RWJUH Rahway & Trinitas Regional Medical Center Community Health Needs Assessment

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PREPARED BY
HEALTH RESOURCES IN ACTION

Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

Trinitas Regional Medical Center | RWJBarnabas HEALTH

Acknowledgements

The following partners led the RWJUH Rahway and Trinitas Regional Medical Center Community Health Needs Assessment:

Robert Wood Johnson University Hospital Rahway Executive Team

- Kirk C. Tice, President & CEO
- Carol Ash, DO, MHCDS, MBA, CMO
- Rodney Dunn, VP & Site Financial Officer
- Ann Marie Shears, RN, MA, NE-BC, VP Patient Services & CNO
- Deborah Gandy, MSN, MSA, RN, CPHQ, VP Clinical Transformation and Integration
- Heather Hays, VP RWJUH Rahway Foundation & Development

Trinitas Regional Medical Center Executive Team

- Gary S. Horan, FACHE, President & CEO
- Laura Ciraco, VP Trinitas Health Foundation & CDO
- John D'Angelo, DO, VP & CMO
- Nancy M. DiLiegro, Ph.D., FACHE, VP Clinical Operations and Physician Services & CCO
- Karen E. Lumpp, CPA, Sr. VP of Finance & CFO
- William McHugh, MD, CPEO
- Mary McTigue, DNP, RNC, CENP, VP Patient Care Services & CNO
- Sister Rosemary Moynihan, VP Mission Effectiveness
- Glenn Nacion, VP & CHRO
- Lisa Dressner, MSW, LCSW, VP Behavioral Health and Psychiatry

CHNA Advisory Committee

The RWJUH Rahway and Trinitas Regional Medical Center 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. This committee was chaired by Donna Mancuso, Director of Marketing and Community Education at RWJUH Rahway and Nancy M. DiLiegro, Ph.D., FACHE, VP Clinical Operations and Physician Services & CCO and Sister Rosemary Moynihan, VP Mission Effectiveness at Trinitas Regional Medical Center. Advisory Committee members included:

- Carol Ash, DO, Chief Medical Officer, RWJUH Rahway
- Colleen Clayton, Chief Membership and Development Officer, Gateway Family YMCA
- Mark Colicchio, Health Officer, City of Elizabeth Department of Health and Human Services
- Shannon Frank, Branch Executive Director, Gateway Family YMCA
- Krishna Garlic, Director of Health & Human Services at City of Elizabeth Co-owner of Collaboration Over Competition
- Doug Harris, retired Trinitas VP of Marketing
- Patrick Koslecki, Director of Diversity and Inclusion, RWJ Rahway
- Pat Roman, NAMI Union County
- Rod Spearman, Union County Fatherhood Initiative Coalition
- Lauren Trattner, DO, Associate Chair, Emergency Department, RWJ Rahway
- Laurie Westra, retired Trinitas VP Quality; Elizabethtown Healthcare Foundation

RWJBarnabas Health Community Health Needs Assessment Steering Committee

Committee Members

- Tamara Cunningham, VP System Development/Planning, Co-Chair
- Cathy Dowdy, SVP and Comptroller, Co-Chair
- Andy Anderson, MD, President, RWJBH Medical Group
- Barbara Mintz, MS, RDN, SVP, Social Impact and Community Investment
- DeAnna L. Minus-Vincent, MPA, Executive Vice President, Chief Social Justice & Accountability Officer
- Deborah Larkin-Carney, RN, BSN, MBA, SVP, Quality and Patient Safety and Patient Experience
- Frank A. Ghinassi, PhD, ABPP, SVP Behavioral Health
- Indu Lew, Executive Vice President, Chief of Staff
- Joseph Jaeger, DrPH, GME/Physician Education
- Jim Andrews, SVP, 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 VP, Corporate Reimbursement
- Susan Solometo, MBA, SVP, Strategy and Operations, Oncology Services
- Suzanne Spernal, 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) Somerset – 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 RWJB Community Health Needs Assessments should be directed to RWJ Barnabas Health System Development/Planning at BHPLanningDept@RWJBH.org.

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Executive Summary

Introduction

In 2022, Robert Wood Johnson University Hospital (RWJUH) Rahway and Trinitas Regional Medical Center (TRMC) initiated the process of a community health needs assessment (CHNA) of the communities it serves in Union County and Middlesex County, New Jersey. The purpose of the CHNA was to provide an empirical foundation for future health planning as well as fulfill the community health needs assessment mandate for non-profit institutions put forth by the IRS.

Health Resources in Action (HRiA), a non-profit public health consultancy organization, provided support, facilitation, and data analysis for the RWJUH Rahway-TRMC CHNA process.

RWJUH Rahway-TRMC CHNA Focus Area

Context

This CHNA was conducted during an unprecedented time due to the novel coronavirus (COVID-19) pandemic and the national movement for racial justice. The COVID-19 pandemic coincided with the activities of this assessment and 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

The 2022 RWJUH Rahway-TRMC CHNA aims to identify the community needs and strengths through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors at multiple levels—from lifestyle behaviors (e.g., healthy eating and active living) to clinical care (e.g., access to medical services) to social and economic factors (e.g., poverty) to the physical environment (e.g., air quality)—which have an impact on the community's health.

The CHNA process aims to describe the health needs of the service area, challenges in addressing these needs, current strengths and assets, and opportunities for action. To accomplish this, the RWJUH Rahway-TRMC CHNA utilized several different methods for data collection including:

- Reviewing existing data on social, economic, and health indicators in Union and Middlesex Counties.
- Conducting a community survey with 443 residents designed and administered by the survey firm Bruno & Ridgway.
- Facilitating 4 virtual focus groups with 50 participants from specific populations of interest (e.g., residents identifying as Haitian (conducted in Haitian Creole), African American residents, Spanish-speaking low-income residents seeking food and/or housing assistance (conducted in Spanish), and volunteers providing food access to economically vulnerable and unhoused residents.)

- Conducting 17 key informant interviews or group discussions with 19 stakeholders in the community from a range of sectors.

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

Population Characteristics

- **Demographics**. Most towns in the hospitals' primary service areas experienced minimal population growth between the periods of 2011-2015 and 2016-2020, and some reduced in population size. The towns of Clark, Cranford, Elizabeth (07201), and Rahway experienced population growth of 3% or more, while the towns of Avenel (-8.6%) and Elizabethport 07206 (-2.6%) experienced population shrinkage. In 2020, fewer than four in ten residents in Union and Middlesex Counties identified as White, non-Hispanic (36.7% and 38.6%). Union County had a higher percentage of residents identifying as Hispanic/Latino (34.0%) and Black, non-Hispanic (19.5%), and Middlesex County had a higher percentage of residents identifying as Asian, non-Hispanic (26.4%).[1] The percent of the population that was foreign-born ranged from 9.8% in Cranford to 49.3% in the 07201 zip code in Elizabeth, as did the percent of the population aged 5+ speaking a language other than English at home, which ranged from 13.0% in Cranford to 77.3% in the 07202 zip code in Elizabeth.[2]

Community Social and Economic Environment

- **Community Strengths and Assets.** When focus group and interview participants were asked to describe the strengths of their community, they were most likely to discuss accessibility, a sense of safety, individual resident qualities (e.g., hardworking), the sense of support and community that exists between residents, and the local supports and organizations that are readily accessible and serve the community.

> *"Our strength is our community because we have a large support system. People know our health department is always here, our FQHC is here, our nurses are available. They know that our hospital is readily available. They have a lot of resources. You have a lot of community support and organizations."*
> – Key informant interviewee

- **Education.** Four-year adjusted high school graduation rates in Union and Middlesex County vary by district and race/ethnicity. District-wide rates ranged from approximately 82-97% depending on the district, with the lowest rates in Elizabeth Public Schools and Roselle Public School District, and the highest rates in Clark Township Public School District and Cranford Public School District. Parent focus group participants frequently discussed area schools in a positive light, noting that there were strong parent-staff relationships, free breakfast and lunch for eligible students, and that students have opportunities to study various fields of interest. However, parents also noted that schools face challenges with overcrowding, limited youth programs, and virtual learning challenges and learning loss due to the pandemic.

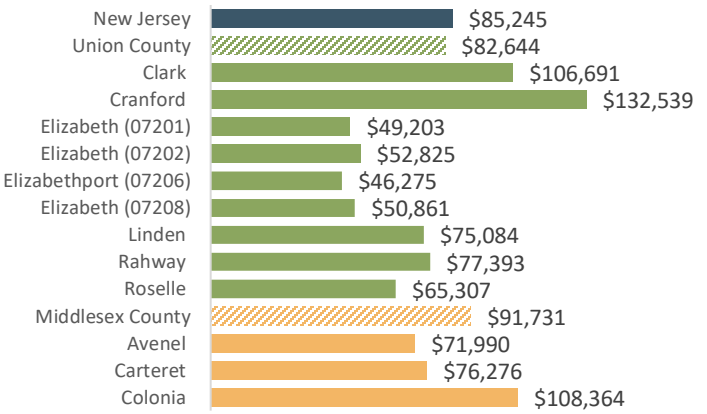
- **Employment and Workforce.** Focus group participants and interviewees spoke about employment challenges in the community and how those struggles relate to economic vulnerability, food and housing instability, and limited access to healthcare. Residents shared that they face challenges with finding jobs, particularly jobs that offer benefits and living wages. The COVID-19 pandemic also resulted in job loss, reduced hours, and inability to work due to a lack of childcare, with participants noting their belief that women and residents of color were more likely to be impacted by job related challenges. Unemployment rates in Union and Middlesex Counties surged to about 9% in 2020 at

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

the time of the pandemic onset and began declining downward to approximately 6% in 2021.[2] The compounded effect of the pandemic and the inability to find jobs may also have influenced residents to stay in poorly paid jobs due to a fear of being without work entirely.

- **Income and Financial Security.** Focus group and interview participants described challenges in accessing income and employment and shared concerns about rising costs for daily necessities (e.g., housing, transportation, childcare, food, and healthcare). These challenges led to situations where residents were forced to choose which necessities they could afford and which they will do without. Disparities also exist, with participants voicing particular concern for older residents and those living on fixed incomes. Data show that median household income ranges from $46,275 in Elizabethport (07206 zip code) to $132,539 in Cranford, nearly a threefold difference.

Median Household Income, by State and County, 2016-2020



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

- **Food Access and Food Insecurity.** Several participants voiced concerns about rising food costs, availability of nutritious foods, access to grocery stores, and knowledge of how to best prepare food in culturally appropriate ways that preserves nutrition. Participants also explained that they saw seniors, families with children, and immigrant communities as being more likely to struggle with food insecurity. Consistent with interviewee and focus group perceptions, data from the Feeding America, Map the Meal Gap shows that in 2020, after the onset of the COVID-19 pandemic, approximately 11% of residents in Union and Middlesex Counties were food insecure, which represents nearly a 4% increase from 2019.[3]

- **Housing.** Residents frequently discussed how they saw housing costs continuing to rise and outpacing incomes, and that there were limited lower-priced housing options. Beyond housing availability, residents explained that structural barriers, such as requirements to earn three-times the monthly rent and being required to provide large down deposits before renting. They noted that these factors led residents to struggle maintaining adequate housing, resulting in many facing homelessness and making difficult trade-offs in meeting other basic needs (e.g., limiting food or medication to afford rent). Community housing supports were also mentioned by residents, who noted that it was difficult to qualify for assistance and that supports frequently had long waitlists. Participants observed that seniors, families, and immigrant residents seem to be more impacted by housing instability. Data further substantiate the experiences voiced by residents. Monthly median housing costs for renter-occupied households from 2016-2020 in Union County were an average of $1,335, and 63.3% of households reported housing costs above 25%+ of monthly household income.

[2] DATA SOURCE: Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012-2021
[3] DATA SOURCE: Feeding America, Map the Meal Gap, 2019 and 2020

Similarly, Middlesex County median housing costs were $1,495 and 58.5% of households reported housing costs above 25%+ of monthly household income.[4]

- **Transportation.** Participants frequently remarked that walkability and public transportation were community assets. However, challenges including parking availability, affordability of transportation services, parking fees and availability, gas prices, and structural barriers to getting a driver's license were all mentioned as transportation challenges. Most residents in the RWJUH Rahway and TRMC primary service areas commuted to work alone by car, truck, or van. Residents in Colonia (82.8%), Clark (78.3%), and Carteret (74.7%) had the highest proportion of commuters who relied on their own car when getting to work, while Cranford (15.6%), Roselle (14.2%), and Rahway (13.6%) had the highest proportion of commuters who used public transportation.[5]

- **Green Space and Built Environment.** Some participants highlighted the built environment in Union and Middlesex Counties as assets, noting amenities such as walkability, access to parks, and nearby stores and libraries. These sentiments were reinforced in community survey data from 2021, which indicate that 82.4% of survey respondents from Union County agreed or completely agreed with the statement, "My community has safe outdoor places to walk and play."

- **Crime and Violence.** In 2020, violent crime against persons (i.e., murder, rape, aggravated assault) varied widely across towns in Union and Middlesex Counties. At 599.6 incidents per 100,000 residents, Elizabeth (citywide) had a rate over three times as high as the state rate (195.4 per 100,000 residents), and Cranford had the lowest rate, 12.3 per 100,000 residents. While a few group and interview participants reported feeling unsafe in certain parts of town or noting a perceived increase in people losing tempers, crime and violence were generally not major themes in conversations.

- **Systemic Racism and Discrimination.** Participants raised concerns regarding the exclusion or marginalization of communities based on immigration status, language, income, and race or ethnicity. Several participants also shared experiences with racism and disrespect when receiving healthcare and other social services, including microaggressions, perceived segregation, lack of language services, and differential treatment. The need to understand the history of racism, systemic oppression, and socioeconomic and health impacts on residents was emphasized as a way to combat racism and discrimination. Among survey respondents, more than one third of Black (35.3%) and a quarter of Hispanic (25.6%) respondents reported experiencing discrimination due to their race/ethnicity when receiving medical care compared to 14.7% of respondents overall. Additionally, over 20% of Hispanic/Latino survey respondents also reported feeling discriminated against when receiving medical care due to their language/speech, a sentiment that was echoed by Haitian Creole residents.

> *"People of color are in these situations because of the color of their skin but that happens all the time… The stories I've heard from other people when they had Covid and were in the hospital, a nurse told me that people of color were treated differently."*
> – Key informant interviewee

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

Community Health Issues

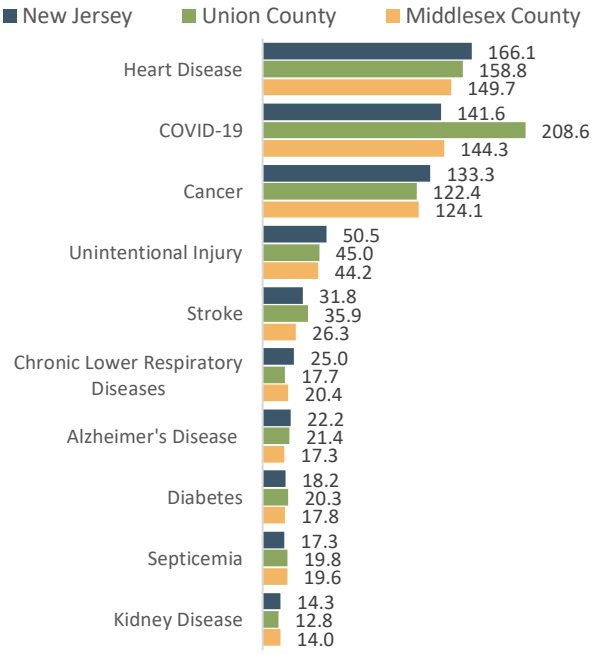
- **Community Perceptions of Health.** When discussing health concerns, participants frequently identified social and economic issues such as financial insecurity, housing, and access to healthy food, and described how these challenges negatively affected healthy eating, obesity, and chronic conditions. Participants also discussed challenges in accessing care, an increase in mental health concerns, and the lingering impacts of the COVID-19 pandemic. Survey respondents identified mental health, overweight/obesity, and high stress lifestyle as their top community health concerns.

- **Leading Causes of Death and Premature Mortality.** In 2020, heart disease, COVID-19, and cancer were the top three causes of death for New Jersey, Union County, and Middlesex County, with COVID-19 having a disproportionate impact in Union County compared to Middlesex and New Jersey rates.[6] In 2018-2020, the premature mortality rate (deaths before 75 years old) was lowest in Middlesex County, compared to Union County and New Jersey overall, but county-level data show that that White, non-Hispanic residents in Middlesex County and Black, non-Hispanic residents in Union County experience higher rates of premature mortality than other residents.

- **Obesity, Healthy Eating, and Physical Activity.** Although obesity was one of the top three health concerns in the community in the 2021 survey, it was not discussed at length in the focus groups or interviews. Instead, focus group and interview participants more frequently discussed challenges such as limited access to grocery stores, lack affordability of healthy foods, reliance on schools and food pantries for food, and difficulty navigating structural barriers and qualifying for assistance, which may not provide enough food or foods that are appropriate for residents' dietary needs. In 2018, 27.6% of Union County adults, and 25.5% of Middlesex County adults were considered obese, which is higher or the same as New Jersey overall (25.5%).[7]

- **Chronic Conditions.** As seen in the hospitals' 2019 CHNAs, chronic disease is an ongoing challenge for the community. Conditions such as heart disease, diabetes, cancer, and COPD are prevalent conditions in Union and Middlesex Counties and among the top 10 leading causes of death at the state and county levels. Survey data indicate that participation in screenings varies by race/ethnicity.[8] Furthermore, non-Hispanic Black and non-Hispanic White residents

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), 2020

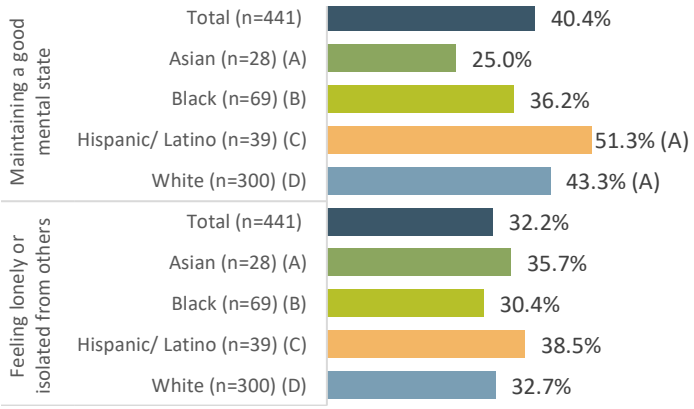
[6] DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health as reported New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020
[7] DATA SOURCE: Centers for Disease Control and Prevention (CDC), U.S. Diabetes Surveillance System, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2018
[8] DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021

experienced higher CVD and cancer mortality rates compared to other racial/ethnic groups.[9] Specific conditions were not discussed at length by participants. However, some interview participants highlighted that chronic disease conditions are being further compounded by discrimination, limited health literacy including not understanding medication uses and instructions, and the use of herbal remedies which may inhibit or delay seeking treatment for chronic conditions.

- **Disability.** During focus groups and interviews, participants rarely discussed the needs of residents with disabilities. Instead, the subject of disabilities was often mentioned when talking about income and the impact having a disability can have on financial security, and the barriers around accessing support services, such as housing and health services. Participants also emphasized the need for the community to connect with and care for older populations, as well as bolster early diagnosis and treatment for youth with learning disabilities or other challenges.

- **Mental Health.** Behavioral health was a key topic in the hospitals' 2019 CHNAs and continued to be a concern in 2022. Mental Health arose in almost all conversations conducted for this CHNA, and it was considered the top community health concern among survey respondents. Job loss and financial insecurity, virtual schooling, social isolation, loss of friends and family members, fear, and the general uncertainty associated with the pandemic were all cited as contributors to increased stress, depression, anxiety, and sense of crisis among residents. Four in ten survey respondents reported that they or someone in their family has personally experienced difficulty with mental health issues since COVID-19 started, and 32.2% reported feeling lonely or isolated since COVID-19 started. While mental health issues affected people of all backgrounds, seniors and youth were thought to be more impacted. Furthermore, participants explained that receiving mental health treatment can be challenging for those without insurance, and that stigma remains a barrier to accessing support. Participants also shared concerns for the involvement of law enforcement in responding to residents in mental health crisis. Mental health was viewed as a co-occurring condition, with residents noting that mental health, substance misuse, and housing instability frequently present challenges simultaneously.

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=441), 2021



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

- **Substance Use.** Focus group and interview participants noted that they saw the pandemic as exacerbating addictive behaviors and substance use, with some participants observing drug use in the streets and in schools. Residents working with unhoused populations commented that they knew of multiple individuals who passed away during the pandemic from alcoholism, while other residents noted that some towns have higher rates of substance use than others. Data on substance

[9] 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

use treatment admissions by primary drug in 2020 indicate that heroin, alcohol, and marijuana were the top three most frequently reported drugs at the time of admission in New Jersey, Union County, and Middlesex County.[10] Rates of age-adjusted drug poisoning mortality have also increased from 2016 to 2020, with the rate doubling in Union County from 14.1 to 28.6 per 100,000.[11]

- **Environmental Health.** The primary natural disaster mentioned by the community was Hurricane Ida, which caused flooding, home loss, and displacement of residents which the community has not fully recovered from. Access to clean water and lead exposure due to water pipes was also discussed as a pressing concern for some participants, who commented that interrupted water access was a common occurrence, and that when water was working, it often had a bad taste, smell, or appearance. Concerns about water safety and lead exposure from the water supply, particularly among children, were of particular concern among participants.

- **Communicable Disease.** COVID-19 continued to be a frequent topic in all focus groups and interviews due to its substantial and far-reaching impacts on all sectors of life. Participants shared the impacts of the pandemic on financial and mental well-being, many of which have persisted or worsened since the onset of the pandemic. Those with children discussed challenges with schooling, social skills development, and education lost. The shutdowns, social distancing, and workforce shortages have also affected healthcare access. Participants explained that vaccinations continue to be a point of fear or mistrust. Case numbers have fluctuated, and racial/ethnic disparities exist among COVID-19 deaths in New Jersey. While Black residents only made up 12.4% of the state population in 2020, they accounted for 16.6% of COVID-19 deaths as of August 2022. Beyond COVID-19, some participants also discussed sexually transmitted infections, explaining that there is a need for honest and informative sexual education for youth and adults, that increased access to contraceptives is needed for health, and that there is a need for more vaccine and testing clinics in the community.

- **Maternal and Infant Health.** Maternal and infant health was a key priority in TRMC's 2019 CHNA. In 2022, participants commented on the need for additional care and support to lower the rates of maternal and infant mortality, particularly among residents who identify as Black or African American. In Union County, 7.5% of births are low birthweight (weighing less than 2,500 grams), with residents identifying as Black, non-Hispanic having the greatest proportion of low-birth-weight births in the county (11.4%) as well as in the state.[12] Accessible and sustainable programs, provider training on disparities and caring for women of color, and partnerships with local organizations to distribute information were emphasized as needs to improve maternal and infant health.

Access to Services

- **Access to Healthcare Services.** While some participants reported accessible and affordable healthcare as a strength of their community, others noted existing disparities in access to healthcare services. Barriers included a lack of awareness of resources, high healthcare costs, a lack of health insurance, a lack of childcare, language and cultural barriers, technology challenges related to

[10] 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, 2019

[11] 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

[12] 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

telehealth, limited health literacy, and unreliable transportation. The top issues survey respondents reported were the ability to schedule an appointment at a convenient time (26.9%), insurance problems (25.8%), wait times (24.0%), cost of care (19.9%), and doctors not accepting new patients (16.3%). It should also be noted that 38.9% of survey respondents indicated that they have never experienced difficulty in getting healthcare.[13] Many focus group and interview participants also discussed structural barriers and gaps in healthcare access, particularly for residents who are undocumented, economically vulnerable, or who lack proof of citizenship. Beyond access, participants commented that holistic approaches to care are more time and labor intensive for staff, many of whom are experiencing burnout and other challenges which may result in workforce shortages and longer wait times.

> *"Many people don't have health insurance. When they leave the hospital, they can't buy their prescriptions. The rent in Elizabeth is very high… Food is also very expensive. Salaries here don't cover the basic needs of a family. For childcare, either you have to pay someone, or you have to depend on family to help with childcare."* - Focus group participant

Community Vision and Suggestions for the Future

- **Expand Accesses to Services and Healthcare Resources.** Expanding access to healthcare resources and services was one of the most frequent recommendations by participants. Suggestions included mobile units, health fairs, and partnering with grassroot initiatives and organizations to further bring health into the community. Increased access to mental health services and expanded crisis supports were also mentioned by residents. When discussing health needs currently impacting the community, COVID-19 was mentioned as an ongoing health challenge with widespread implications on daily life. Residents emphasized the need for continued access to free testing and vaccinations for all members of the community. Additionally, economically vulnerable and undocumented residents have less access and higher need for free or low cost and accessible services.

- **Implement Strategies to Improve the Healthcare Delivery Experience and System.** Focus group and interview participants also frequently shared strategies to help improve the healthcare system, including hiring additional and more qualified staff, increasing accountability for staff, implementing measures to improve satisfaction (e.g., patient satisfaction surveys), and increasing community engagement to inform the healthcare system of community needs at more frequent intervals. Additionally, residents suggested increasing culturally appropriate supports and language services, increasing access to education, and expanding the pipeline for culturally diverse community residents to work in healthcare.

- **Improve Communication and Health Promotion Strategies to Meet the Needs of the Community.** Communication challenges were frequently mentioned by residents as both a barrier to accessing care and a barrier to understanding what resources are available in the community. Participant recommendations included improving outreach to expand awareness of resources, additional promotional and information sharing within the community related to health (e.g., awareness campaigns, public service announcements), improved language access, and taking a holistic and family-oriented approach to healthcare. Participants from communities with a history of distrust of

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

the healthcare system further explained that improved communication is a vital first step to re-building trust between the community and the healthcare system.

- **Address Systemic Racism and Discrimination in Healthcare and Policies.** Racism and discrimination is a topic that was frequently mentioned by participants. Many residents envisioned a future where racism, discrimination, and disparities no longer exist, and shared recommendations to address these challenges. Suggestions included additional training for providers to build empathy and understanding when working with people of different backgrounds, and to develop education and skills related to treating patients with varying skin tones. Accountability and training to help combat racism at local levels, and advocacy to address racism at policy levels, was also suggested.

- **Improve Funding and Structural Challenges That Limit Access to Healthy Living.** Participants indicated a holistic approach that supports housing, economic stability, food access, and access to health insurance is needed. Funding and structural barriers also exist that make it challenging for residents to qualify for support services (e.g., insurance and charity care, housing assistance, and food assistance like SNAP), maintain benefits, and access needed services in a timely manner. Participants also emphasized that residents with chronic conditions and disabilities may face additional challenges and barriers.

Key Themes

- ***Social determinants of health, including housing, food access, and financial security, are top of mind for residents.*** In every focus group and interview with residents in the community, participants shared concerns around accessing daily necessities, such as having a place to live, access to healthy food and clean water, and having financial security**.** Access to housing was of particular concern to residents, with many commenting on a scarcity of affordable housing options and on rising rents. A common sentiment shared by residents was that the pandemic further exacerbated existing challenges and vulnerabilities community residents face, resulting in increased need for support services and assistance since the onset of the pandemic.

- ***Chronic conditions are prevalent in the community and further perpetuated by limited access to healthcare services, low health literacy, and affordability concerns.*** The top ten causes of death in 2020 included heart disease, cancer, chronic lower respiratory diseases, Alzheimer's disease, diabetes, and kidney disease. Many of these conditions were mentioned by residents and are influenced by factors such as healthy eating, physical activity, maintaining good mental health, and generally practicing healthy behaviors. However, residents noted that due to financial difficulties, limited access to health insurance and healthcare, and low health literacy, many residents may be on a path to poor health outcomes in the near and long term.

- ***Communities in Union and Middlesex County are diverse, and residents face barriers and disparities as a result of language, race and ethnicity, access to resources, and other social and cultural factors.*** Participants shared personal anecdotes and concerns around existing disparities resulting from structural racism or others' discriminatory behaviors against residents who speak different languages, are from different cultures, or have less access to resources. As residents reflected on systemic racism and discrimination, they noted that these issues must be addressed at both the systemic and individual levels though advocacy, training, and increased accountability.

- ***Mental health continued to be a significant health concern in Union and Middlesex County communities.*** Mental health issues were the top health concern of survey respondents. Participants also frequently commented that depression, anxiety, grief, anger, and stress have increased since the onset of the pandemic. Some populations, such as youth and seniors, may require additional supports and services tailored to their situations. Overall, stigma and limited healthcare access continue to be significant barriers to accessing mental health treatment.

- ***The COVID-19 pandemic continues to have lingering impacts on residents' daily lives and overall wellbeing.*** Participants discussed the pandemic's continued far-reaching impacts on financial, social, and physical health. Many residents noted that they have been unable to recover from job loss, reduced hours, limited childcare access, and other challenges. Concerns that government supports, such as free COVID testing, test kits, and vaccines were being discontinued was also mentioned by residents.

- ***Residents, social service organizations, and faith communities are highly invested in community health and deepening partnership between communities and healthcare providers.*** Participants frequently emphasized the desire for increased partnerships and collaboration with other organizations, faith communities, and healthcare providers. Residents also stressed the importance of health and the current momentum to further improve the resources and supports available to residents in need.

Conclusion

Through a comprehensive and iterative assessment process that included gathering community input from residents and stakeholders, feedback from a community priorities survey, and quantitative surveillance and secondary data, then initial issue areas were identified as key community needs.

These included (in no particular order):

- Financial insecurity
- Nutrition and food insecurity
- Housing
- Transportation
- Chronic disease (e.g., heart disease, cancer, diabetes)
- Mental health
- Substance use
- COVID-19
- Access to healthcare and social services
- Racism and Discrimination

After a prioritization process with the Advisory Committee and discussions with the hospital, key priority areas for RWJUH Rahway and Trinitas Regional Medical Center will include mental health, nutrition and food insecurity, chronic disease, access to healthcare and social services with an overarching focus on addressing racism and discrimination. The hospitals will also consider their existing expertise, capacity, and experience during the development of their implementation plans in 2023.

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, Robert Wood Johnson University Hospital Rahway (RWJUH Rahway) and Trinitas Regional Medical Center (TRMC) undertook a CHNA process using a mixed-methods, participatory, and collaborative approach.

RWJBarnabas Health (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 acute care hospitals within the system, RWJUH Rahway had nearly 5,100 inpatient admissions, over 31,700 emergency department visits, and over 54,000 outpatient visits in 2021.

RWJUH Rahway is located in Rahway, New Jersey (NJ) and is part of the RWJBH system. As one of the acute care hospitals within the system, RWJUH Rahway is an acute care community hospital with nearly 5,100 inpatient admissions, over 31,700 emergency department visits, and over 54,000 outpatient visits in 2021. Its campus is home to a subacute rehabilitation facility and a long-term acute care hospital.

Trinitas Regional Medical Center, a Catholic teaching hospital sponsored by the Sisters of Charity of Saint Elizabeth, is located in Elizabeth, New Jersey (NJ) and joined the RWJBH system on January 1, 2022. As one of the acute care hospitals within the system, TRMC treats over 17,000 inpatients and sees over 70,000 emergency department visits annually.

This assessment process builds off of previous assessment and planning processes conducted by RWJUH Rahway and TRMC. See Appendix H for a description of the hospitals' activities accomplished and their impact since 2019.

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 RWJUH Rahway and TRMC to support the RWJUH Rahway-TRMC CHNA.

The RWJUH Rahway-TRMC 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 RWJUH Rahway-TRMC needs assessment processes, which was conducted between March-October 2022.

The specific goals of this CHNA are to:

- Systematically identify the needs, strengths, and resources of the community to inform future planning,

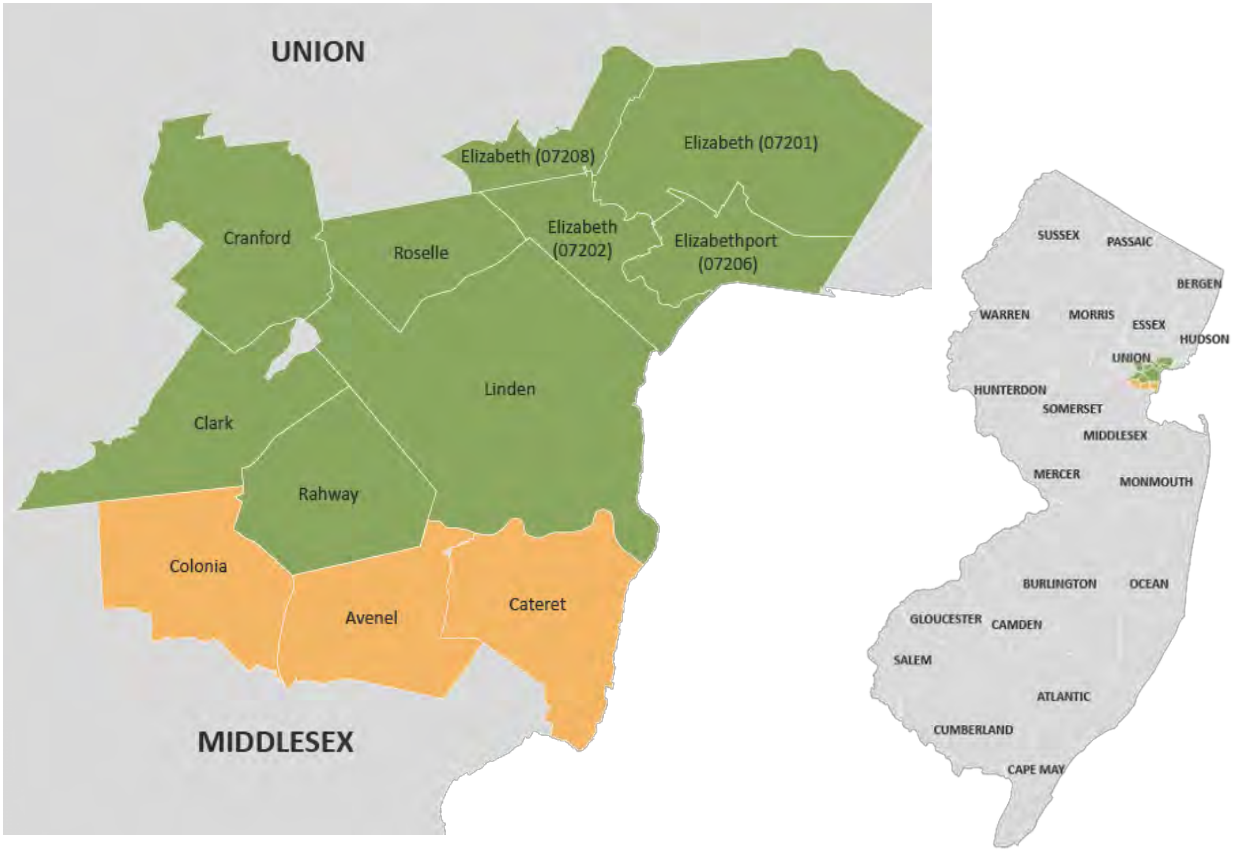
- Understand the current health status of the service area overall and its sub-populations within their social context,
- Engage the community to help determine community needs and social determinant of health needs, and
- Fulfill the IRS mandate for non-profit hospitals.

Area of Focus

This CHNA process aims to fulfill multiple purposes for a range of stakeholders. RWJUH Rahway's primary service area is part of Union County (towns of Clark, Cranford, Linden, Rahway, and Roselle) and three communities in Middlesex County (Avenel, Carteret, and Colonia). TRMC's primary service area includes the city of Elizabeth, including Elizabethport (zip codes 07201, 07202, 07208, and 07206).

To be as inclusive as possible to both hospitals, the focus area for this CHNA includes the seven towns in Union County and the three towns in Middlesex County that are in RWJUH Rahway and TRMC's primary service areas. When only county-level data are available, Union County and Middlesex County are presented. When town-level data are available, seven of Union County's towns are shown as well as data for Avenel, Carteret, and Colonia in Middlesex County. The RWJUH Rahway-TRMC CHNA service area is shown in Figure 1.

Figure 1. Focused RWJUH Rahway-TRMC 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 novel coronavirus (COVID-19) pandemic coincided with the activities of this assessment and 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 February 2022, at the beginning of this CHNA process, the COVID-19 pandemic had already been in effect for nearly 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 COVID-19 section of this report.)

Substantively, during the CHNA process, COVID-19 was and remains a health concern for communities and also has 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.

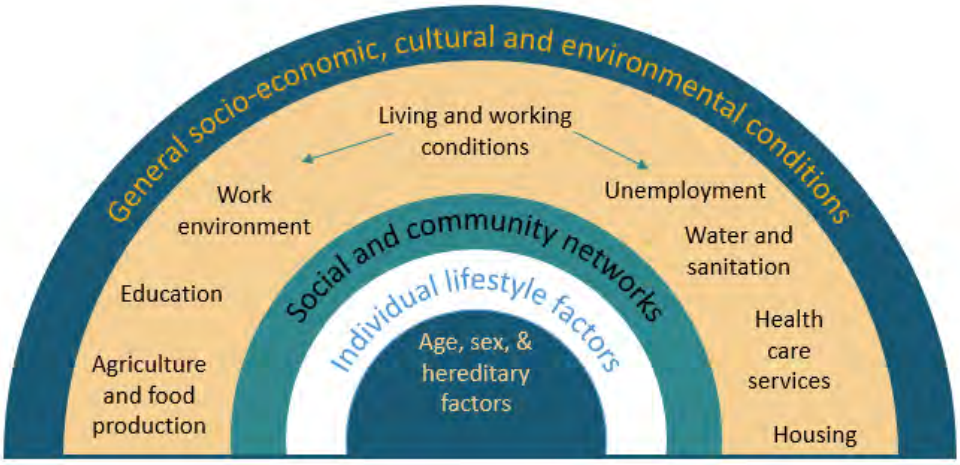
Methods

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.

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 Union and Middlesex Counties 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, RWJUH Rahway, Trinitas Regional Medical Center, the CHNA Advisory 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 will use a consistent framework and minimum set of indicators, but the approach and engagement process are tailored for each community. A Systemwide CHNA Steering Committee was convened twice during 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 the Acknowledgments section.

Advisory Committee Engagement

The two hospitals convened a joint Advisory Committee of community and hospital partners to provide insight and guidance throughout the process. The RWJUH Rahway-TRMC Advisory Committee was engaged at critical intervals. In April 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 the Advisory Committee members. After the April 2022 meeting, members of the Advisory Committee 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 the development of an engagement plan to guide qualitative data collection. During the data collection process, Advisory Committee members also assisted with making connections to support focus groups with community residents, participating in key informant interviews, and/or connecting HRiA to stakeholders in the community. See the Acknowledgements section for a list of Advisory Committee members.

The Advisory Committee reconvened in November 2022. During this meeting, HRiA staff presented the findings from the CHNA process, including the 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 and the community to consider when developing future implementation plans. A detailed description of the prioritization process can be found in the Prioritization Process and Priorities Selected for Planning section.

Community Engagement

Community engagement is described further below under the primary data collection methods. Capturing and lifting up voices 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, 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, such as the United Way of New Jersey's ALICE Study. Additionally, hospitalization data from the RWJBH system is also included in the Appendix.

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.

This 2022 RWJUH Rahway-TRMC community health needs assessment focuses on ten communities that comprise the primary service area for RWJUH Rahway and TRMC. These communities are located in Union and Middlesex Counties. Town-level data are provided when available. When county-level data are shared, data for both counties are presented.

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, since many of the towns in the service area are smaller in population size. 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

Qualitative Discussion: Key Informant Interviews and Focus Groups

Key Informant Interviews
A total of 17 key informant interview discussions were completed with 19 individuals by Zoom or telephone. Interviews were approximately 30-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 department, public safety, economic development, the faith community, school health services, mental health services, community services, and those who serve/work with

specific populations (e.g., immigrant communities, economically vulnerable populations, youth, and senior populations). See the Key Informant Interviewee Organizations and Sectors for the list of key informant interviewees and Appendix B- Key Informant Interview Guide.

Focus Groups

A total of 50 community residents participated in 4 virtual focus groups (telephone or video) conducted with specific populations of interest: residents identifying as Haitian (conducted in Haitian Creole), African American residents, Spanish-speaking low-income residents seeking food and/or housing assistance, and volunteers providing food access to economically vulnerable and unhoused 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 C- Focus Group Guide for the focus group facilitator's guide.

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 five-month period from early April and through the end of 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 by paper in 5 languages (English, Spanish, Portuguese, Arabic, and Chinese).

Outreach for survey dissemination was conducted with assistance from the RWJBH system, the hospitals, and its community partners, as well as through social media and the web. 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. Additionally, an online panel sample was recruited to capture survey responses from specific areas to augment the larger sample.

The final sample of the community priorities survey comprised 443 respondents who were residents of Union County. Appendix E- Additional Data Tables provides a table with the demographic composition of survey respondents. Respondents to the RWJUH Rahway-TRMC Community Health Needs Assessment Survey were predominately White, female, heterosexual, and with a moderate to high socioeconomic status. About 56.3% of the sample were employed full-time. Throughout this report, Union 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.

Further, due to COVID-19, focus groups and interviews were conducted virtually. Therefore, while both video conference and telephone options were offered, some residents who are unable to access the Internet and cell phones may have experienced difficulty participating. Nevertheless, the data gathered from discussions and conversations provide unique insight into individuals' experiences during an unprecedented time. In addition, the findings in this report can be built upon through future data collection efforts.

Population Characteristics

Population Overview

In 2020, the towns that comprise the RWJUH Rahway-TRMC primary service areas (PSAs) had a total population of 320,535 (Table 1). The smallest towns by population were Clark (15,847) and Avenel (17,175), while Elizabeth and Linden were the most populous communities. Avenel also experienced the largest decrease in population from 2015-2020 (-8.6%), while Clark and Elizabeth zip code 07201 experienced the greatest population growth (4.6%).

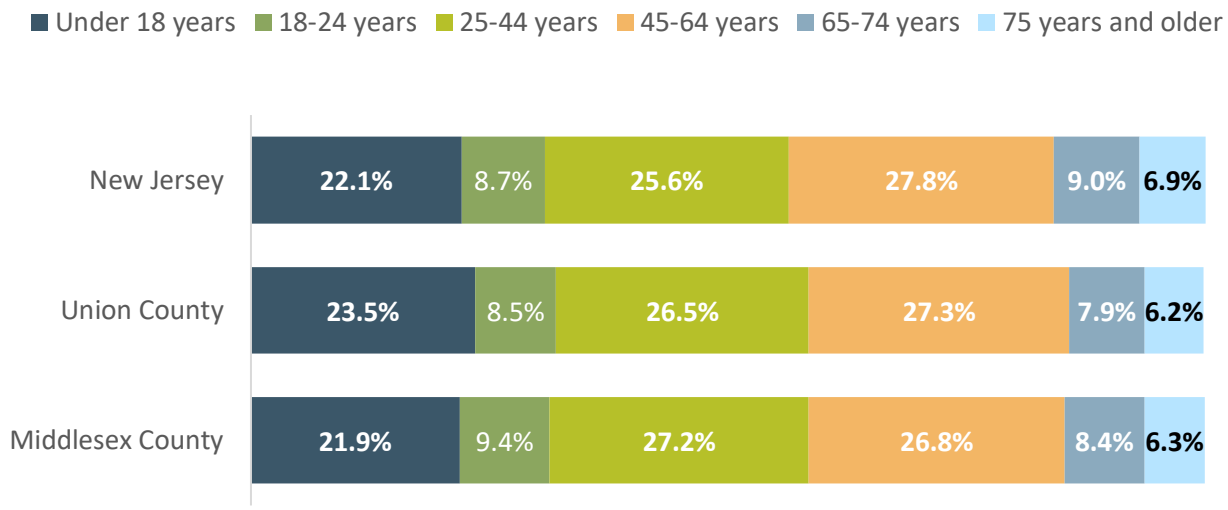
Table 1. Total Population, by State and County, 2011-2015 and 2016-2020

	2015	2020	% change
New Jersey	8,904,413	8,885,418	-0.2%
Union County	548,744	555,208	1.2%
Clark	15,144	15,847	4.6%
Cranford	23,328	24,036	3.0%
Elizabeth (07201)	26,177	27,369	4.6%
Elizabeth (07202)	41,029	41,264	0.6%
Elizabethport (07206)	28,248	27,520	-2.6%
Elizabeth (07208)	32,277	32,319	0.1%
Linden	41,322	42,332	2.4%
Rahway	28,644	29,691	3.7%
Roselle	21,466	21,699	1.1%
Middlesex County	830,300	825,015	-0.6%
Avenel	18,793	17,175	-8.6%
Carteret	23,965	23,501	-1.9%
Colonia	17,517	17,782	1.5%

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

Focus group and interview participants frequently commented on the demographic characteristics of their community, often noting high levels of diversity and tight-knit communities. As one interviewee explained, "*There is a long history of families that have support systems in place, but there's also a large immigrant population*." Participants also shared that there are residents seeking to age in place, and that younger populations face crowding in schools. Quantitative data indicate that both Union and Middlesex County had a similar distribution of ages compared to New Jersey in 2016-2020 (Figure 3), with just over a quarter of these residents being between the ages of 25-44 or 45 to 64 years old. Age distribution data by town can be found in Appendix E- Additional Data Tables. Children aged 18 and under made up 25% or more of residents in Elizabeth zip codes 07201, 07208, and Elizabethport zip code 07206 in 2016-2020, and the largest populations of adults over 65 was in Cranford (19.3%) and Colonia (18.2%). See Appendix E- Additional Data Tables for additional details.

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



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

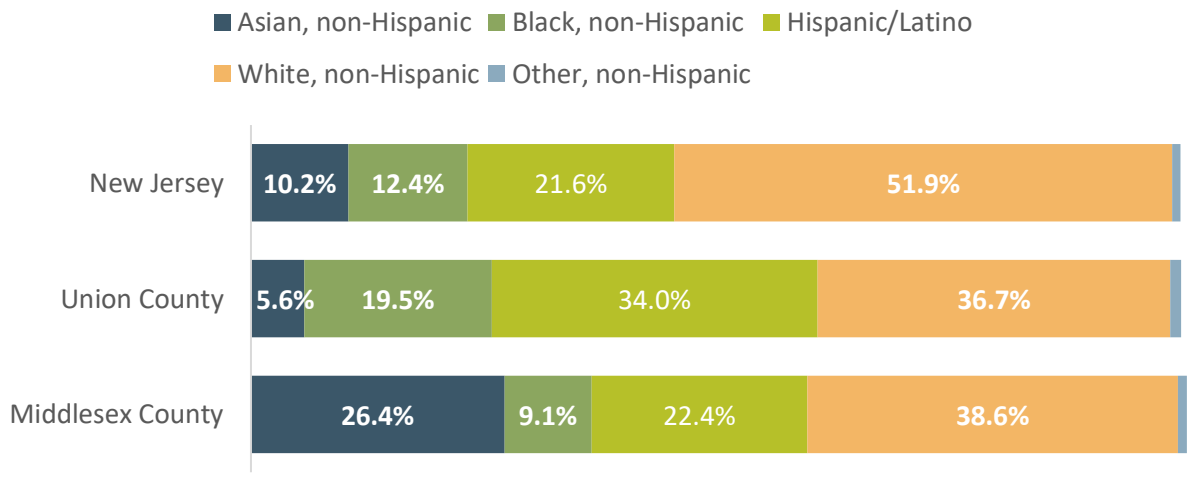
Racial, Ethnic, and Language Diversity

Racial and Ethnic Composition

> *"There is a lot of diversity and when we are able to work together that is a plus, it helps us move forward."*
> – Key informant interviewee

Focus group participants and interviewees commented that the area served by RWJUH Rahway and TRMC is racially and ethnically diverse, which was seen as a positive aspect and asset in the community. However, participants also noted that racism and discrimination are present in the community and that there is more work to be done to address this challenge. Secondary data support these sentiments, showing that the counties and towns RWJUH Rahway and TRMC serve vary in terms of racial and ethnic diversity. Union and Middlesex Counties have more diverse populations than the state, where slightly over half the population identifies as White (Figure 4). According to the 2020 census, over half of Union County's residents identify as Hispanic/Latino or Black, non-Hispanic and 26.4% of Middlesex County's residents identify as Asian, non-Hispanic. In terms of racial/ethnic diversity in towns served by RWJUH Rahway and TRMC, more than two-thirds of residents in Elizabeth zip code 07202 and Elizabethport zip code 07206 identify as Hispanic/Latino, while over 80% of residents in Clark and Cranford identify as non-Hispanic White. Roselle (45.8%), Linden (28.7%), and Rahway (28.6%) had the largest proportion of non-Hispanic Black residents, and Carteret (24.9%) had the largest non-Hispanic Asian population. See Appendix E- Additional Data Tables for detailed data tables, including percentage change in population by race/ethnicity at the state, county, and town levels in 2016-2020 compared with 2011-2015.

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

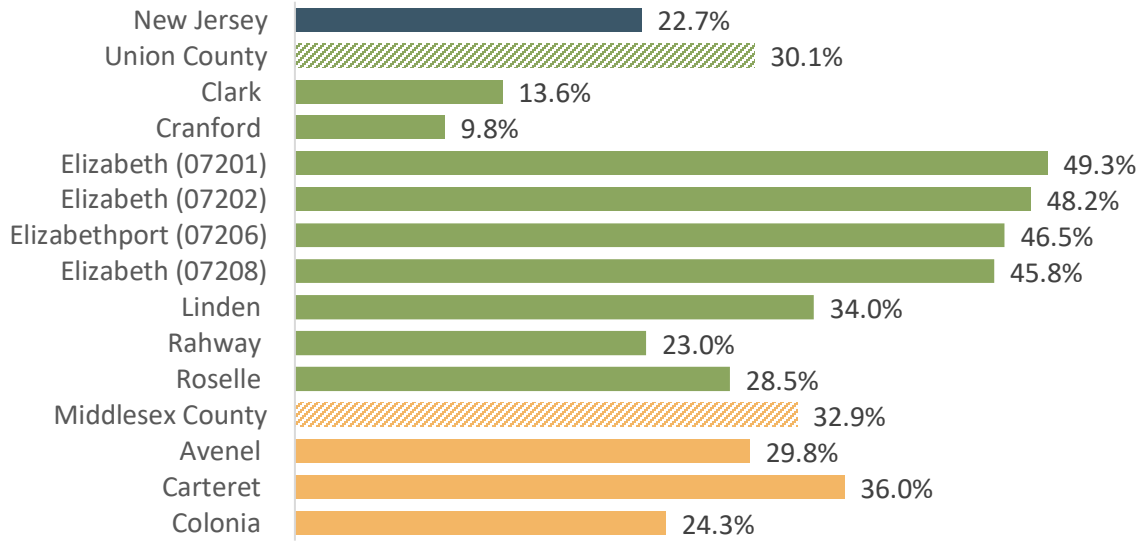


DATA SOURCE: U.S. Census Bureau, Decennial Census of Population and Housing, 2020.
Data labels not shown when <4%

Foreign-Born Population

Multiple focus group and interview participants commented that their communities were incredibly diverse, with numerous immigrants of various backgrounds living in the same area. Participants explained that understanding the history, experiences, and cultures of these residents was imperative to ensure that local programs and services meet the unique needs of this population. When looking at secondary data, the foreign-born population varies across counties and towns served by RWJUH Rahway and TRMC (Figure 5). Elizabeth (07201, 07202, and 07208) and Elizabethport (07206) had the highest proportion of foreign-born residents across the service area (ranging from 45.8% to 49.3%). Union County, and the towns of Clark and Cranford within it, had the lowest proportion of foreign-born residents (30.1%, 13.6%, and 9.8%, respectively).

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

Language Diversity

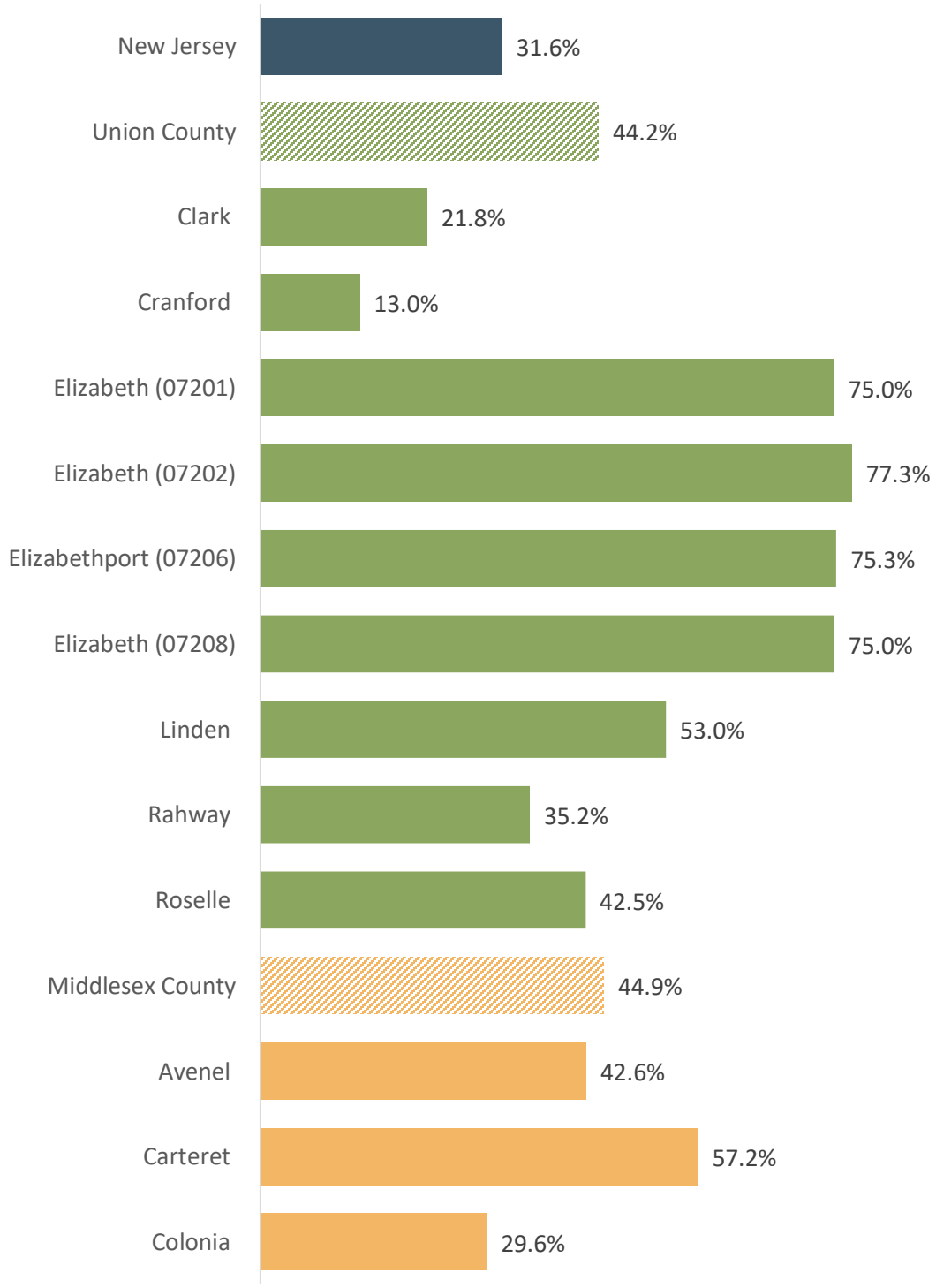
RWJUH Rahway and TRMC serve many residents who speak a language other than English at home. In six of the nine communities (Elizabeth zip codes 07201, 07202, and 07108, Elizabethport zip code 07206, and Linden), half or more residents over age five speak a language other than English at home according to the 2016-2020 American Community Survey (Figure 6). In Elizabeth, over 70% of residents speak a language other than English at home. In contrast, a far smaller proportion of Clark and Cranford residents speak languages other than English at home. Spanish is the most common language other than English spoken at home across most communities. (Table 2) Over 10% of residents in Elizabeth (07201), Avenel, Colonia, and Carteret speak other Indo-European languages at home, while over 5% of residents in Elizabeth (07201), Elizabeth (07208), Linden, and Roselle speak French, Haitian, or Cajun languages.

Table 2. Top 5 Languages Spoken at Home, by State, County, and Town, 2016-2020

	Speak only English	Spanish	French, Haitian, or Cajun	Russian, Polish, or other Slavic languages	Other Indo-European languages
New Jersey	68.4%	16.4%	1.1%	1.7%	5.4%
Union County	55.8%	28.3%	3.0%	1.9%	6.2%
Clark	78.2%	7.0%	0.1%	3.6%	7.8%
Cranford	87.0%	5.0%	0.2%	1.8%	2.9%
Elizabeth (07201)	25.0%	55.0%	6.9%	0.2%	10.1%
Elizabeth (07202)	22.7%	63.9%	4.0%	0.6%	6.7%
Elizabethport (07206)	24.7%	65.4%	0.7%	1.3%	5.3%
Elizabeth (07208)	25.0%	56.6%	6.2%	0.3%	7.1%
Linden	47.0%	27.2%	6.4%	7.1%	8.3%
Rahway	64.8%	23.1%	1.9%	1.9%	5.1%
Roselle	57.5%	28.9%	8.1%	1.3%	2.8%
Middlesex County	55.1%	17.0%	0.5%	2.1%	13.1%
Avenel	57.4%	15.3%	0.2%	1.8%	13.6%
Carteret	42.8%	28.8%	1.0%	0.9%	21.7%
Colonia	70.4%	6.4%	0.9%	5.3%	13.7%

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

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

Community Social and Economic Environment

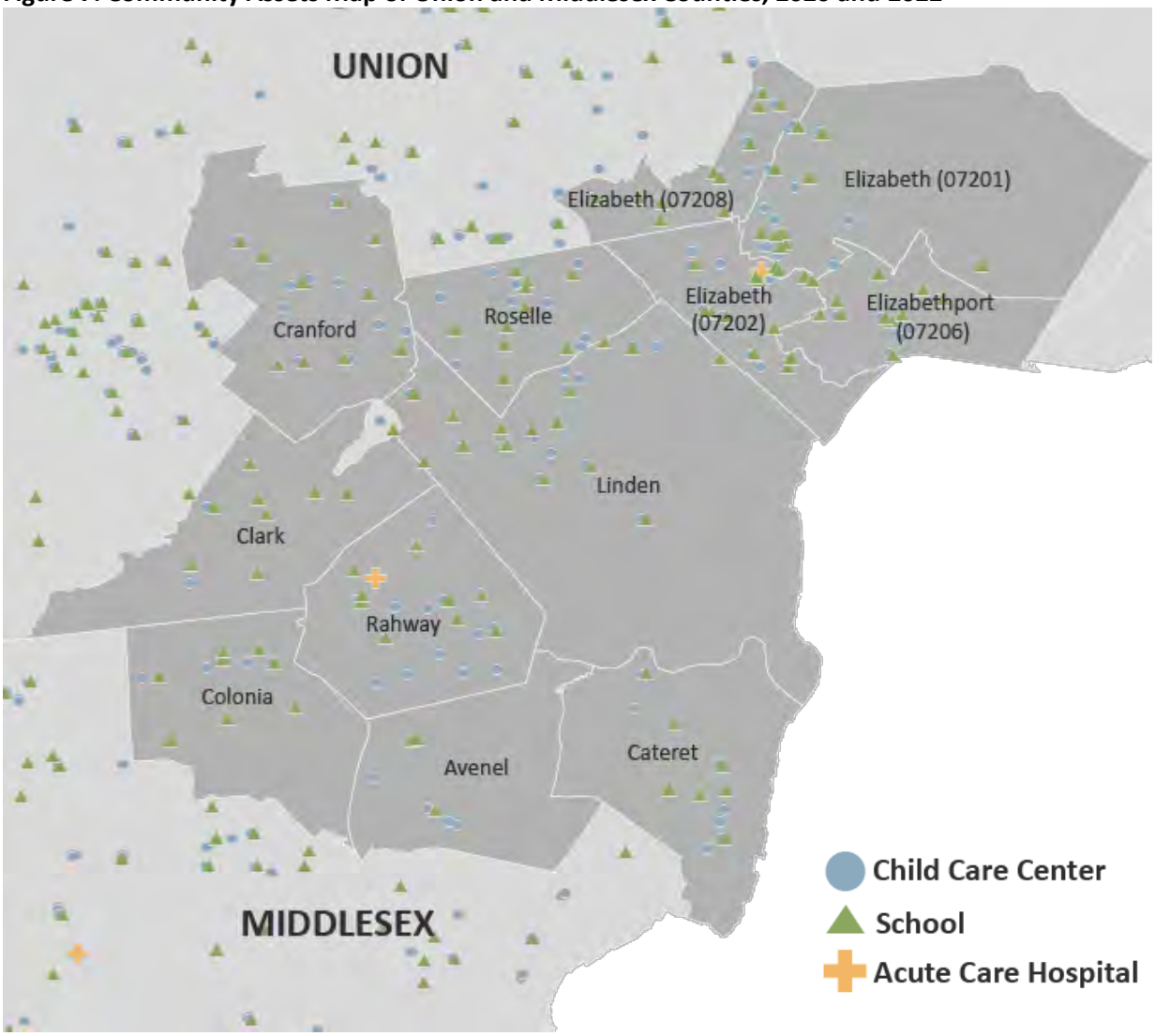
Income, work, education, and other social and economic factors are powerful social determinants of health. For example, jobs that pay a living wage enable workers to live in neighborhoods that promote health (e.g., built environments that promote physical activity and resident engagement, better access 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. Interview and focus group participants readily shared numerous strengths and assets in their community during discussions. These strengths spanned from individual resident qualities to the sense of support and community that exists between residents, to the local supports and organizations that are readily accessible and serve the community. One interviewee described the community culture, stating, "*Elizabeth community is very different. It's like a small town, with lots of the flavor of a small town. Everyone knows everyone, there is a sense of community… People who live in neighborhoods know each other, it's a good city, if people know something they share it."* Another participant explained the accessibility of services and organizations, "*Our strength is our community because we have a large support system. People know our health department is always here, our FQHC is here, our nurses are available. They know that our hospital is readily available. They have a lot of resources. You have a lot of community support and organizations. Our council people, county commissioners, state legislators are very invested in the community."*

Figure 7 below shows the community assets in Union and Middlesex Counties. Within the RWJUH Rahway and TRMC service area, there are 2 acute care hospitals, as well as 116 schools and 116 childcare centers.

