Summary Report

2016 Community Health Needs Assessment Report

Ramapo Ridge Psychiatric Hospital
Total Service Area

Professional Research Consultants, Inc.

CHRISTIAN HEALTH CARE CENTER
MEMORANDUM

Date: December 6, 2016

From: Douglas A. Struyk, President and CEO

Re: Community Health Needs Assessment

In accordance with IRS regulations adopted several years ago, all hospitals are required to complete a Community Health Needs Assessment (CHNA) every three (3) years. Our Ramapo Ridge Psychiatric Hospital causes this requirement to apply to Christian Health Care Center, albeit with an understandable focus on how our available mental health services can meet community need. We completed our first CHNA in 2013 and, now three years later, we are undergoing the same process.

In order to complete an orderly and efficient CHNA, we have repeated our 2013 process by joining with Bergen County's other hospitals (Englewood, Hackensack, Hackensack at Pascack Valley, Holy Name, and Valley) as well as the Bergen County Department of Health in a joint process. The intention is that an effective and comprehensive assessment will identify community needs that the hospitals can then use to generate action plans (i.e. what can we do to meet these community needs?).

At the December 1, 2016 Christian Health Care Center Board of Trustees meeting, Cathy Pilone, Director of Patient/Resident Experience, and our representative to the joint CHNA process referred to above, presented the outcomes of the 2013 process and efforts that are underway, thus far, for the 2016 process which will be followed in early 2017, with an action plan that we will present and review with the board. The Board of Trustees accepted and unanimously approved the 2016 Community Health Needs Assessment for Ramapo Ridge Psychiatric Hospital, which was completed in accordance with Federal requirements.

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Introduction

Professional Research Consultants, Inc.

About This Assessment

A Community Health Needs Assessment (CHNA) is a systematic, data-driven approach to determining the health status, behaviors and needs of residents. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness. A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This CHNA for Ramapo Ridge Psychiatric Hospital is part of a broader regional assessment made possible through the generous support of Christian Health Care Center (Ramapo Ridge Psychiatric Hospital), Englewood Hospital and Medical Center, Hackensack University Medical Center, HackensackUMC at Pascack Valley, Holy Name Medical Center, and The Valley Hospital. Representatives from each of these hospitals, along with representatives of the Bergen County Department of Health Services (BCDHS) and the Community Health Improvement Partnership (CHIP) of Bergen County, worked collaboratively to guide assessments of health needs for Bergen County and for the specific communities served by each hospital.

This Community Health Needs Assessment was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994. Subsequent implementation planning for the county and hospital sponsors, based on the findings of this assessment, will be conducted with the assistance of Strategy Solutions, Inc., a consulting group with more than 20 years of experience in community health planning.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the county, state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey of various community stakeholders.

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 Community Health Improvement Partnership of Bergen County and PRC.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Total Service Area" in this report) is defined as each of the residential ZIP Codes comprising Ramapo Ridge Psychiatric Hospital's primary and secondary service

areas. The primary service area, determined based on the ZIP Codes of residence of recent patients of the hospital, accounts for 41% of overall admissions, which is a lower percentage than is typical for most acute care hospitals; however, as a specialty provider for psychiatric services, Ramapo Ridge Psychiatric Hospital's total catchment area is extremely large, and many of its patients are drawn from a large number of ZIP Codes not necessarily contiguous or near the hospital. This community definition is illustrated in the following map.
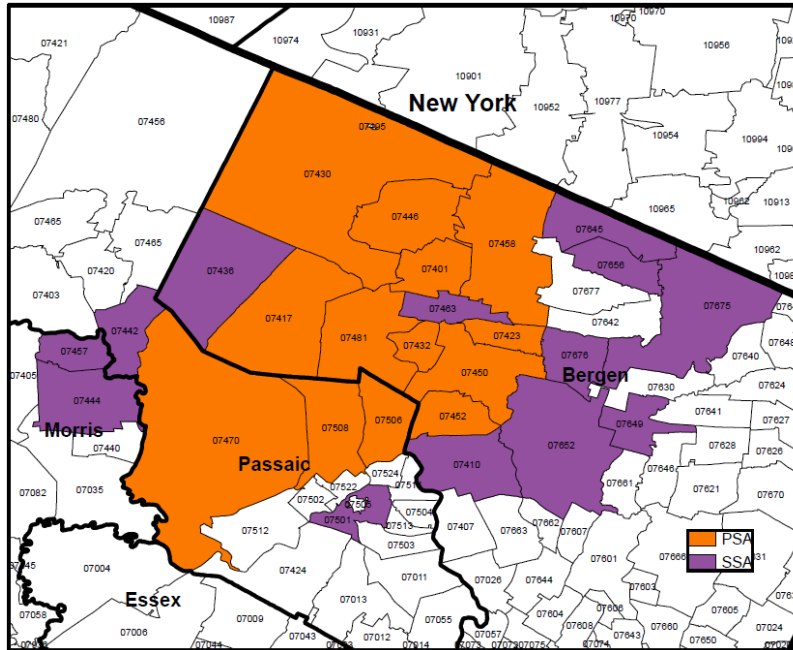
Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a random sample of 438 individuals age 18 and older in the Total Service Area, including 213 in the primary service area and 225 in the secondary service area of Ramapo Ridge Psychiatric Hospital. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Total Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

For statistical purposes, the maximum rate of error associated with a sample size of 438 respondents is ±4.7% at the 95 percent level of confidence.
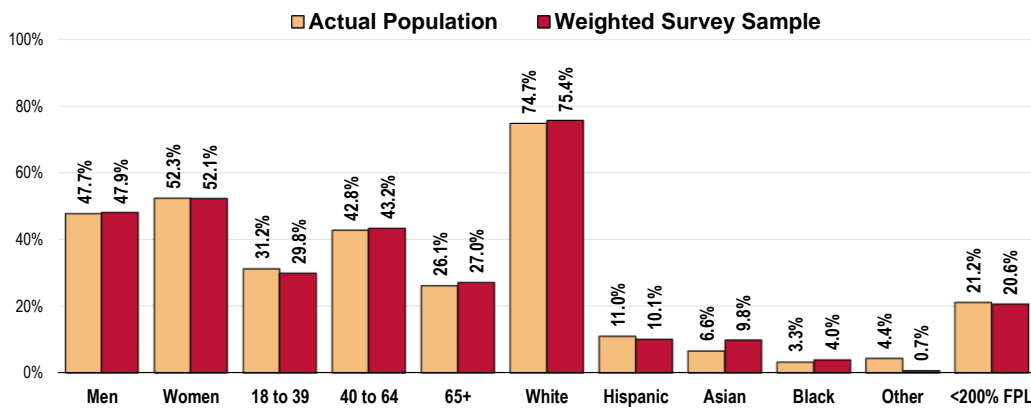
Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, 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 Total 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 healthcare needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(Total Service Area, 2016)

	Actual Population	Weighted Survey Sample
Men	47.7%	47.9%
Women	52.3%	52.1%
18 to 39	31.2%	29.8%
40 to 64	42.8%	43.2%
65+	26.1%	27.0%
White	74.7%	75.4%
Hispanic	11.0%	10.1%
Asian	6.6%	9.8%
Black	3.3%	4.0%
Other	4.4%	0.7%
<200% FPL	21.2%	20.6%

Sources: ● Census 2010, Summary File 3 (SF 3). US Census Bureau.
          ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc.
Notes: ● Actual poverty data is estimated based on county poverty estimates and population counts.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2015 guidelines place the poverty threshold for a family of four at $24,250 annual household income or lower)*. In sample segmentation: "**low/mid income**" refers to community members living in a household with defined poverty status or earning up to 400% of the poverty threshold; "**high income**" refers to those households living on incomes which are 400% or more the federal poverty level.

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 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, 75 community stakeholders in Bergen County took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	**Number Invited**	**Number Participating**
Physician	7	3
Other Health (Non-Physician)	47	32
Public Health Expert	11	8
Social Services Representative	50	22
Community/Business Leader	25	10

Final participation included representatives of the organizations outlined below.

- Bergen County Cancer Education and Early Detection
- Bergen County Department of Health Services
- Bergen County Department of Human Services
- Bergen County School Nurses Association
- Bergen County Special Services
- Bergen County United Way
- Bergen County Youth Services Commission
- Bergen Regional Medical Center
- Bergen Volunteer Center
- Bergenfield/Hackensack Health Departments
- Brightview Senior Living
- CancerCare
- Care Plus Medical Services
- Center for Dentistry at HUMC
- Children's Aid and Family Services

- Christian Health Care Center
- Edgewater Office of Public Health/Health Department
- Englewood Health Department
- Fair Lawn Senior Center
- Friends to Friends Community Church
- Geriatric Services, Inc.
- Gold's Gym
- Hackensack University Medical Center
- HARP of Hackensack University Medical Center
- Healthy Families North Jersey
- High Focus Centers
- Holy Name Medical Center
- Jewish Family Service of Bergen and North Hudson
- Metropolitan AME Zion Church
- Narcotics Anonymous
- North Hudson Community Action Corp Health Center

- Northern Valley ADC
- Paramus Board of Health and Human Services
- Partnership for Maternal and Child Health of North NJ
- Pascack Valley Meals on Wheels
- Senior Source
- Teaneck Health Department/Social

- Services
- Teaneck Police Department
- Community Health Improvement Partnership (CHIP) of Bergen County
- Valley Health System
- Valley Home Care
- West Bergen Mental Healthcare

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

Minority/medically underserved populations represented:

African-Americans, Asians, children, day laborers, the disabled, elderly population, foster children, those with high deductibles, Hispanics, the homeless, immigrants, Koreans, residents with low education level, low income residents, Medicare/Medicaid recipients, the mentally ill, MICA clients, Native Americans, non-English speaking persons, obese individuals, students attending schools in low income areas, teenage mothers, undocumented individuals, unemployed residents, the uninsured/underinsured, veterans

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 be better 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.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)

- Truven Health Analytics and Dignity Health
- 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

Benchmark Data

Bergen County Survey Data

Because this survey was also conducted throughout Bergen County as part of a broader study facilitated by the Community Health Improvement Partnership of Bergen County, comparisons can be made at the county level.

New Jersey Risk Factor Data

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

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2015 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback
process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 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 secondary data indicators (which do not carry sampling error, but might be subject to reporting error), "significance," for the purpose of this report, is determined by a 5% 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 or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

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

IRS Form 990, Schedule H Compliance

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

IRS Form 990, Schedule H (2015)	See Report Page
Part V Section B Line 3a *A definition of the community served by the hospital facility*	5
Part V Section B Line 3b *Demographics of the community*	33
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*	148
Part V Section B Line 3d *How data was obtained*	5
Part V Section B Line 3e *The significant health needs of the community*	14
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*	15
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	7
Part V Section B Line 3i *Information gaps that limit the hospital facility's ability to assess the community's health needs*	11

Summary of Findings

Professional Research Consultants, Inc.

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 and the guidelines set forth in Healthy People 2020. 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); 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.

Areas of Opportunity Identified Through This Assessment	

Access to Healthcare Services	• Barriers to Access
	  ○ Inconvenient Office Hours
	  ○ Appointment Availability
	  ○ Cost of Physician Visit (Secondary Service Area)
	• Specific Source of Ongoing Care (Secondary Service Area)
	• Children's Dental Care

Cancer	• *Cancer is a leading cause of death.* • Cancer Incidence ○ Including Prostate Cancer, Female Breast Cancer Incidence • *Cancer ranked as a top concern in the Online Key Informant Survey.*
Dementia, Including Alzheimer's Disease	• *Dementias/Alzheimer's Disease ranked as a top concern in the Online Key Informant Survey.*
Diabetes	• *Diabetes ranked as a top concern in the Online Key Informant Survey.*
Heart Disease & Stroke	• *Cardiovascular disease is a leading cause of death.* • High Blood Cholesterol Prevalence • High Blood Cholesterol Screening (Secondary Service Area) • *Heart Disease & Stroke ranked as a top concern in the Online Key Informant Survey.*
Mental Health	• Seeking Help for Mental Health • *Mental Health ranked as a top concern in the Online Key Informant Survey.*
Immunizations & Infectious Disease	• Septicemia Deaths
Nutrition, Physical Activity & Weight	• Children's Physical Activity • Daily Fruit/Vegetable Consumption (Secondary Service Area)
Respiratory Diseases	• Environmental Exposure to Smoke (Primary Service Area) ○ Including Among Households With Children
Substance Abuse	• Current Drinking • Seeking Help for Alcohol/Drug Issues • *Substance Abuse ranked as a top concern in the Online Key Informant Survey.*

Prioritization of Health Needs

On August 4, 2016, Ramapo Ridge Psychiatric Hospital, along with the Bergen County Department of Health Services and the other hospitals sponsoring the broader Bergen County assessment project, convened a group of community stakeholders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss and prioritize health issues for Bergen County, based on findings of the countywide Community Health Needs Assessment (CHNA). The results of this prioritization will inform the selection of priorities for each of the hospitals in its respective service area.

Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
    - How many people are affected?
    - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
    - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

    Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. **Substance Abuse**

2. **Mental Health**

3. **Diabetes**

4. **Nutrition, Physical Activity, & Weight**

5. **Access to Healthcare Services**

6. **Heart Disease & Stroke**

7. **Dementias, Including Alzheimer's Disease**

8. **Immunization & Infectious Diseases**

9. **Cancer**

10. **Respiratory Diseases**

While the hospital will likely not implement strategies for all of these health issues, the results of this prioritization exercise will be used to inform the development of Ramapo Ridge Psychiatric Hospital's Implementation Strategy to address the top health needs of the community in the coming years.

Summary Tables:
Comparisons With Benchmark Data

The following tables provide an overview of indicators in the Total Service Area. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Data Summary Tables

■ In the following charts, Total Service Area results are shown in the larger, blue column.

■ The green columns [to the left of the Total Service Area column] provide comparisons between the primary service area and the secondary service area, identifying differences for each as "better than" (☀), "worse than" (🐙), or "similar to" (☁) the opposing service area.

■ The columns to the right of the Total Service Area column provide comparisons between local data and any available county, state and national findings, and Healthy People 2020 targets. Symbols indicate whether the Total Service Area compares favorably (☀), unfavorably (🐙), or comparably (☁) to these external data.

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

Social Determinants	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Linguistically Isolated Population (Percent)			7.5		🌧 6.8	🌧 4.7	
Population in Poverty (Percent)			7.5		☀ 10.7	☀ 15.6	
Population Below 200% FPL (Percent)			18.6		☀ 24.6	☀ 34.5	
Children Below 200% FPL (Percent)			20.8		☀ 31.5	☀ 44.2	
No High School Diploma (Age 25+, Percent)			8.5		☀ 11.6	☀ 13.7	
Unemployment Rate (Age 16+, Percent)			3.8		☀ 4.8	☀ 5.2	
% Worry/Stress Over Rent/Mortgage in Past Year	☁ 33.3	☁ 30.2	31.6	☁ 33.6		☁ 31.6	
% Worried About Food in the Past Year	☁ 12.6	☁ 19.0	16.0	☁ 17.2		☀ 21.0	

Social Determinants (continued)

Social Determinants (continued)	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% Ran Out of Food in the Past Year	☀ 6.2	🌧 12.3	9.5	☀ 13.9		☀ 19.9	
% Food Insecure	☁ 14.2	☁ 19.9	17.2	☁ 19.5		☀ 25.9	

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

☀ better ☁ similar 🌧 worse

Overall Health

Overall Health	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% "Fair/Poor" Physical Health	☁ 11.1	☁ 10.6	10.8	☁ 10.5	☀ 16.9	☀ 18.3	
% Activity Limitations	☁ 12.9	☁ 18.7	16.0	☁ 20.2	☁ 16.3	☁ 20.0	

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

☀ better ☁ similar 🌧 worse

Access to Health Services

Access to Health Services	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	☀ 2.4	🌧 8.8	5.7	☁ 5.6	☀ 15.0	☀ 10.1	🌧 0.0
% [Insured 18-64] Have Coverage Through ACA	☁ 7.9	☁ 12.9	10.5	☁ 9.3		☁ 10.8	
% Difficulty Accessing Healthcare in Past Year (Composite)	☁ 39.8	☁ 38.3	39.0	☁ 40.7		☁ 35.0	
% Inconvenient Hrs Prevented Dr Visit in Past Year	☁ 18.8	☁ 22.4	20.7	☁ 21.5		🌧 14.4	
% Cost Prevented Getting Prescription in Past Year	☁ 5.1	☁ 5.2	5.1	☀ 8.7		☀ 9.5	
% Cost Prevented Physician Visit in Past Year	☀ 5.8	🌧 15.3	10.7	☀ 15.5		☁ 11.5	

Access to Health Services (continued)	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% Difficulty Getting Appointment in Past Year	☁ 25.7	☁ 18.8	22.2	☁ 19.2		🌧 15.4	
% Difficulty Finding Physician in Past Year	☁ 12.2	☁ 8.7	10.4	☁ 11.5		☁ 8.7	
% Transportation Hindered Dr Visit in Past Year	☁ 4.2	☁ 4.5	4.4	☁ 6.5		☁ 5.0	
% Language/Culture Prevented Care in Past Year	☁ 1.4	☁ 0.0	0.7	☀ 2.7		☁ 1.7	
% Skipped Prescription Doses to Save Costs	☁ 5.9	☁ 8.6	7.3	☀ 10.5		☁ 10.2	
% Difficulty Getting Child's Healthcare in Past Year	☁ 4.2	☁ 3.9	4.1	☁ 8.3		☁ 3.9	
% Have Completed Advance Directive Documents	☁ 41.1	☁ 32.5	36.6	☁ 33.7		☁ 33.7	
% Low Health Literacy	☁ 26.6	☁ 21.9	24.1	☁ 22.2		☁ 23.3	
Primary Care Doctors per 100,000			125.4		☀ 85.6	☀ 74.5	
% [Age 18+] Have a Specific Source of Ongoing Care	☀ 83.2	🌧 74.6	78.8	☁ 77.9		☀ 74.0	🌧 95.0
% [Age 18-64] Have a Specific Source of Ongoing Care	☁ 82.1	☁ 73.6	77.9	☁ 74.8		☁ 73.1	🌧 89.4
% [Age 65+] Have a Specific Source of Ongoing Care	☀ 90.5	🌧 77.3	83.2	☁ 88.0		☁ 76.8	🌧 100.0
% Have Had Routine Checkup in Past Year	☁ 69.5	☁ 64.1	66.7	☁ 71.2	🌧 75.9	☁ 70.5	
% Child Has Had Checkup in Past Year	☀ 97.6	🌧 84.3	90.4	☁ 85.4		☁ 89.3	
% Two or More ER Visits in Past Year	☀ 2.2	🌧 6.4	4.5	☀ 7.1		☀ 8.5	

Access to Health Services (continued)	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% Rate Local Healthcare "Fair/Poor"	☁ 4.2	☁ 8.4	6.5	☀ 11.9		☀ 14.2	

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

☀ better	☁ similar	🌧 worse

Arthritis, Osteoporosis & Chronic Back Conditions	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% [50+] Arthritis/Rheumatism	☁ 26.3	☁ 34.5	30.6	☁ 28.6		☁ 32.0	
% [50+] Osteoporosis	☁ 9.9	☁ 7.0	8.4	☁ 8.5		☁ 8.7	🌧 5.3
% Sciatica/Chronic Back Pain	☁ 16.6	☁ 15.3	15.9	☀ 20.7		☁ 19.4	
% Caregiver to a Friend/Family Member	☁ 14.9	☁ 22.0	18.6	☁ 22.1		☁ 20.9	

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

☀ better	☁ similar	🌧 worse

Cancer	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Cancer (Age-Adjusted Death Rate)			142.2	☀ 157.5	☀ 163.6		☀ 161.4
Lung Cancer (Age-Adjusted Death Rate)			32.6	☀ 38.5	☀ 43.4		☀ 45.5
Prostate Cancer (Age-Adjusted Death Rate)			5.9	☀ 18.5	☀ 19.2		☀ 21.8
Female Breast Cancer (Age-Adjusted Death Rate)			11.4	☀ 22.5	☀ 20.9		☀ 20.7

Cancer (continued)	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Colorectal Cancer (Age-Adjusted Death Rate)			12.8		(better) 15.0	(better) 14.6	(better) 14.5
Prostate Cancer Incidence per 100,000			149.0		(better) 157.3	(worse) 131.7	
Female Breast Cancer Incidence per 100,000			134.1		(similar) 130.2	(worse) 123.0	
Lung Cancer Incidence per 100,000			50.7		(better) 60.0	(better) 63.7	
Colorectal Cancer Incidence per 100,000			40.3		(better) 44.4	(similar) 41.9	
Cervical Cancer Incidence per 100,000			7.3		(better) 8.0	(better) 7.7	
% Cancer	(similar) 12.5	(similar) 8.2	10.2	(similar) 8.8			
% [Women 40+] Mammogram in Past 2 Years	(similar) 73.9	(similar) 71.8	72.8	(similar) 66.6	(similar) 74.4	(similar) 74.4	
% [Women 50-74] Mammogram in Past 2 Years	(similar) 73.0	(similar) 76.2	74.7	(similar) 72.2	(similar) 78.2	(similar) 80.3	(similar) 81.1
% [Women 21-65] Pap Smear in Past 3 Years	(similar) 83.5	(similar) 72.9	78.1	(similar) 74.5	(similar) 83.8	(similar) 84.8	(worse) 93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	(similar) 75.9	(similar) 74.6	75.2	(similar) 75.4	(better) 67.7	(similar) 75.6	
% [Age 50+] Blood Stool Test in Past 2 Years	(similar) 27.1	(similar) 28.0	27.5	(similar) 29.1	(better) 11.7	(similar) 31.8	
% [Age 50-75] Colorectal Cancer Screening	(similar) 76.5	(similar) 68.9	72.6	(similar) 72.8	(better) 65.0	(similar) 74.5	(similar) 70.5
% Difficulty Obtaining Cancer Screening in Past Year	(similar) 2.9	(similar) 4.9	4.0	(similar) 5.1			

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

better	similar	worse

Chronic Kidney Disease

Chronic Kidney Disease	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Kidney Disease (Age-Adjusted Death Rate)			12.1		☀ 13.5	☀ 13.2	
% Kidney Disease	⛅ 1.6	⛅ 0.6	1.1	☀ 3.1	☀ 2.4	☀ 3.6	

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

☀ better ⛅ similar 🌧 worse

Dementias, Including Alzheimer's Disease

Dementias, Including Alzheimer's Disease	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Alzheimer's Disease (Age-Adjusted Death Rate)			14.9		☀ 16.9	☀ 24.2	
% [Age 45+] Increasing Confusion/Memory Loss in Past Yr	⛅ 8.8	⛅ 6.8	7.7	⛅ 10.2		☀ 12.8	

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

☀ better ⛅ similar 🌧 worse

Diabetes

Diabetes	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Diabetes Mellitus (Age-Adjusted Death Rate)			14.0		☀ 19.3	☀ 21.1	☀ 20.5
% Diabetes/High Blood Sugar	☀ 6.1	🌧 11.5	8.9	⛅ 9.2	⛅ 9.7	☀ 14.5	
% Borderline/Pre-Diabetes	⛅ 5.6	⛅ 7.1	6.4	⛅ 8.6	🌧 1.4	⛅ 5.7	
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	☀ 62.0	🌧 49.4	55.5	⛅ 55.3		⛅ 55.1	

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

☀ better ⛅ similar 🌧 worse

Hearing & Other Sensory or Communication Disorders	PSA vs. SSA		**Total Service Area**	Total Service Area vs. Benchmarks			
	PSA	**SSA**		**vs. Bergen County**	**vs. NJ**	**vs. US**	**vs. HP2020**
% Deafness/Trouble Hearing	☁ 9.5	☁ 8.1	**8.8**	☁ 9.1		☁ 8.6	

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

☀ better ☁ similar 🌧 worse

Heart Disease & Stroke	PSA vs. SSA		**Total Service Area**	Total Service Area vs. Benchmarks			
	PSA	**SSA**		**vs. Bergen County**	**vs. NJ**	**vs. US**	**vs. HP2020**
Diseases of the Heart (Age-Adjusted Death Rate)			**143.9**		☀ 169.3	☀ 169.1	☀ 156.9
Stroke (Age-Adjusted Death Rate)			**27.2**		☀ 32.2	☀ 36.5	☀ 34.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	☁ 5.9	☁ 6.1	**6.0**	☁ 6.3		☁ 6.9	
% Stroke	☁ 1.7	☁ 2.8	**2.3**	☁ 3.4	☁ 2.6	☁ 2.6	
% Blood Pressure Checked in Past 2 Years	☀ 96.9	🌧 87.5	**92.0**	☁ 90.1		☁ 93.6	☁ 92.6
% Told Have High Blood Pressure (Ever)	☁ 34.6	☁ 34.0	**34.3**	☁ 36.9	☁ 31.1	☁ 36.5	🌧 26.9
% [HBP] Taking Action to Control High Blood Pressure	☁ 91.7	☁ 96.6	**94.1**	☁ 92.7		☁ 92.5	
% Cholesterol Checked in Past 5 Years	☀ 94.3	🌧 88.4	**91.3**	☁ 88.9	☀ 81.0	☀ 87.4	☀ 82.1
% Told Have High Cholesterol (Ever)	☁ 39.5	☁ 40.5	**40.0**	☁ 39.6		🌧 33.5	🌧 13.5
% [HBC] Taking Action to Control High Blood Cholesterol	☀ 86.1	🌧 73.6	**79.5**	☁ 83.4		☁ 84.2	
% 1+ Cardiovascular Risk Factor	☁ 81.1	☁ 82.5	**81.8**	☁ 83.1		☁ 83.0	

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

☀ better ☁ similar 🌧 worse

HIV

HIV	PSA	SSA	Total Service Area	vs. Bergen County	vs. NJ	vs. US	vs. HP2020
HIV/AIDS (Age-Adjusted Death Rate)			0.7		better 2.8	better 2.1	better 3.3
HIV Prevalence per 100,000			240.2		better 505.8	better 353.2	
% [Age 18-44] HIV Test in the Past Year			24.5	similar 29.1		similar 21.3	

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

Legend: ☀ better ☁ similar 🌧 worse

Immunization & Infectious Diseases

Immunization & Infectious Diseases	PSA	SSA	Total Service Area	vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% [Age 65+] Flu Vaccine in Past Year	similar 52.1	similar 53.1	52.7	similar 55.3	similar 59.4	similar 58.9	worse 70.0
% [High-Risk 18-64] Flu Vaccine in Past Year			42.6	similar 41.5		similar 48.0	worse 70.0
% [Age 65+] Pneumonia Vaccine Ever	similar 74.0	similar 75.1	74.6	similar 67.4	better 64.1	similar 76.3	worse 90.0
% [High-Risk 18-64] Pneumonia Vaccine Ever			38.6	similar 38.6		similar 38.7	worse 60.0

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

Legend: ☀ better ☁ similar 🌧 worse

Injury & Violence Prevention

Injury & Violence Prevention	PSA	SSA	Total Service Area	vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Unintentional Injury (Age-Adjusted Death Rate)			23.7		better 31.5	better 39.7	better 36.4
Motor Vehicle Crashes (Age-Adjusted Death Rate)			4.2		better 6.2	better 10.6	better 12.4
% [Age 45+] Fell in the Past Year	similar 23.3	similar 26.5	25.0	similar 23.9		similar 28.2	

Injury & Violence Prevention (continued)	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
[65+] Falls (Age-Adjusted Death Rate)			29.2	☁ 29.1	☀ 57.2	☀ 47.0	
Firearm-Related Deaths (Age-Adjusted Death Rate)			1.8		☀ 5.4	☀ 10.4	☀ 9.3
% Firearm in Home	☁ 11.0	☁ 9.9	10.4	☁ 9.1		☀ 33.8	
% [Homes With Children] Firearm in Home	☁ 9.8	☁ 6.4	8.1	☁ 10.8		☀ 31.0	
% [Homes With Firearms] Weapon(s) Unlocked & Loaded			8.0	☁ 18.2		☀ 20.4	
Homicide (Age-Adjusted Death Rate)			1.3		☀ 4.7	☀ 5.2	☀ 5.5
Violent Crime per 100,000			97.6		☀ 302.0	☀ 395.5	
% Perceive Neighborhood as "Slightly/Not At All Safe"	☀ 1.5	🌧 13.0	7.5	☁ 6.6		☀ 15.3	
% Victim of Violent Crime in Past 5 Years	☁ 1.4	☁ 1.7	1.6	☁ 2.0		☁ 2.3	
% Victim of Domestic Violence (Ever)	🌧 10.5	☀ 5.3	7.8	☀ 11.0		☀ 15.1	

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

☀ better	☁ similar	🌧 worse

Maternal, Infant & Child Health	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Infant Death Rate			3.4		☀ 4.4	☀ 5.9	☀ 6.0

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

☀ better	☁ similar	🌧 worse

Mental Health & Mental Disorders	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% "Fair/Poor" Mental Health	(similar) 8.2	(similar) 9.6	**8.9**	(similar) 10.6		(better) 15.5	
% Diagnosed Depression	(similar) 12.2	(similar) 12.7	**12.4**	(similar) 11.4	(similar) 13.4	(better) 17.9	
% Symptoms of Chronic Depression (2+ Years)	(similar) 17.9	(similar) 20.2	**19.1**	(better) 26.6		(better) 29.9	
Suicide (Age-Adjusted Death Rate)			**7.6**		(similar) 7.9	(better) 12.7	(better) 10.2
% Ever Sought Help for Mental Health	(similar) 24.0	(similar) 19.4	**21.6**	(similar) 23.4		(worse) 27.4	
% Taking Rx/Receiving Mental Health Trtmt	(similar) 9.5	(similar) 8.7	**9.1**	(similar) 10.3		(better) 13.6	
% Unable to Get Mental Health Svcs in Past Yr	(similar) 2.6	(similar) 4.0	**3.4**	(similar) 4.7		(similar) 4.4	
% Typical Day Is "Extremely/Very" Stressful	(similar) 11.8	(similar) 13.5	**12.7**	(similar) 14.4		(similar) 11.7	
% Average <7 Hours of Sleep per Night	(similar) 35.3	(similar) 38.5	**37.0**	(similar) 39.1		(similar) 39.5	

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Legend: (sun) better · (cloud) similar · (rain) worse

Nutrition, Physical Activity & Weight	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	(better) 37.3	(worse) 27.8	**32.3**	(similar) 30.5		(similar) 27.4	
% "Very/Somewhat" Difficult to Buy Fresh Produce	(similar) 15.2	(similar) 16.2	**15.7**	(similar) 15.3		(better) 21.9	
Population With Low Food Access (Percent)			**11.7**		(better) 26.3	(better) 23.6	

	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
Nutrition, Physical Activity & Weight (continued)	**PSA**	**SSA**		**vs. Bergen County**	**vs. NJ**	**vs. US**	**vs. HP2020**
% 7+ Sugar-Sweetened Drinks in Past Week	similar 13.4	similar 16.3	**14.9**	similar 16.9		better 30.2	
% Healthy Weight (BMI 18.5-24.9)	similar 36.1	similar 36.3	**36.2**	similar 35.3	similar 35.1	similar 32.9	similar 33.9
% Overweight (BMI 25+)	similar 57.9	similar 62.8	**60.5**	similar 61.2	similar 63.2	similar 65.2	
% Obese (BMI 30+)	similar 24.7	similar 28.1	**26.5**	similar 25.3	similar 26.9	better 33.4	similar 30.5
% Medical Advice on Weight in Past Year	worse 17.7	better 27.8	**23.1**	similar 23.2		similar 20.4	
% [Overweights] Counseled About Weight in Past Year	worse 24.5	better 37.4	**31.7**	similar 31.8		similar 27.1	
% [Obese Adults] Counseled About Weight in Past Year	worse 33.5	better 56.7	**46.6**	similar 44.8		similar 40.8	
% [Overweights] Trying to Lose Weight Both Diet/Exercise	similar 64.1	similar 69.1	**66.9**	similar 64.6		better 57.0	
% Children [Age 5-17] Overweight (85th Percentile)			**25.8**	similar 28.5		similar 24.2	
% Children [Age 5-17] Obese (95th Percentile)			**14.7**	similar 18.6		similar 9.5	similar 14.5
% No Leisure-Time Physical Activity	similar 22.3	similar 26.9	**24.8**	similar 23.4	similar 23.3	similar 27.9	better 32.6
% Meeting Physical Activity Guidelines	similar 28.4	similar 26.6	**27.4**	similar 25.7	better 21.6	similar 23.6	better 20.1
Recreation/Fitness Facilities per 100,000			**19.8**		better 14.3	better 9.7	
% Child [Age 2-17] Physically Active 1+ Hours per Day			**30.9**	similar 33.6		worse 47.9	

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

better (sun) | similar (cloud) | worse (rain)

Oral Health	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% [Age 18+] Dental Visit in Past Year	☁ 73.4	☁ 76.3	74.9	☁ 73.0	☀ 70.2	☀ 67.2	☀ 49.0
% Child [Age 2-17] Dental Visit in Past Year			71.3	☁ 74.7		🌧 90.7	☀ 49.0
% Have Dental Insurance	☁ 69.5	☁ 64.9	67.1	☁ 67.3		☁ 66.5	

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

	☀ better	☁ similar	🌧 worse

Respiratory Diseases	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
CLRD (Age-Adjusted Death Rate)			21.6		☀ 30.4	☀ 41.4	
Pneumonia/Influenza (Age-Adjusted Death Rate)			10.9		☀ 11.5	☀ 15.1	
% COPD (Lung Disease)	☁ 6.5	☁ 10.5	8.6	☁ 10.3	🌧 5.6	☁ 9.5	
% [Adult] Currently Has Asthma	☁ 4.6	☁ 5.4	5.0	☀ 9.0	☀ 8.3	☀ 9.5	
% [Ever Having Asthma] ER/Urgent Care for Asthma in Past Year			12.3	☁ 11.8			
% [Child 0-17] Currently Has Asthma	☁ 6.4	☁ 4.1	5.1	☁ 3.6		☁ 6.5	

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

	☀ better	☁ similar	🌧 worse

Septicemia

Septicemia	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Septicemia (Age-Adjusted Death Rate)			13.2		☀️ 16.5	🌧️ 10.6	

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

☀️ better ☁️ similar 🌧️ worse

Sexually Transmitted Diseases

Sexually Transmitted Diseases	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Gonorrhea Incidence per 100,000			22.9		☀️ 74.6	☀️ 110.7	
Chlamydia Incidence per 100,000			169.4		☀️ 335.2	☀️ 456.1	
% [Unmarried 18-64] 3+ Sexual Partners in Past Year			9.1	☁️ 11.2		☁️ 10.3	
% [Unmarried 18-64] Using Condoms			47.2	☁️ 49.9		☁️ 44.5	

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

☀️ better ☁️ similar 🌧️ worse

Substance Abuse

Substance Abuse	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)			4.9		☀️ 7.3	☀️ 10.2	☀️ 8.2
% Current Drinker	🌧️ 75.2	☀️ 66.6	70.8	☁️ 68.8	🌧️ 56.3	🌧️ 59.7	
% Excessive Drinker	☁️ 22.0	☁️ 21.8	21.9	☁️ 23.8		☁️ 22.2	☁️ 25.4
% Drinking & Driving in Past Month	☁️ 4.7	☁️ 5.0	4.8	☁️ 5.9		☁️ 4.1	

Substance Abuse (continued)

Substance Abuse (continued)	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
Drug-Induced Deaths (Age-Adjusted Death Rate)			9.6		☀ 14.5	☀ 14.6	☀ 11.3
% Took Prescription Drugs On Own in Past Year	☁ 3.2	☁ 4.1	3.7	☁ 5.4			
% Used Marijuana in Past Year	☁ 2.6	☁ 5.0	3.9	☀ 7.1			
% Illegal Drug Use in Past Year	☀ 0.0	🌧 1.7	0.9	☁ 1.9			
% Ever Sought Help for Alcohol or Drug Problem	☁ 1.2	☁ 0.5	0.8	🌧 2.4		🌧 4.1	
% Life Negatively Affected by Substance Abuse	☁ 29.0	☁ 36.2	32.8	☁ 30.1		☁ 32.2	

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

☀	☁	🌧
better	similar	worse

Tobacco Use

Tobacco Use	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% Current Smoker	🌧 8.6	☀ 3.9	6.1	☀ 9.8	☀ 15.1	☀ 14.0	☀ 12.0
% Someone Smokes at Home	☁ 12.2	☁ 6.8	9.4	☁ 10.3		☁ 10.2	
% [Nonsmokers] Someone Smokes in the Home	☁ 5.3	☁ 5.2	5.3	☁ 4.6		☁ 3.9	
% [Household With Children] Someone Smokes in the Home	🌧 15.6	☀ 3.5	9.6	☁ 9.4		☁ 10.2	
% Currently Use Electronic Cigarettes	☁ 1.5	☁ 2.1	1.8	☀ 3.9		☀ 3.8	

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

☀	☁	🌧
better	similar	worse

Vision	PSA vs. SSA		Total Service Area	Total Service Area vs. Benchmarks			
	PSA	SSA		vs. Bergen County	vs. NJ	vs. US	vs. HP2020
% Blindness/Trouble Seeing	☁ 2.8	☁ 5.2	4.1	☀ 6.8	☁ 3.9	☀ 7.3	
% Eye Exam in Past 2 Years	☁ 61.6	☁ 63.5	62.5	☁ 65.3		☁ 59.3	

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

☀ better	☁ similar	🌧 worse

Data Charts &
Key Informant Input

Community Characteristics

Population Characteristics

The total service area primarily falls within Bergen County, New Jersey. This effort was in fact part of a larger effort to assess health needs across the county. From these shared data, the following represent the population characteristics of Bergen County.

