Chilton Medical Center
Community Health Needs Assessment

2019-2021

Atlantic Health System
Chilton Medical Center

ACKNOWLEDGEMENTS & CHNA COMPLIANCE

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

The 2019-2021 Chilton Medical Center Community Health Needs Assessment (CHNA) was approved by the medical center's Community Health Committee in December 2019. Questions regarding the Community Health Needs Assessment should be directed to:

Atlantic Health System
Chilton Medical Center
Planning & System Development
973-660-3522

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, Chilton Medical Center.

COMPLIANCE CHECKLIST: IRS FORM 990, SCHEDULE H	REPORT PAGE(S)
Part V Section B Line 1a A definition of the community served by the hospital facility	5
Part V Section B Line 1b Demographics of the community	7
Part V Section B Line 1c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	76
Part V Section B Line 1d How data was obtained	Addressed Throughout
Part V Section B Line 1f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 1g The process of identifying and prioritizing community health needs and services to meet the community health need	6
Part V Section B Line 1h The process for consulting with persons representing the community's interests	6
Part V Section B Line 1i Information gaps that limit the hospital facility's ability to assess the community's health needs	None Identified

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EXECUTIVE SUMMARY

Chilton Medical Center (CMC) 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 2019, CMC, 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 Morris and Passaic 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 CMC'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 CMC with a health-centric view of the population it serves, enabling CMC 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 process. 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 CMC's service area, but rather an overview that highlights statistics relevant to CMC's health priorities for the CHNA/CHIP planning and implementation period.

Key components of the CMC CHNA process include:

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

Chilton 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 and adopted as the key health priorities for CMC's 2019-2021 CHNA:

- Pulmonary Disease
- Heart Disease
- Diabetes
- Stroke
- Cancer
- Behavioral Health (including Substance Use as it pertains to Mental Health)

Based on feedback from community partners, health care providers, public health experts, health and human service agencies, and other community representatives, Chilton 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.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Organization Overview

Chilton Medical Center, part of Atlantic Health System, is a non-profit 260-licensed bed hospital in Pompton Plains, New Jersey and employs more than 1,300 people. Chilton Medical Center provides high quality care that is close to home for residents of northern New Jersey. The medical center has been recognized by Castle Connolly Medical, Ltd as a top mid-sized hospital in NJ for multiple consecutive years and has been awarded an "A" Hospital Safety Grade by The Leapfrog Group. Chilton has earned Primary Stroke Center certification from the New Jersey Department of Health and the Joint Commission, the nation's leading health care evaluation and accreditation organization, and also achieved the American Heart Association and American Stroke Association's Get With The Guidelines® Stroke Gold Plus Performance Achievement Award with Target: Stroke Honor Roll Elite.

CMC has received numerous other awards and designations, including:

- U.S. News & World Report High Performing Hospitals for COPD and Heart Failure
- Breast Imaging Center of Excellence, designated by the American College of Radiology
- Accreditation in Breast Ultrasound, Breast Magnetic Resonance Imaging, Stereotactic Breast Biopsy and Mammography
- The Commission on Cancer Certification for The Cancer Center
- Certificate of Accreditation from the American Association of Cardiovascular and Pulmonary Rehabilitation
- Accreditation from the American College of Radiology in Computer Tomography, Magnetic Resonance Imaging, Nuclear Medicine, Radiation Oncology and Ultrasound
- American Academy of Sleep Medicine Accreditation
- Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program for Bariatric Surgery
- Certification by the American Diabetes Association for Chilton's Diabetes Self-Management Education Program
- Highest Status achieved for Nurses Improving Care for Health system Elders program (NICHE)
- Undersea and Hyperbaric Medical Society Accreditation for Comprehensive Wound Healing Center
- Baby Friendly Designation: Baby-Friendly USA
- LGBTQ Healthcare Equality Leader

Atlantic Health System participates in and provides financial support to the North Jersey Health Collaborative (NJHC), 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. NJHC's function is a shared process of community needs assessment and health improvement planning to identify the most pressing health issues and facilitate the development of collaborative action plans to address them. By working together NJHC partners are strategically aligning their efforts and resources to achieve collective impact on the health of our communities and, accomplishing together what we could never do alone.

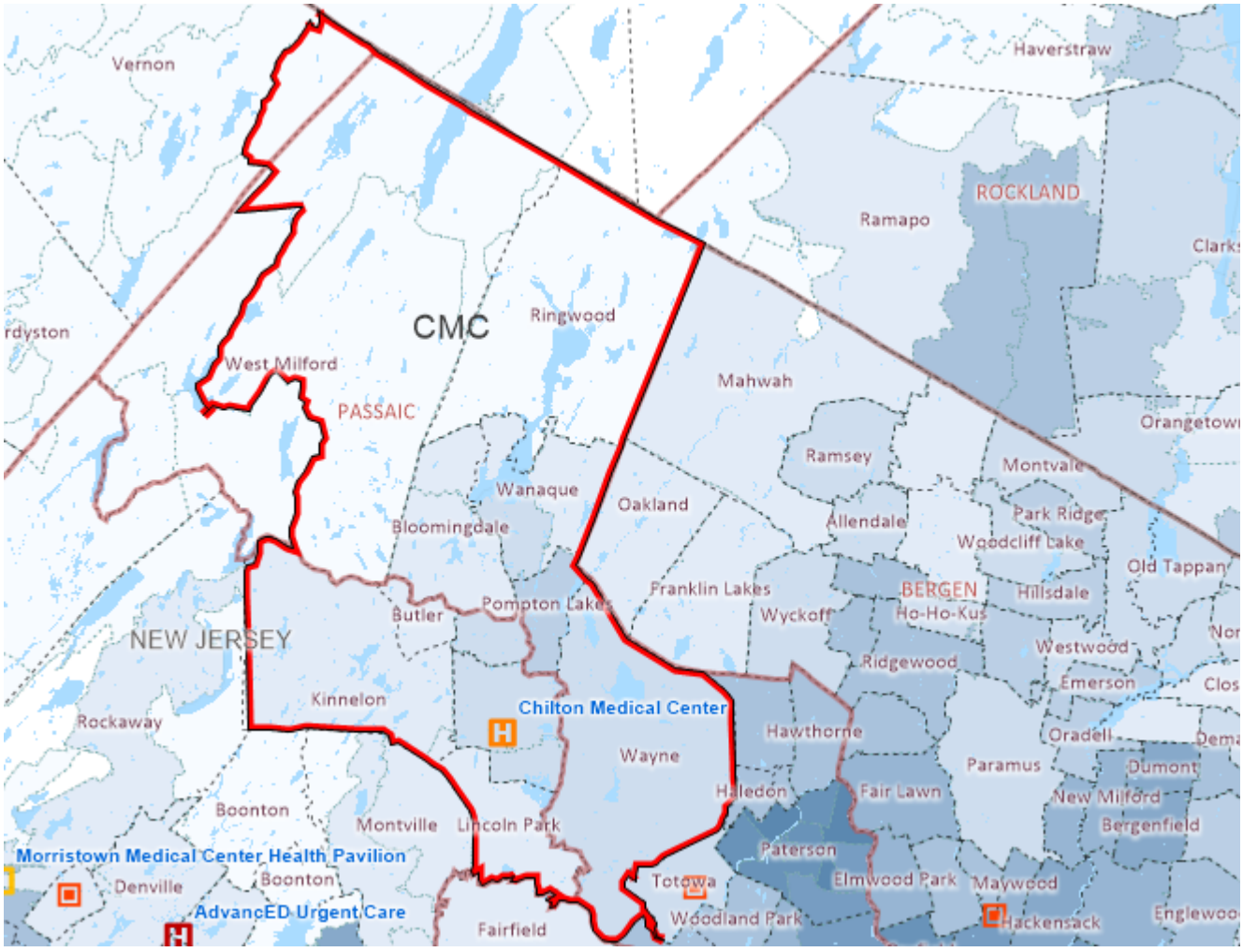
Atlantic Health System participates in the New Jersey Healthy Communities Network (NJHCN) and commits annual funding to their Community Grants Program, which brings together local, regional, and statewide funders, leaders and partners to support communities in implementing healthy eating and active living strategies to advance environment, policy and system changes. Since 2011, the NJHCN Community Grants Program has provided $3.2 million in grants. NJHCN Community Grants Program funding collaborative consists of Atlantic Health System, New Jersey Department of Health, New Jersey Health Initiatives, New Jersey Partnership for Healthy Kids, Partners for Health Foundation, and Salem Health & Wellness Foundation. Evaluation for the Community Grants Program is conducted by Center for Research and Evaluation on Education and Human Services (CREEHS) at Montclair State University.

Community Overview

CMC defines the area it serves as the geographic reach from which it receives 75% of its inpatient admissions. For CMC, this represents 13 ZIP Codes, encompassing portions of Morris and Passaic counties in New Jersey.[1] There is broad racial, ethnic, and socioeconomic diversity across the geographic area served by CMC, from populated urban settings to suburban rural areas of the state. Throughout the service area, CMC always works to identify the health needs of the community it serves. Following are the towns and cities served by CMC.

CMC STARK SERVICE AREA					
ZIP CODE	CITY	COUNTY	ZIP CODE	CITY	COUNTY
07035	LINCOLN PARK	MORRIS	07405	BUTLER	MORRIS
07440	PEQUANNOCK	MORRIS	07444	POMPTON PLAINS	MORRIS
07457	RIVERDALE	MORRIS	07403	BLOOMINGDALE	PASSAIC
07420	HASKELL	PASSAIC	07421	HEWITT	PASSAIC
07442	POMPTON LAKES	PASSAIC	07456	RINGWOOD	PASSAIC
07465	WANAQUE	PASSAIC	07470	WAYNE	PASSAIC
07480	WEST MILFORD	PASSAIC			

Geographic Area Served by Chilton Medical Center



[1] Source: NJDOH Discharge Data Collection System – UB-04 Inpatient Discharges

Methodology

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

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

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

Analytic Support

Atlantic Health System's corporate Planning & System Development staff provided CMC 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. CMC sought community input through key informant surveys of community leaders and partners and included community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge 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. CMC sought to mitigate these limitations by including in the assessment process a diverse cohort of representatives or and/or advocates for underserved populations in the service area.

Prioritization of Needs

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

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SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to evaluate a Secondary Data Profile compiled by the North Jersey Health Collaborative and Atlantic Health System's Planning & System Development department. This county and service area-based profile is comprised of multiple data sources. Secondary data is comprised of data obtained from existing resources (see Appendix 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 ZIP Code level inpatient and emergency room utilization data for the entire CMC service area and, when available AHS specific health care utilization data.

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

Demographic Overview[2]

Passaic County's projected growth is 1.6%, CMC's service area has a growth of 1.5%; due to a projected increase Wanaque, 5.01%, Riverdale, 6.83% and Haskell, 3.18%. At 2,764.88 residents per square mile, Passaic County is the 6th most densely populated county in New Jersey; the 21 counties range from a low of 183.02 population/sq. mile (Salem County) to a high of 14,864.40 population/sq. mile (Hudson County). CMC's service area is predominately White (Non-Hispanic). The New Jersey average for White (Non-Hispanic) is 53.9%, CMC's service area is 80.4%. Approximately 93% of the population, ages 5 years and older, speak English only or speak English "very well"; this is 5 percentage points higher than the New Jersey average.

For 2019, the median household income for the CMC service area was $95,000 which was $17,017 more than the state average (Butler was 155% greater than the state average). There were six towns over $100,000 (Butler, Pequannock, Hewitt, Ringwood, Wayne and West Milford) however, in 2024 there are projected ten towns over $100,000. Ringwood has been projected to increase 10.9% in the next five years, larger than the state average.

Approximately 3.0% of families living in CMC's service area are below the poverty line, compared to about 7.8% statewide. Currently, there are about 3.8% of people within CMC's service area receiving food stamps/SNAP benefits, which was lower than the state average (9.3%).

The New Jersey unemployment rate is 7.9%, CMC's service area was 6.4% and the Passaic County rate was 7.6%. Out of the towns in the service area, approximately 77% were below the state's unemployment rate.

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

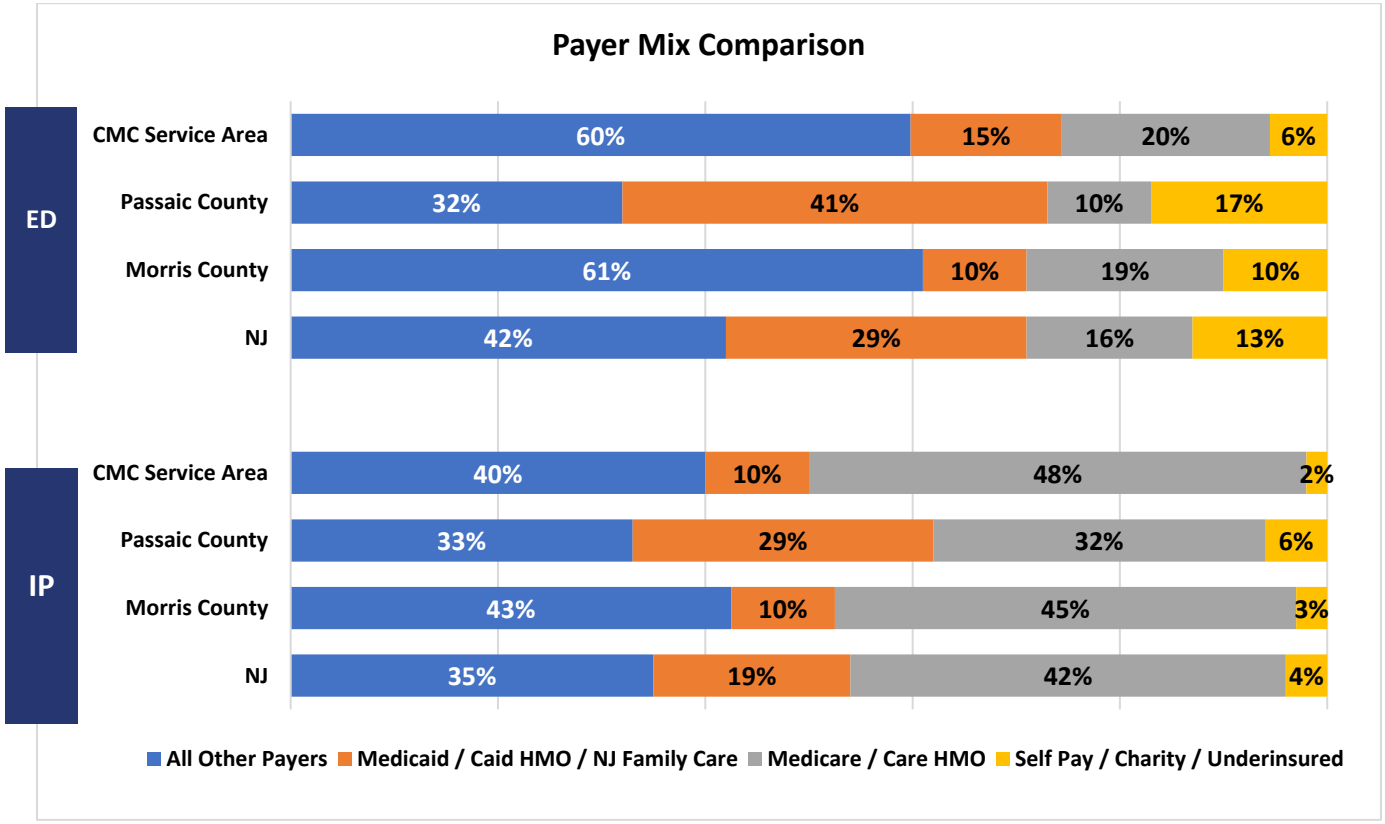
[2] Please see Appendix A for tables with demographic information; Source: New Solutions/Claritas 2019-2024 Demographic File

Health Insurance Coverage / Health Care Access and Payer Mix[3]

Approximately 10.7% of New Jersey's population is uninsured. In the area served by CMC's the figure is less than 7%. AT 15.1%, Passaic County is higher than the state average. Except for Bloomingdale, Haskell and Pompton Lakes, the percent of uninsured population in every town in CMC's service area was less than the state average.

Health insurance coverage can have a significant influence on health outcomes. Among ED visits, CMC's Service Area is approximately 15.0% Medicaid/Caid HMO/NJ Family Care with another 6.0% of Self Pay/Charity Care. The area is approximately 60.0% Commercial and 20.0% Medicare/Care HMO. From a payer mix perspective, the ED payer distribution in the Service Area is more like the distribution in Morris County than the state and Passaic County.

Among inpatients, CMC's Service Area is approximately 10% Medicaid/Medicaid HMO/NJ Family Care with another 2.0% of Self Pay/Charity Care. The area is approximately 40.0% Commercial and 49.0% Medicare/Care HMO. From a payer mix perspective, the inpatient payer distribution in the Service Area is more like the distribution in Morris County than the state and Passaic County.



