

Jersey City Medical Center/ Hudson County Community Health Needs Assessment

November
2022

PREPARED BY
HEALTH RESOURCES IN ACTION

Acknowledgements

The following partners led the RWJBarnabas Health (RWJBH) Jersey City Medical Center/Hudson County Community Health Needs Assessment (CHNA):

Jersey City Medical Center Executive Team

- Michael Prilutsky, Executive Vice President, RWJBarnabas Health; President, Northeast Region, Interim President, Medical Group; and President & CEO, Jersey City Medical Center
- Schubert Perotte, MD, Interim Chief Medical Officer, Chairman & Medical Director Emergency Department
- Douglas Zehner, Regional Chief Financial Officer
- Carla Parker-Hollis, MHA, Chief Operating Officer
- Carlos Lejnieks, Chair of the Board of Trustees
- Mary Cataudella, FACHE, Chief Human Resources Officer
- Robert Winston, MBA, LCSW, FACHE, Vice President of Operations
- Joanne Reich, DNP, RN, NEA-BC, CPHQ, Vice President of Safety, Quality & Regulatory Affairs
- Margaret Ames, DNP, MPA, RN, NEA-BC, CNO, Senior Vice President of Patient Care Services
- Nicole Kagan, Vice President of the Jersey City Medical Center Foundation

Jersey City Medical Center/Hudson County Community Health Needs Assessment Advisory Committee

The Jersey City Medical Center/Hudson County Community Health Needs Assessment was developed with the guidance of numerous partners that provided oversight and input throughout the process as part of an Advisory Committee, facilitated by Kwaku Gyekye, Director, Population Health/Medicine. Many of those individuals are also members of the JCMC Community Outreach & Social Impact Steering Committee, which also provided substantive guidance and support. The full list of Advisory Committee members can be found in Appendix A.

RWJBarnabas Health Community Health Needs Assessment Steering Committee

Committee Members

- Tamara Cunningham, Vice President of System Development/Planning, Co-Chair
- Cathy Dowdy, Senior Vice President and Comptroller, Co-Chair
- Andy Anderson, MD, President, RWJBH Medical Group
- Barbara Mintz, MS, RDN, Senior Vice President of Social Impact and Community Investment
- DeAnna L. Minus-Vincent, MPA, Executive Vice President, Chief Social Justice & Accountability Officer
- Deborah Larkin-Carney, RN, BSN, MBA, Senior Vice President of Quality and Patient Safety and Patient Experience
- Frank A. Ghinassi, PhD, ABPP, Senior Vice President of Behavioral Health
- Indu Lew, Executive Vice President, Chief of Staff
- Joseph Jaeger, DrPH, GME/Physician Education
- Jim Andrews, Senior Vice President of Cardiac & Neurological Services
- Lina Shihabuddin, MD, Chief Population Health Officer
- Mary O'Dowd, MPH, Executive Director of Health Systems and Population Health Integration, Rutgers Biomedical and Health Science
- Patrick Knaus, Executive Vice President, System Strategy
- Perry Halkitis, PhD, MS, MPH, Dean, School of Public Health, Rutgers University

- Rich Henwood, Vice President, Corporate Reimbursement
- Susan Solometo, MBA, Senior Vice President, Strategy and Operations, Oncology Services
- Suzanne Sernal, DNP, APN-BC, RNC-OB, Vice President of Women’s Services
- Trina Parks, MHA, FACHE, Executive Vice President, Chief Corporate Diversity and Inclusion Officer

Facility Representation in the 2021 RWJBH System-wide Steering Committee

- Barnabas Health Behavioral Health Center (BHBHC) – Shari Beirne, Vice President of Marketing and Patient Satisfaction
- Community Medical Center (CMC) – Brian Case, Assistant Vice President of Business Development
- Clara Maass Medical Center (CMMC) – Dr. Frank Dos Santos, Chief Medical Officer
- Children’s Specialized Hospital (CSH) – Megan Granozio, Director of Marketing
- Jersey City Medical Center (JCMC) – Dr. Surendra Khera, MD, MSC, Chair of Medicine and Chief Population Health Officer
- Monmouth Medical Center (MMC) – Jean McKinney, Regional Director, Community Health and Social Impact & Community Investment
- Monmouth Medical Center, Southern Campus (MMCSC) – Judy Colorado, Chief Nursing Officer and Vice President of Patient Care Services
- Newark Beth Israel Medical Center (NBIMC) – Atiya Rashidi, Chief Equity Officer and Vice President of Community Relations
- Robert Wood Johnson University Hospital (RWJUH) Hamilton – Diane Grillo, Vice President, Health Promotion
- Robert Wood Johnson University Hospital (RWJUH) New Brunswick – Mariam Merced, Director, Community Health Promotions
- Robert Wood Johnson University Hospital (RWJUH) Rahway – Donna Mancuso, Manager, Public & Community Affairs
- Robert Wood Johnson University Hospital (RWJUH) – Serena Collado, Director, Community Health
- Cooperman Barnabas Medical Center (CBMC) – Margie Heller, Senior Vice President of Community Health and Global Strategic Partnerships

Technical Advisers:

Health Resources in Action, Community Health Needs Assessment and Planning Consultant
 Bruno and Ridgeway, Inc., Community Survey Consultant

Questions regarding the RWJBH Community Health Needs Assessments should be directed to RWJBarnabas Health System Development/Planning at BHPLanningDept@RWJBH.org.

Contents

- Executive Summary i
- Introduction 1
 - Community Health Needs Assessment Purpose and Goals 1
 - Area of Focus 1
 - Context for the Community Health Needs Assessment 2
 - COVID-19 Pandemic..... 2
 - National Movement for Racial Justice 3
- Methods..... 3
 - Social Determinants of Health Framework 3
 - Upstream Approaches to Health 3
 - Health Equity Lens 4
 - Approach and Community Engagement Process 4
 - RWJBH System Engagement..... 4
 - CHNA Advisory Committee Engagement 5
 - Community Engagement 5
 - Secondary Data: Review of Existing Secondary Data, Reports, and Analyses..... 5
 - Primary Data Collection 6
 - Qualitative Discussion: Key Informant Interviews and Focus Groups..... 6
 - Community Survey..... 7
 - Data Limitations..... 8
- Population Characteristics..... 9
 - Population Overview 9
 - Racial, Ethnic, and Language Diversity 11
 - Racial and Ethnic Composition 11
 - Foreign-Born Population 12
 - Language Diversity..... 14
 - U.S. Veterans 17
- Community Social and Economic Environment..... 20
 - Community Strengths and Assets..... 20
 - Strong Community and Partnerships 20
 - Public Services and Programs 21
 - Other Community Assets..... 22
 - Education 25
 - School Environment and Health 25
 - Public Schooling 25
 - Promising Initiatives 27
 - Inequality 27
 - Employment and Workforce 29
 - Income and Financial Security 33
 - Household Income and Poverty 33
 - Income and Public Assistance..... 37
 - Food Access and Food Security 39
 - Housing 43
 - Housing Landscape 43
 - Housing Instability and Homelessness 43
 - Housing and Technology Infrastructure 47

Transportation	49
Transportation Infrastructure.....	49
Transportation Partnerships.....	49
Green Space and Built Environment.....	52
Flooding and Emergency Preparedness	52
Parks and Green Areas.....	53
Violence Prevention and Safety.....	54
Gun Injury and Violent Crime	56
Hate Crimes and Anger.....	57
Violence Interruption Programs	58
Systemic Racism and Discrimination	58
Systemic Discrimination Based on Legal Status	59
Systemic Discrimination Based on Gender and Sexual Orientation.....	59
Addressing the Systems of Oppression	60
Community Health Issues	61
Community Perceptions of Health	61
Leading Causes of Death and Premature Mortality	63
Obesity, Healthy Eating, and Physical Activity.....	65
Overweight and Obesity	65
Physical Activity	67
Healthy Eating.....	69
Chronic Conditions.....	70
High Cholesterol and High Blood Pressure	70
Heart Disease.....	71
Diabetes.....	73
Cancer.....	74
Chronic Obstructive Pulmonary Disease (COPD).....	82
Disability	82
Behavioral Health: Mental Health and Substance Use.....	84
Mental Health.....	84
Substance Use.....	90
Environmental Health	95
Asthma	95
Air Quality	97
Lead.....	99
Infectious and Communicable Diseases	100
COVID-19	100
Sexual and Reproductive Health and Sexually Transmitted Infections.....	103
Maternal and Infant Health	105
Prenatal Care	106
Perinatal Outcomes: Low and Very Low Birthweight and Preterm Births	106
Maternal and Infant Mortality.....	108
Teen Pregnancy	109
Access to Services	110
Access and Utilization of Preventive Services, Including Immunizations.....	110
Barriers to Accessing Healthcare Services.....	113
Language and Cultural Factors Related to Healthcare Access	118
Community-Based Organizations and Coalitions	119

Community Vision and Suggestions for the Future	120
Expanding and Strengthening Behavioral Health and Overall Healthcare Services.....	120
Health as Human Right: “It is urgent to have access to free, quality health care”	120
Greater Accessibility and Availability of Behavioral Health Services	120
Focusing on the Upstream Factors and the Social Determinants of Health	121
Inequality	121
Economic and Employment Opportunities	121
Built Environment	121
Housing	122
Greater Engagement and Access to Existing Initiatives	122
Access to Services and Community Outreach	122
Partnerships, Community Engagement, and Community Building	122
Key Themes and Conclusions.....	123
Prioritization Process and Priorities Selected for Planning	124
APPENDICES	127
Appendix A- RWJBH Jersey City/Hudson County CHNA Advisory Committee Members	127
Appendix B- Organizations Represented in Key Informant Interviews and Focus Groups	129
Appendix C- Key Informant Interview Guide	130
Appendix D- Focus Group Guide.....	135
Appendix E- Resource Inventory	139
Appendix F- Additional Data Tables.....	160
Appendix G- Hospitalization Data.....	179
Appendix H- Cancer Data.....	199
Appendix I- Outcomes and Results Report of the Previous Implementation Plan	219

Executive Summary

Introduction

In 2022, Jersey City Medical Center (JCMC) undertook a community health needs assessment (CHNA) process. The purpose of the CHNA was to identify and analyze community health needs and assets and prioritize those needs to inform strategies to improve community health. This assessment focused on the following Hudson County areas: Bayonne, Hoboken, Jersey City (zip codes 07302, 07304, 07305, 07306, 07307 and 07310), and Union City.

Context

This CHNA was conducted during an unprecedented period due to the COVID-19 pandemic and the national movement for racial justice. The COVID-19 pandemic impacted both the CHNA data collection process, as well as topics and concerns that residents raised in focus groups and key informant interviews. A wave of national protests for racial equity in 2020 highlighted how racism is embedded in systems across the US. The national movement informed the content of this report including the data collection processes, design of data collection instruments, and the input that was shared during focus groups, key informant interviews, and through survey responses.

Methods

While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health. Data collection was conducted using a social determinants of health framework and a health equity lens. The CHNA process utilized a mixed-methods, participatory approach that engaged agencies, organizations, and community residents through different avenues. The CHNA process was guided by the strategic leadership of the RWJBH Systemwide CHNA Steering Committee, the JCMC Community Outreach & Social Impact Steering Committee, the JCMC/Hudson County CHNA Advisory Committee, and the community overall. Data collection methods included:

- Reviewing existing social, economic, and health data in the JCMC primary and secondary service areas in Hudson County.
- Conducting a community survey with 273 residents designed and administered by Bruno & Ridgway.
- Facilitating 6 virtual focus groups with 105 participants from populations of interest, including veterans, and residents who identified as Black, Asian, and Latino, the latter held in Spanish.
- Conducting 7 key informant interviews with 12 community stakeholders from a range of sectors.
- Facilitating a guided discussion with the JCMC Community Outreach & Social Impact Steering Committee.

Jersey City Medical Center/Hudson County CHNA Focus Area



Findings

The following provides a brief overview of the key findings that emerged from this assessment:

Population Characteristics

- **Demographics.** In 2020, Hudson County was the fourth most populous county in New Jersey with 671,923 residents. Its population increased by 1.4% between 2015 and 2020.¹ Participants in focus group and interview discussions valued Hudson County’s racial/ethnic and language diversity and robust foreign-born population. Residents identifying as Latino made up 40.4% of the county’s residents, followed by those identifying as White (28.5%), Asian (17.0%), and Black (9.8%).² In 2016-2020, the foreign-born population ranged from 19.4% in Hoboken to 62.8% in Jersey City zip code 07310, with many residents from India and the Dominican Republic.³ Veterans made up about 2% of the Hudson County population, with the highest percentage in the city of Bayonne (3.9%).

Community Social and Economic Environment

- **Community Strengths and Assets.** Interviewees and focus group participants mentioned numerous positive aspects of their communities, including an abundance of resources and amenities, community solidarity, and robust partnerships, made stronger during COVID-19. Top strengths identified by community survey respondents in 2021 included that it was easy to find fresh produce and that their communities had safe outdoor places to walk and play. Nearly 60% of respondents indicated that their communities were a good place to raise a family and had places for everyone to socialize.⁴
- **Education.** Graduation rates across Hudson County school districts differed, with Bayonne, Union City, and Jersey City experiencing lower graduation rates than the other communities and the state. There were racial/ethnic disparities in graduation rates, with Black and Latino students experiencing lower graduation rates than their White and Asian counterparts.⁵ Participants identified “Community schools” and Tiger’s Den at Snyder High School, resulting from a partnership between the Jersey City Board of Education, JCMC, educators, families, and the community, as promising initiatives to address the needs of low-income students of color and increase graduation rates.
- **Inequality.** Growing inequality was a recurrent theme in focus groups and interviews with participants describing the area as “*a tale of two cities*.” Development was seen as focusing on the wealthy, while residents emphasized how neighborhood concentrated poverty compounded the effect of household poverty. They highlighted the linkage between income, hopelessness, poor education outcomes, and violence. Inequality was reflected in education, employment and workforce, income and financial security, access to healthcare, and other areas.

“There is something going on almost every week to help with food, home purchases, and other things. That’s one of the things I really love about Jersey City.” – Focus group participant

¹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

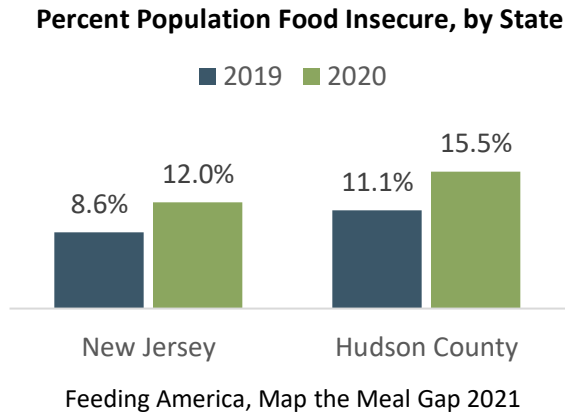
² U.S. Census Bureau, Decennial Census of Population and Housing, 2020

³ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

⁴ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

⁵ New Jersey Department of Education, School Performance, Adjusted Cohort Graduation Rates, 2020-21

- Employment and Workforce.** Unemployment rates in Hudson County were trending downward over the decade prior to the COVID-19 pandemic and rose substantially in 2020, similar to the rest of the state and country. While rates declined in 2021, unemployment has not yet fallen to pre-pandemic levels. Unemployment rates in 2016-2020 ranged from 2.4% in Jersey City zip code 07302 to 7.0% in Jersey City zip code 07305 and 9.2% in Jersey City zip code 07304.⁶ Fewer than four in ten survey respondents agreed that “there are job opportunities in my area.” Participants indicated that LGBTQ+ populations, veterans, and essential workers were the most affected by unemployment and underemployment.
- Income and Financial Security.** Median household income in Hudson County showed stark disparities, ranging from \$49,457 in Union City, with a majority Latino population, to \$153,438 in Hoboken, a predominantly White area.⁷ In 2019, 29.8% of Black children and 23.4% of Latino children lived in poverty, compared to 9.8% in the county overall.⁸ Among veterans, 7.5% lived below the poverty line in the county overall, with 21.4% doing so in Jersey City zip code 07306.⁹ Focus group participants shared the day-to-day challenges of affording housing, food, and healthcare as prices continue to climb across the board. While the rising cost of living affects everyone, participants shared that it has been most painful for low-wage workers and those on fixed incomes, such as seniors.
- Food Access and Food Security.** Participants mentioned that many families with children—often immigrants—, older adults, and those who were housing insecure were struggling to put food, particularly healthy food, on the table. Residents reported that food insecurity increased during the COVID-19 pandemic, despite stepping up food distribution efforts. Around one in four survey respondents overall, and about one in three Latino respondents, indicated that they relied on food pantries or other food assistance programs.¹⁰
- Housing.** Participants reported that affordable housing in their communities was sparse and difficult to obtain. Residents discussed the challenges of qualifying for affordable housing, rising rents due to an influx of New Yorkers, increasing socioeconomic segregation, and homelessness. More than half of renter-occupied households in Hudson County spend 25% or more of their monthly income on housing costs, ranging from 39.0% in Jersey City zip code 07302 to 66.5% in Union City and 64.6% in Jersey City zip code 07305.¹¹



⁶ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

⁷ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

⁸ U.S. Census Bureau, Small Area Income and Poverty Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

⁹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

¹⁰ DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

¹¹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

- Transportation.** Participants valued the ample availability of public transportation options in Hudson County. Most participants indicated that they were not car dependent and noted that it was easy to get around. In addition, participants indicated that the partnerships between health care facilities and private transportation companies facilitated access to health care for older adults, persons with disabilities, and violence survivors.
- Green Space and Built Environment.** Multiple residents expressed their concerns that there were too many new constructions, resulting in overpopulation and a shrinkage of green space. Participants highlighted the importance of emergency preparedness for flooding and mentioned that mitigating redevelopment projects were underway. Residents also noted the contribution of grassroots organizations to public park maintenance, also important for increased water absorption. About 70% of Hudson County survey respondents agreed or completely agreed with the statement, *“My community has safe outdoor places to walk and play.”*¹²
- Violence Prevention and Safety.** Similar to the 2019 CHNA, for many, violence prevention and safety continue to be priority issues for many residents. Participants shared differing views about safety and violence. Many indicated being safe in their neighborhoods, while others reported being nervous about crime. In 2020, Jersey City (432 per 100,000 residents) had more than double the violent crime rate (i.e., murder, rape, aggravated assault) than the state average (195 per 100,000 residents).¹³ Black residents indicated that they experienced a disproportionate burden of violence, including gun violence, and trauma, with Black survey respondents’ marking violence/community safety as the top health priority.¹⁴ Key informant interviewees indicated that Jersey City has robust programs and resources to address and mitigate the impact of violence and trauma, including the Anti-Violence Coalition and Project H.U.D.S.O.N. According to interviewees, promising results to interrupt the cycle of violence have been achieved by reaching survivors soon after injury and providing trauma-informed intensive case management and wraparound services, including safe housing and vocational training, in addition to medical care and counseling.
- Systemic Racism and Discrimination.** With few exceptions, participants spoke of pervasive inequities experienced by people of different groups. Residents discussed the multiplying effect of historical and current discriminatory practices due to multiple conditions, such as race/ethnicity, gender, immigrant status, and socioeconomic status, among others. Participants noted these issues largely impacted communities of color because of the policies and practices embedded throughout society. Residents mentioned that some Hudson County municipalities have put in place programs to address the effects of systemic racism, such as first-time homeowner programs for low-income residents, rent control policies, and programs to promote minority and/or women owned business. However, participants emphasized that more are needed.

“The undocumented are scared to ask for help, and we are seeing that community getting jumped overnight, not wanting to go to the hospital over what they will get charged.”— Focus group participant

¹² Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

¹³ State of New Jersey, Department of Law and Public Safety, Uniform Crime Reporting Unit, 2019

¹⁴ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Community Health Issues

- **Perceptions of Community Health.** Focus group participants and interviewees identified social and economic issues such as financial insecurity, housing, and transportation as top community concerns, noting that these issues affect other aspects of health. Participants also discussed challenges in accessing care, the increase in mental health concerns, and the lingering effects of the COVID-19 pandemic. Community survey respondents ranked mental health, overweight/obesity, high stress lifestyle, affordable housing, and affordable eldercare as the top five health concerns in the community.
- **Leading Causes of Death and Premature Mortality.** Heart disease, COVID-19, and cancer were the top three leading causes of death in Hudson County in 2020. In 2018-2020, Black residents experienced higher rates of premature mortality (deaths before age 75) than any other racial/ethnic groups.¹⁵
- **Obesity, Healthy Eating, and Physical Activity.** While overweight/obesity was identified as the second top health concern (after mental health) by community survey respondents,¹⁶ it was not a prominent theme in conversations with residents. Participants mentioned disparities in the availability and affordability of healthy foods by neighborhood, with some areas considered food deserts. Some residents indicated enjoying the area’s walkability, while others noted safety issues, sidewalks in disrepair, and time constraints as barriers to physical activity.
- **Chronic Diseases.** Like findings from the 2019 CHNA, chronic diseases continue to be a top community concern. Data show racial/ethnic disparities in chronic disease burden across Hudson County. Black residents experienced higher cardiovascular disease mortality rates than other racial/ethnic groups in the county. Diabetes was a top priority concern and participants indicated that it was highly prevalent in their communities. The cancer mortality rate in Hudson County was highest among Black (182.9 per 100,000), followed by White (148.5 per 100,000), residents.¹⁷ In terms of chronic disease screenings, 70% of community survey respondents indicated that they had participated in a cholesterol screening, and nearly 87% had participated in a blood pressure screening in the past two years.¹⁸ Many participants mentioned health care costs as a barrier to chronic disease management.
- **Disability.** While the issue of disabilities did not emerge often in the qualitative discussions, many people with disabilities face economic instability as they rely on government financial assistance programs for their basic needs. A key informant interviewee highlighted the importance of early intervention to address the needs of children with disabilities. The proportion of the population ages

“Diabetes is a very expensive issue in the community, and we’ll often see people forgo their medication because they can’t afford it or forgo healthy foods because they can’t afford it.” – Focus group participant

¹⁵ National Center for Health Statistics, Mortality Files, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018-2020

¹⁶ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

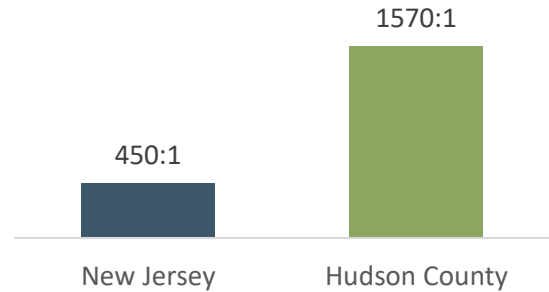
¹⁷ New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

¹⁸ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

18-64 with a disability in Hudson County ranged from 3.2% in Jersey City zip code 07302 to 9.1% in Jersey City zip code 07304.¹⁹

- Mental Health and Substance Use.** Echoing the 2019 CHNA, mental health disorders were the top health priority selected by survey respondents and a prominent theme in interviews and focus groups. Job loss and economic pressures and the uncertainty associated with the pandemic were cited as contributors to increased stress and depression by Hudson County residents, including among veterans and members of the LGBTQ+ community. Participants indicated stigma, long wait times for appointments, and unavailability of multilingual mental health care providers as barriers to accessing care. Several participants identified substance misuse, relapse, and overdose deaths among young people as a further health concern in the aftermath of COVID-19, with the drug poisoning rate increasing from 2016 to 2020.²⁰

Population to Mental Health Provider Ratios, by State and County, 2019



DATA SOURCE: National Provider Identification Registry, Centers for Medicare and Medicaid Services

- Environmental Health.** The rate of age-adjusted ED visits for asthma declined in Hudson County from 2018-2020.²¹ It should be noted that this decline may be due to individuals with asthma being reluctant to seek care during the height of the COVID-19 pandemic. The proportion of children born in 2014 who were tested for lead exposure before 36 months of age is higher in Hudson County (77.6%) than in the state (74.4%).²²

- Communicable Diseases.** Conversations related to COVID-19 primarily focused on how the pandemic exacerbated existing social and economic inequities. Several participants were concerned by the increasing rates of sexually transmitted infections, including HIV and chlamydia, among women of color and the LGBTQ+ population. The rate of HIV transmission for Black New Jersey residents was 30.2 per 100,000 persons, ten times higher than among White residents (3.1 per 100,000). Nearly 3,000 per 100,000 women aged 15-24 contract

“[COVID impacted] housing, food insecurity, jobs, people have a fear of going back to work, and childcare, because there was a time when everything was virtual, how can parents afford to stay home and put food on the table?” – Focus group participant

¹⁹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

²⁰ Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020

²¹ New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020

²² New Jersey Birth Certificate Database, Office of Vital Statistics and Registry; Child Health Program, Family Health Services, as reported by, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2022

chlamydia annually in Hudson County.²³ Participants also expressed concerns about the roll-back of reproductive rights and the negative impact that would have on women’s health, noting the inequitable burden on low-income women.

- **Maternal and Infant Health.** Maternal and infant health indicators are markers of inequity as most maternal and perinatal health complications are preventable with access to quality, adequate, timely care and information, including comprehensive sexuality education. In Hudson County, a lower percentage of Black and Latino residents sought prenatal care in the first trimester compared to Asian and White residents. The rates of low birth weight and preterm births among infants born to Black residents roughly doubled those of White residents,²⁴ indicating health care access barriers.

Access to Services

- **Access to Preventive Services.** Participants reported that access to routine screenings and preventive care declined since the onset of the COVID-19 pandemic, despite the efforts of many partners. Participants indicated that having a primary care provider and/or access to a trusted FQHC facilitated access to care. Approximately 77% of community survey respondents reported having an annual physical exam and 74% a flu shot in the last two years.²⁵
- **Access to Primary Care Services.** Cost, workforce capacity, insurance, and language and cultural factors were most often mentioned by focus group and interview participants as barriers to accessing primary care. Community survey respondents indicated ability to schedule an appointment at a convenient time, insurance problems, cost of care, and wait times as the main barriers to care.²⁶ About 30% of respondents indicated never experiencing barriers. Within the JCMC service area, the proportion of uninsured residents was highest in Union City (23.4%) and lowest in Hoboken (2.7%).²⁷ Some participants, particularly veterans, mentioned experiencing disruptions in access to mental health services during the pandemic, including to support groups and counseling, leading to treatment setbacks and substance use relapse.
- **Community-Based Organizations and Coalitions.** Partnerships between the community-based organizations, hospitals, schools, and the government were seen as a strength in Hudson County and critical to providing services to those in need. City-wide efforts such as HealthierJC have been important to coordinate efforts across multiple partners, including the business community. Residents and public health administrators uplifted the role of community-based nonprofits in bridging the gap to services for those most marginalized. Most participants saw a promising role for a strong and broad coalition in Hudson County.

“We have great partners. Hudson County is very tight, so we all work together – Focus group participant

²³ Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, as reported by the New Jersey State Health Assessment Data (NJSHAD), 2020 & 2021

²⁴ New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

²⁵ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

²⁶ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

²⁷ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Community Vision and Suggestions for the Future

- **Health as Human Right:** *“It is urgent to have access to free, quality health care.”* To overcome cost barriers, participants recommended expanding access to free or low-cost preventive care; loosening the requirements to qualify for free and/or low-cost health insurance; and simplifying the charity care application, including for those who are foreign-born. They also suggested *“meeting people where they are”* by using mobile and school-based clinics, organizing education sessions in all neighborhoods, and offering appointments outside of the regular workday. Participants highlighted the community school model as a promising initiative to promote the well-being of low-income families.
- **Improving Access to Services and Community Outreach.** Echoing 2019 CHNA priorities, many community participants emphasized improving access to primary care as a priority for the coming years. Numerous interviewees and focus group participants noted the need for better communication about existing programs and services. Participants suggested organizing informational sessions in different neighborhoods and languages on topics that affect the community, such as chronic disease management, and developing a centralized list of programs and resources, similar to the mental health directory prepared by the Health Department (<https://healthierjc.com/mental-health/>), but for other conditions.
- **Greater Accessibility and Availability of Behavioral Health Services.** Participants suggested that expanding culturally-competent trauma-informed mental health care, particularly for Black, LGBTQ+, veterans, violence survivors, and young residents, should be a priority in the coming years. They recommended diversifying the mental health workforce, expanding community-based affordable mental health services, increasing long-term treatment and maintenance options for persons with substance use disorders, and developing additional prevention education programs to destigmatize mental health disorders among many cultural groups.
- **Sexual and Reproductive Health and Women’s Health.** Participants underscored the importance of offering comprehensive sexuality education in schools to reduce sexually transmitted infections and reduce unplanned pregnancies among teens; increasing access to information and reproductive health commodities to address the rise in sexually transmitted infections among cisgender women and men-who-have-sex-with-men; and mitigating the repercussions of the rollback in constitutional protections to reproductive choice that could unduly affect low-income women and communities of color, thus, exacerbating existing racial/ethnic and social inequities in maternal and infant health.
- **Reducing Inequity and Focusing on the Social Determinants of Health.** For several interviewees and focus group members, a vision of the future included steps to reduce inequity and address the social determinants of health.
 - **Expanding Employment Opportunities:** Recommendations to improve economic and employment opportunities included: 1) incorporating more vocational training programs in high schools to facilitate transition into the workforce; 2) incentivizing employers to hire veterans and

“My biggest wish for this community is that we don't have such an economically diverse community. If there's a way to really help the families with the lowest economic resources to really have more financial stability, that would be ideal.”
– Key informant interviewee

transgender and other LGBTQ+ people; 3) providing expanded workforce protections (e.g., sick leave, improved wages, childcare) for all workers, including those who are foreign-born; and 4) supporting small business owners.

- **Addressing the Housing Deficit:** Recommendations related to expanding access to housing and addressing homelessness included: 1) earmarking more affordable housing units in the new developments, including housing for veterans; 2) implementing the existing rent control policies, which also apply to foreign-born residents regardless of immigration status; 3) renovating abandoned buildings for low-income families; 4) increasing the availability of safe temporary shelters for unhoused individuals, including for domestic and community violence survivors; and 5) fomenting first-time buyers' subsidies as a promising initiative to address intergenerational poverty.

“Prices have been slowly rising, amazing that they have money to build these new buildings but can’t help people maintain the property they have here....” – Focus group participant

- **Partnerships, Community Engagement, and Community Building.** Participants valued the robust partnerships established among multiple organizations and across sectors and suggested deepening engagement with trusted community-based organizations, such as those representing Asian, Latino, and LGBTQ+ residents, as partners in outreach and information sharing about community services and programs. Participants underscored more community outreach, a strong plan to reengage the community, and investing in the community as strategic areas moving forward.

Key Themes

Several overarching themes emerged from the Jersey City Medical Center/Hudson County 2022 Community Health Needs Assessment. Importantly, several key areas, including increasing access to care, the importance of preventive care, and safety and violence prevention echoed those priorities identified by the community in 2019 as part of the prior CHNA process, and provide an opportunity to continue building upon those efforts.

- ***The Hudson County communities that JCMC serves are diverse and health disparities exist.*** There is great variation in terms of demographic composition, income levels, and health status in Hudson County, with over 40% of residents not English proficient. Secondary data show disparities in healthcare access and health outcomes based on race/ethnicity. A larger proportion of Asian and Latino community survey respondents reported feeling discriminated against when receiving care. Secondary data show that Black residents experience higher rates of premature, cardiovascular, and cancer mortality, and diabetes compared to residents of other racial/ethnic groups.
- ***Residents viewed chronic conditions as prevalent and linked to the social determinants of health.*** Diabetes and high blood pressure were discussed as prevalent in the community, especially among low-income residents and communities of color, and survey respondents indicated “overweight/obesity” was the second most common health issue in their community. However, focus group participants focused on the barriers to healthy living faced by residents, including affording healthy foods, cost of medication, and having time to exercise and to spend outdoors.

- ***Housing, food insecurity, and employment opportunities are top community concerns.*** Participants identified lack of quality affordable housing as a key gap in the area. Food insecurity was another area of concern, with almost half of Latino survey respondents worrying about running out of money to purchase food. Housing and food are related to income. Over 10% of Hudson residents reported being unemployed during the pandemic, with large variation by neighborhood. Overall, participants recommended the adoption of more policies to promote equity and support the well-being of low-income residents.
- ***Mental health was identified as a significant community health concern.*** Mental health was identified as a top community health concern, closely associated with racial/ethnic disparities, economic instability, and chronic conditions. Black residents faced a disproportionate mental health burden. The rate of mental health hospitalizations in 2020 was 70% higher among adult Black residents (107.1 per 100,000) than the Hudson County average (63.1 per 100,000). Black children had 38% higher hospitalization rates for mental health conditions than the county rate (34.7 per 100,000 vs. 25.2 per 100,000). Veterans and LGBTQ+ advocates also highlighted the mental health needs of their communities. Residents mentioned stigma and insufficient culturally competent providers as the principal barriers to mental health care access and emphasized the need to engage in more education efforts.
- ***Violence as an important health concern.*** Violence and safety were raised as community concerns. Some participants indicated that their neighborhoods were safe; however only 40% of survey respondents agreed that violence was not prevalent in their communities.²⁸ Further, violence and safety were mentioned as the top health concern by Black survey respondents. Participants suggested continuing to strengthen efforts to end the cycle of violence by addressing its social determinants of health, through support of programs such as the Anti-Violence Coalition and Project H.U.D.S.O.N.
- ***Hudson County has a wealth of social service organizations and health care services, including those providing preventive care, though many residents experience barriers to accessing these resources.*** Residents remarked that Hudson County had a wealth of health care and social service assets. Residents noted that having a primary care doctor and being linked to a FQHC and/or a community-based organization were facilitating factors to accessing care. They also discussed the importance of culturally competent providers, including providers who spoke their language and looked like them. Veterans and those working with violence survivors highlighted that having peers and mentors who could provide trauma informed care helped to be engaged in care. Participants in the healthcare field unanimously noted a decline in access to preventive care and mentioned this as a priority strategic area. Recommendations in this area included continuing to uplift partnerships and community engagement to bridge the care gap. Another recommendation included better communication about existing programs and services to reach multiple constituencies.

Conclusions

Through this comprehensive and iterative assessment process, ten major areas were identified as community needs after gathering input through qualitative data from residents and stakeholders, feedback from a community priorities survey, and quantitative surveillance and secondary data. These included in no particular order:

²⁸ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

- Financial Insecurity
- Unemployment
- Food Insecurity
- Housing
- Chronic Diseases (e.g., heart disease, cancer, diabetes)
- Infectious Diseases, including COVID-19
- Violence Prevention & Safety
- Mental Health
- Substance Use
- Access to Preventive Care

After a prioritization process with the Advisory Committee and discussions within the hospital taking into consideration existing expertise, capacity, and experience, JCMC will focus on Access to Preventive Care; Chronic Disease Management, including Behavioral Health Services; Food Insecurity and Education; and Violence Prevention and Safety as priorities during the development of its implementation plan in 2023. JCMC will tackle these priority action areas as part of ongoing community engagement efforts and with an overarching emphasis on addressing systemic racism, racial injustice, and discrimination.

Introduction

Community Health Needs Assessment Purpose and Goals

A community health needs assessment (CHNA) is a systematic process to identify and analyze community health needs and assets, prioritize those needs, and then implement strategies to improve community health. In 2022, the RWJBarnabas Health Jersey City Medical Center (JCMC) undertook the current CHNA process using a mixed-methods and participatory approach.

JCMC is located in Jersey City, Hudson County, New Jersey, and is part of the **RWJBarnabas Health (RWJBH)** system. RWJBH is a non-profit healthcare organization which includes 12 acute care hospitals, three acute care children's hospitals, a leading pediatric rehabilitation hospital, a freestanding acute behavioral health hospital, a clinically integrated network of ambulatory care centers, two trauma centers, a satellite emergency department, geriatric centers, the state's largest behavioral health network, ambulatory surgery centers, comprehensive home care and hospice programs, long term care facilities, fitness and wellness centers, retail pharmacy services, medical groups, diagnostic imaging centers, a clinically integrated network and collaborative accountable care organization. As one of the licensed general acute care hospitals and one of two trauma centers within the system, JCMC admits nearly 16,000 inpatients and provides over 201,000 outpatient visits annually. In 2021, the 348-bed hospital attended over 81,100 emergency department visits and delivered nearly 2,000 babies. JCMC is a DNV (which stands for det norske veritas) fully accredited hospital and has been recognized for its excellence in providing care and support for the health and wellness of the Hudson County community.

In early 2021, RWJBH hired **Health Resources in Action (HRiA)**, a non-profit public health consultancy organization, to provide support, help facilitate, and conduct data analysis for the CHNAs across the system. HRiA worked closely with RWJBH, JCMC, the JCMC Community Outreach & Social Impact Steering Committee, and a Jersey City/Hudson County CHNA Advisory Board to support the 2022 JCMC CHNA.

The RWJBH JCMC/Hudson County CHNA aims to gain a greater understanding of the issues that community residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This report presents findings from the 2022 JCMC needs assessment processes, which was conducted between March-September 2022.

The specific goals of this CHNA are to:

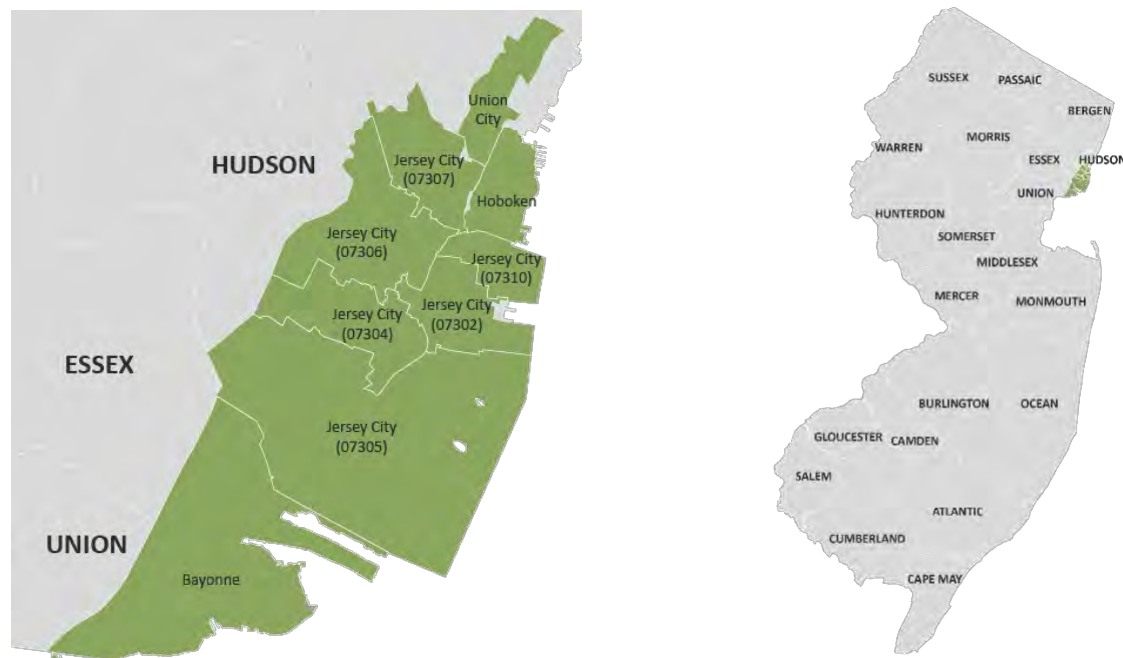
- Systematically identify the needs, strengths, and resources of the community to inform future planning,
- Understand the current health status of the service area overall and its sub-populations within their social context,
- Engage the community to help determine community needs and social determinant of health needs, and
- Fulfill the IRS mandate for non-profit hospitals.

Area of Focus

This CHNA process aims to fulfill multiple purposes for a range of stakeholders. To be as inclusive as possible, the focus area of the RWJBH Jersey City Medical Center/Hudson County CHNA encompasses JCMC's primary and secondary service areas in Hudson County. JCMC's primary service area include the

following Jersey City zip codes: 07302, 07304, 07305, 07306, 07307, and 07310. JCMC's secondary service area includes Bayonne, Union City and Hoboken, which encompass the following zip codes: 07002, 07087, and 07030, respectively. Both the primary and secondary service areas are the focus of this CHNA, represented in Figure 1 below.

Figure 1. Focused JCMC CHNA Area Map



Context for the Community Health Needs Assessment

This CHNA was conducted during an unprecedented time, given the COVID-19 pandemic and the national movement for racial justice. This context had a significant impact on the assessment approach and content.

COVID-19 Pandemic

The country was still recovering from the novel coronavirus (COVID-19) pandemic when the activities of this assessment were conducted. This impacted both the CHNA data collection process and topics, as well as concerns that participants put forth during discussions in focus groups and interviews. In March 2022, at the beginning of this CHNA process, the COVID-19 pandemic had already been in effect for over two years. Logistically, the pandemic impacted the feasibility of convening in-person groups for the CHNA (e.g., subcommittees, focus groups, etc.) and the availability of key stakeholders and community members to participate in CHNA activities, given their focus on addressing immediate needs. Consequently, all data collection and engagement occurred in a virtual setting (e.g., telephone or video focus groups, interviews), and engagement of residents and stakeholders was challenging. (A more detailed description of this engagement process may be found in the Methods section, and COVID-19 data specific to this service area is provided in the Infectious and Communicable Disease section of this report.)

Substantively, during the CHNA process, COVID-19 was and remains a health concern for communities and has also exacerbated underlying inequities and social needs. The pandemic brought to light both the

capabilities and gaps in the healthcare system, the public health infrastructure, and social service networks. In this context, an assessment of the community's strengths and needs, and in particular the social determinants of health, is both critically important and logistically challenging. This CHNA should be considered a snapshot in time, which is consistent with public health best practices. Moving forward, the community should continue to be engaged to understand how identified issues may evolve and what new issues or concerns may emerge over time.

National Movement for Racial Justice

Over the past few years, sparked by the national protests for racial equity amidst the killings of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, and many others, national attention was focused on how racism is embedded in every system and structure of our country, including housing, education, employment, and healthcare. This context impacted the content of the CHNA, including the design of data collection instruments and the input that was shared during interviews and focus groups. While racism and oppression have persisted in this country for over 400 years, it is important to acknowledge the recent focus on these issues in 2022 in the form of increased dialogue, locally and nationally, as context for this assessment. Awareness of racism and discrimination among Hudson City residents was renewed in 2022 with ongoing incidents of anti-Asian hate crimes and the naming of Jersey City by the Buffalo mass shooter.

Methods

The following section details how data for the CHNA were compiled and analyzed, as well as the broader lens used to guide this process.

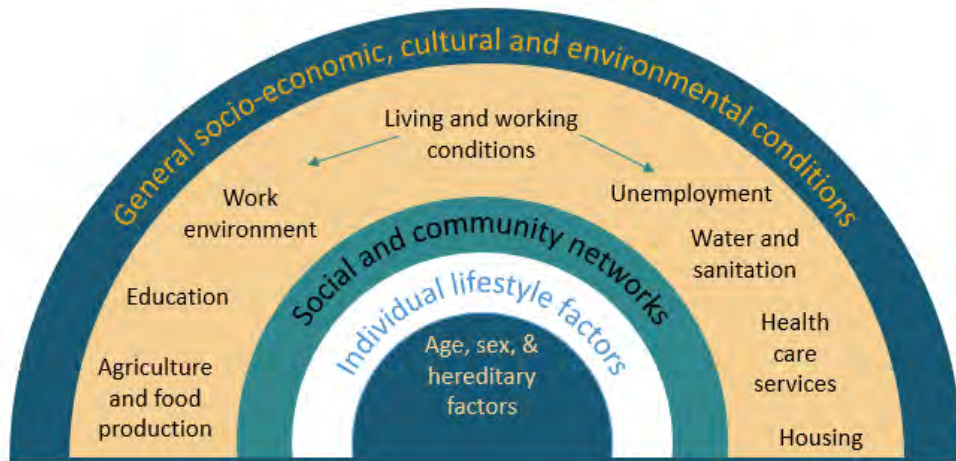
Social Determinants of Health Framework

While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health (Figure 2).

Upstream Approaches to Health

Having a healthy population is about more than delivering quality healthcare to residents. Where a person lives, learns, works, and plays all have an enormous impact on health. Health is not only affected by people's genes and lifestyle behaviors, but by upstream factors such as employment status, quality of housing, and economic policies. Figure 2 provides a visual representation of these relationships, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors, such as employment status and educational opportunities.

Figure 2. Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

The data to which we have access is often a snapshot in time, but the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. To this end, much of this report is dedicated to discussing the social, economic, and community context in which residents live. We hope to understand the current health status of residents and the multitude of factors that influence health to enable the identification of priorities for community health planning, existing strengths and assets upon which to build, and areas for further collaboration and coordination.

Health Equity Lens

The influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory policies, and historical oppression of specific groups are a few of the factors that drive health inequities in the U.S.

In the present report, health patterns for the Hudson County area are described overall, as well as areas of need for particular population groups. Understanding factors that contribute to health patterns for these populations can facilitate the identification of data-informed and evidence-based strategies to provide all residents with the opportunity to live a healthy life.

Approach and Community Engagement Process

The CHNA aimed to engage agencies, organizations, and community residents through different avenues. The CHNA process was guided by strategic leadership from the RWJBH Systemwide CHNA Steering Committee, the JCMC Community Outreach & Social Impact Steering Committee, and the community overall.

RWJBH System Engagement

This CHNA is part of a set of CHNAs being conducted across the entire RWJBH system. Each of these CHNAs uses a consistent framework and a minimum set of indicators but the approach and engagement

process are tailored for each community. A Systemwide CHNA Steering Committee was convened twice prior to the launch of JCMC CHNA process (early and late June 2021). This Steering Committee provided input and feedback on major data elements (e.g., secondary data key indicators, overall Table of Contents) and core prioritization criteria for the planning process. A list of Systemwide CHNA Steering Committee members can be found in Acknowledgments section.

CHNA Advisory Committee Engagement

A CHNA Advisory Committee was constituted to guide the process. The Advisory Committee included over 80 stakeholders representing a range of relevant fields and organizations throughout Hudson County. The CHNA Advisory Committee was engaged at critical intervals throughout this process. In March 2022, the Advisory Committee met for a kick-off meeting during which HRiA provided an overview of the CHNA process and Bruno & Ridgeway, Inc. presented the findings from a community survey the firm conducted in 2021. These two presentations were followed by a brief Q&A and discussion with Advisory Committee members. After the meeting, Advisory Committee members were invited to participate in a survey to help identify what populations and sectors to engage in focus groups and key informant interviews. The results of this survey directly informed development of an engagement plan to guide qualitative data collection. During the data collection process, Advisory Committee members also assisted with organizing focus groups with community residents, participating in key informant interviews, and/or connecting HRiA to stakeholders in the community.

The Advisory Committee reconvened in October 2022. During this meeting, HRiA staff presented the findings from the CHNA process, including preliminary priorities that emerged upon review of the qualitative and secondary data. Advisory Committee members had the opportunity to ask questions, then discussed and voted on the top priorities for the hospital to consider when developing its implementation plan. A detailed description of the prioritization process can be found in the Prioritization Process and Priorities Selected for Planning section.

In addition, the JCMC Community Outreach & Social Impact Steering Committee was engaged throughout the process as a means of obtaining feedback from internal JCMC stakeholders who have firsthand knowledge of the community. Members of the JCMC Steering Committee participated in the Advisory Committee activities and in a focus group in June 2022. The JCMC Steering Committee reviewed the report in full and adopted it in a meeting in November 2022. See Appendix A for a list of CHNA Advisory Committee members, which include the JCMC Steering Committee members.

Community Engagement

Community engagement is described further below under the primary data collection methods. Capturing and lifting up a range of voices, especially those not typically represented in these processes, was a core component to this initiative. It should be noted that, due to the COVID-19 pandemic, the community engagement for this CHNA occurred virtually. Additionally, while the CHNA aimed to engage a cross-section of individuals and to be inclusive of traditionally under-represented communities, outreach was challenging given the pandemic and competing priorities. Nevertheless, by engaging the community through multiple methods and in multiple languages, this CHNA aims to describe community strengths and needs during this unique time.

Secondary Data: Review of Existing Secondary Data, Reports, and Analyses

Secondary data are data that have already been collected for another purpose. Examining secondary data helps us to understand trends, provide a baseline, and identify differences by sub-groups. It also helps in guiding where primary data collection can dive deeper or fill in gaps.

Secondary data for this CHNA were drawn from a variety of sources, including the U.S. Census American Community Survey (ACS), the U.S. Department of Labor Bureau of Labor Statistics, the Federal Bureau of Investigation Uniform Crime Reports, U.S. Bureau of Labor Statistics, County Health Rankings, the New Jersey Department of Education, New Jersey Department of Health's New Jersey State Health Assessment Data (NJSHAD), and a number of other agencies and organizations. This CHNA also utilizes reports from a variety of organizations at the community, state, and national level, including, but not limited to, the United Way of New Jersey's ALICE Study, The Partnership for a HealthierJC, and others. Additionally, hospitalization data from the RWJBH system is also included in Appendix H. Secondary data were analyzed by the agencies that collected or received the data. Data are typically presented as frequencies (%) or rates per 100,000 population. It should be noted that when the narrative makes comparisons between towns, by subpopulation, or with NJ overall, these are lay comparisons and *not* statistically significant differences.

It should also be noted that for most social and economic indicators, the U.S. Census American Community Survey (ACS) 5-year (2016-2020) aggregate datasets were used over the one-year datasets, to improve statistical reliability for areas with smaller population sizes and small population subgroups. Since the ACS uses a probability sampling technique, using the five-year aggregate dataset over the one-year data provides a larger sample size and more precision in its estimates.

Primary Data Collection

Primary data collection entailed a mixed methods approach consisting of interviews, focus groups, and a community survey, as detailed below.

Qualitative Discussion: Key Informant Interviews and Focus Groups

Key Informant Interviews

A total of seven key informant interview discussions were completed with 12 individuals by Zoom or telephone. Interviews were 35-60-minute semi-structured discussions that engaged institutional, organizational, and community leaders as well as front-line staff across sectors. Discussions explored interviewees' experiences of addressing community needs and priorities for future alignment, coordination, and expansion of services, initiatives, and policies. Sectors represented in these interviews included: local public health departments, public education, housing services, the faith community, and those who serve/work with specific populations (e.g., immigrant community, LGBTQ residents, young people). See Appendix B for a list of organizations engaged through key informant interviews and Appendix C for the key informant interview guide.

Focus Groups

A total of 105 community residents participated in 6 virtual focus groups (telephone or video) conducted with specific populations of interest: veterans, Black residents, Spanish-speaking Latino residents, and Asian residents. Focus groups were up to 60-minute semi-structured conversations and aimed to delve deeply into the community's needs, strengths, and opportunities for the future and to gather feedback on priorities for action. Please see Appendix D for the focus group facilitator's guide.

In addition, a guided discussion was carried out with the JCMC Community Outreach & Social Impact Steering Committee, whose members are in direct contact with Hudson City residents in their role as health care providers, hospital administrators, leaders, and community residents themselves. The discussion lasted 60 minutes and was conducted via Zoom. The discussion aimed to determine

perceptions of the strengths and needs of the Hudson County community served by JCMC, and identify the sub-populations most affected, to explore how these issues can be addressed in the future, and to identify opportunities for JCMC to address the community needs more effectively moving forward.

Analyses

The collected qualitative information was coded and then analyzed thematically by data analysts for main categories and sub-themes. Analysts identified key themes that emerged across all groups and interviews as well as the unique issues that were noted for specific populations. Throughout the qualitative findings included in this report, the term “participants” is used to refer to key informant interview and focus group participants. Unique issues that emerged among a group of participants are specified as such. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While differences between towns are noted where appropriate, analyses emphasized findings common across the service area. Selected paraphrased quotes—without personal identifying information—are presented in the narrative of this report to further illustrate points within topic areas.

Community Survey

A community priorities survey was developed and administered over a six-month period from April to August 2021 by the survey firm Bruno & Ridgway, who was contracted directly by the RWJBH system. The survey focused on health issues and concerns that impact the community; community safety and quality of life; personal health attitudes, conditions, and behaviors; barriers to accessing health care; discrimination when receiving medical care; and the impact of COVID-19 and vaccination compliance. The survey was administered online and was available in paper in 5 languages (English, Spanish, Portuguese, Arabic, and Chinese).

Outreach for survey dissemination was conducted with assistance from the RWJBH system, the hospital, and its community partners, as well as through social media and the web. Additionally, an online panel sample was recruited to capture additional survey responses from specific areas to augment the larger sample. Postcards with QR codes that linked to the survey were distributed at vaccination events for community members to take while they waited for their COVID-19 vaccine.

The final sample of the community priorities survey comprised 273 respondents who were residents of Hudson County. Appendix F provides a table with demographic composition of survey respondents. Respondents to the Hudson County Community Health Needs Assessment Survey were predominately White, female, and higher socioeconomic status. About 74% were employed full-time. Throughout this report, Hudson County residents who participated in the Community Health Needs Assessment Survey are referred to as “respondents” (whereas focus group members and interviewees are referred to as “participants” for distinction).

Analyses

Frequencies were calculated for each survey question. Not all respondents answered every question; therefore, denominators in analyses reflect the number of total responses for each question, which varied by question. Statistical testing (Z-tests) was conducted across sub-groups to determine whether there were significance differences between groups. Survey data by race/ethnicity specifically is presented in this report. Racial/ethnic groups are delineated by a letter (A, B, C, D). When a graph has a letter next to the bar, it indicates that the group for that bar has a statistically significant different frequency of responses compared to the group of the letter shown (e.g., when an A is on the bar of White respondents, it indicates that percentage of White respondents answering the question in that

particular way is statistically significantly different than Asian respondents). Significant differences at 90% confidence levels are presented in the report.

Data Limitations

As with all data collection efforts, there are several limitations that should be acknowledged. Numerous secondary data sources were drawn upon in creating this report and each source has its own set of limitations. Overall, it should be noted that different data sources use different ways of measuring similar variables (e.g., different questions to identify race/ethnicity). There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific population groups (e.g., race/ethnicity) or at a more granular geographic level (e.g., town or municipality) due to small sub-sample sizes. In some cases, data from multiple years may have been aggregated to allow for data estimates at a more granular level or among specific groups.

With many organizations and residents focused on the pandemic and its effects, community engagement and timely response to data collection requests were challenging. Additionally, with its online administration method, the community survey used a convenience sample. Since a convenience sample is a type of non-probability sampling, there is potential selection bias in who participated or was asked to participate in the survey. Due to this potential bias, results cannot necessarily be generalized to the larger population. Similarly, while interviews and focus groups provide valuable insights and important in-depth context, due to their non-random sampling methods and small sample sizes, results are not necessarily generalizable. Due to COVID-19, focus groups and interviews were also conducted virtually, and therefore, while both video conference and telephone options were offered, some residents who lack reliable access to the Internet and/or cell phones may have experienced difficulty participating. This report should be considered a snapshot of an unprecedented time, and the findings in this report can be built upon through future data collection efforts.

Population Characteristics

Population Overview

According to the 2016-2020 American Community Survey (U.S. Census), Hudson County is the fourth most populous county in New Jersey (671,923 residents). The Jersey City Medical Center’s primary and secondary service area comprises 6 Jersey City zip codes (totaling 330,002 residents), and the cities of Bayonne (65,112 residents), Hoboken (53,283 residents), and Union City (68,073). There has been great variability in population growth across the areas examined. Whereas New Jersey overall and Hudson County, specifically, have seen minimal changes in total population between the periods 2011-2015 and 2016-2020, Jersey City zip code 07302 experienced a population growth explosion (18.5%), whereas zip codes 07306 and 07307 experienced an important population exodus during the same period (-7.1% and -9.9%, respectively). The population of Bayonne and Union City declined (-0.4% and -0.8%, respectively) and that of Hoboken increased (1.6%) minimally over this time (Table 1).

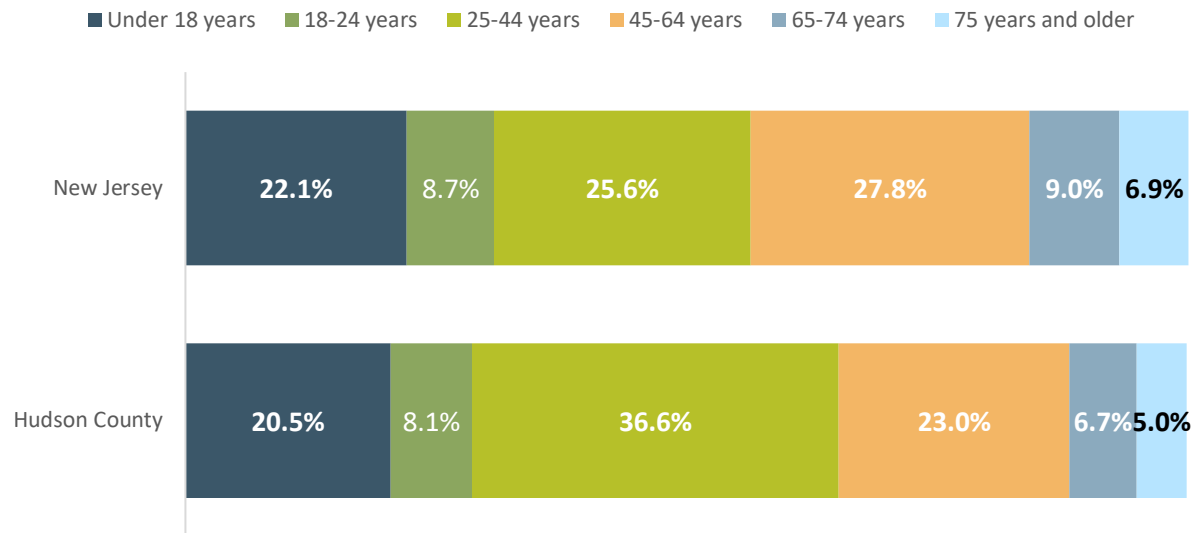
Table 1. Total Population, by State and County, 2011-2015 and 2016-2020

	2015	2020	% change
New Jersey	8,904,413	8,885,418	-0.2%
Hudson County	662,619	671,923	1.4%
Bayonne	65,378	65,112	-0.4%
Hoboken	52,452	53,283	1.6%
Jersey City	327,847	330,002	0.7%
Jersey City (07302)	39,964	47,339	18.5%
Jersey City (07304)	42,935	43,554	1.4%
Jersey City (07305)	63,440	66,595	5.0%
Jersey City (07306)	55,296	51,378	-7.1%
Jersey City (07307)	44,400	40,012	-9.9%
Jersey City (07310)	13,156	13,051	-0.8%
Union City	68,656	68,073	-0.8%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

More young adults lived in Hudson County compared to New Jersey overall in 2016-2020 (Figure 3), with about 37% of the population being between the ages of 25-44 years old; in contrast fewer children under 18 years of age and older adults live in the county. Age distribution data by town and gender can be found in the Appendix of additional data.

Figure 3. Age Distribution, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

When examining age distribution data by race/ethnicity in Hudson County, children under 18 made up a greater percentage of the population among persons of Other Race (26.9%) and Hispanic/Latinos (15.7%), followed by Black (14.6%), and a smaller proportion of Asian (11.2%) and White (10.3%) residents. Adults aged 65 and over comprised 9.9% of the White population compared to 6.1% of the Asian population, see Table 2.

Table 2. Age Distribution, by Race/Ethnicity, State, and County, 2016-2020

	Asian					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	14.6%	5.0%	21.8%	17.0%	4.8%	3.0%
Hudson County	11.2%	4.7%	32.8%	11.9%	3.8%	2.3%
	Black					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	15.0%	6.7%	18.3%	17.3%	4.8%	3.3%
Hudson County	14.6%	6.9%	21.0%	15.7%	4.2%	3.1%
	Hispanic/Latino					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	19.1%	6.7%	20.4%	14.9%	3.3%	2.2%
Hudson County	15.7%	6.1%	20.7%	16.0%	4.4%	3.4%
	White					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	12.2%	5.1%	14.7%	20.1%	7.8%	6.3%
Hudson County	10.3%	4.0%	27.3%	15.8%	5.5%	4.4%

	Some Other Race					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	28.5%	10.3%	32.4%	21.5%	4.6%	2.6%
Hudson County	26.9%	9.3%	33.5%	22.8%	5.1%	2.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

NOTE: Some Other Race includes individuals that identified as American Indian/Alaskan Native, Native Hawaiian or Other Pacific Islander, or as some other race.

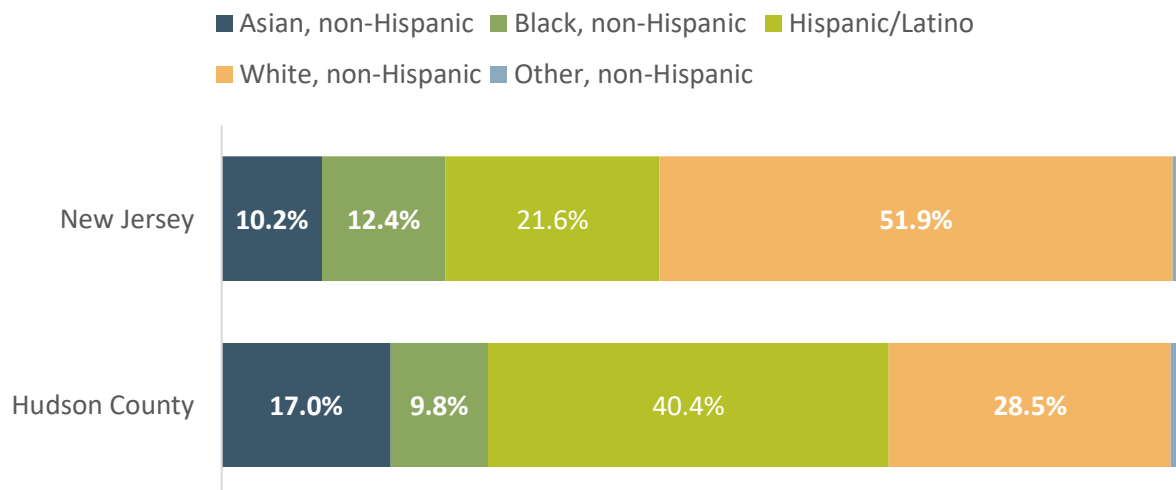
Racial, Ethnic, and Language Diversity

Racial and Ethnic Composition

Focus group members and interviewees described their communities as racially and ethnically diverse and valued this diversity as one of Hudson County’s greatest assets. The secondary data support these perceptions. Hudson County is predominantly made up of Hispanic/Latino residents, which make up 40.4% of its population, followed by White non-Hispanic (28.5%), Asian (17.0%), and Black (9.8%). Hudson County has proportionally more Hispanic/Latino and Asian residents than New Jersey as a whole (Figure 4). See the Appendix for detailed data tables.

“Jersey City’s greatest strength has always been diversity.” – Focus group participant

Figure 4. Racial and Ethnic Distribution, by State and County, 2020



DATA SOURCE: U.S. Census Bureau, Decennial Census of Population and Housing, 2020

Data labels not shown for percentages <4%.

In 2016-2020, the racial and ethnic distributions varied widely across Hudson County (Table 3) with Hoboken and Union City being the most homogenous cities, and zip codes within Jersey City being quite diverse. For example, in Jersey City zip code 07310, 57.3% of the population identified as Asian, compared to 3.5% in Union City. The largest Black population was found in zip codes 07305 and 07304, which made up 44.1% and 34.8% of residents, compared to 2.3% in Union City and 2.6% in Hoboken.

Residents identifying as Hispanic/Latino made up 76.7% of the Union City and 42.2% of the Jersey City zip code 07307 population, in contrast to 9.3% in zip code 07310. Residents identifying as non-Hispanic White were concentrated in Hoboken (67.1% of residents), followed by Bayonne (44.3%), and made the smallest proportion of the population in zip code 07305 (11.7%).

Table 3. Racial and Ethnic Distribution, by Town, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	Other Race/Ethnicity, Non-Hispanic
Hudson County					
Bayonne	9.8%	8.4%	34.5%	44.3%	0.5%
Hoboken	11.7%	2.6%	15.3%	67.1%	0.2%
Jersey City (07302)	32.2%	6.6%	16.7%	40.1%	0.3%
Jersey City (07304)	13.5%	34.8%	32.9%	14.9%	1.4%
Jersey City (07305)	16.7%	44.1%	23.4%	11.7%	1.7%
Jersey City (07306)	34.8%	9.9%	28.4%	23.0%	1.1%
Jersey City (07307)	24.4%	6.5%	42.2%	24.2%	0.9%
Jersey City (07310)	57.3%	5.4%	9.3%	23.1%	1.3%
Union City	3.5%	2.3%	76.7%	15.9%	0.6%

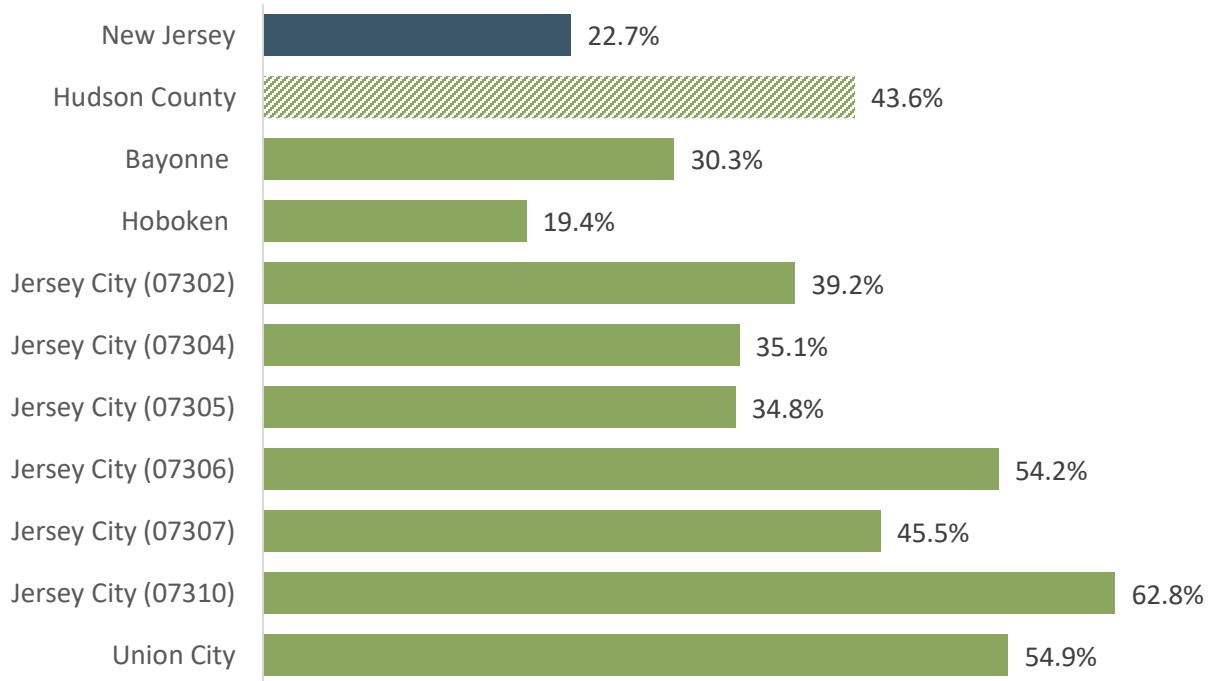
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Foreign-Born Population

Key informant and focus group participants described a robust immigrant community in Hudson County. Multiple waves of migration resulted in pockets of recent and not-so-recent immigrants from many Latin American and Caribbean as well as Southeast Asian countries. Secondary data show varying levels of the foreign-born population across Hudson County. More than two out of every five Hudson County residents are foreign born (43.6%), double the percentage of foreign-born residents in New Jersey as a whole (22.7%). In 2016-2020, the foreign-born population ranged from 19.4% in Hoboken to 62.8% in Jersey City zip code 07310 (Figure 5). In Hudson County, the most common countries of origin for immigrant residents were India and the Dominican Republic (making up 12.8% and 12.1% of the immigrant population, respectively). The majority of other immigrants were from Latin America and the Caribbean, primarily Ecuador, Cuba, and Colombia (see Table 4).

“The [Filipino] community has strong roots, and generations of families that have made Jersey City their home.” – Focus group participant

Figure 5. Percent Foreign Born Population, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 4. Foreign-Born Population by Top Countries of Origin, by State and County, 2016-2020

	New Jersey		Hudson County	
1	India	13.1%	India	12.8%
2	Dominican Republic	9.1%	Dominican Republic	12.1%
3	Mexico	5.1%	Ecuador	6.5%
4	Colombia	4.3%	Cuba	6.4%
5	Ecuador	4.1%	Colombia	5.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

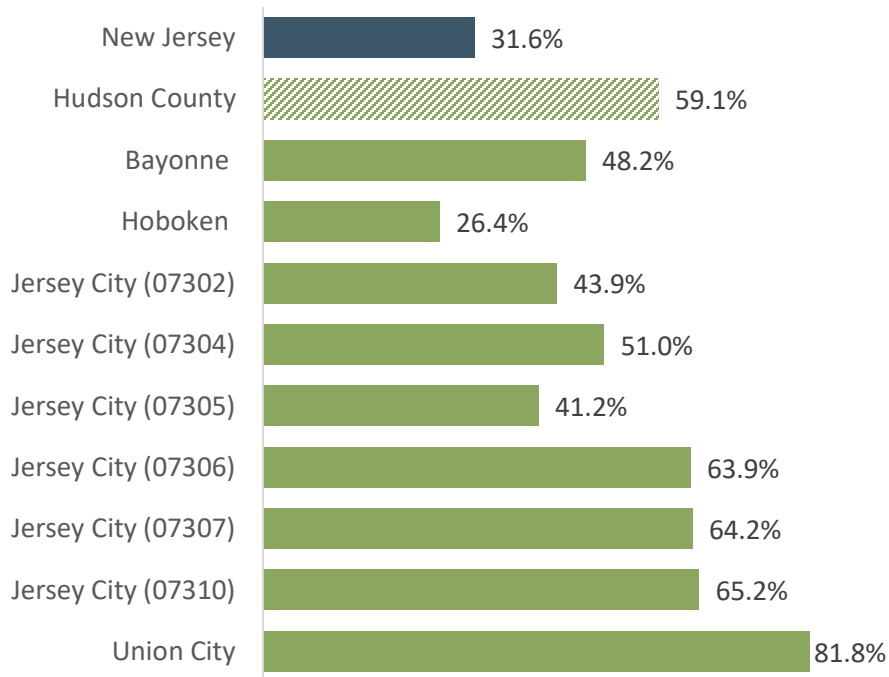
Several participants mentioned the struggles faced by undocumented immigrants in their day-to-day life because of their status. The anti-immigrant rhetoric of recent years, coupled with increases in raids targeting immigrants, has severely affected the mental well-being of this community, provoking undue stress and anxiety. This is coupled by barriers to access basic protections related to employment and housing due to their legal status. Further, these populations have been among the most affected by COVID-19, both in terms of sickness, as well as in terms of job loss. Whereas free or low-cost medical care is available to everyone regardless of documentation status via the FQHCs and other providers, participants commented that more efforts are needed to reach the entire eligible population and bridge the care gap.

“This a time when immigrants are feeling unsafe. They're scared going and saying, “I'm undocumented”.”– Key informant interviewee

Language Diversity

A majority of Hudson County residents over age five (59.1%) reported speaking a language other than English at home in 2016-2020, with large local differences. For example, almost five in six Union County residents (81.8%) and four in six in Jersey City zip codes 07306 (63.9%), 07307 (64.2%), and 07310 (65.2%) spoke a language other than English at home, compared to one in four Hoboken residents (26.4%) (Figure 6). A variety of languages are spoken across Hudson County, as indicated in the secondary data and supported by qualitative discussions. The most spoken languages other than English are Spanish (37.1%), other Indo-European languages (e.g., Portuguese, Hindi, Gujarati) (8.3%), Arabic (2.6%), Chinese (2.4%), and Tagalog (2.1%) (Table 5). Other languages spoken include Russian, Polish and other Slavic languages; French, Haitian or Cajun; Korean; and Vietnamese, reflecting the county's diverse communities. The distribution of these languages is not even. For example, three-quarters of residents in Union City speak Spanish (75.8%), while 24.9% of residents in Jersey City zip code 07310 speak other Indo-European languages and 19.7% speak Chinese. There are also, for example, pockets of Arabic speakers in Bayonne and Jersey City zip codes 07306 and 07304; while the Filipino community is largely concentrated in Jersey City zip codes 07304, 07305, and 07306.

Figure 6. Population Aged 5+ Speak Language Other Than English at Home, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 5. Top Languages Spoken at Home, by State, County, and Town, 2016-2020

	Speak only English	Spanish	Other Indo-European languages	Chinese (incl. Mandarin, Cantonese)	Tagalog (incl. Filipino)	Other Asian and Pacific Island languages	Arabic
New Jersey	68.4%	16.4%	5.4%	1.4%	0.9%	1.5%	0.9%
Hudson County	40.9%	37.1%	8.3%	2.4%	2.1%	1.7%	2.6%
Bayonne	51.8%	25.0%	5.3%	0.6%	2.7%	1.2%	8.1%
Hoboken	73.6%	10.2%	4.6%	4.5%	0.4%	0.8%	0.1%
Jersey City (07302)	56.1%	9.6%	13.6%	7.3%	1.4%	3.6%	0.7%
Jersey City (07304)	49.0%	29.1%	2.3%	0.4%	5.5%	1.5%	6.7%
Jersey City (07305)	58.8%	18.5%	3.4%	0.9%	6.4%	0.3%	2.4%
Jersey City (07306)	36.1%	22.4%	18.9%	1.7%	5.8%	4.2%	6.8%
Jersey City (07307)	35.8%	36.6%	18.2%	1.1%	1.3%	2.1%	1.8%
Jersey City (07310)	34.8%	8.4%	24.9%	19.7%	0.1%	6.3%	0.1%
Union City	18.2%	75.8%	1.8%	1.1%	0.4%	0.4%	0.7%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

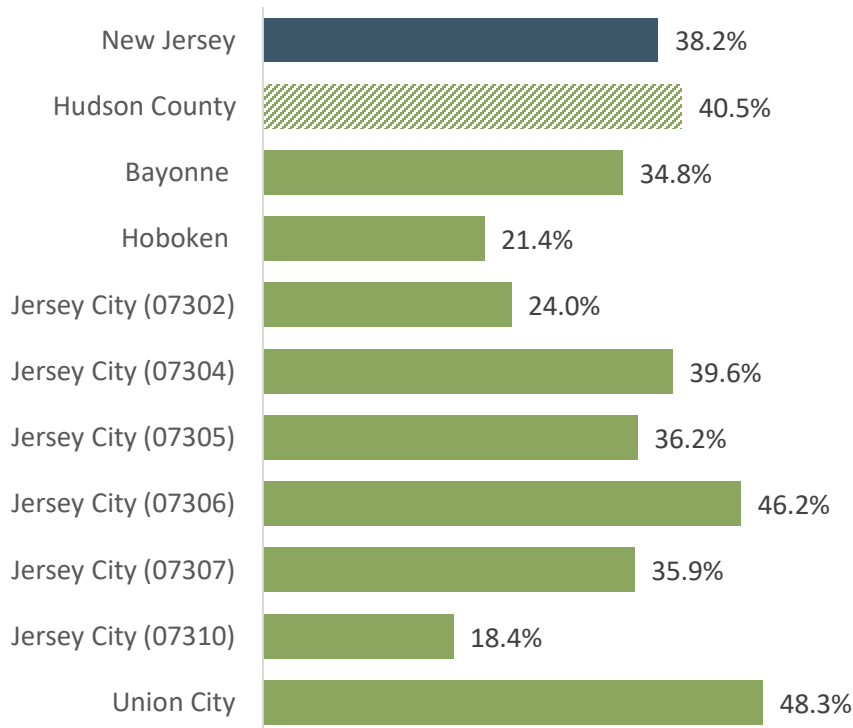
Many participants agreed that one of Jersey City and Hudson County's greatest strength is its diversity. Based on resident feedback, Hudson County is a welcoming place for foreign-born persons, non-English speakers, and people of diverse ethnic backgrounds. A Filipino resident expressed it as, *"the [Filipino] community has strong roots, and generations of families that have made Jersey City their home."* Overwhelmingly, residents indicated that they enjoyed the opportunity to learn about different cultures, and to access foods and other cultural elements from a variety of regions. As a focus group participant explained, *"It's a multicultural city so you have several different ethnicities... you get to learn about the food and people's culture."* Residents overall also

valued that medical and social services providers looked like them and spoke to them in their native language. However, opinions differed in terms of the availability of multilingual providers and providers of color. Whereas residents of Indian descent indicated that *"there are plenty of Indian, multiple language speakers, physicians in the JCMC and in the community,"* Latino residents were more nuanced noting that whereas the federally qualified health centers (FQHCs) had ample Spanish speakers, hospitals in the area needed more staff that spoke their language.

"I do feel welcome by healthcare providers, but I have experienced going with my parents who are immigrants with heavy accents, and I have experienced miscommunication." – Focus group participant

While diversity was a substantial community strength, participants noted that it could also be a challenge to engagement. In Hudson County, 40.5% of residents were not proficient in English in 2016-2020, ranging from 18.4% in Jersey City zip code 07310 to 48.3% in Union City. Lack of English proficiency can pose a barrier to entering the professional workforce, learning, and accessing healthcare. Those working in the social sector worried about populations not reached with information or services. In the words of a public health official, *"we talk to funders all the time about how to translate health information into other languages, how to connect to communities. We talk about it all the time, how to get into mosques, communicate in other ways besides English newspapers, how to create equity for people who are following the news."* In addition, lack of English-proficiency can lead to discrimination. According to survey data, 22.7% of Asian respondents and 17.6% of Latino community respondents specifically described being discriminated against because of language/speech issues when receiving medical care (discussed in greater detail in the Discrimination and Racism section of this report.)

Figure 7. Population Lacking English Proficiency (Out of Population Who Speak a Language Other Than English at Home), by State, County, and Town, 2016-2020

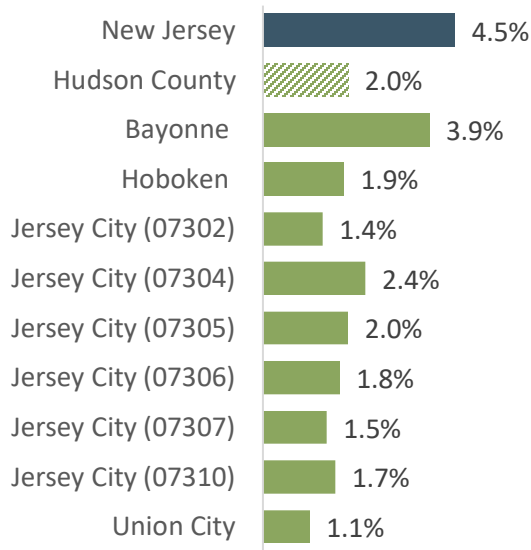


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

U.S. Veterans

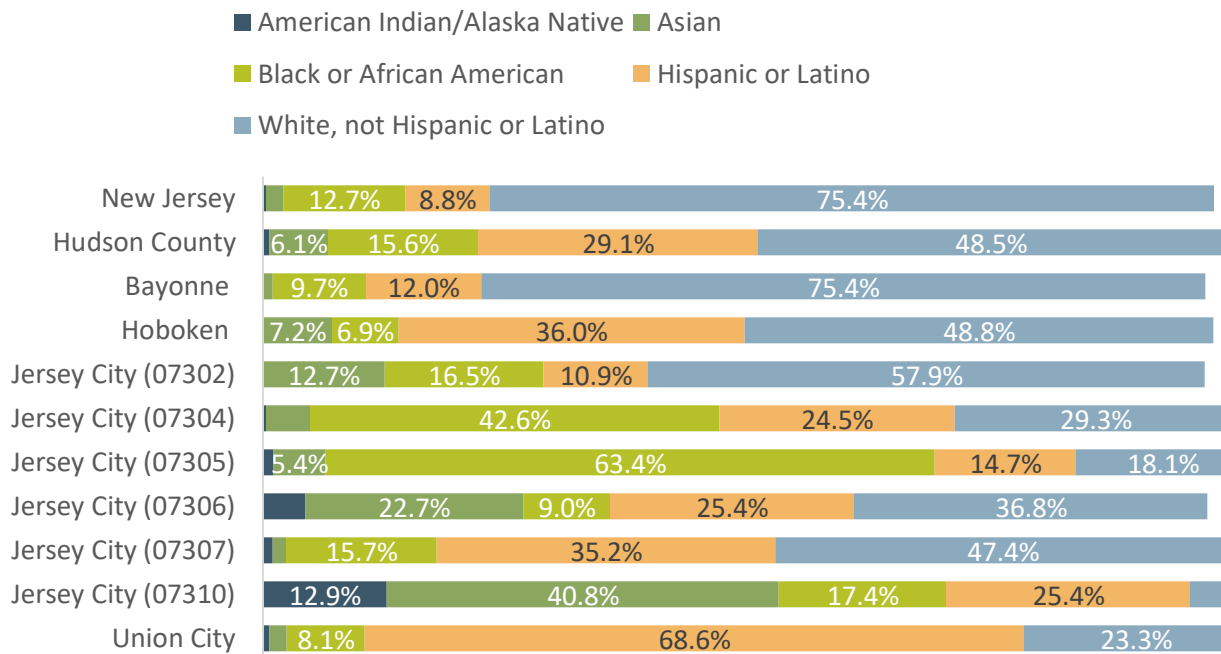
One of the groups whose needs were highlighted during discussions were U.S. veterans. About 2% of the Hudson County population are veterans, with the city of Bayonne having the highest percentage of the areas observed (3.9%) (Figure 8). The race/ethnicity of veterans in Hudson County mimics the diversity of the county’s population. Hudson County has proportionately more veterans who identify as Asian (6.1%), Black (15.6%), and Latino (29.1%) residents than the state (Figure 9), with important variation across neighborhoods. A majority of veterans in Jersey City zip codes 07304 and 07305 identify as Black (42.6% and 63.4%, respectively), whereas 40.8% of veterans in Jersey City zip code 07310 identify as Asian, and 68.6% of veterans in Union City identify as Latino. Bayonne and Jersey City 07302 have the highest concentration of White veterans (75.4% and 57.9%, respectively).

Figure 8. Percent Population 18+ Years with Veteran Status, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 9. Racial/Ethnic Distribution of Veterans, by State, County, and Town, 2016-2020



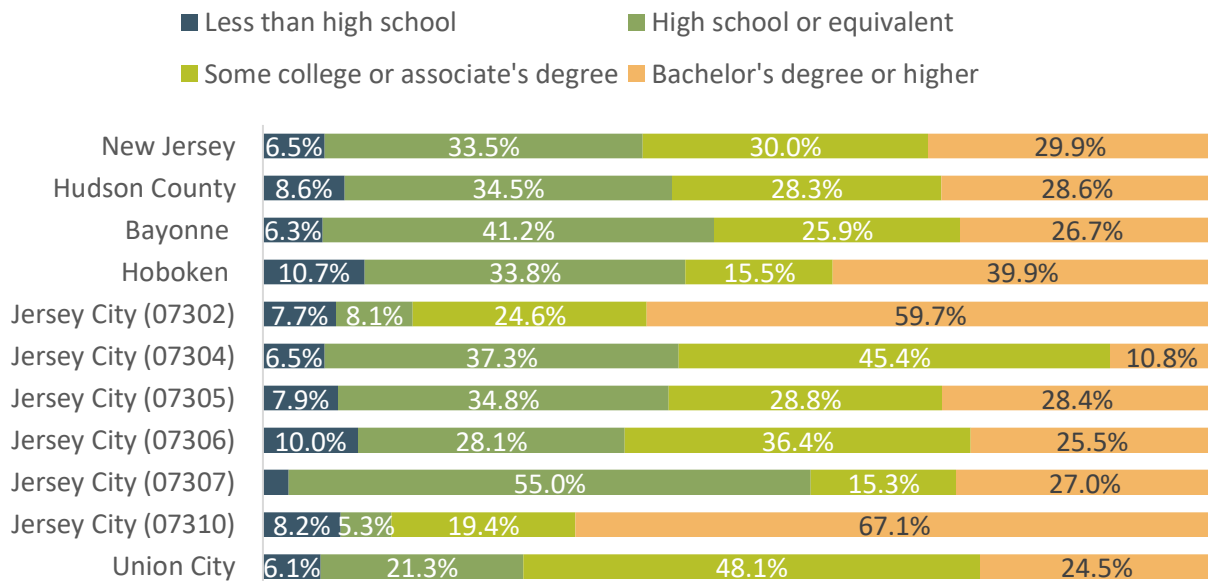
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive unless stated. Values under 5.0% are omitted for clarity.

Veterans in Hudson County remarked that they had limited employment opportunities available to them. They mentioned that, often, the jobs available to them after serving the government were for positions requiring no special skills, underpaid, and with few possibilities for advancement. Education is

an important factor in gaining access to higher-paying positions. When examining the educational attainment of veterans in Hudson County, we observe that most veterans did not have a bachelor’s degree or higher (71.4%) (Figure 10). Only 10.8% of residents obtained a college degree in Jersey City zip code 07304, where many Black veterans reside. Employment and education, together with mental and physical health, are closely related to poverty. A higher proportion of veterans in Hudson County live below the poverty line than in New Jersey (7.5% vs. 5.2%, respectively). This proportion is much higher in Jersey City 07306, where one in five veterans live in poverty, and Jersey City zip code 07305, where 18.0% do. It is important to remember that the poverty line is substantially below a livable income and has become even more so recently with high rates of inflation. Special issues faced by veterans are discussed throughout the report in the specific topic area sections.

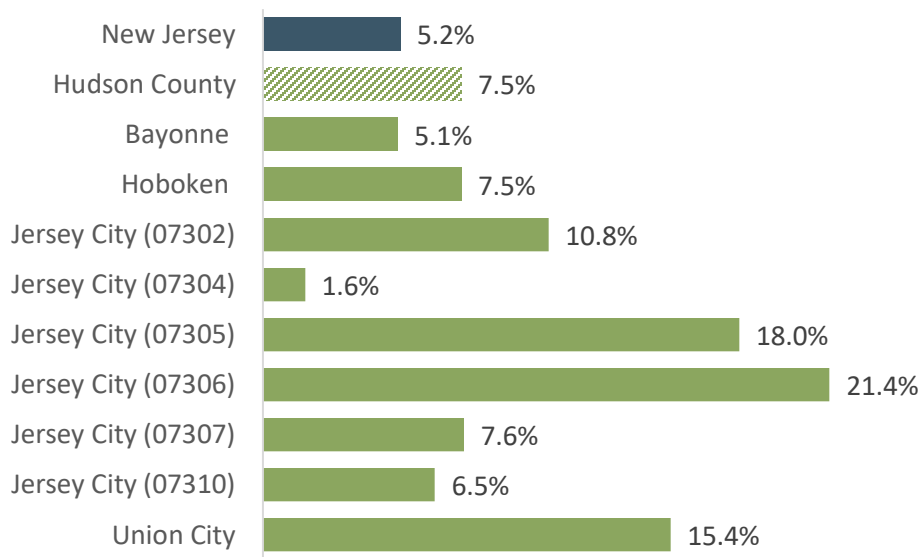
Figure 10. Educational Attainment of Veterans, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

NOTE: Values under 5.0% are omitted for clarity.

Figure 11. Percent Veterans Below Poverty Level, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Community Social and Economic Environment

Income, work, education, and other social and economic factors are powerful social determinants of health. For example, jobs that pay a living wage enable workers to live in neighborhoods that promote health (e.g., built environments that promote physical activity and resident engagement, better access to affordable healthy foods), and provide income and benefits to access health care. In contrast, unemployment, underemployment, and job instability make it difficult to afford housing, goods and services that are linked with health and health care, and also contribute to stressful life circumstances that affect multiple aspects of health.

Community Strengths and Assets

Understanding the resources and services available in a community—as well as their distribution—helps to elucidate the assets that can be drawn upon to address community health, as well as any gaps that might exist.

Strong Community and Partnerships

In addition to diversity noted previously, another strength mentioned by participants was solidarity and a strong sense of community. Time and time again, participants noted that neighbors came together to help those in need. As a resident noted, *“My specific neighborhood is very close knit, you know the people in the area and people are willing to help you. For example, when it snows, I’ve had young kids, young teenagers ask like, can we help you?”*

Residents remarked that the community was able to organize and take action to address people’s needs and this came to the forefront throughout the pandemic, including through generous donations. A healthcare administrator echoed this sentiment, *“these are communities that show up when the need is there, and we saw that during the COVID pandemic. We raised over a million dollars for an emergency response fund, from old donors and new donors.”*

“I’m new to Jersey City, but I noticed since doing Covid work in June that there is a strong sense of community.”
– Focus group participant

At an institutional level, another strength are the robust partnerships established among multiple organizations and across sectors, including grassroots organizations, government, small businesses, social services agencies, and healthcare centers. These collaborations are exemplified by the Partnership for a HealthierJC, made up of nearly 300 member organizations. A public health official noted, *“We have great partners. Hudson County is very tight, so we all work together.”* As a health administrator said when reflecting on the response to COVID-19, *“As organizations ... who did demonstrate that more than whatever resources were available to our community, we all jumped in and that includes Jersey City Medical Center. We were able to get people in and out of the hospitals quickly and people were able to communicate with each other.”* This was echoed by public health staff from different areas of Hudson County, as exemplified by what this participant from Bayonne said, *“Whenever there is an emergency, Bayonne comes together as a community to help people out, through donations or referrals for services.”*

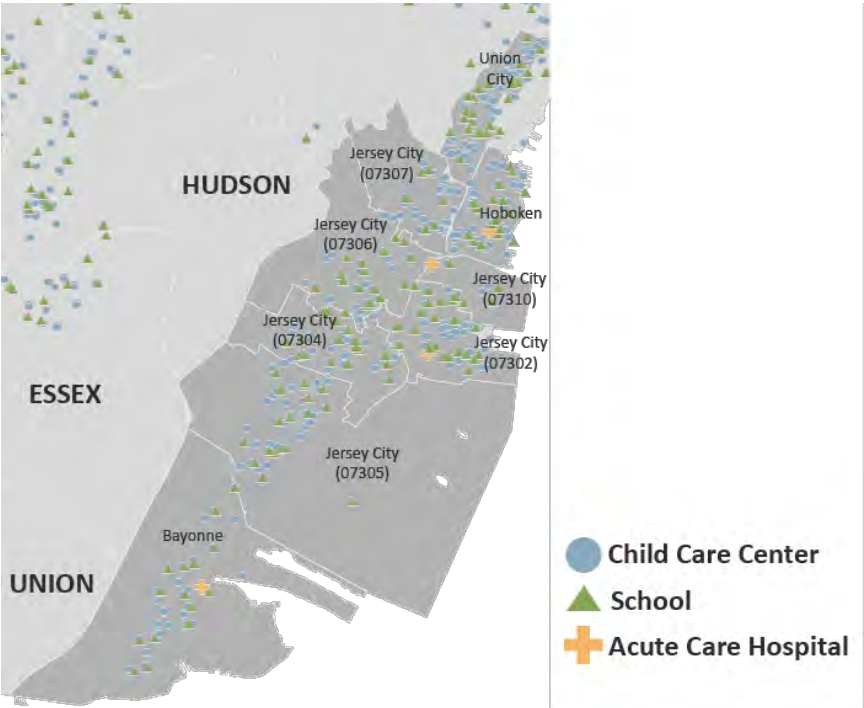
Public Services and Programs

Some participants indicated that their elected officials were a source of strength in Hudson County. A diverse array of residents, including from the Latino, Asian, and LGBTQ+ community, indicated being represented and supported by government leaders. One example of support for the LGBTQ+ community was the recent passing of the law to let students use bathrooms that are consistent with their gender identity, considered an important step in fostering welcoming and safe spaces for gender nonbinary youth. Residents noted that the Jersey City government was responsive to their needs and that they received abundant support during the COVID-19 pandemic, as expressed by a Latino resident, *“The mayor’s office provides very good services; for example, if someone has to travel far to get to the doctor, or if they need translation of a document to Spanish—you can call the mayor’s office for everything.”*

Overall, residents indicated that Hudson County offers many services to people to ensure that residents live well and can access their basic needs. The map below shows the distribution of hospitals, schools, and childcare centers in the area.

There are four acute care hospitals as well as 151 schools and 301 childcare centers in the JCMC service area (Figure 12).

Figure 12. Community Assets Map of Hudson County, 2018 & 2020



DATA SOURCE: New Jersey Geographic Information Network (NJGIN), Schools and Child Care Centers, 2018 and Acute Care Hospitals, 2020

As one resident summed up, “...there is something going on almost every week to help with food, home purchases, that’s one of the things I really love about Jersey City.” A Hoboken resident expressed something similar, noting that a strength in Hoboken were the “strong non-profit organizations and religious organizations that provide supportive services related to housing assistance and information, nutritional support, recreational activities for children, tutoring...” Latino residents discussed how the county offered resources in the community to support people, including people who are low-income, undocumented, and/or without health insurance.

“From my experience, over 20 years, I feel that the greatest strengths are the community-based organizations. We have a wide range of individuals who form different communities, even small grassroots community-based organizations, to engage people in healthy ways.” – Key informant interviewee

Other Community Assets

Community survey respondents partially agreed with these themes. When asked how much they agreed or disagreed with a number of statements about their community, responses were similar to when this survey was administered in 2019. The strengths identified by the greatest proportion of respondents in 2021 were that it was easy to find fresh fruits and vegetables in their communities (73.6%), that their communities had safe outdoor places to walk and play (70.3%), and that their community was a good place to raise a family (59.7%) and to socialize (58.2%) (Figure 13). These were the same top responses in 2019.

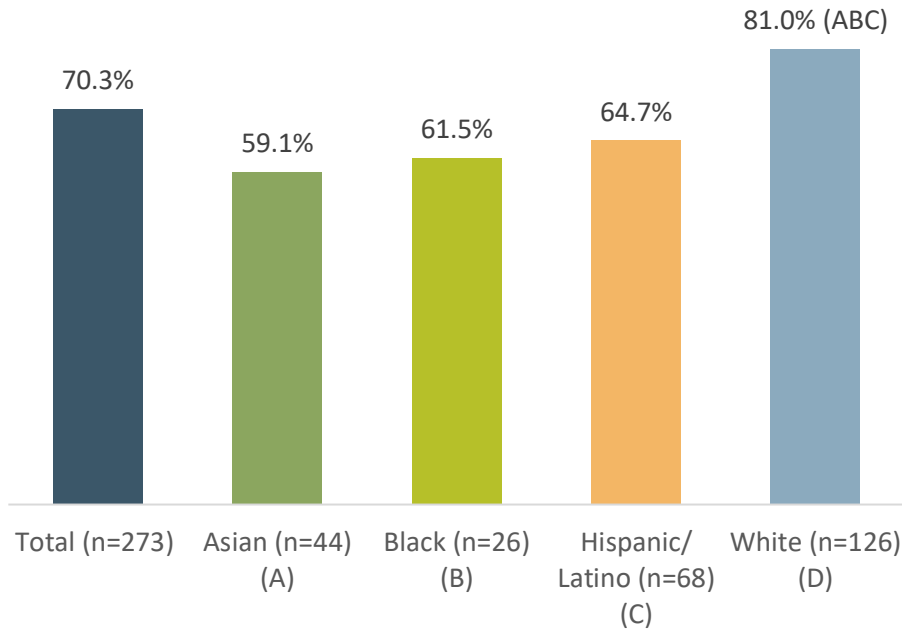
Figure 13. Percent of Community Survey Respondents Noting Strengths in Their Community (Agree or Completely Agree with Statements) (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

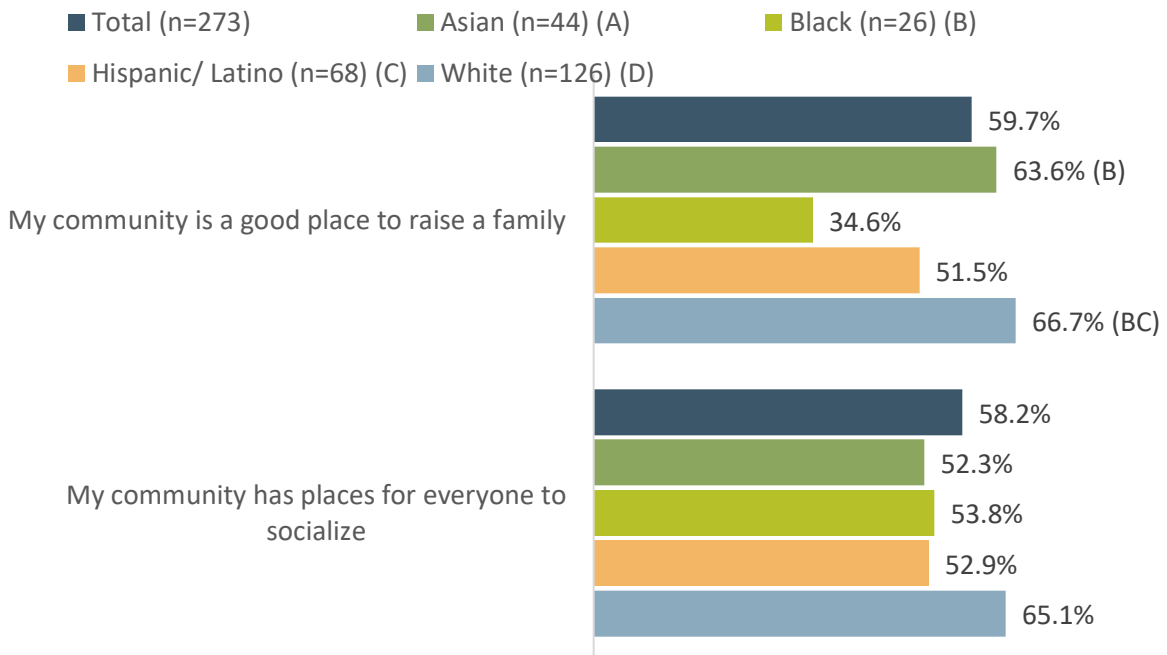
However, responses to these questions varied by race/ethnicity. For example, as can be observed in Figure 14, White respondents were significantly more likely than Asian, Black, and Latino respondents to agree or completely agree that their community had safe outdoor places to walk and play. As described in the Methods section, when a graph of community survey data has a letter next to the bar, it indicates that the group for that bar has a statistically significant different frequency of responses compared to the group of the letter shown. As shown, whereas 81.0% of White respondents perceived outdoor spaces as safe, only 59.1% of Asian respondents did so. Whereas there were no significant differences by respondents' race/ethnicity to the statement about having spaces to socialize, Asian (63.6%) and White (66.7%) respondents more often indicated that the community was a good place to raise their family than Black (34.6%) respondents (Figure 15). (More detailed discussions of responses by different population groups of other survey questions are found in the topic-specific sections of this report.) Additional data are available in Appendix F- Additional Data Tables.

Figure 14. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “My community has safe outdoor places to walk and play”, by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Figure 15. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement, by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Education

Educational attainment is another important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty.

School Environment and Health

A positive school environment is an important determinant of physical and mental wellbeing, as well as academic success, staying in school, and opting to continue on to higher education. An interviewee who was a member of the LGBTQ+ community lauded schools for their efforts to make school safe and welcoming to all youth. In their words, “[LGBTQ+] youth are still dealing with bullying, [but] schools are reaching out to learn and make spaces safer. School leaders come in to engage us as a liaison, to organize school clubs that are inclusive and to receive cultural competency training from us.”

Conversely, being healthy is a key factor in being academically successful. Schools play an important role in facilitating access to care and helping students stay healthy. A school administrator described some of the public school’s efforts to address the mental health needs of students, “We’ve been trying through the schools with our resources to really embed more social and emotional [support to] help students overcome challenges, develop resilience, and be able to speak about their emotions. [We have] incorporated that through the curriculum, through our school counselors, through our school psychologist.” Many students also face poverty and food insecurity; in providing free or low-cost lunches, schools also play an important role in ensuring basic nutrition for children.

Public Schooling

Focus group and interview participants discussed how the public school system in Hudson County faces a variety of issues. One is a lack of sufficient resources to attend to the needs of high-need population groups. There is a perpetual shortage of qualified educators, particularly in those areas where teachers need additional certifications or schooling. An education administrator emphasized that more qualified Special Education teachers, bilingual teachers, and content area teachers, like those that teach Science and Math, are needed to meet the needs of the student population. Another issue that came up was the lack of affordable after school programs, particularly important for children of low-income earners.

In some areas of Hudson County, such as Hoboken, a problem identified by participants was that there is insufficient space to accommodate the growing number of school children. Residents expressed that “[population] growth was not planned,” leading to overcrowding in public and charter schools. Residents discussed how new buildings and improved infrastructure for schools were needed to accommodate the influx of new residents coming to the new condominium buildings.

In spite of these challenges, most Hudson County residents indicated that public school leadership was supportive of students’ needs and open to partnerships with different organizations to better serve the community. Many residents remarked that the school leadership was attuned to the needs of students and their families, many of whom face multiple struggles. Given the large immigrant community in Hudson County, schools must accommodate to the needs of English-language learners.

Key informant interviewees indicated that Hudson County public schools fall along a broad spectrum encompassing both the top-ranking, as well as the lower performing, schools in New Jersey. School performance is determined largely by the socioeconomic situation of the community that draws the student population. There is an inverse association between socioeconomic status and high school graduation rates. Key informant interviewees noted that students experiencing poverty often had to drop out of school to start working and

“We have children who are immigrants and come in when they’re 16 years old and are learning English. They need to graduate from high school, but they also need a job because economically they need to go work. It’s a challenge.”

– Key informant interviewee

contribute an income to their families. These students’ vision for the future oftentimes does not include college as a career path unless they have access to a mentor who can help them enter a professional career. Key informant interviewees explained that low-income students faced multiple obstacles to entering college, including not being able to afford it; having to full-time to support the family; and not seeing the usefulness of a college degree. Based on this context, key informant interviewees indicated that public schools were trying to equip students’ transition into the workforce by incorporating classes and training related to workplace readiness. *“We’ve been working on it trying to incorporate more careers, not just OK you’re gonna graduate and go to college and then get a job. But, you know, addressing the needs of those students who will not go to college.”*

Inequities in school performance are confirmed by graduation rate data from different Hudson County districts. Whereas in 2020-2021 the Hoboken Public School District had graduation rates slightly above those of New Jersey as whole (93.6% and 92.6%, respectively), the public school districts of Bayonne, Union City, and Jersey City had lower graduation rates, with significant disparities by race/ethnicity within districts (Table 6). For example, 95.3% of Asian students graduated from High School in Bayonne in 2020-2021, compared to 86.4% of Black children and 78.5% of Latino children. Additional information on differences in educational attainment by race/ethnicity and by town is available in Appendix F.

Table 6. 4-Year Adjusted Cohort High School Graduation Rate, by Race/Ethnicity and School District, 2020-2021

New Jersey	Statewide	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	2+ Races
	92.6%	97.6%	88.3%	87.4%	95.9%	93.5%
Hudson County	District Wide	Asian	Black	Hispanic	White	Two+ Races
Bayonne School District	86.4%	95.3%	86.4%	78.5%	94.1%	85.7%
Hoboken Public School District	93.6%	*	90.9%	95.2%	89.5%	N
Jersey City Public Schools	78.0%	93.7%	73.8%	72.8%	85.0%	45.5%
Union City School District	88.5%	*	91.7%	88.3%	90.5%	N

DATA SOURCE: New Jersey Department of Education, School Performance, Adjusted Cohort Graduation Rates, 2020-21

NOTE: * indicates that data is not displayed to protect student privacy. An N indicates that no data is available.

Promising Initiatives

To better address the needs of community, the Jersey City Board of Education has partnered with educators, families, and the community as a whole to launch a promising model known as ‘community schools.’ Community schools provide additional services than regular schools to meet the needs of students and families. In addition to regular school offerings, community schools aim to connect students and parents with a wide range of services, including afterschool programs, counseling, and social services. This model has helped to improve attendance, grades, and student and parent engagement. Some of the schools have brought in health clinics that offer nutrition and health care to both students and their families. According to a school administrator, the key to the success of one of the community schools is that *“it’s a very cohesive community,”* with *“good leadership at the school that has been good in working with the community, the providers,”* and the fact that *“the staff, the teachers are all vested and making it successful.”*

Another successful initiative that participants discussed was The Tiger's Den at Snyder High School, a result of a partnership between JCMC, The NJ Department of Children and Families, and the Jersey City Board of Education. The Tiger's Den offers free, confidential social services to students, families, and staff, including psychological counseling, vocational counseling, workplace readiness programs, academic support, summer employment, and after school programs. The Tiger’s Den also assigns students with mentors who they can talk to about their problems and guide them to resolve issues in a positive way. Graduation rate for students participating in The Tiger’s Den was 99% compared to 60% in the school overall.

These are promising strategies to help more students from low-income families finish High School and either enter the workforce in stable employment or continue on to college, two pathways to facilitate the transition to the middle class.

Inequality

Growing inequality, exacerbated as much by the COVID-19 pandemic as by policies and the existing economic model, was a theme that came out strongly in all focus groups and interviews. Most residents across racial/ethnic groups indicated that Jersey City was catering to the wealthy and that income distribution was unequal. As one participant summarized, *“We have the multimillion front, you know, waterfront properties and then we have below the poverty line, urban homes with very urban problems.”* Residents expressed frustration and a sense of injustice witnessing the rapid concentration of wealth in fewer hands, while employment loss and inflation lead more people into poverty. Residents consistently expressed that the city was catering to affluent families in detriment to middle- and low-income residents, and this was evidenced by policies related to real estate credits; infrastructure and public services investments; and a regressive taxation structure. Often, residents attributed racial/ethnic tension to this growing inequality, as expressed by these words, *“From our perspective you do have a lot of stressors around that, especially with gentrification, there is more tension with people originally from the neighborhood as opposite to newcomers. Tax breaks in one section, and in the African American section you can’t get your garbage picked up, there is tension and anger from the ‘tale of two cities’.”* As these words capture, there is also a racial/ethnic component superimposed on inequality, as Latinos and Black residents are disproportionately affected by household and neighborhood poverty. A Black resident reflected thus on the situation, *“they’re not really including us in the expansion of Jersey City. Jersey City is up and coming, but they’re not making room for low to middle income people... And this is people of all races, they’re not gonna pay all that money for taxes, and there are no jobs here.”*

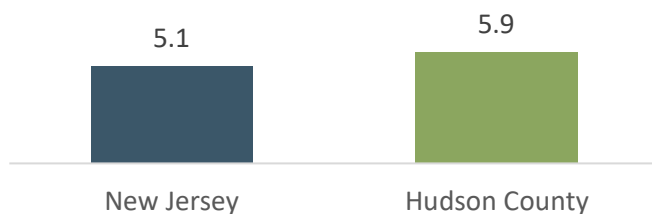
Neighborhood concentrated poverty compounds the effect of household poverty. Explaining the linkage between income, hopelessness, and violence, a resident noted, *“...And then there’s the level of community violence. Feeling really stuck in that cycle that they’re in, violence, income or job opportunities, social determinants of health like housing. People are getting pushed out as more development is coming.”*

“It’s like they don’t want us to be here anymore, they’re just welcoming the rich and affluent... It looks like Jersey City is trying to cater to the affluent instead of the people who grew up here.” – Focus group participant

On reflecting about her vision for the future, a key informant interviewee synthesized the voices of many residents, *“My biggest wish for this community is that we don’t have such an economically diverse community. If there’s a way to really help the families with the lowest resource economic resources to really have a more stable financial sense, that would be the ideal.”*

Inequality is reflected in many of the sections of this report, including education, employment and workforce, income and financial security, and access to healthcare, among others. For example, income inequality is greater in Hudson County (5.9) than in New Jersey overall (5.1) (Figure 16). Income inequality is calculated as the ratio of household income at the 80th percentile to that at the 20th percentile. A higher number indicates a greater income gap between the wealthiest and the poorest households.

Figure 16. Income Inequality (80th to 20th Percentile Income Ratio), by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020

NOTE: The ratio of household income at the 80th percentile to that at the 20th percentile, where the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes, and the 20th percentile is the level of income at which only 20% of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum.

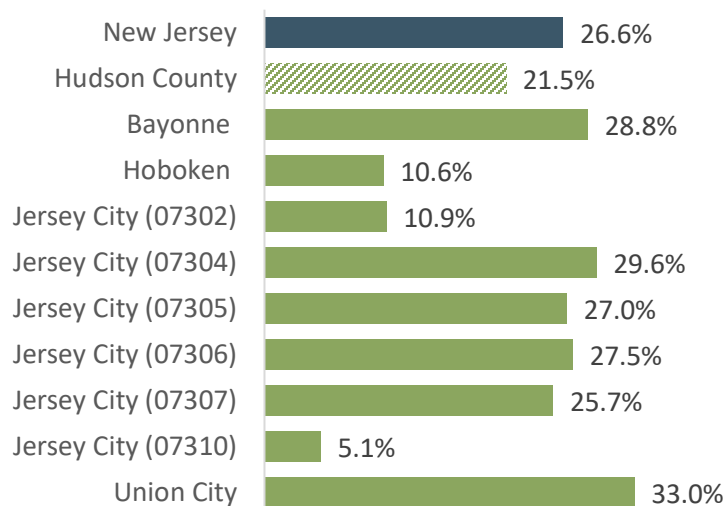
Employment and Workforce

Employment can confer income, benefits, and economic stability – factors that promote physical and mental health. Two main employment-related issues came out of the focus groups and interviews. On the one hand, many noted that employment opportunities were limited in Hudson County, particularly as a result of the pandemic. Often, they mentioned being unemployed or underemployed. Residents also said that employment opportunities were limited even among people with college degrees without the right connections. Job instability affected many residents across multiple groups. Multiple residents complained of the dearth of well-paid employment opportunities, that offer employees health and social benefits, a fixed income, and a living wage. Many of the residents we interviewed were working poor, who, despite working, could not afford housing, or had to choose between rent, food or medicine.

“I feel like getting a [college] degree was for nothing sometimes because like why am I still struggling to make it.” – Focus group participant

Indeed, in 2018, one in five of the County’s households were Asset Limited, Income Constrained, Employed (ALICE), meaning that although employed, they did not earn enough to support their families (Figure 17), ranging from 5.1% in Jersey City zip code 07310 to 33% in Union City.

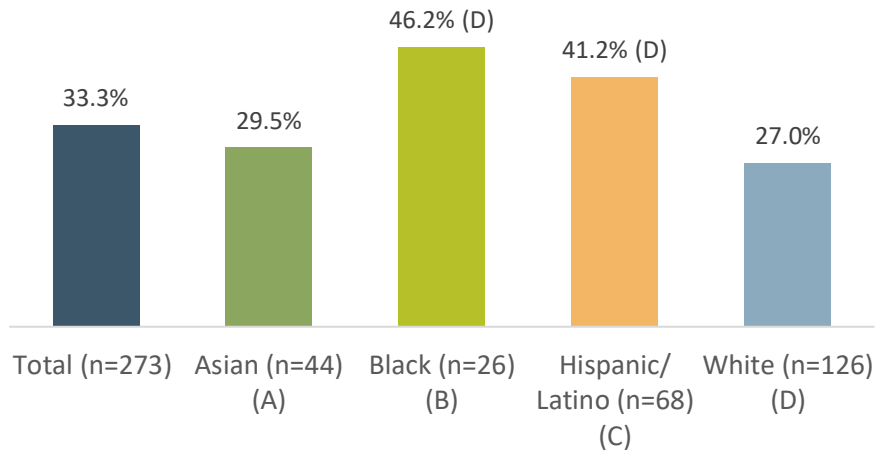
Figure 17. Percent Households Falling into ALICE Population, by State and County, 2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018 as reported by United Ways of New Jersey, Alice in New Jersey: A Financial Hardship Study, 2020

Participants talked about the challenges of the COVID-19 pandemic on essential front-line and lower wage workers, many of whom lost their jobs, either temporarily or permanently. Latino participants mentioned that many factories and restaurants closed during the pandemic and that they could not find jobs. The effects of COVID-19 on employment are also reflected in quantitative data. Black and Latino respondents were significantly more likely than White respondents to report having lost income due to COVID-19 (46.2%, 41.2%, and 27.0%, respectively) (Figure 18). Like New Jersey as a whole, in 2019, prior to the pandemic, Hudson County reported the lowest unemployment rate (3.1%) in recent years according to the Bureau of Labor Statistics (Figure 19). However, unemployment rates in 2020 spiked at 10.2%, recovering slightly to 6.3% in 2021. Additional data can be found in Appendix F- Additional Data Tables.

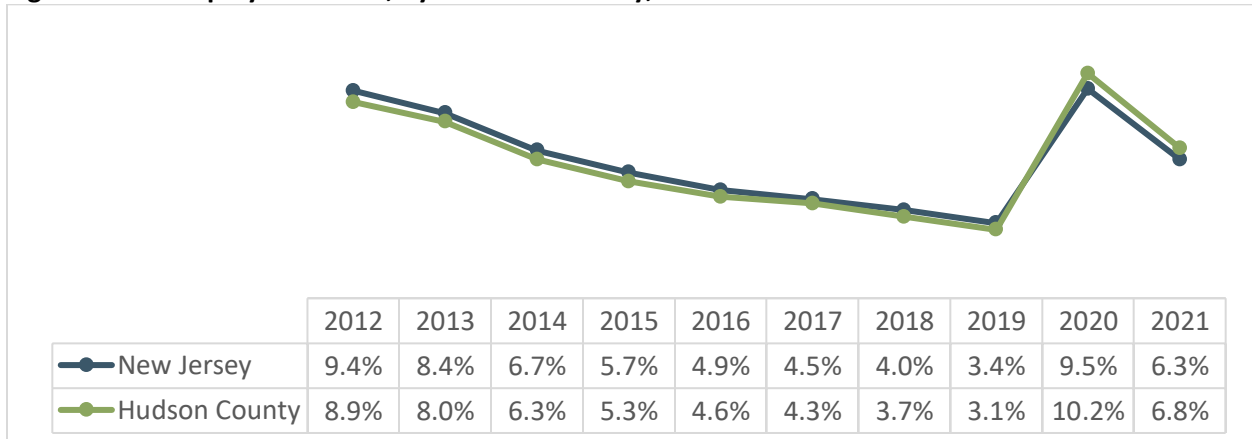
Figure 18. Percent of Community Survey Respondents Reporting that They or a Member of Their Family Lost Employment Due to COVID-19 (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Figure 19. Unemployment Rate, by State and County, 2012-2021



DATA SOURCE: Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012-2021

NOTE: Not seasonally adjusted

The 2016-2020 aggregated data from the American Community Survey show that unemployment rates across Hudson County ranged from 2.4% in Jersey City zip code 07302 to 7.0% in Jersey City zip code 07305 and 9.2% in Jersey City zip code 07304 (Table 7). However, this varies by race/ethnicity (Table 8). Indeed, unemployment rates map onto racial/ethnic groups; as discussed in the section on population characteristics, residents in zip code 070302 are predominantly White (40.1%) and Asian (32.2%), whereas over two-thirds of residents in zip codes 07304 and 07305 are Black and Latino (Table 3). The highest unemployment rates in Hudson County were among Native Hawaiian and Other Pacific Islander residents (35.9%), followed by American Indian and Alaska Native residents (10.1%) in 2016-2020, and the lowest were among Asian (3.5%) and White (4.0%) residents (Table 8). Additional data on unemployment rates can be found in Appendix F- Additional Data Tables.

Table 7. Unemployment Rate among Workers 16 Years and Above, 2016-2020

	2016-2020
New Jersey	5.8%
Hudson County	5.4%
Bayonne	6.5%
Hoboken	3.2%
Jersey City (07302)	2.4%
Jersey City (07304)	9.2%
Jersey City (07305)	7.0%
Jersey City (07306)	4.7%
Jersey City (07307)	4.4%
Jersey City (07310)	2.7%
Union City	6.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

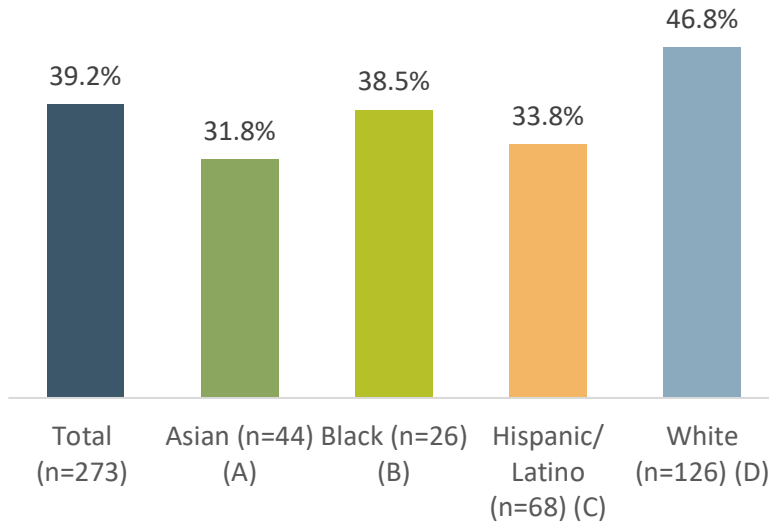
Table 8. Unemployment Rate by Race/Ethnicity, State, and County, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	American Indian and Alaska Native	Native Hawaiian and Other Pacific Islander	Other, Non-Hispanic
New Jersey	4.3%	9.0%	6.4%	5.0%	9.0%	6.5%	6.6%
Hudson County	3.5%	8.1%	6.6%	4.0%	10.1%	35.9%	6.9%
Bayonne	6.9%	6.3%	8.3%	5.6%	0.0%	100.0%	7.3%
Hoboken	3.7%	11.1%	6.3%	2.4%	0.0%	-	3.7%
Jersey City (07302)	1.1%	3.8%	3.3%	2.8%	0.0%	0.0%	2.7%
Jersey City (07304)	4.9%	9.8%	10.0%	9.9%	0.0%	-	10.9%
Jersey City (07305)	4.5%	8.4%	4.8%	8.3%	8.3%	-	6.2%
Jersey City (07306)	3.9%	5.5%	5.9%	5.2%	34.9%	-	3.5%
Jersey City (07307)	2.9%	9.1%	5.7%	2.6%	20.1%	-	3.9%
Jersey City (07310)	3.0%	8.4%	0.4%	2.1%	0.0%	-	0.0%
Union City	7.6%	4.6%	6.5%	3.7%	6.0%	30.2%	8.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When asked about employment in their area, survey respondents were not enthusiastic. Fewer than four in ten respondents agreed that “there are job opportunities in my area.” White respondents were more likely than respondents of any other race/ethnicity to perceive that there were employment opportunities in their area, although the differences were not statistically significant (Figure 20).

Figure 20. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “There are Job Opportunities in My Area,” by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

It is also important to understand overlapping conditions that may affect entering the workforce. Over the same period, unemployment rates in Hudson County were highest among women (5.6% among women compared to 4.9% among men) (Table 22 in the Appendix) and young people (18.8% among 16-19 year-olds and 11.0% among 20 to 24 year-olds) (Table 23 in the Appendix). The greatest difference in the female-to-male employment gap was in Jersey City zip code 07304 (10.8% female vs. 7.7% male unemployment rate), an area with many residents of color.

Residents noted that certain population subgroups in Hudson County faced more obstacles than others when seeking employment opportunities. Because of stigma and discrimination, Black trans women experienced multiple challenges to having a professional career and securing living-wage employment. As one key informant interviewee from the LGBTQ+ community explained, *“Black trans women experience the most barriers to employment. They become sex workers for survival. They have difficult experiences applying to jobs. They are ridiculed when applying to places.”* The options for gainful employment also appeared particularly dire for veterans, who are disproportionately Black and Latino. All veteran focus group participants agreed that the only types of jobs available to them either did not pay a living wage or were government jobs. Veteran focus group members expressed frustration at not being able to access satisfying and stimulating employment with growth opportunities. Residents suggested that more should be done to incentivize employers, including private employers, to hire trans and veteran residents.

When trying to interrupt the cycle of violence, whether domestic or community violence, gainful employment is critical to help survivors get on their feet. As a staff member from a violence interruption program mentioned, *“Employment is always an issue because you can tell folks a better day is coming, but what is the alternative? We try to never use that language unless we have an alternative. My main thing is stay safe and healthy. With the grant we just received, we have an opportunity to have 40-80*

participants, and we train them in electrical, plumbing, HVAC, and carpentry. Now we have something to say, I've got a job for you as long as you learn a skill and graduate from this program."

Time and time again participants mentioned that lack of secure and well-paid employment was an important contributor to depression. As a public health official said, *"Mental health issues happen because [veterans] cannot find jobs, they don't have the money, they have to move in with their parents."* And she continued, *"it's offensive to put someone who served, someone who earned a degree, behind a cash register... why are companies not stepping up, instead of making exorbitant profits, and training?"* Another resident said, *"[Not having a career], has been a part of my mental health depression."*

Income and Financial Security

Income is a powerful social determinant of health that influences where people live and their ability to access resources which affects health and well-being. The effects of poverty—food and housing insecurity, underinsurance, and stress leading to poor physical and mental health—are compounded by environmental factors. Areas with more concentrated poverty are also those with lower-performing schools, higher rates of community violence and substance use, buildings in worse conditions, and food deserts. Discussing issues related to children, a key informant interviewee said, *"We have, you know, that urban child with very limited resources, poverty, a lot of the issues of poverty and intergenerational poverty, with grandparents raising children."*

"People on the fringe of poverty have suffered." – Key informant interviewee

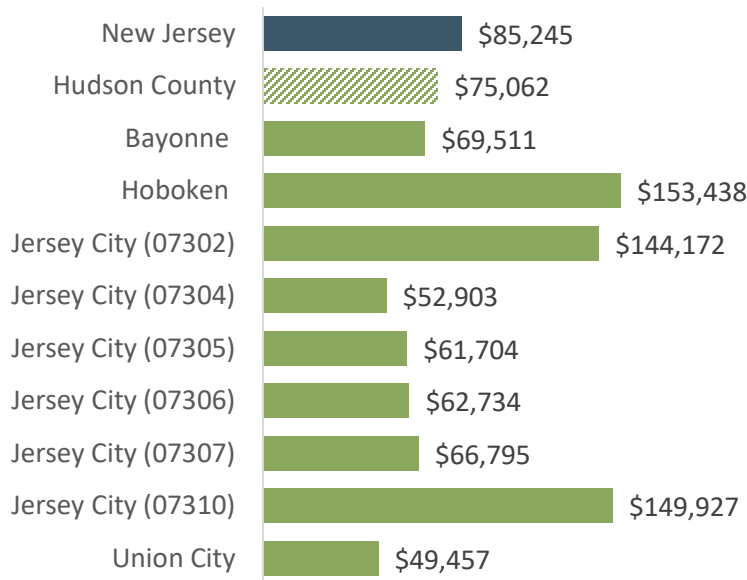
Many households face financial insecurity across many groups. Both children and youth face substantial insecurity, as well as older adults living on retirement. As discussed in the sections on Inequality and Employment and Workforce, inflation was a major concern for low-income earners as wages have not kept up with the cost of living. People across the spectrum were affected and many residents expressed concerns about the future, mentioning that wages were not keeping up with inflation, and as a result, more people were experiencing poverty.

Income and health are interrelated. Participants mentioned that people with chronic illnesses and disabilities often faced financial vulnerability as they were unable to work due to their health. In the words of a resident, *"There's income barriers, which runs into all areas. When you have physical health issues, that leads to loss of income."* On the other hand, residents noted that healthcare was not a priority when income was limited. Therefore, insufficient income becomes a barrier to accessing health insurance, preventive health care, and even treatment to manage chronic diseases. Many residents described that low-wage earners were faced with the dilemma of having to choose between food, rent, or medicine.

Household Income and Poverty

In Hudson County, financial wellbeing and insecurity varied by area. According to the 2016-2020 American Community Survey (U.S. Census), while the median household income for Hudson County (\$75,062) was below that of New Jersey (\$85,245) as a whole, the range in household income showed stark disparities. The median annual household income in 2016-2020 ranged from \$49,457 in Union City, where a majority of residents were Latino, to \$153,438 in Hoboken, with a majority of residents are White (Figure 21). Jersey City zip codes 07304, 07305, 07306, and 07307 all reported having median household incomes below the state average.

Figure 21. Median Household Income, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When analyzing these figures further, data show that Black and Latino households had lower median household incomes relative to the average across Hudson County. While Asian (\$116,309) and White (\$100,853) households reported incomes that were 55% and 34% higher than median household income in Hudson County (\$75,062), respectively, Black (\$53,196) and Hispanic/Latino (\$52,408) households earned 29% and 30% below the county median, respectively (Table 9).

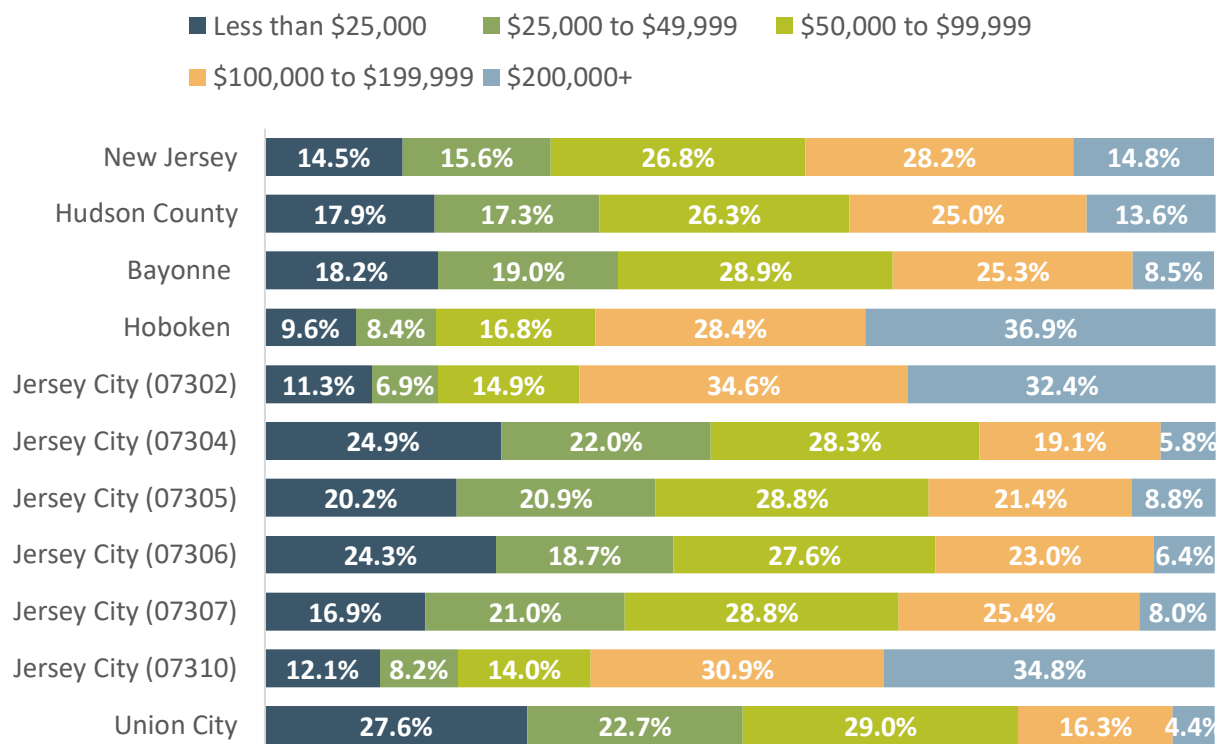
Table 9. Median Household Income, by Race/Ethnicity, State, County, and Town, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	American Indian and Alaska Native	Native Hawaiian and Other Pacific Islander	Some other race
New Jersey	\$126,232	\$55,453	\$60,352	\$96,531	\$59,827	\$61,563	\$54,334
Hudson County	\$116,309	\$53,196	\$52,408	\$100,853	\$54,318	-	\$51,718
Bayonne	\$123,536	\$60,167	\$54,292	\$74,712	-	-	\$53,890
Hoboken	\$197,750	\$83,724	\$44,890	\$162,507	-	-	\$27,139
Jersey City (07302)	\$169,730	\$68,879	\$62,868	\$161,291	-	-	\$43,750
Jersey City (07304)	\$86,061	\$47,968	\$45,266	\$65,026	\$44,238	-	\$48,348
Jersey City (07305)	\$108,294	\$51,155	\$56,458	\$80,389	\$66,982	-	\$48,738
Jersey City (07306)	\$86,347	\$37,470	\$41,429	\$66,761	\$57,798	-	\$43,571
Jersey City (07307)	\$100,659	\$57,778	\$47,904	\$76,976	\$39,293	-	\$55,022
Jersey City (07310)	\$138,083	-	-	\$163,375	-	-	-
Union City	\$83,482	\$44,375	\$44,562	\$74,623	\$58,594	-	\$44,092

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Census estimates demonstrate how higher earning households and low-income households are concentrated in different towns across Hudson County. Around one in three households in Hoboken (36.9%), Jersey City zip code 07302 (32.4%), and Jersey City zip code 07310 (34.8%) had earnings of \$200,000 or higher in 2016-2020 (Figure 22.) On the other hand, more than two in five households in Jersey City zip codes 07304, 07305, and 07306 earned a household income of \$50,000 or less; and half of the households in Union City were in this situation.

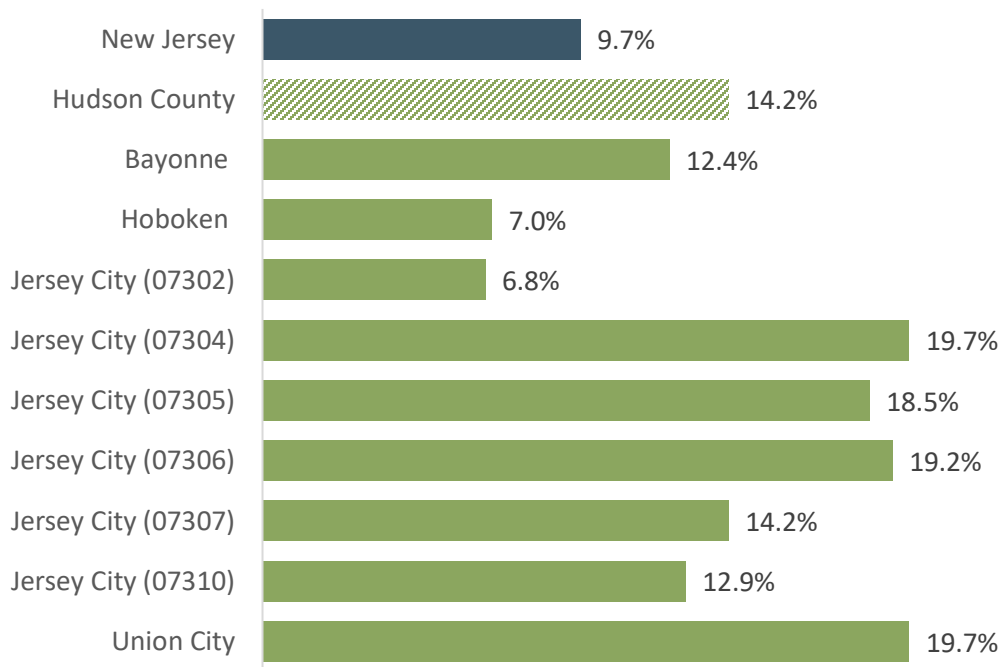
Figure 22. Distribution of Household Income, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

The percentage of Hudson County residents living below the poverty level represents the most extreme level of financial insecurity. For context, the federal poverty line is the same across the country – regardless of cost of living – but changes by household size. In 2021, individuals living alone or considered a household of one would fall below the federal poverty level at an income level of \$12,880, while federal poverty level for a family of four is \$26,500. Figure 23 presents data on the percentage of residents falling below the poverty line in the state, county, and town- and zip-code-level. In Hudson County, 14.2% of individuals fall below the poverty line, but it is nearly 20% in Jersey City zip codes 07304, 07305, 07306, and Union City. Table 10 presents town level poverty data by race/ethnicity.

Figure 23. Individuals Below Poverty Level, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

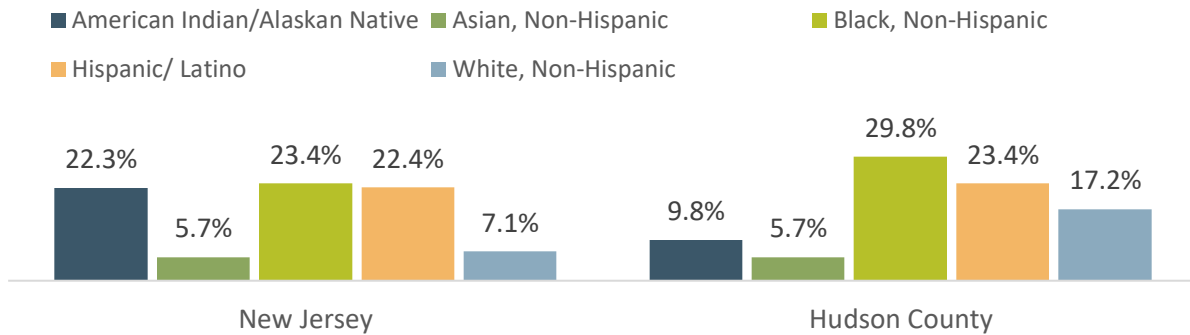
Table 10. Individuals Below Poverty Level, by Race/Ethnicity, State, County, and Town, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	Other Race, Non-Hispanic
New Jersey	6.3%	16.4%	16.9%	6.0%	19.6%
Hudson County	9.3%	19.2%	17.8%	9.7%	17.9%
Bayonne	7.3%	13.8%	14.9%	9.9%	12.8%
Hoboken	8.4%	13.2%	15.5%	4.8%	24.9%
Jersey City (07302)	5.7%	15.6%	14.8%	3.4%	22.7%
Jersey City (07304)	9.1%	19.7%	24.8%	21.4%	23.0%
Jersey City (07305)	6.9%	22.1%	19.5%	18.0%	21.0%
Jersey City (07306)	17.0%	20.3%	20.6%	23.3%	18.7%
Jersey City (07307)	7.5%	14.5%	18.7%	11.6%	21.0%
Jersey City (07310)	13.4%	36.8%	14.0%	7.9%	23.3%
Union City	6.6%	14.5%	21.1%	17.9%	27.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

According to County Health Rankings, 9.8% of children in Hudson County lived in poverty in 2019, but 29.8% of Black children and 23.4% of Hispanic/Latino children lived in poverty (Figure 24).

Figure 24. Children in Poverty, by State and County, 2019

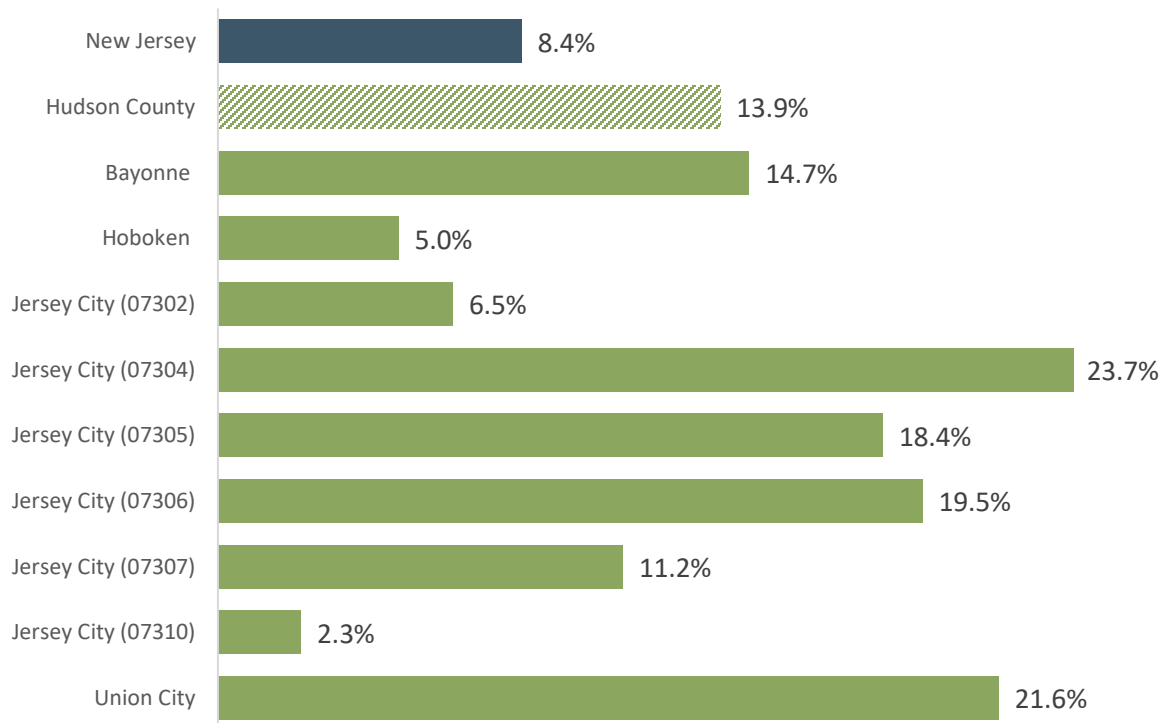


DATA SOURCE: U.S. Census Bureau, Small Area Income and Poverty Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Income and Public Assistance

Several national programs administered by the state help low-income individuals and families in Hudson County afford basic needs and necessities. The Supplemental Nutrition Assistance Program (SNAP) offers nutrition assistance to certain income-eligible Hudson County residents. From 2016-2020, 13.9% of households in Hudson County were receiving SNAP benefits (Figure 25). Of note, Jersey City zip code 07304 had 23.7% and Union City had 21.6% of households receiving SNAP benefits, compared to 2.3% in Jersey City zip code 07310.

Figure 25. Households Receiving Food Stamps/SNAP, by State, County, and Town, 2016-2020

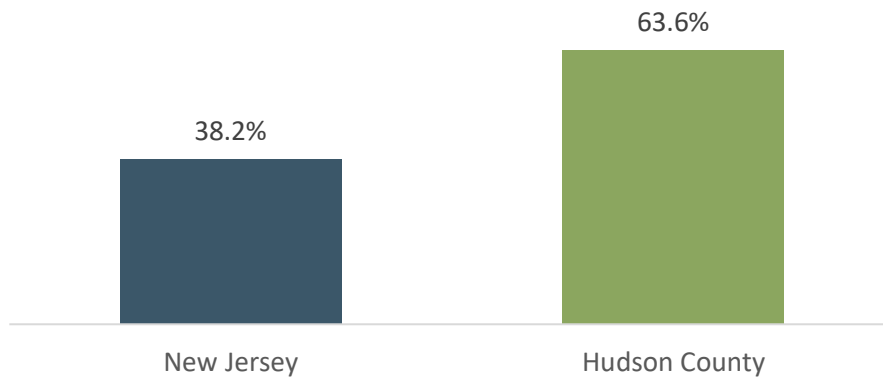


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Public schools nationwide and across New Jersey offer free lunch programs for children living at or near the poverty line (although it should be noted that many public schools currently provide free lunch to all

students as part of the federal COVID-19 relief funding). However, the percentage of children eligible for the traditional free or reduced-price lunch in Hudson County was 63.5% in the 2019-2020 school year, much higher than the state overall (38.2%) (Figure 26).

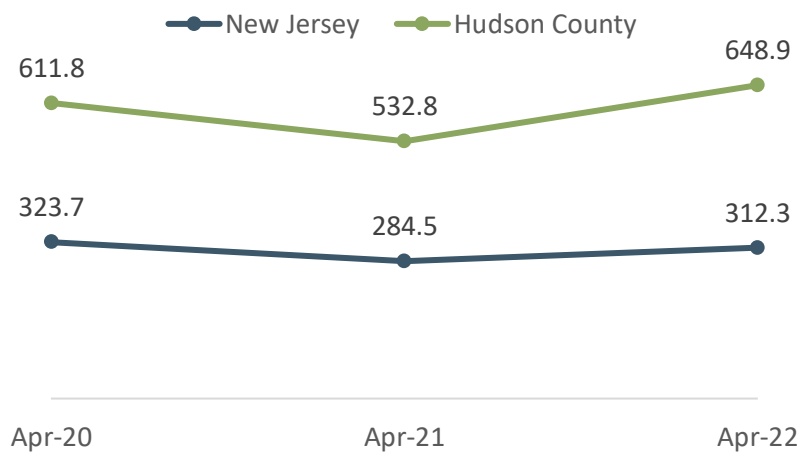
Figure 26. Children Eligible for Free or Reduced-Price Lunch, by State and County, 2019-2020



DATA SOURCE: National Center for Education Statistics, 2019-2020 from University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2021

Work FirstNJ (WFNJ) provides cash assistance and other support services through the federal Temporary Assistance for Needy Families (TANF) program. In Figure 27, the participant rate for persons, adults, and children receiving TANF was much higher in Hudson County than in New Jersey overall and peaked in April 2022 with a rate of 648.9 people participating in Hudson County per 100,000 population, more than double the rate of New Jersey as a whole.

Figure 27. Number of Participating Persons, Adults, and Children Receiving WFNJ/TANF per 100,000, by County, 2021



DATA SOURCE: New Jersey Department of Human Services, Division of Family Development, Current Program Statistics 2020-2022

These public assistance programs are a lifeline for many low-income families and help to ensure adequate nutrition and housing. However, several focus group participants and key informant interviewees mentioned being faced with the dilemma of not earning sufficient income to cover basic expenses, but not qualifying for public assistance, including housing, food, or health support because they exceeded the poverty line threshold. In the words of a focus group participant, *“I know I don’t*

qualify for housing---I make too much money. I checked a few years ago because I live with my mom.” Another participant elaborated, “The problem in Jersey City is that the preferred housing is based upon income... The problem becomes not making enough to pay the rent, but then living with her mom, so she makes too much money because now they’re doing dual income.”

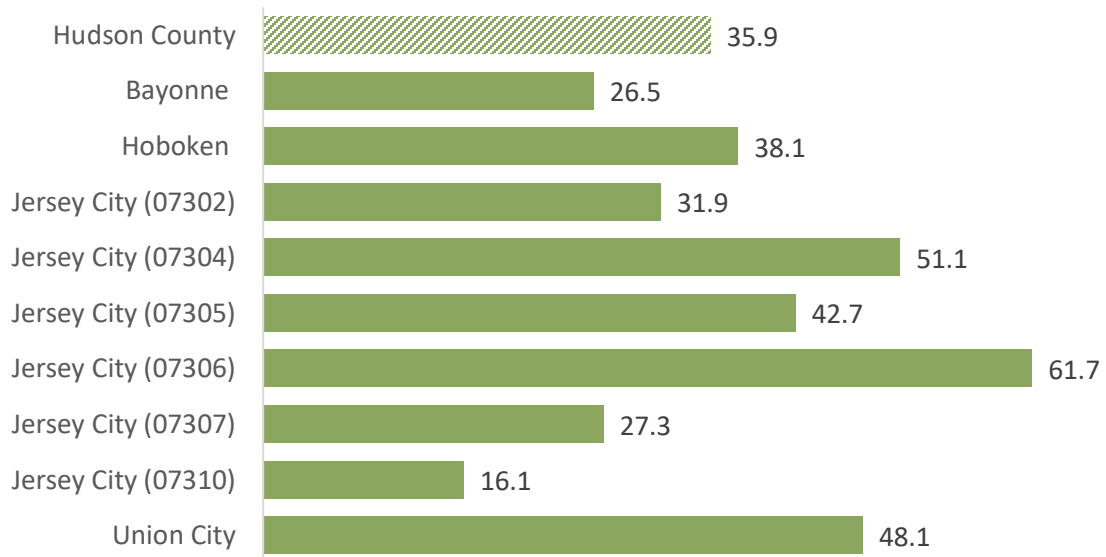
Many residents expressed frustration at losing or not qualifying for benefits because their earnings were too high, yet not being able to buy food and other essentials. Residents suggested that the federal government should change the income eligibility limit and that more opportunities should be provided to continue supporting residents as they transition into the workforce. As discussed in the section on Community Strengths and Assets, residents noted that local government had stepped up to address their needs.

“It is hard to get assistance for housing where I am. You have to be making way below the poverty level.” – Focus group participant

Food Access and Food Security

While many food access barriers are related to income constraints, access may also be more challenging for residents due to geography and transportation challenges. One of the issues highlighted by Hudson County residents was that the quality of the available food varied a lot by neighborhood. Residents noted that some Jersey City neighborhoods were food deserts, and that in others the supermarkets were not affordable. The availability of supermarkets and grocery stores varied a lot by Hudson County area, with Jersey City zip code 07306 having the largest number of supermarkets (61.7 per 100,000 persons) (Figure 28). More data on food deserts in Appendix F- Additional Data Tables.

Figure 28. Grocery Stores and Supermarkets per 100,000 by State, County, and Town, 2018



DATA SOURCE: Community Commons, Census County Business Patterns, analyzed by Center for Applied Research and Engagement Systems (CARES), 2020

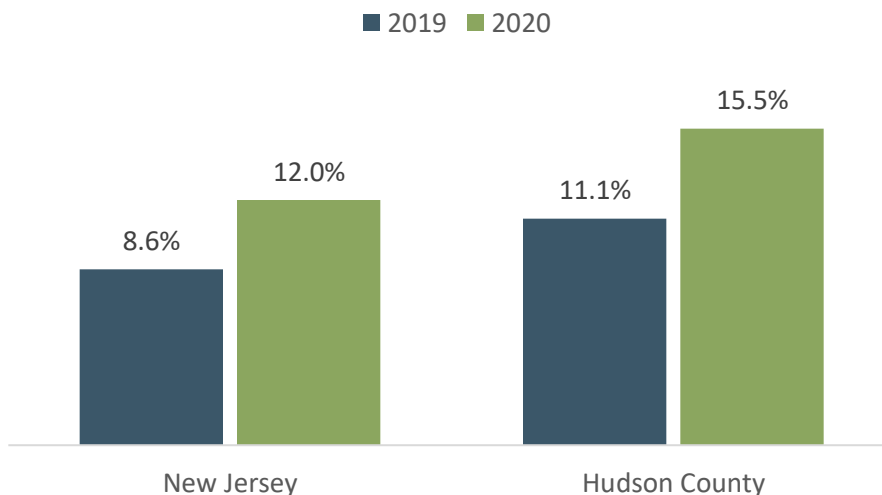
Food insecurity—not having reliable access to enough affordable, nutritious food—is directly related to financial insecurity. Residents mentioned that many families with children, older adults, and those who are housing insecure were struggling to put food, particularly healthy food, on the table. A focus group participant explained the experience of housing insecure families, *“If I’m staying with someone, I may not be able to cook my own food for my kids, as we just have a room, and maybe I have a little microwave that I could use. I don’t want to impose on anybody so I get little, you know, pre-cooked meals... so we don’t get in people’s way.”*

“Diabetes is a very expensive issue in the community, and we’ll often see people forgo their medication because they can’t afford it. Or [they] forgo healthy foods because they can’t afford it.” – Focus group participant

According to data from Feeding America, Map the Meal Gap confirms that food insecurity is a problem for many residents; Hudson County had a higher percentage of food insecure residents than New Jersey as a whole in 2019 and 2020, and this percentage increased from one year to the next (Figure 29).

However, residents also mentioned that food pantries were widely available throughout the city where low-income people could get food and that food vouchers were available to seniors. Participants spoke about the many food distribution efforts that multiple partners, including government agencies, health care institutions, and non-governmental organizations, carried out during the pandemic to mitigate its effects and make sure that residents did not go hungry. Around one in four survey respondents overall, and about one in three Latino respondents, indicated that they relied on food pantries or other food assistance programs in Hudson County (Figure 30). Other indicators of food insecurity are presented in Figure 30.

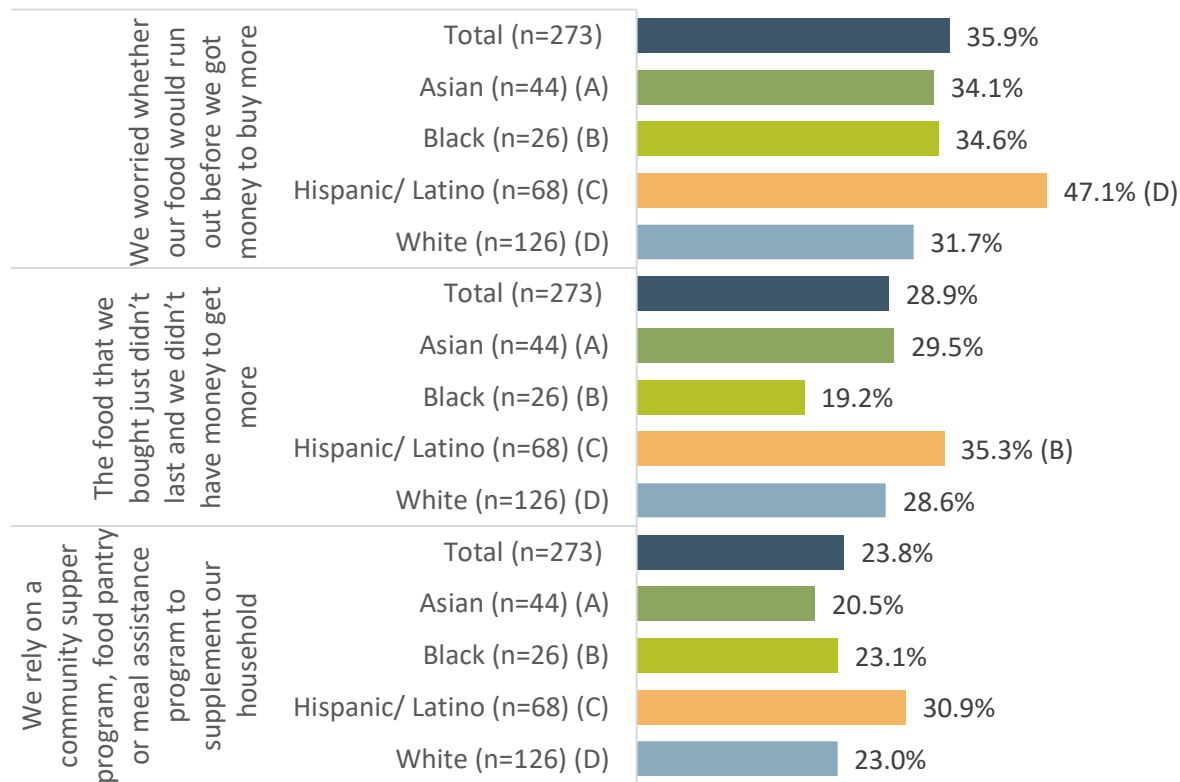
Figure 29. Percent Population Food Insecure, by State and County, 2019 and 2020



DATA SOURCE: Feeding America, Map the Meal Gap, 2019 and 2020

NOTE: 2020 data are estimated projections based on available employment and poverty data, and were revised in March 2021; therefore data are subject to change.

Figure 30. Percent of Community Survey Respondents Reporting Food Insecurity (Noting Statements as Sometimes or Often True), by Race/Ethnicity (n=273), 2021

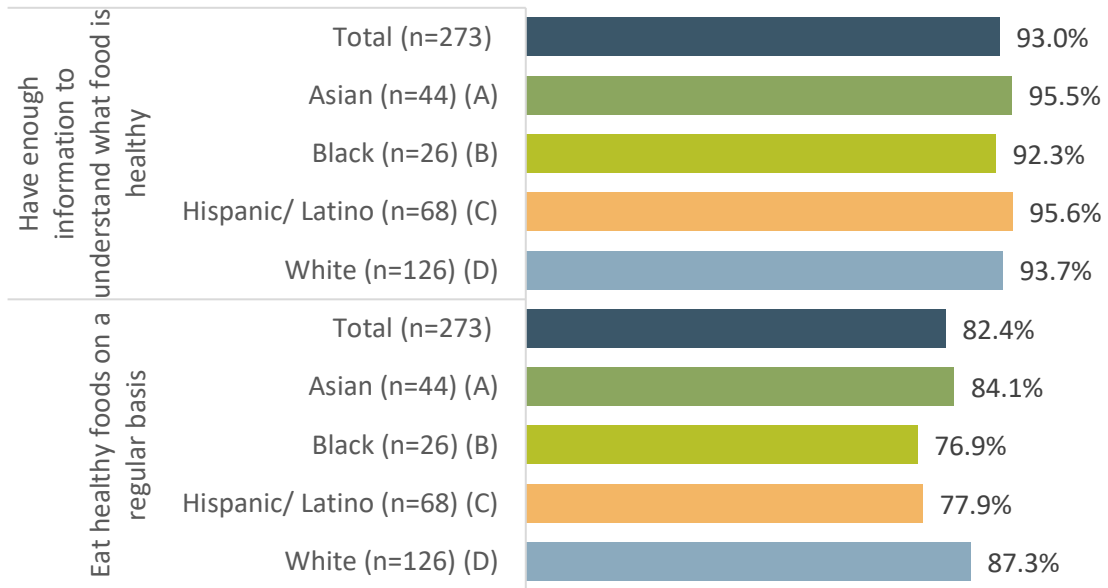


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

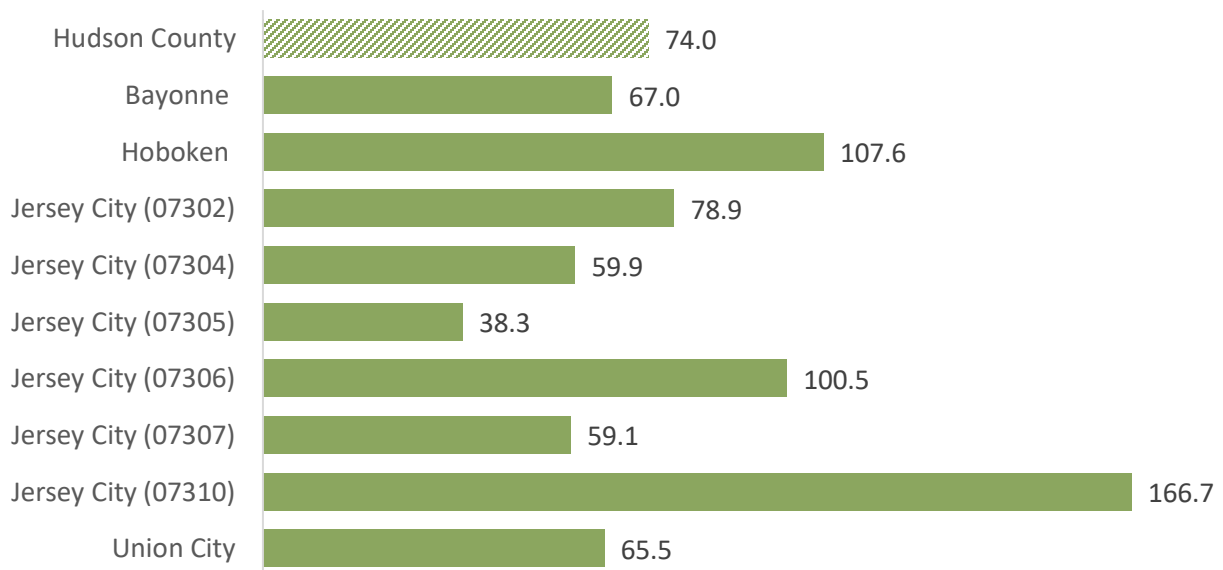
In addition to food affordability and access, nutrition literacy is important to maintain a healthy diet. Many focus group participants were aware of the association between a healthy diet and good health, including its importance in chronic disease management. However, some residents perceived that the main barrier to maintaining a healthy diet was lack of education. As one focus group participant mentioned, *“The problem is that people see fast food as a good, cheap option, but it’s not healthy – not everyone likes fruit and vegetables.”* Survey data does not seem to support this since perception: whereas a majority of survey respondents of all race/ethnicities reported knowing what constituted a healthy diet, fewer reported being able to eat healthy foods on a regular basis (Figure 31), indicating that other factors such as affordability and access may be at play. The discrepancy is most marked among Black and Latino respondents. Further, the availability of fast-food restaurants offering low-cost ultra-processed high caloric foods in certain neighborhoods contributes to the problem (Figure 32).

Figure 31. Percent of Respondents Who Report Having Enough Information on Healthy Foods and Eating Healthy Foods on a Regular Basis, by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Figure 32. Fast Food Establishments per 100,000 by County, and Town, 2020



DATA SOURCE: Community Commons, Census County Business Patterns, analyzed by the Center for Applied Research and Engagement Systems (CARES), 2020

Housing

Safe and affordable housing is integral to the daily lives, health, and well-being of a community.

Housing Landscape

As in past CHNAs, there was consensus among focus group members and interviewees that there is a significant need for affordable housing in Hudson County. Many participants noted that housing costs and high taxes were concerns. They described how affordable housing was scarce for members of their community who needed it, like low-wage earners and fixed income residents, and it is harder for others, such as seniors, veterans, and young families, to remain in the area. In the words of a resident, *“One of my friends... his parents had the house, and then he inherited it, but he ended up moving because the taxes were just too high. And that was someone who had been living in that house since birth. And he’s sixty-something years old, it’s just sad.”*

“It looks like Jersey City is trying to cater to the affluent instead of the people who grew up here.” –

Focus group participant

Assessment participants discussed gentrification – the process by which rising housing costs drive out local residents who are replaced by new wealthy residents. As one interviewee described it, *“We can’t not mention the housing market, it’s a problem overall, but in Jersey the rate of gentrification is increasing rapidly and even those not on the fringe of poverty are experiencing that.”* While participants reported that some new housing is being built, it is not affordable for most. One focus group participant explained it thus, *“It’s not equal. All the buildings they’re putting up are all luxury buildings. When you see the word luxury, you know the rent is astronomical. I can’t afford it... whereas affordable housing or housing for seniors is very limited. There are years long waiting lists. It’s like they don’t want us to be here anymore, they’re just welcoming the rich and affluent....”* Housing costs have been steadily rising in all areas with easy access to New York City, particularly near the waterfront, since 9-11, as New Yorkers sought to leave the city, and COVID-19 accelerated it.

Housing Instability and Homelessness

Inflation and uncontrolled rent increases following COVID-19 exacerbated people’s concerns about housing affordability and housing stability. With some residents’ financial situations being more uncertain or diminishing during the pandemic, there was greater concern that residents might lose their housing, even with the multiple housing eviction moratoriums in place. Overall, 8.8% of respondents in Hudson County reported that they or an immediate family member had lost their housing during the COVID-19 pandemic; this percentage was higher among Latinos (13.2%). Housing availability was also cited by interviewees as an important barrier to break the cycle of violence. Relocation is one of the strategies used to prevent revictimization of community and domestic violence survivors. However, according to violence interrupters, affordable housing options in low-crime neighborhoods are limited.

Several focus group and interview participants mentioned the problem of homelessness in Hudson County communities. Multiple interviewees and focus group participants indicated that the shelters and temporary housing available were insufficient to meet the needs of the population. They considered the paradox of the proliferation of luxury rental buildings in some neighborhoods, and abandoned buildings in others, while many people are left without homes. One resident emphasized, *“Shelter, I think we need more shelters for the homeless people we have.”* On January 26, 2021, there were 882 persons experiencing homelessness on a single night in Hudson County. Of those counted, 56.1% lived in Jersey

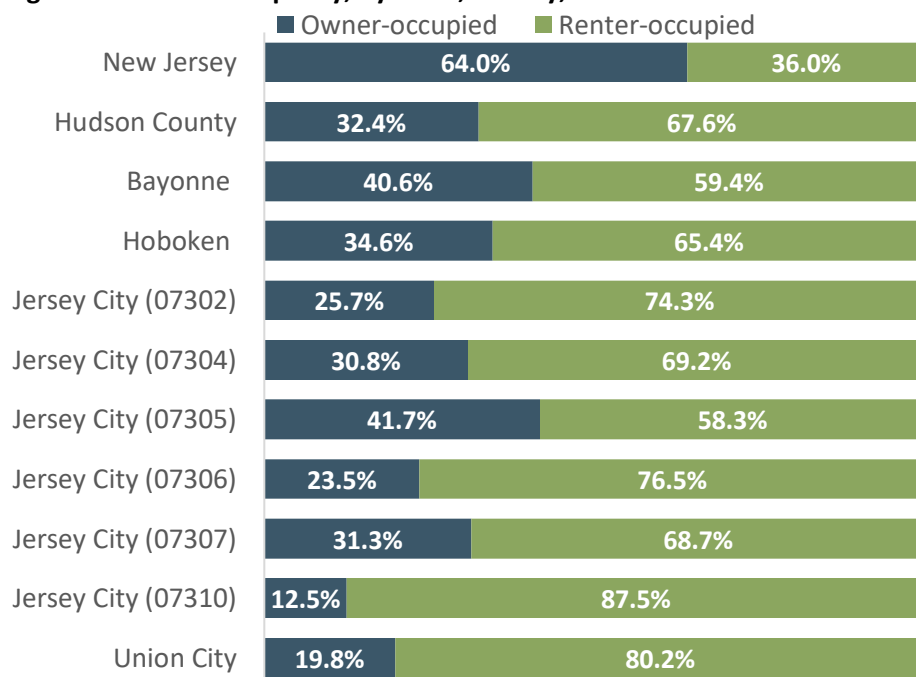
City. Black residents shouldered the burden of homelessness. Whereas Black residents made up 10.3% of the population, and 18.3% of the population living under the poverty line, they made up 39.1% of the population experiencing homelessness.

Participants highlighted three priority action areas to mitigate the housing problem in Hudson County: one was enacting policies related to rent control; the other was reducing real estate taxes; and the third was the urgent need to build or set aside more affordable housing units. A Latino participant expressed, *“The governor should control the rise of rent prices. These days it can cost \$700 for a room in a shared apartment. 10 years ago, an apartment cost \$500-600, but now it can cost \$1,200.”* Housing quality was another issue that came up in interviews. A few focus group participants commented that some of the affordable housing has lead, mold, and asbestos contamination, which can have devastating consequences on residents’ health, particularly among children. The problem was aggravated during COVID-19, which interrupted building quality inspections.

“When I drive past Hoboken there was a long line out a shelter because they need a hot meal or a place to stay.” – Focus group participant

Housing data illuminate important disparities and reflects the concerns uplifted by residents. Proportionally fewer Hudson County residents are homeowners compared to New Jersey as a whole. In New Jersey, 64.0% of housing units were owner occupied in 2016-2020, in contrast to 32.4% in Hudson County (Figure 33). Home ownership ranged from 12.5% in Jersey City zip code 07310 to 40.6% in Bayonne.

Figure 33. Home Occupancy, by State, County, and Town 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Median monthly housing costs for both homeowners and renters varied widely throughout Hudson County and were notably higher in certain locations than in New Jersey as a whole. Median monthly housing costs for owner occupied households with a mortgage ranged from \$2,339 in Jersey City zip code 07304 to roughly \$7,600 in Hoboken and Jersey City zip codes 07302 and 07310 (Table 11). Median monthly housing costs for renter occupied households ranged from \$1,247 in Union City to \$2,945 in Jersey City zip code 07310 during the same period, 2015-2019.

Table 11. Monthly Median Housing Costs, by State and County, 2015-2019

	Owner-occupied	Renter-occupied
New Jersey	\$2,476	\$1,368
Hudson County	\$2,821	\$1,450
Bayonne	\$2,793	\$1,325
Hoboken	\$3,759	\$2,360
Jersey City (07302)	\$3,672	\$2,524
Jersey City (07304)	\$2,339	\$1,204
Jersey City (07305)	\$2,425	\$1,243
Jersey City (07306)	\$2,484	\$1,270
Jersey City (07307)	\$2,751	\$1,382
Jersey City (07310)	\$3,756	\$2,945
Union City	\$2,886	\$1,247

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

The average percent of income spent on housing costs is an important measure of an area’s availability of affordable housing. A larger proportion of New Jersey renters, who tend to be less wealthy than homeowners, spend over a quarter of their earnings on housing. In New Jersey, 46.2% of owner-occupied households with a mortgage and 62.2% of all renters reported spending more than 25% of their income on housing costs (Table 12). Disparities in housing cost burden exist within Hudson County. In Jersey City zip codes 07302 and in Hoboken, less than one in three owner-occupied and 44% of renter-occupied households reported high housing costs whereas 64.4% of owner-occupied and 66.5% of renter-occupied residences in Union City reported spending more than 25% of their income on housing costs. Additional housing data can be found in Appendix F- Additional Data Tables.

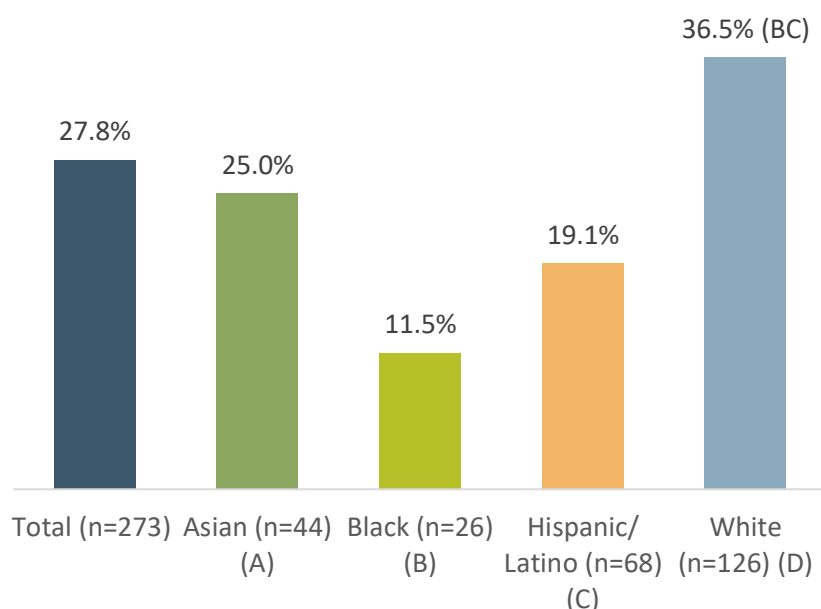
Table 12. Households Whose Housing Costs Are 25%+ of Household Income, by State, County, and Town, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	46.2%	62.2%
Hudson County	51.0%	56.6%
Bayonne	56.2%	57.3%
Hoboken	32.5%	43.4%
Jersey City (07302)	33.3%	39.5%
Jersey City (07304)	55.4%	63.6%
Jersey City (07305)	54.7%	64.6%
Jersey City (07306)	53.0%	55.2%
Jersey City (07307)	53.8%	58.4%
Jersey City (07310)	39.9%	48.7%
Union City	64.4%	66.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When survey respondents were asked whether they agreed or disagreed on statements about assets in their community, the statement about affordable housing had the lowest percentage of agreement. Only 27.8% of survey respondents agreed or completely agreed with the statement that there was enough affordable housing that is safe and well-kept in their community. Agreement was least likely among Black and Latino respondents, where only 11.5% and 19.1%, respectively, agreed/completely agreed with the statement about affordable housing, significantly lower than those of White respondents (36.5%) (Figure 34).

Figure 34. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “There is Enough Affordable Housing that is Safe and Well-Kept in My Community,” by Race/Ethnicity (n=273), 2021

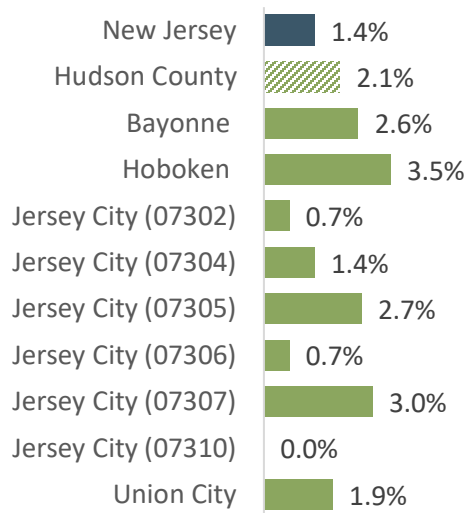


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Homeowner vacancy rate, which represents the proportion of the homeowner inventory that is vacant for sale, is another indicator of lack of affordability, oftentimes due to homeowners' inability to pay real estate taxes. The homeowner vacancy rate was notably higher in Hudson County (2.1%) over the period of 2016-2020 compared to New Jersey (1.4%) (Figure 35). Vacancy rates were particularly elevated in Hoboken (3.5%) and Jersey City zip code 07307 (3.0%) over that time. This reality was also reflected in the interviews with residents. In the words of a Black resident, *“Prices have been slowly rising, amazing that they have money to build these new buildings but can't help people maintain the property they have here – know people who had to move because taxes were too high.”*

Figure 35. Homeowner Vacancy Rate, by State and County, 2016-2020



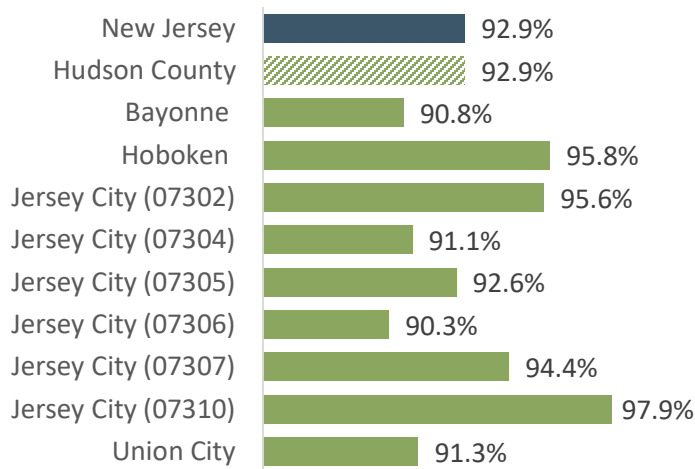
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Housing and Technology Infrastructure

Technology is an important tool to access information, services, and resources for individuals, families, and households. The importance of technology – and the consequences of the digital divide – became even more pressing and evident during the COVID-19 pandemic. The ability to be online, participants noted, is essential for residents to connect to resources for education, employment, and other services. Limited technological infrastructure posed an important barrier to learning when public schools moved to online education during COVID-19. Further, given the growth in telehealth, technology is also becoming essential to accessing healthcare. Yet some community residents do not have access to technology—they are unable to afford computers or Internet access, or do not know how to use it. One health care provider described, *“People working online tend to be good with telehealth, but there are many who don’t know how to connect, don’t have what is needed, it is just as hard to get online as it is to travel.”*

In 2016-2020, about 93% percent of Hudson County households had access to a computer (Figure 36). Households in Jersey City zip code 07306 (90.3%) and Bayonne (90.8%) reported computer access that was below the county-wide percentage; with about 1 in 10 households reporting having no computer at home, compared to almost every household in Jersey City zip code 07310 (97.9%).

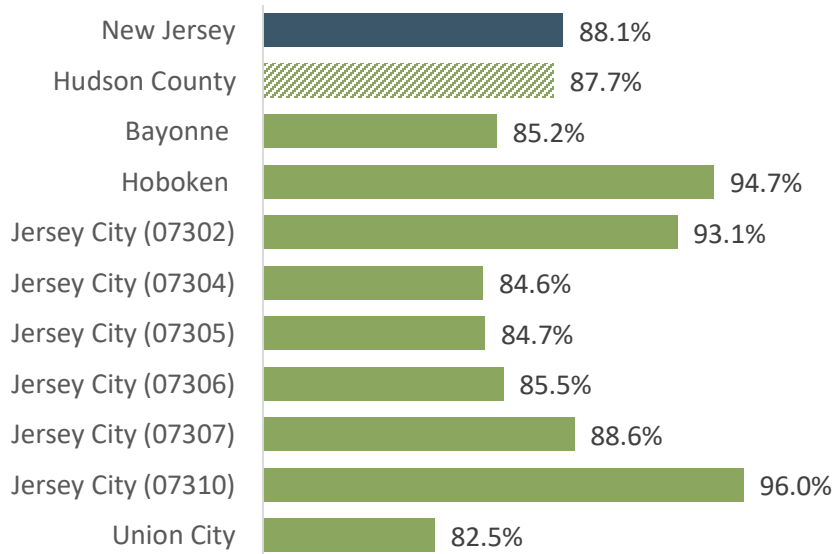
Figure 36. Households with a Computer, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

There were similar trends in household Internet access. Most of the areas that reported a lower percentage of computer access when compared to Hudson County also reported lower levels to the Internet, including Union City (82.5%), and Jersey City zip codes 07304 (84.6%) and 07305 (84.7%) (Figure 37).

Figure 37. Households with Internet, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Transportation

Transportation connects people with and between where they live, learn, play, and work.

Transportation Infrastructure

Transportation was often mentioned by focus group and interview participants as a top asset in Hudson County. Most participants did not indicate that they were car dependent; instead, they noted that it was easy to get around. A Latino immigrant said that *“public transportation is very good for people who don’t drive; everything is close and accessible.”* Affordable and accessible public transportation is important to promote equity, as it provides a means to getting to-and-from work, school, and other locations for low-income residents who cannot afford car expenses and to undocumented residents without a driver’s license.

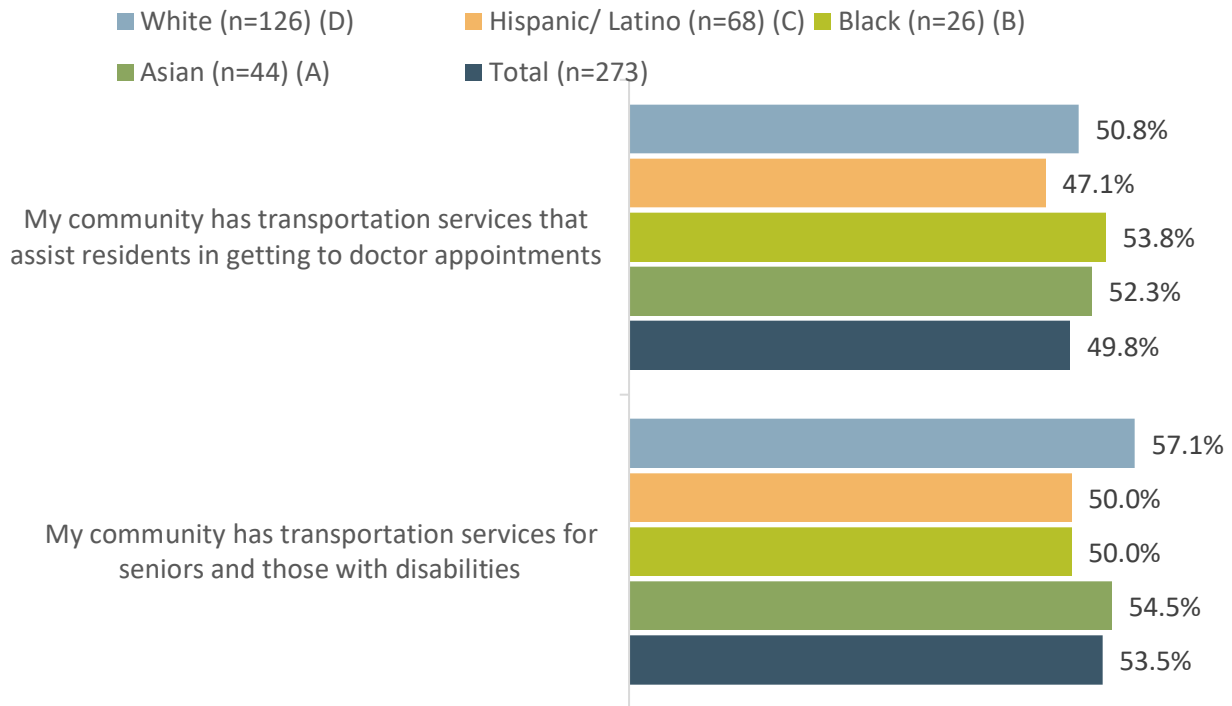
Residents appreciated the proximity of Hudson County to New York City, as a source of business and economic development in the area. This is facilitated by the multiple public transportation options available to and from New York City. One resident described Jersey City *“as a transportation rich area where there is a lot of income and economic opportunity, even if it is not very well distributed to everyone who lives here.”*

Transportation Partnerships

In addition to public transportation, several participants indicated that partnership between health care and social services institutions and private transportation companies were an asset and facilitated access to health care and other services and programs, particularly for older adults and violence survivors.

While transportation was discussed as a significant asset among focus group and interview participants, survey respondents noted some limitations of the transportation infrastructure. As shown in Figure 38, only about half of Hudson County survey respondents agreed or completely agreed with the statement, *“My community has transportation services available for seniors and those with disabilities.”* Similarly, slightly over half of survey respondents agreed/completely agreed that their community had transportation services to assist residents in getting to doctor’s appointments. There were no statistically significant differences in these responses by race/ethnicity.

Figure 38. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Transportation-Related Statements about Their Community, by Race/Ethnicity (n=273), 2021

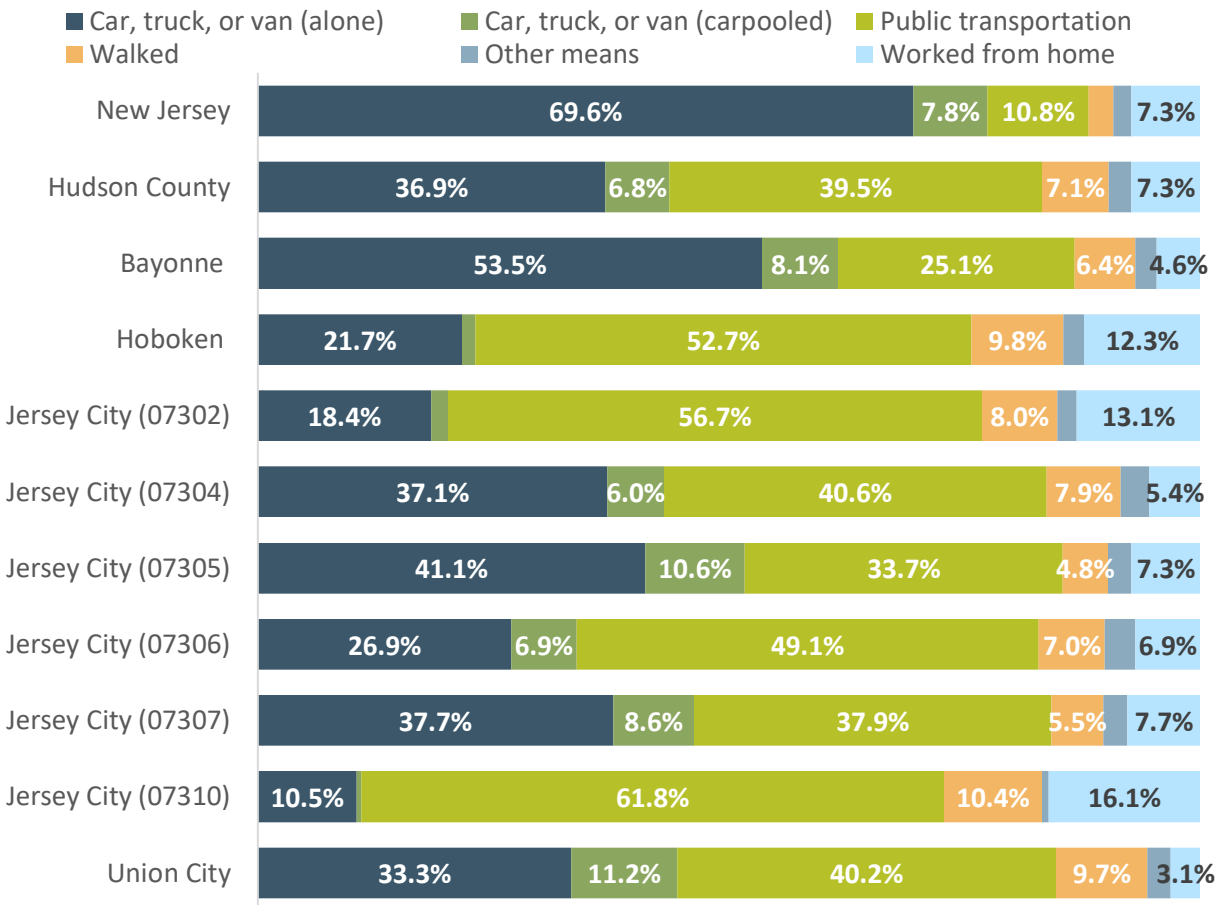


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels.

Data from the U.S. Census confirmed residents' viewpoints regarding transportation. Residents of Hudson County are a lot less car-dependent than those of Jersey City as a whole. In certain areas, such as Hoboken (52.7%) and Jersey City zip codes 07302 (56.7%) and 07310 (61.8%), well over half of residents relied on public transportation (Figure 39). Hudson County residents were also more likely to walk to work than in the state overall, with over 7% of survey respondents reporting doing so. One focus group participant summed it up, *"Another strength [of Hudson County] is how easy it is to commute everywhere. We have the Via shuttles, Path trains, buses."*

Figure 39. Means of Transportation to Work for Workers Aged 16+, by State, County, and Town 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Similar to other factors, owning a private vehicle is not equally distributed across county residents. Those without a car are usually not home-owners. Across Hudson County, 13.7% of owner-occupied households and 40.6% of renter-occupied households did not have access to a personal vehicle in 2016-2020 (Table 13); these percentages are much higher than in New Jersey as a whole, possibly denoting the accessibility of public transportation and Jersey City’s walkability. Car ownership ranged from 9.8% in Jersey City zip code 07305 to 26.0% in Jersey City zip code 07310 among homeowners; and from 31.5% in Bayonne to 61.2% in Jersey City zip code 07310 among renters.

Table 13. Households (Renter v. Owner-Occupied) Without Access to a Vehicle, by State, County, and Town, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	3.6%	24.8%
Hudson County	13.7%	40.6%
Bayonne	10.1%	31.5%
Hoboken	20.2%	38.7%
Jersey City (07302)	24.4%	49.5%
Jersey City (07304)	13.4%	46.9%
Jersey City (07305)	9.8%	38.8%
Jersey City (07306)	19.9%	49.9%
Jersey City (07307)	15.3%	42.1%
Jersey City (07310)	26.0%	61.2%
Union City	19.2%	45.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Green Space and Built Environment

Green space and the built environment influence the public’s health, particularly in relation to chronic diseases. Urban environments and physical spaces can expose people to toxins or pollutants, affecting health conditions such as cancer, lead poisoning, and asthma. Physical space can also influence lifestyles. Playgrounds, green spaces, and trails, as well as bike lanes and safe sidewalks and crosswalks, all encourage physical activity and social interaction, which can positively affect physical and mental health.

Residents raised several issues related to the built environment. Multiple residents across focus groups expressed their concerns that there were too many new constructions. In their view, overbuilding resulted in overpopulation and shrinkage of green spaces. This issue was summed up by one resident, *“Seeing all of these new buildings that are just being built out of nowhere, blocking the view of the city, being built on green areas, parks. I understand the need to have Jersey City well developed but I think over populating is a concern. Even the smallest empty area now has a building.”* As mentioned in the Education section, another problem mentioned by residents was that the public school infrastructure in some districts has not kept up with population growth and cannot accommodate the number of school children. Other residents mentioned that the older constructions had environmental contaminants, including lead and mold, which can have deleterious impact on health (see section on Lead).

Flooding and Emergency Preparedness

Participants remarked that several areas of Hudson County, particularly those near the waterfront, are flood prone. A housing expert explained that preparing the county for future floods and an overall rise in water level was an important public health precaution. A key informant interviewee in the housing sector mentioned that several urban redevelopment projects were underway to mitigate possible harm from floods and other natural disasters. The redevelopments would increase flood storage capacity and improve floodwater absorption. Further, the interviewee noted that new constructions are planned so as to integrate flooding mitigation and water containment measures. Redevelopments in some area

include “new walkways and parks available for all residents” and building higher off the ground to prevent water damage.

Parks and Green Areas

Green area coverage is essential to an environment conducive to good health. Green area coverage not only contributes to air quality and mental and physical health, but it also serves as an important flood mitigation strategy as soil absorbs water more readily than concrete. Multiple initiatives are under way in Hudson County to improve green areas; one is the Jersey City Urban and Community Forestry to promote planting efforts and urban reforestation. A health official noted the important contribution of the Jersey City Parks Coalition to these efforts.

According to the focus group participant, the coalition is a volunteer-run grassroots organization which has spearheaded green area betterment and maintenance projects and community events, such as plantings, throughout different Jersey City neighborhoods. The participant mentioned that they are also lead advocates for more funding for green spaces. The contributions of the Jersey City Parks Coalition were described by a public health official: “They have worked with the city to determine a priority list, master plan, getting a blanket insurance policy to cover all insurance needs for events for all parks.” According to the participant, the coalition reflects the city’s diversity and serves as a vehicle to engage different sectors of the population.

“Where to play safely is not available. When Jersey City is described, it’s often just the one nice part of the city, and rarely about the other quadrants.”

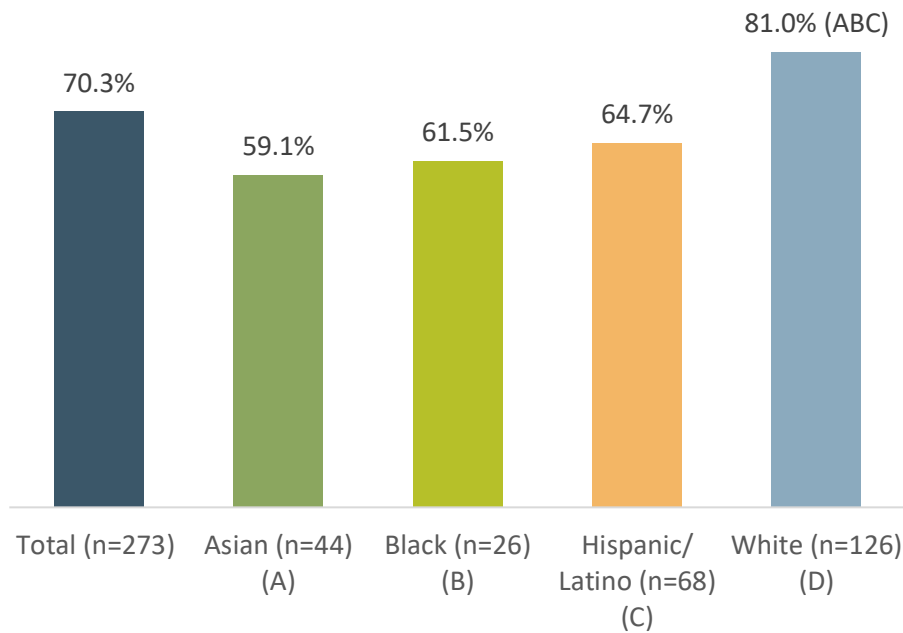
– Focus group participant

Different groups mentioned engaging in various outdoor activities. Veterans remarked on how important being involved in organized team sports was to their physical and mental health; they noted that these recreational opportunities were mainly organized by the city. Latino participants indicated walking was their main exercise and valued having access to well-lit, safe parks in their neighborhood.

As with other topics, there was a diversity of experiences regarding the availability of green space. Whereas some residents indicated that there were plenty of green areas for outdoor activities near their homes, others mentioned not having safe parks nearby. In a participant’s words, “The inner, inner cities, I’m not sure about their parks. I have a park luckily down the street, it’s a nice large park, it is safe, it’s patrolled by police. But if you go up into the Greenville section, I’m not sure about those parks... it’s not as lush and green as Lincoln Park or Liberty Park.”

These differences were reflected in the community survey. About 70% of Hudson County survey respondents agreed or completely agreed with the statement, “My community has safe outdoor places to walk and play” (Figure 40). However, responses significantly differed by race/ethnicity. Asian (59.1%), Black (61.5%), and Latino (64.7%) survey respondents were much less likely than White respondents (81.0%) to agree with the statement about safe outdoor space.

Figure 40. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “My Community has Safe Outdoor Places to Walk and Play,” by Race/Ethnicity (n=273), 2021



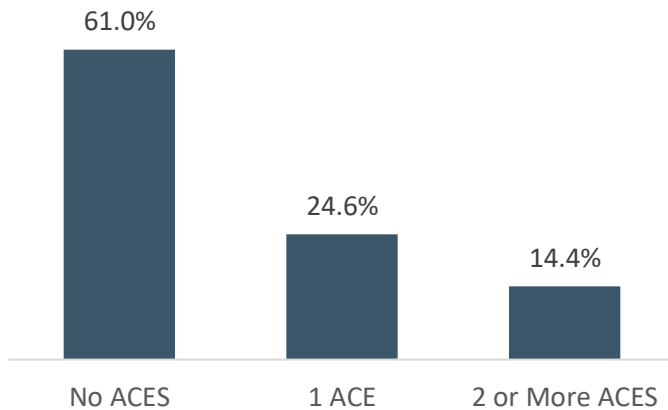
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Violence Prevention and Safety

Violence and trauma have short- and long-term effects on physical and mental health. People can be exposed to violence in many ways: they may be victims and suffer from premature death or injuries or witness or hear about crime and violence in their community. Violence and trauma are inextricably linked to the social determinants of health; people of low socioeconomic status residing in low-resource neighborhoods and schools are at higher risk of experiencing violence. According to an education administrator interviewed, many youths in low-income settings are exposed to domestic and community violence and other adverse childhood experiences, that have a profound impact on their well-being. In 2019, almost two out of every five children in New Jersey had experienced a traumatic event before the age of 18 (Figure 41). (More localized data not available.) Violence interruption professionals discussed how providing a safe and nurturing environment, access to counseling early on to address the symptoms of trauma, and paths to educational and economic opportunities were key strategies to interrupting the cycle of violence.

Figure 41. Percent of Children with Adverse Childhood Experiences (ACEs) in New Jersey, 2019

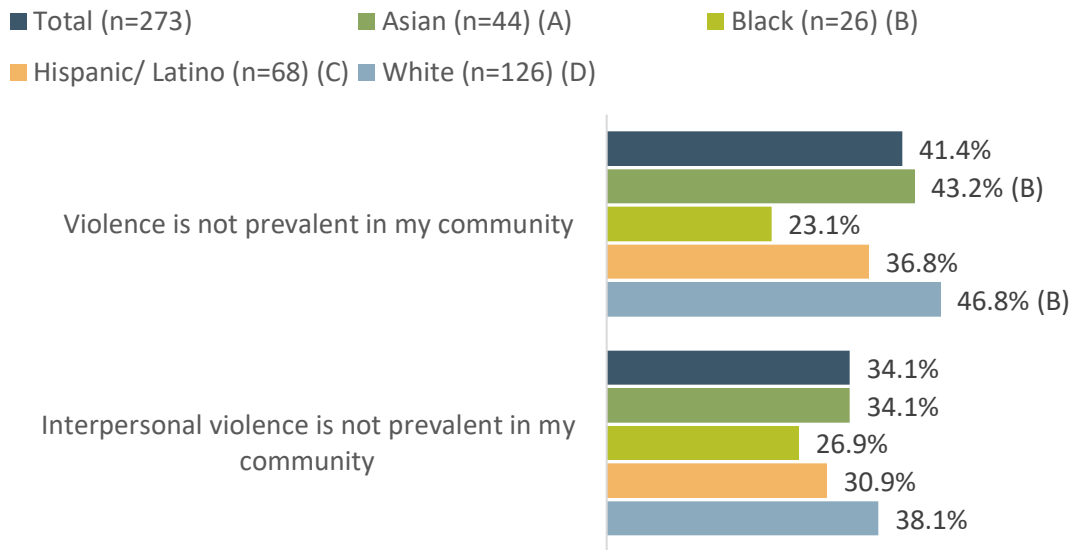


DATA SOURCE: Child and Adolescent Health Measurement Initiative (CAHMI), Data Resource Center for Child and Adolescent Health, National Survey of Children’s Health Interactive Data Query, 2019

Focus group and interview participants shared differing views about safety and violence. Many indicated being safe in their neighborhoods, while others reported being nervous about crime, and yet others that violence was an “*epidemic.*” Residents’ safety concerns were generally related to gun violence, loitering, and substance use by young people. According to survey data and interviewees, persons of color, particularly Black residents, shoulder the burden of violent crime. Figure 42 presents survey data on the percent of respondents who agreed or completely agreed with statements related to violence in their community, overall and by race/ethnicity. Overall, 41.4% of Hudson County survey respondents agreed or completely agreed that violence was not prevalent in their community and 34.1% reported that interpersonal violence was not prevalent in their community. However, responses varied by race/ethnicity, with Black survey respondents being the least likely to agree or completely agree with either of these statements.

“We are very busy, being in Jersey City. We see a lot of violent crime.”– Key informant interviewee

Figure 42. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statements Related to Violence, by Race/Ethnicity (n=273), 2021



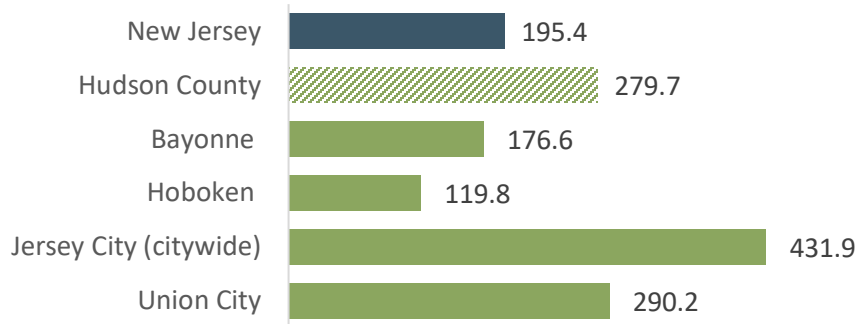
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Gun Injury and Violent Crime

Quantitative data support residents’ varied perceptions of risk. Mortality rate by firearm injury in Jersey City from 2015-2019 was 5.4 deaths per 100,000 residents, higher than those state-wide (5.1 deaths per 100,000 residents) and in Hudson County (3.5 deaths per 100,000 residents). In 2020, rates of violent crime (i.e., murder, rape, aggravated assault) in Hudson County (280 per 100,000 residents) were higher than in New Jersey (195 per 100,000 residents) and varied widely across the county. Jersey City (432 per 100,000 residents) had more than double the crime rate than the state average and 35% higher crime rate than the county overall; Union City’s crime rates were slightly higher than Hudson County’s (290 per 100,000 residents), whereas Bayonne’s (177 per 100,000 residents) and Hoboken’s (120 per 100,000 residents) were lower than the state and county average (Figure 43). Property crime (i.e., burglary, larceny, and auto theft) is much more common than violent crime. Property crime in Hudson County was also above the state average (1,338 and 1,158 incidents per 100,000 persons, respectively). Property crime was most common in Union City (1,694 per 100,000 residents), Jersey City (1,457 per 100,000 residents), and Hoboken (1,405 per 100,000 residents) (Figure 44). Nearly 60,000 domestic violence offenses were recorded in New Jersey in 2019 (New Jersey Uniform Crime Report, 2019).

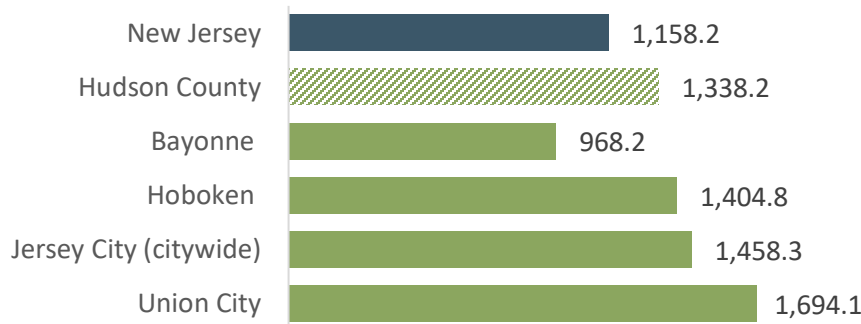
Figure 43. Violent Crime Rate per 100,000 Population, by State, County, and Town, 2020



DATA SOURCE: State of New Jersey, Department of Law and Public Safety, Uniform Crime Reporting Unit, 2019

NOTE: Violent crime includes homicide, rape, robbery, assault and simple assault. Jersey City data represent all zip codes within the city, including those outside of the JCMC service area.

Figure 44. Property Crime Rate per 100,000 Population, by State, County, and Town, 2020



DATA SOURCE: State of New Jersey, Department of Law and Public Safety, Uniform Crime Reporting Unit, Uniform Crime Report, 2020

NOTE: Property crime includes burglary, larceny, and auto theft.

Hate Crimes and Anger

It is of note that residents perceived a change in attitude in the aftermath of COVID-19, which they related to economic and social stressors. Specifically, several residents remarked that people had become less patient and more aggressive since the start of the pandemic. This perception was aggravated by reports of hate crimes motivated by biases against certain groups. As explained by one focus group participant, *“There’s an underlying fear, suspicion, you know, not only among African Americans. I mean it wasn’t that long ago that we had our own shooting up here at a Jewish facility. I think there is a lot of fear in regard to racism and antisemitism.”* Hate crimes were also mentioned as a concern for members of the LGBTQ+ community. A key informant interviewee working with the LGBTQ+ community noted that despite efforts, more action is needed to sensitize police officers, employers, educators, parents, and peers so as to reduce bullying and harassment, particularly against transgender youth and children in non-traditional families.

“It’s almost, I don’t want to say scary, but after the pandemic, everyone is more angry, everyone wants to argue and fight.”— Focus group participant

Violence Interruption Programs

According to key informant interviewees, Jersey City has robust programs and resources to address and mitigate the impact of violence and trauma. Since 2014, the grassroots organization Anti-Violence Coalition has been actively working as violence interrupters in the city's South side. As expressed by a coalition member, *"We've been working ... to make an impact on the community, see what the needs are, and lobby or advocate. We've been on the ground occupying corners, conducting surveys, trying to find out the main reasons why people can't be successful in their lives due to issues in the neighborhood that wrap around violence and trauma."* More recently, the Jersey City Medical Center created a trauma recovery center, which is a national evidence-based model in treating survivors of violence. Additionally, Project H.U.D.S.O.N. is a Hospital-based Violence Intervention Program, associated with the center, which works with community partners to prevent reinjury and retaliatory action. According to interviewees, promising results have been achieved by reaching survivors at bedside, soon after injury, and providing trauma-informed intensive case management and wraparound services, including support for safe housing and vocational training, in addition to medical care and counseling.

Systemic Racism and Discrimination

Perceptions of racism and discrimination varied in qualitative discussions. Overt discrimination due to race/ethnicity or nationality did not often come up. Some participants described witnessing discrimination due to gender and sexual orientation. Focus group and interview participants in multiple conversations brought up issues related to systemic racism and discrimination. With few exceptions, they spoke of pervasive inequities experienced by people of different groups. The conversations highlighted issues of intersectionality; participants discussed the multiplying effect of historical and current discriminatory practices due to multiple conditions, such as race/ethnicity, gender, immigrant status, and socioeconomic status, among others. Participants noted these issues largely impacted communities of color because of the policies and practices embedded throughout society. Highlights from these discussions that touch upon specific topic areas (e.g., inequality, education, housing, violence prevention) are also mentioned in other sections of this report.

A theme that was discussed in most focus groups and interviews was the pervasiveness of systemic racism. One of the ways that this was noted was in the gentrification of Hudson County. Multiple participants discussed how the high cost of housing and taxes are driving people of color out of Jersey City. Both quantitative and qualitative data indicate that there are insufficient affordable housing units. As a Black resident described, *"A lot of the new constructions are rentals so there would be a reduction of generational wealth. Unless you're earning six figures, it will be a challenge to afford rental units in the future. What is affordable may also not be livable because of gang activity or high crime."* Residents also noted structural racism in the perennial lack of investment in predominantly Black neighborhoods of Jersey City. They described these areas as having many abandoned buildings in a state of disrepair.

Focus group and interview participants acknowledged that there has been much more dialogue about racism and discrimination over the past year. Residents indicated that there were efforts underway in Hudson County to curbe at least the most overt forms of discrimination. A focus group participant expressed, *"Jersey City has definitely addressed the Asian hate crimes, even when I was on the PATH train there was a sign that was like there's no room for hate here in Chinese as well."* However, other residents described instances of discrimination and mistreatment against them and their relatives due to their immigrant status. As one resident explained, *"I do feel welcome by healthcare providers, but I have experienced going with my parents who are immigrants with heavy accents, and I have experienced miscommunication."*

Systemic Discrimination Based on Legal Status

A theme that emerged in some of the interviews and focus groups was the plight of undocumented immigrants, who face multiple economic and social stressors. According to focus group participants, the community is often persecuted by safety systems and live in fear of deportation. Residents explained that undocumented immigrants do not qualify for many government programs, often fear seeking care, and have limited power to negotiate with employers and landlords for salaries and rent control. As noted by several participants, many have experienced trauma in their home countries, made worse by unstable conditions. Further, participants remarked that children of undocumented parents or who themselves are undocumented often experience depression and anxiety, largely product of an uncertain future. According to residents, a pathway to legalize the situation of undocumented immigrants to ensure they are afforded all the human rights, many who have been most of their lives in the U.S., is urgently needed to improve their life conditions.

“The undocumented are scared to ask for help, and we are seeing that community getting jumped overnight, not wanting to go to the hospital over what they will get charged.” – Focus group participant

Responses also varied by survey respondents. One-quarter of Latino survey respondents indicated that they had ever been personally discriminated against when receiving medical care for their race/ethnicity and 17.6% because of language/speech issues. Asian residents were more likely to report being discriminated against for their culture/religious background (15.9%) and for language/speech issues (22.7%). Percentages for other race/ethnicities was not available due to small sample sizes. Other forms of discrimination were also mentioned in the survey. Among survey respondents, 14.1% reported having ever been discriminated against because of their age; 14.0% because of their body size; and 16.9% because of their income level.

Systemic Discrimination Based on Gender and Sexual Orientation

A theme that emerged from the qualitative data was discrimination against the LGBTQ+ population. Members of the LGBTQ+ community reported experiencing discrimination based on gender and/or sexual orientation in medical, educational, and professional settings. As described in the Employment section, Black trans women discussed encountering discrimination in employment due to their gender identity. An LGBTQ+ advocate emphasized more safe spaces for LGBTQ+ youth are needed in schools to prevent bullying. Also, more education efforts are needed to sensitize parents, educators, and other adults that interact with LGBTQ+ youth to ensure a supportive environment. As noted by an activist, many educators do not have the skills to address the needs of children growing up in non-traditional families. Additionally, the interviewee discussed how programs to sensitize and train police and healthcare providers should also be offered to promote quality, respectful care that fully addresses the diverse needs of this group, particularly of transgender individuals. One in ten survey respondents in Hudson County reported being discriminated against when receiving medical care because of their gender identity and/or sexual orientation.

