Hackettstown Medical Center Community Health Needs Assessment

DECEMBER 2018

Atlantic Health System
Hackettstown Medical Center

ACKNOWLEDGEMENTS & CHNA COMPLIANCE

Atlantic Health System - Hackettstown Medical Center acknowledges the hard work and dedication of the individuals and the organizations they represent who contributed to HMC's Community Health Needs Assessment.

The 2018-2020 Hackettstown Medical Center's Community Health Needs Assessment was approved by HMC's Community Advisory Board on February 15, 2019. Questions regarding the Community Health Needs Assessment should be directed to:

> **Atlantic Health System**
> **Hackettstown Medical Center**
> Planning & System Development
> 973-660-3522

COMPLIANCE CHECKLIST: IRS FORM 990, SCHEDULE H	REPORT PAGE(S)
Part V Section B Line 1a A definition of the community served by the hospital facility	5
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Part V Section B Line 1c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	62
Part V Section B Line 1d How data was obtained	Addressed Throughout
Part V Section B Line 1f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 1g The process of identifying and prioritizing community health needs and services to meet the community health need	6
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EXECUTIVE SUMMARY

Hackettstown Medical Center (HMC) is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. To that end, beginning in June 2018, HMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, that encompasses portions of Warren, Morris and Sussex counties in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing resident of HMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

The completion of the CHNA provided HMC with an health-centric view of the population it serves, enabling HMC to prioritize relevant health issues and develop a community health implementation plan focused on meeting community needs. This CHNA Final Summary Report serves as a compilation of the overall findings of the CHNA findings. This document is not a compendium of all data and resources examined in the development of the CHNA and the identification of health priorities for HMC's service area, but rather an overview that highlights statistics relevant to HMC's health priorities for the next CHNA/CHIP planning and implementation period.

CHNA Components

- Secondary Data Research
- Key Informant Survey
- Prioritization Session
- Implementation Plan
- Key Community Health Issues

Key Community Health Issues

Hackettstown Medical Center, in conjunction with community partners, examined the findings of qualitative and quantitative data review to prioritize key community health issues. The following issues were identified:

- Substance Use Disorders
- Diabetes
- Need for Mental Health Providers
- Overweight/Obesity
- Preventive Care

Based on feedback from community partners, health care providers, public health experts, health and human service agencies, and other community representatives, Hackettstown Medical Center plans to focus on multiple key community health improvement efforts and will create an implementation strategy of their defined efforts in 2019. This document will be shared with the public shortly thereafter.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Organization Overview

Hackettstown Medical Center has been providing care to the community since 1973, primarily serving Warren, Sussex and Morris counties in New Jersey. From preventive services and outpatient testing, to care for minor injuries and life-threatening illness, HMC offer a wide range of services to keep our local population healthy. The medical center is a designated a Primary Stroke Center by the New Jersey Department of Health and The Joint Commission's advanced certification program. Other accreditations include mammography, nuclear medicine and ultrasound from the American College of Radiology, sleep disorder center accreditation from the American Academy of Sleep Medicine, and Quality of Care recognition for our cardiopulmonary department from the American Association for Respiratory Care. HMC provides education, screenings, support groups and wellness programs for people of all ages through our Center for Healthier Living.

Hackettstown Medical Center provides emergency care that is close to home for many in northwestern New Jersey with access to high-tech specialty services available through Atlantic Health System, when needed. Atlantic Health System Cancer Care provides access to renowned specialists, clinical trials, innovative technology and medical treatments, and compassionate support services right here in NJ. Our vast network of hospitals and providers spans 11 counties, so patients can enter our all-encompassing community of cancer care no matter where they live or work. HMC's Women's Imaging Suite community access to 3D mammograms and other high-tech imaging services.

HMC has received numerous awards and designations, including:
- American College of Radiology Accreditation for C/T Services, Mammography, Nuclear Medicine, PET and Ultrasound
- Certificate of Accreditation from the Undersea and Hyperbaric Medical Society for the Wound Healing Center Hyperbaric Oxygen Therapy Program
- American Academy of Sleep Medicine Accreditation for the Sleep Disorders Center
- Joint Commission Advanced Certification as a Primary Stroke Center
- Joint Commission Certification for Joint Replacement – Hip and Knee
- Certificate of Accreditation from the American Association of Diabetes Educators
- American Association for Respiratory Care Recognition for Quality of Respiratory Care
- College of American Pathologists Accreditation for the Clinical Laboratory
- Top Hospitals: Castle Connolly Medical Ltd.
- Get With the Guidelines® Stroke Silver Plus Performance Achievement Award with Target: Stroke Honor Roll Elite Plus: American Heart Association and American Stroke Association
- Accredited in adult transthoracic and adult transesophageal echocardiography by the Intersocietal Accreditation Commission (IAC)

Hackettstown Medical Center employs more than 650 staff and volunteers, operates 111 licensed hospital beds and is staffed by more than 275 physicians and allied health providers. HMC treated more than 3,000 inpatients, nearly 23,000 emergency room visits and approximately 54,000 outpatient visits in 2017 (the most recent full year of data available). As part of its community benefit programs, HMC provides screenings, health education programs, classes, support groups, vaccinations, and health professions education.

Community Overview

HMC receives 75% of its inpatient admission from 10 ZIP Codes, encompassing portions of Warren, Morris and Sussex counties in New Jersey.[1]

HMC STARK SERVICE AREA					
ZIP CODE	CITY	COUNTY	ZIP CODE	CITY	COUNTY
07828	BUDD LAKE	MORRIS	07825	BLAIRSTOWN	WARREN
07840	HACKETTSTOWN	WARREN	07836	FLANDERS	MORRIS
07882	WASHINGTON	WARREN	07838	GREAT MEADOWS	WARREN
07821	ANDOVER	SUSSEX	07853	LONG VALLEY	MORRIS
07823	BELVIDERE	WARREN	07863	OXFORD	WARREN
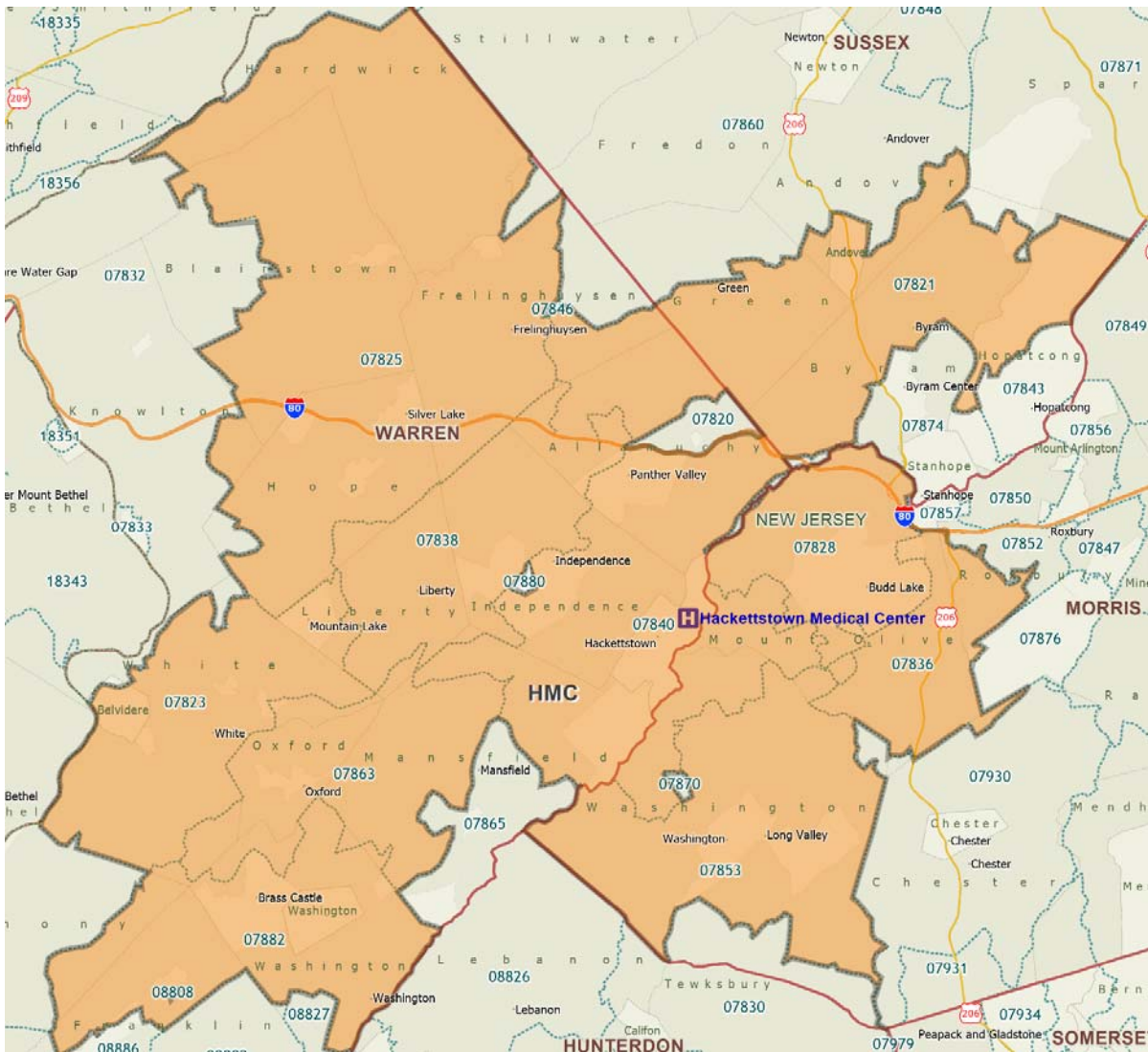
[1] Source: NJDOH Discharge Data Collection System – UB-04 Inpatient Discharges

Methodology

HMC's CHNA comprised quantitative and qualitative research components. A brief synopsis of the components is included below with further details provided throughout the document:

- A Statistical Secondary Data Profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates, and other health statistics for primary and secondary service areas was compiled with findings presented to advisory committees for review and deliberation of priority health issues in the community.

- A Key Informant Survey was conducted with community leaders and partners. Key informants represented a variety of sectors, including public health and medical services, non-profit and social organizations, public schools, and the business community.

Analytic Support

Atlantic Health System Corporate Planning & System Development staff provided HMC with administrative and analytic support throughout the CHNA process. Staff collected and interpreted data from secondary data sources, collected and analyzed data from key informant surveys, and prepared all reports.

Community Representation

Community engagement and feedback were an integral part of the CHNA process. HMC sought community input through key informant surveys of community leaders and partners and included community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

Timelines and other restrictions impacted the ability to survey all potential community stakeholders. HMC sought to mitigate these limitations by including representatives or and/or advocates for diverse and underserved populations throughout the assessment process.

Prioritization of Needs

Following the completion of the CHNA research, HMC's Community Health Advisory Sub-Committee prioritized community health issues and will develop an implementation plan to address prioritized community needs, the content of which will be shared publicly in 2019.

SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to evaluate a Secondary Data Profile compiled by the North Jersey Health Collaborative and Atlantic Health System's Planning & System Development department. This county and service area based profile is comprised of multiple data sources. Secondary data is comprised of data obtained from existing resources (see Appendix A) and includes demographic and household statistics, education and income measures, morbidity and mortality rates, health outcomes, health factors, social determinants of health, and other data points. County-level secondary data were augmented, where possible, by ZIP Code level inpatient and emergency room utilization data for the entire HMC service area and, when available AHS specific health care utilization data.

Secondary data was integrated into a graphical report to inform key stakeholders and HMC Community Advisory Board's Community Health Subcommittee of the current health and socio-economic status of residents in HMC's service area. Following is a summary of key details and findings from the secondary data review. A comprehensive data report is available upon request from Atlantic Health System.

Demographic Statistics

Although Warren county's projected growth is -0.5%, HMC's service area has a growth of 0.7%; due to projected increases in Budd Lake, 2.94%, Flanders, 2.71%, and Hackettstown, 1.44%.

ZIP Code	ZIP Code Name	Population of Base Yr (2010)	Population of Current Yr (2019)	Population of Forecast Yr (2024)	Population Growth: Base Yr to Current Yr (%)	Population Growth: Current Yr to Forecast Yr (%)
			POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES			
07828	BUDD LAKE	13,462	14,269	14,688	5.99%	2.94%
07836	FLANDERS	13,237	13,974	14,352	5.57%	2.71%
07853	LONG VALLEY	12,729	12,817	12,905	0.69%	0.69%
07821	ANDOVER	9,442	8,863	8,696	-6.13%	-1.88%
07823	BELVIDERE	7,509	7,352	7,317	-2.09%	-0.48%
07825	BLAIRSTOWN	9,581	9,187	9,090	-4.11%	-1.06%
07838	GREAT MEADOWS	3,574	3,430	3,402	-4.03%	-0.82%
07840	HACKETTSTOWN	30,376	30,896	31,340	1.71%	1.44%
07863	OXFORD	4,446	4,318	4,282	-2.88%	-0.83%
07882	WASHINGTON	14,583	14,222	14,150	-2.48%	-0.51%
	HMC SERVICE AREA	**118,939**	**119,328**	**120,222**	**0.3%**	**0.7%**
	WARREN COUNTY	**219,883**	**214,072**	**213,083**	**-2.6%**	**-0.5%**
	NEW JERSEY	**8,791,914**	**9,043,262**	**9,195,645**	**2.9%**	**1.7%**

At 295.89 residents per square mile, Warren County is the 4th least densely populated county in New Jersey; the 21 counties range from a low of 187.80 population/sq. mile (Salem County) to a high of 13,744.70 population/sq. mile (Hudson County).

ZIP Code	ZIP Code Name	Population / Square Mile
	POPULATION DENSITY: ZIP CODES AND COMPARATIVE GEOGRAPHIES	
07828	BUDD LAKE	916.70
07836	FLANDERS	937.62
07853	LONG VALLEY	411.72

POPULATION DENSITY: ZIP CODES AND COMPARATIVE GEOGRAPHIES		
ZIP Code	ZIP Code Name	Population / Square Mile
07821	ANDOVER	208.18
07823	BELVIDERE	285.68
07825	BLAIRSTOWN	115.17
07838	GREAT MEADOWS	152.36
07840	HACKETTSTOWN	705.84
07863	OXFORD	186.48
07882	WASHINGTON	493.98
	HMC SERVICE AREA (Avg of ZIP Codes)	441.37
	WARREN COUNTY	295.89
	NEW JERSEY	1178.34

Race & Hispanic[2]

HMC's service area is predominately White (Non-Hispanic). The New Jersey average for White (Non-Hispanic) is 53.9%, HMC's service area is 79.2%.

POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES		White (Non-Hispanic)		Hispanic (of Any Race)		Asian (Non-Hispanic)		Black (Non-Hispanic)		Another Race (Non-Hispanic)	
ZIP Code	ZIP Code Name	2019	2024	2019	2024	2019	2024	2019	2024	2019	2024
07828	BUDD LAKE	61.7%	57.0%	18.0%	20.2%	9.8%	11.0%	8.3%	9.5%	2.2%	2.3%
07836	FLANDERS	73.4%	70.5%	11.4%	13.0%	8.8%	9.6%	4.5%	4.7%	2.0%	2.2%
07853	LONG VALLEY	87.1%	85.1%	6.0%	7.0%	3.6%	4.0%	1.4%	1.7%	1.9%	2.2%
07821	ANDOVER	88.8%	87.6%	6.8%	7.7%	1.8%	1.9%	1.5%	1.6%	1.2%	1.2%
07823	BELVIDERE	92.0%	91.3%	3.6%	4.0%	0.9%	0.9%	2.2%	2.5%	1.3%	1.4%
07825	BLAIRSTOWN	91.6%	90.4%	4.7%	5.4%	1.3%	1.5%	1.5%	1.7%	0.9%	1.0%
07838	GREAT MEADOWS	89.4%	88.1%	6.2%	7.1%	1.8%	1.9%	1.6%	1.9%	1.0%	1.0%
07840	HACKETTSTOWN	73.3%	69.4%	14.0%	16.1%	7.0%	8.0%	3.9%	4.5%	1.8%	1.9%
07863	OXFORD	90.7%	89.8%	4.4%	4.9%	1.5%	1.7%	1.9%	2.1%	1.5%	1.6%
07882	WASHINGTON	82.1%	79.8%	8.3%	9.4%	3.0%	3.3%	4.7%	5.2%	2.0%	2.3%
	HMC SERVICE AREA	79.2%	76.4%	10.2%	11.6%	5.2%	5.8%	3.7%	4.2%	1.7%	1.9%
	WARREN COUNTY	86.8%	84.7%	6.1%	7.2%	2.3%	2.7%	3.0%	3.5%	1.7%	1.9%
	NEW JERSEY	53.9%	50.9%	21.0%	22.8%	10.0%	11.0%	12.8%	12.8%	2.3%	2.5%

Language Spoken at Home[3]

Over 95% of the population, ages 5 years and older, speak English only or speak English "very well"; this is 8 percentage points higher than the New Jersey average.

POPULATION 5 YEARS AND OVER: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Speak English only or speak English "very well"	Speak English less than "very well"	% Speak English less than "very well"
07828	BUDD LAKE	13,054	888	6.4%
07836	FLANDERS	11,162	418	3.6%
07853	LONG VALLEY	12,312	310	2.5%
07821	ANDOVER	8,921	255	2.8%
07823	BELVIDERE	7,292	167	2.2%

[2] Source: New Solutions/Claritas 2019-2024 Demographic File
[3] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

POPULATION 5 YEARS AND OVER: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Speak English only or speak English "very well"	Speak English less than "very well"	% Speak English less than "very well"
07825	BLAIRSTOWN	8,808	233	2.6%
07838	GREAT MEADOWS	3,277	102	3.0%
07840	HACKETTSTOWN	25,841	2,694	9.4%
07863	OXFORD	3,830	59	1.5%
07882	WASHINGTON	13,647	382	2.7%
	HMC SERVICE AREA	108,144	5,508	4.8%
	WARREN COUNTY	101,299	5,503	5.2%
	NEW JERSEY	7,365,008	1,021,939	12.2%

Median Household Income[4]

For 2019, the median household income for the HMC service area was over $97,200 which was $19,200 more than the state average (Long Valley was 196% greater than the state average). There were five towns over $100,000 (Flanders, Long Valley, Andover, Blairstown, and Great Meadows) however, in 2024 there are projected eight towns over $100,000. Great Meadows and Washington have been projected to increase over 11% in the next five years, both larger than the state average.

CURRENT AND PROJECTED MEDIAN HOUSEHOLD INCOME: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	2019 HH INCOME Median HH Income	2024 HH INCOME Median HH Income	% Change Median HH Income - Projected
07828	BUDD LAKE	$ 91,863	$ 100,210	9.1%
07836	FLANDERS	$ 110,531	$ 118,329	7.1%
07853	LONG VALLEY	$ 153,215	$ 166,757	8.8%
07821	ANDOVER	$ 110,222	$ 118,119	7.2%
07823	BELVIDERE	$ 63,155	$ 69,626	10.2%
07825	BLAIRSTOWN	$ 101,067	$ 108,517	7.4%
07838	GREAT MEADOWS	$ 111,080	$ 123,339	11.0%
07840	HACKETTSTOWN	$ 89,693	$ 97,448	8.6%
07863	OXFORD	$ 93,358	$ 103,156	10.5%
07882	WASHINGTON	$ 91,790	$ 102,030	11.2%
	HMC SERVICE AREA	$ 97,213	$ 105,837	8.9%
	WARREN COUNTY	$ 48,140	$ 49,365	2.5%
	NEW JERSEY	$ 77,983	$ 85,857	10.1%

Poverty[5]

The state average for families below poverty was 7.8%; HMC's service area was 3.3% and Warren county was 6.7%. HMC's service area has been projected to have a larger increase in the 'number of families below poverty' than the state average; however, the number of Warren county families has been projected to decrease.

