

# Hackettstown Medical Center Community Health Needs Assessment

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2021 - 2023



Atlantic Health System  
Hackettstown Medical Center

**ACKNOWLEDGEMENTS & CHNA COMPLIANCE**

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

The 2021-2023 Hackettstown Medical Center Community Health Needs Assessment (CHNA) was approved by HMC’s Community Health Committee in December 2021. Questions regarding the Community Health Needs Assessment should be directed to:

**Atlantic Health System**  
**Hackettstown Medical Center**  
 Planning & System Development  
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A copy of this document has been made available to the public via Atlantic Health System’s website at <https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html>. The public may also view a hard copy of this document by making a request directly to the office of the President, Hackettstown Medical Center.

COMPLIANCE CHECKLIST: IRS FORM 990, SCHEDULE H	REPORT PAGE(S)
<b>Part V Section B Line 1a</b> A definition of the community served by the hospital facility	5
<b>Part V Section B Line 1b</b> Demographics of the community	7
<b>Part V Section B Line 1c</b> Existing health care facilities and resources within the community that are available to respond to the health needs of the community	59
<b>Part V Section B Line 1d</b> How data was obtained	Addressed Throughout
<b>Part V Section B Line 1f</b> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
<b>Part V Section B Line 1g</b> The process of identifying and prioritizing community health needs and services to meet the community health need	6
<b>Part V Section B Line 1h</b> The process for consulting with persons representing the community’s interests	6
<b>Part V Section B Line 1i</b> Information gaps that limit the hospital facility’s ability to assess the community’s health needs	None Identified

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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 2021, 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 residents 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 a health-centric view of the population it serves, enabling HMC to prioritize relevant health issues and inform the development of future community health implementation plan(s) 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:

- Heart Disease
- Diabetes and Overweight/Obesity
- Substance Misuse
- Mental Health
- Cancer

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, to be shared with the public on an annual basis through its community health improvement plan (CHIP).

## 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 offers a wide range of services to keep our local population healthy. Hackettstown Medical Center maintains several designations, including Primary Stroke Center from both the New Jersey Department of Health & Senior Services and The Joint Commission's advanced certification program; accreditations from the American College of Radiology for mammography, nuclear medicine and ultrasound; 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. In addition, 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:

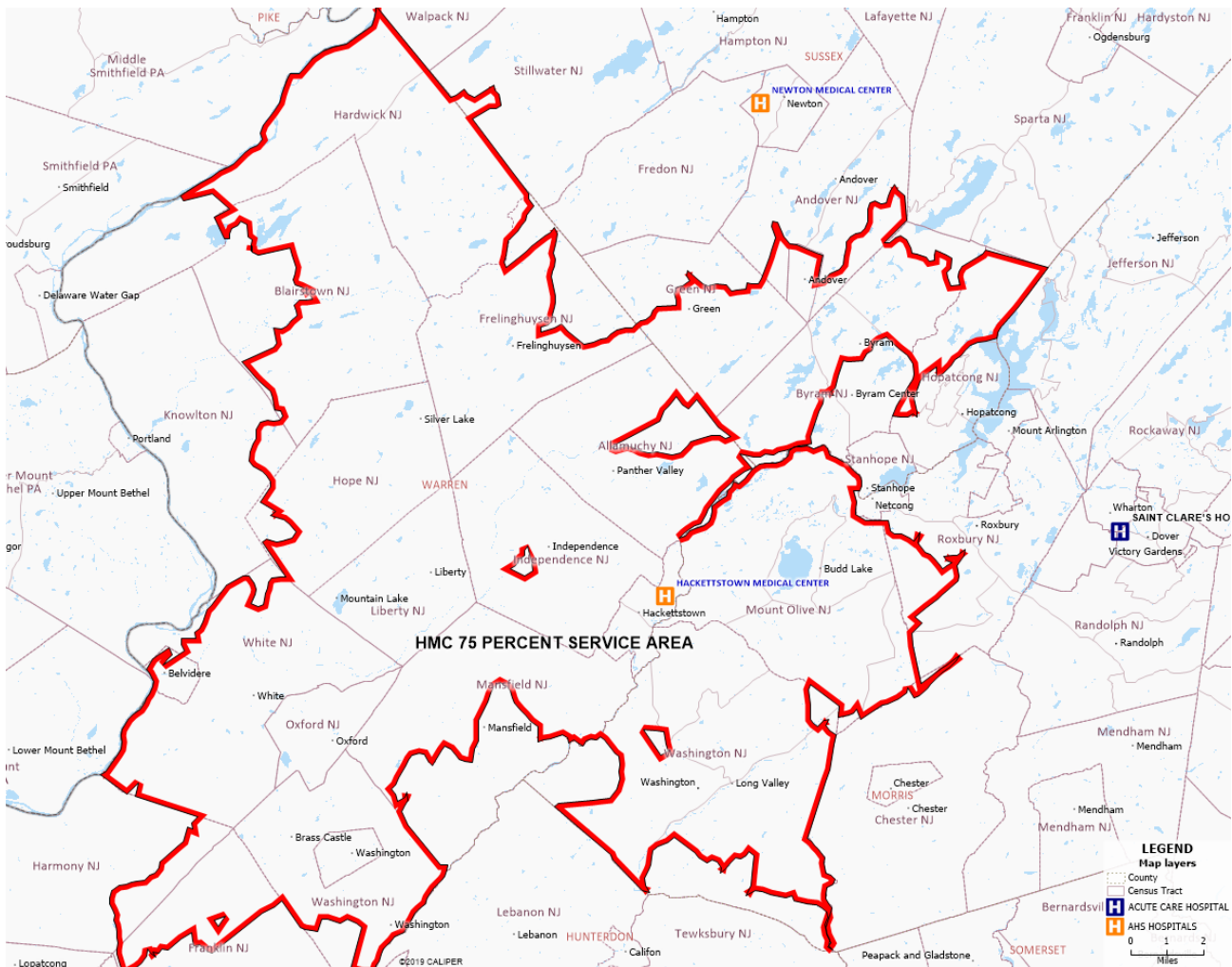
- A high performing hospital in kidney failure and stroke: U.S. News & World Report
- Five-star ratings for the treatment of COPD, heart failure and sepsis: Healthgrades
- American College of Radiology Accreditation for C/T Services, Mammography, Nuclear Medicine, PET and Ultrasound
- Certificate of Accreditation from the Undersea and Hyperbaric Medical Society for the Wound Healing Center Hyperbaric Oxygen Therapy Program
- Geriatric Emergency Department Accreditation from the American College of Emergency Physicians
- 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
- Education Recognition Certificate: American Diabetes Association
- 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 Gold Plus Quality Achievement Award with Target: Stroke Elite Plus, and Target: Diabetes Honor Rolls: American Heart Association and American Stroke Association
- Accredited in adult transthoracic and adult transesophageal echocardiography by the Intersocietal Accreditation Commission (IAC)
- 2021 Environmental Excellence Award: Practice Greenhealth

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 3,500 inpatients and nearly 23,000 emergency room visits in 2020. 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.<sup>1</sup>

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



<sup>1</sup> 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 the service area 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's 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, provided key market insights and prepared all reports.

## Community Representation

Community engagement and feedback were an integral part of the CHNA process. HMC's Community Health Department played a critical role in obtaining 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 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 in the assessment process a diverse cohort of representatives or and/or advocates for underserved population in the service area.

## Prioritization of Needs

Following the completion of the CHNA research, HMC's Community Health Advisory Sub-Committee prioritized community health issues, which are documented herein. HMC will utilize these priorities in its ongoing development of a Community Health Improvement Plan which will be shared publicly on an annual basis.

## SECONDARY DATA PROFILE OVERVIEW

One of the initial undertakings of the CHNA was to evaluate a Secondary Data Profile compiled by the North Jersey Health Collaborative (Conduent Healthy Communities Institute) 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 B) 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 aggregated ZIP Code level health care utilization data.

Secondary data was integrated into a graphical report to inform key stakeholders and HMC's 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

### Demographic Profile<sup>2</sup>

Hackettstown Medical Center's hospital service area encompasses a population of more than 118,000 residents across 10 ZIP Codes primarily in Warren County with portions extending to Sussex and Morris Counties. The area is defined as ZIP Codes from which HMC receives 75% of its inpatient cases. It's projected that total service area population will remain flat through 2025, with variable changes throughout the geography HMC serves. Approximately 18% of the area's population are females of childbearing age (0% change through 2025). About 18% of the area are residents age 65+; by 2025 this cohort will increase to 21%. 20% of the population are age 0-17; this cohort will decrease to 18% by 2025.

- 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).
- 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%.
- 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.
- 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 2025 there are eight towns with a median household income projected to be 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.
- 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.
- 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.

<sup>2</sup> Source: US Census, Claritas, and Sg2 Analytics; Detailed demographic reporting available upon request.



Health insurance coverage can have a significant influence on health outcomes. 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%.

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.

### Localized Data

The ability to gain actionable perspective on the health needs of the population served can be limited in secondary data by geographic or clinical aggregation and to a degree the use of estimates to extrapolate findings. To gain deeper perspective on the needs of the population served by Hackettstown Medical Center, the hospital analyzed deidentified claims that allow for application of a disparity ratio methodology published by the Minnesota Department of Health Center for Health Statistics, Division of Health Policy<sup>4</sup>. This application aids in determining if there are/were disparities among the population we serve directly.

Three separate analyses (race/ethnicity, age, and insurance cohort) were performed on the data using clinical cohorts defined by The Agency For Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Clinical Classification Software – Refined (CCSR). The CCSR aggregates International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes into clinically meaningful categories.

These analyses, not published here, allow for stakeholders to gain deeper understanding of the disparities in the patient population served by HMC and creates, in effect, a roadmap for identifying where resources can best be deployed to address specific patient cohorts. The findings of the analyses will be tracked over time and will serve as key data elements to inform HMC's community health improvement plan.

### Health Status Indicators -Warren County<sup>5</sup>

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 quality of life indicators may be drivers of health status - which is why both categories of data (approximately 206 indicators) are included in this analysis.

For each indicator, a 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

<sup>4</sup> Minnesota Department of Health. Health Disparities by Racial/Ethnic Populations in Minnesota. Available online: <http://www.health.state.mn.us/data/mchs/pubs/raceethn/rankingbyratio20032007.pdf> (accessed on 11 November 2021).

<sup>5</sup> Healthy Communities Institute/Conduent. Data Scoring Tool. New Jersey Health Matters. North Jersey Health Collaborative.

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 of concern are visually highlighted in 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 (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 indicators. The data are organized by major indicator topic and 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, and the trend of an indicator value. A score greater than 2 represents an indicator where the county performs at lower than preferred targets. Where a population segment disparity can be identified that population segment is noted.

HEALTH INDICATOR TOPIC AREAS: SCORE OVER TIME				
Topic	Aug-19	May-21	Nov-21	Trend
Prevention & Safety	2.11	1.90	1.90	Favorable
Respiratory Diseases	1.53	1.62	1.76	Unfavorable
Immunizations & Infectious Diseases	1.56	1.61	1.75	Unfavorable
Cancer	1.90	1.72	1.72	Favorable
Older Adults	1.70	1.69	1.71	Unfavorable
Alcohol & Drug Use	1.73	1.70	1.70	Favorable
Mortality Data	1.72	1.62	1.62	Favorable
Heart Disease & Stroke	1.53	1.62	1.62	Unfavorable
Mental Health & Mental Disorders	1.50	1.60	1.60	Unfavorable
Women's Health	1.74	1.53	1.53	Favorable
Other Conditions	1.71	1.50	1.50	Favorable
Physical Activity	1.37	1.47	1.47	Unfavorable
Children's Health	1.56	1.44	1.45	Favorable
Environmental Health	1.46	1.42	1.45	Favorable
County Health Rankings	1.53	1.44	1.44	Favorable
Maternal, Fetal & Infant Health	1.63	1.38	1.38	Favorable
Wellness & Lifestyle	1.42	1.32	1.36	Favorable
Oral Health		1.26	1.26	Favorable
Health Care Access & Quality	1.71	1.28	1.25	Favorable
Community		1.24	1.21	Favorable
Economy	1.03	1.07	1.12	Unfavorable
Diabetes	1.20	1.07	1.11	Favorable
Education	1.15	0.98	0.98	Favorable

