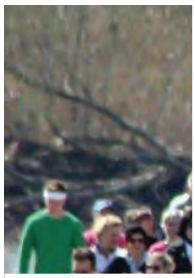
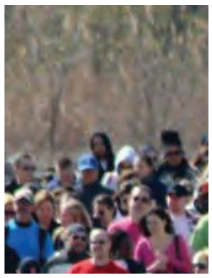
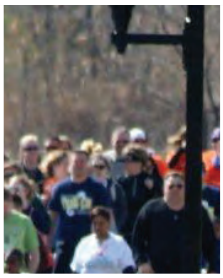
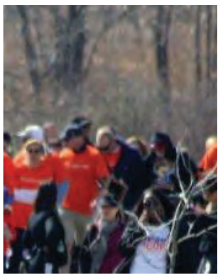
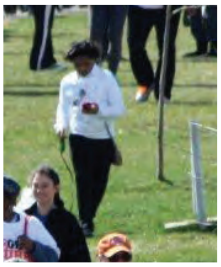
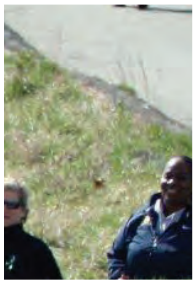





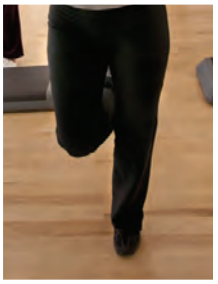








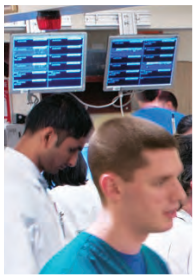
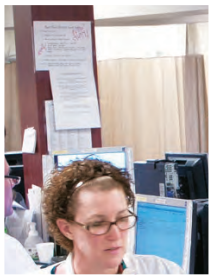
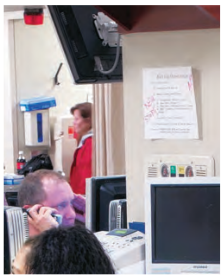




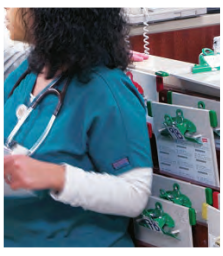





# BERGEN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT & IMPROVEMENT PLAN 2013






CHIP

Community Health *Improvement* Partnership
OF BERGEN COUNTY

# ACKNOWLEDGEMENTS

**THE BERGEN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND STRATEGIC PLANNING PROJECT WAS MADE POSSIBLE THROUGH THE GENEROUS SUPPORT** of Christian Health Care Center, Englewood Hospital and Medical Center, Hackensack University Medical Center, Holy Name Medical Center, and The Valley Hospital. Representatives from these five 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 for more than a year to conduct this assessment and planning project. A steering committee made up of senior representatives from each hospital and the County Department of Health Services guided this project. An advisory committee, which included additional staff from the participating hospitals and BCDHS, as well as representatives from local health departments and a number of Bergen County's leading health and social service organizations, provided additional input. The combined expertise, knowledge, and commitment of the members of these committees was vital to this project. Marla Klein, Partnership Coordinator at BCDHS and Coordinator of the CHIP, managed the project and was the main liaison between the steering committee and John Snow, Inc., the consulting company that was hired to assist with the assessment. Ms. Klein deserves special recognition for her tireless oversight and support of the CHNA process.

During this project, dozens of individuals were interviewed by John Snow, Inc. including administrative and clinical staff from the hospitals, representatives from health and social service agencies, public health officers, other public and elected officials, representatives from advocacy organizations and foundations, and community residents. John Snow, Inc. also conducted a random household mail survey with more than 1,700 residents from Bergen County. A pool of research assistants augmented these findings by collecting nearly 400 additional surveys from low-income, racial/ethnic minority residents of the County at community-based health and social service organizations, open-air markets, faith-based organizations, and other community venues. Finally, information was gathered by the JSI project team from community residents, service providers, and other community health stakeholders through a series of focus groups and listening sessions. These information-gathering efforts allowed the steering and advisory committees to gain a better understanding of the health status, health care needs, service gaps, and barriers to care of those living in Bergen County. The Steering Committee would like to thank all of the people who were involved in this project, particularly those who participated in interviews, survey efforts, focus groups, and community listening sessions.

## LEADERSHIP STEERING COMMITTEE

**Cathy Pilone**, Christian Health Care Center

**Michael Pietrowicz**, Englewood Hospital and Medical Center

**Tom Flynn**, Hackensack University Medical Center

**Catherine Yaxley**, Holy Name Medical Center

**Colette Cummings**, The Valley Hospital

**Marla Klein**, Bergen County Department of Health Services

**Elizabeth Rubock**, Bergen County Department of Health Services

## ADVISORY COMMITTEE

**Nancy Mangieri,** Bergen County Dept. of Health Services

**Doug Struyk**, Christian Health Care Center

**Dave Volpe**, Borough of Bergenfield

**Nelson Xavier-Cruz**, City of Englewood

**John Christ,** City of Hackensack

**Nancy Ellson**, Holy Name Medical Center

**Paul Ostrow,** Holy Name Medical Center

**Vinny Urgola**, North Hudson Community Action Corporation

**Sara Berk**, The Valley Hospital

**Gail Callandrillo**, The Valley Hospital

# EXECUTIVE SUMMARY

## OVERVIEW, PURPOSE, AND COLLABORATION

Bergen County's hospitals, public health institutions, and leading health and social service agencies have a long history of collaboration that has helped to make Bergen County one of the healthiest counties in the State of New Jersey. In fact, in 2013, the Robert Wood Johnson Foundation's County Health Rankings and Roadmaps Program ranked Bergen County as the fourth-healthiest county of the state's 21 counties[1]. This collaboration was initiated in 1996 when the County's hospitals, the Bergen County Department of Health Services (BCDHS), many of the leading health, social service, and academic organizations, and members of the community created a coalition to develop programs that would improve the health of the community. In 2006, this partnership was formalized with the creation of the Community Health Improvement Partnership (CHIP).

The CHIP's mission is to promote collaboration across the County's leading public and private community health stakeholders, ultimately to ensure that Bergen County's residents have access to resources that enable them to reach optimum health, well-being, and quality of life. The CHIP has implemented numerous community health improvement projects, with the support of hospitals, local foundations, the county executive, and the community and has conducted a series of needs assessment and planning projects that have guided community health improvement. The CHIP's last community health needs assessment (CHNA) and community health improvement plan was completed in 2006. This report is a formal update of that assessment and planning process.

This report is the culmination of nearly 18 months of work and was made possible through the generous support of the County's five nonprofit hospitals; Christian Health Care Center, Englewood Hospital and Medical Center, Hackensack University Medical Center, Holy Name Medical Center, and The Valley Hospital. The hospitals' desire to conduct the assessment and update the 2006 Bergen County Community Health Improvement Plan was borne largely of their commitment to the County's residents and their wish to continue their support of the CHIP. However, the project also fulfills a new federal Internal Revenue Service (IRS) requirement, built into the new Patient Protection and Affordable Care Act (PPACA) (National Health Reform), which mandates that all nonprofit hospitals conduct a CHNA and strategic planning process every three years. PPACA requires that the CHNA assess community health need, identify priority health issues and create a community health improvement strategy that addresses how the hospitals, in collaboration with the community, will address the needs and the priorities identified by the CHNA.

PPACA strongly encourages hospitals to conduct their CHNAs collaboratively across hospitals and services areas. Bergen County's nonprofit hospitals have clearly fulfilled this desire by working together through the CHIP. In addition, Bergen County, through the CHIP and BCDHS, collaborated with two neighboring counties to share data and information. The CHNA Steering Committee worked closely with Sister Marion Scranton at St. Mary's Hospital in Passaic County, New Jersey to share information and coordinate their efforts, and shared information with the Rockland County Health Department, which provided their recently completed CHNA report as a resource for this effort. Palisades Medical Center in Hudson County, New Jersey was also approached but opted to work independently.

# APPROACH AND PROCESS

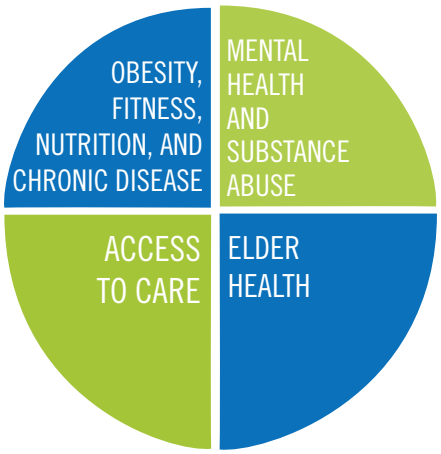
The assessment and planning process was conducted in three phases, which allowed the collaborating organizations to: 1) identify and clarify the health care needs and priorities of the residents of Bergen County; 2) engage stakeholders, including key service providers and residents throughout the County; and 3) develop a detailed Bergen County Community Health Improvement Plan. Each of the five partnering hospitals, in turn, is developing individual implementation plans that will draw from the countywide plan. These individual plans will leverage the hospital's strengths and resources and allow them to meet the needs of those who live and work in the communities they serve.

The assessment process compiled and analyzed an array of quantitative and qualitative health-related data through community interviews, household and community surveys, and focus groups. For the purpose of this assessment, the steering committee defined health broadly to include not just health status and the existence of disease but also social factors, access to care issues, and overall determinants of health. Data was collected at County-level and whenever possible at the city, town, and borough level. State and national data was also compiled to facilitate comparison and benchmarking of County and local data. Key findings from these data are summarized and the bulk of the data is provided in the appendices to this report.

# COMMUNITY HEALTH PRIORITIES AND TARGET POPULATIONS

Once all of the assessment's health-related data was compiled, the steering committee implemented a comprehensive strategic planning process involving the hospitals, public health agencies, the County's leading health and social service providers, and the community at-large. The first task in this process was a strategic planning retreat involving the members of the CHNA's steering and advisory committees. Individual strategic planning meetings were then convened with each of the participating hospitals, the Bergen County Health Department, and CHIP. The project's findings were also presented to a number of community groups, including local health department officials, discharge planners and case managers from the participating hospitals, and the Bergen County Mental Health Task Force. Finally, preliminary findings and results were presented to the public at CHIP's annual meeting, which nearly 100 community residents and other community health stakeholders attended.

The feedback and ideas collected during these meetings and community listening sessions set the stage for the strategic planning process and helped the steering committee to identify a series of County-wide community health priorities as well as demographic, socio-economic, and geographic target populations. The following are the community health priorities and the target populations that the steering committee and the other public health and community health stakeholders identified during this strategic planning process.




# STRATEGIC GOALS & CORE COMMUNITY HEALTH STRATEGIES

The ultimate purpose of this assessment was to provide actionable data and information along with a detailed strategic plan that would engage the community, promote collaboration, and guide the County's community health improvement efforts. With this in mind, the steering committee was charged with identifying a series of goals and objectives along with a set of evidenced-based strategies that would guide the implementation process and become the core of the County's and CHIP's community health improvement plan. The steering committee agreed that whatever goals were identified needed to be attainable using existing resources. The strategies identified also needed to be shown in the existing peer-reviewed literature to be effective and cost-efficient. Finally, the associated community health improvement plan needed to be aligned with existing national, state, and county strategies being promoted by other private and public agencies, such as the New Jersey Department of Health's Shaping NJ initiative, related to obesity, fitness, and nutrition.

The following, organized by priority area, are the strategic goals that resulted from the steering committee retreat, the individual hospital meetings, and the community listening sessions.

| Priority Area One: Obesity, Fitness, Nutrition & Chronic Disease |
|---|
| Goal 1: Increase physical activity |
| Goal 2: Increase healthy eating |
| Goal 3: Increase the number of residents who maintain a healthy weight |
| Goal 4: Promote care coordination and engagement in primary care |
| Goal 5: Improve screening and identification of chronic disease and its risk factors |
| Goal 6: Promote chronic disease management and behavior change |
| **Priority Area Two: Mental Health and Substance Abuse** |
| Goal 1: Reduce depression and isolation |
| Goal 2: Reduce anxiety and stress |
| Goal 3: Reduce stigma related to mental illness |
| Goal 4: Reduce risky and binge drinkers (alcohol) |
| Goal 5: Reduce prescription drug abuse |
| **Priority Area Three: Access to Care** |
| Goal 1: Promote access to and engagement in primary care |
| Goal 2: Promote access to and engagement in dental care |
| Goal 3: Promote access to and engagement in behavioral health care |
| Goal 4: Promote access to and engagement in medical specialty care |
| Goal 5: Increase access to culturally and linguistically appropriate care |
| Goal 6: Reduce transportation barriers |

| Priority Area Four: Elder Health |
|---|
| Goal 1: Reduce inappropriate hospital readmissions |
| Goal 2: Reduce transportation barriers |
| Goal 3: Increase access to caregiver support programs |
| Goal 4: Increase access to end-of-life and palliative care programs |

After considerable discussion and review of the literature, the Steering Committee identified the following set of core strategies and agreed that, in addition to their existing community health improvement efforts, they would advocate for and promote the development of programs in these areas.

## EXPANSION OF ACCESS TO SERVICES

Expand capacity to behavioral health, dental, and medical speciality care services in targeted ways, particularly among the healthcare safety net that serves underserved, low-income, and racial/ethnic minority populations who are more likely to be uninsured or underinsured. Efforts should also reduce barriers to care such as transportation, language, culture, health literacy, and administrative barriers to maintaining insurance coverage.

## CHRONIC DISEASE MANAGEMENT PROGRAMS

Ensure that individuals with or at particular risk of contracting chronic conditions have access to evidenced-based programs that raise awareness, provide education on risk factors and health promotion ideas, and include self-management supports that help individuals manage their conditions and change risky or unhealthy behaviors.

## COMMUNITY-BASED HEALTH AND WELLNESS PROMOTION

Build on existing lectures, workshops, health fairs, screening events, and other programs currently sponsored by hospitals, health departments, and other community health partners in Bergen County. Findings from the community health needs assessment should be used to refine and focus these activities.

## DEVELOPMENT OF DIABETES COLLABORATIVE

The diabetes collaborative would be a community coalition of health and social service providers committed to working together to improve the health and wellbeing of Bergen

County residents with diabetes or at-risk of contracting diabetes. Activities could include linking people without a primary care provider to a medical home, increasing access to chronic disease management and self-management support services, advocating for effective policy and practice change, sharing best practices, and promoting effective prevention strategies.

## PRIMARY CARE ENGAGEMENT

Link people in need to appropriate services, address social determinants of health, promote engagement in care, and improve care coordination and follow-up care. The programs should target specific at-risk populations by socio-economic status, race/ethnicity, geography, and health condition. Programs should provide general health education and ensure that participants are engaged in primary care and other appropriate services. These activities should be provided in conjunction with chronic disease management and behavior change programs.

## BEHAVIORAL HEALTH INTEGRATION

Facilitate targeted or universal screening for mental health conditions and substance abuse in the primary care setting and ensure that people identified with mental health or substance abuse issues are linked to and engaged in care either through formal, enhanced referral arrangements with other behavioral health providers, or through a co-located therapist operating within the primary care clinic.

## PUBLIC HEALTH AND ENVIRONMENTAL INTERVENTIONS

Develop local laws and adopt formal policies by boards or commissions that protect public health, improve enforcement, or change practices in community settings such as in restaurants, grocery stores, and schools. The CHIP should work with state and local policy makers and community leaders to advocate for these efforts.

## REDUCTION OF INAPPROPRIATE HOSPITAL UTILIZATION

Build on existing hospital and community-based efforts and work to reduce the burden and costs associated with inappropriate emergency department and hospital inpatient utilization or inappropriate hospital readmissions. Manage high-utilizers in the emergency department, enhance discharge planning, improve care transitions, and enhance care management and care coordination activities. Emergency department efforts should target “frequent flyers” as well as those with mental health and substance abuse conditions. Inpatient programs should focus on older adults with congestive heart failure, pneumonia, and COPD.

## WORKSITE HEALTH AND WELLNESS PROMOTION

Promote informational and educational strategies, behavioral strategies, policy and environmental approaches, and comprehensive wellness strategies in worksite settings that address health issues such as smoking cessation, stress management, and cholesterol reduction.

**THE COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP (CHIP) OF BERGEN COUNTY** is comprised of community residents as well as more than 50 health, public health, social service, housing, school, business, and other community organizations, including each of the major non-profit hospitals in Bergen County. CHIP has been operating in Bergen County since 2006 and over this time has played a critical role in facilitating community health assessments, strategic planning, and health improvement. CHIP members work collaboratively to implement and promote community health initiatives that improve the health and well-being of those who live, work, or attend school in Bergen County.

## CHIP VALUES

- Systems thinking
- Strategic thinking
- Dialogue
- Action
- Shared vision
- Celebration of successes
- Data-based assessment/evaluation partnerships

## CHIP VISION

*All people in Bergen County will have access to resources that enable them to reach optimum health, well-being and quality of life, supported by a continually improving, clean, safe and economically sound community. Community stakeholders will collaborate to create and leverage resources to build a healthier Bergen County.*

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# BACKGROUND & APPROACH

## OVERVIEW & PURPOSE

In 2006, the Community Health Improvement Partnership (CHIP) completed a community health assessment for Bergen County and developed an associated community health improvement plan. As a result of this assessment the CHIP created five task forces: 1) Access to Health Care; 2) Mental Health; 3) Nutrition and Physical Activity; 4) Alcohol, Tobacco and Other Drugs; and 5) Communication of Health Issues. These task forces worked with CHIP members and other stakeholders on numerous initiatives related to education, prevention, and advocacy geared to improving the health of the region. In 2012, with the generous support of Christian Health Care Center, Englewood Hospital and Medical Center, Hackensack University Medical Center, Holy Name Medical Center, and The Valley Hospital, the CHIP made a commitment to update the 2006 Bergen County Community Health Improvement Plan and contracted with John Snow, Inc., (JSI) a nationally recognized public health research and consulting firm, to assist them with the assessment and planning process.

The hospitals' desire to conduct the assessment and update the 2006 Bergen County Community Health Improvement Plan was borne largely from their commitment to the County's residents and their wish to continue their support of the CHIP. In addition, the project fulfills a new federal Internal Revenue Service (IRS) requirement, built into the new Patient Protection and Affordable Care Act (PPACA) (National Health Reform), which mandates that all nonprofit hospitals conduct a community health needs assessment and strategic planning process every three years. The requirement further stipulates that the community health assessment must involve local public health officials, other health and social service providers, and community residents. Finally, the requirement mandates the development of an associated strategic plan to guide the area's healthcare, public health, and social service organizations and the community in their efforts to address the assessments' priorities.

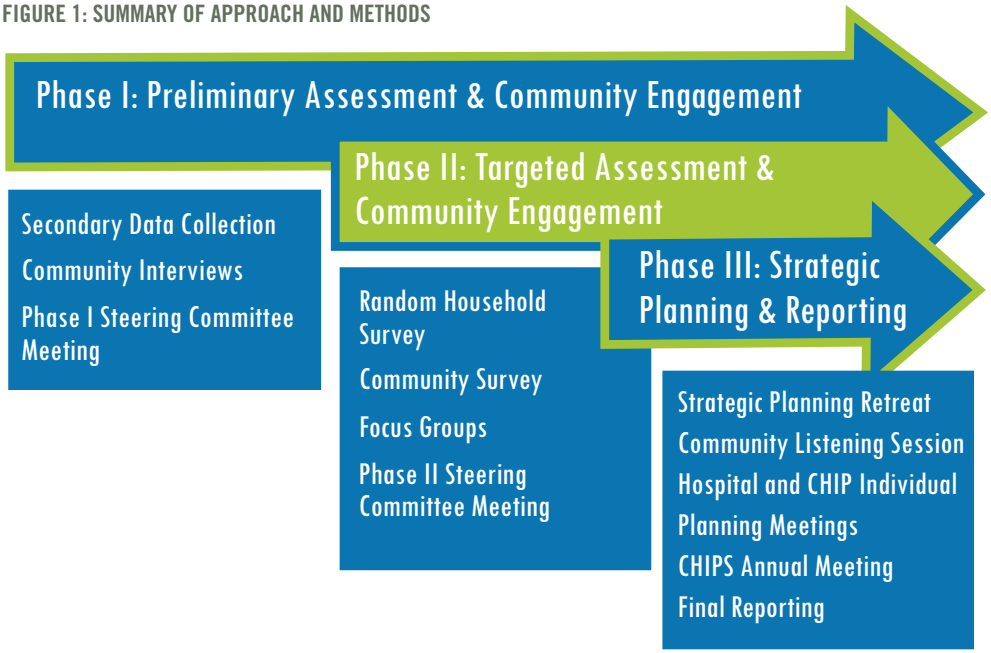
In addition, the Public Health Practice Standards for Local Boards of Health in New Jersey and the national Public Health Accreditation Board require that the Bergen County Department of Health Services (BCDHS) and the County's local health departments complete a community health needs assessment and implement a related health improvement plan.

With these commitments and public mandates in mind, the hospitals, BCDHS, and the CHIP came together to conduct a three-phased community health needs assessment and planning project, and to update the CHIP's existing community health improvement plan. The Mobilizing for Action through Planning and Partnerships (MAPP) process helped inform the planning processes.[2] MAPP is a community-driven strategic planning process for improving community health. The MAPP process utilizes four types of community health needs assessments: 1) a community themes and strengths assessment; 2) a local public health system assessment; 3) a community health status report; and 4) a forces of change assessment. While this present effort did not utilize the MAPP process specifically, all four of the MAPP assessments were addressed in the various components of the approach that was applied for this assessment and planning project.

## ASSESSMENT AND PLANNING APPROACH AND METHODS

A steering committee made up of senior representatives from each hospital and the County Department of Health Services guided this project. An advisory committee, which included additional staff from the participating hospitals and BCDHS, as well as representatives from local health departments and a number of Bergen County's leading health and social service organizations, provided additional input. The assessment and planning process was implemented by the steering committee and was conducted in three phases, which helped the steering committee to: 1) identify and clarify the healthcare needs and priorities of the residents of Bergen County; 2) engage stakeholders, including residents throughout the service area; and 3) develop a detailed, action-oriented strategic plan. The assessment collected an array of quantitative and qualitative data that contributed to a strategic planning process and led to the development of the 2013 Bergen County Community Health Improvement Plan. A summary of the plan is included in this report.

FIGURE 1: SUMMARY OF APPROACH AND METHODS




**IN PHASE I,** the preliminary needs assessment and community engagement effort relied heavily on information collected through existing secondary data from local, state, and national sources. These sources included data on the characteristics of the Bergen County population, as well as their social determinants of health, current health status, access to care, health-related risk factors, and overall morbidity and mortality. Dozens of interviews were also conducted in Phase I to start the community engagement process and capture community perceptions on priority health issues, service gaps, barriers to access, and preliminary ideas about possible strategic responses. More than 80 people were interviewed, including a cross-section of hospital clinical and administrative staff, other health and social service providers, local and county public health officials, elected and appointed public officials, community advocates, clergy, and community residents. At the end of Phase I, the steering committee and other key stakeholders convened a meeting to review preliminary findings, discuss emerging ideas, consider their implications, and finalize plans for Phase II of the assessment.

**FIGURE 2: PHASE I METHODS**

# PHASE I: PRELIMINARY ASSESSMENT & COMMUNITY ENGAGEMENT

## KEY INFORMANT INTERVIEWS

- **80+ INTERVIEWS, STRUCTURED INTERVIEW PROTOCOL (MAJORITY, IN PERSON, ONE-ON-ONE)**

- Hospital clinical & adminstrative staff
- Primary care providers
- Behavioral health providers
- Elder services providers
- Social services providers
- Community leaders
- Public health officials
- Public housing staff
- Advocacy organizations
- Faith-based organizations
- Public officials

## SECONDARY DATA

- **200+ DATA VARIABLES**
- **LOCAL DATA FROM ALL 70 CITIES/TOWNS IN BERGEN COUNTY**
- **NATIONAL, STATE, & COUNTY COMPARISON DATA**

## POPULATION CHARACTERISTICS & SOCIAL DETERMINANTS OF HEALTH

- Age & gender
- Family composition
- Race/ethnicity, language, & ancestry
- Income & poverty status
- Education
- Crime
- Housing
- Employment
- Access to healthy foods & recreational facilities

## HEALTH STATUS, MORBIDITY/MORTALITY & HEALTH-RELATED RISK FACTORS

Prevalence, incidence, death, and hospitalization rates for:

- Disease of the heart
- Cancer
- Infectious disease
- Respiratory disease
- Mental health
- Substance abuse
- Oral health
- Maternal & child health
- Diabetes
- Obesity/overweight
- Physical fitness
- Nutrition
- Smoking

## ACCESS TO CARE & SERVICE UTILIZATION

- Medical & dental insurance status
- Access to primary care
- Access to preventative services
- Access to dental services
- Access to medical specialty services
- Hosptial inpatient utilization
- Emergency department utilization

**IN PHASE II,** a targeted community assessment and engagement process collected additional secondary data to fill in gaps and to clarify questions that arose during the Phase I steering committee meeting. However, the primary focus of Phase II was on collecting detailed primary data directly from community residents through a random household mail survey, a community survey implemented in various community venues, and a series of focus groups. These sources captured detailed information from county residents, including those who are typically hard-to-reach and often left out of assessments of this kind. A randomly selected sample of 4,000 households in Bergen County received an 18-page mail survey. In addition, the same survey was administered by research assistants who captured information from low-income, racial/ethnic minority residents at selected community venues. The focus groups were conducted with members of key target populations, including African Americans, Koreans, Hispanics/Latinos, Elder Care Coordinators and college-aged adults, and gathered specific information related to health and wellness and the most effective community health strategies. The culmination of Phase II was a comprehensive needs assessment report that integrated and analyzed the data collected in Phases I and II. This report became the basis for the strategic planning conducted in Phase III.

