Holy Name Medical Center
Community Health Needs Assessment

2019

Holy Name
Medical Center

ACKNOWLEDGMENTS

EXECUTIVE SUMMARY

OVERVIEW AND PURPOSE

This Community Health Needs Assessment (CHNA) and the associated Implementation Strategy (IS) were prepared for Holy Name Medical Center. Holy Name is a comprehensive 361-bed acute care facility that provides technologically advanced, compassionate and personalized care across a continuum that encompasses education, prevention, diagnosis, treatment, rehabilitation and wellness maintenance. Holy Name has nearly 4,000 employees and admits about 30,000 patients each year. The Medical Center has a national reputation for providing culturally sensitive care to a diverse population, drawing patients from across the New York City region to its specialty centers and renowned doctors. The hospital is known as a high quality, low cost provider of extraordinary clinical care given by compassionate and highly trained physicians and staff.

In addition to its commitment to clinical excellence and respect, Holy Name is committed to being an active partner and collaborator with the communities it serves. The Medical Center acknowledges its role as a critical community resource, but also recognize the value in collaborating with community partners to identify, educate, prevent, and address issues that prevent community residents from accessing the health and social services they need. Through its community benefit programming, Holy Name strives to create and support opportunities for residents of the service area to lead healthy and productive lives.

The CHNA was conducted in collaboration with the Bergen County Department of Health Services (BCDHS), the Community Health Partnership of Bergen County (CHIP), and the other six acute care facilities in Bergen County: Bergen New Bridge Medical Center, Englewood Health, Hackensack Meridian *Health* Hackensack University Medical Center, Hackensack Meridian *Health* Pascack Valley Medical Center, Ramapo Ridge Psychiatric Hospital (part of Christian Health Care Center), and The Valley Hospital. The assessment engaged hundreds of community residents throughout Bergen County, and a range of other community stakeholders, including service providers, community advocates, state and local public officials, faith leaders, and representatives from community-based organizations. The process that was applied to conduct the CHNA and develop the Implementation Strategy exemplifies the spirit of collaboration and community engagement that is such a vital part of Holy Name Medical Center's mission.

This CHNA provides information that will be used to ensure that Holy Name Medical Center's community health programs are appropriately focused and are delivered in ways that are responsive to the needs of those in its primary service area. The assessment also allows Holy Name, as a non-profit entity, to fulfill federal Community Benefits requirements per the Federal Internal Revenue Service (IRS) as part of the Affordable Care Act.

APPROACH AND METHODS

The assessment began in December 2018 and was conducted in three phases, which allowed for the collection of an extensive amount of quantitative and qualitative data (Phase 1); engagement of community residents, key stakeholders, and service providers (Phase 2); and analysis and prioritization of findings for use in developing a data-driven Implementation Strategy (Phase 3).

2019 Bergen County CHNA: Project Phases

Phase 1 Preliminary Assessment and Engagement	Phase 2 Targeted Engagement	Phase 3 Strategic Planning and Reporting
• Secondary Data Collection • Key Informant Interviews • Resource Inventory • Steering Committee Meetings	• Bergen County Random Household Survey • Focus Groups • Community Listening Sessions • Bergen County Community Health Perceptions Survey • Steering Committee Meetings	• Steering Committee Prioritization Meeting • Individual Hospital and BCHDS/CHIP Prioritization Meeting • Final Reporting

Many individuals from across Bergen County were engaged in the assessment and planning process, including:

- Health and social service providers
- BCDHS and CHIP leadership and staff
- Faith leaders
- Community residents
- Hospital leadership, clinicians, and staff
- Health and public health officials
- Community organizers and advocates

HOLY NAME MEDICAL CENTER COMMUNITY HEALTH PRIORITIES AND VULNERABLE POPULATIONS

The CHNA was designed as a population-based assessment, meaning the goal was to identify a full range of community health issues across the demographic and socioeconomic segments of the population. The issues identified were framed in a broad context to ensure that the breadth of unmet needs and community health issues were recognized.

Following an integrated analysis of assessment findings, and prioritization/strategic planning discussions with Holy Name's leadership and staff, four priority areas emerged: chronic and complex conditions[1] and risk factors, mental health and substance use disorder, and social determinants of health and access to care.

To plan community health initiatives and to comply with federal guidelines, there was an effort to identify segments of the population with complex health needs or that face significant barriers to care.

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[1] Literature defines complex chronic conditions as those that "involve multiple morbidities that require the attention of multiple health care providers or facilities and possibly community (home)-based care. A patient with complex chronic disease presents to the health care system with unique needs, disabilities, or functional limitations." *Managing Complexity in Chronic Care. Arlington, VA: Department of Veterans Affairs, Office of Research and Development; 2006.*

Given the assessment findings and Holy Name's clinical expertise, five population segments were identified: older adults, individuals with chronic/complex conditions, racially/ethnically/culturally diverse populations, individuals with limited resources, and youth/adolescents.
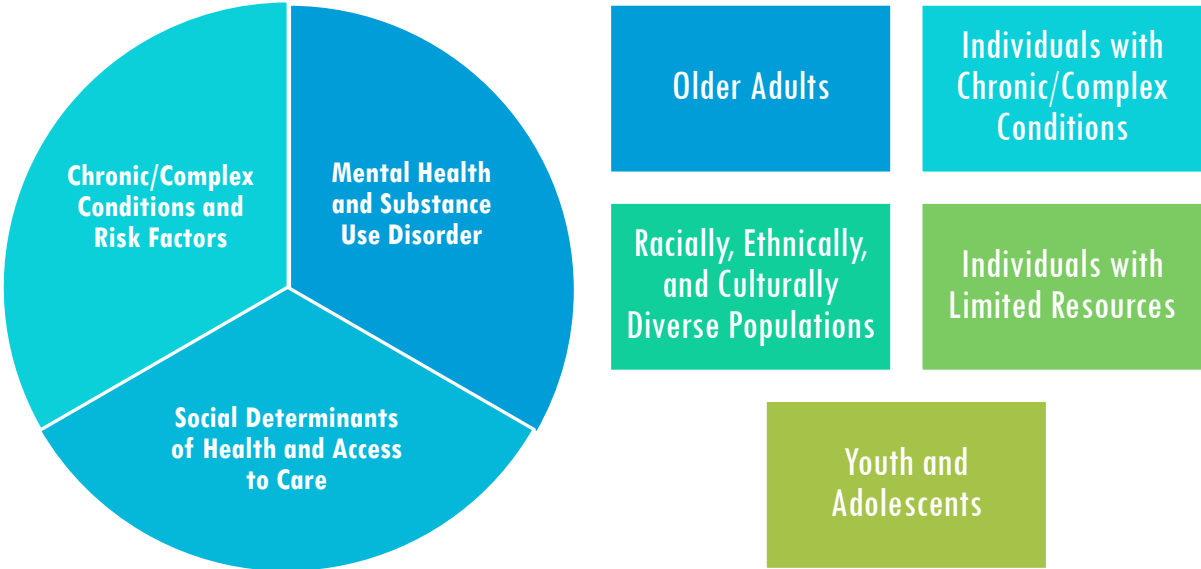
KEY FINDINGS/THEMES

Below is a listing of key findings and themes, organized by chapters of the CHNA report. These findings were used as the basis for the development of Holy Name's Implementation Strategy. For more detailed findings, data sources, and data on disparities by gender identity, race/ethnicity, income, and age, please see the full Community Health Needs Assessment report. Key findings are listed in the order in which they are discussed in this Community Health Needs Assessment report and are not hierarchical.

Key Findings: Wellness, Prevention, and Risk Factors

- All-cause and premature mortality were lower in Bergen and Hudson Counties than New Jersey overall
- One-third (33.2%) of Bergen County Random Household Survey respondents were overweight, while approximately one in five were obese (22.8%)
- Nearly a third (32.9%) of Bergen County Random Household Survey respondents reported that they did not participate in any physical activity or exercise in the past 30 days
- Over 70% of Bergen County Random Household Survey respondents reported that they had a primary care visit and a dental visit within the past year
- Individuals engaged during this assessment prioritized the risk factors associated with chronic and complex conditions (e.g., obesity, poor nutrition, sedentary lifestyle) as key issues of concern

Key Findings: Chronic and Complex Conditions

- Heart disease (#1) and cancer (#2) were the leading causes of death in Bergen and Hudson Counties
- Approximately 1 in 4 (26.5%) Bergen County Random Household Survey respondents had been diagnosed with high blood pressure
- Approximately 1 in 10 (9.7%) Bergen County Random Household Survey respondents had ever been diagnosed with cancer
- Approximately 1 in 10 (11.5%) Bergen County Random Household Survey respondents had ever been diagnosed with diabetes.
- 14.1% of Bergen County Random Household Survey respondents had been diagnosed with asthma
- Influenza and pneumonia mortality rates were significantly high in Bergen County compared to New Jersey overall
- Individuals engaged in this assessment identified older adults, especially those with multiple chronic conditions and those who lack a regular caregiver, as a vulnerable population

Key Findings: Mental Health and Substance Use Disorder

- 6.8% of Bergen County Random Household Survey respondents reported that their mental health was poor for 15 or more days in the past month
- Nearly 1 in 10 (9.7%) of Bergen County Random Household Survey respondents had ever been diagnosed with a depressive disorder
- Over 1 in 10 (12.7%) of Bergen County Random Household Survey respondents had ever been diagnosed with an anxiety disorder
- 18.9% of Bergen County Random Household Survey respondents were current smokers
- Individuals engaged in this assessment characterized e-cigarette and vaping as a critical concern, especially for youth and adolescents
- 15.4% of Bergen County Random Household Survey respondents reported binge drinking in the past 30 days
- Drug-related deaths in Bergen County have increased since 2014, from 8.8 deaths to 13.8 deaths per 100,000
- The number of suspected opioid-overdose deaths has continued to increase annually since 2014; the number of opioids dispensed has decreased annually since 2015

Key Findings: Social Determinants of Health and Access to Care

- The percentage of foreign-born residents and non-English speakers were significantly high in Bergen and Hudson Counties compared to the state overall. Nearly half of Hudson County residents identified as Hispanic/Latino
- In Bergen County, educational attainment was high and unemployment was low compared to the state.
- In Hudson County, educational attainment was low and unemployment was high compared to the state.
- The percentage of individuals and families in poverty is low in Bergen County compared to New Jersey overall. Despite this, individuals engaged in this assessment reported that there were pockets of poverty throughout Bergen County, even in affluent communities, and income, poverty, and employment were issues of concern
- The percentage of individuals and families in poverty in Hudson County was significantly high compared to the state
- Individuals engaged in this assessment identified housing issues – including lack of housing stock and housing affordability –as a major barrier to good health and well-being
- Individuals engaged in this assessment identified access to transportation resources, especially for older adults, low-income populations, and those without a personal vehicle as a barrier to accessing health and social services
- Nearly one-fifth (18.5%) of respondents to the Bergen County Random Household Survey reported that it was very or somewhat difficult to buy fresh produce or vegetables
- Less than 10% of Bergen County residents lacked health insurance. Despite this, respondents to the Bergen County Random Household Survey identified lack of health insurance as the leading social factor or barrier that limited access to care or impacted the health of those living in the community

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BACKGROUND AND APPROACH

OVERVIEW & PURPOSE

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The primary goals for the CHNA and this report are to:

Assess	Community health needs, defined broadly to include health status, social determinants, environmental factors, and service system strengths/weaknesses
Engage	Members of the community, hospital staff and leadership, CHIP/BCDHS staff and leadership, local health departments, and community organizations
Identify	Leading health issues/population segments most at-risk for poor health, based on a review of quantitative and qualitative evidence
Develop	A three-year Implementation Strategy to address community health needs in collaboration with community partners

This CHNA may be used as a source of information and guidance to:
- Clarify issues related to community characteristics, barriers to care, existing service gaps, unmet community need and other health-related factors;
- Prioritize and promote investments in community health initiatives;
- Inform and guide a comprehensive, collaborative community health improvement planning process;
- Facilitate discussion within and across sectors regarding community need, community health improvement, and health equity;
- Serve as a resource to others working to address health inequities

Holy Name is committed to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity, the attainment of the highest level of health for all people, requires focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout the assessment process, efforts were made to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. Holy Name's Implementation Strategy will focus on reaching the geographic, demographic, and socioeconomic segments of the population most at-risk, as well as those with behavioral and physical health needs.

HOLY NAME MEDICAL CENTER SERVICE AREA

HNMC's primary Community Benefits Service Area (CBSA) includes 18 cities and towns, most of which are in southern portion of Bergen County, but also includes North Bergen, West New York, and Union City in Hudson County. Holy Name serves different geographic areas and populations - the communities that are part of the CBSA are an aggregate of these areas and populations. For this assessment, Holy Name made efforts to identify the health needs of all residents within their CBSA, regardless of whether or not they use or have used services at the Hospital or any affiliated facilities.

APPROACH & METHODS

In September 2018, a Steering Committee was formed, comprised of representatives from each hospital and staff from BCDHS. The Steering Committee hired John Snow, Inc. (JSI), a public health research and consulting firm, to support their efforts and complete this CHNA. This Committee met regularly via in-person meetings and conference calls to plan and execute project activities, vet preliminary findings, address challenges, and ensure that the assessment process was inclusive, comprehensive, and objective.

During this process, each hospital and BCDHS engaged their senior leadership and clinical staff. These individuals helped to prioritize community health issues and priority population segments for inclusion in the Implementation Strategies.

The assessment was completed in three phases. Table 1 below provides a summary of each phase and the associated activities. The community engagement index (Appendix A) includes additional information and materials related to the engagement activities/approach.

Table 1: Summary of Approach and Methods

Phase 1 Preliminary Assessment and Engagement	Phase 2 Targeted Engagement	Phase 3 Strategic Planning and Reporting
• Secondary Data Collection • Key Informant Interviews • Resource Inventory • Steering Committee Meetings	• Bergen County Random Household Survey • Focus Groups • Community Listening Sessions • Bergen County Community Health Perceptions Survey • Steering Committee Meetings	• Steering Committee Prioritization Meeting • Individual Hospital and BCHDS/CHIP Prioritization Meeting • Final Reporting

PHASE I

The preliminary needs assessment and engagement effort relied on **secondary data** collected via local, state, and national sources. This information included data on the population characteristics of Bergen County, including demographics, social determinants of health, health status, and morbidity/mortality. Whenever possible, confidence intervals were analyzed to test for statistically significant differences between municipal and State of New Jersey data points. A comprehensive Data Book is included in Appendix B. In this Data Book, data points are color-coded to visualize which municipal-level data points were significantly higher or lower compared to the State overall. Relative to most states, New Jersey does an excellent job at making comprehensive data available at the state, county, and municipal levels through an interactive portal accessible via the New Jersey Department of Health (NJ DOH) website. The most significant limitation in regards to quantitative data was the availability of timely data related to morbidity, mortality, and service utilization. The data sets used in this report are the most up-to-date provided by NJ DOH. The data provided was valuable and allowed for identification of health needs relative to the State and specific communities. However, these data sets in some cases may not reflect recent trends in health statistics. Additionally, quantitative data was not stratified by age, race/ethnicity, income, or other characteristics, which limited the ability to identify health disparities in an objective way. The Bergen County Random Household Survey and the targeted community engagement and qualitative assessment activities allowed for exploration of these issues.

Key informant interviews were conducted with approximately 80 community stakeholders from throughout Bergen County. These interviews confirmed and/or refined the findings from quantitative data sources and provided valuable insight on community need, community health priorities, segments of the population most at-risk, and community health assets. Individual interviews were conducted by-phone using a structured interview guide developed by JSI and the Steering Committee. At the outset, JSI worked with the Steering Committee to identify a representative list of key informants that could provide a deep and broad perspective on the health-related needs of the County. This list included administrative and clinical representatives from each of the hospitals and BCDHS, as well as representatives from across many sectors, including health, public health, social service, academic, and business. Detailed notes were taken for each interview. For a list of interviewees, their organizational affiliations, interview dates, and the interview guide, please see Appendix A. Key themes and findings from these interviews are included in the narrative sections of this report.

During this Phase, JSI staff worked with the Steering Committee to develop a **Resource Inventory**. This inventory was meant to inform what services are available in Bergen County to address community needs as well as to determine the extent to which there are gaps in health-related services. The CHIP and BCDHS staff supported this effort by providing a list of community partners and known resources from across the broad continuum of services, including clinical health care services, community health and social services, and public health resources. This was done primarily by compiling information from existing resource inventories and partner lists from the CHIP, BCDHS, hospitals, and other service providers. The Resource Inventory can be found in Appendix C.

PHASE I: PRELIMINARY ASSESSMENT AND ENGAGEMENT

SECONDARY DATA – 200+ INDCATORS
- Including:
  - *Demographics and socioeconomic status*
  - *Social determinants of health (e.g., housing, transportation, employment)*
  - *Risk factors*
  - *Health status and morbidity/mortality*
  - *Access to care and service utilization*
- Municipal-level data for all cities and towns in Bergen County
- National, New Jersey, and Bergen County comparison data when possible

KEY INFORMANT INTERVIEWS – 80 PHONE AND IN-PERSON
- Interviews conducted using structured interview guide
- Representation across sectors, including:

Clinicians	*Hospital leadership and staff*
Health and public health officials	*Faith-based community*
Community organizations	*Schools and youth/adolescent services*
Older adults/elder services	*Social service providers*
Cultural organizations and advocates	*Behavioral health providers and advocates*

RESOURCE INVENTORY
- Identified existing Bergen County assets/resources across health-related sectors

PHASE II
Phase II included several activities aimed at further engaging community residents and stakeholders – including segments that are typically hard to reach. JSI conducted a mail-based **Bergen County Random Household Survey**, which captured information directly from community residents on health status and overall well-being, service utilization, and barriers to care. To generate the survey sample, a comprehensive survey was distributed to more than 4,000 randomly identified households in the County. The initial random sample of 4,000 households included an oversample of communities with large proportions of Black/African American, Hispanic/Latino, and low-income residents to ensure that enough surveys were generated from households with often under-represented segments of the population. In all, 1,372 community residents responded to the survey, representing a survey response

rate of approximately 31%. Table 2 includes respondent characteristics. Detailed findings from the survey are included in the body of the report and in tabular form in Appendix B.

Table 2: Respondent Characteristics (unweighted) for the Bergen County Random Household Survey (N=1,372)

	All	Male	Female	White	Black/African American	Hispanic/ Latino	Asian	Income <$50,000*	Over 65 years old
Number of respondents to survey	1,372	518	832	959	126	188	151	331	475
Average age	57	59	56	59	55	50	51	61	75
Female (%)	62	-	100	61	68	71	54	71	57
Less than a high school education (%)	4	4	4	4	2	12	1	13	7
Advanced degree (Masters or beyond) (%)	25	28	23	27	20	16	23	4	23
Total Household income (%)									
<$50,000	26	20	30	24	38	41	24	100	36
$50,000 - $124,999	40	43	39	40	31	41	48	--	43
>$125,000	33	37	31	36	31	18	27	--	21

*Throughout the report, the "low-income" cohort refers to are those whose total household income was less than $50,000.

Focus groups were conducted with population segments and health/social service provider groups to gather more precise and nuanced information on the needs of specific segments of the population or from individuals with specific expertise. Focus groups were held at locations that were considered safe and accessible for participants and were facilitated in appropriate languages to ensure full participation. JSI and co-facilitators conducted all focus groups using a guide that was similar to the one used for key informant interviews to ensure consistent data collection. JSI, the BCHDS, the CHIP, and hospital partners worked with organizations in the County to plan these events and identify focus group participants.

JSI facilitated two **community listening sessions**, one in Ridgewood and one in Englewood. These sessions provided an opportunity for anyone who was interested to participate and allowed for the capture of information directly from community residents, staff from community-based organizations, and local service providers. Participants were asked to react to preliminary data findings and to share thoughts on community health needs, barriers to care, vulnerable populations, and community assets and resources. Both sessions were held in locations that were easily accessible, safe, and well known.

Finally, JSI worked with the Steering Committee to develop a web-based **Bergen County Community Health Perceptions Survey** to solicit additional information directly from community residents. Respondents were asked to provide their opinion and perceptions of leading social determinants of health and barriers to care, clinical health issues, vulnerable populations, access to health care services, and opportunities for the hospital to improve community health programming. Surveys were available online, through the SurveyGizmo platform, in multiple languages. Surveys were also made available in hard copy for distribution; hard-copy surveys were collected and the responses were included in the final analysis. The CHIP, BCDHS, hospitals, and public health partners worked in close collaboration with local community organizations, businesses, and stakeholders to distribute the survey to community residents, including those who are typically hard-to-reach (e.g. non-English speakers, diverse populations). Findings from the survey are integrated into the narrative sections of this report.

PHASE II: TARGETED ENGAGEMENT

BERGEN COUNTY RANDOM HOUSEHOLD SURVEY
- County-wide sample
  Distributed via mail to 4,000 randomly selected households; oversampled in Black/African American, Hispanic/Latino, and low-income populations
- 1,372 surveys collected (31% response rate)

Average age of respondent = 57	*14% Hispanic/Latino (N=188)*
61% female (N=832)	*11% Asian (N=151)*
38% male (N=518)	*35% over 65 years of age (N=475)*
70% White (N=959)	*24% low-income (total household income <$50,000*
9% Black/African American (N=126)	*(N=331)*

BERGEN COUNTY COMMUNITY HEALTH PERCEPTIONS SURVEY
- County-wide sample
  Distributed via email, newsletters, social media, and other web-based sources
- 357 surveys collected

FOCUS GROUPS
- 60-90 minute sessions with population and provider segments

Black/African Americans	*Mental health providers and advocates*
Koreans	*Substance use disorder providers*
Spanish-speakers	*Older adult health/elder services providers*
LGBTQ+	*School nurses*
Individuals in recovery from substance use disorder	*Bergen County Health Officers*

COMMUNITY LISTENING SESSIONS
- 2-hour sessions, open to the public

Englewood	*Ridgewood*

PHASE III

Phase III included prioritization and strategic planning meetings with the Steering Committee, individual hospitals, and BCDHS/CHIP members. Meeting participants were presented with findings from the CHNA and were asked to weigh on a set of proposed community health priorities and priority populations. Participants were also asked to contribute information and ideas on current community and population health programs/initiatives that were working well and potential responses to identified needs. JSI used this information to finalize community health priorities and populations for the County overall and for each individual hospital.

Following the prioritization and strategic planning meetings, JSI worked with individual hospitals to draft CHNA reports and Implementation Strategies. These documents were presented for adoption to the governing bodies at each hospital in fall 2019.

POPULATION CHARACTERISTICS AND SOCIAL DETERMINANTS OF HEALTH

To understand community needs and health status for individuals in Bergen County, we begin with a description of community characteristics, including demographics, socioeconomics, and the social determinants of health. This information is critical to recognizing inequities, identifying vulnerable populations and health related disparities, and targeting strategic responses.

The social determinants of health (SDOH) are the conditions in which people live, work, learn and play.[2] These conditions influence and define quality of life for many segments of the population in the CHNA service area. To augment the lack of quantitative data, the key informant interviews, focus groups, listening sessions, and Bergen County Community Health Perceptions Survey specifically solicited feedback on SDOH and barriers to care. A dominant theme from community engagement activities was the impact that the underlying social determinants, particularly housing, transportation, and income/employment have on the residents of Bergen County.

More expansive data tables are included in Holy Name Medical Center's Data Book (Appendix B).