CURRENT AND PROJECTED MEDIAN HOUSEHOLD INCOME: SERVICE AREA & COMPARATIVE GEOGRAPHIES					
ZIP Code	ZIP Code Name	2019 # Families Below Poverty	2019 % Families Below Poverty	2024 # Families Below Poverty	2024 % Families Below Poverty	% Change 2019-2014
07828	BUDD LAKE	189	5.1%	188	4.9%	-0.53%
07836	FLANDERS	63	1.7%	66	1.8%	4.76%

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[4] Source: New Solutions/Claritas 2019-2024 Demographic File
[5] Source: New Solutions/Claritas 2019-2024 Demographic File

		2019 # Families Below Poverty	2019 % Families Below Poverty	2024 # Families Below Poverty	2024 % Families Below Poverty	% Change 2019-2014
ZIP Code	**ZIP Code Name**					
07853	LONG VALLEY	90	2.5%	92	2.5%	2.22%
07821	ANDOVER	63	2.5%	67	2.7%	6.35%
07823	BELVIDERE	63	3.2%	67	3.4%	6.35%
07825	BLAIRSTOWN	89	3.4%	93	3.6%	4.49%
07838	GREAT MEADOWS	23	2.5%	26	2.9%	13.04%
07840	HACKETTSTOWN	280	3.5%	282	3.5%	0.71%
07863	OXFORD	38	3.3%	38	3.3%	0.00%
07882	WASHINGTON	165	4.2%	164	4.2%	-0.61%
	HMC SERVICE AREA	**1,063**	**3.3%**	**1,083**	**3.4%**	**1.88%**
	WARREN COUNTY	**3,882**	**6.7%**	**3,872**	**6.7%**	**-0.26%**
	NEW JERSEY	**179,302**	**7.8%**	**182,371**	**7.8%**	**1.71%**

CURRENT AND PROJECTED MEDIAN HOUSEHOLD INCOME: SERVICE AREA & COMPARATIVE GEOGRAPHIES

Food Stamps / SNAP[6]

Currently, there are about 4% of people within HMC's service area receiving food stamps/SNAP benefits which was lower than the state average, 9.3%, and lower than Warren county, 6.6%. Within HMC's service area, there were no towns higher than the state average.

ZIP Code	ZIP Code Name	Total Households (HH)	HH receiving food stamps/SNAP	% of HH Receiving SNAP
07828	BUDD LAKE	5,617	400	7.1%
07836	FLANDERS	4,364	245	5.6%
07853	LONG VALLEY	4,268	64	1.5%
07821	ANDOVER	3,452	59	1.7%
07823	BELVIDERE	3,351	201	6.0%
07825	BLAIRSTOWN	3,390	72	2.1%
07838	GREAT MEADOWS	1,304	40	3.1%
07840	HACKETTSTOWN	11,648	453	3.9%
07863	OXFORD	1,571	97	6.2%
07882	WASHINGTON	5,473	148	2.7%
	HMC SERVICE AREA	**44,438**	**1,779**	**4.0%**
	WARREN COUNTY	**42,999**	**2,856**	**6.6%**
	NEW JERSEY	**3,195,014**	**298,642**	**9.3%**

ESTIMATED TOTAL HOUSEHOLDS: SERVICE AREA & COMPARATIVE GEOGRAPHIES

Unemployment Rate[7]

The New Jersey unemployment rate is 7.9%, HMC's service area was 7.1% and the Warren county rate was 8.3%. Out of the towns in the service area, 60% were below the state's unemployment rate.

ZIP Code	ZIP Code Name	Employed	Unemployed	% Unemployed
07828	BUDD LAKE	11,467	894	7.8%
07836	FLANDERS	9,316	466	5.0%
07853	LONG VALLEY	10,086	393	3.9%
07821	ANDOVER	7,624	435	5.7%

POPULATION 16 YEARS AND OVER: SERVICE AREA & COMPARATIVE GEOGRAPHIES

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[6] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
[7] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

POPULATION 16 YEARS AND OVER: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Employed	Unemployed	% Unemployed
07823	BELVIDERE	6,744	681	10.1%
07825	BLAIRSTOWN	7,595	638	8.4%
07838	GREAT MEADOWS	2,872	253	8.8%
07840	HACKETTSTOWN	24,604	1,993	8.1%
07863	OXFORD	3,400	262	7.7%
07882	WASHINGTON	11,905	750	6.3%
	HMC SERVICE AREA	95,613	6,765	7.1%
	WARREN COUNTY	91,450	7,595	8.3%
	NEW JERSEY	7,143,654	566,878	7.9%

Education Attainment[8]

The percent of the population within HMC's service area that had 'some high school education or less' was lower than the New Jersey average; meaning that the area's population was, on average, more educated.

CURRENT AND PROJECTED EDUCATION LEVEL (AGE 25+): SERVICE AREA & COMPARATIVE GEOGRAPHIES						
ZIP Code	ZIP Code Name	2019 Some High School or Less	2019 % Some High School or Less	2024 Some High School or Less	2024 % Some High School or Less	% Point Change 2019-2014
07828	BUDD LAKE	714	7.2%	725	7.0%	-0.15%
07836	FLANDERS	304	3.2%	317	3.2%	-0.04%
07853	LONG VALLEY	255	2.9%	282	3.1%	0.15%
07821	ANDOVER	301	4.8%	311	4.9%	0.12%
07823	BELVIDERE	551	9.8%	570	10.0%	0.19%
07825	BLAIRSTOWN	595	8.9%	610	8.9%	0.02%
07838	GREAT MEADOWS	184	7.4%	188	7.3%	-0.09%
07840	HACKETTSTOWN	1,743	8.1%	1,791	8.1%	0.01%
07863	OXFORD	290	9.2%	297	9.3%	0.15%
07882	WASHINGTON	737	7.2%	761	7.4%	0.14%
	HMC SERVICE AREA	5,674	6.8%	5,852	6.8%	0.01%
	WARREN COUNTY	14,323	9.2%	14,433	9.2%	-0.01%
	NEW JERSEY	675,582	10.8%	692,826	10.8%	0.00%

Health Insurance Coverage / Health Care Access[9]

The state average for uninsured was 10.7%; however, HMC's service area and Warren county were both less than 8%. Every town in HMC's service area was less than the state average, Hackettstown had the largest uninsured percent at 10.6%.

CIVILIAN NONINSTITUTIONALIZED POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Insured	Uninsured	% Uninsured
07828	BUDD LAKE	13,482	1,475	9.9%
07836	FLANDERS	11,417	853	7.0%
07853	LONG VALLEY	12,666	505	3.8%
07821	ANDOVER	9,003	467	4.9%
07823	BELVIDERE	7,021	556	7.3%
07825	BLAIRSTOWN	8,795	411	4.5%
07838	GREAT MEADOWS	3,301	235	6.6%

[8] Source: New Solutions/Claritas 2019-2024 Demographic File
[9] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

CIVILIAN NONINSTITUTIONALIZED POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Insured	Uninsured	% Uninsured
07840	HACKETTSTOWN	26,573	3,151	10.6%
07863	OXFORD	3,674	194	5.0%
07882	WASHINGTON	14,111	620	4.2%
	HMC SERVICE AREA	110,043	8,467	7.1%
	WARREN COUNTY	102,168	8,814	7.9%
	NEW JERSEY	7,868,933	938,966	10.7%

Payer Mix

Health insurance coverage can have a significant influence on health outcomes. Among ED visits, HMC's Service Area is approximately 15.6% Medicaid/Caid HMO/NJ Family Care with another 7.0% of Self Pay/Charity Care. The area is approximately 50.0% Commercial and 27.3% Medicare/Care HMO. From a payer mix perspective, the ED payer distribution in the Service Area is more favorable than Warren County overall as well as the State.

Among inpatients, HMC's Service Area is approximately 9.4% Medicaid/Caid HMO/NJ Family Care with another 2.0% of Self Pay/Charity Care. The area is approximately 41.2% Commercial and 47.5% Medicare/Care HMO. From a payer mix perspective, the inpatient payer distribution in the Service Area is more favorable than Warren County overall as well as the State.

Payer Mix Comparison
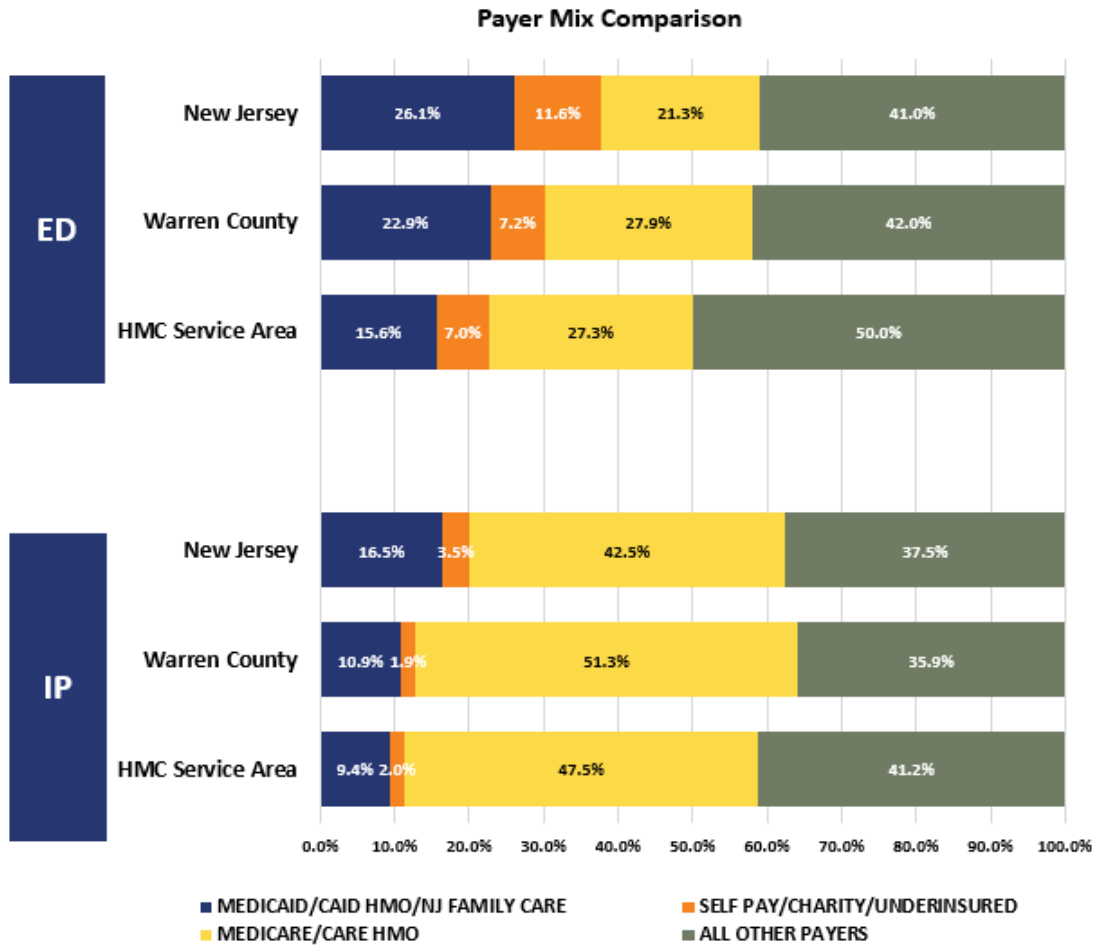
Health Status Indicators[10]

A health status indicator describes an aspect of the population used to measure health or quality of life. Health indicators may include measurements of illness or disease, as well as behaviors and actions related to health. Quality of life indicators include measurements related to economy, education, built environment, social environment, and transportation. We know, from literature, that many quality of life indicators are actually drivers of health status - which is why both categories of data (155 indicators) are included in this analysis.

For each indicator, the county is assigned a score based on its comparison to four things: other NJ counties, whether state and national health targets have been met, and the directional trend of the indicator value over time. These four comparison scores range from 0-3, where 0 indicates the best performance and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Where comparison data is not available, a neutral score is substituted. For ease of interpretation and analysis, indicator comparison scores are visually highlighted in green, yellow or red, showing how the county is faring in each category of comparison.

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results. The weights of each comparison in calculating the indicator scores were decided by the Data Committee of the North Jersey Health Collaborative. Specifically, this committee saw the value in comparing an indicator value against itself (at the last times of reporting; the "trend") and against other local New Jersey counties, for the purposes of prioritizing interventions, which is why these two comparisons are the most heavily weighted.

The following tables represent the county-based scoring of specific health indictors. The data are organized by major indicator topic, indicator groupings, the specific indicators within that grouping and pertinent data points based on available secondary data sources. An indicator can be compared against all US or NJ counties, US or Statewide values, relative to Healthy People 2020 or local targets and the trend of an indicator value. A score greater than 2 represents an indicator where the county performs at lower than preferred. Where a particular population segment disparity can be identified, that population segment is noted.

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[10] Healthy Communities Institute/Conduent. Data Scoring Tool. New Jersey Health Matters. North Jersey Health Collaborative.

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Health	Access to Health Services	Adults with Health Insurance	1	1	1	1	3	2	2	1.5	
		Children with Health Insurance	2	2	2	1	2	1	2	1.75	
		Non-Physician Primary Care Provider Rate	3	3	3	3			1	2.3	
		Preventable Hospital Stays: Medicare Population	2	2	3	3			1	2	
		Primary Care Provider Rate	2	1	3	3				1.95	
Health	County Health Rankings	Clinical Care Ranking	2							1.58	
		Health Behaviors Ranking	2							1.58	
		Morbidity Ranking	1							1.43	
		Mortality Ranking	2							1.58	
		Physical Environment Ranking	1							1.43	
		Social and Economic Factors Ranking	1							1.43	
Health	Immunizations & Infectious Diseases	Age-Adjusted Death due to Influenza and Pneumonia	1		2	0			2	1.38	
		Age-Adjusted Rate of ED Visits Due to Influenza	3							1.73	
		Chlamydia Cases							2	1.6	
		Kindergartners with Required Immunizations	1		1				1	1.25	
		Lyme Disease Cases							2	1.6	
		Syphilis Cases							1	1.4	
		Tuberculosis Incidence Rate	2		0	0	3	0	2	1.23	
Health	Wellness & Lifestyle	Frequent Physical Distress	1	1	1	0				1.05	
		Gonorrhea Cases							1	1.4	
		Insufficient Sleep	1	3	1	1				1.5	
		Life Expectancy for Females	1	0	1	1			1	0.95	
		Life Expectancy for Males	1	0	1	1			1	0.95	
		Poor Physical Health: Average Number of Days	1	1	2	1				1.35	
		Self-Reported General Health Assessment: Poor or Fair	1	1	1	1				1.2	
Health	Prevention & Safety	Age-Adjusted Death Rate due to Unintentional Injuries	2		3	3	3		3	2.48	
		Age-Adjusted Death due to Unintentional Poisonings	2		3	3		3	3	2.48	
Health	Disabilities	Persons with Disability Living in Poverty	0	0	0	0			2	0.7	
		Persons with Disability Living in Poverty (5-year)	2		1	0				1.28	
Health	Heart Disease & Stroke	Age-Adjusted Death Rate: Cerebrovascular Disease (Stroke)	2		2	0	1	3	1	1.43	
		Age-Adjusted Death Rate due to Heart Disease	2		3	2		3	2	2.13	
		Age-Adjusted Death Rate due to Hypertensive Heart Disease	2		3				2	1.9	
		Age-Adjusted Rate of Adult ED Visits for AMI	3							1.73	
		Atrial Fibrillation: Medicare Population	3	3	3	3			2	2.5	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Heart Failure: Medicare Population	2	3	2	3			1	2	
		High Blood Pressure Prevalence	3		3	3	3			2.33	
		Hyperlipidemia: Medicare Population	1	3	1	3			1	1.7	
		Hypertension: Medicare Population	1	3	1	3			1	1.7	
		Ischemic Heart Disease: Medicare Population	3	3	2	3			1	2.15	
		Stroke: Medicare Population	0	3	0	2			1	1.25	
Health	Diabetes	Adults 20+ with Diabetes	1	0	1	1			2	1.15	
		Age-Adjusted Death Rate due to Diabetes	2		2	1		3	1	1.63	
		Diabetes: Medicare Population	1	3	1	3			1	1.7	
		Diabetic Monitoring: Medicare Population	2	2	2	2			1	1.7	
Health	Exercise, Nutrition, & Weight	Adults 20+ who are Obese	2	0	2	1	1	3	2	1.55	
		Adults 20+ who are Sedentary	1	1	2	2	0		1	1.25	
		Child Food Insecurity Rate	2	0	1	0			0	0.75	
		Food Insecure Children Likely Ineligible for Assistance	2	3	3	3			1	2.15	
		Food Insecurity Rate	1	0	0	0			0	0.45	
		Adults 20+ who are Obese	2	0	2	1	1	3	2	1.55	
Health	Older Adults & Aging	Age-Adjusted Death Rate due to Alzheimer's Disease	0		0	0			1	0.73	
		Alzheimer's Disease or Dementia: Medicare Population	0	2	0	1			1	0.95	
Health	Oral Health	Dentist Rate	2	0	3	1			1	1.4	
Health	Environmental & Occ. Health	Children with Elevated Blood Lead Levels	2		3				2	1.9	
Health	Older Adults & Aging	Age-Adjusted Death Rate due to Alzheimer's Disease	0		0	0			1	0.73	
		Alzheimer's Disease or Dementia: Medicare Population	0	2	0	1			1	0.95	
Health	Cancer	Age-Adjusted Death Rate due to Breast Cancer	2	2	1	2	2	1		1.65	
		Age-Adjusted Death Rate due to Cancer	2	1	2	2	2	2	1	1.65	Males
		Age-Adjusted Death Rate due to Colorectal Cancer	2	2	2	3	3	2	1	2.05	
		Age-Adjusted Death Rate due to Lung Cancer	2	1	3	2	2	2	1	1.8	
		Age-Adjusted Death Rate due to Pancreatic Cancer	1	2	1	2			1	1.4	
		Age-Adjusted Death Rate due to Prostate Cancer	2	2	3	2	1	1		1.85	
		All Cancer Incidence Rate	2	3	2	3				2.1	
		Breast Cancer Incidence Rate	0	2	1	2				1.35	
		Cancer: Medicare Population	2	3	2	3			1	2	
		Cervical Cancer Incidence Rate	1	1	2	2	2	2	2	1.7	
		Colorectal Cancer Incidence Rate	3	2	3	3	3	3	2	2.65	
		Liver and Bile Duct Cancer Incidence Rate	1	1	1	1			2	1.3	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Lung and Bronchus Cancer Incidence Rate	2	1	3	2				1.8	
		Mammography Screening: Medicare Population	3	2	2	2			3	2.25	
		Melanoma Incidence Rate	2	2	3	3			2	2.2	
		Non-Hodgkin Lymphoma Incidence Rate	3	3	2	3			2	2.35	
		Oral Cavity and Pharynx Cancer Incidence Rate	2	1	2	1			2	1.6	
		Pancreatic Cancer Incidence Rate	3	3	2	3				2.25	
		Prostate Cancer Incidence Rate	0	3	1	3			0	1.35	
Health	Respiratory Diseases	Age-Adjusted Death Rate: Chronic Lower Respiratory	2		3	0			1	1.48	
		Age-Adjusted Rate of Adult ED Visits for COPD	1							1.43	
		Asthma: Medicare Population	1	2	1	2			3	1.8	
		COPD: Medicare Population	2	1	2	2			2	1.75	
Health	Other Chronic Diseases	Chronic Kidney Disease: Medicare Population	3	3	3	3			2	2.5	
		Osteoporosis: Medicare Population	1	2	1	1			0	1.05	
		Rheumatoid Arthritis or Osteoarthritis: Medicare	1	2	1	2			1	1.4	
Health	Mortality Data	Age-Adjusted Death Rate	2		2				2	1.75	Males
Health	Mental Health & Mental Disorders	Age-Adjusted Death Rate due to Suicide	2		3	0	3	3	0	1.58	
		Age-Adjusted Rate of ED Visits due to Mood Disorder	1							1.43	
		Depression: Medicare Population	3	1	3	1			3	2.1	
		Frequent Mental Distress	1	0	2	0				1.05	
		Inadequate Social Support	1	2	1					1.43	
		Mental Health Provider Rate	1	1	3	3			1	1.7	
		Poor Mental Health: Average Number of Days	1	1	2	1				1.35	
Health	Substance Abuse	Adults who Drink Excessively	2	2	3	2	0			1.8	
		Adults who Smoke	2	1	3	1	3			1.8	
		Age-Adjusted Alcohol-Related ED Visit Rate	1							1.43	
		Age-Adjusted Rate of Substance Use ED Visits	1							1.43	
		Death Rate due to Drug Poisoning	2	2	3	3			3	2.4	
		Opioid Treatment Admission Rate	2		3					1.8	
Health	Maternal, Fetal & Infant	Babies with Low Birth Weight	3		3	3	3	3	2	2.58	
		Babies with Very Low Birth Weight	0		0	0	0	0	1	0.43	
		Infant Mortality Rate	3		3	3	3	3		2.48	
		Mothers who Received Early Prenatal Care	1		1	1	1	2	1	1.18	Ages 18-19, 20-24, 50+, <15
		Mothers who Received No Prenatal Care	0		0	0			1	0.73	
		Preterm Births	3		3	1	3		2	2.13	
		Very Preterm Births	3		3		3			2.1	Ages 18-19