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for Bergen County relative to size, population, and density.

Total Population
(Estimated Population, 2010-2014)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Bergen County	920,456	233.1	3,949.6
New Jersey	8,874,374	7,354.8	1,206.6
United States	314,107,083	3,531,932.3	88.9

Sources: ● US Census Bureau American Community Survey 5-year estimates.
● Retrieved April 2016 from Community Commons at http://www.chna.org.

Age

It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

Total Population by Age Groups, Percent
(2010-2014)
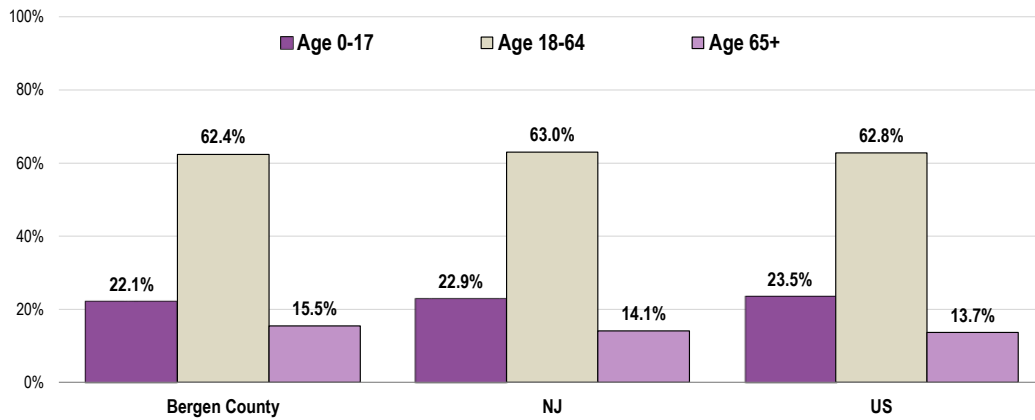
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of Bergen County. Note that ethnicity (Hispanic or Latino) can be of any race.

Total Population by Race Alone, Percent
(2010-2014)
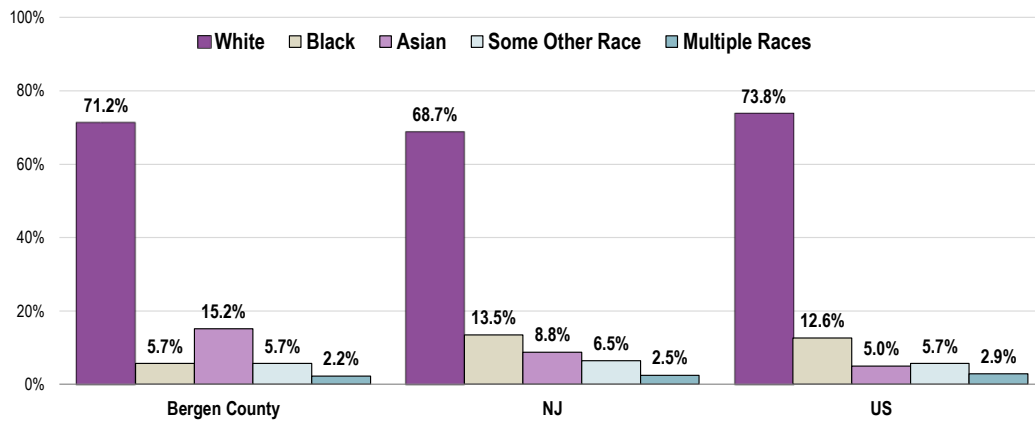
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Hispanic Population
(2010-2014)
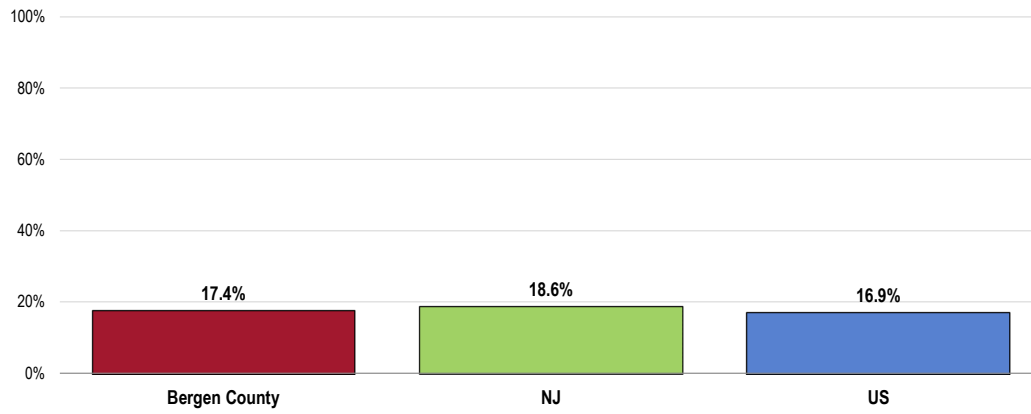
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

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

Social Determinants of Health

About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

- Healthy People 2020 (www.healthypeople.gov)

Poverty

The following chart outlines the proportion of Bergen County below the federal poverty threshold, as well as below 200% of the federal poverty level, in comparison to state and national proportions.
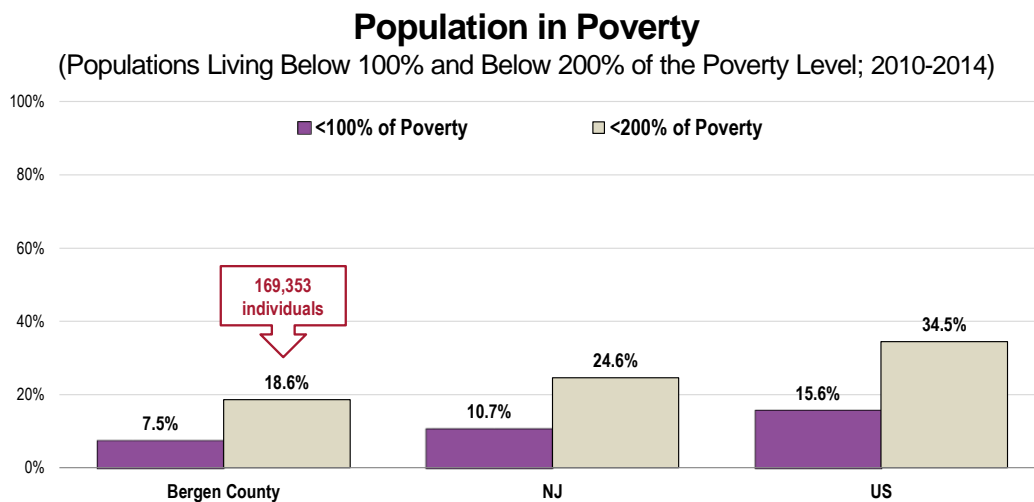
Population in Poverty
(Populations Living Below 100% and Below 200% of the Poverty Level; 2010-2014)

	<100% of Poverty	<200% of Poverty
Bergen County (169,353 individuals)	7.5%	18.6%
NJ	10.7%	24.6%
US	15.6%	34.5%

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

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

Education

Education levels are reflected in the proportion of Bergen County without a high school diploma:
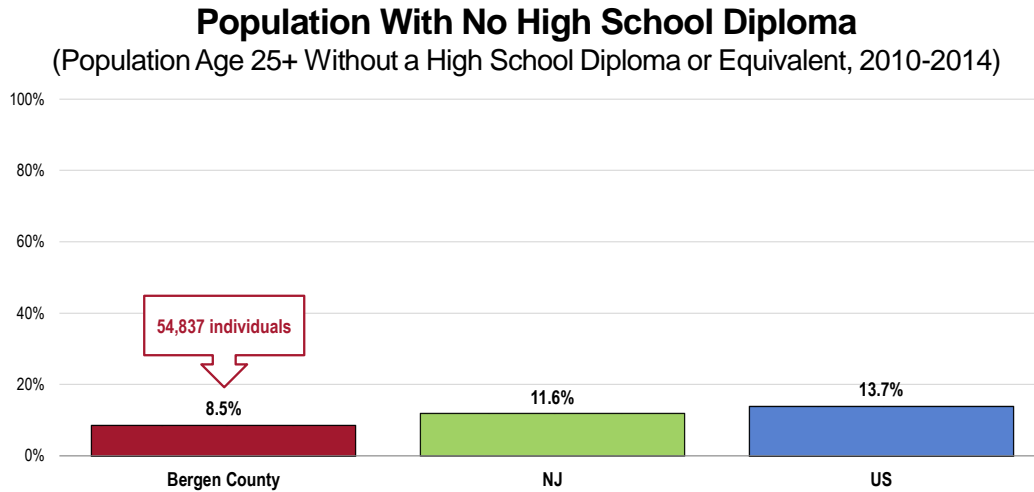
Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2010-2014)

	54,837 individuals		
Bergen County	8.5%		
NJ		11.6%	
US			13.7%

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

High-Need Areas

High-need areas in the Ramapo Ridge Psychiatric Hospital Total Service Area were identified using the Community Health Needs Index (CNI). The CNI score was developed by Dignity Health (formerly known as Catholic Healthcare West [CHW]) and Truven Health Analytics. This index aggregates five socioeconomic indicators that contribute to health disparity: income, culture, education, insurance, and housing. Each ZIP Code is assigned a score 1 (low need) to 5 (high need) for each of the five indicators which are averaged to yield the CNI score for that area. The scores are then compared to the index, which is based on national need, and separated into groups ranging from highest need to lowest need.

Research indicates a strong correlation between high CNI scores and hospital admission rates. Residents who live in areas with the highest need were twice as likely to experience preventable hospitalization for manageable conditions (i.e. ear infections, pneumonia...).

Lowest Need | 1 - 1.7 Lowest | 1.8 - 2.5 2nd Lowest | 2.6 - 3.3 Mid | 3.4 - 4.1 2nd Highest | 4.2 - 5 Highest | Highest Need

Mean(zipcode): 2 / Mean(person): 2.3   CNI Score Median: 1.7   CNI Score Mode: 1.6
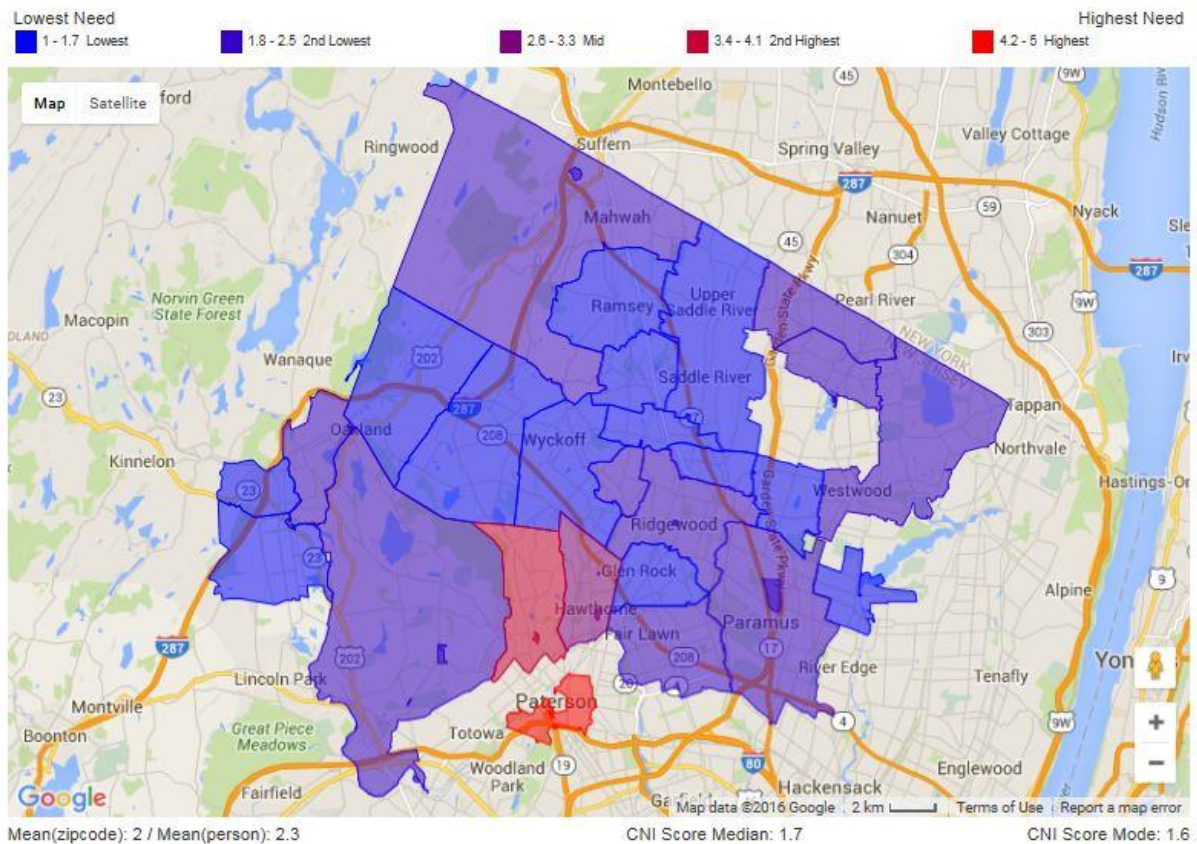
ZIP Code-specific CNI scores are outlined below.

	Zip Code	CNI Score	Population	City	County	State
	07501	5.0	33,926	Paterson	Passaic	New Jersey
	07508	3.6	25,531	Haledon	Passaic	New Jersey
	07506	3.0	19,505	Hawthorne	Passaic	New Jersey
	07442	2.4	11,297	Pompton Lakes	Passaic	New Jersey
	07645	2.4	8,250	Montvale	Bergen	New Jersey
	07675	2.4	27,067	Westwood	Bergen	New Jersey
	07410	2.2	33,343	Fair Lawn	Bergen	New Jersey
	07470	2.2	52,270	Wayne	Passaic	New Jersey
	07432	2.0	7,265	Midland Park	Bergen	New Jersey
	07652	2.0	27,248	Paramus	Bergen	New Jersey
	07656	2.0	9,138	Park Ridge	Bergen	New Jersey
	07430	1.8	26,800	Mahwah	Bergen	New Jersey
	07450	1.8	25,656	Ridgewood	Bergen	New Jersey
	07401	1.6	6,712	Allendale	Bergen	New Jersey
	07423	1.6	4,148	Ho Ho Kus	Bergen	New Jersey
	07444	1.6	11,643	Pompton Plains	Morris	New Jersey
	07446	1.6	14,944	Ramsey	Bergen	New Jersey
	07452	1.6	11,768	Glen Rock	Bergen	New Jersey
	07458	1.6	11,783	Saddle River	Bergen	New Jersey
	07649	1.6	8,103	Oradell	Bergen	New Jersey
	07417	1.4	10,961	Franklin Lakes	Bergen	New Jersey
	07436	1.4	13,146	Oakland	Bergen	New Jersey
	07457	1.4	4,055	Riverdale	Morris	New Jersey
	07463	1.4	9,915	Waldwick	Bergen	New Jersey
	07481	1.4	17,093	Wyckoff	Bergen	New Jersey
	07676	1.4	9,230	Township Of Washington	Bergen	New Jersey

General Health Status

Overall Health Status

Self-Reported Health Status

The initial inquiry of the PRC Community Health Survey asked respondents the following:

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

Self-Reported Health Status
(Total Service Area, 2016)
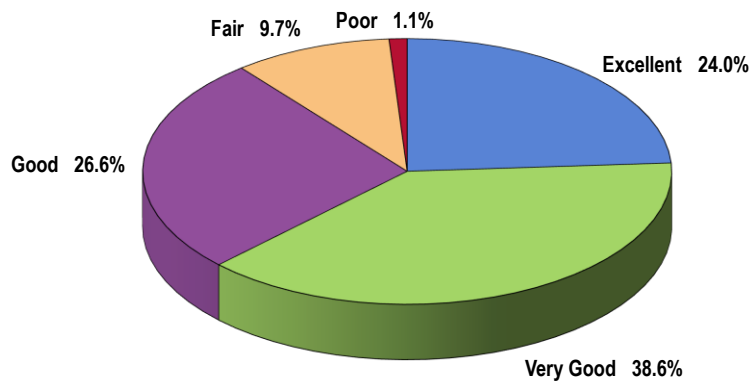
Fair 9.7%	Poor 1.1%
	Excellent 24.0%
Good 26.6%	
	Very Good 38.6%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Asked of all respondents.

The following charts further detail "fair/poor" overall health responses in the Total Service Area in comparison to benchmark data, as well as by basic demographic characteristics (namely by gender, age groupings, income [based on poverty status], and race/ethnicity).

Experience "Fair" or "Poor" Overall Health

Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
11.1%	10.6%	10.8%	10.5%	16.9%	18.3%
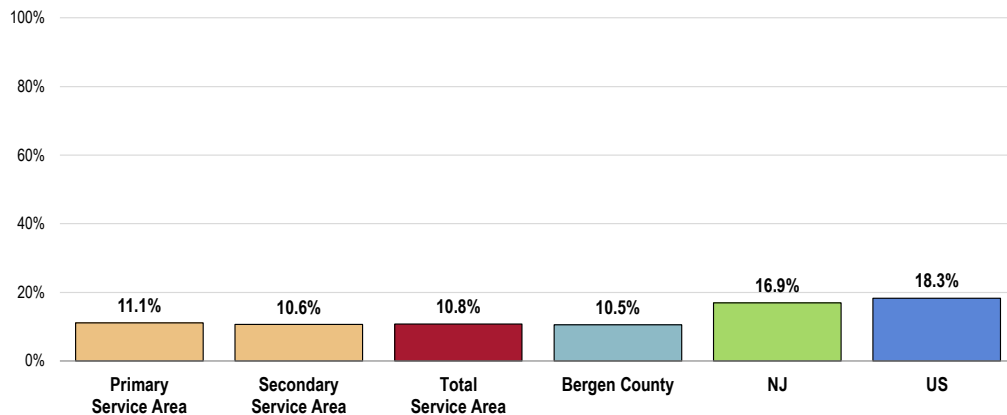
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
          ● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease
             Control and Prevention (CDC): 2014 New Jersey data.
          ● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Experience "Fair" or "Poor" Overall Health
(Total Service Area, 2016)
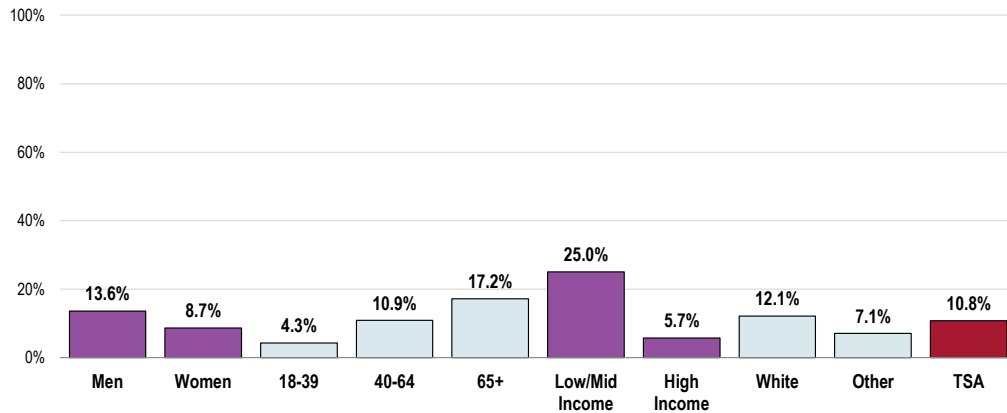
Category	Value
Men	13.6%
Women	8.7%
18-39	4.3%
40-64	10.9%
65+	17.2%
Low/Mid Income	25.0%
High Income	5.7%
White	12.1%
Other	7.1%
TSA	10.8%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Activity Limitations

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

- Healthy People 2020 (www.healthypeople.gov)

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

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem
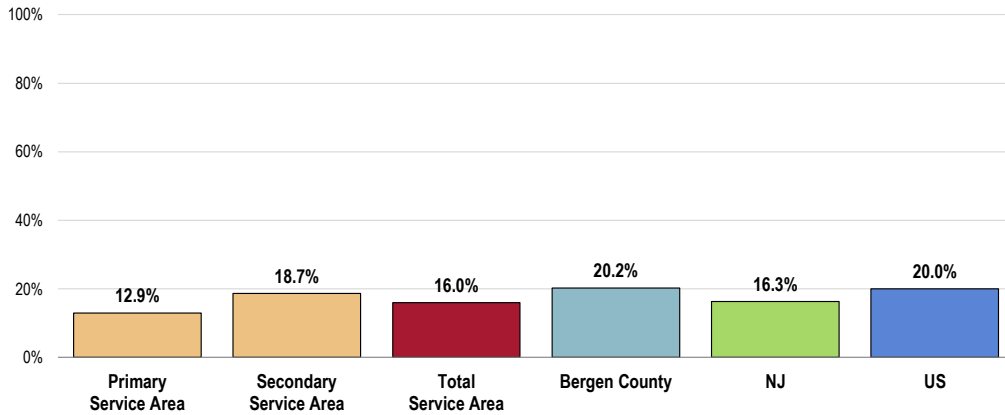
12.9%	18.7%	16.0%	20.2%	16.3%	20.0%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem
(Total Service Area, 2016)
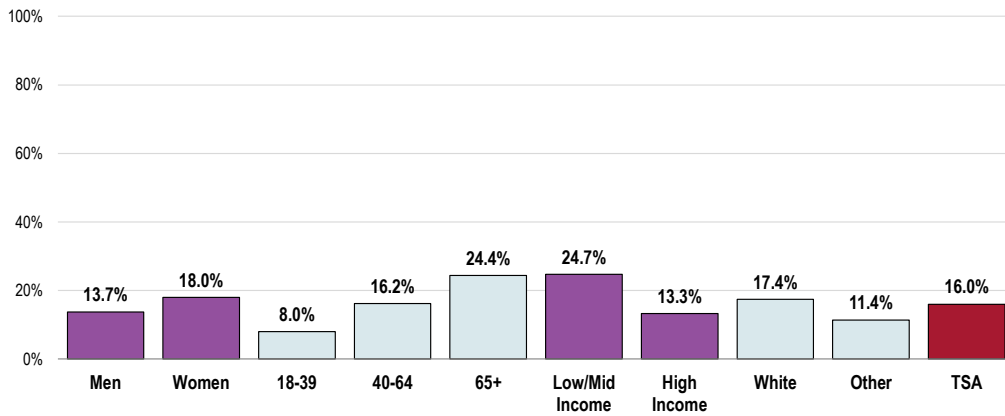
13.7%	18.0%	8.0%	16.2%	24.4%	24.7%	13.3%	17.4%	11.4%	16.0%
Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Mental Health

About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 (www.healthypeople.gov)

Self-Reported Mental Health Status

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

Self-Reported Mental Health Status
(Total Service Area, 2016)
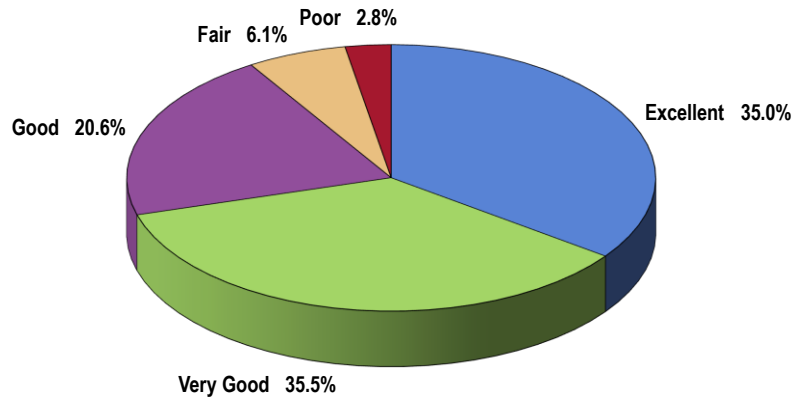
Poor 2.8%
Fair 6.1%
Good 20.6%
Excellent 35.0%
Very Good 35.5%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: ● Asked of all respondents.

Experience "Fair" or "Poor" Mental Health
(Total Service Area, 2016)
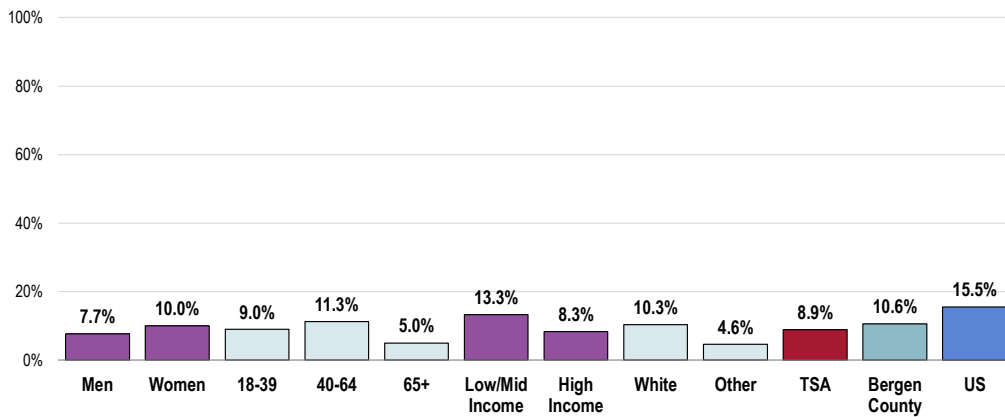
Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA	Bergen County	US
7.7%	10.0%	9.0%	11.3%	5.0%	13.3%	8.3%	10.3%	4.6%	8.9%	10.6%	15.5%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Depression

Diagnosed Depression: "Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"

Have Been Diagnosed With a Depressive Disorder

12.2%	12.7%	12.4%	11.4%	13.4%	17.9%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
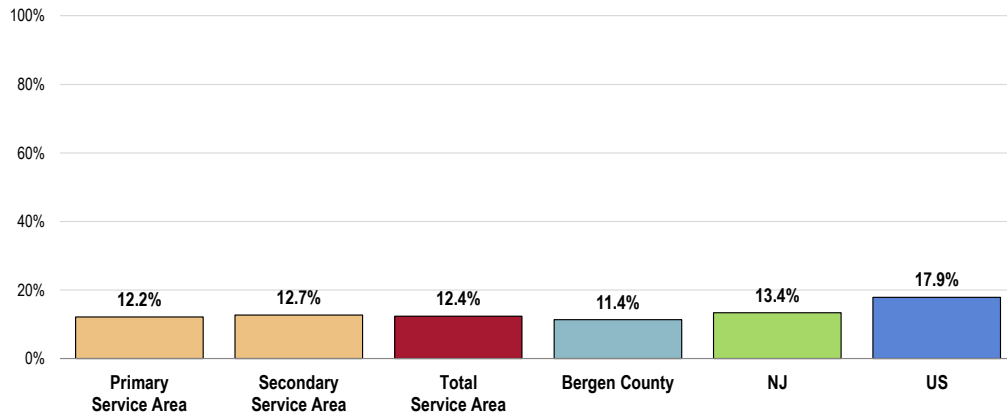
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression: "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"
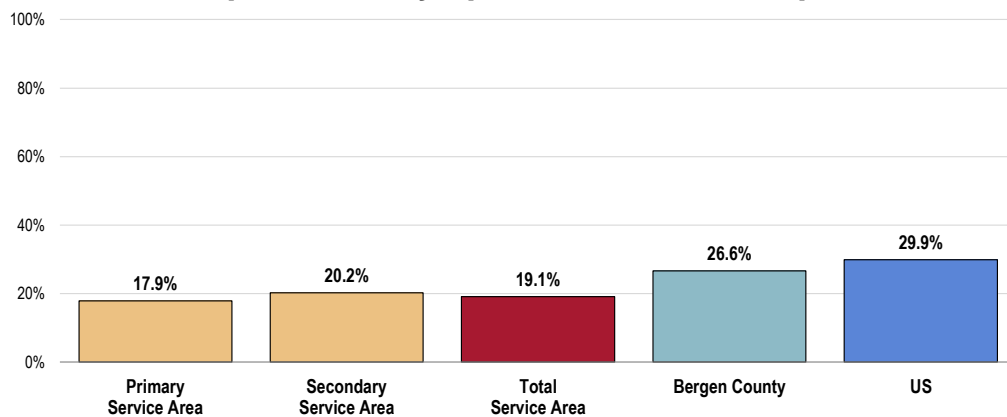
Have Experienced Symptoms of Chronic Depression

17.9%	20.2%	19.1%	26.6%	29.9%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
● 2015 PRC National Health Survey, Professional Research Consultants, 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.

Have Experienced Symptoms of Chronic Depression
(Total Service Area, 2016)
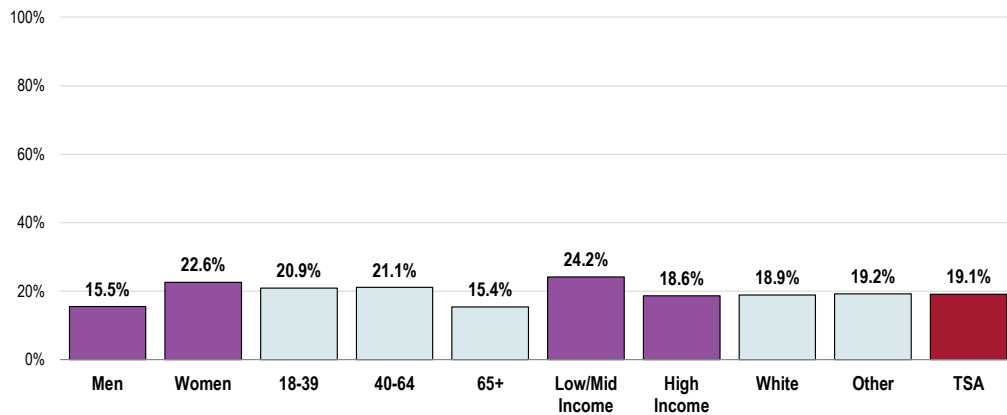
Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA
15.5%	22.6%	20.9%	21.1%	15.4%	24.2%	18.6%	18.9%	19.2%	19.1%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
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.
   ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
   ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in Bergen County. (Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.)

Suicide: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 10.2 or Lower
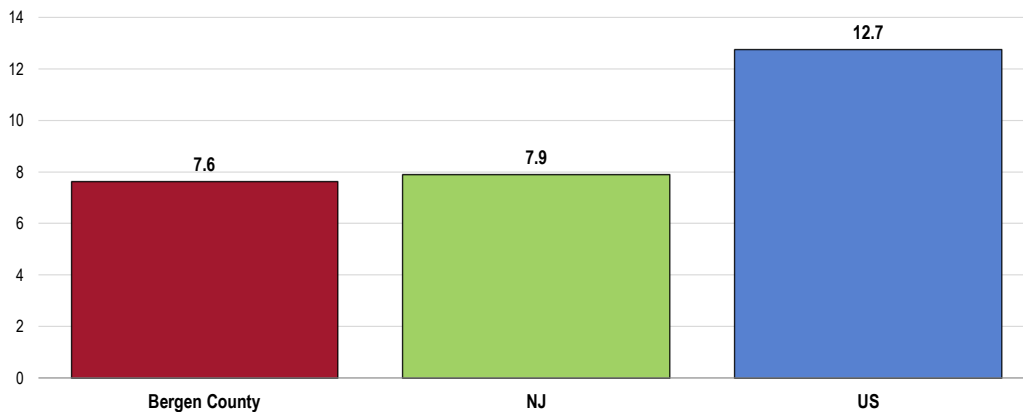
Bergen County	NJ	US
7.6	7.9	12.7

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
   ● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]
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, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

"Have you ever sought help from a professional for a mental or emotional problem?"

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

Mental Health Treatment

Legend: ■ Primary Service Area ■ Secondary Service Area ■ Total Service Area ■ Bergen County ■ US

Ever Sought Help for a Mental or Emotional Problem: 24.0%, 19.4%, 21.6%, 23.4%, 27.4%

Currently Taking Medication/Receiving Mental Health Treatment: 9.5%, 8.7%, 9.1%, 10.3%, 13.6%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 120-121]
          ● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects the total sample of respondents.

"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
(Total Service Area, 2016)

Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA	Bergen County	US
0.0%	6.5%	8.1%	2.4%	0.0%	2.6%	4.1%	2.5%	5.1%	3.4%	4.7%	4.4%
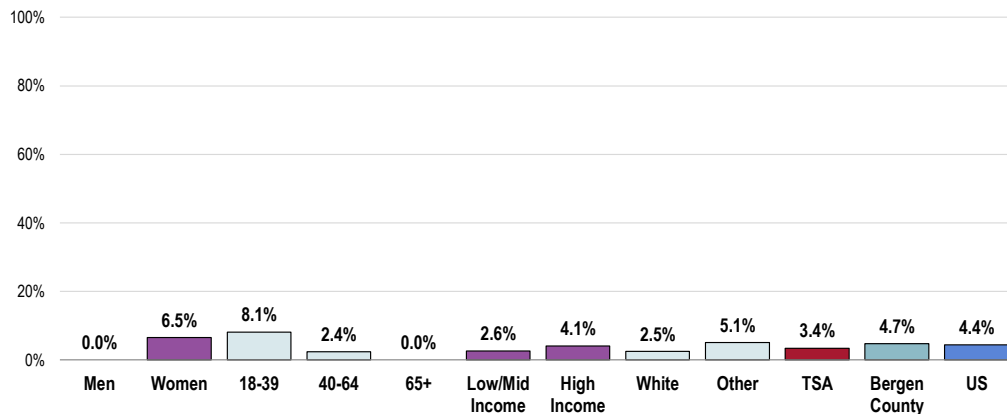
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: ● Asked of all respondents.
          ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
          ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Key Informant Input: Mental Health

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

Perceptions of Mental Health
as a Problem in the Community
(Key Informants, 2016)
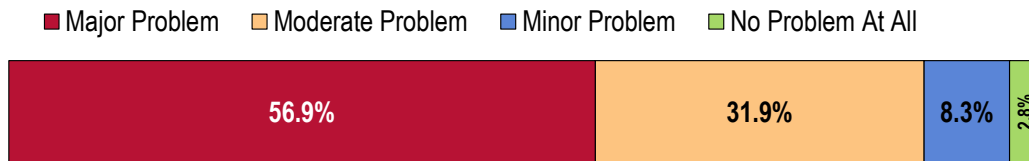
■ Major Problem □ Moderate Problem ■ Minor Problem □ No Problem At All

56.9%	31.9%	8.3%	2.8%

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

Challenges

Among those rating this issue as a "major problem," the following represent what key informants see as the main challenges for persons with mental illness:

Access to Care/Services

Access to care is a huge problem, there are not enough psychiatrists and counselors that can see patients on an emergency basis, especially the teen population. They often end up in our Emergency Rooms and then have to go to Inpatient. Anxiety amongst adults is rising and attributing to physiological disorders; we live in a high stress environment. We are also seeing anxiety on the rise with high school students, who are putting increasing pressure on themselves. - Other Health Provider

Insufficient resources, the problem continues to grow, mismanagement. Crowding the Emergency Departments with insufficient beds for involuntary care. - Other Health Provider

Awareness of resources and access to care. Elimination of stigma. Social support and acceptance to equal stigma reduction. Integration into workforce. Job training and skill development. Early intervention and awareness among youth and families. - Other Health Provider

Accessing mental health for elderly is becoming a challenge. Most of our residents will benefit from in-home services. - Social Services Provider

Inability to receive long term treatment and accessibility to programs and increase use of substance abuse. The community and first responders need better education on how to respond to a mental health crisis. - Other Health Provider

Access to services continues to be a large issue. The community mental health centers do an excellent job, but the need far outweighs their ability to serve. Continued cuts have made services difficult to access. - Other Health Provider

Access to treatment for those who do not have commercial insurance. Shortage of government funded treatment. - Social Services Provider

Access to care. - Other Health Provider

Access and reimbursement for treatment. - Other Health Provider

Access to Mental Health Care. - Other Health Provider

No stability due to transience. Need Housing First model to get people the basics, then can attend to other issues better. More structured day activities leading to education or employment. More psychiatric access. - Community/Business Leader

There are insufficient mental health practitioners to service the community. Entering the system is extremely difficult. Quality mental health care from existing practitioners is a problem. - Public Health Representative

Access to psychiatrist, mental health professionals. - Other Health Provider

Denial/Stigma

> *People's hesitation to seek help. - Community/Business Leader*

> *Mental illness is still not seen as an illness the way physical illness is. We need more than tolerance. Acceptance that people are different should be the goal. - Other Health Provider*

> *Stigma. - Other Health Provider*

> *Overcoming the stigma that comes along with mental health. - Public Health Representative*

> *There is still a stigma around mental health, which prevents people from seeking help. In addition, help is hard to access for those with limited or no insurance. We don't always have the proper safety net for people and they land in jail or become homeless. Hoarding and other code enforcement violations are a huge challenge for municipalities, which only have one tool to deal with these issues. - Community/Business Leader*

> *Stigma, language barriers, cultural barriers. - Other Health Provider*

> *Stigma associated with mental health and the related shame associated with it. This impacts on the number of individuals seeking treatment for mental health disorders. Need for education and increased awareness of mental health disorders. Availability of complementary services, instead of or in addition to medication. - Social Services Provider*

Older Adults

> *Lumping mental health patients with senior citizens is not right. Especially since there is no training for those hired for senior centers, etc. Dangerous situations that employees are unprepared and untrained for arrival. And police are essentially the first-responder that has to deal with these situations. - Social Services Provider*

> *Older adults aging with mental illness. Also older adults aging who have dependent adult children with mental illness. - Social Services Provider*

Contributing Factors

> *High anxiety levels in both adults and kids due to today's pressures. - Community/Business Leader*

> *Safety, homeless, day programs. - Other Health Provider*

> *Social, environmental stress and pressure as the impact of it triggers other issues such as mental health, substance abuse and physical health issues. - Other Health Provider*

Prevalence/Incidence

> *Its prevalence especially in young people. Self-medicating with drugs, alcohol instead of seeking supervised and professional treatment. - Public Health Representative*

> *So prevalent, leaving a big problem with violence and abuse. So misunderstood. - Community/Business Leader*

Disease Management

> *Noncompliance with medication and lack of support. - Social Services Provider*

> *Lack of willingness to follow prescribed treatment or inadequate family/friend support network to assist patient in following prescribed treatment. - Social Services Provider*

Affordable Care/Services

> *Lack of affordable supportive housing. - Other Health Provider*

> *Not enough programs to assist the underinsured, uninsured or seniors on a fixed low income. - Other Health Provider*

Death, Disease & Chronic Conditions

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and cardiovascular disease (heart disease and stroke) are leading causes of death in the community.
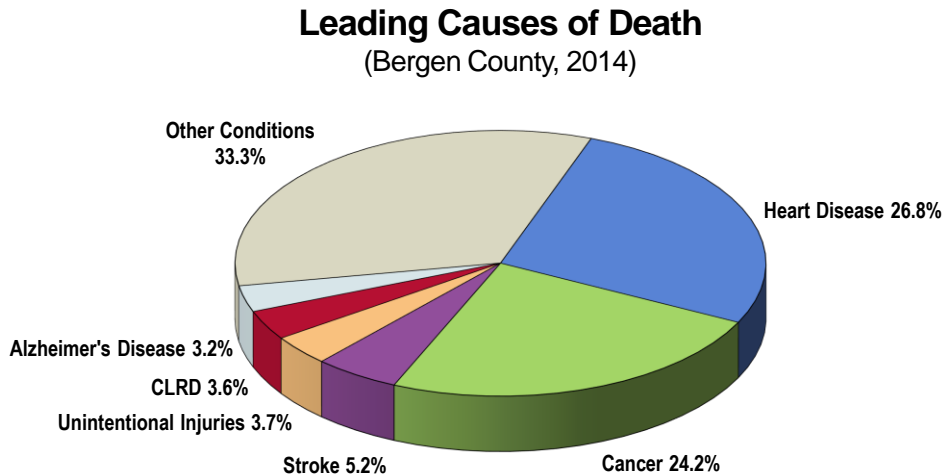
Leading Causes of Death
(Bergen County, 2014)

Other Conditions 33.3%
Heart Disease 26.8%
Cancer 24.2%
Stroke 5.2%
Unintentional Injuries 3.7%
CLRD 3.6%
Alzheimer's Disease 3.2%

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
              ● CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

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

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the area. (For infant mortality data, see *Birth Outcomes & Risks* in the Births section of this report.)