**FIGURE 3: PHASE II METHODS**

## PHASE II: TARGETED ASSESSMENT AND COMMUNITY ENGAGEMENT

### COMMUNITY HEALTH SURVEY

#### RANDOM HOUSEHOLD MAIL SURVEY

- County-wide sample
- 4,000 randomly selected households
- ~ 1,700 returned surveys
- 42% response rate

#### COMMUNITY SURVEY

- Administered by research assistants
- Data collected in 9 community venues
- ~ 400 surveys collected

- 18-page survey
- Questions drawn from validated national surveys
- Survey included questions related to:
  - Repondent demographics and socio-economics
  - Access and barriers to care
  - Health behaviors and lifestyle
  - Chronic disease and prevention
  - Self-reported health status
  - Disabilities and care giving
  - Elder health
  - Perceived health concerns and priorities

### FOCUS GROUPS

5 focus groups with:

- Koreans
- African Americans
- Hispanic/Latinos
- Elder Care Coordinators
- College-aged students (18-22)

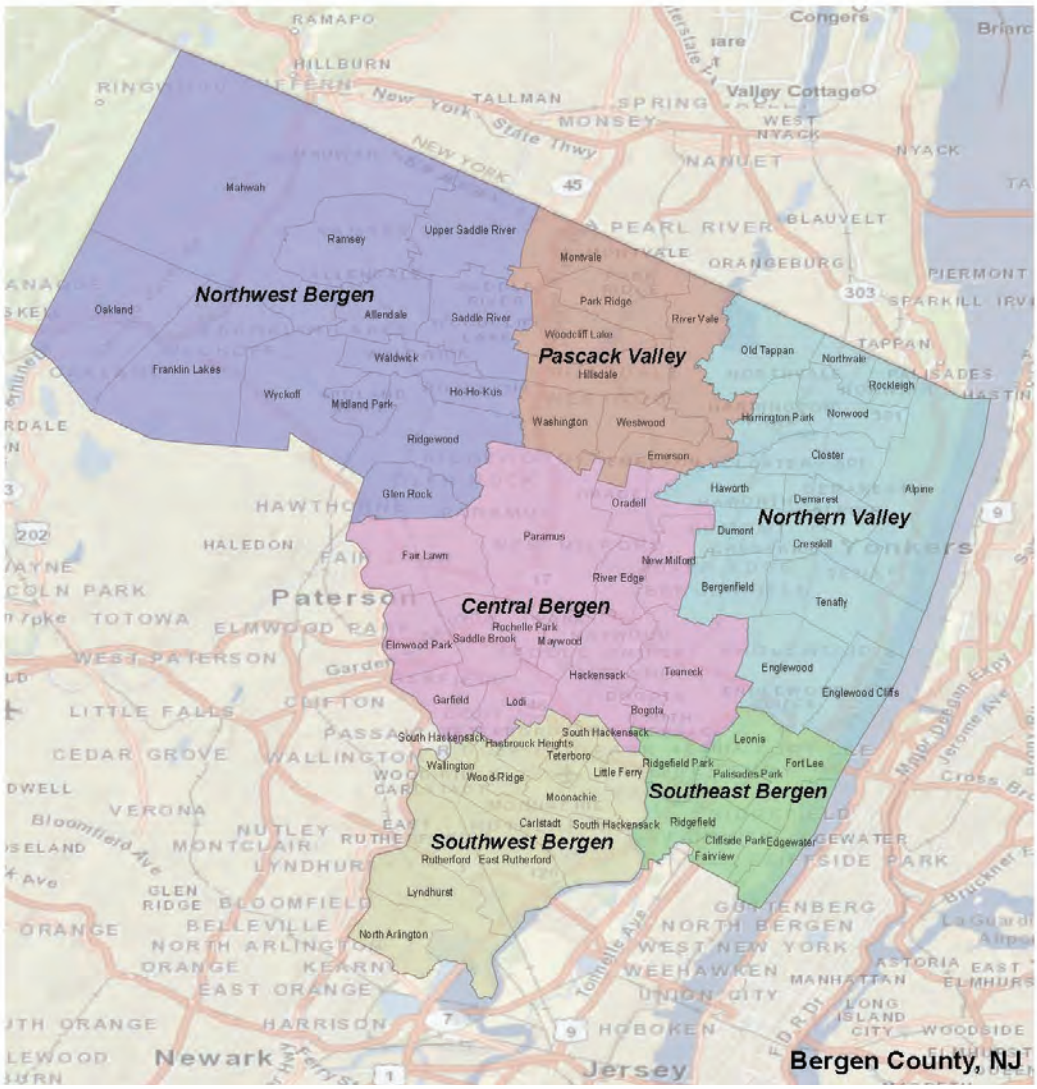
Captured information on:

- Health care priority issues
- Health-related risk factors
- Care seeking attitudes and behaviors
- Barriers to care

**IN PHASE III,** the steering committee implemented a strategic planning and reporting process that vetted the findings from Phases I and II, established community health priorities, and identified a range of strategies that would serve as the basis of the Bergen County Community Health Improvement Plan. In Phase III, the steering and advisory committees participated in a community health retreat. After the retreat, a series of community listening sessions were held with key stakeholders, including local public health officials, a group of mental health and behavioral health advocates, a group of leading health and social service providers, and the community at-large. The purpose of these meetings was to review the data and identify a set of community health priorities and target populations, as well as a series of programmatic strategies for addressing the identified priorities.

The following section discusses the County's population and social factors that impact health status and allow individuals and families to maintain healthy lifestyles and well-being.

**FIGURE 4: MAP OF COUNTY WITH PUBLIC HEALTH REGIONS**



# POPULATION CHARACTERISTCS & SOCIAL DETERMINANTS OF HEALTH

*"Social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between communities."*

- SOCIAL DETERMINANTS OF HEALTH KEY CONCEPTS, WORLD HEALTH ORGANIZATION [3]

**AN UNDERSTANDING OF COMMUNITY NEED AND HEALTH STATUS** begins with knowledge of the population's characteristics as well as the underlying economic and environmental factors that impact health. This information is critical to recognizing disease burden, identifying target populations, setting health-related priorities, and targeting strategic responses. The Bergen County Community Health Needs Assessment (CHNA) included a wide range of quantitative data from the U.S. Census Bureau and other federal, state, and local sources related to age, gender, race/ethnicity, ancestry, income, poverty, family composition, education, crime, unemployment, access to food and recreational facilities, and other determinants of health. The assessment also collected qualitative information from focus groups and community listening sessions that captured community perceptions, highlighted barriers to access, and other factors that impact residents' health.

## Key Findings

- **THE OVERALL SIZE OF BERGEN COUNTY'S POPULATION HAS REMAINED RELATIVELY STABLE SINCE 2000.** In 2010, the County's population was 905,116, representing a 2.4% increase since 2000.[4] However, the demographic composition has changed considerably, particularly with respect to race/ethnicity.
- **BERGEN COUNTY'S POPULATION IS MUCH OLDER RELATIVE TO THE STATE AND THE NATION.** In 2010, 15.1% of Bergen County's population was age 65 or older, compared to 13.5% statewide. The County's median age was 41, compared to 39 for the NJ and 37 for the nation. In 2010, nearly 1 in 3 households (29%) had at least one adult over the age of 65, compared to 26% for the state.[5]

- **BERGEN COUNTY IS PREDOMINANTLY NON-HISPANIC WHITE BUT THERE ARE LARGE PROPORTIONS OF FOREIGN BORN AND RACIAL/ETHNIC MINORITY POPULATIONS, MANY OF WHOM FACE LINGUISTIC AND CULTURAL BARRIERS.** In 2010, 28.5% of the population was foreign-born and 36.7% of residents aged 5 years or older spoke a language other than English at home, compared to 20.3% and 28.7% for NJ and the nation respectively.[6]
- **BERGEN COUNTY HAS THE HIGHEST PROPORTION OF KOREAN-BORN RESIDENTS OF ANY COUNTY IN THE NATION.** In 2010, 6.4% of the County's population was from Korea.[7]
- **DESPITE HAVING A HIGH MEDIAN HOUSEHOLD INCOME, BERGEN COUNTY HAS SIGNIFICANT POCKETS OF POVERTY.** In 2011, Bergen County had the 39th highest median household income of all U.S. counties in the nation. However, in 2011, 18.4% of the County's population lived in low-income households earning less than 200% of the federal poverty level (FPL), compared to 24.7% in the state.[8]
- **BERGEN COUNTY RESIDENTS HAVE HIGHER RATES OF HIGH SCHOOL GRADUATION OR PASSING THEIR GENERAL EDUCATIONAL DEVELOPMENT (GED) TEST COMPARED TO THE NATIONAL AVERAGE.** In 2010, 90.9% of the population had a high school diploma or more, compared to 87.3% nationally.[9]
- **BERGEN COUNTY WAS CLEARLY IMPACTED BY ECONOMIC DOWNTURN AND RECESSION OVER THE PAST FIVE YEARS BUT HAS GENERALLY FARED BETTER THAN THE NATION OVERALL.** Unemployment rates have hovered between 8% and 9% over the past few years but have always been slightly better than the state and national rates. As of November 2012, unemployment in the County was 7.7%, compared to 9.3% for the state.[10]
- **BERGEN COUNTY RESIDENTS OVERALL HAVE GREATER ACCESS TO HEALTHY FOOD OPTIONS AND RECREATIONAL FACILITIES THAN RESIDENTS STATEWIDE. HOWEVER, THERE ARE MAJOR POCKETS WHERE THIS IS NOT THE CASE.** Information gathered from the project's focus groups and strategic planning sessions in the community suggest that there are major geographic areas and demographic pockets in the community where residents struggle to access healthy food and do not have access to safe recreational spaces. Eighty-five percent (85%) of the population reported having access to healthy food options[11] and data from the NJ Department of Health showed greater access to recreational facilities.
- **BERGEN COUNTY HAS DRAMATICALLY LOWER CRIME RATES (VIOLENT AND PROPERTY CRIME) THAN THE STATE OVERALL.** Violent crime rates in Bergen County in 2010 were 101 per 100,000 residents, compared to 299 in NJ; and property crime rates in 2010 were 1,276 per 100,000 residents compared to 1,972 in NJ.[12]

**FIGURE 5: RACE/ETHNICITY AND AGE, INCOME, EDUCATION, AND EMPLOYMENT AND QUALITY OF LIFE AND CRIME**

| RACE/ETHNICITY AND AGE | State of NJ | Bergen County |
|---|---|---|
| Age (Census 2010) | | |
| 0-44 years old | 58.9% | 55.9% |
| 45+ years old | 41.1% | 44.1% |
| 65+ years old | 13.5% | 15.1% |
| Households with one or more people 65+ years old | 25.9% | 28.5% |
| Race/Ethnicity (Census 2010) | | |
| Hispanic or non-White | 40.7% | 37.5% |
| Foreign-born | 20.3% | 28.4% |
| 5+ year olds that speak language other than English in the home | 28.7% | 36.7% |
| % of total population that reports Korean ancestory | 1.1% | 6.4% |

| INCOME, EDUCATION, AND EMPLOYMENT | State of NJ | Bergen County |
|---|---|---|
| Income (ACS 2006-2010 and NJ Department of Education | | |
| Families living below poverty level | 6.7% | 4.3% |
| Persons living below poverty level | 9.1% | 5.8% |
| Person living in low -income households earn <200% FPL | 24.7% | 18.4% |
| Enrolled students eligible for free/reduced-price meals | 32.3% | 16.3% |
| Education Attainment (ACS 2006-2010) | | |
| High school graduate or higher | 87.4% | 90.9% |
| Unemployment (US Bureaur of Labor Statistics - 2012) | | |
| Unemployment (November 2012) | 9.3% | 7.7% |

| QUALITY OF LIFE AND CRIME | State of NJ | Bergen County |
|---|---|---|
| Quality of Life (2011 County Health Ranking) | | |
| ZIP codes with access to healthy foods | 84% | 85% |
| Rates of access to recreational facilities (per 100,000 population) | 15 | 21 |
| Crime (per 100,000 population) (FBI 2010) | | |
| Violent crime rates | 299.2 | 100.9 |
| Property crime rates | 1971.9 | 1276 |

## Implications and Conclusions

Bergen County is older than the state or nation, predominantly white, non-Hispanic and is one of the most affluent communities in the country. Residents are generally well-educated, less likely to be unemployed, and more likely to have access to healthy foods and recreational facilities. Crime rates in the County are much lower than in the state. These factors tend to lead to better health status and, not surprisingly, Bergen County is healthy when compared to the State and the nation with respect to the leading health indicators. According to the Robert Wood Johnson Foundation's County Health Rankings and Roadmaps Program, Bergen County is ranked the 4th healthiest county of New Jersey's 21 counties.[13] However, there are numerous areas with low-income and racial/ethnic minority populations, particularly in the swath of the County located centrally that runs from Garfield and Lodi in the west part of the County, through Hackensack, and ending in Englewood and Fort Lee. This geographic region of the County faces significant disparities and health inequities with respect to access and the leading health indicators. This area is also home to the vast majority of the County's low-income and racial/ethnic minority populations, who clearly are most disadvantaged and face the most significant disparities. Many of the residents in this area also face linguistic and cultural barriers, higher crime rates, have less access to healthy foods and recreational facilities, and struggle with much higher unemployment rates. These factors complicate medical, social, and financial status and ultimately make it particularly challenging to access health care services.

# KEY FINDINGS BY PRIORITY AREA

After reviewing the quantitative and qualitative data compiled during this assessment, the steering and advisory committees identified the following community health priorities:

- Priority Area One: Obesity, Fitness, Nutrition, and Chronic Disease
- Priority Area Two: Mental Health and Substance Abuse
- Priority Area Three: Access to Care
- Priority Area Four: Elder Health

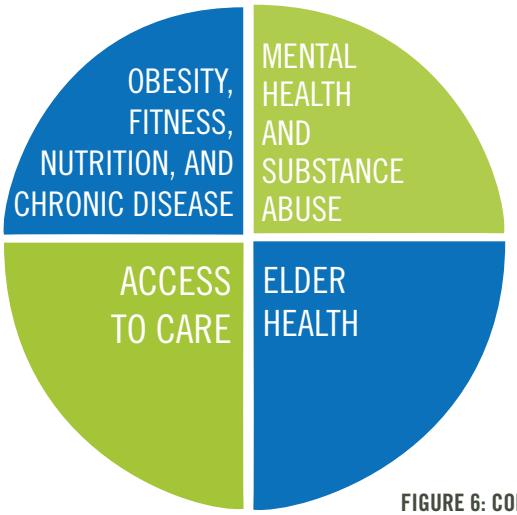



**FIGURE 6: COMMUNITY HEALTH PRIORITY AREAS**

The following discussion provides the supportive evidence and demonstrates why the steering and advisory committees identified these community health priorities. Before this discussion it should be noted that setting priorities is often not a straight-forward task. Community health priorities must be data-driven and rooted in existing evidence but also must consider community resources, gaps in existing programs or services, community perceptions, and overall feasibility or likelihood that the participating stakeholders can affect change. It matters little what the data says if there is no will or ability to address the issue(s), if there are already numerous programs or institutions addressing the issue(s), or if the issue requires broader, more systemic interventions that are outside the purview of the existing stakeholders.

Also, many of the key findings and data elements are inter-related and overlap across the identified priority areas, which has led to some redundancy in the reporting of a number of the leading indicators below. Finally, this report does not address all of the findings from the broad range of data sources that were drawn for this assessment. However, nearly all of the data is provided in the appendices to this report and should be used for different and/or more targeted analyses. While the discussion below highlights some of the positive aspects related to health status in Bergen County, the emphasis is clearly on the County's health disparities and where there are challenges with respect to community health. Clearly, as will be discussed below, there are areas where improvements in health status are critical, particularly for certain sub populations. However, it is important to note that overall Bergen County is an extremely healthy community, and has strong and vibrant healthcare and public health systems.

# PRIORITY AREA 1: OBESITY, FITNESS, NUTRITION, AND CHRONIC DISEASE

## OBESITY, FITNESS, AND NUTRITION

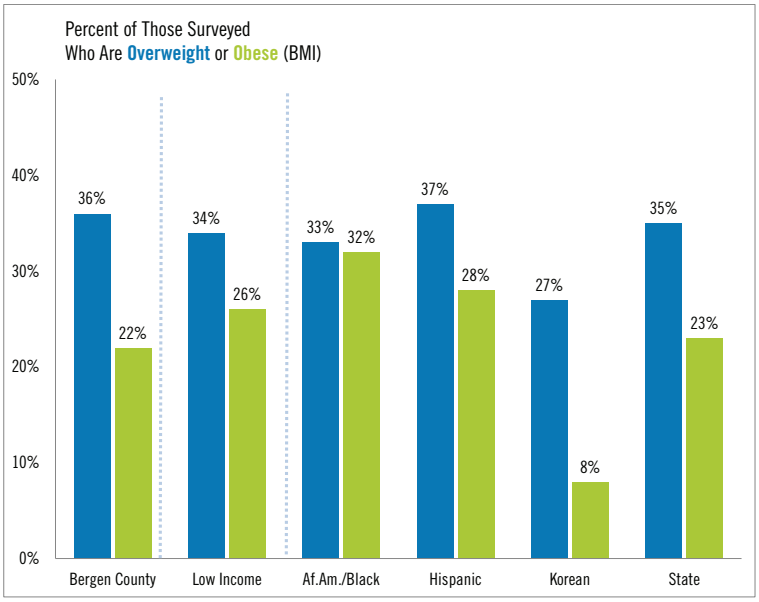
More than one-third of U.S. adults and 17% of U.S. children are obese. Over the past two decades, obesity rates have doubled for adults and actually tripled for children. These trends have spanned all segments of the population, regardless of age, sex, race, ethnicity, education, income, or geographic region. There are certainly segments that have struggled more than others but no segment has been unaffected. Lack of physical fitness and poor nutrition are the leading factors associated with obesity and the leading risk factors associated with chronic diseases, such as heart disease, hypertension, diabetes, cancer, and depression. Good nutrition helps prevent disease,and is essential for healthy growth and development of children and adolescents. Overall fitness and the extent to which people are physically active reduces the risk for many chronic diseases, is linked to good emotional health, and helps to prevent disease.

### Key Findings

- **OVERWEIGHT/OBESITY.** Overall, 58% of County residents had categorically overweight or obese Body Mass Indexes (BMIs), which was the same as the state percentage. These numbers were lower for Koreans (35%) and higher for Hispanics/Latinos (65%), and Blacks/African Americans (65%).[14]

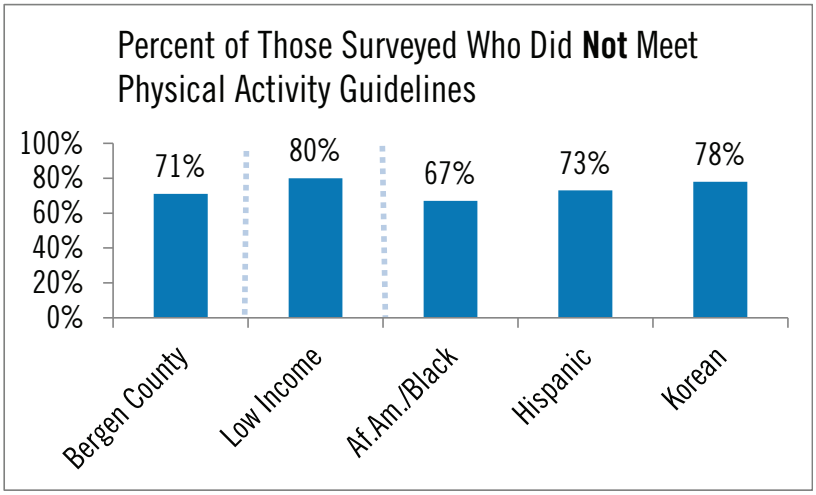
- **OVERWEIGHT/OBESITY.** Household survey participants ranked "Overweight/Obesity" as the most significant health problem across all of the groups, except among the low-income population, where it was ranked second.[15]
- **PHYSICAL EXERCISE.** Substantially lower proportions of Bergen County residents in low-income and racial/ethnic minority groups reported meeting the Centers for Disease Control and Prevention (CDC) physical activity guidelines compared with the state and County overall. In the County, only 20% of low-income populations, 22% of Koreans, and 27% of Hispanics/Latinos reported getting adequate physical exercise.[16]

**FIGURE 7: OVERWEIGHT & OBESITY**




- **PHYSICAL EXERCISE.** Household mail survey participants ranked lack of physical activity as the second-most significant health problem overall. Among other racial/ethnic and regional sub-groups surveyed in the County, lack of exercise was ranked between priorities #2 and #6.[17]

**FIGURE 8: LACK OF PHYSICAL ACTIVITY**



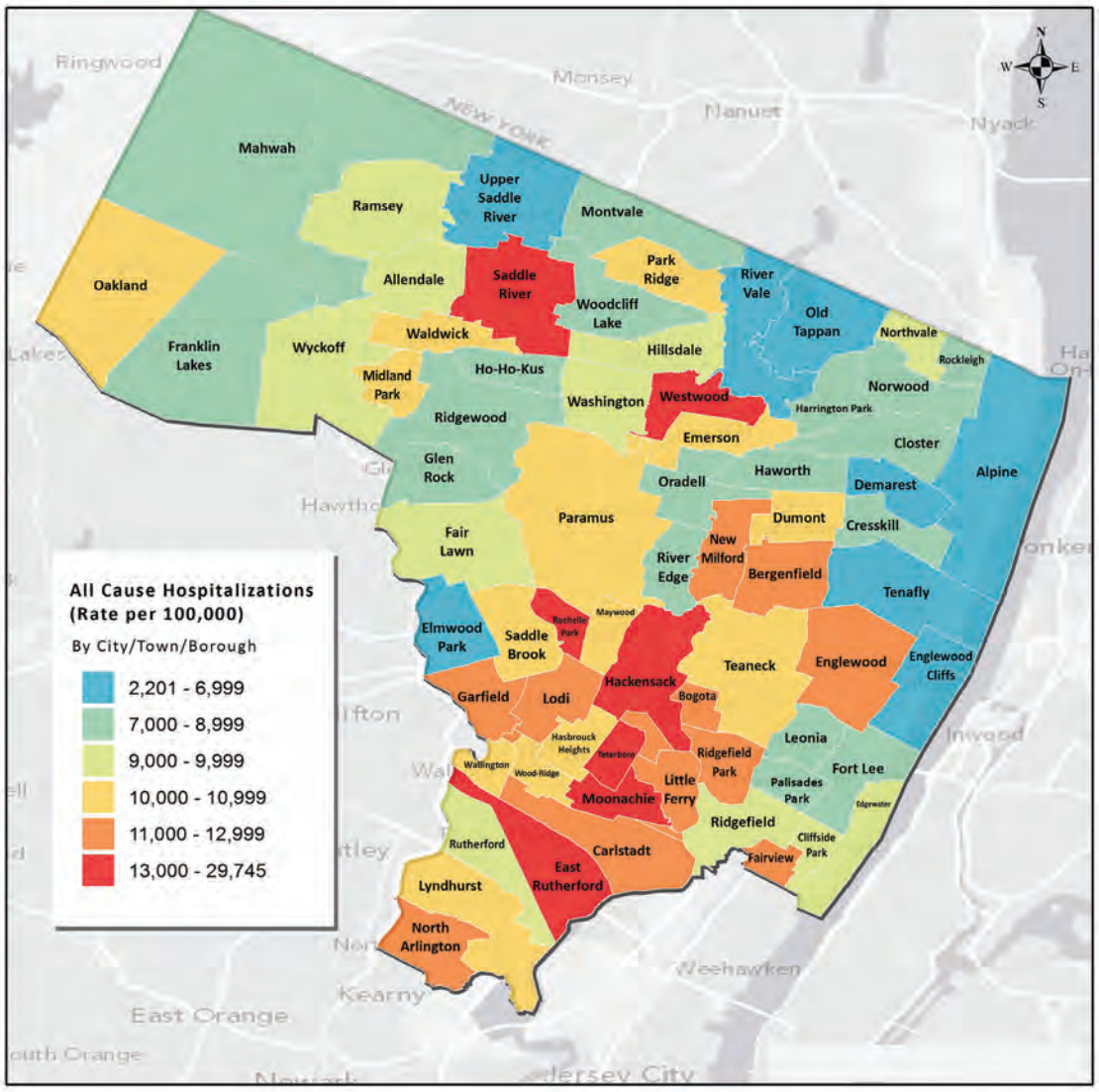
- **NUTRITION.** The proportion of County residents that reported eating five or more servings of fruits or vegetables on an average day (14%) was consistent with the state but still very low.[18] The focus groups with African Americans, Koreans, and Hispanics/Latinos revealed that these populations struggle to access fresh vegetables and fruits and other healthy food options.[19]

## Implications and Conclusions

Data from the assessment showed that overall Bergen County fared as well or even better than the state and the nation with respect to obesity, fitness, and nutrition but these issues were still major concerns and the key health indicators in this area showed high rates of risk that need to be addressed. These issues were particularly troubling among low-income and racial/ethnic minority groups.