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Health	Family Planning	Teen Birth Rate: 15-17	2		3	1				1.73	
	Child Care	Cost of Licensed Child Care as a Percentage of Income	1		1					1.35	
	Employment	Unemployed Workers in Civilian Labor Force	1	1	1	1			1	1.1	
	Government Assistance Program	Households with Cash Public Assistance Income	1	1	0	0			1	0.8	
		Students Eligible for the Free Lunch Program	1	0	0	0			3	1.05	
	Homeownership	Homeownership	1	0	0	0			3	1.05	
	Housing Affordability & Supply	Renters Spending 30% or More of Household Income on Rent	0	3	0	1			0	0.9	
		Severe Housing Problems	0	3	0	1			3	1.5	
Economy	Income	Asset Limited, Income Constrained, Employed (ALICE) HH			3					1.73	
		Income Inequality	0	0	0	0				0.6	
		Median Household Income	1	0	2	0			1	0.95	American Indian or Alaska Native, Hispanic or Latino, Other
		Per Capita Income	1	0	2	0			0	0.75	American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Other, Two or More Races
	Poverty	Children Living Below Poverty Level	1	0	0	0			2	0.85	Black or African American, Hispanic or Latino
		Families Living Below Poverty Level	1	0	0	0			1	0.65	Black or African American, Hispanic or Latino, Two or More Races
		People 65+ Living Below Poverty Level	0	0	0	0			1	0.5	
		People Living 200% Above Poverty Level	1	0	1	0			2	1	
		People Living Below Poverty Level	1	0	0	0			2	0.85	Ages 12-17, 18-24 Black or African American, Hispanic or Latino, Other
		Young Children Living Below Poverty Level	1	0	0	0			1	0.65	Black or African American, Hispanic or Latino
	Child Care	Cost of Family Child Care as a Percentage of Income	0		0					1.05	
Education	Educational Attainment in Adult Population	People 25+ with a Bachelor's Degree or Higher	2	0	3	1			1	1.4	Ages 65+ American Indian, Alaska Native, Other
		People 25+ with a High School Degree or Higher	1	1	1	1			1	1.1	Ages 65+, Asian, Other
	School Resources	Student-to-Teacher Ratio	0	0	1	0			0	0.45	
	Student Performance K-12	Students Passing 11th Grade State Achievement Tests	1		1				1	1.25	
		Students Passing 4th Grade State Achievement Tests	1		1				2	1.45	
		Students Passing 8th Grade State Achievement Tests	1		1				2	1.45	
Government & Politics	Elections & Voting	Voter Turnout: Presidential Election	3		2				3	2.1	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Public Safety	**Crime & Crime Prevention**	Violent Crime Rate	0		0				0	0.75	
	Transportation Safety	Age-Adjusted Death Rate due to Motor Vehicle Collisions	2		3				1	1.7	
		Alcohol-Impaired Driving Deaths	2	1	2	0			2	1.45	
Environment	**Air**	Annual Ozone Air Quality	0	1					2	1.3	
		Annual Particle Pollution	0	0					1	0.95	
		Recognized Carcinogens Released into Air							1	1.4	
	Built Environment	Access to Exercise Opportunities	1	0	1	0				0.9	
		Children with Low Access to a Grocery Store	2	2						1.65	
		Farmers Market Density	0	1						1.2	
		Fast Food Restaurant Density	2	2					1	1.55	
		Food Environment Index	1	0	2	0				1.05	
		Grocery Store Density	1	1						1.35	
		Households with No Car and Low Access to a Grocery Store	3	2						1.8	
		Liquor Store Density	2	3	2	3				2.1	
		Low-Income and Low Access to a Grocery Store	2	1						1.5	
		People 65+ with Low Access to a Grocery Store	1	2						1.5	
		People with Low Access to a Grocery Store	1	2						1.5	
		Recreation and Fitness Facilities	2	0					2	1.45	
		SNAP Certified Stores	3	3						1.95	
	Toxic Chemicals	PBT Released							1	1.4	
	Water	Drinking Water Violations	0	1	0					0.98	
Social Environment	**Children's Social Environment**	Substantiated Child Abuse Rate	2		3	0			2	1.68	
	Family Structure	Single-Parent Households	1	0	0	0			2	0.85	
	Neighborhood/Community Attachment	Linguistic Isolation	1	3	0	0			2	1.3	
		People 65+ Living Alone	1	1	1	1				1.2	
		Social Associations	1	3	1	2			2	1.75	
Transportation	**Commute to Work**	Mean Travel Time to Work	3	3	3	3			2	2.5	Males
		Solo Drivers with a Long Commute	3	3	3	3			3	2.7	
		Workers Commuting by Public Transportation	3	0	3	3	3		2	2.2	Ages 20-24
		Workers who Drive Alone to Work	2	2	3	2			2	2.05	American Indian, Alaska Native, White, non-Hispanic

Mortality Rates[11]

Age-adjusted mortality rates can provide a general sense of a community's health in comparison to other communities. The leading causes of death in the United States are heart disease, cancer, chronic lower respiratory disease, cerebrovascular disease (stroke), and unintentional injuries. In Warren County the top 5 leading causes of death are heart disease, cancer, other causes, unintentional injuries and stroke.

Over the last decade, heart disease and cancer have been the number 1 and 2 causes of death in the county. For heart disease, there's been an uptick of 3.2% over the last 5 years despite a 10 year decrease of 10.8%. For cancer, there have been consistent decreases of 13.3% over the last 5 years and 21.4% over the last decade. The mortality rate for unintentional injuries has more than doubled over the last decade, rising to the 3rd highest mortality rate in the county. There has also been a 53.3% increase in stroke mortality rate over 10 years.

LEADING CAUSES OF DEATH (Age Adjusted) WARREN COUNTY (Deaths Per 100,000 Standard Population)	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	5 Year Change	10 Year Change
Diseases of heart	210.8	196.8	172.4	167.1	202.2	182.2	164.9	174.2	187.4	188.1	3.2%	-10.8%
Cancer (malignant neoplasms)	201.6	187.3	178.7	172.8	163.0	182.6	170.9	161.0	183.0	158.4	-13.3%	-21.4%
Other than 24 Major Causes	117.8	106.5	98.9	90.2	100.0	99.0	93.1	85.7	113.4	102.2	3.2%	-13.2%
Unintentional injuries	27.8	20.2	28.9	33.8	37.7	45.0	30.6	42.1	56.2	56.0	24.4%	101.4%
Stroke (cerebrovascular diseases)	22.7	39.0	30.7	31.7	36.8	34.1	31.2	33.4	29.7	34.8	2.1%	53.3%
Chronic lower respiratory diseases (CLRD)	41.1	45.3	37.6	48.5	36.0	45.9	32.6	43.4	33.4	27.8	-39.4%	-32.4%
Diabetes mellitus	28.5	19.2	24.2	**	17.2	24.9	21.5	20.8	21.0	15.9	-36.1%	-44.2%
Alzheimer's disease	**	**	18.5	15.3	16.9	14.2	17.3	**	16.9	15.3	7.7%	N/A
Nephritis, nephrotic syndrome and nephrosis (kidney disease)	**	**	**	22.8	17.8	16.0	**	**	16.3	13.6	-15.0%	N/A
Influenza and pneumonia	15.4	18.9	**	**	**	**	**	**	15.7	**	N/A	N/A
Septicemia	**	16.3	**	**	**	18.1	20.4	**	**	**	N/A	N/A
Atherosclerosis		**	**	19.1	**	**	**	**	**	**	N/A	N/A

SocioNeeds Index[12]

The 2018 SocioNeeds Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes.

All ZIP Codes, counties, and county equivalents in the United States are given an Index Value from 0 (low need) to 100 (high need). To help you find the areas of highest need in your community, the selected locations are ranked from 1 (low need) to 5 (high need) based on their Index Value.

Community health improvement efforts must determine what sub-populations are most in need in order to most effectively focus services and interventions. Social and economic factors are well known to be strong determinants of health outcomes – those with a low socioeconomic status are more likely to suffer from chronic conditions such as diabetes, obesity, and cancer. The SocioNeeds Index summarizes multiple socio-economic indicators into one composite score for easier identification of high need areas by ZIP Code or county.

Within your community, the ZIP Codes or counties with the highest index values are estimated to have the highest socioeconomic need. The index value for each location is compared to all other similar locations (i.e. counties compare to other counties and ZIP Codes to other ZIP Codes) within the comparison area to assign a relative rank

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[11] Source: State of New Jersey Department of Health: Measurement period: 2007-2016
[12] Healthy Communities Institute 2018. SocioNeeds Index.
http://www.njhealthmatters.org/index.php?module=indicators&controller=index&action=socioneeds

(1-5). Zip Codes are ranked using natural breaks classification, which groups the ZIP Codes into clusters based on similar index values.

The SocioNeeds Index is calculated for a community from several social and economic factors, ranging from poverty to education, that may impact health or access to care. The index is correlated with potentially preventable hospitalization rates and is calculated using Claritas estimates for 2018.

This map represents a socio-needs index for each ZIP Code in Warren county. A higher index is indicative of poorer health outcomes and broadly, the index is designed to aid organizations in allocating efforts to a community that broadly may require more intervention. Darker shading represents a higher need index – and is relative to all ZIP Codes in the State. Within the HMC service area, we see the highest value in Belvidere/White at 35.1. The remainder of the service area ranges from 5.4 to 19.3. The highest index in the county is in Phillipsburg at 55.3.
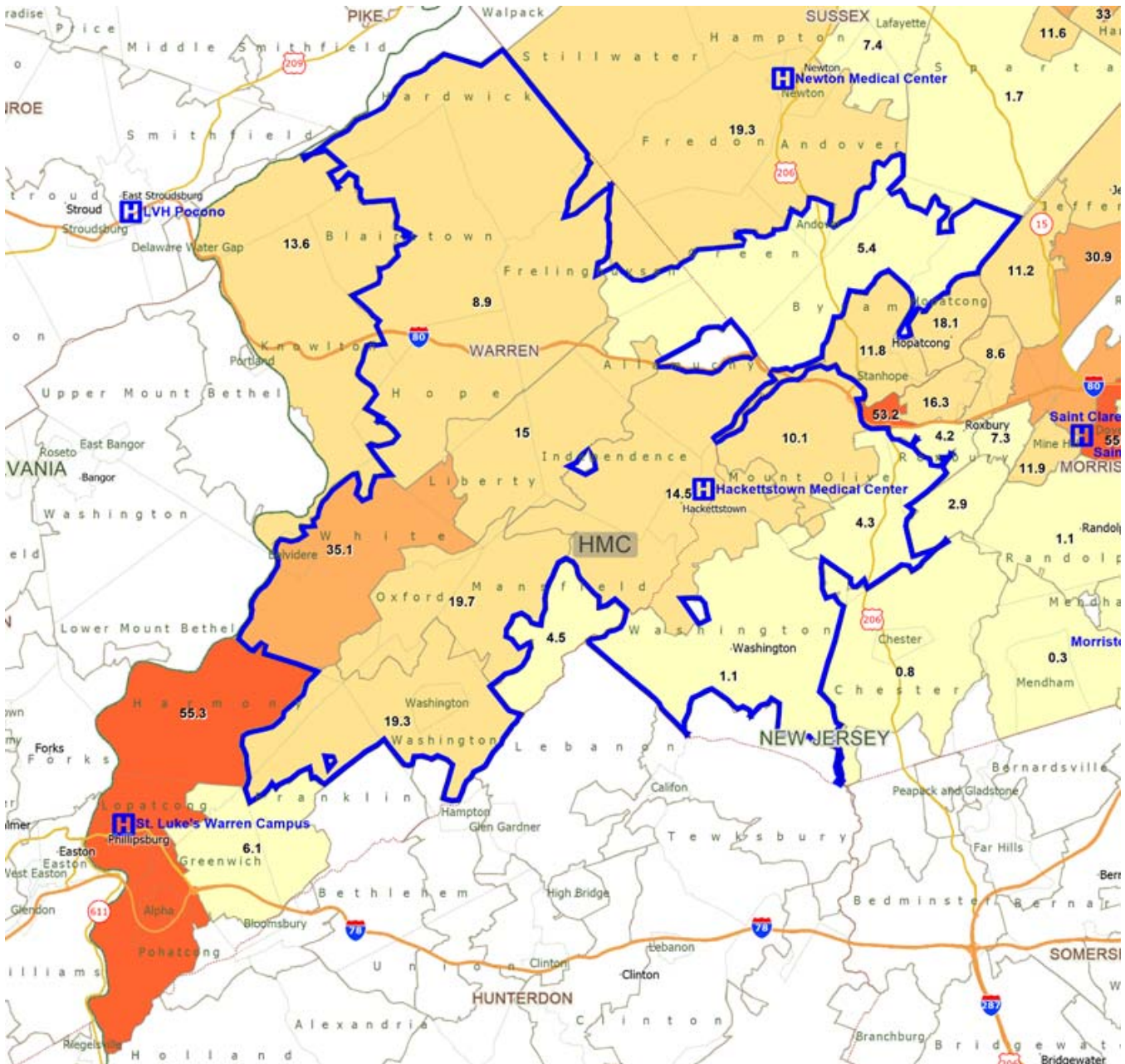
Ambulatory Care Sensitive Conditions: ED & IP (2016 Data – Most Current Available)

ACS conditions are illnesses that can often be managed effectively on an outpatient basis and generally do not result in hospitalization if managed properly. Ambulatory care sensitive conditions can also be used as a way to identify areas that may have access to care issues due to over-use of ED services for primary care services. Generally, a higher ACSC rate in acute settings indicates a cultural acceptance of the ED as a source for primary care – or an area that lacks primary care providers. These conditions, if treated in a more appropriate setting, can lead to broad improvements in community health through primary care expansion or urgent care expansion, which may ultimately lead to a lower chronic disease rate in a community.

ACSCs represent approximately 12% of ED and Inpatient volume in the county and the greatest number of ACSC related discharges are for ENT related illness, Cellulitis, Kidney infections/UTIs, COPD, and Congestive Heart Failure. As one might expect, Phillipsburg has the highest ACSC rate in Warren County. However, there are moderately high rates in the corridor between Hackettstown Medical Center and St. Luke's Health – Warren Campus.

HACKETTSTOWN MC: AMBULATORY CARE SENSITIVE CONDITIONS		
ENT	471	18.4%
CELLULITIS	298	11.7%
KIDNEY/URINARY INFECTION	258	10.1%
COPD	252	9.9%
CONGESTIVE HEART FAILURE	185	7.2%
GASTROINTESTINAL OBSTRUCTION	176	6.9%
DENTAL CONDITIONS	167	6.5%
ASTHMA	146	5.7%
BACTERIAL PNEUMONIA	129	5.1%
HYPERTENSION	117	4.6%
DIABETES	94	3.7%
DEHYDRATION	73	2.9%
CONVULSION	50	2.0%
ANGINA	49	1.9%
GRAND MAL STATUS/EPILEPTIC CONVULSION	40	1.6%
NUTRITION DEFICIENCIES	32	1.3%
PELVIC INFLAMMATORY DISEASE	8	0.3%
HYPOGLYCEMIA	6	0.2%
IMMUNIZATION RELATED PREVENTABLE	1	0.0%
SKIN GRAFTS W CELLULITIS	1	0.0%
TOTAL ACSCs (ED & IP)	2,553	100.0%
ACSCs as a % of Total IP/ED @ Hackettstown	12%	
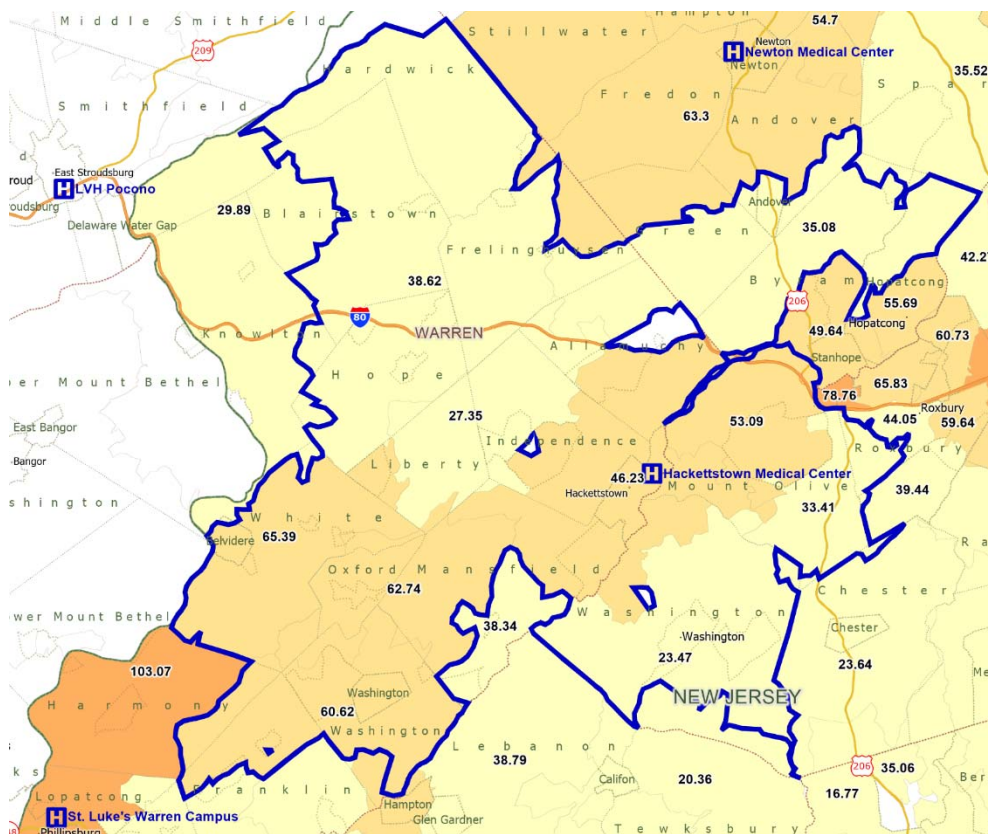
Localized Data: Disease Utilization Rate[13]

For this study, acute care utilization at the ZIP Code level was examined as a proxy for incidence of select diseases or conditions. For certain geographies, AHS can look into ZIP Code groupings to develop hyper-local data sets to inform approaches to community health improvement. In the following charts we see HMC's PSA/SSA rate/1,000 population for specific diseases, with select comparative geographies.