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[2] "Social Determinants of Health: Know What Affects Health," *Centers for Disease Control and Prevention*, 29 Jan. 2018. https://www.cdc.gov/socialdeterminants/

AGE, RACE/ETHNICITY, AND FOREIGN BORN[3]

- **Bergen County has the second highest percentage of adults 65 and over among all counties in New Jersey.** The percentage of Bergen County residents over the age of 65 (16.4%) was significantly high compared to New Jersey overall (15.1%). The median age in Bergen County (41.6) was also higher than New Jersey overall (39.6). In Hudson County, the median age (34.9) and percentage of the population over 65 (11.2%) were significantly low compared to the state.
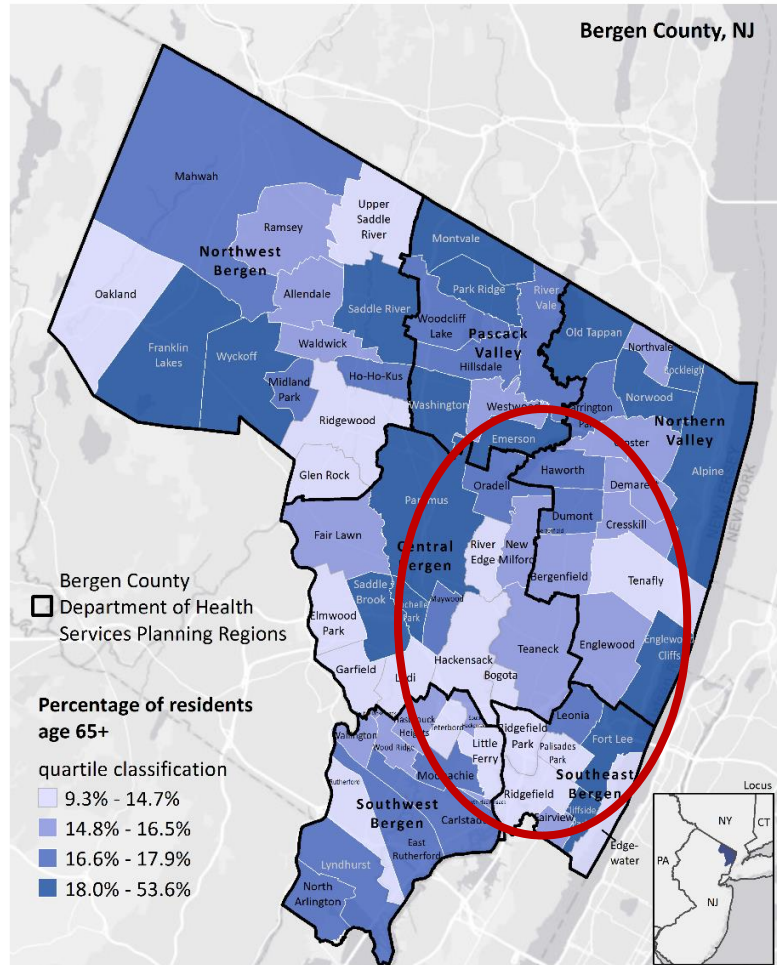
- **The percentage of Asian residents was significantly high in Bergen County (16.2%) and Hudson County (15.2%) compared to the state overall (9.4%).**
  - Among municipalities in Holy Name's primary service area, the percentage of Asian residents was significantly high in Bergenfield (28.0%), Cliffside Park (16.6%), Dumont (16.6%), Englewood (12.3%), Fort Lee (41.4%), Little Ferry (26.2%), New Milford (17.8%), Palisades Park (56.7%), Ridgefield (29.6%), and Ridgefield Park (13.7%) compared to the state overall.

- **The percentage of Black/African American residents in Bergen County (5.3%) was significantly low** compared to the state overall (12.7%). The percentage was similar to the state in Hudson County (12.4%).
  - Among municipalities in Holy Name's primary service area, the percentage of Black/African American residents was significantly high in Englewood (29.3%), Hackensack (22.7%), and Teaneck (25.8%) compared to the state overall.

Figure 1: Percentage of Population Over 65, by Municipality (Bergen County)

Source: US Census Bureau, American Community Survey 5-Year Estimates (2013-2017). The red circle indicates Holy Name's primary service area in Bergen County.

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[3] All statistics from US Census Bureau, American Community Survey, 2013-2017

- **The percentage of Hispanic/Latino residents in Bergen County (18.9%) was similar to the state overall (19.7%). The percentage of Hispanic/Latino residents in Hudson County (43.2%) was significantly high compared to the state overall.**
  - Among municipalities in Holy Name's primary service area, the percentage of Hispanic/Latino residents was higher than the state in Bergenfield (26.3%), Bogota (44.5%), Cliffside Park (30.1%), Englewood (24.5%), Fairview (58.5%), Hackensack (38.2%), Little Ferry (27.3%), Lodi (36.0%), Palisades Park (21.1%), Ridgefield (28.6%), and Ridgefield Park (42.7%).
  - Among the municipalities in Hudson County that are part of Holy Name's primary service area, the percentage of Hispanic/Latino residents was significantly high in North Bergen (73.1%), Union City (79.6%), and West New York (76.9%).

- **The percentage of foreign-born residents was significantly high in Bergen County (30.5%) and Hudson County (43.0%) compared to the state overall.**
  - Among municipalities in Holy Name's service area, the percentage of Hispanic/Latino residents was higher than the state in Bergenfield (38.6%), Cliffside Park (47.5%), Englewood (33.9%), Fairview (51%), Fort Lee (52%), Hackensack (38.8%), Little Ferry (44.3%), Lodi (36.4%), Palisades Park (63.6%), Ridgefield (47.6%), and Ridgefield Park (34.7%).
  - Among the municipalities in Hudson County that are part of Holy Name's primary service area, more than half of residents were foreign-born: North Bergen (52.3%), Union City (59%), and West New York (60%).

Table 3: Age Distribution (2013-2017)

	United States	New Jersey	Bergen County	Hudson County
Median age (years)	37.8	39.6	41.6	34.9
Under 18 (%)	22.9	22.3	21.5	20.4
Ages 20-34 (%)	20.7	19.3	17.4	27.7
Ages 35-44 (%)	12.7	13.0	13.3	15.7
Ages 45-54 (%)	13.4	14.7	15.3	12.6
Ages 55-64 (%)	12.7	13.1	13.6	10.4
Ages over 65 (%)	14.9	15.1	16.4	11.2

Source: US Census Bureau, American Community Survey, 2013-2017
Shading represents statistical significance compared to the state. Data points highlighted in orange were statistically higher compared to the state overall, while figures highlighted in blue were significantly lower.

Table 4: Race, Ethnicity, and Foreign-born (2013-2017)

	United States	New Jersey	Bergen County	Hudson County
Non-Hispanic White (%)	73.0	56.1	57.8	55.3
Non-Hispanic Black (%)	12.7	12.7	5.3	12.4
Non-Hispanic Asian (%)	5.4	9.4	16.2	15.2
Hispanic or Latino of any race (%)	17.6	19.7	18.9	43.2
Foreign-born (%)	13.4	22.1	30.5	43.0

Source: US Census Bureau, American Community Survey, 2013-2017
Shading represents statistical significance compared to the state. Data points highlighted in orange were statistically higher compared to the state overall, while figures highlighted in blue were significantly lower.

LANGUAGE[4]

- **In Bergen County (39.9%) and Hudson County (59.2%), a significantly high percentage of residents speak a language other than English in their home compared to the state overall (31%).**
  - The percentage of these residents with limited English proficiency (LEP) – defined as speaking English "less than very well" – was also significantly high in Bergen County (14.5%) and Hudson County (25.2%) compared to the state (12.2%).
    - In Holy Name's service area, the percentage of residents with LEP was significantly higher than the state in all municipalities except Teaneck.

- **A significantly high percentage of residents speak Asian/Pacific Islander languages in their home in Bergen County (11.5%) and Hudson County (7.2%) compared to the state overall (4.8%).**
  - In HNMC's service area, the percentage of residents who spoke Asian and Pacific Islander languages in their home was significantly higher than the state in Bergenfield (20.2%), Cliffside Park (16.2%), Dumont (11.6%), Fort Lee (34.0%), Hackensack (6.6%), Little Ferry (19.0%), New Milford (13.3%), Palisades Park (52.0%), and Ridgefield (29.0%).

- **In Hudson County, the percentage of residents who speak Spanish in their home (38.3%) is significantly high compared to the state overall (16.1%).** The percentage of Bergen County residents who speak Spanish in their home (14.9%) was significantly low compared to the state.
  - In Holy Name's service area, the percentage of residents who spoke Spanish in their home was significantly higher than the state in Bergenfield (21.2%), Bogota z928.2%), Cliffside Park (27.5%), Fairview (51.9%), Hackensack (33.1%), Little Ferry (24.5%), Lodi (30.1%), Ridgefield (24.3%), and Ridgefield Park (35.4%).
  - Among the municipalities in Hudson County that are part of Holy Name's primary service area, more than half of residents speak Spanish in the home: North Bergen (68.3%), Union City (80%), West New York (73.9%).

- **A significantly high percentage of residents speak Indo-European languages in their home in Bergen County (11.1%) and Hudson County (10.4%) compared to the state overall (8.3%).**
  - In Holy Name's service area, the percentage of residents who spoke other Indo-European languages in their home was significantly higher than the state in Cliffside Park (15.0%), Fairview (13.2%), Fort Lee (14.5%), and Lodi (17.3%).

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[4] All statistics from US Census Bureau, American Community Survey, 2013-2017

Table 5: Percent of Population 5+ who Speak Language Other than English in the Home (2013-2017)

	United States	New Jersey	Bergen County	Hudson County
Language other than English at home (%)	21.3%	31.0	39.9	59.2
With LEP (%)*	8.5%	12.2	14.5	25.2
Spanish at home (%)	13.2%	16.1	14.9	38.3
With LEP (%)	5.4%	7.1	5.1	17.7
Indo-European languages (%)	3.6%	8.3	11.1	10.4
With LEP (%)	1.1%	2.8	3.6	3.5
Asian/Pacific Islander languages (%)	3.5%	4.8	11.5	7.2
With LEP (%)	1.6%	1.9	5.1	2.6
Other languages (%)	0.3%	1.7	2.4	3.3

Source: US Census Bureau, American Community Survey, 2013-2017
Shading represents statistical significance compared to the state. Data points highlighted in orange were statistically higher compared to the state overall, while figures highlighted in blue were significantly lower.

SOCIOECONOMICS

Socioeconomic status (SES), as measured by income, employment status, occupation, education and the extent to which one lives in areas of economic disadvantage, is closely linked to morbidity, mortality and overall well-being.[5]

- **Educational attainment -** The percentage of Bergen County residents with less than a high school diploma (8%) was significantly low compared to New Jersey overall (10.8%). The percentage was significantly higher than the state in Hudson County (16.3%).[6]
    - In Holy Name's service area, the percentage of the population with less than a school diploma was significantly higher than the state in Fairview (28.1%), Hackensack (12.8%), Lodi (16.6%), and Palisades Park (14.0), North Bergen (18.1%), Union City (30.4%), and West New York (26.5%).
    - The percentage of ninth-grade cohorts in Bergen that graduated in four years (95%) was higher than New Jersey overall (91%).[7]
    - The percentage of Bergen County adults ages 25-44 with some post-secondary education (77%) was higher than New Jersey overall (68%).[8]

- **Unemployment rate -** The unemployment rate in Bergen County was significantly low compared to the state of New Jersey overall (3.4% vs. 4.6%). The percentage was significantly high in Hudson County (7.1%).[9]

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[5] Nancy E. Adler and Katherine Newman, "Socioeconomic Disparities in Health: Pathways and Policies," HealthAffairs, 2002; 21(2), doi: https://doi.org/10.1377/hlthaff.21.2.60
[6] US Census Bureau, American Community Survey, 2013-2017
[7] County Health Rankings 2016-2017, from New Jersey Department of Education
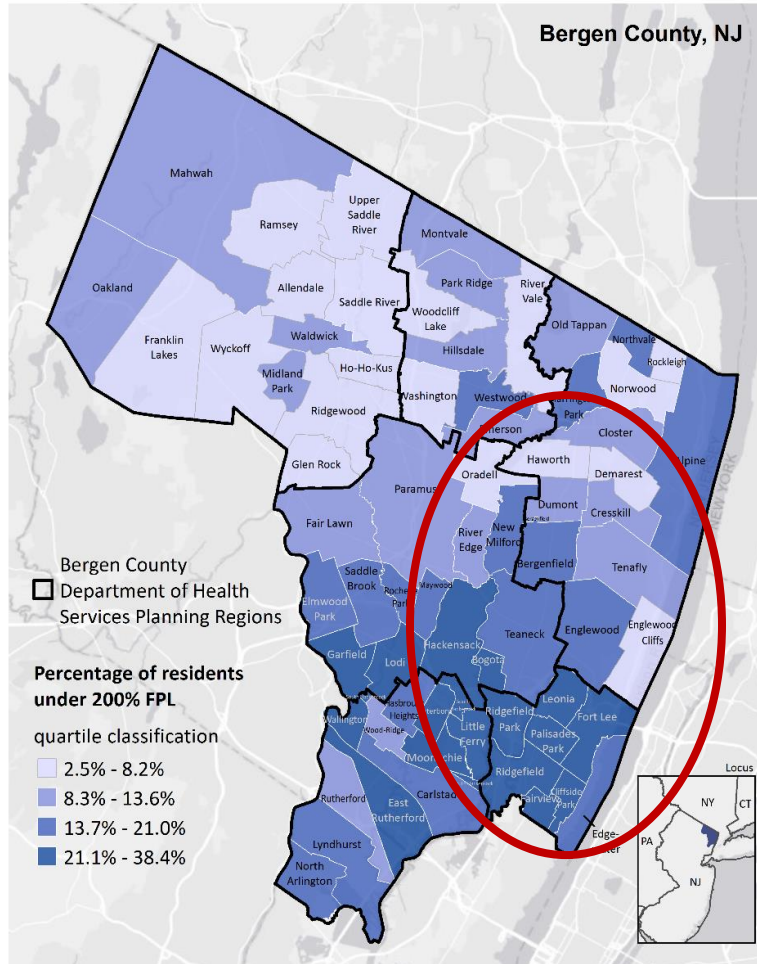[8] US Census Bureau, American Community Survey, 2013-2017
[9] US Census Bureau, American Community Survey, 2013-2017

- o In Holy Name's service area, the unemployment rate was significantly higher than the state in Fairview (7.2%), North Bergen (6.5%), and West New York (6.2%).

- **Individuals and families in poverty –** In Bergen County, the percentage of Bergen County families (5.5%) and individuals (7.2%) living below the poverty level were significantly low compared to the state overall. Percentages were significantly high in Hudson County (Table 6).[10]

  - o In HNMC's service area, the percentage of individuals living below the poverty level was significantly higher than the state in Hackensack (14.3%), North Bergen (15.8%), Union City (23%), and West New York (21.9%). The percentage of families living below the poverty level was significantly higher than the state in Fairview (14.3%), Lodi (11.3%), North Bergen (12.7%), Union City (20.3%), and West New York (17.7%).

Figure 2: Percentage of Residents Below 200% of the Federal Poverty Level, by Municipality (Bergen County)

Source: US Census Bureau, American Community Survey 5-Year Estimates (2013-2017). The red circle indicates Holy Name's primary service area in Bergen County.

  - o In Bergen County, the percentage of individuals with income below 200%, 300%, and 400% of the federal poverty level was lower than the state overall. Percentages were higher than the state in Hudson County (Table 6).

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[10] US Census Bureau, American Community Survey, 2013-2017

Table 6: Unemployment and Poverty (2013-2017)

	United States	New Jersey	Bergen County	Hudson County
Unemployment rate (%)	4.1	4.6	3.4	7.1
Individuals with income below the federal poverty level (%)	14.6	10.7	7.2	17.1
Families with income below the federal poverty level (%)	10.5	7.9	5.5	13.9
Individuals with income <200% of federal poverty level	32.7	24.1	17.6	35.4
Individuals with income <300% of federal poverty level	49.1	37.1	28.3	50.9
Individuals with income <400% of federal poverty level	62.6	48.9	39.1	62.1

Source: US Census Bureau, American Community Survey, 2013-2017
Shading represents statistical significance compared to the state. Data points highlighted in orange were statistically higher compared to the state overall, while figures highlighted in blue were significantly lower.

HOUSING

- **Housing issues – including lack of housing stock and affordability – were identified as barriers to health and well-being in Bergen County.** Many key informants and focus group/forum participants expressed concern over the limited options for affordable housing. This was particularly an issue for older adults, who often bear the burden of household costs (e.g. taxes, maintenance, adaptabilities) while living on fixed incomes.

  > The Bergen County Community Health Perceptions Survey asked people to name the issues they thought prevented people from living a healthy life. "Housing is expensive or unsafe" was the most common response (54.1%).

  - The percentage of owner-occupied units in which ownership costs exceed 35% of total household income, representing a major financial burden, was significantly high in Bergen (31.3%) and Hudson County (35.7%) compared to New Jersey overall (50.7%).[11]
  - The percentage of renter-occupied households whose gross rent exceeded 35% of total household income was significantly low in Bergen County (41.1%) and Hudson County (38.5%) compared to New Jersey overall (43.6%).[12]
  - In Bergen County, over one-fifth of households (22%) had at least one severe housing problem (overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing) - the same as New Jersey overall. The percentage was higher than the state in Hudson County (29%).[13]

[11] US Census Bureau, American Community Survey, 2013-2017
[12] US Census Bureau, American Community Survey, 2013-2017
[13] Comprehensive Housing Affordable Strategy (US Department of Housing and Urban Development), 2011-2015, from County Health Rankings

FOOD INSECURITY

- **The percentage Bergen County's population who lacked adequate access to food (8%) was slightly lower than New Jersey overall (10%).** However, this number equates to 70,200 individuals who reported that they did not have access to a reliable source of food during the past year.[14]

- **Nearly one-fifth of all respondents to the Bergen County Random Household Survey reported that they had been somewhat or very worried about food running out sometime in the past year (19%).**
  - Percentages were highest among low-income (46.8%) and Hispanic/Latino (42.2%) respondents.

- **Nearly one-fifth of all respondents to the Bergen County Random Household Survey reported that it was very or somewhat difficult to buy fresh produce or vegetables (18.5%).**
  - Percentages were highest among Hispanic/Latino (38.4%) and low-income (32.4%) respondents.
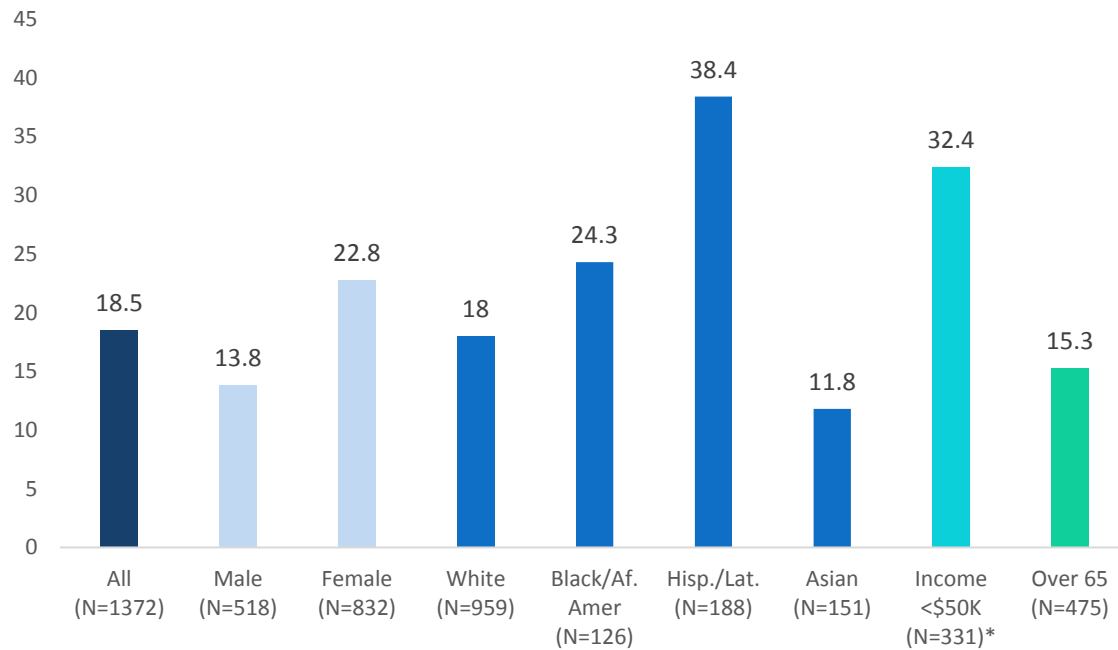
Figure 3: Bergen County Random Household Survey – Very or Somewhat Worried About Food Running Out Sometime During Past Year (%)
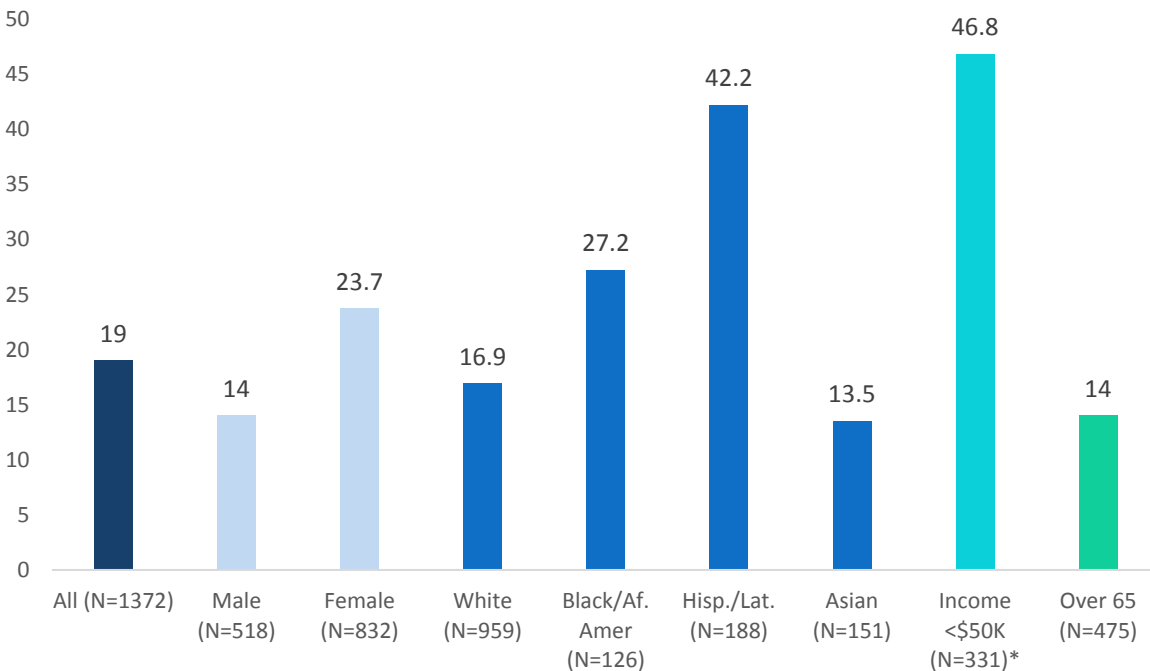
*Total annual household income less than $50,000. This group is described as the "low-income" cohort throughout this report.
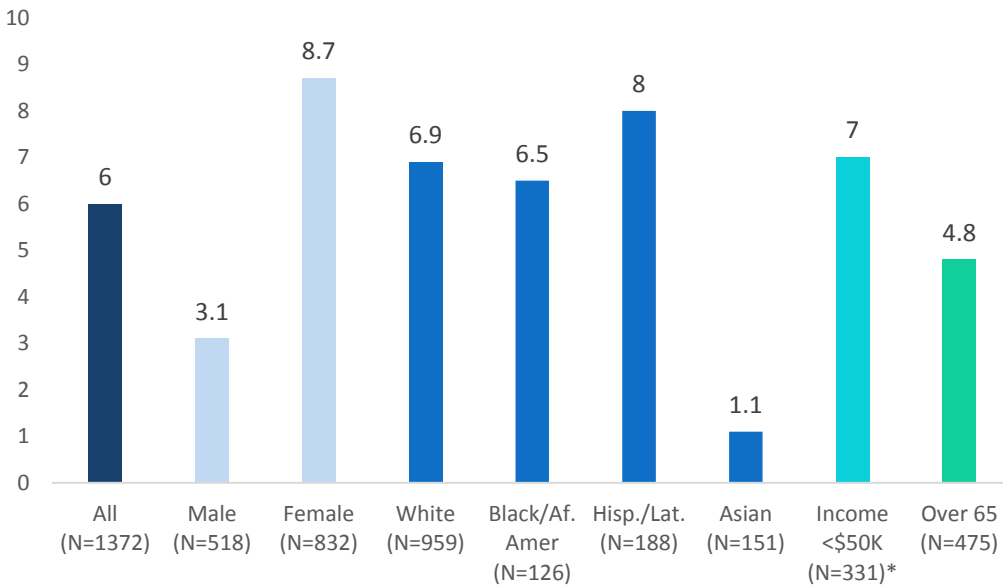

CRIME & VIOLENCE

- **Violent crime and property crime rates were low.**
  - The violent crime rate (e.g., murder/non-negligent manslaughter, forcible rape, robbery, aggravated assault) in Bergen County was significantly low compared to New Jersey overall (228.6). [15]
  - The property crime rates (e.g., burglary, larceny/theft, motor vehicle theft, arson) in Bergen County (966.9) was significantly low compared to New Jersey overall (1537.9).[16]
    - In Holy Name's primary service area, the property crime rate was significantly high in Englewood (1128.7), Hackensack (1485.9), Lodi (1473.1), and Union City (1763.0).
    - In Holy Name's primary service area, the violent crime rate was significantly high in Englewood (260.5%), Fairview (144.1), Hackensack (207.8), and Lodi (172.1).