In the past, obesity prevention and efforts to improve fitness and nutrition have focused on activities such as healthy eating lectures, workshops, and classes, as well as exercise programs and walking groups. These types of activities have, in fact shown to be effective in some settings but only in combination with other activities and a more comprehensive approach. It is not enough to simply encourage physical activity and healthful eating. Research supported by the Centers for Disease Control and Prevention and countless other reputable public and private entities suggests that people need access to healthy foods and places for safe play and recreation where they live, work, and learn. The State of New Jersey, through the Shaping NJ Initiative[20] suggests promoting the following six behaviors to help prevent obesity: 1) Being physically active; 2) Eating fruits and vegetables; 3) Breastfeeding; 4) Avoiding or limiting sugar-sweetened beverages; 5) Avoiding unhealthy snacks such as chips and candy; and 6) Limiting television or computer viewing.[21]

**FIGURE 9: MAP OF ALL CAUSE HOSPITALIZATION RATES**




# CARDIOVASCULAR HEALTH AND DIABETES

Cardiovascular disease is a group of health issues and includes coronary heart disease, hypertension, and cerebrovascular disease or stroke. The major risk factors for heart disease are smoking, hypertension, high cholesterol, overweight/obesity, physical inactivity, poor nutrition, and diabetes. Heart disease and stroke are the first and third leading causes of death, respectively, in the U.S., New Jersey, and in Bergen County. 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.

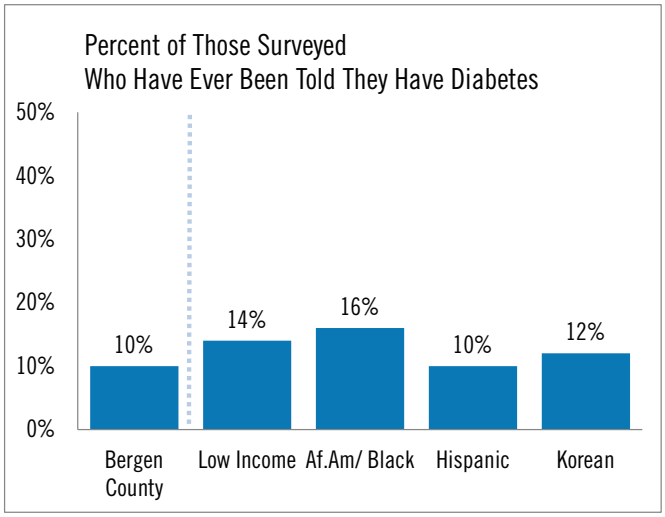
Nationally, diabetes affects an estimated 24 million people and is a leading risk factor for heart disease. People with diabetes are 2 to 4 times more likely than those who do not have diabetes to have heart disease, depending on race/ethnicity. Nationally, diabetes alone is the 7th leading cause of death, lowers life expectancy by 15 years, and is the major cause of kidney failure, lower limb amputation, and blindness. In addition to human costs, the estimated total financial cost of diabetes mellitus in the U.S. in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death.[22]

## Key Findings

- **HOSPITALIZATION AND DEATH RATES FOR HEART DISEASE, STROKE, AND DIABETES.** Hospitalization and death rates per 100,000 people for heart disease, stroke, and diabetes were substantially lower for Bergen County overall, compared to the state. However, there are cities and towns in Bergen County that fare worse than the state and/or County with respect to heart-related diseases.[23] For example, the state death rate per 100,000 for diseases of the heart was 213 compared to 145 for Bergen County overall. For stroke or cerebrovascular disease, the state death rate per 100,000 was 38 compared to 28 for Bergen County overall. The hospitalization rates per 100,000 in Bergen County were also much better by similar magnitudes.

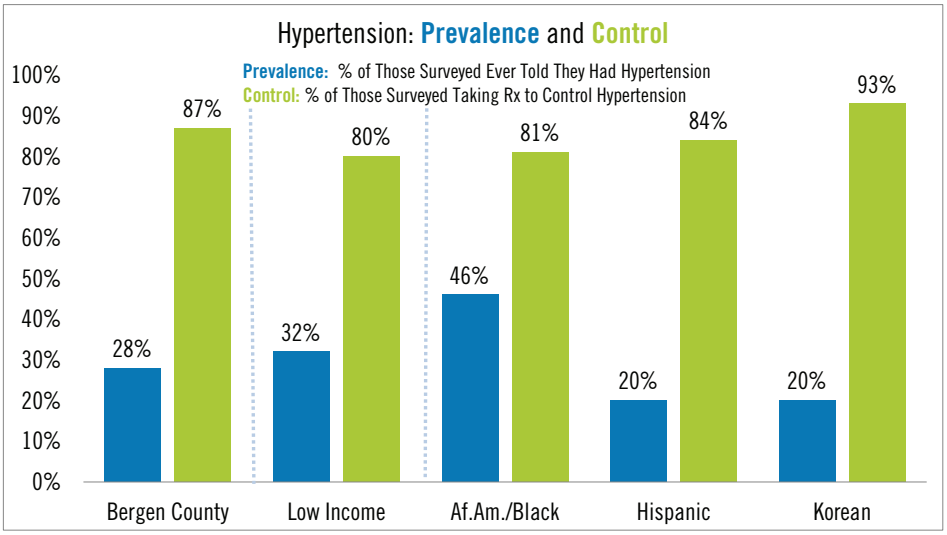
- **DIABETES.** The percentage of Bergen County residents who have ever been told they have diabetes is higher than the State percentage, particularly among Blacks/African Americans, Koreans, and low-income populations more generally. Sixteen percent (16%) of Blacks/African Americans have ever been told they have diabetes, 12% of Koreans, and 14% of low-income residents, compared to 10% for Bergen County overall and 9% for the residents statewide.[24]

**FIGURE 10: DIABETES PREVALENCE**




- **HYPERTENSION AND CONTROL OF HYPERTENSION.** Twenty eight percent (28%) of those who responded to the household mail survey reported being told by their doctor that they have high blood pressure, which is the same as the percentage of residents statewide. However, low-income and racial/ethnic minorities as well as those in the central part of the County were, once again, much more likely to suffer from these risk factors than the overall population.[25] According to the random household mail survey, 32% of low-income residents earning less than 200% of the FPL, 46% of African American/Black residents, and 32% of those in Central Bergen and Northern Valley reported being told that they have high blood pressure. Low-income Bergen County residents with hypertension were also less likely than the population overall to be taking the medications they needed to keep their hypertension in control. Specifically, 87% of Bergen County residents with hypertension were taking medications to control their condition compared to 80% of low-income residents.[26]

**FIGURE 11: HYPERTENSION PREVALENCE**



- **HIGH CHOLESTEROL AND CONTROL OF HIGH CHOLESTEROL.** Similar proportions of County residents (40%) reported ever being told that they have high cholesterol compared to the state (37%). In this case, the proportions were similar across all segments of the population surveyed (ranging from 32-38%), and except for Koreans (23%), were all equally high. Once again, low-income Bergen County residents with high cholesterol were less likely than the population overall to be taking the medications they needed to keep their condition in control. Specifically, 60% of Bergen County residents with high cholesterol were taking medication to control their condition compared to 44% of low-income residents.[27]
- **HEART DISEASE PERCEPTION.** Overall County residents ranked heart disease as the fourth-leading health issue.[28]

## Implications and Conclusions

Disease of the heart and cerebrovascular disease are the #1 and #3 leading causes of death in the nation and the State of New Jersey. Diabetes is ranked in the top 10 leading causes of death. The rankings in Bergen County are no different and while the rates of death and hospitalization in the County are not higher than the state or the nation, the rates are still troubling and these issues are the leading causes of death and illness. There are a number of areas, particularly in the central portion of the County, that have significantly higher rates of death and hospitalization for coronary heart disease, stroke, and diabetes than the state and County. With respect to the major risk factors associated with heart disease (e.g., hypertension and high cholesterol), the issues are much more problematic as the disparities in outcomes are more extreme. Overall, the County rates are comparable to the state. However, there are more individual cities and towns throughout the County that have significantly higher rates. There are also major disparities among low-income and racial/ethnic minority County residents across nearly all risk factors, including, as mentioned above, the behavioral risk factors such as lack of fitness and poor nutrition.

Current efforts to prevent heart disease focus on addressing the underlying risk factors and providing self-management support for those with existing disease or risk factors. Increasingly, community-based and clinical interventions related to preventing cardiovascular disease have focused on reaching out to those at-risk in targeted ways and promoting engagement in primary care and/or chronic disease management services. General education and awareness activities can be effective but should be part of broader campaigns that link people to services and/or more evidenced-based behavior change interventions.


# CANCER HEALTH

**CANCER REFERS TO A CATEGORY OF DISEASES** characterized by the development of abnormal cells that divide uncontrollably and have the ability to infiltrate and destroy normal body tissue. Cancer is the second-leading cause of death in the U.S. and the State of New Jersey. Cancer imposes a major burden on individuals and families with respect to health status, emotional issues, and loss of productivity. It has been estimated that 1 in 2 men, and 1 in 3 women, in the U.S. will be affected by cancer during their lifetime. Cancer affects people across the life cycle but impacts older adults at an even greater rate. New Jersey and Bergen County have larger proportions of older adults than the nation and, therefore, will be even more impacted by cancer. While health and research experts have an idea of the risk factors and what causes cancer, more research is needed. The majority of cancers occur in people who do not have any known risk factors. The major known risk factors for cancer include age, family history of cancer, smoking, overweight/obesity, excessive alcohol consumption, excessive exposure to the sun, unsafe sex, exposure to fumes, secondhand cigarette smoke, and other airborne environmental and occupational pollutants. There are major disparities in health outcomes and death rates across all forms of cancer that are directly associated with race, ethnicity, income, and health insurance coverage.[29]

## Key Findings

- **CANCER (ALL-TYPES).** Overall, Bergen County residents are just as likely to have cancer (all types) as residents statewide (with the exception of breast cancer in women – see below), but they are less likely to die of cancer. Between 2003 and 2007, the incidence rate for cancer was 541 per 100,000 for the County, and 548 per 100,000 for the state, but the death rate per 100,000 for the County was 107, compared to 146 for the state.[30]
- **BREAST CANCER IN WOMEN.** Bergen County women are more likely to develop breast cancer than women statewide. The incidence rate for women with breast cancer in Bergen County is 185 per 100,000, which compares to 168 per 100,000 for women statewide. However, women in Bergen County are still less likely to die of breast cancer.[31]
- **CANCER SCREENING RATES.** Cancer screening rates for County residents overall are similar to the state's rates but there are disparities among low-income and racial/ethnic minority populations across all areas of cancer screening categories.[32]
    - **Recent Mammogram.** Seventy one percent (71%) of women over 40 years old in the State of New Jersey and 68% of Bergen County women over 40 reported having a mammogram in the past two years, compared to 52% of low-income populations, 44% of Koreans, and 64% of African Americans/Blacks. The percentage of Hispanic women reporting having a recent mammogram (67%) was similar to the County percentage (68%).[33]

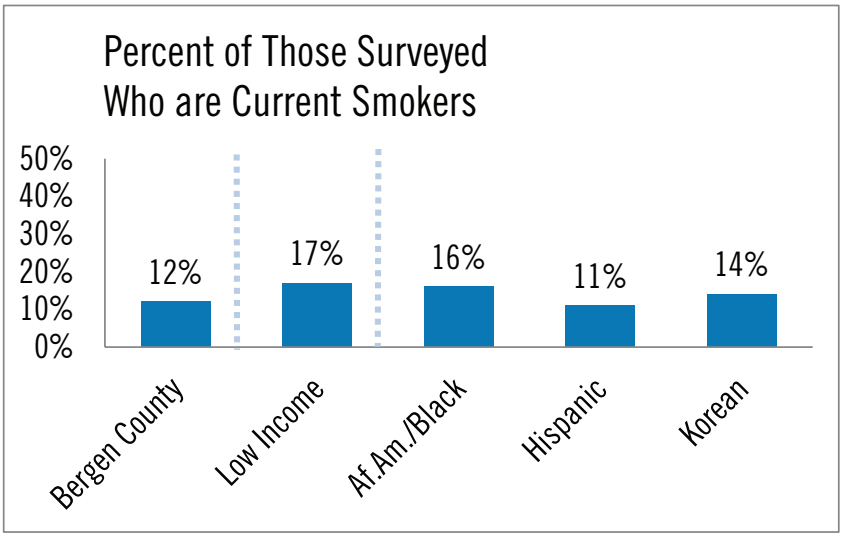
» **Recent Sigmoidoscopy/Colonoscopy**. Sixty four percent (64%) of those 50 years or older in the state and 65% of Bergen County residents over 50 years old reported ever having a sigmoidoscopy/colonoscopy, compared to 48% of low-income residents, 36% of Korean residents, and 55% of Hispanic residents. African American residents were just as likely to be screened (66%) as compared to residents of the County (65%).[34]

**FIGURE 12: CANCER SCREENING RATES**

| | Bergen County | Low Income | Af.Am/ Black | Hispanic | Korean |
|---|---|---|---|---|---|
| Mammogram in past 2 years among women ≥40 years of age | 68% | 52% | 64% | 67% | 44% |
| PSA in past 2 years among men ≥40 years of age | 56% | 38% | 79% | 52% | 31% |
| Ever had sigmoidoscopy among men and women ≥50 years of age | 65% | 48% | 66% | 55% | 36% |
| Pap in past 3 years among women ≥18 years of age | 77% | 65% | 75% | 84% | 47% |

- **SMOKING.** The proportions of residents in the County that reported being current cigarette smokers was consistent with the state proportion and generally consistent across the groups surveyed (NJ, 14%; County, 12%; low-income, 17%; Koreans, 14%; Hispanics, 11%; Black/African Americans, 16%).[15]

**FIGURE 13: SMOKING PREVALANCE**



- **CANCER PERCEPTION.** Household mail survey respondents from Bergen County overall ranked cancer as the third-most important health issue.

## Implications and Conclusions

Nationally, the four most common cancers – breast, prostate, lung, and colorectal – account for roughly half of cases diagnosed and half of cancer deaths. Cancer incidence is impacted greatly by gender and race/ethnicity. Unfortunately, there are disparities in cancer-related deaths with racial and ethnic minority populations more likely to die of cancer than the population overall. The disparities in death rates are linked to screening barriers and access to treatment. Many cancers can be prevented through lifestyle changes (e.g., changes in diet, fitness, and certain patterns of exposure) and early detection. These factors highlight the importance of awareness campaigns, health education, and screening interventions.

Overall, Bergen County fares as well or better than the state with respect to incidence of disease and death across nearly all major cancer types. Breast cancer in women is the exception, in which the death rates are lower but County incidence rates are higher. Incidence rates by race/ethnicity or income were not available at the County- or local-level. However, nationally there is strong evidence showing disparities in cancer-related death among most racial/ethnic minorities when compared to majority, non-Hispanic White populations. The 2012 Bergen County Community Health Needs Assessment Survey results demonstrated clear disparities in cancer screening rates among low-income populations and racial/ethnic minority populations, despite the fact that screening rates for the County were high and comparable to the state.

# RESPIRATORY HEALTH

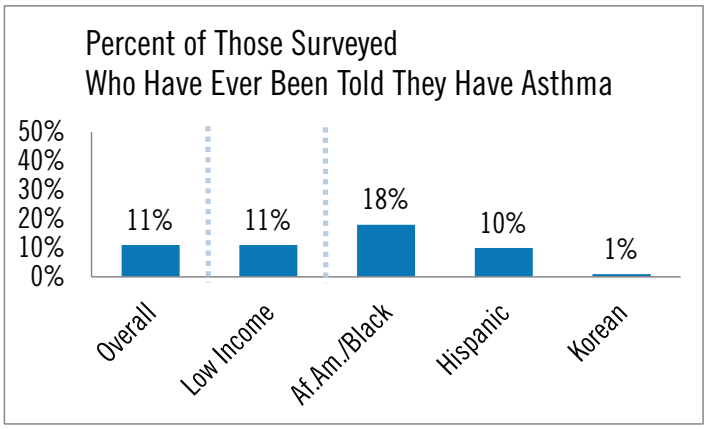
**ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) ARE THE LEADING RESPIRATORY DISEASES** and are significant public health burdens. The major risk factors for respiratory disease include smoking, exposure to secondhand smoke, overweight/obesity, having a mother who smoked during pregnancy, exposure to fumes and other airborne pollutants, and other environmental or occupational pollutants. Asthma is the most common respiratory disease. For some people it is a minor nuisance, but for others it can be a major problem that interferes with daily activities and may lead to life-threatening asthma attacks and frequent emergency department visits. There is no cure for asthma but people can manage their symptoms by controlling their environment and/or taking medication. Currently more than 36 million adults and children nationwide have been diagnosed with

asthma and other respiratory diseases. Health experts and researchers suggest that this may represent only half of the actual burden, as an equal number of cases may not have been diagnosed yet. The impact of respiratory disease is pervasive and affects individuals and their families, as well as schools, workplaces, and society as a whole. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.[35]

## Key Findings

- **ASTHMA.** Eleven percent (11%) of Bergen County residents have ever been told by their doctors that they have asthma, which is comparable to the state rate of 13%. The rate is similar across low-income and racial/ethnic minority groups in the County, except with respect to African American/Black residents (18%) who are nearly twice as likely as Bergen County residents overall to report being told by their doctor that they have asthma.[36]

**FIGURE 14: ASTHMA PREVALANCE**



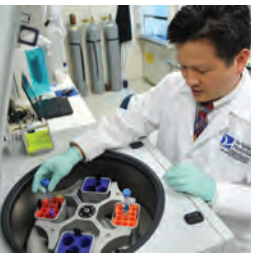

- **EMERGENCY DEPARTMENT USE.** Eleven percent (11%) of Bergen County residents with asthma reported that they went to the hospital emergency department for their asthma in the past 12 months compared to 18% of African Americans with asthma, 31% of Koreans with asthma, and 16% of those living in the Central Bergen region of the County.[37]

- **SMOKING.** The proportion of residents in the County that reported being current cigarette smokers was consistent with the state proportion and generally consistent across the groups surveyed (NJ, 14%; County, 12%; low-income, 17%; Koreans, 14%; Hispanics, 11%; Black/African Americans, 16%).[38]

- **SMOKING QUIT RATES.** High proportions of current smokers in the County across all groups (74%) reported that they had considered quitting in the last 6 months. Other racial/ethnic, income, and geographic sub-groups ranged from 68% to 96%.[39]

## Implications and Conclusions

Respiratory disease in adults is a significant public health issue that affects a substantial portion of Bergen County residents. Data from the project's survey efforts suggest that it leads to inappropriate, preventable, and avoidable emergency department utilization. Consistent with the national literature, the impact of asthma is especially troublesome for African American/Black residents in the County, who, according to data from the assessment's household mail survey, are nearly twice as likely as the County population overall to report being told that they have asthma and nearly twice as likely to report going to the emergency department in the past 12 months for their asthma. Participants in the qualitative interviews and focus groups, particularly in the African American focus group, referenced respiratory disease being a major health issues and further suggested that medications were challenging for them to obtain. The peer-reviewed literature suggests that efforts should be made to identify patients in need of assistance for their asthma through primary care, hospital emergency department, and school-based settings. In addition, the literature includes numerous successful interventions that involve targeted home visits to identify asthma triggers and to develop individual asthma action or management plans that can help patients control their asthma.



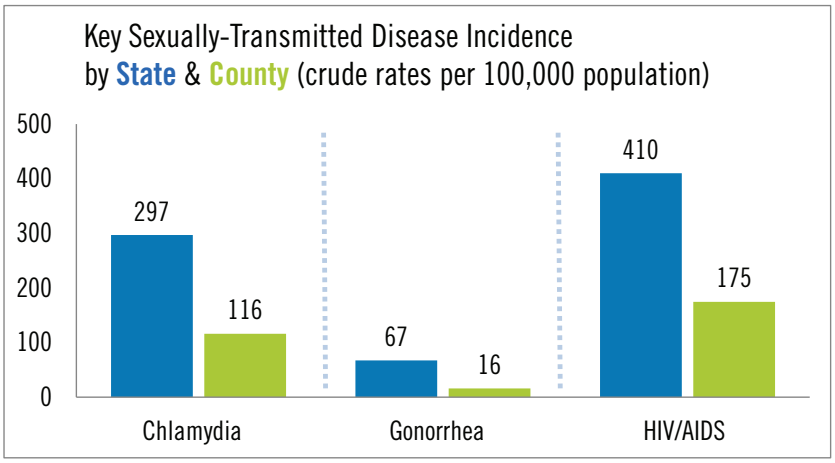
# INFECTIOUS DISEASE

Infectious diseases are disorders caused by organisms, such as bacteria, viruses, fungi, or parasites. Many of these organisms live in our bodies and are normally harmless or even helpful. However, sometimes these organisms can cause disease. Some infectious diseases are passed from person to person or are transmitted via bites from insects or animals. Others are contracted by ingesting contaminated food, water, or through sexual contact. 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. Frequent and thorough hand washing helps to protect from infectious disease. The assessment captured data for each of the leading infectious diseases including chlamydia, gonorrhea, syphilis, HIV/AIDS, Lyme disease, and pneumonia/influenza.[40] In 2009, nearly 3 million people nationwide were infected with one or more of these diseases.[41]

## Key Findings

- **PNEUMONIA/INFLUENZA.** All of the municipalities in the County have lower age adjusted death rates for influenza/pneumonia than the State and County. However, once again, individual municipalities had higher inpatient hospitalization rates related to pneumonia.
- **TUBERCULOSIS.** Bergen County resident's incidence rate (crude rate per 100,000) for tuberculosis in 2010 was comparable to the State's rate overall. The State's crude rate per 100,000 was 4.8 and the County's rate was 4.6.[42]
- **SEXUALLY TRANSMITTED INFECTIONS.** Across all of the sexually transmitted infections listed above (e.g., Chlamydia, Gonorrhea, Syphilis, HIV/AIDS), the incidence and prevalence rates for Bergen County residents overall were lower than the rates for residents Statewide. There were individual towns, cities, or boroughs in Bergen County (e.g., the central region) that had higher rates of disease than the County and/or the State but this was extremely rare.[43]

**FIGURE 15: SEXUALLY TRANSMITTED INFECTION RATES**




## Implications and Conclusions

National and state goals for immunization and infectious diseases are rooted in evidence-based clinical and community activities and services rely primarily on immunization and behavior change with respect to the transmission of disease. Many of these interventions rely heavily on state and local public health departments, and nongovernmental organizations and their assistance with respect to surveillance and the promotion of vaccination. Awareness of disease and completing prevention and treatment courses are essential components for reducing infectious disease transmission.

Overall, Bergen County residents fared better than residents of the state on all of the infectious disease indicators tracked by the State Department of Health. There were a few instances where certain municipalities had slightly higher rates than Bergen County residents overall but this was rare. More often than not the municipalities with higher rates existed within the geographic swath located in the central part of the County. The steering committee did not prioritize any single infectious disease but had discussions regarding the need to promote engagement in primary care and preventive services, and the need to reduce hospital readmissions, particularly for older adults. Pneumonia is one of the leading diagnoses that lead to potentially avoidable hospital inpatient readmission.

# PRIORITY AREA 2: MENTAL HEALTH AND SUBSTANCE ABUSE

## MENTAL HEALTH

**ACCORDING TO A NATIONAL INSTITUTE OF MENTAL HEALTH STUDY PUBLISHED IN 2011**, mental health disorders affect approximately 44 million adults and 13.7 million children each year. In 2011, one in 17 adult Americans suffered from a serious mental illness. More than one in four (26.2%) adults, or approximately 60 million people, suffers from a diagnosable mental disorder, of which the most common forms are depression and anxiety. Mental health disorders are often chronic with physiologic or genetic manifestations and are as disabling as heart disease or cancer in terms of premature death and lost productivity. The annual indirect costs of mental illness are estimated to be more than $79 billion, a large part of which reflects lost productivity. Despite the fact that most mental health disorders are treatable with medication and other therapies, fewer than half of adults and only one-third of children with a diagnosable mental disorder receive treatment, due to lack of screening and identification efforts, shortages in treatment services, and the overall stigma associated with mental illness.

