and created a series of nutrition education events at five Bergen County Food Pantries. These events included live demonstrations utilizing the typical ingredients provided by food pantries and preparing them in appetizing and nutritious ways to serve to food pantry clients. Additionally, an EH Registered Dietitian was available to answer questions and provide education. EH also distributed a newly developed guide on "How to Prepare Healthy Meals Using Food Pantry Ingredients" In English and in Spanish. Over 10,000 guides were distributed to the broader food pantry system in Bergen County. EH also addressed the transportation challenges of populations in the community needing better access to healthcare by providing free Uber Health transportation to medical visits. This translated into over 41,500 rides in 2022.

EH provided further support to the behavioral health of the community, as the residual effects of the pandemic have resulted in an even greater demand for services. EH continued its partnership with the Bergen Family Center to provide youth and adult art therapy workshops, emotional wellness presentations and yoga that reached a combined 200 participants. The annual Behavioral Health Conference was held virtually with 82 behavioral health professionals in attendance. The topic was "Universality of Trauma". EH has employed an Emergency Department Health Equity Social Worker to screen ED patients on social determinants of health

and connect patients to the appropriate resources. A cannabis edibles safety campaign was launched to the public, and additional resources were used to address opioid misuse and general substance misuse education.

A detailed account of all 2022 programming designed to meet Englewood Health's four overarching community health 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 2023.

A total of **30** 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/Stroke, Immunizations and Infectious Diseases, Behavioral Health, Bloodless Medicine and Surgery, Cancer, Emergency Medical Services, Diabetes Education, Live Well Center, Population Health and the Korean Health and Wellness Center. The participants included:

Name	Title
Debra Albanese	VP of Development
Ashley Arellano	Director, Cancer Treatment and Wellness
Andrew Brunnquell	Population Health Coordinator, Behavioral Health
Yamaris Cajamarca	Population Health Coordinator, Live Well Center
Michael Chananie	Director, Public Affairs and Marketing
Ramon Correa	Manager, Bloodless Medicine and Surgery
Barbara Grygotis	Senior Director, Cardiac Surgery
Christine Hamel	Manager, Special Projects

Sooyun Lee	Public Relations Specialist, Korean Health and Wellness
Linda Leighton	Nurse Manager, Behavioral Health
Eunice Jung	Population Health Coordinator, Community Health
Jamie Ketas	VP of Population Health
Cynthia Lewis-Kroning	Program Manager, Graf Center
Danielle Lambert	Manager Behavioral Health, Population Health
Mary O'Connor	Director, Diabetes Education Program
Alicia Park	VP of Communications
Dr. Dipal Patel	Associate Program Director, Internal Medicine Residency Program
Dr. Natasha Rastogi	Associate Director of Ambulatory Care
Mekesha Samuel	Program Manager, Live Well Center
Lauren Savage	Director of Social Work, Population Health
Peter Shin	Chief of Medicine, Department of Medicine
Nancy Solomon	Program Coordinator, Bloodless Medicine
Richard Sposa	Director, Emergency Medical Services
Diana Torres	Manager, Infection Prevention
Cindy Varona	Program Coordinator, Live Well Center
Deborah Weinstein	Senior Director, Population Health Management
Christina Weiselberg	Administrative Director, Breast Care Center
Jennifer Yanowitz	Manager of Strategic Programming, Population Health
Ethan Yoon	Public Relations Specialist, Korean Health and Wellness
Christine Young	Manager, Ambulatory Care Management, Population Health

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 hosted two health fairs in April and July with the charity organization, Save Latin America, in Union City, where representatives from the Live Well Center, Cardiac health and Diabetes Education provided education, resources, and references for over 1,300 community members.
- 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 30 online meditation workshops for the community with over 8,200 participants. Meditations were held in both English and Spanish for several community agencies and available for community members to stream from home.
- The Bloodless Medicine and Surgery Department hosted 4 virtual health seminars in 2022. The topics included information on ways to better care for your health and lifestyle choices, understanding bloodless medicine at Englewood Health, and how health care has changed since COVID-19. The seminars were virtually attended by a combined 7,500 individuals.
- Through its digital platform, EH provided COVID-19 information updates and delivered important medical information to the Korean population using YouTube videos. The combined informational materials, videos, articles, and physician podcasts resulted in almost 2 million views.
- EH used the grant from Screen NJ from 2021 to screen 43 eligible Korean community individuals for lung and colon cancers in 2022.