INDICATOR TOPIC	INDICATOR	County Distribution		Value		Trend	Score >=2	Identified Disparity
		State	US	State	US	Trend		
Alcohol & Drug Use	Adults who Binge Drink	2	1.5	2	2	2	1.91	
	Adults who Drink Excessively	3	2	3	2	1.5	2.21	
	Adults who Use Alcohol: Past 30 Days	2	1.5	2	1.5	1	1.53	
	Age-Adjusted Alcohol-Related Emergency Department Visit Rate	1	1.5	1.5	1.5	1.5	1.41	
	Age-Adjusted Rate of Substance Use Emergency Department Visits	1	1.5	1.5	1.5	1.5	1.41	
	Death Rate due to Drug Poisoning	2	3	1	3	2	2.18	
	Opioid Treatment Admission Rate	2	1.5	2	1.5	2	1.82	
Cancer	Adults with Cancer	3	1	1.5	3	1.5	1.94	
	Age-Adjusted Death Rate due to Breast Cancer	2	2	2	3	3	2.47	
	Age-Adjusted Death Rate due to Cancer	2	1	2	2	1	1.53	
	Age-Adjusted Death Rate due to Colorectal Cancer	0	0	1	1	0	0.35	
	Age-Adjusted Death Rate due to Lung Cancer	2	1	3	2	0	1.41	
	Age-Adjusted Death Rate due to Pancreatic Cancer	3	3	3	3	2	2.71	
	Age-Adjusted Death Rate due to Prostate Cancer	1	0	1	0	1	0.65	
	All Cancer Incidence Rate	2	3	2	3	2	2.35	
	Breast Cancer Incidence Rate	0	2	1	1	1	1.00	
	Cancer: Medicare Population	2	3	1	3	2	2.18	
	Cervical Cancer Incidence Rate	1	1	2	2	1	1.35	
	Cervical Cancer Screening: 21-65	0	0	1.5	1	1.5	0.88	
	Colon Cancer Screening	3	1.5	3	1.5	2	2.18	
	Colorectal Cancer Incidence Rate	2	2	2	3	1	1.88	
	Liver and Bile Duct Cancer Incidence Rate	0	0	0	0	2	0.59	
	Lung and Bronchus Cancer Incidence Rate	2	1	3	2	1	1.71	
	Mammogram in Past 2 Years: 50-74	3	1.5	2	1.5	2	2.00	
	Melanoma Incidence Rate	1	2	3	3	1	1.88	
	Non-Hodgkin Lymphoma Incidence Rate	3	3	3	3	3	3.00	
	Oral Cavity and Pharynx Cancer Incidence Rate	2	1	2	1	2	1.65	
Pancreatic Cancer Incidence Rate	3	3	3	3	2	2.71		
Pap Test in Past 3 Years: 21-65	1	1.5	1	1.5	2	1.47		
Prostate Cancer Incidence Rate	1	3	1	3	1	1.71		
County Health Rankings	Clinical Care Ranking	2	1.5	1.5	1.5	1.5	1.59	
	Health Behaviors Ranking	2	1.5	1.5	1.5	1.5	1.59	
	Morbidity Ranking	1	1.5	1.5	1.5	1.5	1.41	
	Mortality Ranking	1	1.5	1.5	1.5	1.5	1.41	
	Physical Environment Ranking	0	1.5	1.5	1.5	1.5	1.24	
	Social and Economic Factors Ranking	1	1.5	1.5	1.5	1.5	1.41	
	Clinical Care Ranking	2	1.5	1.5	1.5	1.5	1.59	
Community	Age-Adjusted Death Rate due to Motor Vehicle Collisions	2	1.5	3	1.5	1	1.71	
	Alcohol-Impaired Driving Deaths	1	0	0	0	0	0.18	
	Households with an Internet Subscription	1	0	1	1	1.5	0.97	
	Households with One or More Types of Computing Devices	1	0	2	1	1.5	1.15	
	Linguistic Isolation	1	3	0	0	1	1.00	
	Mean Travel Time to Work	3	3	3	3	2	2.71	Male
	People 65+ Living Alone	3	3	3	3	3	3.00	
	Persons with an Internet Subscription	1	0	1	1	1.5	0.97	65+, Other Race/Ethnicity
	Single-Parent Households	1	1	0	0	1.5	0.79	
	Social Associations	1	2	0	1	1	1.00	
Solo Drivers with a Long Commute	3	3	3	3	2	2.71		

INDICATOR TOPIC	INDICATOR	County Distribution		Value		Trend	Score >=2	Identified Disparity
		State	US	State	US	Trend		
	Substantiated Child Abuse Rate	2	1.5	3	0	0	1.15	
	Violent Crime Rate	0	1.5	0	0	0	0.26	
	Voter Turnout: Presidential Election	1	1.5	1	1.5	2	1.47	
	Workers Commuting by Public Transportation	3	0	3	3	1	1.88	20-24, Asian
	Workers who Drive Alone to Work	2	2	3	2	2	2.18	55-59, 60-64, Native Hawaiian/Pacific Islander, White, non-Hispanic
Diabetes	Adults 20+ with Diabetes	1	1	1.5	1.5	2	1.47	
	Adults with Prediabetes	1	1.5	0	1.5	2	1.29	
	Age-Adjusted Death Rate due to Diabetes	1	1.5	1	0	0	0.62	
	Diabetes: Medicare Population	1	2	1	2	0	1.06	
Disabilities	Persons with Disability Living in Poverty	2	1	3	1	1.5	1.68	
	Persons with Disability Living in Poverty (5-year)	2	0	1	0	1.5	0.97	
Education	People 25+ with a bachelor's degree or Higher	2	0	3	1	0	1.06	65+, American Indian/Alaska Native, Other
	People 25+ with a High School Degree or Higher	1	1	1	1	0	0.71	65+, American Indian/Alaska Native, Asian, Other
	Student-to-Teacher Ratio	0	0	1.5	1.5	1	0.82	
Health Care Access & Quality	Adults Unable to Afford to See a Doctor	0	1.5	0	0	1.5	0.71	
	Adults who have had a Routine Checkup	1	1.5	1	1.5	1	1.18	
	Adults with Health Insurance	0	1.5	1	1	1.5	1.06	Hispanic/Latino
	Adults without Health Insurance	1	1	1.5	1	1.5	1.24	
	Children with Health Insurance	0	1.5	1	1	1.5	1.06	
	Non-Physician Primary Care Provider Rate	2	3	3	1.5	0	1.68	
	Persons with Health Insurance	1	0	1	1.5	1	0.91	
	Primary Care Provider Rate	2	1	3	1.5	2	1.91	
Family Planning	Teen Birth Rate: 15-17	2	1.5	3	1	1.5	1.76	
Economy	Child Food Insecurity Rate	1	0	1	0	1.5	0.79	
	Children Living Below Poverty Level	1	0	0	0	1	0.47	Black/African American, Hispanic/Latino, Two or More Races
	Cost of Family Child Care as a Percentage of Income	0	1.5	0	1.5	1.5	0.97	
	Cost of Licensed Child Care as a Percentage of Income	1	1.5	1	1.5	1.5	1.32	
	Families Living Below Poverty Level	1	0	0	0	1	0.47	
	Female Population 16+ in Civilian Labor Force	1	0	1	1	2	1.12	
	Food Insecure Children Likely Ineligible for Assistance	2	2	3	3	1.5	2.21	
	Food Insecurity Rate	2	0	1	0	1.5	0.97	
	Homeownership	1	0	0	0	1.5	0.62	
	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	1	1.5	1	1.5	1.5	1.32	
	Households that are Asset Limited, Income Constrained, Employed (ALICE)	2	1.5	2	1.5	1.5	1.68	
	Households that are Below the Federal Poverty Level	1	1.5	0	1.5	1.5	1.15	
	Households with Cash Public Assistance Income	1	1	1	0	1	0.82	
Income Inequality	0	0	0	0	1.5	0.44		
Median Household Gross Rent	0	1.5	0	2	3	1.50		
Median Household Income	1	0	2	0	0	0.53	Hispanic/Latino, Other	

INDICATOR TOPIC	INDICATOR	County Distribution		Value		Trend	Score >=2	Identified Disparity
		State	US	State	US	Trend		
	Median Housing Unit Value	2	1.5	3	0	0	1.15	
	Median Monthly Owner Costs for Households without a Mortgage	1	1.5	0	3	3	1.85	
	Mortgaged Owners Median Monthly Household Costs	1	1.5	0	3	2	1.56	
	Mortgaged Owners Spending 30% or More of Household Income on Housing	0	2	0	1	1	0.82	
	Overcrowded Households	0	1.5	0	1.5	1	0.82	
	People 65+ Living Below Poverty Level	1	0	0	0	3	1.06	Other
	People Living 200% Above Poverty Level	1	0	1	0	1.5	0.79	
	People Living Below Poverty Level	1	0	0	0	1	0.47	Black/African American, Hispanic/Latino, Other, Two or More Races
	Per Capita Income	2	0	2	0	0	0.71	Hispanic/Latino, Other, Two or More Races
	Population 16+ in Civilian Labor Force	1	0	1	1	2	1.12	
	Projected Child Food Insecurity Rate	1	0	1	1.5	1.5	1.06	
	Projected Food Insecurity Rate	2	0	1	1.5	1.5	1.24	
	Renters Spending 30% or More of Household Income on Rent	1	3	1	2	1.5	1.68	65+
	Severe Housing Problems	0	2	0	0	0	0.35	
	Size of Labor Force	1.5	1.5	1.5	1.5	1	1.35	
	Students Eligible for the Free Lunch Program	1	0	1.5	1.5	3	1.59	
	Total Employment Change	1	1	0	0	1	0.65	
	Unemployed Workers in Civilian Labor Force	1	3	1	3	2	2.00	
	Young Children Living Below Poverty Level	1	0	0	0	1	0.47	Two or More Races
Mortality	Age-Adjusted Death Rate	2	1.5	2	1.5	2	1.82	Male
	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	1	1.5	2	3	1.5	1.76	Male
Environmental Health	Access to Exercise Opportunities	1	0	1	0	1.5	0.79	
	Annual Ozone Air Quality	0	1	1.5	1.5	1	1.00	
	Annual Particle Pollution	3	2	1.5	1.5	2	2.00	
	Blood Lead Levels in Children (>=5 micrograms per deciliter)	2	1.5	1	1.5	2	1.65	
	Children with Low Access to a Grocery Store	2	2	1.5	1.5	1.5	1.68	
	Farmers Market Density	0	1	1.5	1.5	1.5	1.15	
	Fast Food Restaurant Density	2	3	1.5	1.5	2	2.00	
	Food Environment Index	1	0	2	0	1	0.82	
	Grocery Store Density	2	1	1.5	1.5	2	1.65	
	Households with No Car and Low Access to a Grocery Store	3	2	1.5	1.5	1.5	1.85	
	Liquor Store Density	3	3	3	3	2	2.71	
	Low-Income and Low Access to a Grocery Store	2	1	1.5	1.5	1.5	1.50	
	Number of Extreme Heat Days	1.5	1.5	1.5	1.5	2	1.65	
	Number of Extreme Heat Events	1.5	1.5	1.5	1.5	2	1.65	
	Number of Extreme Precipitation Days	1.5	1.5	1.5	1.5	1	1.35	
	PBT Released	1.5	1.5	1.5	1.5	1	1.35	
	People 65+ with Low Access to a Grocery Store	1	2	1.5	1.5	1.5	1.50	
	People with Low Access to a Grocery Store	1	2	1.5	1.5	1.5	1.50	
Recognized Carcinogens Released into Air	1.5	1.5	1.5	1.5	0	1.06		
Recreation and Fitness Facilities	1	0	1.5	1.5	2	1.29		
Heart Disease & Stroke	Adults who Experienced a Heart Attack	0	1.5	0	1.5	1.5	0.97	
	Adults who Experienced a Stroke	2	1.5	3	1.5	3	2.29	

INDICATOR TOPIC	INDICATOR	County Distribution		Value		Trend	Score >=2	Identified Disparity
		State	US	State	US	Trend		
	Adults who Experienced Coronary Heart Disease	2	1.5	3	1.5	2	2.00	
	Adults who Have Taken Medications for High Blood Pressure	1	2	1.5	1	1.5	1.41	
	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	1	1.5	1	0	1	0.91	
	Age-Adjusted Death Rate due to Heart Attack	3	1.5	3	1.5	2	2.18	
	Age-Adjusted Death Rate due to Heart Disease	2	1.5	2	2	2	1.91	Male
	Age-Adjusted Death Rate due to Hypertensive Heart Disease	1	1.5	1	1.5	2	1.47	
	Age-Adjusted Hospitalization Rate due to Heart Attack	0	1.5	0	1.5	0	0.53	
	Age-Adjusted Rate of Adult ED Visits for Acute Myocardial Infarction	3	1.5	1.5	1.5	1.5	1.76	
	Atrial Fibrillation: Medicare Population	3	3	3	3	2	2.71	
	Cholesterol Test History	1	0	1.5	1	1.5	1.06	
	Heart Failure: Medicare Population	1	2	2	2	1	1.53	
	High Blood Pressure Prevalence	1	0	1.5	2	1.5	1.24	
	High Cholesterol Prevalence: Adults 18+	2	1	1.5	2	1.5	1.59	
	Hyperlipidemia: Medicare Population	1	3	1	3	1.5	1.85	
	Hypertension: Medicare Population	2	2	1	2	2	1.82	
	Ischemic Heart Disease: Medicare Population	2	3	2	3	0	1.76	
	Stroke: Medicare Population	0	3	1	3	2	1.82	
<b>Tobacco Use</b>	Adults who Currently Use Smokeless Tobacco	3	1.5	3	1.5	1.5	2.03	Adults who Currently Use Smokeless Tobacco
	Adults who Smoke	2	0	3	1	1.5	1.50	Adults who Smoke
<b>Immunizations &amp; Infectious Diseases</b>	Adults 50+ with Influenza Vaccination	3	1.5	3	1.5	2	2.18	
	Adults with Pneumonia Vaccination	3	1.5	3	1.5	1.5	2.03	
	Age-Adjusted Death Rate due to Influenza and Pneumonia	3	1.5	3	2	3	2.56	
	Age-Adjusted Rate of ED Visits Due to Influenza	3	1.5	1.5	1.5	1.5	1.76	
	COVID-19 Daily Average Case-Fatality Rate	2	2	2	0	1	1.35	
	COVID-19 Daily Average Incidence Rate	3	3	3	3	3	3.00	
	Kindergartners with Required Immunizations	3	1.5	2	1.5	2	2.00	
	Persons Fully Vaccinated Against COVID-19	2	0	1.5	1.5	0	0.88	
	Tuberculosis Incidence Rate	2	1.5	0	1	2	1.38	
	Adults 50+ with Influenza Vaccination	3	1.5	3	1.5	2	2.18	
<b>Maternal, Fetal &amp; Infant Health</b>	Babies with Low Birth Weight	1	1.5	1	1	1.5	1.24	Black/African American, non-Hispanic
	Babies with Very Low Birth Weight	0	1.5	0	0	1	0.56	
	Infant Mortality Rate	3	1.5	3	3	2	2.44	
	Mothers who Received Early Prenatal Care	1	1.5	1	1	1	1.09	20-24, Black/African American, non-Hispanic, Hispanic, Two or More Races, non-Hispanic
	Mothers who Received No Prenatal Care	0	1.5	0	0	1.5	0.71	
	Preterm Births	1	1.5	1	0	1.5	1.06	
	Very Preterm Births	3	1.5	3	1.5	2	2.18	
<b>Mental Health &amp; Mental Disorders</b>	Adults Ever Diagnosed with Depression	0	1.5	1	1.5	0	0.71	
	Age-Adjusted Death Rate due to Suicide	3	1.5	3	1	2	2.09	
	Age-Adjusted Rate of Emergency Department Visits due to Mood Disorder	1	1.5	1.5	1.5	1.5	1.41	
	Depression: Medicare Population	3	2	3	2	2	2.35	
	Frequent Mental Distress	2	1	3	2	1.5	1.85	
	Mental Health Provider Rate	1	1	3	1.5	0	1.15	