Mental health issues are the leading cause of disability in adults and are associated with poor physical health and higher medical utilization. Rates of mental health problems are significantly higher for patients with certain chronic conditions such as diabetes, asthma, and heart conditions. Failure to treat both physical and mental health conditions results in poor health outcomes and higher health care costs. The responsibility for providing

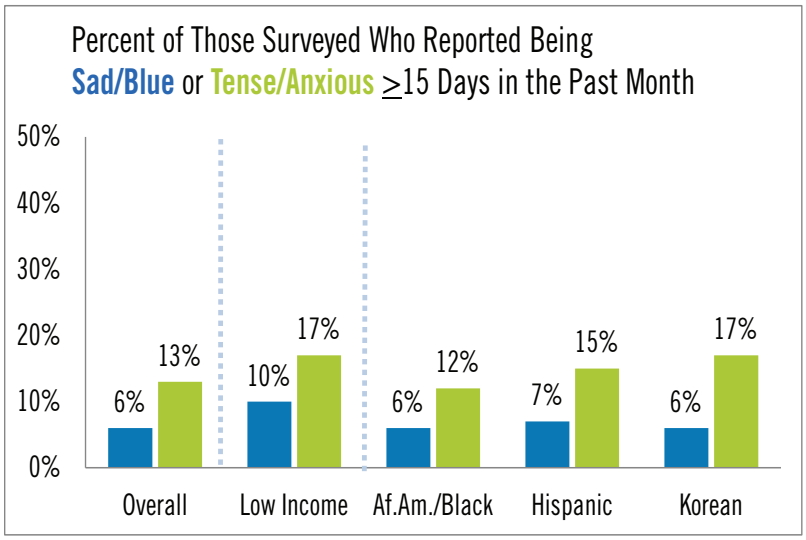
mental health care is falling increasingly to primary care providers. Well over half of treated patients now receive some form of primary care for their mental disorder, and primary care is now the sole form of health care used by more than one-third of patients with a mental disorder accessing the healthcare system. An estimated 11% to 36% of primary care patients have a mental disorder.

The causes of most mental health disorders lie in a combination of genetic and environmental factors that may be biological or psychosocial. Certain demographic and economic groups are more likely than others to experience mental health problems. Some mental health disorders and socioeconomic factors affect individuals' vulnerability to mental illness and mental health problems.[44] [45]

## Key Findings

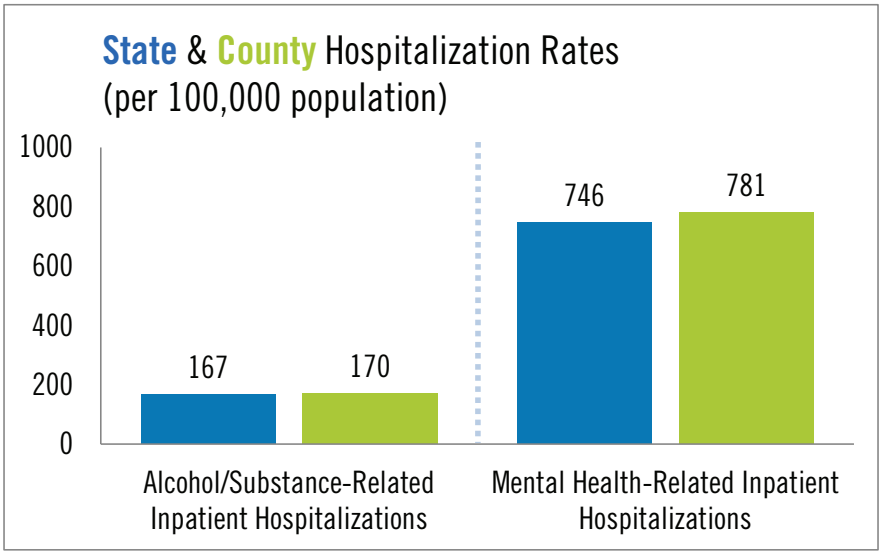
- **MENTAL HEALTH LIMITATIONS.** Low-income and African American/Black populations in Bergen County were more likely to report being limited by physical, emotional, and mental health problems than residents of the state and County overall. Specifically, 18% of Bergen County residents overall reported being limited by physical, emotional, or mental health problems compared to 27% of low-income residents and 24% of African American/Black residents. The remaining racial/ethnic and geographic regions had percentages that ranged from 13 - 20%.[46]
- **DEPRESSION (FEELING SAD OR BLUE).** Low-income populations in Bergen County were nearly twice as likely (10%) as Bergen County residents overall (6%) to report being sad or blue more than 15 days per month. The percentages of the population across other racial/ethnic minority and geographic groups were similar, ranging from 5 to 7 %.[47]

**FIGURE 16: DEPRESSION AND ANXIETY PREVALENCE**



- **ANXIETY (FEELING TENSE).** Low-income and Korean populations in Bergen County were more likely to report being sad or anxious than residents of the County overall. Specifically, 17% of both low-income and Korean populations reported being tense or anxious compared to 13 % of County residents overall.[48]
- **MENTAL HEALTH INPATIENT HOSPITALIZATION.** As mentioned above, Bergen County residents overall have lower death and hospitalization rates per 100,000 than residents statewide across all of the leading diseases and disorders, except with respect to mental health disorders overall and Alzheimer's disease. Bergen County residents had slightly higher inpatient hospitalization rates of 781 per 100,000 for those admitting with mental health disorders of any kind than state residents overall of 746 per 100,000.[49]

**FIGURE 17: MENTAL HEALTH/SUBSTANCE ABUSE INPATIENT HOSPITALIZATION RATES**




## Implications and Conclusions

Mental health, particularly depression, anxiety, and stress, are substantial problems in Bergen County. The effects of depression are dramatic and mental health issues are a clear risk for complicating factors for chronic diseases, such as diabetes, heart disease, and stroke. Low-income racial/ethnic minority populations are more likely to be sad or blue and more likely to be tense or anxious than residents of Bergen County overall. Bergen County residents also have slightly higher inpatient hospitalization rates (per 100,000 residents) for mental health disorders, which is notable in that in all other cases of disease the County overall fares better than the state overall. Finally, qualitative data from the key informant interviews and focus groups unequivocally pointed to the burden that mental health issues

have on individual, families, caregivers, and health and social service providers. A common theme from the qualitative interviews and focus groups, in addition to the overall burden of mental health conditions, was the lack of access to care, particularly for-low-income and racial/ethnic minority populations.

# SUBSTANCE ABUSE

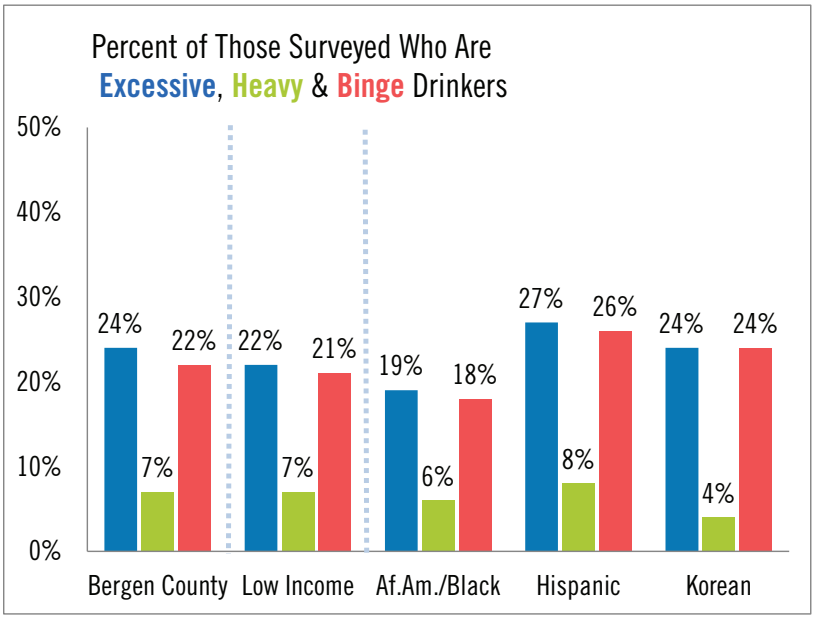
**ALCOHOL IS BY FAR THE MOST COMMONLY USED DRUG IN THE U.S. AND NJ.** According to data from the 2011 National Survey on Drug Use and Health (NSDUH), slightly more than half (51.8%) of Americans aged 12 or older reported being current alcohol drinkers, which translates to an estimated 133.4 million drinkers. An estimated 8.7% or 22.5 million Americans aged 12 or older were current (in the past month) illicit drug users. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, and prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used non-medically. The National Institute for Drug Abuse, estimates that roughly 23 million of those who use drugs, are addicted. Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use despite harmful consequences. Drug addiction is often considered a brain disease because drugs change the brain and these changes can be long lasting and can lead to many harmful, often self-destructive, behaviors. Similar to other chronic diseases, such as diabetes, asthma, heart disease, and depression, substance abuse and drug addiction can be managed successfully with appropriate treatment, although of those who are addicted only roughly 10% are getting the services they need, due once again, to lack of screening and identification efforts, shortages in treatment services, and the overall stigma associated with substance abuse. Estimates of the total cost of substance abuse in the U.S., including productivity and health- and crime-related costs, exceed $600 billion annually.[50]

## Key Findings

- **BINGE DRINKING OVERALL AND BY RACE/ETHNICITY.** The percentage of all residents reporting on the household mail survey as 'binge drinkers'[1] (22%) per Centers for Disease Control and Prevention (CDC) guidelines was substantially higher for residents of Bergen County overall than for those living statewide (13%) across all of the groups surveyed. For low-income populations the percentage was 21%. Koreans, Hispanics/Latinos, and African Americans/Blacks were also all more likely to report being binge drinkers at 24%, 26%, and 18% respectively.[51]

[1] Binge drinking is defined by the CDC as more than 4 alcoholic beverages at any one sitting for women and 5 alcoholic beverages at any one sitting for men.

**FIGURE 18: EXCESSIVE, HEAVY, AND BINGE DRINKING PREVALANCE**




- **BINGE DRINKING BY AGE AND GENDER.** Young adults were more likely to binge drink than older adults. Thirty percent (30%) of adults between the ages of 18 and 24 years old, and 30 % of adults between the ages of 25 and 44 years old, reported binge drinking compared to 21 % of adults between the ages of 44 and 64, and 11% of adults 65 years old or older. Men were more likely to binge drink than women, with 27% of men reporting binge drinking and 18% of women.[52]

- **RISKY DRINKING / HEAVY DRINKING.** The percentage of men and women in Bergen County overall who reported drinking alcohol at "risky" or "heavy" [2] levels per CDC guidelines was nearly twice the state percentage. Seven percent (7%) of Bergen County residents reported drinking alcohol at CDC levels that were "heavy" or "risky" compared to 4% of residents statewide. Eight percent (8%) of Hispanics/Latinos and 7% of low-income populations overall reported being "heavy" drinkers. The remaining groups surveyed were generally consistent, falling between 4% and 6%.[53]

- **MARIJUANA.** The proportions of residents who reported using marijuana was 5% and was consistent across all of groups.[54]

- **PRESCRIPTION DRUG ABUSE.** Nearly 1 in 10 residents (9%) in Bergen County overall reported using prescription drugs inappropriately. The percentage among low-income populations was roughly the same at 9%. The percentages among the other groups surveyed ranged from 5-11%.[55] State data for this indicator is not available.

- **DRIVING WHILE UNDER THE INFLUENCE (DUI).** Fourteen percent (14%) of residents in Bergen County reported driving within two hours of drinking or using illegal drugs.

[2] "Heavy" or "risky" drinking is defined by the CDC as more than 1 alcoholic beverage per day on average (7 drinks per week) for men and more than two alcoholic beverages per day on average (14 drinks per week) for men.

Residents in Northwest Bergen and Pascack Valley were nearly twice as likely as Bergen County residents overall to report driving after with two hours of drinking alcohol or using illegal drugs, with 25% of the population reported as such. This is consistent with national trends that show that more affluent populations are more likely to abuse alcohol and drive while under the influence. The percentages of people who reported driving while under the influence in the low income, racial/ethnic minority groups were lower.[56]

## Implications and Conclusions

Alcohol abuse and risky alcohol consumption is a major issue in Bergen County. Unlike most other health indicators, rates of risky and binge drinking are higher in Bergen County than they are in the state. This is particularly true for binge drinking, as Bergen County adults are nearly twice as likely to binge drink as adults statewide. Binge drinking is more common among young adults and typically decreases with age. It is also more common among men. Data strongly suggests that alcohol abuse and risky drinking are more common among affluent, suburban populations than in low-income, racial/ethnic minority communities. The Bergen County household survey corroborates this finding as does the national literature on alcohol consumption.

Prescription drug abuse is also a substantial issue with 1 in 10 adults in the County reporting abusing prescription drugs. Illicit drug use rates in Bergen County are lower than rates statewide. While comparable data from the state overall is not available, driving under the influence is a major problem with 14% of the population reporting driving within two hours of drinking or using illicit drugs.

# PRIORITY AREA 3: ACCESS TO CARE

**THE EXTENT TO WHICH A FULL CONTINUUM OF HIGH QUALITY, TIMELY, ACCESSIBLE CARE IS AVAILABLE** is undoubtedly critical to overall health and well-being. Whether a person has access to care impacts his or her ability to receive regular preventive, routine, or chronic disease management services and, in turn, has a major, direct impact on that person's overall physical, social, and mental health status, quality of life, and life expectancy. In addition, comprehensive health insurance plays a key role in helping people receive needed care. Other common barriers to care are healthcare provider shortages, transportation, and cost. This assessment did not include a comprehensive health system inventory and capacity assessment. However, quantitative data from the surveys and secondary data sources

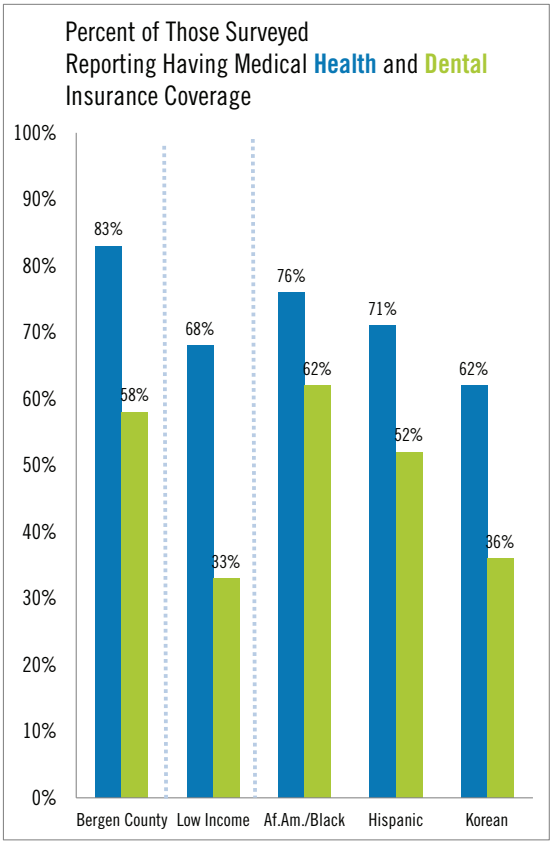
combined with qualitative data from interviews, focus groups, and strategic listening sessions provided valuable information related to healthcare access and the capacity of Bergen County's healthcare system. Specifically, these data informed an assessment of service needs and provider shortages related to primary care, dental, behavioral health, and medical specialty services. Finally, these sources provided information related to barriers to access such as transportation, cost, and appointment wait-times, as well as challenges related to culture, language, and health literacy.

# Key Findings

## INSURANCE COVERAGE

- **MEDICAL HEALTH INSURANCE.** Overall, 83% of Bergen County residents have medical health insurance, which is comparable to the statewide percentage (82%). However, low-income and some racial/ethnic minority populations are much less likely to have health insurance. Only 68% of Bergen County residents living in low-income households earning less than 200% FPL reported having medical health insurance. African American, Hispanic/Latino, and Korean residents also reported considerably lower rates than the County and State averages at 76%, 71%, and 62% respectively. Ninety-eight percent (98%) of residents in the more affluent areas of Northwest Bergen and Pascack Valley reported having medical health insurance.[57]

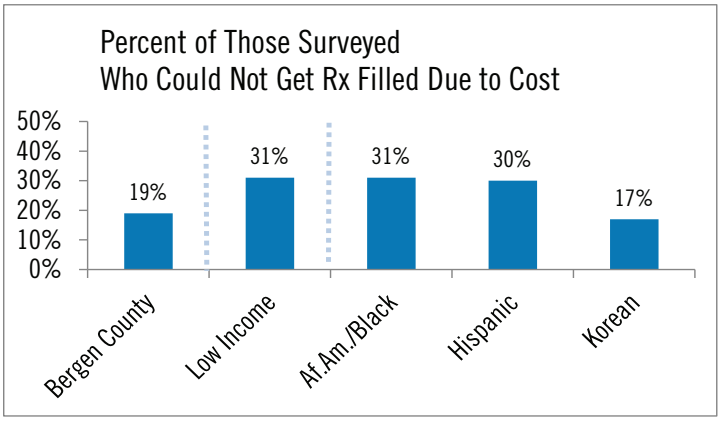
**FIGURE 19: MENTAL AND DENTAL INSURANCE RATES**




- **DENTAL INSURANCE.** Fifty-eight percent (58%) of residents in Bergen County overall reported having dental insurance, compared to only 33% of low-income populations, 36% of Koreans, and 52% of Hispanics/Latinos. [58]

- **ACCESS TO PRESCRIPTION DRUGS.** Access to needed prescription drugs was a major issue for low-income and racial/ethnic minority groups. Overall, 19% of Bergen County residents were unable to get a prescription filled due to cost, compared to 31% of low-income populations, 30% of Hispanics/Latinos, and 31% of African Americans/Blacks. Koreans reported being less likely to face barriers, with only 17 % reporting that they were unable to get a prescription filled due to cost.[59]

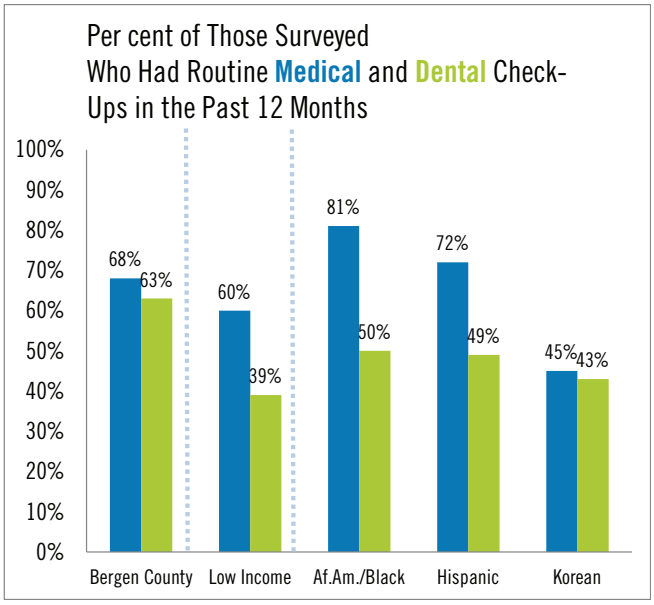
FIGURE 20: ACCESS TO PRESCRIPTION MEDICATIONS




## ACCESS TO CARE

- **ACCESS TO A PRIMARY CARE PROVIDER/DOCTOR.** Eighty-three percent (83%) of residents in the County overall reported having a primary care provider (PCP) or regular doctor that they go to for routine or urgent care, which is slightly lower than the state rate of 86 %. Again, low-income and racial/ethnic minority populations were less likely to have a regular PCP (71% of low-income populations, 78% of Hispanics/Latinos, and only 55% of Koreans).[60]

FIGURE 21: ROUTINE MEDICAL/DENTAL CHECK-UP RATES




- **ROUTINE AND PREVENTATIVE MEDICAL SERVICES.** Low-income populations were less likely than residents of Bergen County overall, or residents statewide, to have had a routine primary care medical visit in the past 12 months. Sixty-eight percent (68%) of residents of the County had a routine primary care visit in the past 12 months, compared to 60% of low-income populations. African Americans were more likely to report having a routine check-up in the past 12 months with a rate of 81% and Hispanics were just as likely with a rate of 72%, whereas Koreans were much less likely, with a rate of 45%.[61]

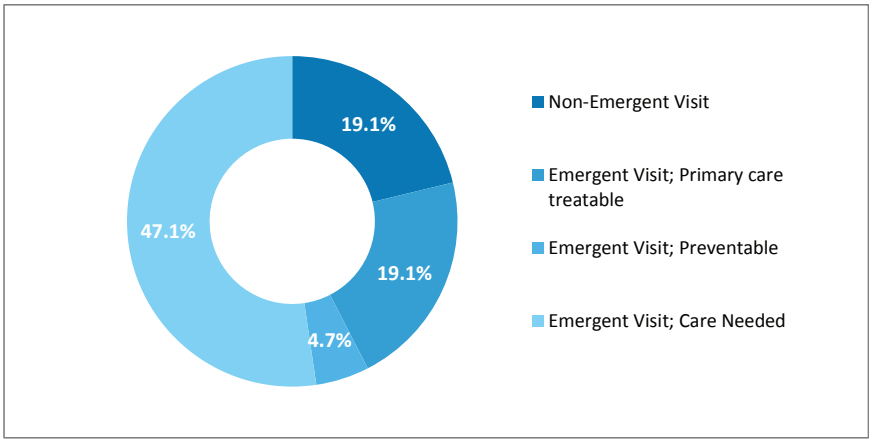
- **ROUTINE AND PREVENTIVE DENTAL SERVICES.** Sixty-three percent (63%) of Bergen County residents reported having a dental visit in the past 12 months, compared to 39% of low-income residents.[62]

- **BEHAVIORAL HEALTH SERVICES.** A key theme across the qualitative interviews and focus groups participants was the impact and burden of mental health and substance abuse issues on the County overall. In the more affluent areas, people discussed the impacts of stress, depression, and isolation as well as lack of access for low- and moderate-income individuals and families. In the low-income areas the discussions centered on lack of access as well as the burden of mental health illness.[63]

- **MEDICAL SPECIALTY CARE SERVICES.** Low-income and racial/ethnic minority residents in the County reported being less likely than County residents overall to have accessed medical specialty care services in the past 12 months. Overall, 57% of County residents had seen a medical specialty care provider in the past 12 months, compared to 47% of low-income populations and 51% of Hispanics/Latinos.[52] Given that the morbidity and mortality rates due to chronic medical conditions are substantially higher in these populations, this finding is particularly noteworthy.

- **EMERGENCY DEPARTMENT UTILIZATION.** Low-income and some racial/ethnic minority populations were more likely to have an emergency room visit in the past 12 months. Overall, 24% of County residents had an emergency room visit in the past 12 months, compared to 35% of low-income populations, and 36% of African Americans/Blacks.[64] Nearly 50% of all hospital emergency visits in Bergen County were non-emergent, emergent but primary care treatable, or emergent but preventable. Although this percentage is slightly lower than the state's rate, it is still relatively high and points to the need to strengthen the primary care system.[65]

**FIGURE: 22 EMERGENT AND NON-EMERGENT ED UTILIZATION**




- **HOSPITAL OVERNIGHT STAY.** Low-income and African American residents who responded to the household mail and community surveys were more likely to report an overnight hospital stay in the past 12 months than Bergen County residents overall. Overall, 12% of Bergen County residents reported a hospital overnight stay, compared to 17% of low-income populations, 16% of those in the community survey sample, and 15% of African-Americans/Blacks.