Figure 7. Community Assets Map of Union and Middlesex Counties, 2020 and 2022



DATA SOURCE: New Jersey Geographic Information Network (NJGIN), Schools and Child Care Centers, 2022 and Acute Care Hospitals, 2020

> *"I've been living in Elizabeth for many years. It's a safe city. I can go out at any time and feel safe on the street. Everything is close, especially the hospital... There are multiple churches that help us. People are very social."*
> – Focus group participant

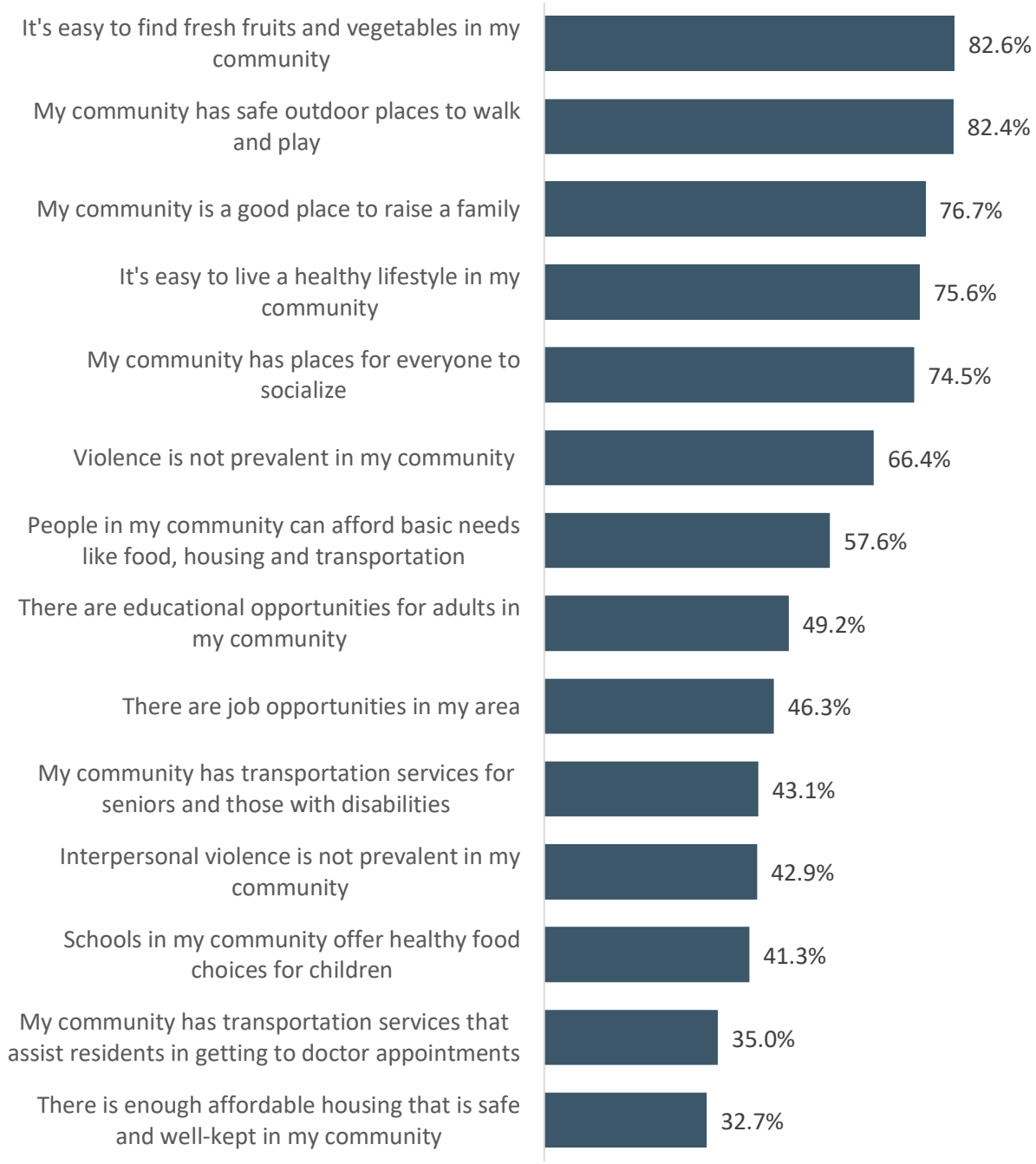
Accessibility was frequently mentioned as a strength in the community, with participants commenting that public transportation was generally viewed favorably. Residents also stated that they felt safe walking on the streets, that many stores and services were within walking distance, and that easily accessible community events were plentiful. As one interviewee summarized, "*Transportation is good, there are many parks around us, that is not a problem. People… have stores and places that are accessible in walking distance to get what they need. We have a supermarket in front of us built three years ago, always new things."* In addition to readily accessible organizations and services, some participants also shared that their close proximity to nearby cities, such as Newark, was a positive attribute of the area.

Strong local organizations and supports were also frequently mentioned as assets by focus group participants and interviewees. Participants shared that a robust network of churches and faith communities support the community, in addition to social service organizations, schools, hospitals and clinics, local non-profit organizations, and more. In addition to numerous supportive organizations, participants also commented on the dedication of community leadership, the engagement from the health departments, and support from organizations such as the local newspapers. As one interviewee explained, "*Rahway is blessed with great leaders in the sacred and secular space, from our mayor to our school superintendent to our interfaith leaders to all of the nonprofits and to our neighbors. We have a lot of great people in Rahway who help and all they need to know is what is the need is."*

Many focus group and interview participants across discussions mentioned a strong and cohesive sense of community as a strength of their area. Residents commented on having long-lasting relationships with friends and neighbors and frequently sharing resources and information within the community. As one interviewee stated, "*We are all connected and we all know each other so we can send people to the correct resources and people who are going to help*." Furthermore, individual resident qualities were mentioned, such as resiliency and being hardworking, in addition to community diversity and a sense of the community coming together to care for each other. As one focus group participant exemplified, "*I work. I've made a lot of friends. I have good work and I'm happy to participate in different things because when I'm learning, I can support and help others and I can refer them to them, which is how we grow."*

Respondents to the community survey were also asked about the strengths of their communities. Overall, survey respondents highlighted healthy living and social connection as key strengths (Figure 8). The strengths identified by the greatest proportion of respondents were that it was easy to find fresh fruits and vegetables in their communities (82.6%) and that their communities had safe outdoor places to walk and play (82.4%).

Figure 8. Percent of Community Survey Respondents Noting Strengths in Their Community (Agree or Completely Agree with Statements) (n=443), 2021



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

Education

Educational attainment is an important measure of socioeconomic position that may reveal additional nuances about populations, in parallel to measures of income, wealth, and poverty. High quality schools and educational opportunities were frequently praised as strengths and assets by focus group and interview participants. Participants commented that they liked the schools attended by their children, that good relationships exist between parents, teacher, and students, and that schools offered free breakfast and lunch. As one focus group participant shared, "*There are certain high schools specifically for what students want to study. There is free breakfast and free lunch if you qualify. The topic of uniforms is a bit controversial because they're expensive, but at the same time, they unify everyone, because everyone dresses the same… The schools are good for my kids and all the kids*."

> *"When things went virtual, we found relationships developed more between teachers and students, and therapists. [This] helped parents and therapists work together and come to agreement on how children are supported, what their abilities are."*
>
> – Key informant interviewee

However, several focus group and interview participants also shared challenges they have experienced related to schools and the education system. These included overcrowding in schools, limited programs for youth, and the impact of the COVID-19 pandemic. While there was an overall sentiment that the pandemic had negative consequences, including learning loss and limited skills development related to virtual learning, one interviewee engaged in the educations system also shared that the pandemic helped strengthen relationships between parents, therapists, educators, and students. Participants also noted that not all children have the same level of learning support at home, as one interviewee commented, "*People had to stay isolated. When the kids are home from school, different ages working on computers, moms trying to do their thing, they didn't know how to support them. People even needed support in helping kids do their homework. They still need access and laptops, and kids don't have that."*

Graduation Rates

Data from the NJ Department of Education for 2020-2021 indicate that the majority (92.6%) of New Jersey students graduated from high school within four years (Table 3). Graduation rates across Elizabeth, Roselle, and Rahway districts were lower than graduation rates in other communities and the state. Graduation rates varied across students of different racial/ethnic backgrounds as well. Black students in the Elizabeth School District had the lowest graduation rate, 78.4%, for any race/ethnicity group across all the school districts.

Table 3. 4-Year Adjusted Cohort High School Graduation Rate, by Race/Ethnicity and School District, 2020

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%
Union County	District Wide	Asian	Black	Hispanic	White	Two+ Races
Clark Township Public School District	96.8%	*	*	100.0%	96.8%	*
Cranford Public School District	96.6%	*	90.9%	100.0%	97.2%	*
Elizabeth Public Schools	82.0%	84.4%	78.4%	81.9%	90.8%	*
Linden Public School District	91.9%	*	91.8%	92.9%	90.0%	100.0%
Rahway Public School District	85.9%	*	88.5%	83.6%	91.4%	*
Roselle Public School District	83.3%	*	83.2%	83.7%	*	*
Roselle Park Public School District	94.0%	100.0%	94.1%	91.6%	97.4%	N
Middlesex County	District Wide	Asian	Black	Hispanic/ Latino	White	Two+ Races
Carteret Public School District	93.0%	94.4%	92.2%	94.2%	90.0%	*

DATA SOURCE: New Jersey Department of Education, School Performance, Adjusted Cohort Graduation Rates, 2020-2021

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

Employment and Workforce

Employment can confer income, benefits, and economic stability – factors that promote health. Focus group and interview participants frequently shared challenges related to economic vulnerability, often relaying that these challenges stemmed from difficulties finding jobs. Themes of unemployment challenges were particularly emphasized in the focus group with economically vulnerable Spanish-speaking residents. As one interviewee explained, "*A lot of people need work. A lot of people complain for months that they can't find work."* Challenges related to finding jobs also lead to residents enduring challenges at work and staying in jobs that do not offer benefits or living wages. One focus group participant shared, "*Jobs are too poorly paid, the minimum. The factory where I work only gives all of us 5-6 hours per day. They don't want to give us the standard 40 hours. No one dares to say anything because we'll end up without work. After the $1550 [I pay in rent], I'm left with $190 in my pocket."*

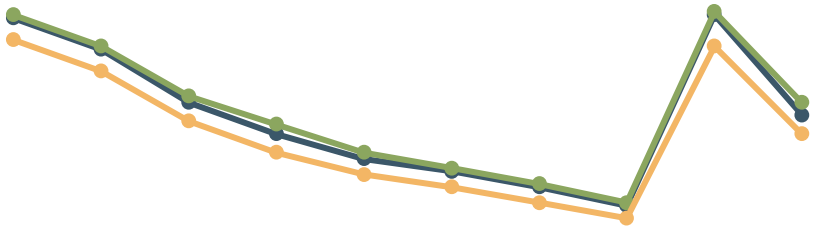
> *"I think the problem with rent is happening everywhere. But jobs aren't paying enough. They say there are jobs, but I was looking for work for 3 months and I had to go back to my old job because there weren't jobs here."*
>
> - Focus group participant

Participants shared their observations that women and residents of color were more likely to be impacted by job related challenges.

Participants also shared that the COVID-19 pandemic had an impact on employment and workforce. Focus group and interview participants discussed job loss, reduced hours, and inability to work due to a lack of childcare. Some residents, interviewees explained, also felt pressure to leave their jobs due to the risks of the pandemic, which furthers economic vulnerability and access to insurance. Furthermore, many businesses also imposed work restrictions based on COVID-19 symptoms, which has resulted in some families losing income due to signs and symptoms that may not be due to COVID-19 infection (e.g., residents experiencing allergy or asthma symptoms). Participants also shared that they felt the pandemic also led to workforce shortages resulting from retirements, burn out, and a general lack of motivation to work. As one interviewee shared, "*Healthcare all over the place is short staffed, RNs are hard to find... All hospitals are experiencing workforce challenges*."

Data from the Bureau of Labor Statistics further reinforce the challenges shared by participants. These data show that unemployment rates in New Jersey and the two counties in the RWJUH Rahway and TRMC service area had been trending downward over the past decade prior to the COVID-19 pandemic, after which rates rose substantially (Figure 9). Throughout the past ten years, Union County has experienced higher unemployment rates than the Middlesex County and the state. Town-level data from the 2016-2020 American Community Survey show that Roselle and Elizabeth zip code 07208 experienced the highest unemployment rates, 8.9% and 7.8% respectively, while Clark experienced the lowest (3.2%) (Table 4).

Figure 9. Unemployment Rate, by State and County, 2012-2021



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
New Jersey	9.4%	8.4%	6.7%	5.7%	4.9%	4.5%	4.0%	3.4%	9.5%	6.3%
Union County	9.5%	8.5%	6.9%	6.0%	5.1%	4.6%	4.1%	3.5%	9.6%	6.7%
Middlesex County	8.7%	7.7%	6.1%	5.1%	4.4%	4.0%	3.5%	3.0%	8.5%	5.7%

DATA SOURCE: Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012-2021
NOTE: Not seasonally adjusted

Table 4. Unemployment Rate Among Workers 16 Years and Above, by State and County, 2016-2020

	2016-2020
New Jersey	5.8%
Union County	5.8%
Clark	3.2%
Cranford	4.1%
Elizabeth (07201)	6.2%
Elizabeth (07202)	4.5%
Elizabethport (07206)	5.9%
Elizabeth (07208)	7.8%
Linden	6.1%
Rahway	6.5%
Roselle	8.9%
Middlesex County	5.8%
Avenel	4.8%
Carteret	6.2%
Colonia	3.4%

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

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. Like the rest of the nation, Union and Middlesex Counties experienced economic challenges due to the COVID-19 pandemic. The loss of employment and income exacerbated the financial vulnerability of individuals and communities.

> *"Food distribution is here once a month, we've seen quite a bit of people, it's the economy and it's changed a lot for some people. They drive up in nice cars. Things changed so quickly, when you're used to living a certain lifestyle and you have to adjust."*
> - Key informant interviewee

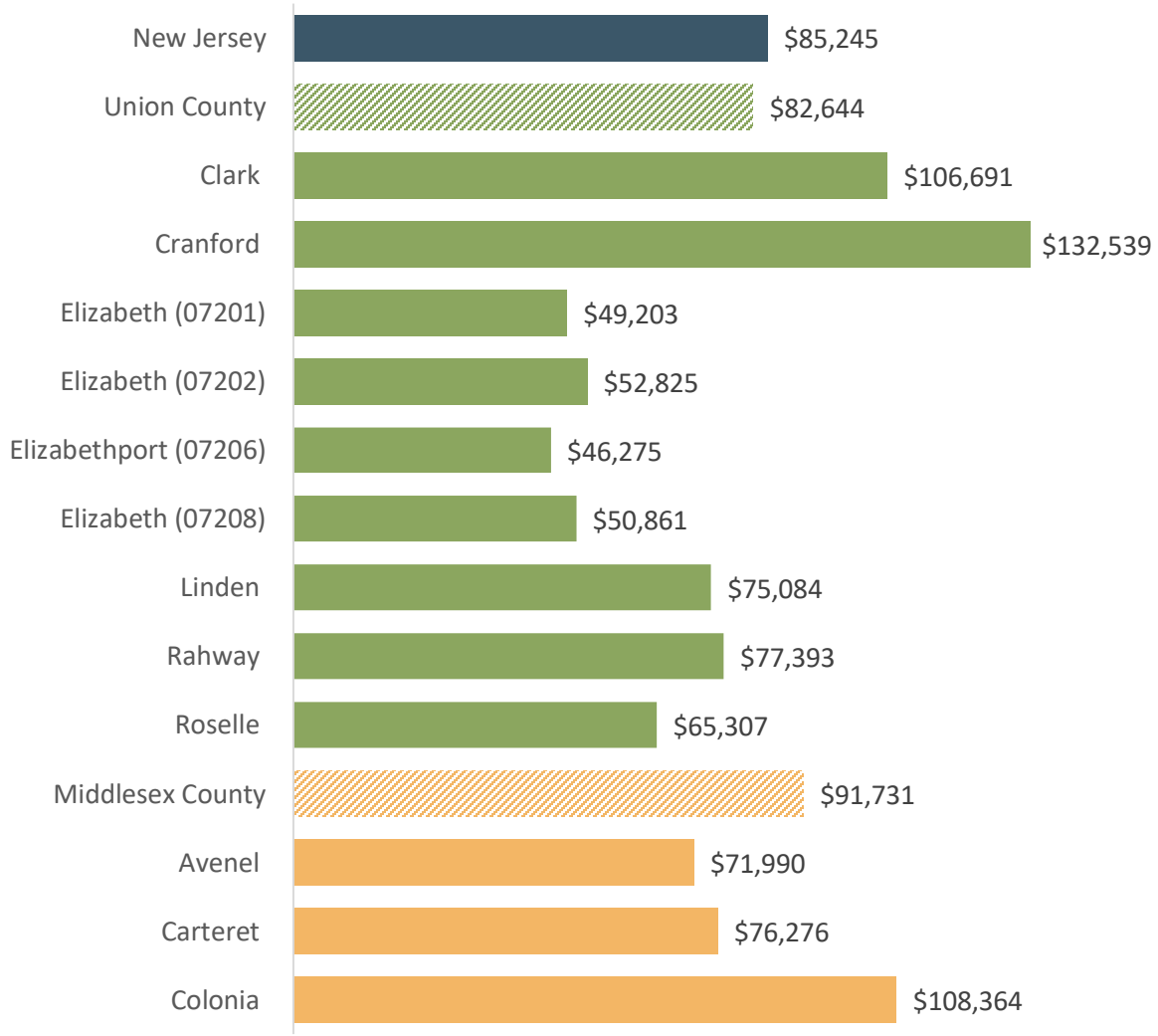
As discussed in the previous section, Employment and Workforce, focus group and interview participants frequently described economic challenges related to lost or reduced employment. Participants also shared concerns about rising costs for daily necessities, namely affecting housing, transportation, childcare, food, and healthcare. Focus group and interview participants also shared their belief that economic challenges are affecting everyone in the community, though residents explained that those with medical challenges, single parents, seniors, and people of color may be more likely to experience financial struggles. As one interviewee explained, "*If I'm in a house and rent goes from $1300 to $1500, salaries aren't going up so then it goes unpaid, even landlords are coming into the soup kitchens. We have working class and homeless, there is no difference between them. Everyone is having a problem regardless of salary because they don't have the money to buy the food. People might be living in a large house but if they lose their job then they are putting money to rent and then they have no money for food.*"

Furthermore, seniors and those living on fixed income, participants explained, are facing increased financial challenges due to rising costs for daily needs. One interviewee remarked, "*The ones [seniors] who live in senior housing get attention, but the ones still in their homes, and winter is coming up, with*

gas prices these people are sitting in their homes weighing whether they can turn on their heat or afford food."

Across the RWJUH Rahway and TRMC service area there is variation in household financial wellbeing. Data from the 2016-2020 American Community Survey show that median household income ranges from $46,275 in Elizabethport (07206 zip code) to $132,539 in Cranford, nearly a threefold difference (Figure 10).

Figure 10. Median Household Income, by State and County, 2016-2020

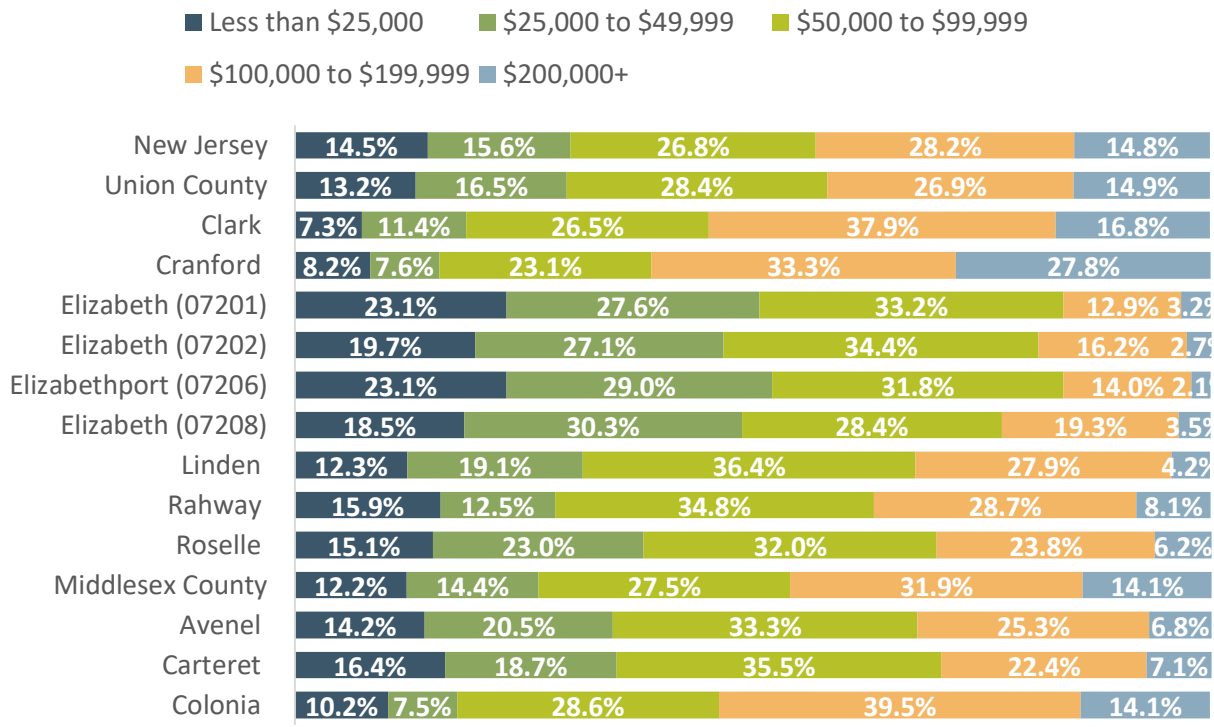


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Data about the concentration of higher and lower income earning households indicates that approximately one in five households in the Elizabeth and Elizabethport zip codes have incomes less than $25,000 annually; in contrast, nearly 30% of households in Cranford have incomes greater than $200,000 (Figure 11). Household incomes also varied across racial and ethnic groups. When looking at median household income by race and ethnicity, Black households had the lowest incomes of all groups in seven communities served by RWJUH Rahway and TRMC, including Clark, Cranford, Elizabeth zip code

07202, Elizabethport zip code 07206, Linden, Rahway, and Roselle. Asian households had the highest income of all groups in nine of the twelve communities served by RWJUH Rahway and TRMC (Appendix E- Additional Data Tables).

Figure 11. 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

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. During focus groups and interviews with residents, many voiced concerns about rising food costs and the ability to access nutritious food. Key challenges included affordability, limited access to grocery stores, knowledge and selection of healthy foods, and food preparation in culturally sensitive ways that preserve nutrition. Participants frequently explained that, due to economic challenges often exacerbated by the pandemic, food insecurity is increasing and impacting many residents in the community. Furthermore, due to increases in food prices, interviewees helping with food pantries and food distribution explained that they are receiving less donations.

> *"We see people coming in every day asking for emergency food, which should only be 2 [distributions] per month. Also seeing a lot of need from undocumented communities. I came up from the soup kitchen, typically [we serve] 40 people, now [we are serving] over 100."*
> - Key informant interviewee

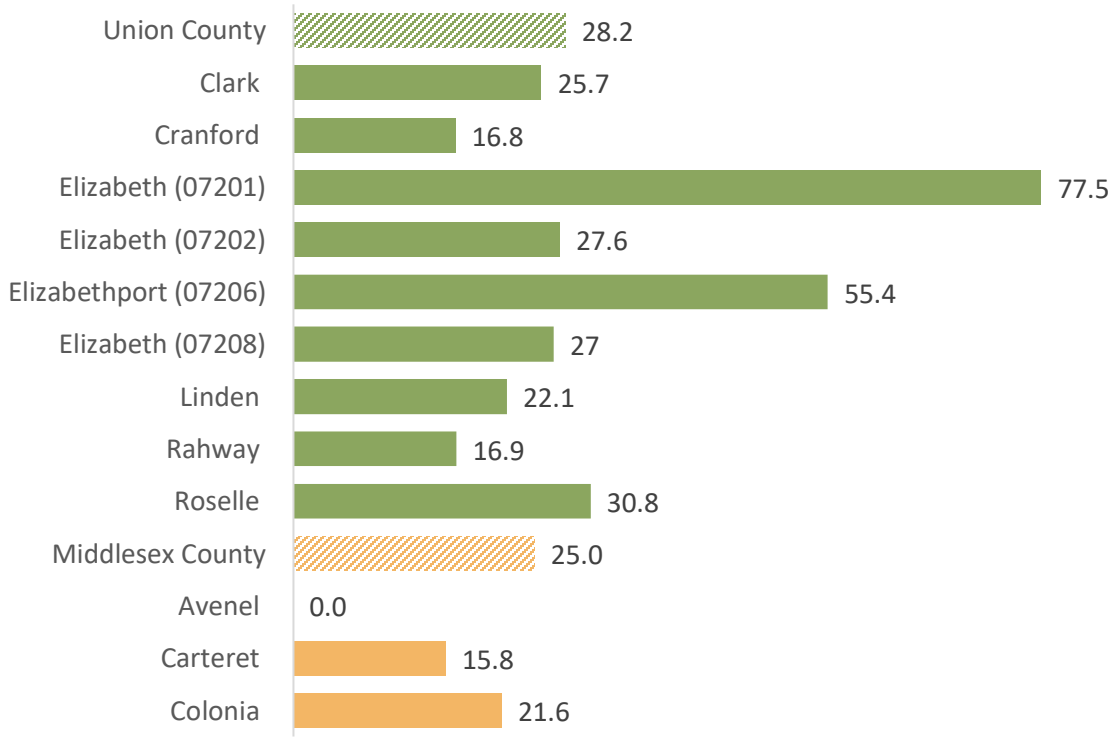
Participants also shared that residents receiving nonperishable food from food pantries may be consuming increased levels of sodium or having other health consequences, as one interviewee

explained, "*Food, whatever comes up is what you eat, churches give out canned food, [which is] high sodium. [Which makes people more] prone to high blood pressure."*

Participants shared that they believed seniors, families with children, and immigrant communities were more likely to struggle with food insecurity and to seek support from community organizations like food pantries. One interviewee further explained, "*It's mostly affecting our seniors on fixed income, inflation, gas, food, something they didn't prepare for when they retired. Seniors are being more impacted, and we deal with this daily and they have no way of earning additional income*." When discussing food accessibility, some participants also felt that the communities served by RWJUH Rahway and TRMC had limited access to grocery stores and supermarkets. As one interviewee elaborated, "*We have food deserts. Definitely those who live paycheck to paycheck are impacted. Those who live in areas that don't have supermarkets are impacted. You have price gouging that may exist in certain communities. Our food pantries and soup kitchens help to some extent, but we have to make this more available and put people in the position to utilize those services*."

Secondary data further illustrate the challenges with food accessibility described by participants. When looking at the number of grocery stores and supermarkets per 100,000 residents, nine out of twelve communities in Union and Middlesex County had less grocery stores and supermarkets than the average number in the county (Figure 12).

Figure 12. Count of Grocery Stores and Supermarkets per 100,000 by State, County, and Town, 2020

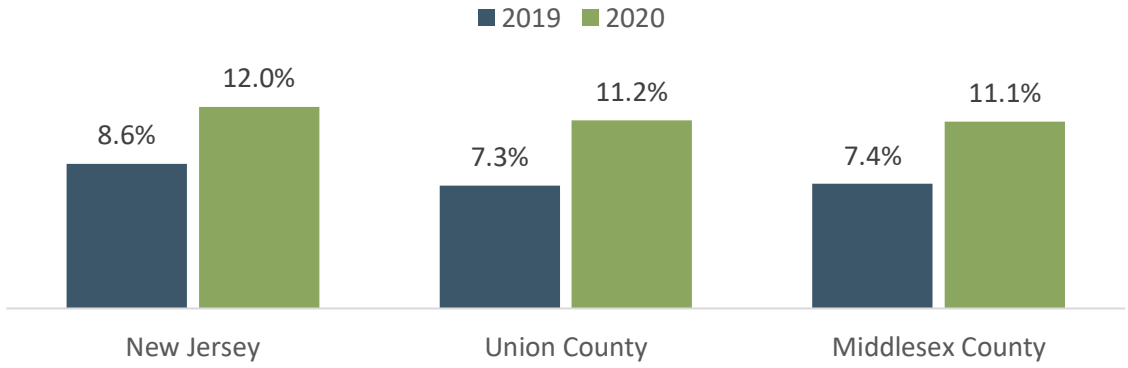


DATA SOURCE: Community Commons, Census County Business Patterns, analyzed by Center for Applied Research and Engagement Systems (CARES), 2020

Consistent with interviewee and focus group perceptions, data from the Feeding America, Map the Meal Gap shows that food insecurity has risen across the region between 2019 and 2020 (Figure 12). In 2020,

after the onset of the COVID-19 pandemic, 11.2% of residents in Union County, and 11.1% of residents in Middlesex County were food insecure, which represents nearly a 4% increase from 2019.

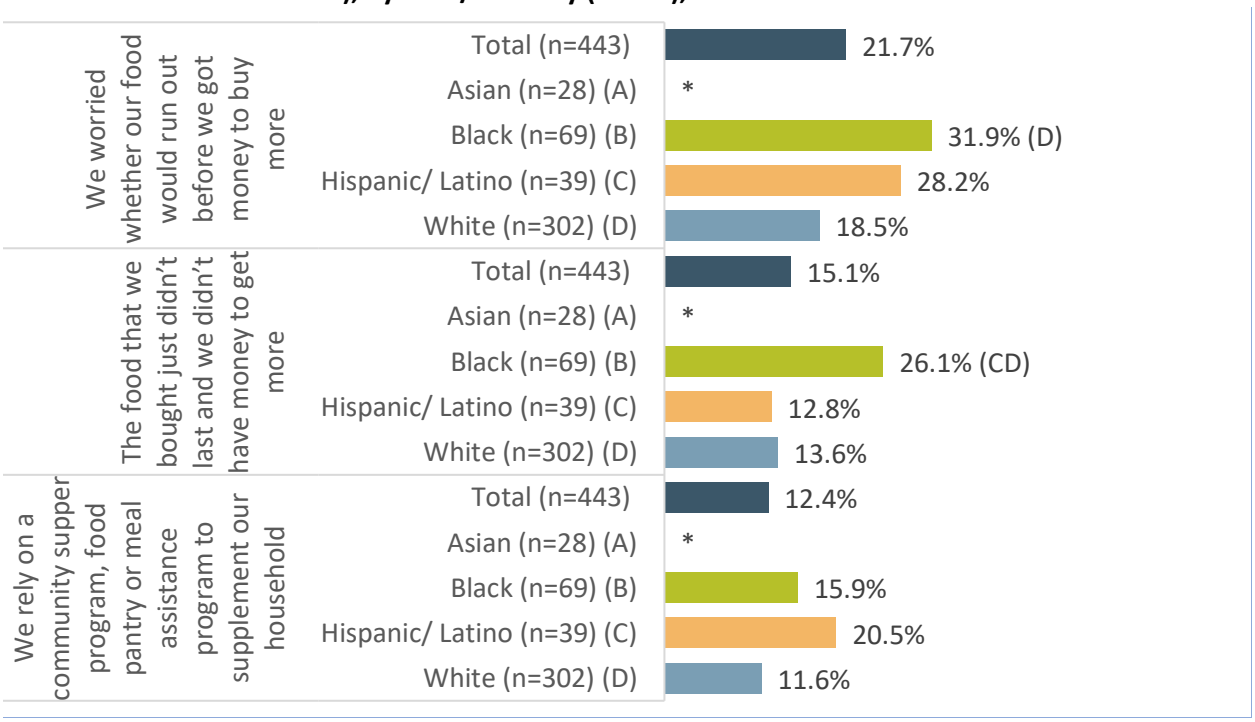
Figure 13. Percent Population Food Insecure, by State and County, 2019 and 2020



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.

Community survey data also confirms that food security is an issue felt among respondents in the RWJUH Rahway and TRMC service area. Over 20% of respondents reported that it was sometimes or often true that they worried their food would run out before they got money to buy more (Figure 14).

Figure 14. Percent of Community Survey Respondents Reporting Food Insecurity (Noting Statements as Sometimes or Often True), by Race/Ethnicity (n=443), 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. * indicates n<5.

Housing

Safe and affordable housing is integral to the daily lives, health, and well-being of a community. However, as housing costs have outpaced wages and incomes, households can struggle to acquire and maintain adequate shelter and face difficult trade-offs in meeting other basic needs. For example, when most of a paycheck goes toward paying rent or mortgage, it makes it hard for individuals to afford doctor visits, healthy foods, utility bills, and reliable transportation to and from work or school.

> *"My biggest worry is that after two years of paying rent, I'll most likely end up living on the street because the rent is horrible. After buying all my medications, I don't have enough with just my retirement [income]."*
> - Focus group participant

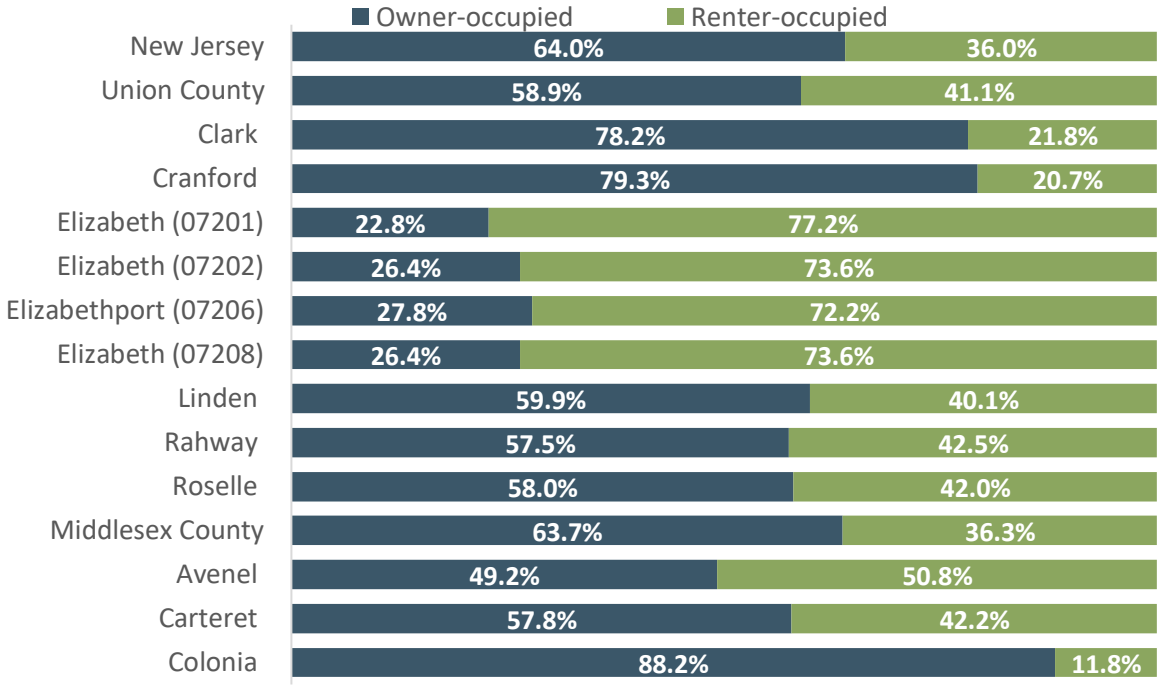
Housing Affordability

Housing was described as a substantial community challenge in nearly every focus group and interview and was a strong theme in the focus group of economically vulnerable Spanish-speaking residents and residents who identify as Black or African American. Participants shared personal experiences of rapidly increasing rents, fears of eviction, and difficulty meeting the eligibility requirements to obtain housing. As one interviewee explained, "*Housing is no longer affordable, and people are losing housing as a result…All the housing being built is luxury. Landlords ask income to be three times the rent... That's a lot more than most people make. We are pushing people out. We have more people asking for rental assistance. There is nowhere to go, everything is prohibitively expensive. We are putting people up in hotels. Eviction never goes off of your record, it's a lifetime sentence. It's a real issue, we try to keep people in houses because it's over if you lose it*."

Despite the need for housing support discussed by participants, focus group members and interviewees also commented on challenges qualifying for housing support. As one participant explained, "*That's the problem, because there is an income limit, and according to them, my income is too high. So, I can't receive help... I always have to worry or stop eating or not buy medication or not go to the doctor, because it's just not enough*." Other participants explained that when residents do qualify for assistance, they may still face long wait times. As one interviewee commented, "*The community doesn't have a sense of the housing system and support, they don't think it exists. You feel hopeless because you are on waitlists for years. I had a senior citizen that was applying for senior housing, people pass away while they are on the waiting list. There is no trust in the waiting list system."*

When looking at secondary data in New Jersey, 64.0% of housing units were owner occupied versus 36.0% renter-occupied (Figure 15). In most towns in the RWJUH Rahway and TRMC service area, owner-occupied units made up a higher percentage of housing stock. Home ownership rates were highest in Colonia (88.2%) and Cranford (79.3%). In contrast, roughly three-quarters of housing units in Elizabeth zip codes and Elizabethport zip code 07206 are renter-occupied.

Figure 15. Home Occupancy, by State, County, and Town 2016-2020



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

Quantitative data from the 2016-2020 American Community Survey indicate that median monthly housing costs for owner-occupied households with a mortgage ranged from $2,101 in Carteret to $3,152 in Cranford (Table 5). Median monthly housing costs for renter-occupied households from 2016-2020 ranged from $1,180 in the Elizabeth zip code 07208 to $1,657 in Colonia.

Table 5. Monthly Median Housing Costs, by State and County, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	$2,476	$1,368
Union County	$2,751	$1,335
Clark	$2,606	$1,460
Cranford	$3,152	$1,583
Elizabeth (07201)	$2,623	$1,211
Elizabeth (07202)	$2,400	$1,199
Elizabethport (07206)	$2,303	$1,226
Elizabeth (07208)	$2,479	$1,180
Linden	$2,447	$1,362
Rahway	$2,429	$1,271
Roselle	$2,304	$1,192
Middlesex County	$2,492	$1,495
Avenel	$2,194	$1,453
Carteret	$2,101	$1,521
Colonia	$2,626	$1,657

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

In New Jersey in 2016-2020, 46.2% of owner-occupied households with a mortgage and 62.2% of renter-occupied households reported spending more than 25% of their income on housing costs (Table 6). Within the RWJUH Rahway and TRMC service area, Elizabethport zip code 07206 had the greatest percentage of owner-occupied households spending more than 25% of their income on housing costs. Roselle had the greatest percentage of renter-occupied households spending more than 25% of their income on housing costs.

Table 6. 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%
Union County	48.6%	63.3%
Clark	43.0%	57.7%
Cranford	38.3%	64.4%
Elizabeth (07201)	66.1%	72.8%
Elizabeth (07202)	68.3%	60.3%
Elizabethport (07206)	71.5%	71.8%
Elizabeth (07208)	53.5%	68.2%
Linden	61.3%	60.1%
Rahway	45.7%	60.3%
Roselle	60.2%	75.9%
Middlesex County	47.3%	58.6%
Avenel	54.1%	57.1%
Carteret	47.7%	71.0%
Colonia	48.4%	64.4%

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

Housing Instability and Homelessness

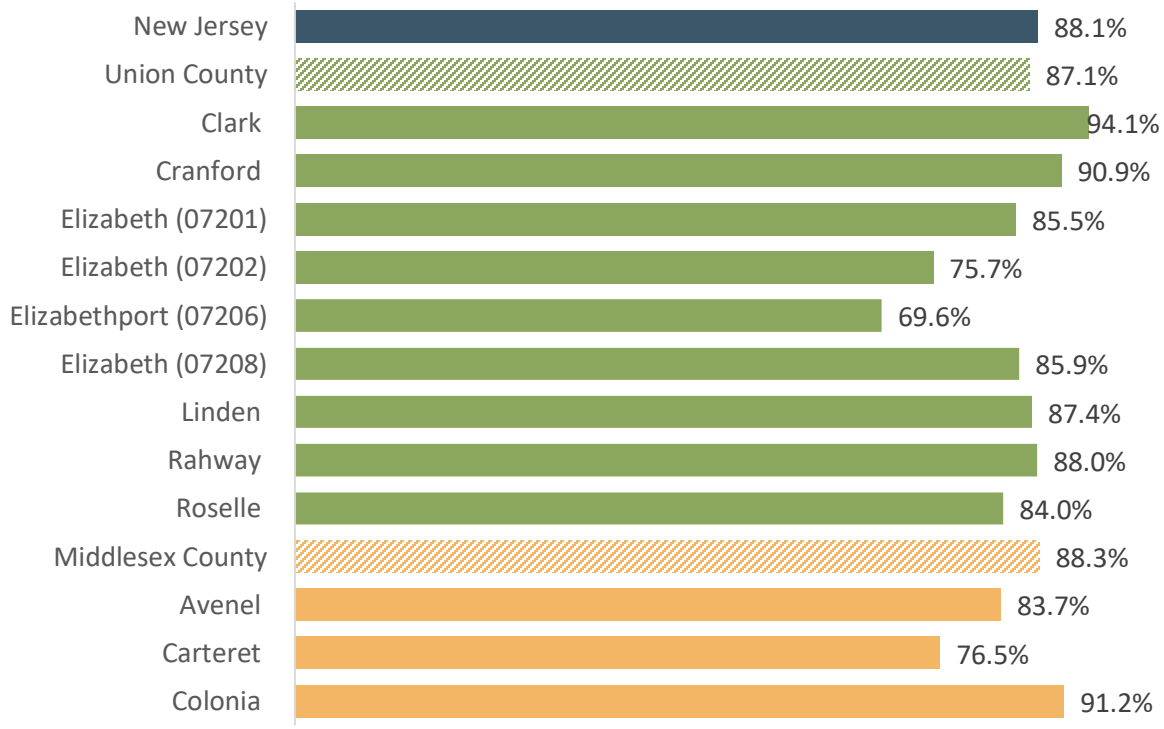
Focus group and interview participants commented that the COVID-19 pandemic exacerbated people's concerns about housing affordability and housing stability. With some residents' financial situations being more uncertain or diminishing during the pandemic, there was more concern that residents might lose their housing. One participant further illuminated this challenge, "*Even getting people into shelters is difficult, they are over flooded. We were paying for hotels or motels, but those are filled to capacity because of the housing crisis because they stopped paying rent, once they lifted the moratorium everyone who was unable or chose not to pay rent is now displaced and homeless and we have nowhere to house or help them. Lots of emergency needs."* Participants observed that seniors, families, and immigrant residents seem to be more impacted by housing instability, and that if residents lose their homes, additional cascading challenges emerge. One interviewee explained, "*There is nowhere to connect homeless individuals for services. If you aren't eligible for services or citizenship you can't get a place in a shelter… If you aren't documented, you have no place to get presentable to hold down a job. If you're not 100% presentable, then they may not be wanted in the job. New York used to have a place where people could shower. That was brilliant. There is nothing [to help with personal hygiene] if you're homeless."*

Housing and Technology Infrastructure

Technology was frequently discussed during focus groups and interviews as an important tool to access information, services, and resources for individuals, families, and households. Participants explained that the importance of technology use and access became evident during the COVID-19 pandemic. The ability to be online, focus group and interview participants noted, is essential for residents to connect to resources for education, employment, health, and other services. 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. The role of technology, particularly as it relates to health, is further discussed in the Technology Access section.

Household Internet access varied by town, with Clark (94.1%) and Colonia (91.2%) having the highest percent of households with Internet in Union and Middlesex Counties. In contrast, Elizabethport (69.6%), Elizabeth (07202) (75.7%) and Carteret (76.5%) had the lowest percent of households with Internet. (Figure 30).

Figure 16. 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

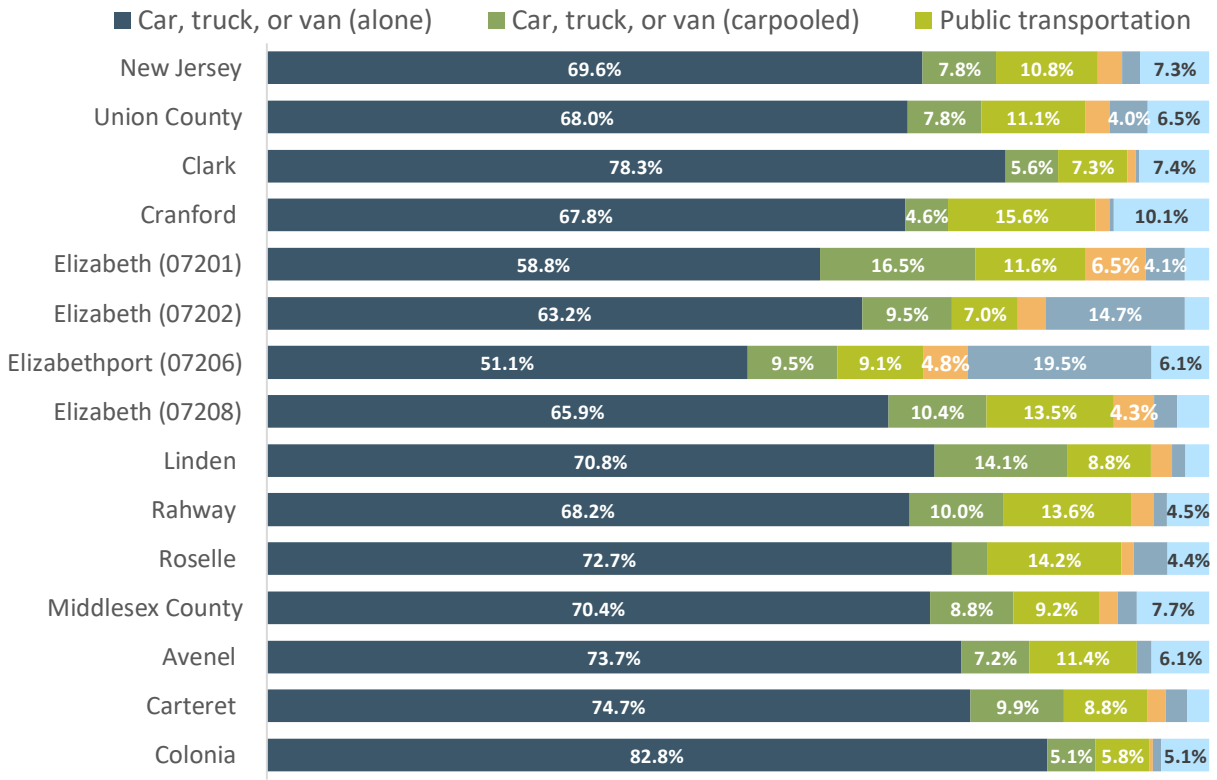
Transportation connects people with and between where they live, learn, play, and work. Transportation is considered an important economic and social factor that can influence the livelihood of individuals. For example, a reliable means of transportation is often required for a person to obtain employment, attend school, and access medical care, and is therefore considered an important social determinant of health. Additionally, barriers to transportation are more likely to exacerbate social and economic circumstances, such as for older persons who can no longer drive themselves, those who are economically vulnerable, or those that have physical limitations.

Though focus group and interview participants frequently remarked that walkability and public transportation were community assets, transportation was also mentioned as a challenge in the community. Participants explained that the ability to find parking, affordability of transportation services and parking fees, structural barriers to obtaining a license, and the cost of gas are all barriers to transportation. One interviewee shared, "*A lot of older residents are riding bikes because they can't afford the gas*." Furthermore, when residents are able to afford transportation, parking struggles persist. As one focus group participant explained, "*Parking is always an issue where I live, I don't have a parking spot so I'm always fighting.*"

> *"Parking is not so good in Union County. You have to ride around and look… And then transportation… the vans to get to and from the hospital facilities. They [residents] may get someone to drop them off but they have no way to get home. Would be nice if they had a service to help people get home."*
> - Focus group participant

Most residents in the RWJUH Rahway and TRMC primary service area commuted to work alone by car, truck, or van, according to data collected primarily prior to the COVID-19 pandemic (Figure 17). However, there are differences across towns. Data from the 2016-2020 American Community Survey show that Colonia (82.8%), Clark (78.3%), and Carteret (74.7%) had the highest proportion of commuters who relied on private transportation while Cranford (15.6%), Roselle (14.2%), and Rahway (13.6%) had the highest proportion of commuters who used public transportation. Elizabeth zip code 07201 had the highest proportion of residents (6.5%) who commuted to work by walking.

Figure 17. Means of Transportation to Work for Workers Aged 16+, by State, County, and Town 2016-2020



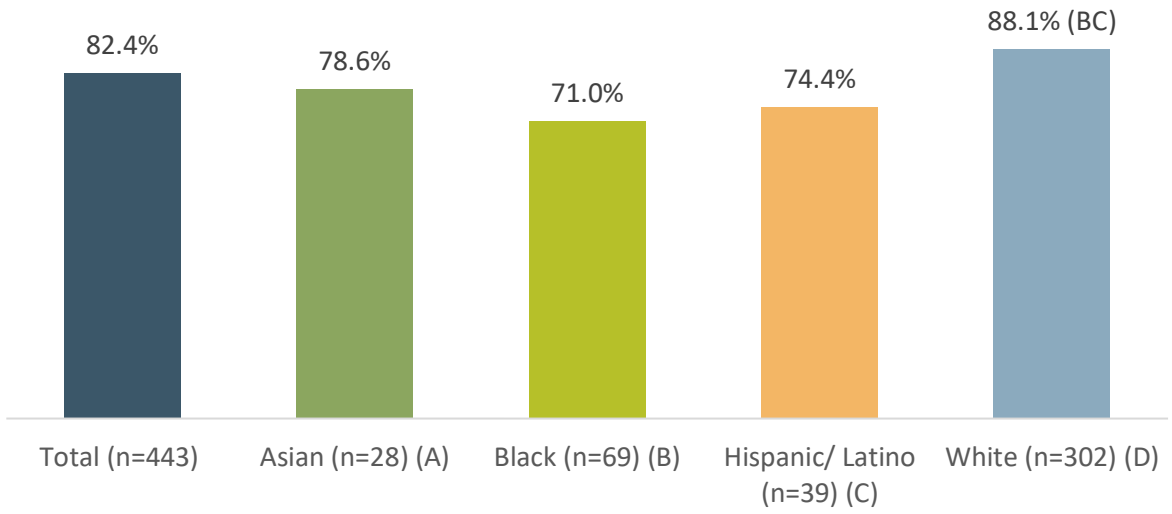
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020
NOTE: Data under 4.0% not labeled.

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. Some focus group members and interviewees highlighted the built environment in Union and Middlesex Counties as assets, noting amenities such as walkability, access to parks, and nearby stores and libraries.

Community survey data from 2021 indicate that 82.4% of survey respondents from Union County agreed or completely agreed with the statement, "My community has safe outdoor places to walk and play." Figure 18 presents data for the overall sample and by race/ethnicity.

Figure 18. 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 =443), 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.

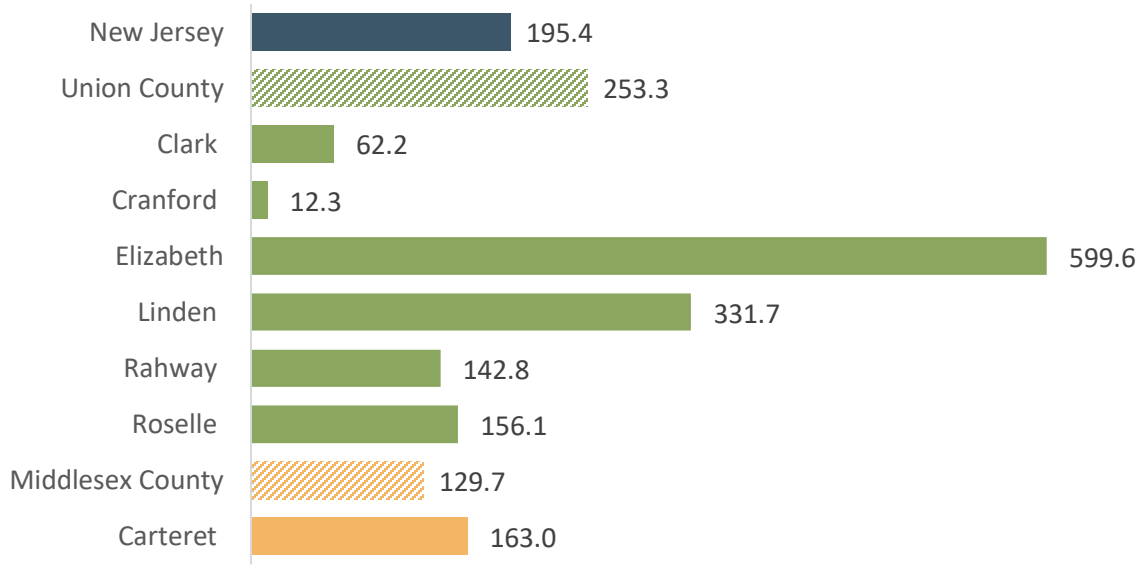
Crime and Violence

Violence and trauma are important public health issues affecting 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. While a few focus group and interview participants reported feeling unsafe in certain parts of town or noting a perceived increase in people losing tempers and experiencing violent outbursts, crime and violence were generally not major themes that emerged in focus groups or key informant interviews.

Data from the Uniform Crime Reporting Unit in the State of New Jersey show that rates of violent crime (i.e., murder, rape, aggravated assault) in 2020 varied widely across the towns RWJUH Rahway and TRMC serve (Figure 19). At 599.6 incidents per 100,000 residents, Elizabeth (citywide) had a rate over

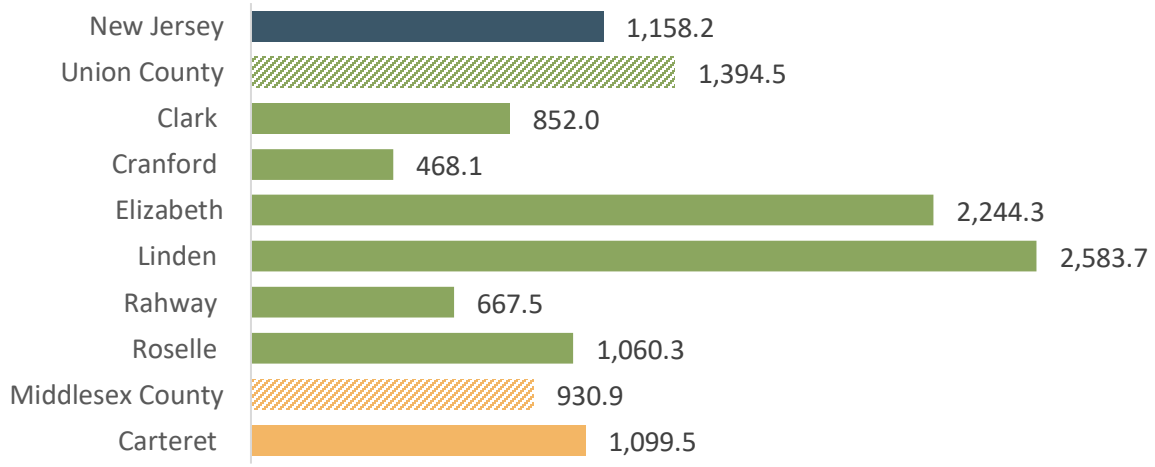
three times as high as the state rate (195.4 per 100,000 residents), and Cranford had the lowest rate, 12.3 per 100,000 residents. Property crime (i.e., burglary, larceny, and auto theft) is much more common than violent crime. Among towns served by RWJUH Rahway and TRMC, property crime was most common in Linden (2,583.7 per 100,000 residents) and Elizabeth (citywide) (2,244.3 per 100,000 residents) and least frequent in Cranford (468.1 per 100,000 residents) and Rahway (667.5 per 100,000 residents) (Figure 20).

Figure 19. 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, 2020
NOTE: * Data not available for town. Violent crime includes murder, rape, robbery, and assault.
NOTE: Towns with missing data (Avenel, Colonia) not presented.

Figure 20. 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: Towns with missing data (Avenel, Colonia) not presented.

Systemic Racism and Discrimination

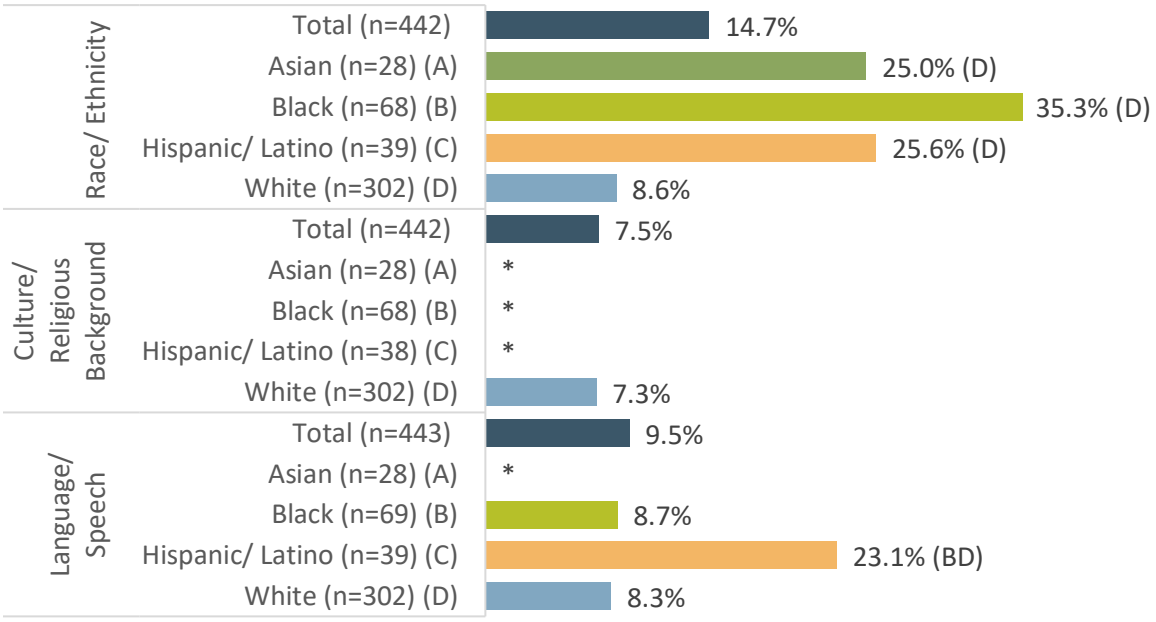
When we look at systematic racism and discrimination issues, such sentiments and behavior are often not fully visible, yet remain pervasive and are often 'structurally' embedded in our educational, economic, and political systems. Such systems consequently produce and condone the unfair and unequal treatment of people based on the color of their skin, language, sexual orientation, and place of origin, among others.

> *"People of color are in these situations because of the color of their skin but that happens all the time… The stories I've heard from other people when they had Covid and were in the hospital, a nurse told me that people of color were treated differently."*
> - Key informant interviewee

Perceptions related to discrimination and racism varied throughout qualitative discussions. Focus group and interview participants raised concerns regarding the exclusion or marginalization of communities based on immigration status, language, income, and race or ethnicity. Several participants shared experiences with racism and disrespect when receiving healthcare and other social services. Experiences included microaggressions, perceived segregation, lack of language services, and differential treatment. As one interviewee explained, "*When you think of the makeup [of the community], the racial disparity is constantly coming out in areas it should not. We are [a diverse state], and to have that stigma in such a small area, is an indictment on us all."* Participants also commented on the need to understand the history of racism, systemic oppression, and socioeconomic impacts on residents. As one participant remarked, "*It's part of our everyday life. Unemployment is always higher in the African American community, and other communities [of color]."* Other participants shared stories of receiving sub-par healthcare or being unable to access lifesaving treatment due to immigration status.

Data from the 2021 community survey provide additional insight into experiences of discrimination when receiving healthcare in Union County. More than one third of Black (35.3%) and a quarter of Hispanic (25.6%) respondents reported experiencing discrimination due to their race/ethnicity when receiving medical care compared to 14.7% of respondents overall (Figure 21). Over 20% of Hispanic survey respondents also reported feeling discriminated against when receiving medical care due to their language/speech.

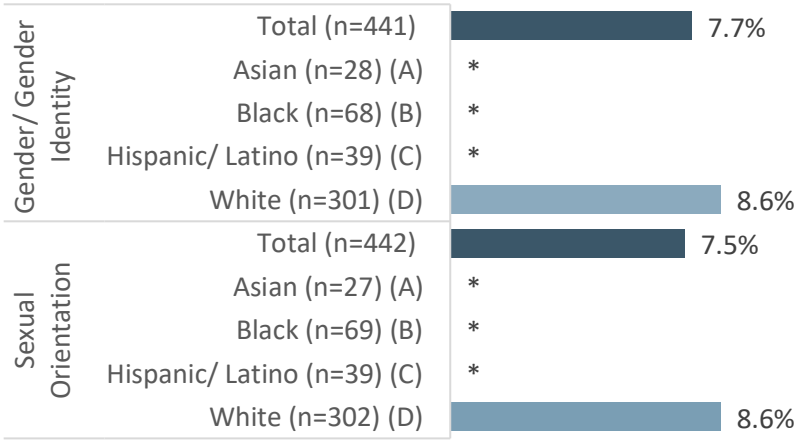
Figure 21. Percent of Community Survey Respondents Indicating Whether They Have Felt Discriminated Against When Receiving Medical Care, by Type of Characteristic and By Race/Ethnicity by Race/Ethnicity, Culture, and Language (n=442), 2021



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. * indicates n<5.