INDICATOR TOPIC	INDICATOR	County Distribution		Value		Trend	Score >=2	Identified Disparity
		State	US	State	US	Trend		
	Poor Mental Health: 14+ Days	2	1	1.5	2	1.5	1.59	
	Poor Mental Health: Average Number of Days	3	1	3	3	1.5	2.21	
Older Adults	Adults 65+ who Received Recommended Preventive Services: Females	2	1	1.5	0	1.5	1.24	
	Adults 65+ who Received Recommended Preventive Services: Males	1	0	1.5	0	1.5	0.88	
	Adults who were Injured in a Fall: 45+	3	1.5	3	1.5	1.5	2.03	
	Adults with Arthritis	1	1.5	2	1.5	1.5	1.50	
	Age-Adjusted Death Rate due to Alzheimer's Disease	0	1.5	0	0	2	0.85	
	Alzheimer's Disease or Dementia: Medicare Population	1	3	1	2	2	1.82	
	Oral Health	Adults 65+ with Total Tooth Loss	1	0	1.5	0	1.5	0.88
Adults who Visited a Dentist		1	0	1.5	1	1.5	1.06	
Dentist Rate		2	0	3	1.5	1	1.44	
Other Conditions	Adults with Kidney Disease	1	0	1.5	1	1.5	1.06	
	Chronic Kidney Disease: Medicare Population	3	3	2	2	2	2.35	
	Osteoporosis: Medicare Population	0	2	0	0	1	0.65	
	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	1	2	1	2	3	1.94	
Physical Activity	Adults 20+ who are Sedentary	1	3	1.5	1.5	1	1.53	
	Adults Engaging in Regular Physical Activity	0	1.5	1	0	1	0.74	
Prevention & Safety	Age-Adjusted Death Rate due to Unintentional Injuries	2	1.5	3	3	3	2.56	Male
	Age-Adjusted Death Rate due to Unintentional Poisonings	2	1.5	3	3	3	2.56	Male
Respiratory Diseases	Adults with COPD	2	0	1.5	1	1.5	1.24	
	Adults with Current Asthma	2	1.5	3	2	2	2.09	
	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	2	1.5	2	0	0	0.97	
	Age-Adjusted Rate of Adult ED Visits for COPD	1	1.5	1.5	1.5	1.5	1.41	
	Asthma: Medicare Population	1	3	1	2	0	1.24	
	COPD: Medicare Population	2	1	3	2	2	2.00	
Sexually Transmitted Infections	Gonorrhea Cases	1.5	1.5	1.5	1.5	2	1.65	
	Syphilis Cases	1.5	1.5	1.5	1.5	1	1.35	
Weight Status	Adults 20+ who are Obese	3	2	1.5	1.5	2	2.00	
Wellness & Lifestyle	Frequent Physical Distress	1	0	2	2	1.5	1.32	
	Insufficient Sleep	2	2	2	2	1.5	1.85	
	Life Expectancy	1	0	2	1	1.5	1.15	
	Poor Physical Health: 14+ Days	2	1	1.5	2	1.5	1.59	
	Poor Physical Health: Average Number of Days	1	1	2	2	1.5	1.50	
	Self-Reported General Health Assessment: Poor or Fair	1	0	1	0	1.5	0.79	

### Mortality Rates<sup>6</sup>

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, accidents (unintentional injuries), chronic lower respiratory disease, cerebrovascular disease (stroke), and Alzheimer’s disease. In Warren County the top 5 leading causes of death are heart disease, cancer, Covid-19 (2020 Preliminary), unintentional injuries, and chronic lower respiratory disease (CLRD).

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 is a 5 point increase over the previous 3-year measurement period. For cancer, there is an overall decrease in the past decade of 19 points. Unintentional injuries have had an increase of 25 points over the past ten years. CLRD shows a drop at the 9 points over the decade. Other notable trends include current to previous period increases in stroke, septicemia, influenza, diabetes, and chronic liver disease.

	3-Year Groups			Current To Previous	Current to 2 <sup>nd</sup> Previous	2020 Preliminary	Current To Previous
	2011-2013	2014-2016	2017-2019				
Diseases of heart *	180.6	180.4	176.4	(4.0)	(4.2)	181.4	5.0
Cancer (malignant neoplasms) *	171.0	166.0	154.6	(11.4)	(16.4)	152.2	(2.4)
COVID-19 (U07.1)						93.7	n/a
Unintentional injuries *	37.7	51.5	53.5	2.0	15.8	62.8	9.3
Chronic lower respiratory diseases (CLRD) *	37.8	34.5	31.6	(2.9)	(6.2)	29	(2.6)
Stroke (cerebrovascular diseases) *	33.7	32.2	25.6	(6.6)	(8.1)	29.1	3.5
Septicemia	16.5	9.8	16.6	6.8	0.1	18.4	1.8
Influenza and pneumonia	10.6	11.3	16.5	5.2	5.9		
Diabetes mellitus	21.0	19.0	16.0	(3.0)	(5.0)	19.8	3.8
Alzheimer's disease	16.0	14.1	15.0	0.9	(1.0)		
Nephritis, nephrotic syndrome and nephrosis (kidney disease)	15.3	14.2	14.9	0.7	(0.4)	12.5	(2.4)
Suicide (intentional self-harm)	12.9	11.7	11.1	(0.6)	(1.8)		
Chronic liver disease and cirrhosis	7.6	10.7	9.6	(1.1)	2.0		
Essential hypertension and hypertensive renal disease	8.0	4.5	9.0	4.5	1.0		
Parkinson's disease	5.3	10.0	8.5	(1.5)	3.2		
In situ neoplasms, benign neopl. & neopl. of uncertain or unknown behavior	6.2	8.2	6.3	(1.9)	0.1		
Atherosclerosis	12.2	5.9	6.0	0.1	(6.2)		
Pneumonitis due to solids and liquids	**	6.6	4.5	(2.1)			
Other than 27 Major Causes	93.2	96.2	107.6	11.4	14.4		

<sup>6</sup> Source: Center for Health Statistics, New Jersey Department of Health. Deaths with unintentional injury as the underlying cause of death. ICD-10 codes: V01-X59, Y85-Y86 Unintentional injuries are commonly referred to as accidents and include poisonings (drugs, alcohol, fumes, pesticides, etc.), motor vehicle crashes, falls, fire, drowning, suffocation, and any other external cause of death. Data suppressed for, Enterocolitis due to Clostridium difficile, Nutritional deficiencies, Atherosclerosis, Aortic aneurysm and dissection, Certain conditions originating in the perinatal period, Congenital malformations, deformations and chromosomal abnormalities (birth defects), Viral hepatitis, Homicide (assault), HIV (human immunodeficiency virus) disease, Complications of medical and surgical care, Anemias, because it does not meet standards of reliability or precision or because it could be used to calculate the number in a cell that has been suppressed. Consider aggregating years to improve the reliability of the estimate.



### SocioNeeds Index<sup>7</sup>

Community health improvement efforts must determine what sub-populations are most in need 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 2021 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). The index summarizes multiple socio-economic indicators into one composite score for easier identification of high need areas by ZIP Code or county.

Within the 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. Zip Codes are ranked using natural breaks classification, which groups the ZIP Codes into clusters based on similar index values.

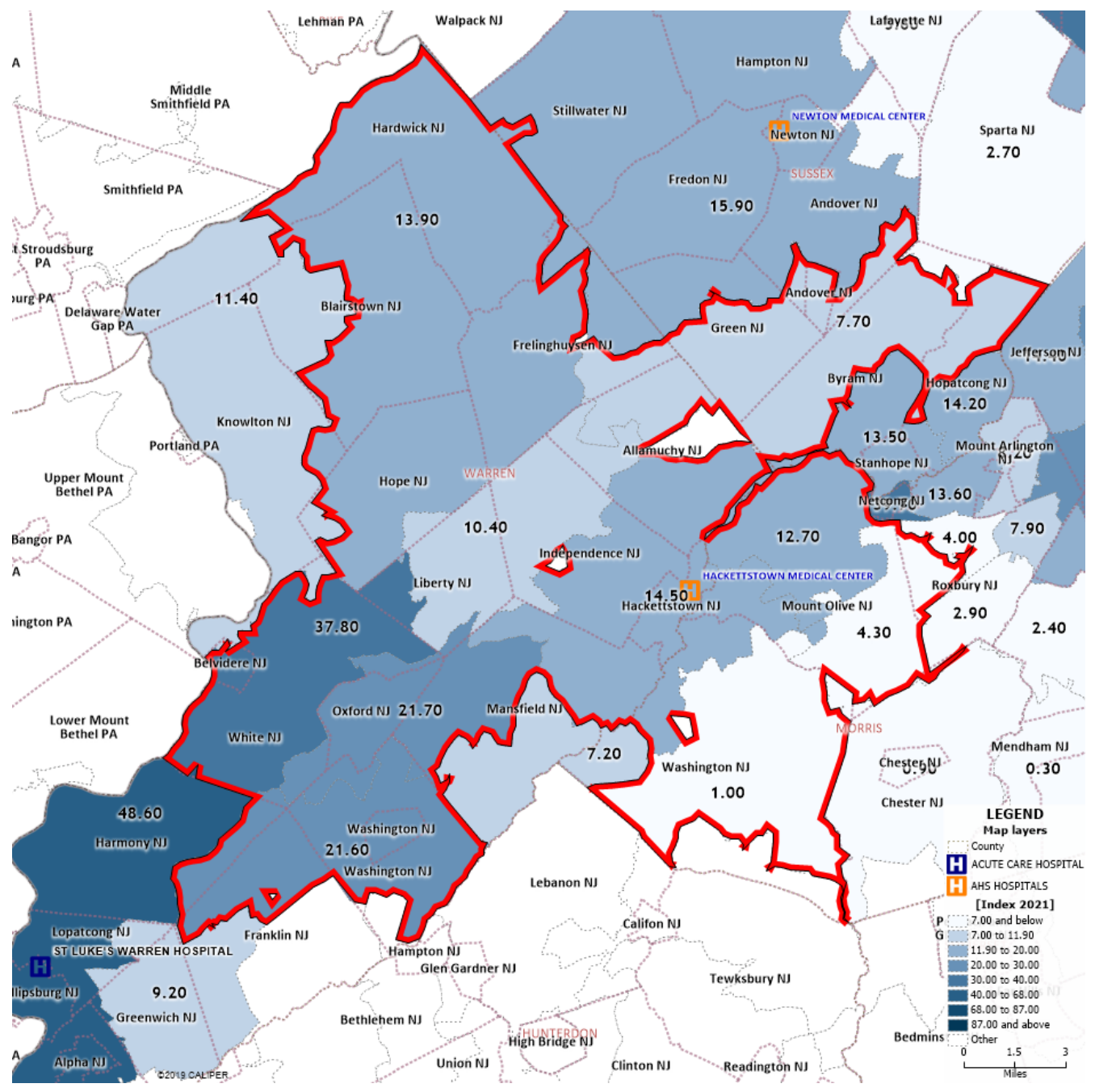
The SocioNeeds Index is calculated for a community from several social and economic factors, ranging from poverty to education, that may impact health or access to care. The index is correlated with potentially preventable hospitalization rates and is calculated using Claritas estimates for 2021.

This map represents a socio-needs index for each ZIP Code within the North Jersey Health Collaborative. 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 37.8. The remainder of the service area ranges from 1.0 (Long Valley) to 21.7 (Oxford). Five towns have a 2021 index that is lower (improved) than 2019.

City	SocioNeeds Index 2019	SocioNeeds Index 2021	Change 2019-2021
Andover	6.3	7.7	
Belvidere	33.2	37.8	
Blairstown	11.9	13.9	
Budd Lake	14.1	12.7	Improved
Flanders	4.8	4.3	Improved
Great Meadows	11.8	10.4	Improved
Hackettstown	15.0	14.5	Improved
Long Valley	1.2	1.0	Improved
Oxford	18.2	21.7	
Washington	13.7	21.6	

<sup>7</sup> Healthy Communities Institute 2021. SocioNeeds Index.



### Food Insecurity Index<sup>8</sup>

The 2020 Food Insecurity Index, created by Conduent Healthy Communities Institute, is a measure of food access that is correlated with economic and household hardship. All zip codes, census tracts, counties, and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need).

The U.S. Department of Agriculture (USDA) defines food insecurity as a lack of consistent access to enough food for an active, healthy life. It is important to know that though hunger and food insecurity are closely related, they are distinct concepts. Hunger refers to a personal, physical sensation of discomfort, while food insecurity refers to a lack of available financial resources for food at the household level.