*“A doctor told a lesbian woman seeking gynecological care that she didn’t need checkups because she didn’t have sex with men.”
– Key informant interviewee*

Addressing the Systems of Oppression

Quality education is a condition to overcoming intergenerational poverty resulting from historical systems of oppression. However, residents remarked that, despite attempts to provide adequate budgets, and largely because school financing relies partly on local cost share, public schools in low-income neighborhoods of Hudson County are under-resourced. Residents noted that the high cost of college poses another barrier for youth growing up in poverty. Further, they explained that the employment opportunities for unskilled workers do not pay a livable wage, nor offer a fixed income and benefits. In the words of a resident, *“There are jobs, I think, if you are well educated that you can sustain yourself on. But if you only have a high-school degree, it might be a bigger challenge.”* Interviewees alluded to how historical discriminatory policies against people of color, such as redlining, coupled with disinvestment and lack of educational and employment opportunities are contributing to growing inequalities and driving more people into the low-middle and low classes.

“The South side is a beautiful part of town, we’ve got some issues in some areas because of systemic racism and lack of investment, but it’s a beautiful part of town.” – Key informant interviewee

Residents mentioned that some Hudson County municipalities have put in place programs to address the effects of systemic racism, such as first-time homeowner programs for low-income residents, rent control policies, and programs to promote minority and/or woman owned businesses. However, participants emphasized that more policies and programs to promote equity and reverse this trend are urgently needed.

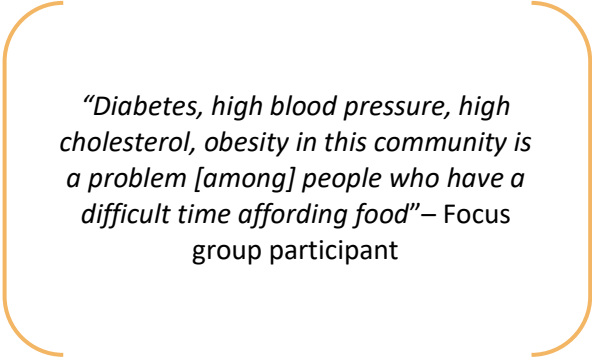
Community Health Issues

Understanding community health issues is a critical step in the CHNA process. The disparities seen in these issues mirror the historical patterns of structural, economic, and racial inequities experienced for generations across the county and the U.S.

Community Perceptions of Health

Understanding residents' perceptions of health helps provide insights into lived experiences, including into the key health concerns and facilitators and barriers to addressing health conditions. When asked about top concerns in their community, focus group participants and interviewees identified social and economic issues such as financial and food insecurity, and housing – and how these were associated with chronic conditions that affect many members of the community, including high-blood pressure, high cholesterol, and diabetes.

Challenges to accessing healthcare, largely due to cost, was also a top concern among residents. Another issue discussed by multiple groups, was the increase in mental health disorders among the entire population, but particularly among youth, seniors, and veterans. Other issues that were mentioned included a rise in community and domestic violence, an increase in sexually transmitted infections, and challenges to women's health, the latter in the context of the wave of legal decisions that curtail reproductive rights.

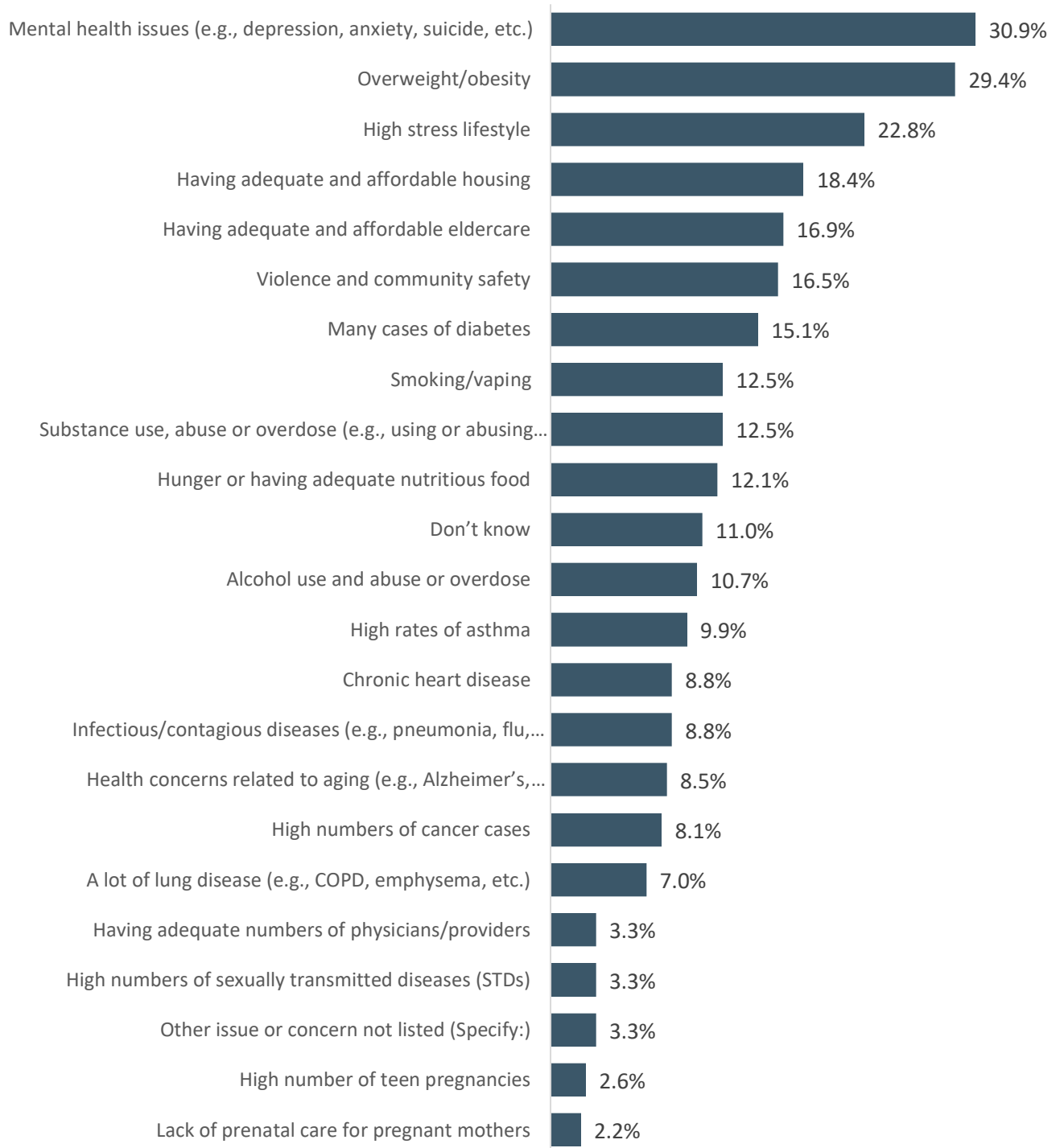


“Diabetes, high blood pressure, high cholesterol, obesity in this community is a problem [among] people who have a difficult time affording food” – Focus group participant

Survey respondents were presented with a list of specific issues and had the ability to add issues not listed. They were asked to mark the top three health concerns or issues for their community. They also were given the option to write in other issues not listed. This feedback complements quantitative data concerning health status and conditions. As shown in Figure 45, mental health, overweight/obesity, and high stress lifestyle were the top three issues noted among survey respondents. This was slightly different than results of the same survey in 2019. In that 2019 survey, obesity was the number one community health concern selected by survey respondents, followed by diabetes and then (tied) substance use and mental health.

While mental health, overweight/obesity, and high stress lifestyle were the top three community health concerns among respondents in the recent survey, differences appeared by race/ethnicity. While respondents identifying as Asian, Latino, and White shared the three priority health topics described above, Black respondents' top priority area was violence/community safety, followed by mental health issues, and adequate and affordable housing (Figure 46).

Figure 45. Percent of Community Survey Respondents Reporting the Top Three Health Issues or Concerns in Their Community (N=272), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Figure 46. Percent of Community Survey Respondents Reporting the Top Health Issues or Concerns in Their Community, by Race/Ethnicity (N=272), 2021

Asian (n=44) (A)	Black (n=26) (B)	Hispanic/ Latino (n=68) (C)	White (n=125) (D)
High stress lifestyle (31.8%) (D)	Violence/Community Safety (38.5%) (ABD)	Mental health issues (39.7%) (A)	Mental health issues (33.6%) (A)
Overweight/ obesity (29.5%)*	Mental health issues (34.6%) (A)	Overweight/ obesity (33.8%)	Overweight/ obesity (29.6%)
Mental health issues (15.9%)	Having adequate and affordable housing (19.2%) (A)*	High stress lifestyle (27.9%)	High stress lifestyle (18.4%)
Violence/Community Safety (13.6%)*	High stress lifestyle (19.2%)*	Substance use, abuse or overdose (23.5%) (AD)*	Having adequate and affordable housing (18.4%)
Having adequate and affordable eldercare (13.6%)*	Overweight/ obesity (19.2%)*	Having adequate and affordable eldercare (23.5%) (B)*	Many cases of diabetes (16.0%)

DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

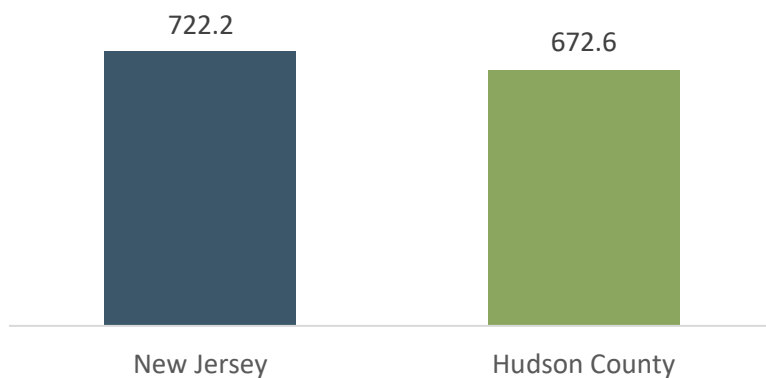
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering. * indicates health issues were tied. Cases where "don't know" was a frequently selected option are not presented in the table.

Leading Causes of Death and Premature Mortality

Mortality rates help to measure the burden and impact of disease on a population, while premature mortality data (deaths before age 75 years old) provide a picture of preventable deaths and point to areas where additional health and public health interventions may be warranted.

The most current mortality data are available for the period 2018-2020, which includes the first year of the COVID-19 pandemic. The age-adjusted mortality rate per 100,000 Hudson County residents was 672.6 in this period (Figure 47); 7% below the mortality rate in New Jersey during the same time period.

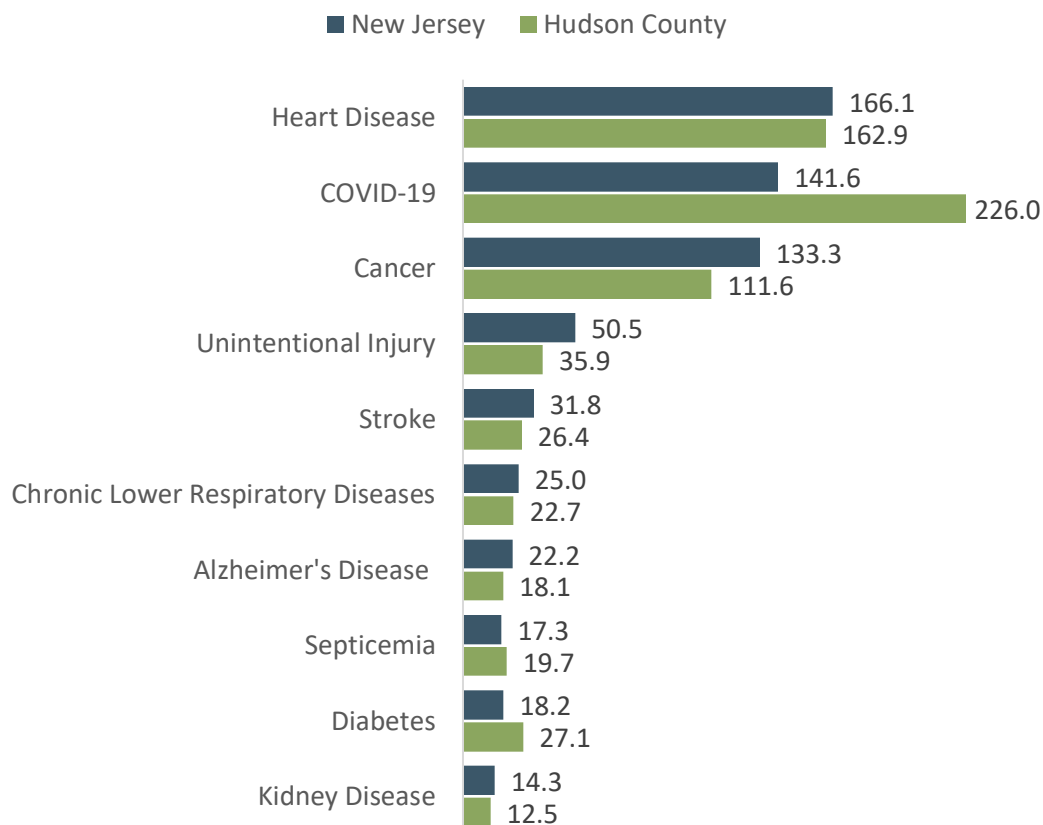
Figure 47. Age-Adjusted Mortality Rate per 100,000 population, 2018-2020



DATA SOURCE: New Jersey Department of Health, New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2018-2020

The leading cause of death in Hudson County in 2020 was heart disease (162.9 per 100,000), followed by COVID-19 (226.6 per 100,000), and cancer (111.6 per 100,000) (Figure 48). Additional leading causes of death included unintentional injury (such as unintentional poisonings including drug overdoses, unintentional motor vehicle accidents, unintentional drownings, and falls), stroke, and chronic lower respiratory disease (CLRD – e.g., chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, and asthma). It is important to note the deleterious impact of COVID-19 on mortality, which became the second cause of death in both the state and the county. The mortality rate by COVID-19 in Hudson County was 46% higher than in the state. Additional data on unintentional injury can be found in Appendix F- Additional Data Tables.

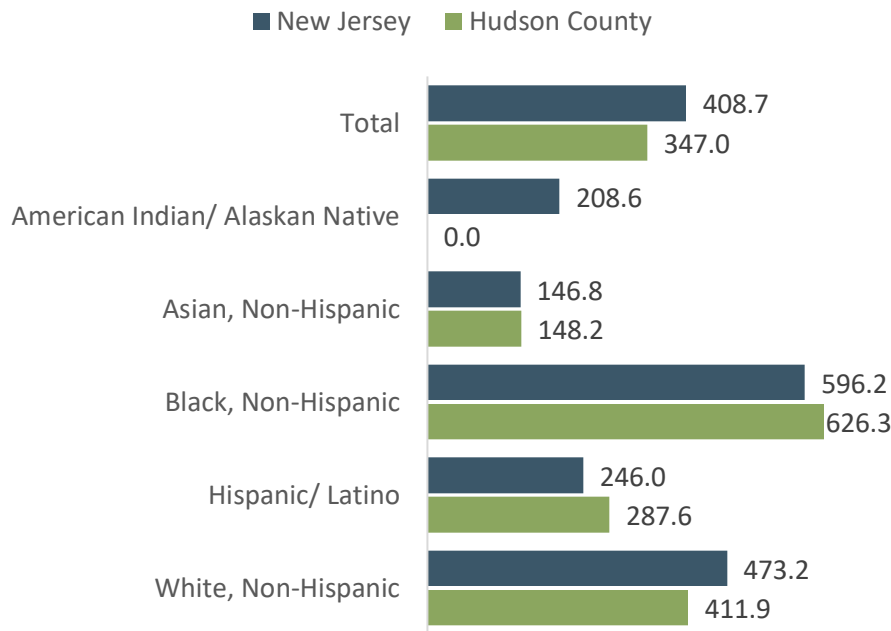
Figure 48. Top 10 Age Adjusted Mortality Rates per 100,000, by State and County, 2020



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health as reported New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2021

Premature mortality, deaths before age 75 years old, is an indicator of untimely death and can provide guidance on where additional investments are needed. In 2018-2020—the time period with the most recent data available—Hudson County had a premature mortality death rate of 347.0 per 100,000 residents, compared to 408.7 per 100,000 New Jersey residents (Figure 49). The rate of premature mortality was highest among Black (626.3) and White (411.9) residents, both above the county and state averages.

Figure 49. Premature Mortality (deaths before age 75) Rate per 100,000 Population, by State and County, 2018-2020



DATA SOURCE: National Center for Health Statistics, Mortality Files, as reported University of Wisconsin Population Rankings & Roadmaps, 2018-2020

Additional data on the overall health of the population can be found in Appendix F- Additional Data Tables.

Obesity, Healthy Eating, and Physical Activity

Obesity is the second leading cause of preventable death in the United States and increases the likelihood of chronic conditions among adults and children.

Overweight and Obesity

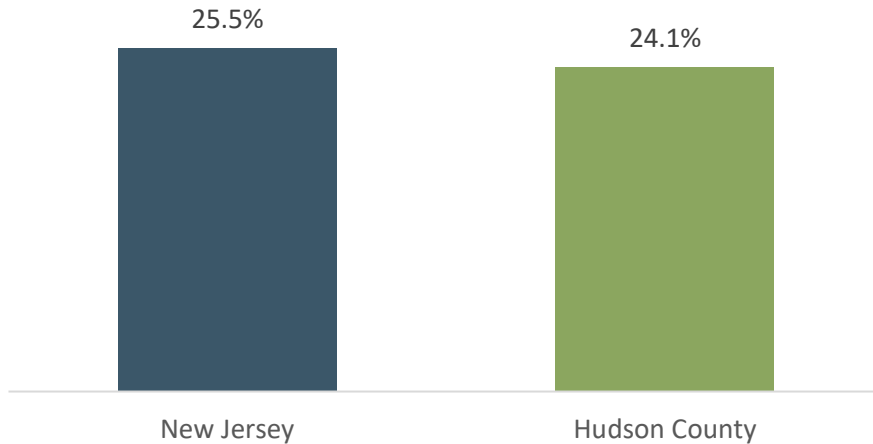
As discussed earlier in the Perceptions of Community Health section, obesity was cited as the second top health concern in the community in the survey (after mental health). However, it was not discussed at length in the focus groups or interviews by participants. Instead, residents from diverse population groups commented on the chronic conditions that are linked to obesity, particularly diabetes, and described how these conditions were prevalent in the community from a very young age. They discussed the social and economic challenges to maintaining a healthy lifestyle, including buying healthy food, access issues in living in a food desert, barriers to seeking medical care, having safe and accessible green space for activity, and time constraints. (See sections related to Food Access and the Built Environment for survey data and surveillance data on perceptions and the landscape related to the food and physical activity environment.)

The latest surveillance data on overweight/obesity is from several years ago. Adults at the state and county level were asked to self-report their height and weight. Based on this self-report, about one in four adults in Hudson County were considered obese, comparable to New Jersey (Figure 50).

In the current community survey for this CHNA, survey respondents were asked to indicate whether they or a household family member were ever told by a doctor or health professional that they had a

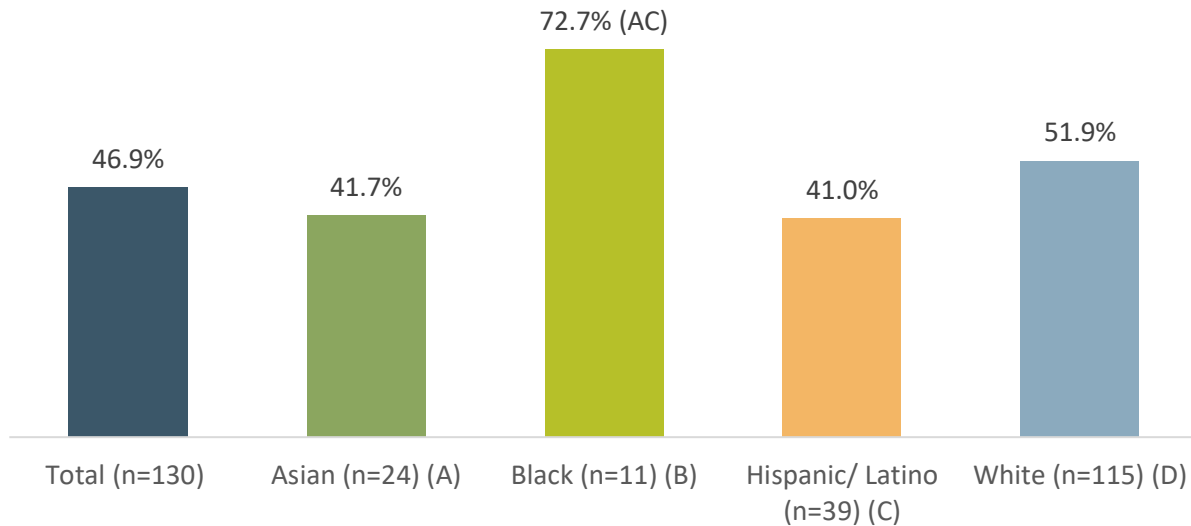
weight problem (Figure 51). Among these respondents, almost half (46.9%) indicated yes, although responses varied by race/ethnicity. Nearly three in four (72.7%) Black respondents reported this, significantly higher than Asian (41.7%) and Latino (41.0%) respondents.

Figure 50. Adults Self-Reported Obese, by State and County, 2018



DATA SOURCE: Centers for Disease Control and Prevention (CDC), U.S. Diabetes Surveillance System, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

Figure 51. Percent of Community Survey Respondents Reporting that They or a Family Member Has Ever Been Told by a Health Professional They Have Had a Weight Problem (n=130), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

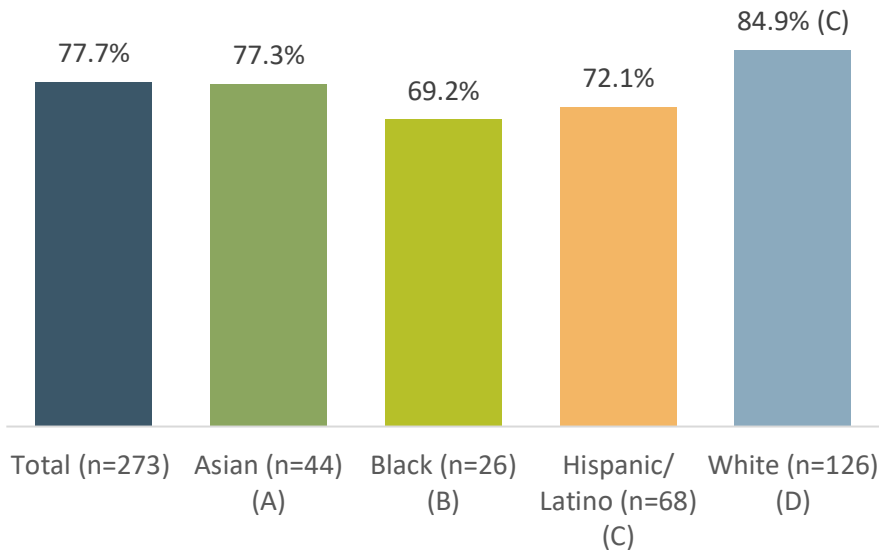
Physical Activity

Some focus group participants discussed that they enjoyed doing physical activity outdoors, while others noted that they did not have time to be physically active. Participants remarked that physical activity was important for maintaining both physical and mental health. A focus group participant explained the importance of exercise for those experiencing mental health problems and to address isolation, *“I wish more veterans would take advantage of opportunities for umpiring and make a little money on the side – I do various leagues, swimming, softball, baseball. [There are] a lot of opportunities for veterans that are just coming out of a mental health area, whereas they want a different avenue to go to, and be part of the community which a lot of veterans try to isolate... But this is something where you can just come out and do, be a part of the community with fellow veterans, you know.”*

“I walk a lot. Walking is the best exercise.” – Focus group participant

Community survey respondents were asked if they were physically active, and nearly 78% indicated yes (Figure 52). However, Black and Latino survey respondents were less likely to say that they were currently physically active, with only 69.2% and 72.3% saying yes, respectively, a lower proportion when compared to White respondents (84.9%). As discussed earlier in this report, Black and Latino survey respondents were also significantly less likely than White respondents to indicate that there were safe outdoor places to walk and play in their community. Community survey respondents who were parents also indicated whether they would describe their children as physically active or sedentary after school or on weekends. About 78% of Hudson County parent survey respondents described their children as physically active, with 21.8% describing them as sedentary. In comparison, only 53.6% of Latino parents indicated their children were physically active. Data is not available for Asian and Black parents.

Figure 52. Percent of Community Survey Respondents Indicating That They Were Physically Active (n=273), 2021

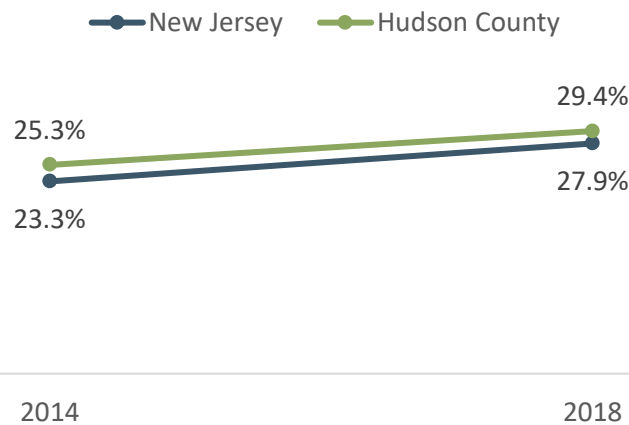


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

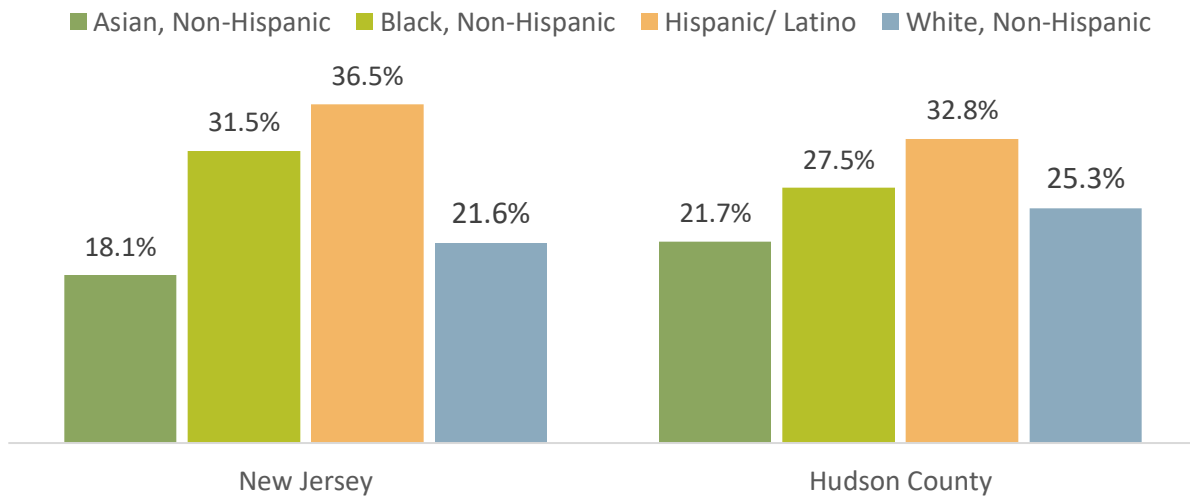
Surveillance data on physical activity, collected pre-COVID, shows similar patterns as the community survey. These data sources collect data on whether respondents had no leisure time activity. Across the state and by county, the percentages of those with no leisure time physical activity were higher in 2018 than in 2014 (Figure 53). In Hudson County, 29.4% of adults reported having no leisure time in 2018, compared to 25.3% in 2014. Surveillance data from 2016 to 2020, by race/ethnicity indicated that Latino respondents were most likely to report having no leisure physical activity time (32.8%) (Figure 54). Data on access to adequate location to engage in physical activity can be found in Figure 133 in the Appendix.

Figure 53. Percent Adults Reported to Have Had No Leisure Time Physical Activity, by State and County, 2014 and 2018



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2014 and 2018

Figure 54. Percent Adults Reported to Have Had No Leisure Time Physical Activity by Race/Ethnicity, by State and County, 2016-2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Healthy Eating

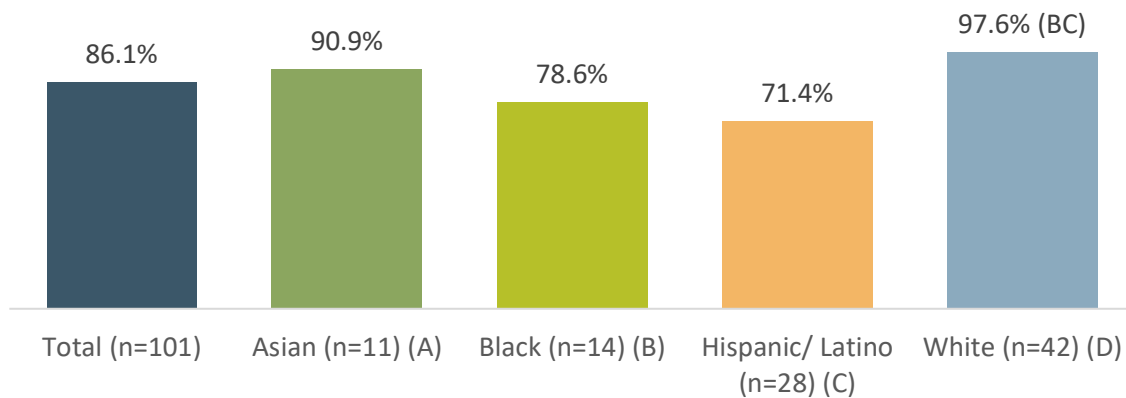
As discussed in the Food Access & Food Insecurity section and Built Environment section of this report, focus group and interview participants talked about the challenges of accessing healthy foods in their communities. These difficulties included lack of availability and affordability of healthy foods, depending on food provided by schools or food pantries, living in a “food desert,” and not having access to a kitchen to cook healthier meals for the family. However, other participants mentioned that there were healthy food outlets available in Hudson County. During COVID-19, multiple participants remarked that the community came together to ensure access to healthy foods to those affected by the pandemic via food drives and delivery of healthy food boxes or supermarket gift cards. Residents also noted that low-income seniors could receive food vouchers. In addition, Jersey City Medical Center has a healthy food pantry which serves people facing food insecurity, many of whom are seniors.

“They were meeting specifically... about the quality of the food that are available to more African American neighborhoods as opposed to downtown Jersey City, from the same food chain, and they had some complaints there... Food deserts are still a problem in our area.” – Focus group participant

Current surveillance data on fruit and vegetable consumption is not available for Hudson County. New Jersey data indicate that 19.1% of New Jersey adults reported in 2017 that they ate vegetables less than one time per day and 33.6% of New Jersey adults reported eating fruit less than one time per day, according to the Behavioral Risk Factor Surveillance Survey.

Eating breakfast daily is an important start to a healthy day. However, current data from the CHNA community survey shows differences by race/ethnicity. Among respondents living with a child, only about three-quarters of Black and Latino survey respondents (78.6% and 71.4%, respectively) reported that their children eat breakfast daily, significantly fewer than White respondents (97.6%) whose children did so (Figure 55).

Figure 55. Percent of Respondents Whose Children Eat Breakfast Daily, among Respondents Who Have Children that Live with Them, by Race/Ethnicity (n=101), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

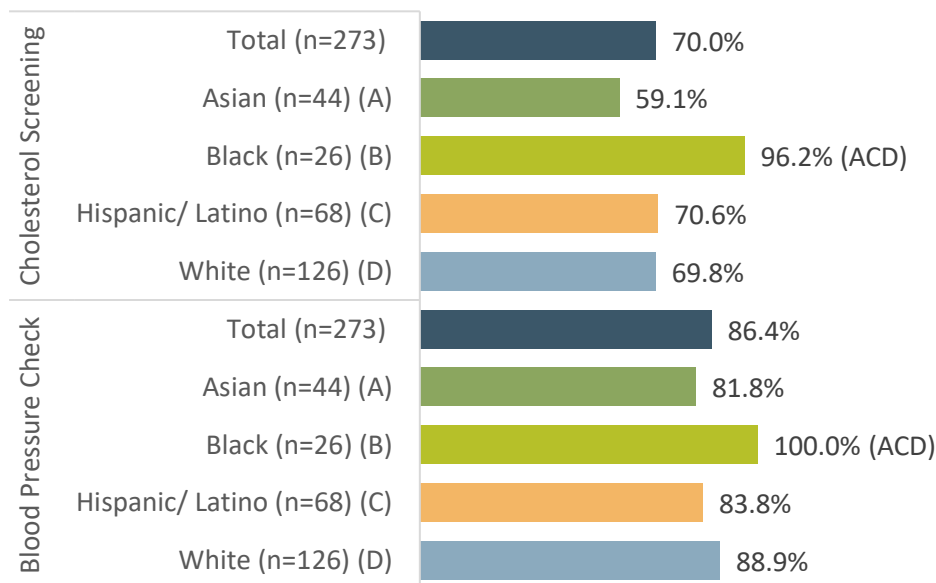
Chronic Conditions

Chronic conditions, such as heart disease, diabetes, COPD, and cancer, are some of the most prevalent conditions in the United States, including in Hudson County. Chronic diseases are also a contributing factor to poor mental health. As a healthcare provider noted, *“There’s a lot of depression surrounding getting diagnosed with one of those [chronic] illnesses. They have access to those programs, but they feel beaten down because of misinformation. When they get more information, they feel that they can manage it. The diagnosis can feel like a death sentence sometimes.”* Although chronic diseases are among the most common and costly health problems, they are also among the most preventable through changes in behavior such as reduced use of tobacco and alcohol and improved diet and physical activity. The following section describes the health data (e.g., screening, incidence, mortality, etc.) related to chronic conditions.

High Cholesterol and High Blood Pressure

Multiple focus group and interview participants mentioned high cholesterol and hypertension as prevalent in the community, including among children. High cholesterol and high blood pressure are significant risk factors for heart disease, stroke, and other chronic diseases.²⁹ Community survey respondents in spring/summer 2021 were asked about their participation in different types of health screenings over the past two years (Figure 56). Many respondents (70.0%) in Hudson County indicated that they have received a cholesterol screening, and 86.4% had participated in a blood pressure screening. Black respondents were significantly more likely than Asian, Latino, and White respondents to indicate that they had participated in either type of screening over the past two years.

Figure 56. Percent of Community Survey Respondents Reporting that They Have Participated in a Cholesterol or Blood Pressure Screening in the Past Two Years (n=273), 2021



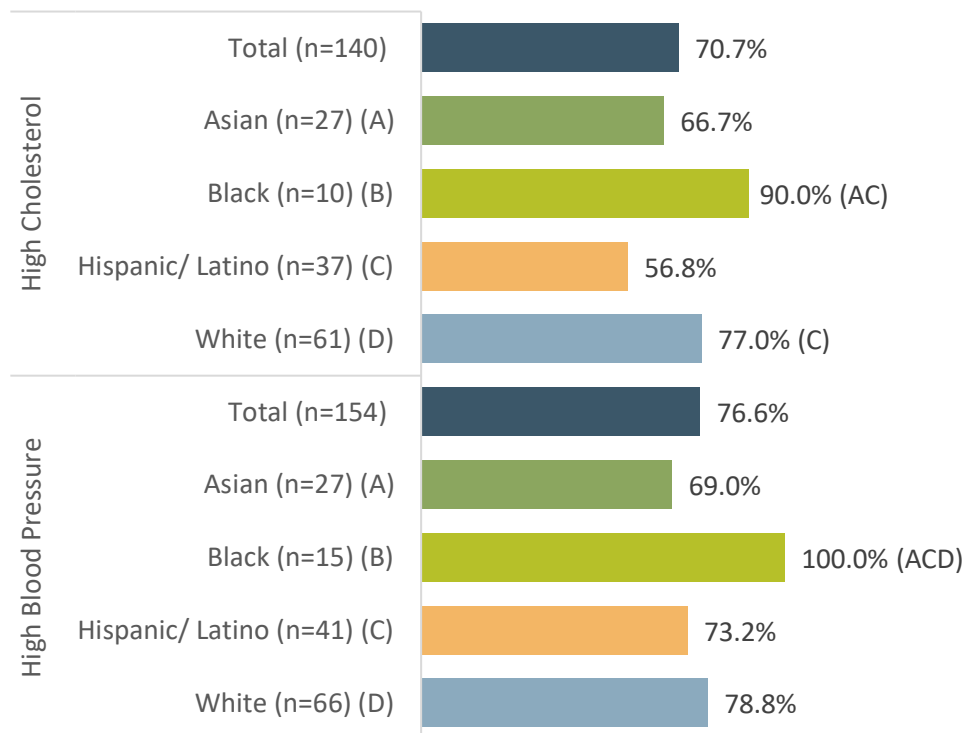
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

²⁹ <https://www.cdc.gov/chronicdisease/resources/publications/factsheets/heart-disease-stroke.htm>

A high proportion of survey respondents report being affected by high cholesterol and high blood pressure. Approximately 71% and 77% of Hudson County survey respondents indicated that they or member of their family had been told by a health professional that they have high cholesterol and blood pressure, respectively (Figure 57). Black respondents, with the highest rates of both, were significantly more likely than Asian, Latino, or Black respondents to indicate that they or a family member had high cholesterol or high blood pressure.

Figure 57. Percent of Community Survey Respondents Reporting that They or a Family Member Has Ever Been Told by a Health Professional They Had High Cholesterol or High Blood Pressure (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

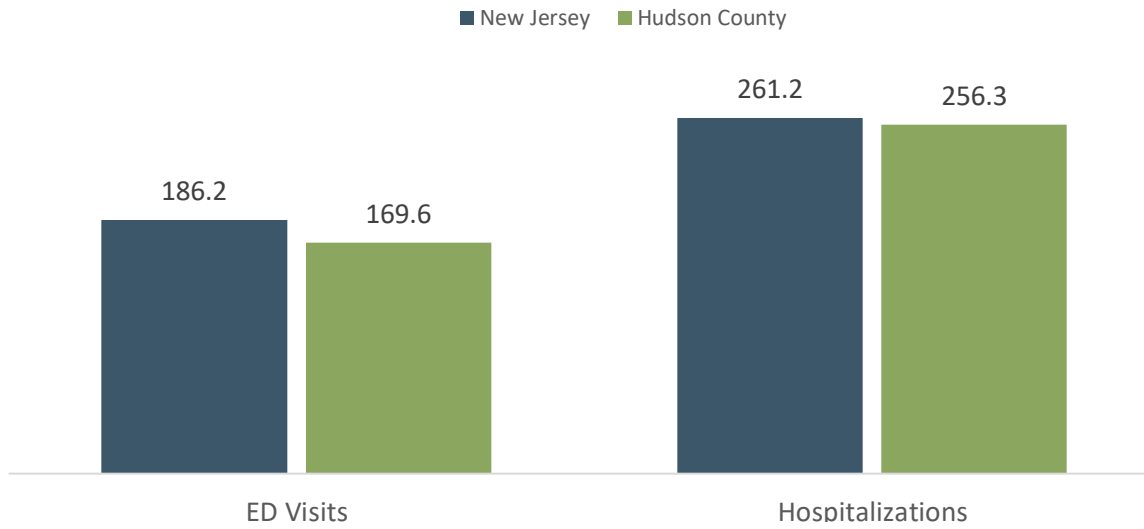
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Heart Disease

While focus group and interview participants did not directly discuss heart disease, it is the leading cause of death in Hudson County, and closely associated with other conditions mentioned by residents such as diabetes, high cholesterol, and lifestyle.

In the following graph, surveillance data are presented on the number of adults visiting the emergency department for major cardiovascular disease. In 2016-2020, the rate of heart disease emergency department (ED) visits per 10,000 population in Hudson County was 169.6 visits and the rate of heart disease hospitalizations per 10,000 population was 256.3, similar to state rates (Figure 58).

Figure 58. ED Visits and Hospitalizations for Major Cardiovascular Disease per 10,000 Population, by State and County, 2016-2020

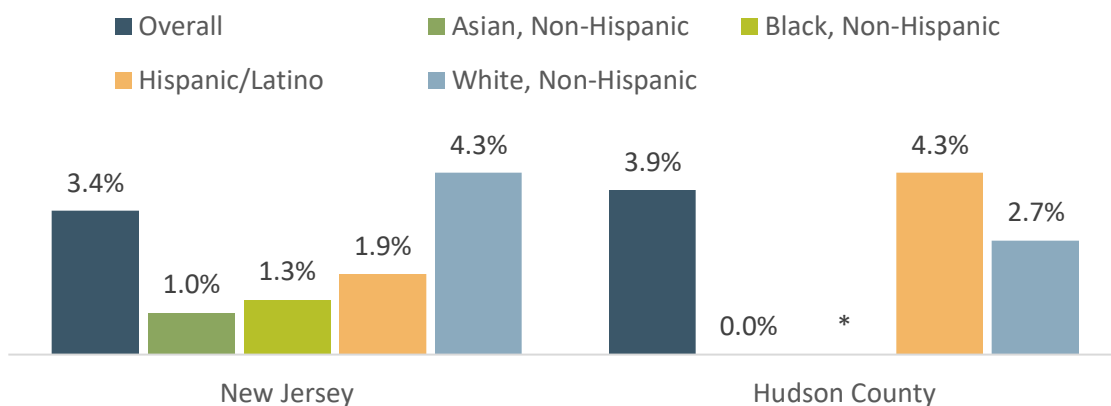


DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

NOTE: Includes primary and secondary diagnosis cardiovascular disease, excluding stroke and hypertension

Figure 59 presents the percentage of adults that reported angina or coronary heart disease in 2020, by race/ethnicity. Across the state, the percentage of those reporting angina or coronary heart disease was highest among White residents (4.3%), followed by Latino (1.9%), Black (1.3%), and Asian residents (1.0%). At the county level, the highest percentage was reported by Latino residents (4.3%), higher than the percentage at county and state level. However, data for Black residents was not reliable due to small sample sizes.

Figure 59. Percent of Adults Reporting Angina or Coronary Heart Disease, by State and County, by Race/Ethnicity, 2020

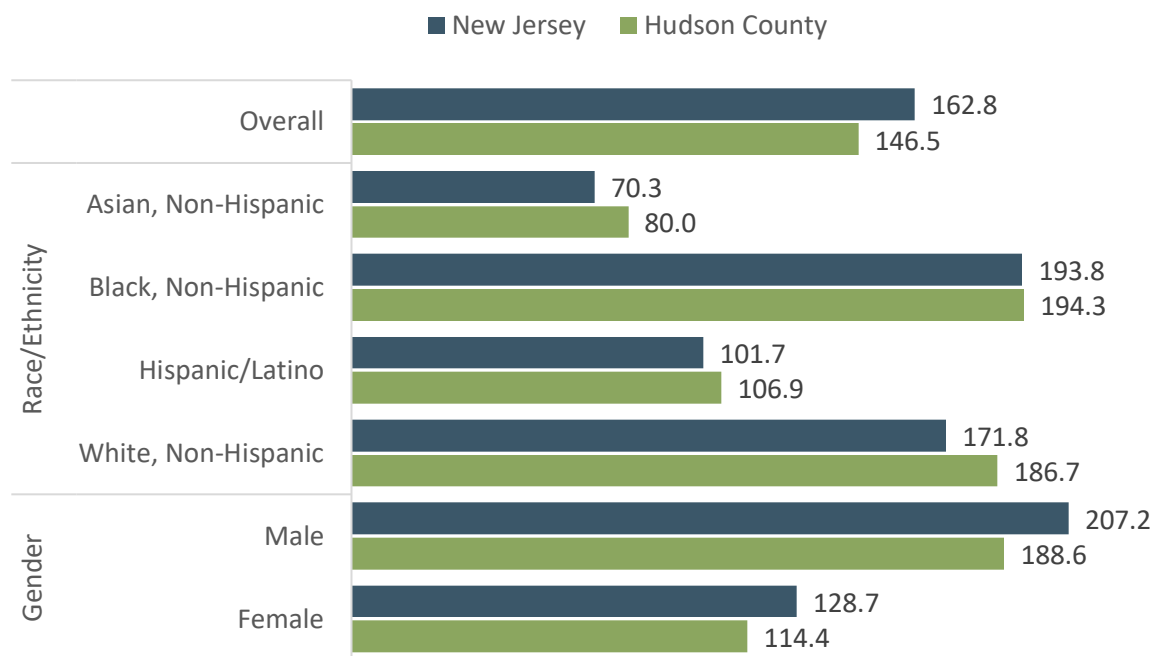


DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Death certificate data is presented for rates of cardiovascular disease mortality per 100,000 in 2016-2020 overall and by race/ethnicity and gender. Across the state, the overall mortality per 100,000 was 162.8 and was highest among Black (194 per 100,000) and White (172 per 100,000) residents, as well as male (206.7 per 100,000) residents (Figure 60). At the county level, the overall cardiovascular disease mortality per 100,000 was 147, lower than in the state. Like New Jersey, mortality was highest among Black (194 per 100,000) and White (187 per 100,000), as well as male (189 per 100,000) residents.

Figure 60. Cardiovascular Disease Mortality per 100,000, by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

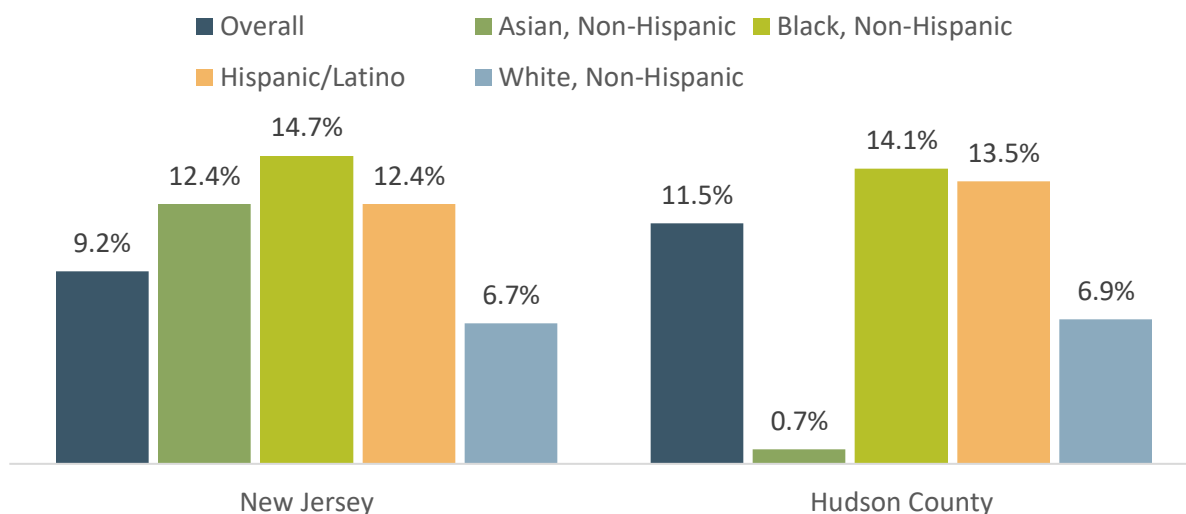
Diabetes

Diabetes was among the top health concerns mentioned by focus group and interviewee participants across the board, including among the Latino, Black, and Asian residents. Participants indicated observing an increase in rates of diabetes in recent years and noted that diabetes was highly prevalent in their communities, starting at a young age. A Latino focus group participant described it as, *“Everyone, even children, has diabetes... What is in the air for everyone to have diabetes?”* Focus group participants attributed the increase in diabetes rates to stress associated with social and economic factors, such as affordable healthy living and access to good healthcare. As one focus group participant stated, *“Diabetes is a very expensive issue in the community, and we’ll often see people forgo their medication because they can’t afford it or forgo healthy foods because they can’t afford it.”* A theme that emerged strongly from participants was the urgent need to address the upstream causes of disease to reduce the incidence of diabetes and other chronic disease among low-income communities and persons of color.

The following figure shows the percent of adults that reported a diagnosis of diabetes overall and by race/ethnicity from 2016 to 2020, the most recent that surveillance data is available. In New Jersey, 9.2% of adults reported a diabetes diagnosis. This percentage was highest among Black, Non-Hispanics (14.7%), followed by Asian, Non-Hispanics (12.1%) and Hispanic/Latino (12.4%), and lowest among White, Non-Hispanics (6.7%) (Figure 61). A higher percentage of adults were diagnosed with diabetes in Hudson County (11.5%). Of note, whereas county rates among Black (14.1%) and White (6.9%) residents were comparable to those of the state, Latinos in Hudson County (13.5%) had higher rates and Asians had much lower rates (0.7%) than in New Jersey.

“We seem taken aback by how prevalent these chronic diseases are so much so that when somebody's first diagnosed, many times they don't even react to it like, “Yeah, well, my father had it, my mother had it, my friends have it, and now I have it.” It's normalized and I think that's a shame. I think we can do more work upfront.” – Focus group participant

Figure 61. Percent of Adults Reported to Have Been Diagnosed with Diabetes, by State and County, 2016-2020



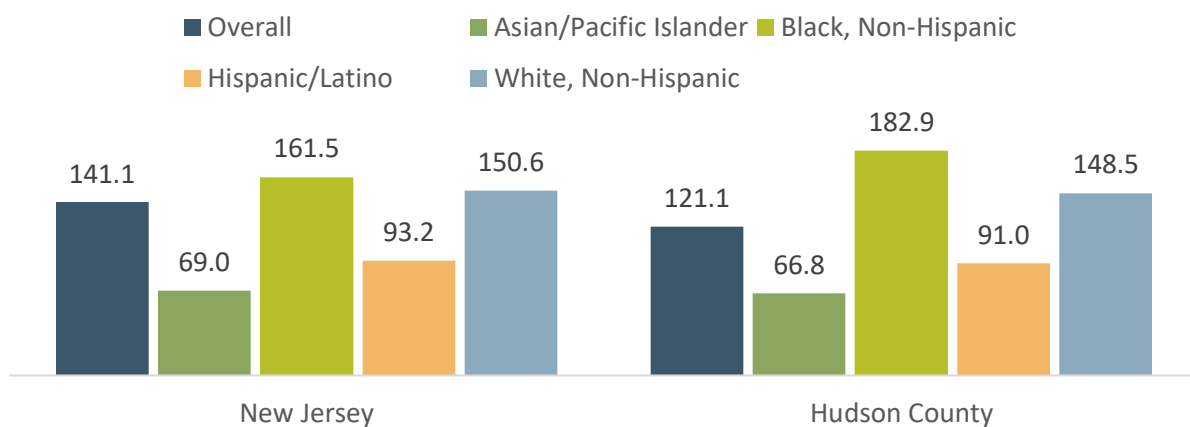
DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Cancer

While cancer is one of the leading causes of death in Hudson County, it was not discussed much during the focus groups or interviews. However, cancer incidence and mortality are closely associated with the social determinants of health. Screening and early detection is a critical strategy to reduce premature deaths and is strongly linked to access to care. Further, lifestyle factors are the most significant risks of developing cancer. Exposure to carcinogens in the built environment, the water, the air, and the soil, because of daily activities at home, school, and the workplace, increases the risk of developing cancer. In addition, a healthy lifestyle – maintaining a healthy diet and weight, and not smoking or consuming alcohol, are preventative factors; as discussed in other sections of the report, some population groups face substantial barriers to sustaining a healthy lifestyle.

Death certificate data is presented below for cancer mortality rates per 100,000 in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality per 100,000 was 141.1 and was highest among Black, Non-Hispanics (161.5 per 100,000) and White, Non-Hispanics (150.6 per 100,000) (Figure 62). The overall cancer mortality rate in Hudson County (121.1 per 100,000) was lower than in the state. Most racial/ethnic groups in Hudson County, had cancer mortality rates comparable to those in New Jersey. However, Black residents' cancer mortality rate (182.9 per 100,000) in Hudson County, was higher than in New Jersey. Appendix I in the back of this report contains additional cancer data including incidence and mortality data and five-year trends for all cancers across New Jersey and Hudson County. There is an additional table of tumor registry data for JCMC, and information on the patient origin of Hudson's outpatient and inpatient cancer treatment population.

Figure 62. Cancer Mortality Rate per 100,000 Population (Overall, Combined for Female Breast, Colorectal, Lung and Bronchus, Male Prostate), by Race/Ethnicity, State, and County, 2016-2020

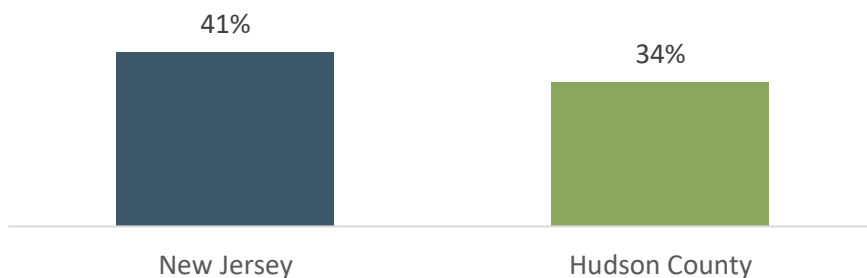


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Breast Cancer

The following figure shows the percentage of female Medicare enrollees, ages 65-74, that received an annual mammography screening in 2019. At the state level, 41.0% of female Medicare enrollees in that age group had received an annual screening (Figure 63). The county rate of 34% was lower than that state rate.

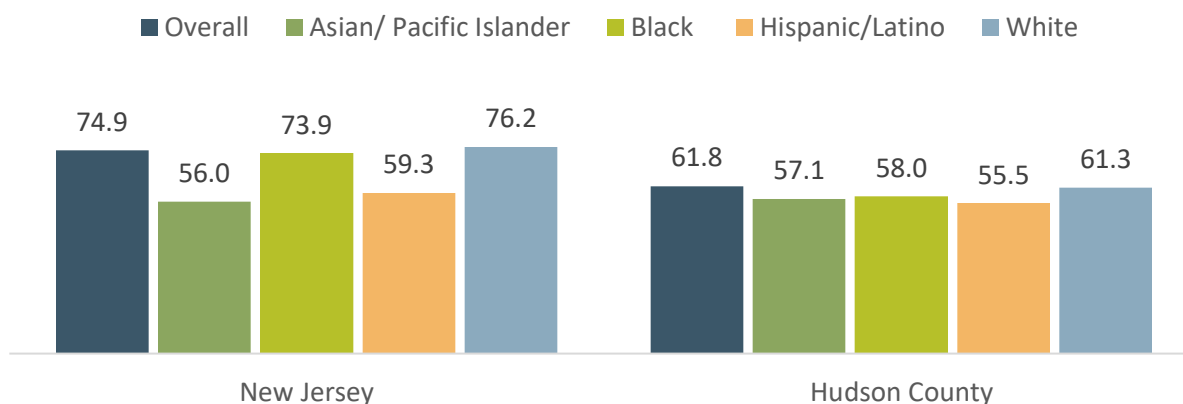
Figure 63. Female Medicare Enrollees Ages 65-74 that Received an Annual Mammography Screening, by State and County, 2019



DATA SOURCE: Centers for Medicare & Medicaid Services, Office of Minority Health's Mapping Medicare Disparities tool, as reported by County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

Cancer registry data is presented for the age-adjusted incidence rate of female breast cancer per 100,000 population in 2015-2019 across New Jersey and in Hudson County, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate was 74.9 per 100,000 and was highest among the White (76.2 per 100,000) and Black (73.9 per 100,000) populations (Figure 64). At the county level, the overall incidence rate in Hudson County (61.8 per 100,000) was lower than in the state. It was highest among the White Hudson County population (61.3 per 100,000) and similar among the Black (58.0 per 100,000), Asian/Pacific Islander (57.1 per 100,000), and Hispanic/Latino (55.5 per 100,000) groups.

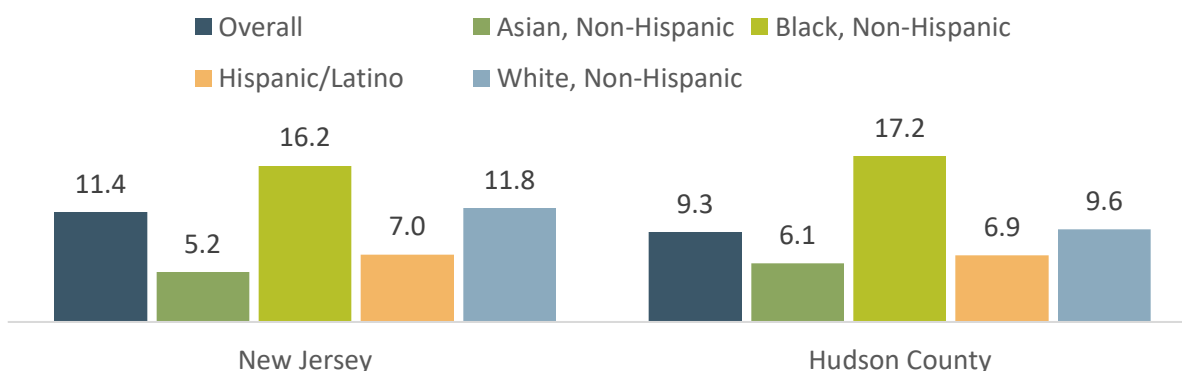
Figure 64. Age-Adjusted Female Breast Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

The state cancer mortality rate was 11.4 per 100,000 persons and was highest among Black women (16.2 per 100,000), followed by White women (11.8 per 100,000) (Figure 65). At the county level, the overall mortality rate was 9.3 per 100,000, lower than in New Jersey. The breast cancer mortality rate among Black women (17.2 per 100,000) in Hudson County nearly doubled that of White residents (9.6 per 100,000), and almost tripled that of Asian women (6.1 per 100,000) and Latinas (6.9 per 100,000).

Figure 65. Breast Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020

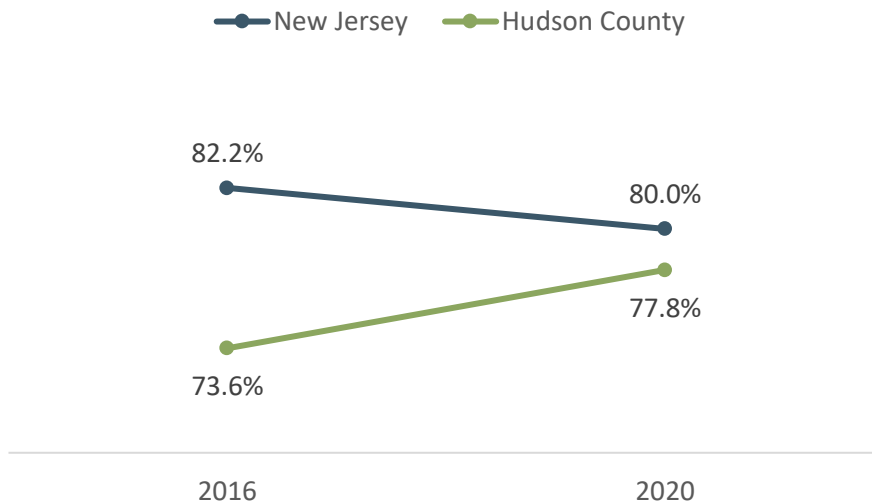


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Cervical Cancer

Data are presented on the percentage of women, ages 21-65, that reported having had a pap test in the past three years in 2016 and 2020, encompassing the first year of COVID-19. At the state level, 82.2% of women in that age group reported having had a pap test in the past three years in 2016 and 80.0% in 2020 (Figure 66). Whereas the percentage of women getting pap tests were lower in Hudson County at both time periods, unlike in New Jersey, the percentage of women obtaining a pap test in the past three years in Hudson County increased from 73.6% in 2016 to 77.8% in 2020.

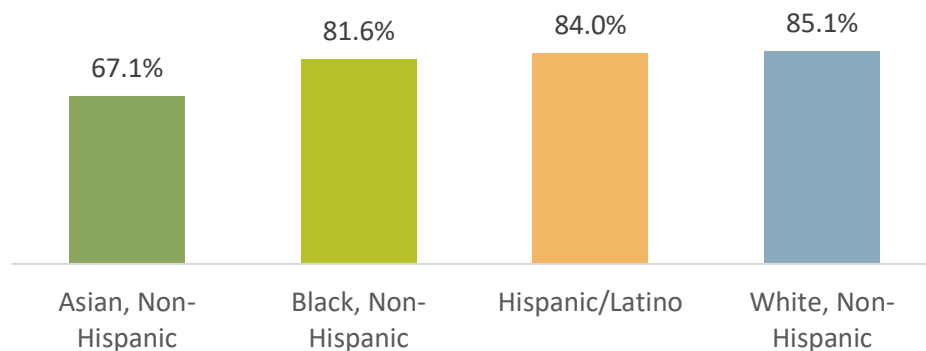
Figure 66. Percent Females Aged 21-65 Reported to Have Had a Pap Test in Past Three Years, by State and County, 2016 and 2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016 and 2020

Data are also presented at the state level on the percentage of females, ages 21-65, that reported having had a pap test in the past three years by race/ethnicity. In New Jersey, 85.1% of White, Non-Hispanics, 84.0% of Hispanics/Latinos, 81.6% of Black, Non-Hispanics, and 67.1% of Asian, Non-Hispanics reported having a pap test in the past three years (Figure 67).

Figure 67. Percent Females Aged 21-65 Reported to Have Had a Pap Test in Past Three Years by Race/Ethnicity, by State, 2020

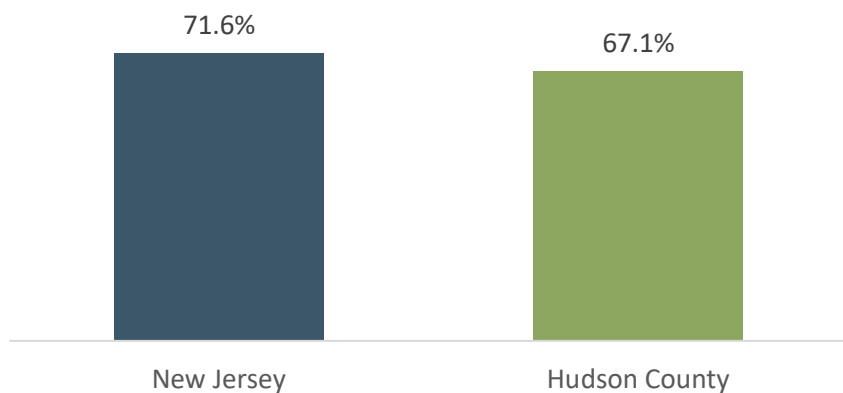


DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Colorectal Cancer

The following figure presents 2020 surveillance data on the percentage of adults aged 50 to 75 who were current – defined as having taken a take-home fecal immunochemical test (FIT) or high-sensitivity fecal occult blood test (FOBT) within the past year, and/or a flexible sigmoidoscopy within the past 5 years with a take-home FIT/FOBT within the past 3 years, and/or a colonoscopy within the past ten years – in their colorectal cancer screenings. At the state level, 71.6% of adults in that age group reported having had a colorectal cancer screening compared to 67.1% in Hudson County (Figure 68).

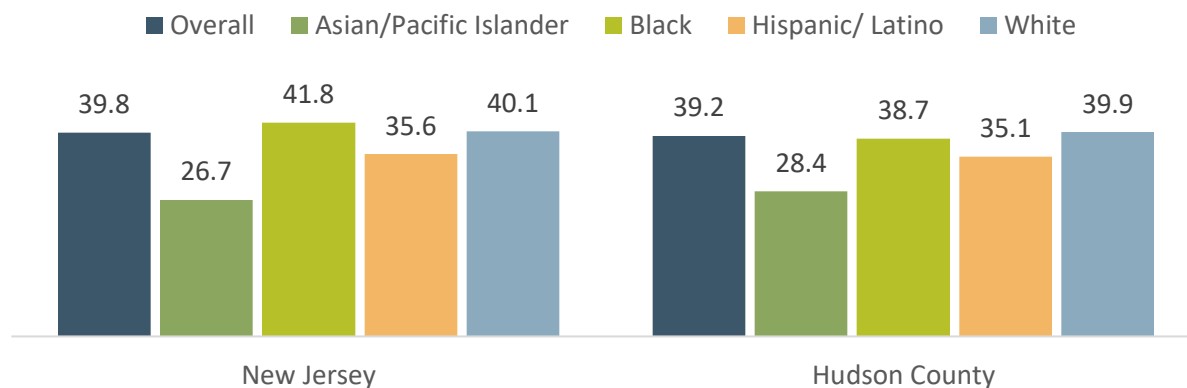
Figure 68. Percent Colorectal Cancer Screening (Adults Aged 50-75), by State and County, 2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Cancer registry data is presented for the age-adjusted incidence rate of colorectal cancer per 100,000 population in 2015-2019 at state and county, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate per 100,000 was 39.8 and was highest among the Black (41.8 per 100,000) and White (40.1 per 100,000) populations (Figure 69). At the county level, the overall incidence rate was 39.2 per 100,000 in Hudson County and was highest among the White (39.9 per 100,000) and Black (38.7 per 100,000) populations.

Figure 69. Age-Adjusted Colorectal Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019

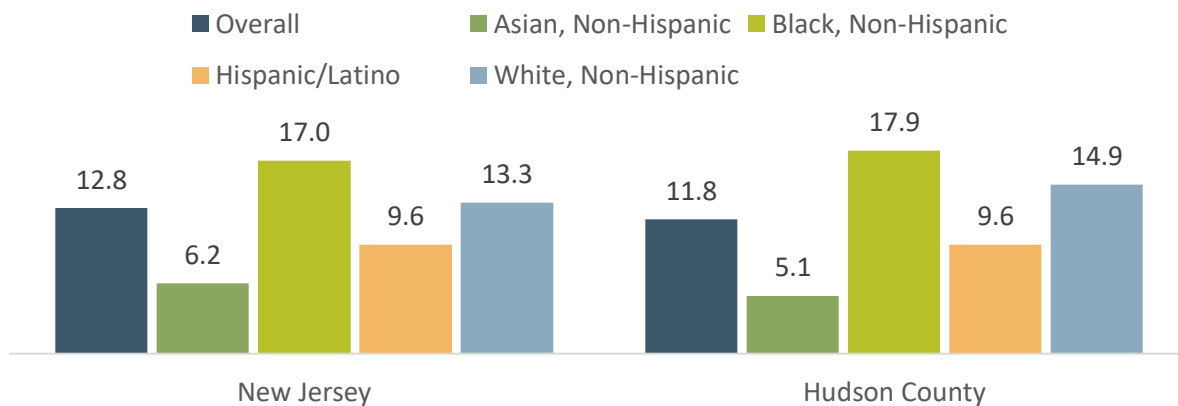


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Death certificate data is presented for rate of colorectal cancer mortality per 100,000 persons in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality rate was 12.8 per 100,000 and was highest among the Black population (17.0 per 100,000), followed by the White population (13.3 per 100,000) (Figure 70). County-level rates were comparable. The overall colorectal cancer mortality in Hudson County was 11.8 per 100,000 persons; highest among Black (17.9 per 100,000) followed by White (14.9 per 100,000) residents.

Figure 70. Colorectal Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020

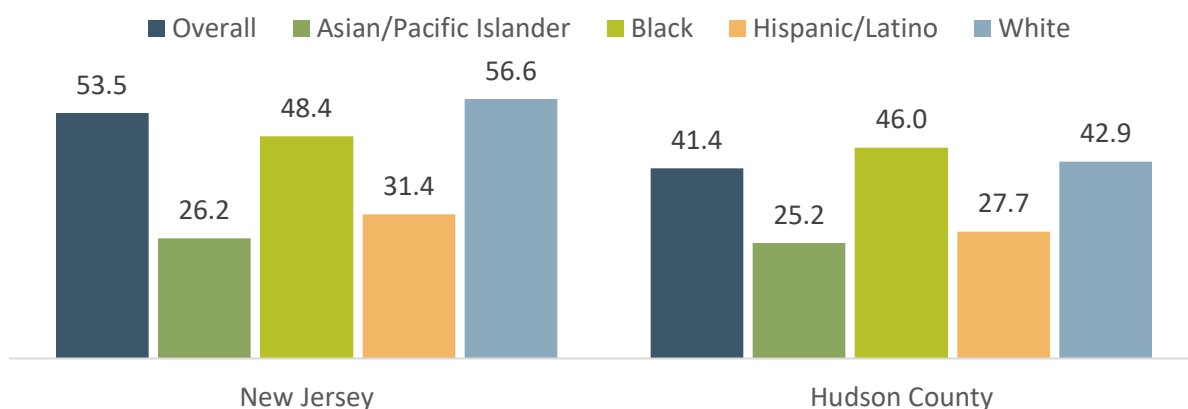


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Lung Cancer

Across the state, the overall age-adjusted lung cancer incidence rate in 2015-2019 was 53.5 per 100,000 residents and was highest among the White (56.6 per 100,000) and Black (48.4 per 100,000) groups (Figure 71). The county-level overall lung cancer incidence rate of 41.4 per 100,000 was lower than in the state. By race/ethnicity, the incidence rate of lung cancer in Hudson County was higher than average among the Black (46.0 per 100,000) and White (42.9 per 100,000) populations.

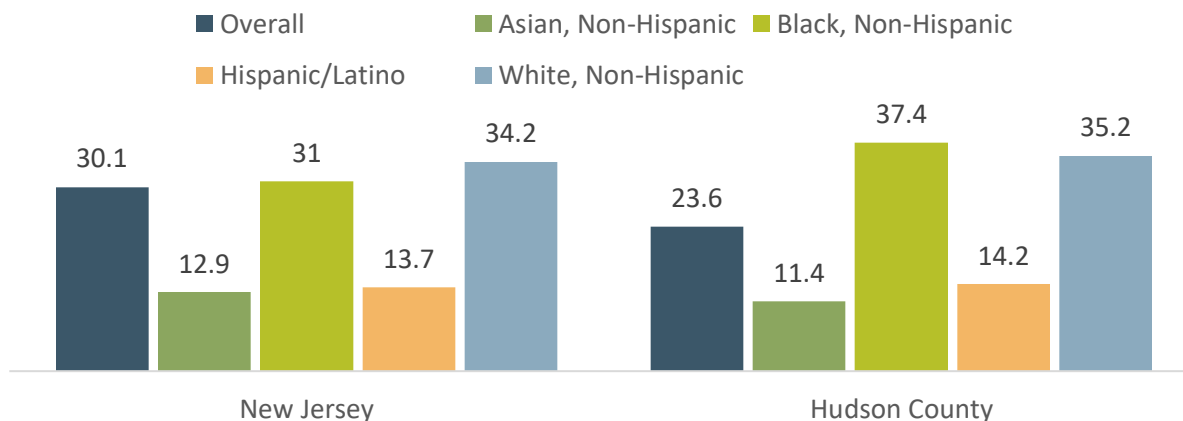
Figure 71. Age-Adjusted Lung Cancer Incidence Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2015-2019



DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

Death certificate data is presented for rate of lung cancer mortality per 100,000 in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality rate per 100,000 was 30.1 and was highest among White, Non-Hispanics (34.2 per 100,000) and Black, Non-Hispanics (31.0 per 100,000) (Figure 72). At the county level, the overall lung cancer mortality per 100,000 was 23.6 in Hudson County and was highest among Black, Non-Hispanics (37.4 per 100,000), followed by White, Non-Hispanics (35.2 per 100,000).

Figure 72. Lung Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020

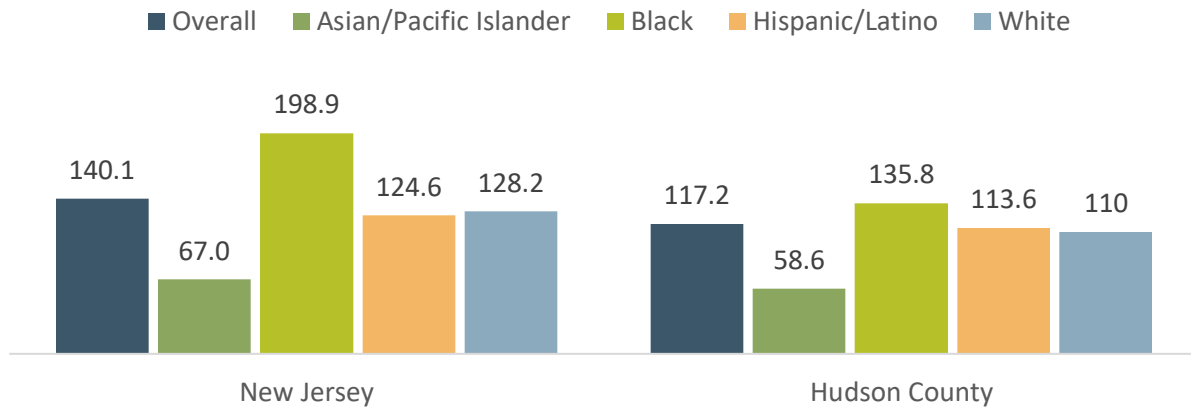


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Prostate Cancer

Cancer registry data is presented for the age-adjusted incidence rate of prostate cancer per 100,000 population in 2015-2019 across New Jersey and in Hudson County, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate was 140.1 and was 198.9 per 100,000 in the Black population (Figure 73). At the state level, incidence rates were similar among Hispanic/Latino (124.6 per 100,000) and White (128.2 per 100,000) populations, and lower among Asian (67.0 per 100,000) groups. At the county level, the overall age-adjusted incidence rate was 117.2 in Hudson County and was highest among Black residents (135.8 per 100,000), comparable among Hispanic/Latino (113.6 per 100,000) and White (110.0 per 100,000) populations, and lowest among Asian groups (58.6 per 100,000).

Figure 73. Age-Adjusted Prostate Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019

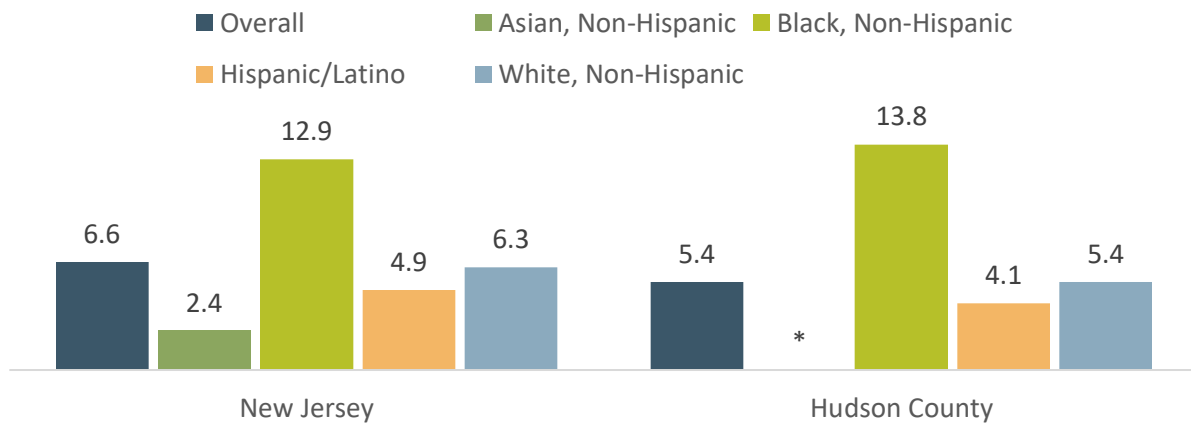


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Death certificate data is presented for rate of prostate cancer mortality per 100,000 in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality rate per 100,000 was 6.6; almost double the average rate among Black, Non-Hispanics (12.9 per 100,000) (Figure 74). At the county level, the overall mortality rate per 100,000 was 5.4 in Hudson County, with rates for Black residents (13.8 per 100,000) 170% higher than the average. Data was not provided for Asians due to small numbers.

Figure 74. Prostate Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020



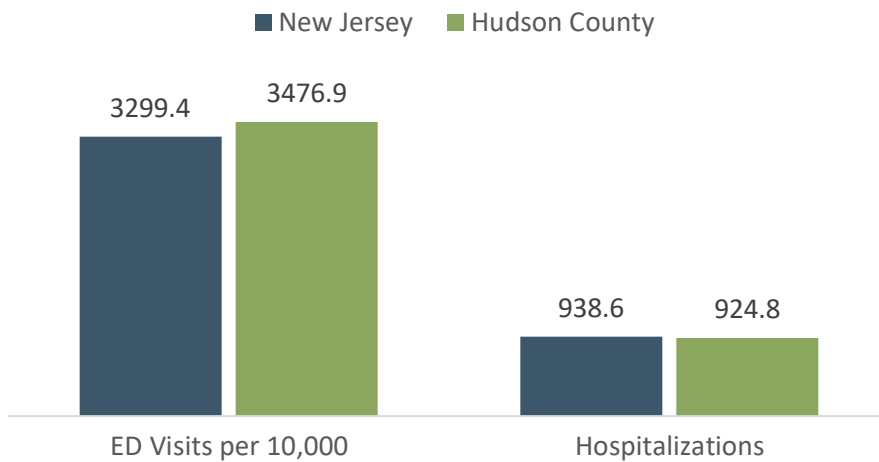
DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. It is the most prevalent disease in the grouping of chronic lower respiratory diseases (CLRD), the sixth leading cause of death in Hudson County in 2020. Data are presented on the rate of emergency department (ED) visits and hospitalizations for COPD per 10,000 population at the state and county level from 2016-2020. The state overall had a rate of 3,299 ED visits and 939 hospitalizations per 10,000 population (Figure 75). Hudson County had a rate of 3,477 ED visits, a rate higher than the state, and 925 hospitalizations per 10,000 population, slightly below the state-wide rate.

Figure 75. Hospitalizations due to COPD per 10,000, by State and County, 2016-2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Disability

Residents who have some type of disability may have difficulty getting around, living independently, or completing self-care activities. Other disabilities, such as hearing impairment, vision impairment, and cognitive impairment, may also impact residents' daily lives. Disabilities affect people of all ages and are most prevalent among older adults.

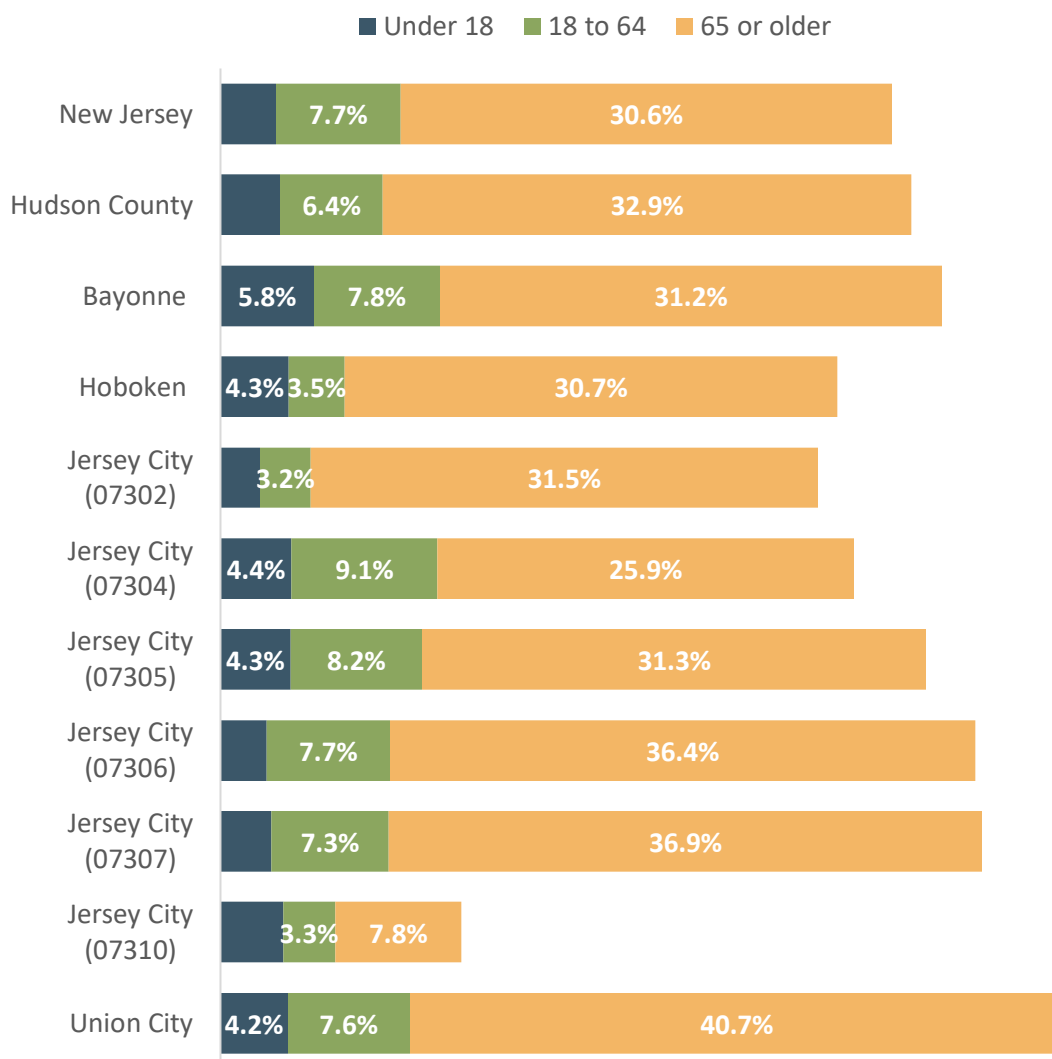
While the issue of disabilities did not emerge often in the qualitative interviews, many people with disabilities face economic instability as they rely on government financial assistance programs for their basic needs. In New Jersey, the Divisions of Developmental Disabilities (DDD) and Disability Services' (DDS) provide support for individuals until they turn 21, and after individuals reach age 60, they can access resources from the Office of Aging and Disability. In addition, it is often challenging for parents of children with disabilities to navigate the education and healthcare system, particularly if they have limited English abilities. Even obtaining a diagnosis may be difficult. For middle and low-income residents, affording care for children with disabilities is also a barrier. One education administrator

"It's called early intervention, where students are identified early. So, if they or the pediatrician notices that there's some developmental delays, we pick them up. We provide services from preschool on through 21." – Key informant interviewee

expressed that there were supportive services for children with special needs starting in preschool to age 21. However, developmental delays are not always easy to diagnose. Further, there are insufficient special education teachers to meet the need.

Data on the civilian noninstitutionalized population by age show that almost four percent of children under 18 years old (3.5%), almost eight percent of 18-64-year-old adults (7.7%), and 30.6% of people 65 or older had a disability in New Jersey in 2016-2020 (Figure 76). At the county level, 3.7% of children under 18 years old, 6.4% of 18-to-64-year-old adults, and 32.9% of adults 65 years of age and older had a disability in Hudson County. Bayonne had the highest proportion of children living with a disability (5.8%) in 2016-2020; in Jersey City zip code 07304, almost 1 in 10 adults aged 18-64 had a disability (9.1%); and in Union City more than 2 in 5 (40.7%) adults 65 and older were living with a disability.

Figure 76. Civilian Noninstitutionalized Population with a Disability, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Behavioral Health: Mental Health and Substance Use

Behavioral health is thought of as the connection between the health and well-being of the body and the mind. In the field, mental health and substance use are typically discussed under the larger framework of behavioral health.

Mental Health

Mental health was identified as a top community health concern. The topic of mental health arose in almost all conversations conducted for this CHNA. Interviewees and focus group members noted that while mental health has been a longstanding health concern, the COVID-19 pandemic has made the issue more pressing. In the words of a Latino focus group participant, *“The pandemic had an adverse effect on everyone—children, teens, and adults—and there have been many people affected psychologically.”* Job loss and economic pressures, virtual schooling, social isolation, and the uncertainty associated with the pandemic were all cited as contributors to increased stress, depression, and trauma among Hudson County residents. At the same time, gun violence has also taken a toll on individual and collective psyches. In addition, poor mental health is often co-morbid with chronic conditions, which are highly prevalent in the population. Among community survey respondents, mental health was the top community health issue with 30.9% of respondents identifying it as an area of concern, as noted previously in the Perceptions of Community Health section.

“The first problem is getting people to recognize the need, it’s a national problem, with the advertising that it’s okay to ask for help.” – Focus group participant

Stigma and Access to Mental Health Care

While mental health issues affected people of all ages, races, and genders, mental health for veterans, unhoused individuals, children and youth, seniors, trans persons, Latino residents, immigrants, and low-income adults were highlighted in the qualitative discussions. Focus group participants noted that anxiety and depression were prevalent in the community and mentioned several barriers to care. Participants highlighted stigma associated with mental health as a hindrance. Participants observed that many people affected by mental health did not recognize mental health as a medical condition, and this was particularly so among the foreign-born population, veterans, and Black residents. As a focus group participant and veteran described, *“We find that to be a problem, that our veterans don’t ask for help, because they’re so darn self-sufficient and a little stubborn.”* A key informant interviewee who self-identified as Black explained that for *“those of African descent, counseling was not something that we did.”*

Mental Health and Economic Instability

Poor mental health is closely associated with economic and housing instability, as described in the section on Employment. Focus group veteran participants expressed that not having employment that afforded them a living wage was a major cause of anxiety and depression. Latino residents in the focus groups shared stories about the challenges of losing their jobs, paying the rent, and feeding their families. An advocate for the LGBTQ+ community described high levels of stress and depression among transgender residents due to unemployment.

Mental Health and Trauma

Trauma is defined as a person’s emotional response to a distressing event or series of events, including experiencing or witnessing violence, abuse and neglect in childhood, and war, among others. A person can have a range of psychological and physical symptoms following trauma that can dramatically hinder well-being and daily functioning, and can, in severe cases, develop post-traumatic stress disorder.

“We need more services because people are not getting the help they need...” – Focus group participant

As described in detail in the section on Violence Prevention and Safety, communities of color have experienced an undue burden of multiple forms of intergenerational, childhood, and adult trauma. As noted earlier, violence and community safety was the top health priority for Black survey respondents. Survivors of violence face many barriers to accessing mental health care. Key informant interviewees explained that many trauma survivors come from cultures and environments that stigmatize mental health conditions. Others experience economic barriers to accessing care. Focus group participants and interviewees highlighted the urgent need to provide trauma informed care and to expand access to counseling and allied services for persons recovering from trauma in Hudson County. A focus group participant described the dire situation of mothers of gun violence victims, *“We met with a group of moms whose children were all impacted by gun violence where the child was lost or criminally involved, the moms decided to get together and support each other. I asked what they did and they said, “We just gather and wait for the next support victim.” These women were in trauma themselves, looking to help others but not able to help themselves.”*

Since 2020, JCMC’s Trauma Recovery Center, a national evidence-based model to treating survivors of violence, has addressed some of the need. The model is based on providing trauma-informed medical care to violence survivors, in addition to counseling to alleviate trauma symptoms, and linkage to community resources to address survivors’ most immediate needs, including relocation, employment, and housing support, among others.

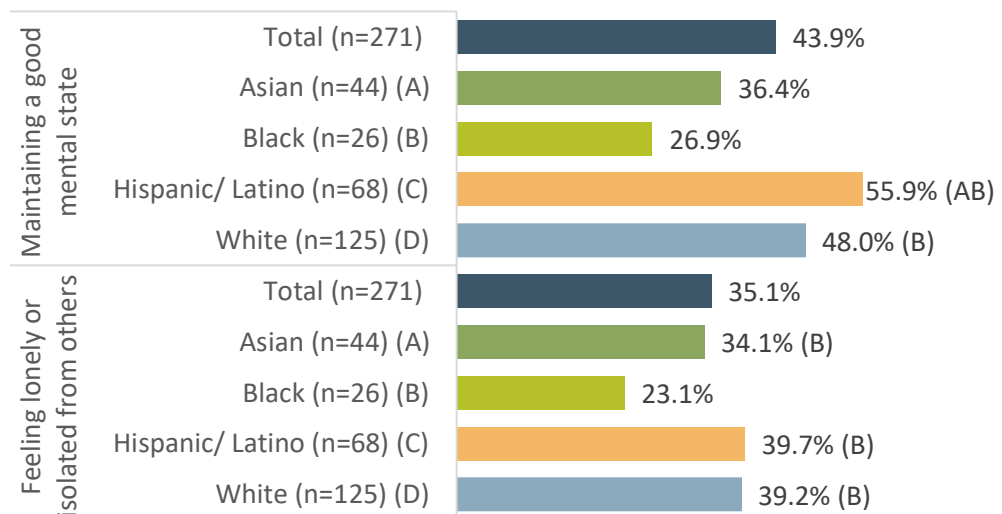
Mental Health and the COVID-19 Pandemic

The COVID-19 pandemic had devastating consequences on mental health across many sectors of the population. The pandemic contributed to anxiety, depression, and stress. Partly due to fear of the virus and uncertainty, partly due to the financial impact, and partly due to isolation. Further, many community members lost loved ones due to COVID-19. Interviewees who worked with seniors talked about isolation and loneliness among older residents, which was harder during the pandemic when senior centers and other social outlets closed. Many residents noted that children and youth were particularly affected as schools closed and they were isolated from their friends and social environment. They indicated that this was compounded by parents’ increased stress levels due to uncertainty and financial worries. Participants mentioned that youth exposed to domestic violence were particularly affected by stay-at-home orders. Suicide ideation among teenagers was mentioned by several participants. A public health official summed up the situation of young people during the pandemic, *“They weren’t in school through the whole pandemic and, you know, perhaps they’re at home with an alcoholic father, or abusive mother, or you know, or no one at all. I think the kids are suffering probably the most as a community.”*

Those working in the health sector talked about the mental health of their staff who have faced tremendous pressure when responding to the pandemic. As an interviewee from public health described, “[Mental health] is a problem, I think, especially after Covid... We were all, you know, as a community, at home. Even me, I wasn't at work, but I was working from home you know, 24/7, 7 days a week. So, I definitely think mental health is a big issue... You have to understand what it is to be doing that all the time.”

Reiterating the impact of the pandemic on mental health, 43.9% of survey respondents reported that they or someone in their family had personally experienced difficulty with maintaining a good mental state, while 35.1% reported being lonely or isolated from others since COVID-19 began (Figure 77). More than half of Latino respondents (55.9%) reported that they or a family member had difficulty maintaining a good mental state during COVID-19, significantly more than Black (26.9%) and White (48.0%) respondents. Black respondents (23.1%) were the least likely of all race/ethnic groups to report being isolated.

Figure 77. Percent of Community Survey Respondents Reporting that They or Someone in Their Immediate Family Has Personally Experienced Difficulty with Mental Health Issues since COVID-19 Started (n=271), 2021



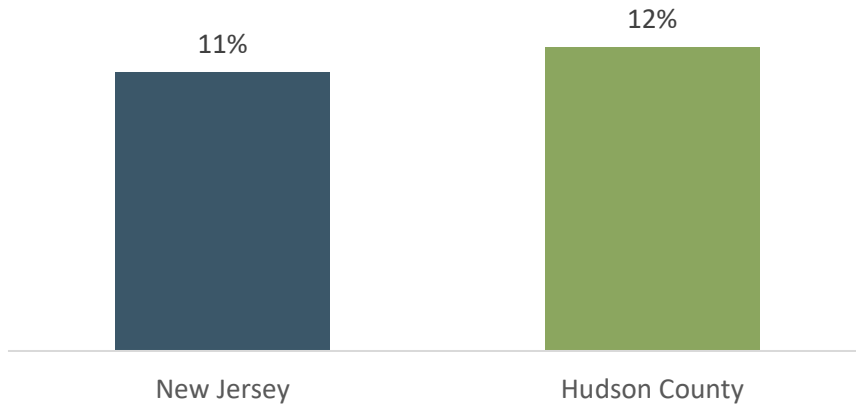
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Mental Health Incidence, Hospitalization, and Mortality

When examining surveillance data on mental health from prior to the COVID-19 pandemic, 12% of adults in Hudson County reported 14 or more days of poor mental health in the past month (Figure 78).

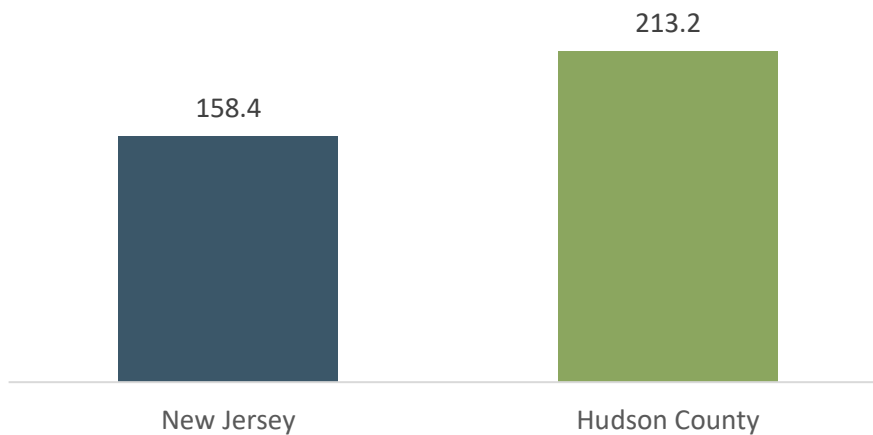
Figure 78. Percent Adults Reported 14 or More Days of Poor Mental Health in Past Month, by State and County, 2018



DATA SOURCE: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2018

Data from 2018 indicate that Hudson County had a rate of 213 emergency department (ED) visits due to mental health per 100,000 population, which was smaller than the rate statewide (158 per 100,000) (Figure 79).

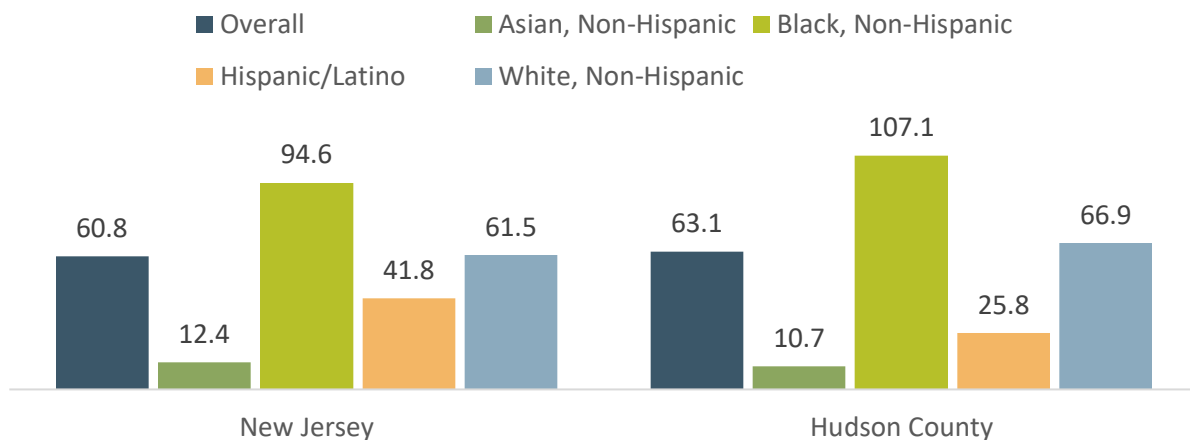
Figure 79. ED Visits Due to Mental Health per 100,000, by State and County, 2018



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2018

Data are presented on the rate of hospitalizations due to mental health per 100,000 population by race/ethnicity in 2020, the first year of the pandemic. The overall county rate was slightly higher than at state level (63.1 per 100,000 in Hudson County vs. 60.8 per 100,000 in New Jersey) (Figure 80). The mental health-related hospitalization rate was highest among the Black population in both the state (94.6 per 100,000) and the county (107.1 per 100,000), followed by White residents (61.5 per 100,000 in New Jersey and 66.9 per 100,000 in Hudson County). County-level rates for mental health hospitalization of Latino and Asian residents were both lower in Hudson County than in New Jersey.

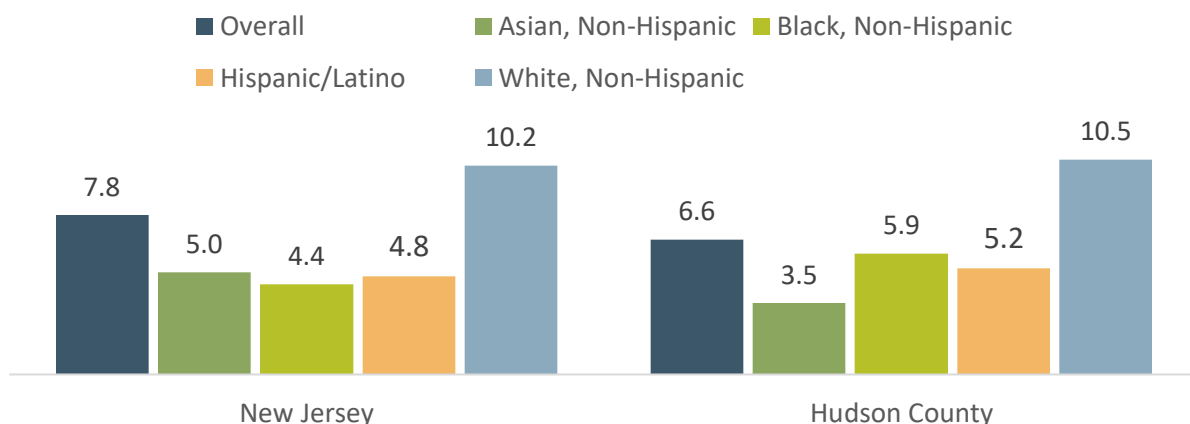
Figure 80. Hospitalizations Due to Mental Health per 100,000, by Race/Ethnicity, State, and County, 2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020

Data from 2016-2020 (aggregated across multiple years due to small numbers) indicate that Hudson County’s suicide rate was 6.6 per 100,000 population. Rates among Asians were lower in the county than in the state, but higher among the other racial/ethnic groups. White residents had the highest suicide rates in the county (10.5 per 100,000), nearly double those of Black (5.9 per 100,000) and Latino (5.2 per 100,000) residents (Figure 81).

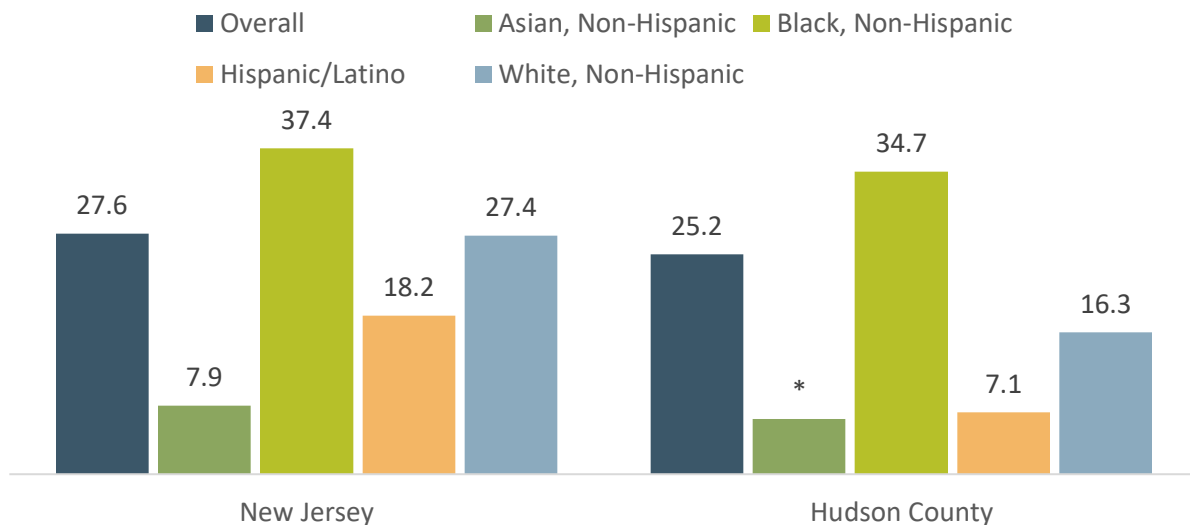
Figure 81. Suicide Rate per 100,000 Population (Age-Adjusted), by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Data from 2020 indicate that Hudson County’s rate of mental health-related hospitalization among children was 25.2 per 100,000 population. Rates in each racial/ethnic group were lower in the county than in the state. Pediatric mental health-related hospitalization rates in Hudson County were more than double among Black children (34.7 per 100,000) compared to the following group, White children (16.3 per 100,000) (Figure 82).

Figure 82. Pediatric Hospitalizations (Ages 19 and Under) Due to Mental Health per 100,000, by Race/Ethnicity, State, and County, 2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Mental Health Services

Focus group members and interviewees reported that finding mental health services in Hudson County can be challenging, especially for residents who are uninsured and/or unable to pay out of pocket for these services. First, even for residents who do seek help, they are not aware of where to obtain it. Second, participants noted that there were insufficient mental health service providers in Hudson County to meet the demand, particularly those that can provide culturally competent services to the diverse population, including gender non-binary people, non-English speakers, and veterans. This leads to long waiting times. As described by a focus group participant, “From the behavioral health side, due to staff shortages and high demand, we’ve had to limit community referrals and take from within the hospital to treat the most acute clients. Those others who need mental health support, we don’t have the bandwidth to help them right now.” A health administrator described the efforts made to hire culturally competent staff, “Not only is it hard finding behavioral health staff, but we also try to mirror the staff we hire, bilingual staff are unicorns because they are hard to find. Matching makeup of the staff, specifically behavioral health, is challenging.”

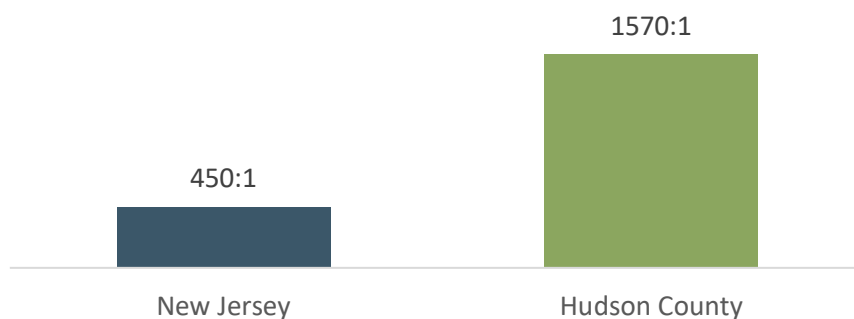
“[It] has been very difficult for our patients to access behavioral health services... we have an extensive waiting list. At any given time to get an appointment with us can take 4 to 6 months, so we’ve tried as much as we can to reach out to all of our partners...”
 – Focus group participant

To facilitate referrals, during COVID-19, the Health Department consolidated a mental health directory, including the suicide prevention hotlines, available at: <https://healthierjc.com/mental-health/>. JCMC and other providers began offering services via telehealth to expand access during the pandemic. However, whereas this strategy worked with certain groups, others without access to technology or with lower digital literacy, did not benefit.

Participants mentioned that schools often identify and connect students to mental health services, but school nurse and student support/counseling offices are understaffed. As one public school administrator expressed, *“We’ve been trying through the schools with our resources to really embed more social, emotional, not just the mental health, but before it gets to the mental health, helping students overcome challenges, developing resilience, by being able to speak about their emotions.”* However, staffing is limited, as are the mental health services that schools can provide.

Data are presented on the ratio of population to mental health providers in 2019. At the state level, there were 450 people for every mental health provider (Figure 83). In Hudson County, the ratio was 1570 people for every mental health provider. The dearth of mental health providers in Hudson County likely worsened during the pandemic.

Figure 83. Ratio of Population to Mental Health Providers, by State and County, 2019



DATA SOURCE: National Provider Identification Registry, Centers for Medicare and Medicaid Services, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

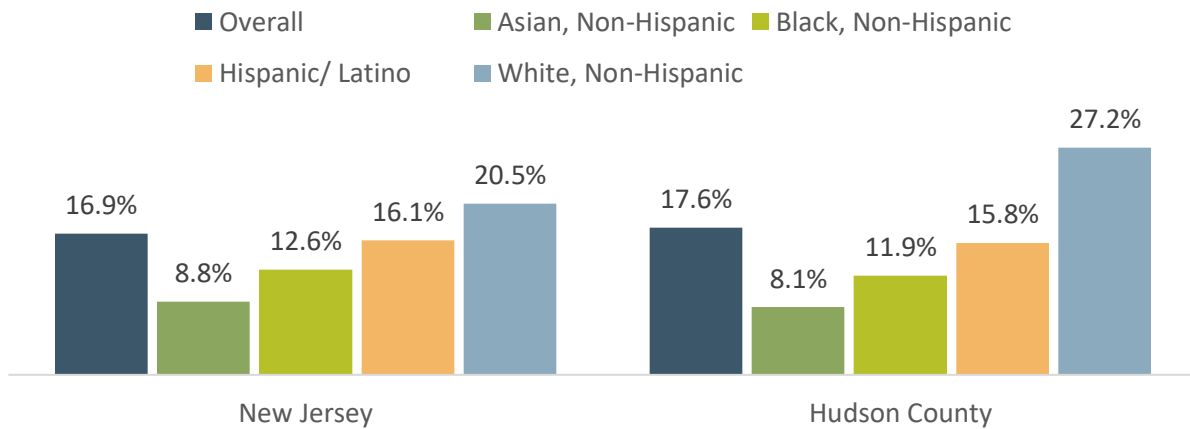
Substance Use

Substance use was mentioned as a community health concern in conversations this year, as it was in prior CHNAs. Problem substance use was described as affecting all groups, across all socioeconomic levels. However, it was mentioned specifically in conversations in the context of unhoused individuals, veterans, and young people; some reported that problem substance use is more hidden among youth in higher income communities. Several participants reported that substance use, particularly alcohol and opioid use, has increased as a result of economic and social stressors. Further, overdose deaths among young people were also noted as a health concern. A healthcare provider remarked, *“I’ll say for us the top conditions that we tend to get a lot of are readmissions for drugs overdose, heroin, opioids, and alcohol. And it’s always the same people who keep coming and coming.”* Some participants mentioned substance use associated with safety concerns, particularly among youth who consume substances. A Latino resident provided the following example, *“When I wait for the bus, there are young people doing drugs or drinking alcohol nearby and that scares me a lot.”* Data for prevalence of substance use, substance-use related mortality, and substance use treatment is presented in the sections below.

Alcohol Use

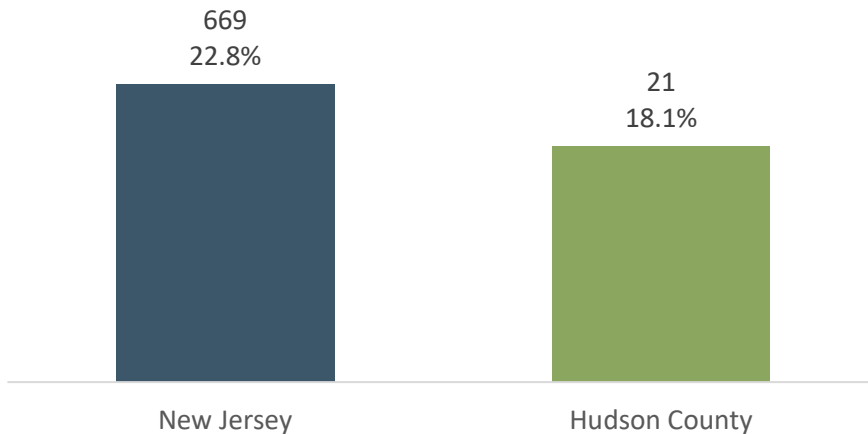
Focus group and interview participants discussed that they were concerned about alcohol consumption as a problem in the community, particularly given difficulty accessing long-term treatment services. Alcohol use is also a contributing factor to other prevalent health conditions, including cardiovascular disease, depression, and violence. Data aggregated for 2017 to 2020 show binge drinking levels – defined as a drinking pattern that brings blood alcohol concentration (BAC) to 0.08 percent or higher, typically by consuming four or more drinks (female), or five or more drinks (male) in a two-hour period – for the state and county and by race/ethnicity. In New Jersey, 16.9% of adults reported binge drinking. This percentage was highest among White (20.5%), followed by Latino (16.1%), Black (12.6%), and Asian (8.8%) residents (Figure 84). At the county level, 17.6% of adults in Hudson County reported binge drinking, with the highest percentage among White (27.2%) residents, followed by Latino (15.8%), Black (11.9%), and Asian (8.1%) residents. Of driving deaths over the period 2015-2019, 22.8% were due to drinking under the influence of alcohol in New Jersey, and 18.1% in Hudson County.

Figure 84. Percent Adults Reported Binge Drinking, by State and County, 2017-2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2017-2020

Figure 85. Alcohol-impaired Driving Deaths, by State and County, 2015-2019



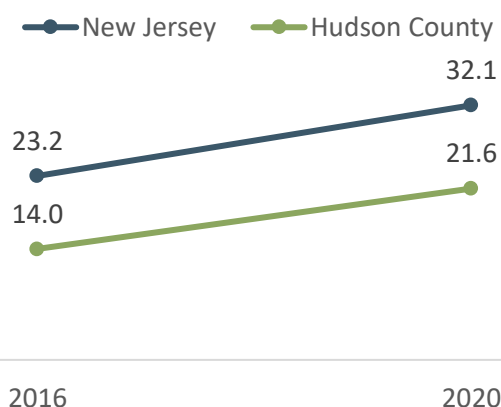
DATA SOURCE: Fatality Analysis Reporting System as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2015-2019

Opioids and Other Drug Use

Misuse of other substances was discussed in several focus group and interview discussions, particularly the use of legal and illegal opiates, and the resulting potential overdose. Others expressed concern about the long-term implications of marijuana legalization on substance use trends in the community.

The following figure shows the age-adjusted drug poisoning mortality rate per 100,000 population in 2016 and 2020. In New Jersey, the age-adjusted rate per 100,000 was 23.2 in 2016 and 32.1 in 2020 (Figure 86). The Hudson County rates were lower than the state, with mortality rates per 100,000 at 14.0 in 2016 and 21.6 in 2020. Similar trends are also presented in Figure 87 for unintentional drug induced poisoning mortality per 100,000.

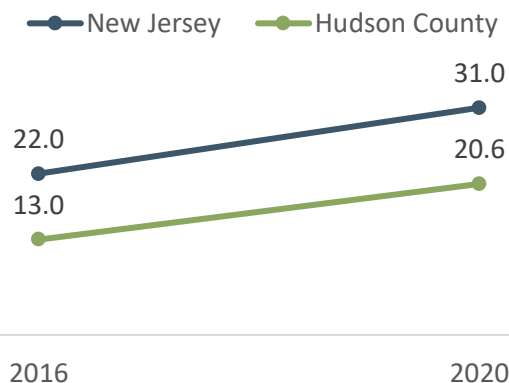
Figure 86. Age-Adjusted Drug Poisoning Mortality Rate per 100,000 Population, by State and County, 2016 and 2020



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020

NOTE: Includes ICD-10 codes X40-X44, X60-X64, X85, and Y10-Y14

Figure 87. Age-Adjusted Unintentional Drug Induced Poisoning Mortality Rate per 100,000 Population, by State and County, 2016 and 2020

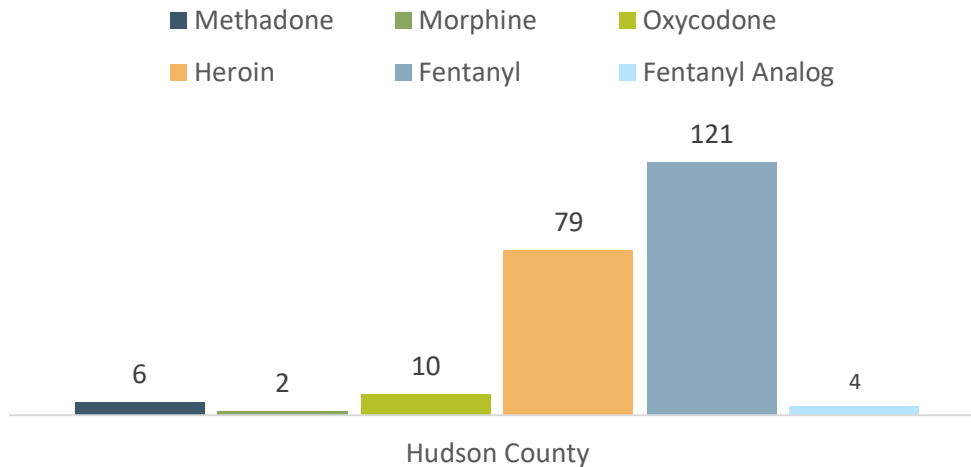


DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020

NOTE: Includes ICD-10 codes X40-X44

State medical examiner data show the count of opioid related deaths by specific drug type in 2019. In Hudson County, there were 121 deaths due to fentanyl, followed by heroin (79), oxycodone (10), methadone (6), and morphine (2) (Figure 88).

Figure 88. Count of Opioid Related Deaths by Drug, by County, 2019

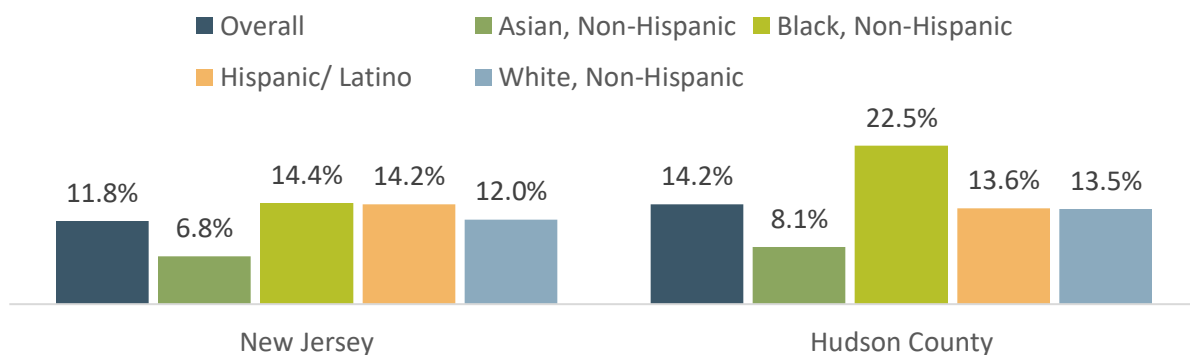


DATA SOURCE: Drug Deaths for 2019, New Jersey Office of the State Medical Examiner

Tobacco Use

Tobacco use is a contributing factor to lung and other cancers, as well as to poor lung health. When looking at the percentage of adults who are current smokers, Figure 89 shows that in New Jersey, 11.8% of adults were current smokers in 2017-2020. This percentage was highest among Black (14.4%) and Latino (14.2%) residents, followed by White (12.0%) and Asian (6.8%) residents. At the county level, 14.2% of residents reported currently smoking overall. Proportionally, more Black residents reported smoking (22.5%) compared to Latino (13.6%), White (13.5%), and Asian (8.1%) adults in Hudson County. Of note, the proportion of Black Hudson County residents who smoked was markedly higher than the county average and of Black smokers in the state.

Figure 89. Percent Adults Reported Current Smokers, by State and County, 2017-2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2017-2020

Substance Use Treatment & Prevention

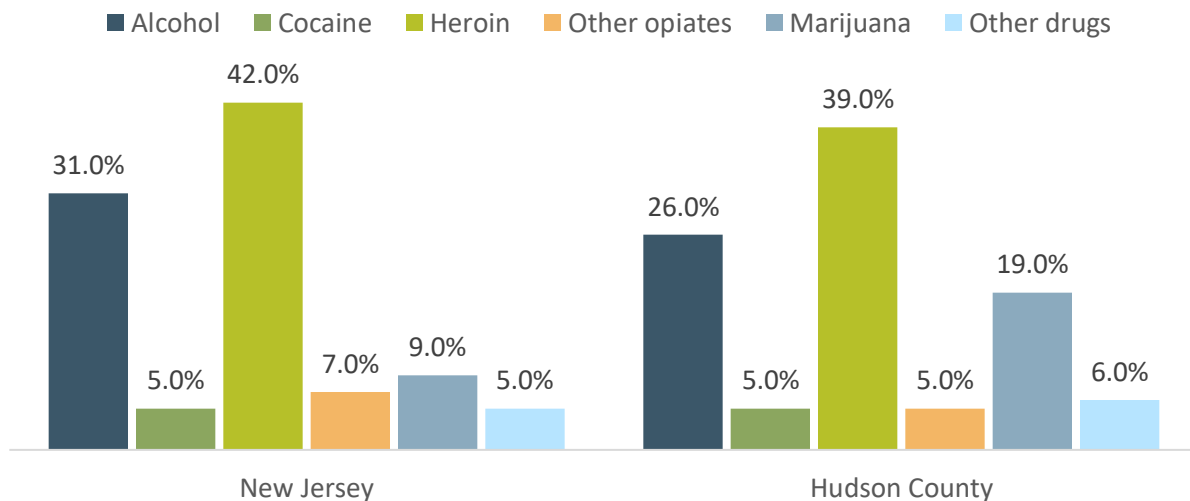
While substance use programs exist in the community, they are insufficient to meet demand according to focus group participants and interviewees. Participants advocated for more local programs, including community-based recovery programs. Several participants mentioned the problem of relapse due to inadequate treatment programs. The disruption in mental health services due to the COVID-19 pandemic further increased the risk of relapse. As a health administrator noted, *“We can detox folks here, but we can’t provide addictions treatment. We can detox people over and over*

“After care is very important because it keeps you sustained with sobriety or whatever mental health issue you have. I think the main thing is talking, talking. I used to have [a] group that no longer happens. I don’t know what happened after Covid that it closed down. But hopefully it’ll come up again ‘cause I really do need it. I miss my veteran groups.” – Focus group participant

again, and we do, that happens in substance abuse treatments, but not having a better solution to move from detox into a 21-day program or something similar is a problem we’ve seen for years... we need a seamless transition between” the facilities, short-term, and long-term treatment programs.

The following figure shows the percentage of substance use treatment admissions by primary drug in 2020. At the state level, 42.0% of admissions were for heroin, 31.0% for alcohol, and under 10% each for marijuana, cocaine, other opiates, and other drugs (Figure 90). In the Hudson County treatment sites, 39.0% of admissions were for heroin, 26.0% for alcohol, 19.0% for marijuana, and under 10% each for other opiates, cocaine, and other drugs.

Figure 90. Percent of Substance Use Treatment Admissions by Primary Drug, by State and County, 2020

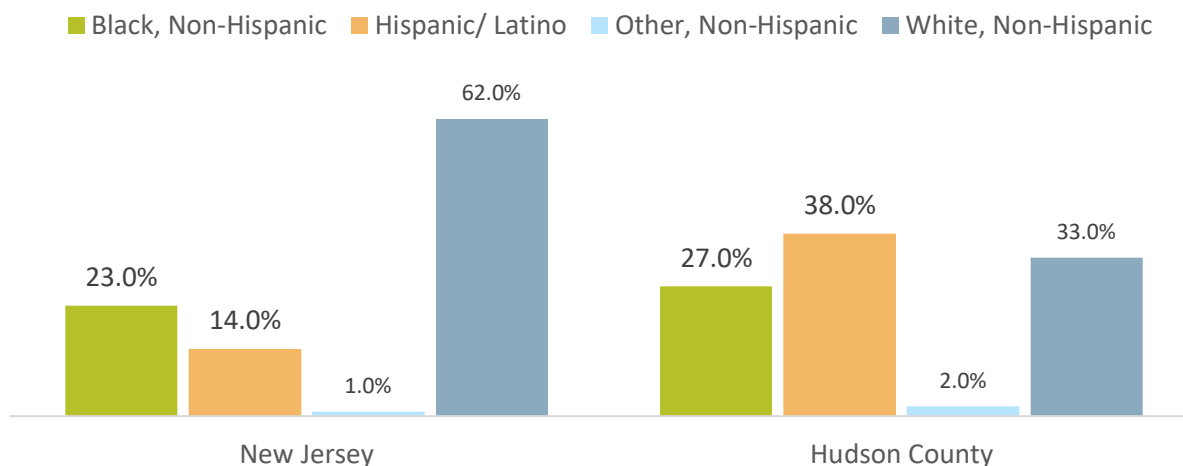


DATA SOURCE: New Jersey Department of Human Services, Division of Mental Health and Addiction Services, New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview, 2020

NOTE: Percentages by county are by county of treatment site

Data is also presented showing the percentage of substance use treatment admissions by race/ethnicity in 2020. At the state level, 62.0% of admissions were of White, Non-Hispanics, followed by 23.0% of Black, Non-Hispanics, 14.0% of Hispanics/Latinos, and 1.0% of other races/ethnicities (Figure 91). In the Hudson County treatment sites, 38.0% of admissions were of Hispanics, followed by 33.0% of White, Non-Hispanics, 27.0% of Black, Non-Hispanics, and 2.0% of other races/ethnicities.

Figure 91. Substance Use Treatment Admissions by Race/Ethnicity, by State and County, 2020



DATA SOURCE: New Jersey Department of Human Services, Division of Mental Health and Addiction Services, New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview, 2020

Environmental Health

A healthy environment is associated with a high quality of life and good health. Environmental factors are various and far reaching and include exposure for hazardous substances in the air, water, soil, or food; natural disasters and climate change; and the built environment.

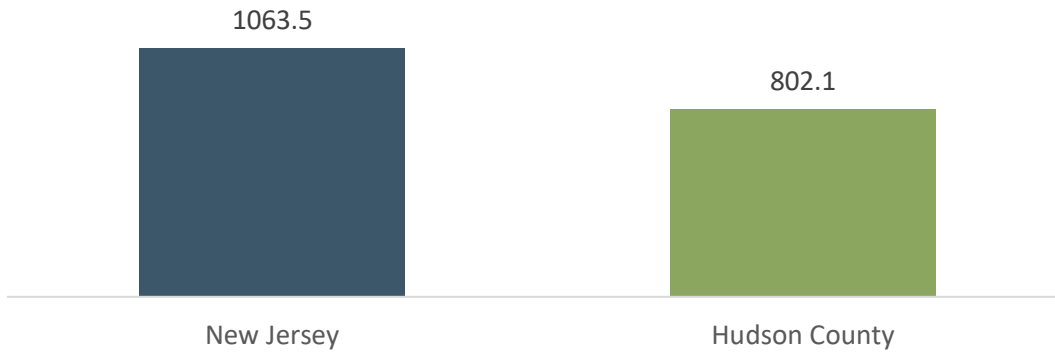
Asthma

Asthma in children was one of the conditions mentioned in the focus groups and interviews as a community problem and as a major cause of missed school days. Public health data typically show that 1 in 13 adults has asthma, and it disproportionately affects low-income communities and communities of color.³⁰ Perceptions of asthma as a community problem are supported by quantitative data.

Data are presented on the rate of asthma hospitalizations per 100,000 population in 2020. The following figure shows that the age-adjusted rate was 1,064 per 100,000 persons in New Jersey and 802 per 100,000 persons in Hudson County (Figure 92).

³⁰ <https://www.aafa.org/asthma-facts/>

Figure 92. Age-Adjusted Rate of Asthma Hospitalizations, by State and County, 2020

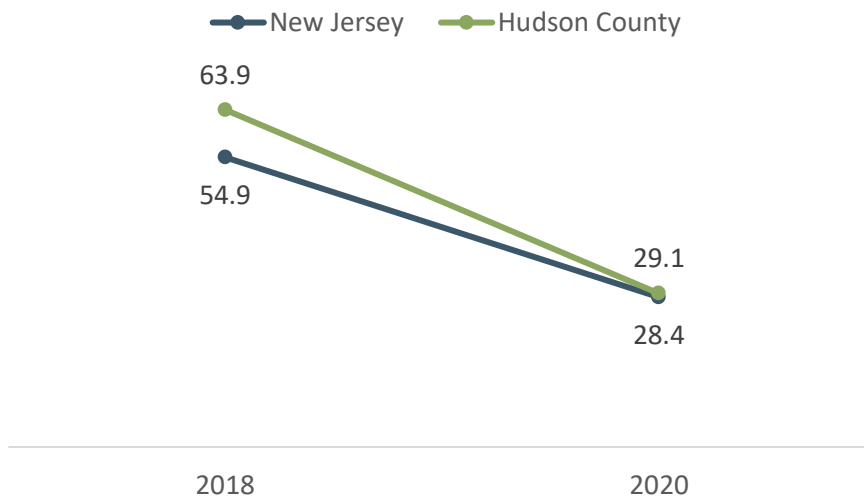


DATA SOURCE: DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020

NOTE: Includes all asthma diagnoses, including primary, secondary, and other diagnoses.

Figure 93 shows age-adjusted asthma emergency department visits in 2018 and 2020. At the state level, there was an important decrease from 2018 (63.9 per 10,000) to 2020 (29.1 per 10,000). Similarly, Hudson County saw a notable decrease of 26.5 asthma ED visits per 10,000 population during the same period.

Figure 93. Age-Adjusted Asthma Emergency Department Visit Rate per 10,000 Population, by State and County, 2018 and 2020

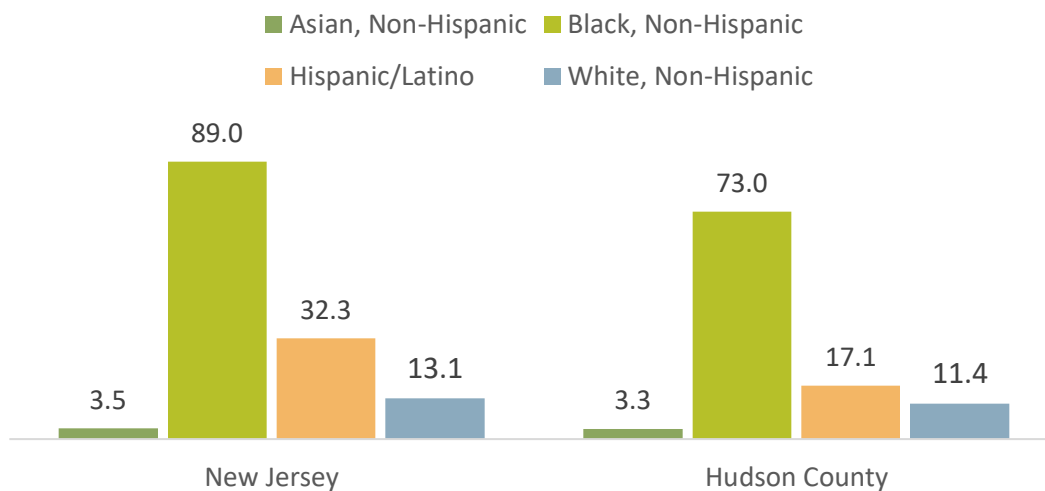


DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020

NOTE: Data includes ED visits where asthma was primary diagnosis

Data from 2020 show significant disparities in asthma rates by race/ethnicity (Figure 94). At state and county levels, Black residents shared a disproportionate burden of asthma ED visits. State-wide, Black, Non-Hispanics had the highest rate of ED visits (89.0 per 10,000), followed by Hispanics/Latinos (32.3 per 10,000), White, Non-Hispanics (13.1 per 10,000), and Asian, Non-Hispanics (3.5 per 10,000). Trends in Hudson County were similar to those state-wide, albeit slightly lower for all race/ethnicities. The highest rate in Hudson County was among Black, Non-Hispanics (73.0 per 10,000), followed by Hispanics/Latinos (17.1 per 10,000), White, Non-Hispanics (11.4 per 10,000), and Asian, Non-Hispanics (3.3 per 10,000).

Figure 94. Age-Adjusted Asthma Emergency Department Visit Rate per 10,000 Population by Race/Ethnicity, by State and County, 2020



DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Data includes ED visits where asthma was primary diagnosis

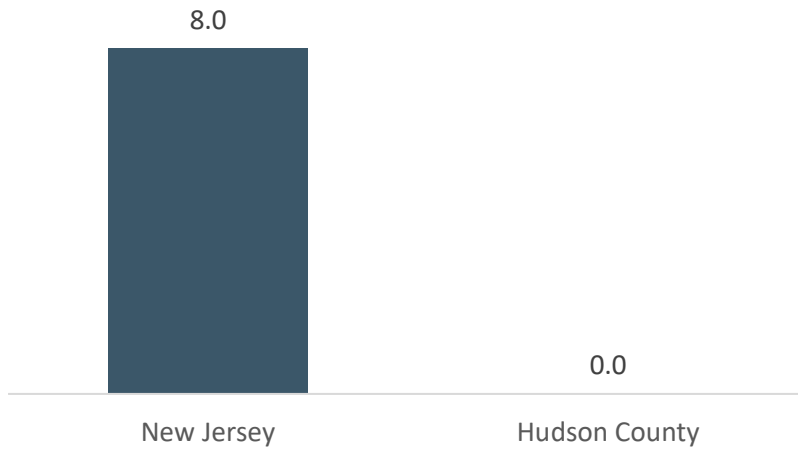
Air Quality

In 2020, there were 8 days statewide and 0 days in Hudson County where ozone in outdoor air exceeded the federal health-based standard for ozone (8-hr period above 0.070 ppm). This is a decrease compared to ozone air quality from 2014-2019; however, it is a possibility that COVID-19 impacted these rates as more people spent time indoors and less time traveling (Figure 95). Data on air quality show an average daily density of fine particulate of 9.3 micrograms per cubic meter in Hudson County, slightly higher than the state average (8.1) (Figure 96). Whereas air quality was not an issue of frequent concern for most participants, a few did remark on vehicular traffic as a source of pollution, particularly in certain neighborhoods.

“The New Jersey Turnpike extension... is a constant construction hazard. People are constantly backed up in traffic and the exhaust, it’s a lot of cars idling in that area, that’s linked to health comorbidities, like asthma.”

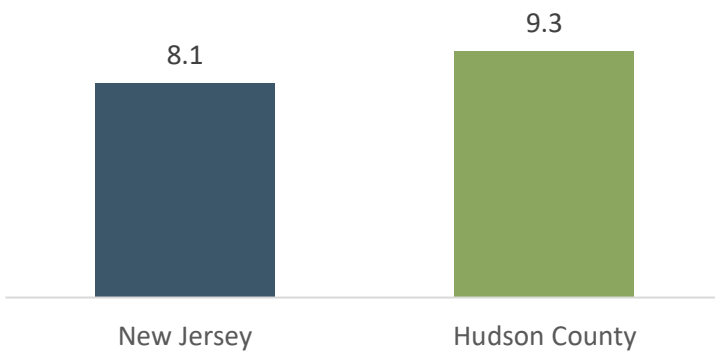
– Key informant interviewee

Figure 95. Ozone in Outdoor Air, Number of Days Ozone Exceeded the National Ambient Air Quality Standards for Ozone (8-hour above 0.070 ppm), 2020



DATA SOURCE: Bureau of Air Monitoring, New Jersey Department of Environmental Protection, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020

Figure 96. Air Pollution-Particulate Matter by State and County, 2018



DATA SOURCE: Center for Disease Control and Prevention (CDC), Environmental Public Health Tracking Network, as reported by, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

Note: Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)

Information on water quality can be found in Appendix F.

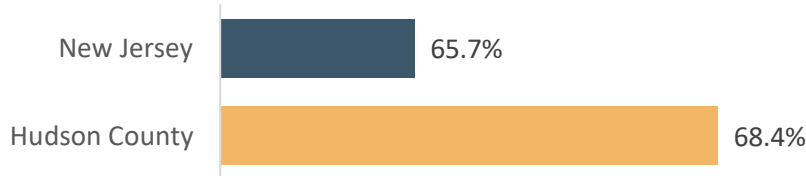
Lead

In 1978, the federal government banned consumer uses of lead-based paint. Exposure to lead among young children, through touching lead dust or paint chips, for example, can harm children’s health, including potential damage to the brain and nervous system, slowed growth and development, and hearing and speech problems.

“A problem like lead poisoning among young children or affecting the IQ levels or things that, as a public health official, we do not feel like there should be any acceptable level of lead in any child’s blood.” – Key informant interviewee

As shown in Figure 97, most of the housing in Hudson County (68.4%) was built prior to 1980, which is a slightly higher percentage than in New Jersey (65.7%). In 2022, New Jersey released new state regulations mandating visual inspections of all rental units built prior to 1978; however, a public health official noted the challenge of implementing such regulations given the number of older housing and the available human resources.

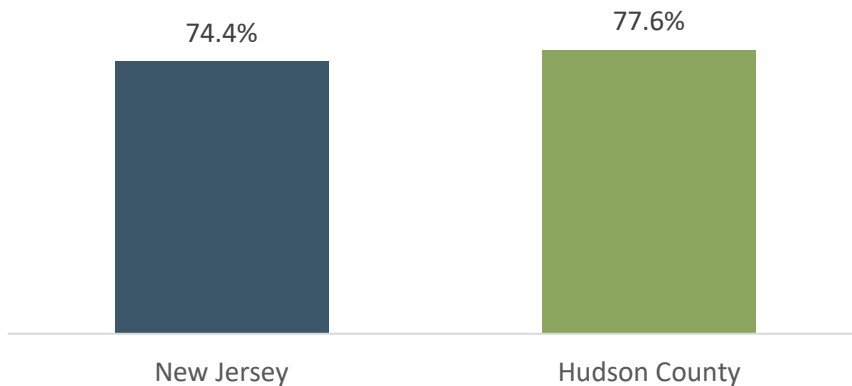
Figure 97. Housing Built Pre-1980, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

New Jersey Child Health Program data shows the percent of children testing for lead exposure before their third birthday in 2014. In Hudson County, 77.6% of children were tested for lead exposure (Figure 98). Across the state of New Jersey, nearly 3 in 4 children were tested for lead exposure. In 2019, 2% of children in Hudson County ages 1 to 5 had blood lead levels meeting or exceeding 5mcg/dL (Figure 129 in Appendix F).

Figure 98. Percent Children Tested for Lead Exposure Before 36 Months of Age Among Children Born in 2014, by State and County



DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry; Child Health Program, Family Health Services, as reported by, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2022

Infectious and Communicable Diseases

This section discusses COVID-19 and sexually transmitted infections.

COVID-19

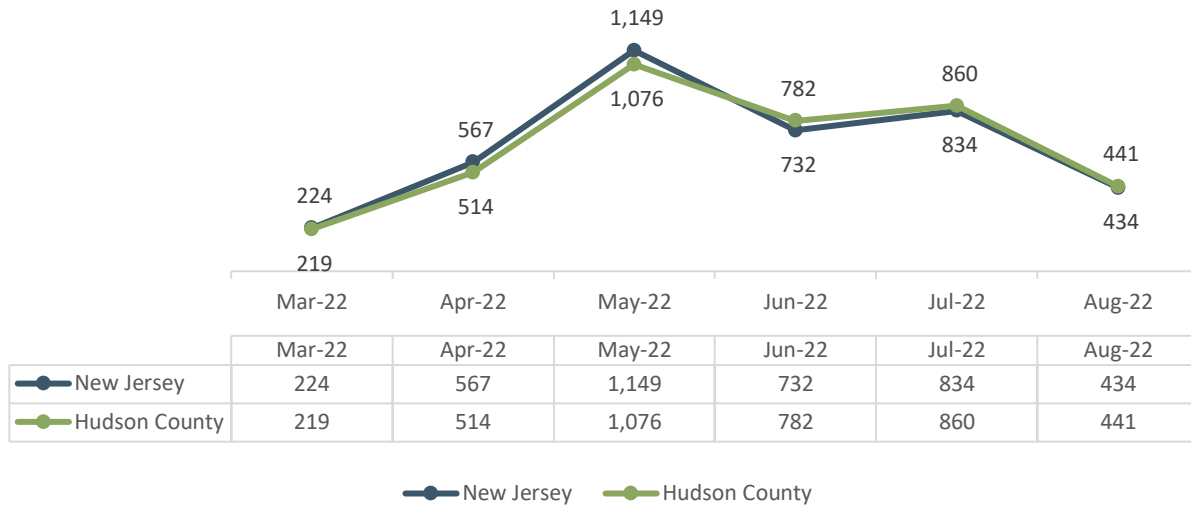
COVID-19 was not extensively discussed in conversations around infectious and communicable diseases. When it was addressed, focus group and interview participants primarily discussed how COVID-19 and the shutdown of businesses and schools had exacerbated the social and economic inequities that already existed. Participants noted that income loss during COVID-19, coupled with inflation, was a major source of stress, anxiety, depression, and other mental health issues. Parents of school children also had to face the challenges of remote schooling, and participants talked about the increase in mental health disorders among children due to isolation. Participants associated the stress-related to COVID-19 on an increase in domestic violence cases. The socioeconomic impacts of COVID-19 were discussed extensively in prior sections (see, for example, the Inequality, Education, Employment and Workforce, and Income and Financial Security sections).

“[COVID impacted] housing, food insecurity, jobs, people have a fear of going back to work, and childcare, because there was a time when everything was virtual, how can parents afford to stay home and put food on the table?” – Focus group participant

Additionally, many in the healthcare fields noted a significant disruption in access to services, particularly in preventive care. They remarked that patients were afraid of seeking care and only did so for emergencies. Several focus group participants observed that COVID-19 had become normalized and were worried that people were not taking the proper precautions, such as masking, to prevent the spread of COVID-19. In terms of COVID-19 testing, there were diverse experiences; whereas some knew of free COVID-19 testing sites, others did not. For the latter, cost was a barrier to COVID-19 testing.

Since April 2020 until September 2022, there have been 2.3 million confirmed cases of COVID-19 in New Jersey and nearly 190,000 in Hudson County. Cases have fluctuated from January 2020 throughout 2022; notable peaks in cases per day across New Jersey include April 5, 2020 (>4,000 cases), January 4, 2021 (>6,700 cases), and December 27, 2021 (>43,000 cases). Below, Figure 99 shows new confirmed cases per day per 100,000 population on the first of the month from March 2022 through August 2022.

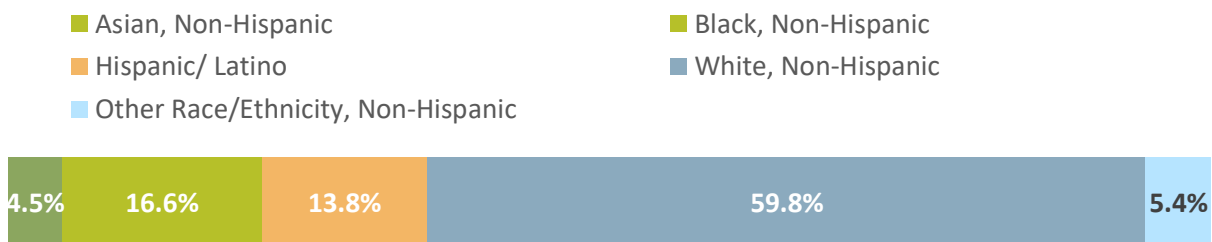
Figure 99. New COVID-19 Cases per 100,000 population, by State and County, 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022

According to data from the New Jersey Department of Public Health, as of August 10, 2022, there were 31,275 deaths from COVID-19 in New Jersey and 2,546 in Hudson County. There are racial/ethnic disparities among COVID-19 deaths in New Jersey. While Black residents made up 12.4% of the New Jersey population, they accounted for 16.6% of COVID-19 deaths in the state (Figure 100). Of note, 59.8% of COVID-19 deaths occurred among White residents, even though they only make up 51.9% of the population. This could potentially be due to the large numbers of White residents aged 65 and older, compared to other racial/ethnic groups.

Figure 100. COVID-19 Confirmed Deaths, by Race/Ethnicity, by State, 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, updated 8/29/2022

As of July 27, 2022, about 6.8 million individuals in New Jersey had been fully vaccinated, representing around 76.5% of the population; Hudson County had reported over half a million fully vaccinated individuals, which is about 80.8% of the population (Table 14). Figure 101 presents the percentage of residents who were fully vaccinated in New Jersey and Hudson County by race/ethnicity as of July 27, 2022.

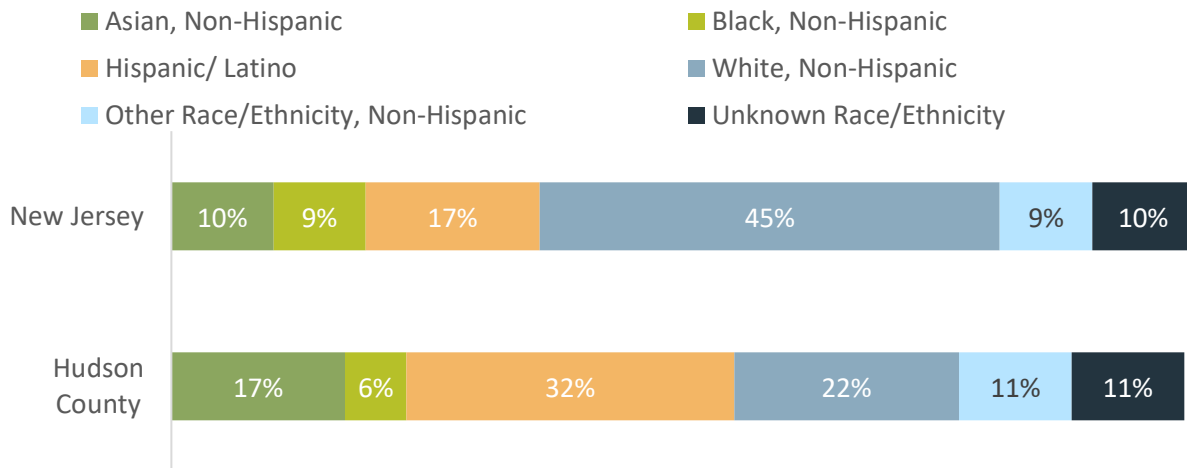
Table 14. Percent of Residents Fully Vaccinated for COVID-19

	Total Vaccinated	Total Population	%
New Jersey	6,795,708	8,885,418	76.5%
Hudson County	543,045	671,923	80.8%

DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022, and U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020 (for total population)

NOTE: Counts are up to date as of July 27th, 2022. Data by race/ethnicity does not include those vaccinated out of state and through federal programs.

Figure 101. Percent of Eligible Residents Fully Vaccinated for COVID-19, by Race/Ethnicity, State, and County, 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022

NOTE: Racial/ethnicity data does not include those vaccinated out of state and by federal programs.

Sexual and Reproductive Health and Sexually Transmitted Infections

Sexual health and sexually transmitted infections (STIs) were brought up as concerns by several focus group and interview participants, particularly those working in public health, education, and with the LGBTQ+ community. Many participants also expressed concerns about shrinking reproductive rights with the recent overturn of Roe vs. Wade, and the negative impact that would have on women's health, particularly in terms of the inequitable burden on low-income women.

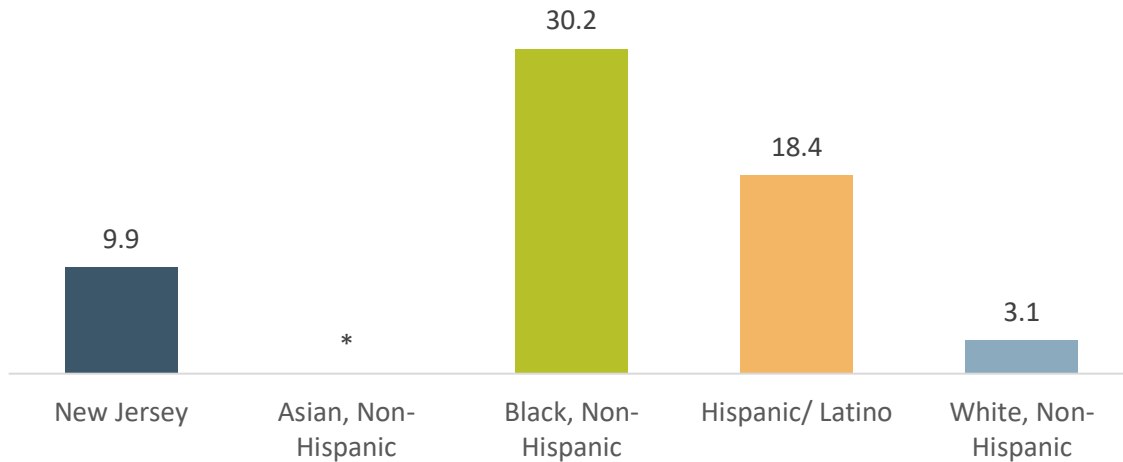
Participants reported increases in incident HIV/AIDS cases during the pandemic and decreases in linkage to care for those persons living with HIV/AIDS. In addition, participants noted that the incidence of other STIs, such as syphilis, had also increased since the pandemic. Limited knowledge related to free testing sites in the population was mentioned as a barrier to timely diagnosis and management. In addition, the cost of treatment, even for insured patients, was brought up as a challenge for middle-low and low-income residents.

“One thing we have to prevent HIV is PrEP, but we don’t know if everyone knows we have it, or where to get tested for free, or even if they should get tested... Clients who come in late have passed through areas of healthcare where they’ve not been tested, so access and education is something we need.” – Focus group participant

Another concern raised by participants was the increase in STIs among young people. As part of the discussion, participants cited parents' lack of awareness of the problem, including in affluent neighborhoods as a main barrier to prevention. Participants raised the absence of comprehensive sexuality education in schools as another impediment to safe sex. According to participants, comprehensive sexuality education provides critical information on healthy sexuality and reproduction and serves to empower adolescents to make choices regarding their health. As residents noted, access to information is of utmost importance in the current climate of curtailing legal protections to reproductive choice.

HIV transmission data was not available for the county but for the state overall. The rate of HIV transmission for Black residents in New Jersey was 30.2 per 100,000 persons, which was ten times the rate of transmission for White residents (3.1 per 100,000) and over three times the rate for all New Jersey residents (9.9 per 100,000) (Figure 102). Hispanic/Latino residents had an HIV transmission rate of 18.4 per 100,00 persons, almost two times greater than that of New Jersey residents.

Figure 102. HIV Transmission per 100,000 Population (Age 13 and Older), by State and Race/Ethnicity, 2020

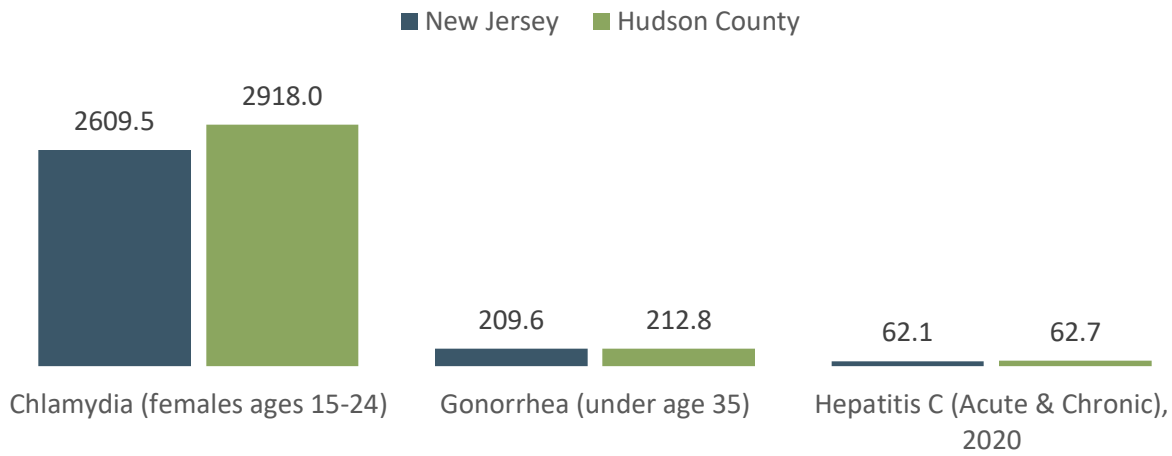


DATA SOURCE: Enhanced HIV/AIDS Reporting System (eHARS), Division of HIV/AIDS, STD, and TB Services, as reported by the New Jersey Health Assessment Data (NJSHAD), 2020
 NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Whereas HIV/AIDS was the STI most named by participants, Chlamydia is the most prevalent STI in New Jersey and Hudson County. In 2021, there were 2,610 cases of Chlamydia per 100,000 population in New Jersey among females aged 15-24, and the case rate was greater for Hudson County (2,918 per 100,000) (Figure 103). Hudson County reported similar levels of Gonorrhea among people under age 35, (213 per 100,000) and Hepatitis B (63 per 1000,000) compared to New Jersey overall (210 and 62 persons per 100,000 persons, respectively). Figure 104 confirms participants’ observations on STI incidence during the pandemic, showing an increase in Syphilis infection rates from 5.3 to 9.8 per 100,000 between 2016 and 2021 in New Jersey, and from 15.4 to 16.5 per 100,000 in Hudson County over the same period. The incidence rate of Syphilis in Hudson County is markedly higher than at state level.

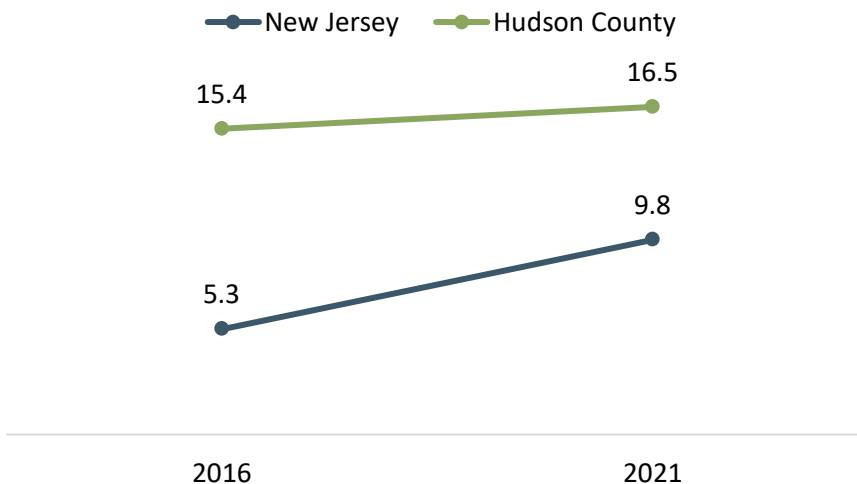
“I [would be remiss] if I don't mention the pressing issues with Roe versus Wade being reversed and access to information to our younger women.... Although New Jersey seems to have a more relaxed and a more progressive view of it, it doesn't mean that it won't impact our young people that are women in particular.” – Focus group participant

Figure 103. Chlamydia, Gonorrhea, and Hepatitis C per 100,000 Population, by State and County, by Most Recent Data Available



DATA SOURCE: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, as reported by the New Jersey State Health Assessment Data (NJSHAD), 2020 & 2021

Figure 104. Syphilis Incidence Rate per 100,000 Population, by State and County, 2016 and 2021



DATA SOURCE: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, Division of HIV, STD, and TB Services, 2016 and 2019

NOTE: Includes primary and secondary syphilis. Crude rate.

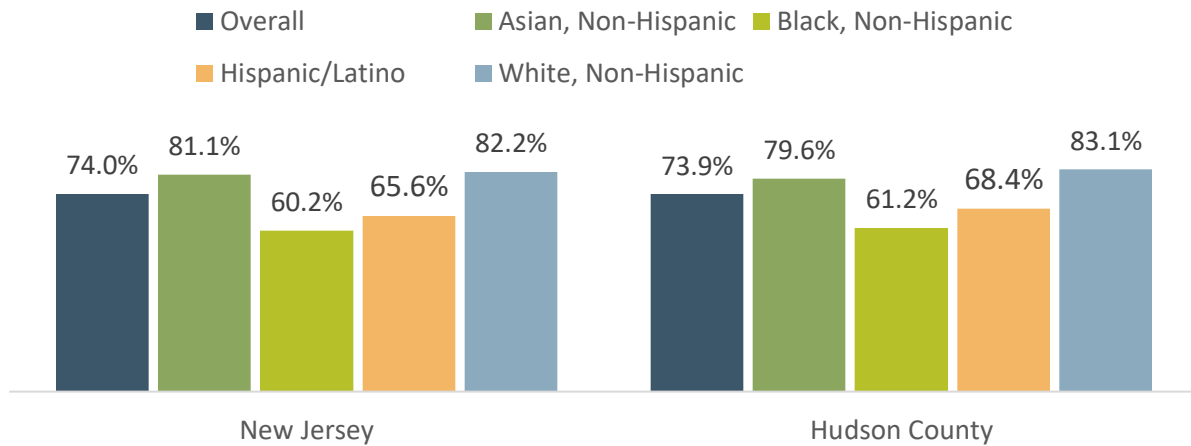
Maternal and Infant Health

The health and well-being of mothers, infants, and children are important indicators of community health. Maternal and infant health indicators are considered markers of inequity as most maternal and perinatal health complications are preventable with access to quality, adequate timely care. Whereas participants did not discuss issues related to maternity and newborn care, they did bring up multiple barriers to accessing care, which may have impeded or severely reduced access to this life saving intervention.

Prenatal Care

Prenatal care is an evidenced-based intervention to improve maternal and perinatal health outcomes. Statewide, nearly three in four births had prenatal care within the first trimester (Figure 105). By race/ethnicity, White, Non-Hispanics (82.2%) had the highest percent receiving prenatal care, followed by Asian, Non-Hispanics (81.1%), Hispanics/Latinos (65.6%), and Black, Non-Hispanics (60.2%). In Hudson County, 73.9% of births received prenatal care in the first trimester. Similar to statewide trends, Hispanics/Latinos (68.4%) and Black, Non-Hispanics (61.2%) in Hudson County had the lowest access to prenatal care. Additional data on access to prenatal care are presented in Figure 131 in the Appendix.

Figure 105. Percent Births with Prenatal Care in First Trimester by Race/Ethnicity, by State, 2016-2020

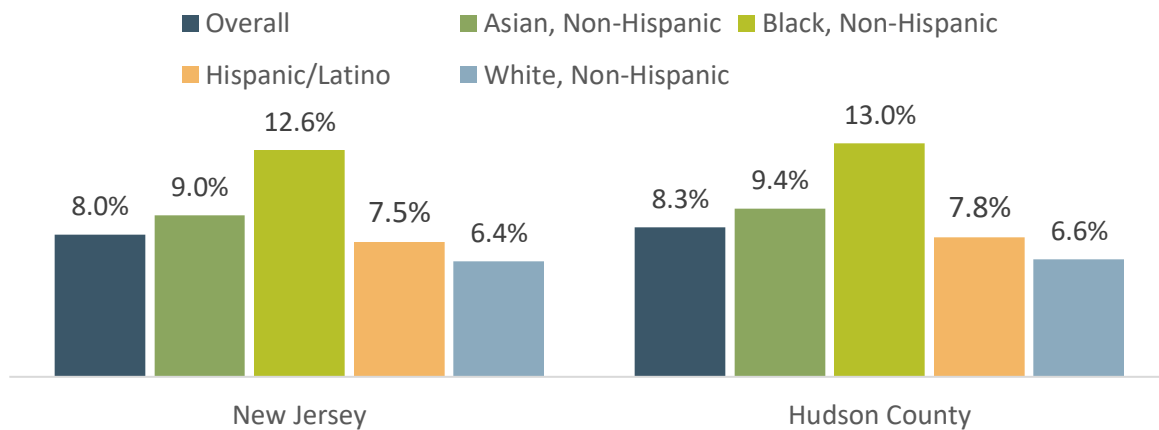


DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Perinatal Outcomes: Low and Very Low Birthweight and Preterm Births

The following figure presents percent of low birthweight births from 2015 to 2019, by race/ethnicity. Across New Jersey, 8.0% of births were low birthweight (weighing less than 2,500 grams) (Figure 106). In New Jersey, Black, Non-Hispanics had the greatest proportion of low weight births (12.6%), followed by Asian, Non-Hispanics (9.0%), Hispanics/Latinos (7.5%), and White, Non-Hispanics (6.4%). Similarly, in 2020, 8.3% of births in Hudson County were low birthweight births, with Black, Non-Hispanics having the highest proportion of low birthweight births (13.0%). In Hudson County, 1.2% of births were very low birthweight (<1,500 grams), with Black, Non-Hispanics (3.0%) having more than double the proportion of very low birthweight births, followed by Hispanics (1.6%) (See Figure 130 in Appendix for more details).

Figure 106. Percent Low Birth Weight Births by Race/Ethnicity, by State and County, 2015-2019

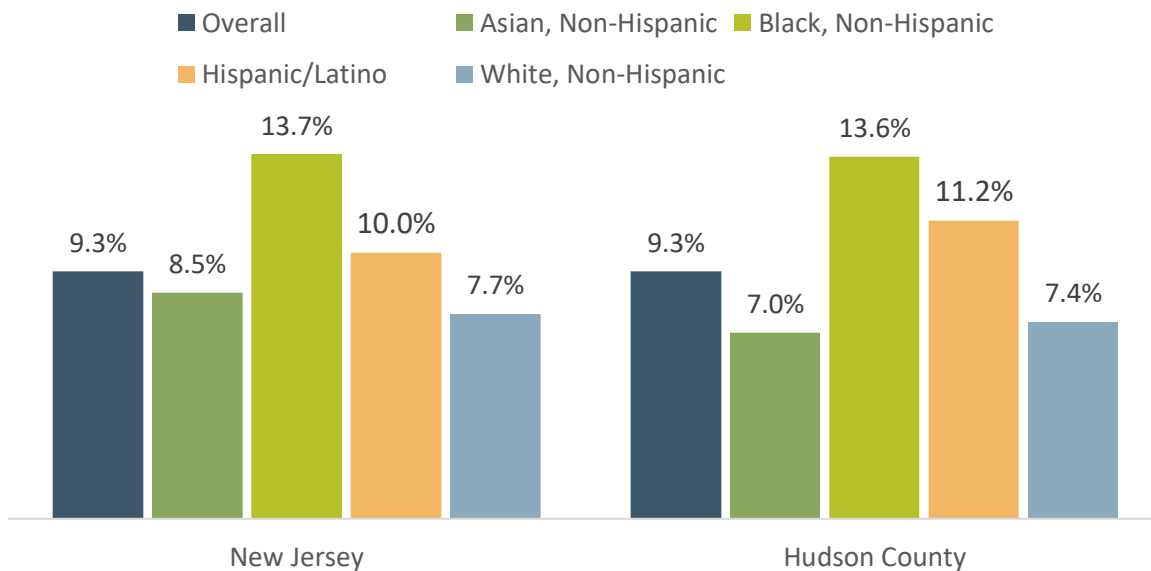


DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

NOTE: Low birth weight as defined as less than 2,500 grams

Figure 107 presents percent of preterm births in 2020 by race/ethnicity. Across New Jersey, 9.3% of births were preterm (less than 37 weeks of gestation). At state level, Black, Non-Hispanics had the greatest proportion of preterm births (13.7%), followed by Hispanics/Latinos (10.0%), Asian, Non-Hispanics (8.5%), and White, Non-Hispanics (7.7%). Similarly, in 2020, 9.3% of births in Hudson County were preterm births with Black, Non-Hispanics (13.6%) and Hispanics/Latinos (11.2%) having the highest proportion of preterm births.

Figure 107. Percent Preterm Births, by Race/Ethnicity, State, and County, 2020



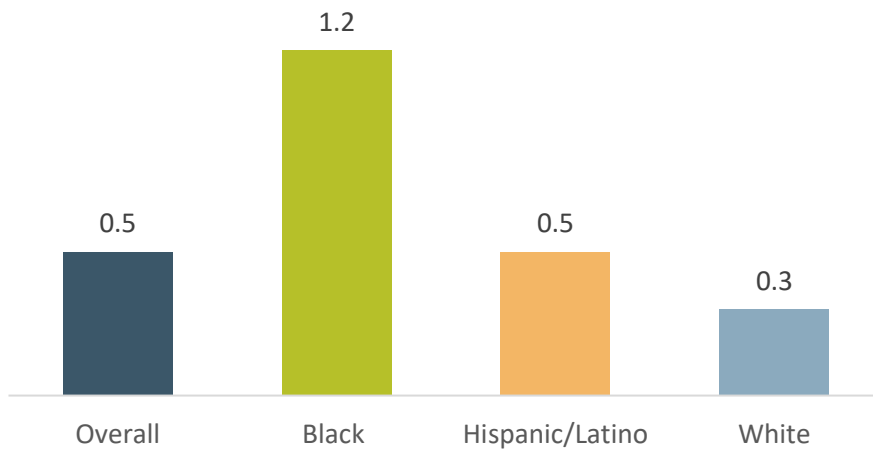
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Preterm is defined as less than 37 weeks gestation

Maternal and Infant Mortality

The vast majority of maternal deaths are preventable with access to timely, adequate, quality care. Thus, it is a marker of health disparities. Across the state, the maternal mortality rate was 0.5 deaths per 100,000 population from 2015 to 2019 (Figure 108). In line with other measures of infant and maternal health, Black, Non-Hispanics had the highest maternal mortality rate (1.2 deaths per 100,000), more than double the state-wide rate, with other racial/ethnic groups closer to the state-wide average. Two factors may have exacerbated disparities in maternal deaths in recent years: the COVID-19 pandemic, which is associated with an increased risk of maternal morbidity and mortality, and which disproportionately affected Black residents and curtailed access to safe abortion care.

Figure 108. Maternal mortality rate per 100,000 population, by State and Race/Ethnicity, 2015-2019



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

In 2015-2019, the statewide infant mortality rate was 4.3 deaths per 1,000 births; Hudson County had a lower infant mortality rate of 2.9 deaths per 1,000 births. The infant mortality rate among Black infants (9.3 per 1,000 births) was double to the state-wide rate (4.3 per 1,000 births) (Table 15). Similarly, the infant mortality rate among Black infants (7.1 per 1,000 births) in Hudson County was 2.5 times the county rate (2.9 per 1,000 births) over the same period.

Table 15. Infant Mortality Rate per 1,000 Births by Race/Ethnicity, by State, 2015-2019

	Overall	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic
New Jersey	4.3	2.5	9.3	4.2	2.6
Hudson County	2.9	*	7.1		*

DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

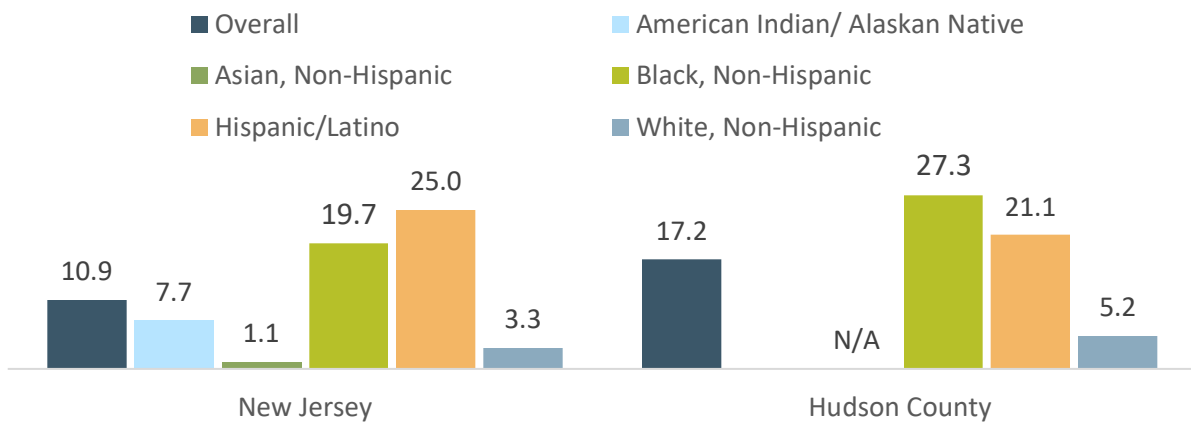
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Teen Pregnancy

Teen pregnancy is associated with poor birth outcomes, particularly among very young teens (aged 10–14-year-old), and to gender-based violence. It has long-term social and economic consequences, as often, pregnant teens drop out of school, curtailing future opportunities for education and employment, and perpetuating the cycle of poverty. While teen pregnancy was not discussed at length during the assessment conversations, participants did talk about how legal challenges and restrictions to safe abortion and post-abortion care may severely curtail teen’s ability to make reproductive choices.

Data from the New Jersey Birth Certificate Database show the number of teen births per 1,000 female population from 2014 to 2020, by race/ethnicity. At the state level, the overall teen birth rate was 10.9 per 1,000 and the highest teen birth rate was among Hispanics/Latinos (25.0 per 1,000), followed by Black, Non-Hispanics (19.7 per 1,000). In Hudson County, the overall teen birth rate was higher than the state, 17.2 per 1,000 (Figure 109). The highest teen birth rate in Hudson County was 27.3 per 1,000 among Black, Non-Hispanics, followed by Hispanics/Latinos (21.1 per 1,000).

Figure 109. Number of Births per 1,000 Female Population Ages 15 to 19, by Race/Ethnicity, State, and County, 2014-2020



DATA SOURCE: National Center for Health Statistics, Natality Files, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2014-2020

NOTE: Data for Asian and American Indian/Alaskan Native residents is not available due to low numbers.

Access to Services

This section discusses the use of healthcare and other services, barriers to accessing these services, and health professional landscape in the region. Access to healthcare services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death.

Access and Utilization of Preventive Services, Including Immunizations

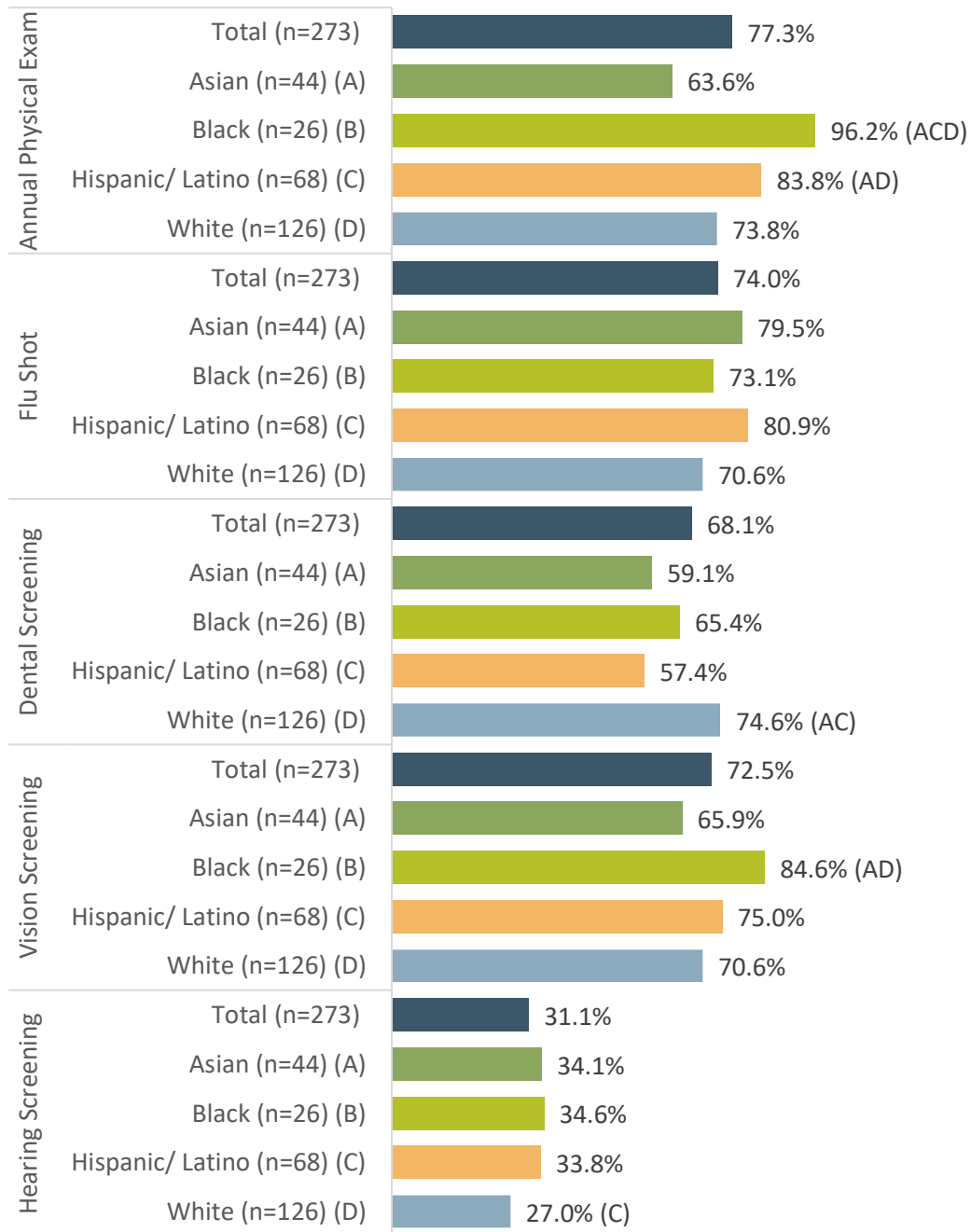
Participants in the healthcare field unanimously noted a decline in access to preventive care in Hudson County during the pandemic. Some focus group and interview participants discussed delaying care, particularly routine preventive services, in recent years. Reasons cited included the high cost of care, being uninsured, not having sick leave, not having providers that spoke their language, and/or not having childcare available.

On the other hand, participants indicated that having a primary care provider and/or access to a trusted FQHC were two factors that facilitated access to care.

“Primary care is a big issue for [most] of our children who have free and reduced meals. They live below the poverty line and they don't have a set primary care provider, pediatrician or doctor, and they are not going for all the routine tests that children should get.” – Key informant interviewee

The community survey fielded in spring/summer 2021 asked respondents about their participation in various healthcare screenings, including preventive services, in the past two years. Approximately 77% of Hudson County survey respondents reported receiving an annual physical exam; 73% a vision screening; 68% a dental screening; and approximately 74% a flu shot in the past two years. Fewer – 31% – reported having a hearing screening. Figure 110 presents these data for all Hudson County survey respondents and by race/ethnicity.

Figure 110. Percent of Community Survey Respondents Reporting that They Had Participated in a General Preventive Services and Screenings in the Past Two Years (n=273), 2021



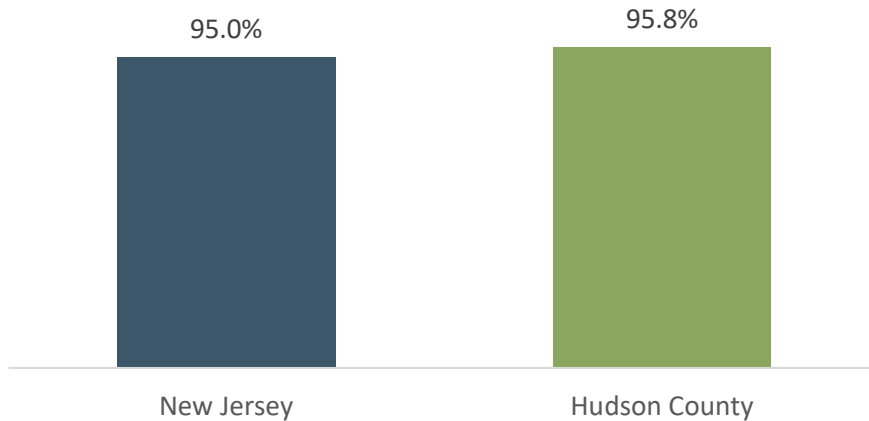
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph

Immunizations are an important preventive measure. Participants mentioned that many children in Hudson County received their full vaccination schedule through school health clinics; however, adults,

particularly those who were uninsured, faced barriers to vaccination. These patterns were confirmed by surveillance data. Among children in Hudson County, surveillance data from 2017-2018 indicate nearly 96% of children were fully immunized (Figure 111). However, 2019 data indicate that only 38% of Fee-for-Service (FFS) Medicare enrollees reported having received an annual flu vaccination in Hudson County, compared to 51% in New Jersey overall (Figure 112). Further, only one in five (20.4%) of eligible Hudson County residents reported receiving a pneumonia vaccine in 2020 (Figure 113). Given the disruption of COVID-19 on access to care, current percentages may be lower.

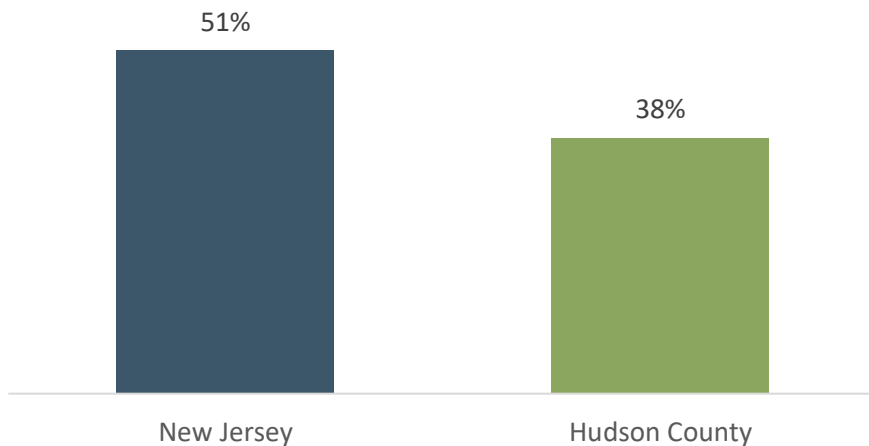
Figure 111. Percent of Immunized Children, by State and County, 2017-2018



DATA SOURCE: Annual Immunization Status Reports, Communicable Disease Service, New Jersey Department of Health, as reported by New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2017-2018

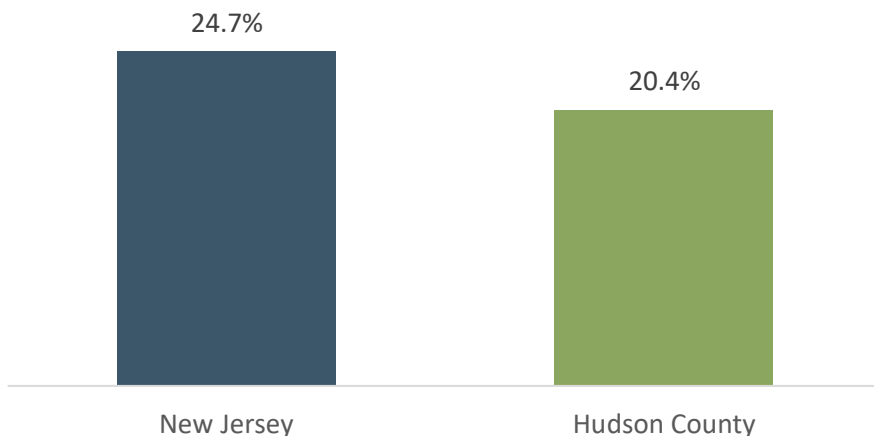
NOTE: Includes childcare/preschool, Kindergarten/Grade 1 (entry level), Grade 6, and transfer students in any grade

Figure 112. Percentage of Fee-for-Service (FFS) Medicare Enrollees that Had an Annual Flu Vaccination, by State and County, 2019



DATA SOURCE: Centers for Medicare & Medicaid Services, Office of Minority Health's Mapping Medicare Disparities tool, as reported by County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Figure 113. Age-Adjusted Pneumococcal Vaccination (Ever), by State and County, 2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Barriers to Accessing Healthcare Services

While many focus group members and interviewees reported that Hudson County had some healthcare assets and that there is a lot of collaboration among these assets, accessing these can be challenging for some residents. High healthcare cost was the top barrier mentioned by residents, providers, and healthcare administrators. Other barriers identified through discussions were lack of insurance and/or insurance challenges, scheduling convenience, long wait times, provider availability, stigma and discrimination, and language and cultural barriers. In addition, fear of institutions due to the increase in anti-immigrant discourse and persecution of undocumented individuals was cited as a major impediment for care access among this population.

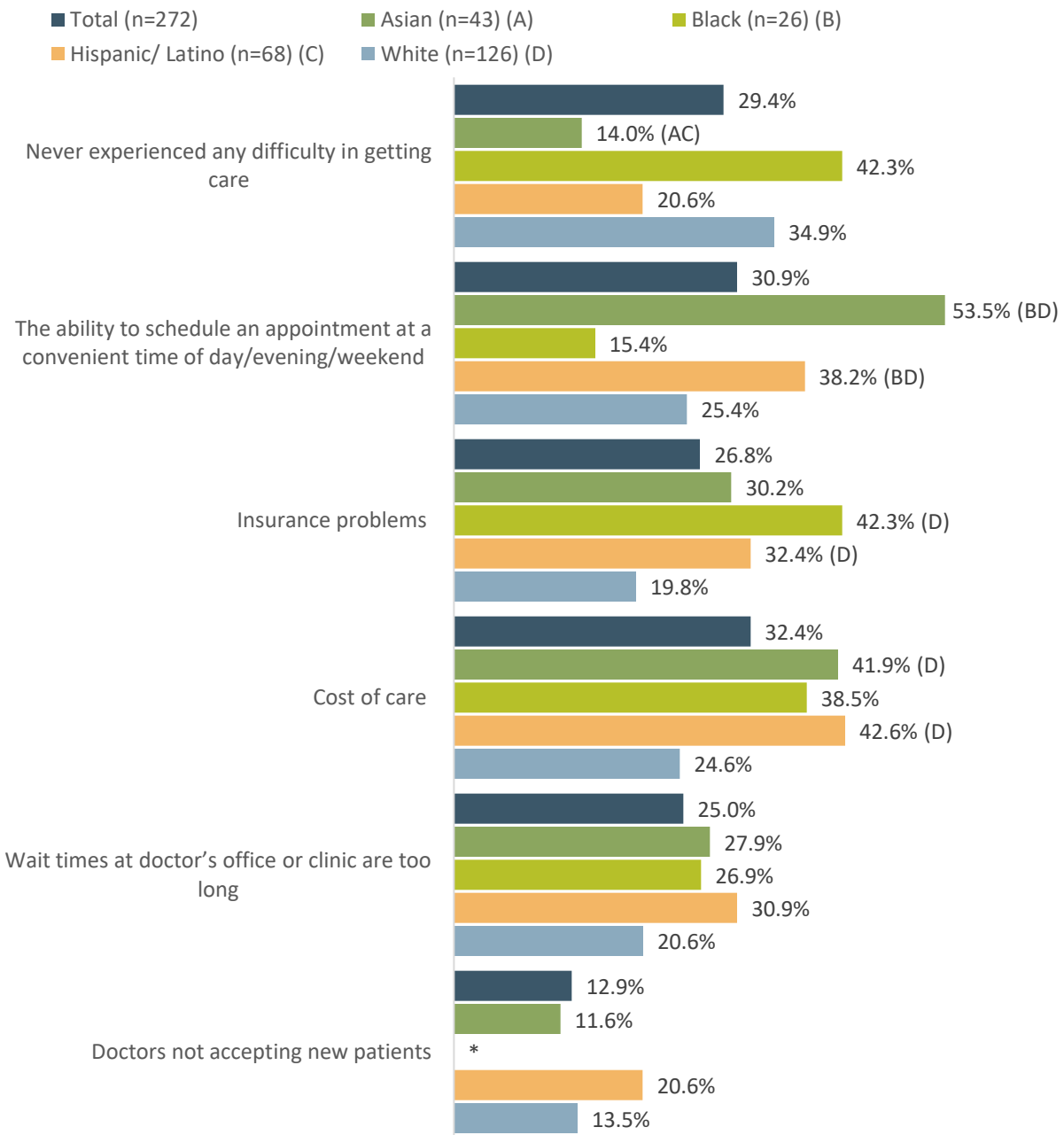
Many residents indicated that they only sought care from hospitals in an emergency; high and unpredictable cost of hospital care, trust, and unavailability of bilingual providers were some of the issues that made residents prefer to seek care from community-based clinics, FQHCs, or private practices. Participants also noted that disruptions to the healthcare system due to the pandemic, e.g., temporary closures and retirement of older providers, further distanced residents from services.

“Preventive care is pretty much nonexistent. Most community members might not have primary care linkage, they often provide the name of a specialist when asked who their PCP is. There are a lot of gaps in terms of availability and being able to afford to see a PCP.” – Focus group participant

Barriers to healthcare access were discussed in multiple ways (e.g., survey, focus groups, interviews) and different issues emerged via the various methods. In the community survey, respondents selected which barriers they had experienced from a list. Only 29.4% of survey respondents indicated that they have never experienced any difficulty in getting healthcare. Overall, the top issues selected were cost of care (32.4%) and ability to schedule an appointment at a convenient time (30.9%) (Figure 114). Differences emerged by race/ethnicity. White respondents were the most likely to report that they did not have an issue accessing care (34.9%); ability to schedule an appointment was marked by 53.5% of Asian

respondents; Black respondents were the most likely to note insurance problems (42.3%); and over 40% of Asian and Latino respondents marked cost of care as an issue (See Cost of Care section below).

Figure 114. Percent of Community Survey Respondents Reporting Which Issues Made It Difficult for Them or a Family Member to Get Medical Treatment or Care When Needed (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph. Asterisks (*) denote insufficient data to calculate reliable rate

Cost of Care

Cost of care emerged as the primary barrier to accessing services across most focus groups and interviews. As described above, Latino (42.6%) and Asian (41.9%) respondents were more likely than White (23.6%) respondents to mark cost of care as a barrier (Figure 114). Many Black respondents also mentioned cost of care as a barrier (38.5%).

This barrier existed for both preventive care and more complex care. Some participants noted that they were able to access free health screenings when offered by the city, hospitals or the FQHCs. However, others did not, and remarked on having to pay a fee for basic preventive services, including COVID-19 tests, as a disincentive. In the words of a Latina resident, *“They sent me a \$400 bill for a mammogram, and I wasn’t working. Later I learned that there are organizations that offer it for free.”* Even for insured individuals, the cost of medication and treatment of chronic diseases, including diabetes and cancer, is unaffordable. Many patients are faced with the dilemma of paying for rent, food, or medicine. Cost of care is a barrier for low-income residents, overall, but an even greater barrier for undocumented residents, as they are not eligible to receive government insurance. Participants in the Latino focus groups described being particularly wary of going to the hospital because of the high cost of care and going only in emergencies. Numerous residents remarked that obtaining charity care is an onerous task and many remarked that they had been rejected. Cost of care is also a barrier for middle-low income families, as they do not qualify for Medicaid or other government programs, but they cannot afford to pay for the medical bills. Even veterans who are insured through the Veterans Administration complained of the hurdles of accessing care and of receiving high hospital bills if they had to seek services in a non-affiliated hospital.

Health Insurance

Several participants stated that lack of health insurance and insufficient coverage are barriers to accessing healthcare. Healthcare providers and administrators indicated that many patients were uninsured and had difficulty accessing care. Multiple participants noted that uninsured patients would rather seek care from private physicians, rather than the hospital, because they fear the hospital costs. As described by this resident, *“People that don’t have insurance or a primary care doctor have to find a private physician. When I first arrived to this country and had a job that didn’t offer insurance, I had to spend all day waiting to see the doctor. There were usually about 60 people waiting.”*

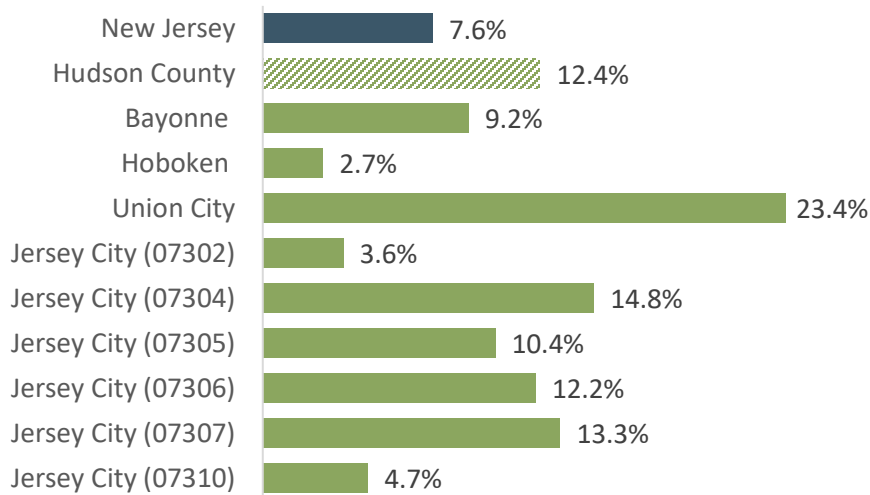
“If you don’t have a doctor who’s caring, or for like, people who are on Medicaid and Medicare, it’s difficult. Like the seniors who are on Medicare, they have to pay a copay.... If you don’t have the Part D for prescriptions, you don’t get a deal on the prescriptions. I think that’s horrible, after working your whole life....” – Key informant interviewee

Participants indicated that even with insurance, people faced many challenges. As one person stated, *“The lack of accepting insurances [is a big problem], not a lot places accept state insurance. They may not have the “right state insurance” according to some companies.”* Participants enrolled in Medicare were grateful to have this insurance, however, one participant mentioned the high copays and the high cost of medicine without Part D.

Census data indicate that health insurance coverage is still an issue for many Hudson County residents, although this varies by neighborhood. A higher percentage of the population in Hudson County was uninsured than in New Jersey (12.4% vs. 7.6%) (Figure 115). Only 2.7% of Hoboken residents were

uninsured compared to 23.4% of Union City residents, and 14.8% of residents in Jersey City zip code 07304. More than one in ten residents are uninjured in Jersey City zip codes 07305, 07306, and 07307. Percentage of the population with private health insurance can be found in Figure 132 in the Appendix.

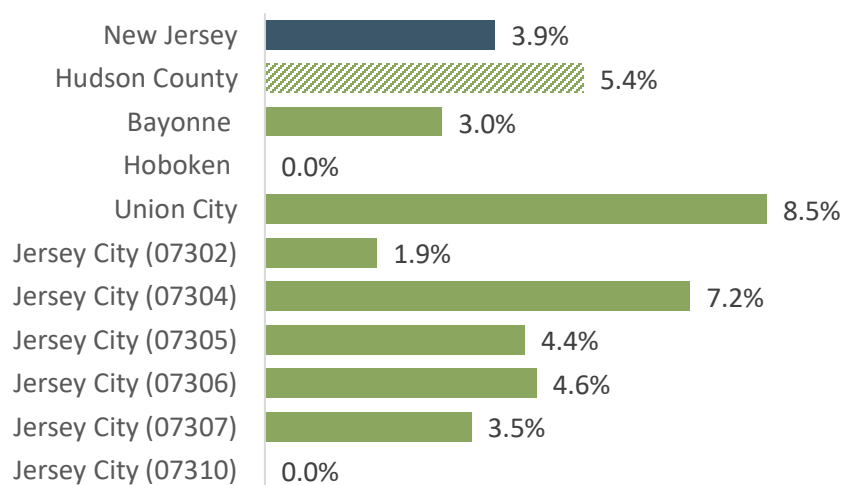
Figure 115. Percent Population Uninsured, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Children have greater access to primary care than their caregivers. Many children live in mixed immigration status households; they qualify for free or low-cost state health insurance as U.S. citizens, but their parents do not. Children can also access primary care through school clinics. In 2016-2020, 5.4% of children under age 19 were uninsured in Hudson County, less than half of the percentage of uninsured adults (12.4%) in the county, but higher than the state average (3.9%) (Figure 116). No children were uninsured in Hoboken and Jersey City zip code 07310 according to the American Community Survey data, compared to 8.5% of children in Union City and 7.2% of children in Jersey City zip code 07304.

Figure 116. Percent Under Age 19 Uninsured, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Health Provider Availability

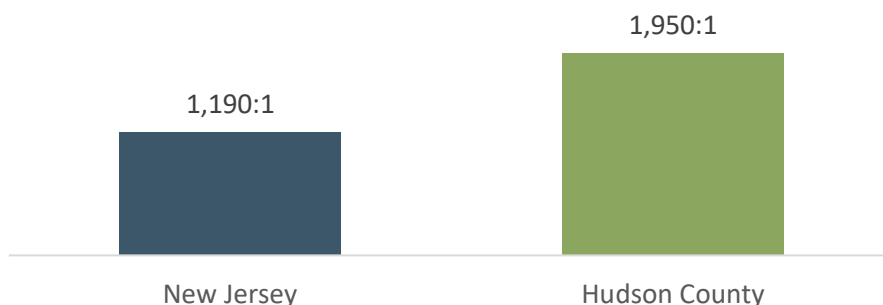
Focus group and interview participants noted that there seemed to be an insufficient number of healthcare and social services providers for the number of residents in Hudson County. As a result, patients waited months for an appointment and faced long wait times prior to the visit. Participants indicated a dearth of both primary care providers and specialists.

“When we studied the data a few years ago, people didn’t understand what we meant about the ratio of people to doctors, that was like 2400:1, there were also poor numbers for mental health, and I would guess that’s gotten worse.” – Focus group participant

Focus group participants in the healthcare field noted that it was difficult to hire and retain staff in community-based non-profit organizations. A major barrier was inadequate compensation. Staff did not receive competitive salaries and benefits packages due to federal funding regulations, including salary caps, lack of sick leave, and temporary contracts. As a focus group participant described, *“We are all struggling with staff retention, providers, nurses, CMAs, everyone right now. It’s almost like we can’t afford them. No matter how much we pay people, they can be traveling nurses and make way more.”* According to participants, sickness, staff burnout, and safety concerns during the pandemic further exacerbated the situation. Another problem noted related to provider retention were the inadequate affordable childcare options for staff with children. Whereas offering appointments during work hours is a problem for clients without sick leave, it is difficult to staff the evening hours. As a focus group participant in the healthcare field explained, *“We couldn’t extend hours with staff because they need to pick up their children. The policy of the daycare providers is if they aren’t there by 6, they call CPS. If we need to give late hours, Head Start should be required to give late hours.”* Participants in the healthcare field remarked that not all communities were represented by the staff; whereas there were plenty of Indian providers who spoke multiple languages, this was not so for Spanish and other languages.

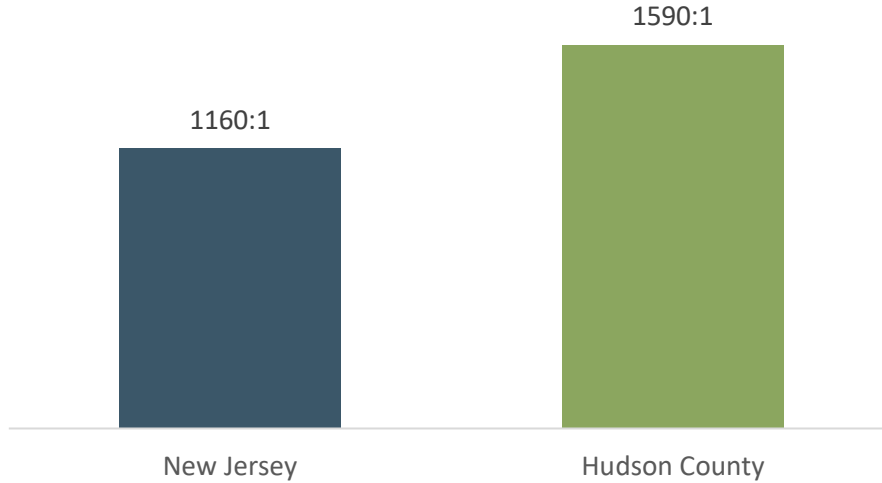
As described about mental healthcare providers in the Mental Health section above, more general and specialty care providers are needed in Hudson County. Surveillance data from 2017 indicate that Hudson County had fewer people per every primary care physician (1,950:1) than New Jersey overall (1,190:1), indicating a smaller person to provider ratio (Figure 117). The need is noted even more urgently with specialty care. For example, the ratio of persons per dentists in Hudson County was 1,590:1 in 2018, compared to 1,160 in New Jersey (Figure 118). The pandemic has probably increased this ratio.

Figure 117. Ratio of Population to Primary Care Physicians, by State and County, 2017



DATA SOURCE: American Medical Association, Area Health Resource File, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2017

Figure 118. Ratio of Population to Dentists, by State and County, 2018



DATA SOURCE: National Provider Identification file, Centers for Medicare and Medicaid Services, Area Health Resource File, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2018

Language and Cultural Factors Related to Healthcare Access

Participants in the healthcare and social service field noted using different strategies to bridge language and cultural barriers. Many sites, including the hospital and the health department, described having agreements with translation companies to provide telephonic support in any language. In addition, healthcare partners in most settings develop and disseminate informational materials and provide signage in multiple languages. Staff at many of the healthcare sites are themselves bi- or multilingual speakers.

From a cultural perspective, many of the health care institutions in the area hire local staff, who represent the community. This strategy goes a long way in building trust with community members and overcoming some of the wariness for hospitals. As one healthcare employee explained, *“Being born and raised here, I can say it’s the diversity of who we are that makes us special. Also being residents of the area who can identify what the needs are and try to address them in our agencies as residents.”*

Another strategy is finding cultural ambassadors or credible messengers that can be a go-between for the healthcare institutions and the community. In the view of some participants, this strategy is there on paper, but needs to be implemented more proactively. As explained by a participant, *“For people who speak languages other than English, we need not just the commitment to having it there, but actively promoting it, so that influential voices in those communities serve as ambassadors to say, you know if you if you speak Hindi, there’s somebody at the medical center for you, or if you speak Pashto.”*

“In general, we see access problems for Latinos, partly language based, and I think I’ve seen it largely as reflective of the fact that any non-English outreach tends to be an afterthought and not an attempt to truly connect and promote to those communities.” – Focus group participant

Certain groups are more represented than others. Healthcare staff explained that good strides had been made in reaching the Black and the Hindi communities; however, reaching Latinos and other immigrants has been difficult; further, more work is needed to increase trust in the Black community. An advocate highlighted the need for more racial equity training for healthcare providers, *“I’ve heard of horrific experiences because of being African American, healthcare providers don’t understand the pain of African American folk.”* When describing the healthcare workforce needed in Hudson County, an administrator described, *“It’s not just culturally competent, it’s a workforce that looks like the community and helps with institutional trust issues found in different populations but especially with low income, African American, immigrant, rural, blue collar, politically leaning communities.”* To complement this observation, several Latino residents described language as a barrier to accessing health at hospitals. One patient described this experience, *“They gave me a referral for an eye doctor, they made an appointment for a video call, but I couldn’t attend the appointment because it’s always only in English, nothing else. They need staff who are bilingual.”*

Community-Based Organizations and Coalitions

Hudson County was described as having substantial and strong social services. Community-based nonprofits were seen as mission-driven and committed to their clients. Partnerships between the community-based organizations, hospitals, schools, and the government were seen as a strength in Hudson County and critical to providing services to those in need. As described by a public health administrator, *“Overall, as a city and a group of health industry collaborators, I think the hospital, the FQHCs, and the Department of Health, we have always worked hand in hand to address the needs, we are also involved in an HIV ending committee, but also access to healthcare, specific and broad topics.”* As mentioned earlier in this report, participants also spoke about city-wide efforts such as HealthierJC, which have promoted prevention, identified and addressed public health gaps, and coordinated efforts across public health, hospitals, and community-based nonprofits, as well engaged the business community.

“From my experience, over 20 years, I feel that the greatest strength are the community-based organizations. We have a wide range of individuals who form different communities, even small grassroots community-based organizations, to engage people in healthy ways.” – Focus group participant

Residents and public health administrators uplifted the role of community-based nonprofits in bridging the gap to services for those most marginalized. Residents noted how staff at FQHCs went out of their way to address their physical, mental, and social needs, being their first stop for primary healthcare, regardless of immigration status. Many residents seek free screenings from non-profit groups serving the LGBTQ+, Asian, Latino, and African-American communities. Latino residents expressed trust in the FQHC staff and described getting support to obtain the social services they were eligible for. A community-based service administrator described their vision as an integral part of the community, *“We like that the community thinks of us as their go-to place, community health centers, sometimes generations of patients. Sometimes we see someone as a child now bringing their children to pediatrics, from birth to death.”*

One limitation that participants noted about community-based groups was their limited financial and human resources. Sustainability and dependence on grant funding, that is, funding which is variable and

short-term, were mentioned as problems. When speaking about the importance of uplifting community-based partners, a healthcare administrator noted, “Most of the strengths we mentioned are double edged. There’s a lot of organizations that aren’t well resourced financially, they are trying to do some good work, but with no sustainable resources or capacity to expand.”

In part because of this, most participants saw a role for a stronger coalition in Hudson County that includes well-resourced hospitals. Participants expressed that there was a lot of collaboration among government actors, hospitals, schools, and community-based organizations. They remarked that each partner complemented each other and collaborated well, as shown during the pandemic. Focus group participants indicated that there was continued room for growth in this area.

“There is also a deficit related to location, both Newark and NYC have better developed social infrastructure, especially in nonprofit, philanthropic, and people-powered engagement. It’s a challenge I’ve seen linked to our location.” – Focus group participant

Community Vision and Suggestions for the Future

Focus group and interview participants were asked for their suggestions for addressing identified needs and their vision for the future. The following section summarizes and presents participants’ recommendations for future consideration.

Expanding and Strengthening Behavioral Health and Overall Healthcare Services

Health as Human Right: “It is urgent to have access to free, quality health care”

Almost unanimously, cost emerged as a primary barrier to healthcare access in qualitative discussion. Many residents indicated that healthcare should be free. Residents underscored the value of preventive care as a cost-effective intervention and urged partners to continue expanding access to these services. Participants also highlighted challenges with health insurance coverage. To address these barriers, residents recommended offering more free screenings, loosening the requirements to qualify for free and/or low-cost health insurance, and simplifying the charity care application. Participants also suggested making more efforts to “meet people where they are,” through mobile clinics and education sessions based in different neighborhoods. Participants highlighted the community school model, entailing private-public partnerships between the education and healthcare sectors, and the community, as a promising initiative to promote the well-being of low-income families.

Greater Accessibility and Availability of Behavioral Health Services

Participants remarked on the difficulties faced by all groups, particularly Black, LGBTQ+, veterans, and young residents, to accessing quality, culturally competent mental health care. Participants highlighted the need for more mental health workers. Focus group participants and interviewees hoped to see more community-based mental health services, including recovery programs that are affordable and accept all insurance types. They also advocated for more prevention education programs to address problem substance use in the community, especially among youth and veterans. Participants suggested providing more education to address the stigma that surrounds mental health among many cultural groups. The need for more language capacity within the behavioral health services field was also discussed, as well as training in caring for patients of different backgrounds, including LGBTQ+ patients, and those who have experienced trauma, such as veterans.

Sexual and Reproductive Health and Women’s Health

Focus group members and interviewees were concerned about the increase in sexually transmitted infections among some groups, including cisgender women and men-who-have-sex-with-men, and about the repercussions of the rollback in constitutional protections to reproductive choice. Several participants warned that access to sexual and reproductive health services could be curtailed, even if New Jersey has progressive reproductive health policies. They noted that this would unduly affect low-income women and communities of color, thus, exacerbating existing racial/ethnic and social inequities in maternal and infant health. Some participants recommended being vigilant about reproductive health and rights protections to support the sexual and reproductive rights of all people in New Jersey. They also underscored the importance of offering comprehensive sexuality education in schools.

Focusing on the Upstream Factors and the Social Determinants of Health

Inequality

Growing inequality emerged as an issue of concern among most focus groups and interview participants. Residents noticed this in neighborhood-level differences in school resources, in safety, in employment opportunities, and in the built environment. Participants attributed growing inequality on policies that cater to residents in the highest social strata and expressed frustration at this ‘*tale of two cities.*’ Residents suggested that more progressive policies on taxation, employment, education budgets, and healthcare were needed to reverse this trend.

“My biggest wish for this community is that we don't have such an economically diverse community. If there's a way to really help the families with the lowest economic resources to really have more financial stability, that would be ideal.” – Key informant interviewee

Economic and Employment Opportunities

Expanding economic opportunities, especially for low-income workers, Latino residents, veterans, LGBTQ+ residents, particularly transgender people, and violence survivors was suggested as a priority area by many assessment participants. Participants recommended improving initiatives to help those who face barriers to employment obtain jobs. Suggestions included incorporating more vocational training programs in high schools to facilitate transition into the workforce, and education and incentives for employers hiring veterans and transgender and other LGBTQ+ people. Additional proposals included supporting small business owners and providing expanded workforce protections (e.g., sick leave, improved wages, childcare) for all workers, particularly those in healthcare.

Built Environment

Several issues emerged as concerns in the built environment. One was overdevelopment leading to overpopulation and loss of green areas; the other was the focus on building luxury rentals, resulting in gentrification. Participants enjoyed Hudson County’s varied public transportation options, its walkability, and its parks. They praised current community efforts to extend green areas supportive of healthy lifestyles. Residents also highlighted the need for redevelopment and urban planning in flood-prone areas to mitigate water damage as an important emergency preparedness strategy.

Housing

Access to affordable housing in safe neighborhoods was among the most discussed issues in qualitative discussions. Residents expressed concern about inflation and high taxes, coupled with the lingering economic impact of the pandemic on housing affordability, impending evictions, and homelessness, and looked for initiatives to mitigate these challenges and the high cost of housing. Participants proposed earmarking more affordable housing units in the new developments, including housing for veterans; implementing the existing rent control policies, which also apply to foreign-born residents regardless of immigration status; and fomenting first-time buyers' subsidies as a promising initiative to address intergenerational poverty.

Greater Engagement and Access to Existing Initiatives

Access to Services and Community Outreach

Interviewees and focus group participants observed that information about existing services and programs were not readily accessible to community members. They recommended more be done to raise awareness about existing programs. Participants suggested organizing more education and awareness building efforts both in person and virtually in different neighborhoods and in different languages on topics that most affect the community, including on managing diabetes and high blood pressure, and on recognizing the signs of stroke. Other suggestions to bridge access to health and social services included deploying mobile vans to other areas in the county; expanding health clinics that offer care for free and/or at low-cost to both children and families, particularly local and school-based clinics; and offering appointments outside of the regular workday. Some participants recommended developing a centralized list of health and social service programs and resources, similar to the mental health directory prepared by the Health Department (<https://healthierjc.com/mental-health/>), but for other conditions.

“Do more preventive family care, I think it would be very profitable for the state really because it's cheaper to prevent than to deal with.” – Key informant interviewee

Partnerships, Community Engagement, and Community Building

Participants valued the robust partnerships established among multiple organizations and across sectors, including grassroots organizations, government, small businesses, social services agencies, and FQHCs, as exemplified by the Partnership for a HealthierJC. Participants suggested continuing to deepen engagement and collaboration with trusted community-based organizations, such as those representing Asian, Latino, and LGBTQ+ residents, as partners in outreach and information sharing about community services and programs. Several participants stressed the importance of engaging faith-based organizations, especially given their reach and level of trust in the community. Other participants discussed the need to collaborate and hire credible messengers – respected community members – to build bridges with the community. Participants underscored more community outreach, a strong plan to reengage the community, and investing in the community as strategic areas moving forward.