- **COMMUNITY PERCEPTION.** Low-income survey respondents ranked lack of access to health care services as the leading health issue. In addition, this topic was a major theme in each of the three racial/ethnic minority focus groups.[66]

### BARRIERS TO ACCESS

- **FINANCIAL BARRIERS.** Based on survey responses, key informant interviews, focus groups, and community listening sessions, the most significant barrier to access is the cost of co-pays, deductibles, and out-of-pocket expenses for people across the County. As noted above, nearly 1 in 5 residents of the County reported being unable to get a prescription filled in the past 12 months due to cost. For low-income and racial/ethnic minority populations, nearly 1 in 3 residents experienced financial barriers to getting prescriptions filled. Older adults also faced barriers related to housing and caregiving expenses as they age and become more in need of assistance.
- **TRANSPORTATION BARRIERS.** The second most common barrier that survey respondents, interviewees, focus group participants, and other stakeholders reported was transportation. This was a particular barrier for older adults and those living in the northernmost or southernmost regions of the County, where the travel distances can be longer and public transportation services are more limited.
- **CULTURAL, LANGUAGE AND HEALTH LITERACY BARRIERS.** The need to adapt health education and promotion messages to meet the unique cultural and linguistic needs of Bergen County's diverse population is also a barrier. Some respondents and interviewees, including health and social service providers and patient advocacy organizations, cited health literacy as a major barrier.[67]

## Implications and Conclusions

Bergen County is fortunate to have a strong and vibrant health care system that spans the health care continuum from public health and social service providers, to primary care medical, dental, behavioral health, hospital (emergency and inpatient services), rehabilitation, and long-term care services. There are no absolute gaps in services but there are substantial barriers to care that prevent many people from receiving the care that they need, when they need it, and where they need it. The quantitative and qualitative assessment data clearly show that large segments of the population, particularly low-income and racial ethnic minority populations, face barriers to care and struggle to access services. Some struggle due to the complexity of their medical, social, financial, and family support situations. Others are challenged by linguistic, cultural, and health literacy barriers. Many struggle because they are uninsured or Medicaid-insured and have difficulty finding service providers willing to provide discounted care.

# PRIORITY AREA 4: ELDER HEALTH

Advancements in medical services, particularly with respect to end-of-life care, preventive services, and pharmaceuticals, have contributed to dramatic increases in life expectancy in the U.S. These advances, in addition to very high birth rates between 1946 and 1964, will lead to major shifts in the age distribution of Americans over the next 30 years. By 2030, the population of adults aged 65 and older in the U.S. is expected to double to more 71 million people. According to numerous research studies one-third to one-half of babies born today will live to 100 years old.

Advances in medical and preventive services are also producing major changes in the leading causes of death for all age groups, especially older adults. Currently, about 80 % of older Americans live with at least one chronic condition. Another important factor is that America's older adult population is also becoming more racially and ethnically diverse and the burden of chronic diseases and conditions — especially high blood pressure, diabetes and cancer — is significantly worse in these populations. Data from the National Health Interview Survey (NHIS) indicates that 39% of non-Hispanic white adults aged 65 years or older report very good or excellent health, compared with 24% of non-Hispanic blacks and 29% of Hispanics/Latinos.[68]

Bergen County will likely be impacted by these trends to a greater extent than the nation or the state given the County's particularly large proportion of older adults. As noted above, in 2010, 15.1% of Bergen County's population was age 65 or older compared to 13.5% statewide. Nearly 1-in-3 households (29%) has at least one adult over the age of 65 living, compared to 26% for the state. In 2010, 28.5% of Bergen County's population was foreign born and 36.7 % of residents age 5 years or older spoke a language other than English at home, compared to 20.3% and 28.7% in NJ and the nation respectively. These differences may seem insignificant but given the added health burden experienced by this age group, it translates to a substantial burden on families, caregivers, and the health system overall.[69]

# Key Findings

## CHRONIC DISEASE

The prevalence of chronic disease increases substantially with age across nearly all major chronic disease categories.

- **DIABETES, HYPERTENSION, AND HIGH CHOLESTEROL.** Nineteen percent (19%) of Bergen County elders 75 years and older have ever been told by their doctor that they have diabetes, which is three times greater than the County average overall of 6%. Sixty five percent of elders 75 years and older have ever been told that they have hypertension, which is twice the County average of 28%. Forty nine percent (49%) of elders 75 years and older have ever been told that they have high cholesterol, compared to 40% of adults in the County overall.[70]

- **CANCER.** Twenty-nine percent (29%) of elders 75 years and older have ever been told that they have cancer, compared to 9% of adults in the County overall.[71]

**FIGURE 23: CHRONIC DISEASE PREVALANCE - PHYSICAL HEALTH BY AGE**

| Chronic Disease | 18-44 years | 45-64 years | 65+ years | 75+ years | Overall | Region | |
|---|---|---|---|---|---|---|---|
| | | | | | | Bergen County | State of NJ |
| Ever told had diabetes – adult | 2% | 21% | 24% | 19% | 10% | 6% | 9% |
| Ever told had angina or coronary heart disease | <1% | 3% | 15% | 19% | 4% | 4% | 4% |
| Ever told asthma – adult | 11% | 7% | 16% | 11% | 11% | 13% | 13% |
| Ever told had high blood pressure/ hypertension | 8% | 32% | 61% | 65% | 28% | 28% | 28% |
| Ever told had cancer | 2% | 8% | 27% | 29% | 9% | N/A | N/A |

## MENTAL HEALTH AND SUBSTANCE ABUSE

- **ISOLATION.** Findings from the key informant interviews, focus groups, and community listening sessions highlighted the impact that isolation has on older adults. Interviewees suggested that this was especially problematic in more affluent communities, as older adults who have been widowed often have the means to remain at home on their own with the help of home health aides or personal care attendants. This situation can be much more isolating than a nursing home or assisted living arrangement.

- **ANXIETY AND DEPRESSION.** Many older adults experience anxiety and/or depression. Twelve percent (12%) of adults 75 years and older reported being tense or anxious and 11% of adults in this age group reported being sad or blue more than 15 days out of the month on average.[72] State rates for this age group are not available.

- **PHYSICAL, EMOTIONAL, AND MENTAL HEALTH LIMITATIONS.** Thirty-eight percent (38%) of elders 75 years and older reported being limited in their activities due to their physical, emotional, or mental health problems.[73]

## ACCESS TO CARE

- **TRANSPORTATION BARRIERS.** Due to Medicare, elders are more likely to be insured for medical health issues than other age groups, but according to the interviews face significant transportation barriers that limited their access to services and their ability to get appropriate preventive or follow-up care. This was particularly problematic for those rehabilitating from a hospital stay.
- **LACK OF CARE COORDINATION.** According to the interviews, focus groups, and listening sessions, older adults lack care coordination and have fragmented services. This was due partly to transportation barriers but also to the sheer number of different providers that older adults need to manage their heath. Providers also discussed the challenges related to delayed and inappropriate communication between providers that hindered follow up services in the community.

**FIGURE 24: CHRONIC DISEASE PREVALANCE - BEHAVIORAL HEALTH BY AGE**

| Health Indicator | 18-44 years | 45-64 years | 65+ years | 75+ years | Overall |
|---|---|---|---|---|---|
| % reporting fair/poor health | 8% | 13% | 24% | 30% | 13% |
| Average days in poor physical health in past 30 days | 2 days | 3 days | 4 days | 5 days | 3 days |
| % people with > 15 days in poor physical health | 4% | 7% | 12% | 13% | 7% |
| Average days in poor mental health in 30 days | 3 days | 3 days | 3 days | 3 days | 3 days |
| % people with > 15 days in poor mental health | 7% | 8% | 7% | 10% | 7% |
| % people with > 15 days sad or blue | 6% | 6% | 8% | 11% | 6% |
| % people with > 15 days tense or anxious | 14% | 12% | 9% | 12% | 13% |
| % limited in any way in any activities by physical, mental or emotional problems | 12% | 19% | 32% | 38% | 18% |

## Implications and Conclusions

Older adults are disproportionately impacted by chronic medical and behavioral health issues. Part of this additional burden is associated with the regular aging process but many of these issues can be prevented or at least delayed. As stated above, Bergen County has higher proportions of older adults than the state and the nation and so this issue is expected to become even more pronounced in the coming years. In 2010, 15.1% of Bergen County's population was age 65 or older and nearly 1-in-3 households had at least one adult over the age of 65 living in it. Given these factors, it will be critical for health and social service stakeholders throughout the County to work together to tailor health education, prevention, health promotion, and service engagement efforts specifically to older adults.

# COMMUNITY HEALTH PRIORITIES & TARGET POPULATIONS

## COMMUNITY HEALTH PRIORITIES

Once all of the assessment's findings were compiled, the project's steering committee participated in a comprehensive strategic planning process. The steering and advisory committees convened a strategic planning retreat, and organized individual strategic planning meetings with each of the participating hospitals, the Bergen County Department of Health Services, and the CHIP. The project's findings were also presented to a number of community groups, including local health department officials, discharge planners and case managers from the participating hospitals, and the Bergen County Mental Health Task Force. Finally, preliminary findings and results were presented to the public at the CHIP's annual meeting on January 30, 2013 at Holy Name Medical Center, which nearly 100 community residents and other community health stakeholders attended. During this meeting, the steering committee used interactive audience polling software to collect anonymous feedback on health priorities and core strategies. These strategic planning efforts helped the steering committee to: 1) Agree on a series of countywide, community health priorities; 2) Identify demographic and socio-economic target populations; and 3) Develop a menu of potential core strategies that guide program development efforts over the next three years.

The following are the community health priorities identified during this extensive process.

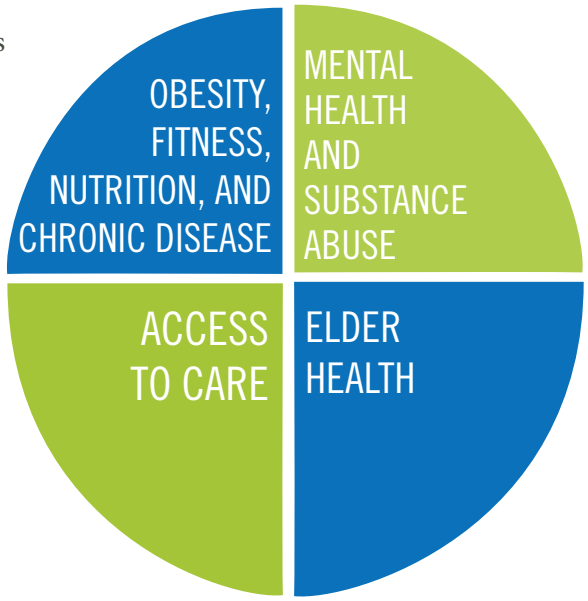



FIGURE 25: COMMUNITY HEALTH PRIORITIES

# TARGET POPULATIONS

The CHIP along with its hospital, public health, and other community partners is committed to improving the health status and well-being of all County residents. The Bergen County Community Health Improvement Plan discussed in the next section incorporates many activities and goals that will be implemented by the CHIP, the hospitals, and other partners in the County and will address the leading health issues facing its residents. However, assessment findings clearly indicated major health disparities among low income and racial/ethnic minority populations across nearly all of the leading healthcare indicators. More specifically, Hispanics/Latinos, Koreans, and African Americans/Blacks in Bergen County face significant disparities in health outcomes when compared to their non-Hispanic, white counterparts. Residents in households earning less than 200% of the FPL also face disparities in health outcomes. Finally, older adults are disproportionately affected by many health issues, particularly chronic medical and mental health conditions. Given these findings, the steering and advisory committees agreed to encourage stakeholders throughout the County to target low-income and racial/ethnic minority populations as well as older adults as it implements its community health improvement interventions. It should also be noted that geographically, much of the disparity is experienced by those living in the swath of cities in towns in central Bergen.


FIGURE 26: TARGET POPULATIONS

Many of the strategic and programmatic interventions that arise because of this assessment will be aimed at improving the health and well-being of all residents throughout Bergen County. However, successful community health interventions are typically targeted at specific communities or populations to ensure that activities are tailored to their interests, motivating factors, and cultural or linguistic needs. Therefore, special emphasis will be placed on low-income and racial/ethnic minority populations, and those in central Bergen, as well as older adults throughout the County.

# SUMMARY BERGEN COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN AND CORE STRATEGIES


## PRIORITY AREA 1: OBESITY, FITNESS NUTRITION, AND CHRONIC DISEASE

Bergen County's hospitals, health departments, community-based health and social service providers, educational institutions, and other community organizations conduct a broad range of health awareness, education, prevention, screening activities, and campaigns. These efforts have an important impact on the County's health and well-being and should be refined and expanded based on the assessment's findings. Efforts should be linguistically and culturally appropriate and understandable for those who have limited health literacy skills.

Peer-reviewed research shows the significant impact that non-clinical, community-based prevention policies and strategies have on promoting healthy behaviors, reducing risky behaviors, expanding access to healthy foods, raising awareness, and providing important education messages. With this in mind, the CHIP and its partners should promote these efforts within corporations, public health departments, schools, groceries/bodegas, and other community venues. Research also shows that health awareness, education, prevention, screening activities, and community campaigns on their own are usually not enough to prevent disease, reduce disparities, and promote healthy behaviors. These non-clinical interventions must be combined with enhanced clinical referral, follow-up, care coordination, and care management services that link people to appropriate care and promote engagement in services. These care coordination and follow-up activities can help inform people about their health and other important health issues, or may help people to better understand the risks and factors related to managing conditions.

The following goals and objectives focus on enhancing outreach, education, and screening activities. Specifically, they aim to ensure that most at-risk populations are linked to care, supported to engage in care, and able to manage their chronic conditions and/or address risk factors.

**FIGURE 27: PRIORITY AREA ONE**

| PRIORITY AREA ONE: OBESITY, FITNESS, NUTRITION, & CHRONIC DISEASE | | |
|---|---|---|
| **Goal** | **Target Population** | **Strategies / Programmatic Objectives** |
| GOAL 1: INCREASE PHYSICAL ACTIVITY | • Children & youth<br>• Adults<br>• Elders | • Promote behavioral interventions to reduce screen time<br>• Increase time spent walking or biking<br>• Promote counseling and behavior change |
| GOAL 2: INCREASE HEALTHY EATING | • Children & youth<br>• Adults<br>• Elders | • Increase access to healthy diverse foods in schools<br>• Increase daily consumption of fruits and vegetables<br>• Reduce access to sugary, sweetened beverages<br>• Increase access to healthy, diverse foods<br>• Promote counseling and behavior change<br>• Promote exclusive breastfeeding among new mothers |
| GOAL 3: INCREASE NUMBER OF RESIDENTS WHO MAINTAIN A HEALTHY WEIGHT | • Children & youth<br>• Adults<br>• Elders | • Promote health education, wellness, and screening for obesity (school-based, community-based, and worksite settings)<br>• Increase proportion of worksites that offer nutrition or weight management classes<br>• Increase proportion of primary care providers who regularly assess BMI<br>• Promote counseling and behavior change interventions |
| GOAL 4: PROMOTE CARE COORDINATION & ENGAGEMENT IN PRIMARY CARE | • Adults and children<br>• Low income<br>• Racial/ethnic minorities | • Promote programs that link residents to quality primary care (hospital, school, and community-based settings) |
| GOAL 5: IMPROVE SCREENING & IDENTIFICATION OF CHRONIC DISEASE AND ASSOCIATED RISK FACTORS | • Adults with or at-risk of chronic disease<br>• Low income<br>• Racial/ethnic minorities | • Promote health education, wellness, and screening for hypertension, diabetes, depression, and other leading chronic diseases (hospital, primary care, community, and worksite settings) |
| GOAL 6: PROMOTE CHRONIC DISEASE MANAGEMENT & BEHAVIOR CHANGE | • Adults with or at-risk of chronic disease<br>• Low income<br>• Racial/ethnic minorities | • Implement community-based and primary care-based chronic disease management and behavior change programs |

# PRIORITY AREA 2: MENTAL HEALTH AND SUBSTANCE ABUSE

The burden of mental illness and substance abuse on Bergen County residents is substantial. These issues impact all segments and age groups in the population. Large numbers of residents are affected by both mental health and substance abuse conditions. There is also a correlation between many of the most common chronic conditions – heart disease, stroke, hypertension, and asthma – and mental health issues. Some studies have shown that up to 80% of chronic, physical health conditions among low-income populations have an underlying emotional, mental health, or substance abuse origin.

As discussed above, significant proportions of the population are limited by mental and emotional health issues, and have reported being sad or anxious for a majority of the days in any given month. Hospitalization rates for substance abuse and mental health are higher in many of the County's cities and towns when compared to the State. Large portions of the population also engage in alcohol abuse and binge drinking. Despite increased community awareness and sensitivity about mental illness and addiction, there is still a great deal of stigma related to these conditions and there is a general lack of appreciation of the fact that these issues are often rooted in genetics and physiology, similar to other chronic diseases.

**FIGURE 28 PRIORITY AREA TWO**

| PRIORITY AREA TWO: MENTAL HEALTH & SUBSTANCE ABUSE | | |
|---|---|---|
| **Goal** | **Target Population** | **Strategies / Programmatic Objectives** |
| GOAL 1: REDUCE DEPRESSION & ISOLATION | • Children & youth<br>• Adults<br>• Elders<br>• Low income families & individuals | • Increase the proportion of primary care providers who regularly assess for depression<br>• Promote the integration of mental health services in the primary care setting |
| GOAL 2: REDUCE ANXIETY & STRESS | • Children & youth<br>• Adults<br>• Elders<br>• Low-income families & individuals | • Increase the proportion of primary care providers who regularly assess for anxiety and stress<br>• Promote the integration of mental health services in the primary care setting<br>• Promote activities that increase socialization or positive social interactions and relationships, particularly for elders |
| GOAL 3: REDUCE STIGMA RELATED TO MENTAL ILLNESS | • Children & youth<br>• Adults<br>• Elders<br>• Low income families & individuals | • Promote mental health education and awareness (hospital, primary care, school, community, and worksite settings) |
| GOAL 4: REDUCE RISKY & BINGE DRINKING | • Adults<br>• Elders<br>• Suburban & more affluent populations | • Increase the proportion of primary care providers who regularly assess for alcohol abuse<br>• Promote the integration of substance abuse services in the primary care setting |
| GOAL 5: REDUCE PRESCRIPTION DRUG ABUSE | • Adults<br>• Elders<br>• Suburban & more affluent populations | • Increase the proportion of primary care providers who regularly assess for prescription drug abuse<br>• Promote the integration of substance abuse services in the primary care setting |


# PRIORITY AREA 3: ACCESS TO CARE

Bergen County has a strong and comprehensive healthcare system that spans the healthcare continuum. There are no complete gaps in coverage or access across any of the major service categories. However, large segments of the population face barriers to care and struggle to access services. Findings from the assessment showed widespread disparities in health outcomes and access among low-income, racial/ethnic minority populations, and to some extent older adults and those living in suburban or rural areas with limited transportation. Efforts need to be made to expand capacity in targeted ways, particularly among the health care safety net that serves underserved, low-income, and racial/ethnic minority populations who are more likely to be uninsured or underinsured. The assessment exposed significant barriers to dental, behavioral health, and medical specialty care access. Insurance coverage and benefits are often more limited in these areas. In addition, the assessment exposed significant linguistic, cultural, health literacy, and transportation barriers.

The following goals and objectives address access barriers and capacity gaps. They also help to ensure that those most at-risk engage in the care they need, and are supported in their efforts to manage their chronic conditions and/or address risk factors.

FIGURE 29 PRIORITY AREA THREE

| PRIORITY AREA THREE: ACCESS TO CARE | | |
|---|---|---|
| **Goal** | **Target Population** | **Strategies / Programmatic Objectives** |
| **GOAL 1: PROMOTE ACCESS AND ENGAGEMENT IN PRIMARY CARE** | • Children & youth<br>• Adults<br>• Elders<br>• Low income families & individuals | • Community-based programs that link people without a primary care provider to a medical home<br>• ED-based programs that link people admitted through ED without a primary care provider to a medical home |
| **GOAL 2: PROMOTE ACCESS AND ENGAGEMENT IN DENTAL CARE** | • Children & youth<br>• Adults<br>• Elders<br>• Low income families & individuals | • Community-based programs that link people without a dental provider to a dental home<br>• Expand dental care access in Federally Qualified Health Centers (FQHC) and other safety net clinics<br>• Develop volunteer health care provider network |
| **GOAL 3: PROMOTE ACCESS AND ENGAGEMENT IN BEHAVIORAL HEALTH CARE** | • Children & youth<br>• Adults<br>• Elders<br>• Low income families & individuals | • Promote the integration of mental health services in the primary care setting.<br>• Expand dental care access in FQHCs<br>• Expand mental health access in FQHCs and other safety net clinics<br>• Develop volunteer health care provider network |
| **GOAL 4: PROMOTE ACCESS AND ENGAGEMENT IN MEDICAL SPECIALTY CARE** | • Children & youth<br>• Adults<br>• Elders<br>• Low income families & individuals | • Expand medical specialty care access in FQHCs and other safety net clinics<br>• Develop volunteer medical specialty care network |
| **GOAL 5: INCREASE ACCESS TO CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE** | • Children & youth<br>• Adults<br>• Elders<br>• Low-income families & individuals | • Develop linguistically and culturally appropriate educational materials |
| **GOAL 6: DECREASE TRANSPORTATION BARRIERS** | • Children & youth<br>• Adults<br>• Elders<br>• Low income families & individuals | • Advocate for improvements in public transportation<br>• Promote the development of improved transportation services in hospital and other health and social service settings |

# PRIORITY AREA 4: ELDER HEALTH

With respect to elder health, there is a great deal of overlap of specific health indicators and priorities that have been identified for the population overall. The health issues for elders are not different, just more prevalent and often more extreme. Certain health issues are also often more challenging because many elders are isolated, have limited support, and face additional barriers such as access to transportation. The most significant issues the interviews, focus groups, and listening sessions identified were related to care coordination, hospital discharge planning, and caregiver support.

The participating hospitals have vibrant programs to address service coordination, improve follow-up care, and ensure that older adults are engaged in the services they need. There are also numerous organizations in the County that provide transportation support. However, these efforts need to be enhanced and refined based on data from this assessment. Moving forward, it is critical that these issues be addressed so that the network of hospitals, healthcare providers, and elder services organizations work collaboratively to address the increasing needs of this group.

The following goals and objectives address the existing access to care coordination issues, barriers, and targeted service gaps identified through the process.

**FIGURE 30: PRIORITY AREA FOUR**

| PRIORITY AREA FOUR: ELDER HEALTH | | |
|---|---|---|
| **Goal** | **Target Population** | **Strategies/Programmatic Objectives** |
| GOAL 1: REDUCE INAPPROPRIATE HOSPITAL READMISSIONS | • Adults<br>• Elders | • Improve care coordination and follow-up for older adults in the community<br>• Reduce fragmentation of services after hospital discharge |
| GOAL 2: REDUCE TRANSPORTATION BARRIERS | • Adults<br>• Elders | • Advocate for improvements in public transportation<br>• Promote the development of improved transportation services in hospital and other health and social service settings |
| GOAL 3: INCREASE ACCESS TO CAREGIVER SUPPORT PROGRAMS | • Adults<br>• Elders | • Promote and/or implement education and awareness programs for caregivers |
| GOAL 4: INCREASE ACCESS TO END-OF-LIFE AND PALLIATIVE CARE PROGRAMS | • Adults<br>• Elders | • Promote the development of end-of-life and palliative care programs |

# CORE STRATEGIES

## EXPANSION OF ACCESS TO SERVICES

Expand capacity to behavioral health, dental, and medical speciality care services in targeted ways, particularly among the healthcare safety net that serves underserved, low-income, and racial/ethnic minority populations who are more likely to be uninsured or underinsured. Efforts should also reduce barriers to care such as transportation, language, culture, health literacy, and administrative barriers to maintaining insurance coverage.

## CHRONIC DISEASE MANAGEMENT PROGRAMS

Ensure that individuals with or at particular risk of contracting chronic conditions have access to evidenced-based programs that raise awareness, provide education on risk factors and health promotion ideas, and include self-management supports that help individuals manage their conditions and change risky or unhealthy behaviors.

## COMMUNITY HEALTH AND WELLNESS PROMOTION

Build on existing lectures, workshops, health fairs, screening events, and other programs currently sponsored by hospitals, health departments, and other community health partners in Bergen County. Findings from the community health needs assessment should be used to refine and focus these activities.

## DEVELOPMENT OF DIABETES COLLABORATIVE

The diabetes collaborative would be a community coalition of health and social service providers committed to working together to improve the health and wellbeing of Bergen County residents with diabetes or at-risk of contracting diabetes. Activities could include linking people without a primary care provider to a medical home, increasing access to chronic disease management and self-management support services, advocating for effective policy and practice change, sharing best practices, and promoting effective prevention strategies.

## PRIMARY CARE ENGAGEMENT

Link people in need to appropriate services, address social determinants of health, promote engagement in care, and improve care coordination and follow-up care. The programs should target specific at-risk populations by socio-economic status, race/ethnicity, geography, and health condition. Programs should provide general health education and ensure that participants are engaged in primary care and other appropriate services. These activities should be provided in conjunction with chronic disease management and behavior change programs.

## BEHAVIORAL HEALTH INTEGRATION

Facilitate targeted or universal screening for mental health conditions and substance abuse in the primary care setting and ensure that people identified with mental health or substance abuse issues are linked to and engaged in care either through formal, enhanced referral arrangements with other behavioral health providers, or through a co-located therapist operating within the primary care clinic.

## PUBLIC HEALTH AND ENVIRONMENTAL INTERVENTIONS

Develop local laws and adopt formal policies by boards or commissions that protect public health, improve enforcement, or change practices in community settings such as in restaurants, grocery stores, and schools. The CHIP should work with state and local policy makers and community leaders to advocate for these efforts.