Age-Adjusted Death Rates for Selected Causes
(2012-14 Deaths per 100,000 Population)

	Bergen County	NJ	US	HP2020
Diseases of the Heart	143.9	169.3	169.1	156.9*
Malignant Neoplasms (Cancers)	142.2	157.5	163.6	161.4
Fall-Related Deaths (65+)	29.2	29.1	57.2	47.0
Cerebrovascular Disease (Stroke)	27.2	32.2	36.5	34.8
Unintentional Injuries	23.7	31.5	39.7	36.4
Chronic Lower Respiratory Disease (CLRD)	21.6	30.4	41.4	n/a
Alzheimer's Disease	14.9	16.9	24.2	n/a
Diabetes Mellitus	14.0	19.3	21.1	20.5*
Septicemia	13.2	16.5	10.6	n/a
Kidney Diseases	12.1	13.5	13.2	n/a
Pneumonia/Influenza	10.9	11.5	15.1	n/a
Drug-Induced	9.6	14.5	14.6	11.3
Intentional Self-Harm (Suicide)	7.6	7.9	12.7	10.2
Cirrhosis/Liver Disease	4.9	7.3	10.2	8.2
Motor Vehicle Deaths	4.2	6.2	10.6	12.4
Firearm-Related	1.8	5.4	10.4	9.3
Homicide	1.3	4.7	5.2	5.5
HIV/AIDS	0.7	2.8	2.1	3.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov.

Note:
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in Bergen County.

Heart Disease: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 156.9 or Lower (Adjusted)
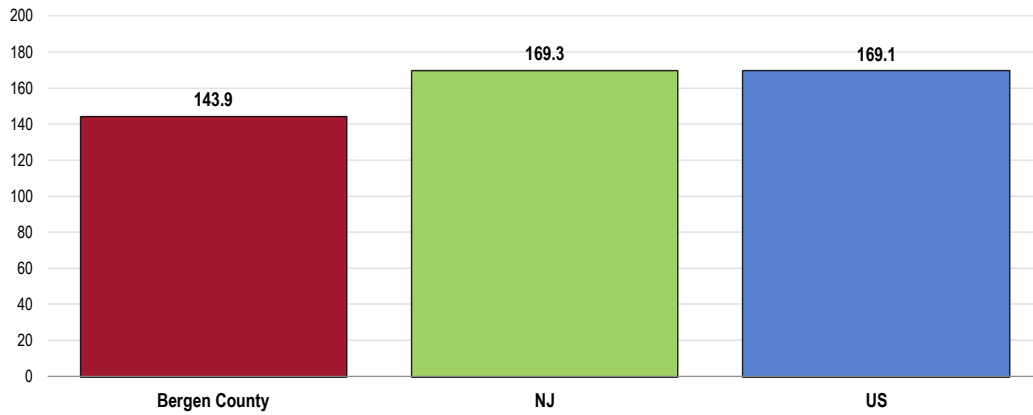
Bar chart showing age-adjusted heart disease mortality: Bergen County 143.9, NJ 169.3, US 169.1.

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

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, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 34.8 or Lower

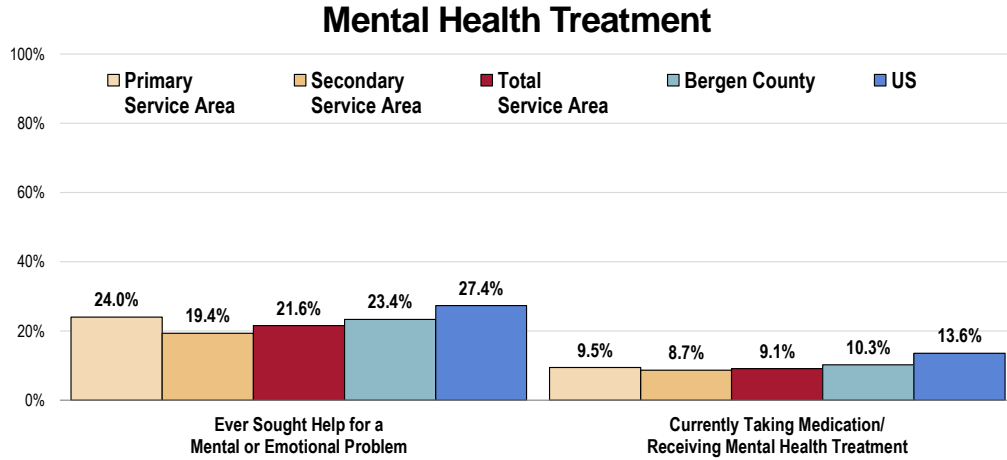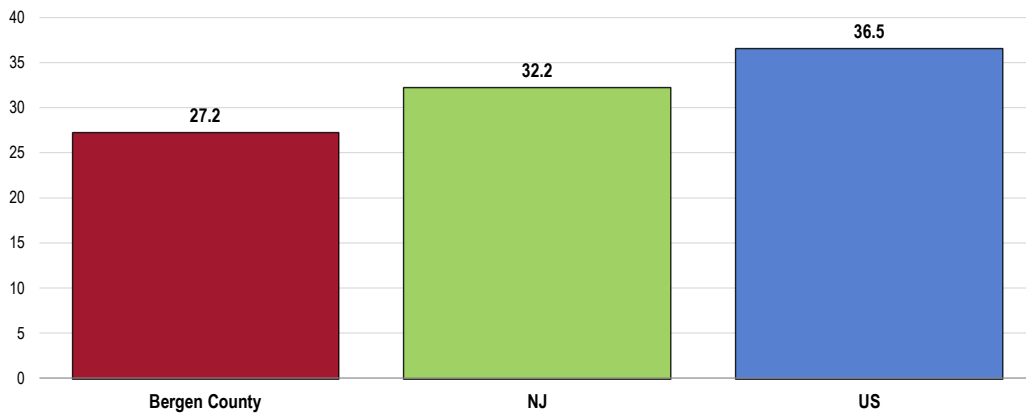Bar chart showing age-adjusted stroke mortality: Bergen County 27.2, NJ 32.2, US 36.5.

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

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, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

"Has a doctor, nurse or other health professional ever told you that you had: A Heart Attack, Also Called a Myocardial Infarction; or Angina or Coronary Heart Disease?" (Heart disease prevalence below is a calculated prevalence that includes those responding affirmatively to either.)

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

Prevalence of Heart Disease

	Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US
	5.9%	6.1%	6.0%	6.3%	6.9%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

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

Prevalence of Stroke

	Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
	1.7%	2.8%	2.3%	3.4%	2.6%	2.6%
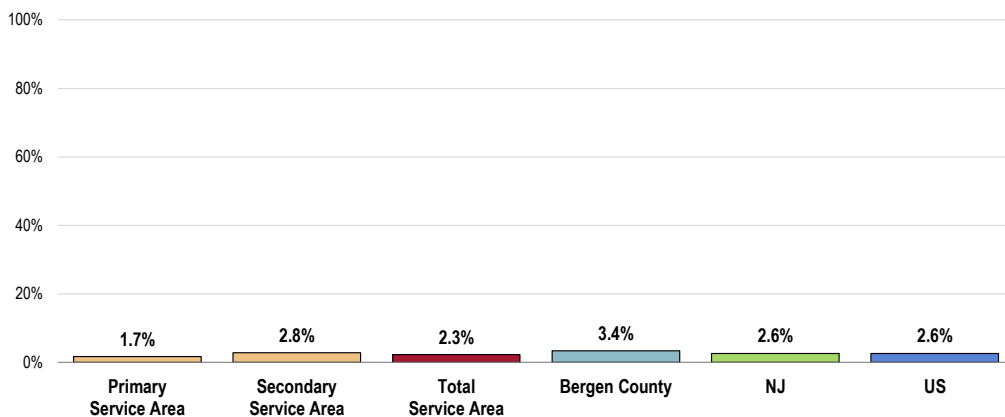
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 35]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

About Cardiovascular Risk

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

- Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure & Cholesterol Prevalence

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

- "Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"

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

- "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 2020 Target = 26.9% or Lower

94.1% of adults with multiple HBP readings are taking action to help control their levels (such as medication, diet, and/or exercise).

Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
34.6%	34.0%	34.3%	36.9%	31.1%	36.5%
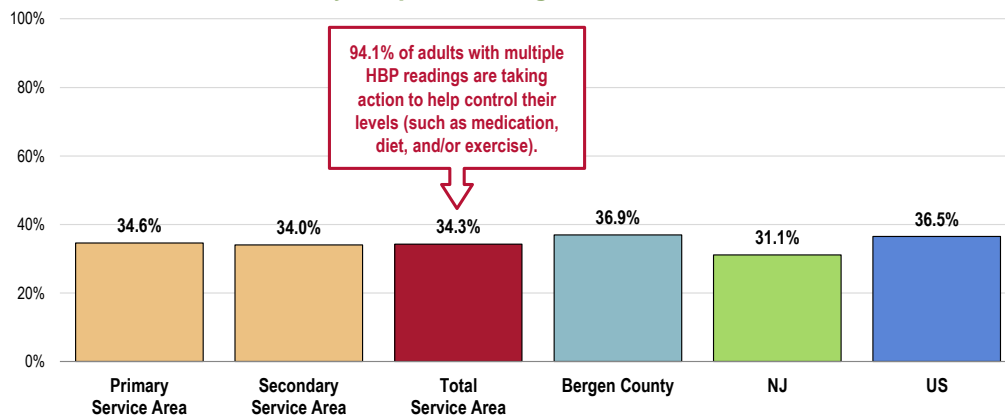
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 43, 147]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 New Jersey data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Asked of all respondents.

Prevalence of High Blood Cholesterol
Healthy People 2020 Target = 13.5% or Lower

79.5% of adults are taking action to help control their levels (such as medication, diet, and/or exercise).

	Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US
	39.5%	40.5%	40.0%	39.6%	33.5%
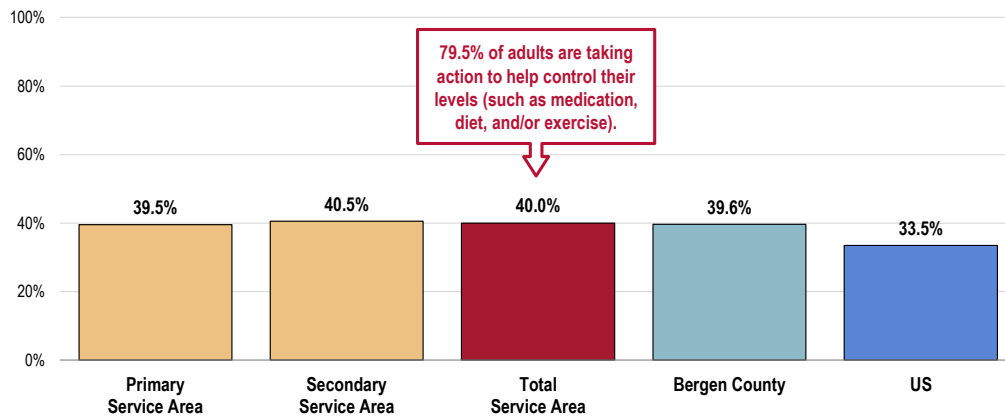
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 46, 148]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

Notes:
- Asked of all respondents.

About Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Total Cardiovascular Risk

The following chart reflects the percentage of adults in the Total Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol. See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the Modifiable Health Risk section of this report.

Present One or More Cardiovascular Risks or Behaviors
(Total Service Area, 2016)

	Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA	Bergen County	US
%	91.1%	73.3%	64.8%	87.3%	90.6%	80.1%	81.9%	80.7%	85.3%	81.8%	83.1%	83.0%
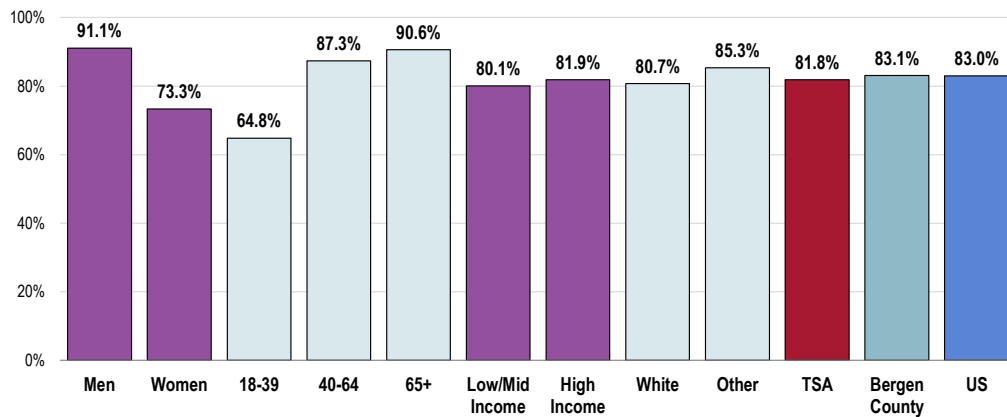
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
Notes: ● Asked of all respondents.
● Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

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

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2016)
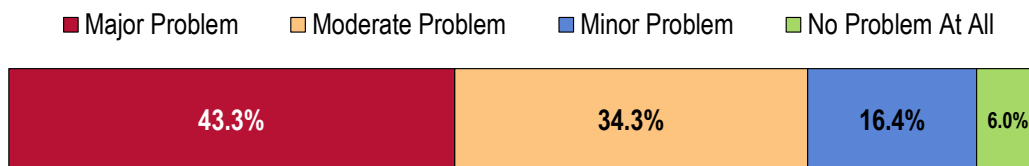
■ Major Problem ☐ Moderate Problem ■ Minor Problem ☐ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
43.3%	34.3%	16.4%	6.0%

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

Top Concerns

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

Leading Cause of Death

> *Heart Disease and stroke- the combination- are the leading cause of death in the United States. These are high priority issues. - Public Health Representative*

> *With cancer, leading cause of death. - Social Services Provider*

> *Heart Disease and stroke continues to be in the top three leading causes of death, not only in Paramus or the state, but nationally. Health-damaging behaviors- such as tobacco use, lack of physical activity and poor diets- are major causes to heart disease and other chronic diseases. Paramus Board of Health works with community partners and organizations to educate the public on how to prevent heart disease. Every February for National Heart Awareness Month, we raise money for the American Heart Association with programs, and we have had the Jeannie Card made up and sent to all residents. The Jeannie Card was produced after a resident came in to tell his story about his wife suddenly dying, due to symptoms they did not realize were warning signs for a heart attack. He wanted to create an awareness to prevent this from happening to anyone else. - Public Health Representative*

> *Heart disease is the leading cause of death in the United States. Stroke is the third-leading cause of death in the United States. Together, heart disease and stroke are among the most widespread and costly health problems facing the Nation today, accounting for more than $500 billion in health care expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable. - Public Health Representative*

Lifestyle

> *Inadequate exercise, poor eating habits, cost of healthy food and availability of same are prevalent in many communities. Particularly in low income and more urban settings in the county. - Social Services Provider*

> *Current trend in lifestyle, poor eating habits yielding increased incidence of obesity and lack of activity. - Other Health Provider*

> *Sedentary lifestyle, poor diet, high stress levels. - Other Health Provider*

> *Poor diets and eating habits have led to people being overweight and more at risk. - Community/Business Leader*

> *A large percentage of the population in the community tends to be overweight, lack appropriate physical exercise, and smoke and/or drink excessively. - Community/Business Leader*

Health Education

> *Lack of education. People's poor diets, smoking and overall bad lifestyle; for example, no exercise. - Social Services Provider*

> *Education and access to treatments. - Other Health Provider*

> *People needs education about healthy living habits and how to balance all aspects of their lives. - Social Services Provider*

Aging Population

> *Elderly population. May not know they have hypertension. - Other Health Provider*

> *With the aging population, we see an increase in HD and stroke. There is a lack of knowledge about early signs of stroke the different symptomology of men vs. women. This older population grew up in a time when exercise was not a necessity, smoking was the norm, and eating healthy was not widely discussed. So we are now dealing with all these effects. - Other Health Provider*

Prevalence/Incidence

> *Heart disease and stroke is prevalent in the clients for PV Meals on Wheels. - Social Services Provider*

> *I hear from doctors that it is a big problem. - Social Services Provider*

Vulnerable Populations

> *Heart disease still goes undetected in women. Again, the population is aging. - Other Health Provider*

> *Increased risk factors related to demographics. - Other Health Provider*

Affordable Care/Services

> *Low income -and even folks with adequate income- allowing weight gain and poor health control. Again, cost of medical care and proper diet make it hard to control advance of symptoms until full-blown. - Community/Business Leader*

Comorbidities

> *Seems to be a correlation between diabetes and obesity; lack of exercise and stress are very high in the community. - Community/Business Leader*

Disease Management

Compliance with medications, follow up visits, exercise, and compliance with diet. - Other Health Provider

Genetic Predisposition

Genetic predisposition, language barriers, increased risk factors. - Other Health Provider

Cancer

About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in Bergen County.
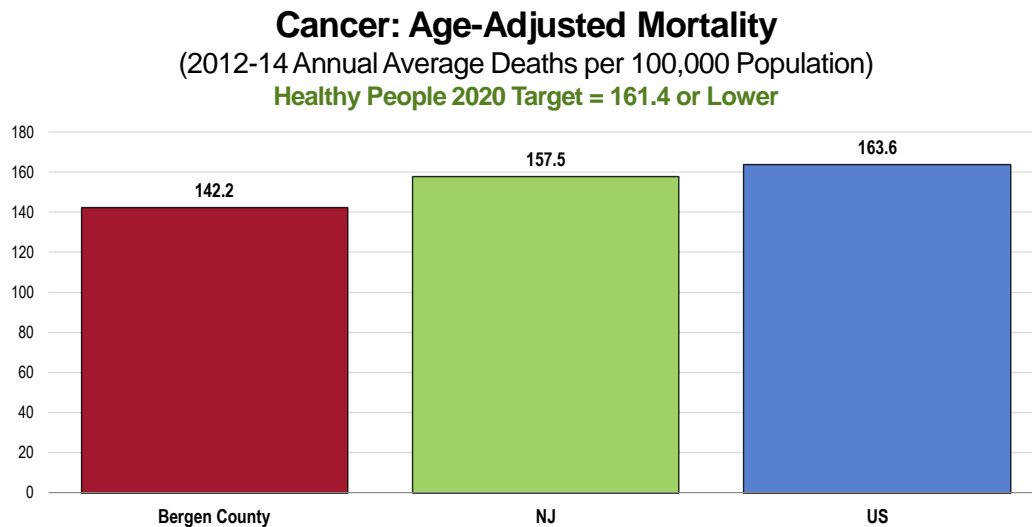
Cancer: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 161.4 or Lower

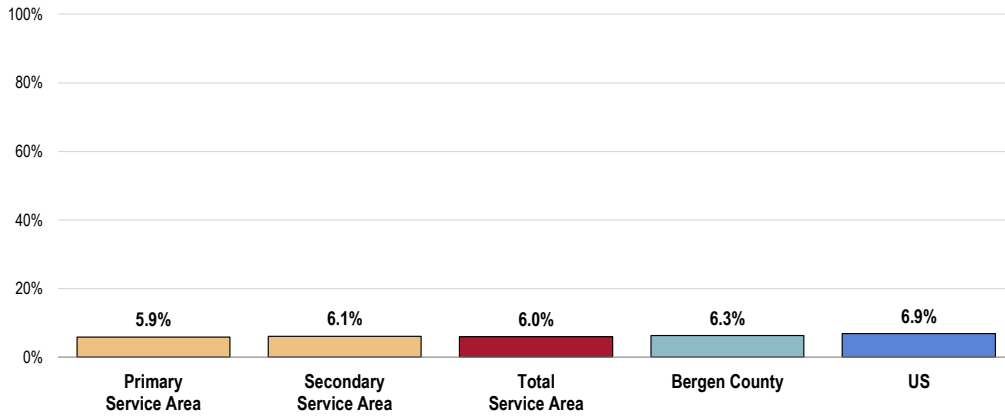|	Bergen County	NJ	US
	142.2	157.5	163.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

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, age-adjusted to the 2000 US Standard Population.

Lung cancer is by far the leading cause of cancer deaths in Bergen County. Other leading sites include colorectal cancer (both genders), breast cancer among women, and prostate cancer among men.

Age-Adjusted Cancer Death Rates by Site
(2012-14 Annual Average Deaths per 100,000 Population)

	Bergen County	NJ	US	HP2020
ALL CANCERS	142.2	157.5	163.6	161.4
Lung Cancer	32.6	38.5	43.4	45.5
Colorectal Cancer	12.8	15.0	14.6	14.5
Female Breast Cancer	11.4	22.5	20.9	20.7
Prostate Cancer	5.9	18.5	19.2	21.8

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov

Cancer Incidence

Incidence rates (or case rates) reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. They are usually expressed as cases per 100,000 population per year. Here, these rates are also age-adjusted.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2008-12)

Legend: ■ Bergen County ■ NJ ■ US

	Prostate Cancer	Female Breast Cancer	Lung Cancer	Colon/Rectal Cancer	Cervical Cancer
Bergen County	149.0	134.1	50.7	40.3	7.3
NJ	157.3	130.2	60.0	44.4	8.0
US	131.7	123.0	63.7	41.9	7.7
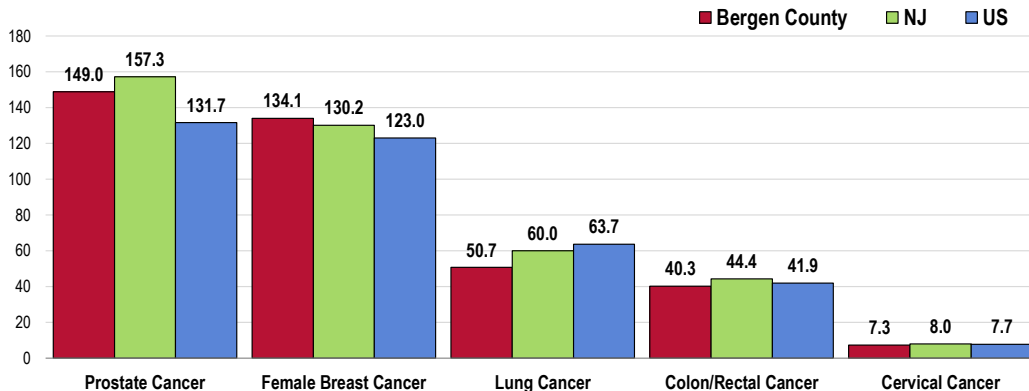
Sources: ● State Cancer Profiles.
● Retrieved April 2016 from Community Commons at http://www.chna.org.
Notes: ● This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Cancer Risk

About Cancer Risk

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

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

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

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

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

Female Breast Cancer Screening

About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

- 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.

Breast Cancer Screening: "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?" (Calculated below among women age 50 to 74 indicating screening within the past 2 years.)

Have Had a Mammogram in the Past Two Years
(Among Women Age 50-74)
Healthy People 2020 Target = 81.1% or Higher
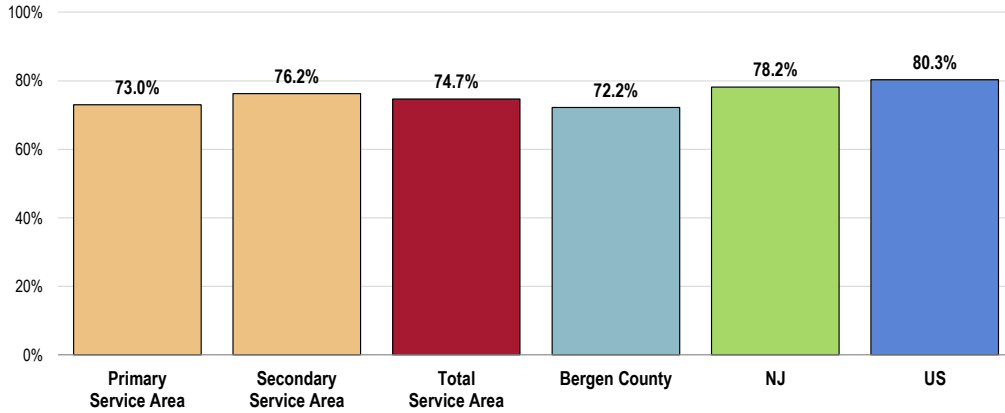
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

Notes:
- Reflects female respondents 50-74.

Cervical Cancer Screenings

About Screening for Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

- 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.

Cervical Cancer Screening: **"A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?" (Calculated below among women age 21 to 65 indicating screening within the past 3 years.)**

Have Had a Pap Smear in the Past Three Years
(Among Women Age 21-65)
Healthy People 2020 Target = 93.0% or Higher

	Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
	83.5%	72.9%	78.1%	74.5%	83.8%	84.8%
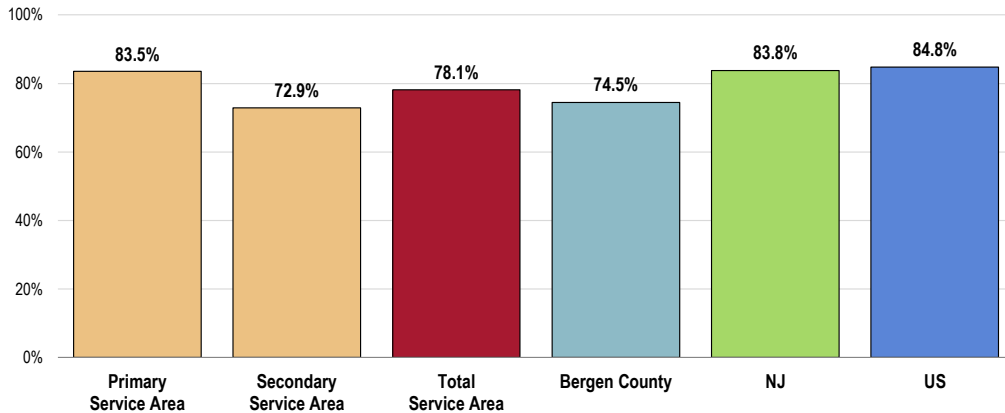
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

Notes:
- Reflects female respondents age 21 to 65.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

- 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.

Colorectal Cancer Screening: **"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?" and "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?" (Calculated below among both genders age 50 to 75 indicating fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years.)**

Have Had a Colorectal Cancer Screening
(Among Adults Age 50-75)
Healthy People 2020 Target = 70.5% or Higher

76.5%	68.9%	72.6%	72.8%	65.0%	74.5%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
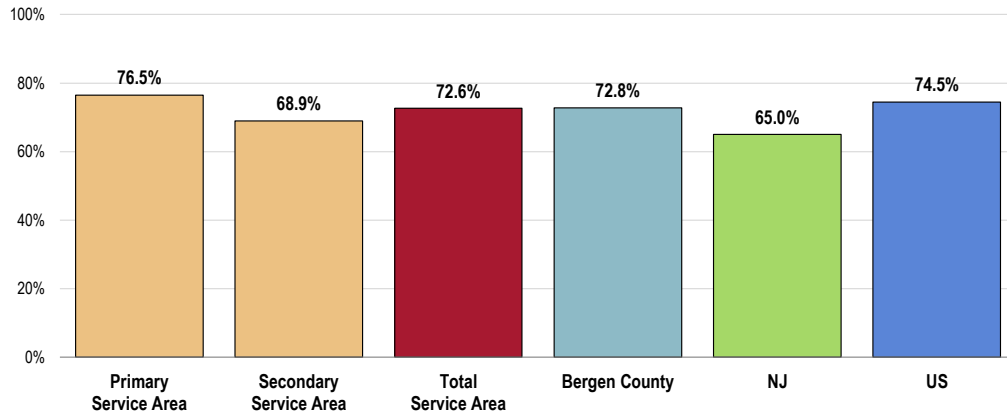
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

Notes:
- Asked of all respondents age 50 through 75.
- In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

Key Informant Input: Cancer

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

Perceptions of Cancer
as a Problem in the Community
(Key Informants, 2016)

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

Major Problem	Moderate Problem	Minor Problem	No Problem At All
44.3%	37.1%	10.0%	8.6%

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Prevalence/Incidence

> *There are so many types of cancers, and we are a large community; it becomes a major problem. - Community/Business Leader*

> *NJ has a history of cancer clusters, and I am sure that Bergen County also is susceptible. Treatment seems to be very accessible for the well-to-do and insured, but still takes a monumental toll. While there is a great deal of information and education available, I do not know to what extent people take advantage of the screenings. - Community/Business Leader*

> *There are many individuals of differing ages with diagnoses of cancer. - Social Services Provider*

> *Increased prevalence. - Social Services Provider*

Empirically, it's everywhere. Slightly hyperbolic, but seemingly true. - Community/Business Leader

Especially breast cancer. It seems everyone knows multiple cancer survivors, decedents and those battling cancer. - Other Health Provider

Everyone is touched by cancer to some extent. - Community/Business Leader

Despite the enormous headway we have made with many cancers such as breast, liver, pancreatic and all GI cancers are still causing death in relatively short periods of time. - Other Health Provider

I have seen many Meals on Wheels clients with different forms of cancer. - Social Services Provider

Growing incidence and lethality of the disease. - Social Services Provider

Pediatric disorders treated as a pediatric specialty here, with increased #s. More research needed re: diagnosis, genetic predisposition possibilities, preventions, etc. - Other Health Provider

Cancer is a major problem- not only in our community- but is the second leading cause of death in NJ. Prostate cancer is the most common, while lung cancer continues to be the single largest cause of death, while we may never know the exact science behind. - Public Health Representative

Cancer of all types seem to be a growing epidemic within our community. It started with breast and prostate, and now it has hit all organs. Treatments have improved greatly, still no cure in spite of all the money through various organizations being raised. - Other Health Provider

Because of the high incidence and lack of treatment options for the uninsured or underinsured. - Public Health Representative

Everyone in the community has either had that diagnosis or has someone in the family or a close friend who had dealt with it. - Other Health Provider

Number of occurrences. - Social Services Provider

Aging Population

Older adults are not always participating in preventive screening because transportation to doctors is limited. And because Medicare Advantage plans limit what doctors they can see. In addition, treatment for cancer can be expected, especially some of the chemo drugs. Affording these treatments pose problems for low-income seniors. - Social Services Provider

Elderly population that cannot afford cancer treatment due to co pays, balancing billing, or access to care, any age, if they are uninsured. - Other Health Provider

Varied age groups, however we have a large number of seniors. A population where cancer is on the rise. I do not think we do a good enough job at screening. - Other Health Provider

Early Detection

Patients ignoring symptoms for early detection and not having the financial means to seek until too late. - Social Services Provider

Lack of motivation on part of consumer to available themselves of preventative care/early detection. - Other Health Provider

Cancer screening. - Other Health Provider

Impact on Families/Caregivers

Too many lives and families are affected, and the cost of care is huge. More access to preventative options are needed. Treating and attempting to recover from the disease should not render families bankrupt or prohibit access to care by those who are under or not insured. - Other Health Provider

I work with cancer patients and their families, and the needs for emotional support- as well as financial aid- is most important and lacking. - Social Services Provider

Affordable Care/Services

I think we have a lot of programs that help finance screening programs but not diagnostic testing. Patient who cannot afford diagnostic testing go untreated. - Other Health Provider

It is hard for some individuals to obtain treatment. And even if they do, the costs and co-pays of drugs and treatments and hospitals are prohibitive. For these reasons often symptoms are ignored until the cancer is so far gone that treatment will not even help. - Community/Business Leader

Leading Cause of Death

Leading cause of death, along with heart disease. - Social Services Provider

Cancer is rapidly becoming the leading cause of death. This would be a high concern in any community in the United States. - Public Health Representative

Nutrition

The bad nutrition that we have; and sometimes, for some, there is no alternative. Stress inherent to our society, general contaminants in the environment. Not enough activity and exercise for many of us. - Social Services Provider

Environmental Contributors

The community has concerns regarding a superfund site (hexavalent chromium) which is a known carcinogen. - Other Health Provider

Genetic Predisposition

Genetic predisposition, lifestyle. Increased risks. - Other Health Provider

Respiratory Disease

About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

Asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

- Healthy People 2020 (www.healthypeople.gov)

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Respiratory Disease Deaths

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

Pneumonia and influenza mortality is also illustrated in the following chart. For prevalence of vaccinations against pneumonia and influenza, see also *Immunization & Infectious Disease*.

CLRD: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
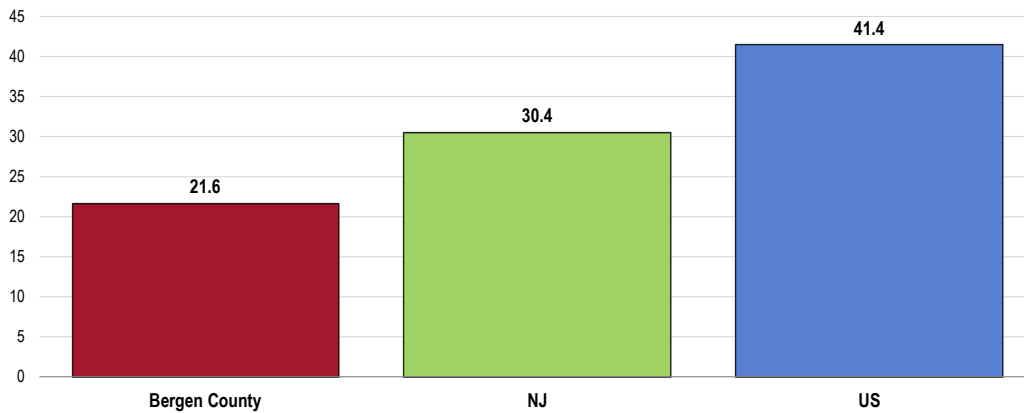
Bar chart showing CLRD age-adjusted mortality rates: Bergen County 21.6, NJ 30.4, US 41.4

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
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, age-adjusted to the 2000 US Standard Population.
            ● CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)

Bar chart showing Pneumonia/Influenza age-adjusted mortality rates: Bergen County 10.9, NJ 11.5, US 15.1

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
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, age-adjusted to the 2000 US Standard Population.