Live Well			
Date	Activity/Topic	Program Purpose	Results
1/19/22	Partnership for Healthy Eating Dinner (Meal Kit)	Education & Awareness	15 attendees
2/3/22	BFC Senior Adult Day Program Series*	Education & Awareness	15 attendees
2/10/22 & 2/17/22	Live Well Nutritionally (2-part series)	Education & Awareness	12 attendees
2/28/22	Cooking Concepts	Education & Awareness	13 attendees
3/14/22	Live Well Nutritionally (2-part series)	Education & Awareness	12 attendees
3/15/22	Food Pantry Event at Office of Concern Food Pantry at St. Cecilia	Education & Awareness	250 attendees
3/24/22	Food Pantry Event at Dumont Senior Center	Education & Awareness	60 attendees
3/28/22	Live Well Nutritionally (Spanish)	Education & Awareness	8 attendees
4/5/22	Food Pantry Event at Meadowlands YMCA	Education & Awareness	150 attendees
4/6/22	The Zone Program	Education & Awareness	22 attendees
4/11/22	Live Well Nutritionally (LIVE)	Education & Awareness	38 attendees
5/11/22	Partnership for Healthy Eating (Virtual)	Education & Awareness	25 attendees
5/13/22	Bergen County Food Security Task Force Summit	Education & Awareness	100 attendees
6/12/22	Metro Community Church – Open Store Event	Education & Awareness	400 attendees
6/18/22	Juneteenth	Education & Awareness	150 attendees

6/22/22	Women's Rights Information Center (WRIC) – Summer Wellness Program	Education & Awareness	10 attendees
7/11/22	HS Wellness Program	Education & Awareness	12 attendees
7/23/22	Save Latin America Health Fair	Education & Awareness	300 attendees
8/1/22	Diabetes Presentation w/ Mary O'Connor	Education & Awareness	15 attendees
8/10/22	Youth Apprenticeship Career Day Presentation	Education & Awareness	27 attendees
9/14/22	SESCIL Social	Education & Awareness	60 attendees
10/11/22	MetroLIFE – Youth Wellness Program (10 sessions)	Education & Awareness	12 attendees
10/17/22	BFC – Family Success Center Caregivers	Education & Awareness	9 attendees
10/23/22	Breast Cancer "A Walk for Awareness"	Education & Awareness	80 attendees
10/26/22	Englewood DOH – Get Fit in the Fall (4x)	Education & Awareness	17 attendees
10/27/22	BFC – Adult Day Program (6 sessions)	Education & Awareness	16 attendees
10/27/22	Harvest Festival	Education & Awareness	300 attendees
11/7/22	BFC – SESCIL (6 sessions)	Education & Awareness	14 attendees
11/7/22	BFC – Family Success Center (Spanish)	Education & Awareness	15 attendees
11/16/22	BFC – Hippy	Education & Awareness	13 attendees