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[15] FBI Uniform Crime Reporting: Offenses Known to Law Enforcement 2017
[16] FBI Uniform Crime Reporting: Offenses Known to Law Enforcement 2017

- **6% of Bergen County Random Household Survey respondents reported that they had experienced intimate partner violence.** Among these respondents:
  - ○ Hispanic/Latino respondents were more likely to report intimate partner violence (8.0%) and Asian respondents were least likely to report intimate partner violence (1.1%).
  - ○ Female respondents were more than twice as likely to report intimate partner violence compared to male respondents (8.7% vs. 3.1%).

Figure 5: Bergen County Random Household Survey – Had Experienced Intimate Partner Violence (%)

All (N=1372)	Male (N=518)	Female (N=832)	White (N=959)	Black/Af. Amer (N=126)	Hisp./Lat. (N=188)	Asian (N=151)	Income <$50K (N=331)*	Over 65 (N=475)
6	3.1	8.7	6.9	6.5	8	1.1	7	4.8

KEY FINDINGS: WELLNESS, PREVENTION, AND RISK FACTORS

At the core of the CHNA process is understanding leading risk factors and the extent to which individuals participate in certain risky behaviors. This information is critical to assessing health status, clarifying health-related disparities and identifying health priorities. The CHNA captures a wide range of quantitative data from federal and municipal data sources and from the Bergen County Random Household Survey. Qualitative information gathered from key informant interviews, focus groups, listening sessions, and the web-based Community Health Perceptions Survey informed the key findings sections of this report by providing perspective on the confounding and contributing factors of illness, health priorities, barriers to care, service gaps and possible strategic responses to the issues identified.

OVERALL HEALTH STATUS

- **Overall health status among Bergen County residents was good.**
  - o Among all Bergen County Random Household Survey respondents, 87% reported that their general health was excellent, very good, or good. Only 13% reported their health status as fair or poor.
    - ▪ Over one fourth (25.3%) of low-income respondents reported fair or poor health status.
  - o 19.7% of respondents to the Bergen County Random Household Survey responded that they are limited in some way because of a physical, mental, or emotional problem. Percentages were highest among low-income respondents (31.9%), respondents over 65 (31.1%), and Black/African American respondents (27.7%).

- **All-cause mortality and premature mortality was lower than the state overall in Bergen County.**
  - o The all-cause mortality rate was significantly lower in Bergen County (760) and Hudson County (556) than New Jersey overall (810.7).[17]
    - ▪ In Holy Name's primary service area, the all-cause mortality rate was significantly higher than the state in New Milford (894.5).
  - o The premature mortality rate – or the years of life lost before age 75 – was lower in Bergen County (3,800) than the state overall (5,700).[18]
  - o The average age of death was significantly high in Bergen County (78.2) and significantly low in Hudson County (72.0) compared to New Jersey overall (75.0).[19]

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[17] Deaths per 100, New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017
[18] Years of potential life lost before age 75 per 100,000 (age-adjusted); National Center for Health Statistics – Mortality Files, 2015-2017
[19] New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017

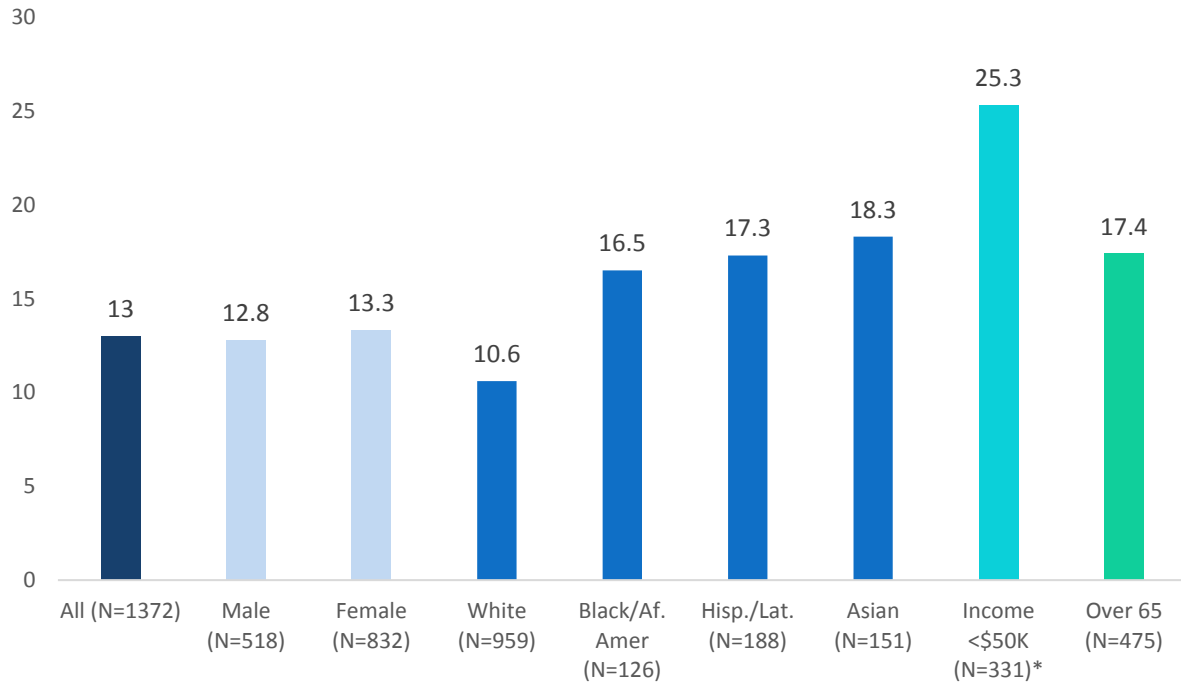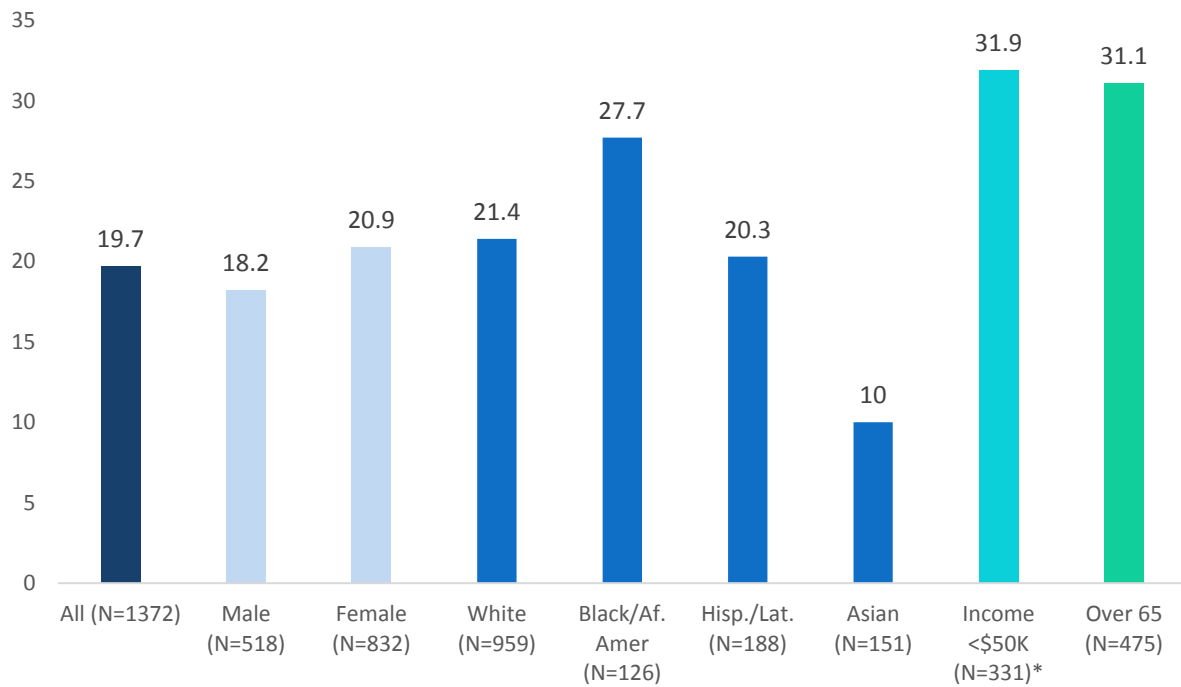**Figure 6: Bergen County Random Household Survey - Self Reported Health Status as Fair or Poor (%)**

	All (N=1372)	Male (N=518)	Female (N=832)	White (N=959)	Black/Af. Amer (N=126)	Hisp./Lat. (N=188)	Asian (N=151)	Income <$50K (N=331)*	Over 65 (N=475)
%	13	12.8	13.3	10.6	16.5	17.3	18.3	25.3	17.4

Figure 7: Bergen County Random Household Survey - Limited in Some Way Due to Physical, Mental, or Emotional Problems (%)

	All (N=1372)	Male (N=518)	Female (N=832)	White (N=959)	Black/Af. Amer (N=126)	Hisp./Lat. (N=188)	Asian (N=151)	Income <$50K (N=331)*	Over 65 (N=475)
%	19.7	18.2	20.9	21.4	27.7	20.3	10	31.9	31.1

NUTRITION & WEIGHT

- **One-third (33.2%) of all respondents to the Bergen County Random Household Survey were overweight, while 22.8% were obese.**
  - 41% of Black/African American respondents reported being overweight, and 30.6% reported as obese. These percentages were highest among all racial/ethnic cohorts.
  - Obesity percentages were also high among low-income (29.25) and Hispanic/Latino (29%) respondents.

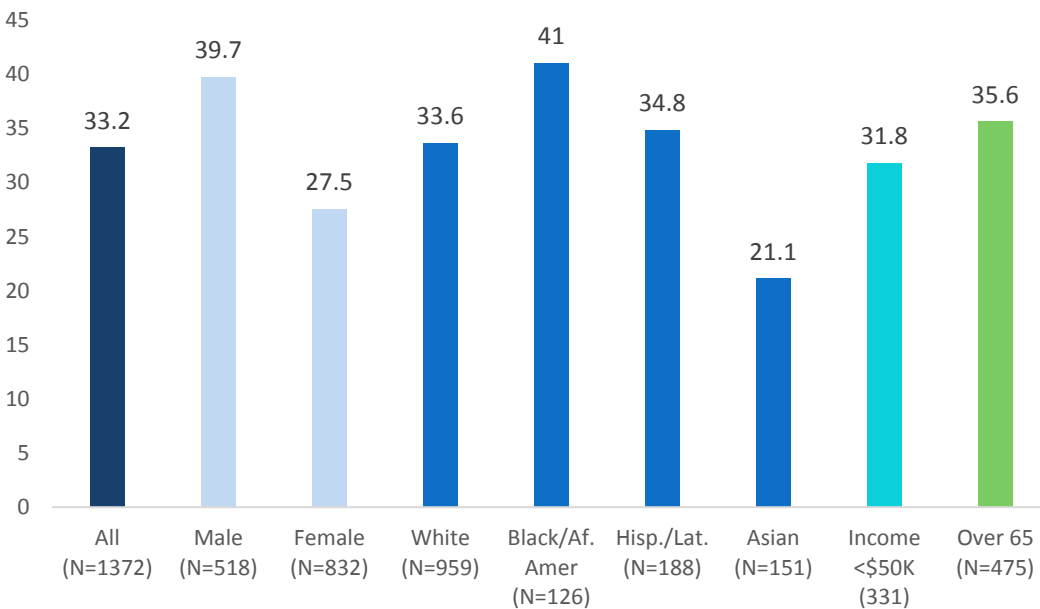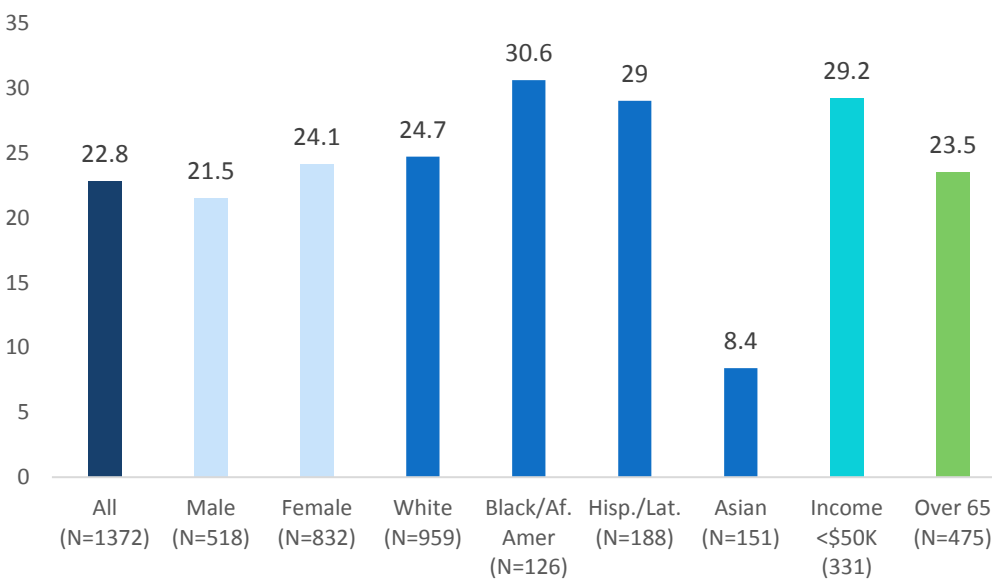**Figure 8: Bergen County Random Household Survey - Overweight (%)**

Figure 9: Bergen County Random Household Survey - Obese (%)

- **75.4% of Bergen County Random Household Survey respondents reported that, on average, they had less than three servings of fruit per day in the past month.** Daily fruit consumption was lowest among Asian (86.6%) and Hispanic/Latino (85.9%) respondents.

- **78.8% of survey respondents reported that, on average, they had less than three servings of vegetables per day in the past month.** Percentages were highest among Hispanic/Latino (83.1%) and Asian (83.1%) respondents.

Figure 10: Bergen County Random Household Survey – Less Than 3 Servings of Fruit a Day (%)
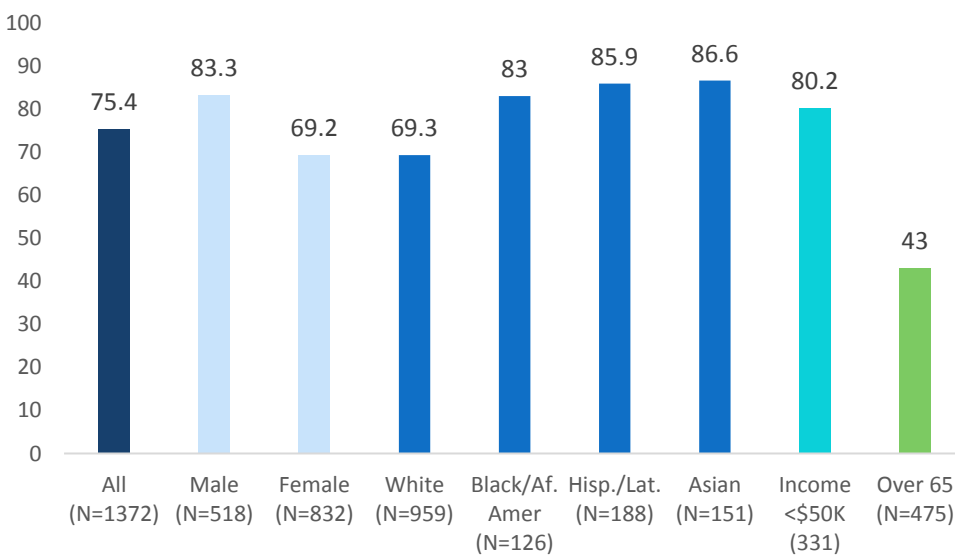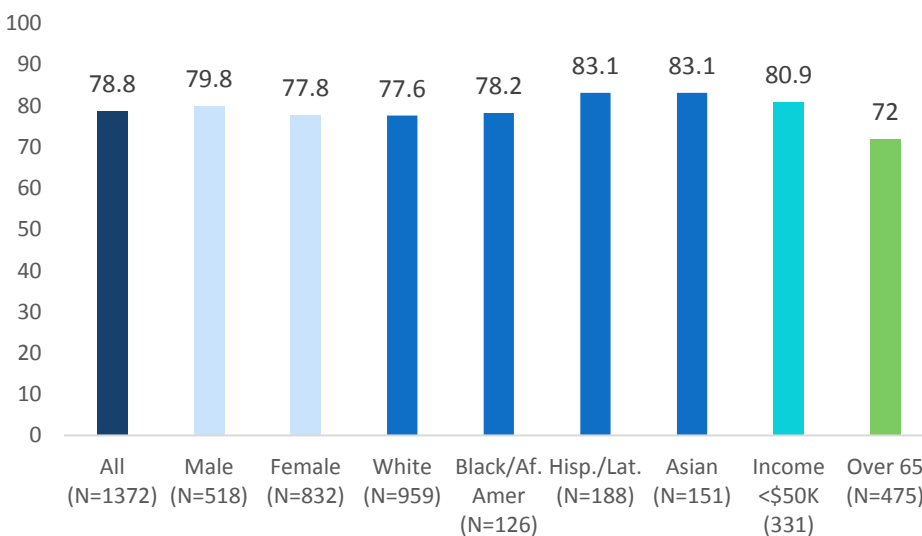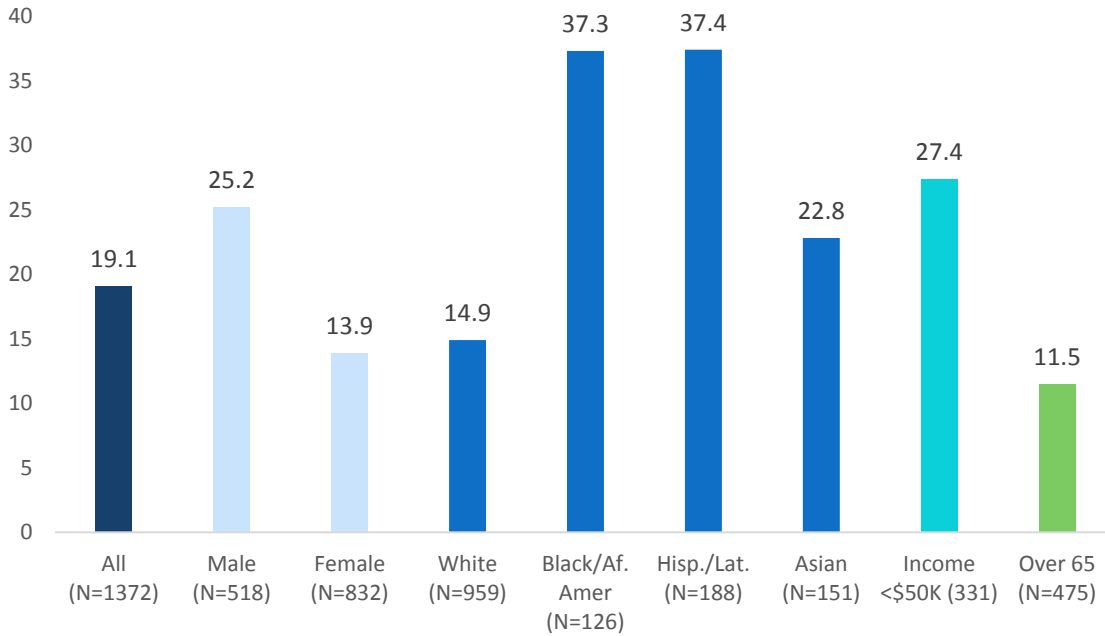

Figure 11: Bergen County Random Household Survey – Less Than 3 Servings of Vegetables a Day (%)

29

- **19.1% of survey respondents reported drinking sugar sweetened drinks (e.g., Kool-Aid, lemonade, sweet tea, sports drinks, energy drinks) on more than 5 days in the past week.**
  - o Percentages were nearly double among Hispanic/Latino (37.4%) and Black/African American (37.3%) survey respondents.

Figure 12: Bergen County Random Household Survey — Has Sugar Sweetened Drinks 5+ Days a Week (%)


PHYSICAL ACTIVITY

- **The Bergen County Random Household Survey revealed disparities in regular physical activity.** 32.9% of all respondents reported that they did not participate in any physical activity or exercise, outside of their normal job, in the past 30 days; only 18.6% reported moderate exercise in the past 30 days.
  - o Low-income respondents (47.9%), Hispanic/Latino respondents (43.2%), Black/African American respondents (41.6%), and Asian (41.2%) respondents reported less exercise than other cohorts.

The Bergen County Community Health Perceptions Survey asked people to name the issues they thought prevented people from living a healthy life. "Physical inactivity or sedentary lifestyle" was the second most common response (44.5%).