Heart Attack

The rate/1,000 population has increased over the period in all comparative geographies, with the exception of Hackettstown. The highest rate among comparative geographies is in Phillipsburg. All comparative geographies, with the exception of the AHS region, have a rate that is the 60th percentile or higher.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	1.67	1.56	1.77	1.68	1.71	0.0	60%
Western Region	1.59	1.61	1.63	2.06	2.09	0.5	70%
AHS Region	1.09	1.03	1.01	1.06	1.19	0.1	40%
Hackettstown	2.53	2.16	2.91	2.22	2.25	(0.3)	80%
Phillipsburg	1.70	1.57	1.50	1.99	2.79	1.1	90%
Warren County	1.89	1.80	1.92	2.03	2.34	0.5	80%

Heart Failure

The rate/1,000 population has increased over the period in the HMC PSA/SSA, the AHS region and in Hackettstown. The highest rate among comparative geographies is in Hackettstown. The rate/1,000 is in the 70th percentile or higher in Hackettstown, Phillipsburg and Warren County

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	2.89	3.01	2.94	2.87	3.13	0.2	50%
Western Region	3.53	3.09	2.85	3.08	3.20	(0.3)	50%
AHS Region	2.96	2.93	2.92	3.05	3.07	0.1	50%
Hackettstown	4.33	4.88	4.51	4.93	4.59	0.3	80%
Phillipsburg	7.09	3.51	3.14	3.84	3.89	(3.2)	70%
Warren County	4.41	3.49	3.57	3.75	3.93	(0.5)	70%

Hypertension

The rate/1,000 population has increased over the period in across all comparative regions. The highest rate among comparative geographies is in Phillipsburg, where the rate is at the 90th percentile. All other comparative geographies have a rate that is at the 50th percentile, or lower.

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[13] Source: NJ UB-04 Discharges; 2012-2016. Inpatient and Emergency Dept (treat/release) Utilization rate/1,000 population.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	95.40	97.10	93.15	99.93	100.84	5.4	40%
Western Region	106.66	110.70	111.95	117.60	121.15	14.5	50%
AHS Region	104.18	104.42	105.18	109.38	113.31	9.1	50%
Hackettstown	110.03	111.53	105.93	118.20	113.72	3.7	50%
Phillipsburg	185.07	203.60	199.27	193.74	188.93	3.9	90%
Warren County	131.06	137.92	134.48	137.06	135.88	4.8	60%

Stroke/TIA

The rate/1,000 population has increased over the period across all comparative regions, with the exception of Phillipsburg. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is at or below the 50th percentile across all comparative geographies.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	1.99	2.13	2.26	2.30	2.21	0.2	20%
Western Region	2.38	2.49	2.57	2.69	2.81	0.4	50%
AHS Region	2.48	2.46	2.50	2.47	2.59	0.1	40%
Hackettstown	2.04	2.46	2.94	2.58	2.28	0.2	30%
Phillipsburg	3.26	2.72	3.18	2.91	3.03	(0.2)	50%
Warren County	2.54	2.55	2.89	2.62	2.80	0.3	50%

Diabetes

The rate/1,000 population has increased over the period in across all comparative regions. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is at or above the 70th percentile in Phillipsburg, and more broadly in Warren County.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	38.79	39.26	36.23	40.42	42.51	3.7	40%
Western Region	43.61	45.29	45.39	48.34	50.85	7.2	60%
AHS Region	44.82	45.34	46.03	47.84	49.71	4.9	50%
Hackettstown	44.23	45.18	41.42	48.03	45.87	1.6	50%
Phillipsburg	80.20	84.20	89.49	80.24	84.97	4.8	80%
Warren County	54.33	55.87	55.38	56.40	59.03	4.7	70%

Obesity

The rate/1,000 population has increased over the period across all comparative regions, with the exception of Hackettstown. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is in the 80th percentile in Phillipsburg.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	12.21	13.00	12.66	15.43	13.89	1.7	40%
Western Region	12.67	13.51	13.66	15.94	15.25	2.6	50%
AHS Region	10.86	11.33	12.01	13.17	13.98	3.1	40%
Hackettstown	13.40	16.51	14.25	18.21	12.34	(1.1)	30%
Phillipsburg	18.46	17.16	17.94	22.29	21.96	3.5	80%
Warren County	14.40	14.91	14.99	18.42	16.76	2.4	60%

COPD & Allied Health Conditions

The rate/1,000 population has increased over the period in across all comparative regions, with the exception of Hackettstown. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is in the 70th percentile or higher in Phillipsburg, as well as the broader Western Region and Warren County.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	17.93	17.60	16.23	18.81	20.16	2.2	50%
Western Region	20.78	20.75	22.35	24.97	27.77	7.0	70%
AHS Region	15.44	15.24	15.08	15.97	17.87	2.4	40%
Hackettstown	20.95	21.20	17.88	21.83	20.74	(0.2)	50%
Phillipsburg	33.83	34.46	43.15	46.22	54.99	21.2	90%
Warren County	23.77	24.21	25.72	29.15	32.14	8.4	70%

Asthma

The rate/1,000 population has increased over the period across all comparative regions, with the exception of Hackettstown. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is in the 70th percentile or higher in Phillipsburg, as well as the broader AHS and Western Regions and Warren County.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	19.97	20.22	20.73	24.62	23.70	3.7	40%
Western Region	24.33	23.46	28.70	33.37	36.39	12.1	70%
AHS Region	32.67	30.99	31.39	32.96	33.18	0.5	70%
Hackettstown	22.36	23.03	19.68	23.85	18.85	(3.5)	30%
Phillipsburg	31.28	36.87	60.00	69.30	85.14	53.9	90%
Warren County	22.96	25.03	31.80	37.20	40.10	17.1	70%

Pneumonia

The rate/1,000 population has increased across the broader AHS region but decreased in more focused geographies. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is in the 70th percentile in Phillipsburg.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	4.10	3.75	3.46	3.72	3.55	(0.5)	20%
Western Region	5.26	4.39	4.22	4.29	4.50	(0.8)	40%
AHS Region	4.88	4.48	4.12	4.23	4.93	0.1	40%
Hackettstown	3.87	3.47	3.79	4.47	3.35	(0.5)	10%
Phillipsburg	7.97	7.18	5.77	5.18	6.64	(1.3)	70%
Warren County	5.16	4.79	4.36	4.45	4.62	(0.5)	40%

Cellulitis

The rate/1,000 population has decreased over the period across all comparative regions. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is in the 90th percentile in Phillipsburg.
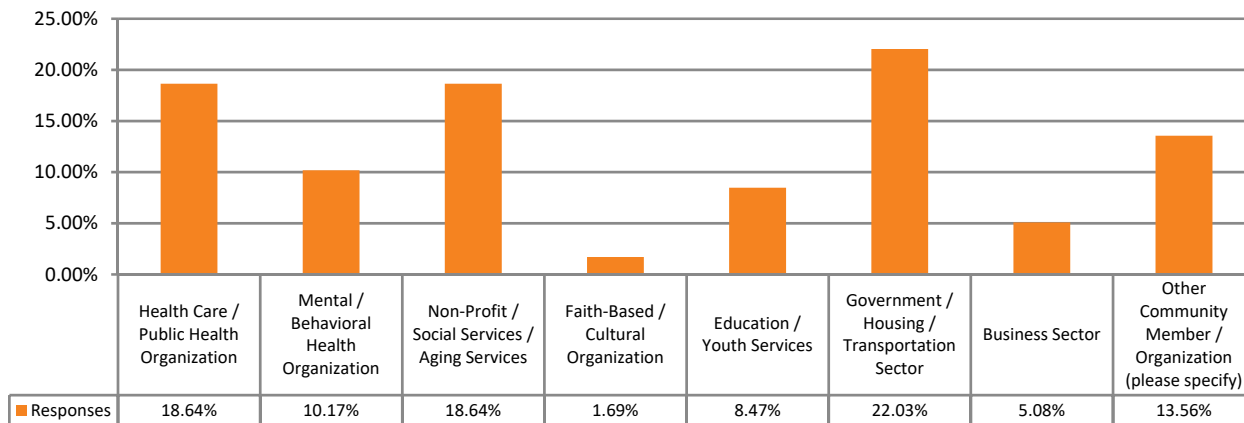
GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	6.55	7.35	6.78	6.67	6.43	(0.1)	40%
Western Region	8.79	8.70	8.68	9.21	8.56	(0.2)	60%
AHS Region	7.98	7.86	7.65	7.52	7.19	(0.8)	50%
Hackettstown	6.67	8.06	7.23	7.15	6.35	(0.3)	40%
Phillipsburg	17.78	19.13	17.39	18.65	15.21	(2.6)	90%
Warren County	10.19	11.29	10.03	10.46	9.26	(0.9)	60%

Renal Failure

The rate/1,000 population has increased over the period across all comparative regions, with the exception of Phillipsburg. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is in the 70th percentile in Phillipsburg.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	1.77	2.03	1.81	1.72	2.23	0.5	50%
Western Region	2.01	2.25	2.29	2.09	2.25	0.2	50%
AHS Region	1.76	1.76	1.79	1.96	2.15	0.4	50%
Hackettstown	1.71	1.93	2.32	1.86	2.28	0.6	50%
Phillipsburg	3.36	3.68	4.61	3.81	3.37	0.0	70%
Warren County	2.36	2.79	3.00	2.49	2.72	0.4	60%

Mental Health (Acute Care Setting)

The rate/1,000 population has increased over the period across all comparative regions, with the exception of Hackettstown. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is in the 80th percentile in Phillipsburg.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	12.97	13.20	12.93	12.81	13.09	0.1	50%
Western Region	15.05	13.79	14.75	15.35	15.88	0.8	60%
AHS Region	13.36	13.48	13.55	13.98	14.22	0.9	50%
Hackettstown	14.91	15.76	15.40	13.51	13.06	(1.9)	50%
Phillipsburg	21.03	18.73	20.36	21.60	22.99	2.0	80%
Warren County	15.48	14.66	15.01	15.43	16.06	0.6	60%

Substance Use Disorders (Acute Care Setting)

The rate/1,000 population has increased over the period across all comparative regions, with the exception of Hackettstown. The highest rate among comparative geographies is in Phillipsburg. The rate/1,000 is in the 70th percentile in Phillipsburg, as well as across the AHS region.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	Rate Change '12 to '16	Statewide Percentile Rank
HMC PSA/SSA	5.56	5.00	5.17	6.67	6.13	0.6	40%
Western Region	6.71	5.96	5.94	7.18	7.18	0.5	50%
AHS Region	8.03	8.06	8.26	8.98	9.24	1.2	70%
Hackettstown	6.34	4.32	4.12	6.79	5.11	(1.2)	20%
Phillipsburg	8.21	8.10	7.11	10.01	9.50	1.3	70%
Warren County	6.21	5.65	5.33	7.65	6.87	0.7	50%

KEY INFORMANT FINDINGS

Background

HMC received 59 responses to its community-based key-stakeholder survey. The survey was administered on-line and via written response as needed. Two additional respondent's answers were stricken from the analysis due to incomplete responses. Below we show the segmentation of the respondents.

Which one of these categories would you say BEST represents your organization's community affiliation? (CHOOSE 1)

	Health Care / Public Health Organization	Mental / Behavioral Health Organization	Non-Profit / Social Services / Aging Services	Faith-Based / Cultural Organization	Education / Youth Services	Government / Housing / Transportation Sector	Business Sector	Other Community Member / Organization (please specify)
Responses	18.64%	10.17%	18.64%	1.69%	8.47%	22.03%	5.08%	13.56%

Below we show the breakdown of the percent of respondents who selected each health issue in the 2018 survey. Issues are ranked on the number of participants who selected the issue. Each respondent chose 5. This year, the top 5 ranked issues were mental health/suicide, substance abuse / alcohol abuse, access to the care / uninsured, overweight / obesity, and diabetes. In 2015 the top 5 were substance abuse/alcohol abuse, mental health/suicide, overweight/obesity, cancer, and heart disease.

What are the top 5 health issues you see in your community? (CHOOSE 5)

	Mental Health / Suicide	Substance Abuse / Alcohol Abuse	Access to Care / Uninsured	Overweight / Obesity	Diabetes	Heart Disease	Cancer	Dental Health	Domestic Violence	Tobacco	Maternal / Infant Health	Other (specify):	Stroke	Sexually Transmitted Diseases
Responses	85.51%	81.16%	68.12%	55.07%	40.58%	39.13%	30.43%	28.99%	20.29%	17.39%	14.49%	11.59%	5.80%	1.45%
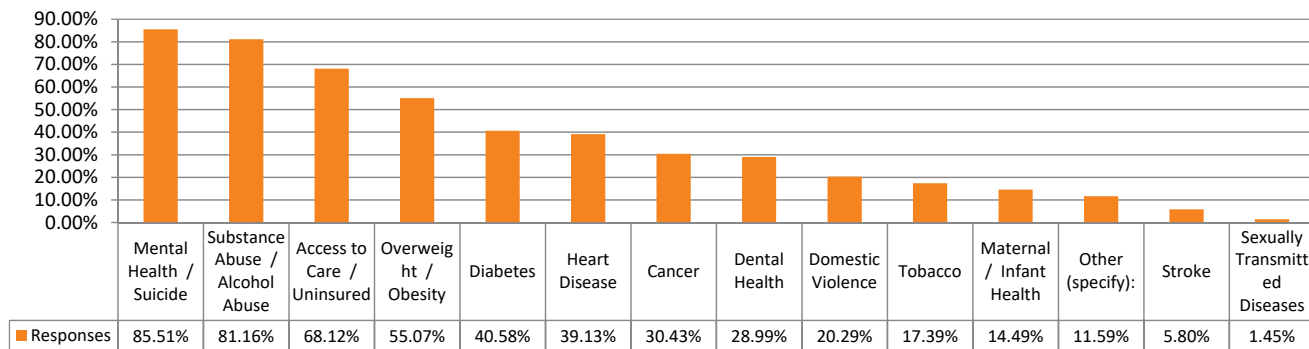
The respondents' top significant health issue in 2018 is access to care / uninsured, followed by mental health / suicide, substance abuse / alcohol abuse. In 2015, the top issue identified by key stakeholders was substance abuse / alcohol abuse.

Of those health issues mentioned, which 1 is the most significant (CHOOSE 1)

	Access to Care / Uninsured	Mental Health / Suicide	Substance Abuse / Alcohol Abuse	Overweight / Obesity	Heart Disease	Cancer	Dental Health	Domestic Violence	Other (specify):	Diabetes	Maternal / Infant Health	Sexually Transmitted Diseases	Stroke	Tobacco
■ Responses	27.54%	26.09%	20.29%	7.25%	4.35%	2.90%	2.90%	2.90%	2.90%	1.45%	1.45%	0.00%	0.00%	0.00%
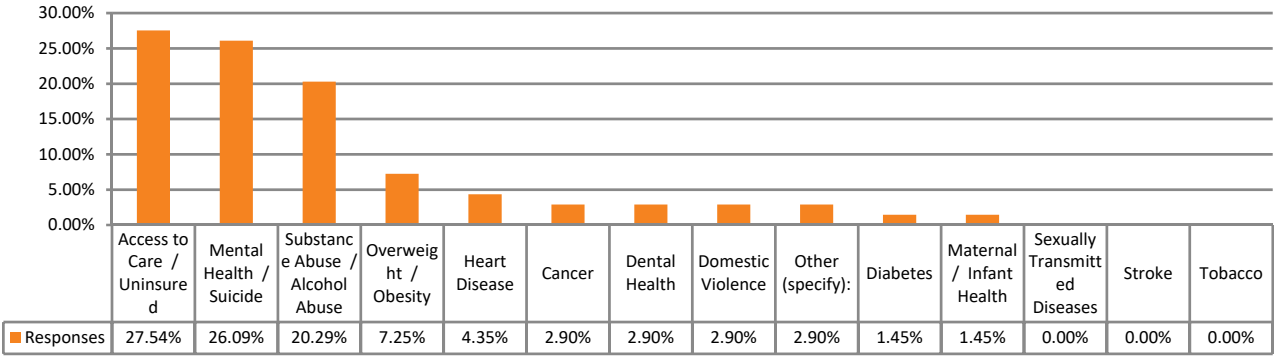
Select Stakeholder Comments: Top Health Issue

- *Access to care continues to be challenge in Warren County, specifically in low income populations and their access to specialty care when needed*
- *People in area don't have primary physicians*
- *Residents cannot get to the services (transportation and other access to care barriers)*
- *There are not enough mental health providers in our community. There are long wait lists, not a lot of options for un/under insured, and treatment seems be like a revolving door*
- *It is extremely difficult to link patients to mental health specialists.*
- *Substance use/alcohol abuse and mental health issues are significant health issues in the local community and impact or are impacted by other concurrent health issues*

The second set of questions concerned the ability of local residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bi-lingual providers. Respondents were provided with statements such as: "Residents in the area are able to access a primary care provider when needed." They were then asked to rate their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree).