[3] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates; NJ UB-04 Statewide Discharge Data Collection System

Health Status Indicators[4]

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

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

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Health	Access to Health Services	Non-Physician Primary Care Provider Rate	3	3	3	3			0	2.17	
		Adults Unable to Afford to See a Doctor	3		3	3			1	2.14	
		Adults with Health Insurance	3		2	2	3			2.08	Ages 26-34; Hispanic or Latino, Other
		Mental Health Provider Rate	2	1	3	3				2.00	
		Primary Care Provider Rate	2	1	3	3				2.00	
		Clinical Care Ranking	3							1.75	
		Children with Health Insurance	2		2	1	2			1.64	
		Dentist Rate	2	0	3	1			1	1.39	
		Preventable Hospital Stays: Medicare Population	2	1	2	2			0	1.33	
		Adults who have had a Routine Checkup	0		1				1	1.06	
Health	County Health Rankings	Clinical Care Ranking	3							1.75	
		Health Behaviors Ranking	2							1.58	
		Morbidity Ranking	2							1.58	
		Social and Economic Factors Ranking	2							1.58	
		Mortality Ranking	1							1.42	
		Physical Environment Ranking	1							1.42	
Health	Immunizations & Infectious Diseases	Tuberculosis Incidence Rate	2		2	3	3		1	1.97	
		Syphilis Cases							3	1.83	
		Adults 50+ with Influenza Vaccination	2		2					1.67	
		Chlamydia Cases							2	1.61	
		Lyme Disease Cases							2	1.61	
		Age-Adjusted Rate of ED Visits Due to Influenza	2							1.58	
		Adults with Pneumonia Vaccination	2		2				1	1.56	
		Age-Adjusted Death Rate due to Influenza and Pneumonia	2		2	0				1.42	
		Kindergartners with Required Immunizations	2		1				1	1.39	
		Self-Reported General Health Assessment: Poor or Fair	3	3	3	3				2.50	
		Poor Physical Health: Average Number of Days	2	1	2	2				1.67	
		Morbidity Ranking	2							1.58	
		Frequent Physical Distress	2	2	2	0				1.50	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Health	Wellness & Lifestyle	Insufficient Sleep	1	3	1	1					
		Limited Activity due to a Health Problem	1		2						
		Life Expectancy	1	0	1	1				1.00	
Health	Prevention & Safety	Severe Housing Problems	3	3	3	3			1	2.39	
		Age-Adjusted Death Rate due to Unintentional Poisonings	1		0	1			3	1.42	Males; White, non-Hispanic
		Adults who were Injured in a Fall: 45+	1		1					1.33	
		Death Rate due to Drug Poisoning	1	1	0	1			3	1.33	
		Age-Adjusted Death Rate due to Motor Vehicle Collisions	1		1				1	1.22	
		Age-Adjusted Death Rate due to Unintentional Injuries	1		0	0	0		2	0.86	Males
Health	Disabilities	Persons with Disability Living in Poverty (5-year)	2	1	3	1				1.67	
		Persons with Disability Living in Poverty	2	1	2	0			0	1.00	
Health	Heart Disease & Stroke	Hypertension: Medicare Population	3	3	2	3			2	2.44	
		Atrial Fibrillation: Medicare Population	0	3	1	3			3	2.00	
		Adults who Experienced a Stroke	2		3				2	1.94	
		Ischemic Heart Disease: Medicare Population	1	3	1	3			2	1.94	
		High Blood Pressure Prevalence	2		2	2	3			1.92	
		Age-Adjusted Death Rate due to Hypertensive Heart Disease	3		3				1	1.89	
		Hyperlipidemia: Medicare Population	1	3	1	3				1.83	
		Stroke: Medicare Population	1	3	1	3			1	1.72	
		Heart Failure: Medicare Population	2	2	2	3			0	1.67	
		Age-Adjusted Death Rate due to Heart Attack	3						1	1.64	
		Age-Adjusted Rate of Adult ED Visits for Acute Myocardial Infarction	1							1.42	
		Adults who Experienced a Heart Attack	1		1					1.33	
		Age-Adjusted Death Rate due to Heart Disease	1		2	2			0	1.25	Males; Black, non-Hispanic, White, non-Hispanic
		Adults who Experienced Coronary Heart Disease	1		0				1	1.06	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Age-Adjusted Hospitalization Rate due to Heart Attack	0		0				1	0.89	
		Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	0		1	0	0		1	0.64	
Health	Diabetes	Age-Adjusted Death Rate due to Diabetes	3		3	3			3	2.58	Black, non-Hispanic
		Diabetes: Medicare Population	2	3	2	3			2	2.28	
		Diabetic Monitoring: Medicare Population	2	2	2	2			0	1.50	
		Adults with Prediabetes	0		0					1.00	
		Adults 20+ with Diabetes	1	0	1				1	0.97	
Health	Exercise, Nutrition & Weight	Farmers Market Density	2	2						1.67	
		Recreation and Fitness Facilities	3	1						1.67	
		Adults 20+ who are Sedentary	2	2			0		2	1.61	
		Adults Engaging in Regular Physical Activity	3		3	0	0			1.58	
		Health Behaviors Ranking	2							1.58	
		Child Food Insecurity Rate	3	0	3	1			1	1.56	
		Fast Food Restaurant Density	0	2						1.33	
		People 65+ with Low Access to a Grocery Store	1	1						1.33	
		SNAP Certified Stores	0	1					2	1.28	
		Children with Low Access to a Grocery Store	0	1						1.17	
		People with Low Access to a Grocery Store	0	1						1.17	
		Adults 20+ who are Obese	1	0			0		2	1.11	
		Food Insecurity Rate	2	0	2	0			1	1.06	
		Grocery Store Density	0	0						1.00	
		Households with No Car and Low Access to a Grocery Store	0	0						1.00	
		Low-Income and Low Access to a Grocery Store	0	0						1.00	
		Food Environment Index	1	0	2	0			1	0.89	
		Access to Exercise Opportunities	1	0	1	0				0.83	
		Food Insecure Children Likely Ineligible for Assistance	0	0	0	1			2	0.78	
		Osteoporosis: Medicare Population	3	3	3	3			2	2.61	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Alzheimer's Disease or Dementia: Medicare Population	2	3	2	3			3	2.50	
		Hypertension: Medicare Population	3	3	2	3			2	2.44	
		People 65+ Living Below Poverty Level	3	2	3	3				2.33	Black or African American, Hispanic or Latino, Other, Two or More Races
		Diabetes: Medicare Population	2	3	2	3			2	2.28	
		Rheumatoid Arthritis or Osteoarthritis: Medicare Population	2	2	2	2			3	2.17	
		Mammography Screening: Medicare Population	3	2	2	2			2	2.11	
		Asthma: Medicare Population	2	3	2	3			1	2.06	
		Atrial Fibrillation: Medicare Population	0	3	1	3			3	2.00	
		Cancer: Medicare Population	1	3	1	3			2	1.94	
Health	Older Adults & Aging	Ischemic Heart Disease: Medicare Population	1	3	1	3			2	1.94	
		Chronic Kidney Disease: Medicare Population	1	2	1	2			3	1.83	
		Hyperlipidemia: Medicare Population	1	3	1	3				1.83	
		Stroke: Medicare Population	1	3	1	3			1	1.72	
		Adults 50+ with Influenza Vaccination	2		2					1.67	
		Heart Failure: Medicare Population	2	2	2	3			0	1.67	
		Diabetic Monitoring: Medicare Population	2	2	2	2			0	1.5	
		Age-Adjusted Death Rate due to Alzheimer's Disease	1		1	0			3	1.42	
		Adults who were Injured in a Fall: 45+	1		1					1.33	
		Adults with Arthritis	1		1					1.33	
		Depression: Medicare Population	1	1	1	0			3	1.33	
		People 65+ with Low Access to a Grocery Store	1	1						1.33	
		COPD: Medicare Population	1	1	1	0			2	1.11	
		People 65+ Living Alone	0	0	1	0			1	0.56	
Health	Oral Health	Dentist Rate	2	0	3	1			1	1.39	
		Oral Cavity and Pharynx Cancer Incidence Rate	1	0	1	0			2	0.94	Males
		Blood Lead Levels in Children (>=5 micrograms per deciliter)	3		3				2	2.11	
		Asthma: Medicare Population	2	3	2	3			1	2.06	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Health	Environmental & Occupational Health	Adults with Current Asthma	2		3	2				1.92	
		Lyme Disease Cases							2	1.61	
		Physical Environment Ranking	1							1.42	
		Colon Cancer Screening	3		3	3	3			2.42	
		Age-Adjusted Death Rate due to Breast Cancer	2	2	2	3	3			2.17	
		Mammography Screening: Medicare Population	3	2	2	2			2	2.11	
		Mammogram in Past 2 Years: 50-74	3		2	2	2			1.97	
		Cancer: Medicare Population	1	3	1	3			2	1.94	
		Liver and Bile Duct Cancer Incidence Rate	2	2	2	2			2	1.94	Males
		Prostate Cancer Incidence Rate	2	3	2	3			0	1.83	
		Cervical Cancer Incidence Rate	2	2	2	2	2		1	1.78	
		Pap Test in Past 3 Years: 21-65	2		2	2				1.75	
Health	Cancer	Age-Adjusted Death Rate due to Colorectal Cancer	1	1	2	2	2		1	1.44	
		Pancreatic Cancer Incidence Rate	0	2	1	2			2	1.44	
		Age-Adjusted Death Rate due to Prostate Cancer	2	1	2	2	0		1	1.39	Black
		Age-Adjusted Death Rate due to Pancreatic Cancer	1	1	1	2			1	1.22	
		Non-Hodgkin Lymphoma Incidence Rate	0	2	1	2			1	1.22	
		Breast Cancer Incidence Rate	0	1	0	1			2	0.94	
		Oral Cavity and Pharynx Cancer Incidence Rate	1	0	1	0			2	0.94	Males
		Colorectal Cancer Incidence Rate	0	1	1	2	2		0	0.89	
		All Cancer Incidence Rate	0	1	1	2			0	0.83	Males
		Age-Adjusted Death Rate due to Cancer	1	0	1	1	1		0	0.61	Males
		Melanoma Incidence Rate	0	0	0	0			2	0.61	
		Lung and Bronchus Cancer Incidence Rate	1	0	0	0			0	0.33	Males
		Age-Adjusted Death Rate due to Lung Cancer	0	0	0	0	0		0	0.00	Males
		Asthma: Medicare Population	2	3	2	3			1	2.06	
		Tuberculosis Incidence Rate	2		2	3	3		1	1.97	
		Adults with Current Asthma	2		3	2				1.92	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Adults 50+ with Influenza Vaccination	2		2					1.67	
		Adults with Pneumonia Vaccination	2		2				1	1.56	
		Age-Adjusted Death Rate due to Influenza and Pneumonia	2		2	0				1.42	
Health	Respiratory Diseases	Age-Adjusted Rate of Adult ED Visits for COPD	1							1.42	
		COPD: Medicare Population	1	1	1	0			2	1.11	
		Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	1		1	0			0	0.75	
		Lung and Bronchus Cancer Incidence Rate	1	0	0	0			0	0.33	Males
		Age-Adjusted Death Rate due to Lung Cancer	0	0	0	0	0		0	0.00	Males
		Osteoporosis: Medicare Population	3	3	3	3			2	2.61	
Health	Other Chronic Diseases	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	2	2	2	2			3	2.17	
		Chronic Kidney Disease: Medicare Population	1	2	1	2			3	1.83	
		Adults with Arthritis	1		1					1.33	
		Alcohol-Impaired Driving Deaths	3	3	3	3			2	2.61	
		Age-Adjusted Death Rate due to Diabetes	3		3	3			3	2.58	Black, non-Hispanic
		Age-Adjusted Death Rate due to Breast Cancer	2	2	2	3	3			2.17	
		Age-Adjusted Death Rate due to Hypertensive Heart Disease	3		3				1	1.89	
		Age-Adjusted Death Rate due to Heart Attack	3						1	1.64	
		Age-Adjusted Death Rate due to Colorectal Cancer	1	1	2	2	2		1	1.44	
		Age-Adjusted Death Rate due to Alzheimer's Disease	1		1	0			3	1.42	
		Age-Adjusted Death Rate due to Influenza and Pneumonia	2		2	0				1.42	
		Age-Adjusted Death Rate due to Unintentional Poisonings	1		0	1			3	1.42	Males; White, non-Hispanic
		Mortality Ranking	1							1.42	
Health	Mortality Data	Age-Adjusted Death Rate due to Prostate Cancer	2	1	2	2	0		1	1.39	Black
		Death Rate due to Drug Poisoning	1	1	0	1			3	1.33	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Age-Adjusted Death Rate due to Heart Disease	1		2	2			0	1.25	Males; Black, non-Hispanic, White, non-Hispanic
		Age-Adjusted Death Rate due to Motor Vehicle Collisions	1		1				1	1.22	
		Age-Adjusted Death Rate due to Pancreatic Cancer	1	1	1	2			1	1.22	
		Infant Mortality Rate	1		1	0	0		2	1.03	
		Age-Adjusted Death Rate	1		1				0	1	Males; Black, non-Hispanic, White, non-Hispanic
		Life Expectancy	1	0	1	1				1.00	
		Age-Adjusted Death Rate due to Unintentional Injuries	1		0	0	0		2	0.86	Males
		Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	1		1	0			0	0.75	
		Age-Adjusted Years of Potential Life Lost							2	1.61	
		Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	0		1	0	0		1	0.64	
		Age-Adjusted Death Rate due to Cancer	1	0	1	1	1		0	0.61	Males
		Age-Adjusted Death Rate due to Suicide	0		0	0	0		1	0.47	Males; White, non-Hispanic
		Age-Adjusted Death Rate due to Lung Cancer	0	0	0	0	0		0	0.00	Males
Health	Mental Health & Mental Disorders	Alzheimer's Disease or Dementia: Medicare Population	2	3	2	3			3	2.50	
		Mental Health Provider Rate	2	1	3	3				2.00	
		Frequent Mental Distress	3	1	2	0				1.50	
		Age-Adjusted Death Rate due to Alzheimer's Disease	1		1	0			3	1.42	
		Age-Adjusted Rate of Emergency Department Visits due to Mood Disorder	1							1.42	
		Adults Ever Diagnosed with Depression	1		2				1	1.39	
		Depression: Medicare Population	1	1	1	0			3	1.33	
		Poor Mental Health: Average Number of Days	1	1	2	1				1.33	
		Age-Adjusted Death Rate due to Suicide	0		0	0	0		1	0.47	Males; White, non-Hispanic
		Alcohol-Impaired Driving Deaths	3	3	3	3			2	2.61	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Liquor Store Density	3	3	3	3			2	2.61	
		Adults who Currently Use Smokeless Tobacco	3		3				2	2.11	
		Adults who Smoke	2	1	3	1	3			1.83	
		Opioid Treatment Admission Rate	1		2				3	1.83	
		Age-Adjusted Alcohol-Related Emergency Department Visit Rate	3							1.75	
Health	Substance Abuse	Age-Adjusted Rate of Substance Use Emergency Department Visits	3							1.75	
		Health Behaviors Ranking	2							1.58	
		Death Rate due to Drug Poisoning	1	1	0	1			3	1.33	
		Adults who Use Alcohol: Past 30 Days	1		1				1	1.22	
		Adults who Drink Excessively	0	1	1	1	0			0.83	
		Adults who Binge Drink	1		0	0	0		0	0.42	
		Mothers who Received Early Prenatal Care	2		2	2	2		2	1.92	Ages 15-17, 18-19, 20-24; Black, non-Hispanic, Hispanic
		Teen Birth Rate: 15-17	3		3	2			0	1.75	Hispanic
		Preterm Births	2		2	0	2			1.47	
		Babies with Low Birth Weight	1		1	1	2			1.31	Ages 15-17; Black, non-Hispanic
Health	Maternal, Fetal & Infant Health	Very Preterm Births	1		1		1		1	1.17	
		Infant Mortality Rate	1		1	0	0		2	1.03	
		Mothers who Received No Prenatal Care	1		0	0				0.92	
		Babies with Very Low Birth Weight	1		0	0	0		1	0.64	Ages 40-44
Health	Family Planning	Teen Birth Rate: 15-17	3		3	2			0	1.75	Hispanic
		Children Living Below Poverty Level	3	2	3	3			3	2.67	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other
		People Living Below Poverty Level	3	2	3	3			3	2.67	Ages 12-17, 6-11, <6; American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, Two or More Races
		Homeownership	3	3	3	3			2	2.61	
		Families Living Below Poverty Level	3	2	3	3			2	2.44	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, Two or More Races
		Students Eligible for the Free Lunch Program	3	2	3	3			2	2.44	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Economy		Young Children Living Below Poverty Level	3	2	3	3			2	2.44	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other
		Renters Spending 30% or More of Household Income on Rent	3	3	3	3			1	2.39	Ages 15-24, 65+
		Severe Housing Problems	3	3	3	3			1	2.39	
		People 65+ Living Below Poverty Level	3	2	3	3				2.33	Black or African American, Hispanic or Latino, Other, Two or More Races
		Cost of Licensed Child Care as a Percentage of Income	3		3					2.00	
		Households that are Below the Federal Poverty Level	3		3					2.00	
		People Living 200% Above Poverty Level	3	1	3	2			1	1.89	
		Unemployed Workers in Civilian Labor Force	2	2	3	2			1	1.89	
		Cost of Family Child Care as a Percentage of Income	2		3					1.83	
		Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	2		3					1.83	
		Households with Cash Public Assistance Income	2	2	3	3			0	1.83	
		Per Capita Income	3	0	3	2			1	1.72	Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, Two or More Races
		Households that are Asset Limited, Income Constrained, Employed (ALICE)	2		2					1.67	
		Income Inequality	2	3	1	1				1.67	
		Persons with Disability Living in Poverty (5-year)	2	1	3	1				1.67	
		Social and Economic Factors Ranking	2							1.58	
		Child Food Insecurity Rate	3	0	3	1			1	1.56	
		SNAP Certified Stores	0	1					2	1.28	
		Median Household Income	2	0	3	1			0	1.17	Black or African American, Hispanic or Latino, Other, Two or More Races
		Food Insecurity Rate	2	0	2	0			1	1.06	
		Low-Income and Low Access to a Grocery Store	0	0						1.00	
		Persons with Disability Living in Poverty	2	1	2	0			0	1.00	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Food Insecure Children Likely Ineligible for Assistance	0	0	0	1			2	0.78	
		Students Passing 4th Grade State Achievement Tests	3		3				2	2.11	
		Cost of Licensed Child Care as a Percentage of Income	3		3					2.00	
		Students Passing 8th Grade State Achievement Tests	3		3					2.00	
		People 25+ with a Bachelor's Degree or Higher	3	0	3	3			1	1.89	Ages 65+; Black or African American, Other, Two or More Races
Education		People 25+ with a High School Degree or Higher	3	2	2	2			1	1.89	Ages 65+; American Indian or Alaska Native
		Cost of Family Child Care as a Percentage of Income	2		3					1.83	
		Students Passing 11th Grade State Achievement Tests	3		2					1.83	
		Student-to-Teacher Ratio	3	0	2	0			2	1.44	
Gov't & Politics		Voter Turnout: Presidential Election	2		2				2	1.78	
		Alcohol-Impaired Driving Deaths	3	3	3	3			2	2.61	
		Violent Crime Rate	3		3	1			1	1.81	
Public Safety		Substantiated Child Abuse Rate	2		2	0			2	1.53	
		Age-Adjusted Death Rate due to Motor Vehicle Collisions	1		1				1	1.22	
		Liquor Store Density	3	3	3	3			2	2.61	
		Severe Housing Problems	3	3	3	3			1	2.39	
		Blood Lead Levels in Children (>=5 micrograms per deciliter)	3		3				2	2.11	
		Farmers Market Density	2	2						1.67	
		Recreation and Fitness Facilities	3	1						1.67	
		Annual Ozone Air Quality	1	2					2	1.61	
		Months of Mild Drought or Worse							2	1.61	
		Number of Extreme Precipitation Days							2	1.61	
		Weeks of Moderate Drought or Worse							2	1.61	
		Physical Environment Ranking	1							1.42	
		Number of Extreme Heat Days							1	1.39	
		Number of Extreme Heat Events							1	1.39	
		PBT Released							1	1.39	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Environment		Fast Food Restaurant Density	0	2						1.33	
		People 65+ with Low Access to a Grocery Store	1	1						1.33	
		SNAP Certified Stores	0	1					2	1.28	
		Children with Low Access to a Grocery Store	0	1						1.17	
		Daily Dose of UV Irradiance	0		1					1.17	
		People with Low Access to a Grocery Store	0	1						1.17	
		Annual Particle Pollution	0	0						1.00	
		Grocery Store Density	0	0						1.00	
		Households with No Car and Low Access to a Grocery Store	0	0						1.00	
		Low-Income and Low Access to a Grocery Store	0	0						1.00	
		Food Environment Index	1	0	2	0			1	0.89	
		Access to Exercise Opportunities	1	0	1	0				0.83	
		Children Living Below Poverty Level	3	2	3	3			3	2.67	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other
		People Living Below Poverty Level	3	2	3	3			3	2.67	Ages 12-17, 6-11, <6; American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, Two or More Races
		Homeownership	3	3	3	3			2	2.61	
		Single-Parent Households	2	3	3	3			2	2.44	
		Young Children Living Below Poverty Level	3	2	3	3			2	2.44	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other
		Linguistic Isolation	3	3	3	3			1	2.39	
		Social Associations	3	3	3	3			1	2.39	
		Cost of Licensed Child Care as a Percentage of Income	3		3					2.00	
		People 25+ with a Bachelor's Degree or Higher	3	0	3	3			1	1.89	Ages 65+; Black or African American, Other, Two or More Races
Social Environment		People 25+ with a High School Degree or Higher	3	2	2	2			1	1.89	Ages 65+; American Indian or Alaska Native
		Cost of Family Child Care as a Percentage of Income	2		3					1.83	
		Households with an Internet Subscription	3	1	2	2				1.83	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Households with One or More Types of Computing Devices	3	1	2	2				1.83	
		Voter Turnout: Presidential Election	2		2				2	1.78	
		Per Capita Income	3	0	3	2			1	1.72	Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, Two or More Races
		Mean Travel Time to Work	0	3	0	2			3	1.67	Males
		Social and Economic Factors Ranking	2							1.58	
		Substantiated Child Abuse Rate	2		2	0			2	1.53	
		Median Household Income	2	0	3	1			0	1.17	Black or African American, Hispanic or Latino, Other, Two or More Races
		People 65+ Living Alone	0	0	1	0			1	0.56	
		Mean Travel Time to Work	0	3	0	2			3	1.67	Males
		Solo Drivers with a Long Commute	1	2	0	2			3	1.67	
		Workers Commuting by Public Transportation	1	0	3	0	0		2	1.11	Ages 45-54, 55-59, 65+; White, non-Hispanic
Transportation		Households with No Car and Low Access to a Grocery Store	0	0						1.00	
		Workers who Drive Alone to Work	0	0	1	1				0.72	Ages 55-59, 60-64, 65+; White, non-Hispanic

Mortality Rates[5]

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

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 has been a 23.2 point decrease over 5 years and 40.6 point decrease over a decade. There have also been large decreases in the Cancer mortality rate over the 5 and 10 year periods. For unintentional injuries, there was a 15.5 point increase over the course of a decade. Stroke and Septicemia mortality saw small increases over 10 years at 0.5 and 2.2 points, respectively. Other notable areas of declining mortality rates include chronic lower respiratory disease (CLRD) and diabetes.