## REDUCTION OF INAPPROPRIATE HOSPITAL UTILIZATION

Build on existing hospital and community-based efforts and work to reduce the burden and costs associated with inappropriate emergency department and hospital inpatient utilization or inappropriate hospital readmissions. Manage high-utilizers in the emergency department, enhance discharge planning, improve care transitions, and enhance care management and care coordination activities. Emergency department efforts should target “frequent flyers” as well as those with mental health and substance abuse conditions. Inpatient programs should focus on older adults with congestive heart failure, pneumonia, and COPD.

## WORKSITE HEALTH EDUCATION, WELLNESS, AND SCREENING PROGRAMS

Promote informational and educational strategies, behavioral strategies, policy and environmental approaches, and comprehensive wellness strategies in worksite settings that address health issues such as smoking cessation, stress management, and cholesterol reduction.

# ENDNOTES


1 County Health Rankings and Roadmaps: A Healthier Nation, County by County. http://www.countyhealthrankings.org/ accessed on March 26, 2013

2 Mobilizing for Action through Planning and Partnerships (MAPP). http://www.naccho.org/topics/infrastructure/mapp/. Accessed in March 2013.

3 World Health Organization. http://www.who.int/social_determinants/en/. Accessed in March 2013.

4 Decennial Census 2010

5 American Community Survey (ACS) 2006-2010

6 Decennial Census 2010

7 Ibid.

8 American Community Survey (ACS) 2006-2010

9 Ibid.

10 New Jersey Department of Labor and Workforce Development Current Employment Statistics

11 Community Health Needs Assessment 2012, Random Household Mail Survey

12 2010 FBI's Uniform Crime Reports

13 County Health Rankings and Roadmaps: A Healthier Nation, County by County. http://www.countyhealthrankings.org/. Accessed in March 2013.

14 Community Health Needs Assessment 2012, Random Household Mail Survey

15Community Health Needs Assessment 2012, Random Household Mail Survey

16 Ibid.

17 Ibid.

18 Ibid.

19 Community Health Needs Assessment 2012, Focus Groups

20 Shaping NJ – State Partnership for Nutrition, Physical Fitness and Obesity Prevention. http://www.state.nj.us/health/fhs/shapingnj/work/shapingnj. Accessed in March 2013.

21 Healthy People 2020 (http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=29)

22 Healthy People 2020 (Heart Disease Overview,http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=8)

23 New Jersey State Health Assessment Data - Mortality for 2003-2007 (http://www4.state.nj.us/dhss-shad/query)

24 Community Health Needs Assessment 2012, Random Household Mail Survey

25 Ibid.

26 Ibid.

27 Ibid.

28 Ibid.

29 Healthy People 2020. (HP 2020 Health Topics and Objectives,http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=5)

30 New Jersey cancer registry data for 2005-2009 (http://www.cancer-rates.info/nj/index.php)

31 Ibid.

32 Community Health Needs Assessment 2012, Random Household Mail Survey

33 Ibid.

34 Ibid.

35 Healthy People 2020 (Respiratory Disease Overview, http://healthypeople.gov/2020/TopicsObjectives2020/overview.aspx?topicId=36)

36 Community Health Needs Assessment 2012, Random Household Mail Survey

37 Ibid.

38 Ibid.

39 Ibid.

40 Healthy People 2020. (Infectious Disease Overview and Objectives, http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=23)

41 AVERTING HIV and AIDS. http://www.avert.org/std-statistics-america.htm. Accessed in March 2013.

42 NJ Department of Health and Senior Services Sexually Transmitted Disease (STD) Program 2010 Data (http://www.state.nj.us/health/std/stats.html)

43 NJ Department of Health and Senior Services Tuberculosis (TB) Control Program 2010 Data (http://www.state.nj.us/health/tb/documents/tbstats/county.pdf)

44 Mental Health Care Services in Primary Care: Tackling the Issues in the Context of Health Care Reform, October 2011 (http://www.americanprogress.org/wp-content/uploads/issues/2010/10/pdf/mentalhealth.pdf)

45 Healthy People 2020 (http://www.healthypeople.gov/2020/topicsobjectives2020/ebr.aspx?topicId=40)

46 Community Health Needs Assessment 2012, Random Household Mail Survey

47 Ibid.

48 Ibid.

49 Individual Hospital Inpatient Utilization Data 2012

50 2011 National Survey on Drug Use and Health: Summary of National Findings (http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.htm)

51 Community Health Needs Assessment 2012, Random Household Mail Survey

52 Ibid.

53 Ibid.

54 Ibid.

55 Ibid.

56 Ibid.

57 Ibid.

58 Ibid.

59 Ibid.

60 Ibid.

61 Ibid.

62 Ibid.

63 Community Health Needs Assessment 2012, Key Informant Interviews and Focus Groups

64 Ibid.

65 Individual Hospital Inpatient Utilization Data 2012

66 Community Health Needs Assessment 2012, Focus Groups

67 Community Health Needs Assessment 2012, Key Informant Interviews and Focus Groups

68 CDC National Health Interview Survey (NHIS) (http://www.cdc.gov/nchs/nhis.htm)

69 The State of Aging and Health in America 2007, CDC (http://www.cdc.gov/Aging/pdf/saha_2007.pdf)

70 Community Health Needs Assessment 2012, Random Household Mail Survey

71 Ibid.

72 Ibid.

73 Ibid.

Appendix 1

# BERGEN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY RESULTS

# SUMMARY OF RESULTS OF THE BERGEN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT HOUSEHOLD AND CONVENIENCE SURVEYS NOVEMBER 2012

**Table 1: Number of respondents and response rates for the Bergen County household survey sample (N=1644) and convenience sample (N=374).**
Reporting ***unweighted*** data on respondents' average age, gender and household income for the Bergen County household survey sample.

| | Central Bergen/ Northern Valley | Northwest Bergen/ Pascack Valley | Southeast/ Southwest Bergen | Non-Hispanic African-Americans | Hispanics | Non-Hispanic Koreans | Low Income | Overall | Convenience |
|---|---|---|---|---|---|---|---|---|---|
| **Number of respondents to survey** | **431** | **484** | **384** | **136** | **103** | **106** | **392** | **1644** | **374** |
| **Response rate** | 44% | 49% | 39% | 42% | 32% | 33% | .. | 42% | .. |
| **Average age** | 55 | 56 | 54 | 53 | 48 | 49 | 56 | 55 | 42 |
| **% female** | 63% | 59% | 61% | 72% | 63% | 56% | 66% | 61% | 75% |
| **Household income** | | | | | | | | | |
| **% <$50,000** | 39% | 17% | 41% | 50% | 51% | 43% | 91% | 33% | 59% |
| **% $50,000-124,999** | 43% | 38% | 40% | 40% | 38% | 41% | 9% | 41% | 34% |
| **% $125,000 or more** | 18% | 45% | 19% | 9% | 11% | 16% | 0% | 26% | 6% |

*Data for this variable represents subset of survey respondents.

**Table 2: Demographics of the Bergen County household survey sample (N=1644) and Convenience sample (N=374) compared to Bergen County and state data for NJ.**
Reporting ***weighted*** survey data for Bergen County household survey sample.

| Demographics | Central Bergen/ Northern Valley (N=431) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=384) | Non-Hispanic African-Americans (N=136) | Hispanics (N=103) | Non-Hispanic Koreans (N=106) | Low Income (N=392) | Overall (N=1644) | Convenience (N=374) | Region | | SOURCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Bergen County | State of NJ | |
| **Gender – female (A2)** | 54% | 51% | 53% | 63% | 53% | 51% | 56% | 53% | 75% | 52% | 51% | Decennial Census 2010 |
| **Average Age (A1)** | 49 | 52 | 48 | 47 | 44 | 44 | 49 | 50 | 42 | N/A | N/A | N/A |
| **65 years or older** | 20% | 21% | 20% | 21% | 7% | 11% | 23% | 20% | 7% | 15% | 14% | Decennial Census 2010 |
| **Minority (non-White race and/or Hispanic ethnicity) (A5)** | 48% | 10% | 50% | 100% | 100% | 100% | 59% | 39% | 66% | 38% | 41% | Decennial Census 2010 |
| **Non-English Speaking (A7)** | 14% | 1% | 21% | 0% | 29% | 50% | 26% | 13% | 21% | 37% | 29% | American Community Survey (ACS) 2006-2010 |
| **Married (A8)** | 53% | 70% | 53% | 29% | 53% | 71% | 40% | 57% | 46% | 56% | 51% | ACS 2006-2010 (population 15+ years old) |
| **Less than high school education (A9)** | 7% | 1% 6% | | 4% | 12% | 3% | 5% | 5% | 8% | 9% | 13% | ACS 2006-2010 |
| **Households with children < 18 (A11)** | 35% | 41% | 37% | 37% | 49% | 42% | 47% | 37% | 59% | 5% | 7% | ACS 2006-2010 |
| **Income ≥$125,000 (A13)** | 18% | 49% | 21% | 9% | 11% | 17% | 0% | 26% | 6% | N/A | N/A | N/A |
| ***Among non-retirees… Unemployed (A10)** | 9% | 2% | 10% | 17% | 11% | 7% | 20% | 8% | 10% | 8% | 10% | NJ Department of Labor and Workforce Development Current Employment Statistics |

*Data for this variable represents subset of survey respondents.

**Table 3: Health care access and utilization: Bergen County household survey sample (N=1644) and Convenience sample (N=374) compared to Bergen County and NJ state data.**
Reporting ***weighted*** survey data for Bergen County household survey sample.

| Area | Description | Central Bergen/ Northern Valley (N=431) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=384) | Non-Hispanic African-Americans (N=136) | Hispanics (N=103) | Non-Hispanic Koreans (N=106) | Low Income (N=392) | Overall (N=1644) | Convenience (N=374) | Region | | SOURCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Bergen County | State of NJ | |
| **General Access** | Received all needed health services in past 12 mos. (B18)<br>Did not receive all needed services<br>Did not need care | 72%<br>14%<br>14% | 80%<br>6%<br>14% | 60%<br>19%<br>21% | 68%<br>16%<br>16% | 58%<br>23%<br>19% | 40%<br>32%<br>28% | 52%<br>30%<br>18% | 70%<br>13%<br>16% | 60%<br>24%<br>16% | N/A | N/A | N/A |
| **Primary Care** | Regular PCP or personal doctor (B6) | 85% | 90% | 75% | 84% | 78% | 55% | 71% | 83% | 72% | 88% | 86% | 2010 NJ BRFSS |
| | Routine check-up in the past 12 mos. (B10) | 72% | 66% | 63% | 81% | 72% | 45% | 60% | 68% | 69% | 74% | 76% | 2010 NJ BRFSS |
| | Traveled less than 20 miles for Primary Care Services (B11) | 97% | 98% | 94% | 96% | 96% | 93% | 94% | 96% | 94% | N/A | N/A | N/A |
| | Adults 18-64 currently insured (B3) | 80% | 98% | 76% | 76% | 71% | 62% | 68% | 83% | 30% | 82% | 82% | 2010 NJ BRFSS |
| | Any time in the past 12 months that respondent didn't have any health insurance (B1) | 19% | 6% | 20% | 26% | 29% | 30% | 34% | 16% | 38% | N/A | N/A | N/A |
| **Dental Care** | Dental insurance (B23) | 56% | 68% | 53% | 62% | 52% | 36% | 33% | 58% | 46% | N/A | N/A | N/A |
| | Dental care in last 12 mos. (B24) | 58% | 80% | 56% | 50% | 49% | 43% | 39% | 63% | 50% | 79% | 74% | 2010 NJ BRFSS |
| | **Among those that didn't get dental care…*<br>Top 3 reasons didn't receive dental care (B25):<br>Cost<br>No insurance<br>No reason to go/no problems<br>No doctor/provider | <br><br><br>37%<br>44%<br>30% | <br><br><br>33%<br>23%<br>37% | <br><br><br>41%<br>45%<br>33% | <br><br><br>38%<br>47%<br>28% | <br><br><br>41%<br>54%<br>20% | <br><br><br>46%<br>57%<br>32% | <br><br><br>60%<br>72%<br>14% | <br><br><br>37%<br>42%<br>32% | <br><br><br>37%<br>58%<br>18% | N/A | N/A | N/A |

*Data for this variable represents subset of survey respondents.

| Area | Description | Central Bergen/ Northern Valley (N=431) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=384) | Non-Hispanic African-Americans (N=136) | Hispanics (N=103) | Non-Hispanic Koreans (N=106) | Low Income (N=392) | Overall (N=1644) | Convenience (N=374) | Region | | SOURCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Bergen County | State of NJ | |
| **Prescriptions** | Prescription coverage (B5) | 90% | 95% | 89% | 90% | 83% | 87% | 79% | 91% | 84% | N/A | N/A | N/A |
| | Couldn't get prescription in past 12 mos. because of cost (B22) | 22% | 10% | 20% | 31% | 30% | 17% | 31% | 19% | 34% | N/A | N/A | N/A |
| **Specialty Care** | Specialty care utilization in the past 12 mos. (B13) | 56% | 67% | 49% | 48% | 51% | 34% | 47% | 57% | 49% | N/A | N/A | N/A |
| | Traveled less than 20 miles for Specialty Care Services (B15) | 95% | 91% | 94% | 94% | 93% | 96% | 95% | 94% | 93% | N/A | N/A | N/A |
| **Hospital Care** | Overnight hospital stay in the past 12 mos. (B16) | 13% | 8% | 13% | 15% | 10% | 11% | 17% | 12% | 16% | N/A | N/A | N/A |
| | ER Utilization in the past 12 mos. (B12) | 26% | 23% | 23% | 36% | 28% | 16% | 35% | 24% | 38% | N/A | N/A | N/A |
| **Barriers to Care*** | *Among those that didn't get all services…*<br>Top 3 reasons didn't receive all services (B19):<br>Cost<br>No insurance<br>Wait time too long<br>No doctor/provider<br>Other reason | 53%<br>68%<br>--<br>--<br>15% | 64%<br>27%<br>--<br>--<br>27% | 57%<br>53%<br>11%<br>11%<br>-- | 52%<br>66%<br>--<br>--<br>29% | 51%<br>59%<br>--<br>--<br>19% | 59%<br>60%<br>14%<br>--<br>-- | 54%<br>64%<br>--<br>--<br>12% | 56%<br>58%<br>--<br>--<br>14% | 45%<br>59%<br>--<br>13%<br>-- | N/A | N/A | N/A |

*Data for this variable represents subset of survey respondents.

**Table 4: Preventive care: Bergen County household survey sample (N=1644) and convenience sample (N=374) compared to Bergen County and NJ state data.**
Reporting ***weighted*** survey data for the Bergen County household survey sample.

| Preventive Care* | Central Bergen/ Northern Valley (N=431) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=384) | Non-Hispanic African-Americans (N=136) | Hispanics (N=103) | Non-Hispanic Koreans (N=106) | Low Income (N=392) | Overall (N=1644) | Convenience (N=374) | Region | | SOURCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Bergen County | State of NJ | |
| ***Among women ≥40 years of age*** | | | | | | | | | | | | |
| **Ever had mammogram (D28)** | 88% | 94% | 81% | 86% | 86% | 74% | 80% | 88% | 94% | 68% | 71% | 2010 New Jersey BRFSS |
| **Mammogram in past 2 years (D29)** | 65% | 79% | 61% | 64% | 67% | 44% | 52% | 68% | 79% | | | |
| ***Among men ≥40 years of age*** | | | | | | | | | | | | |
| **Ever had PSA (D33)** | 73% | 68% | 55% | 89% | 66% | 38% | 48% | 67% | 44% | 59% | 54% | 2010 New Jersey BRFSS |
| **PSA in past 2 years (D34)** | 62% | 58% | 44% | 79% | 52% | 31% | 38% | 56% | 38% | | | |
| ***Among men and women ≥50 years of age*** | | | | | | | | | | | | |
| **Ever had sigmoidoscopy/ colonoscopy (D26)** | 64% | 71% | 58% | 66% | 55% | 36% | 48% | 65% | 56% | 65% | 64% | 2010 New Jersey BRFSS |
| ***Among women ≥18 years of age*** | | | | | | | | | | | | |
| **Ever had Pap test (D31)** | 88% | 96% | 85% | 92% | 92% | 58% | 82% | 89% | 82% | 80% | 82% | 2010 New Jersey BRFSS |
| **Pap in past 3 years (D32)** | 75% | 86% | 72% | 75% | 84% | 47% | 65% | 77% | 72% | | | |

*Data for this variable represents subset of survey respondents.

**Table 5: Chronic Disease: Bergen County household survey sample (N=1644) and convenience sample (N=374) compared to Bergen County and NJ state data.**
Reporting ***weighted*** survey data for the Bergen County household survey sample.

| Chronic Disease | Central Bergen/ Northern Valley (N=639) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=521) | Non-Hispanic African-Americans (N=133) | Hispanics (N=182) | Non-Hispanic Koreans (N=128) | Low Income (N=392) | Overall (N=1644) | Convenience Sample Survey (N=374) | Region | | SOURCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Bergen County | State of NJ | |
| **Ever told had diabetes – adult (D1)** | 12% | 7% | 7% | 16% | 10% | 12% | 14% | 10% | 8% | 6% | 9% | 2010 New Jersey BRFSS |
| **Ever told asthma – adult (D8)** | 11% | 12% | 9% | 18% | 10% | 1% | 11% | 11% | 14% | 13% | 13% | 2010 New Jersey BRFSS |
| ***Among those with asthma...* ER in past 12 months for asthma (D10)** | 16% | 3% | 11% | 18% | 0% | 31% | 10% | 11% | 35% | N/A | N/A | N/A |
| **Ever told had high blood pressure/hypertension (D11)** | 32% | 25% | 23% | 46% | 20% | 20% | 32% | 28% | 22% | 28% | 28% | 2009 New Jersey BRFSS |
| ***Among those with hypertension...* Taking Rx for Hypertension (D12)** | 85% | 88% | 90% | 81% | 84% | 93% | 80% | 87% | 75% | 80% | 81% | 2009 New Jersey BRFSS |
| **Ever had blood cholesterol checked (D13)** | 89% | 96% | 87% | 83% | 85% | 89% | 83% | 90% | 76% | 89% | 85% | 2009 New Jersey BRFSS |
| ***Among those with cholesterol ever checked...* Ever told had High Cholesterol (D14)** | 37% | 37% | 33% | 38% | 32% | 23% | 34% | 36% | 33% | 40% | 37% | 2009 New Jersey BRFSS |
| ***Among those with high cholesterol...* Taking Rx to lower cholesterol (D15)** | 62% | 61% | 56% | 58% | 51% | 42% | 44% | 60% | 44% | N/A | N/A | N/A |
| **Ever told had cancer (D22)** | 9% | 12% | 7% | 7% | 2% | 5% | 6% | 9% | 6% | N/A | N/A | N/A |
| **Ever told had angina or coronary heart disease (D18)** | 4% | 4% | 4% | 5% | 0% | 1% | 5% | 4% | 4% | 4% | 4% | 2010 New Jersey BRFSS |

*Data for this variable represents subset of survey respondents.

**Table 6: Health behavior data: Bergen County household survey sample (N=1644) and convenience sample (N=374) compared to Bergen County and NJ state data.**
Reporting ***weighted*** survey data for the Bergen County household survey sample.

| Behavior | Description | Central Bergen/ Northern Valley (N=639) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=521) | Non-Hispanic African-Americans (N=133) | Hispanics (N=182) | Non-Hispanic Koreans (N=128) | Low Income (N=392) | Overall (N=1644) | Convenience Sample Survey (N=374) | Region | | SOURCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Bergen County | State of NJ | |
| **Weight** | % Overweight (BMI) (C1/C2) | 35% | 37% | 37% | 33% | 37% | 27% | 34% | 36% | 39% | 31% | 35% | 2010 NJ BRFSS |
| | % Obese (BMI) (C1/C2) | 25% | 19% | 20% | 32% | 28% | 8% | 26% | 22% | 24% | 22% | 23% | |
| | Overweight or Obese (C1/C2) | 60% | 56% | 57% | 65% | 65% | 35% | 60% | 58% | 63% | 53% | 58% | |
| **Exercise** | Met physical activity guidelines (C3-C8) | 27% | 34% | 26% | 33% | 27% | 22% | 20% | 29% | 32% | 45% | 44% | 2009 NJ BRFSS |
| | Participated in any physical activities or exercises, other than regular job, in past month (C9) | 66% | 81% | 68% | 72% | 63% | 67% | 59% | 70% | 58% | 79% | 73% | 2010 NJ BRFSS |
| **Nutrition** | 5 or more fruits and vegetables, excluding juices on average per day (C10-C14) | 59% | 55% | 62% | 67% | 69% | 65% | 61% | 59% | 71% | 14% | 14% | 2011 NJ BRFSS |
| | 1+ servings of fruit on average per day (C10) | 91% | 90% | 88% | 88% | 92% | 90% | 88% | 90% | 90% | N/A | N/A | N/A |
| | 1+ servings of beans on average per day (C11) | 57% | 46% | 60% | 65% | 83% | 68% | 63% | 55% | 73% | N/A | N/A | N/A |
| | 1+ servings of green vegetables on average per day (C12) | 87% | 90% | 87% | 91% | 89% | 89% | 86% | 87% | 88% | N/A | N/A | N/A |
| | 1+ servings of orange-colored vegetables on average per day (C13) | 61% | 54% | 66% | 69% | 65% | 70% | 69% | 61% | 75% | N/A | N/A | N/A |
| | 1+ servings of other vegetables on average per day (C14) | 92% | 92% | 92% | 88% | 92% | 91% | 90% | 92% | 92% | N/A | N/A | N/A |
| | No regular soda or sweetened fruit drinks on an average day (C15) | 63% | 83% | 73% | 44% | 53% | 72% | 55% | 70% | 48% | N/A | N/A | N/A |

*Data for this variable represents subset of survey respondents.

| Behavior | Description | Central Bergen/ Northern Valley (N=639) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=521) | Non-Hispanic African-Americans (N=133) | Hispanics (N=182) | Non-Hispanic Koreans (N=128) | Low Income (N=392) | Overall (N=1644) | Convenience Sample Survey (N=374) | Region | | SOURCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | Bergen County | State of NJ | |
| **Tobacco** | Former smoker (C17) | 22% | 34% | 27% | 18% | 17% | 31% | 19% | 26% | 13% | N/A | N/A | N/A |
| | Never smoker (C16) | 64% | 57% | 62% | 66% | 72% | 55% | 64% | 62% | 70% | N/A | N/A | N/A |
| | Current Smoker (C17) | 14% | 9% | 12% | 16% | 11% | 14% | 17% | 12% | 16% | 16% | 14% | 2010 NJ BRFSS |
| | *Among current smokers... Consider quitting smoking in next 6 mos.(C19) | 75% | 75% | 74% | 84% | 96% | 68% | 69% | 74% | 78% | N/A | N/A | N/A |
| **Alcohol** | Excessive drinker (C21-25) | 22% | 28% | 23% | 19% | 27% | 24% | 22% | 24% | 25% | N/A | N/A | N/A |
| | Heavy drinker (C21-25) | 8% | 7% | 7% | 6% | 8% | 4% | 7% | 7% | 5% | 7% | 4% | 2010 NJ BRFSS |
| | Binge drinker (C21-25) | 21% | 26% | 22% | 18% | 26% | 24% | 21% | 22% | 24% | 17% | 13% | |
| **Drug Use in Past 12 months** | Marijuana (C26) | 5% | 5% | 6% | 5% | 4% | 3% | 3% | 5% | 6% | N/A | N/A | N/A |
| | Cocaine (C27) | <1% | 0% | 0% | 0% | 0% | 0% | <1% | <1% | <1% | N/A | N/A | N/A |
| | Heroin (C28) | <1% | 0% | 0% | 0% | 0% | 0% | <1% | <1% | 1% | N/A | N/A | N/A |
| | Legal drugs used on own (C30) | 9% | 7% | 9% | 11% | 8% | 5% | 9% | 9% | 15% | N/A | N/A | N/A |
| **Gambling in Past 12 months** | Gambled in the past 12 months (C34) | 16% | 16% | 15% | 14% | 13% | 17% | 8% | 16% | 11% | N/A | N/A | N/A |
| | *Among gamblers in past year: Restless/irritable/anxious when trying to cut down on gambling (C35) | 4% | 1% | 3% | 5% | 0% | 6% | 2% | 3% | 11% | N/A | N/A | N/A |
| | *Among gamblers in past year: Tried to keep family/friends from knowing how much gambled (C36) | 3% | 3% | 6% | 0% | 0% | 10% | 11% | 4% | 22% | N/A | N/A | N/A |
| | *Among gamblers in past yr: Got help from family/friends /welfare due to financial trouble from gambling (C37) | 2% | 0% | 2% | 0% | 0% | 6% | 0% | 1% | 8% | N/A | N/A | N/A |
| **Injury Prevention** | Drove within 2 hours of drinking or using illegal drugs in past month (C31) | 9% | 25% | 11% | 6% | 7% | 8% | 5% | 14% | 6% | N/A | N/A | N/A |
| | In car with driver DUI (C32) | 9% | 22% | 11% | 8% | 8% | 6% | 5% | 13% | 8% | N/A | N/A | N/A |
| | Adult seat belt use – always (C33) | 95% | 93% | 96% | 97% | 96% | 98% | 93% | 94% | 6% | 87% | 86% | 2010 NJ BRFSS |

*Data for this variable represents subset of survey respondents.