In addition, about 7.7% of survey respondents from Union County indicated that they had felt discriminated against when receiving medical services because of their gender/gender identity and 7.5% reported this relative to their sexual orientation (Figure 22).

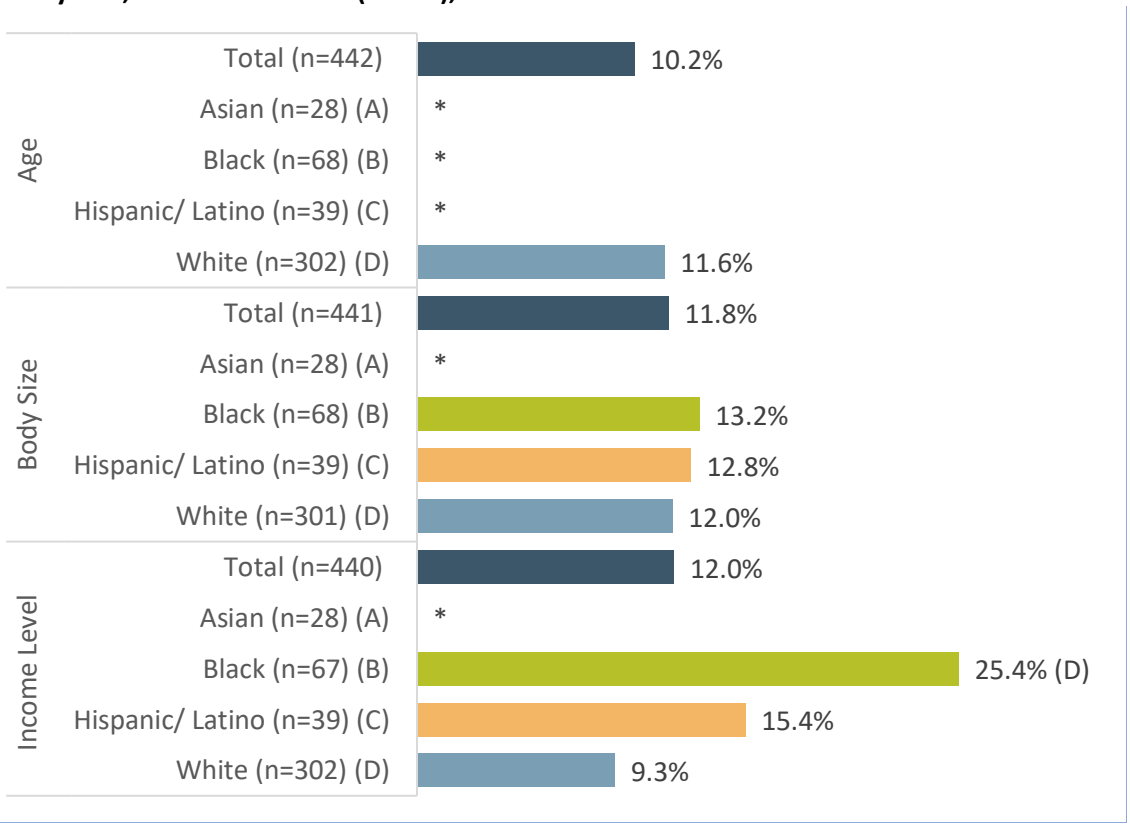
Figure 22. Percent of Community Survey Respondents Indicating Whether They Have Felt Discriminated Against When Receiving Medical Care, by Type of Characteristic and By Race/Ethnicity by Gender/Gender Identity & Sexual Orientation (n=441), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
NOTE: * indicates n<5.

The survey asked about experiences with discrimination due to other factors, such as age, body size, and income level, when receiving medical care (Figure 23). With regard to body size and income level, Black respondents, followed by Hispanic/Latino respondents, had the highest proportion of respondents indicating experiencing this type of discrimination. However, please note that all findings related to discrimination should be interpreted with caution given the small sub-sample sizes.

Figure 23. Percent of Community Survey Respondents Indicating Whether They Have Felt Discriminated Against When Receiving Medical Care, by Type of Characteristic and By Race/Ethnicity by Age, Body Size, and Income Level (n=442), 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. * indicates n<5.

Despite the challenges around racism and discrimination mentioned by focus group and interview participants, many participants also shared a feeling that many social service organizations, such as food pantries, housing support organizations, and faith communities, provided unconditional support that did not discriminate. Additionally, there was a feeling of progress communicated by some residents, as one focus group participant shared, "*Diversity, equity, inclusion, and social justice movements are making changes in the authority figures of the community*." Another interviewee also expressed their desire to support positive changes, commenting, "*It's devastating that a human being will die when there could be a possibility of doing a lot of things, but we are so limited and the only thing we have is our faith… I know that I need to work with partners, and see how we can reach out to politicians to put in place better laws that will cover all of us and help those that are more vulnerable."*

Community Health Issues

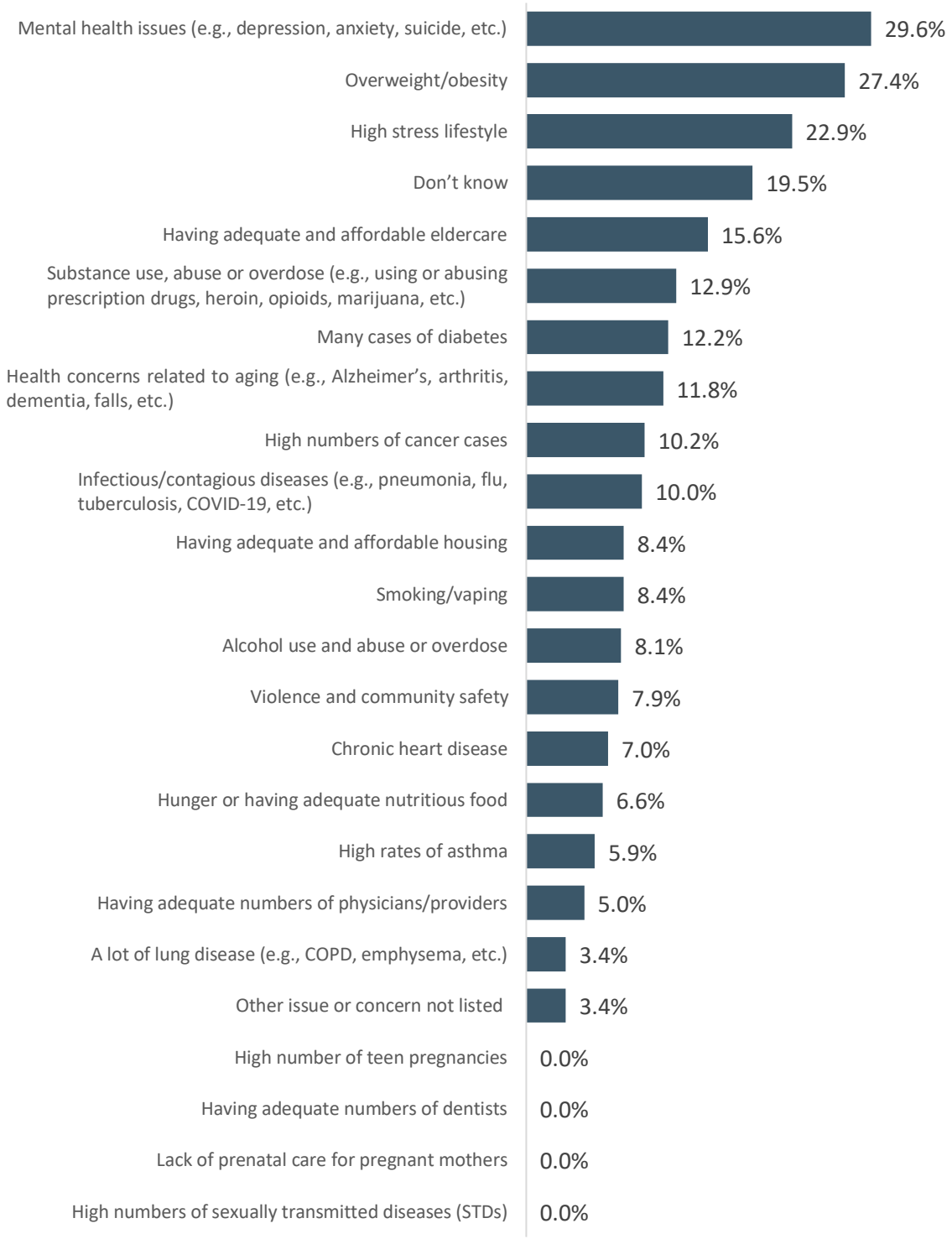
Understanding community health issues is a critical step in the CHNA process. The disparities seen in these issues mirror the historical patterns of structural, economic, and racial inequities experienced for generations across the city and the U.S.

Community Perceptions of Health

Understanding residents' perceptions of health helps provide insights into lived experiences, including key health concerns and facilitators and barriers to addressing health conditions. Focus group participants and interviewees were asked about top concerns in their communities. Participants identified social and economic issues such as financial insecurity, housing, and access to healthy food – and how these affected health issues such as healthy eating, obesity, and chronic conditions. They also discussed the challenges of accessing care, the increase in mental health concerns, and the lingering effects of the COVID-19 pandemic.

Community survey respondents were presented with a list of specific issues and the ability to add issues not listed from which they were asked to mark the top three health concerns or issues for their community. Respondents to the community survey ranked mental health (29.6%), followed by overweight/obesity (27.4%), high stress lifestyle (22.9%), adequate and affordable eldercare (15.6%), and substance use (12.9%) as the top five health issues in their communities (Figure 24). The prioritization of mental health in 2022 and concerns about high stress lifestyle likely reflect the impact of the COVID-19 pandemic and its social and economic consequences. It should also be noted that nearly one in five survey respondents indicated that they "don't know" their top health concerns in the community.

Figure 24. Percent of Community Survey Respondents Reporting the Top Three Health Issues or Concerns in Their Community (n=442), 2021



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

When looking at survey responses by race/ethnicity, there are some notable differences (Figure 25). Mental health issues was the top concern among respondents from each racial/ethnic group, and overweight/obesity was the second leading top health concern among White, Hispanic/Latino, and Black survey respondents. A high stress lifestyle was also noted as the second leading top health concern for Asian respondents, and among the top five health concerns for other groups. Hispanic/Latino respondents were the only group to include many cases of diabetes and substance use in the top five health concerns, and Black respondents were the only group to include affordable housing.

Figure 25. Percent of Community Survey Respondents Reporting the Top Health Issues or Concerns in Their Community, by Race/Ethnicity (n=442), 2021

Asian (n=28) (A)	Black (n=69) (B)	Hispanic/ Latino (n=39) (C)	White (n=301) (D)
Mental health issues (32.1%)*	Mental health issues (34.8%)	Mental health issues (46.2%) (D)	Mental health issues (27.6%)
High stress lifestyle (32.1%)*	Overweight/ obesity (27.5%)	Overweight/ obesity (33.3%)	Overweight/ obesity (27.2%)
Overweight/ obesity (25.0%)	Having adequate and affordable eldercare (17.4%)	High stress lifestyle (25.6%)	High stress lifestyle (25.2%) (B)
	High stress lifestyle (15.9%)*	Many cases of diabetes (15.4%)*	Having adequate and affordable eldercare (16.3%)
	Having adequate and affordable housing (15.9%) (CD)*	Substance use, abuse or overdose (15.4%)*	Health concerns related to aging (e.g., Alzheimer's, arthritis, dementia, falls, etc.) (13.6%) (BC)

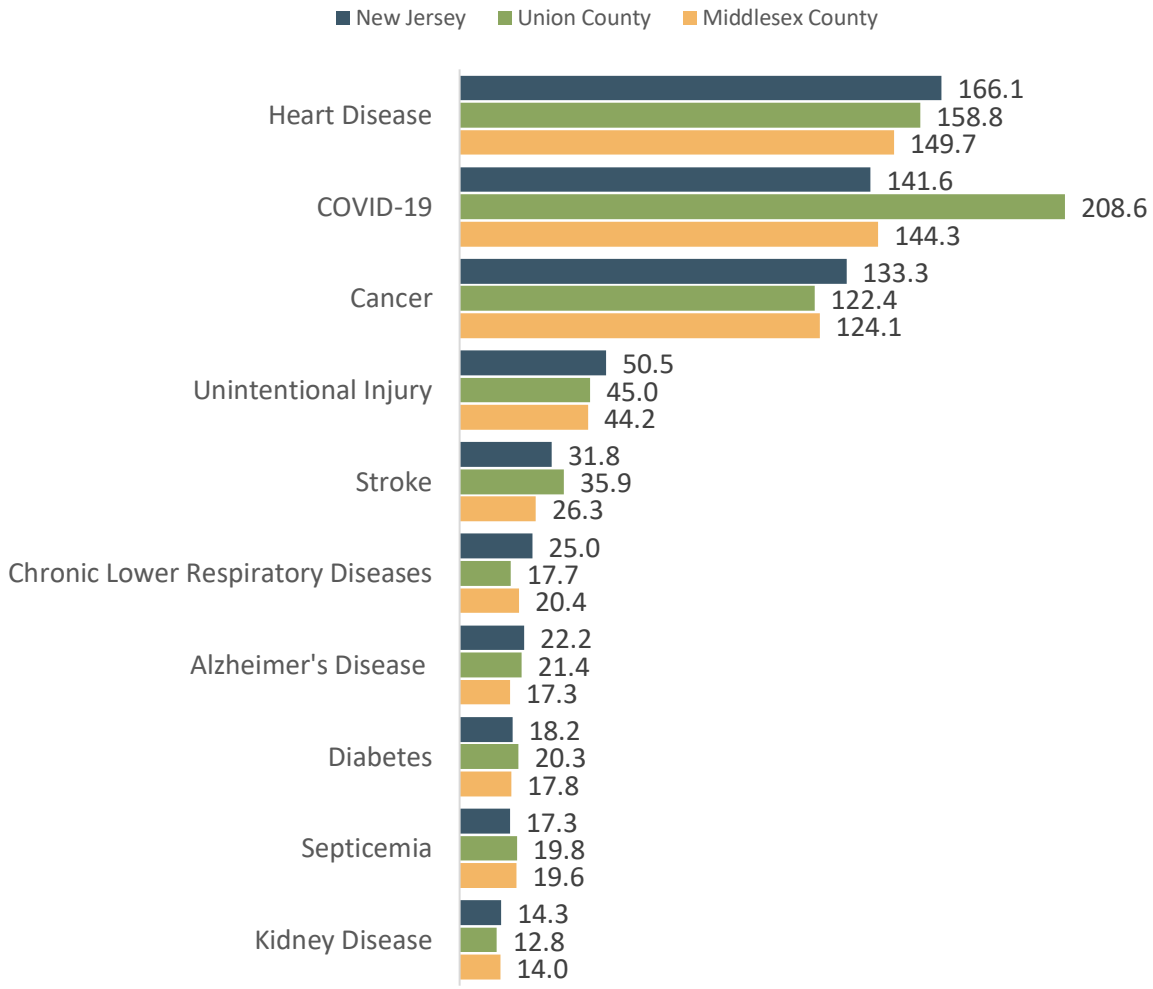
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering. * indicates health issues were tied. Cases where "don't know" was a frequently selected option or cases where n<5 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. Figure 26 presents age-adjusted mortality rates per 100,000 residents in 2020 for different diseases for the state of New Jersey and Union and Middlesex Counties. Heart disease, COVID-19, and cancer are the top three causes of death for the state and both counties. Additional leading causes of death include 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), Alzheimer's Disease, diabetes, septicemia, and kidney disease.

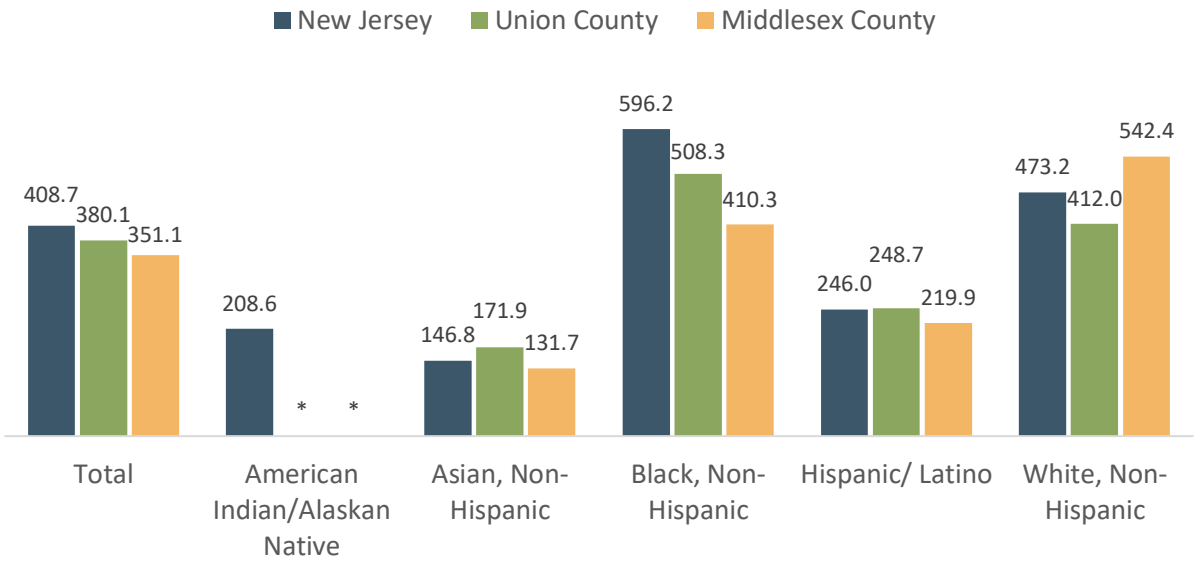
Figure 26. Top 10 Age Adjusted Mortality Rates per 100,000, by State and County, 2020



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), 2020
Note: Unintentional injury uses ICD-10 codes: V01-X59, Y85-Y86. Unintentional injuries include poisonings (drugs, alcohol, fumes, pesticides, etc.), motor vehicle crashes, falls, drowning, suffocation, and any other external cause of death.

Figure 27 shows premature mortality (deaths before age 75) per 100,000 population by state, county, and race/ethnicity. In 2018-2020, the premature mortality rate in both Union County (380.1 per 100,000) and Middlesex County (351.1 per 100,000) was lower than for the state (408.7 per 100,000). Data about premature mortality in 2018-2020 across different racial and ethnic groups show that non-Hispanic White and non-Hispanic Black residents in Union and Middlesex Counties experience higher rates of premature mortality than Hispanic/Latino and non-Hispanic Asian residents.

Figure 27. Premature Mortality (deaths before age 75) Rate per 100,000 Population, by State and County, by Race/Ethnicity, 2018-2020



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), 2019
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

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.

> "*Not being around other people, constant internalizing of everything and if you don't have that release you keep doing things for the relief. I've watched people eating who aren't hungry to fill the void.*"
> – Key informant interviewee

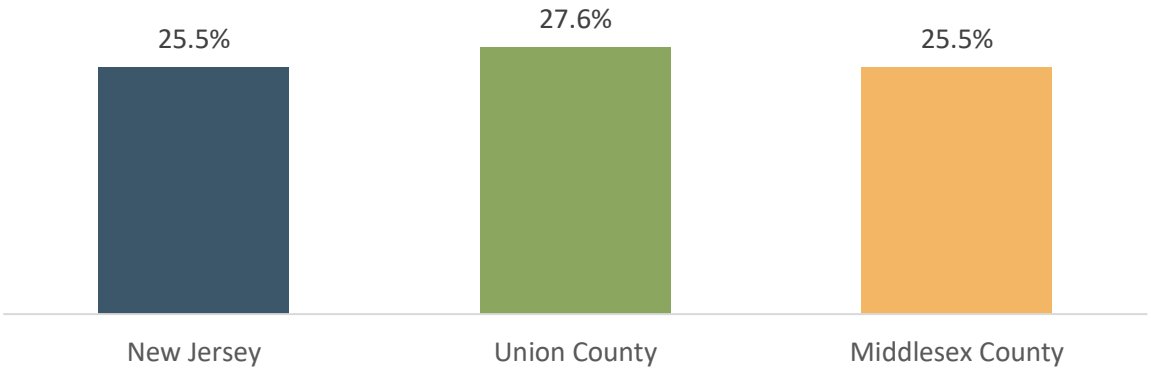
As discussed earlier in the Community Perceptions of Health section, obesity was cited among the top three health concerns in the community on the survey. However, obesity was not discussed at length in the focus groups or interviews by participants. Instead, focus group and interview participants more frequently discussed challenges with access to healthy food and food instability, and unhealthy eating habits that have worsened during the COVID-19 pandemic. (See section on Food Access and Food Security for additional details.) Interviewees commented on their observations that senior populations are relying on frozen dinners instead of fresh and healthy foods, that members of the Haitian community experience some struggles preparing food in palatable and culturally appropriate ways while maintaining nutritional benefits, and that some residents with mental health challenges may be using eating as a coping mechanism.

Overweight, Obesity, and Physical Activity

The latest surveillance data on overweight/obesity is from several years ago (2018) and does not capture any developments that may have occurred during the pandemic. Adults at the state and county level were asked to self-report their height and weight. Based on this self-report, 27.6% of adults in

Union County and 25.5% of adults in Middlesex County were considered obese, which is equivalent or higher than the 25.5% of adults in New Jersey who self-reported as obese (Figure 28).

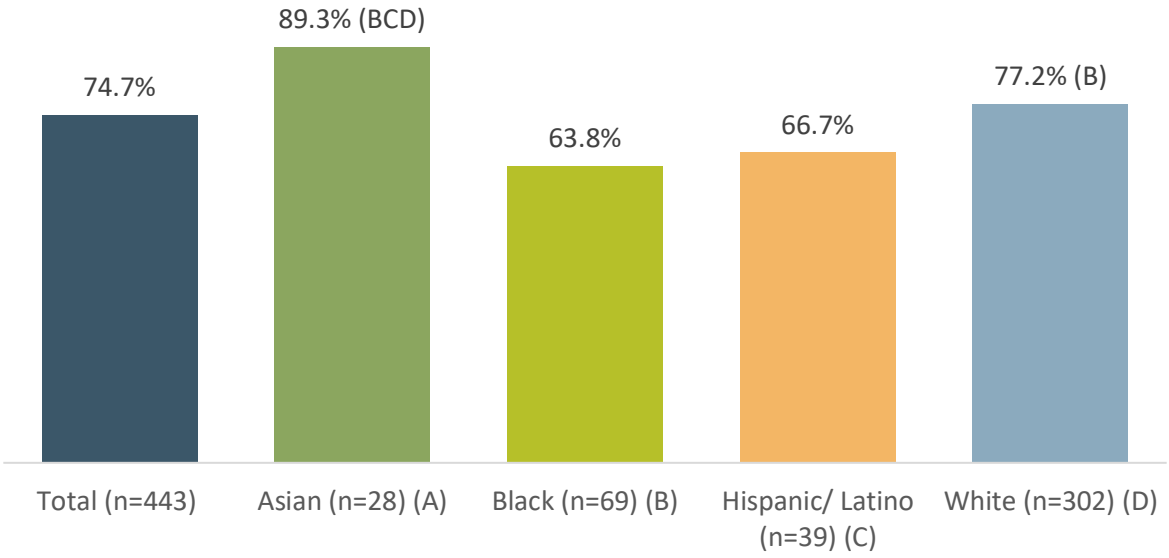
Figure 28. Adults Self-Reported Obese, by State and County, 2018



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, 2018

Community survey respondents were asked whether they felt that they were physically active, and 74.7% indicated yes (Figure 29). However, Black and Hispanic/Latino survey respondents were least likely to say that they were currently physically active, with only 63.8% and 66.7% saying yes respectively, a lower proportion when compared to White respondents (77.2%) and Asian respondents (89.3%). Please note, results by race/ethnicity should be interpreted with caution given the small sub-sample sizes.

Figure 29. Percent of Community Survey Respondents Indicating that They Felt That They are Physically Active (n=443), 2021



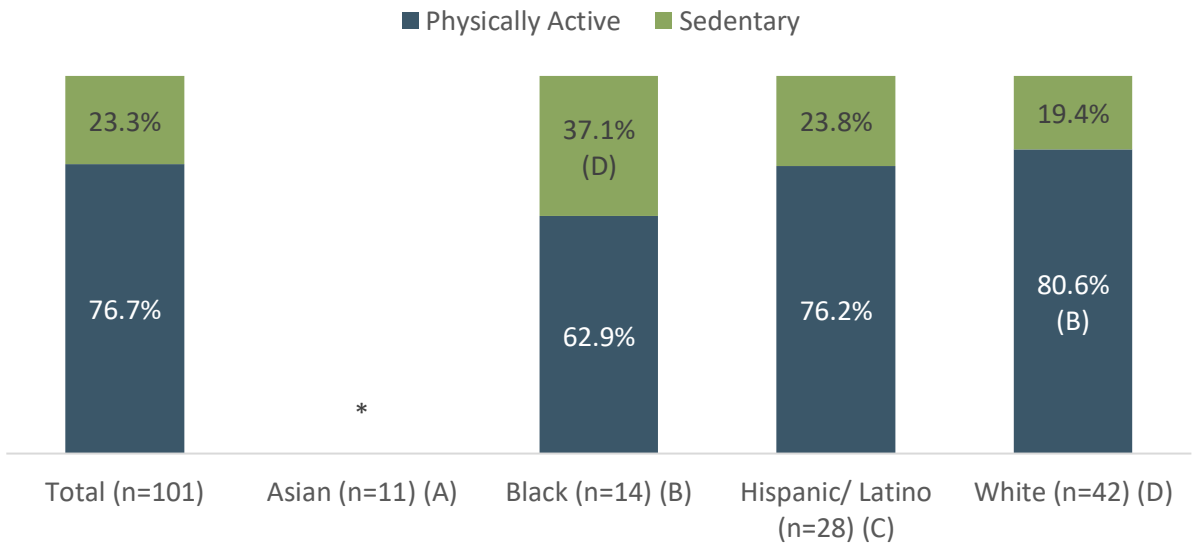
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Healthy Eating

Access to healthy food and nutrition, particularly as they relate to obesity and chronic conditions, were priorities defined in both the RWJUH Rahway and TRMC 2019 CHNAs. As mentioned in the Food Access & Food Insecurity section of this report, focus group and interview participants discussed the challenges of accessing healthy and affordable foods in their communities. These difficulties included limited access to grocery stores, the lack of affordable healthy foods, relying on foods provided by schools and/or food pantries, and challenges navigating structural barriers and qualifying for assistance, which may not provide enough food or foods that are appropriate for residents' dietary needs. Additionally, some residents face challenges putting healthy meals together or preparing food in healthy ways.

Community survey respondents who were parents also indicated whether they would describe their children as physically active or sedentary after school or on weekends (Figure 30). Responses indicate that 76.7% of Union County parent/caregiver survey respondents describe their children as physically active, with 23.3% describing their children as sedentary. However, Black respondents were least likely to describe their children as physically active (62.9%) and most likely to describe their children as sedentary (37.1%). (Due to a limited number of responses from Asian respondents, data for this group are not presented in Figure 30.)

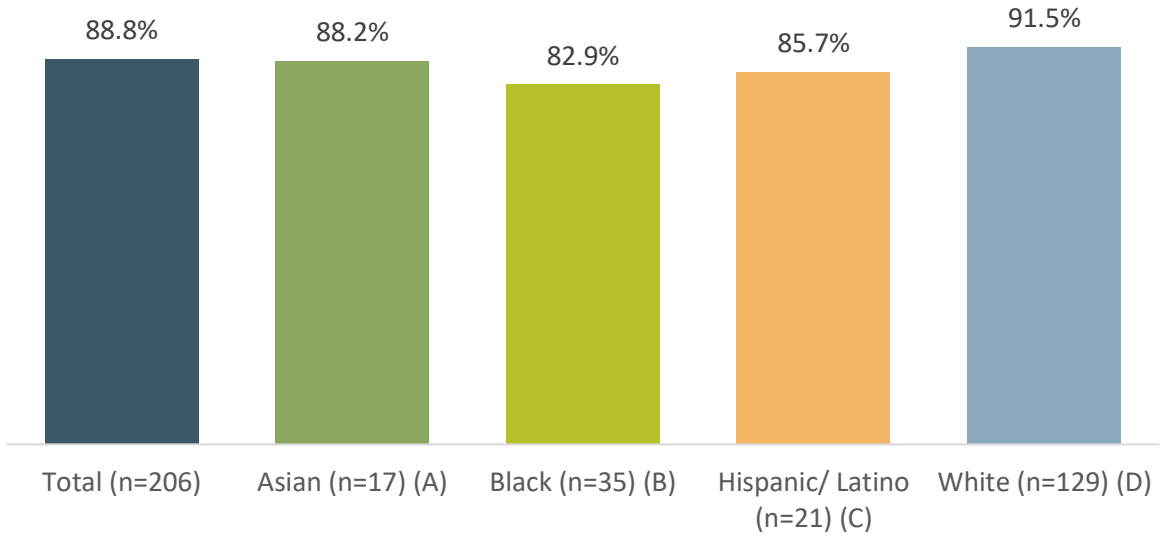
Figure 30. Percent Survey Respondents who are Parents or Guardians who Described Their Children as Physically Active or Sedentary during After School Hours and Weekends (n=101), 2021



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. * indicates n<5 in either physically active or sedentary responses.

Survey respondents who were parents or guardians also reported whether their children eat breakfast on a daily basis (Figure 31). Nearly nine in ten survey respondents (88.8%) indicated that their children regularly ate breakfast, with Black (82.9%) respondents being least likely to report that their children eat breakfast daily, and White respondents being most likely to report this (91.5%).

Figure 31. Percent of Community Survey Respondents who are Parents or Guardians Reporting Whether Children Eat Breakfast Daily (n=206), 2021



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

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 Union and Middlesex Counties. 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. Focus group and interview participants were more likely to discuss social and economic factors that contribute to chronic disease; however, some participants noted that residents are facing high blood pressure, hypertension, diabetes, and COPD. Participants also explained that limited health literacy, including not understanding medication uses and instructions, and the use of herbal remedies may inhibit or delay seeking treatment for chronic conditions.

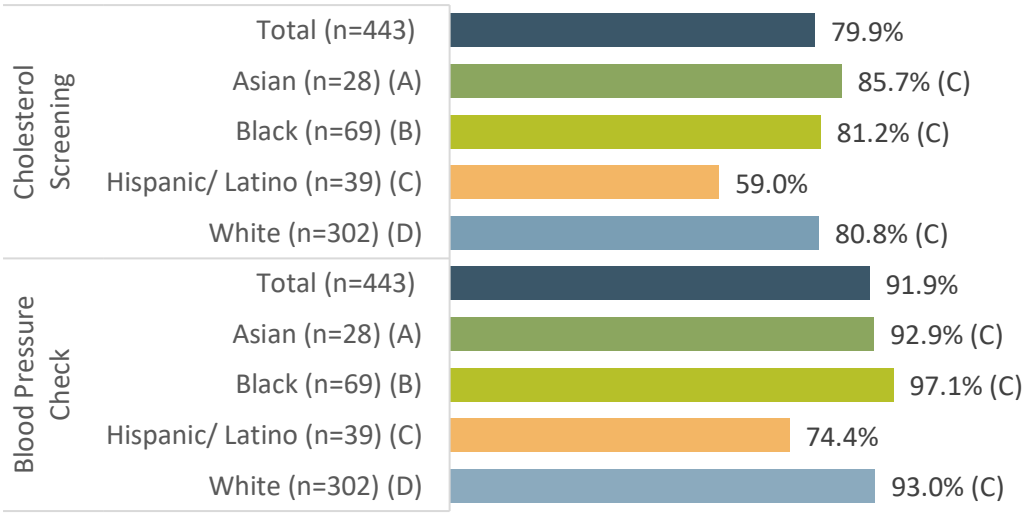
> *"A lot of people of color, because of those realities, they deal with high blood pressure, hypertension, diabetes, and obesity as well. Because of those issues and being isolated, people have put on a lot of weight because of the fear and uncertainty."*
> – Key informant interviewee

The following section describes the health data (e.g., screening, incidence, mortality, etc.) related to chronic conditions.

High Cholesterol and High Blood Pressure

Community survey respondents in spring/summer 2021 were asked about their participation in different types of health screenings over the past two years (Figure 32). Nearly three-quarters (79.9%) of Union County survey respondents indicated that they have received a cholesterol screening, and 91.9% had participated in a blood pressure screening. Asian respondents reported being most likely to receive a cholesterol screening compared to other groups, while Black respondents were most likely to indicate that they had participated in a blood pressure screening over the past two years. Hispanic/Latino respondents were the least likely population to participate in either screening.

Figure 32. Percent of Community Survey Respondents Reporting that They Have Participated in a Cholesterol or Blood Pressure Screening in the Past Two Years (n=443), 2021



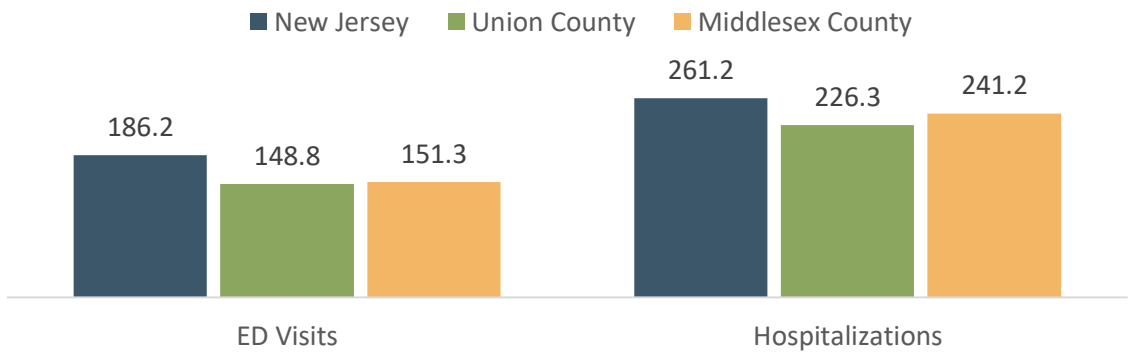
DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Heart Disease

While focus group and interview participants mentioned issues related to obesity and healthy eating, they did not discuss heart disease as a primary issue of concern. However, heart disease is still one of the top two leading causes of death in Union and Middlesex Counties, as referenced in the Leading Causes of Death and Premature Mortality section of this report.

In 2016-2020, the rate of major cardiovascular disease emergency department (ED) visits per 10,000 population was 186.2 visits and the rate of heart disease hospitalizations per 10,000 population was 261.2 hospitalizations in New Jersey (Figure 33). Union County had a rate of 148.8 ED visits and 226.3 hospitalizations per 10,000 population, while Middlesex County had a rate of 151.3 ED visits and 241.2 hospitalizations per 10,000 population.

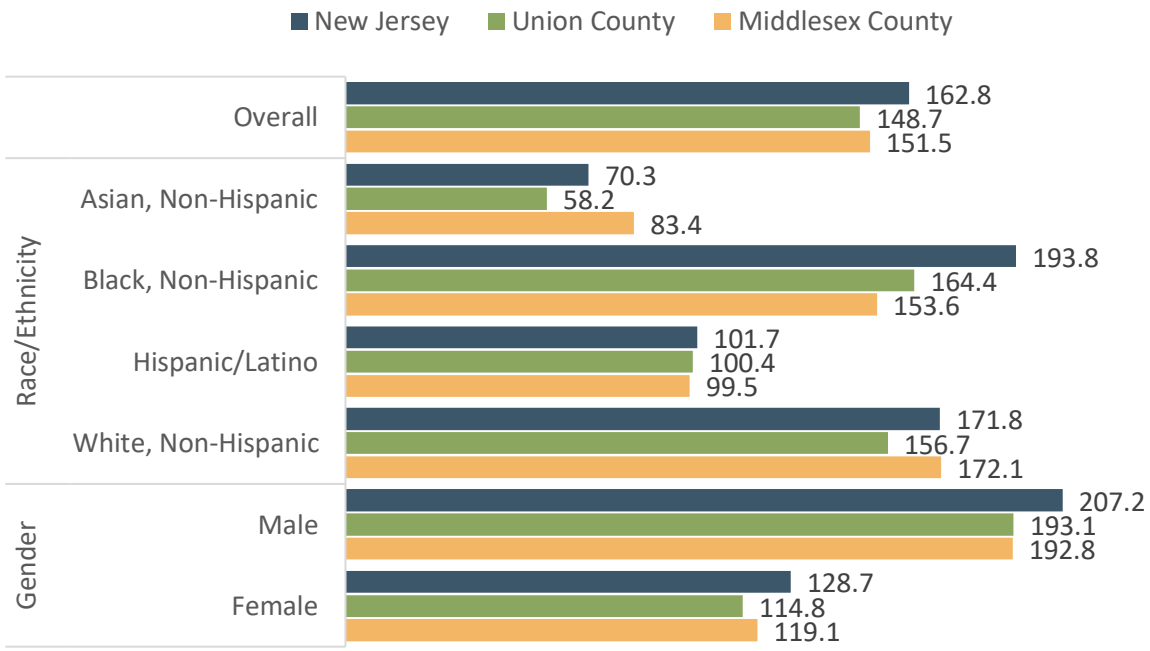
Figure 33. ED Visits and Hospitalizations for Major Cardiovascular Disease per 10,000 Population, by State and County, 2016-2020



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

Death certificate data is presented for rate 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, non-Hispanics (193.8 per 100,000) and White, non-Hispanics (171.8 per 100,000) (Figure 34). At the county level, the overall mortality per 100,000 was 148.7 in Union County and was highest among Black, non-Hispanics (164.4 per 100,000) and White, non-Hispanics (156.7 per 100,000). Similarly, the overall mortality per 100,000 for Middlesex County was 151.5 and was highest among White, non-Hispanics (172.1 per 100,000) and Black, non-Hispanics (153.6 per 100,000) and males (192.8 per 100,000). Across the state and both counties, males had higher rates of cardiovascular disease mortality than females.

Figure 34. 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

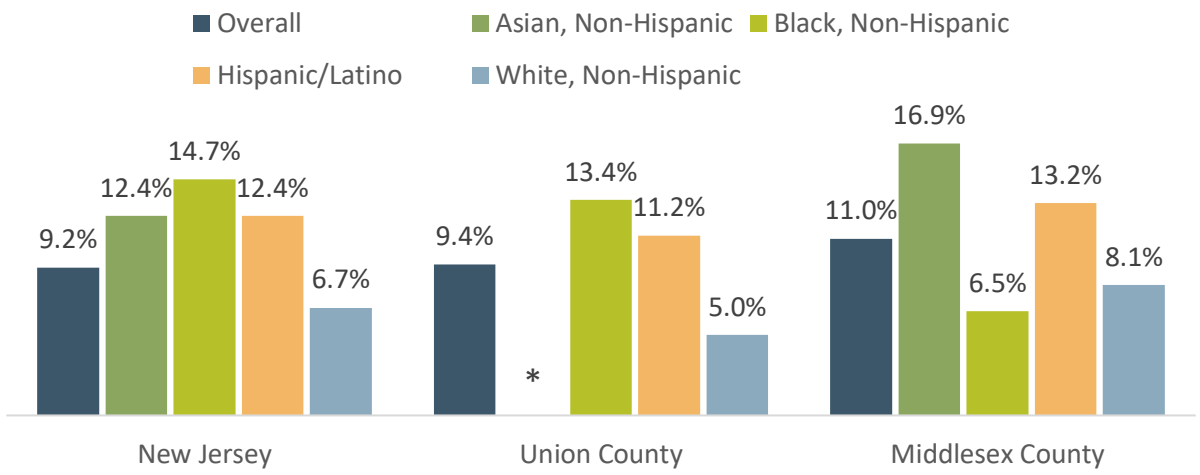
In focus groups and interviews, diabetes was discussed as an issue of concern generally and within the Haitian community, but participants primarily expressed concerns with the social and economic factors contributing to the disease—such as affordable healthy living, mental and social health, and access to good healthcare—more than the condition itself. One interviewee discussed the need for programs offered for diabetes, "*We cater to the senior population. We do chronic disease programs for diabetes. [We hold the program] every 6 weeks and cap [participation] at 20. [The group is] always full. The need for health education is out there, for support groups.*"

> *"Diabetes is huge, [we participate in] health fairs and A1c is always high, blood pressure is always high, some people get referred to the hospital but decline to go."*
> - Key informant interviewee

The following figure shows the percent of adults that reported a diagnosis of diabetes overall and by race/ethnicity in 2016 to 2020, the most recent surveillance data 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 (12.4%), Hispanic/Latino (12.4%), and White, non-Hispanics (6.7%) (Figure 35). In Union County, 9.4% of adults reported a diabetes diagnosis, with the highest percentage among Black, non-Hispanic (13.4%), followed by Hispanic/Latino (11.2%) and White, non-Hispanic (5.0%) adults. Overall rates were slightly higher in Middlesex County, with 11% of adults reporting a diagnosis, with the highest percentage among Asian, non-Hispanic (16.9%), Hispanic/Latino (13.2%), White, non-Hispanic (8.1%), and Black, non-Hispanic (6.5%) adults.

Figure 35. Percent Adults Reported to Have Been Diagnosed with Diabetes, by State and County, 2016-2020



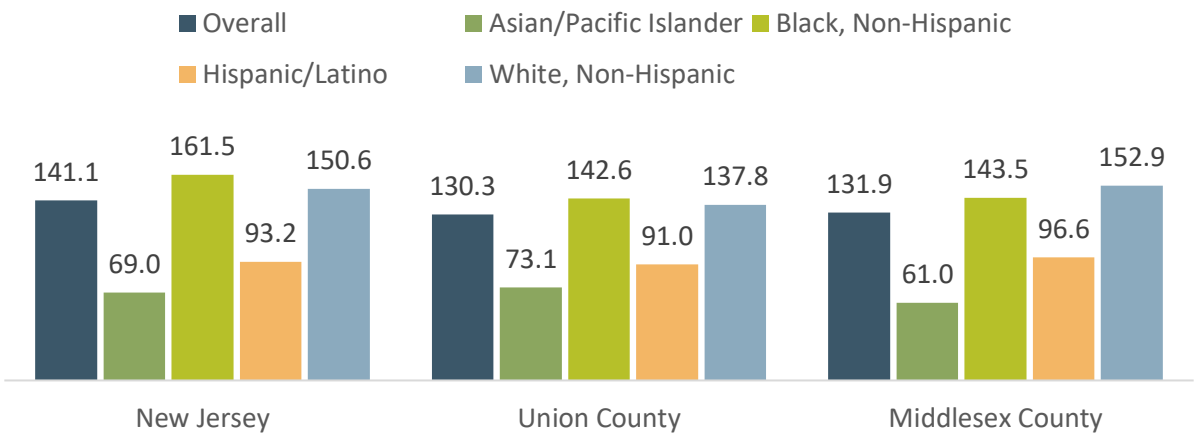
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Cancer

While cancer is one of the top three leading causes of death in Union and Middlesex Counties, it was not frequently discussed during the focus groups or interviews. Death certificate data is presented below for cancer mortality rates per 100,000 (Overall, Female Breast, Colorectal, Lung and Bronchus, Male Prostate), by race/ethnicity from 2016-2020 (Figure 36). Across the state, the overall mortality per 100,000 was 141.1 and was highest among Black, non-Hispanic (161.5 per 100,000) and White, non-Hispanic (150.6 per 100,000). At the county level, the overall mortality per 100,000 was 130.3 in Union County and 131.9 in Middlesex County. County rates for Union and Middlesex Counties were highest among Black, non-Hispanic (142.6 per 100,000 and 143.5 per 100,000 respectively) and White, non-Hispanic (137.8 per 100,000 and 152.9 per 100,000 respectively).

Appendix G contains additional cancer data including incidence and mortality data and five-year trends for various cancers across New Jersey and Union and Middlesex Counties.

Figure 36. Cancer Mortality Rate per 100,000 Population (Overall, Female Breast, Colorectal, Lung and Bronchus, Male Prostate), by State and County, 2016-2020

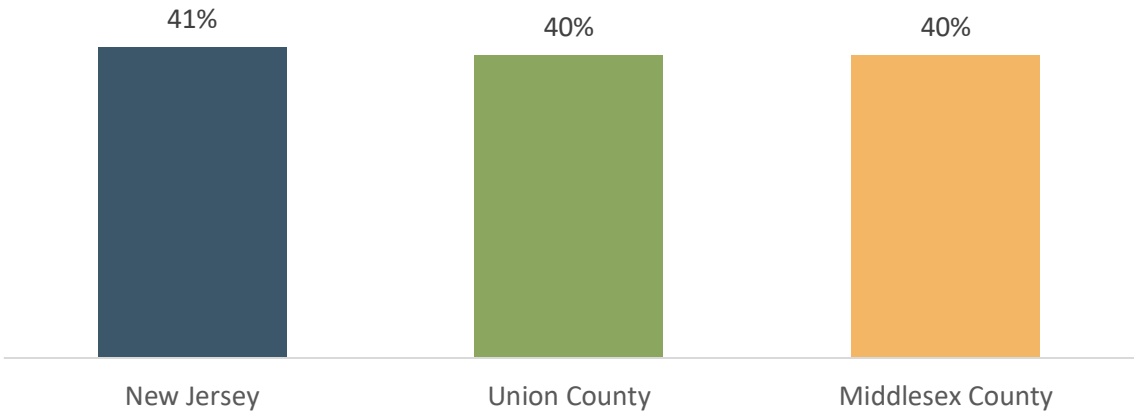


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

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 37). In both Union County and Middlesex County, 40.0% of this group had received an annual screening.

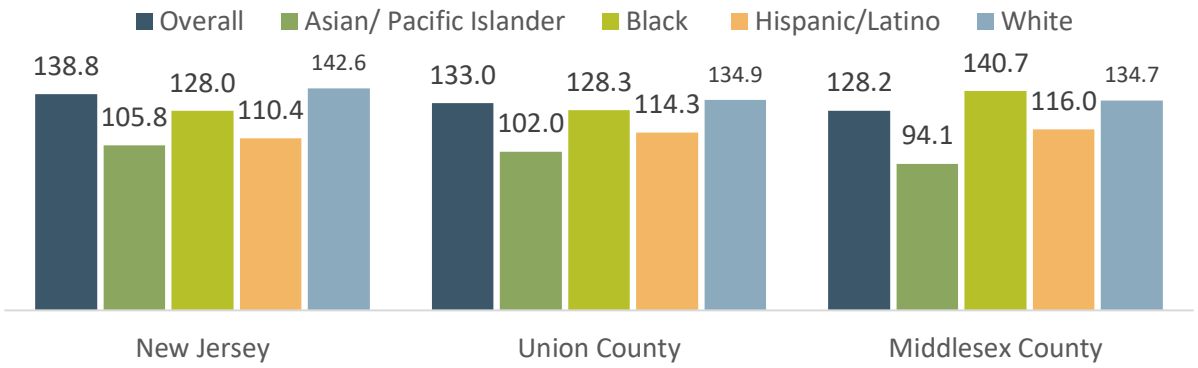
Figure 37. Female Medicare Enrollees, ages 65-74, that Received an Annual Mammography Screening, by State and County, 2019



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, 2019

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, Union, and Middlesex Counties, overall and by race/ethnicity. Across the state, the overall age-adjusted incidence rate per 100,000 was 138.8 and was highest among the White population (142.6 per 100,000) and Black population (128.0 per 100,000) (Figure 38). At the county level, the overall incidence rate per 100,000 was 133.3 in Union County and 128.2 in Middlesex County. Similar to the incidence rates statewide, rates were highest among the White and Black populations. Rates were also higher among Hispanic/Latino populations compared to Asian/Pacific Islander populations.

Figure 38. Age-Adjusted Female Breast Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019

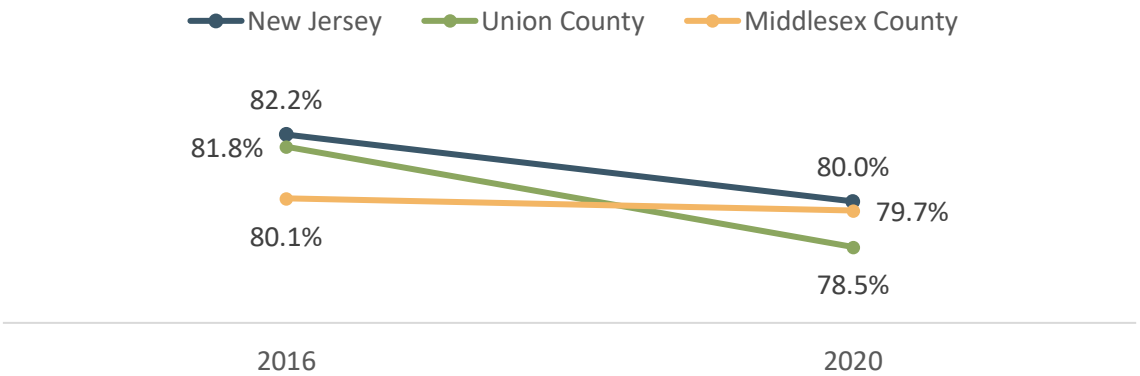


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019
NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Cervical Cancer

Data presented in the figure below show the state level percentage of females, ages 21-65, that reported having had a pap test in the past three years in 2016 and 2020. In New Jersey (82.2% to 80.0%), Union County (81.8% to 79.7%), and in Middlesex County (80.1% to 79.7%), rates of females ages 21-65 reporting to have a pap test in the past three years declined. (Figure 39).

Figure 39. Percent Females Aged 21-65 Reported to Have Had a Pap Test in Past Three Years, by State and County, 2016 and 2020

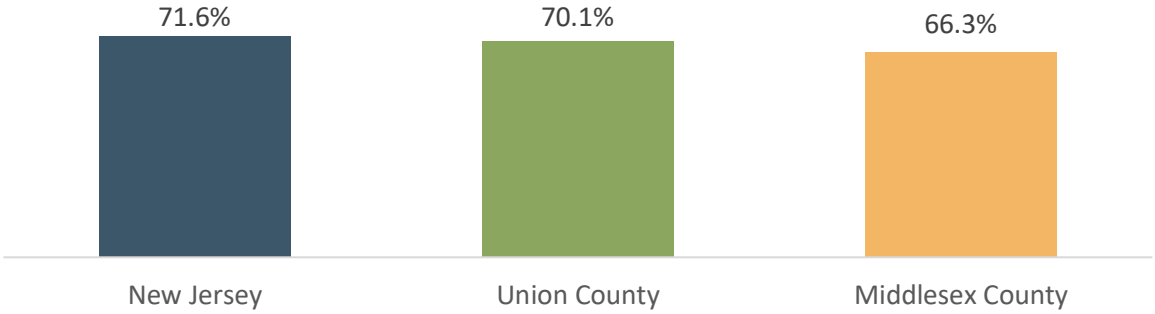


DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016 and 2020

Colorectal Cancer

The following figure presents 2020 surveillance data on the percentage of adults aged 50 to 75 who are current in their colorectal cancer screenings. At the state level, 71.6% of adults in that age group reported having had a colorectal cancer screening (Figure 40). In Union County and Middlesex County, 70.1% and 66.3% of this group reported having a screening, respectively.

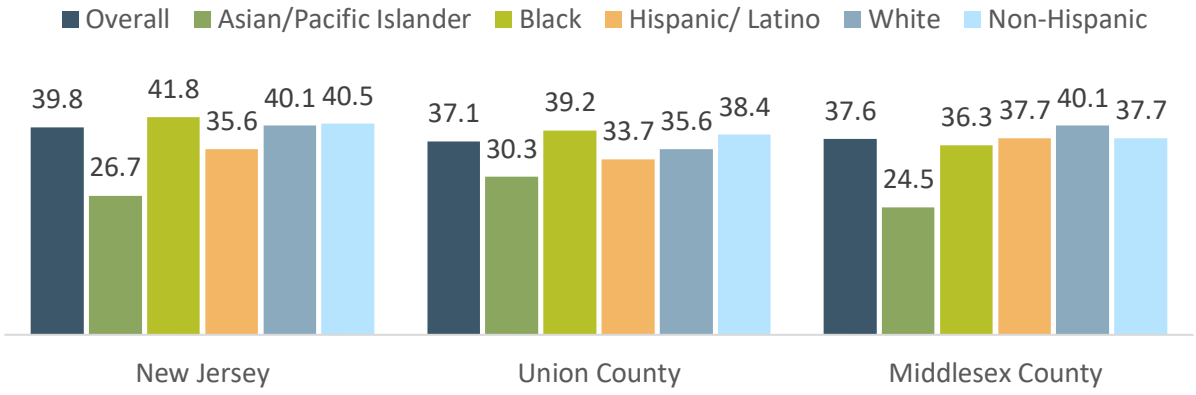
Figure 40. Percent with Current* Colorectal Cancer Screening (Adults Aged 50-75), by State and County, 2020



*Note: An individual is considered current if they have had 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
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 across New Jersey, Union County, and Middlesex 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 (40.5 per 100,000) populations (Figure 41). At the county level, the overall incidence rate per 100,000 was 37.1 in Union County and was highest among the Black (39.2 per 100,000) and White populations (38.4 per 100,000). In Middlesex County, the overall incidence rate per 100,000 was 37.6 and was highest among the White population (40.1 per 100,000) and Black (37.7 per 100,000) and Hispanic/Latino (37.7 per 100,000) populations.

Figure 41. Age-Adjusted Colorectal Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019

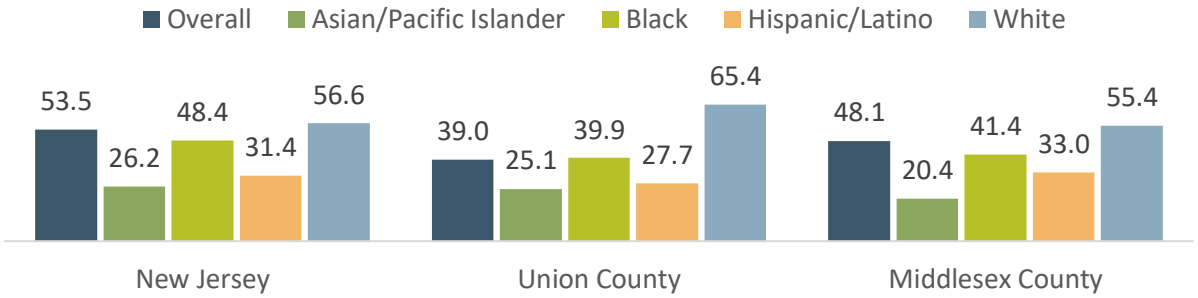


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019
NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Lung Cancer

Figure 42 shows the age-adjusted incidence rate of lung cancer per 100,000 population in 2015-2019 for New Jersey overall, and for Union and Middlesex Counties by race/ethnicity. Union (39.0) and Middlesex (48.1) Counties all have lower lung cancer incidence rates than the state overall (53.5). Age-adjusted lung cancer incidence rates among White residents were higher than the overall rate in the state and in both counties. Rates among Black residents, Asian/Pacific Islander residents, and residents who identified as Hispanic/Latino were lower than the overall rate in the state and in both counties. Because race and Hispanic origin are not mutually exclusive in the New Jersey State Cancer Registry cancer incidence data, caution should be used when comparing rates among Hispanic residents to rates in the different racial groups.

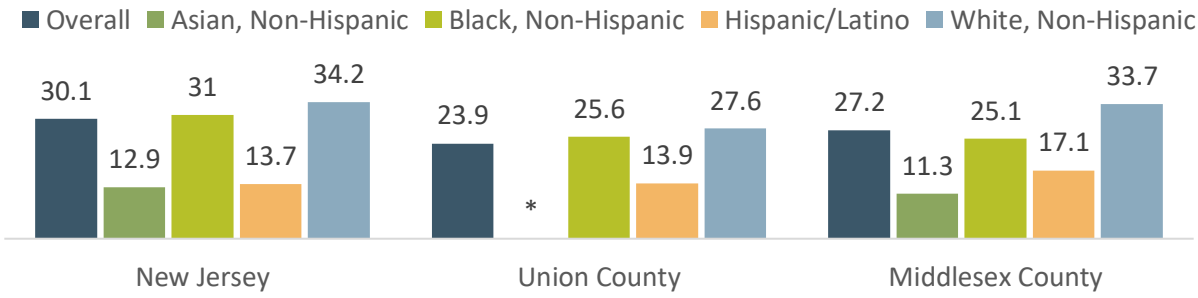
Figure 42. Age-Adjusted Lung Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



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 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-Hispanic (34.2 per 100,000) and Black, non-Hispanic (31.0.4 per 100,000) (Figure 43). At the county level, the overall mortality per 100,000 was 23.9 in Union County and 27.2 in Middlesex County. In both counties, rates were highest among White, non-Hispanic (27.6 per 100,000 in Union and 33.7 per 100,000 in Middlesex), followed by Black, non-Hispanic (25.6 per 100,000 in Union and 25.1 in Middlesex).

Figure 43. Lung/Bronchus Cancer Mortality Rate per 100,000 Population by State and County, 2016-2020

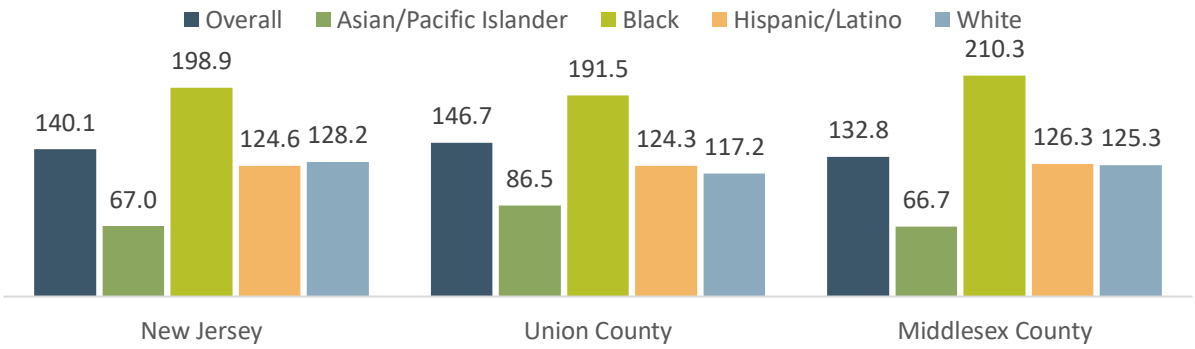


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

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 Union and Middlesex Counties, 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 44). At the state level, incidence rates were similar among White (128.2 per 100,000) and Hispanic/Latino (124.6 per 100,000) populations. At the county levels, the overall age-adjusted incidence rate was 146.7 in Union and 132.8 in Middlesex County. Similar to the state, rates were highest among Black residents, followed by Hispanic/Latino and White populations.

Figure 44. Age-Adjusted Prostate Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019

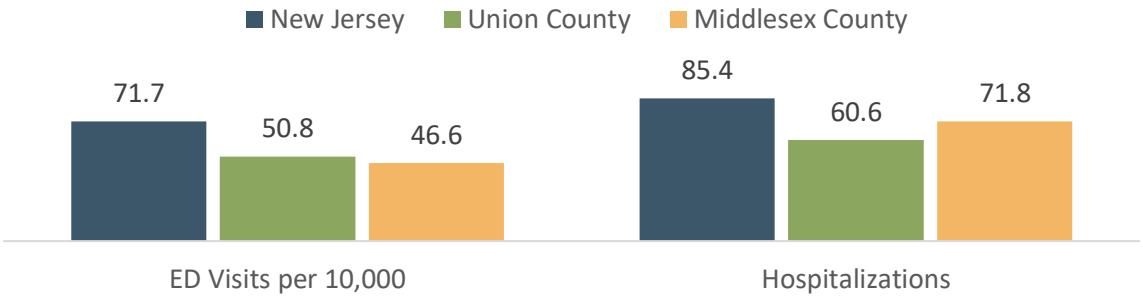


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019
NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

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 one of the main diseases in the grouping of chronic lower respiratory disease (CLRD), the sixth leading cause of death in the state in 2020 (see Figure 26). New Jersey Department of Health data from 2016-2020 show that the state overall had a rate of 71.7 ED visits and 85.4 hospitalizations per 10,000 population (Figure 45). Union County had a rate of 50.8 ED visits and 60.6 hospitalizations per 10,000 population, and Middlesex County has a rage of 46.6 ED visits and 71.8 hospitalizations per 10,000.