Prevalence of Respiratory Diseases

COPD

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

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)

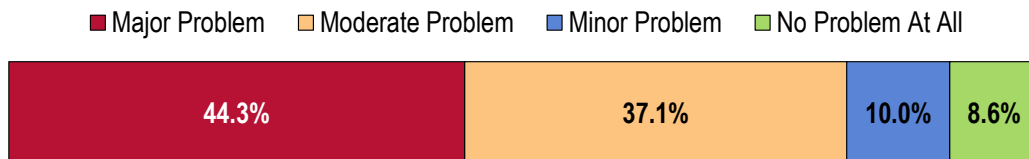|					
6.5%	10.5%	8.6%	10.3%	5.6%	9.5%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
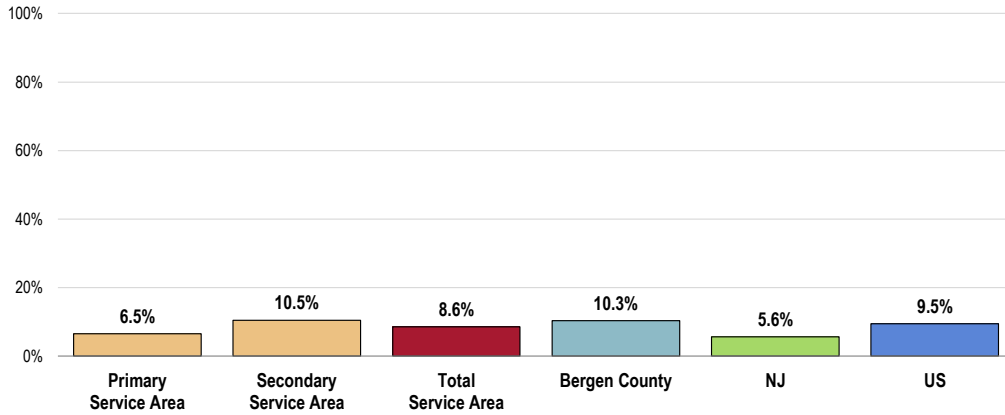
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Asthma

Adults: "Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?" (Calculated below as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma ["current asthma"]).

Children: "Has a doctor or other health professional ever told you that this child had asthma?" and "Does this child still have asthma?" (Calculated below as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma ["current asthma"]).

Adult Asthma: Current Prevalence

4.6%	5.4%	5.0%	9.0%	8.3%	9.5%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
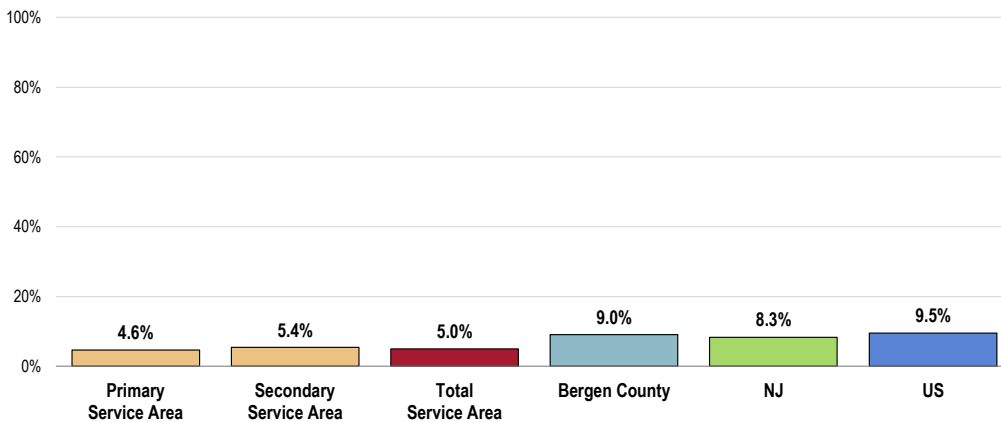
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.

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

Childhood Asthma: Current Prevalence
(Among Parents of Children Age 0-17)

Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US
6.4%	4.1%	5.1%	3.6%	6.5%
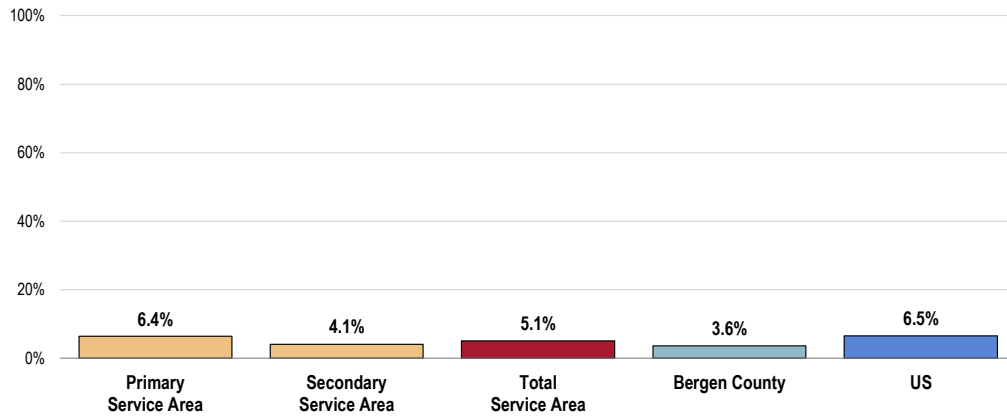
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.
● Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

Key Informant Input: Respiratory Disease

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

Perceptions of Respiratory Diseases
as a Problem in the Community
(Key Informants, 2016)

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

Major Problem	Moderate Problem	Minor Problem	No Problem At All
9.4%	54.7%	25.0%	10.9%

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

Top Concerns

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

Smoking

> *COPD in smokers, asthma, flu/pneumonia. - Other Health Provider*
>
> *Smoking and COPD. - Social Services Provider*

Genetic Predisposition

> *Genetic predisposition. - Other Health Provider*

Injury & Violence

About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as "accidents," "acts of fate," or as "part of life." However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence
- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Leading causes of accidental death in Bergen County include the following:

Leading Causes of Accidental Death
(Bergen County, 2012-14)
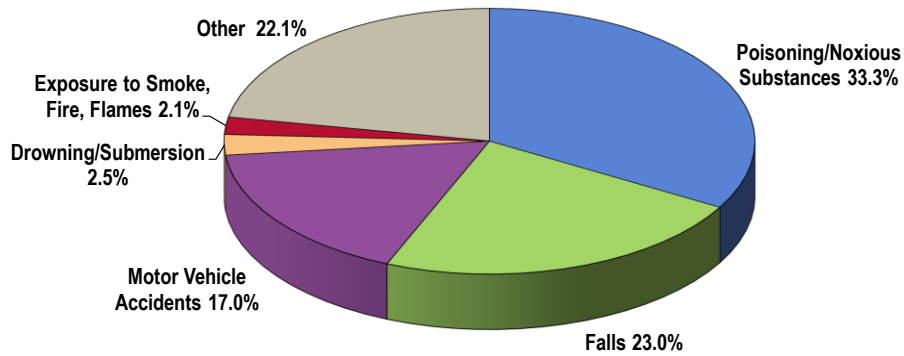
- Other 22.1%
- Exposure to Smoke, Fire, Flames 2.1%
- Drowning/Submersion 2.5%
- Motor Vehicle Accidents 17.0%
- Falls 23.0%
- Poisoning/Noxious Substances 33.3%

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in Bergen County.

- Note the Healthy People 2020 targets.

Unintentional Injuries: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 36.4 or Lower
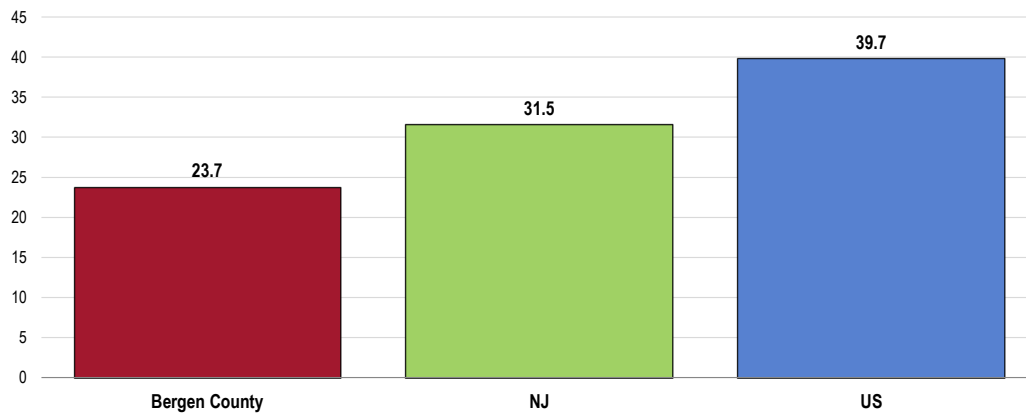
	Bergen County	NJ	US
	23.7	31.5	39.7

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]
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, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Deaths for Selected Injury-Related Causes

The following chart outlines shows age-adjusted mortality rates for drug-induced deaths, motor vehicle crash deaths, and fall-related deaths (among adults age 65+).

Select Injury Death Rates
(By Cause of Death; Annual Average Deaths per 100,000 Population)

■ Bergen County　■ NJ　■ US

	Drug-Induced Deaths* HP2020 Goal = 11.3 or Lower	Motor Vehicle Accidents HP2020 Goal = 12.4 or Lower	Falls (65+) HP2020 Goal = 47.0 or Lower
Bergen County	9.6	4.2	29.2
NJ	14.5	6.2	29.1
US	14.6	10.6	57.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1, IVP-23.2, SA-12]

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, age-adjusted to the 2000 US Standard Population.
- *Drug-induced deaths include both intentional and unintentional drug overdoses.

Intentional Injury (Violence)

Homicide

Age-adjusted mortality attributed to homicide is shown below.

Homicide: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 5.5 or Lower
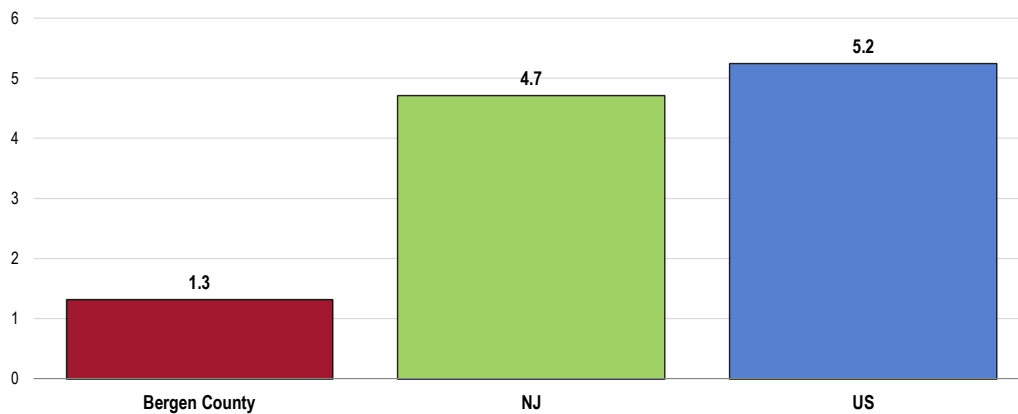
Bergen County	NJ	US
1.3	4.7	5.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-29]

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, age-adjusted to the 2000 US Standard Population.

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault. Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime
(Rate per 100,000 Population, 2010-2012)
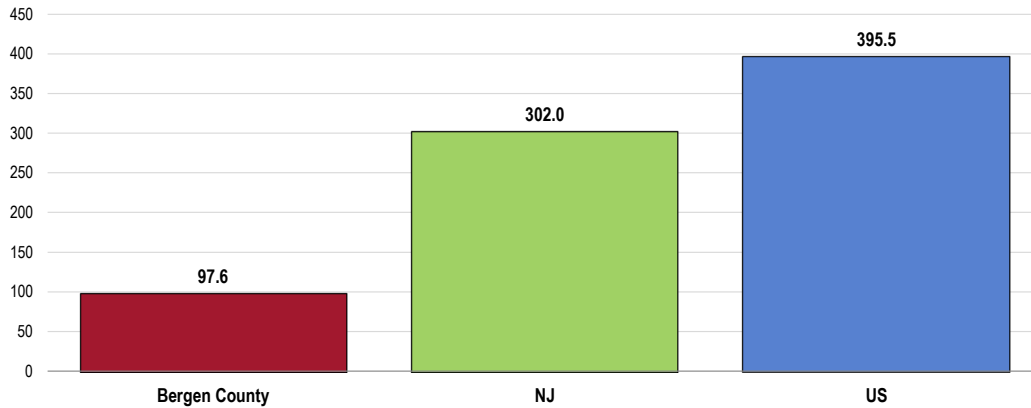
Sources: ● Federal Bureau of Investigation, FBI Uniform Crime Reports.
● Retrieved April 2016 from Community Commons at http://www.chna.org.
Notes: ● This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
● Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Violent Crime Experience: **"Have you been the victim of a violent crime in your area in the past 5 years?"**

Victim of a Violent Crime in the Past Five Years
(Total Service Area, 2016)
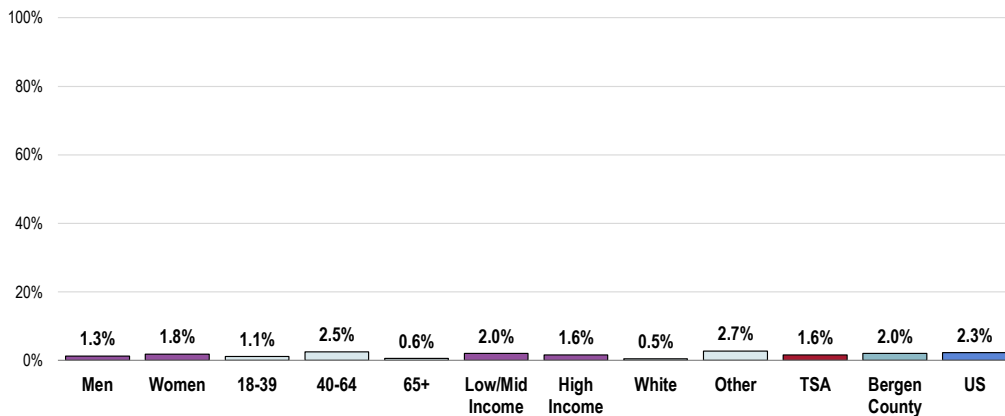
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Intimate Partner Violence: **"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"**

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner
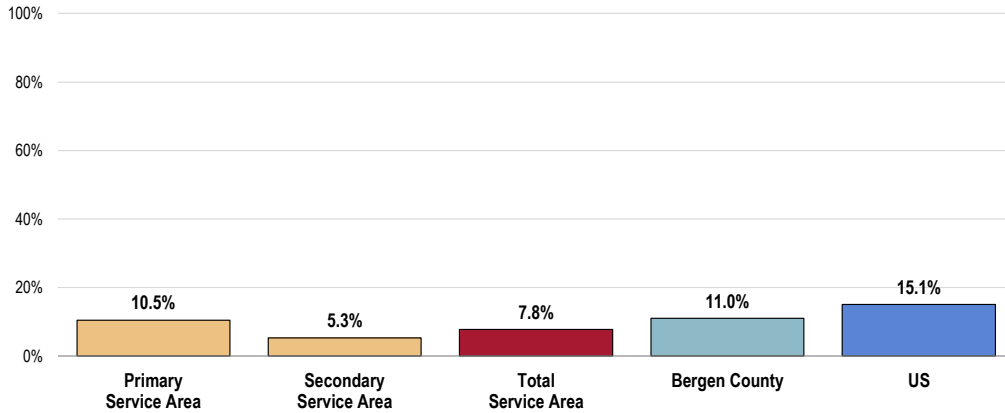
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Neighborhood Safety

"How safe from crime do you consider your neighborhood to be? Would you say: extremely safe, quite safe, slightly safe, or not at all safe?"

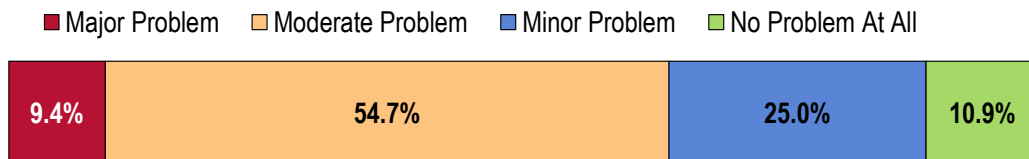## Perceive Own Neighborhood as "Slightly" or "Not At All" Safe
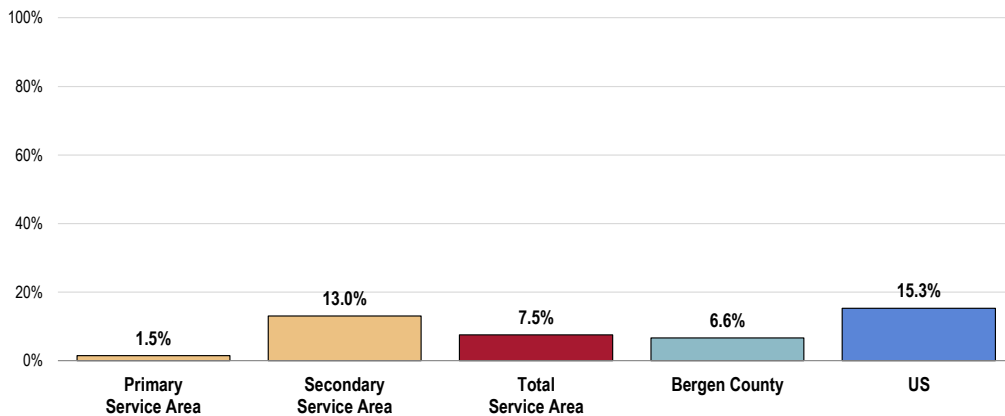
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Perceive Own Neighborhood as "Slightly" or "Not At All" Safe
(Total Service Area, 2016)
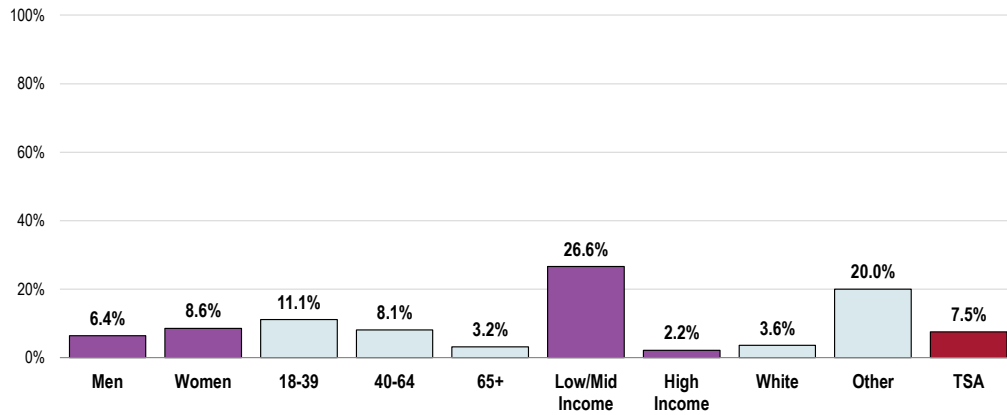
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Key Informant Input: Injury & Violence

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

Perceptions of Injury and Violence
as a Problem in the Community
(Key Informants, 2016)
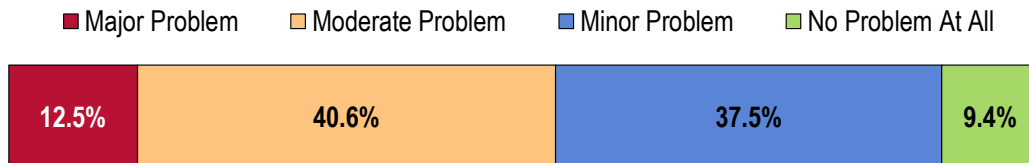
■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

12.5%	40.6%	37.5%	9.4%

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

Top Concerns

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

Vulnerable Populations

> *The major problems related to violence and injury tend to be clustered most frequently in the lower-income and urban communities in the county. Although, there seems to be a rise in the number of incidents throughout the county. - Social Services Provider*

> *Language barriers. - Other Health Provider*

Unintentional Injuries

> *High incidence of motor vehicle and pedestrian injuries and deaths- especially in older adult population. - Other Health Provider*

Gun Violence

> *Gun control, education for domestic violence and pressures of everyday living stresses allow for so much more reactive violence. - Community/Business Leader*

Gangs

> *I believe gang violence in parts of the county/state represents a real threat to all of our safety. - Other Health Provider*

Domestic Violence

> *Domestic violence caused by joblessness, alcoholism, etc. - Social Services Provider*

Diabetes

About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for Bergen County is shown in the following chart.

- Note the Healthy People 2020 target (as adjusted to account for diabetes mellitus-coded deaths).
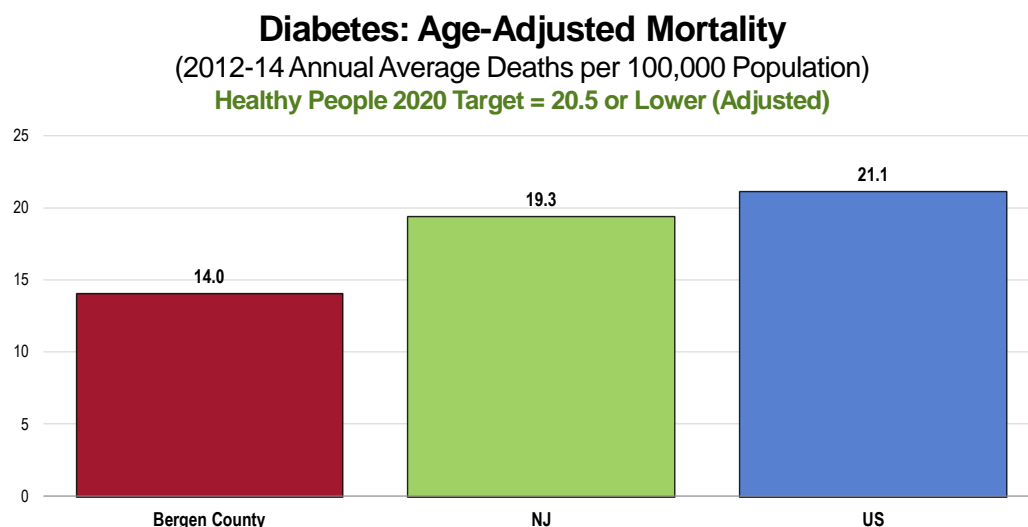
Diabetes: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 20.5 or Lower (Adjusted)

Bergen County	NJ	US
14.0	19.3	21.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
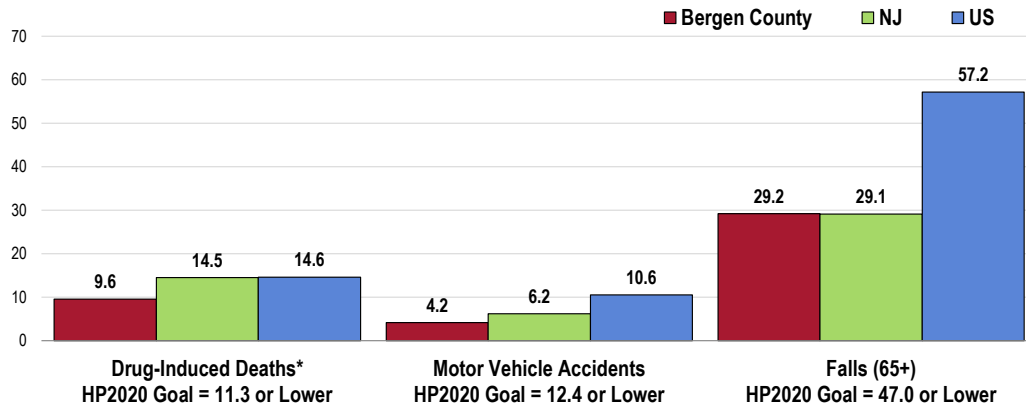- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

"Have you ever been told by a doctor that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)"

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

Prevalence of Diabetes
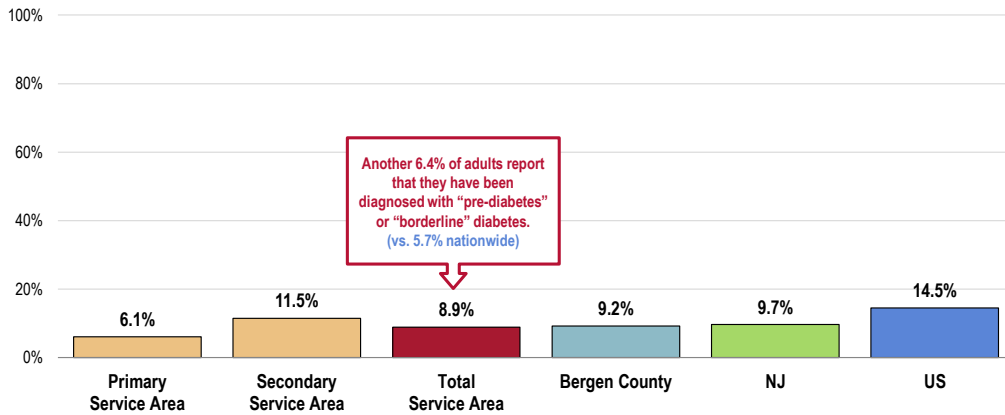
Another 6.4% of adults report that they have been diagnosed with "pre-diabetes" or "borderline" diabetes.
(vs. 5.7% nationwide)

Primary Service Area	6.1%
Secondary Service Area	11.5%
Total Service Area	8.9%
Bergen County	9.2%
NJ	9.7%
US	14.5%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.

Notes:
- Asked of all respondents.

Prevalence of Diabetes

(Total Service Area, 2016)
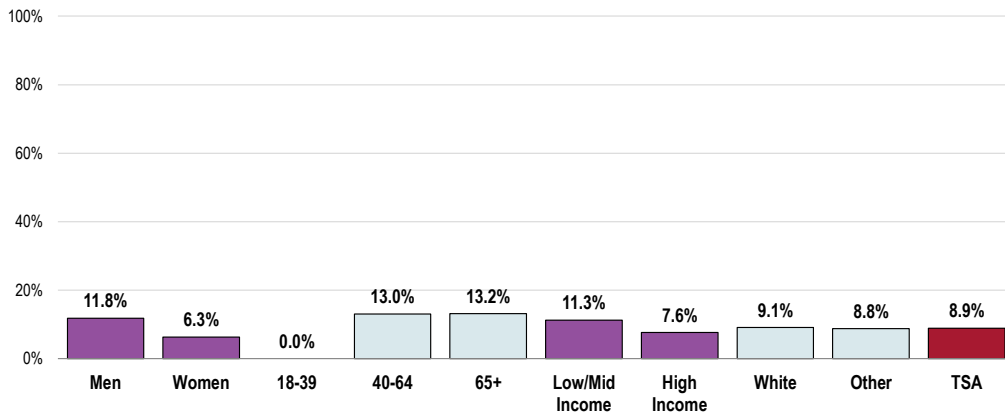
Men	11.8%
Women	6.3%
18-39	0.0%
40-64	13.0%
65+	13.2%
Low/Mid Income	11.3%
High Income	7.6%
White	9.1%
Other	8.8%
TSA	8.9%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.
- Excludes gestational diabetes (occurring only during pregnancy).

Diabetes Testing

"Have you had a test for high blood sugar or diabetes within the past three years?"

Have Had Blood Sugar Tested in the Past Three Years
(Among Nondiabetics)

Category	Percentage
Primary Service Area	62.0%
Secondary Service Area	49.4%
Total Service Area	55.5%
Bergen County	55.3%
US	55.1%
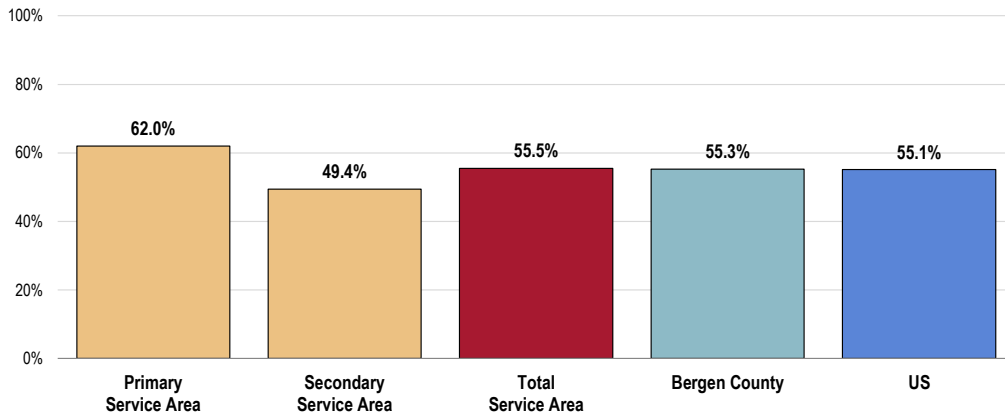
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of respondents who have not been diagnosed with diabetes.

Key Informant Input: Diabetes

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

Perceptions of Diabetes
as a Problem in the Community
(Key Informants, 2016)
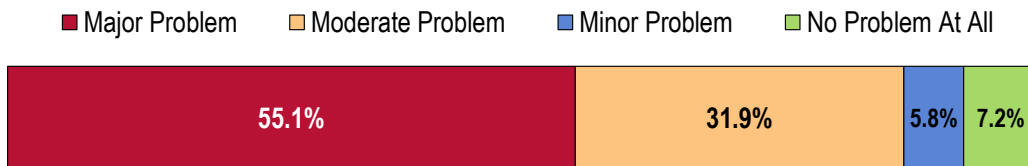
■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
55.1%	31.9%	5.8%	7.2%

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

Challenges

Among those rating this issue as a "major problem," the biggest challenges for people with diabetes are seen as:

Disease Management

> *Staying on an appropriate diet, accessing and taking medications. - Social Services Provider*
> *Adjusting to living with newly-diagnosed diabetes. - Other Health Provider*
> *Compliance with care. - Other Health Provider*
> *Medical follow-up and buying the medication. - Social Services Provider*

Compliance with diet and exercise. - Other Health Provider

Understanding and managing their disease properly with medication, diet, and exercise. Without close oversight and proper education, many challenges can arise. - Social Services Provider

Acceptance of pre-diabetes as a disease. Very few programs geared to this population. Need more How-To's for pre-diabetics and diabetics: what to eat, recipes, how to shop. - Other Health Provider

Keeping their blood sugar numbers in normal ranges to help avoid future ailments related to their diabetes. - Community/Business Leader

People do not want to take care of their own health. - Public Health Representative

Health Education

Understanding how nutrition and exercise can help them prevent and/or manage this disease. - Community/Business Leader

Understanding what to eat. - Other Health Provider

Education and prevention Type II, acceptance of nutritional counseling. - Community/Business Leader

More awareness and new treatments. - Social Services Provider

Diabetic Education and compliance. - Other Health Provider

Lack of information and interpretation of nutrition as it relates to the disease. - Other Health Provider

Diet and education. - Social Services Provider

Prevalence/Incidence

Approximately 45% of PV Meals on Wheels clients have diabetes. - Social Services Provider

Diabetes is prevalent in our health center population. Major obstacle for our patients is access to specialty care, medications such as insulin for uninsured, eye exams for uninsured. Health education on diabetes and nutritional counseling are also needed services that are difficult to obtain. - Other Health Provider

It is anticipated that the rate of people with diabetes is increasing. It is estimated that close to a half a million adults in NJ have been diagnosed with diabetes and about 200,000 people do not even know they have it. The biggest challenges for people with diabetes in Paramus, first-off, is to be screened. Once they are screened, it is important that they get educated on how to control diabetes and are aware of its complications. It is also important to improve the quality of care for diabetes and access to care. - Public Health Representative

Nutrition

The ability to cook single meals that are within the sugar nutrition guidelines. Affording diabetic socks, etc., to help with disease. Affordable and tasty alternatives to the "crap" food around. - Social Services Provider

To me, it's about preventing the onset of diabetes but promoting weight loss and exercise. - Public Health Representative

Eating habits and lack of exercise. - Community/Business Leader

Diagnosis/Treatment

Initial diagnosis of the disease. Many people have the disease but don't know it. - Physician

Detection of the disease. Adequate nutritional counseling. Managing and balancing nutrition and exercise. - Social Services Provider

Disease which is diagnosed much later than it should be, due to lack of insurance. Cost of insulin and follow-up care. - Other Health Provider

Costs for proper diet and medication, and availability of medical control necessary to monitor the patients. - Community/Business Leader

Access to Care/Services

Medication and supplies. Access. - Other Health Provider

Not enough resources for patients. - Physician

Lack of availability to proper care and patient unwillingness to follow prescribed treatment. - Social Services Provider

Obtaining medications is not financially feasible for most patients. - Other Health Provider

Language Barriers

Language barriers, educational barriers. Lack of knowledge of available resources. - Other Health Provider

Support Groups

Finding support groups and nutritional support. - Public Health Representative

Obesity

Overweight. - Social Services Provider

Alzheimer's Disease

About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined below.

Alzheimer's Disease: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)

	Bergen County	NJ	US
Rate	14.9	16.9	24.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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, age-adjusted to the 2000 US Standard Population.

Confusion & Memory Loss

Adults Age 45 and Older: "During the past 12 months, have you experienced confusion or memory loss that is happening more often or getting worse?"

Experienced Increasing Confusion/Memory Loss in Past Year
(Among Respondents Age 45 and Older)
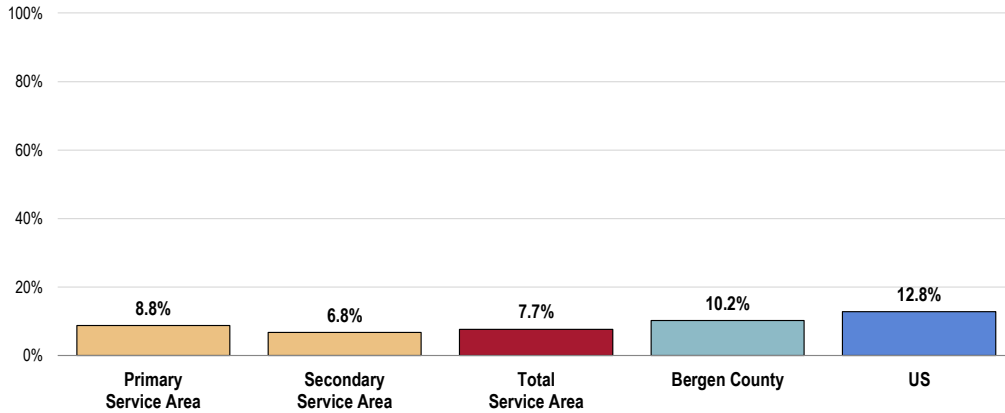
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of those respondents age 45 and older.