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	5 Year Change	10 Year Change
Diseases of heart	**198.7**	**182.1**	**193.8**	**177.2**	**181.3**	**167.1**	**170.4**	**164.2**	**155.2**	**158.1**	**(23.2)**	**(40.6)**
Cancer (malignant neoplasms)	**169.8**	**162.3**	**160.2**	**164.4**	**149.2**	**153.8**	**153.9**	**142.8**	**139.7**	**138.7**	**(10.5)**	**(31.1)**
Unintentional injuries	**22.4**	**21.7**	**25.7**	**27.2**	**32**	**32.4**	**29.2**	**27.9**	**36.2**	**37.9**	**5.9**	**15.5**
Stroke (cerebrovascular diseases)	**33.7**	**35.6**	**33.6**	**34.3**	**32.4**	**31.8**	**24.3**	**31**	**26.8**	**34.2**	**1.8**	**0.5**
Septicemia	**23.5**	**22.8**	**18.8**	**23**	**22**	**22.7**	**23.5**	**21.1**	**24.7**	**25.7**	**3.7**	**2.2**
Chronic lower respiratory diseases (CLRD)	30	25.7	26.9	33	33.4	29.5	31.8	26.8	25.4	24	(9.4)	(6.0)
Alzheimer's disease	16.8	13.5	17.8	15.1	16.6	13.6	18.3	17.7	16.7	21.7	5.1	4.9
Diabetes mellitus	28.7	23.1	23	21.1	23	21.3	21.4	23.6	24.6	19.7	(3.3)	(9.0)
Nephritis, nephrotic syndrome and nephrosis (kidney disease)	17.1	15.4	12.7	13.9	12.1	11.7	13.8	13	15.7	13.8	1.7	(3.3)
Influenza and pneumonia	15.9	15.7	12.1	12.4	13.4	12.7	13.5	13.2	9.8	12.5	(0.9)	(3.4)
Chronic liver disease and cirrhosis	10	9	8.5	6.9	6.9	8	10.4	8.9	7.1	9.1	2.2	(0.9)
Essential hypertension and hypertensive renal disease	5.6	5.7	8.7	8.8	8.7	8.2	6.7	6.9	8	7.5	(1.2)	1.9
Suicide (intentional self-harm)	7.3	8.6	6.8	5.5	5.7	7	6.5	5.1	4.3	7	1.3	(0.3)
Parkinson's disease	4.8	4.3	7.5	6.2	5.2	7.2	6.3	7.9	6.2	6.3	1.1	1.5
Homicide (assault)	**	4.7	4.3	4.6	5.5	4.5	5.4	4.1	**	5.6	0.1	N/A
Pneumonitis due to solids and liquids	**	**	**	**	4.1	**	4	6.3	5	4.7	0.6	N/A
In situ neoplasms, benign neopl. & neopl. of uncertain or unknown behavior	4.5	5.5	5.1	7.8	**	3.9	5.4	5.8	3.4	4	N/A	(0.5)
Other than 24 Major Causes	106.7	94.7	103.1	106.2	108.3	111.9	102.2	111.2	110.1	114.8	6.5	8.1
Viral hepatitis	**	**	**	**	**	**	**	**	**	**	N/A	N/A
Anemias	**	**	**	**	**	**	**	**	**	**	N/A	N/A
Atherosclerosis	**	**	**	**	**	**	**	**	**	**	N/A	N/A
Aortic aneurysm and dissection	**	**	**	**	**	**	**	**	**	**	N/A	N/A
Congenital malformations, deformations and chromosomal abnormalities	**	**	**	**	**	**	**	**	**	**	N/A	N/A
HIV (human immunodeficiency virus) disease	7.2	7.3	3.9	5.6	4	4.6	**	4.3	**	**	N/A	N/A
Certain conditions originating in the perinatal period	**	**	4.4	4	**	**	**	4	4	**	N/A	N/A

Source: Center for Health Statistics, New Jersey Department of Health

***The value has been suppressed 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.*

SocioNeeds Index[6]

Community health improvement efforts must determine what sub populations are most in need in order to most effectively focus services and interventions. Social and economic factors are well known to be strong determinants of health outcomes – those with a low socioeconomic status are more likely to suffer from chronic conditions such as diabetes, obesity, and cancer. The 2019 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.

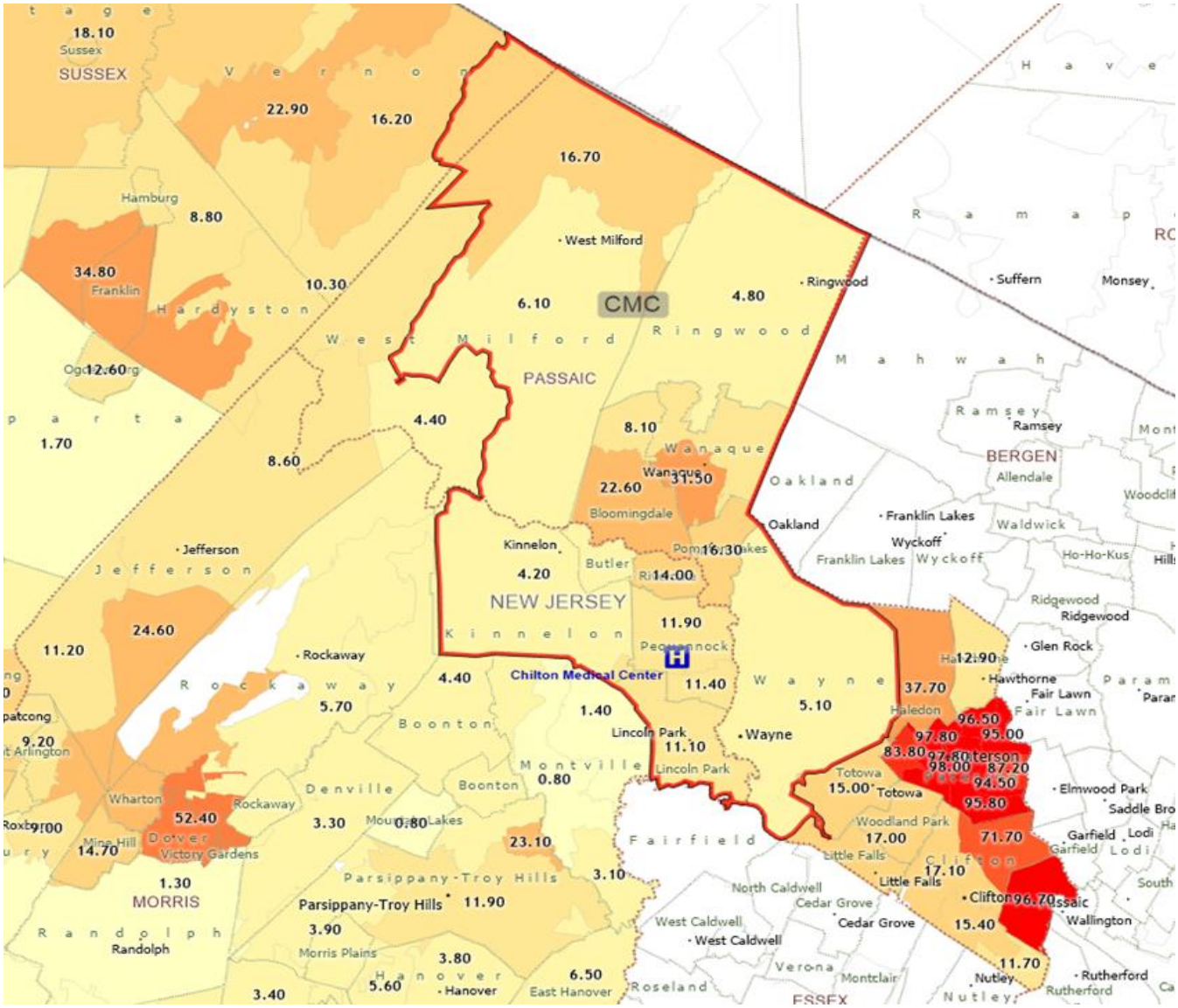
[5] Source: State of New Jersey Department of Health: Measurement period: 2007-2016

[6] Healthy Communities Institute 2018. SocioNeeds Index.
http://www.njhealthmatters.org/index.php?module=indicators&controller=index&action=socioneeds

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 compared 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 2019.

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.



Ambulatory Care Sensitive Conditions (ACS): ED & IP[7]

ACS conditions are illnesses that can often be managed effectively on an outpatient basis and generally do not result in hospitalization if managed properly. 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 and urgent care expansion which may ultimately lead to a lower chronic disease rate in a community.

Below are ACS condition discharges that occurred in the area served by CMC. The greatest overall ACS volume is for ENT related issues among the ED population, followed by kidney and urinary tract infections, cellulitis, GI obstruction and asthma. Among inpatients the greatest number of ACS conditions are for chronic obstructive pulmonary disorder, congestive heart failure, kidney and urinary tract infection, bacterial pneumonia and dehydration. Addressing these areas of utilization (i.e. providing care in a lower cost setting when possible) may help to decrease the cost of care provided to these patients and potentially create a stronger patient/primary care provider relationship.

CHILTON MC SERVICE AREA: AMB CARE SENSITIVE CONDITIONS				
ACS Condition Cohort (Cell values <10 Masked)	NJE17: ED		NJS17: IP	
ENT	1,548	25.2%	**	**
Kidney/Urinary Infection	931	15.2%	295	13.3%
Cellulitis	530	8.6%	209	9.4%
COPD	315	5.1%	387	17.4%
Dehydration	438	7.1%	244	11.0%
Bacterial Pneumonia	295	4.8%	275	12.4%
Asthma	445	7.2%	74	3.3%
Gastrointestinal Obstruction	473	7.7%	42	1.9%
Congestive Heart Failure	75	1.2%	302	13.6%
Dental Conditions	342	5.6%	**	**
Diabetes	167	2.7%	152	6.8%
Hypertension	302	4.9%	11	0.5%
Grand Mal Status/other Epileptic Convulsion	142	2.3%	121	5.4%
Convulsion	100	1.6%	45	2.0%
Angina	22	0.4%	15	0.7%
Nutrition Deficiencies	**	**	32	1.4%
Hypoglycemia	**	**	**	**
Pelvic Inflammatory Disease	**	**	**	**
Immunization Related Preventable	**	**	**	**
Other Tuberculosis	**	**	**	**
Pulmonary Tuberculosis	**	**	**	**
Grand Total	**6,140**	**100.0%**	**2,226**	**100.0%**
ACSCs at % of Total ED or Inpatient CMC Service Area	**13.9%**		**13.4%**	

[7] 2017 Data – Most Current Available at time of analysis

Localized Data: Disease Utilization Rate[8]

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

Heart Attack

The rate/1,000 population decreased over the period in the CMC 75% Service Area. The highest rate among comparative geographies is in Pompton Plains. The rate/1,000 population in Pompton Plains is in the 90th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	1.53	1.49	1.45	1.42	1.79	1.48	(0.1)	70%	50%
NORTHERN REGION	1.15	1.07	1.04	1.07	1.28	1.24	0.1	40%	40%
AHS REGION	1.08	1.03	1.00	1.06	1.19	1.17	0.1	40%	40%
Pompton Plains	2.52	3.57	2.57	2.20	3.40	3.37	0.9	90%	90%
Paterson	0.91	0.83	0.82	1.00	1.10	1.18	0.3	30%	40%
Passaic County	1.02	0.99	0.92	0.97	1.03	1.03	0.0	30%	30%
NEW JERSEY	1.30	1.26	1.27	1.36	1.49	1.46	0.2	50%	50%

Heart Failure

The rate/1,000 population has decreased over the period in Pompton Plains. The highest rate among comparative geographies is in Pompton Plains. The rate/1,000 population in Pompton Plains is in the 80th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	3.00	3.10	3.74	3.87	3.45	3.45	0.4	60%	50%
NORTHERN REGION	3.43	3.43	3.49	3.60	3.73	3.83	0.4	60%	60%
AHS REGION	2.95	2.93	2.92	3.05	3.07	3.20	0.2	50%	40%
Pompton Plains	7.01	6.96	6.64	6.67	4.62	5.79	(1.2)	80%	80%
Paterson	4.14	4.15	3.68	4.22	3.92	4.19	0.0	70%	70%
Passaic County	2.88	2.92	3.10	3.02	3.34	3.33	0.5	50%	50%
NEW JERSEY	3.33	3.26	3.30	3.40	3.45	3.66	0.3	60%	60%

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

Hypertension

The rate/1,000 population has increased over the period across all comparative areas. The highest rate among comparative geographies is in Pompton Plains. The rate/1,000 population in Pompton Plains is in the 90th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	106.71	106.56	114.15	118.88	123.39	129.75	23.0	50%	50%
NORTHERN REGION	125.08	122.55	122.68	130.08	134.05	134.01	8.9	60%	60%
AHS REGION	104.14	104.35	105.14	109.35	113.27	114.46	10.3	50%	40%
Pompton Plains	166.81	174.43	190.07	183.78	193.71	209.03	42.2	90%	90%
Paterson	142.92	137.47	126.88	130.58	142.07	146.51	3.6	70%	70%
Passaic County	101.94	100.75	104.40	110.16	108.10	106.80	4.9	40%	30%
NEW JERSEY	112.08	111.11	112.34	118.03	126.14	130.76	18.7	60%	50%

Stroke/TIA

The rate/1,000 population has increased over the period in the CMC 75% Service Area and in Pompton Plains. The highest rate among comparative geographies is in Pompton Plains. The rate/1,000 population in Pompton Plains is in the 90th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	3.05	3.02	3.16	3.18	3.45	3.21	0.2	70%	60%
NORTHERN REGION	2.55	2.60	2.76	2.64	2.73	2.53	(0.0)	50%	40%
AHS REGION	2.48	2.46	2.50	2.47	2.59	2.47	(0.0)	40%	40%
Pompton Plains	5.48	6.78	7.08	6.59	5.40	5.88	0.4	90%	90%
Paterson	3.59	3.04	2.82	3.06	3.11	3.32	(0.3)	60%	70%
Passaic County	2.40	2.52	2.72	2.53	2.54	2.38	(0.0)	40%	40%
NEW JERSEY	2.95	2.90	2.95	2.88	2.92	2.77	(0.2)	50%	50%

Diabetes

The rate/1,000 population has increased over the period across all comparative areas. The highest rate among comparative geographies is in Paterson. The rate/1,000 population in Pompton Plains is in the 80th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	39.31	39.43	42.15	44.86	44.87	48.73	9.4	40%	50%
NORTHERN REGION	56.49	56.38	56.95	60.61	62.61	63.33	6.8	70%	70%
AHS REGION	44.81	45.32	46.03	47.83	49.70	50.65	5.8	50%	50%

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
Pompton Plains	47.99	48.60	53.98	53.48	52.46	58.89	10.9	60%	60%
Paterson	72.98	71.12	68.57	71.08	76.58	78.87	5.9	80%	80%
Passaic County	45.33	45.02	46.82	49.73	48.83	48.64	3.3	50%	50%
NEW JERSEY	48.90	49.00	49.75	52.07	55.38	57.67	8.8	60%	60%

Obesity

The rate/1,000 population has increased over the period across all comparative areas. The highest rate among comparative geographies is in Paterson. The rate/1,000 population in Paterson is in the 60th percentile.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	8.22	9.28	10.75	10.69	12.91	15.93	7.7	40%	40%
NORTHERN REGION	13.92	14.16	14.98	16.01	16.74	18.98	5.1	60%	50%
AHS REGION	10.86	11.33	12.01	13.17	13.98	16.83	6.0	40%	40%
Pompton Plains	6.20	8.20	10.09	8.43	11.24	15.57	9.4	20%	40%
Paterson	13.66	12.83	13.63	15.49	18.08	21.05	7.4	60%	60%
Passaic County	10.13	10.88	12.23	13.51	13.61	15.89	5.8	40%	40%
NEW JERSEY	12.52	13.04	13.78	14.84	15.89	19.27	6.8	50%	50%

COPD & Allied Health Conditions

The rate/1,000 population has increased over the period across all comparative regions. The highest rate among comparative geographies is in Pompton Plains. The rate/1,000 population in Pompton Plains is in the 80th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	20.26	20.17	21.97	23.15	23.75	22.95	2.7	60%	60%
NORTHERN REGION	16.64	16.53	16.27	17.42	20.22	18.83	2.2	50%	40%
AHS REGION	15.43	15.22	15.06	15.96	17.86	16.86	1.4	40%	40%
Pompton Plains	31.28	34.24	34.42	33.72	36.42	39.44	8.2	80%	80%
Paterson	13.08	13.04	12.27	13.51	18.80	17.06	4.0	40%	40%
Passaic County	13.55	13.28	13.60	14.23	14.92	13.80	0.3	30%	20%
NEW JERSEY	19.65	19.37	19.14	20.17	22.78	22.02	2.4	60%	50%