Figure 13: Bergen County Random Household Survey – No Physical Activity in Past 30 Days (%)
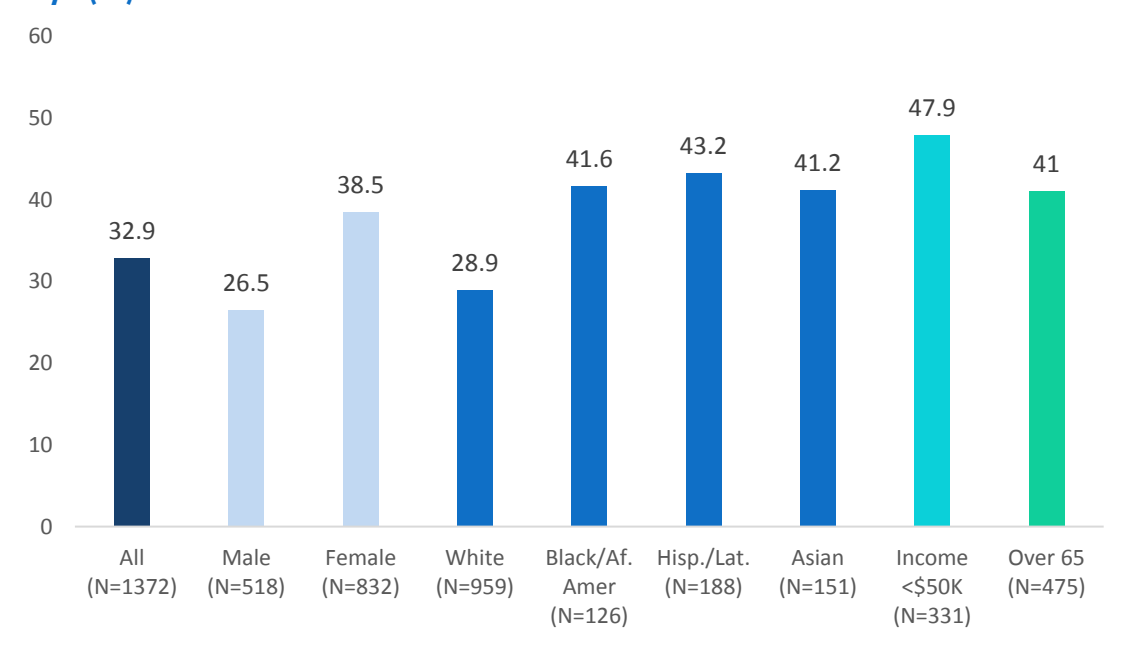
ROUTINE HEALTH VISITS

- **Primary care providers.** Among all respondents to the Bergen County Random Household Survey, 83.9% reported that they had one person they considered their personal care doctor or primary care provider. Percentages were lowest among Hispanic/Latino respondents (77.2%).

- **Primary care visits.** Among all respondents to the Bergen County Random Household Survey, 70.3% reported that they had a primary care visit within the last year. Percentages were similar across racial/ethnic cohorts. Percentages were highest among respondents over 65 years old (87.4%).

- **Disparities in dental visits.** Approximately 70% of respondents reported having been to the dentist within the past year. Percentages were lowest among low-income respondents (54.1%) and Black/African American respondents (55.9%).

Figure 14: Bergen County Random Household Survey — Has Primary Doctor/Primary Care Provider (%)
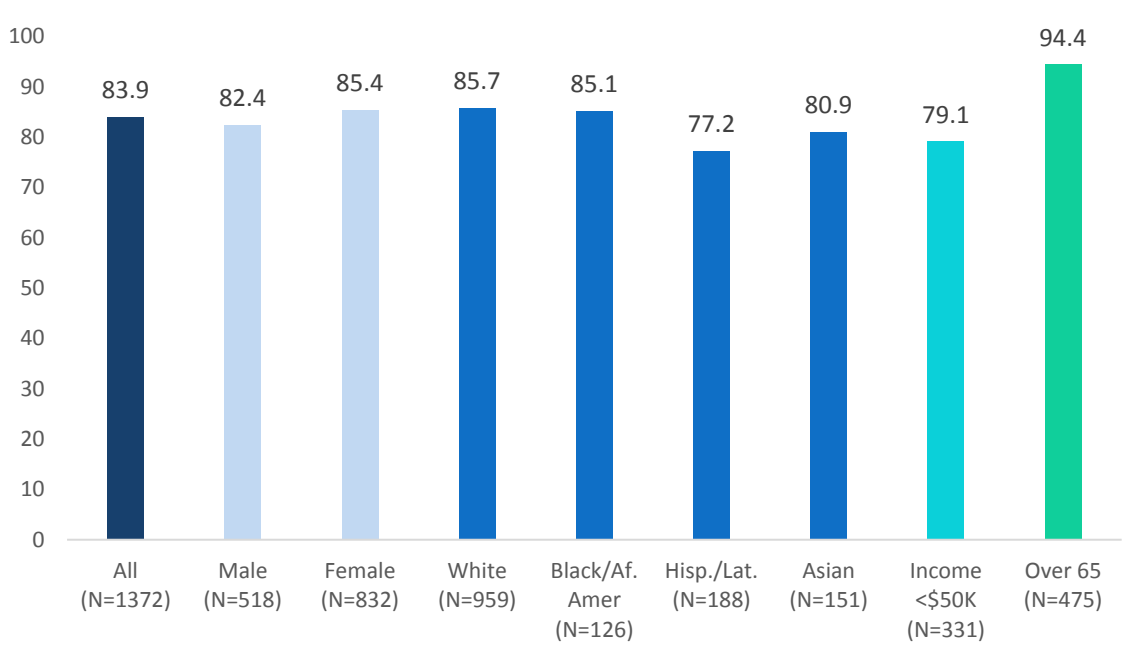
Category	Value
All (N=1372)	83.9
Male (N=518)	82.4
Female (N=832)	85.4
White (N=959)	85.7
Black/Af. Amer (N=126)	85.1
Hisp./Lat. (N=188)	77.2
Asian (N=151)	80.9
Income <$50K (N=331)	79.1
Over 65 (N=475)	94.4

Figure 15: Bergen County Random Household Survey — Had Primary Care Visit within Past Year (%)

Category	Value
All (N=1372)	70.3
Male (N=518)	68.7
Female (N=832)	72
White (N=959)	70.3
Black/Af. Amer (N=126)	70.8
Hisp./Lat. (N=188)	67.1
Asian (N=151)	73.6
Income <$50K (N=331)	70.6
Over 65 (N=475)	87.4
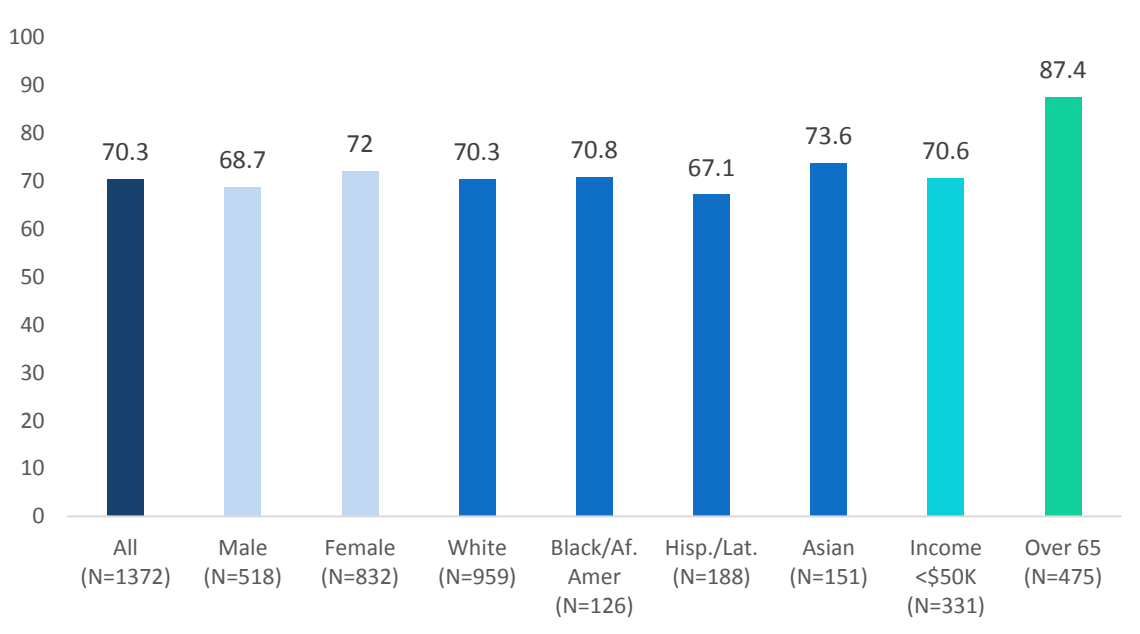
Figure 16: Bergen County Random Household Survey – Had Dental Visit within Past Year (%)

Bar chart showing percentage of respondents who had a dental visit within the past year by demographic group:

Group	Percentage
All (N=1372)	70.6
Male (N=518)	71
Female (N=832)	70.3
White (N=959)	73.8
Black/Af. Amer (N=126)	55.9
Hisp./Lat. (N=188)	65.1
Asian (N=151)	70.1
Income <$50K (N=331)	54.1
Over 65 (N=475)	68.5
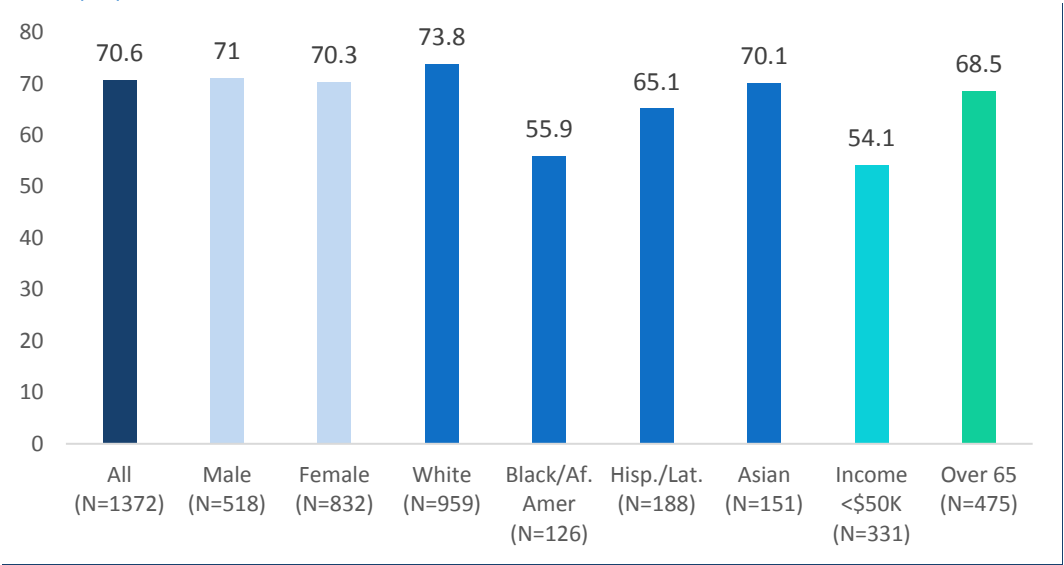
KEY FINDINGS: CHRONIC AND COMPLEX CONDITIONS

Chronic and complex conditions such as heart disease, cancer, stroke, Alzheimer's disease, and diabetes are the leading causes of death and disability in the United States, and are the leading drivers of the nation's $3.3 trillion annual healthcare costs.[20] Over half of American adults have at least one chronic condition, while 40% have two or more.[21] Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

This section discusses specific conditions in rough order of how they were prioritized in the assessment process. Age-specific findings (older adult health/healthy aging and children/families) follow the discussion of specific conditions.

CARDIOVASCULAR & CEREBROVASCULAR DISEASES

- **Heart disease was the leading cause of death in Bergen County in 2017**, representing 25.7% of all deaths. Heart disease was also the leading cause of death in Hudson County, representing 25.4% of deaths.[22]

- **Cardiovascular and cerebrovascular disease mortality, inpatient hospitalization, and emergency discharge rates were significantly low in Bergen County and Hudson County compared to the state overall.** Despite this, key informants, focus group/listening session participants, and community residents in Bergen County identified these issues as priorities.

> The Bergen County Community Health Perceptions Survey asked respondents what health issues they think people in their community struggle with the most. "Cardiovascular conditions (e.g., high blood pressure/hypertension, heart disease)" was the most common response (49.2%).

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[20] "Chronic Diseases in America," *Centers for Disease Control and Prevention,* 15 April 2019, https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

[21] CDC, *Chronic Diseases in America*

[22] New Jersey Department of Health, Death Certificate Database, Office of Vital Statistics and Registry (2017)

Table 7: Cardiovascular and Cerebrovascular Disease Mortality, Inpatient Hospitalizations, and Emergency Room Discharges (crude rates per 100,000)

	New Jersey	Bergen County	Hudson County
Cardiovascular disease			
Mortality	207.3	199.3	142.2
Inpatient hospitalizations*	1082.6	871.1	831.4
Emergency department discharges*	303.6	252.5	253.7
Cerebrovascular disease			
Mortality	38.3	36.7	26.5
Inpatient hospitalizations*	243.0	206.3	196.6
Emergency department discharges*	38.0	19.2	31.1

*Source: Ne*w Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017
*Source: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, 2016
Shading represents statistical significance compared to the state data point. Figures highlighted in <mark>orange</mark> were significantly higher compared to the state overall, while figures highlighted in <mark>blue</mark> were significantly lower.

- **Racial/ethnic, age, and income disparities.** The Bergen County Random Household Survey revealed disparities in the percentage of residents who had been told by a doctor that they had high blood pressure, had a heart attack, or had a stroke.
  - Approximately 1 in 4 Bergen County Random Household Survey respondents had been diagnosed with high blood pressure by a physician (26.5%).
    - Percentages were highest among respondents over 65 (57.8%) and Black/African American respondents (37.5%).
  - 2.7% of Bergen County Random Household Survey respondents had experienced a physician-diagnosed myocardial infarction (heart attack).
    - Percentages were highest among respondents over 65 (8.1%) and male respondents (4.0%).
  - 1.8% of Bergen County Random Household Survey respondents had experienced a stroke.
    - Percentages were highest among respondents over 65 (6.1%), Black/African American respondents (4.0%), and low-income respondents (3.8%).

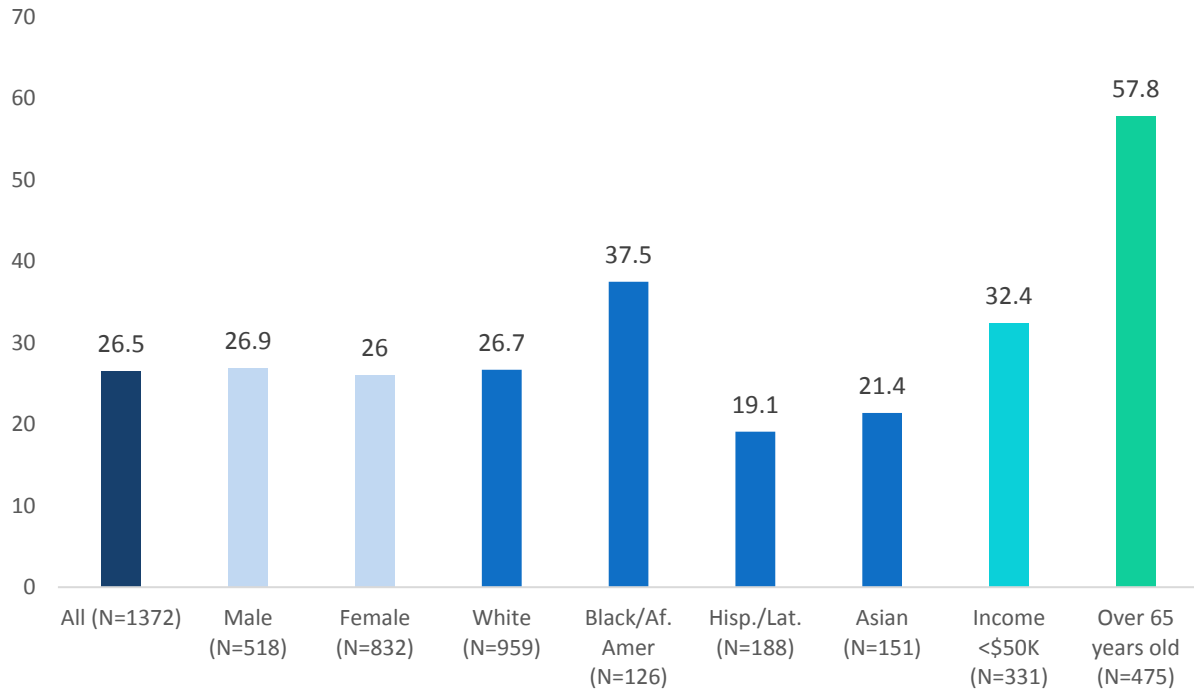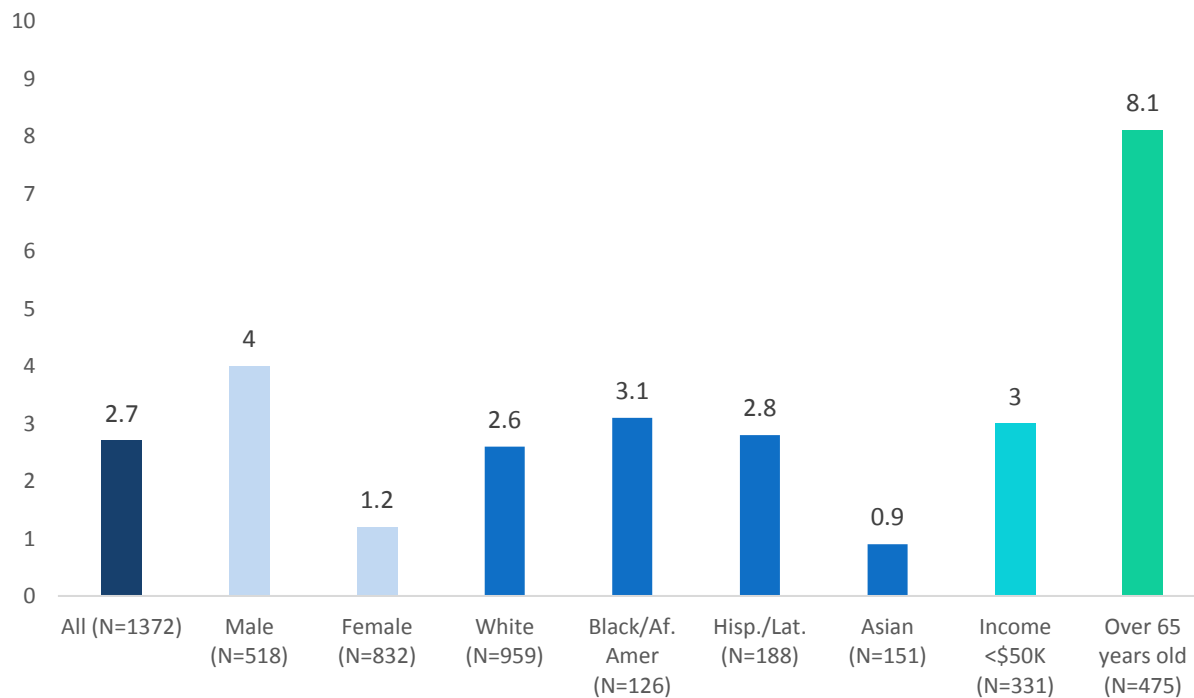**Figure 17: Bergen County Random Household Survey — Has Physician-Diagnosed High Blood Pressure (%)**

Category	%
All (N=1372)	26.5
Male (N=518)	26.9
Female (N=832)	26
White (N=959)	26.7
Black/Af. Amer (N=126)	37.5
Hisp./Lat. (N=188)	19.1
Asian (N=151)	21.4
Income <$50K (N=331)	32.4
Over 65 years old (N=475)	57.8

Figure 18: Bergen County Random Household Survey — Has Had a Physician-Diagnosed Heart Attack (%)

Category	%
All (N=1372)	2.7
Male (N=518)	4
Female (N=832)	1.2
White (N=959)	2.6
Black/Af. Amer (N=126)	3.1
Hisp./Lat. (N=188)	2.8
Asian (N=151)	0.9
Income <$50K (N=331)	3
Over 65 years old (N=475)	8.1

CANCER

SCREENINGS

- **Low-income respondents reported less frequent mammograms.** Among respondents to the Bergen County Random Household Survey, a smaller percentage of low-income women over 40 reported having had a recent mammogram (57.3%) compared to all female respondents over 40 (68.1%).

- **Disparities for recent PSA tests among men over 40.** Among men over 40 who responded to the Bergen County Random Household Survey, 44.9% reported a recent prostate antigen test (PSA). Percentages were lowest among low-income respondents (31.7%) and Hispanic/Latino respondents (33.5%).

- **Disparities in sigmoidoscopies/colonoscopies.** Among individuals over 50 who responded to the Bergen County Random Household Survey, 70.4% reported having ever had a sigmoidoscopy/colonoscopy. Percentages were lowest among Hispanic/Latino respondents (55.0%) and low-income respondents (56.7%).

- **Disparities in recent Pap tests.** Among women over 18 who responded to the Bergen County Random Household Survey, 58.9% reported having had a recent Pap test. Percentages were lowest among Asian respondents (39.2%) and low-income respondents (40.0%).