Graf Center			
Date	Activity/Topic	Program Purpose	Results
Weekly Zoom	Meditation In Spanish	Education	3,680 attendees
Weekly Zoom	Yoga for Breast Cancer	Education	121 attendees
Weekly Zoom	Yoga for Recovery	Education	3,985 attendees
Weekly Zoom	Meditation & Movement	Education	4,659 attendees
Weekly Zoom	Meditation for Depression/Anxiety	Education	1,725 attendees
1/6/22	Nutrition Workshop: Food science 101 - Being healthy is not a trend	Education	5 attendees
1/24	Massage Workshop: Reiki for strengthening the Immune System	Education	15 attendees
2/3/22	Nutrition Workshop: Heart health	Education	41 attendees
2/21/22	Heart Health Acupuncture Workshop	Education	14 attendees
2/23/22	Heart Smart daily exercises workshop	Education	15 attendees
3/2/22	Pain Management Acupuncture Workshop	Education	20 attendees
3/3/22	Nutrition Workshop: Pre-natal/post-natal	Education	38 attendees
3/7/22	Massage Workshop: What is manual Lymphatic drainage?	Education	26 attendees
3/23/22	Tools to support wellness: teachers 1.5 dev. hours/ Chip/Braven health/ Nutrition & Meditation	Education	43 attendees
4/6/22	Nutrition Workshop: IBS: supporting a healthy gut	Education	7 attendees

4/27/22	Parkinson's Acupuncture Workshop	Education	10 attendees
5/4/22	Gut Health Acupuncture Workshop	Education	12 attendees
Summer	Meditation& Yoga on the lawn	Education	25 attendees
Summer	3 classes a week: Parks & Recreation camp - Jersey City	Education	100 attendees
7/11/22	Nutrition for the classroom: Using mindfulness/Med 1.5 Dev. Hours	Education	27 attendees
7/19/22	Sports injuries Acupuncture Workshop	Education	9 attendees
7/20/22	Balancing Hormones Acupuncture Workshop	Education	17 attendees
8/11/22	Nutrition Workshop: Whole Foods Tour	Education	6 attendees
8/22/22	Nutrition for the classroom: Using mindfulness/Med 1.5 Dev. Hours	Education	55 attendees
9/11/22	Nutrition Workshop: Choosing healthy snacks/back to school	Education	13 attendees
9/21/22	Stress & Anxiety Acupuncture Workshop	Education	1 attendee
10/13/22	Zen Den: Aromatherapy	Education	8 attendees
10-17-10/21	Nutrition Workshop: Lunch & Learn - Cancer	Education	21 attendees
10/26/22	Cancer Acupuncture Workshop	Education	7 attendees
10/26/22	"C" word: cancer Workshop	Education	3 attendees
11/17/22	Shersheret Empowerment for Cancer Patients	Education	10 attendees
Various 12 classes	Story time - meditation for tots with music & story in public local libraries	Education	300 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 2022. Over 200 individuals participated and were screened.
- The North Hudson Community Action Corporation Englewood Health Center screened over 50 individuals for colon cancer in 2022.
- The Korean Communication team distributed 43 FIT kits to community members for colon cancer screening. The team organized free screenings, scheduled screenings, and provided additional resources to individuals with abnormal results.

Objective 3: Implement programs and events with local and regional collaboratives that address issues related to wellness, prevention and risk factors.

- EH's Live Well Center focuses on the 3 tenets of good health: emotional, nutritional and physical wellness. The programs are implemented in collaboration with local agencies in the community and are conducted in multiple languages.
- 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 guides were formally distributed to community food pantry partners in 2022.
- 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.

Objective 4: Expand upon our system wide care management program

- EH has employed an Emergency Department Health Equity Social Worker to screen ED patients on social determinants of health and connecting patients to the appropriate resources.
- EH expanded 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, Englewood Health Physicians' offices, and In-

patient care coordination. (see Priority Area: Social Determinants of Health and Access to Care, Goal 4).

- In 2022, EH hired an additional two care coordinators (now totaling 13 Care Coordinators) spread across 16 EHPN practices focused on supporting patient needs and navigating their medical care
- The care coordination team also expanded geographically into Essex County furthering the opportunity to better engage and support patients in need.