On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in the area.
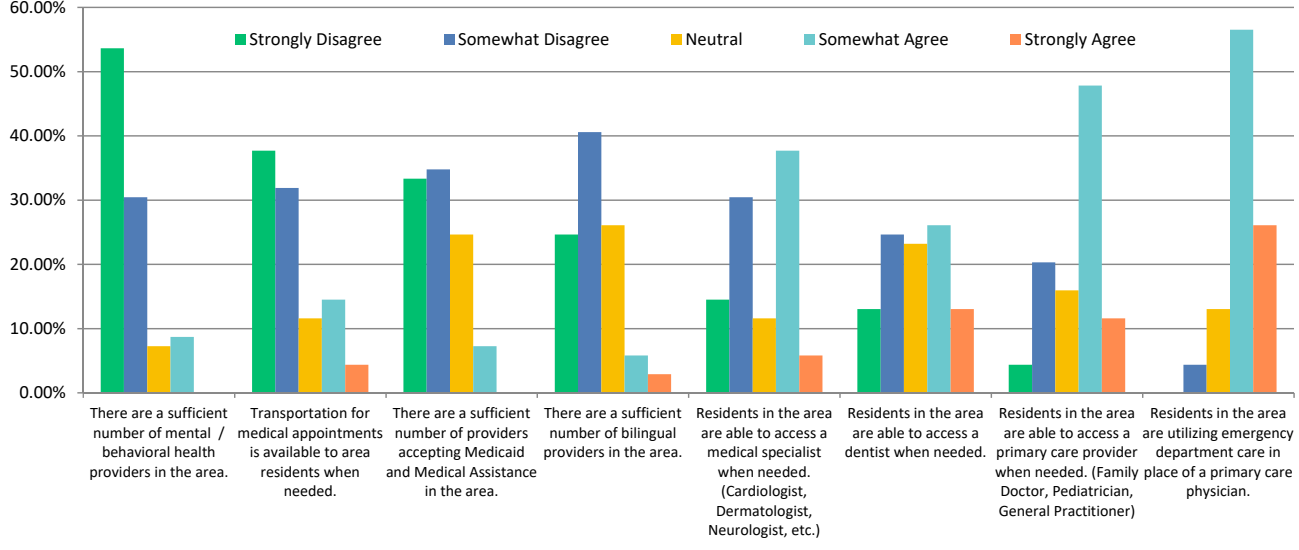
After rating availability of health care services, respondents were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The barriers that were most frequently selected are summarized below. It is Important to note that all respondents felt there were some barriers to access.

In 2018, Lack of Transportation has been rated by participants as being the most significant barrier (72.46%), followed by Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.) at (69.57%). Other barriers that were rated by participants as being the most significant included inability to navigate health care system, lack of health insurance coverage, availability of providers/appointments (time) and language/cultural barriers.

In 2015 the most significant barrier was inability to pay out of pocket expenses (78.2%) then followed by the same barriers currently identified. There appears to be no change in perception to barriers to access of care from the community.

What are the most significant barriers that keep people in the community from accessing health care when they need it? (Select all that apply)

	Lack of Transportation	Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)	Inability to Navigate Health Care System	Lack of Health Insurance Coverage	Availability of Providers / Appointments	Language / Cultural Barriers	Lack of Health Literacy	Basic Needs Not Met (Food / Shelter)	Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)	Lack of Child Care	Lack of Trust	Other (please specify)	None / No Barriers
Responses	72.46%	69.57%	57.97%	57.97%	49.28%	34.78%	26.09%	23.19%	23.19%	15.94%	11.59%	7.25%	0.00%

When respondents were asked for their choice of TOP significant barrier, Inability to Pay Out of Pocket Expenses was chosen (26.09%). Lack of Transportation, Availability of Providers/Appointments and Lack of Health Insurance Coverage followed. After selecting the most significant barriers, informants were asked to share any additional information regarding the barriers to accessing health care.

Of those barriers mentioned in question 5, which 1 is the most significant. (CHOOSE 1)

	Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)	Lack of Transportation	Availability of Providers / Appointments	Lack of Health Insurance Coverage	Inability to Navigate Health Care System	Basic Needs Not Met (Food / Shelter)	Lack of Health Literacy	Lack of Trust	Language / Cultural Barriers	Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)	Other (please specify)	Lack of Child Care	None / No Barriers
Responses	26.09%	20.29%	15.94%	14.49%	10.14%	4.35%	2.90%	1.45%	1.45%	1.45%	1.45%	0.00%	0.00%

Select Stakeholder Comments: Health Care Access & Barriers
- *Transportation is a major issue in the rural areas of our county. Few transportation options.*
- *Transportation in Warren County has to be scheduled three days in advance.*
- *Senior and disabled utilize Easton Coach and logistic care. They need to give several days' notice before receiving the transportation service.*
- *Lack of Health Literacy.*
- *Immigrant, non-English speakers are fearful of seeking care. In addition to well understood cultural differences, there is now an additional burden of alienation and lack of trust in any organized institution which makes it less likely for this population to see health care, particularly non-emergent, preventative health care initiatives.*
- *Warren County families living in poverty do not have adequate access to medical or mental health/addiction services.*
- *It has become more difficult to assist patients navigating the financial screening process.*

The top three population groups identified by key informants as being underserved when compared to the general population were:
- low-income/poor
- uninsured/underinsured
- Hispanic/Latino
- followed closely by seniors/elderly and homeless.

There were no significant differences from the 2015 survey's top 3: low-income/the poor, uninsured/underinsured individuals and the homeless. Responding to the "other" option in the survey, respondents also mentioned "people with disabilities, transgender, immigrants/minorities and veterans" as being underserved.

Are there specific populations in this community that you think are not being adequately served by local health services?

	YES, proceed to Question 9	NO, proceed to Question 10
Responses	75.36%	24.64%

If #8 YES, which populations are underserved? (Select all that apply)

	Low-income / Poor	Uninsured / Underinsured	Hispanic / Latino	Seniors / Aging / Elderly	Homeless	Immigrant / Refugee	Children / Youth	Disabled	Other (please specify)	Young Adults	Black / African-American	None
Responses	75.00%	65.91%	45.45%	43.18%	40.91%	27.27%	22.73%	18.18%	18.18%	15.91%	13.64%	0.00%
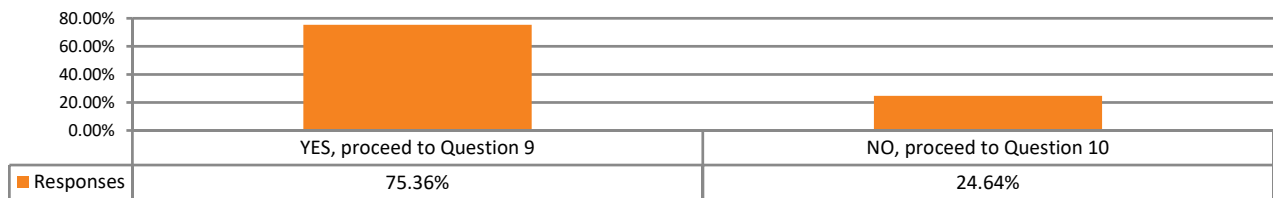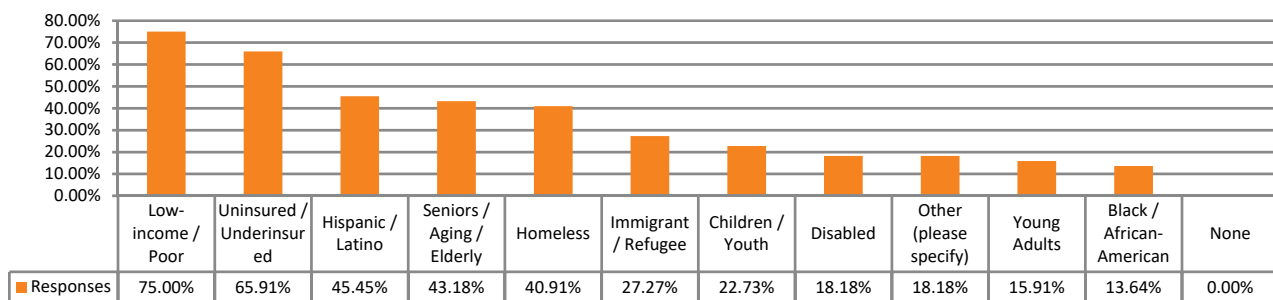
Nearly three-fourths of key informants indicated that hospital emergency departments are the primary place where uninsured/underinsured individuals go when they need medical care. Health Clinic/FQHC and Walk-in/Urgent Care Center were also mentioned as preferred places to obtain medical care. These results were consistent with previous survey data.
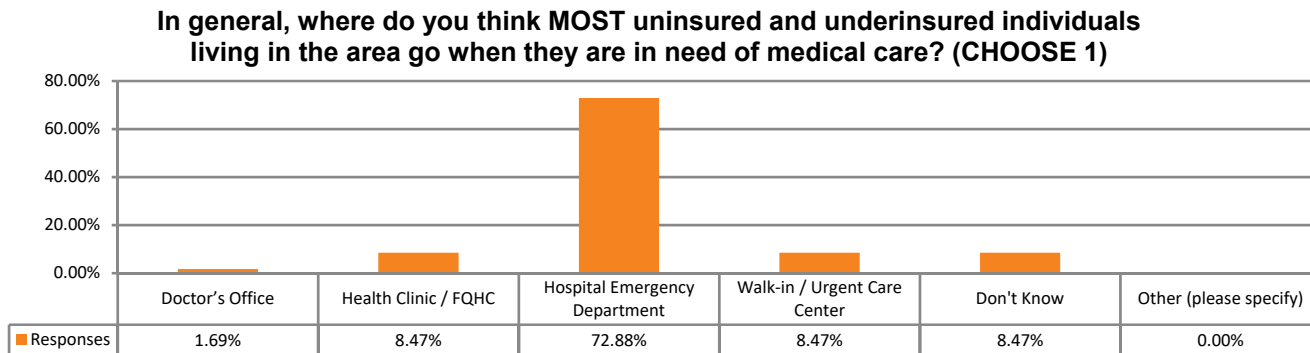
In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care? (CHOOSE 1)

	Doctor's Office	Health Clinic / FQHC	Hospital Emergency Department	Walk-in / Urgent Care Center	Don't Know	Other (please specify)
Responses	1.69%	8.47%	72.88%	8.47%	8.47%	0.00%

Mental Health Services, Free/Low Cost Dental Care, Free/Low Cost Medical Care, Transportation and Substance Abuse Services were mentioned by nearly 65% of the key informants as the most needed resources in the community necessary to improve access to health care for residents of the area. In the 2015 survey, prescription assistance was chosen (which also falls into the free/low cost medical care).

Related to health and quality of life, what resources or services do you think are missing in the community? (Select all that apply)

	Mental Health Services	Free / Low Cost Dental Care	Free / Low Cost Medical Care	Transportation	Substance Abuse Services	Prescription Assistance	Medical Specialists	Bilingual Services	Health Education / Information / Outreach	Health Screenings	Primary Care Providers	Other (please specify)	None
Responses	69.49%	55.93%	54.24%	54.24%	47.46%	35.59%	23.73%	23.73%	22.03%	20.34%	18.64%	10.17%	1.69%

Lastly, key informants were asked to identify challenges people in the community face in trying to maintain healthy lifestyles. The most common themes that emerged in participants' responses include:

- Inappropriate utilization of the ED due to following reasons;
    - *Lack of transportation*
    - *Lack of insurance*
    - *Lack of clinics and clinic hours besides Zufall*
    - *Limited services available*
    - *Lack of mental health providers*
- Lack of providers who take Medicaid / lack of residents signing up for Medicaid – need outreach of financial counselors
- Lack of primary care providers and local specialists
- Lack of follow up care

IDENTIFICATION OF COMMUNITY HEALTH NEEDS

Prioritization

Following a review of secondary data and key informant findings, a select group of providers, community health agency representatives and community stakeholders were asked to participate in a prioritization session. The prioritization ballot listed 19 issues identified during the analysis phase of the community health needs assessment. Participants in the prioritization process were asked to assign a value of 1 (Very Low) to 5 (Very High) to 7 prioritization criteria for each of the 19 identified health issues.

Weighted averages for each impact on an issue were calculated. For each of the seven potential impacts on an issue, the weighted averages were combined to create an overall weighted average for each issue (the overall ranking). The most impactful factor for each issue had the highest weighted average of the seven impacts for that issue, the least impactful factor had the lowest weighted average for that issue. Two ballots were omitted due to improper responses. One ballot with incomplete responses was included in the overall weighting.

The 19 issues identified for prioritization were:
- Access to Care for Low Income / Uninsured
- Access to Health Services
- Access to Specialists When Needed
- Cancer
- Diabetes
- Educational Attainment in Adult Population
- Exercise, Nutrition, & Weight
- Heart Disease & Stroke
- Income Disparities & Poverty
- Maternal, Fetal & Infant Health Disparities
- Mental Health & Mental Disorders
- Need for Bilingual Providers
- Need for Health Care Providers Who Accept Medicaid
- Need for Mental Health Providers
- Overweight/Obesity
- Preventative Care
- Substance Use Disorders
- Transportation for Medical Appointments
- Use of the Emergency Room for Primary Care

The 7 prioritization criteria used to evaluate each issue were:
- Number of people impacted
- The risk of morbidity and mortality associated with the problem
- Impact of the problem on vulnerable populations
- Availability of resources to address the problem
- Relationship of issue to other community issues
- Meaningful progress can be made within a 3-year period
- Is within the organization's capability/ competency to impact

Weighted results were presented to the Hackettstown Medical Center Community Advisory Board, which adopted the 5 highest weighted issues as community health priorities for the 2018-2020-HMC Community Health Needs Assessment.
- Substance Use Disorders
- Diabetes
- Need for Mental Health Providers
- Overweight/Obesity
- Preventive Care

Following is a broad overview of each of the 5 health priorities. HMC will develop a Community Health Improvement Plan (CHIP) to address these 5 health priorities in 2019.

IDENTIFIED HEALTH PRIORITIES

Substance Use Disorders[14]

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Following are overviews of the most common substance use disorders in the United States.

Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea, constipation, and, depending upon the amount of drug taken, can depress respiration. Illegal opioid drugs, such as heroin and legally available pain relievers such as oxycodone and hydrocodone can cause serious health effects in those who misuse them. Some people experience a euphoric response to opioid medications, and it is common that people misusing opioids try to intensify their experience by snorting or injecting them. These methods increase their risk for serious medical complications, including overdose. Other users have switched from prescription opiates to heroin as a result of availability and lower price. Because of variable purity and other chemicals and drugs mixed with heroin on the black market, this also increases risk of overdose. Overdoses with opioid pharmaceuticals led to almost 17,000 deaths in 2011. Since 1999, opiate overdose deaths have increased 265% among men and 400% among women.

In 2014, an estimated 1.9 million people had an opioid use disorder related to prescription pain relievers and an estimated 586,000 had an opioid use disorder related to heroin use.

Symptoms of opioid use disorders include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.

Stimulants increase alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. They include a wide range of drugs that have historically been used to treat conditions, such as obesity, attention deficit hyperactivity disorder and, occasionally, depression. Like other prescription medications, stimulants can be diverted for illegal use. The most commonly abused stimulants are amphetamines, methamphetamine, and cocaine. Stimulants can be synthetic (such as amphetamines) or can be plant-derived (such as cocaine). They are usually taken orally, snorted, or intravenously.

In 2014, an estimated 913,000 people ages 12 and older had a stimulant use disorder because of cocaine use, and an estimated 476,000 people had a stimulant use disorder as a result of using other stimulants besides methamphetamines. In 2014, almost 569,000 people in the United States ages 12 and up reported using methamphetamines in the past month.

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[14] https://www.samhsa.gov/disorders/substance-use

Symptoms of stimulant use disorders include craving for stimulants, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use stimulants, and withdrawal symptoms that occur after stopping or reducing use, including fatigue, vivid and unpleasant dreams, sleep problems, increased appetite, or irregular problems in controlling movement.

Marijuana is the most-used drug after alcohol and tobacco in the United States. According to SAMHSA data:
- In 2014, about 22.2 million people ages 12 and up reported using marijuana during the past month.
- Also, in 2014, there were 2.6 million people in that age range who had used marijuana for the first time within the past 12 months. People between the ages of 12 and 49 report first using the drug at an average age of 18.5.

In the past year, 4.2 million people ages 12 and up met criteria for a substance use disorder based on marijuana use.

Marijuana's immediate effects include distorted perception, difficulty with thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure to cancer-causing compounds. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Some symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use.

According to the CDC, more than 480,000 deaths each year are caused by cigarette smoking. Tobacco use and smoking do damage to nearly every organ in the human body, often leading to lung cancer, respiratory disorders, heart disease, stroke, and other illnesses.

In 2014, an estimated 66.9 million Americans aged 12 or older were current users of a tobacco product (25.2%). Young adults aged 18 to 25 had the highest rate of current use of a tobacco product (35%), followed by adults aged 26 or older (25.8%), and by youths aged 12 to 17 (7%).

In 2014, the prevalence of current use of a tobacco product was 37.8% for American Indians or Alaska Natives, 27.6% for whites, 26.6% for blacks, 30.6% for Native Hawaiians or other Pacific Islanders, 18.8% for Hispanics, and 10.2% for Asians.

Excessive alcohol use can increase a person's risk of developing serious health problems in addition to those issues associated with intoxication behaviors and alcohol withdrawal symptoms. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use causes 88,000 deaths a year.

Data from the National Survey on Drug Use and Health (NSDUH) show that in 2014, slightly more than half (52.7%) of Americans ages 12 and up reported being current drinkers of alcohol. Most people drink alcohol in moderation. However, of those 176.6 million alcohol users, an estimated 17 million have an AUD. Many Americans begin drinking at an early age. In 2012, about 24% of eighth graders and 64% of twelfth graders used alcohol in the past year.

The definitions for the different levels of drinking include the following:

- Moderate Drinking—According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.
- Binge Drinking—SAMHSA defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 drinks for women and 5 drinks for men over a 2-hour period.
- Heavy Drinking—SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Excessive drinking can put you at risk of developing an alcohol use disorder in addition to other health and safety problems. Genetics have also been shown to be a risk factor for the development of an AUD.

To be diagnosed with an AUD, individuals must meet certain diagnostic criteria. Some of these criteria include problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

Hallucinogens can be chemically synthesized (as with lysergic acid diethylamide or LSD) or may occur naturally (as with psilocybin mushrooms, peyote). These drugs can produce visual and auditory hallucinations, feelings of detachment from one's environment and oneself, and distortions in time and perception.

In 2014, approximately 246,000 Americans had a hallucinogen use disorder. Symptoms of hallucinogen use disorder include craving for hallucinogens, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, use in risky situations like driving, development of tolerance, and spending a great deal of time to obtain and use hallucinogens.

Diabetes[15]

Diabetes mellitus (DM) occurs when the body cannot produce enough insulin or cannot respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications.

Many forms of diabetes exist. The 3 common types of DM are:
- Type 2 diabetes, which results from a combination of resistance to the action of insulin and insufficient insulin production
- Type 1 diabetes, which results when the body loses its ability to produce insulin
- Gestational diabetes, a common complication of pregnancy. Gestational diabetes can lead to perinatal complications in mother and child and substantially increases the likelihood of cesarean section. Gestational diabetes is also a risk factor for the mother and, later in life, the child's subsequent development of type 2 diabetes after the affected pregnancy.