Figure 45. ED Visits and 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
NOTE: Includes primary and secondary diagnosis chronic obstructive pulmonary disease

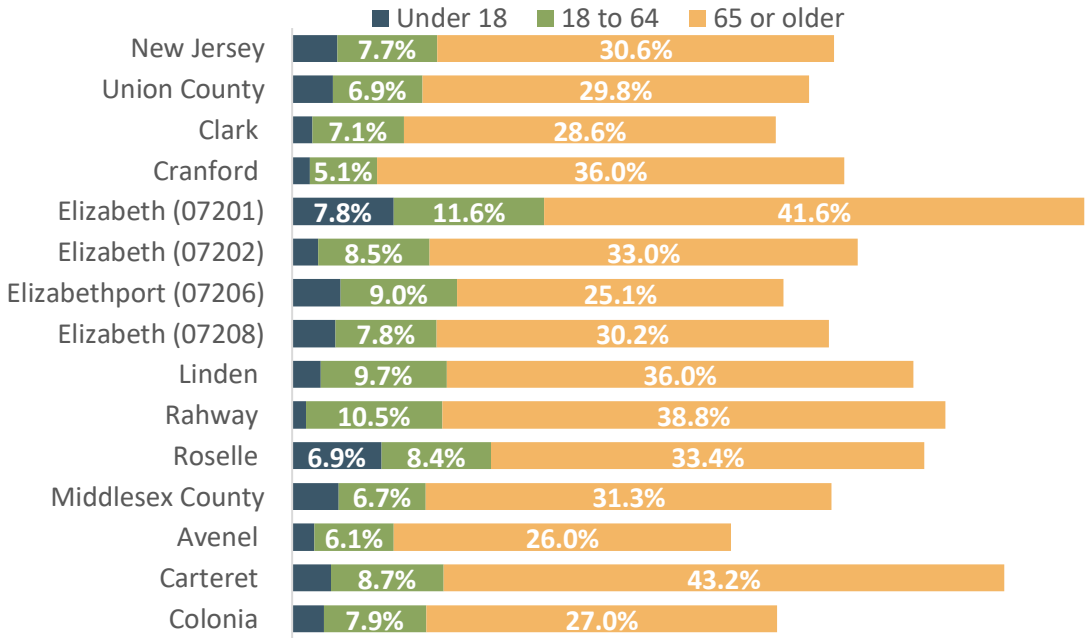
Disability

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.

During focus groups and interviews, participants rarely discussed the needs of residents with disabilities. Instead, the subject of disabilities was often mentioned when talking about income and the impact having a disability can have on financial security, and the barriers around accessing support services, such as housing and health services. One interviewee explained, "*I would like to know if there's going to be more housing for people who are disabled. I have [a health condition] and for me there's no help anywhere… There is no accessible housing, there is nothing that can help me as a disabled person. I would love for Elizabeth or the County to do more for us. I am grateful for what is done, very grateful, but I would love for a little bit more for people like us. We're not even visible. Let's just say that we're invisible for the community.*" Multiple focus group and interview participants also emphasized the need for the community to connect with and care for older populations, as well as bolster early diagnosis and treatment for youth with learning disabilities or other challenges.

American Community Survey Data around the civilian noninstitutionalized population by age show that 7.7% percent of people 18-64 years old and 30.6% of people 65 or older had a disability in New Jersey (Figure 46). 3.5% percent of the state population under 18 had a disability. At the county levels, rates of disabilities vary. Elizabeth (07201) had the highest percentage of residents under 18 years of age with a disability (7.8%) and the highest percentage of adults aged 18-64 with a disability (11.6%). Carteret (43.2%), Elizabeth (41.6%), and Rahway (38.8%) had the highest percentage of adults aged 65 and older with disabilities.

Figure 46. 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. As mentioned in the 2019 CHNAs for TRMC and RWJUH Rahway, Behavioral Health was, and continues to be, a pressing need in the community.

Mental Health

The topic of mental health was prevalent in nearly all focus groups and interviews conducted for this CHNA. Participants identified depression, anxiety, grief, anger, and stress as mental health challenges for residents and noted that they felt these challenges have increased since the onset of the pandemic. Job loss and financial insecurity, virtual schooling, social isolation, loss of friends and family members, fear, and the general uncertainty associated with the pandemic were all cited as contributors to increased stress, depression, anxiety, and sense of crisis among residents. As one interviewee explained, "*People who were on the edge managing their lives, with COVID that ended, they couldn't throw in another thing. We're seeing a lot more people needing counseling [for] depression, stress*."

> *"There is still a stigma around mental health, definitely within the African American community. It's starting to be embraced more, there's more awareness and destigmatizing it, and more people speaking out. The awareness campaigns are helping, but not enough people are being diagnosed or treated. We rely on law enforcement to be first responders, and that escalates problems."*
> - Key informant interviewee

Mental health among seniors was frequently mentioned in focus groups and interviews, with participants commenting that this population has been facing isolation, Alzheimer's disease, and dementia. One interviewee shared, "*With the aging population, I'm seeing a lot of dementia. That has a lot of challenges, especially because you have to go with the right doctor to get diagnosed."* Participants also noted that older populations may be more likely to have limited transportation, limited incomes, and less access to technology, all of which can decrease or impede access to healthcare and services.

Youth are another population that was frequently mentioned by participants when discussing mental health needs. When thinking about younger children, participants noted that the pandemic may have had consequences, such as learning difficulties, lack of focus, and children having a difficult time detaching from their parents to attend school or daycare. Additionally, some youth may be facing difficult situations, such as having a parent that is incarcerated, and need additional supports. Participants also commented that, when services are needed, they may not be readily accessible. As one interviewee shared, "*Youth mental health services are thin, and it's difficult to get the services you need. This is a national issue, and we need to step up the mental health opportunities especially for people turning 18. The system drops them like a hot potato. The need is much greater than what is available*."

Law Enforcement and Mental Health

Several participants commented on the role of law enforcement in mental health, particularly when it comes to responding to mental health needs and crises in the community. Participants shared concerns for the involvement of law enforcement, noting that some situations can be triggering for the individual with mental health needs, or that situations can escalate and require the use of force. As one participant shared, "*I don't recommend getting the police involved with mental health because they may have to use force, so it's very complicated. Before you could take a person to a mental hospital, but that changed because people were admitted who didn't have issues, it's a balance but there needs to be a way to*

determine when a person can't take care of themselves, other than the criminal system, for them to get the care they need." Another participant further elaborated on this concern, "*Mental health is at the top of my list. Being able to assess that this is someone who is in need of a specialist, [and needs someone] who can defuse the situation rather than escalate it. Individuals are being viewed as a criminal, and really, it's some mental issues that someone needs to detect before it gets to an escalated situation*."

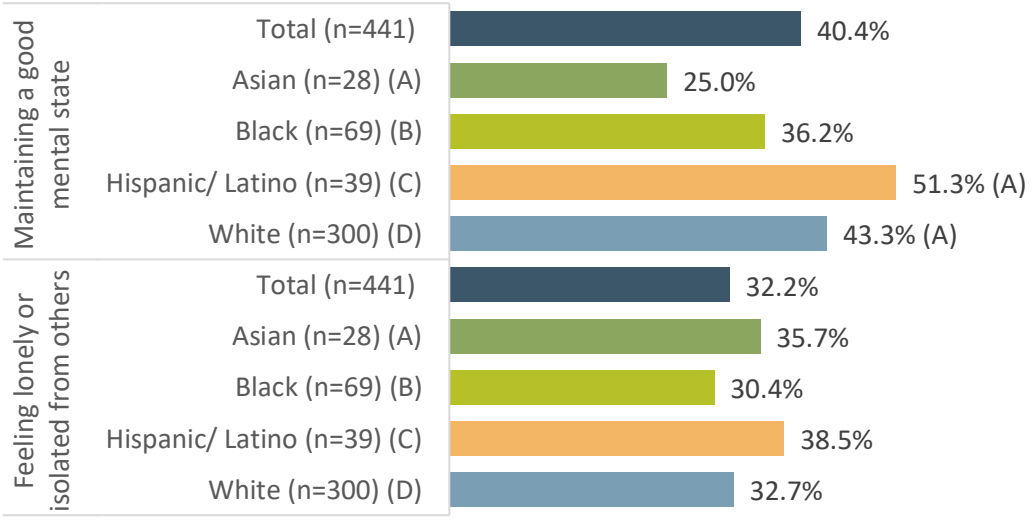
Mental Health Stigma

Further complicating mental health needs and access to care in the community is the role of stigma. Despite the perceived increases in needs noted by the participants, stigma continues to discourage individuals from seeking care. As one interviewee explained, "*We're real good at putting the mask on. People can't put the mask on because the reality is there. We need to normalize it [mental health]. People are scared of a diagnosis*." Participants also commented that, beyond the fear of a diagnosis or label, residents also avoid services referred to as mental health, even if they would otherwise participate in the program or activity. However, despite the challenges, organizations in the community continue to plan ways to engage and break through the stigma, as one participant shared, "*Mental health issues seem to be taboo, we don't like to talk about it in the church, families, on the job. We're going to have mental health experts out there at the resource fair, to try to break the stigma, inviting people to talk with confidentiality. We can help you move through these stressful times. I can see it all over members of our congregation, people don't look the same. People are walking around unhappy, so how do we dig into that, how do we have some transform and have a happy life?*"

Mental Health and the COVID-19 Pandemic

Reiterating the impact of the pandemic on mental health, 40.4% of survey respondents reported that they or someone in their family has personally experienced difficulty with maintaining a good mental state, while 32.2% reported feeling lonely or isolated from others since COVID-19 began (Figure 47).

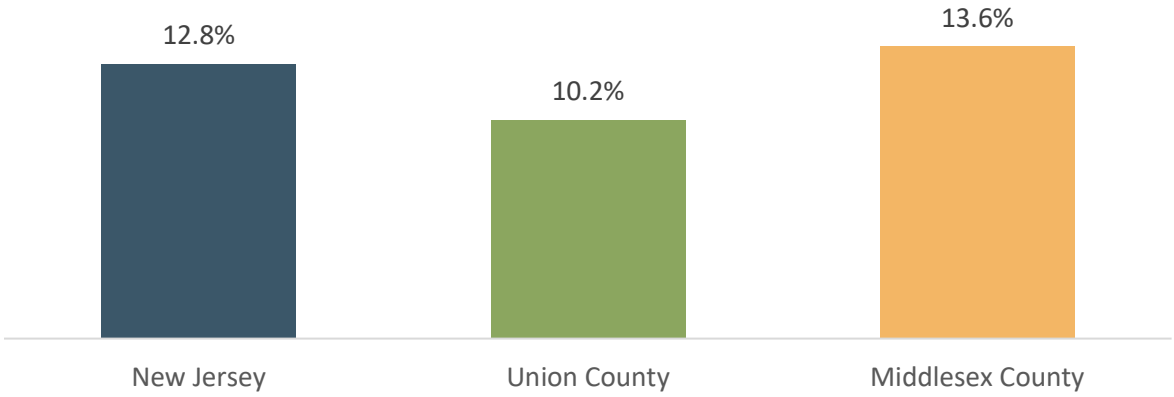
Figure 47. Percent of Community Survey Respondents Reporting that They or Someone in Their Immediate Family Has Personally Experienced Difficulty with Mental Health Issues since COVID-19 Started (n=441), 2021



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.

When examining surveillance data on mental health from prior to the COVID-19 pandemic, one in ten adults in Union County reported 14 or more days of poor mental health in the past month (10.0%). This rate is lower than for New Jersey overall (12.8%) and in Middlesex County (13.6%) (Figure 48).

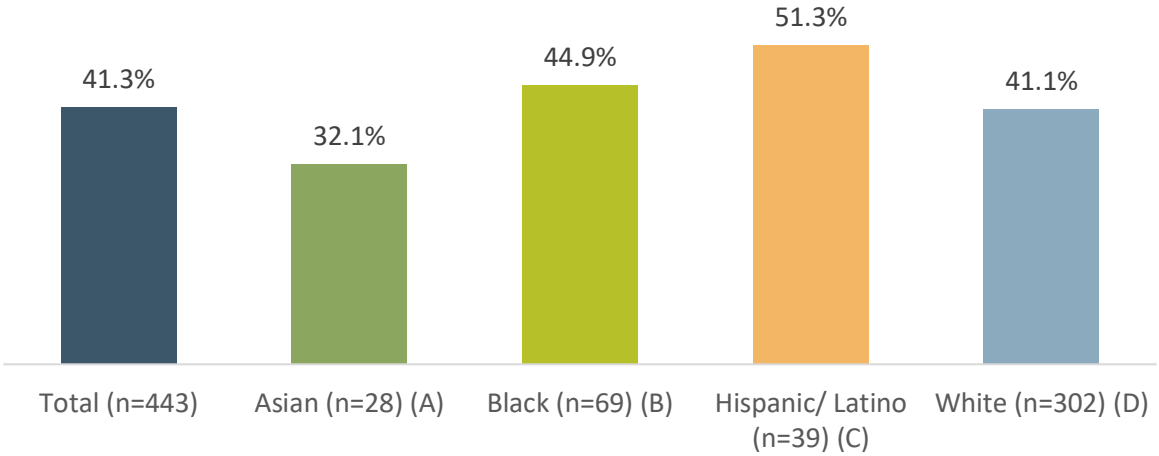
Figure 48. Percent Adults Reported 14 or More Days of Poor Mental Health in Past Month, by State and County, 2020



DATA SOURCE: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020

In the community survey fielded in spring/summer 2021, 41.3% of community survey respondents in Union County indicated that they or a family member has ever been told by a health professional that they had depression or anxiety (Figure 49). This percentage was highest in Hispanic/Latino respondents (51.3%), followed by Black respondents (44.9%), White respondents (41.1%), and Asian respondents (32.1%). However, caution is recommended when interpreting these results due to the small sample sizes for the respondents identifying as Asian, Black, and Hispanic/Latino.

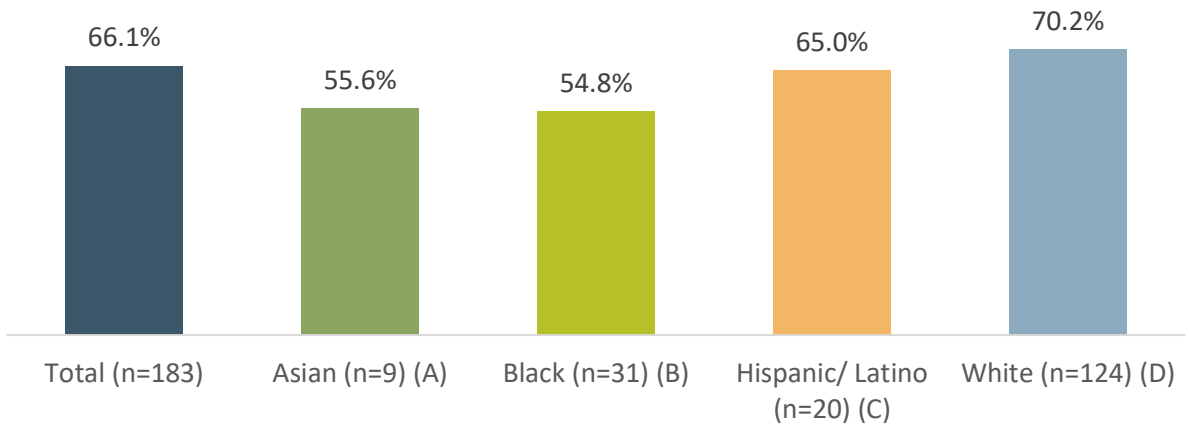
Figure 49. Percent of Community Survey Respondents Reporting that They or a Family Member Has Ever Been Told by a Health Professional They Had Depression or Anxiety (n=443), 2021



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

Of those respondents who reported that they or a family member has ever been told by a health professional that they had depression or anxiety, 66.1% of Union County community survey respondents reported that they or their family member are currently under treatment for depression or anxiety. (Figure 50). Across racial and ethnic groups, more than half of survey respondents who indicated that they or a family member had a diagnosis of depression or anxiety have received treatment in the past two years.

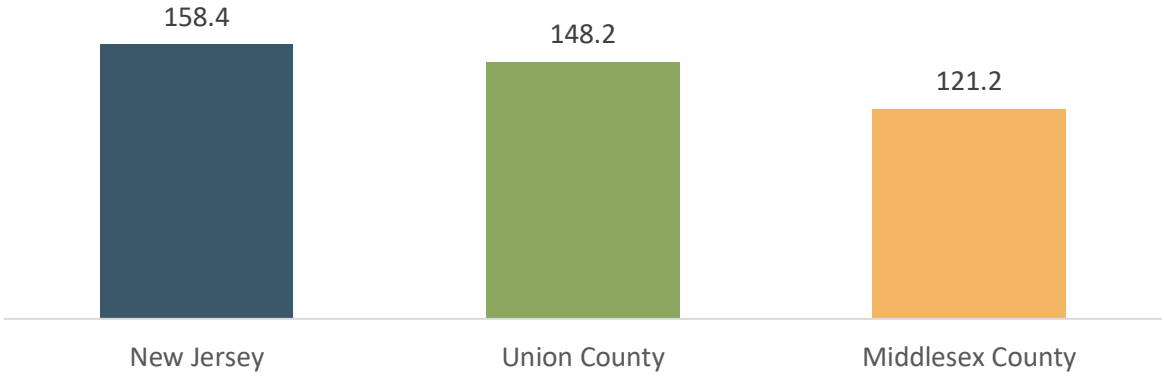
Figure 50. Of Those Told by a Doctor They or Their Family Member Had Depression or Anxiety, Percent of Community Survey Respondents Reporting that They or a Family Member is Currently Under Treatment for Depression or Anxiety (n=183), 2021



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

Mental health surveillance data from New Jersey Department of Health can be found in this section and in Appendix E- Additional Data Tables. The 2020 data indicate that Union County had a rate of 148.2 emergency department (ED) visits due to mental health per 100,000 population, which was slightly lower than the rate statewide (158.4) and higher than the rate in Middlesex County (121.2) (Figure 51). When interpreting the data in Figure 51 it should also be noted that ED visits by county reflect the geographic area the patient resides in, not the location of the facility where the ED visit took place.

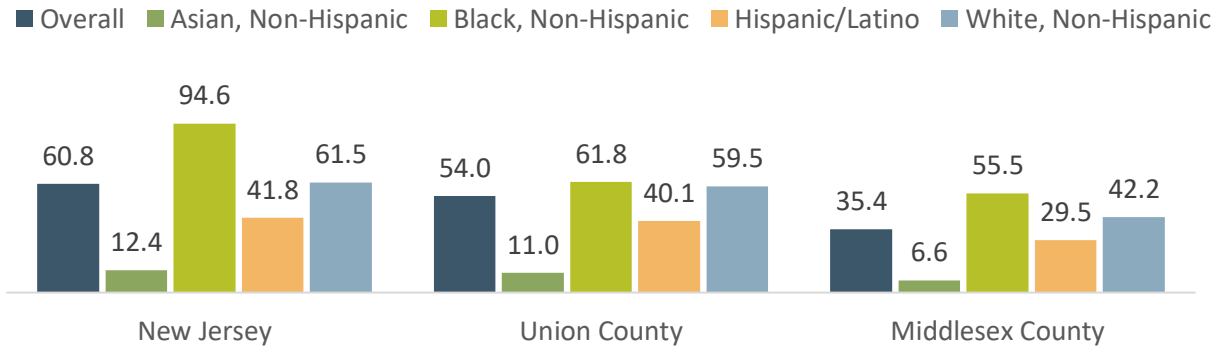
Figure 51. ED Visits due to Mental Health per 100,000, by State and County, 2020



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 are presented on the rate of hospitalizations due to mental health per 100,000 population by race/ethnicity in 2020. The state rate was highest among Black, non-Hispanics (94.6 per 100,000), followed by White, non-Hispanics (61.5 per 100,000), Hispanic/Latino (41.8 per 100,000), and Asian, non-Hispanics (12.4 per 100,000) (Figure 52). At the county level, the Union County rate was highest among Black, non-Hispanics (61.8 per 100,000), followed by White, non-Hispanics (59.5 per 100,000), Hispanic/Latino (40.1 per 100,000), and Asian, non-Hispanics (11.0 per 100,000). Similarly, the Middlesex County rate was highest among Black, non-Hispanics (55.5 per 100,000), followed by White, non-Hispanics (42.2 per 100,000), Hispanic/Latino (29.5 per 100,000), and Asian, non-Hispanics (6.6 per 100,000).

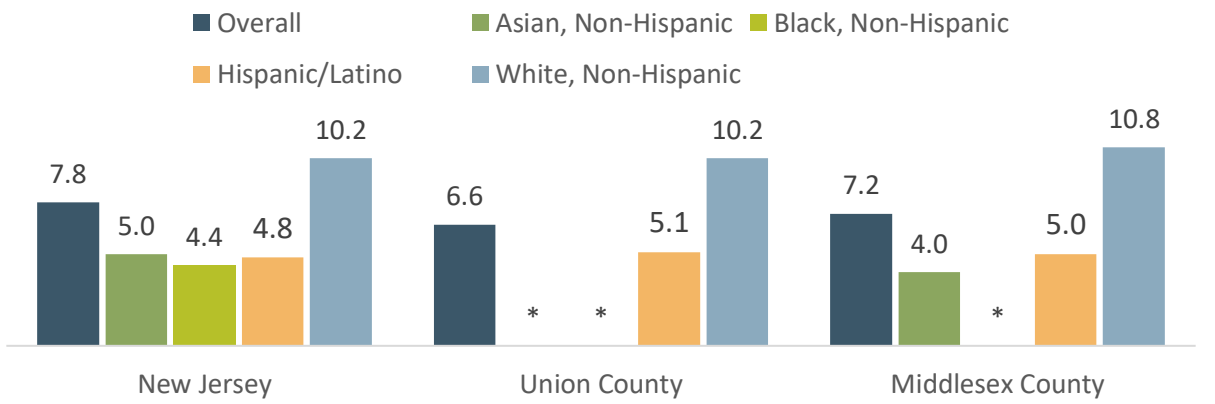
Figure 52. Hospitalizations due to Mental Health per 100,000, by Race/Ethnicity, State, and County, 2020



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 Union County's suicide rate was 6.6 per 100,000 population. This overall rate was slightly lower than that seen in Middlesex County (7.2) and New Jersey overall (7.8) (Figure 53). Data by race/ethnicity was unavailable for many populations at the county level.

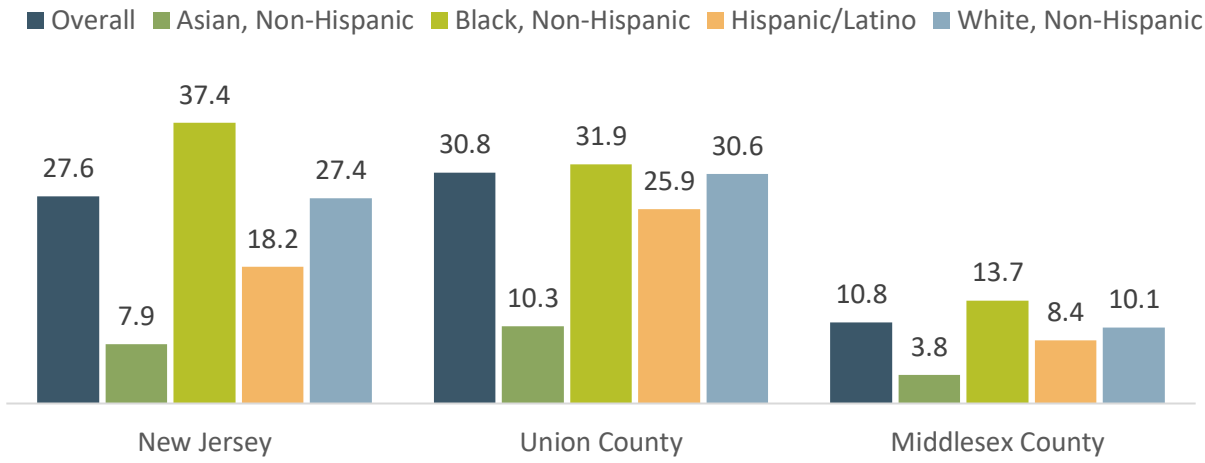
Figure 53. Suicide Rate per 100,000 Population (Age-Adjusted), by State and County, 2016-2020



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
NOTE: * indicates data not available

Figure 54 presents 2020 data on the rate of pediatric hospitalizations for youth 19 and under due to mental health per 100,000 population by race/ethnicity. The Union County rate was highest among Black, non-Hispanics (31.9 per 100,000), followed by White, non-Hispanics (30.6 per 100,000), and Hispanic/Latino (25.9 per 100,000). Rates in Middlesex County reflected the same pattern as Union County and New Jersey overall, though rates in Middlesex County were lower than Union County and New Jersey.

Figure 54. Pediatric Hospitalizations (Ages 19 and under) due to Mental Health per 10,000, by Race/Ethnicity, State, and County, 2020



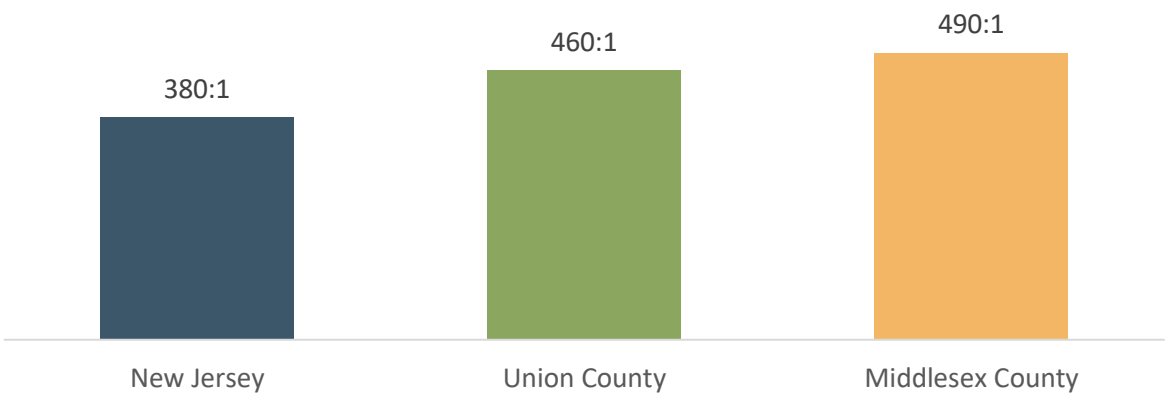
DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020

Treatment and Supports

Though the mental health services provided by the hospitals were frequently mentioned during focus groups and interviews, participants shared that they still felt there were difficulties accessing treatment and services for some members of the community. One interviewee stated, "*If you don't have health insurance, it takes 2-3 months to get counseling unless it's an emergency."* Access to information before and after treatment, particularly for caregivers, was also noted as a challenge illuminated by one participant, "*A diagnosis of mental illness is always a sucker punch. When they get hospitalized, they are confined for a few weeks and the patient gets a medical plan for what to do when they come out of hospital, but the person who is their caregiver gets zero. They don't know about the different organizations that can support them and get information into the hands of the loved ones. They don't know about us, about this free course*." Participants also commented on the integrated nature of mental health with other conditions, such as substance use, and how those conditions can create challenges meeting everyday needs. As one participant explained, "*If we had a better mental health and addiction therapy system, some people who are homeless have mental problems and we can work that in a different way and help them better."*

Data are presented on the ratio of population to mental health providers in 2021. At the state level, there were 380 people for every mental health provider (Figure 55). In Union County, the ratio was 460 people for every mental health provider, and in Middlesex County the rate was 490 people for every mental health provider.

Figure 55. Ratios of Population to Mental Health Providers, by State and County, 2021



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, 2021

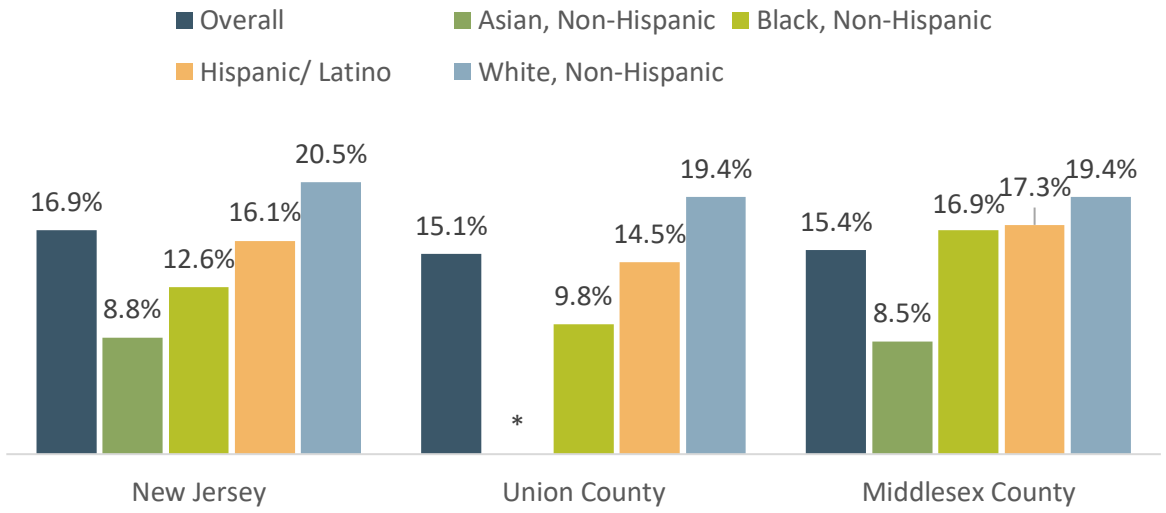
Substance Use

Substance misuse was mentioned as a concern by several focus group and interview participants. Participants noted that they felt the pandemic was exacerbating addictive behaviors and substance use, with some participants noting that they observed drug use in the streets and in schools. One interviewee explained, "*Some have died from the alcoholism and being out there [on the streets]. Maybe 6-7 [people] have passed during the pandemic*." Another focus group member described that substance use prevalence in the community depends on location, stating, "*In respect to drugs, I think it depends on the area you live in in Elizabeth. There are some areas that are better than others. They're just "pockets" of the city, I don't think it affects everyone. But there are people that talk badly about Elizabeth because of it*."

> *"Mental health and substance use, some patients will even do illegal drugs. We try to reach them, and they don't pick up... [I'm] not sure if the community knows to call crisis prevention. [There is a] need for counseling, education for what to do, if you have this problem call this number. Same with substance use, big thing in the community ... People come in for treatment and leave before discharge."*
> - Key informant interviewee

Data from 2017-2020 show binge drinking behaviors 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, non-Hispanics (20.5%), followed by Hispanics/Latinos (16.1%), Black, non-Hispanics (12.6%), and Asian, non-Hispanics (8.8%) (see figure on following page). At the county level, 15.1% of adults in Union County reported binge drinking, with the highest percentage among White, non-Hispanics (19.4%) and followed by Hispanics (14.5%) and Black, non-Hispanics (9.8%). Middlesex County reported similar rates to Union County and the state, with the exception that rates among Black, non-Hispanic residents were higher in Middlesex County (16.9%).

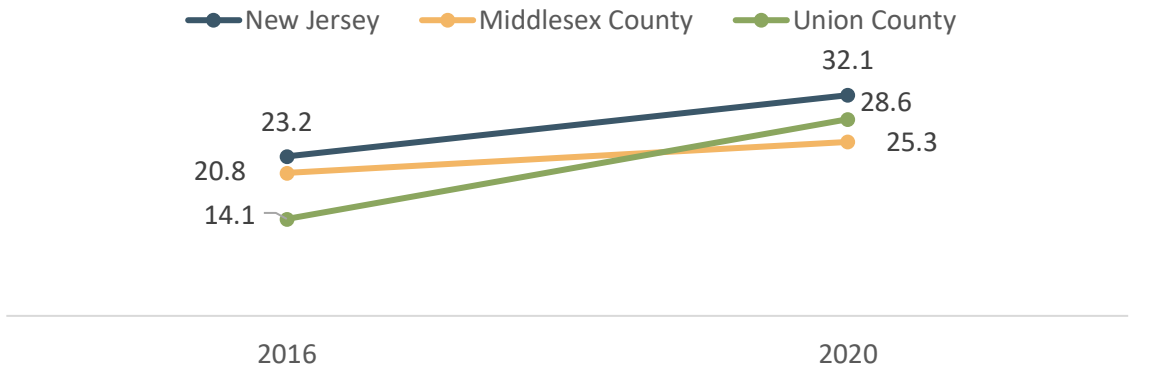
Figure 56. Percent Adults Reported Binge Drinking, by State and County, 2017-2020



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

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 57). Union County rates were lower than the state, with mortality rates per 100,000 at 14.1 in 2016 and 28.6 in 2020. Middlesex County rates per 100,000 were 20.8 in 2016 and 25.3 in 2020.

Figure 57. Age-Adjusted Drug Poisoning Mortality Rate per 100,000 Population, by State and County, 2016 and 2020

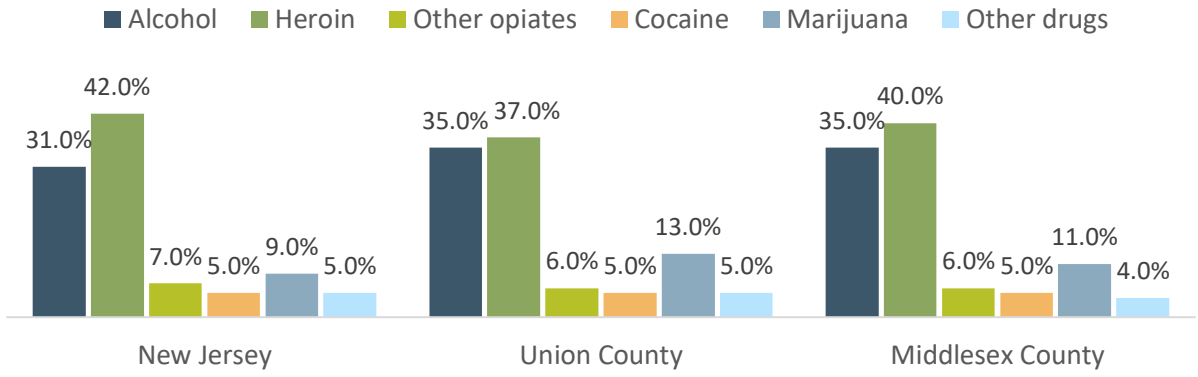


DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020
NOTE: Includes ICD-10 codes X40-X44, X60-X64, X85, and Y10-Y14

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, 9.0% for marijuana, and under 7% each for cocaine, other opiates, and other drugs (Figure 58). In Union County treatment sites, 37.0% of admissions were for heroin, 35.0% for alcohol, 13.0% for marijuana, and under 6% each for other opiates, cocaine, and other drugs. Middlesex County data reflected a similar pattern to Union

County and the state, where 40.0% of admissions were for heroin, 35.0% for alcohol, 11.0% for marijuana, and under 6% each for other opiates, cocaine, and other drugs.

Figure 58. 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

Environmental Health

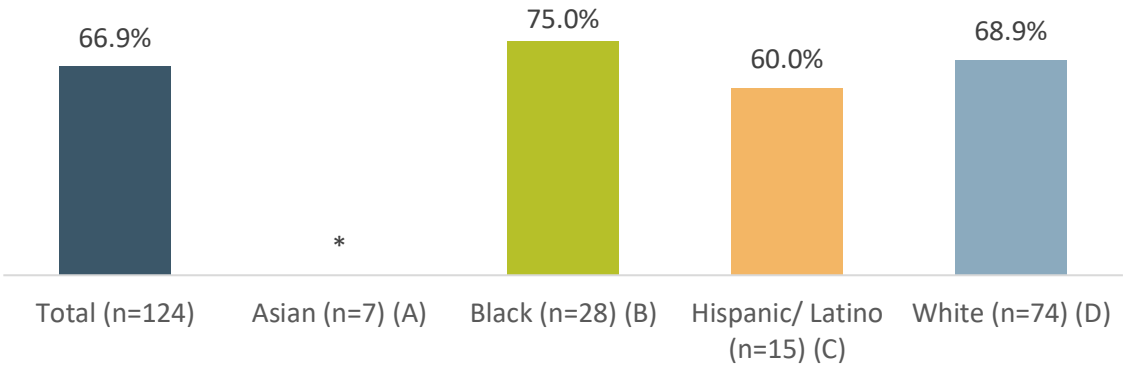
A healthy environment is associated with a high quality of life and good health. Environmental factors are various and far reaching and include exposure for hazardous substances in the air, water, soil, or food; natural disasters and climate change; and the built environment. This section describes both environmental health factors across the RWJUH Rahway-TRMC service area and the prevalence of conditions these factors can trigger.

Though environmental factors were not frequently discussed during focus groups and interviews, a few participants shared concerns about access to clean water, lead exposure, and impacts of natural disasters. One natural disaster mentioned by the community was Hurricane Ida, which caused flooding, home loss, and displacement of residents.

Asthma

Asthma and respiratory ailments were not a prevalent theme in the focus groups and interviews. In the community survey conducted in 2021, respondents were asked to indicate whether they or a household family member were ever told by a doctor or health professional that they had asthma. Among those responding they or a family member had been told they had asthma, respondents were then asked if they were currently under care for asthma. Nearly two thirds (66.9%) of survey respondents who had indicated that they or a family member had been told by a doctor they had asthma reported that they or their family member were currently under care for asthma (Figure 59). Black (75.0%) and White (68.9%) respondents reported this more frequently than Hispanic/Latino (60.0%) respondents.

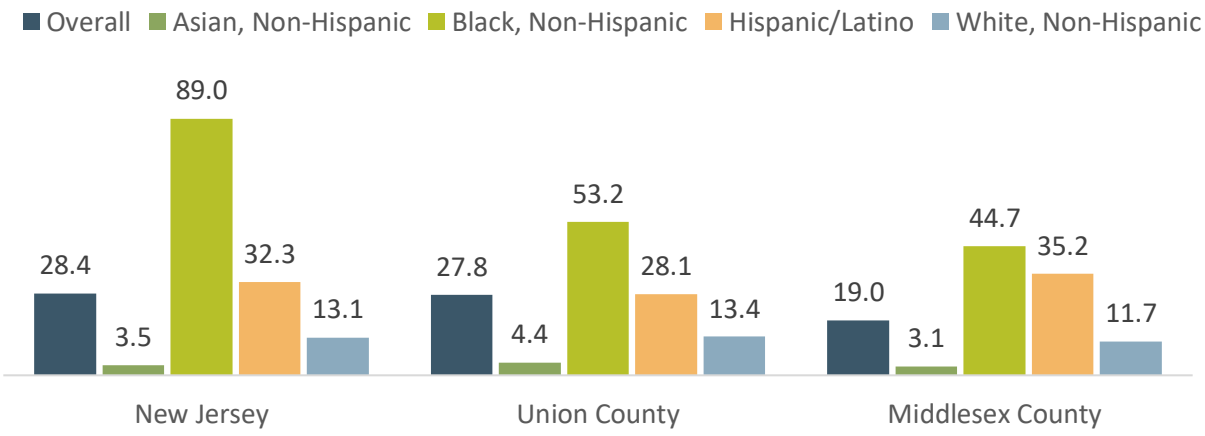
Figure 59. Of Those Told by a Doctor They or Their Family Member Had Asthma, Percent of Community Survey Respondents Reporting that They or a Family Member Are Currently Under Care for Asthma (n=124), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
NOTE: * indicates n<5 that reported that they or a family member are currently under care for asthma.

Data is also presented for age-adjusted asthma ED visits per 10,000 in 2020, by race/ethnicity. At the state level, 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) (Figure 60). Rates in Union County were similar to those at the state level for all race/ethnicities, with the exception of Black, non-Hispanic residents who continued to have the highest rates overall but at a lower rate than the state level. The rates in Middlesex County were also similar to the state, albeit lower overall, with the exception of Hispanic/Latino asthma emergency department visit rates, which was 35.2 per 10,000 population.

Figure 60. Age-Adjusted Asthma Emergency Department Visit Rate per 10,000 Population by Race/Ethnicity, by State and County, 2020

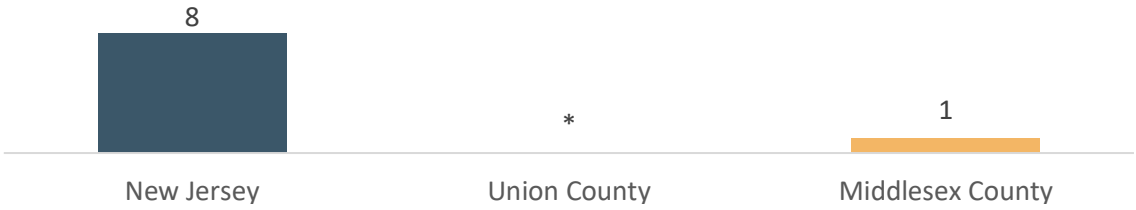


DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018
NOTE: Data includes ED visits where asthma was primary diagnosis

Air Quality

In 2020, there were 8 days statewide where ozone in outdoor air exceeded the federal health-based standard for ozone (8-hr period above 0.070 ppm) (Figure 61). In Union County a reliable rate could not be calculated, and in Middlesex County there was one day where the air exceeded the federal health-based standard for ozone. It is a possibility that COVID-19 impacted these rates as more people spent time indoors and less time traveling.

Figure 61. Ozone in Outdoor Air, Number of Days Ozone Exceeded the National Ambient Air Quality Standards for Ozone (8-hour above 0.070 ppm), 2020

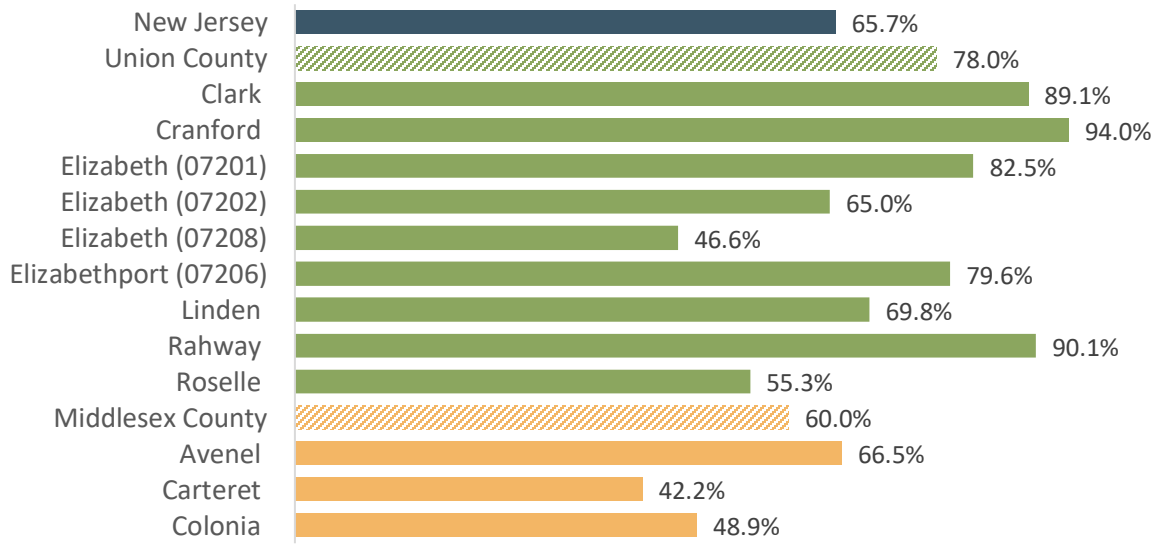


DATA SOURCE: Bureau of Air Monitoring, New Jersey Department of Environmental Protection, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Lead and Water Quality

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. The following figure shows the proportion of housing built prior to 1980. As shown in Figure 62, 65.7% of housing was built prior to 1980 at the state level; however, there are notable differences by town. Among towns in Union and Middlesex Counties, Cranford had the highest percentage of housing built before 1980 (94.0%), followed by Rahway (90.1%) and Clark (89.1%). Towns in Union County, on average, had a higher percentage of housing units built pre-1980 compared to towns in Middlesex County.

Figure 62. Housing Built Pre-1980, by State, County, and Town, 2016-2020

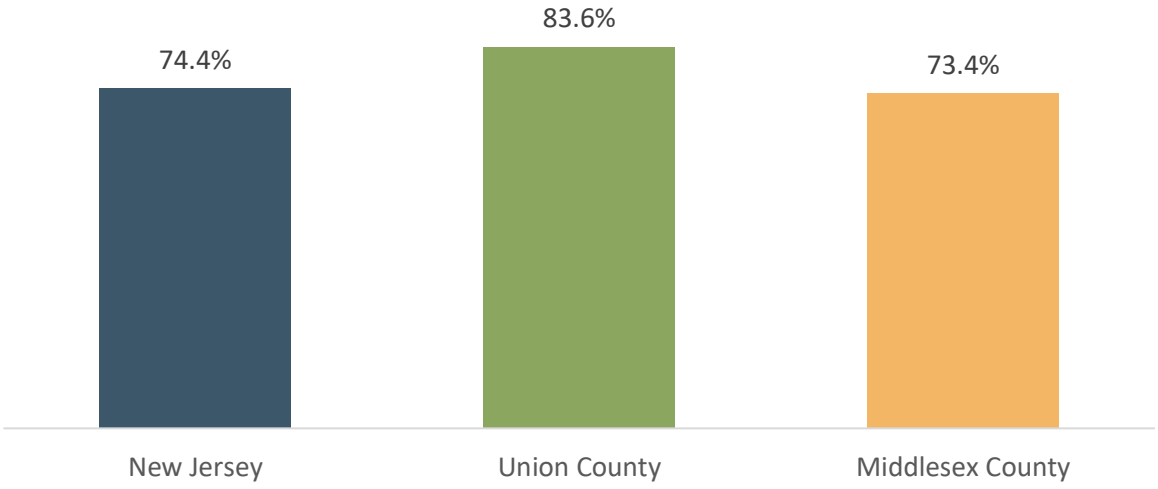


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Access to clean water and lead exposure due to water pipes was a pressing concern for some participants and was a key item of discussion during a focus group with residents identifying as Black or African American. Participants commented that interrupted water access was a common occurrence, and that when water was working it often had a bad taste, smell, or appearance. Water access challenges are also occurring in schools, as one focus group participant explained, "*In the schools they turn off the water fountains. Some schools use a water filter type thing, according to the mayor it was addressed by changing the pipes, I've seen them doing the work, but I don't know how far they are."* Residents also reported that they frequently have water shut off without receiving prior notice, and that is it common to receive notice that the water contains contaminants. The lack of access to water results in residents purchasing bottled water for daily needs, but concerns persist about coming into contact with the water for hand washing, showering, and other daily needs. As one participant shared, "*Sometimes we are notified of the water shut offs, sometimes we aren't. Washing your hands and showering, even if we aren't ingesting it there are other ways to absorb it [contaminants from the water]."* The topic of lead exposure from the water supply, particularly among children, was of particular concern among participants. Regular testing of lead levels in children and at-home kits for testing lead were strongly recommended and cited as needs for the community.

Data from the New Jersey Child Health Program reinforces the concerns shared by the community. This data shows the percent of children testing for lead exposure before their third birthday in 2014. Across the state of New Jersey, nearly 3 in 4 children were tested for lead exposure (Figure 63). In Union County, 83.6% of children were tested for lead exposure. From 2012 to 2015, 0.4% of children in New Jersey ages 1 to 5 have ever had blood lead levels meeting or exceeding 10mcg/dL.

Figure 63. Percent Children Tested for Lead Exposure Before 36 Months of Age Among Children Born in 2014, by State and County, 2014



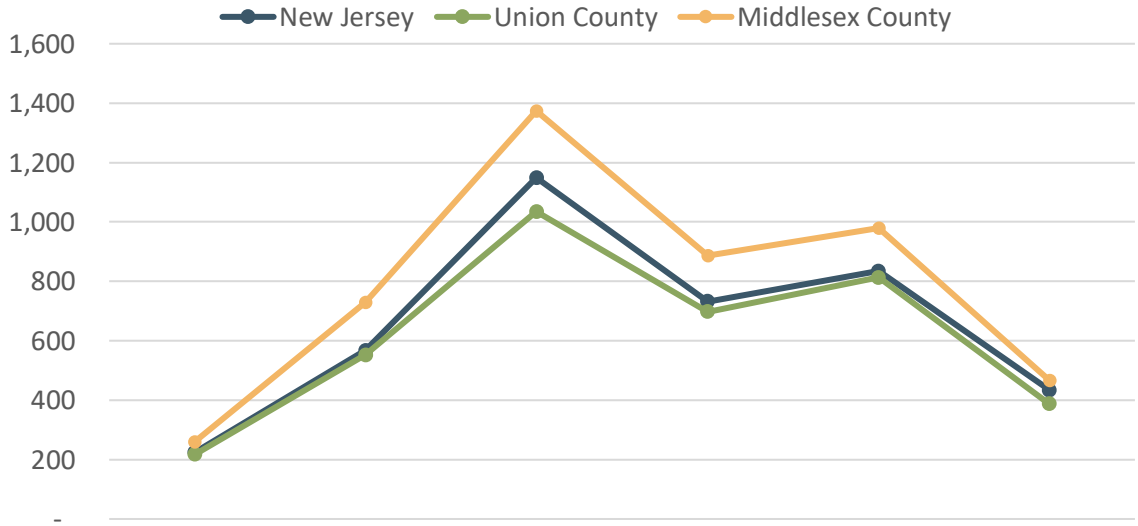
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry; Child Health Program, Family Health Services, as reported by, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2014

Infectious and Communicable Disease
This section discusses COVID-19 and sexually transmitted infections.

COVID-19
COVID-19 was a dominant topic in focus group conversations and interviews. The COVID-19 pandemic has affected all sectors of life and created substantial challenges for many. Participants shared the impacts of the pandemic on financial and mental well-being, many of which have persisted or worsened in the years since the onset of the pandemic. Those with children discussed challenges with schooling, social skills development, and education lost. The shutdowns and social distancing mandated through the pandemic and workforce shortages continuing today have also affected healthcare access as well. Focus group participants and interviewees explained that masking is less common in 2022, often relying on the individual to make assessments on masking and safety in each situation, and that vaccine use continues to be a point of fear or mistrust. Furthermore, healthcare institutions are viewed negatively in some communities due to their association with COVID outcomes, and other community members refuse to be tested after potential exposures. Local faith leaders and social service organizations continue to provide COVID guidance and serve as testing and vaccination sites, but community concerns persist.

There were 2,340,061 confirmed cases of COVID-19 in New Jersey and 151,557 cases in Union County as of October 11, 2022. Cases have fluctuated throughout the spring and summer of 2022 in New Jersey; notable peaks in cases per month include May (1,149 new cases per 100,000 population) and July (834 new cases per 100,000 population).

Figure 64. New COVID-19 Cases per 100,000 population, by State and County, 2022

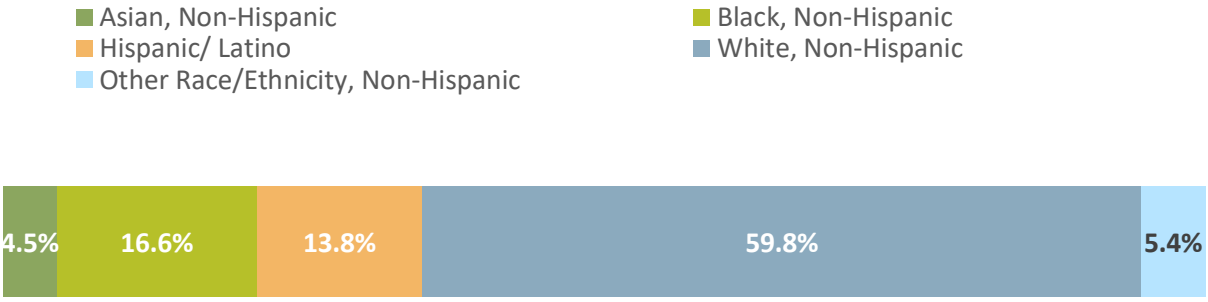


	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
New Jersey	224	567	1,149	732	834	434
Union County	217	552	1,035	698	813	387
Middlesex County	260	729	1,374	886	980	467

DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022
NOTE: August data is as of 8/23/2022.

There are racial/ethnic disparities among COVID-19 deaths in New Jersey. While Black residents only make up 12.4% of the New Jersey population, they accounted for 16.6% of COVID-19 deaths across the state (Figure 65).

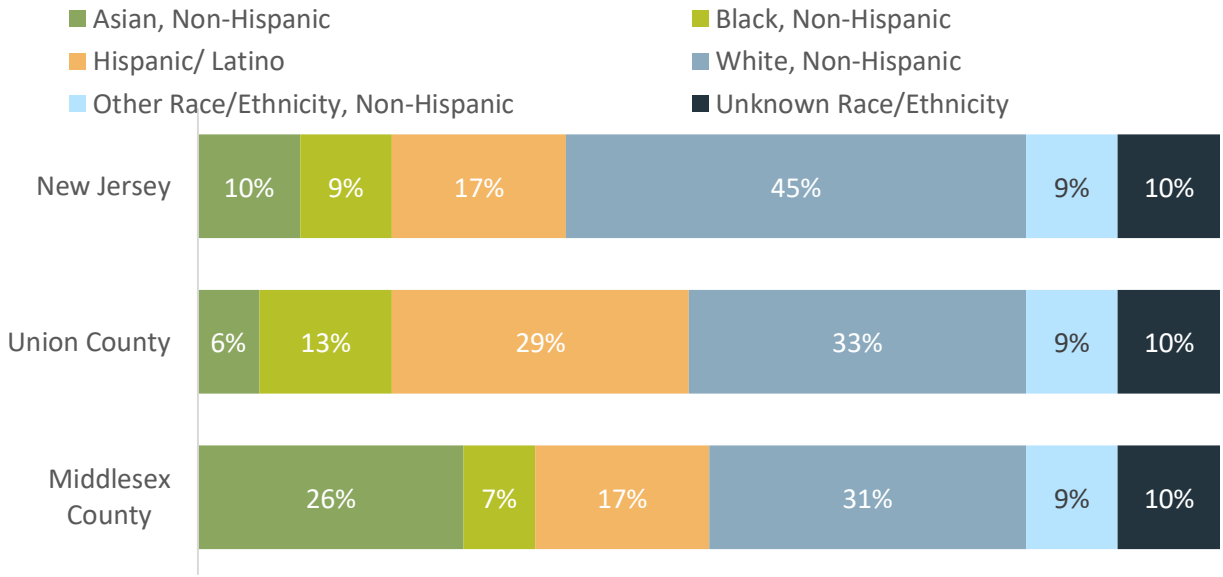
Figure 65. COVID-19 Confirmed Deaths, by Race/Ethnicity, by State, 2022



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

As of September 28, 2022, 7,084,779 individuals in New Jersey have been fully vaccinated, representing around 80% of the population (using 2020 census population estimates to calculate the percentage); Union County has reported a total of 431,838 individuals that are fully vaccinated, which is about 78% of the county's 2020 census population. The figure below shows the proportion of fully vaccinated individuals by race/ethnicity across the state and by county (Figure 66).

Figure 66. Percent of Eligible Residents Fully Vaccinated for COVID-19, by Race/Ethnicity, State, and County, 2022



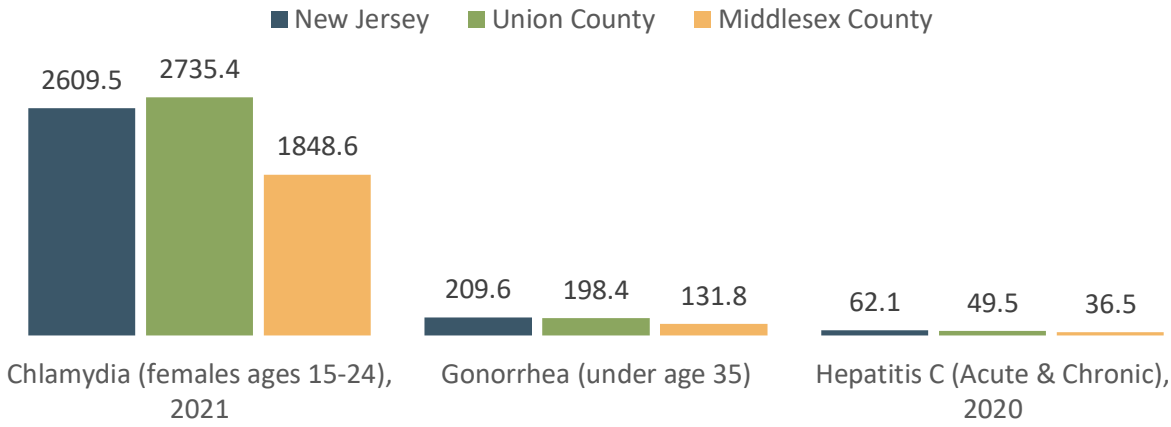
DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022
NOTE: Racial/ethnicity data does not include those vaccinated out of state and by federal programs. Fully vaccinated refers to individuals who have received a single dose from a one-dose vaccine course, e.g., the J&J vaccine, or their second dose from a two-dose course.

Sexual Health and Sexually Transmitted Diseases

Sexual health and sexually transmitted diseases were not frequently brought up during focus groups and interviews. Some participants shared that there is a need for honest and informative sexual education for youth and adults, that increased access to contraceptives is needed for health, and that there is a need for more vaccine and testing clinics in the community.

In 2021, there were 2,609.5 cases of chlamydia per 100,000 population in New Jersey among females aged 15-24, and the case rate was slightly higher for Union County (2,735.4 per 100,000) (Figure 67). Union County reported lower levels of gonorrhea, of people under age 35 (198.4 per 100,000) and Hepatitis C (49.5 per 1000,000) compared to New Jersey overall (209.6 and 62.1 persons per 100,000 persons respectively). Middlesex County reported lower rates of chlamydia (1848.6 per 100,000), gonorrhea (131.8 per 100,000), and Hepatitis C (36.5 per 100,000) compared to New Jersey and Union County.

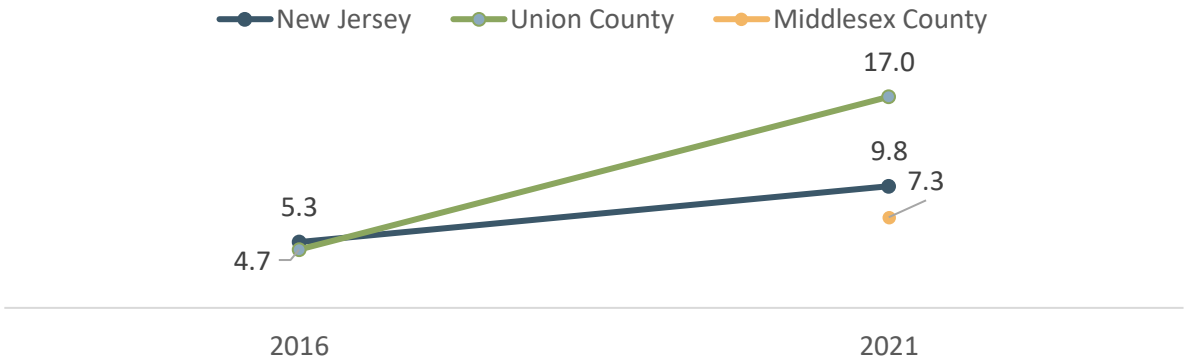
Figure 67. Chlamydia, Gonorrhea, and Hepatitis C per 100,000 Population, by State and County, 2020 & 2021



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

Data from 2016 and 2021 shows that syphilis incidence increased in New Jersey from 5.3 cases per 100,000 residents in 2016 to 9.8 cases per 100,000 residents in 2021 (Figure 68). While Union County had a slightly lower incidence rate than the state in 2016, the Syphilis incidence increased by more than threefold in 2021, up to 17.0 cases per 100,000. In 2021, Middlesex County had the lowest syphilis incidence rate, at 7.3 per 100,000.

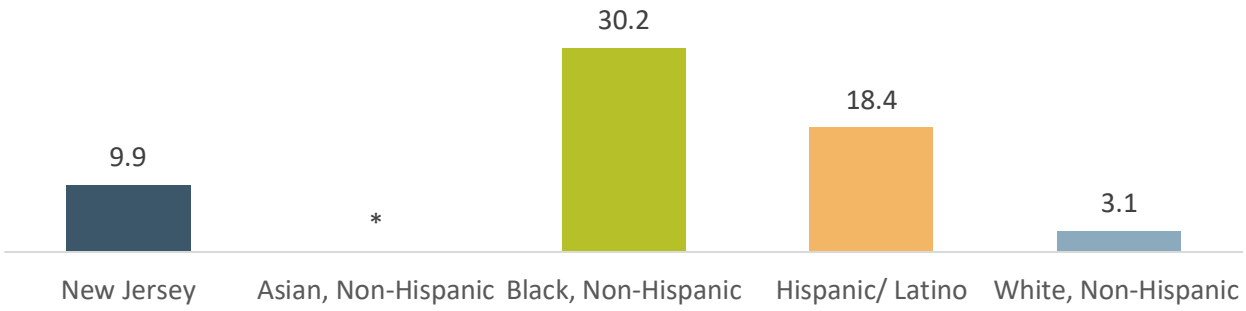
Figure 68. Syphilis Incidence Rate per 100,000 Population, by State and County, 2016 and 2021



DATA SOURCE: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, Division of HIV, STD, and TB Services, 2016 and 2021
NOTE: Includes primary and secondary syphilis. Crude rate. 2016 data for Middlesex County is insufficient to calculate reliable rate.

HIV transmission data was not available for the county. Instead, data is presented for the state overall. The rate of HIV transmission for Black residents in New Jersey was 30.2 per 100,000 persons, which was over nine 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 69). Hispanic/Latino residents had a HIV transmission rate of 18.4 per 100,00 persons, nearly double that of New Jersey residents.