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

- EH held a Cardiovascular Disease Management Program that aided patients in behavior modification around exercise, healthier behaviors, medication management, and emotional wellness while living with a chronic condition. 8 participants completed the program.
- The Korean Center outreach to the community included a focus on cardiovascular and blood clot-related articles and podcasts aimed at 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.
- Cardiologists in the physician network hosted a free monthly virtual series on various cardiac related topics.
- In November 2022, EH hosted a Live Heart Healthy Program, focusing on hypertension, nutrition, cholesterol, mental health, and fitness.

Cardiovascular			
Date	Activity/Topic	Program Purpose	Results
11/3/2022	Live Heart Healthy Program	awareness, risk factors, education, health promotion	16 attendees
November, December 2022	Dr. Suede Virtual Heart Health Seminars	Awareness & Education	30 attendees
May 2022	American Heart Association's Tri-County Cycle Nation	Awareness & Education	25 attendees
October 2022	American Heart Association Heart Walk	Awareness & Education	100 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 240 patients over the course of 2022.
- The Cancer Center screened over 20 individuals for lung cancer (See Priority Area: Wellness & Prevention, Goal 1).

Cancer			
Date	Activity/Topic	Program Purpose	Results
3/18/22, 3/25/22	Colorectal Cancer Screenings	Screening	16 screened
10/23/22	Breast Cancer "A Walk for Awareness"	Education & Awareness	Over 500 attendees
10/29/22	Breast Cancer Screenings	Screening, Education, & Awareness	39 attendees
11/12/22	Lung Cancer Screening	Screening, Education, & Awareness	27 screened

Improve health status of patients with cardiovascular disease

- EH held a Cardiovascular Disease Management Program that aided patients in behavior modification around exercise, healthier behaviors, medication management, and emotional wellness (See Priority Area: Chronic and Complex Conditions, Goal 2).

Improve health status of patients with diabetes

- Diabetes management resources were provided at large EH events, such as Save Latin America Health Fair.
- Diabetes prevention and management presentations were conducted and educated over 500 community members.
- EH continued to screen for Gestational Diabetes among the uninsured women in the community. 83 women were screened for gestational diabetes in 2022. In addition, 22 women were provided with nutrition and dietary counseling related to their pregnancies.

Diabetes			
Date	Activity/Topic	Program Purpose	Results
2/10/2022	Eating on a Budget	Education	10 attendees
4/24/22	Save Latin America Health Fair	Screening, Education, & Awareness	1000 attendees
4/24/2022	Diabetes Prevention and Management/ Pentecostal Church, NJ Region, Women Ministry	Risk factors, Prevention, healthy behaviors, health promotion	300 attendees
8/1/2022	Diabetes Presentation	Education & Awareness	15 attendees
9/17/22	Community Baptist Church block party	Diabetes awareness, risk factors, education	200 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.
- As stated previously, 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.
    - There are over 2,000 care plans under Englewood Health, with over 200 patients being “high-risk”.

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 2022. These campaigns covered Mental Health Awareness Month in May and opioid misuse prevention in October.
- Englewood Hospital has an ongoing media campaign for edible safety, informing patients on safe storing of edibles and cannabis education.
- 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 2022.
- 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 increased need of behavioral health services due to the impact of COVID-19. 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 2022, EH continued using 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 Live Well group partnered with the Bergen Family Center to provide educational programs for the seniors who attend the adult day program.
- 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
2/10/2022	Mykee Fowlin Performance	Education & Awareness	40 attendees
2/24/2022-3/24/2022	Palestroni Art Therapy Series with BFC	Education & Awareness	11 attendees
3/3/2022, 3/10/2022	Bergen Family Center: Adult Creative Art Therapy	Education & Awareness	15 attendees
3/8/2022-3/17/2022	Coffee and Self-Care with the Nurtured Heart Approach	Education & Awareness	32 attendees
3/1/2022-ongoing	Edible Safety Campaign	Education & Awareness	Ongoing campaign
3/30/2022	Teens for Peace (BFC & Englewood Rotary Club)	Education & Awareness	13 attendees
May 2022	ECT Information Video	Education & Awareness	Ongoing campaign
5/19/2022	Tips for Caring for Individuals with Dementia	Education & Awareness	12 attendees
6/9/2022	Get Connected: Mental Health and Substance Misuse	Education & Awareness	60 attendees
9/29/2022	Cannabis Safety Town Hall	Education & Awareness	36 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, 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