Effective therapy can prevent or delay diabetic complications. However, about 28 percent of Americans with DM are undiagnosed, and another 86 million American adults have blood glucose levels that greatly increase their risk of developing type 2 DM in the next several years. Diabetes complications tend to be more common and more

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[15] https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes

severe among people whose diabetes is poorly controlled, which makes DM an immense and complex public health challenge. Preventive care practices are essential to better health outcomes for people with diabetes.

DM affects an estimated 29.1 million people in the United States and is the 7th leading cause of death. Diagnosed DM:
- Increases the all-cause mortality rate 1.8 times compared to persons without diagnosed diabetes
- Increases the risk of heart attack by 1.8 times
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness
- In addition to these human costs, the estimated total financial cost of DM in the United States in 2012 was $245 billion, which includes the costs of medical care, disability, and premature death.
- The number of DM cases continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with DM, and possibly earlier onset of type 2 DM, there is growing concern about:
    o The possibility of substantial increases in prevalence of diabetes-related complications in part due to the rise in rates of obesity
    o The possibility that the increase in the number of persons with DM and the complexity of their care might overwhelm existing health care systems
    o The need to take advantage of recent discoveries on the individual and societal benefits of improved diabetes management and prevention by bringing life-saving discoveries into wider practice
    o The clear need to complement improved diabetes management strategies with efforts in primary prevention among those at risk for developing type 2 DM

Four "transition points" in the natural history of diabetes health care provide opportunities to reduce the health and economic burden of DM:
- Primary prevention: Movement from no diabetes to diabetes
- Testing and early diagnosis: Movement from unrecognized to recognized diabetes
- Access to care for all persons with diabetes: Movement from no diabetes care to access to appropriate diabetes care
- Improved quality of care: Movement from inadequate to adequate care
  Disparities in diabetes risk:
- People from minority populations are more likely to be affected by type 2 diabetes. Minority groups constitute 25 percent of all adult patients with diabetes in the United States and represent the majority of children and adolescents with type 2 diabetes.
- African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians and other Pacific Islanders are at particularly high risk for the development of type 2 diabetes.
- Diabetes prevalence rates among American Indians are 2 to 5 times those of whites. On average, African American adults are 1.7 times as likely and Mexican Americans and Puerto Ricans are twice as likely to have the disease as non-Hispanic whites of similar age.
  Barriers to progress in diabetes care include:
- Systems problems (challenges due to the design of health care systems)
- The troubling increase in the number of people with diabetes, which may result in a decrease in the attention and resources available per person to treat DM

Evidence is emerging that diabetes is associated with additional comorbidities including:
- Cognitive impairment
- Incontinence

- Fracture risk
- Cancer risk and prognosis

The importance of both diabetes and these comorbidities will continue to increase as the population ages. Therapies that have proven to reduce microvascular and macrovascular complications will need to be assessed in light of the newly identified comorbidities.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals. Based on this, new public health approaches are emerging that may deserve monitoring at the national level. For example, the Diabetes Prevention Program research trial demonstrated that lifestyle intervention had its greatest impact in older adults and was effective in all racial and ethnic groups. Translational studies of this work have also shown that delivery of the lifestyle intervention in group settings at the community level are also effective at reducing type 2 diabetes risk. The National Diabetes Prevention Program has now been established to implement the lifestyle intervention nationwide.

Another emerging issue is the effect on public health of new laboratory-based criteria, such as introducing the use of A1c for diagnosis of type 2 diabetes or for recognizing high risk for type 2 diabetes. These changes may impact the number of individuals with undiagnosed diabetes and facilitate the introduction of type 2 diabetes prevention at a public health level.

Several studies have suggested that process indicators such as foot exams, eye exams, and measurement of A1c may not be sensitive enough to capture all aspects of quality of care that ultimately result in reduced morbidity. New diabetes quality-of-care indicators are currently under development and may help determine whether appropriate, timely, evidence-based care is linked to risk factor reduction. In addition, the scientific evidence that type 2 diabetes can be prevented or delayed has stimulated new research into the best markers and approaches for identifying and referring high-risk individuals to prevention programs in community settings.

Finally, it may be possible to achieve additional reduction in the risk of type 2 diabetes or its complications by influencing various behavioral risk factors, such as specific dietary choices, which have not been tested in large randomized controlled trials.

Need for Mental Health Providers[16]

Most counties in the United States face shortages of mental health professionals. In 96 percent of the counties in the nation, there is a shortage of psychiatrists who prescribe medications for people with serious mental illness (SMI). From 2003 to 2013, the number of practicing psychiatrists decreased by 10 percent when adjusted for population size. Many psychiatrists are shifting to private practice, accepting only cash for reimbursement. In part, this may reflect low reimbursement for psychiatric services from state Medicaid programs and Medicaid-contracted managed care payers, cuts to federal and state funding for public sector programs, and inadequate rate setting for psychiatric services. The greatest shortages are in poorer and more rural counties. The need for child psychiatrists is even greater than the shortage of psychiatrists for adults with SMI. The lack of access to psychiatric services creates several issues, such as long wait times for scheduled appointments, often leading to emergency department visits and hospitalizations.

Expanding the workforce by allowing advanced practice registered nurses to practice to the full extent of their training, broadening the scope of practice of psychologists to prescribe some medications, and educating more

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[16] https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

advanced practice registered nurses and psychiatric-mental health physician assistants, are examples of strategies to address the shortage. Tele-mental health is widely accepted as a mechanism that can address shortages in some geographic areas. One county in five also has a shortage of non-prescriber mental health professionals, defined as psychologists, advanced practice psychiatric nurses, social workers, licensed professional counselors, and marriage and family therapists. Also, there are categories of mental health service providers, including licensed professional counselors and marriage and family therapists, whose services are not eligible for reimbursement by Medicare. Peer support can play an important role in a functioning mental health system and should be included as a part of a full continuum of services, whenever possible. Peer support services have been demonstrated to promote recovery and resiliency through the generation of hope, engagement in treatment services, and activation for improved health outcomes. Youth and family peer support services have also generated notable outcomes in this area.

Most states report insufficient psychiatric crisis response capacity as well as insufficient numbers of inpatient psychiatric hospital beds. It is critical that every state have adequate bed capacity to respond to the needs of people experiencing both psychiatric crises and those who need longer periods of inpatient care, such as people in forensic care (care that is provided because of involvement in the criminal or juvenile justice systems). In many areas, bed shortages have led to long delays in gaining access to treatment and an increase in individuals waiting for competency restoration services needed to restore competency to participate in legal proceedings. A report by the National Association of State Mental Health Program Directors Research Institute found that most states (35 of the 46 who responded) have shortages of psychiatric hospital beds. The configuration of available beds and the number of beds per 100,000 population varies substantially across states, but few states report they have adequate numbers of inpatient beds to meet needs. Use of a variety of strategies, such as building psychiatric respite bed capacity, may help to address these capacity issues.

- As a whole, the workforce is too few, aging into retirement, inadequately reimbursed; inadequately supported and trained, and facing significant changes affecting practice, credentialing, funding, and ability to keep up with changes in practice models driven by changing science, technologies and systems.
- Shortages of qualified workers, recruitment and retention of staff and an aging workforce have long been cited as problems.
- Lack of workers in rural/frontier areas and the need for a workforce more reflective of the racial and ethnic composition of the U.S. population create additional barriers to accessing care for many.
- Recruitment and retention efforts are hampered by inadequate compensation, which discourages many from entering or remaining in the field.
- The misperceptions and prejudice surrounding mental and substance use disorders and those who experience them are imputed to those who work in the field.
- Pre-service education and continuing education and training of the workforce have been found wanting, as evidenced by the long delays in adoption of evidence-based practices, underutilization of technology, and lack of skills in critical thinking. These education and training deficiencies are even more problematic with the increasing integration of primary care and mental or substance use disorder treatment, and the focus on improving quality of care and outcomes.
- Of additional concern … the current workforce is unprepared to meet the mental and substance use disorder treatment needs of the rapidly growing population of older adults.

Several themes emerged as common factors that are influencing workforce trends across the country.[17]

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[17] SAMHSA. (2017, September). ATTC: Network Coordinating Office. National Workforce Report 2017. From http://attcnetwork.org/documents/ATTC_Network_Natl_Report2017_single.pdf (

- The Affordable Care Act and Medicaid expansion: The Patient Protection and Affordable Care Act (ACA) and accompanying reforms expanded access to SUD treatment to millions of Americans. Treatment agencies need more staff to treat more clients. Many existing SUD staff need to complete additional coursework or pursue master's level degrees.
- Clinical supervision: In many states, clinical supervision is also required when implementing evidence-based practices. Organizations that invest in their staff by providing good clinical supervision may have greater success with workforce recruitment and retention.
- Healthcare integration: The movement to integrate mental health and SUD treatment with primary care has had an impact on the workforce. SUD professionals are under increasing pressure to acquire skills that allow them to work in integrated healthcare settings, and primary care physicians, nurses, and other medical professionals are beginning to play larger roles in SUD treatment and recovery services.
- The opioid epidemic: No state in the country has been spared from the devastation of the opioid epidemic. Building the capacity of the SUD workforce to provide effective evidence-based treatment for opioid use disorders has been a top priority.

What are some strategies to increase the size of the workforce to better provide evidence-based mental health services and supports?[18]

- HRSA has taken a number of steps to address these workforce challenges as part of its mission to prepare a diverse workforce and improve the workforce distribution to increase access for underserved communities. Among its many programs, HRSA awards health professional and graduate medical education training grants and operates scholarship and loan repayment programs.
- Of particular note is the National Health Service Corps, where, as of September 2015, roughly 30 percent of its field strength of 9,683 was composed of behavioral health providers, meeting service obligations by providing care in areas of high need.
- HRSA is also putting increased emphasis on expanding the delivery of medication-assisted treatment, increasing SBI, and coordinating RSS. The development of the workforce qualified to deliver these services and services to address co-occurring medical and mental disorders will have significant implications for the national workforce's ability to reach the full potential of integration.

What are SAMHSA and other Federal agencies doing to address the workforce crisis and enhance recovery supports as an integral part of the solution?[19]

- SAMHSA will support active strategies to strengthen and expand the behavioral health workforce and improve the behavioral health knowledge and skills of those health care workers not considered behavioral health specialists. Through technical assistance, training, partnerships, and traditional and social media outreach, SAMHSA will promote an integrated, aligned, and competent workforce.
- This workforce will enhance the availability of prevention and treatment for substance abuse and mental illness, strengthen the capabilities of behavioral health professionals, and promote health system infrastructure that can deliver competent, organized behavioral health services.
- SAMHSA will monitor and assess the needs of youth, young adult and adult peers, communities, and health professionals in meeting behavioral health needs within America's transforming health promotion and health care delivery systems.
- SAMHSA also recognizes the growing understanding and value of peer providers to assist with engagement, support, and peer services. Increasing the peer and paraprofessional workforce and increasing the evidence base for the best uses of peer and paraprofessional behavioral health services

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[18] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.
[19] SAMHSA. Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018

and supports, will require additional commitment and will help to expand the reach of limited professional treatment and support professionals.

What is the best way to ensure the behavioral health workforce has access to the information they need to remain current in advancing technologies in prevention, treatment and recovery support? [20]

- Strong health IT systems improve the organization and usability of clinical data, thereby helping patients, health care professionals, and health system leaders coordinate care, promote shared decision-making, and engage in quality improvement efforts. These systems have the capacity to easily provide information in multiple languages and to put patients in touch with culturally appropriate providers through telehealth.

What kinds of training programs or strategies might BH managers adopt to enhance staff retention? [21]

- Members of the behavioral health workforce benefit from continued training and clinical supervision to maintain high-quality services. In addition, these practices and other organizational factors may prevent staff from experiencing burnout and may assist in overcoming challenges in retention of qualified workers.
- For example, clinical supervision has been shown to serve as a protective factor in substance abuse treatment counselors' turnover, emotional exhaustion, and job satisfaction. In the substance abuse treatment field, staff turnover has been found to be as high as 50 percent in some contexts, with average annual estimates around 32 percent for counselors. Substance abuse treatment facilities can play a key role in supporting their workforce through training and supervision practices.

What are initiatives that increase access to providers in underserved areas and integrate behavioral health and primary care?

- The National Network to Eliminate Disparities (NNED) in Behavioral Health is dedicated to promoting equality in behavioral health services for individuals, families, and communities. NNED, with help from SAMHSA and the National Alliance for Multi-Ethnic Behavioral Health Associations, builds coalitions of racial, ethnic, cultural, and sexual minority communities and groups dedicated to removing disparities in behavioral health care. [22]
- The Minority Fellowship Programs (MFP) increase the knowledge of issues related to mental health conditions and addictions among minorities, and to improve the quality of mental health services and substance abuse prevention and treatment delivered to ethnic minority populations. SAMHSA provides grants to encourage and facilitate the doctoral and post-doctoral development of nurses, psychiatrists, social workers, psychologists, marriage and family therapists, and professional counselors by providing funding to organizations which oversee the fellowship opportunities.
- Graduate Psychology Education (GPE) Program: HRSA grants in the GPE program support interdisciplinary training for health service psychologists to provide mental and behavioral health care services to underserved populations, such as those in rural areas, older adults, children, chronically ill or disabled persons, and victims of abuse or trauma, including returning military personnel.
- HRSA's National Health Service Corps are health professionals who provide primary health care services in underserved communities in exchange for either loan repayment assistance or scholarships to help pay the costs of their medical education.
- SAMHSA's cooperative agreement with Historically Black Colleges and Universities supports a Center for Excellence in Substance Abuse and Mental Health which provides student internships at minority serving institutions. [23]

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[20] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

[21] Sherman, Laura, Lynch, Sean, et. al. Behavioral Health Workforce: Quality Assurance Practices in Substance Abuse Treatment Facilities. The CBHSQ Report. SAMHSA.

[22] SAMHSA. (n.d.). Serving the Needs of Diverse Populations.

[23] SAMHSA. (2013, January 24). Report to Congress on Nation's Substance Abuse and Mental Health Workforce Issues.

- CMS is providing technical and program support to states to introduce policy, program, and payment reforms to identify individuals with substance use disorders, expand coverage for effective treatment, expand access to services, and develop data collection, measurement, and payment mechanisms that promote better outcomes.
- Medicaid is also encouraging the trend to integration in other ways, including supporting new models for delivering primary care, expanding the role of existing community-based care delivery systems, enacting mental health and substance use disorder parity for Medicaid and Children's Health Insurance Program (CHIP) as included in the final rule that CMS finalized in March 2016.[24]

Overweight/Obesity[25]

Each year, the *State of Obesity: Better Policies for a Healthier America* report, issued by the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF), highlights the latest obesity trends as well as strategies, policies, programs, and practices that can reverse the epidemic. State of Obesity also demonstrates the level of commitment necessary to effectively fight obesity on a large scale and includes key recommendations for specific action.

New studies documenting national obesity rates and trends from the past year reinforce what we already know: obesity rates are alarmingly high; sustained, meaningful reductions have not yet been achieved nationally except possibly among our youngest children in low-income families; many populations continue to see steady increases in obesity; and racial, ethnic, and geographic disparities are persistent. Therefore, addressing the obesity epidemic remains imperative for ensuring the health of the nation.

According to the most recent National Health and Nutrition Examination Survey (NHANES), 18.5 percent of children and 39.6 percent of adults had obesity in 2015–2016. These are the highest rates ever documented by NHANES. There were no statistically significant changes in youth or adult rates compared with the 2013–2014 survey, but rates have increased significantly since 1999–2000, when 13.9 percent of children and 30.5 percent of adults had obesity.

The severity of racial, ethnic, and geographic disparities remains striking. Black and Latino children and adults continue to have higher obesity rates than Whites and Asians. The Youth Risk Behavior Survey, which is based on self-reported data, found that 14.8 percent of U.S. high school students had obesity in 2017. That survey also reported persistent inequities–18.2 percent of Black and Latino high schoolers had obesity compared with 12.5 percent of their White peers. Two other studies found that adults and children who live in rural areas have higher rates of severe obesity.

Accelerating progress to address obesity will require collaboration, sufficient resources, and sustained efforts, including by federal, state, and local agencies and the private sector. For decades, experts at CDC, National Institutes of Health (NIH), U.S. Department of Agriculture (USDA), U.S. Department of Education, the Administration for Children and Families, and the Food and Drug Administration (FDA) have been researching and developing strategies to prevent and address obesity. Over the past 15 years, policymakers have taken significant steps to implement new approaches through the WIC program, the Supplemental Nutrition Assistance Program, the National School Lunch and Breakfast Programs, updated menu labeling rules, and an updated Nutrition Facts label. Some of these efforts were delayed or weakened, preventing full implementation and thus denying researchers the ability to effectively study which efforts best help people maintain a healthy weight.

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[24] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.
[25] https://stateofobesity.org/wp-content/uploads/2018/09/stateofobesity2018.pdf

For instance, a USDA rule published in November 2017 scaled back key nutrition standards for school breakfast and lunch programs that went into effect in 2012. The question is whether schools will continue the healthy changes that they already implemented. In 23 states, 100 percent of school food agencies were compliant as of September 2016 and at least 90 percent of agencies were compliant in every state. FDA requirements for food retailers and restaurants to post calorie information on menus and elsewhere went into effect in May 2018, more than eight years after becoming law and after several unnecessary delays. Recent federal budget proposals include deep cuts to key health programs such as the CDC's National Center for Chronic Disease Prevention and Health Promotion. This cut would eliminate dedicated funding for addressing nutrition, physical activity, and obesity.

Limiting policies and funding for obesity prevention efforts at a moment when the enormity and intractability of this public health problem is so pressing will have adverse consequences for the country and its residents. After all, Americans' health is directly tied to national security and the U.S. economy.

In response to ongoing high levels of obesity, the United States must be bold enough to find and test new strategies, and resolute enough to intensify evidence-based solutions that are already making a difference. This means communities, governments, and other institutions need to work across sectors and levels to support policies, practices, and programs that work. Over time, these investments can pay off—in lives saved and in reduced healthcare costs.

The annual State of Obesity reports have documented how, over the past 15 years, a series of evidenced-based policies and programs have helped Americans eat healthier and provided more opportunities for physical activity in their homes, schools, and communities. These initiatives have taken root at the local, state, and federal levels, with participation from the private sector.

A renewed commitment to obesity prevention policies and programs, and continued innovation at the state and local levels is critical to achieving success among more children and adults in our country. Effective obesity prevention efforts also require substantial investment to support multifaceted, multi-sector collaborations; merging multiple sources of public and private funding can best ensure that these efforts are sustainable as a long-term enterprise. This is particularly important for populations that have elevated risk.

TFAH and RWJF recommend three guiding principles regarding obesity prevention:
1) Promote policies and scale programs that take a multi-sector approach. Multi-sector aligned initiatives—collaborations that involve, for example, health departments, schools, transportation departments, local businesses, and other agencies—are more likely to achieve results.
2) Adopt and implement policies that help make healthy choices easy. Federal, state, and local governments can create conditions in schools, communities, and workplaces that make healthy eating and active living accessible, affordable, and convenient.
3) Invest in programs that level the playing field for all individuals and families. While obesity affects all populations, some have significantly higher levels than others—often due to social and economic factors largely beyond their control, such as racism, poverty, and lack of access to healthcare. Carefully designed initiatives, that are informed by community input and address these challenges, are critically important. Investing in these programs requires not only adequate funding, but also staffing, public promotion, and other community resources.