Key Themes and Conclusions

Through a review of the secondary social, economic, and epidemiological data; a community survey; and discussions with community residents and stakeholders, this assessment report examines the current health status of Hudson County during an unprecedented time given economic volatility, the COVID-19 pandemic, and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- ***Some residents are struggling with lack of employment and economic opportunities.*** In 2016-2020, unemployment rates across Hudson County ranged from 2.4% in Jersey City zip code 07302 to 7.0% in Jersey City zip code 07305 and 9.2% in Jersey City zip code 07304. The unemployment rates mapped onto racial/ethnic groups; residents in zip code 07302 are predominantly White (40.1%) and Asian (32.2%), whereas over two-thirds of residents in zip codes 07304 and 07305 are Black and Latinos. More resources for career transitions and job training and technology were identified as critical to addressing these disparities. Focus group participants highlighted the need for more support and employer incentives for veterans and LGBTQ+ residents facing employment discrimination.
- ***Housing affordability is a main concern in Hudson County.*** Housing affordability was identified as a pressing concern, particularly for persons of color, veterans, LGBTQ+ persons, immigrants, and low-income residents. Participants expressed that too many luxury rentals were being built, instead of affordable housing for families. There are many renters across the area. In New Jersey, 64.0% of housing units were owner occupied in 2016-2020, in contrast to 32.4% in Hudson County. Home ownership ranged from 12.5% in Jersey City zip code 07310 to 40.6% in Bayonne. Disparities in housing cost burden exist within Hudson County. In Jersey City zip codes 07302 and in Hoboken, less than one in three owner-occupied and 44% of renter-occupied households reported high housing costs whereas 64.4% of owner-occupied and 66.5% of renter-occupied residences in Union City reported spending more than 25% of their income on housing costs. Qualitative discussions highlighted how veterans in Hudson County tend to work in low-wage jobs and often live in multigenerational housing. Housing availability was also cited by interviewees as an important barrier to breaking the cycle of violence. Relocation is one of the strategies used to prevent revictimization of community and domestic violence survivors. However, according to violence interrupters, affordable housing options in low-crime neighborhoods are limited. Several focus group and interview participants mentioned the problem of homelessness in Hudson County communities and indicated that the shelters and temporary housing available were insufficient to meet the need. Solutions proposed included earmarking more affordable housing units in the new developments; extending first-time buyers' subsidies, particularly for persons of color; and renovating and repurposing abandoned homes for low-income families.
- ***Mental health was identified as a significant community health concern.*** Mental health was identified as a top community health concern, closely associated with economic instability and chronic conditions. Black residents faced a disproportionate mental health burden. The rate of mental health hospitalizations in 2020 was 70% higher among adult Black residents (107.1 per 100,000) than the Hudson County average (63.1 per 100,000). Black children had 38% higher hospitalized rates for mental health conditions than the county rate (34.7 per 100,000 vs. 25.2 per

100,000). Residents mentioned stigma and low numbers of culturally competent providers as the principal barriers to mental health care access.

- **Residents viewed chronic conditions as prevalent and linked to the social determinants of health.** Diabetes and high blood pressure were discussed as prevalent in the community, especially among low-income residents and communities of color, and survey respondents indicated “overweight/obesity” was the second most common health issue in their community. However, focus group participants focused on the barriers to healthy living including affording healthy foods, cost medication, and having time to exercise and be outside.
- **Educational opportunities were seen as an important driving factor for future success.** A positive and supportive school environment is important to physical and mental wellbeing, as well as to future educational and professional opportunities. Health supports academic success. Schools play an important role in facilitating access to care and helping students stay healthy, and Hudson County public schools engage with communities in multiple ways to support students. However, some schools face challenges due to insufficient resources. Inequities in school performance are confirmed by graduation rate data from different Hudson County districts. Whereas the high school graduation rate in the Hoboken Public School District was 93.6% in 2020-2021, the public school districts of Bayonne, Union City, and Jersey City had lower graduation rates. There were significant disparities by race/ethnicity within districts; 95.3% of Asian students graduated from high school in Bayonne in 2020-2021, compared to 86.4% of Black children, and 78.5% of Latino children. Partnership based programs such as the community schools and The Tiger's Den at Snyder High School are a promising strategy to equalize outcomes among diverse students.
- **Hudson County has a wealth of social service organizations and health care services, including those providing preventive care, though many residents experience barriers to accessing these resources.** Residents remarked that having a primary care doctor and being linked to a FQHC as facilitating factors to accessing care. They also discussed the importance of culturally competent providers, including providers who spoke their language and looked like them. Veterans and those working with violence survivors highlighted that having peers and mentors who could provide trauma informed care helped to be engaged in care. The high healthcare cost was the top barrier mentioned by residents, providers, and healthcare administrators. Participants in the healthcare field unanimously noted a decline in access to preventive care and mentioned this as a priority strategic area. They uplifted partnerships and community engagement as ways to bridge the care gap.

Prioritization Process and Priorities Selected for Planning

Prioritization allows hospitals, organizations, and coalitions to target and align resources, leverage efforts, and focus on achievable goals and strategies for addressing community needs. Priorities for this process were identified by examining data and themes from the CHNA findings utilizing a systematic, engaged approach. This section describes the process and outcomes of the prioritization process.

Criteria for Prioritization

A set of criteria were used to determine the priority issues for action. The RWJBH Systemwide CHNA Steering Committee put forth the following criteria to guide prioritization processes across the RWJBH system.

Prioritization Criteria

- **Burden:** How much does this issue affect health in the community?
- **Equity:** Will addressing this issue substantially benefit those most in need?
- **Impact:** Can working on this issue achieve both short-term and long-term changes? Is there an opportunity to enhance access/accessibility?
- **Systems Change:** Is there an opportunity to focus on/implement strategies that address policy, systems, and environmental change?
- **Feasibility:** Can we take steps to address this issue, given the current infrastructure, capacity, and political will?
- **Collaboration/Critical Mass:** Are existing groups across sectors already working on or willing to work on this issue together?
- **Significance to Community:** Was this issue identified as a top need by a significant number of community members?

Prioritization Process

The prioritization process was multifaceted and aimed to be inclusive, participatory, and data-driven.

Step 1: Input from Community Members and Stakeholders via Primary Data Collection

During each step of the primary data collection phase of the CHNA, assessment participants were asked for input. Key informant interviewees and focus group participants were asked about the most pressing concerns in their communities and the three highest priority issues for future action and investment (see Key Informant Interview and Focus Group Guides in the Appendices). Community survey respondents were also asked to select up to four of the most important issues for future action in their communities, noted in the Community Health Issues section of the CHNA Report.

Based on responses gathered from key informant interviews, focus group participants, and community survey respondents, as well as social, economic, and health data from surveillance systems, ten initial issue areas were identified for Hudson County (listed below in no particular order):

- Financial Insecurity
- Unemployment
- Food Insecurity
- Housing
- Chronic Diseases (e.g., heart disease, cancer, diabetes)
- Infectious Diseases, including COVID-19
- Violence Prevention & Safety
- Mental Health
- Substance Use
- Access to Preventive Care

Step 2: Data-Informed Voting via a Prioritization Meeting

On October 27, 2022, a 90-minute virtual community meeting was held with the RWJBH Jersey City/Hudson County CHNA Advisory Committee (see Appendix A for members), so Advisory Committee members could discuss and vote on preliminary priorities for action. During the virtual prioritization meeting on Zoom, attendees heard a brief data presentation on the key findings from the CHNAs conducted across Hudson County.

Next, meeting participants were divided into small groups to reflect on and discuss the data and offer their perspectives and feedback on the various issues. Meeting participants then shared information from their discussions with the full group.

At the end of the meeting, using Zoom’s polling tool, participants were asked to vote for up to four of the ten priorities identified from the data and based on the specific prioritization criteria (Burden, Equity, Impact, Systems Change, Feasibility, Collaboration/Critical Mass, and Significance to Community). A total of thirty-two Advisory Committee members voted during the Community Prioritization Meeting. In addition, polling remained open for an additional week to gather responses from those who were not able to attend the meeting. An additional six responses were received during this period.

Voting ranked the following issues as top priorities, with mental health receiving the highest percentage of responses.

	Percentage	Vote #s
Mental Health	74%	28/38
Housing	74%	28/38
Financial Insecurity	61%	23/38
Chronic Disease	50%	19/38
Violence Prevention & Safety	42%	16/38
Access to Preventive Care	34%	13/38
Food Insecurity	29%	11/38
Substance use	21%	8/38
Unemployment	16%	6/38
Infectious Disease	5%	2/38

After a prioritization process with the Advisory Committee and discussions within the hospital taking into consideration existing expertise, capacity, and experience, JCMC will focus on Access to Preventive Care; Chronic Disease Management, including Behavioral Health Services; Food Insecurity and Education; and Violence Prevention and Safety as priorities during the development of its implementation plan in 2023. JCMC will tackle these priority action areas as part of ongoing community engagement efforts and with an overarching emphasis on addressing systemic racism, racial injustice, and discrimination.

APPENDICES

Appendix A- RWJBH Jersey City/Hudson County CHNA Advisory Committee Members

- Deborah Almonte, Jersey City Medical Center
- Jenny Andrews, Jersey City Medical Center
- Maureen Archibald, Jersey City Medical Center
- Tara Artesi, Legal Assistance to Medical Patients (LAMP) Project
- Adrienne Austin, Jersey City Medical Center
- Pamela Baker, Collaborative Support Programs (CSPNJ)
- Raket Barrientos, Jersey City Medical Center
- Patrick Beaty, MD, Metropolitan Family Health Network
- Paul Bellan-Boyer, Jersey City Department of Health and Human Services
- Christina Bishop-Feeny, Jersey City Medical Center
- Sheridan Blackwell, Jersey City Medical Center
- Kimberly Blackwell, Jersey City Medical Center
- Whitney Bracco, Jersey City Medical Center
- Jenna Camacho, Jersey City Medical Center
- Scott Carey, Metropolitan Family Health Network
- Kristin Carlino, Jersey City Medical Center
- Kristy Case, Jersey City Medical Center
- Suzanne Cavanaugh, City of Bayonne
- Ritu Chandak, Jersey City Medical Center
- Jamie Chebra, Jersey City Medical Center
- Jessica Chung, Jersey City Medical Center
- Timothy Daniels, Jersey City Medical Center
- Christine Dimaculangan, Jersey City Medical Center
- Cheryl Dorn, Peace Care
- Joan Dublin, Metropolitan Family Health Network
- Mark Duda, Visiting Nurse Association Health Group
- Leah Dungee, Jersey City Medical Center
- Joan Eccleston, Jersey City Department of Health and Human Services
- Edoardo Ferrante, City of Bayonne
- Marissa Fisher, Jersey City Medical Center
- Stacey Flanagan, Jersey City Department of Health and Human Services
- Juliet Foster, Division of Veterans Affairs, Jersey City Department of Health and Human Services
- Katherine Fromm, Jersey City Medical Center
- Marli Gelfand, Jersey City Medical Center
- Silvana Gomez, Jersey City Medical Center
- Stephanie Gonzalez, Jersey City Medical Center
- William Gonzalez, Jersey City Medical Center
- Kwaku Gyekye, Jersey City Medical Center
- Tina Harvey, Jersey City Medical Center
- Victoria Hayes, York Street Project

- Angelo Hunt, St. Lucy's Shelter
- Linda Ivory-Green, Jersey City Department of Health and Human Services
- Maryanne Kelleher, Jersey City Department of Health and Human Services
- Surendra Khera, MD, Jersey City Medical Center
- Kenneth King, Jersey City Medical Center
- Rita Knause, MD, North Hudson Community Action Corporation
- Jordan Kowalczewski, Barnabas Health Medical Group
- Theresa Laflam, Jersey City Medical Center
- Mabel Laforgia, Jersey City Medical Center
- Judy Lagani, Lincoln High School and Dickinson High School
- Maria Veronica Lavarro, Jersey City Medical Center
- Michael Loftus, Jersey City Medical Center
- Mike McLean, Jersey City Department of Health and Human Services
- Janet Merly-Liranzo, Peace Care St. Ann's
- Susan Milan, Garden State Episcopal Community Development Corporation
- Stephanie Mills, Hudson Pride
- Stacie Newton, Jersey City Medical Center
- Tri Nguyen, Jersey City Medical Center
- Michele O'Reilly, City of Bayonne - Health Division
- Maria Otadoy, Jersey City Medical Center
- Lashawn Overton, Jersey City Medical Center
- Grace Palmer, Jersey City Medical Center
- Alicia Parker, Hyacinth AIDS Foundation
- Leo Pellegrini, Health & Human Services of Hoboken
- Joan Quigley, North Hudson Community Action Corporation
- Tara Reid, Jersey City Medical Center
- Jeffery Rodriguez, Jersey City Medical Center
- Elizabeth Schedl, Hudson Pride
- Aniello Semioli, Jersey City Medical Center
- Jessica Semioli, Jersey City Medical Center
- Thomas Sheehy, Peace Care St. Joseph's
- Tina Siciliano, Jotham W. Wakeman School, PS #6
- Veronica Siringano, Jersey City Medical Center
- Iesha Suber, Jersey City Medical Center
- Eva Tawiah, Jersey City Medical Center
- Amanda Tobias, Jersey City Medical Center
- Vito Veneruso, North Hudson Community Action Corporation
- Yvonne Waller, Snyder Higher School
- Vanessa Watson-Hill, Jersey City Medical Center
- Ewelina Wojtaszek, Jersey City Medical Center
- Monica Younger, Jersey City Medical Center
- Joseph Zapata, Hudson Pride

Appendix B- Organizations Represented in Key Informant Interviews and Focus Groups

Organization	Sector
Jersey City Department of Health and Human Services	Local public health officials
City of Bayonne Health Division	Local public health officials
Hoboken Housing Authority	Local housing officials
Jersey City Public Schools	Local education officials
Metropolitan Family Health Network	Local healthcare administrators
Alliance Community Healthcare	Local healthcare administrators
North Hudson Community Action Corporation	Local healthcare administrators
Hudson Pride	LGBTQ+ social service providers
JCMC Community Outreach and Steering Committee	Health care and social services providers
Islamic Center of Jersey City/JCMC Chaplaincy	Faith-based leaders
Archdiocese of Newark/JCMC Chaplaincy	Faith-based leaders

Appendix C- Key Informant Interview Guide

Health Resources in Action JCMC/Hudson County Community Health Needs Assessment

Goals of the key informant interview

- To determine perceptions of the strengths and needs of the community served by JCMC/Hudson County, and identify sub-populations most affected
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

[NOTE: THE QUESTIONS IN THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

I. BACKGROUND (5 MINUTES)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today.
- A few months ago, the JCMC/Hudson County coalition began undertaking a community health assessment effort to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these with a wide range of people - community members, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.
- We recognize this is a unique time we are in. Given the COVID-19 pandemic, an assessment of the community's needs and strengths is even more important than ever.
- Our interview will last about 45 – 60 minutes. After all the interview and focus group discussions are completed, we will be writing a summary report of the general themes that have emerged during these discussions. We will not include any names or identifying information in that report. All names and responses will remain confidential. Nothing sensitive that you say here will be connected directly to you in our report.

[Discuss permission to record, if relevant]

- Do you have any questions before we begin?

II. INTRODUCTION (5 MINUTES)

1. Can you tell me a bit about your organization/agency? [TAILOR PROBES DEPENDING ON AGENCY OR IF COMMUNITY LEADER NOT AFFILIATED WITH ORGANIZATION]

- a. [PROBE ON ORGANIZATION: What is your organization’s mission/services? What communities do you work in? Who are the main clients/audiences?]
 - i. What are some of the biggest challenges your organization faces in conducting your work in the community?
 - ii. How have these changed during COVID-19? What new challenges do you anticipate going forward?

III. COMMUNITY PERCEPTIONS AND SOCIAL/ECONOMIC FACTORS (10 MINUTES)

- 2. How would you describe the community served by your organization/ that you serve? (NOTE THAT WE ARE DEFINING COMMUNITY BROADLY – NOT NECESSARILY GEOGRAPHICALLY BASED)
 - a. What do you consider to be the community’s strongest assets/strengths?
 - b. How have you seen the community change over the last several years?
 - c. What are some of the community’s biggest concerns/issues in general? What challenges do residents face in their day-to-day lives? [PROBE IF NOT YET MENTIONED ON: transportation; affordable housing; discrimination; financial stress; food security; violence; employment; cultural understanding; language access; impacts of environmental problems and climate change, etc.] REPEAT QUESTIONS FOR DIFFERENT ISSUES]
 - i. What populations (geography, age, race, gender, income/education, veteran status, etc.) do you see as being most affected by these issues?
 - ii. How has [ISSUE] affected their daily lives?
 - iii. How have these issues changed during/since COVID-19?

[REPEAT SET OF QUESTIONS FOR TWO OR THREE ISSUES MENTIONED]

IV. HEALTH ISSUES (10 MINUTES)

- 3. What do you think are the most pressing health concerns in the community/among the residents you work with? Why? [PROBE ON SPECIFICSPROBE FOR HEALTH ISSUES NOT DIRECTLY RELATED TO COVID-19, OR ISSUES THAT HAVE CHANGED BECAUSE OF COVID-19, EG, CHRONIC DISEASE, HYPERTENSION, ETC.]
 - a. How has [HEALTH ISSUE] affected the residents you work with? [PROBE FOR DETAILS: IN WHAT WAY? CAN YOU PROVIDE SOME EXAMPLES?]
 - i. From your experience, what are peoples’ biggest challenges to addressing [THIS ISSUE]?
 - ii. To what extent, do you see [BARRIER] to addressing this issue among the residents you work with/your organization serves?

[PROBE ON BARRIERS BROUGHT UP/MOST APPROPRIATE FOR POPULATION GROUP:
Cost or economic hardship, transportation, stigma, attitudes towards seeking services,
built environment, availability/access to resources or services, knowledge of existing
resources/services, social support, discrimination, insurance coverage, language/cultural
barriers, etc.]

4. What are current or emerging trends that could have an impact on the public health system or the community? Has anything become apparent due to the Coronavirus pandemic?
5. How important is prevention in the community?
 - i. How easy is it to access preventive services in your community?
 - ii. What are some of the ways that you access care (Probes: at the hospital, clinical, community-based, telehealth)?
 - iii. Has anybody you or someone you know used telehealth to get care? How satisfied were you/them with the care received via telehealth?

V. *TAILORED SECTION - SPECIFIC QUESTIONS ON PARTICULAR ISSUES, DEPENDING ON WHO THE INTERVIEWEE IS. SELECT QUESTIONS TAILORED TO INDIVIDUAL EXPERTISE AND ASK A FEW QUESTIONS IF NOT YET BROUGHT UP. (5-10 MINUTES)*

For Interviewees Working in Housing and/or Transportation

- What barriers do you see residents experiencing around accessing affordable and healthy housing? How about with transportation?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- What has been working well in the community to improve access to healthy, affordable housing? How about related to transportation? What has been challenging or not working well? Where are there opportunities for improvement or innovation?

For Interviewees Working in Financial Instability, Employment, and Workforce Development

- What challenges are residents facing regarding hiring, employment, or job security?
- What were the needs in this community around workforce development? What is needed to improve residents' employability? What training or resources are needed?
- Are there any approaches to improving workforce development and financial stability that you think will have to change in light of the pandemic and its impacts?

For Interviewees Working with Communities where Discrimination is a Concern

- What are some of the specific challenges around discrimination that your communities face?
- What should health care and social service providers consider when treating health and other issues in diverse populations? How can institutions best respond to the needs of diverse groups? (e.g. religious, racial/ethnic, etc.)
- How has the pandemic and/or movements for racial justice impacted addressing issues and needs of diverse groups?

For Interviewees Working with Seniors/Older Adults

- What are some of the challenges seniors are facing in your community?
- Are there particular structural, institutional, or policy-related barriers that have affected seniors in your community?
- How has the pandemic and its effects impacted seniors and organizations serving older adults?
- What has been going “right” that could be built on going forward?

For Interviewees Working in the Areas of Substance Use or Mental Health

- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- How has the pandemic impacted community members regarding substance use and mental health?
*mention other KIIIs have brought up suicide in youth; isolation in older populations
- What are your major concerns for the future? What has been going “right” that could be built on going forward?

For Interviewees Working with Veterans

- What are some of the challenges veterans are facing in your community?
- Are there particular structural, institutional, or policy-related barriers that have affected veterans in your community?
- How has the pandemic and its effects impacted seniors and organizations serving veterans?
- Among the veterans, who have been the most affected by these issues (age, sex, race, etc.)
- What has been going “right” that could be built on going forward?

For Interviewees Working with Youth/Young Adults

- What are some of the challenges youths are facing in your community?
- What should health care and social service providers consider when treating health and other issues in youth populations? How can institutions best respond to the needs of younger individuals?
- How has the pandemic and its effects impacted youths and organizations serving younger individuals?
- What are your major concerns for the future? Do you have examples of programs or approaches that have been working well that could be built on going forward?

For Interviewees Working in Food Assistance and Food Security

- What barriers do you see residents experiencing around accessing affordable and healthy food?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- What has been working well in the community to improve access to healthy, affordable food?
- What has been challenging or not working well? What opportunities exist for improvement or innovation?

VI. VISION FOR THE FUTURE (10 MINUTES)

6. I’d like you to think ahead about the future of your community. When you think about the community 3 years from now, what would you like to see? What’s your vision?
 - a. What do you see as the next steps in helping this vision become reality?

- b. We talked about a number of strengths or assets in the community. [MENTION POTENTIAL STRENGTHS- Community resilience, diversity, number of organization/services available, community engagement, etc.] How can we build on or tap into these strengths to move us towards a healthier community?
7. As you think about your vision, what do you think needs to be in place to support sustainable change?
- a. How do we move forward with lasting change across organizations and systems?
 - b. How can we better serve/address the needs of the culturally diverse community of JC/Hudson County?
 - c. Where do you see yourself or your organization in this?
8. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive this funding?

VII. OTHER

9. We are also interested in finding out ways people receive news and current events. Thinking about the ways people might get information, where do you get news and information from? What about ways you prefer to search for news and information – (television, radio, print, smartphone, computer or tablet).

VIII. CLOSING (5 MINUTES)

Thank you so much for your time and sharing your opinions. Your perspectives about the communities you work with will be a great help in determining how to improve the systems that affect the health of this population. Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier?

Thank you again. Your feedback is valuable, and we greatly appreciate your time and for sharing your opinion.

Appendix D- Focus Group Guide

Health Resources in Action JCMC/Hudson County Community Health Needs Assessment

Goals of the focus group:

- To determine perceptions of the strengths and needs of the community
- To understand residents' current experiences and challenges
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

I. BACKGROUND (5-10 minutes)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your families are fine during these uncertain times.
- This discussion will last about 60 minutes. [DEPENDING ON FORMAT OF FOCUS GROUP] Please turn on your video, if possible, so that we can all see each other speaking. As a reminder, please keep yourself on MUTE until you want to speak.

NORMALLY, WE WOULD BE DOING THIS IN-PERSON.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.
- A few months ago, JCMC/Hudson County began a community health assessment to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these with a wide range of people - community members, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.
- We recognize this is a unique time we have been in. Given the COVID-19 pandemic, an assessment of the community's needs and strengths is even more important than ever.
- After discussions with several groups are done, we will be writing a report summarizing what has come up. In that report, we might provide some general information on what we discussed tonight, but we will not include any names or identifying information. Your responses will be strictly confidential. In the report, nothing you say here will be connected to your name.
- [NOTE IF AUDIORECORDING] We plan to audio record these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the notetaking. No

one but the analysts at Health Resources in Action, who are writing the report, will be listening to the audio recordings. Does anyone have any concerns with me turning the recorder on now?

- Any questions before we begin our introductions and discussion?

II. INTRODUCTIONS (5 minutes)

Now, first let's spend a little time getting to know one another. When I call your name, please unmute yourself and tell us: 1) Your first name; 2) what city or town you live in; and 3) something about yourself you'd like to share— such as how many children you have or what activities you like to do for fun. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY ASSETS AND CONCERNS (20 minutes)

For the following questions, we will be discussing the strengths and concerns in your community.

1. If someone was thinking about moving into your community, what would you say are some of your community's biggest strengths? What are the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]
 - a. How have these strengths changed during COVID-19?
2. To contrast that, what are some of the biggest problems or concerns in your community? How have these concerns changed during COVID-19? [PROBE ON ISSUES IF NEEDED – TRANSPORTATION, HOUSING AFFORDABILITY, ECONOMIC SECURITY, HEALTH CONCERNS, ETC.]
 - a. Just thinking about day-to-day life –working, getting your kids to school, things like that – what are some of the challenges or struggles you deal with on a day-to-day basis? [PROBE ON ISSUES IF NEEDED – TRANSPORTATION, HOUSING AFFORDABILITY, ECONOMIC SECURITY, HEALTH CONCERNS, VIOLENCE, ETC.]
 - b. How have these changed during COVID-19?
 - c. What specific population groups do you think have been most at-risk for/affected by these issues in your community?
3. In the past year, there has been more national dialogue around racial injustice, inequity, and structural racism. How has this dialogue played out in JC/Hudson County? How have issues of inequity played out in the community?
 - a. How can different community organizations effectively contribute to the ongoing conversation and movement for racial justice?
4. What do you think are the most pressing health concerns in your community?
 - a. Who is most at-risk for/have been most affected by these issues?
5. Thinking about health and wellness, what makes it easier to be healthy in your community?

- a. What supports your health and wellness?
- b. What makes it easy to access care?
- c. What makes it harder to be healthy in your community?
 - i. How easy is it to access preventive services in your community?
 - ii. What are some of the ways that you access care (Probes: at the hospital, clinical, community-based, telehealth)?
 - iii. Has anybody you or someone you know used telehealth to get care? How satisfied were you/them with the care received via telehealth?

IV. PERCEPTIONS OF COMMUNITY NEEDS, BARRIERS, AND OPPORTUNITIES (15 minutes)

What are the top three issues of concern that have been mentioned? [MODERATOR TO NAME THE MAJOR 3-4 ISSUES – HEALTH, TRANSPORTATION, SOCIAL, ECONOMIC, VIOLENCE, ETC. --THAT HAVE COME UP SO FAR.] Let’s talk about some of the issues.

- 6. Do you agree with this list as the major concerns/issues in your community? Is there a major issue that is missing?
- 7. Let’s talk about [ISSUE]. (*Moderator to select one major issue discussed.*) What are some of the barriers or challenges residents face in dealing with [ISSUE]? [PROBE: BARRIERS TO SERVICES, ASSISTANCE, COORDINATION, SOCIAL/ECONOMIC FACTORS, DISCRIMINATION, SAFETY, ETC.]
 - a. Thinking about your larger community environment – the services and resources available, your state and local policies or practices, etc. -- what do you see as some of the biggest challenges for your community to tackle this issue or make improvements?
 - b. What do you think should happen in the community to address this issue? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

[REPEAT Q6 FOR 1-2 OTHER MAJOR ISSUES THAT WERE DISCUSSED]

V. VISION OF COMMUNITY HEALTH IMPROVEMENT AND INVOLVEMENT (10 minutes)

- 8. I’d like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see? What is your vision for the future?
 - a. What do you think needs to happen in the community to make this vision a reality?
 - b. Who should be involved in this effort? What should be Jersey City Medical Center’s role in making this happen?
 - c. What should be the role of a community coalition that brings together multiple groups?
- 9. We talked about a lot of things today. Thinking about what would make the most impact, who is most affected by the different issues we talked about, and how realistic it is to make change: What

do you think are the most important areas of action to improve health in your community? If organizations and agencies are going to work together to tackle the community's biggest issues, what should they put at the top of the list as things to do?

VI. CLOSING (2 minutes)

Thank you so much for your time. This is a very difficult time for everyone, and your perspective will be a great help in determining how to improve the systems that affect your community.

That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon. [TALK ABOUT NEXT STEPS OF THE PROCESS, SPECIFICALLY HOW PARTICIPANTS CAN GET INVOLVED FURTHER OR RECEIVE THE FINAL REPORT OR SUMMARY OF THE REPORT.]

Appendix E- Resource Inventory

Appendix F- Additional Data Tables

Table 16. Survey Respondent Characteristics, n=556, 2001

Age		Income	
Under 30	15.6%	Under \$25,000	12.0%
30 to 49	46.7%	\$25,000 to \$50,000	21.1%
50 to 64	27.0%	\$50,001 to \$100,000	31.5%
65+	10.7%	\$100,001 to \$125,000	11.2%
Gender		\$125,001 to \$150,000	6.4%
Female	67.5%	\$150,001 to \$200,000	7.2%
Male	32.5%	Over \$200,000	10.8%
Additional Gender Category/ Transgender	0.2%*	Employment	
Race/Ethnicity		Employed full-time	72.4%
African American/ Black	9.3%	Employed part-time	6.8%
Asian	15.7%	Student	3.9%
Hispanic/ Latino(a)	24.3%	Homemaker	1.1%
Multiracial	2.5%	Disabled	1.8%
White/ Caucasian	45.0%	Retired	7.5%
Other	3.2%	Unemployed	6.5%
Sexual Orientation		Marital Status	
Heterosexual	86.3%	Married	46.2%
Homosexual	6.7%	Single	31.1%
Bisexual	4.7%	Separated/divorced/widowed	15.8%
Additional Sexual Orientation	2.4%	Domestic partnership/civil union/living together	7.0%
Education			
Less than high school graduate or GED	2.2%		
High school graduate or GED	9.6%		
Some college	14.4%		
Associate or technical degree/certification	9.3%		
College graduate	30.4%		
Postgraduate or professional degree	34.1%		

DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Table 17. Age Distribution and Percent Change, by Town, 2011-2015, 2016-2020

	Under 18 years			18-24 years			25-44 years			45-64 years			65-74 years			75 years and older		
	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change
Hudson County																		
Bayonne	22.0%	23.5%	1.5%	8.3%	6.5%	-1.8%	29.8%	29.8%	0.0%	27.0%	25.9%	-1.1%	7.2%	7.8%	0.6%	5.8%	6.3%	0.5%
Hoboken	13.2%	13.9%	0.7%	10.1%	9.8%	-0.3%	56.7%	55.0%	-1.7%	14.0%	15.2%	1.2%	3.1%	3.2%	0.1%	2.8%	3.0%	0.2%
Jersey City (07302)	7.2%	14.6%	7.4%	5.2%	3.6%	-1.6%	55.1%	58.6%	3.5%	17.3%	15.0%	-2.3%	4.1%	4.6%	0.5%	4.0%	3.8%	-0.2%
Jersey City (07304)	15.5%	25.0%	9.5%	9.4%	7.6%	-1.8%	31.7%	32.4%	0.7%	26.3%	24.1%	-2.2%	6.2%	6.3%	0.1%	3.9%	4.5%	0.6%
Jersey City (07305)	16.7%	25.3%	8.6%	10.7%	9.2%	-1.5%	28.9%	29.2%	0.3%	23.8%	23.6%	-0.2%	7.5%	8.2%	0.7%	4.6%	4.6%	0.0%
Jersey City (07306)	12.8%	19.6%	6.8%	10.6%	9.1%	-1.5%	37.8%	37.0%	-0.8%	22.0%	20.8%	-1.2%	6.0%	7.8%	1.8%	3.5%	5.9%	2.4%
					8													
Jersey City (07307)	14.3%	20.2%	5.9%	9.4%	.1%	-1.3%	34.7%	38.9%	4.2%	23.6%	22.0%	-1.6%	5.9%	6.6%	0.7%	4.3%	4.2%	-0.1%
Jersey City (07310)	4.9%	11.2%	6.3%	10.2%	9.6%	-0.6%	60.6%	64.9%	4.3%	15.0%	10.5%	-4.5%	1.7%	3.2%	1.5%	0.4%	0.6%	0.2%
Union City	22.3%	22.5%	0.2%	10.4%	9.5%	-0.9%	32.0%	31.8%	-0.2%	25.2%	25.4%	0.2%	5.7%	5.5%	-0.2%	4.4%	5.3%	0.9%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

Table 18. Age Distribution, by Gender, State, and County, 2016-2020

	Under 18 years		18-24 years		25-44 years		45-64 years		65-74 years		75 years and older	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
New Jersey	23.0%	21.0%	9.0%	8.2%	26.5%	25.0%	27.3%	27.7%	8.6%	9.7%	5.7%	8.4%
Hudson County	20.9%	20.0%	8.3%	7.5%	38.3%	35.4%	22.5%	23.1%	6.2%	7.6%	3.9%	6.3%
Bayonne	24.7%	20.6%	7.2%	7.6%	29.3%	28.4%	25.9%	26.8%	8.6%	8.8%	4.3%	7.9%
Hoboken	13.5%	13.6%	13.6%	7.8%	51.6%	54.9%	14.5%	16.9%	4.2%	3.3%	2.7%	3.6%
Jersey City (07302)	15.2%	14.0%	3.6%	3.6%	60.6%	56.2%	14.4%	15.5%	2.8%	6.5%	3.4%	4.3%
Jersey City (07304)	25.6%	24.6%	8.1%	7.3%	32.8%	32.2%	24.0%	24.1%	6.9%	5.7%	2.6%	6.2%
Jersey City (07305)	26.9%	23.7%	9.2%	9.1%	30.4%	28.0%	23.5%	23.7%	6.2%	10.0%	3.7%	5.5%
Jersey City (07306)	18.8%	20.4%	9.4%	8.7%	38.7%	34.9%	20.4%	21.5%	7.6%	7.9%	5.1%	6.7%
Jersey City (07307)	19.7%	20.7%	8.8%	7.3%	42.3%	35.4%	20.7%	23.2%	5.5%	7.8%	2.9%	5.5%
Jersey City (07310)	12.4%	9.8%	7.0%	12.8%	66.2%	63.2%	10.3%	10.7%	3.2%	3.3%	0.8%	0.2%
Union City	21.9%	21.9%	9.1%	10.0%	32.8%	29.7%	26.6%	24.2%	5.9%	7.1%	3.7%	7.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Community Social and Economic Environment

Table 19. Membership in Social Associations, by State and County, 2019

	# Associations	Social Association Rate
New Jersey	7721	8.7
Hudson County	376	5.6

DATA SOURCE: County Business Patterns as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Educational Attainment

Table 20. Educational Attainment among Adults 25 Years and Older, by State, County, and Town, 2016-2020

	Less than 9th grade	9th to 12th grade, no diploma	High school graduate/ GED	Some college, no degree	Associate degree	Bachelor's degree	Graduate or professional degree
New Jersey	4.7%	5.1%	26.7%	16.1%	6.6%	24.8%	15.9%
Hudson County	8.6%	5.7%	24.4%	12.6%	4.6%	26.4%	17.6%
Bayonne	6.0%	5.0%	30.3%	15.6%	5.3%	25.9%	11.9%
Hoboken	2.3%	2.2%	8.3%	6.4%	1.2%	48.4%	31.2%
Jersey City (07302)	2.9%	1.9%	8.3%	7.2%	2.4%	39.0%	38.5%
Jersey City (07304)	6.7%	7.9%	32.0%	13.5%	6.3%	22.8%	10.9%
Jersey City (07305)	6.5%	6.8%	30.7%	16.3%	6.4%	20.6%	12.7%
Jersey City (07306)	8.4%	6.9%	20.2%	12.5%	4.5%	30.7%	16.9%
Jersey City (07307)	8.3%	6.4%	24.8%	13.5%	4.6%	26.0%	16.4%
Jersey City (07310)	0.5%	1.0%	4.7%	4.5%	1.6%	31.7%	56.1%
Union City	18.1%	7.5%	33.1%	13.1%	5.1%	15.5%	7.6%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 21. Educational Attainment Among Adults 25 Years and Older, by Race/Ethnicity, State, County and Town, 2016-2020

	Asian, NH		Black, NH		Hispanic/ Latino		White, NH		Other race, NH	
	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+
New Jersey	92.8%	71.0%	88.6%	25.2%	75.6%	20.6%	94.6%	45.1%	71.4%	15.3%
Hudson County	93.4%	75.3%	87.4%	31.0%	75.8%	21.3%	92.7%	59.1%	75.6%	17.3%
Bayonne	93.6%	68.8%	90.0%	33.5%	79.9%	20.8%	92.6%	41.7%	77.5%	17.5%
Hoboken	97.1%	90.1%	86.1%	31.1%	78.3%	33.2%	98.7%	88.7%	67.0%	30.3%
Jersey City (07302)	97.8%	91.1%	93.2%	47.1%	81.3%	43.3%	98.2%	83.5%	71.4%	34.3%
Jersey City (07304)	90.0%	57.8%	86.7%	28.4%	77.2%	18.4%	91.5%	50.7%	80.2%	17.1%
Jersey City (07305)	92.6%	56.5%	88.5%	26.7%	74.8%	17.9%	92.6%	45.6%	70.5%	11.1%
Jersey City (07306)	89.0%	68.2%	80.9%	26.7%	73.2%	19.8%	90.7%	51.4%	74.8%	20.9%
Jersey City (07307)	87.3%	66.8%	84.7%	35.3%	80.4%	20.7%	89.8%	51.9%	75.8%	16.9%
Jersey City (07310)	99.4%	96.1%	94.5%	27.5%	95.3%	76.8%	98.1%	84.6%	81.5%	65.2%
Union City	84.3%	64.6%	79.0%	26.1%	69.9%	16.0%	90.9%	48.2%	73.7%	15.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Unemployment Rates

Table 22. Unemployment Rate by Gender, State, County, and Town, 2016-2020

	Female	Male
New Jersey	5.6%	5.4%
Hudson County	5.6%	4.9%
Bayonne	6.5%	6.3%
Hoboken	1.9%	3.8%
Jersey City (07302)	2.5%	2.1%
Jersey City (07304)	10.8%	7.7%
Jersey City (07305)	6.6%	6.7%
Jersey City (07306)	5.0%	4.5%
Jersey City (07307)	5.7%	3.8%
Jersey City (07310)	3.6%	2.3%
Union City	6.1%	5.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

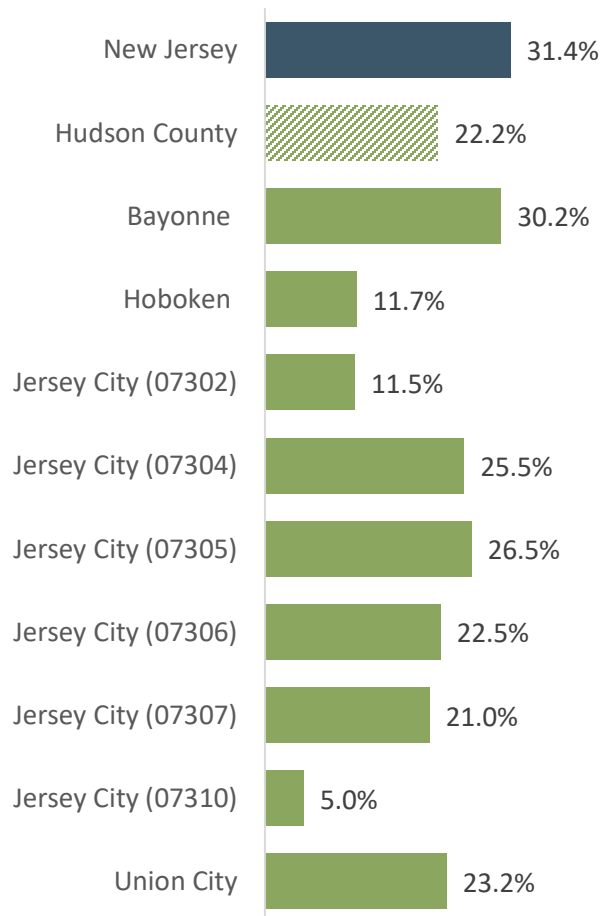
Table 23. Unemployment Rate by Age, State, and County, 2016-2020

	16 to 19 years	20 to 24 years	25 to 29 years	30 to 34 years	35 to 44 years	45 to 54 years	55 to 59 years	60 to 64 years	65 to 74 years	75 years and over
New Jersey	17.2%	11.4%	6.5%	5.2%	4.6%	4.6%	4.5%	4.4%	4.8%	4.2%
Hudson County	18.8%	11.0%	4.8%	4.3%	4.1%	5.7%	5.5%	4.0%	5.6%	1.7%
Bayonne	30.8%	14.4%	4.9%	9.7%	4.2%	6.2%	4.1%	4.4%	1.2%	0.0%
Hoboken	64.5%	5.0%	2.4%	1.1%	2.2%	6.6%	3.4%	5.7%	6.6%	0.0%
Jersey City (07302)	10.4%	6.7%	2.5%	2.1%	1.4%	4.1%	1.3%	2.9%	0.0%	18.3%
Jersey City (07304)	13.8%	22.5%	6.6%	8.7%	7.6%	10.5%	7.8%	3.8%	7.0%	0.0%
Jersey City (07305)	25.3%	14.4%	6.6%	6.6%	5.7%	5.3%	3.9%	6.1%	8.5%	0.0%
Jersey City (07306)	10.4%	8.3%	3.1%	4.0%	3.8%	5.4%	8.1%	3.7%	3.4%	0.0%
Jersey City (07307)	4.8%	9.1%	6.1%	4.0%	3.7%	3.8%	2.6%	4.4%	0.0%	0.0%
Jersey City (07310)	0.0%	0.0%	0.4%	1.6%	7.8%	1.6%	12.6%	0.0%	0.0%	0.0%
Union City	17.7%	10.4%	8.3%	5.0%	3.2%	5.2%	5.8%	4.3%	12.9%	0.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Income and Financial Security

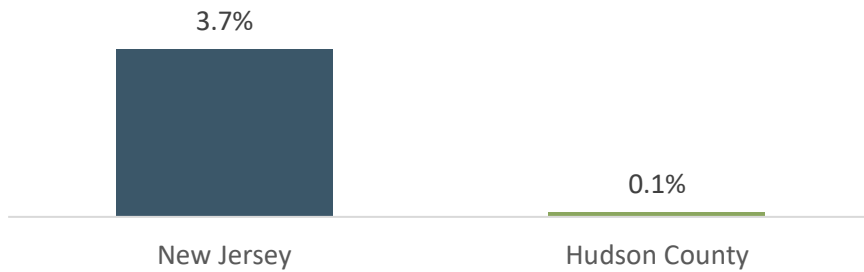
Figure 119. Percent Households Receiving Social Security Income, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Food Access and Food Security

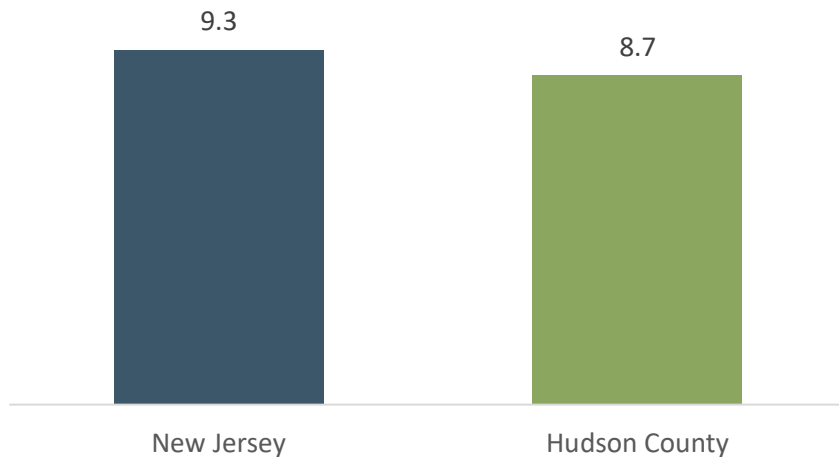
Figure 120. Food Desert Among Residents, by State and County, 2019



DATA SOURCE: U.S. Department of Agriculture, Economic Research Service, Food Access Research Atlas, 2019 , as reported by, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

NOTE: Food desert defined as the percentage of population with low income and without access to a grocery store at 1 mile for urban areas and 10 miles for rural areas

Figure 121. Food Environment Index, by State and County, 2019



DATA SOURCE: USDA Food Environment Atlas, Map the Meal Gap from Feeding America, 2019 as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

NOTE: Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).

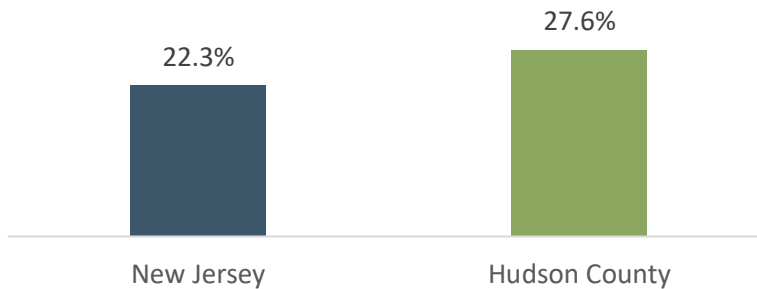
Housing

Table 24. Household Occupants per Room, by State and County, 2016-2020

	1.00 or less	1.01 to 1.50	1.51 or more
New Jersey	96.7%	2.1%	1.1%
Hudson County	92.1%	5.1%	2.8%
Bayonne	94.5%	4.0%	1.5%
Hoboken	96.2%	1.9%	1.9%
Jersey City (07302)	93.5%	3.0%	3.5%
Jersey City (07304)	93.2%	4.3%	2.5%
Jersey City (07305)	91.4%	6.9%	1.7%
Jersey City (07306)	88.4%	7.1%	4.5%
Jersey City (07307)	91.2%	6.6%	2.1%
Jersey City (07310)	93.3%	2.7%	4.0%
Union City	88.4%	8.9%	2.6%

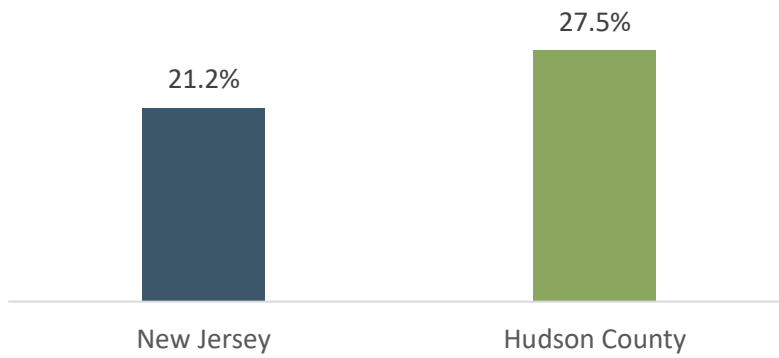
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 122. Percentage of Children That Live in a Household Headed by a Single Parent by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020

Figure 123. Severe Housing Problems, by State and County, 2014-2018

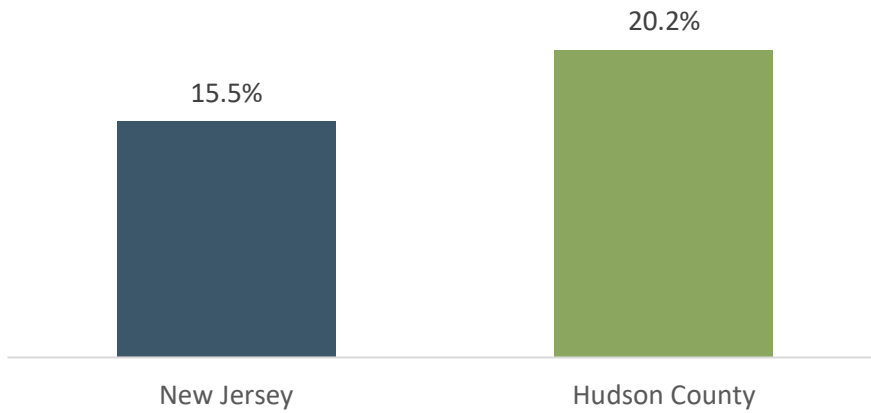


DATA SOURCE: U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy (CHAS) data, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2014-2018

NOTE: Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.

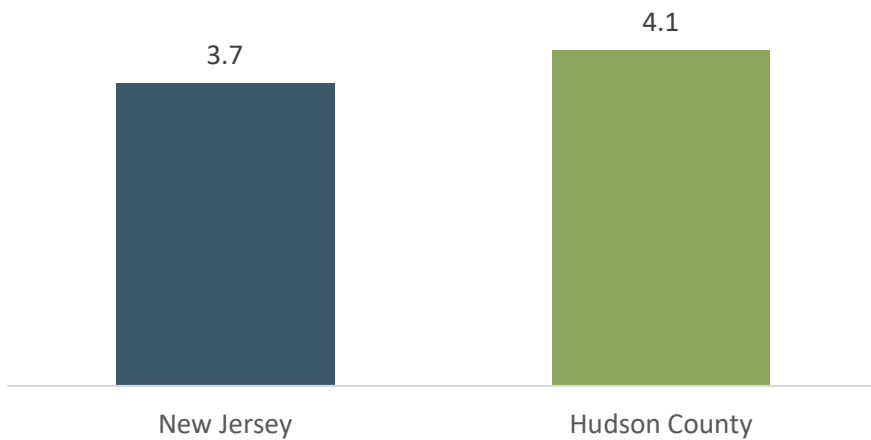
Overall Health

Figure 124. Percent Poor or Fair Health, by State and County, 2018



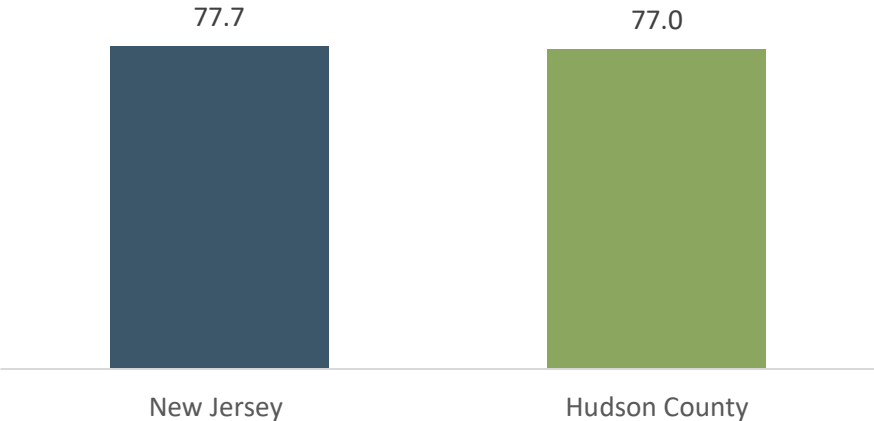
DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018

Figure 125. Poor Physical Health Days by State and County, 2018



DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018

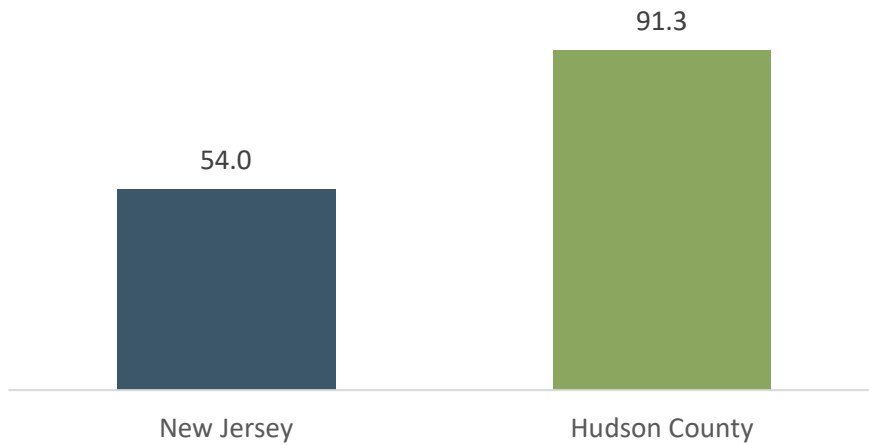
Figure 126. Life Expectancy by State and County, 2020



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health 2020

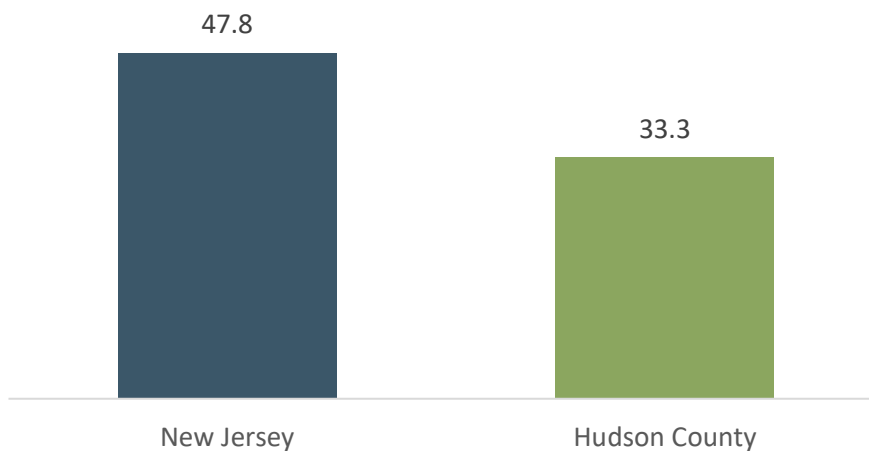
Community Health Issues: Unintentional Injury

Figure 127. ED Visits Due to Unintentional Injury (Age Adjusted) per 10,000, by State and County, 2016-2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

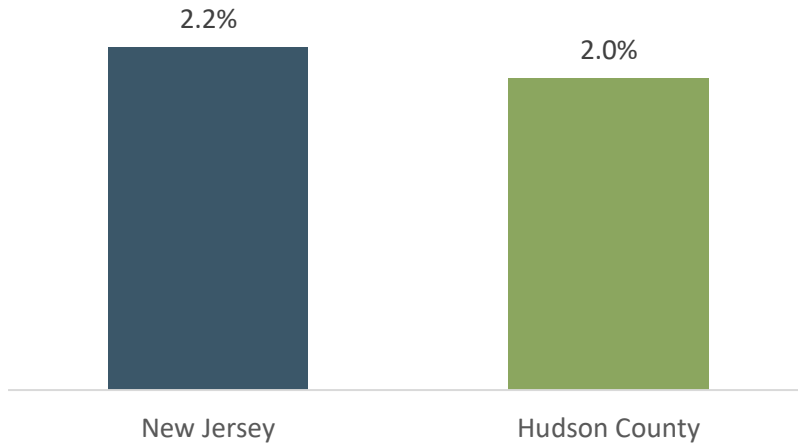
Figure 128. Unintentional Injury Deaths per 100,000 Population, by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Environmental Health

Figure 129. Percent of Children Aged 1 -5 Years With Elevated Blood Lead Level ($\geq 5\text{mcg/dL}$), by State and County, 2019



DATA SOURCE: Childhood Lead Exposure in New Jersey Annual Report, New Jersey Department of Public Health, Office of Local Public Health, Childhood Lead Program, State Fiscal Year 2019

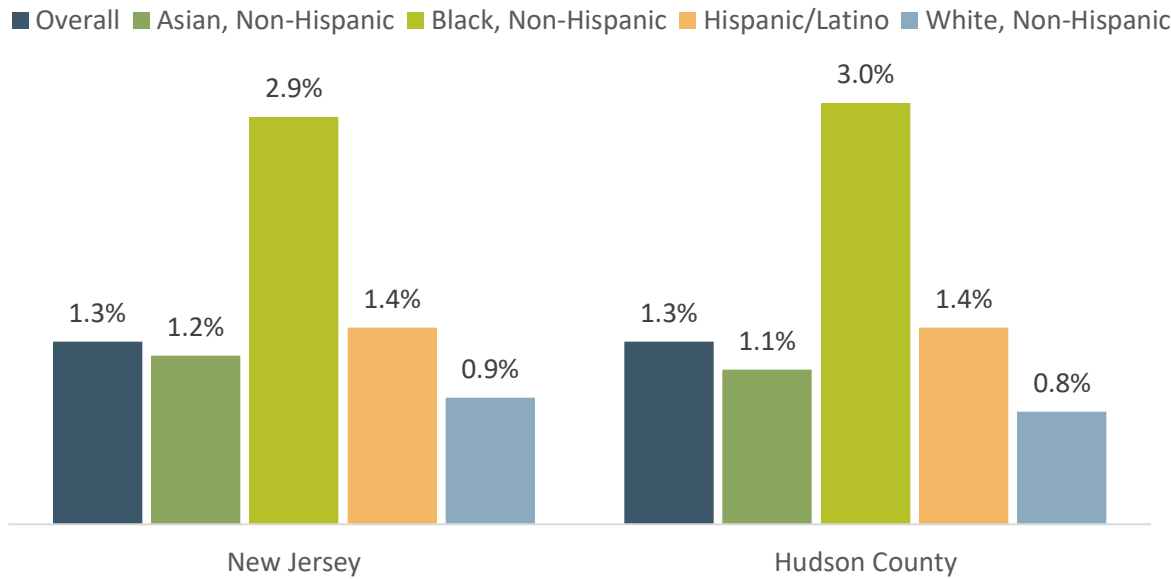
Table 25. Drinking water violations by County, 2020

	Violation?	Z-score
Hudson County	Yes	0.55

DATA SOURCE: Environmental Protection Agency, Safe Drinking Water Information System, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2020

Maternal and Infant Health

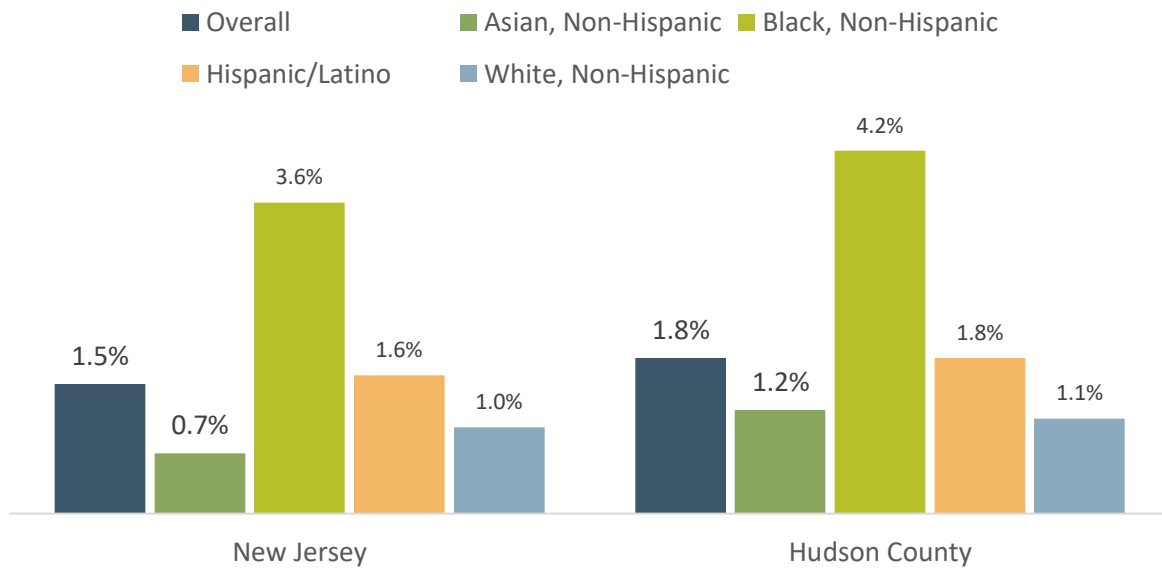
Figure 130. Percent Very Low Birth Weight Births by Race/Ethnicity, by State and County, 2016-2020



DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018

NOTE: Very low birth weight is defined as less than 1,500 grams

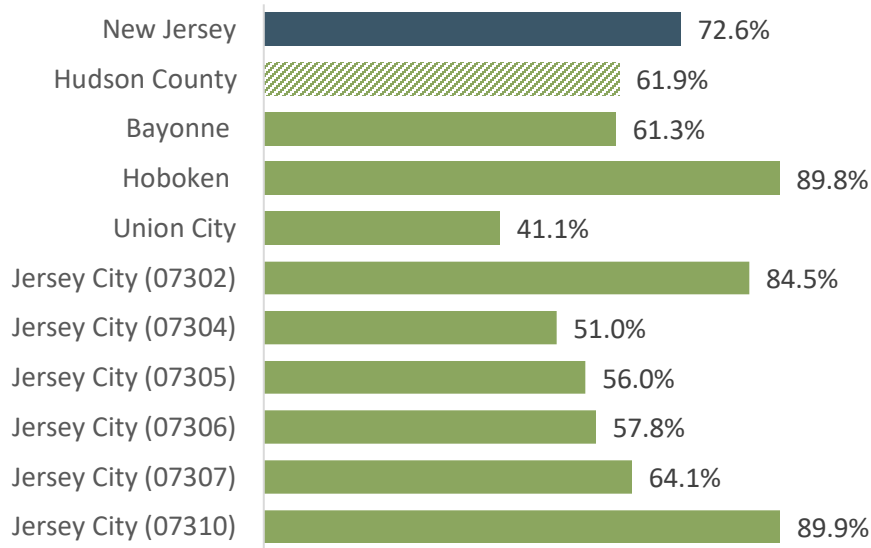
Figure 131. Percent Births with No Prenatal Care Overall by Race/Ethnicity, by State, 2016-2020



DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Access to care

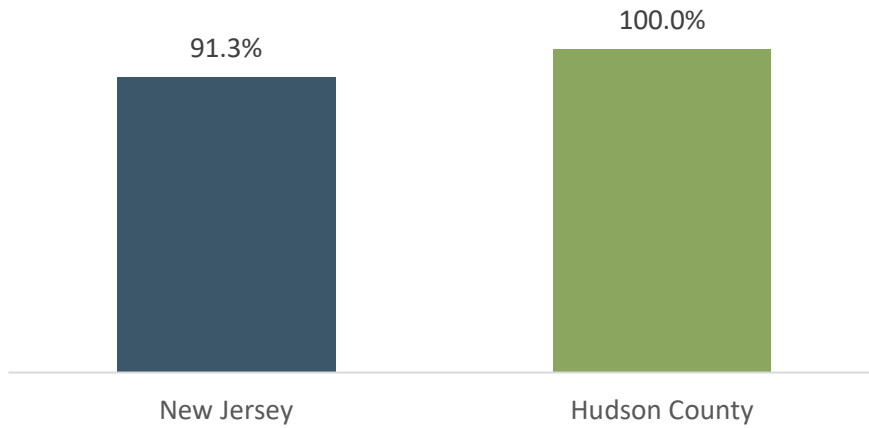
Figure 132. Population with Private Insurance, by State, County and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Healthy Living and Food Access

Figure 133. Population with Adequate Access to Location for Physical Activity, by State and County, 2010 and 2021



DATA SOURCE: ESRI & U.S. Census Tigerline Files, Business Analyst, Delorme map data, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2010 & 2021

Appendix G- Hospitalization Data

Figure 134. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

Year	Age	Count of Patients Treated & Released		Rate per 100,000 Population	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	0-17	690,506	51,760	334.4	394.6
	18-44	1,259,377	103,514	416.8	332.5
	45-64	757,159	57,306	302.2	351.9
	65+	450,704	26,472	320.4	335.2
	All Ages	3,157,746	239,052	350.9	349.3
2018	0-17	673,100	55,046	343.2	384.5
	18-44	1,217,047	106,138	394.5	355.1
	45-64	748,821	60,686	301.1	371.5
	65+	463,456	29,233	322.9	363.9
	All Ages	3,102,424	251,103	345.9	366.2
2019	0-17	658,207	54,165	334.6	367.6
	18-44	1,219,299	105,103	392.2	343.3
	45-64	760,293	61,161	305.8	371.2
	65+	489,485	30,209	330.6	363.8
	All Ages	3,127,284	250,638	345.8	357.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 135. Emergency Room Treat & Release Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	142,919	69.2
	18-44	242,892	80.4
	45-64	139,427	55.6
	65+	82,129	58.4
	All Ages	607,367	67.5
2018	0-17	145,643	74.3
	18-44	239,710	77.7
	45-64	139,051	55.9
	65+	82,293	57.3
	All Ages	606,697	67.6
2019	0-17	142,215	72.3
	18-44	238,051	76.6
	45-64	141,147	56.8
	65+	88,005	59.0
	All Ages	609,418	67.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 136. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Hudson County Resident Patients Treated at Jersey City Medical Center by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	14,408	109.8
	18-44	31,198	100.2
	45-64	16,790	103.1
	65+	6,004	76.0
	All Ages	68,400	100.0
2018	0-17	17,482	122.1
	18-44	34,556	115.6
	45-64	19,045	116.6
	65+	7,220	89.9
	All Ages	78,303	114.2
2019	0-17	17,702	120.1
	18-44	33,980	111.0
	45-64	19,291	117.1
	65+	7,159	86.2
	All Ages	78,132	111.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 137. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	22,166	379.0
	18-44	48,947	400.8
	45-64	24,888	404.2
	65+	9,897	351.7
	All Ages	105,898	391.8
2018	0-17	23,229	398.0
	18-44	48,661	399.7
	45-64	25,856	419.4
	65+	10,520	366.9
	All Ages	108,266	400.3
2019	0-17	22,870	380.0
	18-44	47,095	375.8
	45-64	26,442	424.4
	65+	10,618	356.2
	All Ages	107,025	385.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 138. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	12,194	208.5
	18-44	26,549	217.4
	45-64	13,755	223.4
	65+	5,201	184.8
	All Ages	57,699	213.4
2018	0-17	13,137	225.1
	18-44	26,700	219.3
	45-64	14,305	232.1
	65+	5,740	200.2
	All Ages	59,882	221.4
2019	0-17	13,196	219.3
	18-44	26,026	207.7
	45-64	14,642	235.0
	65+	5,733	192.3
	All Ages	59,597	214.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 139. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count		Rate per 100,000 Population	
		New Jersey Residents	Hudson County	New Jersey Residents	Hudson County
2017	American Indian or Alaska Native	6,530	498	201.1	111.9
	Asian	80,692	9,697	92.2	92.8
	Black or African American	780,645	48,599	628.0	555.3
	Hawaiian & Pacific Islander	3,949	343	985.5	864.0
	Other Race	610,721	90,795	935.3	902.1
	Two or More Races	11,014	286	38.6	8.8
	White	1,563,896	88,834	264.8	250.8
	All Race/Ethnicities	3,057,447	239,052	340.0	-
2018	American Indian or Alaska Native	6,035	467	185.4	105.2
	Asian	80,655	9,231	90.3	85.7
	Black or African American	755,704	50,013	608.9	574.7
	Hawaiian & Pacific Islander	8,405	305	2,031.7	734.9
	Other Race	633,209	97,951	961.3	977.2
	Two or More Races	11,395	303	39.5	9.3
	White	1,509,245	92,833	258.0	262.7
	All Race/Ethnicities	3,004,648	251,103	335.0	-
2019	American Indian or Alaska Native	5,360	417	164.0	92.8
	Asian	81,556	9,822	89.8	87.4
	Black or African American	754,534	47,955	600.1	549.6
	Hawaiian & Pacific Islander	4,203	280	1,005.3	689.7
	Other Race	683,104	107,983	1,012.6	1,049.7
	Two or More Races	11,025	406	37.5	12.2
	White	1,486,019	83,775	253.0	232.3
	All Race/Ethnicities	3,025,801	250,638	334.6	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 140. Emergency Room Treat & Release Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000
2017	American Indian or Alaska Native	608	18.7
	Asian	17,289	19.8
	Black or African American	197,472	158.9
	Hawaiian & Pacific Islander	577	144.0
	Other Race	147,525	225.9
	Two or More Races	1,571	5.5
	White	227,264	38.5
	All Race/Ethnicities	592,306	-
2018	American Indian or Alaska Native	548	16.8
	Asian	17,617	19.7
	Black or African American	198,391	159.8
	Hawaiian & Pacific Islander	474	114.6
	Other Race	153,992	233.8
	Two or More Races	1,745	6.0
	White	219,439	37.5
	All Race/Ethnicities	592,206	-
2019	American Indian or Alaska Native	593	18.1
	Asian	18,706	20.6
	Black or African American	195,413	155.4
	Hawaiian & Pacific Islander	480	114.8
	Other Race	162,149	240.4
	Two or More Races	1,946	6.6
	White	215,469	36.7
	All Race/Ethnicities	594,756	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 141. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	177	133.9
	Asian	6,648	93.5
	Black or African American	40,238	621.5
	Hawaiian & Pacific Islander	83	477.0
	Other Race	36,029	1,040.2
	Two or More Races	122	9.1
	White	22,601	266.2
	All Race/Ethnicities	105,898	391.8
2018	American Indian or Alaska Native	152	116.3
	Asian	6,441	88.6
	Black or African American	40,906	638.5
	Hawaiian & Pacific Islander	100	502.5
	Other Race	38,693	1,135.2
	Two or More Races	93	7.0
	White	21,881	258.2
	All Race/Ethnicities	108,266	400.3
2019	American Indian or Alaska Native	144	110.5
	Asian	6,844	90.3
	Black or African American	39,118	611.3
	Hawaiian & Pacific Islander	87	467.7
	Other Race	40,136	1,147.5
	Two or More Races	148	10.8
	White	20,548	234.5
	All Race/Ethnicities	107,025	385.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 142. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	64	48.4
	Asian	4,227	59.5
	Black or African American	27,453	424
	Hawaiian & Pacific Islander	16	92
	Other Race	11,071	319.6
	Two or More Races	93	6.9
	White	14,775	174
	All Race/Ethnicities	57,699	213.4
2018	American Indian or Alaska Native	61	46.7
	Asian	4,036	55.5
	Black or African American	28,045	437.7
	Hawaiian & Pacific Islander	14	70.4
	Other Race	13,822	405.5
	Two or More Races	78	5.8
	White	13,826	163.2
	All Race/Ethnicities	59,882	221.4
2019	American Indian or Alaska Native	61	46.8
	Asian	4,290	56.6
	Black or African American	26,718	417.5
	Hawaiian & Pacific Islander	21	112.9
	Other Race	15,321	438
	Two or More Races	100	7.3
	White	13,086	149.3
	All Race/Ethnicities	59,597	214.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 143. Emergency Room Treat & Release Counts and Rates for Behavioral Health per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

Year	Age	Count		Rate per 1,000	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	0-17	24,837	1,732	12.0	13.2
	18-44	91,990	8,601	30.4	27.6
	45-64	55,496	6,315	22.1	38.8
	65+	10,688	1,105	7.6	14.0
	All Ages	183,011	17,753	20.3	25.9
2018	0-17	26,241	1,965	13.4	13.7
	18-44	90,808	9,026	29.4	30.2
	45-64	55,715	6,442	22.4	39.4
	65+	11,055	1,177	7.7	14.7
	All Ages	183,819	18,610	20.5	27.1
2019	0-17	25,172	2,027	12.8	13.8
	18-44	90,172	9,340	29.0	30.5
	45-64	54,046	6,489	21.7	39.4
	65+	11,851	1,149	8.0	13.8
	All Ages	181,241	19,005	20.0	27.1

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 144. Emergency Room Treat & Release Counts and Rates for Behavioral Health per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Race, 2017-2019

Year	Race/Ethnicity	Count		Rate per 1,000	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	American Indian or Alaska Native	334	32	10.3	7.2
	Asian	3,380	401	3.9	3.8
	Black or African American	44,153	3,965	35.5	45.3
	Hawaiian & Pacific Islander	187	14	46.7	35.3
	Other Race	22,769	5,104	34.9	50.7
	Two or More Races	490	9	1.7	0.3
	White	106,929	7,802	18.1	22.0
	All Race/Ethnicities	178,242	17,327	19.8	25.3
2018	American Indian or Alaska Native	350	18	10.8	4.1
	Asian	3,497	401	3.9	3.7
	Black or African American	44,282	4111	35.7	47.2
	Hawaiian & Pacific Islander	187	14	45.2	33.7
	Other Race	24,682	5832	37.5	58.2
	Two or More Races	651	8	2.3	0.2
	White	104,601	7,738	17.9	21.9
	All Race/Ethnicities	178,250	18,122	19.9	26.4
2019	American Indian or Alaska Native	322	29	9.8	6.5
	Asian	3,466	397	3.8	3.5
	Black or African American	43,789	4,140	34.8	47.4
	Hawaiian & Pacific Islander	187	14	44.7	34.5
	Other Race	27,076	6,749	40.1	65.6
	Two or More Races	609	19	2.1	0.6
	White	99,593	6,999	17.0	19.4
	All Race/Ethnicities	175,042	18,347	19.4	26.2

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 145. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

Year	Age	Count		Rate per 1,000 Population	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	0-17	131,591	11,463	63.7	87.4
	18-44	231,158	18,870	76.5	60.6
	45-64	226,349	15,103	90.3	92.7
	65+	363,285	20,289	258.2	256.9
	All Ages	952,383	65,725	105.8	96.0
2018	0-17	130,739	11,682	66.7	81.6
	18-44	225,360	18,841	73.0	63.0
	45-64	221,118	15,200	88.9	93.0
	65+	364,459	20,160	254.0	251.0
	All Ages	941,676	65,883	105.0	96.1
2019	0-17	127,024	10,929	64.6	74.2
	18-44	218,270	17,589	70.2	57.5
	45-64	215,320	14,098	86.6	85.6
	65+	368,288	19,428	248.7	234.0
	All Ages	928,902	62,044	102.7	88.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 146. Inpatient Discharge Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	32,923	15.9
	18-44	50,878	16.8
	45-64	44,240	17.7
	65+	68,104	48.4
	All Ages	196,145	21.8
2018	0-17	32,768	16.7
	18-44	49,365	16.0
	45-64	43,076	17.3
	65+	67,477	47.0
	All Ages	192,686	21.5
2019	0-17	32,107	16.3
	18-44	48,316	15.5
	45-64	41,662	16.8
	65+	67,539	45.6
	All Ages	189,624	21.0

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 147. Inpatient Discharge Counts and Rates per 1,000 Population of Hudson County Resident Patients Treated at Jersey City Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	2,291	17.5
	18-44	4,906	15.8
	45-64	4,219	25.9
	65+	3,898	49.4
	All Ages	15,314	22.4
2018	0-17	2,142	15.0
	18-44	4,571	15.3
	45-64	3,851	23.6
	65+	3,853	48.0
	All Ages	14,417	21.0
2019	0-17	2,043	13.9
	18-44	4,307	14.1
	45-64	3,619	22.0
	65+	3,771	45.4
	All Ages	13,740	19.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 148. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	4,801	82.1
	18-44	8,409	68.9
	45-64	6,755	109.7
	65+	7,134	253.5
	All Ages	27,099	100.2
2018	0-17	4,821	82.6
	18-44	8,380	68.8
	45-64	6,592	106.9
	65+	7,106	247.8
	All Ages	26,899	99.5
2019	0-17	4,583	76.1
	18-44	7,729	61.7
	45-64	6,186	99.3
	65+	6,918	232.1
	All Ages	25,416	91.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 149. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	1,885	32.2
	18-44	3,916	32.1
	45-64	3,468	56.3
	65+	3,336	118.5
	All Ages	12,605	46.6
2018	0-17	1,750	30
	18-44	3,571	29.3
	45-64	3,095	50.2
	65+	3,277	114.3
	All Ages	11,693	43.2
2019	0-17	1,620	26.9
	18-44	3,330	26.6
	45-64	2,861	45.9
	65+	3,211	107.7
	All Ages	11,022	39.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 150. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count		Rate per 1,000 Population	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	American Indian or Alaska Native	1913	153	58.9	34.4
	Asian	40,158	4,789	45.9	45.9
	Black or African American	164,073	10,493	132.0	119.9
	Hawaiian & Pacific Islander	1438	182	358.9	458.40
	Other Race	135,193	21,802	207.0	216.60
	Two or More Races	1733	62	6.1	1.9
	White	607,875	28,244	102.9	79.7
	All Race/Ethnicities	952,383	65,725	268.3	-
2018	American Indian or Alaska Native	1689	165	51.9	37.2
	Asian	40,286	5,021	45.1	46.6
	Black or African American	160,752	9,925	129.5	114
	Hawaiian & Pacific Islander	2146	121	518.7	291.60
	Other Race	146,436	23,138	222.3	230.8
	Two or More Races	1929	52	6.7	1.6
	White	588,438	27,461	100.6	77.7
	All Race/Ethnicities	941,676	65,883	267.7	-
2019	American Indian or Alaska Native	1559	171	47.7	38.1
	Asian	38,291	4,602	42.2	41
	Black or African American	156,678	9,286	124.6	106.4
	Hawaiian & Pacific Islander	1442	94	344.9	231.5
	Other Race	152,844	23,016	226.6	223.7
	Two or More Races	1767	79	6.0	2.4
	White	576,321	24,796	98.1	68.8
	All Race/Ethnicities	928,902	62,044	262.7	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System 2021

Figure 151. Inpatient Discharge Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rater per 1,000
2017	American Indian or Alaska Native	207	6.4
	Asian	8,753	10.0
	Black or African American	45,498	36.6
	Hawaiian & Pacific Islander	188	46.9
	Other Race	33,999	52.1
	Two or More Races	255	0.9
	White	107,245	18.2
	All Race/Ethnicities	196,145	55.2
2018	American Indian or Alaska Native	181	5.6
	Asian	8,850	9.9
	Black or African American	45,635	36.8
	Hawaiian & Pacific Islander	199	48.1
	Other Race	34,880	53.0
	Two or More Races	250	0.9
	White	102,691	17.6
	All Race/Ethnicities	192,686	54.8
2019	American Indian or Alaska Native	244	7.5
	Asian	8,642	9.5
	Black or African American	44,186	35.1
	Hawaiian & Pacific Islander	200	47.8
	Other Race	34,415	51.0
	Two or More Races	339	1.2
	White	101,598	17.3
	All Race/Ethnicities	189,624	53.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 152. Inpatient Discharge Counts and Rates per 1,000 Population of Hudson County Resident Patients Treated at Jersey City Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	26	5.8
	Asian	1,523	14.6
	Black or African American	5,454	62.3
	Hawaiian & Pacific Islander	-	20.2
	Other Race	3,325	33.0
	Two or More Races	11	0.3
	White	4,967	14.0
	All Race/Ethnicities	15,314	-
2018	American Indian or Alaska Native	15	3.4
	Asian	1,468	13.6
	Black or African American	4,872	56.0
	Hawaiian & Pacific Islander	-	14.5
	Other Race	3,738	37.3
	Two or More Races	10	0.3
	White	4,308	12.2
	All Race/Ethnicities	14,417	-
2019	American Indian or Alaska Native	25	5.6
	Asian	1,433	12.8
	Black or African American	4,498	51.5
	Hawaiian & Pacific Islander	-	14.8
	Other Race	3,938	38.3
	Two or More Races	14	0.4
	White	3,826	10.6
	All Race/Ethnicities	13,740	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 153. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	69	52.2
	Asian	2,997	42.2
	Black or African American	8,650	133.6
	Hawaiian & Pacific Islander	53	304.6
	Other Race	8,180	236.2
	Two or More Races	17	1.3
	White	7,133	84.0
	All Race/Ethnicities	27,099	100.2
2018	American Indian or Alaska Native	66	50.5
	Asian	3,218	44.3
	Black or African American	8,172	127.6
	Hawaiian & Pacific Islander	53	266.3
	Other Race	8,809	258.4
	Two or More Races	22	1.6
	White	6,559	77.4
	All Race/Ethnicities	26,899	99.5
2019	American Indian or Alaska Native	78	59.9
	Asian	2,948	38.9
	Black or African American	7,667	119.8
	Hawaiian & Pacific Islander	41	220.4
	Other Race	8,612	246.2
	Two or More Races	25	1.8
	White	6,045	69.0
	All Race/Ethnicities	25,416	91.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 154. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	24	18.2
	Asian	1,375	19.3
	Black or African American	5,162	79.7
	Hawaiian & Pacific Islander	-	40.2
	Other Race	2,543	73.4
	Two or More Races	-	0.4
	White	3,488	41.1
	All Race/Ethnicities	12,605	46.6
2018	American Indian or Alaska Native	15	11.5
	Asian	1,320	18.2
	Black or African American	4,574	71.4
	Hawaiian & Pacific Islander	-	25.1
	Other Race	2,874	84.3
	Two or More Races	-	0.7
	White	2,896	34.2
	All Race/Ethnicities	11,693	43.2
2019	American Indian or Alaska Native	23	17.7
	Asian	1,288	17
	Black or African American	4,256	66.5
	Hawaiian & Pacific Islander	-	32.3
	Other Race	2,908	83.1
	Two or More Races	-	0.6
	White	2,533	28.9
	All Race/Ethnicities	11,022	39.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 155. Hospital Admission Rates per 1,000 Population, by Race/Ethnicity, New Jersey and Jersey City Medical Center, 2019

		Admission Rate per 1,000			
		Total Overall	Acute	Chronic	Diabetic
New Jersey	Asian	2.6	0.8	1.8	0.4
	Black	16.7	3.0	13.7	4.1
	Hispanic	5.4	1.4	4.0	1.5
	White	9.6	2.9	6.7	1.5
	All Race/Ethnicities	10.4	2.8	7.7	2.0
Jersey City Medical Center	Asian	3.2	1.0	2.2	0.6
	Black	17.8	3.0	14.8	4.6
	Hispanic	4.8	1.2	3.6	1.3
	White	6.3	1.5	4.8	1.3
	All Race/Ethnicities	10.5	2.2	8.2	2.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 156. Hospital Admission Rates per 1,000 Population by Reason for Admission, by Race/Ethnicity, New Jersey and Jersey City Medical Center, 2019

		Admission Rate per 1,000			
		Total Overall	Cardiac	Mental Health	Substance Use
New Jersey	Asian	5.2	3.9	1.0	0.3
	Black	26.1	16.6	6.7	2.7
	Hispanic	10.3	6.2	2.6	1.5
	White	17.2	12.2	3.2	1.9
	All Race/Ethnicities	18.6	12.5	4.0	2.1
Jersey City Medical Center	Asian	28.4	3.9	0.9	0.4
	Black	105.5	17.6	8.2	3.9
	Hispanic	43.9	5.3	2.5	1.3
	White	44.0	6.1	4.0	2.5
	All Race/Ethnicities	76.2	10.8	5.4	2.9

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 157. Hospital Admission and Emergency Department Visit Rates per 1,000 Population, by Age and Race/Ethnicity, New Jersey and Jersey City Medical Center, 2019

	Admission Rate per 1,000 Population						Emergency Department Visits per 1,000 Population				
	Age	Asian	Black	Hispanic	White	All Race/Ethnicities	Asian	Black	Hispanic	White	All Race/Ethnicities
New Jersey	All	5.2	26.1	10.3	17.2	18.6	108.8	682.4	430.2	271.2	403
	Under 18	0.4	1.9	1.4	1.1	1.6	99.8	477.1	497.4	181.7	344
	18 to 64	3.5	26.5	9.3	12	15	91.4	760.5	392.4	248	396.6
	65+	25.3	73.3	46.6	48.7	54.8	233.8	698.1	548.2	428.5	505.8
Jersey City Medical Center	All	28.4	105.5	43.9	44.0	76.2	109.4	690.3	282.4	173.4	447.0
	Under 18	3.9	16.4	10.4	5.5	14.2	100.5	433.6	260.8	113.6	390.2
	18 to 64	24.4	111.4	43.5	34.9	72.6	93.9	791.9	274.1	169.3	447.6
	65+	113.2	275.2	136.4	135.4	223.6	258.6	697.2	402.7	267.2	558.1

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 158. Inpatient Discharge Counts and Rates per 1,000 Diagnosed with Mental Diseases and Disorders & Alcohol/Drug Use or Induced Mental Disorder Treated in New Jersey, by County of Residence, 2017-2019

Year	Count		Rate per 1,000 Population	
	New Jersey	Hudson County	New Jersey	Hudson County
2017	73,005	5,658	8.1	8.3
2018	69,282	5,643	7.7	8.2
2019	65,610	5,439	7.3	7.8

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 159. Inpatient Discharge Counts and Rates per 1,000 Diagnosed with Diseases and Disorders of the Circulatory System Treated in New Jersey, by County of Residence, 2017-2019

Year	Count		Rate per 1,000 Population	
	New Jersey	Hudson County	New Jersey	Mercer County
2017	126,968	7,598	14.1	11.1
2018	125,886	7,521	14.0	11
2019	126,198	7,411	14.0	10.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 160. Inpatient Discharge Counts and Rates per 1,000, Residents of Hudson County Treated at Jersey City Medical Center, by Major Diagnostic Category, 2017-2019

Major Diagnostic Category	Count			Rate per 1,000 Population		
	2017	2018	2019	2017	2018	2019
Mental Diseases and Disorders & Alcohol/Drug Use or Induced Mental Disorder	1,302	1,313	1,237	1.9	1.9	1.8
Diseases and Disorders of the Circulatory System	1,990	1,826	1,858	2.9	2.7	2.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Appendix H- Cancer Data

Table 26. CANCER INCIDENCE RATE REPORT: CANCER PATIENT ORIGIN - HUDSON COUNTY 2020

Almost eighty percent of JCMC’s cancer inpatients and 65.8% of cancer outpatients resided in the Primary Service Area. In total, 91.1% of inpatients and 88.7% of outpatients resided in Hudson County. Jersey City (07305 and 07304) represent the largest segment of JCMC’s inpatient cancer patients. Similarly, Jersey City (07305 and 07306) represent the largest segments of JCMC’s outpatient cancer patients. The health factors and outcomes explored in the CHNA bear relevance to the oncology services and its review of specific cancer needs for the community.

CANCER PATIENT ORIGIN	2020 JCMC IP PATIENTS	%	2020 JCMC OP PATIENTS	%
Hudson County	1,000	91.1%	449	88.7%
Primary Service Area	800	72.9%	333	65.8%
Secondary Service Area	177	16.1%	82	16.2%
Out of Service Area (NJ)	103	9.4%	90	17.8%
Out of State	18	1.6%	1	0.2%
TOTAL	1,098	100.0%	506	100.0%
Jersey City (07305)	334	30.4%	115	22.7%
Jersey City (07304)	193	17.6%		
Jersey City (07306)			90	17.8%

Source; Decision Support; IP volume includes cases with ICD10 principal or secondary codes C00 thru D49.9 (Neoplasms); OP volume includes cases with ICD10 principal or secondary codes Z51.0 or Z51.11 (Chemo and Radiation Therapy).

Table 27. CANCER INCIDENCE RATE REPORT: HUDSON COUNTY 2013-2017

INCIDENCE RATE REPORT FOR HUDSON COUNTY 2013-2017				
Cancer Site	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trend
All Cancer Sites	403.5	2607	falling	-1.2
Bladder	17.6	108	falling	-1.6
Brain & ONS	5.7	38	*	*
Breast	111.1	389	stable	0.5
Cervix	9.4	33	falling	-2.2
Colon & Rectum	40.3	259	falling	-2.9
Esophagus	3.2	20	falling	-2.8
Kidney & Renal Pelvis	12.8	84	stable	0.5
Leukemia	11.5	72	stable	0
Liver & Bile Duct	8.7	57	rising	2.6
Lung & Bronchus	43.7	273	falling	-2.5
Melanoma of the Skin	8.2	53	stable	-0.7
Non-Hodgkin Lymphoma	17.1	110	stable	-0.4
Oral Cavity & Pharynx	8.3	55	stable	-1.3
Ovary	11.7	41	stable	-1.1
Pancreas	14	87	rising	2.1
Prostate	112.7	319	falling	-3.9
Stomach	9.5	60	falling	-1.7
Thyroid	15.1	107	stable	-0.1
Uterus (Corpus & Uterus, NOS)	26.8	98	stable	0.6

The source for D2 and following tables D3, D4, D5 and D6 is: <https://statecancerprofiles.cancer.gov>

Table 28. CANCER INCIDENCE DETAILED RATE REPORT: HUDSON COUNTY 2013-2017 SELECT CANCER SITES: RISING INCIDENCE RATES

		Liver & Bile Duct	Pancreas
INCIDENCE RATE REPORT FOR HUDSON COUNTY 2013-2017 All Races (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.7	14
	Average Annual Count	57	87
	Recent Trend	rising	rising
	Recent 5-Year Trend in Incidence Rates	2.6	2.1
White Non-Hispanic, All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.3	15
	Average Annual Count	19	34
	Recent Trend	stable	rising
	Recent 5-Year Trend in Incidence Rates	2.5	1.9
Black (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.2	15.8
	Average Annual Count	8	14
	Recent Trend	stable	stable
	Recent 5-Year Trend in Incidence Rates	2.1	2.9
Asian or Pacific Islander (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	6.1	9.4
	Average Annual Count	5	6
	Recent Trend	stable	stable
	Recent 5-Year Trend in Incidence Rates	-1.7	4.8
Hispanic (any race), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.8	12.3
	Average Annual Count	24	32
	Recent Trend	rising	stable
	Recent 5-Year Trend in Incidence Rates	3.1	2.2
MALES	Age-Adjusted Incidence Rate - cases per 100,000	14	15.1
	Average Annual Count	41	40
	Recent Trend	rising	rising
	Recent 5-Year Trend in Incidence Rates	2.5	2.4
FEMALES	Age-Adjusted Incidence Rate - cases per 100,000	4.5	13.2
	Average Annual Count	16	47
	Recent Trend	stable	rising
	Recent 5-Year Trend in Incidence Rates	2.4	1.9

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).

Table 29. APPENDIX D4: CANCER MORTALITY RATE REPORT: HUDSON COUNTY 2014-2018

MORTALITY RATE REPORT: HUDSON COUNTY 2014-2018					
Cancer Site	Met Healthy People Objective of ***?	Age-Adjusted Mortality Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trend in Mortality Rates
All Cancer Sites	***	129.4	819	falling	-2.5
Bladder	***	3.9	24	stable	0.5
Brain & ONS	***	2.7	18	*	*
Breast	***	18.2	66	falling	-2.4
Cervix	***	1.8	7	falling	-4.2
Colon & Rectum	***	14	89	falling	-3
Esophagus	***	2.9	19	falling	-2.3
Kidney & Renal Pelvis	***	2.8	18	stable	-0.9
Leukemia	***	4.1	26	falling	-2.4
Liver & Bile Duct	***	6	39	stable	0.5
Lung & Bronchus	***	26.8	168	falling	-3.1
Melanoma of the Skin	***	0.9	6	falling	-2.1
Non-Hodgkin Lymphoma	***	4.1	26	falling	-3.8
Oral Cavity & Pharynx	***	1.5	10	falling	-4
Ovary	***	5.7	21	falling	-2.1
Pancreas	***	10.8	67	rising	6
Prostate	***	15.7	37	falling	-3.8
Stomach	***	4.3	27	falling	-2.2
Thyroid	***	*	3 or fewer	*	*
Uterus (Corpus & Uterus, NOS)	***	6	22	stable	0.3

*** No Healthy People 2020 Objective for this cancer.

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area- sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).

Table 30. CANCER MORTALITY DETAILED RATE REPORT (Highest Volume): ESSEX COUNTY 2014-2018

		Liver & Bile Duct
MORTALITY RATE REPORT FOR ESSEX COUNTY 2014-2018 All Races (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	6.2
	Average Annual Count	55
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.2
White Non-Hispanic, All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	4.3
	Average Annual Count	16
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	0.3
Black (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	8.9
	Average Annual Count	31
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.8
Asian or Pacific Islander (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	*
	Average Annual Count	3 or fewer
	Recent Trend	*
	Recent 5-Year Trend in Death Rates	*
Hispanic (any race), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	5.1
	Average Annual Count	6
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	1.8
MALES	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	9.7
	Average Annual Count	37
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.2
FEMALES	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	3.7
	Average Annual Count	19
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	0.9

*** No Healthy People 2020 Objective for this cancer.

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).

Table 31. CANCER INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
All Cancer Sites: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	485.9	51,689	falling	-0.8
US (SEER+NPCR)	448.7	1,673,102	falling	-1
Cape May County	564.6	881	stable	-0.2
Salem County	554.1	462	stable	0
Gloucester County	541.6	1,853	stable	-0.2
Burlington County	527.8	2,956	falling	-0.4
Camden County	524.6	3,123	falling	-0.4
Monmouth County	523.2	4,160	stable	0.4
Ocean County	521.2	4,511	falling	-0.6
Cumberland County	512	895	stable	0.1
Sussex County	510.3	932	falling	-0.8
Warren County	506.4	706	falling	-0.8
Mercer County	503.9	2,138	falling	-0.6
Atlantic County	495.8	1,699	falling	-0.8
Morris County	487.9	3,030	falling	-0.9
Hunterdon County	475.1	794	stable	-0.4
Bergen County	472.4	5,571	falling	-1
Somerset County	463.3	1,827	falling	-0.8
Essex County	462.1	3,930	falling	-0.7
Middlesex County	460.8	4,293	falling	-0.9
Union County	453.7	2,802	falling	-1.2
Passaic County	451.6	2,510	falling	-0.8
Hudson County	403.5	2,607	falling	-1.2
Bladder: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	23.1	2,487	falling	-1.1
US (SEER+NPCR)	20	74,787	falling	-1.9
Cape May County	30.9	51	stable	-0.3
Warren County	27.2	39	stable	-0.4
Gloucester County	27.1	90	stable	0
Atlantic County	26.8	93	stable	-0.6
Salem County	26.5	23	stable	0.6
Burlington County	26.5	151	stable	-0.2
Sussex County	25.9	48	stable	0

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Hunterdon County	25.9	43	stable	0.5
Monmouth County	25.5	206	stable	-0.3
Camden County	25	148	stable	-0.8
Cumberland County	25	43	stable	-0.7
Morris County	24.2	152	falling	-1.5
Ocean County	23.9	231	falling	-2.2
Middlesex County	22.8	211	falling	-1
Bergen County	22.6	277	falling	-1.6
Passaic County	22.2	124	stable	-1
Mercer County	20.7	88	falling	-1.4
Union County	20.4	127	falling	-2
Somerset County	20.1	79	stable	-1.2
Essex County	18.4	154	falling	-1.4
Hudson County	17.6	108	falling	-1.6
Brain & ONS: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	6.8	673	*	*
US (SEER+NPCR)	6.5	22,781	*	*
Salem County	9.6	7	*	*
Warren County	9.1	12	*	*
Hunterdon County	8.6	12	*	*
Sussex County	7.9	13	*	*
Gloucester County	7.8	25	*	*
Burlington County	7.7	39	*	*
Ocean County	7.7	54	*	*
Mercer County	7.3	29	*	*
Bergen County	7.2	77	*	*
Morris County	7.2	40	*	*
Atlantic County	6.9	22	*	*
Cumberland County	6.9	11	*	*
Camden County	6.9	38	*	*
Middlesex County	6.8	60	*	*
Monmouth County	6.8	50	*	*
Passaic County	6.7	35	*	*
Somerset County	6.5	23	*	*
Cape May County	5.8	7	*	*
Hudson County	5.7	38	*	*
Union County	5.6	33	*	*

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Essex County	5.5	46	*	*
Breast: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	136.6	7,668	rising	0.5
US (SEER+NPCR)	125.9	244,411	rising	0.3
Morris County	148.1	480	stable	0
Burlington County	147	433	rising	1.3
Hunterdon County	146.2	129	stable	0.2
Monmouth County	146.2	616	stable	0.1
Gloucester County	144.3	267	stable	0.3
Somerset County	144.2	306	stable	0.1
Mercer County	141.9	316	stable	0.2
Camden County	141	450	stable	0.6
Bergen County	140.8	865	stable	0.5
Essex County	137.4	641	rising	1.9
Union County	136.7	454	stable	0
Cape May County	135.7	106	stable	-0.1
Sussex County	135.6	129	stable	-0.2
Ocean County	132.9	586	stable	-0.2
Atlantic County	131.4	238	stable	0.2
Salem County	130.6	56	stable	0.1
Middlesex County	129.7	639	stable	-0.1
Warren County	125.9	92	stable	-0.7
Passaic County	124.4	367	rising	1.1
Cumberland County	118.9	108	stable	0.6
Hudson County	111.1	389	stable	0.5
Cervix: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.7	382	falling	-1.9
US (SEER+NPCR)	7.6	12,833	stable	0.3
Cumberland County	15.3	11	stable	-1.4
Cape May County	11.7	5	stable	0.8
Salem County	10.6	3	*	*
Hudson County	9.4	33	falling	-2.2
Union County	9.3	29	stable	-0.3
Atlantic County	9.2	14	stable	-1.1
Essex County	9.2	40	falling	-3
Passaic County	8.6	23	stable	-2.1
Ocean County	8.2	27	stable	-1.5

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Camden County	8.1	23	falling	-2.7
Warren County	8	4	stable	-0.5
Somerset County	7.5	13	stable	4.7
Gloucester County	6.9	12	stable	-0.8
Middlesex County	6.9	32	stable	-1.5
Bergen County	6.8	36	stable	-0.9
Burlington County	6.4	16	stable	12.6
Morris County	6.3	18	stable	-1.1
Mercer County	6.2	12	falling	-3.9
Monmouth County	6.1	21	stable	-2.3
Sussex County	5.9	5	stable	-2.7
Hunterdon County	5.1	3	falling	-4
Colon & Rectum: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	40.8	4,342	falling	-1.6
US (SEER+NPCR)	38.4	142,225	falling	-1.4
Salem County	48.4	40	falling	-2.6
Cape May County	46.5	72	falling	-2.8
Cumberland County	46.3	80	falling	-2.5
Gloucester County	44.8	151	falling	-2.7
Burlington County	44.7	249	stable	-1
Ocean County	43.7	393	falling	-1.8
Camden County	43.7	256	falling	-2.9
Warren County	42.8	61	falling	-3
Sussex County	42.1	74	falling	-3.4
Essex County	42.1	354	stable	-0.1
Monmouth County	40.9	325	falling	-3.3
Atlantic County	40.4	138	falling	-3.6
Hudson County	40.3	259	falling	-2.9
Middlesex County	39.6	370	falling	-3
Passaic County	39.5	220	stable	-0.8
Union County	39.1	243	falling	-3.2
Bergen County	39	464	stable	1.1
Hunterdon County	37.7	62	falling	-2.6
Mercer County	37.3	158	falling	-3.3
Morris County	37.1	233	falling	-3.4
Somerset County	35.2	139	falling	-3.4

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Esophagus: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	4.3	469	falling	-1.3
US (SEER+NPCR)	4.5	17,419	falling	-1.1
Warren County	7	10	stable	-0.1
Gloucester County	6.4	23	rising	2.2
Cape May County	6.4	10	stable	1.4
Sussex County	6.1	12	stable	-1.1
Ocean County	5.7	52	stable	-0.7
Cumberland County	5.1	9	stable	-0.3
Camden County	5	31	stable	-0.8
Hunterdon County	4.7	8	stable	-1.8
Salem County	4.7	4	stable	-3.4
Morris County	4.6	30	stable	-0.4
Passaic County	4.5	25	stable	-0.3
Burlington County	4.4	25	stable	-0.9
Atlantic County	4.3	15	falling	-2.1
Monmouth County	4.3	36	falling	-2
Mercer County	4.2	18	falling	-2.8
Essex County	3.7	32	falling	-3
Union County	3.7	23	stable	-1.9
Middlesex County	3.6	34	falling	-2
Bergen County	3.2	39	falling	-1.4
Hudson County	3.2	20	falling	-2.8
Somerset County	3.2	13	stable	-1.6
Kidney & Renal Pelvis: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	16.3	1,736	rising	0.8
US (SEER+NPCR)	16.8	62,705	rising	0.6
Cumberland County	21	36	stable	-10.5
Burlington County	19.6	110	stable	1.3
Camden County	19.6	116	rising	2
Gloucester County	18.6	65	stable	0.4
Ocean County	17.8	147	rising	1.5
Mercer County	17.7	76	rising	2
Salem County	17.7	15	stable	0.2
Atlantic County	17.4	60	stable	0.2
Cape May County	17.3	26	stable	2.1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Monmouth County	16.7	133	rising	0.9
Warren County	16.5	22	stable	0.8
Bergen County	16.4	194	stable	0.5
Passaic County	15.8	88	stable	0.9
Morris County	15.7	98	stable	0.7
Middlesex County	15.7	146	stable	0
Sussex County	15.4	31	stable	-0.4
Union County	15	93	stable	0.2
Somerset County	14.6	58	stable	-0.1
Hunterdon County	13.8	23	stable	-0.7
Essex County	13.4	115	stable	0.6
Hudson County	12.8	84	stable	0.5
Leukemia: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	15.7	1,610	rising	0.8
US (SEER+NPCR)	14.2	51,227	falling	-2.1
Sussex County	19.4	32	rising	2.9
Monmouth County	17.4	134	rising	1.5
Gloucester County	17.4	58	stable	1.2
Ocean County	16.9	145	stable	0.6
Morris County	16.8	101	rising	1.2
Mercer County	16.6	68	rising	1.8
Cape May County	16.5	23	stable	-1.2
Burlington County	16.3	88	stable	0.9
Cumberland County	16.1	28	rising	1.7
Warren County	16	21	stable	0.4
Union County	15.7	93	stable	1
Bergen County	15.6	182	stable	1.3
Passaic County	15.6	83	stable	1
Somerset County	15.4	57	stable	-0.5
Middlesex County	15.4	139	stable	0.3
Camden County	15.3	88	stable	0.4
Hunterdon County	14.7	23	stable	-0.8
Essex County	14.2	117	stable	0.5
Atlantic County	13.7	45	stable	-0.2
Salem County	13.7	10	stable	-1.1
Hudson County	11.5	72	stable	0

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Liver & Bile Duct: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.8	869	rising	2.1
US (SEER+NPCR)	8.4	33,355	stable	0.4
Cumberland County	10.5	19	rising	4.8
Cape May County	9.9	17	stable	4
Camden County	9.4	60	rising	2.4
Atlantic County	9.1	32	stable	2.1
Hudson County	8.7	57	rising	2.6
Gloucester County	8.6	30	rising	2.1
Mercer County	8.4	37	stable	1.8
Ocean County	8.3	75	rising	3.2
Salem County	8.3	7	stable	-15.4
Passaic County	8.2	47	stable	1.1
Essex County	7.9	71	stable	0.8
Middlesex County	7.9	76	rising	2.5
Burlington County	7.7	45	rising	2.4
Monmouth County	7.6	64	rising	2.4
Bergen County	7.1	89	stable	1.1
Warren County	6.7	10	stable	1.9
Sussex County	6.7	13	stable	1.5
Morris County	6.6	43	rising	2.2
Union County	6.3	40	rising	1.8
Somerset County	6	25	stable	1.6
Hunterdon County	5.4	10	rising	3
Lung & Bronchus: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	55.3	5,950	falling	-1.6
US (SEER+NPCR)	58.3	221,568	falling	-2
Salem County	85.4	73	rising	2.5
Cape May County	76.3	130	stable	-0.8
Gloucester County	74.6	252	falling	-1.2
Ocean County	70.8	672	falling	-1.1
Cumberland County	69.2	123	falling	-0.8
Camden County	67.2	404	falling	-1.4
Atlantic County	64.7	226	falling	-1.9
Warren County	63.8	91	stable	-1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Sussex County	62.5	114	falling	-1.3
Burlington County	61.8	350	falling	-1
Monmouth County	59.7	482	falling	-1.5
Mercer County	56.7	242	falling	-1.5
Middlesex County	49.7	459	falling	-2.1
Bergen County	49.4	598	falling	-1.7
Hunterdon County	48.6	81	stable	-1.2
Morris County	47.7	300	falling	-2
Essex County	46.9	393	falling	-2.4
Passaic County	44.8	250	falling	-5.8
Somerset County	44	173	falling	-1.8
Hudson County	43.7	273	falling	-2.5
Union County	43.1	262	falling	-2.2
Melanoma of the Skin: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	22.2	2,335	stable	0.5
US (SEER+NPCR)	22.3	81,226	rising	1.8
Cape May County	51.3	77	rising	3.3
Hunterdon County	39.8	65	stable	1.9
Ocean County	34	283	stable	0.2
Salem County	32.4	26	stable	-16.8
Monmouth County	32.1	249	rising	1.6
Sussex County	31.9	56	rising	3.1
Gloucester County	27.2	91	stable	0.7
Atlantic County	27.1	92	rising	1.6
Morris County	26.7	164	stable	0.2
Burlington County	26.4	146	stable	0.5
Warren County	25.7	34	stable	0.1
Somerset County	24.4	97	stable	0.2
Camden County	21.7	128	stable	0.3
Mercer County	21.1	88	stable	0.4
Middlesex County	18.1	167	stable	1
Bergen County	18	212	falling	-1.3
Cumberland County	16.4	28	stable	1.3
Union County	15.7	97	stable	0.2
Passaic County	14.3	77	stable	0.2
Essex County	12.2	103	stable	-0.1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Hudson County	8.2	53	stable	-0.7
Non-Hodgkin Lymphoma: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	21.8	2,272	stable	0
US (SEER+NPCR)	19.3	70,661	falling	-1.5
Warren County	24.9	34	stable	-0.2
Monmouth County	24.3	188	stable	0
Morris County	23.7	145	stable	-0.3
Somerset County	23.7	92	stable	0.3
Sussex County	23.5	41	stable	-0.5
Atlantic County	23.2	78	stable	0
Bergen County	23.1	268	stable	0.1
Mercer County	22.6	94	stable	0
Ocean County	22.5	196	stable	0.4
Gloucester County	22.1	73	rising	0.9
Middlesex County	22.1	202	stable	-0.1
Cumberland County	22	37	stable	-0.1
Union County	21.1	129	stable	-6.5
Burlington County	21.1	117	stable	-0.5
Salem County	20.8	17	stable	-0.5
Hunterdon County	20.6	35	stable	-0.3
Camden County	20.6	122	stable	-0.4
Passaic County	20.4	109	stable	0.4
Essex County	18.4	153	stable	-0.7
Cape May County	18.3	29	stable	-0.3
Hudson County	17.1	110	stable	-0.4
Oral Cavity & Pharynx: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	11.1	1,204	rising	0.8
US (SEER+NPCR)	11.8	45,129	stable	0
Salem County	16.1	14	stable	1.2
Cape May County	14.6	23	stable	0.2
Atlantic County	14.4	51	rising	1.5
Cumberland County	14	25	rising	2.3
Monmouth County	12.9	105	rising	1
Ocean County	12.8	108	rising	1.7
Sussex County	12.7	25	stable	1.7

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Camden County	12.2	75	stable	1.2
Warren County	11.7	17	stable	2.1
Gloucester County	11.5	41	stable	0.8
Hunterdon County	11.4	21	stable	1.9
Morris County	11.4	74	rising	1.7
Burlington County	11.2	65	stable	1.3
Middlesex County	10.7	100	rising	1.6
Essex County	10.7	92	rising	8.2
Somerset County	10.5	43	stable	0.4
Passaic County	10.1	57	stable	-0.2
Bergen County	9.5	115	stable	-0.1
Mercer County	9.4	42	falling	-1.2
Union County	9	57	stable	-0.1
Hudson County	8.3	55	stable	-1.3
Ovary: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	11.8	679	falling	-2.1
US (SEER+NPCR)	10.9	21,338	falling	-3.1
Cape May County	17.1	13	stable	0.2
Somerset County	13.6	29	falling	-2.1
Camden County	13.4	42	falling	-1.6
Mercer County	13.2	30	stable	-0.9
Burlington County	12.8	39	stable	-0.9
Warren County	12.5	9	stable	0.2
Atlantic County	12.3	22	falling	-2.7
Gloucester County	12.3	23	falling	-2.9
Ocean County	12	55	stable	-1.1
Hunterdon County	11.9	11	falling	-2.7
Middlesex County	11.8	59	falling	-2.1
Hudson County	11.7	41	stable	-1.1
Morris County	11.4	38	falling	-2.5
Bergen County	11.3	72	falling	-3.9
Essex County	11.3	54	falling	-1.8
Passaic County	11.2	34	falling	-2.7
Monmouth County	11	48	falling	-2.2
Union County	10.6	36	falling	-2.4
Cumberland County	10.4	9	stable	15.6
Sussex County	10.2	10	falling	-3.3

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Salem County	9.3	4	stable	-2.1
Pancreas: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	14.4	1,556	rising	1.1
US (SEER+NPCR)	12.9	48,832	rising	0.8
Warren County	17	24	stable	1.8
Mercer County	16.1	69	rising	2.3
Salem County	15.9	14	stable	1.5
Burlington County	15.9	91	rising	2
Ocean County	15.7	148	rising	1.5
Hunterdon County	15.4	27	rising	2.2
Camden County	15.1	91	rising	1.1
Gloucester County	14.7	50	stable	0.8
Cape May County	14.7	25	stable	0.4
Monmouth County	14.5	121	rising	1.3
Essex County	14.2	120	stable	0.7
Atlantic County	14.2	50	stable	1.3
Bergen County	14.1	171	stable	0.3
Morris County	14	90	rising	1.3
Hudson County	14	87	rising	2.1
Passaic County	13.5	76	stable	0
Sussex County	13.5	25	stable	2.3
Cumberland County	13.4	24	stable	0.6
Union County	13.4	82	stable	0.5
Middlesex County	12.9	121	stable	0.8
Somerset County	12.8	51	stable	1.1
Prostate: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	131.3	6,723	falling	-2.9
US (SEER+NPCR)	104.5	192,918	stable	-0.4
Essex County	153.1	593	falling	-3.2
Cape May County	152.9	122	falling	-1.9
Mercer County	148.1	300	falling	-2.3
Burlington County	147.9	407	falling	-3.1
Camden County	142.3	405	falling	-1.8
Gloucester County	140.7	236	falling	-1.8
Monmouth County	139.3	549	falling	-2.2
Salem County	139.3	58	stable	-1.7
Passaic County	136.2	359	falling	-2.5

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Union County	134.6	390	falling	-3.7
Cumberland County	129.8	109	stable	-0.6
Bergen County	128.6	729	falling	-3.3
Morris County	127.6	392	falling	-3.3
Middlesex County	124.1	555	stable	1.2
Somerset County	122	232	falling	-2.9
Warren County	120	85	falling	-3.5
Sussex County	119.2	117	falling	-4.3
Atlantic County	117.7	203	falling	-2.5
Hudson County	112.7	319	falling	-3.9
Ocean County	112.1	466	falling	-3.6
Hunterdon County	108	94	rising	9.1
Stomach: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.9	847	falling	-1.1
US (SEER+NPCR)	6.5	24,190	falling	-1.1
Passaic County	10.4	58	stable	-0.2
Union County	9.7	59	stable	-0.8
Hudson County	9.5	60	falling	-1.7
Essex County	9	76	falling	-2
Cumberland County	8.8	15	stable	-2
Camden County	8.7	51	stable	0.3
Bergen County	8.6	104	stable	-0.9
Mercer County	8.1	34	stable	-0.5
Atlantic County	7.7	26	stable	-1
Middlesex County	7.5	70	falling	-2.5
Sussex County	7.5	14	stable	0.3
Burlington County	7	40	stable	-0.4
Ocean County	7	62	stable	-0.7
Somerset County	7	28	falling	-1.8
Gloucester County	6.7	23	stable	-0.9
Monmouth County	6.7	56	falling	-1.5
Morris County	6.4	41	falling	-1.7
Salem County	5.9	5	stable	0
Hunterdon County	5.7	9	stable	-0.1
Warren County	5.6	8	stable	0.7
Cape May County	5.1	8	stable	-1.6
Thyroid: All Races (includes Hispanic), Both Sexes, All Ages				

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
New Jersey	19.3	1,840	stable	-0.3
US (SEER+NPCR)	14.3	48,211	falling	-2.2
Monmouth County	26.8	182	stable	1.4
Gloucester County	24.4	76	rising	4
Mercer County	24.1	96	rising	4
Ocean County	24	147	rising	5.4
Camden County	22	118	rising	2.7
Burlington County	20.8	102	rising	2.4
Bergen County	20.3	207	stable	0.3
Salem County	20.2	13	rising	4
Somerset County	19.8	71	falling	-12.1
Middlesex County	19.2	169	stable	-0.9
Morris County	19.1	102	stable	-3.9
Sussex County	18	29	rising	3.9
Warren County	17	20	stable	1.6
Atlantic County	16.9	48	stable	0.9
Passaic County	16.2	85	stable	-7.6
Cape May County	16	17	rising	2.4
Union County	15.8	92	falling	-8.9
Hudson County	15.1	107	stable	-0.1
Cumberland County	14.6	24	stable	0.5
Hunterdon County	14.4	20	rising	3.6
Essex County	13.7	113	rising	4.3
Uterus (Corpus & Uterus, NOS): All Races (includes Hispanic), BothSexes, All Ages				
New Jersey	31.9	1,913	rising	0.8
US (SEER+NPCR)	27	55,004	rising	1.2
Warren County	39.3	30	stable	1.2
Cumberland County	39.1	37	rising	1.9
Cape May County	38.2	32	rising	3.1
Sussex County	36.3	38	stable	0.9
Camden County	35.3	119	rising	2.1
Mercer County	34.3	82	rising	1.6
Hunterdon County	34.3	31	stable	-1
Gloucester County	33.7	66	stable	1.2
Salem County	33.7	16	stable	1.1
Essex County	33.5	165	rising	1.7

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Morris County	32.8	115	stable	0.3
Atlantic County	32.4	61	stable	1.2
Somerset County	32.4	73	stable	0.4
Burlington County	32.2	101	stable	1
Middlesex County	32	168	stable	0.5
Ocean County	31.5	150	stable	0.2
Monmouth County	30.8	140	stable	-0.2
Bergen County	29.9	198	stable	-0.1
Union County	29.3	102	stable	1
Passaic County	28.8	90	stable	0.3
Hudson County	26.8	98	stable	0.6

Table 32. JERSEY CITY MEDICAL CENTER - TUMOR REGISTRY SUMMARY

In 2019, JCMC’s tumor registry data showed that 3.4% and 19.0% of overall cases were Stage 3 and Stage 4 respectively. The following primary sites were made up of more than 25% of Stage 4 cases: Respiratory System(64.7%), followed by Male genital Organs (40.0%) and Digestive Organs (32.6).

Compared to 2018, there was a decrease of 386 cases (-66.3%) in 2019. The three biggest decreases in overall cases occurred in Breast (-79, -55.2%), followed by Digestive Organs (-75, -61.0%) and Respiratory System (-50, -72.5%). Please note that case volume counts smaller than 10 are suppressed. Staging percentages are calculated on analytic cases only.

MainSite	SubSite	Cases (both analytic and non-analytic)		2018			2019			2018 - 2019			
		2018	2019	% Stage 3	% Stage 4	Total % Stage 3 & 4	% Stage 3	% Stage 4	Total % Stage 3 & 4	Change in Case Volume	Change in % points for Stage 3	Change in % points for Stage 4	Change in % points for Stage 3 & 4
BREAST		143	64	5.9%	0.0%	5.9%	0.0%	0.0%	0.0%	(79)	(5.9)	0.0	(5.9)
DIGESTIVE ORGANS		123	48	17.3%	27.6%	44.9%	4.3%	32.6%	37.0%	(75)	(13.0)	5.1	(7.9)
	COLON	39	20	35.3%	17.6%	52.9%	5.3%	42.1%	47.4%	(19)	(30.0)	24.5	(5.6)
	LIVER AND INTRAHEPATIC BILE DUCTS	11		0.0%	33.3%	33.3%	0.0%	50.0%	50.0%	(9)	0.0	16.7	16.7
	PANCREAS	28		0.0%	52.4%	52.4%	0.0%	33.3%	33.3%	(21)	0.0	(19.0)	(19.0)
	RECTUM	11		0.0%	11.1%	11.1%	0.0%	33.3%	33.3%	(8)	0.0	22.2	22.2
EYE, BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM		22		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(20)	0.0	0.0	0.0
FEMALE GENITAL ORGANS		43	11	3.8%	23.1%	26.9%	25.0%	12.5%	37.5%	(32)	21.2	(10.6)	10.6
HEMATOPOIETIC AND RETICULOENDOTHELIAL SYSTEMS		38	11	0.0%	9.1%	9.1%	0.0%	12.5%	12.5%	(27)	0.0	3.4	3.4
LYMPH NODES		27		22.2%	33.3%	55.6%	0.0%	16.7%	16.7%	(20)	(22.2)	(16.7)	(38.9)
MALE GENITAL ORGANS		34		0.0%	55.6%	55.6%	0.0%	40.0%	40.0%	(27)	0.0	(15.6)	(15.6)
RESPIRATORY SYSTEM AND INTRATORACIC ORGANS		69	19	4.3%	55.3%	59.6%	11.8%	64.7%	76.5%	(50)	7.5	9.4	16.9
	BRONCHUS AND LUNG	61	17	4.9%	58.5%	63.4%	13.3%	66.7%	80.0%	(44)	8.5	8.1	16.6
THYROID AND OTHER ENDOCRINE GLANDS		33		3.2%	3.2%	6.5%	0.0%	10.0%	10.0%	(23)	(3.2)	6.8	3.5
	UNKNOWN PRIMARY SITE	15		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(11)	0.0	0.0	0.0
URINARY TRACT		20		0.0%	9.1%	9.1%	0.0%	0.0%	0.0%	(15)	0.0	(9.1)	(9.1)
	BLADDER	12		0.0%	16.7%	16.7%	0.0%	0.0%	0.0%	(9)	0.0	(16.7)	(16.7)
Grand Total		582	196	7.6%	17.6%	25.2%	3.4%	19.0%	22.4%	(386)	(4.2)	1.4	(2.8)

Appendix I- Outcomes and Results Report of the Previous Implementation Plan

Contents

- Executive Summary..... i
- Introduction 1
 - Community Health Needs Assessment Purpose and Goals..... 1
 - Area of Focus 1
 - Context for the Community Health Needs Assessment 2
 - COVID-19 Pandemic..... 2
 - National Movement for Racial Justice 3
- Methods..... 3
 - Social Determinants of Health Framework..... 3
 - Upstream Approaches to Health 3
 - Health Equity Lens 4
 - Approach and Community Engagement Process..... 4
 - RWJBH System Engagement 4
 - CHNA Advisory Committee Engagement..... 5
 - Community Engagement 5
 - Secondary Data: Review of Existing Secondary Data, Reports, and Analyses 5
 - Primary Data Collection 6
 - Qualitative Discussion: Key Informant Interviews and Focus Groups 6
 - Community Survey..... 7
 - Data Limitations 8
- Population Characteristics 9
 - Population Overview..... 9
 - Racial, Ethnic, and Language Diversity..... 11
 - Racial and Ethnic Composition 11
 - Foreign-Born Population..... 12
 - Language Diversity..... 14
 - U.S. Veterans..... 17
- Community Social and Economic Environment..... 20
 - Community Strengths and Assets 20
 - Strong Community and Partnerships..... 20
 - Public Services and Programs 21
 - Other Community Assets 22
 - Education 25
 - School Environment and Health 25
 - Public Schooling 25
 - Promising Initiatives..... 27
 - Inequality 27
 - Employment and Workforce..... 29
 - Income and Financial Security 33
 - Household Income and Poverty..... 33
 - Income and Public Assistance..... 37
 - Food Access and Food Security..... 39
 - Housing 43
 - Housing Landscape 43
 - Housing Instability and Homelessness..... 43
 - Housing and Technology Infrastructure 47

Contents

- Executive Summary i
- Introduction 1
 - Community Health Needs Assessment Purpose and Goals 1
 - Area of Focus 1
 - Context for the Community Health Needs Assessment 2
 - COVID-19 Pandemic..... 2
 - National Movement for Racial Justice 3
- Methods..... 3
 - Social Determinants of Health Framework 3
 - Upstream Approaches to Health 3
 - Health Equity Lens 4
 - Approach and Community Engagement Process 4
 - RWJBH System Engagement..... 4
 - CHNA Advisory Committee Engagement 5
 - Community Engagement 5
 - Secondary Data: Review of Existing Secondary Data, Reports, and Analyses..... 5
 - Primary Data Collection 6
 - Qualitative Discussion: Key Informant Interviews and Focus Groups..... 6
 - Community Survey..... 7
 - Data Limitations..... 8
- Population Characteristics..... 9
 - Population Overview 9
 - Racial, Ethnic, and Language Diversity 11
 - Racial and Ethnic Composition 11
 - Foreign-Born Population 12
 - Language Diversity..... 14
 - U.S. Veterans 17
- Community Social and Economic Environment..... 20
 - Community Strengths and Assets..... 20
 - Strong Community and Partnerships 20
 - Public Services and Programs 21
 - Other Community Assets..... 22
 - Education 25
 - School Environment and Health 25
 - Public Schooling 25
 - Promising Initiatives 27
 - Inequality 27
 - Employment and Workforce 29
 - Income and Financial Security 33
 - Household Income and Poverty 33
 - Income and Public Assistance..... 37
 - Food Access and Food Security 39
 - Housing 43
 - Housing Landscape 43
 - Housing Instability and Homelessness 43
 - Housing and Technology Infrastructure 47

Transportation	49
Transportation Infrastructure.....	49
Transportation Partnerships.....	49
Green Space and Built Environment.....	52
Flooding and Emergency Preparedness	52
Parks and Green Areas.....	53
Violence Prevention and Safety.....	54
Gun Injury and Violent Crime	56
Hate Crimes and Anger.....	57
Violence Interruption Programs	58
Systemic Racism and Discrimination	58
Systemic Discrimination Based on Legal Status	59
Systemic Discrimination Based on Gender and Sexual Orientation.....	59
Addressing the Systems of Oppression	60
Community Health Issues	61
Community Perceptions of Health	61
Leading Causes of Death and Premature Mortality	63
Obesity, Healthy Eating, and Physical Activity.....	65
Overweight and Obesity	65
Physical Activity	67
Healthy Eating.....	69
Chronic Conditions.....	70
High Cholesterol and High Blood Pressure	70
Heart Disease.....	71
Diabetes.....	73
Cancer.....	74
Chronic Obstructive Pulmonary Disease (COPD).....	82
Disability	82
Behavioral Health: Mental Health and Substance Use.....	84
Mental Health.....	84
Substance Use.....	90
Environmental Health	95
Asthma	95
Air Quality	97
Lead.....	99
Infectious and Communicable Diseases	100
COVID-19	100
Sexual and Reproductive Health and Sexually Transmitted Infections.....	103
Maternal and Infant Health	105
Prenatal Care	106
Perinatal Outcomes: Low and Very Low Birthweight and Preterm Births	106
Maternal and Infant Mortality.....	108
Teen Pregnancy	109
Access to Services	110
Access and Utilization of Preventive Services, Including Immunizations.....	110
Barriers to Accessing Healthcare Services.....	113
Language and Cultural Factors Related to Healthcare Access	118
Community-Based Organizations and Coalitions	119

Community Vision and Suggestions for the Future	120
Expanding and Strengthening Behavioral Health and Overall Healthcare Services.....	120
Health as Human Right: “It is urgent to have access to free, quality health care”	120
Greater Accessibility and Availability of Behavioral Health Services	120
Focusing on the Upstream Factors and the Social Determinants of Health	121
Inequality	121
Economic and Employment Opportunities	121
Built Environment	121
Housing	122
Greater Engagement and Access to Existing Initiatives	122
Access to Services and Community Outreach	122
Partnerships, Community Engagement, and Community Building	122
Key Themes and Conclusions.....	123
Prioritization Process and Priorities Selected for Planning	124
APPENDICES	127
Appendix A- RWJBH Jersey City/Hudson County CHNA Advisory Committee Members	127
Appendix B- Organizations Represented in Key Informant Interviews and Focus Groups	129
Appendix C- Key Informant Interview Guide	130
Appendix D- Focus Group Guide.....	135
Appendix E- Resource Inventory	139
Appendix F- Additional Data Tables.....	160
Appendix G- Hospitalization Data.....	179
Appendix H- Cancer Data.....	199
Appendix I- Outcomes and Results Report of the Previous Implementation Plan	219

Executive Summary

Introduction

In 2022, Jersey City Medical Center (JCMC) undertook a community health needs assessment (CHNA) process. The purpose of the CHNA was to identify and analyze community health needs and assets and prioritize those needs to inform strategies to improve community health. This assessment focused on the following Hudson County areas: Bayonne, Hoboken, Jersey City (zip codes 07302, 07304, 07305, 07306, 07307 and 07310), and Union City.

Context

This CHNA was conducted during an unprecedented period due to the COVID-19 pandemic and the national movement for racial justice. The COVID-19 pandemic impacted both the CHNA data collection process, as well as topics and concerns that residents raised in focus groups and key informant interviews. A wave of national protests for racial equity in 2020 highlighted how racism is embedded in systems across the US. The national movement informed the content of this report including the data collection processes, design of data collection instruments, and the input that was shared during focus groups, key informant interviews, and through survey responses.

Methods

While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health. Data collection was conducted using a social determinants of health framework and a health equity lens. The CHNA process utilized a mixed-methods, participatory approach that engaged agencies, organizations, and community residents through different avenues. The CHNA process was guided by the strategic leadership of the RWJBH Systemwide CHNA Steering Committee, the JCMC Community Outreach & Social Impact Steering Committee, the JCMC/Hudson County CHNA Advisory Committee, and the community overall. Data collection methods included:

- Reviewing existing social, economic, and health data in the JCMC primary and secondary service areas in Hudson County.
- Conducting a community survey with 273 residents designed and administered by Bruno & Ridgway.
- Facilitating 6 virtual focus groups with 105 participants from populations of interest, including veterans, and residents who identified as Black, Asian, and Latino, the latter held in Spanish.
- Conducting 7 key informant interviews with 12 community stakeholders from a range of sectors.
- Facilitating a guided discussion with the JCMC Community Outreach & Social Impact Steering Committee.

Jersey City Medical Center/Hudson County CHNA Focus Area



Findings

The following provides a brief overview of the key findings that emerged from this assessment:

Population Characteristics

- **Demographics.** In 2020, Hudson County was the fourth most populous county in New Jersey with 671,923 residents. Its population increased by 1.4% between 2015 and 2020.¹ Participants in focus group and interview discussions valued Hudson County’s racial/ethnic and language diversity and robust foreign-born population. Residents identifying as Latino made up 40.4% of the county’s residents, followed by those identifying as White (28.5%), Asian (17.0%), and Black (9.8%).² In 2016-2020, the foreign-born population ranged from 19.4% in Hoboken to 62.8% in Jersey City zip code 07310, with many residents from India and the Dominican Republic.³ Veterans made up about 2% of the Hudson County population, with the highest percentage in the city of Bayonne (3.9%).

Community Social and Economic Environment

- **Community Strengths and Assets.** Interviewees and focus group participants mentioned numerous positive aspects of their communities, including an abundance of resources and amenities, community solidarity, and robust partnerships, made stronger during COVID-19. Top strengths identified by community survey respondents in 2021 included that it was easy to find fresh produce and that their communities had safe outdoor places to walk and play. Nearly 60% of respondents indicated that their communities were a good place to raise a family and had places for everyone to socialize.⁴
- **Education.** Graduation rates across Hudson County school districts differed, with Bayonne, Union City, and Jersey City experiencing lower graduation rates than the other communities and the state. There were racial/ethnic disparities in graduation rates, with Black and Latino students experiencing lower graduation rates than their White and Asian counterparts.⁵ Participants identified “Community schools” and Tiger’s Den at Snyder High School, resulting from a partnership between the Jersey City Board of Education, JCMC, educators, families, and the community, as promising initiatives to address the needs of low-income students of color and increase graduation rates.
- **Inequality.** Growing inequality was a recurrent theme in focus groups and interviews with participants describing the area as “*a tale of two cities*.” Development was seen as focusing on the wealthy, while residents emphasized how neighborhood concentrated poverty compounded the effect of household poverty. They highlighted the linkage between income, hopelessness, poor education outcomes, and violence. Inequality was reflected in education, employment and workforce, income and financial security, access to healthcare, and other areas.

“There is something going on almost every week to help with food, home purchases, and other things. That’s one of the things I really love about Jersey City.” – Focus group participant

¹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

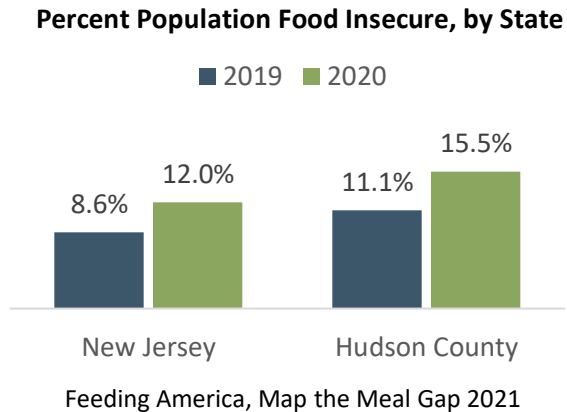
² U.S. Census Bureau, Decennial Census of Population and Housing, 2020

³ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

⁴ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

⁵ New Jersey Department of Education, School Performance, Adjusted Cohort Graduation Rates, 2020-21

- Employment and Workforce.** Unemployment rates in Hudson County were trending downward over the decade prior to the COVID-19 pandemic and rose substantially in 2020, similar to the rest of the state and country. While rates declined in 2021, unemployment has not yet fallen to pre-pandemic levels. Unemployment rates in 2016-2020 ranged from 2.4% in Jersey City zip code 07302 to 7.0% in Jersey City zip code 07305 and 9.2% in Jersey City zip code 07304.⁶ Fewer than four in ten survey respondents agreed that “there are job opportunities in my area.” Participants indicated that LGBTQ+ populations, veterans, and essential workers were the most affected by unemployment and underemployment.
- Income and Financial Security.** Median household income in Hudson County showed stark disparities, ranging from \$49,457 in Union City, with a majority Latino population, to \$153,438 in Hoboken, a predominantly White area.⁷ In 2019, 29.8% of Black children and 23.4% of Latino children lived in poverty, compared to 9.8% in the county overall.⁸ Among veterans, 7.5% lived below the poverty line in the county overall, with 21.4% doing so in Jersey City zip code 07306.⁹ Focus group participants shared the day-to-day challenges of affording housing, food, and healthcare as prices continue to climb across the board. While the rising cost of living affects everyone, participants shared that it has been most painful for low-wage workers and those on fixed incomes, such as seniors.
- Food Access and Food Security.** Participants mentioned that many families with children—often immigrants—, older adults, and those who were housing insecure were struggling to put food, particularly healthy food, on the table. Residents reported that food insecurity increased during the COVID-19 pandemic, despite stepping up food distribution efforts. Around one in four survey respondents overall, and about one in three Latino respondents, indicated that they relied on food pantries or other food assistance programs.¹⁰
- Housing.** Participants reported that affordable housing in their communities was sparse and difficult to obtain. Residents discussed the challenges of qualifying for affordable housing, rising rents due to an influx of New Yorkers, increasing socioeconomic segregation, and homelessness. More than half of renter-occupied households in Hudson County spend 25% or more of their monthly income on housing costs, ranging from 39.0% in Jersey City zip code 07302 to 66.5% in Union City and 64.6% in Jersey City zip code 07305.¹¹



⁶ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

⁷ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

⁸ U.S. Census Bureau, Small Area Income and Poverty Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

⁹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

¹⁰ DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

¹¹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

- Transportation.** Participants valued the ample availability of public transportation options in Hudson County. Most participants indicated that they were not car dependent and noted that it was easy to get around. In addition, participants indicated that the partnerships between health care facilities and private transportation companies facilitated access to health care for older adults, persons with disabilities, and violence survivors.
- Green Space and Built Environment.** Multiple residents expressed their concerns that there were too many new constructions, resulting in overpopulation and a shrinkage of green space. Participants highlighted the importance of emergency preparedness for flooding and mentioned that mitigating redevelopment projects were underway. Residents also noted the contribution of grassroots organizations to public park maintenance, also important for increased water absorption. About 70% of Hudson County survey respondents agreed or completely agreed with the statement, *“My community has safe outdoor places to walk and play.”*¹²
- Violence Prevention and Safety.** Similar to the 2019 CHNA, for many, violence prevention and safety continue to be priority issues for many residents. Participants shared differing views about safety and violence. Many indicated being safe in their neighborhoods, while others reported being nervous about crime. In 2020, Jersey City (432 per 100,000 residents) had more than double the violent crime rate (i.e., murder, rape, aggravated assault) than the state average (195 per 100,000 residents).¹³ Black residents indicated that they experienced a disproportionate burden of violence, including gun violence, and trauma, with Black survey respondents’ marking violence/community safety as the top health priority.¹⁴ Key informant interviewees indicated that Jersey City has robust programs and resources to address and mitigate the impact of violence and trauma, including the Anti-Violence Coalition and Project H.U.D.S.O.N. According to interviewees, promising results to interrupt the cycle of violence have been achieved by reaching survivors soon after injury and providing trauma-informed intensive case management and wraparound services, including safe housing and vocational training, in addition to medical care and counseling.
- Systemic Racism and Discrimination.** With few exceptions, participants spoke of pervasive inequities experienced by people of different groups. Residents discussed the multiplying effect of historical and current discriminatory practices due to multiple conditions, such as race/ethnicity, gender, immigrant status, and socioeconomic status, among others. Participants noted these issues largely impacted communities of color because of the policies and practices embedded throughout society. Residents mentioned that some Hudson County municipalities have put in place programs to address the effects of systemic racism, such as first-time homeowner programs for low-income residents, rent control policies, and programs to promote minority and/or women owned business. However, participants emphasized that more are needed.

“The undocumented are scared to ask for help, and we are seeing that community getting jumped overnight, not wanting to go to the hospital over what they will get charged.”— Focus group participant

¹² Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

¹³ State of New Jersey, Department of Law and Public Safety, Uniform Crime Reporting Unit, 2019

¹⁴ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Community Health Issues

- **Perceptions of Community Health.** Focus group participants and interviewees identified social and economic issues such as financial insecurity, housing, and transportation as top community concerns, noting that these issues affect other aspects of health. Participants also discussed challenges in accessing care, the increase in mental health concerns, and the lingering effects of the COVID-19 pandemic. Community survey respondents ranked mental health, overweight/obesity, high stress lifestyle, affordable housing, and affordable eldercare as the top five health concerns in the community.
- **Leading Causes of Death and Premature Mortality.** Heart disease, COVID-19, and cancer were the top three leading causes of death in Hudson County in 2020. In 2018-2020, Black residents experienced higher rates of premature mortality (deaths before age 75) than any other racial/ethnic groups.¹⁵
- **Obesity, Healthy Eating, and Physical Activity.** While overweight/obesity was identified as the second top health concern (after mental health) by community survey respondents,¹⁶ it was not a prominent theme in conversations with residents. Participants mentioned disparities in the availability and affordability of healthy foods by neighborhood, with some areas considered food deserts. Some residents indicated enjoying the area’s walkability, while others noted safety issues, sidewalks in disrepair, and time constraints as barriers to physical activity.
- **Chronic Diseases.** Like findings from the 2019 CHNA, chronic diseases continue to be a top community concern. Data show racial/ethnic disparities in chronic disease burden across Hudson County. Black residents experienced higher cardiovascular disease mortality rates than other racial/ethnic groups in the county. Diabetes was a top priority concern and participants indicated that it was highly prevalent in their communities. The cancer mortality rate in Hudson County was highest among Black (182.9 per 100,000), followed by White (148.5 per 100,000), residents.¹⁷ In terms of chronic disease screenings, 70% of community survey respondents indicated that they had participated in a cholesterol screening, and nearly 87% had participated in a blood pressure screening in the past two years.¹⁸ Many participants mentioned health care costs as a barrier to chronic disease management.
- **Disability.** While the issue of disabilities did not emerge often in the qualitative discussions, many people with disabilities face economic instability as they rely on government financial assistance programs for their basic needs. A key informant interviewee highlighted the importance of early intervention to address the needs of children with disabilities. The proportion of the population ages

“Diabetes is a very expensive issue in the community, and we’ll often see people forgo their medication because they can’t afford it or forgo healthy foods because they can’t afford it.” – Focus group participant

¹⁵ National Center for Health Statistics, Mortality Files, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018-2020

¹⁶ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

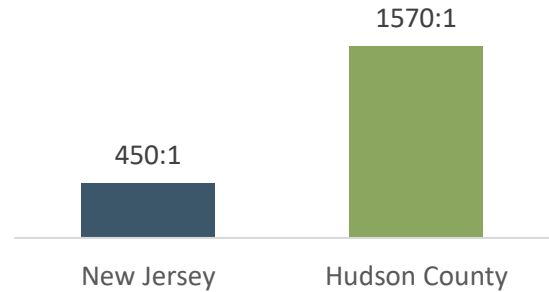
¹⁷ New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

¹⁸ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

18-64 with a disability in Hudson County ranged from 3.2% in Jersey City zip code 07302 to 9.1% in Jersey City zip code 07304.¹⁹

- Mental Health and Substance Use.** Echoing the 2019 CHNA, mental health disorders were the top health priority selected by survey respondents and a prominent theme in interviews and focus groups. Job loss and economic pressures and the uncertainty associated with the pandemic were cited as contributors to increased stress and depression by Hudson County residents, including among veterans and members of the LGBTQ+ community. Participants indicated stigma, long wait times for appointments, and unavailability of multilingual mental health care providers as barriers to accessing care. Several participants identified substance misuse, relapse, and overdose deaths among young people as a further health concern in the aftermath of COVID-19, with the drug poisoning rate increasing from 2016 to 2020.²⁰

Population to Mental Health Provider Ratios, by State and County, 2019



DATA SOURCE: National Provider Identification Registry, Centers for Medicare and Medicaid Services

- Environmental Health.** The rate of age-adjusted ED visits for asthma declined in Hudson County from 2018-2020.²¹ It should be noted that this decline may be due to individuals with asthma being reluctant to seek care during the height of the COVID-19 pandemic. The proportion of children born in 2014 who were tested for lead exposure before 36 months of age is higher in Hudson County (77.6%) than in the state (74.4%).²²

- Communicable Diseases.** Conversations related to COVID-19 primarily focused on how the pandemic exacerbated existing social and economic inequities. Several participants were concerned by the increasing rates of sexually transmitted infections, including HIV and chlamydia, among women of color and the LGBTQ+ population. The rate of HIV transmission for Black New Jersey residents was 30.2 per 100,000 persons, ten times higher than among White residents (3.1 per 100,000). Nearly 3,000 per 100,000 women aged 15-24 contract

“[COVID impacted] housing, food insecurity, jobs, people have a fear of going back to work, and childcare, because there was a time when everything was virtual, how can parents afford to stay home and put food on the table?” – Focus group participant

¹⁹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

²⁰ Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020

²¹ New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020

²² New Jersey Birth Certificate Database, Office of Vital Statistics and Registry; Child Health Program, Family Health Services, as reported by, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2022

chlamydia annually in Hudson County.²³ Participants also expressed concerns about the roll-back of reproductive rights and the negative impact that would have on women’s health, noting the inequitable burden on low-income women.

- **Maternal and Infant Health.** Maternal and infant health indicators are markers of inequity as most maternal and perinatal health complications are preventable with access to quality, adequate, timely care and information, including comprehensive sexuality education. In Hudson County, a lower percentage of Black and Latino residents sought prenatal care in the first trimester compared to Asian and White residents. The rates of low birth weight and preterm births among infants born to Black residents roughly doubled those of White residents,²⁴ indicating health care access barriers.

Access to Services

- **Access to Preventive Services.** Participants reported that access to routine screenings and preventive care declined since the onset of the COVID-19 pandemic, despite the efforts of many partners. Participants indicated that having a primary care provider and/or access to a trusted FQHC facilitated access to care. Approximately 77% of community survey respondents reported having an annual physical exam and 74% a flu shot in the last two years.²⁵
- **Access to Primary Care Services.** Cost, workforce capacity, insurance, and language and cultural factors were most often mentioned by focus group and interview participants as barriers to accessing primary care. Community survey respondents indicated ability to schedule an appointment at a convenient time, insurance problems, cost of care, and wait times as the main barriers to care.²⁶ About 30% of respondents indicated never experiencing barriers. Within the JCMC service area, the proportion of uninsured residents was highest in Union City (23.4%) and lowest in Hoboken (2.7%).²⁷ Some participants, particularly veterans, mentioned experiencing disruptions in access to mental health services during the pandemic, including to support groups and counseling, leading to treatment setbacks and substance use relapse.
- **Community-Based Organizations and Coalitions.** Partnerships between the community-based organizations, hospitals, schools, and the government were seen as a strength in Hudson County and critical to providing services to those in need. City-wide efforts such as HealthierJC have been important to coordinate efforts across multiple partners, including the business community. Residents and public health administrators uplifted the role of community-based nonprofits in bridging the gap to services for those most marginalized. Most participants saw a promising role for a strong and broad coalition in Hudson County.

“We have great partners. Hudson County is very tight, so we all work together – Focus group participant

²³ Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, as reported by the New Jersey State Health Assessment Data (NJSHAD), 2020 & 2021

²⁴ New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

²⁵ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

²⁶ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

²⁷ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Community Vision and Suggestions for the Future

- **Health as Human Right:** *“It is urgent to have access to free, quality health care.”* To overcome cost barriers, participants recommended expanding access to free or low-cost preventive care; loosening the requirements to qualify for free and/or low-cost health insurance; and simplifying the charity care application, including for those who are foreign-born. They also suggested *“meeting people where they are”* by using mobile and school-based clinics, organizing education sessions in all neighborhoods, and offering appointments outside of the regular workday. Participants highlighted the community school model as a promising initiative to promote the well-being of low-income families.
- **Improving Access to Services and Community Outreach.** Echoing 2019 CHNA priorities, many community participants emphasized improving access to primary care as a priority for the coming years. Numerous interviewees and focus group participants noted the need for better communication about existing programs and services. Participants suggested organizing informational sessions in different neighborhoods and languages on topics that affect the community, such as chronic disease management, and developing a centralized list of programs and resources, similar to the mental health directory prepared by the Health Department (<https://healthierjc.com/mental-health/>), but for other conditions.
- **Greater Accessibility and Availability of Behavioral Health Services.** Participants suggested that expanding culturally-competent trauma-informed mental health care, particularly for Black, LGBTQ+, veterans, violence survivors, and young residents, should be a priority in the coming years. They recommended diversifying the mental health workforce, expanding community-based affordable mental health services, increasing long-term treatment and maintenance options for persons with substance use disorders, and developing additional prevention education programs to destigmatize mental health disorders among many cultural groups.
- **Sexual and Reproductive Health and Women’s Health.** Participants underscored the importance of offering comprehensive sexuality education in schools to reduce sexually transmitted infections and reduce unplanned pregnancies among teens; increasing access to information and reproductive health commodities to address the rise in sexually transmitted infections among cisgender women and men-who-have-sex-with-men; and mitigating the repercussions of the rollback in constitutional protections to reproductive choice that could unduly affect low-income women and communities of color, thus, exacerbating existing racial/ethnic and social inequities in maternal and infant health.
- **Reducing Inequity and Focusing on the Social Determinants of Health.** For several interviewees and focus group members, a vision of the future included steps to reduce inequity and address the social determinants of health.
 - **Expanding Employment Opportunities:** Recommendations to improve economic and employment opportunities included: 1) incorporating more vocational training programs in high schools to facilitate transition into the workforce; 2) incentivizing employers to hire veterans and

“My biggest wish for this community is that we don't have such an economically diverse community. If there's a way to really help the families with the lowest economic resources to really have more financial stability, that would be ideal.”
– Key informant interviewee

transgender and other LGBTQ+ people; 3) providing expanded workforce protections (e.g., sick leave, improved wages, childcare) for all workers, including those who are foreign-born; and 4) supporting small business owners.

- **Addressing the Housing Deficit:** Recommendations related to expanding access to housing and addressing homelessness included: 1) earmarking more affordable housing units in the new developments, including housing for veterans; 2) implementing the existing rent control policies, which also apply to foreign-born residents regardless of immigration status; 3) renovating abandoned buildings for low-income families; 4) increasing the availability of safe temporary shelters for unhoused individuals, including for domestic and community violence survivors; and 5) fomenting first-time buyers' subsidies as a promising initiative to address intergenerational poverty.

“Prices have been slowly rising, amazing that they have money to build these new buildings but can’t help people maintain the property they have here....” – Focus group participant

- **Partnerships, Community Engagement, and Community Building.** Participants valued the robust partnerships established among multiple organizations and across sectors and suggested deepening engagement with trusted community-based organizations, such as those representing Asian, Latino, and LGBTQ+ residents, as partners in outreach and information sharing about community services and programs. Participants underscored more community outreach, a strong plan to reengage the community, and investing in the community as strategic areas moving forward.

Key Themes

Several overarching themes emerged from the Jersey City Medical Center/Hudson County 2022 Community Health Needs Assessment. Importantly, several key areas, including increasing access to care, the importance of preventive care, and safety and violence prevention echoed those priorities identified by the community in 2019 as part of the prior CHNA process, and provide an opportunity to continue building upon those efforts.

- ***The Hudson County communities that JCMC serves are diverse and health disparities exist.*** There is great variation in terms of demographic composition, income levels, and health status in Hudson County, with over 40% of residents not English proficient. Secondary data show disparities in healthcare access and health outcomes based on race/ethnicity. A larger proportion of Asian and Latino community survey respondents reported feeling discriminated against when receiving care. Secondary data show that Black residents experience higher rates of premature, cardiovascular, and cancer mortality, and diabetes compared to residents of other racial/ethnic groups.
- ***Residents viewed chronic conditions as prevalent and linked to the social determinants of health.*** Diabetes and high blood pressure were discussed as prevalent in the community, especially among low-income residents and communities of color, and survey respondents indicated “overweight/obesity” was the second most common health issue in their community. However, focus group participants focused on the barriers to healthy living faced by residents, including affording healthy foods, cost of medication, and having time to exercise and to spend outdoors.

- ***Housing, food insecurity, and employment opportunities are top community concerns.*** Participants identified lack of quality affordable housing as a key gap in the area. Food insecurity was another area of concern, with almost half of Latino survey respondents worrying about running out of money to purchase food. Housing and food are related to income. Over 10% of Hudson residents reported being unemployed during the pandemic, with large variation by neighborhood. Overall, participants recommended the adoption of more policies to promote equity and support the well-being of low-income residents.
- ***Mental health was identified as a significant community health concern.*** Mental health was identified as a top community health concern, closely associated with racial/ethnic disparities, economic instability, and chronic conditions. Black residents faced a disproportionate mental health burden. The rate of mental health hospitalizations in 2020 was 70% higher among adult Black residents (107.1 per 100,000) than the Hudson County average (63.1 per 100,000). Black children had 38% higher hospitalization rates for mental health conditions than the county rate (34.7 per 100,000 vs. 25.2 per 100,000). Veterans and LGBTQ+ advocates also highlighted the mental health needs of their communities. Residents mentioned stigma and insufficient culturally competent providers as the principal barriers to mental health care access and emphasized the need to engage in more education efforts.
- ***Violence as an important health concern.*** Violence and safety were raised as community concerns. Some participants indicated that their neighborhoods were safe; however only 40% of survey respondents agreed that violence was not prevalent in their communities.²⁸ Further, violence and safety were mentioned as the top health concern by Black survey respondents. Participants suggested continuing to strengthen efforts to end the cycle of violence by addressing its social determinants of health, through support of programs such as the Anti-Violence Coalition and Project H.U.D.S.O.N.
- ***Hudson County has a wealth of social service organizations and health care services, including those providing preventive care, though many residents experience barriers to accessing these resources.*** Residents remarked that Hudson County had a wealth of health care and social service assets. Residents noted that having a primary care doctor and being linked to a FQHC and/or a community-based organization were facilitating factors to accessing care. They also discussed the importance of culturally competent providers, including providers who spoke their language and looked like them. Veterans and those working with violence survivors highlighted that having peers and mentors who could provide trauma informed care helped to be engaged in care. Participants in the healthcare field unanimously noted a decline in access to preventive care and mentioned this as a priority strategic area. Recommendations in this area included continuing to uplift partnerships and community engagement to bridge the care gap. Another recommendation included better communication about existing programs and services to reach multiple constituencies.

Conclusions

Through this comprehensive and iterative assessment process, ten major areas were identified as community needs after gathering input through qualitative data from residents and stakeholders, feedback from a community priorities survey, and quantitative surveillance and secondary data. These included in no particular order:

²⁸ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

- Financial Insecurity
- Unemployment
- Food Insecurity
- Housing
- Chronic Diseases (e.g., heart disease, cancer, diabetes)
- Infectious Diseases, including COVID-19
- Violence Prevention & Safety
- Mental Health
- Substance Use
- Access to Preventive Care

After a prioritization process with the Advisory Committee and discussions within the hospital taking into consideration existing expertise, capacity, and experience, JCMC will focus on Access to Preventive Care; Chronic Disease Management, including Behavioral Health Services; Food Insecurity and Education; and Violence Prevention and Safety as priorities during the development of its implementation plan in 2023. JCMC will tackle these priority action areas as part of ongoing community engagement efforts and with an overarching emphasis on addressing systemic racism, racial injustice, and discrimination.

Introduction

Community Health Needs Assessment Purpose and Goals

A community health needs assessment (CHNA) is a systematic process to identify and analyze community health needs and assets, prioritize those needs, and then implement strategies to improve community health. In 2022, the RWJBarnabas Health Jersey City Medical Center (JCMC) undertook the current CHNA process using a mixed-methods and participatory approach.

JCMC is located in Jersey City, Hudson County, New Jersey, and is part of the **RWJBarnabas Health (RWJBH)** system. RWJBH is a non-profit healthcare organization which includes 12 acute care hospitals, three acute care children's hospitals, a leading pediatric rehabilitation hospital, a freestanding acute behavioral health hospital, a clinically integrated network of ambulatory care centers, two trauma centers, a satellite emergency department, geriatric centers, the state's largest behavioral health network, ambulatory surgery centers, comprehensive home care and hospice programs, long term care facilities, fitness and wellness centers, retail pharmacy services, medical groups, diagnostic imaging centers, a clinically integrated network and collaborative accountable care organization. As one of the licensed general acute care hospitals and one of two trauma centers within the system, JCMC admits nearly 16,000 inpatients and provides over 201,000 outpatient visits annually. In 2021, the 348-bed hospital attended over 81,100 emergency department visits and delivered nearly 2,000 babies. JCMC is a DNV (which stands for det norske veritas) fully accredited hospital and has been recognized for its excellence in providing care and support for the health and wellness of the Hudson County community.

In early 2021, RWJBH hired **Health Resources in Action (HRiA)**, a non-profit public health consultancy organization, to provide support, help facilitate, and conduct data analysis for the CHNAs across the system. HRiA worked closely with RWJBH, JCMC, the JCMC Community Outreach & Social Impact Steering Committee, and a Jersey City/Hudson County CHNA Advisory Board to support the 2022 JCMC CHNA.

The RWJBH JCMC/Hudson County CHNA aims to gain a greater understanding of the issues that community residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This report presents findings from the 2022 JCMC needs assessment processes, which was conducted between March-September 2022.

The specific goals of this CHNA are to:

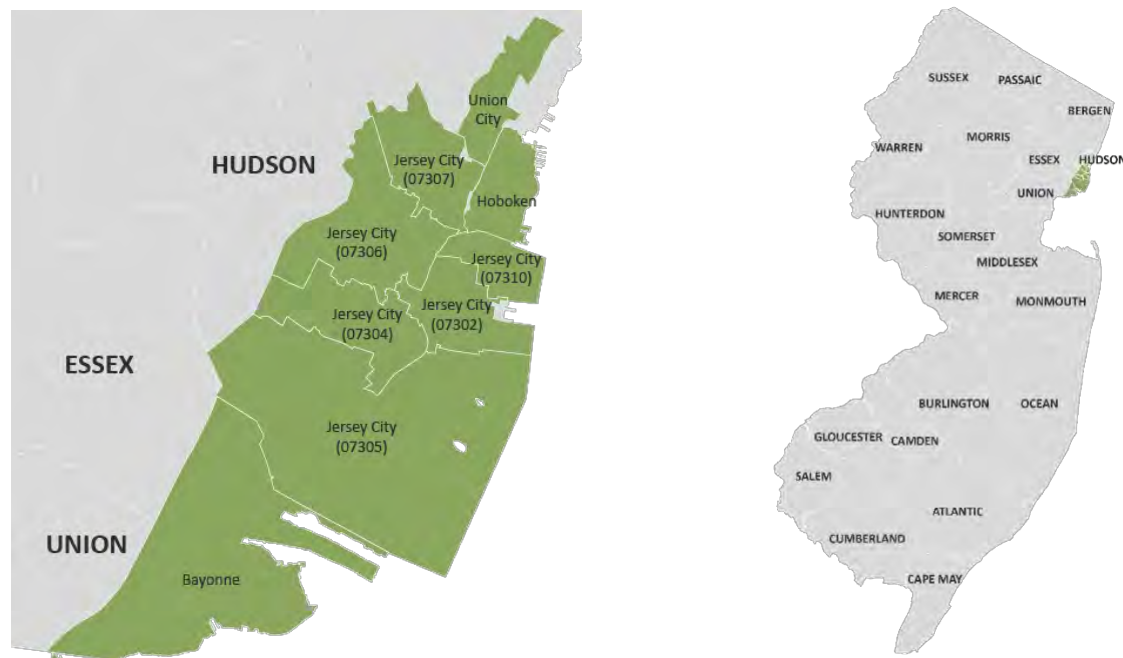
- Systematically identify the needs, strengths, and resources of the community to inform future planning,
- Understand the current health status of the service area overall and its sub-populations within their social context,
- Engage the community to help determine community needs and social determinant of health needs, and
- Fulfill the IRS mandate for non-profit hospitals.

Area of Focus

This CHNA process aims to fulfill multiple purposes for a range of stakeholders. To be as inclusive as possible, the focus area of the RWJBH Jersey City Medical Center/Hudson County CHNA encompasses JCMC's primary and secondary service areas in Hudson County. JCMC's primary service area include the

following Jersey City zip codes: 07302, 07304, 07305, 07306, 07307, and 07310. JCMC's secondary service area includes Bayonne, Union City and Hoboken, which encompass the following zip codes: 07002, 07087, and 07030, respectively. Both the primary and secondary service areas are the focus of this CHNA, represented in Figure 1 below.

Figure 1. Focused JCMC CHNA Area Map



Context for the Community Health Needs Assessment

This CHNA was conducted during an unprecedented time, given the COVID-19 pandemic and the national movement for racial justice. This context had a significant impact on the assessment approach and content.

COVID-19 Pandemic

The country was still recovering from the novel coronavirus (COVID-19) pandemic when the activities of this assessment were conducted. This impacted both the CHNA data collection process and topics, as well as concerns that participants put forth during discussions in focus groups and interviews. In March 2022, at the beginning of this CHNA process, the COVID-19 pandemic had already been in effect for over two years. Logistically, the pandemic impacted the feasibility of convening in-person groups for the CHNA (e.g., subcommittees, focus groups, etc.) and the availability of key stakeholders and community members to participate in CHNA activities, given their focus on addressing immediate needs. Consequently, all data collection and engagement occurred in a virtual setting (e.g., telephone or video focus groups, interviews), and engagement of residents and stakeholders was challenging. (A more detailed description of this engagement process may be found in the Methods section, and COVID-19 data specific to this service area is provided in the Infectious and Communicable Disease section of this report.)

Substantively, during the CHNA process, COVID-19 was and remains a health concern for communities and has also exacerbated underlying inequities and social needs. The pandemic brought to light both the

capabilities and gaps in the healthcare system, the public health infrastructure, and social service networks. In this context, an assessment of the community's strengths and needs, and in particular the social determinants of health, is both critically important and logistically challenging. This CHNA should be considered a snapshot in time, which is consistent with public health best practices. Moving forward, the community should continue to be engaged to understand how identified issues may evolve and what new issues or concerns may emerge over time.

National Movement for Racial Justice

Over the past few years, sparked by the national protests for racial equity amidst the killings of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, and many others, national attention was focused on how racism is embedded in every system and structure of our country, including housing, education, employment, and healthcare. This context impacted the content of the CHNA, including the design of data collection instruments and the input that was shared during interviews and focus groups. While racism and oppression have persisted in this country for over 400 years, it is important to acknowledge the recent focus on these issues in 2022 in the form of increased dialogue, locally and nationally, as context for this assessment. Awareness of racism and discrimination among Hudson City residents was renewed in 2022 with ongoing incidents of anti-Asian hate crimes and the naming of Jersey City by the Buffalo mass shooter.

Methods

The following section details how data for the CHNA were compiled and analyzed, as well as the broader lens used to guide this process.

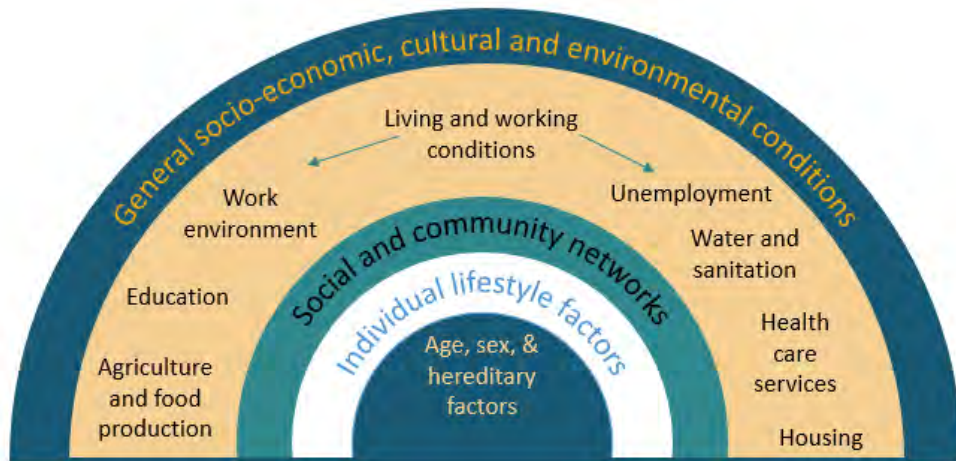
Social Determinants of Health Framework

While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health (Figure 2).

Upstream Approaches to Health

Having a healthy population is about more than delivering quality healthcare to residents. Where a person lives, learns, works, and plays all have an enormous impact on health. Health is not only affected by people's genes and lifestyle behaviors, but by upstream factors such as employment status, quality of housing, and economic policies. Figure 2 provides a visual representation of these relationships, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors, such as employment status and educational opportunities.

Figure 2. Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

The data to which we have access is often a snapshot in time, but the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. To this end, much of this report is dedicated to discussing the social, economic, and community context in which residents live. We hope to understand the current health status of residents and the multitude of factors that influence health to enable the identification of priorities for community health planning, existing strengths and assets upon which to build, and areas for further collaboration and coordination.

Health Equity Lens

The influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory policies, and historical oppression of specific groups are a few of the factors that drive health inequities in the U.S.

In the present report, health patterns for the Hudson County area are described overall, as well as areas of need for particular population groups. Understanding factors that contribute to health patterns for these populations can facilitate the identification of data-informed and evidence-based strategies to provide all residents with the opportunity to live a healthy life.

Approach and Community Engagement Process

The CHNA aimed to engage agencies, organizations, and community residents through different avenues. The CHNA process was guided by strategic leadership from the RWJBH Systemwide CHNA Steering Committee, the JCMC Community Outreach & Social Impact Steering Committee, and the community overall.

RWJBH System Engagement

This CHNA is part of a set of CHNAs being conducted across the entire RWJBH system. Each of these CHNAs uses a consistent framework and a minimum set of indicators but the approach and engagement

process are tailored for each community. A Systemwide CHNA Steering Committee was convened twice prior to the launch of JCMC CHNA process (early and late June 2021). This Steering Committee provided input and feedback on major data elements (e.g., secondary data key indicators, overall Table of Contents) and core prioritization criteria for the planning process. A list of Systemwide CHNA Steering Committee members can be found in Acknowledgments section.

CHNA Advisory Committee Engagement

A CHNA Advisory Committee was constituted to guide the process. The Advisory Committee included over 80 stakeholders representing a range of relevant fields and organizations throughout Hudson County. The CHNA Advisory Committee was engaged at critical intervals throughout this process. In March 2022, the Advisory Committee met for a kick-off meeting during which HRiA provided an overview of the CHNA process and Bruno & Ridgeway, Inc. presented the findings from a community survey the firm conducted in 2021. These two presentations were followed by a brief Q&A and discussion with Advisory Committee members. After the meeting, Advisory Committee members were invited to participate in a survey to help identify what populations and sectors to engage in focus groups and key informant interviews. The results of this survey directly informed development of an engagement plan to guide qualitative data collection. During the data collection process, Advisory Committee members also assisted with organizing focus groups with community residents, participating in key informant interviews, and/or connecting HRiA to stakeholders in the community.

The Advisory Committee reconvened in October 2022. During this meeting, HRiA staff presented the findings from the CHNA process, including preliminary priorities that emerged upon review of the qualitative and secondary data. Advisory Committee members had the opportunity to ask questions, then discussed and voted on the top priorities for the hospital to consider when developing its implementation plan. A detailed description of the prioritization process can be found in the Prioritization Process and Priorities Selected for Planning section.

In addition, the JCMC Community Outreach & Social Impact Steering Committee was engaged throughout the process as a means of obtaining feedback from internal JCMC stakeholders who have firsthand knowledge of the community. Members of the JCMC Steering Committee participated in the Advisory Committee activities and in a focus group in June 2022. The JCMC Steering Committee reviewed the report in full and adopted it in a meeting in November 2022. See Appendix A for a list of CHNA Advisory Committee members, which include the JCMC Steering Committee members.

Community Engagement

Community engagement is described further below under the primary data collection methods. Capturing and lifting up a range of voices, especially those not typically represented in these processes, was a core component to this initiative. It should be noted that, due to the COVID-19 pandemic, the community engagement for this CHNA occurred virtually. Additionally, while the CHNA aimed to engage a cross-section of individuals and to be inclusive of traditionally under-represented communities, outreach was challenging given the pandemic and competing priorities. Nevertheless, by engaging the community through multiple methods and in multiple languages, this CHNA aims to describe community strengths and needs during this unique time.

Secondary Data: Review of Existing Secondary Data, Reports, and Analyses

Secondary data are data that have already been collected for another purpose. Examining secondary data helps us to understand trends, provide a baseline, and identify differences by sub-groups. It also helps in guiding where primary data collection can dive deeper or fill in gaps.

Secondary data for this CHNA were drawn from a variety of sources, including the U.S. Census American Community Survey (ACS), the U.S. Department of Labor Bureau of Labor Statistics, the Federal Bureau of Investigation Uniform Crime Reports, U.S. Bureau of Labor Statistics, County Health Rankings, the New Jersey Department of Education, New Jersey Department of Health's New Jersey State Health Assessment Data (NJSHAD), and a number of other agencies and organizations. This CHNA also utilizes reports from a variety of organizations at the community, state, and national level, including, but not limited to, the United Way of New Jersey's ALICE Study, The Partnership for a HealthierJC, and others. Additionally, hospitalization data from the RWJBH system is also included in Appendix H. Secondary data were analyzed by the agencies that collected or received the data. Data are typically presented as frequencies (%) or rates per 100,000 population. It should be noted that when the narrative makes comparisons between towns, by subpopulation, or with NJ overall, these are lay comparisons and *not* statistically significant differences.

It should also be noted that for most social and economic indicators, the U.S. Census American Community Survey (ACS) 5-year (2016-2020) aggregate datasets were used over the one-year datasets, to improve statistical reliability for areas with smaller population sizes and small population subgroups. Since the ACS uses a probability sampling technique, using the five-year aggregate dataset over the one-year data provides a larger sample size and more precision in its estimates.

Primary Data Collection

Primary data collection entailed a mixed methods approach consisting of interviews, focus groups, and a community survey, as detailed below.

Qualitative Discussion: Key Informant Interviews and Focus Groups

Key Informant Interviews

A total of seven key informant interview discussions were completed with 12 individuals by Zoom or telephone. Interviews were 35-60-minute semi-structured discussions that engaged institutional, organizational, and community leaders as well as front-line staff across sectors. Discussions explored interviewees' experiences of addressing community needs and priorities for future alignment, coordination, and expansion of services, initiatives, and policies. Sectors represented in these interviews included: local public health departments, public education, housing services, the faith community, and those who serve/work with specific populations (e.g., immigrant community, LGBTQ residents, young people). See Appendix B for a list of organizations engaged through key informant interviews and Appendix C for the key informant interview guide.

Focus Groups

A total of 105 community residents participated in 6 virtual focus groups (telephone or video) conducted with specific populations of interest: veterans, Black residents, Spanish-speaking Latino residents, and Asian residents. Focus groups were up to 60-minute semi-structured conversations and aimed to delve deeply into the community's needs, strengths, and opportunities for the future and to gather feedback on priorities for action. Please see Appendix D for the focus group facilitator's guide.

In addition, a guided discussion was carried out with the JCMC Community Outreach & Social Impact Steering Committee, whose members are in direct contact with Hudson City residents in their role as health care providers, hospital administrators, leaders, and community residents themselves. The discussion lasted 60 minutes and was conducted via Zoom. The discussion aimed to determine

perceptions of the strengths and needs of the Hudson County community served by JCMC, and identify the sub-populations most affected, to explore how these issues can be addressed in the future, and to identify opportunities for JCMC to address the community needs more effectively moving forward.

Analyses

The collected qualitative information was coded and then analyzed thematically by data analysts for main categories and sub-themes. Analysts identified key themes that emerged across all groups and interviews as well as the unique issues that were noted for specific populations. Throughout the qualitative findings included in this report, the term “participants” is used to refer to key informant interview and focus group participants. Unique issues that emerged among a group of participants are specified as such. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While differences between towns are noted where appropriate, analyses emphasized findings common across the service area. Selected paraphrased quotes—without personal identifying information—are presented in the narrative of this report to further illustrate points within topic areas.

Community Survey

A community priorities survey was developed and administered over a six-month period from April to August 2021 by the survey firm Bruno & Ridgway, who was contracted directly by the RWJBH system. The survey focused on health issues and concerns that impact the community; community safety and quality of life; personal health attitudes, conditions, and behaviors; barriers to accessing health care; discrimination when receiving medical care; and the impact of COVID-19 and vaccination compliance. The survey was administered online and was available in paper in 5 languages (English, Spanish, Portuguese, Arabic, and Chinese).

Outreach for survey dissemination was conducted with assistance from the RWJBH system, the hospital, and its community partners, as well as through social media and the web. Additionally, an online panel sample was recruited to capture additional survey responses from specific areas to augment the larger sample. Postcards with QR codes that linked to the survey were distributed at vaccination events for community members to take while they waited for their COVID-19 vaccine.

The final sample of the community priorities survey comprised 273 respondents who were residents of Hudson County. Appendix F provides a table with demographic composition of survey respondents. Respondents to the Hudson County Community Health Needs Assessment Survey were predominately White, female, and higher socioeconomic status. About 74% were employed full-time. Throughout this report, Hudson County residents who participated in the Community Health Needs Assessment Survey are referred to as “respondents” (whereas focus group members and interviewees are referred to as “participants” for distinction).

Analyses

Frequencies were calculated for each survey question. Not all respondents answered every question; therefore, denominators in analyses reflect the number of total responses for each question, which varied by question. Statistical testing (Z-tests) was conducted across sub-groups to determine whether there were significance differences between groups. Survey data by race/ethnicity specifically is presented in this report. Racial/ethnic groups are delineated by a letter (A, B, C, D). When a graph has a letter next to the bar, it indicates that the group for that bar has a statistically significant different frequency of responses compared to the group of the letter shown (e.g., when an A is on the bar of White respondents, it indicates that percentage of White respondents answering the question in that

particular way is statistically significantly different than Asian respondents). Significant differences at 90% confidence levels are presented in the report.

Data Limitations

As with all data collection efforts, there are several limitations that should be acknowledged. Numerous secondary data sources were drawn upon in creating this report and each source has its own set of limitations. Overall, it should be noted that different data sources use different ways of measuring similar variables (e.g., different questions to identify race/ethnicity). There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific population groups (e.g., race/ethnicity) or at a more granular geographic level (e.g., town or municipality) due to small sub-sample sizes. In some cases, data from multiple years may have been aggregated to allow for data estimates at a more granular level or among specific groups.

With many organizations and residents focused on the pandemic and its effects, community engagement and timely response to data collection requests were challenging. Additionally, with its online administration method, the community survey used a convenience sample. Since a convenience sample is a type of non-probability sampling, there is potential selection bias in who participated or was asked to participate in the survey. Due to this potential bias, results cannot necessarily be generalized to the larger population. Similarly, while interviews and focus groups provide valuable insights and important in-depth context, due to their non-random sampling methods and small sample sizes, results are not necessarily generalizable. Due to COVID-19, focus groups and interviews were also conducted virtually, and therefore, while both video conference and telephone options were offered, some residents who lack reliable access to the Internet and/or cell phones may have experienced difficulty participating. This report should be considered a snapshot of an unprecedented time, and the findings in this report can be built upon through future data collection efforts.

Population Characteristics

Population Overview

According to the 2016-2020 American Community Survey (U.S. Census), Hudson County is the fourth most populous county in New Jersey (671,923 residents). The Jersey City Medical Center’s primary and secondary service area comprises 6 Jersey City zip codes (totaling 330,002 residents), and the cities of Bayonne (65,112 residents), Hoboken (53,283 residents), and Union City (68,073). There has been great variability in population growth across the areas examined. Whereas New Jersey overall and Hudson County, specifically, have seen minimal changes in total population between the periods 2011-2015 and 2016-2020, Jersey City zip code 07302 experienced a population growth explosion (18.5%), whereas zip codes 07306 and 07307 experienced an important population exodus during the same period (-7.1% and -9.9%, respectively). The population of Bayonne and Union City declined (-0.4% and -0.8%, respectively) and that of Hoboken increased (1.6%) minimally over this time (Table 1).

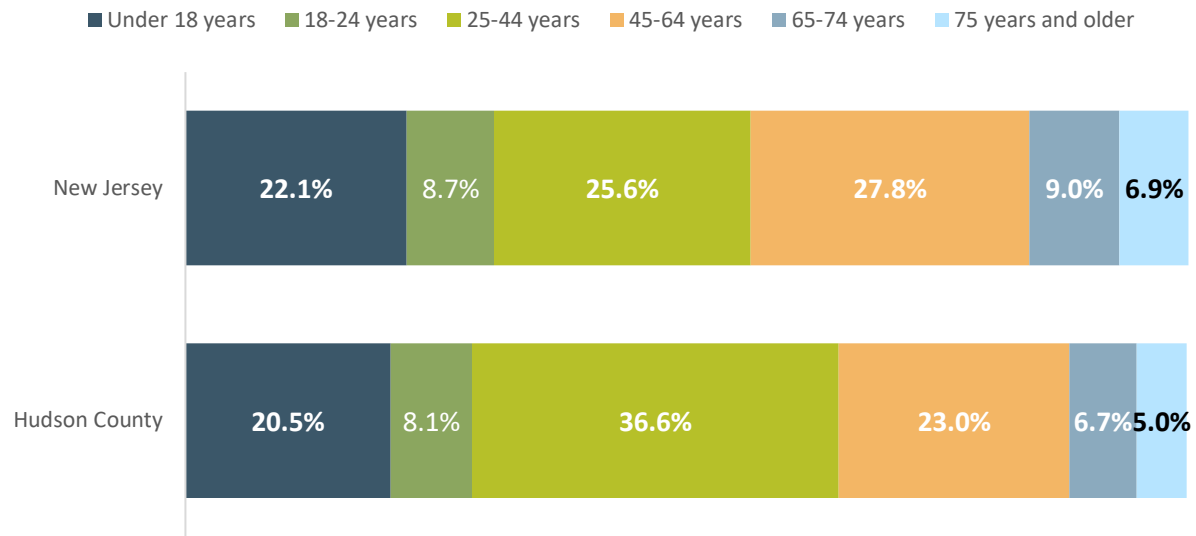
Table 1. Total Population, by State and County, 2011-2015 and 2016-2020

	2015	2020	% change
New Jersey	8,904,413	8,885,418	-0.2%
Hudson County	662,619	671,923	1.4%
Bayonne	65,378	65,112	-0.4%
Hoboken	52,452	53,283	1.6%
Jersey City	327,847	330,002	0.7%
Jersey City (07302)	39,964	47,339	18.5%
Jersey City (07304)	42,935	43,554	1.4%
Jersey City (07305)	63,440	66,595	5.0%
Jersey City (07306)	55,296	51,378	-7.1%
Jersey City (07307)	44,400	40,012	-9.9%
Jersey City (07310)	13,156	13,051	-0.8%
Union City	68,656	68,073	-0.8%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

More young adults lived in Hudson County compared to New Jersey overall in 2016-2020 (Figure 3), with about 37% of the population being between the ages of 25-44 years old; in contrast fewer children under 18 years of age and older adults live in the county. Age distribution data by town and gender can be found in the Appendix of additional data.

Figure 3. Age Distribution, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

When examining age distribution data by race/ethnicity in Hudson County, children under 18 made up a greater percentage of the population among persons of Other Race (26.9%) and Hispanic/Latinos (15.7%), followed by Black (14.6%), and a smaller proportion of Asian (11.2%) and White (10.3%) residents. Adults aged 65 and over comprised 9.9% of the White population compared to 6.1% of the Asian population, see Table 2.

Table 2. Age Distribution, by Race/Ethnicity, State, and County, 2016-2020

	Asian					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	14.6%	5.0%	21.8%	17.0%	4.8%	3.0%
Hudson County	11.2%	4.7%	32.8%	11.9%	3.8%	2.3%
	Black					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	15.0%	6.7%	18.3%	17.3%	4.8%	3.3%
Hudson County	14.6%	6.9%	21.0%	15.7%	4.2%	3.1%
	Hispanic/Latino					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	19.1%	6.7%	20.4%	14.9%	3.3%	2.2%
Hudson County	15.7%	6.1%	20.7%	16.0%	4.4%	3.4%
	White					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	12.2%	5.1%	14.7%	20.1%	7.8%	6.3%
Hudson County	10.3%	4.0%	27.3%	15.8%	5.5%	4.4%

	Some Other Race					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	28.5%	10.3%	32.4%	21.5%	4.6%	2.6%
Hudson County	26.9%	9.3%	33.5%	22.8%	5.1%	2.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

NOTE: Some Other Race includes individuals that identified as American Indian/Alaskan Native, Native Hawaiian or Other Pacific Islander, or as some other race.

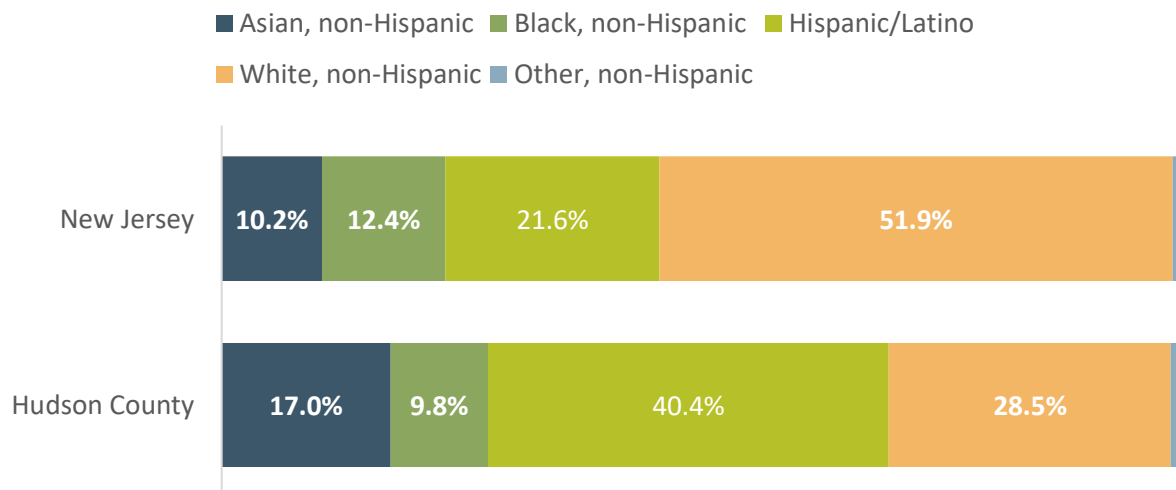
Racial, Ethnic, and Language Diversity

Racial and Ethnic Composition

Focus group members and interviewees described their communities as racially and ethnically diverse and valued this diversity as one of Hudson County’s greatest assets. The secondary data support these perceptions. Hudson County is predominantly made up of Hispanic/Latino residents, which make up 40.4% of its population, followed by White non-Hispanic (28.5%), Asian (17.0%), and Black (9.8%). Hudson County has proportionally more Hispanic/Latino and Asian residents than New Jersey as a whole (Figure 4). See the Appendix for detailed data tables.

“Jersey City’s greatest strength has always been diversity.” – Focus group participant

Figure 4. Racial and Ethnic Distribution, by State and County, 2020



DATA SOURCE: U.S. Census Bureau, Decennial Census of Population and Housing, 2020

Data labels not shown for percentages <4%.

In 2016-2020, the racial and ethnic distributions varied widely across Hudson County (Table 3) with Hoboken and Union City being the most homogenous cities, and zip codes within Jersey City being quite diverse. For example, in Jersey City zip code 07310, 57.3% of the population identified as Asian, compared to 3.5% in Union City. The largest Black population was found in zip codes 07305 and 07304, which made up 44.1% and 34.8% of residents, compared to 2.3% in Union City and 2.6% in Hoboken.

Residents identifying as Hispanic/Latino made up 76.7% of the Union City and 42.2% of the Jersey City zip code 07307 population, in contrast to 9.3% in zip code 07310. Residents identifying as non-Hispanic White were concentrated in Hoboken (67.1% of residents), followed by Bayonne (44.3%), and made the smallest proportion of the population in zip code 07305 (11.7%).

Table 3. Racial and Ethnic Distribution, by Town, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	Other Race/Ethnicity, Non-Hispanic
Hudson County					
Bayonne	9.8%	8.4%	34.5%	44.3%	0.5%
Hoboken	11.7%	2.6%	15.3%	67.1%	0.2%
Jersey City (07302)	32.2%	6.6%	16.7%	40.1%	0.3%
Jersey City (07304)	13.5%	34.8%	32.9%	14.9%	1.4%
Jersey City (07305)	16.7%	44.1%	23.4%	11.7%	1.7%
Jersey City (07306)	34.8%	9.9%	28.4%	23.0%	1.1%
Jersey City (07307)	24.4%	6.5%	42.2%	24.2%	0.9%
Jersey City (07310)	57.3%	5.4%	9.3%	23.1%	1.3%
Union City	3.5%	2.3%	76.7%	15.9%	0.6%

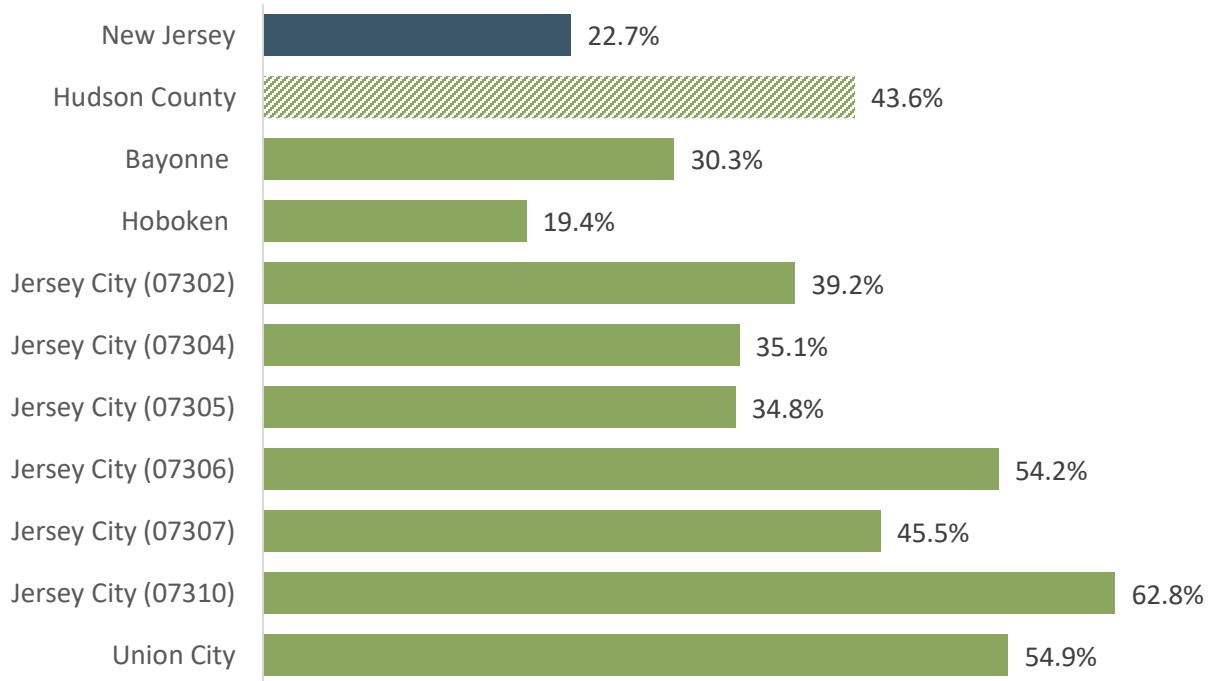
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Foreign-Born Population

Key informant and focus group participants described a robust immigrant community in Hudson County. Multiple waves of migration resulted in pockets of recent and not-so-recent immigrants from many Latin American and Caribbean as well as Southeast Asian countries. Secondary data show varying levels of the foreign-born population across Hudson County. More than two out of every five Hudson County residents are foreign born (43.6%), double the percentage of foreign-born residents in New Jersey as a whole (22.7%). In 2016-2020, the foreign-born population ranged from 19.4% in Hoboken to 62.8% in Jersey City zip code 07310 (Figure 5). In Hudson County, the most common countries of origin for immigrant residents were India and the Dominican Republic (making up 12.8% and 12.1% of the immigrant population, respectively). The majority of other immigrants were from Latin America and the Caribbean, primarily Ecuador, Cuba, and Colombia (see Table 4).

“The [Filipino] community has strong roots, and generations of families that have made Jersey City their home.” – Focus group participant

Figure 5. Percent Foreign Born Population, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 4. Foreign-Born Population by Top Countries of Origin, by State and County, 2016-2020

New Jersey		Hudson County		
1	India	13.1%	India	12.8%
2	Dominican Republic	9.1%	Dominican Republic	12.1%
3	Mexico	5.1%	Ecuador	6.5%
4	Colombia	4.3%	Cuba	6.4%
5	Ecuador	4.1%	Colombia	5.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

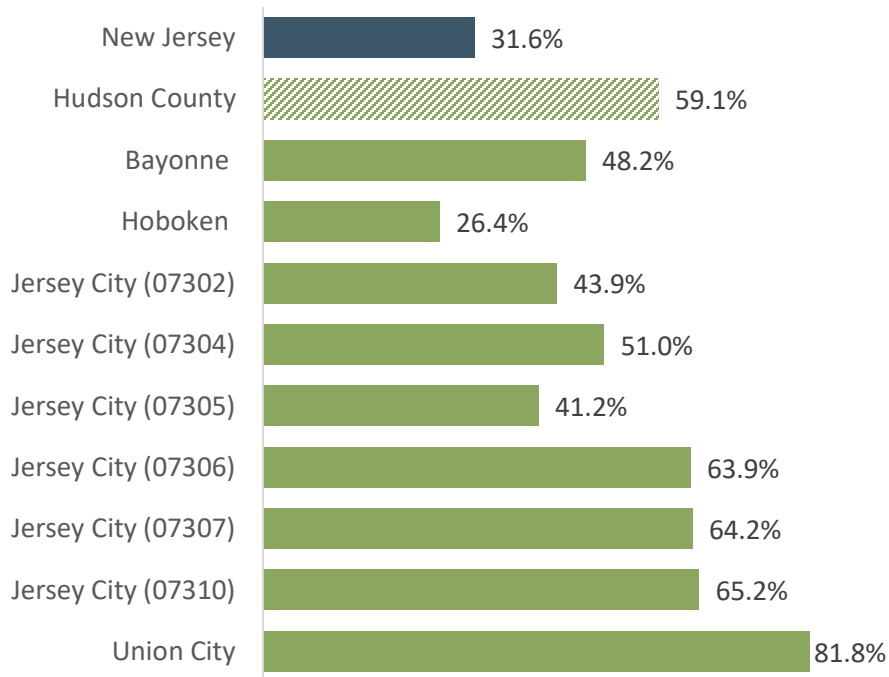
Several participants mentioned the struggles faced by undocumented immigrants in their day-to-day life because of their status. The anti-immigrant rhetoric of recent years, coupled with increases in raids targeting immigrants, has severely affected the mental well-being of this community, provoking undue stress and anxiety. This is coupled by barriers to access basic protections related to employment and housing due to their legal status. Further, these populations have been among the most affected by COVID-19, both in terms of sickness, as well as in terms of job loss. Whereas free or low-cost medical care is available to everyone regardless of documentation status via the FQHCs and other providers, participants commented that more efforts are needed to reach the entire eligible population and bridge the care gap.

“This a time when immigrants are feeling unsafe. They're scared going and saying, “I'm undocumented”.”– Key informant interviewee

Language Diversity

A majority of Hudson County residents over age five (59.1%) reported speaking a language other than English at home in 2016-2020, with large local differences. For example, almost five in six Union County residents (81.8%) and four in six in Jersey City zip codes 07306 (63.9%), 07307 (64.2%), and 07310 (65.2%) spoke a language other than English at home, compared to one in four Hoboken residents (26.4%) (Figure 6). A variety of languages are spoken across Hudson County, as indicated in the secondary data and supported by qualitative discussions. The most spoken languages other than English are Spanish (37.1%), other Indo-European languages (e.g., Portuguese, Hindi, Gujarati) (8.3%), Arabic (2.6%), Chinese (2.4%), and Tagalog (2.1%) (Table 5). Other languages spoken include Russian, Polish and other Slavic languages; French, Haitian or Cajun; Korean; and Vietnamese, reflecting the county's diverse communities. The distribution of these languages is not even. For example, three-quarters of residents in Union City speak Spanish (75.8%), while 24.9% of residents in Jersey City zip code 07310 speak other Indo-European languages and 19.7% speak Chinese. There are also, for example, pockets of Arabic speakers in Bayonne and Jersey City zip codes 07306 and 07304; while the Filipino community is largely concentrated in Jersey City zip codes 07304, 07305, and 07306.

Figure 6. Population Aged 5+ Speak Language Other Than English at Home, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 5. Top Languages Spoken at Home, by State, County, and Town, 2016-2020

	Speak only English	Spanish	Other Indo-European languages	Chinese (incl. Mandarin, Cantonese)	Tagalog (incl. Filipino)	Other Asian and Pacific Island languages	Arabic
New Jersey	68.4%	16.4%	5.4%	1.4%	0.9%	1.5%	0.9%
Hudson County	40.9%	37.1%	8.3%	2.4%	2.1%	1.7%	2.6%
Bayonne	51.8%	25.0%	5.3%	0.6%	2.7%	1.2%	8.1%
Hoboken	73.6%	10.2%	4.6%	4.5%	0.4%	0.8%	0.1%
Jersey City (07302)	56.1%	9.6%	13.6%	7.3%	1.4%	3.6%	0.7%
Jersey City (07304)	49.0%	29.1%	2.3%	0.4%	5.5%	1.5%	6.7%
Jersey City (07305)	58.8%	18.5%	3.4%	0.9%	6.4%	0.3%	2.4%
Jersey City (07306)	36.1%	22.4%	18.9%	1.7%	5.8%	4.2%	6.8%
Jersey City (07307)	35.8%	36.6%	18.2%	1.1%	1.3%	2.1%	1.8%
Jersey City (07310)	34.8%	8.4%	24.9%	19.7%	0.1%	6.3%	0.1%
Union City	18.2%	75.8%	1.8%	1.1%	0.4%	0.4%	0.7%

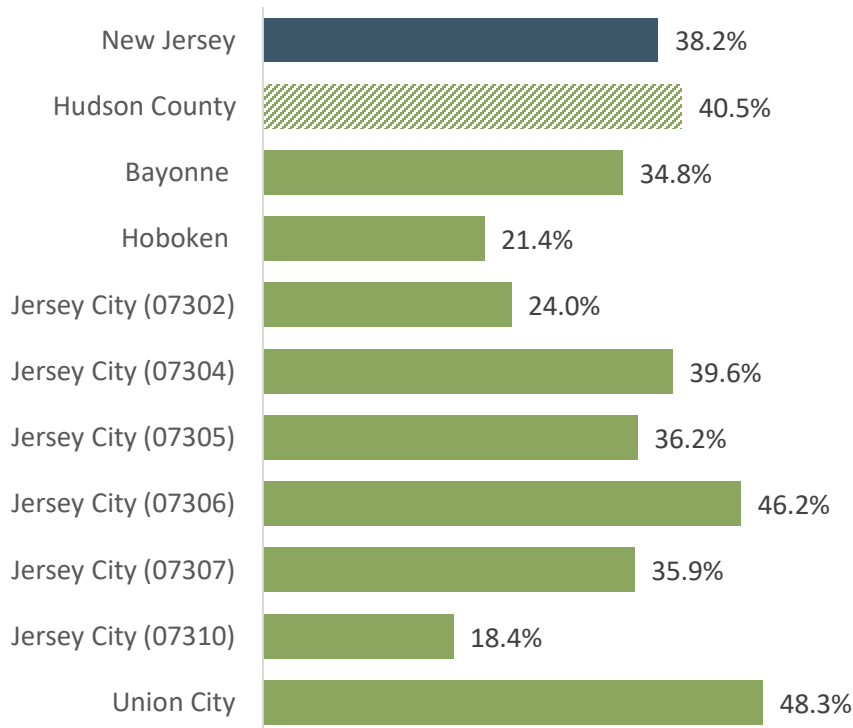
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Many participants agreed that one of Jersey City and Hudson County's greatest strength is its diversity. Based on resident feedback, Hudson County is a welcoming place for foreign-born persons, non-English speakers, and people of diverse ethnic backgrounds. A Filipino resident expressed it as, *"the [Filipino] community has strong roots, and generations of families that have made Jersey City their home."* Overwhelmingly, residents indicated that they enjoyed the opportunity to learn about different cultures, and to access foods and other cultural elements from a variety of regions. As a focus group participant explained, *"It's a multicultural city so you have several different ethnicities... you get to learn about the food and people's culture."* Residents overall also valued that medical and social services providers looked like them and spoke to them in their native language. However, opinions differed in terms of the availability of multilingual providers and providers of color. Whereas residents of Indian descent indicated that *"there are plenty of Indian, multiple language speakers, physicians in the JCMC and in the community,"* Latino residents were more nuanced noting that whereas the federally qualified health centers (FQHCs) had ample Spanish speakers, hospitals in the area needed more staff that spoke their language.

"I do feel welcome by healthcare providers, but I have experienced going with my parents who are immigrants with heavy accents, and I have experienced miscommunication." – Focus group participant

While diversity was a substantial community strength, participants noted that it could also be a challenge to engagement. In Hudson County, 40.5% of residents were not proficient in English in 2016-2020, ranging from 18.4% in Jersey City zip code 07310 to 48.3% in Union City. Lack of English proficiency can pose a barrier to entering the professional workforce, learning, and accessing healthcare. Those working in the social sector worried about populations not reached with information or services. In the words of a public health official, *"we talk to funders all the time about how to translate health information into other languages, how to connect to communities. We talk about it all the time, how to get into mosques, communicate in other ways besides English newspapers, how to create equity for people who are following the news."* In addition, lack of English-proficiency can lead to discrimination. According to survey data, 22.7% of Asian respondents and 17.6% of Latino community respondents specifically described being discriminated against because of language/speech issues when receiving medical care (discussed in greater detail in the Discrimination and Racism section of this report.)

Figure 7. Population Lacking English Proficiency (Out of Population Who Speak a Language Other Than English at Home), by State, County, and Town, 2016-2020

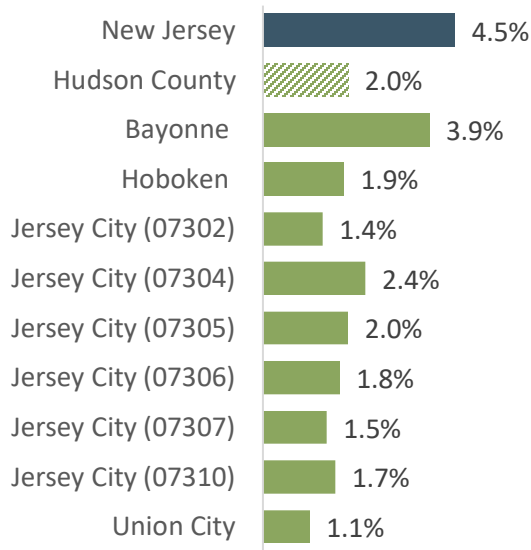


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

U.S. Veterans

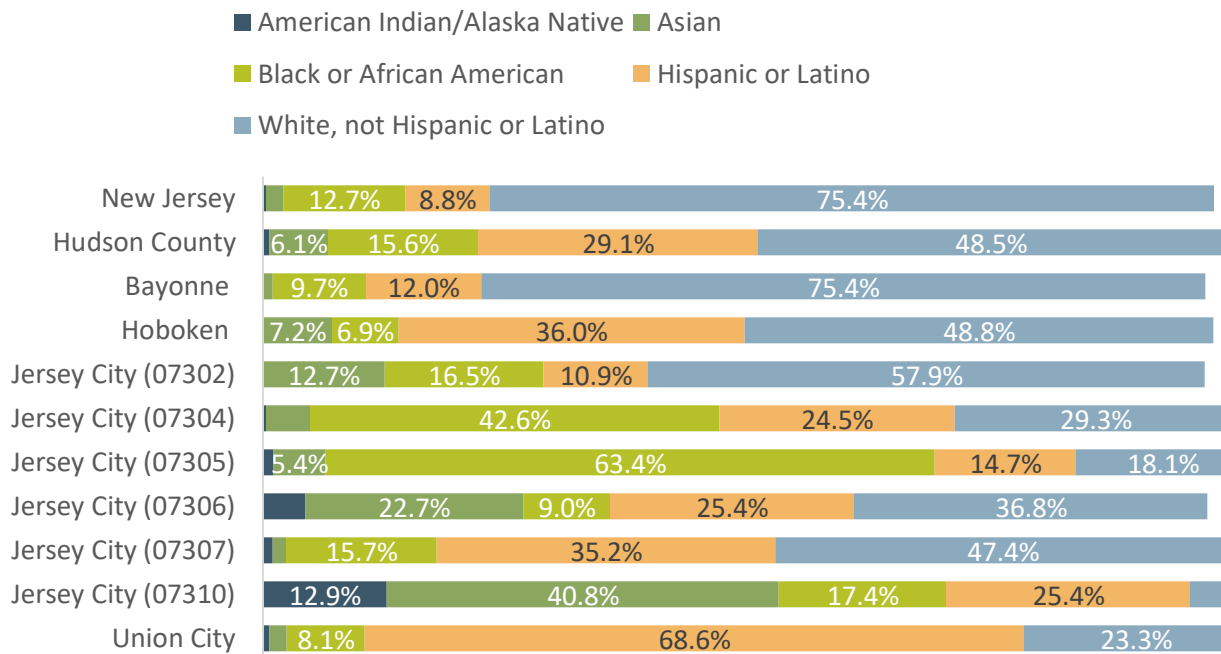
One of the groups whose needs were highlighted during discussions were U.S. veterans. About 2% of the Hudson County population are veterans, with the city of Bayonne having the highest percentage of the areas observed (3.9%) (Figure 8). The race/ethnicity of veterans in Hudson County mimics the diversity of the county’s population. Hudson County has proportionately more veterans who identify as Asian (6.1%), Black (15.6%), and Latino (29.1%) residents than the state (Figure 9), with important variation across neighborhoods. A majority of veterans in Jersey City zip codes 07304 and 07305 identify as Black (42.6% and 63.4%, respectively), whereas 40.8% of veterans in Jersey City zip code 07310 identify as Asian, and 68.6% of veterans in Union City identify as Latino. Bayonne and Jersey City 07302 have the highest concentration of White veterans (75.4% and 57.9%, respectively).

Figure 8. Percent Population 18+ Years with Veteran Status, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 9. Racial/Ethnic Distribution of Veterans, by State, County, and Town, 2016-2020



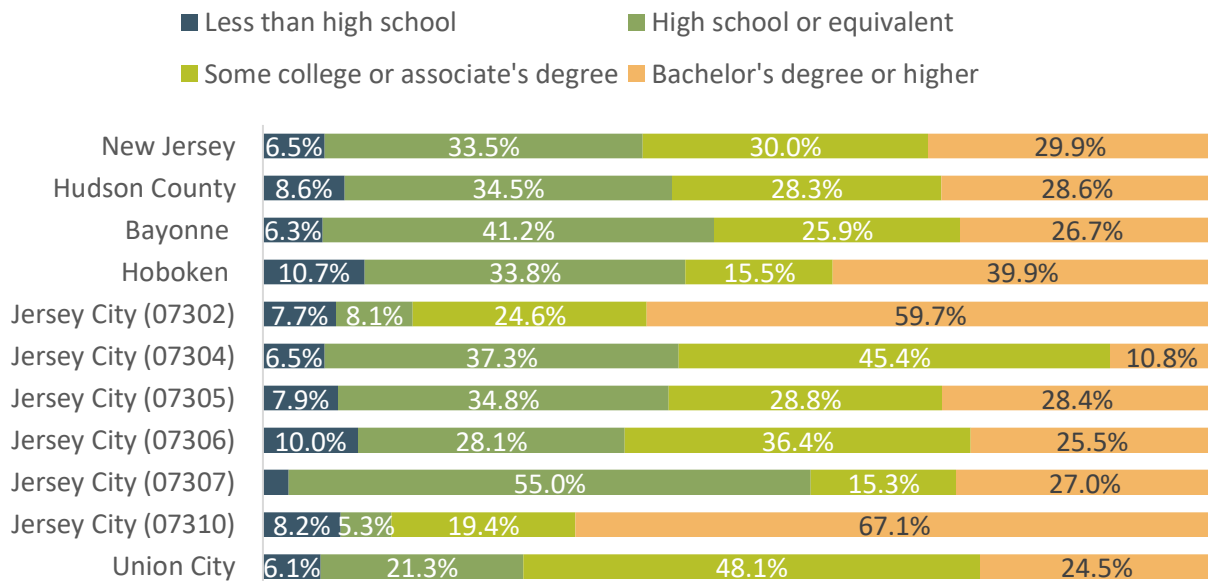
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive unless stated. Values under 5.0% are omitted for clarity.

Veterans in Hudson County remarked that they had limited employment opportunities available to them. They mentioned that, often, the jobs available to them after serving the government were for positions requiring no special skills, underpaid, and with few possibilities for advancement. Education is

an important factor in gaining access to higher-paying positions. When examining the educational attainment of veterans in Hudson County, we observe that most veterans did not have a bachelor’s degree or higher (71.4%) (Figure 10). Only 10.8% of residents obtained a college degree in Jersey City zip code 07304, where many Black veterans reside. Employment and education, together with mental and physical health, are closely related to poverty. A higher proportion of veterans in Hudson County live below the poverty line than in New Jersey (7.5% vs. 5.2%, respectively). This proportion is much higher in Jersey City 07306, where one in five veterans live in poverty, and Jersey City zip code 07305, where 18.0% do. It is important to remember that the poverty line is substantially below a livable income and has become even more so recently with high rates of inflation. Special issues faced by veterans are discussed throughout the report in the specific topic area sections.

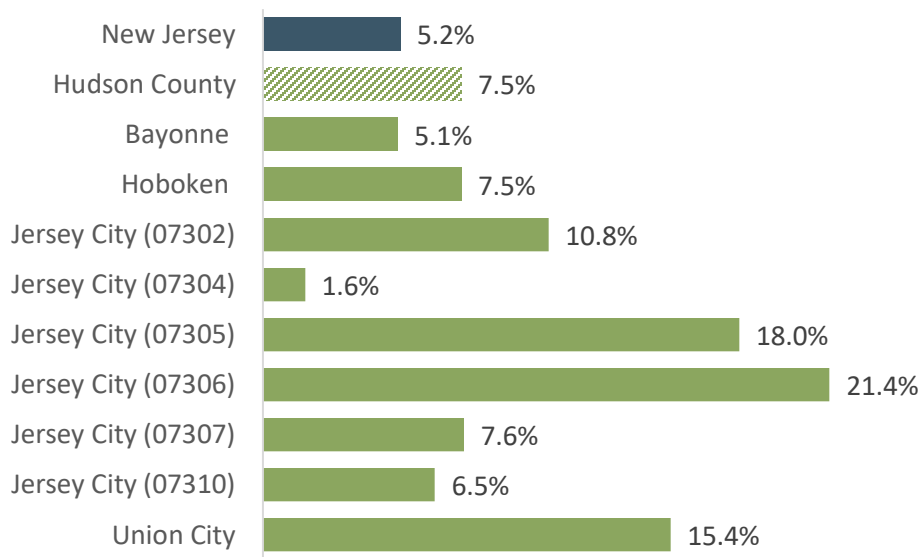
Figure 10. Educational Attainment of Veterans, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

NOTE: Values under 5.0% are omitted for clarity.

Figure 11. Percent Veterans Below Poverty Level, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Community Social and Economic Environment

Income, work, education, and other social and economic factors are powerful social determinants of health. For example, jobs that pay a living wage enable workers to live in neighborhoods that promote health (e.g., built environments that promote physical activity and resident engagement, better access to affordable healthy foods), and provide income and benefits to access health care. In contrast, unemployment, underemployment, and job instability make it difficult to afford housing, goods and services that are linked with health and health care, and also contribute to stressful life circumstances that affect multiple aspects of health.

Community Strengths and Assets

Understanding the resources and services available in a community—as well as their distribution—helps to elucidate the assets that can be drawn upon to address community health, as well as any gaps that might exist.

Strong Community and Partnerships

In addition to diversity noted previously, another strength mentioned by participants was solidarity and a strong sense of community. Time and time again, participants noted that neighbors came together to help those in need. As a resident noted, *“My specific neighborhood is very close knit, you know the people in the area and people are willing to help you. For example, when it snows, I’ve had young kids, young teenagers ask like, can we help you?”*

Residents remarked that the community was able to organize and take action to address people’s needs and this came to the forefront throughout the pandemic, including through generous donations. A healthcare administrator echoed this sentiment, *“these are communities that show up when the need is there, and we saw that during the COVID pandemic. We raised over a million dollars for an emergency response fund, from old donors and new donors.”*

“I’m new to Jersey City, but I noticed since doing Covid work in June that there is a strong sense of community.”
– Focus group participant

At an institutional level, another strength are the robust partnerships established among multiple organizations and across sectors, including grassroots organizations, government, small businesses, social services agencies, and healthcare centers. These collaborations are exemplified by the Partnership for a HealthierJC, made up of nearly 300 member organizations. A public health official noted, *“We have great partners. Hudson County is very tight, so we all work together.”* As a health administrator said when reflecting on the response to COVID-19, *“As organizations ... who did demonstrate that more than whatever resources were available to our community, we all jumped in and that includes Jersey City Medical Center. We were able to get people in and out of the hospitals quickly and people were able to communicate with each other.”* This was echoed by public health staff from different areas of Hudson County, as exemplified by what this participant from Bayonne said, *“Whenever there is an emergency, Bayonne comes together as a community to help people out, through donations or referrals for services.”*

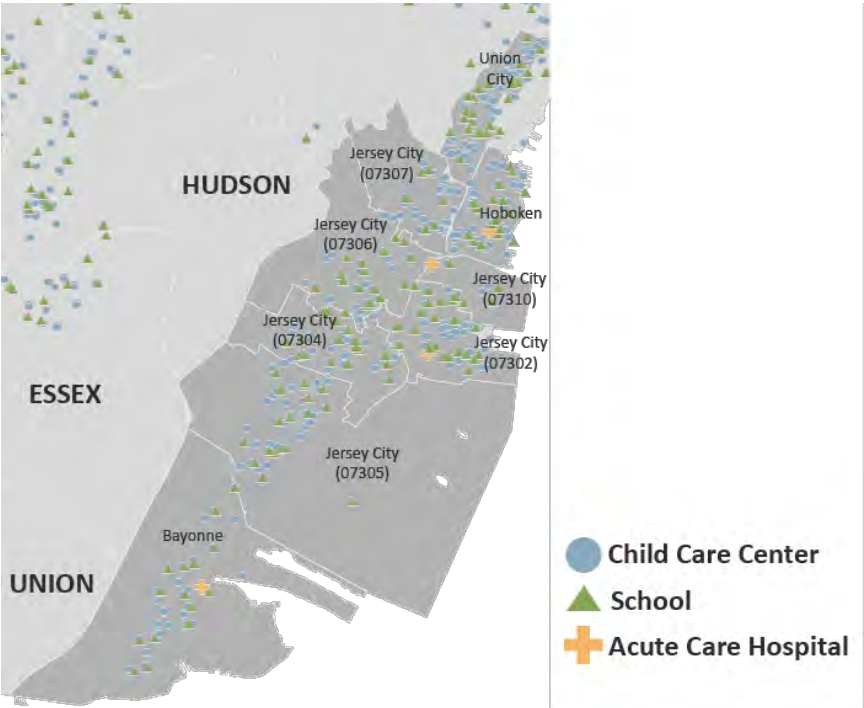
Public Services and Programs

Some participants indicated that their elected officials were a source of strength in Hudson County. A diverse array of residents, including from the Latino, Asian, and LGBTQ+ community, indicated being represented and supported by government leaders. One example of support for the LGBTQ+ community was the recent passing of the law to let students use bathrooms that are consistent with their gender identity, considered an important step in fostering welcoming and safe spaces for gender nonbinary youth. Residents noted that the Jersey City government was responsive to their needs and that they received abundant support during the COVID-19 pandemic, as expressed by a Latino resident, *“The mayor’s office provides very good services; for example, if someone has to travel far to get to the doctor, or if they need translation of a document to Spanish—you can call the mayor’s office for everything.”*

Overall, residents indicated that Hudson County offers many services to people to ensure that residents live well and can access their basic needs. The map below shows the distribution of hospitals, schools, and childcare centers in the area.