**Table 7: Self-reported health status (physical and mental): Bergen County household survey sample (N=1644) and convenience sample (N=374) compared to Bergen County and NJ state data.** Reporting ***weighted*** survey data for Bergen County household survey sample.

| General Health Status | Central Bergen/ Northern Valley (N=639) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=521) | Non-Hispanic African-Americans (N=133) | Hispanics (N=182) | Non-Hispanic Koreans (N=128) | Low Income (N=392) | Overall (N=1644) | Convenience Sample Survey (N=374) | Region | | SOURCE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Bergen County | State of NJ | |
| **% reporting fair/poor health (E1)** | 14% | 7% | 16% | 24% | 12% | 24% | 26% | 13% | 16% | 13% | 15% | 2010 New Jersey BRFSS |
| **Average days in poor physical health in past 30 days (E4)** | 3 days | 2 days | 3 days | 3 days | 3 days | 3 days | 4 days | 3 days | 3 days | 3 days | 3 days | 2010 New Jersey BRFSS |
| **% people with ≥ 15 days in poor physical health (E4)** | 8% | 4% | 7% | 9% | 8% | 6% | 12% | 7% | 9% | 6% | 9% | 2010 New Jersey BRFSS |
| **Average days in poor mental health in 30 days (E5)** | 3 days | 2 days | 3 days | 3 days | 3 days | 4 days | 4 days | 3 days | 4 days | 3 days | 3 days | 2010 New Jersey BRFSS |
| **% people with ≥ 15 days in poor mental health (E5)** | 8% | 6% | 8% | 8% | 8% | 12% | 12% | 7% | 10% | 10% | 10% | 2010 New Jersey BRFSS |
| **% people with ≥ 15 days sad or blue (E6)** | 6% | 5% | 7% | 6% | 7% | 6% | 10% | 6% | 10% | N/A | N/A | N/A |
| **% people with ≥ 15 days tense or anxious (E7)** | 13% | 10% | 14% | 12% | 15% | 17% | 17% | 13% | 13% | N/A | N/A | N/A |
| **% people with ≥ 15 days felt healthy/full of energy (E9)** | 64% | 65% | 56% | 61% | 63% | 50% | 56% | 62% | 55% | N/A | N/A | N/A |
| **% limited in any way in any activities by physical, mental or emotional problems (E2)** | 20% | 17% | 17% | 24% | 15% | 13% | 27% | 18% | 17% | 17% | 15% | 2010 New Jersey BRFSS |

*Data for this variable represents subset of survey respondents.

**Table 8: Ranking of ten most important factors to healthy community[1]: Bergen County household survey sample (N=1644) and convenience sample (N=374).**
Reporting ***weighted*** survey data for Bergen County household survey sample.

| Most important factors to healthy community (H1) | Central Bergen/ Northern Valley (N=639) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=521) | Non-Hispanic African-Americans (N=133) | Hispanics (N=182) | Non-Hispanic Koreans (N=128) | Low income (N=392) | Convenience Sample Survey (N=374) | Overall (N=1644) |
|---|---|---|---|---|---|---|---|---|---|
| **Low crime/safe neighborhoods** | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 |
| **Good place to raise children** | 2 | 2 | 2 | 2 | 3 | 2 | 2 | 1 | 2 |
| **Access to health care** | 3 | 4 | 3 | 3 | 4 | 5 | 3 | 4 | 3 |
| **Good schools** | 4 | 3 | 5 | 8 | 2 | 9 | 4 | 3 | 4 |
| **Clean environment** | 5 | 5 | 4 | 4 | 5 | 3 | 5 | 5 | 5 |
| **Good jobs/healthy economy** | 6 | 6 | 6 | 5 | 7 | 4 | 6 | 6 | 6 |
| **Strong family life** | 7 | 7 | 7 | | 6 | 7 | 8 | 7 | 7 |
| **Healthy behaviors/lifestyle** | 8 | 8 | 8 | 7 | 8 | 6 | 10 | 8 | 8 |
| **Good place to grow old** | 10 | 9 | 9 | 10 | | 8 | 9 | 10 | 9 |
| **Affordable housing** | 9 | | | 6 | 10 | | 7 | 9 | 10 |
| **Community organizations** | | | | 9 | | 10 | | | |
| **Parks/recreation areas** | | 10 | 10 | | 9 | | | | |

[1] *Out of 18 possible options*

*Data for this variable represents subset of survey respondents.

**Table 9: Ranking of ten most significant health conditions/concerns affecting your community[2]: Bergen County household survey sample (N=1644) and convenience sample (N=374).**
Reporting ***weighted*** survey data for Bergen County household survey sample.

| Most significant health concerns (H2) | Central Bergen/ Northern Valley (N=639) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=521) | Non-Hispanic African-Americans (N=133) | Hispanics (N=182) | Non-Hispanic Koreans (N=128) | Low Income (N=392) | Convenience Sample Survey (N=374) | Overall (N=1644) |
|---|---|---|---|---|---|---|---|---|---|
| **Obesity/overweight** | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 1 |
| **Lack of exercise** | 3 | 3 | 2 | 4 | 5 | 4 | 6 | 2 | 2 |
| **Cancer** | 2 | 2 | 5 | 7 | 4 | 10 | 4 | 3 | 3 |
| **Heart disease/heart attacks** | 6 | 4 | 6 | 5 | | 9 | 8 | | 4 |
| **Lack of access to health care** | 5 | | 3 | 3 | 3 | 2 | 1 | 4 | 5 |
| **Diabetes** | 4 | 7 | 7 | 2 | 2 | 7 | 3 | 5 | 6 |
| **Tobacco use** | 8 | 9 | 4 | | 6 | 6 | 7 | 7 | 7 |
| **Mental health issues** | 9 | 6 | 8 | 9 | 9 | 3 | 9 | 9 | 8 |
| **Substance abuse issues** | 7 | 5 | 10 | 6 | 7 | | 5 | 6 | 9 |
| **Poor nutrition** | 10 | 8 | | 10 | 10 | | | 10 | 10 |
| **Lack of preventive services** | | | 9 | 8 | 8 | 5 | 10 | 8 | |
| **Motor vehicle accidents** | | | | | | 8 | | | |
| **Autism** | | 10 | | | | | | | |

[2] *Out of 28 possible options*

*Data for this variable represents subset of survey respondents.

**Table 10: Ranking of ten behaviors/lifestyle issues that put community's health at risk[3]: Bergen County household survey sample (N=1644) and Convenience sample (N=374).**
Reporting ***weighted*** survey data for Bergen County household survey sample.

| Behaviors/lifestyle issues that put community's health at risk (H3) | Central Bergen/ Northern Valley (N=639) | Northwest Bergen/ Pascack Valley (N=484) | Southeast/ Southwest Bergen (N=521) | Non-Hispanic African-Americans (N=133) | Hispanics (N=182) | Non-Hispanic Koreans (N=128) | Low Income (N=392) | Convenience Sample Survey (N=374) | Overall (N=1644) |
|---|---|---|---|---|---|---|---|---|---|
| **Lack of physical activity/exercise** | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 2 | 1 |
| **Poor eating habits/nutrition** | 2 | 2 | 2 | 1 | 1 | 2 | 1 | 1 | 2 |
| **Risky driving** | 3 | 3 | 3 | 4 | 4 | 4 | 4 | 8 | 3 |
| **Drinking and driving** | 6 | 4 | 4 | 7 | 8 | 3 | 3 | 3 | 4 |
| **Not going to the doctor for yearly check ups** | 5 | 9 | 5 | 3 | 3 | 5 | 5 | 10 | 5 |
| **Illegal drug use/substance abuse** | 4 | 8 | 7 | 5 | 5 | 8 | 6 | 4 | 6 |
| **Adult tobacco use** | 9 | 10 | 6 | | 7 | 7 | 10 | 5 | 7 |
| **Youth illegal drug use/substance abuse** | 8 | 5 | 10 | 9 | 6 | | 7 | 9 | 8 |
| **Bullying in schools** | 10 | 6 | | 8 | 9 | 10 | 9 | 6 | 9 |
| **Depression** | 7 | | 9 | | 10 | 6 | 8 | 7 | 10 |
| **Adult alcohol abuse** | | | | | | 9 | | | |
| **Not going to the dentist for cleanings/care** | | | | 10 | | | | | |
| **Underage drinking** | | 7 | 8 | | | | | | |
| **Unsafe sex** | | | | 6 | | | | | |

[3] *Out of 24 possible options*

*Data for this variable represents subset of survey respondents.

Appendix 2

# KEY DEMOGRAPHIC AND SOCIO-ECONOMIC VARIABLES FOR BERGEN COUNTY AND ITS CITIES, TOWNS, AND BOROUGHS

# BERGEN COUNTY SOCIAL DEMOGRAPHICS

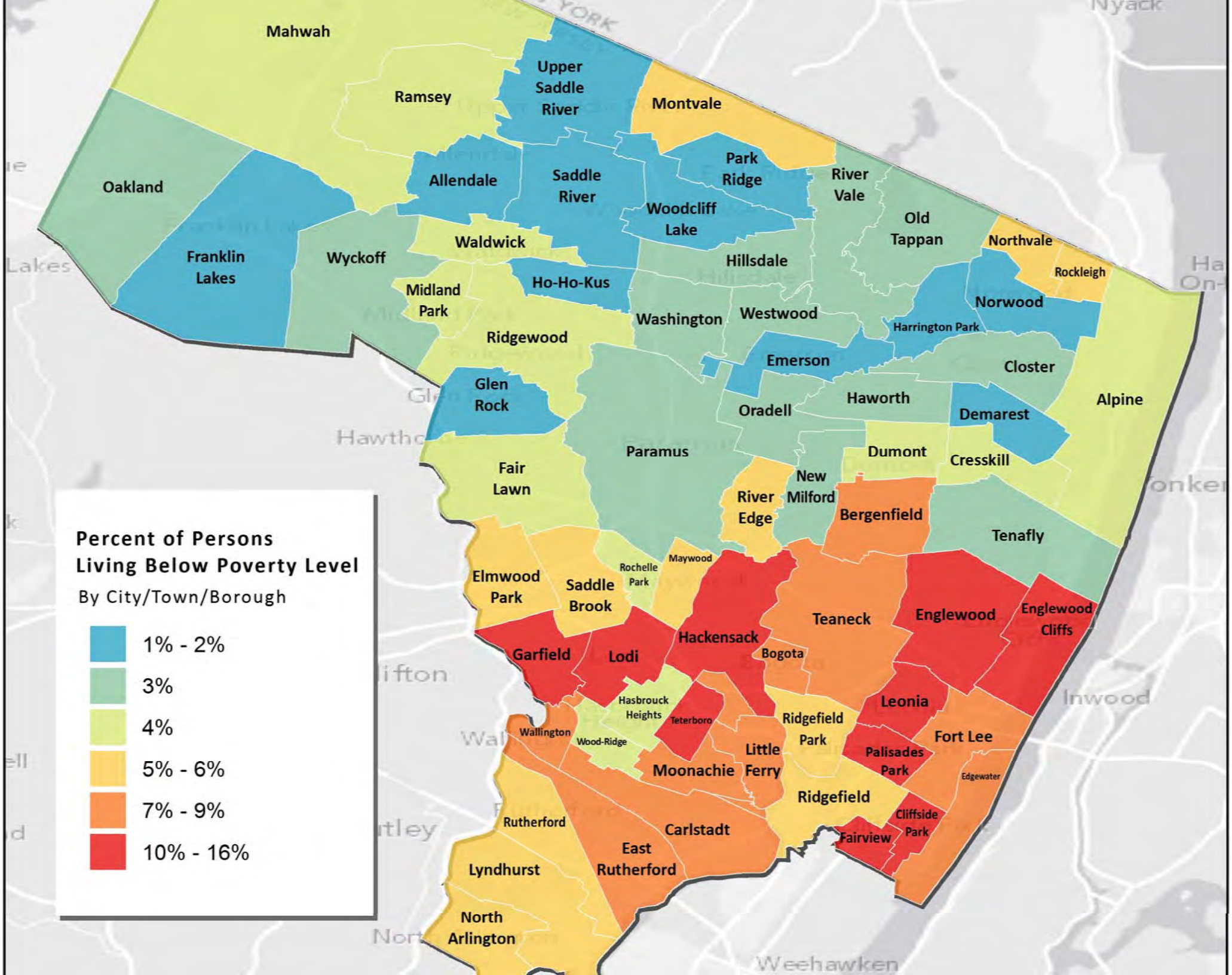
| | Total Population | Ages 0-19 | Ages 20-64 | Ages 65+ | % Non-Hispanic White | % Hispanic | Median Household Income |
|---|---|---|---|---|---|---|---|
| Bergen County | 905,116 | 24.8% | 60.1% | 15.1% | 83.9% | 16.1% | $83,443 |
| Allendale | 6,505 | 30.7% | 54.8% | 14.5% | 95.3% | 4.7% | $126,804 |
| Alpine | 1,849 | 24.5% | 56.4% | 19.1% | 95.2% | 4.8% | $178,889 |
| Bergenfield | 26,764 | 26.5% | 60.5% | 13.0% | 73.5% | 26.5% | $86,191 |
| Bogota | 8,187 | 26.6% | 61.8% | 11.7% | 61.3% | 38.7% | $75,598 |
| Carlstadt | 6,127 | 22.6% | 62.0% | 15.3% | 82.0% | 18.0% | $67,500 |
| Cliffside Park | 23,594 | 19.0% | 63.5% | 17.5% | 71.6% | 28.4% | $68,780 |
| Closter | 8,373 | 29.0% | 57.5% | 13.5% | 94.0% | 6.0% | $119,485 |
| Cresskill | 8,573 | 28.8% | 53.8% | 17.4% | 93.7% | 6.3% | $104,386 |
| Demarest | 4,881 | 29.8% | 55.8% | 14.4% | 95.6% | 4.4% | $138,789 |
| Dumont | 17,479 | 24.8% | 59.7% | 15.5% | 85.2% | 14.8% | $84,682 |
| East Rutherford | 8,913 | 20.2% | 66.3% | 13.5% | 82.5% | 17.5% | $65,813 |
| Edgewater | 11,513 | 18.6% | 69.7% | 11.6% | 88.9% | 11.1% | $91,554 |
| Elmwood Park | 19,403 | 23.2% | 62.1% | 14.7% | 78.8% | 21.2% | $69,480 |
| Emerson | 7,401 | 25.5% | 54.6% | 19.8% | 91.6% | 8.4% | $106,464 |
| Englewood City | 27,147 | 24.4% | 61.4% | 14.2% | 72.5% | 27.5% | $68,253 |
| Englewood Cliffs | 5,281 | 22.9% | 53.0% | 24.1% | 94.0% | 6.0% | $116,563 |
| Fair Lawn | 32,457 | 24.0% | 59.6% | 16.3% | 89.8% | 10.2% | $95,725 |
| Fairview | 13,835 | 22.1% | 65.9% | 12.0% | 45.4% | 54.6% | $45,672 |
| Fort Lee | 35,345 | 18.4% | 59.8% | 21.8% | 89.0% | 11.0% | $69,911 |
| Franklin Lakes | 10,590 | 29.5% | 54.1% | 16.4% | 95.0% | 5.0% | $147,885 |
| Garfield City | 30,487 | 25.8% | 63.0% | 11.2% | 67.8% | 32.2% | $51,233 |
| Glen Rock | 11,601 | 32.0% | 55.1% | 12.9% | 95.5% | 4.5% | $147,230 |
| Hackensack City | 43,010 | 20.6% | 67.0% | 12.4% | 64.7% | 35.3% | $57,820 |
| Harrington Park | 4,664 | 29.7% | 55.4% | 14.9% | 96.5% | 3.5% | $112,171 |
| Hasbrouck Heights | 11,842 | 24.2% | 60.8% | 15.0% | 85.1% | 14.9% | $94,537 |
| Haworth | 3,382 | 30.1% | 54.6% | 15.3% | 95.6% | 4.4% | $131,058 |
| Hillsdale | 10,219 | 28.6% | 56.6% | 14.8% | 92.2% | 7.8% | $120,919 |
| Hohokus | 4,078 | 30.8% | 53.3% | 16.0% | 95.9% | 4.1% | $161,761 |
| Leonia | 8,937 | 24.3% | 60.6% | 15.1% | 83.3% | 16.7% | $68,260 |
| Little Ferry | 10,626 | 21.7% | 65.2% | 13.2% | 77.0% | 23.0% | $56,792 |
| Lodi | 24,136 | 23.4% | 63.5% | 13.1% | 69.5% | 30.5% | $55,565 |
| Lyndhurst | 20,554 | 21.0% | 63.4% | 15.7% | 81.7% | 18.3% | $71,369 |
| Mahwah | 25,890 | 25.8% | 60.0% | 14.2% | 93.7% | 6.3% | $93,936 |
| Maywood | 9,555 | 22.7% | 61.6% | 15.7% | 81.3% | 18.7% | $81,875 |
| Midland Park | 7,128 | 26.0% | 58.0% | 16.0% | 93.4% | 6.6% | $81,294 |
| Montvale | 7,844 | 28.5% | 57.0% | 14.5% | 94.7% | 5.3% | $116,154 |
| Moonachie | 2,708 | 20.5% | 63.3% | 16.2% | 75.6% | 24.4% | $56,411 |
| New Milford | 16,341 | 23.0% | 61.2% | 15.8% | 86.4% | 13.6% | $74,864 |
| North Arlington | 15,392 | 19.6% | 64.1% | 16.3% | 79.1% | 20.9% | $70,777 |
| Northvale | 4,640 | 27.0% | 58.3% | 14.6% | 91.9% | 8.1% | $86,198 |
| Norwood | 5,711 | 25.2% | 54.7% | 20.0% | 95.4% | 4.6% | $96,757 |
| Oakland | 12,754 | 27.9% | 57.9% | 14.2% | 94.7% | 5.3% | $115,797 |
| Old Tappan | 5,750 | 29.4% | 54.5% | 16.1% | 95.0% | 5.0% | $120,650 |
| Oradell | 7,978 | 28.0% | 55.4% | 16.6% | 95.0% | 5.0% | $135,173 |
| Palisades Park | 19,622 | 18.4% | 70.2% | 11.4% | 81.8% | 18.2% | $62,913 |
| Paramus | 26,342 | 23.8% | 54.4% | 21.9% | 92.7% | 7.3% | $104,105 |