TFAH and RWJF offer the following specific recommendations to Healthcare System and Providers:
- Hospitals should no longer sell or serve sugary drinks on their campuses; they should also improve the nutritional quality of meals and promote breastfeeding.

- Nonprofit hospitals should prioritize childhood obesity prevention programs as they work to meet their community benefit requirements.
- All public and private health plans should cover the full range of obesity-prevention, treatment, and management services, including nutritional counseling, medications, and behavioral health consultation.
- Medicare should encourage eligible beneficiaries to enroll in obesity counseling as a covered benefit and evaluate its use and effectiveness. Health plans, medical schools, continuing medical education, and public health departments should raise awareness about the need and availability of these services.
- The healthcare system should extend programs that are effective in terms of costs and performance, such as the Diabetes Prevention Program (DPP) and the community health worker–clinical coordination models. Providers and payers should allocate resources to educating and referring patients to DPP and other covered benefits as appropriate.
- Public and private payers should cover value-based purchasing models that incorporate health outcome measures that incentivize clinicians to prioritize healthy weight.

Preventive Care[26]

Six in ten Americans live with at least one chronic disease, like heart disease, cancer, stroke, or diabetes. These and other chronic diseases are the leading causes of death and disability in America, and they are also a leading driver of health care costs.

Nationally, Americans use preventive services at about half the recommended rate. Cost-sharing such as deductibles, co-insurance, or copayments also reduce the likelihood that preventive services will be used. One study found that the rate of women getting a mammogram went up as much as 9% when cost-sharing was removed. Health problems are a major drain on the economy, resulting in 69 million workers reporting missed days due to illness each year, and reducing economic output by $260 billion per year. Increasing the use of proven preventive services can encourage greater workplace productivity.

Chronic diseases, such as heart disease, cancer, and diabetes, are responsible for 7 of every 10 deaths among Americans each year and account for 75% of the nation's health spending. These chronic diseases can be largely preventable through close partnership with your healthcare team, or can be detected through appropriate screenings, when treatment works best.

Eating healthy, exercising regularly, avoiding tobacco, and receiving preventive services such as cancer screenings, preventive visits and vaccinations are just a few examples of ways people can stay healthy. The right preventive care at every stage of life helps all Americans stay healthy, avoid or delay the onset of disease, keep diseases they already have from becoming worse or debilitating, lead productive lives, and reduce costs.

And yet, despite the benefits of many preventive health services, too many Americans go without needed preventive care, often because of financial barriers. Even families with insurance may be deterred by copayments and deductibles from getting cancer screenings, immunizations for their children and themselves, and well-baby check-ups that they need to keep their families healthy.

The Affordable Care Act (ACA) makes preventive care affordable and accessible by requiring certain private health plans to cover certain recommended preventive services without charging a deductible, copayment, co-insurance, or other cost sharing. Under this new requirement, those services including well-woman visits, support for breastfeeding equipment, domestic violence screening and counseling, became more broadly available without

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[26] https://www.cdc.gov/chronicdisease/index.htm

cost sharing. For people with Medicare, The Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 established a three-part standard for Medicare coverage of preventive services, and the ACA directs Medicare to waive beneficiary co-insurance and deductible liability for certain covered preventive services.

Opportunities for prevention impact all Americans, regardless of age, income, or perceived health status. Each year, potentially preventable chronic diseases (e.g., heart disease, cancer, diabetes) are responsible for millions of premature deaths among Americans. The five leading causes of death in the U.S. are heart disease, cancer, chronic lower respiratory disease, stroke, and unintentional injuries. Because health problems impact productivity, health problems are a major drain on the economy, resulting in 69 million workers reporting missed days due to illness each year. This loss of productivity reduces economic output by $260 billion per year.

Although most Americans underuse preventive services, individuals experiencing social, economic, or environmental disadvantages are even less likely to use these services. Examples of obstacles include lack of access to quality and affordable health care, lack of access to healthy food choices, unsafe environments, and a lack of educational and employment opportunities.

Preventing disease is key to improving America's health and keeping rising health costs under control. When we invest in prevention, the benefits are broadly shared. Children grow up in communities, homes, and families that nurture their healthy development, and adults are productive and healthy, both inside and outside the workplace. Businesses benefit because a healthier workforce reduces long term health care costs and increases stability and productivity. Furthermore, communities that offer a healthy, productive, stable workforce can be more attractive places for families to live and for businesses to locate.[27]

The U.S. Preventive Services Task Force (USPSTF or Task Force) is an independent, volunteer panel of national experts in prevention, primary care, and evidence-based medicine. The Task Force makes evidence-based recommendations about clinical preventive services to improve the health of all Americans. The Task Force comprehensively assesses the potential benefits and harms of preventive services, including screening tests, behavioral counseling, and preventive medications.

The USPSTF is charged by Congress to provide an annual report that identifies gaps in the scientific evidence base and recommends areas for future research. In some cases, clinical preventive services have been well studied for the general population, but there are important evidence gaps that prevent the USPSTF from making recommendations for specific populations and age groups. In each annual Report to Congress, the Task Force calls for more research in those areas where evidence for specific populations or age groups is lacking.

The eighth annual report, which covers 2017 to 2018, has identified the following seven high-priority recent research gaps related to cancer prevention and cardiovascular health where more research is needed.

Cancer Prevention
1. Screening for Cervical Cancer, Especially Among Diverse Populations
2. Screening for Prostate Cancer, Especially Among African American Men and Men with a Family History
3. Screening and Behavioral Counseling for Skin Cancer

Cardiovascular Health
1. Screening for Atrial Fibrillation with Electrocardiography
2. Screening for Cardiovascular Disease Risk with Electrocardiography
3. Risk Assessment for Cardiovascular Disease with Nontraditional Risk Factors

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[27] https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/PreventiveHealth.html

4. Screening for Peripheral Artery Disease and Cardiovascular Disease Risk Assessment with the Ankle-Brachial Index

Examples of research needed within these topics include: how providing preventive services affects health outcomes; identifying tools that can accurately assess people's risk for a specific disease; and the effectiveness of treatments for people who are found to have a disease through screening. Future research in these areas can help fill these gaps and may result in important new recommendations that will help to improve the health of Americans.

The USPSTF hopes that identifying evidence gaps and highlighting them as priority areas for research will inspire public and private researchers to collaborate and target their efforts to generate new knowledge and address important health priorities. [28]

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[28] https://www.uspreventiveservicestaskforce.org/Page/Name/eighth-annual-report-to-congress-on-high-priority-evidence-gaps-for-clinical-preventive-services

APPENDIX A: SECONDARY DATA SOURCES

The following table represents data sources for health-related indicators that were reviewed as part of HMC's CHNA secondary data analysis.

SOURCE
American Community Survey (ACS) 1-Year
American Community Survey (ACS) 5-Year
American Community Survey Supplemental Estimates
American Lung Association (ALA)
BRFSS
Bureau of Labor Statistics (BLS)
CDC (Diabetes Atlas)
CDC (Heart Disease and Stroke Atlas)
CDC (WONDER)
CDC's National Center for Health Statistics
Centers for Medicare & Medicaid Services (CMS)
Claritas Consumer Buying Power
Claritas Pop-Facts® Demographics
Conduent Healthy Communities Institute SocioNeeds Index
County Business Patterns
County Health Rankings (CHR)
Environmental Protection Agency (EPA)
Fatality Analysis Reporting System (FARS)
Feeding America
Food Atlas (USDA)
Institute for Health Metrics and Evaluation (IHME)
National Cancer Institute (NCI)
National Center for Education Statistics (NCES)
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
National Survey on Drug Use and Health (NSDUH)
New Jersey Department of Health UB-04 Deidentified Hospital Discharge Data
Small Area Health Insurance Estimates (SAHIE)
The Robert Wood Johnson Foundation and the CDC Foundation 500 Cities Project
U.S. Census Quickfacts
U.S. Small-area Life Expectancy Estimates Project (USALEEP)
USDA Census of Agriculture
Youth Risk Behavior Survey (YRBS)

APPENDIX B: SECONDARY DATA INDICATORS[29]

The following table represents health-related indicators that were reviewed as part of HMC's CHNA secondary data analysis. The data are compiled and maintained by the Conduent Healthy Communities Institute in collaboration with The North Jersey Health Collaborative (NJHC, the Collaborative), an independent, self-governed 501(c)(3) organization with a diverse set of partners representing health care, public health, social services and other community organizations.

PRIMARY TOPIC	INDICATOR
Economy	Cost of Family Child Care as a Percentage of Income
	Cost of Licensed Child Care as a Percentage of Income
Economy / Employment	Unemployed Workers in Civilian Labor Force
Economy / Government Assistance Programs	Households with Cash Public Assistance Income
	Students Eligible for the Free Lunch Program
Economy / Homelessness	Homelessness by County
Economy / Homeownership	Homeownership
Economy / Housing Affordability & Supply	Renters Spending 30% or More of Household Income on Rent
	Severe Housing Problems
Economy / Income	Households that are Asset Limited, Income Constrained, Employed (ALICE)
	Income Inequality
	Median Household Income
	Median Household Income By Age - 25-44
	Median Household Income By Age - 45-64
	Median Household Income By Age - 65+
	Median Household Income By Age - Under 25
	Median Income Per Individual Worker
	Median Individual Worker Income - Female
	Median Individual Worker Income - Male
	Per Capita Income
	Children Living Below Poverty Level
	Children Under 5 Years Old Living in Poverty
	Families Living Below Poverty Level
	Households with Children Receiving SNAP
	People 65+ Living Below Poverty Level
	People Living 200% Above Poverty Level
	People Living Below Poverty Level
	Utility Assistance for Low-Income Households
	Young Children Living Below Poverty Level
Education / Educational Attainment in Adult Population	People 25+ with a Bachelor's Degree or Higher
	People 25+ with a High School Degree or Higher
Education / School Resources	Student-to-Teacher Ratio
Education / Student Performance K-12	Students Passing 11th Grade State Achievement Tests

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[29] Data indicators accessed via Healthy Communities Institute. Community Dashboard; The North Jersey Health Collaborative; http://www.njhealthmatters.org/

PRIMARY TOPIC	INDICATOR
	Students Passing 4th Grade State Achievement Tests
	Students Passing 8th Grade State Achievement Tests
Environment / Air	Annual Ozone Air Quality
	Annual Particle Pollution
	Recognized Carcinogens Released into Air
Environment / Built Environment	Access to Exercise Opportunities
	Children with Low Access to a Grocery Store
	Children with Low Access to a Grocery Store (% of Total Pop)
	Farmers Market Density
	Fast Food Restaurant Density
	Food Environment Index
	Grocery Store Density
	Households with No Car and Low Access to a Grocery Store
	Liquor Store Density
	Low-Income and Low Access to a Grocery Store
	People 65+ with Low Access to a Grocery Store
	People 65+ with Low Access to a Grocery Store (% of Total Pop)
	People with Low Access to a Grocery Store
	Recreation and Fitness Facilities
Environment / Built Environment	SNAP Certified Stores
Environment / Toxic Chemicals	PBT Released
	Risk factor for childhood lead exposure: Pre-1950 Housing
Environment / Water	Drinking Water Violations
Government & Politics / Elections & Voting	Voter Turnout: Presidential Election
Health	Adults Never Tested for HIV
	Age-Adjusted Years of Potential Life Lost
Health / Access to Health Services	Adults who enrolled in the health insurance marketplace
	Adults who have had a Routine Checkup
	Adults who were prohibited from visiting doctor due to cost
	Adults with at least one primary care provider
	Adults with Health Insurance
	Adults with Health Insurance: 18-64
	Adults with No Health Insurance
	Adults with no personal doctor or health care provider
	Adults with no routine doctor checkup in past year
	Children with Health Insurance
	Children with Health Insurance: 0-17
	Medicare Healthcare Costs
	Non-Physician Primary Care Provider Rate
	Persons with Private Health Insurance Only
	Persons with Public Health Insurance Only
	Preventable Hospital Stays: Medicare Population
	Primary Care Provider Rate

PRIMARY TOPIC	INDICATOR
	Adults 50+ with No Recent Blood Stool Test
	Adults 50+ with No Recent Sigmoidoscopy or Colonoscopy
	Adults Diagnosed with Cancer
	Adults with Cancer
	Age-Adjusted Death Rate due to Breast Cancer
	Age-Adjusted Death Rate due to Cancer
	Age-Adjusted Death Rate due to Colorectal Cancer
	Age-Adjusted Death Rate due to Lung Cancer
	Age-Adjusted Death Rate due to Pancreatic Cancer
	Age-Adjusted Death Rate due to Prostate Cancer
	All Cancer Incidence Rate
	Breast Cancer Incidence Rate
	Cancer: Medicare Population
	Cervical Cancer Incidence Rate
	Colon Cancer Screening
	Colorectal Cancer Incidence Rate
	Liver and Bile Duct Cancer Incidence Rate
	Lung and Bronchus Cancer Incidence Rate
	Mammogram in Past 2 Years: 50-74
	Mammography Screening: Medicare Population
	Melanoma Incidence Rate
	Non-Hodgkin Lymphoma Incidence Rate
	Oral Cavity and Pharynx Cancer Incidence Rate
	Pancreatic Cancer Incidence Rate
	Pap Test in Past 3 Years: 21-65
	Prostate Cancer Incidence Rate
Health / County Health Rankings	Clinical Care Ranking
	Health Behaviors Ranking
	Morbidity Ranking
	Mortality Ranking
	Physical Environment Ranking
	Social and Economic Factors Ranking
Health / Diabetes	Adults 20+ with Diabetes
	Adults with Diabetes
	Adults with Prediabetes
	Age-Adjusted Death Rate due to Diabetes
	Diabetes: Medicare Population
	Diabetic Monitoring: Medicare Population
Health / Disabilities	Adults Limited by Physical, Mental or Emotional Problems
	Persons with a Cognitive Difficulty
	Persons with a Disability
	Persons with a Disability (5-year)
	Persons with a Hearing Difficulty

PRIMARY TOPIC	INDICATOR
	Persons with a Self-Care Difficulty
	Persons with a Vision Difficulty
	Persons with an Ambulatory Difficulty
	Persons with Disability Living in Poverty
	Persons with Disability Living in Poverty (5-year)
Health / Environmental & Occupational Health	Children with Elevated Blood Lead Levels
Health / Exercise, Nutrition, & Weight	Adults 20+ who are Obese
	Adults 20+ who are Sedentary
	Adults Who Are Obese
	Adults who are Sedentary
	Adults with no physical activity in past month
	Child Food Insecurity Rate
	Food Insecure Children Likely Ineligible for Assistance
	Food Insecurity Rate
Health / Family Planning	Teen Birth Rate: 15-17
Health / Heart Disease & Stroke	Adults Diagnosed with Heart Disease
	Adults reporting that they have had a heart attack in their lifetime
	Adults who Experienced a Stroke
	Adults who Experienced Coronary Heart Disease
	Adults Who Have Suffered a Stroke
	Adults who Have Taken Medications for High Blood Pressure
	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)
	Age-Adjusted Death Rate due to Heart Disease
	Age-Adjusted Death Rate due to Hypertensive Heart Disease
	Age-Adjusted Rate of Adult ED Visits for Acute Myocardial Infarction
	Atrial Fibrillation: Medicare Population
	Cholesterol Test History
	Heart Failure: Medicare Population
	High Blood Pressure Prevalence
	High Cholesterol Prevalence: Adults 18+
	Hyperlipidemia: Medicare Population
	Hypertension: Medicare Population
	Ischemic Heart Disease: Medicare Population
	Stroke: Medicare Population
Health / Immunizations & Infectious Diseases	Adults with No Flu Shot
	Adults with No Pneumonia Shot
	Age-Adjusted Death Rate due to Influenza and Pneumonia
	Age-Adjusted Rate of ED Visits Due to Influenza
	Chlamydia Cases
	First Grade Students with Required Immunizations
	Gonorrhea Cases
	Hepatitis C Cases
	HIV/AIDS Prevalence Rate

PRIMARY TOPIC	INDICATOR
	Kindergartners with Required Immunizations
	Lyme Disease Cases
	Pre-Kindergarten Students with Required Immunizations
	School-Aged Children that are Unvaccinated Due to Religious Exemption
	Sixth Grade Students with Required Immunizations
	Syphilis Cases
	Transfer Children with Required Immunizations
	Tuberculosis Incidence Rate
Health / Maternal, Fetal & Infant Health	Babies with Low Birth Weight
	Babies with Very Low Birth Weight
	Infant Mortality Rate
	Mothers who Received Early Prenatal Care
	Mothers who Received No Prenatal Care
	Preterm Births
	Very Preterm Births
Health / Men's Health	Men 40+ with no Recent Digital Rectal Exam
	Men 40+ with No Recent PSA Test
Health / Mental Health & Mental Disorders	Adults with a Depressive Disorder
	Adults with an Anxiety Disorder
	Age-Adjusted Death Rate due to Suicide
	Age-Adjusted Rate of Emergency Department Visits due to Mood Disorder
	Depression: Medicare Population
	Frequent Mental Distress
	Health-Related Quality of Life: Poor Mental Health Days
	Inadequate Social Support
	Mental Health Provider Rate
	Poor Mental Health: 14+ Days
	Poor Mental Health: Average Number of Days
Health / Mortality Data	Age-Adjusted Death Rate
Health / Older Adults & Aging	Adults 45 and Older with Recent Fall
	Adults 65+ who Received Recommended Preventive Services: Females
	Adults 65+ who Received Recommended Preventive Services: Males
	Adults 65+ with a Disability
	Adults 65+ with a Hearing Difficulty
	Adults 65+ with a Self-Care Difficulty
	Adults 65+ with a Vision Difficulty
	Adults 65+ with an Independent Living Difficulty
	Adults with Arthritis
	Age-Adjusted Death Rate due to Alzheimer's Disease
	Alzheimer's Disease or Dementia: Medicare Population
Health / Oral Health	Adults 65+ with Total Tooth Loss
	Adult Adults who Visited a Dentist
	Dentist Rate

PRIMARY TOPIC	INDICATOR
Health / Other Chronic Diseases	Adults with Kidney Disease
	Age Adjusted Death Rate due to Chronic Kidney Disease
	Chronic Kidney Disease: Medicare Population
	Osteoporosis: Medicare Population
	Rheumatoid Arthritis or Osteoarthritis: Medicare Population
Health / Prevention & Safety	Age-Adjusted Death Rate due to Unintentional Injuries
	Age-Adjusted Death Rate due to Unintentional Poisonings
Health / Respiratory Diseases	Adults with Asthma
	Adults with COPD
	Adults with Current Asthma
	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases
	Age-Adjusted Rate of Adult ED Visits for COPD
	Asthma: Medicare Population
	COPD: Medicare Population
Health / Substance Abuse	Adults who Binge Drink
	Adults who Chew Tobacco
	Adults who Currently Drink Alcohol
	Adults who Currently Smoke Cigarettes
	Adults who Drink Excessively
	Adults who Have Smoked More Than 100 Cigarettes in Lifetime
	Adults who Smoke
	Age-Adjusted Alcohol-Related Emergency Department Visit Rate
	Age-Adjusted Rate of Substance Use Emergency Department Visits
	Death Rate due to Drug Poisoning
	Opioid Treatment Admission Rate
Health / Wellness & Lifestyle	Frequent Physical Distress
	Health-Related Quality of Life: Poor Physical Health Days
	Insufficient Sleep
	Life Expectancy
	Life Expectancy for Females
	Life Expectancy for Males
	Poor Physical Health: 14+ Days
	Poor Physical Health: Average Number of Days
	Self-Reported General Health Assessment: Poor or Fair
	Self-Reported General Health Assessment: Poor or Fair (2013 CHANC-NJ CHNA)
Health / Women's Health	Woman with No Recent Clinical Breast Exam
	Women 21 and Older with No Recent Pap Test
	Women 40 and Older with No Recent Mammogram
Public Safety / Crime & Crime Prevention	Violent Crime Rate
Public Safety / Transportation Safety	Age-Adjusted Death Rate due to Motor Vehicle Collisions
	Alcohol-Impaired Driving Deaths
Social Environment / Children's Social Environment	Substantiated Child Abuse Rate
Social Environment / Demographics	Within County Disparity in Life Expectancy at Birth

PRIMARY TOPIC	INDICATOR
Social Environment / Family Structure	Adults who are Caregivers
	Single-Parent Households
Social Environment / Neighborhood/Community Attachment	Linguistic Isolation
	People 65+ Living Alone
	Social Associations
Social Environment / Social & Civic Involvement	Civic Engagement Ranking
Transportation / Commute to Work	Mean Travel Time to Work
	Solo Drivers with a Long Commute
	Workers Commuting by Public Transportation
	Workers who Drive Alone to Work

APPENDIX C: KEY INFORMANT SURVEY TOOL

The Affordable Care Act added new a requirement that every 501(c)(3) hospital organization is required to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy at least once every three years effective for tax years beginning after March 23, 2012.