There are four acute care hospitals as well as 151 schools and 301 childcare centers in the JCMC service area (Figure 12).

Figure 12. Community Assets Map of Hudson County, 2018 & 2020



DATA SOURCE: New Jersey Geographic Information Network (NJGIN), Schools and Child Care Centers, 2018 and Acute Care Hospitals, 2020

As one resident summed up, “...there is something going on almost every week to help with food, home purchases, that’s one of the things I really love about Jersey City.” A Hoboken resident expressed something similar, noting that a strength in Hoboken were the “strong non-profit organizations and religious organizations that provide supportive services related to housing assistance and information, nutritional support, recreational activities for children, tutoring...” Latino residents discussed how the county offered resources in the community to support people, including people who are low-income, undocumented, and/or without health insurance.

“From my experience, over 20 years, I feel that the greatest strengths are the community-based organizations. We have a wide range of individuals who form different communities, even small grassroots community-based organizations, to engage people in healthy ways.” – Key informant interviewee

Other Community Assets

Community survey respondents partially agreed with these themes. When asked how much they agreed or disagreed with a number of statements about their community, responses were similar to when this survey was administered in 2019. The strengths identified by the greatest proportion of respondents in 2021 were that it was easy to find fresh fruits and vegetables in their communities (73.6%), that their communities had safe outdoor places to walk and play (70.3%), and that their community was a good place to raise a family (59.7%) and to socialize (58.2%) (Figure 13). These were the same top responses in 2019.

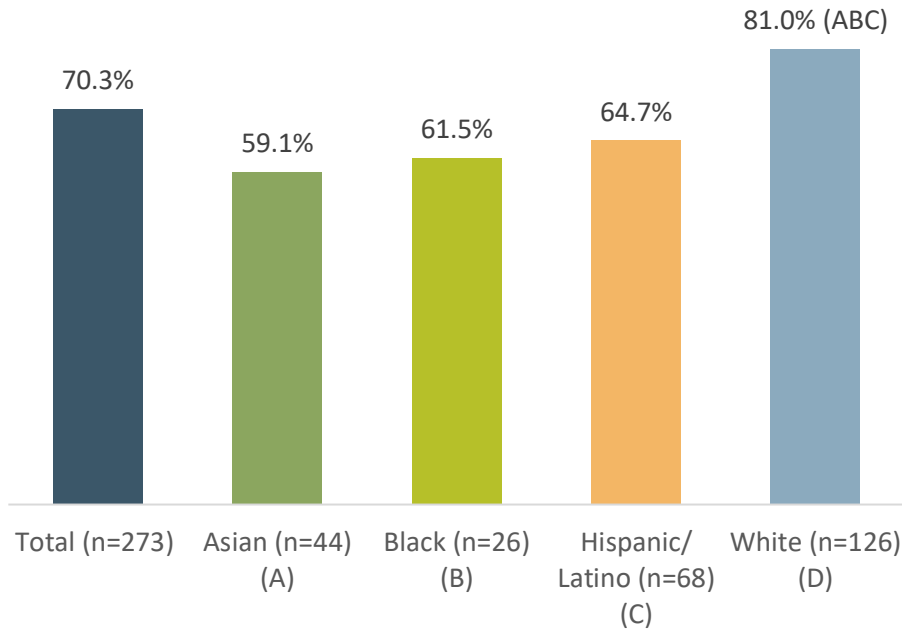
Figure 13. Percent of Community Survey Respondents Noting Strengths in Their Community (Agree or Completely Agree with Statements) (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

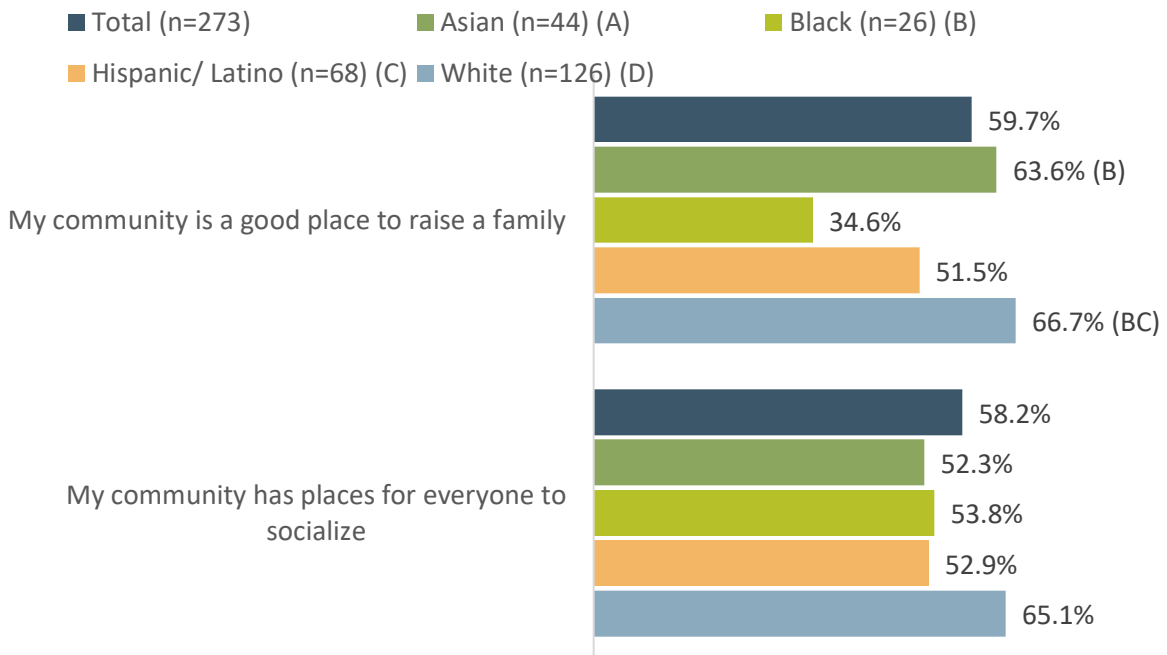
However, responses to these questions varied by race/ethnicity. For example, as can be observed in Figure 14, White respondents were significantly more likely than Asian, Black, and Latino respondents to agree or completely agree that their community had safe outdoor places to walk and play. As described in the Methods section, when a graph of community survey data has a letter next to the bar, it indicates that the group for that bar has a statistically significant different frequency of responses compared to the group of the letter shown. As shown, whereas 81.0% of White respondents perceived outdoor spaces as safe, only 59.1% of Asian respondents did so. Whereas there were no significant differences by respondents' race/ethnicity to the statement about having spaces to socialize, Asian (63.6%) and White (66.7%) respondents more often indicated that the community was a good place to raise their family than Black (34.6%) respondents (Figure 15). (More detailed discussions of responses by different population groups of other survey questions are found in the topic-specific sections of this report.) Additional data are available in Appendix F- Additional Data Tables.

Figure 14. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “My community has safe outdoor places to walk and play”, by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Figure 15. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement, by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Education

Educational attainment is another important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty.

School Environment and Health

A positive school environment is an important determinant of physical and mental wellbeing, as well as academic success, staying in school, and opting to continue on to higher education. An interviewee who was a member of the LGBTQ+ community lauded schools for their efforts to make school safe and welcoming to all youth. In their words, “[LGBTQ+] youth are still dealing with bullying, [but] schools are reaching out to learn and make spaces safer. School leaders come in to engage us as a liaison, to organize school clubs that are inclusive and to receive cultural competency training from us.”

Conversely, being healthy is a key factor in being academically successful. Schools play an important role in facilitating access to care and helping students stay healthy. A school administrator described some of the public school’s efforts to address the mental health needs of students, “We’ve been trying through the schools with our resources to really embed more social and emotional [support to] help students overcome challenges, develop resilience, and be able to speak about their emotions. [We have] incorporated that through the curriculum, through our school counselors, through our school psychologist.” Many students also face poverty and food insecurity; in providing free or low-cost lunches, schools also play an important role in ensuring basic nutrition for children.

Public Schooling

Focus group and interview participants discussed how the public school system in Hudson County faces a variety of issues. One is a lack of sufficient resources to attend to the needs of high-need population groups. There is a perpetual shortage of qualified educators, particularly in those areas where teachers need additional certifications or schooling. An education administrator emphasized that more qualified Special Education teachers, bilingual teachers, and content area teachers, like those that teach Science and Math, are needed to meet the needs of the student population. Another issue that came up was the lack of affordable after school programs, particularly important for children of low-income earners.

In some areas of Hudson County, such as Hoboken, a problem identified by participants was that there is insufficient space to accommodate the growing number of school children. Residents expressed that “[population] growth was not planned,” leading to overcrowding in public and charter schools. Residents discussed how new buildings and improved infrastructure for schools were needed to accommodate the influx of new residents coming to the new condominium buildings.

In spite of these challenges, most Hudson County residents indicated that public school leadership was supportive of students’ needs and open to partnerships with different organizations to better serve the community. Many residents remarked that the school leadership was attuned to the needs of students and their families, many of whom face multiple struggles. Given the large immigrant community in Hudson County, schools must accommodate to the needs of English-language learners.

Key informant interviewees indicated that Hudson County public schools fall along a broad spectrum encompassing both the top-ranking, as well as the lower performing, schools in New Jersey. School performance is determined largely by the socioeconomic situation of the community that draws the student population. There is an inverse association between socioeconomic status and high school graduation rates. Key informant interviewees noted that students experiencing poverty often had to drop out of school to start working and

“We have children who are immigrants and come in when they're 16 years old and are learning English. They need to graduate from high school, but they also need a job because economically they need to go work. It's a challenge.”

– Key informant interviewee

contribute an income to their families. These students’ vision for the future oftentimes does not include college as a career path unless they have access to a mentor who can help them enter a professional career. Key informant interviewees explained that low-income students faced multiple obstacles to entering college, including not being able to afford it; having to full-time to support the family; and not seeing the usefulness of a college degree. Based on this context, key informant interviewees indicated that public schools were trying to equip students’ transition into the workforce by incorporating classes and training related to workplace readiness. *“We've been working on it trying to incorporate more careers, not just OK you're gonna graduate and go to college and then get a job. But, you know, addressing the needs of those students who will not go to college.”*

Inequities in school performance are confirmed by graduation rate data from different Hudson County districts. Whereas in 2020-2021 the Hoboken Public School District had graduation rates slightly above those of New Jersey as whole (93.6% and 92.6%, respectively), the public school districts of Bayonne, Union City, and Jersey City had lower graduation rates, with significant disparities by race/ethnicity within districts (Table 6). For example, 95.3% of Asian students graduated from High School in Bayonne in 2020-2021, compared to 86.4% of Black children and 78.5% of Latino children. Additional information on differences in educational attainment by race/ethnicity and by town is available in Appendix F.

Table 6. 4-Year Adjusted Cohort High School Graduation Rate, by Race/Ethnicity and School District, 2020-2021

New Jersey	Statewide	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	2+ Races
	92.6%	97.6%	88.3%	87.4%	95.9%	93.5%
Hudson County	District Wide	Asian	Black	Hispanic	White	Two+ Races
Bayonne School District	86.4%	95.3%	86.4%	78.5%	94.1%	85.7%
Hoboken Public School District	93.6%	*	90.9%	95.2%	89.5%	N
Jersey City Public Schools	78.0%	93.7%	73.8%	72.8%	85.0%	45.5%
Union City School District	88.5%	*	91.7%	88.3%	90.5%	N

DATA SOURCE: New Jersey Department of Education, School Performance, Adjusted Cohort Graduation Rates, 2020-21

NOTE: * indicates that data is not displayed to protect student privacy. An N indicates that no data is available.

Promising Initiatives

To better address the needs of community, the Jersey City Board of Education has partnered with educators, families, and the community as a whole to launch a promising model known as ‘community schools.’ Community schools provide additional services than regular schools to meet the needs of students and families. In addition to regular school offerings, community schools aim to connect students and parents with a wide range of services, including afterschool programs, counseling, and social services. This model has helped to improve attendance, grades, and student and parent engagement. Some of the schools have brought in health clinics that offer nutrition and health care to both students and their families. According to a school administrator, the key to the success of one of the community schools is that *“it’s a very cohesive community,”* with *“good leadership at the school that has been good in working with the community, the providers,”* and the fact that *“the staff, the teachers are all vested and making it successful.”*

Another successful initiative that participants discussed was The Tiger's Den at Snyder High School, a result of a partnership between JCMC, The NJ Department of Children and Families, and the Jersey City Board of Education. The Tiger's Den offers free, confidential social services to students, families, and staff, including psychological counseling, vocational counseling, workplace readiness programs, academic support, summer employment, and after school programs. The Tiger’s Den also assigns students with mentors who they can talk to about their problems and guide them to resolve issues in a positive way. Graduation rate for students participating in The Tiger’s Den was 99% compared to 60% in the school overall.

These are promising strategies to help more students from low-income families finish High School and either enter the workforce in stable employment or continue on to college, two pathways to facilitate the transition to the middle class.

Inequality

Growing inequality, exacerbated as much by the COVID-19 pandemic as by policies and the existing economic model, was a theme that came out strongly in all focus groups and interviews. Most residents across racial/ethnic groups indicated that Jersey City was catering to the wealthy and that income distribution was unequal. As one participant summarized, *“We have the multimillion front, you know, waterfront properties and then we have below the poverty line, urban homes with very urban problems.”* Residents expressed frustration and a sense of injustice witnessing the rapid concentration of wealth in fewer hands, while employment loss and inflation lead more people into poverty. Residents consistently expressed that the city was catering to affluent families in detriment to middle- and low-income residents, and this was evidenced by policies related to real estate credits; infrastructure and public services investments; and a regressive taxation structure. Often, residents attributed racial/ethnic tension to this growing inequality, as expressed by these words, *“From our perspective you do have a lot of stressors around that, especially with gentrification, there is more tension with people originally from the neighborhood as opposite to newcomers. Tax breaks in one section, and in the African American section you can’t get your garbage picked up, there is tension and anger from the ‘tale of two cities’.”* As these words capture, there is also a racial/ethnic component superimposed on inequality, as Latinos and Black residents are disproportionately affected by household and neighborhood poverty. A Black resident reflected thus on the situation, *“they’re not really including us in the expansion of Jersey City. Jersey City is up and coming, but they’re not making room for low to middle income people... And this is people of all races, they’re not gonna pay all that money for taxes, and there are no jobs here.”*

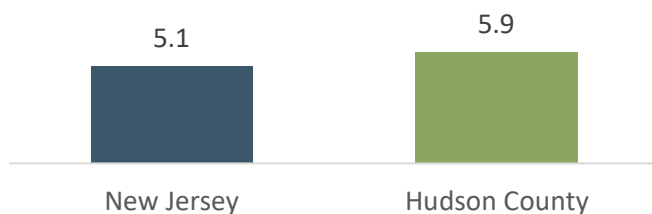
Neighborhood concentrated poverty compounds the effect of household poverty. Explaining the linkage between income, hopelessness, and violence, a resident noted, *“...And then there’s the level of community violence. Feeling really stuck in that cycle that they’re in, violence, income or job opportunities, social determinants of health like housing. People are getting pushed out as more development is coming.”*

“It’s like they don’t want us to be here anymore, they’re just welcoming the rich and affluent... It looks like Jersey City is trying to cater to the affluent instead of the people who grew up here.” – Focus group participant

On reflecting about her vision for the future, a key informant interviewee synthesized the voices of many residents, *“My biggest wish for this community is that we don’t have such an economically diverse community. If there’s a way to really help the families with the lowest resource economic resources to really have a more stable financial sense, that would be the ideal.”*

Inequality is reflected in many of the sections of this report, including education, employment and workforce, income and financial security, and access to healthcare, among others. For example, income inequality is greater in Hudson County (5.9) than in New Jersey overall (5.1) (Figure 16). Income inequality is calculated as the ratio of household income at the 80th percentile to that at the 20th percentile. A higher number indicates a greater income gap between the wealthiest and the poorest households.

Figure 16. Income Inequality (80th to 20th Percentile Income Ratio), by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020

NOTE: The ratio of household income at the 80th percentile to that at the 20th percentile, where the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes, and the 20th percentile is the level of income at which only 20% of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum.

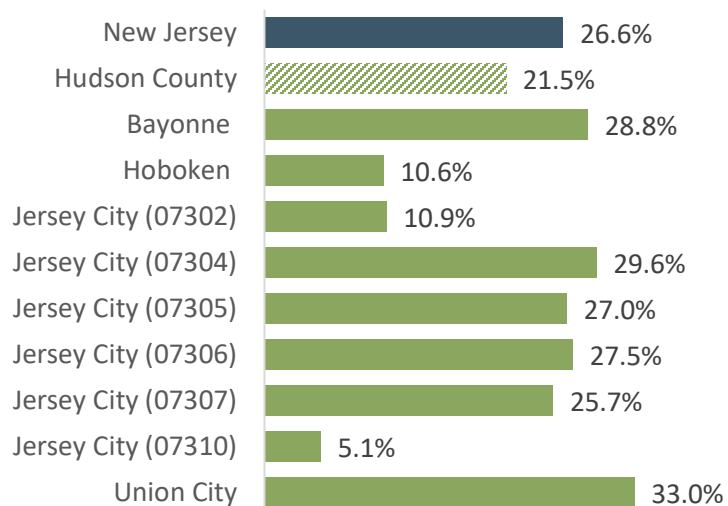
Employment and Workforce

Employment can confer income, benefits, and economic stability – factors that promote physical and mental health. Two main employment-related issues came out of the focus groups and interviews. On the one hand, many noted that employment opportunities were limited in Hudson County, particularly as a result of the pandemic. Often, they mentioned being unemployed or underemployed. Residents also said that employment opportunities were limited even among people with college degrees without the right connections. Job instability affected many residents across multiple groups. Multiple residents complained of the dearth of well-paid employment opportunities, that offer employees health and social benefits, a fixed income, and a living wage. Many of the residents we interviewed were working poor, who, despite working, could not afford housing, or had to choose between rent, food or medicine.

“I feel like getting a [college] degree was for nothing sometimes because like why am I still struggling to make it.” – Focus group participant

Indeed, in 2018, one in five of the County’s households were Asset Limited, Income Constrained, Employed (ALICE), meaning that although employed, they did not earn enough to support their families (Figure 17), ranging from 5.1% in Jersey City zip code 07310 to 33% in Union City.

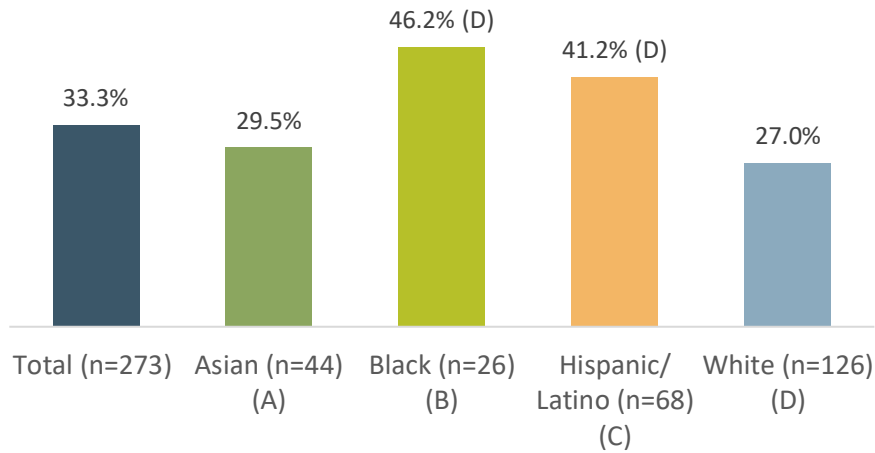
Figure 17. Percent Households Falling into ALICE Population, by State and County, 2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018 as reported by United Ways of New Jersey, Alice in New Jersey: A Financial Hardship Study, 2020

Participants talked about the challenges of the COVID-19 pandemic on essential front-line and lower wage workers, many of whom lost their jobs, either temporarily or permanently. Latino participants mentioned that many factories and restaurants closed during the pandemic and that they could not find jobs. The effects of COVID-19 on employment are also reflected in quantitative data. Black and Latino respondents were significantly more likely than White respondents to report having lost income due to COVID-19 (46.2%, 41.2%, and 27.0%, respectively) (Figure 18). Like New Jersey as a whole, in 2019, prior to the pandemic, Hudson County reported the lowest unemployment rate (3.1%) in recent years according to the Bureau of Labor Statistics (Figure 19). However, unemployment rates in 2020 spiked at 10.2%, recovering slightly to 6.3% in 2021. Additional data can be found in Appendix F- Additional Data Tables.

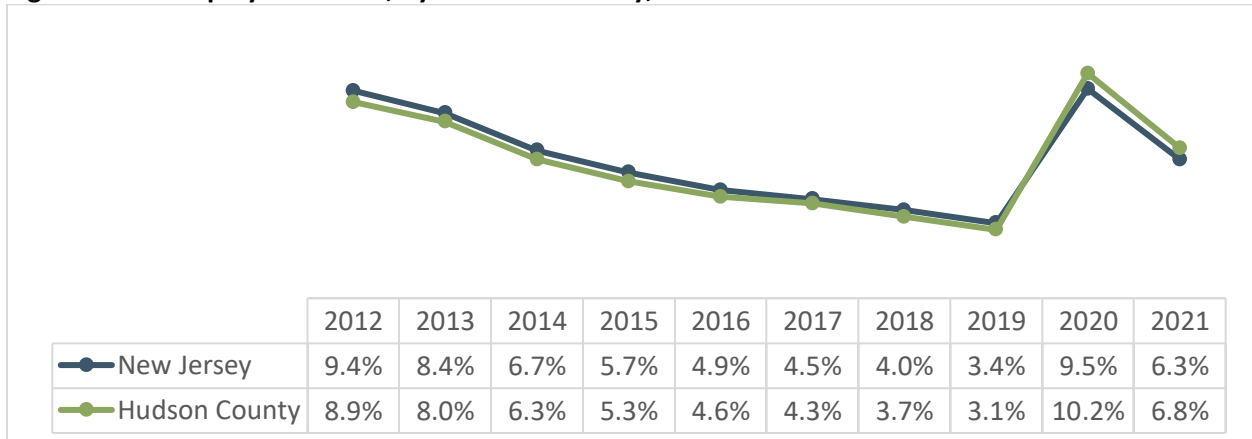
Figure 18. Percent of Community Survey Respondents Reporting that They or a Member of Their Family Lost Employment Due to COVID-19 (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Figure 19. Unemployment Rate, by State and County, 2012-2021



DATA SOURCE: Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012-2021

NOTE: Not seasonally adjusted

The 2016-2020 aggregated data from the American Community Survey show that unemployment rates across Hudson County ranged from 2.4% in Jersey City zip code 07302 to 7.0% in Jersey City zip code 07305 and 9.2% in Jersey City zip code 07304 (Table 7). However, this varies by race/ethnicity (Table 8). Indeed, unemployment rates map onto racial/ethnic groups; as discussed in the section on population characteristics, residents in zip code 070302 are predominantly White (40.1%) and Asian (32.2%), whereas over two-thirds of residents in zip codes 07304 and 07305 are Black and Latino (Table 3). The highest unemployment rates in Hudson County were among Native Hawaiian and Other Pacific Islander residents (35.9%), followed by American Indian and Alaska Native residents (10.1%) in 2016-2020, and the lowest were among Asian (3.5%) and White (4.0%) residents (Table 8). Additional data on unemployment rates can be found in Appendix F- Additional Data Tables.

Table 7. Unemployment Rate among Workers 16 Years and Above, 2016-2020

	2016-2020
New Jersey	5.8%
Hudson County	5.4%
Bayonne	6.5%
Hoboken	3.2%
Jersey City (07302)	2.4%
Jersey City (07304)	9.2%
Jersey City (07305)	7.0%
Jersey City (07306)	4.7%
Jersey City (07307)	4.4%
Jersey City (07310)	2.7%
Union City	6.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

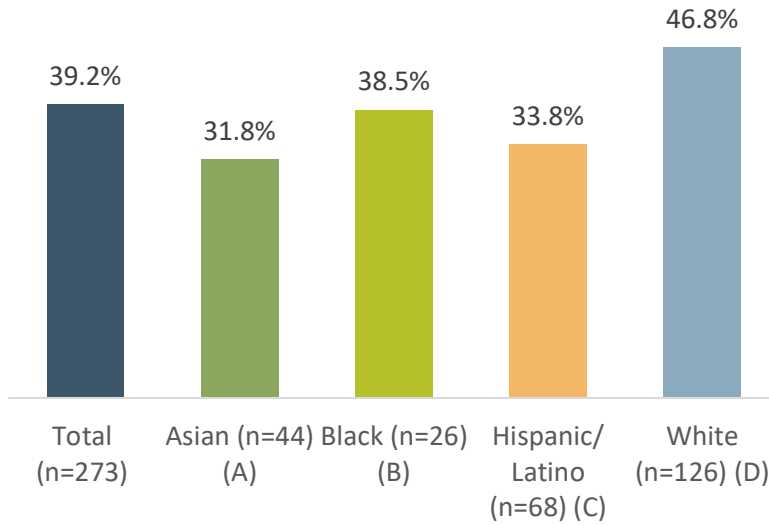
Table 8. Unemployment Rate by Race/Ethnicity, State, and County, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	American Indian and Alaska Native	Native Hawaiian and Other Pacific Islander	Other, Non-Hispanic
New Jersey	4.3%	9.0%	6.4%	5.0%	9.0%	6.5%	6.6%
Hudson County	3.5%	8.1%	6.6%	4.0%	10.1%	35.9%	6.9%
Bayonne	6.9%	6.3%	8.3%	5.6%	0.0%	100.0%	7.3%
Hoboken	3.7%	11.1%	6.3%	2.4%	0.0%	-	3.7%
Jersey City (07302)	1.1%	3.8%	3.3%	2.8%	0.0%	0.0%	2.7%
Jersey City (07304)	4.9%	9.8%	10.0%	9.9%	0.0%	-	10.9%
Jersey City (07305)	4.5%	8.4%	4.8%	8.3%	8.3%	-	6.2%
Jersey City (07306)	3.9%	5.5%	5.9%	5.2%	34.9%	-	3.5%
Jersey City (07307)	2.9%	9.1%	5.7%	2.6%	20.1%	-	3.9%
Jersey City (07310)	3.0%	8.4%	0.4%	2.1%	0.0%	-	0.0%
Union City	7.6%	4.6%	6.5%	3.7%	6.0%	30.2%	8.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When asked about employment in their area, survey respondents were not enthusiastic. Fewer than four in ten respondents agreed that “there are job opportunities in my area.” White respondents were more likely than respondents of any other race/ethnicity to perceive that there were employment opportunities in their area, although the differences were not statistically significant (Figure 20).

Figure 20. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “There are Job Opportunities in My Area,” by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

It is also important to understand overlapping conditions that may affect entering the workforce. Over the same period, unemployment rates in Hudson County were highest among women (5.6% among women compared to 4.9% among men) (Table 22 in the Appendix) and young people (18.8% among 16-19 year-olds and 11.0% among 20 to 24 year-olds) (Table 23 in the Appendix). The greatest difference in the female-to-male employment gap was in Jersey City zip code 07304 (10.8% female vs. 7.7% male unemployment rate), an area with many residents of color.

Residents noted that certain population subgroups in Hudson County faced more obstacles than others when seeking employment opportunities. Because of stigma and discrimination, Black trans women experienced multiple challenges to having a professional career and securing living-wage employment. As one key informant interviewee from the LGBTQ+ community explained, *“Black trans women experience the most barriers to employment. They become sex workers for survival. They have difficult experiences applying to jobs. They are ridiculed when applying to places.”* The options for gainful employment also appeared particularly dire for veterans, who are disproportionately Black and Latino. All veteran focus group participants agreed that the only types of jobs available to them either did not pay a living wage or were government jobs. Veteran focus group members expressed frustration at not being able to access satisfying and stimulating employment with growth opportunities. Residents suggested that more should be done to incentivize employers, including private employers, to hire trans and veteran residents.

When trying to interrupt the cycle of violence, whether domestic or community violence, gainful employment is critical to help survivors get on their feet. As a staff member from a violence interruption program mentioned, *“Employment is always an issue because you can tell folks a better day is coming, but what is the alternative? We try to never use that language unless we have an alternative. My main thing is stay safe and healthy. With the grant we just received, we have an opportunity to have 40-80*

participants, and we train them in electrical, plumbing, HVAC, and carpentry. Now we have something to say, I've got a job for you as long as you learn a skill and graduate from this program."

Time and time again participants mentioned that lack of secure and well-paid employment was an important contributor to depression. As a public health official said, *"Mental health issues happen because [veterans] cannot find jobs, they don't have the money, they have to move in with their parents."* And she continued, *"it's offensive to put someone who served, someone who earned a degree, behind a cash register... why are companies not stepping up, instead of making exorbitant profits, and training?"* Another resident said, *"[Not having a career], has been a part of my mental health depression."*

Income and Financial Security

Income is a powerful social determinant of health that influences where people live and their ability to access resources which affects health and well-being. The effects of poverty—food and housing insecurity, underinsurance, and stress leading to poor physical and mental health—are compounded by environmental factors. Areas with more concentrated poverty are also those with lower-performing schools, higher rates of community violence and substance use, buildings in worse conditions, and food deserts. Discussing issues related to children, a key informant interviewee said, *"We have, you know, that urban child with very limited resources, poverty, a lot of the issues of poverty and intergenerational poverty, with grandparents raising children."*

"People on the fringe of poverty have suffered." – Key informant interviewee

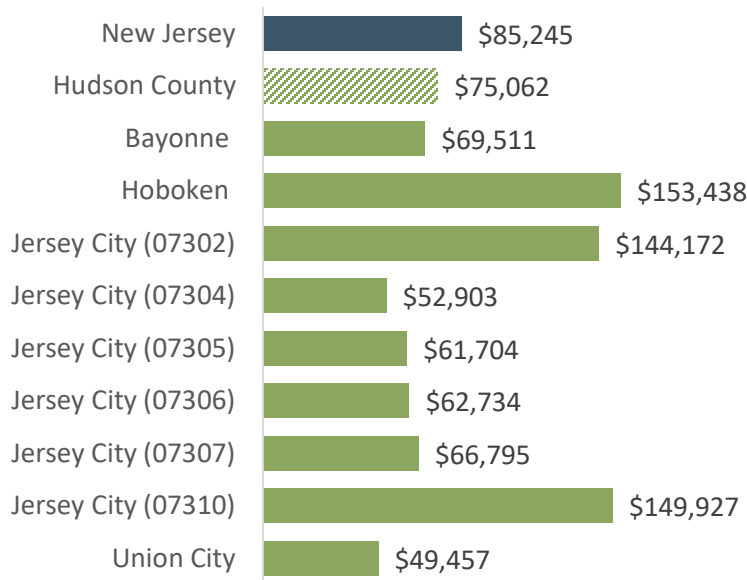
Many households face financial insecurity across many groups. Both children and youth face substantial insecurity, as well as older adults living on retirement. As discussed in the sections on Inequality and Employment and Workforce, inflation was a major concern for low-income earners as wages have not kept up with the cost of living. People across the spectrum were affected and many residents expressed concerns about the future, mentioning that wages were not keeping up with inflation, and as a result, more people were experiencing poverty.

Income and health are interrelated. Participants mentioned that people with chronic illnesses and disabilities often faced financial vulnerability as they were unable to work due to their health. In the words of a resident, *"There's income barriers, which runs into all areas. When you have physical health issues, that leads to loss of income."* On the other hand, residents noted that healthcare was not a priority when income was limited. Therefore, insufficient income becomes a barrier to accessing health insurance, preventive health care, and even treatment to manage chronic diseases. Many residents described that low-wage earners were faced with the dilemma of having to choose between food, rent, or medicine.

Household Income and Poverty

In Hudson County, financial wellbeing and insecurity varied by area. According to the 2016-2020 American Community Survey (U.S. Census), while the median household income for Hudson County (\$75,062) was below that of New Jersey (\$85,245) as a whole, the range in household income showed stark disparities. The median annual household income in 2016-2020 ranged from \$49,457 in Union City, where a majority of residents were Latino, to \$153,438 in Hoboken, with a majority of residents are White (Figure 21). Jersey City zip codes 07304, 07305, 07306, and 07307 all reported having median household incomes below the state average.

Figure 21. Median Household Income, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When analyzing these figures further, data show that Black and Latino households had lower median household incomes relative to the average across Hudson County. While Asian (\$116,309) and White (\$100,853) households reported incomes that were 55% and 34% higher than median household income in Hudson County (\$75,062), respectively, Black (\$53,196) and Hispanic/Latino (\$52,408) households earned 29% and 30% below the county median, respectively (Table 9).

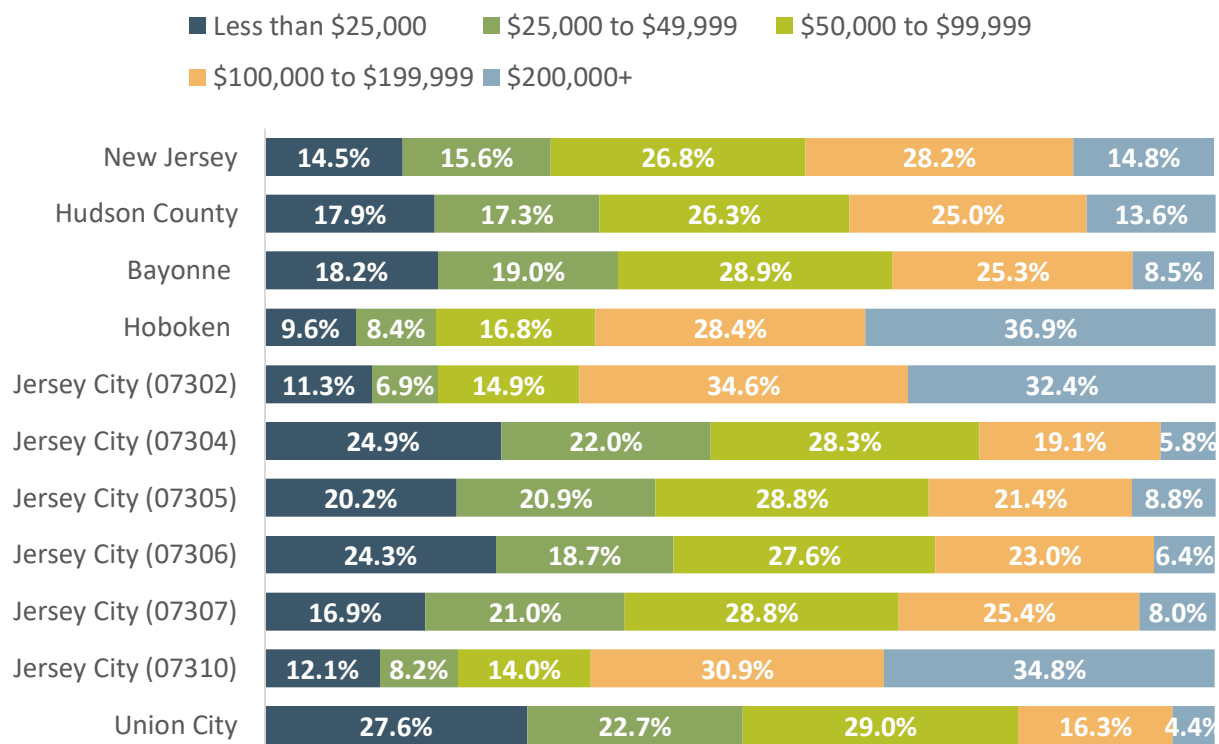
Table 9. Median Household Income, by Race/Ethnicity, State, County, and Town, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	American Indian and Alaska Native	Native Hawaiian and Other Pacific Islander	Some other race
New Jersey	\$126,232	\$55,453	\$60,352	\$96,531	\$59,827	\$61,563	\$54,334
Hudson County	\$116,309	\$53,196	\$52,408	\$100,853	\$54,318	-	\$51,718
Bayonne	\$123,536	\$60,167	\$54,292	\$74,712	-	-	\$53,890
Hoboken	\$197,750	\$83,724	\$44,890	\$162,507	-	-	\$27,139
Jersey City (07302)	\$169,730	\$68,879	\$62,868	\$161,291	-	-	\$43,750
Jersey City (07304)	\$86,061	\$47,968	\$45,266	\$65,026	\$44,238	-	\$48,348
Jersey City (07305)	\$108,294	\$51,155	\$56,458	\$80,389	\$66,982	-	\$48,738
Jersey City (07306)	\$86,347	\$37,470	\$41,429	\$66,761	\$57,798	-	\$43,571
Jersey City (07307)	\$100,659	\$57,778	\$47,904	\$76,976	\$39,293	-	\$55,022
Jersey City (07310)	\$138,083	-	-	\$163,375	-	-	-
Union City	\$83,482	\$44,375	\$44,562	\$74,623	\$58,594	-	\$44,092

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Census estimates demonstrate how higher earning households and low-income households are concentrated in different towns across Hudson County. Around one in three households in Hoboken (36.9%), Jersey City zip code 07302 (32.4%), and Jersey City zip code 07310 (34.8%) had earnings of \$200,000 or higher in 2016-2020 (Figure 22.) On the other hand, more than two in five households in Jersey City zip codes 07304, 07305, and 07306 earned a household income of \$50,000 or less; and half of the households in Union City were in this situation.

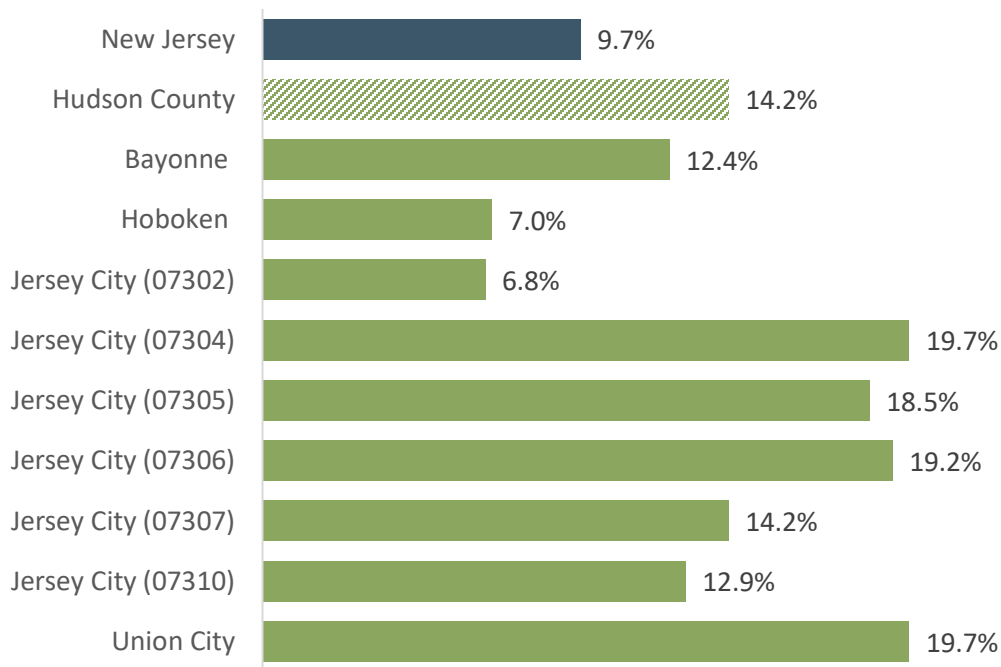
Figure 22. Distribution of Household Income, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

The percentage of Hudson County residents living below the poverty level represents the most extreme level of financial insecurity. For context, the federal poverty line is the same across the country – regardless of cost of living – but changes by household size. In 2021, individuals living alone or considered a household of one would fall below the federal poverty level at an income level of \$12,880, while federal poverty level for a family of four is \$26,500. Figure 23 presents data on the percentage of residents falling below the poverty line in the state, county, and town- and zip-code-level. In Hudson County, 14.2% of individuals fall below the poverty line, but it is nearly 20% in Jersey City zip codes 07304, 07305, 07306, and Union City. Table 10 presents town level poverty data by race/ethnicity.

Figure 23. Individuals Below Poverty Level, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

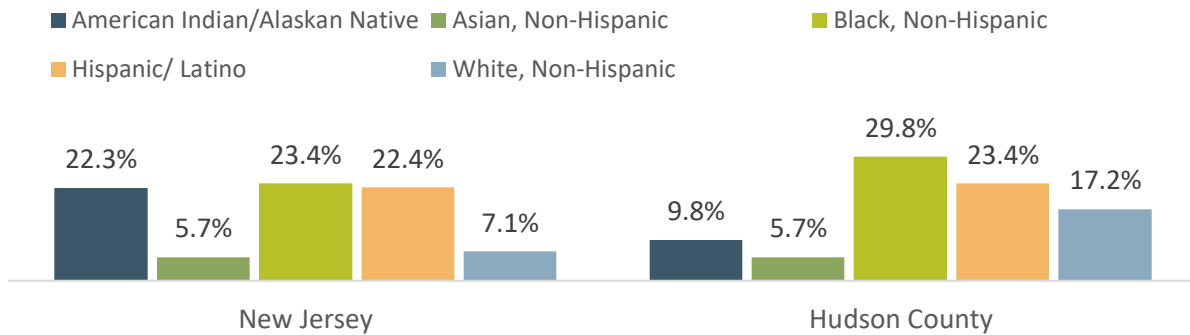
Table 10. Individuals Below Poverty Level, by Race/Ethnicity, State, County, and Town, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	Other Race, Non-Hispanic
New Jersey	6.3%	16.4%	16.9%	6.0%	19.6%
Hudson County	9.3%	19.2%	17.8%	9.7%	17.9%
Bayonne	7.3%	13.8%	14.9%	9.9%	12.8%
Hoboken	8.4%	13.2%	15.5%	4.8%	24.9%
Jersey City (07302)	5.7%	15.6%	14.8%	3.4%	22.7%
Jersey City (07304)	9.1%	19.7%	24.8%	21.4%	23.0%
Jersey City (07305)	6.9%	22.1%	19.5%	18.0%	21.0%
Jersey City (07306)	17.0%	20.3%	20.6%	23.3%	18.7%
Jersey City (07307)	7.5%	14.5%	18.7%	11.6%	21.0%
Jersey City (07310)	13.4%	36.8%	14.0%	7.9%	23.3%
Union City	6.6%	14.5%	21.1%	17.9%	27.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

According to County Health Rankings, 9.8% of children in Hudson County lived in poverty in 2019, but 29.8% of Black children and 23.4% of Hispanic/Latino children lived in poverty (Figure 24).

Figure 24. Children in Poverty, by State and County, 2019

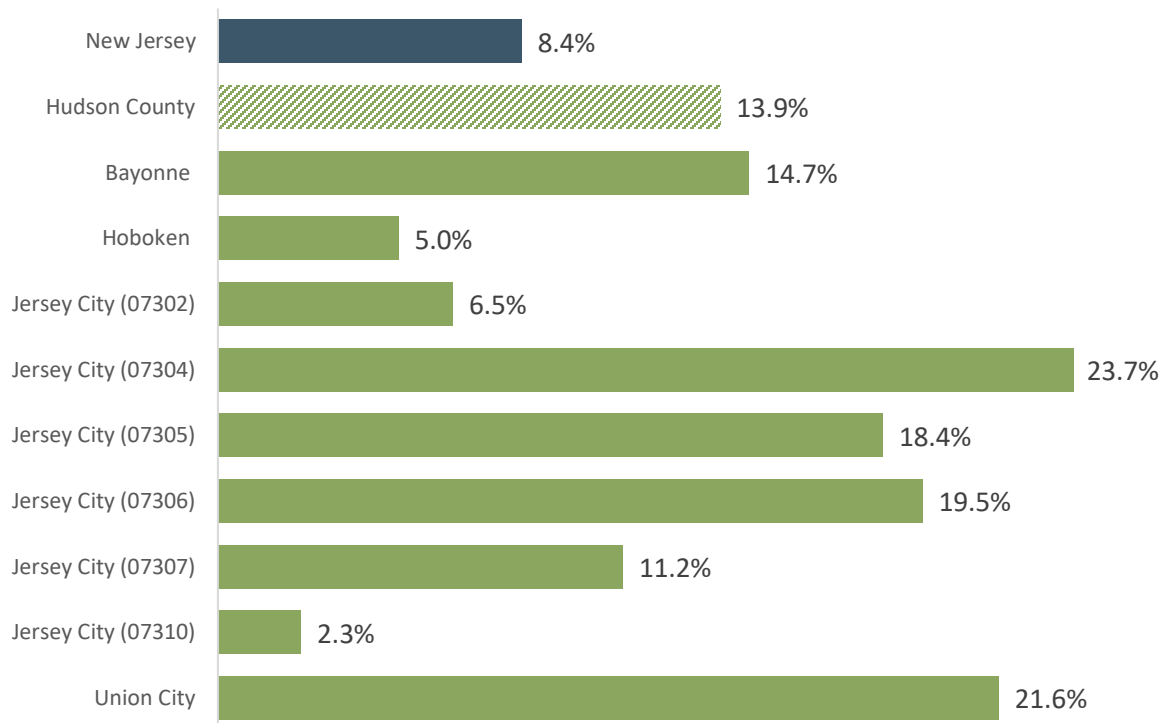


DATA SOURCE: U.S. Census Bureau, Small Area Income and Poverty Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Income and Public Assistance

Several national programs administered by the state help low-income individuals and families in Hudson County afford basic needs and necessities. The Supplemental Nutrition Assistance Program (SNAP) offers nutrition assistance to certain income-eligible Hudson County residents. From 2016-2020, 13.9% of households in Hudson County were receiving SNAP benefits (Figure 25). Of note, Jersey City zip code 07304 had 23.7% and Union City had 21.6% of households receiving SNAP benefits, compared to 2.3% in Jersey City zip code 07310.

Figure 25. Households Receiving Food Stamps/SNAP, by State, County, and Town, 2016-2020

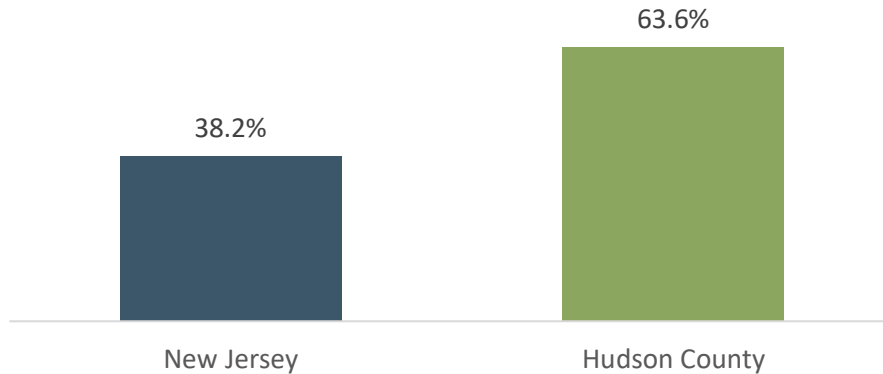


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Public schools nationwide and across New Jersey offer free lunch programs for children living at or near the poverty line (although it should be noted that many public schools currently provide free lunch to all

students as part of the federal COVID-19 relief funding). However, the percentage of children eligible for the traditional free or reduced-price lunch in Hudson County was 63.5% in the 2019-2020 school year, much higher than the state overall (38.2%) (Figure 26).

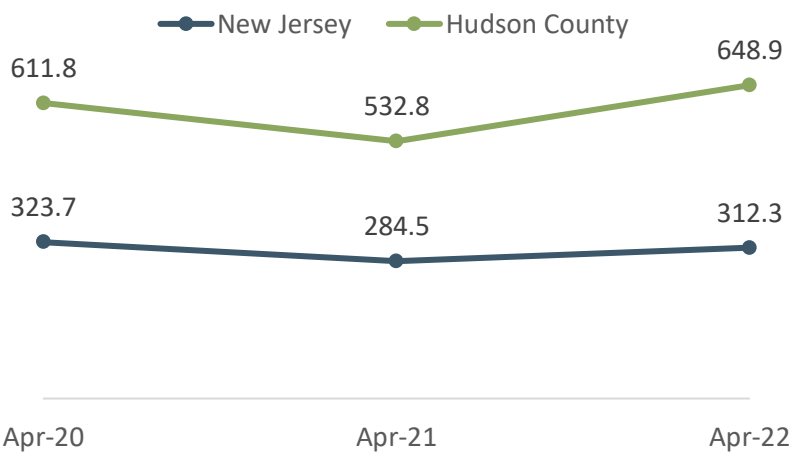
Figure 26. Children Eligible for Free or Reduced-Price Lunch, by State and County, 2019-2020



DATA SOURCE: National Center for Education Statistics, 2019-2020 from University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2021

Work FirstNJ (WFNJ) provides cash assistance and other support services through the federal Temporary Assistance for Needy Families (TANF) program. In Figure 27, the participant rate for persons, adults, and children receiving TANF was much higher in Hudson County than in New Jersey overall and peaked in April 2022 with a rate of 648.9 people participating in Hudson County per 100,000 population, more than double the rate of New Jersey as a whole.

Figure 27. Number of Participating Persons, Adults, and Children Receiving WFNJ/TANF per 100,000, by County, 2021



DATA SOURCE: New Jersey Department of Human Services, Division of Family Development, Current Program Statistics 2020-2022

These public assistance programs are a lifeline for many low-income families and help to ensure adequate nutrition and housing. However, several focus group participants and key informant interviewees mentioned being faced with the dilemma of not earning sufficient income to cover basic expenses, but not qualifying for public assistance, including housing, food, or health support because they exceeded the poverty line threshold. In the words of a focus group participant, *"I know I don't*

qualify for housing---I make too much money. I checked a few years ago because I live with my mom.” Another participant elaborated, *“The problem in Jersey City is that the preferred housing is based upon income... The problem becomes not making enough to pay the rent, but then living with her mom, so she makes too much money because now they’re doing dual income.”*

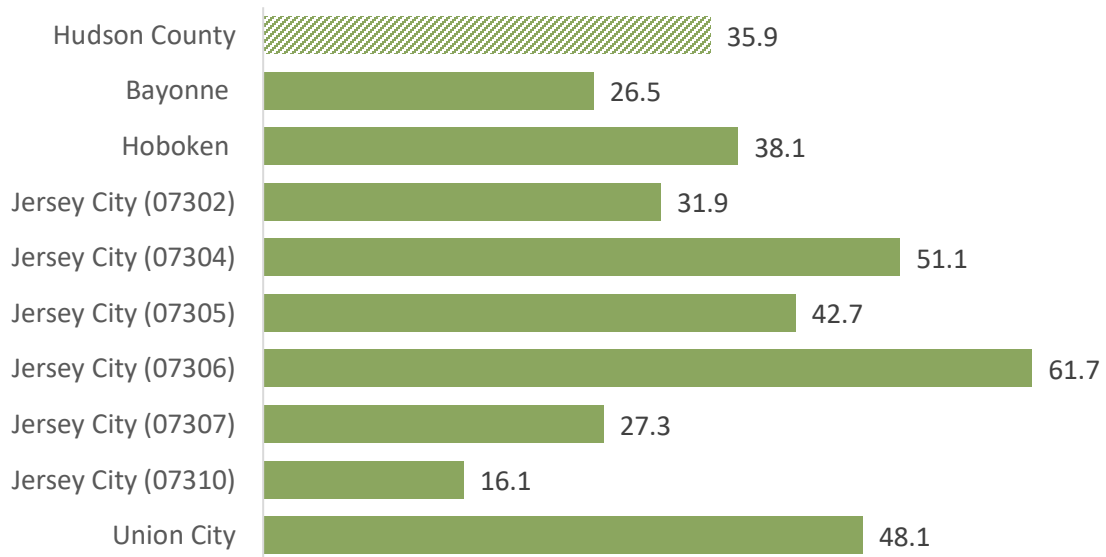
Many residents expressed frustration at losing or not qualifying for benefits because their earnings were too high, yet not being able to buy food and other essentials. Residents suggested that the federal government should change the income eligibility limit and that more opportunities should be provided to continue supporting residents as they transition into the workforce. As discussed in the section on Community Strengths and Assets, residents noted that local government had stepped up to address their needs.

“It is hard to get assistance for housing where I am. You have to be making way below the poverty level.” – Focus group participant

Food Access and Food Security

While many food access barriers are related to income constraints, access may also be more challenging for residents due to geography and transportation challenges. One of the issues highlighted by Hudson County residents was that the quality of the available food varied a lot by neighborhood. Residents noted that some Jersey City neighborhoods were food deserts, and that in others the supermarkets were not affordable. The availability of supermarkets and grocery stores varied a lot by Hudson County area, with Jersey City zip code 07306 having the largest number of supermarkets (61.7 per 100,000 persons) (Figure 28). More data on food deserts in Appendix F- Additional Data Tables.

Figure 28. Grocery Stores and Supermarkets per 100,000 by State, County, and Town, 2018



DATA SOURCE: Community Commons, Census County Business Patterns, analyzed by Center for Applied Research and Engagement Systems (CARES), 2020

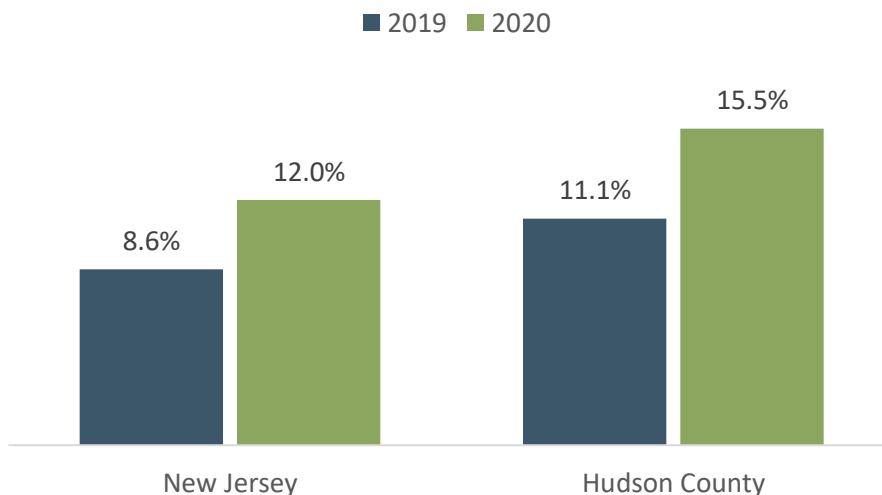
Food insecurity—not having reliable access to enough affordable, nutritious food—is directly related to financial insecurity. Residents mentioned that many families with children, older adults, and those who are housing insecure were struggling to put food, particularly healthy food, on the table. A focus group participant explained the experience of housing insecure families, *“If I’m staying with someone, I may not be able to cook my own food for my kids, as we just have a room, and maybe I have a little microwave that I could use. I don’t want to impose on anybody so I get little, you know, pre-cooked meals... so we don’t get in people’s way.”*

“Diabetes is a very expensive issue in the community, and we’ll often see people forgo their medication because they can’t afford it. Or [they] forgo healthy foods because they can’t afford it.” – Focus group participant

According to data from Feeding America, Map the Meal Gap confirms that food insecurity is a problem for many residents; Hudson County had a higher percentage of food insecure residents than New Jersey as a whole in 2019 and 2020, and this percentage increased from one year to the next (Figure 29).

However, residents also mentioned that food pantries were widely available throughout the city where low-income people could get food and that food vouchers were available to seniors. Participants spoke about the many food distribution efforts that multiple partners, including government agencies, health care institutions, and non-governmental organizations, carried out during the pandemic to mitigate its effects and make sure that residents did not go hungry. Around one in four survey respondents overall, and about one in three Latino respondents, indicated that they relied on food pantries or other food assistance programs in Hudson County (Figure 30). Other indicators of food insecurity are presented in Figure 30.

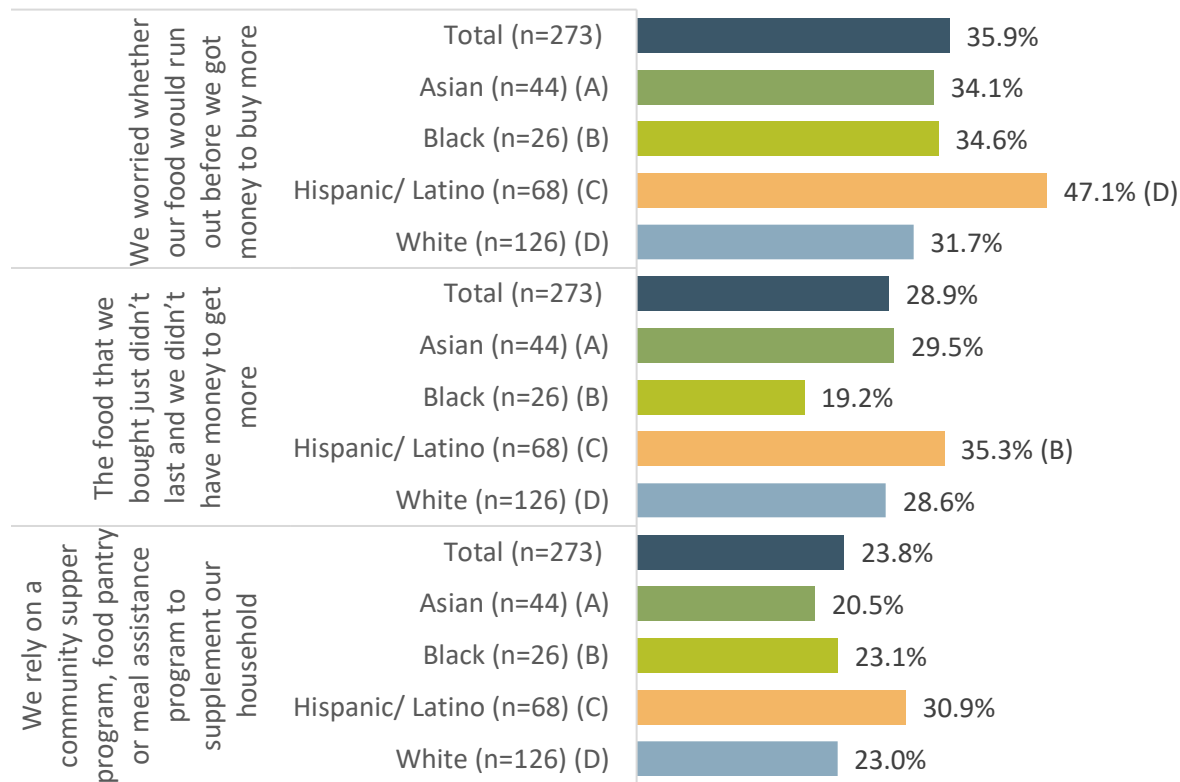
Figure 29. Percent Population Food Insecure, by State and County, 2019 and 2020



DATA SOURCE: Feeding America, Map the Meal Gap, 2019 and 2020

NOTE: 2020 data are estimated projections based on available employment and poverty data, and were revised in March 2021; therefore data are subject to change.

Figure 30. Percent of Community Survey Respondents Reporting Food Insecurity (Noting Statements as Sometimes or Often True), by Race/Ethnicity (n=273), 2021

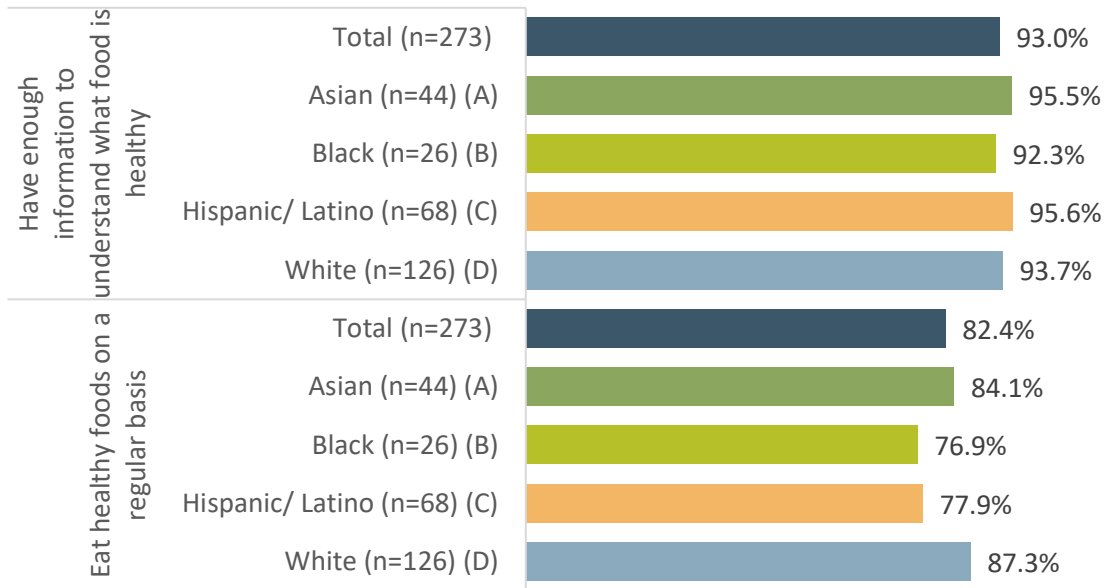


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

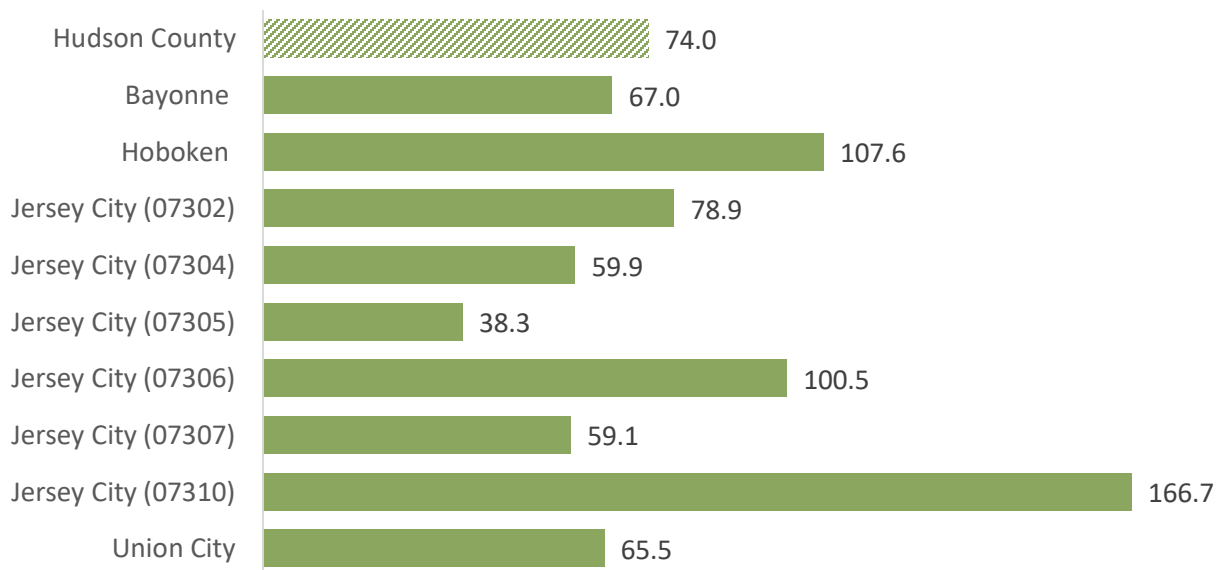
In addition to food affordability and access, nutrition literacy is important to maintain a healthy diet. Many focus group participants were aware of the association between a healthy diet and good health, including its importance in chronic disease management. However, some residents perceived that the main barrier to maintaining a healthy diet was lack of education. As one focus group participant mentioned, *“The problem is that people see fast food as a good, cheap option, but it’s not healthy – not everyone likes fruit and vegetables.”* Survey data does not seem to support this since perception: whereas a majority of survey respondents of all race/ethnicities reported knowing what constituted a healthy diet, fewer reported being able to eat healthy foods on a regular basis (Figure 31), indicating that other factors such as affordability and access may be at play. The discrepancy is most marked among Black and Latino respondents. Further, the availability of fast-food restaurants offering low-cost ultra-processed high caloric foods in certain neighborhoods contributes to the problem (Figure 32).

Figure 31. Percent of Respondents Who Report Having Enough Information on Healthy Foods and Eating Healthy Foods on a Regular Basis, by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Figure 32. Fast Food Establishments per 100,000 by County, and Town, 2020



DATA SOURCE: Community Commons, Census County Business Patterns, analyzed by the Center for Applied Research and Engagement Systems (CARES), 2020

Housing

Safe and affordable housing is integral to the daily lives, health, and well-being of a community.

Housing Landscape

As in past CHNAs, there was consensus among focus group members and interviewees that there is a significant need for affordable housing in Hudson County. Many participants noted that housing costs and high taxes were concerns. They described how affordable housing was scarce for members of their community who needed it, like low-wage earners and fixed income residents, and it is harder for others, such as seniors, veterans, and young families, to remain in the area. In the words of a resident, *“One of my friends... his parents had the house, and then he inherited it, but he ended up moving because the taxes were just too high. And that was someone who had been living in that house since birth. And he’s sixty-something years old, it’s just sad.”*

“It looks like Jersey City is trying to cater to the affluent instead of the people who grew up here.” –

Focus group participant

Assessment participants discussed gentrification – the process by which rising housing costs drive out local residents who are replaced by new wealthy residents. As one interviewee described it, *“We can’t not mention the housing market, it’s a problem overall, but in Jersey the rate of gentrification is increasing rapidly and even those not on the fringe of poverty are experiencing that.”* While participants reported that some new housing is being built, it is not affordable for most. One focus group participant explained it thus, *“It’s not equal. All the buildings they’re putting up are all luxury buildings. When you see the word luxury, you know the rent is astronomical. I can’t afford it... whereas affordable housing or housing for seniors is very limited. There are years long waiting lists. It’s like they don’t want us to be here anymore, they’re just welcoming the rich and affluent....”* Housing costs have been steadily rising in all areas with easy access to New York City, particularly near the waterfront, since 9-11, as New Yorkers sought to leave the city, and COVID-19 accelerated it.

Housing Instability and Homelessness

Inflation and uncontrolled rent increases following COVID-19 exacerbated people’s concerns about housing affordability and housing stability. With some residents’ financial situations being more uncertain or diminishing during the pandemic, there was greater concern that residents might lose their housing, even with the multiple housing eviction moratoriums in place. Overall, 8.8% of respondents in Hudson County reported that they or an immediate family member had lost their housing during the COVID-19 pandemic; this percentage was higher among Latinos (13.2%). Housing availability was also cited by interviewees as an important barrier to break the cycle of violence. Relocation is one of the strategies used to prevent revictimization of community and domestic violence survivors. However, according to violence interrupters, affordable housing options in low-crime neighborhoods are limited.

Several focus group and interview participants mentioned the problem of homelessness in Hudson County communities. Multiple interviewees and focus group participants indicated that the shelters and temporary housing available were insufficient to meet the needs of the population. They considered the paradox of the proliferation of luxury rental buildings in some neighborhoods, and abandoned buildings in others, while many people are left without homes. One resident emphasized, *“Shelter, I think we need more shelters for the homeless people we have.”* On January 26, 2021, there were 882 persons experiencing homelessness on a single night in Hudson County. Of those counted, 56.1% lived in Jersey

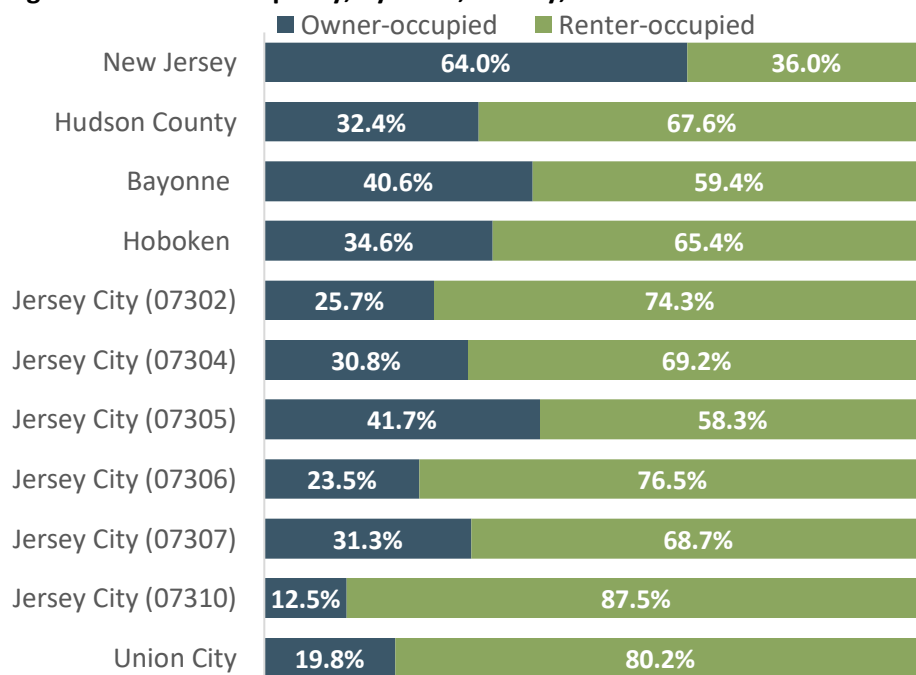
City. Black residents shouldered the burden of homelessness. Whereas Black residents made up 10.3% of the population, and 18.3% of the population living under the poverty line, they made up 39.1% of the population experiencing homelessness.

Participants highlighted three priority action areas to mitigate the housing problem in Hudson County: one was enacting policies related to rent control; the other was reducing real estate taxes; and the third was the urgent need to build or set aside more affordable housing units. A Latino participant expressed, *“The governor should control the rise of rent prices. These days it can cost \$700 for a room in a shared apartment. 10 years ago, an apartment cost \$500-600, but now it can cost \$1,200.”* Housing quality was another issue that came up in interviews. A few focus group participants commented that some of the affordable housing has lead, mold, and asbestos contamination, which can have devastating consequences on residents’ health, particularly among children. The problem was aggravated during COVID-19, which interrupted building quality inspections.

“When I drive past Hoboken there was a long line out a shelter because they need a hot meal or a place to stay.” – Focus group participant

Housing data illuminate important disparities and reflects the concerns uplifted by residents. Proportionally fewer Hudson County residents are homeowners compared to New Jersey as a whole. In New Jersey, 64.0% of housing units were owner occupied in 2016-2020, in contrast to 32.4% in Hudson County (Figure 33). Home ownership ranged from 12.5% in Jersey City zip code 07310 to 40.6% in Bayonne.

Figure 33. Home Occupancy, by State, County, and Town 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Median monthly housing costs for both homeowners and renters varied widely throughout Hudson County and were notably higher in certain locations than in New Jersey as a whole. Median monthly housing costs for owner occupied households with a mortgage ranged from \$2,339 in Jersey City zip code 07304 to roughly \$7,600 in Hoboken and Jersey City zip codes 07302 and 07310 (Table 11). Median monthly housing costs for renter occupied households ranged from \$1,247 in Union City to \$2,945 in Jersey City zip code 07310 during the same period, 2015-2019.

Table 11. Monthly Median Housing Costs, by State and County, 2015-2019

	Owner-occupied	Renter-occupied
New Jersey	\$2,476	\$1,368
Hudson County	\$2,821	\$1,450
Bayonne	\$2,793	\$1,325
Hoboken	\$3,759	\$2,360
Jersey City (07302)	\$3,672	\$2,524
Jersey City (07304)	\$2,339	\$1,204
Jersey City (07305)	\$2,425	\$1,243
Jersey City (07306)	\$2,484	\$1,270
Jersey City (07307)	\$2,751	\$1,382
Jersey City (07310)	\$3,756	\$2,945
Union City	\$2,886	\$1,247

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

The average percent of income spent on housing costs is an important measure of an area’s availability of affordable housing. A larger proportion of New Jersey renters, who tend to be less wealthy than homeowners, spend over a quarter of their earnings on housing. In New Jersey, 46.2% of owner-occupied households with a mortgage and 62.2% of all renters reported spending more than 25% of their income on housing costs (Table 12). Disparities in housing cost burden exist within Hudson County. In Jersey City zip codes 07302 and in Hoboken, less than one in three owner-occupied and 44% of renter-occupied households reported high housing costs whereas 64.4% of owner-occupied and 66.5% of renter-occupied residences in Union City reported spending more than 25% of their income on housing costs. Additional housing data can be found in Appendix F- Additional Data Tables.

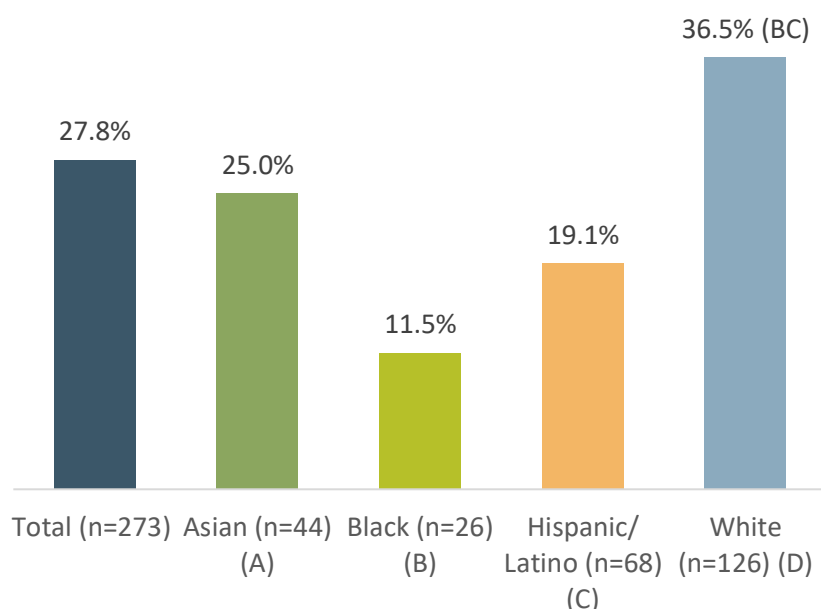
Table 12. Households Whose Housing Costs Are 25%+ of Household Income, by State, County, and Town, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	46.2%	62.2%
Hudson County	51.0%	56.6%
Bayonne	56.2%	57.3%
Hoboken	32.5%	43.4%
Jersey City (07302)	33.3%	39.5%
Jersey City (07304)	55.4%	63.6%
Jersey City (07305)	54.7%	64.6%
Jersey City (07306)	53.0%	55.2%
Jersey City (07307)	53.8%	58.4%
Jersey City (07310)	39.9%	48.7%
Union City	64.4%	66.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When survey respondents were asked whether they agreed or disagreed on statements about assets in their community, the statement about affordable housing had the lowest percentage of agreement. Only 27.8% of survey respondents agreed or completely agreed with the statement that there was enough affordable housing that is safe and well-kept in their community. Agreement was least likely among Black and Latino respondents, where only 11.5% and 19.1%, respectively, agreed/completely agreed with the statement about affordable housing, significantly lower than those of White respondents (36.5%) (Figure 34).

Figure 34. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “There is Enough Affordable Housing that is Safe and Well-Kept in My Community,” by Race/Ethnicity (n=273), 2021

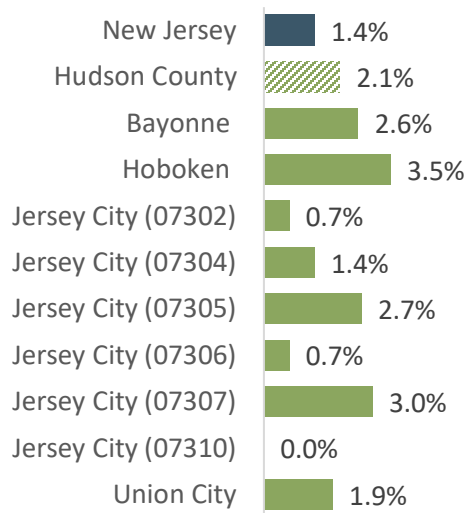


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Homeowner vacancy rate, which represents the proportion of the homeowner inventory that is vacant for sale, is another indicator of lack of affordability, oftentimes due to homeowners' inability to pay real estate taxes. The homeowner vacancy rate was notably higher in Hudson County (2.1%) over the period of 2016-2020 compared to New Jersey (1.4%) (Figure 35). Vacancy rates were particularly elevated in Hoboken (3.5%) and Jersey City zip code 07307 (3.0%) over that time. This reality was also reflected in the interviews with residents. In the words of a Black resident, *“Prices have been slowly rising, amazing that they have money to build these new buildings but can't help people maintain the property they have here – know people who had to move because taxes were too high.”*

Figure 35. Homeowner Vacancy Rate, by State and County, 2016-2020



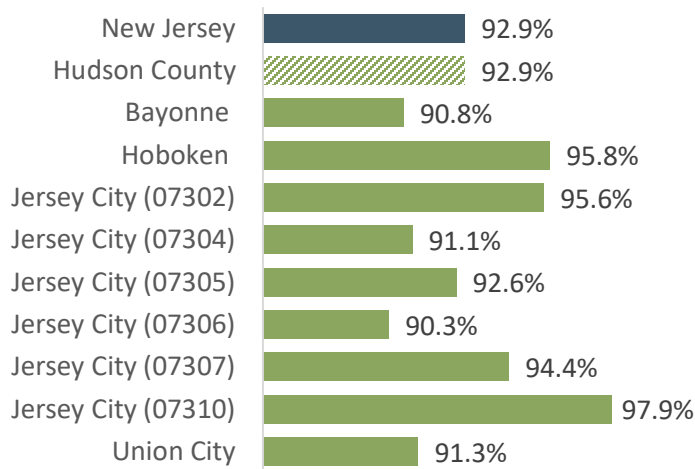
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Housing and Technology Infrastructure

Technology is an important tool to access information, services, and resources for individuals, families, and households. The importance of technology – and the consequences of the digital divide – became even more pressing and evident during the COVID-19 pandemic. The ability to be online, participants noted, is essential for residents to connect to resources for education, employment, and other services. Limited technological infrastructure posed an important barrier to learning when public schools moved to online education during COVID-19. Further, given the growth in telehealth, technology is also becoming essential to accessing healthcare. Yet some community residents do not have access to technology—they are unable to afford computers or Internet access, or do not know how to use it. One health care provider described, *“People working online tend to be good with telehealth, but there are many who don’t know how to connect, don’t have what is needed, it is just as hard to get online as it is to travel.”*

In 2016-2020, about 93% percent of Hudson County households had access to a computer (Figure 36). Households in Jersey City zip code 07306 (90.3%) and Bayonne (90.8%) reported computer access that was below the county-wide percentage; with about 1 in 10 households reporting having no computer at home, compared to almost every household in Jersey City zip code 07310 (97.9%).

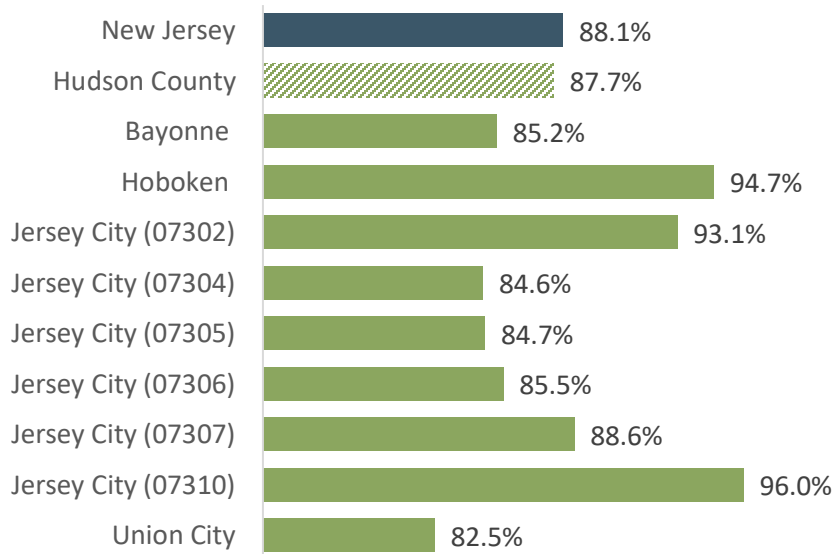
Figure 36. Households with a Computer, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

There were similar trends in household Internet access. Most of the areas that reported a lower percentage of computer access when compared to Hudson County also reported lower levels to the Internet, including Union City (82.5%), and Jersey City zip codes 07304 (84.6%) and 07305 (84.7%) (Figure 37).

Figure 37. Households with Internet, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Transportation

Transportation connects people with and between where they live, learn, play, and work.

Transportation Infrastructure

Transportation was often mentioned by focus group and interview participants as a top asset in Hudson County. Most participants did not indicate that they were car dependent; instead, they noted that it was easy to get around. A Latino immigrant said that *“public transportation is very good for people who don’t drive; everything is close and accessible.”* Affordable and accessible public transportation is important to promote equity, as it provides a means to getting to-and-from work, school, and other locations for low-income residents who cannot afford car expenses and to undocumented residents without a driver’s license.

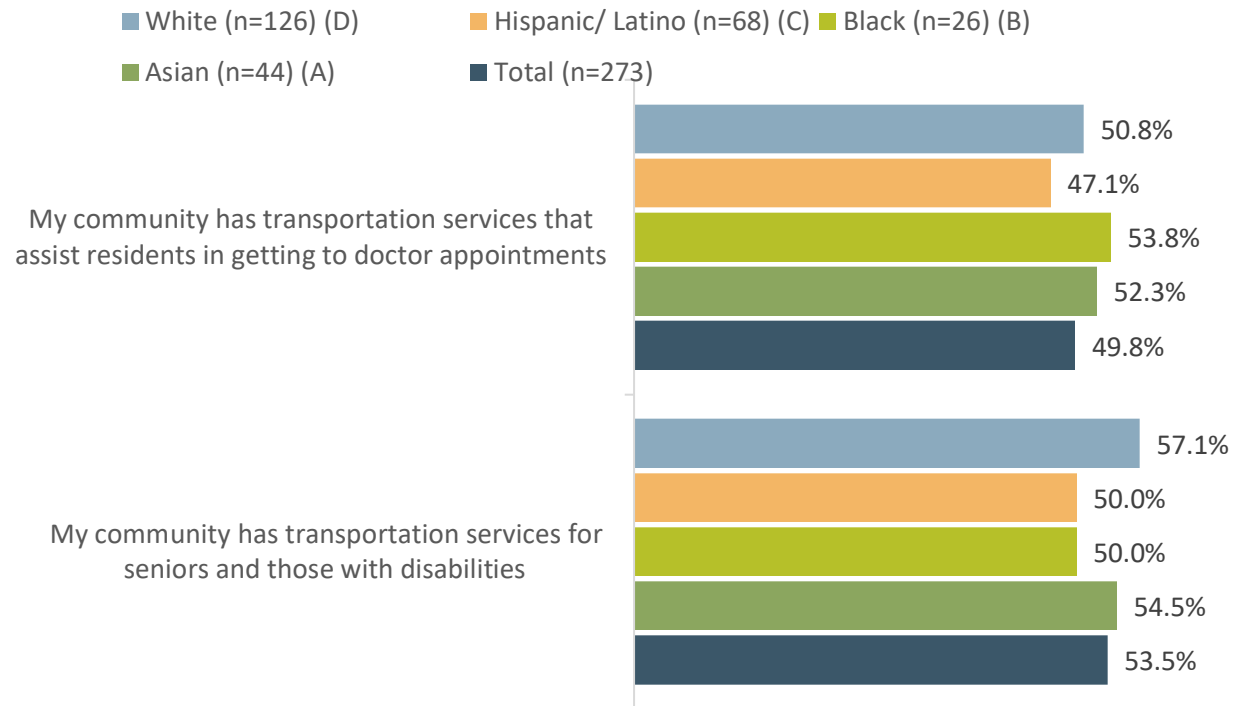
Residents appreciated the proximity of Hudson County to New York City, as a source of business and economic development in the area. This is facilitated by the multiple public transportation options available to and from New York City. One resident described Jersey City *“as a transportation rich area where there is a lot of income and economic opportunity, even if it is not very well distributed to everyone who lives here.”*

Transportation Partnerships

In addition to public transportation, several participants indicated that partnership between health care and social services institutions and private transportation companies were an asset and facilitated access to health care and other services and programs, particularly for older adults and violence survivors.

While transportation was discussed as a significant asset among focus group and interview participants, survey respondents noted some limitations of the transportation infrastructure. As shown in Figure 38, only about half of Hudson County survey respondents agreed or completely agreed with the statement, *“My community has transportation services available for seniors and those with disabilities.”* Similarly, slightly over half of survey respondents agreed/completely agreed that their community had transportation services to assist residents in getting to doctor’s appointments. There were no statistically significant differences in these responses by race/ethnicity.

Figure 38. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Transportation-Related Statements about Their Community, by Race/Ethnicity (n=273), 2021

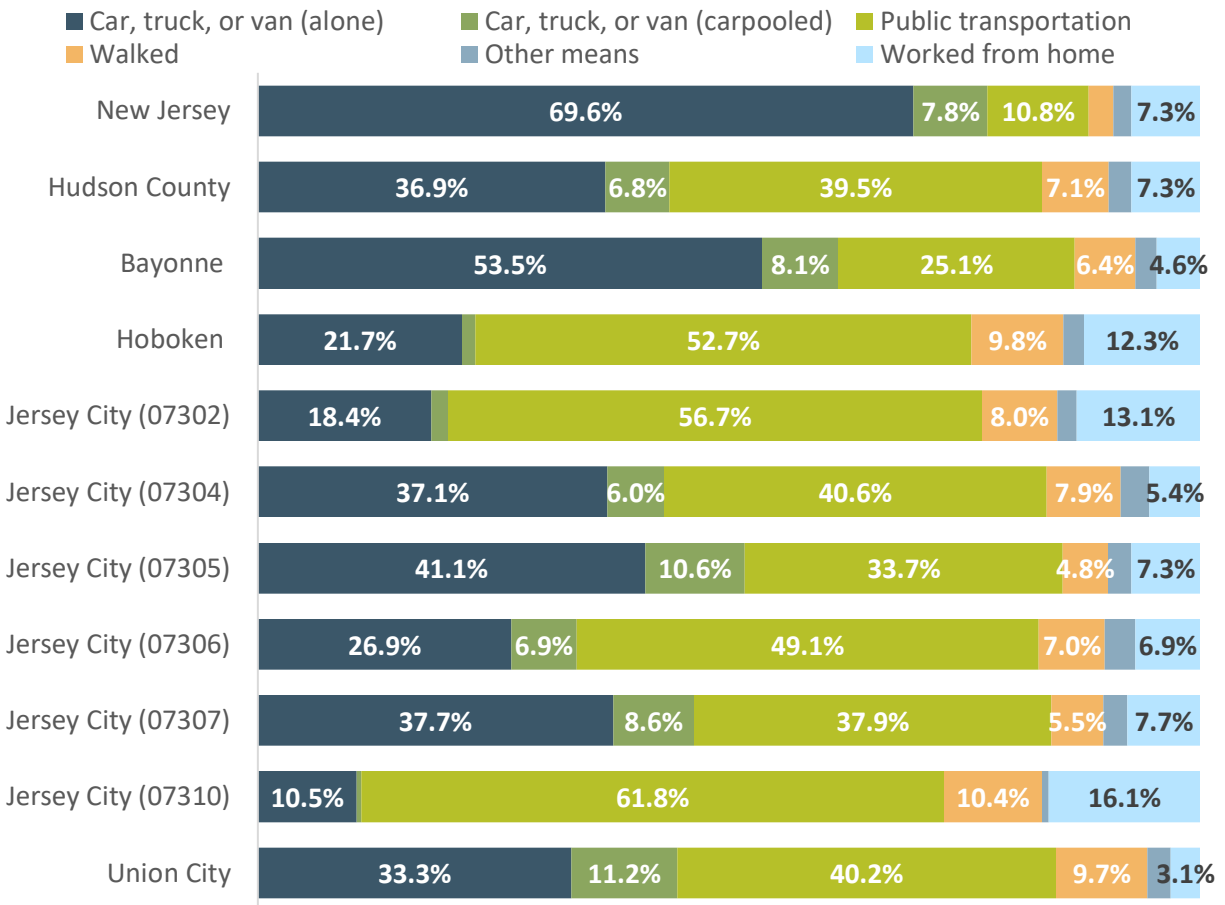


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels.

Data from the U.S. Census confirmed residents' viewpoints regarding transportation. Residents of Hudson County are a lot less car-dependent than those of Jersey City as a whole. In certain areas, such as Hoboken (52.7%) and Jersey City zip codes 07302 (56.7%) and 07310 (61.8%), well over half of residents relied on public transportation (Figure 39). Hudson County residents were also more likely to walk to work than in the state overall, with over 7% of survey respondents reporting doing so. One focus group participant summed it up, *"Another strength [of Hudson County] is how easy it is to commute everywhere. We have the Via shuttles, Path trains, buses."*

Figure 39. Means of Transportation to Work for Workers Aged 16+, by State, County, and Town 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Similar to other factors, owning a private vehicle is not equally distributed across county residents. Those without a car are usually not home-owners. Across Hudson County, 13.7% of owner-occupied households and 40.6% of renter-occupied households did not have access to a personal vehicle in 2016-2020 (Table 13); these percentages are much higher than in New Jersey as a whole, possibly denoting the accessibility of public transportation and Jersey City’s walkability. Car ownership ranged from 9.8% in Jersey City zip code 07305 to 26.0% in Jersey City zip code 07310 among homeowners; and from 31.5% in Bayonne to 61.2% in Jersey City zip code 07310 among renters.

Table 13. Households (Renter v. Owner-Occupied) Without Access to a Vehicle, by State, County, and Town, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	3.6%	24.8%
Hudson County	13.7%	40.6%
Bayonne	10.1%	31.5%
Hoboken	20.2%	38.7%
Jersey City (07302)	24.4%	49.5%
Jersey City (07304)	13.4%	46.9%
Jersey City (07305)	9.8%	38.8%
Jersey City (07306)	19.9%	49.9%
Jersey City (07307)	15.3%	42.1%
Jersey City (07310)	26.0%	61.2%
Union City	19.2%	45.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Green Space and Built Environment

Green space and the built environment influence the public’s health, particularly in relation to chronic diseases. Urban environments and physical spaces can expose people to toxins or pollutants, affecting health conditions such as cancer, lead poisoning, and asthma. Physical space can also influence lifestyles. Playgrounds, green spaces, and trails, as well as bike lanes and safe sidewalks and crosswalks, all encourage physical activity and social interaction, which can positively affect physical and mental health.

Residents raised several issues related to the built environment. Multiple residents across focus groups expressed their concerns that there were too many new constructions. In their view, overbuilding resulted in overpopulation and shrinkage of green spaces. This issue was summed up by one resident, *“Seeing all of these new buildings that are just being built out of nowhere, blocking the view of the city, being built on green areas, parks. I understand the need to have Jersey City well developed but I think over populating is a concern. Even the smallest empty area now has a building.”* As mentioned in the Education section, another problem mentioned by residents was that the public school infrastructure in some districts has not kept up with population growth and cannot accommodate the number of school children. Other residents mentioned that the older constructions had environmental contaminants, including lead and mold, which can have deleterious impact on health (see section on Lead).

Flooding and Emergency Preparedness

Participants remarked that several areas of Hudson County, particularly those near the waterfront, are flood prone. A housing expert explained that preparing the county for future floods and an overall rise in water level was an important public health precaution. A key informant interviewee in the housing sector mentioned that several urban redevelopment projects were underway to mitigate possible harm from floods and other natural disasters. The redevelopments would increase flood storage capacity and improve floodwater absorption. Further, the interviewee noted that new constructions are planned so as to integrate flooding mitigation and water containment measures. Redevelopments in some area

include “new walkways and parks available for all residents” and building higher off the ground to prevent water damage.

Parks and Green Areas

Green area coverage is essential to an environment conducive to good health. Green area coverage not only contributes to air quality and mental and physical health, but it also serves as an important flood mitigation strategy as soil absorbs water more readily than concrete. Multiple initiatives are under way in Hudson County to improve green areas; one is the Jersey City Urban and Community Forestry to promote planting efforts and urban reforestation. A health official noted the important contribution of the Jersey City Parks Coalition to these efforts.

According to the focus group participant, the coalition is a volunteer-run grassroots organization which has spearheaded green area betterment and maintenance projects and community events, such as plantings, throughout different Jersey City neighborhoods. The participant mentioned that they are also lead advocates for more funding for green spaces. The contributions of the Jersey City Parks Coalition were described by a public health official: “They have worked with the city to determine a priority list, master plan, getting a blanket insurance policy to cover all insurance needs for events for all parks.” According to the participant, the coalition reflects the city’s diversity and serves as a vehicle to engage different sectors of the population.

“Where to play safely is not available. When Jersey City is described, it’s often just the one nice part of the city, and rarely about the other quadrants.”

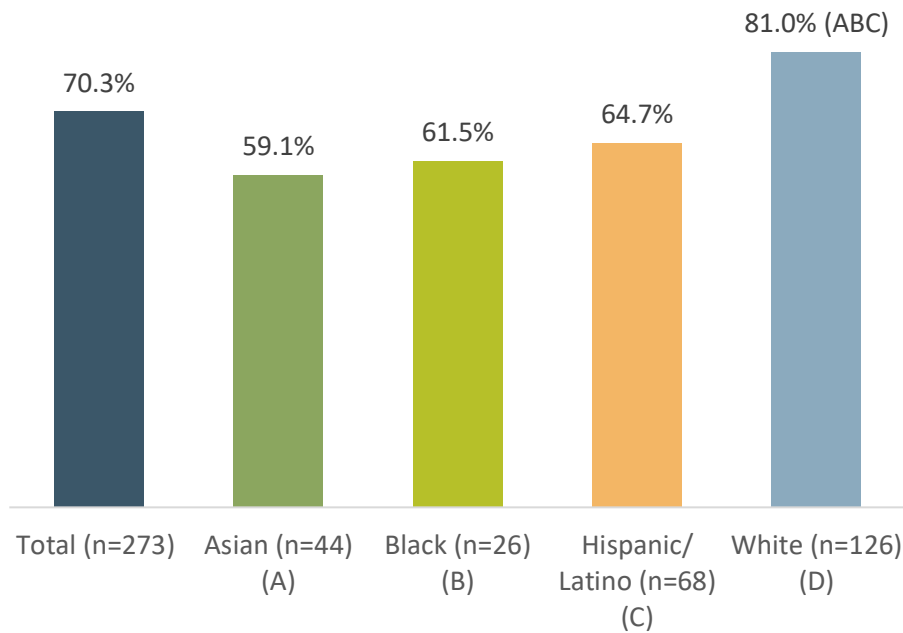
– Focus group participant

Different groups mentioned engaging in various outdoor activities. Veterans remarked on how important being involved in organized team sports was to their physical and mental health; they noted that these recreational opportunities were mainly organized by the city. Latino participants indicated walking was their main exercise and valued having access to well-lit, safe parks in their neighborhood.

As with other topics, there was a diversity of experiences regarding the availability of green space. Whereas some residents indicated that there were plenty of green areas for outdoor activities near their homes, others mentioned not having safe parks nearby. In a participant’s words, “The inner, inner cities, I’m not sure about their parks. I have a park luckily down the street, it’s a nice large park, it is safe, it’s patrolled by police. But if you go up into the Greenville section, I’m not sure about those parks... it’s not as lush and green as Lincoln Park or Liberty Park.”

These differences were reflected in the community survey. About 70% of Hudson County survey respondents agreed or completely agreed with the statement, “My community has safe outdoor places to walk and play” (Figure 40). However, responses significantly differed by race/ethnicity. Asian (59.1%), Black (61.5%), and Latino (64.7%) survey respondents were much less likely than White respondents (81.0%) to agree with the statement about safe outdoor space.

Figure 40. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “My Community has Safe Outdoor Places to Walk and Play,” by Race/Ethnicity (n=273), 2021



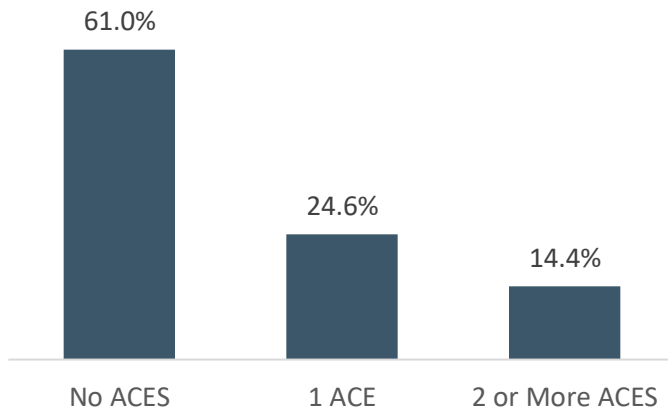
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Violence Prevention and Safety

Violence and trauma have short- and long-term effects on physical and mental health. People can be exposed to violence in many ways: they may be victims and suffer from premature death or injuries or witness or hear about crime and violence in their community. Violence and trauma are inextricably linked to the social determinants of health; people of low socioeconomic status residing in low-resource neighborhoods and schools are at higher risk of experiencing violence. According to an education administrator interviewed, many youths in low-income settings are exposed to domestic and community violence and other adverse childhood experiences, that have a profound impact on their well-being. In 2019, almost two out of every five children in New Jersey had experienced a traumatic event before the age of 18 (Figure 41). (More localized data not available.) Violence interruption professionals discussed how providing a safe and nurturing environment, access to counseling early on to address the symptoms of trauma, and paths to educational and economic opportunities were key strategies to interrupting the cycle of violence.

Figure 41. Percent of Children with Adverse Childhood Experiences (ACEs) in New Jersey, 2019

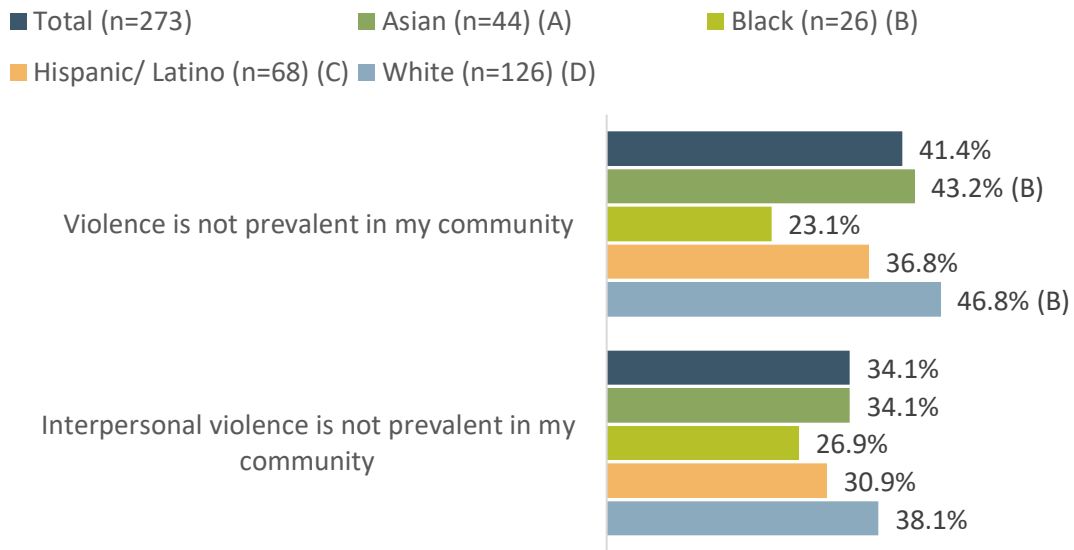


DATA SOURCE: Child and Adolescent Health Measurement Initiative (CAHMI), Data Resource Center for Child and Adolescent Health, National Survey of Children’s Health Interactive Data Query, 2019

Focus group and interview participants shared differing views about safety and violence. Many indicated being safe in their neighborhoods, while others reported being nervous about crime, and yet others that violence was an “epidemic.” Residents’ safety concerns were generally related to gun violence, loitering, and substance use by young people. According to survey data and interviewees, persons of color, particularly Black residents, shoulder the burden of violent crime. Figure 42 presents survey data on the percent of respondents who agreed or completely agreed with statements related to violence in their community, overall and by race/ethnicity. Overall, 41.4% of Hudson County survey respondents agreed or completely agreed that violence was not prevalent in their community and 34.1% reported that interpersonal violence was not prevalent in their community. However, responses varied by race/ethnicity, with Black survey respondents being the least likely to agree or completely agree with either of these statements.

“We are very busy, being in Jersey City. We see a lot of violent crime.”– Key informant interviewee

Figure 42. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statements Related to Violence, by Race/Ethnicity (n=273), 2021



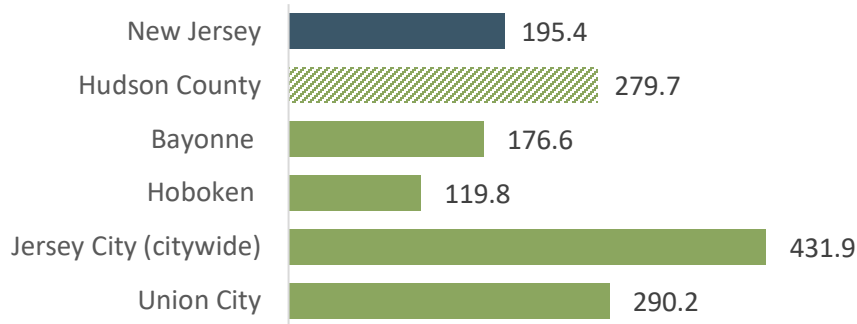
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Gun Injury and Violent Crime

Quantitative data support residents’ varied perceptions of risk. Mortality rate by firearm injury in Jersey City from 2015-2019 was 5.4 deaths per 100,000 residents, higher than those state-wide (5.1 deaths per 100,000 residents) and in Hudson County (3.5 deaths per 100,000 residents). In 2020, rates of violent crime (i.e., murder, rape, aggravated assault) in Hudson County (280 per 100,000 residents) were higher than in New Jersey (195 per 100,000 residents) and varied widely across the county. Jersey City (432 per 100,000 residents) had more than double the crime rate than the state average and 35% higher crime rate than the county overall; Union City’s crime rates were slightly higher than Hudson County’s (290 per 100,000 residents), whereas Bayonne’s (177 per 100,000 residents) and Hoboken’s (120 per 100,000 residents) were lower than the state and county average (Figure 43). Property crime (i.e., burglary, larceny, and auto theft) is much more common than violent crime. Property crime in Hudson County was also above the state average (1,338 and 1,158 incidents per 100,000 persons, respectively). Property crime was most common in Union City (1,694 per 100,000 residents), Jersey City (1,457 per 100,000 residents), and Hoboken (1,405 per 100,000 residents) (Figure 44). Nearly 60,000 domestic violence offenses were recorded in New Jersey in 2019 (New Jersey Uniform Crime Report, 2019).

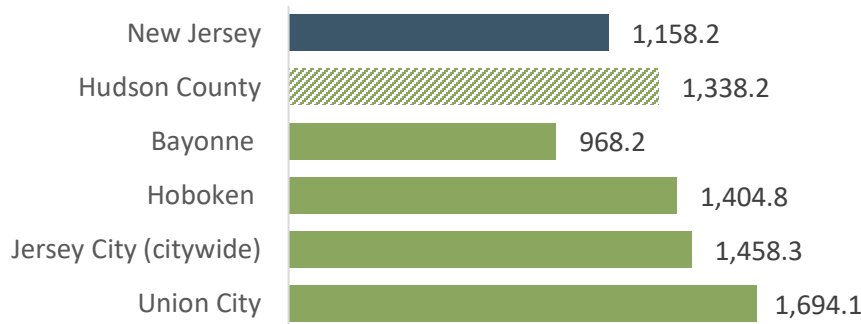
Figure 43. Violent Crime Rate per 100,000 Population, by State, County, and Town, 2020



DATA SOURCE: State of New Jersey, Department of Law and Public Safety, Uniform Crime Reporting Unit, 2019

NOTE: Violent crime includes homicide, rape, robbery, assault and simple assault. Jersey City data represent all zip codes within the city, including those outside of the JCMC service area.

Figure 44. Property Crime Rate per 100,000 Population, by State, County, and Town, 2020



DATA SOURCE: State of New Jersey, Department of Law and Public Safety, Uniform Crime Reporting Unit, Uniform Crime Report, 2020

NOTE: Property crime includes burglary, larceny, and auto theft.

Hate Crimes and Anger

It is of note that residents perceived a change in attitude in the aftermath of COVID-19, which they related to economic and social stressors. Specifically, several residents remarked that people had become less patient and more aggressive since the start of the pandemic. This perception was aggravated by reports of hate crimes motivated by biases against certain groups. As explained by one focus group participant, *“There’s an underlying fear, suspicion, you know, not only among African Americans. I mean it wasn’t that long ago that we had our own shooting up here at a Jewish facility. I think there is a lot of fear in regard to racism and antisemitism.”* Hate crimes were also mentioned as a concern for members of the LGBTQ+ community. A key informant interviewee working with the LGBTQ+ community noted that despite efforts, more action is needed to sensitize police officers, employers, educators, parents, and peers so as to reduce bullying and harassment, particularly against transgender youth and children in non-traditional families.

“It’s almost, I don’t want to say scary, but after the pandemic, everyone is more angry, everyone wants to argue and fight.”— Focus group participant

Violence Interruption Programs

According to key informant interviewees, Jersey City has robust programs and resources to address and mitigate the impact of violence and trauma. Since 2014, the grassroots organization Anti-Violence Coalition has been actively working as violence interrupters in the city's South side. As expressed by a coalition member, *"We've been working ... to make an impact on the community, see what the needs are, and lobby or advocate. We've been on the ground occupying corners, conducting surveys, trying to find out the main reasons why people can't be successful in their lives due to issues in the neighborhood that wrap around violence and trauma."* More recently, the Jersey City Medical Center created a trauma recovery center, which is a national evidence-based model in treating survivors of violence. Additionally, Project H.U.D.S.O.N. is a Hospital-based Violence Intervention Program, associated with the center, which works with community partners to prevent reinjury and retaliatory action. According to interviewees, promising results have been achieved by reaching survivors at bedside, soon after injury, and providing trauma-informed intensive case management and wraparound services, including support for safe housing and vocational training, in addition to medical care and counseling.

Systemic Racism and Discrimination

Perceptions of racism and discrimination varied in qualitative discussions. Overt discrimination due to race/ethnicity or nationality did not often come up. Some participants described witnessing discrimination due to gender and sexual orientation. Focus group and interview participants in multiple conversations brought up issues related to systemic racism and discrimination. With few exceptions, they spoke of pervasive inequities experienced by people of different groups. The conversations highlighted issues of intersectionality; participants discussed the multiplying effect of historical and current discriminatory practices due to multiple conditions, such as race/ethnicity, gender, immigrant status, and socioeconomic status, among others. Participants noted these issues largely impacted communities of color because of the policies and practices embedded throughout society. Highlights from these discussions that touch upon specific topic areas (e.g., inequality, education, housing, violence prevention) are also mentioned in other sections of this report.

A theme that was discussed in most focus groups and interviews was the pervasiveness of systemic racism. One of the ways that this was noted was in the gentrification of Hudson County. Multiple participants discussed how the high cost of housing and taxes are driving people of color out of Jersey City. Both quantitative and qualitative data indicate that there are insufficient affordable housing units. As a Black resident described, *"A lot of the new constructions are rentals so there would be a reduction of generational wealth. Unless you're earning six figures, it will be a challenge to afford rental units in the future. What is affordable may also not be livable because of gang activity or high crime."* Residents also noted structural racism in the perennial lack of investment in predominantly Black neighborhoods of Jersey City. They described these areas as having many abandoned buildings in a state of disrepair.

Focus group and interview participants acknowledged that there has been much more dialogue about racism and discrimination over the past year. Residents indicated that there were efforts underway in Hudson County to curbe at least the most overt forms of discrimination. A focus group participant expressed, *"Jersey City has definitely addressed the Asian hate crimes, even when I was on the PATH train there was a sign that was like there's no room for hate here in Chinese as well."* However, other residents described instances of discrimination and mistreatment against them and their relatives due to their immigrant status. As one resident explained, *"I do feel welcome by healthcare providers, but I have experienced going with my parents who are immigrants with heavy accents, and I have experienced miscommunication."*

Systemic Discrimination Based on Legal Status

A theme that emerged in some of the interviews and focus groups was the plight of undocumented immigrants, who face multiple economic and social stressors. According to focus group participants, the community is often persecuted by safety systems and live in fear of deportation. Residents explained that undocumented immigrants do not qualify for many government programs, often fear seeking care, and have limited power to negotiate with employers and landlords for salaries and rent control. As noted by several participants, many have experienced trauma in their home countries, made worse by unstable conditions. Further, participants remarked that children of undocumented parents or who themselves are undocumented often experience depression and anxiety, largely product of an uncertain future. According to residents, a pathway to legalize the situation of undocumented immigrants to ensure they are afforded all the human rights, many who have been most of their lives in the U.S., is urgently needed to improve their life conditions.

“The undocumented are scared to ask for help, and we are seeing that community getting jumped overnight, not wanting to go to the hospital over what they will get charged.” – Focus group participant

Responses also varied by survey respondents. One-quarter of Latino survey respondents indicated that they had ever been personally discriminated against when receiving medical care for their race/ethnicity and 17.6% because of language/speech issues. Asian residents were more likely to report being discriminated against for their culture/religious background (15.9%) and for language/speech issues (22.7%). Percentages for other race/ethnicities was not available due to small sample sizes. Other forms of discrimination were also mentioned in the survey. Among survey respondents, 14.1% reported having ever been discriminated against because of their age; 14.0% because of their body size; and 16.9% because of their income level.

Systemic Discrimination Based on Gender and Sexual Orientation

A theme that emerged from the qualitative data was discrimination against the LGBTQ+ population. Members of the LGBTQ+ community reported experiencing discrimination based on gender and/or sexual orientation in medical, educational, and professional settings. As described in the Employment section, Black trans women discussed encountering discrimination in employment due to their gender identity. An LGBTQ+ advocate emphasized more safe spaces for LGBTQ+ youth are needed in schools to prevent bullying. Also, more education efforts are needed to sensitize parents, educators, and other adults that interact with LGBTQ+ youth to ensure a supportive environment. As noted by an activist, many educators do not have the skills to address the needs of children growing up in non-traditional families. Additionally, the interviewee discussed how programs to sensitize and train police and healthcare providers should also be offered to promote quality, respectful care that fully addresses the diverse needs of this group, particularly of transgender individuals. One in ten survey respondents in Hudson County reported being discriminated against when receiving medical care because of their gender identity and/or sexual orientation.

*“A doctor told a lesbian woman seeking gynecological care that she didn’t need checkups because she didn’t have sex with men.”
– Key informant interviewee*

Addressing the Systems of Oppression

Quality education is a condition to overcoming intergenerational poverty resulting from historical systems of oppression. However, residents remarked that, despite attempts to provide adequate budgets, and largely because school financing relies partly on local cost share, public schools in low-income neighborhoods of Hudson County are under-resourced. Residents noted that the high cost of college poses another barrier for youth growing up in poverty. Further, they explained that the employment opportunities for unskilled workers do not pay a livable wage, nor offer a fixed income and benefits. In the words of a resident, *“There are jobs, I think, if you are well educated that you can sustain yourself on. But if you only have a high-school degree, it might be a bigger challenge.”* Interviewees alluded to how historical discriminatory policies against people of color, such as redlining, coupled with disinvestment and lack of educational and employment opportunities are contributing to growing inequalities and driving more people into the low-middle and low classes.

“The South side is a beautiful part of town, we’ve got some issues in some areas because of systemic racism and lack of investment, but it’s a beautiful part of town.” – Key informant interviewee

Residents mentioned that some Hudson County municipalities have put in place programs to address the effects of systemic racism, such as first-time homeowner programs for low-income residents, rent control policies, and programs to promote minority and/or woman owned businesses. However, participants emphasized that more policies and programs to promote equity and reverse this trend are urgently needed.

Community Health Issues

Understanding community health issues is a critical step in the CHNA process. The disparities seen in these issues mirror the historical patterns of structural, economic, and racial inequities experienced for generations across the county and the U.S.

Community Perceptions of Health

Understanding residents' perceptions of health helps provide insights into lived experiences, including into the key health concerns and facilitators and barriers to addressing health conditions. When asked about top concerns in their community, focus group participants and interviewees identified social and economic issues such as financial and food insecurity, and housing – and how these were associated with chronic conditions that affect many members of the community, including high-blood pressure, high cholesterol, and diabetes.

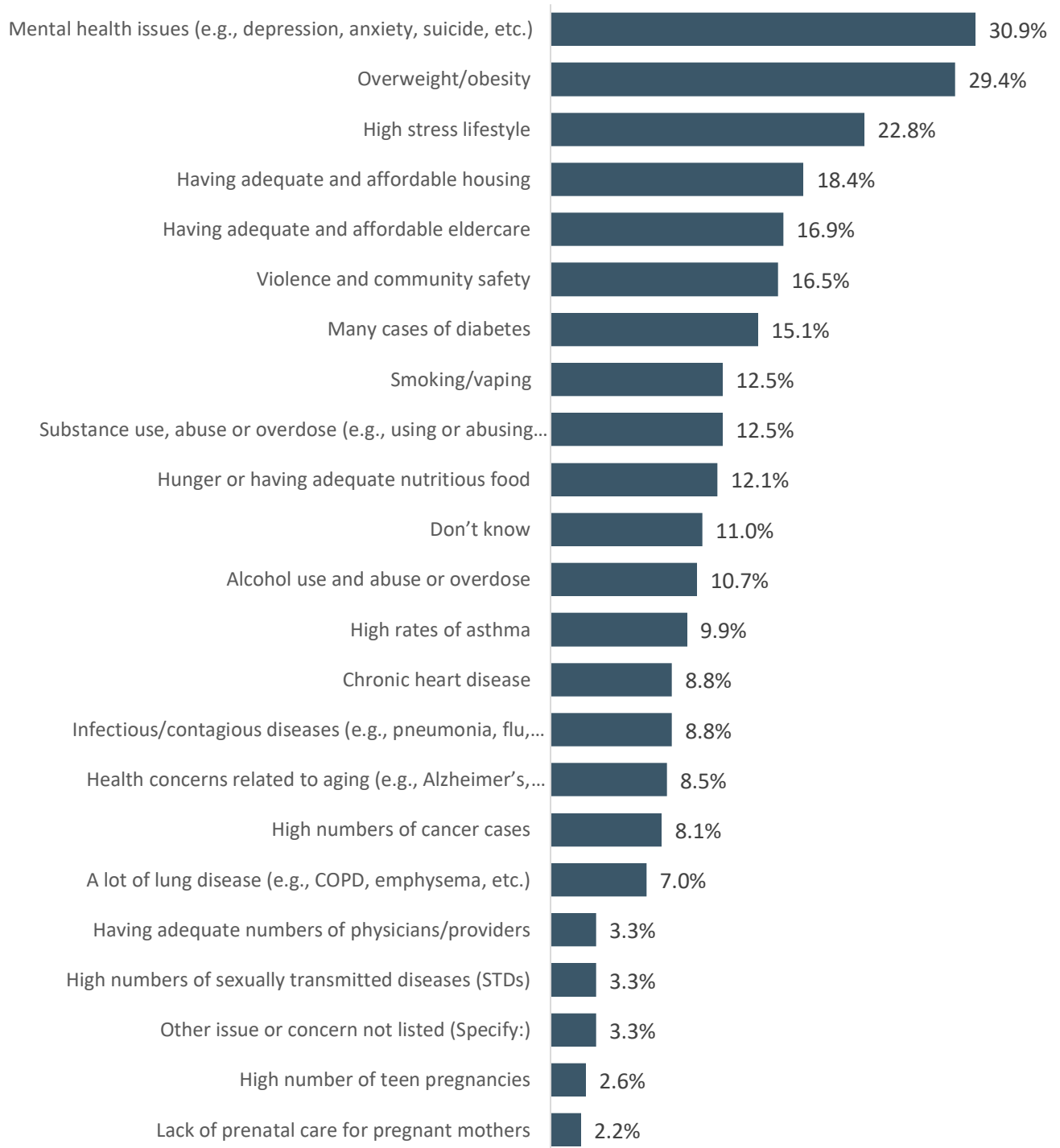
Challenges to accessing healthcare, largely due to cost, was also a top concern among residents. Another issue discussed by multiple groups, was the increase in mental health disorders among the entire population, but particularly among youth, seniors, and veterans. Other issues that were mentioned included a rise in community and domestic violence, an increase in sexually transmitted infections, and challenges to women's health, the latter in the context of the wave of legal decisions that curtail reproductive rights.

“Diabetes, high blood pressure, high cholesterol, obesity in this community is a problem [among] people who have a difficult time affording food” – Focus group participant

Survey respondents were presented with a list of specific issues and had the ability to add issues not listed. They were asked to mark the top three health concerns or issues for their community. They also were given the option to write in other issues not listed. This feedback complements quantitative data concerning health status and conditions. As shown in Figure 45, mental health, overweight/obesity, and high stress lifestyle were the top three issues noted among survey respondents. This was slightly different than results of the same survey in 2019. In that 2019 survey, obesity was the number one community health concern selected by survey respondents, followed by diabetes and then (tied) substance use and mental health.

While mental health, overweight/obesity, and high stress lifestyle were the top three community health concerns among respondents in the recent survey, differences appeared by race/ethnicity. While respondents identifying as Asian, Latino, and White shared the three priority health topics described above, Black respondents' top priority area was violence/community safety, followed by mental health issues, and adequate and affordable housing (Figure 46).

Figure 45. Percent of Community Survey Respondents Reporting the Top Three Health Issues or Concerns in Their Community (N=272), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Figure 46. Percent of Community Survey Respondents Reporting the Top Health Issues or Concerns in Their Community, by Race/Ethnicity (N=272), 2021

Asian (n=44) (A)	Black (n=26) (B)	Hispanic/ Latino (n=68) (C)	White (n=125) (D)
High stress lifestyle (31.8%) (D)	Violence/Community Safety (38.5%) (ABD)	Mental health issues (39.7%) (A)	Mental health issues (33.6%) (A)
Overweight/ obesity (29.5%)*	Mental health issues (34.6%) (A)	Overweight/ obesity (33.8%)	Overweight/ obesity (29.6%)
Mental health issues (15.9%)	Having adequate and affordable housing (19.2%) (A)*	High stress lifestyle (27.9%)	High stress lifestyle (18.4%)
Violence/Community Safety (13.6%)*	High stress lifestyle (19.2%)*	Substance use, abuse or overdose (23.5%) (AD)*	Having adequate and affordable housing (18.4%)
Having adequate and affordable eldercare (13.6%)*	Overweight/ obesity (19.2%)*	Having adequate and affordable eldercare (23.5%) (B)*	Many cases of diabetes (16.0%)

DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

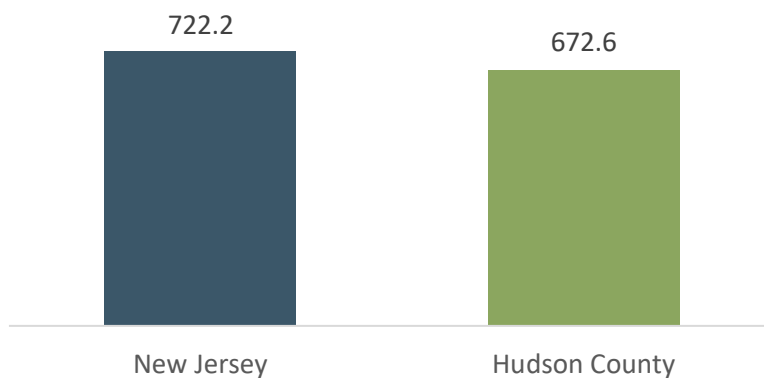
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering. * indicates health issues were tied. Cases where "don't know" was a frequently selected option are not presented in the table.

Leading Causes of Death and Premature Mortality

Mortality rates help to measure the burden and impact of disease on a population, while premature mortality data (deaths before age 75 years old) provide a picture of preventable deaths and point to areas where additional health and public health interventions may be warranted.

The most current mortality data are available for the period 2018-2020, which includes the first year of the COVID-19 pandemic. The age-adjusted mortality rate per 100,000 Hudson County residents was 672.6 in this period (Figure 47); 7% below the mortality rate in New Jersey during the same time period.

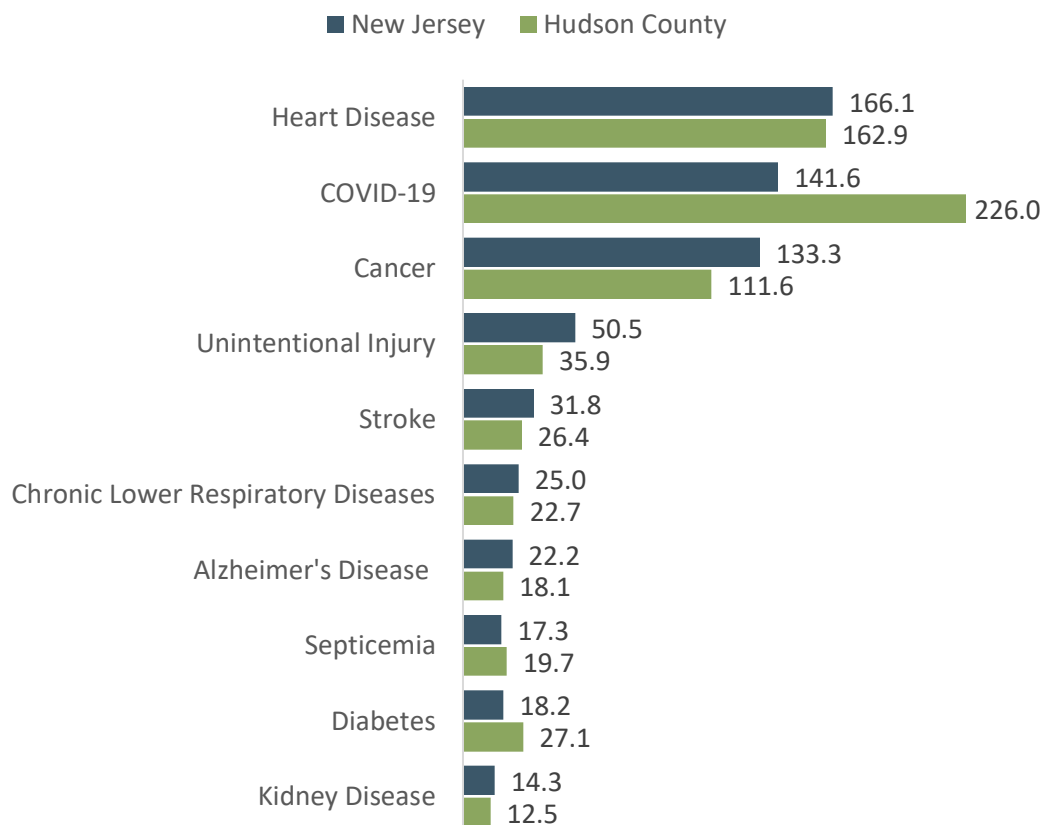
Figure 47. Age-Adjusted Mortality Rate per 100,000 population, 2018-2020



DATA SOURCE: New Jersey Department of Health, New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2018-2020

The leading cause of death in Hudson County in 2020 was heart disease (162.9 per 100,000), followed by COVID-19 (226.6 per 100,000), and cancer (111.6 per 100,000) (Figure 48). Additional leading causes of death included unintentional injury (such as unintentional poisonings including drug overdoses, unintentional motor vehicle accidents, unintentional drownings, and falls), stroke, and chronic lower respiratory disease (CLRD – e.g., chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, and asthma). It is important to note the deleterious impact of COVID-19 on mortality, which became the second cause of death in both the state and the county. The mortality rate by COVID-19 in Hudson County was 46% higher than in the state. Additional data on unintentional injury can be found in Appendix F- Additional Data Tables.

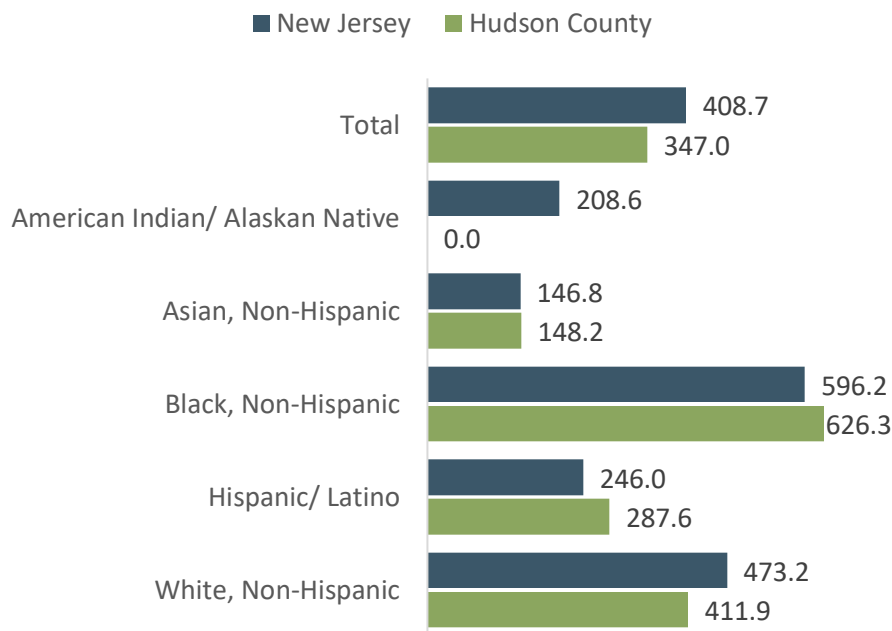
Figure 48. Top 10 Age Adjusted Mortality Rates per 100,000, by State and County, 2020



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health as reported New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2021

Premature mortality, deaths before age 75 years old, is an indicator of untimely death and can provide guidance on where additional investments are needed. In 2018-2020—the time period with the most recent data available—Hudson County had a premature mortality death rate of 347.0 per 100,000 residents, compared to 408.7 per 100,000 New Jersey residents (Figure 49). The rate of premature mortality was highest among Black (626.3) and White (411.9) residents, both above the county and state averages.

Figure 49. Premature Mortality (deaths before age 75) Rate per 100,000 Population, by State and County, 2018-2020



DATA SOURCE: National Center for Health Statistics, Mortality Files, as reported University of Wisconsin Population Rankings & Roadmaps, 2018-2020

Additional data on the overall health of the population can be found in Appendix F- Additional Data Tables.

Obesity, Healthy Eating, and Physical Activity

Obesity is the second leading cause of preventable death in the United States and increases the likelihood of chronic conditions among adults and children.

Overweight and Obesity

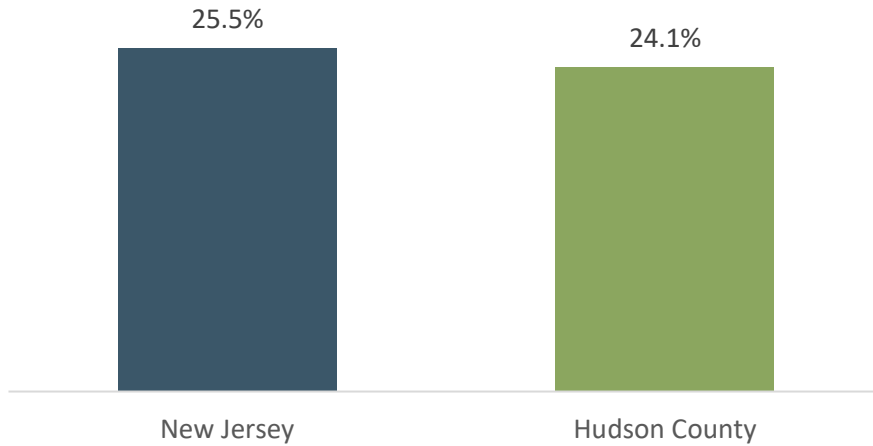
As discussed earlier in the Perceptions of Community Health section, obesity was cited as the second top health concern in the community in the survey (after mental health). However, it was not discussed at length in the focus groups or interviews by participants. Instead, residents from diverse population groups commented on the chronic conditions that are linked to obesity, particularly diabetes, and described how these conditions were prevalent in the community from a very young age. They discussed the social and economic challenges to maintaining a healthy lifestyle, including buying healthy food, access issues in living in a food desert, barriers to seeking medical care, having safe and accessible green space for activity, and time constraints. (See sections related to Food Access and the Built Environment for survey data and surveillance data on perceptions and the landscape related to the food and physical activity environment.)

The latest surveillance data on overweight/obesity is from several years ago. Adults at the state and county level were asked to self-report their height and weight. Based on this self-report, about one in four adults in Hudson County were considered obese, comparable to New Jersey (Figure 50).

In the current community survey for this CHNA, survey respondents were asked to indicate whether they or a household family member were ever told by a doctor or health professional that they had a

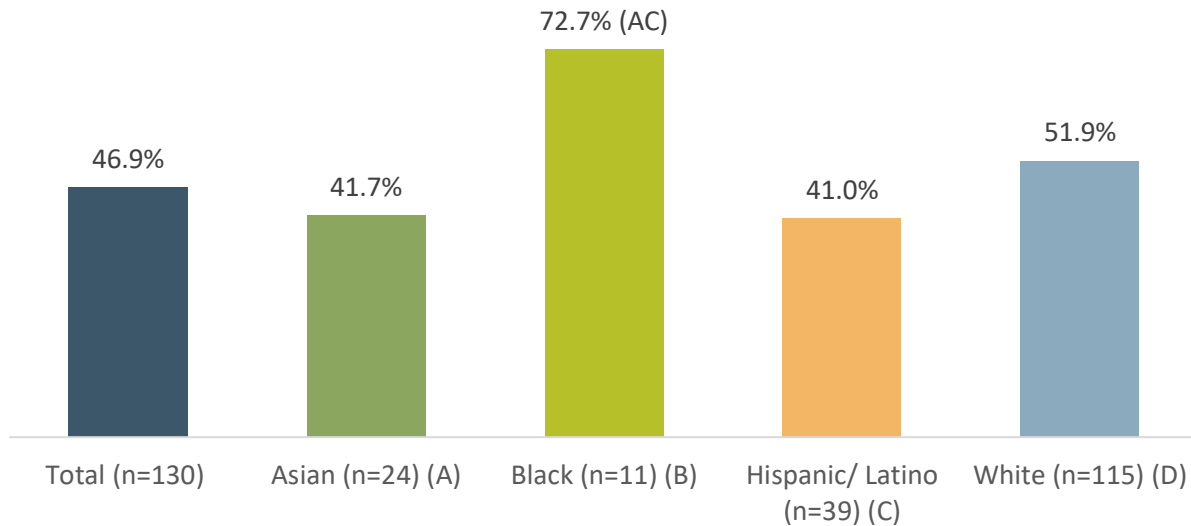
weight problem (Figure 51). Among these respondents, almost half (46.9%) indicated yes, although responses varied by race/ethnicity. Nearly three in four (72.7%) Black respondents reported this, significantly higher than Asian (41.7%) and Latino (41.0%) respondents.

Figure 50. Adults Self-Reported Obese, by State and County, 2018



DATA SOURCE: Centers for Disease Control and Prevention (CDC), U.S. Diabetes Surveillance System, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

Figure 51. Percent of Community Survey Respondents Reporting that They or a Family Member Has Ever Been Told by a Health Professional They Have Had a Weight Problem (n=130), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

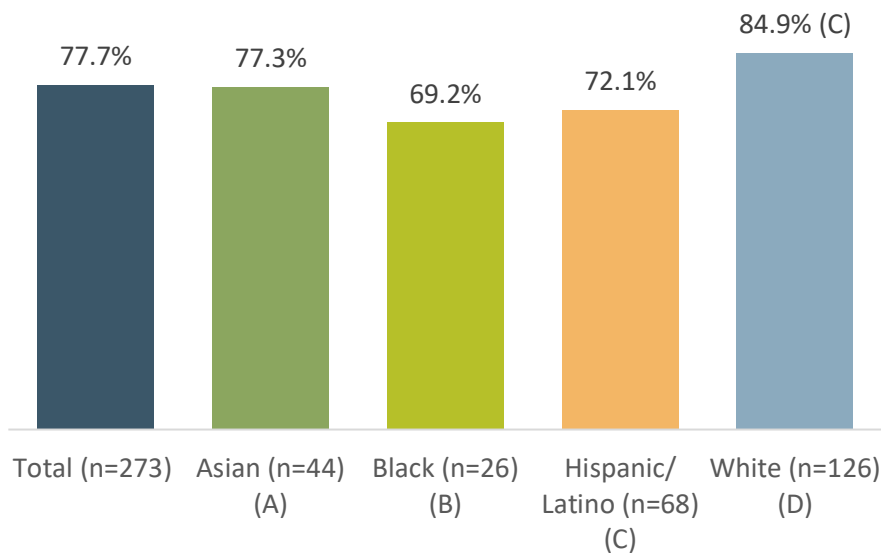
Physical Activity

Some focus group participants discussed that they enjoyed doing physical activity outdoors, while others noted that they did not have time to be physically active. Participants remarked that physical activity was important for maintaining both physical and mental health. A focus group participant explained the importance of exercise for those experiencing mental health problems and to address isolation, *“I wish more veterans would take advantage of opportunities for umpiring and make a little money on the side – I do various leagues, swimming, softball, baseball. [There are] a lot of opportunities for veterans that are just coming out of a mental health area, whereas they want a different avenue to go to, and be part of the community which a lot of veterans try to isolate... But this is something where you can just come out and do, be a part of the community with fellow veterans, you know.”*

“I walk a lot. Walking is the best exercise.” – Focus group participant

Community survey respondents were asked if they were physically active, and nearly 78% indicated yes (Figure 52). However, Black and Latino survey respondents were less likely to say that they were currently physically active, with only 69.2% and 72.3% saying yes, respectively, a lower proportion when compared to White respondents (84.9%). As discussed earlier in this report, Black and Latino survey respondents were also significantly less likely than White respondents to indicate that there were safe outdoor places to walk and play in their community. Community survey respondents who were parents also indicated whether they would describe their children as physically active or sedentary after school or on weekends. About 78% of Hudson County parent survey respondents described their children as physically active, with 21.8% describing them as sedentary. In comparison, only 53.6% of Latino parents indicated their children were physically active. Data is not available for Asian and Black parents.

Figure 52. Percent of Community Survey Respondents Indicating That They Were Physically Active (n=273), 2021

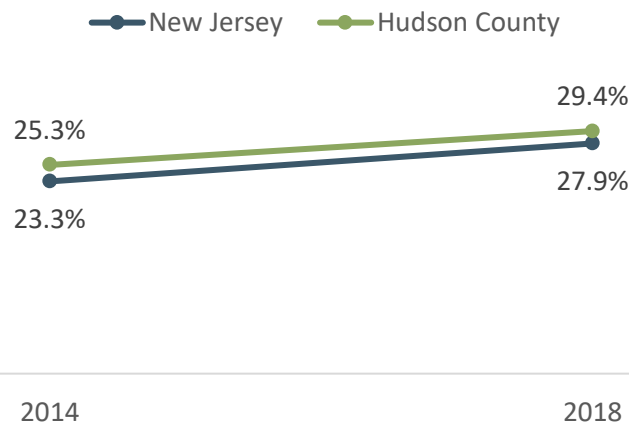


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

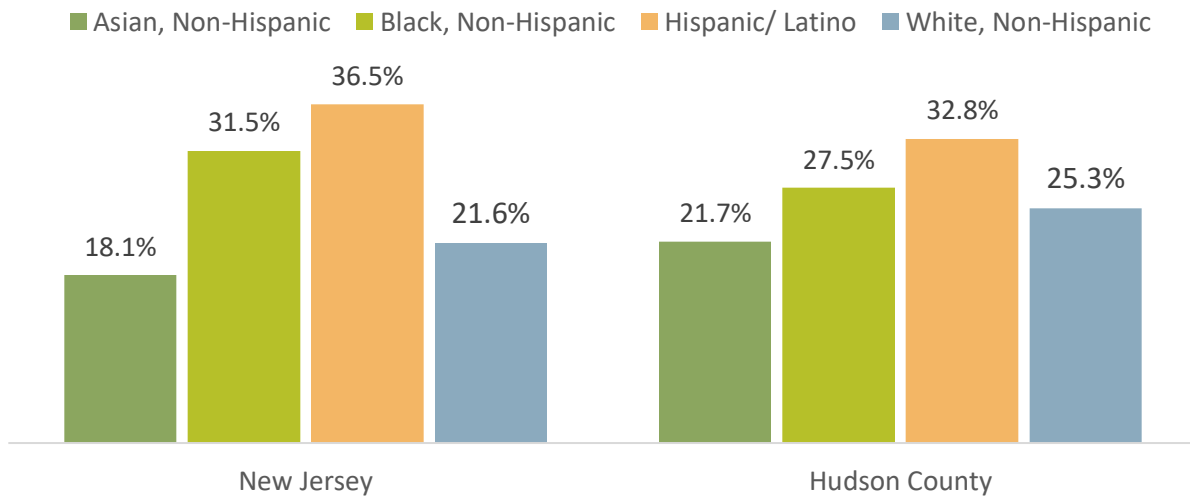
Surveillance data on physical activity, collected pre-COVID, shows similar patterns as the community survey. These data sources collect data on whether respondents had no leisure time activity. Across the state and by county, the percentages of those with no leisure time physical activity were higher in 2018 than in 2014 (Figure 53). In Hudson County, 29.4% of adults reported having no leisure time in 2018, compared to 25.3% in 2014. Surveillance data from 2016 to 2020, by race/ethnicity indicated that Latino respondents were most likely to report having no leisure physical activity time (32.8%) (Figure 54). Data on access to adequate location to engage in physical activity can be found in Figure 133 in the Appendix.

Figure 53. Percent Adults Reported to Have Had No Leisure Time Physical Activity, by State and County, 2014 and 2018



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2014 and 2018

Figure 54. Percent Adults Reported to Have Had No Leisure Time Physical Activity by Race/Ethnicity, by State and County, 2016-2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Healthy Eating

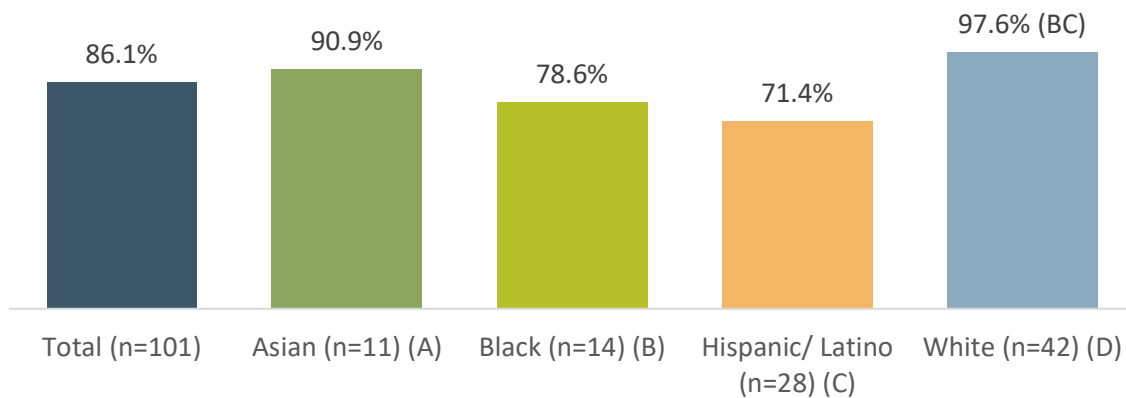
As discussed in the Food Access & Food Insecurity section and Built Environment section of this report, focus group and interview participants talked about the challenges of accessing healthy foods in their communities. These difficulties included lack of availability and affordability of healthy foods, depending on food provided by schools or food pantries, living in a “food desert,” and not having access to a kitchen to cook healthier meals for the family. However, other participants mentioned that there were healthy food outlets available in Hudson County. During COVID-19, multiple participants remarked that the community came together to ensure access to healthy foods to those affected by the pandemic via food drives and delivery of healthy food boxes or supermarket gift cards. Residents also noted that low-income seniors could receive food vouchers. In addition, Jersey City Medical Center has a healthy food pantry which serves people facing food insecurity, many of whom are seniors.

“They were meeting specifically... about the quality of the food that are available to more African American neighborhoods as opposed to downtown Jersey City, from the same food chain, and they had some complaints there... Food deserts are still a problem in our area.” – Focus group participant

Current surveillance data on fruit and vegetable consumption is not available for Hudson County. New Jersey data indicate that 19.1% of New Jersey adults reported in 2017 that they ate vegetables less than one time per day and 33.6% of New Jersey adults reported eating fruit less than one time per day, according to the Behavioral Risk Factor Surveillance Survey.

Eating breakfast daily is an important start to a healthy day. However, current data from the CHNA community survey shows differences by race/ethnicity. Among respondents living with a child, only about three-quarters of Black and Latino survey respondents (78.6% and 71.4%, respectively) reported that their children eat breakfast daily, significantly fewer than White respondents (97.6%) whose children did so (Figure 55).

Figure 55. Percent of Respondents Whose Children Eat Breakfast Daily, among Respondents Who Have Children that Live with Them, by Race/Ethnicity (n=101), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

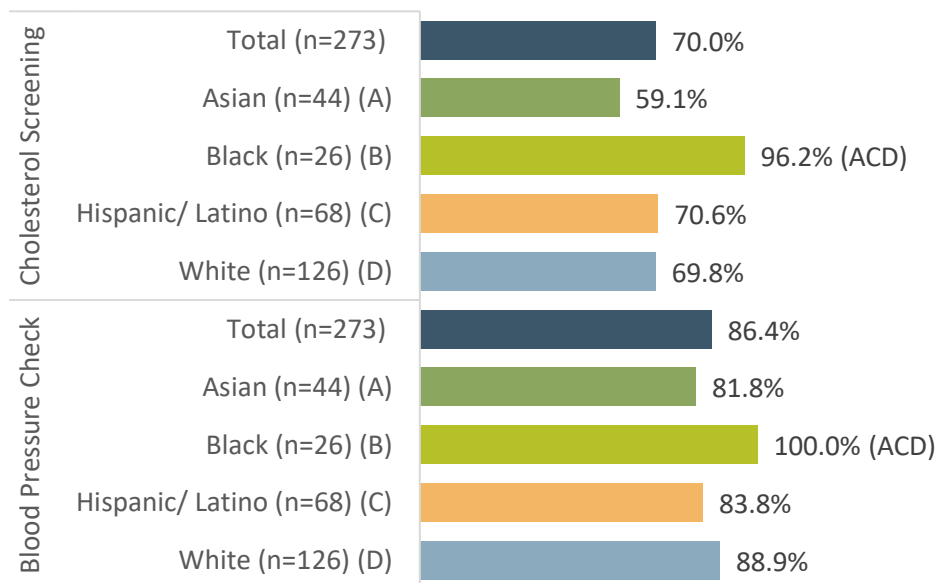
Chronic Conditions

Chronic conditions, such as heart disease, diabetes, COPD, and cancer, are some of the most prevalent conditions in the United States, including in Hudson County. Chronic diseases are also a contributing factor to poor mental health. As a healthcare provider noted, *“There’s a lot of depression surrounding getting diagnosed with one of those [chronic] illnesses. They have access to those programs, but they feel beaten down because of misinformation. When they get more information, they feel that they can manage it. The diagnosis can feel like a death sentence sometimes.”* Although chronic diseases are among the most common and costly health problems, they are also among the most preventable through changes in behavior such as reduced use of tobacco and alcohol and improved diet and physical activity. The following section describes the health data (e.g., screening, incidence, mortality, etc.) related to chronic conditions.

High Cholesterol and High Blood Pressure

Multiple focus group and interview participants mentioned high cholesterol and hypertension as prevalent in the community, including among children. High cholesterol and high blood pressure are significant risk factors for heart disease, stroke, and other chronic diseases.²⁹ Community survey respondents in spring/summer 2021 were asked about their participation in different types of health screenings over the past two years (Figure 56). Many respondents (70.0%) in Hudson County indicated that they have received a cholesterol screening, and 86.4% had participated in a blood pressure screening. Black respondents were significantly more likely than Asian, Latino, and White respondents to indicate that they had participated in either type of screening over the past two years.

Figure 56. Percent of Community Survey Respondents Reporting that They Have Participated in a Cholesterol or Blood Pressure Screening in the Past Two Years (n=273), 2021



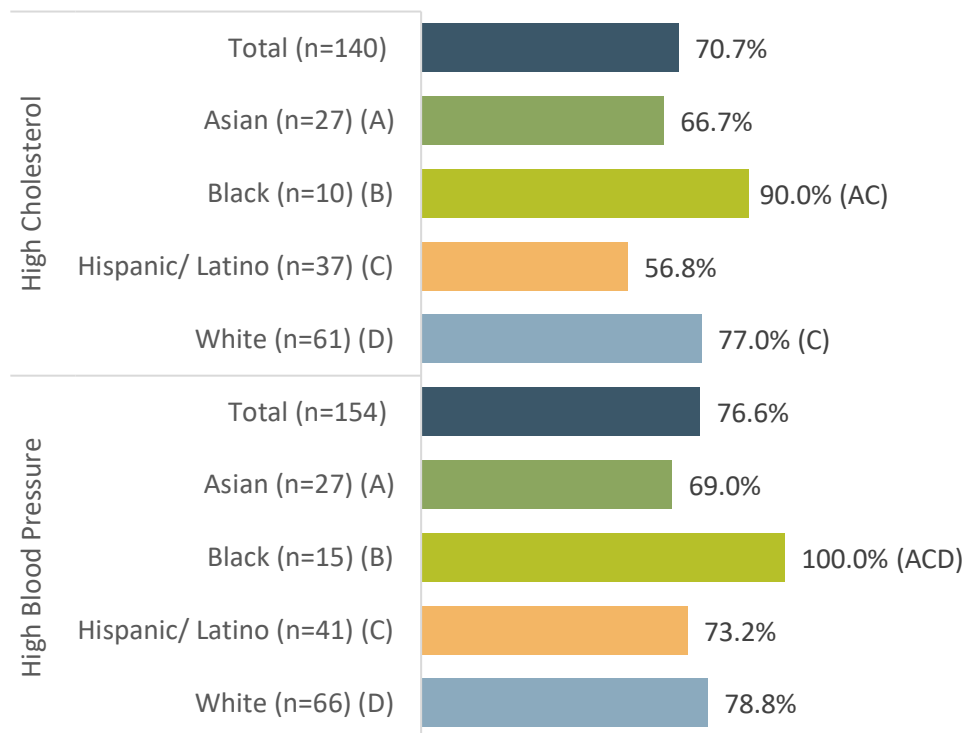
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

²⁹ <https://www.cdc.gov/chronicdisease/resources/publications/factsheets/heart-disease-stroke.htm>

A high proportion of survey respondents report being affected by high cholesterol and high blood pressure. Approximately 71% and 77% of Hudson County survey respondents indicated that they or member of their family had been told by a health professional that they have high cholesterol and blood pressure, respectively (Figure 57). Black respondents, with the highest rates of both, were significantly more likely than Asian, Latino, or Black respondents to indicate that they or a family member had high cholesterol or high blood pressure.

Figure 57. Percent of Community Survey Respondents Reporting that They or a Family Member Has Ever Been Told by a Health Professional They Had High Cholesterol or High Blood Pressure (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

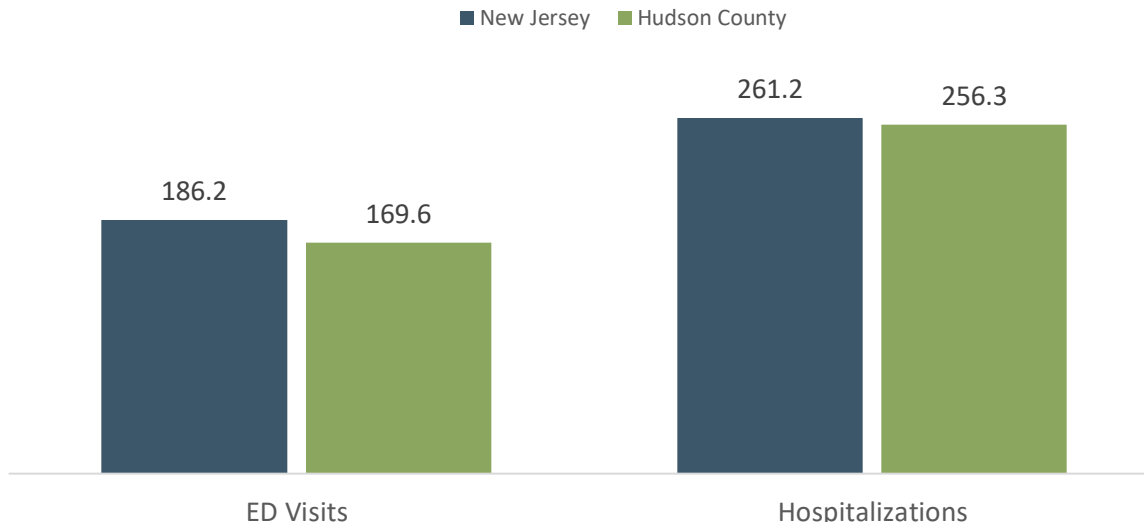
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Heart Disease

While focus group and interview participants did not directly discuss heart disease, it is the leading cause of death in Hudson County, and closely associated with other conditions mentioned by residents such as diabetes, high cholesterol, and lifestyle.

In the following graph, surveillance data are presented on the number of adults visiting the emergency department for major cardiovascular disease. In 2016-2020, the rate of heart disease emergency department (ED) visits per 10,000 population in Hudson County was 169.6 visits and the rate of heart disease hospitalizations per 10,000 population was 256.3, similar to state rates (Figure 58).

Figure 58. ED Visits and Hospitalizations for Major Cardiovascular Disease per 10,000 Population, by State and County, 2016-2020

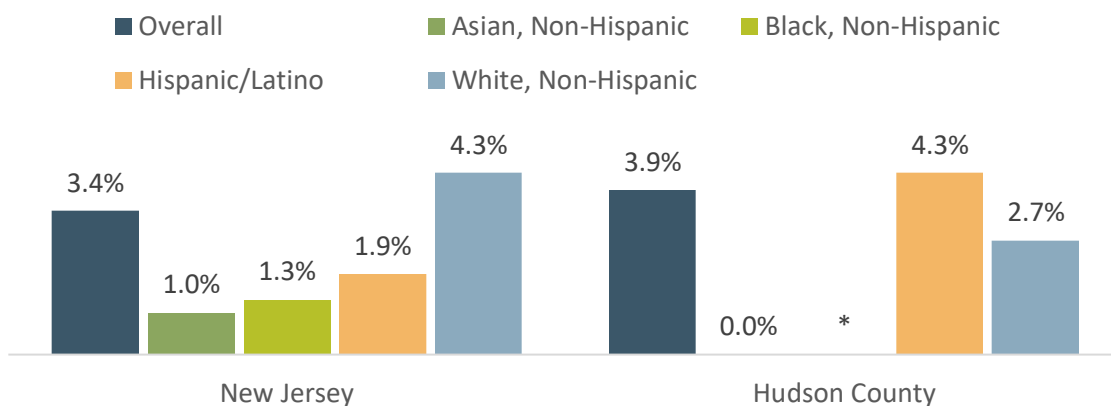


DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

NOTE: Includes primary and secondary diagnosis cardiovascular disease, excluding stroke and hypertension

Figure 59 presents the percentage of adults that reported angina or coronary heart disease in 2020, by race/ethnicity. Across the state, the percentage of those reporting angina or coronary heart disease was highest among White residents (4.3%), followed by Latino (1.9%), Black (1.3%), and Asian residents (1.0%). At the county level, the highest percentage was reported by Latino residents (4.3%), higher than the percentage at county and state level. However, data for Black residents was not reliable due to small sample sizes.

Figure 59. Percent of Adults Reporting Angina or Coronary Heart Disease, by State and County, by Race/Ethnicity, 2020

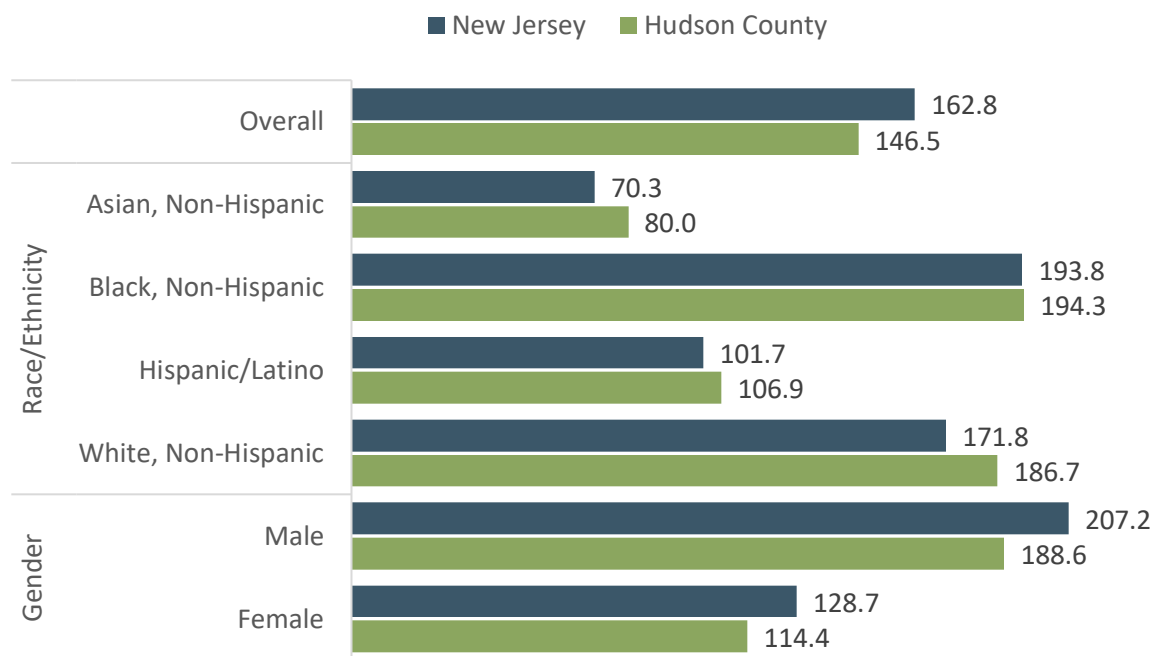


DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Death certificate data is presented for rates of cardiovascular disease mortality per 100,000 in 2016-2020 overall and by race/ethnicity and gender. Across the state, the overall mortality per 100,000 was 162.8 and was highest among Black (194 per 100,000) and White (172 per 100,000) residents, as well as male (206.7 per 100,000) residents (Figure 60). At the county level, the overall cardiovascular disease mortality per 100,000 was 147, lower than in the state. Like New Jersey, mortality was highest among Black (194 per 100,000) and White (187 per 100,000), as well as male (189 per 100,000) residents.

Figure 60. Cardiovascular Disease Mortality per 100,000, by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

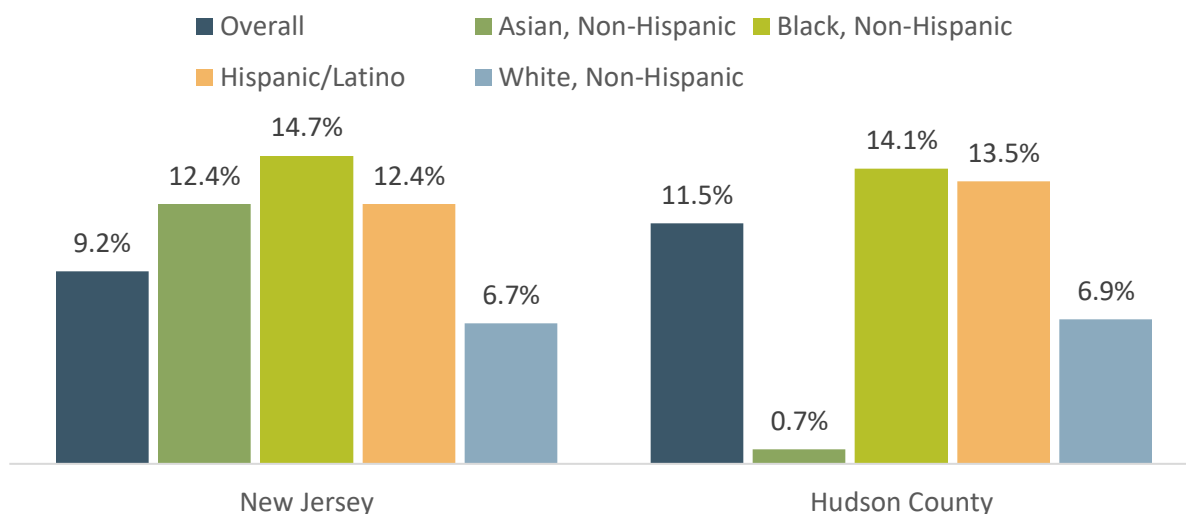
Diabetes

Diabetes was among the top health concerns mentioned by focus group and interviewee participants across the board, including among the Latino, Black, and Asian residents. Participants indicated observing an increase in rates of diabetes in recent years and noted that diabetes was highly prevalent in their communities, starting at a young age. A Latino focus group participant described it as, *“Everyone, even children, has diabetes... What is in the air for everyone to have diabetes?”* Focus group participants attributed the increase in diabetes rates to stress associated with social and economic factors, such as affordable healthy living and access to good healthcare. As one focus group participant stated, *“Diabetes is a very expensive issue in the community, and we’ll often see people forgo their medication because they can’t afford it or forgo healthy foods because they can’t afford it.”* A theme that emerged strongly from participants was the urgent need to address the upstream causes of disease to reduce the incidence of diabetes and other chronic disease among low-income communities and persons of color.

The following figure shows the percent of adults that reported a diagnosis of diabetes overall and by race/ethnicity from 2016 to 2020, the most recent that surveillance data is available. In New Jersey, 9.2% of adults reported a diabetes diagnosis. This percentage was highest among Black, Non-Hispanics (14.7%), followed by Asian, Non-Hispanics (12.1%) and Hispanic/Latino (12.4%), and lowest among White, Non-Hispanics (6.7%) (Figure 61). A higher percentage of adults were diagnosed with diabetes in Hudson County (11.5%). Of note, whereas county rates among Black (14.1%) and White (6.9%) residents were comparable to those of the state, Latinos in Hudson County (13.5%) had higher rates and Asians had much lower rates (0.7%) than in New Jersey.

“We seem taken aback by how prevalent these chronic diseases are so much so that when somebody's first diagnosed, many times they don't even react to it like, “Yeah, well, my father had it, my mother had it, my friends have it, and now I have it.” It's normalized and I think that's a shame. I think we can do more work upfront.” – Focus group participant

Figure 61. Percent of Adults Reported to Have Been Diagnosed with Diabetes, by State and County, 2016-2020



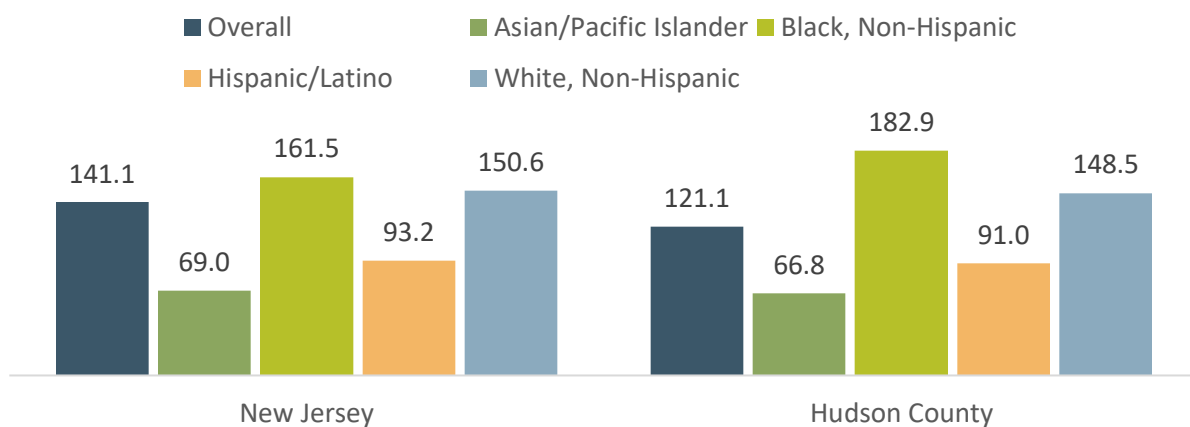
DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Cancer

While cancer is one of the leading causes of death in Hudson County, it was not discussed much during the focus groups or interviews. However, cancer incidence and mortality are closely associated with the social determinants of health. Screening and early detection is a critical strategy to reduce premature deaths and is strongly linked to access to care. Further, lifestyle factors are the most significant risks of developing cancer. Exposure to carcinogens in the built environment, the water, the air, and the soil, because of daily activities at home, school, and the workplace, increases the risk of developing cancer. In addition, a healthy lifestyle – maintaining a healthy diet and weight, and not smoking or consuming alcohol, are preventative factors; as discussed in other sections of the report, some population groups face substantial barriers to sustaining a healthy lifestyle.

Death certificate data is presented below for cancer mortality rates per 100,000 in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality per 100,000 was 141.1 and was highest among Black, Non-Hispanics (161.5 per 100,000) and White, Non-Hispanics (150.6 per 100,000) (Figure 62). The overall cancer mortality rate in Hudson County (121.1 per 100,000) was lower than in the state. Most racial/ethnic groups in Hudson County, had cancer mortality rates comparable to those in New Jersey. However, Black residents' cancer mortality rate (182.9 per 100,000) in Hudson County, was higher than in New Jersey. Appendix I in the back of this report contains additional cancer data including incidence and mortality data and five-year trends for all cancers across New Jersey and Hudson County. There is an additional table of tumor registry data for JCMC, and information on the patient origin of Hudson's outpatient and inpatient cancer treatment population.

Figure 62. Cancer Mortality Rate per 100,000 Population (Overall, Combined for Female Breast, Colorectal, Lung and Bronchus, Male Prostate), by Race/Ethnicity, State, and County, 2016-2020

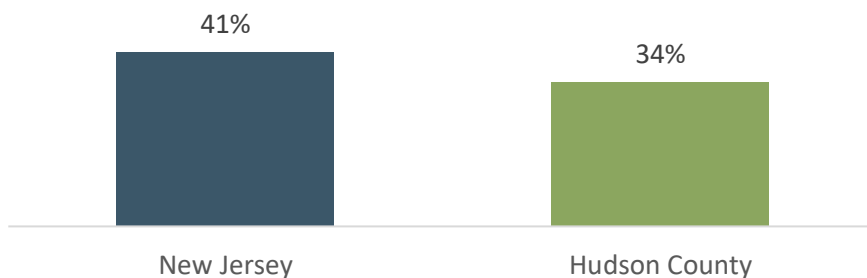


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Breast Cancer

The following figure shows the percentage of female Medicare enrollees, ages 65-74, that received an annual mammography screening in 2019. At the state level, 41.0% of female Medicare enrollees in that age group had received an annual screening (Figure 63). The county rate of 34% was lower than that state rate.

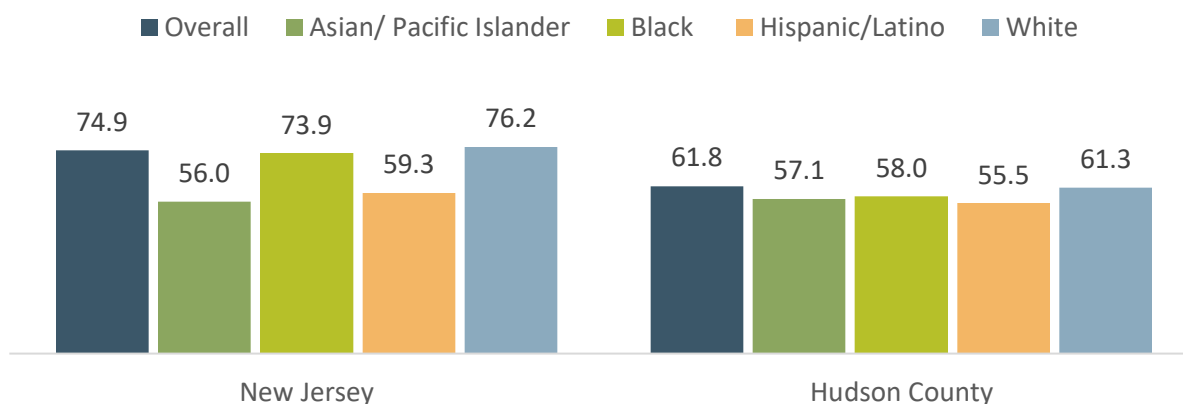
Figure 63. Female Medicare Enrollees Ages 65-74 that Received an Annual Mammography Screening, by State and County, 2019



DATA SOURCE: Centers for Medicare & Medicaid Services, Office of Minority Health's Mapping Medicare Disparities tool, as reported by County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

Cancer registry data is presented for the age-adjusted incidence rate of female breast cancer per 100,000 population in 2015-2019 across New Jersey and in Hudson County, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate was 74.9 per 100,000 and was highest among the White (76.2 per 100,000) and Black (73.9 per 100,000) populations (Figure 64). At the county level, the overall incidence rate in Hudson County (61.8 per 100,000) was lower than in the state. It was highest among the White Hudson County population (61.3 per 100,000) and similar among the Black (58.0 per 100,000), Asian/Pacific Islander (57.1 per 100,000), and Hispanic/Latino (55.5 per 100,000) groups.

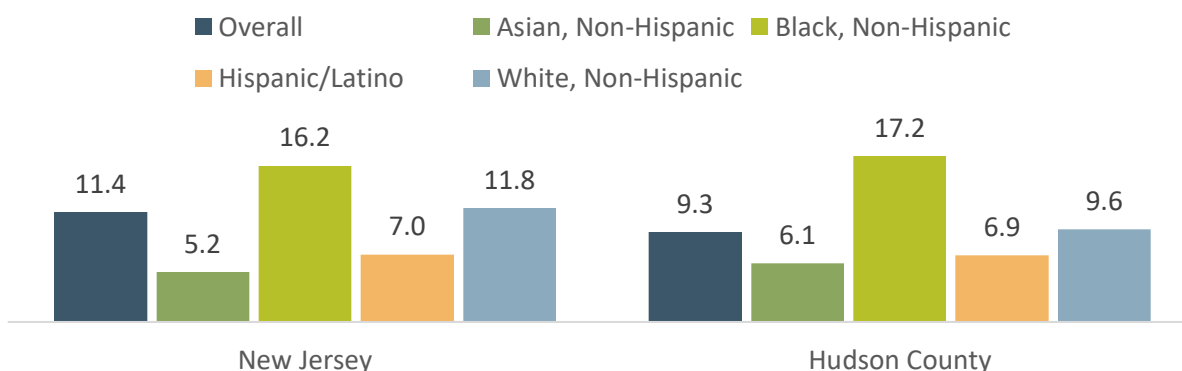
Figure 64. Age-Adjusted Female Breast Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

The state cancer mortality rate was 11.4 per 100,000 persons and was highest among Black women (16.2 per 100,000), followed by White women (11.8 per 100,000) (Figure 65). At the county level, the overall mortality rate was 9.3 per 100,000, lower than in New Jersey. The breast cancer mortality rate among Black women (17.2 per 100,000) in Hudson County nearly doubled that of White residents (9.6 per 100,000), and almost tripled that of Asian women (6.1 per 100,000) and Latinas (6.9 per 100,000).

Figure 65. Breast Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020

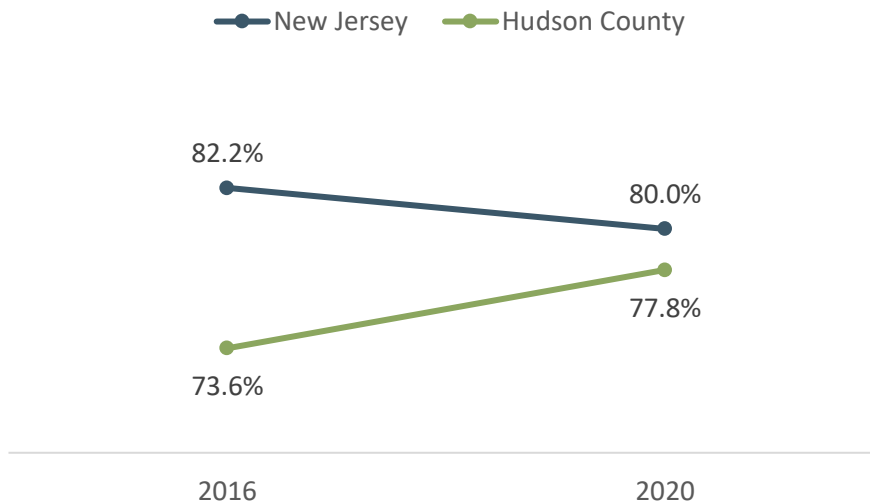


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Cervical Cancer

Data are presented on the percentage of women, ages 21-65, that reported having had a pap test in the past three years in 2016 and 2020, encompassing the first year of COVID-19. At the state level, 82.2% of women in that age group reported having had a pap test in the past three years in 2016 and 80.0% in 2020 (Figure 66). Whereas the percentage of women getting pap tests were lower in Hudson County at both time periods, unlike in New Jersey, the percentage of women obtaining a pap test in the past three years in Hudson County increased from 73.6% in 2016 to 77.8% in 2020.

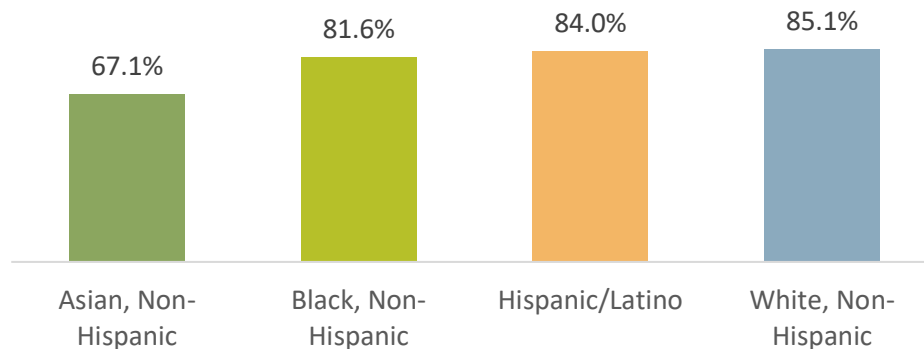
Figure 66. Percent Females Aged 21-65 Reported to Have Had a Pap Test in Past Three Years, by State and County, 2016 and 2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016 and 2020

Data are also presented at the state level on the percentage of females, ages 21-65, that reported having had a pap test in the past three years by race/ethnicity. In New Jersey, 85.1% of White, Non-Hispanics, 84.0% of Hispanics/Latinos, 81.6% of Black, Non-Hispanics, and 67.1% of Asian, Non-Hispanics reported having a pap test in the past three years (Figure 67).

Figure 67. Percent Females Aged 21-65 Reported to Have Had a Pap Test in Past Three Years by Race/Ethnicity, by State, 2020

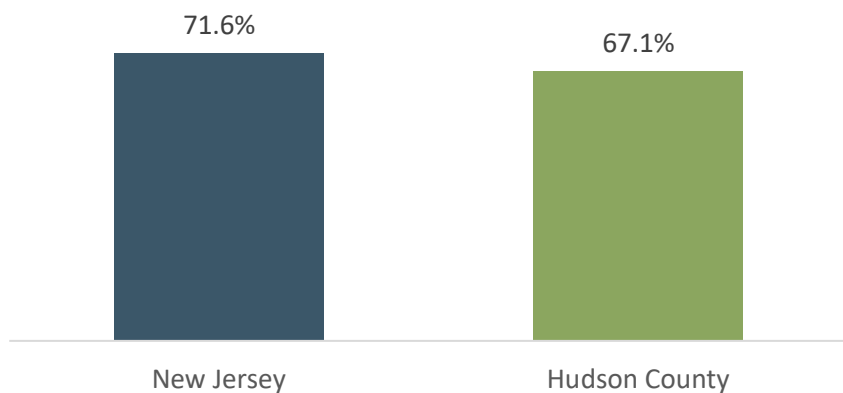


DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Colorectal Cancer

The following figure presents 2020 surveillance data on the percentage of adults aged 50 to 75 who were current – defined as having taken a take-home fecal immunochemical test (FIT) or high-sensitivity fecal occult blood test (FOBT) within the past year, and/or a flexible sigmoidoscopy within the past 5 years with a take-home FIT/FOBT within the past 3 years, and/or a colonoscopy within the past ten years – in their colorectal cancer screenings. At the state level, 71.6% of adults in that age group reported having had a colorectal cancer screening compared to 67.1% in Hudson County (Figure 68).

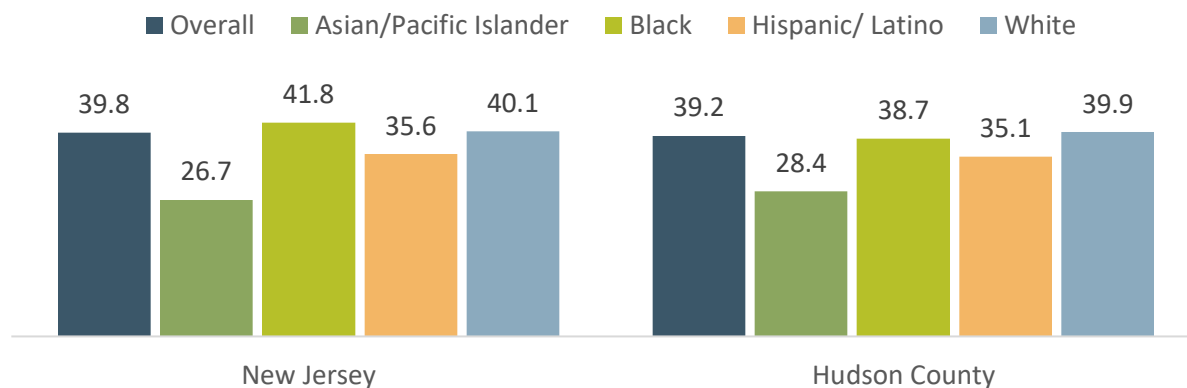
Figure 68. Percent Colorectal Cancer Screening (Adults Aged 50-75), by State and County, 2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Cancer registry data is presented for the age-adjusted incidence rate of colorectal cancer per 100,000 population in 2015-2019 at state and county, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate per 100,000 was 39.8 and was highest among the Black (41.8 per 100,000) and White (40.1 per 100,000) populations (Figure 69). At the county level, the overall incidence rate was 39.2 per 100,000 in Hudson County and was highest among the White (39.9 per 100,000) and Black (38.7 per 100,000) populations.

Figure 69. Age-Adjusted Colorectal Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019

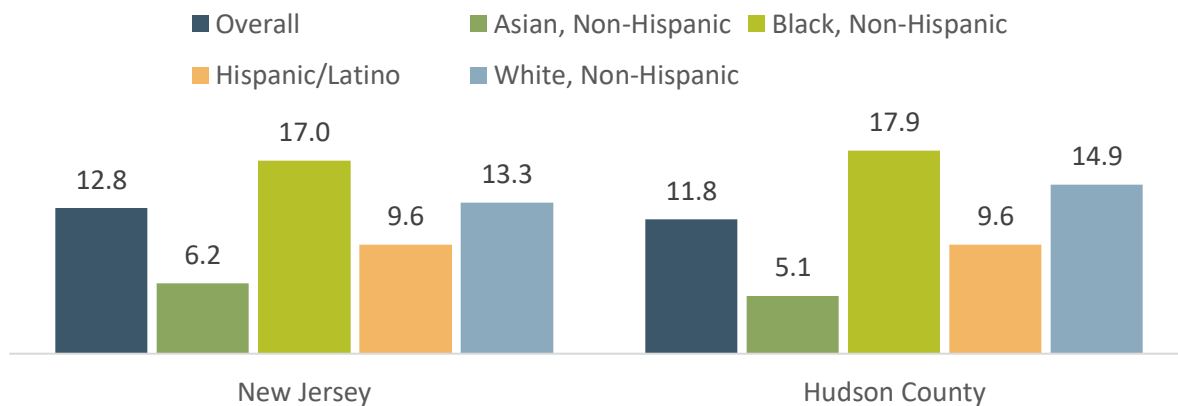


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Death certificate data is presented for rate of colorectal cancer mortality per 100,000 persons in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality rate was 12.8 per 100,000 and was highest among the Black population (17.0 per 100,000), followed by the White population (13.3 per 100,000) (Figure 70). County-level rates were comparable. The overall colorectal cancer mortality in Hudson County was 11.8 per 100,000 persons; highest among Black (17.9 per 100,000) followed by White (14.9 per 100,000) residents.

Figure 70. Colorectal Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020

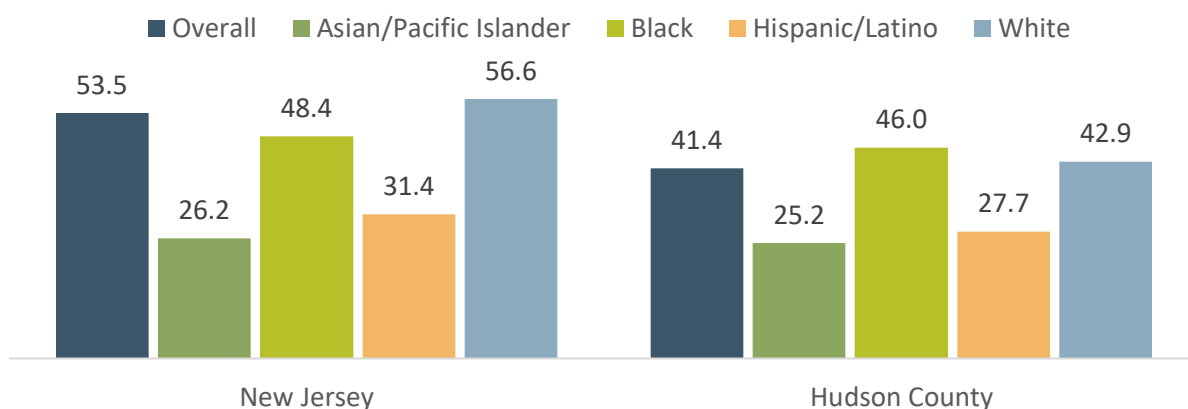


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Lung Cancer

Across the state, the overall age-adjusted lung cancer incidence rate in 2015-2019 was 53.5 per 100,000 residents and was highest among the White (56.6 per 100,000) and Black (48.4 per 100,000) groups (Figure 71). The county-level overall lung cancer incidence rate of 41.4 per 100,000 was lower than in the state. By race/ethnicity, the incidence rate of lung cancer in Hudson County was higher than average among the Black (46.0 per 100,000) and White (42.9 per 100,000) populations.

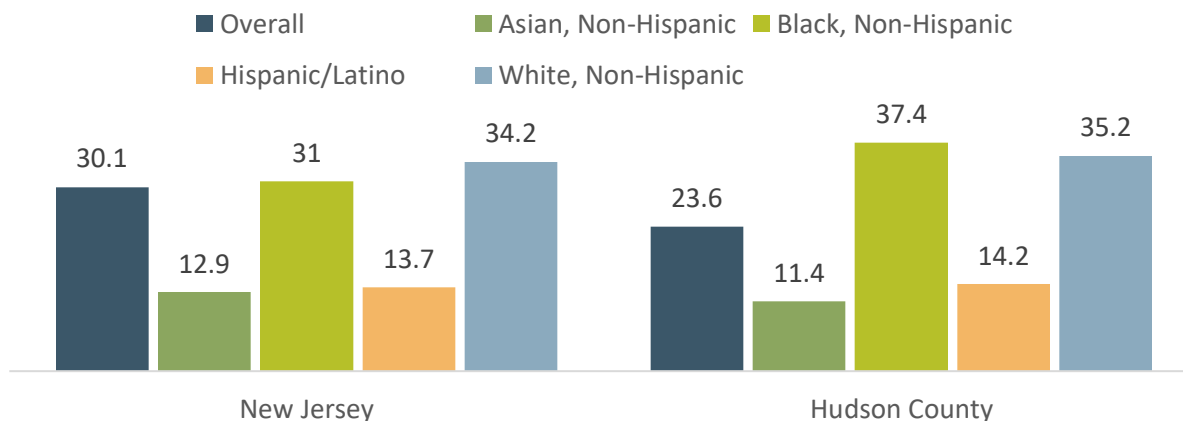
Figure 71. Age-Adjusted Lung Cancer Incidence Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2015-2019



DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

Death certificate data is presented for rate of lung cancer mortality per 100,000 in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality rate per 100,000 was 30.1 and was highest among White, Non-Hispanics (34.2 per 100,000) and Black, Non-Hispanics (31.0 per 100,000) (Figure 72). At the county level, the overall lung cancer mortality per 100,000 was 23.6 in Hudson County and was highest among Black, Non-Hispanics (37.4 per 100,000), followed by White, Non-Hispanics (35.2 per 100,000).

Figure 72. Lung Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020

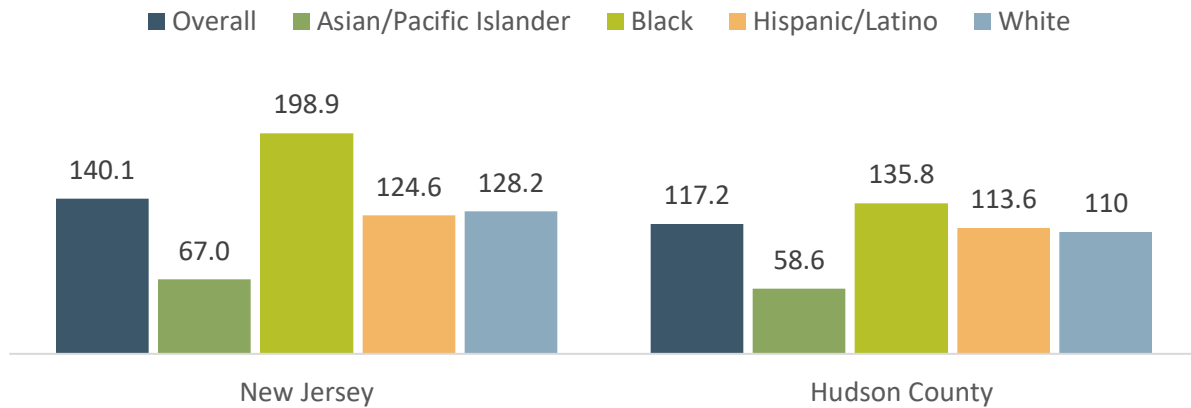


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Prostate Cancer

Cancer registry data is presented for the age-adjusted incidence rate of prostate cancer per 100,000 population in 2015-2019 across New Jersey and in Hudson County, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate was 140.1 and was 198.9 per 100,000 in the Black population (Figure 73). At the state level, incidence rates were similar among Hispanic/Latino (124.6 per 100,000) and White (128.2 per 100,000) populations, and lower among Asian (67.0 per 100,000) groups. At the county level, the overall age-adjusted incidence rate was 117.2 in Hudson County and was highest among Black residents (135.8 per 100,000), comparable among Hispanic/Latino (113.6 per 100,000) and White (110.0 per 100,000) populations, and lowest among Asian groups (58.6 per 100,000).

Figure 73. Age-Adjusted Prostate Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019

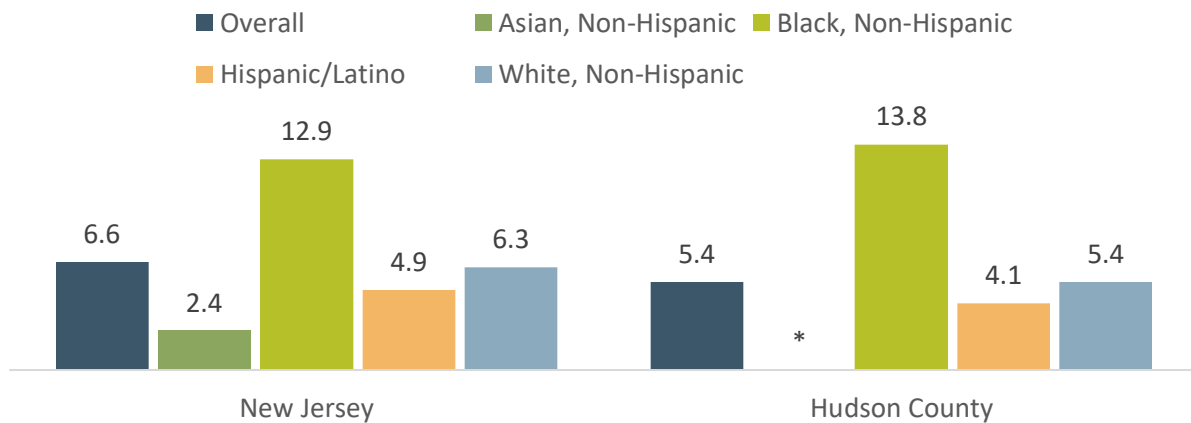


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Death certificate data is presented for rate of prostate cancer mortality per 100,000 in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality rate per 100,000 was 6.6; almost double the average rate among Black, Non-Hispanics (12.9 per 100,000) (Figure 74). At the county level, the overall mortality rate per 100,000 was 5.4 in Hudson County, with rates for Black residents (13.8 per 100,000) 170% higher than the average. Data was not provided for Asians due to small numbers.

Figure 74. Prostate Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020



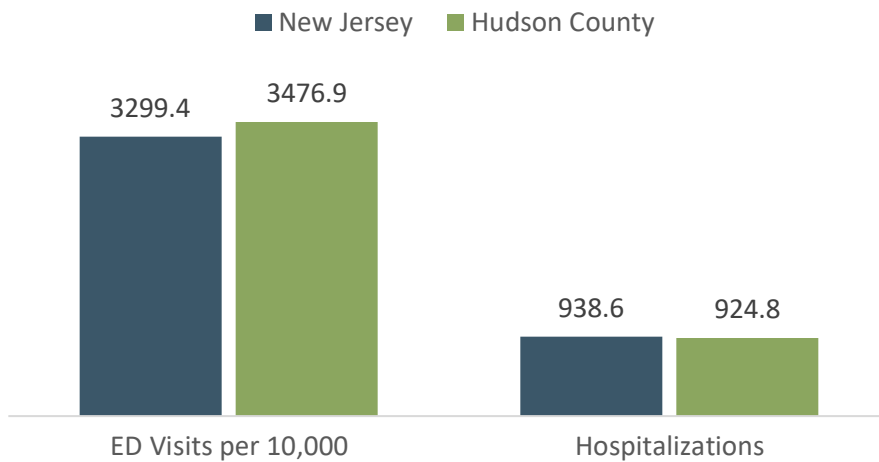
DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. It is the most prevalent disease in the grouping of chronic lower respiratory diseases (CLRD), the sixth leading cause of death in Hudson County in 2020. Data are presented on the rate of emergency department (ED) visits and hospitalizations for COPD per 10,000 population at the state and county level from 2016-2020. The state overall had a rate of 3,299 ED visits and 939 hospitalizations per 10,000 population (Figure 75). Hudson County had a rate of 3,477 ED visits, a rate higher than the state, and 925 hospitalizations per 10,000 population, slightly below the state-wide rate.

Figure 75. Hospitalizations due to COPD per 10,000, by State and County, 2016-2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Disability

Residents who have some type of disability may have difficulty getting around, living independently, or completing self-care activities. Other disabilities, such as hearing impairment, vision impairment, and cognitive impairment, may also impact residents' daily lives. Disabilities affect people of all ages and are most prevalent among older adults.

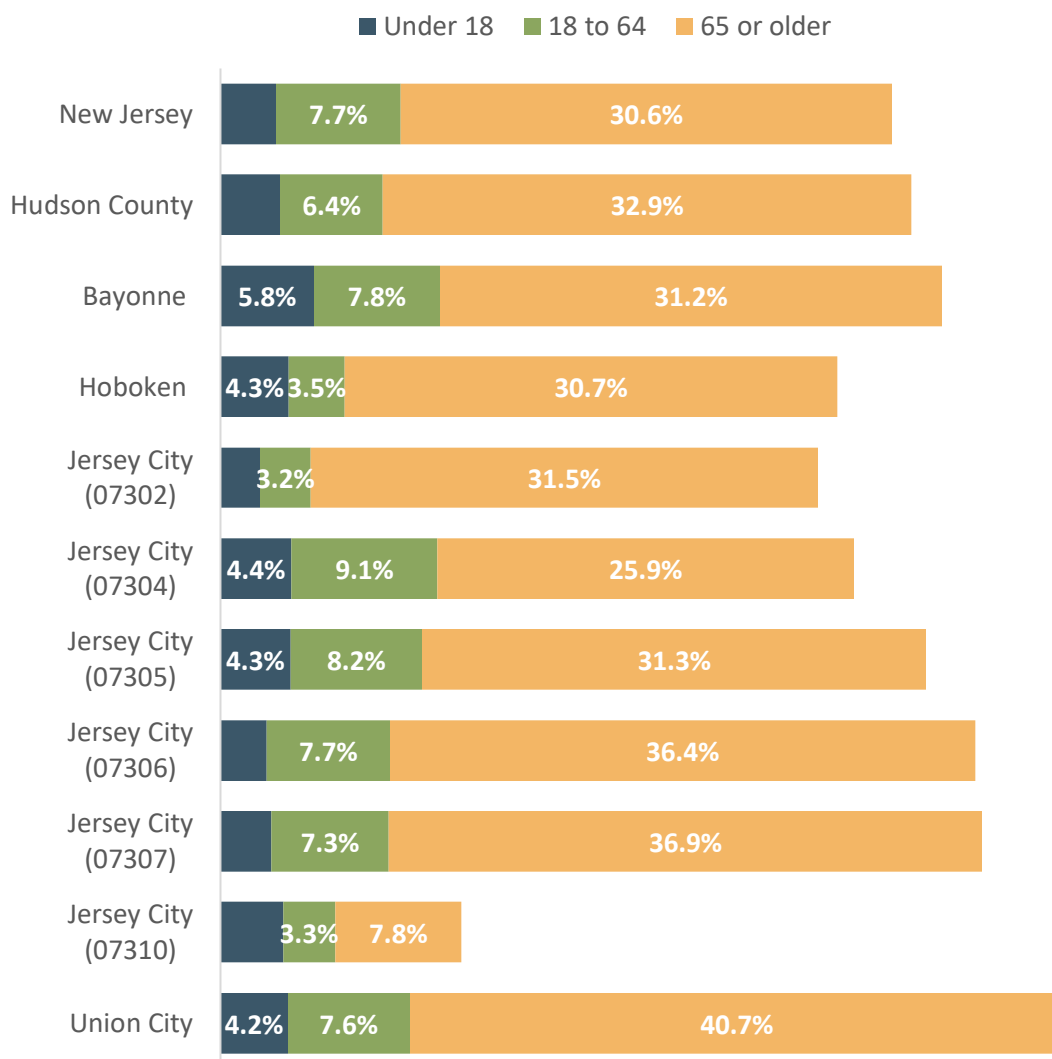
While the issue of disabilities did not emerge often in the qualitative interviews, many people with disabilities face economic instability as they rely on government financial assistance programs for their basic needs. In New Jersey, the Divisions of Developmental Disabilities (DDD) and Disability Services' (DDS) provide support for individuals until they turn 21, and after individuals reach age 60, they can access resources from the Office of Aging and Disability. In addition, it is often challenging for parents of children with disabilities to navigate the education and healthcare system, particularly if they have limited English abilities. Even obtaining a diagnosis may be difficult. For middle and low-income residents, affording care for children with disabilities is also a barrier. One education administrator

"It's called early intervention, where students are identified early. So, if they or the pediatrician notices that there's some developmental delays, we pick them up. We provide services from preschool on through 21." – Key informant interviewee

expressed that there were supportive services for children with special needs starting in preschool to age 21. However, developmental delays are not always easy to diagnose. Further, there are insufficient special education teachers to meet the need.

Data on the civilian noninstitutionalized population by age show that almost four percent of children under 18 years old (3.5%), almost eight percent of 18-64-year-old adults (7.7%), and 30.6% of people 65 or older had a disability in New Jersey in 2016-2020 (Figure 76). At the county level, 3.7% of children under 18 years old, 6.4% of 18-to-64-year-old adults, and 32.9% of adults 65 years of age and older had a disability in Hudson County. Bayonne had the highest proportion of children living with a disability (5.8%) in 2016-2020; in Jersey City zip code 07304, almost 1 in 10 adults aged 18-64 had a disability (9.1%); and in Union City more than 2 in 5 (40.7%) adults 65 and older were living with a disability.

Figure 76. Civilian Noninstitutionalized Population with a Disability, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Behavioral Health: Mental Health and Substance Use

Behavioral health is thought of as the connection between the health and well-being of the body and the mind. In the field, mental health and substance use are typically discussed under the larger framework of behavioral health.

Mental Health

Mental health was identified as a top community health concern. The topic of mental health arose in almost all conversations conducted for this CHNA. Interviewees and focus group members noted that while mental health has been a longstanding health concern, the COVID-19 pandemic has made the issue more pressing. In the words of a Latino focus group participant, *“The pandemic had an adverse effect on everyone—children, teens, and adults—and there have been many people affected psychologically.”* Job loss and economic pressures, virtual schooling, social isolation, and the uncertainty associated with the pandemic were all cited as contributors to increased stress, depression, and trauma among Hudson County residents. At the same time, gun violence has also taken a toll on individual and collective psyches. In addition, poor mental health is often co-morbid with chronic conditions, which are highly prevalent in the population. Among community survey respondents, mental health was the top community health issue with 30.9% of respondents identifying it as an area of concern, as noted previously in the Perceptions of Community Health section.

“The first problem is getting people to recognize the need, it’s a national problem, with the advertising that it’s okay to ask for help.” – Focus group participant

Stigma and Access to Mental Health Care

While mental health issues affected people of all ages, races, and genders, mental health for veterans, unhoused individuals, children and youth, seniors, trans persons, Latino residents, immigrants, and low-income adults were highlighted in the qualitative discussions. Focus group participants noted that anxiety and depression were prevalent in the community and mentioned several barriers to care. Participants highlighted stigma associated with mental health as a hindrance. Participants observed that many people affected by mental health did not recognize mental health as a medical condition, and this was particularly so among the foreign-born population, veterans, and Black residents. As a focus group participant and veteran described, *“We find that to be a problem, that our veterans don’t ask for help, because they’re so darn self-sufficient and a little stubborn.”* A key informant interviewee who self-identified as Black explained that for *“those of African descent, counseling was not something that we did.”*

Mental Health and Economic Instability

Poor mental health is closely associated with economic and housing instability, as described in the section on Employment. Focus group veteran participants expressed that not having employment that afforded them a living wage was a major cause of anxiety and depression. Latino residents in the focus groups shared stories about the challenges of losing their jobs, paying the rent, and feeding their families. An advocate for the LGBTQ+ community described high levels of stress and depression among transgender residents due to unemployment.

Mental Health and Trauma

Trauma is defined as a person’s emotional response to a distressing event or series of events, including experiencing or witnessing violence, abuse and neglect in childhood, and war, among others. A person can have a range of psychological and physical symptoms following trauma that can dramatically hinder well-being and daily functioning, and can, in severe cases, develop post-traumatic stress disorder.

“We need more services because people are not getting the help they need...” – Focus group participant

As described in detail in the section on Violence Prevention and Safety, communities of color have experienced an undue burden of multiple forms of intergenerational, childhood, and adult trauma. As noted earlier, violence and community safety was the top health priority for Black survey respondents. Survivors of violence face many barriers to accessing mental health care. Key informant interviewees explained that many trauma survivors come from cultures and environments that stigmatize mental health conditions. Others experience economic barriers to accessing care. Focus group participants and interviewees highlighted the urgent need to provide trauma informed care and to expand access to counseling and allied services for persons recovering from trauma in Hudson County. A focus group participant described the dire situation of mothers of gun violence victims, *“We met with a group of moms whose children were all impacted by gun violence where the child was lost or criminally involved, the moms decided to get together and support each other. I asked what they did and they said, “We just gather and wait for the next support victim.” These women were in trauma themselves, looking to help others but not able to help themselves.”*

Since 2020, JCMC’s Trauma Recovery Center, a national evidence-based model to treating survivors of violence, has addressed some of the need. The model is based on providing trauma-informed medical care to violence survivors, in addition to counseling to alleviate trauma symptoms, and linkage to community resources to address survivors’ most immediate needs, including relocation, employment, and housing support, among others.

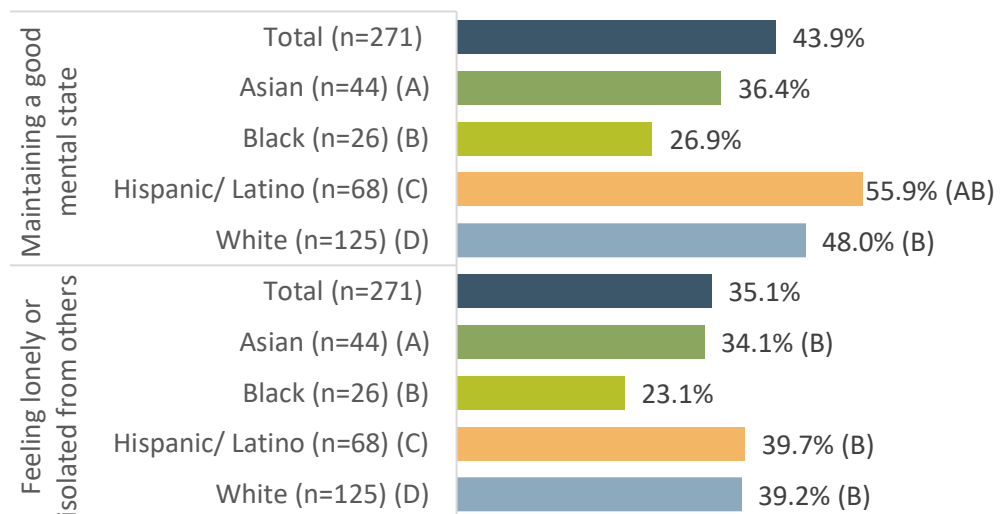
Mental Health and the COVID-19 Pandemic

The COVID-19 pandemic had devastating consequences on mental health across many sectors of the population. The pandemic contributed to anxiety, depression, and stress. Partly due to fear of the virus and uncertainty, partly due to the financial impact, and partly due to isolation. Further, many community members lost loved ones due to COVID-19. Interviewees who worked with seniors talked about isolation and loneliness among older residents, which was harder during the pandemic when senior centers and other social outlets closed. Many residents noted that children and youth were particularly affected as schools closed and they were isolated from their friends and social environment. They indicated that this was compounded by parents’ increased stress levels due to uncertainty and financial worries. Participants mentioned that youth exposed to domestic violence were particularly affected by stay-at-home orders. Suicide ideation among teenagers was mentioned by several participants. A public health official summed up the situation of young people during the pandemic, *“They weren’t in school through the whole pandemic and, you know, perhaps they’re at home with an alcoholic father, or abusive mother, or you know, or no one at all. I think the kids are suffering probably the most as a community.”*

Those working in the health sector talked about the mental health of their staff who have faced tremendous pressure when responding to the pandemic. As an interviewee from public health described, “[Mental health] is a problem, I think, especially after Covid... We were all, you know, as a community, at home. Even me, I wasn't at work, but I was working from home you know, 24/7, 7 days a week. So, I definitely think mental health is a big issue... You have to understand what it is to be doing that all the time.”

Reiterating the impact of the pandemic on mental health, 43.9% of survey respondents reported that they or someone in their family had personally experienced difficulty with maintaining a good mental state, while 35.1% reported being lonely or isolated from others since COVID-19 began (Figure 77). More than half of Latino respondents (55.9%) reported that they or a family member had difficulty maintaining a good mental state during COVID-19, significantly more than Black (26.9%) and White (48.0%) respondents. Black respondents (23.1%) were the least likely of all race/ethnic groups to report being isolated.

Figure 77. Percent of Community Survey Respondents Reporting that They or Someone in Their Immediate Family Has Personally Experienced Difficulty with Mental Health Issues since COVID-19 Started (n=271), 2021



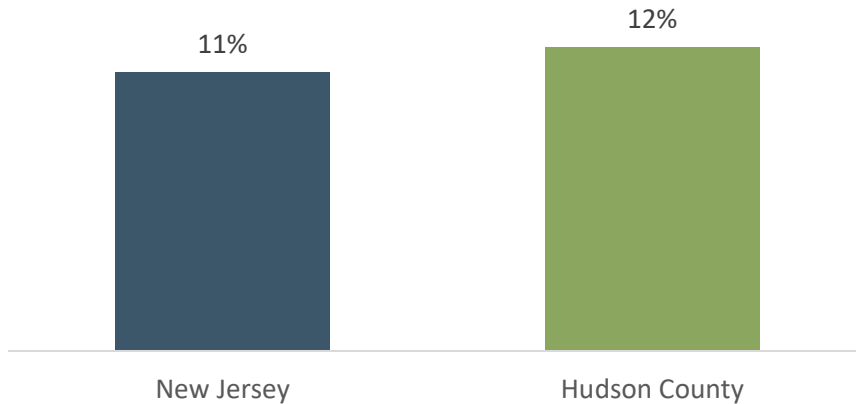
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Mental Health Incidence, Hospitalization, and Mortality

When examining surveillance data on mental health from prior to the COVID-19 pandemic, 12% of adults in Hudson County reported 14 or more days of poor mental health in the past month (Figure 78).