Figure 69. 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), 2019

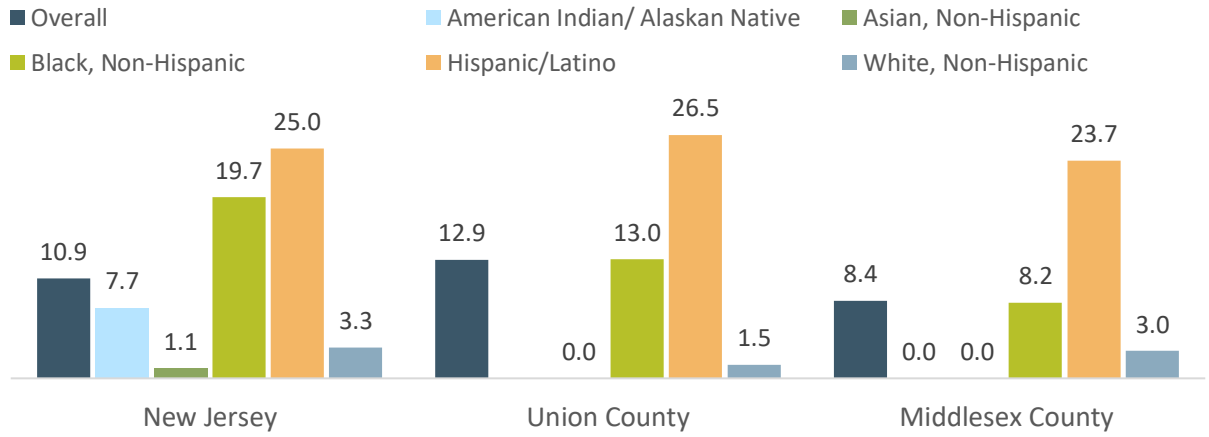
Maternal and Infant Health

The health and well-being of mothers, infants, and children are important indicators of community health. Some participants commented on the need for additional care and support to lower the rates of maternal and infant mortality, particularly among residents who identify as Black or African American. Accessible and sustainable programs, provider training on disparities and caring for women of color, and partnerships with local organizations to distribute information, were emphasized as needs to improve maternal and infant health. As one interviewee shared, "*We have healthcare, we can provide services, the way doctors are trained – particularly when it comes to urban corridors – the treatment is different and being able to provide services to the community you are committed to. You can have all of the skills,*

but being able to provide services becomes a huge issue particularly in regard to mothers having babies, our doctors need to be aware of those disparities and how to treat women of color. There is no reason why Black babies are dying and parents are dying. That should never be the case. We have the healthcare."

Data from the New Jersey Birth Certificate Database shows 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 is 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), American Indians/Alaskan Natives (7.7 per 1,000), White, non-Hispanics (3.3 per 1,000), and Asian, non-Hispanics (1.1 per 1,000). In Union County the overall teen birth rate was 12.9 per 1,000 (Figure 70). The highest birth rate in Union County was 26.5 per 1,000 among Hispanics/Latinos, followed by Black, non-Hispanics (13.0 per 1,000), and White, non-Hispanics (1.5 per 1,000). The overall teen birthrate was lower in Middlesex County than in New Jersey overall and Union County, with 8.4 births per 1,000 overall. The highest birth rate in Middlesex County was in Hispanic/Latino residents (23.7 per 1,000), followed by Black, non-Hispanic residents (8.2 per 1,000) and White, non-Hispanic residents (3.0 per 1,000).

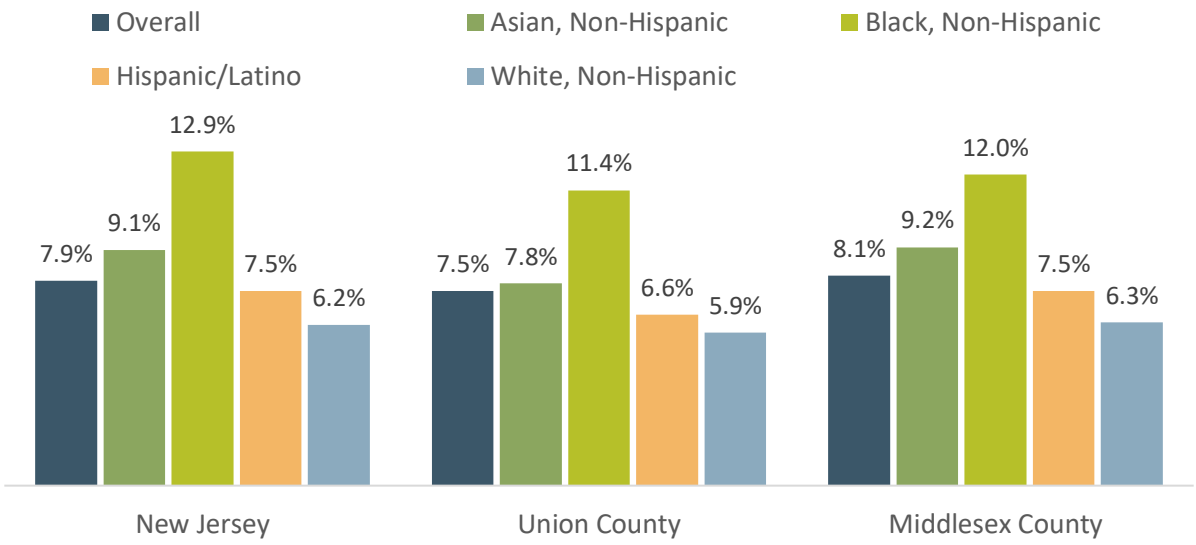
Figure 70. Number of Births per 1,000 Female Population Ages 15 to 19, by Race/Ethnicity, State, and County, 2014-2020



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

The following figure presents the percent of low birthweight births from 2016-2020, by race/ethnicity. Across New Jersey, 7.9% of births are low birthweight (weighing less than 2,500 grams) (Figure 71). In New Jersey, Black, non-Hispanics have the greatest proportion of low weight births (12.9%), followed by Asian, non-Hispanics (9.1%), Hispanics/Latinos (7.5%), and White, non-Hispanics (6.2%). Similarly, 7.5% of births in Union County were low birth weight births with Black, non-Hispanics having the highest proportion of low-birth-weight births (11.4%). Middlesex County reflected slightly higher rates than Union County, with 8.1% of overall births being low-birth-weight births.

Figure 71. Percent Low Birth Weight Births by Race/Ethnicity, by State and County, 2016-2020



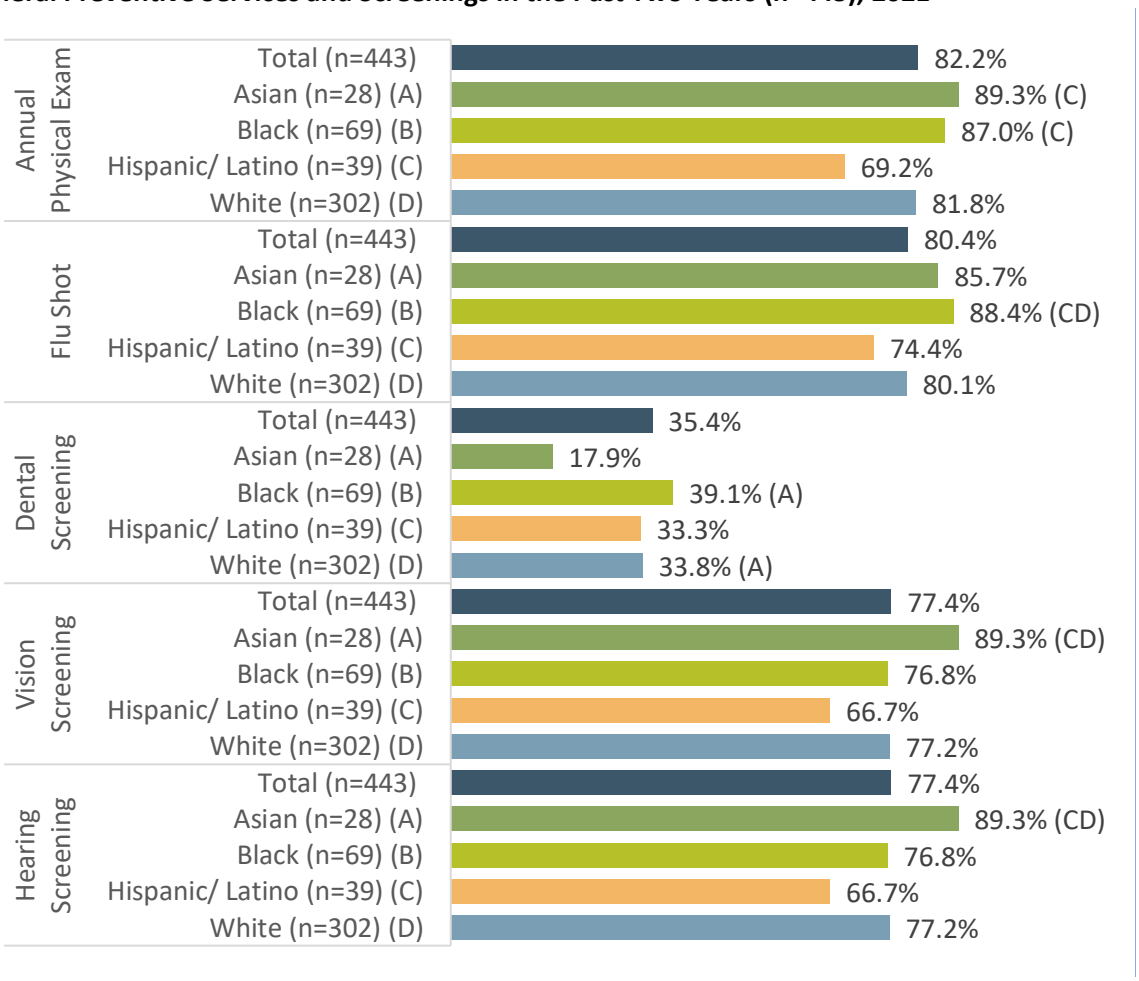
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020
NOTE: Low birth weight as defined as less than 2,500 grams

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.

The community survey fielded in spring/summer 2021 asked respondents about their participation in various healthcare screenings, including preventive services. Approximately 82.2% of survey respondents indicated that they had participated in an annual physical exam in the past two years while 80.4% said they received a flu shot. The same percent of respondents, 77.4%, indicated that they had a vision screening and a hearing screening in the past two years. Dental screenings had the lowest participation rates, with only 35.4% of respondents reporting a dental screening in the past two years. On average, respondents identifying as Hispanic/Latino reported the lower utilization rates for annual physical exams, flu shots, vision screenings, and hearing screenings, while residents identifying as Asian reported the lowest utilization rates for dental screenings. Figure 72 presents these data for survey respondents overall and by race/ethnicity.

Figure 72. Percent of Community Survey Respondents Reporting that They Have Participated in a General Preventive Services and Screenings in the Past Two Years (n=443), 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.

Barriers to Accessing Healthcare Services

While some focus group members and interviewees reported that the strength of Union and Middlesex Counties included accessible and affordable healthcare assets, other residents noted existing disparities in access to healthcare services. Barriers commonly identified through focus groups and interviews included a lack of awareness of resources, high healthcare costs, a lack of childcare, language and cultural barriers, technology challenges related to telehealth, limited health literacy, and unreliable transportation.

> *"Many people don't have health insurance. When they leave the hospital, they can't buy their prescriptions. The rent in Elizabeth is very high… Food is also very expensive. Salaries here don't cover the basic needs of a family. For childcare, either you have to pay someone, or you have to depend on family to help with childcare."*
> - Focus group participant

Barriers to healthcare access were discussed in multiple ways through the survey, focus groups, and interviews, and different challenges emerged through the various methods. Data provided in the 2022 SullivanCotter's Physician Needs Assessment, which focused on the Trinitas Regional Medical Center primary service area (mainly Elizabeth), indicates that there are deficits in the number of providers to meet the demand in the community. These deficits are, on average, greater in primary care including family medicine, internal medicine, and pediatrics. One notable example is the category of primary care family medicine physicians, which has a deficit of 29.04 FTE physicians in 2022, with the need expected to increase to a deficit of 30.92 FTE physicians by 2025. Additional specialties with deficits (where demand outstrips provider supply) include gastroenterology, general surgery, obstetrics and gynecology, orthopedic surgery, radiology, ophthalmology, emergency medicine, and pediatric subspecialties. In each of these areas, the deficit is expected to worsen by 2025 (Table 7).

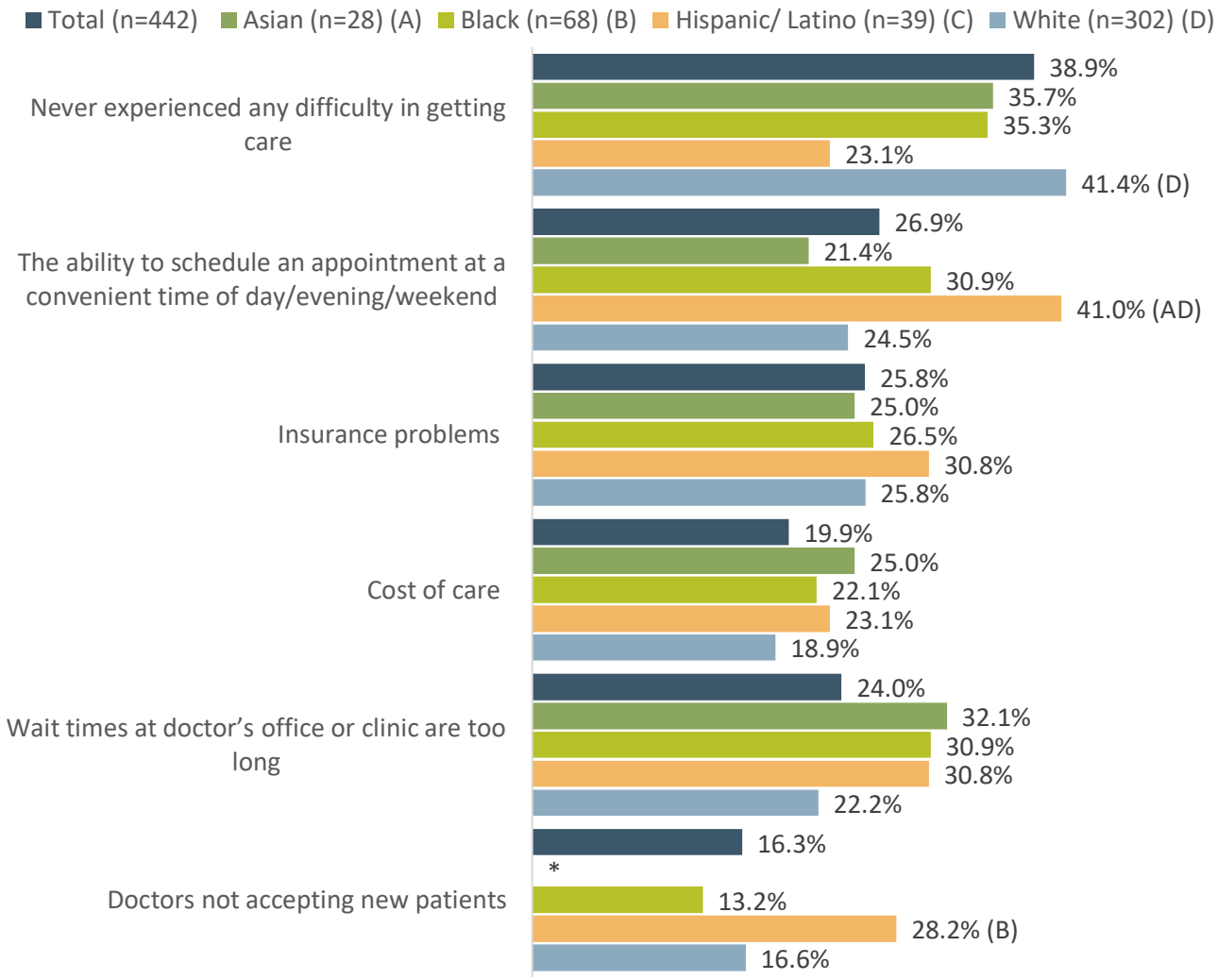
Table 7. Provider Surplus and Deficit Results by Specialty, TRMC Primary Service Area, 2022

		2022			2025		
Specialty Group	**Main Specialty**	**Supply (FTEs)**	**Demand (FTEs)**	**Surplus/ Deficit**	**Supply (FTEs)**	**Demand (FTEs)**	**Surplus/ Deficit**
Primary Care	Family Medicine	7.55	36.59	(29.04)	6.64	37.56	(30.92)
	Internal Medicine	30.33	34.71	(4.38)	27.60	35.85	(8.25)
	Pediatrics	4.47	19.46	(14.99)	4.38	19.71	(15.32)

DATA SOURCE: Physician Needs Assessment, SullivanCotter, 2022

In addition to lack of provider availability, there are a number of other challenges to residents accessing healthcare. In the CHNA community survey, respondents reported which barriers they have experienced from a list of options. Importantly, it should be noted that 38.9% of survey respondents indicated that they have never experienced difficulty in getting healthcare. The top issues survey respondents marked overall were ability to schedule an appointment at a convenient time (26.9%), insurance problems (25.8%), wait times (24.0%), cost of care (19.9%), and doctors not accepting new patients (16.3%). Figure 73 presents this data overall and by race/ethnicity.

Figure 73. 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=442), 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. * indicates n<5.

Awareness of Resources

Many focus group and interview participants shared that they frequently observe a lack of awareness of local resources among members in the community, which becomes a challenge to accessing general and specialty care. Staff at social service organizations in particular commented that they face challenges getting information into the hands of residents who need it. Participants noted that they felt some populations struggle with accessing information more than others, namely older adult populations who may have difficulty navigating the Internet or using technology, economically vulnerable residents without Internet access, and parents or adults in high-stress situations who may not have the space to process information being shared. As one interviewee explained, "*My staff are trained to expand and elaborate on connecting to community resources, family support, and planning. We need more family workers to go out into the community and looking at ways, we have some people call, even though we*

run email campaigns with calendars and menus, people may not acknowledge because they are in crisis mode. We give out handouts, but someone who's worried about where they are going to sleep that night and what to eat, the information may not get internalized even if it makes it into the hands of the people who need it." Multiple participants also shared that they take extra measures to share information beyond social media, including hiring additional staff, printing information in the newspaper, and posting signs or flyers.

Healthcare Affordability

Healthcare affordability remains a critical barrier to accessing healthcare for many populations, focus group and interview participants explained. While some residents may be able to access health insurance and attend doctor appointments, the cost of copays, medications, and follow ups may present financial barriers beyond what residents feel they can manage. As one participant shared, "*It's difficult because money moves everything and resources are limited, but there are people who need, and others who have health insurance. Even though we pay a lot, and we need to pay copays that are incredibly high, and supposedly that money is used for those who cannot afford healthcare, but it seems that it doesn't make sense to pay so much and there are so many people who are not covered.*"

> *"The cost of medicines is too high... If another country can get a lower cost, why do we have to pay these astronomical amounts of money? That's only greed. With the money they receive they can save more lives… there's a lot of people dying, not just in other countries, we are dying right here because we can't access the medicines we need."*
> – Key informant interviewee

The impact of the COVID-19 pandemic and economic challenges further strain residents' financial situations, with some residents commenting that they frequently decide between basic necessities. One interviewee elaborated, "*People don't have enough money to pay for all their needs, such as medications. Even the $70 that patients have to pay for Charity Care is a barrier to receiving health care. People feel that they have to make choices between whether to pay for housing, food, or health care.*" Furthermore, when residents are able to access support programs like food stamps or charity care, there are concerns about continuing to qualify and maintain those benefits.

Childcare and Caregiving Responsibilities

Some focus group and interview participants commented that affordable childcare presents a barrier to healthcare access and generally presents a challenge for many members of the community. As one focus group participant explained, "*For childcare, either you have to pay someone, or you have to depend on family to help with childcare*." For families that pay for childcare, childcare services may be limited, and the costs are a challenge for families. One participant stated, "*Even if you are a two-parent household, one of those salaries is going to go to childcare*." However, despite the high cost of childcare, participants also remarked that childcare providers struggle to pay staff appropriate salaries due to policy barriers, further limiting childcare access due to workforce challenges.

Discrimination, Language, and Cultural Barriers

Though participants commented on local diversity as an asset to the community, barriers to accessing healthcare such as discrimination, language barriers, and cultural barriers persist, particularly for residents born outside of the U.S. and residents who identify as people of color. As discussed in the Systemic Racism and Discrimination section of this report, participants often noted that disparities in

access, resources, and quality of goods and services are often driven by systemic injustice in the community. In the healthcare system, participants noted that language barriers are a challenge for some community members, particularly notable among those of Haitian descent, and that on-site in-person translators are necessary to overcome this challenge. A lack of language and cultural support, focus group participants noted, can result in dissatisfaction with the healthcare system and distrust of treatment options provided. Furthermore, the language gap widens beyond primary care services, including language barriers when accessing mental health and therapy services, as one participant noted, "*A lot of language barriers, therapists had some Spanish but not fluent, trying to use translators. Still a challenge in the [school] districts. Not enough translators.*"

> *"Anyone who has COVID will do Haitian remedies, concoctions, but they will avoid the hospital unless they are in a really bad situation."*
> – Key informant interviewee

Perhaps exacerbated by language barriers, cultural barriers are also persistent in communities of color. Interviewees frequently commented on the history of racism and discrimination impacting residents who identify as Black or African American, and how those historical injustices are reflected in fear and hesitation when considering COVID-19 tests and vaccination. In the Haitian community, participants shared that word of mouth and recommendations are key inputs for healthcare decision making. When residents do not understand their healthcare treatments, have negative experiences, or experience unintended side effects, word spreads through the community and residents become more apprehensive when seeking healthcare in the future. As one interviewee shared, "*For the Haitian culture, welcoming is the main aspect, the way they are greeted determines how they will interact with you. They will come in with preconceived notion… It's hard because it's a cultural aspect, but there used to be a strong trust, once lost they go somewhere else*." Participants also shared that, when there is mistrust or limited access to the medical community, residents will first seek out herbal remedies which may ultimately delay treatment for chronic conditions or, if not disclosed, conflict with medications and treatment options prescribed.

Technology Access

The role of technology in access to care and everyday needs was frequently commented on by participants. Technology was recognized as a primary means to access information, as integral for school-aged youth for education, and as a method of connecting residents for socialization. As discussed in the Housing and Technology Infrastructure section, discrepancies in technology access continue though the pandemic, despite the rapidly changing environment and increased reliance on technology due to social distancing guidelines. Seniors, in particular, were mentioned as a population that has more limited access to technology and therefore, participants explained, are more likely to struggle with finding healthcare and isolation. However, some interviewees also shared local programs, such as a mobile technology center, that are currently being used to help bridge the technology gap and provide safe, reliable access to technology and learning supports for those in need. One participant shared, "*Even for our young people and parents we provide free Internet because schooling is dependent on it, Internet and Wi-Fi needs to be given to every senior.*"

Health Literacy

> *"[Residents are] sharing medication. [They think] 'I have the same symptoms, so your prescription would work for me too'."*
>
> – Key informant interviewee

Multiple participants commented on the concept of health literacy as a barrier when accessing healthcare and completing treatments prescribed by providers. Interviewees shared observations of residents who frequently did not understand why certain activities were happening, such as bloodwork, who did not have tools and knowledge for self-monitoring, and who did not understand the purpose or instructions for medications prescribed. This lack of understanding, often perpetuated by short interactions with doctors and a lack of written instructions, deepens mistrust of the medical community in some cultural groups and can result in non-compliance with treatment plans, medication sharing, a reliance on herbal remedies, and the possibility of being prescribed conflicting or duplicative treatments. As one interviewee commented, *"Most are very compliant, but the health literacy makes it difficult, if you are prescribed the same medication by different providers they don't know if they are taking the same medication*." Furthermore, when residents do not understand the medications they are prescribed, they also may not understand what side effects to look for, which can result in discomfort, distrust, and even a viewpoint that the doctor is seeking to cause them harm. Residents may also feel like they are being discriminated against if they are not prescribed a medication for an ailment they are seeking treatment for or if they are given a generic medication instead of brand name medications.

Transportation

As described in the Transportation section earlier in this report, focus group and interview participants perceived access to reliable and affordable transportation as a barrier for many residents to access healthcare. Barriers frequently mentioned included parking fees, parking availability, gas prices, and other high prices associated with the cost of transportation. Some participants described existing programs, such as transportation provided to the hospital, but often remarked that unaddressed gaps remain. Participants further explained that older adults and individuals who are economically vulnerable are most likely to face transportation challenges.

Safety Net Services and Services for Undocumented Residents

> *"She trusts us and talked to us about needing a kidney transplant. I started doing my own research and found out she isn't able to get on the transplant list because of her undocumented status. Even if she had the money for health insurance, she isn't able to do so because of US laws… I assumed we had a system in place to assist all the human beings in our midst, and then I found out that's not true."*
>
> – Key informant interviewee

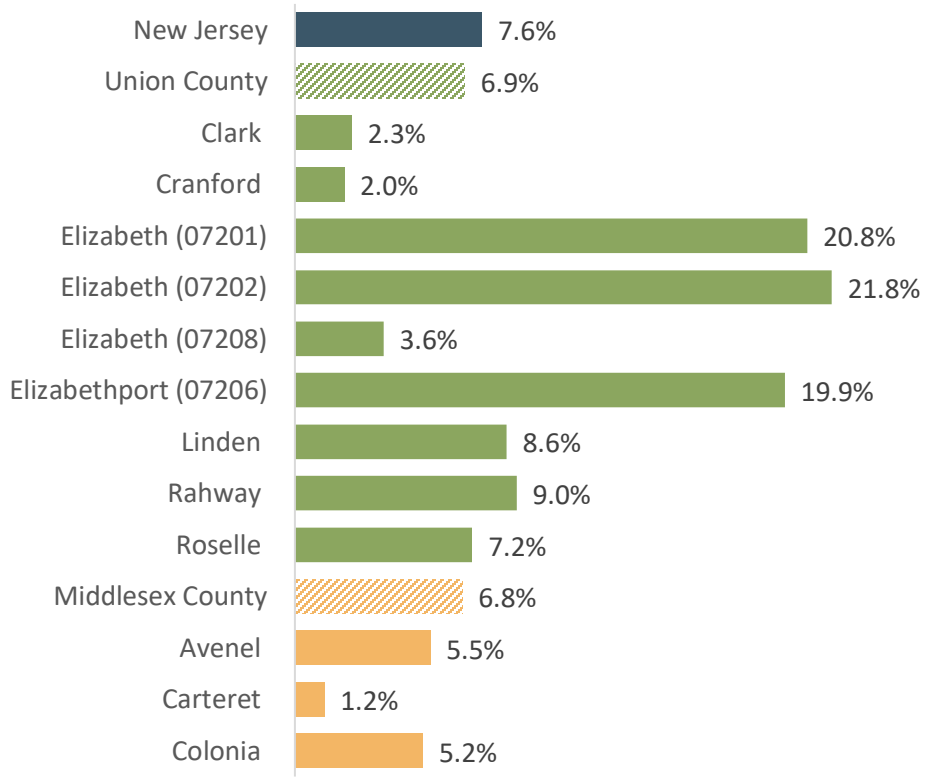
One key gap noted by focus group and interview participants was a lack of healthcare options for immigrants, citizens without documentation, and residents who are undocumented. Compared to citizens, even economically vulnerable citizens, participants explained that there are truly limited options for these populations beyond support provided by organizations like food pantries and members of the faith community. Participants shared personal anecdotes illuminating the lack of care options available, including residents seeking organ transplants who passed away due to a lack of care access, residents suffering unsafe living and working conditions, and residents who faced unsafe conditions while immigrating to the United States who have been unable to access healthcare. As one participant shared, "*One [resident] gave a testimony about his experience of*

spending days in the forest, no food, water and when they do find water, it's unsanitized, they [the resident] need a full examination but because of insurance he and his family cannot go to the hospital. Since they have been here, they haven't seen a doctor at all." As emphasized by this anecdote, it should also be noted that healthcare providers may need additional training and support to understand the conditions immigrants may be experiencing so that they can provide tailored care that may not be standard for the average citizen.

Participants also explained that, even in instances where the resident can afford health insurance, policy barriers continue to prohibit them from accessing services. These barriers to healthcare, participants explained, can have widespread public health consequences beyond the populations impacted. As one interviewee reinforced, *"Most get charity care, but otherwise, even if they can pay for it, most of the immigrants work because then they can't do anything. Even when they can pay for health insurance they aren't allowed to. The government is putting all of us at risk, if there is an illness that affect[s] others and they can't get treatment, it puts us all at risk."*

American Community Survey data indicate that barriers related to health insurance coverage vary by town. About 7.6% of New Jersey residents were uninsured in 2016-2020; and lower proportions of residents in Union County (6.9%) and Middlesex County (6.8%) were uninsured during this time (Figure 74). The proportion of uninsured residents across the communities RWJUH Rahway and TRMC serve is highest in the Elizabeth zip codes 07202 (21.8%), 07201 (20.8%), and Elizabethport 07208 (19.9%). There are far fewer uninsured residents in Carteret (1.2%), Cranford (2.0%), and Clark (2.3%).

Figure 74. Percent Population Uninsured, by State, County, and Town, 2016-2020



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

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 these community recommendations for future consideration.

Several suggestions emerged from the focus group and interviews. The suggestions most frequently discussed included improving information and resource sharing, expanding access to services and resources that address the social determinants of health, improving the healthcare delivery experience and system, addressing systemic racism and discrimination, and improving funding and structural challenges that limit access to healthy lives.

Expand Access to Services and Healthcare Resources

Expanding access to healthcare resources and services was one of the most frequently cited recommendations as focus group and interview participants imagined a better future. These often included services reaching further into the community to bypass barriers like transportation, expanding crisis and behavioral health services, expanding free services for residents without health insurance, and continuing to support access to free COVID-19 vaccines and testing.

Mobile Units, Health Fairs, and Other Ways to Bring Healthcare into Communities

Focus group and interview participants shared visions for the future where healthcare access became a more visible and embedded aspect of the community. Suggestions posed by participants included mobile units, health fairs, and grassroots initiatives and organizations to help bring health into the community. As one participant shared, "*We need to have more community health fairs, more grassroots initiatives for health and wellness, more satellite opportunities… the hospital needs to be more part of the community as a whole*." Another interviewee expanded on this idea, further elaborating on the types of services that could be made available locally in the community, "*The community will benefit a lot from a clinic van, bringing screening services, pharmacy, a practitioner, and no questions asked [for example, documentation status] services*." One participant working with unhoused populations also shared a vision to use mobile units as a way of bringing much needed hygiene supports, such as showers, into the community. This would allow unhoused populations a safe space to for grooming which may also increase unhoused residents' abilities to maintain health and employment.

Crisis Support and Mental Health for All Ages

Mental health was one of the most frequently cited needs in the community, as discussed in the Mental Health section of this report. As participants reflected on the needs of the community and imagined an ideal future, they suggested expanding emergency crisis supports, therapies and workshops, transitional services, and support groups. As one participant elaborated, *"Mental health – we just don't have enough mental health services. More groups or something to give people a place to be. Transition housing while you are getting settled. We take folks to psych emergency, and they are back in our office a few hours later with an appointment for a month from now."* Furthermore, appropriate crises services would help reduce interactions between police and residents in mental health emergencies, thereby reducing the risk of escalation and use of force. Beyond emergency services, residents also suggested additional support groups and therapies to help with long term treatment and social connection.

Services for Economically Vulnerable and Immigrant Populations

Healthcare access and services, particularly for vulnerable residents without access to safety net supports and health insurance, were frequently emphasized by participants. As participants reflected on suggestions for the future, they commented on the need for free and accessible healthcare services, including routine visits, chronic disease care, specialty care, and medication support. One participant explained their experiences with Charity Care, including persistent barriers that can prohibit access for the economically vulnerable, "*It's not very difficult, but there are people who don't have a family member that can give them the $70 needed to first receive Charity Care, the first visit with the doctor. That's the problem. That $70 covers one year. The next year you have to pay $70 again to renew Charity Care. But that doesn't cover medications, so many people come here to… the pharmacy and gives [the pharmacy] people vouchers for their medications. At the pharmacy they give generics. But there are medications that cost a lot and don't have a generic. So it's not easy for people who are sick.*"

Furthermore, many immigrant communities have limited access to social safety nets and supports but have a significant need for care, which could be remedied by expanded services that are free and openly available.

Continued Access to Free COVID-19 Testing and Vaccinations

Lastly, several participants commented that they have observed reduced access to COVID-19 testing and vaccinations that are free of charge and accessible. Given the challenges faced by economically vulnerable communities, participants suggested that healthcare institutions, local social services organizations, and faith community members continue to partner with the goal of continuing to offer free access to these services in the community.

Implement Strategies to Improve the Healthcare Delivery Experience and System

Focus group and interview participants also frequently shared suggestions for ways the healthcare delivery system could be improved. These strategies included hiring additional and more qualified staff, increasing accountability for staff, implementing measures to improve satisfaction (e.g., patient satisfaction surveys) and increasing community engagement to inform the healthcare system of community needs at more frequent intervals. Additionally, residents suggested increasing culturally appropriate supports and language services, increasing access to education, and expanding the pipeline for culturally diverse community residents to work in healthcare. Many of these recommendations would help overcome barriers to accessing care discussed earlier in this report, such as reducing discrimination, language challenges, and cultural barriers, as well as helping to improve the patient experience. As one participant elaborated, *"[Hospitals need to demonstrate] better results. If you have a bad reputation, we need to shift the result. Staff need to be sensitive, [and improve] outcome results. How can we keep them [patients] abreast of the progress so they understand the end result of the process. How can you message to these individuals who need to learn the lingo to communicate with doctors… Nurses have so many clients and don't have the time to sit down and listen. Time constraints due to patient load*."

> *"If someone doesn't speak the language, they should find an interpreter in person for them to translate and interact with them. Doctors should be spending more time with the patient to explain what the medication they prescribe them is about, the side effects, how they should take the meds."*
> – Focus group participant

Improve Communication and Health Promotion Strategies to Meet the Needs of the Community
Communication was a frequently mentioned topic in focus groups and interviews, and participants cited communications challenges as both a barrier to accessing care and a barrier to understanding what resources are available in the community. Participants shared recommendations to improve communication in the community and in healthcare settings, including through improved outreach to expand awareness of resources, additional promotional and information sharing within the community related to health (e.g., awareness campaigns, public service announcements), improved language access, and taking a holistic and family-oriented approach to healthcare. As one participant summarized, "*There have to be systems in place, events, people, organizations in place, on a consistent, caring, continuous, and creative level. We have to be able to engage the people, to draw them in, so they can get excited about their health. We have to be proactive instead of reactive when it comes to meeting needs, getting the word out, helping people. It takes time, work, our presence, patience, power, and strength from all of us, it's not easy work. It's a process, we have to continue to work hard to keep them in place*." Participants from communities with a history of distrust of the healthcare system, such as the Haitian community, further explained that improved communication is a vital first step to re-building trust between the community and the healthcare system.

Address Systemic Racism and Discrimination in Healthcare and Policies
Racism and discrimination is a topic that was frequently mentioned by participants, particularly those who are part of, or work closely with, populations who identify as people of color. Detailed information on this topic can be found in the Systemic Racism and Discrimination section in this report. As focus group and interview participants reflected on their vision for the future, many envisioned a world where racism, discrimination, and disparities no longer exist. As one interviewee shared, "*I want to live in a society where I'm not profiled because of my race, gender, or age. I want to see people love people because they love people. We need to put the guns and bad feeling[s] away*." To help address these challenges, participants suggested additional training for providers to build empathy and understanding when working with people of different backgrounds, and to develop education and skills related to treating patients with varying skin tones. Furthermore, accountability and training to help combat racism at local levels, and advocacy to address racism at policy levels, was also suggested.

> *"It's more than rules and regulations, it's your heart. If you are just there for money, then these things [discrimination] will happen and prejudice will get in the way. We have to do racism and boundaries workshops."*
> – Focus group participant

Improve Funding and Structural Challenges That Limit Access to Healthy Living
Focus group and interview participants frequently shared anecdotes and concerns that emphasized the interconnectedness of the social determinants of health and the ability to live a healthy life. These themes and concerns are discussed in greater detail in earlier sections of this report, such as Income and Financial Security, Food Access and Food Security, Housing, and Transportation. As participants imagined recommendations for the future, they often made comments indicating a holistic approach to healthcare is needed, such as supporting housing, economic stability, food access, and access to health insurance. Participants shared that funding and structural barriers exist that make it challenging for residents to qualify for support services, maintain benefits, and access needed services in a timely manner. As one participant shared, "*My daughter has been sick many times and wasn't able to get an appointment. They would give me appointments for 3 months from now. My daughter was born in the U.S., but in Pennsylvania. It wasn't easy to get health insurance for her here [in New Jersey]. I finally*

found her a pediatrician once I was able to get her health insurance. The pediatrician that I found is more flexible and gives us appointments. I don't have a doctor [myself]; I don't have insurance. I tried to go to a doctor recently, but they were all too expensive."

Beyond healthcare, additional housing support was frequently recommended by participants, particularly for residents with disabilities and chronic conditions. One participant elaborated, "*Everything that I receive from Social Security goes towards rent. I don't have money to pay anything else. Thankfully, I don't have to pay for medicine or going to the doctor. And I have food stamps. But there's no money left over for anything else. They won't even put you on a waitlist for [Section 8] Housing unless you're homeless. I've lived here for 22 years, so I don't want to have to go anywhere else*." The sentiment that residents need additional supports for daily needs, and that good health is deeply influenced by social and environmental factors, was further reiterated as one participant stated, "*The bottom line is basic needs need to be met, helping the community understand physical and mental health. If you are unwell you won't succeed at everything else you have going on.*"

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 the service areas for RWJUH Rahway and Trinitas Regional Medical Center during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- **Social determinants of health, including housing, food access, and financial security, are top of mind for residents.** In every focus group and interview with residents in the community, participants shared concerns around accessing daily necessities, such as having a place to live, access to healthy food and clean water, and having financial security**.** Access to housing was of particular concern to residents, with many commenting on a scarcity of affordable housing options and on rising rents. Residents' concerns about housing affordability are further reinforced through the secondary data. Housing costs represent a large portion of household budgets, with the percentage of households spending 25% or more of their income on housing costs ranging from 38.3% to 71.5% for owner-occupied housing, and 57.1% to 75.9% for renter-occupied housing. Residents frequently remarked that housing prices are so high that they often have to choose between paying rent, purchasing food, and paying for other necessities like medications. Individuals seeking assistance with food supports has also increased, a further sign of economic vulnerability in the population. The percentage of households receiving food stamps or SNAP range by community, with the lowest percentage being 0.6% in Clark to nearly 20% in Elizabeth's 07201 zip code. Rates of individuals below poverty level also vary by community, with percentages ranging between approximately 3%-20%. A common sentiment shared by residents was that the pandemic further exacerbated existing challenges and vulnerabilities community residents face, resulting in increased need for support services and assistance since the onset of the pandemic.

- **Chronic conditions are prevalent in the community and further perpetuated by limited access to healthcare services, low health literacy, and affordability concerns.** Chronic conditions, nutrition, and access to healthy foods were key themes in the RWJUH Rahway and TRMC 2019 CHNAs. Though chronic conditions were less frequently discussed during focus groups and interviews compared to the social determinants of health, data indicate that some populations in the community face higher disease burdens than others. According to data from the Death Certificate Database, the top causes

of death in 2020 were heart disease, COVID-19, cancer, unintentional injury, stroke, chronic lower respiratory diseases, Alzheimer's disease, diabetes, septicemia, and kidney disease. Many of these conditions are influenced by factors such as healthy eating, physical activity, maintaining good mental health, and generally practicing healthy behaviors. However, residents noted that due to additional stressors, financial difficulties, limited access to health insurance and healthcare, and low health literacy, many residents may be on a path to poor health outcomes in the near and long term. Residents shared recommendations to improve health and chronic disease for the community, including expanding mental healthcare access, improving the healthcare delivery system, and increasing access through the delivery of free or low-cost health services in the community on a regular basis.

- **Communities in Union and Middlesex County are diverse, and residents face barriers and disparities as a result of language, race and ethnicity, access to resources, and other social and cultural factors.** The communities in the RWJUH Rahway-TRMC service area are diverse, with residents coming together in community from different demographic compositions, income levels, health statuses, and cultures. However, residents also expressed concerns, namely existing disparities resulting from structural racism or others' discriminatory behaviors against residents who speak different languages, are from different cultures, or have less access to resources. Residents also shared personal anecdotes of receiving differential treatment when seeking health services and feeling discriminated against due to immigration status, race and ethnicity, or other factors. These challenges, residents noted, can lead to long-term impacts, such as higher rates of maternal and infant mortality among residents identifying as Black or African American. As residents reflected on systemic racism and discrimination, they shared recommendations noting that these issues must be addressed at both the systemic and individual levels. Recommendations included advocacy to support policy changes that promote equity, additional training for providers, and increased accountability and focus on patient satisfaction.

- **Mental health continued to be a significant health concern in Union and Middlesex County communities.** Behavioral Health was a key concern in both the RWJUH Rahway and TRMC 2019 CHNAs, which were conducted prior to the onset of the pandemic. Community concerns about mental health were expressed in nearly every focus group and interview conducted as part of this community health needs assessment, with many residents commenting that the pandemic exacerbated existing challenges and needs. These concerns are further reinforced through the community survey data, where respondents reported that mental health issues were their top health concern, and that a high stress lifestyle was their third highest health concern. Depression, anxiety, grief, anger, and stress were frequently identified mental health challenges. Participants also noted that some populations in the community, such as youth and seniors, may face additional challenges compared to the general community and require additional supports and services tailored to their situations. Stigma and access continue to be significant barriers to accessing treatment and support, though some residents believed that awareness campaigns and recent health promotional materials are helping to lessen the stigma of seeking services. As participants reflected on the needs of the community and imagined an ideal future, they suggested developing and promoting additional emergency crisis supports, increasing access to therapies and workshops, expanding transitional services, continuing to develop and engage support groups, and implementing systems to reduce or avoid interactions between residents in mental health crisis and law enforcement.

- **The COVID-19 pandemic continues to have lingering impacts on residents' daily lives and overall wellbeing.** Though the pandemic has been a consistent part of resident's daily lives since its onset, participants discussed the pandemic's continued far-reaching impacts on financial, social, and physical health. Current economic challenges were of particular concern, with many residents noting that they have been unable to recover from job loss, reduced hours, limited childcare access, and other challenges contributing to economic vulnerability. Residents also shared concerns that government supports, such as free COVID testing, test kits, and vaccines were becoming more difficult to access which could increase financial strain on families by shifting those costs to individuals.

- **Residents, social service organizations, and faith communities are highly invested in community health and deepening partnership between communities and healthcare providers.** As part of this community health needs assessment, focus groups and interviews were conducted with numerous residents, organizations, and sectors. In each conversation, participants shared the different strategies they are implementing to support the health of the community, and many emphasized the desire for increased partnerships and collaboration with other organizations, faith communities, and healthcare providers. Strong community organizations and supports were described as a key strength of the community in the Community Strengths and Assets section of this report, and the conversations with residents further emphasized the importance of health and the current momentum to further improve the resources and supports available to residents in need.

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 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 (in no particular order):

- Systemic racism and injustice
- Financial insecurity and employment
- Nutrition and Food insecurity
- Housing
- Transportation
- Chronic disease (e.g., heart disease, cancer, diabetes)
- Mental health
- Substance use
- COVID-19
- Access to healthcare and social services

Step 2: Data-Informed Voting via a Prioritization Meeting
On November 4, 2022, a 90-minute virtual community meeting was held with the RWJUH Rahway-TRMC CHNA Advisory Committee (see Acknowledgements 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 CHNA conducted across the RWJUH Rahway-TRMC primary service areas.

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 fifteen Advisory Committee members voted during the Community Prioritization Meeting.

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

	Percentage	Vote #s
Mental health	87%	13/15
Nutrition and food insecurity	80%	12/15
Chronic disease (e.g., heart disease, cancer, diabetes)	67%	10/15
Access to healthcare and social services	67%	10/15
Housing	33%	5/15
Financial insecurity	27%	4/15
Racism and discrimination	20%	3/15
Substance use	7%	1/15
Transportation	7%	1/15
COVID-19	0%	0/15

Key priority areas for RWJUH Rahway and TRMC will include mental health, nutrition and food insecurity, chronic health conditions, access to healthcare and social services, with an overarching focus on racism and discrimination. The hospitals will also consider their existing expertise, capacity, and experience during the development of their implementation plans in 2023.

APPENDICES

Appendix A – Key Informant Interviewee Organizations and Sectors
Appendix B – Key Informant Interview Guide
Appendix C – Focus Group Guide
Appendix D – Resource Inventory
Appendix E – Additional Data Tables
Appendix F – Hospitalization Data
Appendix G – Cancer Data
Appendix H –Outcomes and Results Report of the Previous Implementation Plans

Appendix A- Key Informant Interviewee Organizations and Sectors

Organization	Population/Sector
Rahway Food for Friends Trinitas Regional Medical Center	Residents who are food insecure and/or unhoused
Elizabeth Coalition to House the Homeless	Residents who are housing insecure
Santa Isabel Lutheran Church	Residents working with immigrant communities
National Alliance on Mental Illness	Mental health providers
Trinitas Regional Medical Center	Healthcare providers
Agape Family Worship Center, Holy Trinity Church, Ebenezer African Methodist Episcopal Church of Rahway, Mount Teman African Methodist Episcopal Church, New Hope Memorial Baptist Church	Leaders in the faith community
Trinitas Regional Medical Center	Violence prevention
Gateway Family YMCA Trinitas Regional Medical Center Rahway Community Action Organization	Youth and families
City of Elizabeth Department of Public Health	Public Health Officials
Jefferson Park Ministries	Residents of Haitian descent
Township of Union	Economic development and senior populations

Appendix B- Key Informant Interview Guide

Health Resources in Action
RWJUH Rahway-Trinitas Regional Medical Center Community Health Needs Assessment
Virtual Key Informant Interview Guide

Goals of the key informant interview

- To determine perceptions of the strengths and needs of the community served by RWJUH Rahway-Trinitas Regional Medical Center, 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 RWJUH Rahway-Trinitas Regional Medical Center 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 20 – 30 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.

- Do you consent to participate in this conversation today? Participation is voluntary, and if I ask a question that you don't feel comfortable answering it's okay for us to skip and move on to the next questions.

- Do you have any questions before we begin?

- Do you consent to me recording our conversation today to support our internal notes and analysis? Please note that these will not be shared with anyone outside of the HRiA team.

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?]

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)**

1. How would you describe the community served by your organization/ that you serve? (NOTE THAT WE ARE DEFINING COMMUNITY BROADLY – NOT NECESSARILY GEOGRAPHICALLY BASED)

- What do you consider to be the community's strongest assets/strengths?

- How have you seen the community change over the last several years?

- What are some of its 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 and stigma; 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, 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 SPECIFICS: obesity; access to care; mental health; PTDS; LGBTQ+ health; maternal and child health; social services, etc. PROBE FOR HEALTH ISSUES NOT DIRECTLY RELATED TO COVID-19, OR ISSUES THAT HAVE CHANGED BECAUSE OF COVID-19]

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, 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?

V. ***TAILORED SECTION*** **- SPECIFIC QUESTIONS ON PARTICULAR ISSUES, DEPENDING ON WHO THE INTERVIEWEE IS. SELECT QUESTIONS TAILORED TO INDIVIDUAL EXPERTISE AND ASK A FEW QUESITONS 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 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 if other KIIs have brought up suicide in youth; isolation in older populations; PTSD
- What are your major concerns for the future? What has been going “right” that could be built on going forward?

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 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)**

5. 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- Ex: 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?

6. As you think about your vision, what do you think needs to be in place to support <u>sustainable</u> change?
   a. How do we move forward with lasting change across <u>organizations and systems</u>?
   b. Where do you see yourself or your organization in this?

7. 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 be prioritized?

VII. **CLOSING (5 MINUTES)**

Thank you so much for your time and sharing your opinions.
That's it for my questions. Here is how we would like to wrap up. (Please read both questions below as written so participants can say what is forgotten or provide an illustrative quote)

Is there anything else that you would like to mention that we didn't discuss today?
Or
If you had one major takeaway call to action, need, or issue for us to address urgently, what would that be, and why?

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

Appendix C- Focus Group Guide

Health Resources in Action
RWJUH Rahway-Trinitas Regional Medical Center Community Health Needs Assessment
Virtual Focus Group Guide

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 AND AUDIENCE] 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.

- 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, the RWJUH Rahway-Trinitas Regional Medical Center 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 have been in. Given the COVID-19 pandemic, an assessment of the community's needs and strengths is even more important than ever.

- We will be conducting several of these discussion groups around the area. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, we might provide some general information on what we discussed tonight, but I 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 RECORDING] We would like to record these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the note-taking. 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 questions they want to ask before I begin recording? Does anyone have any concerns or objections with me turning the recorder on now?

- Does everyone consent to participating in this conversation today? Participation is voluntary, and if I ask a question that you don't feel comfortable answering it's okay to skip and move on to the next question. Please nod or unmute to communicate that you consent to be part of this focus group.

- Does anyone have 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 the biggest strengths about your community - or 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, NAVIGATING SERVICES, ETC.]

    b. How have these changed during COVID-19?

    c. What specific population groups do you think have been most at-risk for 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 the [COMMUNITY NAME] community? How have issues of inequity played out in the [COMMUNITY NAME] 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? [PROBE ON ISSUES IF NEEDED – ACCESS TO HEALTHCARE, OBESITY, MENTAL HEALTH, VIOLENCE, MATERNAL AND CHILD HEALTH, INSURANCE, ETC.]
    a. How did these health issues affect your community? In what way?
        i. How have these changed during COVID-19?

b. What specific population group(s) are most at-risk for these issues?

5. Thinking about health and wellness, what makes it easier to be healthy in your community?
   i. What supports your health and wellness?

6. What makes it harder to be healthy in your community?

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, ETC. --THAT HAVE COME UP SO FAR.] Let's talk about some of the issues.

7. Do you agree with this list as the major concerns/issues in your community? Is there a major issue that is missing?

8. 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, 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)**

9. 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?

10. 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?

VII. **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. Here is how we would like to wrap up. (Please read both questions below as written so participants can say what is forgotten or provide an illustrative quote)

Is there anything else that you would like to mention that we didn't discuss today?
Or
If you had one major takeaway/call to action, need, or issue for us to address urgently, what would that be, and why?

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.]

Health Resources For Union County

Part 1: Acute, Long Term and Medical Ambulatory Services

Source: Department of Health
Download Oct 3, 2022

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
ADULT DAY HEALTH CARE SERVICES	NZDOUG	2ND HOME SPRINGFIELD	40 STERN AVENUE	SPRINGFIELD	NJ	07081	UNION	(973) 376-4004	(973) 376-8060	2ND HOME SPRINGFIELD LLC
ADULT DAY HEALTH CARE SERVICES	908116	2nd Home Sweet Home Operations, LLC	550 NORTH BROAD STREET	ELIZABETH	NJ	07208	UNION	(908) 994-0050	(908) 994-0056	HOME SWEET HOME OPERATIONS, LLC
ADULT DAY HEALTH CARE SERVICES	908300	AristaCare at Norwood Terrace	40-44 NORWOOD AVENUE	PLAINFIELD	NJ	07060	UNION	(908) 769-1400	(908) 769-8092	NORWOOD TERRACE NURSING AND REHABILITATION CENTER
ADULT DAY HEALTH CARE SERVICES	908115	Cedar Harbor Medical Day Care Center	545 EAST 1ST AVENUE	ROSELLE	NJ	07203	UNION	(908) 298-8588	(908) 298-8511	CEDAR HARBOR MEDICAL DAY CARE CENTER, LLC
ADULT DAY HEALTH CARE SERVICES	908113	Daybreak Adult Daycare At Elizabeth	712 NEWARK AVENUE	ELIZABETH	NJ	07208	UNION	(908) 353-3530	(908) 353-3529	DAYBREAK ADULT DAYCARE AT ELIZABETH LLC
ADULT DAY HEALTH CARE SERVICES	908112	Five Star Adult Medical Day Care Center	1201 DEERFIELD TERRACE	LINDEN	NJ	07036	UNION	(908) 486-5750	(908) 486-3325	FIVE STAR ADULT MEDICAL DAY CARE CENTER LLC
ADULT DAY HEALTH CARE SERVICES	908110	SAGE Spend A Day	290 BROAD STREET	SUMMIT	NJ	07901	UNION	(908) 598-5520	(908) 598-5545	SAGE ELDERCARE, INC.
ADULT DAY HEALTH CARE SERVICES	18202	SarahCare At Watchung Square	1115 GLOBE AVENUE	MOUNTAINSIDE	NJ	07092	UNION	(908) 561-8888	(908) 222-3481	SARAHCARE @ WATCHUNG SQUARE, LLC
ADULT DAY HEALTH CARE SERVICES	908117	Senior Spirit Of Roselle Park	430 EAST WESTFIELD AVENUE	ROSELLE PARK	NJ	07204	UNION	(908) 241-9393	(908) 241-5622	SENIOR SPIRIT OF ROSELLE PARK, LLC
ADULT DAY HEALTH CARE SERVICES	20004	TownSquare Adult Medical Day Care Center, Inc	1155 EAST JERSEY STREET	ELIZABETH	NJ	07201	UNION	(908) 787-0980	(908) 787-0983	TOWN SQUARE ADULT MEDICAL DAY CARE CENTER INC
AMBULATORY CARE FACILITY	24977	AQ MODERN DIAGNOSTIC IMAGING	315 ELMORA AVENUE	ELIZABETH	NJ	07208	UNION	(856) 524-1559	(856) 210-1888	AQ MODERN DIAGNOSTIC IMAGING, INC.
AMBULATORY CARE FACILITY	25233	ATLANTIC IMAGING SERVICES AT CLARK	140 CENTRAL AVENUE, SUITE 600	CLARK	NJ	07066	UNION	(732) 943-5030	(732) 943-5031	ATLANTIC IMAGING SERVICES, L.L.C.
AMBULATORY CARE FACILITY	23294	DYNAMIC MEDICAL IMAGING L.L.C.	950 WEST CHESTNUT STREET	UNION	NJ	07083	UNION	(908) 687-2552	(908) 687-6552	DYNAMIC MEDICAL IMAGING, LLC
AMBULATORY CARE FACILITY	23061	NJIN OF CRANFORD	25 SOUTH UNION AVENUE	CRANFORD	NJ	07016	UNION	(908) 709-1323	(908) 709-1329	THE NEW JERSEY IMAGING NETWORK LLC
AMBULATORY CARE FACILITY	23213	NJIN OF UNION	445 CHESTNUT STREET	UNION	NJ	07083	UNION	(908) 687-6054	(908) 688-1131	THE NEW JERSEY IMAGING NETWORK LLC
AMBULATORY CARE FACILITY	24329	NJU CANCER TREATMENT CENTERS	570 SOUTH AVENUE	CRANFORD	NJ	07016	UNION	(908) 603-4200	(908) 497-1633	NEW JERSEY UROLOGY, LLC
AMBULATORY CARE FACILITY	24038	RAHWAY REGIONAL CANCER CENTER	892 TRUSSLER PLACE	RAHWAY	NJ	07065	UNION	(732) 382-5550	(732) 382-2407	RAHWAY RADIATION ONCOLOGY ASSOCIATES, P.C.
AMBULATORY CARE FACILITY	25059	SUMMIT MEDICAL GROUP	1 DIAMOND HILL ROAD, SUITE LG601	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 273-4300		SUMMIT MEDICAL GROUP, PA
AMBULATORY CARE FACILITY	24811	SUMMIT MEDICAL GROUP, P.A.	574 SPRINGFIELD AVENUE	WESTFIELD	NJ	07091	UNION	(908) 673-7257	(908) 673-7179	SUMMIT MEDICAL GROUP, PA
AMBULATORY CARE FACILITY	25089	THE BIRTH CENTER OF NEW JERSEY, LLC	1945 US 22 WEST	UNION	NJ	07083	UNION	(908) 624-9665	(908) 624-9632	THE BIRTH CENTER OF NEW JERSEY, LLC
AMBULATORY CARE FACILITY	22518	UNIVERSITY RADIOLOGY AT TRINITAS, LLC	415 MORRIS AVENUE	ELIZABETH	NJ	07208	UNION	(908) 351-7600	(908) 351-4406	UNIVERSITY RADIOLOGY AT TRINITAS, L.L.C.