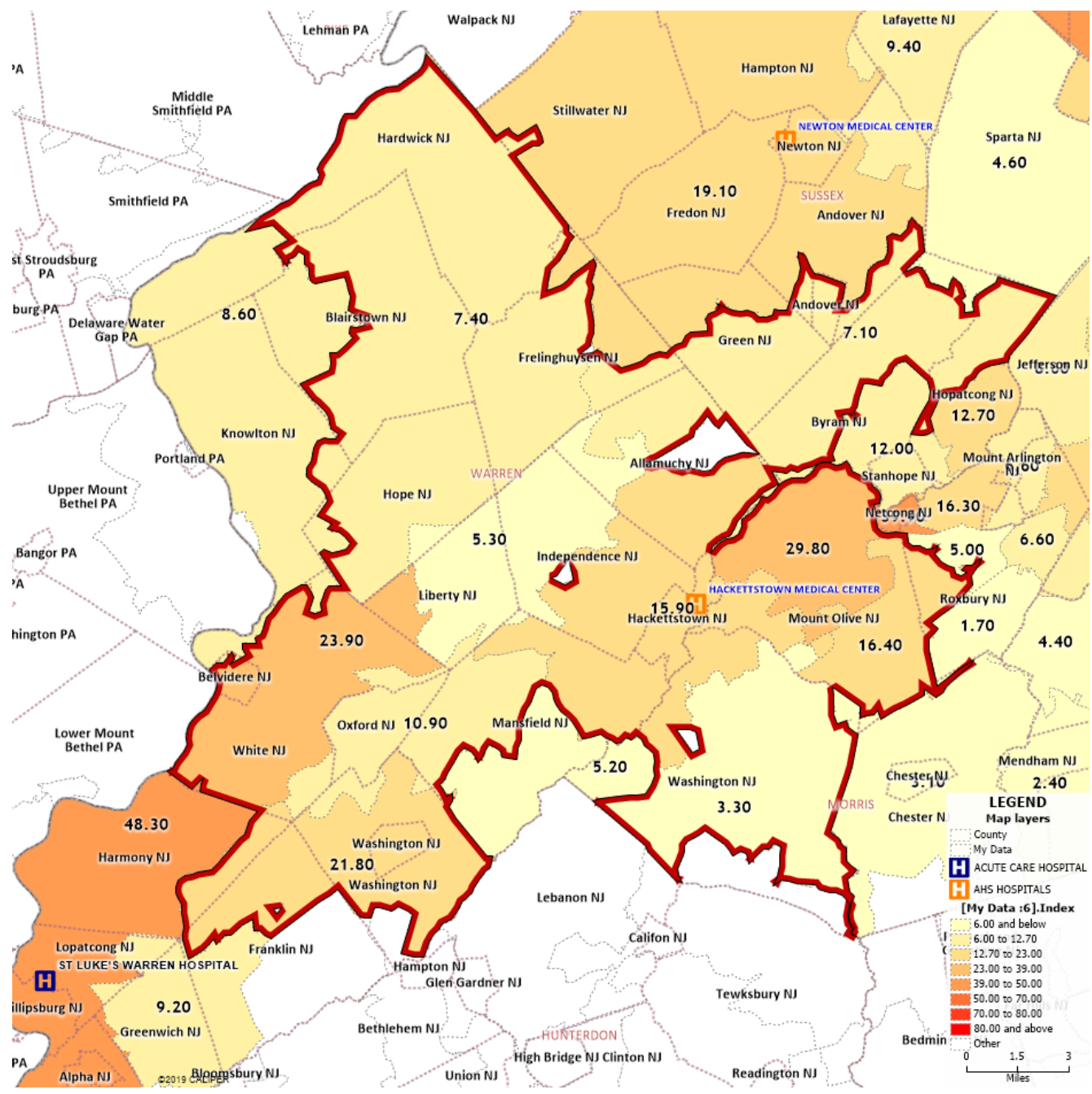
Extensive research reveals food insecurity is a complex problem. Many people do not have the resources to meet their basic needs, challenges which increase a family’s risk of food insecurity. Though food insecurity is closely related to poverty, not all people living below the poverty line experience food insecurity and people living above the poverty line can experience food insecurity.

Food insecurity does not exist in isolation, as low-income families are affected by multiple, overlapping issues like lack of affordable housing, social isolation, chronic or acute health problems, high medical costs, and low wages. Taken together, these issues are important social determinants of health, defined as the “conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.” To that end-AHS will aim to align its social determinants of health efforts to the Healthy people 2030 objectives to guide evidence-based programs, and other actions to improve health and well-being of the community.

Effective responses to food insecurity must address the overlapping challenges posed by the social determinants of health.

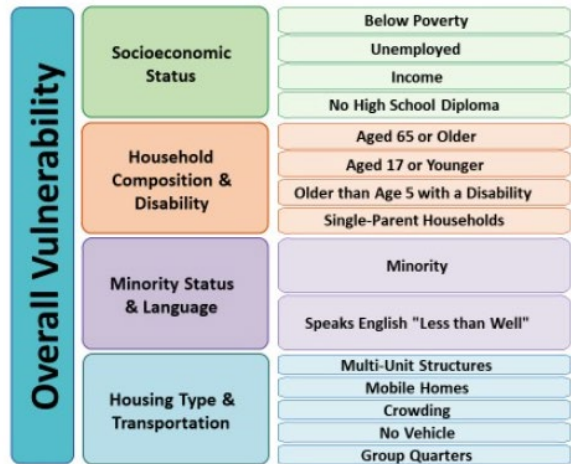
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<sup>8</sup> Healthy Communities Institute 2020. Food Insecurity Index.

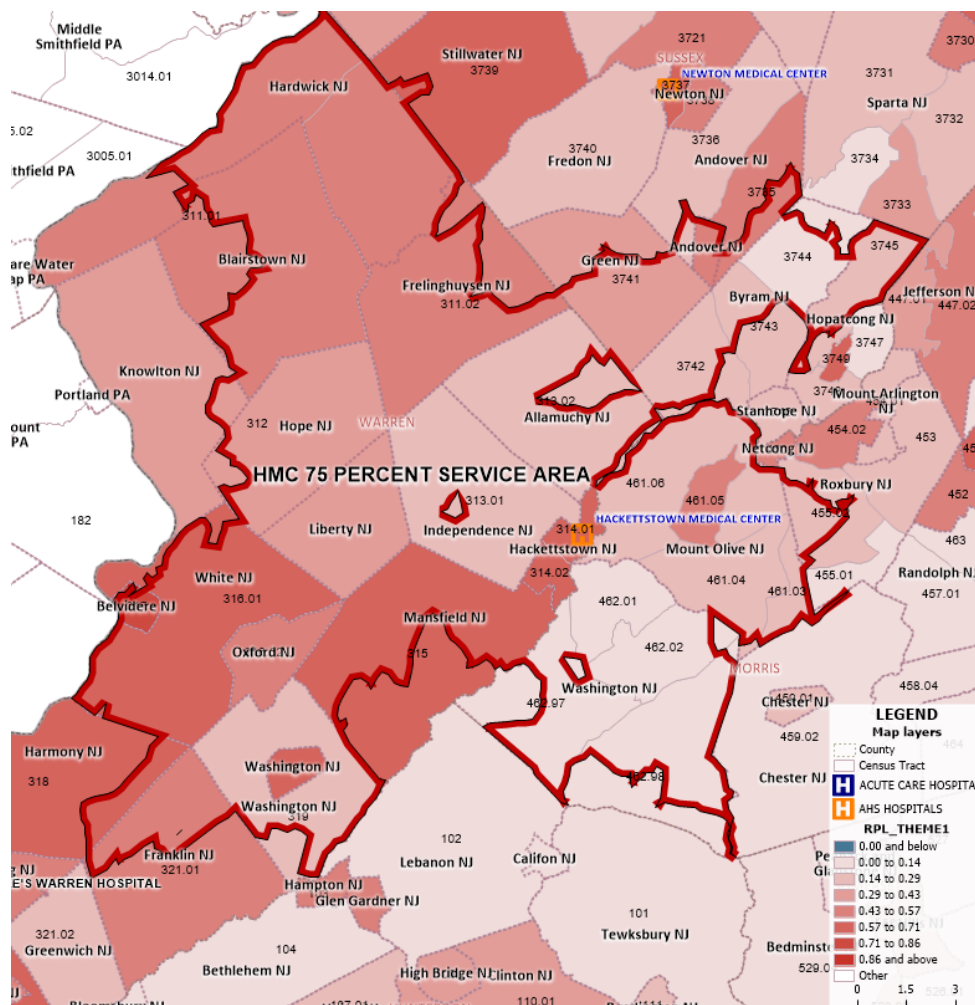


### CDC ATSDR Social Vulnerability Index

The CDC Agency for Toxic Substance and Disease Registry (ATSDR) Social Vulnerability Index (SVI) uses U.S. Census data to determine the social vulnerability of every census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. The CDC/ATSDR SVI ranks each tract on 15 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes. Each tract receives a separate ranking for each of the four themes, as well as an overall ranking.



Social Vulnerability refers to the resilience of communities (the ability to survive and thrive) when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss. Four theme rankings are compiled (shown below) as well as an overall tract level ranking.



**Ambulatory Care Sensitive Conditions: ED & IP**

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 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.

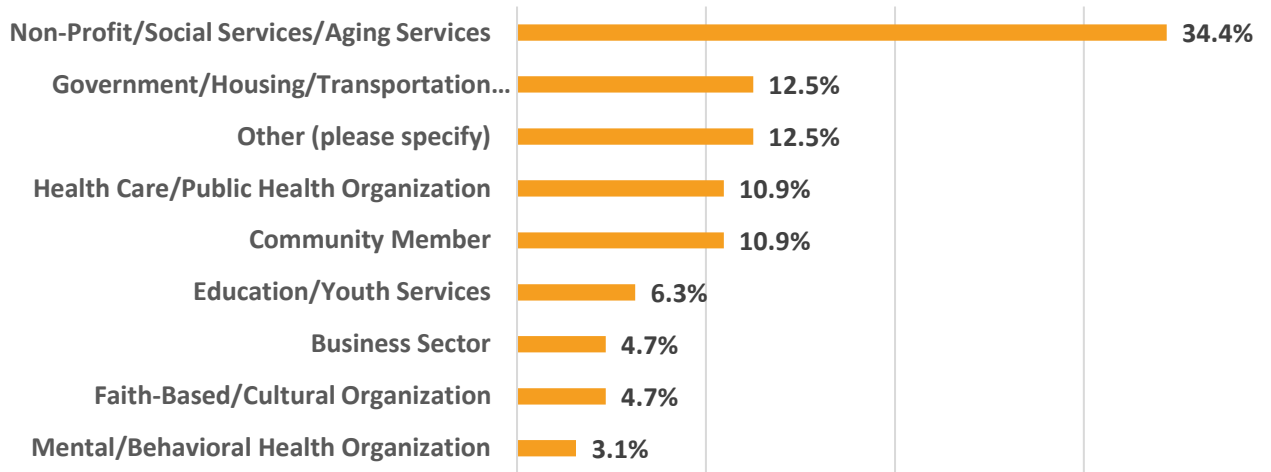
ACSCs represent approximately 12% of ED and Inpatient volume in the county and the greatest number of ACSC related discharges are for ENT related illness, Cellulitis, Kidney infections/UTIs, COPD, and Congestive Heart Failure. Phillipsburg has the highest ACSC rate in Warren County. There are moderately 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%
<b>TOTAL ACSCs (ED &amp; IP)</b>	<b>2,553</b>	<b>100.0%</b>
<b>ACSCs as a % of Total IP/ED @ Hackettstown</b>	<b>12%</b>	

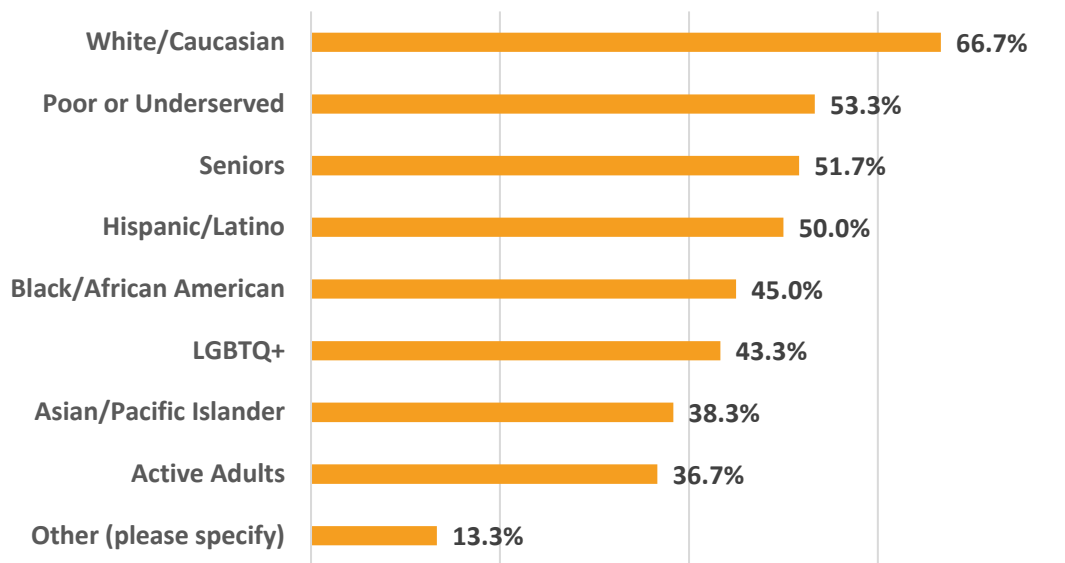
**KEY INFORMANT FINDINGS**

HMC received 61 responses to its community-based key-stakeholder survey, which was administered online. Below we show the breakdown of the respondents’ organizational and community affiliations and alignment with community populations.