Asthma

The rate/1,000 population increased at the statewide level. There were decreases in all other comparative geographies. The highest rate among comparative geographies is in Paterson. The rate/1,000 population in Paterson is in the 80th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	26.03	25.05	24.93	25.00	23.66	23.86	(2.2)	40%	50%
NORTHERN REGION	50.66	47.63	46.72	49.96	51.60	49.82	(0.8)	80%	80%
AHS REGION	32.67	30.98	31.39	32.96	33.18	31.52	(1.2)	70%	60%
Pompton Plains	26.87	25.15	23.80	24.32	24.23	26.72	(0.1)	50%	60%
Paterson	66.55	63.07	57.46	58.03	56.67	55.94	(10.6)	80%	80%
Passaic County	30.99	28.51	30.07	32.10	31.50	27.85	(3.1)	60%	60%
NEW JERSEY	33.93	32.47	32.87	34.61	35.94	34.82	0.9	70%	70%

Pneumonia

The rate/1,000 population has increased in the Northern Region, the AHS Region, and in Paterson. The highest rate among comparative geographies is in Paterson, which has a rate at the 90th percentile. The rate/1,000 population in Pompton Plains is in the 80th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	5.86	5.94	6.29	5.66	6.16	5.86	(0.0)	60%	60%
NORTHERN REGION	5.01	4.78	4.24	4.45	5.42	5.83	0.8	50%	60%
AHS REGION	4.88	4.48	4.11	4.22	4.93	5.00	0.1	40%	50%
Pompton Plains	9.53	8.65	9.38	8.43	9.15	8.56	(1.0)	80%	80%
Paterson	5.89	5.25	5.37	6.04	7.55	9.34	3.4	80%	90%
Passaic County	5.38	4.67	4.23	4.46	5.17	5.23	(0.1)	40%	50%
NEW JERSEY	5.81	5.41	4.98	5.08	5.85	5.65	(0.2)	60%	60%

Cellulitis

The rate/1,000 population increased over the period in Paterson. The highest rate among comparative geographies is in Paterson. The rate/1,000 population in Paterson is in the 90th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	7.03	7.10	6.64	7.16	6.54	6.43	(0.6)	40%	40%
NORTHERN REGION	10.21	10.07	9.86	9.52	9.09	8.76	(1.5)	60%	60%
AHS REGION	7.98	7.86	7.65	7.52	7.19	6.91	(1.1)	50%	50%

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
Pompton Plains	8.36	9.10	7.88	8.78	6.54	6.31	(2.0)	40%	40%
Paterson	15.61	16.19	16.53	16.18	16.93	17.82	2.2	90%	90%
Passaic County	8.26	8.20	8.12	7.77	7.42	7.27	(1.0)	50%	50%
NEW JERSEY	10.42	10.03	9.75	9.44	8.86	8.53	(1.9)	60%	60%

Renal Failure

The rate/1,000 population has increased over the period across all comparative regions. The highest rate among comparative geographies is in Pompton Plains. The rate/1,000 population in Pompton Plains is in the 90th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	1.59	1.56	1.95	2.30	2.57	2.72	1.1	60%	70%
NORTHERN REGION	2.22	2.17	2.06	2.33	2.61	2.60	0.4	60%	60%
AHS REGION	1.76	1.76	1.79	1.96	2.15	2.10	0.3	50%	50%
Pompton Plains	1.89	1.69	3.63	3.07	4.27	4.32	2.4	80%	90%
Paterson	2.24	2.43	2.70	2.83	3.21	3.01	0.8	70%	70%
Passaic County	1.77	1.77	1.63	1.90	2.14	2.11	0.3	50%	50%
NEW JERSEY	2.09	2.08	2.11	2.30	2.53	2.42	0.3	60%	60%

Mental Health (Acute Care Setting)

The rate/1,000 population has increased over the period across all comparative regions. The highest rate among comparative geographies is in Paterson. The rate/1,000 population in Paterson is in the 90th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	11.68	11.39	12.60	12.64	12.41	13.39	1.7	40%	50%
NORTHERN REGION	16.13	16.81	16.61	17.16	17.60	17.33	1.2	70%	60%
AHS REGION	13.35	13.47	13.53	13.97	14.21	14.51	1.2	50%	50%
Pompton Plains	13.12	13.55	12.03	11.94	13.42	15.31	2.2	50%	50%
Paterson	26.42	26.70	26.71	28.93	28.43	28.84	2.4	90%	90%
Passaic County	13.41	13.81	13.38	14.35	14.31	14.15	0.7	50%	50%
NEW JERSEY	15.33	15.19	15.31	15.59	15.98	16.60	1.3	60%	60%

Substance Use Disorders (Acute Care Setting)

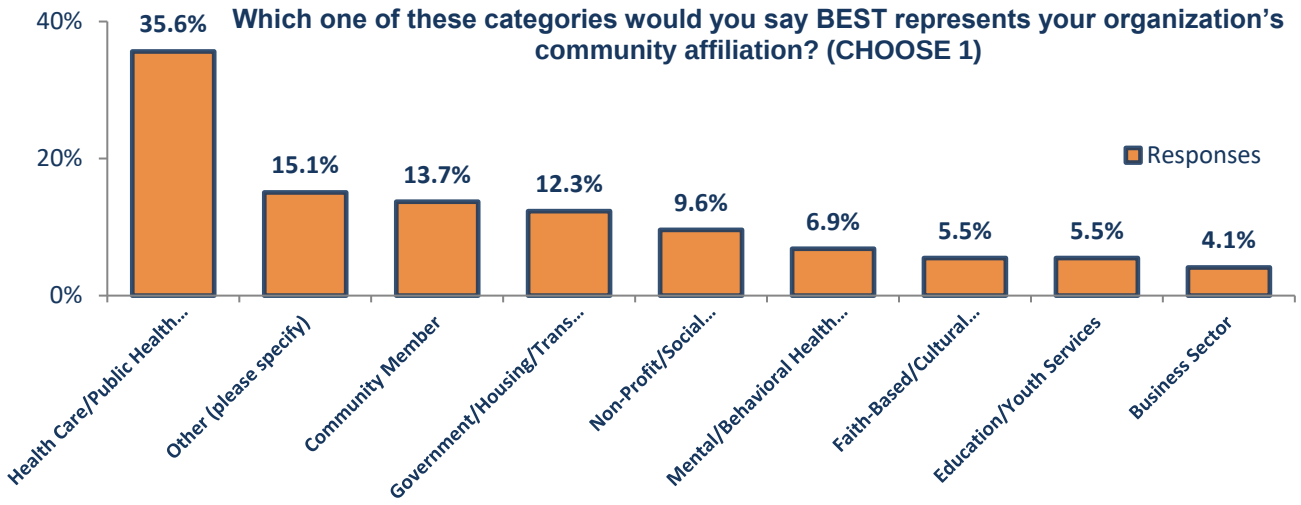
The rate/1,000 population has increased over the period in all comparative regions. The highest rate among comparative geographies is in Paterson. The rate/1,000 population in Paterson is in the 90th percentile based on a statewide rank.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
CMC 75% Service Area	5.27	5.32	5.71	6.75	6.32	6.98	1.7	40%	50%
NORTHERN REGION	10.03	9.71	9.82	11.30	12.29	12.75	2.7	80%	80%
AHS REGION	8.02	8.06	8.25	8.97	9.23	9.46	1.4	70%	70%
Pompton Plains	5.48	5.26	4.69	6.23	5.66	6.23	0.7	30%	40%
Paterson	18.19	20.37	21.41	20.88	21.22	22.72	4.5	90%	90%
Passaic County	8.45	8.99	9.12	10.02	11.54	11.30	2.8	80%	70%
NEW JERSEY	8.63	8.66	8.77	9.56	10.08	10.22	1.6	70%	70%

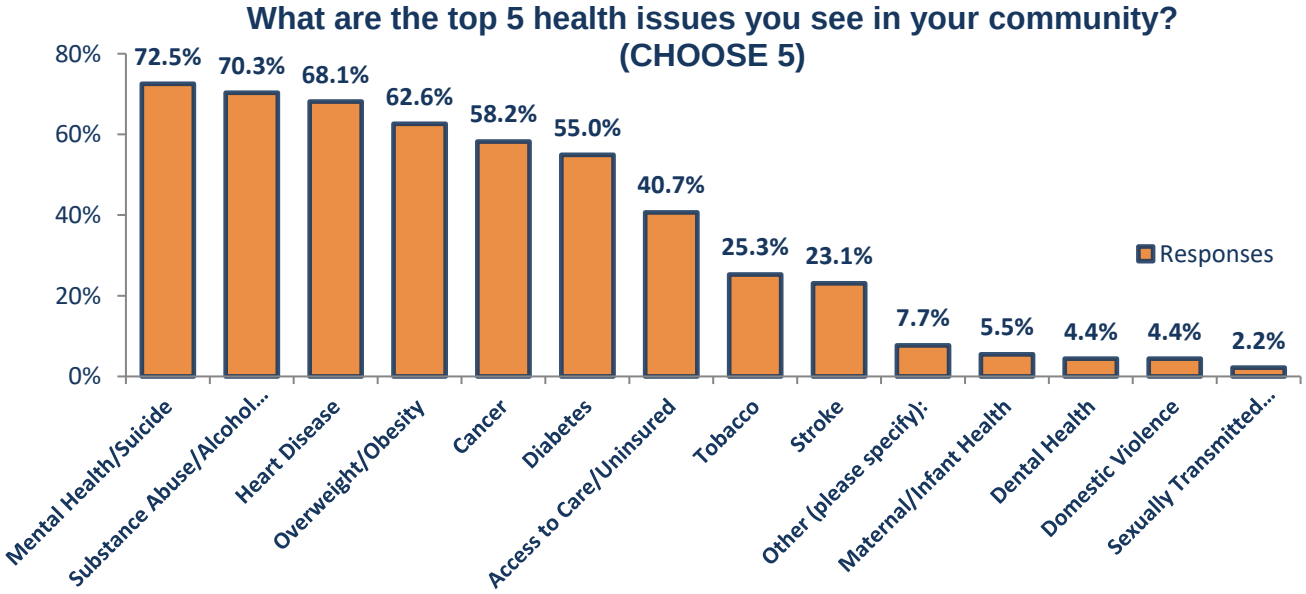
KEY INFORMANT FINDINGS

Background

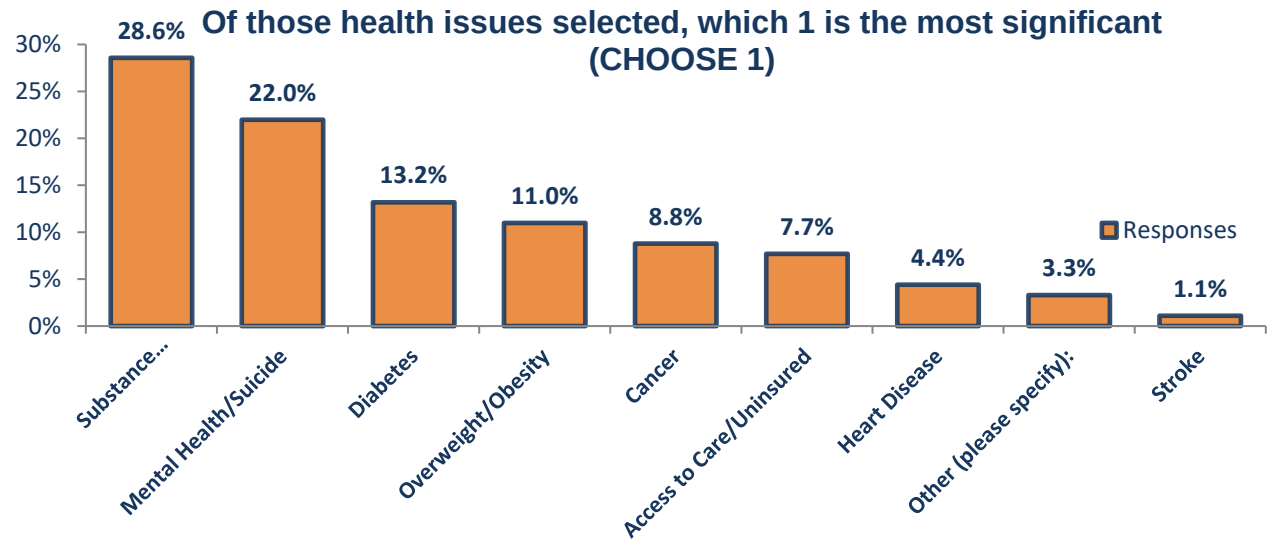
CMC received 91 responses to its community-based key-stakeholder survey, which was administered online. Below we show the breakdown of the respondents' organizational and community affiliations by category.



Below we show the breakdown of the percent of respondents who selected each health issue in the 2019 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, heart disease, overweight/obesity, and cancer.



The respondents' top significant health issue in 2019 is substance/alcohol abuse, followed by mental health/ suicide and diabetes.

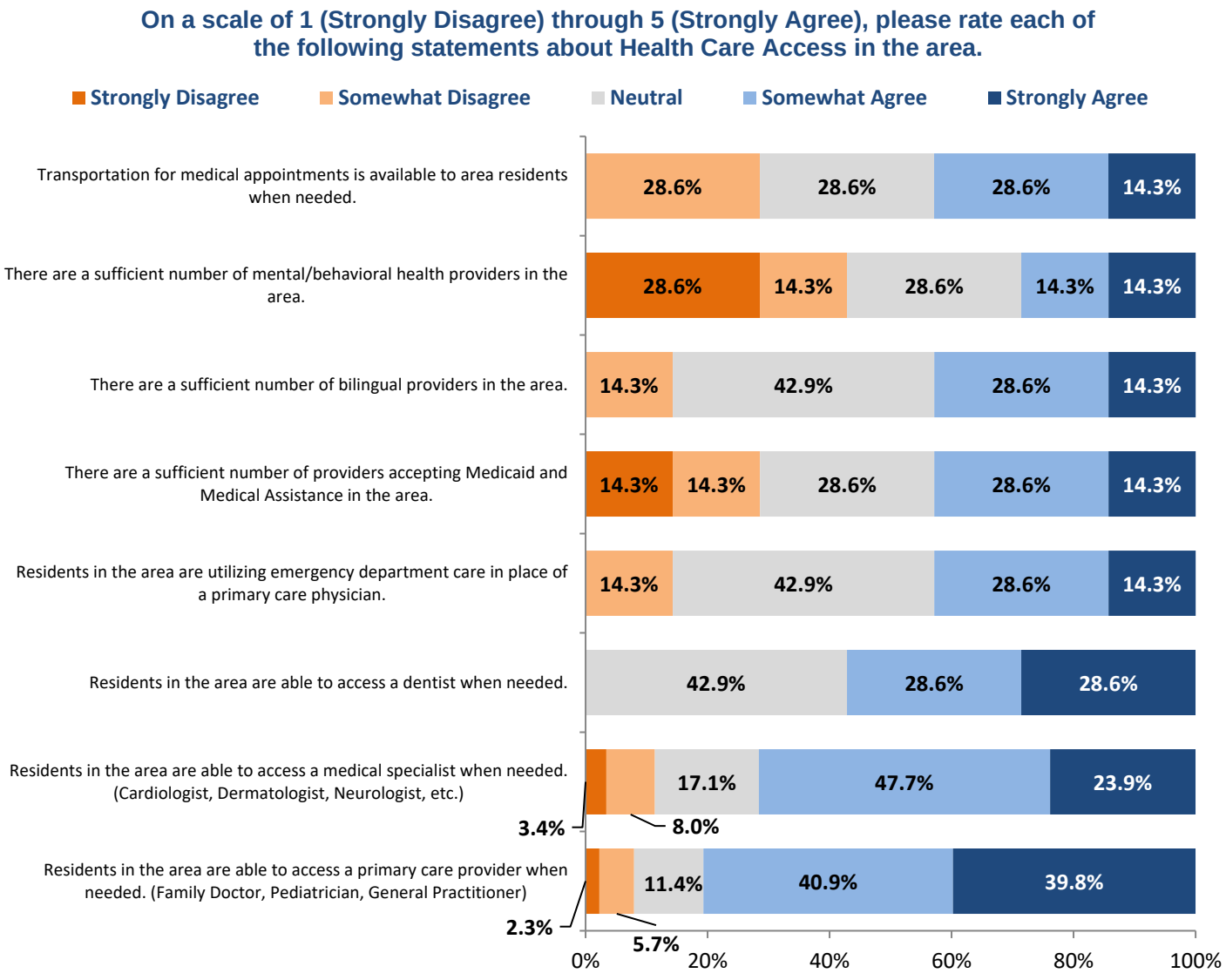


Select Stakeholder Comments: Top Health Issue

- *Overweight/Obesity is a factor in several of the leading causes of morbidity and mortality in our community. It is a root issue that needs to be addressed.*
- *In conversations with law enforcement, I am constantly reminded of issues with substance abuse, alcohol abuse, with a close second to mental health issues.*
- *Considering so many diseases are connected to our diet and how hard it is to manage weight as we age, solving this issue has the potential to solve so many other health issues.*
- *It is in my opinion that many of the issues stem specifically from mental health well-being, which should be treated as a root cause of other issues.*
- *Lack of mental health resources available and little education surrounding existing services.*
- *I think overall, substance abuse, and the opioid crisis in particular, is front and center in terms of the health and well-being of our residents.*

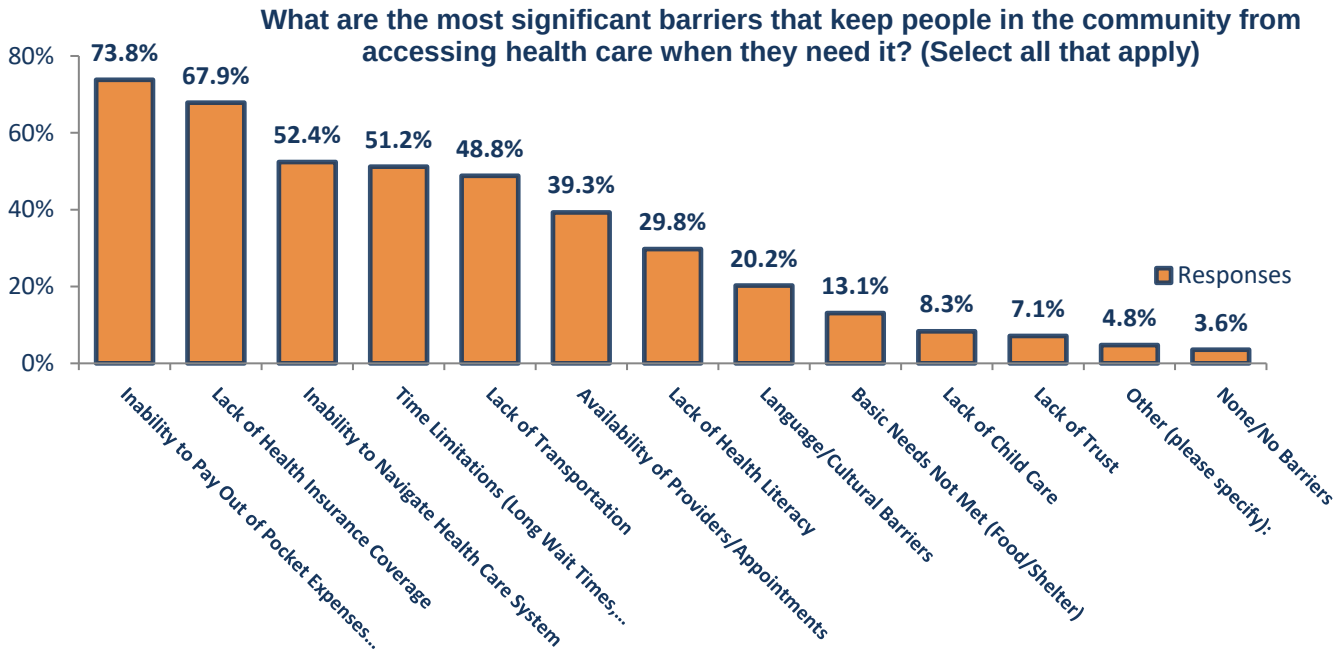
The second set of questions concerned the ability of residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bi-lingual providers.