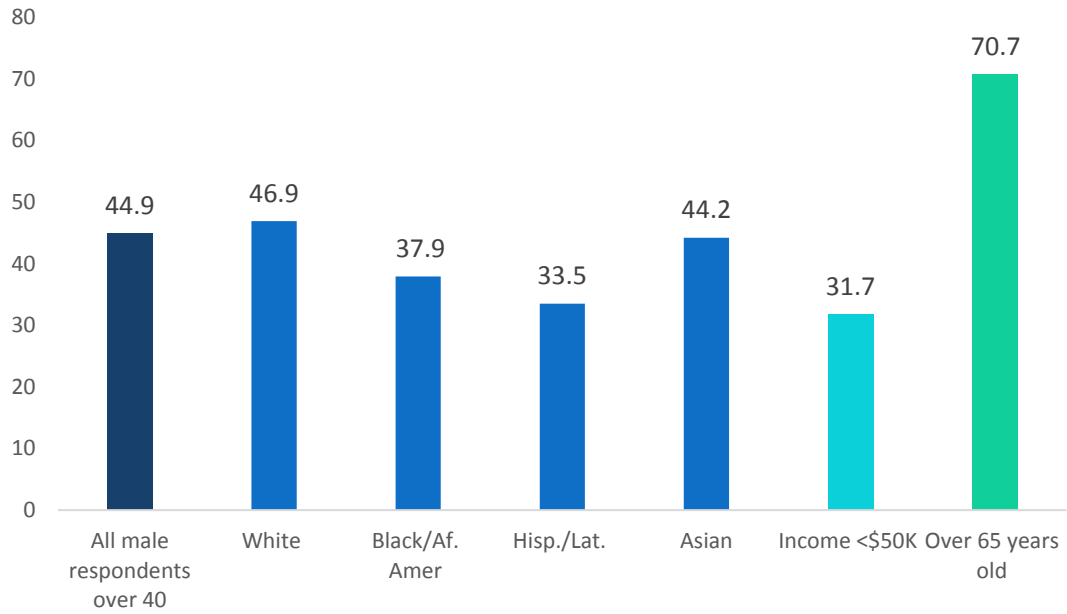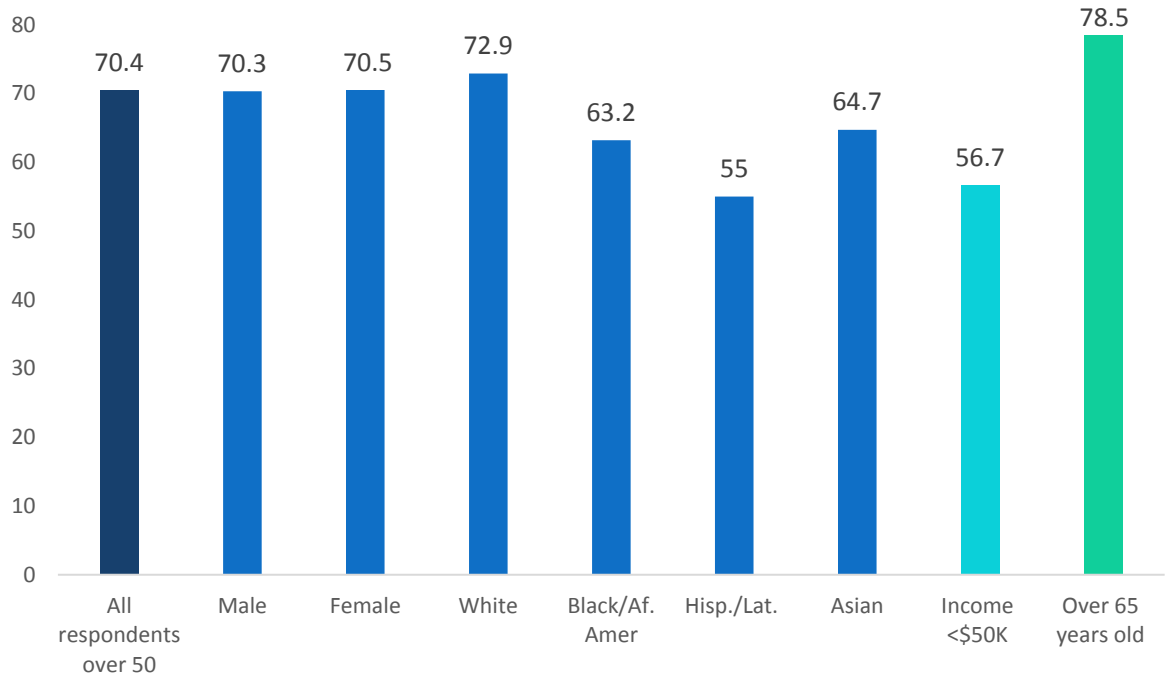**Figure 19: Bergen County Random Household Survey — Recent Mammogram among Women Over 40 (%)**
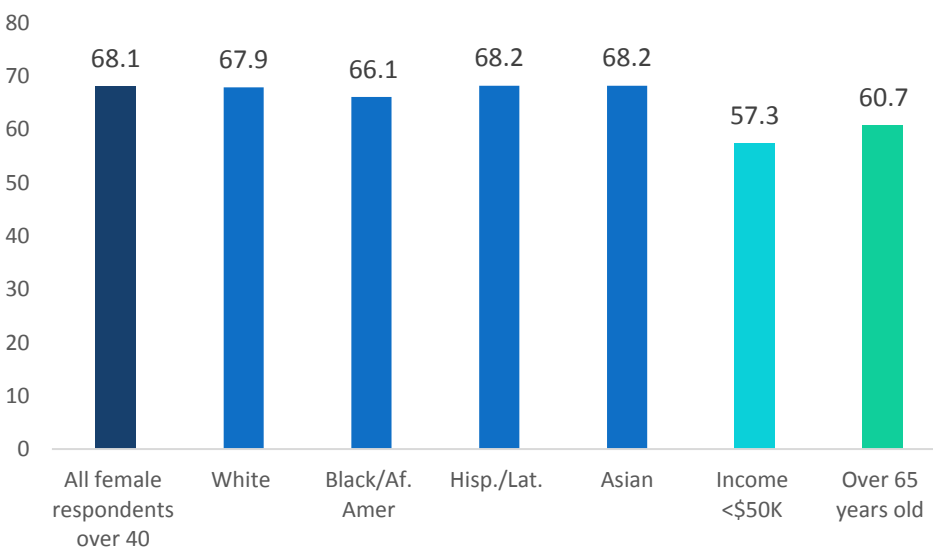
Figure 20: Bergen County Random Household Survey — Recent PSA among Men Over 40 (%)*


[2]The Prostate-Specific Antigen (PSA) test is primarily used to screen for prostate cancer.

Figure 21: Bergen County Random Household Survey — Ever Had Sigmoidoscopy/Colonoscopy among Men and Women Over 50(%)*

*Sigmoidoscopies and colonoscopies are the two main procedures to screen for colorectal cancer

## Figure 22: Bergen County Random Household Survey – Recent Pap among Women Over 18 (%)**
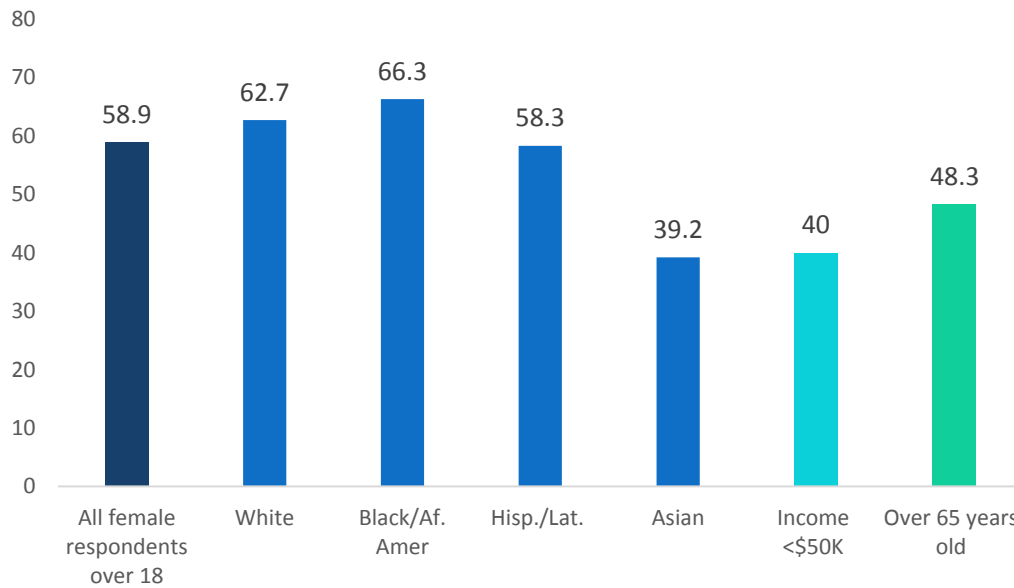
**The Papanicolaou (Pap) test is a method of cervical screening used to detect potentially precancerous and cancerous processes in the cervix.

DIAGNOSES

- **Approximately 1 in 10 Bergen County Random Household Survey respondents had ever been diagnosed with cancer (9.7%).** The percentage was higher among respondents over 65 (26.5%) and White respondents (12.0%).

Figure 23: Bergen County Random Household Survey – Ever Been Diagnosed With Cancer (Any Type) (%)
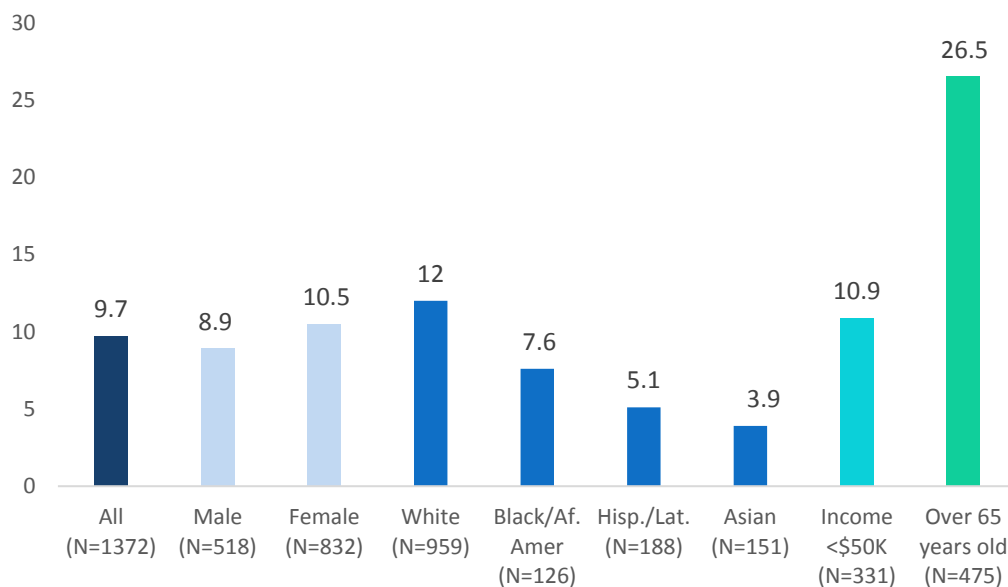
MORTALITY

- **Cancer was the second leading cause of death in Bergen County in 2017,** representing 22.6% of all deaths. It was also the second leading cause of death in Hudson County, representing 20.3% of deaths. [23]

> Key informants and focus group/listening session participants identified several needs for individuals with cancer and their caregivers, including more support groups, alternative/integrative therapies, assistance with care navigation and management, and respite services.

- **Cancer mortality rates similar to New Jersey.** In Bergen County, across all-types of cancer, breast cancer, colorectal cancer, lung cancer, and prostate cancer, mortality rates were similar to New Jersey overall (Figure 25). Mortality rates were lower than the state in Hudson County.

Figure 24: Cancer Mortality (crude rates per 100,000), 2013-2017
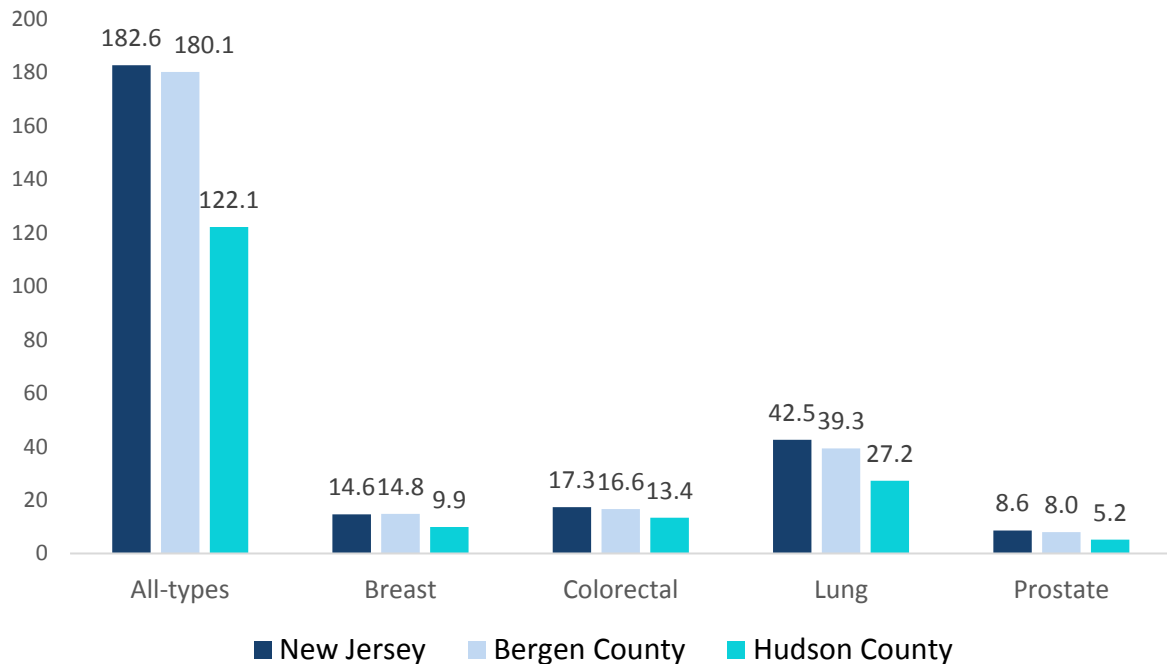
Source: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017

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[23] New Jersey Department of Health, Death Certificate Database, Office of Vital Statistics and Registry (2017)

DIABETES

- **Over 10% of survey respondents reported that they had diabetes.**
  - ○ Among respondents to the Bergen County Random Household Survey, 11.5% reported that they had been diagnosed with diabetes.
    - ○ Percentages were highest among respondents over 65 (22.1%), low-income respondents (16.7%), and Black/African American respondents (15.7%).
  - ○ 11.2% Bergen County Random Household Survey respondents reported that a physician had told them that they had borderline or pre-diabetes.
    - ○ Percentages were highest among respondents over 65 (19.8%) and low-income respondents (16.3%).

> Key informants and focus group/listening session participants prioritized many of the risk factors for diabetes — poor nutrition, physical inactivity, and obesity — and discussed the need for diabetes management and support services for those affected.

Figure 25: Bergen County Random Household Survey — Ever Been Diagnosed With Diabetes (%)

Bar chart values:
- All (N=1372): 11.5
- Male (N=518): 12.2
- Female (N=832): 10.9
- White (N=959): 11.1
- Black/Af. Amer (N=126): 15.7
- Hisp./Lat. (N=188): 7.8
- Asian (N=151): 12.1
- Income <$50K (N=331): 16.7
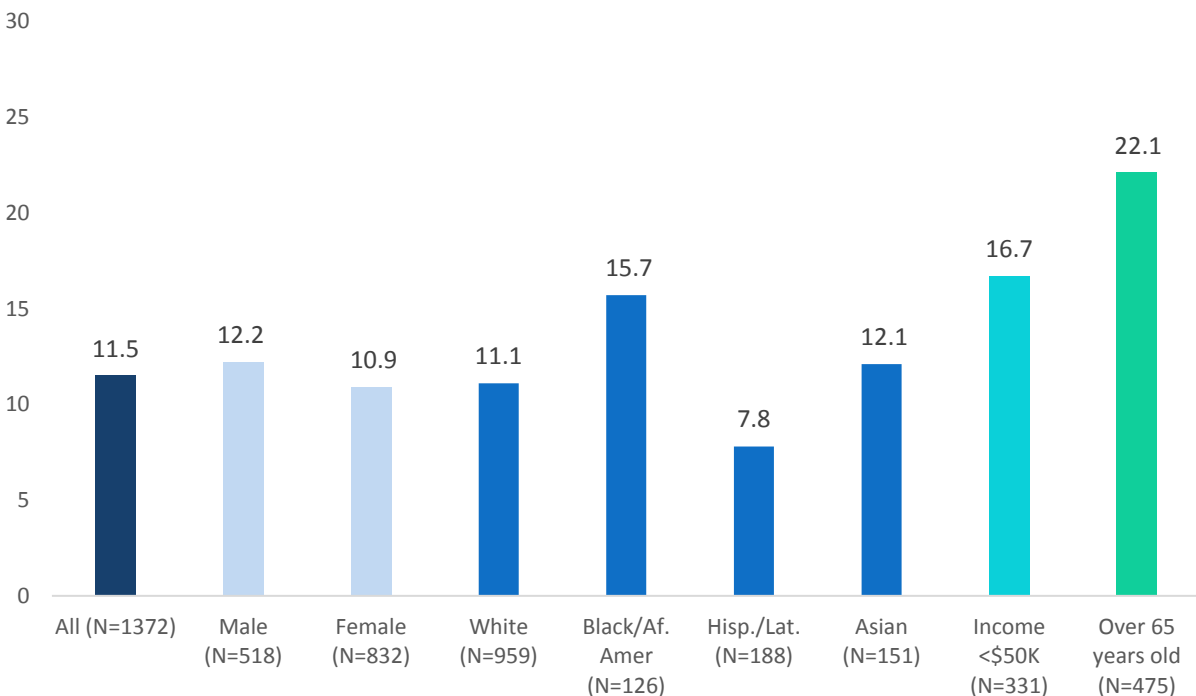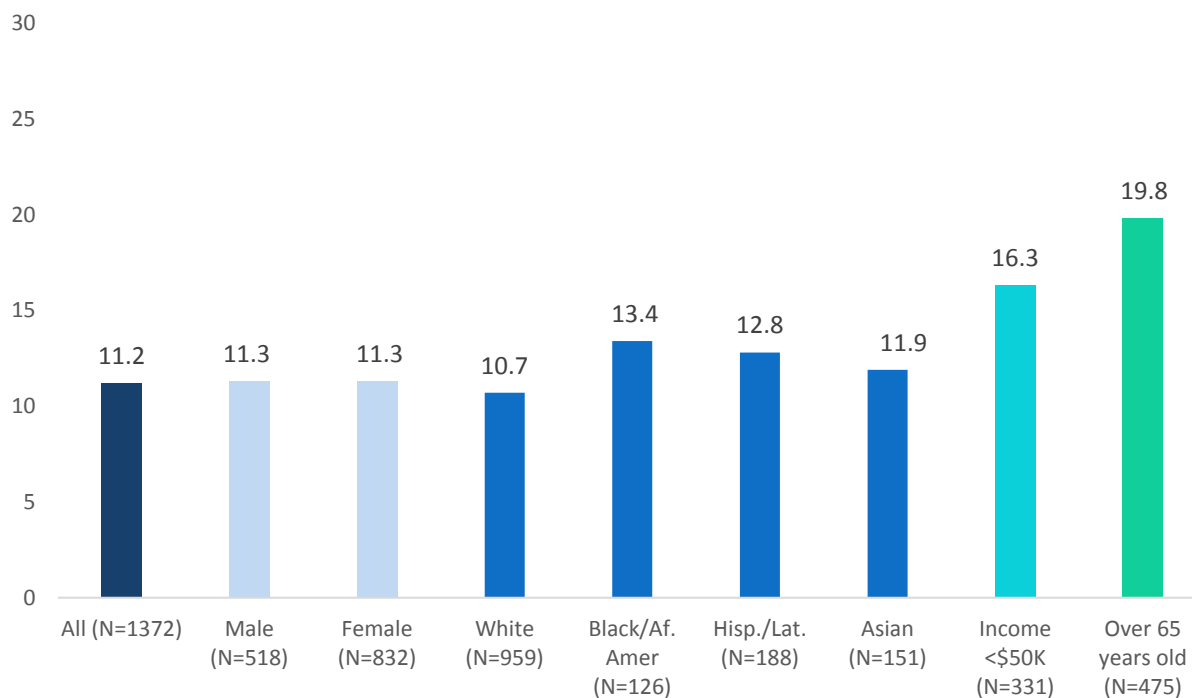- Over 65 years old (N=475): 22.1

Figure 26: Bergen County Random Household Survey — Ever Been Told They Had Borderline/Pre-Diabetes (%)

- **Diabetes mortality, inpatient hospitalizations, and emergency discharges were significantly lower than the State in Bergen County.** Rates were similar to the state in Hudson County.
  - In Bergen County, the diabetes mortality rate (17.9) was significantly low compared to New Jersey overall (22.1).[24] In Hudson County, the diabetes mortality rate was similar to the state overall (22.8).
  - In Bergen County, the rates of inpatient hospitalizations (105.6) and emergency department discharges (100.4) due to diabetes were significantly low compared to New Jersey overall (177.1 and 189.9, respectively).

Table 8: Diabetes Mortality, Inpatient Hospitalizations, and Emergency Department Visits

	New Jersey	Bergen County	Hudson County
Diabetes mortality	22.1	17.9	22.8
Diabetes inpatient hospitalizations*	177.1	105.6	190.1
Diabetes emergency room visits*	189.9	100.4	219.6

Source: Crude rates per 100,000; New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017
*Source: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, 2016
Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

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[24] New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017

ASTHMA

- 14.1% of respondents to the Bergen County Random Household Survey reported that a doctor had told them that they had asthma.
  - Percentages were highest among Black/African American (19.2%) respondents.

Figure 27: Bergen County Random Household Survey – Ever Been Told They Had Asthma (%)
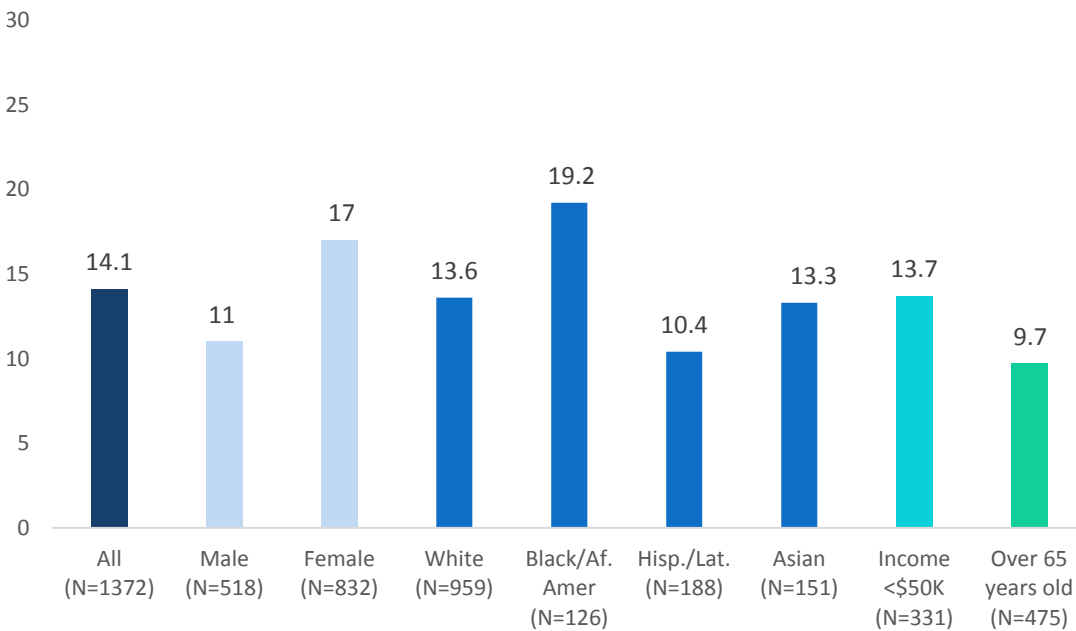
INFECTIOUS DISEASE

- **Pneumonia/Influenza -** The Influenza/pneumonia mortality rate was significantly high in Bergen County (16.5) compared to New Jersey overall (14.6). The rate was significantly lower than the state in Hudson County (10.7).[25]
  - Over half of Bergen County residents had not received a flu vaccination within the past 12 months.[26]

- **Hospitalizations –** The rate of inpatient hospitalizations due to pneumoconiosis and other lung diseases due to external agents was similar in Bergen County (55.8) and New Jersey overall (58.3).

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[25] New Jersey Death Certificate Database, Office of Vital Statistics and Registry, crude death rate per 100,000 2013-2017
[26] New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health, age-adjusted rates per 100,000 (2012-2016)

- **Sexually transmitted diseases** – Chlamydia, gonorrhea, and syphilis case counts were significantly low in Bergen County compared to New Jersey overall. Chlamydia and Syphilis case counts were significantly higher than the state in Hudson County (Table 9).

Table 9: Sexually Transmitted Diseases

	New Jersey	Bergen County	Hudson County
Chlamydia cases (counts per 100,000), 2013-2017	1772.8	947.8	2028.2
Gonorrhea cases (counts per 100,000), 2013-2017	427.7	147.2	469.3
Syphilis cases - primary, secondary, latent (counts per 100,000), 2013-2017	77.4	47.4	193.7

Source: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, 2013-2017
Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

- **Other communicable diseases** – In Bergen County Hepatitis B and Tuberculosis case rates in Bergen County was similar to New Jersey overall. Hepatitis C case rates were significantly lower than the state. HIV prevalence was lower than the state. In Bergen County, Hepatitis B case rates were significantly higher than the state. HIV prevalence and Tuberculosis case rates were also higher than the state, though statistical significance could not be calculated.