Key Informant Input: Dementias, Including Alzheimer's Disease

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

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community
(Key Informants, 2016)
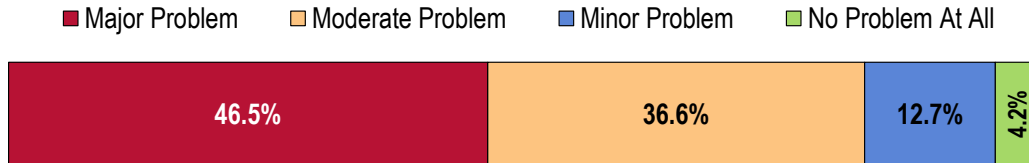
■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

46.5%	36.6%	12.7%	4.2%

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Aging Population

> *Increasing as people live longer. - Social Services Provider*

> *The statistic is that close to 50% of adults 85 years of age and older have some form of dementia. People are aging, and it appears that the number of people diagnosed with dementia has increased in the last ten years. Dementia is a devastating disease, and I see caregivers struggling to provide the needed care to their older relatives or spouses. Connecting with supportive care services poses problems, either reluctance to involve with the care system, the cost of care, or the behavior of the older adult with dementia makes connecting to the system difficult. - Social Services Provider*

> *The growing number of senior populations in Bergen County increases the number of people with dementia. This disease has a huge impact on the family. With little support offered, the stress on the caregiver- especially if also elderly- is tremendous. - Other Health Provider*

> *Increased population of older adults, especially population 85 years and older. Many older adults live alone and lack family support. - Other Health Provider*

There are a lot of elderly people living in Bergen County, and as I talk with them- as well as their children- it is a big issue. - Social Services Provider

People are living longer, and dementia/AD becomes an increasing problem with the elderly. - Other Health Provider

High volume of elderly who live alone and have dementia. - Other Health Provider

As the population of Bergen County gets older, we are seeing a lot more people with dementia. I suspect that many people are living at home in single family homes with difficulty accessing all the support needed to care for someone with memory problem. - Community/Business Leader

As the "old" population grows in size and lives longer, there will be a greater prevalence of dementia. Dementia specific assisted living facilities are prohibitively expensive. Many older adults are outliving their resources and lack resources. - Other Health Provider

People are living longer, and patients are being diagnosed quicker. - Social Services Provider

We are living longer and now it is identified earlier. - Other Health Provider

The risk of Alzheimer's increases greatly with age. After the age of 65, the risk of developing the disease doubles every 5 years. It is about 50% by age 85. People have described Alzheimer's as worse than having cancer. In addition, Alzheimer's places an enormous emotional burden on family and caregivers. - Public Health Representative

Prevalence/Incidence

I see different levels in all ages. - Social Services Provider

One in 6 people will develop it. - Social Services Provider

Because of the rising numbers of people diagnosed with this illness and not enough treatment places available to provide the specific care. - Social Services Provider

Many Meals on Wheels clients have dementia or Alzheimer's disease. - Social Services Provider

Fastest-growing disease and affecting all ages, younger and younger. Stigma of the disease often slows down allowing it to be identified and treated. - Community/Business Leader

Progressing rapidly with no cure. - Community/Business Leader

Seems to be a continuously growing disease state with no real cure. - Social Services Provider

Speaking with Internal Medicine and Geriatric physicians, they are starting to see more and more patients presenting with this disease. At a recent health fair, which targeted Dementia/Alzheimer's, there were many family members in attendance, who spoke of a loved one now suffering with this disease. - Other Health Provider

Impact on Families/Caregivers

One and four adults will be caregivers. More community support services are need to provide care for persons with Alzheimer's. Also more information needs to be available about services that do exist. - Social Services Provider

Many families wish to keep their elder family members at home, and there are limited amounts of daycare facilities. Long Term Care facilities need to be specifically designed to protect residents with dementia/Alzheimer's, and the space for this specialty is limited. - Public Health Representative

Oftentimes, it is difficult for families to find care that is sufficient in the home. Many families are hesitant to make decisions on behalf of their loved ones, and affordable assisted living options may not always be available to all without selling a home. And people wait too long to make decisions and end up in a crisis mode. Resources are available, but people may be hesitant to reach out or not know where to begin. - Social Services Provider

Not enough to keep family members at home. Bergen County has an aging population. - Other Health Provider

Care of elderly by family members. Cost issues and care needs at home. - Community/Business Leader

Diagnosis/Treatment

Often is goes undetected or treated with other symptoms as part of another problem. Doctors don't take into account mental health when doing a physical. Families are very much scattered over the globe and don't see their parents enough to determine if their mental status is adequate for driving and maintaining a household. - Social Services Provider

Delirium, mortality associated with it during the hospitalization. - Other Health Provider

Access to Care/Services

Not enough clinical support for patients and families. - Physician

Access to Providers

Not enough qualified doctors who accept and treat persons with this disease. - Physician

Genetic Predisposition

Genetic predisposition. - Other Health Provider

Kidney Disease

About Chronic Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart.

Kidney Disease: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)

|	Bergen County	NJ	US
	12.1	13.5	13.2

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
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, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"

Prevalence of Kidney Disease

	Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
	1.6%	0.6%	1.1%	3.1%	2.4%	3.6%
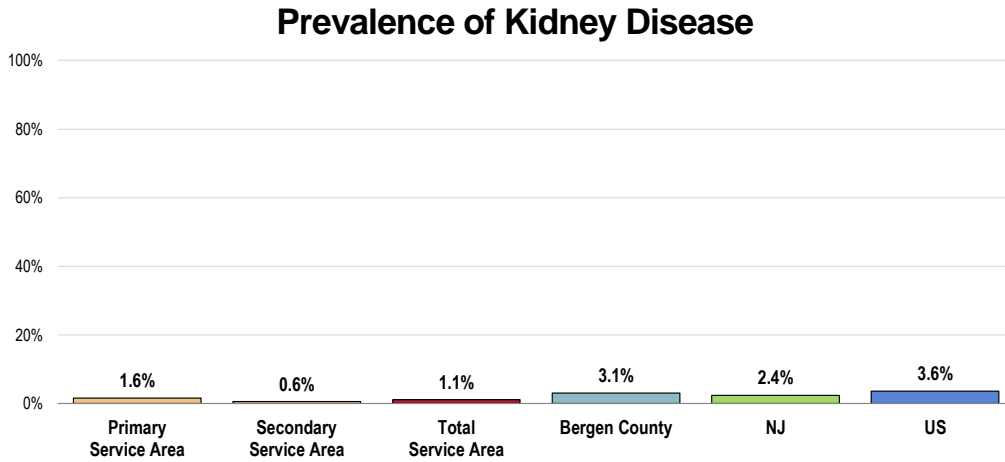
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Chronic Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Chronic Kidney Disease* as a problem in the community:
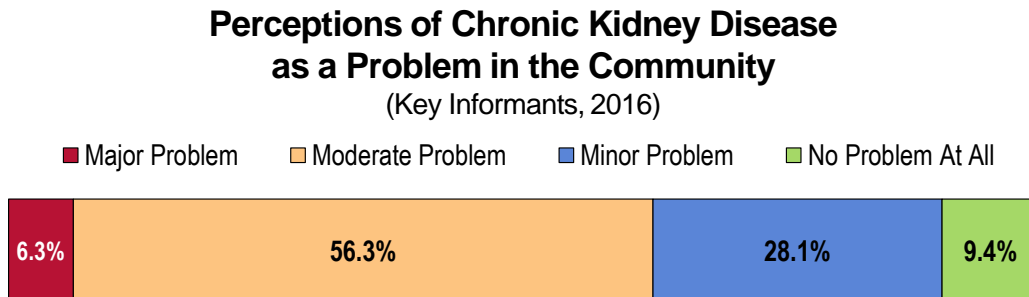
Perceptions of Chronic Kidney Disease as a Problem in the Community
(Key Informants, 2016)

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

6.3%	56.3%	28.1%	9.4%

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Affordable Care/Services

> *The cost and time of treatment is not always available to the needy. And, again, usually by the time it is diagnosed, it is way into the disease. - Community/Business Leader*

Comorbidities

> *We have obesity, hypertension, and diabetes. - Social Services Provider*

Septicemia

About Sepsis & Septicemia

Sepsis is the body's overwhelming and life-threatening response to infection which can lead to tissue damage, organ failure, and death. It is difficult to predict, diagnose, and treat. Patients who develop sepsis have an increased risk of complications and death and face higher healthcare costs and longer treatment. CDC is working to increase sepsis awareness and improve treatment among the public, healthcare providers, and healthcare facilities. Read personal stories and perspectives on sepsis at: CDC's Safe Healthcare Blog.

CDC's National Center for Health Statistics (NCHS) estimates that, based upon information collected for billing purposes, the number of times people were in the hospital with sepsis or septicemia (another word for sepsis) increased from 621,000 in the year 2000 to 1,141,000 in 2008.

- Centers for Disease Control and Prevention (www.cdc.gov)

Age-Adjusted Septicemia Deaths

Age-adjusted septicemia mortality for the area is shown in the following chart.
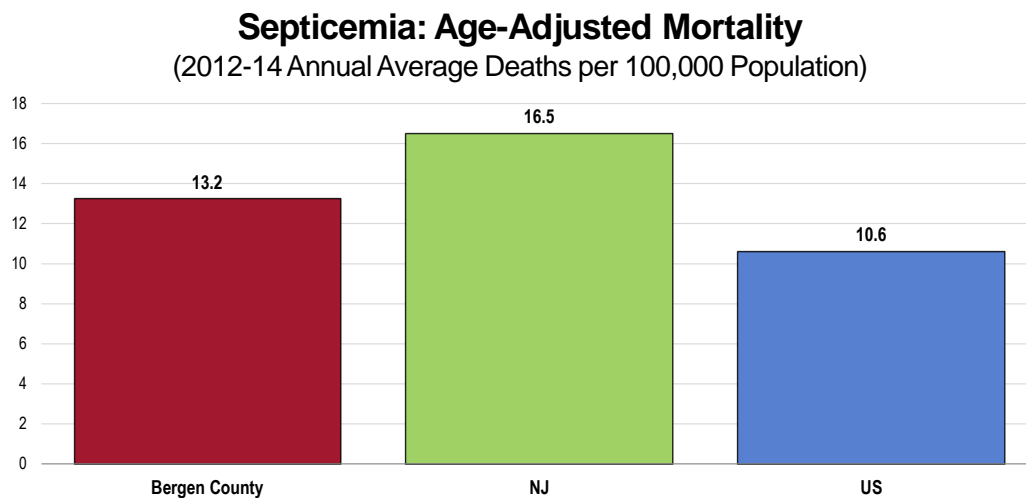
Septicemia: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)

Bergen County	NJ	US
13.2	16.5	10.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.

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, age-adjusted to the 2000 US Standard Population.

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active.   Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least $50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

- Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Back Conditions

"Would you please tell me if you have ever suffered from or been diagnosed with arthritis or rheumatism?" (Reported below among only those age 50+.)

"Would you please tell me if you have ever suffered from or been diagnosed with osteoporosis?" (Reported below among only those age 50+.)

"Would you please tell me if you have ever suffered from or been diagnosed with sciatica or chronic back pain?" (Reported below among all adults age 18+.)

See also *Activity Limitations* in the General Health Status section of this report.

Prevalence of Potentially Disabling Conditions

Primary Service Area | Secondary Service Area | Total Service Area | Bergen County | US

Arthritis/Rheumatism (50+)
- 26.3%
- 34.5%
- 30.6%
- 28.6%
- 32.0%

Osteoporosis (50+)
HP2020 Objective = 5.3% or Lower
- 9.9%
- 7.0%
- 8.4%
- 8.5%
- 8.7%

Sciatica/Chronic Back Pain (18+)
- 16.6%
- 15.3%
- 15.9%
- 20.7%
- 19.4%
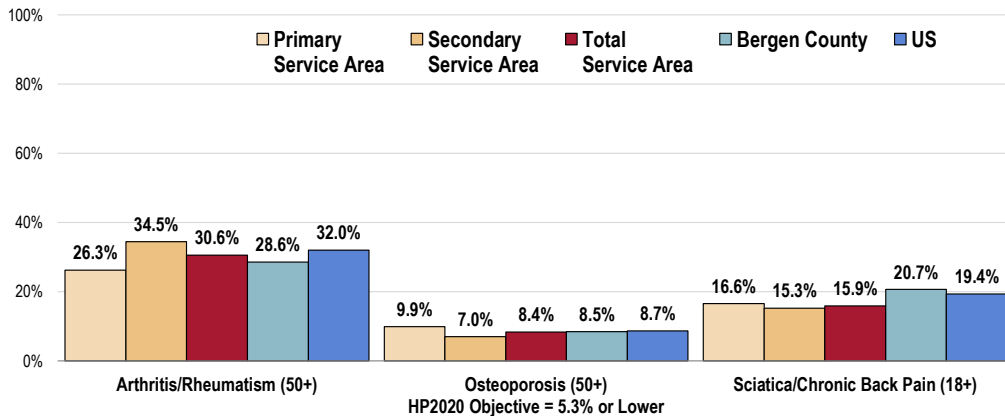
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 28, 161-162]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AOCBC-10]

Notes:
- The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

The following chart outlines key informants' perceptions of the severity of *Arthritis, Osteoporosis & Chronic Back Conditions* as a problem in the community:

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community
(Key Informants, 2016)
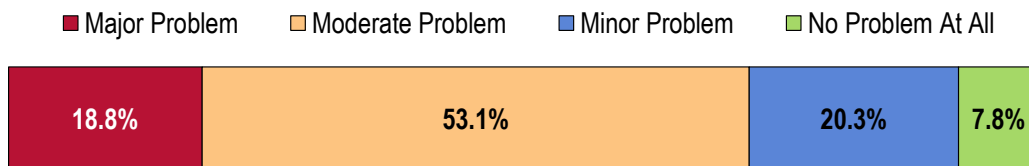
Major Problem | Moderate Problem | Minor Problem | No Problem At All

| 18.8% | 53.1% | 20.3% | 7.8% |

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Aging Population

> *We have an aging population. And in the affluent areas- which comprise much of Bergen County- seniors wish to remain physically active. This activity enhances back and arthritic problems. - Other Health Provider*

> *Our community is aging with many post-menopausal residents. Access to specialists and general information regarding prevention is lacking. - Community/Business Leader*

> *The aging community, who exhibit these issue, were not knowledgeable about prevention when they could have had benefit from lifestyle changes. And now many deal with these problems. Also, living longer contributes. - Other Health Provider*

> *Not only with the aging population, but also how we stress extreme physical exercise on the young, we are seeing more repetitive injuries younger in life. - Other Health Provider*

> *We feel this condition applies to almost everybody aging- not only in the county, but nationally. Think about it, everyone I know has a back condition. The health care providers can tell you that doctors are very busy treating people with all the above conditions. - Public Health Representative*

Prevalence/Incidence

Common health condition associated with morbidity/work loss. - Other Health Provider

Chronic conditions, such as back pain, reduce productivity and lead to dependence on pain medication. - Social Services Provider

Pediatric arthritis and immunological disorders treated as a specialty here, with increased #s. More research needed re: diagnosis, genetic predisposition possibilities, preventions, etc. - Other Health Provider

These are the physical conditions that patients come frequently to our emergency room for pain medications, etc. - Social Services Provider

Health Education

Many people complain about these conditions and are not sure what to do to help improve them. - Community/Business Leader

Insufficient Physical Activity

Lack of exercise as a whole. Lack of embracing benefits of stretching. Leading sedentary lives. Poor eating habits that are not viewed as poor. - Community/Business Leader

Work Conditions

Because of overwork and poor nutrition. - Social Services Provider

Genetic Predisposition

Genetic predisposition, lack of education about condition. - Other Health Provider

Vision & Hearing Impairment

Vision Trouble

About Vision

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

- Healthy People 2020 (www.healthypeople.gov)

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

- Healthy People 2020 (www.healthypeople.gov)

"Would you please tell me if you have ever suffered from or been diagnosed with blindness or trouble seeing, even when wearing glasses?"

"Would you please tell me if you have ever suffered from or been diagnosed with deafness or trouble hearing?"

Prevalence of Blindness/Deafness

	Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US
Blindness/Trouble Seeing Even With Glasses	2.8	5.2%	4.1%	6.8%	7.3%
Deafness/Trouble Hearing	9.5	8.1%	8.8%	9.1%	8.6%

New Jersey = 3.9%
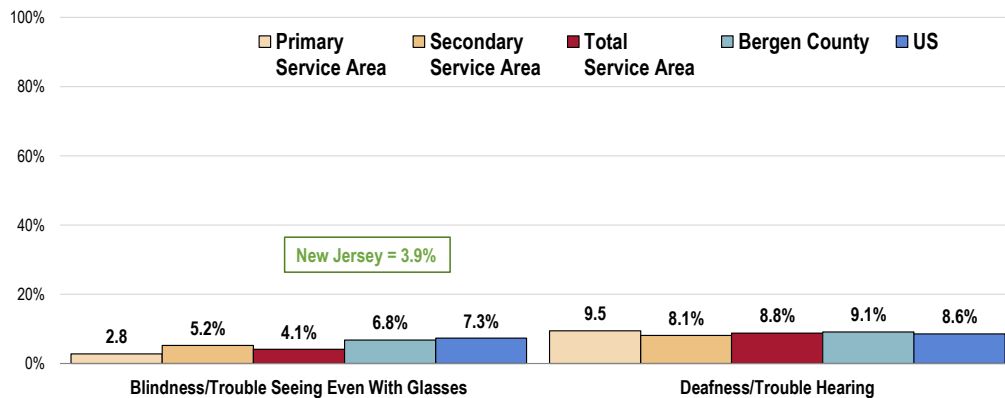
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 25-26]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.

Notes:
- Reflects the total sample of respondents.

Key Informant Input: Vision & Hearing

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

Perceptions of Vision and Hearing
as a Problem in the Community
(Key Informants, 2016)
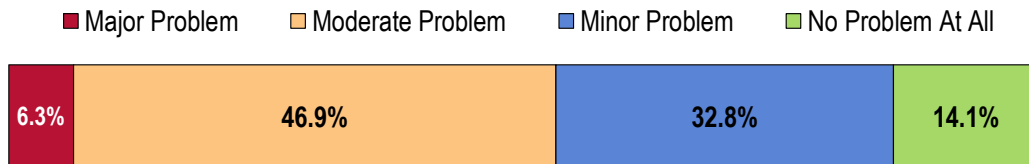
■ Major Problem　□ Moderate Problem　■ Minor Problem　□ No Problem At All

6.3%	46.9%	32.8%	14.1%

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

Top Concerns

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

Aging Population

> *DMV, local police, and primary care physicians need to work together to decide if driving is still appropriate for certain senior citizens. Hearing aid devices are terribly expensive, and there's very little backing, if any, from health insurance. Two major senses that- if at a loss- can be detrimental and even harmful to seniors. - Social Services Provider*

> *Again, we are an aging population. Hearing and vision diminishes with age. - Other Health Provider*

Affordable Care/Services

> *Not available in most clinics for free or low cost. - Other Health Provider*

Infectious Disease

About Immunization & Infectious Diseases

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by $9.9 billion.
- Saves $33.4 billion in indirect costs.
- Healthy People 2020 (www.healthypeople.gov)

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

- Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

"There are two ways to get the seasonal flu vaccine, one is a shot in the arm and the other is a spray, mist, or drop in the nose called FluMist®. During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?"

"A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the seasonal flu shot. Have you ever had a pneumonia shot?"

Chart columns below show these findings among those age 65+. Percentages for "high-risk" adults age 18-64 in the Total Service Area are also shown; here, "high-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

● Note also the Healthy People 2020 targets.

Older Adults: Have Had a Flu Vaccination in the Past Year
(Among Adults Age 65+)
Healthy People 2020 Target = 70.0% or Higher
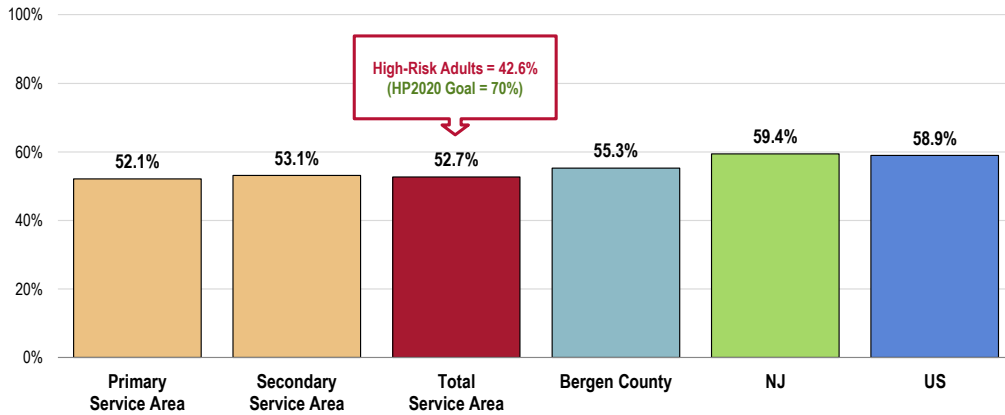
High-Risk Adults = 42.6%
(HP2020 Goal = 70%)

52.1%	53.1%	52.7%	55.3%	59.4%	58.9%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 163-164]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12]

Notes: ● Reflects respondents 65 and older.
● "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
● Includes FluMist as a form of vaccination.

Older Adults: Have Ever Had a Pneumonia Vaccine
(Among Adults Age 65+)
Healthy People 2020 Target = 90.0% or Higher
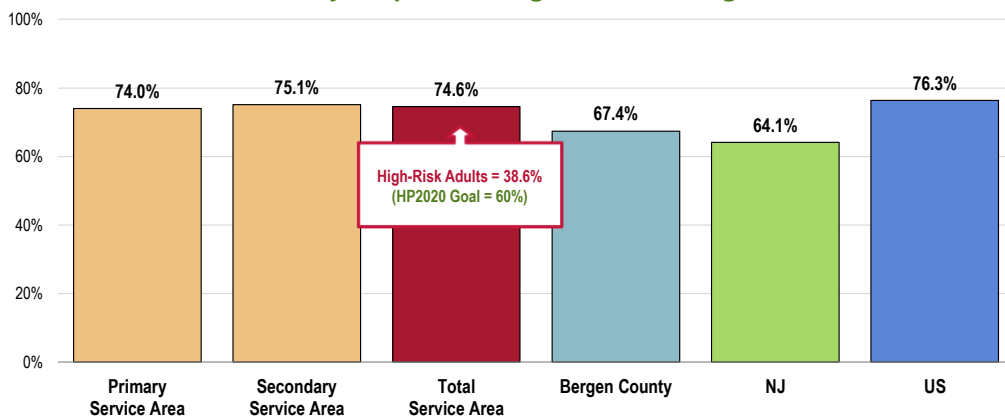
High-Risk Adults = 38.6%
(HP2020 Goal = 60%)

74.0%	75.1%	74.6%	67.4%	64.1%	76.3%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 165-166]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives IID-13.1, IID-13.2]

Notes: ● Reflects respondents 65 and older.
● "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

HIV

About HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

- Healthy People 2020 (www.healthypeople.gov)

HIV/AIDS Deaths

The following chart outlines age-adjusted mortality rates for Bergen County in comparison with state and national rates.

HIV/AIDS: Age-Adjusted Mortality
(2004-13 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 3.3 or Lower
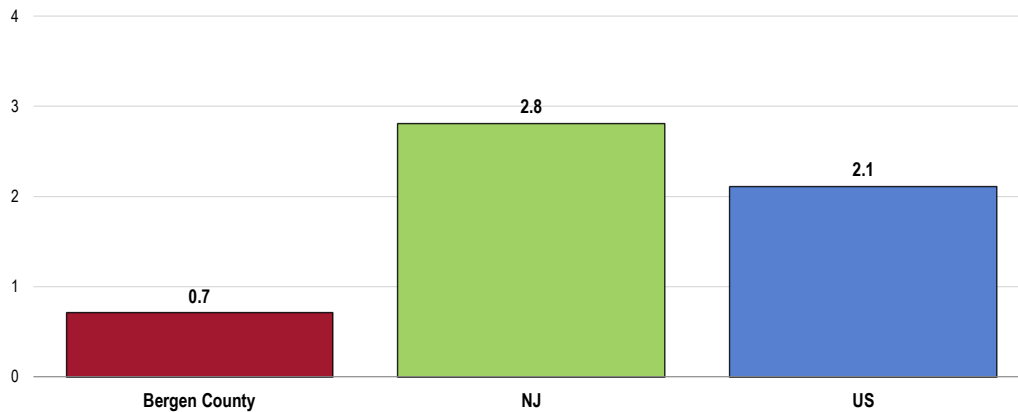
	Bergen County	NJ	US
	0.7	2.8	2.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

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, age-adjusted to the 2000 US Standard Population.

HIV Prevalence

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in Bergen County.

HIV Prevalence
(Prevalence Rate of HIV per 100,000 Population, 2013)
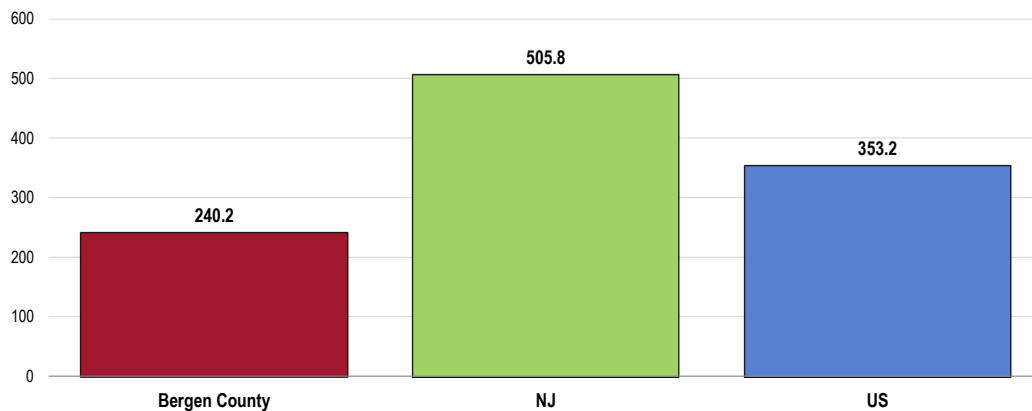
	Bergen County	NJ	US
	240.2	505.8	353.2

Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

HIV Testing

"Not counting tests you may have had when donating or giving blood, when was the last time you were tested for HIV?" (Reported below only among adults age 18 to 44.)

Tested for HIV in the Past Year
(Among Adults Age 18-44)
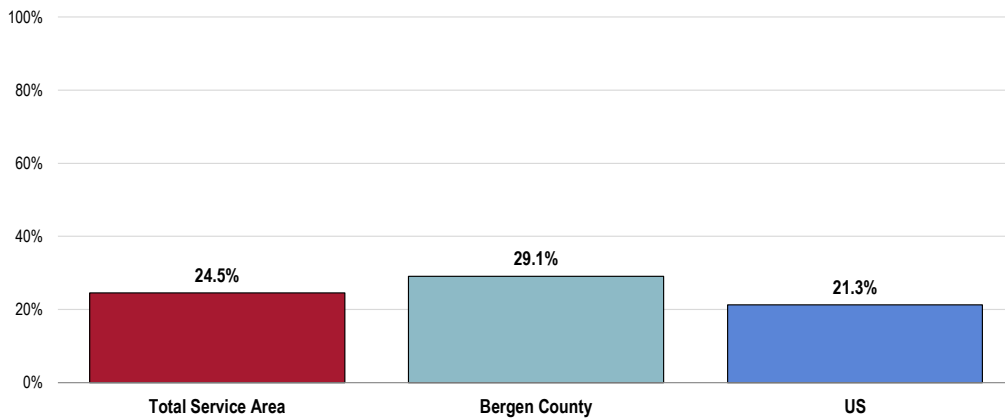
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]
          • 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Reflects respondents age 18 to 44.

Key Informant Input: HIV/AIDS

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

Perceptions of HIV/AIDS
as a Problem in the Community
(Key Informants, 2016)

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

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs**. The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities**. Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities**. Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications**. Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons "linked" by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

Chlamydia. Chlamydia is the most commonly reported STD in the United States; most people who have chlamydia don't know it 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 STDs.

Chlamydia & Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2014)
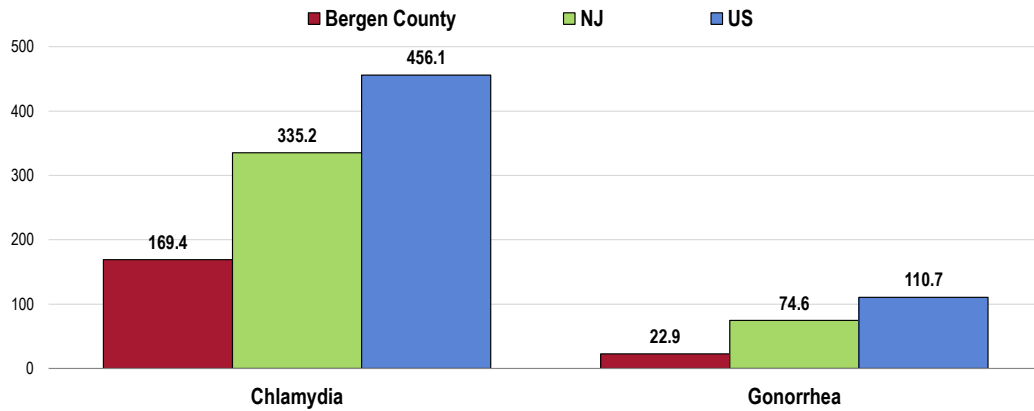
■ Bergen County   ■ NJ   ■ US

Chlamydia:
- Bergen County: 169.4
- NJ: 335.2
- US: 456.1

Gonorrhea:
- Bergen County: 22.9
- NJ: 74.6
- US: 110.7

Sources: ● Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2014.
            ● Retrieved April 2016 from Community Commons at http://www.chna.org.
Notes: ● This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Safe Sexual Practices

Sexual Partners

"During the past 12 months, with how many people have you had sexual intercourse?"

"Was a condom used the last time you had sexual intercourse?"

Each of these is reported below only among adults who are unmarried and between the ages of 18 and 64.

Sexual Risk
(Unmarried Adults Age 18-64)

■ Total Service Area   ■ Bergen County   ■ US

3+ Sexual Partners in the Past Year:
- Total Service Area: 9.1%
- Bergen County: 11.2%
- US: 10.3%

Used Condom During Last Sexual Intercourse:
- Total Service Area: 47.2%
- Bergen County: 49.9%
- US: 44.5%
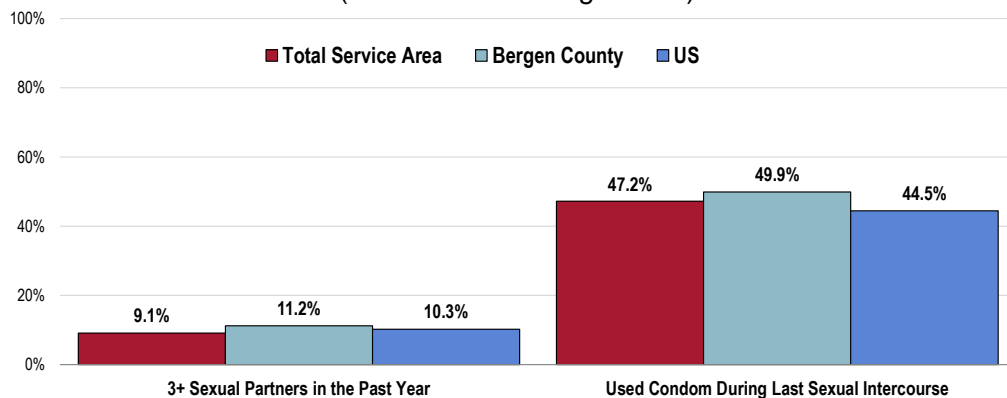
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 97-98]
            ● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects unmarried respondents under the age of 65.

Key Informant Input: Sexually Transmitted Diseases

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

Perceptions of Sexually Transmitted Diseases
as a Problem in the Community
(Key Informants, 2016)
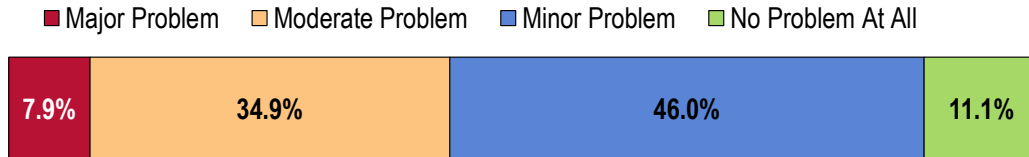
■ Major Problem   □ Moderate Problem   ■ Minor Problem   ■ No Problem At All

7.9%	34.9%	46.0%	11.1%

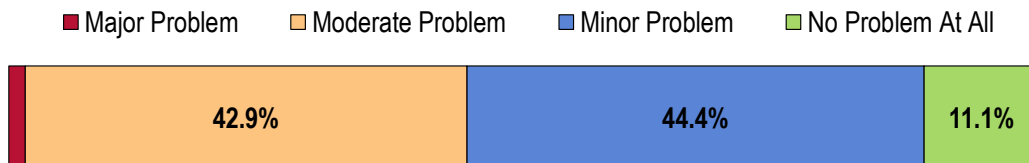Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

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

Access to Care/Services

> *There is currently no STD clinic. - Other Health Provider*

Prevalence/Incidence

> *Data shows there is an increase in STD among youth and elderly. - Social Services Provider*

Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

The following chart outlines key informants' perceptions of the severity of *Immunization & Infectious Diseases* as a problem in the community:

Perceptions of Immunization and Infectious Diseases
as a Problem in the Community
(Key Informants, 2016)
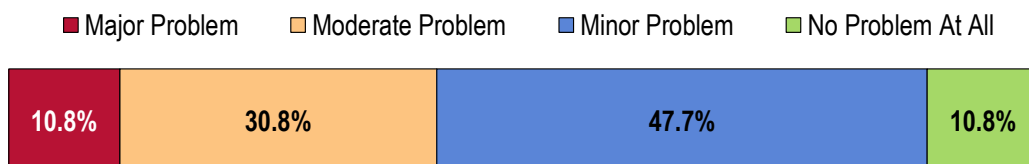
■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

10.8%	30.8%	47.7%	10.8%

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

Top Concerns

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

Vaccination Coverage

The vaccination rates are dropping. More preventable disease is occurring due to non-vaccination, inadequate vaccination, and vaccine failure. A county as large as Bergen with almost 1 million people is in danger of outbreaks if the population is unvaccinated. Travel is a factor. - Public Health Representative

Voluntary exclusion/delay of immunizations creates a serious public health issue. Vaccine hesitant or refusing parents need education. - Social Services Provider

Vaccine preventable diseases. Influenza. - Other Health Provider

Population not taking vaccinations. - Social Services Provider

We believe that many infectious diseases can be prevented by simply giving out vaccines and education on proper hand washing. We work with the State and investigate all reportable communicable disease. While some diseases can be effectively controlled, there are always new emerging diseases that appear. - Public Health Representative

We are a more global community, many do not have all needed vaccines and health insurance to obtain them. Poor uptake of HPV vaccine in NJ. - Other Health Provider

Prevalence/Incidence

The rate of positive Hepatitis B and C has risen. Poor rate of adults with vaccines, such as Tdap. Flu vaccines are easily accessible in many locations. - Other Health Provider

Births

About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

- Healthy People 2020 (www.healthypeople.gov)

Birth Outcomes & Risks

Infant Mortality

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

- Note the Healthy People 2020 target.

Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births, 2012-2014)
Healthy People 2020 Target = 6.0 or Lower

Bergen County	NJ	US
3.4	4.4	5.9
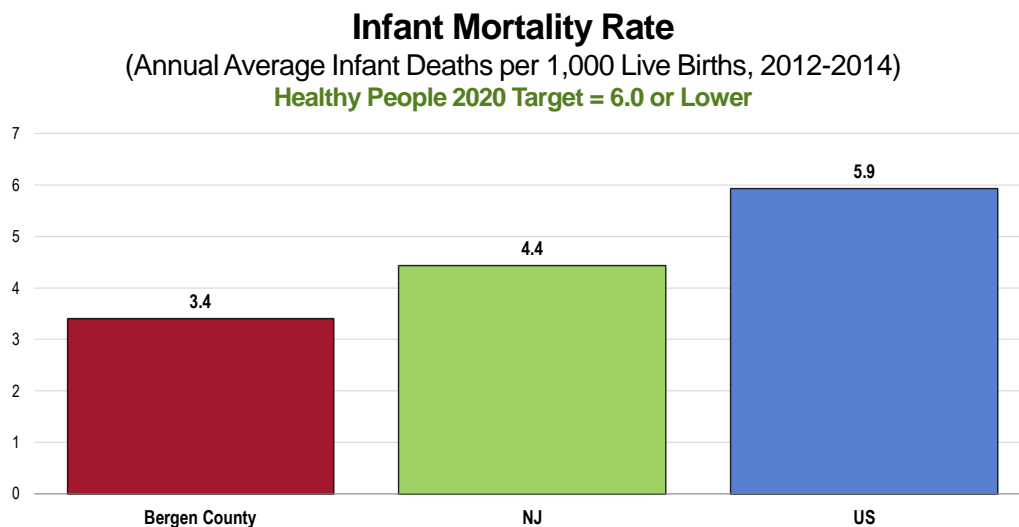
Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System: 2012-14. Accessed using CDC WONDER.
- Retrieved April 2016 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Key Informant Input: Infant & Child Health

The following chart outlines key informants' perceptions of the severity of *Infant & Child Health* as a problem in the community:
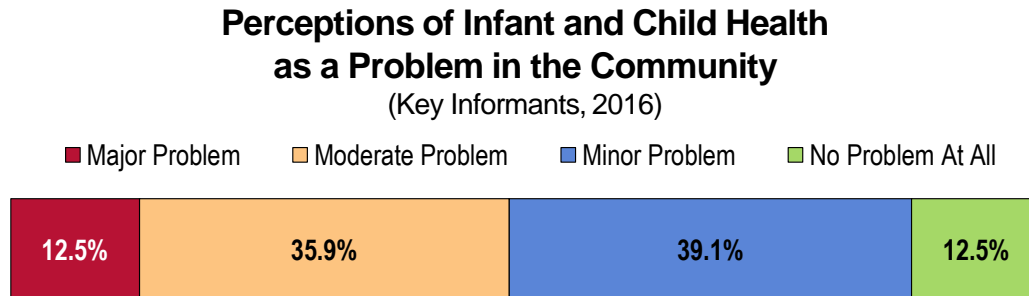
Perceptions of Infant and Child Health
as a Problem in the Community
(Key Informants, 2016)

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

12.5%	35.9%	39.1%	12.5%

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

Top Concerns

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

Affordable Care/Services

> *Children should be able to achieve their optimal physical and mental and spiritual health. Children who have health coverage have a better chance of being healthy and are less likely to miss school because they are sick. It is important for children to be healthy and perform to their highest potential while in school. - Public Health Representative*

> *The working poor just getting by. - Social Services Provider*

Prevalence/Incidence

> *I recently read a report that indicated that infant mortality and low birth weight were on the rise in Bergen. I was surprised, but I don't know much about the issue. I do know it is a significant indicator of overall community health. - Community/Business Leader*

Health Education

> *I think there is an increasing need for teaching how important those first years of life are and how decisions made in those years have long-term effect. - Social Services Provider*

Access to Care/Services

> *Lack of knowledge of available resources, language barriers. - Other Health Provider*

Autism

> *Autism, NJ has one in 41 children diagnosed with autism. - Community/Business Leader*

Adolescent Health

> *Teen health care. Need programs to address specific problems and concerns. - Other Health Provider*

Family Planning

About Teen Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

- Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Family Planning

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

Perceptions of Family Planning
as a Problem in the Community
(Key Informants, 2016)
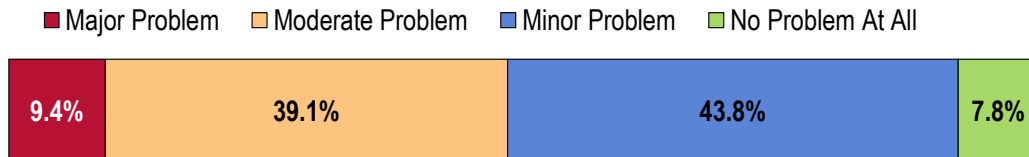
■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

9.4%	39.1%	43.8%	7.8%

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

Top Concerns

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

Access to Care/Services

> *Family Planning services for individuals without private insurance are difficult to access in Bergen County. Planned Parenthood and FQHC's frequently do not have appointment hours outside of standard business hours, and individuals may not be able to afford to miss work to receive services. - Social Services Provider*

> *Access to prenatal care and coordination of prenatal care for high risk pregnancies is an issue. Since many hospitals have subcontracted their prenatal clinics to FQHC's, women who require high risk prenatal services are not receiving same continuity. - Social Services Provider*

> *Lack thereof, especially to the population who is dependent upon special programs, like mental health services or public assistance. - Other Health Provider*

Health Education

> *Lack of education in family and access to birth control. - Social Services Provider*

> *Families are in need of learning how to plan for different aspects of their lives. - Social Services Provider*

Modifiable Health Risks

Actual Causes Of Death

About Contributors to Mortality

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual behavior** (20,000), and **illicit use of drugs** (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

- Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Factors Contributing to Premature Deaths in the United States
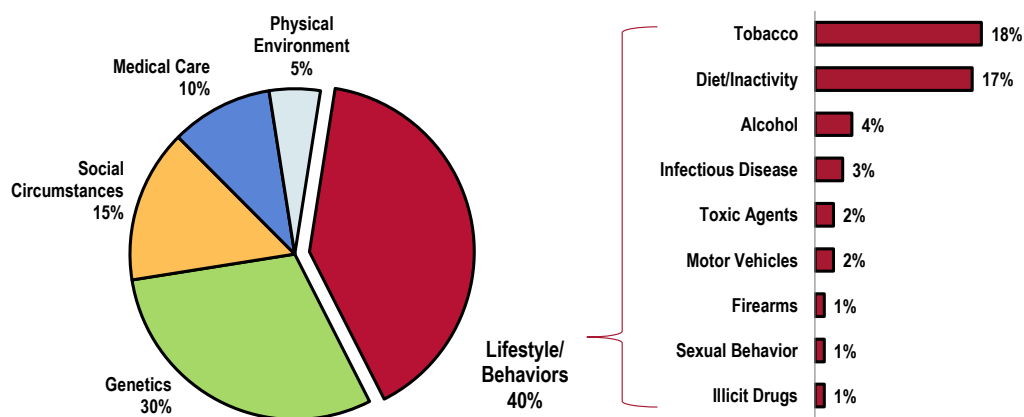
Sources: ● "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/April 2002.
"Actual Causes of Death in the United States": (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

Nutrition, Physical Activity & Weight

Nutrition

About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

- Healthy People 2020 (www.healthypeople.gov)

Daily Recommendation of Fruits/Vegetables

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

"Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

"How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for adults at the respondent level. The proportion reporting having 5 or more servings per day is shown below.

Consume Five or More Servings of Fruits/Vegetables Per Day
(Total Service Area, 2016)

	Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA	Bergen County	US
%	22.0%	41.9%	39.6%	30.2%	28.1%	23.2%	33.2%	34.6%	24.2%	32.3%	30.5%	27.4%
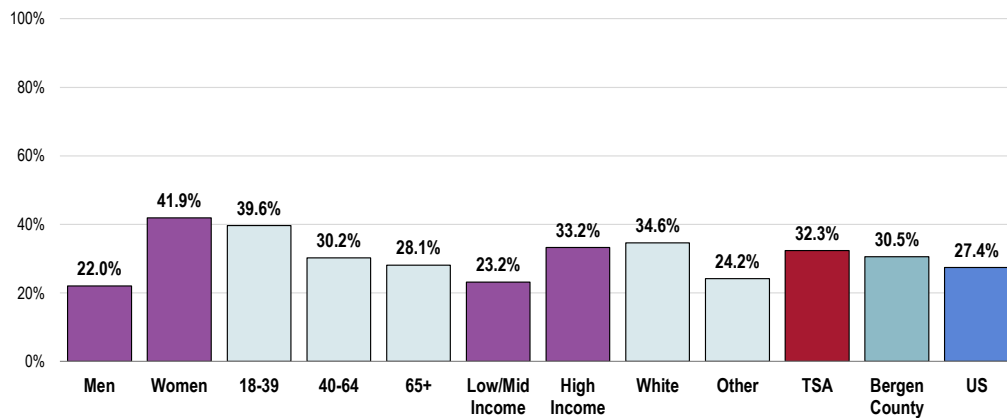
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.
● For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

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

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(Total Service Area, 2016)

Category	Percent
Men	10.6%
Women	20.5%
18-39	26.2%
40-64	14.5%
65+	7.3%
Low/Mid Income	32.6%
High Income	11.6%
White	12.8%
Other	24.6%
TSA	15.7%
Bergen County	15.3%
US	21.9%
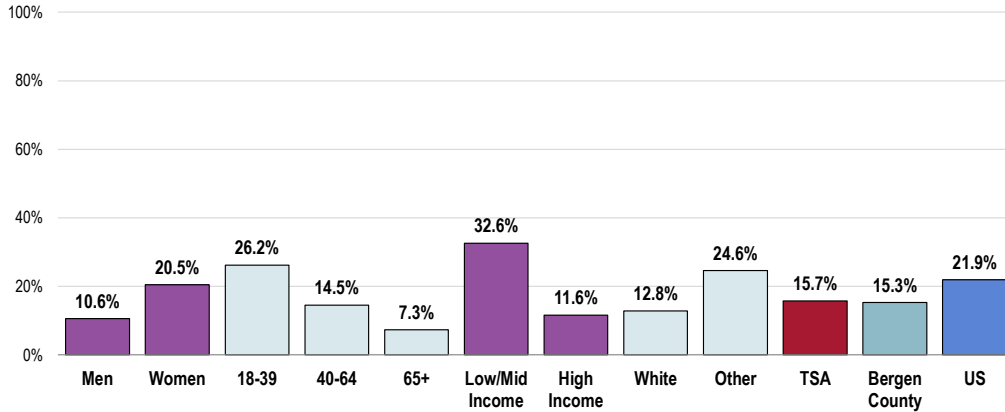
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. The chart for this indicator below is based on US Department of Agriculture data.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)

106,037 individuals have low food access

Category	Percent
Bergen County	11.7%
NJ	26.3%
US	23.6%
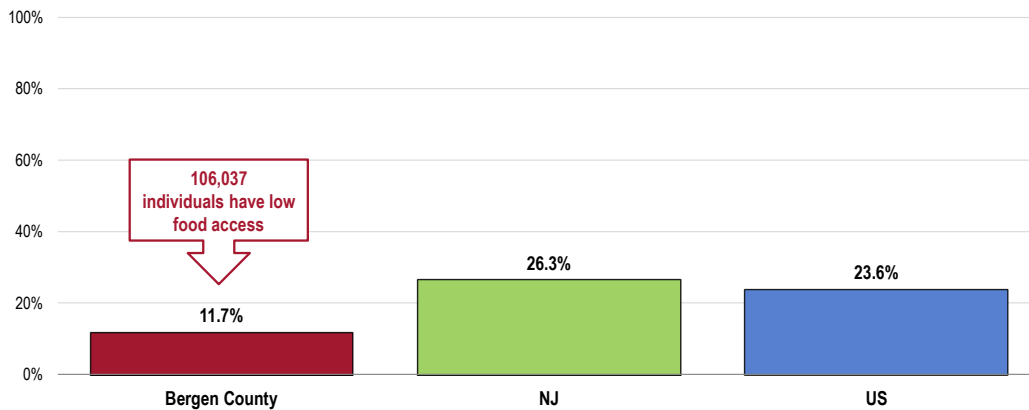
Sources: ● US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
● Retrieved April 2016 from Community Commons at http://www.chna.org.
Notes: ● This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

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

- Note the corresponding Healthy People 2020 target in the chart below.

No Leisure-Time Physical Activity in the Past Month
Healthy People 2020 Target = 32.6% or Lower

22.3%	26.9%	24.8%	23.4%	23.3%	27.9%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
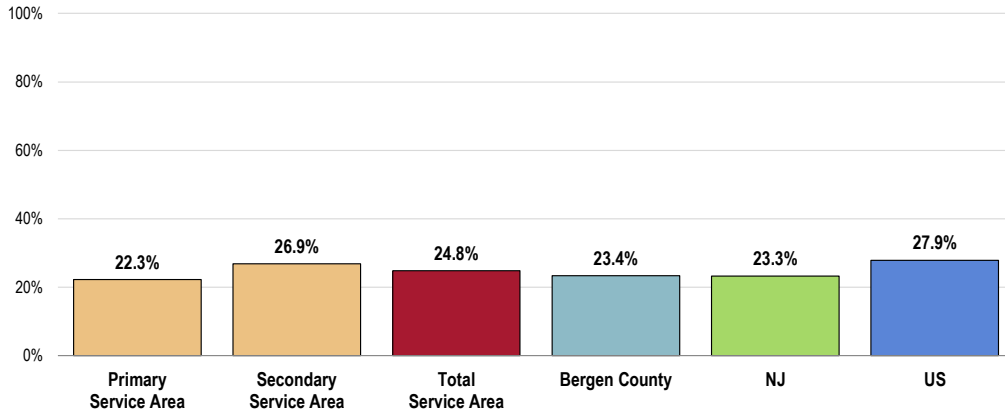
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.

Recommended Levels of Physical Activity

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

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

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

Meeting Physical Activity Recommendations

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

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

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

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

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

Respondents were also asked about strengthening exercises:

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

"Meeting physical activity recommendations" includes adequate levels of <u>both</u> aerobic and strengthening activity:

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

Meets Physical Activity Recommendations
(Total Service Area, 2016)
Healthy People 2020 Target = 20.1% or Higher

	Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA	Bergen County	NJ	US
	26.5%	28.3%	29.6%	29.0%	24.5%	18.9%	30.3%	27.1%	29.4%	27.4%	25.7%	21.6%	23.6%
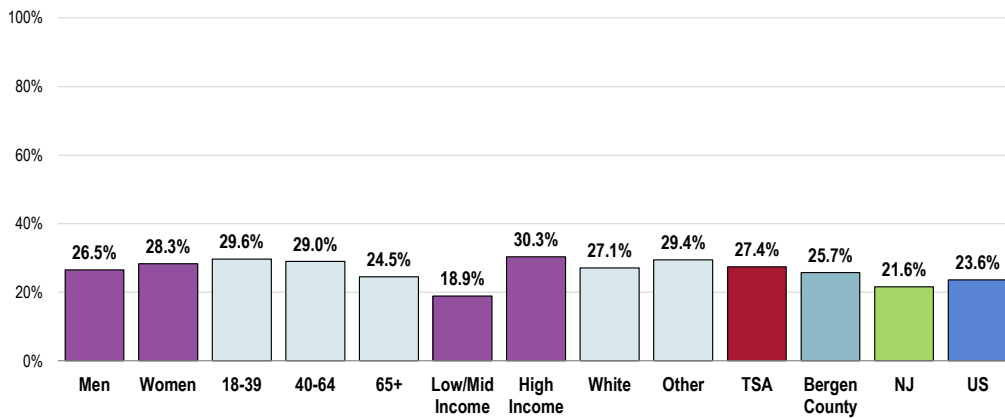
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2013 New Jersey data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-4]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.
- 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 <u>and</u> report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

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

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

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 142]
- 2015 PRC National Health Survey, Professional Research Consultants, 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

Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight, not Obese	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.

Adult Weight Status

"About how much do you weigh without shoes?"

"About how tall are you without shoes?"

"Are you now trying to lose weight?"

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

- Note the Healthy People 2020 target for obesity.

Prevalence of Total Overweight
(Percent of Adults With a Body Mass Index of 25.0 or Higher)

66.9% are trying to lose weight.

	Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
Percent	57.9%	62.8%	60.5%	61.2%	63.2%	65.2%
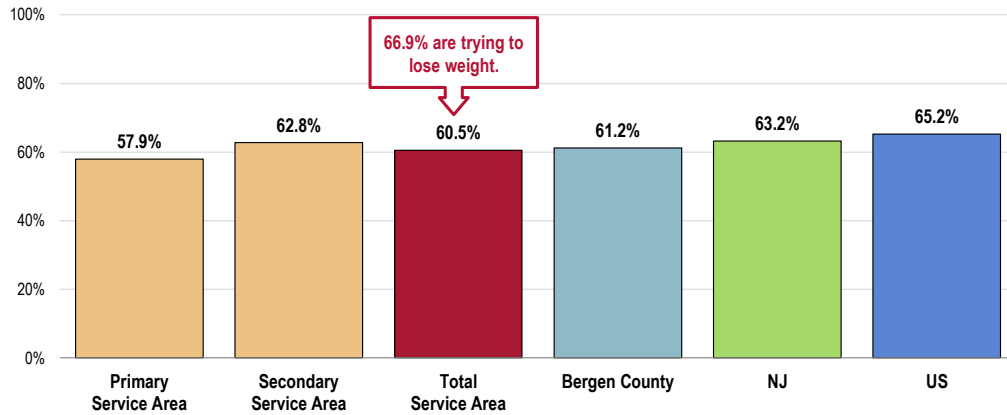
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 176-177]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.

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

Prevalence of Obesity
(Percent of Adults With a Body Mass Index of 30.0 or Higher)
Healthy People 2020 Target = 30.5% or Lower
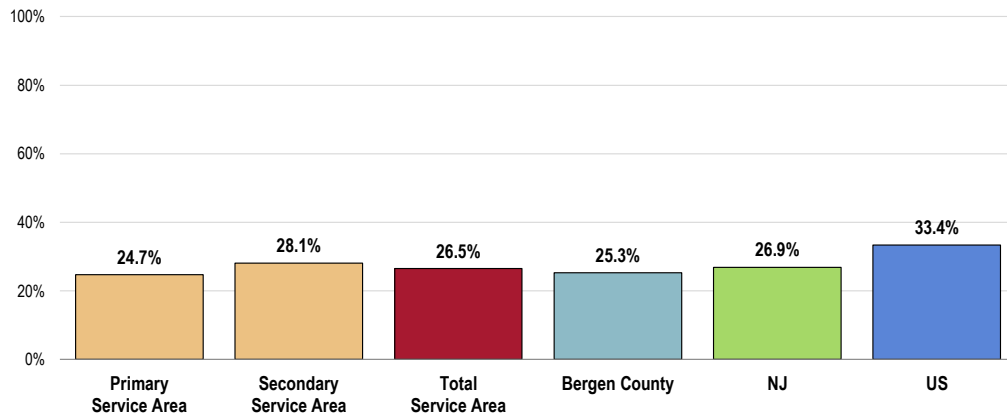
	Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
Percent	24.7%	28.1%	26.5%	25.3%	26.9%	33.4%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.

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

Prevalence of Obesity
(Percent of Adults With a BMI of 30.0 or Higher; Service Area, 2016)
Healthy People 2020 Target = 30.5% or Lower
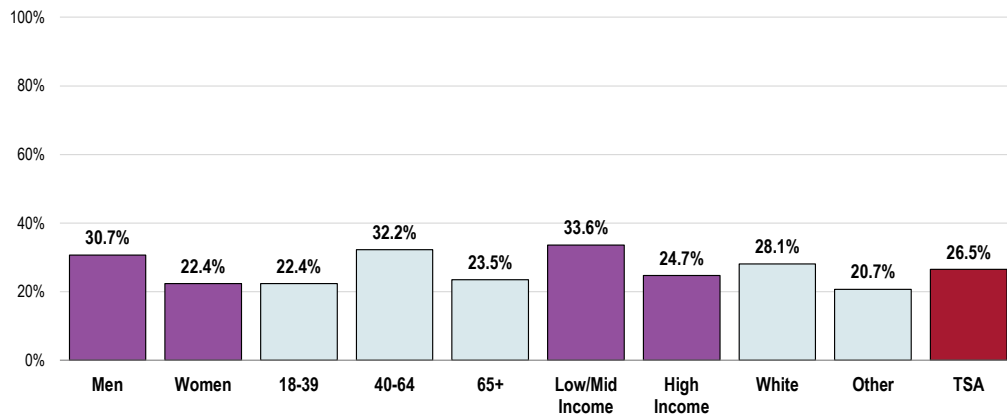
	Value
Men	30.7%
Women	22.4%
18-39	22.4%
40-64	32.2%
65+	23.5%
Low/Mid Income	33.6%
High Income	24.7%
White	28.1%
Other	20.7%
TSA	26.5%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.
- 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.

Childhood Overweight & Obesity

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:

"How much does this child weigh without shoes?"

"About how tall is this child?"

Child Total Overweight Prevalence
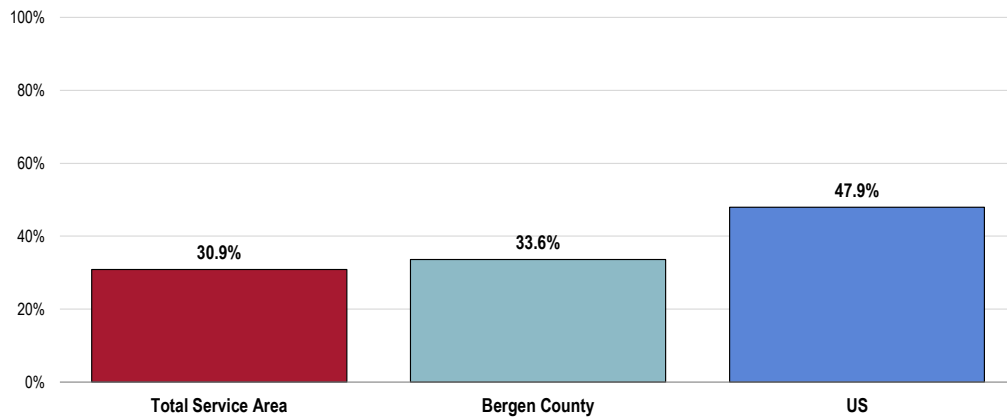### (Children Age 5-17 Who Are Overweight/Obese; BMI in the 85th Percentile or Higher)
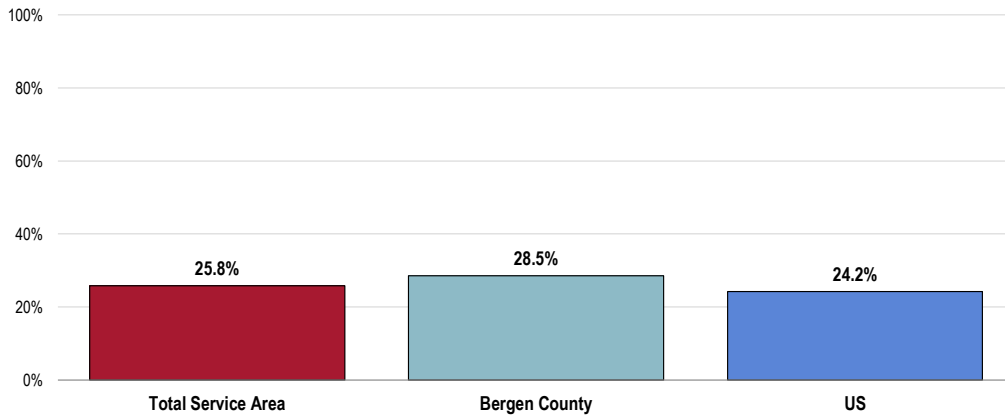
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

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.

Child Obesity Prevalence
(Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)
Healthy People 2020 Target = 14.5% or Lower
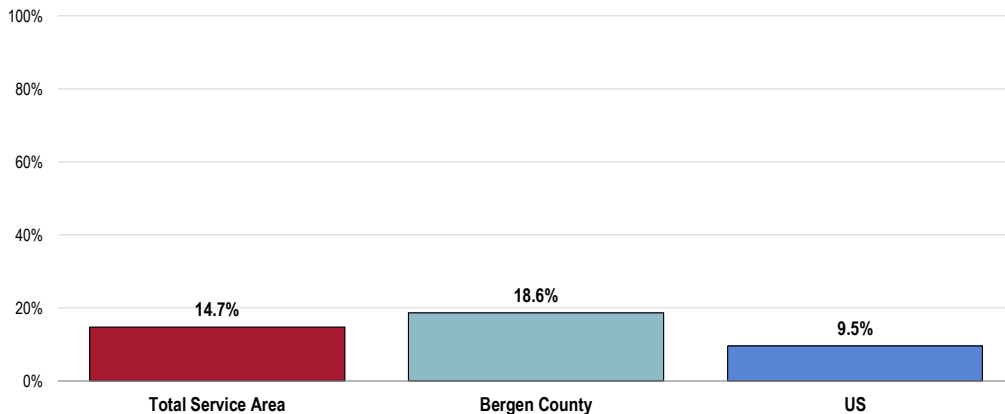
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 180]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-10.4]

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th 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:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2016)
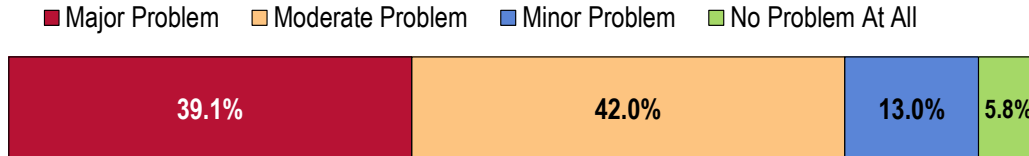
■ Major Problem □ Moderate Problem ■ Minor Problem □ No Problem At All

39.1%	42.0%	13.0%	5.8%

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

Top Concerns

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

Insufficient Physical Activity

> *This is hard to address. There are 2 extremes - the athletic, healthy population, and the overweight, unhealthy other end. Children in the schools are taught about healthy behavior, but if it's not in the family, the seed doesn't grow into healthy behavior as an adult. - Public Health Representative*

> *Getting people to be more active, eat better, and make better choices so they can maintain an ideal weight and physical fitness level. - Community/Business Leader*

> *Time is limited with working families; the common complaint is that there is little time for exercise or making healthy meals. Many weight-loss options are available in the community. Winter weather is a deterrent. Also, more hands-on education on nutrition will be helpful. - Other Health Provider*

> *Sedentary activity, not motivated. - Other Health Provider*

> *Sedentary lifestyles and a lack of relevant, emphasis, and exercise programs. - Community/Business Leader*

Poor Nutrition

> *Portion size, poor diet choices, and a lack of activity. - Social Services Provider*

> *The biggest challenge to get the public to eat less and move more has always been the highest priority in the county. For one, a lot of people are on the move, they don't have time to create a healthy meal and opt for fast food. Gym memberships are quite high, and not a lot of people can afford to be a member of the gym. The cost of healthy food is sometimes more expensive than food that is not so healthy. - Public Health Representative*

> *Changing our eating patterns is difficult. - Other Health Provider*

Access to Healthy Foods

> *Not every town is lucky enough to have a Senior Activity Center with meals at a suggested donation through the County or free exercise classes. Many gyms are too expensive for senior citizens. - Social Services Provider*

> *Expense of healthy food choices, overabundance of fast food restaurants. - Other Health Provider*

> *Access to affordable healthy food and recreational spaces. - Other Health Provider*

> *Lack of proper food/nutrition available due to inadequate family/friends network to assist. - Social Services Provider*

Health Education

> *Education and motivation. - Social Services Provider*

> *There are not enough free places that families can access for education and physical activities. Wintertime is more difficult. - Social Services Provider*

> *The greatest need is to connect with a group that can offer education and motivation in the long-range need to address the three components. - Other Health Provider*

Easily accessible and affordable programs. People are not practicing healthy eating habits. - Social Services Provider

Obesity

Overweight and obesity are major problems. Difficult to motivate individuals to live healthy lifestyles and to change their lifestyle habits and to change the habits of their families and to sustain change. - Physician

Obesity and diabetes is prevalent in the adult and pediatric population. Limited resources are available for patient education. - Other Health Provider

The nation is becoming more obese as a whole every year. And despite all interventions, has continued to worsen. - Public Health Representative

Access to Providers

Not enough trained professionals to address the needs of the community. - Other Health Provider

Genetic Predisposition

Genetic predisposition, cultural habits. - Other Health Provider

Substance Abuse

About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 (www.healthypeople.gov)

Related Age-Adjusted Mortality

Cirrhosis/Liver Disease. Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The chart below outlines age-adjusted mortality for cirrhosis/liver disease in Bergen County.

Drug-Induced Deaths. Drug-induced deaths include all deaths for which drugs are the underlying cause, including those attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use (e.g., drug-induced Cushing's syndrome). 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. These deaths may also be either intentional (e.g., suicide) or unintentional (accidental). The chart below outlines local age-adjusted mortality for drug-induced deaths.

- Note the corresponding Healthy People 2020 targets.

Cirrhosis/Liver Disease: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 8.2 or Lower
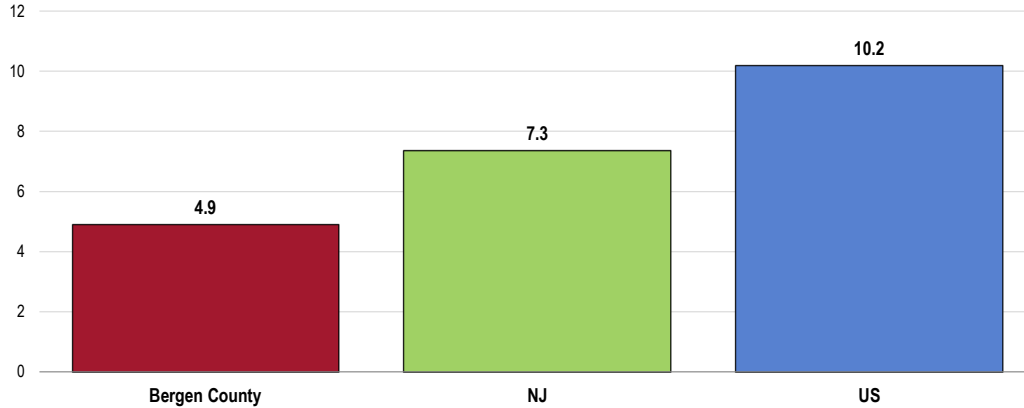
Bar chart showing age-adjusted mortality rates:
- Bergen County: 4.9
- NJ: 7.3
- US: 10.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

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, age-adjusted to the 2000 US Standard Population.

Drug-Induced Deaths: Age-Adjusted Mortality
(2012-14 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 11.3 or Lower
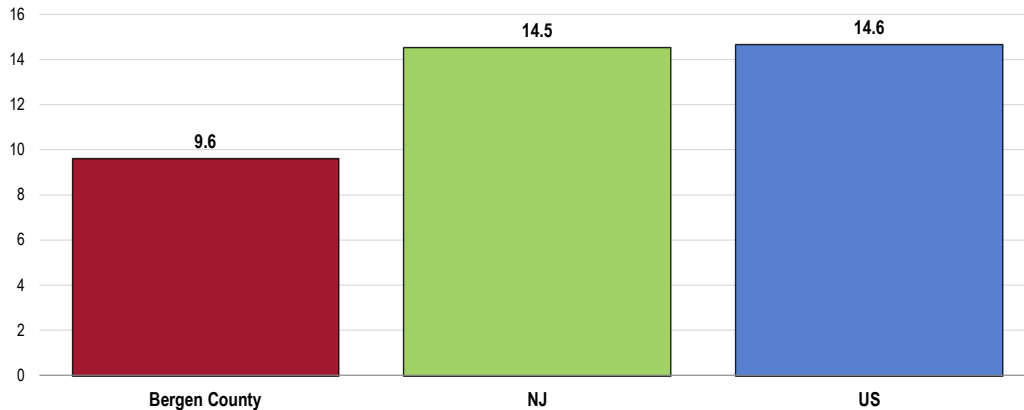
Bar chart showing age-adjusted mortality rates:
- Bergen County: 9.6
- NJ: 14.5
- US: 14.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

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, age-adjusted to the 2000 US Standard Population.

Alcohol Use

Excessive Drinkers. Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) <u>or</u> 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.

"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

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

"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?"

Excessive Drinkers
(Total Service Area, 2016)
Healthy People 2020 Target = 25.4% or Lower

Category	Percentage
Men	29.4%
Women	15.2%
18-39	28.2%
40-64	21.6%
65+	16.3%
Low/Mid Income	19.2%
High Income	24.6%
White	19.9%
Other	27.6%
TSA	21.9%
Bergen County	23.8%
US	22.2%
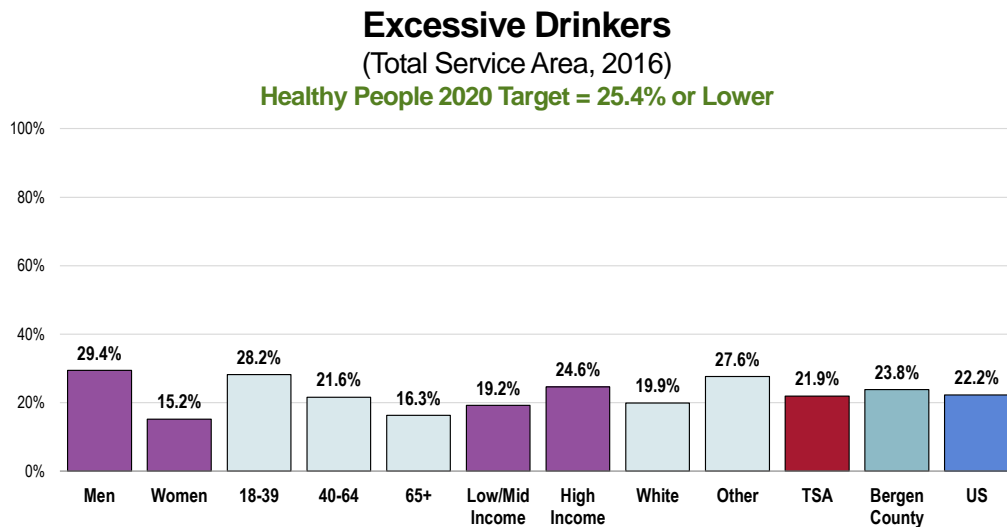
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) <u>OR</u> 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.

Drinking & Driving. 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 the actual incidence of drinking and driving in the community is likely higher.

"During the past 30 days, how many times have you driven when you've had perhaps too much to drink?"

Have Driven in the Past Month
After Perhaps Having Too Much to Drink

4.7%	5.0%	4.8%	5.9%	4.1%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US
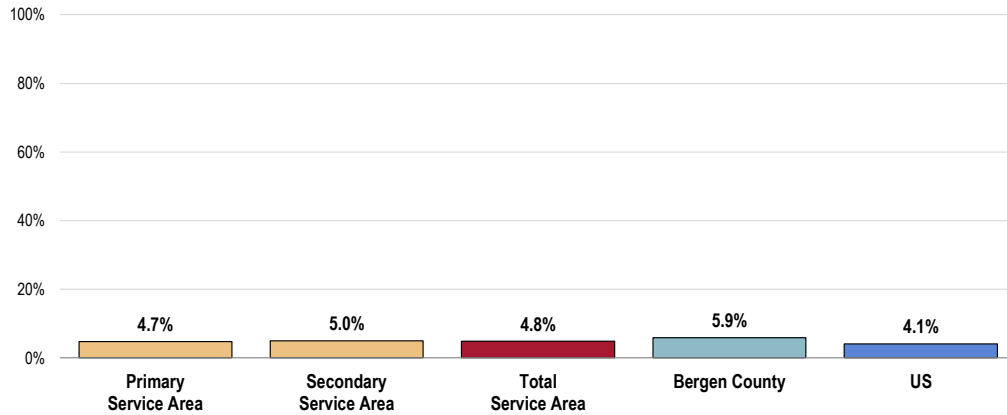
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Drug Use

Respondents were asked several questions about their drug use during the past year and were reminded that their answers are strictly confidential.

"Taking prescription drugs on your own means taking medicine without a doctor's prescription, in larger amounts than prescribed, or for a longer period than prescribed. In the past 12 months, have you used sedatives, tranquilizers or anti-anxiety drugs, painkillers, or stimulants on your own?"

"In the past 12 months, have you used marijuana?"

"In the past 12 months, have you used cocaine or crack, heroin, or any other illegal drugs or substances?"

Drug Use in The Past Year

Legend: ■ Primary Service Area □ Secondary Service Area ■ Total Service Area ■ Bergen County

	Took Prescription Drugs on Own	Used Marijuana	Used Illegal Drugs
Primary	3.2%	2.6%	0.0%
Secondary	4.1%	5.0%	1.7%
Total	3.7%	3.9%	0.9%
Bergen County	5.4%	7.1%	1.9%
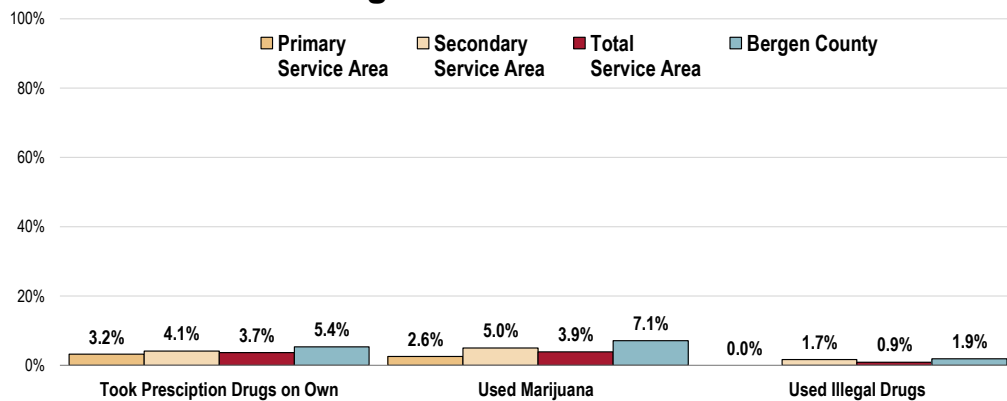
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 307-309]
Notes: • Asked of all respondents.
• Taking prescription drugs on your own means taking medicine without a doctor's prescription, in larger amounts than prescribed, or for a longer period than prescribed.

Alcohol & Drug Treatment

"Have you ever sought professional help for an alcohol or drug-related problem?"