- As noted earlier, 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. 431 patients were identified as food insecure: 294 individuals were identified through Englewood Health and 137 individuals were identified through the North Hudson Community Action Corporation Englewood Health Center. 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.

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 into 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 41,500 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 2022 the FIRI program expanded to include the Emergency Department and the North Hudson Community Action Corporation.
    - Nearly 38,000 patients were screened for food insecurity in 2022.
    - About 200 patients were connected with local resources.
- In 2022, additional Hudson County food partners were provided to better connect patients and community members to food resources.
- In 2022, the Live Well Center distributed the "A Guide to Healthy Eating with Food Pantry Ingredients" booklets to local food pantry clients. EH provided 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.

- EH will open the Shirvan Family Live Well Center in 2023 to engage and educate at-risk populations on preventative health and wellness measures. The center will be located at 59 W. Palisade Ave in downtown Englewood and all services provided will be free.
- In 2022, EH expanded its urgent care centers and are now located in downtown Englewood, Jersey City, Fair Lawn, and Cresskill: providing increased access to convenient care.

Bloodless Medicine			
Date	Activity/Topic	Program Purpose	Results
1/29/22	Spanish seminar: *Mejorando su Salud en 2022*	Education & Awareness	750 attendees
2/26/22	Seminar: AHealthier You in 2022	Education & Awareness	1,531 attendees
6/25/22	Seminar: Continue to Strive for Good Physical and Mental Health in 2022	Education & Awareness	2,500 attendees
10/15/22	Seminar: How Healthcare Has Changed Since Covid	Education & Awareness	2,500 attendees

EMS			
Date	Activity/Topic	Program Purpose	Results
4/19/2022	Girl Scout EMS Demonstration	Education & Awareness / Community Safety	20 attendees
2/2/2022 - 11/30/22	EMS Training	Training	225 attendees

Korean Communications			
Date	Activity/Topic	Program Purpose	Results
8 sessions	Smoking cessation video series	Education	147 participants 5 CT lung screening 21 referred to screening
1/17/2022	YouTube video: Covid 19 Vaccine - Omicron symptoms and vaccine passes	Education and Community Needs	22,182 views
1/22/2022	YouTube video: Covid 19 Vaccine - Paxlovid and other Covid treatments	Education and Community Needs	1,631 views
2/21/2022	YouTube video: Covid 19 Vaccine - Is Novavax safe? Side Effects? Mixing vaccines?	Education and Community Needs	45,322 views
2/28/2022	YouTube video: Covid 19/Cardiology - What are some post Covid effects? Higher risk of heart disease?	Education and Community Needs	134,805 views
3/10/2022	YouTube video: Covid 19/Medication - Using Pepcid as Covid treatment	Education and Community Needs	1,647 views
3/20/2022	YouTube video: Covid 19 - New Omicron variant: BA2	Education and Community Needs	3,015 views
3/27/2022	YouTube video: Covid 19 - Who are super-immuned to Covid, Natural killer cells?	Education and Community Needs	9,316 views
5/15/2022	YouTube video: Covid 19 - Vaccine Who should get the second booster?	Education and Community Needs	5,374 views
6/19/2022	YouTube video: Covid 19/Cardiology - Those who experience long Covid and when to seek medical help	Education and Community Needs	1,164 views
7/18/2022	YouTube video: Chronic conditions - Things you need to know about diabetes	Education and Community Needs	723 views
7/24/2022	YouTube video: Neurology - Stroke in the summer and mini stroke	Education and Community Needs	677 views
8/21/2022	YouTube video: Neurology - The danger of brain aneurysm	Education and Community Needs	793 views