Table 10: Communicable Diseases

	New Jersey	Bergen County	Hudson County
Hepatitis B – acute, chronic, and perinatal (cases per 100,000), 2013-2017	4.2	4.3	5.6
Hepatitis C – acute, chronic, and perinatal (cases per 100,000), 2013-2017	85.5	40.9	84.1
HIV prevalence among those 13 years or older (cases per 100,000) 2015*	474	222	885
Tuberculosis (cases per 100,000), 2018**	3.3	3.7	7.4

Source: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, 2013-2017
*Source: National Center for HIV/AIDS, Viral Hepatitis, STD, and TB prevention, 2015
**Source: New Jersey Department of Health Tuberculosis Control Program

OLDER ADULT HEALTH/HEALTHY AGING

Additional information on the health of older adults is included throughout this report, where data is stratified by age.

- **Falls –** 14.9% of Bergen County Random Household Survey respondents 65 or older reported that they had fallen at least once in the past 3 months.

- **Advanced Directives/End of Life Care –** 58.7% of Bergen County Random Household Survey respondents 65 or older reported that they had no legal documents that provide end of life instructions (e.g., medical power of attorney, health care proxies, and advanced directives).

- **Social and emotional support –** 12.7% of Bergen County Random Household Survey respondents 65 or older reported that they rarely or never get the social and emotional support they need.
  - Within this same age cohort, 32% reported that they do not regularly participate in activities that allow them to socialize.

- **Neurological and memory disorders.**
  - The Alzheimer's disease mortality rate was significantly high in Bergen County (30.6) compared to New Jersey overall (25.2). The rate in Hudson County was significantly low (12.7).
  - The Parkinson's disease mortality rate in Bergen County (8.3) was similar to the state overall (9.5). The rate in Hudson County was significantly low (3.8).

The Bergen County Community Health Perceptions Survey asked people to name the populations with the greatest health needs. "Older adults (65+)" was the most common response (66.2%).

Many key informants and focus group/listening session participants were concerned about social isolation and depression for older adults, especially those that are frail, live alone, and lack a regular caregiver.

Table 11: Alzheimer's and Parkinson's Disease Mortality

	New Jersey	Bergen County	Hudson County
Alzheimer's Disease mortality (crude rate per 100,000)	25.2	30.6	12.7
Parkinson's disease mortality (crude rate per 100,000)	8.3	9.5	3.8

Source: Crude rates per 100,000; New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017
Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

MATERNAL & INFANT HEALTH

- **Teen births** – The adolescent birth rate was significantly low in Bergen County (1.4) compared to the state overall (5.3). The adolescent birth was significantly higher than the state in Hudson County (9.7).

- **Adequate prenatal care** – Approximately 66% of pregnant women in Bergen County and 58% of pregnant women in Hudson County received adequate prenatal care. [27]

- **Low birthweight and preterm births** – The percentage of low birthweight (<2500 g) infants and preterm births (<37 weeks) in Bergen County and Hudson County were similar to the state overall.

Table 12: Maternal and Infant Health

	New Jersey	Bergen County	Hudson County
Adolescent (15-19) birth rate per 1,000	5.3	1.4	9.7
Adequate prenatal care (%)	67.1	66.4	57.8
Low birthweight (%) (2017)	8.1	7.9	8.4
Preterm births <37 weeks (%)	9.6	9.7	9.5

Source: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, 2013-2017
Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower

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[27] The Kotelchuck Index, also called the Adequacy of Prenatal Care Utilization (APNCU) Index, uses two crucial elements obtained from birth certificate data-when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services). The Kotelchuck Index classifies the adequacy of initiation as follows: pregnancy months 1 and 2, months 3 and 4, months 5 and 6, and months 7 to 9, with the underlying assumption that the earlier prenatal care begins the better. To classify the adequacy of received services, the number of prenatal visits is compared to the expected number of visits for the period between when care began and the delivery date. A ratio of observed to expected visits is calculated and grouped into four categories-Inadequate (received less than 50% of expected visits), Intermediate (50%-79%), Adequate (80%-109%), and Adequate Plus (110% or more). The final Kotelchuck index measure combines these two dimensions into a single summary score. The profiles define adequate prenatal care as a score of 80% or greater on the Kotelchuck Index.

KEY FINDINGS: MENTAL HEALTH AND SUBSTANCE USE

Information on access to mental health and substance use treatment and support services is included in the "Social Determinants of Health and Access to Care" section of this report.

MENTAL HEALTH

- **Mental health issues were discussed for all population segments in Bergen County, though emphasis was on youth/adolescents, isolated older adults, and immigrants, refugees, and non-English speakers.**

  > Mental health, including depression, anxiety, stress, and other conditions — was overwhelmingly identified by key informants, focus group/listening session participants, and stakeholders as one of the leading health issue for residents of Bergen County.

  - **Youth/Adolescents -** Depression, stress, and anxiety are mental health issues affecting youth and adolescents. Several individuals cited increased pressure to succeed in school and extracurricular activities, the impacts of social media, and increased social isolation due to use of technology as contributing factors.

  - **Older Adults -** Many key informants and focus group/listening session participants identified social isolation as an issue for older adults. Participants suggested several reasons for this isolation – a lack of friends or family, inability to leave the home due to frailty or limited access to transportation, or unwillingness to leave the home for unknown reasons. While there are many active senior centers and Councils on Aging in Bergen County, participants reported that it was difficult for some older adults to attend activities or utilize services because of transportation or mobility issues.

  - **Immigrants, Refugees, non-English speakers -** In a focus group with Koreans in Bergen County – many of whom were older adults – social isolation was identified as a significant issue. Participants spoke about the loneliness that comes along with being a new immigrant, a non-English speaker, or someone who doesn't identify with a particular culture. Participants also noted that mental health issues have historically been considered taboo in Korean culture – many individuals do not feel comfortable speaking about these issues with family, friends, or health care providers.

Figure 28: Bergen County Random Household Survey — Sad, Blue, Depressed More Than 15 Days in Last Month (%)
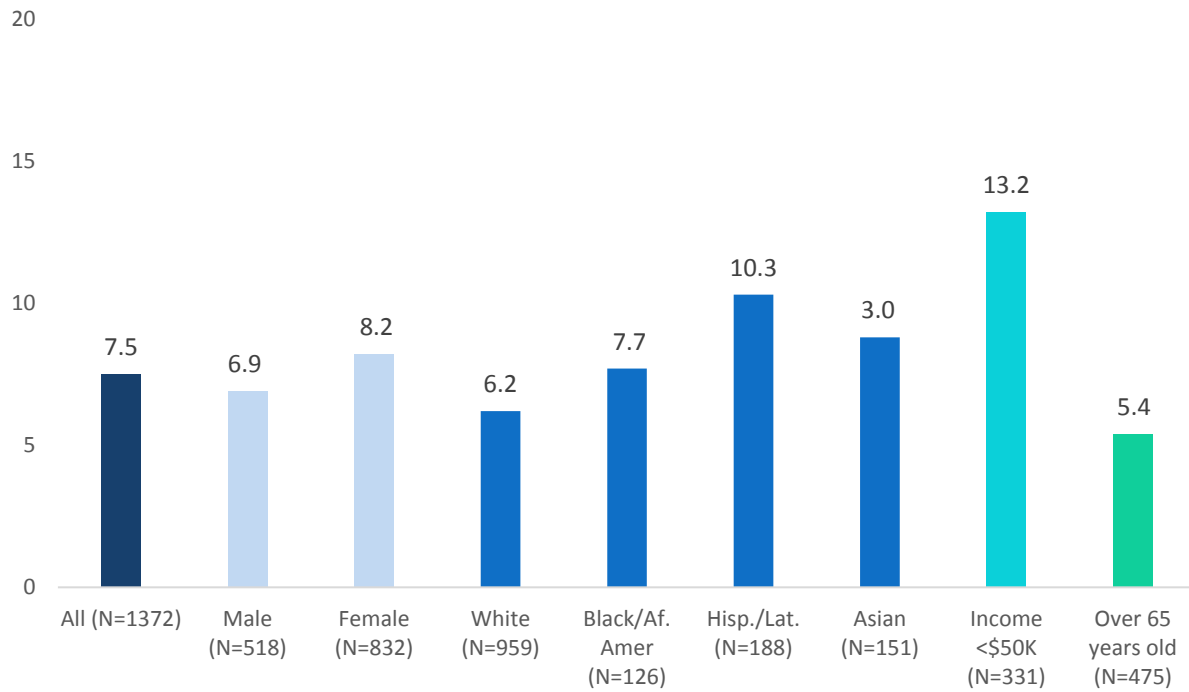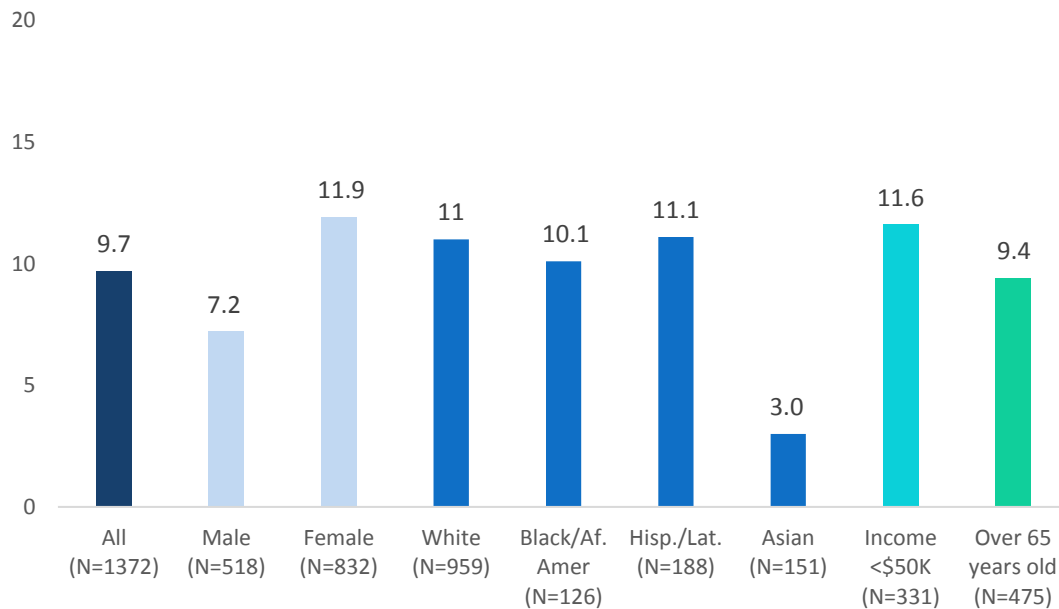

Figure 29: Bergen County Random Household Survey — Ever Been Diagnosed With Depressive Disorder (%)

- 13.9% of respondents reported that they had felt worried, tense, or anxious for more than 15 days within the past month. Percentages were highest among low-income (22.4%), female (16.1%), and Hispanic/Latino (15.8%) respondents.

- o **Over 1 in 10 with anxiety.** 12.7% of respondents to the Bergen County Random Household Survey reported that they had been diagnossed with an anxiety disorder. Percentages were highest among white (15.6%) and female (15.2%) respondents.

Figure 30: Bergen County Random Household Survey — Worried, Anxious, Tense More Than 15 Days in Last Month (%)
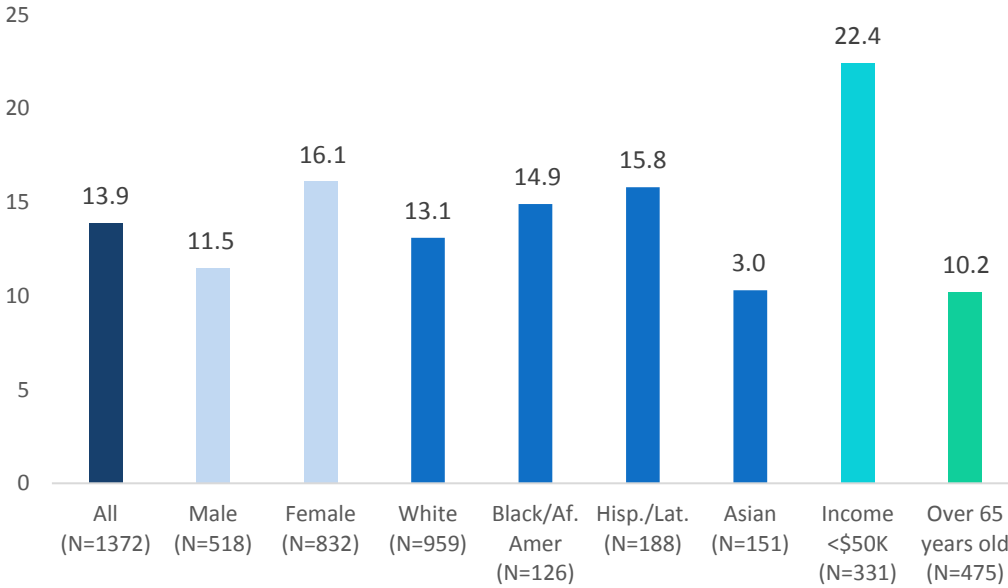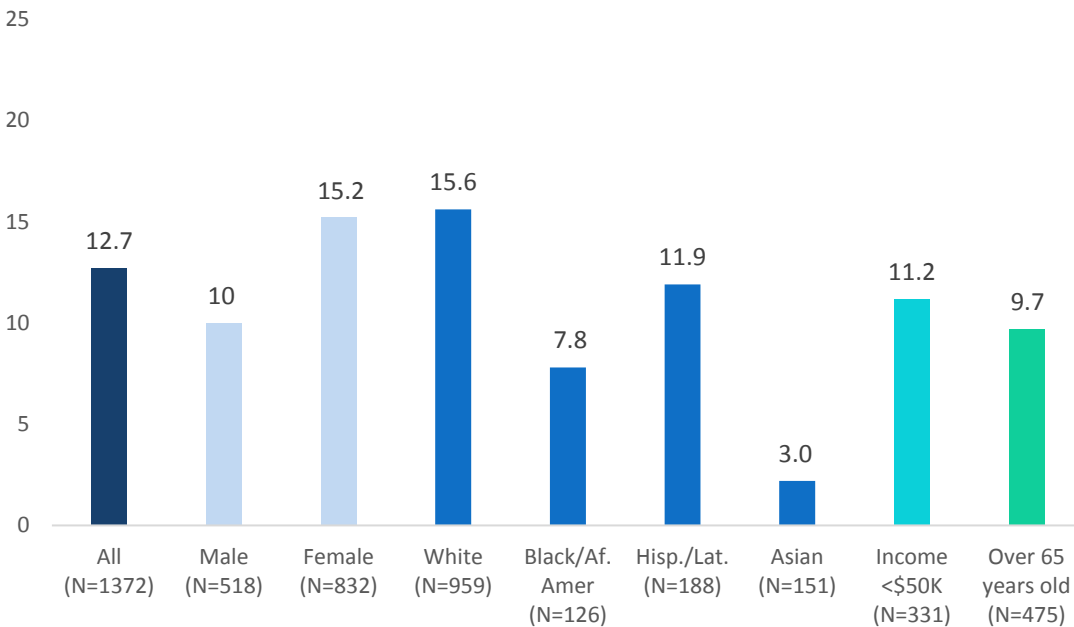

Figure 31: Bergen County Random Household Survey — Ever Been Diagnosed With Anxiety Disorder (%)

- **Mental and behavioral disorder inpatient hospitalization rate significantly high in Bergen County (557.3) compared to the state overall (525.1).** The rate was similar to the state overall in Hudson County (530.7).

Table 13: Mental and Behavioral Disorder Hospitalizations and Emergency Department Discharges

	New Jersey	Bergen County	Hudson County
Mental and behavioral disorder inpatient hospitalizations	525.1	557.3	530.7
Mental and behavioral disorder emergency department discharges	1122.9	651.4	1027.2

Source: Crude rates per 100,000; New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, 2016

Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower

SUBSTANCE USE

TOBACCO USE AND E-CIGARETTE/VAPING

- **18.9% of Bergen County Random Household Survey respondents were smokers.**
  - Nearly half of all Asian respondents (49%) smoked. The percentage was also high among low-income respondents (28.8%).

- **6.0% of Bergen County Random Household Survey respondents reported having used an e-cigarette or vapor product within the past 12 months.** It should be noted that the Bergen County Random Household Survey was aimed at reaching individuals over 18, thus the small percentage represents use among adult respondents only. According to the 2018 National Youth Tobacco Survey, e-cigarette use among high school students increased by a staggering 78% from 2017 to 2018.[28]
  - Among the Bergen County Random Household Survey respondents who reported using an e-cigarette/vapor product in the past 12 months, 24.7% reported that they used it to help them quit smoking.

> Key informants and focus group/listening session participants identified e-cigarette use among youth/adolescents as a critical issue.

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[28] "2018 NYTS Data: A Startling Rise in Youth E-Cigarette Use." *U.S. Food and Drug Administration*. Feb 6 2019. https://www.fda.gov/tobacco-products/youth-and-tobacco/2018-nyts-data-startling-rise-youth-e-cigarette-use

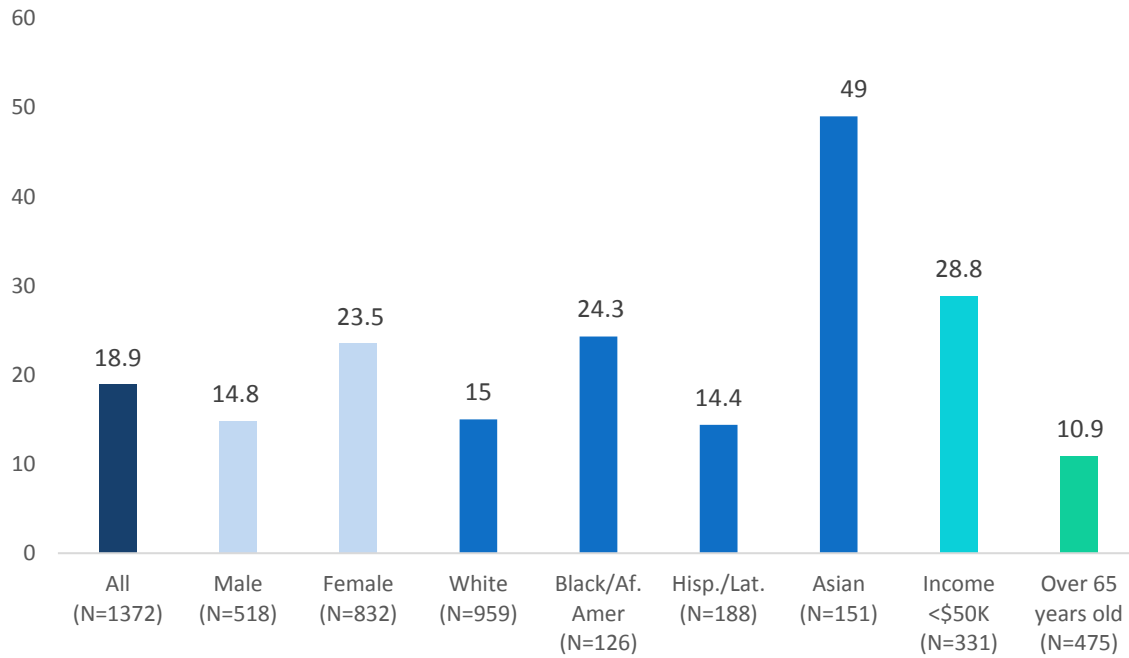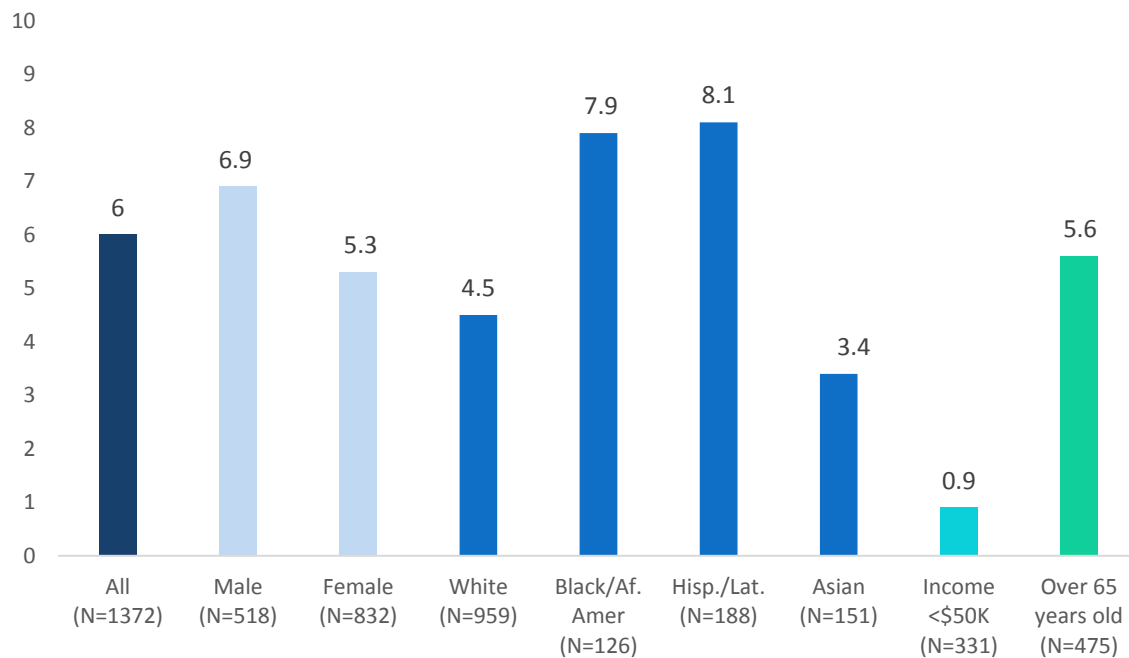**Figure 32: Bergen County Random Household Survey – Current Cigarette Smokers (%)**

Figure 33: Bergen County Random Household Survey – Used E-Cigarettes/Vapor Products in Past Year (%)


ALCOHOL USE

- **Risky/heavy drinking -** 5.0% of respondents to the Bergen County Random Household Survey reported heavy/risky drinking in the past 30 days – defined as having more than one alcoholic

beverage per day on average (7 drinks per week) for women, and more than two alcoholic beverages per day on average (14 drinks per week) for men.

- **Binge drinking -** 15.4% of respondents to the Bergen County Random Household Survey reported binge drinking in the past 30 days – defined as more than four alcoholic beverages at any one sitting for women, and five alcoholic beverages at any one sitting for men. Percentages were highest among male (19.2%) respondents.