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).



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.

In 2019, Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.) was rated by participants as the most significant barrier (73.8%), followed by Lack of Health Insurance Coverage at 67.9%. Other barriers that were rated by participants as being the most significant included inability to navigate health care system, Time Limitations (Long Wait Times, Limited Office Hours, Time off Work), and Lack of Transportation.



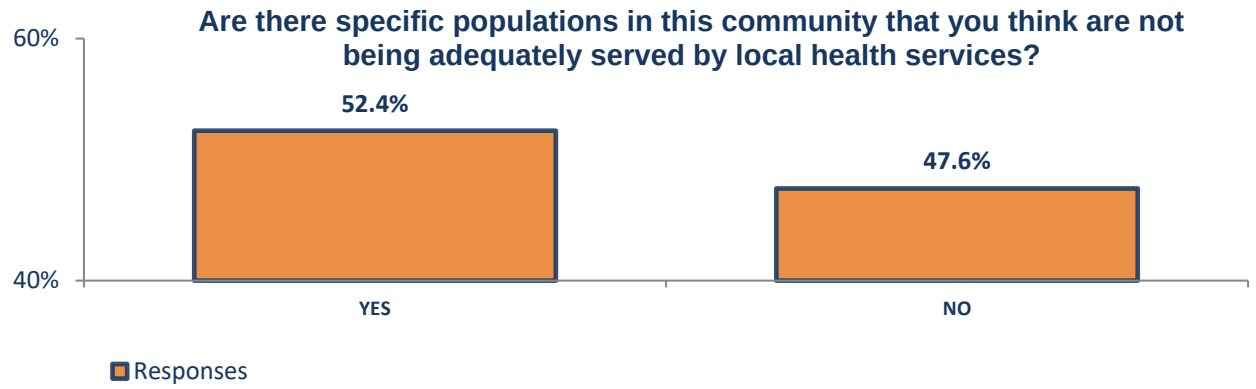
When respondents were asked for their choice of top significant barrier, Inability to Pay Out of Pocket Expenses was identified (28.6%). Lack of Health Insurance Coverage, Inability to Navigate the Healthcare System, and Time Limitations followed. After selecting the most significant barriers, informants were asked to share any additional information regarding these barriers.

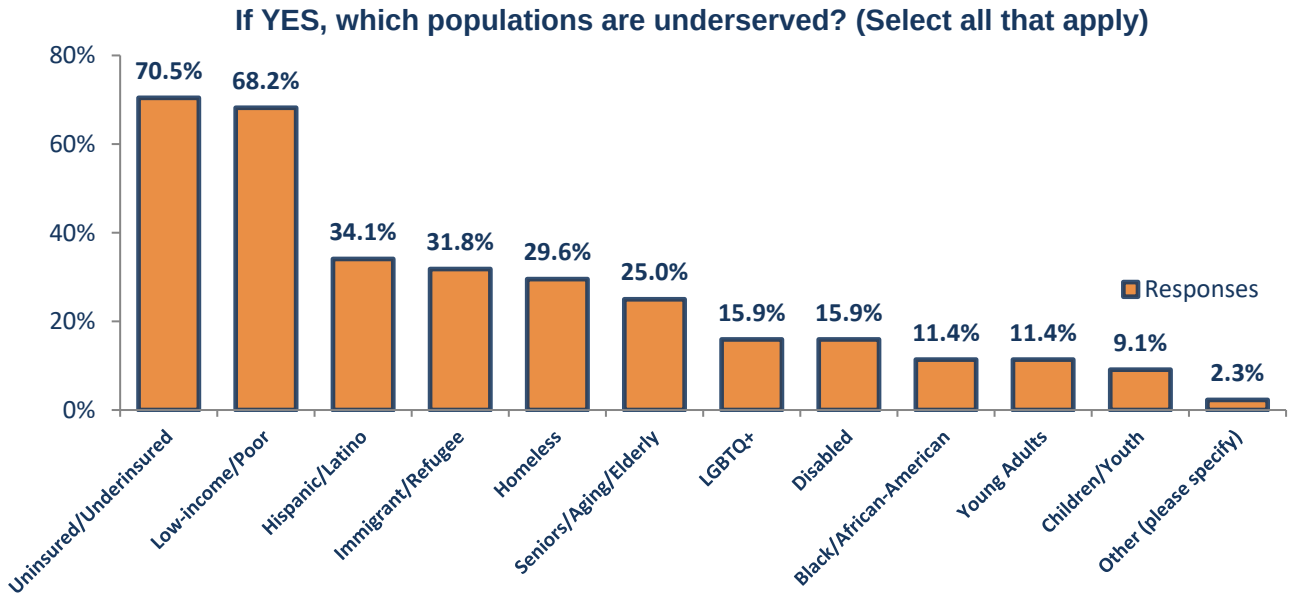
Select Stakeholder Comments: Healthcare Access & Barriers

- *The combination of inability to pay out of pocket expenses and the lack of Medicaid/Medicare providers keeps people from accessing regular, preventive and follow-up care.*
- *Copays are constantly rising, even as premiums are rising and services provided are becoming more limited.*
- *Health care coverage for many of our area residents is not readily available especially for those residents that do not have employment, those who are not US citizens, and those who simply cannot afford it.*
- *Basic living expenses overshadow the need for health care. Therefore, people choose to pay rent and buy food, rather than take care of important health issues.*
- *I think transportation and limited budgets are the biggest issues for our elderly populations.*

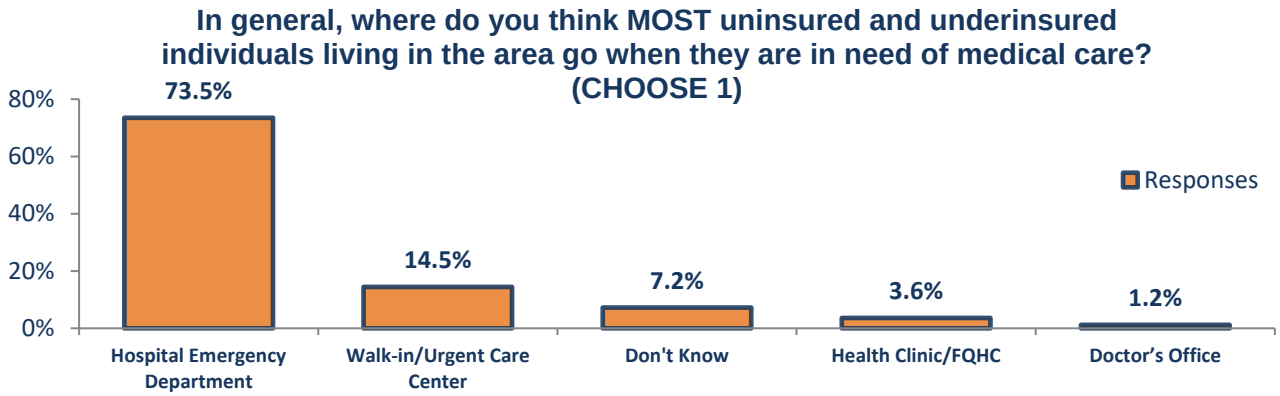
The top three population groups identified by key informants as being underserved when compared to the general population in this current survey were:

- Uninsured/Underinsured
- Low-income/Poor
- Hispanic/Latino
- Followed closely by Immigrant/Refugee, Homeless, and Seniors/Aging/Elderly.

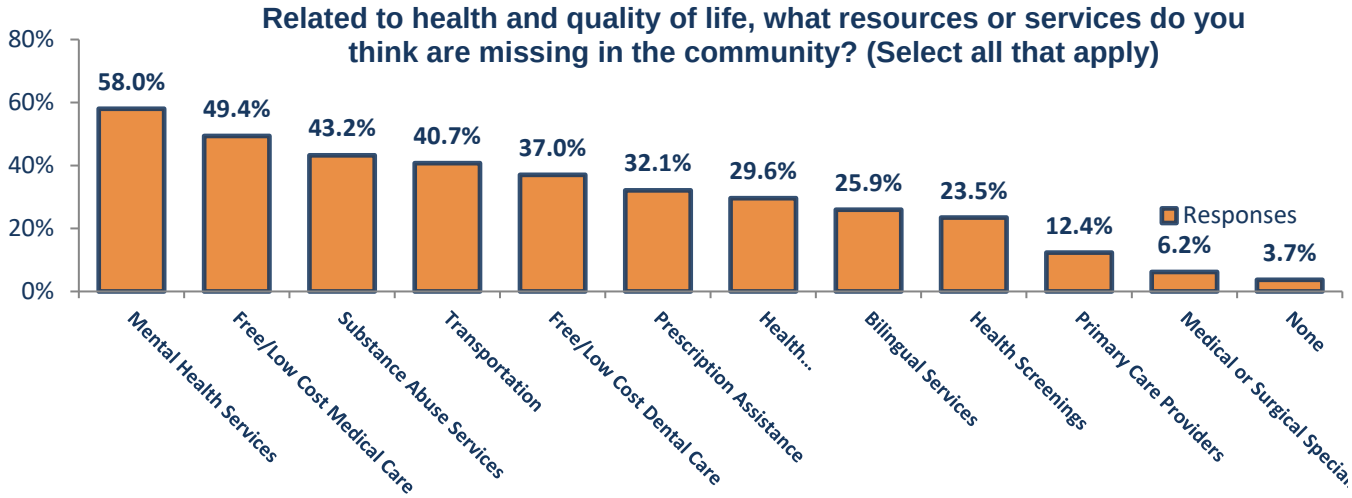




73.5% of key informants indicated that hospital emergency departments as the primary place where uninsured/underinsured individuals go when they need medical care. Walk-in/Urgent Care Center was also mentioned as a preferred place to obtain medical care.



Mental Health Services, Free/Low Cost Medical Care, Substance Abuse Services, and Transportation were most frequently indicated by key stakeholders as the most needed resources in the community to improve health and quality of life for residents.



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 14 health issues or concerns, which were identified during the primary and secondary analysis phases of the community health needs assessment. For each of the 14 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 Chilton Medical Center or can be positively impacted by community health improvement efforts directed by CMC. 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 14 identified health issues. Respondents to the stakeholder survey were given the option to abstain from offering a ranking on any individual criteria.

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

The 14 issues identified for prioritization in the area served by CMC were:

- Cancer
- Heart Disease
- Mental Health in the Aging/Elderly Population
- Mental Health in the General Population
- Obesity/Unhealthy Weight
- Substance Misuse
- Diabetes
- Barriers to Healthcare Access
- Stroke
- Tobacco Use & Vaping
- Maternal and Child Health
- Women's Health
- Alzheimer's/Dementia
- Pulmonary Diseases (Including COPD)

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 Chilton Medical Center Community Health Advisory Committee, who in partnership with hospital administration and the medical center's Community Advisory Board recommended the adoption of the following priority areas for inclusion in the 2019-2021 CHNA for CMC.

- Pulmonary Disease
- Heart Disease
- Diabetes
- Stroke
- Cancer
- Behavioral Health (including Substance Use as it pertains to Mental Health)

Following is a broad overview of each of the 6 health priorities. CMC will develop a Community Health Improvement Plan (CHIP) to address these 6 health priorities in 2020 and annually thereafter.

IDENTIFIED HEALTH PRIORITIES

Pulmonary Disease[9]

In the area served by Chilton Medical Center, there are identified health concerns or disparities among the population that are related to pulmonary disease, including high combined inpatient and emergency utilization rates/1,000 population for asthma and chronic obstructive pulmonary disease (COPD).

Asthma and chronic obstructive pulmonary disease are significant public health burdens.[10,11] Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

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

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

Several additional respiratory conditions and respiratory hazards, including infectious agents and occupational and environmental exposures, are covered in other areas of Healthy People 2020. Examples include tuberculosis, lung cancer, acquired immunodeficiency syndrome (AIDS), pneumonia, occupational lung disease, and smoking.

Currently more than 25 million people in the United States have asthma. Approximately 14.8 million adults have been diagnosed with COPD, and approximately 12 million people have not yet been diagnosed. The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the health care system, the burden of respiratory diseases also falls on society; it is paid for with tax dollars, higher health insurance rates, and lost productivity. Annual health care expenditures for asthma alone are estimated at $20.7 billion.

Asthma[12]

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

Risk factors for asthma currently being investigated include:

- Having a parent with asthma

[9] https://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases

[10] Moorman JE, Akinbami LJ, Bailey CM, Zahran HS, King ME, Johnson CA, et al. National surveillance of asthma: United States, 2001-2010. Vital & health statistics Series 3, Analytical and epidemiological studies / [US Dept of Health and Human Services, Public Health Service, National Center for Health Statistics]. 2012(35):1-67.

[11] Ford ES, Croft JB, Mannino DM, Wheaton AG, Zhang X, Giles WH. Chronic obstructive pulmonary disease (COPD) surveillance–United States, 1999–2011: Chest. 2013 Jul;144(1):284-305. doi: 10.1378/chest.13-0809.

[12] National Institutes of Health, National Heart, Lung, and Blood Institute (NHLBI). National asthma education and prevention program expert panel report 3 (EPR3): Guidelines for the diagnosis and management of asthma. Bethesda, MD: NHLBI; 2007 [cited 2016 Aug 12]. Available from: http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm

- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, particularly for low-income and minority populations. Populations with higher rates of asthma include:

- Children
- Women (among adults) and boys (among children)
- African Americans
- Puerto Ricans
- People living in the northeastern United States
- People living below the federal poverty level
- Employees with certain exposures in the workplace

While there is currently no cure for asthma, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

COPD[13]

COPD is the 4th leading cause of death in the United States. In 2014, approximately 142,000 individuals died from COPD, and almost as many died from lung cancer (approximately 155,500) in the same year. In nearly 8 out of 10 cases, COPD is caused by exposure to cigarette smoke. Other environmental exposures (such as those in the workplace) may also cause COPD.

Genetic factors strongly influence the development of the disease. For example, not all smokers develop COPD. Quitting smoking may slow the progression of the disease. Women and men are affected equally, yet more women than men have died of COPD since 2000.

Exposure to lung irritants — such as air pollution, dust, and chemical or other fumes — in the workplace and exposure to secondhand smoke or air pollutants may also contribute to COPD. Additionally, nearly 20 percent of COPD patients report a history of asthma, which may also be a contributing factor.

In 2013, the following groups were more likely to report having COPD:[14]

- Women
- People aged 65 to 74 years and ≥75 years
- American Indians/Alaska Natives and multiracial non-Hispanics
- People who were unemployed, retired, or unable to work
- People with less than a high school education
- People who were divorced, widowed, or separated
- Current or former smokers
- People with a history of asthma

[13] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Compressed mortality file 1999–2014. CDC WONDER on-line database, compiled from Compressed Mortality File 1999–2014 Series 20 No. 2L. Atlanta: CDC; 2015 [cited 2016 Aug 12]. Available from: http://wonder.cdc.gov/cmf-icd10.html

[14] https://www.cdc.gov/copd/basics-about.html

The strong association with tobacco use makes COPD highly preventable through interventions that focus on discouraging youth and young adults from starting to smoke, encouraging adults to quit, and providing smoking-cessation support to current smokers. Other efforts include programs and policies aimed at reducing exposure to dust and chemicals in the workplace, as well as exposure to indoor and outdoor air pollutants.[15]

Other Pulmonary Disease-Related Concerns[16]

Other important respiratory diseases not yet discussed include idiopathic pulmonary fibrosis, sarcoidosis, respiratory distress syndromes, and upper airway conditions such as rhinitis and chronic sinusitis. In some cases, effective preventive interventions do not exist. In others, nationally representative trend data for disease prevalence and/or incidence, causative exposures, and other preventable risk factors are not available for tracking of measurable goals. It is hoped that, as preventive interventions and surveillance for respiratory hazards and diseases continue to improve, future versions of Healthy People will include measurable goals for at least some of these additional respiratory hazards and diseases.

Other emerging issues in the Respiratory Diseases topic area include:

- Assessing the impact of climate change (temperature extremes, the increased geographic span of allergens, and air quality) on asthma causation and exacerbations
- Increasing importance of indoor air quality as a cause of work-related respiratory symptoms and asthma in a service economy
- Increasing use of nanotechnology and resulting exposures to engineered nanoparticles
- Increasing exposures to respiratory hazards such as isocyanates used in “green” building materials
- Applying knowledge about gene-environment interactions and epigenetics to respiratory disease prevention
- Using knowledge about primary causes of asthma (determination of distinct asthma phenotypes) in developing effective prevention strategies, such as weight control and allergen avoidance
- Developing novel treatments to alter the progression of disease severity and, ultimately, to prevent asthma onset
- Using personalized medicine (tailoring treatment to a patient’s specific phenotype, genetics, and history)
- Identifying new respiratory hazards, as has been done during the last decade for diacetyl and other butter-flavoring chemicals; nylon, rayon, and polypropylene flock; and World Trade Center dust
- Improving COPD awareness and clinical case-finding in the population at large, and in the health care delivery system at the state and local levels
- Establishing a surveillance system for COPD

Heart Disease[17]

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

- The rate of hypertension among Medicare beneficiaries
- An unfavorable rate of atrial fibrillation among Medicare beneficiaries
- Areas of concern related to the rate of ischemic heart disease among Medicare beneficiaries

[15] https://www.nhlbi.nih.gov/sites/default/files/media/docs/COPD%20National%20Action%20Plan%20508_0.pdf

[16] https://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases

[17] https://www.cdc.gov/heartdisease/about.htm

- The age-adjusted death rate due to heart disease, with identified disparities among males, Non-Hispanic Blacks, and Non-Hispanic Whites
- Areas of concern regarding the age-adjusted death rate due to hypertensive 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.[18] 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.
- Angina: 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.

[18] www.cdc.gov/nchs/ data/nvsr/nvsr60/nvsr60_03.pdf

- 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. The majority of 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[19]

In the area served by Chilton Medical Center, there are identified health concerns or disparities among the population that are related to diabetes, including:

- Increasing inpatient and emergency utilization rates/1,000 population for diabetes and obesity
- High mortality for diabetes, with an identified disparity among black males
- Diabetes incidence in the Medicare population

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.

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

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.

Stroke[20]

In the area served by Chilton Medical Center, there are identified health concerns or disparities among the population that are related to Stroke, including high combined inpatient and emergency utilization rates/1,000 population for stroke/TIA. The rate/1,000 population has increased over the period in the CMC 75% Service Area and in Pompton Plains. The highest rate among comparative geographies is in Pompton Plains. The rate/1,000 population in Pompton Plains is in the 90th percentile based on a statewide rank.

Stroke is a disease that affects the arteries leading to and within the brain. It is the fifth highest cause of death and a leading cause of disability in the United States.