**Which one of these categories would you say BEST represents your organization’s community affiliation or is a group you align yourself with? (CHOOSE 1)**

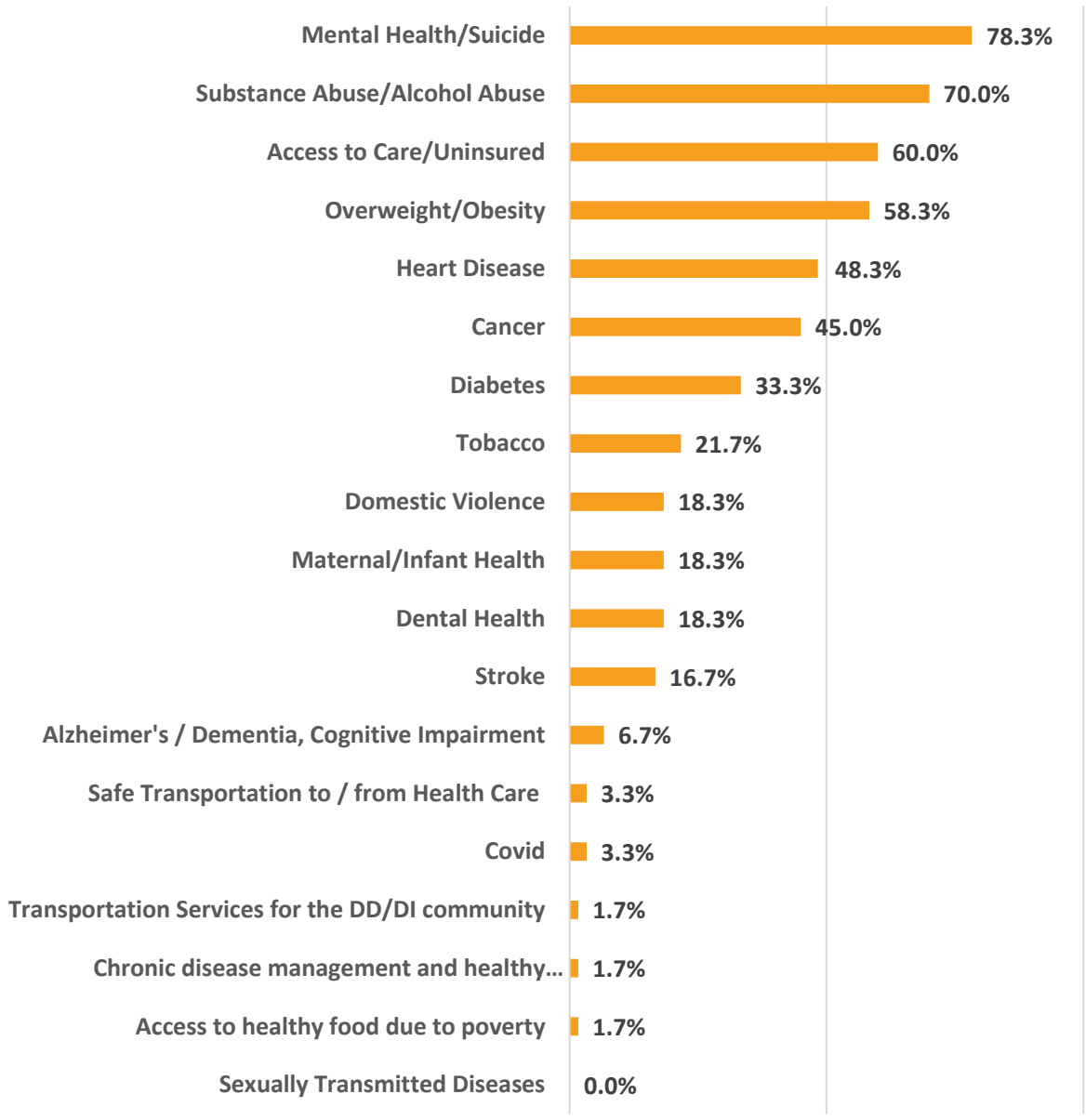


**Which of the following represent the community(s) your organization serves or that you personally align with? (Select all that apply)**



Below we show the breakdown of the percent of respondents who selected each health issue in the 2021 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 care/uninsured, overweight/obesity, and heart disease.

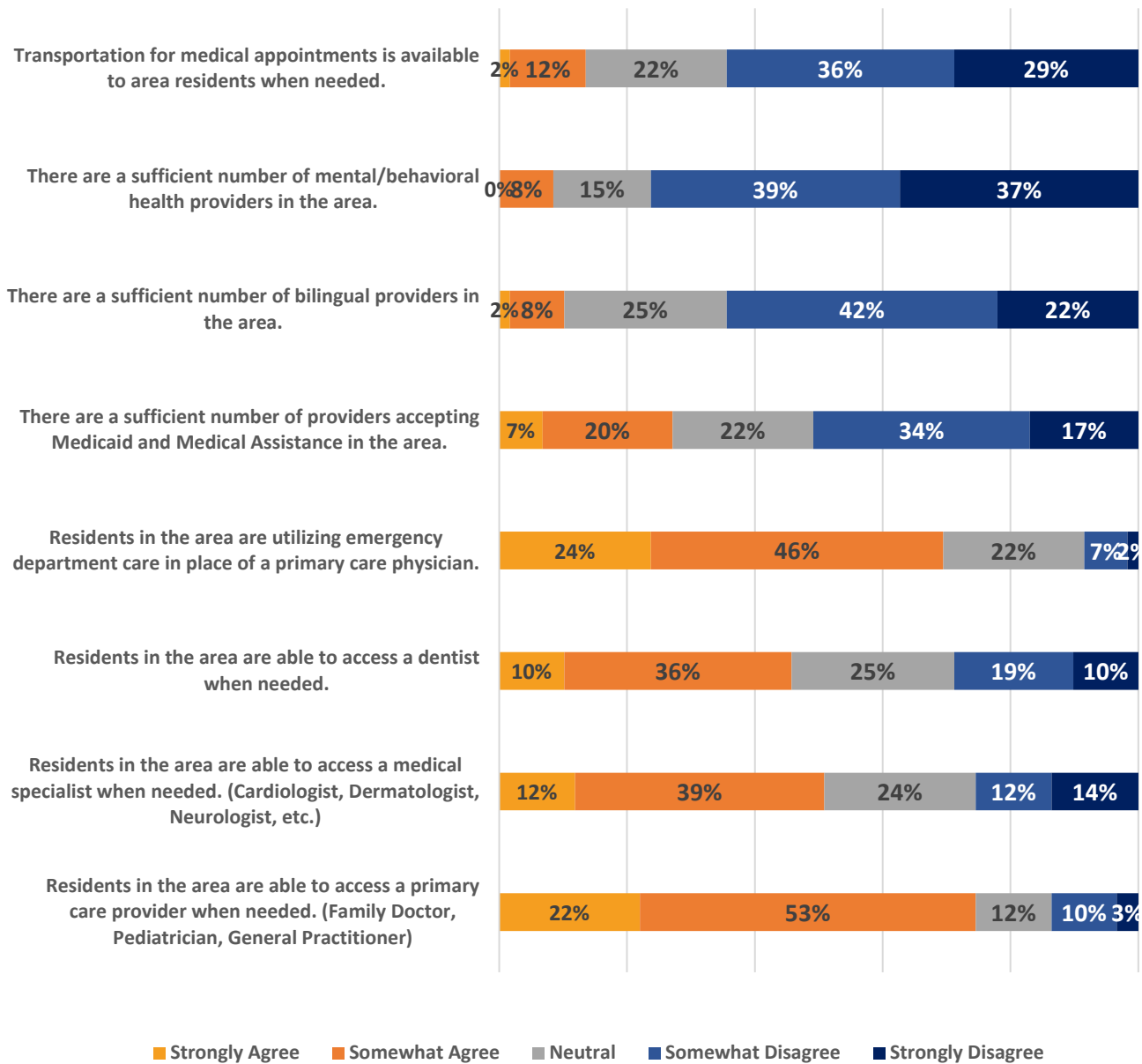
**What are the top 5 health issues you see in your community? (CHOOSE 5)**





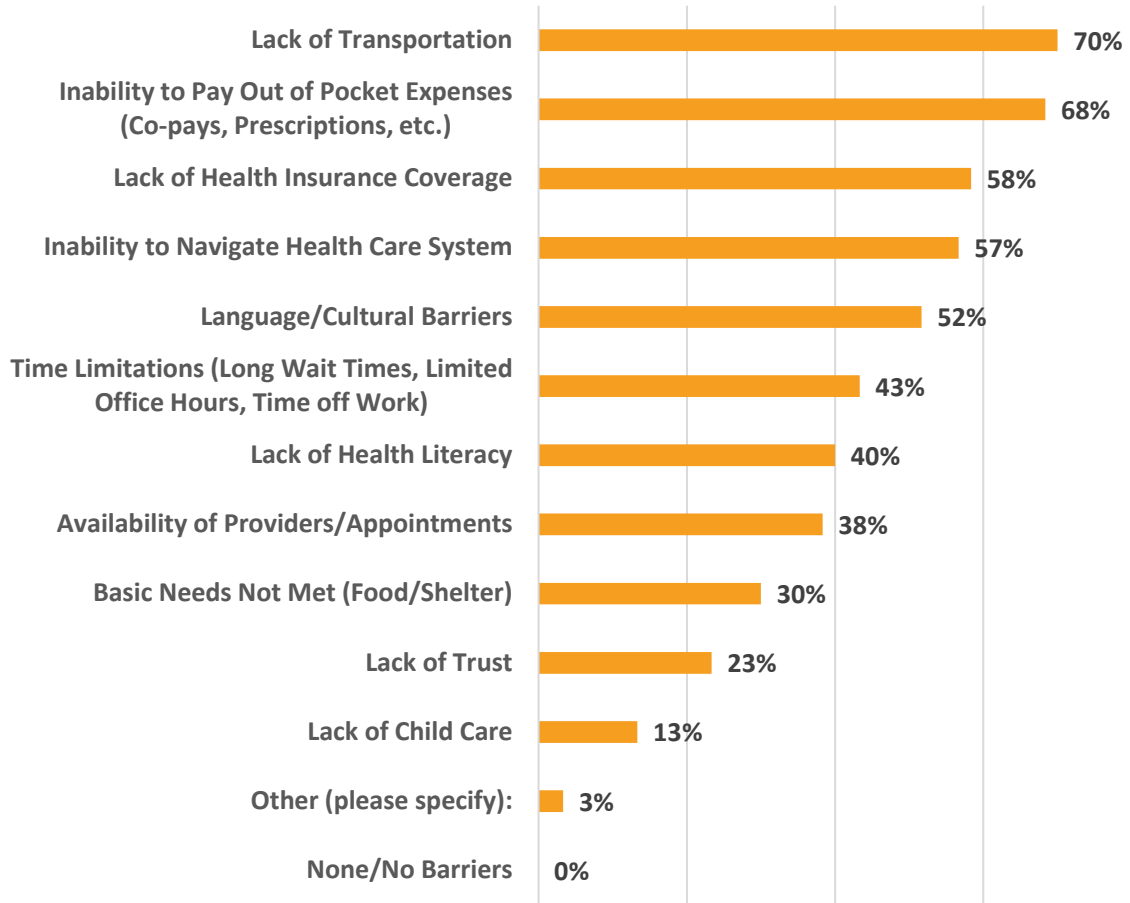
Respondents were asked about the ability of residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bi-lingual providers. Respondents were provided with statements such as: “Residents in the area are able to access 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.**



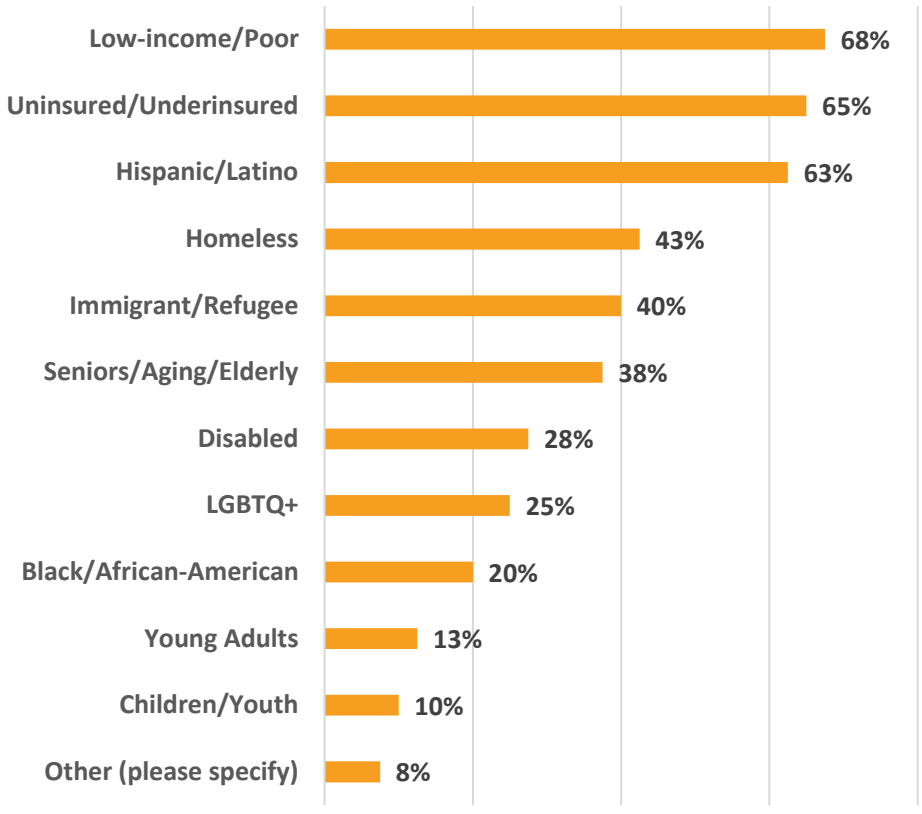
After rating availability of health care services, respondents were asked about the most significant barriers that keep people in their community from accessing healthcare when they need it. The barriers that were most frequently selected are summarized below.

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



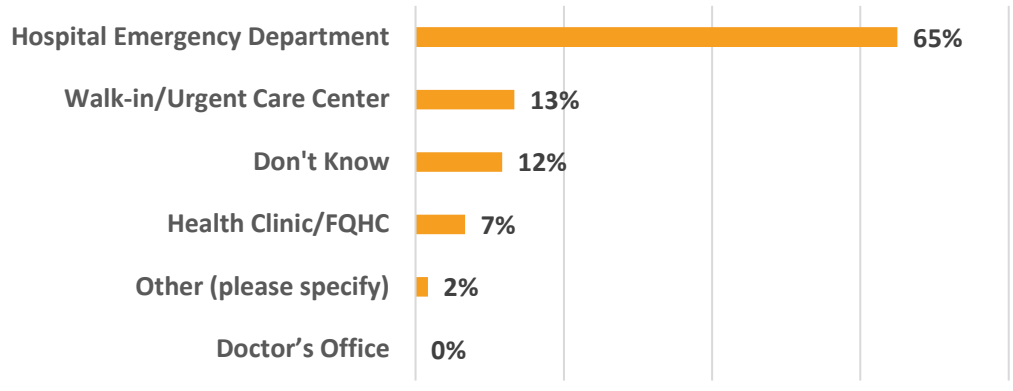
Respondents were asked if there were populations in the community that were not being adequately served by local health services. The top three population groups identified by key informants as being underserved when compared to the general population in this current survey were, low-income/poor, uninsured/underinsured, and Hispanic/Latino. These were followed by homeless, immigrant/refugee, and seniors/aging/elderly.