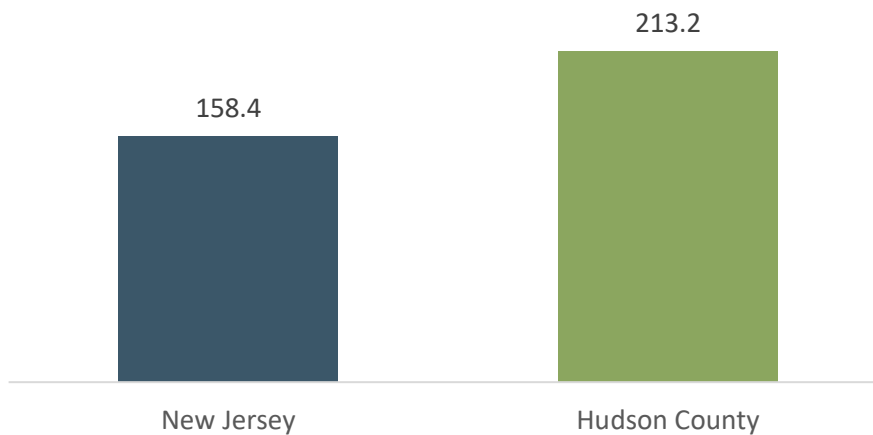
Figure 78. Percent Adults Reported 14 or More Days of Poor Mental Health in Past Month, by State and County, 2018



DATA SOURCE: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2018

Data from 2018 indicate that Hudson County had a rate of 213 emergency department (ED) visits due to mental health per 100,000 population, which was smaller than the rate statewide (158 per 100,000) (Figure 79).

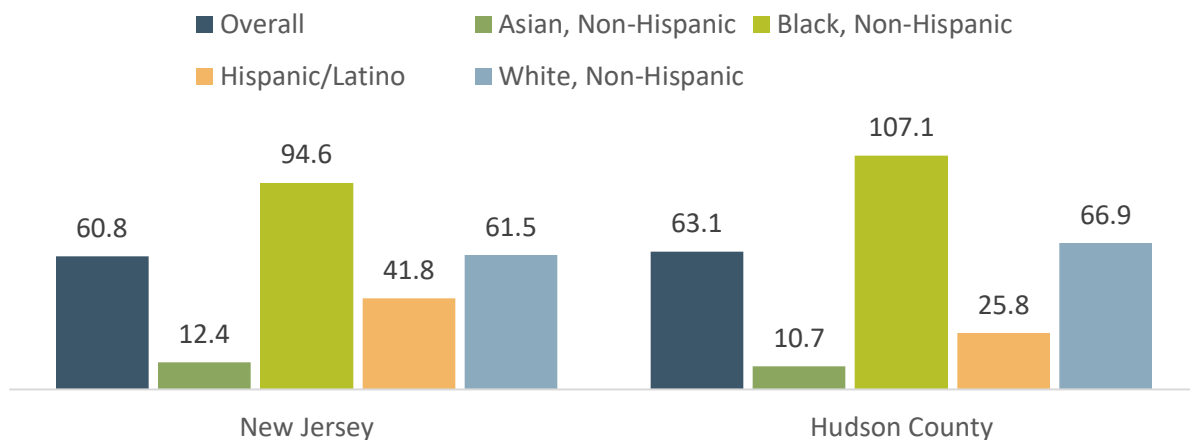
Figure 79. ED Visits Due to Mental Health per 100,000, by State and County, 2018



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2018

Data are presented on the rate of hospitalizations due to mental health per 100,000 population by race/ethnicity in 2020, the first year of the pandemic. The overall county rate was slightly higher than at state level (63.1 per 100,000 in Hudson County vs. 60.8 per 100,000 in New Jersey) (Figure 80). The mental health-related hospitalization rate was highest among the Black population in both the state (94.6 per 100,000) and the county (107.1 per 100,000), followed by White residents (61.5 per 100,000 in New Jersey and 66.9 per 100,000 in Hudson County). County-level rates for mental health hospitalization of Latino and Asian residents were both lower in Hudson County than in New Jersey.

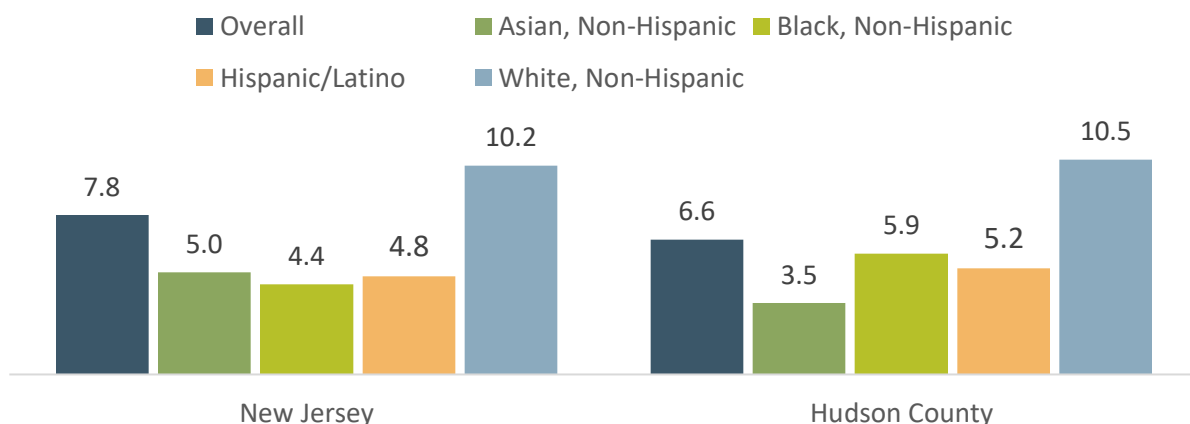
Figure 80. Hospitalizations Due to Mental Health per 100,000, by Race/Ethnicity, State, and County, 2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020

Data from 2016-2020 (aggregated across multiple years due to small numbers) indicate that Hudson County’s suicide rate was 6.6 per 100,000 population. Rates among Asians were lower in the county than in the state, but higher among the other racial/ethnic groups. White residents had the highest suicide rates in the county (10.5 per 100,000), nearly double those of Black (5.9 per 100,000) and Latino (5.2 per 100,000) residents (Figure 81).

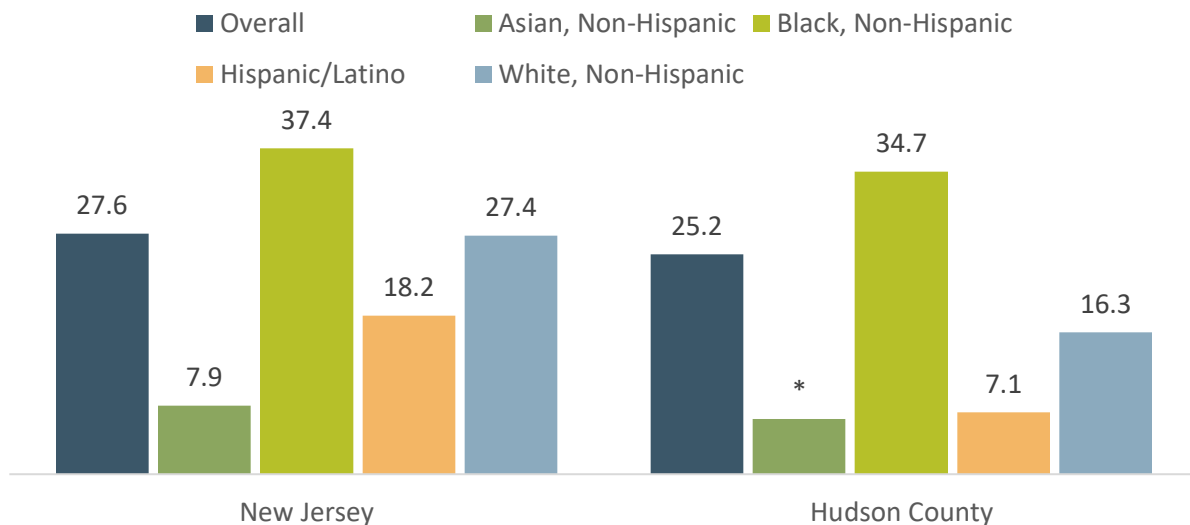
Figure 81. Suicide Rate per 100,000 Population (Age-Adjusted), by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Data from 2020 indicate that Hudson County’s rate of mental health-related hospitalization among children was 25.2 per 100,000 population. Rates in each racial/ethnic group were lower in the county than in the state. Pediatric mental health-related hospitalization rates in Hudson County were more than double among Black children (34.7 per 100,000) compared to the following group, White children (16.3 per 100,000) (Figure 82).

Figure 82. Pediatric Hospitalizations (Ages 19 and Under) Due to Mental Health per 100,000, by Race/Ethnicity, State, and County, 2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Mental Health Services

Focus group members and interviewees reported that finding mental health services in Hudson County can be challenging, especially for residents who are uninsured and/or unable to pay out of pocket for these services. First, even for residents who do seek help, they are not aware of where to obtain it. Second, participants noted that there were insufficient mental health service providers in Hudson County to meet the demand, particularly those that can provide culturally competent services to the diverse population, including gender non-binary people, non-English speakers, and veterans. This leads to long waiting times. As described by a focus group participant, “From the behavioral health side, due to staff shortages and high demand, we’ve had to limit community referrals and take from within the hospital to treat the most acute clients. Those others who need mental health support, we don’t have the bandwidth to help them right now.” A health administrator described the efforts made to hire culturally competent staff, “Not only is it hard finding behavioral health staff, but we also try to mirror the staff we hire, bilingual staff are unicorns because they are hard to find. Matching makeup of the staff, specifically behavioral health, is challenging.”

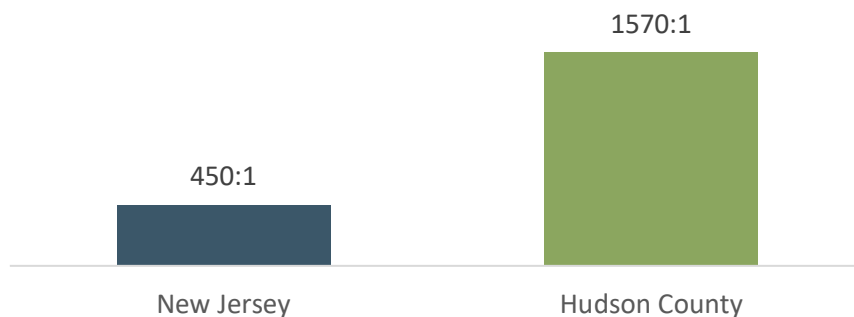
“[It] has been very difficult for our patients to access behavioral health services... we have an extensive waiting list. At any given time to get an appointment with us can take 4 to 6 months, so we’ve tried as much as we can to reach out to all of our partners...”
 – Focus group participant

To facilitate referrals, during COVID-19, the Health Department consolidated a mental health directory, including the suicide prevention hotlines, available at: <https://healthierjc.com/mental-health/>. JCMC and other providers began offering services via telehealth to expand access during the pandemic. However, whereas this strategy worked with certain groups, others without access to technology or with lower digital literacy, did not benefit.

Participants mentioned that schools often identify and connect students to mental health services, but school nurse and student support/counseling offices are understaffed. As one public school administrator expressed, *“We’ve been trying through the schools with our resources to really embed more social, emotional, not just the mental health, but before it gets to the mental health, helping students overcome challenges, developing resilience, by being able to speak about their emotions.”* However, staffing is limited, as are the mental health services that schools can provide.

Data are presented on the ratio of population to mental health providers in 2019. At the state level, there were 450 people for every mental health provider (Figure 83). In Hudson County, the ratio was 1570 people for every mental health provider. The dearth of mental health providers in Hudson County likely worsened during the pandemic.

Figure 83. Ratio of Population to Mental Health Providers, by State and County, 2019



DATA SOURCE: National Provider Identification Registry, Centers for Medicare and Medicaid Services, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

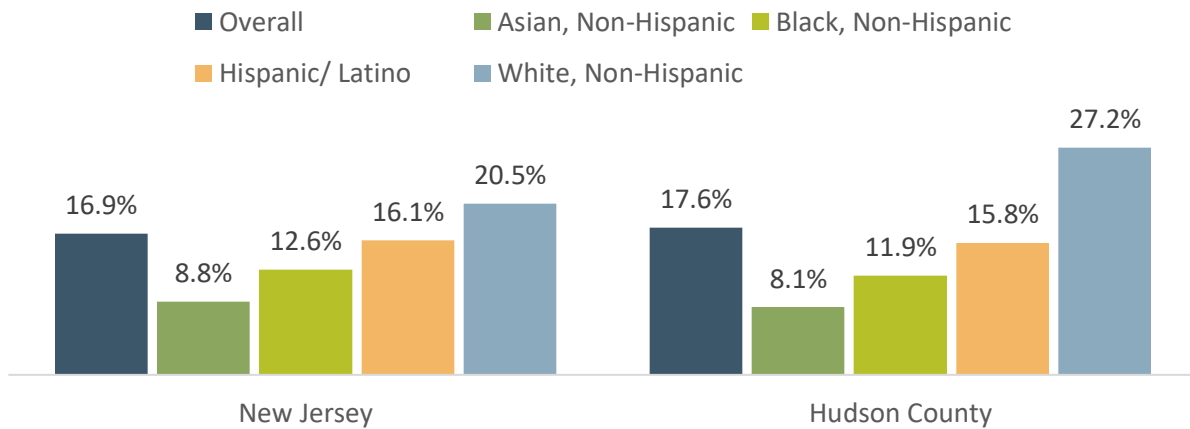
Substance Use

Substance use was mentioned as a community health concern in conversations this year, as it was in prior CHNAs. Problem substance use was described as affecting all groups, across all socioeconomic levels. However, it was mentioned specifically in conversations in the context of unhoused individuals, veterans, and young people; some reported that problem substance use is more hidden among youth in higher income communities. Several participants reported that substance use, particularly alcohol and opioid use, has increased as a result of economic and social stressors. Further, overdose deaths among young people were also noted as a health concern. A healthcare provider remarked, *“I’ll say for us the top conditions that we tend to get a lot of are readmissions for drugs overdose, heroin, opioids, and alcohol. And it’s always the same people who keep coming and coming.”* Some participants mentioned substance use associated with safety concerns, particularly among youth who consume substances. A Latino resident provided the following example, *“When I wait for the bus, there are young people doing drugs or drinking alcohol nearby and that scares me a lot.”* Data for prevalence of substance use, substance-use related mortality, and substance use treatment is presented in the sections below.

Alcohol Use

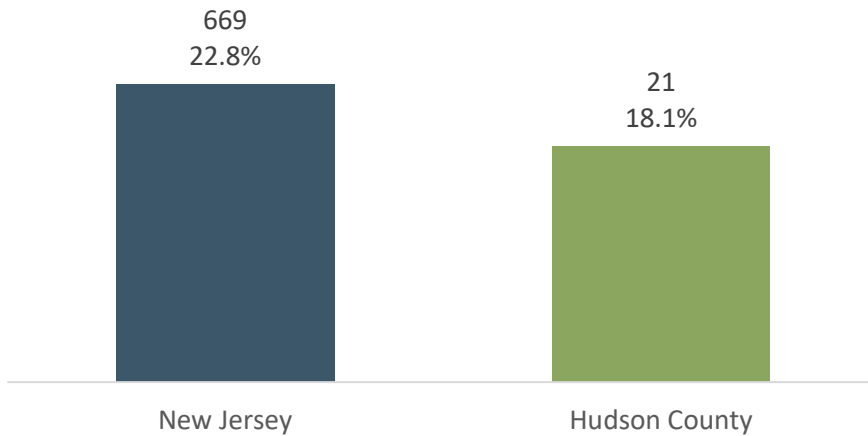
Focus group and interview participants discussed that they were concerned about alcohol consumption as a problem in the community, particularly given difficulty accessing long-term treatment services. Alcohol use is also a contributing factor to other prevalent health conditions, including cardiovascular disease, depression, and violence. Data aggregated for 2017 to 2020 show binge drinking levels – defined as a drinking pattern that brings blood alcohol concentration (BAC) to 0.08 percent or higher, typically by consuming four or more drinks (female), or five or more drinks (male) in a two-hour period – for the state and county and by race/ethnicity. In New Jersey, 16.9% of adults reported binge drinking. This percentage was highest among White (20.5%), followed by Latino (16.1%), Black (12.6%), and Asian (8.8%) residents (Figure 84). At the county level, 17.6% of adults in Hudson County reported binge drinking, with the highest percentage among White (27.2%) residents, followed by Latino (15.8%), Black (11.9%), and Asian (8.1%) residents. Of driving deaths over the period 2015-2019, 22.8% were due to drinking under the influence of alcohol in New Jersey, and 18.1% in Hudson County.

Figure 84. Percent Adults Reported Binge Drinking, by State and County, 2017-2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2017-2020

Figure 85. Alcohol-impaired Driving Deaths, by State and County, 2015-2019



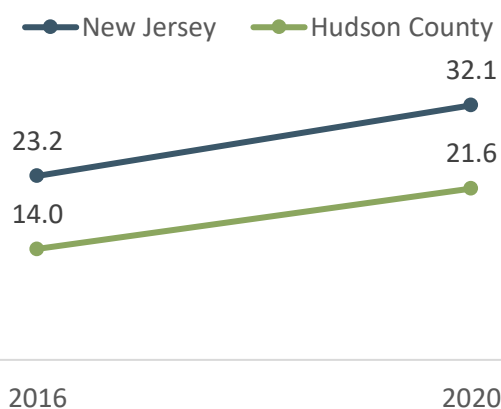
DATA SOURCE: Fatality Analysis Reporting System as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2015-2019

Opioids and Other Drug Use

Misuse of other substances was discussed in several focus group and interview discussions, particularly the use of legal and illegal opiates, and the resulting potential overdose. Others expressed concern about the long-term implications of marijuana legalization on substance use trends in the community.

The following figure shows the age-adjusted drug poisoning mortality rate per 100,000 population in 2016 and 2020. In New Jersey, the age-adjusted rate per 100,000 was 23.2 in 2016 and 32.1 in 2020 (Figure 86). The Hudson County rates were lower than the state, with mortality rates per 100,000 at 14.0 in 2016 and 21.6 in 2020. Similar trends are also presented in Figure 87 for unintentional drug induced poisoning mortality per 100,000.

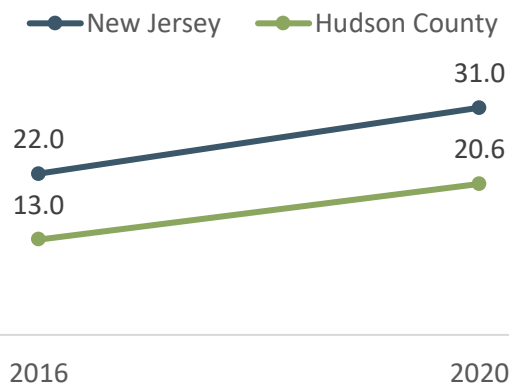
Figure 86. Age-Adjusted Drug Poisoning Mortality Rate per 100,000 Population, by State and County, 2016 and 2020



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020

NOTE: Includes ICD-10 codes X40-X44, X60-X64, X85, and Y10-Y14

Figure 87. Age-Adjusted Unintentional Drug Induced Poisoning Mortality Rate per 100,000 Population, by State and County, 2016 and 2020

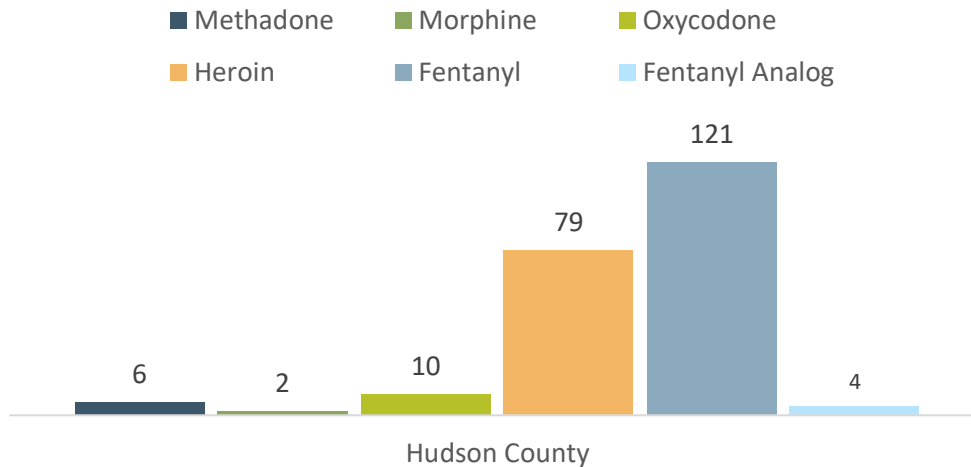


DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020

NOTE: Includes ICD-10 codes X40-X44

State medical examiner data show the count of opioid related deaths by specific drug type in 2019. In Hudson County, there were 121 deaths due to fentanyl, followed by heroin (79), oxycodone (10), methadone (6), and morphine (2) (Figure 88).

Figure 88. Count of Opioid Related Deaths by Drug, by County, 2019

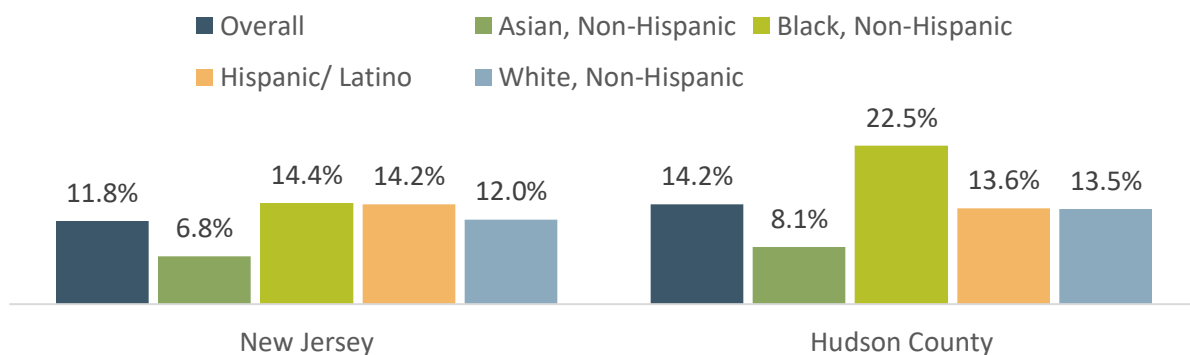


DATA SOURCE: Drug Deaths for 2019, New Jersey Office of the State Medical Examiner

Tobacco Use

Tobacco use is a contributing factor to lung and other cancers, as well as to poor lung health. When looking at the percentage of adults who are current smokers, Figure 89 shows that in New Jersey, 11.8% of adults were current smokers in 2017-2020. This percentage was highest among Black (14.4%) and Latino (14.2%) residents, followed by White (12.0%) and Asian (6.8%) residents. At the county level, 14.2% of residents reported currently smoking overall. Proportionally, more Black residents reported smoking (22.5%) compared to Latino (13.6%), White (13.5%), and Asian (8.1%) adults in Hudson County. Of note, the proportion of Black Hudson County residents who smoked was markedly higher than the county average and of Black smokers in the state.

Figure 89. Percent Adults Reported Current Smokers, by State and County, 2017-2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2017-2020

Substance Use Treatment & Prevention

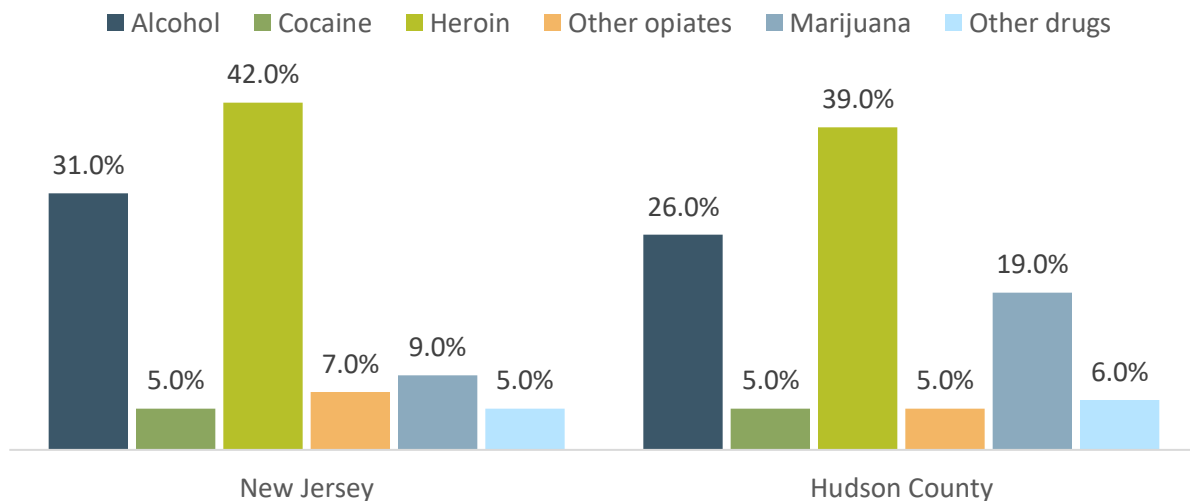
While substance use programs exist in the community, they are insufficient to meet demand according to focus group participants and interviewees. Participants advocated for more local programs, including community-based recovery programs. Several participants mentioned the problem of relapse due to inadequate treatment programs. The disruption in mental health services due to the COVID-19 pandemic further increased the risk of relapse. As a health administrator noted, *“We can detox folks here, but we can’t provide addictions treatment. We can detox people over and over*

“After care is very important because it keeps you sustained with sobriety or whatever mental health issue you have. I think the main thing is talking, talking. I used to have [a] group that no longer happens. I don’t know what happened after Covid that it closed down. But hopefully it’ll come up again ‘cause I really do need it. I miss my veteran groups.” – Focus group participant

again, and we do, that happens in substance abuse treatments, but not having a better solution to move from detox into a 21-day program or something similar is a problem we’ve seen for years... we need a seamless transition between” the facilities, short-term, and long-term treatment programs.

The following figure shows the percentage of substance use treatment admissions by primary drug in 2020. At the state level, 42.0% of admissions were for heroin, 31.0% for alcohol, and under 10% each for marijuana, cocaine, other opiates, and other drugs (Figure 90). In the Hudson County treatment sites, 39.0% of admissions were for heroin, 26.0% for alcohol, 19.0% for marijuana, and under 10% each for other opiates, cocaine, and other drugs.

Figure 90. Percent of Substance Use Treatment Admissions by Primary Drug, by State and County, 2020

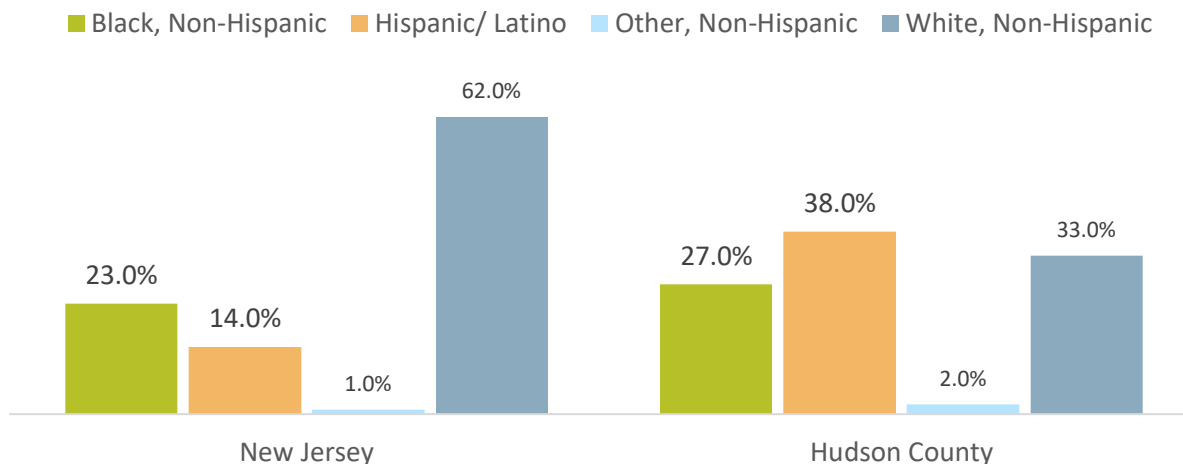


DATA SOURCE: New Jersey Department of Human Services, Division of Mental Health and Addiction Services, New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview, 2020

NOTE: Percentages by county are by county of treatment site

Data is also presented showing the percentage of substance use treatment admissions by race/ethnicity in 2020. At the state level, 62.0% of admissions were of White, Non-Hispanics, followed by 23.0% of Black, Non-Hispanics, 14.0% of Hispanics/Latinos, and 1.0% of other races/ethnicities (Figure 91). In the Hudson County treatment sites, 38.0% of admissions were of Hispanics, followed by 33.0% of White, Non-Hispanics, 27.0% of Black, Non-Hispanics, and 2.0% of other races/ethnicities.

Figure 91. Substance Use Treatment Admissions by Race/Ethnicity, by State and County, 2020



DATA SOURCE: New Jersey Department of Human Services, Division of Mental Health and Addiction Services, New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview, 2020

Environmental Health

A healthy environment is associated with a high quality of life and good health. Environmental factors are various and far reaching and include exposure for hazardous substances in the air, water, soil, or food; natural disasters and climate change; and the built environment.

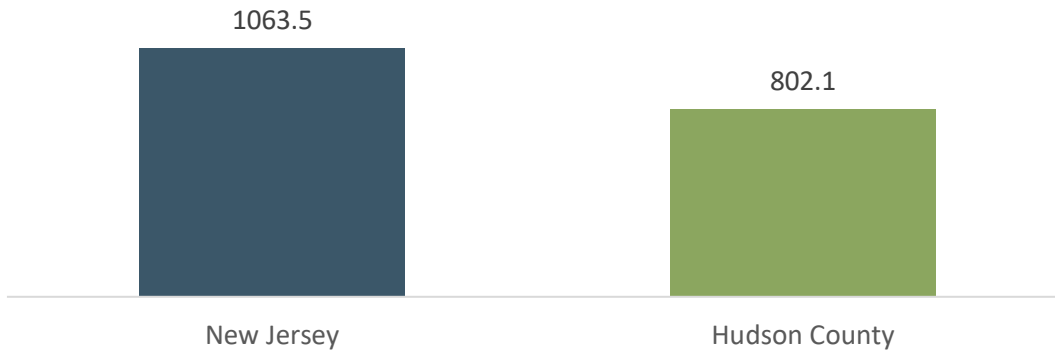
Asthma

Asthma in children was one of the conditions mentioned in the focus groups and interviews as a community problem and as a major cause of missed school days. Public health data typically show that 1 in 13 adults has asthma, and it disproportionately affects low-income communities and communities of color.³⁰ Perceptions of asthma as a community problem are supported by quantitative data.

Data are presented on the rate of asthma hospitalizations per 100,000 population in 2020. The following figure shows that the age-adjusted rate was 1,064 per 100,000 persons in New Jersey and 802 per 100,000 persons in Hudson County (Figure 92).

³⁰ <https://www.aafa.org/asthma-facts/>

Figure 92. Age-Adjusted Rate of Asthma Hospitalizations, by State and County, 2020

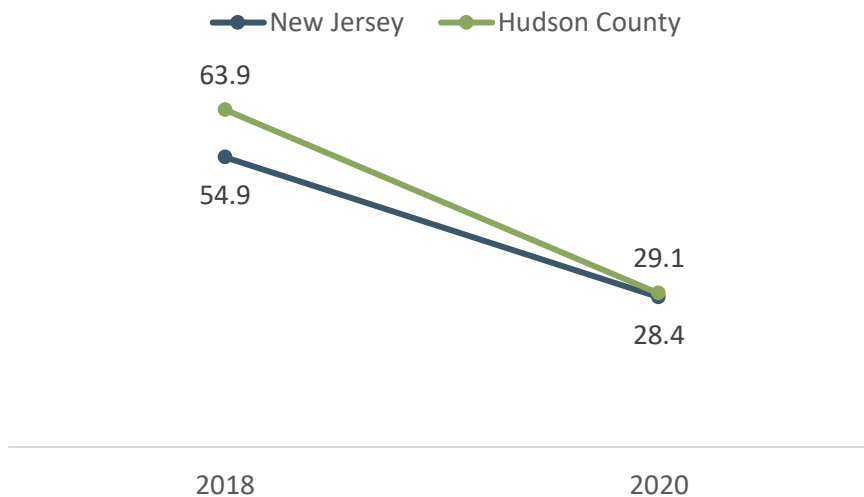


DATA SOURCE: DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020

NOTE: Includes all asthma diagnoses, including primary, secondary, and other diagnoses.

Figure 93 shows age-adjusted asthma emergency department visits in 2018 and 2020. At the state level, there was an important decrease from 2018 (63.9 per 10,000) to 2020 (29.1 per 10,000). Similarly, Hudson County saw a notable decrease of 26.5 asthma ED visits per 10,000 population during the same period.

Figure 93. Age-Adjusted Asthma Emergency Department Visit Rate per 10,000 Population, by State and County, 2018 and 2020

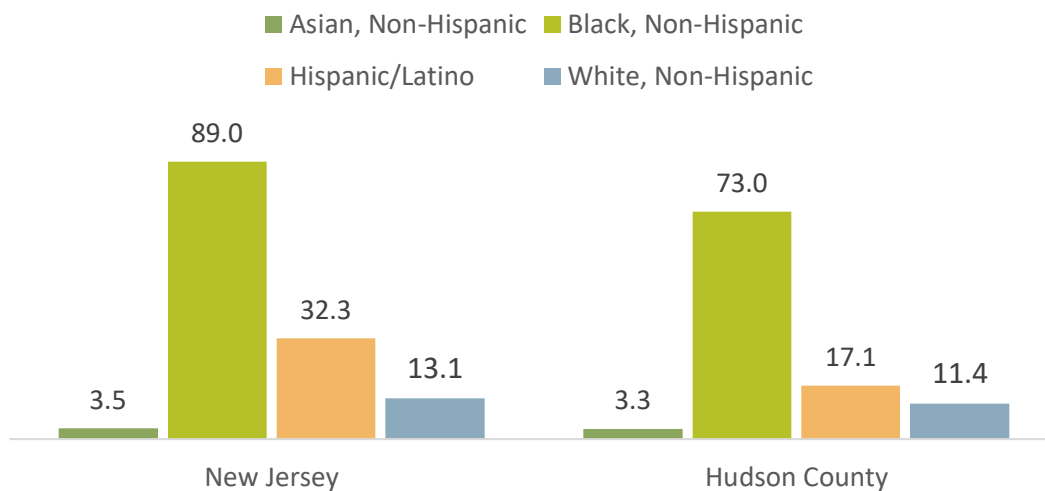


DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020

NOTE: Data includes ED visits where asthma was primary diagnosis

Data from 2020 show significant disparities in asthma rates by race/ethnicity (Figure 94). At state and county levels, Black residents shared a disproportionate burden of asthma ED visits. State-wide, Black, Non-Hispanics had the highest rate of ED visits (89.0 per 10,000), followed by Hispanics/Latinos (32.3 per 10,000), White, Non-Hispanics (13.1 per 10,000), and Asian, Non-Hispanics (3.5 per 10,000). Trends in Hudson County were similar to those state-wide, albeit slightly lower for all race/ethnicities. The highest rate in Hudson County was among Black, Non-Hispanics (73.0 per 10,000), followed by Hispanics/Latinos (17.1 per 10,000), White, Non-Hispanics (11.4 per 10,000), and Asian, Non-Hispanics (3.3 per 10,000).

Figure 94. Age-Adjusted Asthma Emergency Department Visit Rate per 10,000 Population by Race/Ethnicity, by State and County, 2020



DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Data includes ED visits where asthma was primary diagnosis

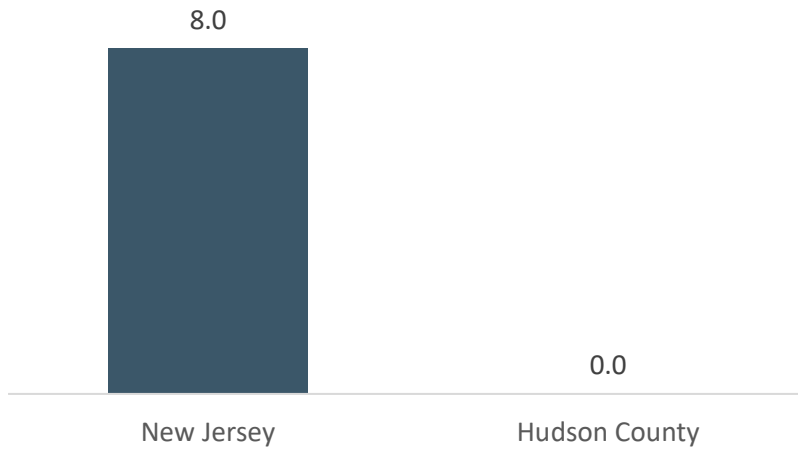
Air Quality

In 2020, there were 8 days statewide and 0 days in Hudson County where ozone in outdoor air exceeded the federal health-based standard for ozone (8-hr period above 0.070 ppm). This is a decrease compared to ozone air quality from 2014-2019; however, it is a possibility that COVID-19 impacted these rates as more people spent time indoors and less time traveling (Figure 95). Data on air quality show an average daily density of fine particulate of 9.3 micrograms per cubic meter in Hudson County, slightly higher than the state average (8.1) (Figure 96). Whereas air quality was not an issue of frequent concern for most participants, a few did remark on vehicular traffic as a source of pollution, particularly in certain neighborhoods.

“The New Jersey Turnpike extension... is a constant construction hazard. People are constantly backed up in traffic and the exhaust, it’s a lot of cars idling in that area, that’s linked to health comorbidities, like asthma.”

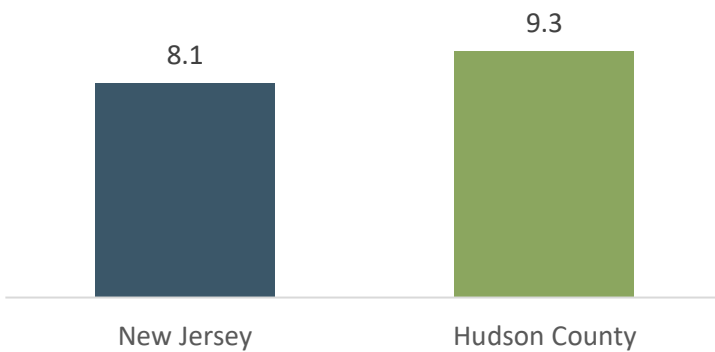
– Key informant interviewee

Figure 95. Ozone in Outdoor Air, Number of Days Ozone Exceeded the National Ambient Air Quality Standards for Ozone (8-hour above 0.070 ppm), 2020



DATA SOURCE: Bureau of Air Monitoring, New Jersey Department of Environmental Protection, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020

Figure 96. Air Pollution-Particulate Matter by State and County, 2018



DATA SOURCE: Center for Disease Control and Prevention (CDC), Environmental Public Health Tracking Network, as reported by, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

Note: Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)

Information on water quality can be found in Appendix F.

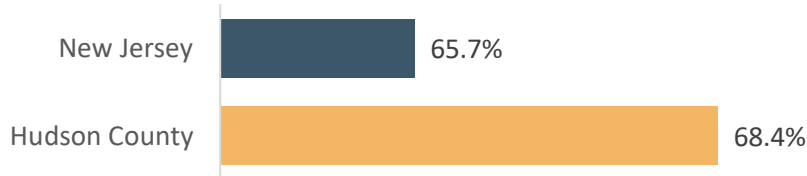
Lead

In 1978, the federal government banned consumer uses of lead-based paint. Exposure to lead among young children, through touching lead dust or paint chips, for example, can harm children’s health, including potential damage to the brain and nervous system, slowed growth and development, and hearing and speech problems.

“A problem like lead poisoning among young children or affecting the IQ levels or things that, as a public health official, we do not feel like there should be any acceptable level of lead in any child’s blood.” – Key informant interviewee

As shown in Figure 97, most of the housing in Hudson County (68.4%) was built prior to 1980, which is a slightly higher percentage than in New Jersey (65.7%). In 2022, New Jersey released new state regulations mandating visual inspections of all rental units built prior to 1978; however, a public health official noted the challenge of implementing such regulations given the number of older housing and the available human resources.

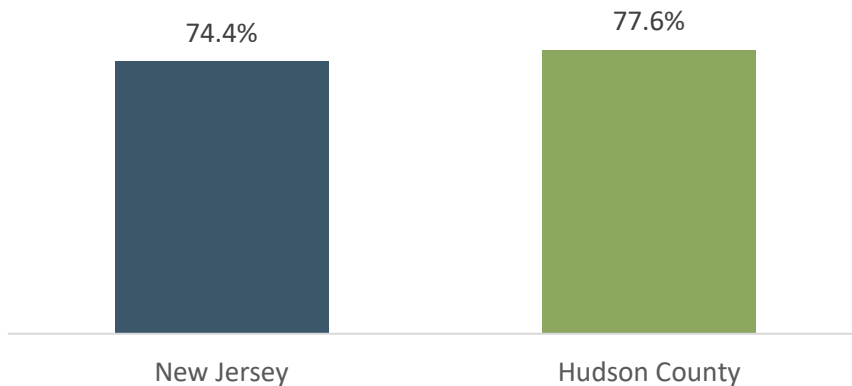
Figure 97. Housing Built Pre-1980, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

New Jersey Child Health Program data shows the percent of children testing for lead exposure before their third birthday in 2014. In Hudson County, 77.6% of children were tested for lead exposure (Figure 98). Across the state of New Jersey, nearly 3 in 4 children were tested for lead exposure. In 2019, 2% of children in Hudson County ages 1 to 5 had blood lead levels meeting or exceeding 5mcg/dL (Figure 129 in Appendix F).

Figure 98. Percent Children Tested for Lead Exposure Before 36 Months of Age Among Children Born in 2014, by State and County



DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry; Child Health Program, Family Health Services, as reported by, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2022

Infectious and Communicable Diseases

This section discusses COVID-19 and sexually transmitted infections.

COVID-19

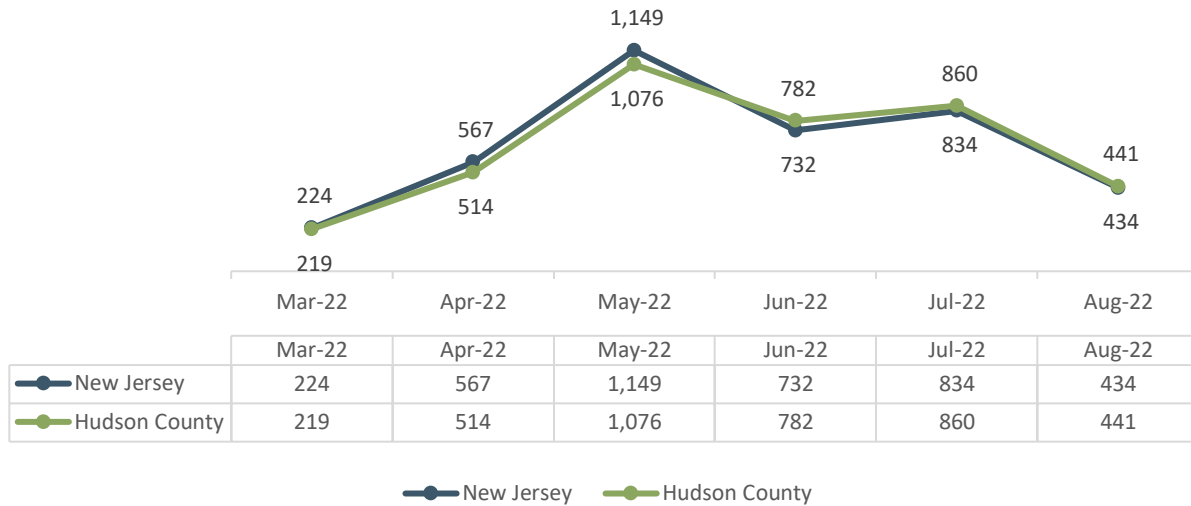
COVID-19 was not extensively discussed in conversations around infectious and communicable diseases. When it was addressed, focus group and interview participants primarily discussed how COVID-19 and the shutdown of businesses and schools had exacerbated the social and economic inequities that already existed. Participants noted that income loss during COVID-19, coupled with inflation, was a major source of stress, anxiety, depression, and other mental health issues. Parents of school children also had to face the challenges of remote schooling, and participants talked about the increase in mental health disorders among children due to isolation. Participants associated the stress-related to COVID-19 on an increase in domestic violence cases. The socioeconomic impacts of COVID-19 were discussed extensively in prior sections (see, for example, the Inequality, Education, Employment and Workforce, and Income and Financial Security sections).

“[COVID impacted] housing, food insecurity, jobs, people have a fear of going back to work, and childcare, because there was a time when everything was virtual, how can parents afford to stay home and put food on the table?” – Focus group participant

Additionally, many in the healthcare fields noted a significant disruption in access to services, particularly in preventive care. They remarked that patients were afraid of seeking care and only did so for emergencies. Several focus group participants observed that COVID-19 had become normalized and were worried that people were not taking the proper precautions, such as masking, to prevent the spread of COVID-19. In terms of COVID-19 testing, there were diverse experiences; whereas some knew of free COVID-19 testing sites, others did not. For the latter, cost was a barrier to COVID-19 testing.

Since April 2020 until September 2022, there have been 2.3 million confirmed cases of COVID-19 in New Jersey and nearly 190,000 in Hudson County. Cases have fluctuated from January 2020 throughout 2022; notable peaks in cases per day across New Jersey include April 5, 2020 (>4,000 cases), January 4, 2021 (>6,700 cases), and December 27, 2021 (>43,000 cases). Below, Figure 99 shows new confirmed cases per day per 100,000 population on the first of the month from March 2022 through August 2022.

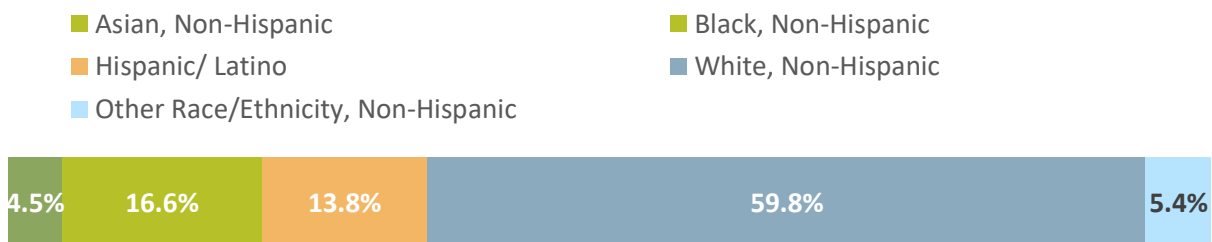
Figure 99. New COVID-19 Cases per 100,000 population, by State and County, 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022

According to data from the New Jersey Department of Public Health, as of August 10, 2022, there were 31,275 deaths from COVID-19 in New Jersey and 2,546 in Hudson County. There are racial/ethnic disparities among COVID-19 deaths in New Jersey. While Black residents made up 12.4% of the New Jersey population, they accounted for 16.6% of COVID-19 deaths in the state (Figure 100). Of note, 59.8% of COVID-19 deaths occurred among White residents, even though they only make up 51.9% of the population. This could potentially be due to the large numbers of White residents aged 65 and older, compared to other racial/ethnic groups.

Figure 100. COVID-19 Confirmed Deaths, by Race/Ethnicity, by State, 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, updated 8/29/2022

As of July 27, 2022, about 6.8 million individuals in New Jersey had been fully vaccinated, representing around 76.5% of the population; Hudson County had reported over half a million fully vaccinated individuals, which is about 80.8% of the population (Table 14). Figure 101 presents the percentage of residents who were fully vaccinated in New Jersey and Hudson County by race/ethnicity as of July 27, 2022.

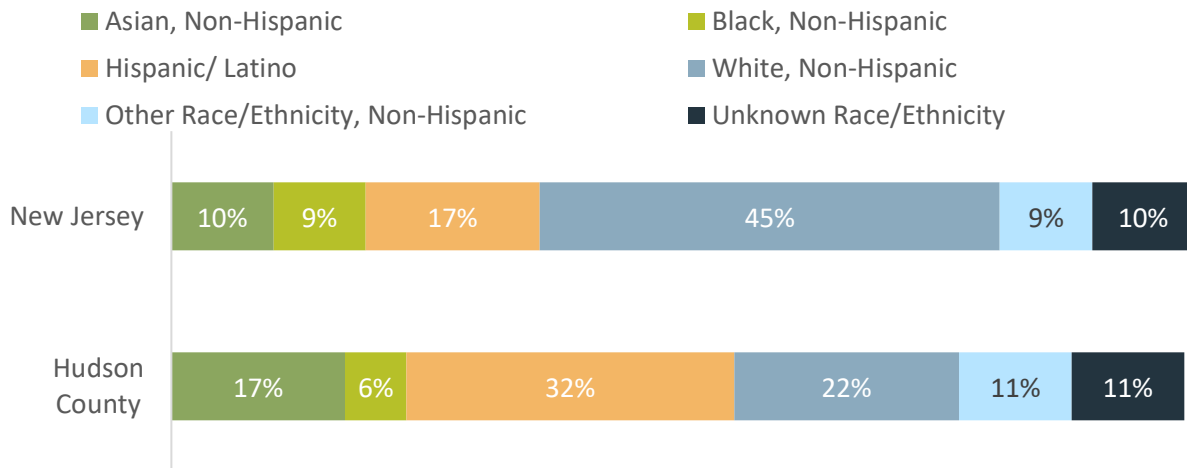
Table 14. Percent of Residents Fully Vaccinated for COVID-19

	Total Vaccinated	Total Population	%
New Jersey	6,795,708	8,885,418	76.5%
Hudson County	543,045	671,923	80.8%

DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022, and U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020 (for total population)

NOTE: Counts are up to date as of July 27th, 2022. Data by race/ethnicity does not include those vaccinated out of state and through federal programs.

Figure 101. Percent of Eligible Residents Fully Vaccinated for COVID-19, by Race/Ethnicity, State, and County, 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022

NOTE: Racial/ethnicity data does not include those vaccinated out of state and by federal programs.

Sexual and Reproductive Health and Sexually Transmitted Infections

Sexual health and sexually transmitted infections (STIs) were brought up as concerns by several focus group and interview participants, particularly those working in public health, education, and with the LGBTQ+ community. Many participants also expressed concerns about shrinking reproductive rights with the recent overturn of Roe vs. Wade, and the negative impact that would have on women's health, particularly in terms of the inequitable burden on low-income women.

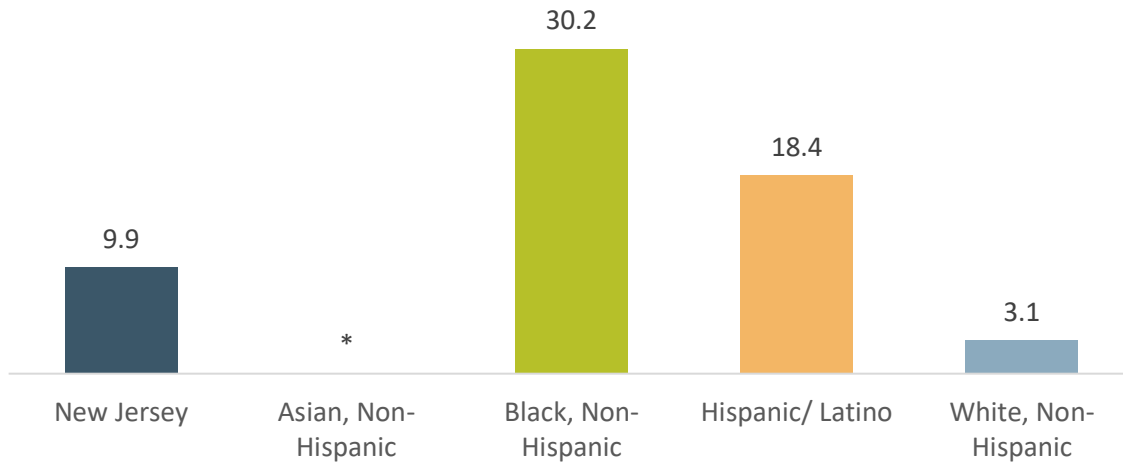
Participants reported increases in incident HIV/AIDS cases during the pandemic and decreases in linkage to care for those persons living with HIV/AIDS. In addition, participants noted that the incidence of other STIs, such as syphilis, had also increased since the pandemic. Limited knowledge related to free testing sites in the population was mentioned as a barrier to timely diagnosis and management. In addition, the cost of treatment, even for insured patients, was brought up as a challenge for middle-low and low-income residents.

“One thing we have to prevent HIV is PrEP, but we don’t know if everyone knows we have it, or where to get tested for free, or even if they should get tested... Clients who come in late have passed through areas of healthcare where they’ve not been tested, so access and education is something we need.” – Focus group participant

Another concern raised by participants was the increase in STIs among young people. As part of the discussion, participants cited parents' lack of awareness of the problem, including in affluent neighborhoods as a main barrier to prevention. Participants raised the absence of comprehensive sexuality education in schools as another impediment to safe sex. According to participants, comprehensive sexuality education provides critical information on healthy sexuality and reproduction and serves to empower adolescents to make choices regarding their health. As residents noted, access to information is of utmost importance in the current climate of curtailing legal protections to reproductive choice.

HIV transmission data was not available for the county but for the state overall. The rate of HIV transmission for Black residents in New Jersey was 30.2 per 100,000 persons, which was ten times the rate of transmission for White residents (3.1 per 100,000) and over three times the rate for all New Jersey residents (9.9 per 100,000) (Figure 102). Hispanic/Latino residents had an HIV transmission rate of 18.4 per 100,00 persons, almost two times greater than that of New Jersey residents.

Figure 102. HIV Transmission per 100,000 Population (Age 13 and Older), by State and Race/Ethnicity, 2020

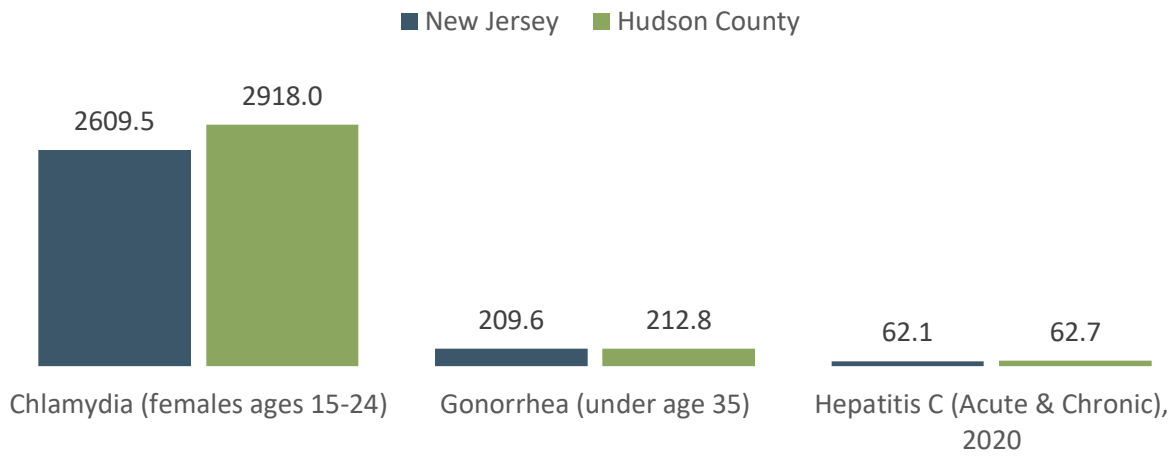


DATA SOURCE: Enhanced HIV/AIDS Reporting System (eHARS), Division of HIV/AIDS, STD, and TB Services, as reported by the New Jersey Health Assessment Data (NJSHAD), 2020
 NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Whereas HIV/AIDS was the STI most named by participants, Chlamydia is the most prevalent STI in New Jersey and Hudson County. In 2021, there were 2,610 cases of Chlamydia per 100,000 population in New Jersey among females aged 15-24, and the case rate was greater for Hudson County (2,918 per 100,000) (Figure 103). Hudson County reported similar levels of Gonorrhea among people under age 35, (213 per 100,000) and Hepatitis B (63 per 1000,000) compared to New Jersey overall (210 and 62 persons per 100,000 persons, respectively). Figure 104 confirms participants’ observations on STI incidence during the pandemic, showing an increase in Syphilis infection rates from 5.3 to 9.8 per 100,000 between 2016 and 2021 in New Jersey, and from 15.4 to 16.5 per 100,000 in Hudson County over the same period. The incidence rate of Syphilis in Hudson County is markedly higher than at state level.

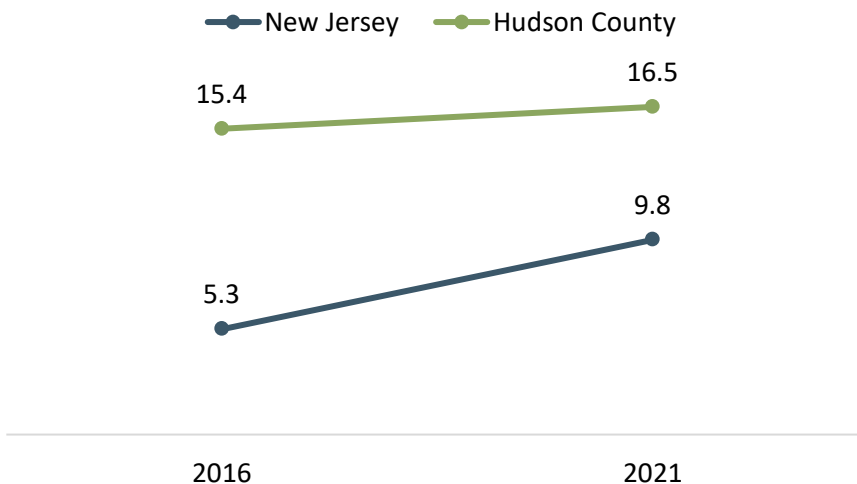
“I [would be remiss] if I don't mention the pressing issues with Roe versus Wade being reversed and access to information to our younger women.... Although New Jersey seems to have a more relaxed and a more progressive view of it, it doesn't mean that it won't impact our young people that are women in particular.” – Focus group participant

Figure 103. Chlamydia, Gonorrhea, and Hepatitis C per 100,000 Population, by State and County, by Most Recent Data Available



DATA SOURCE: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, as reported by the New Jersey State Health Assessment Data (NJSHAD), 2020 & 2021

Figure 104. Syphilis Incidence Rate per 100,000 Population, by State and County, 2016 and 2021



DATA SOURCE: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, Division of HIV, STD, and TB Services, 2016 and 2019

NOTE: Includes primary and secondary syphilis. Crude rate.

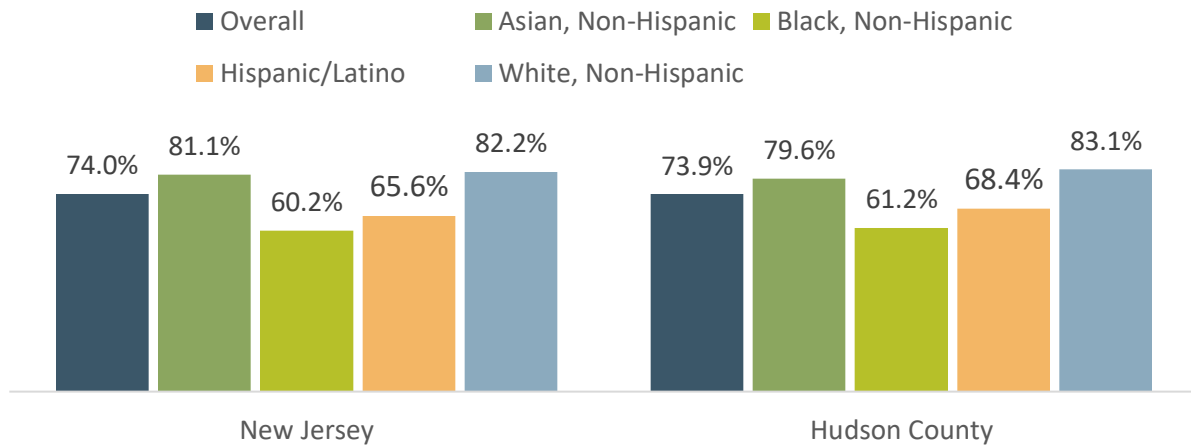
Maternal and Infant Health

The health and well-being of mothers, infants, and children are important indicators of community health. Maternal and infant health indicators are considered markers of inequity as most maternal and perinatal health complications are preventable with access to quality, adequate timely care. Whereas participants did not discuss issues related to maternity and newborn care, they did bring up multiple barriers to accessing care, which may have impeded or severely reduced access to this life saving intervention.

Prenatal Care

Prenatal care is an evidenced-based intervention to improve maternal and perinatal health outcomes. Statewide, nearly three in four births had prenatal care within the first trimester (Figure 105). By race/ethnicity, White, Non-Hispanics (82.2%) had the highest percent receiving prenatal care, followed by Asian, Non-Hispanics (81.1%), Hispanics/Latinos (65.6%), and Black, Non-Hispanics (60.2%). In Hudson County, 73.9% of births received prenatal care in the first trimester. Similar to statewide trends, Hispanics/Latinos (68.4%) and Black, Non-Hispanics (61.2%) in Hudson County had the lowest access to prenatal care. Additional data on access to prenatal care are presented in Figure 131 in the Appendix.

Figure 105. Percent Births with Prenatal Care in First Trimester by Race/Ethnicity, by State, 2016-2020

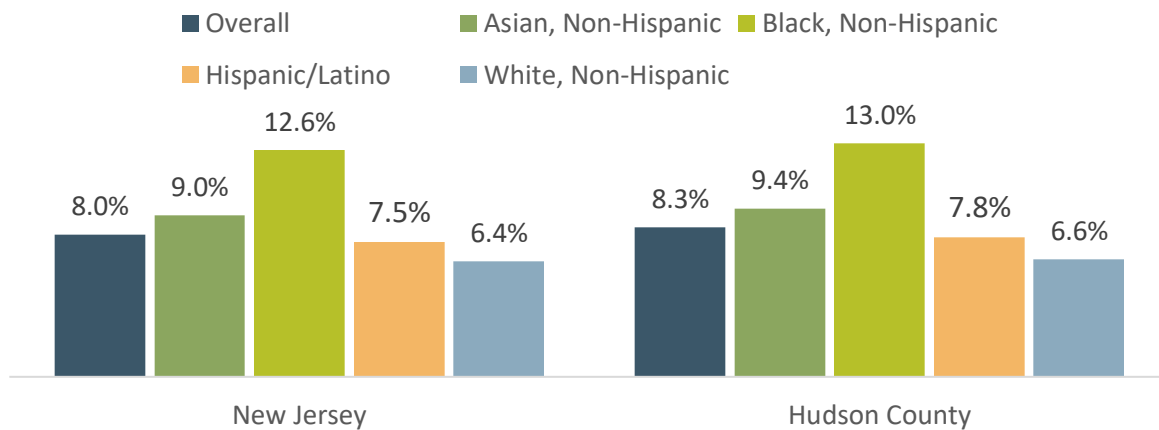


DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Perinatal Outcomes: Low and Very Low Birthweight and Preterm Births

The following figure presents percent of low birthweight births from 2015 to 2019, by race/ethnicity. Across New Jersey, 8.0% of births were low birthweight (weighing less than 2,500 grams) (Figure 106). In New Jersey, Black, Non-Hispanics had the greatest proportion of low weight births (12.6%), followed by Asian, Non-Hispanics (9.0%), Hispanics/Latinos (7.5%), and White, Non-Hispanics (6.4%). Similarly, in 2020, 8.3% of births in Hudson County were low birthweight births, with Black, Non-Hispanics having the highest proportion of low birthweight births (13.0%). In Hudson County, 1.2% of births were very low birthweight (<1,500 grams), with Black, Non-Hispanics (3.0%) having more than double the proportion of very low birthweight births, followed by Hispanics (1.6%) (See Figure 130 in Appendix for more details).

Figure 106. Percent Low Birth Weight Births by Race/Ethnicity, by State and County, 2015-2019

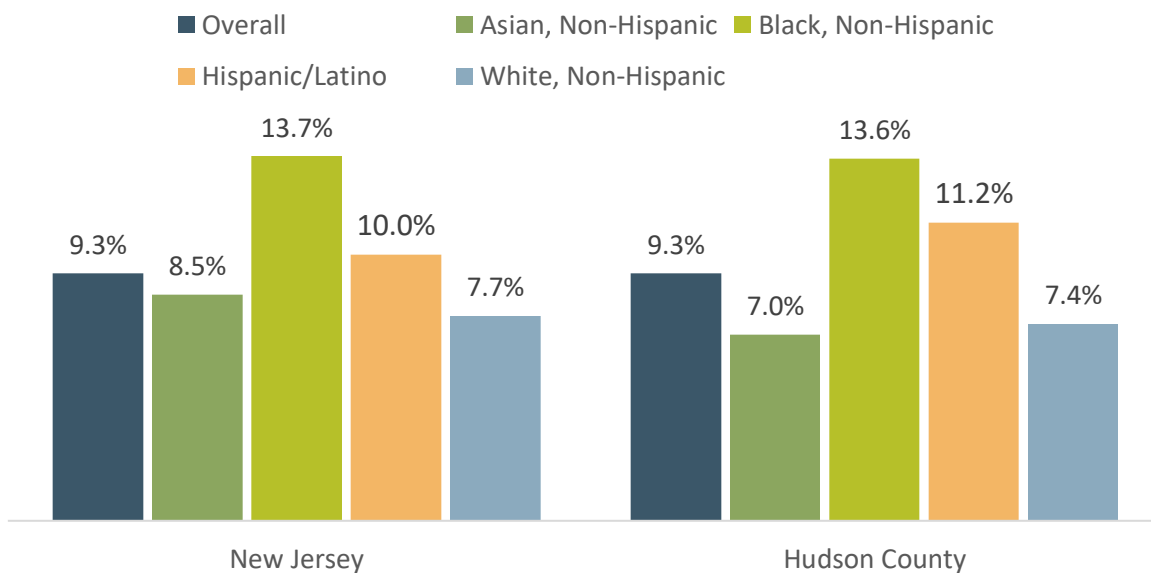


DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

NOTE: Low birth weight as defined as less than 2,500 grams

Figure 107 presents percent of preterm births in 2020 by race/ethnicity. Across New Jersey, 9.3% of births were preterm (less than 37 weeks of gestation). At state level, Black, Non-Hispanics had the greatest proportion of preterm births (13.7%), followed by Hispanics/Latinos (10.0%), Asian, Non-Hispanics (8.5%), and White, Non-Hispanics (7.7%). Similarly, in 2020, 9.3% of births in Hudson County were preterm births with Black, Non-Hispanics (13.6%) and Hispanics/Latinos (11.2%) having the highest proportion of preterm births.

Figure 107. Percent Preterm Births, by Race/Ethnicity, State, and County, 2020



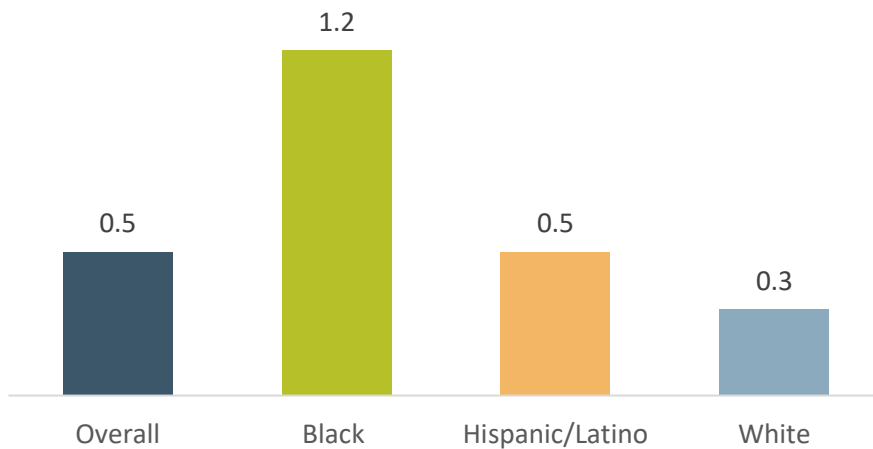
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Preterm is defined as less than 37 weeks gestation

Maternal and Infant Mortality

The vast majority of maternal deaths are preventable with access to timely, adequate, quality care. Thus, it is a marker of health disparities. Across the state, the maternal mortality rate was 0.5 deaths per 100,000 population from 2015 to 2019 (Figure 108). In line with other measures of infant and maternal health, Black, Non-Hispanics had the highest maternal mortality rate (1.2 deaths per 100,000), more than double the state-wide rate, with other racial/ethnic groups closer to the state-wide average. Two factors may have exacerbated disparities in maternal deaths in recent years: the COVID-19 pandemic, which is associated with an increased risk of maternal morbidity and mortality, and which disproportionately affected Black residents and curtailed access to safe abortion care.

Figure 108. Maternal mortality rate per 100,000 population, by State and Race/Ethnicity, 2015-2019



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

In 2015-2019, the statewide infant mortality rate was 4.3 deaths per 1,000 births; Hudson County had a lower infant mortality rate of 2.9 deaths per 1,000 births. The infant mortality rate among Black infants (9.3 per 1,000 births) was double to the state-wide rate (4.3 per 1,000 births) (Table 15). Similarly, the infant mortality rate among Black infants (7.1 per 1,000 births) in Hudson County was 2.5 times the county rate (2.9 per 1,000 births) over the same period.

Table 15. Infant Mortality Rate per 1,000 Births by Race/Ethnicity, by State, 2015-2019

	Overall	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic
New Jersey	4.3	2.5	9.3	4.2	2.6
Hudson County	2.9	*	7.1		*

DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

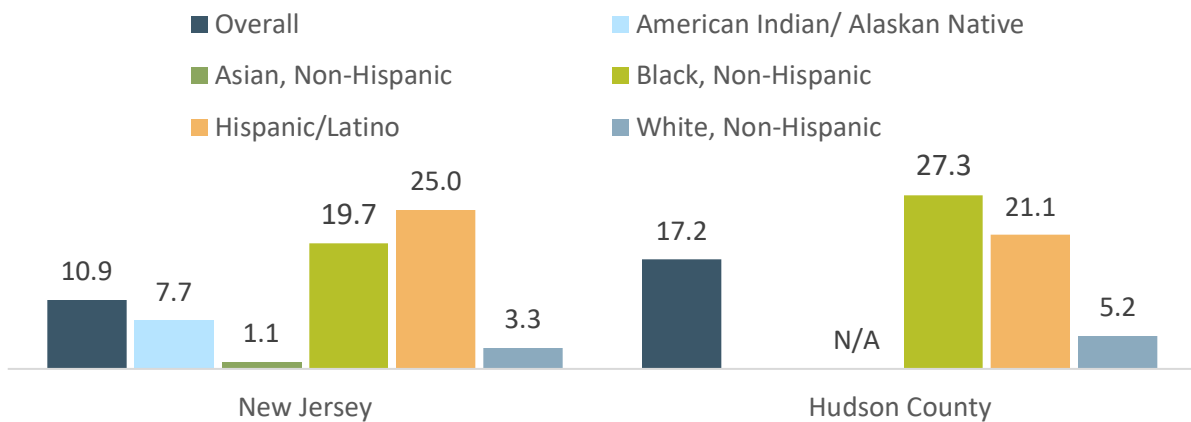
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Teen Pregnancy

Teen pregnancy is associated with poor birth outcomes, particularly among very young teens (aged 10–14-year-old), and to gender-based violence. It has long-term social and economic consequences, as often, pregnant teens drop out of school, curtailing future opportunities for education and employment, and perpetuating the cycle of poverty. While teen pregnancy was not discussed at length during the assessment conversations, participants did talk about how legal challenges and restrictions to safe abortion and post-abortion care may severely curtail teen’s ability to make reproductive choices.

Data from the New Jersey Birth Certificate Database show the number of teen births per 1,000 female population from 2014 to 2020, by race/ethnicity. At the state level, the overall teen birth rate was 10.9 per 1,000 and the highest teen birth rate was among Hispanics/Latinos (25.0 per 1,000), followed by Black, Non-Hispanics (19.7 per 1,000). In Hudson County, the overall teen birth rate was higher than the state, 17.2 per 1,000 (Figure 109). The highest teen birth rate in Hudson County was 27.3 per 1,000 among Black, Non-Hispanics, followed by Hispanics/Latinos (21.1 per 1,000).

Figure 109. Number of Births per 1,000 Female Population Ages 15 to 19, by Race/Ethnicity, State, and County, 2014-2020



DATA SOURCE: National Center for Health Statistics, Natality Files, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2014-2020

NOTE: Data for Asian and American Indian/Alaskan Native residents is not available due to low numbers.

Access to Services

This section discusses the use of healthcare and other services, barriers to accessing these services, and health professional landscape in the region. Access to healthcare services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death.

Access and Utilization of Preventive Services, Including Immunizations

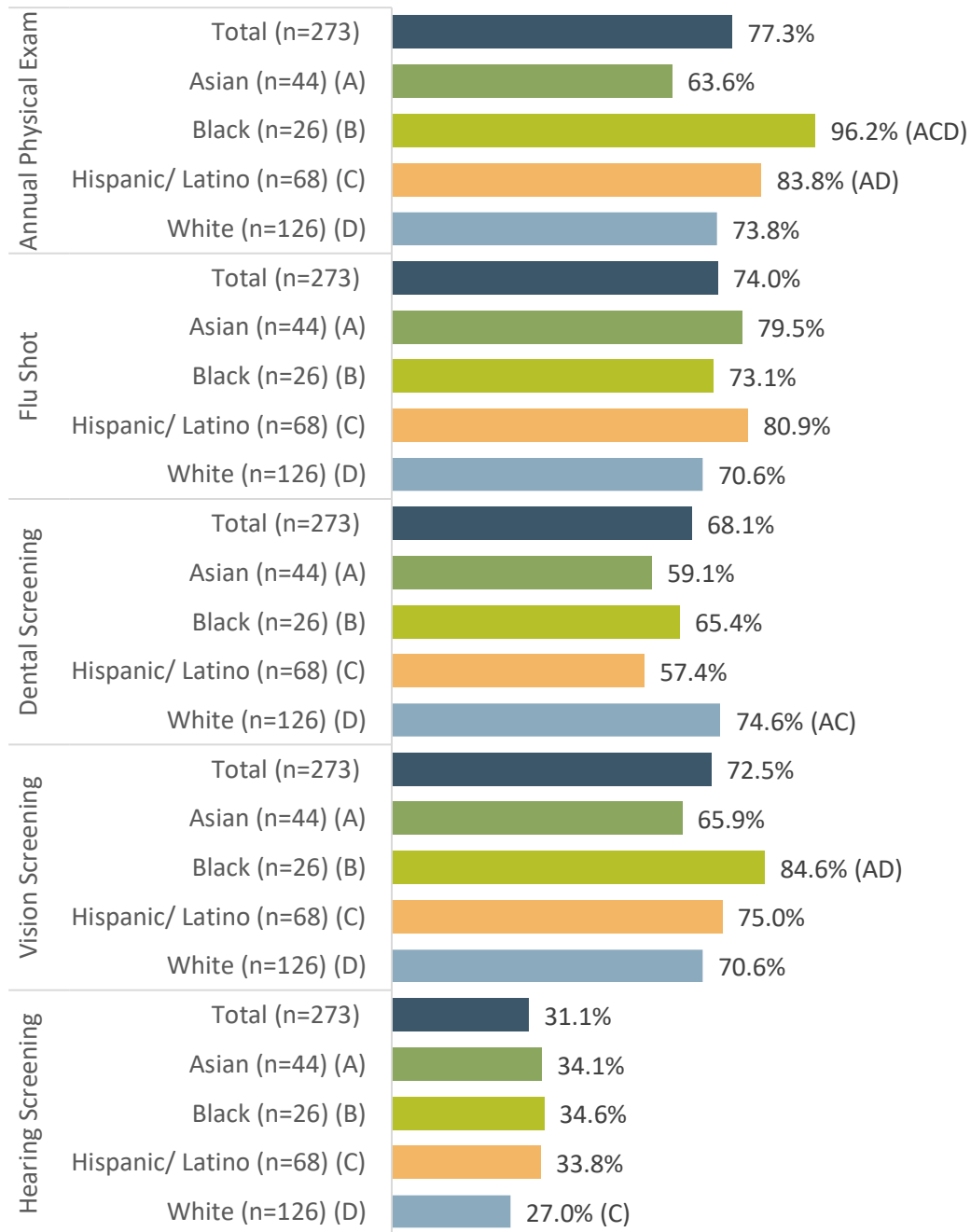
Participants in the healthcare field unanimously noted a decline in access to preventive care in Hudson County during the pandemic. Some focus group and interview participants discussed delaying care, particularly routine preventive services, in recent years. Reasons cited included the high cost of care, being uninsured, not having sick leave, not having providers that spoke their language, and/or not having childcare available.

On the other hand, participants indicated that having a primary care provider and/or access to a trusted FQHC were two factors that facilitated access to care.

“Primary care is a big issue for [most] of our children who have free and reduced meals. They live below the poverty line and they don't have a set primary care provider, pediatrician or doctor, and they are not going for all the routine tests that children should get.” – Key informant interviewee

The community survey fielded in spring/summer 2021 asked respondents about their participation in various healthcare screenings, including preventive services, in the past two years. Approximately 77% of Hudson County survey respondents reported receiving an annual physical exam; 73% a vision screening; 68% a dental screening; and approximately 74% a flu shot in the past two years. Fewer – 31% – reported having a hearing screening. Figure 110 presents these data for all Hudson County survey respondents and by race/ethnicity.

Figure 110. Percent of Community Survey Respondents Reporting that They Had Participated in a General Preventive Services and Screenings in the Past Two Years (n=273), 2021



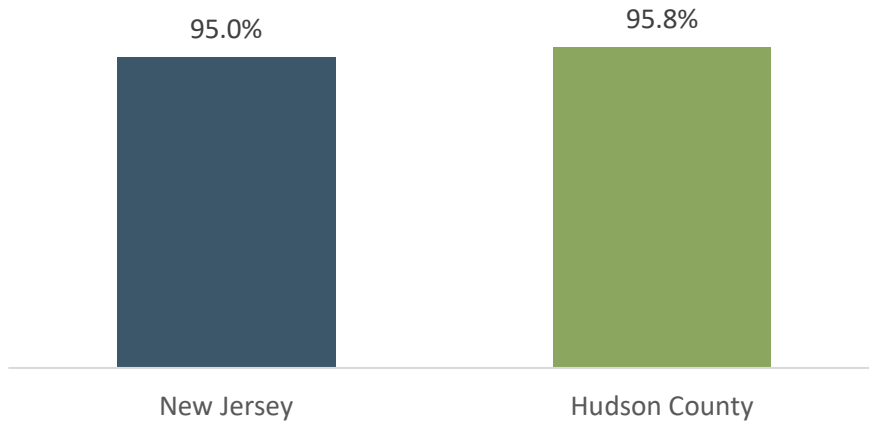
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph

Immunizations are an important preventive measure. Participants mentioned that many children in Hudson County received their full vaccination schedule through school health clinics; however, adults,

particularly those who were uninsured, faced barriers to vaccination. These patterns were confirmed by surveillance data. Among children in Hudson County, surveillance data from 2017-2018 indicate nearly 96% of children were fully immunized (Figure 111). However, 2019 data indicate that only 38% of Fee-for-Service (FFS) Medicare enrollees reported having received an annual flu vaccination in Hudson County, compared to 51% in New Jersey overall (Figure 112). Further, only one in five (20.4%) of eligible Hudson County residents reported receiving a pneumonia vaccine in 2020 (Figure 113). Given the disruption of COVID-19 on access to care, current percentages may be lower.

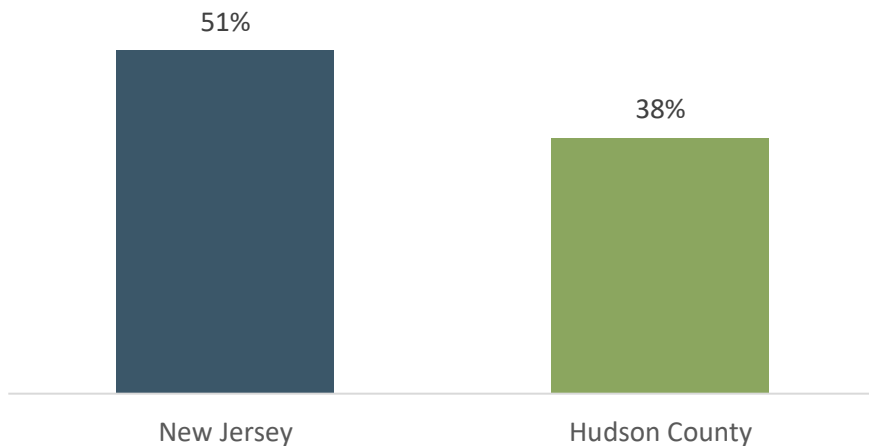
Figure 111. Percent of Immunized Children, by State and County, 2017-2018



DATA SOURCE: Annual Immunization Status Reports, Communicable Disease Service, New Jersey Department of Health, as reported by New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2017-2018

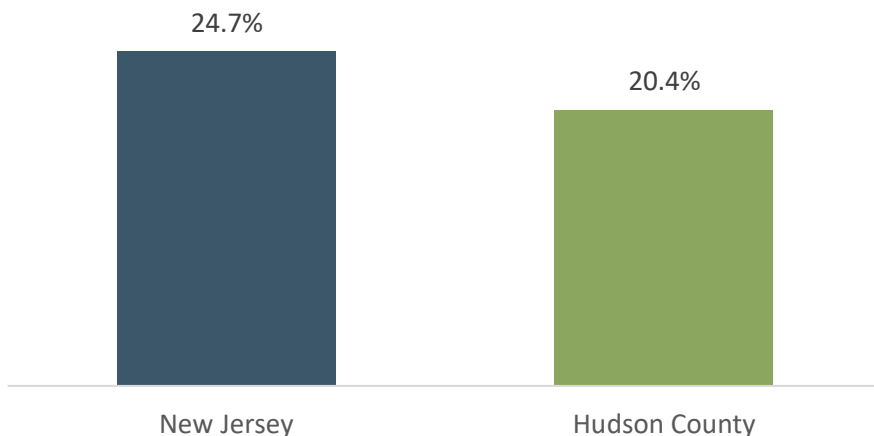
NOTE: Includes childcare/preschool, Kindergarten/Grade 1 (entry level), Grade 6, and transfer students in any grade

Figure 112. Percentage of Fee-for-Service (FFS) Medicare Enrollees that Had an Annual Flu Vaccination, by State and County, 2019



DATA SOURCE: Centers for Medicare & Medicaid Services, Office of Minority Health's Mapping Medicare Disparities tool, as reported by County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Figure 113. Age-Adjusted Pneumococcal Vaccination (Ever), by State and County, 2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Barriers to Accessing Healthcare Services

While many focus group members and interviewees reported that Hudson County had some healthcare assets and that there is a lot of collaboration among these assets, accessing these can be challenging for some residents. High healthcare cost was the top barrier mentioned by residents, providers, and healthcare administrators. Other barriers identified through discussions were lack of insurance and/or insurance challenges, scheduling convenience, long wait times, provider availability, stigma and discrimination, and language and cultural barriers. In addition, fear of institutions due to the increase in anti-immigrant discourse and persecution of undocumented individuals was cited as a major impediment for care access among this population.

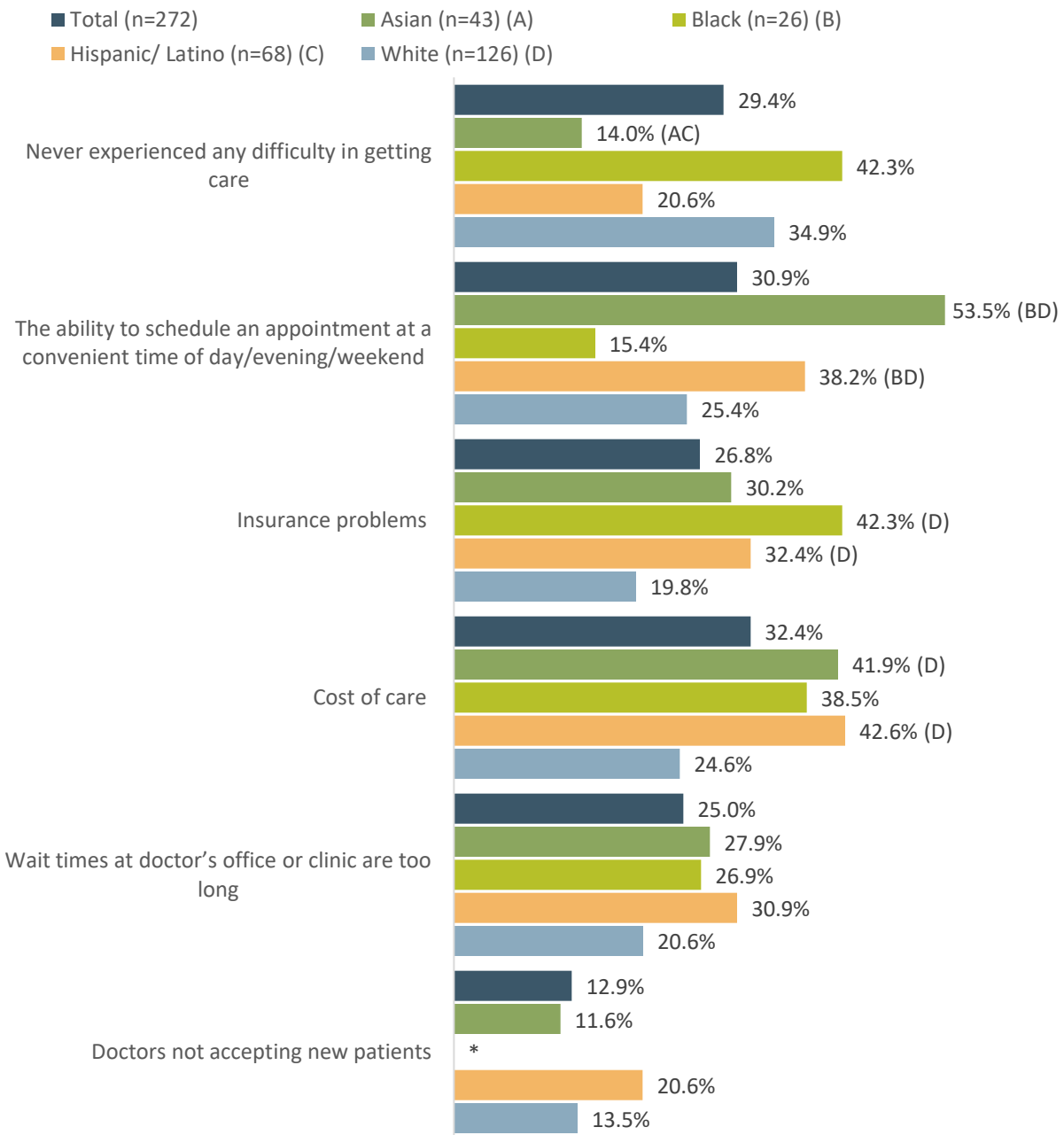
Many residents indicated that they only sought care from hospitals in an emergency; high and unpredictable cost of hospital care, trust, and unavailability of bilingual providers were some of the issues that made residents prefer to seek care from community-based clinics, FQHCs, or private practices. Participants also noted that disruptions to the healthcare system due to the pandemic, e.g., temporary closures and retirement of older providers, further distanced residents from services.

“Preventive care is pretty much nonexistent. Most community members might not have primary care linkage, they often provide the name of a specialist when asked who their PCP is. There are a lot of gaps in terms of availability and being able to afford to see a PCP.” – Focus group participant

Barriers to healthcare access were discussed in multiple ways (e.g., survey, focus groups, interviews) and different issues emerged via the various methods. In the community survey, respondents selected which barriers they had experienced from a list. Only 29.4% of survey respondents indicated that they have never experienced any difficulty in getting healthcare. Overall, the top issues selected were cost of care (32.4%) and ability to schedule an appointment at a convenient time (30.9%) (Figure 114). Differences emerged by race/ethnicity. White respondents were the most likely to report that they did not have an issue accessing care (34.9%); ability to schedule an appointment was marked by 53.5% of Asian

respondents; Black respondents were the most likely to note insurance problems (42.3%); and over 40% of Asian and Latino respondents marked cost of care as an issue (See Cost of Care section below).

Figure 114. Percent of Community Survey Respondents Reporting Which Issues Made It Difficult for Them or a Family Member to Get Medical Treatment or Care When Needed (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph. Asterisks (*) denote insufficient data to calculate reliable rate

Cost of Care

Cost of care emerged as the primary barrier to accessing services across most focus groups and interviews. As described above, Latino (42.6%) and Asian (41.9%) respondents were more likely than White (23.6%) respondents to mark cost of care as a barrier (Figure 114). Many Black respondents also mentioned cost of care as a barrier (38.5%).

This barrier existed for both preventive care and more complex care. Some participants noted that they were able to access free health screenings when offered by the city, hospitals or the FQHCs. However, others did not, and remarked on having to pay a fee for basic preventive services, including COVID-19 tests, as a disincentive. In the words of a Latina resident, *“They sent me a \$400 bill for a mammogram, and I wasn’t working. Later I learned that there are organizations that offer it for free.”* Even for insured individuals, the cost of medication and treatment of chronic diseases, including diabetes and cancer, is unaffordable. Many patients are faced with the dilemma of paying for rent, food, or medicine. Cost of care is a barrier for low-income residents, overall, but an even greater barrier for undocumented residents, as they are not eligible to receive government insurance. Participants in the Latino focus groups described being particularly wary of going to the hospital because of the high cost of care and going only in emergencies. Numerous residents remarked that obtaining charity care is an onerous task and many remarked that they had been rejected. Cost of care is also a barrier for middle-low income families, as they do not qualify for Medicaid or other government programs, but they cannot afford to pay for the medical bills. Even veterans who are insured through the Veterans Administration complained of the hurdles of accessing care and of receiving high hospital bills if they had to seek services in a non-affiliated hospital.

Health Insurance

Several participants stated that lack of health insurance and insufficient coverage are barriers to accessing healthcare. Healthcare providers and administrators indicated that many patients were uninsured and had difficulty accessing care. Multiple participants noted that uninsured patients would rather seek care from private physicians, rather than the hospital, because they fear the hospital costs. As described by this resident, *“People that don’t have insurance or a primary care doctor have to find a private physician. When I first arrived to this country and had a job that didn’t offer insurance, I had to spend all day waiting to see the doctor. There were usually about 60 people waiting.”*

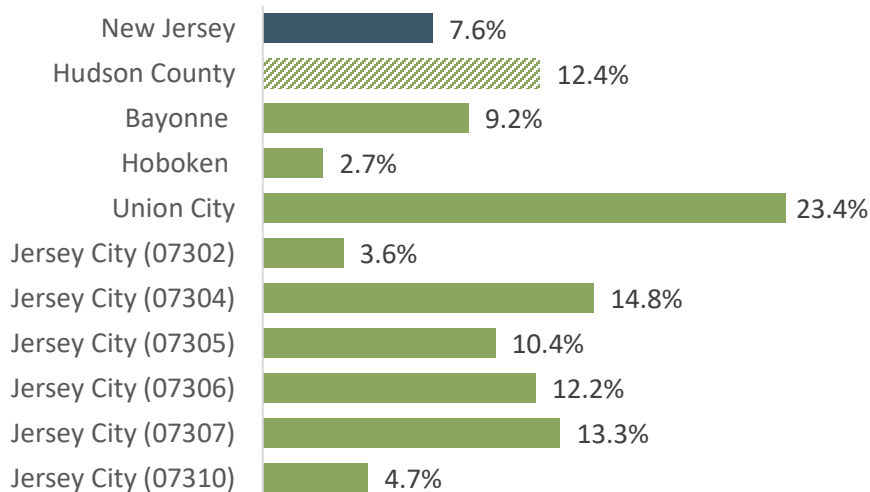
“If you don’t have a doctor who’s caring, or for like, people who are on Medicaid and Medicare, it’s difficult. Like the seniors who are on Medicare, they have to pay a copay.... If you don’t have the Part D for prescriptions, you don’t get a deal on the prescriptions. I think that’s horrible, after working your whole life....” – Key informant interviewee

Participants indicated that even with insurance, people faced many challenges. As one person stated, *“The lack of accepting insurances [is a big problem], not a lot places accept state insurance. They may not have the “right state insurance” according to some companies.”* Participants enrolled in Medicare were grateful to have this insurance, however, one participant mentioned the high copays and the high cost of medicine without Part D.

Census data indicate that health insurance coverage is still an issue for many Hudson County residents, although this varies by neighborhood. A higher percentage of the population in Hudson County was uninsured than in New Jersey (12.4% vs. 7.6%) (Figure 115). Only 2.7% of Hoboken residents were

uninsured compared to 23.4% of Union City residents, and 14.8% of residents in Jersey City zip code 07304. More than one in ten residents are uninjured in Jersey City zip codes 07305, 07306, and 07307. Percentage of the population with private health insurance can be found in Figure 132 in the Appendix.

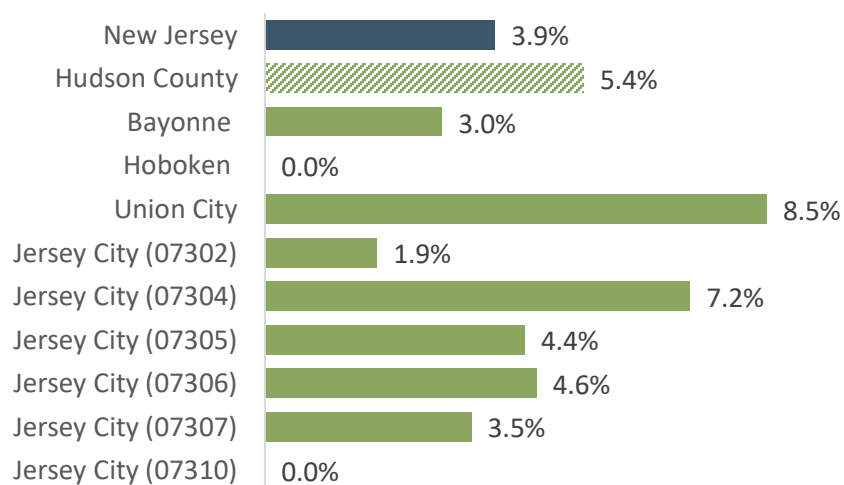
Figure 115. Percent Population Uninsured, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Children have greater access to primary care than their caregivers. Many children live in mixed immigration status households; they qualify for free or low-cost state health insurance as U.S. citizens, but their parents do not. Children can also access primary care through school clinics. In 2016-2020, 5.4% of children under age 19 were uninsured in Hudson County, less than half of the percentage of uninsured adults (12.4%) in the county, but higher than the state average (3.9%) (Figure 116). No children were uninsured in Hoboken and Jersey City zip code 07310 according to the American Community Survey data, compared to 8.5% of children in Union City and 7.2% of children in Jersey City zip code 07304.

Figure 116. Percent Under Age 19 Uninsured, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Health Provider Availability

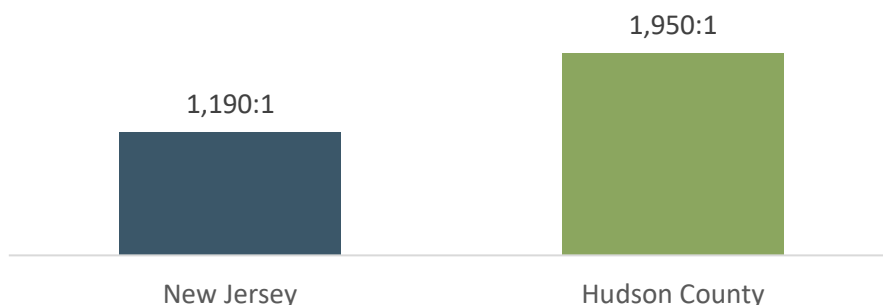
Focus group and interview participants noted that there seemed to be an insufficient number of healthcare and social services providers for the number of residents in Hudson County. As a result, patients waited months for an appointment and faced long wait times prior to the visit. Participants indicated a dearth of both primary care providers and specialists.

“When we studied the data a few years ago, people didn’t understand what we meant about the ratio of people to doctors, that was like 2400:1, there were also poor numbers for mental health, and I would guess that’s gotten worse.” – Focus group participant

Focus group participants in the healthcare field noted that it was difficult to hire and retain staff in community-based non-profit organizations. A major barrier was inadequate compensation. Staff did not receive competitive salaries and benefits packages due to federal funding regulations, including salary caps, lack of sick leave, and temporary contracts. As a focus group participant described, *“We are all struggling with staff retention, providers, nurses, CMAs, everyone right now. It’s almost like we can’t afford them. No matter how much we pay people, they can be traveling nurses and make way more.”* According to participants, sickness, staff burnout, and safety concerns during the pandemic further exacerbated the situation. Another problem noted related to provider retention were the inadequate affordable childcare options for staff with children. Whereas offering appointments during work hours is a problem for clients without sick leave, it is difficult to staff the evening hours. As a focus group participant in the healthcare field explained, *“We couldn’t extend hours with staff because they need to pick up their children. The policy of the daycare providers is if they aren’t there by 6, they call CPS. If we need to give late hours, Head Start should be required to give late hours.”* Participants in the healthcare field remarked that not all communities were represented by the staff; whereas there were plenty of Indian providers who spoke multiple languages, this was not so for Spanish and other languages.

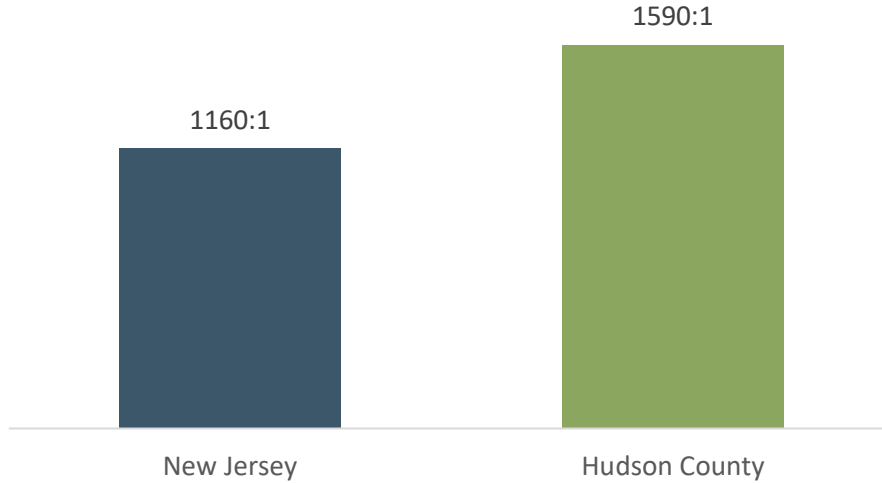
As described about mental healthcare providers in the Mental Health section above, more general and specialty care providers are needed in Hudson County. Surveillance data from 2017 indicate that Hudson County had fewer people per every primary care physician (1,950:1) than New Jersey overall (1,190:1), indicating a smaller person to provider ratio (Figure 117). The need is noted even more urgently with specialty care. For example, the ratio of persons per dentists in Hudson County was 1,590:1 in 2018, compared to 1,160 in New Jersey (Figure 118). The pandemic has probably increased this ratio.

Figure 117. Ratio of Population to Primary Care Physicians, by State and County, 2017



DATA SOURCE: American Medical Association, Area Health Resource File, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2017

Figure 118. Ratio of Population to Dentists, by State and County, 2018



DATA SOURCE: National Provider Identification file, Centers for Medicare and Medicaid Services, Area Health Resource File, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2018

Language and Cultural Factors Related to Healthcare Access

Participants in the healthcare and social service field noted using different strategies to bridge language and cultural barriers. Many sites, including the hospital and the health department, described having agreements with translation companies to provide telephonic support in any language. In addition, healthcare partners in most settings develop and disseminate informational materials and provide signage in multiple languages. Staff at many of the healthcare sites are themselves bi- or multilingual speakers.

From a cultural perspective, many of the health care institutions in the area hire local staff, who represent the community. This strategy goes a long way in building trust with community members and overcoming some of the wariness for hospitals. As one healthcare employee explained, *“Being born and raised here, I can say it’s the diversity of who we are that makes us special. Also being residents of the area who can identify what the needs are and try to address them in our agencies as residents.”*

Another strategy is finding cultural ambassadors or credible messengers that can be a go-between for the healthcare institutions and the community. In the view of some participants, this strategy is there on paper, but needs to be implemented more proactively. As explained by a participant, *“For people who speak languages other than English, we need not just the commitment to having it there, but actively promoting it, so that influential voices in those communities serve as ambassadors to say, you know if you if you speak Hindi, there’s somebody at the medical center for you, or if you speak Pashto.”*

“In general, we see access problems for Latinos, partly language based, and I think I’ve seen it largely as reflective of the fact that any non-English outreach tends to be an afterthought and not an attempt to truly connect and promote to those communities.” – Focus group participant

Certain groups are more represented than others. Healthcare staff explained that good strides had been made in reaching the Black and the Hindi communities; however, reaching Latinos and other immigrants has been difficult; further, more work is needed to increase trust in the Black community. An advocate highlighted the need for more racial equity training for healthcare providers, *“I’ve heard of horrific experiences because of being African American, healthcare providers don’t understand the pain of African American folk.”* When describing the healthcare workforce needed in Hudson County, an administrator described, *“It’s not just culturally competent, it’s a workforce that looks like the community and helps with institutional trust issues found in different populations but especially with low income, African American, immigrant, rural, blue collar, politically leaning communities.”* To complement this observation, several Latino residents described language as a barrier to accessing health at hospitals. One patient described this experience, *“They gave me a referral for an eye doctor, they made an appointment for a video call, but I couldn’t attend the appointment because it’s always only in English, nothing else. They need staff who are bilingual.”*

Community-Based Organizations and Coalitions

Hudson County was described as having substantial and strong social services. Community-based nonprofits were seen as mission-driven and committed to their clients. Partnerships between the community-based organizations, hospitals, schools, and the government were seen as a strength in Hudson County and critical to providing services to those in need. As described by a public health administrator, *“Overall, as a city and a group of health industry collaborators, I think the hospital, the FQHCs, and the Department of Health, we have always worked hand in hand to address the needs, we are also involved in an HIV ending committee, but also access to healthcare, specific and broad topics.”* As mentioned earlier in this report, participants also spoke about city-wide efforts such as HealthierJC, which have promoted prevention, identified and addressed public health gaps, and coordinated efforts across public health, hospitals, and community-based nonprofits, as well engaged the business community.

“From my experience, over 20 years, I feel that the greatest strength are the community-based organizations. We have a wide range of individuals who form different communities, even small grassroots community-based organizations, to engage people in healthy ways.” – Focus group participant

Residents and public health administrators uplifted the role of community-based nonprofits in bridging the gap to services for those most marginalized. Residents noted how staff at FQHCs went out of their way to address their physical, mental, and social needs, being their first stop for primary healthcare, regardless of immigration status. Many residents seek free screenings from non-profit groups serving the LGBTQ+, Asian, Latino, and African-American communities. Latino residents expressed trust in the FQHC staff and described getting support to obtain the social services they were eligible for. A community-based service administrator described their vision as an integral part of the community, *“We like that the community thinks of us as their go-to place, community health centers, sometimes generations of patients. Sometimes we see someone as a child now bringing their children to pediatrics, from birth to death.”*

One limitation that participants noted about community-based groups was their limited financial and human resources. Sustainability and dependence on grant funding, that is, funding which is variable and

short-term, were mentioned as problems. When speaking about the importance of uplifting community-based partners, a healthcare administrator noted, “Most of the strengths we mentioned are double edged. There’s a lot of organizations that aren’t well resourced financially, they are trying to do some good work, but with no sustainable resources or capacity to expand.”

In part because of this, most participants saw a role for a stronger coalition in Hudson County that includes well-resourced hospitals. Participants expressed that there was a lot of collaboration among government actors, hospitals, schools, and community-based organizations. They remarked that each partner complemented each other and collaborated well, as shown during the pandemic. Focus group participants indicated that there was continued room for growth in this area.

“There is also a deficit related to location, both Newark and NYC have better developed social infrastructure, especially in nonprofit, philanthropic, and people-powered engagement. It’s a challenge I’ve seen linked to our location.” – Focus group participant

Community Vision and Suggestions for the Future

Focus group and interview participants were asked for their suggestions for addressing identified needs and their vision for the future. The following section summarizes and presents participants’ recommendations for future consideration.

Expanding and Strengthening Behavioral Health and Overall Healthcare Services

Health as Human Right: “It is urgent to have access to free, quality health care”

Almost unanimously, cost emerged as a primary barrier to healthcare access in qualitative discussion. Many residents indicated that healthcare should be free. Residents underscored the value of preventive care as a cost-effective intervention and urged partners to continue expanding access to these services. Participants also highlighted challenges with health insurance coverage. To address these barriers, residents recommended offering more free screenings, loosening the requirements to qualify for free and/or low-cost health insurance, and simplifying the charity care application. Participants also suggested making more efforts to “meet people where they are,” through mobile clinics and education sessions based in different neighborhoods. Participants highlighted the community school model, entailing private-public partnerships between the education and healthcare sectors, and the community, as a promising initiative to promote the well-being of low-income families.

Greater Accessibility and Availability of Behavioral Health Services

Participants remarked on the difficulties faced by all groups, particularly Black, LGBTQ+, veterans, and young residents, to accessing quality, culturally competent mental health care. Participants highlighted the need for more mental health workers. Focus group participants and interviewees hoped to see more community-based mental health services, including recovery programs that are affordable and accept all insurance types. They also advocated for more prevention education programs to address problem substance use in the community, especially among youth and veterans. Participants suggested providing more education to address the stigma that surrounds mental health among many cultural groups. The need for more language capacity within the behavioral health services field was also discussed, as well as training in caring for patients of different backgrounds, including LGBTQ+ patients, and those who have experienced trauma, such as veterans.

Sexual and Reproductive Health and Women’s Health

Focus group members and interviewees were concerned about the increase in sexually transmitted infections among some groups, including cisgender women and men-who-have-sex-with-men, and about the repercussions of the rollback in constitutional protections to reproductive choice. Several participants warned that access to sexual and reproductive health services could be curtailed, even if New Jersey has progressive reproductive health policies. They noted that this would unduly affect low-income women and communities of color, thus, exacerbating existing racial/ethnic and social inequities in maternal and infant health. Some participants recommended being vigilant about reproductive health and rights protections to support the sexual and reproductive rights of all people in New Jersey. They also underscored the importance of offering comprehensive sexuality education in schools.

Focusing on the Upstream Factors and the Social Determinants of Health

Inequality

Growing inequality emerged as an issue of concern among most focus groups and interview participants. Residents noticed this in neighborhood-level differences in school resources, in safety, in employment opportunities, and in the built environment. Participants attributed growing inequality on policies that cater to residents in the highest social strata and expressed frustration at this ‘*tale of two cities.*’ Residents suggested that more progressive policies on taxation, employment, education budgets, and healthcare were needed to reverse this trend.

“My biggest wish for this community is that we don't have such an economically diverse community. If there's a way to really help the families with the lowest economic resources to really have more financial stability, that would be ideal.” – Key informant interviewee

Economic and Employment Opportunities

Expanding economic opportunities, especially for low-income workers, Latino residents, veterans, LGBTQ+ residents, particularly transgender people, and violence survivors was suggested as a priority area by many assessment participants. Participants recommended improving initiatives to help those who face barriers to employment obtain jobs. Suggestions included incorporating more vocational training programs in high schools to facilitate transition into the workforce, and education and incentives for employers hiring veterans and transgender and other LGBTQ+ people. Additional proposals included supporting small business owners and providing expanded workforce protections (e.g., sick leave, improved wages, childcare) for all workers, particularly those in healthcare.

Built Environment

Several issues emerged as concerns in the built environment. One was overdevelopment leading to overpopulation and loss of green areas; the other was the focus on building luxury rentals, resulting in gentrification. Participants enjoyed Hudson County’s varied public transportation options, its walkability, and its parks. They praised current community efforts to extend green areas supportive of healthy lifestyles. Residents also highlighted the need for redevelopment and urban planning in flood-prone areas to mitigate water damage as an important emergency preparedness strategy.

Housing

Access to affordable housing in safe neighborhoods was among the most discussed issues in qualitative discussions. Residents expressed concern about inflation and high taxes, coupled with the lingering economic impact of the pandemic on housing affordability, impending evictions, and homelessness, and looked for initiatives to mitigate these challenges and the high cost of housing. Participants proposed earmarking more affordable housing units in the new developments, including housing for veterans; implementing the existing rent control policies, which also apply to foreign-born residents regardless of immigration status; and fomenting first-time buyers' subsidies as a promising initiative to address intergenerational poverty.

Greater Engagement and Access to Existing Initiatives

Access to Services and Community Outreach

Interviewees and focus group participants observed that information about existing services and programs were not readily accessible to community members. They recommended more be done to raise awareness about existing programs. Participants suggested organizing more education and awareness building efforts both in person and virtually in different neighborhoods and in different languages on topics that most affect the community, including on managing diabetes and high blood pressure, and on recognizing the signs of stroke. Other suggestions to bridge access to health and social services included deploying mobile vans to other areas in the county; expanding health clinics that offer care for free and/or at low-cost to both children and families, particularly local and school-based clinics; and offering appointments outside of the regular workday. Some participants recommended developing a centralized list of health and social service programs and resources, similar to the mental health directory prepared by the Health Department (<https://healthierjc.com/mental-health/>), but for other conditions.

“Do more preventive family care, I think it would be very profitable for the state really because it's cheaper to prevent than to deal with.” – Key informant interviewee

Partnerships, Community Engagement, and Community Building

Participants valued the robust partnerships established among multiple organizations and across sectors, including grassroots organizations, government, small businesses, social services agencies, and FQHCs, as exemplified by the Partnership for a HealthierJC. Participants suggested continuing to deepen engagement and collaboration with trusted community-based organizations, such as those representing Asian, Latino, and LGBTQ+ residents, as partners in outreach and information sharing about community services and programs. Several participants stressed the importance of engaging faith-based organizations, especially given their reach and level of trust in the community. Other participants discussed the need to collaborate and hire credible messengers – respected community members – to build bridges with the community. Participants underscored more community outreach, a strong plan to reengage the community, and investing in the community as strategic areas moving forward.

Key Themes and Conclusions

Through a review of the secondary social, economic, and epidemiological data; a community survey; and discussions with community residents and stakeholders, this assessment report examines the current health status of Hudson County during an unprecedented time given economic volatility, the COVID-19 pandemic, and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- ***Some residents are struggling with lack of employment and economic opportunities.*** In 2016-2020, unemployment rates across Hudson County ranged from 2.4% in Jersey City zip code 07302 to 7.0% in Jersey City zip code 07305 and 9.2% in Jersey City zip code 07304. The unemployment rates mapped onto racial/ethnic groups; residents in zip code 07302 are predominantly White (40.1%) and Asian (32.2%), whereas over two-thirds of residents in zip codes 07304 and 07305 are Black and Latinos. More resources for career transitions and job training and technology were identified as critical to addressing these disparities. Focus group participants highlighted the need for more support and employer incentives for veterans and LGBTQ+ residents facing employment discrimination.
- ***Housing affordability is a main concern in Hudson County.*** Housing affordability was identified as a pressing concern, particularly for persons of color, veterans, LGBTQ+ persons, immigrants, and low-income residents. Participants expressed that too many luxury rentals were being built, instead of affordable housing for families. There are many renters across the area. In New Jersey, 64.0% of housing units were owner occupied in 2016-2020, in contrast to 32.4% in Hudson County. Home ownership ranged from 12.5% in Jersey City zip code 07310 to 40.6% in Bayonne. Disparities in housing cost burden exist within Hudson County. In Jersey City zip codes 07302 and in Hoboken, less than one in three owner-occupied and 44% of renter-occupied households reported high housing costs whereas 64.4% of owner-occupied and 66.5% of renter-occupied residences in Union City reported spending more than 25% of their income on housing costs. Qualitative discussions highlighted how veterans in Hudson County tend to work in low-wage jobs and often live in multigenerational housing. Housing availability was also cited by interviewees as an important barrier to breaking the cycle of violence. Relocation is one of the strategies used to prevent revictimization of community and domestic violence survivors. However, according to violence interrupters, affordable housing options in low-crime neighborhoods are limited. Several focus group and interview participants mentioned the problem of homelessness in Hudson County communities and indicated that the shelters and temporary housing available were insufficient to meet the need. Solutions proposed included earmarking more affordable housing units in the new developments; extending first-time buyers' subsidies, particularly for persons of color; and renovating and repurposing abandoned homes for low-income families.
- ***Mental health was identified as a significant community health concern.*** Mental health was identified as a top community health concern, closely associated with economic instability and chronic conditions. Black residents faced a disproportionate mental health burden. The rate of mental health hospitalizations in 2020 was 70% higher among adult Black residents (107.1 per 100,000) than the Hudson County average (63.1 per 100,000). Black children had 38% higher hospitalized rates for mental health conditions than the county rate (34.7 per 100,000 vs. 25.2 per

100,000). Residents mentioned stigma and low numbers of culturally competent providers as the principal barriers to mental health care access.

- **Residents viewed chronic conditions as prevalent and linked to the social determinants of health.** Diabetes and high blood pressure were discussed as prevalent in the community, especially among low-income residents and communities of color, and survey respondents indicated “overweight/obesity” was the second most common health issue in their community. However, focus group participants focused on the barriers to healthy living including affording healthy foods, cost medication, and having time to exercise and be outside.
- **Educational opportunities were seen as an important driving factor for future success.** A positive and supportive school environment is important to physical and mental wellbeing, as well as to future educational and professional opportunities. Health supports academic success. Schools play an important role in facilitating access to care and helping students stay healthy, and Hudson County public schools engage with communities in multiple ways to support students. However, some schools face challenges due to insufficient resources. Inequities in school performance are confirmed by graduation rate data from different Hudson County districts. Whereas the high school graduation rate in the Hoboken Public School District was 93.6% in 2020-2021, the public school districts of Bayonne, Union City, and Jersey City had lower graduation rates. There were significant disparities by race/ethnicity within districts; 95.3% of Asian students graduated from high school in Bayonne in 2020-2021, compared to 86.4% of Black children, and 78.5% of Latino children. Partnership based programs such as the community schools and The Tiger's Den at Snyder High School are a promising strategy to equalize outcomes among diverse students.
- **Hudson County has a wealth of social service organizations and health care services, including those providing preventive care, though many residents experience barriers to accessing these resources.** Residents remarked that having a primary care doctor and being linked to a FQHC as facilitating factors to accessing care. They also discussed the importance of culturally competent providers, including providers who spoke their language and looked like them. Veterans and those working with violence survivors highlighted that having peers and mentors who could provide trauma informed care helped to be engaged in care. The high healthcare cost was the top barrier mentioned by residents, providers, and healthcare administrators. Participants in the healthcare field unanimously noted a decline in access to preventive care and mentioned this as a priority strategic area. They uplifted partnerships and community engagement as ways to bridge the care gap.

Prioritization Process and Priorities Selected for Planning

Prioritization allows hospitals, organizations, and coalitions to target and align resources, leverage efforts, and focus on achievable goals and strategies for addressing community needs. Priorities for this process were identified by examining data and themes from the CHNA findings utilizing a systematic, engaged approach. This section describes the process and outcomes of the prioritization process.

Criteria for Prioritization

A set of criteria were used to determine the priority issues for action. The RWJBH Systemwide CHNA Steering Committee put forth the following criteria to guide prioritization processes across the RWJBH system.

Prioritization Criteria

- **Burden:** How much does this issue affect health in the community?
- **Equity:** Will addressing this issue substantially benefit those most in need?
- **Impact:** Can working on this issue achieve both short-term and long-term changes? Is there an opportunity to enhance access/accessibility?
- **Systems Change:** Is there an opportunity to focus on/implement strategies that address policy, systems, and environmental change?
- **Feasibility:** Can we take steps to address this issue, given the current infrastructure, capacity, and political will?
- **Collaboration/Critical Mass:** Are existing groups across sectors already working on or willing to work on this issue together?
- **Significance to Community:** Was this issue identified as a top need by a significant number of community members?

Prioritization Process

The prioritization process was multifaceted and aimed to be inclusive, participatory, and data-driven.

Step 1: Input from Community Members and Stakeholders via Primary Data Collection

During each step of the primary data collection phase of the CHNA, assessment participants were asked for input. Key informant interviewees and focus group participants were asked about the most pressing concerns in their communities and the three highest priority issues for future action and investment (see Key Informant Interview and Focus Group Guides in the Appendices). Community survey respondents were also asked to select up to four of the most important issues for future action in their communities, noted in the Community Health Issues section of the CHNA Report.

Based on responses gathered from key informant interviews, focus group participants, and community survey respondents, as well as social, economic, and health data from surveillance systems, ten initial issue areas were identified for Hudson County (listed below in no particular order):

- Financial Insecurity
- Unemployment
- Food Insecurity
- Housing
- Chronic Diseases (e.g., heart disease, cancer, diabetes)
- Infectious Diseases, including COVID-19
- Violence Prevention & Safety
- Mental Health
- Substance Use
- Access to Preventive Care

Step 2: Data-Informed Voting via a Prioritization Meeting

On October 27, 2022, a 90-minute virtual community meeting was held with the RWJBH Jersey City/Hudson County CHNA Advisory Committee (see Appendix A for members), so Advisory Committee members could discuss and vote on preliminary priorities for action. During the virtual prioritization meeting on Zoom, attendees heard a brief data presentation on the key findings from the CHNAs conducted across Hudson County.

Next, meeting participants were divided into small groups to reflect on and discuss the data and offer their perspectives and feedback on the various issues. Meeting participants then shared information from their discussions with the full group.

At the end of the meeting, using Zoom’s polling tool, participants were asked to vote for up to four of the ten priorities identified from the data and based on the specific prioritization criteria (Burden, Equity, Impact, Systems Change, Feasibility, Collaboration/Critical Mass, and Significance to Community). A total of thirty-two Advisory Committee members voted during the Community Prioritization Meeting. In addition, polling remained open for an additional week to gather responses from those who were not able to attend the meeting. An additional six responses were received during this period.

Voting ranked the following issues as top priorities, with mental health receiving the highest percentage of responses.

	Percentage	Vote #s
Mental Health	74%	28/38
Housing	74%	28/38
Financial Insecurity	61%	23/38
Chronic Disease	50%	19/38
Violence Prevention & Safety	42%	16/38
Access to Preventive Care	34%	13/38
Food Insecurity	29%	11/38
Substance use	21%	8/38
Unemployment	16%	6/38
Infectious Disease	5%	2/38

After a prioritization process with the Advisory Committee and discussions within the hospital taking into consideration existing expertise, capacity, and experience, JCMC will focus on Access to Preventive Care; Chronic Disease Management, including Behavioral Health Services; Food Insecurity and Education; and Violence Prevention and Safety as priorities during the development of its implementation plan in 2023. JCMC will tackle these priority action areas as part of ongoing community engagement efforts and with an overarching emphasis on addressing systemic racism, racial injustice, and discrimination.

APPENDICES

Appendix A- RWJBH Jersey City/Hudson County CHNA Advisory Committee Members

- Deborah Almonte, Jersey City Medical Center
- Jenny Andrews, Jersey City Medical Center
- Maureen Archibald, Jersey City Medical Center
- Tara Artesi, Legal Assistance to Medical Patients (LAMP) Project
- Adrienne Austin, Jersey City Medical Center
- Pamela Baker, Collaborative Support Programs (CSPNJ)
- Raket Barrientos, Jersey City Medical Center
- Patrick Beaty, MD, Metropolitan Family Health Network
- Paul Bellan-Boyer, Jersey City Department of Health and Human Services
- Christina Bishop-Feeny, Jersey City Medical Center
- Sheridan Blackwell, Jersey City Medical Center
- Kimberly Blackwell, Jersey City Medical Center
- Whitney Bracco, Jersey City Medical Center
- Jenna Camacho, Jersey City Medical Center
- Scott Carey, Metropolitan Family Health Network
- Kristin Carlino, Jersey City Medical Center
- Kristy Case, Jersey City Medical Center
- Suzanne Cavanaugh, City of Bayonne
- Ritu Chandak, Jersey City Medical Center
- Jamie Chebra, Jersey City Medical Center
- Jessica Chung, Jersey City Medical Center
- Timothy Daniels, Jersey City Medical Center
- Christine Dimaculangan, Jersey City Medical Center
- Cheryl Dorn, Peace Care
- Joan Dublin, Metropolitan Family Health Network
- Mark Duda, Visiting Nurse Association Health Group
- Leah Dungee, Jersey City Medical Center
- Joan Eccleston, Jersey City Department of Health and Human Services
- Edoardo Ferrante, City of Bayonne
- Marissa Fisher, Jersey City Medical Center
- Stacey Flanagan, Jersey City Department of Health and Human Services
- Juliet Foster, Division of Veterans Affairs, Jersey City Department of Health and Human Services
- Katherine Fromm, Jersey City Medical Center
- Marli Gelfand, Jersey City Medical Center
- Silvana Gomez, Jersey City Medical Center
- Stephanie Gonzalez, Jersey City Medical Center
- William Gonzalez, Jersey City Medical Center
- Kwaku Gyekye, Jersey City Medical Center
- Tina Harvey, Jersey City Medical Center
- Victoria Hayes, York Street Project

- Angelo Hunt, St. Lucy's Shelter
- Linda Ivory-Green, Jersey City Department of Health and Human Services
- Maryanne Kelleher, Jersey City Department of Health and Human Services
- Surendra Khera, MD, Jersey City Medical Center
- Kenneth King, Jersey City Medical Center
- Rita Knause, MD, North Hudson Community Action Corporation
- Jordan Kowalczewski, Barnabas Health Medical Group
- Theresa Laflam, Jersey City Medical Center
- Mabel Laforgia, Jersey City Medical Center
- Judy Lagani, Lincoln High School and Dickinson High School
- Maria Veronica Lavarro, Jersey City Medical Center
- Michael Loftus, Jersey City Medical Center
- Mike McLean, Jersey City Department of Health and Human Services
- Janet Merly-Liranzo, Peace Care St. Ann's
- Susan Milan, Garden State Episcopal Community Development Corporation
- Stephanie Mills, Hudson Pride
- Stacie Newton, Jersey City Medical Center
- Tri Nguyen, Jersey City Medical Center
- Michele O'Reilly, City of Bayonne - Health Division
- Maria Otadoy, Jersey City Medical Center
- Lashawn Overton, Jersey City Medical Center
- Grace Palmer, Jersey City Medical Center
- Alicia Parker, Hyacinth AIDS Foundation
- Leo Pellegrini, Health & Human Services of Hoboken
- Joan Quigley, North Hudson Community Action Corporation
- Tara Reid, Jersey City Medical Center
- Jeffery Rodriguez, Jersey City Medical Center
- Elizabeth Schedl, Hudson Pride
- Aniello Semioli, Jersey City Medical Center
- Jessica Semioli, Jersey City Medical Center
- Thomas Sheehy, Peace Care St. Joseph's
- Tina Siciliano, Jotham W. Wakeman School, PS #6
- Veronica Siringano, Jersey City Medical Center
- Iesha Suber, Jersey City Medical Center
- Eva Tawiah, Jersey City Medical Center
- Amanda Tobias, Jersey City Medical Center
- Vito Veneruso, North Hudson Community Action Corporation
- Yvonne Waller, Snyder Higher School
- Vanessa Watson-Hill, Jersey City Medical Center
- Ewelina Wojtaszek, Jersey City Medical Center
- Monica Younger, Jersey City Medical Center
- Joseph Zapata, Hudson Pride

Appendix B- Organizations Represented in Key Informant Interviews and Focus Groups

Organization	Sector
Jersey City Department of Health and Human Services	Local public health officials
City of Bayonne Health Division	Local public health officials
Hoboken Housing Authority	Local housing officials
Jersey City Public Schools	Local education officials
Metropolitan Family Health Network	Local healthcare administrators
Alliance Community Healthcare	Local healthcare administrators
North Hudson Community Action Corporation	Local healthcare administrators
Hudson Pride	LGBTQ+ social service providers
JCMC Community Outreach and Steering Committee	Health care and social services providers
Islamic Center of Jersey City/JCMC Chaplaincy	Faith-based leaders
Archdiocese of Newark/JCMC Chaplaincy	Faith-based leaders

Appendix C- Key Informant Interview Guide

Health Resources in Action JCMC/Hudson County Community Health Needs Assessment

Goals of the key informant interview

- To determine perceptions of the strengths and needs of the community served by JCMC/Hudson County, and identify sub-populations most affected
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

[NOTE: THE QUESTIONS IN THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

I. BACKGROUND (5 MINUTES)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today.
- A few months ago, the JCMC/Hudson County coalition began undertaking a community health assessment effort to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these with a wide range of people - community members, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.
- We recognize this is a unique time we are in. Given the COVID-19 pandemic, an assessment of the community's needs and strengths is even more important than ever.
- Our interview will last about 45 – 60 minutes. After all the interview and focus group discussions are completed, we will be writing a summary report of the general themes that have emerged during these discussions. We will not include any names or identifying information in that report. All names and responses will remain confidential. Nothing sensitive that you say here will be connected directly to you in our report.

[Discuss permission to record, if relevant]

- Do you have any questions before we begin?

II. INTRODUCTION (5 MINUTES)

1. Can you tell me a bit about your organization/agency? [TAILOR PROBES DEPENDING ON AGENCY OR IF COMMUNITY LEADER NOT AFFILIATED WITH ORGANIZATION]

- a. [PROBE ON ORGANIZATION: What is your organization’s mission/services? What communities do you work in? Who are the main clients/audiences?]
 - i. What are some of the biggest challenges your organization faces in conducting your work in the community?
 - ii. How have these changed during COVID-19? What new challenges do you anticipate going forward?

III. COMMUNITY PERCEPTIONS AND SOCIAL/ECONOMIC FACTORS (10 MINUTES)

- 2. How would you describe the community served by your organization/ that you serve? (NOTE THAT WE ARE DEFINING COMMUNITY BROADLY – NOT NECESSARILY GEOGRAPHICALLY BASED)
 - a. What do you consider to be the community’s strongest assets/strengths?
 - b. How have you seen the community change over the last several years?
 - c. What are some of the community’s biggest concerns/issues in general? What challenges do residents face in their day-to-day lives? [PROBE IF NOT YET MENTIONED ON: transportation; affordable housing; discrimination; financial stress; food security; violence; employment; cultural understanding; language access; impacts of environmental problems and climate change, etc.] REPEAT QUESTIONS FOR DIFFERENT ISSUES]
 - i. What populations (geography, age, race, gender, income/education, veteran status, etc.) do you see as being most affected by these issues?
 - ii. How has [ISSUE] affected their daily lives?
 - iii. How have these issues changed during/since COVID-19?

[REPEAT SET OF QUESTIONS FOR TWO OR THREE ISSUES MENTIONED]

IV. HEALTH ISSUES (10 MINUTES)

- 3. What do you think are the most pressing health concerns in the community/among the residents you work with? Why? [PROBE ON SPECIFICSPROBE FOR HEALTH ISSUES NOT DIRECTLY RELATED TO COVID-19, OR ISSUES THAT HAVE CHANGED BECAUSE OF COVID-19, EG, CHRONIC DISEASE, HYPERTENSION, ETC.]
 - a. How has [HEALTH ISSUE] affected the residents you work with? [PROBE FOR DETAILS: IN WHAT WAY? CAN YOU PROVIDE SOME EXAMPLES?]
 - i. From your experience, what are peoples’ biggest challenges to addressing [THIS ISSUE]?
 - ii. To what extent, do you see [BARRIER] to addressing this issue among the residents you work with/your organization serves?

[PROBE ON BARRIERS BROUGHT UP/MOST APPROPRIATE FOR POPULATION GROUP:
Cost or economic hardship, transportation, stigma, attitudes towards seeking services,
built environment, availability/access to resources or services, knowledge of existing
resources/services, social support, discrimination, insurance coverage, language/cultural
barriers, etc.]

4. What are current or emerging trends that could have an impact on the public health system or the community? Has anything become apparent due to the Coronavirus pandemic?
5. How important is prevention in the community?
 - i. How easy is it to access preventive services in your community?
 - ii. What are some of the ways that you access care (Probes: at the hospital, clinical, community-based, telehealth)?
 - iii. Has anybody you or someone you know used telehealth to get care? How satisfied were you/them with the care received via telehealth?

V. *TAILORED SECTION - SPECIFIC QUESTIONS ON PARTICULAR ISSUES, DEPENDING ON WHO THE INTERVIEWEE IS. SELECT QUESTIONS TAILORED TO INDIVIDUAL EXPERTISE AND ASK A FEW QUESTIONS IF NOT YET BROUGHT UP. (5-10 MINUTES)*

For Interviewees Working in Housing and/or Transportation

- What barriers do you see residents experiencing around accessing affordable and healthy housing? How about with transportation?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- What has been working well in the community to improve access to healthy, affordable housing? How about related to transportation? What has been challenging or not working well? Where are there opportunities for improvement or innovation?

For Interviewees Working in Financial Instability, Employment, and Workforce Development

- What challenges are residents facing regarding hiring, employment, or job security?
- What were the needs in this community around workforce development? What is needed to improve residents' employability? What training or resources are needed?
- Are there any approaches to improving workforce development and financial stability that you think will have to change in light of the pandemic and its impacts?

For Interviewees Working with Communities where Discrimination is a Concern

- What are some of the specific challenges around discrimination that your communities face?
- What should health care and social service providers consider when treating health and other issues in diverse populations? How can institutions best respond to the needs of diverse groups? (e.g. religious, racial/ethnic, etc.)
- How has the pandemic and/or movements for racial justice impacted addressing issues and needs of diverse groups?

For Interviewees Working with Seniors/Older Adults

- What are some of the challenges seniors are facing in your community?
- Are there particular structural, institutional, or policy-related barriers that have affected seniors in your community?
- How has the pandemic and its effects impacted seniors and organizations serving older adults?
- What has been going “right” that could be built on going forward?

For Interviewees Working in the Areas of Substance Use or Mental Health

- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- How has the pandemic impacted community members regarding substance use and mental health?
*mention other KIIIs have brought up suicide in youth; isolation in older populations
- What are your major concerns for the future? What has been going “right” that could be built on going forward?

For Interviewees Working with Veterans

- What are some of the challenges veterans are facing in your community?
- Are there particular structural, institutional, or policy-related barriers that have affected veterans in your community?
- How has the pandemic and its effects impacted seniors and organizations serving veterans?
- Among the veterans, who have been the most affected by these issues (age, sex, race, etc.)
- What has been going “right” that could be built on going forward?

For Interviewees Working with Youth/Young Adults

- What are some of the challenges youths are facing in your community?
- What should health care and social service providers consider when treating health and other issues in youth populations? How can institutions best respond to the needs of younger individuals?
- How has the pandemic and its effects impacted youths and organizations serving younger individuals?
- What are your major concerns for the future? Do you have examples of programs or approaches that have been working well that could be built on going forward?

For Interviewees Working in Food Assistance and Food Security

- What barriers do you see residents experiencing around accessing affordable and healthy food?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- What has been working well in the community to improve access to healthy, affordable food?
- What has been challenging or not working well? What opportunities exist for improvement or innovation?

VI. VISION FOR THE FUTURE (10 MINUTES)

6. I’d like you to think ahead about the future of your community. When you think about the community 3 years from now, what would you like to see? What’s your vision?
 - a. What do you see as the next steps in helping this vision become reality?

- b. We talked about a number of strengths or assets in the community. [MENTION POTENTIAL STRENGTHS- Community resilience, diversity, number of organization/services available, community engagement, etc.] How can we build on or tap into these strengths to move us towards a healthier community?
7. As you think about your vision, what do you think needs to be in place to support sustainable change?
- a. How do we move forward with lasting change across organizations and systems?
 - b. How can we better serve/address the needs of the culturally diverse community of JC/Hudson County?
 - c. Where do you see yourself or your organization in this?
8. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive this funding?

VII. OTHER

9. We are also interested in finding out ways people receive news and current events. Thinking about the ways people might get information, where do you get news and information from? What about ways you prefer to search for news and information – (television, radio, print, smartphone, computer or tablet).

VIII. CLOSING (5 MINUTES)

Thank you so much for your time and sharing your opinions. Your perspectives about the communities you work with will be a great help in determining how to improve the systems that affect the health of this population. Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier?

Thank you again. Your feedback is valuable, and we greatly appreciate your time and for sharing your opinion.

Appendix D- Focus Group Guide

Health Resources in Action JCMC/Hudson County Community Health Needs Assessment

Goals of the focus group:

- To determine perceptions of the strengths and needs of the community
- To understand residents' current experiences and challenges
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

I. BACKGROUND (5-10 minutes)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your families are fine during these uncertain times.
- This discussion will last about 60 minutes. [DEPENDING ON FORMAT OF FOCUS GROUP] Please turn on your video, if possible, so that we can all see each other speaking. As a reminder, please keep yourself on MUTE until you want to speak.

NORMALLY, WE WOULD BE DOING THIS IN-PERSON.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.
- A few months ago, JCMC/Hudson County began a community health assessment to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these with a wide range of people - community members, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.
- We recognize this is a unique time we have been in. Given the COVID-19 pandemic, an assessment of the community's needs and strengths is even more important than ever.
- After discussions with several groups are done, we will be writing a report summarizing what has come up. In that report, we might provide some general information on what we discussed tonight, but we will not include any names or identifying information. Your responses will be strictly confidential. In the report, nothing you say here will be connected to your name.
- [NOTE IF AUDIORECORDING] We plan to audio record these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the notetaking. No

one but the analysts at Health Resources in Action, who are writing the report, will be listening to the audio recordings. Does anyone have any concerns with me turning the recorder on now?

- Any questions before we begin our introductions and discussion?

II. INTRODUCTIONS (5 minutes)

Now, first let's spend a little time getting to know one another. When I call your name, please unmute yourself and tell us: 1) Your first name; 2) what city or town you live in; and 3) something about yourself you'd like to share— such as how many children you have or what activities you like to do for fun. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY ASSETS AND CONCERNS (20 minutes)

For the following questions, we will be discussing the strengths and concerns in your community.

1. If someone was thinking about moving into your community, what would you say are some of your community's biggest strengths? What are the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]
 - a. How have these strengths changed during COVID-19?
2. To contrast that, what are some of the biggest problems or concerns in your community? How have these concerns changed during COVID-19? [PROBE ON ISSUES IF NEEDED – TRANSPORTATION, HOUSING AFFORDABILITY, ECONOMIC SECURITY, HEALTH CONCERNS, ETC.]
 - a. Just thinking about day-to-day life –working, getting your kids to school, things like that – what are some of the challenges or struggles you deal with on a day-to-day basis? [PROBE ON ISSUES IF NEEDED – TRANSPORTATION, HOUSING AFFORDABILITY, ECONOMIC SECURITY, HEALTH CONCERNS, VIOLENCE, ETC.]
 - b. How have these changed during COVID-19?
 - c. What specific population groups do you think have been most at-risk for/affected by these issues in your community?
3. In the past year, there has been more national dialogue around racial injustice, inequity, and structural racism. How has this dialogue played out in JC/Hudson County? How have issues of inequity played out in the community?
 - a. How can different community organizations effectively contribute to the ongoing conversation and movement for racial justice?
4. What do you think are the most pressing health concerns in your community?
 - a. Who is most at-risk for/have been most affected by these issues?
5. Thinking about health and wellness, what makes it easier to be healthy in your community?

- a. What supports your health and wellness?
- b. What makes it easy to access care?
- c. What makes it harder to be healthy in your community?
 - i. How easy is it to access preventive services in your community?
 - ii. What are some of the ways that you access care (Probes: at the hospital, clinical, community-based, telehealth)?
 - iii. Has anybody you or someone you know used telehealth to get care? How satisfied were you/them with the care received via telehealth?

IV. PERCEPTIONS OF COMMUNITY NEEDS, BARRIERS, AND OPPORTUNITIES (15 minutes)

What are the top three issues of concern that have been mentioned? [MODERATOR TO NAME THE MAJOR 3-4 ISSUES – HEALTH, TRANSPORTATION, SOCIAL, ECONOMIC, VIOLENCE, ETC. --THAT HAVE COME UP SO FAR.] Let’s talk about some of the issues.

- 6. Do you agree with this list as the major concerns/issues in your community? Is there a major issue that is missing?
- 7. Let’s talk about [ISSUE]. (*Moderator to select one major issue discussed.*) What are some of the barriers or challenges residents face in dealing with [ISSUE]? [PROBE: BARRIERS TO SERVICES, ASSISTANCE, COORDINATION, SOCIAL/ECONOMIC FACTORS, DISCRIMINATION, SAFETY, ETC.]
 - a. Thinking about your larger community environment – the services and resources available, your state and local policies or practices, etc. -- what do you see as some of the biggest challenges for your community to tackle this issue or make improvements?
 - b. What do you think should happen in the community to address this issue? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

[REPEAT Q6 FOR 1-2 OTHER MAJOR ISSUES THAT WERE DISCUSSED]

V. VISION OF COMMUNITY HEALTH IMPROVEMENT AND INVOLVEMENT (10 minutes)

- 8. I’d like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see? What is your vision for the future?
 - a. What do you think needs to happen in the community to make this vision a reality?
 - b. Who should be involved in this effort? What should be Jersey City Medical Center’s role in making this happen?
 - c. What should be the role of a community coalition that brings together multiple groups?
- 9. We talked about a lot of things today. Thinking about what would make the most impact, who is most affected by the different issues we talked about, and how realistic it is to make change: What

do you think are the most important areas of action to improve health in your community? If organizations and agencies are going to work together to tackle the community's biggest issues, what should they put at the top of the list as things to do?

VI. CLOSING (2 minutes)

Thank you so much for your time. This is a very difficult time for everyone, and your perspective will be a great help in determining how to improve the systems that affect your community.

That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon. [TALK ABOUT NEXT STEPS OF THE PROCESS, SPECIFICALLY HOW PARTICIPANTS CAN GET INVOLVED FURTHER OR RECEIVE THE FINAL REPORT OR SUMMARY OF THE REPORT.]

Appendix E- Resource Inventory

Appendix F- Additional Data Tables

Table 16. Survey Respondent Characteristics, n=556, 2001

Age		Income	
Under 30	15.6%	Under \$25,000	12.0%
30 to 49	46.7%	\$25,000 to \$50,000	21.1%
50 to 64	27.0%	\$50,001 to \$100,000	31.5%
65+	10.7%	\$100,001 to \$125,000	11.2%
Gender		\$125,001 to \$150,000	6.4%
Female	67.5%	\$150,001 to \$200,000	7.2%
Male	32.5%	Over \$200,000	10.8%
Additional Gender Category/ Transgender	0.2%*	Employment	
Race/Ethnicity		Employed full-time	72.4%
African American/ Black	9.3%	Employed part-time	6.8%
Asian	15.7%	Student	3.9%
Hispanic/ Latino(a)	24.3%	Homemaker	1.1%
Multiracial	2.5%	Disabled	1.8%
White/ Caucasian	45.0%	Retired	7.5%
Other	3.2%	Unemployed	6.5%
Sexual Orientation		Marital Status	
Heterosexual	86.3%	Married	46.2%
Homosexual	6.7%	Single	31.1%
Bisexual	4.7%	Separated/divorced/widowed	15.8%
Additional Sexual Orientation	2.4%	Domestic partnership/civil union/living together	7.0%
Education			
Less than high school graduate or GED	2.2%		
High school graduate or GED	9.6%		
Some college	14.4%		
Associate or technical degree/certification	9.3%		
College graduate	30.4%		
Postgraduate or professional degree	34.1%		

DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Table 17. Age Distribution and Percent Change, by Town, 2011-2015, 2016-2020

	Under 18 years			18-24 years			25-44 years			45-64 years			65-74 years			75 years and older		
	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change
Hudson County																		
Bayonne	22.0%	23.5%	1.5%	8.3%	6.5%	-1.8%	29.8%	29.8%	0.0%	27.0%	25.9%	-1.1%	7.2%	7.8%	0.6%	5.8%	6.3%	0.5%
Hoboken	13.2%	13.9%	0.7%	10.1%	9.8%	-0.3%	56.7%	55.0%	-1.7%	14.0%	15.2%	1.2%	3.1%	3.2%	0.1%	2.8%	3.0%	0.2%
Jersey City (07302)	7.2%	14.6%	7.4%	5.2%	3.6%	-1.6%	55.1%	58.6%	3.5%	17.3%	15.0%	-2.3%	4.1%	4.6%	0.5%	4.0%	3.8%	-0.2%
Jersey City (07304)	15.5%	25.0%	9.5%	9.4%	7.6%	-1.8%	31.7%	32.4%	0.7%	26.3%	24.1%	-2.2%	6.2%	6.3%	0.1%	3.9%	4.5%	0.6%
Jersey City (07305)	16.7%	25.3%	8.6%	10.7%	9.2%	-1.5%	28.9%	29.2%	0.3%	23.8%	23.6%	-0.2%	7.5%	8.2%	0.7%	4.6%	4.6%	0.0%
Jersey City (07306)	12.8%	19.6%	6.8%	10.6%	9.1%	-1.5%	37.8%	37.0%	-0.8%	22.0%	20.8%	-1.2%	6.0%	7.8%	1.8%	3.5%	5.9%	2.4%
					8													
Jersey City (07307)	14.3%	20.2%	5.9%	9.4%	.1%	-1.3%	34.7%	38.9%	4.2%	23.6%	22.0%	-1.6%	5.9%	6.6%	0.7%	4.3%	4.2%	-0.1%
Jersey City (07310)	4.9%	11.2%	6.3%	10.2%	9.6%	-0.6%	60.6%	64.9%	4.3%	15.0%	10.5%	-4.5%	1.7%	3.2%	1.5%	0.4%	0.6%	0.2%
Union City	22.3%	22.5%	0.2%	10.4%	9.5%	-0.9%	32.0%	31.8%	-0.2%	25.2%	25.4%	0.2%	5.7%	5.5%	-0.2%	4.4%	5.3%	0.9%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

Table 18. Age Distribution, by Gender, State, and County, 2016-2020

	Under 18 years		18-24 years		25-44 years		45-64 years		65-74 years		75 years and older	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
New Jersey	23.0%	21.0%	9.0%	8.2%	26.5%	25.0%	27.3%	27.7%	8.6%	9.7%	5.7%	8.4%
Hudson County	20.9%	20.0%	8.3%	7.5%	38.3%	35.4%	22.5%	23.1%	6.2%	7.6%	3.9%	6.3%
Bayonne	24.7%	20.6%	7.2%	7.6%	29.3%	28.4%	25.9%	26.8%	8.6%	8.8%	4.3%	7.9%
Hoboken	13.5%	13.6%	13.6%	7.8%	51.6%	54.9%	14.5%	16.9%	4.2%	3.3%	2.7%	3.6%
Jersey City (07302)	15.2%	14.0%	3.6%	3.6%	60.6%	56.2%	14.4%	15.5%	2.8%	6.5%	3.4%	4.3%
Jersey City (07304)	25.6%	24.6%	8.1%	7.3%	32.8%	32.2%	24.0%	24.1%	6.9%	5.7%	2.6%	6.2%
Jersey City (07305)	26.9%	23.7%	9.2%	9.1%	30.4%	28.0%	23.5%	23.7%	6.2%	10.0%	3.7%	5.5%
Jersey City (07306)	18.8%	20.4%	9.4%	8.7%	38.7%	34.9%	20.4%	21.5%	7.6%	7.9%	5.1%	6.7%
Jersey City (07307)	19.7%	20.7%	8.8%	7.3%	42.3%	35.4%	20.7%	23.2%	5.5%	7.8%	2.9%	5.5%
Jersey City (07310)	12.4%	9.8%	7.0%	12.8%	66.2%	63.2%	10.3%	10.7%	3.2%	3.3%	0.8%	0.2%
Union City	21.9%	21.9%	9.1%	10.0%	32.8%	29.7%	26.6%	24.2%	5.9%	7.1%	3.7%	7.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Community Social and Economic Environment

Table 19. Membership in Social Associations, by State and County, 2019

	# Associations	Social Association Rate
New Jersey	7721	8.7
Hudson County	376	5.6

DATA SOURCE: County Business Patterns as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Educational Attainment

Table 20. Educational Attainment among Adults 25 Years and Older, by State, County, and Town, 2016-2020

	Less than 9th grade	9th to 12th grade, no diploma	High school graduate/ GED	Some college, no degree	Associate degree	Bachelor's degree	Graduate or professional degree
New Jersey	4.7%	5.1%	26.7%	16.1%	6.6%	24.8%	15.9%
Hudson County	8.6%	5.7%	24.4%	12.6%	4.6%	26.4%	17.6%
Bayonne	6.0%	5.0%	30.3%	15.6%	5.3%	25.9%	11.9%
Hoboken	2.3%	2.2%	8.3%	6.4%	1.2%	48.4%	31.2%
Jersey City (07302)	2.9%	1.9%	8.3%	7.2%	2.4%	39.0%	38.5%
Jersey City (07304)	6.7%	7.9%	32.0%	13.5%	6.3%	22.8%	10.9%
Jersey City (07305)	6.5%	6.8%	30.7%	16.3%	6.4%	20.6%	12.7%
Jersey City (07306)	8.4%	6.9%	20.2%	12.5%	4.5%	30.7%	16.9%
Jersey City (07307)	8.3%	6.4%	24.8%	13.5%	4.6%	26.0%	16.4%
Jersey City (07310)	0.5%	1.0%	4.7%	4.5%	1.6%	31.7%	56.1%
Union City	18.1%	7.5%	33.1%	13.1%	5.1%	15.5%	7.6%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 21. Educational Attainment Among Adults 25 Years and Older, by Race/Ethnicity, State, County and Town, 2016-2020

	Asian, NH		Black, NH		Hispanic/ Latino		White, NH		Other race, NH	
	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+
New Jersey	92.8%	71.0%	88.6%	25.2%	75.6%	20.6%	94.6%	45.1%	71.4%	15.3%
Hudson County	93.4%	75.3%	87.4%	31.0%	75.8%	21.3%	92.7%	59.1%	75.6%	17.3%
Bayonne	93.6%	68.8%	90.0%	33.5%	79.9%	20.8%	92.6%	41.7%	77.5%	17.5%
Hoboken	97.1%	90.1%	86.1%	31.1%	78.3%	33.2%	98.7%	88.7%	67.0%	30.3%
Jersey City (07302)	97.8%	91.1%	93.2%	47.1%	81.3%	43.3%	98.2%	83.5%	71.4%	34.3%
Jersey City (07304)	90.0%	57.8%	86.7%	28.4%	77.2%	18.4%	91.5%	50.7%	80.2%	17.1%
Jersey City (07305)	92.6%	56.5%	88.5%	26.7%	74.8%	17.9%	92.6%	45.6%	70.5%	11.1%
Jersey City (07306)	89.0%	68.2%	80.9%	26.7%	73.2%	19.8%	90.7%	51.4%	74.8%	20.9%
Jersey City (07307)	87.3%	66.8%	84.7%	35.3%	80.4%	20.7%	89.8%	51.9%	75.8%	16.9%
Jersey City (07310)	99.4%	96.1%	94.5%	27.5%	95.3%	76.8%	98.1%	84.6%	81.5%	65.2%
Union City	84.3%	64.6%	79.0%	26.1%	69.9%	16.0%	90.9%	48.2%	73.7%	15.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Unemployment Rates

Table 22. Unemployment Rate by Gender, State, County, and Town, 2016-2020

	Female	Male
New Jersey	5.6%	5.4%
Hudson County	5.6%	4.9%
Bayonne	6.5%	6.3%
Hoboken	1.9%	3.8%
Jersey City (07302)	2.5%	2.1%
Jersey City (07304)	10.8%	7.7%
Jersey City (07305)	6.6%	6.7%
Jersey City (07306)	5.0%	4.5%
Jersey City (07307)	5.7%	3.8%
Jersey City (07310)	3.6%	2.3%
Union City	6.1%	5.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

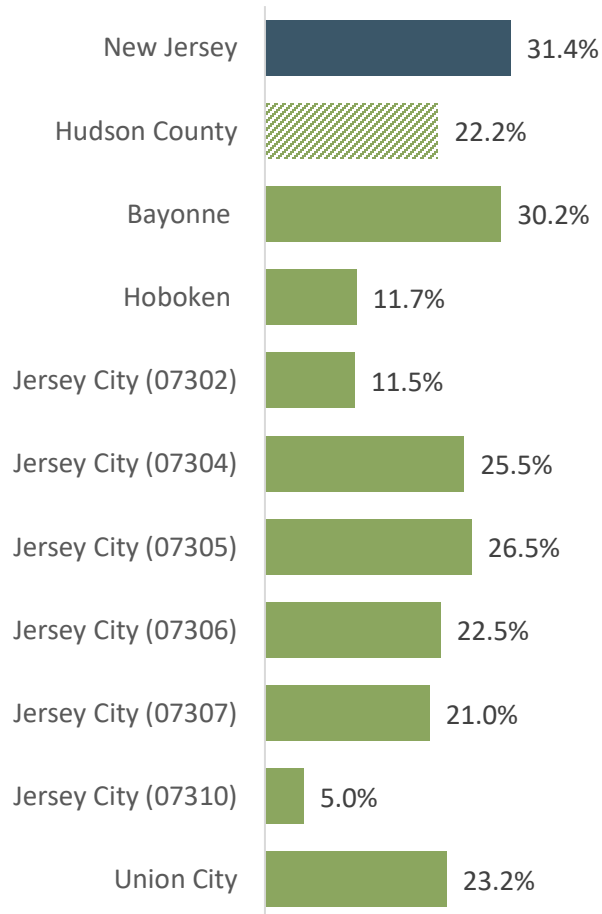
Table 23. Unemployment Rate by Age, State, and County, 2016-2020

	16 to 19 years	20 to 24 years	25 to 29 years	30 to 34 years	35 to 44 years	45 to 54 years	55 to 59 years	60 to 64 years	65 to 74 years	75 years and over
New Jersey	17.2%	11.4%	6.5%	5.2%	4.6%	4.6%	4.5%	4.4%	4.8%	4.2%
Hudson County	18.8%	11.0%	4.8%	4.3%	4.1%	5.7%	5.5%	4.0%	5.6%	1.7%
Bayonne	30.8%	14.4%	4.9%	9.7%	4.2%	6.2%	4.1%	4.4%	1.2%	0.0%
Hoboken	64.5%	5.0%	2.4%	1.1%	2.2%	6.6%	3.4%	5.7%	6.6%	0.0%
Jersey City (07302)	10.4%	6.7%	2.5%	2.1%	1.4%	4.1%	1.3%	2.9%	0.0%	18.3%
Jersey City (07304)	13.8%	22.5%	6.6%	8.7%	7.6%	10.5%	7.8%	3.8%	7.0%	0.0%
Jersey City (07305)	25.3%	14.4%	6.6%	6.6%	5.7%	5.3%	3.9%	6.1%	8.5%	0.0%
Jersey City (07306)	10.4%	8.3%	3.1%	4.0%	3.8%	5.4%	8.1%	3.7%	3.4%	0.0%
Jersey City (07307)	4.8%	9.1%	6.1%	4.0%	3.7%	3.8%	2.6%	4.4%	0.0%	0.0%
Jersey City (07310)	0.0%	0.0%	0.4%	1.6%	7.8%	1.6%	12.6%	0.0%	0.0%	0.0%
Union City	17.7%	10.4%	8.3%	5.0%	3.2%	5.2%	5.8%	4.3%	12.9%	0.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Income and Financial Security

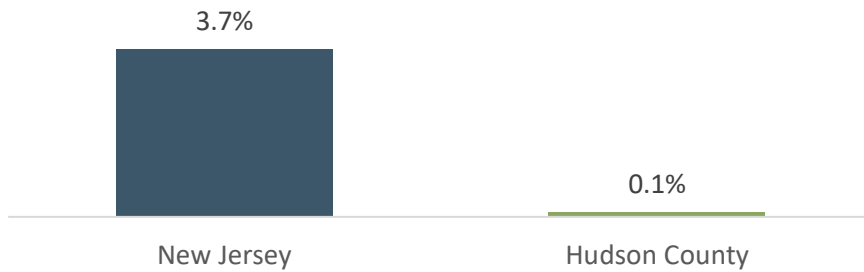
Figure 119. Percent Households Receiving Social Security Income, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Food Access and Food Security

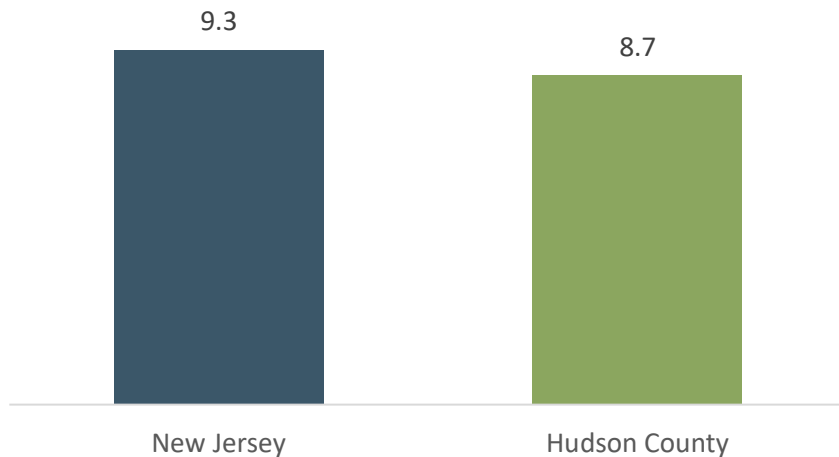
Figure 120. Food Desert Among Residents, by State and County, 2019



DATA SOURCE: U.S. Department of Agriculture, Economic Research Service, Food Access Research Atlas, 2019 , as reported by, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

NOTE: Food desert defined as the percentage of population with low income and without access to a grocery store at 1 mile for urban areas and 10 miles for rural areas

Figure 121. Food Environment Index, by State and County, 2019



DATA SOURCE: USDA Food Environment Atlas, Map the Meal Gap from Feeding America, 2019 as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

NOTE: Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).

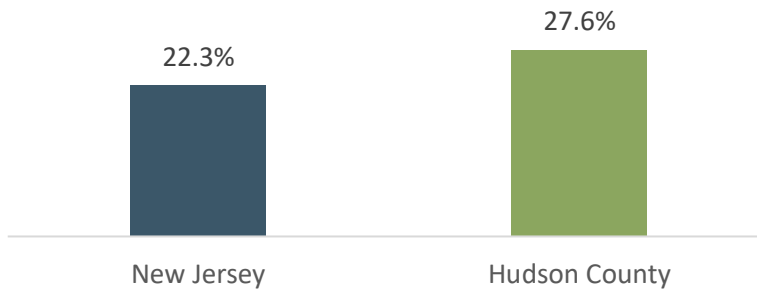
Housing

Table 24. Household Occupants per Room, by State and County, 2016-2020

	1.00 or less	1.01 to 1.50	1.51 or more
New Jersey	96.7%	2.1%	1.1%
Hudson County	92.1%	5.1%	2.8%
Bayonne	94.5%	4.0%	1.5%
Hoboken	96.2%	1.9%	1.9%
Jersey City (07302)	93.5%	3.0%	3.5%
Jersey City (07304)	93.2%	4.3%	2.5%
Jersey City (07305)	91.4%	6.9%	1.7%
Jersey City (07306)	88.4%	7.1%	4.5%
Jersey City (07307)	91.2%	6.6%	2.1%
Jersey City (07310)	93.3%	2.7%	4.0%
Union City	88.4%	8.9%	2.6%

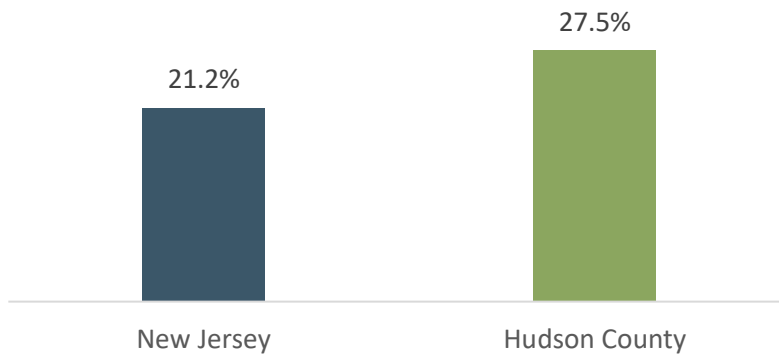
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 122. Percentage of Children That Live in a Household Headed by a Single Parent by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020

Figure 123. Severe Housing Problems, by State and County, 2014-2018

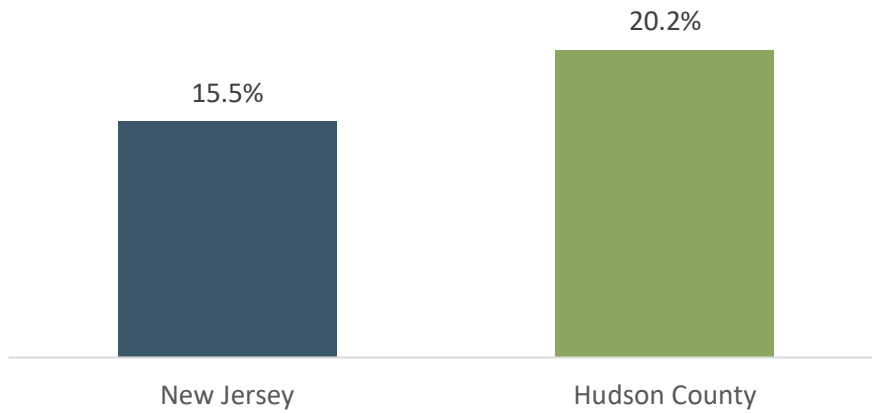


DATA SOURCE: U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy (CHAS) data, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2014-2018

NOTE: Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.

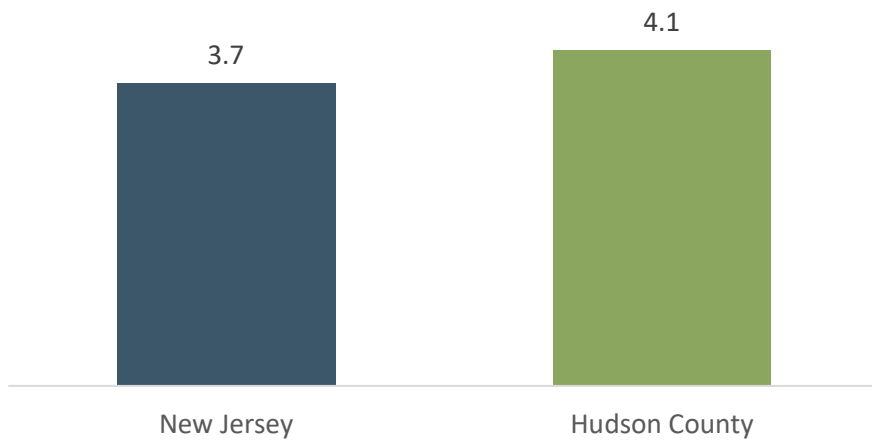
Overall Health

Figure 124. Percent Poor or Fair Health, by State and County, 2018



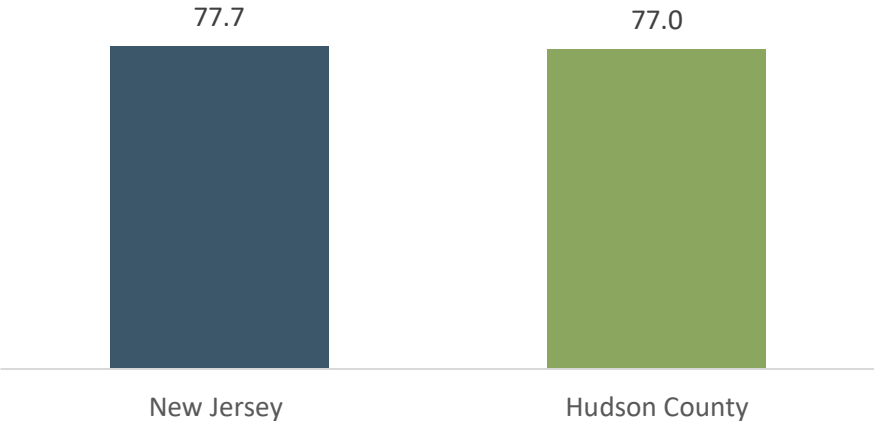
DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018

Figure 125. Poor Physical Health Days by State and County, 2018



DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018

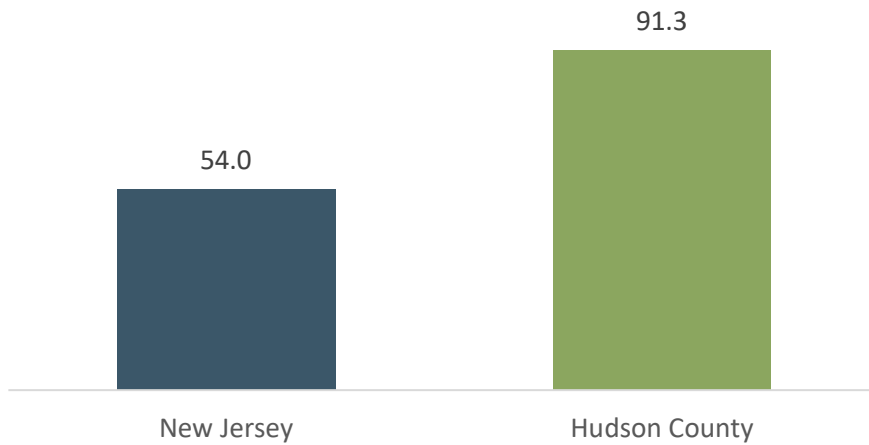
Figure 126. Life Expectancy by State and County, 2020



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health 2020

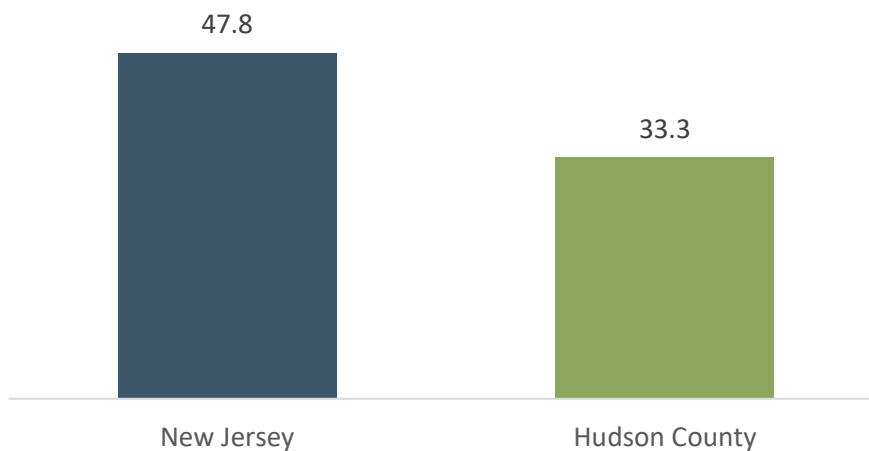
Community Health Issues: Unintentional Injury

Figure 127. ED Visits Due to Unintentional Injury (Age Adjusted) per 10,000, by State and County, 2016-2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

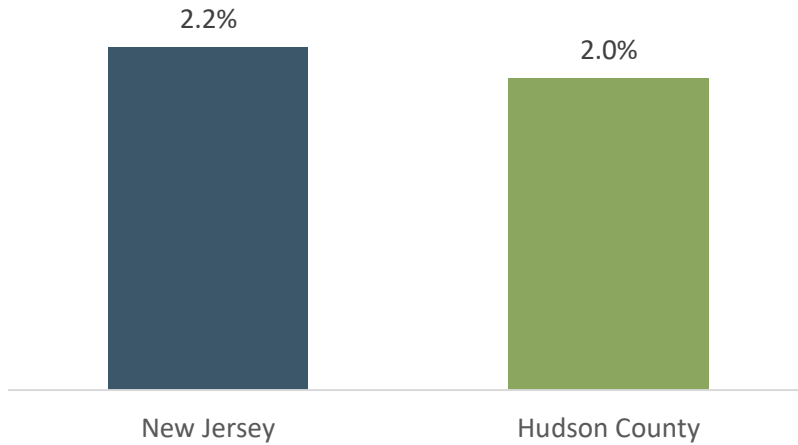
Figure 128. Unintentional Injury Deaths per 100,000 Population, by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Environmental Health

Figure 129. Percent of Children Aged 1 -5 Years With Elevated Blood Lead Level ($\geq 5\text{mcg/dL}$), by State and County, 2019



DATA SOURCE: Childhood Lead Exposure in New Jersey Annual Report, New Jersey Department of Public Health, Office of Local Public Health, Childhood Lead Program, State Fiscal Year 2019

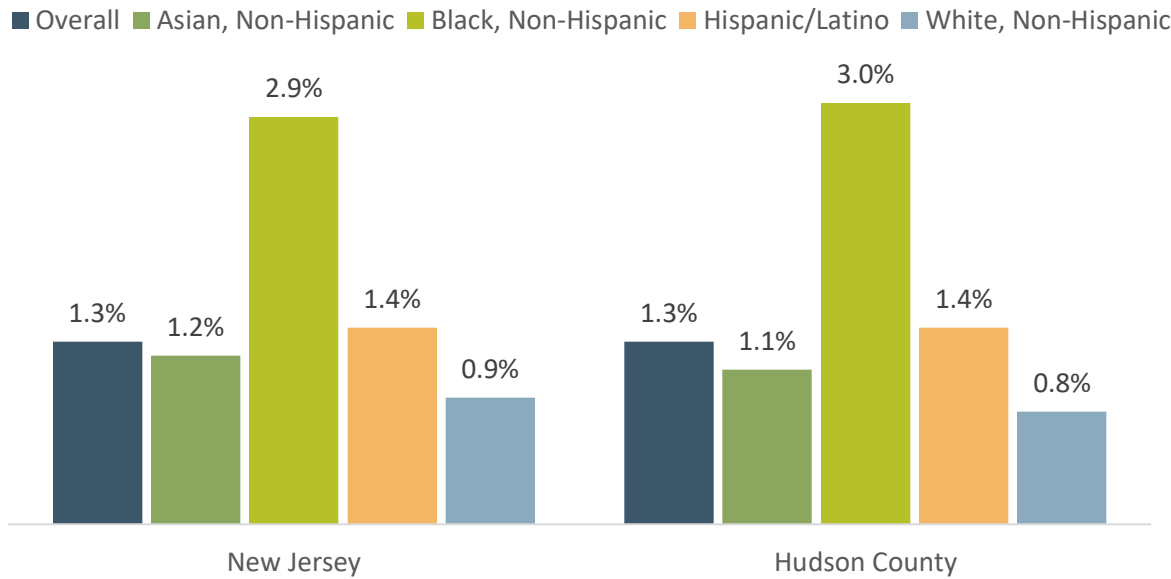
Table 25. Drinking water violations by County, 2020

	Violation?	Z-score
Hudson County	Yes	0.55

DATA SOURCE: Environmental Protection Agency, Safe Drinking Water Information System, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2020

Maternal and Infant Health

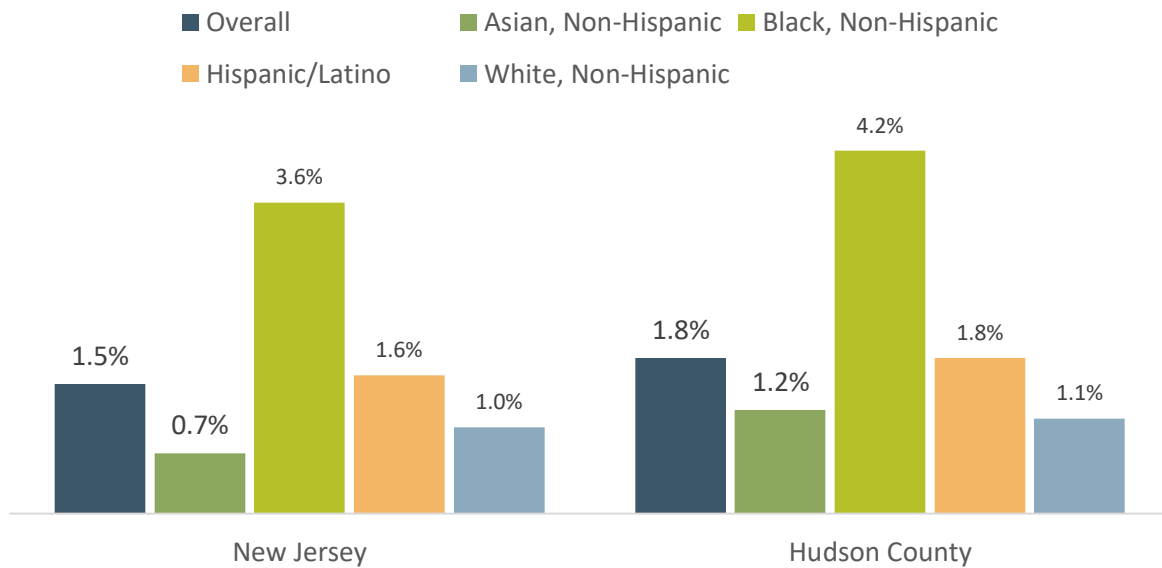
Figure 130. Percent Very Low Birth Weight Births by Race/Ethnicity, by State and County, 2016-2020



DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018

NOTE: Very low birth weight is defined as less than 1,500 grams

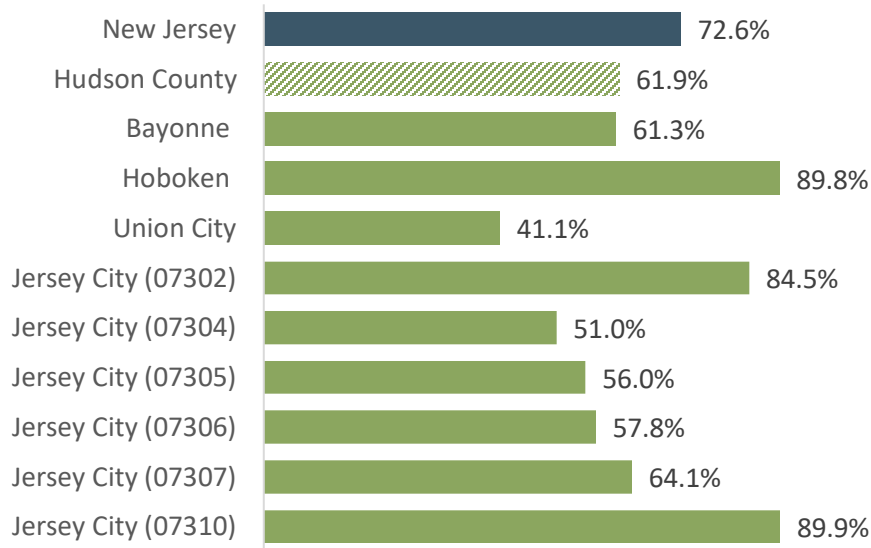
Figure 131. Percent Births with No Prenatal Care Overall by Race/Ethnicity, by State, 2016-2020



DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Access to care

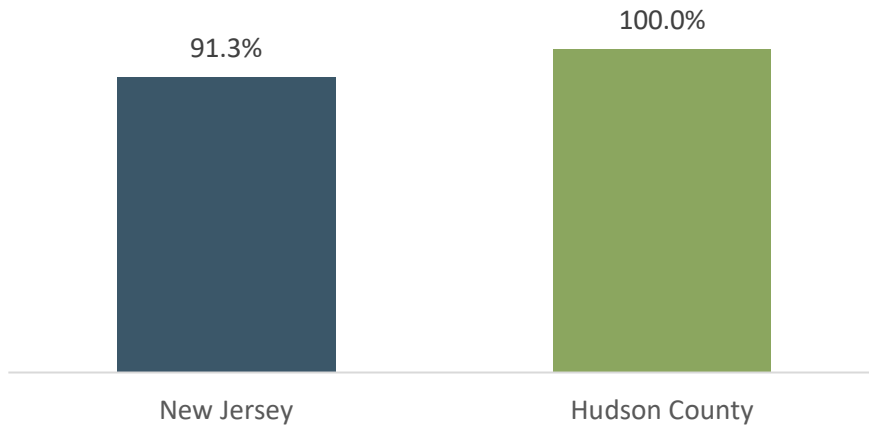
Figure 132. Population with Private Insurance, by State, County and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Healthy Living and Food Access

Figure 133. Population with Adequate Access to Location for Physical Activity, by State and County, 2010 and 2021



DATA SOURCE: ESRI & U.S. Census Tigerline Files, Business Analyst, Delorme map data, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2010 & 2021

Appendix G- Hospitalization Data

Figure 134. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

Year	Age	Count of Patients Treated & Released		Rate per 100,000 Population	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	0-17	690,506	51,760	334.4	394.6
	18-44	1,259,377	103,514	416.8	332.5
	45-64	757,159	57,306	302.2	351.9
	65+	450,704	26,472	320.4	335.2
	All Ages	3,157,746	239,052	350.9	349.3
2018	0-17	673,100	55,046	343.2	384.5
	18-44	1,217,047	106,138	394.5	355.1
	45-64	748,821	60,686	301.1	371.5
	65+	463,456	29,233	322.9	363.9
	All Ages	3,102,424	251,103	345.9	366.2
2019	0-17	658,207	54,165	334.6	367.6
	18-44	1,219,299	105,103	392.2	343.3
	45-64	760,293	61,161	305.8	371.2
	65+	489,485	30,209	330.6	363.8
	All Ages	3,127,284	250,638	345.8	357.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 135. Emergency Room Treat & Release Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	142,919	69.2
	18-44	242,892	80.4
	45-64	139,427	55.6
	65+	82,129	58.4
	All Ages	607,367	67.5
2018	0-17	145,643	74.3
	18-44	239,710	77.7
	45-64	139,051	55.9
	65+	82,293	57.3
	All Ages	606,697	67.6
2019	0-17	142,215	72.3
	18-44	238,051	76.6
	45-64	141,147	56.8
	65+	88,005	59.0
	All Ages	609,418	67.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 136. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Hudson County Resident Patients Treated at Jersey City Medical Center by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	14,408	109.8
	18-44	31,198	100.2
	45-64	16,790	103.1
	65+	6,004	76.0
	All Ages	68,400	100.0
2018	0-17	17,482	122.1
	18-44	34,556	115.6
	45-64	19,045	116.6
	65+	7,220	89.9
	All Ages	78,303	114.2
2019	0-17	17,702	120.1
	18-44	33,980	111.0
	45-64	19,291	117.1
	65+	7,159	86.2
	All Ages	78,132	111.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 137. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	22,166	379.0
	18-44	48,947	400.8
	45-64	24,888	404.2
	65+	9,897	351.7
	All Ages	105,898	391.8
2018	0-17	23,229	398.0
	18-44	48,661	399.7
	45-64	25,856	419.4
	65+	10,520	366.9
	All Ages	108,266	400.3
2019	0-17	22,870	380.0
	18-44	47,095	375.8
	45-64	26,442	424.4
	65+	10,618	356.2
	All Ages	107,025	385.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 138. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	12,194	208.5
	18-44	26,549	217.4
	45-64	13,755	223.4
	65+	5,201	184.8
	All Ages	57,699	213.4
2018	0-17	13,137	225.1
	18-44	26,700	219.3
	45-64	14,305	232.1
	65+	5,740	200.2
	All Ages	59,882	221.4
2019	0-17	13,196	219.3
	18-44	26,026	207.7
	45-64	14,642	235.0
	65+	5,733	192.3
	All Ages	59,597	214.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 139. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count		Rate per 100,000 Population	
		New Jersey Residents	Hudson County	New Jersey Residents	Hudson County
2017	American Indian or Alaska Native	6,530	498	201.1	111.9
	Asian	80,692	9,697	92.2	92.8
	Black or African American	780,645	48,599	628.0	555.3
	Hawaiian & Pacific Islander	3,949	343	985.5	864.0
	Other Race	610,721	90,795	935.3	902.1
	Two or More Races	11,014	286	38.6	8.8
	White	1,563,896	88,834	264.8	250.8
	All Race/Ethnicities	3,057,447	239,052	340.0	-
2018	American Indian or Alaska Native	6,035	467	185.4	105.2
	Asian	80,655	9,231	90.3	85.7
	Black or African American	755,704	50,013	608.9	574.7
	Hawaiian & Pacific Islander	8,405	305	2,031.7	734.9
	Other Race	633,209	97,951	961.3	977.2
	Two or More Races	11,395	303	39.5	9.3
	White	1,509,245	92,833	258.0	262.7
	All Race/Ethnicities	3,004,648	251,103	335.0	-
2019	American Indian or Alaska Native	5,360	417	164.0	92.8
	Asian	81,556	9,822	89.8	87.4
	Black or African American	754,534	47,955	600.1	549.6
	Hawaiian & Pacific Islander	4,203	280	1,005.3	689.7
	Other Race	683,104	107,983	1,012.6	1,049.7
	Two or More Races	11,025	406	37.5	12.2
	White	1,486,019	83,775	253.0	232.3
	All Race/Ethnicities	3,025,801	250,638	334.6	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 140. Emergency Room Treat & Release Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000
2017	American Indian or Alaska Native	608	18.7
	Asian	17,289	19.8
	Black or African American	197,472	158.9
	Hawaiian & Pacific Islander	577	144.0
	Other Race	147,525	225.9
	Two or More Races	1,571	5.5
	White	227,264	38.5
	All Race/Ethnicities	592,306	-
2018	American Indian or Alaska Native	548	16.8
	Asian	17,617	19.7
	Black or African American	198,391	159.8
	Hawaiian & Pacific Islander	474	114.6
	Other Race	153,992	233.8
	Two or More Races	1,745	6.0
	White	219,439	37.5
	All Race/Ethnicities	592,206	-
2019	American Indian or Alaska Native	593	18.1
	Asian	18,706	20.6
	Black or African American	195,413	155.4
	Hawaiian & Pacific Islander	480	114.8
	Other Race	162,149	240.4
	Two or More Races	1,946	6.6
	White	215,469	36.7
	All Race/Ethnicities	594,756	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 141. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	177	133.9
	Asian	6,648	93.5
	Black or African American	40,238	621.5
	Hawaiian & Pacific Islander	83	477.0
	Other Race	36,029	1,040.2
	Two or More Races	122	9.1
	White	22,601	266.2
	All Race/Ethnicities	105,898	391.8
2018	American Indian or Alaska Native	152	116.3
	Asian	6,441	88.6
	Black or African American	40,906	638.5
	Hawaiian & Pacific Islander	100	502.5
	Other Race	38,693	1,135.2
	Two or More Races	93	7.0
	White	21,881	258.2
	All Race/Ethnicities	108,266	400.3
2019	American Indian or Alaska Native	144	110.5
	Asian	6,844	90.3
	Black or African American	39,118	611.3
	Hawaiian & Pacific Islander	87	467.7
	Other Race	40,136	1,147.5
	Two or More Races	148	10.8
	White	20,548	234.5
	All Race/Ethnicities	107,025	385.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 142. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	64	48.4
	Asian	4,227	59.5
	Black or African American	27,453	424
	Hawaiian & Pacific Islander	16	92
	Other Race	11,071	319.6
	Two or More Races	93	6.9
	White	14,775	174
	All Race/Ethnicities	57,699	213.4
2018	American Indian or Alaska Native	61	46.7
	Asian	4,036	55.5
	Black or African American	28,045	437.7
	Hawaiian & Pacific Islander	14	70.4
	Other Race	13,822	405.5
	Two or More Races	78	5.8
	White	13,826	163.2
	All Race/Ethnicities	59,882	221.4
2019	American Indian or Alaska Native	61	46.8
	Asian	4,290	56.6
	Black or African American	26,718	417.5
	Hawaiian & Pacific Islander	21	112.9
	Other Race	15,321	438
	Two or More Races	100	7.3
	White	13,086	149.3
	All Race/Ethnicities	59,597	214.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 143. Emergency Room Treat & Release Counts and Rates for Behavioral Health per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

Year	Age	Count		Rate per 1,000	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	0-17	24,837	1,732	12.0	13.2
	18-44	91,990	8,601	30.4	27.6
	45-64	55,496	6,315	22.1	38.8
	65+	10,688	1,105	7.6	14.0
	All Ages	183,011	17,753	20.3	25.9
2018	0-17	26,241	1,965	13.4	13.7
	18-44	90,808	9,026	29.4	30.2
	45-64	55,715	6,442	22.4	39.4
	65+	11,055	1,177	7.7	14.7
	All Ages	183,819	18,610	20.5	27.1
2019	0-17	25,172	2,027	12.8	13.8
	18-44	90,172	9,340	29.0	30.5
	45-64	54,046	6,489	21.7	39.4
	65+	11,851	1,149	8.0	13.8
	All Ages	181,241	19,005	20.0	27.1

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 144. Emergency Room Treat & Release Counts and Rates for Behavioral Health per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Race, 2017-2019

Year	Race/Ethnicity	Count		Rate per 1,000	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	American Indian or Alaska Native	334	32	10.3	7.2
	Asian	3,380	401	3.9	3.8
	Black or African American	44,153	3,965	35.5	45.3
	Hawaiian & Pacific Islander	187	14	46.7	35.3
	Other Race	22,769	5,104	34.9	50.7
	Two or More Races	490	9	1.7	0.3
	White	106,929	7,802	18.1	22.0
	All Race/Ethnicities	178,242	17,327	19.8	25.3
2018	American Indian or Alaska Native	350	18	10.8	4.1
	Asian	3,497	401	3.9	3.7
	Black or African American	44,282	4111	35.7	47.2
	Hawaiian & Pacific Islander	187	14	45.2	33.7
	Other Race	24,682	5832	37.5	58.2
	Two or More Races	651	8	2.3	0.2
	White	104,601	7,738	17.9	21.9
	All Race/Ethnicities	178,250	18,122	19.9	26.4
2019	American Indian or Alaska Native	322	29	9.8	6.5
	Asian	3,466	397	3.8	3.5
	Black or African American	43,789	4,140	34.8	47.4
	Hawaiian & Pacific Islander	187	14	44.7	34.5
	Other Race	27,076	6,749	40.1	65.6
	Two or More Races	609	19	2.1	0.6
	White	99,593	6,999	17.0	19.4
	All Race/Ethnicities	175,042	18,347	19.4	26.2

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 145. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

Year	Age	Count		Rate per 1,000 Population	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	0-17	131,591	11,463	63.7	87.4
	18-44	231,158	18,870	76.5	60.6
	45-64	226,349	15,103	90.3	92.7
	65+	363,285	20,289	258.2	256.9
	All Ages	952,383	65,725	105.8	96.0
2018	0-17	130,739	11,682	66.7	81.6
	18-44	225,360	18,841	73.0	63.0
	45-64	221,118	15,200	88.9	93.0
	65+	364,459	20,160	254.0	251.0
	All Ages	941,676	65,883	105.0	96.1
2019	0-17	127,024	10,929	64.6	74.2
	18-44	218,270	17,589	70.2	57.5
	45-64	215,320	14,098	86.6	85.6
	65+	368,288	19,428	248.7	234.0
	All Ages	928,902	62,044	102.7	88.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 146. Inpatient Discharge Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	32,923	15.9
	18-44	50,878	16.8
	45-64	44,240	17.7
	65+	68,104	48.4
	All Ages	196,145	21.8
2018	0-17	32,768	16.7
	18-44	49,365	16.0
	45-64	43,076	17.3
	65+	67,477	47.0
	All Ages	192,686	21.5
2019	0-17	32,107	16.3
	18-44	48,316	15.5
	45-64	41,662	16.8
	65+	67,539	45.6
	All Ages	189,624	21.0

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 147. Inpatient Discharge Counts and Rates per 1,000 Population of Hudson County Resident Patients Treated at Jersey City Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	2,291	17.5
	18-44	4,906	15.8
	45-64	4,219	25.9
	65+	3,898	49.4
	All Ages	15,314	22.4
2018	0-17	2,142	15.0
	18-44	4,571	15.3
	45-64	3,851	23.6
	65+	3,853	48.0
	All Ages	14,417	21.0
2019	0-17	2,043	13.9
	18-44	4,307	14.1
	45-64	3,619	22.0
	65+	3,771	45.4
	All Ages	13,740	19.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 148. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	4,801	82.1
	18-44	8,409	68.9
	45-64	6,755	109.7
	65+	7,134	253.5
	All Ages	27,099	100.2
2018	0-17	4,821	82.6
	18-44	8,380	68.8
	45-64	6,592	106.9
	65+	7,106	247.8
	All Ages	26,899	99.5
2019	0-17	4,583	76.1
	18-44	7,729	61.7
	45-64	6,186	99.3
	65+	6,918	232.1
	All Ages	25,416	91.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 149. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	1,885	32.2
	18-44	3,916	32.1
	45-64	3,468	56.3
	65+	3,336	118.5
	All Ages	12,605	46.6
2018	0-17	1,750	30
	18-44	3,571	29.3
	45-64	3,095	50.2
	65+	3,277	114.3
	All Ages	11,693	43.2
2019	0-17	1,620	26.9
	18-44	3,330	26.6
	45-64	2,861	45.9
	65+	3,211	107.7
	All Ages	11,022	39.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 150. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count		Rate per 1,000 Population	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	American Indian or Alaska Native	1913	153	58.9	34.4
	Asian	40,158	4,789	45.9	45.9
	Black or African American	164,073	10,493	132.0	119.9
	Hawaiian & Pacific Islander	1438	182	358.9	458.40
	Other Race	135,193	21,802	207.0	216.60
	Two or More Races	1733	62	6.1	1.9
	White	607,875	28,244	102.9	79.7
	All Race/Ethnicities	952,383	65,725	268.3	-
2018	American Indian or Alaska Native	1689	165	51.9	37.2
	Asian	40,286	5,021	45.1	46.6
	Black or African American	160,752	9,925	129.5	114
	Hawaiian & Pacific Islander	2146	121	518.7	291.60
	Other Race	146,436	23,138	222.3	230.8
	Two or More Races	1929	52	6.7	1.6
	White	588,438	27,461	100.6	77.7
	All Race/Ethnicities	941,676	65,883	267.7	-
2019	American Indian or Alaska Native	1559	171	47.7	38.1
	Asian	38,291	4,602	42.2	41
	Black or African American	156,678	9,286	124.6	106.4
	Hawaiian & Pacific Islander	1442	94	344.9	231.5
	Other Race	152,844	23,016	226.6	223.7
	Two or More Races	1767	79	6.0	2.4
	White	576,321	24,796	98.1	68.8
	All Race/Ethnicities	928,902	62,044	262.7	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System 2021

Figure 151. Inpatient Discharge Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000
2017	American Indian or Alaska Native	207	6.4
	Asian	8,753	10.0
	Black or African American	45,498	36.6
	Hawaiian & Pacific Islander	188	46.9
	Other Race	33,999	52.1
	Two or More Races	255	0.9
	White	107,245	18.2
	All Race/Ethnicities	196,145	55.2
2018	American Indian or Alaska Native	181	5.6
	Asian	8,850	9.9
	Black or African American	45,635	36.8
	Hawaiian & Pacific Islander	199	48.1
	Other Race	34,880	53.0
	Two or More Races	250	0.9
	White	102,691	17.6
	All Race/Ethnicities	192,686	54.8
2019	American Indian or Alaska Native	244	7.5
	Asian	8,642	9.5
	Black or African American	44,186	35.1
	Hawaiian & Pacific Islander	200	47.8
	Other Race	34,415	51.0
	Two or More Races	339	1.2
	White	101,598	17.3
	All Race/Ethnicities	189,624	53.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 152. Inpatient Discharge Counts and Rates per 1,000 Population of Hudson County Resident Patients Treated at Jersey City Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	26	5.8
	Asian	1,523	14.6
	Black or African American	5,454	62.3
	Hawaiian & Pacific Islander	-	20.2
	Other Race	3,325	33.0
	Two or More Races	11	0.3
	White	4,967	14.0
	All Race/Ethnicities	15,314	-
2018	American Indian or Alaska Native	15	3.4
	Asian	1,468	13.6
	Black or African American	4,872	56.0
	Hawaiian & Pacific Islander	-	14.5
	Other Race	3,738	37.3
	Two or More Races	10	0.3
	White	4,308	12.2
	All Race/Ethnicities	14,417	-
2019	American Indian or Alaska Native	25	5.6
	Asian	1,433	12.8
	Black or African American	4,498	51.5
	Hawaiian & Pacific Islander	-	14.8
	Other Race	3,938	38.3
	Two or More Races	14	0.4
	White	3,826	10.6
	All Race/Ethnicities	13,740	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 153. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	69	52.2
	Asian	2,997	42.2
	Black or African American	8,650	133.6
	Hawaiian & Pacific Islander	53	304.6
	Other Race	8,180	236.2
	Two or More Races	17	1.3
	White	7,133	84.0
	All Race/Ethnicities	27,099	100.2
2018	American Indian or Alaska Native	66	50.5
	Asian	3,218	44.3
	Black or African American	8,172	127.6
	Hawaiian & Pacific Islander	53	266.3
	Other Race	8,809	258.4
	Two or More Races	22	1.6
	White	6,559	77.4
	All Race/Ethnicities	26,899	99.5
2019	American Indian or Alaska Native	78	59.9
	Asian	2,948	38.9
	Black or African American	7,667	119.8
	Hawaiian & Pacific Islander	41	220.4
	Other Race	8,612	246.2
	Two or More Races	25	1.8
	White	6,045	69.0
	All Race/Ethnicities	25,416	91.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 154. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	24	18.2
	Asian	1,375	19.3
	Black or African American	5,162	79.7
	Hawaiian & Pacific Islander	-	40.2
	Other Race	2,543	73.4
	Two or More Races	-	0.4
	White	3,488	41.1
	All Race/Ethnicities	12,605	46.6
2018	American Indian or Alaska Native	15	11.5
	Asian	1,320	18.2
	Black or African American	4,574	71.4
	Hawaiian & Pacific Islander	-	25.1
	Other Race	2,874	84.3
	Two or More Races	-	0.7
	White	2,896	34.2
	All Race/Ethnicities	11,693	43.2
2019	American Indian or Alaska Native	23	17.7
	Asian	1,288	17
	Black or African American	4,256	66.5
	Hawaiian & Pacific Islander	-	32.3
	Other Race	2,908	83.1
	Two or More Races	-	0.6
	White	2,533	28.9
	All Race/Ethnicities	11,022	39.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 155. Hospital Admission Rates per 1,000 Population, by Race/Ethnicity, New Jersey and Jersey City Medical Center, 2019

		Admission Rate per 1,000			
		Total Overall	Acute	Chronic	Diabetic
New Jersey	Asian	2.6	0.8	1.8	0.4
	Black	16.7	3.0	13.7	4.1
	Hispanic	5.4	1.4	4.0	1.5
	White	9.6	2.9	6.7	1.5
	All Race/Ethnicities	10.4	2.8	7.7	2.0
Jersey City Medical Center	Asian	3.2	1.0	2.2	0.6
	Black	17.8	3.0	14.8	4.6
	Hispanic	4.8	1.2	3.6	1.3
	White	6.3	1.5	4.8	1.3
	All Race/Ethnicities	10.5	2.2	8.2	2.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 156. Hospital Admission Rates per 1,000 Population by Reason for Admission, by Race/Ethnicity, New Jersey and Jersey City Medical Center, 2019

		Admission Rate per 1,000			
		Total Overall	Cardiac	Mental Health	Substance Use
New Jersey	Asian	5.2	3.9	1.0	0.3
	Black	26.1	16.6	6.7	2.7
	Hispanic	10.3	6.2	2.6	1.5
	White	17.2	12.2	3.2	1.9
	All Race/Ethnicities	18.6	12.5	4.0	2.1
Jersey City Medical Center	Asian	28.4	3.9	0.9	0.4
	Black	105.5	17.6	8.2	3.9
	Hispanic	43.9	5.3	2.5	1.3
	White	44.0	6.1	4.0	2.5
	All Race/Ethnicities	76.2	10.8	5.4	2.9

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 157. Hospital Admission and Emergency Department Visit Rates per 1,000 Population, by Age and Race/Ethnicity, New Jersey and Jersey City Medical Center, 2019

	Admission Rate per 1,000 Population						Emergency Department Visits per 1,000 Population				
	Age	Asian	Black	Hispanic	White	All Race/Ethnicities	Asian	Black	Hispanic	White	All Race/Ethnicities
New Jersey	All	5.2	26.1	10.3	17.2	18.6	108.8	682.4	430.2	271.2	403
	Under 18	0.4	1.9	1.4	1.1	1.6	99.8	477.1	497.4	181.7	344
	18 to 64	3.5	26.5	9.3	12	15	91.4	760.5	392.4	248	396.6
	65+	25.3	73.3	46.6	48.7	54.8	233.8	698.1	548.2	428.5	505.8
Jersey City Medical Center	All	28.4	105.5	43.9	44.0	76.2	109.4	690.3	282.4	173.4	447.0
	Under 18	3.9	16.4	10.4	5.5	14.2	100.5	433.6	260.8	113.6	390.2
	18 to 64	24.4	111.4	43.5	34.9	72.6	93.9	791.9	274.1	169.3	447.6
	65+	113.2	275.2	136.4	135.4	223.6	258.6	697.2	402.7	267.2	558.1

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 158. Inpatient Discharge Counts and Rates per 1,000 Diagnosed with Mental Diseases and Disorders & Alcohol/Drug Use or Induced Mental Disorder Treated in New Jersey, by County of Residence, 2017-2019

Year	Count		Rate per 1,000 Population	
	New Jersey	Hudson County	New Jersey	Hudson County
2017	73,005	5,658	8.1	8.3
2018	69,282	5,643	7.7	8.2
2019	65,610	5,439	7.3	7.8

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 159. Inpatient Discharge Counts and Rates per 1,000 Diagnosed with Diseases and Disorders of the Circulatory System Treated in New Jersey, by County of Residence, 2017-2019

Year	Count		Rate per 1,000 Population	
	New Jersey	Hudson County	New Jersey	Mercer County
2017	126,968	7,598	14.1	11.1
2018	125,886	7,521	14.0	11
2019	126,198	7,411	14.0	10.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 160. Inpatient Discharge Counts and Rates per 1,000, Residents of Hudson County Treated at Jersey City Medical Center, by Major Diagnostic Category, 2017-2019

Major Diagnostic Category	Count			Rate per 1,000 Population		
	2017	2018	2019	2017	2018	2019
Mental Diseases and Disorders & Alcohol/Drug Use or Induced Mental Disorder	1,302	1,313	1,237	1.9	1.9	1.8
Diseases and Disorders of the Circulatory System	1,990	1,826	1,858	2.9	2.7	2.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Appendix H- Cancer Data

Table 26. CANCER INCIDENCE RATE REPORT: CANCER PATIENT ORIGIN - HUDSON COUNTY 2020

Almost eighty percent of JCMC’s cancer inpatients and 65.8% of cancer outpatients resided in the Primary Service Area. In total, 91.1% of inpatients and 88.7% of outpatients resided in Hudson County. Jersey City (07305 and 07304) represent the largest segment of JCMC’s inpatient cancer patients. Similarly, Jersey City (07305 and 07306) represent the largest segments of JCMC’s outpatient cancer patients. The health factors and outcomes explored in the CHNA bear relevance to the oncology services and its review of specific cancer needs for the community.

CANCER PATIENT ORIGIN	2020 JCMC IP PATIENTS	%	2020 JCMC OP PATIENTS	%
Hudson County	1,000	91.1%	449	88.7%
Primary Service Area	800	72.9%	333	65.8%
Secondary Service Area	177	16.1%	82	16.2%
Out of Service Area (NJ)	103	9.4%	90	17.8%
Out of State	18	1.6%	1	0.2%
TOTAL	1,098	100.0%	506	100.0%
Jersey City (07305)	334	30.4%	115	22.7%
Jersey City (07304)	193	17.6%		
Jersey City (07306)			90	17.8%

Source; Decision Support; IP volume includes cases with ICD10 principal or secondary codes C00 thru D49.9 (Neoplasms); OP volume includes cases with ICD10 principal or secondary codes Z51.0 or Z51.11 (Chemo and Radiation Therapy).

Table 27. CANCER INCIDENCE RATE REPORT: HUDSON COUNTY 2013-2017

INCIDENCE RATE REPORT FOR HUDSON COUNTY 2013-2017				
Cancer Site	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trend
All Cancer Sites	403.5	2607	falling	-1.2
Bladder	17.6	108	falling	-1.6
Brain & ONS	5.7	38	*	*
Breast	111.1	389	stable	0.5
Cervix	9.4	33	falling	-2.2
Colon & Rectum	40.3	259	falling	-2.9
Esophagus	3.2	20	falling	-2.8
Kidney & Renal Pelvis	12.8	84	stable	0.5
Leukemia	11.5	72	stable	0
Liver & Bile Duct	8.7	57	rising	2.6
Lung & Bronchus	43.7	273	falling	-2.5
Melanoma of the Skin	8.2	53	stable	-0.7
Non-Hodgkin Lymphoma	17.1	110	stable	-0.4
Oral Cavity & Pharynx	8.3	55	stable	-1.3
Ovary	11.7	41	stable	-1.1
Pancreas	14	87	rising	2.1
Prostate	112.7	319	falling	-3.9
Stomach	9.5	60	falling	-1.7
Thyroid	15.1	107	stable	-0.1
Uterus (Corpus & Uterus, NOS)	26.8	98	stable	0.6

The source for D2 and following tables D3, D4, D5 and D6 is: <https://statecancerprofiles.cancer.gov>

Table 28. CANCER INCIDENCE DETAILED RATE REPORT: HUDSON COUNTY 2013-2017 SELECT CANCER SITES: RISING INCIDENCE RATES

		Liver & Bile Duct	Pancreas
INCIDENCE RATE REPORT FOR HUDSON COUNTY 2013-2017 All Races (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.7	14
	Average Annual Count	57	87
	Recent Trend	rising	rising
	Recent 5-Year Trend in Incidence Rates	2.6	2.1
White Non-Hispanic, All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.3	15
	Average Annual Count	19	34
	Recent Trend	stable	rising
	Recent 5-Year Trend in Incidence Rates	2.5	1.9
Black (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.2	15.8
	Average Annual Count	8	14
	Recent Trend	stable	stable
	Recent 5-Year Trend in Incidence Rates	2.1	2.9
Asian or Pacific Islander (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	6.1	9.4
	Average Annual Count	5	6
	Recent Trend	stable	stable
	Recent 5-Year Trend in Incidence Rates	-1.7	4.8
Hispanic (any race), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.8	12.3
	Average Annual Count	24	32
	Recent Trend	rising	stable
	Recent 5-Year Trend in Incidence Rates	3.1	2.2
MALES	Age-Adjusted Incidence Rate - cases per 100,000	14	15.1
	Average Annual Count	41	40
	Recent Trend	rising	rising
	Recent 5-Year Trend in Incidence Rates	2.5	2.4
FEMALES	Age-Adjusted Incidence Rate - cases per 100,000	4.5	13.2
	Average Annual Count	16	47
	Recent Trend	stable	rising
	Recent 5-Year Trend in Incidence Rates	2.4	1.9

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).

Table 29. APPENDIX D4: CANCER MORTALITY RATE REPORT: HUDSON COUNTY 2014-2018

MORTALITY RATE REPORT: HUDSON COUNTY 2014-2018					
Cancer Site	Met Healthy People Objective of ***?	Age-Adjusted Mortality Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trend in Mortality Rates
All Cancer Sites	***	129.4	819	falling	-2.5
Bladder	***	3.9	24	stable	0.5
Brain & ONS	***	2.7	18	*	*
Breast	***	18.2	66	falling	-2.4
Cervix	***	1.8	7	falling	-4.2
Colon & Rectum	***	14	89	falling	-3
Esophagus	***	2.9	19	falling	-2.3
Kidney & Renal Pelvis	***	2.8	18	stable	-0.9
Leukemia	***	4.1	26	falling	-2.4
Liver & Bile Duct	***	6	39	stable	0.5
Lung & Bronchus	***	26.8	168	falling	-3.1
Melanoma of the Skin	***	0.9	6	falling	-2.1
Non-Hodgkin Lymphoma	***	4.1	26	falling	-3.8
Oral Cavity & Pharynx	***	1.5	10	falling	-4
Ovary	***	5.7	21	falling	-2.1
Pancreas	***	10.8	67	rising	6
Prostate	***	15.7	37	falling	-3.8
Stomach	***	4.3	27	falling	-2.2
Thyroid	***	*	3 or fewer	*	*
Uterus (Corpus & Uterus, NOS)	***	6	22	stable	0.3

*** No Healthy People 2020 Objective for this cancer.

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area- sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).

Table 30. CANCER MORTALITY DETAILED RATE REPORT (Highest Volume): ESSEX COUNTY 2014-2018

		Liver & Bile Duct
MORTALITY RATE REPORT FOR ESSEX COUNTY 2014-2018 All Races (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	6.2
	Average Annual Count	55
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.2
White Non-Hispanic, All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	4.3
	Average Annual Count	16
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	0.3
Black (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	8.9
	Average Annual Count	31
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.8
Asian or Pacific Islander (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	*
	Average Annual Count	3 or fewer
	Recent Trend	*
	Recent 5-Year Trend in Death Rates	*
Hispanic (any race), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	5.1
	Average Annual Count	6
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	1.8
MALES	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	9.7
	Average Annual Count	37
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.2
FEMALES	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	3.7
	Average Annual Count	19
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	0.9

*** No Healthy People 2020 Objective for this cancer.

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).