_____

Hackettstown Medical Center (HMC) is undertaking a comprehensive community health needs assessment for 2018 to re-evaluate the health needs of individuals living in the hospital service area within Warren, Morris and Sussex counties in New Jersey. The purpose of the assessment is to gather current statistics and qualitative feedback on the key health issues facing service area residents. The completion of the CHNA will enable HMC to take an in-depth look at its community and the findings will be utilized to prioritize public health issues and develop a community health implementation plan focused on meeting community needs.

1. What are the top 5 health issues you see in your community? (CHOOSE 5)

- ☐ Access to Care/Uninsured
- ☐ Cancer
- ☐ Dental Health
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Maternal/Infant Health
- ☐ Mental Health/Suicide

- ☐ Overweight/Obesity
- ☐ Sexually Transmitted Diseases
- ☐ Stroke
- ☐ Substance Abuse/Alcohol Abuse
- ☐ Tobacco
- ☐ Domestic Violence
- ☐ Other (specify):

2. Of those health issues mentioned, which 1 is the most significant (CHOOSE 1)

- ☐ Access to Care/Uninsured
- ☐ Cancer
- ☐ Dental Health
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Maternal/Infant Health
- ☐ Mental Health/Suicide

- ☐ Overweight/Obesity
- ☐ Sexually Transmitted Diseases
- ☐ Stroke
- ☐ Substance Abuse/Alcohol Abuse
- ☐ Tobacco
- ☐ Domestic Violence
- ☐ Other (specify):

3. Please share any additional information regarding these health issues and your reasons for ranking them this way in the box below:

_____
_____
_____
_____
_____
_____
_____
_____
_____

4. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about Health Care Access in the area.

	(1) Strongly Disagree	(2) Somewhat Disagree	(3) Neutral	(4) Somewhat Agree	(5) Strongly Agree
Residents in the area are able to access a primary care provider when needed. (Family Doctor, Pediatrician, General Practitioner)					
Residents in the area are able to access a medical specialist when needed. (Cardiologist, Dermatologist, Neurologist, etc.)					
Residents in the area are able to access a dentist when needed.					
Residents in the area are utilizing emergency department care in place of a primary care physician.					
There are a sufficient number of providers accepting Medicaid and Medical Assistance in the area.					
There are a sufficient number of bilingual providers in the area.					
There are a sufficient number of mental/behavioral health providers in the area.					
Transportation for medical appointments is available to area residents when needed.					

5. What are the most significant barriers that keep people in the community from accessing health care when they need it? (Select all that apply)

- ☐ Availability of Providers/Appointments
- ☐ Basic Needs Not Met (Food/Shelter)
- ☐ Inability to Navigate Health Care System
- ☐ Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
- ☐ Lack of Child Care
- ☐ Lack of Health Insurance Coverage
- ☐ Lack of Transportation
- ☐ Lack of Trust
- ☐ Language/Cultural Barriers
- ☐ Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
- ☐ Lack of Health Literacy
- ☐ None/No Barriers
- ☐ Other (please specify)

6. Of those barriers mentioned in question 5, which 1 is the most significant. (CHOOSE 1)

- ☐ Availability of Providers/Appointments
- ☐ Basic Needs Not Met (Food/Shelter)
- ☐ Inability to Navigate Health Care System
- ☐ Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
- ☐ Lack of Child Care
- ☐ Lack of Health Insurance Coverage
- ☐ Lack of Transportation
- ☐ Lack of Trust
- ☐ Language/Cultural Barriers
- ☐ Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
- ☐ Lack of Health Literacy
- ☐ None/No Barriers
- ☐ Other (please specify)

7. Please share any additional information regarding barriers to health care in the box below:

_____
_____
_____
_____
_____
_____
_____
_____
_____

8. Are there specific populations in this community that you think are not being adequately served by local health services?

- YES, proceed to Question 9
- NO, proceed to Question 10

9. If #8 YES, which populations are underserved? (Select all that apply)

- ☐ Uninsured/Underinsured
- ☐ Low-income/Poor
- ☐ Hispanic/Latino
- ☐ Black/African-American
- ☐ Immigrant/Refugee
- ☐ Disabled

- ☐ Children/Youth
- ☐ Young Adults
- ☐ Seniors/Aging/Elderly
- ☐ Homeless
- ☐ None
- ☐ Other (please specify)

10. In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care? (CHOOSE 1)

- ☐ Doctor's Office
- ☐ Health Clinic/FQHC
- ☐ Hospital Emergency Department

- ☐ Walk-in/Urgent Care Center
- ☐ Don't Know
- ☐ Other (please specify)

11. Please share any additional information regarding Uninsured/Underinsured Individuals & Underserved Populations in the box below:

_____
_____
_____
_____
_____
_____
_____
_____
_____

12. Related to health and quality of life, what resources or services do you think are missing in the community? (Select all that apply)

- ☐ Free/Low Cost Medical Care
- ☐ Free/Low Cost Dental Care
- ☐ Primary Care Providers
- ☐ Medical Specialists
- ☐ Mental Health Services
- ☐ Substance Abuse Services
- ☐ Bilingual Services

- ☐ Transportation
- ☐ Prescription Assistance
- ☐ Health Education/Information/Outreach
- ☐ Health Screenings
- ☐ None
- ☐ Other (please specify)

13. What challenges do people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy and/or trying to manage chronic conditions like diabetes or heart disease?

_____
_____
_____
_____
_____

14. In your opinion, what is being done well in the community in terms of health and quality of life? (Community Assets/Strengths/Successes)

_____
_____
_____
_____
_____

15. What recommendations or suggestions do you have to improve health and quality of life in the community?

_____
_____
_____
_____
_____

16. Name & Contact Information: (Note: Your name and organization is required to track survey participation.
Your identity WILL NOT be associated with your responses.)

- • Name _____
- • Title _____
- • Organization _____
- • Email address: _____

17. Which one of these categories would you say BEST represents your organization's community affiliation? (CHOOSE 1)

☐ Health Care/Public Health Organization
☐ Mental/Behavioral Health Organization
☐ Non-Profit/Social Services/Aging Services
☐ Faith-Based/Cultural Organization
☐ Education/Youth Services

☐ Government/Housing/Transportation Sector
☐ Business Sector
☐ Community Member
☐ Other (please specify)

18. What is your gender?

☐ Male
☐ Female

19. Which one of these groups would you say BEST represents the race/ethnicity of the clients you serve? (CHOOSE 1)

☐ White/Caucasian
☐ Black/African American
☐ Asian/Pacific Islander

☐ Hispanic/Latino
☐ Other (please specify)

20. Hackettstown Medical Center and its partners will use the information gathered through this survey in guiding their community health improvement activities. Please share any other feedback you may have for them below:

_____
_____
_____
_____
_____

APPENDIX D: KEY INFORMANT SURVEY PARTICIPANTS

Name	Agency	Title
Allison Millian	Hackettstown High School	School Nurse
Angela Musella	Washington Township Health Department	Health Officer
Barbara-Jayne Lewthwaite	Centenary University	Chair, HMC Community Advisory Board
Beth Ann Dispoto	North Warren Regional School District	School Nurse
Bill Hunt	Warren County Office of Emergency Management	Emergency Management Coordinator
Bogden Bienko	Panther Valley Pharmacy	Owner
Bridget Jones	Hackettstown Medical Center	Staff Development
Cecilia Clayton	Karen Ann Quinlan Hospice	Executive Director
Cheryl Wilson	Great Meadows Middle School	School Nurse
Clay Hinrichs, MD	Hackettstown Medical Center	President, Medical Staff
Darren Tynan	Hackettstown Police Department	Sergeant
David Mango	Hackettstown and Great Meadows Schools	Superintendent
Deborah Beards	House of Good Shepard	Director
Deborah Berry-Toon	Project Self-Sufficiency	Director
Donna Watridge	Hackettstown Medical Center	Chief Nursing Officer
Edward Smith	Board of Chosen Freeholders	Freeholder Director
Elizabeth Sartori	Hackettstown Medical Center	Counseling and Addiction Center
Eric Cross	Dukes Landscaping Management	President
Eva Turbiner	Zufall Health	President & CEO
Frank Fowler	Trinity United Methodist Church	Reverend Doctor
Helen Giles	Mt. Olive Twp. Public Health	Public Health Nurse
Helen Marie Hardgrove	Long Valley First Aide Squad	Chief
Helen Watkins	Warren County Health Department	Warren County Public Health Nurse
James J. Travis	Sasco Insurance	President
James Macauley	Hackettstown Police Department	Chielf, HPD
Jan McDyer	Warren County Transportation Coordinator	Transportation Coordinator
Jason Sarnoski	Freehold Deputy Director	Freeholder Deputy Director
Jim Sheldon	Hackettstown BID	Executive Director
John J. Johnson	John Johnson Dodge	Owner
Joseph Cifalino	Hackettstown Honda	General Manager
Joseph DiPaolo	Hackettstown Medical Center	President
Kevin O'Neill	Warren County Surrogate	Surrogate
Lakshmi Baskaram	Warren County Division on Aging and Disability Services	Director
Laura Hawkins	Hackettstown Medical Center	Community Health Coordinator
Leslie Deherde	Hackettstown Medical Center	Manager, Emergency Services
Maria DiGiovanni	Township of Hackettstown	Mayor
Mary Beth Maciag	Planned Parenthood	Nurse Practitioner

Name	Agency	Title
Mary Guglielmo	Warren County Health Department	Warren County Public Health Nurse
MaryJo Harris	Warren County Coalition for Safe and Healthy Communities	Community Coalition Coordinator
Maulik Trivedi	Hackettstown Medical Center	ER Physician
Michael Lavery	Lavery, Selvaggi, Abromitis and Cohen	Founding Partner
Michael Reilly	Mansfield Police Department	Chief of Police
Michele Cameron	Atlantic Home Health Care & Hospice	Manager
Nancy DelPlato	Hackettstown Medical Center	Health Start
Nancy Quinn	NORWESCAP WIC Program	Program Director
Norman Worth	WRNJ Radio	President
Pauk Owens, MD	Hackettstown Medical Center	Director, MD
Peter Summers	Warren County Health Department	Health Officer
Rachel Stephenson	NORWESCAP (Northwest NJ Community Action Partnership)	Program Coordinator
Ray Nisivoccia	Nisivoccia LLP	Founding Partner
Richard Burke	Warren County Prosecutor	Warren County Prosecutor
Richard Gardner	Board of Chosen Freeholders	Freeholder
Richard McDonald	Family Guidance of Warren County	Executive Director
Robin Ennis	United Way of Northern NJ	Caregiver Coalition Coordinator
Sarah Shoemaker	Warren County Health Department	Public Health Planner
Scott Burd	Warren County Division of Senior Service	Executive Director
Shannon Brennan	Warren County Mental Health Board	Mental Health Administrator
Shawn Buskirk	Warren County Department of Human Services	Director
Shri Babu	Bentley Commons at Paragon Village	Director of Nursing
Stephanie Ponist	Chelsea at Brookfield	Executive Director
Stephen Beecher	Mount Olive Police Department	Chief of Police
Susan Fishbough	Warren County Temporary Assistance	Adm. Supervisor
Theresa Lord-Stout	Centenary University	Director, Health Services
Timothy McDonough	Hope Township	Mayor
Tracy Fazzolari	Home Instead	Director
Trevor Weigle	Mount Olive Township	Health Director
Yvette Day	Community Prevention Resources	Executive Director

APPENDIX E: PRIORITIZATION PARTICIPANTS

Name	Agency	Title
Barbara-Jayne Lewthwaite	Centenary University	Chair, HMC Community Advisory Board
Bogden Bienko	Panther Valley Pharmacy	Owner
Darren Tynan	Hackettstown Police Department	Sergeant
David Mango	Hackettstown and Great Meadows Schools	Superintendent
Donna Watridge	Hackettstown Medical Center	Chief Nursing Officer
Elizabeth Sartori	Hackettstown Medical Center	Counseling and Addiction Center
Eric Cross	Dukes Landscaping Management	President
Frank Fowler	Trinity United Methodist Church	Reverend Doctor
Helen Watkins	Warren County Health Department	Warren County Public Health Nurse
Joseph DiPaolo	Hackettstown Medical Center	President
Kevin Murphy	Hackettstown Medical Center	CFO
Laura Hawkins	Hackettstown Medical Center	Community Health Coordinator
Leslie Deherde	Hackettstown Medical Center	Manager, Emergency Services
Maria DiGiovanni	Township of Hackettstown	Mayor
Mary Guglielmo	Warren County Health Dept.	Warren County Public Health Nurse
Maulik Trivedi	Hackettstown Medical Center	Director, EMA
Norman Worth	WRNJ Radio	President
Pauk Owens, MD	Hackettstown Medical Center	Director, MD
Peter Summers	Warren County Health Department	Health Officer
Richard McDonald	Family Guidance of Warren County	Executive Director
Sarah Shoemaker	Warren County Health Department	Public Health Planner

APPENDIX F: WARREN COUNTY LICENSED HEALTH FACILITIES[30]

Facility	Type/Services
CH Ambulatory Surgery Center of Lopatcong 212 Red School Lane Phillipsburg, NJ 08865 (610) 861-8080	Ambulatory Care Facility
Coordinated Health-Lapatcong Township 222 Red School Lane Phillipsburg, NJ 08865 (610) 861-8080	Ambulatory Care Facility Magnetic Resonance Imaging (MRI) - Closed
Counseling and Addiction Center 112 East Avenue, Unit 9 Hackettstown, NJ 07840 (908) 850-6810	Hospital-Based, Off-Site Ambulatory Care Facility Drug Abuse Treatment
Fresenius Medical Care Phillipsburg 471 Center Street Phillipsburg, NJ 08865 (908) 454-7440	Ambulatory Care Facility Chronic Hemodialysis Peritoneal Dialysis Training Station(s)
Hackettstown Diagnostic Associates LLC 254 B Mountain Avenue - Ste 102 Hackettstown, NJ 07840 (908) 979-1621	Ambulatory Care Facility Computerized Tomography (CT) - Fixed Magnetic Resonance Imaging (MRI) - Open
Hackettstown Medical Center 651 Willow Grove St Hackettstown, NJ 07840 (908) 852-5100	General Acute Care Hospital
Hei Jin Chung MD, PC 601 Coventry Drive Phillipsburg, New Jersey 08865 (908) 859-5676	Surgical Practice
Integramed Medical New Jersey, L.L.C. 171 State Route 173, Suite 301 Asbury, New Jersey 08802 (908) 781-0666	Surgical Practice
OPEN MRI OF PHILLIPSBURG 430 Memorial Parkway Phillipsburg, NJ 08865 (908) 213-3600	Ambulatory Care Facility Computerized Tomography (CT) - Fixed Magnetic Resonance Imaging (MRI) - Open
Planned Parenthood of Northern, Central and Southern New Jersey, Inc. 66 East Washington Avenue Washington, NJ 07882 (973) 539-9580	Ambulatory Care Facility - Satellite Family Planning - Satellite
St Luke's Hillcrest Outpatient Care Center 755 Memorial Parkway, Building 100 Phillipsburg, NJ 08865 (908) 847-6700	Hospital-Based, Off-Site Ambulatory Care Facility Primary Care
ST LUKE'S WARREN HOSPITAL 185 Roseberry St Phillipsburg, NJ 08865 (908) 847-6700	General Acute Care Hospital
St Luke's Warren Hospital Center For Sleep Medicine 89 Roseberry Street	Hospital-Based, Off-Site Ambulatory Care Facility Sleep Center

[30] https://nj.gov/health/healthfacilities/about-us/facility-types/

Facility	Type/Services
Phillipsburg, NJ 08865 (908) 847-6700	
St Luke's Washington Outpatient Center 315 Route 31 S Washington, NJ 07882 (908) 847-6700	Hospital-Based, Off-Site Ambulatory Care Facility Physical Therapy Primary Care
Zufall Health Center Inc 5b Doctors Park Hackettstown, NJ 07840 (908) 452-5366	Ambulatory Care Facility - Satellite Dental Primary Care - Satellite
The Chelsea at Brookfield 1 Brookfield Court Belvidere, NJ 07823 (908)475-5556	Assisted Living Residence
Brakeley Park Center 290 Red School Lane Phillipsburg, NJ 08865 (908)859-2800	Long Term Care Facility & Residential Health Care
Clover Rest Home 28 Washington Street Columbia, NJ 07832 (908)496-4307	Long Term Care Facility
Forest Manor Health Care Center 145 State Park Road Hope, NJ 07844 (908)459-4128	Long Term Care Facility
House of The Good Shepherd 798 Willow Grove Street Hackettstown, NJ 07840 (908)684-5900	Long Term Care Facility & Assisted Living Residence Comprehensive Personal Care Home
Lopatcong Center 390 Red School Lane Phillipsburg, NJ 08865 (908)859-0200	Long Term Care Facility
Phillipsburg Center 843 Wilbur Avenue Phillipsburg, NJ 08865 (908)454-2627	Long Term Care Facility
Selah Care Center 131/133 Fourth Street Belvidere, NJ 07823 (908)797-7193	Residential Dementia Care Home
Warren Haven Rehab and Nursing Center 350 Oxford Road Oxford, NJ 07863 (908)453-7700	Long Term Care Facility

PREPARED FOR

HACKETTSTOWN MEDICAL CENTER

BY

ATLANTIC HEALTH SYSTEM
PLANNING & SYSTEM DEVELOPMENT

Atlantic Health System
Hackettstown Medical Center