9/11/2022	YouTube video: Covid 19 Vaccine - What is the bivalent vaccine and comparing with other Covid vaccines	Education and Community Needs	1,121 views
9/18/2022	YouTube video: Neurology - What is Autism spectrum disorder?	Education and Community Needs	466 views
10/17/2022	YouTube video: Covid 19 Vaccine - Covid Vaccine 2nd Booster and Flu Shot Doctor Experience	Education and Community Needs	317 views
10/18/2022	Covid 19 Vaccine Same Day Covid Booster and Flu Shot Thoughts	Education and Community Needs	1,909 views
11/9/2022	Pain Management When to use heat or cold therapy	Education and Community Needs	901 views
11/17/2022	Gastroenterology Needs Importance of Endoscopy and Colonoscopy	Education and Community	1,373 views
12/11/2022	Pain Management Chronic and Acute Pain Management and Treatment	Education and Community Needs	646 views

COMMUNITY BENEFIT REPORT

ENGLEWOOD HEALTH

Care that transforms. Care you can trust.

OVERVIEW

The 2023 Community Health Benefit Report provides a high-level overview of key initiatives and activities provided by Englewood Health to support the health and well-being of the populations served. Englewood Health is dedicated to engaging our patients and community members in a wide range of educational opportunities, prevention programs, and wellness efforts with the goals of improving access, enhancing the health of the community, advancing healthcare knowledge, and offsetting the burden of government or other community efforts.

ENGLEWOOD HEALTH SYSTEM PROFILE

Englewood Health is a health system comprising Englewood Hospital, an acute care community teaching hospital, and the Englewood Health Physician Network, a network of more than 600 providers.

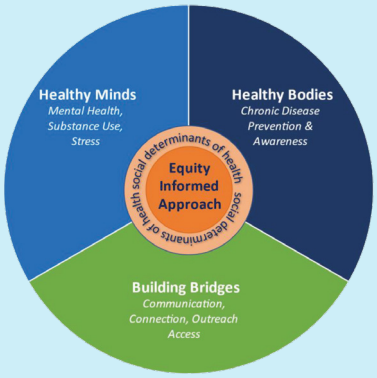
1 HOSPITAL
100+ LOCATIONS

- **1,200+** Physicians and other providers
- **100+** Locations in **5** counties
- **4** Urgent care centers
- **4** Imaging centers
- **1** Outpatient behavioral health center
- **2** Community education and resource centers
- **1** Integrative medicine center
- **8** Training programs for students, residents/fellows, and professionals

STRATEGIC FOCUS 2023-2025

Englewood Health's health equity and population health efforts work in harmony. The health system implements targeted outreach to underserved communities to enhance individual and public health, prevent disease, support lifelong wellness, reduce the burden of mental health challenges and substance use disorders, and meet the specific needs of diverse populations. An essential component to all of these initiatives is to remove any barriers to vital resource connections, to further enable community members to have access to the resources and tools they need to live their healthiest lives.

The criteria for the Englewood Health community health initiatives are guided by our 2023–2025 implementation strategy, based on the results of the 2022 Community Health Needs Assessment. The plan focuses on the development of **Healthy Minds, Healthy Bodies and Building Bridges**. Our goals are achieved by optimizing Englewood Health's internal network to increase capacity and access; engaging, educating, and screening its community members; and strengthening its community partnerships



COMMUNITY BENEFIT ACTIVITIES

- Community Health Education
- Community Health Screenings
- Immunization Clinics
- Meals and Nutrition Access
- Clinical Research Studies
- Health Professional Education
- Health Partnerships and Collaboration
- Charity Care

2023 HIGHLIGHTS: HEALTH EQUITY, ACCESS, EDUCATION, AND PREVENTION

The Shirvan Family Live Well Center

The 2023 opening of the center is a proactive strategy to improve the lifestyle choices, health knowledge, and skill levels among our community members to help prevent chronic diseases and support those with existing conditions. This innovative center, launched in downtown Englewood, focuses on nutritional, emotional, and physical wellness. The program offerings are scalable, comprehensive, and are designed to promote systemic behavioral lifestyle changes for all ages. In 2023, the program recruited more than 2,000 participants.