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



65% of key informants indicated hospital emergency departments as the primary place where uninsured/underinsured individuals go when they are in need of medical care, this was down from 73% in the previous survey. Walk-in/Urgent Care Center and Health Clinic/FQHC were also mentioned as preferred places to obtain medical care. No respondents selected the Doctor's Office as the primary place where uninsured/underinsured individuals go when in need of care.

**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)**



## AHS' APPROACH TO ADDRESSING COMMUNITY HEALTH IMPROVEMENT AND ACCESS TO CARE

Atlantic Health System approaches community health improvement with proven and effective methods for addressing access to care. Where necessary or appropriate, individual activities specific to distinct populations served by hospitals are documented. Particular efforts addressed from a system perspective for all AHS hospitals include diversity and inclusion, virtual care and community involvement, supportive funding for community partners or collaboratives that are focused on common areas of concern related to community health needs, and health and wellness for older adults and at-risk populations.

### *Virtual Platforms and Community Health*

The impact of Covid-19 on Atlantic Health System and the communities we serve has been profound. As our co-workers battle the pandemic daily, our focus on community health was challenged to create safe and effective opportunities for communities to connect about their ongoing health needs. Many of the most effective methods for maintaining contact with those in need were virtual; community groups, support groups for high-risk patients, caregiver outreach, diabetes, oncology, and cardiovascular all became reliant on virtual tools to maintain needed contact with our community. In many cases the effort to connect virtually during a time of crisis led to increased levels interaction and a broader reach for programs. This positive response to virtual offerings and interaction has become a common rallying point for AHS and its communities; this level of connection has become another successful tool that AHS will build upon as it seeks to broaden its reach to at-risk populations.

### *Care Coordination and Social Determinants of Health*

At Atlantic Health System, we focus on connecting clinical, behavioral, and social care across the health care continuum to produce great health outcomes, improve the patient experience, and lower the total cost of care. The care coordination department of nurses, social workers, community health workers, and behavioral health clinicians, ensure that each patient's clinical, behavioral, and social needs are met to manage safe transitions of care and support people with complex chronic conditions.

### *Diversity and Inclusion*

AHS strives for an inclusive health care environment where patients, visitors and team members are welcomed and afforded equitable treatment regardless of sexual orientation, gender, gender identity and expression, race, ethnicity, immigration status, socioeconomic background, disability and/or age.

### *Supporting Funding of Community Partners and Community Health Needs*

The Community Advisory Boards (CAB) at Morristown, Overlook, Chilton, Newton, and Hackettstown Medical Centers all provide annual funding opportunities for community partners in the form of grants likely to enhance resources available in the community and address elements of health priorities identified in the individual hospital's community health needs assessment. Grants are funded through a competitive review process, which includes a requirement that approved funding be linked to an identified community health need.

AHS provides additional support to community partners through the New Jersey Healthy Communities Network. The NJHCN supports local policy, systems, and environmental changes to enhance physical activity, nutrition, and address Social Determinants of Health. Through its hospital community health

advisory boards and foundations AHS provide funding and technical assistance for community organizations in the hospitals' service areas.

#### *Community Health Education and Wellness / New Vitality*

Community Health offers a wide variety of system-wide health and wellness programs to meet the needs of the community across the lifespan. New Vitality is AHS' unique health and wellness program tailored to meet the needs of today's older adults and other at-risk populations. These programs promote healthy lifestyles and reduces community's modifiable risk factors for chronic disease through expanded health education programming in alignment with AHS community health improvement plan. One of the program's goals is to offer system-wide programs on the following topics: cardiac, stroke, cancer, pulmonary, diabetes, behavioral health, and coronavirus.

#### *Other Collaborative Support*

In addition to actions within a specific strategy, Atlantic Health System is contributing a great deal of resources to support the CHNA/Implementation Strategy Process via in-kind support for the North Jersey Health Collaborative. Our resource and financial investments in the collaborative reflect our belief that bringing groups together, across sectors, is a significant community health intervention by itself. The Collaborative structure allows us to address our identified health needs, while also building capacity in individual local organizations, as well as our hospitals, to meet the needs of our community. It also serves to coordinate health and social service agencies in a way that enables them to invest collaboratively in best-practices.

Atlantic's contributions to the collaborative include:

- AHS staff provide technical assistance and evaluation support for NJHC on an as needed basis
- AHS service in NJHC workgroups and boards
- Participation by AHS staff in NJHC meetings on an as needed basis.
- Financial support for the North Jersey Health Collaborative, underwriting of [www.njhealthmatters.com](http://www.njhealthmatters.com), and underlying secondary data sources.

**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 other community stakeholders were asked to participate in a health issue prioritization survey. The prioritization survey included 17 health issues or concerns, which were identified during the primary and secondary analysis phases of the community health needs assessment. For each of the 17 health issues included in the survey, participants in this prioritization process were asked to respond to six statements related to the extent to which the health-related disparity or concern impacts the community served by Hackettstown Medical Center or can be positively impacted by community health improvement efforts directed by Hackettstown Medical Center. In completing their responses, prioritization survey participants were asked to provide their perspective based on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree) for six criteria for each of the 17 identified health issues.

The 17 issues identified for prioritization were:

- Heart Disease
- Obesity / Unhealthy Weight
- Diabetes
- Substance Misuse
- Cancer
- Access to Care for Underserved / Insurance Coverage
- Mental Health
- Health Education / Health Literacy
- Access to Providers
- Food Insecurity
- Barriers to Transportation Access
- Maternal and Child Health
- Domestic Violence
- Injuries / Poisonings
- Language Barriers
- Muscle and Bone Diseases
- Diseases of the Genitourinary System

The six 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
- Is within the organization’s capability/competency to impact over the next three years

Weighted averages for each impact on an issue were calculated. For each of the six 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 six impacts for that issue, the least impactful factor had the lowest weighted average for that issue. These results were presented to the Hackettstown Medical Center Community Health Committee, who, in partnership with hospital administration, recommended the adoption of the following priority areas for inclusion in the 2021-2023 CHNA for HMC.

- Heart Disease
- Diabetes and Overweight/Obesity
- Substance Misuse
- Mental Health
- Cancer

Following is a broad overview of each of the health priorities. HMC will develop a Community Health Improvement Plan (CHIP) to address these health priorities in 2022 and annually thereafter.

## IDENTIFIED HEALTH PRIORITIES

### Heart Disease<sup>9</sup>

In the area served by Hackettstown Medical Center, there are identified health concerns or disparities among the population that are related to heart disease.

Heart disease currently stands as the leading cause of death in the United States, with more than 600,000 Americans dying of heart disease and related conditions each year.<sup>10</sup> This amounts to one in every four deaths in the United States annually. Several health conditions, your lifestyle, and your age and family history can increase your risk for heart disease. About half of all Americans (47%) have at least one of the three key risk factors for heart disease: high blood pressure, high cholesterol, and smoking. Some of the risk factors for heart disease cannot be controlled, such as your age or family history. But you can take steps to lower your risk by changing the factors you can control.

The term “heart disease” refers to several types of heart conditions.

*Coronary artery disease (CAD)* is the most common type of heart disease in the United States. For some people, the first sign of CAD is a heart attack. CAD is caused by plaque buildup in the walls of the arteries that supply blood to the heart (called coronary arteries) and other parts of the body. Plaque is made up of deposits of cholesterol and other substances in the artery. Plaque buildup causes the inside of the arteries to narrow over time, which could partially or totally block the blood flow. This process is called atherosclerosis.

Too much plaque buildup and narrowed artery walls can make it harder for blood to flow through your body. When your heart muscle doesn’t get enough blood, you may have chest pain or discomfort, called angina. Angina is the most common symptom of CAD. Over time, CAD can weaken the heart muscle. This may lead to heart failure, a serious condition where the heart can’t pump blood the way that it should. An irregular heartbeat, or arrhythmia, also can develop. Being overweight, physical inactivity, unhealthy eating, and smoking tobacco are risk factors for CAD. A family history of heart disease also increases your risk for CAD.

*Heart Attack*, also called a myocardial infarction, occurs when a part of the heart muscle doesn’t receive enough blood flow. The more time that passes without treatment to restore blood flow, the greater the damage to the heart muscle. Learn more about the signs and symptoms of a heart attack.

Every year, about 790,000 Americans have a heart attack. Of these cases, 580,000 are a first heart attack and 210,000 happen to people who have already had a first heart attack. One of 5 heart attacks is silent—the damage is done, but the person is not aware of it. Coronary artery disease (CAD) is the main cause of heart attack. Less common causes are severe spasm, or sudden contraction, of a coronary artery that can stop blood flow to the heart muscle.

Other related conditions include:

- Acute coronary syndrome: a term that includes heart attack and unstable angina.

<sup>9</sup> <https://www.cdc.gov/heartdisease/about.htm>

<sup>10</sup> [www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60\\_03.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_03.pdf)

- Angina: a symptom of coronary artery disease, is chest pain or discomfort that occurs when the heart muscle is not getting enough blood. Angina may feel like pressure or a squeezing pain in the chest. The pain also may occur in the shoulders, arms, neck, jaw, or back. It may feel like indigestion.
- Stable angina: happens during physical activity or under mental or emotional stress.
- Unstable angina: chest pain that occurs even while at rest, without apparent reason. This type of angina is a medical emergency.
- Aortic aneurysm and dissection: conditions that can affect the aorta, the major artery that carries blood from the heart to the body. An aneurysm is an enlargement in the aorta that can rupture or burst. A dissection is a tear in the aorta. Both conditions are medical emergencies.
- Arrhythmias: irregular or unusually fast or slow heartbeats. Arrhythmias can be serious. One example is called ventricular fibrillation. This type of arrhythmia causes an abnormal heart rhythm that leads to death unless treated right away with an electrical shock to the heart (called defibrillation). Other arrhythmias are less severe but can develop into more serious conditions, such as atrial fibrillation, which can cause a stroke.
- Atherosclerosis: occurs when plaque builds up in the arteries that supply blood to the heart (called coronary arteries). Plaque is made up of cholesterol deposits. Plaque buildup causes arteries to narrow over time.
- Atrial fibrillation: a type of arrhythmia that can cause rapid, irregular beating of the heart's upper chambers. Blood may pool and clot inside the heart, increasing the risk for heart attack and stroke.
- Cardiomyopathy: occurs when the heart muscle becomes enlarged or stiff. This can lead to inadequate heart pumping (or weak heart pump) or other problems. Cardiomyopathy has many causes, including family history of the disease, prior heart attacks, uncontrolled high blood pressure, and viral or bacterial infections.
- Congenital heart defects: problems with the heart that are present at birth. They are the most common type of major birth defect. Examples include abnormal heart valves or holes in the heart's walls that divide the heart's chambers. Congenital heart defects range from minor to severe.
- Heart failure: often called congestive heart failure (CHF) because of fluid buildup in the lungs, liver, gastrointestinal tract, and the arms and legs. Heart failure is a serious condition that occurs when the heart can't pump enough blood to meet the body's needs. It does not mean that the heart has stopped but that muscle is too weak to pump enough blood. Most heart failure cases are chronic, or long-term heart failures. The only cure for heart failure is a heart transplant. However, heart failure can be managed with medications or medical procedures.
- Peripheral arterial disease (PAD): occurs when the arteries that supply blood to the arms and legs (the periphery) become narrow or stiff. PAD usually results from atherosclerosis, the buildup of plaque and narrowing of the arteries. With this condition, blood flow and oxygen to the arm and leg muscles are low or even fully blocked. Signs and symptoms include leg pain, numbness, and swelling in the ankles and feet.
- Rheumatic heart disease is damage to the heart valves caused by a bacterial (streptococcal) infection called rheumatic fever.

## Diabetes<sup>11</sup>

HMC is committed to its continued work with community partners to ensure that the many years of funding committed by HMC for projects that work to stem the spread of chronic diseases linked to diabetes and obesity continue to drive successful improvements in overall health of the community.

<sup>11</sup> <https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes>



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 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:
  - The possibility of substantial increases in prevalence of diabetes-related complications in part due to the rise in rates of obesity
  - The possibility that the increase in the number of persons with DM and the complexity of their care might overwhelm existing health care systems
  - 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
  - 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 most 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 considering 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.

## Obesity<sup>12</sup>

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 to 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.

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

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<sup>12</sup> <https://stateofobesity.org/wp-content/uploads/2018/09/stateofobesity2018.pdf>

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.

### Substance Misuse<sup>13</sup>

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 because 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

<sup>13</sup> <https://www.samhsa.gov/disorders/substance-use>

diverted for illegal use. The most 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 because 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.

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.

## **Mental Health**

### ***Need for Mental Health Providers<sup>14</sup>***

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,

<sup>14</sup> [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/ismicc\\_2017\\_report\\_to\\_congress.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf)

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 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 in five counties 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.

- 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.<sup>15</sup>

- 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?<sup>16</sup>

- HRSA has taken several 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 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?<sup>17</sup>

- 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.

<sup>15</sup> SAMHSA. (2017, September). ATTC: Network Coordinating Office. National Workforce Report 2017. From [http://attcnetwork.org/documents/ATTC\\_Network\\_Natl\\_Report2017\\_single.pdf](http://attcnetwork.org/documents/ATTC_Network_Natl_Report2017_single.pdf) (

<sup>16</sup> U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

<sup>17</sup> SAMHSA. Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018

- 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 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?<sup>18</sup>

- 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?<sup>19</sup>

- 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.<sup>20</sup>
- 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.

<sup>18</sup> U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

<sup>19</sup> Sherman, Laura, Lynch, Sean, et. al. Behavioral Health Workforce: Quality Assurance Practices in Substance Abuse Treatment Facilities. The CBHSQ Report. SAMHSA.

<sup>20</sup> SAMHSA. (n.d.). Serving the Needs of Diverse Populations.