Have Ever Sought Professional Help
for an Alcohol/Drug-Related Problem

Primary Service Area	1.2%
Secondary Service Area	0.5%
Total Service Area	0.8%
Bergen County	2.4%
US	4.1%
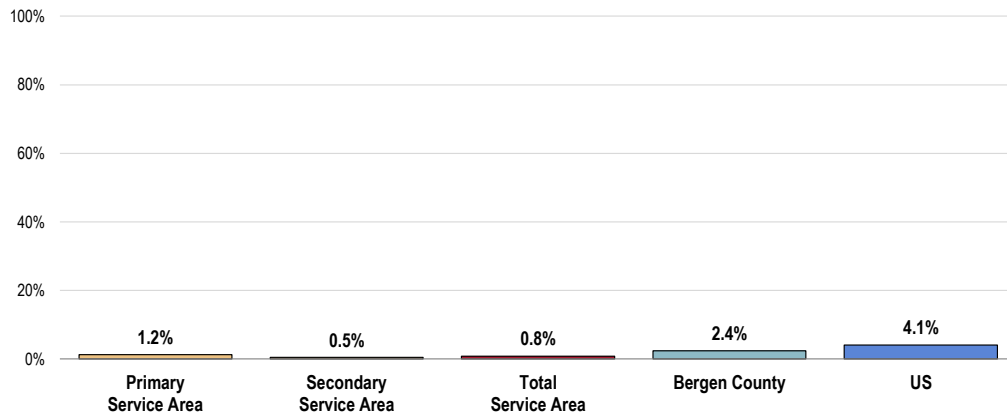
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 68]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Personal Impact of Substance Abuse

"To what degree has your life been negatively affected by your own or someone else's substance abuse 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 Abuse (by Self or Someone Else)
(Total Service Area, 2016)

Men	28.5%
Women	36.8%
18-39	43.1%
40-64	31.9%
65+	23.1%
Low/Mid Income	39.9%
High Income	33.3%
White	34.4%
Other	28.2%
TSA	32.8%
Bergen County	30.1%
US	32.2%
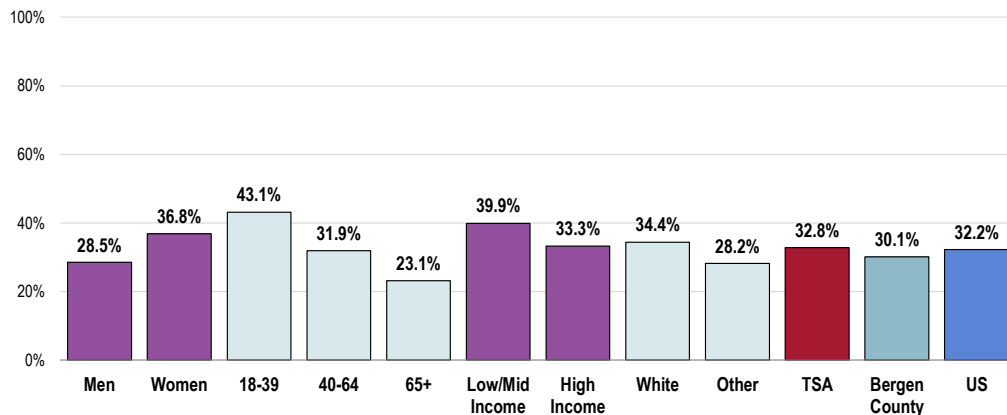
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Key Informant Input: Substance Abuse

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

Perceptions of Substance Abuse
as a Problem in the Community
(Key Informants, 2016)
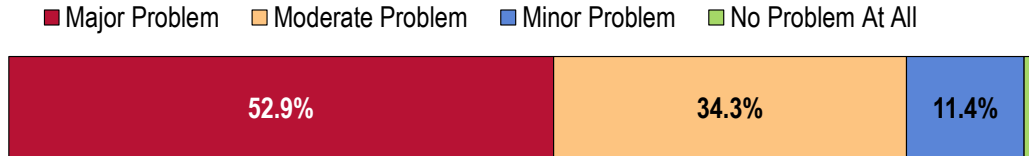
■ Major Problem ☐ Moderate Problem ■ Minor Problem ☐ No Problem At All

52.9%	34.3%	11.4%	

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

Barriers to Treatment

Among those rating this issue as a "major problem," the greatest barriers to accessing substance abuse treatment are viewed as:

Access to Care/Services

Shortage of treatment available in Bergen County at the inpatient level. Also for those who are indigent or don't have commercial insurance. - Social Services Provider

There are not enough beds for detox for those without insurance, and not enough beds for rehabilitation. There are not enough coordinated services to assist people in recovery. - Social Services Provider

Access to care in a timely manner. Available practitioners- especially Psychiatrists- who are the ones to prescribe medications. Availability of quality care for those without any or good insurance coverage. - Other Health Provider

No treatment facilities. - Social Services Provider

Lack of availability and inability to use public transportation to follow-up treatment at outpatient facilities. Perception that drugs are not a problem in this community or that it is a disease. - Other Health Provider

Inpatient rehab. - Other Health Provider

There are not enough beds or programs for the challenges we face. Access for low-income people is particularly strained. - Community/Business Leader

Extended care beyond detox, access to rehab, and longer-term halfway house or residential programming. Also, more community supports as in the mental health community, Intensive Case Management type services. Housing First model again becomes important, as many people do not have the safety of a stable home from which to build their rehabilitation efforts. - Community/Business Leader

There are few beds for such a large county experiencing a surge in substance abuse. - Other Health Provider

Money to go to proper care centers and the growing availability of cheap drugs. Economic stresses for the general population just too hard to buck. - Community/Business Leader

Poor management, too many patients using Emergency Rooms as their source. Insufficient resources to truly manage substance abuse. - Other Health Provider

Insurance plans, lack of education, shame, cost and distance. - Community/Business Leader

Insurance. - Other Health Provider

Lack of providers and treatment areas in community. - Other Health Provider

Opioids

Increase in opiate use, due to prescription drugs for pain management. - Social Services Provider

The greatest barrier at this moment-in-time with respect to opioid addiction is the production of too many pills by the pharmaceutical industry, and the leakage of these products into the community.   This directly leads to the heroin problem. Alcohol abuse is starting to take a backseat. - Public Health Representative

The current heroin epidemic. Not enough rehab centers for those trying to stay sober. Legislation weak on doctors prescribing painkillers, which leads to heroin addiction. - Public Health Representative

Bergen County is an affluent community. There is an overwhelming amount of drug abuse by teenagers and young adults. They have the financial resources to purchase drugs, such as heroin and cocaine. I think that the financial stability of the community minimizes the true problem. I think that there should be an assessment in regards to the true drug abuse happening in the area and an action plan put in place to create awareness. We have hundreds of young adults going to our local hospitals on the verge of an overdose annually. We must bring this to the forefront, despite the stigma that it may create. - Other Health Provider

Denial/Stigma

Having the individual realize that there is a problem. - Public Health Representative

Denial on the part of the substance abuser. - Other Health Provider

Hesitance to seek help. - Community/Business Leader

Stigma. Awareness. Early intervention and education. - Other Health Provider

Stigma is a huge barrier to getting people into care. Low levels of resident housing options to allow people to stay in their home area. - Public Health Representative

Stigma, lack of services. Lack of funding. - Other Health Provider

Affordable Care/Services

Financial assistance to pay for treatment for those without insurance. Lack of available detox services to meet the needs of the community, lack of appropriate treatment services, and timeframes established by insurance carriers that aren't realistic in terms of needs. Lack of recovery support services while a person is contemplating treatment, is in treatment, and is post-treatment. There remains a strong stigma attached to substance use disorders. Community members do not know when problems are present, who to outreach for information and support, and services that are available in the community. - Social Services Provider

Health Education

Residents need to learn more about services available in the county. - Social Services Provider

Families knowing where to turn if this happens to them. - Community/Business Leader

Addiction

Criminalizing addiction and lack of resources for treatment. - Social Services Provider

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **alcohol** as the most problematic substance abused in the community, followed by **prescription medications**.

	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Alcohol	57.1%	14.3%	14.3%	6
Prescription Medications	0.0%	28.6%	28.6%	4
Heroin or Other Opioids	28.6%	14.3%	0.0%	3
Cocaine or Crack	0.0%	14.3%	28.6%	3
Marijuana	0.0%	14.3%	14.3%	2
Over-The-Counter Medications	14.3%	0.0%	0.0%	1
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	14.3%	0.0%	1
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	0.0%	14.3%	1

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

"Do you now smoke cigarettes every day, some days, or not at all?"

- Note the Healthy People 2020 target.
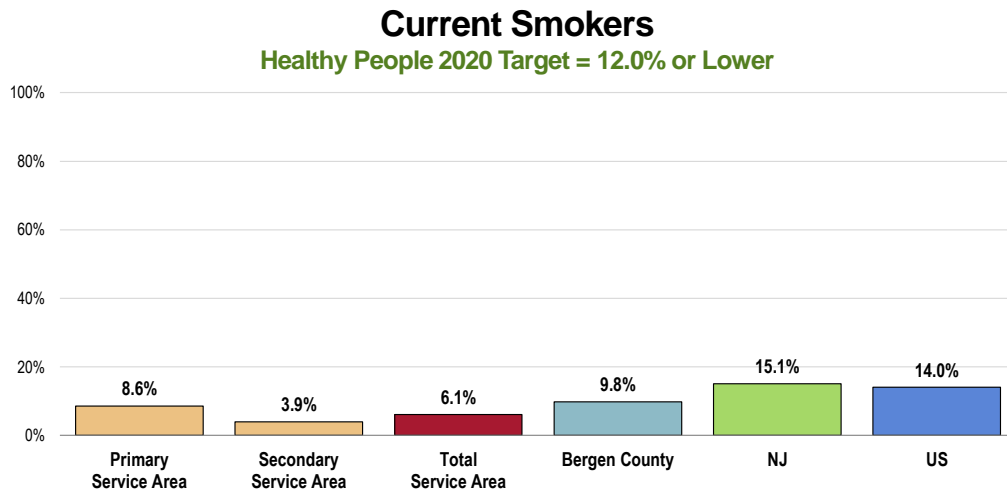
Current Smokers
Healthy People 2020 Target = 12.0% or Lower

Category	Percent
Primary Service Area	8.6%
Secondary Service Area	3.9%
Total Service Area	6.1%
Bergen County	9.8%
NJ	15.1%
US	14.0%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers
(Total Service Area, 2016)
Healthy People 2020 Target = 12.0% or Lower
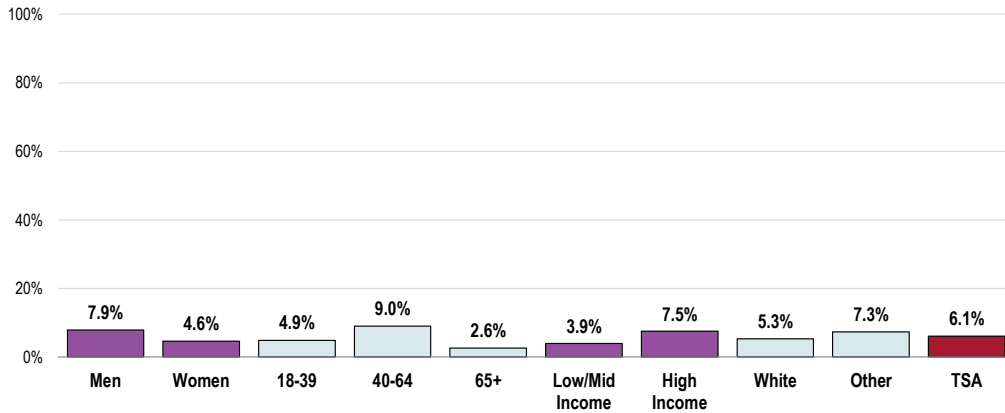
Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA
7.9%	4.6%	4.9%	9.0%	2.6%	3.9%	7.5%	5.3%	7.3%	6.1%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.
- Includes regular and occasion smokers (every day and some days).

Secondhand Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only households with children age 0-17.

Member of Household Smokes at Home

Households with children exposed to smoke in the home: 9.6%

Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US
12.2%	6.8%	9.4%	10.3%	10.2%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 58, 184]
- 2015 PRC National Health Survey, Professional Research Consultants, 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.

E-Cigarette Use

"The next question is about electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic cigarette?"

Electronic Cigarette Use
(Total Service Area, 2016)

Never Tried 93.8%

Use Every Day 0.2%
Use on Some Days 1.6%
Tried, Don't Currently Use 4.3%
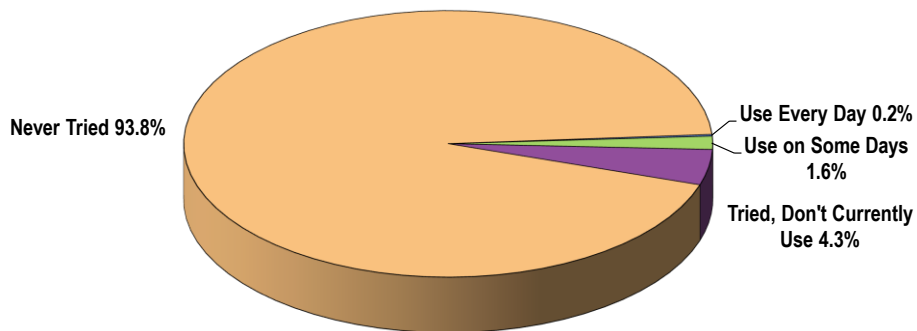
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 62]
Notes: ● Asked of all respondents.

Key Informant Input: Tobacco Use

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

Perceptions of Tobacco Use
as a Problem in the Community
(Key Informants, 2016)
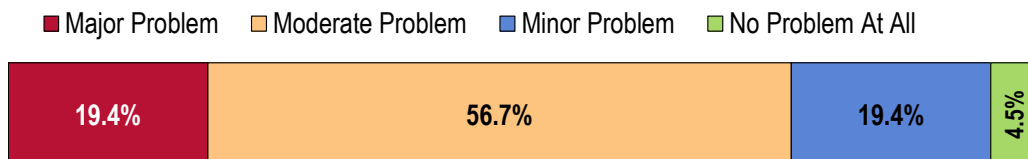
■ Major Problem   □ Moderate Problem   ■ Minor Problem   ■ No Problem At All

| 19.4% | 56.7% | 19.4% | 4.5% |

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

Top Concerns

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

Prevalence/Incidence

> *Tobacco use is one of the leading causes of illness and disability in our community. - Other Health Provider*
>
> *While now more expensive, still the most available product for kids and folks to access. - Community/Business Leader*
>
> *People still smoke, knowing that it's bad for them. - Physician*

Addiction

Governing body is unwilling to enact resolutions to prohibit smoking at public events or enforce violations to non-smoking areas, such as hookah facilities. - Other Health Provider

Have not wiped out this addiction. - Social Services Provider

Comorbidities

Smoking is a risk factor for heart disease and secondhand smoke is a leading asthma trigger in our pediatric population. There is a lack of smoking cessation programs to refer our underserved patient population. - Other Health Provider

Leading Cause of Death

Tobacco is the single most preventable cause of death in the State, the country and the world. - Public Health Representative

Access to Health Services

Lack of Health Insurance Coverage (Age 18 to 64)

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources. 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 healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?"

"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"

Lack of Healthcare Insurance Coverage
(Among Adults Age 18-64)
Healthy People 2020 Target = 0.0% (Universal Coverage)

	Value
Men:	5.9%
Women:	5.5%
Age 18-39:	9.8%
Age 40-64:	2.8%

Category	Percentage
Primary Service Area	2.4%
Secondary Service Area	8.8%
Total Service Area	5.7%
Bergen County	5.6%
NJ	15.0%
US	10.1%
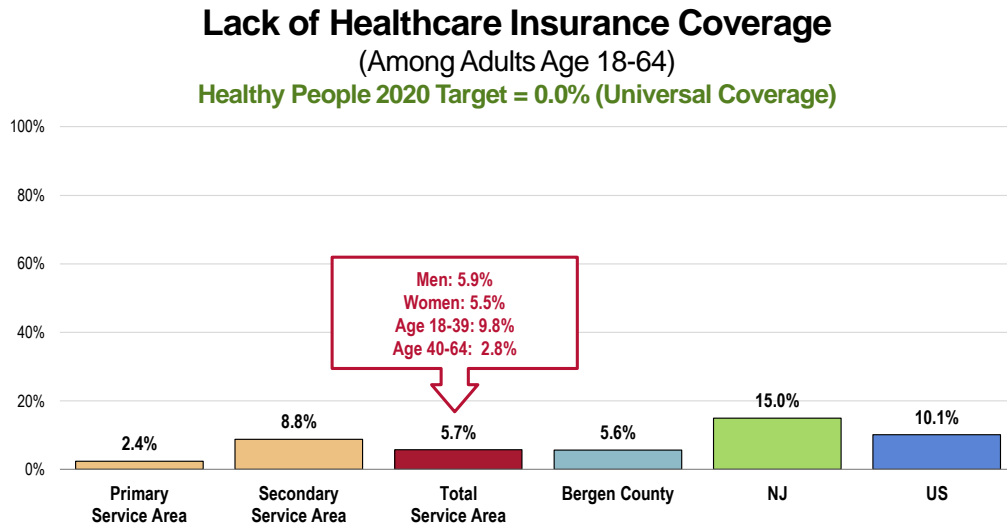
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
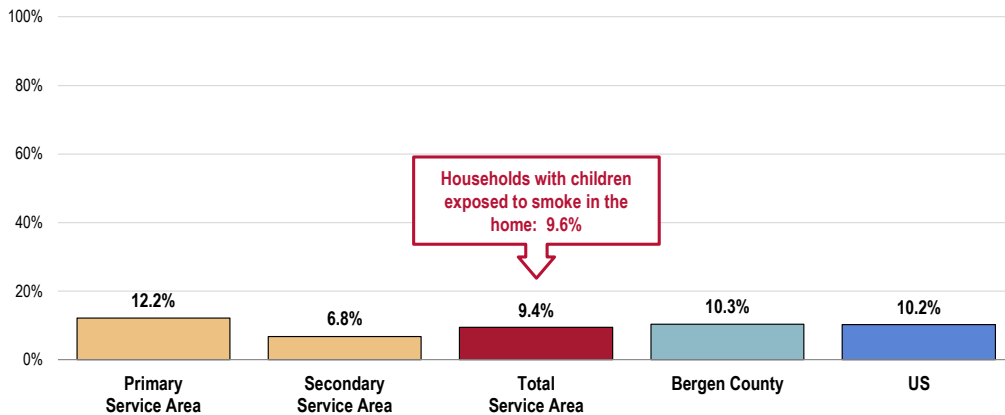- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 (www.healthypeople.gov)

Barriers to Healthcare Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when…

- … you needed medical care, but had **difficulty finding a doctor**?"
- … you had difficulty **getting an appointment** to see a doctor?"
- … you needed to see a doctor, but could not because of the **cost**?"
- … a **lack of transportation** made it difficult or prevented you from seeing a doctor or making a medical appointment?"
- … you were not able to see a doctor because the **office hours were not convenient**?"
- … you needed a **prescription medicine**, but did not get it because you could not afford it?"
- … you were not able to see a doctor due to **language or cultural differences**?"

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

**Barriers to Access Have
Prevented Medical Care in the Past Year**
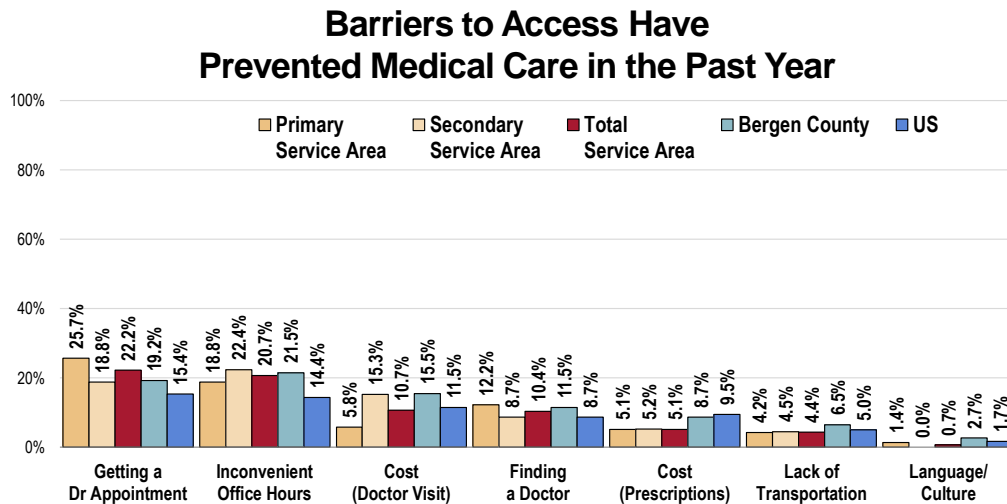
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

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

Chart showing "Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year" with bars: Primary Service Area 39.8%, Secondary Service Area 38.3%, Total Service Area 39.0%, Bergen County 40.7%, US 35.0%.
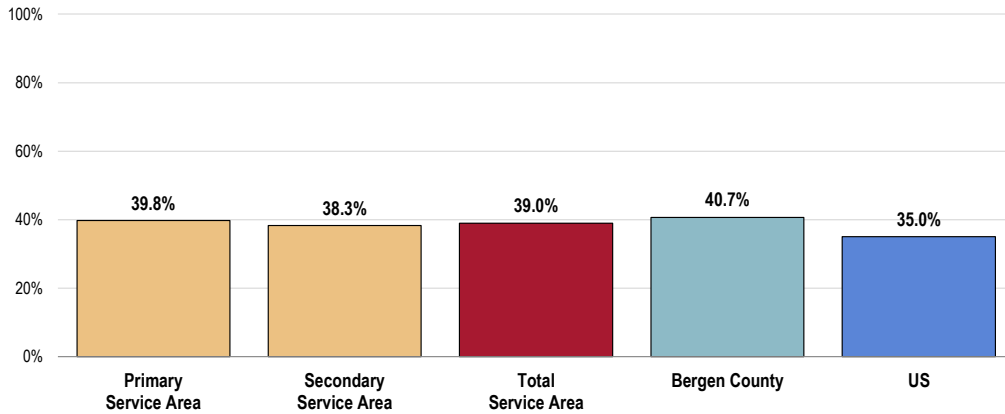
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
               ● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
               ● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year
(Total Service Area, 2016)
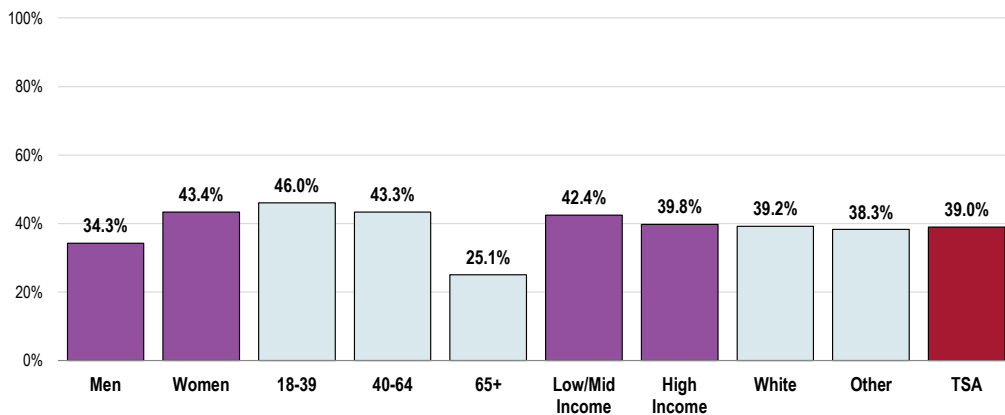
Chart showing bars: Men 34.3%, Women 43.4%, 18-39 46.0%, 40-64 43.3%, 65+ 25.1%, Low/Mid Income 42.4%, High Income 39.8%, White 39.2%, Other 38.3%, TSA 39.0%.

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
Notes: ● Asked of all respondents.
               ● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
               ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
               ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

"Was there a time in the past 12 months when you needed medical care for this child, but could not get it?"

Had Trouble Obtaining Medical Care for Child in the Past Year
(Among Parents of Children 0-17)

Parents with trouble obtaining medical care for their child mainly reported barriers due to cost, lack of insurance coverage, or poor availability.

Category	Percent
Total Service Area: Age 0-10	1.3%
Total Service Area: Age 11-17	7.0%
Total Service Area	4.1%
Bergen County	8.3%
US	3.9%
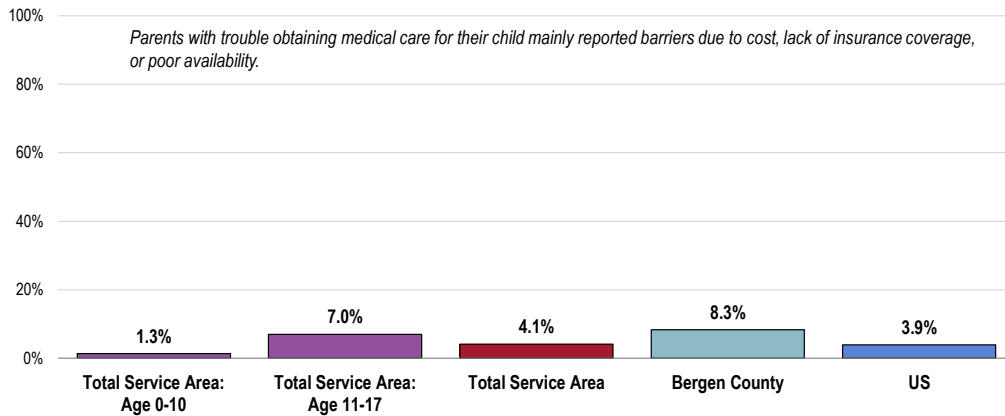
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 136-137]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

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

Key Informant Input: Access to Healthcare Services

The following chart outlines key informants' perceptions of the severity of *Access to Healthcare Services* as a problem in the community:

Perceptions of Access to Healthcare Services
as a Problem in the Community
(Key Informants, 2016)
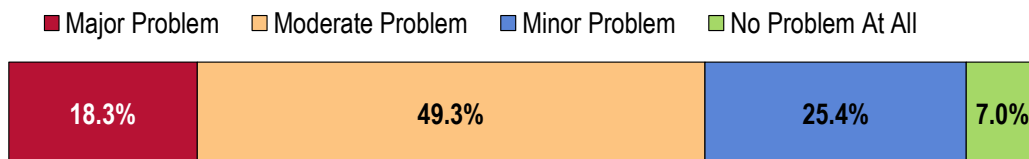
■ Major Problem ☐ Moderate Problem ■ Minor Problem ☐ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
18.3%	49.3%	25.4%	7.0%

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

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

Affordable Care/Services

> Lack of health insurance or underinsured. Cost of treatments and medications. - Social Services Provider

> Cost and transportation. - Community/Business Leader

> Patients with no insurance have very limited resources. Access to medications. Homeless patients with chronic conditions are not allow in the shelter and have no place to go. - Other Health Provider

> Not enough care for underinsured or uninsured. Hospitals closing clinics and outsourcing to federal funded clinics that do provide minimal specialty services. - Other Health Provider

Transportation

> Lack of transportation, since it is elemental to many other issues. - Other Health Provider

> Inadequate public transportation. Lack of coordination of services. - Other Health Provider

> Transportation and low-cost or no-cost services are seldom available. Understanding of how to receive services when you are under-insured is especially challenging. - Public Health Representative

> Transportation to get minimize the isolation of the frail elderly. - Social Services Provider

Vulnerable Populations

> Disparities in healthcare are a major problem in our community. Ethnic minorities, socioeconomic disadvantaged, and the mentally ill have difficulties accessing our healthcare system. The stigma of mental illness continues to be a barrier. - Other Health Provider

> Services for lower income developmentally disabled adults. Both acute care and subacute care resources are limited and difficult to access in a timely fashion. - Community/Business Leader

> Lack of work and poverty. - Social Services Provider

Health Insurance Issues

> It is a most confusing system. Residents get the run-around, do not understand what their options are, explanations are not clear, and services are limited- with many gaps in service. - Public Health Representative

> Insurance. How to obtain information about Affordable Health Care, Medicaid and Medicare. - Other Health Provider

Access to Providers

> Limited access to primary care physicians in the community. Physicians that will not take managed Medicaid. Lack of transportation to get to physician's office. - Social Services Provider

> If people can get an appointment with a primary doctor, sometimes they can't afford to buy the medications or to continue with their medical care, due to copayments. - Social Services Provider

Language Barriers

> My multicultural community can't navigate the public health system due to language barriers, fear, or limited Internet access. Even healthcare professional are sometimes finding it difficult to access the system. We have no hospital in our town, so transportation becomes an issue. - Public Health Representative

> Language barriers. - Other Health Provider

Specialists

> Podiatry. - Community/Business Leader

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") were further asked to identify the type of care they perceive as the most difficult to access in the community.

	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Mental Health Care	27.3%	36.4%	10.0%	8
Chronic Disease Care	27.3%	9.1%	10.0%	5
Substance Abuse Treatment	0.0%	18.2%	30.0%	5
Dental Care	18.2%	0.0%	20.0%	4
Elder Care	9.1%	0.0%	30.0%	4
Specialty Care	18.2%	0.0%	0.0%	2
Pain Management	0.0%	18.2%	0.0%	2
Primary Care	0.0%	18.2%	0.0%	2

Health Literacy

To measure respondents' ability to understand health-related information, respondents were asked the following questions:

"How often is health information written in a way that is easy for you to understand? Would you say: always, nearly always, sometimes, seldom, or never?"

"How often do you need to have someone help you read health information? Would you say: always, nearly always, sometimes, seldom, or never?"

"How often is health information spoken in a way that is easy for you to understand? Would you say: always, nearly always, sometimes, seldom, or never?"

"In general, how confident are you in your ability to fill out health forms yourself? Would you say: extremely confident, somewhat confident, or not at all confident?"

Low health literacy is defined here as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Low Health Literacy
(Total Service Area, 2016)

Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA	Bergen County	US
27.8%	20.7%	33.9%	25.3%	10.5%	18.8%	27.5%	20.1%	32.4%	24.1%	22.2%	23.3%
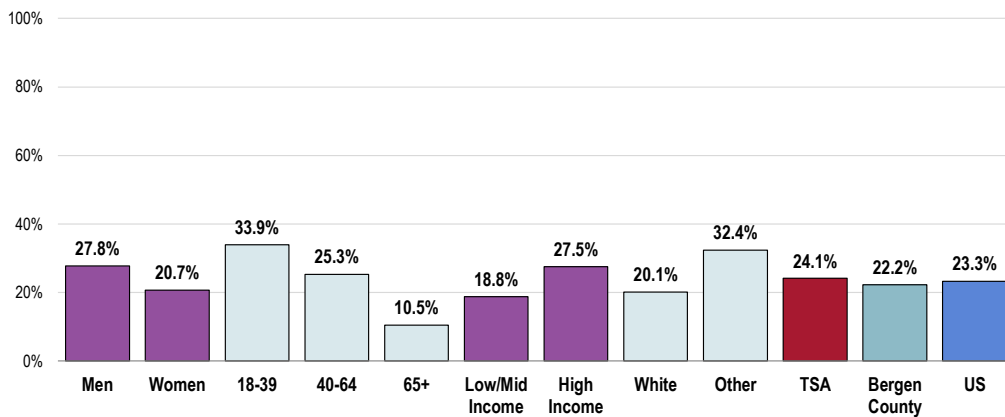
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]
Notes: ● Asked of all respondents.
  ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
  ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.
  ● Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population, 2012)

	Bergen County	NJ	US
Value	125.4	85.6	74.5
Physicians	1,152 Primary Care Physicians	7,588 Primary Care Physicians	233,862 Primary Care Physicians
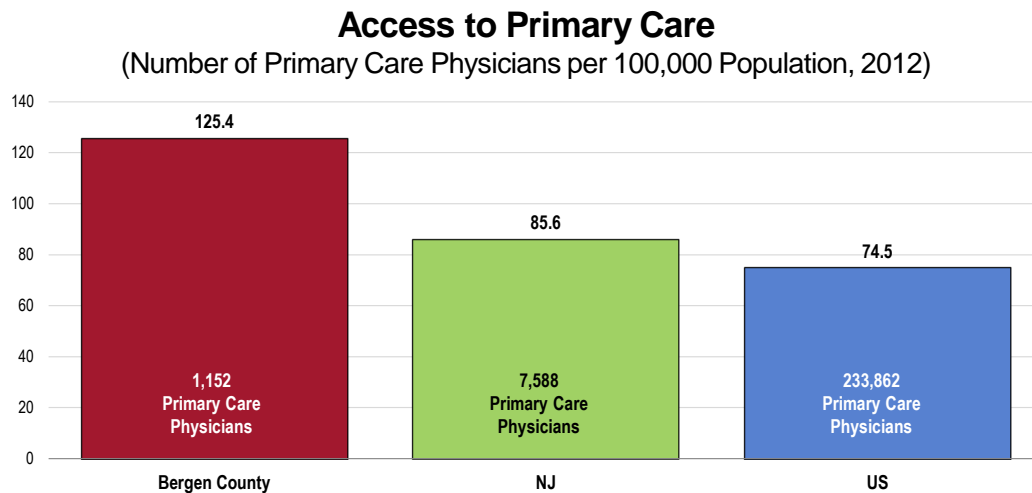
Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2012.
- Retrieved April 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

"Is there a particular place that you usually go to if you are sick or need advice about your health?"

"What kind of place is it: a medical clinic, an urgent care center/walk-in clinic, a doctor's office, a hospital emergency room, military or other VA healthcare, or some other place?"

The following chart illustrates the proportion of the Total Service Area population with a specific source of ongoing medical care. Note that a hospital emergency room is <u>not</u> considered a specific source of ongoing care in this instance.

- Note the Healthy People 2020 objective.

Have a Specific Source of Ongoing Medical Care
(Total Service Area, 2016)
Healthy People 2020 Target = 95.0% or Higher

Men	Women	18-39	40-64	65+	Low/Mid Income	High Income	White	Other	TSA	Bergen County	US
80.7%	77.2%	70.0%	83.5%	83.2%	68.0%	81.2%	80.8%	69.9%	78.8%	77.9%	74.0%
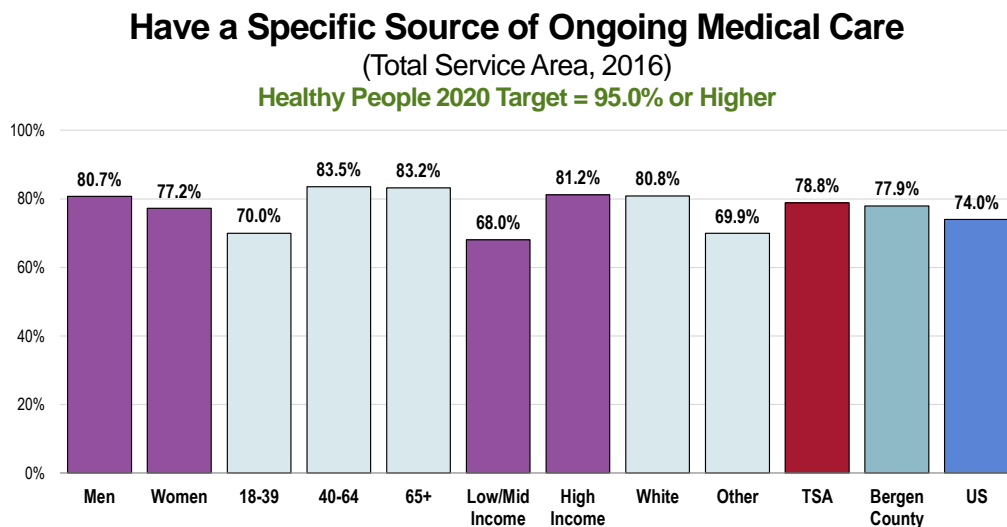
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-193]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Utilization of Primary Care Services

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

Children: "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"

Have Visited a Physician for a Checkup in the Past Year

69.5%	64.1%	66.7%	71.2%	75.9%	70.5%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	NJ	US
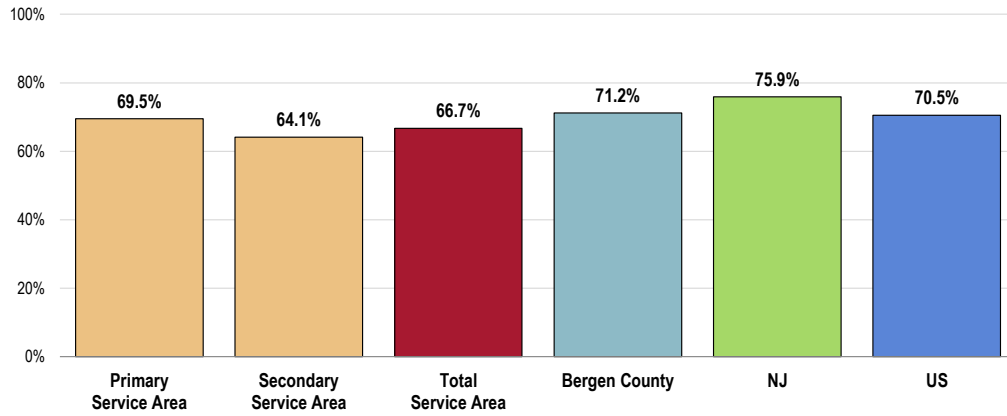
Sources:
● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 New Jersey data.
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: ● Asked of all respondents.

Child Has Visited a Physician
for a Routine Checkup in the Past Year
(Among Parents of Children 0-17)

83.8%	97.4%	90.4%	85.4%	89.3%
Total Service Area: Age 0-10	Total Service Area: Age 11-17	Total Service Area	Bergen County	US
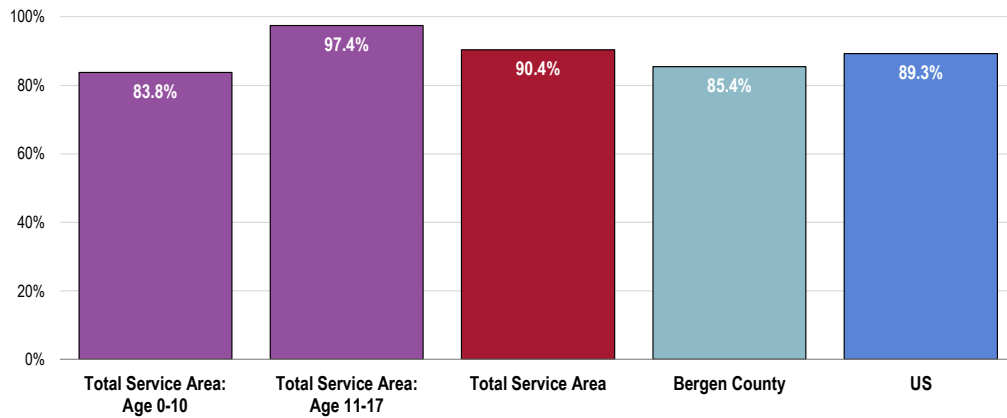
Sources:
● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.