Table 31. CANCER INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
All Cancer Sites: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	485.9	51,689	falling	-0.8
US (SEER+NPCR)	448.7	1,673,102	falling	-1
Cape May County	564.6	881	stable	-0.2
Salem County	554.1	462	stable	0
Gloucester County	541.6	1,853	stable	-0.2
Burlington County	527.8	2,956	falling	-0.4
Camden County	524.6	3,123	falling	-0.4
Monmouth County	523.2	4,160	stable	0.4
Ocean County	521.2	4,511	falling	-0.6
Cumberland County	512	895	stable	0.1
Sussex County	510.3	932	falling	-0.8
Warren County	506.4	706	falling	-0.8
Mercer County	503.9	2,138	falling	-0.6
Atlantic County	495.8	1,699	falling	-0.8
Morris County	487.9	3,030	falling	-0.9
Hunterdon County	475.1	794	stable	-0.4
Bergen County	472.4	5,571	falling	-1
Somerset County	463.3	1,827	falling	-0.8
Essex County	462.1	3,930	falling	-0.7
Middlesex County	460.8	4,293	falling	-0.9
Union County	453.7	2,802	falling	-1.2
Passaic County	451.6	2,510	falling	-0.8
Hudson County	403.5	2,607	falling	-1.2
Bladder: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	23.1	2,487	falling	-1.1
US (SEER+NPCR)	20	74,787	falling	-1.9
Cape May County	30.9	51	stable	-0.3
Warren County	27.2	39	stable	-0.4
Gloucester County	27.1	90	stable	0
Atlantic County	26.8	93	stable	-0.6
Salem County	26.5	23	stable	0.6
Burlington County	26.5	151	stable	-0.2
Sussex County	25.9	48	stable	0

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Hunterdon County	25.9	43	stable	0.5
Monmouth County	25.5	206	stable	-0.3
Camden County	25	148	stable	-0.8
Cumberland County	25	43	stable	-0.7
Morris County	24.2	152	falling	-1.5
Ocean County	23.9	231	falling	-2.2
Middlesex County	22.8	211	falling	-1
Bergen County	22.6	277	falling	-1.6
Passaic County	22.2	124	stable	-1
Mercer County	20.7	88	falling	-1.4
Union County	20.4	127	falling	-2
Somerset County	20.1	79	stable	-1.2
Essex County	18.4	154	falling	-1.4
Hudson County	17.6	108	falling	-1.6
Brain & ONS: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	6.8	673	*	*
US (SEER+NPCR)	6.5	22,781	*	*
Salem County	9.6	7	*	*
Warren County	9.1	12	*	*
Hunterdon County	8.6	12	*	*
Sussex County	7.9	13	*	*
Gloucester County	7.8	25	*	*
Burlington County	7.7	39	*	*
Ocean County	7.7	54	*	*
Mercer County	7.3	29	*	*
Bergen County	7.2	77	*	*
Morris County	7.2	40	*	*
Atlantic County	6.9	22	*	*
Cumberland County	6.9	11	*	*
Camden County	6.9	38	*	*
Middlesex County	6.8	60	*	*
Monmouth County	6.8	50	*	*
Passaic County	6.7	35	*	*
Somerset County	6.5	23	*	*
Cape May County	5.8	7	*	*
Hudson County	5.7	38	*	*
Union County	5.6	33	*	*

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Essex County	5.5	46	*	*
Breast: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	136.6	7,668	rising	0.5
US (SEER+NPCR)	125.9	244,411	rising	0.3
Morris County	148.1	480	stable	0
Burlington County	147	433	rising	1.3
Hunterdon County	146.2	129	stable	0.2
Monmouth County	146.2	616	stable	0.1
Gloucester County	144.3	267	stable	0.3
Somerset County	144.2	306	stable	0.1
Mercer County	141.9	316	stable	0.2
Camden County	141	450	stable	0.6
Bergen County	140.8	865	stable	0.5
Essex County	137.4	641	rising	1.9
Union County	136.7	454	stable	0
Cape May County	135.7	106	stable	-0.1
Sussex County	135.6	129	stable	-0.2
Ocean County	132.9	586	stable	-0.2
Atlantic County	131.4	238	stable	0.2
Salem County	130.6	56	stable	0.1
Middlesex County	129.7	639	stable	-0.1
Warren County	125.9	92	stable	-0.7
Passaic County	124.4	367	rising	1.1
Cumberland County	118.9	108	stable	0.6
Hudson County	111.1	389	stable	0.5
Cervix: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.7	382	falling	-1.9
US (SEER+NPCR)	7.6	12,833	stable	0.3
Cumberland County	15.3	11	stable	-1.4
Cape May County	11.7	5	stable	0.8
Salem County	10.6	3	*	*
Hudson County	9.4	33	falling	-2.2
Union County	9.3	29	stable	-0.3
Atlantic County	9.2	14	stable	-1.1
Essex County	9.2	40	falling	-3
Passaic County	8.6	23	stable	-2.1
Ocean County	8.2	27	stable	-1.5

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Camden County	8.1	23	falling	-2.7
Warren County	8	4	stable	-0.5
Somerset County	7.5	13	stable	4.7
Gloucester County	6.9	12	stable	-0.8
Middlesex County	6.9	32	stable	-1.5
Bergen County	6.8	36	stable	-0.9
Burlington County	6.4	16	stable	12.6
Morris County	6.3	18	stable	-1.1
Mercer County	6.2	12	falling	-3.9
Monmouth County	6.1	21	stable	-2.3
Sussex County	5.9	5	stable	-2.7
Hunterdon County	5.1	3	falling	-4
Colon & Rectum: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	40.8	4,342	falling	-1.6
US (SEER+NPCR)	38.4	142,225	falling	-1.4
Salem County	48.4	40	falling	-2.6
Cape May County	46.5	72	falling	-2.8
Cumberland County	46.3	80	falling	-2.5
Gloucester County	44.8	151	falling	-2.7
Burlington County	44.7	249	stable	-1
Ocean County	43.7	393	falling	-1.8
Camden County	43.7	256	falling	-2.9
Warren County	42.8	61	falling	-3
Sussex County	42.1	74	falling	-3.4
Essex County	42.1	354	stable	-0.1
Monmouth County	40.9	325	falling	-3.3
Atlantic County	40.4	138	falling	-3.6
Hudson County	40.3	259	falling	-2.9
Middlesex County	39.6	370	falling	-3
Passaic County	39.5	220	stable	-0.8
Union County	39.1	243	falling	-3.2
Bergen County	39	464	stable	1.1
Hunterdon County	37.7	62	falling	-2.6
Mercer County	37.3	158	falling	-3.3
Morris County	37.1	233	falling	-3.4
Somerset County	35.2	139	falling	-3.4

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Esophagus: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	4.3	469	falling	-1.3
US (SEER+NPCR)	4.5	17,419	falling	-1.1
Warren County	7	10	stable	-0.1
Gloucester County	6.4	23	rising	2.2
Cape May County	6.4	10	stable	1.4
Sussex County	6.1	12	stable	-1.1
Ocean County	5.7	52	stable	-0.7
Cumberland County	5.1	9	stable	-0.3
Camden County	5	31	stable	-0.8
Hunterdon County	4.7	8	stable	-1.8
Salem County	4.7	4	stable	-3.4
Morris County	4.6	30	stable	-0.4
Passaic County	4.5	25	stable	-0.3
Burlington County	4.4	25	stable	-0.9
Atlantic County	4.3	15	falling	-2.1
Monmouth County	4.3	36	falling	-2
Mercer County	4.2	18	falling	-2.8
Essex County	3.7	32	falling	-3
Union County	3.7	23	stable	-1.9
Middlesex County	3.6	34	falling	-2
Bergen County	3.2	39	falling	-1.4
Hudson County	3.2	20	falling	-2.8
Somerset County	3.2	13	stable	-1.6
Kidney & Renal Pelvis: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	16.3	1,736	rising	0.8
US (SEER+NPCR)	16.8	62,705	rising	0.6
Cumberland County	21	36	stable	-10.5
Burlington County	19.6	110	stable	1.3
Camden County	19.6	116	rising	2
Gloucester County	18.6	65	stable	0.4
Ocean County	17.8	147	rising	1.5
Mercer County	17.7	76	rising	2
Salem County	17.7	15	stable	0.2
Atlantic County	17.4	60	stable	0.2
Cape May County	17.3	26	stable	2.1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Monmouth County	16.7	133	rising	0.9
Warren County	16.5	22	stable	0.8
Bergen County	16.4	194	stable	0.5
Passaic County	15.8	88	stable	0.9
Morris County	15.7	98	stable	0.7
Middlesex County	15.7	146	stable	0
Sussex County	15.4	31	stable	-0.4
Union County	15	93	stable	0.2
Somerset County	14.6	58	stable	-0.1
Hunterdon County	13.8	23	stable	-0.7
Essex County	13.4	115	stable	0.6
Hudson County	12.8	84	stable	0.5
Leukemia: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	15.7	1,610	rising	0.8
US (SEER+NPCR)	14.2	51,227	falling	-2.1
Sussex County	19.4	32	rising	2.9
Monmouth County	17.4	134	rising	1.5
Gloucester County	17.4	58	stable	1.2
Ocean County	16.9	145	stable	0.6
Morris County	16.8	101	rising	1.2
Mercer County	16.6	68	rising	1.8
Cape May County	16.5	23	stable	-1.2
Burlington County	16.3	88	stable	0.9
Cumberland County	16.1	28	rising	1.7
Warren County	16	21	stable	0.4
Union County	15.7	93	stable	1
Bergen County	15.6	182	stable	1.3
Passaic County	15.6	83	stable	1
Somerset County	15.4	57	stable	-0.5
Middlesex County	15.4	139	stable	0.3
Camden County	15.3	88	stable	0.4
Hunterdon County	14.7	23	stable	-0.8
Essex County	14.2	117	stable	0.5
Atlantic County	13.7	45	stable	-0.2
Salem County	13.7	10	stable	-1.1
Hudson County	11.5	72	stable	0

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Liver & Bile Duct: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.8	869	rising	2.1
US (SEER+NPCR)	8.4	33,355	stable	0.4
Cumberland County	10.5	19	rising	4.8
Cape May County	9.9	17	stable	4
Camden County	9.4	60	rising	2.4
Atlantic County	9.1	32	stable	2.1
Hudson County	8.7	57	rising	2.6
Gloucester County	8.6	30	rising	2.1
Mercer County	8.4	37	stable	1.8
Ocean County	8.3	75	rising	3.2
Salem County	8.3	7	stable	-15.4
Passaic County	8.2	47	stable	1.1
Essex County	7.9	71	stable	0.8
Middlesex County	7.9	76	rising	2.5
Burlington County	7.7	45	rising	2.4
Monmouth County	7.6	64	rising	2.4
Bergen County	7.1	89	stable	1.1
Warren County	6.7	10	stable	1.9
Sussex County	6.7	13	stable	1.5
Morris County	6.6	43	rising	2.2
Union County	6.3	40	rising	1.8
Somerset County	6	25	stable	1.6
Hunterdon County	5.4	10	rising	3
Lung & Bronchus: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	55.3	5,950	falling	-1.6
US (SEER+NPCR)	58.3	221,568	falling	-2
Salem County	85.4	73	rising	2.5
Cape May County	76.3	130	stable	-0.8
Gloucester County	74.6	252	falling	-1.2
Ocean County	70.8	672	falling	-1.1
Cumberland County	69.2	123	falling	-0.8
Camden County	67.2	404	falling	-1.4
Atlantic County	64.7	226	falling	-1.9
Warren County	63.8	91	stable	-1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Sussex County	62.5	114	falling	-1.3
Burlington County	61.8	350	falling	-1
Monmouth County	59.7	482	falling	-1.5
Mercer County	56.7	242	falling	-1.5
Middlesex County	49.7	459	falling	-2.1
Bergen County	49.4	598	falling	-1.7
Hunterdon County	48.6	81	stable	-1.2
Morris County	47.7	300	falling	-2
Essex County	46.9	393	falling	-2.4
Passaic County	44.8	250	falling	-5.8
Somerset County	44	173	falling	-1.8
Hudson County	43.7	273	falling	-2.5
Union County	43.1	262	falling	-2.2
Melanoma of the Skin: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	22.2	2,335	stable	0.5
US (SEER+NPCR)	22.3	81,226	rising	1.8
Cape May County	51.3	77	rising	3.3
Hunterdon County	39.8	65	stable	1.9
Ocean County	34	283	stable	0.2
Salem County	32.4	26	stable	-16.8
Monmouth County	32.1	249	rising	1.6
Sussex County	31.9	56	rising	3.1
Gloucester County	27.2	91	stable	0.7
Atlantic County	27.1	92	rising	1.6
Morris County	26.7	164	stable	0.2
Burlington County	26.4	146	stable	0.5
Warren County	25.7	34	stable	0.1
Somerset County	24.4	97	stable	0.2
Camden County	21.7	128	stable	0.3
Mercer County	21.1	88	stable	0.4
Middlesex County	18.1	167	stable	1
Bergen County	18	212	falling	-1.3
Cumberland County	16.4	28	stable	1.3
Union County	15.7	97	stable	0.2
Passaic County	14.3	77	stable	0.2
Essex County	12.2	103	stable	-0.1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Hudson County	8.2	53	stable	-0.7
Non-Hodgkin Lymphoma: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	21.8	2,272	stable	0
US (SEER+NPCR)	19.3	70,661	falling	-1.5
Warren County	24.9	34	stable	-0.2
Monmouth County	24.3	188	stable	0
Morris County	23.7	145	stable	-0.3
Somerset County	23.7	92	stable	0.3
Sussex County	23.5	41	stable	-0.5
Atlantic County	23.2	78	stable	0
Bergen County	23.1	268	stable	0.1
Mercer County	22.6	94	stable	0
Ocean County	22.5	196	stable	0.4
Gloucester County	22.1	73	rising	0.9
Middlesex County	22.1	202	stable	-0.1
Cumberland County	22	37	stable	-0.1
Union County	21.1	129	stable	-6.5
Burlington County	21.1	117	stable	-0.5
Salem County	20.8	17	stable	-0.5
Hunterdon County	20.6	35	stable	-0.3
Camden County	20.6	122	stable	-0.4
Passaic County	20.4	109	stable	0.4
Essex County	18.4	153	stable	-0.7
Cape May County	18.3	29	stable	-0.3
Hudson County	17.1	110	stable	-0.4
Oral Cavity & Pharynx: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	11.1	1,204	rising	0.8
US (SEER+NPCR)	11.8	45,129	stable	0
Salem County	16.1	14	stable	1.2
Cape May County	14.6	23	stable	0.2
Atlantic County	14.4	51	rising	1.5
Cumberland County	14	25	rising	2.3
Monmouth County	12.9	105	rising	1
Ocean County	12.8	108	rising	1.7
Sussex County	12.7	25	stable	1.7

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Camden County	12.2	75	stable	1.2
Warren County	11.7	17	stable	2.1
Gloucester County	11.5	41	stable	0.8
Hunterdon County	11.4	21	stable	1.9
Morris County	11.4	74	rising	1.7
Burlington County	11.2	65	stable	1.3
Middlesex County	10.7	100	rising	1.6
Essex County	10.7	92	rising	8.2
Somerset County	10.5	43	stable	0.4
Passaic County	10.1	57	stable	-0.2
Bergen County	9.5	115	stable	-0.1
Mercer County	9.4	42	falling	-1.2
Union County	9	57	stable	-0.1
Hudson County	8.3	55	stable	-1.3
Ovary: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	11.8	679	falling	-2.1
US (SEER+NPCR)	10.9	21,338	falling	-3.1
Cape May County	17.1	13	stable	0.2
Somerset County	13.6	29	falling	-2.1
Camden County	13.4	42	falling	-1.6
Mercer County	13.2	30	stable	-0.9
Burlington County	12.8	39	stable	-0.9
Warren County	12.5	9	stable	0.2
Atlantic County	12.3	22	falling	-2.7
Gloucester County	12.3	23	falling	-2.9
Ocean County	12	55	stable	-1.1
Hunterdon County	11.9	11	falling	-2.7
Middlesex County	11.8	59	falling	-2.1
Hudson County	11.7	41	stable	-1.1
Morris County	11.4	38	falling	-2.5
Bergen County	11.3	72	falling	-3.9
Essex County	11.3	54	falling	-1.8
Passaic County	11.2	34	falling	-2.7
Monmouth County	11	48	falling	-2.2
Union County	10.6	36	falling	-2.4
Cumberland County	10.4	9	stable	15.6
Sussex County	10.2	10	falling	-3.3

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Salem County	9.3	4	stable	-2.1
Pancreas: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	14.4	1,556	rising	1.1
US (SEER+NPCR)	12.9	48,832	rising	0.8
Warren County	17	24	stable	1.8
Mercer County	16.1	69	rising	2.3
Salem County	15.9	14	stable	1.5
Burlington County	15.9	91	rising	2
Ocean County	15.7	148	rising	1.5
Hunterdon County	15.4	27	rising	2.2
Camden County	15.1	91	rising	1.1
Gloucester County	14.7	50	stable	0.8
Cape May County	14.7	25	stable	0.4
Monmouth County	14.5	121	rising	1.3
Essex County	14.2	120	stable	0.7
Atlantic County	14.2	50	stable	1.3
Bergen County	14.1	171	stable	0.3
Morris County	14	90	rising	1.3
Hudson County	14	87	rising	2.1
Passaic County	13.5	76	stable	0
Sussex County	13.5	25	stable	2.3
Cumberland County	13.4	24	stable	0.6
Union County	13.4	82	stable	0.5
Middlesex County	12.9	121	stable	0.8
Somerset County	12.8	51	stable	1.1
Prostate: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	131.3	6,723	falling	-2.9
US (SEER+NPCR)	104.5	192,918	stable	-0.4
Essex County	153.1	593	falling	-3.2
Cape May County	152.9	122	falling	-1.9
Mercer County	148.1	300	falling	-2.3
Burlington County	147.9	407	falling	-3.1
Camden County	142.3	405	falling	-1.8
Gloucester County	140.7	236	falling	-1.8
Monmouth County	139.3	549	falling	-2.2
Salem County	139.3	58	stable	-1.7
Passaic County	136.2	359	falling	-2.5

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Union County	134.6	390	falling	-3.7
Cumberland County	129.8	109	stable	-0.6
Bergen County	128.6	729	falling	-3.3
Morris County	127.6	392	falling	-3.3
Middlesex County	124.1	555	stable	1.2
Somerset County	122	232	falling	-2.9
Warren County	120	85	falling	-3.5
Sussex County	119.2	117	falling	-4.3
Atlantic County	117.7	203	falling	-2.5
Hudson County	112.7	319	falling	-3.9
Ocean County	112.1	466	falling	-3.6
Hunterdon County	108	94	rising	9.1
Stomach: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.9	847	falling	-1.1
US (SEER+NPCR)	6.5	24,190	falling	-1.1
Passaic County	10.4	58	stable	-0.2
Union County	9.7	59	stable	-0.8
Hudson County	9.5	60	falling	-1.7
Essex County	9	76	falling	-2
Cumberland County	8.8	15	stable	-2
Camden County	8.7	51	stable	0.3
Bergen County	8.6	104	stable	-0.9
Mercer County	8.1	34	stable	-0.5
Atlantic County	7.7	26	stable	-1
Middlesex County	7.5	70	falling	-2.5
Sussex County	7.5	14	stable	0.3
Burlington County	7	40	stable	-0.4
Ocean County	7	62	stable	-0.7
Somerset County	7	28	falling	-1.8
Gloucester County	6.7	23	stable	-0.9
Monmouth County	6.7	56	falling	-1.5
Morris County	6.4	41	falling	-1.7
Salem County	5.9	5	stable	0
Hunterdon County	5.7	9	stable	-0.1
Warren County	5.6	8	stable	0.7
Cape May County	5.1	8	stable	-1.6
Thyroid: All Races (includes Hispanic), Both Sexes, All Ages				

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
New Jersey	19.3	1,840	stable	-0.3
US (SEER+NPCR)	14.3	48,211	falling	-2.2
Monmouth County	26.8	182	stable	1.4
Gloucester County	24.4	76	rising	4
Mercer County	24.1	96	rising	4
Ocean County	24	147	rising	5.4
Camden County	22	118	rising	2.7
Burlington County	20.8	102	rising	2.4
Bergen County	20.3	207	stable	0.3
Salem County	20.2	13	rising	4
Somerset County	19.8	71	falling	-12.1
Middlesex County	19.2	169	stable	-0.9
Morris County	19.1	102	stable	-3.9
Sussex County	18	29	rising	3.9
Warren County	17	20	stable	1.6
Atlantic County	16.9	48	stable	0.9
Passaic County	16.2	85	stable	-7.6
Cape May County	16	17	rising	2.4
Union County	15.8	92	falling	-8.9
Hudson County	15.1	107	stable	-0.1
Cumberland County	14.6	24	stable	0.5
Hunterdon County	14.4	20	rising	3.6
Essex County	13.7	113	rising	4.3
Uterus (Corpus & Uterus, NOS): All Races (includes Hispanic), BothSexes, All Ages				
New Jersey	31.9	1,913	rising	0.8
US (SEER+NPCR)	27	55,004	rising	1.2
Warren County	39.3	30	stable	1.2
Cumberland County	39.1	37	rising	1.9
Cape May County	38.2	32	rising	3.1
Sussex County	36.3	38	stable	0.9
Camden County	35.3	119	rising	2.1
Mercer County	34.3	82	rising	1.6
Hunterdon County	34.3	31	stable	-1
Gloucester County	33.7	66	stable	1.2
Salem County	33.7	16	stable	1.1
Essex County	33.5	165	rising	1.7

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Morris County	32.8	115	stable	0.3
Atlantic County	32.4	61	stable	1.2
Somerset County	32.4	73	stable	0.4
Burlington County	32.2	101	stable	1
Middlesex County	32	168	stable	0.5
Ocean County	31.5	150	stable	0.2
Monmouth County	30.8	140	stable	-0.2
Bergen County	29.9	198	stable	-0.1
Union County	29.3	102	stable	1
Passaic County	28.8	90	stable	0.3
Hudson County	26.8	98	stable	0.6

Table 32. JERSEY CITY MEDICAL CENTER - TUMOR REGISTRY SUMMARY

In 2019, JCMC’s tumor registry data showed that 3.4% and 19.0% of overall cases were Stage 3 and Stage 4 respectively. The following primary sites were made up of more than 25% of Stage 4 cases: Respiratory System(64.7%), followed by Male genital Organs (40.0%) and Digestive Organs (32.6).

Compared to 2018, there was a decrease of 386 cases (-66.3%) in 2019. The three biggest decreases in overall cases occurred in Breast (-79, -55.2%), followed by Digestive Organs (-75, -61.0%) and Respiratory System (-50, -72.5%). Please note that case volume counts smaller than 10 are suppressed. Staging percentages are calculated on analytic cases only.

MainSite	SubSite	Cases (both analytic and non-analytic)		2018			2019			2018 - 2019			
		2018	2019	% Stage 3	% Stage 4	Total % Stage 3 & 4	% Stage 3	% Stage 4	Total % Stage 3 & 4	Change in Case Volume	Change in % points for Stage 3	Change in % points for Stage 4	Change in % points for Stage 3 & 4
BREAST		143	64	5.9%	0.0%	5.9%	0.0%	0.0%	0.0%	(79)	(5.9)	0.0	(5.9)
DIGESTIVE ORGANS		123	48	17.3%	27.6%	44.9%	4.3%	32.6%	37.0%	(75)	(13.0)	5.1	(7.9)
	COLON	39	20	35.3%	17.6%	52.9%	5.3%	42.1%	47.4%	(19)	(30.0)	24.5	(5.6)
	LIVER AND INTRAHEPATIC BILE DUCTS	11		0.0%	33.3%	33.3%	0.0%	50.0%	50.0%	(9)	0.0	16.7	16.7
	PANCREAS	28		0.0%	52.4%	52.4%	0.0%	33.3%	33.3%	(21)	0.0	(19.0)	(19.0)
	RECTUM	11		0.0%	11.1%	11.1%	0.0%	33.3%	33.3%	(8)	0.0	22.2	22.2
EYE, BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM		22		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(20)	0.0	0.0	0.0
FEMALE GENITAL ORGANS		43	11	3.8%	23.1%	26.9%	25.0%	12.5%	37.5%	(32)	21.2	(10.6)	10.6
HEMATOPOIETIC AND RETICULOENDOTHELIAL SYSTEMS		38	11	0.0%	9.1%	9.1%	0.0%	12.5%	12.5%	(27)	0.0	3.4	3.4
LYMPH NODES		27		22.2%	33.3%	55.6%	0.0%	16.7%	16.7%	(20)	(22.2)	(16.7)	(38.9)
MALE GENITAL ORGANS		34		0.0%	55.6%	55.6%	0.0%	40.0%	40.0%	(27)	0.0	(15.6)	(15.6)
RESPIRATORY SYSTEM AND INTRATORACIC ORGANS		69	19	4.3%	55.3%	59.6%	11.8%	64.7%	76.5%	(50)	7.5	9.4	16.9
	BRONCHUS AND LUNG	61	17	4.9%	58.5%	63.4%	13.3%	66.7%	80.0%	(44)	8.5	8.1	16.6
THYROID AND OTHER ENDOCRINE GLANDS		33		3.2%	3.2%	6.5%	0.0%	10.0%	10.0%	(23)	(3.2)	6.8	3.5
	UNKNOWN PRIMARY SITE	15		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(11)	0.0	0.0	0.0
URINARY TRACT		20		0.0%	9.1%	9.1%	0.0%	0.0%	0.0%	(15)	0.0	(9.1)	(9.1)
	BLADDER	12		0.0%	16.7%	16.7%	0.0%	0.0%	0.0%	(9)	0.0	(16.7)	(16.7)
Grand Total		582	196	7.6%	17.6%	25.2%	3.4%	19.0%	22.4%	(386)	(4.2)	1.4	(2.8)

Appendix I- Outcomes and Results Report of the Previous Implementation Plan

Transportation	49
Transportation Infrastructure.....	49
Transportation Partnerships.....	49
Green Space and Built Environment.....	52
Flooding and Emergency Preparedness.....	52
Parks and Green Areas.....	53
Violence Prevention and Safety.....	54
Gun Injury and Violent Crime	56
Hate Crimes and Anger	57
Violence Interruption Programs	58
Systemic Racism and Discrimination	58
Systemic Discrimination Based on Legal Status.....	59
Systemic Discrimination Based on Gender and Sexual Orientation	59
Addressing the Systems of Oppression	60
Community Health Issues	61
Community Perceptions of Health.....	61
Leading Causes of Death and Premature Mortality.....	63
Obesity, Healthy Eating, and Physical Activity	65
Overweight and Obesity	65
Physical Activity	67
Healthy Eating.....	69
Chronic Conditions.....	70
High Cholesterol and High Blood Pressure	70
Heart Disease	71
Diabetes	73
Cancer	74
Chronic Obstructive Pulmonary Disease (COPD).....	82
Disability.....	82
Behavioral Health: Mental Health and Substance Use	84
Mental Health	84
Substance Use.....	90
Environmental Health	95
Asthma	95
Air Quality	97
Lead.....	99
Infectious and Communicable Diseases	100
COVID-19.....	100
Sexual and Reproductive Health and Sexually Transmitted Infections	103
Maternal and Infant Health	105
Prenatal Care	106
Perinatal Outcomes: Low and Very Low Birthweight and Preterm Births	106
Maternal and Infant Mortality.....	108
Teen Pregnancy.....	109
Access to Services	110
Access and Utilization of Preventive Services, Including Immunizations	110
Barriers to Accessing Healthcare Services	113
Language and Cultural Factors Related to Healthcare Access.....	118
Community-Based Organizations and Coalitions	119

Community Vision and Suggestions for the Future	120
Expanding and Strengthening Behavioral Health and Overall Healthcare Services	120
Health as Human Right: “It is urgent to have access to free, quality health care”	120
Greater Accessibility and Availability of Behavioral Health Services.....	120
Focusing on the Upstream Factors and the Social Determinants of Health.....	121
Inequality	121
Economic and Employment Opportunities.....	121
Built Environment	121
Housing	122
Greater Engagement and Access to Existing Initiatives.....	122
Access to Services and Community Outreach	122
Partnerships, Community Engagement, and Community Building	122
Key Themes and Conclusions.....	123
Prioritization Process and Priorities Selected for Planning.....	124
APPENDICES	127
Appendix A- RWJBH Jersey City/Hudson County CHNA Advisory Committee Members	127
Appendix B- Organizations Represented in Key Informant Interviews and Focus Groups.....	129
Appendix C- Key Informant Interview Guide	130
Appendix D- Focus Group Guide.....	135
Appendix E- Resource Inventory.....	139
Appendix F- Additional Data Tables.....	160
Appendix G- Hospitalization Data.....	179
Appendix H- Cancer Data	199
Appendix I- Outcomes and Results Report of the Previous Implementation Plan.....	219

Executive Summary

Introduction

In 2022, Jersey City Medical Center (JCMC) undertook a community health needs assessment (CHNA) process. The purpose of the CHNA was to identify and analyze community health needs and assets and prioritize those needs to inform strategies to improve community health. This assessment focused on the following Hudson County areas: Bayonne, Hoboken, Jersey City (zip codes 07302, 07304, 07305, 07306, 07307 and 07310), and Union City.

Context

This CHNA was conducted during an unprecedented period due to the COVID-19 pandemic and the national movement for racial justice. The COVID-19 pandemic impacted both the CHNA data collection process, as well as topics and concerns that residents raised in focus groups and key informant interviews. A wave of national protests for racial equity in 2020 highlighted how racism is embedded in systems across the US. The national movement informed the content of this report including the data collection processes, design of data collection instruments, and the input that was shared during focus groups, key informant interviews, and through survey responses.

Methods

While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community’s health. Data collection was conducted using a social determinants of health framework and a health equity lens. The CHNA process utilized a mixed-methods, participatory approach that engaged agencies, organizations, and community residents through different avenues. The CHNA process was guided by the strategic leadership of the RWJBH Systemwide CHNA Steering Committee, the JCMC Community Outreach & Social Impact Steering Committee, the JCMC/Hudson County CHNA Advisory Committee, and the community overall. Data collection methods included:

- Reviewing existing social, economic, and health data in the JCMC primary and secondary service areas in Hudson County.
- Conducting a community survey with 273 residents designed and administered by Bruno & Ridgway.
- Facilitating 6 virtual focus groups with 105 participants from populations of interest, including veterans, and residents who identified as Black, Asian, and Latino, the latter held in Spanish.
- Conducting 7 key informant interviews with 12 community stakeholders from a range of sectors.
- Facilitating a guided discussion with the JCMC Community Outreach & Social Impact Steering Committee.

Jersey City Medical Center/Hudson County CHNA Focus Area



Findings

The following provides a brief overview of the key findings that emerged from this assessment:

Population Characteristics

- **Demographics.** In 2020, Hudson County was the fourth most populous county in New Jersey with 671,923 residents. Its population increased by 1.4% between 2015 and 2020.¹ Participants in focus group and interview discussions valued Hudson County’s racial/ethnic and language diversity and robust foreign-born population. Residents identifying as Latino made up 40.4% of the county’s residents, followed by those identifying as White (28.5%), Asian (17.0%), and Black (9.8%).² In 2016-2020, the foreign-born population ranged from 19.4% in Hoboken to 62.8% in Jersey City zip code 07310, with many residents from India and the Dominican Republic.³ Veterans made up about 2% of the Hudson County population, with the highest percentage in the city of Bayonne (3.9%).

Community Social and Economic Environment

- **Community Strengths and Assets.** Interviewees and focus group participants mentioned numerous positive aspects of their communities, including an abundance of resources and amenities, community solidarity, and robust partnerships, made stronger during COVID-19. Top strengths identified by community survey respondents in 2021 included that it was easy to find fresh produce and that their communities had safe outdoor places to walk and play. Nearly 60% of respondents indicated that their communities were a good place to raise a family and had places for everyone to socialize.⁴
- **Education.** Graduation rates across Hudson County school districts differed, with Bayonne, Union City, and Jersey City experiencing lower graduation rates than the other communities and the state. There were racial/ethnic disparities in graduation rates, with Black and Latino students experiencing lower graduation rates than their White and Asian counterparts.⁵ Participants identified “Community schools” and Tiger’s Den at Snyder High School, resulting from a partnership between the Jersey City Board of Education, JCMC, educators, families, and the community, as promising initiatives to address the needs of low-income students of color and increase graduation rates.
- **Inequality.** Growing inequality was a recurrent theme in focus groups and interviews with participants describing the area as “*a tale of two cities*.” Development was seen as focusing on the wealthy, while residents emphasized how neighborhood concentrated poverty compounded the effect of household poverty. They highlighted the linkage between income, hopelessness, poor education outcomes, and violence. Inequality was reflected in education, employment and workforce, income and financial security, access to healthcare, and other areas.

“There is something going on almost every week to help with food, home purchases, and other things. That’s one of the things I really love about Jersey City.” – Focus group participant

¹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

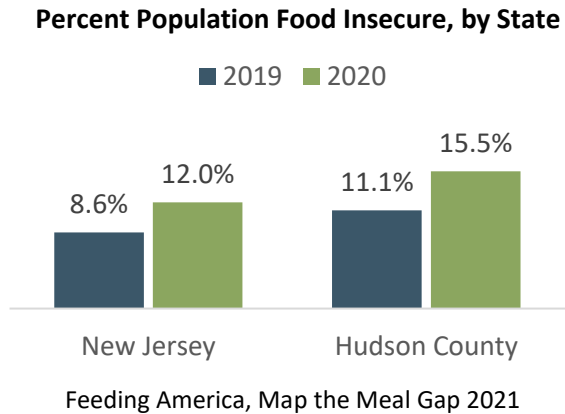
² U.S. Census Bureau, Decennial Census of Population and Housing, 2020

³ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

⁴ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

⁵ New Jersey Department of Education, School Performance, Adjusted Cohort Graduation Rates, 2020-21

- Employment and Workforce.** Unemployment rates in Hudson County were trending downward over the decade prior to the COVID-19 pandemic and rose substantially in 2020, similar to the rest of the state and country. While rates declined in 2021, unemployment has not yet fallen to pre-pandemic levels. Unemployment rates in 2016-2020 ranged from 2.4% in Jersey City zip code 07302 to 7.0% in Jersey City zip code 07305 and 9.2% in Jersey City zip code 07304.⁶ Fewer than four in ten survey respondents agreed that “there are job opportunities in my area.” Participants indicated that LGBTQ+ populations, veterans, and essential workers were the most affected by unemployment and underemployment.
- Income and Financial Security.** Median household income in Hudson County showed stark disparities, ranging from \$49,457 in Union City, with a majority Latino population, to \$153,438 in Hoboken, a predominantly White area.⁷ In 2019, 29.8% of Black children and 23.4% of Latino children lived in poverty, compared to 9.8% in the county overall.⁸ Among veterans, 7.5% lived below the poverty line in the county overall, with 21.4% doing so in Jersey City zip code 07306.⁹ Focus group participants shared the day-to-day challenges of affording housing, food, and healthcare as prices continue to climb across the board. While the rising cost of living affects everyone, participants shared that it has been most painful for low-wage workers and those on fixed incomes, such as seniors.
- Food Access and Food Security.** Participants mentioned that many families with children—often immigrants—, older adults, and those who were housing insecure were struggling to put food, particularly healthy food, on the table. Residents reported that food insecurity increased during the COVID-19 pandemic, despite stepping up food distribution efforts. Around one in four survey respondents overall, and about one in three Latino respondents, indicated that they relied on food pantries or other food assistance programs.¹⁰
- Housing.** Participants reported that affordable housing in their communities was sparse and difficult to obtain. Residents discussed the challenges of qualifying for affordable housing, rising rents due to an influx of New Yorkers, increasing socioeconomic segregation, and homelessness. More than half of renter-occupied households in Hudson County spend 25% or more of their monthly income on housing costs, ranging from 39.0% in Jersey City zip code 07302 to 66.5% in Union City and 64.6% in Jersey City zip code 07305.¹¹



⁶ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

⁷ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

⁸ U.S. Census Bureau, Small Area Income and Poverty Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

⁹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

¹⁰ DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

¹¹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

- Transportation.** Participants valued the ample availability of public transportation options in Hudson County. Most participants indicated that they were not car dependent and noted that it was easy to get around. In addition, participants indicated that the partnerships between health care facilities and private transportation companies facilitated access to health care for older adults, persons with disabilities, and violence survivors.
- Green Space and Built Environment.** Multiple residents expressed their concerns that there were too many new constructions, resulting in overpopulation and a shrinkage of green space. Participants highlighted the importance of emergency preparedness for flooding and mentioned that mitigating redevelopment projects were underway. Residents also noted the contribution of grassroots organizations to public park maintenance, also important for increased water absorption. About 70% of Hudson County survey respondents agreed or completely agreed with the statement, *“My community has safe outdoor places to walk and play.”*¹²
- Violence Prevention and Safety.** Similar to the 2019 CHNA, for many, violence prevention and safety continue to be priority issues for many residents. Participants shared differing views about safety and violence. Many indicated being safe in their neighborhoods, while others reported being nervous about crime. In 2020, Jersey City (432 per 100,000 residents) had more than double the violent crime rate (i.e., murder, rape, aggravated assault) than the state average (195 per 100,000 residents).¹³ Black residents indicated that they experienced a disproportionate burden of violence, including gun violence, and trauma, with Black survey respondents’ marking violence/community safety as the top health priority.¹⁴ Key informant interviewees indicated that Jersey City has robust programs and resources to address and mitigate the impact of violence and trauma, including the Anti-Violence Coalition and Project H.U.D.S.O.N. According to interviewees, promising results to interrupt the cycle of violence have been achieved by reaching survivors soon after injury and providing trauma-informed intensive case management and wraparound services, including safe housing and vocational training, in addition to medical care and counseling.
- Systemic Racism and Discrimination.** With few exceptions, participants spoke of pervasive inequities experienced by people of different groups. Residents discussed the multiplying effect of historical and current discriminatory practices due to multiple conditions, such as race/ethnicity, gender, immigrant status, and socioeconomic status, among others. Participants noted these issues largely impacted communities of color because of the policies and practices embedded throughout society. Residents mentioned that some Hudson County municipalities have put in place programs to address the effects of systemic racism, such as first-time homeowner programs for low-income residents, rent control policies, and programs to promote minority and/or women owned business. However, participants emphasized that more are needed.

“The undocumented are scared to ask for help, and we are seeing that community getting jumped overnight, not wanting to go to the hospital over what they will get charged.”— Focus group participant

¹² Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

¹³ State of New Jersey, Department of Law and Public Safety, Uniform Crime Reporting Unit, 2019

¹⁴ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Community Health Issues

- **Perceptions of Community Health.** Focus group participants and interviewees identified social and economic issues such as financial insecurity, housing, and transportation as top community concerns, noting that these issues affect other aspects of health. Participants also discussed challenges in accessing care, the increase in mental health concerns, and the lingering effects of the COVID-19 pandemic. Community survey respondents ranked mental health, overweight/obesity, high stress lifestyle, affordable housing, and affordable eldercare as the top five health concerns in the community.
- **Leading Causes of Death and Premature Mortality.** Heart disease, COVID-19, and cancer were the top three leading causes of death in Hudson County in 2020. In 2018-2020, Black residents experienced higher rates of premature mortality (deaths before age 75) than any other racial/ethnic groups.¹⁵
- **Obesity, Healthy Eating, and Physical Activity.** While overweight/obesity was identified as the second top health concern (after mental health) by community survey respondents,¹⁶ it was not a prominent theme in conversations with residents. Participants mentioned disparities in the availability and affordability of healthy foods by neighborhood, with some areas considered food deserts. Some residents indicated enjoying the area’s walkability, while others noted safety issues, sidewalks in disrepair, and time constraints as barriers to physical activity.
- **Chronic Diseases.** Like findings from the 2019 CHNA, chronic diseases continue to be a top community concern. Data show racial/ethnic disparities in chronic disease burden across Hudson County. Black residents experienced higher cardiovascular disease mortality rates than other racial/ethnic groups in the county. Diabetes was a top priority concern and participants indicated that it was highly prevalent in their communities. The cancer mortality rate in Hudson County was highest among Black (182.9 per 100,000), followed by White (148.5 per 100,000), residents.¹⁷ In terms of chronic disease screenings, 70% of community survey respondents indicated that they had participated in a cholesterol screening, and nearly 87% had participated in a blood pressure screening in the past two years.¹⁸ Many participants mentioned health care costs as a barrier to chronic disease management.
- **Disability.** While the issue of disabilities did not emerge often in the qualitative discussions, many people with disabilities face economic instability as they rely on government financial assistance programs for their basic needs. A key informant interviewee highlighted the importance of early intervention to address the needs of children with disabilities. The proportion of the population ages

“Diabetes is a very expensive issue in the community, and we’ll often see people forgo their medication because they can’t afford it or forgo healthy foods because they can’t afford it.” – Focus group participant

¹⁵ National Center for Health Statistics, Mortality Files, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018-2020

¹⁶ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

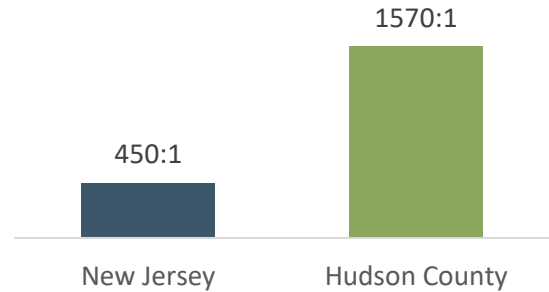
¹⁷ New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

¹⁸ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

18-64 with a disability in Hudson County ranged from 3.2% in Jersey City zip code 07302 to 9.1% in Jersey City zip code 07304.¹⁹

- **Mental Health and Substance Use.** Echoing the 2019 CHNA, mental health disorders were the top health priority selected by survey respondents and a prominent theme in interviews and focus groups. Job loss and economic pressures and the uncertainty associated with the pandemic were cited as contributors to increased stress and depression by Hudson County residents, including among veterans and members of the LGBTQ+ community. Participants indicated stigma, long wait times for appointments, and unavailability of multilingual mental health care providers as barriers to accessing care. Several participants identified substance misuse, relapse, and overdose deaths among young people as a further health concern in the aftermath of COVID-19, with the drug poisoning rate increasing from 2016 to 2020.²⁰

Population to Mental Health Provider Ratios, by State and County, 2019



DATA SOURCE: National Provider Identification Registry, Centers for Medicare and Medicaid Services

- **Environmental Health.** The rate of age-adjusted ED visits for asthma declined in Hudson County from 2018-2020.²¹ It should be noted that this decline may be due to individuals with asthma being reluctant to seek care during the height of the COVID-19 pandemic. The proportion of children born in 2014 who were tested for lead exposure before 36 months of age is higher in Hudson County (77.6%) than in the state (74.4%).²²
- **Communicable Diseases.** Conversations related to COVID-19 primarily focused on how the pandemic exacerbated existing social and economic inequities. Several participants were concerned by the increasing rates of sexually transmitted infections, including HIV and chlamydia, among women of color and the LGBTQ+ population. The rate of HIV transmission for Black New Jersey residents was 30.2 per 100,000 persons, ten times higher than among White residents (3.1 per 100,000). Nearly 3,000 per 100,000 women aged 15-24 contract

“[COVID impacted] housing, food insecurity, jobs, people have a fear of going back to work, and childcare, because there was a time when everything was virtual, how can parents afford to stay home and put food on the table?” – Focus group participant

¹⁹ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

²⁰ Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020

²¹ New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020

²² New Jersey Birth Certificate Database, Office of Vital Statistics and Registry; Child Health Program, Family Health Services, as reported by, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2022

chlamydia annually in Hudson County.²³ Participants also expressed concerns about the roll-back of reproductive rights and the negative impact that would have on women’s health, noting the inequitable burden on low-income women.

- **Maternal and Infant Health.** Maternal and infant health indicators are markers of inequity as most maternal and perinatal health complications are preventable with access to quality, adequate, timely care and information, including comprehensive sexuality education. In Hudson County, a lower percentage of Black and Latino residents sought prenatal care in the first trimester compared to Asian and White residents. The rates of low birth weight and preterm births among infants born to Black residents roughly doubled those of White residents,²⁴ indicating health care access barriers.

Access to Services

- **Access to Preventive Services.** Participants reported that access to routine screenings and preventive care declined since the onset of the COVID-19 pandemic, despite the efforts of many partners. Participants indicated that having a primary care provider and/or access to a trusted FQHC facilitated access to care. Approximately 77% of community survey respondents reported having an annual physical exam and 74% a flu shot in the last two years.²⁵
- **Access to Primary Care Services.** Cost, workforce capacity, insurance, and language and cultural factors were most often mentioned by focus group and interview participants as barriers to accessing primary care. Community survey respondents indicated ability to schedule an appointment at a convenient time, insurance problems, cost of care, and wait times as the main barriers to care.²⁶ About 30% of respondents indicated never experiencing barriers. Within the JCMC service area, the proportion of uninsured residents was highest in Union City (23.4%) and lowest in Hoboken (2.7%).²⁷ Some participants, particularly veterans, mentioned experiencing disruptions in access to mental health services during the pandemic, including to support groups and counseling, leading to treatment setbacks and substance use relapse.
- **Community-Based Organizations and Coalitions.** Partnerships between the community-based organizations, hospitals, schools, and the government were seen as a strength in Hudson County and critical to providing services to those in need. City-wide efforts such as HealthierJC have been important to coordinate efforts across multiple partners, including the business community. Residents and public health administrators uplifted the role of community-based nonprofits in bridging the gap to services for those most marginalized. Most participants saw a promising role for a strong and broad coalition in Hudson County.

“We have great partners. Hudson County is very tight, so we all work together – Focus group participant

²³ Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, as reported by the New Jersey State Health Assessment Data (NJSHAD), 2020 & 2021

²⁴ New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

²⁵ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

²⁶ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

²⁷ U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Community Vision and Suggestions for the Future

- **Health as Human Right:** *“It is urgent to have access to free, quality health care.”* To overcome cost barriers, participants recommended expanding access to free or low-cost preventive care; loosening the requirements to qualify for free and/or low-cost health insurance; and simplifying the charity care application, including for those who are foreign-born. They also suggested *“meeting people where they are”* by using mobile and school-based clinics, organizing education sessions in all neighborhoods, and offering appointments outside of the regular workday. Participants highlighted the community school model as a promising initiative to promote the well-being of low-income families.
- **Improving Access to Services and Community Outreach.** Echoing 2019 CHNA priorities, many community participants emphasized improving access to primary care as a priority for the coming years. Numerous interviewees and focus group participants noted the need for better communication about existing programs and services. Participants suggested organizing informational sessions in different neighborhoods and languages on topics that affect the community, such as chronic disease management, and developing a centralized list of programs and resources, similar to the mental health directory prepared by the Health Department (<https://healthierjc.com/mental-health/>), but for other conditions.
- **Greater Accessibility and Availability of Behavioral Health Services.** Participants suggested that expanding culturally-competent trauma-informed mental health care, particularly for Black, LGBTQ+, veterans, violence survivors, and young residents, should be a priority in the coming years. They recommended diversifying the mental health workforce, expanding community-based affordable mental health services, increasing long-term treatment and maintenance options for persons with substance use disorders, and developing additional prevention education programs to destigmatize mental health disorders among many cultural groups.
- **Sexual and Reproductive Health and Women’s Health.** Participants underscored the importance of offering comprehensive sexuality education in schools to reduce sexually transmitted infections and reduce unplanned pregnancies among teens; increasing access to information and reproductive health commodities to address the rise in sexually transmitted infections among cisgender women and men-who-have-sex-with-men; and mitigating the repercussions of the rollback in constitutional protections to reproductive choice that could unduly affect low-income women and communities of color, thus, exacerbating existing racial/ethnic and social inequities in maternal and infant health.
- **Reducing Inequity and Focusing on the Social Determinants of Health.** For several interviewees and focus group members, a vision of the future included steps to reduce inequity and address the social determinants of health.
 - **Expanding Employment Opportunities:** Recommendations to improve economic and employment opportunities included: 1) incorporating more vocational training programs in high schools to facilitate transition into the workforce; 2) incentivizing employers to hire veterans and

“My biggest wish for this community is that we don't have such an economically diverse community. If there's a way to really help the families with the lowest economic resources to really have more financial stability, that would be ideal.”
– Key informant interviewee

transgender and other LGBTQ+ people; 3) providing expanded workforce protections (e.g., sick leave, improved wages, childcare) for all workers, including those who are foreign-born; and 4) supporting small business owners.

- **Addressing the Housing Deficit:** Recommendations related to expanding access to housing and addressing homelessness included: 1) earmarking more affordable housing units in the new developments, including housing for veterans; 2) implementing the existing rent control policies, which also apply to foreign-born residents regardless of immigration status; 3) renovating abandoned buildings for low-income families; 4) increasing the availability of safe temporary shelters for unhoused individuals, including for domestic and community violence survivors; and 5) fomenting first-time buyers' subsidies as a promising initiative to address intergenerational poverty.

“Prices have been slowly rising, amazing that they have money to build these new buildings but can’t help people maintain the property they have here...” – Focus group participant

- **Partnerships, Community Engagement, and Community Building.** Participants valued the robust partnerships established among multiple organizations and across sectors and suggested deepening engagement with trusted community-based organizations, such as those representing Asian, Latino, and LGBTQ+ residents, as partners in outreach and information sharing about community services and programs. Participants underscored more community outreach, a strong plan to reengage the community, and investing in the community as strategic areas moving forward.

Key Themes

Several overarching themes emerged from the Jersey City Medical Center/Hudson County 2022 Community Health Needs Assessment. Importantly, several key areas, including increasing access to care, the importance of preventive care, and safety and violence prevention echoed those priorities identified by the community in 2019 as part of the prior CHNA process, and provide an opportunity to continue building upon those efforts.

- ***The Hudson County communities that JCMC serves are diverse and health disparities exist.*** There is great variation in terms of demographic composition, income levels, and health status in Hudson County, with over 40% of residents not English proficient. Secondary data show disparities in healthcare access and health outcomes based on race/ethnicity. A larger proportion of Asian and Latino community survey respondents reported feeling discriminated against when receiving care. Secondary data show that Black residents experience higher rates of premature, cardiovascular, and cancer mortality, and diabetes compared to residents of other racial/ethnic groups.
- ***Residents viewed chronic conditions as prevalent and linked to the social determinants of health.*** Diabetes and high blood pressure were discussed as prevalent in the community, especially among low-income residents and communities of color, and survey respondents indicated “overweight/obesity” was the second most common health issue in their community. However, focus group participants focused on the barriers to healthy living faced by residents, including affording healthy foods, cost of medication, and having time to exercise and to spend outdoors.

- ***Housing, food insecurity, and employment opportunities are top community concerns.*** Participants identified lack of quality affordable housing as a key gap in the area. Food insecurity was another area of concern, with almost half of Latino survey respondents worrying about running out of money to purchase food. Housing and food are related to income. Over 10% of Hudson residents reported being unemployed during the pandemic, with large variation by neighborhood. Overall, participants recommended the adoption of more policies to promote equity and support the well-being of low-income residents.
- ***Mental health was identified as a significant community health concern.*** Mental health was identified as a top community health concern, closely associated with racial/ethnic disparities, economic instability, and chronic conditions. Black residents faced a disproportionate mental health burden. The rate of mental health hospitalizations in 2020 was 70% higher among adult Black residents (107.1 per 100,000) than the Hudson County average (63.1 per 100,000). Black children had 38% higher hospitalization rates for mental health conditions than the county rate (34.7 per 100,000 vs. 25.2 per 100,000). Veterans and LGBTQ+ advocates also highlighted the mental health needs of their communities. Residents mentioned stigma and insufficient culturally competent providers as the principal barriers to mental health care access and emphasized the need to engage in more education efforts.
- ***Violence as an important health concern.*** Violence and safety were raised as community concerns. Some participants indicated that their neighborhoods were safe; however only 40% of survey respondents agreed that violence was not prevalent in their communities.²⁸ Further, violence and safety were mentioned as the top health concern by Black survey respondents. Participants suggested continuing to strengthen efforts to end the cycle of violence by addressing its social determinants of health, through support of programs such as the Anti-Violence Coalition and Project H.U.D.S.O.N.
- ***Hudson County has a wealth of social service organizations and health care services, including those providing preventive care, though many residents experience barriers to accessing these resources.*** Residents remarked that Hudson County had a wealth of health care and social service assets. Residents noted that having a primary care doctor and being linked to a FQHC and/or a community-based organization were facilitating factors to accessing care. They also discussed the importance of culturally competent providers, including providers who spoke their language and looked like them. Veterans and those working with violence survivors highlighted that having peers and mentors who could provide trauma informed care helped to be engaged in care. Participants in the healthcare field unanimously noted a decline in access to preventive care and mentioned this as a priority strategic area. Recommendations in this area included continuing to uplift partnerships and community engagement to bridge the care gap. Another recommendation included better communication about existing programs and services to reach multiple constituencies.

Conclusions

Through this comprehensive and iterative assessment process, ten major areas were identified as community needs after gathering input through qualitative data from residents and stakeholders, feedback from a community priorities survey, and quantitative surveillance and secondary data. These included in no particular order:

²⁸ Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

- Financial Insecurity
- Unemployment
- Food Insecurity
- Housing
- Chronic Diseases (e.g., heart disease, cancer, diabetes)
- Infectious Diseases, including COVID-19
- Violence Prevention & Safety
- Mental Health
- Substance Use
- Access to Preventive Care

After a prioritization process with the Advisory Committee and discussions within the hospital taking into consideration existing expertise, capacity, and experience, JCMC will focus on Access to Preventive Care; Chronic Disease Management, including Behavioral Health Services; Food Insecurity and Education; and Violence Prevention and Safety as priorities during the development of its implementation plan in 2023. JCMC will tackle these priority action areas as part of ongoing community engagement efforts and with an overarching emphasis on addressing systemic racism, racial injustice, and discrimination.

Introduction

Community Health Needs Assessment Purpose and Goals

A community health needs assessment (CHNA) is a systematic process to identify and analyze community health needs and assets, prioritize those needs, and then implement strategies to improve community health. In 2022, the RWJBarnabas Health Jersey City Medical Center (JCMC) undertook the current CHNA process using a mixed-methods and participatory approach.

JCMC is located in Jersey City, Hudson County, New Jersey, and is part of the **RWJBarnabas Health (RWJBH)** system. RWJBH is a non-profit healthcare organization which includes 12 acute care hospitals, three acute care children's hospitals, a leading pediatric rehabilitation hospital, a freestanding acute behavioral health hospital, a clinically integrated network of ambulatory care centers, two trauma centers, a satellite emergency department, geriatric centers, the state's largest behavioral health network, ambulatory surgery centers, comprehensive home care and hospice programs, long term care facilities, fitness and wellness centers, retail pharmacy services, medical groups, diagnostic imaging centers, a clinically integrated network and collaborative accountable care organization. As one of the licensed general acute care hospitals and one of two trauma centers within the system, JCMC admits nearly 16,000 inpatients and provides over 201,000 outpatient visits annually. In 2021, the 348-bed hospital attended over 81,100 emergency department visits and delivered nearly 2,000 babies. JCMC is a DNV (which stands for det norske veritas) fully accredited hospital and has been recognized for its excellence in providing care and support for the health and wellness of the Hudson County community.

In early 2021, RWJBH hired **Health Resources in Action (HRiA)**, a non-profit public health consultancy organization, to provide support, help facilitate, and conduct data analysis for the CHNAs across the system. HRiA worked closely with RWJBH, JCMC, the JCMC Community Outreach & Social Impact Steering Committee, and a Jersey City/Hudson County CHNA Advisory Board to support the 2022 JCMC CHNA.

The RWJBH JCMC/Hudson County CHNA aims to gain a greater understanding of the issues that community residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This report presents findings from the 2022 JCMC needs assessment processes, which was conducted between March-September 2022.

The specific goals of this CHNA are to:

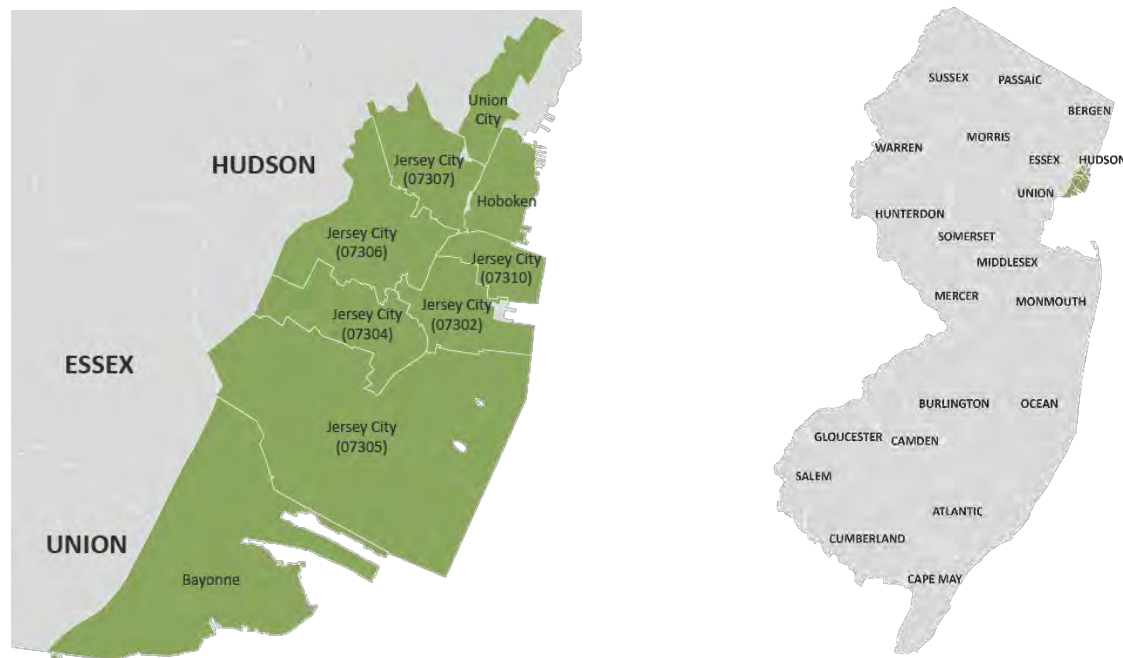
- Systematically identify the needs, strengths, and resources of the community to inform future planning,
- Understand the current health status of the service area overall and its sub-populations within their social context,
- Engage the community to help determine community needs and social determinant of health needs, and
- Fulfill the IRS mandate for non-profit hospitals.

Area of Focus

This CHNA process aims to fulfill multiple purposes for a range of stakeholders. To be as inclusive as possible, the focus area of the RWJBH Jersey City Medical Center/Hudson County CHNA encompasses JCMC's primary and secondary service areas in Hudson County. JCMC's primary service area include the

following Jersey City zip codes: 07302, 07304, 07305, 07306, 07307, and 07310. JCMC's secondary service area includes Bayonne, Union City and Hoboken, which encompass the following zip codes: 07002, 07087, and 07030, respectively. Both the primary and secondary service areas are the focus of this CHNA, represented in Figure 1 below.

Figure 1. Focused JCMC CHNA Area Map



Context for the Community Health Needs Assessment

This CHNA was conducted during an unprecedented time, given the COVID-19 pandemic and the national movement for racial justice. This context had a significant impact on the assessment approach and content.

COVID-19 Pandemic

The country was still recovering from the novel coronavirus (COVID-19) pandemic when the activities of this assessment were conducted. This impacted both the CHNA data collection process and topics, as well as concerns that participants put forth during discussions in focus groups and interviews. In March 2022, at the beginning of this CHNA process, the COVID-19 pandemic had already been in effect for over two years. Logistically, the pandemic impacted the feasibility of convening in-person groups for the CHNA (e.g., subcommittees, focus groups, etc.) and the availability of key stakeholders and community members to participate in CHNA activities, given their focus on addressing immediate needs. Consequently, all data collection and engagement occurred in a virtual setting (e.g., telephone or video focus groups, interviews), and engagement of residents and stakeholders was challenging. (A more detailed description of this engagement process may be found in the Methods section, and COVID-19 data specific to this service area is provided in the Infectious and Communicable Disease section of this report.)

Substantively, during the CHNA process, COVID-19 was and remains a health concern for communities and has also exacerbated underlying inequities and social needs. The pandemic brought to light both the

capabilities and gaps in the healthcare system, the public health infrastructure, and social service networks. In this context, an assessment of the community's strengths and needs, and in particular the social determinants of health, is both critically important and logistically challenging. This CHNA should be considered a snapshot in time, which is consistent with public health best practices. Moving forward, the community should continue to be engaged to understand how identified issues may evolve and what new issues or concerns may emerge over time.

National Movement for Racial Justice

Over the past few years, sparked by the national protests for racial equity amidst the killings of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, and many others, national attention was focused on how racism is embedded in every system and structure of our country, including housing, education, employment, and healthcare. This context impacted the content of the CHNA, including the design of data collection instruments and the input that was shared during interviews and focus groups. While racism and oppression have persisted in this country for over 400 years, it is important to acknowledge the recent focus on these issues in 2022 in the form of increased dialogue, locally and nationally, as context for this assessment. Awareness of racism and discrimination among Hudson City residents was renewed in 2022 with ongoing incidents of anti-Asian hate crimes and the naming of Jersey City by the Buffalo mass shooter.

Methods

The following section details how data for the CHNA were compiled and analyzed, as well as the broader lens used to guide this process.

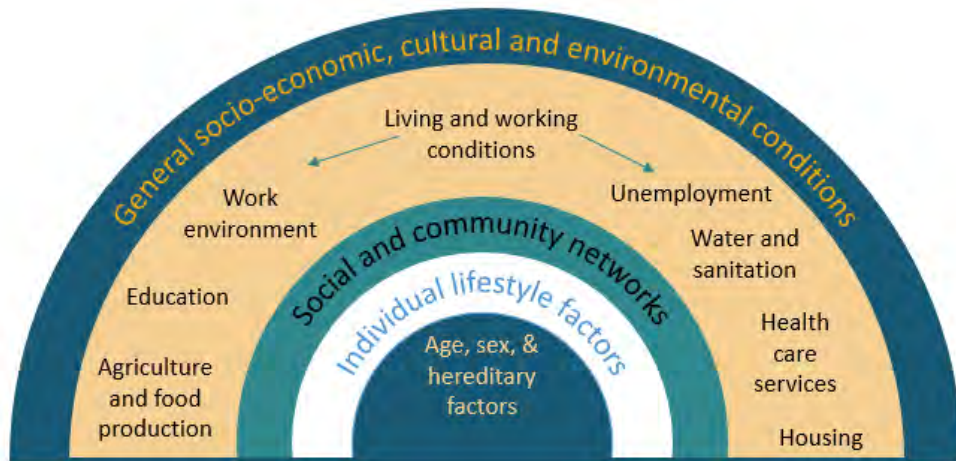
Social Determinants of Health Framework

While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health (Figure 2).

Upstream Approaches to Health

Having a healthy population is about more than delivering quality healthcare to residents. Where a person lives, learns, works, and plays all have an enormous impact on health. Health is not only affected by people's genes and lifestyle behaviors, but by upstream factors such as employment status, quality of housing, and economic policies. Figure 2 provides a visual representation of these relationships, demonstrating how individual lifestyle factors, which are closest to health outcomes, are influenced by more upstream factors, such as employment status and educational opportunities.

Figure 2. Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

The data to which we have access is often a snapshot in time, but the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. To this end, much of this report is dedicated to discussing the social, economic, and community context in which residents live. We hope to understand the current health status of residents and the multitude of factors that influence health to enable the identification of priorities for community health planning, existing strengths and assets upon which to build, and areas for further collaboration and coordination.

Health Equity Lens

The influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory policies, and historical oppression of specific groups are a few of the factors that drive health inequities in the U.S.

In the present report, health patterns for the Hudson County area are described overall, as well as areas of need for particular population groups. Understanding factors that contribute to health patterns for these populations can facilitate the identification of data-informed and evidence-based strategies to provide all residents with the opportunity to live a healthy life.

Approach and Community Engagement Process

The CHNA aimed to engage agencies, organizations, and community residents through different avenues. The CHNA process was guided by strategic leadership from the RWJBH Systemwide CHNA Steering Committee, the JCMC Community Outreach & Social Impact Steering Committee, and the community overall.

RWJBH System Engagement

This CHNA is part of a set of CHNAs being conducted across the entire RWJBH system. Each of these CHNAs uses a consistent framework and a minimum set of indicators but the approach and engagement

process are tailored for each community. A Systemwide CHNA Steering Committee was convened twice prior to the launch of JCMC CHNA process (early and late June 2021). This Steering Committee provided input and feedback on major data elements (e.g., secondary data key indicators, overall Table of Contents) and core prioritization criteria for the planning process. A list of Systemwide CHNA Steering Committee members can be found in Acknowledgments section.

CHNA Advisory Committee Engagement

A CHNA Advisory Committee was constituted to guide the process. The Advisory Committee included over 80 stakeholders representing a range of relevant fields and organizations throughout Hudson County. The CHNA Advisory Committee was engaged at critical intervals throughout this process. In March 2022, the Advisory Committee met for a kick-off meeting during which HRiA provided an overview of the CHNA process and Bruno & Ridgeway, Inc. presented the findings from a community survey the firm conducted in 2021. These two presentations were followed by a brief Q&A and discussion with Advisory Committee members. After the meeting, Advisory Committee members were invited to participate in a survey to help identify what populations and sectors to engage in focus groups and key informant interviews. The results of this survey directly informed development of an engagement plan to guide qualitative data collection. During the data collection process, Advisory Committee members also assisted with organizing focus groups with community residents, participating in key informant interviews, and/or connecting HRiA to stakeholders in the community.

The Advisory Committee reconvened in October 2022. During this meeting, HRiA staff presented the findings from the CHNA process, including preliminary priorities that emerged upon review of the qualitative and secondary data. Advisory Committee members had the opportunity to ask questions, then discussed and voted on the top priorities for the hospital to consider when developing its implementation plan. A detailed description of the prioritization process can be found in the Prioritization Process and Priorities Selected for Planning section.

In addition, the JCMC Community Outreach & Social Impact Steering Committee was engaged throughout the process as a means of obtaining feedback from internal JCMC stakeholders who have firsthand knowledge of the community. Members of the JCMC Steering Committee participated in the Advisory Committee activities and in a focus group in June 2022. The JCMC Steering Committee reviewed the report in full and adopted it in a meeting in November 2022. See Appendix A for a list of CHNA Advisory Committee members, which include the JCMC Steering Committee members.

Community Engagement

Community engagement is described further below under the primary data collection methods. Capturing and lifting up a range of voices, especially those not typically represented in these processes, was a core component to this initiative. It should be noted that, due to the COVID-19 pandemic, the community engagement for this CHNA occurred virtually. Additionally, while the CHNA aimed to engage a cross-section of individuals and to be inclusive of traditionally under-represented communities, outreach was challenging given the pandemic and competing priorities. Nevertheless, by engaging the community through multiple methods and in multiple languages, this CHNA aims to describe community strengths and needs during this unique time.

Secondary Data: Review of Existing Secondary Data, Reports, and Analyses

Secondary data are data that have already been collected for another purpose. Examining secondary data helps us to understand trends, provide a baseline, and identify differences by sub-groups. It also helps in guiding where primary data collection can dive deeper or fill in gaps.

Secondary data for this CHNA were drawn from a variety of sources, including the U.S. Census American Community Survey (ACS), the U.S. Department of Labor Bureau of Labor Statistics, the Federal Bureau of Investigation Uniform Crime Reports, U.S. Bureau of Labor Statistics, County Health Rankings, the New Jersey Department of Education, New Jersey Department of Health's New Jersey State Health Assessment Data (NJSHAD), and a number of other agencies and organizations. This CHNA also utilizes reports from a variety of organizations at the community, state, and national level, including, but not limited to, the United Way of New Jersey's ALICE Study, The Partnership for a HealthierJC, and others. Additionally, hospitalization data from the RWJBH system is also included in Appendix H. Secondary data were analyzed by the agencies that collected or received the data. Data are typically presented as frequencies (%) or rates per 100,000 population. It should be noted that when the narrative makes comparisons between towns, by subpopulation, or with NJ overall, these are lay comparisons and *not* statistically significant differences.

It should also be noted that for most social and economic indicators, the U.S. Census American Community Survey (ACS) 5-year (2016-2020) aggregate datasets were used over the one-year datasets, to improve statistical reliability for areas with smaller population sizes and small population subgroups. Since the ACS uses a probability sampling technique, using the five-year aggregate dataset over the one-year data provides a larger sample size and more precision in its estimates.

Primary Data Collection

Primary data collection entailed a mixed methods approach consisting of interviews, focus groups, and a community survey, as detailed below.

Qualitative Discussion: Key Informant Interviews and Focus Groups

Key Informant Interviews

A total of seven key informant interview discussions were completed with 12 individuals by Zoom or telephone. Interviews were 35-60-minute semi-structured discussions that engaged institutional, organizational, and community leaders as well as front-line staff across sectors. Discussions explored interviewees' experiences of addressing community needs and priorities for future alignment, coordination, and expansion of services, initiatives, and policies. Sectors represented in these interviews included: local public health departments, public education, housing services, the faith community, and those who serve/work with specific populations (e.g., immigrant community, LGBTQ residents, young people). See Appendix B for a list of organizations engaged through key informant interviews and Appendix C for the key informant interview guide.

Focus Groups

A total of 105 community residents participated in 6 virtual focus groups (telephone or video) conducted with specific populations of interest: veterans, Black residents, Spanish-speaking Latino residents, and Asian residents. Focus groups were up to 60-minute semi-structured conversations and aimed to delve deeply into the community's needs, strengths, and opportunities for the future and to gather feedback on priorities for action. Please see Appendix D for the focus group facilitator's guide.

In addition, a guided discussion was carried out with the JCMC Community Outreach & Social Impact Steering Committee, whose members are in direct contact with Hudson City residents in their role as health care providers, hospital administrators, leaders, and community residents themselves. The discussion lasted 60 minutes and was conducted via Zoom. The discussion aimed to determine

perceptions of the strengths and needs of the Hudson County community served by JCMC, and identify the sub-populations most affected, to explore how these issues can be addressed in the future, and to identify opportunities for JCMC to address the community needs more effectively moving forward.

Analyses

The collected qualitative information was coded and then analyzed thematically by data analysts for main categories and sub-themes. Analysts identified key themes that emerged across all groups and interviews as well as the unique issues that were noted for specific populations. Throughout the qualitative findings included in this report, the term “participants” is used to refer to key informant interview and focus group participants. Unique issues that emerged among a group of participants are specified as such. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While differences between towns are noted where appropriate, analyses emphasized findings common across the service area. Selected paraphrased quotes—without personal identifying information—are presented in the narrative of this report to further illustrate points within topic areas.

Community Survey

A community priorities survey was developed and administered over a six-month period from April to August 2021 by the survey firm Bruno & Ridgway, who was contracted directly by the RWJBH system. The survey focused on health issues and concerns that impact the community; community safety and quality of life; personal health attitudes, conditions, and behaviors; barriers to accessing health care; discrimination when receiving medical care; and the impact of COVID-19 and vaccination compliance. The survey was administered online and was available in paper in 5 languages (English, Spanish, Portuguese, Arabic, and Chinese).

Outreach for survey dissemination was conducted with assistance from the RWJBH system, the hospital, and its community partners, as well as through social media and the web. Additionally, an online panel sample was recruited to capture additional survey responses from specific areas to augment the larger sample. Postcards with QR codes that linked to the survey were distributed at vaccination events for community members to take while they waited for their COVID-19 vaccine.

The final sample of the community priorities survey comprised 273 respondents who were residents of Hudson County. Appendix F provides a table with demographic composition of survey respondents. Respondents to the Hudson County Community Health Needs Assessment Survey were predominately White, female, and higher socioeconomic status. About 74% were employed full-time. Throughout this report, Hudson County residents who participated in the Community Health Needs Assessment Survey are referred to as “respondents” (whereas focus group members and interviewees are referred to as “participants” for distinction).

Analyses

Frequencies were calculated for each survey question. Not all respondents answered every question; therefore, denominators in analyses reflect the number of total responses for each question, which varied by question. Statistical testing (Z-tests) was conducted across sub-groups to determine whether there were significance differences between groups. Survey data by race/ethnicity specifically is presented in this report. Racial/ethnic groups are delineated by a letter (A, B, C, D). When a graph has a letter next to the bar, it indicates that the group for that bar has a statistically significant different frequency of responses compared to the group of the letter shown (e.g., when an A is on the bar of White respondents, it indicates that percentage of White respondents answering the question in that

particular way is statistically significantly different than Asian respondents). Significant differences at 90% confidence levels are presented in the report.

Data Limitations

As with all data collection efforts, there are several limitations that should be acknowledged. Numerous secondary data sources were drawn upon in creating this report and each source has its own set of limitations. Overall, it should be noted that different data sources use different ways of measuring similar variables (e.g., different questions to identify race/ethnicity). There may be a time lag for many data sources from the time of data collection to data availability. Some data are not available by specific population groups (e.g., race/ethnicity) or at a more granular geographic level (e.g., town or municipality) due to small sub-sample sizes. In some cases, data from multiple years may have been aggregated to allow for data estimates at a more granular level or among specific groups.

With many organizations and residents focused on the pandemic and its effects, community engagement and timely response to data collection requests were challenging. Additionally, with its online administration method, the community survey used a convenience sample. Since a convenience sample is a type of non-probability sampling, there is potential selection bias in who participated or was asked to participate in the survey. Due to this potential bias, results cannot necessarily be generalized to the larger population. Similarly, while interviews and focus groups provide valuable insights and important in-depth context, due to their non-random sampling methods and small sample sizes, results are not necessarily generalizable. Due to COVID-19, focus groups and interviews were also conducted virtually, and therefore, while both video conference and telephone options were offered, some residents who lack reliable access to the Internet and/or cell phones may have experienced difficulty participating. This report should be considered a snapshot of an unprecedented time, and the findings in this report can be built upon through future data collection efforts.

Population Characteristics

Population Overview

According to the 2016-2020 American Community Survey (U.S. Census), Hudson County is the fourth most populous county in New Jersey (671,923 residents). The Jersey City Medical Center’s primary and secondary service area comprises 6 Jersey City zip codes (totaling 330,002 residents), and the cities of Bayonne (65,112 residents), Hoboken (53,283 residents), and Union City (68,073). There has been great variability in population growth across the areas examined. Whereas New Jersey overall and Hudson County, specifically, have seen minimal changes in total population between the periods 2011-2015 and 2016-2020, Jersey City zip code 07302 experienced a population growth explosion (18.5%), whereas zip codes 07306 and 07307 experienced an important population exodus during the same period (-7.1% and -9.9%, respectively). The population of Bayonne and Union City declined (-0.4% and -0.8%, respectively) and that of Hoboken increased (1.6%) minimally over this time (Table 1).

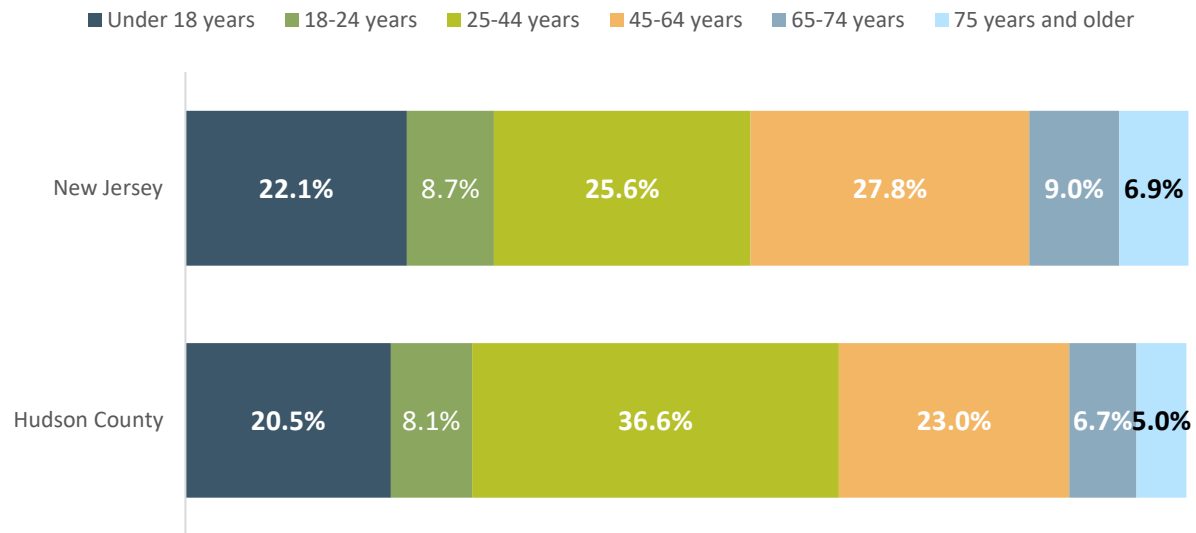
Table 1. Total Population, by State and County, 2011-2015 and 2016-2020

	2015	2020	% change
New Jersey	8,904,413	8,885,418	-0.2%
Hudson County	662,619	671,923	1.4%
Bayonne	65,378	65,112	-0.4%
Hoboken	52,452	53,283	1.6%
Jersey City	327,847	330,002	0.7%
Jersey City (07302)	39,964	47,339	18.5%
Jersey City (07304)	42,935	43,554	1.4%
Jersey City (07305)	63,440	66,595	5.0%
Jersey City (07306)	55,296	51,378	-7.1%
Jersey City (07307)	44,400	40,012	-9.9%
Jersey City (07310)	13,156	13,051	-0.8%
Union City	68,656	68,073	-0.8%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

More young adults lived in Hudson County compared to New Jersey overall in 2016-2020 (Figure 3), with about 37% of the population being between the ages of 25-44 years old; in contrast fewer children under 18 years of age and older adults live in the county. Age distribution data by town and gender can be found in the Appendix of additional data.

Figure 3. Age Distribution, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

When examining age distribution data by race/ethnicity in Hudson County, children under 18 made up a greater percentage of the population among persons of Other Race (26.9%) and Hispanic/Latinos (15.7%), followed by Black (14.6%), and a smaller proportion of Asian (11.2%) and White (10.3%) residents. Adults aged 65 and over comprised 9.9% of the White population compared to 6.1% of the Asian population, see Table 2.

Table 2. Age Distribution, by Race/Ethnicity, State, and County, 2016-2020

	Asian					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	14.6%	5.0%	21.8%	17.0%	4.8%	3.0%
Hudson County	11.2%	4.7%	32.8%	11.9%	3.8%	2.3%
	Black					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	15.0%	6.7%	18.3%	17.3%	4.8%	3.3%
Hudson County	14.6%	6.9%	21.0%	15.7%	4.2%	3.1%
	Hispanic/Latino					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	19.1%	6.7%	20.4%	14.9%	3.3%	2.2%
Hudson County	15.7%	6.1%	20.7%	16.0%	4.4%	3.4%
	White					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	12.2%	5.1%	14.7%	20.1%	7.8%	6.3%
Hudson County	10.3%	4.0%	27.3%	15.8%	5.5%	4.4%

	Some Other Race					
	Under 18 years	18-24 years	25-44 years	45-64 years	65-74 years	75 years and older
New Jersey	28.5%	10.3%	32.4%	21.5%	4.6%	2.6%
Hudson County	26.9%	9.3%	33.5%	22.8%	5.1%	2.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

NOTE: Some Other Race includes individuals that identified as American Indian/Alaskan Native, Native Hawaiian or Other Pacific Islander, or as some other race.

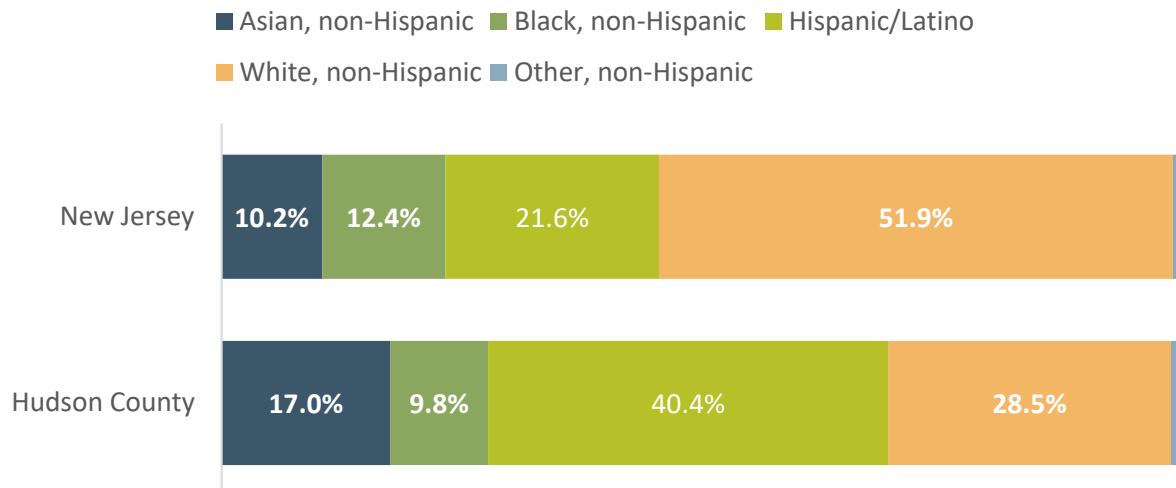
Racial, Ethnic, and Language Diversity

Racial and Ethnic Composition

Focus group members and interviewees described their communities as racially and ethnically diverse and valued this diversity as one of Hudson County’s greatest assets. The secondary data support these perceptions. Hudson County is predominantly made up of Hispanic/Latino residents, which make up 40.4% of its population, followed by White non-Hispanic (28.5%), Asian (17.0%), and Black (9.8%). Hudson County has proportionally more Hispanic/Latino and Asian residents than New Jersey as a whole (Figure 4). See the Appendix for detailed data tables.

“Jersey City’s greatest strength has always been diversity.” – Focus group participant

Figure 4. Racial and Ethnic Distribution, by State and County, 2020



DATA SOURCE: U.S. Census Bureau, Decennial Census of Population and Housing, 2020

Data labels not shown for percentages <4%.

In 2016-2020, the racial and ethnic distributions varied widely across Hudson County (Table 3) with Hoboken and Union City being the most homogenous cities, and zip codes within Jersey City being quite diverse. For example, in Jersey City zip code 07310, 57.3% of the population identified as Asian, compared to 3.5% in Union City. The largest Black population was found in zip codes 07305 and 07304, which made up 44.1% and 34.8% of residents, compared to 2.3% in Union City and 2.6% in Hoboken.

Residents identifying as Hispanic/Latino made up 76.7% of the Union City and 42.2% of the Jersey City zip code 07307 population, in contrast to 9.3% in zip code 07310. Residents identifying as non-Hispanic White were concentrated in Hoboken (67.1% of residents), followed by Bayonne (44.3%), and made the smallest proportion of the population in zip code 07305 (11.7%).

Table 3. Racial and Ethnic Distribution, by Town, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	Other Race/Ethnicity, Non-Hispanic
Hudson County					
Bayonne	9.8%	8.4%	34.5%	44.3%	0.5%
Hoboken	11.7%	2.6%	15.3%	67.1%	0.2%
Jersey City (07302)	32.2%	6.6%	16.7%	40.1%	0.3%
Jersey City (07304)	13.5%	34.8%	32.9%	14.9%	1.4%
Jersey City (07305)	16.7%	44.1%	23.4%	11.7%	1.7%
Jersey City (07306)	34.8%	9.9%	28.4%	23.0%	1.1%
Jersey City (07307)	24.4%	6.5%	42.2%	24.2%	0.9%
Jersey City (07310)	57.3%	5.4%	9.3%	23.1%	1.3%
Union City	3.5%	2.3%	76.7%	15.9%	0.6%

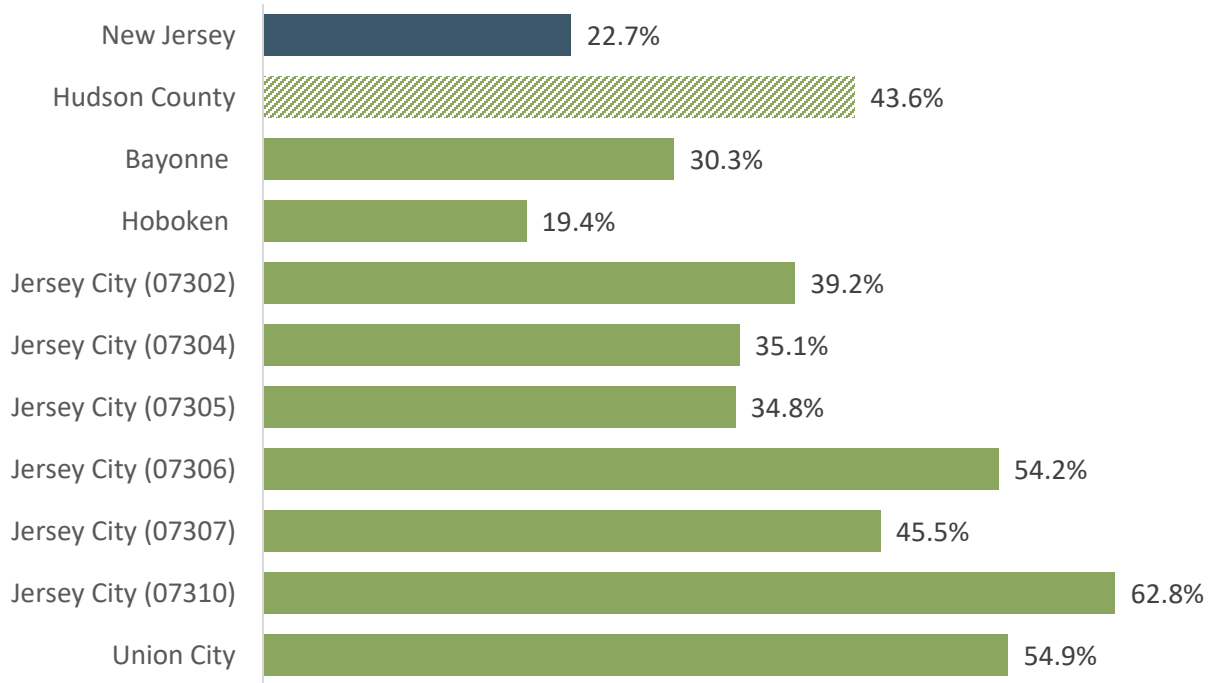
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Foreign-Born Population

Key informant and focus group participants described a robust immigrant community in Hudson County. Multiple waves of migration resulted in pockets of recent and not-so-recent immigrants from many Latin American and Caribbean as well as Southeast Asian countries. Secondary data show varying levels of the foreign-born population across Hudson County. More than two out of every five Hudson County residents are foreign born (43.6%), double the percentage of foreign-born residents in New Jersey as a whole (22.7%). In 2016-2020, the foreign-born population ranged from 19.4% in Hoboken to 62.8% in Jersey City zip code 07310 (Figure 5). In Hudson County, the most common countries of origin for immigrant residents were India and the Dominican Republic (making up 12.8% and 12.1% of the immigrant population, respectively). The majority of other immigrants were from Latin America and the Caribbean, primarily Ecuador, Cuba, and Colombia (see Table 4).

“The [Filipino] community has strong roots, and generations of families that have made Jersey City their home.” – Focus group participant

Figure 5. Percent Foreign Born Population, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 4. Foreign-Born Population by Top Countries of Origin, by State and County, 2016-2020

New Jersey		Hudson County		
1	India	13.1%	India	12.8%
2	Dominican Republic	9.1%	Dominican Republic	12.1%
3	Mexico	5.1%	Ecuador	6.5%
4	Colombia	4.3%	Cuba	6.4%
5	Ecuador	4.1%	Colombia	5.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

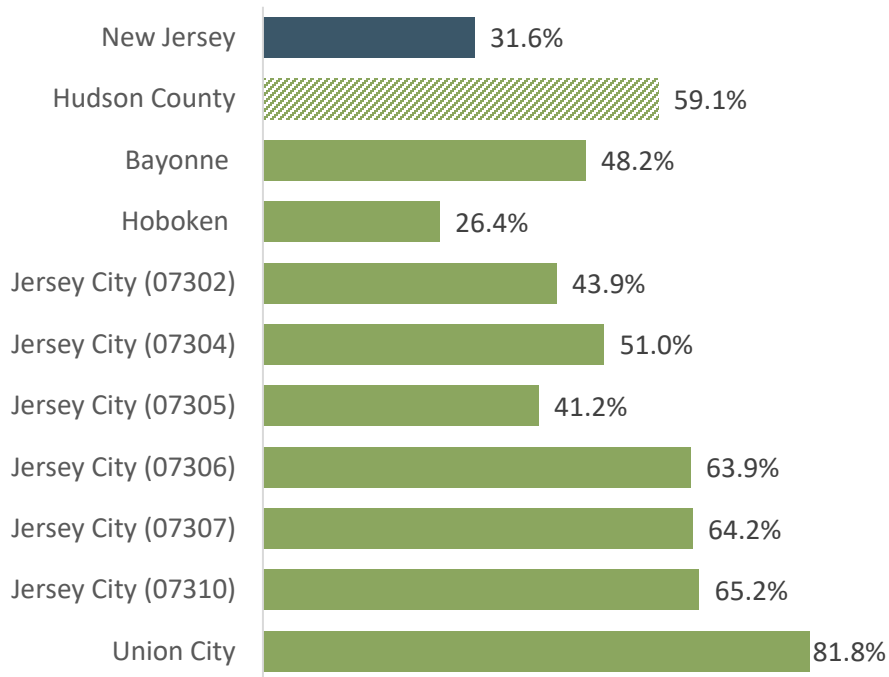
Several participants mentioned the struggles faced by undocumented immigrants in their day-to-day life because of their status. The anti-immigrant rhetoric of recent years, coupled with increases in raids targeting immigrants, has severely affected the mental well-being of this community, provoking undue stress and anxiety. This is coupled by barriers to access basic protections related to employment and housing due to their legal status. Further, these populations have been among the most affected by COVID-19, both in terms of sickness, as well as in terms of job loss. Whereas free or low-cost medical care is available to everyone regardless of documentation status via the FQHCs and other providers, participants commented that more efforts are needed to reach the entire eligible population and bridge the care gap.

“This a time when immigrants are feeling unsafe. They're scared going and saying, “I'm undocumented”.”– Key informant interviewee

Language Diversity

A majority of Hudson County residents over age five (59.1%) reported speaking a language other than English at home in 2016-2020, with large local differences. For example, almost five in six Union County residents (81.8%) and four in six in Jersey City zip codes 07306 (63.9%), 07307 (64.2%), and 07310 (65.2%) spoke a language other than English at home, compared to one in four Hoboken residents (26.4%) (Figure 6). A variety of languages are spoken across Hudson County, as indicated in the secondary data and supported by qualitative discussions. The most spoken languages other than English are Spanish (37.1%), other Indo-European languages (e.g., Portuguese, Hindi, Gujarati) (8.3%), Arabic (2.6%), Chinese (2.4%), and Tagalog (2.1%) (Table 5). Other languages spoken include Russian, Polish and other Slavic languages; French, Haitian or Cajun; Korean; and Vietnamese, reflecting the county's diverse communities. The distribution of these languages is not even. For example, three-quarters of residents in Union City speak Spanish (75.8%), while 24.9% of residents in Jersey City zip code 07310 speak other Indo-European languages and 19.7% speak Chinese. There are also, for example, pockets of Arabic speakers in Bayonne and Jersey City zip codes 07306 and 07304; while the Filipino community is largely concentrated in Jersey City zip codes 07304, 07305, and 07306.

Figure 6. Population Aged 5+ Speak Language Other Than English at Home, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 5. Top Languages Spoken at Home, by State, County, and Town, 2016-2020

	Speak only English	Spanish	Other Indo-European languages	Chinese (incl. Mandarin, Cantonese)	Tagalog (incl. Filipino)	Other Asian and Pacific Island languages	Arabic
New Jersey	68.4%	16.4%	5.4%	1.4%	0.9%	1.5%	0.9%
Hudson County	40.9%	37.1%	8.3%	2.4%	2.1%	1.7%	2.6%
Bayonne	51.8%	25.0%	5.3%	0.6%	2.7%	1.2%	8.1%
Hoboken	73.6%	10.2%	4.6%	4.5%	0.4%	0.8%	0.1%
Jersey City (07302)	56.1%	9.6%	13.6%	7.3%	1.4%	3.6%	0.7%
Jersey City (07304)	49.0%	29.1%	2.3%	0.4%	5.5%	1.5%	6.7%
Jersey City (07305)	58.8%	18.5%	3.4%	0.9%	6.4%	0.3%	2.4%
Jersey City (07306)	36.1%	22.4%	18.9%	1.7%	5.8%	4.2%	6.8%
Jersey City (07307)	35.8%	36.6%	18.2%	1.1%	1.3%	2.1%	1.8%
Jersey City (07310)	34.8%	8.4%	24.9%	19.7%	0.1%	6.3%	0.1%
Union City	18.2%	75.8%	1.8%	1.1%	0.4%	0.4%	0.7%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

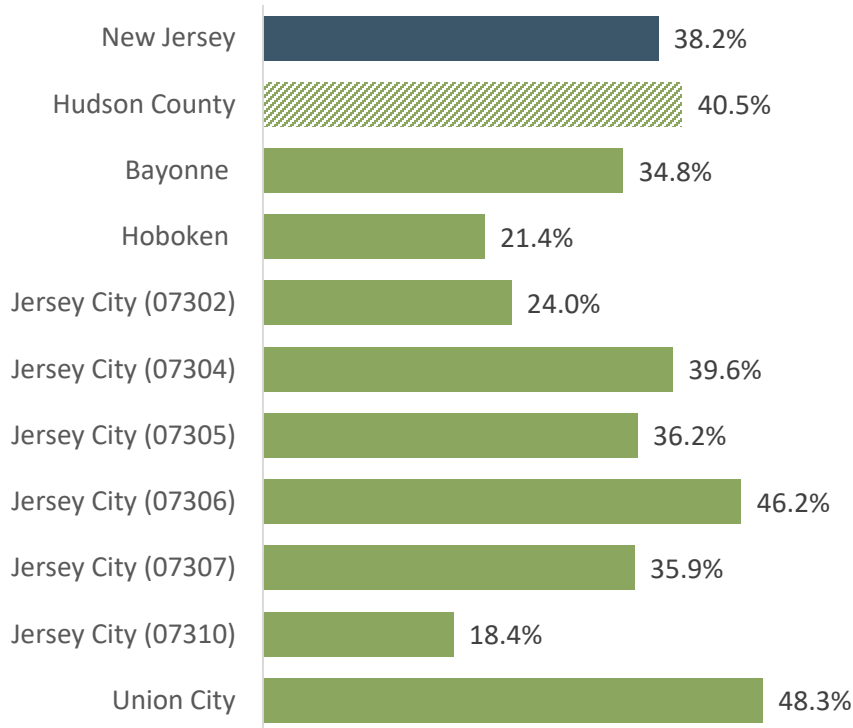
Many participants agreed that one of Jersey City and Hudson County's greatest strength is its diversity. Based on resident feedback, Hudson County is a welcoming place for foreign-born persons, non-English speakers, and people of diverse ethnic backgrounds. A Filipino resident expressed it as, *"the [Filipino] community has strong roots, and generations of families that have made Jersey City their home."* Overwhelmingly, residents indicated that they enjoyed the opportunity to learn about different cultures, and to access foods and other cultural elements from a variety of regions. As a focus group participant explained, *"It's a multicultural city so you have several different ethnicities... you get to learn about the food and people's culture."* Residents overall also

"I do feel welcome by healthcare providers, but I have experienced going with my parents who are immigrants with heavy accents, and I have experienced miscommunication." – Focus group participant

valued that medical and social services providers looked like them and spoke to them in their native language. However, opinions differed in terms of the availability of multilingual providers and providers of color. Whereas residents of Indian descent indicated that *"there are plenty of Indian, multiple language speakers, physicians in the JCMC and in the community,"* Latino residents were more nuanced noting that whereas the federally qualified health centers (FQHCs) had ample Spanish speakers, hospitals in the area needed more staff that spoke their language.

While diversity was a substantial community strength, participants noted that it could also be a challenge to engagement. In Hudson County, 40.5% of residents were not proficient in English in 2016-2020, ranging from 18.4% in Jersey City zip code 07310 to 48.3% in Union City. Lack of English proficiency can pose a barrier to entering the professional workforce, learning, and accessing healthcare. Those working in the social sector worried about populations not reached with information or services. In the words of a public health official, *"we talk to funders all the time about how to translate health information into other languages, how to connect to communities. We talk about it all the time, how to get into mosques, communicate in other ways besides English newspapers, how to create equity for people who are following the news."* In addition, lack of English-proficiency can lead to discrimination. According to survey data, 22.7% of Asian respondents and 17.6% of Latino community respondents specifically described being discriminated against because of language/speech issues when receiving medical care (discussed in greater detail in the Discrimination and Racism section of this report.)

Figure 7. Population Lacking English Proficiency (Out of Population Who Speak a Language Other Than English at Home), by State, County, and Town, 2016-2020

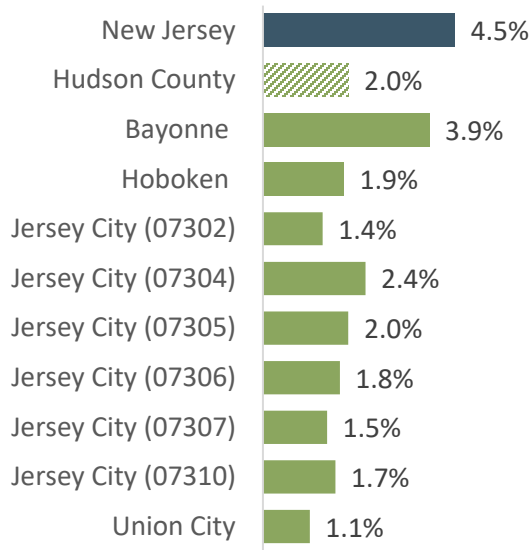


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

U.S. Veterans

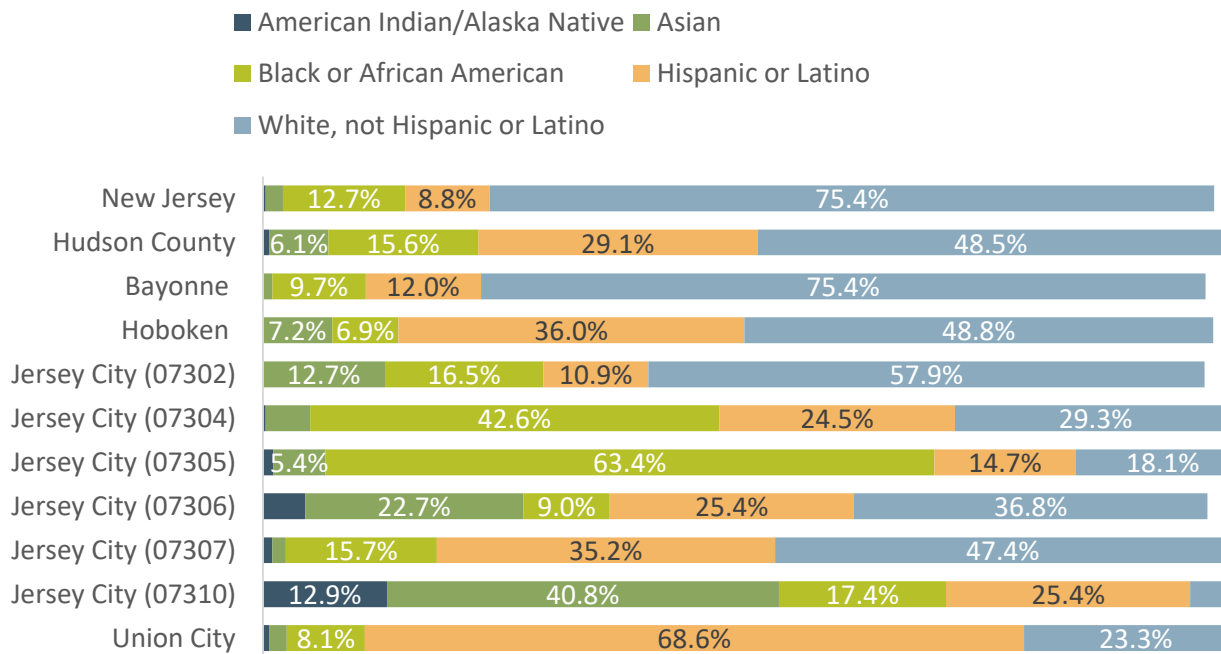
One of the groups whose needs were highlighted during discussions were U.S. veterans. About 2% of the Hudson County population are veterans, with the city of Bayonne having the highest percentage of the areas observed (3.9%) (Figure 8). The race/ethnicity of veterans in Hudson County mimics the diversity of the county’s population. Hudson County has proportionately more veterans who identify as Asian (6.1%), Black (15.6%), and Latino (29.1%) residents than the state (Figure 9), with important variation across neighborhoods. A majority of veterans in Jersey City zip codes 07304 and 07305 identify as Black (42.6% and 63.4%, respectively), whereas 40.8% of veterans in Jersey City zip code 07310 identify as Asian, and 68.6% of veterans in Union City identify as Latino. Bayonne and Jersey City 07302 have the highest concentration of White veterans (75.4% and 57.9%, respectively).

Figure 8. Percent Population 18+ Years with Veteran Status, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 9. Racial/Ethnic Distribution of Veterans, by State, County, and Town, 2016-2020



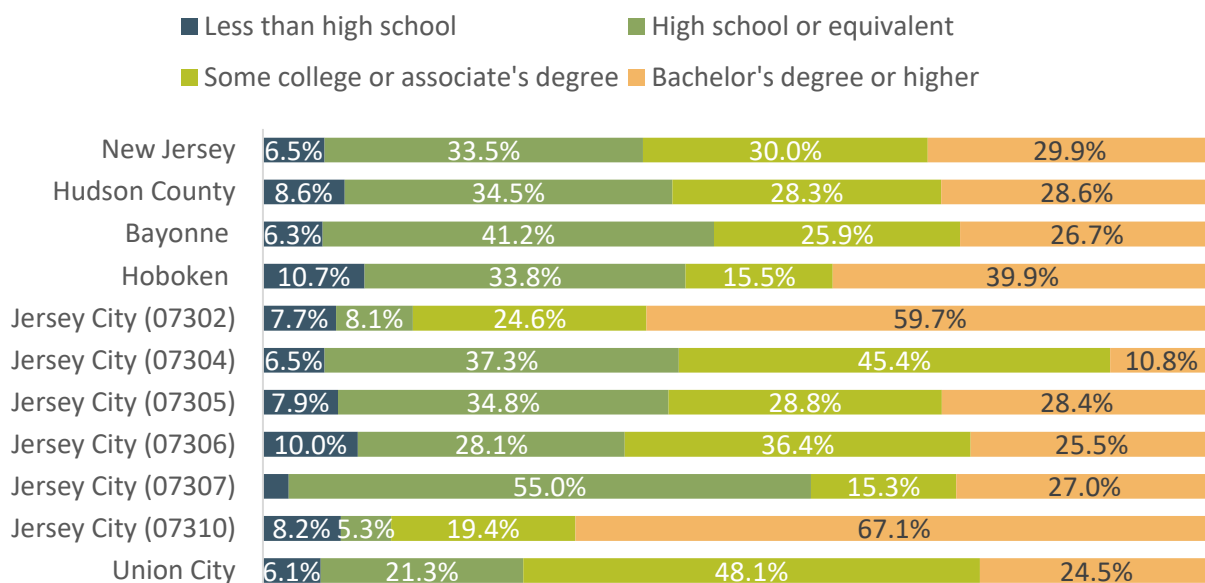
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive unless stated. Values under 5.0% are omitted for clarity.

Veterans in Hudson County remarked that they had limited employment opportunities available to them. They mentioned that, often, the jobs available to them after serving the government were for positions requiring no special skills, underpaid, and with few possibilities for advancement. Education is

an important factor in gaining access to higher-paying positions. When examining the educational attainment of veterans in Hudson County, we observe that most veterans did not have a bachelor's degree or higher (71.4%) (Figure 10). Only 10.8% of residents obtained a college degree in Jersey City zip code 07304, where many Black veterans reside. Employment and education, together with mental and physical health, are closely related to poverty. A higher proportion of veterans in Hudson County live below the poverty line than in New Jersey (7.5% vs. 5.2%, respectively). This proportion is much higher in Jersey City 07306, where one in five veterans live in poverty, and Jersey City zip code 07305, where 18.0% do. It is important to remember that the poverty line is substantially below a livable income and has become even more so recently with high rates of inflation. Special issues faced by veterans are discussed throughout the report in the specific topic area sections.

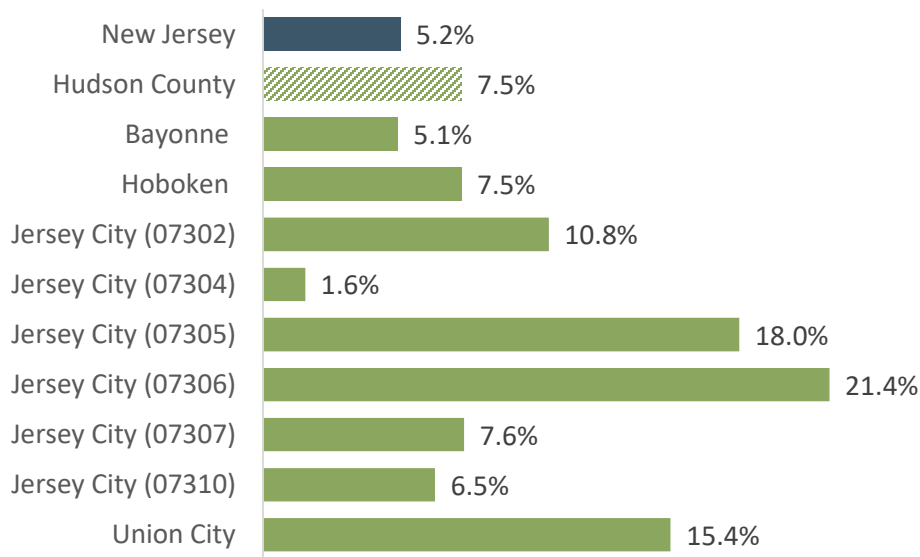
Figure 10. Educational Attainment of Veterans, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

NOTE: Values under 5.0% are omitted for clarity.

Figure 11. Percent Veterans Below Poverty Level, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Community Social and Economic Environment

Income, work, education, and other social and economic factors are powerful social determinants of health. For example, jobs that pay a living wage enable workers to live in neighborhoods that promote health (e.g., built environments that promote physical activity and resident engagement, better access to affordable healthy foods), and provide income and benefits to access health care. In contrast, unemployment, underemployment, and job instability make it difficult to afford housing, goods and services that are linked with health and health care, and also contribute to stressful life circumstances that affect multiple aspects of health.

Community Strengths and Assets

Understanding the resources and services available in a community—as well as their distribution—helps to elucidate the assets that can be drawn upon to address community health, as well as any gaps that might exist.

Strong Community and Partnerships

In addition to diversity noted previously, another strength mentioned by participants was solidarity and a strong sense of community. Time and time again, participants noted that neighbors came together to help those in need. As a resident noted, *“My specific neighborhood is very close knit, you know the people in the area and people are willing to help you. For example, when it snows, I’ve had young kids, young teenagers ask like, can we help you?”*

Residents remarked that the community was able to organize and take action to address people’s needs and this came to the forefront throughout the pandemic, including through generous donations. A healthcare administrator echoed this sentiment, *“these are communities that show up when the need is there, and we saw that during the COVID pandemic. We raised over a million dollars for an emergency response fund, from old donors and new donors.”*

“I’m new to Jersey City, but I noticed since doing Covid work in June that there is a strong sense of community.”
– Focus group participant

At an institutional level, another strength are the robust partnerships established among multiple organizations and across sectors, including grassroots organizations, government, small businesses, social services agencies, and healthcare centers. These collaborations are exemplified by the Partnership for a HealthierJC, made up of nearly 300 member organizations. A public health official noted, *“We have great partners. Hudson County is very tight, so we all work together.”* As a health administrator said when reflecting on the response to COVID-19, *“As organizations ... who did demonstrate that more than whatever resources were available to our community, we all jumped in and that includes Jersey City Medical Center. We were able to get people in and out of the hospitals quickly and people were able to communicate with each other.”* This was echoed by public health staff from different areas of Hudson County, as exemplified by what this participant from Bayonne said, *“Whenever there is an emergency, Bayonne comes together as a community to help people out, through donations or referrals for services.”*

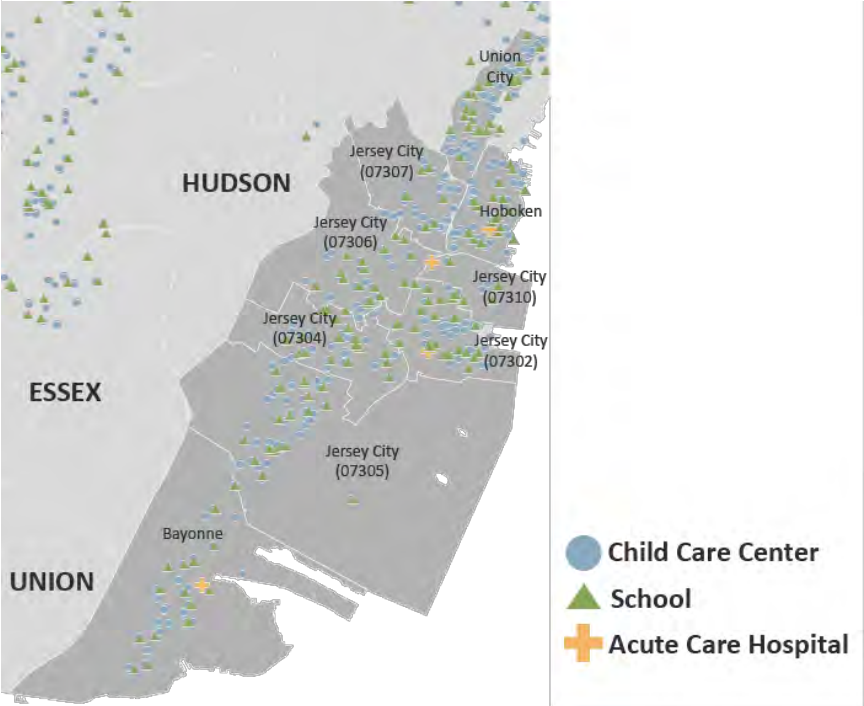
Public Services and Programs

Some participants indicated that their elected officials were a source of strength in Hudson County. A diverse array of residents, including from the Latino, Asian, and LGBTQ+ community, indicated being represented and supported by government leaders. One example of support for the LGBTQ+ community was the recent passing of the law to let students use bathrooms that are consistent with their gender identity, considered an important step in fostering welcoming and safe spaces for gender nonbinary youth. Residents noted that the Jersey City government was responsive to their needs and that they received abundant support during the COVID-19 pandemic, as expressed by a Latino resident, *“The mayor’s office provides very good services; for example, if someone has to travel far to get to the doctor, or if they need translation of a document to Spanish—you can call the mayor’s office for everything.”*

Overall, residents indicated that Hudson County offers many services to people to ensure that residents live well and can access their basic needs. The map below shows the distribution of hospitals, schools, and childcare centers in the area.

There are four acute care hospitals as well as 151 schools and 301 childcare centers in the JCMC service area (Figure 12).

Figure 12. Community Assets Map of Hudson County, 2018 & 2020



DATA SOURCE: New Jersey Geographic Information Network (NJGIN), Schools and Child Care Centers, 2018 and Acute Care Hospitals, 2020

As one resident summed up, “...there is something going on almost every week to help with food, home purchases, that’s one of the things I really love about Jersey City.” A Hoboken resident expressed something similar, noting that a strength in Hoboken were the “strong non-profit organizations and religious organizations that provide supportive services related to housing assistance and information, nutritional support, recreational activities for children, tutoring...” Latino residents discussed how the county offered resources in the community to support people, including people who are low-income, undocumented, and/or without health insurance.

“From my experience, over 20 years, I feel that the greatest strengths are the community-based organizations. We have a wide range of individuals who form different communities, even small grassroots community-based organizations, to engage people in healthy ways.” – Key informant interviewee

Other Community Assets

Community survey respondents partially agreed with these themes. When asked how much they agreed or disagreed with a number of statements about their community, responses were similar to when this survey was administered in 2019. The strengths identified by the greatest proportion of respondents in 2021 were that it was easy to find fresh fruits and vegetables in their communities (73.6%), that their communities had safe outdoor places to walk and play (70.3%), and that their community was a good place to raise a family (59.7%) and to socialize (58.2%) (Figure 13). These were the same top responses in 2019.

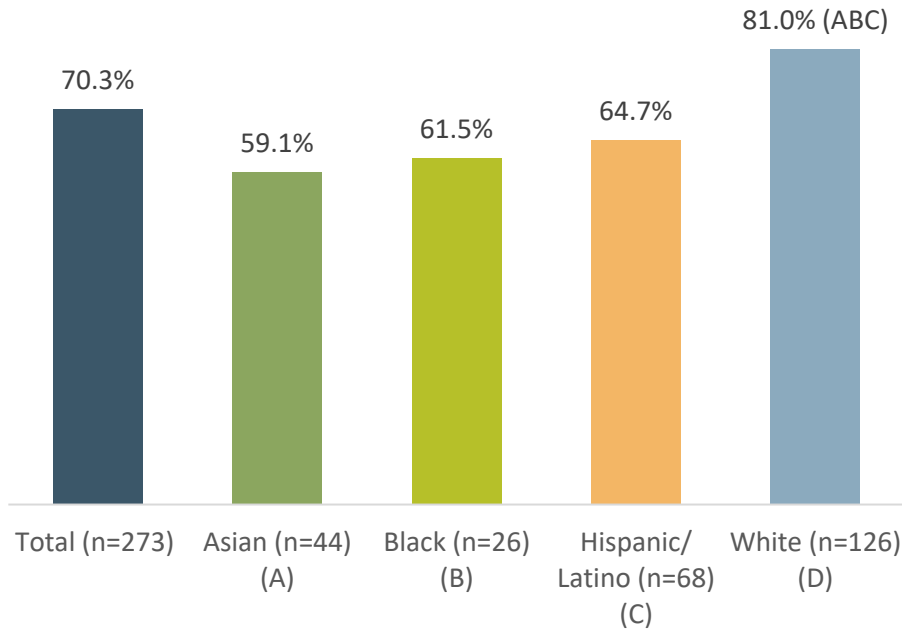
Figure 13. Percent of Community Survey Respondents Noting Strengths in Their Community (Agree or Completely Agree with Statements) (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

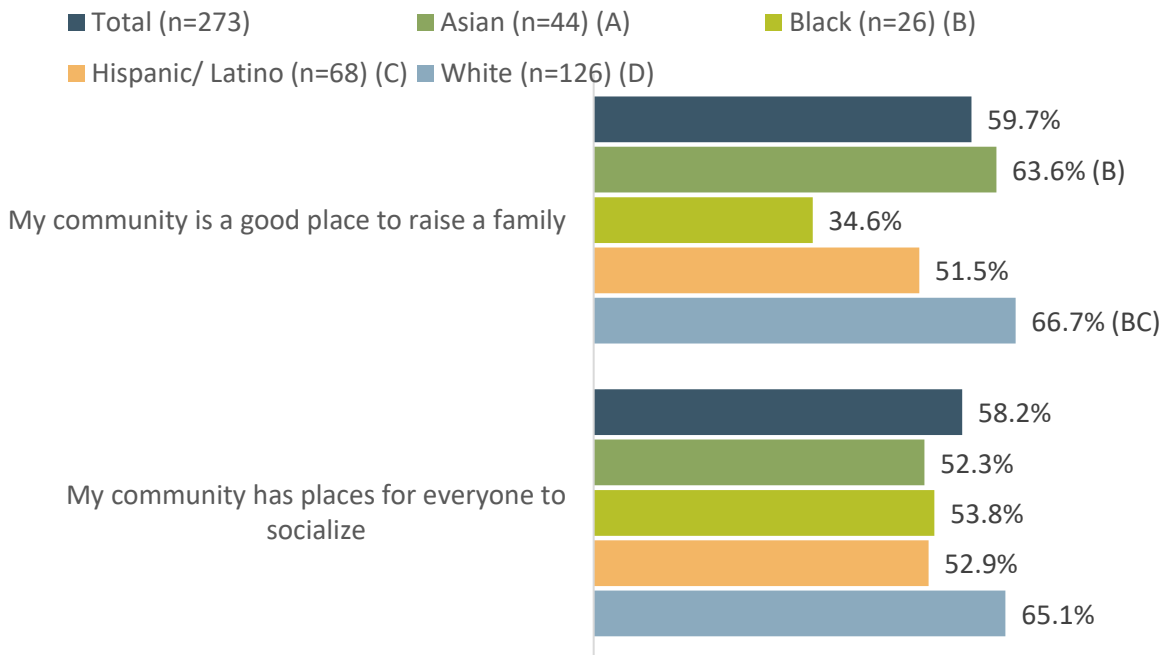
However, responses to these questions varied by race/ethnicity. For example, as can be observed in Figure 14, White respondents were significantly more likely than Asian, Black, and Latino respondents to agree or completely agree that their community had safe outdoor places to walk and play. As described in the Methods section, when a graph of community survey data has a letter next to the bar, it indicates that the group for that bar has a statistically significant different frequency of responses compared to the group of the letter shown. As shown, whereas 81.0% of White respondents perceived outdoor spaces as safe, only 59.1% of Asian respondents did so. Whereas there were no significant differences by respondents' race/ethnicity to the statement about having spaces to socialize, Asian (63.6%) and White (66.7%) respondents more often indicated that the community was a good place to raise their family than Black (34.6%) respondents (Figure 15). (More detailed discussions of responses by different population groups of other survey questions are found in the topic-specific sections of this report.) Additional data are available in Appendix F- Additional Data Tables.

Figure 14. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “My community has safe outdoor places to walk and play”, by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Figure 15. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement, by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Education

Educational attainment is another important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty.

School Environment and Health

A positive school environment is an important determinant of physical and mental wellbeing, as well as academic success, staying in school, and opting to continue on to higher education. An interviewee who was a member of the LGBTQ+ community lauded schools for their efforts to make school safe and welcoming to all youth. In their words, “[LGBTQ+] youth are still dealing with bullying, [but] schools are reaching out to learn and make spaces safer. School leaders come in to engage us as a liaison, to organize school clubs that are inclusive and to receive cultural competency training from us.”

Conversely, being healthy is a key factor in being academically successful. Schools play an important role in facilitating access to care and helping students stay healthy. A school administrator described some of the public school’s efforts to address the mental health needs of students, “We’ve been trying through the schools with our resources to really embed more social and emotional [support to] help students overcome challenges, develop resilience, and be able to speak about their emotions. [We have] incorporated that through the curriculum, through our school counselors, through our school psychologist.” Many students also face poverty and food insecurity; in providing free or low-cost lunches, schools also play an important role in ensuring basic nutrition for children.

Public Schooling

Focus group and interview participants discussed how the public school system in Hudson County faces a variety of issues. One is a lack of sufficient resources to attend to the needs of high-need population groups. There is a perpetual shortage of qualified educators, particularly in those areas where teachers need additional certifications or schooling. An education administrator emphasized that more qualified Special Education teachers, bilingual teachers, and content area teachers, like those that teach Science and Math, are needed to meet the needs of the student population. Another issue that came up was the lack of affordable after school programs, particularly important for children of low-income earners.

In some areas of Hudson County, such as Hoboken, a problem identified by participants was that there is insufficient space to accommodate the growing number of school children. Residents expressed that “[population] growth was not planned,” leading to overcrowding in public and charter schools. Residents discussed how new buildings and improved infrastructure for schools were needed to accommodate the influx of new residents coming to the new condominium buildings.

In spite of these challenges, most Hudson County residents indicated that public school leadership was supportive of students’ needs and open to partnerships with different organizations to better serve the community. Many residents remarked that the school leadership was attuned to the needs of students and their families, many of whom face multiple struggles. Given the large immigrant community in Hudson County, schools must accommodate to the needs of English-language learners.

Key informant interviewees indicated that Hudson County public schools fall along a broad spectrum encompassing both the top-ranking, as well as the lower performing, schools in New Jersey. School performance is determined largely by the socioeconomic situation of the community that draws the student population. There is an inverse association between socioeconomic status and high school graduation rates. Key informant interviewees noted that students experiencing poverty often had to drop out of school to start working and

“We have children who are immigrants and come in when they’re 16 years old and are learning English. They need to graduate from high school, but they also need a job because economically they need to go work. It’s a challenge.”

– Key informant interviewee

contribute an income to their families. These students’ vision for the future oftentimes does not include college as a career path unless they have access to a mentor who can help them enter a professional career. Key informant interviewees explained that low-income students faced multiple obstacles to entering college, including not being able to afford it; having to full-time to support the family; and not seeing the usefulness of a college degree. Based on this context, key informant interviewees indicated that public schools were trying to equip students’ transition into the workforce by incorporating classes and training related to workplace readiness. *“We’ve been working on it trying to incorporate more careers, not just OK you’re gonna graduate and go to college and then get a job. But, you know, addressing the needs of those students who will not go to college.”*

Inequities in school performance are confirmed by graduation rate data from different Hudson County districts. Whereas in 2020-2021 the Hoboken Public School District had graduation rates slightly above those of New Jersey as whole (93.6% and 92.6%, respectively), the public school districts of Bayonne, Union City, and Jersey City had lower graduation rates, with significant disparities by race/ethnicity within districts (Table 6). For example, 95.3% of Asian students graduated from High School in Bayonne in 2020-2021, compared to 86.4% of Black children and 78.5% of Latino children. Additional information on differences in educational attainment by race/ethnicity and by town is available in Appendix F.

Table 6. 4-Year Adjusted Cohort High School Graduation Rate, by Race/Ethnicity and School District, 2020-2021

New Jersey	Statewide	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	2+ Races
	92.6%	97.6%	88.3%	87.4%	95.9%	93.5%
Hudson County	District Wide	Asian	Black	Hispanic	White	Two+ Races
Bayonne School District	86.4%	95.3%	86.4%	78.5%	94.1%	85.7%
Hoboken Public School District	93.6%	*	90.9%	95.2%	89.5%	N
Jersey City Public Schools	78.0%	93.7%	73.8%	72.8%	85.0%	45.5%
Union City School District	88.5%	*	91.7%	88.3%	90.5%	N

DATA SOURCE: New Jersey Department of Education, School Performance, Adjusted Cohort Graduation Rates, 2020-21

NOTE: * indicates that data is not displayed to protect student privacy. An N indicates that no data is available.

Promising Initiatives

To better address the needs of community, the Jersey City Board of Education has partnered with educators, families, and the community as a whole to launch a promising model known as ‘community schools.’ Community schools provide additional services than regular schools to meet the needs of students and families. In addition to regular school offerings, community schools aim to connect students and parents with a wide range of services, including afterschool programs, counseling, and social services. This model has helped to improve attendance, grades, and student and parent engagement. Some of the schools have brought in health clinics that offer nutrition and health care to both students and their families. According to a school administrator, the key to the success of one of the community schools is that *“it’s a very cohesive community,”* with *“good leadership at the school that has been good in working with the community, the providers,”* and the fact that *“the staff, the teachers are all vested and making it successful.”*

Another successful initiative that participants discussed was The Tiger's Den at Snyder High School, a result of a partnership between JCMC, The NJ Department of Children and Families, and the Jersey City Board of Education. The Tiger's Den offers free, confidential social services to students, families, and staff, including psychological counseling, vocational counseling, workplace readiness programs, academic support, summer employment, and after school programs. The Tiger’s Den also assigns students with mentors who they can talk to about their problems and guide them to resolve issues in a positive way. Graduation rate for students participating in The Tiger’s Den was 99% compared to 60% in the school overall.

These are promising strategies to help more students from low-income families finish High School and either enter the workforce in stable employment or continue on to college, two pathways to facilitate the transition to the middle class.

Inequality

Growing inequality, exacerbated as much by the COVID-19 pandemic as by policies and the existing economic model, was a theme that came out strongly in all focus groups and interviews. Most residents across racial/ethnic groups indicated that Jersey City was catering to the wealthy and that income distribution was unequal. As one participant summarized, *“We have the multimillion front, you know, waterfront properties and then we have below the poverty line, urban homes with very urban problems.”* Residents expressed frustration and a sense of injustice witnessing the rapid concentration of wealth in fewer hands, while employment loss and inflation lead more people into poverty. Residents consistently expressed that the city was catering to affluent families in detriment to middle- and low-income residents, and this was evidenced by policies related to real estate credits; infrastructure and public services investments; and a regressive taxation structure. Often, residents attributed racial/ethnic tension to this growing inequality, as expressed by these words, *“From our perspective you do have a lot of stressors around that, especially with gentrification, there is more tension with people originally from the neighborhood as opposite to newcomers. Tax breaks in one section, and in the African American section you can’t get your garbage picked up, there is tension and anger from the ‘tale of two cities’.”* As these words capture, there is also a racial/ethnic component superimposed on inequality, as Latinos and Black residents are disproportionately affected by household and neighborhood poverty. A Black resident reflected thus on the situation, *“they’re not really including us in the expansion of Jersey City. Jersey City is up and coming, but they’re not making room for low to middle income people... And this is people of all races, they’re not gonna pay all that money for taxes, and there are no jobs here.”*

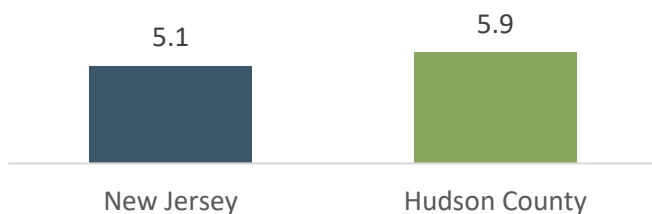
Neighborhood concentrated poverty compounds the effect of household poverty. Explaining the linkage between income, hopelessness, and violence, a resident noted, *“...And then there’s the level of community violence. Feeling really stuck in that cycle that they’re in, violence, income or job opportunities, social determinants of health like housing. People are getting pushed out as more development is coming.”*

“It’s like they don’t want us to be here anymore, they’re just welcoming the rich and affluent... It looks like Jersey City is trying to cater to the affluent instead of the people who grew up here.” – Focus group participant

On reflecting about her vision for the future, a key informant interviewee synthesized the voices of many residents, *“My biggest wish for this community is that we don’t have such an economically diverse community. If there’s a way to really help the families with the lowest resource economic resources to really have a more stable financial sense, that would be the ideal.”*

Inequality is reflected in many of the sections of this report, including education, employment and workforce, income and financial security, and access to healthcare, among others. For example, income inequality is greater in Hudson County (5.9) than in New Jersey overall (5.1) (Figure 16). Income inequality is calculated as the ratio of household income at the 80th percentile to that at the 20th percentile. A higher number indicates a greater income gap between the wealthiest and the poorest households.

Figure 16. Income Inequality (80th to 20th Percentile Income Ratio), by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020

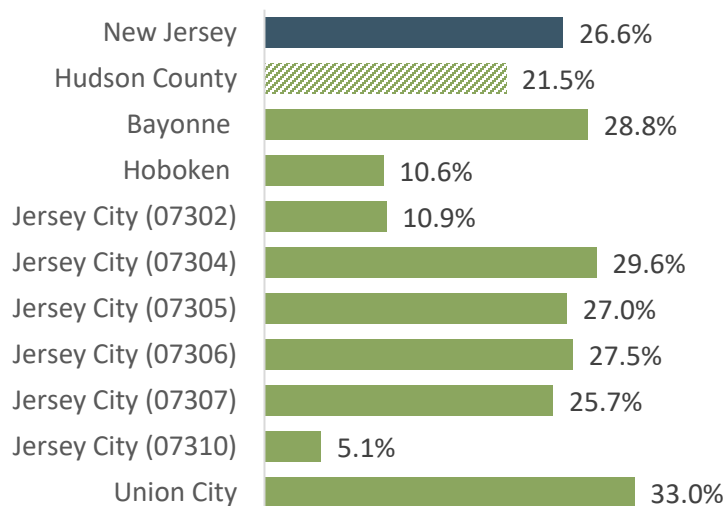
NOTE: The ratio of household income at the 80th percentile to that at the 20th percentile, where the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes, and the 20th percentile is the level of income at which only 20% of households have lower incomes. A higher inequality ratio indicates greater division between the top and bottom ends of the income spectrum.

Employment and Workforce

Employment can confer income, benefits, and economic stability – factors that promote physical and mental health. Two main employment-related issues came out of the focus groups and interviews. On the one hand, many noted that employment opportunities were limited in Hudson County, particularly as a result of the pandemic. Often, they mentioned being unemployed or underemployed. Residents also said that employment opportunities were limited even among people with college degrees without the right connections. Job instability affected many residents across multiple groups. Multiple residents complained of the dearth of well-paid employment opportunities, that offer employees health and social benefits, a fixed income, and a living wage. Many of the residents we interviewed were working poor, who, despite working, could not afford housing, or had to choose between rent, food or medicine. Indeed, in 2018, one in five of the County’s households were Asset Limited, Income Constrained, Employed (ALICE), meaning that although employed, they did not earn enough to support their families (Figure 17), ranging from 5.1% in Jersey City zip code 07310 to 33% in Union City.

“I feel like getting a [college] degree was for nothing sometimes because like why am I still struggling to make it.” – Focus group participant

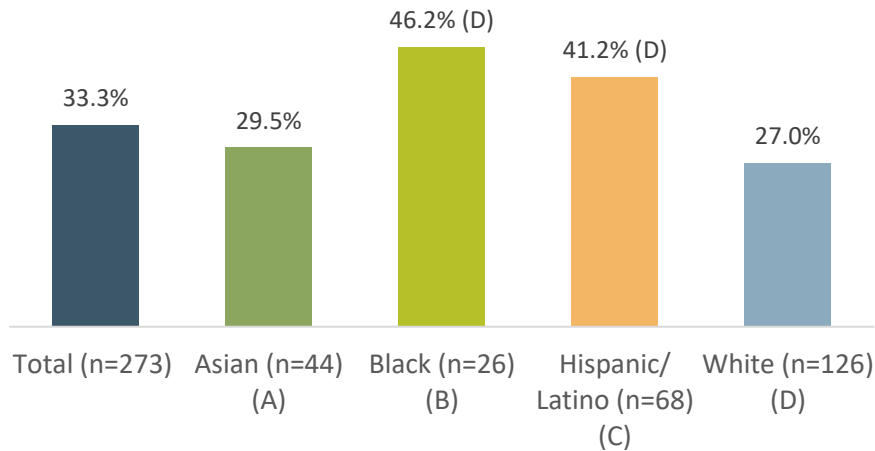
Figure 17. Percent Households Falling into ALICE Population, by State and County, 2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018 as reported by United Ways of New Jersey, Alice in New Jersey: A Financial Hardship Study, 2020

Participants talked about the challenges of the COVID-19 pandemic on essential front-line and lower wage workers, many of whom lost their jobs, either temporarily or permanently. Latino participants mentioned that many factories and restaurants closed during the pandemic and that they could not find jobs. The effects of COVID-19 on employment are also reflected in quantitative data. Black and Latino respondents were significantly more likely than White respondents to report having lost income due to COVID-19 (46.2%, 41.2%, and 27.0%, respectively) (Figure 18). Like New Jersey as a whole, in 2019, prior to the pandemic, Hudson County reported the lowest unemployment rate (3.1%) in recent years according to the Bureau of Labor Statistics (Figure 19). However, unemployment rates in 2020 spiked at 10.2%, recovering slightly to 6.3% in 2021. Additional data can be found in Appendix F- Additional Data Tables.

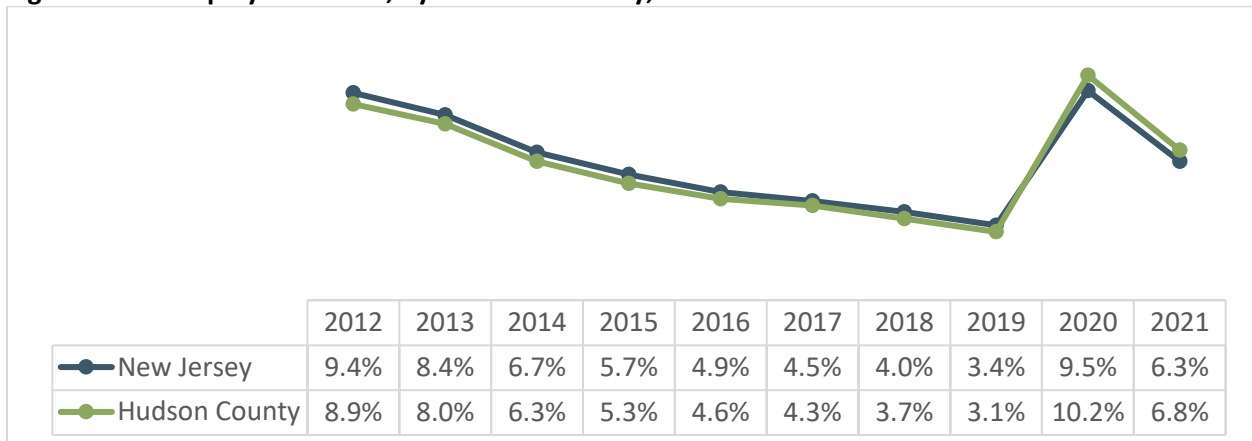
Figure 18. Percent of Community Survey Respondents Reporting that They or a Member of Their Family Lost Employment Due to COVID-19 (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Figure 19. Unemployment Rate, by State and County, 2012-2021



DATA SOURCE: Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012-2021

NOTE: Not seasonally adjusted

The 2016-2020 aggregated data from the American Community Survey show that unemployment rates across Hudson County ranged from 2.4% in Jersey City zip code 07302 to 7.0% in Jersey City zip code 07305 and 9.2% in Jersey City zip code 07304 (Table 7). However, this varies by race/ethnicity (Table 8). Indeed, unemployment rates map onto racial/ethnic groups; as discussed in the section on population characteristics, residents in zip code 070302 are predominantly White (40.1%) and Asian (32.2%), whereas over two-thirds of residents in zip codes 07304 and 07305 are Black and Latino (Table 3). The highest unemployment rates in Hudson County were among Native Hawaiian and Other Pacific Islander residents (35.9%), followed by American Indian and Alaska Native residents (10.1%) in 2016-2020, and the lowest were among Asian (3.5%) and White (4.0%) residents (Table 8). Additional data on unemployment rates can be found in Appendix F- Additional Data Tables.

Table 7. Unemployment Rate among Workers 16 Years and Above, 2016-2020

	2016-2020
New Jersey	5.8%
Hudson County	5.4%
Bayonne	6.5%
Hoboken	3.2%
Jersey City (07302)	2.4%
Jersey City (07304)	9.2%
Jersey City (07305)	7.0%
Jersey City (07306)	4.7%
Jersey City (07307)	4.4%
Jersey City (07310)	2.7%
Union City	6.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

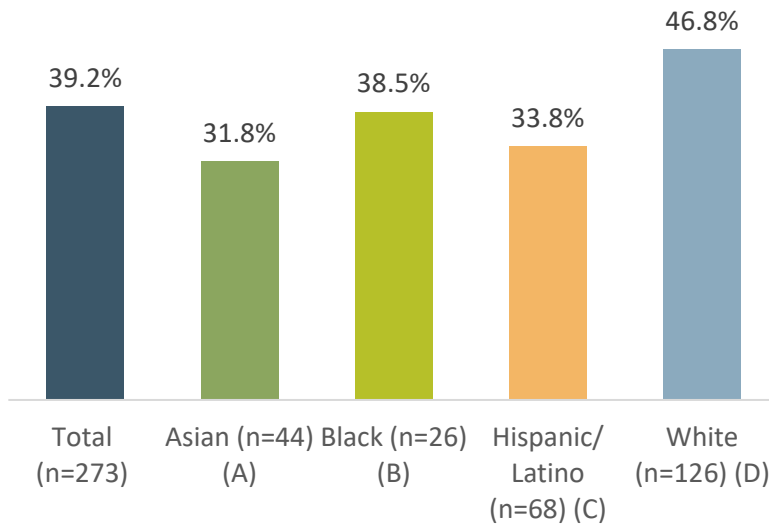
Table 8. Unemployment Rate by Race/Ethnicity, State, and County, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	American Indian and Alaska Native	Native Hawaiian and Other Pacific Islander	Other, Non-Hispanic
New Jersey	4.3%	9.0%	6.4%	5.0%	9.0%	6.5%	6.6%
Hudson County	3.5%	8.1%	6.6%	4.0%	10.1%	35.9%	6.9%
Bayonne	6.9%	6.3%	8.3%	5.6%	0.0%	100.0%	7.3%
Hoboken	3.7%	11.1%	6.3%	2.4%	0.0%	-	3.7%
Jersey City (07302)	1.1%	3.8%	3.3%	2.8%	0.0%	0.0%	2.7%
Jersey City (07304)	4.9%	9.8%	10.0%	9.9%	0.0%	-	10.9%
Jersey City (07305)	4.5%	8.4%	4.8%	8.3%	8.3%	-	6.2%
Jersey City (07306)	3.9%	5.5%	5.9%	5.2%	34.9%	-	3.5%
Jersey City (07307)	2.9%	9.1%	5.7%	2.6%	20.1%	-	3.9%
Jersey City (07310)	3.0%	8.4%	0.4%	2.1%	0.0%	-	0.0%
Union City	7.6%	4.6%	6.5%	3.7%	6.0%	30.2%	8.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When asked about employment in their area, survey respondents were not enthusiastic. Fewer than four in ten respondents agreed that “there are job opportunities in my area.” White respondents were more likely than respondents of any other race/ethnicity to perceive that there were employment opportunities in their area, although the differences were not statistically significant (Figure 20).

Figure 20. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “There are Job Opportunities in My Area,” by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

It is also important to understand overlapping conditions that may affect entering the workforce. Over the same period, unemployment rates in Hudson County were highest among women (5.6% among women compared to 4.9% among men) (Table 22 in the Appendix) and young people (18.8% among 16-19 year-olds and 11.0% among 20 to 24 year-olds) (Table 23 in the Appendix). The greatest difference in the female-to-male employment gap was in Jersey City zip code 07304 (10.8% female vs. 7.7% male unemployment rate), an area with many residents of color.

Residents noted that certain population subgroups in Hudson County faced more obstacles than others when seeking employment opportunities. Because of stigma and discrimination, Black trans women experienced multiple challenges to having a professional career and securing living-wage employment. As one key informant interviewee from the LGBTQ+ community explained, *“Black trans women experience the most barriers to employment. They become sex workers for survival. They have difficult experiences applying to jobs. They are ridiculed when applying to places.”* The options for gainful employment also appeared particularly dire for veterans, who are disproportionately Black and Latino. All veteran focus group participants agreed that the only types of jobs available to them either did not pay a living wage or were government jobs. Veteran focus group members expressed frustration at not being able to access satisfying and stimulating employment with growth opportunities. Residents suggested that more should be done to incentivize employers, including private employers, to hire trans and veteran residents.

When trying to interrupt the cycle of violence, whether domestic or community violence, gainful employment is critical to help survivors get on their feet. As a staff member from a violence interruption program mentioned, *“Employment is always an issue because you can tell folks a better day is coming, but what is the alternative? We try to never use that language unless we have an alternative. My main thing is stay safe and healthy. With the grant we just received, we have an opportunity to have 40-80*

participants, and we train them in electrical, plumbing, HVAC, and carpentry. Now we have something to say, I've got a job for you as long as you learn a skill and graduate from this program.”

Time and time again participants mentioned that lack of secure and well-paid employment was an important contributor to depression. As a public health official said, *“Mental health issues happen because [veterans] cannot find jobs, they don't have the money, they have to move in with their parents.”* And she continued, *“it's offensive to put someone who served, someone who earned a degree, behind a cash register... why are companies not stepping up, instead of making exorbitant profits, and training?”* Another resident said, *“[Not having a career], has been a part of my mental health depression.”*

Income and Financial Security

Income is a powerful social determinant of health that influences where people live and their ability to access resources which affects health and well-being. The effects of poverty—food and housing insecurity, underinsurance, and stress leading to poor physical and mental health—are compounded by environmental factors. Areas with more concentrated poverty are also those with lower-performing schools, higher rates of community violence and substance use, buildings in worse conditions, and food deserts. Discussing issues related to children, a key informant interviewee said, *“We have, you know, that urban child with very limited resources, poverty, a lot of the issues of poverty and intergenerational poverty, with grandparents raising children.”*

“People on the fringe of poverty have suffered.” – Key informant interviewee

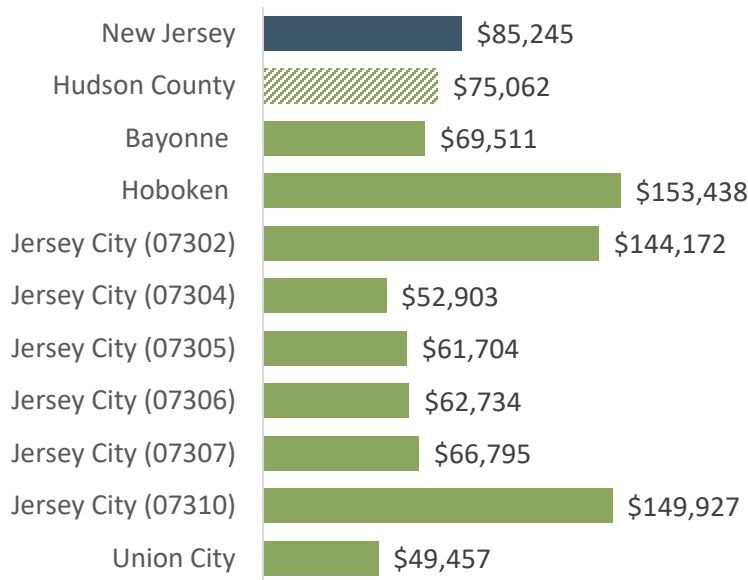
Many households face financial insecurity across many groups. Both children and youth face substantial insecurity, as well as older adults living on retirement. As discussed in the sections on Inequality and Employment and Workforce, inflation was a major concern for low-income earners as wages have not kept up with the cost of living. People across the spectrum were affected and many residents expressed concerns about the future, mentioning that wages were not keeping up with inflation, and as a result, more people were experiencing poverty.

Income and health are interrelated. Participants mentioned that people with chronic illnesses and disabilities often faced financial vulnerability as they were unable to work due to their health. In the words of a resident, *“There's income barriers, which runs into all areas. When you have physical health issues, that leads to loss of income.”* On the other hand, residents noted that healthcare was not a priority when income was limited. Therefore, insufficient income becomes a barrier to accessing health insurance, preventive health care, and even treatment to manage chronic diseases. Many residents described that low-wage earners were faced with the dilemma of having to choose between food, rent, or medicine.

Household Income and Poverty

In Hudson County, financial wellbeing and insecurity varied by area. According to the 2016-2020 American Community Survey (U.S. Census), while the median household income for Hudson County (\$75,062) was below that of New Jersey (\$85,245) as a whole, the range in household income showed stark disparities. The median annual household income in 2016-2020 ranged from \$49,457 in Union City, where a majority of residents were Latino, to \$153,438 in Hoboken, with a majority of residents are White (Figure 21). Jersey City zip codes 07304, 07305, 07306, and 07307 all reported having median household incomes below the state average.

Figure 21. Median Household Income, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When analyzing these figures further, data show that Black and Latino households had lower median household incomes relative to the average across Hudson County. While Asian (\$116,309) and White (\$100,853) households reported incomes that were 55% and 34% higher than median household income in Hudson County (\$75,062), respectively, Black (\$53,196) and Hispanic/Latino (\$52,408) households earned 29% and 30% below the county median, respectively (Table 9).

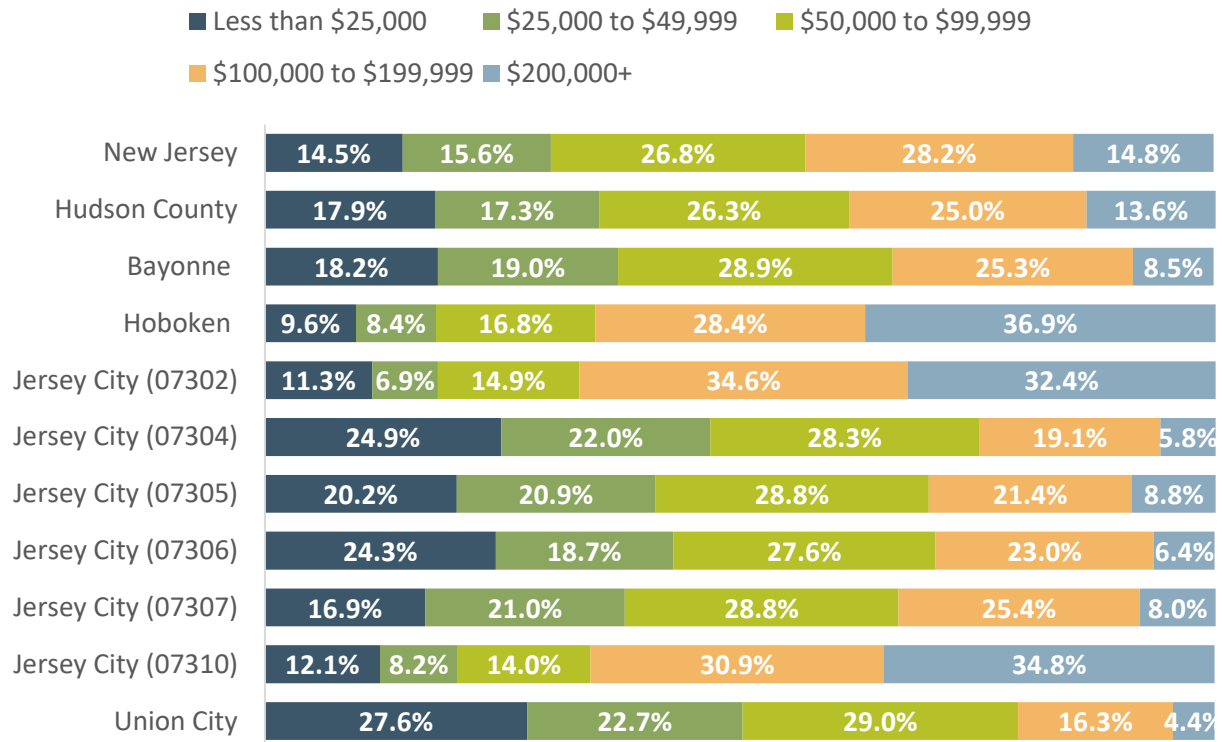
Table 9. Median Household Income, by Race/Ethnicity, State, County, and Town, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic	American Indian and Alaska Native	Native Hawaiian and Other Pacific Islander	Some other race
New Jersey	\$126,232	\$55,453	\$60,352	\$96,531	\$59,827	\$61,563	\$54,334
Hudson County	\$116,309	\$53,196	\$52,408	\$100,853	\$54,318	-	\$51,718
Bayonne	\$123,536	\$60,167	\$54,292	\$74,712	-	-	\$53,890
Hoboken	\$197,750	\$83,724	\$44,890	\$162,507	-	-	\$27,139
Jersey City (07302)	\$169,730	\$68,879	\$62,868	\$161,291	-	-	\$43,750
Jersey City (07304)	\$86,061	\$47,968	\$45,266	\$65,026	\$44,238	-	\$48,348
Jersey City (07305)	\$108,294	\$51,155	\$56,458	\$80,389	\$66,982	-	\$48,738
Jersey City (07306)	\$86,347	\$37,470	\$41,429	\$66,761	\$57,798	-	\$43,571
Jersey City (07307)	\$100,659	\$57,778	\$47,904	\$76,976	\$39,293	-	\$55,022
Jersey City (07310)	\$138,083	-	-	\$163,375	-	-	-
Union City	\$83,482	\$44,375	\$44,562	\$74,623	\$58,594	-	\$44,092

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Census estimates demonstrate how higher earning households and low-income households are concentrated in different towns across Hudson County. Around one in three households in Hoboken (36.9%), Jersey City zip code 07302 (32.4%), and Jersey City zip code 07310 (34.8%) had earnings of \$200,000 or higher in 2016-2020 (Figure 22.) On the other hand, more than two in five households in Jersey City zip codes 07304, 07305, and 07306 earned a household income of \$50,000 or less; and half of the households in Union City were in this situation.

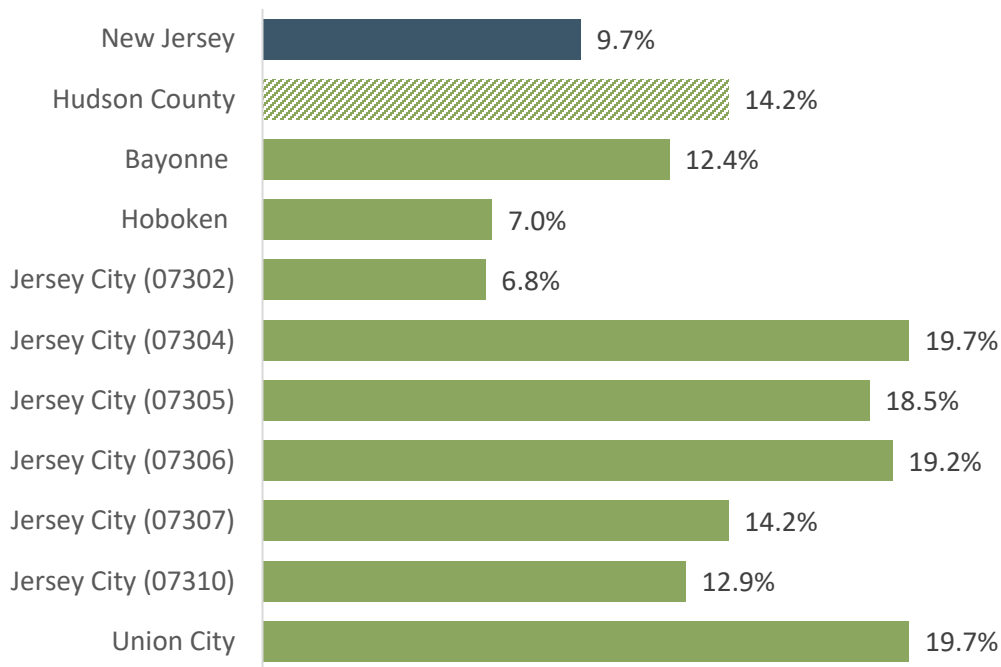
Figure 22. Distribution of Household Income, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

The percentage of Hudson County residents living below the poverty level represents the most extreme level of financial insecurity. For context, the federal poverty line is the same across the country – regardless of cost of living – but changes by household size. In 2021, individuals living alone or considered a household of one would fall below the federal poverty level at an income level of \$12,880, while federal poverty level for a family of four is \$26,500. Figure 23 presents data on the percentage of residents falling below the poverty line in the state, county, and town- and zip-code-level. In Hudson County, 14.2% of individuals fall below the poverty line, but it is nearly 20% in Jersey City zip codes 07304, 07305, 07306, and Union City. Table 10 presents town level poverty data by race/ethnicity.

Figure 23. Individuals Below Poverty Level, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

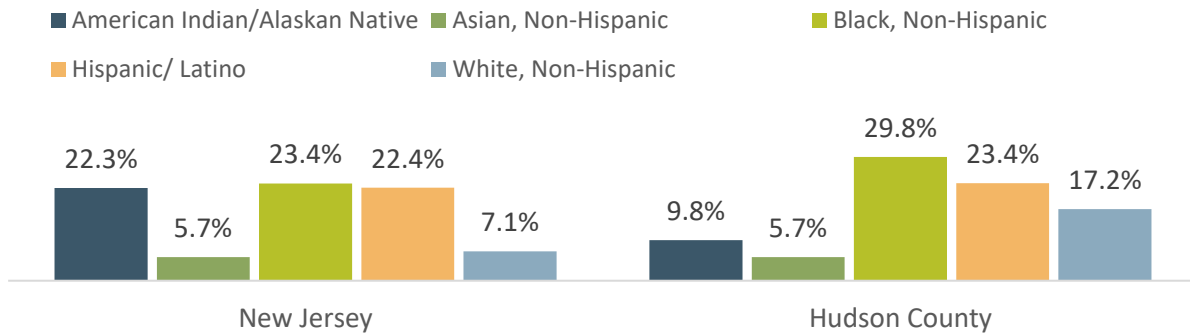
Table 10. Individuals Below Poverty Level, by Race/Ethnicity, State, County, and Town, 2016-2020

	Asian, Non- Hispanic	Black, Non- Hispanic	Hispanic/ Latino	White, Non- Hispanic	Other Race, Non-Hispanic
New Jersey	6.3%	16.4%	16.9%	6.0%	19.6%
Hudson County	9.3%	19.2%	17.8%	9.7%	17.9%
Bayonne	7.3%	13.8%	14.9%	9.9%	12.8%
Hoboken	8.4%	13.2%	15.5%	4.8%	24.9%
Jersey City (07302)	5.7%	15.6%	14.8%	3.4%	22.7%
Jersey City (07304)	9.1%	19.7%	24.8%	21.4%	23.0%
Jersey City (07305)	6.9%	22.1%	19.5%	18.0%	21.0%
Jersey City (07306)	17.0%	20.3%	20.6%	23.3%	18.7%
Jersey City (07307)	7.5%	14.5%	18.7%	11.6%	21.0%
Jersey City (07310)	13.4%	36.8%	14.0%	7.9%	23.3%
Union City	6.6%	14.5%	21.1%	17.9%	27.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

According to County Health Rankings, 9.8% of children in Hudson County lived in poverty in 2019, but 29.8% of Black children and 23.4% of Hispanic/Latino children lived in poverty (Figure 24).

Figure 24. Children in Poverty, by State and County, 2019

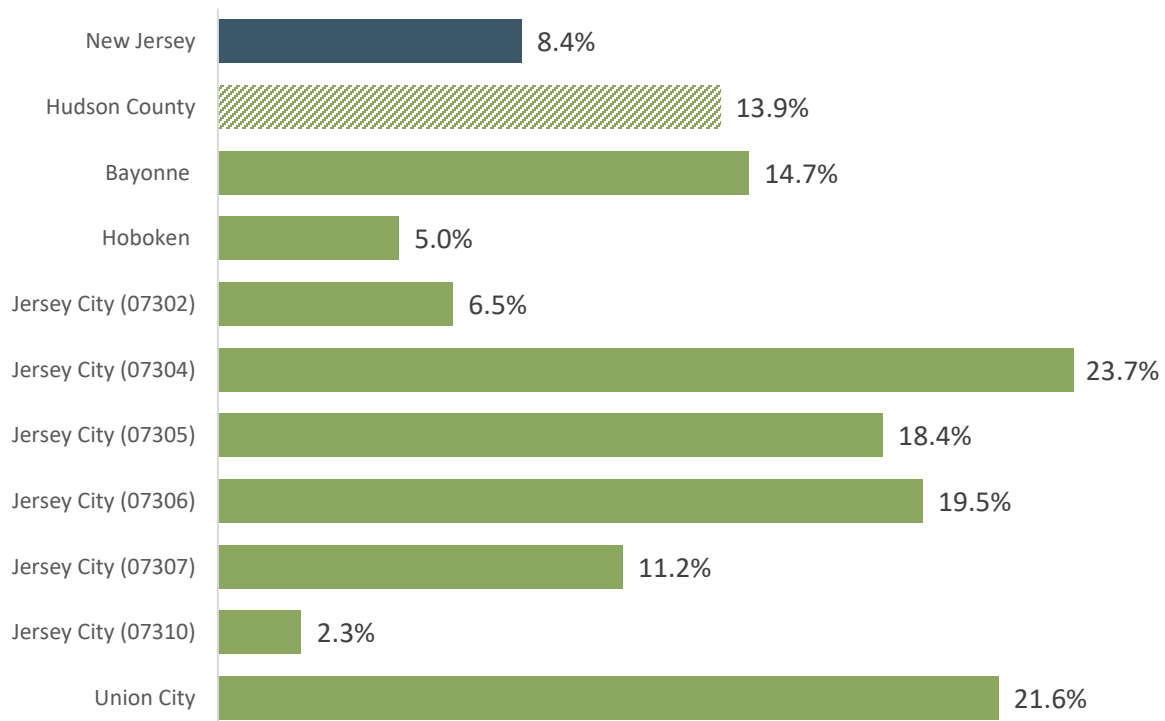


DATA SOURCE: U.S. Census Bureau, Small Area Income and Poverty Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Income and Public Assistance

Several national programs administered by the state help low-income individuals and families in Hudson County afford basic needs and necessities. The Supplemental Nutrition Assistance Program (SNAP) offers nutrition assistance to certain income-eligible Hudson County residents. From 2016-2020, 13.9% of households in Hudson County were receiving SNAP benefits (Figure 25). Of note, Jersey City zip code 07304 had 23.7% and Union City had 21.6% of households receiving SNAP benefits, compared to 2.3% in Jersey City zip code 07310.

Figure 25. Households Receiving Food Stamps/SNAP, by State, County, and Town, 2016-2020

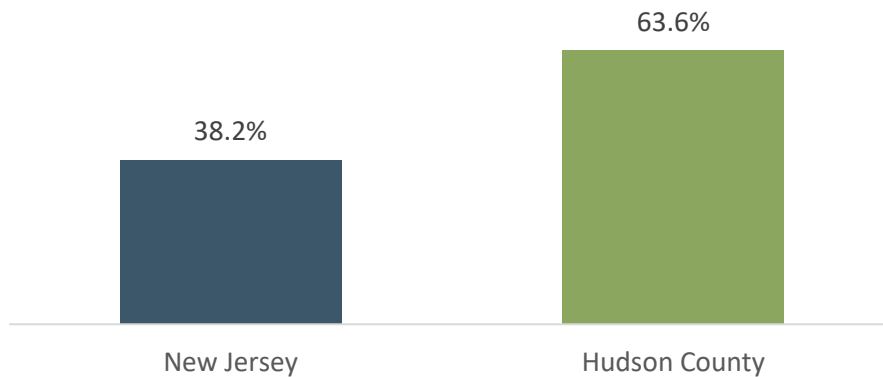


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Public schools nationwide and across New Jersey offer free lunch programs for children living at or near the poverty line (although it should be noted that many public schools currently provide free lunch to all

students as part of the federal COVID-19 relief funding). However, the percentage of children eligible for the traditional free or reduced-price lunch in Hudson County was 63.5% in the 2019-2020 school year, much higher than the state overall (38.2%) (Figure 26).

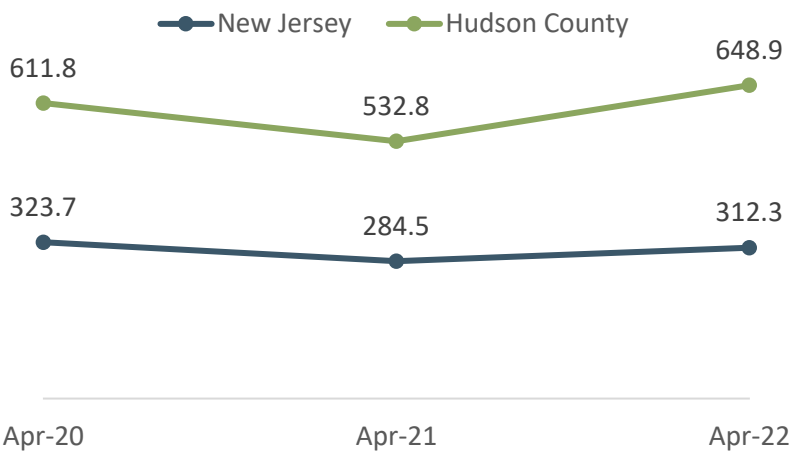
Figure 26. Children Eligible for Free or Reduced-Price Lunch, by State and County, 2019-2020



DATA SOURCE: National Center for Education Statistics, 2019-2020 from University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2021

Work FirstNJ (WFNJ) provides cash assistance and other support services through the federal Temporary Assistance for Needy Families (TANF) program. In Figure 27, the participant rate for persons, adults, and children receiving TANF was much higher in Hudson County than in New Jersey overall and peaked in April 2022 with a rate of 648.9 people participating in Hudson County per 100,000 population, more than double the rate of New Jersey as a whole.

Figure 27. Number of Participating Persons, Adults, and Children Receiving WFNJ/TANF per 100,000, by County, 2021



DATA SOURCE: New Jersey Department of Human Services, Division of Family Development, Current Program Statistics 2020-2022

These public assistance programs are a lifeline for many low-income families and help to ensure adequate nutrition and housing. However, several focus group participants and key informant interviewees mentioned being faced with the dilemma of not earning sufficient income to cover basic expenses, but not qualifying for public assistance, including housing, food, or health support because they exceeded the poverty line threshold. In the words of a focus group participant, *“I know I don’t*

qualify for housing---I make too much money. I checked a few years ago because I live with my mom.” Another participant elaborated, “The problem in Jersey City is that the preferred housing is based upon income... The problem becomes not making enough to pay the rent, but then living with her mom, so she makes too much money because now they’re doing dual income.”

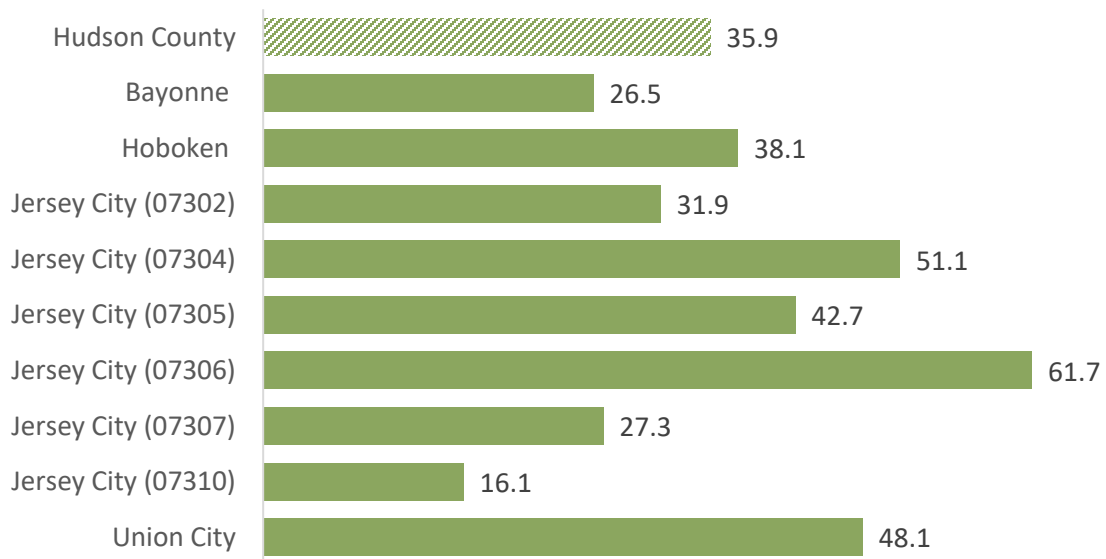
Many residents expressed frustration at losing or not qualifying for benefits because their earnings were too high, yet not being able to buy food and other essentials. Residents suggested that the federal government should change the income eligibility limit and that more opportunities should be provided to continue supporting residents as they transition into the workforce. As discussed in the section on Community Strengths and Assets, residents noted that local government had stepped up to address their needs.

“It is hard to get assistance for housing where I am. You have to be making way below the poverty level.” – Focus group participant

Food Access and Food Security

While many food access barriers are related to income constraints, access may also be more challenging for residents due to geography and transportation challenges. One of the issues highlighted by Hudson County residents was that the quality of the available food varied a lot by neighborhood. Residents noted that some Jersey City neighborhoods were food deserts, and that in others the supermarkets were not affordable. The availability of supermarkets and grocery stores varied a lot by Hudson County area, with Jersey City zip code 07306 having the largest number of supermarkets (61.7 per 100,000 persons) (Figure 28). More data on food deserts in Appendix F- Additional Data Tables.

Figure 28. Grocery Stores and Supermarkets per 100,000 by State, County, and Town, 2018



DATA SOURCE: Community Commons, Census County Business Patterns, analyzed by Center for Applied Research and Engagement Systems (CARES), 2020

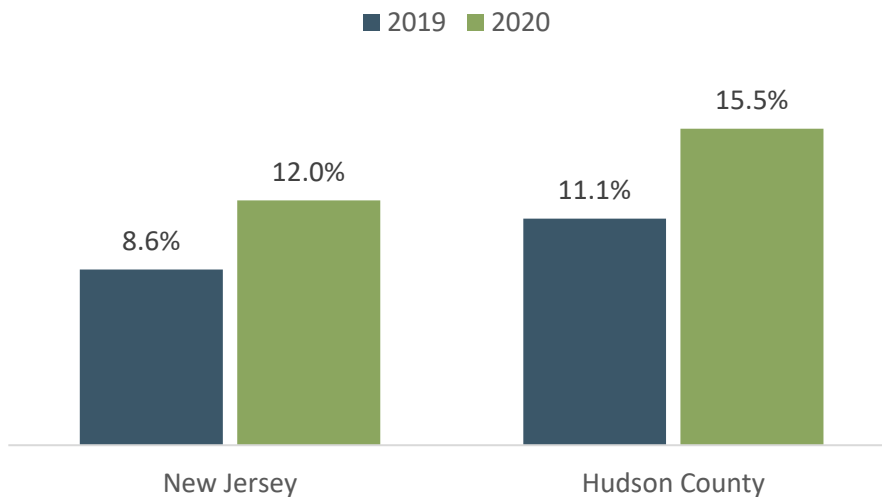
Food insecurity—not having reliable access to enough affordable, nutritious food—is directly related to financial insecurity. Residents mentioned that many families with children, older adults, and those who are housing insecure were struggling to put food, particularly healthy food, on the table. A focus group participant explained the experience of housing insecure families, *“If I’m staying with someone, I may not be able to cook my own food for my kids, as we just have a room, and maybe I have a little microwave that I could use. I don’t want to impose on anybody so I get little, you know, pre-cooked meals... so we don’t get in people’s way.”*

“Diabetes is a very expensive issue in the community, and we’ll often see people forgo their medication because they can’t afford it. Or [they] forgo healthy foods because they can’t afford it.” – Focus group participant

According to data from Feeding America, Map the Meal Gap confirms that food insecurity is a problem for many residents; Hudson County had a higher percentage of food insecure residents than New Jersey as a whole in 2019 and 2020, and this percentage increased from one year to the next (Figure 29).

However, residents also mentioned that food pantries were widely available throughout the city where low-income people could get food and that food vouchers were available to seniors. Participants spoke about the many food distribution efforts that multiple partners, including government agencies, health care institutions, and non-governmental organizations, carried out during the pandemic to mitigate its effects and make sure that residents did not go hungry. Around one in four survey respondents overall, and about one in three Latino respondents, indicated that they relied on food pantries or other food assistance programs in Hudson County (Figure 30). Other indicators of food insecurity are presented in Figure 30.

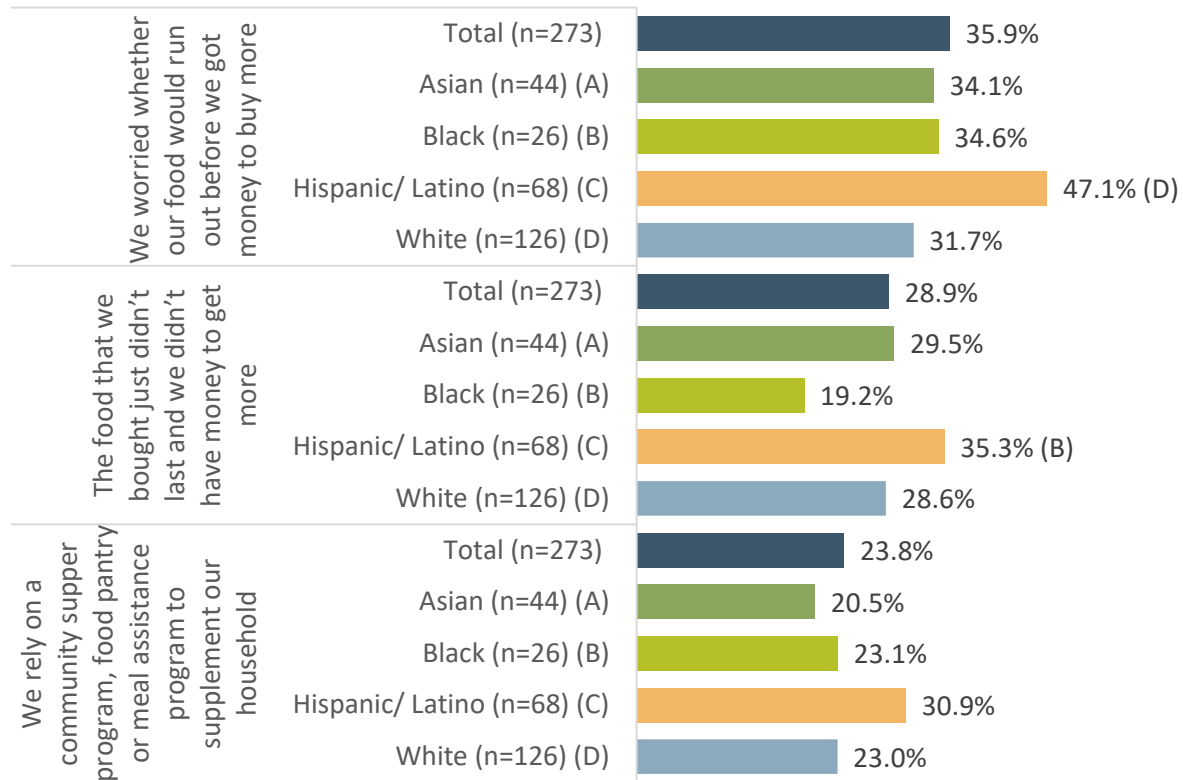
Figure 29. Percent Population Food Insecure, by State and County, 2019 and 2020



DATA SOURCE: Feeding America, Map the Meal Gap, 2019 and 2020

NOTE: 2020 data are estimated projections based on available employment and poverty data, and were revised in March 2021; therefore data are subject to change.

Figure 30. Percent of Community Survey Respondents Reporting Food Insecurity (Noting Statements as Sometimes or Often True), by Race/Ethnicity (n=273), 2021

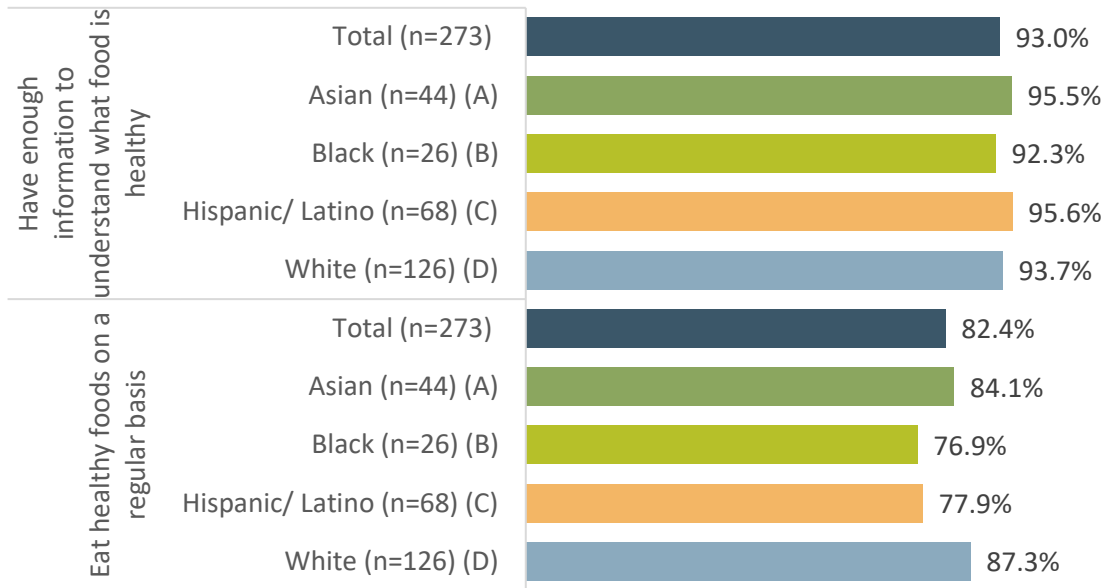


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

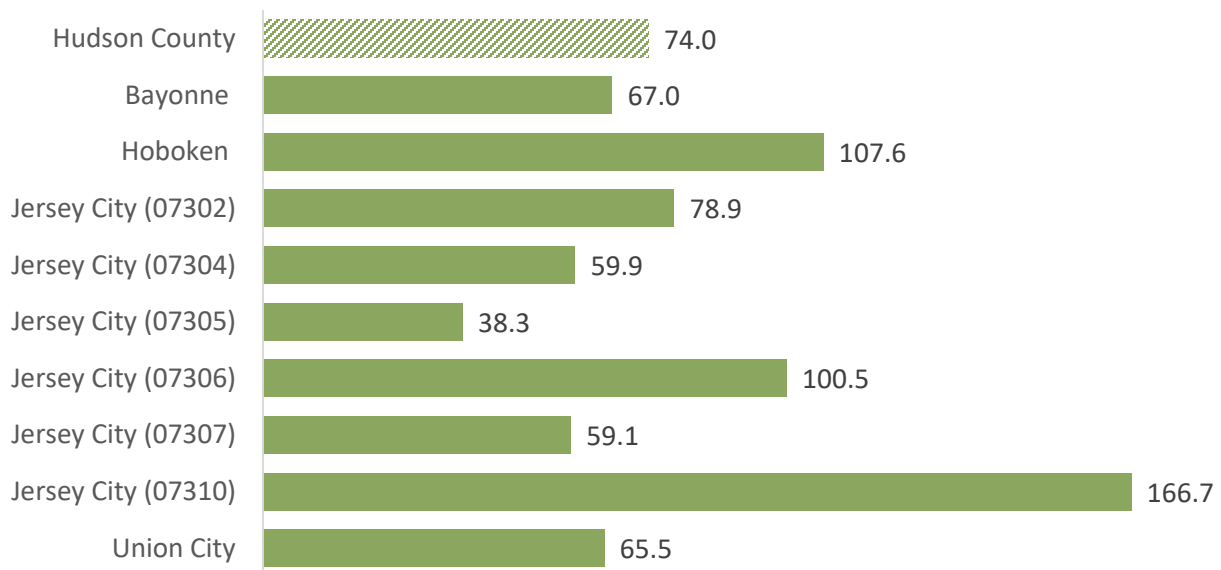
In addition to food affordability and access, nutrition literacy is important to maintain a healthy diet. Many focus group participants were aware of the association between a healthy diet and good health, including its importance in chronic disease management. However, some residents perceived that the main barrier to maintaining a healthy diet was lack of education. As one focus group participant mentioned, *“The problem is that people see fast food as a good, cheap option, but it’s not healthy – not everyone likes fruit and vegetables.”* Survey data does not seem to support this since perception: whereas a majority of survey respondents of all race/ethnicities reported knowing what constituted a healthy diet, fewer reported being able to eat healthy foods on a regular basis (Figure 31), indicating that other factors such as affordability and access may be at play. The discrepancy is most marked among Black and Latino respondents. Further, the availability of fast-food restaurants offering low-cost ultra-processed high caloric foods in certain neighborhoods contributes to the problem (Figure 32).

Figure 31. Percent of Respondents Who Report Having Enough Information on Healthy Foods and Eating Healthy Foods on a Regular Basis, by Race/Ethnicity (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Figure 32. Fast Food Establishments per 100,000 by County, and Town, 2020



DATA SOURCE: Community Commons, Census County Business Patterns, analyzed by the Center for Applied Research and Engagement Systems (CARES), 2020

Housing

Safe and affordable housing is integral to the daily lives, health, and well-being of a community.

Housing Landscape

As in past CHNAs, there was consensus among focus group members and interviewees that there is a significant need for affordable housing in Hudson County. Many participants noted that housing costs and high taxes were concerns. They described how affordable housing was scarce for members of their community who needed it, like low-wage earners and fixed income residents, and it is harder for others, such as seniors, veterans, and young families, to remain in the area. In the words of a resident, *“One of my friends... his parents had the house, and then he inherited it, but he ended up moving because the taxes were just too high. And that was someone who had been living in that house since birth. And he’s sixty-something years old, it’s just sad.”*

“It looks like Jersey City is trying to cater to the affluent instead of the people who grew up here.” –
Focus group participant

Assessment participants discussed gentrification – the process by which rising housing costs drive out local residents who are replaced by new wealthy residents. As one interviewee described it, *“We can’t not mention the housing market, it’s a problem overall, but in Jersey the rate of gentrification is increasing rapidly and even those not on the fringe of poverty are experiencing that.”* While participants reported that some new housing is being built, it is not affordable for most. One focus group participant explained it thus, *“It’s not equal. All the buildings they’re putting up are all luxury buildings. When you see the word luxury, you know the rent is astronomical. I can’t afford it... whereas affordable housing or housing for seniors is very limited. There are years long waiting lists. It’s like they don’t want us to be here anymore, they’re just welcoming the rich and affluent....”* Housing costs have been steadily rising in all areas with easy access to New York City, particularly near the waterfront, since 9-11, as New Yorkers sought to leave the city, and COVID-19 accelerated it.

Housing Instability and Homelessness

Inflation and uncontrolled rent increases following COVID-19 exacerbated people’s concerns about housing affordability and housing stability. With some residents’ financial situations being more uncertain or diminishing during the pandemic, there was greater concern that residents might lose their housing, even with the multiple housing eviction moratoriums in place. Overall, 8.8% of respondents in Hudson County reported that they or an immediate family member had lost their housing during the COVID-19 pandemic; this percentage was higher among Latinos (13.2%). Housing availability was also cited by interviewees as an important barrier to break the cycle of violence. Relocation is one of the strategies used to prevent revictimization of community and domestic violence survivors. However, according to violence interrupters, affordable housing options in low-crime neighborhoods are limited.

Several focus group and interview participants mentioned the problem of homelessness in Hudson County communities. Multiple interviewees and focus group participants indicated that the shelters and temporary housing available were insufficient to meet the needs of the population. They considered the paradox of the proliferation of luxury rental buildings in some neighborhoods, and abandoned buildings in others, while many people are left without homes. One resident emphasized, *“Shelter, I think we need more shelters for the homeless people we have.”* On January 26, 2021, there were 882 persons experiencing homelessness on a single night in Hudson County. Of those counted, 56.1% lived in Jersey

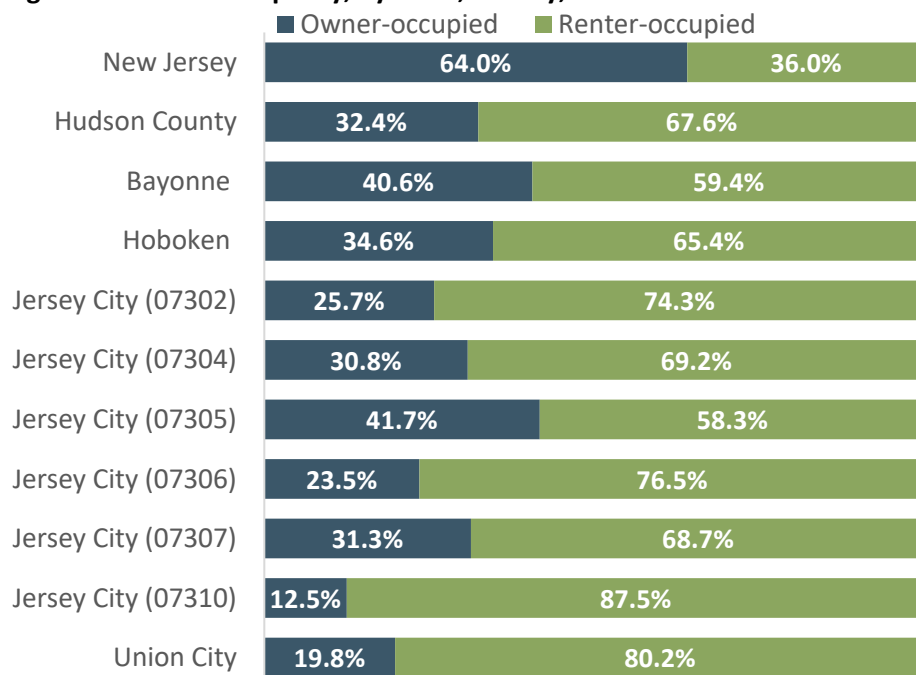
City. Black residents shouldered the burden of homelessness. Whereas Black residents made up 10.3% of the population, and 18.3% of the population living under the poverty line, they made up 39.1% of the population experiencing homelessness.

Participants highlighted three priority action areas to mitigate the housing problem in Hudson County: one was enacting policies related to rent control; the other was reducing real estate taxes; and the third was the urgent need to build or set aside more affordable housing units. A Latino participant expressed, *“The governor should control the rise of rent prices. These days it can cost \$700 for a room in a shared apartment. 10 years ago, an apartment cost \$500-600, but now it can cost \$1,200.”* Housing quality was another issue that came up in interviews. A few focus group participants commented that some of the affordable housing has lead, mold, and asbestos contamination, which can have devastating consequences on residents’ health, particularly among children. The problem was aggravated during COVID-19, which interrupted building quality inspections.

“When I drive past Hoboken there was a long line out a shelter because they need a hot meal or a place to stay.” – Focus group participant

Housing data illuminate important disparities and reflects the concerns uplifted by residents. Proportionally fewer Hudson County residents are homeowners compared to New Jersey as a whole. In New Jersey, 64.0% of housing units were owner occupied in 2016-2020, in contrast to 32.4% in Hudson County (Figure 33). Home ownership ranged from 12.5% in Jersey City zip code 07310 to 40.6% in Bayonne.

Figure 33. Home Occupancy, by State, County, and Town 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Median monthly housing costs for both homeowners and renters varied widely throughout Hudson County and were notably higher in certain locations than in New Jersey as a whole. Median monthly housing costs for owner occupied households with a mortgage ranged from \$2,339 in Jersey City zip code 07304 to roughly \$7,600 in Hoboken and Jersey City zip codes 07302 and 07310 (Table 11). Median monthly housing costs for renter occupied households ranged from \$1,247 in Union City to \$2,945 in Jersey City zip code 07310 during the same period, 2015-2019.

Table 11. Monthly Median Housing Costs, by State and County, 2015-2019

	Owner-occupied	Renter-occupied
New Jersey	\$2,476	\$1,368
Hudson County	\$2,821	\$1,450
Bayonne	\$2,793	\$1,325
Hoboken	\$3,759	\$2,360
Jersey City (07302)	\$3,672	\$2,524
Jersey City (07304)	\$2,339	\$1,204
Jersey City (07305)	\$2,425	\$1,243
Jersey City (07306)	\$2,484	\$1,270
Jersey City (07307)	\$2,751	\$1,382
Jersey City (07310)	\$3,756	\$2,945
Union City	\$2,886	\$1,247

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

The average percent of income spent on housing costs is an important measure of an area’s availability of affordable housing. A larger proportion of New Jersey renters, who tend to be less wealthy than homeowners, spend over a quarter of their earnings on housing. In New Jersey, 46.2% of owner-occupied households with a mortgage and 62.2% of all renters reported spending more than 25% of their income on housing costs (Table 12). Disparities in housing cost burden exist within Hudson County. In Jersey City zip codes 07302 and in Hoboken, less than one in three owner-occupied and 44% of renter-occupied households reported high housing costs whereas 64.4% of owner-occupied and 66.5% of renter-occupied residences in Union City reported spending more than 25% of their income on housing costs. Additional housing data can be found in Appendix F- Additional Data Tables.

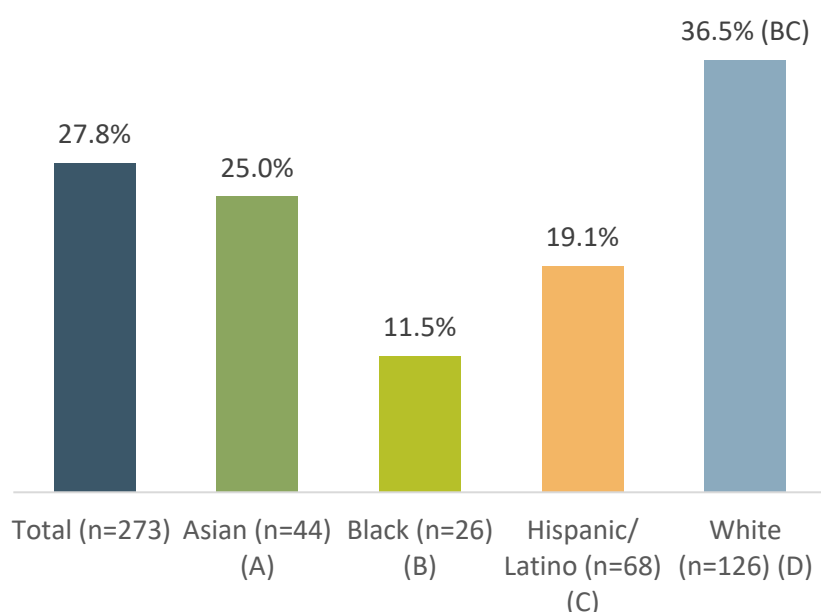
Table 12. Households Whose Housing Costs Are 25%+ of Household Income, by State, County, and Town, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	46.2%	62.2%
Hudson County	51.0%	56.6%
Bayonne	56.2%	57.3%
Hoboken	32.5%	43.4%
Jersey City (07302)	33.3%	39.5%
Jersey City (07304)	55.4%	63.6%
Jersey City (07305)	54.7%	64.6%
Jersey City (07306)	53.0%	55.2%
Jersey City (07307)	53.8%	58.4%
Jersey City (07310)	39.9%	48.7%
Union City	64.4%	66.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

When survey respondents were asked whether they agreed or disagreed on statements about assets in their community, the statement about affordable housing had the lowest percentage of agreement. Only 27.8% of survey respondents agreed or completely agreed with the statement that there was enough affordable housing that is safe and well-kept in their community. Agreement was least likely among Black and Latino respondents, where only 11.5% and 19.1%, respectively, agreed/completely agreed with the statement about affordable housing, significantly lower than those of White respondents (36.5%) (Figure 34).

Figure 34. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “There is Enough Affordable Housing that is Safe and Well-Kept in My Community,” by Race/Ethnicity (n=273), 2021

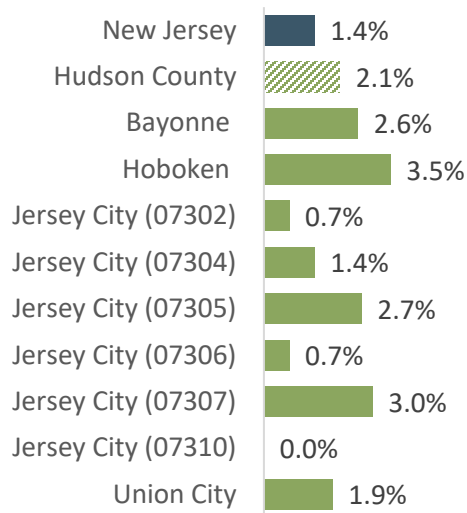


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Homeowner vacancy rate, which represents the proportion of the homeowner inventory that is vacant for sale, is another indicator of lack of affordability, oftentimes due to homeowners' inability to pay real estate taxes. The homeowner vacancy rate was notably higher in Hudson County (2.1%) over the period of 2016-2020 compared to New Jersey (1.4%) (Figure 35). Vacancy rates were particularly elevated in Hoboken (3.5%) and Jersey City zip code 07307 (3.0%) over that time. This reality was also reflected in the interviews with residents. In the words of a Black resident, *“Prices have been slowly rising, amazing that they have money to build these new buildings but can't help people maintain the property they have here – know people who had to move because taxes were too high.”*

Figure 35. Homeowner Vacancy Rate, by State and County, 2016-2020



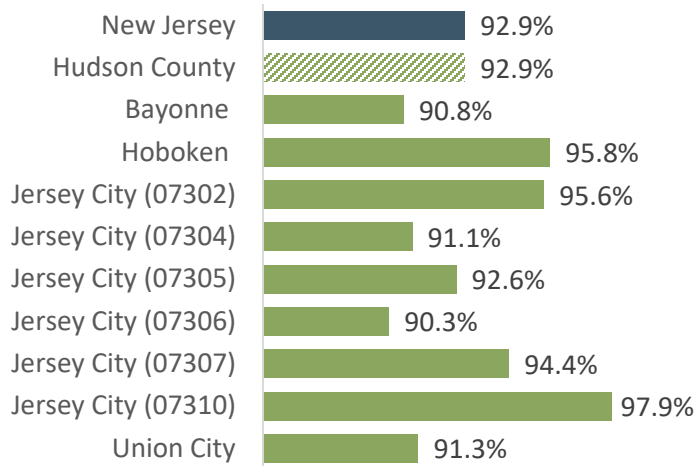
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Housing and Technology Infrastructure

Technology is an important tool to access information, services, and resources for individuals, families, and households. The importance of technology – and the consequences of the digital divide – became even more pressing and evident during the COVID-19 pandemic. The ability to be online, participants noted, is essential for residents to connect to resources for education, employment, and other services. Limited technological infrastructure posed an important barrier to learning when public schools moved to online education during COVID-19. Further, given the growth in telehealth, technology is also becoming essential to accessing healthcare. Yet some community residents do not have access to technology—they are unable to afford computers or Internet access, or do not know how to use it. One health care provider described, *“People working online tend to be good with telehealth, but there are many who don’t know how to connect, don’t have what is needed, it is just as hard to get online as it is to travel.”*

In 2016-2020, about 93% percent of Hudson County households had access to a computer (Figure 36). Households in Jersey City zip code 07306 (90.3%) and Bayonne (90.8%) reported computer access that was below the county-wide percentage; with about 1 in 10 households reporting having no computer at home, compared to almost every household in Jersey City zip code 07310 (97.9%).

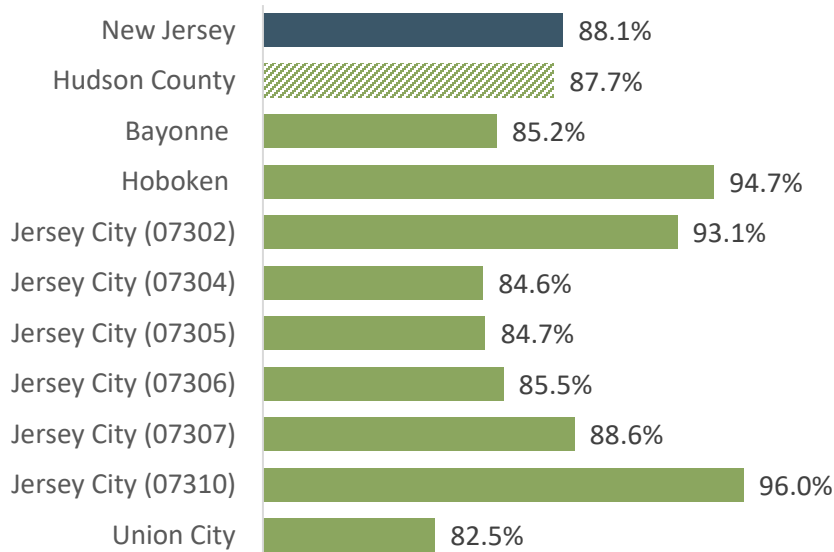
Figure 36. Households with a Computer, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

There were similar trends in household Internet access. Most of the areas that reported a lower percentage of computer access when compared to Hudson County also reported lower levels to the Internet, including Union City (82.5%), and Jersey City zip codes 07304 (84.6%) and 07305 (84.7%) (Figure 37).

Figure 37. Households with Internet, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Transportation

Transportation connects people with and between where they live, learn, play, and work.

Transportation Infrastructure

Transportation was often mentioned by focus group and interview participants as a top asset in Hudson County. Most participants did not indicate that they were car dependent; instead, they noted that it was easy to get around. A Latino immigrant said that *“public transportation is very good for people who don’t drive; everything is close and accessible.”* Affordable and accessible public transportation is important to promote equity, as it provides a means to getting to-and-from work, school, and other locations for low-income residents who cannot afford car expenses and to undocumented residents without a driver’s license.

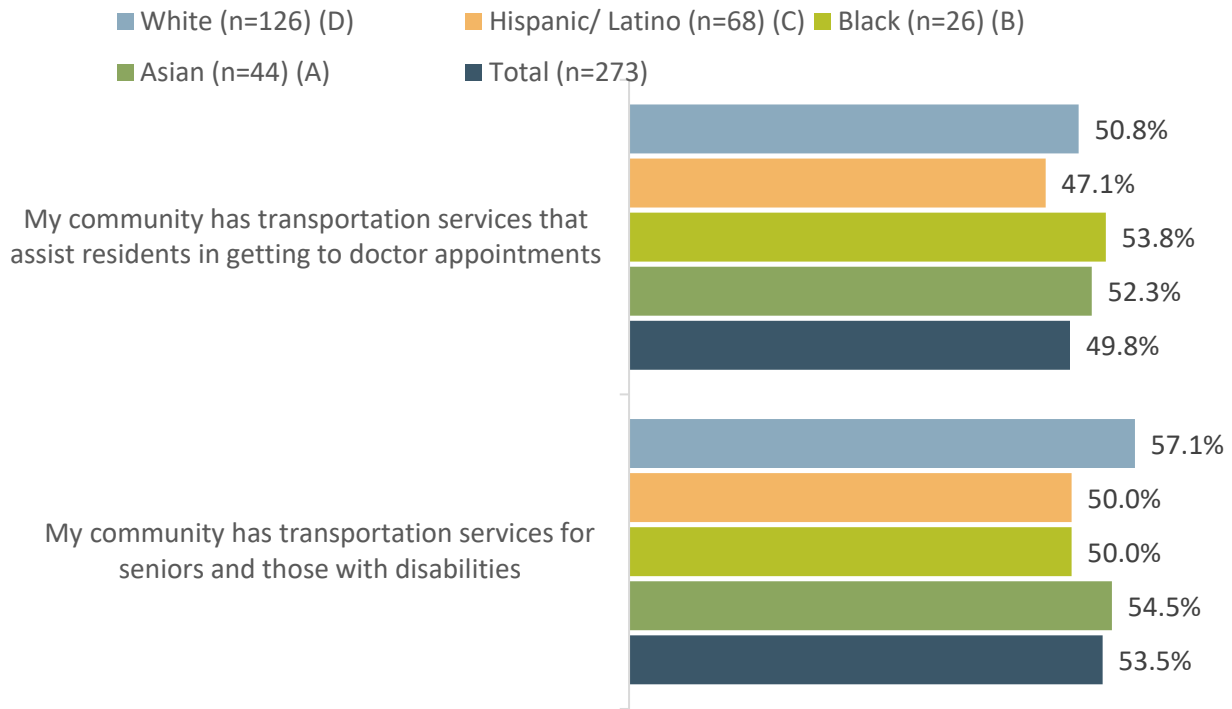
Residents appreciated the proximity of Hudson County to New York City, as a source of business and economic development in the area. This is facilitated by the multiple public transportation options available to and from New York City. One resident described Jersey City *“as a transportation rich area where there is a lot of income and economic opportunity, even if it is not very well distributed to everyone who lives here.”*

Transportation Partnerships

In addition to public transportation, several participants indicated that partnership between health care and social services institutions and private transportation companies were an asset and facilitated access to health care and other services and programs, particularly for older adults and violence survivors.

While transportation was discussed as a significant asset among focus group and interview participants, survey respondents noted some limitations of the transportation infrastructure. As shown in Figure 38, only about half of Hudson County survey respondents agreed or completely agreed with the statement, *“My community has transportation services available for seniors and those with disabilities.”* Similarly, slightly over half of survey respondents agreed/completely agreed that their community had transportation services to assist residents in getting to doctor’s appointments. There were no statistically significant differences in these responses by race/ethnicity.

Figure 38. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Transportation-Related Statements about Their Community, by Race/Ethnicity (n=273), 2021

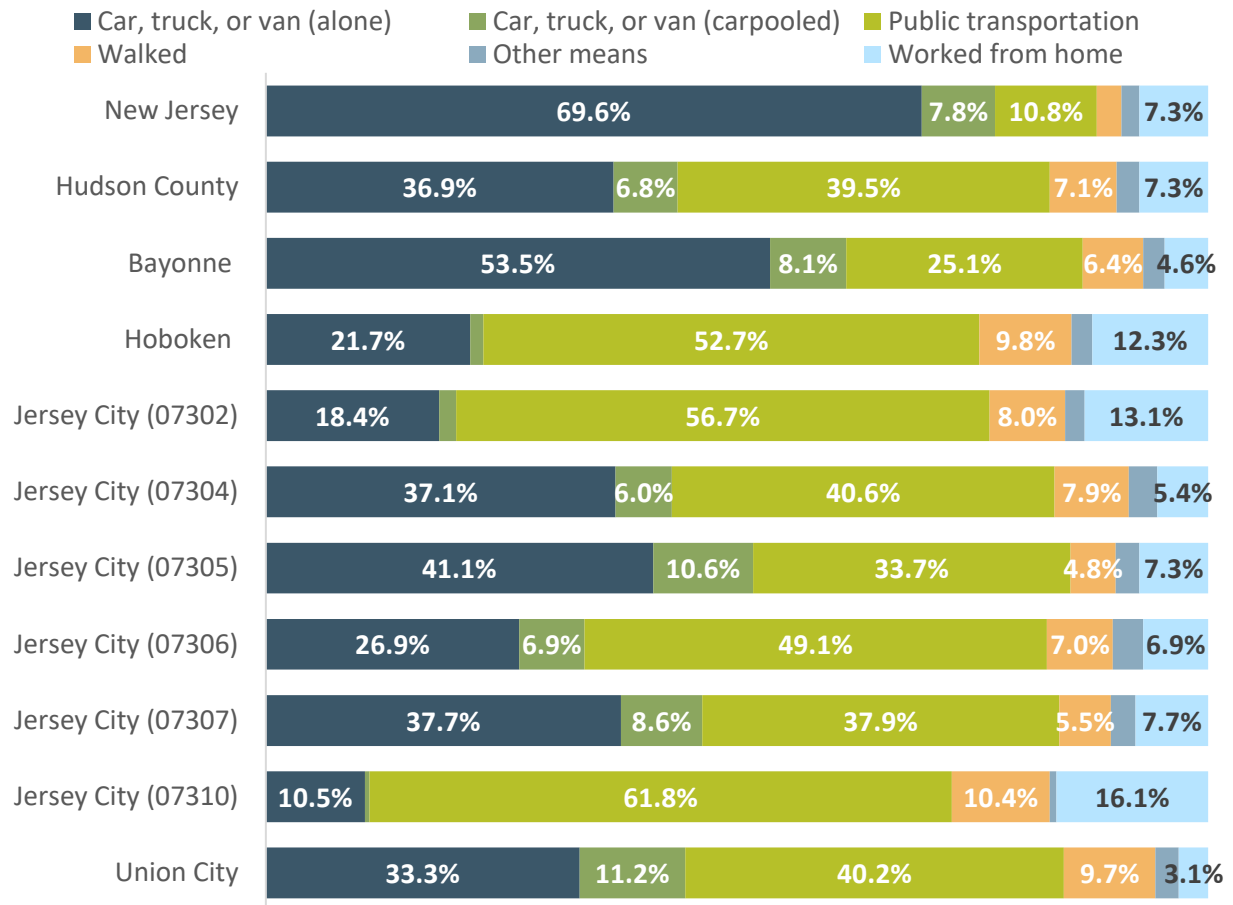


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels.

Data from the U.S. Census confirmed residents' viewpoints regarding transportation. Residents of Hudson County are a lot less car-dependent than those of Jersey City as a whole. In certain areas, such as Hoboken (52.7%) and Jersey City zip codes 07302 (56.7%) and 07310 (61.8%), well over half of residents relied on public transportation (Figure 39). Hudson County residents were also more likely to walk to work than in the state overall, with over 7% of survey respondents reporting doing so. One focus group participant summed it up, *"Another strength [of Hudson County] is how easy it is to commute everywhere. We have the Via shuttles, Path trains, buses."*

Figure 39. Means of Transportation to Work for Workers Aged 16+, by State, County, and Town 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Similar to other factors, owning a private vehicle is not equally distributed across county residents. Those without a car are usually not home-owners. Across Hudson County, 13.7% of owner-occupied households and 40.6% of renter-occupied households did not have access to a personal vehicle in 2016-2020 (Table 13); these percentages are much higher than in New Jersey as a whole, possibly denoting the accessibility of public transportation and Jersey City’s walkability. Car ownership ranged from 9.8% in Jersey City zip code 07305 to 26.0% in Jersey City zip code 07310 among homeowners; and from 31.5% in Bayonne to 61.2% in Jersey City zip code 07310 among renters.

Table 13. Households (Renter v. Owner-Occupied) Without Access to a Vehicle, by State, County, and Town, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	3.6%	24.8%
Hudson County	13.7%	40.6%
Bayonne	10.1%	31.5%
Hoboken	20.2%	38.7%
Jersey City (07302)	24.4%	49.5%
Jersey City (07304)	13.4%	46.9%
Jersey City (07305)	9.8%	38.8%
Jersey City (07306)	19.9%	49.9%
Jersey City (07307)	15.3%	42.1%
Jersey City (07310)	26.0%	61.2%
Union City	19.2%	45.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Green Space and Built Environment

Green space and the built environment influence the public’s health, particularly in relation to chronic diseases. Urban environments and physical spaces can expose people to toxins or pollutants, affecting health conditions such as cancer, lead poisoning, and asthma. Physical space can also influence lifestyles. Playgrounds, green spaces, and trails, as well as bike lanes and safe sidewalks and crosswalks, all encourage physical activity and social interaction, which can positively affect physical and mental health.

Residents raised several issues related to the built environment. Multiple residents across focus groups expressed their concerns that there were too many new constructions. In their view, overbuilding resulted in overpopulation and shrinkage of green spaces. This issue was summed up by one resident, *“Seeing all of these new buildings that are just being built out of nowhere, blocking the view of the city, being built on green areas, parks. I understand the need to have Jersey City well developed but I think over populating is a concern. Even the smallest empty area now has a building.”* As mentioned in the Education section, another problem mentioned by residents was that the public school infrastructure in some districts has not kept up with population growth and cannot accommodate the number of school children. Other residents mentioned that the older constructions had environmental contaminants, including lead and mold, which can have deleterious impact on health (see section on Lead).

Flooding and Emergency Preparedness

Participants remarked that several areas of Hudson County, particularly those near the waterfront, are flood prone. A housing expert explained that preparing the county for future floods and an overall rise in water level was an important public health precaution. A key informant interviewee in the housing sector mentioned that several urban redevelopment projects were underway to mitigate possible harm from floods and other natural disasters. The redevelopments would increase flood storage capacity and improve floodwater absorption. Further, the interviewee noted that new constructions are planned so as to integrate flooding mitigation and water containment measures. Redevelopments in some area

include “new walkways and parks available for all residents” and building higher off the ground to prevent water damage.