Asian Health and Wellness

In 2023, the Englewood Health Physician Network opened an Asian Health and Wellness site to better meet the healthcare needs of the Korean and Chinese populations in Northern New Jersey. The site helps community members access optimal medical care by reducing financial, cultural and language barriers. With a focus on chronic disease prevention and early detection, the site offers services such as patient and financial navigation and assistance with social services and crisis support. Additionally, the team works with other departments at Englewood Health to provide both in-person and virtual educational programs. Recent programs provided health education on diabetes, hepatitis, dementia, and behavioral health conditions.

Health Screenings & Education Initiatives

In 2023, Englewood Health implemented a wide range of public health education programs as well as an extensive series of free public health screenings. The events were predominantly conducted at community-based locations to increase accessibility and engagement. The education efforts included CPR and AED training, stroke detection, addiction understanding and awareness, diabetes, dementia and aging, nutrition, heart health, women's health and other topics. Cancer screenings were conducted for lung, breast, colon, and prostate throughout a large number of underserved communities, thereby broadening access to care and improving health outcomes

Strategic Leadership Appointments

Englewood Health continues to invest strategically in essential staff positions to further support the strategic plan. This includes hiring Anita Ramsetty, MD, as Director of Health Equity. In this new role, Dr. Ramsetty is responsible for shaping the health system's efforts to advance health equity. She focuses on developing programs and resources to address social determinants of health, remove barriers to care and education, and reduce health disparities across Englewood Health's patient populations and the communities it serves. As part of its continued expansion of mental health services for the community, Englewood Health has appointed Magdalena Spariosu, MD, as its new Director of Behavioral Health. In this new role, Dr. Spariosu spearheads strategic planning and clinical oversight for both inpatient and outpatient behavioral health services, with a focus on expanding access to compassionate, patient-centered, evidence-based care.

Expansion of Care

In 2023, Englewood Health increased access by implementing targeted growth strategies focusing on the needs of the individual communities served. This included the development of the East Campus in Englewood Cliffs, providing more than 45,000 sq. ft. of multispecialty offices. Additionally Englewood Health expanded its medical specialty resources including obesity medicine, addiction medicine, endocrinology, oncology and more at sites across the region including Jersey City.

600 Englewood Health implemented close to 600 programs

50,000 These programs impacted more than 50,000 individuals*

2,000 Close to 2,000 patients received charity care

*Includes digital programming

COMMUNITY BENEFIT REPORT

ENGLEWOOD HEALTH

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- Community Health Screenings
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- Clinical Research Studies
- Health Professional Education
- Health Partnerships and Collaboration
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2024 HIGHLIGHTS

Supporting a Healthier Community: A Year of Outreach and Care

In 2024, through a wide range of initiatives and outreach programs, our dedicated teams made a significant impact on the lives of countless individuals. We conducted over 138,000 Social Determinants of Health (SDOH) screenings to better understand and address the needs of our patients. Additionally, our Find Help digital resource program launched in July 2024 and is integrated into our electronic health record system. In the first five months of using this new system, we connected nearly 900 patients with identified needs to essential resources and services. For the first time, we hosted a screening event on the annual Lung Cancer Screening Day, a nationwide initiative to promote early lung cancer detection through low-dose computed tomography (LDCT) screenings, and our year-to-date total now surpasses 2,300 individuals screened. Englewood Health hosted more than 400 educational events and health lectures, empowering more than 21,000 community members with valuable health knowledge. These remarkable achievements underscore our strong commitment to delivering comprehensive care that extends beyond hospital walls, and we remain dedicated to fostering a healthier community.