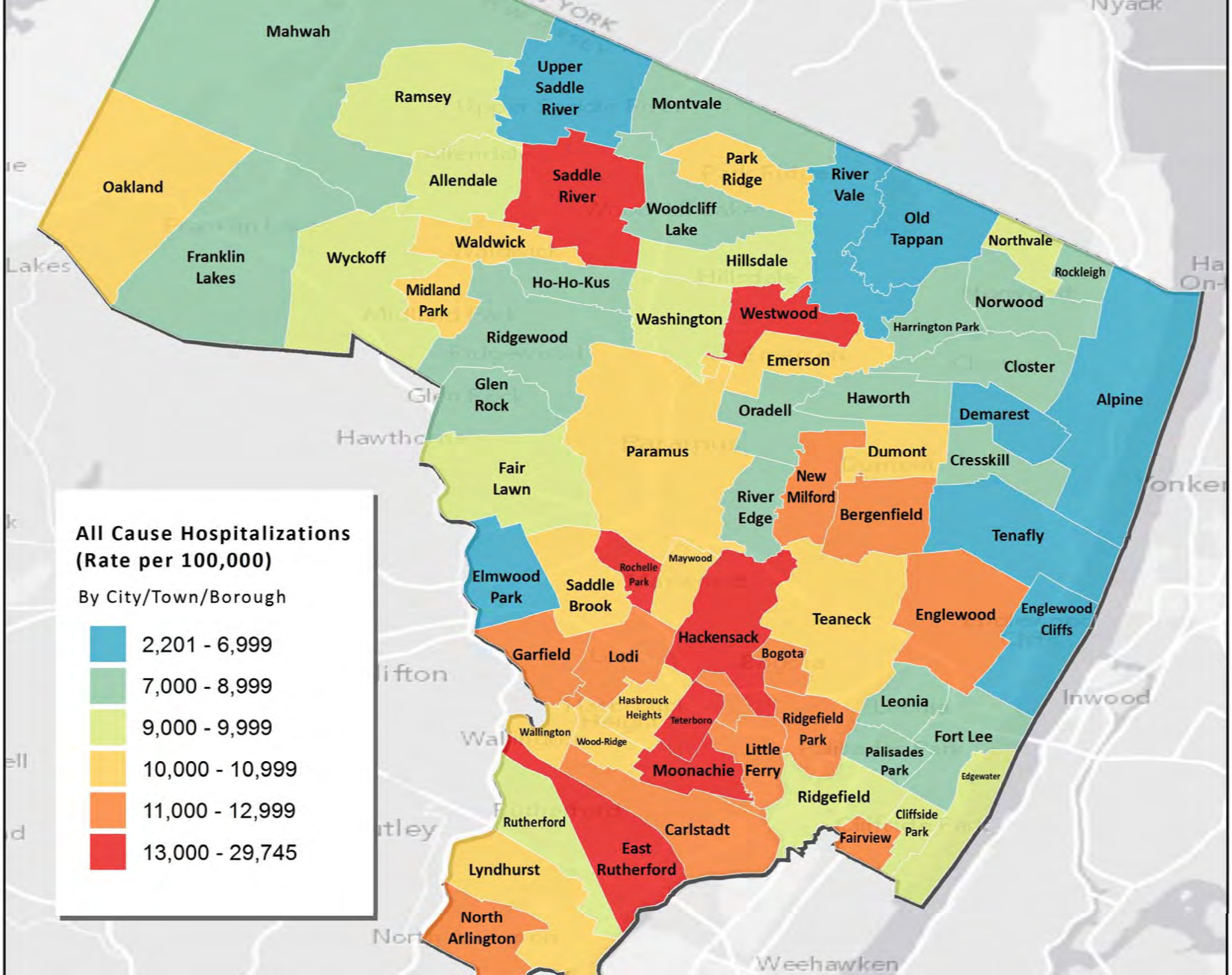
# BERGEN COUNTY SOCIAL DEMOGRAPHICS

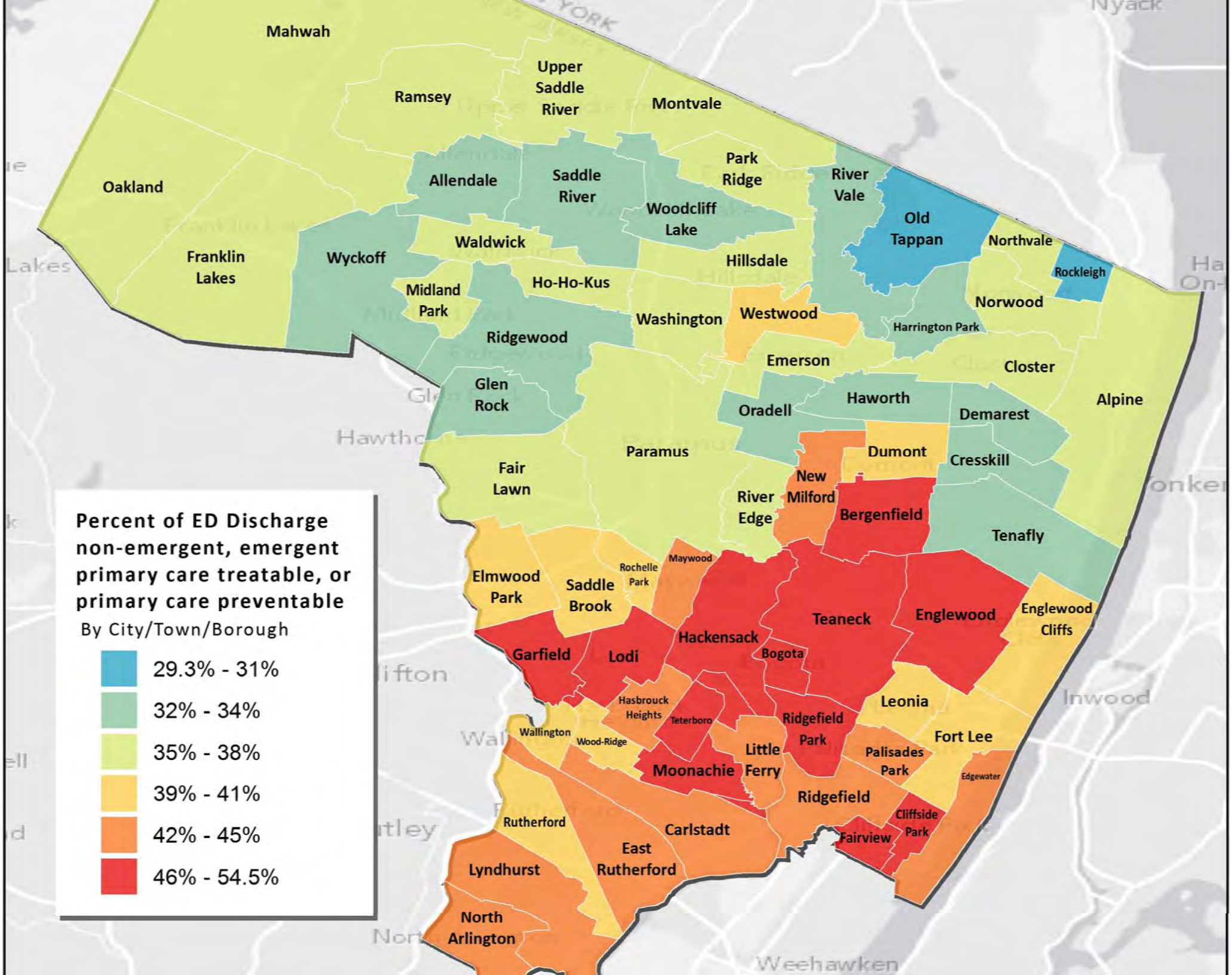
| | Total Population | Ages 0-19 | Ages 20-64 | Ages 65+ | % Non-Hispanic White | % Hispanic | Median Household Income |
|---|---|---|---|---|---|---|---|
| Park Ridge | 8,645 | 24.5% | 56.3% | 19.2% | 92.3% | 7.7% | $107,917 |
| Ramsey | 14,473 | 28.8% | 58.5% | 12.7% | 94.0% | 6.0% | $119,241 |
| Ridgefield | 11,032 | 24.1% | 61.6% | 14.3% | 78.6% | 21.4% | $58,942 |
| Ridgefield Park | 12,729 | 24.4% | 63.1% | 12.5% | 63.8% | 36.2% | $68,671 |
| Ridgewood Village | 24,958 | 32.6% | 55.0% | 12.5% | 94.7% | 5.3% | $154,348 |
| River Edge | 11,340 | 27.6% | 58.6% | 13.8% | 92.3% | 7.7% | $101,708 |
| Rivervale | 9,659 | 28.5% | 55.7% | 15.9% | 95.0% | 5.0% | $127,917 |
| Rochelle Park | 5,530 | 19.9% | 60.1% | 19.9% | 83.7% | 16.3% | $69,473 |
| Rockleigh | 531 | 17.1% | 25.8% | 57.1% | 96.2% | 3.8% | $177,708 |
| Rutherford | 18,061 | 23.7% | 62.8% | 13.5% | 85.9% | 14.1% | $83,837 |
| Saddle Brook | 13,659 | 22.0% | 61.4% | 16.5% | 87.8% | 12.2% | $78,283 |
| Saddle River | 3,152 | 22.6% | 53.0% | 24.5% | 94.9% | 5.1% | $113,125 |
| South Hackensack | 2,378 | 24.0% | 60.1% | 15.9% | 66.7% | 33.3% | $73,542 |
| Teaneck | 39,776 | 28.1% | 57.0% | 14.8% | 83.5% | 16.5% | $94,068 |
| Tenafly | 14,488 | 33.2% | 53.3% | 13.5% | 94.6% | 5.4% | $131,370 |
| Teterboro | 67 | 25.4% | 61.2% | 13.4% | 64.2% | 35.8% | $81,719 |
| Upper Saddle River | 8,208 | 32.5% | 54.4% | 13.1% | 95.7% | 4.3% | $180,429 |
| Waldwick | 9,625 | 27.0% | 58.5% | 14.5% | 91.4% | 8.6% | $100,510 |
| Wallington | 11,335 | 20.1% | 66.4% | 13.5% | 89.2% | 10.8% | $52,652 |
| Washington | 9,102 | 24.5% | 55.6% | 20.0% | 94.6% | 5.4% | $117,750 |
| Westwood | 10,908 | 23.5% | 59.9% | 16.6% | 88.4% | 11.6% | $77,451 |
| Woodcliff Lake | 5,730 | 29.8% | 53.8% | 16.4% | 94.6% | 5.4% | $125,161 |
| Wood-Ridge | 7,626 | 23.6% | 61.7% | 14.7% | 86.9% | 13.1% | $93,809 |
| Wychoff | 16,696 | 29.6% | 53.7% | 16.6% | 95.6% | 4.4% | $152,305 |

Appendix 3

# BERGEN COUNTY THEMATIC MAPS


Mahwah
Ramsey
Upper Saddle River
Montvale
Oakland
Allendale
Saddle River
Park Ridge
River Vale
Woodcliff Lake
Old Tappan
Northvale
Rockleigh
Franklin Lakes
Wyckoff
Waldwick
Hillsdale
Ho-Ho-Kus
Midland Park
Ridgewood
Washington
Westwood
Harrington Park
Norwood
Emerson
Closter
Glen Rock
Oradell
Haworth
Demarest
Alpine
Paramus
Dumont
Cresskill
Fair Lawn
River Edge
New Milford
Bergenfield
Tenafly
Elmwood Park
Saddle Brook
Rochelle Park
Maywood
Englewood
Englewood Cliffs
Teaneck
Hackensack
Garfield
Lodi
Bogota
Leonia
Hasbrouck Heights
Teterboro
Wallington
Wood-Ridge
Ridgefield Park
Fort Lee
Palisades Park
Little Ferry
Moonachie
Edgewater
Ridgefield
Cliffside Park
Rutherford
Carlstadt
Fairview
East Rutherford
Lyndhurst
North Arlington
Percent of Persons Living Below Poverty Level
By City/Town/Borough
1% - 2%
3%
4%
5% - 6%
7% - 9%
10% - 16%


All Cause Hospitalizations
(Rate per 100,000)
By City/Town/Borough
2,201 - 6,999
7,000 - 8,999
9,000 - 9,999
10,000 - 10,999
11,000 - 12,999
13,000 - 29,745
Mahwah
Upper Saddle River
Ramsey
Montvale
Oakland
Allendale
Saddle River
Park Ridge
River Vale
Old Tappan
Northvale
Rockleigh
Franklin Lakes
Wyckoff
Waldwick
Woodcliff Lake
Hillsdale
Midland Park
Ho-Ho-Kus
Washington
Westwood
Norwood
Harrington Park
Ridgewood
Emerson
Closter
Glen Rock
Oradell
Haworth
Demarest
Alpine
Paramus
Dumont
Cresskill
Fair Lawn
New Milford
River Edge
Bergenfield
Tenafly
Elmwood Park
Saddle Brook
Rochelle Park
Maywood
Teaneck
Englewood
Englewood Cliffs
Garfield
Lodi
Hackensack
Bogota
Hasbrouck Heights
Teterboro
Leonia
Wallington
Wood-Ridge
Ridgefield Park
Fort Lee
Little Ferry
Palisades Park
Moonachie
Edgewater
Ridgefield
Rutherford
Carlstadt
Cliffside Park
Fairview
East Rutherford
Lyndhurst
North Arlington


Mahwah
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Upper Saddle River
Montvale
Oakland
Allendale
Saddle River
Park Ridge
River Vale
Old Tappan
Northvale
Rockleigh
Franklin Lakes
Wyckoff
Waldwick
Woodcliff Lake
Hillsdale
Midland Park
Ho-Ho-Kus
Washington
Westwood
Norwood
Harrington Park
Ridgewood
Emerson
Closter
Glen Rock
Haworth
Oradell
Demarest
Alpine
Paramus
Dumont
Cresskill
Fair Lawn
New Milford
River Edge
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Elmwood Park
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Teaneck
Englewood
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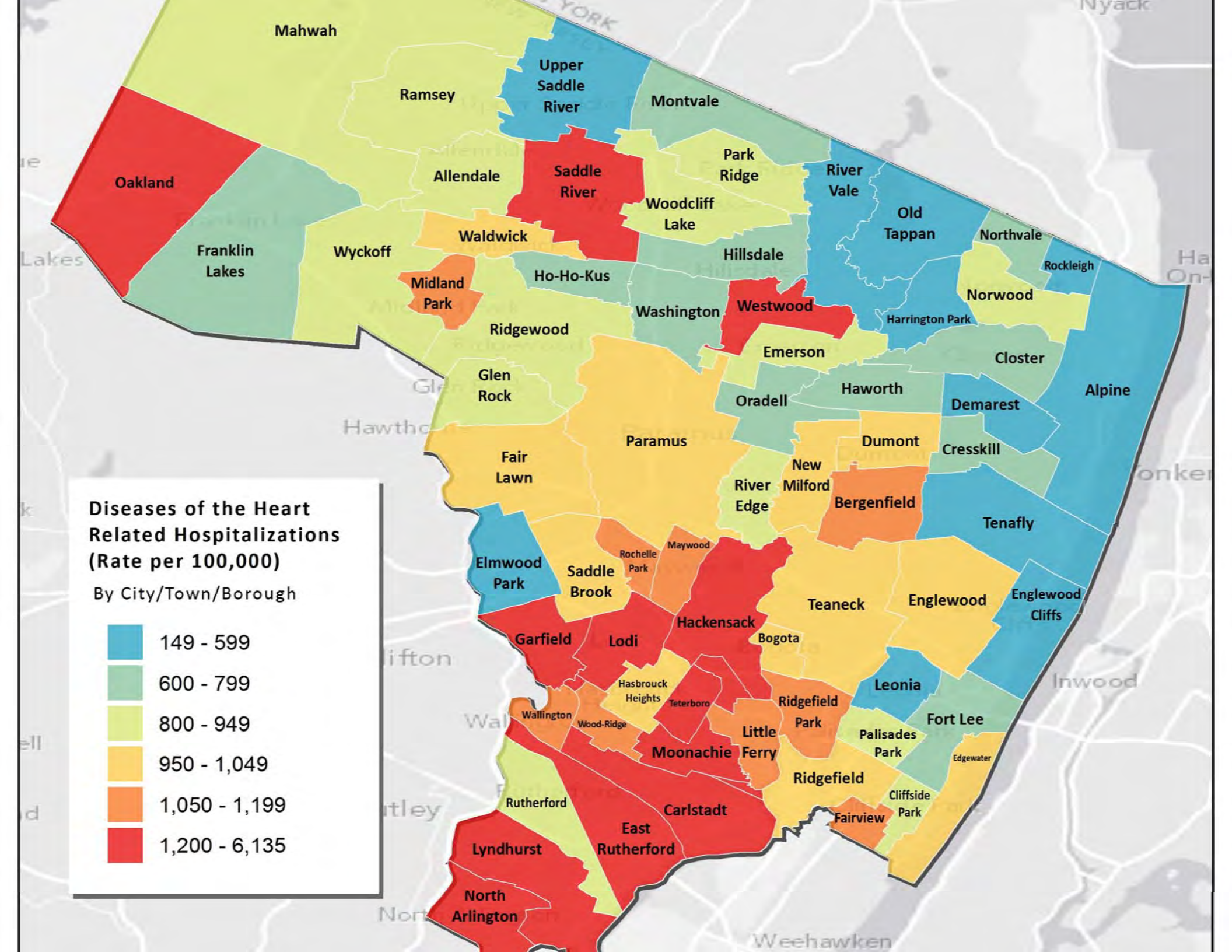
Hackensack
Bogota
Hasbrouck Heights
Teterboro
Ridgefield Park
Leonia
Wallington
Wood-Ridge
Little Ferry
Palisades Park
Fort Lee
Moonachie
Edgewater
Ridgefield
Rutherford
Carlstadt
Cliffside Park
Fairview
East Rutherford
Lyndhurst
North Arlington
Percent of ED Discharge non-emergent, emergent primary care treatable, or primary care preventable
By City/Town/Borough
29.3% - 31%
32% - 34%
35% - 38%
39% - 41%
42% - 45%
46% - 54.5%


Diseases of the Heart Related Hospitalizations (Rate per 100,000)
By City/Town/Borough
149 - 599
600 - 799
800 - 949
950 - 1,049
1,050 - 1,199
1,200 - 6,135
Mahwah
Ramsey
Upper Saddle River
Montvale
Oakland
Allendale
Saddle River
Park Ridge
River Vale
Old Tappan
Northvale
Rockleigh
Franklin Lakes
Wyckoff
Waldwick
Woodcliff Lake
Hillsdale
Ho-Ho-Kus
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Cliffside Park
Carlstadt
Fairview
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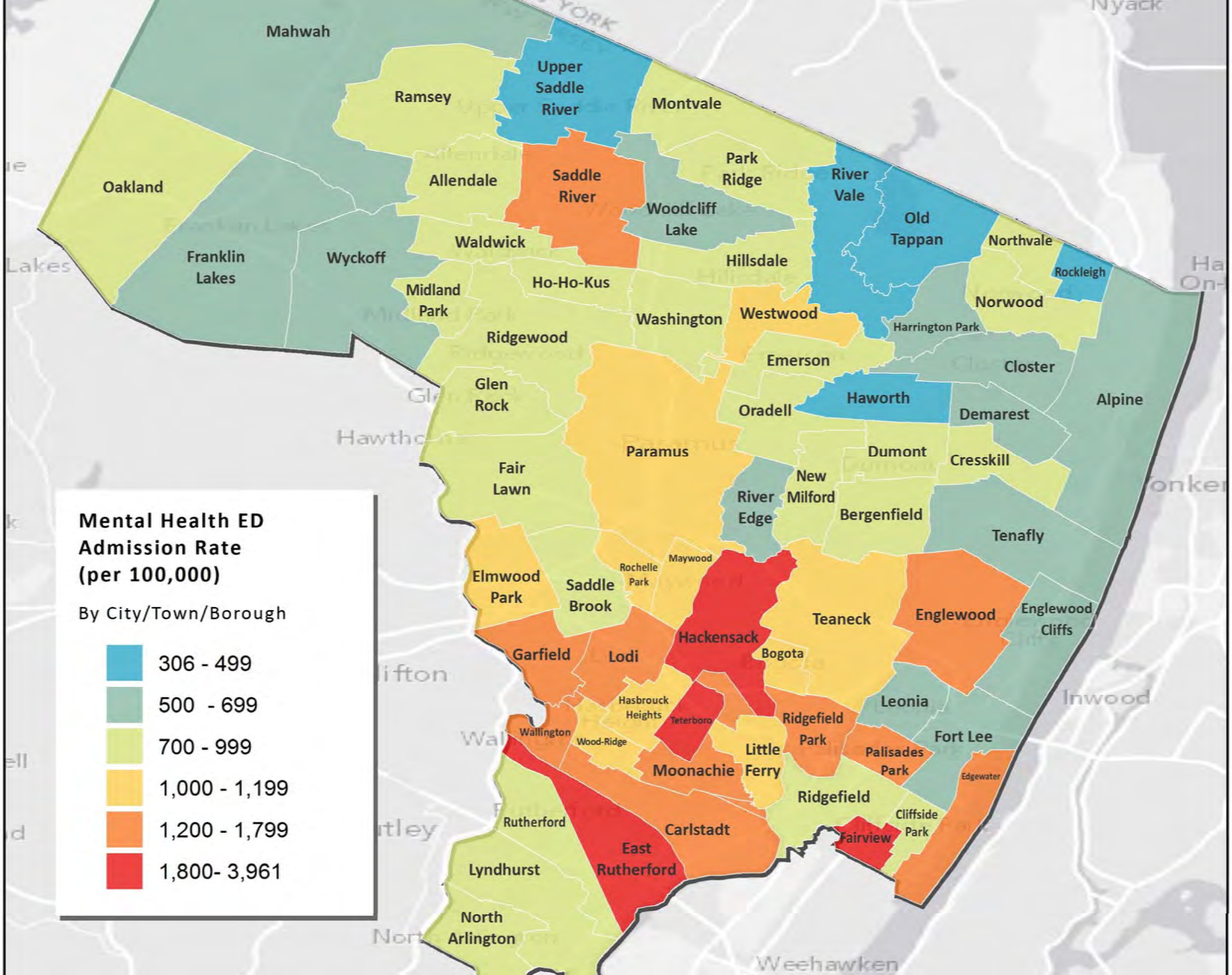
Lyndhurst
North Arlington


Mahwah
Upper Saddle River
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Rockleigh
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Wyckoff
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Midland Park
Ho-Ho-Kus
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Ridgewood
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Bogota
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Hasbrouck Heights
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Ridgefield Park
Wallington
Wood-Ridge
Fort Lee
Little Ferry
Palisades Park
Moonachie
Edgewater
Ridgefield
Cliffside Park
Rutherford
Carlstadt
Fairview
East Rutherford
Lyndhurst
North Arlington
Mental Health ED Admission Rate (per 100,000)
By City/Town/Borough
306 - 499
500 - 699
700 - 999
1,000 - 1,199
1,200 - 1,799
1,800- 3,961

Appendix 4

# FOCUS GROUP SUMMARY RESULTS

# MAJOR THEMES FROM FOCUS GROUPS

| Health Issue | Low Income / Racial Ethnic Minority | | | Young Adult | Older Adults |
|---|---|---|---|---|---|
| | Low Income African-American | Low Income Hispanic | Low Income Korean | Ramapo College Students | Discharge Planners & Care Coordinators |
| **Major Health Issues by Priority Level** | | | | | |
| Poverty / Lack of Employment/Jobs | High | High | High | Low | Low |
| General Health Awareness and Education | High | High | High | Moderate | High |
| Obesity, Fitness and Nutrition | High | High | Moderate | Moderate | Moderate |
| Tobacco Use | High | Low | Low | High | Low |
| Cardiovascular Disease and Diabetes | High | High | Low | Low | High |
| Cancer | High | Moderate | Low | Low | Moderate |
| Respiratory Disease | High | Moderate | Low | Low | High |
| Infectious Disease | Low | Low | Low | Low | Low |
| Maternal and Child Health | Low | Low | Low | Low | Low |
| Mental Health | Moderate | Moderate | Moderate | High | High |
| Substance Abuse | High | High | High | High | High |
| **Barriers to Care by Priority Level** | | | | | |
| Provider shortages / Lack of Access | Moderate | High | High | Low | Low |
| Inability to Navigate Health Care System | High | High | High | Low | Low |
| Lack of Education / Awareness | High | High | High | Moderate | Low |
| Lack of Insurance | Moderate | High | High | Low | Low |
| High Cost of Care | High | High | High | Low | High |
| Lack of Transportation | Moderate | Moderate | Moderate | Moderate | High |
| Lack of Awareness of Available Services | Moderate | Moderate | Moderate | Moderate | Moderate |
| Health Literacy | Moderate | High | High | Low | High |
| Cultural and Linguistics Barriers | Low | High | High | Low | Moderate |
| Provider Communication | Low | High | High | Low | High |
| Poor Care Coordination/Case Management | High | High | High | Low | High |
| **Other Issues by Priority Level** | | | | | |
| Lack of Access to Healthy Foods | High | High | Moderate | Low | Low |
| Lack of Access to Recreational Facilities | High | High | High | Low | Low |
| Housing Issues | High | High | Low | Low | Low |
| Access to Medication / Med. Management | High | High | High | Low | High |

Appendix 5

# KEY INFORMANT INTERVIEW SUMMARY RESULTS

# BERGEN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

## Summary of Findings from Key Informant Interviews

## Major Health and Social Service Issues

- Need to develop programs that target high rates of diabetes, high blood pressure, heart disease, and cancer
- Need to develop and/or spread programs that target obesity, poor nutrition, and lack of physical exercise for adults/children
- Need to educate and raise awareness about the most common causes of illness, risky behaviors, and key health promotion messages
- Need to raise awareness and educate the public about the signs and symptoms of mental illness and substance abuse and expand access to treatment and services

## Major Health and Social Service Issues
**(Continued)**

- Need to better coordinate services and address fragmented system of care for older adults, especially upon discharge from the hospital (Depression, anxiety, stress, ADHD/ADD, alcohol, prescription drugs, marijuana, other illicit drugs)
- Need to better manage transitions from hospitals w/ respect to medication management and primary care follow-up
- Need to better integrate health and social services in schools – teachers, nurses, counselors
- Need to expand access to oral health and medical specialty care services for low income Medicaid insured and uninsured population segments

## Populations most at-risk
(High need populations)

- Low income populations
- Racial/ethnic minorities (esp. Korean and Hispanic)
- Older adults
- Undocumented populations (esp. Hispanic/Latinos)
- Disabled adults, severely or chronically mentally ill
- Unemployed population
- Middle-aged adults in the sandwich generation

## Strengths/Weaknesses of Service System

- **Strengths**
  - Very good access to broad range of health care services for insured and those in high income brackets
  - Good collaborative relationships between health department, public schools, and many major safety net providers
- **Service gaps/shortages**
  - Mental health services for low and middle income groups
  - Oral health and medical specialty care services for low income and middle income groups who are underinsured
  - Primary care shortages and lack of continuity of care for low income populations

## Strengths/Weaknesses of Service System (Continued)

- **Barriers to access**
  - Cost/economic issues
  - Cultural and language barriers
  - Transportation
  - Lack of capacity, long wait-times, particularly for low income re: mental health, oral health, and medical specialty care services
  - Lack of coordination and fragmentation of services, particularly for older adults and ethnic/minority populations
  - Lack of awareness among vulnerable populations regarding safety-net services available

## Strengths/Weaknesses of Service System (Continued)

- High rates of chronic disease and its major risk factors
- Lack of health education / preventive services
- Limited mental health, oral health, and specialty care access for low income populations
- Elder health issues (chronic disease, mental health, isolation, fragmentation of services, etc.)

Appendix 6

# CHIP SPONSORS AND MEMBER ORGANIZATIONS

# CHIP SPONSORS AND MEMBER ORGANIZATIONS

## FOUNDERS

Bergen County Department of Health Services
Bergen County Health Officers' Society
Bergen County Public Health Partnership

## FEATURED SPONSORS

AMERIGROUP
Bergen County Cooperative Library System
HealthFirst
Holy Name Medical Center
Horizon NJ Health
United Health Care - Community Plan
Y Creative Group

## SPONSORS

Assemblywoman Connie Wagner
Bergen Community College
Bergen Regional Medical Center
Center for Alcohol and Drug Resources: Children's Aid and Family Services
Diabetes Foundation, Inc.
Fairway Market
Hackensack Health Department
HARP (Health Awareness Regional Program)
HealthBarn USA
Kaplen JCC on the Palisades
Lyndhurst Health Department
NJ FamilyCare
North Hudson Community Action Corporation
Northern NJ Maternal/Child Health Consortium
Paramus Health Department
Renaissance Meadowlands Hotel
Ridgewood YMCA
Teaneck Health Department
Whole Foods Market

## MEMBERS

American Cancer Society of Northern New Jersey
AmeriChoice
Bergen County Board of Social Services
Bergen County Community Transportation
Bergen County Executive Office
Bergen County Department of Human Services - Family Guidance
Bergen County Division of Senior Services
Bergen County Division of Community Development
Bergen County Health Care Center
Bergen County Housing, Health and Human Services Center
Bergen County Juvenile Officers Association
Bergen County Police Chiefs Association
Bergen County Prosecutor's Office
Bergen County School Nurses Association
Bergen County Student Assistance Counselors
Bergen County Workforce Investment Board
Bergen Volunteer Medical Initiative, Inc.
Bergen's Promise, Inc.
CancerCare NJ
CAPE Center of Bergen County (Collaboration Access Planning Education)
Caregivers Coalition of Bergen County
CarePlus NJ, Inc.
Citizens at Large
Comprehensive Behavioral Healthcare, Inc.
Family Support Organization
Fairleigh Dickinson University
Garfield Health Department
Hackensack University Medical Center
Meadowlands YMCA/YWCA
Montclair State University
New Jersey City University
New Jersey Department of Health and Senior Services
New Jersey Department of Human Services
Palisades Regional Academy
Ramapo College
The Valley Hospital
United Way of Bergen County
Vantage Health Systems
Volt Fitness
Youth Services Commission

## HEALTH OFFICERS

Bergen County is divided up into 13 health jurisdictions and each of the jurisdictions has an assigned Health Officer. All 13 Health Officers are members of the CHIP with many serving on the CORE Committee and on multiple Task Forces.

BERGEN COUNTY
DEPARTMENT OF HEALTH SERVICES

CHIP

Community Health
*Improvement* Partnership
OF BERGEN COUNTY

Christian
Health Care
Center

Holy Name
Medical Center

ENGLEWOOD
HOSPITAL AND MEDICAL CENTER
AN AFFILIATE OF MOUNT SINAI SCHOOL OF MEDICINE

The Valley
Hospital
Valley Health System

HackensackUMC
Where medicine meets innovation

JSI
John Snow, Inc.

BERGEN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT 2013