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
AMBULATORY CARE FACILITY	23473	UNIVERSITY RADIOLOGY GROUP, LLC	210 W ST GEORGES AVENUE	LINDEN	NJ	07036	UNION	(908) 587-0035	(908) 587-0037	UNIVERSITY RADIOLOGY GROUP, LLC
AMBULATORY CARE FACILITY	24872	WOMEN'S HEALTHCARE IMAGING CENTER	1896 MORRIS AVENUE	UNION	NJ	07083	UNION	(908) 964-0004	(908) 964-0034	WOMEN'S HEALTHCARE IMAGING, CORP
AMBULATORY CARE FACILITY - SATELLITE	22756	NEIGHBORHOOD HEALTH CENTER THE HEALTHY PLACE	427 DARROW AVENUE	PLAINFIELD	NJ	07063	UNION	(908) 731-4288	(908) 731-7570	NEIGHBORHOOD HEALTH SERVICES CORPORATION
AMBULATORY CARE FACILITY - SATELLITE	72092	PLANNED PARENTHOOD OF NORTHERN, CENTRAL AND SOUTHERN NEW JERSEY, INC.	123 PARK AVENUE	PLAINFIELD	NJ	07060	UNION	(908) 756-3736	(908) 756-9272	PLANNED PARENTHOOD OF NCSNJ
AMBULATORY CARE FACILITY - SATELLITE	72038	PLANNED PARENTHOOD OF NORTHERN, CENTRAL AND SOUTHERN NEW JERSEY, INC.	1171 ELIZABETH AVENUE	ELIZABETH	NJ	07201	UNION	(973) 879-1306	(908) 353-6822	PLANNED PARENTHOOD OF NCSNJ
AMBULATORY SURGICAL CENTER	R24714	ACCESS CARE PHYSICIANS OF NJ L.L.C.	1050 GALLOPING HILL ROAD, SUITE 101	UNION	NJ	07083	UNION	(908) 686-0123	(908) 686-0014	ACCESS CARE PHYSICIANS OF NJ, L.L.C.
AMBULATORY SURGICAL CENTER	22987	CENTER FOR AMBULATORY SURGERY, LLC	1450 ROUTE 22 WEST	MOUNTAINSIDE	NJ	07092	UNION	(908) 233-2020	(908) 233-9322	CENTER FOR AMBULATORY SURGERY
AMBULATORY SURGICAL CENTER	R24498	ENDO-SURGI CENTER, PA	1201 MORRIS AVENUE	UNION	NJ	07083	UNION	(908) 686-0066	(908) 686-5388	ENDO SURGI CENTER PA
AMBULATORY SURGICAL CENTER	22511	GASTRO-SURGI CENTER OF NEW JERSEY, THE	1132 SPRUCE DRIVE	MOUNTAINSIDE	NJ	07092	UNION	(908) 317-0071	(908) 317-0103	THE GASTRO-SURGI CENTER OF NEW JERSEY, LLC
AMBULATORY SURGICAL CENTER	R24579	LINDEN SURGICAL CENTER, LLC	210 WEST ST GEORGE AVENUE	LINDEN	NJ	07036	UNION	(908) 587-1888	(908) 587-9545	LINDEN SURGICAL CENTER, LLC
AMBULATORY SURGICAL CENTER	22724	MORRIS AVENUE ENDOSCOPY LLC	200 SHEFFIELD STREET STE 101	MOUNTAINSIDE	NJ	07092	UNION	(908) 241-8900	(908) 241-8933	MORRIS AVENUE ENDOSCOPY, LLC
AMBULATORY SURGICAL CENTER	R24726	NEW JERSEY INTERVENTIONAL ASSOCIATES LLC	1050 GALLOPING HILL ROAD, SUITE 102	UNION	NJ	07083	UNION	(908) 686-1350	(908) 686-1382	NEW JERSEY INTERVENTIONAL ASSOCIATES, LLC
AMBULATORY SURGICAL CENTER	24093	SUMMIT MEDICAL GROUP PA	1 DIAMOND HILL ROAD, SUITE 1B142	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 273-4300	(908) 673-7382	SUMMIT MEDICAL GROUP, PA
AMBULATORY SURGICAL CENTER	23028	UNION COUNTY SURGERY CENTER, L.L.C.	950 WEST CHESTNUT STREET	UNION	NJ	07083	UNION	(908) 688-2700	(908) 688-7424	UNION COUNTY SURGERY CENTER, L.L.C.
AMBULATORY SURGICAL CENTER	24207	UNION SURGERY CENTER, LLC	1000 GALLOPING HILL ROAD	UNION	NJ	07083	UNION	(908) 258-7666	(908) 258-7654	UNION COUNTY SURGERY CENTER, L.L.C.
ASSISTED LIVING PROGRAM	90A100	Center for Hope Hospice Inc.	1900 RARITAN ROAD	SCOTCH PLAINS	NJ	07076	UNION	(908) 889-7780	(908) 288-9151	CENTER FOR HOPE HOSPICE
ASSISTED LIVING RESIDENCE	90A120	Amber Court of Elizabeth, LLC	1155 EAST JERSEY STREET	ELIZABETH	NJ	07201	UNION	(908) 352-9200	(908) 352-8026	AMBER COURT OF ELIZABETH, LLC
ASSISTED LIVING RESIDENCE	AL20001	Arbor Terrace Mountainside	1050 SPRINGFIELD AVENUE	MOUNTAINSIDE	NJ	07092	UNION	(908) 760-0599		SHP VI MOUNTAINSIDE LLC

vFACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
ASSISTED LIVING RESIDENCE	90a001	BRANDYWINE LIVING AT SUMMIT	41 SPRINGFIELD AVENUE	SUMMIT	NJ	07901	UNION	(908) 522-8852	(908) 522-8862	WELL BL PORTFOLIO 1 OPCO LLC
ASSISTED LIVING RESIDENCE	90122	Brighton Gardens of Mountainside	1350 ROUTE 22 WEST	MOUNTAINSIDE	NJ	07092	UNION	(908) 654-4460	(908) 654-4467	PRIME CARE ONE, LLC
ASSISTED LIVING RESIDENCE	90A000	The Chelsea at Fanwood	295 SOUTH AVENUE	FANWOOD	NJ	07023	UNION	(908) 654-5200	(908) 789-0451	FANWOOD SENIOR CARE, LLC
ASSISTED LIVING RESIDENCE	20A105	Continuing Care At Lantern Hill	537 MOUNTAIN AVENUE	NEW PROVIDENCE	NJ	07974	UNION	(908) 516-9300	(908) 516-9325	LANTERN HILL, INC.
ASSISTED LIVING RESIDENCE	90144	Sunrise Assisted Living Of Westfield	240 SPRINGFIELD AVENUE	WESTFIELD	NJ	07090	UNION	(908) 317-3030	(908) 789-5778	SZR WESTFIELD ASSISTED LIVING, LLC
ASSISTED LIVING RESIDENCE	20A014	Sunrise Of Summit	26 RIVER ROAD	SUMMIT	NJ	07901	UNION	(908) 673-1400	(908) 673-1401	SUNRISE OF SUMMIT LLC
COMPREHENSIVE OUTPATIENT REHAB	23133	QUALCARE THERAPY CENTER INC & SLEEP DIAGNOSTICS OF NJ	2333 MORRIS AVENUE, SUITE B-210	UNION	NJ	07083	UNION	(908) 688-3366	(908) 688-8115	QUALCARE THERAPY CNT, INC & SLEEP DIAGNOSTICS NJ
COMPREHENSIVE PERSONAL CARE HOME	90C000	ARISTACARE AT DELAIRE	400 WEST STIMPSON AVENUE	LINDEN	NJ	07036	UNION	(908) 862-3399	(908) 862-6967	LINDEN GARDEN ESTATES, LLC
COMPREHENSIVE PERSONAL CARE HOME	82472	Atria Cranford	10 JACKSON DRIVE	CRANFORD	NJ	07016	UNION	(908) 709-4300	(908) 709-1460	WG CRANFORD SH, LLC
COMPREHENSIVE PERSONAL CARE HOME	20C003	Birchwood Square at Cranford	205 BIRCHWOOD AVENUE	CRANFORD	NJ	07016	UNION	(908) 272-6660	(908) 276-2424	CRNC OPERATING, LLC
END STAGE RENAL DIALYSIS	42001	BIO-MEDICAL APPLICATIONS OF HILLSIDE	879 RAHWAY AVENUE	UNION	NJ	07083	UNION	(908) 378-6387	(908) 688-7108	FRESENIUS MEDICAL CARE
END STAGE RENAL DIALYSIS	25179	ELMORA DIALYSIS	547 MORRIS AVENUE	ELIZABETH	NJ	07208	UNION	(908) 436-9201	(908) 436-9206	PINSON DIALYSIS, LLC
END STAGE RENAL DIALYSIS	22289	FRESENIUS MEDICAL CARE KENILWORTH	131 SOUTH 31ST STREET	KENILWORTH	NJ	07033	UNION	(908) 241-0453	(908) 241-5731	NNA SAINT BARNABAS, LLC
END STAGE RENAL DIALYSIS	24459	FRESENIUS MEDICAL CARE LINDEN	630 WEST ST GEORGES	LINDEN	NJ	07036	UNION	(908) 925-5161	(908) 925-5197	FRESENIUS MEDICAL CARE LINDEN LLC
END STAGE RENAL DIALYSIS	24065	HILLSIDE DIALYSIS	1529 NORTH BROAD STREET	HILLSIDE	NJ	07205	UNION	(973) 474-1199	(973) 474-1198	TOTAL RENAL CARE, INC.
END STAGE RENAL DIALYSIS	23228	NATIONAL NEPHROLOGY ASSOCIATES, INC	595 DIVISION STREET, SUITE B	ELIZABETH	NJ	07201	UNION	(908) 436-3007	(908) 436-3008	NNA OF ELIZABETH
END STAGE RENAL DIALYSIS	23079	PLAINFIELD DIALYSIS	1200 RANDOLPH ROAD	PLAINFIELD	NJ	07060	UNION	(908) 757-6030	(908) 757-6282	DVA RENAL HEALTHCARE, INC
END STAGE RENAL DIALYSIS	24924	RAHWAY DIALYSIS	800 HARRISON STREET	RAHWAY	NJ	07065	UNION	(732) 680-0373	(732) 680-0376	GEBHARD DIALYSIS, LLC
END STAGE RENAL DIALYSIS	22318	SUMMIT DIALYSIS	1139 SPRUCE DRIVE	MOUNTAINSIDE	NJ	07092	UNION	(908) 232-7800	(908) 232-9188	DVA RENAL HEALTHCARE, INC.
FEDERALLY QUALIFIED HEALTH CENTERS	22271	NEIGHBORHOOD HEALTH CENTER PLAINFIELD	1700 MYRTLE AVENUE	PLAINFIELD	NJ	07063	UNION	(908) 753-6401	(908) 753-7570	NEIGHBORHOOD HEALTH SERVICES CORPORATION
FEDERALLY QUALIFIED HEALTH CENTERS	23072	NEIGHBORHOOD HEALTH SERVICES CORPORATION	178-184 FIRST STREET	ELIZABETH	NJ	07206	UNION	(908) 355-4459	(908) 226-6685	NEIGHBORHOOD HEALTH SERVICES CORPORATION

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
GENERAL ACUTE CARE HOSPITAL	12005	OVERLOOK MEDICAL CENTER	99 BEAUVOIR AVENUE	SUMMIT	NJ	07902	UNION	(908) 522-2000	(908) 273-5134	AHS HOSPITAL CORP.
GENERAL ACUTE CARE HOSPITAL	12006	ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL AT RAHWAY	865 STONE ST	RAHWAY	NJ	07065	UNION	(732) 381-4200	(732) 499-6337	ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL AT RAHWAY
GENERAL ACUTE CARE HOSPITAL	12007	TRINITAS REGIONAL MEDICAL CENTER	225 WILLIAMSON STREET	ELIZABETH	NJ	07207	UNION	(908) 994-5000	(908) 994-5756	TRINITAS REGIONAL MEDICAL CENTER
HOME HEALTH AGENCY	22301	HOLY REDEEMER HOME CARE	354 UNION AVENUE	ELIZABETH	NJ	07208	UNION	(908) 352-5694	(908) 659-4470	VISITING NURSE AND HEALTH SERVICES, INC
HOSPICE CARE BRANCH	22796	HOLY REDEEMER HOSPICE	354 UNION AVENUE	ELIZABETH	NJ	07208	UNION	(908) 352-5694	(908) 659-4470	HOLY REDEEMER HEALTH SYSTEM
HOSPICE CARE PROGRAM	22841	ASCEND HOSPICE	1600 ST GEORGE AVENUE, SUITE 312	RAHWAY	NJ	07065	UNION	(908) 931-9080	(908) 931-9081	CARE ALTERNATIVES, INC.
HOSPICE CARE PROGRAM	22782	CENTER FOR HOPE HOSPICE AND PALLIATIVE CARE	1900 RARITAN ROAD	SCOTCH PLAINS	NJ	07076	UNION	(908) 889-7780	(908) 889-5172	CENTER FOR HOPE HOSPICE
HOSPICE CARE PROGRAM	23391	HOMESIDE HOSPICE LLC	67 WALNUT AVENUE, SUITE 205	CLARK	NJ	07066	UNION	(732) 381-3444	(732) 381-3445	JOURNEY INVESTMENTS LLC
HOSPICE CARE PROGRAM	24987	SWAN HOSPICE	57 BRANT AVENUE, SUITE 100	CLARK	NJ	07066	UNION	(908) 818-1700	(347) 689-1627	NJ HOSPICE HOLDINGS LLC
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1526	CHILDREN'S SPECIALIZED HOSPITAL CENTER AT UNION	2840 MORRIS AVENUE	UNION	NJ	07083	UNION	(732) 258-7000	(732) 258-7210	CHILDREN'S SPECIALIZED HOSPITAL
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1105	CHILDREN'S SPECIALIZED HOSPITAL PRIMARY CARE	150 NEW PROVIDENCE ROAD	MOUNTAINSIDE	NJ	07092	UNION	(732) 258-7050	(732) 258-7210	CHILDREN'S SPECIALIZED HOSPITAL
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1242	JFK MEDICAL CENTER-MUHLENBERG CAMPUS	PARK AVENUE AND RANDOLPH ROAD	PLAINFIELD	NJ	07061	UNION	(732) 321-7000	(732) 549-8532	HMH HOSPITALS CORPORATION
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1233	OVERLOOK HEALTH SERVICES AT ONE SPRINGFIELD AVENUE	1 SPRINGFIELD AVENUE	SUMMIT	NJ	07901	UNION	(908) 934-6651	(908) 273-0104	OVERLOOK MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1210	OVERLOOK MEDICAL CENTER-UNION CAMPUS	1000 GALLOPING HILL ROAD	UNION	NJ	07083	UNION	(973) 522-6300	(908) 964-2160	OVERLOOK MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1040	RENAL DIALYSIS SATELLITE	10 NORTH WOOD AVENUE	LINDEN	NJ	07036	UNION	(908) 862-7400	(908) 862-5245	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1050	TRINITAS ADULT PSYCHIATRIC CLINIC	654 EAST JERSEY STREET	ELIZABETH	NJ	07206	UNION	(908) 994-7552	(908) 994-7054	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1404	TRINITAS AMBULATORY SURGERY CENTER	225 WILLIAMSON STREET	ELIZABETH	NJ	07202	UNION	(908) 994-8944	(908) 994-8349	TRINITAS REGIONAL MEDICAL CENTER

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1051	TRINITAS CHILD AND ADOLESCENT PSYCHIATRIC CLINIC	655 EAST JERSEY STREET	ELIZABETH	NJ	07206	UNION	(908) 994-7354	(908) 994-7247	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1042	TRINITAS COMPREHENSIVE CANCER CENTER	225 WILLIAMSON STREET	ELIZABETH	NJ	07202	UNION	(908) 994-8000	(908) 994-8748	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1503	TRINITAS CRANFORD DIALYSIS	205 BIRCHWOOD AVENUE	CRANFORD	NJ	07016	UNION	(908) 994-6660	(908) 994-5134	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1031	TRINITAS HEALTH CENTER - JEFFERSON AVENUE	65 JEFFERSON AVENUE	ELIZABETH	NJ	07201	UNION	(908) 994-5094	(908) 994-5631	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1048	TRINITAS HIV CLINIC	655 LIVINGSTON STREET	ELIZABETH	NJ	07206	UNION	(908) 994-7605	(908) 994-7301	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1177	TRINITAS HOSPITAL ADDICTION SERVICES	654 EAST JERSEY STREET	ELIZABETH	NJ	07206	UNION	(908) 994-7556	(908) 994-7170	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1027	TRINITAS HOSPITAL DOROTHY B HERSH CLINIC	655 EAST JERSEY STREET	ELIZABETH	NJ	07208	UNION	(908) 994-5112	(908) 994-5574	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1479	TRINITAS REGIONAL MEDICAL CENTER PRIMARY CARE SATELLITE	654 EAST JERSEY STREET	ELIZABETH	NJ	07206	UNION	(908) 994-7271	(908) 994-6054	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1279	TRINITAS REGIONAL MEDICAL CENTER SLEEP	2 JACKSON DRIVE, HOMEWOOD SUITES	CRANFORD	NJ	07016	UNION	(908) 994-8694	(908) 351-8697	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1041	TRINITAS RENAL DIALYSIS SATELLITE	629 LIVINGSTON STREET	ELIZABETH	NJ	07206	UNION	(908) 994-7011	(908) 994-7025	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1049	TRINITAS SUBSTANCE ABUSE CLINIC	655 EAST JERSEY STREET	ELIZABETH	NJ	07206	UNION	(908) 994-7438	(908) 994-7191	TRINITAS REGIONAL MEDICAL CENTER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1425	WOUND HEALING PROGRAM AT UNION CAMPUS	1000 GALLOPING HILL ROAD	UNION	NJ	07083	UNION	(908) 522-6300		OVERLOOK MEDICAL CENTER
LONG TERM CARE FACILITY	062018	RAHWAY GARDEN GROUP LLC	1777 LAWRENCE STREET	RAHWAY	NJ	07065	UNION	(732) 499-7927		RAHWAY GARDEN GROUP LLC
LONG TERM CARE FACILITY	062020	AristaCare at Norwood Terrace	40 NORWOOD AVENUE	PLAINFIELD	NJ	07060	UNION	(908) 769-1400	(908) 769-8092	NORWOOD TERRACE NURSING AND REHABILITATION CENTER
LONG TERM CARE FACILITY	062017	Linden Garden Estates	400 W STIMPSON AVE	LINDEN	NJ	07036	UNION	(908) 862-3399	(908) 862-6967	LINDEN GARDEN ESTATES, LLC

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
LONG TERM CARE FACILITY	062002	Ashbrook Care & Rehabilitation Center	1610 RARITAN ROAD	SCOTCH PLAINS	NJ	07076	UNION	(908) 889-5500	(908) 889-6573	ASHBROOK CARE & REHABILITATION CENTER, LLC
LONG TERM CARE FACILITY	062016	Autumn Lake Healthcare At Berkeley Heights	35 COTTAGE STREET	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 897-1000	(908) 425-4546	BHEIGHTS ASSOCIATES, LLC
LONG TERM CARE FACILITY	12006L	Care Connection Rahway	865 STONE STREET	RAHWAY	NJ	07065	UNION	(732) 499-6460	(732) 388-4111	CARE CONNECTION RAHWAY, LLC
LONG TERM CARE FACILITY	22249L	Children's Specialized Hospital	150 NEW PROVIDENCE ROAD	MOUNTAINSIDE	NJ	07092	UNION	(908) 233-3720	(908) 301-5587	CHILDREN'S SPECIALIZED HOSPITAL
LONG TERM CARE FACILITY	062211	Clark Nursing And Rehabilitation Center	1213 WESTFIELD AVENUE	CLARK	NJ	07066	UNION	(732) 396-7100	(732) 396-1924	CLARK NURSING & REHABILITATION CENTER, LLC
LONG TERM CARE FACILITY	062013	COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD	WESTFIELD	NJ	07090	UNION	(908) 233-9700	(908) 233-4266	COMPLETE CARE AT WESTFIELD, LLC
LONG TERM CARE FACILITY	062022	Complete Care at Woodlands	1400 WOODLAND AVE	PLAINFIELD	NJ	07060	UNION	(908) 753-1113	(908) 753-9558	COMPLETE CARE AT WOODLANDS LLC
LONG TERM CARE FACILITY	20016	Continuing Care At Lantern Hill	537 MOUNTAIN AVENUE	NEW PROVIDENCE	NJ	07974	UNION	(908) 516-9400	(908) 516-9425	LANTERN HILL, INC.
LONG TERM CARE FACILITY	062004	Cornell Hall Care & Rehabilitation Center	234 CHESTNUT STREET	UNION	NJ	07083	UNION	(908) 687-7800	(908) 687-1417	CORNELL HALL CARE & REHABILITATION CENTER, LLC
LONG TERM CARE FACILITY	062005	Cranford Park Rehabilitation & Healthcare Center	600 LINCOLN PARK EAST	CRANFORD	NJ	07016	UNION	(908) 276-7100	(908) 276-0173	CRANFORD PARK REHABILITATION & HEALTHCARE CTR, LLC
LONG TERM CARE FACILITY	062006	Crnc Operating LLC	205 BIRCHWOOD AVE	CRANFORD	NJ	07016	UNION	(908) 272-6660	(908) 276-2424	CRNC OPERATING, LLC
LONG TERM CARE FACILITY	62007X	Elizabeth Nursing And Rehab Center	1048 GROVE STREET	ELIZABETH	NJ	07202	UNION	(908) 354-0002	(908) 354-0033	BRACHA, INC.
LONG TERM CARE FACILITY	32003	Elmora Hills Health & Rehabilitation Center	225 W JERSEY STREET	ELIZABETH	NJ	07202	UNION	(908) 353-1220	(908) 353-0102	ELMORA HILLS HEALTH & REHABILITATION CENTER, LLC
LONG TERM CARE FACILITY	062009	HACKENSACK MERIDIAN AMBULATORY CARE, INC.	1340 PARK AVE	PLAINFIELD	NJ	07060	UNION	(908) 754-3100	(908) 754-3418	HACKENSACK MERIDIAN AMBULATORY CARE, INC
LONG TERM CARE FACILITY	602030	Plaza Healthcare & Rehabilitation Center	456 RAHWAY AVENUE	ELIZABETH	NJ	07202	UNION	(908) 354-1300	(908) 629-9610	PLAZA HEALTHCARE & REHABILITATION CENTER, LLC
LONG TERM CARE FACILITY	062021	ProMedica Skilled Nursing and Rehabilitation - Mountainside	1180 ROUTE 22 WEST	MOUNTAINSIDE	NJ	07092	UNION	(908) 654-0020	(800) 504-0270	MANOR CARE OF MOUNTAINSIDE NJ, LLC
LONG TERM CARE FACILITY	22001L	Runnells Center for Rehabilitation & Healthcare	40 WATCHUNG WAY	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 771-5700	(908) 771-9654	RUNNELLS OPERATING LLC
LONG TERM CARE FACILITY	062023	South Mountain Healthcare & Rehabilitation	2385 SPRINGFIELD AVENUE	VAUXHALL	NJ	07088	UNION	(908) 688-3400	(908) 964-7502	SOUTH MOUNTAIN REHABILITATION CENTER LLC
LONG TERM CARE FACILITY	062008	Spring Grove Rehabilitation and Healthcare Center	144 GALES DRIVE	NEW PROVIDENCE	NJ	07974	UNION	(908) 464-8600	(908) 464-3969	SPRING GROVE OPERATOR, LLC
LONG TERM CARE FACILITY	12001L	Trinitas Hospital	655 EAST JERSEY STREET	ELIZABETH	NJ	07206	UNION	(908) 994-7525	(908) 994-7047	TRINITAS REGIONAL MEDICAL CENTER

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
PEDIATRIC COMMUNITY TRANSITIONAL HOMES	23965	AIDS RESOURCE FOUNDATION FOR CHILDREN/ST. CLARES ELIZABETH	643 PEARL STREET	ELIZABETH	NJ	07202	UNION	(908) 351-8746	(908) 355-1708	SAINT CLARE'S HOMES FOR CHILDREN
PSYCHIATRIC HOSPITAL	52006	SUMMIT OAKS HOSPITAL	19 PROSPECT ST	SUMMIT	NJ	07901	UNION	(908) 522-7000	(908) 522-7098	SUMMIT OAKS HOSPITAL
PSYCHIATRIC SPECIAL HOSPITAL	22001	CORNERSTONE BEHAVIORAL HEALTH HOSPITAL OF UNION COUNTY	40 WATCHUNG WAY	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 771-5857	(908) 771-5820	COUNTY OF UNION
SPECIAL HOSPITAL	24426	CARE ONE AT TRINITAS REGIONAL MEDICAL CENTER	225 WILLIAMSON ST 7 NORTH	ELIZABETH	NJ	07207	UNION	(908) 994-5412	(908) 994-8860	THE REHABILITATION HOSPITAL AT RARITAN BAY MEDICAL
SPECIAL HOSPITAL	23268	KINDRED HOSPITAL NEW JERSEY-RAHWAY	865 STONE STREET	RAHWAY	NJ	07065	UNION	(732) 669-8200	(732) 669-8229	KINDRED HOSPITALS EAST, LLC
SURGICAL PRACTICE	R24592	CARDIOVASCULAR CARE GROUP, THE	433 CENTRAL AVENUE - 2ND FLOOR	WESTFIELD	NJ	07090	UNION	(973) 759-9000	(973) 759-2487	THE CARDIOVASCULAR CARE GROUP, PC
SURGICAL PRACTICE	R24618	MED FEM AESTHETIC CENTER	33 OVERLOOK ROAD, SUITE 302	SUMMIT	NJ	07901	UNION	(908) 522-1777	(908) 522-3051	MED FEM AESTHETIC CENTER
SURGICAL PRACTICE	R24840	SPRINGFIELD SURGERY CENTER, L.L.C.	105 MORRIS AVENUE, FIRST FLOOR	SPRINGFIELD	NJ	07081	UNION	(973) 718-5550	(973) 376-0729	SPRINGFIELD SURGERY CENTER, LLC
SURGICAL PRACTICE	R24587	WESTFIELD PLASTIC SURGICAL CENTER	955 SO SPRINGFIELD AVENUE, BLDG A, SUITE 105	SPRINGFIELD	NJ	07081	UNION	(908) 654-6540	(908) 654-6504	WESTFIELD PLASTIC SURGICAL CENTER

Health Resources
For
Union County

Part 2: Mental Health Services

Source: Department of Human Services, Division of Mental Health and Addiction Services
Download Oct 3, 2022

Union County

Acute Care Family Support

Mental Health Association in NJ
88 Pompton Avenue
Verona, NJ 07044
(973) 571-4100

Deaf Enhanced Screening Center

Trinitas Regional Medical Center
925 East Jersey Street
Elizabeth, NJ 07201
(908) 994-8131

Homeless Services (PATH)

Bridgeway Rehabilitation Services
265 West Grand Street
Elizabeth, NJ 07202
(908) 249-4100

Integrated Case Management Services Mt. Carmel Guild Behavioral Healthcare
505 South Avenue East
Cranford, NJ 07016
(908) 497-3918

Involuntary Outpatient Commitment

Trinitas Regional Medical Center
654 East Jersey Street
Elizabeth, NJ 07206
(908) 994-7543

Outpatient

Trinitas Regional Medical Center - Dept. of Psychiatry 655 East Jersey Street
Elizabeth, NJ 07201
(908) 994-7278

Outpatient

UCPC Behavioral Healthcare 117-119 Roosevelt Avenue
Plainfield, NJ 07060
(908) 756-6870 (press #4)

Partial Care

UCPC Behavioral Healthcare 117-119 Roosevelt Avenue
Plainfield, NJ 07060
(908) 756-6870 (press #3), (908) 686-0560 or (973) 571-4100

County Mental Health Board

Union County Administration Building
Elizabethtown Plaza
Elizabeth, NJ 07207
(908) 527-4844

Deaf Enhanced STCF

Trinitas Regional Medical Center
655 East Jersey Street
Elizabeth, NJ 07201
(908) 994-7205 / 7202
HOTLINE: (908) 351-6684

Intensive Family Support Services

Mental Health Association in NJ
361-363 Monroe Avenue
Kenilworth, NJ 07033
(908) 272-5309

Intensive Outpatient Treatment and Support Services (IOTSS)

TLC Program at Trinitas Regional Medical Center
654 East Jersey Street
Elizabeth, NJ 07206
(908) 994-7278

(908) 994-7131 (after hours)

Justice Involved Services

Trinitas Regional Medical Center
655 East Jersey Street
Elizabeth, NJ 07206
(908) 994-7278 or (908) 994- 7131

Outpatient

Mt. Carmel Guild Behavioral Healthcare
108 Alden Street
Cranford, NJ 07016
(908) 497-3904 / 3925 / 3919

Partial Care

Mt. Carmel Guild Behavioral Healthcare
1160 Raymond Boulevard
Newark, NJ 07102
(973) 596-3971 or (908) 497-3968

Partial Care

Trinitas Regional Medical Center - Dept. of Psychiatry
655 East Jersey Street
Elizabeth, NJ 07201
(908) 497-3968 or call center (908) 994-7131

Union County (Continued)

Partial Care

Bridgeway House
567 Morris Avenue
Elizabeth, NJ 07208
(908) 355-7200

PRIMARY SCREENING CENTER for UNION

Trinitas Regional Medical Center
655 East Jersey Street
Elizabeth, NJ 07201
HOTLINE: (908) 994-7131

Emergency Services - Affiliated w/Screening Center

Overlook Hospital
99 Beavior @ Silvan Road
Summit, NJ 07901
HOTLINE: (201) 841-8078

Program of Assertive Community Treatment (PACT)

Bridgeway Rehabilitation, Inc.
313 E. Front Street
Plainfield, NJ 07060
(908) 791-0505 (PACT II)

Residential Services

Volunteers of America
205 West Milton Avenue
Rahway, NJ 07065
(732) 827-2444

Residential Services

SERV Centers of NJ
130 Dermody Street
Cranford, NJ 07016
(908) 276-0490

Partial Care

Bridgeway House
567 Morris Avenue
Elizabeth, NJ 07208
(908) 355-7200

Emergency Services - Affiliated w/Screening Center

RWJ University Hospital Rahway
865 Stone Street
Rahway, NJ 07065
HOTLINE: (732) 499-6165 or (732) 381-4949

Program of Assertive Community Treatment (PACT)

Bridgeway Rehabilitation, Inc.
96 W. Grand Street
Elizabeth, NJ 07202
(908) 352-0242 (PACT I)

Program of Assertive Community Treatment (PACT)

Bridgeway Rehabilitation, Inc.
1023 Commerce Avenue
Union, NJ 07083
(908) 688-5400 (PACT III)

Self-Help Center

New Beginnings SHC
516 Morris Avenue - 1st floor
Elizabeth, NJ 07208
(908) 352-7830

Self-Help Center

Park Avenue SHC
333 Park Avenue
Plainfield, NJ 07060
(908) 757-1350

Self-Help Center

Esperanza
673 Morris Ave., Suite 100
Springfield, NJ 07080
908-810-1001
(Spanish-speaking staff)

Union County (Continued)

Short Term Care Facility
Trinitas Regional Medical Center
655 East Jersey Street
Elizabeth, NJ 07026
(908) 994-7275

Supported Employment Services Bridgeway House
1023 Commerce Street
Elizabeth, NJ 07208
(908) 687-9666

Community Support Services & Medically Enhanced Community Support Services
Bridgeway House
265 West Grand Street
Elizabeth, NJ 07208
(908) 249-4100

Voluntary Unit
Trinitas Regional Medical Center
655 East Jersey Street
Elizabeth, NJ 07206
(908) 994-7205

Supported Education
Bridgeway Rehabilitation Services
LEARN of Central NJ
1023 Commerce Street, 2nd Floor
Union, NJ
07083 (908)
687-9666

Community Support Services
Advance Housing, Inc.
100 Hollister Road - Suite 203
Teterboro, NJ 07608
(201) 498-9140

Systems Advocacy
Community Health Law Project
65 Jefferson Street
Elizabeth, NJ 07201
(908) 355-8282

Systems Advocacy
United Family & Children's Society
305 West 7th Street
Plainfield, NJ 07060
(908) 755-4848

Health Resources
For
Union County

Part 3: Addiction Health Services

Source: Department of Human Services, Division of Mental Health and Addiction
Download Oct 3, 2022

Addiction Services at Overlook Medical Center
License No:2000091
Agency Type: Non-Profit
Phone No:9085224800

Services:
- Intensive Outpatient Treatment
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
2 WALNUT STREET
SUMMIT NJ 07902
County: Union

American Day CD Centers, LLC d/b/a/ High Focus Centers
License No:2000537
Agency Type: Profit
Phone No:9082722474

Services:
- Intensive Outpatient Treatment
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
16 COMMERCE DRIVE
CRANFORD NJ 07016
County: Union

Brick City Medical LLC d/b/a Suburban Health Clinic
License No:2000828
Agency Type:Profit
Phone No:9082588765

Services:
- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Opiate Treatment Program
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
43 Progress Street
Union NJ 07083
County: Union

Bridgeway Rehabilitation Services
License No: 2000048
Agency Type: Non-Profit
Phone No: 7322614962

Services:
- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
567 MORRIS AVE
ELIZABETH NJ 07208
County: Union

Chukwuemeka Ibeku MD/DO
NPI Number:1023059722
Phone No: 908-686-9440

Services:
- Medication-Assisted Treatment

Address:
940 Stuyvesant Ave
2
Union New Jersey 07083
County: Union

Counseling Center at Clark, LLC
License No: 2000538
Agency Type:Unknown

Services:
- Co-Occurring Treatment Services
- Intensive Outpatient Treatment

Address:
60 WALNUT AVENUE
SUITE 201
CLARK NJ 07066

Phone No: 7328821920

- Outpatient Treatment
- Partial Care

IDRC affiliated: **Yes**

County: Union

Intervention Specialist
License No: 2000618
Agency Type: Profit
Phone No: 9082890700

Services:
- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

IDRC affiliated: **Yes**

Address:
333 North Broad Street
Suite B
Elizabeth NJ 07208
County: Union

Ludmila Gudz ATMD
NPI Number: 1386747806
Phone No: 9086240090

Services:
- Medication-Assisted Treatment

Address:
2333 Morris Ave # B-115

Union New Jersey 07083
County: Union

Manfred Obi MD/DO
NPI Number: 1467634360
Phone No: 973-951-0653

Services:
- Medication-Assisted Treatment

Address:
1235 Morris Ave Ste 1
Union New Jersey 07083
County: Union

Olubunmi Adetule NP
NPI Number: 1245786979
Phone No: 908-276-2244

Services:
- Medication-Assisted Treatment

Address:
11 Dundar Rd
Springfield New Jersey 07081
County: Union

Organization for Recovery, Inc.
License No: 2000304
Agency Type: Unknown
Phone No: 9087694700

Services:
- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Opiate Treatment Program
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
519 North Ave
Plainfield NJ 07060
County: Union

Organization For Recovery, Inc.
License No: 2000427
Agency Type: Unknown
Phone No: 9087694700

Services:
- Co-Occurring Treatment Services
- Opiate Treatment Program
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
120 W 7TH ST
PLAINFIELD NJ 07060
County: Union

PROCEED, Inc.

Services:

Address:

License No: 2000311
Agency Type: Non-Profit
Phone No: 9083517727

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

IDRC affiliated: **Yes**

1122-1130 E GRAND ST
ELIZABETH NJ 07201
County: Union

PROCEED, Inc.
License No: 2000634
Agency Type: Non-Profit
Phone No: 9083517727

Services:

- Co-Occurring Treatment Services
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
1126 DICKINSON STREET
ELIZABETH NJ 07201
County: Union

Real House, Inc.
License No: 1000148
Agency Type: Unknown
Phone No: 9085272400

Services:

- Co-Occurring Treatment Services
- Halfway House Substance Abuse Treatment
  Beds Capacity: 26 Available:2

IDRC affiliated: **Yes**

Address:
419-421 WESTMINSTER AVENUE
ELIZABETH NJ 07208
County: Union

Real House,Inc.
License No: 1000154
Agency Type: Profit
Phone No: 9737462400

Services:

- Co-Occurring Treatment Services
- Halfway House Substance Abuse Treatment
  Beds Capacity: 26 Available:2

IDRC affiliated: **Yes**

Address:
1089-91 East Jersey Street
Elizabeth NJ 07201
County: Union

SBH Union IOP, LLC
License No: 2000591
Agency Type: Profit
Phone No: 9084815050

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

IDRC affiliated: **Yes**

Address:
2780 MORRIS AVENUE
SUITE 2D
UNION NJ 07083
County: Union

Social Clubhouse Inc.
License No: 2000617
Agency Type: Unknown
Phone No: 9733762500

Services:

- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment

Address:
58 Brown Avenue
Springfield NJ 07081
County: Union

IDRC affiliated: **Yes**

Suzanne Zemel MD
NPI Number: 1467507681
Phone No: 9737964222

Services:
- Medication-Assisted Treatment

Address:
123W 7th St
Plainfield New Jersey 07060
County: Union

Suzanne Zemel MD
NPI Number: 1467507681
Phone No: 9737964222

Services:
- Medication-Assisted Treatment

Address:
161Wilder Dr
Hillside New Jersey 07205
County: Union

The Lennard Clinic, Inc.
License No: 2000417
Agency Type: Unknown
Phone No: 9083520850

Services:
- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Opiate Treatment Program
- Outpatient Treatment
- Partial Care

IDRC affiliated: **Yes**

Address:
850WOODRUFF LN
ELIZABETH NJ 07201
County: Union

Trinitas Hospital/Addiction Services
License No: 2000101
Agency Type: Non-Profit
Phone No: 9089947556

Services:
- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

IDRC affiliated: **Yes**

Address:
654E JERSEY ST
ELIZABETH NJ 07206
County: Union

Union Fresh Start LLC
License No: 1000094
Agency Type: Profit
Phone No: 9084814400

Services:
- Long Term Residential Substance Abuse Treatment
  Beds Capacity: 32
  Available:2
- Inpatient Withdrawal Management
  Beds Capacity: 40
  Available:7

IDRC affiliated: **Yes**

Address:
1000Galloping Hill Rd.
Union NJ 07083
County: Union

Appendix E- Additional Data Tables

Population Overview

Table 8. Union County CHNA Survey Respondent Sample Characteristics (N=443), 2021

Survey Respondent Characteristics	n=443		
Age		**Income**	
Under 30	6.6%	Under $25,000	6.2%
30 to 49	35.5%	$25,000 to $50,000	12.9%
50 to 64	33.4%	$50,001 to $100,000	18.9%
65+	24.5%	$100,001 to $125,000	11.7%
Gender		$125,001 to $150,000	14.7%
Female	73.3%	$150,001 to $200,000	15.2%
Male	26.0%	Over $200,000	20.4%
Additional Gender Category/ Transgender	0.7%*	**Employment**	
Race/Ethnicity		Employed full-time	56.3%
African American/ Black	15.0%	Employed part-time	12.2%
Asian	6.1%	Student	3.0%
Hispanic/ Latino, Latino(a)	8.5%	Homemaker	3.4%
Multiracial	2.8%	Disabled	3.0%
White/ Caucasian	65.7%	Retired	17.9%
Other	2.0%	Unemployed	4.3%
Sexual Orientation		**Marital Status**	
Heterosexual	94.9%	Married	63.7%
Homosexual	0.0%	Single	18.3%
Bisexual	2.9%	Separated/divorced/widowed	13.3%
Additional Sexual Orientation	2.2%	Domestic partnership/civil union/living together	4.7%
Education			
Less than high school graduate or GED	0.9%*		
High school graduate or GED	7.7%		
Some college	10.0%		
Associate or technical degree/certification	10.9%		
College graduate	31.1%		
Post graduate or professional degree	39.5%		

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

Table 9. Total Population, by Gender, State, and County, 2011-2015 and 2016-2020

	2015		2020		% change	
	Male	Female	Male	Female	Male	Female
New Jersey	48.8%	51.2%	48.9%	51.1%	0.1%	-0.1%
Union County	48.7%	51.3%	48.8%	51.2%	0.1%	-0.1%
Clark	47.3%	52.7%	51.0%	49.0%	3.7%	-3.7%
Cranford	47.6%	52.4%	49.2%	50.8%	1.6%	-1.6%
Elizabeth (07201)	51.6%	48.4%	51.2%	48.8%	-0.4%	0.4%
Elizabeth (07202)	50.0%	50.0%	49.2%	50.8%	-0.8%	0.8%
Elizabethport (07206)	48.9%	51.1%	48.5%	51.5%	-0.4%	0.4%
Elizabeth (07208)	48.3%	51.7%	49.1%	50.9%	0.8%	-0.8%
Linden	48.3%	51.7%	48.1%	51.9%	-0.2%	0.2%
Rahway	48.4%	51.6%	50.6%	49.4%	2.2%	-2.2%
Roselle	44.6%	55.4%	46.9%	53.1%	2.3%	-2.3%
Middlesex County	49.2%	50.8%	49.3%	50.7%	0.1%	-0.1%
Avenel	59.6%	40.4%	58.4%	41.6%	-1.2%	1.2%
Carteret	48.4%	51.6%	49.0%	51.0%	0.6%	-0.6%
Colonia	47.1%	52.9%	47.2%	52.8%	0.1%	-0.1%

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

Table 10. Percent Change in Racial and Ethnic Distribution, by Town, 2011-2020

	Asian			Black or African-American			Hispanic/ Latino			White, NH			Other Race, NH		
	2015	2020	% change	2015	2020	% change	2015	2020	% change	2015	2020	% change	2015	2020	% change
Union County															
Clark	1.8%	3.8%	2.0%	1.2%	1.7%	0.5%	10.9%	10.1%	-0.8%	84.8%	83.7%	-1.1%	0.4%	0.5%	0.1%
Cranford	2.4%	3.7%	1.3%	3.2%	2.1%	-1.1%	8.1%	7.8%	-0.3%	84.7%	83.0%	-1.7%	0.1%	1.6%	1.5%
Elizabeth (07201)	0.5%	0.8%	0.3%	24.2%	22.6%	-1.6%	59.8%	60.2%	0.4%	13.4%	13.9%	0.5%	1.5%	0.9%	-0.6%
Elizabeth (07202)	2.1%	1.8%	-0.3%	11.9%	14.6%	2.7%	65.4%	66.5%	1.1%	16.1%	13.7%	-2.4%	2.7%	2.8%	0.1%
Elizabeth -port (07206)	0.4%	0.6%	0.2%	18.8%	19.3%	0.5%	70.5%	67.2%	-3.3%	8.9%	8.1%	-0.8%	1.1%	2.8%	1.7%
Elizabeth (07208)	3.6%	3.0%	-0.6%	16.7%	18.2%	1.5%	60.5%	60.2%	-0.3%	17.3%	15.9%	-1.4%	0.9%	1.8%	0.9%
Linden	2.4%	3.3%	0.9%	26.7%	28.7%	2.0%	30.7%	31.7%	1.0%	38.0%	33.4%	-4.6%	0.7%	0.6%	-0.1%
Rahway	3.9%	6.1%	2.2%	30.7%	28.6%	-2.1%	26.8%	29.3%	2.5%	35.4%	32.7%	-2.7%	1.2%	1.3%	0.1%
Roselle	2.9%	1.3%	-1.6%	51.3%	45.8%	-5.5%	28.5%	33.2%	4.7%	15.6%	12.8%	-2.8%	1.1%	4.5%	3.4%
Middlesex County															
Avenel	21.3%	21.2%	-0.1%	23.8%	20.7%	-3.1%	15.8%	22.1%	6.3%	37.2%	34.3%	-2.9%	0.5%	1.1%	0.6%
Carteret	22.3%	24.9%	2.6%	12.5%	9.9%	-2.6%	29.1%	37.3%	8.2%	34.4%	26.1%	-8.3%	0.6%	0.5%	-0.1%
Colonia	13.0%	13.6%	0.6%	3.8%	5.8%	2.0%	11.8%	13.5%	1.7%	69.7%	64.7%	-5.0%	0.4%	0.5%	0.1%

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

Table 11. 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%
Union County	24.5%	22.6%	8.7%	8.1%	27.2%	25.9%	27.2%	27.2%	7.6%	8.7%	5.0%	7.6%
Clark	25.0%	15.0%	8.5%	6.2%	24.9%	28.4%	24.4%	25.6%	8.9%	11.5%	8.3%	13.3%
Cranford	26.8%	20.8%	6.1%	5.2%	23.3%	23.2%	28.9%	27.8%	8.2%	9.3%	6.7%	13.7%
Elizabeth (07201)	23.7%	27.6%	8.8%	6.7%	33.9%	31.4%	24.5%	24.0%	5.2%	5.8%	4.0%	4.4%
Elizabeth (07202)	24.0%	22.8%	11.8%	9.5%	29.3%	27.9%	24.0%	25.0%	6.4%	8.0%	4.6%	6.7%
Elizabeth-port (07206)	30.4%	29.2%	10.3%	12.5%	29.4%	26.9%	24.0%	22.0%	4.4%	4.5%	1.5%	5.0%
Elizabeth (07208)	27.2%	26.3%	8.5%	9.7%	27.5%	25.7%	27.1%	25.3%	6.0%	8.0%	3.6%	4.9%
Linden	22.3%	19.8%	7.3%	8.1%	28.4%	27.2%	29.7%	27.9%	7.4%	9.2%	4.8%	7.7%
Rahway	21.8%	18.2%	10.4%	6.5%	30.6%	31.2%	26.1%	25.4%	7.0%	10.0%	4.1%	8.8%
Roselle	24.0%	19.6%	11.9%	11.9%	26.6%	24.5%	24.2%	27.6%	7.2%	9.4%	6.0%	6.9%
Middesex County												
Avenel	18.3%	24.2%	4.1%	6.7%	33.6%	26.4%	34.3%	26.4%	7.0%	9.8%	2.6%	6.6%
Carteret	25.6%	20.4%	6.5%	8.8%	28.3%	27.1%	28.0%	28.9%	6.6%	6.0%	5.0%	8.8%
Colonia	20.5%	19.4%	7.0%	6.3%	26.2%	23.4%	28.2%	29.9%	11.7%	11.1%	6.4%	10.0%

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

Racial, Ethnic, and Language Diversity

Table 12. 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%
Union County	13.8%	3.9%	22.1%	17.4%	5.2%	3.2%
Middlesex County	16.6%	5.5%	22.0%	15.8%	4.3%	2.7%
	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%
Union County	13.9%	6.0%	18.0%	18.3%	5.2%	3.7%
Middlesex County	14.5%	7.7%	18.6%	18.2%	4.4%	2.6%
	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%
Union County	18.7%	6.4%	20.8%	15.5%	3.3%	2.2%
Middlesex County	19.5%	7.3%	20.2%	14.8%	3.0%	1.9%

	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%
Union County	12.7%	4.5%	14.6%	20.6%	7.6%	6.4%
Middlesex County	10.0%	5.7%	14.7%	20.5%	8.4%	6.9%
	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%
Union County	29.8%	11.1%	32.6%	20.4%	3.9%	2.2%
Middlesex County	30.4%	9.0%	31.8%	21.7%	4.1%	3.1%

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.

Table 13. Racial and Ethnic Distribution, by Town, 2016-2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/ Latino	White, Non-Hispanic	Other Race/ Ethnicity, Non-Hispanic
Union County					
Clark	3.8%	1.7%	10.1%	83.7%	0.5%
Cranford	3.7%	2.1%	7.8%	83.0%	1.6%
Elizabeth (07201)	0.8%	22.6%	60.2%	13.9%	0.9%
Elizabeth (07202)	1.8%	14.6%	66.5%	13.7%	2.8%
Elizabethport (07206)	0.6%	19.3%	67.2%	8.1%	2.8%
Elizabeth (07208)	3.0%	18.2%	60.2%	15.9%	1.8%
Linden	3.3%	28.7%	31.7%	33.4%	0.6%
Rahway	6.1%	28.6%	29.3%	32.7%	1.3%
Roselle	1.3%	45.8%	33.2%	12.8%	4.5%
Middlesex County					
Avenel	21.2%	20.7%	22.1%	34.3%	1.1%
Carteret	24.9%	9.9%	37.3%	26.1%	0.5%
Colonia	13.6%	5.8%	13.5%	64.7%	0.5%

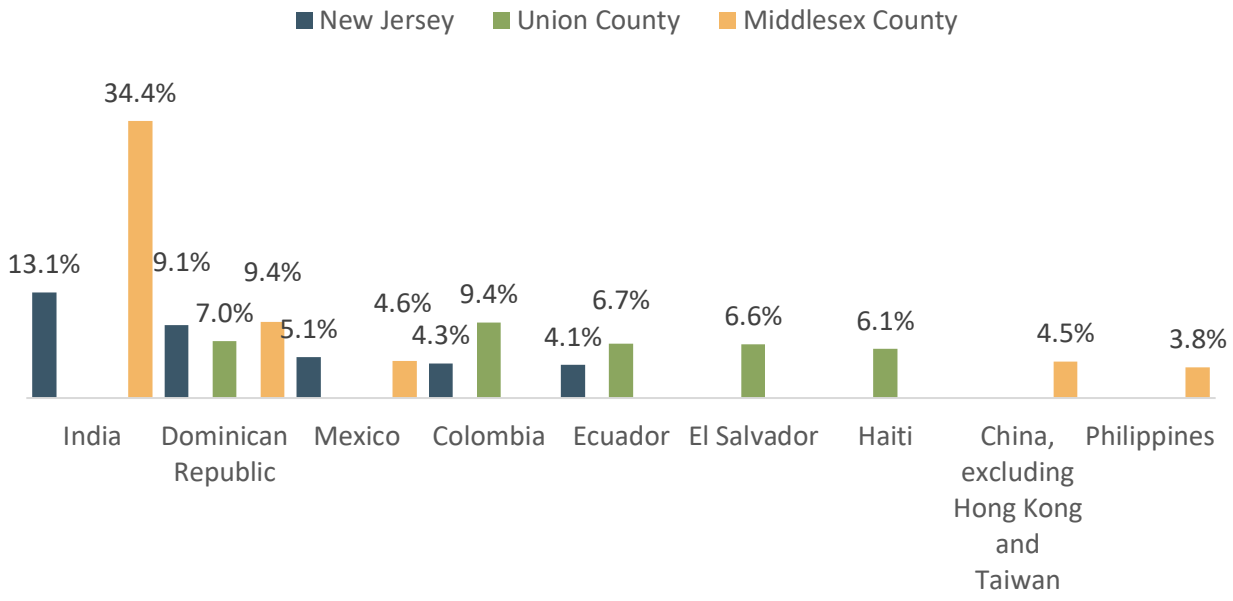
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 14. Racial and Ethnic Distribution, by Town, 2011-2015

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/ Latino	White, Non-Hispanic	Other Race/ Ethnicity, Non-Hispanic
Union County					
Clark	1.8%	1.2%	10.9%	84.8%	0.4%
Cranford	2.4%	3.2%	8.1%	84.7%	0.1%
Elizabeth (07201)	0.5%	24.2%	59.8%	13.4%	1.5%
Elizabeth (07202)	2.1%	11.9%	65.4%	16.1%	2.7%
Elizabethport (07206)	0.4%	18.8%	70.5%	8.9%	1.1%
Elizabeth (07208)	3.6%	16.7%	60.5%	17.3%	0.9%
Linden	2.4%	26.7%	30.7%	38.0%	0.7%
Rahway	3.9%	30.7%	26.8%	35.4%	1.2%
Roselle	2.9%	51.3%	28.5%	15.6%	1.1%
Middlesex County					
Avenel	21.3%	23.8%	15.8%	37.2%	0.5%
Carteret	22.3%	12.5%	29.1%	34.4%	0.6%
Colonia	13.0%	3.8%	11.8%	69.7%	0.4%

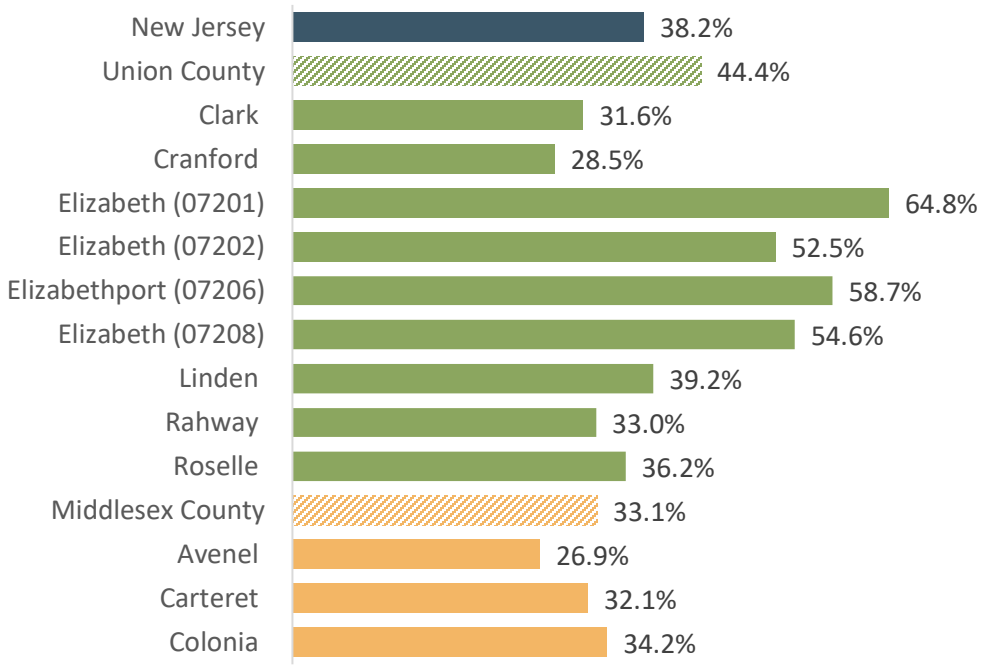
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015

Figure 75. Foreign-Born Population by Top Countries of Origin, by State and County, 2016-2020



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

Figure 76. 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

Education

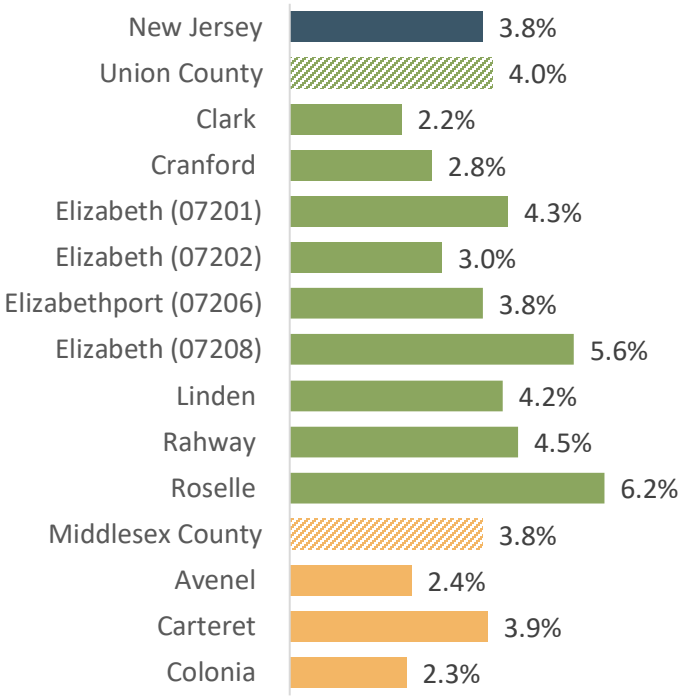
Figure 77. Educational Attainment among Adults 25 Years and Older, by Race/Ethnicity and Town, 2016-2020

	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%
Union County	92.3%	70.8%	90.7%	25.0%	74.4%	18.7%	93.5%	51.0%	69.3%	13.8%
Clark	89.3%	50.4%	89.4%	78.0%	87.1%	40.9%	93.7%	43.1%	94.4%	64.2%
Cranford	97.7%	82.2%	84.3%	8.7%	89.1%	39.4%	97.2%	61.4%	80.0%	45.2%
Elizabeth (07201)	76.7%	23.3%	81.0%	11.7%	74.0%	16.9%	82.4%	20.1%	74.5%	16.4%
Elizabeth (07202)	92.0%	32.2%	89.2%	13.0%	73.1%	9.4%	75.5%	17.1%	70.2%	5.8%
Elizabethport (07206)	73.0%	18.9%	80.9%	9.4%	55.6%	4.7%	78.2%	18.0%	55.0%	2.2%
Elizabeth (07208)	78.7%	58.0%	89.5%	18.8%	74.7%	19.2%	85.8%	28.2%	75.8%	16.9%
Linden	86.1%	60.2%	91.1%	24.8%	82.3%	21.2%	87.6%	21.9%	74.0%	16.4%
Rahway	98.5%	77.0%	90.6%	25.9%	81.9%	18.7%	94.6%	33.4%	81.6%	17.5%
Roselle	94.0%	61.8%	92.3%	19.9%	79.6%	16.5%	90.1%	36.4%	75.2%	10.2%
Middlesex County	92.9%	74.5%	93.1%	36.2%	75.2%	18.7%	93.6%	40.7%	74.0%	18.0%
Avenel	87.7%	64.7%	92.2%	16.6%	93.8%	14.0%	90.3%	14.9%	97.5%	33.0%
Carteret	78.8%	45.8%	98.8%	33.0%	75.3%	17.2%	87.6%	23.7%	62.9%	10.3%
Colonia	96.1%	66.0%	96.1%	53.3%	79.6%	26.6%	93.5%	37.0%	53.0%	12.3%

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

Employment and Workforce

Figure 78. Unemployment Rate among Civilian Labor Force, by State, County, and Town, 2016-2020



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

Table 15. Unemployment Rate by Gender, State, County, and Town, 2016-2020

	Female	Male
New Jersey	5.6%	5.4%
Union County	5.6%	5.0%
Clark	2.3%	4.4%
Cranford	1.7%	4.7%
Elizabeth (07201)	9.5%	2.4%
Elizabeth (07202)	3.8%	5.4%
Elizabethport (07206)	6.7%	4.4%
Elizabeth (07208)	7.5%	6.8%
Linden	5.2%	6.1%
Rahway	6.8%	6.6%
Roselle	10.1%	6.3%
Middlesex County	5.8%	4.9%
Avenel	4.7%	4.7%
Carteret	4.3%	4.6%
Colonia	4.5%	2.0%

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

Table 16. 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%
Union County	3.1%	7.7%	6.1%	4.7%	5.2%	0.0%	5.6%
Clark	2.2%	0.4%	1.4%	3.6%	-	-	7.9%
Cranford	2.1%	13.6%	5.5%	3.9%	-	-	11.4%
Elizabeth (07201)	0.0%	6.0%	6.8%	5.1%	25.4%	-	5.6%
Elizabeth (07202)	11.4%	7.4%	3.1%	4.9%	0.0%	-	3.5%
Elizabethport (07206)	9.4%	8.2%	4.7%	3.2%	0.0%	-	5.4%
Elizabeth (07208)	4.7%	6.7%	8.8%	5.6%	0.0%	-	5.3%
Linden	1.0%	8.4%	6.1%	4.3%	1.5%	0.0%	4.6%
Rahway	2.6%	6.8%	8.3%	5.3%	0.0%	-	5.1%
Roselle	7.7%	10.7%	5.8%	11.1%	-	-	3.2%
Middlesex County	5.2%	6.0%	6.0%	5.9%	4.0%	6.1%	7.2%
Avenel	7.3%	2.2%	3.1%	5.2%	0.0%	-	0.3%
Carteret	9.8%	5.0%	3.2%	7.4%	0.0%	30.0%	0.0%
Colonia	4.1%	4.7%	3.6%	3.2%	0.0%	-	9.0%

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

Table 17. Population Employed by Industry Type, State, County, and Town, 2016-2020

	Agriculture, forestry, fishing and hunting, and mining	Construction	Manufacturing	Wholesale trade	Retail trade	Transportation and warehousing, and utilities	Information	Finance and insurance, and real estate and rental and leasing	Professional, scientific, and management, and administrative and waste management services	Educational services, and health care and social assistance	Arts, entertainment, and recreation, and accommodation and food services	Other services, except public administration	Public administration
New Jersey	0.3%	5.9%	8.1%	3.3%	10.7%	6.4%	2.6%	8.5%	13.7%	24.1%	7.8%	4.2%	4.4%
Union County	0.2%	6.2%	8.9%	3.4%	10.0%	10.2%	2.4%	8.3%	12.9%	21.9%	6.9%	4.8%	3.9%
Clark	0.0%	6.3%	9.3%	7.6%	11.9%	5.5%	3.0%	5.4%	12.9%	25.3%	5.0%	3.8%	4.1%
Cranford	0.2%	4.3%	7.3%	3.1%	5.2%	4.2%	4.6%	13.6%	16.2%	26.6%	6.8%	4.2%	3.7%
Elizabeth (07201)	1.4%	11.6%	9.2%	3.8%	13.6%	14.6%	0.6%	1.5%	11.6%	12.9%	8.5%	7.5%	3.2%
Elizabeth (07202)	0.0%	7.7%	11.5%	3.8%	10.4%	19.2%	0.5%	3.4%	11.4%	19.1%	6.7%	4.0%	2.4%
Elizabethport (07206)	0.0%	8.8%	10.8%	6.1%	11.3%	20.2%	1.3%	1.6%	8.8%	16.3%	6.5%	6.3%	2.1%
Elizabeth (07208)	0.0%	7.6%	9.4%	4.6%	9.1%	13.5%	1.5%	3.6%	11.4%	19.8%	8.3%	6.1%	5.1%
Linden	0.0%	8.2%	7.8%	3.2%	11.4%	11.5%	1.9%	5.7%	9.7%	22.0%	6.0%	5.7%	6.8%
Rahway	0.1%	4.8%	11.3%	3.5%	11.0%	9.5%	2.8%	8.5%	12.8%	21.3%	6.0%	2.8%	5.6%
Roselle	0.0%	3.7%	5.7%	1.9%	15.1%	15.2%	2.1%	6.2%	6.8%	26.4%	8.0%	3.9%	5.0%
Middlesex County	0.1%	5.1%	8.6%	3.6%	10.4%	8.1%	2.7%	9.1%	16.3%	22.3%	6.1%	3.7%	3.8%
Avenel	0.0%	4.3%	7.3%	3.7%	11.7%	11.4%	4.9%	8.1%	13.5%	22.1%	6.7%	2.2%	4.1%
Carteret	0.1%	5.0%	10.2%	4.1%	15.1%	15.5%	2.4%	5.0%	10.7%	17.6%	6.3%	4.2%	3.7%
Colonia	0.0%	5.3%	7.6%	3.2%	13.9%	5.9%	2.3%	9.3%	13.5%	23.0%	7.3%	3.3%	5.4%

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

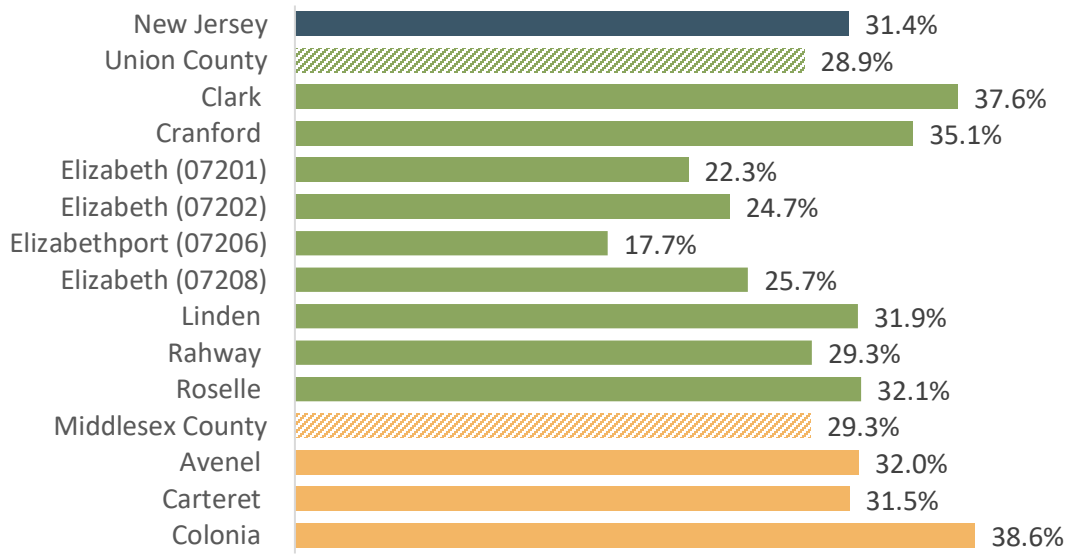
Income and Financial Security

Table 18. 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
Union County	$127,356	$65,964	$62,403	$108,476	$58,600	-	$60,715
Clark	$159,185	$76,730	$106,863	$107,961	-	-	$105,208
Cranford	$184,402	$41,625	$124,107	$135,809	-	-	$74,868
Elizabeth (07201)	$24,803	$44,113	$46,599	$61,375	-	-	$54,241
Elizabeth (07202)	$70,789	$52,463	$51,623	$51,812	$147,988	-	$50,694
Elizabethport (07206)	$84,904	$29,722	$49,036	$74,333	-	-	$50,794
Elizabeth (07208)	$68,179	$49,199	$47,173	$79,050	-	-	$50,174
Linden	$94,028	$72,353	$75,968	$75,954	-	-	$72,578
Rahway	$114,083	$70,188	$75,438	$84,443	-	-	$80,941
Roselle	$96,891	$59,255	$67,252	$70,000	-	-	$66,311
Middlesex County	$129,467	$79,063	$65,771	$90,473	$87,727	$40,000	$63,651
Avenel	$93,256	$71,484	$47,446	$78,199	-	-	$63,750
Carteret	$82,480	$84,197	$73,606	$68,139	-	-	-
Colonia	$139,904	$90,278	$96,029	$105,357	-	-	$70,451

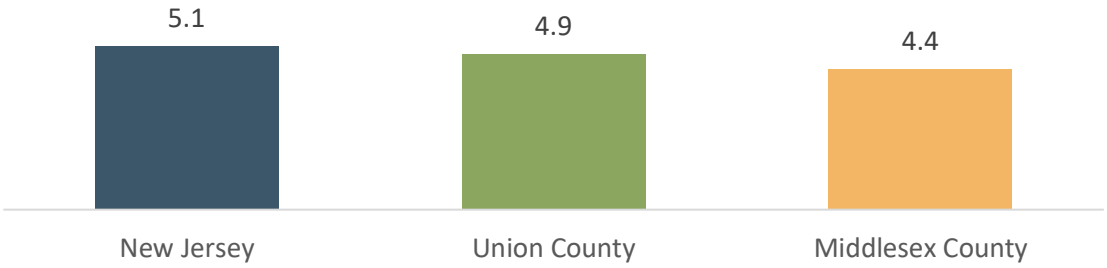
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 79. 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

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



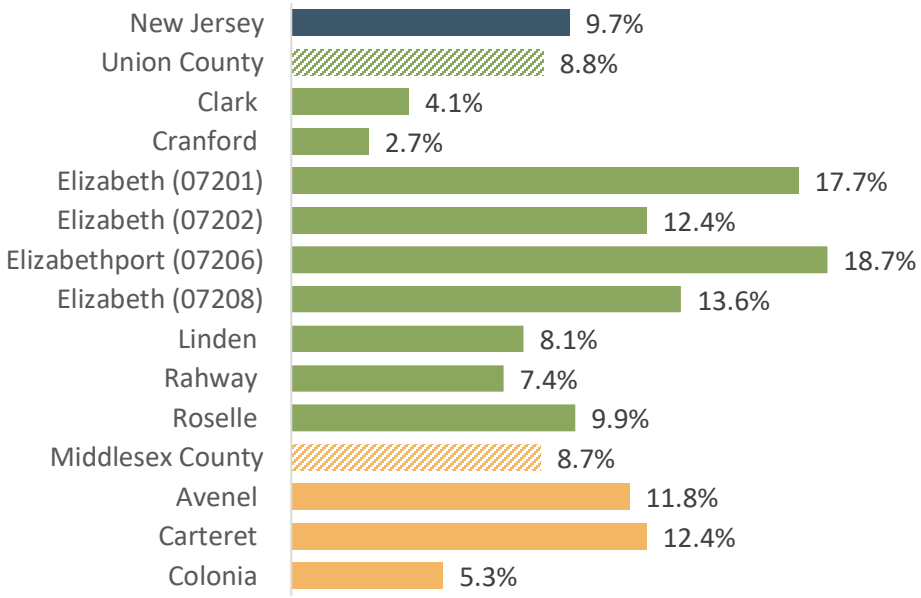
DATA SOURCE: U.S. Census Bureau, American Community Survey as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020
NOTE: The ratio of household income at the 80th percentile to that at the 20th percentile, where the incomes 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.