- 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.<sup>21</sup>
- 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.<sup>22</sup>

## Cancer

In the area served by Hackettstown Medical Center, there are identified health concerns or disparities among the population that are related to cancer.

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in 5 years, yet cancer remains a leading cause of death in the United States, second only to heart disease.<sup>23</sup>

Many cancers are preventable by reducing risk factors such as:

- Use of tobacco products
- Physical inactivity and poor nutrition
- Obesity
- Ultraviolet light exposure

Other cancers can be prevented by getting vaccinated against human papillomavirus (HPV) and hepatitis B virus. In addition to prevention, screening is effective in identifying some types of cancers in early, often highly treatable stages including:

- Breast cancer (using mammography)
- Cervical cancer (using Pap test alone or combined Pap test and HPV test)
- Colorectal cancer (using stool-based testing, sigmoidoscopy, or colonoscopy)

For cancers with evidence-based screening tools, early detection must address the continuum of care from screening to appropriate follow-up of abnormal test results and referral to cancer treatment.<sup>24</sup>

<sup>21</sup> SAMHSA. (2013, January 24). Report to Congress on Nation's Substance Abuse and Mental Health Workforce Issues.

<sup>22</sup> U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

<sup>23</sup> <https://www.healthypeople.gov/2020/topics-objectives/topic/cancer>

<sup>24</sup> Zapka, J. G., et al. (2003). A framework for improving the quality of cancer care: the case of breast and cervical cancer screening. *Cancer Epidemiology and Prevention Biomarkers*, 12(1), 4-13.

However, while scientific advances and medical breakthroughs in cancer treatment options and their efficacy, the benefits of these health improvements have thus far been felt disproportionately by only a small, sub-section of the population. To explain this phenomenon, researchers have pointed to the complex and interrelated factors, which contribute to the risk of developing cancer, and to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups.<sup>25</sup>

The most obvious factors are a lack of health care coverage and low socioeconomic status (SES). SES is most often based on any number of factors including – but not limited to – a person’s income, education level, occupation, social status in the community, and geographic location (where the person lives). Studies have found that SES, more than race or ethnicity, predicts the likelihood of an individual’s or group’s access to things like:

- Education
- Health insurance and health care services
- Safe and healthy living and working conditions, including places free from exposure to environmental toxins

All of these are factors associated with the risk of developing and surviving cancer.

Additionally, SES also appears to play a major role in the prevalence of behavioral risk factors for cancer (like tobacco smoking, physical inactivity, obesity, and excessive alcohol use), as well as rates of cancer screenings, with those with lower SES having fewer cancer screenings.

In addition to – and in some cases, on top of – the socioeconomic, racial, and ethnic disparity trends which have long been prevalent in cancer prevalence and outcomes data, this past decade has seen new emerging trends and issues associated with cancer, largely due to the aging population, increases in cancer survivorship, and shifts in lifestyle habits.

Recently, overweight and obesity have emerged as new risk factors for developing certain cancers, including but not limited to colorectal, breast, uterine corpus (endometrial), pancreas, and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.<sup>26</sup>

Cancer survivors often face physical, emotional, social, and financial challenges because of their cancer diagnosis and treatment. Survivors are at risk of recurrence of their first cancer and are at greater risk of developing other cancers and other health conditions. Factors that increase these risks for survivors include:

- The immediate and long-term effects of cancer and its treatment
- Obesity and unhealthy behaviors, such as smoking and lack of physical activity
- Genetic changes

In the coming decade, as the number of cancer survivors is expected to increase by more than 30% to 18 million, understanding survivors’ health status and behaviors will become increasingly important.<sup>27</sup>

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<sup>25</sup> <https://www.healthypeople.gov/2020/topics-objectives/topic/cancer>

<sup>26</sup> <http://seer.cancer.gov>

<sup>27</sup> De Moor, J. S., et al. (2013). Cancer survivors in the United States: prevalence across the survivorship trajectory and implications for care. *Cancer Epidemiology and Prevention Biomarkers*, 22(4), 561-570.

**APPENDIX A: INSURANCE COVERAGE ESTIMATES**

**Health Insurance Coverage Estimates<sup>28</sup>**

INSURANCE COVERAGE ESTIMATES - HOUSEHOLDS						
ZIP Code		Commercial	Medicaid	Medicare	Uninsured	Total
07821	ANDOVER	5,700	1200	1847	401	9,148
07823	BELVIDERE	4,079	1095	2,025	375	7,574
07825	BLAIRSTOWN	5,359	1438	2,096	498	9,391
07828	BUDD LAKE	10,245	1534	2033	693	14,505
07836	FLANDERS	10,225	1515	2,113	695	14,548
07838	GREAT MEADOWS	2,108	558	679	200	3,545
07840	HACKETTSTOWN	18,925	5351	5895	1770	31,941
07853	LONG VALLEY	8,746	1290	2369	593	12,998
07863	OXFORD	2,600	706	925	242	4,473
07882	WASHINGTON	8,653	2387	2,727	811	14,578
<b>HMC SERVICE AREA</b>		<b>76,640</b>	<b>17,074</b>	<b>22,709</b>	<b>6,278</b>	<b>122,701</b>

INSURANCE COVERAGE ESTIMATES - HOUSEHOLDS						
ZIP Code		Commercial	Medicaid	Medicare	Other	Total
07828	BUDD LAKE	62.3%	13.1%	20.2%	4.4%	100%
07840	HACKETTSTOWN	53.9%	14.5%	26.7%	5.0%	100%
07882	WASHINGTON	57.1%	15.3%	22.3%	5.3%	100%
07821	ANDOVER	70.6%	10.6%	14.0%	4.8%	100%
07823	BELVIDERE	70.3%	10.4%	14.5%	4.8%	100%
07825	BLAIRSTOWN	59.5%	15.7%	19.2%	5.6%	100%
07836	FLANDERS	59.2%	16.8%	18.5%	5.5%	100%
07838	GREAT MEADOWS	67.3%	9.9%	18.2%	4.6%	100%
07853	LONG VALLEY	58.1%	15.8%	20.7%	5.4%	100%
07863	OXFORD	59.4%	16.4%	18.7%	5.6%	100%
<b>HMC SERVICE AREA</b>		<b>62.46%</b>	<b>13.92%</b>	<b>18.51%</b>	<b>5.12%</b>	<b>100%</b>

<sup>28</sup> Source: Sg2 Analytics

**APPENDIX B: 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
Annie E. Casey Foundation
CDC - PLACES
Centers for Disease Control and Prevention
Centers for Medicare & Medicaid Services
County Health Rankings
Emergency Department Data
Feeding America
Healthy Communities Institute
National Cancer Institute
National Center for Education Statistics
National Environmental Public Health Tracking Network
New Jersey Association of Child Care Resource and Referral Agencies
NJ State Health Assessment Data & US Census
State of New Jersey Department of Health
State of New Jersey Department of Human Services, Division of Mental Health and Addiction Services
State of New Jersey Department of State
U.S. Bureau of Labor Statistics
U.S. Census - County Business Patterns
U.S. Census Bureau - Small Area Health Insurance Estimates
U.S. Department of Agriculture - Food Environment Atlas
U.S. Environmental Protection Agency
United For ALICE

**APPENDIX C: HEALTH INDICATORS<sup>29</sup>**

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
<b>Alcohol &amp; Drug Use</b>	Adults who Binge Drink
	Adults who Drink Excessively
	Adults who Use Alcohol: Past 30 Days
	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
<b>Cancer</b>	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
	Cervical Cancer Screening: 21-65
	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
	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	
<b>Community</b>	Age-Adjusted Death Rate due to Motor Vehicle Collisions
	Alcohol-Impaired Driving Deaths
	Households with an Internet Subscription

<sup>29</sup> Data indicators accessed via Healthy Communities Institute. Community Dashboard/

Primary Topic	Indicator
	Households with One or More Types of Computing Devices
	Linguistic Isolation
	Mean Travel Time to Work
	People 65+ Living Alone
	Persons with an Internet Subscription
	Single-Parent Households
	Social Associations
	Solo Drivers with a Long Commute
	Substantiated Child Abuse Rate
	Violent Crime Rate
	Voter Turnout: Presidential Election
	Within County Disparity in Life Expectancy at Birth
	Workers Commuting by Public Transportation
	Workers who Drive Alone to Work
<b>County Health Rankings</b>	Clinical Care Ranking
	Health Behaviors Ranking
	Morbidity Ranking
	Mortality Ranking
	Physical Environment Ranking
	Social and Economic Factors Ranking
<b>Diabetes</b>	Adults 20+ with Diabetes
	Adults with Prediabetes
	Age-Adjusted Death Rate due to Diabetes
	Diabetes: Medicare Population
<b>Disabilities</b>	Persons with Disability Living in Poverty
	Persons with Disability Living in Poverty (5-year)
<b>Economy</b>	Child Food Insecurity Rate
	Children Living Below Poverty Level
	Cost of Family Child Care as a Percentage of Income
	Cost of Licensed Child Care as a Percentage of Income
	Families Living Below Poverty Level
	Female Population 16+ in Civilian Labor Force
	Food Insecure Children Likely Ineligible for Assistance
	Food Insecurity Rate
	Homeownership
	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold
	Households that are Asset Limited, Income Constrained, Employed (ALICE)
	Households that are Below the Federal Poverty Level
	Households with Cash Public Assistance Income
	Income Inequality



Primary Topic	Indicator
	Median Household Gross Rent
	Median Household Income
	Median Housing Unit Value
	Median Monthly Owner Costs for Households without a Mortgage
	Mortgaged Owners Median Monthly Household Costs
	Mortgaged Owners Spending 30% or More of Household Income on Housing
	Overcrowded Households
	People 65+ Living Below Poverty Level
	People Living 200% Above Poverty Level
	People Living Below Poverty Level
	Per Capita Income
	Population 16+ in Civilian Labor Force
	Projected Child Food Insecurity Rate
	Projected Food Insecurity Rate
	Renters Spending 30% or More of Household Income on Rent
	Severe Housing Problems
	Size of Labor Force
	Students Eligible for the Free Lunch Program
	Total Employment Change
	Unemployed Workers in Civilian Labor Force
	Young Children Living Below Poverty Level
<b>Education</b>	People 25+ with a bachelor’s degree or Higher
	People 25+ with a High School Degree or Higher
	Student-to-Teacher Ratio
<b>Environmental Health</b>	Access to Exercise Opportunities
	Blood Lead Levels in Children (>=5 micrograms per deciliter)
	Children with Low Access to a Grocery Store
	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
	Number of Extreme Heat Events
	Number of Extreme Precipitation Days
	PBT Released
	People 65+ with Low Access to a Grocery Store
	People with Low Access to a Grocery Store
	Recognized Carcinogens Released into Air
	Recreation and Fitness Facilities

Primary Topic	Indicator
	SNAP Certified Stores
	Weeks of Moderate Drought or Worse
	WIC Certified Stores
<b>Health</b>	Age-Adjusted Years of Potential Life Lost
<b>Health Care Access &amp; Quality</b>	Adults Unable to Afford to See a Doctor
	Adults who have had a Routine Checkup
	Adults with Health Insurance
	Adults without Health Insurance
	Children with Health Insurance
	Non-Physician Primary Care Provider Rate
	Persons with Health Insurance
	Primary Care Provider Rate
<b>Heart Disease &amp; Stroke</b>	Adults who Experienced a Heart Attack
	Adults who Experienced a Stroke
	Adults who Experienced Coronary Heart Disease
	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 Attack
	Age-Adjusted Death Rate due to Heart Disease
	Age-Adjusted Death Rate due to Hypertensive Heart Disease
	Age-Adjusted Hospitalization Rate due to Heart Attack
	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
<b>Immunizations &amp; Infectious Diseases</b>	Adults 50+ with Influenza Vaccination
	Adults with Pneumonia Vaccination
	Age-Adjusted Death Rate due to Influenza and Pneumonia
	Age-Adjusted Rate of ED Visits Due to Influenza
	COVID-19 Daily Average Case-Fatality Rate
	COVID-19 Daily Average Incidence Rate
	Kindergartners with Required Immunizations
	Lyme Disease Cases
	Persons Fully Vaccinated Against COVID-19

Primary Topic	Indicator
	Tuberculosis Incidence Rate
<b>Maternal, Fetal &amp; Infant Health</b>	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
<b>Mental Health &amp; Mental Disorders</b>	Adults Ever Diagnosed with Depression Age-Adjusted Death Rate due to Suicide Age-Adjusted Rate of Emergency Department Visits due to Mood Disorder Depression: Medicare Population Frequent Mental Distress Mental Health Provider Rate Poor Mental Health: 14+ Days Poor Mental Health: Average Number of Days
<b>Mortality Data</b>	Age-Adjusted Death Rate Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
<b>Older Adults</b>	Adults 65+ who Received Recommended Preventive Services: Females Adults 65+ who Received Recommended Preventive Services: Males Adults who were Injured in a Fall: 45+ Adults with Arthritis Age-Adjusted Death Rate due to Alzheimer's Disease Alzheimer's Disease or Dementia: Medicare Population
<b>Oral Health</b>	Adults 65+ with Total Tooth Loss Adults who Visited a Dentist Dentist Rate
<b>Other Conditions</b>	Adults with Kidney Disease Chronic Kidney Disease: Medicare Population Osteoporosis: Medicare Population Rheumatoid Arthritis or Osteoarthritis: Medicare Population
<b>Physical Activity</b>	Adults 20+ who are Sedentary Adults Engaging in Regular Physical Activity
<b>Prevention &amp; Safety</b>	Age-Adjusted Death Rate due to Unintentional Injuries Age-Adjusted Death Rate due to Unintentional Poisonings
<b>Respiratory Diseases</b>	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

Primary Topic	Indicator
	COPD: Medicare Population
<b>Sexually Transmitted Infections</b>	Chlamydia Cases
	Gonorrhea Cases
<b>Tobacco Use</b>	Adults who Currently Use Smokeless Tobacco
	Adults who Smoke
<b>Weight Status</b>	Adults 20+ who are Obese
<b>Wellness &amp; Lifestyle</b>	Frequent Physical Distress
	Insufficient Sleep
	Life Expectancy
	Poor Physical Health: 14+ Days
	Poor Physical Health: Average Number of Days
	Self-Reported General Health Assessment: Poor or Fair

**APPENDIX D: KEY INFORMANT / STAKEHOLDER SURVEY INSTRUMENT**

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 (CHNA) to re-evaluate the health needs of individuals living in the hospital service area. 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.