## Figure 34: Bergen County Random Household Survey – Binge Drinking (%)
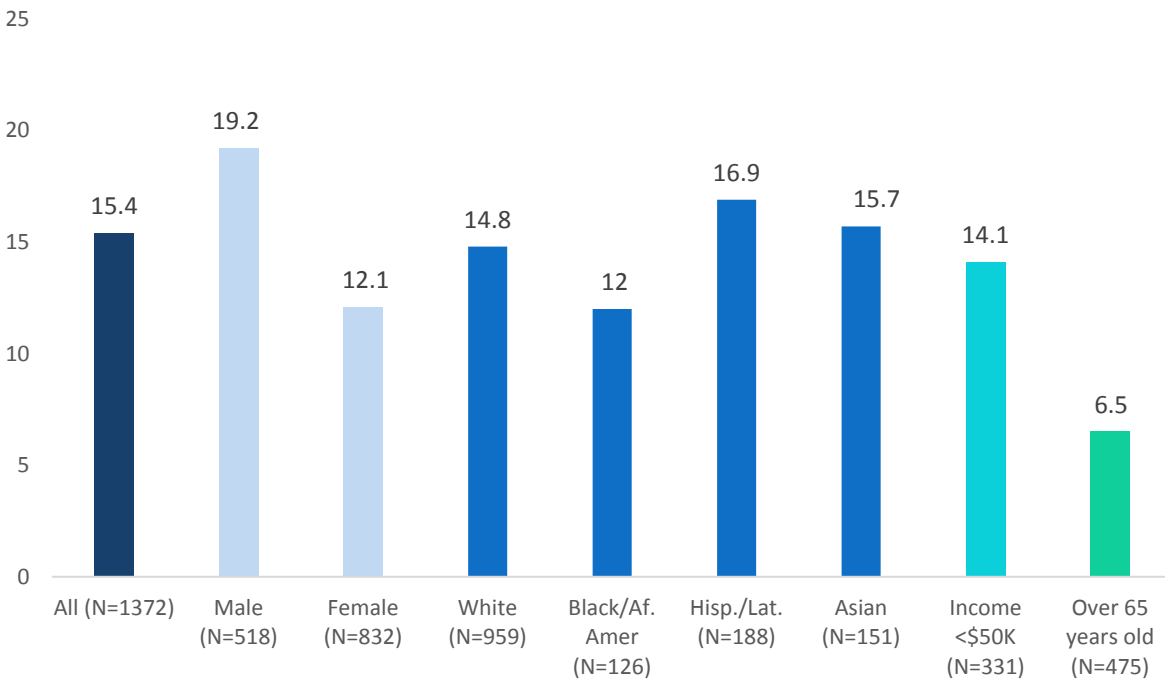
ILLICIT DRUG USE

- **7.8% of Random Household Survey respondents reported having used drugs (e.g., heroin, cocaine, crack, painkillers like Percocet, Dilaudid, Demerol, Vicodin, and OxyContin) within the past 12 months.** It should be noted that individuals who responded that they used painkillers did not define whether these substances were used as-prescribed or for recreational purposes.

- **In both Bergen and Hudson Counties, opioid overdose deaths have increased every year since 2014.**

- **The number of Naloxone (Narcan) administrations – to rapidly reverse an opioid overdose – have increased every year since 2015 in both counties.**

- **Prescriptions dispensed decreased.** Since 2015, the number of opioid prescriptions dispensed has steadily decreased in both Bergen and Hudson Counties.

Figure 35: Suspected Opioid Overdose Deaths in Bergen and Hudson Counties
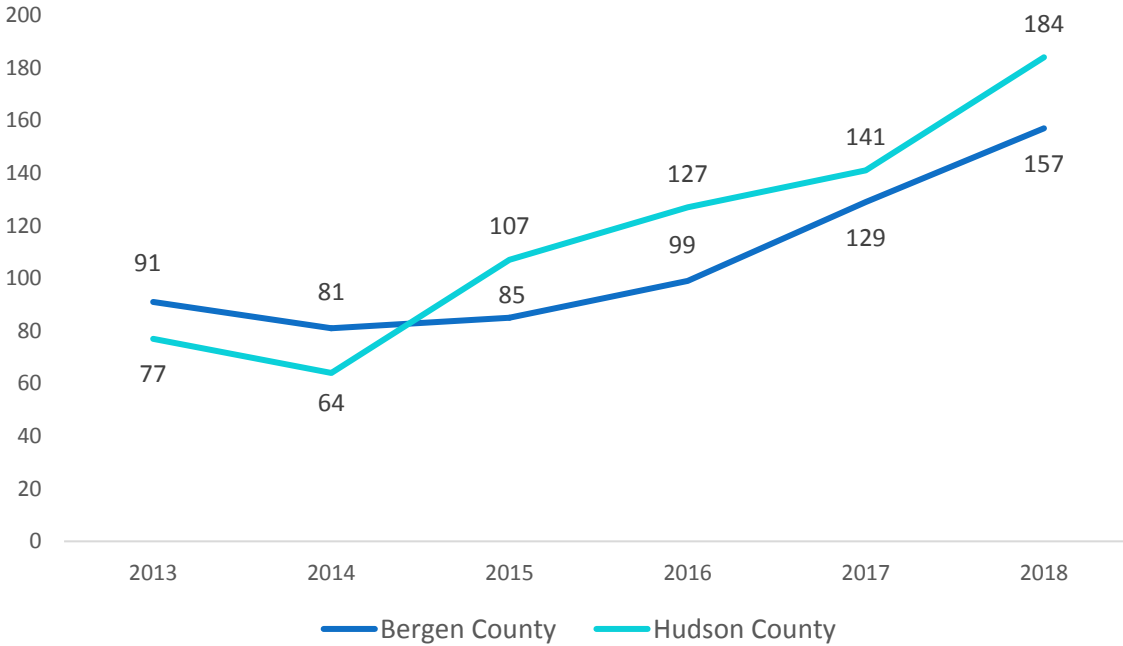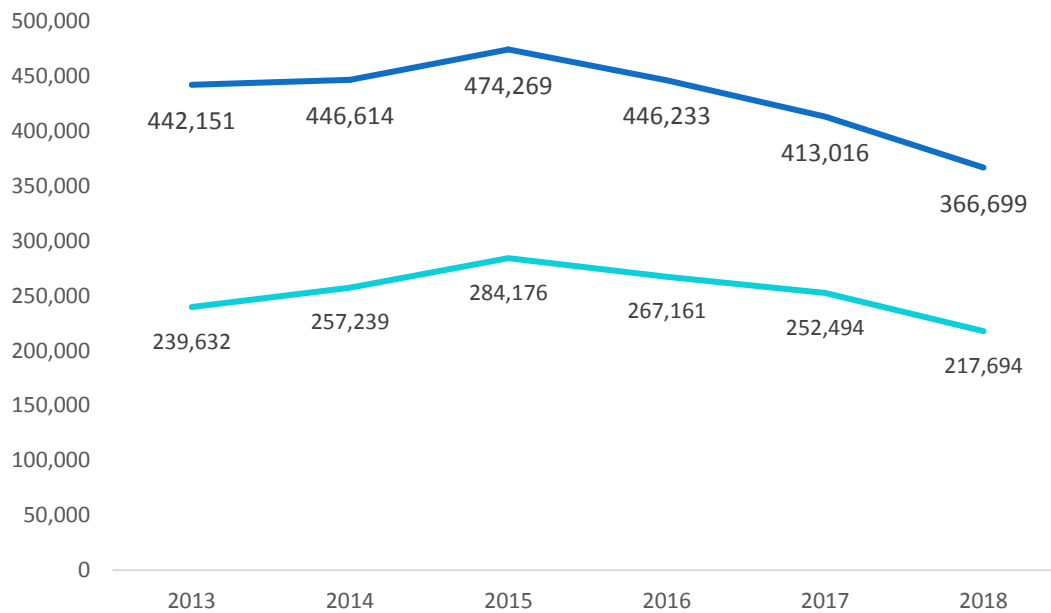

Source: NJCares, Office of the New Jersey Coordinator for Addiction Responses and Enforcement Strategies; State of New Jersey Office of the Attorney General

Figure 36: Naloxone (Narcan) Administrations in Bergen and Hudson Counties
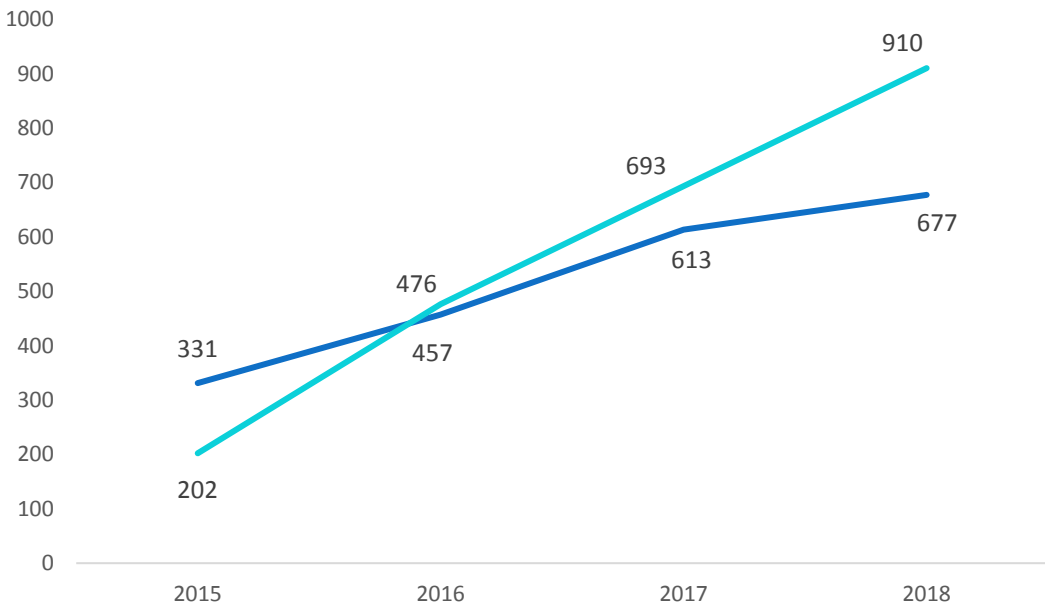
Source: NJCares, Office of the New Jersey Coordinator for Addiction Responses and Enforcement Strategies; State of New Jersey Office of the Attorney General

Figure 37: Opioid Prescriptions Dispensed in Bergen and Hudson Counties


Source: NJCares, Office of the New Jersey Coordinator for Addiction Responses and Enforcement Strategies; State of New Jersey Office of the Attorney General

MARIJUANA USE

- 11% of Random Household Survey respondents reported that they currently use marijuana.
  - Percentages were highest among male (14.6%) and white (13.1%) respondents.

Figure 38: Bergen County Random Household Survey — Currently Uses Marijuana (%)
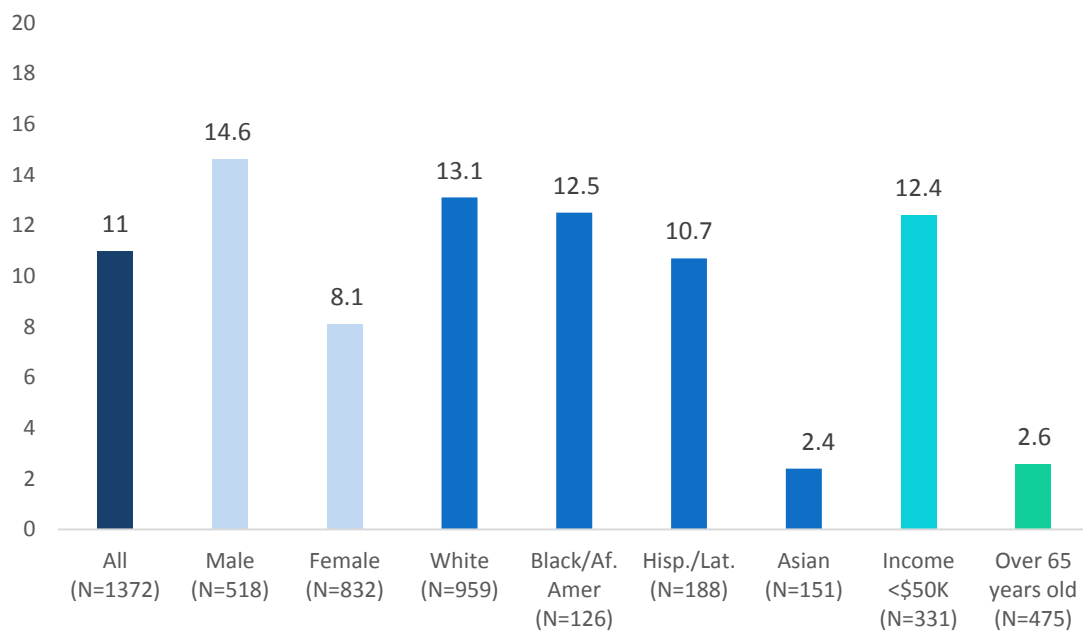
SUBSTANCE USE INPATIENT HOSPITALIZATIONS AND EMERGENCY DISCHARGES

- Inpatient hospitalizations and emergency department discharges due to injuries, poisonings, and toxic effects of drugs were significantly low in Bergen County compared to the state overall. The inpatient hospitalization rate was significantly low in Hudson County compared to the state (Table 14).

Table 14: Substance Use Hospitalizations and Emergency Department Discharges

	New Jersey	Bergen County	Hudson County
Injuries, poisonings, and toxic effect of drugs inpatient hospitalizations	145.9	103.2	114.4
Injuries, poisonings, and toxic effect of drugs emergency department discharges	1478.9	1120.4	1348.9

Source: Crude rates per 100,000; New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, 2016

Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower
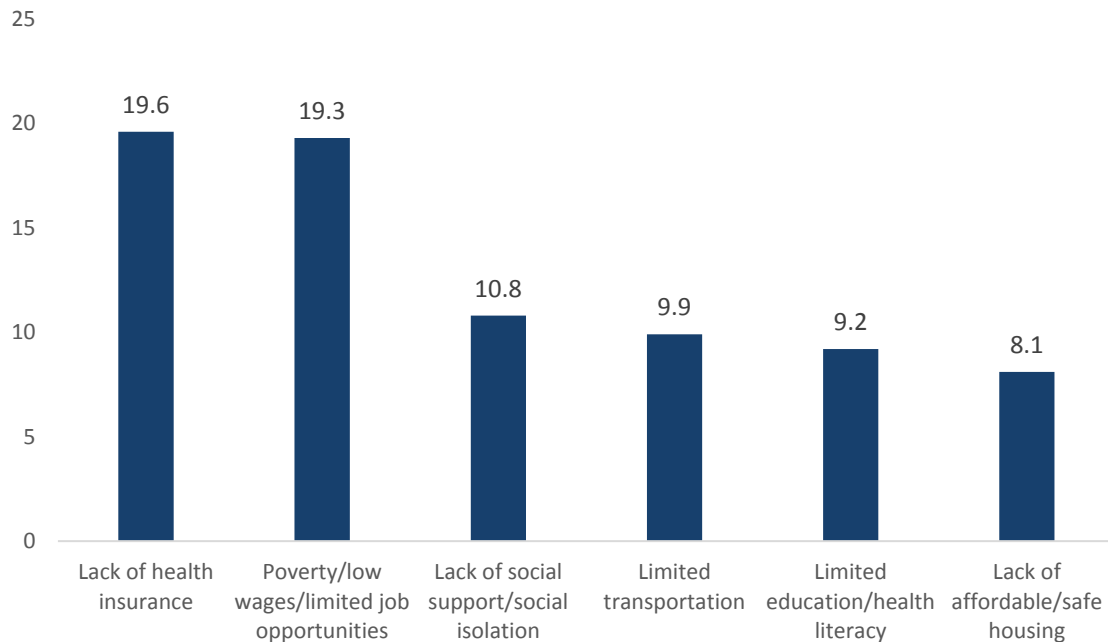
KEY FINDINGS: SOCIAL DETERMINANTS AND ACCESS TO CARE

PERCEIVED BARRIERS TO CARE

Just as it is important to understand and characterize disease burden, it is important to understand whether individuals are able to access health care services when they want them, where they want them, and how they want them. Throughout the assessment, key informants, focus/group listening session participants, and key stakeholders described the common barriers to care people when face when trying to access care in Bergen County. Many of these barriers are associated with the social determinants of the health – inability to pay for needed services or health insurance, lack of transportation, and linguistic/cultural barriers. Other barriers were related to issues within the health service system – lack of providers, inability to find appointments, and fragmented service systems.

- **Receiving all needed medical services -** 10.1% of Bergen County Random Household Survey respondents reported that they did not receive all of the medical services they needed in the past 12 months. Percentages were highest among low-income (14.4%) respondents.
  - Among those who did not receive needed care (of any kind) within the past 12 months, 4.1% of respondents reported that it was because of the high cost of care; 2.2% reported that it was because they had no health insurance.

- **Factors that limit access to care and impact health -** Bergen County Random Household Survey respondents were asked to identify the leading social factors or barriers that limit access to care or impact the health of those living in the community.
  - Lack of health insurance, poverty/low wages/limited job opportunities, lack of social support and social isolation, limited transportation, limited education/health literacy, and lack of affordable and/or safe housing were the top six responses.

HEALTH INSURANCE

Whether an individual has health insurance—and the extent to which it helps to pay for needed acute services and access to a full continuum of high-quality, timely and accessible preventive and disease management or follow-up services—has been shown to be critical to overall health and well-being.[29]

- **Insurance types -** In Bergen County, the percentage of the population that was uninsured (9.2%) was significantly low compared to New Jersey overall (9.7%). The percentage was significantly high in Hudson County (16.2%).[30]
  - The percentage of Bergen County residents with public insurance (e.g., Medicaid, Medicare) was also significantly low compared to New Jersey overall (24.3% vs. 29.7%). The perentage was significantly high in Hudson County (31.7%).
  - The percentage of Bergen County residents with private insurance (76.4%) was significantly high compared to New Jersey overall (71.6%). The percentage was significantly low in Hudson County (58.2%).

> The Bergen County Community Health Perceptions Survey asked people to name the issues they thought prevented people from living a healthy life. "No or limited health insurance" was the second most common response

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[29] "Health Insurance and Access to Care," *National Center for Health Statistics*, Feb. 2017, https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf
[30] US Census Bureau, American Community Survey, 2013-2017

Table 15: Health Insurance (2013-2017)

	New Jersey	Bergen County	Hudson County
Uninsured (%)	9.7	9.2	16.2
Public health insurance (e.g., Medicaid, Medicare) (%)	29.7	24.3	31.7
Private health insurance (%)	71.6	76.4	58.2

Source: US Census Bureau, American Community Survey, 2013-2017
Shading represents statistical significance compared to the state. Figures highlighted in orange were significantly high compared to the state overall, while figures highlighted in blue were significantly low.

- **Among respondents to the Bergen County Random Household Survey, 10.9% reported that they had been uninsured sometime within the past year.**
  - Percentages were highest among low-income (26.4%), Hispanic/Latino (20.2%), and Black/African American (19.3%) respondents.

Figure 40: Bergen County Random Household Survey – Uninsured Sometime Within Past Year (%)
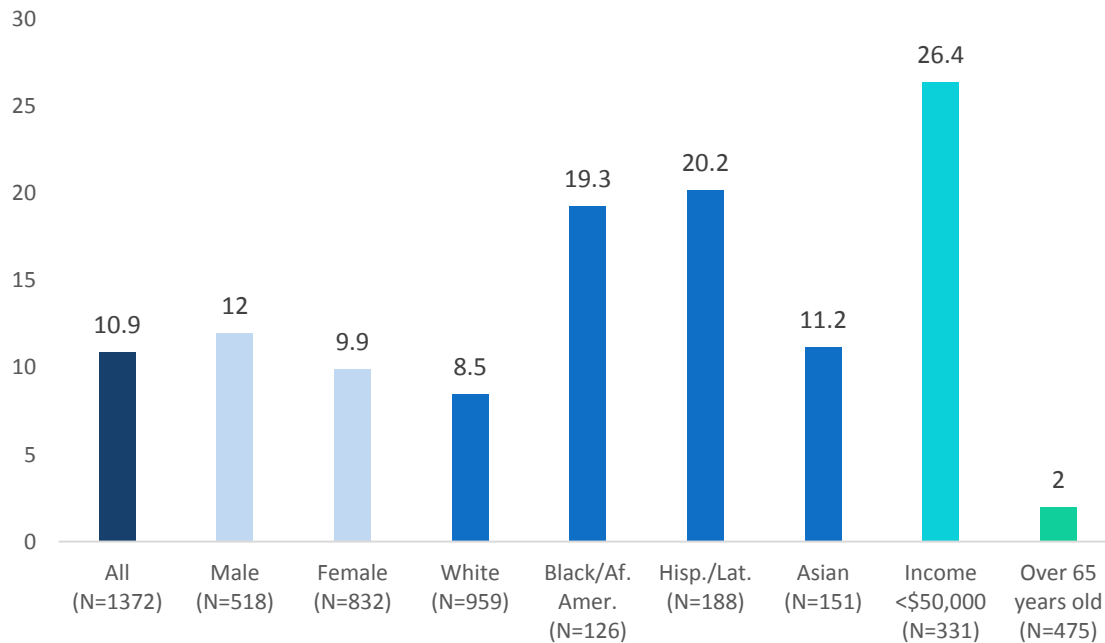

SERVICE UTILIZATION

- **20.2% of Bergen County Random Household Survey respondents reported that they had visited the emergency room one or more times in the past year.**
  - Percentages were highest among Black/African American respondents (28.8%) and those over 65 (24.9%).

- **9.3% of Bergen County Random Household Survey respondents reported that they had stayed in a hospital overnight for care of observation one or more times in the past year.**

Figure 41: Bergen County Random Household Survey – Visited Emergency Room At Least Once in Past Year (%)
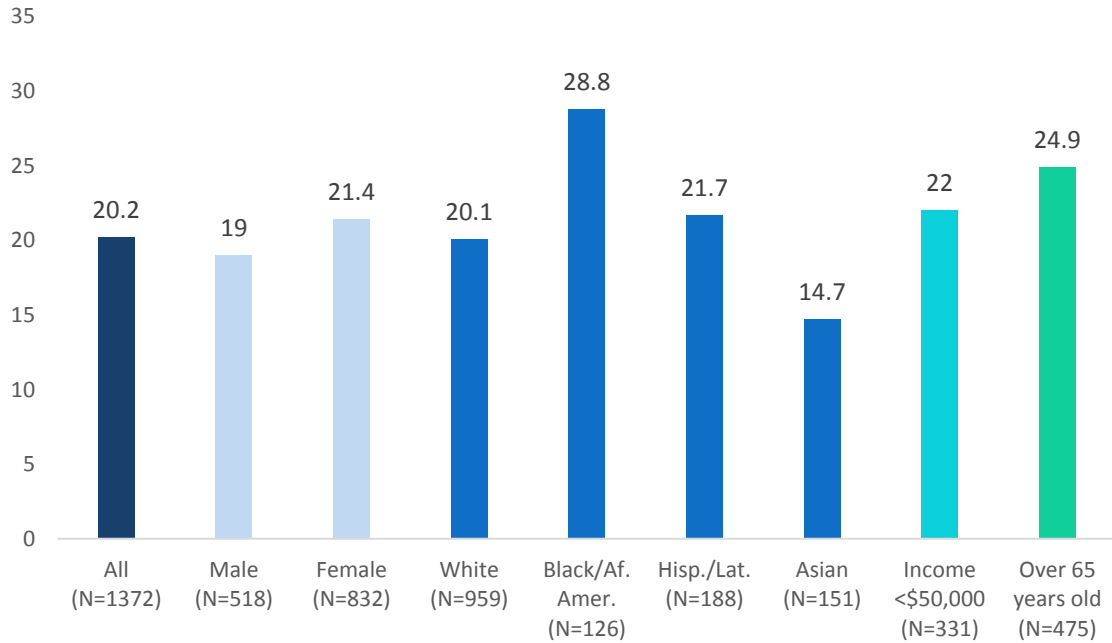
One of the major themes of this assessment was that individuals struggle to access behavioral healthcare services, including psychiatry, inpatient/outpatient mental health treatment, substance use detoxification and rehabilitation, outpatient substance use treatment, and medication-assisted treatment. Many of the individuals engaged during this assessment reported that hospitals and community partners were working to fill service gaps and address the needs of individuals and the community at-large, yet people continue to face delays or barriers to care due to limited providers and specialists, limited treatment beds, and social determinants that impede access to care (e.g., insurance coverage, transportation, employment, health literacy). Many participants also discussed the co-morbidity that often occurs between mental health and substance use issues, which complicates treatment options.