A stroke occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts (or ruptures). When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it and brain cells die. When brain cells die during a stroke, the abilities controlled by that area of the brain are lost. These abilities may include speech, movement, and memory. The way a stroke affects you depends on where the stroke occurs in the brain and how much of the brain is damaged.

Stroke can be caused either by a clot obstructing the flow of blood to the brain (called an ischemic stroke) or by a blood vessel rupturing and preventing blood flow to the brain (called a hemorrhagic stroke). A TIA (transient ischemic attack), or "mini stroke", is caused by a temporary clot.

- Ischemic stroke occurs when a vessel supplying blood to the brain is obstructed. It accounts for about 87 percent of all strokes. Fatty deposits lining the vessel walls, called atherosclerosis, are the main cause for ischemic stroke. Fatty deposits can cause two types of obstruction:
    - Cerebral thrombosis is a thrombus (blood clot) that develops at the fatty plaque within the blood vessel.
    - Cerebral embolism is a blood clot that forms at another location in the circulatory system, usually the heart and large arteries of the upper chest and neck. Part of the blood clot breaks loose, enters the bloodstream and travels through the brain's blood vessels until it reaches vessels too small to let it pass. A main cause of embolism is an irregular heartbeat called atrial fibrillation. It can cause clots to form in the heart, dislodge and travel to the brain.
- Hemorrhagic strokes make up about 13 percent of stroke cases. It's caused by a weakened vessel that ruptures and bleeds into the surrounding brain. The blood accumulates and compresses the surrounding brain tissue. The two types of hemorrhagic strokes are intracerebral (within the brain) hemorrhage or subarachnoid hemorrhage. A hemorrhagic stroke occurs when a weakened blood vessel ruptures. Two types of weakened blood vessels usually cause hemorrhagic stroke: aneurysms and arteriovenous malformations (AVMs).

[20] https://www.stroke.org/en/about-stroke

- A Transient Ischemic Attack (TIA) is often called a mini-stroke, but it's really a major warning. TIA is a temporary blockage of blood flow to the brain. Since it doesn't cause permanent damage, it's often ignored. But this is a big mistake. TIAs may signal a full-blown stroke ahead.

- Strokes without a known cause are called "cryptogenic." In most cases, a stroke is caused by a blood clot that blocks blood flow to the brain. But in some instances, despite testing, the cause can't be determined. That's why it's important to dig deeper for a definitive diagnosis. Collaboration by neurologists, cardiologists, electrophysiologists and others may reveal the answers needed to provide targeted treatment for preventing recurrent strokes. Having a stroke of unknown cause, or cryptogenic stroke, may be frustrating and overwhelming. With a proper diagnostic work-up and collaboration with your physician, you can take part in finding the cause of your stroke and help prevent another one from occurring.

- Brain stem strokes can have complex symptoms, and they can be difficult to diagnose. A person may have vertigo, dizziness and severe imbalance without the hallmark of most strokes — weakness on one side of the body. The symptoms of vertigo dizziness or imbalance usually occur together; dizziness alone is not a sign of stroke. A brain stem stroke can also cause double vision, slurred speech and decreased level of consciousness.

When you first notice symptoms, get help immediately. F.A.S.T. is an easy way to remember the sudden signs of stroke. Learning the signs and symptoms of strokes and getting to a hospital quickly will give you the best chance of having a positive outcome after a stroke. When you spot the signs, you'll know when you need to call 9-1-1 for help. F.A.S.T. stands for:

- **Face** Drooping Does one side of the face droop or does it feel numb? Ask the person to smile. Is the person's smile uneven?
- **Arm** Weakness Is one arm weak or numb? Ask the person to raise both arms. Does one arm drift downward?
- **Speech** Difficulty Is speech slurred? Is the person unable to speak or hard to understand? Ask the person to repeat a simple sentence, like "The sky is blue." Is the sentence repeated correctly?
- **Time** to call 9-1-1 If someone shows any of these symptoms, even if the symptoms go away, call 9-1-1 and get the person to the hospital immediately. Check the time so you'll know when the first symptoms appeared.

Once you have had a stroke, you are at a greater risk for another stroke. Up to 80 percent of second clot-related strokes may be preventable. Following are steps that can reduce the risk for a stroke:

- Monitor your blood pressure.
- Control your cholesterol.
- Keep your blood sugar down.
- Get active.
- Eat better.
- Lose weight if you need to.
- Don't smoke, period.
- Talk to your doctor about aspirin* or other medications.

The American Stroke Association provides extensive information about the causes, types, preventative steps and treatment of stroke.

Cancer

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

- The rate of colon cancer screening
- The age-adjusted death rate due to breast cancer
- The rate of mammography screening among Medicare beneficiaries
- The incidence of liver and bile duct cancer, with an identified disparity among men
- The age-adjusted death rate due to prostate cancer, with an identified disparity among African Americans
- The oral cavity and pharynx cancer incidence rate, with an identified disparity among males
- The overall cancer incidence rate, with an identified disparity among men
- The overall age-adjusted death rate due to cancer, with an identified disparity among men
- The incidence of lung and bronchus cancer, with an identified disparity among males
- The age-adjusted death rate due to lung cancer, with an identified disparity among men

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.[21]

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.[22]

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,

[21] https://www.healthypeople.gov/2020/topics-objectives/topic/cancer
[22] 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.

which contribute to the risk of developing cancer, and to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups.[23]

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.[24]

Cancer survivors often face physical, emotional, social, and financial challenges as a result 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.[25]

Behavioral Health Including Substance Use Disorders

Throughout the CHNA process, access to and availability of behavioral health services, including both substance misuse and mental health services, consistently rose to the top as key areas of need in the community. In the area served by Chilton Medical Center, there are identified health concerns or disparities related to mental health and

[23] https://www.healthypeople.gov/2020/topics-objectives/topic/cancer
[24] http://seer.cancer.gov
[25] 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.

substance misuse in both the general and aging/elderly populations. Survey responses from and discussions with Chilton Medical Center's stakeholders revealed that mental health concerns are prevalent both in the general and elderly populations. However, the way in which these issues present within these populations often varies. During its community health improvement plan development, CMC will take steps to address behavioral health-related concerns and needs with approaches geared toward subsets of the populations served by the medical center.

Mental Health

Need for Mental Health Providers[26]

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

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

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

- 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.[27]

- 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?[28]

- 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.

[27] SAMHSA. (2017, September). ATTC: Network Coordinating Office. National Workforce Report 2017. From http://attcnetwork.org/documents/ATTC_Network_Natl_Report2017_single.pdf (
[28] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

- 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?[29]

- SAMHSA will support active strategies to strengthen and expand the behavioral health workforce and improve the behavioral health knowledge and skills of those health care workers not considered behavioral health specialists. Through technical assistance, training, partnerships, and traditional and social media outreach, SAMHSA will promote an integrated, aligned, and competent workforce.
- This workforce will enhance the availability of prevention and treatment for substance abuse and mental illness, strengthen the capabilities of behavioral health professionals, and promote health system infrastructure that can deliver competent, organized behavioral health services.
- SAMHSA will monitor and assess the needs of youth, young adult and adult peers, communities, and health professionals in meeting behavioral health needs within America's transforming health promotion and health care delivery systems.
- SAMHSA also recognizes the growing understanding and value of peer providers to assist with engagement, support, and peer services. Increasing the peer and paraprofessional workforce and increasing the evidence base for the best uses of peer and paraprofessional behavioral health services 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? [30]

- 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?[31]

- 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

[29] SAMHSA. Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018
[30] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.
[31] Sherman, Laura, Lynch, Sean, et. al. Behavioral Health Workforce: Quality Assurance Practices in Substance Abuse Treatment Facilities. The CBHSQ Report. SAMHSA.

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.[32]
- The Minority Fellowship Programs (MFP) increase the knowledge of issues related to mental health conditions and addictions among minorities, and to improve the quality of mental health services and substance abuse prevention and treatment delivered to ethnic minority populations. SAMHSA provides grants to encourage and facilitate the doctoral and post-doctoral development of nurses, psychiatrists, social workers, psychologists, marriage and family therapists, and professional counselors by providing funding to organizations which oversee the fellowship opportunities.
- Graduate Psychology Education (GPE) Program: HRSA grants in the GPE program support interdisciplinary training for health service psychologists to provide mental and behavioral health care services to underserved populations, such as those in rural areas, older adults, children, chronically ill or disabled persons, and victims of abuse or trauma, including returning military personnel.
- HRSA's National Health Service Corps are health professionals who provide primary health care services in underserved communities in exchange for either loan repayment assistance or scholarships to help pay the costs of their medical education.
- SAMHSA's cooperative agreement with Historically Black Colleges and Universities supports a Center for Excellence in Substance Abuse and Mental Health which provides student internships at minority serving institutions.[33]
- 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.[34]

Substance Use Disorders

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

[32] SAMHSA. (n.d.). Serving the Needs of Diverse Populations.
[33] SAMHSA. (2013, January 24). Report to Congress on Nation's Substance Abuse and Mental Health Workforce Issues.
[34] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Following are overviews of the most common substance use disorders in the United States.

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

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

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

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

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

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.

APPENDIX A: DEMOGRAPHIC TABLES[35]

Total Population

POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES						
ZIP Code	ZIP Code Name	Population of Base Yr (2010)	Population of Current Yr (2019)	Population of Forecast Yr (2024)	Population Growth: Base Yr to Current Yr (%)	Population Growth: Current Yr to Forecast Yr (%)
07035	LINCOLN PARK	10,678	10,349	10,271	-3.08%	-0.75%
07405	BUTLER	17,732	18,014	18,209	1.59%	1.08%
07440	PEQUANNOCK	4,542	4,392	4,355	-3.30%	-0.84%
07444	POMPTON PLAINS	10,944	11,434	11,716	4.48%	2.47%
07457	RIVERDALE	3,567	4,200	4,487	17.75%	6.83%
07403	BLOOMINGDALE	7,589	7,939	8,129	4.61%	2.39%
07420	HASKELL	4,989	5,318	5,487	6.59%	3.18%
07421	HEWITT	7,472	7,440	7,470	-0.43%	0.40%
07442	POMPTON LAKES	11,104	11,300	11,445	1.77%	1.28%
07456	RINGWOOD	12,227	12,529	12,724	2.47%	1.56%
07465	WANAQUE	6,188	6,911	7,257	11.68%	5.01%
07470	WAYNE	51,856	52,657	53,254	1.54%	1.13%
07480	WEST MILFORD	15,920	16,225	16,426	1.92%	1.24%
	CMC SERVICE AREA	**164,808**	**168,708**	**171,230**	**2.4%**	**1.5%**
	PASSAIC COUNTY	**219,883**	**501,193**	**514,211**	**2.6%**	**1.6%**
	NEW JERSEY	**8,791,914**	**9,043,262**	**9,195,645**	**2.9%**	**1.7%**

Population Density

POPULATION DENSITY: ZIP CODES AND COMPARATIVE GEOGRAPHIES		
ZIP Code	ZIP Code Name	Population / Square Mile
07035	LINCOLN PARK	1,547.09
07405	BUTLER	913.80
07440	PEQUANNOCK	2,805.93
07444	POMPTON PLAINS	2,216.81
07457	RIVERDALE	2,064.98
07403	BLOOMINGDALE	1,230.92
07420	HASKELL	2,044.06
07421	HEWITT	277.65
07442	POMPTON LAKES	3,888.90
07456	RINGWOOD	490.80
07465	WANAQUE	857.00
07470	WAYNE	2,190.42
07480	WEST MILFORD	475.76
	CMC SERVICE AREA	**1,023.29**
	PASSAIC COUNTY	**2,764.88**
	NEW JERSEY	**1,303.47**

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

Race & Hispanic

POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES											
		White (Non-Hispanic)		Hispanic (of Any Race)		Asian (Non-Hispanic)		Black (Non-Hispanic)		Another Race (Non-Hispanic)	
ZIP Code	ZIP Code Name	2019	2024	2019	2024	2019	2024	2019	2024	2019	2024
07035	LINCOLN PARK	75.7%	73.3%	11.9%	13.4%	8.7%	9.5%	1.6%	1.6%	2.0%	2.2%
07405	BUTLER	82.7%	80.3%	9.6%	10.9%	4.7%	5.2%	1.4%	1.7%	1.6%	1.8%
07440	PEQUANNOCK	88.8%	87.4%	6.3%	7.0%	2.7%	3.0%	0.4%	0.4%	1.8%	2.2%
07444	POMPTON PLAINS	91.4%	90.7%	5.2%	5.6%	1.7%	1.6%	0.8%	1.0%	0.9%	1.0%
07457	RIVERDALE	80.2%	77.6%	9.1%	10.2%	6.8%	7.6%	1.5%	1.7%	2.5%	2.9%
07403	BLOOMINGDALE	80.3%	76.6%	14.3%	17.4%	2.5%	2.6%	1.7%	2.1%	1.3%	1.4%
07420	HASKELL	68.7%	64.2%	16.2%	19.0%	7.8%	8.7%	4.7%	5.4%	2.6%	2.8%
07421	HEWITT	86.4%	84.7%	7.8%	9.0%	1.3%	1.4%	1.9%	2.1%	2.6%	2.8%
07442	POMPTON LAKES	73.5%	68.6%	16.4%	20.0%	6.9%	7.7%	1.3%	1.4%	1.9%	2.3%
07456	RINGWOOD	85.5%	83.7%	7.3%	8.3%	2.0%	2.2%	1.2%	1.2%	4.0%	4.6%
07465	WANAQUE	80.9%	78.5%	11.1%	12.9%	3.1%	3.1%	3.1%	3.5%	1.8%	1.7%
07470	WAYNE	75.9%	72.4%	10.8%	12.8%	9.8%	10.8%	1.6%	1.8%	1.9%	2.2%
07480	WEST MILFORD	86.9%	84.7%	8.5%	10.3%	1.6%	1.7%	1.3%	1.4%	0.4%	1.9%
	CMC SERVICE AREA	**80.4%**	**77.6%**	**10.3%**	**12.1%**	**5.8%**	**6.3%**	**1.6%**	**1.8%**	**2.0%**	**2.3%**
	PASSAIC COUNTY	**39.8%**	**36.6%**	**42.8%**	**46.1%**	**5.5%**	**5.9%**	**10.1%**	**9.6%**	**1.8%**	**1.8%**
	NEW JERSEY	**53.9%**	**50.9%**	**21.0%**	**22.8%**	**10.0%**	**11.0%**	**12.8%**	**12.8%**	**2.3%**	**2.5%**

Language Spoken at Home

POPULATION 5 YEARS AND OVER: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Speak English only or speak English "very well"	Speak English less than "very well"	% Speak English less than "very well"
07035	LINCOLN PARK	9,071	1,059	10.5%
07405	BUTLER	15,690	1,016	6.1%
07440	PEQUANNOCK	4,170	200	4.6%
07444	POMPTON PLAINS	10,265	335	3.2%
07457	RIVERDALE	3,691	237	6.0%
07403	BLOOMINGDALE	6,416	880	12.1%
07420	HASKELL	4,465	457	9.3%
07421	HEWITT	6,911	70	1.0%
07442	POMPTON LAKES	9,097	1,437	13.6%
07465	RINGWOOD	11,246	310	2.7%
07465	WANAQUE	6,093	275	4.3%
07470	WAYNE	48,007	4,552	8.7%
07480	WEST MILFORD	15,254	514	3.3%
	CMC SERVICE AREA	**150,376**	**11,342**	**7.0%**
	PASSAIC COUNTY	**376,581**	**94,891**	**20.1%**
	NEW JERSEY	**7,365,008**	**1,021,939**	**12.2%**

Median Household Income

CURRENT AND PROJECTED MEDIAN HOUSEHOLD INCOME: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	2019 HH INCOME Median HH Income	2024 HH INCOME Median HH Income	% Change Median HH Income - Projected
07035	LINCOLN PARK	$ 94,318	$ 100,911	7.0%
07405	BUTLER	$ 121,058	$ 132,003	9.0%
07440	PEQUANNOCK	$ 102,816	$ 111,135	8.1%
07444	POMPTON PLAINS	$ 78,719	$ 84,861	7.8%
07457	RIVERDALE	$ 95,000	$ 101,399	6.7%
07403	BLOOMINGDALE	$ 90,876	$ 99,726	9.7%
07420	HASKELL	$ 85,347	$ 91,179	6.8%
07421	HEWITT	$ 100,659	$ 109,021	8.3%
07442	POMPTON LAKES	$ 96,830	$ 104,293	7.7%
07456	RINGWOOD	$ 121,393	$ 134,667	10.9%
07465	WANAQUE	$ 94,664	$ 100,666	6.3%
07470	WAYNE	$ 116,546	$ 127,572	9.5%
07480	WEST MILFORD	$ 111,014	$ 121,277	9.2%
	CMC SERVICE AREA	**$ 95,000**	**$ 101,399**	**6.7%**
	PASSAIC COUNTY	**$ 85,374**	**$ 92,296**	**8.1%**
	NEW JERSEY	**$ 77,983**	**$ 85,857**	**10.1%**

Poverty

CURRENT AND PROJECTED MEDIAN HOUSEHOLD INCOME: SERVICE AREA & COMPARATIVE GEOGRAPHIES						
ZIP Code	ZIP Code Name	2019 # Families Below Poverty	2019 % Families Below Poverty	2024 # Families Below Poverty	2024 % Families Below Poverty	% Change 2019-2014
07035	LINCOLN PARK	93	3.6%	90	3.5%	-3.32%
07405	BUTLER	121	2.4%	111	2.2%	-8.26%
07440	PEQUANNOCK	50	4.1%	46	3.8%	-8.00%
07444	POMPTON PLAINS	71	2.5%	74	2.6%	4.23%
07457	RIVERDALE	48	4.5%	51	4.4%	6.25%
07403	BLOOMINGDALE	99	4.7%	111	5.1%	12.12%
07420	HASKELL	82	6.1%	87	6.2%	6.10%
07421	HEWITT	79	3.8%	86	4.1%	8.86%
07442	POMPTON LAKES	128	4.3%	132	4.4%	3.13%
07456	RINGWOOD	50	1.4%	53	1.5%	6.00%
07465	WANAQUE	29	1.4%	28	1.3%	-3.45%
07470	WAYNE	412	2.9%	457	3.2%	10.92%
07480	WEST MILFORD	79	1.8%	91	2.0%	15.19%
	CMC SERVICE AREA	**1,341**	**3.0%**	**1,417**	**3.1%**	**5.67%**
	PASSAIC COUNTY	**17,221**	**13.9%**	**17,467**	**13.9%**	**1.43%**
	NEW JERSEY	**179,302**	**7.8%**	**182,371**	**7.8%**	**1.71%**

Food Stamps / SNAP

ESTIMATED TOTAL HOUSEHOLDS: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Total Households (HH)	HH receiving food stamps/SNAP	% of HH Receiving SNAP
07035	LINCOLN PARK	3,886	74	1.9%
07405	BUTLER	6,177	98	1.6%
07440	PEQUANNOCK	1,558	82	5.3%
07444	POMPTON PLAINS	4,761	71	1.5%
07457	RIVERDALE	1,924	28	1.5%
07403	BLOOMINGDALE	2,741	195	7.1%
07420	HASKELL	1,552	121	7.8%
07421	HEWITT	2,575	180	7.0%
07442	POMPTON LAKES	3,941	275	7.0%
07456	RINGWOOD	3,797	126	3.3%
07465	WANAQUE	2,600	80	3.1%
07470	WAYNE	18,240	686	3.8%
07480	WEST MILFORD	5,775	245	4.2%
	CMC SERVICE AREA	**59,527**	**2,261**	**3.8%**
	PASSAIC COUNTY	**161,415**	**31,520**	**19.5%**
	NEW JERSEY	**3,195,014**	**298,642**	**9.3%**