**. 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 selected, 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:**

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**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:**

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**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 11)

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

- |   |   |
|---|---|
| <input type="checkbox"/> Uninsured/Underinsured | <input type="checkbox"/> Children/Youth         |
| <input type="checkbox"/> Low-income/Poor        | <input type="checkbox"/> Young Adults           |
| <input type="checkbox"/> Hispanic/Latino        | <input type="checkbox"/> Seniors/Aging/Elderly  |
| <input type="checkbox"/> Black/African-American | <input type="checkbox"/> Homeless               |
| <input type="checkbox"/> Immigrant/Refugee      | <input type="checkbox"/> LGBTQ+                 |
| <input type="checkbox"/> Disabled               | <input type="checkbox"/> Other (please specify) |

**10. What are the top 5 health issues you see affecting the underserved population(s) you selected? (CHOOSE 5)**

- |   |  |
|---|--|
| <input type="checkbox"/> Access to Care/Uninsured | <input type="checkbox"/> Overweight/Obesity            |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Dental Health            | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Substance Abuse/Alcohol Abuse |
| <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Tobacco                       |
| <input type="checkbox"/> Maternal/Infant Health   | <input type="checkbox"/> Domestic Violence             |
| <input type="checkbox"/> Mental Health/Suicide    | <input type="checkbox"/> Other (specify):              |

**11. 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)**

- |  |   |
|--|---|
| <input type="checkbox"/> Doctor's Office               | <input type="checkbox"/> Walk-in/Urgent Care Center |
| <input type="checkbox"/> Health Clinic/FQHC            | <input type="checkbox"/> Don't Know                 |
| <input type="checkbox"/> Hospital Emergency Department | <input type="checkbox"/> Other (please specify)     |

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

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**13. 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 or Surgical Specialists
- Mental Health Services
- Substance Abuse Services
- Bilingual Services
- Transportation
- Prescription Assistance
- Health Education/Information/Outreach
- Health Screenings
- None
- Other (please specify):

**14. 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?**

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

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**16. What recommendations or suggestions do you have to improve health services that impact the health needs of the community?**

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**17. Name & Contact Information: (Note: Your name and email address are required to track survey participation. Your identity WILL NOT be associated with your responses.)**

- Name (Required) \_\_\_\_\_
- Organization \_\_\_\_\_
- Address \_\_\_\_\_
- Address 2 \_\_\_\_\_
- City/Town \_\_\_\_\_
- State/Province \_\_\_\_\_
- ZIP/Postal Code \_\_\_\_\_
- Email (Required) \_\_\_\_\_

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

- |  |   |
|--|---|
| <input type="checkbox"/> Health Care/Public Health Organization    | <input type="checkbox"/> Government/Housing/Transportation Sector |
| <input type="checkbox"/> Mental/Behavioral Health Organization     | <input type="checkbox"/> Business Sector                          |
| <input type="checkbox"/> Non-Profit/Social Services/Aging Services | <input type="checkbox"/> Community Member                         |
| <input type="checkbox"/> Faith-Based/Cultural Organization         | <input type="checkbox"/> Other (please specify)                   |
| <input type="checkbox"/> Education/Youth Services                  |   |

**19. Which of the following represents the community(s) your organization serves? (Select all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> White/Caucasian        | <input type="checkbox"/> Poor or Underserved    |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> LGBTQ+                 |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Hispanic/Latino        |
| <input type="checkbox"/> Seniors                | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Active Adults          |   |

**20. Hackettstown Medical Center 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:**

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**APPENDIX E: KEY INFORMANT SURVEY PARTICIPANTS**

Hackettstown Medical Center solicited input in the stakeholder survey process from a wide-ranging group of organizations serving the needs of residents who are served by the hospital and health system. Following are the organizations from which HMC solicited responses to a stakeholder survey.

Organizational Affiliation(s)	Organizational Affiliation(s)	Organizational Affiliation(s)
Abilities of Northwest Jersey	Hackettstown Stigma Free Task Force	Project Self-Sufficiency
AHS - HMC Leadership	Healing Partners Counseling	RE/MAX Heritage Properties
AHS Behavioral Health	Heath Village	Rutgers Cooperative Extension of Warren County
AHS Diabetes and Nutrition Center at NMC	Hispanic Resource Center	Sasco-Otterstedt Insurance Services
Allamuchy Owls	HMC Case Management	Smoking Cessation
Alzheimer's Association Greater NJ Chapter	HMC Emergency Department	SNAP-Ed
Alzheimer's New Jersey	HMC Foundation	Spiritual Care
American Cancer Society, Eastern Division	Home Instead of Warren & Hunterdon	St. James Episcopal
APG Eldercare Services	House of the Good Shepherd	Sussex County Division of Child Protection and Permanency
Atlantic Home Care & Hospice	John Johnson Automotive Group	The Arc of Warren County
Bridgeway Behavioral Health Services	Karen Ann Quinlan Hospice	Tobacco-Free for a Healthy NJ, The Center for Prevention and Counseling
Cancer Institute of New Jersey	Lavery, Selvaggi, Abromitis & Cohen	Town of Hackettstown
Cardiology and ICU	LocalShare	TransOptions
CASA SHaW	Mayor, Hope	Trinity United Methodist Church
Centenary University	Mt Olive Health Department	United Way of Northern New Jersey
Church of the Assumption	NAMI of Warren County	Visiting Homemaker Service of Warren County
Coalition for Healthy & Safe Communities	NewBridge	Warren Chronic Disease Coalition / NORWESCAP
Community Health & Care Coordination Social Services	Nisivoccia & Company	Warren County Community College
Community Prevention Resources of Warren County	NJ VA	Warren County Division of Aging and Disability Services
Contextual Family Services	NJ211	Warren County Division of Human Services
DASACC	NMC Emergency Department	Warren County Division of TA and SS
DAWN CIL	NMC Foundation	Warren County Habitat for Humanity
Duke's Landscape Management	NMC Medical Imaging/Radiology	Warren County Health Department
Family Guidance Center of Warren County	North Jersey Health Collaborative	Warren County Human Services
Family Intervention Services	North Warren Counseling Center	Warren County Library
Family Promise of Warren County	NORWESCAP	Warren County Prosecutor's Office
Family Support Organization of Hunterdon, Somerset & Warren	Outreach Connection	Warren County School
Garden State Equality	Panther Valley Ecumenical Church	Warren County School Nurses' Association
Gethsemane Lutheran Church	Parent to Parent Addiction Services	Warren County Sheriff's Office
Grace Church on the Mount	Pass It Along	Warren County Technical School
Hackettstown Business Improvement District	Patient Experience	Warren Hills Regional School District
Hackettstown Library	Peace by Piece	WRNJ Radio
Hackettstown Police Department	Pharmacy	Zufall Health
Hackettstown Public School District	Planned Parenthood of New Jersey	

**APPENDIX F: PRIORITIZATION PARTICIPANTS**

Hackettstown Medical Center solicited input in the prioritization phase of the CHNA process from a sub-set of organizations who participated in the stakeholder survey and serve the needs of residents served by the hospital and health system. Following are the organizations solicited for input in the prioritization survey.

Organization
AHS - HMC Leadership
AHS Behavioral Health
Centenary University
Community Health & Care Coordination Social Services
Duke's Landscape Management
HMC CH Committee / CAB
HMC Community Advisory Board
Mayor, Hope
NMC Emergency Department
NORWESCAP
RE/MAX Heritage Properties
SNAP-Ed
United Way of Northern New Jersey
Warren County Division of Human Services
WRNJ Radio
Zufall Health

**APPENDIX G: HMC SERVICE AREA & WARREN COUNTY LICENSED HEALTH FACILITIES<sup>30</sup>**

FACILITY TYPE	NAME	ADDRESS	CITY	STATE	ZIP
AMBULATORY CARE FACILITY	CENTER FOR HEALTHIER LIVING	108 BILBY ROAD # 101	HACKETTSTOWN	NJ	07840
	COORDINATED HEALTH-LAPATCONG TOWNSHIP	222 RED SCHOOL LANE	PHILLIPSBURG	NJ	08865
	COUNSELING AND ADDICTION CENTER	112 EAST AVENUE, UNIT 9	HACKETTSTOWN	NJ	07840
	HACKETTSTOWN DIAGNOSTIC ASSOCIATES	254 B MOUNTAIN AVENUE	HACKETTSTOWN	NJ	07840
	657 WILLOW GROVE STREET			NJ	07840
	OPEN 3T MRI OF NORTH JERSEY		HACKETTSTOWN		
	OPEN MRI OF PHILLIPSBURG	430 MEMORIAL PARKWAY	PHILLIPSBURG	NJ	08865
	PLANNED PARENTHOOD OF NORTHERN, CENTRAL AND SOUTHERN NEW JERSEY	66 EAST WASHINGTON AVENUE	WASHINGTON	NJ	07882
	RADIOLOGY ASSOCIATES OF HACKETTSTOWN			NJ	07840
	57 ROUTE 46, SUITE 212		HACKETTSTOWN		
AMBULATORY SURGICAL CENTER	ST LUKE'S HILLCREST OUTPATIENT	755 MEMORIAL PARKWAY	PHILLIPSBURG	NJ	08865
	ST LUKE'S CENTER FOR SLEEP MEDICINE	89 ROSEBERRY STREET	PHILLIPSBURG	NJ	08865
	ST LUKE'S OUTPATIENT CENTER	315 ROUTE 31 S	WASHINGTON	NJ	07882
	EMMAUS SURGICAL CENTER LLC	57 ROUTE 46, SUITE 104	HACKETTSTOWN	NJ	07840
ASSISTED LIVING RESIDENCE	PHILLIPSBURG AMBULATORY SURGERY CENTER	212 RED SCHOOL LANE	PHILLIPSBURG	NJ	08865
	BENTLEY COMMONS AT PARAGON VILLAGE	425/427 ROUTE 46 EAST	HACKETTSTOWN	NJ	07840
	798 WILLOW GROVE STREET			NJ	07840
COMPREHENSIVE PERSONAL CARE HOME	HOUSE OF THE GOOD SHEPHERD	1 BROOKFIELD COURT	BELVIDERE	NJ	07823
	THE CHELSEA AT BROOKFIELD				
END STAGE RENAL DIALYSIS	798 WILLOW GROVE STREET			NJ	07840
	HOUSE OF THE GOOD SHEPHERD PHILLIPSBURG	471 CENTER STREET	PHILLIPSBURG	NJ	08865
FEDERALLY QUALIFIED HEALTH CENTERS	PHYSICIANS DIALYSIS HACKETTSTOWN	657 WILLOW GROVE ST	HACKETTSTOWN	NJ	07840
	ZUFALL HEALTH CENTER INC	117 SEBER ROAD, BUILDING 5	HACKETTSTOWN	NJ	07840
GENERAL ACUTE CARE HOSPITAL	HACKETTSTOWN MEDICAL CENTER	651 WILLOW GROVE ST	HACKETTSTOWN	NJ	07840
	ST LUKE'S WARREN HOSPITAL	185 ROSEBERRY ST	PHILLIPSBURG	NJ	08865
HOSPICE CARE PROGRAM	COMPASSIONATE CARE HOSPICE OF NORTHERN NJ, LLC	500 INTERNATIONAL DRIVE, SUITE 333	BUDD LAKE	NJ	07828
	1 EDGEVIEW DRIVE, UNIT B3			NJ	07840
	ENNOBLE CARE HOSPICE, LLC		HACKETTSTOWN		
LONG TERM CARE FACILITY	BRAKELEY PARK CENTER	290 RED SCHOOL LANE	PHILLIPSBURG	NJ	08865
	CLOVER REST HOME	28 WASHINGTON STREET	COLUMBIA	NJ	07832
	FOREST MANOR HEALTH CARE CENTER	145 STATE PARK ROAD	HOPE	NJ	07844
	451 SCHOOLEY'S MOUNTAIN RD			NJ	07840
	HEATH VILLAGE		HACKETTSTOWN		
	798 WILLOW GROVE STREET			NJ	07840
	HOUSE OF THE GOOD SHEPHERD		HACKETTSTOWN		
	LIMECREST SUBACUTE AND REHABILITATION CENTER	1 O'BRIEN LANE	ANDOVER	NJ	07821
PHILLIPSBURG CENTER	LOPATCONG CENTER	390 RED SCHOOL LANE	PHILLIPSBURG	NJ	08865
	843 WILBUR AVENUE		PHILLIPSBURG	NJ	08865

<sup>30</sup> <https://nj.gov/health/healthfacilities/about-us/facility-types/>

FACILITY TYPE	NAME	ADDRESS	CITY	STATE	ZIP
	WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD	OXFORD	NJ	07863
	WOODLAND BEHAVIORAL AND NURSING CENTER	99 MULFORD ROAD	ANDOVER	NJ	07821
	SELAH CARE CENTER	131/133 FOURTH STREET	BELVIDERE	NJ	07823
RESIDENTIAL HEALTH CARE	BRAKELEY PARK CENTER	290 RED SCHOOL LANE	PHILLIPSBURG	NJ	08865
	HEATH VILLAGE	430 SCHOOLEY'S MOUNTAIN RD	HACKETTSTOWN	NJ	07840
SURGICAL PRACTICE	INTEGRAMED MEDICAL NEW JERSEY, L.L.C.	171 STATE ROUTE 173, SUITE 301	ASBURY	NJ	08802

PREPARED FOR  
HACKETTSTOWN MEDICAL CENTER  
BY  
ATLANTIC HEALTH SYSTEM  
PLANNING & SYSTEM DEVELOPMENT



Atlantic Health System  

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Hackettstown Medical Center