Parks and Green Areas

Green area coverage is essential to an environment conducive to good health. Green area coverage not only contributes to air quality and mental and physical health, but it also serves as an important flood mitigation strategy as soil absorbs water more readily than concrete. Multiple initiatives are under way in Hudson County to improve green areas; one is the Jersey City Urban and Community Forestry to promote planting efforts and urban reforestation. A health official noted the important contribution of the Jersey City Parks Coalition to these efforts.

According to the focus group participant, the coalition is a volunteer-run grassroots organization which has spearheaded green area betterment and maintenance projects and community events, such as plantings, throughout different Jersey City neighborhoods. The participant mentioned that they are also lead advocates for more funding for green spaces. The contributions of the Jersey City Parks Coalition were described by a public health official: “They have worked with the city to determine a priority list, master plan, getting a blanket insurance policy to cover all insurance needs for events for all parks.” According to the participant, the coalition reflects the city’s diversity and serves as a vehicle to engage different sectors of the population.

“Where to play safely is not available. When Jersey City is described, it’s often just the one nice part of the city, and rarely about the other quadrants.”

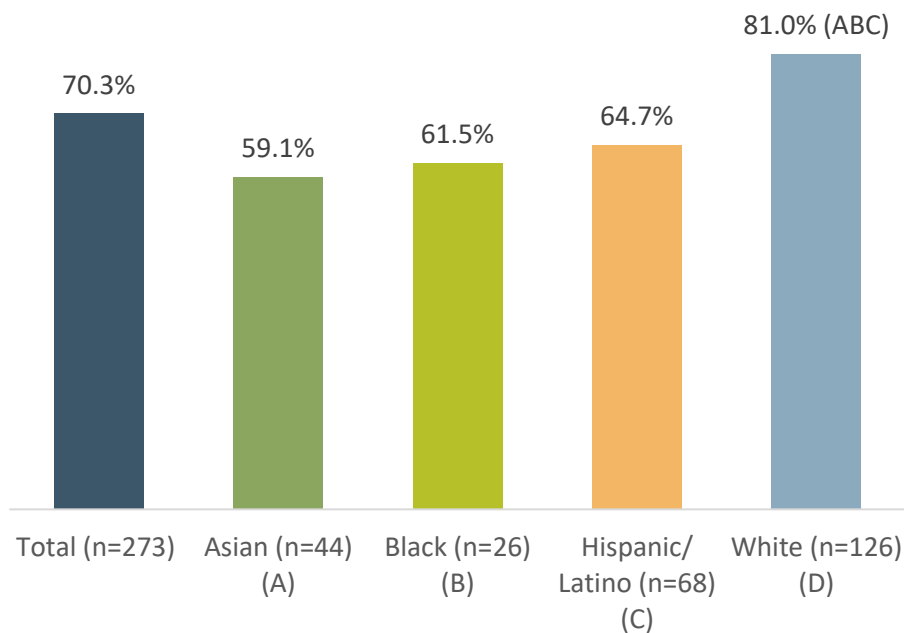
– Focus group participant

Different groups mentioned engaging in various outdoor activities. Veterans remarked on how important being involved in organized team sports was to their physical and mental health; they noted that these recreational opportunities were mainly organized by the city. Latino participants indicated walking was their main exercise and valued having access to well-lit, safe parks in their neighborhood.

As with other topics, there was a diversity of experiences regarding the availability of green space. Whereas some residents indicated that there were plenty of green areas for outdoor activities near their homes, others mentioned not having safe parks nearby. In a participant’s words, “The inner, inner cities, I’m not sure about their parks. I have a park luckily down the street, it’s a nice large park, it is safe, it’s patrolled by police. But if you go up into the Greenville section, I’m not sure about those parks... it’s not as lush and green as Lincoln Park or Liberty Park.”

These differences were reflected in the community survey. About 70% of Hudson County survey respondents agreed or completely agreed with the statement, “My community has safe outdoor places to walk and play” (Figure 40). However, responses significantly differed by race/ethnicity. Asian (59.1%), Black (61.5%), and Latino (64.7%) survey respondents were much less likely than White respondents (81.0%) to agree with the statement about safe outdoor space.

Figure 40. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement “My Community has Safe Outdoor Places to Walk and Play,” by Race/Ethnicity (n=273), 2021



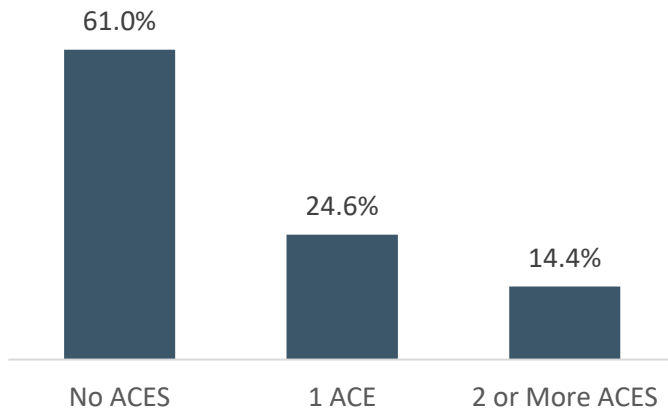
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Violence Prevention and Safety

Violence and trauma have short- and long-term effects on physical and mental health. People can be exposed to violence in many ways: they may be victims and suffer from premature death or injuries or witness or hear about crime and violence in their community. Violence and trauma are inextricably linked to the social determinants of health; people of low socioeconomic status residing in low-resource neighborhoods and schools are at higher risk of experiencing violence. According to an education administrator interviewed, many youths in low-income settings are exposed to domestic and community violence and other adverse childhood experiences, that have a profound impact on their well-being. In 2019, almost two out of every five children in New Jersey had experienced a traumatic event before the age of 18 (Figure 41). (More localized data not available.) Violence interruption professionals discussed how providing a safe and nurturing environment, access to counseling early on to address the symptoms of trauma, and paths to educational and economic opportunities were key strategies to interrupting the cycle of violence.

Figure 41. Percent of Children with Adverse Childhood Experiences (ACEs) in New Jersey, 2019

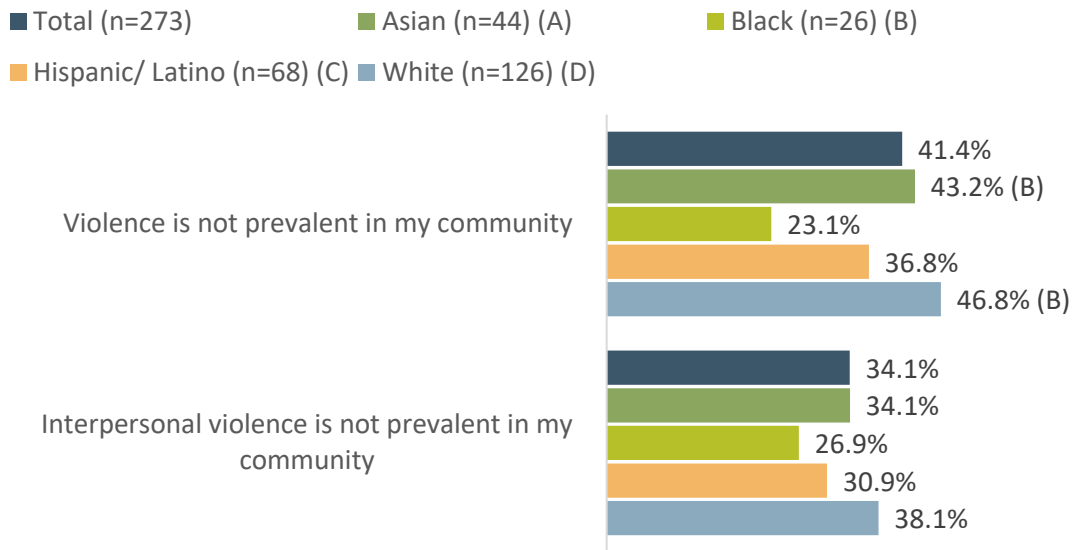


DATA SOURCE: Child and Adolescent Health Measurement Initiative (CAHMI), Data Resource Center for Child and Adolescent Health, National Survey of Children’s Health Interactive Data Query, 2019

Focus group and interview participants shared differing views about safety and violence. Many indicated being safe in their neighborhoods, while others reported being nervous about crime, and yet others that violence was an “epidemic.” Residents’ safety concerns were generally related to gun violence, loitering, and substance use by young people. According to survey data and interviewees, persons of color, particularly Black residents, shoulder the burden of violent crime. Figure 42 presents survey data on the percent of respondents who agreed or completely agreed with statements related to violence in their community, overall and by race/ethnicity. Overall, 41.4% of Hudson County survey respondents agreed or completely agreed that violence was not prevalent in their community and 34.1% reported that interpersonal violence was not prevalent in their community. However, responses varied by race/ethnicity, with Black survey respondents being the least likely to agree or completely agree with either of these statements.

“We are very busy, being in Jersey City. We see a lot of violent crime.”– Key informant interviewee

Figure 42. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statements Related to Violence, by Race/Ethnicity (n=273), 2021



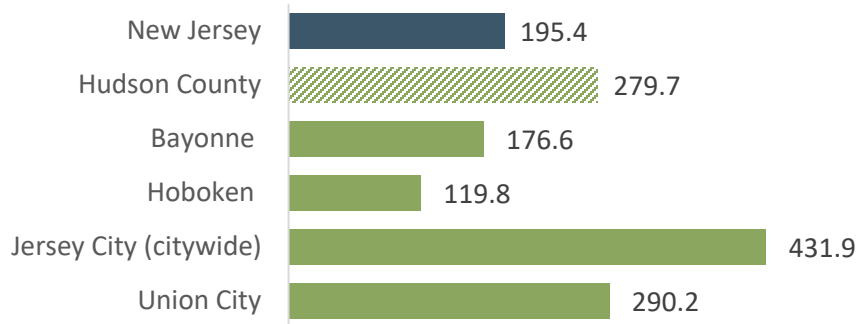
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Gun Injury and Violent Crime

Quantitative data support residents’ varied perceptions of risk. Mortality rate by firearm injury in Jersey City from 2015-2019 was 5.4 deaths per 100,000 residents, higher than those state-wide (5.1 deaths per 100,000 residents) and in Hudson County (3.5 deaths per 100,000 residents). In 2020, rates of violent crime (i.e., murder, rape, aggravated assault) in Hudson County (280 per 100,000 residents) were higher than in New Jersey (195 per 100,000 residents) and varied widely across the county. Jersey City (432 per 100,000 residents) had more than double the crime rate than the state average and 35% higher crime rate than the county overall; Union City’s crime rates were slightly higher than Hudson County’s (290 per 100,000 residents), whereas Bayonne’s (177 per 100,000 residents) and Hoboken’s (120 per 100,000 residents) were lower than the state and county average (Figure 43). Property crime (i.e., burglary, larceny, and auto theft) is much more common than violent crime. Property crime in Hudson County was also above the state average (1,338 and 1,158 incidents per 100,000 persons, respectively). Property crime was most common in Union City (1,694 per 100,000 residents), Jersey City (1,457 per 100,000 residents), and Hoboken (1,405 per 100,000 residents) (Figure 44). Nearly 60,000 domestic violence offenses were recorded in New Jersey in 2019 (New Jersey Uniform Crime Report, 2019).

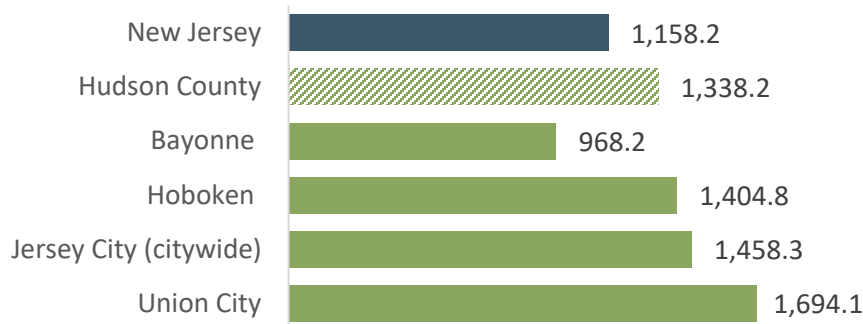
Figure 43. Violent Crime Rate per 100,000 Population, by State, County, and Town, 2020



DATA SOURCE: State of New Jersey, Department of Law and Public Safety, Uniform Crime Reporting Unit, 2019

NOTE: Violent crime includes homicide, rape, robbery, assault and simple assault. Jersey City data represent all zip codes within the city, including those outside of the JCMC service area.

Figure 44. Property Crime Rate per 100,000 Population, by State, County, and Town, 2020



DATA SOURCE: State of New Jersey, Department of Law and Public Safety, Uniform Crime Reporting Unit, Uniform Crime Report, 2020

NOTE: Property crime includes burglary, larceny, and auto theft.

Hate Crimes and Anger

It is of note that residents perceived a change in attitude in the aftermath of COVID-19, which they related to economic and social stressors. Specifically, several residents remarked that people had become less patient and more aggressive since the start of the pandemic. This perception was aggravated by reports of hate crimes motivated by biases against certain groups. As explained by one focus group participant, *“There’s an underlying fear, suspicion, you know, not only among African Americans. I mean it wasn’t that long ago that we had our own shooting up here at a Jewish facility. I think there is a lot of fear in regard to racism and antisemitism.”* Hate crimes were also mentioned as a concern for members of the LGBTQ+ community. A key informant interviewee working with the LGBTQ+ community noted that despite efforts, more action is needed to sensitize police officers, employers, educators, parents, and peers so as to reduce bullying and harassment, particularly against transgender youth and children in non-traditional families.

“It’s almost, I don’t want to say scary, but after the pandemic, everyone is more angry, everyone wants to argue and fight.”— Focus group participant

Violence Interruption Programs

According to key informant interviewees, Jersey City has robust programs and resources to address and mitigate the impact of violence and trauma. Since 2014, the grassroots organization Anti-Violence Coalition has been actively working as violence interrupters in the city's South side. As expressed by a coalition member, *"We've been working ... to make an impact on the community, see what the needs are, and lobby or advocate. We've been on the ground occupying corners, conducting surveys, trying to find out the main reasons why people can't be successful in their lives due to issues in the neighborhood that wrap around violence and trauma."* More recently, the Jersey City Medical Center created a trauma recovery center, which is a national evidence-based model in treating survivors of violence. Additionally, Project H.U.D.S.O.N. is a Hospital-based Violence Intervention Program, associated with the center, which works with community partners to prevent reinjury and retaliatory action. According to interviewees, promising results have been achieved by reaching survivors at bedside, soon after injury, and providing trauma-informed intensive case management and wraparound services, including support for safe housing and vocational training, in addition to medical care and counseling.

Systemic Racism and Discrimination

Perceptions of racism and discrimination varied in qualitative discussions. Overt discrimination due to race/ethnicity or nationality did not often come up. Some participants described witnessing discrimination due to gender and sexual orientation. Focus group and interview participants in multiple conversations brought up issues related to systemic racism and discrimination. With few exceptions, they spoke of pervasive inequities experienced by people of different groups. The conversations highlighted issues of intersectionality; participants discussed the multiplying effect of historical and current discriminatory practices due to multiple conditions, such as race/ethnicity, gender, immigrant status, and socioeconomic status, among others. Participants noted these issues largely impacted communities of color because of the policies and practices embedded throughout society. Highlights from these discussions that touch upon specific topic areas (e.g., inequality, education, housing, violence prevention) are also mentioned in other sections of this report.

A theme that was discussed in most focus groups and interviews was the pervasiveness of systemic racism. One of the ways that this was noted was in the gentrification of Hudson County. Multiple participants discussed how the high cost of housing and taxes are driving people of color out of Jersey City. Both quantitative and qualitative data indicate that there are insufficient affordable housing units. As a Black resident described, *"A lot of the new constructions are rentals so there would be a reduction of generational wealth. Unless you're earning six figures, it will be a challenge to afford rental units in the future. What is affordable may also not be livable because of gang activity or high crime."* Residents also noted structural racism in the perennial lack of investment in predominantly Black neighborhoods of Jersey City. They described these areas as having many abandoned buildings in a state of disrepair.

Focus group and interview participants acknowledged that there has been much more dialogue about racism and discrimination over the past year. Residents indicated that there were efforts underway in Hudson County to curbe at least the most overt forms of discrimination. A focus group participant expressed, *"Jersey City has definitely addressed the Asian hate crimes, even when I was on the PATH train there was a sign that was like there's no room for hate here in Chinese as well."* However, other residents described instances of discrimination and mistreatment against them and their relatives due to their immigrant status. As one resident explained, *"I do feel welcome by healthcare providers, but I have experienced going with my parents who are immigrants with heavy accents, and I have experienced miscommunication."*

Systemic Discrimination Based on Legal Status

A theme that emerged in some of the interviews and focus groups was the plight of undocumented immigrants, who face multiple economic and social stressors. According to focus group participants, the community is often persecuted by safety systems and live in fear of deportation. Residents explained that undocumented immigrants do not qualify for many government programs, often fear seeking care, and have limited power to negotiate with employers and landlords for salaries and rent control. As noted by several participants, many have experienced trauma in their home countries, made worse by unstable conditions. Further, participants remarked that children of undocumented parents or who themselves are undocumented often experience depression and anxiety, largely product of an uncertain future. According to residents, a pathway to legalize the situation of undocumented immigrants to ensure they are afforded all the human rights, many who have been most of their lives in the U.S., is urgently needed to improve their life conditions.

“The undocumented are scared to ask for help, and we are seeing that community getting jumped overnight, not wanting to go to the hospital over what they will get charged.” – Focus group participant

Responses also varied by survey respondents. One-quarter of Latino survey respondents indicated that they had ever been personally discriminated against when receiving medical care for their race/ethnicity and 17.6% because of language/speech issues. Asian residents were more likely to report being discriminated against for their culture/religious background (15.9%) and for language/speech issues (22.7%). Percentages for other race/ethnicities was not available due to small sample sizes. Other forms of discrimination were also mentioned in the survey. Among survey respondents, 14.1% reported having ever been discriminated against because of their age; 14.0% because of their body size; and 16.9% because of their income level.

Systemic Discrimination Based on Gender and Sexual Orientation

A theme that emerged from the qualitative data was discrimination against the LGBTQ+ population. Members of the LGBTQ+ community reported experiencing discrimination based on gender and/or sexual orientation in medical, educational, and professional settings. As described in the Employment section, Black trans women discussed encountering discrimination in employment due to their gender identity. An LGBTQ+ advocate emphasized more safe spaces for LGBTQ+ youth are needed in schools to prevent bullying. Also, more education efforts are needed to sensitize parents, educators, and other adults that interact with LGBTQ+ youth to ensure a supportive environment. As noted by an activist, many educators do not have the skills to address the needs of children growing up in non-traditional families. Additionally, the interviewee discussed how programs to sensitize and train police and healthcare providers should also be offered to promote quality, respectful care that fully addresses the diverse needs of this group, particularly of transgender individuals. One in ten survey respondents in Hudson County reported being discriminated against when receiving medical care because of their gender identity and/or sexual orientation.

*“A doctor told a lesbian woman seeking gynecological care that she didn’t need checkups because she didn’t have sex with men.”
– Key informant interviewee*

Addressing the Systems of Oppression

Quality education is a condition to overcoming intergenerational poverty resulting from historical systems of oppression. However, residents remarked that, despite attempts to provide adequate budgets, and largely because school financing relies partly on local cost share, public schools in low-income neighborhoods of Hudson County are under-resourced. Residents noted that the high cost of college poses another barrier for youth growing up in poverty. Further, they explained that the employment opportunities for unskilled workers do not pay a livable wage, nor offer a fixed income and benefits. In the words of a resident, *“There are jobs, I think, if you are well educated that you can sustain yourself on. But if you only have a high-school degree, it might be a bigger challenge.”* Interviewees alluded to how historical discriminatory policies against people of color, such as redlining, coupled with disinvestment and lack of educational and employment opportunities are contributing to growing inequalities and driving more people into the low-middle and low classes.

“The South side is a beautiful part of town, we’ve got some issues in some areas because of systemic racism and lack of investment, but it’s a beautiful part of town.” – Key informant interviewee

Residents mentioned that some Hudson County municipalities have put in place programs to address the effects of systemic racism, such as first-time homeowner programs for low-income residents, rent control policies, and programs to promote minority and/or woman owned businesses. However, participants emphasized that more policies and programs to promote equity and reverse this trend are urgently needed.

Community Health Issues

Understanding community health issues is a critical step in the CHNA process. The disparities seen in these issues mirror the historical patterns of structural, economic, and racial inequities experienced for generations across the county and the U.S.

Community Perceptions of Health

Understanding residents' perceptions of health helps provide insights into lived experiences, including into the key health concerns and facilitators and barriers to addressing health conditions. When asked about top concerns in their community, focus group participants and interviewees identified social and economic issues such as financial and food insecurity, and housing – and how these were associated with chronic conditions that affect many members of the community, including high-blood pressure, high cholesterol, and diabetes.

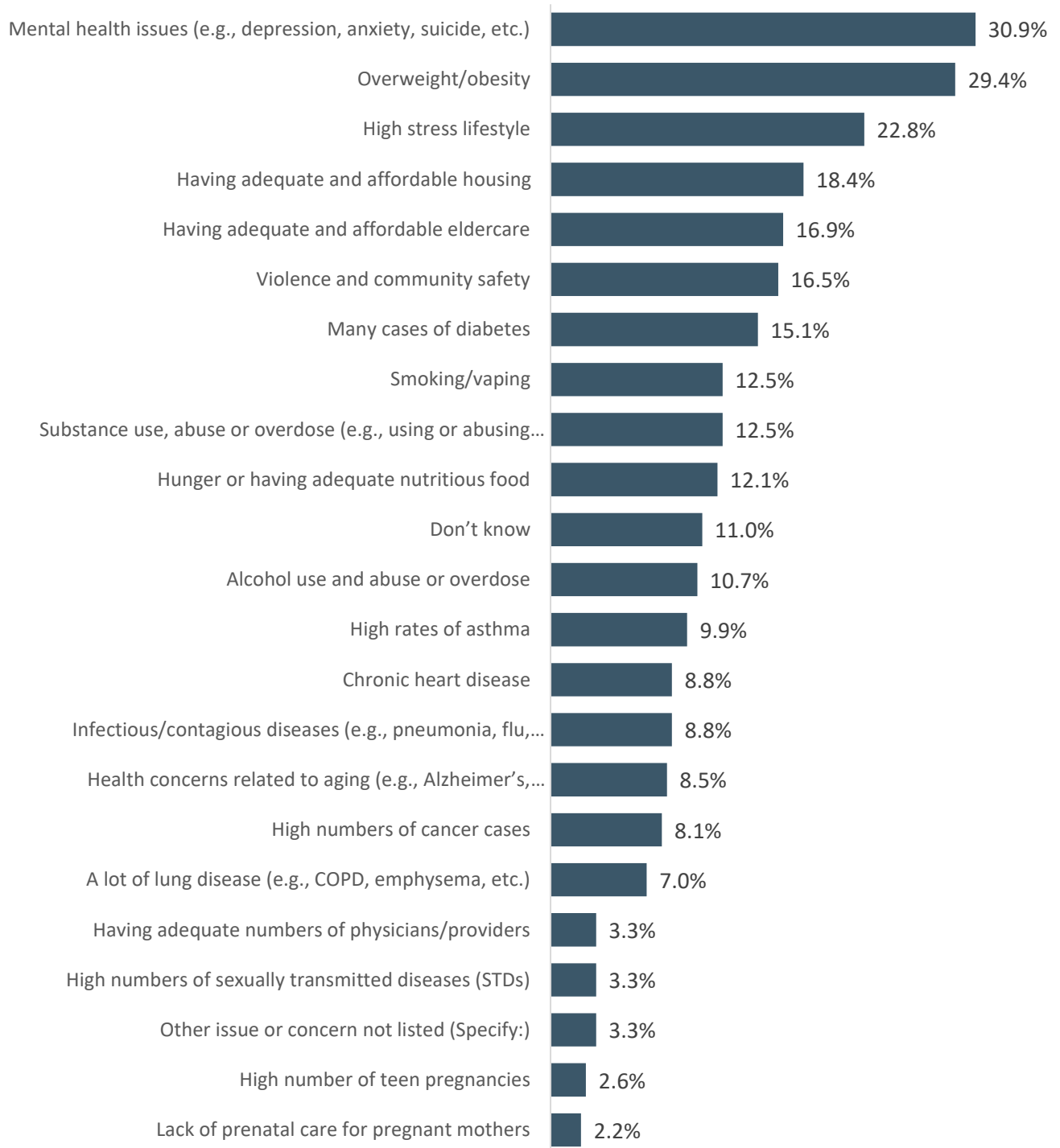
Challenges to accessing healthcare, largely due to cost, was also a top concern among residents. Another issue discussed by multiple groups, was the increase in mental health disorders among the entire population, but particularly among youth, seniors, and veterans. Other issues that were mentioned included a rise in community and domestic violence, an increase in sexually transmitted infections, and challenges to women's health, the latter in the context of the wave of legal decisions that curtail reproductive rights.

“Diabetes, high blood pressure, high cholesterol, obesity in this community is a problem [among] people who have a difficult time affording food” – Focus group participant

Survey respondents were presented with a list of specific issues and had the ability to add issues not listed. They were asked to mark the top three health concerns or issues for their community. They also were given the option to write in other issues not listed. This feedback complements quantitative data concerning health status and conditions. As shown in Figure 45, mental health, overweight/obesity, and high stress lifestyle were the top three issues noted among survey respondents. This was slightly different than results of the same survey in 2019. In that 2019 survey, obesity was the number one community health concern selected by survey respondents, followed by diabetes and then (tied) substance use and mental health.

While mental health, overweight/obesity, and high stress lifestyle were the top three community health concerns among respondents in the recent survey, differences appeared by race/ethnicity. While respondents identifying as Asian, Latino, and White shared the three priority health topics described above, Black respondents' top priority area was violence/community safety, followed by mental health issues, and adequate and affordable housing (Figure 46).

Figure 45. Percent of Community Survey Respondents Reporting the Top Three Health Issues or Concerns in Their Community (N=272), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Figure 46. Percent of Community Survey Respondents Reporting the Top Health Issues or Concerns in Their Community, by Race/Ethnicity (N=272), 2021

Asian (n=44) (A)	Black (n=26) (B)	Hispanic/ Latino (n=68) (C)	White (n=125) (D)
High stress lifestyle (31.8%) (D)	Violence/Community Safety (38.5%) (ABD)	Mental health issues (39.7%) (A)	Mental health issues (33.6%) (A)
Overweight/ obesity (29.5%)*	Mental health issues (34.6%) (A)	Overweight/ obesity (33.8%)	Overweight/ obesity (29.6%)
Mental health issues (15.9%)	Having adequate and affordable housing (19.2%) (A)*	High stress lifestyle (27.9%)	High stress lifestyle (18.4%)
Violence/Community Safety (13.6%)*	High stress lifestyle (19.2%)*	Substance use, abuse or overdose (23.5%) (AD)*	Having adequate and affordable housing (18.4%)
Having adequate and affordable eldercare (13.6%)*	Overweight/ obesity (19.2%)*	Having adequate and affordable eldercare (23.5%) (B)*	Many cases of diabetes (16.0%)

DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

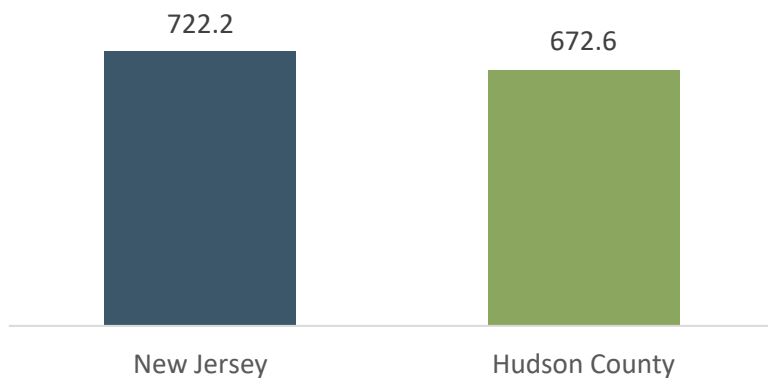
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering. * indicates health issues were tied. Cases where "don't know" was a frequently selected option are not presented in the table.

Leading Causes of Death and Premature Mortality

Mortality rates help to measure the burden and impact of disease on a population, while premature mortality data (deaths before age 75 years old) provide a picture of preventable deaths and point to areas where additional health and public health interventions may be warranted.

The most current mortality data are available for the period 2018-2020, which includes the first year of the COVID-19 pandemic. The age-adjusted mortality rate per 100,000 Hudson County residents was 672.6 in this period (Figure 47); 7% below the mortality rate in New Jersey during the same time period.

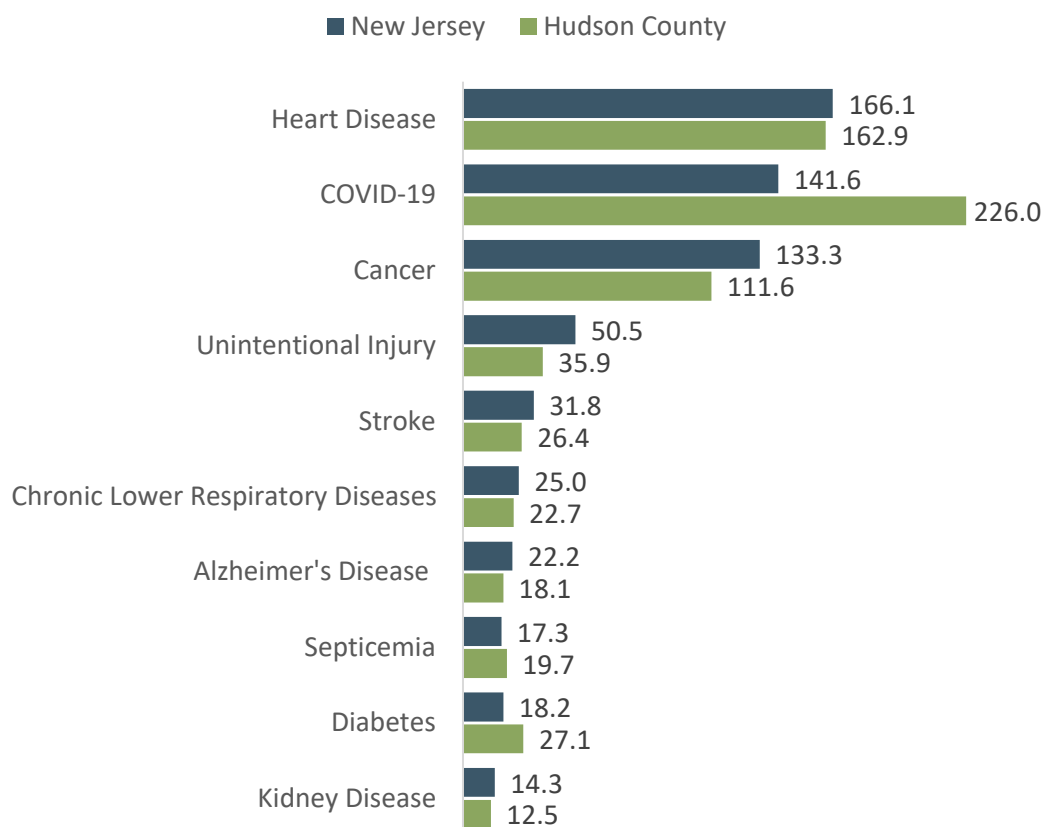
Figure 47. Age-Adjusted Mortality Rate per 100,000 population, 2018-2020



DATA SOURCE: New Jersey Department of Health, New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2018-2020

The leading cause of death in Hudson County in 2020 was heart disease (162.9 per 100,000), followed by COVID-19 (226.6 per 100,000), and cancer (111.6 per 100,000) (Figure 48). Additional leading causes of death included unintentional injury (such as unintentional poisonings including drug overdoses, unintentional motor vehicle accidents, unintentional drownings, and falls), stroke, and chronic lower respiratory disease (CLRD – e.g., chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, and asthma). It is important to note the deleterious impact of COVID-19 on mortality, which became the second cause of death in both the state and the county. The mortality rate by COVID-19 in Hudson County was 46% higher than in the state. Additional data on unintentional injury can be found in Appendix F- Additional Data Tables.

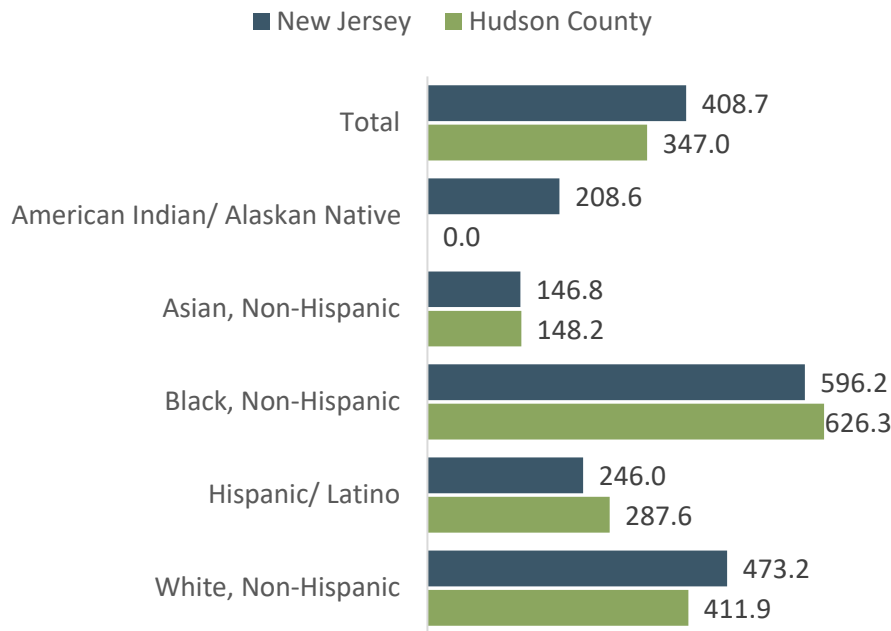
Figure 48. Top 10 Age Adjusted Mortality Rates per 100,000, by State and County, 2020



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health as reported New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2021

Premature mortality, deaths before age 75 years old, is an indicator of untimely death and can provide guidance on where additional investments are needed. In 2018-2020—the time period with the most recent data available—Hudson County had a premature mortality death rate of 347.0 per 100,000 residents, compared to 408.7 per 100,000 New Jersey residents (Figure 49). The rate of premature mortality was highest among Black (626.3) and White (411.9) residents, both above the county and state averages.

Figure 49. Premature Mortality (deaths before age 75) Rate per 100,000 Population, by State and County, 2018-2020



DATA SOURCE: National Center for Health Statistics, Mortality Files, as reported University of Wisconsin Population Rankings & Roadmaps, 2018-2020

Additional data on the overall health of the population can be found in Appendix F- Additional Data Tables.

Obesity, Healthy Eating, and Physical Activity

Obesity is the second leading cause of preventable death in the United States and increases the likelihood of chronic conditions among adults and children.

Overweight and Obesity

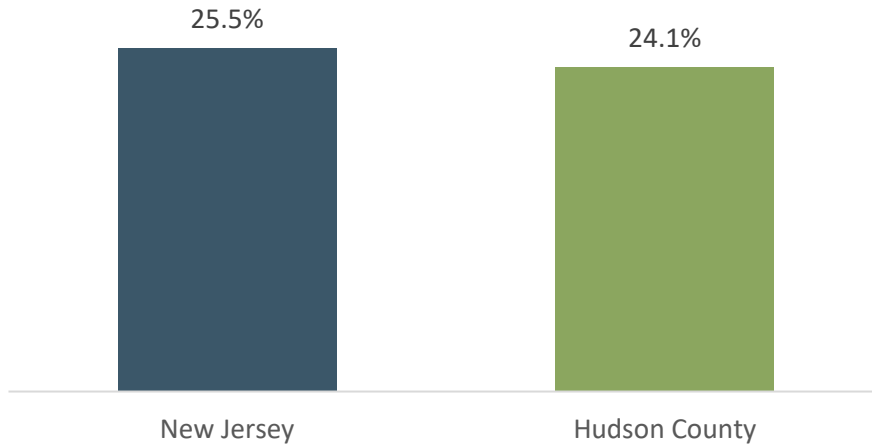
As discussed earlier in the Perceptions of Community Health section, obesity was cited as the second top health concern in the community in the survey (after mental health). However, it was not discussed at length in the focus groups or interviews by participants. Instead, residents from diverse population groups commented on the chronic conditions that are linked to obesity, particularly diabetes, and described how these conditions were prevalent in the community from a very young age. They discussed the social and economic challenges to maintaining a healthy lifestyle, including buying healthy food, access issues in living in a food desert, barriers to seeking medical care, having safe and accessible green space for activity, and time constraints. (See sections related to Food Access and the Built Environment for survey data and surveillance data on perceptions and the landscape related to the food and physical activity environment.)

The latest surveillance data on overweight/obesity is from several years ago. Adults at the state and county level were asked to self-report their height and weight. Based on this self-report, about one in four adults in Hudson County were considered obese, comparable to New Jersey (Figure 50).

In the current community survey for this CHNA, survey respondents were asked to indicate whether they or a household family member were ever told by a doctor or health professional that they had a

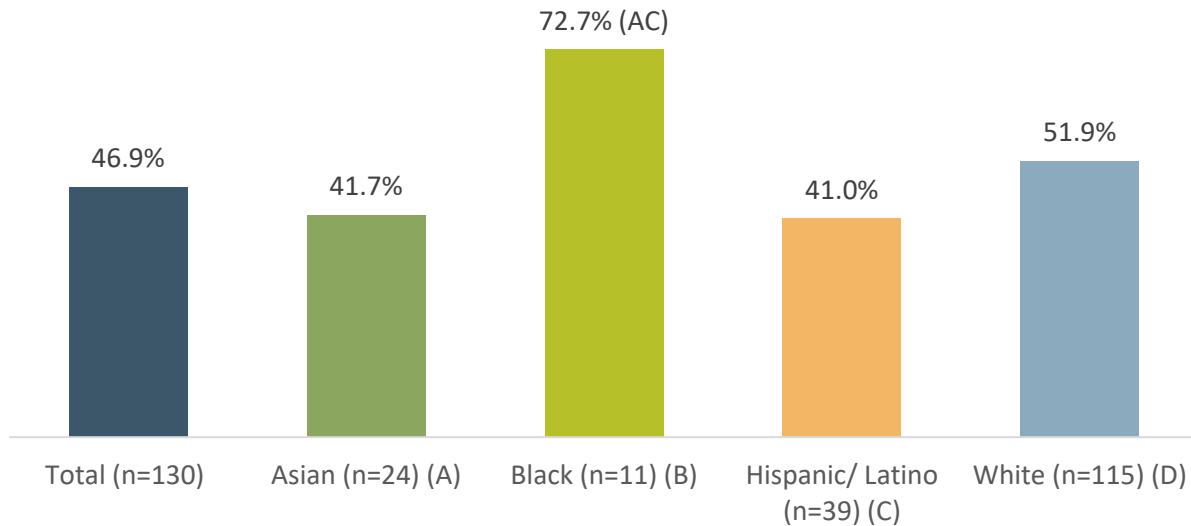
weight problem (Figure 51). Among these respondents, almost half (46.9%) indicated yes, although responses varied by race/ethnicity. Nearly three in four (72.7%) Black respondents reported this, significantly higher than Asian (41.7%) and Latino (41.0%) respondents.

Figure 50. Adults Self-Reported Obese, by State and County, 2018



DATA SOURCE: Centers for Disease Control and Prevention (CDC), U.S. Diabetes Surveillance System, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

Figure 51. Percent of Community Survey Respondents Reporting that They or a Family Member Has Ever Been Told by a Health Professional They Have Had a Weight Problem (n=130), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

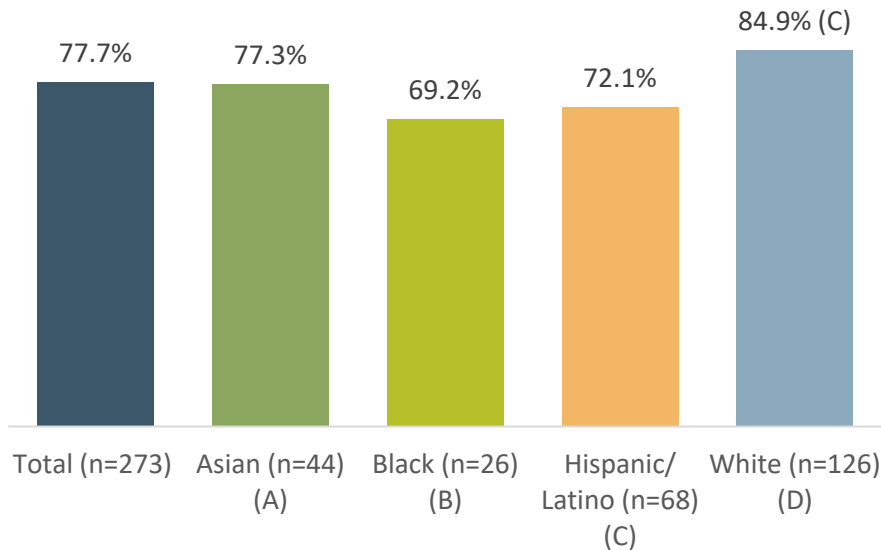
Physical Activity

Some focus group participants discussed that they enjoyed doing physical activity outdoors, while others noted that they did not have time to be physically active. Participants remarked that physical activity was important for maintaining both physical and mental health. A focus group participant explained the importance of exercise for those experiencing mental health problems and to address isolation, *“I wish more veterans would take advantage of opportunities for umpiring and make a little money on the side – I do various leagues, swimming, softball, baseball. [There are] a lot of opportunities for veterans that are just coming out of a mental health area, whereas they want a different avenue to go to, and be part of the community which a lot of veterans try to isolate... But this is something where you can just come out and do, be a part of the community with fellow veterans, you know.”*

“I walk a lot. Walking is the best exercise.” – Focus group participant

Community survey respondents were asked if they were physically active, and nearly 78% indicated yes (Figure 52). However, Black and Latino survey respondents were less likely to say that they were currently physically active, with only 69.2% and 72.3% saying yes, respectively, a lower proportion when compared to White respondents (84.9%). As discussed earlier in this report, Black and Latino survey respondents were also significantly less likely than White respondents to indicate that there were safe outdoor places to walk and play in their community. Community survey respondents who were parents also indicated whether they would describe their children as physically active or sedentary after school or on weekends. About 78% of Hudson County parent survey respondents described their children as physically active, with 21.8% describing them as sedentary. In comparison, only 53.6% of Latino parents indicated their children were physically active. Data is not available for Asian and Black parents.

Figure 52. Percent of Community Survey Respondents Indicating That They Were Physically Active (n=273), 2021

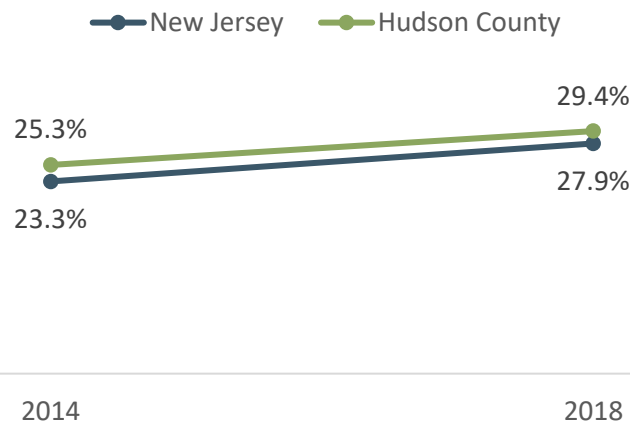


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

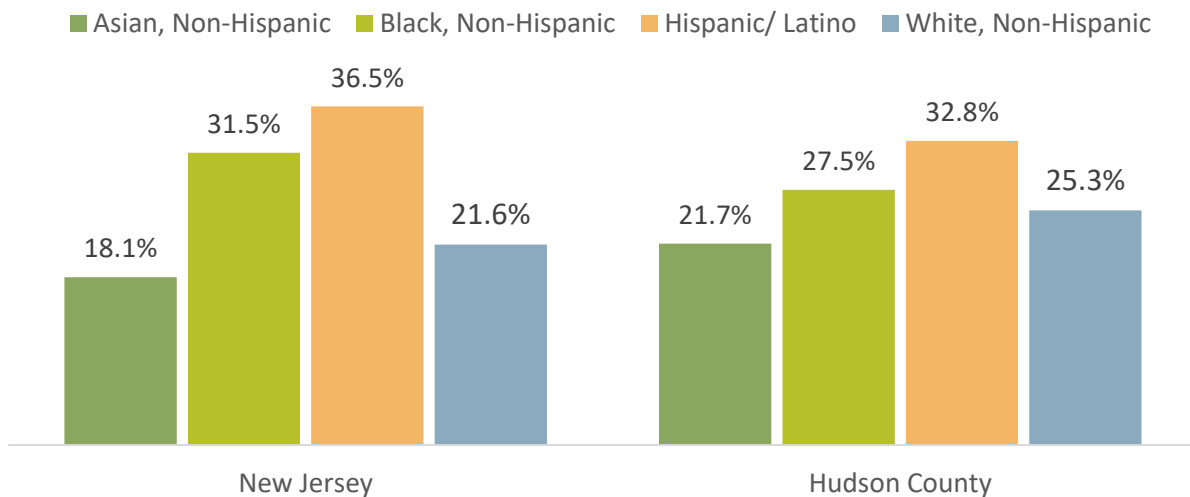
Surveillance data on physical activity, collected pre-COVID, shows similar patterns as the community survey. These data sources collect data on whether respondents had no leisure time activity. Across the state and by county, the percentages of those with no leisure time physical activity were higher in 2018 than in 2014 (Figure 53). In Hudson County, 29.4% of adults reported having no leisure time in 2018, compared to 25.3% in 2014. Surveillance data from 2016 to 2020, by race/ethnicity indicated that Latino respondents were most likely to report having no leisure physical activity time (32.8%) (Figure 54). Data on access to adequate location to engage in physical activity can be found in Figure 133 in the Appendix.

Figure 53. Percent Adults Reported to Have Had No Leisure Time Physical Activity, by State and County, 2014 and 2018



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2014 and 2018

Figure 54. Percent Adults Reported to Have Had No Leisure Time Physical Activity by Race/Ethnicity, by State and County, 2016-2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Healthy Eating

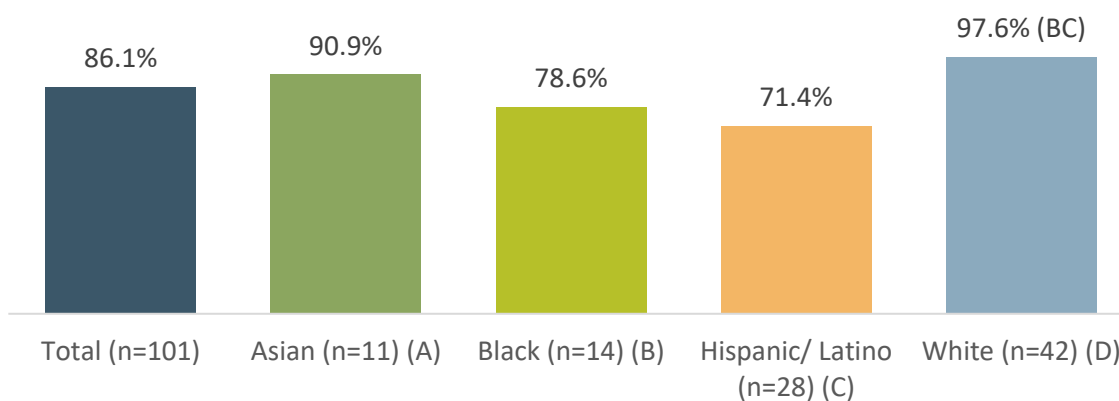
As discussed in the Food Access & Food Insecurity section and Built Environment section of this report, focus group and interview participants talked about the challenges of accessing healthy foods in their communities. These difficulties included lack of availability and affordability of healthy foods, depending on food provided by schools or food pantries, living in a “food desert,” and not having access to a kitchen to cook healthier meals for the family. However, other participants mentioned that there were healthy food outlets available in Hudson County. During COVID-19, multiple participants remarked that the community came together to ensure access to healthy foods to those affected by the pandemic via food drives and delivery of healthy food boxes or supermarket gift cards. Residents also noted that low-income seniors could receive food vouchers. In addition, Jersey City Medical Center has a healthy food pantry which serves people facing food insecurity, many of whom are seniors.

“They were meeting specifically... about the quality of the food that are available to more African American neighborhoods as opposed to downtown Jersey City, from the same food chain, and they had some complaints there... Food deserts are still a problem in our area.” – Focus group participant

Current surveillance data on fruit and vegetable consumption is not available for Hudson County. New Jersey data indicate that 19.1% of New Jersey adults reported in 2017 that they ate vegetables less than one time per day and 33.6% of New Jersey adults reported eating fruit less than one time per day, according to the Behavioral Risk Factor Surveillance Survey.

Eating breakfast daily is an important start to a healthy day. However, current data from the CHNA community survey shows differences by race/ethnicity. Among respondents living with a child, only about three-quarters of Black and Latino survey respondents (78.6% and 71.4%, respectively) reported that their children eat breakfast daily, significantly fewer than White respondents (97.6%) whose children did so (Figure 55).

Figure 55. Percent of Respondents Whose Children Eat Breakfast Daily, among Respondents Who Have Children that Live with Them, by Race/Ethnicity (n=101), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

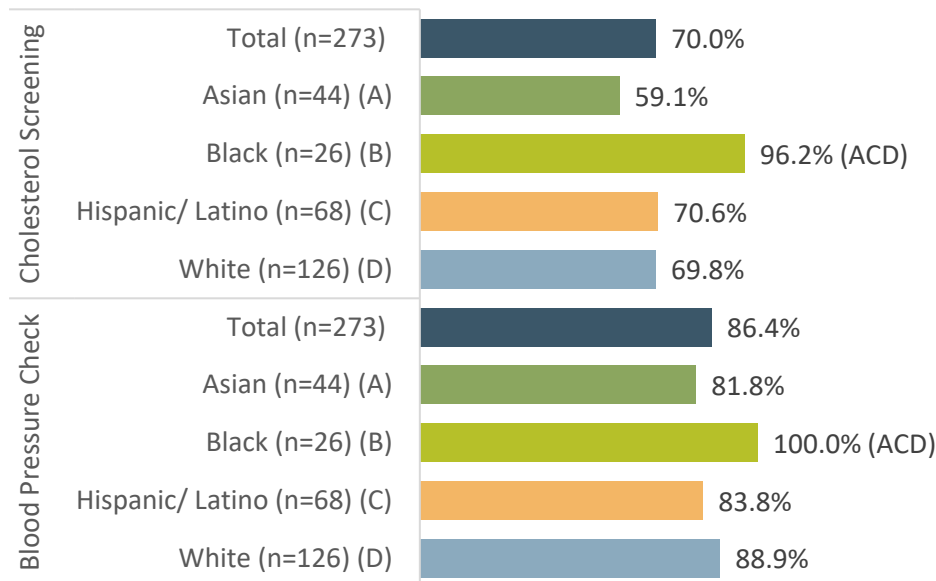
Chronic Conditions

Chronic conditions, such as heart disease, diabetes, COPD, and cancer, are some of the most prevalent conditions in the United States, including in Hudson County. Chronic diseases are also a contributing factor to poor mental health. As a healthcare provider noted, *“There’s a lot of depression surrounding getting diagnosed with one of those [chronic] illnesses. They have access to those programs, but they feel beaten down because of misinformation. When they get more information, they feel that they can manage it. The diagnosis can feel like a death sentence sometimes.”* Although chronic diseases are among the most common and costly health problems, they are also among the most preventable through changes in behavior such as reduced use of tobacco and alcohol and improved diet and physical activity. The following section describes the health data (e.g., screening, incidence, mortality, etc.) related to chronic conditions.

High Cholesterol and High Blood Pressure

Multiple focus group and interview participants mentioned high cholesterol and hypertension as prevalent in the community, including among children. High cholesterol and high blood pressure are significant risk factors for heart disease, stroke, and other chronic diseases.²⁹ Community survey respondents in spring/summer 2021 were asked about their participation in different types of health screenings over the past two years (Figure 56). Many respondents (70.0%) in Hudson County indicated that they have received a cholesterol screening, and 86.4% had participated in a blood pressure screening. Black respondents were significantly more likely than Asian, Latino, and White respondents to indicate that they had participated in either type of screening over the past two years.

Figure 56. Percent of Community Survey Respondents Reporting that They Have Participated in a Cholesterol or Blood Pressure Screening in the Past Two Years (n=273), 2021



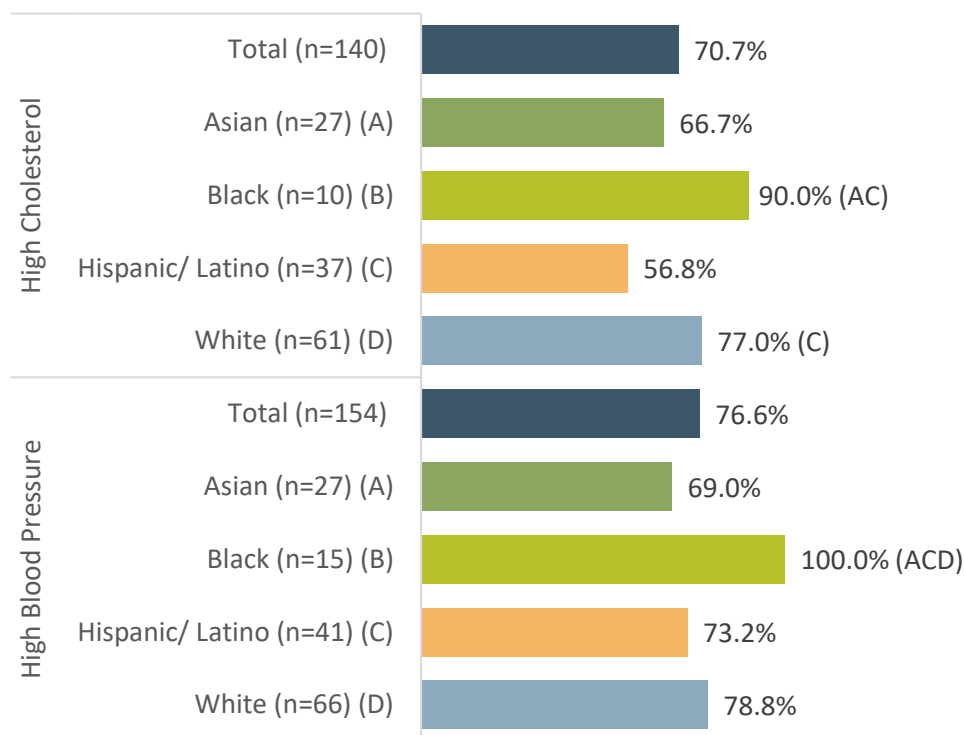
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

²⁹ <https://www.cdc.gov/chronicdisease/resources/publications/factsheets/heart-disease-stroke.htm>

A high proportion of survey respondents report being affected by high cholesterol and high blood pressure. Approximately 71% and 77% of Hudson County survey respondents indicated that they or member of their family had been told by a health professional that they have high cholesterol and blood pressure, respectively (Figure 57). Black respondents, with the highest rates of both, were significantly more likely than Asian, Latino, or Black respondents to indicate that they or a family member had high cholesterol or high blood pressure.

Figure 57. Percent of Community Survey Respondents Reporting that They or a Family Member Has Ever Been Told by a Health Professional They Had High Cholesterol or High Blood Pressure (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

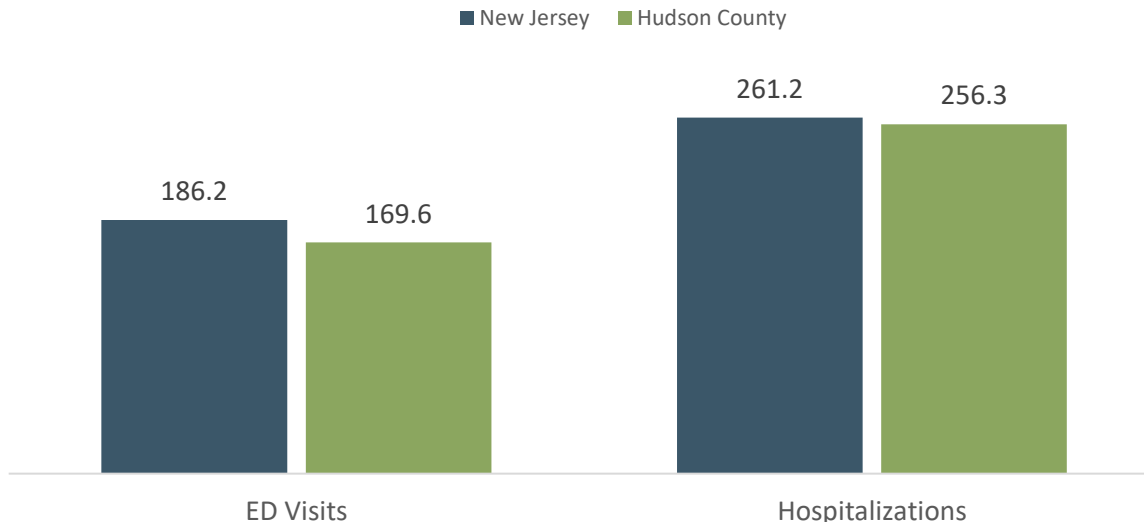
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Heart Disease

While focus group and interview participants did not directly discuss heart disease, it is the leading cause of death in Hudson County, and closely associated with other conditions mentioned by residents such as diabetes, high cholesterol, and lifestyle.

In the following graph, surveillance data are presented on the number of adults visiting the emergency department for major cardiovascular disease. In 2016-2020, the rate of heart disease emergency department (ED) visits per 10,000 population in Hudson County was 169.6 visits and the rate of heart disease hospitalizations per 10,000 population was 256.3, similar to state rates (Figure 58).

Figure 58. ED Visits and Hospitalizations for Major Cardiovascular Disease per 10,000 Population, by State and County, 2016-2020

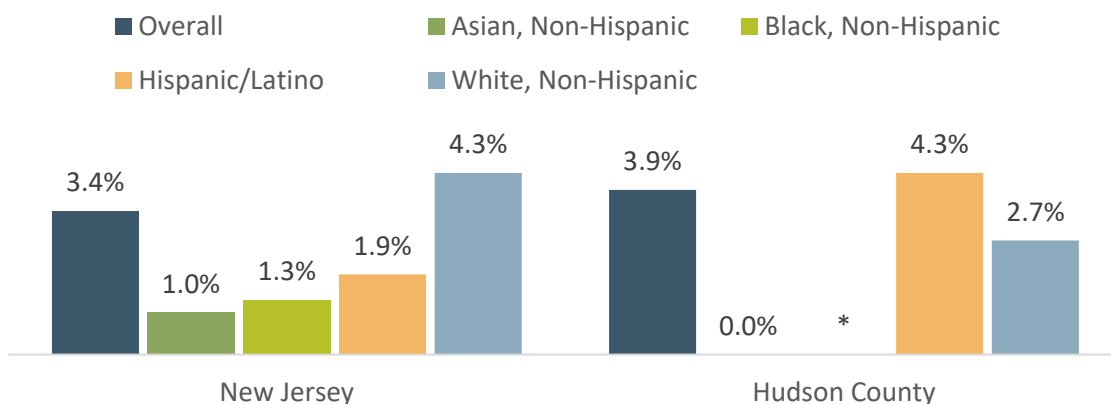


DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

NOTE: Includes primary and secondary diagnosis cardiovascular disease, excluding stroke and hypertension

Figure 59 presents the percentage of adults that reported angina or coronary heart disease in 2020, by race/ethnicity. Across the state, the percentage of those reporting angina or coronary heart disease was highest among White residents (4.3%), followed by Latino (1.9%), Black (1.3%), and Asian residents (1.0%). At the county level, the highest percentage was reported by Latino residents (4.3%), higher than the percentage at county and state level. However, data for Black residents was not reliable due to small sample sizes.

Figure 59. Percent of Adults Reporting Angina or Coronary Heart Disease, by State and County, by Race/Ethnicity, 2020

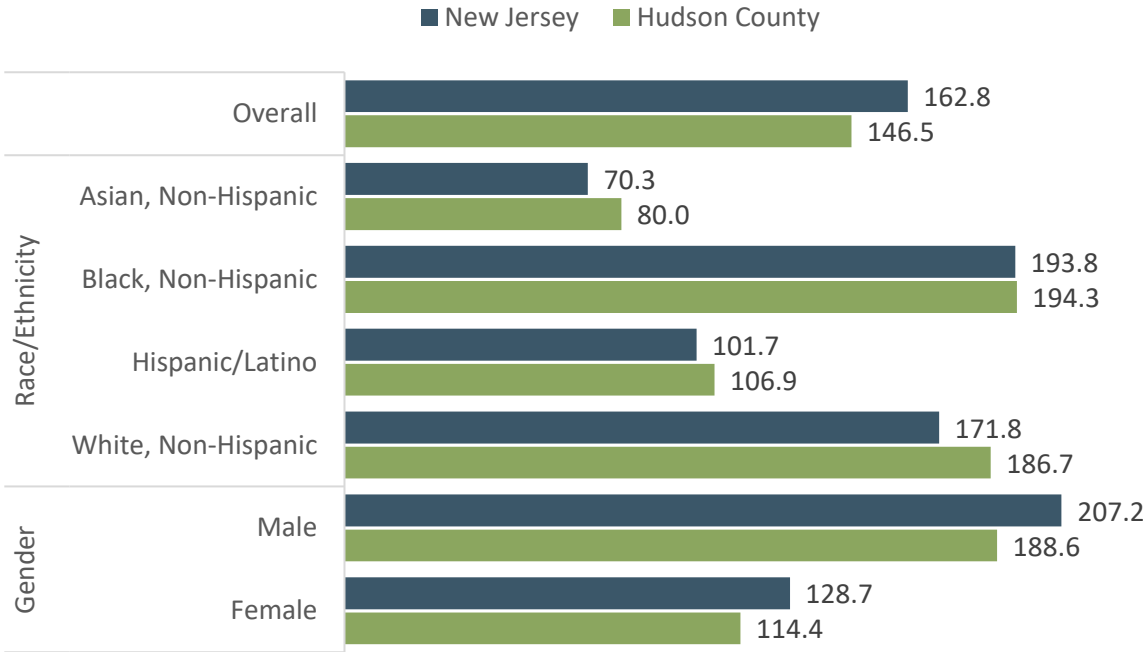


DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Death certificate data is presented for rates of cardiovascular disease mortality per 100,000 in 2016-2020 overall and by race/ethnicity and gender. Across the state, the overall mortality per 100,000 was 162.8 and was highest among Black (194 per 100,000) and White (172 per 100,000) residents, as well as male (206.7 per 100,000) residents (Figure 60). At the county level, the overall cardiovascular disease mortality per 100,000 was 147, lower than in the state. Like New Jersey, mortality was highest among Black (194 per 100,000) and White (187 per 100,000), as well as male (189 per 100,000) residents.

Figure 60. Cardiovascular Disease Mortality per 100,000, by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

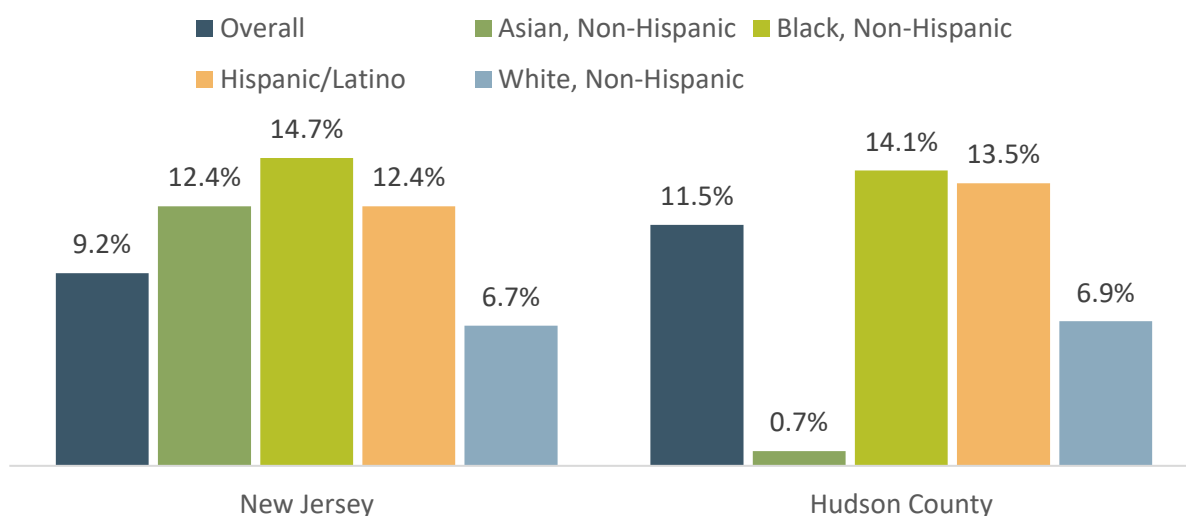
Diabetes

Diabetes was among the top health concerns mentioned by focus group and interviewee participants across the board, including among the Latino, Black, and Asian residents. Participants indicated observing an increase in rates of diabetes in recent years and noted that diabetes was highly prevalent in their communities, starting at a young age. A Latino focus group participant described it as, *“Everyone, even children, has diabetes... What is in the air for everyone to have diabetes?”* Focus group participants attributed the increase in diabetes rates to stress associated with social and economic factors, such as affordable healthy living and access to good healthcare. As one focus group participant stated, *“Diabetes is a very expensive issue in the community, and we’ll often see people forgo their medication because they can’t afford it or forgo healthy foods because they can’t afford it.”* A theme that emerged strongly from participants was the urgent need to address the upstream causes of disease to reduce the incidence of diabetes and other chronic disease among low-income communities and persons of color.

The following figure shows the percent of adults that reported a diagnosis of diabetes overall and by race/ethnicity from 2016 to 2020, the most recent that surveillance data is available. In New Jersey, 9.2% of adults reported a diabetes diagnosis. This percentage was highest among Black, Non-Hispanics (14.7%), followed by Asian, Non-Hispanics (12.1%) and Hispanic/Latino (12.4%), and lowest among White, Non-Hispanics (6.7%) (Figure 61). A higher percentage of adults were diagnosed with diabetes in Hudson County (11.5%). Of note, whereas county rates among Black (14.1%) and White (6.9%) residents were comparable to those of the state, Latinos in Hudson County (13.5%) had higher rates and Asians had much lower rates (0.7%) than in New Jersey.

“We seem taken aback by how prevalent these chronic diseases are so much so that when somebody's first diagnosed, many times they don't even react to it like, “Yeah, well, my father had it, my mother had it, my friends have it, and now I have it.” It's normalized and I think that's a shame. I think we can do more work upfront.” – Focus group participant

Figure 61. Percent of Adults Reported to Have Been Diagnosed with Diabetes, by State and County, 2016-2020



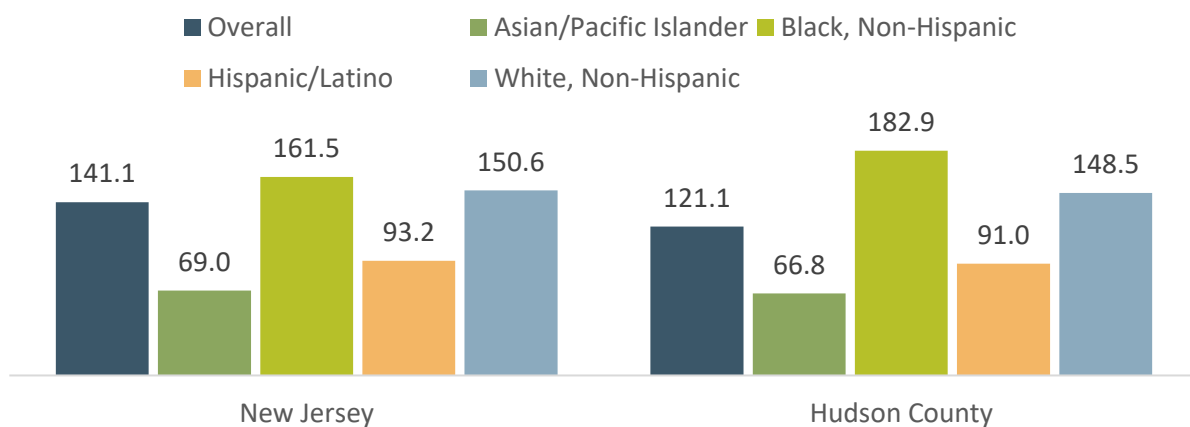
DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Cancer

While cancer is one of the leading causes of death in Hudson County, it was not discussed much during the focus groups or interviews. However, cancer incidence and mortality are closely associated with the social determinants of health. Screening and early detection is a critical strategy to reduce premature deaths and is strongly linked to access to care. Further, lifestyle factors are the most significant risks of developing cancer. Exposure to carcinogens in the built environment, the water, the air, and the soil, because of daily activities at home, school, and the workplace, increases the risk of developing cancer. In addition, a healthy lifestyle – maintaining a healthy diet and weight, and not smoking or consuming alcohol, are preventative factors; as discussed in other sections of the report, some population groups face substantial barriers to sustaining a healthy lifestyle.

Death certificate data is presented below for cancer mortality rates per 100,000 in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality per 100,000 was 141.1 and was highest among Black, Non-Hispanics (161.5 per 100,000) and White, Non-Hispanics (150.6 per 100,000) (Figure 62). The overall cancer mortality rate in Hudson County (121.1 per 100,000) was lower than in the state. Most racial/ethnic groups in Hudson County, had cancer mortality rates comparable to those in New Jersey. However, Black residents' cancer mortality rate (182.9 per 100,000) in Hudson County, was higher than in New Jersey. Appendix I in the back of this report contains additional cancer data including incidence and mortality data and five-year trends for all cancers across New Jersey and Hudson County. There is an additional table of tumor registry data for JCMC, and information on the patient origin of Hudson's outpatient and inpatient cancer treatment population.

Figure 62. Cancer Mortality Rate per 100,000 Population (Overall, Combined for Female Breast, Colorectal, Lung and Bronchus, Male Prostate), by Race/Ethnicity, State, and County, 2016-2020

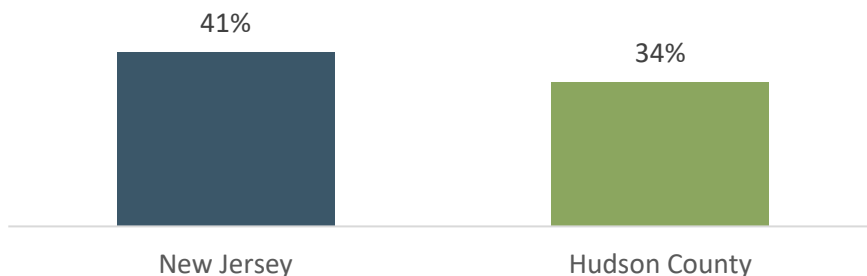


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Breast Cancer

The following figure shows the percentage of female Medicare enrollees, ages 65-74, that received an annual mammography screening in 2019. At the state level, 41.0% of female Medicare enrollees in that age group had received an annual screening (Figure 63). The county rate of 34% was lower than that state rate.

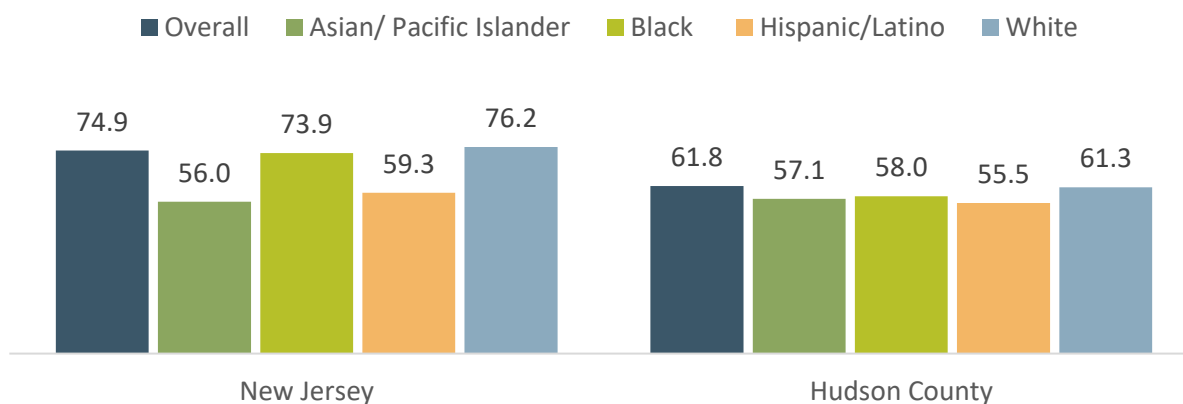
Figure 63. Female Medicare Enrollees Ages 65-74 that Received an Annual Mammography Screening, by State and County, 2019



DATA SOURCE: Centers for Medicare & Medicaid Services, Office of Minority Health's Mapping Medicare Disparities tool, as reported by County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

Cancer registry data is presented for the age-adjusted incidence rate of female breast cancer per 100,000 population in 2015-2019 across New Jersey and in Hudson County, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate was 74.9 per 100,000 and was highest among the White (76.2 per 100,000) and Black (73.9 per 100,000) populations (Figure 64). At the county level, the overall incidence rate in Hudson County (61.8 per 100,000) was lower than in the state. It was highest among the White Hudson County population (61.3 per 100,000) and similar among the Black (58.0 per 100,000), Asian/Pacific Islander (57.1 per 100,000), and Hispanic/Latino (55.5 per 100,000) groups.

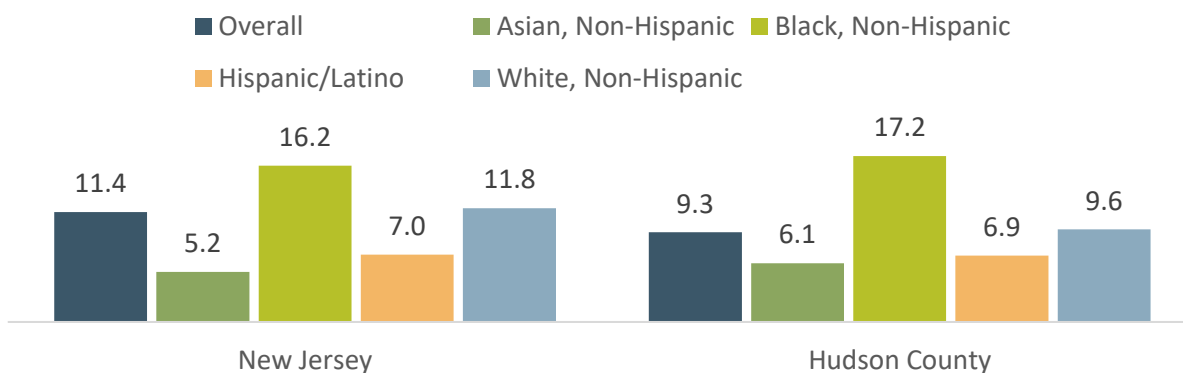
Figure 64. Age-Adjusted Female Breast Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

The state cancer mortality rate was 11.4 per 100,000 persons and was highest among Black women (16.2 per 100,000), followed by White women (11.8 per 100,000) (Figure 65). At the county level, the overall mortality rate was 9.3 per 100,000, lower than in New Jersey. The breast cancer mortality rate among Black women (17.2 per 100,000) in Hudson County nearly doubled that of White residents (9.6 per 100,000), and almost tripled that of Asian women (6.1 per 100,000) and Latinas (6.9 per 100,000).

Figure 65. Breast Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020

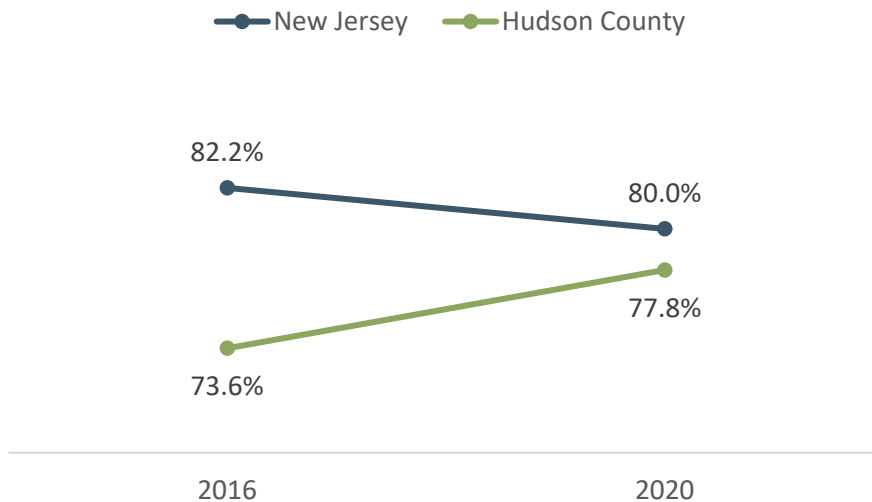


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Cervical Cancer

Data are presented on the percentage of women, ages 21-65, that reported having had a pap test in the past three years in 2016 and 2020, encompassing the first year of COVID-19. At the state level, 82.2% of women in that age group reported having had a pap test in the past three years in 2016 and 80.0% in 2020 (Figure 66). Whereas the percentage of women getting pap tests were lower in Hudson County at both time periods, unlike in New Jersey, the percentage of women obtaining a pap test in the past three years in Hudson County increased from 73.6% in 2016 to 77.8% in 2020.

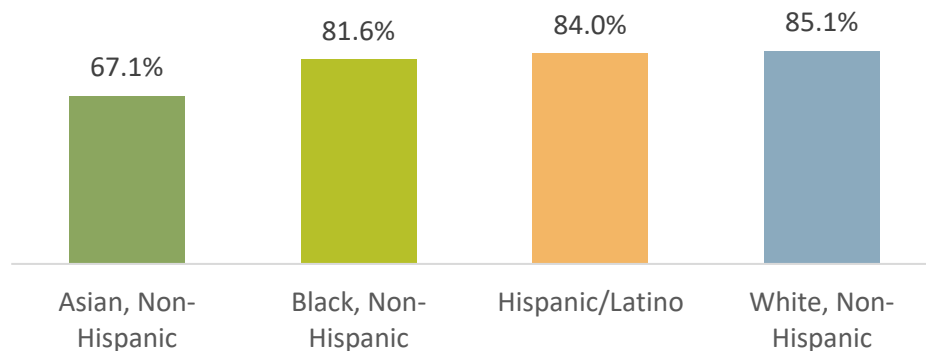
Figure 66. Percent Females Aged 21-65 Reported to Have Had a Pap Test in Past Three Years, by State and County, 2016 and 2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016 and 2020

Data are also presented at the state level on the percentage of females, ages 21-65, that reported having had a pap test in the past three years by race/ethnicity. In New Jersey, 85.1% of White, Non-Hispanics, 84.0% of Hispanics/Latinos, 81.6% of Black, Non-Hispanics, and 67.1% of Asian, Non-Hispanics reported having a pap test in the past three years (Figure 67).

Figure 67. Percent Females Aged 21-65 Reported to Have Had a Pap Test in Past Three Years by Race/Ethnicity, by State, 2020

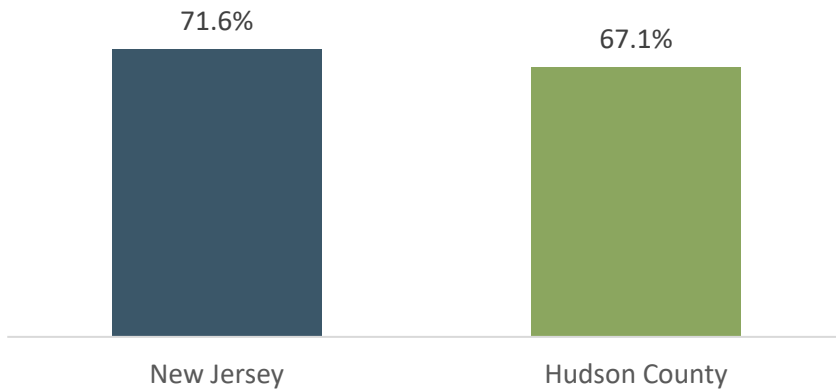


DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Colorectal Cancer

The following figure presents 2020 surveillance data on the percentage of adults aged 50 to 75 who were current – defined as having taken a take-home fecal immunochemical test (FIT) or high-sensitivity fecal occult blood test (FOBT) within the past year, and/or a flexible sigmoidoscopy within the past 5 years with a take-home FIT/FOBT within the past 3 years, and/or a colonoscopy within the past ten years – in their colorectal cancer screenings. At the state level, 71.6% of adults in that age group reported having had a colorectal cancer screening compared to 67.1% in Hudson County (Figure 68).

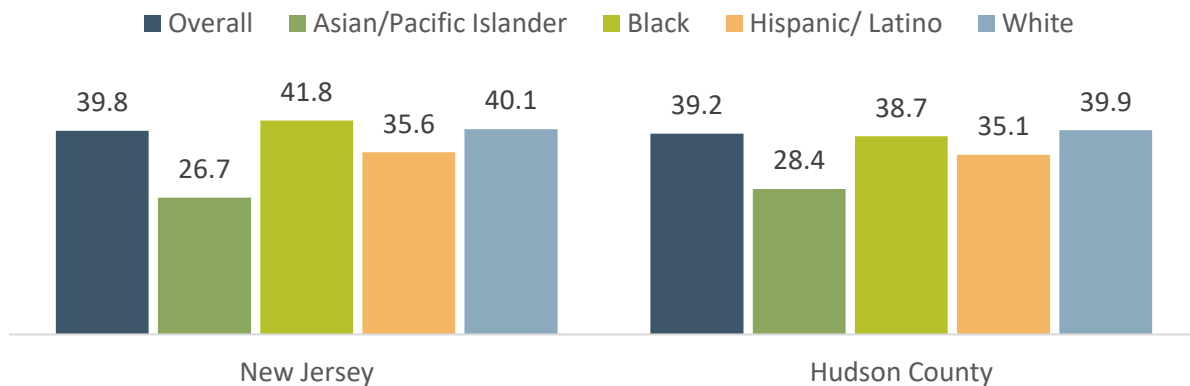
Figure 68. Percent Colorectal Cancer Screening (Adults Aged 50-75), by State and County, 2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Cancer registry data is presented for the age-adjusted incidence rate of colorectal cancer per 100,000 population in 2015-2019 at state and county, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate per 100,000 was 39.8 and was highest among the Black (41.8 per 100,000) and White (40.1 per 100,000) populations (Figure 69). At the county level, the overall incidence rate was 39.2 per 100,000 in Hudson County and was highest among the White (39.9 per 100,000) and Black (38.7 per 100,000) populations.

Figure 69. Age-Adjusted Colorectal Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019

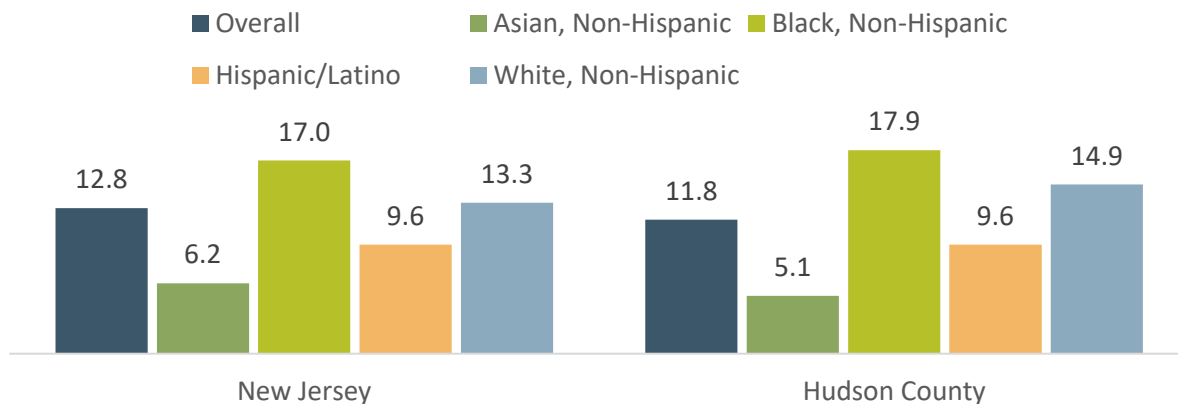


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Death certificate data is presented for rate of colorectal cancer mortality per 100,000 persons in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality rate was 12.8 per 100,000 and was highest among the Black population (17.0 per 100,000), followed by the White population (13.3 per 100,000) (Figure 70). County-level rates were comparable. The overall colorectal cancer mortality in Hudson County was 11.8 per 100,000 persons; highest among Black (17.9 per 100,000) followed by White (14.9 per 100,000) residents.

Figure 70. Colorectal Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020

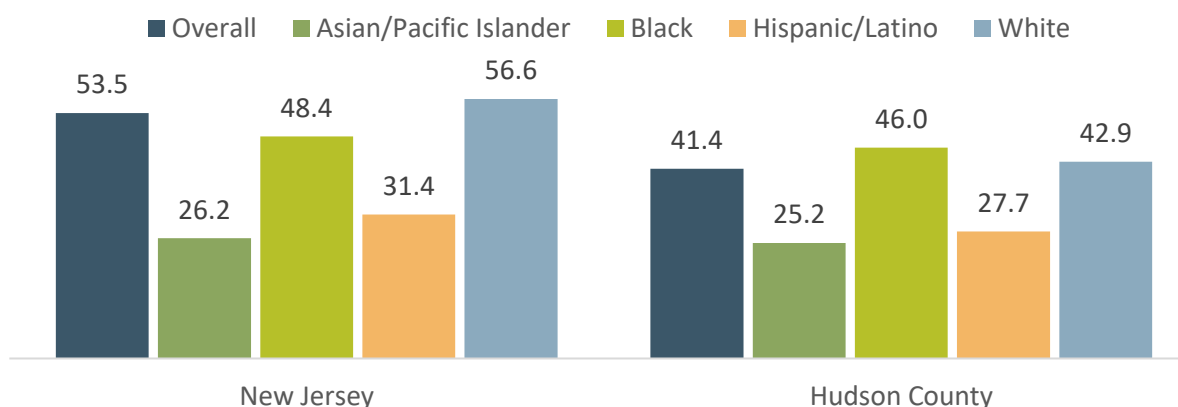


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Lung Cancer

Across the state, the overall age-adjusted lung cancer incidence rate in 2015-2019 was 53.5 per 100,000 residents and was highest among the White (56.6 per 100,000) and Black (48.4 per 100,000) groups (Figure 71). The county-level overall lung cancer incidence rate of 41.4 per 100,000 was lower than in the state. By race/ethnicity, the incidence rate of lung cancer in Hudson County was higher than average among the Black (46.0 per 100,000) and White (42.9 per 100,000) populations.

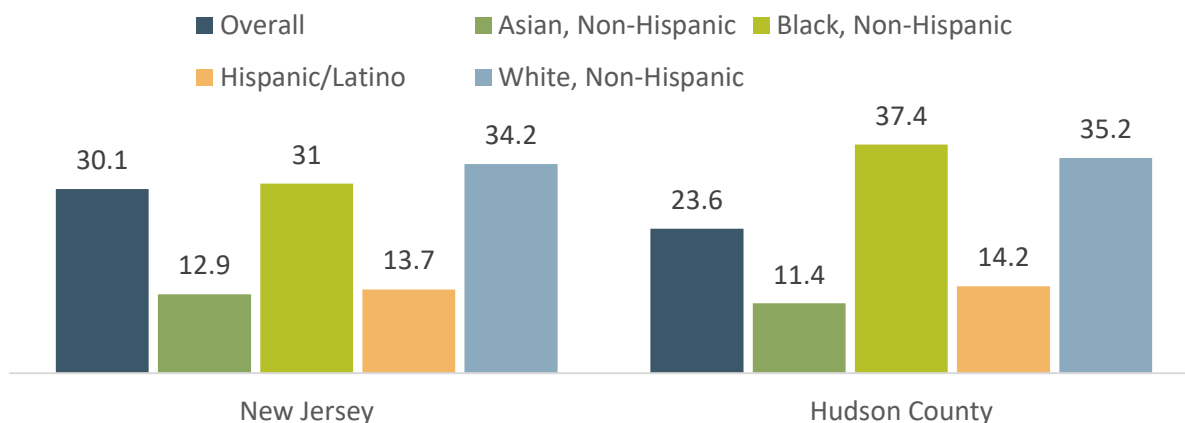
Figure 71. Age-Adjusted Lung Cancer Incidence Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2015-2019



DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

Death certificate data is presented for rate of lung cancer mortality per 100,000 in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality rate per 100,000 was 30.1 and was highest among White, Non-Hispanics (34.2 per 100,000) and Black, Non-Hispanics (31.0 per 100,000) (Figure 72). At the county level, the overall lung cancer mortality per 100,000 was 23.6 in Hudson County and was highest among Black, Non-Hispanics (37.4 per 100,000), followed by White, Non-Hispanics (35.2 per 100,000).

Figure 72. Lung Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020

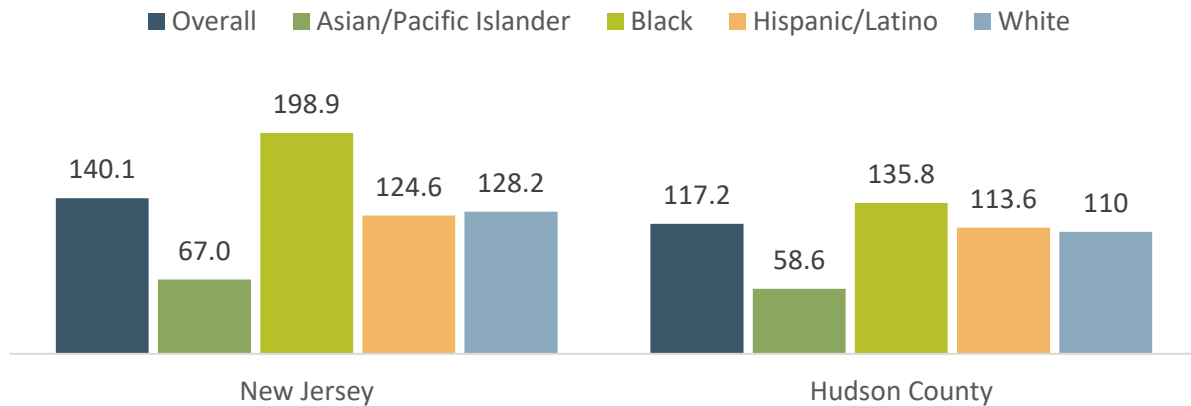


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Prostate Cancer

Cancer registry data is presented for the age-adjusted incidence rate of prostate cancer per 100,000 population in 2015-2019 across New Jersey and in Hudson County, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate was 140.1 and was 198.9 per 100,000 in the Black population (Figure 73). At the state level, incidence rates were similar among Hispanic/Latino (124.6 per 100,000) and White (128.2 per 100,000) populations, and lower among Asian (67.0 per 100,000) groups. At the county level, the overall age-adjusted incidence rate was 117.2 in Hudson County and was highest among Black residents (135.8 per 100,000), comparable among Hispanic/Latino (113.6 per 100,000) and White (110.0 per 100,000) populations, and lowest among Asian groups (58.6 per 100,000).

Figure 73. Age-Adjusted Prostate Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019

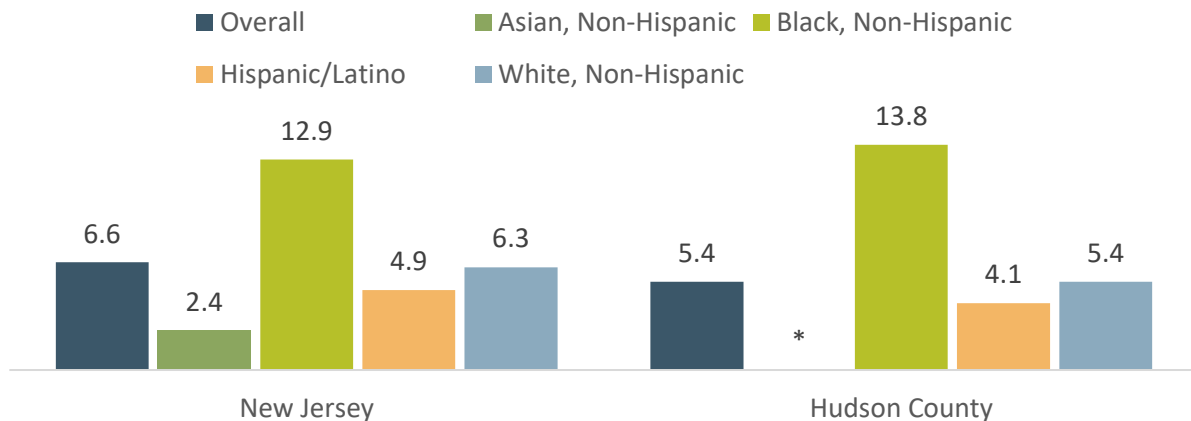


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019

NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Death certificate data is presented for rate of prostate cancer mortality per 100,000 in 2016-2020 overall and by race/ethnicity. Across the state, the overall mortality rate per 100,000 was 6.6; almost double the average rate among Black, Non-Hispanics (12.9 per 100,000) (Figure 74). At the county level, the overall mortality rate per 100,000 was 5.4 in Hudson County, with rates for Black residents (13.8 per 100,000) 170% higher than the average. Data was not provided for Asians due to small numbers.

Figure 74. Prostate Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020



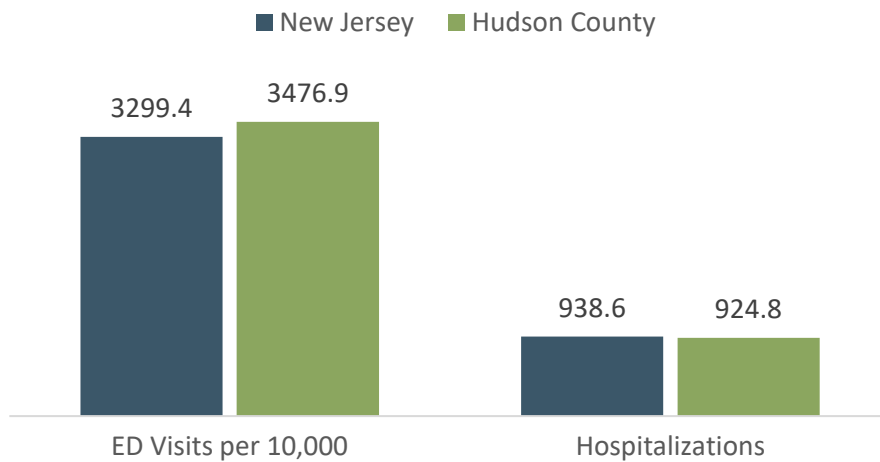
DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. It is the most prevalent disease in the grouping of chronic lower respiratory diseases (CLRD), the sixth leading cause of death in Hudson County in 2020. Data are presented on the rate of emergency department (ED) visits and hospitalizations for COPD per 10,000 population at the state and county level from 2016-2020. The state overall had a rate of 3,299 ED visits and 939 hospitalizations per 10,000 population (Figure 75). Hudson County had a rate of 3,477 ED visits, a rate higher than the state, and 925 hospitalizations per 10,000 population, slightly below the state-wide rate.

Figure 75. Hospitalizations due to COPD per 10,000, by State and County, 2016-2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Disability

Residents who have some type of disability may have difficulty getting around, living independently, or completing self-care activities. Other disabilities, such as hearing impairment, vision impairment, and cognitive impairment, may also impact residents’ daily lives. Disabilities affect people of all ages and are most prevalent among older adults.

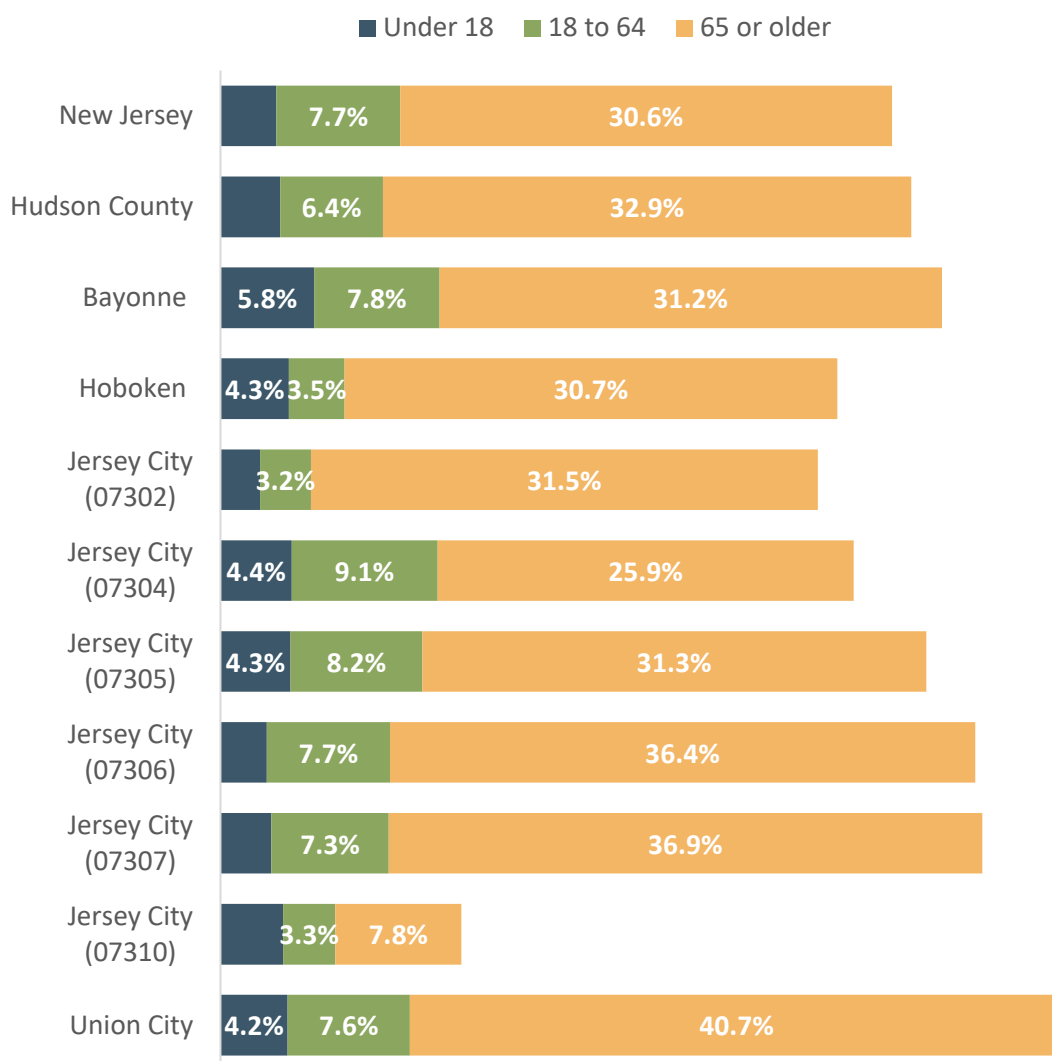
While the issue of disabilities did not emerge often in the qualitative interviews, many people with disabilities face economic instability as they rely on government financial assistance programs for their basic needs. In New Jersey, the Divisions of Developmental Disabilities (DDD) and Disability Services’ (DDS) provide support for individuals until they turn 21, and after individuals reach age 60, they can access resources from the Office of Aging and Disability. In addition, it is often challenging for parents of children with disabilities to navigate the education and healthcare system, particularly if they have limited English abilities. Even obtaining a diagnosis may be difficult. For middle and low-income residents, affording care for children with disabilities is also a barrier. One education administrator

“It’s called early intervention, where students are identified early. So, if they or the pediatrician notices that there’s some developmental delays, we pick them up. We provide services from preschool on through 21.” – Key informant interviewee

expressed that there were supportive services for children with special needs starting in preschool to age 21. However, developmental delays are not always easy to diagnose. Further, there are insufficient special education teachers to meet the need.

Data on the civilian noninstitutionalized population by age show that almost four percent of children under 18 years old (3.5%), almost eight percent of 18-64-year-old adults (7.7%), and 30.6% of people 65 or older had a disability in New Jersey in 2016-2020 (Figure 76). At the county level, 3.7% of children under 18 years old, 6.4% of 18-to-64-year-old adults, and 32.9% of adults 65 years of age and older had a disability in Hudson County. Bayonne had the highest proportion of children living with a disability (5.8%) in 2016-2020; in Jersey City zip code 07304, almost 1 in 10 adults aged 18-64 had a disability (9.1%); and in Union City more than 2 in 5 (40.7%) adults 65 and older were living with a disability.

Figure 76. Civilian Noninstitutionalized Population with a Disability, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Behavioral Health: Mental Health and Substance Use

Behavioral health is thought of as the connection between the health and well-being of the body and the mind. In the field, mental health and substance use are typically discussed under the larger framework of behavioral health.

Mental Health

Mental health was identified as a top community health concern. The topic of mental health arose in almost all conversations conducted for this CHNA. Interviewees and focus group members noted that while mental health has been a longstanding health concern, the COVID-19 pandemic has made the issue more pressing. In the words of a Latino focus group participant, *“The pandemic had an adverse effect on everyone—children, teens, and adults—and there have been many people affected psychologically.”* Job loss and economic pressures, virtual schooling, social isolation, and the uncertainty associated with the pandemic were all cited as contributors to increased stress, depression, and trauma among Hudson County residents. At the same time, gun violence has also taken a toll on individual and collective psyches. In addition, poor mental health is often co-morbid with chronic conditions, which are highly prevalent in the population. Among community survey respondents, mental health was the top community health issue with 30.9% of respondents identifying it as an area of concern, as noted previously in the Perceptions of Community Health section.

“The first problem is getting people to recognize the need, it’s a national problem, with the advertising that it’s okay to ask for help.” – Focus group participant

Stigma and Access to Mental Health Care

While mental health issues affected people of all ages, races, and genders, mental health for veterans, unhoused individuals, children and youth, seniors, trans persons, Latino residents, immigrants, and low-income adults were highlighted in the qualitative discussions. Focus group participants noted that anxiety and depression were prevalent in the community and mentioned several barriers to care. Participants highlighted stigma associated with mental health as a hindrance. Participants observed that many people affected by mental health did not recognize mental health as a medical condition, and this was particularly so among the foreign-born population, veterans, and Black residents. As a focus group participant and veteran described, *“We find that to be a problem, that our veterans don’t ask for help, because they’re so darn self-sufficient and a little stubborn.”* A key informant interviewee who self-identified as Black explained that for *“those of African descent, counseling was not something that we did.”*

Mental Health and Economic Instability

Poor mental health is closely associated with economic and housing instability, as described in the section on Employment. Focus group veteran participants expressed that not having employment that afforded them a living wage was a major cause of anxiety and depression. Latino residents in the focus groups shared stories about the challenges of losing their jobs, paying the rent, and feeding their families. An advocate for the LGBTQ+ community described high levels of stress and depression among transgender residents due to unemployment.

Mental Health and Trauma

Trauma is defined as a person’s emotional response to a distressing event or series of events, including experiencing or witnessing violence, abuse and neglect in childhood, and war, among others. A person can have a range of psychological and physical symptoms following trauma that can dramatically hinder well-being and daily functioning, and can, in severe cases, develop post-traumatic stress disorder.

“We need more services because people are not getting the help they need...” – Focus group participant

As described in detail in the section on Violence Prevention and Safety, communities of color have experienced an undue burden of multiple forms of intergenerational, childhood, and adult trauma. As noted earlier, violence and community safety was the top health priority for Black survey respondents. Survivors of violence face many barriers to accessing mental health care. Key informant interviewees explained that many trauma survivors come from cultures and environments that stigmatize mental health conditions. Others experience economic barriers to accessing care. Focus group participants and interviewees highlighted the urgent need to provide trauma informed care and to expand access to counseling and allied services for persons recovering from trauma in Hudson County. A focus group participant described the dire situation of mothers of gun violence victims, *“We met with a group of moms whose children were all impacted by gun violence where the child was lost or criminally involved, the moms decided to get together and support each other. I asked what they did and they said, “We just gather and wait for the next support victim.” These women were in trauma themselves, looking to help others but not able to help themselves.”*

Since 2020, JCMC’s Trauma Recovery Center, a national evidence-based model to treating survivors of violence, has addressed some of the need. The model is based on providing trauma-informed medical care to violence survivors, in addition to counseling to alleviate trauma symptoms, and linkage to community resources to address survivors’ most immediate needs, including relocation, employment, and housing support, among others.

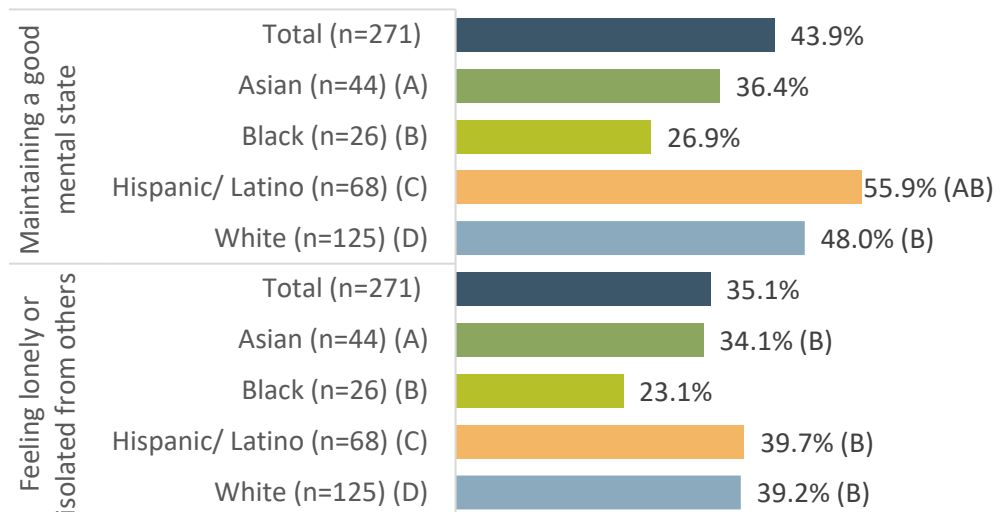
Mental Health and the COVID-19 Pandemic

The COVID-19 pandemic had devastating consequences on mental health across many sectors of the population. The pandemic contributed to anxiety, depression, and stress. Partly due to fear of the virus and uncertainty, partly due to the financial impact, and partly due to isolation. Further, many community members lost loved ones due to COVID-19. Interviewees who worked with seniors talked about isolation and loneliness among older residents, which was harder during the pandemic when senior centers and other social outlets closed. Many residents noted that children and youth were particularly affected as schools closed and they were isolated from their friends and social environment. They indicated that this was compounded by parents’ increased stress levels due to uncertainty and financial worries. Participants mentioned that youth exposed to domestic violence were particularly affected by stay-at-home orders. Suicide ideation among teenagers was mentioned by several participants. A public health official summed up the situation of young people during the pandemic, *“They weren’t in school through the whole pandemic and, you know, perhaps they’re at home with an alcoholic father, or abusive mother, or you know, or no one at all. I think the kids are suffering probably the most as a community.”*

Those working in the health sector talked about the mental health of their staff who have faced tremendous pressure when responding to the pandemic. As an interviewee from public health described, “[Mental health] is a problem, I think, especially after Covid... We were all, you know, as a community, at home. Even me, I wasn't at work, but I was working from home you know, 24/7, 7 days a week. So, I definitely think mental health is a big issue... You have to understand what it is to be doing that all the time.”

Reiterating the impact of the pandemic on mental health, 43.9% of survey respondents reported that they or someone in their family had personally experienced difficulty with maintaining a good mental state, while 35.1% reported being lonely or isolated from others since COVID-19 began (Figure 77). More than half of Latino respondents (55.9%) reported that they or a family member had difficulty maintaining a good mental state during COVID-19, significantly more than Black (26.9%) and White (48.0%) respondents. Black respondents (23.1%) were the least likely of all race/ethnic groups to report being isolated.

Figure 77. Percent of Community Survey Respondents Reporting that They or Someone in Their Immediate Family Has Personally Experienced Difficulty with Mental Health Issues since COVID-19 Started (n=271), 2021



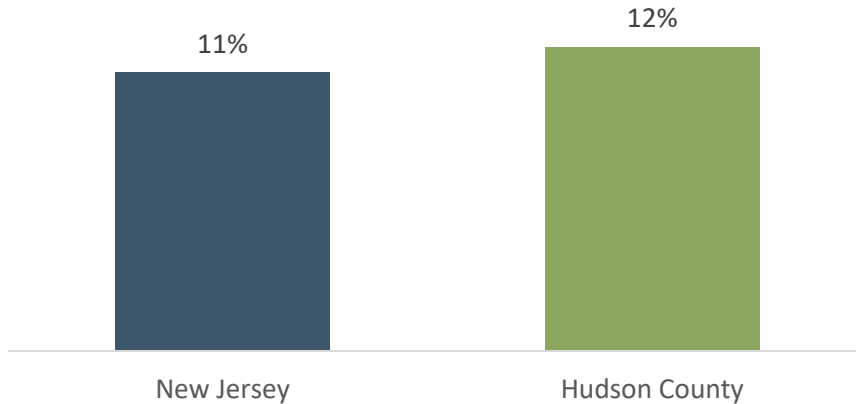
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Mental Health Incidence, Hospitalization, and Mortality

When examining surveillance data on mental health from prior to the COVID-19 pandemic, 12% of adults in Hudson County reported 14 or more days of poor mental health in the past month (Figure 78).

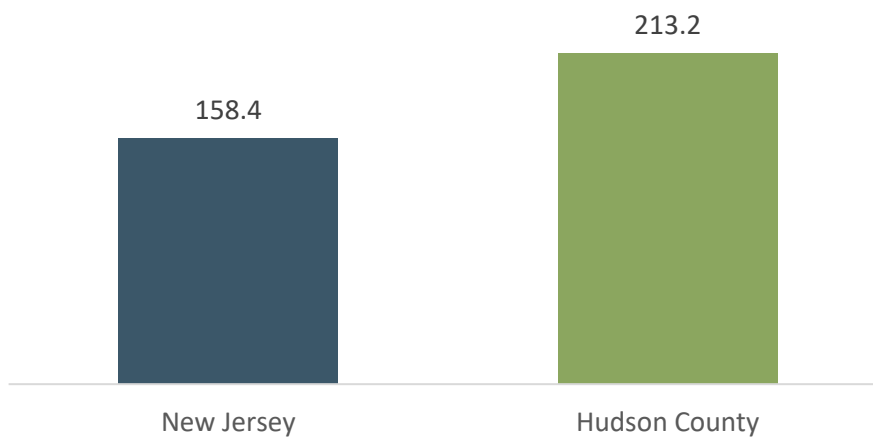
Figure 78. Percent Adults Reported 14 or More Days of Poor Mental Health in Past Month, by State and County, 2018



DATA SOURCE: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2018

Data from 2018 indicate that Hudson County had a rate of 213 emergency department (ED) visits due to mental health per 100,000 population, which was smaller than the rate statewide (158 per 100,000) (Figure 79).

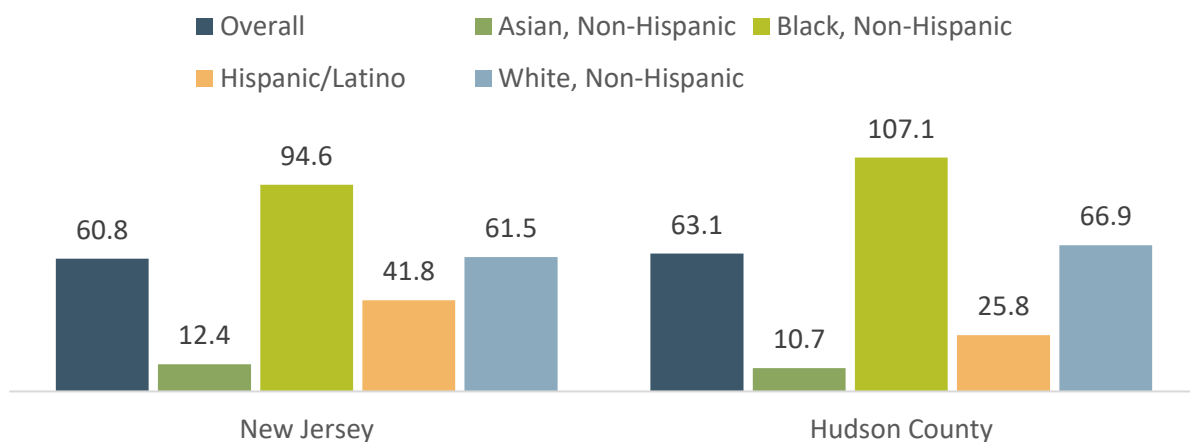
Figure 79. ED Visits Due to Mental Health per 100,000, by State and County, 2018



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2018

Data are presented on the rate of hospitalizations due to mental health per 100,000 population by race/ethnicity in 2020, the first year of the pandemic. The overall county rate was slightly higher than at state level (63.1 per 100,000 in Hudson County vs. 60.8 per 100,000 in New Jersey) (Figure 80). The mental health-related hospitalization rate was highest among the Black population in both the state (94.6 per 100,000) and the county (107.1 per 100,000), followed by White residents (61.5 per 100,000 in New Jersey and 66.9 per 100,000 in Hudson County). County-level rates for mental health hospitalization of Latino and Asian residents were both lower in Hudson County than in New Jersey.

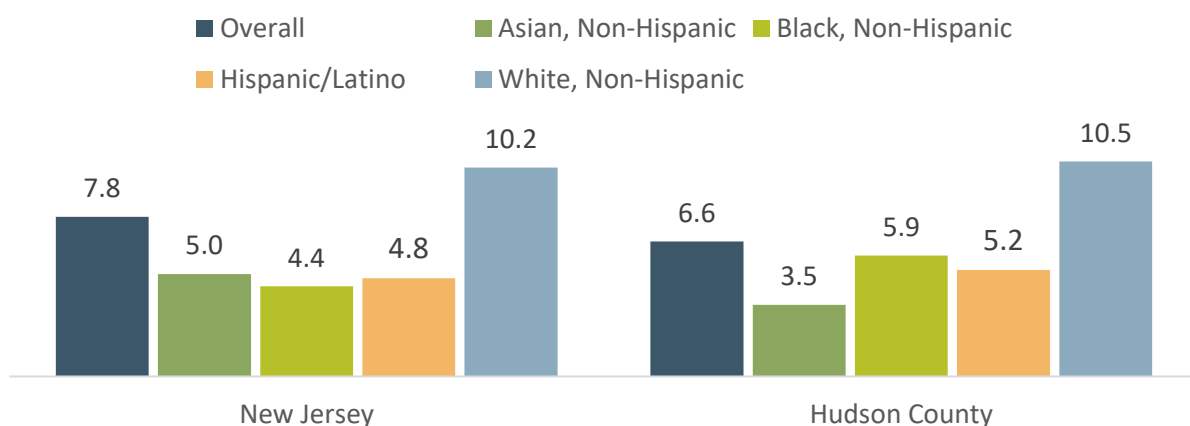
Figure 80. Hospitalizations Due to Mental Health per 100,000, by Race/Ethnicity, State, and County, 2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020

Data from 2016-2020 (aggregated across multiple years due to small numbers) indicate that Hudson County's suicide rate was 6.6 per 100,000 population. Rates among Asians were lower in the county than in the state, but higher among the other racial/ethnic groups. White residents had the highest suicide rates in the county (10.5 per 100,000), nearly double those of Black (5.9 per 100,000) and Latino (5.2 per 100,000) residents (Figure 81).

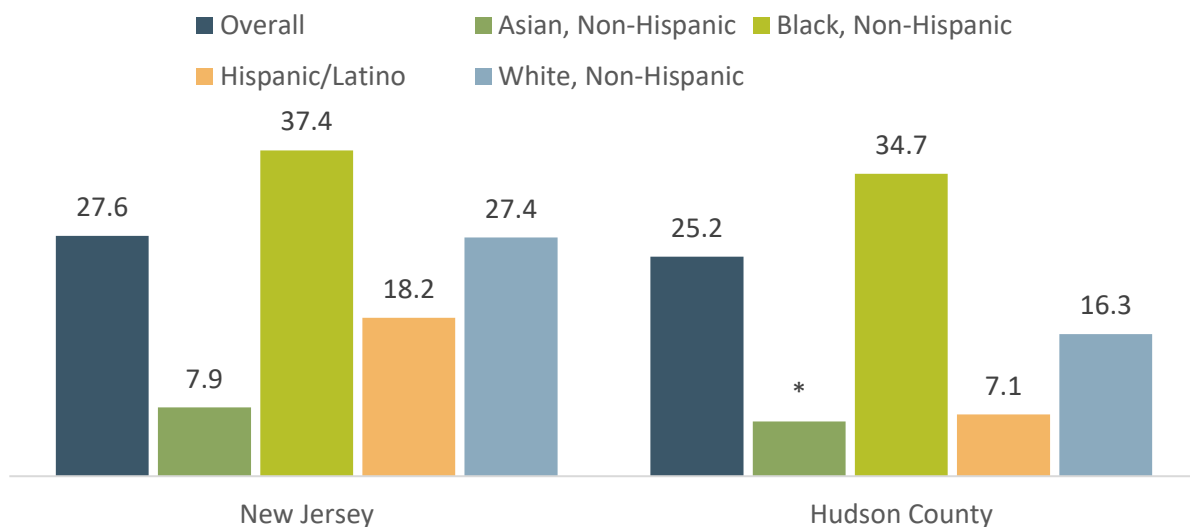
Figure 81. Suicide Rate per 100,000 Population (Age-Adjusted), by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Data from 2020 indicate that Hudson County’s rate of mental health-related hospitalization among children was 25.2 per 100,000 population. Rates in each racial/ethnic group were lower in the county than in the state. Pediatric mental health-related hospitalization rates in Hudson County were more than double among Black children (34.7 per 100,000) compared to the following group, White children (16.3 per 100,000) (Figure 82).

Figure 82. Pediatric Hospitalizations (Ages 19 and Under) Due to Mental Health per 100,000, by Race/Ethnicity, State, and County, 2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Mental Health Services

Focus group members and interviewees reported that finding mental health services in Hudson County can be challenging, especially for residents who are uninsured and/or unable to pay out of pocket for these services. First, even for residents who do seek help, they are not aware of where to obtain it. Second, participants noted that there were insufficient mental health service providers in Hudson County to meet the demand, particularly those that can provide culturally competent services to the diverse population, including gender non-binary people, non-English speakers, and veterans. This leads to long waiting times. As described by a focus group participant, “From the behavioral health side, due to staff shortages and high demand, we’ve had to limit community referrals and take from within the hospital to treat the most acute clients. Those others who need mental health support, we don’t have the bandwidth to help them right now.” A health administrator described the efforts made to hire culturally competent staff, “Not only is it hard finding behavioral health staff, but we also try to mirror the staff we hire, bilingual staff are unicorns because they are hard to find. Matching makeup of the staff, specifically behavioral health, is challenging.”

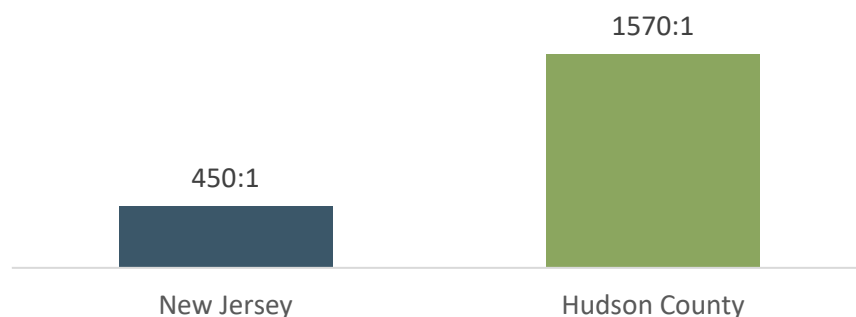
“[It] has been very difficult for our patients to access behavioral health services... we have an extensive waiting list. At any given time to get an appointment with us can take 4 to 6 months, so we’ve tried as much as we can to reach out to all of our partners...”
 – Focus group participant

To facilitate referrals, during COVID-19, the Health Department consolidated a mental health directory, including the suicide prevention hotlines, available at: <https://healthierjc.com/mental-health/>. JCMC and other providers began offering services via telehealth to expand access during the pandemic. However, whereas this strategy worked with certain groups, others without access to technology or with lower digital literacy, did not benefit.

Participants mentioned that schools often identify and connect students to mental health services, but school nurse and student support/counseling offices are understaffed. As one public school administrator expressed, *“We’ve been trying through the schools with our resources to really embed more social, emotional, not just the mental health, but before it gets to the mental health, helping students overcome challenges, developing resilience, by being able to speak about their emotions.”* However, staffing is limited, as are the mental health services that schools can provide.

Data are presented on the ratio of population to mental health providers in 2019. At the state level, there were 450 people for every mental health provider (Figure 83). In Hudson County, the ratio was 1570 people for every mental health provider. The dearth of mental health providers in Hudson County likely worsened during the pandemic.

Figure 83. Ratio of Population to Mental Health Providers, by State and County, 2019



DATA SOURCE: National Provider Identification Registry, Centers for Medicare and Medicaid Services, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

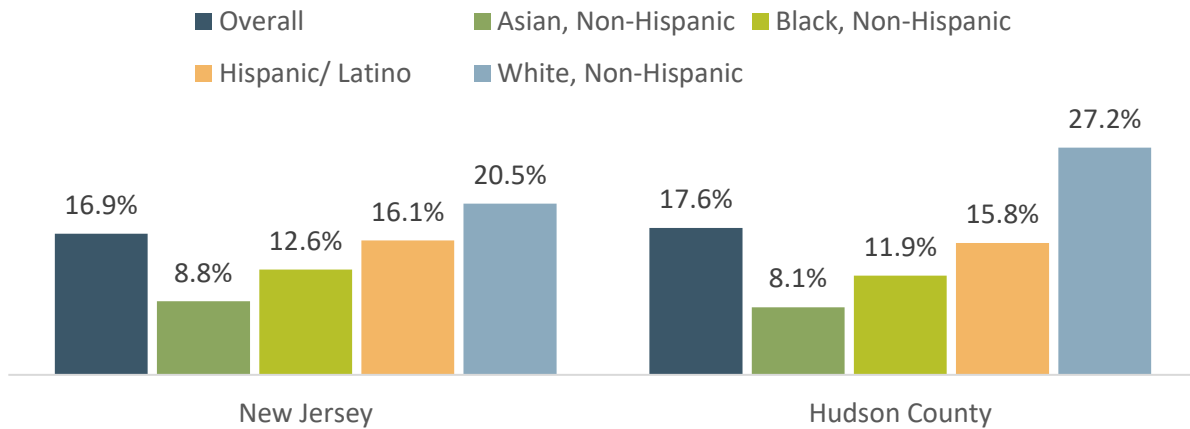
Substance Use

Substance use was mentioned as a community health concern in conversations this year, as it was in prior CHNAs. Problem substance use was described as affecting all groups, across all socioeconomic levels. However, it was mentioned specifically in conversations in the context of unhoused individuals, veterans, and young people; some reported that problem substance use is more hidden among youth in higher income communities. Several participants reported that substance use, particularly alcohol and opioid use, has increased as a result of economic and social stressors. Further, overdose deaths among young people were also noted as a health concern. A healthcare provider remarked, *“I’ll say for us the top conditions that we tend to get a lot of are readmissions for drugs overdose, heroin, opioids, and alcohol. And it’s always the same people who keep coming and coming.”* Some participants mentioned substance use associated with safety concerns, particularly among youth who consume substances. A Latino resident provided the following example, *“When I wait for the bus, there are young people doing drugs or drinking alcohol nearby and that scares me a lot.”* Data for prevalence of substance use, substance-use related mortality, and substance use treatment is presented in the sections below.

Alcohol Use

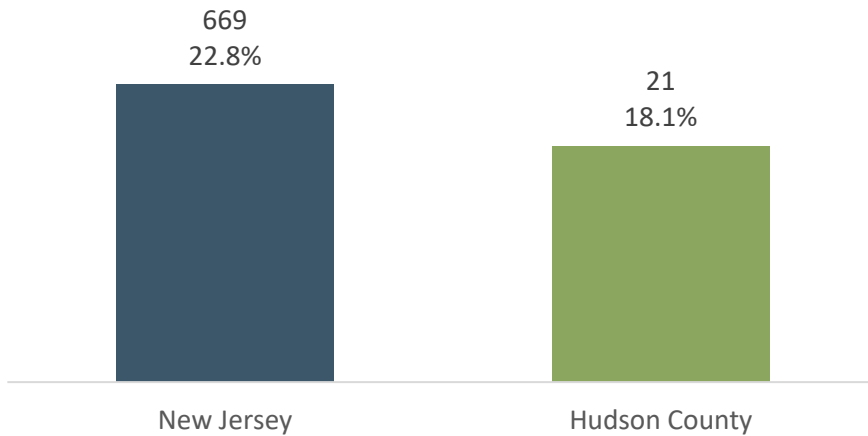
Focus group and interview participants discussed that they were concerned about alcohol consumption as a problem in the community, particularly given difficulty accessing long-term treatment services. Alcohol use is also a contributing factor to other prevalent health conditions, including cardiovascular disease, depression, and violence. Data aggregated for 2017 to 2020 show binge drinking levels – defined as a drinking pattern that brings blood alcohol concentration (BAC) to 0.08 percent or higher, typically by consuming four or more drinks (female), or five or more drinks (male) in a two-hour period – for the state and county and by race/ethnicity. In New Jersey, 16.9% of adults reported binge drinking. This percentage was highest among White (20.5%), followed by Latino (16.1%), Black (12.6%), and Asian (8.8%) residents (Figure 84). At the county level, 17.6% of adults in Hudson County reported binge drinking, with the highest percentage among White (27.2%) residents, followed by Latino (15.8%), Black (11.9%), and Asian (8.1%) residents. Of driving deaths over the period 2015-2019, 22.8% were due to drinking under the influence of alcohol in New Jersey, and 18.1% in Hudson County.

Figure 84. Percent Adults Reported Binge Drinking, by State and County, 2017-2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2017-2020

Figure 85. Alcohol-impaired Driving Deaths, by State and County, 2015-2019



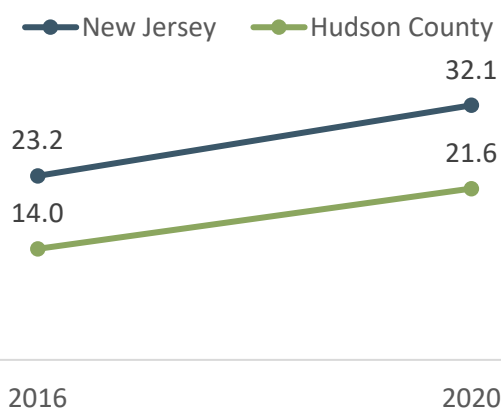
DATA SOURCE: Fatality Analysis Reporting System as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2015-2019

Opioids and Other Drug Use

Misuse of other substances was discussed in several focus group and interview discussions, particularly the use of legal and illegal opiates, and the resulting potential overdose. Others expressed concern about the long-term implications of marijuana legalization on substance use trends in the community.

The following figure shows the age-adjusted drug poisoning mortality rate per 100,000 population in 2016 and 2020. In New Jersey, the age-adjusted rate per 100,000 was 23.2 in 2016 and 32.1 in 2020 (Figure 86). The Hudson County rates were lower than the state, with mortality rates per 100,000 at 14.0 in 2016 and 21.6 in 2020. Similar trends are also presented in Figure 87 for unintentional drug induced poisoning mortality per 100,000.

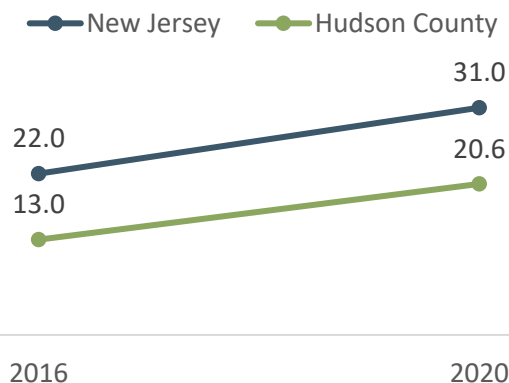
Figure 86. Age-Adjusted Drug Poisoning Mortality Rate per 100,000 Population, by State and County, 2016 and 2020



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020

NOTE: Includes ICD-10 codes X40-X44, X60-X64, X85, and Y10-Y14

Figure 87. Age-Adjusted Unintentional Drug Induced Poisoning Mortality Rate per 100,000 Population, by State and County, 2016 and 2020

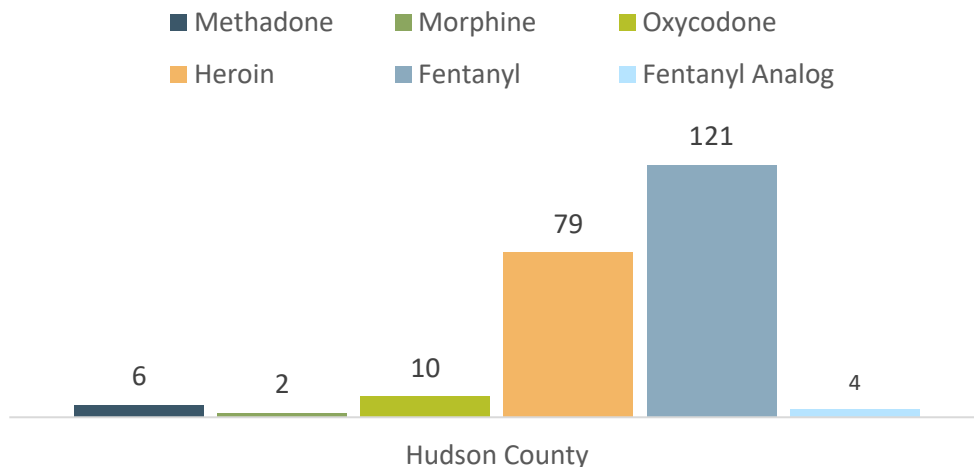


DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020

NOTE: Includes ICD-10 codes X40-X44

State medical examiner data show the count of opioid related deaths by specific drug type in 2019. In Hudson County, there were 121 deaths due to fentanyl, followed by heroin (79), oxycodone (10), methadone (6), and morphine (2) (Figure 88).

Figure 88. Count of Opioid Related Deaths by Drug, by County, 2019

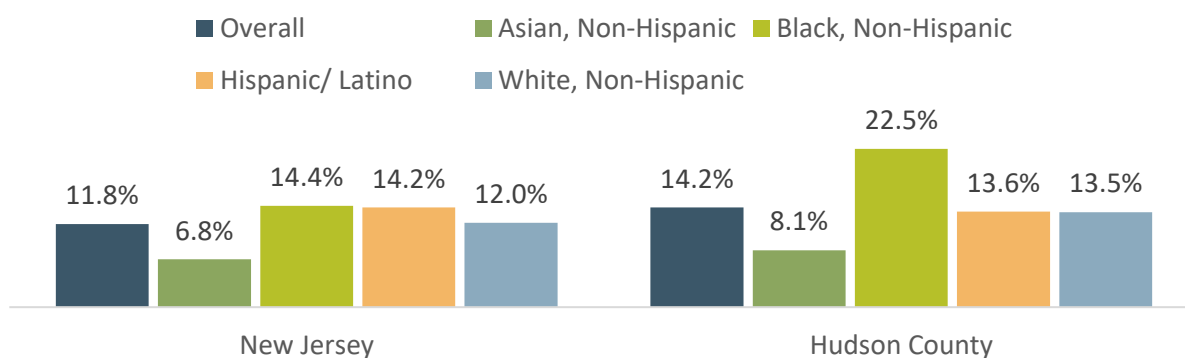


DATA SOURCE: Drug Deaths for 2019, New Jersey Office of the State Medical Examiner

Tobacco Use

Tobacco use is a contributing factor to lung and other cancers, as well as to poor lung health. When looking at the percentage of adults who are current smokers, Figure 89 shows that in New Jersey, 11.8% of adults were current smokers in 2017-2020. This percentage was highest among Black (14.4%) and Latino (14.2%) residents, followed by White (12.0%) and Asian (6.8%) residents. At the county level, 14.2% of residents reported currently smoking overall. Proportionally, more Black residents reported smoking (22.5%) compared to Latino (13.6%), White (13.5%), and Asian (8.1%) adults in Hudson County. Of note, the proportion of Black Hudson County residents who smoked was markedly higher than the county average and of Black smokers in the state.

Figure 89. Percent Adults Reported Current Smokers, by State and County, 2017-2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2017-2020

Substance Use Treatment & Prevention

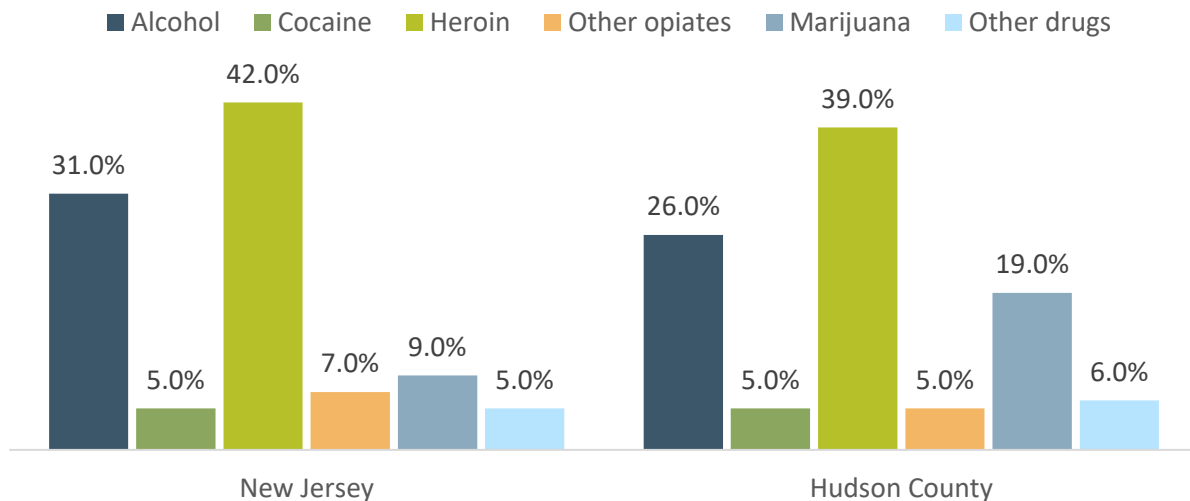
While substance use programs exist in the community, they are insufficient to meet demand according to focus group participants and interviewees. Participants advocated for more local programs, including community-based recovery programs. Several participants mentioned the problem of relapse due to inadequate treatment programs. The disruption in mental health services due to the COVID-19 pandemic further increased the risk of relapse. As a health administrator noted, *“We can detox folks here, but we can’t provide addictions treatment. We can detox people over and over*

“After care is very important because it keeps you sustained with sobriety or whatever mental health issue you have. I think the main thing is talking, talking. I used to have [a] group that no longer happens. I don't know what happened after Covid that it closed down. But hopefully it'll come up again 'cause I really do need it. I miss my veteran groups.” – Focus group participant

again, and we do, that happens in substance abuse treatments, but not having a better solution to move from detox into a 21-day program or something similar is a problem we’ve seen for years... we need a seamless transition between” the facilities, short-term, and long-term treatment programs.

The following figure shows the percentage of substance use treatment admissions by primary drug in 2020. At the state level, 42.0% of admissions were for heroin, 31.0% for alcohol, and under 10% each for marijuana, cocaine, other opiates, and other drugs (Figure 90). In the Hudson County treatment sites, 39.0% of admissions were for heroin, 26.0% for alcohol, 19.0% for marijuana, and under 10% each for other opiates, cocaine, and other drugs.

Figure 90. Percent of Substance Use Treatment Admissions by Primary Drug, by State and County, 2020

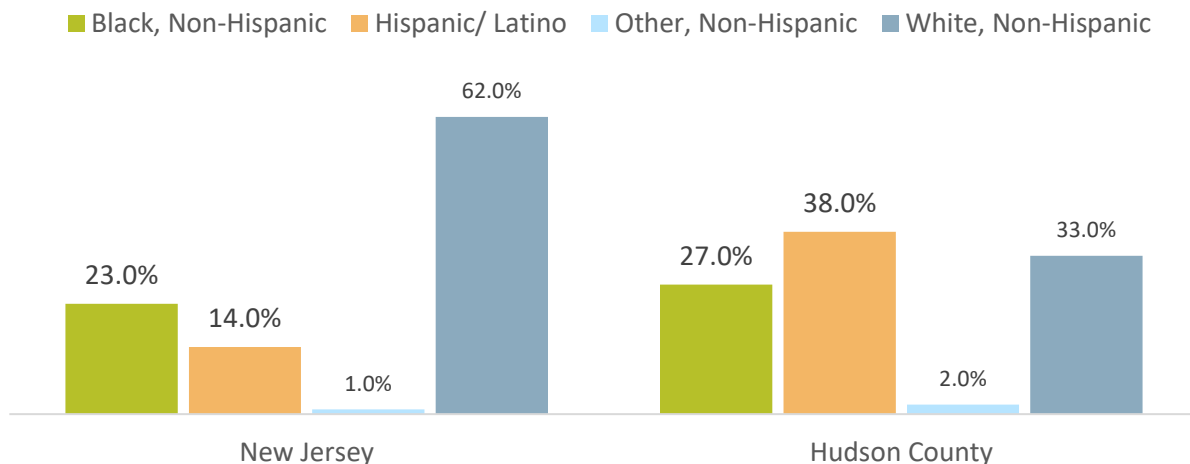


DATA SOURCE: New Jersey Department of Human Services, Division of Mental Health and Addiction Services, New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview, 2020

NOTE: Percentages by county are by county of treatment site

Data is also presented showing the percentage of substance use treatment admissions by race/ethnicity in 2020. At the state level, 62.0% of admissions were of White, Non-Hispanics, followed by 23.0% of Black, Non-Hispanics, 14.0% of Hispanics/Latinos, and 1.0% of other races/ethnicities (Figure 91). In the Hudson County treatment sites, 38.0% of admissions were of Hispanics, followed by 33.0% of White, Non-Hispanics, 27.0% of Black, Non-Hispanics, and 2.0% of other races/ethnicities.

Figure 91. Substance Use Treatment Admissions by Race/Ethnicity, by State and County, 2020



DATA SOURCE: New Jersey Department of Human Services, Division of Mental Health and Addiction Services, New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview, 2020

Environmental Health

A healthy environment is associated with a high quality of life and good health. Environmental factors are various and far reaching and include exposure for hazardous substances in the air, water, soil, or food; natural disasters and climate change; and the built environment.

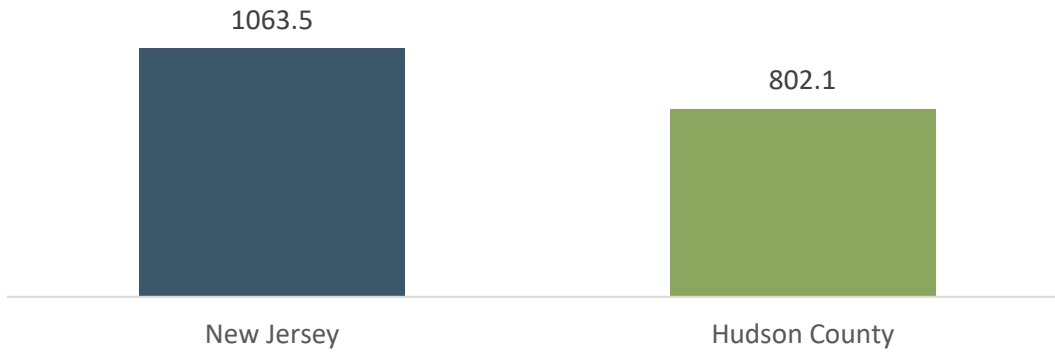
Asthma

Asthma in children was one of the conditions mentioned in the focus groups and interviews as a community problem and as a major cause of missed school days. Public health data typically show that 1 in 13 adults has asthma, and it disproportionately affects low-income communities and communities of color.³⁰ Perceptions of asthma as a community problem are supported by quantitative data.

Data are presented on the rate of asthma hospitalizations per 100,000 population in 2020. The following figure shows that the age-adjusted rate was 1,064 per 100,000 persons in New Jersey and 802 per 100,000 persons in Hudson County (Figure 92).

³⁰ <https://www.aafa.org/asthma-facts/>

Figure 92. Age-Adjusted Rate of Asthma Hospitalizations, by State and County, 2020

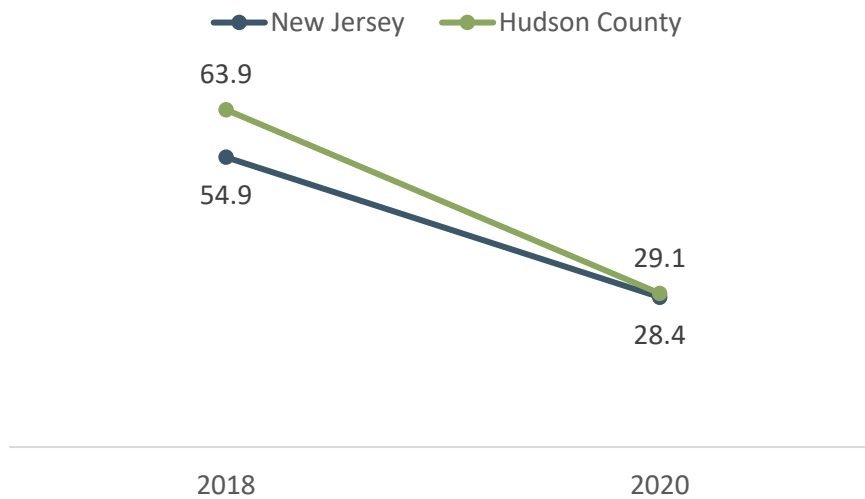


DATA SOURCE: DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020

NOTE: Includes all asthma diagnoses, including primary, secondary, and other diagnoses.

Figure 93 shows age-adjusted asthma emergency department visits in 2018 and 2020. At the state level, there was an important decrease from 2018 (63.9 per 10,000) to 2020 (29.1 per 10,000). Similarly, Hudson County saw a notable decrease of 26.5 asthma ED visits per 10,000 population during the same period.

Figure 93. Age-Adjusted Asthma Emergency Department Visit Rate per 10,000 Population, by State and County, 2018 and 2020

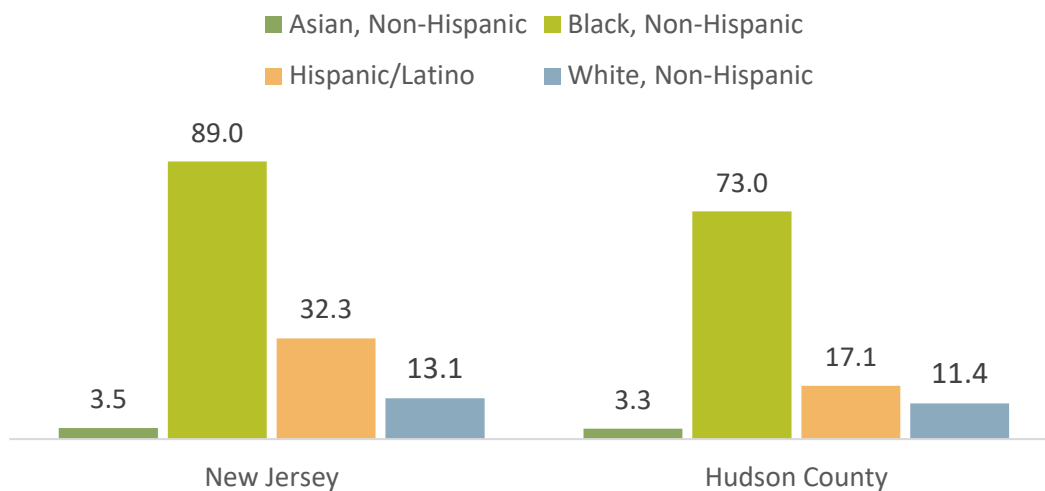


DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020

NOTE: Data includes ED visits where asthma was primary diagnosis

Data from 2020 show significant disparities in asthma rates by race/ethnicity (Figure 94). At state and county levels, Black residents shared a disproportionate burden of asthma ED visits. State-wide, Black, Non-Hispanics had the highest rate of ED visits (89.0 per 10,000), followed by Hispanics/Latinos (32.3 per 10,000), White, Non-Hispanics (13.1 per 10,000), and Asian, Non-Hispanics (3.5 per 10,000). Trends in Hudson County were similar to those state-wide, albeit slightly lower for all race/ethnicities. The highest rate in Hudson County was among Black, Non-Hispanics (73.0 per 10,000), followed by Hispanics/Latinos (17.1 per 10,000), White, Non-Hispanics (11.4 per 10,000), and Asian, Non-Hispanics (3.3 per 10,000).

Figure 94. Age-Adjusted Asthma Emergency Department Visit Rate per 10,000 Population by Race/Ethnicity, by State and County, 2020



DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Data includes ED visits where asthma was primary diagnosis

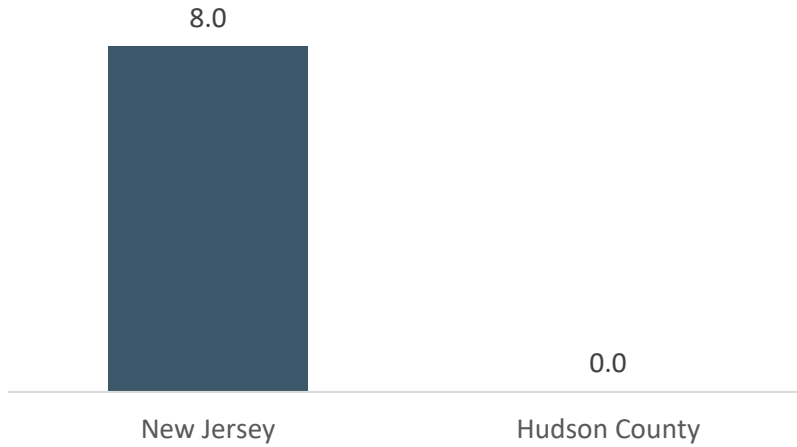
Air Quality

In 2020, there were 8 days statewide and 0 days in Hudson County where ozone in outdoor air exceeded the federal health-based standard for ozone (8-hr period above 0.070 ppm). This is a decrease compared to ozone air quality from 2014-2019; however, it is a possibility that COVID-19 impacted these rates as more people spent time indoors and less time traveling (Figure 95). Data on air quality show an average daily density of fine particulate of 9.3 micrograms per cubic meter in Hudson County, slightly higher than the state average (8.1) (Figure 96). Whereas air quality was not an issue of frequent concern for most participants, a few did remark on vehicular traffic as a source of pollution, particularly in certain neighborhoods.

“The New Jersey Turnpike extension... is a constant construction hazard. People are constantly backed up in traffic and the exhaust, it’s a lot of cars idling in that area, that’s linked to health comorbidities, like asthma.”

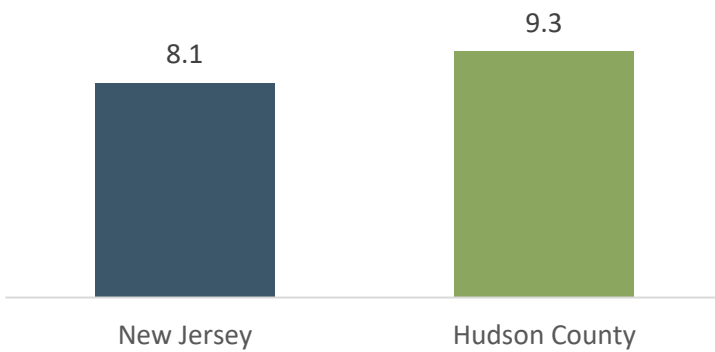
– Key informant interviewee

Figure 95. Ozone in Outdoor Air, Number of Days Ozone Exceeded the National Ambient Air Quality Standards for Ozone (8-hour above 0.070 ppm), 2020



DATA SOURCE: Bureau of Air Monitoring, New Jersey Department of Environmental Protection, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020

Figure 96. Air Pollution-Particulate Matter by State and County, 2018



DATA SOURCE: Center for Disease Control and Prevention (CDC), Environmental Public Health Tracking Network, as reported by, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

Note: Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)

Information on water quality can be found in Appendix F.

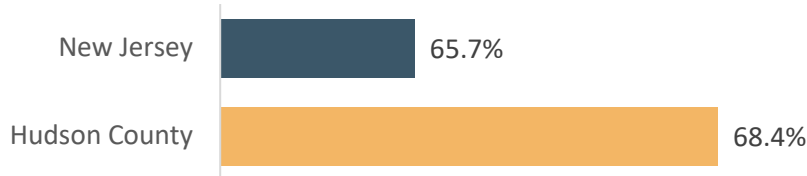
Lead

In 1978, the federal government banned consumer uses of lead-based paint. Exposure to lead among young children, through touching lead dust or paint chips, for example, can harm children’s health, including potential damage to the brain and nervous system, slowed growth and development, and hearing and speech problems.

“A problem like lead poisoning among young children or affecting the IQ levels or things that, as a public health official, we do not feel like there should be any acceptable level of lead in any child’s blood.” – Key informant interviewee

As shown in Figure 97, most of the housing in Hudson County (68.4%) was built prior to 1980, which is a slightly higher percentage than in New Jersey (65.7%). In 2022, New Jersey released new state regulations mandating visual inspections of all rental units built prior to 1978; however, a public health official noted the challenge of implementing such regulations given the number of older housing and the available human resources.

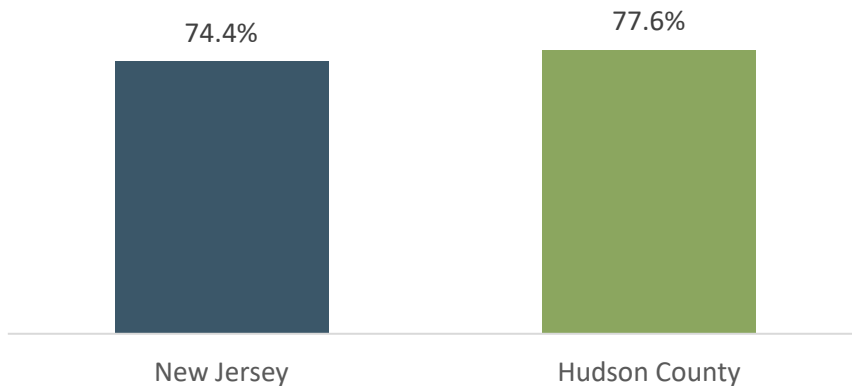
Figure 97. Housing Built Pre-1980, by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

New Jersey Child Health Program data shows the percent of children testing for lead exposure before their third birthday in 2014. In Hudson County, 77.6% of children were tested for lead exposure (Figure 98). Across the state of New Jersey, nearly 3 in 4 children were tested for lead exposure. In 2019, 2% of children in Hudson County ages 1 to 5 had blood lead levels meeting or exceeding 5mcg/dL (Figure 129 in Appendix F).

Figure 98. Percent Children Tested for Lead Exposure Before 36 Months of Age Among Children Born in 2014, by State and County



DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry; Child Health Program, Family Health Services, as reported by, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2022

Infectious and Communicable Diseases

This section discusses COVID-19 and sexually transmitted infections.

COVID-19

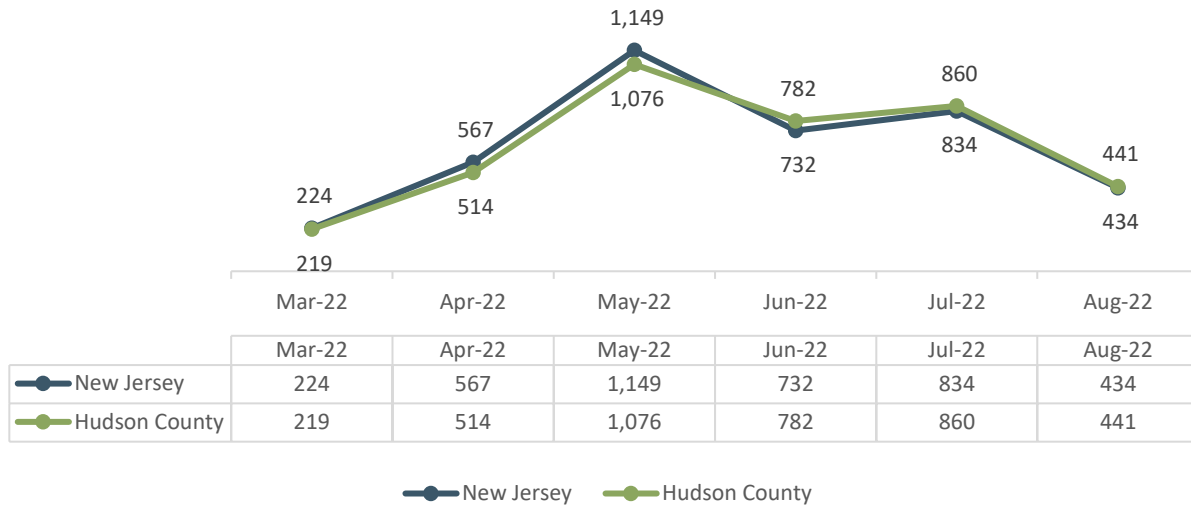
COVID-19 was not extensively discussed in conversations around infectious and communicable diseases. When it was addressed, focus group and interview participants primarily discussed how COVID-19 and the shutdown of businesses and schools had exacerbated the social and economic inequities that already existed. Participants noted that income loss during COVID-19, coupled with inflation, was a major source of stress, anxiety, depression, and other mental health issues. Parents of school children also had to face the challenges of remote schooling, and participants talked about the increase in mental health disorders among children due to isolation. Participants associated the stress-related to COVID-19 on an increase in domestic violence cases. The socioeconomic impacts of COVID-19 were discussed extensively in prior sections (see, for example, the Inequality, Education, Employment and Workforce, and Income and Financial Security sections).

“[COVID impacted] housing, food insecurity, jobs, people have a fear of going back to work, and childcare, because there was a time when everything was virtual, how can parents afford to stay home and put food on the table?” – Focus group participant

Additionally, many in the healthcare fields noted a significant disruption in access to services, particularly in preventive care. They remarked that patients were afraid of seeking care and only did so for emergencies. Several focus group participants observed that COVID-19 had become normalized and were worried that people were not taking the proper precautions, such as masking, to prevent the spread of COVID-19. In terms of COVID-19 testing, there were diverse experiences; whereas some knew of free COVID-19 testing sites, others did not. For the latter, cost was a barrier to COVID-19 testing.

Since April 2020 until September 2022, there have been 2.3 million confirmed cases of COVID-19 in New Jersey and nearly 190,000 in Hudson County. Cases have fluctuated from January 2020 throughout 2022; notable peaks in cases per day across New Jersey include April 5, 2020 (>4,000 cases), January 4, 2021 (>6,700 cases), and December 27, 2021 (>43,000 cases). Below, Figure 99 shows new confirmed cases per day per 100,000 population on the first of the month from March 2022 through August 2022.

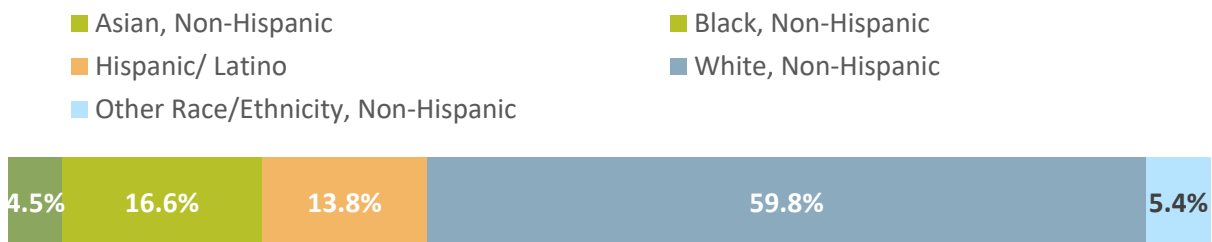
Figure 99. New COVID-19 Cases per 100,000 population, by State and County, 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022

According to data from the New Jersey Department of Public Health, as of August 10, 2022, there were 31,275 deaths from COVID-19 in New Jersey and 2,546 in Hudson County. There are racial/ethnic disparities among COVID-19 deaths in New Jersey. While Black residents made up 12.4% of the New Jersey population, they accounted for 16.6% of COVID-19 deaths in the state (Figure 100). Of note, 59.8% of COVID-19 deaths occurred among White residents, even though they only make up 51.9% of the population. This could potentially be due to the large numbers of White residents aged 65 and older, compared to other racial/ethnic groups.

Figure 100. COVID-19 Confirmed Deaths, by Race/Ethnicity, by State, 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, updated 8/29/2022

As of July 27, 2022, about 6.8 million individuals in New Jersey had been fully vaccinated, representing around 76.5% of the population; Hudson County had reported over half a million fully vaccinated individuals, which is about 80.8% of the population (Table 14). Figure 101 presents the percentage of residents who were fully vaccinated in New Jersey and Hudson County by race/ethnicity as of July 27, 2022.

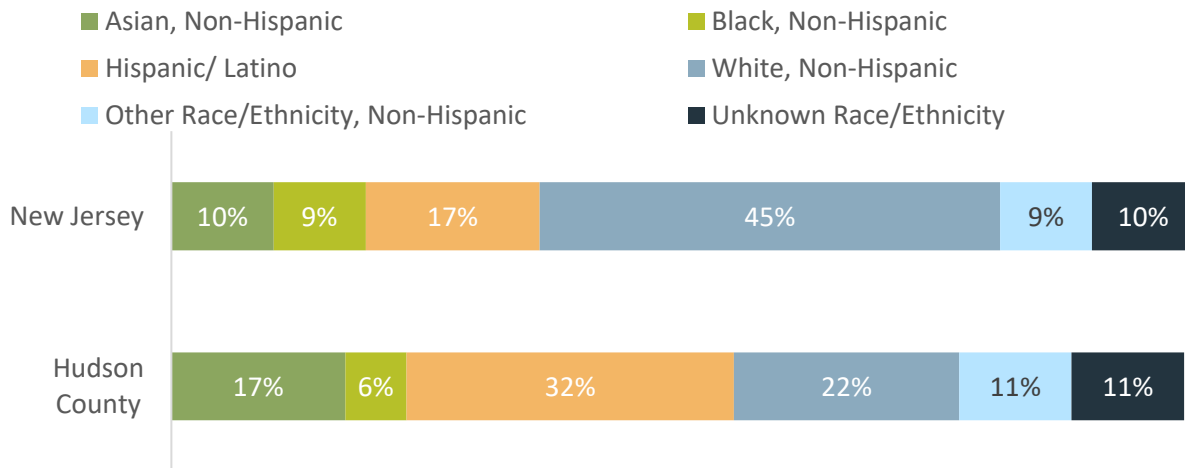
Table 14. Percent of Residents Fully Vaccinated for COVID-19

	Total Vaccinated	Total Population	%
New Jersey	6,795,708	8,885,418	76.5%
Hudson County	543,045	671,923	80.8%

DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022, and U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020 (for total population)

NOTE: Counts are up to date as of July 27th, 2022. Data by race/ethnicity does not include those vaccinated out of state and through federal programs.

Figure 101. Percent of Eligible Residents Fully Vaccinated for COVID-19, by Race/Ethnicity, State, and County, 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022

NOTE: Racial/ethnicity data does not include those vaccinated out of state and by federal programs.

Sexual and Reproductive Health and Sexually Transmitted Infections

Sexual health and sexually transmitted infections (STIs) were brought up as concerns by several focus group and interview participants, particularly those working in public health, education, and with the LGBTQ+ community. Many participants also expressed concerns about shrinking reproductive rights with the recent overturn of Roe vs. Wade, and the negative impact that would have on women's health, particularly in terms of the inequitable burden on low-income women.

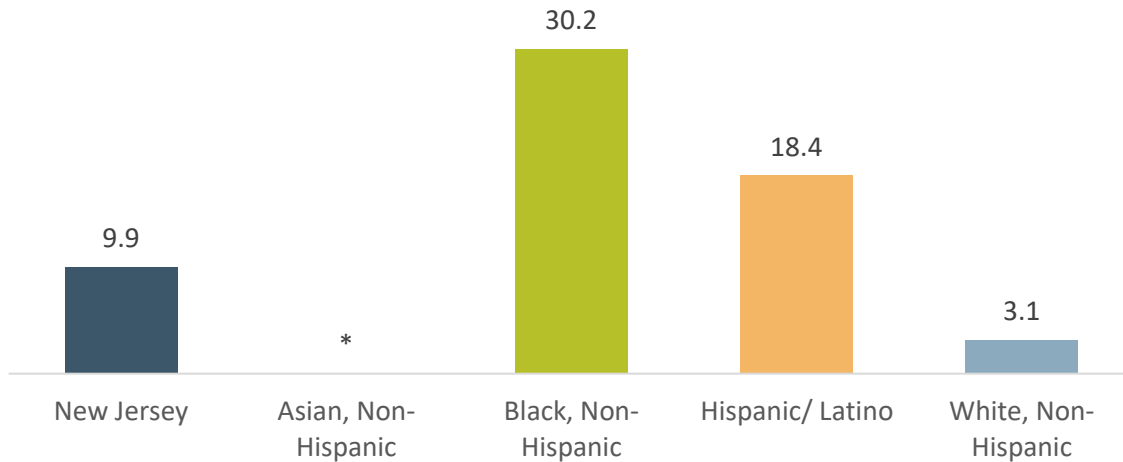
Participants reported increases in incident HIV/AIDS cases during the pandemic and decreases in linkage to care for those persons living with HIV/AIDS. In addition, participants noted that the incidence of other STIs, such as syphilis, had also increased since the pandemic. Limited knowledge related to free testing sites in the population was mentioned as a barrier to timely diagnosis and management. In addition, the cost of treatment, even for insured patients, was brought up as a challenge for middle-low and low-income residents.

“One thing we have to prevent HIV is PrEP, but we don’t know if everyone knows we have it, or where to get tested for free, or even if they should get tested... Clients who come in late have passed through areas of healthcare where they’ve not been tested, so access and education is something we need.” – Focus group participant

Another concern raised by participants was the increase in STIs among young people. As part of the discussion, participants cited parents' lack of awareness of the problem, including in affluent neighborhoods as a main barrier to prevention. Participants raised the absence of comprehensive sexuality education in schools as another impediment to safe sex. According to participants, comprehensive sexuality education provides critical information on healthy sexuality and reproduction and serves to empower adolescents to make choices regarding their health. As residents noted, access to information is of utmost importance in the current climate of curtailing legal protections to reproductive choice.

HIV transmission data was not available for the county but for the state overall. The rate of HIV transmission for Black residents in New Jersey was 30.2 per 100,000 persons, which was ten times the rate of transmission for White residents (3.1 per 100,000) and over three times the rate for all New Jersey residents (9.9 per 100,000) (Figure 102). Hispanic/Latino residents had an HIV transmission rate of 18.4 per 100,00 persons, almost two times greater than that of New Jersey residents.

Figure 102. HIV Transmission per 100,000 Population (Age 13 and Older), by State and Race/Ethnicity, 2020

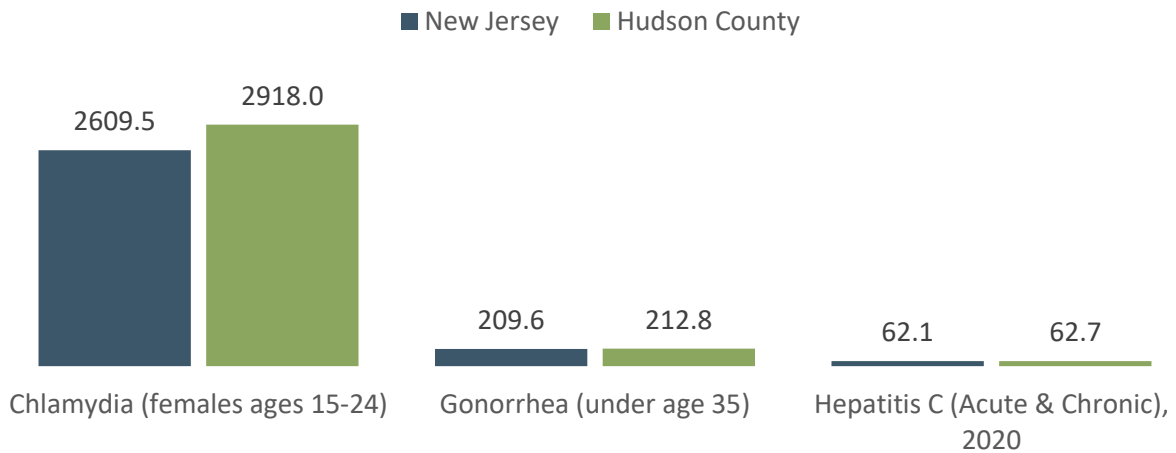


DATA SOURCE: Enhanced HIV/AIDS Reporting System (eHARS), Division of HIV/AIDS, STD, and TB Services, as reported by the New Jersey Health Assessment Data (NJSHAD), 2020
 NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Whereas HIV/AIDS was the STI most named by participants, Chlamydia is the most prevalent STI in New Jersey and Hudson County. In 2021, there were 2,610 cases of Chlamydia per 100,000 population in New Jersey among females aged 15-24, and the case rate was greater for Hudson County (2,918 per 100,000) (Figure 103). Hudson County reported similar levels of Gonorrhea among people under age 35, (213 per 100,000) and Hepatitis B (63 per 1000,000) compared to New Jersey overall (210 and 62 persons per 100,000 persons, respectively). Figure 104 confirms participants’ observations on STI incidence during the pandemic, showing an increase in Syphilis infection rates from 5.3 to 9.8 per 100,000 between 2016 and 2021 in New Jersey, and from 15.4 to 16.5 per 100,000 in Hudson County over the same period. The incidence rate of Syphilis in Hudson County is markedly higher than at state level.

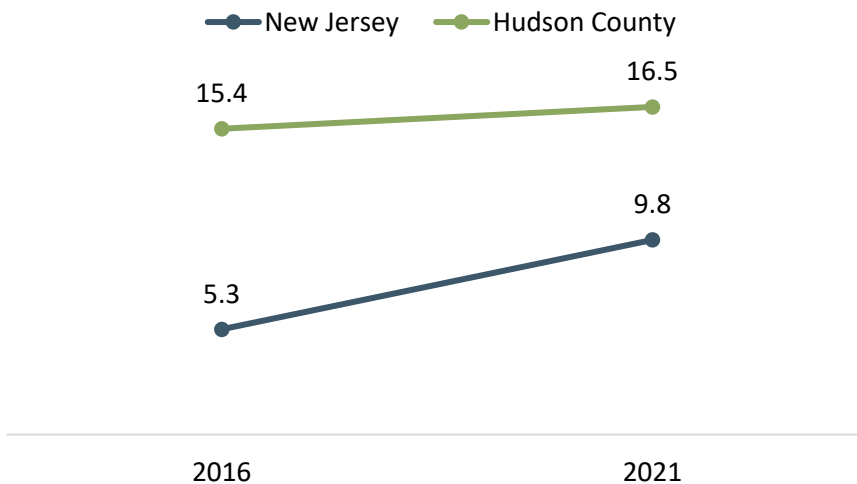
“I [would be remiss] if I don't mention the pressing issues with Roe versus Wade being reversed and access to information to our younger women.... Although New Jersey seems to have a more relaxed and a more progressive view of it, it doesn't mean that it won't impact our young people that are women in particular.” – Focus group participant

Figure 103. Chlamydia, Gonorrhea, and Hepatitis C per 100,000 Population, by State and County, by Most Recent Data Available



DATA SOURCE: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, as reported by the New Jersey State Health Assessment Data (NJSHAD), 2020 & 2021

Figure 104. Syphilis Incidence Rate per 100,000 Population, by State and County, 2016 and 2021



DATA SOURCE: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, Division of HIV, STD, and TB Services, 2016 and 2019

NOTE: Includes primary and secondary syphilis. Crude rate.

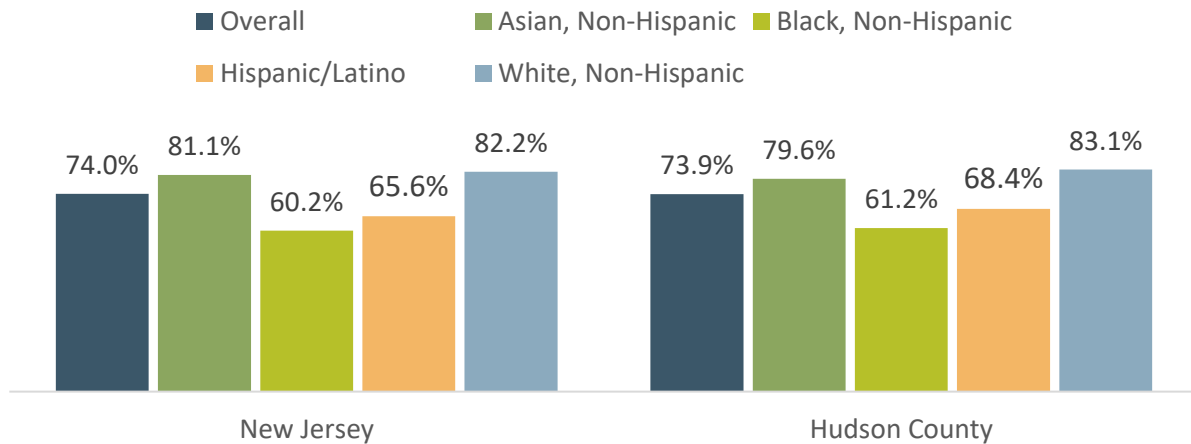
Maternal and Infant Health

The health and well-being of mothers, infants, and children are important indicators of community health. Maternal and infant health indicators are considered markers of inequity as most maternal and perinatal health complications are preventable with access to quality, adequate timely care. Whereas participants did not discuss issues related to maternity and newborn care, they did bring up multiple barriers to accessing care, which may have impeded or severely reduced access to this life saving intervention.

Prenatal Care

Prenatal care is an evidenced-based intervention to improve maternal and perinatal health outcomes. Statewide, nearly three in four births had prenatal care within the first trimester (Figure 105). By race/ethnicity, White, Non-Hispanics (82.2%) had the highest percent receiving prenatal care, followed by Asian, Non-Hispanics (81.1%), Hispanics/Latinos (65.6%), and Black, Non-Hispanics (60.2%). In Hudson County, 73.9% of births received prenatal care in the first trimester. Similar to statewide trends, Hispanics/Latinos (68.4%) and Black, Non-Hispanics (61.2%) in Hudson County had the lowest access to prenatal care. Additional data on access to prenatal care are presented in Figure 131 in the Appendix.

Figure 105. Percent Births with Prenatal Care in First Trimester by Race/Ethnicity, by State, 2016-2020

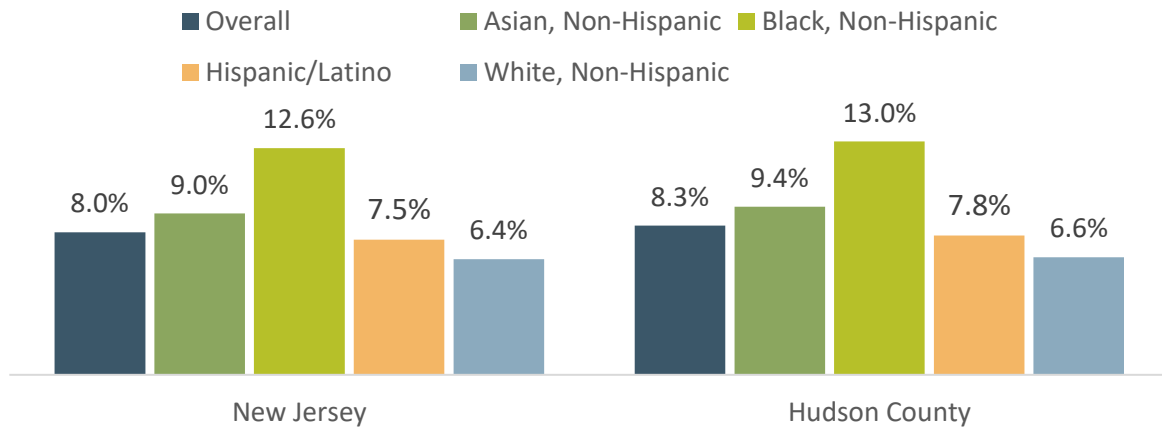


DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Perinatal Outcomes: Low and Very Low Birthweight and Preterm Births

The following figure presents percent of low birthweight births from 2015 to 2019, by race/ethnicity. Across New Jersey, 8.0% of births were low birthweight (weighing less than 2,500 grams) (Figure 106). In New Jersey, Black, Non-Hispanics had the greatest proportion of low weight births (12.6%), followed by Asian, Non-Hispanics (9.0%), Hispanics/Latinos (7.5%), and White, Non-Hispanics (6.4%). Similarly, in 2020, 8.3% of births in Hudson County were low birthweight births, with Black, Non-Hispanics having the highest proportion of low birthweight births (13.0%). In Hudson County, 1.2% of births were very low birthweight (<1,500 grams), with Black, Non-Hispanics (3.0%) having more than double the proportion of very low birthweight births, followed by Hispanics (1.6%) (See Figure 130 in Appendix for more details).

Figure 106. Percent Low Birth Weight Births by Race/Ethnicity, by State and County, 2015-2019

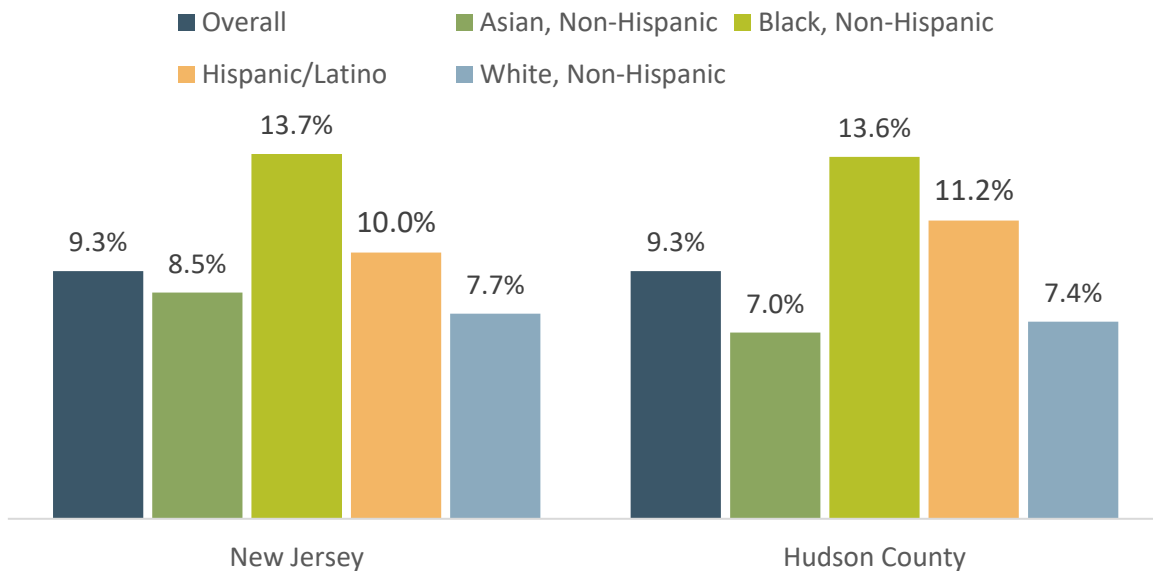


DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

NOTE: Low birth weight as defined as less than 2,500 grams

Figure 107 presents percent of preterm births in 2020 by race/ethnicity. Across New Jersey, 9.3% of births were preterm (less than 37 weeks of gestation). At state level, Black, Non-Hispanics had the greatest proportion of preterm births (13.7%), followed by Hispanics/Latinos (10.0%), Asian, Non-Hispanics (8.5%), and White, Non-Hispanics (7.7%). Similarly, in 2020, 9.3% of births in Hudson County were preterm births with Black, Non-Hispanics (13.6%) and Hispanics/Latinos (11.2%) having the highest proportion of preterm births.

Figure 107. Percent Preterm Births, by Race/Ethnicity, State, and County, 2020



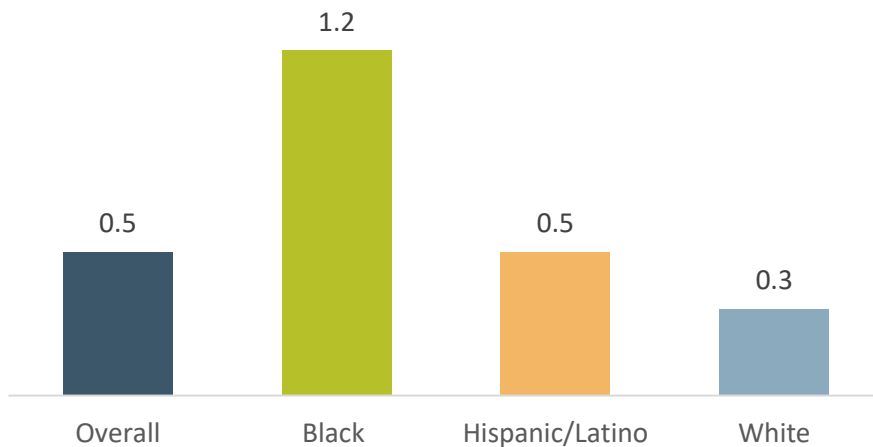
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020

NOTE: Preterm is defined as less than 37 weeks gestation

Maternal and Infant Mortality

The vast majority of maternal deaths are preventable with access to timely, adequate, quality care. Thus, it is a marker of health disparities. Across the state, the maternal mortality rate was 0.5 deaths per 100,000 population from 2015 to 2019 (Figure 108). In line with other measures of infant and maternal health, Black, Non-Hispanics had the highest maternal mortality rate (1.2 deaths per 100,000), more than double the state-wide rate, with other racial/ethnic groups closer to the state-wide average. Two factors may have exacerbated disparities in maternal deaths in recent years: the COVID-19 pandemic, which is associated with an increased risk of maternal morbidity and mortality, and which disproportionately affected Black residents and curtailed access to safe abortion care.

Figure 108. Maternal mortality rate per 100,000 population, by State and Race/Ethnicity, 2015-2019



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

In 2015-2019, the statewide infant mortality rate was 4.3 deaths per 1,000 births; Hudson County had a lower infant mortality rate of 2.9 deaths per 1,000 births. The infant mortality rate among Black infants (9.3 per 1,000 births) was double to the state-wide rate (4.3 per 1,000 births) (Table 15). Similarly, the infant mortality rate among Black infants (7.1 per 1,000 births) in Hudson County was 2.5 times the county rate (2.9 per 1,000 births) over the same period.

Table 15. Infant Mortality Rate per 1,000 Births by Race/Ethnicity, by State, 2015-2019

	Overall	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic
New Jersey	4.3	2.5	9.3	4.2	2.6
Hudson County	2.9	*	7.1		*

DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

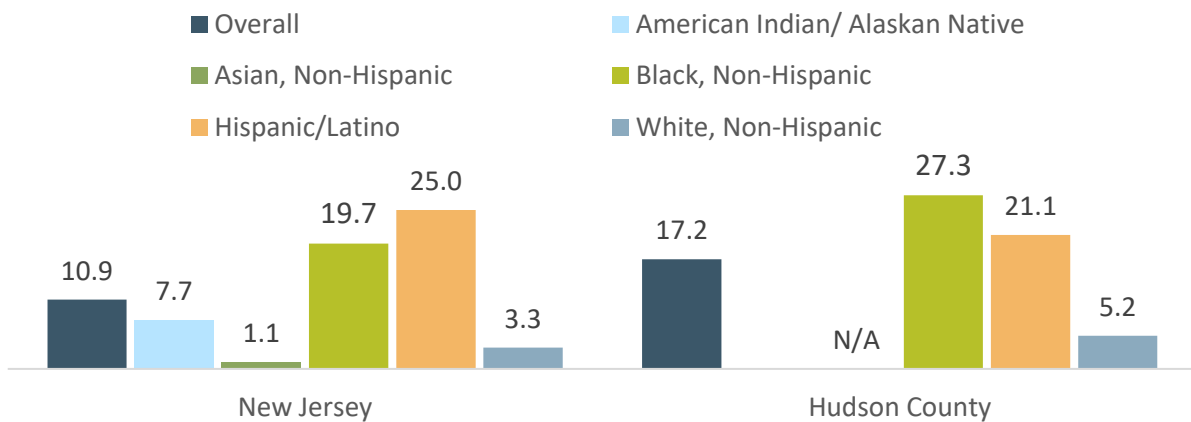
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Teen Pregnancy

Teen pregnancy is associated with poor birth outcomes, particularly among very young teens (aged 10–14-year-old), and to gender-based violence. It has long-term social and economic consequences, as often, pregnant teens drop out of school, curtailing future opportunities for education and employment, and perpetuating the cycle of poverty. While teen pregnancy was not discussed at length during the assessment conversations, participants did talk about how legal challenges and restrictions to safe abortion and post-abortion care may severely curtail teen’s ability to make reproductive choices.

Data from the New Jersey Birth Certificate Database show the number of teen births per 1,000 female population from 2014 to 2020, by race/ethnicity. At the state level, the overall teen birth rate was 10.9 per 1,000 and the highest teen birth rate was among Hispanics/Latinos (25.0 per 1,000), followed by Black, Non-Hispanics (19.7 per 1,000). In Hudson County, the overall teen birth rate was higher than the state, 17.2 per 1,000 (Figure 109). The highest teen birth rate in Hudson County was 27.3 per 1,000 among Black, Non-Hispanics, followed by Hispanics/Latinos (21.1 per 1,000).

Figure 109. Number of Births per 1,000 Female Population Ages 15 to 19, by Race/Ethnicity, State, and County, 2014-2020



DATA SOURCE: National Center for Health Statistics, Natality Files, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2014-2020

NOTE: Data for Asian and American Indian/Alaskan Native residents is not available due to low numbers.

Access to Services

This section discusses the use of healthcare and other services, barriers to accessing these services, and health professional landscape in the region. Access to healthcare services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death.

Access and Utilization of Preventive Services, Including Immunizations

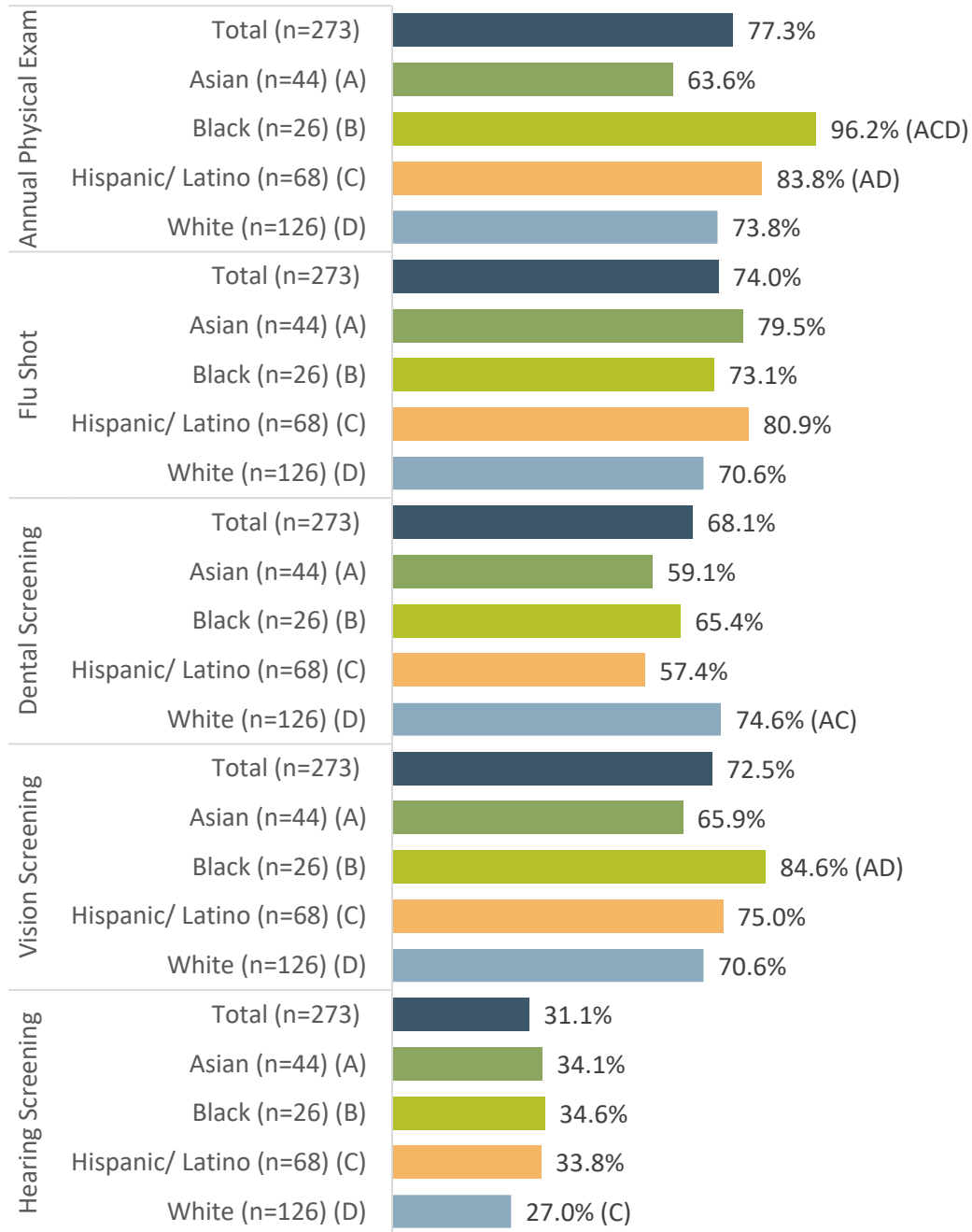
Participants in the healthcare field unanimously noted a decline in access to preventive care in Hudson County during the pandemic. Some focus group and interview participants discussed delaying care, particularly routine preventive services, in recent years. Reasons cited included the high cost of care, being uninsured, not having sick leave, not having providers that spoke their language, and/or not having childcare available.

On the other hand, participants indicated that having a primary care provider and/or access to a trusted FQHC were two factors that facilitated access to care.

“Primary care is a big issue for [most] of our children who have free and reduced meals. They live below the poverty line and they don't have a set primary care provider, pediatrician or doctor, and they are not going for all the routine tests that children should get.” – Key informant interviewee

The community survey fielded in spring/summer 2021 asked respondents about their participation in various healthcare screenings, including preventive services, in the past two years. Approximately 77% of Hudson County survey respondents reported receiving an annual physical exam; 73% a vision screening; 68% a dental screening; and approximately 74% a flu shot in the past two years. Fewer – 31% – reported having a hearing screening. Figure 110 presents these data for all Hudson County survey respondents and by race/ethnicity.

Figure 110. Percent of Community Survey Respondents Reporting that They Had Participated in a General Preventive Services and Screenings in the Past Two Years (n=273), 2021



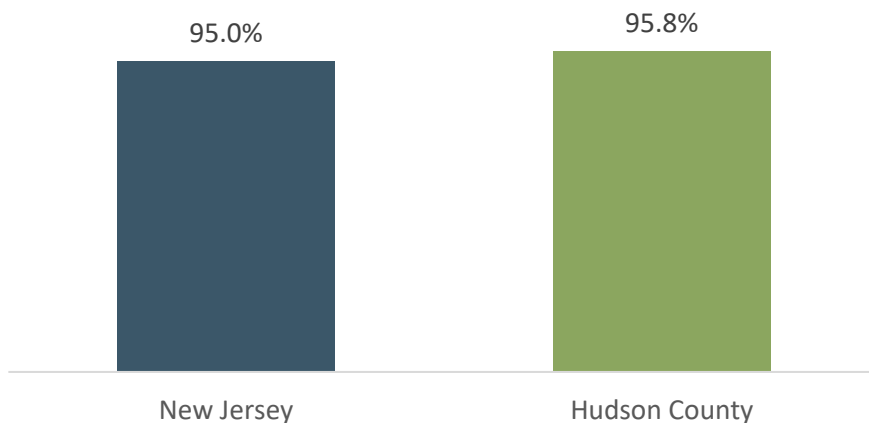
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph

Immunizations are an important preventive measure. Participants mentioned that many children in Hudson County received their full vaccination schedule through school health clinics; however, adults,

particularly those who were uninsured, faced barriers to vaccination. These patterns were confirmed by surveillance data. Among children in Hudson County, surveillance data from 2017-2018 indicate nearly 96% of children were fully immunized (Figure 111). However, 2019 data indicate that only 38% of Fee-for-Service (FFS) Medicare enrollees reported having received an annual flu vaccination in Hudson County, compared to 51% in New Jersey overall (Figure 112). Further, only one in five (20.4%) of eligible Hudson County residents reported receiving a pneumonia vaccine in 2020 (Figure 113). Given the disruption of COVID-19 on access to care, current percentages may be lower.

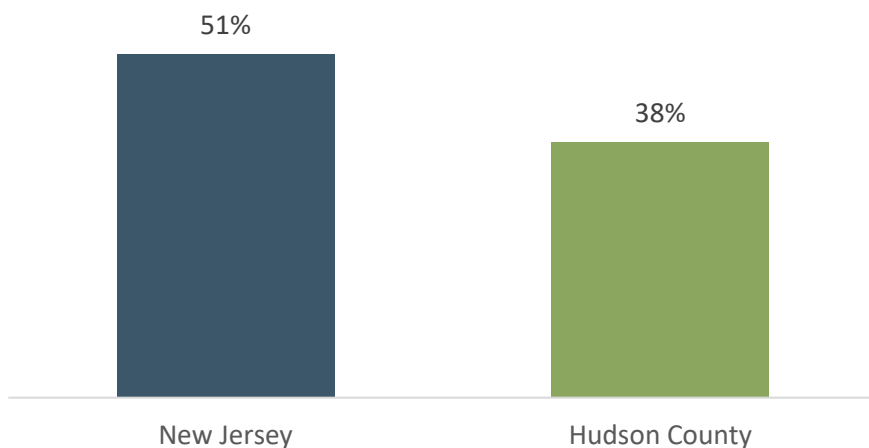
Figure 111. Percent of Immunized Children, by State and County, 2017-2018



DATA SOURCE: Annual Immunization Status Reports, Communicable Disease Service, New Jersey Department of Health, as reported by New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2017-2018

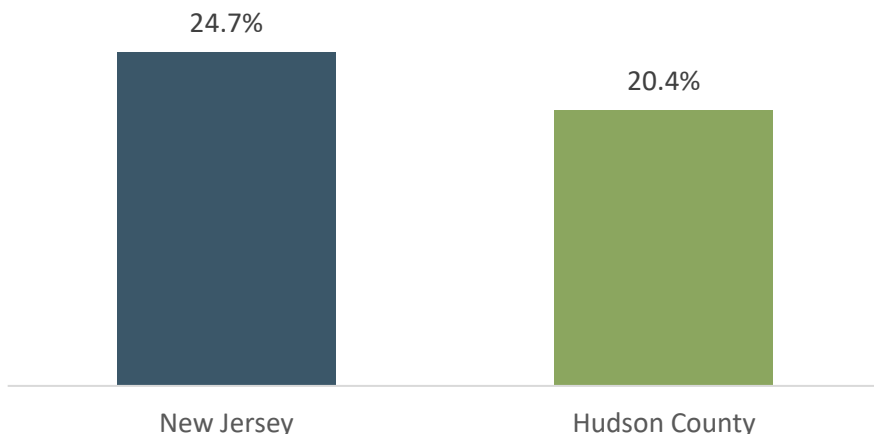
NOTE: Includes childcare/preschool, Kindergarten/Grade 1 (entry level), Grade 6, and transfer students in any grade

Figure 112. Percentage of Fee-for-Service (FFS) Medicare Enrollees that Had an Annual Flu Vaccination, by State and County, 2019



DATA SOURCE: Centers for Medicare & Medicaid Services, Office of Minority Health's Mapping Medicare Disparities tool, as reported by County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Figure 113. Age-Adjusted Pneumococcal Vaccination (Ever), by State and County, 2020



DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Barriers to Accessing Healthcare Services

While many focus group members and interviewees reported that Hudson County had some healthcare assets and that there is a lot of collaboration among these assets, accessing these can be challenging for some residents. High healthcare cost was the top barrier mentioned by residents, providers, and healthcare administrators. Other barriers identified through discussions were lack of insurance and/or insurance challenges, scheduling convenience, long wait times, provider availability, stigma and discrimination, and language and cultural barriers. In addition, fear of institutions due to the increase in anti-immigrant discourse and persecution of undocumented individuals was cited as a major impediment for care access among this population.

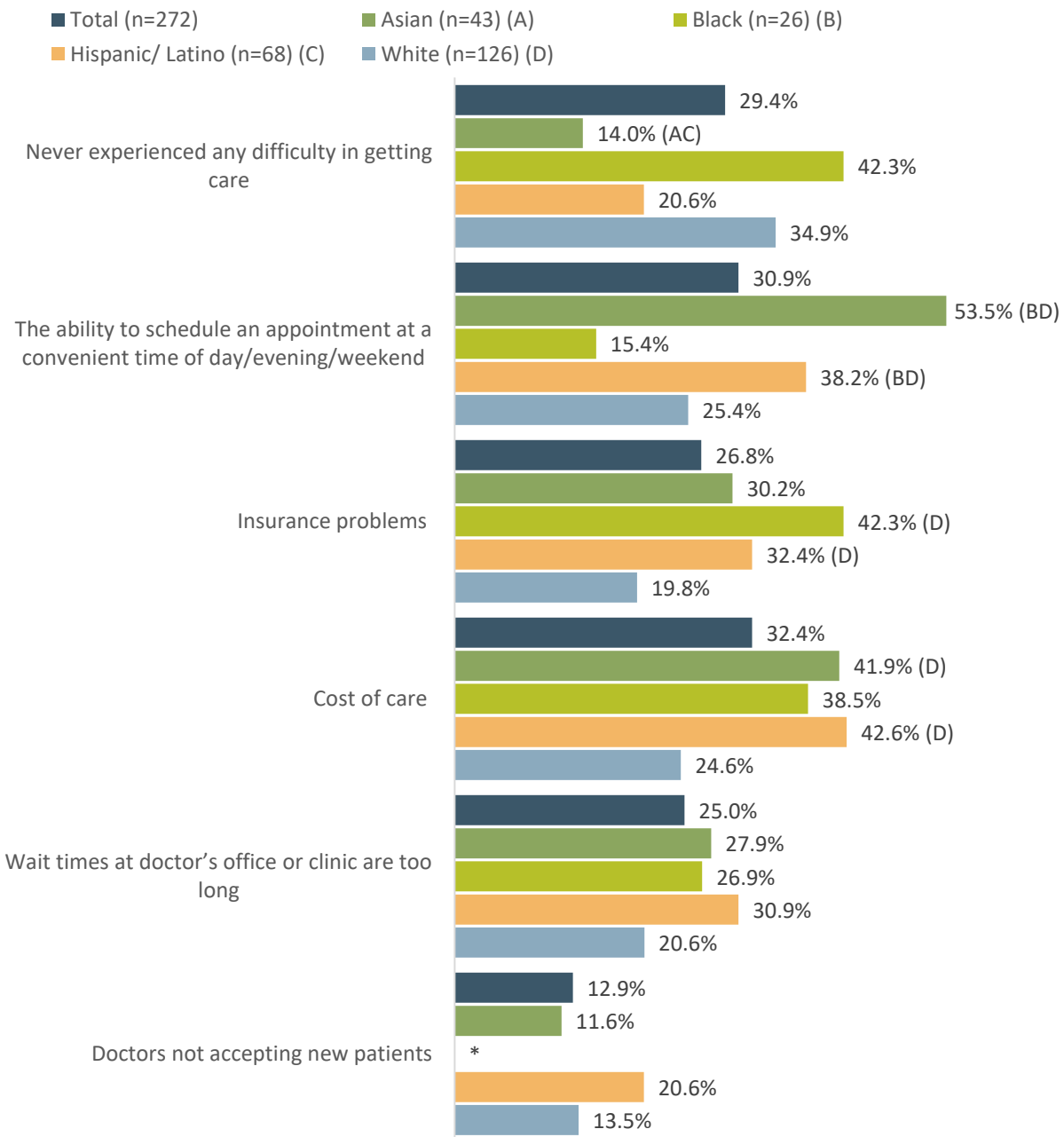
“Preventive care is pretty much nonexistent. Most community members might not have primary care linkage, they often provide the name of a specialist when asked who their PCP is. There are a lot of gaps in terms of availability and being able to afford to see a PCP.” – Focus group participant

Many residents indicated that they only sought care from hospitals in an emergency; high and unpredictable cost of hospital care, trust, and unavailability of bilingual providers were some of the issues that made residents prefer to seek care from community-based clinics, FQHCs, or private practices. Participants also noted that disruptions to the healthcare system due to the pandemic, e.g., temporary closures and retirement of older providers, further distanced residents from services.

Barriers to healthcare access were discussed in multiple ways (e.g., survey, focus groups, interviews) and different issues emerged via the various methods. In the community survey, respondents selected which barriers they had experienced from a list. Only 29.4% of survey respondents indicated that they have never experienced any difficulty in getting healthcare. Overall, the top issues selected were cost of care (32.4%) and ability to schedule an appointment at a convenient time (30.9%) (Figure 114). Differences emerged by race/ethnicity. White respondents were the most likely to report that they did not have an issue accessing care (34.9%); ability to schedule an appointment was marked by 53.5% of Asian

respondents; Black respondents were the most likely to note insurance problems (42.3%); and over 40% of Asian and Latino respondents marked cost of care as an issue (See Cost of Care section below).

Figure 114. Percent of Community Survey Respondents Reporting Which Issues Made It Difficult for Them or a Family Member to Get Medical Treatment or Care When Needed (n=273), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph. Asterisks (*) denote insufficient data to calculate reliable rate

Cost of Care

Cost of care emerged as the primary barrier to accessing services across most focus groups and interviews. As described above, Latino (42.6%) and Asian (41.9%) respondents were more likely than White (23.6%) respondents to mark cost of care as a barrier (Figure 114). Many Black respondents also mentioned cost of care as a barrier (38.5%).

This barrier existed for both preventive care and more complex care. Some participants noted that they were able to access free health screenings when offered by the city, hospitals or the FQHCs. However, others did not, and remarked on having to pay a fee for basic preventive services, including COVID-19 tests, as a disincentive. In the words of a Latina resident, *“They sent me a \$400 bill for a mammogram, and I wasn’t working. Later I learned that there are organizations that offer it for free.”* Even for insured individuals, the cost of medication and treatment of chronic diseases, including diabetes and cancer, is unaffordable. Many patients are faced with the dilemma of paying for rent, food, or medicine. Cost of care is a barrier for low-income residents, overall, but an even greater barrier for undocumented residents, as they are not eligible to receive government insurance. Participants in the Latino focus groups described being particularly wary of going to the hospital because of the high cost of care and going only in emergencies. Numerous residents remarked that obtaining charity care is an onerous task and many remarked that they had been rejected. Cost of care is also a barrier for middle-low income families, as they do not qualify for Medicaid or other government programs, but they cannot afford to pay for the medical bills. Even veterans who are insured through the Veterans Administration complained of the hurdles of accessing care and of receiving high hospital bills if they had to seek services in a non-affiliated hospital.

Health Insurance

Several participants stated that lack of health insurance and insufficient coverage are barriers to accessing healthcare. Healthcare providers and administrators indicated that many patients were uninsured and had difficulty accessing care. Multiple participants noted that uninsured patients would rather seek care from private physicians, rather than the hospital, because they fear the hospital costs. As described by this resident, *“People that don’t have insurance or a primary care doctor have to find a private physician. When I first arrived to this country and had a job that didn’t offer insurance, I had to spend all day waiting to see the doctor. There were usually about 60 people waiting.”*

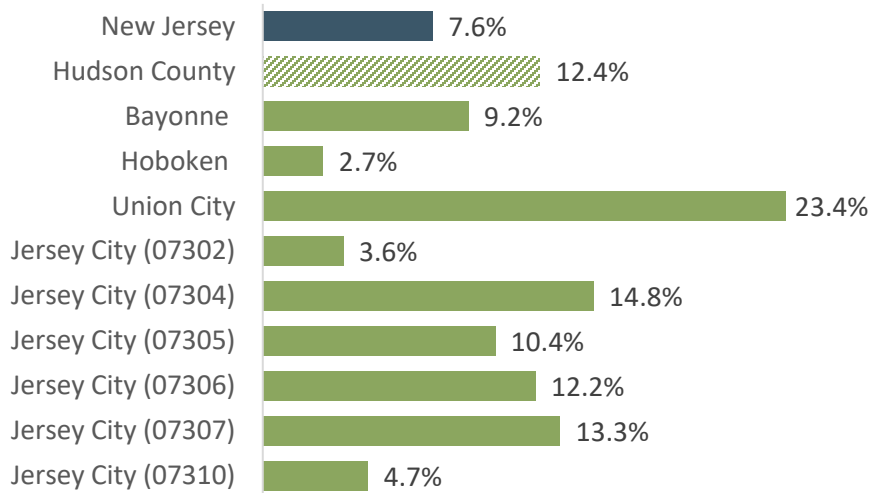
“If you don’t have a doctor who’s caring, or for like, people who are on Medicaid and Medicare, it’s difficult. Like the seniors who are on Medicare, they have to pay a copay.... If you don’t have the Part D for prescriptions, you don’t get a deal on the prescriptions. I think that’s horrible, after working your whole life....” – Key informant interviewee

Participants indicated that even with insurance, people faced many challenges. As one person stated, *“The lack of accepting insurances [is a big problem], not a lot places accept state insurance. They may not have the “right state insurance” according to some companies.”* Participants enrolled in Medicare were grateful to have this insurance, however, one participant mentioned the high copays and the high cost of medicine without Part D.

Census data indicate that health insurance coverage is still an issue for many Hudson County residents, although this varies by neighborhood. A higher percentage of the population in Hudson County was uninsured than in New Jersey (12.4% vs. 7.6%) (Figure 115). Only 2.7% of Hoboken residents were

uninsured compared to 23.4% of Union City residents, and 14.8% of residents in Jersey City zip code 07304. More than one in ten residents are uninjured in Jersey City zip codes 07305, 07306, and 07307. Percentage of the population with private health insurance can be found in Figure 132 in the Appendix.