- **9.3% of Random Household Survey respondents that they received counseling, treatment, or medicine for mental health or substance use issues within the last 12 months.** Percentages were highest among low-income (11.2%) respondents.
  - o   17.8% of Bergen County Random Household Survey respondents reported that they never or rarely get the social/emotional help they need. Percentages were highest among Asian (34.3%), low-income (25.6%), and male (23.5%) respondents.

- **16.5% of respondents reported that they did not receive needed mental health care in the past year.** Percentages were highest among Black/African American (20.2%) and white (17.7%) respondents.

- **7.0% of respondents reported that they did not receive needed substance use treatment in the past year**. Percentages were highest among low-income (10.8%) and Asian (9.0%) respondents.

Figure 42: Bergen County Random Household Survey – Received Counseling, Treatment, or Medicine for Mental Health/Substance Use Issue in Past Year (%)
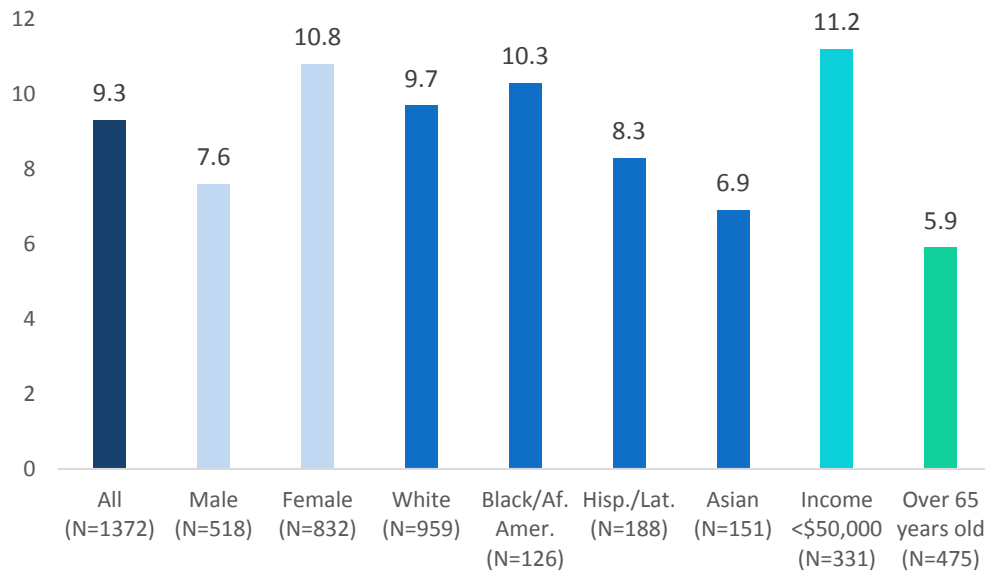

Figure 43: Bergen County Random Household Survey - Did Not Receive Needed Mental Health Treatment (%)
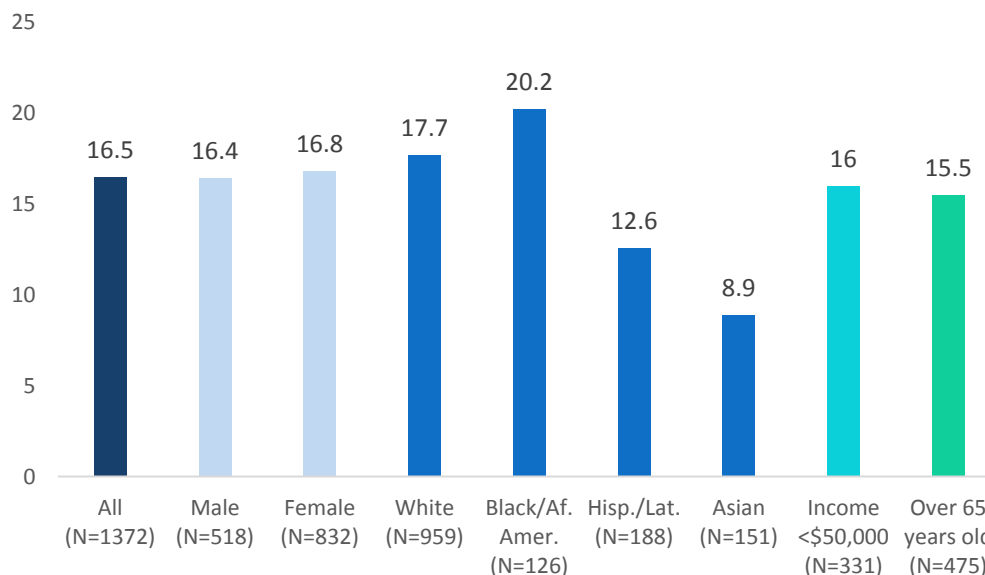
Figure 44: Bergen County Random Household Survey — Did Not Receive Needed Substance Use Treatment (%)

Category	Value
All (N=1372)	7.1
Male (N=518)	8.6
Female (N=832)	5.9
White (N=959)	6
Black/Af. Amer. (N=126)	4.6
Hisp./Lat. (N=188)	8.3
Asian (N=151)	9
Income <$50,000 (N=331)	10.8
Over 65 years old (N=475)	8.5
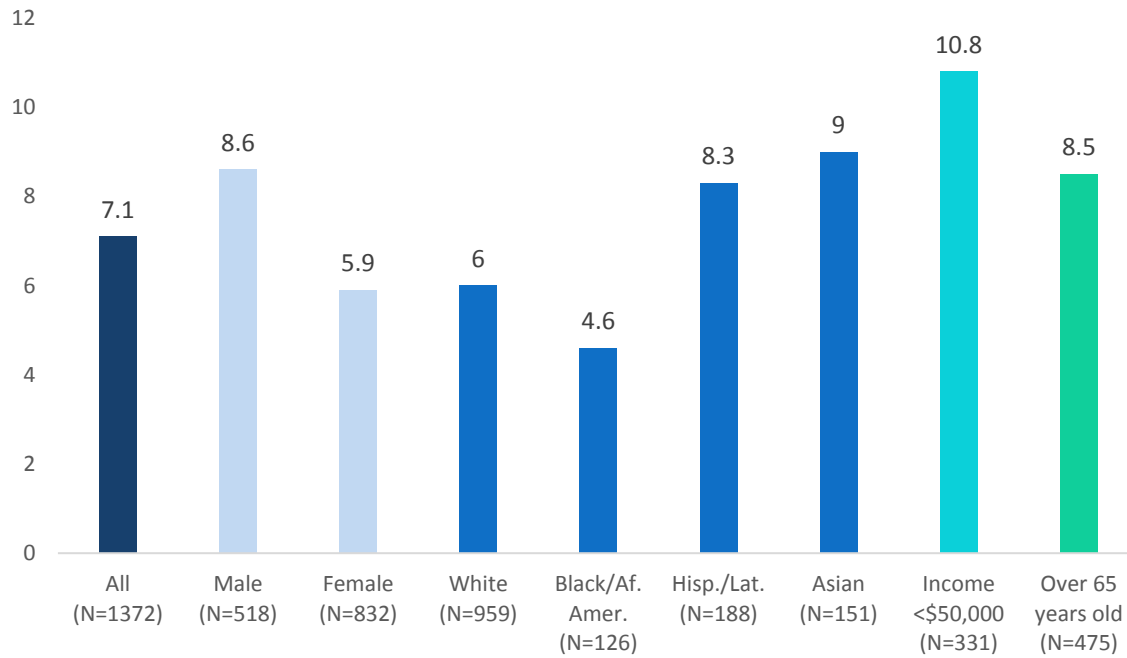
Figure 45: Bergen County Random Household Survey — Never or Rarely Get Social/Emotional Help They Need (%)

Category	Value
All (N=1372)	17.8
Male (N=518)	23.5
Female (N=832)	12.7
White (N=959)	15
Black/Af. Amer. (N=126)	11.5
Hisp./Lat. (N=188)	20.1
Asian (N=151)	34.3
Income <$50,000 (N=331)	25.6
Over 65 years old (N=475)	12.7
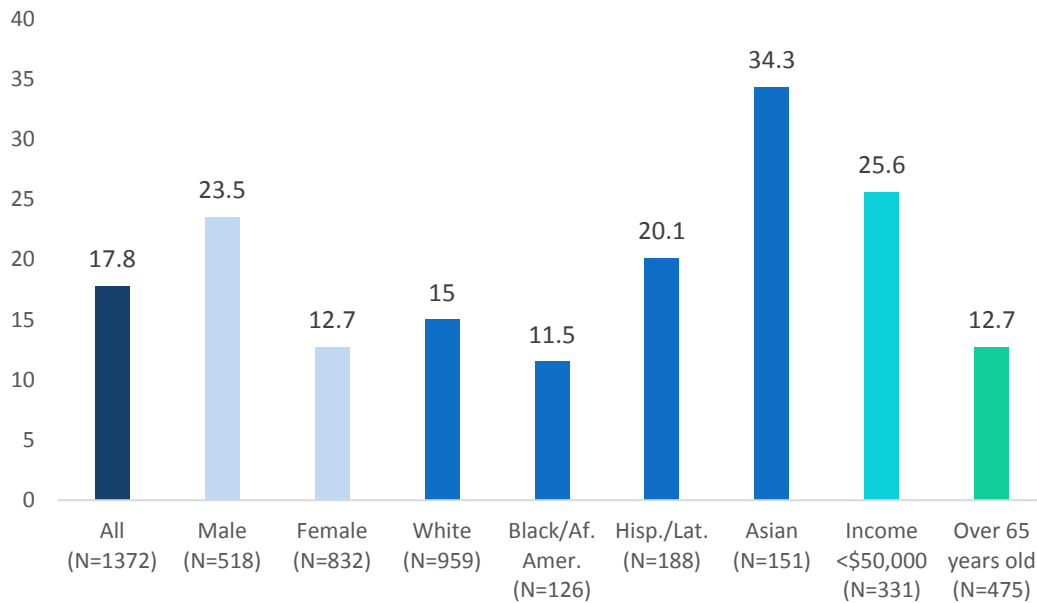
SUMMARY IMPLEMENTATION STRATEGY

This section provides a summary of the planning principles applied to the development of Holy Name Medical Center's Implementation Strategy. Below is also a discussion of the priority populations that the Implementation Strategy aims to reach, and goals, objectives, and strategies within each identified priority area. A full Implementation Strategy, with goals, objectives, strategies, sample measures, and potential community partners may be found in Appendix D.
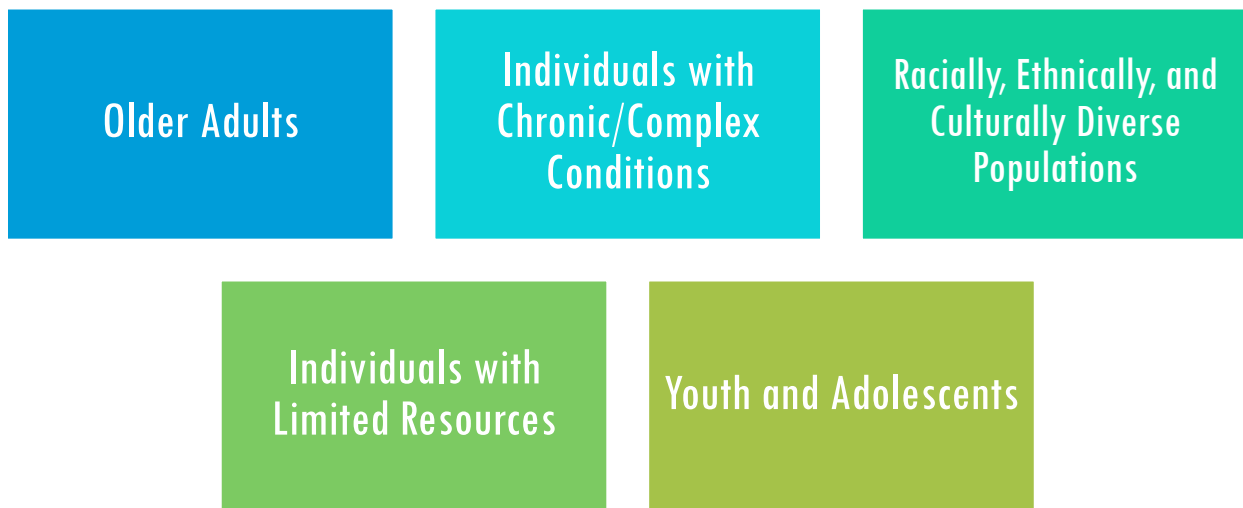
IMPLEMENTATION STRATEGY PLANNING PRINCIPLES

The following defines the types of programmatic strategies and interventions that were applied in the development of the Implementation Strategy.

- **Identification of those At-risk (Outreach, Screening, Assessment and Referral):** Screening and assessment programs reduce the risk of death or ill health from a specific condition by offering tests to help identify those who could benefit from treatment. A critical component of screening and referral efforts is to provide linkages to providers, treatment, and supportive services should an issue be detected.

- **Health Education and Prevention:** Initiatives that aim to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, or altering unhealthy behaviors. Programs might include targeted efforts to raise awareness about a particular condition or provide information on risk and protective factors.

- **Behavior Modification and Chronic Disease Management:** Evidence-based behavioral modification and/or chronic disease management programs that encourage individuals to manage their health conditions, change unhealthy behaviors, and make informed decisions about their health and care.

- **Care Coordination and Service Integration:** Initiatives that integrate existing services and expand access to care by coordinating health services, patient needs, and information.

- **Patient Navigation and Access to Care:** Efforts which aim to help individuals navigate the health care system and improve access to services when and where they need them.

- **Cross-Sector Collaboration and Partnership:** Includes collaborations, partnerships, and support of providers and community organizations across multiple sectors (e.g., health, public health, education, public safety, and community health).

PRIORITY POPULATIONS

Holy Name Medical Center is committed to improving the health status and well-being of all residents living in Bergen County - certainly all geographic, demographic, and socioeconomic segments of the population face challenges that may impede their ability to access care or maintain good health. Regardless of age, gender, race/ethnicity, income, family history, or other characteristics, everyone is impacted in some way by health-related disparities. With this in mind, Holy Name's Implementation Strategy includes activities that will support all residents, across all segments of the population. However, based on the assessment's quantitative and qualitative findings, there was agreement that Holy Name should prioritize certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care, service gaps, or adverse social determinants of health, which put them at greater risk.

Figure 46: Holy Name Medical Center Priority Populations 2020-2022

Older Adults	Individuals with Chronic/Complex Conditions	Racially, Ethnically, and Culturally Diverse Populations
	Individuals with Limited Resources	Youth and Adolescents

OLDER ADULTS

The challenges faced by older adults came up in nearly every interview and focus group. Chronic disease, social isolation/lack of family support, living on fixed incomes, affordable housing, and transportation were identified as significant issues. In the U.S. and New Jersey, older adults are among the fastest growing age groups.

Older adults experience a higher risk of chronic and complex conditions such as heart disease, cancer, stroke, diabetes, and neurological disorders (e.g., dementia, Alzheimer's, Parkinson's disease). These conditions contribute to the leading causes of death for older adults and may affect an individual's quality of life, especially for those who manage two or more chronic conditions.[31]

Significant proportions of this group experience hospitalizations, are admitted to nursing homes, and receive home health services and other social supports in home and community settings. Individuals

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[31] "Older Adults." *HealthyPeople.gov, Office of Disease Prevention and Health Promotion,* https://www.healthypeople.gov/2020/topics-objectives/topic/older-adults

engaged in this assessment were also concerned about the lack of services and programs addressing end-of-life care (e.g., palliative care, hospice care) and planning. Addressing these concerns demands a service system that is robust, diverse, and responsive.

INDIVIDUALS WITH CHRONIC AND COMPLEX CONDITIONS

Heart disease and cancer were the leading causes of death in New Jersey and in Bergen County. Along with other conditions, including asthma and diabetes, these conditions are considered to be chronic and complex and may strike early in one's life, possibly ending in premature death. It is important to note that the risk and protective factors for many chronic/complex conditions are the same, including lack of physical activity, poor nutrition, obesity, and substance misuse. Individuals with chronic/complex conditions often face significant barriers to care (e.g., transportation, lack of health literacy, fragmented care). These issues are exacerbated for frail elders, individuals without caregivers, those with limited mobility, those who lack financial resources, and individuals with complex behavioral health issues. Many key informants cited a need for care management, navigation, and care coordination for these populations. Several individuals also suggested a need for caregiver support programs and resources.

RACIALLY, ETHNICALLY, AND CULTURALLY DIVERSE POPULATIONS

Holy Name Medical Center serves a diverse population. Holy Name, and individuals engaged during this assessment, identified racially, ethnically, and culturally diverse populations as those that often face significantly disparities in accessing health care services. These populations may also experience disparities related to the social determinants of health (e.g. housing, income and employment, access to transportation) and overall health status. Holy Name is committed to providing culturally competent health care and will continue to work towards improving health care access and outcomes for all individuals in their service area.

Holy Name is also engaged in efforts to provide health care and supportive services to residents in Milot, Haiti. For more information, please see Appendix E.

INDIVIDUALS WITH LIMITED RESOURCES

Key informants, focus group participants, and hospital leadership discussed the challenges that many individuals and families face when they are forced to decide between necessary goods and services, including housing, food, transportation, childcare, and health care services. These choices often lead to missed care or delays in care, due to either the direct costs of care (co-pays and deductibles) or the indirect costs of transportation, childcare, or missed wages. Individuals engaged in this assessment identified lack of affordable housing as one of the leading issues in the region. Participants also spoke of the intense challenges that many moderate income individuals and families face due to the high cost of living in Bergen County, combined with the fact that most of those in middle-income cohorts are not eligible for subsidized public programs like Medicaid, food stamps, and Healthy Start. Holy Name will continue to support low-resource segments of the population to access the healthcare and community services they need to lead healthy and productive lives.
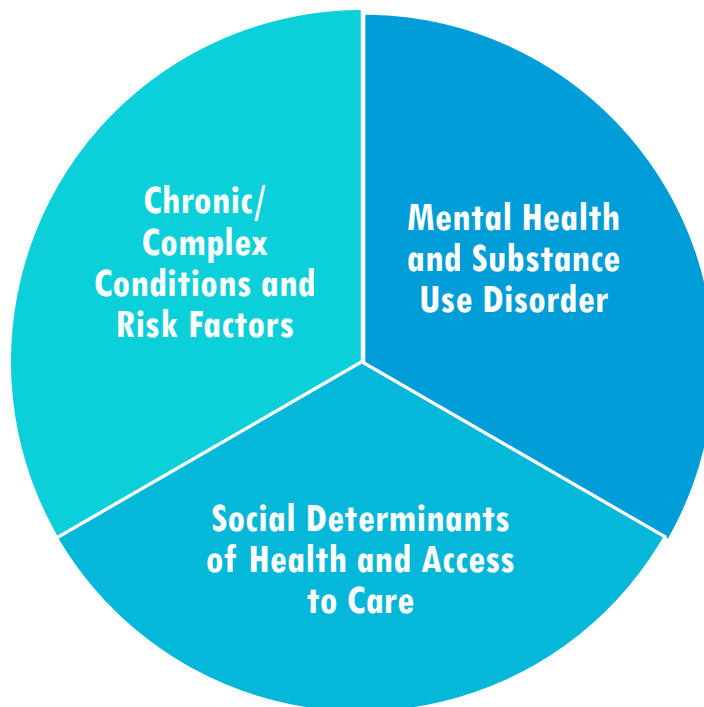
YOUTH AND ADOLESCENTS

Individuals that were engaged during this assessment identified youth as one of the most vulnerable and at-risk populations in the region. Participants' reasons for believing this group should be prioritized varied, but centered on the prevalence and impact of mental health and substance use. Children and adolescents are both in critical formative and transitional period that include biological and developmental milestones that are important to establishing long-term identity and independence. Although adolescents are generally healthy, they do struggle with health and social issues, such as obesity (e.g., poor nutrition and lack of physical activity), mental health (e.g., depression, anxiety, stress), substance use (e.g., cigarettes/vaping, marijuana, alcohol, opiates), sexually transmitted infectious, and injuries due to accidents. In order to thrive children and adolescents need strong, supportive families and/or other support networks to guide them through the early stages of life.

GOALS, OBJECTIVES, AND STRATEGIES BY PRIORITY AREA

Holy Name's community health priorities have been framed broadly to ensure that the full breadth of unmet needs and community health issues are recognized. The priorities have been identified to maximize impact, reduce disparities, and promote collaboration and cross-sector partnership.

Based on the findings from CHNA activities, and Holy Name's clinical expertise and service lines, leadership opted to prioritize the following community health issues: chronic/complex conditions and risk factors, mental health and substance use disorder, and social determinants of health and access to care.

Figure 47: Holy Name Medical Center Community Health Priority Areas 2020-2022

PRIORITY AREA: CHRONIC/COMPLEX CONDITIONS AND RISK FACTORS

Goals	Objectives
(1) Enhance access to health education, screening, and referral services (2) Support individuals with chronic/complex conditions and their caregivers (3) Enhance understanding of end-of-life needs and care	• Continue to screen for chronic/complex conditions and risk factors and refer to appropriate services • Increase the number of individuals who receive education regarding chronic/complex conditions and risk factors • Increase skills, confidence, and abilities of parents and caregivers • Increase the number of individuals from priority populations engaged in care • Continue to monitor and coordinate care for adults with chronic/complex conditions • Promote chronic disease management and behavioral change • Increase healthy eating and physical activity • Increase access to end of life and palliative care programs • Decrease social isolation among older adults • Increase the number of adults with advance healthcare directives • Continue to provide support for the health care of impoverished persons in Milot, Haiti

PRIORITY AREA: MENTAL HEALTH AND SUBSTANCE USE DISORDER

Goals	Objectives
(1) Support and/or implement strategies that promote mental, emotional, and social well-being	• Enhance identification of individuals with undiagnosed mental/behavioral health conditions • Support efforts that aim to reduce the stigma associated with mental/behavioral health and substance use disorder • Support initiatives that promote healthy mental, emotional, and social behaviors • Expand access to behavioral health screening, treatment, and supportive services • Collaborate with clinical and community-based partners to address mental/behavioral health and substance use disorder

PRIORITY AREA: SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO CARE

Goals	Objectives
(1) Address the social determinants of health and access to care issues that inhibit the ability of individuals to lead happy, healthy, and productive lives (2) Reduce health disparities	• Support programs and policies that address the social determinants of health • Address common barriers to accessing health care • Support efforts that address the risk factors and impacts of domestic and interpersonal violence • Promote care coordination and engagement in primary care • Address cultural competency, health literacy, and language issues to reduce health disparities • Reduce inappropriate use of the emergency room and hospital readmissions

COMMUNITY HEALTH NEEDS NOT PRIORITIZED BY HOLY NAME MEDICAL CENTER

It is important to note that there are community health needs that were identified through the Community Health Needs Assessment that were not prioritized for inclusion in the Implementation Strategy. Reasons for this include:

- Feasibility of Holy Name Medical Center having an impact on this issue in the short or long term
- Clinical expertise of the organization
- The issue is currently addressed by community partners in a way that does not warrant additional support

Poverty/employment, housing stability, transportation, and certain levels of behavioral and substance abuse needs were identified as community needs, but were deemed to be outside of Holy Name Medical Center's primary sphere of influence. Holy Name remains open and willing to work with hospitals and other public and private partners to address these issues should an opportunity arise.