Successfully Leveraging Digital Engagement to Improve Access

Accessibility to care is essential to supporting the health of the populations we serve. Englewood Health has revolutionized important aspects of care and engagement through tailored messaging and access options. Through automated digital campaigns, we have connected to thousands of patients, empowering them to take charge of their health. With self-scheduling links, phone options, and soon, virtual agents, we have made healthcare more accessible and convenient. This effort has achieved strong results, with over 10,000 patients scheduling their own mammogram screenings, colorectal screenings, and annual physicals. Soon, we will be able to send text messages in multiple languages, further personalizing the patient experience. As we move forward, we continue to explore innovative solutions, such as generative AI virtual agents, to engage patients in their preferred language and ensure a seamless experience.

The Shirvan Family Live Well Center

In 2024, the Shirvan Family Live Well Center empowered individuals to take control of their health and well-being through free education, hands-on classes, and workshops. Building on its mission, the center provided a range of programs and services promoting healthy living, disease prevention, and overall wellness. With over 6,200 participant visits, close to 900 classes, and almost 40 health talks from Englewood Health clinicians, the center is making a positive impact. Health education topics have included diabetes, cancer, women's health, behavioral health, heart health, and general health, which have been well-received. The efforts have led to 90% of the audience feeling knowledgeable and more equipped to manage, understand and navigate their own health needs and wellbeing.

Advancing Maternal Health and Wellness

Maternal health is a pressing national public health issue, with 80% of pregnancy-related deaths being largely preventable (CDC). In response, Englewood Health expanded its focus on maternal health programming and initiatives across multiple areas. As research has shown that healthy behaviors, such as regular exercise, balanced nutrition, and emotional wellness reduce the risk of pregnancy complications and contribute to long-term maternal and infant health, the Maternal Healthy Living Program was launched in spring 2024. This program, held at the Shirvan Family Live Well Center, provides comprehensive prenatal classes focused on three key wellness areas: physical, emotional, and nutritional wellness. Through health education and practical application, the program aimed to equip women with tools to maintain healthy lifestyles during pregnancy, and beyond.

The Maternal Child Health Blood Pressure Monitoring Program, launched December 2023, provides blood pressure monitoring packs to antepartum and postpartum patients with hypertension disorders. In its first year, 204 packs were distributed to patients. The program includes a blood pressure machine, educational materials, tracking journals, instructions for self-monitoring, and guidance on when to seek medical attention. Eligible patients are educated on using blood pressure machine, including a teach-back session with a nurse before discharge, to ensure understanding. The program aims to empower patients to manage their blood pressure and seek timely medical attention, if needed.

Expansion of Behavioral Health Services and Care

Englewood Health has made significant strides in expanding its behavioral health services, focusing on accessibility, addiction support, and destigmatizing mental health needs. To achieve this, the organization has invested in educational events, awareness campaigns, and critical expansion of services. We recently opened a dedicated behavioral health access center, designed to triage and connect individuals with the appropriate resources, including psychiatrists, social workers, and other essential services.

In 2024, the Emergency Department expanded its substance misuse screening program, and has since screened over 20,000 patients. This initiative enables the healthcare team to identify individuals struggling with addiction and provide them with connections to resources and care. To increase local access to these services, we launched a comprehensive addiction medicine program, led by Dr. Sharde McLeish. By providing personalized care, screenings, medication-assisted treatments, and behavioral interventions, the program aims to support individuals struggling with addiction on their journey to recovery and wellness.

600 Englewood Health implemented close to 600 programs

36,000 These programs impacted more than 36,000 individuals*

2,000 Close to 2,000 patients received charity care

*Includes digital programming