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

Emergency Room Utilization

"In the past 12 months, how many times have you gone to a hospital emergency room about your own health? This includes ER visits that resulted in a hospital admission." (Responses below reflect the percentage with two or more visits in the past year.)

"What is the main reason you used the emergency room instead of going to a doctor's office or clinic?"

Have Used a Hospital
Emergency Room More Than Once in the Past Year

Used the ER because:
• Emergency Situation = 78.2%
• Weekend/After Hours = 11.9%
• Access Problems = 2.4%

Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US
2.2%	6.4%	4.5%	7.1%	8.5%

Sources:
● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes:
● Asked of all respondents.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use; excessive alcohol use;** and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

- Healthy People 2020 (www.healthypeople.gov)

Dental Care

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

- Note the Healthy People 2020 target.

Have Visited a Dentist or
Dental Clinic Within the Past Year
(Total Service Area, 2016)
Healthy People 2020 Target = 49.0% or Higher

Chart: Percentage of respondents who have visited a dentist or dental clinic within the past year.

Category	Percentage
Men	77.5%
Women	72.5%
18-39	60.0%
40-64	79.8%
65+	84.2%
Low/Mid Income	58.5%
High Income	78.6%
White	80.9%
Other	57.6%
Dental Insur.	84.4%
No Dental Insur.	56.7%
TSA	74.9%
Bergen County	73.0%
NJ	70.2%
US	67.2%
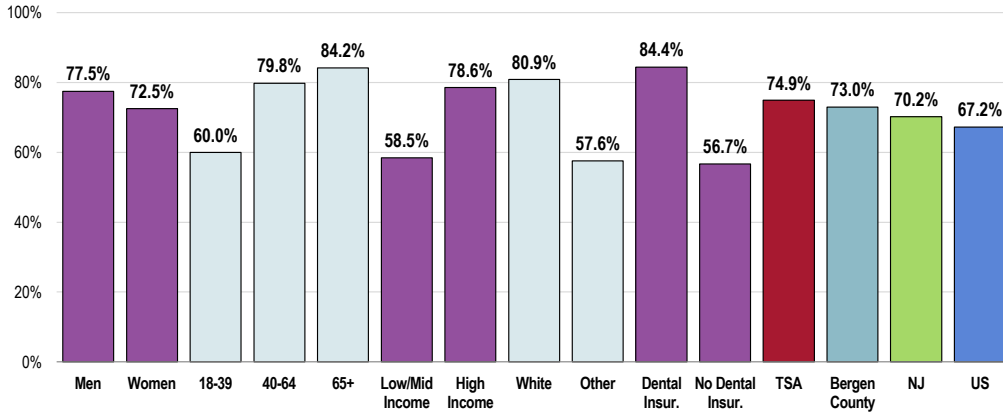
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low/Mid Income" includes households with incomes up to 400% of the federal poverty level; "High Income" includes households with incomes at 400% or more of the federal poverty level.

Dental Insurance

"Do you currently have any health insurance coverage that pays for at least part of your dental care?"

Have Insurance Coverage
That Pays All or Part of Dental Care Costs

Chart: Percentage of respondents who have insurance coverage that pays all or part of dental care costs.

Category	Percentage
Primary Service Area	69.5%
Secondary Service Area	64.9%
Total Service Area	67.1%
Bergen County	67.3%
US	66.5%
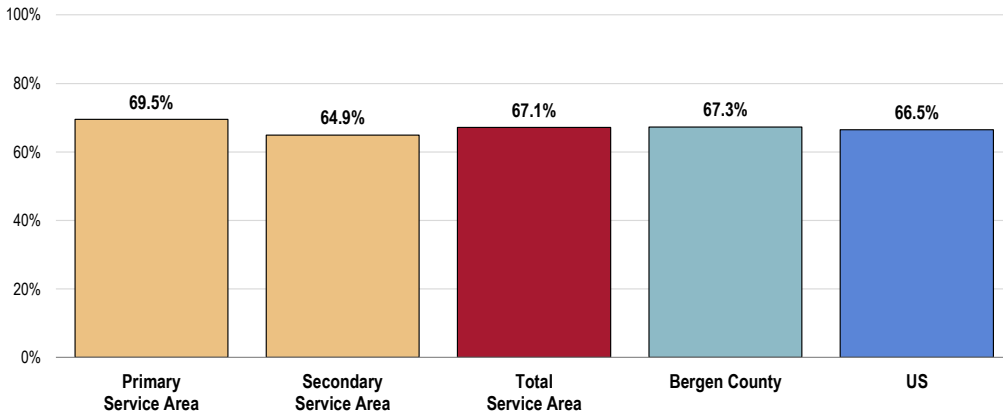
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
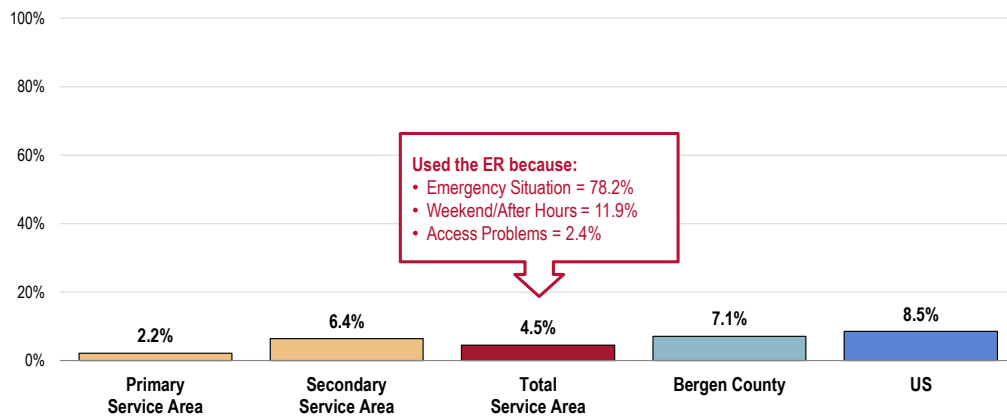- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

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

Perceptions of Oral Health
as a Problem in the Community
(Key Informants, 2016)
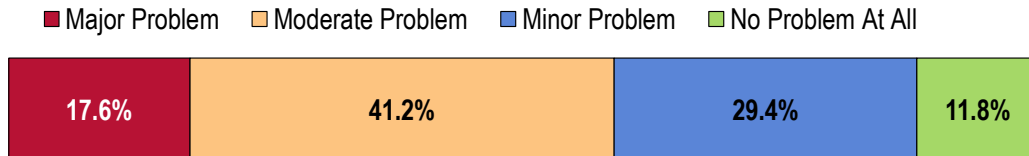
■ Major Problem ☐ Moderate Problem ■ Minor Problem ☐ No Problem At All

17.6%	41.2%	29.4%	11.8%

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

Top Concerns

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

Insurance Issues

> Oral surgery and Pediatric Dentistry is limited in Bergen County for the medically underserved population. There is a limited number of providers that accept uninsured or publicly insured patients. As an FQHC we have our own limitations. - Other Health Provider

> Dental services not covered by Medicare. - Other Health Provider

> Routine dental and dental services are not covered by Medicare and the expense associated with dental care poses a hardship for low income seniors. Due to the expense, many seniors do not regularly see a dentist. - Social Services Provider

> Dental care is one of those health issues that are rarely talked about nor covered by insurance. My sense is that people let it go because they cannot afford regular dental care. There is very little access for low income people. - Community/Business Leader

> For seniors in Bergen County, dental care is not covered by Medicare and for those living on a fixed income it is difficult to afford dental care. - Social Services Provider

> Dental care is not cover by most insurance, copayments are high. - Social Services Provider

> Limited insurance coverage and price of dental car in Bergen County. - Other Health Provider

Affordable Care/Services

> No availability to receive free or sliding scale dental care. Some referrals to outside sources such as the North Hudson Community Action Center and UMDMJ in Newark. Poor accessibility by public transportation and long wait for services. - Other Health Provider

> One of the longest ongoing conversations when speaking about community needs is the poor access to low-cost dental care. - Public Health Representative

Prevalence/Incidence

> So many seem, empirically, to have unhealthy teeth. - Community/Business Leader

Vision Care

"When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light." (Responses in the following chart represent those with an eye exam within the past 2 years.)

See also *Vision & Hearing* in the Death, Disease & Chronic Conditions section of this report.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

|	Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US
	61.6%	63.5%	62.5%	65.3%	59.3%
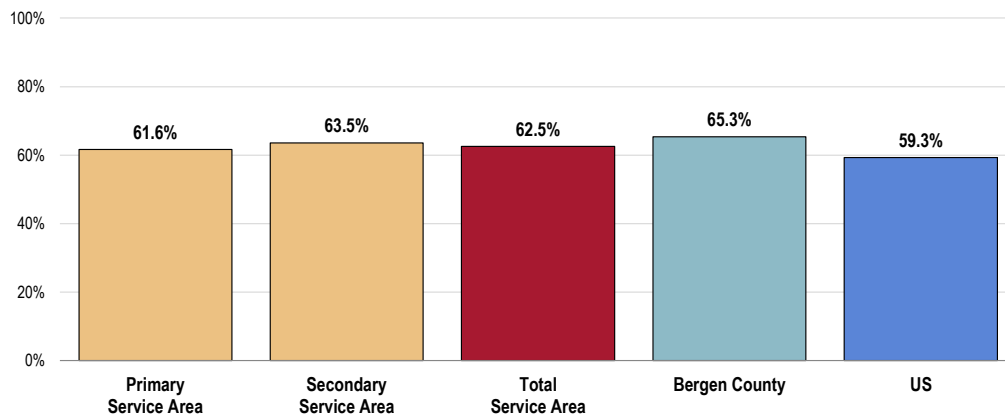
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]
            ● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Local Resources

Perceptions of Local Healthcare Services

"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair or poor?" (Combined "fair/poor" responses are outlined in the following chart.)

Perceive Local Healthcare Services as "Fair/Poor"

4.2%	8.4%	6.5%	11.9%	14.2%
Primary Service Area	Secondary Service Area	Total Service Area	Bergen County	US

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

- *American Cancer Society*
- *Bergen County Community Transportation*
- *Bergen County Department of Human Services*
- *Bergen Volunteer Medical Initiative*
- *Cancer Care*
- *Cancer Education and Early Detection*
- *Community Mental Health Centers*
- *Doctor's Offices*
- *Federally Qualified Health Centers*
- *Free Clinics*
- *Health Departments*
- *Health Fairs*
- *Health Screenings*
- *Hospitals*
- *North Hudson Community Action Corporation*
- *Planned Parenthood*
- *Public Health Nurses*
- *Public Transportation*
- *Social Services*
- *Veterans Benefits*
- *Volunteer Services*

Arthritis, Osteoporosis
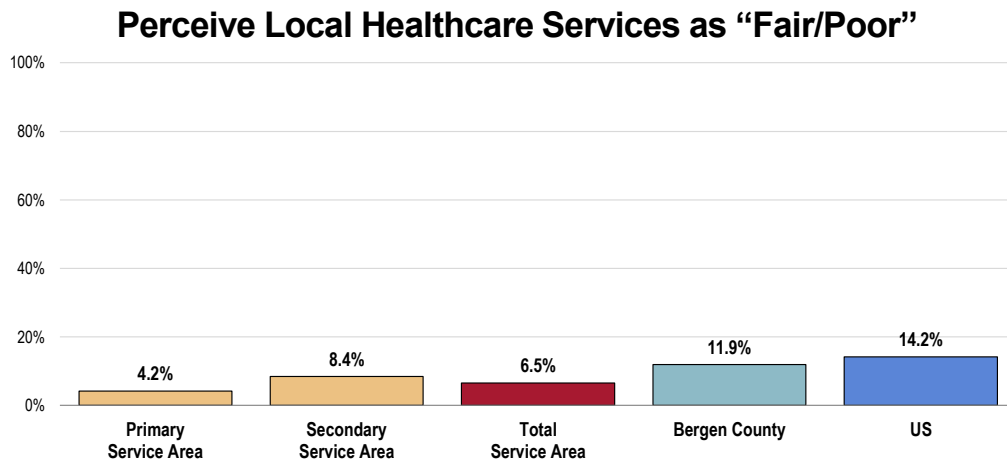**& Chronic Back Conditions**

- *Churches*
- *Complimentary Therapies*
- *Doctor's Office*
- *Educational Information*
- *Fitness Centers/Gyms*
- *Food Stamp Program*
- *Free Clinics*
- *Hospitals*
- *Nutritional Services*
- *Pain Management*
- *Parish Nurses*
- *Urgent Care*
- *Wellness Center*
- *YMCA*

Cancer

- *American Cancer Society*

- *Bergen Volunteer Medical Initiative*
- *Cancer Education and Early Detection*
- *Charity Care*
- *County-Sponsored Screenings*
- *Doctor's Offices*
- *Educational Information*
- *Environmental Investigation Programs*
- *Federally Qualified Health Centers*
- *Free Clinics*
- *Health Departments*
- *Hospice*
- *Hospitals*
- *Library*
- *North Hudson Community Action Corporation*
- *Nutritional Services*
- *NYU School of Environmental Medicine*
- *Public Health Nurses*
- *Smoking Cessation Programs*
- *Susan G. Komen Organization*
- *Total Hearing*
- *Urgent Care*
- *Volunteer Services*
- *Yearly Survival Day*

Chronic Kidney Disease

- *Bergen County Community Transportation*
- *Dialysis Center*
- *Hospitals*
- *Kidney Foundation*
- *National Organizations*
- *Volunteer Services*

Dementias, Including Alzheimer's Disease

- *A Place for Mom*
- *Adult Day Care*
- *Adult Protective Service*
- *Alzheimer's Association*
- *Alzheimer's Disease Education Center*
- *Alzheimer's New Jersey*
- *Alzheimer's Resource Center*
- *Alzheimer's Support Groups*
- *Assisted Living*
- *Bergen County Senior Services Programs*

Bergen County Office on Aging
Broadway Adult Day Care
Caregiver Information Referral Hotline
Comprehensive Services on Aging
County Services
Doctor's Offices
Gallen Adult Day Care
Griswold Home Care
Hillsdale Memory Care Living Homes
Home Care
Hospitals
Jewish Community Center
Jewish Family Service
Jewish Home
Memory Care Living
North Hudson Community Action Corporation
Nursing Homes
Regency Memory Care Club
Respite Program
Senior Centers
Senior Connections
Senior Helpers of Bergen County
Support Groups
Visiting Homemakers
Volunteer Services

Diabetes

American Diabetes Association
Bergen County Diabetic Savings Plan
Bergen County Monthly Support Meetings
Bergen Volunteer Medical Initiative
Community Programs
Davita Dialysis
Diabetes Case Management
Diabetes Education
Diabetes Foundation
Doctor's Offices
Fitness Centers/Gyms
Globe Shoes
Health Departments
Hospitals
Midland Park Senior Center
North Hudson Community Action Corporation
Nutritional Services
Online Resources
Parish Nurse
Partnership for Prescription Assistance
Patient Assistance Program
Public Health Adult Health Consultation
Program

State Pharmaceutical Assistance Program
Support Groups

Family Planning

Birth Haven
Birthright Family Planning Assistance
Program
Doctor's Offices
Good Council
North Hudson Community Action Corporation
Planned Parenthood
Section 8

Hearing & Vision

AARP
Doctor's Offices
Hospitals
Philips Eye Specialists
Total Hearing

Heart Disease & Stroke

AA/NA
Alder Aphasia Center
American Heart Association
Bergen County Department of Human Services
Bergen Volunteer Medical Initiative
Community Health Improvement Partnership
(CHIP)
Doctor's Offices
Educational Information
Farmer's Markets
Fitness Centers/Gyms
Health Departments
Hospitals
National Heart Association
New Jersey Department of Health
New Jersey Quit Line
Overeaters Anonymous
Parks and Recreation
Public Health Adult Health Consultation Program
Red Dress
Support Groups
Town Health Educator
Weight Watchers
Wellness Center
YMCA

Immunization & Infectious Diseases

Bergen County Department of Human Services
CDC

County Health Resources
Doctor's Office
Health Departments
Medical Society of New Jersey
New Jersey Department of Health
North Hudson Community Action Corporation
Partnership for Maternal and Child Health of North NJ
PassPort Health Travel Vaccine Clinic
Pharmacy
Supermarkets
Travel Kids HUMG Pediatric Infectious Diseases

Infant & Child Health

Children's Aid and Family Services
Hospitals
Medicaid
New Jersey Department of Human Services
Partnership for Maternal and Child Health of North NJ
Section 8
Voucher System for Child Care
WIC

Injury & Violence

AA/NA
Bergen County Judicial System
Center for Hope and Safety
Domestic Alternatives
Elected Officials
Hospitals
Jewish Home
Law Enforcement
Mental Health Providers
School System
Shelter for Our Sisters
Support Groups

Mental Health

12 Step Programs
Advance Housing
Advantage Health Systems
Bergen County 211
Bergen County Key Resources
Bergen County Shelter
Care Plus
Comprehensive Behavioral Healthcare Inc.
Community Health Improvement Partnership (CHIP)
Community Mental Health Centers

County Resource of 262
Day Care Programs
Division of Mental Health
Doctor's Offices
DVR for Employment Training
Friendship House
Health and Human Services Department
Health Departments
High Focus Centers
Hospitals
Law Enforcement
Mental Health Board Office
Mental Health Providers
Residential Group Homes for Adults
School System
Stigma Free Initiatives
Support Groups
Van Ost Institute
Vantage Health System
Wellness Center
West Bergen Mental Healthcare
Westwood Mental Health
Youth Services New Jersey Children's System of Care

Nutrition, Physical Activity & Weight

Bergen County Website
Community Health Improvement Partnership (CHIP)
Community Mental Health Centers
Community Programs
Division of Senior Services
Farmer's Markets
Fast Food Restaurants
Fitness Centers/Gyms
Food Pantries
Gold's Gym
Health Departments
Hospitals
Inserra Supermarket
Mayor's Fitness Challenge
National Organizations
Nutritional Services
Online Resources
Paramus Annual Weight Loss Challenge
Parks and Recreation
Senior Center
ShopRite Dieticians
SNAP
Town Sponsored Activity Challenges

Veggiacator Educator
Village Hall Program
Weight Loss Programs
Weight Watchers
Wellness Center
YMCA

Oral Health

Bergen Community College
Doctor's Offices
Federally Qualified Health Centers
Hospitals
Newark UNDNJ
North Hudson Community Action Corporation
Southeast Senior Center
Visiting Dental Associates

Respiratory Diseases

Educational Information
Hospitals
Medications
Support Groups

Sexually Transmitted Diseases

Bergen County Department of Health Services
CDC
Federally Qualified Health Centers
HIV Resource Buddies of New Jersey
Planned Parenthood

Substance Abuse

12 Step Programs
AA/NA
Addiction Hotline
Addiction Recovery Program
Alpha Healing Center
Bergen County Drug/Alcohol Program
Care Plus
Children's Aid and Family Services

Company EAP Programs
DARE
Doctor's Offices
Drug/Alcohol Alliances
Evergreen House
Health Departments
Hospitals
High Focus Centers
Law Enforcement
Mental Health Providers
Methadone Clinics
Municipal Alliances
New Jersey Addiction Services Hotline
New Jersey Recovery Advocates
New Pathways
Outpatient Drug Counseling Center
Peer Recovery Warmline
Private Treatment Center
Spring House for Women
State IME
Straight and Narrow
Summit Oaks Carrier Clinic
The Center for Alcohol and Drug Resources
Treatment Centers
Turning Point

Tobacco Use

American Cancer Society
American Lung Association
Doctor's Offices
Health Departments
Hospitals
Medical Organizations
New Jersey Department Smoke Free Air Act Initiative
New Jersey GASP
New Jersey Quit Line
Support Groups
The Center for Alcohol and Drug Resources

Appendices

Appendix I: Special Populations

In order to better understand the health needs of the Korean and African American communities in Bergen County, additional and distinct Online Key Informant Surveys were administered about these populations to individuals who work with or otherwise have a global perspective of their needs. The following represent the input received around the health issues measured for these groups.

Health Needs of Korean Residents

Top Health Concerns

When presented with a list of 20 potential health issues, participating key informants most often rated the following as "major" problems specific to the Korean population in Bergen County:

Evaluation of Health Issues				
Health Issue	% Major Problem	% Moderate Problem	% Minor Problem	% No Problem At All
Dementia/Alzheimer's Disease	50.0	40.0	10.0	0.0
Diabetes	50.0	40.0	10.0	0.0
Mental Health	45.5	45.5	9.1	0.0
Access to Healthcare Services	45.5	9.1	36.4	9.1
Cancer	33.3	55.6	11.1	0.0

Reasons for "Major Problem" Responses

The sections below highlight what key informants offered as their main reasons for rating the following issues as "major" problems for the Bergen County Korean population.

Dementias, Including Alzheimer's Disease

Aging Population

> *Too many elders have them, but they either refuse to agree that they have dementia, or no one is around to take care of them. - Social Services Provider (responding about the Bergen County Korean population)*

Alcohol Use

> *Heavy use of alcohol earlier in life causes dementia. Also, being an immigrant, social isolation from their community might cause dementia. - Community Leader (responding about the Bergen County Korean population)*

Housing

> *Many admissions to psychiatry from families who cannot provide dementia care to their loved ones at home. They tend to keep their loved ones at home, rather than sending them to assisted living or nursing homes- as part of their culture. - Other Health Provider (responding about the Bergen County Korean population)*

Impact on Families/Caregivers

> *Most Koreans try to take care of their parents (who suffer from dementia and Alzheimer's disease) from home without getting professional help, regardless of status of health insurance- because that is cultural norm. Not all Koreans are the same. - Public Health Representative (responding about the Bergen County Korean population)*

Diabetes

Access to Primary Care Providers

Access to primary care, especially Korean-speaking. - Physician (responding about the Bergen County Korean population)

Nutrition

Korean food is salty and very hard to measure for correct amount and calories. - Social Services Provider (responding about the Bergen County Korean population)

Prevalence/Incidence

[A high percentage] of Korean Americans are either diabetic or pre-diabetic due to carb-related diet, lack of exercise and stress levels. - Other Health Provider (responding about the Bergen County Korean population)

Vulnerable Populations

Diabetes is a chronic disease, and Asian and Native American populations are more vulnerable. Without insurance coverage, follow-up with doctor and prescription cost are too costly. Some people just try not to take prescription medication, believing that it will be better. - Public Health Representative (responding about the Bergen County Korean population)

Mental Health

Health Education

Lack of awareness and education in mental health issues within our community. Lack of psychological and psychiatric services, both in English and Korean. - Community Leader (responding about the Bergen County Korean population)

Educate immigrants to understand the cultural difference and how to communicate with the second generation. - Community Leader (responding about the Bergen County Korean population)

Prevalence/Incidence

Mental health problems among Korean American children are underestimated. There is scant research or interest, as they tend to be stereotypically viewed as "model" children. For low-income Korean American families in particular, socioeconomic pressure. - Community Leader (responding about the Bergen County Korean population)

Many people at all age levels suffer from mental health issues. However, community resources are pretty limited and stigma associated with mental illnesses is very high. - Other Health Provider (responding about the Bergen County Korean population)

Stigma

Stigma and a limited number of staff members who speak Korean. Limited staff who understand Korean culture. Patients have a difficult time accepting non-Korean staff assistance. - Other Health Provider (responding about the Bergen County Korean population)

Access to Healthcare Services

Insurance Issues

Korean Americans remain to be one of most uninsured populations in Bergen County. There are limited resources that can speak the language and are able to provide ACA enrollment services. - Other Health Provider (responding about the Bergen County Korean population)

The greatest difficulties in obtaining or accessing medical care are experienced by low-income people without health insurance. - Community Leader (responding about the Bergen County Korean population)

Health insurance premium cost, and language barrier. - Public Health Representative (responding about the Bergen County Korean population)

There are so many Koreans who do not have health Insurance. The Obamacare is not working for these people. Premium is too high and coverage is too low, they'd rather pay penalty instead of premium of the insurance. Found this trend for young people. - Social Services Provider (responding about the Bergen County Korean population)

Stigma

Stigma is a huge concern for this patient population. Limited number of staff members who speak Korean adds to feelings of isolation. - Other Health Provider (responding about the Bergen County Korean population)

Cancer

Prevalence/Incidence

> *Cancer prevalence rate is high, especially stomach, colon, lung, liver, and breast cancers. Not sure why, but westernization of food intake and stress level might be contributing factors. - Other Health Provider (responding about the Bergen County Korean population)*

> *Breast cancer. - Community Leader (responding about the Bergen County Korean population)*

Nutrition

> *Because of their diet habits (spicy and salty food), Korea is one of top countries for stomach cancer. Heavy use of tobaccos and lung cancer happens a lot among the Korean. - Community Leader (responding about the Bergen County Korean population)*

Health Needs of African American Residents

Top Health Concerns

When presented with a list of 20 potential health issues, participating key informants most often rated the following as "major" problems for the African American population in Bergen County:

Evaluation of Health Issues				
Health Issue	**% Major Problem**	**% Moderate Problem**	**% Minor Problem**	**% No Problem At All**
Nutrition, Physical Activity & Weight	62.5	37.5	0.0	0.0
Diabetes	62.5	25.0	12.5	0.0
Heart Disease and Stroke	55.6	33.3	11.1	0.0
Cancer	50.0	37.5	12.5	0.0
Chronic Kidney Disease	50.0	37.5	12.5	0.0

Reasons for "Major Problem" Responses

The sections below highlight what key informants offered as their main reasons for rating the following issues as "major" problems specific to the Bergen County African American population.

Nutrition, Physical Activity & Weight

Prevalence/Incidence

> *Due to untreated long-term hypertension, the African American population overall has a high burden of disease from chronic kidney disease. - Physician (responding about the Bergen County African American population)*

> *A large percentage of African Americans have kidney disease and are on dialysis. - Community Leader (responding about the Bergen County African American population)*

> *A number of residents are on dialysis. - Community Leader (responding about the Bergen County African American population)*

Lifestyle

> *Poor nutrition, stress and lack of exercise. - Community Leader (responding about the Bergen County African American population)*

Diabetes

Access to Care/Services

Access to health care services, follow-up with physicians, lack of understanding of chronic diseases, prohibitive costs of medication and health care services. - Community Leader (responding about the Bergen County African American population)

Access to primary care and education for nutrition. - Physician (responding about the Bergen County African American population)

Health Education

Continued access to educational programs on the effects of diabetes, medication and equipment for monitoring. - Community Leader (responding about the Bergen County African American population)

Not having enough information regarding diet and the importance of medication. - Community Leader (responding about the Bergen County African American population)

Lifestyle

Unhealthy diets passed down through the culture. Lack of physical or economic access to healthy foods. - Community Leader (responding about the Bergen County African American population)

Heart Disease & Stroke

Co-Occurrences

Due to obesity, family history, smoking, untreated hypertension, high cholesterol and diet, there is a high burden of disease in the African American community from heart disease and stroke. - Physician (responding about the Bergen County African American population)

Stress, diet, nutrition, genetics and lifestyles. - Community Leader (responding about the Bergen County African American population)

Health Education

Lack of information regarding these diseases. - Community Leader (responding about the Bergen County African American population)

Continued education on nutrition and stress management. - Community Leader (responding about the Bergen County African American population)

Prevention

Rates for screening are lower. Cardiac risks are greater. - Physician (responding about the Bergen County African American population)

Cancer

Prevalence/Incidence

There is a large burden of cancer in the African American community, and given lapses in screening programs, the population is at greater risk for late detection. - Physician (responding about the Bergen County African American population)

Breast cancer, prostate cancer and other cancers are prominent in the community and require more education and interventions. - Community Leader (responding about the Bergen County African American population)

Co-Occurrences

Environmental concerns (such as exposure to conditions not suitable), healthy diets, and importance of pre-screening. - Community Leader (responding about the Bergen County African American population)

Prevention

Lower rates of screening and higher incidence of certain cancers like prostate. - Physician (responding about the Bergen County African American population)

Chronic Kidney Disease

Prevalence/Incidence

Due to untreated long-term hypertension, the African American population overall has a high burden of disease from

chronic kidney disease. - Physician (responding about the Bergen County African American population)

A large percentage of African Americans have kidney disease and are on dialysis. - Community Leader (responding about the Bergen County African American population)

A number of residents are on dialysis. - Community Leader (responding about the Bergen County African American population)

Lifestyle

Poor nutrition, stress and lack of exercise. - Community Leader (responding about the Bergen County African American population)

Appendix II: Evaluation of Past Activities

Bergen County 2013 Community Health Needs Assessment Implementation Strategy Evaluation 2016

In 2013, The Bergen County Department of Health Services, in collaboration with Englewood Hospital and Medical Center, Hackensack University Medical Center, Hackensack University Medical Center at Pascack Valley, Holy Name Medical Center, Ramapo Ridge Psychiatric Hospital, and The Valley Hospital conducted a joint Community Health Needs Assessment (CHNA) and created a community benefit/community health strategic plan in April of 2013. The Bergen County CHNA process identified four priority areas outlined in **Figure 1** as the most important priority issues for the County's health and social services providers to work collaboratively on over the next three-years. The target populations for these initiatives are outlined in **Figure 2.**

Figure 1. Bergen County Four Priority Areas
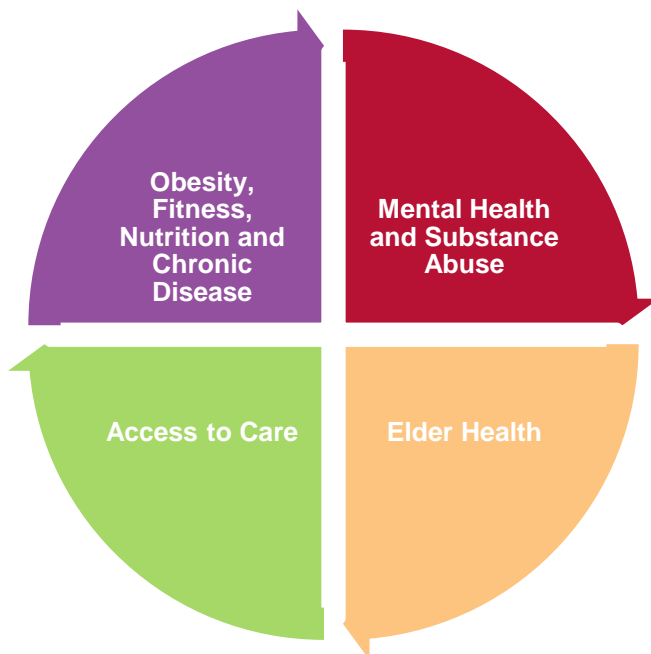
Figure 2. Bergen County Targeted Populations

With the assistance of Strategy Solutions, Inc., the Erie, PA-based consulting group engaged by PRC to assist with Bergen County CHNA, an evaluation of the implementation strategies undertaken since the completion of the 2013 CHNA was conducted. Although the measureable population health outcomes for most county level indicators did not move substantially over the three-year period, the partners are working individually and collaboratively to improve the health of the community. Overall population health improvements are expected over time.

Bergen County Diabetes Detection and Management Collaborative

While the Bergen County Department of Health Services and each of the individual hospitals created individual strategic plans to address the priorities areas, all participated in a county-wide Bergen Collaborative Diabetes Screening day in the spring of 2014. This county-wide event helped to identify people who are at risk for diabetes, provided access to treatment options and follow the progress of these people over a one-year period. Since depression and anxiety often accompany chronic diseases like diabetes, participants were also screened for these two mental health conditions. Between all locations in the county, over 10,000 people were screened for diabetes. The majority (63%) of the participants were also screened for depression.

Collaborative Mental Health Needs Assessment and Planning

During the first half of 2016, five of the county's hospital providers (Englewood Hospital and Medical Center, Hackensack University Medical Center, Holy Name Medical Center, Ramapo Ridge Psychiatric Hospital and The Valley Hospital) began an evaluation of Bergen Regional Medical Center, a County-owned 1,084 bed hospital serving long-term (SNF) patients (53% of licensed beds), psychiatric patients (31%) and acute care patients (16%), of which over 75% are admitted for detox related to drug and/or alcohol abuse. Pending completion of the detailed evaluation, the five-organization collaborative may propose its participation in the County's exploration of options, which may include oversight and restructure of the hospital, for improving care.

Evaluation of Individual Hospital 2013 CHNA Implementation Strategies

The following table depicts the priority areas that the Bergen County Department of Health Services and each of the collaborating hospitals selected to include in their 2013 CHNA Implementation Strategies.

Bergen County 2013 CHNA Implementation Strategies

Priority Area	Department of Health Services	Englewood	Hackensack UMC	Hackensack UMC-PV	Holy Name	Ramapo	Valley
Obesity, Fitness, Nutrition & Chronic Disease	X	X	X	X	X		X
Mental Health & Substance Abuse	X	X	X	X	X	X	X
Access to Care		X	X	X	X	X	X
Elder Health		X	X	X	X	X	X

Ramapo Ridge (Ramapo) at Christian Health Care Center

Ramapo Ridge (Ramapo) at Christian Health Care Center is a psychiatric hospital located in Wyckoff, NJ providing inpatient services to adults, including a specialty in the geriatric population. The primary focus areas for community benefit and community health strategy in response to the 2013 CHNA included Mental Health and Substance Abuse, Elder Health and Access to Care. As secondary foci, Ramapo partnered with other health organizations and stakeholders to address patient issues related to obesity, fitness, nutrition, and chronic disease. The target population for the hospital's strategy was residents throughout the primary service area, but efforts also focused on elders and the low income populations that live in various pockets throughout the service area. Ramapo's concentration in the priority area of *Mental Health and Substance Abuse* led to the following outcomes:

- **Screen Vulnerable Population for Risk/Presence of Depression and/or Substance Abuse.** Ramapo administered the PHQ-9 Patient Depression Questionnaire and CAGE-AID alcohol and drug screening during the County-wide collaborative diabetes screening event in spring 2014. The hospital's goal for those willing to participate in the screening was 70%, although the actual number of participants screened was 63%.

- **Link Individuals who Screen Positive for Depression and/or Substance Abuse to Appropriate Services**. Ramapo provided contact information for appropriate level of services for all individuals who screened positive for depression and/or substance abuse. The hospital met its goal of 100% of those screened who had any signs/symptoms of depression being offered an appointment for counseling services within 72 hours.

- **Ensure Engagement with Mental Health Professional When Indicated**. Ramapo created a follow-up phone contact person two weeks after screening for all those who screened positive for depression and/or substance abuse to determine whether or not they connected with a mental health professional. Although the hospital's goal was to get 70% of the people connected, this goal was not achieved as those who were offered counseling services ultimately declined appointments, but did accept information on how to reach out for help.

- **Increase Awareness of Signs and Symptoms of Mental Illness and Available Resources**. Ramapo partnered with stakeholders (Wyckoff YMCA, Wyckoff Board of Health, Valley Hospital, social services organizations, CHIP, schools, local medical centers, and faith-based organizations) to provide educational presentations on dementia, mental illnesses, treatment options, and other relevant mental health topics. For the years 2013-2015, Ramapo conducted approximately 90 hours of programs in the community that targeted various topics associated with Mental Health. These programs included multiple topics related to dementia, identifying and managing mental illnesses and treatment approaches, aging issues, issues associated with substance use disorders and many topics around maintaining a healthy mind and body.

Regarding the priority area of *Elder Health*, Ramapo's implementation strategies included the following:

- **Improve Management of Chronic Illnesses, Including Mental Health conditions, Among the Elderly.** Ramapo partnered with Valley Hospital and Bergen Regional Medical Center to provide education and screening targeting the elderly by involving local faith-based organizations and senior centers. This was achieved by targeting the high risk and underserved populations by offering to sponsor "Living a Healthy Life with Chronic Conditions," a Stanford University intensive 7-week educational series. This educational series has been offered throughout the county for the three years ending 2015 and is anticipated to continue to be offered in the future.

Access to Care is another priority area that Ramapo participated in with the following goal:

- **Streamline Access to Elders Requiring Psychiatric Hospitalization.** For elders needing psychiatric hospitalization, Ramapo established a direct admit process from Nursing Homes and Assisted Living facilities, with the goal of being able to bypass Emergency Room visits expressly to obtain medical clearance for admission. The hospital also monitored the wait time in the Emergency Room for individuals referred to Ramapo. In assessing the percentage of those referred by Nursing Homes/Assisted Living Facilities that could be directly admitted to the hospital and therefore bypass the Emergency Room, Ramapo stated that medical clearance was indicated in the majority of cases but that the direct admit process is ongoing monitoring and review. The hospital did report that they achieved their goal of having a wait time of equal to or less than 4 hours for individuals in the Emergency Department to be transferred to Ramapo once a disposition for admission was determined. This occurred 87% of the time during this reporting period. This measure also continues to be monitored and reviewed.