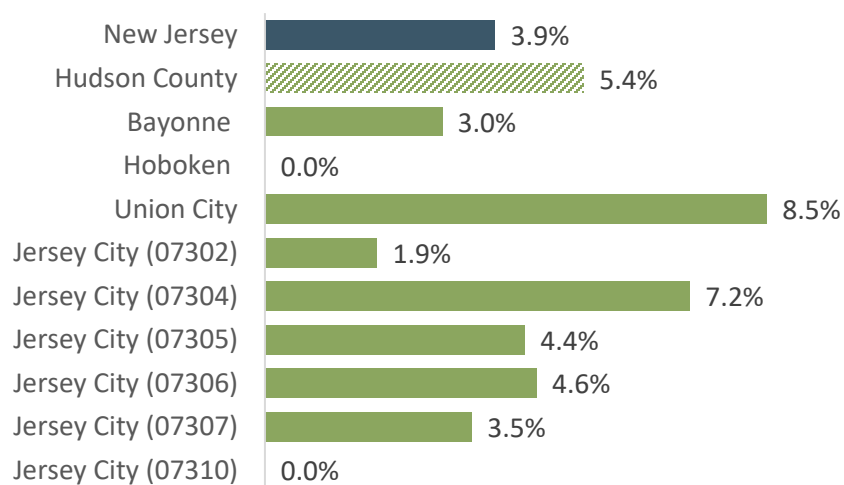
Figure 115. Percent Population Uninsured, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Children have greater access to primary care than their caregivers. Many children live in mixed immigration status households; they qualify for free or low-cost state health insurance as U.S. citizens, but their parents do not. Children can also access primary care through school clinics. In 2016-2020, 5.4% of children under age 19 were uninsured in Hudson County, less than half of the percentage of uninsured adults (12.4%) in the county, but higher than the state average (3.9%) (Figure 116). No children were uninsured in Hoboken and Jersey City zip code 07310 according to the American Community Survey data, compared to 8.5% of children in Union City and 7.2% of children in Jersey City zip code 07304.

Figure 116. Percent Under Age 19 Uninsured, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Health Provider Availability

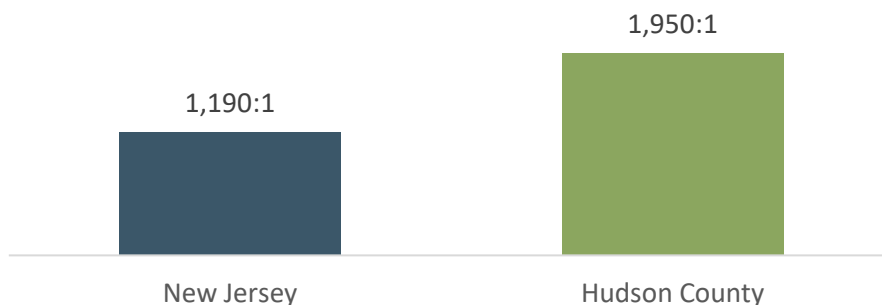
Focus group and interview participants noted that there seemed to be an insufficient number of healthcare and social services providers for the number of residents in Hudson County. As a result, patients waited months for an appointment and faced long wait times prior to the visit. Participants indicated a dearth of both primary care providers and specialists.

“When we studied the data a few years ago, people didn’t understand what we meant about the ratio of people to doctors, that was like 2400:1, there were also poor numbers for mental health, and I would guess that’s gotten worse.” – Focus group participant

Focus group participants in the healthcare field noted that it was difficult to hire and retain staff in community-based non-profit organizations. A major barrier was inadequate compensation. Staff did not receive competitive salaries and benefits packages due to federal funding regulations, including salary caps, lack of sick leave, and temporary contracts. As a focus group participant described, *“We are all struggling with staff retention, providers, nurses, CMAs, everyone right now. It’s almost like we can’t afford them. No matter how much we pay people, they can be traveling nurses and make way more.”* According to participants, sickness, staff burnout, and safety concerns during the pandemic further exacerbated the situation. Another problem noted related to provider retention were the inadequate affordable childcare options for staff with children. Whereas offering appointments during work hours is a problem for clients without sick leave, it is difficult to staff the evening hours. As a focus group participant in the healthcare field explained, *“We couldn’t extend hours with staff because they need to pick up their children. The policy of the daycare providers is if they aren’t there by 6, they call CPS. If we need to give late hours, Head Start should be required to give late hours.”* Participants in the healthcare field remarked that not all communities were represented by the staff; whereas there were plenty of Indian providers who spoke multiple languages, this was not so for Spanish and other languages.

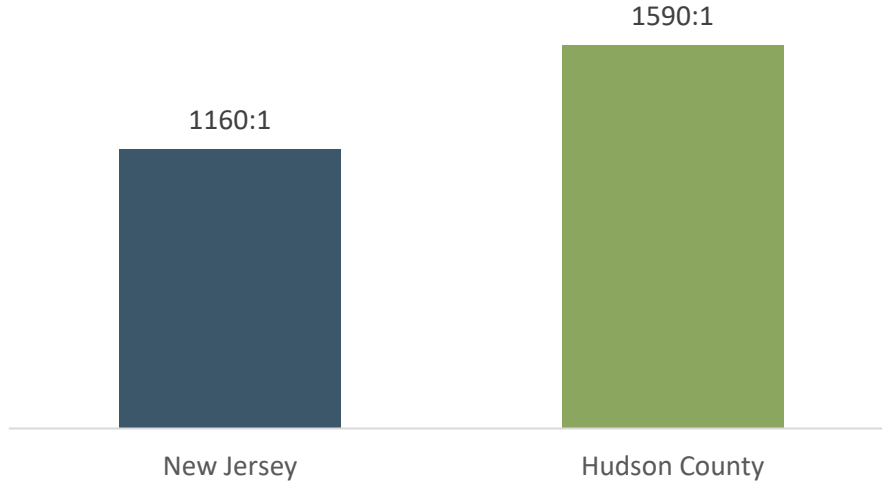
As described about mental healthcare providers in the Mental Health section above, more general and specialty care providers are needed in Hudson County. Surveillance data from 2017 indicate that Hudson County had fewer people per every primary care physician (1,950:1) than New Jersey overall (1,190:1), indicating a smaller person to provider ratio (Figure 117). The need is noted even more urgently with specialty care. For example, the ratio of persons per dentists in Hudson County was 1,590:1 in 2018, compared to 1,160 in New Jersey (Figure 118). The pandemic has probably increased this ratio.

Figure 117. Ratio of Population to Primary Care Physicians, by State and County, 2017



DATA SOURCE: American Medical Association, Area Health Resource File, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2017

Figure 118. Ratio of Population to Dentists, by State and County, 2018



DATA SOURCE: National Provider Identification file, Centers for Medicare and Medicaid Services, Area Health Resource File, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2018

Language and Cultural Factors Related to Healthcare Access

Participants in the healthcare and social service field noted using different strategies to bridge language and cultural barriers. Many sites, including the hospital and the health department, described having agreements with translation companies to provide telephonic support in any language. In addition, healthcare partners in most settings develop and disseminate informational materials and provide signage in multiple languages. Staff at many of the healthcare sites are themselves bi- or multilingual speakers.

From a cultural perspective, many of the health care institutions in the area hire local staff, who represent the community. This strategy goes a long way in building trust with community members and overcoming some of the wariness for hospitals. As one healthcare employee explained, *“Being born and raised here, I can say it’s the diversity of who we are that makes us special. Also being residents of the area who can identify what the needs are and try to address them in our agencies as residents.”*

Another strategy is finding cultural ambassadors or credible messengers that can be a go-between for the healthcare institutions and the community. In the view of some participants, this strategy is there on paper, but needs to be implemented more proactively. As explained by a participant, *“For people who speak languages other than English, we need not just the commitment to having it there, but actively promoting it, so that influential voices in those communities serve as ambassadors to say, you know if you speak Hindi, there’s somebody at the medical center for you, or if you speak Pashto.”*

“In general, we see access problems for Latinos, partly language based, and I think I’ve seen it largely as reflective of the fact that any non-English outreach tends to be an afterthought and not an attempt to truly connect and promote to those communities.” – Focus group participant

Certain groups are more represented than others. Healthcare staff explained that good strides had been made in reaching the Black and the Hindi communities; however, reaching Latinos and other immigrants has been difficult; further, more work is needed to increase trust in the Black community. An advocate highlighted the need for more racial equity training for healthcare providers, *“I’ve heard of horrific experiences because of being African American, healthcare providers don’t understand the pain of African American folk.”* When describing the healthcare workforce needed in Hudson County, an administrator described, *“It’s not just culturally competent, it’s a workforce that looks like the community and helps with institutional trust issues found in different populations but especially with low income, African American, immigrant, rural, blue collar, politically leaning communities.”* To complement this observation, several Latino residents described language as a barrier to accessing health at hospitals. One patient described this experience, *“They gave me a referral for an eye doctor, they made an appointment for a video call, but I couldn’t attend the appointment because it’s always only in English, nothing else. They need staff who are bilingual.”*

Community-Based Organizations and Coalitions

Hudson County was described as having substantial and strong social services. Community-based nonprofits were seen as mission-driven and committed to their clients. Partnerships between the community-based organizations, hospitals, schools, and the government were seen as a strength in Hudson County and critical to providing services to those in need. As described by a public health administrator, *“Overall, as a city and a group of health industry collaborators, I think the hospital, the FQHCs, and the Department of Health, we have always worked hand in hand to address the needs, we are also involved in an HIV ending committee, but also access to healthcare, specific and broad topics.”* As mentioned earlier in this report, participants also spoke about city-wide efforts such as HealthierJC, which have promoted prevention, identified and addressed public health gaps, and coordinated efforts across public health, hospitals, and community-based nonprofits, as well engaged the business community.

“From my experience, over 20 years, I feel that the greatest strength are the community-based organizations. We have a wide range of individuals who form different communities, even small grassroots community-based organizations, to engage people in healthy ways.” – Focus group participant

Residents and public health administrators uplifted the role of community-based nonprofits in bridging the gap to services for those most marginalized. Residents noted how staff at FQHCs went out of their way to address their physical, mental, and social needs, being their first stop for primary healthcare, regardless of immigration status. Many residents seek free screenings from non-profit groups serving the LGBTQ+, Asian, Latino, and African-American communities. Latino residents expressed trust in the FQHC staff and described getting support to obtain the social services they were eligible for. A community-based service administrator described their vision as an integral part of the community, *“We like that the community thinks of us as their go-to place, community health centers, sometimes generations of patients. Sometimes we see someone as a child now bringing their children to pediatrics, from birth to death.”*

One limitation that participants noted about community-based groups was their limited financial and human resources. Sustainability and dependence on grant funding, that is, funding which is variable and

short-term, were mentioned as problems. When speaking about the importance of uplifting community-based partners, a healthcare administrator noted, *“Most of the strengths we mentioned are double edged. There’s a lot of organizations that aren’t well resourced financially, they are trying to do some good work, but with no sustainable resources or capacity to expand.”*

In part because of this, most participants saw a role for a stronger coalition in Hudson County that includes well-resourced hospitals. Participants expressed that there was a lot of collaboration among government actors, hospitals, schools, and community-based organizations. They remarked that each partner complemented each other and collaborated well, as shown during the pandemic. Focus group participants indicated that there was continued room for growth in this area.

“There is also a deficit related to location, both Newark and NYC have better developed social infrastructure, especially in nonprofit, philanthropic, and people-powered engagement. It’s a challenge I’ve seen linked to our location.” – Focus group participant

Community Vision and Suggestions for the Future

Focus group and interview participants were asked for their suggestions for addressing identified needs and their vision for the future. The following section summarizes and presents participants’ recommendations for future consideration.

Expanding and Strengthening Behavioral Health and Overall Healthcare Services

Health as Human Right: “It is urgent to have access to free, quality health care”

Almost unanimously, cost emerged as a primary barrier to healthcare access in qualitative discussion. Many residents indicated that healthcare should be free. Residents underscored the value of preventive care as a cost-effective intervention and urged partners to continue expanding access to these services. Participants also highlighted challenges with health insurance coverage. To address these barriers, residents recommended offering more free screenings, loosening the requirements to qualify for free and/or low-cost health insurance, and simplifying the charity care application. Participants also suggested making more efforts to *“meet people where they are,”* through mobile clinics and education sessions based in different neighborhoods. Participants highlighted the community school model, entailing private-public partnerships between the education and healthcare sectors, and the community, as a promising initiative to promote the well-being of low-income families.

Greater Accessibility and Availability of Behavioral Health Services

Participants remarked on the difficulties faced by all groups, particularly Black, LGBTQ+, veterans, and young residents, to accessing quality, culturally competent mental health care. Participants highlighted the need for more mental health workers. Focus group participants and interviewees hoped to see more community-based mental health services, including recovery programs that are affordable and accept all insurance types. They also advocated for more prevention education programs to address problem substance use in the community, especially among youth and veterans. Participants suggested providing more education to address the stigma that surrounds mental health among many cultural groups. The need for more language capacity within the behavioral health services field was also discussed, as well as training in caring for patients of different backgrounds, including LGBTQ+ patients, and those who have experienced trauma, such as veterans.

Sexual and Reproductive Health and Women’s Health

Focus group members and interviewees were concerned about the increase in sexually transmitted infections among some groups, including cisgender women and men-who-have-sex-with-men, and about the repercussions of the rollback in constitutional protections to reproductive choice. Several participants warned that access to sexual and reproductive health services could be curtailed, even if New Jersey has progressive reproductive health policies. They noted that this would unduly affect low-income women and communities of color, thus, exacerbating existing racial/ethnic and social inequities in maternal and infant health. Some participants recommended being vigilant about reproductive health and rights protections to support the sexual and reproductive rights of all people in New Jersey. They also underscored the importance of offering comprehensive sexuality education in schools.

Focusing on the Upstream Factors and the Social Determinants of Health

Inequality

Growing inequality emerged as an issue of concern among most focus groups and interview participants. Residents noticed this in neighborhood-level differences in school resources, in safety, in employment opportunities, and in the built environment. Participants attributed growing inequality on policies that cater to residents in the highest social strata and expressed frustration at this ‘*tale of two cities.*’ Residents suggested that more progressive policies on taxation, employment, education budgets, and healthcare were needed to reverse this trend.

“My biggest wish for this community is that we don't have such an economically diverse community. If there's a way to really help the families with the lowest economic resources to really have more financial stability, that would be ideal.” – Key informant interviewee

Economic and Employment Opportunities

Expanding economic opportunities, especially for low-income workers, Latino residents, veterans, LGBTQ+ residents, particularly transgender people, and violence survivors was suggested as a priority area by many assessment participants. Participants recommended improving initiatives to help those who face barriers to employment obtain jobs. Suggestions included incorporating more vocational training programs in high schools to facilitate transition into the workforce, and education and incentives for employers hiring veterans and transgender and other LGBTQ+ people. Additional proposals included supporting small business owners and providing expanded workforce protections (e.g., sick leave, improved wages, childcare) for all workers, particularly those in healthcare.

Built Environment

Several issues emerged as concerns in the built environment. One was overdevelopment leading to overpopulation and loss of green areas; the other was the focus on building luxury rentals, resulting in gentrification. Participants enjoyed Hudson County’s varied public transportation options, its walkability, and its parks. They praised current community efforts to extend green areas supportive of healthy lifestyles. Residents also highlighted the need for redevelopment and urban planning in flood-prone areas to mitigate water damage as an important emergency preparedness strategy.

Housing

Access to affordable housing in safe neighborhoods was among the most discussed issues in qualitative discussions. Residents expressed concern about inflation and high taxes, coupled with the lingering economic impact of the pandemic on housing affordability, impending evictions, and homelessness, and looked for initiatives to mitigate these challenges and the high cost of housing. Participants proposed earmarking more affordable housing units in the new developments, including housing for veterans; implementing the existing rent control policies, which also apply to foreign-born residents regardless of immigration status; and fomenting first-time buyers' subsidies as a promising initiative to address intergenerational poverty.

Greater Engagement and Access to Existing Initiatives

Access to Services and Community Outreach

Interviewees and focus group participants observed that information about existing services and programs were not readily accessible to community members. They recommended more be done to raise awareness about existing programs. Participants suggested organizing more education and awareness building efforts both in person and virtually in different neighborhoods and in different languages on topics that most affect the community, including on managing diabetes and high blood pressure, and on recognizing the signs of stroke. Other suggestions to bridge access to health and social services included deploying mobile vans to other areas in the county; expanding health clinics that offer care for free and/or at low-cost to both children and families, particularly local and school-based clinics; and offering appointments outside of the regular workday. Some participants recommended developing a centralized list of health and social service programs and resources, similar to the mental health directory prepared by the Health Department (<https://healthierjc.com/mental-health/>), but for other conditions.

“Do more preventive family care, I think it would be very profitable for the state really because it's cheaper to prevent than to deal with.” – Key informant interviewee

Partnerships, Community Engagement, and Community Building

Participants valued the robust partnerships established among multiple organizations and across sectors, including grassroots organizations, government, small businesses, social services agencies, and FQHCs, as exemplified by the Partnership for a HealthierJC. Participants suggested continuing to deepen engagement and collaboration with trusted community-based organizations, such as those representing Asian, Latino, and LGBTQ+ residents, as partners in outreach and information sharing about community services and programs. Several participants stressed the importance of engaging faith-based organizations, especially given their reach and level of trust in the community. Other participants discussed the need to collaborate and hire credible messengers – respected community members – to build bridges with the community. Participants underscored more community outreach, a strong plan to reengage the community, and investing in the community as strategic areas moving forward.

Key Themes and Conclusions

Through a review of the secondary social, economic, and epidemiological data; a community survey; and discussions with community residents and stakeholders, this assessment report examines the current health status of Hudson County during an unprecedented time given economic volatility, the COVID-19 pandemic, and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- ***Some residents are struggling with lack of employment and economic opportunities.*** In 2016-2020, unemployment rates across Hudson County ranged from 2.4% in Jersey City zip code 07302 to 7.0% in Jersey City zip code 07305 and 9.2% in Jersey City zip code 07304. The unemployment rates mapped onto racial/ethnic groups; residents in zip code 07302 are predominantly White (40.1%) and Asian (32.2%), whereas over two-thirds of residents in zip codes 07304 and 07305 are Black and Latinos. More resources for career transitions and job training and technology were identified as critical to addressing these disparities. Focus group participants highlighted the need for more support and employer incentives for veterans and LGBTQ+ residents facing employment discrimination.
- ***Housing affordability is a main concern in Hudson County.*** Housing affordability was identified as a pressing concern, particularly for persons of color, veterans, LGBTQ+ persons, immigrants, and low-income residents. Participants expressed that too many luxury rentals were being built, instead of affordable housing for families. There are many renters across the area. In New Jersey, 64.0% of housing units were owner occupied in 2016-2020, in contrast to 32.4% in Hudson County. Home ownership ranged from 12.5% in Jersey City zip code 07310 to 40.6% in Bayonne. Disparities in housing cost burden exist within Hudson County. In Jersey City zip codes 07302 and in Hoboken, less than one in three owner-occupied and 44% of renter-occupied households reported high housing costs whereas 64.4% of owner-occupied and 66.5% of renter-occupied residences in Union City reported spending more than 25% of their income on housing costs. Qualitative discussions highlighted how veterans in Hudson County tend to work in low-wage jobs and often live in multigenerational housing. Housing availability was also cited by interviewees as an important barrier to breaking the cycle of violence. Relocation is one of the strategies used to prevent revictimization of community and domestic violence survivors. However, according to violence interrupters, affordable housing options in low-crime neighborhoods are limited. Several focus group and interview participants mentioned the problem of homelessness in Hudson County communities and indicated that the shelters and temporary housing available were insufficient to meet the need. Solutions proposed included earmarking more affordable housing units in the new developments; extending first-time buyers' subsidies, particularly for persons of color; and renovating and repurposing abandoned homes for low-income families.
- ***Mental health was identified as a significant community health concern.*** Mental health was identified as a top community health concern, closely associated with economic instability and chronic conditions. Black residents faced a disproportionate mental health burden. The rate of mental health hospitalizations in 2020 was 70% higher among adult Black residents (107.1 per 100,000) than the Hudson County average (63.1 per 100,000). Black children had 38% higher hospitalized rates for mental health conditions than the county rate (34.7 per 100,000 vs. 25.2 per

100,000). Residents mentioned stigma and low numbers of culturally competent providers as the principal barriers to mental health care access.

- **Residents viewed chronic conditions as prevalent and linked to the social determinants of health.** Diabetes and high blood pressure were discussed as prevalent in the community, especially among low-income residents and communities of color, and survey respondents indicated “overweight/obesity” was the second most common health issue in their community. However, focus group participants focused on the barriers to healthy living including affording healthy foods, cost medication, and having time to exercise and be outside.
- **Educational opportunities were seen as an important driving factor for future success.** A positive and supportive school environment is important to physical and mental wellbeing, as well as to future educational and professional opportunities. Health supports academic success. Schools play an important role in facilitating access to care and helping students stay healthy, and Hudson County public schools engage with communities in multiple ways to support students. However, some schools face challenges due to insufficient resources. Inequities in school performance are confirmed by graduation rate data from different Hudson County districts. Whereas the high school graduation rate in the Hoboken Public School District was 93.6% in 2020-2021, the public school districts of Bayonne, Union City, and Jersey City had lower graduation rates. There were significant disparities by race/ethnicity within districts; 95.3% of Asian students graduated from high school in Bayonne in 2020-2021, compared to 86.4% of Black children, and 78.5% of Latino children. Partnership based programs such as the community schools and The Tiger's Den at Snyder High School are a promising strategy to equalize outcomes among diverse students.
- **Hudson County has a wealth of social service organizations and health care services, including those providing preventive care, though many residents experience barriers to accessing these resources.** Residents remarked that having a primary care doctor and being linked to a FQHC as facilitating factors to accessing care. They also discussed the importance of culturally competent providers, including providers who spoke their language and looked like them. Veterans and those working with violence survivors highlighted that having peers and mentors who could provide trauma informed care helped to be engaged in care. The high healthcare cost was the top barrier mentioned by residents, providers, and healthcare administrators. Participants in the healthcare field unanimously noted a decline in access to preventive care and mentioned this as a priority strategic area. They uplifted partnerships and community engagement as ways to bridge the care gap.

Prioritization Process and Priorities Selected for Planning

Prioritization allows hospitals, organizations, and coalitions to target and align resources, leverage efforts, and focus on achievable goals and strategies for addressing community needs. Priorities for this process were identified by examining data and themes from the CHNA findings utilizing a systematic, engaged approach. This section describes the process and outcomes of the prioritization process.

Criteria for Prioritization

A set of criteria were used to determine the priority issues for action. The RWJBH Systemwide CHNA Steering Committee put forth the following criteria to guide prioritization processes across the RWJBH system.

Prioritization Criteria

- **Burden:** How much does this issue affect health in the community?
- **Equity:** Will addressing this issue substantially benefit those most in need?
- **Impact:** Can working on this issue achieve both short-term and long-term changes? Is there an opportunity to enhance access/accessibility?
- **Systems Change:** Is there an opportunity to focus on/implement strategies that address policy, systems, and environmental change?
- **Feasibility:** Can we take steps to address this issue, given the current infrastructure, capacity, and political will?
- **Collaboration/Critical Mass:** Are existing groups across sectors already working on or willing to work on this issue together?
- **Significance to Community:** Was this issue identified as a top need by a significant number of community members?

Prioritization Process

The prioritization process was multifaceted and aimed to be inclusive, participatory, and data-driven.

Step 1: Input from Community Members and Stakeholders via Primary Data Collection

During each step of the primary data collection phase of the CHNA, assessment participants were asked for input. Key informant interviewees and focus group participants were asked about the most pressing concerns in their communities and the three highest priority issues for future action and investment (see Key Informant Interview and Focus Group Guides in the Appendices). Community survey respondents were also asked to select up to four of the most important issues for future action in their communities, noted in the Community Health Issues section of the CHNA Report.

Based on responses gathered from key informant interviews, focus group participants, and community survey respondents, as well as social, economic, and health data from surveillance systems, ten initial issue areas were identified for Hudson County (listed below in no particular order):

- Financial Insecurity
- Unemployment
- Food Insecurity
- Housing
- Chronic Diseases (e.g., heart disease, cancer, diabetes)
- Infectious Diseases, including COVID-19
- Violence Prevention & Safety
- Mental Health
- Substance Use
- Access to Preventive Care

Step 2: Data-Informed Voting via a Prioritization Meeting

On October 27, 2022, a 90-minute virtual community meeting was held with the RWJBH Jersey City/Hudson County CHNA Advisory Committee (see Appendix A for members), so Advisory Committee members could discuss and vote on preliminary priorities for action. During the virtual prioritization meeting on Zoom, attendees heard a brief data presentation on the key findings from the CHNAs conducted across Hudson County.

Next, meeting participants were divided into small groups to reflect on and discuss the data and offer their perspectives and feedback on the various issues. Meeting participants then shared information from their discussions with the full group.

At the end of the meeting, using Zoom’s polling tool, participants were asked to vote for up to four of the ten priorities identified from the data and based on the specific prioritization criteria (Burden, Equity, Impact, Systems Change, Feasibility, Collaboration/Critical Mass, and Significance to Community). A total of thirty-two Advisory Committee members voted during the Community Prioritization Meeting. In addition, polling remained open for an additional week to gather responses from those who were not able to attend the meeting. An additional six responses were received during this period.

Voting ranked the following issues as top priorities, with mental health receiving the highest percentage of responses.

	Percentage	Vote #s
Mental Health	74%	28/38
Housing	74%	28/38
Financial Insecurity	61%	23/38
Chronic Disease	50%	19/38
Violence Prevention & Safety	42%	16/38
Access to Preventive Care	34%	13/38
Food Insecurity	29%	11/38
Substance use	21%	8/38
Unemployment	16%	6/38
Infectious Disease	5%	2/38

After a prioritization process with the Advisory Committee and discussions within the hospital taking into consideration existing expertise, capacity, and experience, JCMC will focus on Access to Preventive Care; Chronic Disease Management, including Behavioral Health Services; Food Insecurity and Education; and Violence Prevention and Safety as priorities during the development of its implementation plan in 2023. JCMC will tackle these priority action areas as part of ongoing community engagement efforts and with an overarching emphasis on addressing systemic racism, racial injustice, and discrimination.

APPENDICES

Appendix A- RWJBH Jersey City/Hudson County CHNA Advisory Committee Members

- Deborah Almonte, Jersey City Medical Center
- Jenny Andrews, Jersey City Medical Center
- Maureen Archibald, Jersey City Medical Center
- Tara Artesi, Legal Assistance to Medical Patients (LAMP) Project
- Adrienne Austin, Jersey City Medical Center
- Pamela Baker, Collaborative Support Programs (CSPNJ)
- Raket Barrientos, Jersey City Medical Center
- Patrick Beaty, MD, Metropolitan Family Health Network
- Paul Bellan-Boyer, Jersey City Department of Health and Human Services
- Christina Bishop-Feeny, Jersey City Medical Center
- Sheridan Blackwell, Jersey City Medical Center
- Kimberly Blackwell, Jersey City Medical Center
- Whitney Bracco, Jersey City Medical Center
- Jenna Camacho, Jersey City Medical Center
- Scott Carey, Metropolitan Family Health Network
- Kristin Carlino, Jersey City Medical Center
- Kristy Case, Jersey City Medical Center
- Suzanne Cavanaugh, City of Bayonne
- Ritu Chandak, Jersey City Medical Center
- Jamie Chebra, Jersey City Medical Center
- Jessica Chung, Jersey City Medical Center
- Timothy Daniels, Jersey City Medical Center
- Christine Dimaculangan, Jersey City Medical Center
- Cheryl Dorn, Peace Care
- Joan Dublin, Metropolitan Family Health Network
- Mark Duda, Visiting Nurse Association Health Group
- Leah Dungee, Jersey City Medical Center
- Joan Eccleston, Jersey City Department of Health and Human Services
- Edoardo Ferrante, City of Bayonne
- Marissa Fisher, Jersey City Medical Center
- Stacey Flanagan, Jersey City Department of Health and Human Services
- Juliet Foster, Division of Veterans Affairs, Jersey City Department of Health and Human Services
- Katherine Fromm, Jersey City Medical Center
- Marli Gelfand, Jersey City Medical Center
- Silvana Gomez, Jersey City Medical Center
- Stephanie Gonzalez, Jersey City Medical Center
- William Gonzalez, Jersey City Medical Center
- Kwaku Gyekye, Jersey City Medical Center
- Tina Harvey, Jersey City Medical Center
- Victoria Hayes, York Street Project

- Angelo Hunt, St. Lucy's Shelter
- Linda Ivory-Green, Jersey City Department of Health and Human Services
- Maryanne Kelleher, Jersey City Department of Health and Human Services
- Surendra Khera, MD, Jersey City Medical Center
- Kenneth King, Jersey City Medical Center
- Rita Knause, MD, North Hudson Community Action Corporation
- Jordan Kowalczewski, Barnabas Health Medical Group
- Theresa Laflam, Jersey City Medical Center
- Mabel Laforgia, Jersey City Medical Center
- Judy Lagani, Lincoln High School and Dickinson High School
- Maria Veronica Lavarro, Jersey City Medical Center
- Michael Loftus, Jersey City Medical Center
- Mike McLean, Jersey City Department of Health and Human Services
- Janet Merly-Liranzo, Peace Care St. Ann's
- Susan Milan, Garden State Episcopal Community Development Corporation
- Stephanie Mills, Hudson Pride
- Stacie Newton, Jersey City Medical Center
- Tri Nguyen, Jersey City Medical Center
- Michele O'Reilly, City of Bayonne - Health Division
- Maria Otadoy, Jersey City Medical Center
- Lashawn Overton, Jersey City Medical Center
- Grace Palmer, Jersey City Medical Center
- Alicia Parker, Hyacinth AIDS Foundation
- Leo Pellegrini, Health & Human Services of Hoboken
- Joan Quigley, North Hudson Community Action Corporation
- Tara Reid, Jersey City Medical Center
- Jeffery Rodriguez, Jersey City Medical Center
- Elizabeth Schedl, Hudson Pride
- Aniello Semioli, Jersey City Medical Center
- Jessica Semioli, Jersey City Medical Center
- Thomas Sheehy, Peace Care St. Joseph's
- Tina Siciliano, Jotham W. Wakeman School, PS #6
- Veronica Siringano, Jersey City Medical Center
- Iesha Suber, Jersey City Medical Center
- Eva Tawiah, Jersey City Medical Center
- Amanda Tobias, Jersey City Medical Center
- Vito Veneruso, North Hudson Community Action Corporation
- Yvonne Waller, Snyder Higher School
- Vanessa Watson-Hill, Jersey City Medical Center
- Ewelina Wojtaszek, Jersey City Medical Center
- Monica Younger, Jersey City Medical Center
- Joseph Zapata, Hudson Pride

Appendix B- Organizations Represented in Key Informant Interviews and Focus Groups

Organization	Sector
Jersey City Department of Health and Human Services	Local public health officials
City of Bayonne Health Division	Local public health officials
Hoboken Housing Authority	Local housing officials
Jersey City Public Schools	Local education officials
Metropolitan Family Health Network	Local healthcare administrators
Alliance Community Healthcare	Local healthcare administrators
North Hudson Community Action Corporation	Local healthcare administrators
Hudson Pride	LGBTQ+ social service providers
JCMC Community Outreach and Steering Committee	Health care and social services providers
Islamic Center of Jersey City/JCMC Chaplaincy	Faith-based leaders
Archdiocese of Newark/JCMC Chaplaincy	Faith-based leaders

Appendix C- Key Informant Interview Guide

Health Resources in Action JCMC/Hudson County Community Health Needs Assessment

Goals of the key informant interview

- To determine perceptions of the strengths and needs of the community served by JCMC/Hudson County, and identify sub-populations most affected
- To explore how these issues can be addressed in the future
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

[NOTE: THE QUESTIONS IN THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

I. BACKGROUND (5 MINUTES)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today.
- A few months ago, the JCMC/Hudson County coalition began undertaking a community health assessment effort to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these with a wide range of people - community members, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.
- We recognize this is a unique time we are in. Given the COVID-19 pandemic, an assessment of the community's needs and strengths is even more important than ever.
- Our interview will last about 45 – 60 minutes. After all the interview and focus group discussions are completed, we will be writing a summary report of the general themes that have emerged during these discussions. We will not include any names or identifying information in that report. All names and responses will remain confidential. Nothing sensitive that you say here will be connected directly to you in our report.

[Discuss permission to record, if relevant]

- Do you have any questions before we begin?

II. INTRODUCTION (5 MINUTES)

1. Can you tell me a bit about your organization/agency? [TAILOR PROBES DEPENDING ON AGENCY OR IF COMMUNITY LEADER NOT AFFILIATED WITH ORGANIZATION]

- a. [PROBE ON ORGANIZATION: What is your organization’s mission/services? What communities do you work in? Who are the main clients/audiences?]
 - i. What are some of the biggest challenges your organization faces in conducting your work in the community?
 - ii. How have these changed during COVID-19? What new challenges do you anticipate going forward?

III. COMMUNITY PERCEPTIONS AND SOCIAL/ECONOMIC FACTORS (10 MINUTES)

2. How would you describe the community served by your organization/ that you serve? (NOTE THAT WE ARE DEFINING COMMUNITY BROADLY – NOT NECESSARILY GEOGRAPHICALLY BASED)
 - a. What do you consider to be the community’s strongest assets/strengths?
 - b. How have you seen the community change over the last several years?
 - c. What are some of the community’s biggest concerns/issues in general? What challenges do residents face in their day-to-day lives? [PROBE IF NOT YET MENTIONED ON: transportation; affordable housing; discrimination; financial stress; food security; violence; employment; cultural understanding; language access; impacts of environmental problems and climate change, etc.] REPEAT QUESTIONS FOR DIFFERENT ISSUES]
 - i. What populations (geography, age, race, gender, income/education, veteran status, etc.) do you see as being most affected by these issues?
 - ii. How has [ISSUE] affected their daily lives?
 - iii. How have these issues changed during/since COVID-19?

[REPEAT SET OF QUESTIONS FOR TWO OR THREE ISSUES MENTIONED]

IV. HEALTH ISSUES (10 MINUTES)

3. What do you think are the most pressing health concerns in the community/among the residents you work with? Why? [PROBE ON SPECIFICSPROBE FOR HEALTH ISSUES NOT DIRECTLY RELATED TO COVID-19, OR ISSUES THAT HAVE CHANGED BECAUSE OF COVID-19, EG, CHRONIC DISEASE, HYPERTENSION, ETC.]
 - a. How has [HEALTH ISSUE] affected the residents you work with? [PROBE FOR DETAILS: IN WHAT WAY? CAN YOU PROVIDE SOME EXAMPLES?]
 - i. From your experience, what are peoples’ biggest challenges to addressing [THIS ISSUE]?
 - ii. To what extent, do you see [BARRIER] to addressing this issue among the residents you work with/your organization serves?

[PROBE ON BARRIERS BROUGHT UP/MOST APPROPRIATE FOR POPULATION GROUP:
Cost or economic hardship, transportation, stigma, attitudes towards seeking services,
built environment, availability/access to resources or services, knowledge of existing
resources/services, social support, discrimination, insurance coverage, language/cultural
barriers, etc.]

4. What are current or emerging trends that could have an impact on the public health system or the community? Has anything become apparent due to the Coronavirus pandemic?
5. How important is prevention in the community?
 - i. How easy is it to access preventive services in your community?
 - ii. What are some of the ways that you access care (Probes: at the hospital, clinical, community-based, telehealth)?
 - iii. Has anybody you or someone you know used telehealth to get care? How satisfied were you/them with the care received via telehealth?

V. *TAILORED SECTION* - SPECIFIC QUESTIONS ON PARTICULAR ISSUES, DEPENDING ON WHO THE INTERVIEWEE IS. SELECT QUESTIONS TAILORED TO INDIVIDUAL EXPERTISE AND ASK A FEW QUESTIONS IF NOT YET BROUGHT UP. (5-10 MINUTES)

For Interviewees Working in Housing and/or Transportation

- What barriers do you see residents experiencing around accessing affordable and healthy housing? How about with transportation?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- What has been working well in the community to improve access to healthy, affordable housing? How about related to transportation? What has been challenging or not working well? Where are there opportunities for improvement or innovation?

For Interviewees Working in Financial Instability, Employment, and Workforce Development

- What challenges are residents facing regarding hiring, employment, or job security?
- What were the needs in this community around workforce development? What is needed to improve residents' employability? What training or resources are needed?
- Are there any approaches to improving workforce development and financial stability that you think will have to change in light of the pandemic and its impacts?

For Interviewees Working with Communities where Discrimination is a Concern

- What are some of the specific challenges around discrimination that your communities face?
- What should health care and social service providers consider when treating health and other issues in diverse populations? How can institutions best respond to the needs of diverse groups? (e.g. religious, racial/ethnic, etc.)
- How has the pandemic and/or movements for racial justice impacted addressing issues and needs of diverse groups?

For Interviewees Working with Seniors/Older Adults

- What are some of the challenges seniors are facing in your community?
- Are there particular structural, institutional, or policy-related barriers that have affected seniors in your community?
- How has the pandemic and its effects impacted seniors and organizations serving older adults?
- What has been going “right” that could be built on going forward?

For Interviewees Working in the Areas of Substance Use or Mental Health

- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- How has the pandemic impacted community members regarding substance use and mental health?
*mention other KILs have brought up suicide in youth; isolation in older populations
- What are your major concerns for the future? What has been going “right” that could be built on going forward?

For Interviewees Working with Veterans

- What are some of the challenges veterans are facing in your community?
- Are there particular structural, institutional, or policy-related barriers that have affected veterans in your community?
- How has the pandemic and its effects impacted seniors and organizations serving veterans?
- Among the veterans, who have been the most affected by these issues (age, sex, race, etc.)
- What has been going “right” that could be built on going forward?

For Interviewees Working with Youth/Young Adults

- What are some of the challenges youths are facing in your community?
- What should health care and social service providers consider when treating health and other issues in youth populations? How can institutions best respond to the needs of younger individuals?
- How has the pandemic and its effects impacted youths and organizations serving younger individuals?
- What are your major concerns for the future? Do you have examples of programs or approaches that have been working well that could be built on going forward?

For Interviewees Working in Food Assistance and Food Security

- What barriers do you see residents experiencing around accessing affordable and healthy food?
- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?
- What has been working well in the community to improve access to healthy, affordable food?
- What has been challenging or not working well? What opportunities exist for improvement or innovation?

VI. VISION FOR THE FUTURE (10 MINUTES)

6. I’d like you to think ahead about the future of your community. When you think about the community 3 years from now, what would you like to see? What’s your vision?
 - a. What do you see as the next steps in helping this vision become reality?

- b. We talked about a number of strengths or assets in the community. [MENTION POTENTIAL STRENGTHS- Community resilience, diversity, number of organization/services available, community engagement, etc.] How can we build on or tap into these strengths to move us towards a healthier community?
7. As you think about your vision, what do you think needs to be in place to support sustainable change?
- a. How do we move forward with lasting change across organizations and systems?
 - b. How can we better serve/address the needs of the culturally diverse community of JC/Hudson County?
 - c. Where do you see yourself or your organization in this?
8. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive this funding?

VII. OTHER

9. We are also interested in finding out ways people receive news and current events. Thinking about the ways people might get information, where do you get news and information from? What about ways you prefer to search for news and information – (television, radio, print, smartphone, computer or tablet).

VIII. CLOSING (5 MINUTES)

Thank you so much for your time and sharing your opinions. Your perspectives about the communities you work with will be a great help in determining how to improve the systems that affect the health of this population. Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier?

Thank you again. Your feedback is valuable, and we greatly appreciate your time and for sharing your opinion.

Appendix D- Focus Group Guide

Health Resources in Action JCMC/Hudson County Community Health Needs Assessment

Goals of the focus group:

- To determine perceptions of the strengths and needs of the community
- To understand residents' current experiences and challenges
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

I. BACKGROUND (5-10 minutes)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your families are fine during these uncertain times.
- This discussion will last about 60 minutes. [DEPENDING ON FORMAT OF FOCUS GROUP] Please turn on your video, if possible, so that we can all see each other speaking. As a reminder, please keep yourself on MUTE until you want to speak.

NORMALLY, WE WOULD BE DOING THIS IN-PERSON.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.
- A few months ago, JCMC/Hudson County began a community health assessment to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these with a wide range of people - community members, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.
- We recognize this is a unique time we have been in. Given the COVID-19 pandemic, an assessment of the community's needs and strengths is even more important than ever.
- After discussions with several groups are done, we will be writing a report summarizing what has come up. In that report, we might provide some general information on what we discussed tonight, but we will not include any names or identifying information. Your responses will be strictly confidential. In the report, nothing you say here will be connected to your name.
- [NOTE IF AUDIORECORDING] We plan to audio record these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the notetaking. No

one but the analysts at Health Resources in Action, who are writing the report, will be listening to the audio recordings. Does anyone have any concerns with me turning the recorder on now?

- Any questions before we begin our introductions and discussion?

II. INTRODUCTIONS (5 minutes)

Now, first let's spend a little time getting to know one another. When I call your name, please unmute yourself and tell us: 1) Your first name; 2) what city or town you live in; and 3) something about yourself you'd like to share— such as how many children you have or what activities you like to do for fun. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY ASSETS AND CONCERNS (20 minutes)

For the following questions, we will be discussing the strengths and concerns in your community.

1. If someone was thinking about moving into your community, what would you say are some of your community's biggest strengths? What are the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]
 - a. How have these strengths changed during COVID-19?
2. To contrast that, what are some of the biggest problems or concerns in your community? How have these concerns changed during COVID-19? [PROBE ON ISSUES IF NEEDED – TRANSPORTATION, HOUSING AFFORDABILITY, ECONOMIC SECURITY, HEALTH CONCERNS, ETC.]
 - a. Just thinking about day-to-day life –working, getting your kids to school, things like that – what are some of the challenges or struggles you deal with on a day-to-day basis? [PROBE ON ISSUES IF NEEDED – TRANSPORTATION, HOUSING AFFORDABILITY, ECONOMIC SECURITY, HEALTH CONCERNS, VIOLENCE, ETC.]
 - b. How have these changed during COVID-19?
 - c. What specific population groups do you think have been most at-risk for/affected by these issues in your community?
3. In the past year, there has been more national dialogue around racial injustice, inequity, and structural racism. How has this dialogue played out in JC/Hudson County? How have issues of inequity played out in the community?
 - a. How can different community organizations effectively contribute to the ongoing conversation and movement for racial justice?
4. What do you think are the most pressing health concerns in your community?
 - a. Who is most at-risk for/have been most affected by these issues?
5. Thinking about health and wellness, what makes it easier to be healthy in your community?

- a. What supports your health and wellness?
- b. What makes it easy to access care?
- c. What makes it harder to be healthy in your community?
 - i. How easy is it to access preventive services in your community?
 - ii. What are some of the ways that you access care (Probes: at the hospital, clinical, community-based, telehealth)?
 - iii. Has anybody you or someone you know used telehealth to get care? How satisfied were you/them with the care received via telehealth?

IV. PERCEPTIONS OF COMMUNITY NEEDS, BARRIERS, AND OPPORTUNITIES (15 minutes)

What are the top three issues of concern that have been mentioned? [MODERATOR TO NAME THE MAJOR 3-4 ISSUES – HEALTH, TRANSPORTATION, SOCIAL, ECONOMIC, VIOLENCE, ETC. --THAT HAVE COME UP SO FAR.] Let’s talk about some of the issues.

- 6. Do you agree with this list as the major concerns/issues in your community? Is there a major issue that is missing?
- 7. Let’s talk about [ISSUE]. (*Moderator to select one major issue discussed.*) What are some of the barriers or challenges residents face in dealing with [ISSUE]? [PROBE: BARRIERS TO SERVICES, ASSISTANCE, COORDINATION, SOCIAL/ECONOMIC FACTORS, DISCRIMINATION, SAFETY, ETC.]
 - a. Thinking about your larger community environment – the services and resources available, your state and local policies or practices, etc. -- what do you see as some of the biggest challenges for your community to tackle this issue or make improvements?
 - b. What do you think should happen in the community to address this issue? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

[REPEAT Q6 FOR 1-2 OTHER MAJOR ISSUES THAT WERE DISCUSSED]

V. VISION OF COMMUNITY HEALTH IMPROVEMENT AND INVOLVEMENT (10 minutes)

- 8. I’d like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see? What is your vision for the future?
 - a. What do you think needs to happen in the community to make this vision a reality?
 - b. Who should be involved in this effort? What should be Jersey City Medical Center’s role in making this happen?
 - c. What should be the role of a community coalition that brings together multiple groups?
- 9. We talked about a lot of things today. Thinking about what would make the most impact, who is most affected by the different issues we talked about, and how realistic it is to make change: What

do you think are the most important areas of action to improve health in your community? If organizations and agencies are going to work together to tackle the community's biggest issues, what should they put at the top of the list as things to do?

VI. CLOSING (2 minutes)

Thank you so much for your time. This is a very difficult time for everyone, and your perspective will be a great help in determining how to improve the systems that affect your community.

That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon. [TALK ABOUT NEXT STEPS OF THE PROCESS, SPECIFICALLY HOW PARTICIPANTS CAN GET INVOLVED FURTHER OR RECEIVE THE FINAL REPORT OR SUMMARY OF THE REPORT.]

Appendix E- Resource Inventory

Health Resources for Hudson County

Part 1: Acute, Long Term and Medical Ambulatory Services

Acute, Long Term Care and Medical Ambulatory Services

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
ADULT DAY HEALTH CARE SERVICES	408111	2nd Home Union City, LLC	3610 PALISADES AVENUE	UNION CITY	NJ	07087	HUDSON	(201) 864-0400	(201) 864-6833	2ND HOME UNION CITY OPERATIONS, LLC
ADULT DAY HEALTH CARE SERVICES	D6OGUT	ACTIVE DAY AT CASA MANITO	324 55TH STREET	WEST NEW YORK	NJ	07093	HUDSON	(201) 223-6800	(201) 223-6885	SENIOR CARE CENTERS OF AMERICA, INC.
ADULT DAY HEALTH CARE SERVICES	L9N0H7	ACTIVE DAY OF NORTH BERGEN	6201 GRAND AVENUE	NORTH BERGEN	NJ	07047	HUDSON	(201) 869-4443	(201) 869-0814	SENIOR CARE CENTERS OF AMERICA, INC.
ADULT DAY HEALTH CARE SERVICES	408112	AdultCare Adult Day Care	1607 MANHATTAN AVENUE	UNION CITY	NJ	07087	HUDSON	(201) 864-5400	(201) 864-1512	ADULTCARE, INC.
ADULT DAY HEALTH CARE SERVICES	408200	Advanced Services International Day Care Plus	49-51 MORTON PLACE	JERSEY CITY	NJ	07305	HUDSON	(201) 209-0001	(201) 209-1333	ADVANCED SERVICES INTERNATIONAL, INC.
ADULT DAY HEALTH CARE SERVICES	408212	Bayonne Adult Medical Day Care Center	801-803 BROADWAY	BAYONNE	NJ	07002	HUDSON	(201) 243-0035	(201) 243-0036	BAYONNE ADULT MEDICAL DAY CARE CORP. OF BAYONNE
ADULT DAY HEALTH CARE SERVICES	09010	Care With Love Adult Day Care Center	953 GARFIELD AVENUE	JERSEY CITY	NJ	07304	HUDSON	(201) 333-8883	(201) 333-8897	CARE WITH LOVE ADULT DAYCARE CENTER, INC
ADULT DAY HEALTH CARE SERVICES	408110	Happy Days 3 Adult Healthcare Center, L.L.C.	591 MONTGOMERY STREET	JERSEY CITY	NJ	07302	HUDSON	(201) 938-0300		HD HEALTHCARE SERVICES
ADULT DAY HEALTH CARE SERVICES	09001	Mi Casa Es Su Casa II, Inc	6120 BUCHANAN PLACE (PO BOX 4074)	WEST NEW YORK	NJ	07093	HUDSON	(201) 537-2211	(201) 537-2209	MI CASA ES SU CASA II, INC.
ADULT DAY HEALTH CARE SERVICES	408331	Senior Spirit Of Jersey City	675 GARFIELD AVENUE	JERSEY CITY	NJ	07305	HUDSON	(201) 761-0280	(201) 761-0290	FAMILY SENIOR HEALTH, LLC
ADULT DAY HEALTH CARE SERVICES	408330	St. Ann's Home for the Aged	198 OLD BERGEN ROAD	JERSEY CITY	NJ	07305	HUDSON	(201) 433-0950	(201) 433-6554	ST. ANN'S HOME FOR THE AGED
ADULT DAY HEALTH CARE SERVICES	408210	Sunflower Medical Adult Day Care	300 BROADWAY	BAYONNE	NJ	07002	HUDSON	(201) 243-0666	(201) 243-1836	METROPOLITAN LIFE CARE CORP
AMBULATORY CARE FACILITY	23345	60TH STREET MRI	6001 MONROE PLACE	WEST NEW YORK	NJ	07093	HUDSON	(201) 854-1200	(201) 854-3333	RICARDO T. BALDONADO, M.D.
AMBULATORY CARE FACILITY	22788	ADVANCED MAGNETIC IMAGING ASSOCIATES, P.A.	6410-6416 BERGENLINE AVENUE	WEST NEW YORK	NJ	07093	HUDSON	(201) 295-1099	(201) 295-1035	AHSAN ZAFAR, M.D.
AMBULATORY CARE FACILITY	24803	ADVANCED OPEN MRI OF WEST HUDSON	723 ELM STREET	KEARNY	NJ	07032	HUDSON	(201) 997-7300	(201) 997-2709	SKS HEALTHCARE LLC
AMBULATORY CARE FACILITY	25055	AGILE URGENT CARE	20 MEADOWLANDS PARKWAY	SECAUCUS	NJ	07094	HUDSON	(201) 381-4800	(201) 381-4700	AGILE URGENT CARE OF SECAUCUS, LLC
AMBULATORY CARE FACILITY	25172	ALLIANCE COMMUNITY HEALTHCARE	115 CHRISTOPHER COLUMBUS DRIVE	JERSEY CITY	NJ	07302	HUDSON	(201) 451-6300	(201) 451-8300	HORIZON HEALTH CENTER

Acute, Long Term Care and Medical Ambulatory Services

AMBULATORY CARE FACILITY	23058	BERGENLINE X-RAY DIAGNOSTIC CENTER, CORP	400-02 43RD STREET	UNION CITY	NJ	07087	HUDSON	(201) 348-6060	(201) 348-2064	BERGENLINE X-RAY DIAGNOSTIC CENTER, CORP
AMBULATORY CARE FACILITY	23347	CITY RADIOLOGY, LLC	657 BROADWAY	BAYONNE	NJ	07002	HUDSON	(201) 822-2235	(201) 437-1418	HUDSON RADIOLOGY CENTER OF NJ
AMBULATORY CARE FACILITY	70991	HOBOKEN FAMILY PLANNING, INC.	124 GRAND STREET	HOBOKEN	NJ	07030	HUDSON	(201) 963-0300	(201) 963-0303	HOBOKEN FAMILY PLANNING, INC
AMBULATORY CARE FACILITY	80320	HUDSON MRI, P.A.	2811 KENNEDY BOULEVARD	NORTH BERGEN	NJ	07047	HUDSON	(201) 659-1177	(201) 659-2262	HUDSON MRI, PA
AMBULATORY CARE FACILITY	22912	HUDSON RIVER RADIOLOGY	550 NEWARK AVENUE, UNIT 102	JERSEY CITY	NJ	07306	HUDSON	(201) 239-1250	(201) 484-8807	HUDSON RIVER RADIOLOGY CENTER LLC
AMBULATORY CARE FACILITY	22559	HUDSON RIVER RADIOLOGY	547 SUMMIT AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 656-5050	(201) 484-8807	HUDSON RIVER RADIOLOGY CENTER LLC
AMBULATORY CARE FACILITY	23951	HUDSON RIVER RADIOLOGY CENTER	120-152 48TH STREET	UNION CITY	NJ	07087	HUDSON	(201) 665-8707	(800) 706-0381	HUDSON RIVER RADIOLOGY CENTER LLC
AMBULATORY CARE FACILITY	24767	JERSEY ADVANCED MRI & DIAGNOSTIC CENTER	2127 KENNEDY BOULEVARD	NORTH BERGEN	NJ	07047	HUDSON	(201) 552-9464	(201) 552-9467	JERSEY ADVANCED MRI AND DIAGNOSTIC CENTER
AMBULATORY CARE FACILITY	24478	JERSEY CITY DIAGNOSTIC CENTER	2300 KENNEDY BOULEVARD	JERSEY CITY	NJ	07304	HUDSON	(201) 432-2100	(201) 432-1900	JERSEY CITY DIAGNOSTIC CENTER
AMBULATORY CARE FACILITY	24396	LUTHERAN SENIOR LIFE AT JERSEY CITY	377 JERSEY AVENUE, SUITE 310	JERSEY CITY	NJ	07302	HUDSON	(201) 706-2091	(201) 706-2092	LUTHERAN SOCIAL MINISTRIES OF NEW JERSEY
AMBULATORY CARE FACILITY	23188	MONTCLAIR RADIOLOGICAL ASSOCIATES, P.A.	79 HUDSON STREET, SUITE 100	HOBOKEN	NJ	07030	HUDSON	(973) 661-4674	(973) 284-0956	MONTCLAIR RADIOLOGICAL ASSOCIATES, P.A.
AMBULATORY CARE FACILITY	25067	MONTCLAIR RADIOLOGICAL ASSOCIATES, PA	550 SUMMIT AVENUE	JERSEY CITY	NJ	07306	HUDSON	(973) 284-0038	(973) 778-6203	MONTCLAIR RADIOLOGICAL ASSOCIATES, PA
AMBULATORY CARE FACILITY	24830	NHCAC HARRISON HEALTH CENTER	326 HARRISON AVENUE	HARRISON	NJ	07029	HUDSON	(201) 941-3040		NORTH HUDSON COMMUNITY ACTION CORPORATION
AMBULATORY CARE FACILITY	25051	NJIN OF BAYONNE	519 BROADWAY, SUITE 155	BAYONNE	NJ	07002	HUDSON	(201) 608-6250	(201) 608-6260	NEW JERSEY IMAGING NETWORKS, LLC
AMBULATORY CARE FACILITY	25165	NJIN OF JERSEY CITY	600 PAVONIA AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 630-0316	(973) 875-5230	THE NEW JERSEY IMAGING NETWORK LLC
AMBULATORY CARE FACILITY	22927	NJIN OF UNION CITY	3196 KENNEDY BOULEVARD	UNION CITY	NJ	07087	HUDSON	(201) 865-6100	(201) 865-6102	THE NEW JERSEY IMAGING NETWORK LLC
AMBULATORY CARE FACILITY	25008	PAIN AND DISABILITY INSTITUTE, P.C.	193 PALISADE AVENUE, BASEMENT	JERSEY CITY	NJ	07306	HUDSON	(201) 656-4324	(201) 656-4019	PAIN AND DISABILITY INSTITUTE, P.C.

Acute, Long Term Care and Medical Ambulatory Services

AMBULATORY CARE FACILITY	80305	PARKSIDE MEDICAL CENTER	127 LAFAYETTE STREET	JERSEY CITY	NJ	07304	HUDSON	(201) 434-1111	(201) 432-0192	KHALEIDOSCOPE HEALTH CARE, INC
AMBULATORY CARE FACILITY	25203	SKR MEDICAL ADVISORS, LLC	2100 88TH STREET, BUILDING G	NORTH BERGEN	NJ	07047	HUDSON	(201) 588-1300		SKR MEDICAL ADVISORS, LLC
AMBULATORY CARE FACILITY	25140	URGENT MEDICAL CARE AND MRI, LLC	3540 JOHN F KENNEDY BOULEVARD	JERSEY CITY	NJ	07307	HUDSON	(201) 333-2221		URGENT MEDICAL CENTER AND MRI, LLC
AMBULATORY CARE FACILITY	70992	WEST NEW YORK FAMILY PLANNING CENTER	5305 HUDSON AVENUE	WEST NEW YORK	NJ	07093	HUDSON	(201) 866-8071	(201) 866-3807	HOBOKEN FAMILY PLANNING, INC
AMBULATORY CARE FACILITY - SATELLITE	22863	HOBOKEN FAMILY PLANNING SUMMIT CENTER	1206 SUMMIT AVENUE	UNION CITY	NJ	07087	HUDSON	(201) 319-9200	(201) 319-9121	HOBOKEN FAMILY PLANNING, INC
AMBULATORY CARE FACILITY - SATELLITE	24360	NHCAC HEALTH CENTER AT UNION CITY HIGH SCHOOL	2500 KENNEDY BOULEVARD	UNION CITY	NJ	07087	HUDSON	(201) 553-7888	(201) 553-7886	NORTH HUDSON COMMUNITY ACTION CORPORATION
AMBULATORY CARE FACILITY - SATELLITE	24107	NORTH HUDSON CAC MOBILE HEALTH VAN	5301 BROADWAY	WEST NEW YORK	NJ	07093	HUDSON	(201) 583-6822	(201) 330-3803	NORTH HUDSON COMMUNITY ACTION CORPORATION
AMBULATORY SURGICAL CENTER	23180	AMBULATORY CENTER FOR ENDOSCOPY, LLC	9226 KENNEDY BOULEVARD, UNIT A	NORTH BERGEN	NJ	07047	HUDSON	(201) 295-0900	(201) 869-9501	AMBULATORY CENTER FOR ENDOSCOPY LLC
AMBULATORY SURGICAL CENTER	24067	AMBULATORY CENTER FOR ENDOSCOPY, LLC	7600 RIVER ROAD, 4TH FLOOR	NORTH BERGEN	NJ	07047	HUDSON	(201) 705-1080	(201) 705-1090	AMBULATORY CENTER FOR ENDOSCOPY LLC
AMBULATORY SURGICAL CENTER	R24621	AMBULATORY PAIN AND DISABILITY MANAGEMENT CENTER	191 PALISADE AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 656-4324	(201) 656-4019	AMBULATORY PAIN & DISABILITY MANAGEMENT CENTER LLC
AMBULATORY SURGICAL CENTER	24224	CENTER FOR MODERN SURGERY, LLC	210 MEADOWLAND PARKWAY # 5	SECAUCUS	NJ	07094	HUDSON	(201) 330-9090	(201) 330-9092	42 SERVICES, LLC
AMBULATORY SURGICAL CENTER	24351	HARRISON ENDO SURGICAL CENTER, L.L.C.	620 ESSEX STREET	HARRISON	NJ	07029	HUDSON	(973) 474-1040	(973) 474-1030	HARRISON ENDO SURGICAL CENTER, L.L.C.
AMBULATORY SURGICAL CENTER	R24650	PAVONIA SURGICAL CENTER, LLC	600 PAVONIA AVENUE, STE 4	JERSEY CITY	NJ	07306	HUDSON	(201) 216-1700	(201) 216-1800	PAVONIA SURGERY CENTER, PA
AMBULATORY SURGICAL CENTER	24362	SURGICARE SURGICAL ASSOCIATES OF JERSEY CITY	631-645 GRAND STREET	JERSEY CITY	NJ	07304	HUDSON	(201) 830-2280	(201) 599-8338	SURGICARE SURGICAL ASSOCIATES OF JERSEY CITY LLC

Acute, Long Term Care and Medical Ambulatory Services

AMBULATORY SURGICAL CENTER	80193	SURGICORE OF JERSEY CITY, LLC	550 NEWARK AVENUE, 5TH FLOOR	JERSEY CITY	NJ	07306	HUDSON	(201) 795-0205	(201) 795-0737	SURGICORE OF JERSEY CITY, LLC
ASSISTED LIVING RESIDENCE	7U0NFD	Alaris Health at The Atrium	330 NINTH STREET	JERSEY CITY	NJ	07302	HUDSON	(201) 716-8000	(201) 716-8005	HAMILTON PARK ATRIUM OPCO, LLC
COMPREHENSIVE OUTPATIENT REHAB	22872	THERAPRO-CORF, L.L.C.	9225 KENNEDY BOULEVARD	NORTH BERGEN	NJ	07047	HUDSON	(201) 869-2707	(201) 869-2717	THERAPRO-CORF, L.L.C.
COMPREHENSIVE OUTPATIENT REHAB	22936	THERAPRO-CORF, L.L.C.	600 PAVONIA AVENUE - 7TH FLOOR	JERSEY CITY	NJ	07306	HUDSON	(201) 418-0088	(201) 418-9420	THERAPRO-CORF, L.L.C.
COMPREHENSIVE PERSONAL CARE HOME	403330	HUDSON HILLS SENIOR LIVING, LLC	3161 KENNEY BOULEVARD	NORTH BERGEN	NJ	07047	HUDSON	(201) 867-3585	(201) 758-5013	HUDSON HILLS SENIOR LIVING, LLC
END STAGE RENAL DIALYSIS	23196	ALARIS HEALTH DIALYSIS AT HAMILTON PARK	328 NINTH STREET	JERSEY CITY	NJ	07302	HUDSON	(201) 516-7700	(201) 716-7711	HAMILTON PARK DIALYSIS OPCO LLC
END STAGE RENAL DIALYSIS	22816	BAYONNE RENAL CENTER	434-436 BROADWAY - PO BOX169	BAYONNE	NJ	07002	HUDSON	(201) 436-1644	(201) 436-5133	BAYONNE RENAL CENTER, LLC
END STAGE RENAL DIALYSIS	42303	BIO-MEDICAL APPLICATIONS OF HOBOKEN	1600 WILLOW AVENUE	HOBOKEN	NJ	07030	HUDSON	(201) 656-7500	(201) 656-7552	FRESENIUS MEDICAL CARE HOBOKEN, LLC
END STAGE RENAL DIALYSIS	40901	BIO-MEDICAL APPLICATIONS OF JERSEY CITY	107-123 PACIFIC AVENUE	JERSEY CITY	NJ	07304	HUDSON	(201) 451-3760	(201) 451-2863	FRESENIUS MEDICAL CARE JERSEY CITY, LLC
END STAGE RENAL DIALYSIS	24873	DIALYSIS PALISADES MEDICAL CENTER	7650 RIVER ROAD, SUITE 150	NORTH BERGEN	NJ	07047	HUDSON	(201) 861-1031	(201) 758-2794	NORTE DIALYSIS, L.L.C.
END STAGE RENAL DIALYSIS	25092	FRESENIUS KIDNEY CARE BAYONNE	29 E 29TH STREET	BAYONNE	NJ	07002	HUDSON	(201) 858-5358	(201) 858-5206	FRESENIUS MEDICAL CARE BAYONNE, LLC
END STAGE RENAL DIALYSIS	25058	FRESENIUS KIDNEY CARE OF SECAUCUS	200 MEADOWLANDS PARKWAY	SECAUCUS	NJ	07094	HUDSON	(201) 865-6145	(201) 262-0604	FRESENIUS MEDICAL CARE SECAUCUS, LLC
END STAGE RENAL DIALYSIS	24771	FRESENIUS MEDICAL CARE NORTH JERSEY CITY	29 COTTAGE STREET	JERSEY CITY	NJ	07306	HUDSON	(201) 876-7964	(201) 876-7965	FRESENIUS MEDICAL CARE JERSEY CITY, LLC
END STAGE RENAL DIALYSIS	24831	FRESENIUS MEDICAL CARE UNION CITY HOME, L.L.C.	3196 KENNEDY BOULEVARD	UNION CITY	NJ	07087	HUDSON	(201) 601-4702	(201) 864-3167	HUDSON HOME THERAPIES
END STAGE RENAL DIALYSIS	22515	FRESENIUS MEDICAL CARE UNION HILL	508 31ST STREET	UNION CITY	NJ	07087	HUDSON	(201) 902-9382	(201) 902-0661	BIO-MEDICAL APPLICATIONS OF NEW JERSEY, INC.
END STAGE RENAL DIALYSIS	22532	JERSEY CITY DIALYSIS	1310 5TH STREET	NORTH BERGEN	NJ	07047	HUDSON	(201) 770-9220	(201) 770-9225	TOTAL RENAL CARE, INC.

Acute, Long Term Care and Medical Ambulatory Services

END STAGE RENAL DIALYSIS	24893	JERSEY CITY GRAND HOME DIALYSIS	422 GRAND STREET	JERSEY CITY	NJ	07302	HUDSON	(201) 332-6413	(201) 536-8093	PERSHING DIALYSIS, L.L.C.
END STAGE RENAL DIALYSIS	24980	JERSEY CITY SUMMIT DIALYSIS	414 SUMMIT AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 420-8431	(201) 459-0967	HAWN DIALYSIS, L.L.C.
END STAGE RENAL DIALYSIS	22862	RENEX DIALYSIS CLINIC OF HARRISON	620 ESSEX STREET	HARRISON	NJ	07029	HUDSON	(973) 482-7772	(973) 482-0102	NNA OF HARRISON
FEDERALLY QUALIFIED HEALTH CENTERS	22657	ALLIANCE COMMUNITY HEALTHCARE, INC	714 BERGEN AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 451-6300	(201) 451-0619	HORIZON HEALTH CENTER
FEDERALLY QUALIFIED HEALTH CENTERS	22956	ALLIANCE COMMUNITY HEALTHCARE, INC	115 CHRISTOPHER COLUMBUS DRIVE	JERSEY CITY	NJ	07302	HUDSON	(201) 451-6300	(201) 451-0619	HORIZON HEALTH CENTER
FEDERALLY QUALIFIED HEALTH CENTERS	24249	BERGEN AVENUE HEALTH CENTER	857 BERGEN AVENUE	JERSEY CITY	NJ	07305	HUDSON	(201) 478-5829	(201) 478-5814	METROPOLITAN FAMILY HEALTH NETWORK
FEDERALLY QUALIFIED HEALTH CENTERS	24088	METROPOLITAN FAMILY HEALTH NETWORK, INC	5300 BERGENLINE AVENUE	WEST NEW YORK	NJ	07093	HUDSON	(201) 478-5800	(201) 478-5814	METROPOLITAN FAMILY HEALTH NETWORK
FEDERALLY QUALIFIED HEALTH CENTERS	24089	METROPOLITAN FAMILY HEALTH NETWORK, INC	935 GARFIELD AVENUE	JERSEY CITY	NJ	07304	HUDSON	(201) 478-5877	(201) 478-5814	METROPOLITAN FAMILY HEALTH NETWORK
FEDERALLY QUALIFIED HEALTH CENTERS	82450	NORTH HUDSON CAC HEALTH CENTER AT JERSEY CITY	324 PALISADES AVENUE	JERSEY CITY	NJ	07304	HUDSON	(201) 459-8888	(201) 239-0318	NORTH HUDSON COMMUNITY ACTION CORPORATION
FEDERALLY QUALIFIED HEALTH CENTERS	22387	NORTH HUDSON CAC HEALTH CENTER AT NORTH BERGEN	1116 43RD STREET	NORTH BERGEN	NJ	07047	HUDSON	(201) 583-6822	(201) 392-8090	NORTH HUDSON COMMUNITY ACTION CORPORATION
FEDERALLY QUALIFIED HEALTH CENTERS	22448	NORTH HUDSON CAC HEALTH CENTER AT UNION CITY	714-31 STREET	UNION CITY	NJ	07087	HUDSON	(201) 863-7077	(201) 863-2508	NORTH HUDSON COMMUNITY ACTION CORPORATION
FEDERALLY QUALIFIED HEALTH CENTERS	70974	NORTH HUDSON CAC HEALTH CENTER AT WEST NEW YORK	5301 BROADWAY	WEST NEW YORK	NJ	07093	HUDSON	(201) 866-9320	(201) 223-0306	NORTH HUDSON COMMUNITY ACTION CORPORATION
GENERAL ACUTE CARE HOSPITAL	10902	CAREPOINT HEALTH-CHRIST HOSPITAL	176 PALISADE AVE	JERSEY CITY	NJ	07306	HUDSON	(201) 795-8200	(201) 795-8796	HUDSON HOSPITAL OPCO, LLC
GENERAL ACUTE CARE HOSPITAL	10905	HMH HOSPITALS CORPORATION	7600 RIVER RD	NORTH BERGEN	NJ	07047	HUDSON	(201) 854-5004	(201) 854-5036	HMH HOSPITALS CORPORATION

Acute, Long Term Care and Medical Ambulatory Services

GENERAL ACUTE CARE HOSPITAL	10906	HUDSON REGIONAL HOSPITAL	55 MEADOWLANDS PKWY	SECAUCUS	NJ	07094	HUDSON	(201) 392-3200	(201) 392-3527	NJMHMC, LLC
GENERAL ACUTE CARE HOSPITAL	10908	HUMC OPCO, LLC	308 WILLOW AVE	HOBOKEN	NJ	07030	HUDSON	(201) 418-1000	(201) 418-1011	HUMC OPCO, L.L.C.
GENERAL ACUTE CARE HOSPITAL	10901	IJKG OPCO, L.L.C.	29 EAST 29TH ST	BAYONNE	NJ	07002	HUDSON	(201) 858-5000	(201) 858-7355	IJKG OPCO, L.L.C.
GENERAL ACUTE CARE HOSPITAL	10904	JERSEY CITY MEDICAL CENTER	355 GRAND STREET	JERSEY CITY	NJ	07302	HUDSON	(201) 915-2000	(201) 915-2029	JERSEY CITY MEDICAL CENTER
HOME HEALTH AGENCY	22363	BAYADA HOME HEALTH CARE, INC.	299 GRAND STREET	JERSEY CITY	NJ	07302	HUDSON	(201) 377-6000	(201) 377-6083	BAYADA HOME HEALTH CARE, INC.
HOME HEALTH AGENCY	70901	BAYONNE VISITING NURSE ASSOCIATION	120 LEFANTE WAY, SOUTH COVE COMMONS SHOPPING CTR	BAYONNE	NJ	07002	HUDSON	(201) 339-2500	(201) 339-1255	PATIENT CARE OF HUDSON COUNTY, L.L.C.
HOME HEALTH AGENCY	70905	PROMISE CARE, NJ	2 JEFFERSON AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 418-6800	(201) 418-6817	PROMISE CARE OF HUDSON COUNTY, LLC
HOSPICE CARE PROGRAM	24815	BAYADA HOME HEALTH CARE INC	5901 WEST SIDE AVENUE, SUITE 502A	NORTH BERGEN	NJ	07047	HUDSON	(201) 630-2158	(201) 516-6033	BAYADA HOME HEALTH CARE, INC.
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1487	BREAST CENTER AT PALISADES MEDICAL CENTER	7650 RIVER ROAD, SUITE 240	NORTH BERGEN	NJ	07047	HUDSON	(201) 295-4800		HMH HOSPITALS CORPORATION
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1447	CAREPOINT HEALTH CHRIST HOSPITAL MOBILE VAN	176 PALISADE AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 795-8200	(201) 795-8796	CHRIST HOSPITAL
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1320	CAREPOINT HEALTH-CHRIST HOSPITAL IMAGING CENTER	142 PALISADE AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 795-8401	(201) 795-0874	HUDSON HOSPITAL OPCO, LLC
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1502	CHILDREN'S SPECIALIZED OUTPATIENT CENTER JERSEY CITY	1825 JFK BOULEVARD	JERSEY CITY	NJ	07305	HUDSON	(609) 222-2222		CHILDREN'S SPECIALIZED HOSPITAL
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1458	CHRIST HOSPITAL NEIGHBORHOOD HEALTH CLINIC- UNION CITY	1901 WEST STREET	UNION CITY	NJ	07087	HUDSON	(201) 795-8405	(201) 795-8796	CHRIST HOSPITAL
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1494	JCMC RADIATION ONCOLOGY	631 GRAND STREET	JERSEY CITY	NJ	07303	HUDSON	(201) 942-3999	(201) 942-3998	JERSEY CITY MEDICAL CENTER

Acute, Long Term Care and Medical Ambulatory Services

HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1336	JCMC WOMEN'S HEALTH AND MATERNAL FETAL MEDICINE CENTER	116 NEWARK AVENUE, 3RD FLOOR	JERSEY CITY	NJ	07302	HUDSON	(201) 915-2000	(201) 915-2029	JERSEY CITY MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1482	JERSEY CITY MEDICAL CENTER AMBULATORY SURGERY CENTER	377 JERSEY AVENUE, SUITE 510	JERSEY CITY	NJ	07302	HUDSON	(201) 878-3200	(201) 915-2029	JERSEY CITY MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1124	JERSEY CITY MEDICAL CENTER AT GREENVILLE	1825 KENNEDY BLVD, GREENVILLE MED ARTS COMPLEX	JERSEY CITY	NJ	07304	HUDSON	(201) 946-6460	(201) 946-6489	JERSEY CITY MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1491	JERSEY CITY MEDICAL CENTER SLEEP CENTER	333 GRAND STREET	JERSEY CITY	NJ	07302	HUDSON	(201) 915-2029		JERSEY CITY MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1486	JERSEY CITY MEDICAL CENTER SPECIALITY CARE CENTER	414 GRAND STREET, SUITE 14	JERSEY CITY	NJ	07302	HUDSON	(201) 915-2000	(201) 915-2029	JERSEY CITY MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1121	JERSEY CITY MEDICAL CENTER- AMBULATORY CARE CENTER	395 GRAND STREET	JERSEY CITY	NJ	07302	HUDSON	(201) 521-5922	(201) 915-2029	JERSEY CITY MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1122	JERSEY CITY MEDICAL CENTER- JERSEY CITY FAMILY HEALTH CENTER	418 SUMMIT AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 432-4600	(201) 915-2029	JERSEY CITY MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1464	JERSEY CITY MEDICAL SATELLITE EMERGENCY DEPARTMENT	519 BROADWAY, SUITE 100	BAYONNE	NJ	07002	HUDSON	(201) 915-2000	(201) 915-2029	JERSEY CITY MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1274	LIBERTY HEALTH IMAGING CENTER	377 SKINNER MEMORIAL DRIVE	JERSEY CITY	NJ	07302	HUDSON	(201) 915-2696	(201) 915-2029	JERSEY CITY MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1156	NEIGHBORHOOD HEALTH CENTER OF HOBOKEN UNIVERSITY MEDICAL CENTER	122-132 CLINTON STREET	HOBOKEN	NJ	07030	HUDSON	(201) 418-1000	(201) 428-1011	HUMC OPCO, L.L.C.

Acute, Long Term Care and Medical Ambulatory Services

HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1442	SLEEP/WAKE CENTER AT PALISADES MEDICAL CENTER	7600 RIVER ROAD	NORTH BERGEN	NJ	07047	HUDSON	(201) 854-5412	(201) 861-7952	HMH HOSPITALS CORPORATION
HOSPITAL-BASED, OFF-SITE AMBULATORY SURGICAL CTR	1361	NEWARK BETH ISRAEL PHYSICIANS SPECIALTY PRACTICE BAYONNE	16 EAST 29TH STREET	BAYONNE	NJ	07002	HUDSON	(973) 926-6696	(201) 858-0874	NEWARK BETH ISRAEL MEDICAL CENTER
LONG TERM CARE FACILITY	060909	Newport Garden Group, LLC	198 STEVENS AVE	JERSEY CITY	NJ	07305	HUDSON	(201) 451-9000	(201) 451-0609	NEWPORT GARDEN GROUP LLC
LONG TERM CARE FACILITY	NJ11952	Alaris Health at Belgrove	195 BELGROVE DRIVE	KEARNY	NJ	07032	HUDSON	(973) 844-4800	(973) 844-4899	SUB ACUTE REHABILITATION CENTER AT KEARNY, LLC
LONG TERM CARE FACILITY	060910	Caslte Healthcare Providers LLC	615 23RD STREET	UNION CITY	NJ	07087	HUDSON	(201) 348-0818	(201) 348-0783	CASTLE HILL HEALTHCARE PROVIDERS, LLC
LONG TERM CARE FACILITY	060906	Alaris Health at Hamilton Park	525 MONMOUTH STREET	JERSEY CITY	NJ	07302	HUDSON	(201) 653-8800	(201) 653-3074	HAMILTON PARK OPCO, LLC
LONG TERM CARE FACILITY	10909	Alaris Health at Kearny	206 BERGEN AVE	KEARNY	NJ	07032	HUDSON	(201) 955-7067	(201) 955-7547	WEST HUDSON SUB ACUTE CARE CENTER, LLC
LONG TERM CARE FACILITY	60918	Alaris Health at The Fountains	595 COUNTY AVENUE	SECAUCUS	NJ	07094	HUDSON	(201) 863-8866	(201) 863-1057	SECAUCUS HEALTH CARE CENTER, LLC
LONG TERM CARE FACILITY	060907	Hackensack Meridian Ambulatory Care, Inc	7600 RIVER ROAD	NORTH BERGEN	NJ	07047	HUDSON	(201) 854-5400	(201) 854-8798	HACKENSACK MERIDIAN AMBULATORY CARE, INC.
LONG TERM CARE FACILITY	09006	Hoboken University Medical Center Transitional Care Unit	308 WILLOW AVENUE	HOBOKEN	NJ	07030	HUDSON	(201) 418-1000	(201) 418-1780	HUMC OPCO, L.L.C.
LONG TERM CARE FACILITY	030901	HUDSON HILLS SENIOR LIVING, LLC	3161 KENNEDY BLVD	NORTH BERGEN	NJ	07047	HUDSON	(201) 867-3585	(201) 758-5014	HUDSON HILLS SENIOR LIVING, LLC
LONG TERM CARE FACILITY	060902	HUDSONVIEW CENTER FOR REHABILITATION AND HEALTH CARE, LLC	9020 WALL STREET	NORTH BERGEN	NJ	07047	HUDSON	(201) 861-4040	(201) 869-8842	HUDSONVIEW CENTER FOR REHABI AND HEALTH CARE, LLC
LONG TERM CARE FACILITY	406001	Manhattanview Nursing Home	3200 HUDSON AVENUE	UNION CITY	NJ	07087	HUDSON	(201) 325-8400	(201) 325-8410	MANHATTANVIEW OPERATIONS, L.L.C.
LONG TERM CARE FACILITY	060905	Optima Carre Jersey City, LLC	178-198 OGDEN AVE	JERSEY CITY	NJ	07307	HUDSON	(201) 963-1800	(201) 963-0018	OPTIMA CARE JERSEY CITY, LLC
LONG TERM CARE FACILITY	030904	Peace Care St. Ann's	198 OLD BERGEN ROAD	JERSEY CITY	NJ	07305	HUDSON	(201) 433-0950	(201) 433-6554	ST. ANN'S HOME FOR THE AGED, CORP.

Acute, Long Term Care and Medical Ambulatory Services

LONG TERM CARE FACILITY	030905	Peace Care St. Joseph's	537 PAVONIA AVENUE	JERSEY CITY	NJ	07306	HUDSON	(201) 653-8300	(201) 653-7705	MARGARET ANNA CUSACK CARE CENTER, INC.
PEDIATRIC COMMUNITY TRANSITIONAL HOMES	23963	AIDS RESOURCE FOUNDATION FOR CHILDREN/ST. CLARE'S JERSEY CITY	15 CLIFTON PLACE	JERSEY CITY	NJ	07303	HUDSON	(201) 435-5040	(201) 435-5586	SAINT CLARE'S HOMES FOR CHILDREN
PEDIATRIC DAY HEALTH CARE SERVICES	408332	UCP Of Hudson County Pediatric Medical Day Care	721 BROADWAY	BAYONNE	NJ	07002	HUDSON	(201) 436-2200	(201) 436-6642	UNITED CEREBRAL PALSY OF HUDSON COUNTY
PSYCHIATRIC HOSPITAL	60908	HUDSON COUNTY MEADOWVIEW PSYCHIATRIC HOSPITAL	595 COUNTY AVENUE	SECAUCUS	NJ	07094	HUDSON	(201) 369-5252	(201) 369-5260	COUNTY OF HUDSON
SURGICAL PRACTICE	R24901	MARCO A PELOSI M.D., P.A.	350 KENNEDY BOULEVARD	BAYONNE	NJ	07002	HUDSON	(201) 858-1800	(201) 858-1002	MARCO A. PELOSI, MD, P.A.
SURGICAL PRACTICE	R24643	UROLOGY GROUP OF NEW JERSEY, LLC	534 AVENUE E, SUITE 2A	BAYONNE	NJ	07002	HUDSON	(973) 323-1320	(973) 323-1329	UROLOGY GROUP OF NEW JERSEY LLC

Health Resources for Hudson County

Part 2: Mental Health Services

HUDSON COUNTY

Acute Care Family Support

Jersey City Medical Center
355 Grand Street
Jersey City, NJ 07302
(201) 915-2268

Screening Center

Jersey City Medical Center
355 Grand Street
Jersey City, NJ 07304
(201) 915-2210

Early Intervention Support Services (*Crisis Intervention Services*)

Bridgeway, Inc.
152 Central Avenue
Jersey City, NJ 07306
(201) 885-2539

Integrated Case Management Services

Jersey City Medical Center
1805 Kennedy Boulevard
Jersey City, NJ 07305
(201) 402-4617

Intensive Outpatient Treatment & Support Services

Jersey City Medical Center
395 Grand Street
Jersey City, NJ 07302
(201) 915-2478

Outpatient

Bayonne CMHC @ Trinitas
601 Broadway
Bayonne, NJ 07002
(201) 339-9200

County Mental Health Board

Hudson County Department of Health & Human Services
830 Bergen Avenue, 2B
Jersey City, NJ 07306
(201) 369-5280, ext. 4250

STCF

Jersey City Medical Center
395 Grand Street
Jersey City, NJ 07304
(201) 915-2349

Homeless Services (PATH)

Jersey City Medical Center
1825 Kennedy Blvd
Jersey City, NJ 07305
(201) 204-0040

Intensive Family Support Services

Catholic Charities
249 Virginia Avenue
Jersey City, NJ 07304
(201) 798-9906

Involuntary Outpatient Commitment

Jersey City Medical Center
1805 Kennedy Boulevard
Jersey City, NJ 07305
(201) 402-4617

Justice Involved Services

Jersey City Medical Center
395 Grand Street, 3rd Floor
Jersey City, NJ 07302
(201) 915-2272

Outpatient

Family Service Bureau of Newark
391 Kearny Avenue
Kearny, NJ 07032
(201) 246-8077

Outpatient

Mt. Carmel Guild Behavioral Healthcare
285 Magnolia Avenue
Jersey City, NJ 07306
(201) 395-4800

[Back to Table of Contents](#)

HUDSON COUNTY (Continued)

<p>Outpatient Palisades Medical Center Counseling Center 7101 Kennedy Boulevard North Bergen, NJ 07047 (201) 854-0500</p> <p>Outpatient Hoboken Medical Center 122 Clinton Street Hoboken, NJ 07030 (201) 792-8200</p> <p>Partial Care Mt. Carmel Guild Behavioral Healthcare 285 Magnolia Avenue Jersey City, NJ 07306 (201) 395-4800</p> <p>PRIMARY SCREENING CENTER for HUDSON Jersey City Medical Center 355 Grand Street Jersey City, NJ 07302 HOTLINE: (866) 367-6023 or (201) 915-2210</p> <p><i>Emergency Services - Affiliated w/Screening Center</i> Palisades Medical Center 7600 River Road North Bergen, NJ 07047 HOTLINE: (201) 854-5760</p> <p>Program of Assertive Community Treatment (PACT) Bridgeway Rehabilitation Inc. 862 Newark Avenue Jersey City, NJ 07306 (201) 653-3980</p> <p>Residential Services Jersey City Medical Center 395 Grand Street Jersey City, NJ 07302 (201) 402-4621</p>	<p>Outpatient Christ Hospital CMHC 174 Palisades Avenue Jersey City, NJ 07306 (201) 795-8375</p> <p>Outpatient Mt. Carmel Guild Behavioral Healthcare 2201 Bergenline Avenue Union City, NJ 07087 (201) 558-3700</p> <p>Partial Care Bayonne CMHC @ Trinitas 601 Broadway Bayonne, NJ 07002 (201) 339-9200</p> <p>Partial Care Mt. Carmel Guild Behavioral Healthcare 2201 Bergenline Avenue Union City, NJ 07087 (201) 558-3700</p> <p><i>Emergency Services – Affiliated w/Screening Center</i> Christ Hospital 176 Palisades Avenue Jersey City, NJ 07306 HOTLINE: (201) 795-8374</p> <p><i>Emergency Services - Affiliated w/Screening Center</i> Hoboken Medical Center 308 Willow Avenue Hoboken, NJ 07030 HOTLINE: (201) 418-2090</p> <p>Residential Intensive Support Team / Community Support Svc Garden State Episcopal 118 Summit Ave Jersey City, NJ 07304 (201) 209-9301</p>
--	--

[Back to Table of Contents](#)

HUDSON COUNTY (Continued)

Residential Services

SERV Centers of NJ – Hudson & Passaic Counties
1373 Broad Street
Clifton, NJ 07013
(862) 291-0077

Short Term Care Facility

Jersey City Medical Center
355 Grand Street
Jersey City, NJ 07304
(201) 915-2349

Supported Employment

Catholic Charities
1009 Kennedy Blvd
North Bergen, NJ 07047
(201) 271-9532

Community Support Services

Jersey City Medical Center
1805 JFK Blvd
Jersey City, NJ 07305
(201) 402-4621

Community Support Services / RIST

Bridgeway RIST
615 North Broad Street
Elizabeth, NJ 07208
973-373-0777

Systems Advocacy

Mental Health Association
35 Journal Square, Suite 827
Jersey City, NJ 07306
(201) 653-4700

Systems Advocacy

Community Health Law Project
650 Bloomfield Avenue
Bloomfield, NJ 07003
(973) 680-5599

Residential Services

Mt. Carmel Guild Behavioral Healthcare
619 Grove Street
Jersey City, NJ 07310
(201) 656-7201 , Ext. 208

Wellness Center

Hudson County SHC
124 Claremont Ave
Jersey City, NJ 07305
(201) 420-8013

Supported Education

Bridgeway Rehabilitation Services
LEARN of Central NJ
1023 Commerce Avenue, 2nd Floor
Union, NJ 07083
(908) 686-9666

Community Support Services

SERV Centers of NJ - Northern Regional Office
1373 Broad Street
Clifton, NJ 07013
(862) 291-0077

Community Support Services

Garden State Episcopal Community Development Corp.
118 Summit Avenue
Jersey City, NJ 07304
(201) 209-9301

Systems Advocacy

Community Health Law Project
35 Journal Square, Suite 831
Jersey City, NJ 07306
(201) 630-6201

[Back to Table of Contents](#)

Health Resources for Hudson County

Part 3: Addiction Health Services



ADDICTION SERVICES TREATMENT DIRECTORY

Carole Johnson
 Commissioner
 Department of Human Services
 (DHS)

Valerie Mielke
 Assistant Commissioner
 Division of Mental Health and Addiction Services
 (DMHAS)

A W II, LLC d/b/a Endeavor House North

License No: 1000149
 Agency Type: Profit
 Phone No: 2019910035

Services:

- Short Term Residential Substance Abuse Treatment
Beds Capacity: 31 Available: 22
- Inpatient Withdrawal Management
Beds Capacity: 26 Available: 25

Address:

206 BERGEN AVENUE
 KEARNEY NJ 07302
County:Hudson

IDRC affiliated: Yes

A W II, LLC d/b/a Endeavor House North

License No: 2000802
 Agency Type: Unknown
 Phone No: 2019910035

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

Address:

206 BERGEN AVENUE
 KEARNEY NJ 07302
County:Hudson

IDRC affiliated: Yes

Christ Hospital Counseling and Resource Center

License No: 2000468
 Agency Type: Non-Profit
 Phone No: 2017958200

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment

Address:

176 PALISADE AVE
 JERSEY CITY NJ 07306
County:Hudson

IDRC affiliated: Yes

C-LINE COMMUNITY OUTREACH

License No: 2000071
 Agency Type: Unknown
 Phone No: 2012001965

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment

Address:

110 MARTIN LUTHER KING DRIVE
 JERSEY CITY NJ 07305
County:Hudson

IDRC affiliated: Yes

C-Line Counseling Center

License No: 2000511
 Agency Type: Non-Profit
 Phone No: 9737824828

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment

Address:

680 BROADWAY
 SUITE 514
 PATERSON NJ 07509
County:Hudson

- Outpatient Treatment

IDRC affiliated: Yes


CURA, Inc.

License No: 1000085
Agency Type: Unknown
Phone No: 9736223570

Services:

- Co-Occurring Treatment Services
 - Long Term Residential Substance Abuse Treatment
- Beds Capacity: 96 Available:50**

Address:

 595 COUNTY AVE
BUILDING W-5
SECAUCUS NJ 07094

County:Hudson

IDRC affiliated: Yes


Deepak Amin

NPI Number: 1659372829
Phone No: 2018631797

Services:

- Medication-Assisted Treatment

Address:

 4522 Kennedy Boulevard
Union City New Jersey 07087

County:Hudson

Deepak Amin ATMD

NPI Number: 1659372829
Phone No: 2018631797

Services:

- Medication-Assisted Treatment

Address:

 4522 Kennedy Blvd

Union City New Jersey 07087

County:Hudson

Deepak Amin ATMD

NPI Number: 1659372829
Phone No: 2018693532

Services:

- Medication-Assisted Treatment

Address:

 6515 Boulevard East G 2

West New York New Jersey
07093

County:Hudson

Doney Jain MD/DO

NPI Number: 1720484777
Phone No: 973-896-2914

Services:

- Medication-Assisted Treatment

Address:

 751 Bergen Ave
Jersey City New Jersey 07306

County:Hudson

Family Service Bureau of Newark: Kearny Program

License No: 2000452
Agency Type: Non-Profit
Phone No: 2012461357

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment

Address:

 379 KEARNY AVE
KEARNY NJ 07032

County:Hudson

IDRC affiliated: Yes


Freedom of Choice Healthcare, Inc.

License No: 2000567
Agency Type: Unknown

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient

Address:

 533 32nd Street
Union City NJ 07087

County:Hudson

Phone No: 2017666617

- Treatment
- Outpatient Treatment
 - Partial Care


Garden Heights, Inc.

License No: 2000703
Agency Type: Unknown
Phone No: 8552120245

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

Address:

 26 Journal Square
Suite 1202
Jersey City NJ 07306
County:Hudson

IDRC affiliated: Yes

Health Path Camino de Salud, Consulting Services


License No: 2000049
Agency Type: Non-Profit
Phone No: 2018662934

Services:

- Outpatient Treatment

IDRC affiliated: Yes

Address:

 204-18TH ST
UNION CITY NJ 07087
County:Hudson

Hoboken University Medical Center, Giant Steps


License No: 2000209
Agency Type: Non-Profit
Phone No: 2017928290

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

IDRC affiliated: Yes

Address:

 61 MONROE ST
HOBOKEN NJ 07030
County:Hudson

Integrity, Inc.


License No: 1000036
Agency Type: Non-Profit
Phone No: 2015837100

Services:

- Co-Occurring Treatment Services
- Long Term Residential Substance Abuse Treatment
Beds Capacity: 152 Available:51
- Opiate Treatment Program

IDRC affiliated: Yes

Address:

 595 COUNTY AVENUE,
BUILDING #6
SECAUCUS NJ 07094
County:Hudson


Integrity, Inc.

License No: 1000123
Agency Type: Non-Profit
Phone No: 9736230600

Services:

- Co-Occurring Treatment Services
- Short Term Residential Substance Abuse Treatment
Beds Capacity: 31 Available:2
- Inpatient Withdrawal Management

Address:

 595 COUNTY AVENUE,
BUILDING 7
2ND FLOOR
SECAUCUS NJ 07094
County:Hudson

IDRC affiliated: Yes


Integrity, Inc.

License No: 2000154
Agency Type: Non-Profit
Phone No: 2015837100

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

Address:

 595 COUNTY AVE
SECAUCUS NJ 07094

County:Hudson

IDRC affiliated: Yes

**Integrity, Inc. at Hudson
County Correctional Facility**

License No: 4000138
Agency Type: Profit
Phone No: 9736230600

Services:

- Co-Occurring Treatment Services
- Long Term Residential Substance Abuse Treatment

Beds Capacity: 120 Available:17

Address:

 30-35 HACKENSACK AVE
KEARNY NJ 07032

County:Hudson

IDRC affiliated: Yes

**Integrity, Inc., Halfway
House**


License No: 1000119
Agency Type: Non-Profit
Phone No: 9736230600

Services:

- Co-Occurring Treatment Services
- Halfway House Substance Abuse Treatment

Beds Capacity: 31 Available:3

Address:

 595 COUNTY AVE
SECAUCUS NJ 07094

County:Hudson

IDRC affiliated: Yes

**Inter County Council on
Drug and Alcohol Abuse**

License No: 2000435
Agency Type: Non-Profit
Phone No: 2019987422

Services:

- Co-Occurring Treatment Services
- Opiate Treatment Program
- Outpatient Treatment

Address:

 480 KEARNY AVE
KEARNY NJ 07032

County:Hudson

IDRC affiliated: Yes

**Khaleidoscope Health Care,
Inc.**

License No: 2000361
Agency Type: Non-Profit
Phone No: 2014515425

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Opiate Treatment Program
- Outpatient Treatment

Address:

 75 HARRISON AVE
JERSEY CITY NJ 07304

County:Hudson

IDRC affiliated: Yes

Maher Badri MD

NPI Number: 1982785085

Phone No: 2018689449

Services:

- Medication-Assisted Treatment


Address: 7823 Bergenline Ave Fl 2North Bergen New Jersey
07047**County:**Hudson**Maher Badri MD**

NPI Number: 1982785085

Phone No: 2012951616

Services:

- Medication-Assisted Treatment

Address: 8915 Bergenwood Ave Ste 3North Bergen New Jersey
07047**County:**Hudson**Maher Badri MD/DO**

NPI Number: 1982785085

Phone No: 201-295-1616

Services:

- Medication-Assisted Treatment

Address: 7823 Bergenline Ave 2North Bergen New Jersey
07047**County:**Hudson**Michael Ojelade**

NPI Number: 1710279534

Phone No: 2014341111

Services:

- Medication-Assisted Treatment

Address: 127 Lafayette Street

Jersey City New Jersey 07304


County:Hudson**Nadeem Haque MD/DO**

NPI Number: 1538121926

Phone No: 201-823-4400

Services:

- Medication-Assisted Treatment

Address: 631 Broadway 2

Bayonne New Jersey 07002

County:Hudson**New Pathway Counseling
(Hudson)**

License No: 2000083

Agency Type: Profit

Phone No: 2014361022

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

Address: 993-995 BROADWAY
BAYONNE NJ 07002**County:**Hudson*IDRC affiliated: Yes***North Hudson Community
Action Corporation Health
Center**


License No: 2000159

Agency Type: Non-Profit

Phone No: 2018669320

Services:

- Outpatient Treatment

*IDRC affiliated: Yes***Address:** 5301 BROADWAY
WEST NEW YORK NJ 07093**County:**Hudson


North Star Behavioral Health

License No: 2000577
Agency Type: Profit
Phone No: 2015355959

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

Address:

 354 Avenue C
Bayonne NJ 07002
County:Hudson

IDRC affiliated: Yes


Paul Teodoro MD/DO

NPI Number: 1720177405
Phone No: 201-798-1200

Services:

- Medication-Assisted Treatment

Address:

 422 Grand St
A
Hoboken New Jersey 07030
County:Hudson


Saleem Mahmood ATMD

NPI Number: 1700991247
Phone No: 2014325222

Services:

- Medication-Assisted Treatment

Address:

 1971 John F Kennedy Blvd
Jersey City New Jersey 07305
County:Hudson


Saleem Mahmood ATMD

NPI Number: 1700991247
Phone No: 2014325744

Services:

- Medication-Assisted Treatment

Address:

 8 Jordan Ave
Jersey City New Jersey 07306
County:Hudson

Spectrum Health Care, Inc.

License No: 2000142
Agency Type: Non-Profit
Phone No: 2018606100

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Opiate Treatment Program
- Outpatient Treatment

Address:

 74-80 Pacific Ave.
Jersey City NJ 07304-3216
County:Hudson

IDRC affiliated: Yes


Straight & Narrow, Inc.

License No: 1000061
Agency Type: Non-Profit
Phone No: 9733456000

Services:

- Co-Occurring Treatment Services
 - Long Term Residential Substance Abuse Treatment
- Beds Capacity: 42 Available: 21**

Address:

 595 COUNTY AVE
BUILDING 7
SECAUCUS NJ 07094
County:Hudson

IDRC affiliated: Yes

Trinitas Regional Medical Center d/b/a Bayonne**Services:**

- Co-Occurring Treatment

Address:

 597 BROADWAY

**Community Mental Health
Center**

License No: 2000683

Agency Type: Non-Profit

Phone No: 2013399200

Services

- Intensive Outpatient Treatment
- Outpatient Treatment

IDRC affiliated: Yes

BAYONNE NJ 07002

County: Hudson

Appendix F- Additional Data Tables

Table 16. Survey Respondent Characteristics, n=556, 2001

Age		Income	
Under 30	15.6%	Under \$25,000	12.0%
30 to 49	46.7%	\$25,000 to \$50,000	21.1%
50 to 64	27.0%	\$50,001 to \$100,000	31.5%
65+	10.7%	\$100,001 to \$125,000	11.2%
Gender		\$125,001 to \$150,000	6.4%
Female	67.5%	\$150,001 to \$200,000	7.2%
Male	32.5%	Over \$200,000	10.8%
Additional Gender Category/ Transgender	0.2%*	Employment	
Race/Ethnicity		Employed full-time	72.4%
African American/ Black	9.3%	Employed part-time	6.8%
Asian	15.7%	Student	3.9%
Hispanic/ Latino(a)	24.3%	Homemaker	1.1%
Multiracial	2.5%	Disabled	1.8%
White/ Caucasian	45.0%	Retired	7.5%
Other	3.2%	Unemployed	6.5%
Sexual Orientation		Marital Status	
Heterosexual	86.3%	Married	46.2%
Homosexual	6.7%	Single	31.1%
Bisexual	4.7%	Separated/divorced/widowed	15.8%
Additional Sexual Orientation	2.4%	Domestic partnership/civil union/living together	7.0%
Education			
Less than high school graduate or GED	2.2%		
High school graduate or GED	9.6%		
Some college	14.4%		
Associate or technical degree/certification	9.3%		
College graduate	30.4%		
Postgraduate or professional degree	34.1%		

DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

Table 17. Age Distribution and Percent Change, by Town, 2011-2015, 2016-2020

	Under 18 years			18-24 years			25-44 years			45-64 years			65-74 years			75 years and older		
	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change	2011-2015	2016-2020	% change
Hudson County																		
Bayonne	22.0%	23.5%	1.5%	8.3%	6.5%	-1.8%	29.8%	29.8%	0.0%	27.0%	25.9%	-1.1%	7.2%	7.8%	0.6%	5.8%	6.3%	0.5%
Hoboken	13.2%	13.9%	0.7%	10.1%	9.8%	-0.3%	56.7%	55.0%	-1.7%	14.0%	15.2%	1.2%	3.1%	3.2%	0.1%	2.8%	3.0%	0.2%
Jersey City (07302)	7.2%	14.6%	7.4%	5.2%	3.6%	-1.6%	55.1%	58.6%	3.5%	17.3%	15.0%	-2.3%	4.1%	4.6%	0.5%	4.0%	3.8%	-0.2%
Jersey City (07304)	15.5%	25.0%	9.5%	9.4%	7.6%	-1.8%	31.7%	32.4%	0.7%	26.3%	24.1%	-2.2%	6.2%	6.3%	0.1%	3.9%	4.5%	0.6%
Jersey City (07305)	16.7%	25.3%	8.6%	10.7%	9.2%	-1.5%	28.9%	29.2%	0.3%	23.8%	23.6%	-0.2%	7.5%	8.2%	0.7%	4.6%	4.6%	0.0%
Jersey City (07306)	12.8%	19.6%	6.8%	10.6%	9.1%	-1.5%	37.8%	37.0%	-0.8%	22.0%	20.8%	-1.2%	6.0%	7.8%	1.8%	3.5%	5.9%	2.4%
					8													
Jersey City (07307)	14.3%	20.2%	5.9%	9.4%	.1%	-1.3%	34.7%	38.9%	4.2%	23.6%	22.0%	-1.6%	5.9%	6.6%	0.7%	4.3%	4.2%	-0.1%
Jersey City (07310)	4.9%	11.2%	6.3%	10.2%	9.6%	-0.6%	60.6%	64.9%	4.3%	15.0%	10.5%	-4.5%	1.7%	3.2%	1.5%	0.4%	0.6%	0.2%
Union City	22.3%	22.5%	0.2%	10.4%	9.5%	-0.9%	32.0%	31.8%	-0.2%	25.2%	25.4%	0.2%	5.7%	5.5%	-0.2%	4.4%	5.3%	0.9%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

Table 18. Age Distribution, by Gender, State, and County, 2016-2020

	Under 18 years		18-24 years		25-44 years		45-64 years		65-74 years		75 years and older	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
New Jersey	23.0%	21.0%	9.0%	8.2%	26.5%	25.0%	27.3%	27.7%	8.6%	9.7%	5.7%	8.4%
Hudson County	20.9%	20.0%	8.3%	7.5%	38.3%	35.4%	22.5%	23.1%	6.2%	7.6%	3.9%	6.3%
Bayonne	24.7%	20.6%	7.2%	7.6%	29.3%	28.4%	25.9%	26.8%	8.6%	8.8%	4.3%	7.9%
Hoboken	13.5%	13.6%	13.6%	7.8%	51.6%	54.9%	14.5%	16.9%	4.2%	3.3%	2.7%	3.6%
Jersey City (07302)	15.2%	14.0%	3.6%	3.6%	60.6%	56.2%	14.4%	15.5%	2.8%	6.5%	3.4%	4.3%
Jersey City (07304)	25.6%	24.6%	8.1%	7.3%	32.8%	32.2%	24.0%	24.1%	6.9%	5.7%	2.6%	6.2%
Jersey City (07305)	26.9%	23.7%	9.2%	9.1%	30.4%	28.0%	23.5%	23.7%	6.2%	10.0%	3.7%	5.5%
Jersey City (07306)	18.8%	20.4%	9.4%	8.7%	38.7%	34.9%	20.4%	21.5%	7.6%	7.9%	5.1%	6.7%
Jersey City (07307)	19.7%	20.7%	8.8%	7.3%	42.3%	35.4%	20.7%	23.2%	5.5%	7.8%	2.9%	5.5%
Jersey City (07310)	12.4%	9.8%	7.0%	12.8%	66.2%	63.2%	10.3%	10.7%	3.2%	3.3%	0.8%	0.2%
Union City	21.9%	21.9%	9.1%	10.0%	32.8%	29.7%	26.6%	24.2%	5.9%	7.1%	3.7%	7.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Community Social and Economic Environment

Table 19. Membership in Social Associations, by State and County, 2019

	# Associations	Social Association Rate
New Jersey	7721	8.7
Hudson County	376	5.6

DATA SOURCE: County Business Patterns as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Educational Attainment

Table 20. Educational Attainment among Adults 25 Years and Older, by State, County, and Town, 2016-2020

	Less than 9th grade	9th to 12th grade, no diploma	High school graduate/ GED	Some college, no degree	Associate degree	Bachelor's degree	Graduate or professional degree
New Jersey	4.7%	5.1%	26.7%	16.1%	6.6%	24.8%	15.9%
Hudson County	8.6%	5.7%	24.4%	12.6%	4.6%	26.4%	17.6%
Bayonne	6.0%	5.0%	30.3%	15.6%	5.3%	25.9%	11.9%
Hoboken	2.3%	2.2%	8.3%	6.4%	1.2%	48.4%	31.2%
Jersey City (07302)	2.9%	1.9%	8.3%	7.2%	2.4%	39.0%	38.5%
Jersey City (07304)	6.7%	7.9%	32.0%	13.5%	6.3%	22.8%	10.9%
Jersey City (07305)	6.5%	6.8%	30.7%	16.3%	6.4%	20.6%	12.7%
Jersey City (07306)	8.4%	6.9%	20.2%	12.5%	4.5%	30.7%	16.9%
Jersey City (07307)	8.3%	6.4%	24.8%	13.5%	4.6%	26.0%	16.4%
Jersey City (07310)	0.5%	1.0%	4.7%	4.5%	1.6%	31.7%	56.1%
Union City	18.1%	7.5%	33.1%	13.1%	5.1%	15.5%	7.6%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 21. Educational Attainment Among Adults 25 Years and Older, by Race/Ethnicity, State, County and Town, 2016-2020

	Asian, NH		Black, NH		Hispanic/ Latino		White, NH		Other race, NH	
	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+
New Jersey	92.8%	71.0%	88.6%	25.2%	75.6%	20.6%	94.6%	45.1%	71.4%	15.3%
Hudson County	93.4%	75.3%	87.4%	31.0%	75.8%	21.3%	92.7%	59.1%	75.6%	17.3%
Bayonne	93.6%	68.8%	90.0%	33.5%	79.9%	20.8%	92.6%	41.7%	77.5%	17.5%
Hoboken	97.1%	90.1%	86.1%	31.1%	78.3%	33.2%	98.7%	88.7%	67.0%	30.3%
Jersey City (07302)	97.8%	91.1%	93.2%	47.1%	81.3%	43.3%	98.2%	83.5%	71.4%	34.3%
Jersey City (07304)	90.0%	57.8%	86.7%	28.4%	77.2%	18.4%	91.5%	50.7%	80.2%	17.1%
Jersey City (07305)	92.6%	56.5%	88.5%	26.7%	74.8%	17.9%	92.6%	45.6%	70.5%	11.1%
Jersey City (07306)	89.0%	68.2%	80.9%	26.7%	73.2%	19.8%	90.7%	51.4%	74.8%	20.9%
Jersey City (07307)	87.3%	66.8%	84.7%	35.3%	80.4%	20.7%	89.8%	51.9%	75.8%	16.9%
Jersey City (07310)	99.4%	96.1%	94.5%	27.5%	95.3%	76.8%	98.1%	84.6%	81.5%	65.2%
Union City	84.3%	64.6%	79.0%	26.1%	69.9%	16.0%	90.9%	48.2%	73.7%	15.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Unemployment Rates

Table 22. Unemployment Rate by Gender, State, County, and Town, 2016-2020

	Female	Male
New Jersey	5.6%	5.4%
Hudson County	5.6%	4.9%
Bayonne	6.5%	6.3%
Hoboken	1.9%	3.8%
Jersey City (07302)	2.5%	2.1%
Jersey City (07304)	10.8%	7.7%
Jersey City (07305)	6.6%	6.7%
Jersey City (07306)	5.0%	4.5%
Jersey City (07307)	5.7%	3.8%
Jersey City (07310)	3.6%	2.3%
Union City	6.1%	5.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

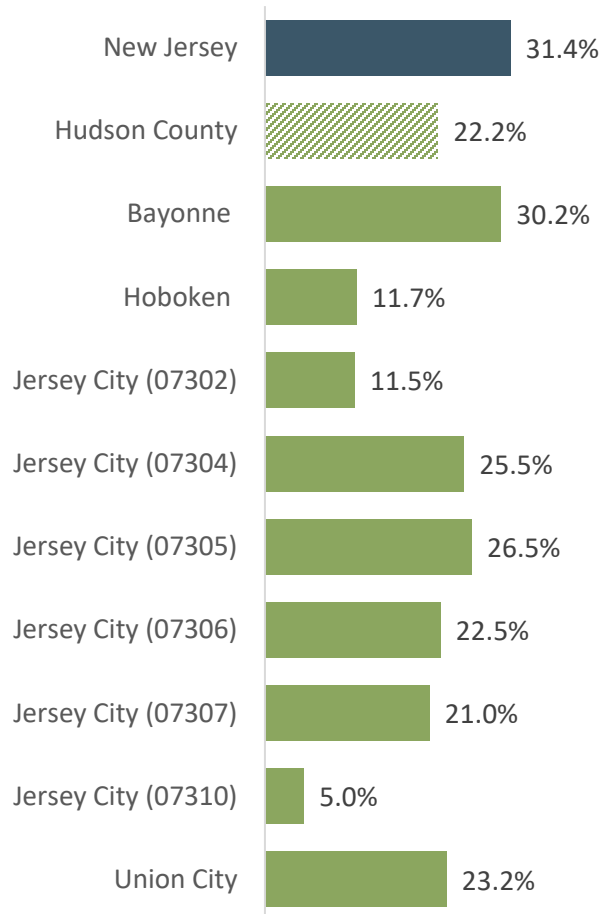
Table 23. Unemployment Rate by Age, State, and County, 2016-2020

	16 to 19 years	20 to 24 years	25 to 29 years	30 to 34 years	35 to 44 years	45 to 54 years	55 to 59 years	60 to 64 years	65 to 74 years	75 years and over
New Jersey	17.2%	11.4%	6.5%	5.2%	4.6%	4.6%	4.5%	4.4%	4.8%	4.2%
Hudson County	18.8%	11.0%	4.8%	4.3%	4.1%	5.7%	5.5%	4.0%	5.6%	1.7%
Bayonne	30.8%	14.4%	4.9%	9.7%	4.2%	6.2%	4.1%	4.4%	1.2%	0.0%
Hoboken	64.5%	5.0%	2.4%	1.1%	2.2%	6.6%	3.4%	5.7%	6.6%	0.0%
Jersey City (07302)	10.4%	6.7%	2.5%	2.1%	1.4%	4.1%	1.3%	2.9%	0.0%	18.3%
Jersey City (07304)	13.8%	22.5%	6.6%	8.7%	7.6%	10.5%	7.8%	3.8%	7.0%	0.0%
Jersey City (07305)	25.3%	14.4%	6.6%	6.6%	5.7%	5.3%	3.9%	6.1%	8.5%	0.0%
Jersey City (07306)	10.4%	8.3%	3.1%	4.0%	3.8%	5.4%	8.1%	3.7%	3.4%	0.0%
Jersey City (07307)	4.8%	9.1%	6.1%	4.0%	3.7%	3.8%	2.6%	4.4%	0.0%	0.0%
Jersey City (07310)	0.0%	0.0%	0.4%	1.6%	7.8%	1.6%	12.6%	0.0%	0.0%	0.0%
Union City	17.7%	10.4%	8.3%	5.0%	3.2%	5.2%	5.8%	4.3%	12.9%	0.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Income and Financial Security

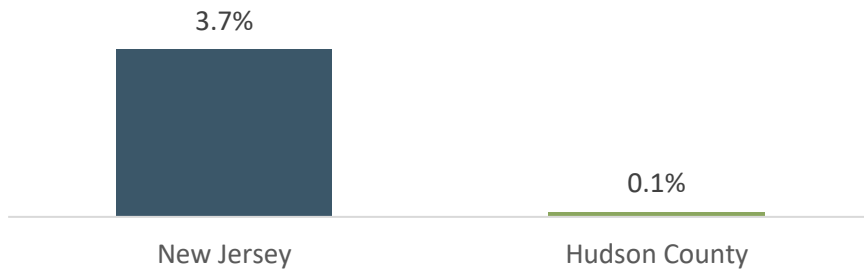
Figure 119. Percent Households Receiving Social Security Income, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Food Access and Food Security

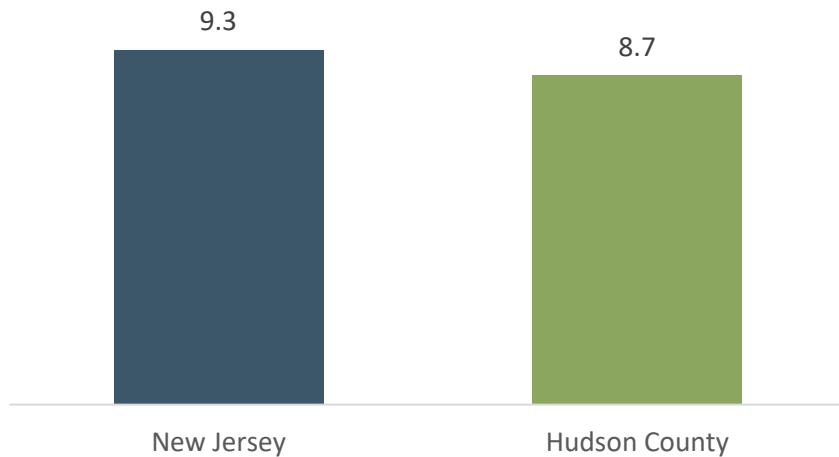
Figure 120. Food Desert Among Residents, by State and County, 2019



DATA SOURCE: U.S. Department of Agriculture, Economic Research Service, Food Access Research Atlas, 2019 , as reported by, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

NOTE: Food desert defined as the percentage of population with low income and without access to a grocery store at 1 mile for urban areas and 10 miles for rural areas

Figure 121. Food Environment Index, by State and County, 2019



DATA SOURCE: USDA Food Environment Atlas, Map the Meal Gap from Feeding America, 2019 as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

NOTE: Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).

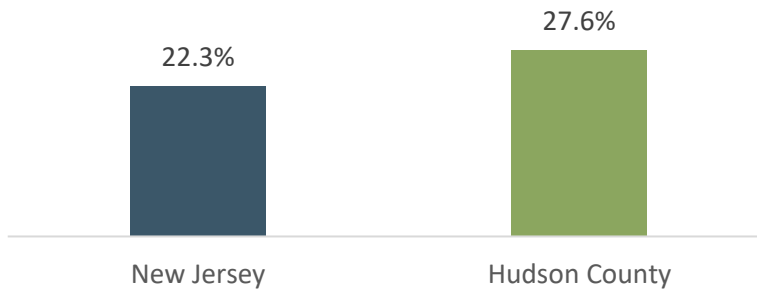
Housing

Table 24. Household Occupants per Room, by State and County, 2016-2020

	1.00 or less	1.01 to 1.50	1.51 or more
New Jersey	96.7%	2.1%	1.1%
Hudson County	92.1%	5.1%	2.8%
Bayonne	94.5%	4.0%	1.5%
Hoboken	96.2%	1.9%	1.9%
Jersey City (07302)	93.5%	3.0%	3.5%
Jersey City (07304)	93.2%	4.3%	2.5%
Jersey City (07305)	91.4%	6.9%	1.7%
Jersey City (07306)	88.4%	7.1%	4.5%
Jersey City (07307)	91.2%	6.6%	2.1%
Jersey City (07310)	93.3%	2.7%	4.0%
Union City	88.4%	8.9%	2.6%

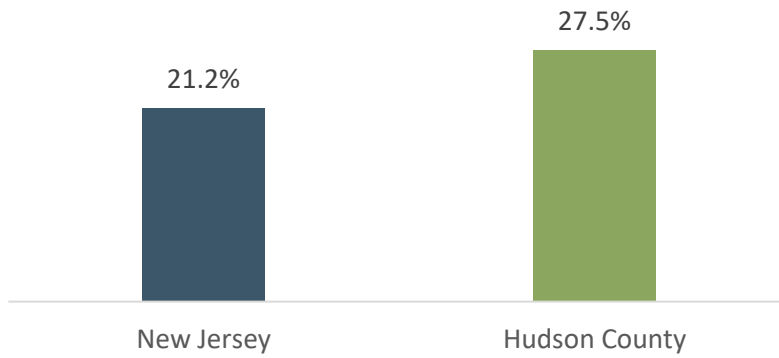
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 122. Percentage of Children That Live in a Household Headed by a Single Parent by State and County, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020

Figure 123. Severe Housing Problems, by State and County, 2014-2018

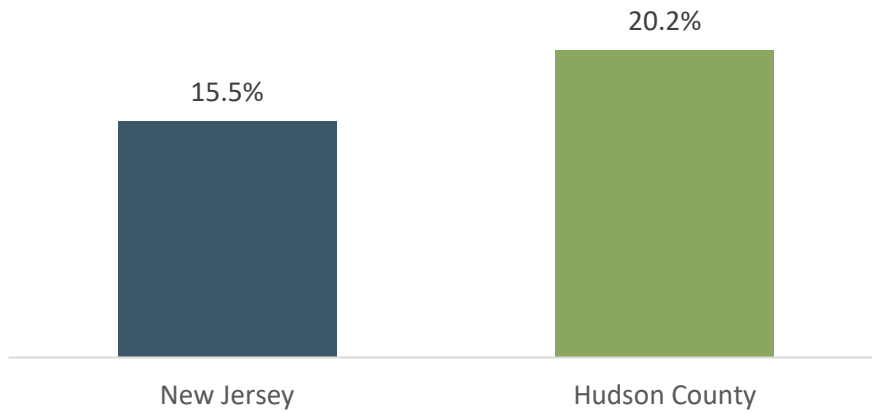


DATA SOURCE: U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy (CHAS) data, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2014-2018

NOTE: Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.

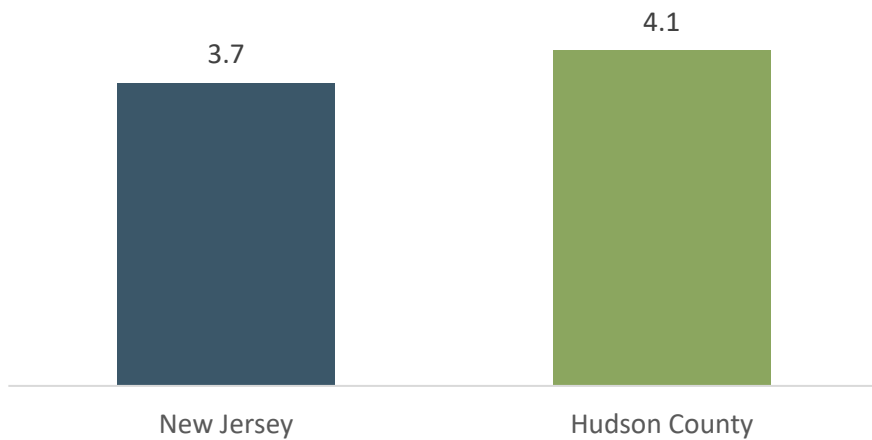
Overall Health

Figure 124. Percent Poor or Fair Health, by State and County, 2018



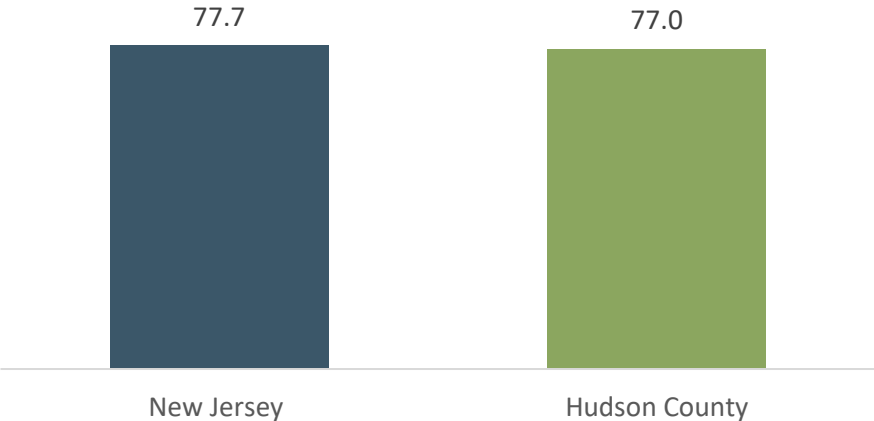
DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018

Figure 125. Poor Physical Health Days by State and County, 2018



DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018

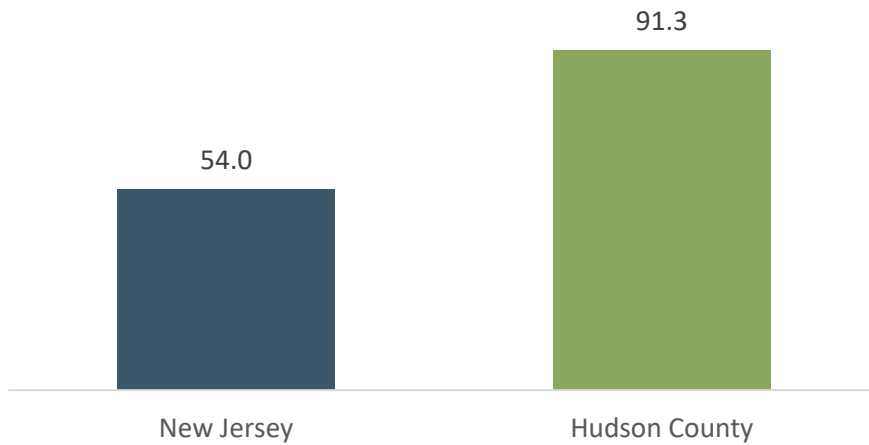
Figure 126. Life Expectancy by State and County, 2020



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health 2020

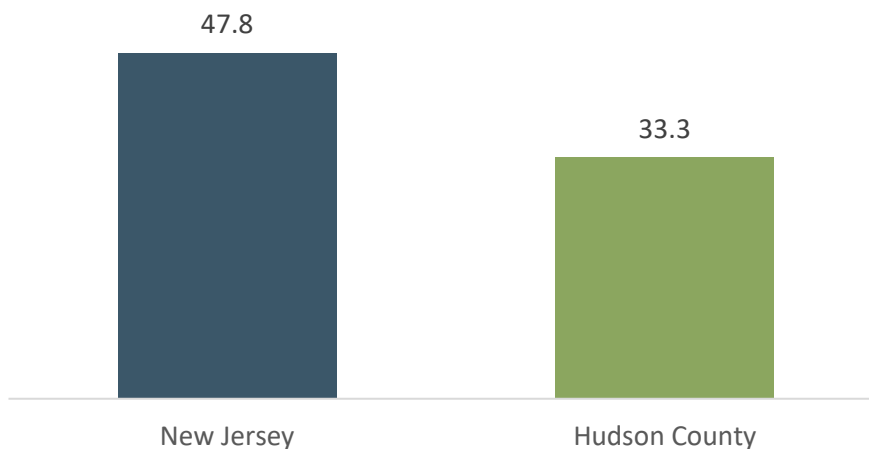
Community Health Issues: Unintentional Injury

Figure 127. ED Visits Due to Unintentional Injury (Age Adjusted) per 10,000, by State and County, 2016-2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2016-2020

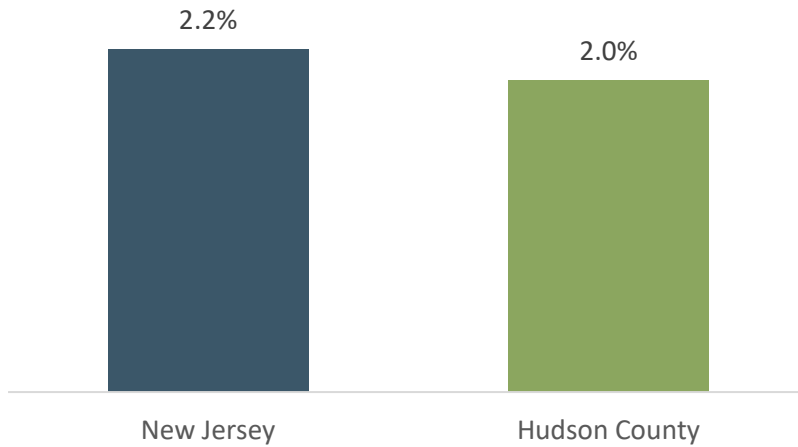
Figure 128. Unintentional Injury Deaths per 100,000 Population, by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Environmental Health

Figure 129. Percent of Children Aged 1 -5 Years With Elevated Blood Lead Level ($\geq 5\text{mcg/dL}$), by State and County, 2019



DATA SOURCE: Childhood Lead Exposure in New Jersey Annual Report, New Jersey Department of Public Health, Office of Local Public Health, Childhood Lead Program, State Fiscal Year 2019

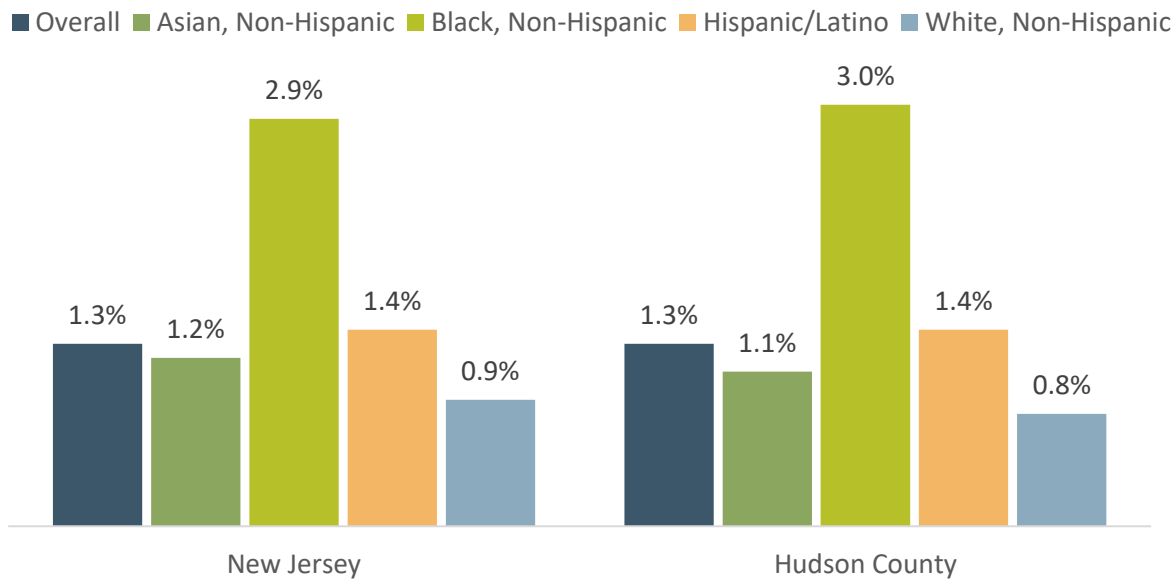
Table 25. Drinking water violations by County, 2020

	Violation?	Z-score
Hudson County	Yes	0.55

DATA SOURCE: Environmental Protection Agency, Safe Drinking Water Information System, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2020

Maternal and Infant Health

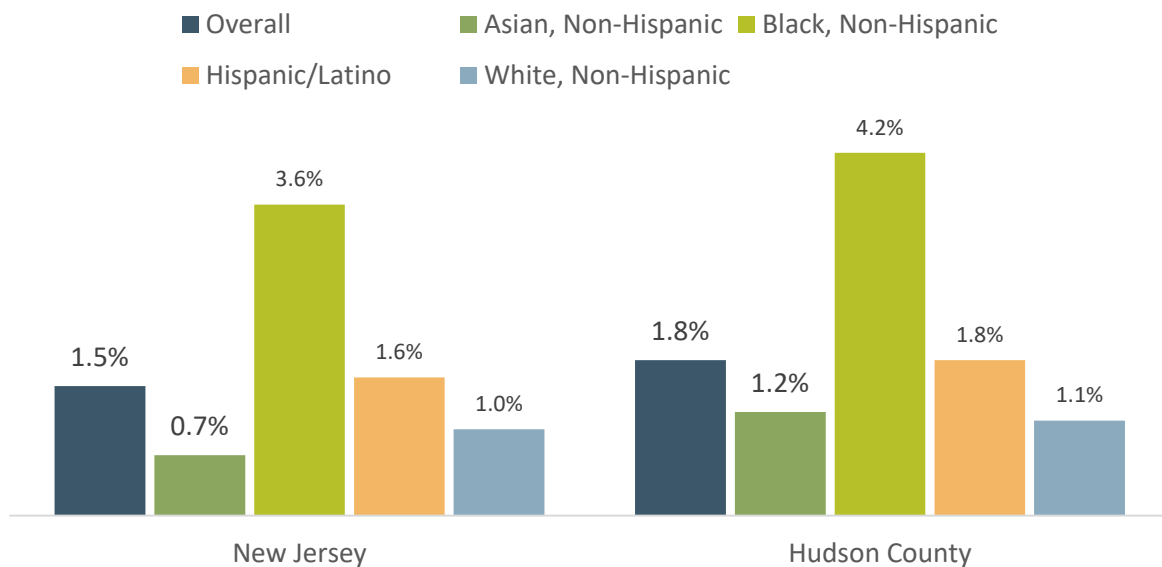
Figure 130. Percent Very Low Birth Weight Births by Race/Ethnicity, by State and County, 2016-2020



DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018

NOTE: Very low birth weight is defined as less than 1,500 grams

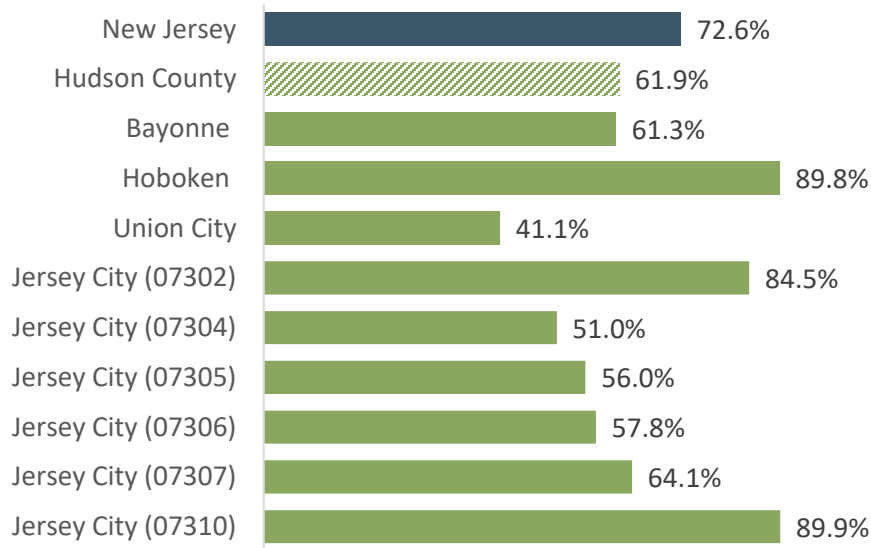
Figure 131. Percent Births with No Prenatal Care Overall by Race/Ethnicity, by State, 2016-2020



DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Access to care

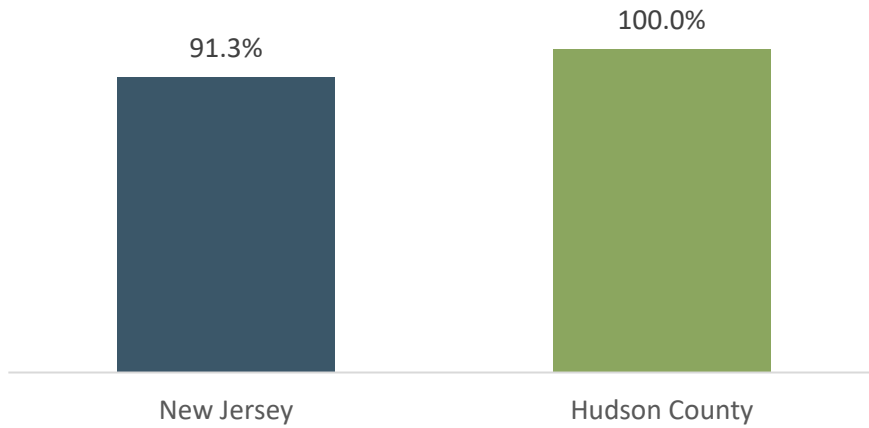
Figure 132. Population with Private Insurance, by State, County and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Healthy Living and Food Access

Figure 133. Population with Adequate Access to Location for Physical Activity, by State and County, 2010 and 2021



DATA SOURCE: ESRI & U.S. Census Tigerline Files, Business Analyst, Delorme map data, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2010 & 2021

Appendix G- Hospitalization Data

Figure 134. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

Year	Age	Count of Patients Treated & Released		Rate per 100,000 Population	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	0-17	690,506	51,760	334.4	394.6
	18-44	1,259,377	103,514	416.8	332.5
	45-64	757,159	57,306	302.2	351.9
	65+	450,704	26,472	320.4	335.2
	All Ages	3,157,746	239,052	350.9	349.3
2018	0-17	673,100	55,046	343.2	384.5
	18-44	1,217,047	106,138	394.5	355.1
	45-64	748,821	60,686	301.1	371.5
	65+	463,456	29,233	322.9	363.9
	All Ages	3,102,424	251,103	345.9	366.2
2019	0-17	658,207	54,165	334.6	367.6
	18-44	1,219,299	105,103	392.2	343.3
	45-64	760,293	61,161	305.8	371.2
	65+	489,485	30,209	330.6	363.8
	All Ages	3,127,284	250,638	345.8	357.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 135. Emergency Room Treat & Release Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	142,919	69.2
	18-44	242,892	80.4
	45-64	139,427	55.6
	65+	82,129	58.4
	All Ages	607,367	67.5
2018	0-17	145,643	74.3
	18-44	239,710	77.7
	45-64	139,051	55.9
	65+	82,293	57.3
	All Ages	606,697	67.6
2019	0-17	142,215	72.3
	18-44	238,051	76.6
	45-64	141,147	56.8
	65+	88,005	59.0
	All Ages	609,418	67.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 136. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Hudson County Resident Patients Treated at Jersey City Medical Center by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	14,408	109.8
	18-44	31,198	100.2
	45-64	16,790	103.1
	65+	6,004	76.0
	All Ages	68,400	100.0
2018	0-17	17,482	122.1
	18-44	34,556	115.6
	45-64	19,045	116.6
	65+	7,220	89.9
	All Ages	78,303	114.2
2019	0-17	17,702	120.1
	18-44	33,980	111.0
	45-64	19,291	117.1
	65+	7,159	86.2
	All Ages	78,132	111.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 137. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	22,166	379.0
	18-44	48,947	400.8
	45-64	24,888	404.2
	65+	9,897	351.7
	All Ages	105,898	391.8
2018	0-17	23,229	398.0
	18-44	48,661	399.7
	45-64	25,856	419.4
	65+	10,520	366.9
	All Ages	108,266	400.3
2019	0-17	22,870	380.0
	18-44	47,095	375.8
	45-64	26,442	424.4
	65+	10,618	356.2
	All Ages	107,025	385.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 138. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	12,194	208.5
	18-44	26,549	217.4
	45-64	13,755	223.4
	65+	5,201	184.8
	All Ages	57,699	213.4
2018	0-17	13,137	225.1
	18-44	26,700	219.3
	45-64	14,305	232.1
	65+	5,740	200.2
	All Ages	59,882	221.4
2019	0-17	13,196	219.3
	18-44	26,026	207.7
	45-64	14,642	235.0
	65+	5,733	192.3
	All Ages	59,597	214.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 139. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count		Rate per 100,000 Population	
		New Jersey Residents	Hudson County	New Jersey Residents	Hudson County
2017	American Indian or Alaska Native	6,530	498	201.1	111.9
	Asian	80,692	9,697	92.2	92.8
	Black or African American	780,645	48,599	628.0	555.3
	Hawaiian & Pacific Islander	3,949	343	985.5	864.0
	Other Race	610,721	90,795	935.3	902.1
	Two or More Races	11,014	286	38.6	8.8
	White	1,563,896	88,834	264.8	250.8
	All Race/Ethnicities	3,057,447	239,052	340.0	-
2018	American Indian or Alaska Native	6,035	467	185.4	105.2
	Asian	80,655	9,231	90.3	85.7
	Black or African American	755,704	50,013	608.9	574.7
	Hawaiian & Pacific Islander	8,405	305	2,031.7	734.9
	Other Race	633,209	97,951	961.3	977.2
	Two or More Races	11,395	303	39.5	9.3
	White	1,509,245	92,833	258.0	262.7
	All Race/Ethnicities	3,004,648	251,103	335.0	-
2019	American Indian or Alaska Native	5,360	417	164.0	92.8
	Asian	81,556	9,822	89.8	87.4
	Black or African American	754,534	47,955	600.1	549.6
	Hawaiian & Pacific Islander	4,203	280	1,005.3	689.7
	Other Race	683,104	107,983	1,012.6	1,049.7
	Two or More Races	11,025	406	37.5	12.2
	White	1,486,019	83,775	253.0	232.3
	All Race/Ethnicities	3,025,801	250,638	334.6	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 140. Emergency Room Treat & Release Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000
2017	American Indian or Alaska Native	608	18.7
	Asian	17,289	19.8
	Black or African American	197,472	158.9
	Hawaiian & Pacific Islander	577	144.0
	Other Race	147,525	225.9
	Two or More Races	1,571	5.5
	White	227,264	38.5
	All Race/Ethnicities	592,306	-
2018	American Indian or Alaska Native	548	16.8
	Asian	17,617	19.7
	Black or African American	198,391	159.8
	Hawaiian & Pacific Islander	474	114.6
	Other Race	153,992	233.8
	Two or More Races	1,745	6.0
	White	219,439	37.5
	All Race/Ethnicities	592,206	-
2019	American Indian or Alaska Native	593	18.1
	Asian	18,706	20.6
	Black or African American	195,413	155.4
	Hawaiian & Pacific Islander	480	114.8
	Other Race	162,149	240.4
	Two or More Races	1,946	6.6
	White	215,469	36.7
	All Race/Ethnicities	594,756	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 141. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	177	133.9
	Asian	6,648	93.5
	Black or African American	40,238	621.5
	Hawaiian & Pacific Islander	83	477.0
	Other Race	36,029	1,040.2
	Two or More Races	122	9.1
	White	22,601	266.2
	All Race/Ethnicities	105,898	391.8
2018	American Indian or Alaska Native	152	116.3
	Asian	6,441	88.6
	Black or African American	40,906	638.5
	Hawaiian & Pacific Islander	100	502.5
	Other Race	38,693	1,135.2
	Two or More Races	93	7.0
	White	21,881	258.2
	All Race/Ethnicities	108,266	400.3
2019	American Indian or Alaska Native	144	110.5
	Asian	6,844	90.3
	Black or African American	39,118	611.3
	Hawaiian & Pacific Islander	87	467.7
	Other Race	40,136	1,147.5
	Two or More Races	148	10.8
	White	20,548	234.5
	All Race/Ethnicities	107,025	385.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 142. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	64	48.4
	Asian	4,227	59.5
	Black or African American	27,453	424
	Hawaiian & Pacific Islander	16	92
	Other Race	11,071	319.6
	Two or More Races	93	6.9
	White	14,775	174
	All Race/Ethnicities	57,699	213.4
2018	American Indian or Alaska Native	61	46.7
	Asian	4,036	55.5
	Black or African American	28,045	437.7
	Hawaiian & Pacific Islander	14	70.4
	Other Race	13,822	405.5
	Two or More Races	78	5.8
	White	13,826	163.2
	All Race/Ethnicities	59,882	221.4
2019	American Indian or Alaska Native	61	46.8
	Asian	4,290	56.6
	Black or African American	26,718	417.5
	Hawaiian & Pacific Islander	21	112.9
	Other Race	15,321	438
	Two or More Races	100	7.3
	White	13,086	149.3
	All Race/Ethnicities	59,597	214.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 143. Emergency Room Treat & Release Counts and Rates for Behavioral Health per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

Year	Age	Count		Rate per 1,000	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	0-17	24,837	1,732	12.0	13.2
	18-44	91,990	8,601	30.4	27.6
	45-64	55,496	6,315	22.1	38.8
	65+	10,688	1,105	7.6	14.0
	All Ages	183,011	17,753	20.3	25.9
2018	0-17	26,241	1,965	13.4	13.7
	18-44	90,808	9,026	29.4	30.2
	45-64	55,715	6,442	22.4	39.4
	65+	11,055	1,177	7.7	14.7
	All Ages	183,819	18,610	20.5	27.1
2019	0-17	25,172	2,027	12.8	13.8
	18-44	90,172	9,340	29.0	30.5
	45-64	54,046	6,489	21.7	39.4
	65+	11,851	1,149	8.0	13.8
	All Ages	181,241	19,005	20.0	27.1

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 144. Emergency Room Treat & Release Counts and Rates for Behavioral Health per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Race, 2017-2019

Year	Race/Ethnicity	Count		Rate per 1,000	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	American Indian or Alaska Native	334	32	10.3	7.2
	Asian	3,380	401	3.9	3.8
	Black or African American	44,153	3,965	35.5	45.3
	Hawaiian & Pacific Islander	187	14	46.7	35.3
	Other Race	22,769	5,104	34.9	50.7
	Two or More Races	490	9	1.7	0.3
	White	106,929	7,802	18.1	22.0
	All Race/Ethnicities	178,242	17,327	19.8	25.3
2018	American Indian or Alaska Native	350	18	10.8	4.1
	Asian	3,497	401	3.9	3.7
	Black or African American	44,282	4111	35.7	47.2
	Hawaiian & Pacific Islander	187	14	45.2	33.7
	Other Race	24,682	5832	37.5	58.2
	Two or More Races	651	8	2.3	0.2
	White	104,601	7,738	17.9	21.9
	All Race/Ethnicities	178,250	18,122	19.9	26.4
2019	American Indian or Alaska Native	322	29	9.8	6.5
	Asian	3,466	397	3.8	3.5
	Black or African American	43,789	4,140	34.8	47.4
	Hawaiian & Pacific Islander	187	14	44.7	34.5
	Other Race	27,076	6,749	40.1	65.6
	Two or More Races	609	19	2.1	0.6
	White	99,593	6,999	17.0	19.4
	All Race/Ethnicities	175,042	18,347	19.4	26.2

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 145. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

Year	Age	Count		Rate per 1,000 Population	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	0-17	131,591	11,463	63.7	87.4
	18-44	231,158	18,870	76.5	60.6
	45-64	226,349	15,103	90.3	92.7
	65+	363,285	20,289	258.2	256.9
	All Ages	952,383	65,725	105.8	96.0
2018	0-17	130,739	11,682	66.7	81.6
	18-44	225,360	18,841	73.0	63.0
	45-64	221,118	15,200	88.9	93.0
	65+	364,459	20,160	254.0	251.0
	All Ages	941,676	65,883	105.0	96.1
2019	0-17	127,024	10,929	64.6	74.2
	18-44	218,270	17,589	70.2	57.5
	45-64	215,320	14,098	86.6	85.6
	65+	368,288	19,428	248.7	234.0
	All Ages	928,902	62,044	102.7	88.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 146. Inpatient Discharge Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	32,923	15.9
	18-44	50,878	16.8
	45-64	44,240	17.7
	65+	68,104	48.4
	All Ages	196,145	21.8
2018	0-17	32,768	16.7
	18-44	49,365	16.0
	45-64	43,076	17.3
	65+	67,477	47.0
	All Ages	192,686	21.5
2019	0-17	32,107	16.3
	18-44	48,316	15.5
	45-64	41,662	16.8
	65+	67,539	45.6
	All Ages	189,624	21.0

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 147. Inpatient Discharge Counts and Rates per 1,000 Population of Hudson County Resident Patients Treated at Jersey City Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	2,291	17.5
	18-44	4,906	15.8
	45-64	4,219	25.9
	65+	3,898	49.4
	All Ages	15,314	22.4
2018	0-17	2,142	15.0
	18-44	4,571	15.3
	45-64	3,851	23.6
	65+	3,853	48.0
	All Ages	14,417	21.0
2019	0-17	2,043	13.9
	18-44	4,307	14.1
	45-64	3,619	22.0
	65+	3,771	45.4
	All Ages	13,740	19.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 148. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	4,801	82.1
	18-44	8,409	68.9
	45-64	6,755	109.7
	65+	7,134	253.5
	All Ages	27,099	100.2
2018	0-17	4,821	82.6
	18-44	8,380	68.8
	45-64	6,592	106.9
	65+	7,106	247.8
	All Ages	26,899	99.5
2019	0-17	4,583	76.1
	18-44	7,729	61.7
	45-64	6,186	99.3
	65+	6,918	232.1
	All Ages	25,416	91.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 149. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	1,885	32.2
	18-44	3,916	32.1
	45-64	3,468	56.3
	65+	3,336	118.5
	All Ages	12,605	46.6
2018	0-17	1,750	30
	18-44	3,571	29.3
	45-64	3,095	50.2
	65+	3,277	114.3
	All Ages	11,693	43.2
2019	0-17	1,620	26.9
	18-44	3,330	26.6
	45-64	2,861	45.9
	65+	3,211	107.7
	All Ages	11,022	39.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 150. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count		Rate per 1,000 Population	
		New Jersey	Hudson County	New Jersey	Hudson County
2017	American Indian or Alaska Native	1913	153	58.9	34.4
	Asian	40,158	4,789	45.9	45.9
	Black or African American	164,073	10,493	132.0	119.9
	Hawaiian & Pacific Islander	1438	182	358.9	458.40
	Other Race	135,193	21,802	207.0	216.60
	Two or More Races	1733	62	6.1	1.9
	White	607,875	28,244	102.9	79.7
	All Race/Ethnicities	952,383	65,725	268.3	-
2018	American Indian or Alaska Native	1689	165	51.9	37.2
	Asian	40,286	5,021	45.1	46.6
	Black or African American	160,752	9,925	129.5	114
	Hawaiian & Pacific Islander	2146	121	518.7	291.60
	Other Race	146,436	23,138	222.3	230.8
	Two or More Races	1929	52	6.7	1.6
	White	588,438	27,461	100.6	77.7
	All Race/Ethnicities	941,676	65,883	267.7	-
2019	American Indian or Alaska Native	1559	171	47.7	38.1
	Asian	38,291	4,602	42.2	41
	Black or African American	156,678	9,286	124.6	106.4
	Hawaiian & Pacific Islander	1442	94	344.9	231.5
	Other Race	152,844	23,016	226.6	223.7
	Two or More Races	1767	79	6.0	2.4
	White	576,321	24,796	98.1	68.8
	All Race/Ethnicities	928,902	62,044	262.7	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System 2021

Figure 151. Inpatient Discharge Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rater per 1,000
2017	American Indian or Alaska Native	207	6.4
	Asian	8,753	10.0
	Black or African American	45,498	36.6
	Hawaiian & Pacific Islander	188	46.9
	Other Race	33,999	52.1
	Two or More Races	255	0.9
	White	107,245	18.2
	All Race/Ethnicities	196,145	55.2
2018	American Indian or Alaska Native	181	5.6
	Asian	8,850	9.9
	Black or African American	45,635	36.8
	Hawaiian & Pacific Islander	199	48.1
	Other Race	34,880	53.0
	Two or More Races	250	0.9
	White	102,691	17.6
	All Race/Ethnicities	192,686	54.8
2019	American Indian or Alaska Native	244	7.5
	Asian	8,642	9.5
	Black or African American	44,186	35.1
	Hawaiian & Pacific Islander	200	47.8
	Other Race	34,415	51.0
	Two or More Races	339	1.2
	White	101,598	17.3
	All Race/Ethnicities	189,624	53.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 152. Inpatient Discharge Counts and Rates per 1,000 Population of Hudson County Resident Patients Treated at Jersey City Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	26	5.8
	Asian	1,523	14.6
	Black or African American	5,454	62.3
	Hawaiian & Pacific Islander	-	20.2
	Other Race	3,325	33.0
	Two or More Races	11	0.3
	White	4,967	14.0
	All Race/Ethnicities	15,314	-
2018	American Indian or Alaska Native	15	3.4
	Asian	1,468	13.6
	Black or African American	4,872	56.0
	Hawaiian & Pacific Islander	-	14.5
	Other Race	3,738	37.3
	Two or More Races	10	0.3
	White	4,308	12.2
	All Race/Ethnicities	14,417	-
2019	American Indian or Alaska Native	25	5.6
	Asian	1,433	12.8
	Black or African American	4,498	51.5
	Hawaiian & Pacific Islander	-	14.8
	Other Race	3,938	38.3
	Two or More Races	14	0.4
	White	3,826	10.6
	All Race/Ethnicities	13,740	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 153. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated in New Jersey, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	69	52.2
	Asian	2,997	42.2
	Black or African American	8,650	133.6
	Hawaiian & Pacific Islander	53	304.6
	Other Race	8,180	236.2
	Two or More Races	17	1.3
	White	7,133	84.0
	All Race/Ethnicities	27,099	100.2
2018	American Indian or Alaska Native	66	50.5
	Asian	3,218	44.3
	Black or African American	8,172	127.6
	Hawaiian & Pacific Islander	53	266.3
	Other Race	8,809	258.4
	Two or More Races	22	1.6
	White	6,559	77.4
	All Race/Ethnicities	26,899	99.5
2019	American Indian or Alaska Native	78	59.9
	Asian	2,948	38.9
	Black or African American	7,667	119.8
	Hawaiian & Pacific Islander	41	220.4
	Other Race	8,612	246.2
	Two or More Races	25	1.8
	White	6,045	69.0
	All Race/Ethnicities	25,416	91.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 154. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Jersey City Medical Center's Primary Service Area Treated at Jersey City Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	24	18.2
	Asian	1,375	19.3
	Black or African American	5,162	79.7
	Hawaiian & Pacific Islander	-	40.2
	Other Race	2,543	73.4
	Two or More Races	-	0.4
	White	3,488	41.1
	All Race/Ethnicities	12,605	46.6
2018	American Indian or Alaska Native	15	11.5
	Asian	1,320	18.2
	Black or African American	4,574	71.4
	Hawaiian & Pacific Islander	-	25.1
	Other Race	2,874	84.3
	Two or More Races	-	0.7
	White	2,896	34.2
	All Race/Ethnicities	11,693	43.2
2019	American Indian or Alaska Native	23	17.7
	Asian	1,288	17
	Black or African American	4,256	66.5
	Hawaiian & Pacific Islander	-	32.3
	Other Race	2,908	83.1
	Two or More Races	-	0.6
	White	2,533	28.9
	All Race/Ethnicities	11,022	39.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 155. Hospital Admission Rates per 1,000 Population, by Race/Ethnicity, New Jersey and Jersey City Medical Center, 2019

		Admission Rate per 1,000			
		Total Overall	Acute	Chronic	Diabetic
New Jersey	Asian	2.6	0.8	1.8	0.4
	Black	16.7	3.0	13.7	4.1
	Hispanic	5.4	1.4	4.0	1.5
	White	9.6	2.9	6.7	1.5
	All Race/Ethnicities	10.4	2.8	7.7	2.0
Jersey City Medical Center	Asian	3.2	1.0	2.2	0.6
	Black	17.8	3.0	14.8	4.6
	Hispanic	4.8	1.2	3.6	1.3
	White	6.3	1.5	4.8	1.3
	All Race/Ethnicities	10.5	2.2	8.2	2.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 156. Hospital Admission Rates per 1,000 Population by Reason for Admission, by Race/Ethnicity, New Jersey and Jersey City Medical Center, 2019

		Admission Rate per 1,000			
		Total Overall	Cardiac	Mental Health	Substance Use
New Jersey	Asian	5.2	3.9	1.0	0.3
	Black	26.1	16.6	6.7	2.7
	Hispanic	10.3	6.2	2.6	1.5
	White	17.2	12.2	3.2	1.9
	All Race/Ethnicities	18.6	12.5	4.0	2.1
Jersey City Medical Center	Asian	28.4	3.9	0.9	0.4
	Black	105.5	17.6	8.2	3.9
	Hispanic	43.9	5.3	2.5	1.3
	White	44.0	6.1	4.0	2.5
	All Race/Ethnicities	76.2	10.8	5.4	2.9

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 157. Hospital Admission and Emergency Department Visit Rates per 1,000 Population, by Age and Race/Ethnicity, New Jersey and Jersey City Medical Center, 2019

	Admission Rate per 1,000 Population						Emergency Department Visits per 1,000 Population				
	Age	Asian	Black	Hispanic	White	All Race/Ethnicities	Asian	Black	Hispanic	White	All Race/Ethnicities
New Jersey	All	5.2	26.1	10.3	17.2	18.6	108.8	682.4	430.2	271.2	403
	Under 18	0.4	1.9	1.4	1.1	1.6	99.8	477.1	497.4	181.7	344
	18 to 64	3.5	26.5	9.3	12	15	91.4	760.5	392.4	248	396.6
	65+	25.3	73.3	46.6	48.7	54.8	233.8	698.1	548.2	428.5	505.8
Jersey City Medical Center	All	28.4	105.5	43.9	44.0	76.2	109.4	690.3	282.4	173.4	447.0
	Under 18	3.9	16.4	10.4	5.5	14.2	100.5	433.6	260.8	113.6	390.2
	18 to 64	24.4	111.4	43.5	34.9	72.6	93.9	791.9	274.1	169.3	447.6
	65+	113.2	275.2	136.4	135.4	223.6	258.6	697.2	402.7	267.2	558.1

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 158. Inpatient Discharge Counts and Rates per 1,000 Diagnosed with Mental Diseases and Disorders & Alcohol/Drug Use or Induced Mental Disorder Treated in New Jersey, by County of Residence, 2017-2019

Year	Count		Rate per 1,000 Population	
	New Jersey	Hudson County	New Jersey	Hudson County
2017	73,005	5,658	8.1	8.3
2018	69,282	5,643	7.7	8.2
2019	65,610	5,439	7.3	7.8

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 159. Inpatient Discharge Counts and Rates per 1,000 Diagnosed with Diseases and Disorders of the Circulatory System Treated in New Jersey, by County of Residence, 2017-2019

Year	Count		Rate per 1,000 Population	
	New Jersey	Hudson County	New Jersey	Mercer County
2017	126,968	7,598	14.1	11.1
2018	125,886	7,521	14.0	11
2019	126,198	7,411	14.0	10.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Figure 160. Inpatient Discharge Counts and Rates per 1,000, Residents of Hudson County Treated at Jersey City Medical Center, by Major Diagnostic Category, 2017-2019

Major Diagnostic Category	Count			Rate per 1,000 Population		
	2017	2018	2019	2017	2018	2019
Mental Diseases and Disorders & Alcohol/Drug Use or Induced Mental Disorder	1,302	1,313	1,237	1.9	1.9	1.8
Diseases and Disorders of the Circulatory System	1,990	1,826	1,858	2.9	2.7	2.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Appendix H- Cancer Data

Table 26. CANCER INCIDENCE RATE REPORT: CANCER PATIENT ORIGIN - HUDSON COUNTY 2020

Almost eighty percent of JCMC’s cancer inpatients and 65.8% of cancer outpatients resided in the Primary Service Area. In total, 91.1% of inpatients and 88.7% of outpatients resided in Hudson County. Jersey City (07305 and 07304) represent the largest segment of JCMC’s inpatient cancer patients. Similarly, Jersey City (07305 and 07306) represent the largest segments of JCMC’s outpatient cancer patients. The health factors and outcomes explored in the CHNA bear relevance to the oncology services and its review of specific cancer needs for the community.

CANCER PATIENT ORIGIN	2020 JCMC IP PATIENTS	%	2020 JCMC OP PATIENTS	%
Hudson County	1,000	91.1%	449	88.7%
Primary Service Area	800	72.9%	333	65.8%
Secondary Service Area	177	16.1%	82	16.2%
Out of Service Area (NJ)	103	9.4%	90	17.8%
Out of State	18	1.6%	1	0.2%
TOTAL	1,098	100.0%	506	100.0%
Jersey City (07305)	334	30.4%	115	22.7%
Jersey City (07304)	193	17.6%		
Jersey City (07306)			90	17.8%

Source; Decision Support; IP volume includes cases with ICD10 principal or secondary codes C00 thru D49.9 (Neoplasms); OP volume includes cases with ICD10 principal or secondary codes Z51.0 or Z51.11 (Chemo and Radiation Therapy).

Table 27. CANCER INCIDENCE RATE REPORT: HUDSON COUNTY 2013-2017

INCIDENCE RATE REPORT FOR HUDSON COUNTY 2013-2017				
Cancer Site	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trend
All Cancer Sites	403.5	2607	falling	-1.2
Bladder	17.6	108	falling	-1.6
Brain & ONS	5.7	38	*	*
Breast	111.1	389	stable	0.5
Cervix	9.4	33	falling	-2.2
Colon & Rectum	40.3	259	falling	-2.9
Esophagus	3.2	20	falling	-2.8
Kidney & Renal Pelvis	12.8	84	stable	0.5
Leukemia	11.5	72	stable	0
Liver & Bile Duct	8.7	57	rising	2.6
Lung & Bronchus	43.7	273	falling	-2.5
Melanoma of the Skin	8.2	53	stable	-0.7
Non-Hodgkin Lymphoma	17.1	110	stable	-0.4
Oral Cavity & Pharynx	8.3	55	stable	-1.3
Ovary	11.7	41	stable	-1.1
Pancreas	14	87	rising	2.1
Prostate	112.7	319	falling	-3.9
Stomach	9.5	60	falling	-1.7
Thyroid	15.1	107	stable	-0.1
Uterus (Corpus & Uterus, NOS)	26.8	98	stable	0.6

The source for D2 and following tables D3, D4, D5 and D6 is: <https://statecancerprofiles.cancer.gov>

Table 28. CANCER INCIDENCE DETAILED RATE REPORT: HUDSON COUNTY 2013-2017 SELECT CANCER SITES: RISING INCIDENCE RATES

		Liver & Bile Duct	Pancreas
INCIDENCE RATE REPORT FOR HUDSON COUNTY 2013-2017 All Races (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.7	14
	Average Annual Count	57	87
	Recent Trend	rising	rising
	Recent 5-Year Trend in Incidence Rates	2.6	2.1
White Non-Hispanic, All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.3	15
	Average Annual Count	19	34
	Recent Trend	stable	rising
	Recent 5-Year Trend in Incidence Rates	2.5	1.9
Black (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.2	15.8
	Average Annual Count	8	14
	Recent Trend	stable	stable
	Recent 5-Year Trend in Incidence Rates	2.1	2.9
Asian or Pacific Islander (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	6.1	9.4
	Average Annual Count	5	6
	Recent Trend	stable	stable
	Recent 5-Year Trend in Incidence Rates	-1.7	4.8
Hispanic (any race), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	8.8	12.3
	Average Annual Count	24	32
	Recent Trend	rising	stable
	Recent 5-Year Trend in Incidence Rates	3.1	2.2
MALES	Age-Adjusted Incidence Rate - cases per 100,000	14	15.1
	Average Annual Count	41	40
	Recent Trend	rising	rising
	Recent 5-Year Trend in Incidence Rates	2.5	2.4
FEMALES	Age-Adjusted Incidence Rate - cases per 100,000	4.5	13.2
	Average Annual Count	16	47
	Recent Trend	stable	rising
	Recent 5-Year Trend in Incidence Rates	2.4	1.9

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).

Table 29. APPENDIX D4: CANCER MORTALITY RATE REPORT: HUDSON COUNTY 2014-2018

MORTALITY RATE REPORT: HUDSON COUNTY 2014-2018					
Cancer Site	Met Healthy People Objective of ***?	Age-Adjusted Mortality Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trend in Mortality Rates
All Cancer Sites	***	129.4	819	falling	-2.5
Bladder	***	3.9	24	stable	0.5
Brain & ONS	***	2.7	18	*	*
Breast	***	18.2	66	falling	-2.4
Cervix	***	1.8	7	falling	-4.2
Colon & Rectum	***	14	89	falling	-3
Esophagus	***	2.9	19	falling	-2.3
Kidney & Renal Pelvis	***	2.8	18	stable	-0.9
Leukemia	***	4.1	26	falling	-2.4
Liver & Bile Duct	***	6	39	stable	0.5
Lung & Bronchus	***	26.8	168	falling	-3.1
Melanoma of the Skin	***	0.9	6	falling	-2.1
Non-Hodgkin Lymphoma	***	4.1	26	falling	-3.8
Oral Cavity & Pharynx	***	1.5	10	falling	-4
Ovary	***	5.7	21	falling	-2.1
Pancreas	***	10.8	67	rising	6
Prostate	***	15.7	37	falling	-3.8
Stomach	***	4.3	27	falling	-2.2
Thyroid	***	*	3 or fewer	*	*
Uterus (Corpus & Uterus, NOS)	***	6	22	stable	0.3

*** No Healthy People 2020 Objective for this cancer.

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area- sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).

Table 30. CANCER MORTALITY DETAILED RATE REPORT (Highest Volume): ESSEX COUNTY 2014-2018

		Liver & Bile Duct
MORTALITY RATE REPORT FOR ESSEX COUNTY 2014-2018 All Races (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	6.2
	Average Annual Count	55
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.2
White Non-Hispanic, All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	4.3
	Average Annual Count	16
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	0.3
Black (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	8.9
	Average Annual Count	31
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.8
Asian or Pacific Islander (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	*
	Average Annual Count	3 or fewer
	Recent Trend	*
	Recent 5-Year Trend in Death Rates	*
Hispanic (any race), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	5.1
	Average Annual Count	6
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	1.8
MALES	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	9.7
	Average Annual Count	37
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.2
FEMALES	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	3.7
	Average Annual Count	19
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	0.9

*** No Healthy People 2020 Objective for this cancer.

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).

Table 31. CANCER INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
All Cancer Sites: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	485.9	51,689	falling	-0.8
US (SEER+NPCR)	448.7	1,673,102	falling	-1
Cape May County	564.6	881	stable	-0.2
Salem County	554.1	462	stable	0
Gloucester County	541.6	1,853	stable	-0.2
Burlington County	527.8	2,956	falling	-0.4
Camden County	524.6	3,123	falling	-0.4
Monmouth County	523.2	4,160	stable	0.4
Ocean County	521.2	4,511	falling	-0.6
Cumberland County	512	895	stable	0.1
Sussex County	510.3	932	falling	-0.8
Warren County	506.4	706	falling	-0.8
Mercer County	503.9	2,138	falling	-0.6
Atlantic County	495.8	1,699	falling	-0.8
Morris County	487.9	3,030	falling	-0.9
Hunterdon County	475.1	794	stable	-0.4
Bergen County	472.4	5,571	falling	-1
Somerset County	463.3	1,827	falling	-0.8
Essex County	462.1	3,930	falling	-0.7
Middlesex County	460.8	4,293	falling	-0.9
Union County	453.7	2,802	falling	-1.2
Passaic County	451.6	2,510	falling	-0.8
Hudson County	403.5	2,607	falling	-1.2
Bladder: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	23.1	2,487	falling	-1.1
US (SEER+NPCR)	20	74,787	falling	-1.9
Cape May County	30.9	51	stable	-0.3
Warren County	27.2	39	stable	-0.4
Gloucester County	27.1	90	stable	0
Atlantic County	26.8	93	stable	-0.6
Salem County	26.5	23	stable	0.6
Burlington County	26.5	151	stable	-0.2
Sussex County	25.9	48	stable	0

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Hunterdon County	25.9	43	stable	0.5
Monmouth County	25.5	206	stable	-0.3
Camden County	25	148	stable	-0.8
Cumberland County	25	43	stable	-0.7
Morris County	24.2	152	falling	-1.5
Ocean County	23.9	231	falling	-2.2
Middlesex County	22.8	211	falling	-1
Bergen County	22.6	277	falling	-1.6
Passaic County	22.2	124	stable	-1
Mercer County	20.7	88	falling	-1.4
Union County	20.4	127	falling	-2
Somerset County	20.1	79	stable	-1.2
Essex County	18.4	154	falling	-1.4
Hudson County	17.6	108	falling	-1.6
Brain & ONS: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	6.8	673	*	*
US (SEER+NPCR)	6.5	22,781	*	*
Salem County	9.6	7	*	*
Warren County	9.1	12	*	*
Hunterdon County	8.6	12	*	*
Sussex County	7.9	13	*	*
Gloucester County	7.8	25	*	*
Burlington County	7.7	39	*	*
Ocean County	7.7	54	*	*
Mercer County	7.3	29	*	*
Bergen County	7.2	77	*	*
Morris County	7.2	40	*	*
Atlantic County	6.9	22	*	*
Cumberland County	6.9	11	*	*
Camden County	6.9	38	*	*
Middlesex County	6.8	60	*	*
Monmouth County	6.8	50	*	*
Passaic County	6.7	35	*	*
Somerset County	6.5	23	*	*
Cape May County	5.8	7	*	*
Hudson County	5.7	38	*	*
Union County	5.6	33	*	*

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Essex County	5.5	46	*	*
Breast: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	136.6	7,668	rising	0.5
US (SEER+NPCR)	125.9	244,411	rising	0.3
Morris County	148.1	480	stable	0
Burlington County	147	433	rising	1.3
Hunterdon County	146.2	129	stable	0.2
Monmouth County	146.2	616	stable	0.1
Gloucester County	144.3	267	stable	0.3
Somerset County	144.2	306	stable	0.1
Mercer County	141.9	316	stable	0.2
Camden County	141	450	stable	0.6
Bergen County	140.8	865	stable	0.5
Essex County	137.4	641	rising	1.9
Union County	136.7	454	stable	0
Cape May County	135.7	106	stable	-0.1
Sussex County	135.6	129	stable	-0.2
Ocean County	132.9	586	stable	-0.2
Atlantic County	131.4	238	stable	0.2
Salem County	130.6	56	stable	0.1
Middlesex County	129.7	639	stable	-0.1
Warren County	125.9	92	stable	-0.7
Passaic County	124.4	367	rising	1.1
Cumberland County	118.9	108	stable	0.6
Hudson County	111.1	389	stable	0.5
Cervix: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.7	382	falling	-1.9
US (SEER+NPCR)	7.6	12,833	stable	0.3
Cumberland County	15.3	11	stable	-1.4
Cape May County	11.7	5	stable	0.8
Salem County	10.6	3	*	*
Hudson County	9.4	33	falling	-2.2
Union County	9.3	29	stable	-0.3
Atlantic County	9.2	14	stable	-1.1
Essex County	9.2	40	falling	-3
Passaic County	8.6	23	stable	-2.1
Ocean County	8.2	27	stable	-1.5

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Camden County	8.1	23	falling	-2.7
Warren County	8	4	stable	-0.5
Somerset County	7.5	13	stable	4.7
Gloucester County	6.9	12	stable	-0.8
Middlesex County	6.9	32	stable	-1.5
Bergen County	6.8	36	stable	-0.9
Burlington County	6.4	16	stable	12.6
Morris County	6.3	18	stable	-1.1
Mercer County	6.2	12	falling	-3.9
Monmouth County	6.1	21	stable	-2.3
Sussex County	5.9	5	stable	-2.7
Hunterdon County	5.1	3	falling	-4
Colon & Rectum: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	40.8	4,342	falling	-1.6
US (SEER+NPCR)	38.4	142,225	falling	-1.4
Salem County	48.4	40	falling	-2.6
Cape May County	46.5	72	falling	-2.8
Cumberland County	46.3	80	falling	-2.5
Gloucester County	44.8	151	falling	-2.7
Burlington County	44.7	249	stable	-1
Ocean County	43.7	393	falling	-1.8
Camden County	43.7	256	falling	-2.9
Warren County	42.8	61	falling	-3
Sussex County	42.1	74	falling	-3.4
Essex County	42.1	354	stable	-0.1
Monmouth County	40.9	325	falling	-3.3
Atlantic County	40.4	138	falling	-3.6
Hudson County	40.3	259	falling	-2.9
Middlesex County	39.6	370	falling	-3
Passaic County	39.5	220	stable	-0.8
Union County	39.1	243	falling	-3.2
Bergen County	39	464	stable	1.1
Hunterdon County	37.7	62	falling	-2.6
Mercer County	37.3	158	falling	-3.3
Morris County	37.1	233	falling	-3.4
Somerset County	35.2	139	falling	-3.4

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Esophagus: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	4.3	469	falling	-1.3
US (SEER+NPCR)	4.5	17,419	falling	-1.1
Warren County	7	10	stable	-0.1
Gloucester County	6.4	23	rising	2.2
Cape May County	6.4	10	stable	1.4
Sussex County	6.1	12	stable	-1.1
Ocean County	5.7	52	stable	-0.7
Cumberland County	5.1	9	stable	-0.3
Camden County	5	31	stable	-0.8
Hunterdon County	4.7	8	stable	-1.8
Salem County	4.7	4	stable	-3.4
Morris County	4.6	30	stable	-0.4
Passaic County	4.5	25	stable	-0.3
Burlington County	4.4	25	stable	-0.9
Atlantic County	4.3	15	falling	-2.1
Monmouth County	4.3	36	falling	-2
Mercer County	4.2	18	falling	-2.8
Essex County	3.7	32	falling	-3
Union County	3.7	23	stable	-1.9
Middlesex County	3.6	34	falling	-2
Bergen County	3.2	39	falling	-1.4
Hudson County	3.2	20	falling	-2.8
Somerset County	3.2	13	stable	-1.6
Kidney & Renal Pelvis: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	16.3	1,736	rising	0.8
US (SEER+NPCR)	16.8	62,705	rising	0.6
Cumberland County	21	36	stable	-10.5
Burlington County	19.6	110	stable	1.3
Camden County	19.6	116	rising	2
Gloucester County	18.6	65	stable	0.4
Ocean County	17.8	147	rising	1.5
Mercer County	17.7	76	rising	2
Salem County	17.7	15	stable	0.2
Atlantic County	17.4	60	stable	0.2
Cape May County	17.3	26	stable	2.1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Monmouth County	16.7	133	rising	0.9
Warren County	16.5	22	stable	0.8
Bergen County	16.4	194	stable	0.5
Passaic County	15.8	88	stable	0.9
Morris County	15.7	98	stable	0.7
Middlesex County	15.7	146	stable	0
Sussex County	15.4	31	stable	-0.4
Union County	15	93	stable	0.2
Somerset County	14.6	58	stable	-0.1
Hunterdon County	13.8	23	stable	-0.7
Essex County	13.4	115	stable	0.6
Hudson County	12.8	84	stable	0.5
Leukemia: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	15.7	1,610	rising	0.8
US (SEER+NPCR)	14.2	51,227	falling	-2.1
Sussex County	19.4	32	rising	2.9
Monmouth County	17.4	134	rising	1.5
Gloucester County	17.4	58	stable	1.2
Ocean County	16.9	145	stable	0.6
Morris County	16.8	101	rising	1.2
Mercer County	16.6	68	rising	1.8
Cape May County	16.5	23	stable	-1.2
Burlington County	16.3	88	stable	0.9
Cumberland County	16.1	28	rising	1.7
Warren County	16	21	stable	0.4
Union County	15.7	93	stable	1
Bergen County	15.6	182	stable	1.3
Passaic County	15.6	83	stable	1
Somerset County	15.4	57	stable	-0.5
Middlesex County	15.4	139	stable	0.3
Camden County	15.3	88	stable	0.4
Hunterdon County	14.7	23	stable	-0.8
Essex County	14.2	117	stable	0.5
Atlantic County	13.7	45	stable	-0.2
Salem County	13.7	10	stable	-1.1
Hudson County	11.5	72	stable	0

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Liver & Bile Duct: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.8	869	rising	2.1
US (SEER+NPCR)	8.4	33,355	stable	0.4
Cumberland County	10.5	19	rising	4.8
Cape May County	9.9	17	stable	4
Camden County	9.4	60	rising	2.4
Atlantic County	9.1	32	stable	2.1
Hudson County	8.7	57	rising	2.6
Gloucester County	8.6	30	rising	2.1
Mercer County	8.4	37	stable	1.8
Ocean County	8.3	75	rising	3.2
Salem County	8.3	7	stable	-15.4
Passaic County	8.2	47	stable	1.1
Essex County	7.9	71	stable	0.8
Middlesex County	7.9	76	rising	2.5
Burlington County	7.7	45	rising	2.4
Monmouth County	7.6	64	rising	2.4
Bergen County	7.1	89	stable	1.1
Warren County	6.7	10	stable	1.9
Sussex County	6.7	13	stable	1.5
Morris County	6.6	43	rising	2.2
Union County	6.3	40	rising	1.8
Somerset County	6	25	stable	1.6
Hunterdon County	5.4	10	rising	3
Lung & Bronchus: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	55.3	5,950	falling	-1.6
US (SEER+NPCR)	58.3	221,568	falling	-2
Salem County	85.4	73	rising	2.5
Cape May County	76.3	130	stable	-0.8
Gloucester County	74.6	252	falling	-1.2
Ocean County	70.8	672	falling	-1.1
Cumberland County	69.2	123	falling	-0.8
Camden County	67.2	404	falling	-1.4
Atlantic County	64.7	226	falling	-1.9
Warren County	63.8	91	stable	-1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Sussex County	62.5	114	falling	-1.3
Burlington County	61.8	350	falling	-1
Monmouth County	59.7	482	falling	-1.5
Mercer County	56.7	242	falling	-1.5
Middlesex County	49.7	459	falling	-2.1
Bergen County	49.4	598	falling	-1.7
Hunterdon County	48.6	81	stable	-1.2
Morris County	47.7	300	falling	-2
Essex County	46.9	393	falling	-2.4
Passaic County	44.8	250	falling	-5.8
Somerset County	44	173	falling	-1.8
Hudson County	43.7	273	falling	-2.5
Union County	43.1	262	falling	-2.2
Melanoma of the Skin: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	22.2	2,335	stable	0.5
US (SEER+NPCR)	22.3	81,226	rising	1.8
Cape May County	51.3	77	rising	3.3
Hunterdon County	39.8	65	stable	1.9
Ocean County	34	283	stable	0.2
Salem County	32.4	26	stable	-16.8
Monmouth County	32.1	249	rising	1.6
Sussex County	31.9	56	rising	3.1
Gloucester County	27.2	91	stable	0.7
Atlantic County	27.1	92	rising	1.6
Morris County	26.7	164	stable	0.2
Burlington County	26.4	146	stable	0.5
Warren County	25.7	34	stable	0.1
Somerset County	24.4	97	stable	0.2
Camden County	21.7	128	stable	0.3
Mercer County	21.1	88	stable	0.4
Middlesex County	18.1	167	stable	1
Bergen County	18	212	falling	-1.3
Cumberland County	16.4	28	stable	1.3
Union County	15.7	97	stable	0.2
Passaic County	14.3	77	stable	0.2
Essex County	12.2	103	stable	-0.1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Hudson County	8.2	53	stable	-0.7
Non-Hodgkin Lymphoma: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	21.8	2,272	stable	0
US (SEER+NPCR)	19.3	70,661	falling	-1.5
Warren County	24.9	34	stable	-0.2
Monmouth County	24.3	188	stable	0
Morris County	23.7	145	stable	-0.3
Somerset County	23.7	92	stable	0.3
Sussex County	23.5	41	stable	-0.5
Atlantic County	23.2	78	stable	0
Bergen County	23.1	268	stable	0.1
Mercer County	22.6	94	stable	0
Ocean County	22.5	196	stable	0.4
Gloucester County	22.1	73	rising	0.9
Middlesex County	22.1	202	stable	-0.1
Cumberland County	22	37	stable	-0.1
Union County	21.1	129	stable	-6.5
Burlington County	21.1	117	stable	-0.5
Salem County	20.8	17	stable	-0.5
Hunterdon County	20.6	35	stable	-0.3
Camden County	20.6	122	stable	-0.4
Passaic County	20.4	109	stable	0.4
Essex County	18.4	153	stable	-0.7
Cape May County	18.3	29	stable	-0.3
Hudson County	17.1	110	stable	-0.4
Oral Cavity & Pharynx: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	11.1	1,204	rising	0.8
US (SEER+NPCR)	11.8	45,129	stable	0
Salem County	16.1	14	stable	1.2
Cape May County	14.6	23	stable	0.2
Atlantic County	14.4	51	rising	1.5
Cumberland County	14	25	rising	2.3
Monmouth County	12.9	105	rising	1
Ocean County	12.8	108	rising	1.7
Sussex County	12.7	25	stable	1.7

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Camden County	12.2	75	stable	1.2
Warren County	11.7	17	stable	2.1
Gloucester County	11.5	41	stable	0.8
Hunterdon County	11.4	21	stable	1.9
Morris County	11.4	74	rising	1.7
Burlington County	11.2	65	stable	1.3
Middlesex County	10.7	100	rising	1.6
Essex County	10.7	92	rising	8.2
Somerset County	10.5	43	stable	0.4
Passaic County	10.1	57	stable	-0.2
Bergen County	9.5	115	stable	-0.1
Mercer County	9.4	42	falling	-1.2
Union County	9	57	stable	-0.1
Hudson County	8.3	55	stable	-1.3
Ovary: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	11.8	679	falling	-2.1
US (SEER+NPCR)	10.9	21,338	falling	-3.1
Cape May County	17.1	13	stable	0.2
Somerset County	13.6	29	falling	-2.1
Camden County	13.4	42	falling	-1.6
Mercer County	13.2	30	stable	-0.9
Burlington County	12.8	39	stable	-0.9
Warren County	12.5	9	stable	0.2
Atlantic County	12.3	22	falling	-2.7
Gloucester County	12.3	23	falling	-2.9
Ocean County	12	55	stable	-1.1
Hunterdon County	11.9	11	falling	-2.7
Middlesex County	11.8	59	falling	-2.1
Hudson County	11.7	41	stable	-1.1
Morris County	11.4	38	falling	-2.5
Bergen County	11.3	72	falling	-3.9
Essex County	11.3	54	falling	-1.8
Passaic County	11.2	34	falling	-2.7
Monmouth County	11	48	falling	-2.2
Union County	10.6	36	falling	-2.4
Cumberland County	10.4	9	stable	15.6
Sussex County	10.2	10	falling	-3.3

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Salem County	9.3	4	stable	-2.1
Pancreas: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	14.4	1,556	rising	1.1
US (SEER+NPCR)	12.9	48,832	rising	0.8
Warren County	17	24	stable	1.8
Mercer County	16.1	69	rising	2.3
Salem County	15.9	14	stable	1.5
Burlington County	15.9	91	rising	2
Ocean County	15.7	148	rising	1.5
Hunterdon County	15.4	27	rising	2.2
Camden County	15.1	91	rising	1.1
Gloucester County	14.7	50	stable	0.8
Cape May County	14.7	25	stable	0.4
Monmouth County	14.5	121	rising	1.3
Essex County	14.2	120	stable	0.7
Atlantic County	14.2	50	stable	1.3
Bergen County	14.1	171	stable	0.3
Morris County	14	90	rising	1.3
Hudson County	14	87	rising	2.1
Passaic County	13.5	76	stable	0
Sussex County	13.5	25	stable	2.3
Cumberland County	13.4	24	stable	0.6
Union County	13.4	82	stable	0.5
Middlesex County	12.9	121	stable	0.8
Somerset County	12.8	51	stable	1.1
Prostate: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	131.3	6,723	falling	-2.9
US (SEER+NPCR)	104.5	192,918	stable	-0.4
Essex County	153.1	593	falling	-3.2
Cape May County	152.9	122	falling	-1.9
Mercer County	148.1	300	falling	-2.3
Burlington County	147.9	407	falling	-3.1
Camden County	142.3	405	falling	-1.8
Gloucester County	140.7	236	falling	-1.8
Monmouth County	139.3	549	falling	-2.2
Salem County	139.3	58	stable	-1.7
Passaic County	136.2	359	falling	-2.5

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Union County	134.6	390	falling	-3.7
Cumberland County	129.8	109	stable	-0.6
Bergen County	128.6	729	falling	-3.3
Morris County	127.6	392	falling	-3.3
Middlesex County	124.1	555	stable	1.2
Somerset County	122	232	falling	-2.9
Warren County	120	85	falling	-3.5
Sussex County	119.2	117	falling	-4.3
Atlantic County	117.7	203	falling	-2.5
Hudson County	112.7	319	falling	-3.9
Ocean County	112.1	466	falling	-3.6
Hunterdon County	108	94	rising	9.1
Stomach: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.9	847	falling	-1.1
US (SEER+NPCR)	6.5	24,190	falling	-1.1
Passaic County	10.4	58	stable	-0.2
Union County	9.7	59	stable	-0.8
Hudson County	9.5	60	falling	-1.7
Essex County	9	76	falling	-2
Cumberland County	8.8	15	stable	-2
Camden County	8.7	51	stable	0.3
Bergen County	8.6	104	stable	-0.9
Mercer County	8.1	34	stable	-0.5
Atlantic County	7.7	26	stable	-1
Middlesex County	7.5	70	falling	-2.5
Sussex County	7.5	14	stable	0.3
Burlington County	7	40	stable	-0.4
Ocean County	7	62	stable	-0.7
Somerset County	7	28	falling	-1.8
Gloucester County	6.7	23	stable	-0.9
Monmouth County	6.7	56	falling	-1.5
Morris County	6.4	41	falling	-1.7
Salem County	5.9	5	stable	0
Hunterdon County	5.7	9	stable	-0.1
Warren County	5.6	8	stable	0.7
Cape May County	5.1	8	stable	-1.6
Thyroid: All Races (includes Hispanic), Both Sexes, All Ages				

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
New Jersey	19.3	1,840	stable	-0.3
US (SEER+NPCR)	14.3	48,211	falling	-2.2
Monmouth County	26.8	182	stable	1.4
Gloucester County	24.4	76	rising	4
Mercer County	24.1	96	rising	4
Ocean County	24	147	rising	5.4
Camden County	22	118	rising	2.7
Burlington County	20.8	102	rising	2.4
Bergen County	20.3	207	stable	0.3
Salem County	20.2	13	rising	4
Somerset County	19.8	71	falling	-12.1
Middlesex County	19.2	169	stable	-0.9
Morris County	19.1	102	stable	-3.9
Sussex County	18	29	rising	3.9
Warren County	17	20	stable	1.6
Atlantic County	16.9	48	stable	0.9
Passaic County	16.2	85	stable	-7.6
Cape May County	16	17	rising	2.4
Union County	15.8	92	falling	-8.9
Hudson County	15.1	107	stable	-0.1
Cumberland County	14.6	24	stable	0.5
Hunterdon County	14.4	20	rising	3.6
Essex County	13.7	113	rising	4.3
Uterus (Corpus & Uterus, NOS): All Races (includes Hispanic), BothSexes, All Ages				
New Jersey	31.9	1,913	rising	0.8
US (SEER+NPCR)	27	55,004	rising	1.2
Warren County	39.3	30	stable	1.2
Cumberland County	39.1	37	rising	1.9
Cape May County	38.2	32	rising	3.1
Sussex County	36.3	38	stable	0.9
Camden County	35.3	119	rising	2.1
Mercer County	34.3	82	rising	1.6
Hunterdon County	34.3	31	stable	-1
Gloucester County	33.7	66	stable	1.2
Salem County	33.7	16	stable	1.1
Essex County	33.5	165	rising	1.7

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Morris County	32.8	115	stable	0.3
Atlantic County	32.4	61	stable	1.2
Somerset County	32.4	73	stable	0.4
Burlington County	32.2	101	stable	1
Middlesex County	32	168	stable	0.5
Ocean County	31.5	150	stable	0.2
Monmouth County	30.8	140	stable	-0.2
Bergen County	29.9	198	stable	-0.1
Union County	29.3	102	stable	1
Passaic County	28.8	90	stable	0.3
Hudson County	26.8	98	stable	0.6

Table 32. JERSEY CITY MEDICAL CENTER - TUMOR REGISTRY SUMMARY

In 2019, JCMC’s tumor registry data showed that 3.4% and 19.0% of overall cases were Stage 3 and Stage 4 respectively. The following primary sites were made up of more than 25% of Stage 4 cases: Respiratory System(64.7%), followed by Male genital Organs (40.0%) and Digestive Organs (32.6).

Compared to 2018, there was a decrease of 386 cases (-66.3%) in 2019. The three biggest decreases in overall cases occurred in Breast (-79, -55.2%), followed by Digestive Organs (-75, -61.0%) and Respiratory System (-50, -72.5%). Please note that case volume counts smaller than 10 are suppressed. Staging percentages are calculated on analytic cases only.

MainSite	SubSite	Cases (both analytic and non-analytic)		2018			2019			2018 - 2019			
		2018	2019	% Stage 3	% Stage 4	Total % Stage 3 & 4	% Stage 3	% Stage 4	Total % Stage 3 & 4	Change in Case Volume	Change in % points for Stage 3	Change in % points for Stage 4	Change in % points for Stage 3 & 4
BREAST		143	64	5.9%	0.0%	5.9%	0.0%	0.0%	0.0%	(79)	(5.9)	0.0	(5.9)
DIGESTIVE ORGANS		123	48	17.3%	27.6%	44.9%	4.3%	32.6%	37.0%	(75)	(13.0)	5.1	(7.9)
	COLON	39	20	35.3%	17.6%	52.9%	5.3%	42.1%	47.4%	(19)	(30.0)	24.5	(5.6)
	LIVER AND INTRAHEPATIC BILE DUCTS	11		0.0%	33.3%	33.3%	0.0%	50.0%	50.0%	(9)	0.0	16.7	16.7
	PANCREAS	28		0.0%	52.4%	52.4%	0.0%	33.3%	33.3%	(21)	0.0	(19.0)	(19.0)
	RECTUM	11		0.0%	11.1%	11.1%	0.0%	33.3%	33.3%	(8)	0.0	22.2	22.2
EYE, BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM		22		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(20)	0.0	0.0	0.0
FEMALE GENITAL ORGANS		43	11	3.8%	23.1%	26.9%	25.0%	12.5%	37.5%	(32)	21.2	(10.6)	10.6
HEMATOPOIETIC AND RETICULOENDOTHELIAL SYSTEMS		38	11	0.0%	9.1%	9.1%	0.0%	12.5%	12.5%	(27)	0.0	3.4	3.4
LYMPH NODES		27		22.2%	33.3%	55.6%	0.0%	16.7%	16.7%	(20)	(22.2)	(16.7)	(38.9)
MALE GENITAL ORGANS		34		0.0%	55.6%	55.6%	0.0%	40.0%	40.0%	(27)	0.0	(15.6)	(15.6)
RESPIRATORY SYSTEM AND INTRATORACIC ORGANS		69	19	4.3%	55.3%	59.6%	11.8%	64.7%	76.5%	(50)	7.5	9.4	16.9
	BRONCHUS AND LUNG	61	17	4.9%	58.5%	63.4%	13.3%	66.7%	80.0%	(44)	8.5	8.1	16.6
THYROID AND OTHER ENDOCRINE GLANDS		33		3.2%	3.2%	6.5%	0.0%	10.0%	10.0%	(23)	(3.2)	6.8	3.5
	UNKNOWN PRIMARY SITE	15		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(11)	0.0	0.0	0.0
URINARY TRACT		20		0.0%	9.1%	9.1%	0.0%	0.0%	0.0%	(15)	0.0	(9.1)	(9.1)
	BLADDER	12		0.0%	16.7%	16.7%	0.0%	0.0%	0.0%	(9)	0.0	(16.7)	(16.7)
Grand Total		582	196	7.6%	17.6%	25.2%	3.4%	19.0%	22.4%	(386)	(4.2)	1.4	(2.8)

Appendix I- Outcomes and Results Report of the Previous Implementation Plan

Community Health Needs Assessment

Implementation Plan Results 2019-2021



**Jersey City
Medical Center**

**RWJ Barnabas
HEALTH**

Introduction

In 2019, Jersey City Medical Center (“JCMC”) conducted and adopted its Community Health Needs Assessment (“CHNA”) which consisted of a community health needs survey of residents in our service area, a detailed review of primary and secondary source data, key informant interviews, and meetings with local health officials and community stakeholders. The Plan can be accessed at <https://www.rwjbh.org/documents/community-health-needs-assessment/JCMC-CHNA-1219.pdf>

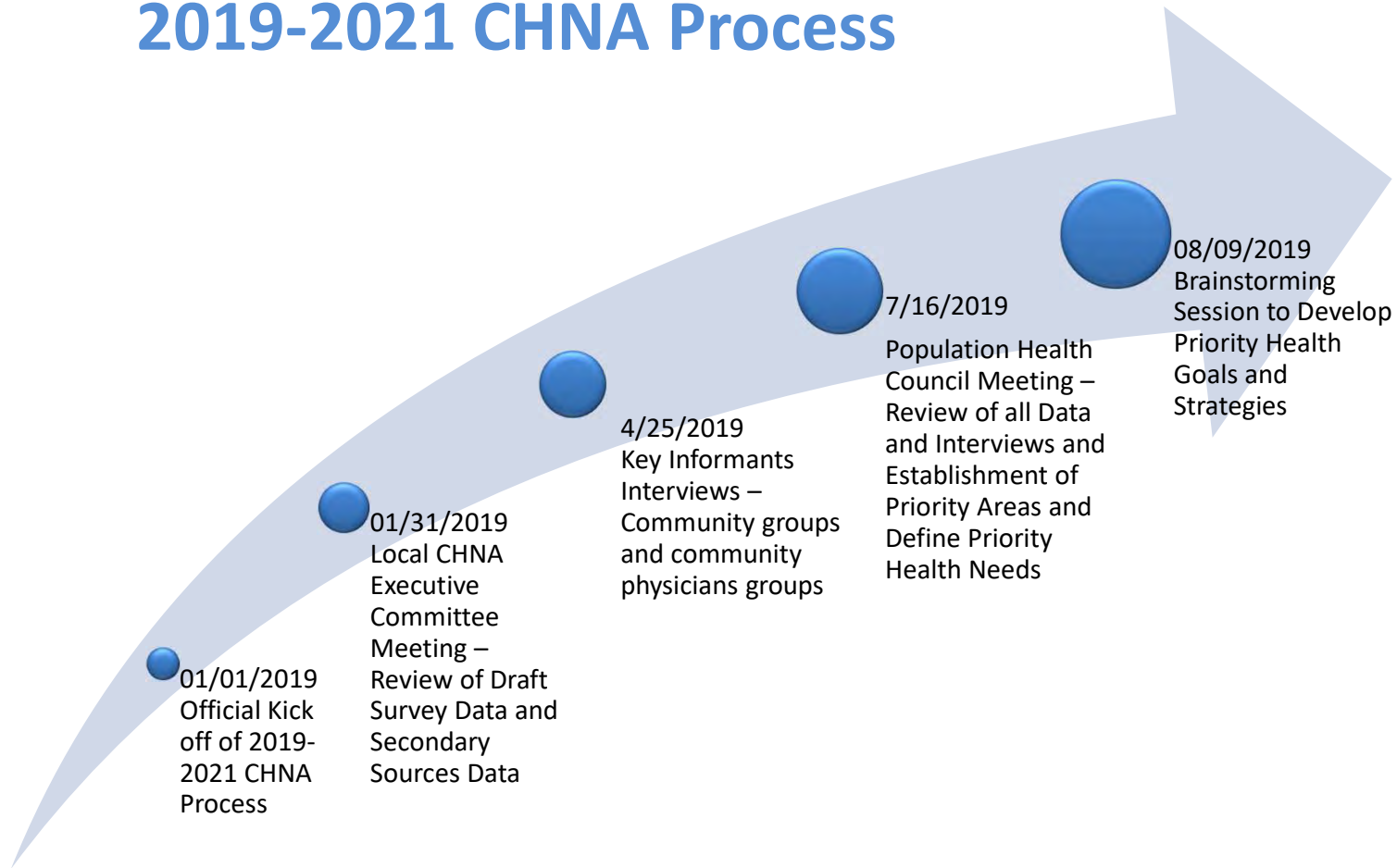
Through the CHNA process, health need priorities were chosen based on the Medical Center’s capacity, resources, competencies, and the needs specific to the populations it serves. These issues are within the hospital’s purview, competency and resources to impact in a meaningful manner. The Implementation Plan addresses the manner in which JCMC will address each priority need and the expected outcome for the evaluation of its efforts. After a comprehensive analysis and rigorous prioritization process resulted in the following final four selected priority areas*:

1. Preventive Health Care Services
2. Access to Health Care (Primary Care and Behavioral Health)
3. Chronic Disease Management (Diabetes & Hypertension)
4. Violence/Safety

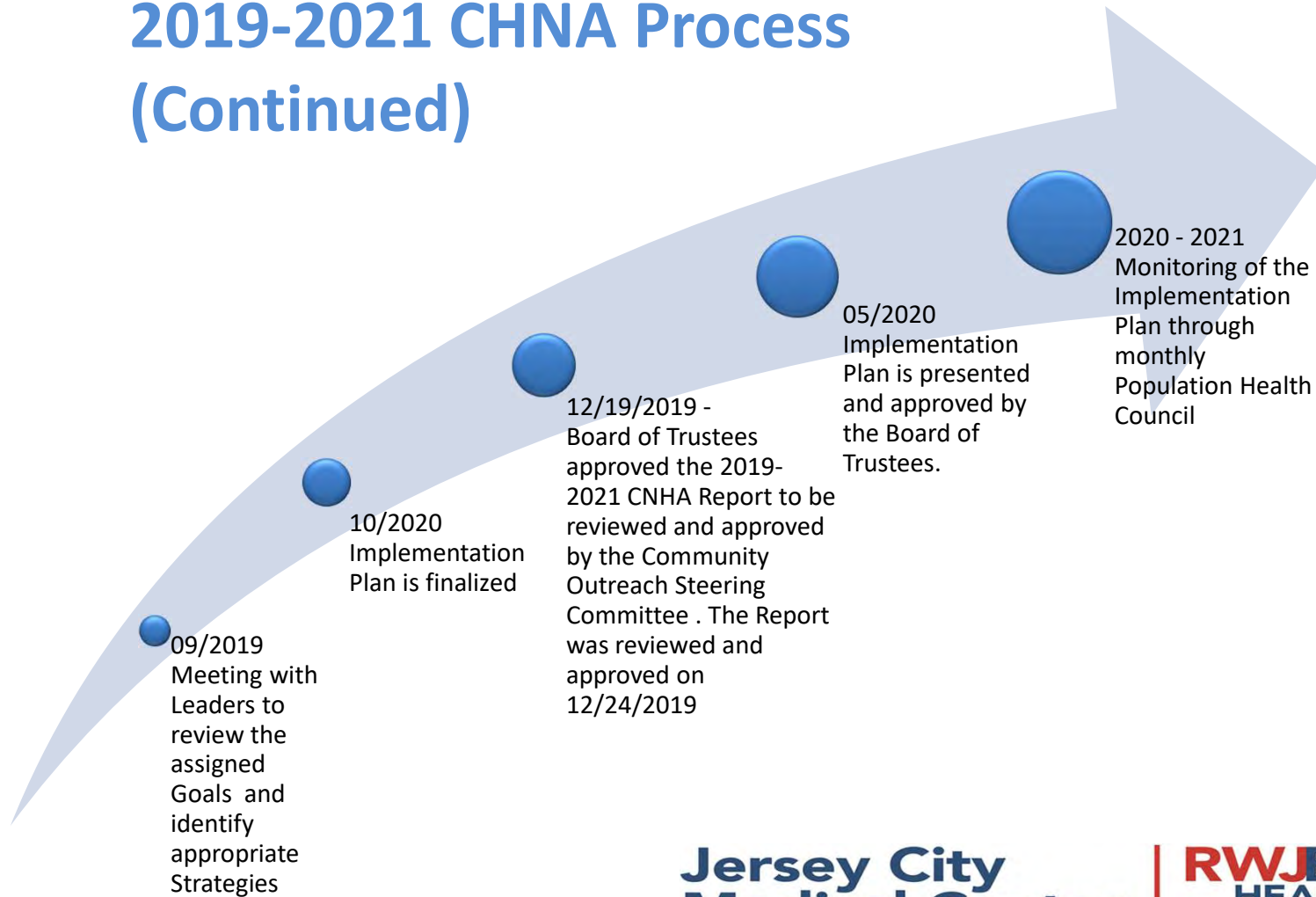
JCMC is active as a founding member of HealthierJC which is made up of key stakeholders (government, civic, community-based organizations, faith-based organizations and healthcare providers) who are focused on proactively reducing health disparities and improving the health of community members. JCMC will continue to work with the HealthierJC coalition, other providers and community organizations to improve the health and welfare of our communities.

**The four priority areas do not represent the full extent of the Medical Center’s community benefit activities or its support of the community’s health needs. Other significant needs identified through the CHNA include maternal/infant care, transportation, insurance, finances/poverty, language barriers, and outreach to diverse populations. Many of which are already being addressed in existing programs and through other credible means. The hospital, with limited resources, will work on prioritized needs and continually work with the community and other providers and agencies to improve health status. Action for some needs may be better addressed by other agencies/organizations or deferred to another timeframe.*

2019-2021 CHNA Process



2019-2021 CHNA Process (Continued)





Implementation Plan

**Jersey City
Medical Center** | **RWJBarnabas**
HEALTH

Priority Health Needs & Respective Goals

Priority Health Need	Goal
Preventive Health Care Services	Increase the number of health screenings & consumer education to improve health & wellbeing
Access to Care	Improve access to primary care, mental health, & substance abuse services
Chronic Disease Management: Diabetes, Hypertension, & Obesity	Reduce the Impact of Chronic Disease through education & programs targeting better disease and care management
Violence Prevention & Safety	To promote safety and decrease incidence of violence with a focus on individual behaviors, physical environment, and social environment

Goal 1:

Preventive Health Care Services

Increase the number of health screenings & consumer education to improve health & wellbeing

Key Findings:

- In 2016, a lower percentage of Hudson County adults over age 50 (56.2%) participated in colorectal screening than adults statewide (65.1%)
- In 2016, the percent of Hudson County adults who received a flu shot (60.1%) was lower than the *Healthy People 2020* target of 90%.

Strategy	KPI	Outcomes
1.1: Increase community based health screenings and intervention in vulnerable populations by 5% by December 31, 2021.	# health screenings conducted # number of individuals linked to primary care	Health Screenings (2019) – 827 Events -34,120 participants Health Screenings (2020) – 357 Events – 6,525 participants. 3,027 staffing hours completed while providing over 30 unique community programs Health Screenings (2021) – 247 Events – 3,438 participants. 4,369 staffing hours completed while providing over 17 unique community programs Primary Care Patient Visits/Service Linkages – 5,123 (2019), 4,441 (2020) 8,415 (2021) – Increase of 65% COVID-19 vaccine clinic conducted 18,870 vaccinations for community residents. Special accommodations were made for home-bound patients, behavioral health patients, homeless shelters, PACE (Program of All-inclusive Care for the Elderly) program members, Jersey City public schools, etc.
1.2: Increase community based consumer education in vulnerable populations by 5% by December 31, 2021.	# of health and wellbeing related education sessions	Health Education Sessions (2019) – 827 Events Health Education Sessions (2020) – 357 Events Health Education Sessions (2021) – 247 Events
1.3: Initiate oncology-specific (colon and lung) screenings by December 31, 2021.	# of colon cancer screenings # of lung cancer screenings # of patients outreach and educated	337 patients outreach and educated in 2019. 1,872 patients outreach and educated in 2020-2021. A 500% increase in patient outreach from baseline year of 2019. 91 lung cancer screenings (through Nurse Navigation only) – 2019. 117 lung cancer screenings in 2020-2021 74 colon cancer screenings (through Nurse Navigation only) 2020-2021 – Services established in July, 2020.

Goal 2:

Access to Care

Improve access to primary care, mental health, & substance abuse services

Key Findings:

- In 2015, 14.8% of Hudson County's 18-64 population was uninsured in comparison to the statewide rate of 10%
- In 2015, Hudson County performed in the worst performing quartile of all New Jersey counties for the ratio of population to primary care physicians.

Strategy	KPI	Outcomes
1.1: Increase adult outpatient mental health services at 2 co-located primary care sites by December 31, 2021.	# of patients seen # of clinical interventions	Establishment of a co-located primary care and mental health services in Journal Square in September, 2020 and expanded telepsychiatry services to community residents. 668 patients were seen in 2020. 2,652 patients were seen in 2021. Additional providers and expansive network of mental health specialist has been established via telehealth.
1.2: Improve access to mental health crisis services through an additional offsite- crisis location by December 31, 2021.	# of visits	63 individuals provided with housing vouchers and complex case management services in 2019-2021. Comprehensive network of behavioral health providers and clinical pathways developed. Increased access to providers 2 (2020) and 6.8 FTE in 2021.
1.3: Increase access to primary care physicians by opening 3 primary care locations by December 31, 2021.	# of new PCP # of hours added # of community members able to be served	Expansion of ambulatory care services – Primary Care Services (Greenville, Bayonne, J. Square & Heights Sites), JCMC/Greenville/Bayonne retail pharmacy, Infusion Center and Colony Plaza Specialty Clinics operational. Greenville Primary Care added new providers 1 PCP (2019), 2 PCP's (2020) and 3 PCP's (2021). Addition of 17 sub-specialty physicians in 2021 to improve access and coverage for community members Increased clinic hours to 50 hours on Weekdays and expanded late hours to 7PM

Goal 3:

Chronic Disease Management

Reduce the Impact of Chronic Disease through education & programs targeting improved disease and care management

Key Findings:

- The percent of Hudson County residents with a BMI of ≥ 30 trended upward from 27.4% in 2011 to 31.2% in 2016.
- Within Hudson County, the percent of adults reporting no leisure-time physical activity trended upward from 27% in 2014 to 36% in 2016.

Strategy	KPI	Outcomes
1.1: Utilize locally hired CHWs to link individuals with chronic disease to primary care and other needed community resources by December 31, 2020.	# of individuals connected to primary care # individuals link to community resources	688 individuals screened for social determinants of health barriers in 2020. 3,086 community residents provided with community service linkages in 2020. 785 individuals screened for social determinants of health barriers in 2021. 4,200 community residents provided with community service linkages in 2021.
1.2: Initiate nutritional disease specific education and counseling	# nutrition consultations	Registered Dietician provided nutrition consultations for 611 community members (Services established in April, 2021) Distributed 925 Turkey Vouchers (\$46,250 value) and food supplies to Jersey City patients facing food insecurity for Thanksgiving in 2020-2021 Distributed 440 prepared meals to Jersey City Residents during the COVID-19 pandemic in 2020
1.3: Implement Fresh Food Farmacy Program to provide healthy foods and disease-specific education focused on nutrition by December 31, 2020	# of patients who were referred and received services from the Fresh Food Farmacy	116 patients seen (services established in April, 2021) The Green Apple Rx Food FARMacy Greenville conducted 661 SDOH screens and enrolled 116 clients facing food insecurity. 1,178 pounds of food donated through Campus Kitchen to community members in 2021

Goal 4:

Violence Prevention & Safety

To promote safety and decrease incidence of violence with a focus on individual behaviors, physical environment, and social environment

Key Findings:

- Hudson County ranked in the poorest performing quartile for burglaries statewide and the middle quartile for domestic violence arrests compared to all NJ counties.
- In 2017, the violent crime rate in Hudson County was 325/100,000 reflecting the worst performing quartile for the County Health Rankings

Strategy	KPI	Outcomes
1.1: Grow JCMC’s hospital-based violence intervention program for at-risk community members by 10% through December 31, 2021.	# of participants in HVIP Rate of recidivism	89 active participants (2019) 10% recidivism rate Project Hudson served 246 clients through services provided by both JCMC and community partner (JCACM) in 2021 Financial contribution of \$2,000 for Gun Violence education training in 2021
1.2: Provide peer counseling and mental health services to trauma patients through December 31, 2021.	# of patients seen by mental health worker # of participants in peer counseling	322 Referrals for Mental Health Counselling and Support (2021) 112 participants in peer counseling (2021)
1.3: Develop and implement a program to deliver support groups and workshops for victims and families	# of support groups # of workshops # of participants served	48 Support Group Sessions and 1,766 Community residents served in 2021. Distributed 1900 face masks and 600 Personal Protective Equipment kits to area Shelters, community partners and local businesses in 2020.