Table 19. 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%
Union County	4.7%	11.9%	12.5%	4.5%	14.4%
Clark	12.0%	1.6%	5.3%	3.7%	3.4%
Cranford	3.2%	16.9%	1.6%	2.3%	1.4%
Elizabeth (07201)	50.4%	21.0%	19.1%	8.2%	17.4%
Elizabeth (07202)	13.4%	20.4%	11.2%	10.3%	12.3%
Elizabethport (07206)	5.8%	25.4%	17.6%	9.3%	19.9%
Elizabeth (07208)	15.8%	9.7%	14.9%	8.8%	17.7%
Linden	11.0%	7.5%	8.3%	8.9%	10.5%
Rahway	2.1%	14.0%	4.9%	4.0%	2.9%
Roselle	7.2%	10.3%	7.3%	11.7%	5.9%
Middlesex County	5.4%	9.7%	16.5%	6.4%	19.1%
Avenel	5.4%	19.4%	17.6%	11.8%	3.0%
Carteret	17.2%	11.7%	15.3%	6.8%	37.6%
Colonia	3.8%	17.1%	16.1%	2.4%	48.9%

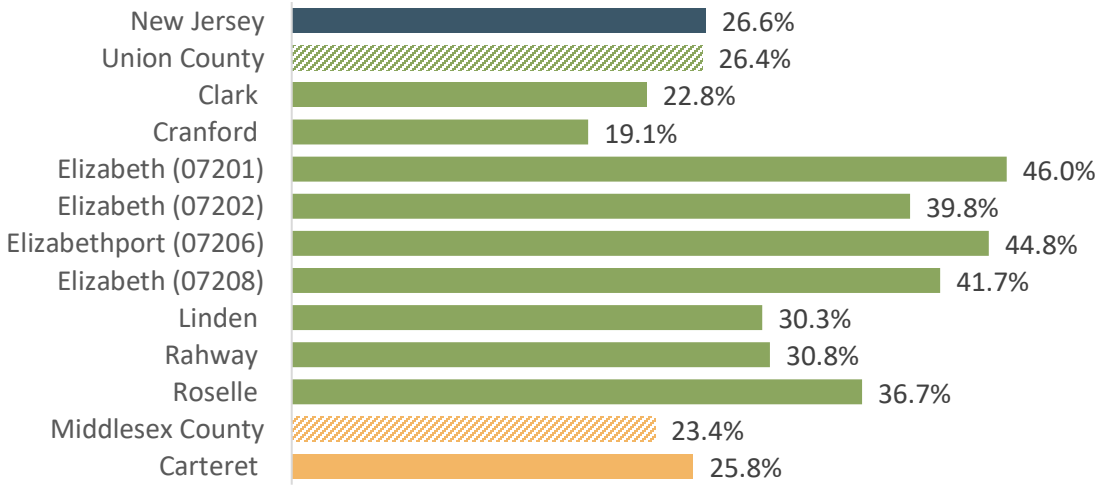
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 81. Individuals Below Poverty Level, by State, County, and Town, 2016-2020



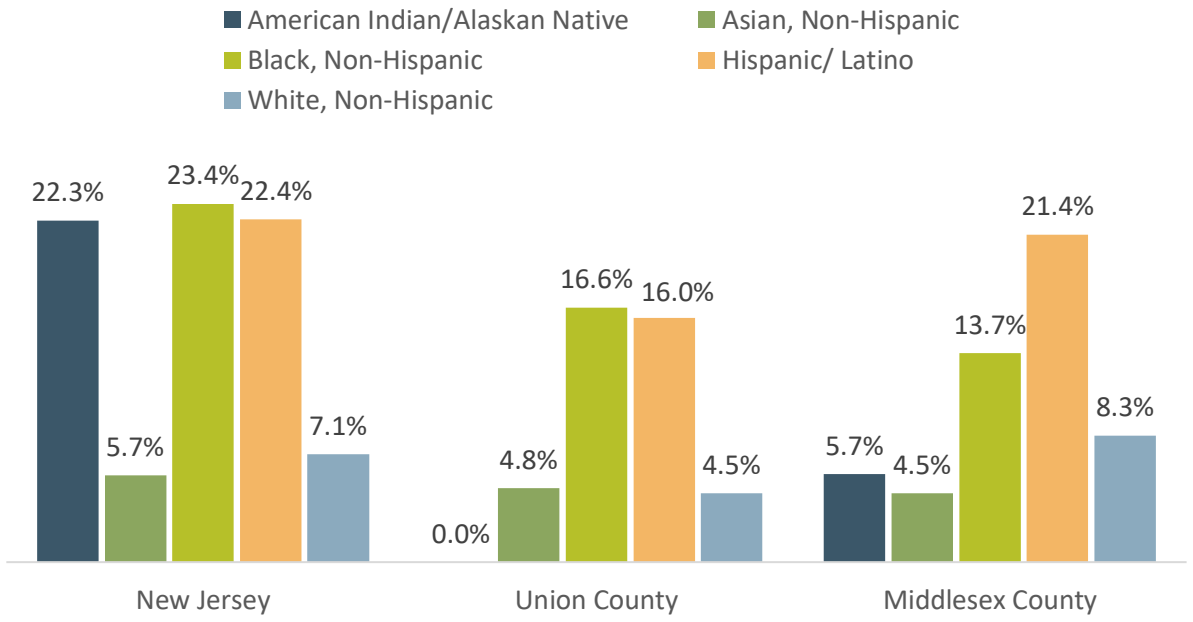
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 82. Percent Households Falling into ALICE Population, by State and County, 2018



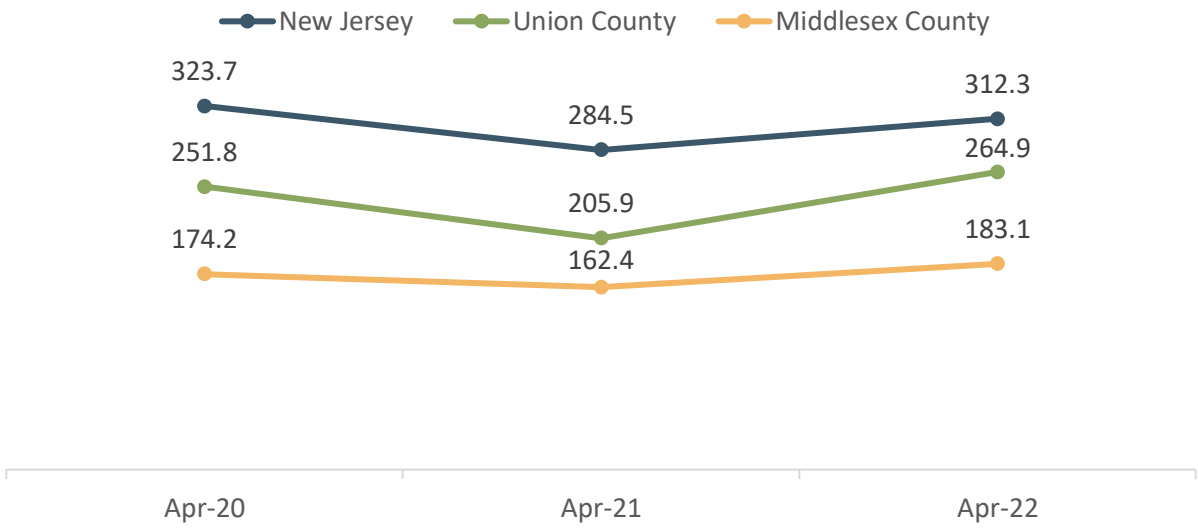
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018 as reported by United Ways of New Jersey, Alice in New Jersey: A Financial Hardship Study, 2020
NOTE: ALICE refers to the population in our communities that are Asset Limited, Income Constrained, Employed. The ALICE population represents those among us who are working, but due to child care costs, transportation challenges, high cost of living and so much more are living paycheck to paycheck.

Figure 83. 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

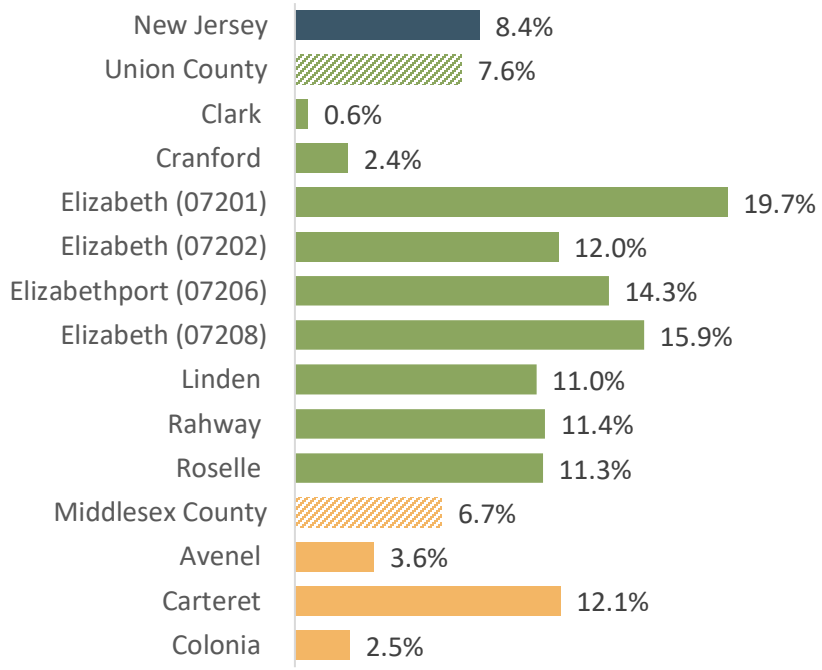
Figure 84. Number of Participating Persons, Adults, and Children Receiving WFNJ/TANF per 100,000, by County, 2021



DATA SOURCE: Current Program Statistics, Division of Family Development, New Jersey Department of Human Services, 2020-2021

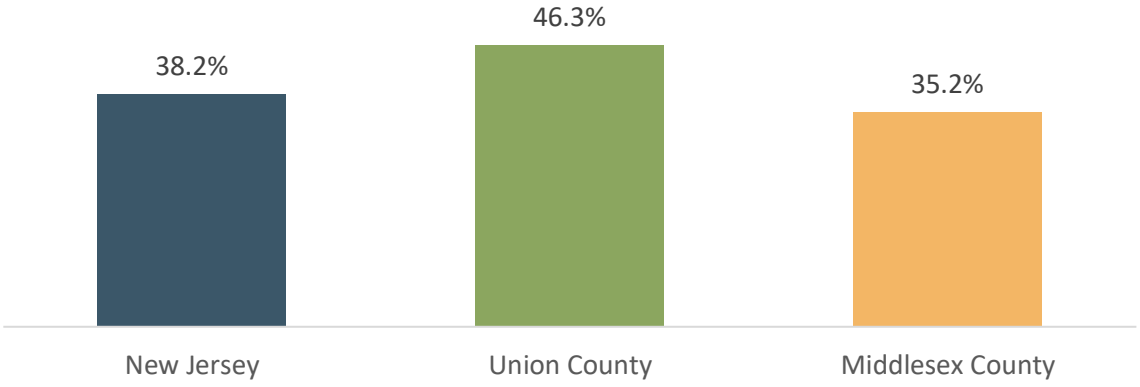
Food Access and Food Security

Figure 85. Households Receiving Food Stamps/SNAP, by State, County, and Town, 2016-2020



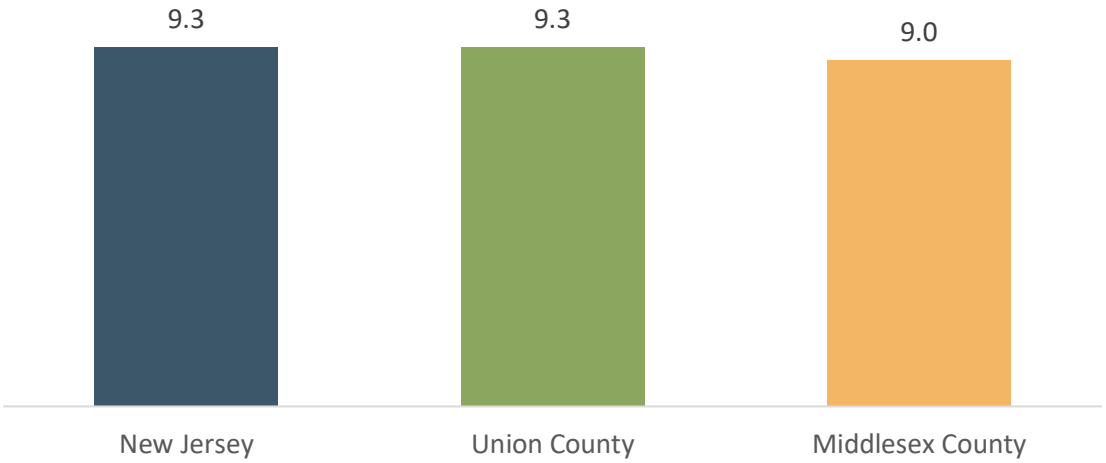
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 86. Children Eligible for Free or Reduced-Price Lunch, by State and County, 2019-2020



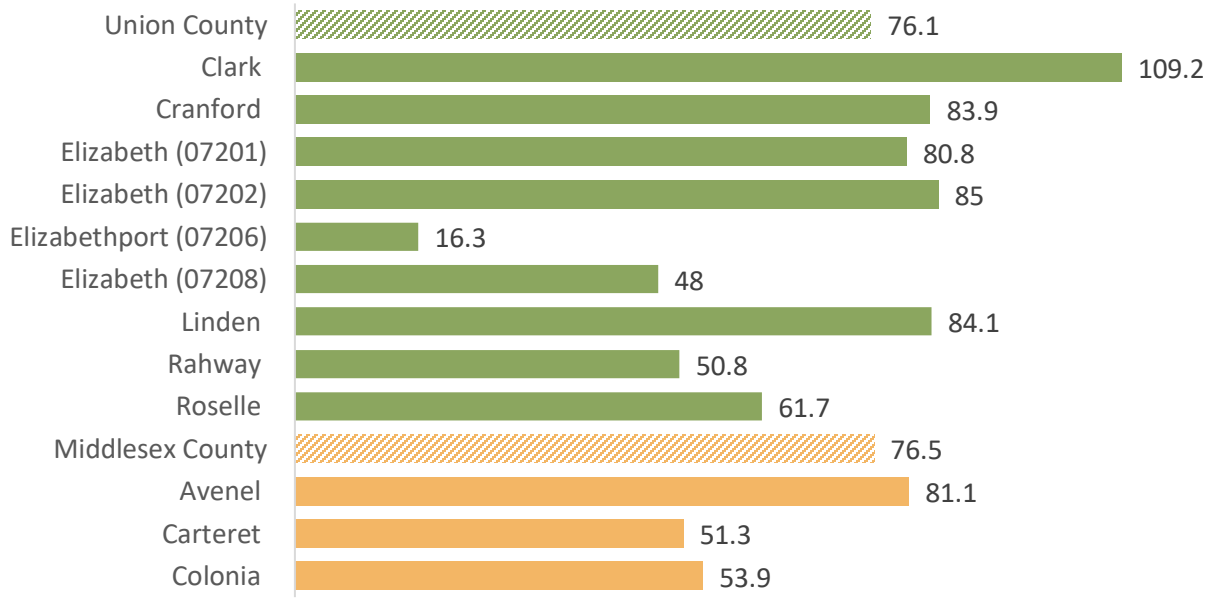
DATA SOURCE: National Center for Education Statistics, 2019-2020 from University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2021

Figure 87. Food Environment Index, by State and County, 2019



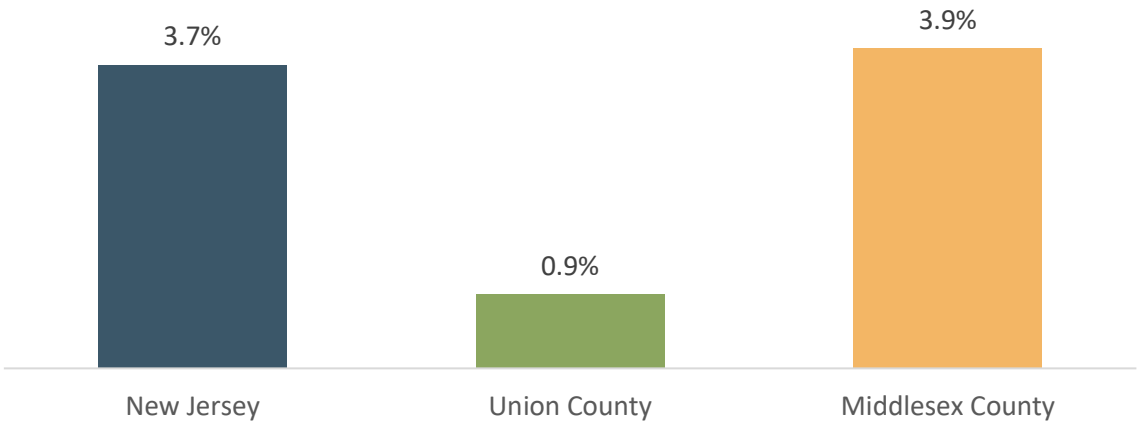
DATA SOURCE: USDA Food Environment Atlas, Map the Meal Gap from Feeding America, 2019 as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022
NOTE: Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).

Figure 88. Fast Food Establishments per 100,000 by County, and Town, 2020



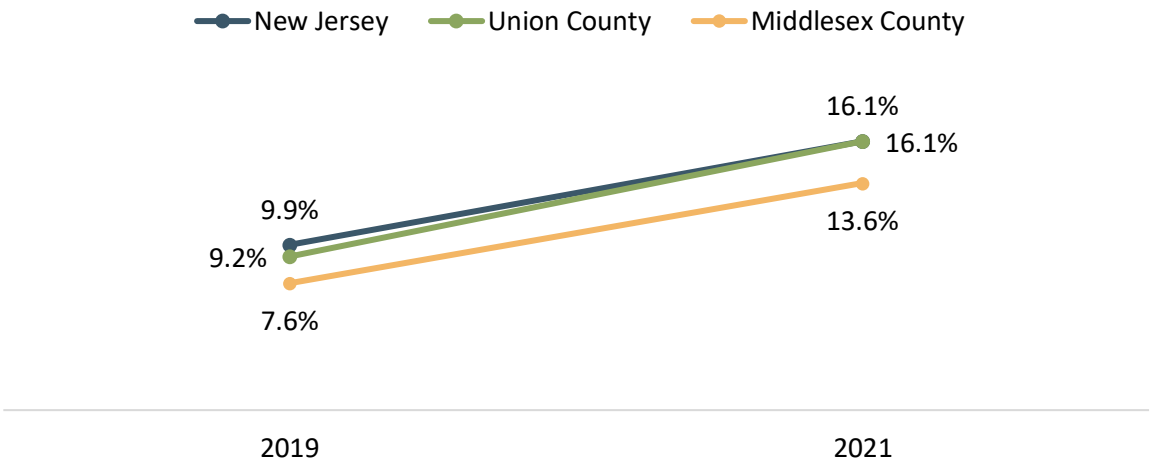
DATA SOURCE: Community Commons, Census County Business Patterns, analyzed by Center for Applied Research and Engagement Systems (CARES), 2020

Figure 89. Food Desert Among Residents, by State and County, 2019



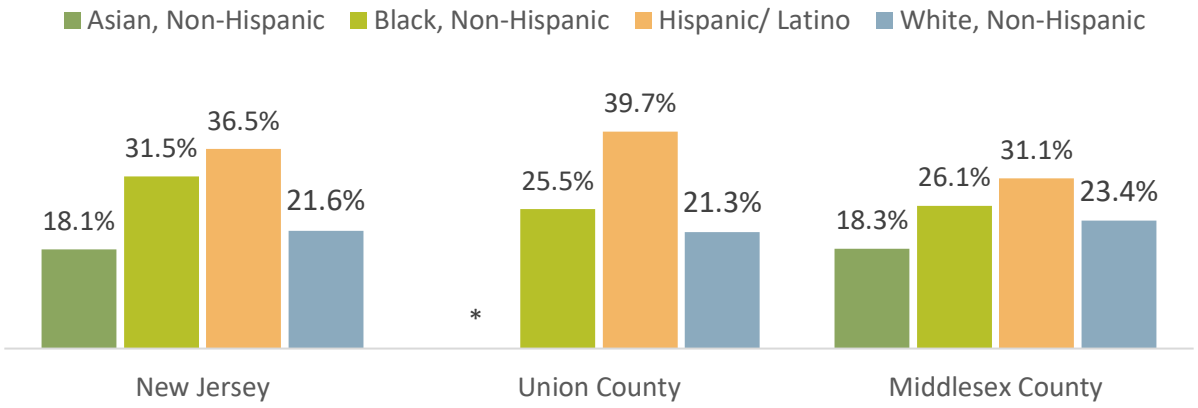
DATA SOURCE: U.S. Department of Agriculture, Economic Research Service, Food Access Research Atlas, 2019, as reported by, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022
NOTE: Food desert defined as the percentage of population with low income and without access to a grocery store at 1 mile for urban areas and 10 miles for rural areas

Figure 90. Percent Under 18 Food Insecure, by State and County, 2019 and 2021



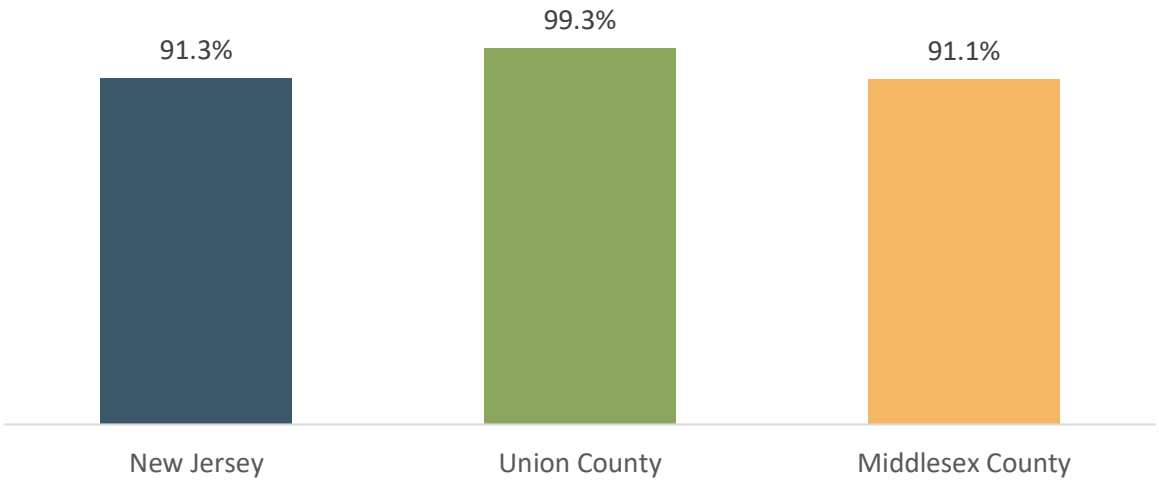
DATA SOURCE: Feeding America, Map the Meal Gap 2021
NOTE: 2021 data are projections of food insecurity levels in response to projected changes to annual unemployment and poverty due to COVID-19.

Figure 91. 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
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

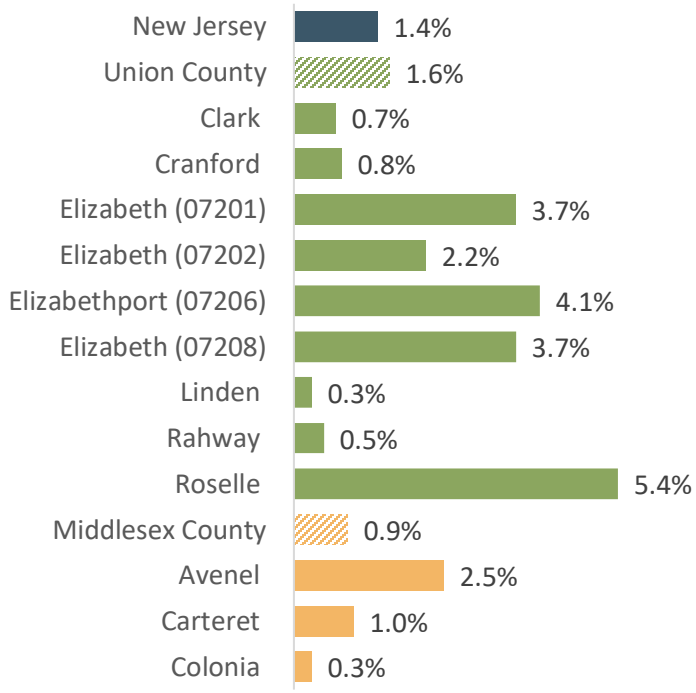
Figure 92. Population with adequate access to location for physical activity, by State and County, 2010 and 2021



DATA SOURCE: ESRI & U.S. Census Tigerline Files, Business Analyst, Delorme map data, 2010 & 2021, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022

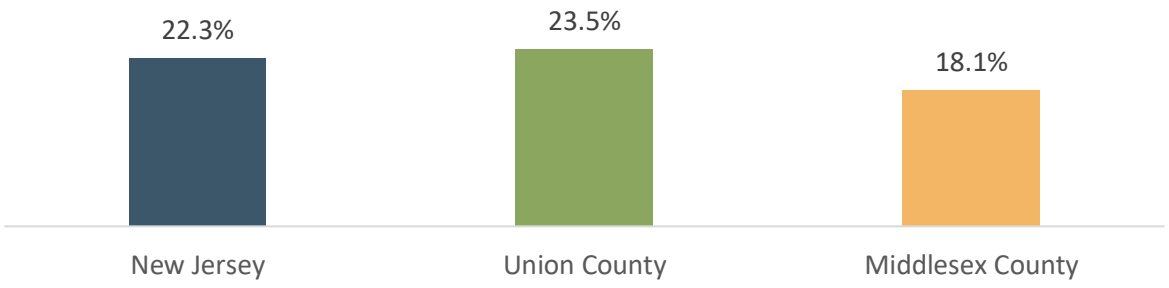
Housing

Figure 93. Homeowner Vacancy Rate, by State and County, 2016-2020



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

Figure 94. Percentage of children that live in a household headed by a single parent by State and County, 2016-2020



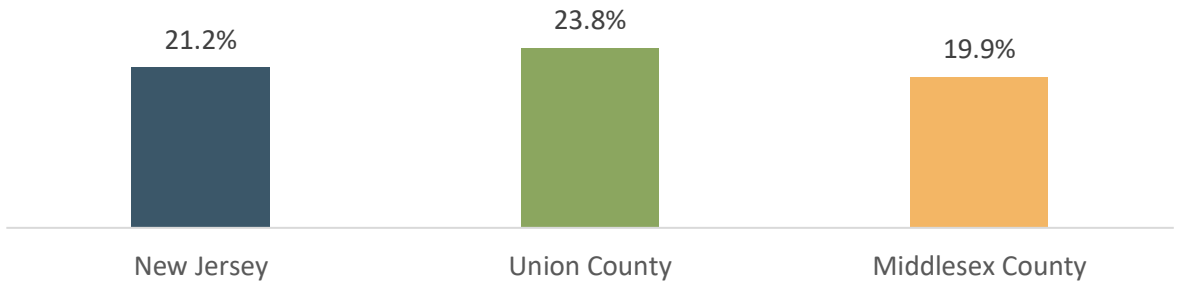
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020

Table 20. 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%
Union County	95.4%	3.0%	1.5%
Clark	98.5%	1.5%	0.0%
Cranford	99.6%	0.3%	0.1%
Elizabeth (07201)	91.6%	7.0%	1.4%
Elizabeth (07202)	90.6%	4.4%	5.0%
Elizabethport (07206)	91.7%	6.5%	1.8%
Elizabeth (07208)	88.2%	8.1%	3.8%
Linden	96.7%	2.7%	0.6%
Rahway	97.5%	1.9%	0.5%
Roselle	94.3%	4.5%	1.2%
Middlesex County	95.6%	3.0%	1.4%
Avenel	91.9%	6.5%	1.6%
Carteret	91.6%	6.6%	1.8%
Colonia	97.6%	1.7%	0.7%

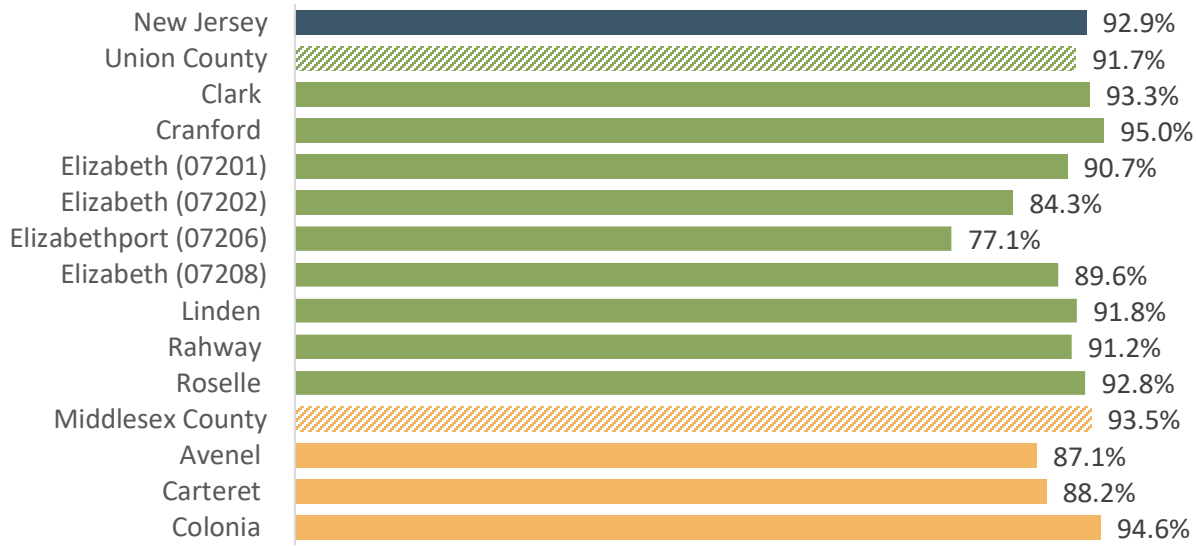
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 95. 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.

Figure 96. 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

Transportation

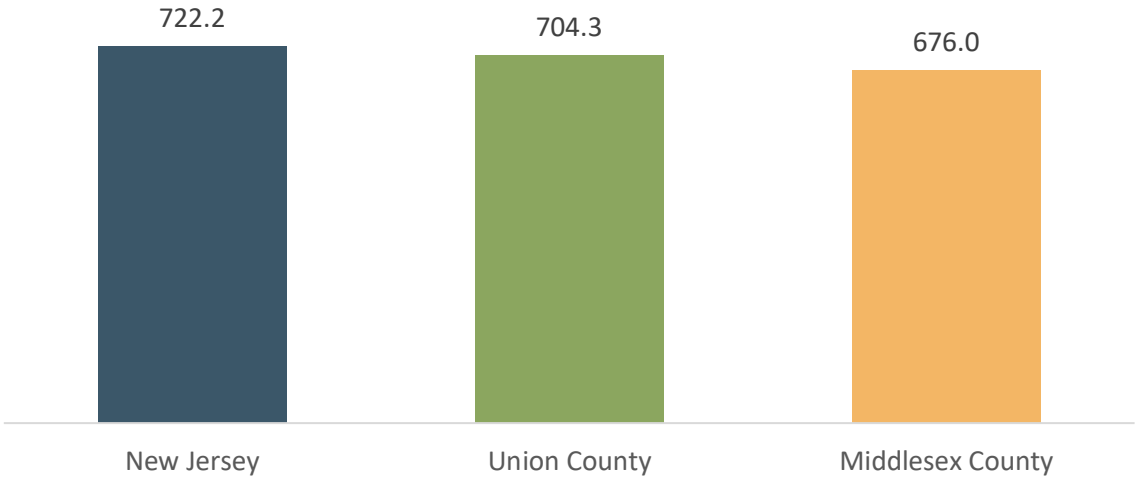
Table 21. Households (Renter v. Owner-Occupied) Without Access to a Vehicle, by State and County, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	3.6%	24.8%
Union County	3.3%	21.2%
Clark	2.9%	5.8%
Cranford	1.5%	15.1%
Elizabeth (07201)	2.0%	31.5%
Elizabeth (07202)	6.9%	23.2%
Elizabethport (07206)	8.4%	34.9%
Elizabeth (07208)	2.1%	24.6%
Linden	5.5%	18.4%
Rahway	5.2%	21.9%
Roselle	2.4%	21.4%
Middlesex County	3.1%	17.0%
Avenel	3.1%	7.8%
Carteret	5.7%	12.2%
Colonia	3.7%	5.4%

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

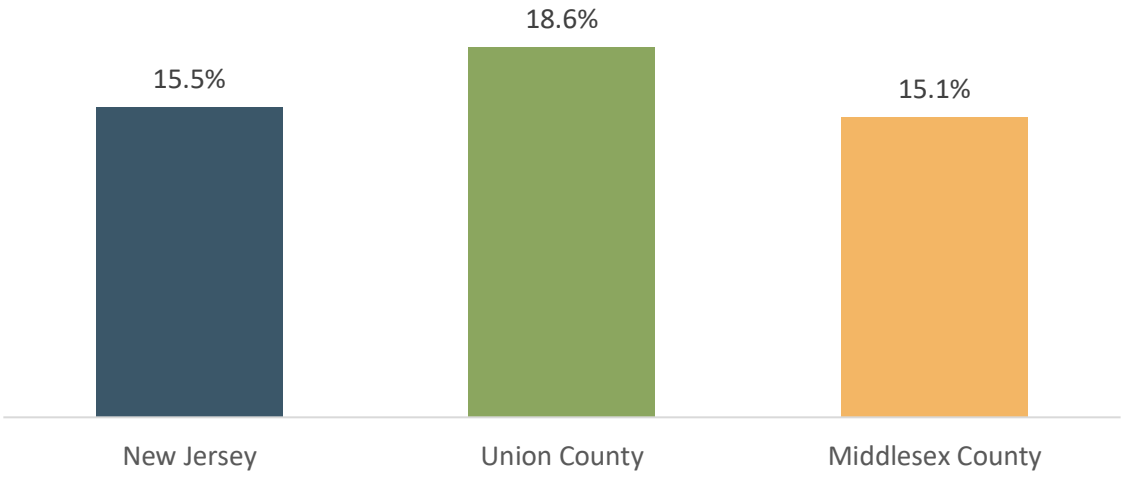
Leading Causes of Death and Premature Mortality

Figure 97. Age-Adjusted Mortality Rate per 100,000 population, by State and County, 2018-2020



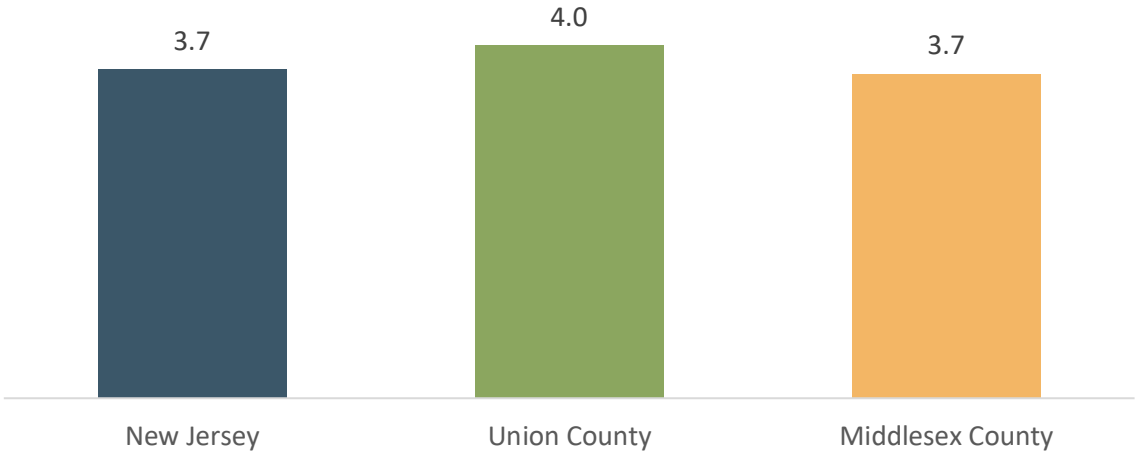
DATA SOURCE: New Jersey Department of Health, New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2018-2020
NOTE: Municipalities' data is for 2019 only.

Figure 98. Percent Poor or Fair Health, by State and County, 2018



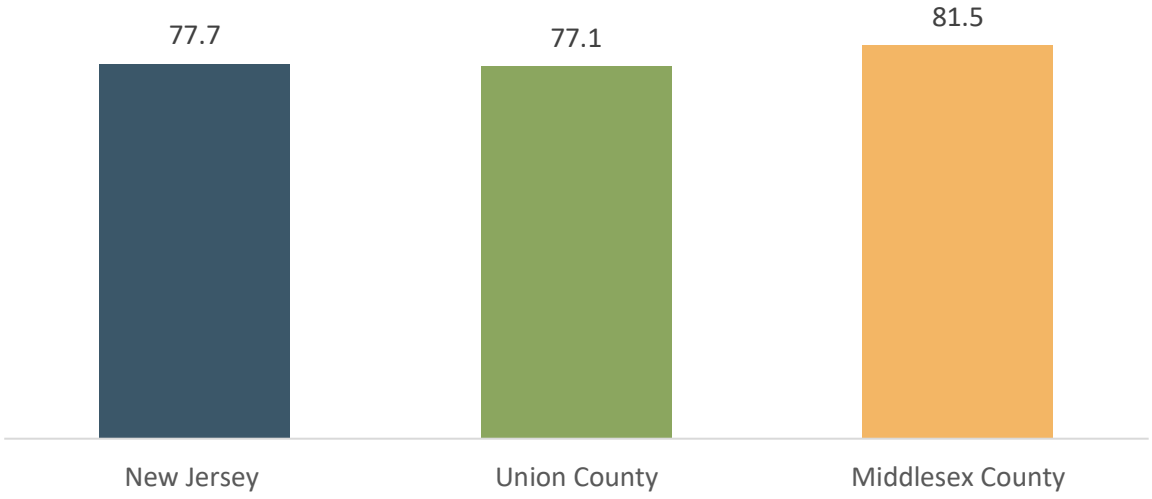
DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2022

Figure 99. Poor Physical Health Days by State and County, 2018



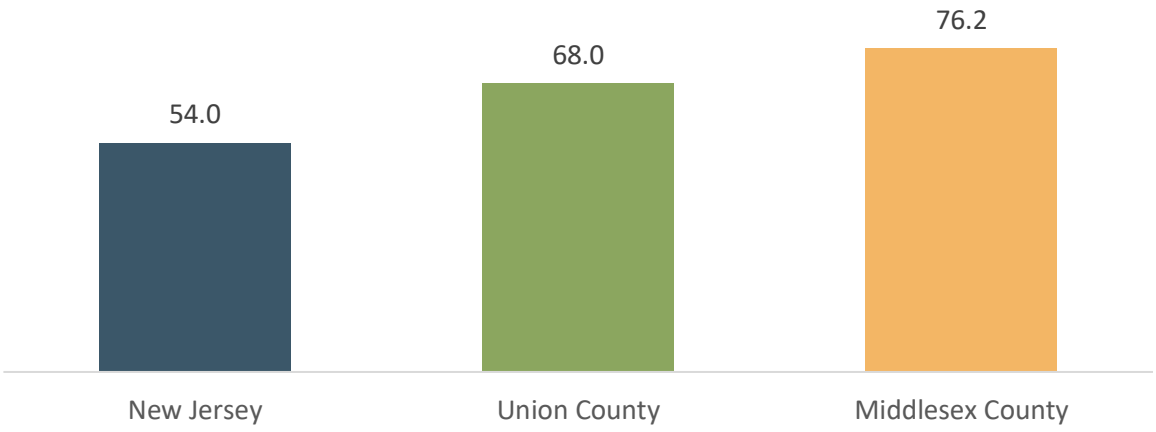
DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2022

Figure 100. Life Expectancy by State and County, 2020



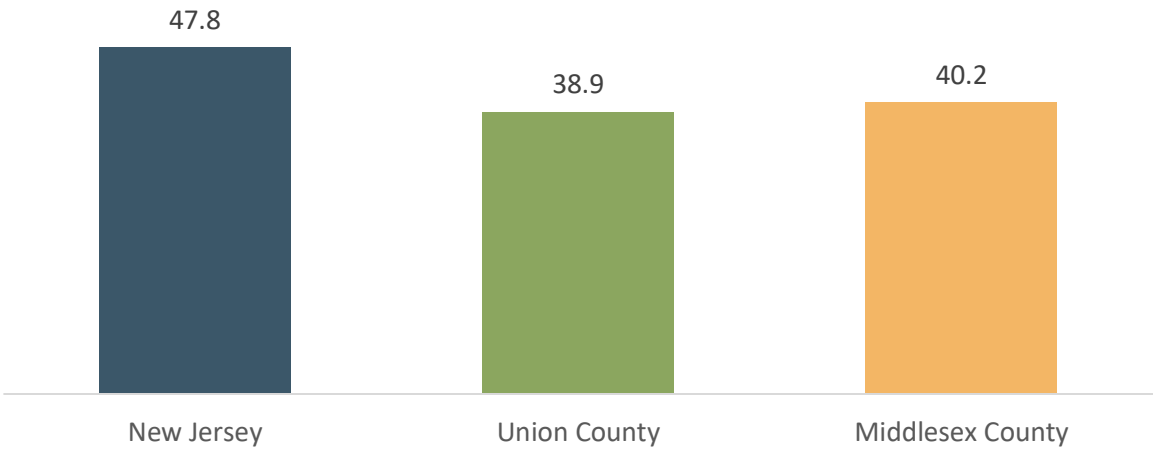
DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health 2020

Figure 101. 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

Figure 102. 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

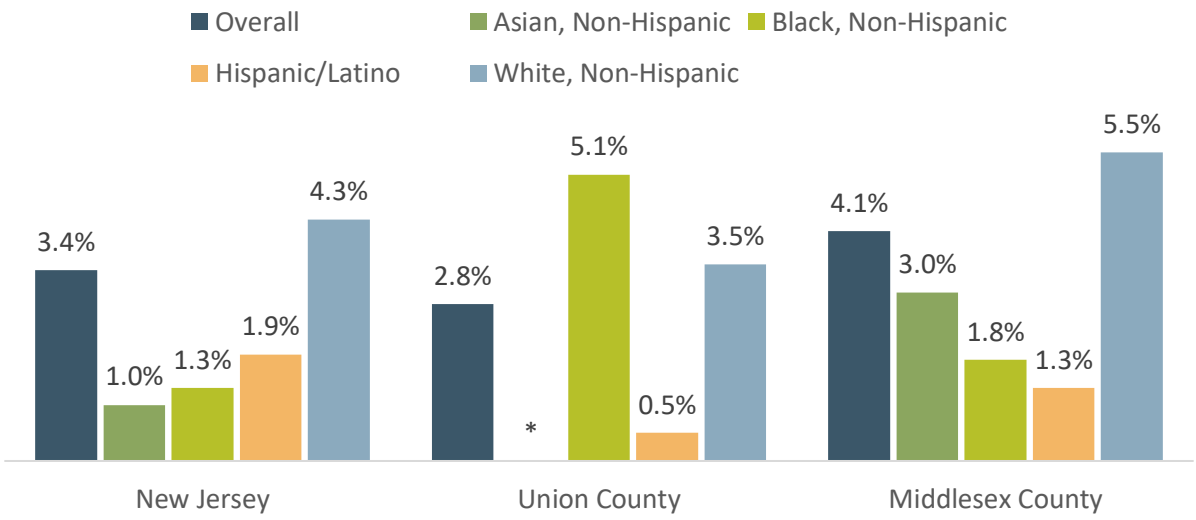
Table 22. Domestic Violence Offenses, by State, 2019

	2019
New Jersey	59,645

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

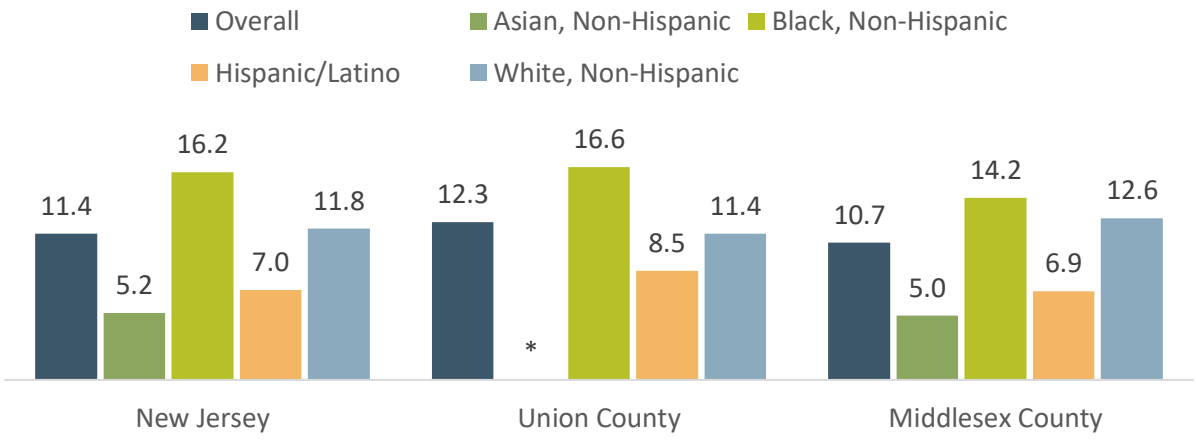
Chronic Conditions

Figure 103. Adults Reporting Angina or Coronary Heart Disease, by State and County, by Race/Ethnicity, 2020



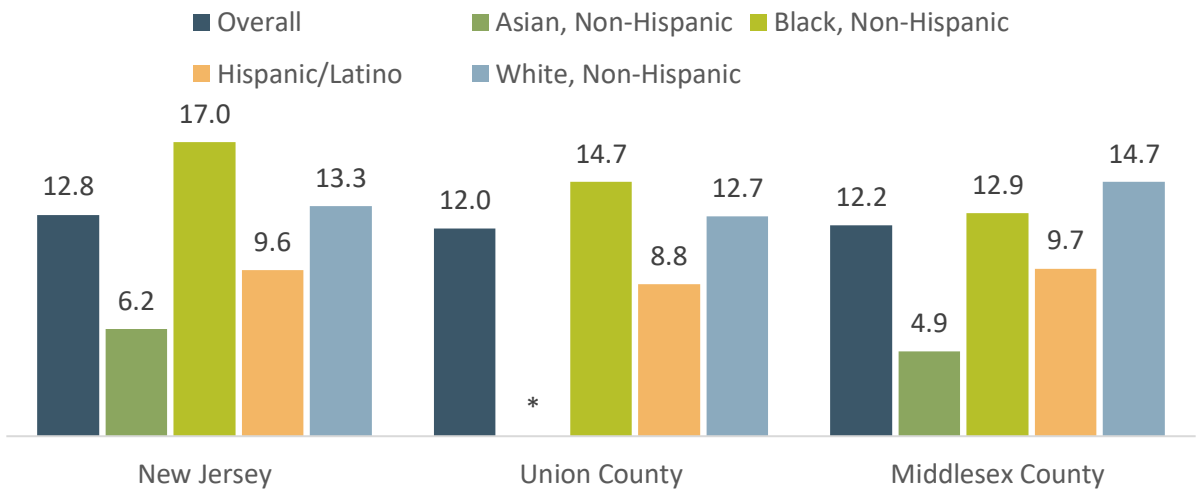
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2018
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 104. Breast Cancer Mortality Rate per 100,000 Population, by State and County, 2016-2020



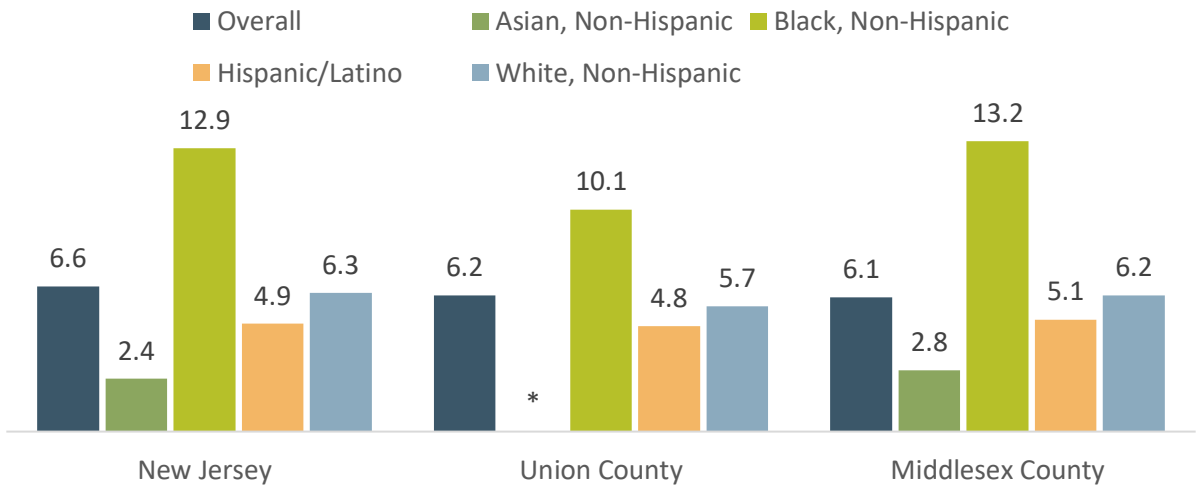
DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 105. Colorectal Cancer Mortality Rate 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, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

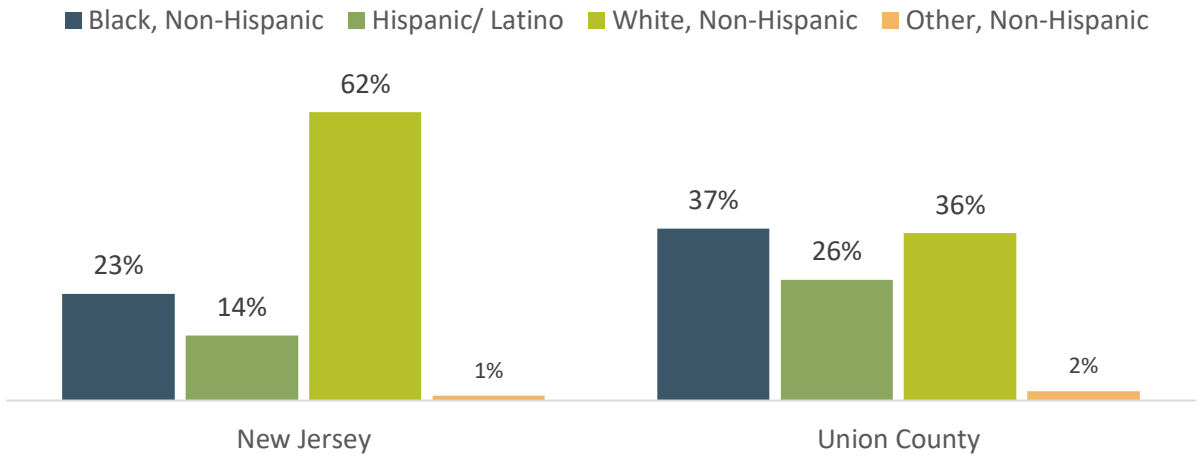
Figure 106. Prostate Cancer Mortality Rate per 100,000 Population, by State and County, 2016-2020



DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

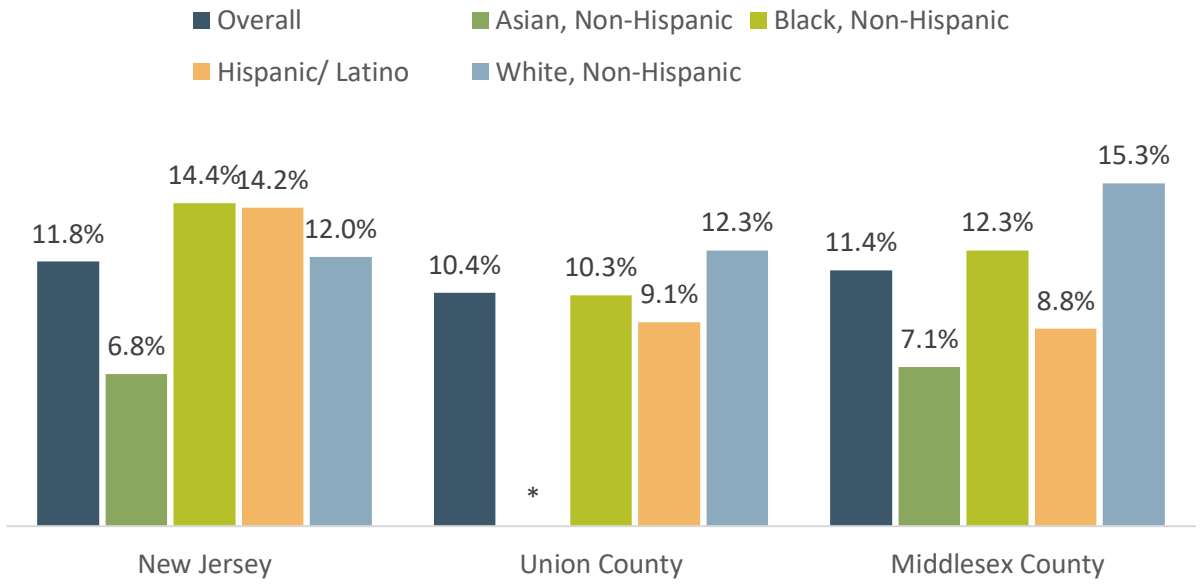
Substance Use

Figure 107. Substance Use Treatment Admissions by Race/Ethnicity, by State and County, 2020



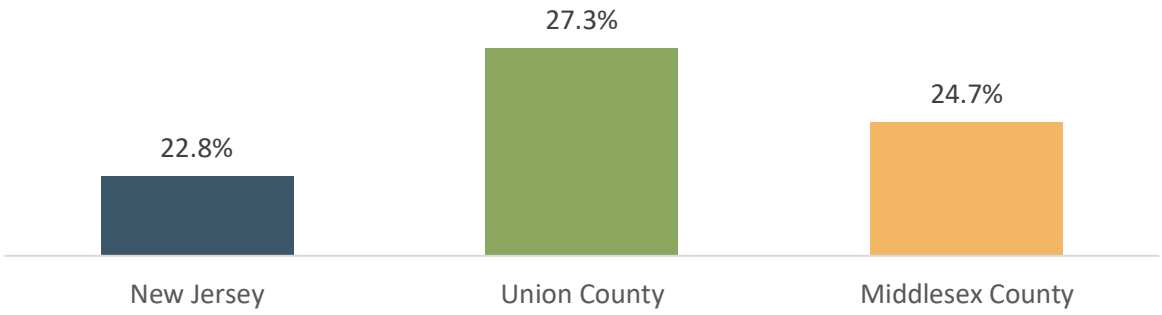
DATA SOURCE: New Jersey Department of Human Services, Division of Mental Health and Addiction Services, New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview, 2020

Figure 108. Percent Adults Reported Current Smokers, by State and County, 2017-2020



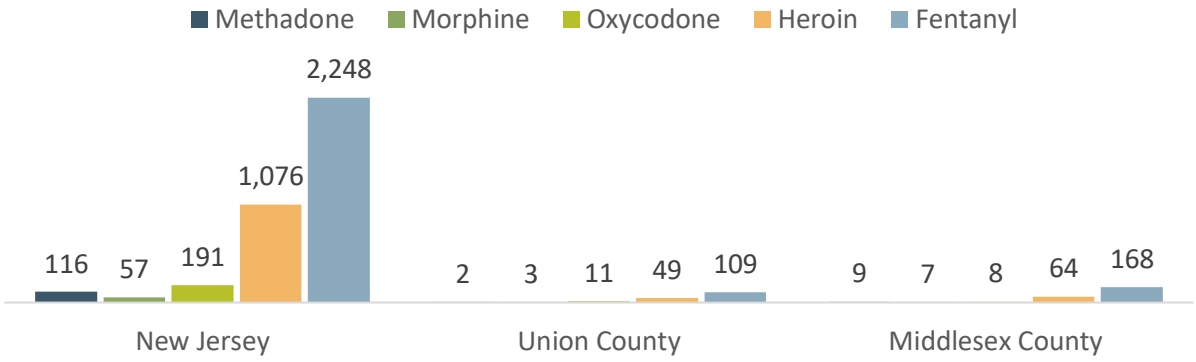
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2017-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 109. Alcohol-impaired Driving Deaths, by State and County, 2016-2020



DATA SOURCE: Fatality Analysis Reporting System as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020

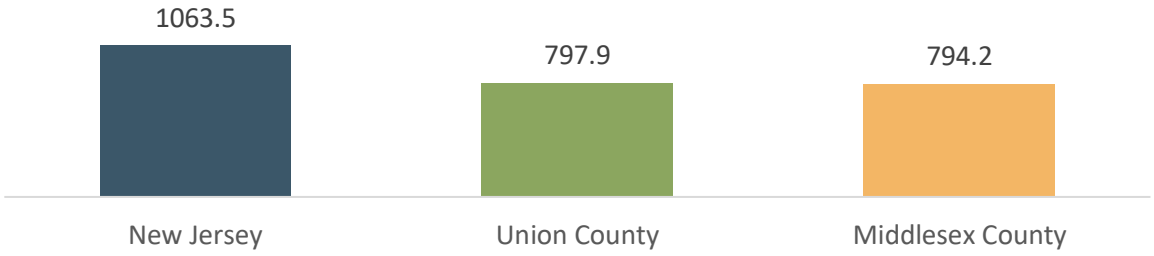
Figure 110. Count of Opioid Related Deaths by Drug, by State and County, 2019



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

Environmental Health

Figure 111. Age-Adjusted Rate of Asthma Hospitalizations, by State and County, 2020



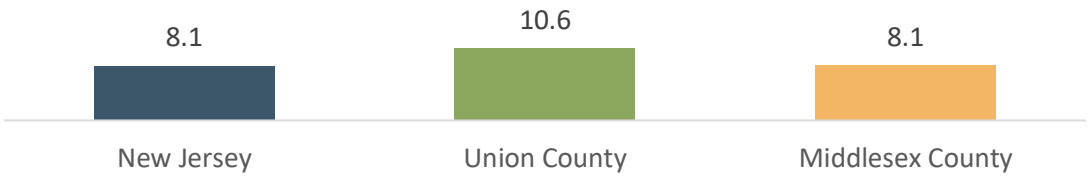
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020
NOTE: Includes all asthma diagnoses, including primary, secondary, and other diagnoses.