Unemployment Rate

POPULATION 16 YEARS AND OVER: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Population 16 Years and Older	Unemployed	% Unemployed
07035	LINCOLN PARK	8,939	340	3.8%
07405	BUTLER	14,304	973	6.8%
07440	PEQUANNOCK	3,626	450	12.4%
07444	POMPTON PLAINS	9,113	647	7.1%
07457	RIVERDALE	3,531	240	6.8%
07403	BLOOMINGDALE	6,416	577	9.0%
07420	HASKELL	4,193	302	7.2%
07421	HEWITT	6,052	575	9.5%
07442	POMPTON LAKES	9,078	590	6.5%
07456	RINGWOOD	9,669	541	5.6%
07465	WANAQUE	5,785	364	6.3%
07470	WAYNE	45,376	2813	6.2%
07480	WEST MILFORD	13,348	534	4.0%
	CMC SERVICE AREA	**139,430**	**8,947**	**6.4%**
	PASSAIC COUNTY	**396,937**	**28,165**	**7.6%**
	NEW JERSEY	**7,143,654**	**566,878**	**7.9%**

Education Attainment

CURRENT AND PROJECTED EDUCATION LEVEL (AGE 25+): SERVICE AREA & COMPARATIVE GEOGRAPHIES						
ZIP Code	ZIP Code Name	2019 Some High School or Less	2019 % Some High School or Less	2024 Some High School or Less	2024 % Some High School or Less	% Point Change 2019-2014
07035	LINCOLN PARK	561	7.1%	560	7.2%	0.01%
07405	BUTLER	596	4.7%	616	4.6%	-0.02%
07440	PEQUANNOCK	180	5.8%	187	5.9%	0.14%
07444	POMPTON PLAINS	449	5.1%	478	5.2%	0.06%
07457	RIVERDALE	244	7.8%	225	7.7%	-0.06%
07403	BLOOMINGDALE	505	8.9%	531	9.1%	0.24%
07420	HASKELL	474	12.4%	486	12.2%	-0.16%
07421	HEWITT	412	7.7%	417	7.7%	-0.04%
07442	POMPTON LAKES	528	6.6%	548	6.7%	0.12%
07456	RINGWOOD	642	7.4%	670	7.5%	0.07%
07465	WANAQUE	275	5.4%	289	5.4%	-0.02%
07470	WAYNE	2,484	6.6%	2,590	6.7%	0.06%
07480	WEST MILFORD	706	6.0%	736	6.1%	0.10%
	CMC SERVICE AREA	**8,056**	**6.6%**	**8,363**	**6.67%**	**0.05%**
	PASSAIC COUNTY	**60,888**	**17.9%**	**62,217**	**17.9%**	**-0.01%**
	NEW JERSEY	**675,582**	**10.8%**	**692,826**	**10.8%**	**0.00%**

Status of Health Insurance

CIVILIAN NONINSTITUTIONALIZED POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Insured	Uninsured	% Uninsured
07035	LINCOLN PARK	9,594	614	6.0%
07405	BUTLER	16,606	1,107	6.2%
07440	PEQUANNOCK	4,162	331	7.4%
07444	POMPTON PLAINS	10,479	512	4.7%
07457	RIVERDALE	3,969	237	5.6%
07403	BLOOMINGDALE	6,872	898	11.6%
07420	HASKELL	4,1298	564	11.8%
07421	HEWITT	6,703	578	7.9%
07442	POMPTON LAKES	9,958	1,205	10.8%
07456	RINGWOOD	11,717	387	3.2%
07465	WANAQUE	6,549	254	3.7%
07470	WAYNE	50,832	3,233	6.0%
07480	WEST MILFORD	15,314	1,100	6.7%
	CMC SERVICE AREA	**156,953**	**11,020**	**6.6%**
	PASSAIC COUNTY	**426,523**	**75,909**	**15.1%**
	NEW JERSEY	**7,868,933**	**938,966**	**10.7%**

APPENDIX B: SECONDARY DATA SOURCES

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

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

APPENDIX C: SECONDARY DATA INDICATORS[36]

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

PRIMARY TOPIC	INDICATOR
Economy	Cost of Family Child Care as a Percentage of Income
	Cost of Licensed Child Care as a Percentage of Income
Economy / Employment	Unemployed Workers in Civilian Labor Force
Economy / Government Assistance Programs	Households with Cash Public Assistance Income
	Students Eligible for the Free Lunch Program
Economy / Homelessness	Homelessness by County
Economy / Homeownership	Homeownership
Economy / Housing Affordability & Supply	Renters Spending 30% or More of Household Income on Rent
	Severe Housing Problems
Economy / Income	Households that are 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
	Income Inequality
	Median Household Income
	Median Household Income by Age – 25-44
	Per Capita Income
Economy / Poverty	Children Living Below Poverty Level
	Children Under 5 Years Old Living in Poverty
	Families Living Below Poverty Level
	Households Receiving SNAP with Children
	People 65+ Living Below Poverty Level
	People Living 200% Above Poverty Level
	People Living Below Poverty Level
	Utility Assistance for Low-Income Households
	Young Children Living Below Poverty Level
Education / Educational Attainment in Adult Population	People 25 + with a Bachelor's Degree or Higher
	People 25 + with a High School Degree or Higher
Education / School Resources	Student-to-Teacher Ratio
Education / Student Performance K-12	Students Passing 11th Grade State Achievement Tests
	Students Passing 4th Grade State Achievement Tests
	Students Passing 8th Grade State Achievement Tests
Environment / Air	Annual Ozone Air Quality

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

PRIMARY TOPIC	INDICATOR
	Annual Particle Pollution
	Recognized Carcinogens Released into Air
Environment / Built Environment	Access to Exercise Opportunities
	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
	People 65+ with Low Access to a Grocery Store
	People with Low Access to a Grocery Store
	Recreation and Fitness Facilities
	SNAP Certified Stores
Environment / Toxic Chemicals	PBT Released
	Risk Factor for Childhood Lead Exposure: Pre-1950 Housing
Environment / Weather & Climate	Daily Dose of UV Irradiance
	Months of Mild Drought or Worse
	Number of Extreme Hot Days
	Number of Extreme Heat Events
	Number of Extreme Precipitation Days
	Weeks of Moderate Drought or Worse
Government & Politics / Elections & Voting	Voter Turnout: Presidential Election
Health	Age-Adjusted Years of Potential Life Lost
Health / Access to Health Services	Adults Unable to Afford to See a Doctor
	Adults who enrolled in the health insurance marketplace
	Adults who have had a Routine Checkup
	Adults with at least one primary care provider
	Adults with Health Insurance
	Adults with Health Insurance: 18-64
	Children with Health Insurance
	Children with Health Insurance 0-17
	Medicare Healthcare Costs
	Non-Physician Primary Care Provider Rate
	Persons with Private Health Insurance Only
	Persons with Public Health Insurance Only
	Preventable Hospital Stays: Medicare Population
	Primary Care Provider Rate
Health / Cancer	Age-Adjusted Death Rate due to Breast Cancer
	Age-Adjusted Death Rate due to Cancer
	Age-Adjusted Death Rate due to Colorectal Cancer

PRIMARY TOPIC	INDICATOR
	Age-Adjusted Death Rate due to Lung Cancer
	Age-Adjusted Death Rate due to Pancreatic Cancer
	Age-Adjusted Death Rate due to Prostate Cancer
	All Cancer Incidence Rate
	Breast Cancer Incidence Rate
	Cancer: Medicare Population
	Cervical Cancer Incidence Rate
	Colon Cancer Screening
	Colorectal Cancer Incidence Rate
	Liver and Bile Duct Cancer Incidence Rate
	Lung and Bronchus Cancer Incidence Rate
	Mammogram in Past 2 Years: 50-74
	Mammography Screening: Medicare Population
	Melanoma Incidence Rate
	Non-Hodgkin Lymphoma Incidence Rate
	Oral Cavity and Pharynx Cancer Incidence Rate
	Pancreatic Cancer Incidence Rate
	Pap Test in Past 3 Years: 21-65
	Prostate Cancer Incidence Rate
Health / County Health Rankings	Clinical Care Ranking
	Health Behaviors Ranking
	Morbidity Ranking
	Mortality Ranking
	Physical Environment Ranking
	Social and Economic Factors Ranking
Health / Diabetes	Adults 20+ with Diabetes
	Adults with Prediabetes
	Age-Adjusted Death Rate due to Diabetes
	Diabetes: Medicare Population
	Diabetic Monitoring: Medicare Population
Health / Disabilities	Persons with a Cognitive Difficulty
	Persons with a Disability
	Persons with a Disability (5-year)
	Persons with a Hearing Difficulty
	Persons with a Self-Care Difficulty
	Persons with a Vision Difficulty
	Persons with an Ambulatory Difficulty
	Persons with Disability Living in Poverty
	Persons with Disability Living in Poverty (5-year)
Health / Environmental & Occupational Health	Blood Lead Levels in Children (>5 micrograms per deciliter)
Health / Exercise, Nutrition, & Weight	Adults 20+ who are Obese
	Adults 20+ who are Sedentary
	Adults Engaging in Regular Physical Activity

PRIMARY TOPIC	INDICATOR
	Child Food Insecurity Rate
	Food Insecure Children Likely Inelgible for Assistance
	Food Insecurity Rate
Health / Family Planning	Teen Birth Rate: 15-17
Health / Heart Disease & Stroke	Adults who Experienced a Heart Attack
	Adults who Experience a Stroke
	Adults who Experienced Coronary Heart Disease
	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
	Atrial Fibrillation: Medicare Population
	Heart Failure: Medicare Population
	High Blood Pressure Prevalence
	Hyperlipidemia: Medicare Population
	Hypertension: Medicare Population
	Ischemic Heart Disease: Medicare Population
	Stroke: Medicare Population
Health / Immunizations & Infectious Diseases	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
	Chlamydia Cases
	First Grade Students with Required Immunizations
	Gonorrhea Cases
	HIV/AIDS Prevalence Rate
	Kindergartners with Required Immunizations
	Lyme Disease Cases
	Pre-Kindergarten Students with Required Immunizations
	School-Aged Children that are Unvaccinated Due to Religious Exemption
	Sixth Grade Students with Required Immunizations
	Syphilis Cases
	Transfer Children with Required Immunizations
	Tuberculosis Incidence Rate
Health / Maternal, Fetal & Infant Health	Babies with Low Birth Weight
	Babies with Very Low Birth Weight
	Infant Mortality Rate
	Mothers who Received Early Prenatal Care
	Mothers who Received No Prenatal Care
	Preterm Births
	Very Preterm Births
Health / Mental Health & Mental Disorders	Adults Ever Diagnosed with Depression

PRIMARY TOPIC	INDICATOR
	Age-Adjusted Death Rate due to Suicide
	Depression: Medicare Population
	Frequent Mental Distress
	Inadequate Social Support
	Mental Health Provider Rate
	Poor Mental Health: Average Number of Days
Health / Mortality Data	Age-Adjusted Death Rate
Health / Older Adults & Aging	Adults 65+ with a Disability
	Adults 65+ with a Hearing Difficulty
	Adults 65+ with a Self-Care Difficulty
	Adults 65+ with a Vision Difficulty
	Adults 65+ with an Independent Living Difficulty
	Adults 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
Health / Oral Health	Dentist Rate
Health / Other Chronic Diseases	Age Adjusted Death Rate due to Chronic Kidney Disease
	Chronic Kidney Disease: Medicare Population
	Osteoporosis: Medicare Population
	Rheumatoid Arthritis or Osteoarthritis: Medicare Population
Health / Prevention & Safety	Age-Adjusted Death Rate due to Unintentional Injuries
	Age-Adjusted Death Rate due to Unintentional Poisonings
Health / Respiratory Diseases	Adults with Current Asthma
	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases
	Age-Adjusted Rate of Adult ED Visits for COPD
	Asthma: Medicare Population
	COPD: Medicare Population
Health / Substance Abuse	Adults who Binge Drink
	Adults who Currently Use Smokeless Tobacco
	Adults who Drink Excessively
	Adults who Smoke
	Adults who Use Alcohol: Past 30 days
	Adults who Have Smoked More Than 100 Cigarettes in Lifetime
	Age-Adjusted Rate of Substance Use Emergency Department Visits
	Death Rate due to Drug Poisoning
	Opioid Treatment Admission Rate
Health / Wellness & Lifestyle	Frequent Physical Distress
	Insufficient Sleep
	Life Expectancy
	Limited Activity due to a Health Problem
	Poor Physical Health: Average Number of Days
	Self-Reported General Health Assessment: Poor or Fair

PRIMARY TOPIC	INDICATOR
Public Safety / Crime & Crime Prevention	Violent Crime Rate
Public Safety / Transportation Safety	Age-Adjusted Death Rate due to Motor Vehicle Collisions
	Alcohol-Impaired Driving Deaths
Social Environment	Households with an Internet Subscription
	Households with One or More Types of Computing Devices
Social Environment / Children's Social Environment	Substantiated Child Abuse Rate
Social Environment / Demographics	Within County Disparity in Life Expectancy at Birth
Social Environment / Family Structure	Single-Parent Households
Social Environment / Neighborhood/Community Attachment	Linguistic Isolation
	People 65+ Living Alone
	Social Associations
Social Environment / Social & Civic Involvement	Civic Engagement Ranking
Transportation / Commute to Work	Mean Travel Time to Work
	Solo Drivers with a Long Commute
	Workers Commuting by Public Transportation
	Workers who Drive Alone to Work

APPENDIX D: KEY INFORMANT SURVEY TOOL

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

Chilton Medical Center (CMC) 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 CMC to take an in-depth look at its community and the findings will be utilized to prioritize public health issues and develop a community health implementation plan focused on meeting community needs.

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

- ☐ Access to Care/Uninsured
- ☐ Cancer
- ☐ Dental Health
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Maternal/Infant Health
- ☐ Mental Health/Suicide
- ☐ Overweight/Obesity
- ☐ Sexually Transmitted Diseases
- ☐ Stroke
- ☐ Substance Abuse/Alcohol Abuse
- ☐ Tobacco
- ☐ Domestic Violence
- ☐ Other (specify):

2. Of those health issues 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:

_____
_____
_____
_____
_____
_____
_____
_____

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

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

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

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

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

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

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

_____
_____
_____
_____
_____
_____
_____
_____

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

- YES, (*proceed to Question 9*)
- NO, (*proceed to Question 11*)

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

- ☐ Uninsured/Underinsured
- ☐ Low-income/Poor
- ☐ Hispanic/Latino
- ☐ Black/African-American
- ☐ Immigrant/Refugee
- ☐ Disabled
- ☐ Children/Youth
- ☐ Young Adults
- ☐ Seniors/Aging/Elderly
- ☐ Homeless
- ☐ LGBTQ+
- ☐ Other (please specify)

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

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)

- ☐ Doctor's Office
- ☐ Health Clinic/FQHC
- ☐ Hospital Emergency Department
- ☐ Walk-in/Urgent Care Center
- ☐ Don't Know
- ☐ Other (please specify)

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

_____
_____
_____
_____
_____
_____

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?

_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

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)

- ☐ Health Care/Public Health Organization
- ☐ Mental/Behavioral Health Organization
- ☐ Non-Profit/Social Services/Aging Services
- ☐ Faith-Based/Cultural Organization
- ☐ Education/Youth Services
- ☐ Government/Housing/Transportation Sector
- ☐ Business Sector
- ☐ Community Member
- ☐ Other (please specify)

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

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian/Pacific Islander
- ☐ Seniors
- ☐ Active Adults
- ☐ Poor or Underserved
- ☐ LGBTQ+
- ☐ Hispanic/Latino
- ☐ Other (please specify)

20. Chilton 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:

_____
_____
_____
_____

APPENDIX E: KEY INFORMANT SURVEY PARTICIPANTS

Chilton 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 CMC solicited responses to a stakeholder survey.

Organization	Organization
Atlantic Ambulance	Girl Scouts of Northern NJ
Atlantic Health System	Grace United Presbyterian Church of Wayne
Atlantic Health System Behavioral Health	Greenwood Baptist Church
Atlantic Health System, New Vitality Program	Highlands Family Success Center
Boonton United Methodist Church	Holy Faith Lutheran Church
Borough of Bloomingdale	Lincoln Park Public Schools
Borough of Bloomingdale Health Department	Mental Health Association In Passaic County
Borough of Bloomingdale Police Department	Montville Township Health Department
Borough of Butler Police Department	Montville United Methodist Church
Borough of Lincoln Park	Morris County Division of Senior Services
Borough of Lincoln Park Fire Department	Morris County Prevention is Key
Borough of Lincoln Park Health Department	Newbridge Services
Borough of Lincoln Park Municipal Alliance	Our Saviour Lutheran Church
Borough of Lincoln Park Police Department	Passaic County Division of Senior Services
Borough of Pompton Lakes	Passaic County Health Department
Borough of Pompton Lakes Health Department	Pequannock Township
Borough of Pompton Lakes Police Department	Pequannock Township Fire Department
Borough of Ringwood	Pequannock Township Health Department
Borough of Ringwood Health Department	Pequannock Township Police Department
Borough of Ringwood Police Department	Pequannock Township School District
Borough of Riverdale	Pequannock Twp Coalition
Borough of Riverdale Health Department	Pompton Lakes Coalition
Borough of Riverdale Police Department	Pompton Lakes School District
Borough of Wanaque	Ponds Reformed Church
Borough of Wanaque	Ringwood School District
Borough of Wanaque Police Department	Riverdale Public Schools
Borough of Wanaque Health Department	Rutgers Cooperative Extension - Passaic County
Boys & Girls Clubs of Northwest NJ	Shomrei Torah Wayne Conservative Congregation
Butler Borough	ShopRite of Lincoln Park
Butler Borough Health Department	ShopRite of Little Falls
Butler Municial Alliance	ShopRite of Oakland
Butler Public Schools	ShopRite of Wayne
Caring People Home Health Agency	ShopRite of West Milford
Cedar Crest Senior Living Community	St. Anthony's Church of Butler
Center for Family Resources	St. Catherine's Church of Bologna

Organization	Organization
Chilton Medical Center	St. David's Episcopal Church Kinnelon
Chilton Medical Center Administration	St. Mary's Church Pompton Lakes
Chilton Medical Center Clergy Council	St. Simon The Apostle Church
Chilton Medical Center Community Advisory Board (CAB)	United for Prevention is Passaic County
Chilton Medical Center Community Health Advisory Committee (CHAC)	Wanaque School District
Chilton Medical Center Dental Staff	Wayne Alliance for the Prevention of Substance Abuse
Chilton Medical Center Diabetes Center	Wayne Counseling Center
Chilton Medical Center Foundation	Wayne Police Athletic League (PAL)
Chilton Medical Center, Cardiology	Wayne Township
Chilton Medical Center, Community Health Program	Wayne Township Fire Department
Chilton Medical Center, Emergency Services	Wayne Township Police Department
Chilton Medical Center, Nursing Education	Wayne Township Public Schools
Chilton Medical Center, Oncology Services	Wayne YMCA
Community Partners for Hope	West Milford Township
Echo Lake Baptist Church	West Milford Township Police Department
First Reformed Church of Pompton Plains	West Milford Twp School District
Garden State Equality	William Paterson University Department of Public Health

APPENDIX F: PRIORITIZATION PARTICIPANTS

Chilton 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 included in the prioritization survey.

Organization
Atlantic Ambulance
Atlantic Health System – Chilton Medical Center
Atlantic Health System Planning & System Development
Borough of Bloomingdale Health Department
Borough of Butler Police Department
Borough of Lincoln Park Health Department
Borough of Pompton Lakes Health Department
Borough of Ringwood Health Department
Borough of Riverdale
Borough of Riverdale Health Department
Borough of Wanaque
Borough of Wanaque Health Department
Boys & Girls Clubs of Northwest NJ
Chilton Medical Center Administration
Chilton Medical Center Clergy Council
Chilton Medical Center Community Advisory Board (CAB)
Chilton Medical Center Community Health Advisory Committee (CHAC)
Chilton Medical Center Foundation
Chilton Medical Center, Community Health Program
First Reformed Church of Pompton Plains
Montville Township Health Department
Newbridge Services
Passaic County Division of Senior Services
Pequannock Township Health Department
President Chilton Medical Center Medical/Dental Staff
Wayne Counseling Center
Wayne Public Health Department
Wayne Township
Wayne YMCA

APPENDIX G: PASSAIC COUNTY LICENSED HEALTH FACILITIES[37]

Facility	Type/Services
Clifton Family Practice 1135 BROAD STREET CLIFTON, NJ 07013 (973)-754-4100	Hospital-based, Off-site Ambulatory Care Facility
St Joseph's Ambulatory Imaging Center at Clifton 1135 BROAD STREET CLIFTON, NJ 07013 (973)-569-6300	Hospital-based, Off-site Ambulatory Care Facility
Csh Outpatient Center at Clifton 1135 BROAD STREET CLIFTON, NJ 07013 (732)-258-7050	Hospital-based, Off-site Ambulatory Care Facility
NJIN of Clifton 1339 BROAD STREET CLIFTON, NJ 07013 (973)-778-9600	Ambulatory Care Facility
Clifton Surgery Center 1117 ROUTE 46 EAST, SUITE 303 CLIFTON, NJ 07013 (973)-779-7210	Ambulatory Care Facility
Physicians Dialysis Passaic 10 CLIFTON BLVD, SUITE 1 CLIFTON, NJ 07011 (973)-594-9100	Ambulatory Care Facility
Lifecare Diagnostic Imaging, Inc. 1117 ROUTE 46 EAST CLIFTON, NJ 07013 (973)-470-2533	Ambulatory Care Facility
Compassionate Care Hospice 1373 BROAD STREET, SUITE 306 CLIFTON, NJ 07013 (973)-916-1400	Hospice
ENDO-SURGICAL CENTER OF NORTH JERSEY 999 CLIFTON AVENUE CLIFTON, NJ 07013 (973)-777-3938	Ambulatory Care Facility
Medical Imaging Center of North Jersey, Inc. 1111 PAULISON AVENUE CLIFTON, NJ 07015 (973)-253-2900	Ambulatory Care Facility
Main Avenue Clifton Surgery Center 1084 MAIN AVENUE, SECOND FLOOR CLIFTON, NJ 07011 (973)-473-4040	Ambulatory Care Facility
Millennium Healthcare of Clifton, LLC 925 CLIFTON AVENUE, SUITE 201 CLIFTON, NJ 07013 (973)-249-7700	Ambulatory Care Facility
Clifton Dialysis Center, L.L.C. 251 CLIFTON AVENUE, UNIT A CLIFTON, NJ 07011 (973)-546-3750	Ambulatory Care Facility

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

Facility	Type/Services
Clifton MRI, LLC 750 CLIFTON AVENUE CLIFTON, NJ 07013 (973)-852-3690	Ambulatory Care Facility
Patient Care New Jersey 4 BRIGHTON ROAD, SUITE 403 CLIFTON, NJ 07012 (973)-365-5200	Home Health Agency
Premier Endoscopy 164 BRIGHTON ROAD CLIFTON, NJ 07013 (973)-859-3700	Ambulatory Care Facility
Advanced Surgery Center of Clifton, LLC 1200 ROUTE 46 WEST CLIFTON, NJ 07013 (973)-773-5600	Ambulatory Care Facility
Same Day Procedures, L.L.C. 1060 CLIFTON AVENUE, 2ND FLOOR CLIFTON, NJ 07013 (973)-773-0101	Ambulatory Care Facility
Affiliated Endoscopy Services of Clifton 925 CLIFTON AVENUE, SUITE 100 Clifton, New Jersey 07013 (973)- 798-6900	Surgical Practice
North Jersey Vascular Center, L.L.C. 1429 BROAD STREET Clifton, New Jersey 07013 (973)- 532-7899	Surgical Practice
Valley Hospital Community Care 1114 GOFFLE ROAD HAWTHORNE, NJ 07506 (973)-427-7676	Hospital-based, Off-site Ambulatory Care Facility
Center for Special Surgery at Hawthorne 104 LINCOLN AVENUE HAWTHORNE, NJ 07506 (973)-427-6800	Ambulatory Care Facility
North Haledon Dialysis 953 BELMONT AVENUE NORTH HALEDON, NJ 07508 (973)-427-4675	Ambulatory Care Facility
St Mary's General Hospital 350 BOULEVARD PASSAIC, NJ 07055 (973)-365-4300	General Acute Care Hospital
Garden State Open MRI 831 MAIN AVENUE PASSAIC, NJ 07055 (973)-614-9400	Ambulatory Care Facility
North Hudson Community Action Corp 220 PASSAIC STREET PASSAIC, NJ 07055 (201)-917-2715	Ambulatory Care Facility
Passaic Medical and Wellness 916-922 MAIN AVENUE, SUITE 2-B PASSAIC, NJ 07055 (732)-429-7165	Ambulatory Care Facility
St Joseph's Depaul Ambulatory Care Center	Hospital-based, Off-site Ambulatory Care Facility

Facility	Type/Services
11 GETTY AVENUE, BUILDING #275 PATERSON, NJ 07503 (973)-754-2299	
St Joseph's University Medical Center 703 MAIN ST PATERSON, NJ 07503 (973)-754-2010	General Acute Care Hospital
Eva's Village, Inc 20 JACKSON STREET PATERSON, NJ 07501 (973)-523-6220	Ambulatory Care Facility
Sall/Myers Medical Associates, P.A. 100 HAMILTON PLAZA, 3RD FLOOR PATERSON, NJ 07505 (973)-279-2323	Ambulatory Care Facility
Planned Parenthood of Metropolitan New Jersey 680 BROADWAY PATERSON, NJ 07514 (973)-345-3883	Ambulatory Care Facility- Satellite
New Jersey MRI Systems 583 BROADWAY PATERSON, NJ 07514 (973)-357-9900	Ambulatory Care Facility
Paterson Community Health Dental Van 32 CLINTON STREET PATERSON, NJ 07522 (973)-790-6594	Ambulatory Care Facility- Satellite
Barnett Surgical Center, LLC 680 BROADWAY, SUITE 202 PATERSON, NJ 07514 (973)-782-4118	Ambulatory Care Facility
New Horizon Surgical Center, LLC 680 BROADWAY, SUITE 201 PATERSON, NJ 07514 (973)-782-4202	Ambulatory Care Facility
Accelerated Surgical Center of North Jersey LLC 680 BROADWAY, SUITE 203 PATERSON, NJ 07514 (973)-225-0732	Ambulatory Care Facility
ST JOSEPH'S SJRMC DIALYSIS 703 MAIN ST PATERSON, NJ 07503 (973)-754-3570	Ambulatory Care Facility
St Joseph's Paterson Dialysis 11 GETTY AVENUE, BUILDING 275 PATERSON, NJ 07503 (973)-684-3490	Ambulatory Care Facility
ARA Great Falls Dialysis 498 E 30TH STREET PATERSON, NJ 07504 (973)-569-0500	Ambulatory Care Facility
East Paterson Dialysis 680 BROADWAY, SUITE 103 PATERSON, NJ 07514 (973)-357-8079	Ambulatory Care Facility
Hospice Agency of NJ, Inc. 175 MARKET STREET, SUITE 202	Hospice

Facility	Type/Services
PATERSON, NJ 07505 (973)-977-2223	
Paterson Community Health Center Inc 32 CLINTON STREET PATERSON, NJ 07522 (973)-790-6594	Ambulatory Care Facility
Paterson Community Health Center 227 BROADWAY PATERSON, NJ 07501 (973)-278-2600	Ambulatory Care Facility- Satellite
Planned Parenthood of Metropolitan New Jersey 750 HAMBURG TURNPIKE POMPTON LAKES, NJ 07442 (973)-622-3900	Ambulatory Care Facility- Satellite
Ambulatory Surgical Center of Pompton Lakes, LLC 111 WANAQUE AVENUE Pompton Lakes, New Jersey 07442 (973)- 467-2700	Surgical Practice
VHS Hospice Services of New Jersey 783 RIVERVIEW DRIVE TOTOWA, NJ 07512 (973)-256-4636	Hospice
Visiting Health Services of New Jersey 783 RIVERVIEW DRIVE, SECOND FLOOR TOTOWA, NJ 07511 (973)-256-4636	Home Health Agency
St Joseph's Wayne Medical Center 224 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-942-6900	General Acute Care Hospital
University Imaging 246 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-595-1300	Hospital-based, Off-site Ambulatory Care Facility
St Joseph's Cardiovascular Center Wayne 246 HAMBURG TURNPIKE, SUITE 201 WAYNE, NJ 07470 (973)-942-1141	Hospital-based, Off-site Ambulatory Care Facility
Chilton Health Network at Pike Drive 1 PIKE DRIVE WAYNE, NJ 07470 (973)-831-5080	Hospital-based, Off-Site Ambulatory Care Facility
234 Building 234 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-754-2002	Hospital-based, Off-site, Ambulatory Care Facility
St Joseph's Wayne Dialysis 57 WILLOWBROOK BOULEVARD WAYNE, NJ 07470 (973)-890-2792	Ambulatory Care Facility
Medical Park Imaging, P.A. 330 RATZER ROAD WAYNE, NJ 07470 (973)-696-5770	Ambulatory Care Facility
North Jersey Therapy Center/North Jersey Diagnostics Center, LLC 500 VALLEY ROAD, SUITE 101	Ambulatory Care Facility

Facility	Type/Services
WAYNE, NJ 07470 (973)-595-7500	
Wayne Surgical Center 1176 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-709-1900	Ambulatory Care Facility
Kindred Hospital NJ-Wayne 224 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-636-7256	Special Hospital
Denville Diagnostic Imaging and Open MRI, L.L.C. 601 HAMBURG TURNPIKE SUITE 201 WAYNE, NJ 07470 (973)-238-0700	Ambulatory Care Facility
ENT and Allergy Associates, L.L.P. 1211 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-633-0808	Ambulatory Care Facility
Surgicare Surgical Associates of Wayne LLC 246 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-790-0954	Ambulatory Care Facility
Imaging Sub-Specialists of North Jersey, LLC 504 VALLEY ROAD WAYNE, NJ 07470 (973)-317-5780	Ambulatory Care Facility
Hudson River Radiology 516 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-720-0050	Ambulatory Care Facility
Wayne Cancer Center 234 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-310-0300	Ambulatory Care Facility
Brookside Urgent Care & Walk-In Medical Center 705 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-922-1000	Ambulatory Care Facility
Vitas Healthcare Wayne In-Patient Hospice Unit 220 HAMBURG TURNPIKE, SUITE #24 WAYNE, NJ 07470 (973)-994-4738	Hospice
NORTH JERSEY GASTROENTEROLOGY & ENDOSCOPY CENTER PA 1825 ROUTE 23 SOUTH WAYNE, NJ 07470 (973)-633-1484	Ambulatory Care Facility
Elite Surgical Center LLC 307 HAMBURG TURNPIKE WAYNE, NJ 07470 (973)-790-7700	Ambulatory Care Facility
Gastroenterology Diagnostics of Northern NJ, PA 205 BROWERTOWN ROAD - SUITE 102 WEST PATERSON, NJ 07424 (973)-890-4780	Ambulatory Care Facility
St Joseph's Cardiovascular Center Woodland Park 999 MC BRIDE AVENUE WOODLAND PARK, NJ 07424	Hospital-based, Off-site Ambulatory Care Facility

Facility	Type/Services
(973)-256-5667	
Woodland Park Dialysis Center, L.L.C. 1225 MCBRIDE AVENUE WOODLAND PARK, NJ 07424 (973)-890-2394	Ambulatory Care Facility
McBride Surgical Center LLC 1167 MCBRIDE AVENUE, SUITE 4 WOODLAND PARK, NJ 07424 (973)-837-6150	Ambulatory Care Facility
Azura Surgery Center Woodland Park 1225 MCBRIDE AVENUE, SUITE 117 WOODLAND PARK, NJ 07424 (973)-837-1018	Ambulatory Care Facility
Ganchi Plastic Surgery Center, LLC 246 HAMBURG TURNPIKE, SUITE 307 Wayne, New Jersey 07470 (973)-942-6600	Surgical Practice
2nd Home Passaic, LLC 63 Grove Street Passaic, NJ07055 (973)-779-4228	Adult Day Health Care Services
Buckingham Adult Medical Day Care Center, LLC 316 North 6th Street Prospect Park, NJ07508 (973)-904-3870	Adult Day Health Care Services
The Care Factory Inc 397 Haledon Avenue, Suite 202 Haledon, NJ07508 (862)-257-3323	Adult Day Health Care Services
Complete Care at Hamilton, LLC 56 Hamilton Avenue Passaic, NJ07055 (973)-773-7070	Long Term Care Facility
Doctors Subacute Healthcare, LLC 59 Birch Street Paterson, NJ07522 (973)-942-8899	Long Term Care Facility
The New Caring of Prospect Park LLC 262 N. 10th Street Prospect Park, NJ07508 (973)-904-9042	Adult Day Health Care Services
The Wanaque Center for Nursing & Rehabilitation 1433 Ringwood Ave Haskell, NJ07420 (973)-839-2119	Long Term Care Facility
2nd Home Adult Medical Day Care 100 Hamilton Plaza Ground Floor Paterson, NJ07505 (973)-523-3179	Adult Day Health Care Services
2nd Home Totowa 120 Commerce Way Totowa, NJ07512 (973)-890-5888	Adult Day Health Care Services
A Plus Adult Medical Day Care 575 East 18th Street Paterson, NJ07514 (973)-977-9100	Adult Day Health Care Services

Facility	Type/Services
Arden Courts of Wayne 800 Hamburg Turnpike Wayne, NJ07470 (973)-942-5600	Assisted Living Residence
Atrium Post-Acute Care of Wayne 1120 Alps Road Wayne, NJ07470 (973)-694-2100	Long Term Care Facility
Atrium Post-Acute Care of Wayne View 2020 Route 23 North Wayne, NJ07470 (973)-305-8400	Long Term Care Facility
Brookdale Wayne 820 Hamburg Turnpike Wayne, NJ07470 (973)-942-4800	Assisted Living Residence
Care One at Wayne 493 Black Oak Ridge Road Wayne, NJ07470 (973)-692-9500	Assisted Living Residence Long Term Care Facility
The Chelsea at Bald Eagle 197 Cahill Cross Road West Milford, NJ07480 (973)-728-6000	Assisted Living Residence
Chestnut Hill Convalescent Center 360 Chestnut Street Passaic, NJ07055 (973)-777-7800	Long Term Care Facility
Chestnut Hill Residence 338 Chestnut Street Passaic, NJ07055 (973)-777-7800	Assisted Living Residence
Christian Health Care Adult Day Services 2000 Siena Village Wayne, NJ07470 (973)-305-9155	Adult Day Health Care Services
COMPLETE CARE AT PASSAIC LLC 77 East 43rd Street Paterson, NJ07514 (973)-754-6700	Long Term Care Facility
Daughters of Miriam Center 155 Hazel Street Clifton, NJ07011 (973)-772-3700	Long Term Care Facility
Diamond Years Adult Medical Day Care Center, LLC 360 West Clinton Street Haledon, NJ07508 (973)-942-4111	Adult Day Health Care Services
Golden Years Adult Day Care Center 1225 Mcbride Avenue Woodland Park, NJ07424 (973)-782-4112	Adult Day Health Care Services
Happy Home Adult Day Care 680 Broadway, Suite 601 Paterson, NJ07514 (862)-336-1701	Adult Day Health Care Services
The Health Center at Bloomingdale	Long Term Care Facility

Facility	Type/Services
255 Union Ave Bloomingdale, NJ07403 (973)-283-1700	
Holland Christian Home 151 Graham Avenue North Haledon, NJ07508 (973)-427-4087	Long Term Care Facility Residential Health Care
Lakeland Health Care Center 25 Fifth Avenue Haskell, NJ07420 (973)-839-6000	Long Term Care Facility
Lakeview Rehabilitation and Care Center 130 Terhune Drive Wayne, NJ07470 (973)-839-4500	Long Term Care Facility
Llanfair House Care & Rehabilitation Center 1140 Black Oak Ridge Road Wayne, NJ07470 (973)-835-7443	Long Term Care Facility
Mi Casa Es Su Casa Inc 911 E 23rd St Paterson, NJ07543 (973)-345-4300	Adult Day Health Care Services
Milford Manor 69 Maple Road West Milford, NJ07480 (973)-697-5640	Long Term Care Facility
Oak Ridge Rehabilitation & Nursing Center 261 Terhune Drive Wayne, NJ07470 (973)-835-3871	Long Term Care Facility
Preakness Healthcare Center 305 Oldham Road Wayne, NJ07470 (973)-585-2132	Long Term Care Facility
Regency Gardens Nursing Center 296 Hamburg Turnpike Wayne, NJ07470 (973)-790-5800	Long Term Care Facility
St. Joseph's Home for Elderly 140 Shepherd Lane Totowa, NJ07512 (973)-942-0300	Long Term Care Facility Residential Health Care
Straight and Narrow Medical Day Care 182 First Street, 1st Floor Passaic, NJ07055 (973)-405-6675	Adult Day Health Care Services
Sunrise Assisted Living of Wayne 184 Berdan Avenue Wayne, NJ07470 (973)-628-4900	Assisted Living Residence
Sweet Home Adult Medical Day Care 45 E Madison Avenue Clifton, NJ07011 (973)-478-4200	Adult Day Health Care Services
Van Dyk's Senior Residence of Hawthorne 644 Goffle Road	Assisted Living Residence

Facility	Type/Services
Hawthorne, NJ07506 (973)-636-7000	
Xanadu Adult Medical Day Care Center 615 Main Street Passaic, NJ07055 (973)-365-0079	Adult Day Health Care Services

PREPARED FOR

CHILTON MEDICAL CENTER

BY

ATLANTIC HEALTH SYSTEM
PLANNING & SYSTEM DEVELOPMENT

Atlantic Health System

Chilton Medical Center