Table 23. Percent of Children Aged 1 -5 Years With Elevated Blood Lead Level (>= 5mcg/dL), by State and County, 2019

	%
New Jersey	2.2%
Union County	2.1%
Middlesex County	1.9%

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

Figure 112. 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, 2018

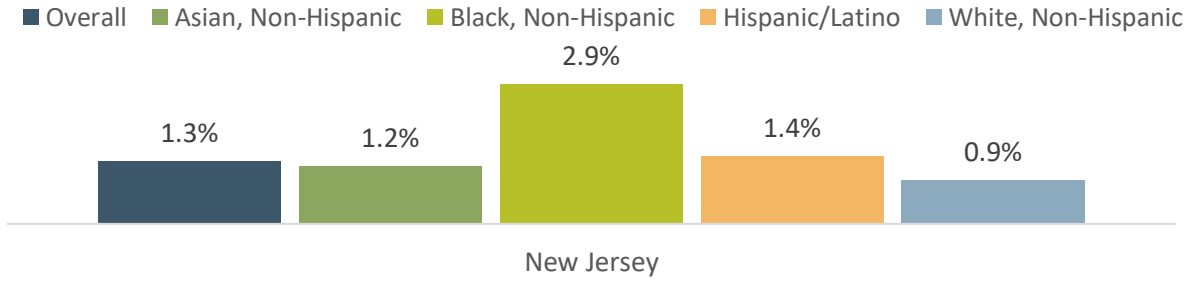
Table 24. Drinking Water Violations by County, 2020

	Z-score	Violation
Union County	-1.75	No
Middlesex County	0.55	Yes

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

Maternal and Infant Health

Figure 113. Percent Very Low Birth Weight Births by Race/Ethnicity, by State, 2016-2020



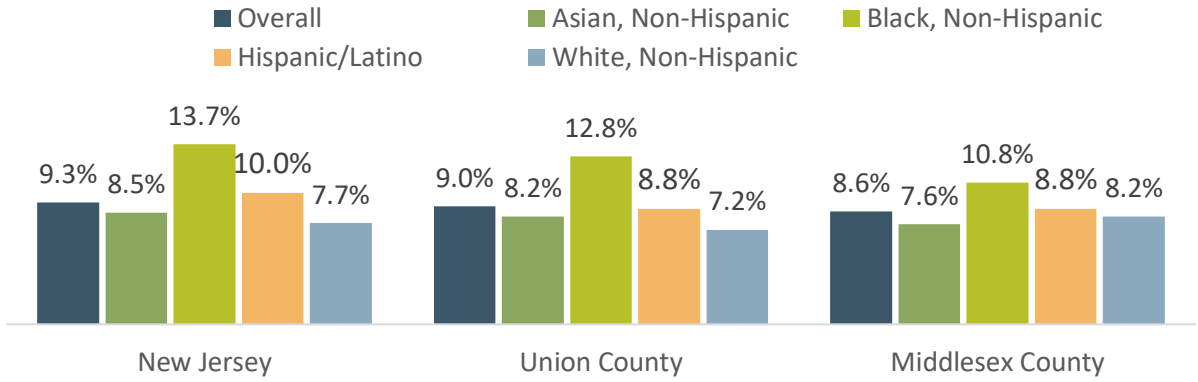
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018
NOTE: Very low birth weight is defined as less than 1,500 grams

Table 25. Percent Very Low Birth Weight Births, by Race/Ethnicity, by State and County, 2020

	Overall	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/ Latino	White, Non-Hispanic
New Jersey	1.2%	1.4%	3.0%	1.4%	0.9%
Union County	1.2%	*	2.6%	1.1%	0.6%
Middlesex County	1.1%	0.8%	2.3%	1.3%	0.8%

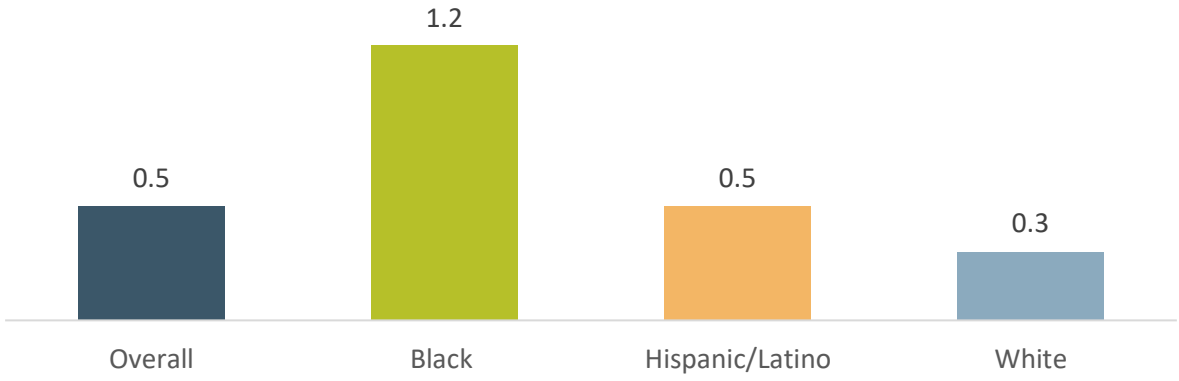
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020
NOTE: Very low birth weight is defined as less than 1,500 grams

Figure 114. Percent Preterm Births, by Race/Ethnicity, State, and County, 2020



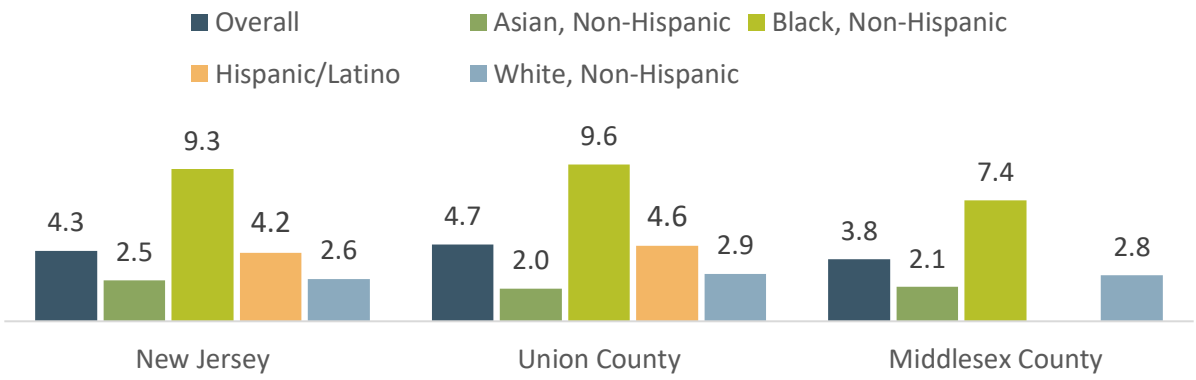
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020
NOTE: Preterm is defined as less than 37 weeks gestation

Figure 115. Maternal Mortality Rate per 100,000 Population, by State and Race/Ethnicity, 2015-2019



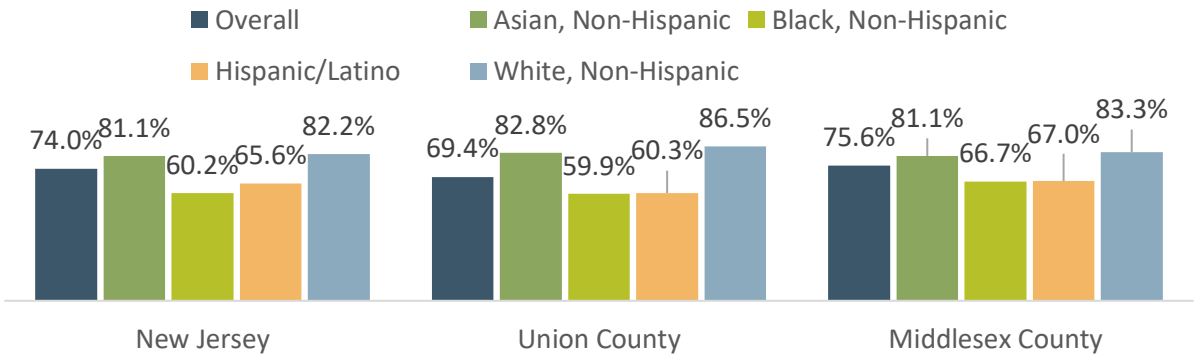
DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

Figure 116. Infant Mortality Rate per 1,000 Births by Race/Ethnicity, by State, 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: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 117. Percent Births with Prenatal Care in First Trimester by Race/Ethnicity, by State, 2016-2020



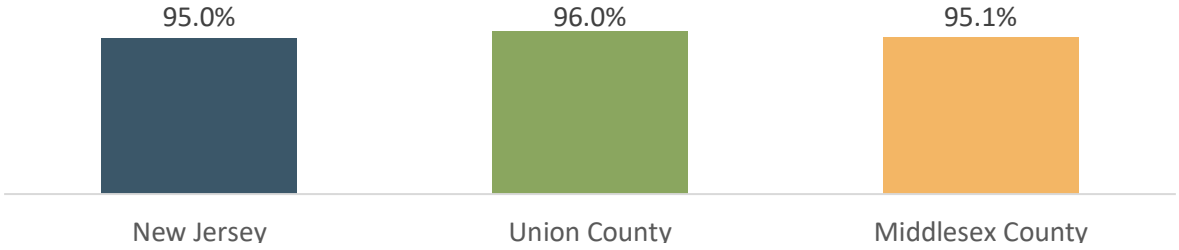
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Table 26. Percent Births with No Prenatal Care Overall by Race/Ethnicity, by State, 2016-2020

	Overall	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/Latino	White, Non-Hispanic
New Jersey	1.5%	0.7%	3.6%	1.6%	1.0%
Union County	2.1%	1.1%	3.5%	1.9%	1.4%
Middlesex County	1.1%	0.5%	1.7%	1.4%	1.1%

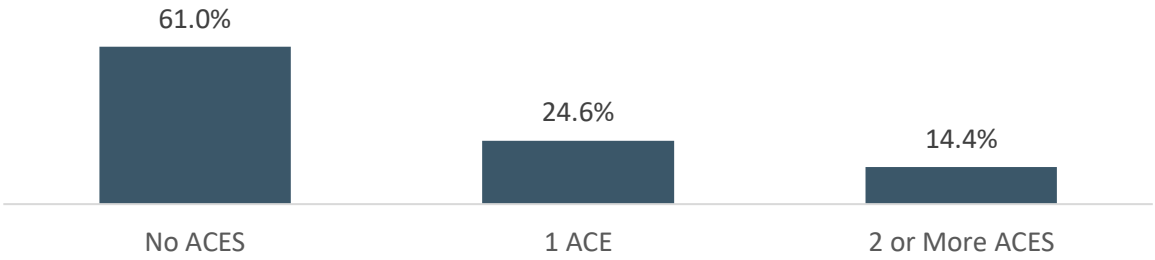
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Figure 118. 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

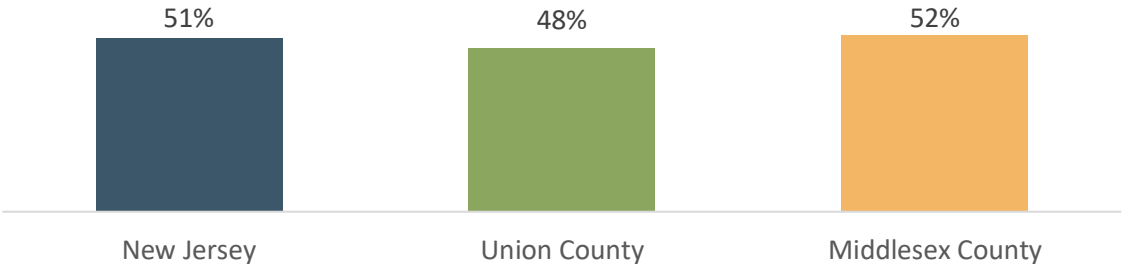
Figure 119. Percent of Children with Adverse Childhood Experiences (ACEs), by State, 2019



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

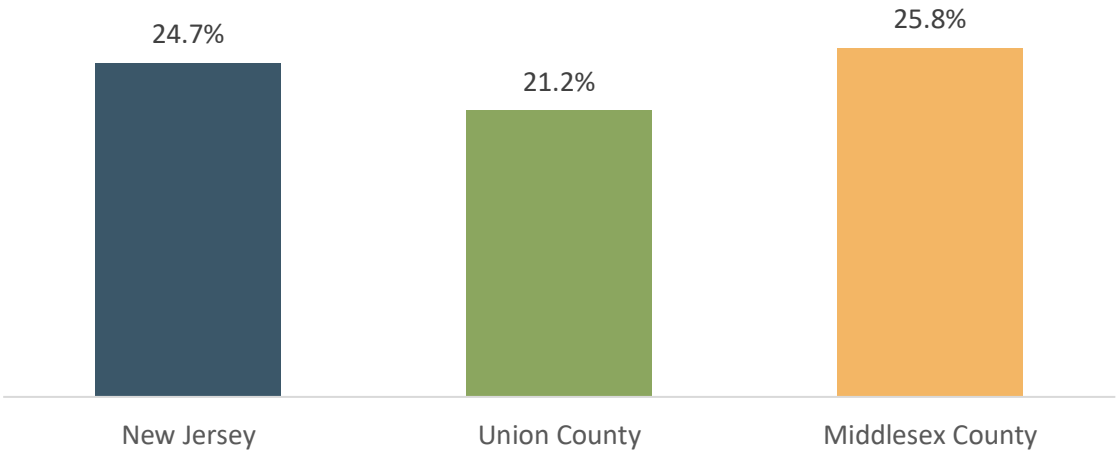
Access to Care

Figure 120. Percentage of Fee-for-Service (FFS) Medicare Enrollees That had an Annual Flu Vaccination, by State and County, 2019



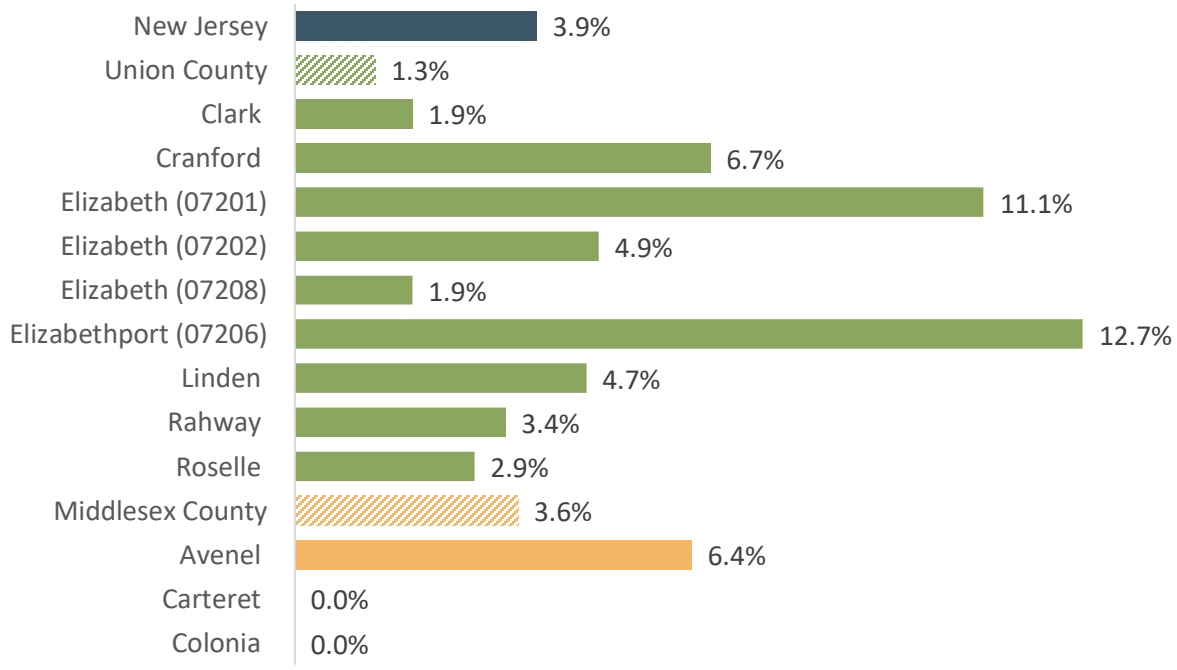
DATA SOURCE: Centers for Medicare & Medicaid Services, Office of Minority Health's Mapping Medicare Disparities tool, as reported by County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Figure 121. Age-Adjusted Pneumococcal Vaccination (Ever), by State and County, 2020



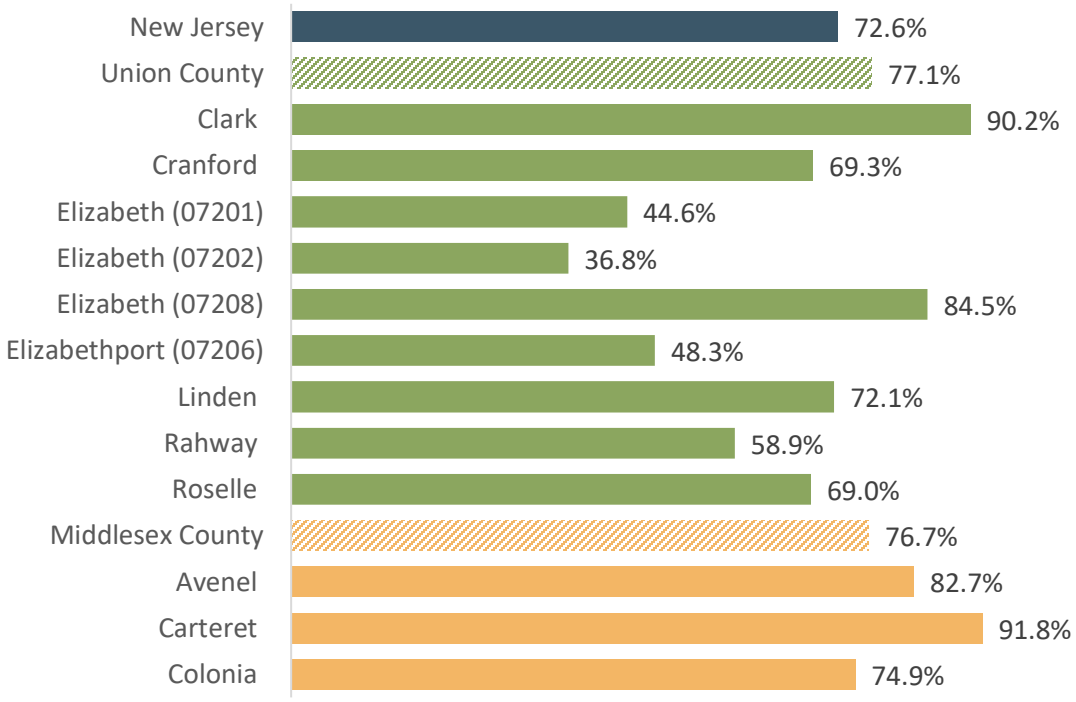
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020

Figure 122. Population Under 19 with No Health Insurance, by State, County, and Town, 2016-2020



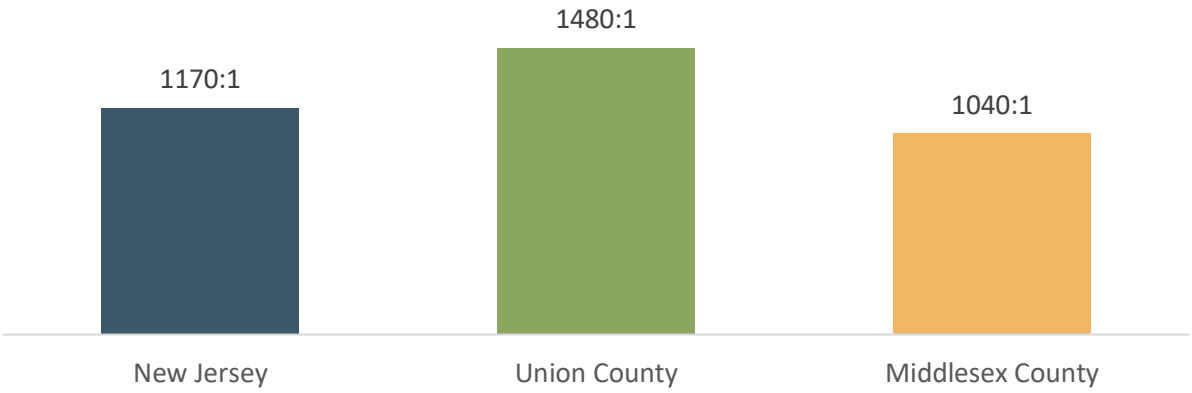
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 123. Population with Private Insurance, by State, County and Town, 2016-2020



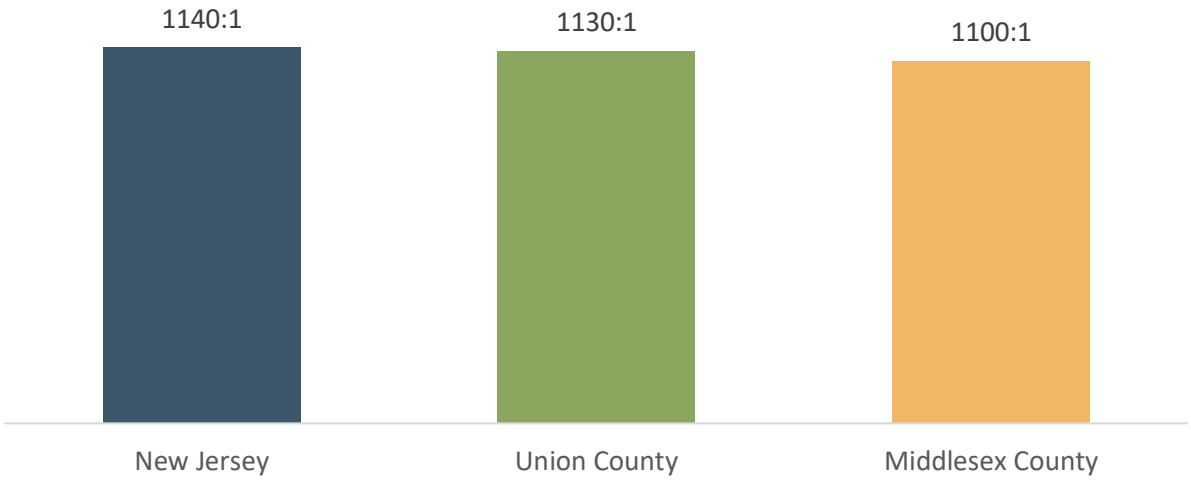
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020
NOTE: Data for Middlesex County are not available via 2016-2020 estimates. Data shown are 2015-2019 estimates.

Figure 124. Ratio of Population to Primary Care Physicians, by State and County, 2019



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, 2019

Figure 125. Ratio of Population to Dentists, by State and County, 2020



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, 2020

Appendix F- Hospitalization Data

Table 27. 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

		Count of Patients Treated & Released			Rate per 100,000 Population		
Year	Age	New Jersey	Union County	Middlesex County	New Jersey	Union County	Middlesex County
2017	0-17	690,506	50548.0	55,640	334.4	385.1	300.0
	18-44	1,259,377	81876.0	90,686	416.8	414.9	289.9
	45-64	757,159	46930.0	53,227	302.2	303.6	232.4
	65+	450,704	23744.0	31,574	320.4	305.3	260.1
	All Ages	3,157,746	203,098	231,127	350.9	362.0	272.3
2018	0-17	673,100	47,598	54,528	343.2	363.5	300.4
	18-44	1,217,047	77,243	86,864	394.5	395.1	280.9
	45-64	748,821	44,774	51,435	301.1	290.4	226.7
	65+	463,456	22,868	31,172	322.9	289.2	252.2
	All Ages	3,102,424	192,483	223,999	345.9	343.9	266.2
2019	0-17	658,207	49,358	51,727	334.6	373.5	284.4
	18-44	1,219,299	80,210	86,019	392.2	402.7	277.2
	45-64	760,293	47,553	51,416	305.8	306.0	226.5
	65+	489,485	25,961	32,739	330.6	315.4	254.6
	All Ages	3,127,284	203,082	221,901	345.8	356.9	261.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 28. 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

Table 29. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Union County Resident Patients Treated at RWJUH Rahway, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	3,203	24.4
	18-44	9,837	49.8
	45-64	6,159	39.8
	65+	3,995	51.4
	All Ages	23,194	41.3
2018	0-17	3,122	23.8
	18-44	9,700	49.6
	45-64	5,934	38.5
	65+	3,826	48.4
	All Ages	22,582	40.3
2019	0-17	2,905	22.0
	18-44	8,882	44.6
	45-64	5,885	37.9
	65+	3,898	47.4
	All Ages	21,570	37.9

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 30. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Union County Resident Patients Treated at Trinitas Regional Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	10,262	78.2
	18-44	22,829	115.7
	45-64	13,120	84.9
	65+	5,003	64.3
	All Ages	51,214	91.3
2018	0-17	9,744	74.4
	18-44	22,189	113.5
	45-64	13,097	84.9
	65+	5,495	69.5
	All Ages	50,525	90.3
2019	0-17	9,742	73.7
	18-44	22,564	113.3
	45-64	13,242	85.2
	65+	5,841	71.0
	All Ages	51,389	90.3

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 31. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in RWJUH Rahway's Primary Service Area Treated in New Jersey, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	13,305	327.0
	18-44	25,213	370.1
	45-64	15,512	282.1
	65+	8,738	304.4
	All Ages	62,768	326.1
2018	0-17	12,589	312.3
	18-44	24,132	355.3
	45-64	15,045	274.8
	65+	8,527	291.8
	All Ages	60,293	313.7
2019	0-17	12,880	316.7
	18-44	24,282	350.4
	45-64	15,093	273.8
	65+	9,107	299.0
	All Ages	61,362	313.8

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 32. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Trinitas Regional 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	19,596	577.6
	18-44	31,115	594.7
	45-64	15,895	497.1
	65+	5,666	421.8
	All Ages	72,272	548.9
2018	0-17	19,054	562.0
	18-44	29,971	577.0
	45-64	15,783	490.2
	65+	5,923	431.0
	All Ages	70,731	536.7
2019	0-17	20,176	587.9
	18-44	31,153	592.3
	45-64	16,736	514.2
	65+	6,624	463.3
	All Ages	74,689	558.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 33. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in RWJUH Rahway's Primary Service Area Treated at RWJUH Rahway, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	3,129	-
	18-44	9,805	143.9
	45-64	6,537	118.9
	65+	4,313	150.2
	All Ages	23,784	123.5
2018	0-17	2,999	-
	18-44	9,438	139.0
	45-64	6,299	115.0
	65+	4,015	137.4
	All Ages	22,751	118.4
2019	0-17	2,833	-
	18-44	8,844	127.6
	45-64	6,106	110.8
	65+	4,140	135.9
	All Ages	21,923	112.1

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 34. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Trinitas Regional Medical Center's Primary Service Area Treated at Trinitas Regional Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	8,647	254.9
	18-44	18,357	350.9
	45-64	10,345	323.5
	65+	3,744	278.7
	All Ages	41,093	312.1
2018	0-17	8,122	239.6
	18-44	17,821	343.1
	45-64	10,335	321.0
	65+	4,071	296.2
	All Ages	40,349	306.2
2019	0-17	8,140	237.2
	18-44	17,971	341.7
	45-64	10,382	319.0
	65+	4,401	307.8
	All Ages	40,894	305.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 35. 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

		Count			Rate per 100,000 Population		
Year	Race/Ethnicity	New Jersey Residents	Union County	Middlesex County	New Jersey Residents	Union County	Middlesex County
2017	American Indian or Alaska Native	6,530	208	1,028	201.1	81.0	326.9
	Asian	80,692	2,968	16,176	92.2	92.6	78.9
	Black or African American	780,645	64,182	36,192	628.0	495.1	412.1
	Hawaiian & Pacific Islander	3,949	316	224	985.5	1,356.2	759.3
	Other Race	610,721	54,043	84,002	935.3	932.9	1,265.6
	Two or More Races	11,014	372	646	38.6	17.7	22.8
	White	1,563,896	81,009	92,859	264.8	239.5	211.3
	All Race/Ethnicities	3,057,447	203,098	231,127	340.0	-	-
2018	American Indian or Alaska Native	6,035	225	1,023	185.4	89.1	320.2
	Asian	80,655	2,897	15,727	90.3	89.1	76.1
	Black or African American	755,704	59,363	35,351	608.9	458.4	402.6
	Hawaiian & Pacific Islander	8,405	2,555	317	2,031.7	10,826.3	1,174.1
	Other Race	633,209	50,541	85,097	961.3	862.2	1,269.1
	Two or More Races	11,395	381	683	39.5	17.8	24.1
	White	1,509,245	76,521	85,801	258.0	228.1	199.6
	All Race/Ethnicities	3,004,648	192,483	223,999	335.0	-	-
2019	American Indian or Alaska Native	5,360	244	620	164.0	93.5	196.8
	Asian	81,556	3,056	16,293	89.8	93.8	77.7
	Black or African American	754,534	59,201	35,583	600.1	448.4	403.2
	Hawaiian & Pacific Islander	4,203	413	349	1,005.3	1,735.3	1,203.4
	Other Race	683,104	57,821	83,512	1,012.6	952.9	1,209.1
	Two or More Races	11,025	399	779	37.5	18.3	27.1
	White	1,486,019	81,948	84,765	253.0	241.3	197.4
	All Race/Ethnicities	3,025,801	203,082	221,901	334.6	-	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 36. 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

Table 37. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in RWJUH Rahway'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	18	7.0
	Asian	318	9.9
	Black or African American	8,700	67.1
	Hawaiian & Pacific Islander	16	68.7
	Other Race	3,502	60.4
	Two or More Races	89	4.2
	White	10,551	31.2
	All Race/Ethnicities	23,194	-
2018	American Indian or Alaska Native	34	13.5
	Asian	335	10.3
	Black or African American	8,446	65.2
	Hawaiian & Pacific Islander	12	50.8
	Other Race	4,325	73.8
	Two or More Races	119	5.6
	White	9,311	27.7
	All Race/Ethnicities	22,582	-
2019	American Indian or Alaska Native	28	10.7
	Asian	287	8.8
	Black or African American	8,256	62.5
	Hawaiian & Pacific Islander	16	67.2
	Other Race	4,773	78.7
	Two or More Races	79	3.6
	White	8,131	23.9
	All Race/Ethnicities	21,570	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 38. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Trinitas Regional 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	116	45.2
	Asian	824	25.7
	Black or African American	23,713	182.9
	Hawaiian & Pacific Islander	131	562.2
	Other Race	4,253	73.4
	Two or More Races	182	8.6
	White	45,189	133.6
	All Race/Ethnicities	74,408	-
2018	American Indian or Alaska Native	152	60.2
	Asian	693	21.3
	Black or African American	21,935	169.4
	Hawaiian & Pacific Islander	141	597.5
	Other Race	4,810	82.1
	Two or More Races	172	8.0
	White	45,204	134.7
	All Race/Ethnicities	73,107	-
2019	American Indian or Alaska Native	169	64.7
	Asian	618	19.0
	Black or African American	20,552	155.7
	Hawaiian & Pacific Islander	139	584.0
	Other Race	5,189	85.5
	Two or More Races	134	6.1
	White	46,158	135.9
	All Race/Ethnicities	72,959	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 39. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in RWJUH Rahway's Primary Service Area Treated at RWJUH Rahway, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	141	240.6
	Asian	1,949	116.2
	Black or African American	20,277	472.7
	Hawaiian & Pacific Islander	87	1,191.8
	Other Race	13,137	902.9
	Two or More Races	185	28.2
	White	26,992	243.0
	All Race/Ethnicities	62,768	326.1
2018	American Indian or Alaska Native	154	271.6
	Asian	1,955	114.6
	Black or African American	19,302	448.6
	Hawaiian & Pacific Islander	343	4,900.0
	Other Race	13,515	906.6
	Two or More Races	204	30.5
	White	24,820	225.9
	All Race/Ethnicities	60,293	313.7
2019	American Indian or Alaska Native	130	222.2
	Asian	1,921	111.2
	Black or African American	19,658	446.6
	Hawaiian & Pacific Islander	117	1,581.1
	Other Race	14,872	951.4
	Two or More Races	183	26.7
	White	24,481	220.3
	All Race/Ethnicities	61,362	313.8

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 40. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in Trinitas Regional Medical Center's Primary Service Area Treated at Trinitas Regional Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	104	86.7
	Asian	477	166.1
	Black or African American	17,815	637.4
	Hawaiian & Pacific Islander	125	1893.9
	Other Race	20,176	884.1
	Two or More Races	102	16.4
	White	33,473	474.6
	All Race/Ethnicities	72,272	548.9
2018	American Indian or Alaska Native	118	98.3
	Asian	435	152.4
	Black or African American	16,363	584.6
	Hawaiian & Pacific Islander	1,333	18513.9
	Other Race	18,502	807.8
	Two or More Races	99	15.8
	White	33,881	480.6
	All Race/Ethnicities	70,731	536.7
2019	American Indian or Alaska Native	118	95.0
	Asian	468	169.0
	Black or African American	16,369	578.9
	Hawaiian & Pacific Islander	147	2130.4
	Other Race	21,958	934.1
	Two or More Races	93	14.6
	White	35,536	496.7
	All Race/Ethnicities	74,689	558.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 41. 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

		Count			Rate per 1,000 Population		
Year	Age	New Jersey	Union County	Middlesex County	New Jersey	Union County	Middlesex County
2017	0-17	24,837	1565	1259	12.0	11.9	6.8
	18-44	91,990	5235	6511	30.4	26.5	20.8
	45-64	55,496	3709	3355	22.1	24.0	14.6
	65+	10,688	652	802	7.6	8.4	6.6
	All Ages	183,011	11,161	11,927	20.3	19.9	14.1
2018	0-17	26,241	1650	1422	13.4	12.6	7.8
	18-44	90,808	5502	6745	29.4	28.1	21.8
	45-64	55,715	3751	3298	22.4	24.3	14.5
	65+	11,055	554	920	7.7	7.0	7.4
	All Ages	183,819	11,457	12,385	20.5	20.5	14.7
2019	0-17	25,172	1677	1291	12.8	12.7	7.1
	18-44	90,172	5279	6901	29.0	26.5	22.2
	45-64	54,046	3437	3357	21.7	22.1	14.8
	65+	11,851	556	845	8.0	6.8	6.6
	All Ages	181,241	10,949	12,394	20.0	19.2	14.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 42. 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

		Count			Rate per 1,000 Population		
Year	Race/Ethnicity	New Jersey	Union County	Middlesex County	New Jersey	Union County	Middlesex County
2017	American Indian or Alaska Native	334	7	36	10.3	2.7	11.4
	Asian	3,380	108	647	3.9	3.4	3.2
	Black or African American	44,153	3,287	1,820	35.5	25.4	20.7
	Hawaiian & Pacific Islander	187	35	14	46.7	150.2	47.5
	Other Race	22,769	1,428	2,981	34.9	24.6	44.9
	Two or More Races	490	12	33	1.7	0.6	1.2
	White	106,929	6,067	6,285	18.1	17.9	14.3
	All Race/Ethnicities	178,242	10,944	11,816	19.8	18.8	14.2
2018	American Indian or Alaska Native	350	15	48	10.8	5.9	15.0
	Asian	3,497	109	642	3.9	3.4	3.1
	Black or African American	44,282	3,265	2,022	35.7	25.2	23.0
	Hawaiian & Pacific Islander	187	35	14	45.2	148.3	51.9
	Other Race	24,682	1,224	3,592	37.5	20.9	53.6
	Two or More Races	651	14	40	2.3	0.7	1.4
	White	104,601	6,467	5,897	17.9	19.3	13.7
	All Race/Ethnicities	178,250	11,129	12,255	19.9	19.2	14.9
2019	American Indian or Alaska Native	322	19	18	9.8	7.3	5.7
	Asian	3,466	114	637	3.8	3.5	3.0
	Black or African American	43,789	2,852	2,164	34.8	21.6	24.5
	Hawaiian & Pacific Islander	187	35	14	44.7	147.1	48.3
	Other Race	27,076	1,490	3,231	40.1	24.6	46.8
	Two or More Races	609	24	27	2.1	1.1	0.9
	White	99,593	6,119	6,075	17.0	18.0	14.1
	All Race/Ethnicities	175,042	10,653	12,166	19.4	18.1	14.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 43. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Treated in New Jersey, by Patient County of Residence and Age, 2017-2019

		Count			Rate per 1,000 Population		
Year	Age	New Jersey Residents	Union County	Middlesex County	New Jersey Residents	Union County	Middlesex County
2017	0-17	131,591	9,637	12,355	63.7	73.4	66.6
	18-44	231,158	14,755	19,275	76.5	74.8	61.6
	45-64	226,349	12,559	17,644	90.3	81.2	77.0
	65+	363,285	18,555	30,500	258.2	238.6	251.2
	All Ages	952,383	55,506	79,774	105.8	98.9	94.0
2018	0-17	130,739	9,343	12,011	66.7	71.4	66.2
	18-44	225,360	14,108	18,193	73.0	72.2	58.8
	45-64	221,118	12,087	17,134	88.9	78.4	75.5
	65+	364,459	17,348	29,623	254.0	219.4	239.6
	All Ages	941,676	52,886	76,961	105.0	94.5	91.5
2019	0-17	127,024	9,475	11,221	64.6	71.7	61.7
	18-44	218,270	14,011	17,357	70.2	70.3	55.9
	45-64	215,320	12,071	17,001	86.6	77.7	74.9
	65+	368,288	18,320	30,289	248.7	222.5	235.6
	All Ages	928,902	53,877	75,868	102.7	94.7	89.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 44. 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

Table 45. Inpatient Discharge Counts and Rates per 1,000 Population of Union County Resident Patients Treated at RWJUH Rahway, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	18-44	307	1.6
	45-64	888	5.7
	65+	2,166	27.8
	All Ages	3,361	6.0
2018	18-44	299	1.5
	45-64	910	5.9
	65+	2,104	26.6
	All Ages	3,313	5.9
2019	18-44	363	1.8
	45-64	960	6.2
	65+	2,211	26.9
	All Ages	3,534	6.2

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 46. Inpatient Discharge Counts and Rates per 1,000 Population of Union County Resident Patients Treated at Trinitas Regional Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	1,925	14.7
	18-44	3,624	18.4
	45-64	3,103	20.1
	65+	3,609	46.4
	All Ages	12,261	21.9
2018	0-17	1,767	13.5
	18-44	3,334	17.1
	45-64	2,889	18.7
	65+	3,535	44.7
	All Ages	11,525	20.6
2019	0-17	1,586	12.0
	18-44	2,949	14.8
	45-64	2,463	15.8
	65+	3,057	37.1
	All Ages	10,055	17.7

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 47. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in RWJUH Rahway's Primary Service Area Treated in New Jersey, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	2,874	70.6
	18-44	4,548	66.8
	45-64	4,454	81.0
	65+	6,919	241.0
	All Ages	18,795	97.6
2018	0-17	2,825	70.1
	18-44	4,403	64.8
	45-64	4,248	77.6
	65+	6,671	228.3
	All Ages	18,147	94.4
2019	0-17	2,715	66.8
	18-44	4,314	62.2
	45-64	4,264	77.3
	65+	6,978	229.1
	All Ages	18,271	93.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 48. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Trinitas Regional 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	2,883	85.0
	18-44	4,480	85.6
	45-64	3,515	109.9
	65+	3,612	268.9
	All Ages	14,490	110.1
2018	0-17	2,852	84.1
	18-44	4,509	86.8
	45-64	3,456	107.3
	65+	3,521	256.2
	All Ages	14,338	108.8
2019	0-17	2,781	81.0
	18-44	4,171	79.3
	45-64	3,292	101.1
	65+	3,386	236.8
	All Ages	13,630	101.9

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 49. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in RWJUH Rahway's Primary Service Area Treated at RWJUH Rahway, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	18-44	301	4.4
	45-64	923	16.8
	65+	2,235	77.9
	All Ages	3,459	18.0
2018	18-44	289	4.3
	45-64	957	17.5
	65+	2,221	76.0
	All Ages	3,467	18.0
2019	18-44	352	5.1
	45-64	977	17.7
	65+	2,257	74.1
	All Ages	3,586	18.3

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 50. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Trinitas Regional Medical Center's Primary Service Area Treated at Trinitas Regional Medical Center, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	1,286	37.9
	18-44	2,408	46.0
	45-64	2,157	67.5
	65+	2,492	185.5
	All Ages	8,343	63.4
2018	0-17	1,261	37.2
	18-44	2,336	45.0
	45-64	2,014	62.6
	65+	2,398	174.5
	All Ages	8,009	60.8
2019	0-17	1,158	33.7
	18-44	2,086	39.7
	45-64	1,709	52.5
	65+	2,058	143.9
	All Ages	7,011	52.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 51. 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

		Count			Rate per 1,000 Population		
Year	Race/Ethnicity	New Jersey	Union County	Middlesex County	New Jersey	Union County	Middlesex County
2017	American Indian or Alaska Native	1913	64	271	58.9	24.9	86.2
	Asian	40,158	1,640	10,010	45.9	51.1	48.8
	Black or African American	164,073	14,247	8,729	132.0	109.9	99.4
	Hawaiian & Pacific Islander	1438	105	122	358.9	450.6	413.6
	Other Race	135,193	10,075	16,669	207.0	173.9	251.1
	Two or More Races	1733	90	74	6.1	4.3	2.6
	White	607,875	29,285	43,899	102.9	86.6	99.9
	All Race/Ethnicities	952,383	55,506	79,774	268.3	-	-
2018	American Indian or Alaska Native	1689	61	257	51.9	24.1	80.4
	Asian	40,286	1,530	9,399	45.1	47.1	45.5
	Black or African American	160,752	13,386	8,583	129.5	103.4	97.8
	Hawaiian & Pacific Islander	2146	484	142	518.7	2050.8	525.9
	Other Race	146,436	10,481	16,760	222.3	178.8	250.0
	Two or More Races	1929	63	89	6.7	2.9	3.1
	White	588,438	26,881	41,731	100.6	80.1	97.1
	All Race/Ethnicities	941,676	52,886	76,961	267.7	-	-
2019	American Indian or Alaska Native	1559	104	160	47.7	24.1	50.8
	Asian	38,291	1,486	9,018	42.2	47.1	43.0
	Black or African American	156,678	13,213	8,830	124.6	103.4	100.1
	Hawaiian & Pacific Islander	1442	191	125	344.9	2050.8	431.0
	Other Race	152,844	11,423	16,628	226.6	178.8	240.7
	Two or More Races	1767	72	86	6.0	2.9	3.0
	White	576,321	27,388	41,021	98.1	80.1	95.5
	All Race/Ethnicities	928,902	53,877	75,868	262.7	-	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System 2021

Table 52. 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

Table 53. Inpatient Discharge Counts and Rates per 1,000 Population of Union County Resident Patients Treated at RWJUH Rahway, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rater per 1,000 Population
2017	American Indian or Alaska Native	-	-
	Asian	51	1.6
	Black or African American	932	7.2
	Hawaiian & Pacific Islander	-	-
	Other Race	245	4.2
	Two or More Races	-	-
	White	2,123	6.3
	All Race/Ethnicities	3,361	-
2018	American Indian or Alaska Native	-	-
	Asian	45	1.4
	Black or African American	920	7.1
	Hawaiian & Pacific Islander	-	-
	Other Race	304	5.2
	Two or More Races	-	-
	White	2,032	6.1
	All Race/Ethnicities	3,313	-
2019	American Indian or Alaska Native	-	-
	Asian	49	1.5
	Black or African American	1,076	8.2
	Hawaiian & Pacific Islander	-	-
	Other Race	401	6.6
	Two or More Races	-	-
	White	1,991	5.9
	All Race/Ethnicities	3,534	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 54. Inpatient Discharge Counts and Rates per 1,000 Population of Union County Resident Patients Treated at Trinitas Regional Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rater per 1,000 Population
2017	American Indian or Alaska Native	28	10.9
	Asian	185	5.8
	Black or African American	3,317	25.6
	Hawaiian & Pacific Islander	41	176.0
	Other Race	139	2.4
	Two or More Races	28	1.3
	White	8,523	25.2
	All Race/Ethnicities	12,261	-
2018	American Indian or Alaska Native	26	10.3
	Asian	116	3.6
	Black or African American	2,802	21.6
	Hawaiian & Pacific Islander	127	538.1
	Other Race	102	1.7
	Two or More Races	14	0.7
	White	8,338	24.8
	All Race/Ethnicities	11,525	-
2019	American Indian or Alaska Native	48	18.4
	Asian	86	2.6
	Black or African American	2,233	16.9
	Hawaiian & Pacific Islander	111	466.4
	Other Race	79	1.3
	Two or More Races	14	0.6
	White	7,484	22.0
	All Race/Ethnicities	10,055	-

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 55. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in RWJUH Rahway'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	44	75.1
	Asian	1,053	62.8
	Black or African American	4,411	102.8
	Hawaiian & Pacific Islander	28	383.6
	Other Race	2,757	189.5
	Two or More Races	29	4.4
	White	10,473	94.3
	All Race/Ethnicities	18,795	97.6
2018	American Indian or Alaska Native	47	82.9
	Asian	1,018	59.7
	Black or African American	4,002	93.0
	Hawaiian & Pacific Islander	83	1185.7
	Other Race	3,001	201.3
	Two or More Races	25	3.7
	White	9,971	90.7
	All Race/Ethnicities	18,147	94.4
2019	American Indian or Alaska Native	38	65.0
	Asian	962	55.7
	Black or African American	4,137	94.0
	Hawaiian & Pacific Islander	60	810.8
	Other Race	3,193	204.3
	Two or More Races	23	3.4
	White	9,858	88.7
	All Race/Ethnicities	18,271	93.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 56. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Trinitas Regional 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	19	15.8
	Asian	182	63.4
	Black or African American	3,437	123.0
	Hawaiian & Pacific Islander	30	454.5
	Other Race	3,294	144.3
	Two or More Races	23	3.7
	White	7,505	106.4
	All Race/Ethnicities	14,490	110.1
2018	American Indian or Alaska Native	17	14.2
	Asian	130	45.6
	Black or African American	3,304	118.0
	Hawaiian & Pacific Islander	196	2722.2
	Other Race	3,242	141.5
	Two or More Races	20	3.2
	White	7,429	105.4
	All Race/Ethnicities	14,338	108.8
2019	American Indian or Alaska Native	40	32.2
	Asian	107	38.6
	Black or African American	2,896	102.4
	Hawaiian & Pacific Islander	67	971.0
	Other Race	3,582	152.4
	Two or More Races	18	2.8
	White	6,920	96.7
	All Race/Ethnicities	13,630	101.9

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 57. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in RWJUH Rahway's Primary Service Area Treated at RWJUH Rahway, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	-	-
	Asian	94	5.6
	Black or African American	857	20
	Hawaiian & Pacific Islander	-	-
	Other Race	216	14.8
	Two or More Races	-	-
	White	2,277	20.5
	All Race/Ethnicities	3,459	18
2018	American Indian or Alaska Native	-	-
	Asian	94	5.5
	Black or African American	848	19.7
	Hawaiian & Pacific Islander	-	-
	Other Race	292	19.6
	Two or More Races	-	-
	White	2,217	20.2
	All Race/Ethnicities	3,467	18
2019	American Indian or Alaska Native	-	-
	Asian	88	5.1
	Black or African American	952	21.6
	Hawaiian & Pacific Islander	-	-
	Other Race	367	23.5
	Two or More Races	-	-
	White	2,161	19.4
	All Race/Ethnicities	3,586	18.3

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 58. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in Trinitas Regional Medical Center's Primary Service Area Treated at Trinitas Regional Medical Center, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	15	12.5
	Asian	88	30.6
	Black or African American	2,090	74.8
	Hawaiian & Pacific Islander	11	166.7
	Other Race	95	4.2
	Two or More Races	15	2.4
	White	6,029	85.5
	All Race/Ethnicities	8,343	63.4
2018	American Indian or Alaska Native	14	11.7
	Asian	49	17.2
	Black or African American	1,781	63.6
	Hawaiian & Pacific Islander	80	1111.1
	Other Race	64	2.8
	Two or More Races	-	1.3
	White	6,013	85.3
	All Race/Ethnicities	8,009	60.8
2019	American Indian or Alaska Native	27	21.7
	Asian	42	15.2
	Black or African American	1,403	49.6
	Hawaiian & Pacific Islander	57	826.1
	Other Race	49	2.1
	Two or More Races	-	0.9
	White	5,427	75.9
	All Race/Ethnicities	7,011	52.4

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 59. Hospital Admission Rates per 1,000 Population, by Race/Ethnicity, New Jersey, RWJUH Rahway, and Trinitas Regional 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
RWJUH Rahway	Asian	3.0	0.9	2.0	0.3
	Black	12.5	2.5	9.9	3.0
	Hispanic	4.8	1.5	3.3	1.2
	White	9.0	2.2	6.8	1.5
	All Race/Ethnicities	9.8	2.4	7.4	1.9
TRMC	Asian	4.3	1.8	2.5	1.4
	Black	16.1	2.8	13.2	3.4
	Hispanic	6.7	1.9	4.8	2.0
	White	4.6	1.2	3.4	1.0
	All Race/Ethnicities	10.8	2.6	8.2	2.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 60. Hospital Admission Rates per 1,000 Population by Reason for Admission, by Race/Ethnicity, New Jersey, RWJUH Rahway, and Trinitas Regional 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
RWJUH Rahway	Asian	37.4	4.4	0.8	0.4
	Black	79.0	13.0	3.6	1.1
	Hispanic	50.4	5.7	2.5	1.1
	White	67.7	12.2	2.9	1.2
	All Race/Ethnicities	76.9	12.3	3.4	1.3
TRMC	Asian	6.5	5.1	0.4	1.1
	Black	24.5	14.0	7.3	3.3
	Hispanic	12.9	7.6	3.6	1.6
	White	8.2	4.3	2.7	1.1
	All Race/Ethnicities	82.9	10.9	5.6	2.6

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 61. Hospital Admission and Emergency Department Visit Rates per 1,000 Population, by Age and Race/Ethnicity, New Jersey, RWJUH Rahway, and TRMC, 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	403.0
	Under 18	0.4	1.9	1.4	1.1	1.6	99.8	477.1	497.4	181.7	344.0
	18 to 64	3.5	26.5	9.3	12.0	15.0	91.4	760.5	392.4	248.0	396.6
	65+	25.3	73.3	46.6	48.7	54.8	233.8	698.1	548.2	428.5	505.8
RWJUH Rahway	All	37.4	79.0	50.4	67.7	76.9	126.2	494.6	352.6	226.0	366.1
	Under 18	9.6	18.1	16.5	9.7	16.5	121.3	375.6	447.2	152.8	327.4
	18 to 64	35.5	72.8	47.4	49.7	65.2	104.5	524.7	307.9	205.6	354.8
	65+	117.6	219.9	159.1	177.9	205.7	296.6	557.3	480.4	357.3	463.9
TRMC	All	6.5	24.5	12.9	8.2	82.9	172.9	625.1	501.7	211.0	616.1
	Under 18	0.4	1.0	1.1	0.4	6.0	49.8	116.7	141.8	40.6	155.0
	18 to 64	1.8	17.2	7.3	4.6	53.6	96.8	444.3	307.5	137.7	392.3
	65+	4.3	6.4	4.5	3.2	23.3	26.4	64.1	52.4	32.7	68.8

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 62. 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

	Count			Rate per 1,000 Population		
Year	New Jersey Residents	Union County	Middlesex County	New Jersey Residents	Union County	Middlesex County
2017	73,005	3,966	4,471	8.1	7.1	5.3
2018	69,282	3,790	4,063	7.7	6.8	4.8
2019	65,610	3,659	3,647	7.3	6.4	4.3

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 63. 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

	Count			Rate per 1,000 Population		
Year	New Jersey Residents	Union County	Middlesex County	New Jersey Residents	Union County	Middlesex County
2017	126,968	6,710	10,851	14.1	12	12.8
2018	125,886	6,525	10,552	14.0	11.7	12.5
2019	126,198	6,562	10,841	14.0	11.5	12.8

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Table 64. Inpatient Discharge Counts and Rates per 1,000, Residents of Union County Treated at RWJUH Rahway, by Major Diagnostic Category, 2017-2019

	Count			Rate per 1,000 Population		
Major Diagnostic Category	2017	2018	2019	2017	2018	2019
Mental Diseases and Disorders & Alcohol/Drug Use or Induced Mental Disorder	36	47	56	0.1	0.1	0.1
Diseases and Disorders of the Circulatory System	854	807	877	1.5	1.4	1.5

DATA SOURCE: NJ State Database, 2017-2019; courtesy of RWJH Barnabas Hospital System

Appendix G- Cancer Data

CANCER INCIDENCE RATE REPORT: CANCER PATIENT ORIGIN UNION COUNTY 2020

RWJUH Rahway

Seventy four percent of RWJUH Rahway's cancer inpatients and 39.1% of cancer outpatients resided in the Primary Service Area. In total, 66.0% of inpatients and 55.4% of outpatients resided in Union County. Rahway (07065) and Linden (07036) represent the largest segment of RWJ-R's inpatient cancer patients. Similarly, the same zip codes represent the largest segments of RWJ-H'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 RWJ RAH IP PATIENTS	%	2020 RWJ RAH OP PATIENTS	%
Union County	310	66.0%	51	55.4%
Primary Service Area	348	74.0%	36	39.1%
Secondary Service Area	66	14.0%	34	37.0%
Out of Service Area (NJ)	51	10.9%	19	20.7%
Out of State	5	1.1%	3	3.3%
TOTAL	**470**	**100.0%**	**92**	**100.0%**
Rahway (07065)	104	22.1%	12	13.0%
Linden (07036)	104	22.1%	9	9.8%

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).

Trinitas Regional Medical Center

Almost fifty-six percent of TRMC's cancer inpatients and 69.8% of cancer outpatients resided in the Primary Service Area. In total, 88.1% of inpatients and 92.3% of outpatients resided in Union County. Elizabeth (07202) and Elizabeth (07206) represent the largest segment of TRMC's inpatient cancer patients. Similarly, Elizabeth (07202) an Elizabeth (07201) represent the largest segments of TRMC'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	2019 TRMC IP	%	2019 TRMC OP	%
Union County	52	88.1%	370	92.3%
Primary Service Area	33	55.9%	280	69.8%
Secondary Service Area	15	25.4%	86	21.4%
Out of Service Area (NJ)	9	15.3%	31	7.7%
Out of State	2	3.4%	4	1.0%
TOTAL	**59**	**1.5%**	**401**	**6.8%**
Elizabeth (07202)	17	28.8%	97	24.2%
Elizabeth (07206)	7	11.9%		
Elizabeth (07201)			68	17.0%

Source: TRMC

CANCER INCIDENCE RATE REPORT: UNION COUNTY 2013-2017

INCIDENCE RATE REPORT FOR UNION 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	453.7	2802	falling	-1.2
Bladder	20.4	127	falling	-2
Brain & ONS	5.6	33	*	*
Breast	136.7	454	stable	0
Cervix	9.3	29	stable	-0.3
Colon & Rectum	39.1	243	falling	-3.2
Esophagus	3.7	23	stable	-1.9
Kidney & Renal Pelvis	15	93	stable	0.2
Leukemia	15.7	93	stable	1
Liver & Bile Duct	6.3	40	rising	1.8
Lung & Bronchus	43.1	262	falling	-2.2
Melanoma of the Skin	15.7	97	stable	0.2
Non-Hodgkin Lymphoma	21.1	129	stable	-6.5
Oral Cavity & Pharynx	9	57	stable	-0.1
Ovary	10.6	36	falling	-2.4
Pancreas	13.4	82	stable	0.5
Prostate	134.6	390	falling	-3.7
Stomach	9.7	59	stable	-0.8
Thyroid	15.8	92	falling	-8.9
Uterus (Corpus & Uterus, NOS)	29.3	102	stable	1

The Source for D2 and following tables D3, D4, D5 and D6 is: https://statecancerprofiles.cancer.gov

CANCER INCIDENCE DETAILED RATE REPORT: UNION COUNTY 2013-2017SELECT CANCER SITES: RISING INCIDENCE RATES

		Liver & Bile Duct
INCIDENCE RATE REPORT FOR UNION COUNTY 2013-2017 All Races (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	6.3
	Average Annual Count	40
	Recent Trend	rising
	Recent 5-Year Trend in Incidence Rates	1.8
White Non-Hispanic, All Ages	Age-Adjusted Incidence Rate - cases per 100,000	5.5
	Average Annual Count	19
	Recent Trend	rising
	Recent 5-Year Trend in Incidence Rates	2.1
Black (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	6.4
	Average Annual Count	9
	Recent Trend	stable
	Recent 5-Year Trend in Incidence Rates	0.9
Asian or Pacific Islander (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	*
	Average Annual Count	3 or fewer
	Recent Trend	*
	Recent 5-Year Trend in Incidence Rates	*
Hispanic (any race), All Ages	Age-Adjusted Incidence Rate - cases per 100,000	7.7
	Average Annual Count	10
	Recent Trend	stable
	Recent 5-Year Trend in Incidence Rates	0.6
MALES	Age-Adjusted Incidence Rate - cases per 100,000	9.4
	Average Annual Count	27
	Recent Trend	stable
	Recent 5-Year Trend in Incidence Rates	0.8
FEMALES	Age-Adjusted Incidence Rate - cases per 100,000	3.7
	Average Annual Count	13
	Recent Trend	rising
	Recent 5-Year Trend in Incidence Rates	2.6

** 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).*

CANCER MORTALITY RATE REPORT: UNION COUNTY 2014-2018

MORTALITY RATE REPORT: UNION 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 Trendin Mortality Rates
All Cancer Sites	***	139.4	876	falling	-2
Bladder	***	4.2	26	stable	-1
Brain & ONS	***	3.7	23	*	*
Breast	***	20.8	75	falling	-2.3
Cervix	***	2.2	8	falling	-2.8
Colon & Rectum	***	13.2	84	falling	-3
Esophagus	***	3	19	falling	-2.2
Kidney & Renal Pelvis	***	2.4	16	falling	-2.6
Leukemia	***	5.5	34	falling	-1.3
Liver & Bile Duct	***	5.4	34	rising	1.2
Lung & Bronchus	***	27.6	172	falling	-7
Melanoma of the Skin	***	1.5	10	stable	-1.4
Non-Hodgkin Lymphoma	***	5.5	34	falling	-2.2
Oral Cavity & Pharynx	***	2.3	15	falling	-2.4
Ovary	***	6.7	24	falling	-2.3
Pancreas	***	10.4	65	stable	-0.3
Prostate	***	17	42	falling	-3.7
Stomach	***	4.1	25	falling	-3.4
Thyroid	***	0.6	3	*	*
Uterus (Corpus & Uterus, NOS)	***	6	21	stable	0.7

*** 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).*

CANCER MORTALITY DETAILED RATE REPORT (Highest Volume): UNION COUNTY 2014-2018

		Liver & Bile Duct
MORTALITY RATE REPORT FOR UNION COUNTY 2014-2018 All Races (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	5.4
	Average Annual Count	34
	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	4.9
	Average Annual Count	17
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	2.2
Black (includes Hispanic), All Ages	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	5.9
	Average Annual Count	8
	Recent Trend	stable
	Recent 5-Year Trend in Death Rates	2.1
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	6.9
	Average Annual Count	8
	Recent Trend	*
	Recent 5-Year Trend in Death Rates	*
MALES	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	7.5
	Average Annual Count	20
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	1.8
FEMALES	Met Healthy People Objective	***
	Age-Adjusted Death Rate - per 100,000	3.8
	Average Annual Count	14
	Recent Trend	rising
	Recent 5-Year Trend in Death Rates	2.2

**** 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).*

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	*	*

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	5.6	33	*	*
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

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
Passaic County	8.6	23	stable	-2.1
Ocean County	8.2	27	stable	-1.5
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

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	37.1	233	falling	-3.4
Somerset County	35.2	139	falling	-3.4
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

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
Atlantic County	17.4	60	stable	0.2
Cape May County	17.3	26	stable	2.1
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

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	13.7	10	stable	-1.1
Hudson County	11.5	72	stable	0
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

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
Atlantic County	64.7	226	falling	-1.9
Warren County	63.8	91	stable	-1
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

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
Passaic County	14.3	77	stable	0.2
Essex County	12.2	103	stable	-0.1
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

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
Ocean County	12.8	108	rising	1.7
Sussex County	12.7	25	stable	1.7
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

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	10.6	36	falling	-2.4
Cumberland County	10.4	9	stable	15.6
Sussex County	10.2	10	falling	-3.3
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

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
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
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

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	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				
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), Both Sexes, 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

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
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
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

RWJUH Rahway - TUMOR REGISTRY SUMMARY

In 2019, RWJUH Rahway's tumor registry data showed that 6.2% and 13.0% 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: Lip and Oral Cavity(66.6%), followed by Respiratory Systems (41.4%).

Compared to 2018, there was a decrease of 215 cases (-29.5%) in 2019. The three biggest decreases in overall casesoccurred in Breast (-143, -72.2%), followed by Male Genital Organs (-68, -49.3%) and Digestive Organ (-32, -14.3%). Please note that case volume counts smaller than 10 are suppressed. Staging percentages are calculated on analyticcases only.

		Cases (both analytic and non-analytic)		2018			2019			2018 - 2019			
MainSite	SubSite	2018	2019	% Stage3	% Stage 4	Total % Stage3 & 4	% Stage 3	% Stage4	Total % Stage3 & 4	Changein Case Volume	Changein % points for Stage 3	Changein % points for Stage 4	Changein % points for Stage 3 & 4
BREAST		**198**	**55**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**(143)**	**0.0**	**0.0**	**0.0**
DIGESTIVE ORGANS		**223**	**191**	**25.7%**	**14.3%**	**40.0%**	**14.3%**	**16.7%**	**31.0%**	**(32)**	**(11.4)**	**2.4**	**(9.0)**
	COLON	105	92	57.1%	0.0%	57.1%	26.7%	6.7%	33.3%	(13)	(30.5)	6.7	(23.8)
	ESOPHAGUS	12		0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	(6)	0.0	(50.0)	(50.0)
	PANCREAS	13	13	0.0%	50.0%	50.0%	0.0%	57.1%	57.1%	0	0.0	7.1	7.1
	RECTUM	39	44	0.0%	50.0%	50.0%	0.0%	33.3%	33.3%	5	0.0	(16.7)	(16.7)
	STOMACH	33		0.0%	20.0%	20.0%	0.0%	25.0%	25.0%	(26)	0.0	5.0	5.0
FEMALE GENITAL ORGANS		**12**	**11**	**0.0%**	**66.7%**	**66.7%**	**0.0%**	**0.0%**	**0.0%**	**(1)**	**0.0**	**(66.7)**	**(66.7)**
HEMATOPOIETIC AND RETICULOENDOTHELI ALSYSTEMS		**18**	**37**	**0.0%**	**8.3%**	**8.3%**	**0.0%**	**0.0%**	**0.0%**	**19**	**0.0**	**(8.3)**	**(8.3)**
LIP, ORAL CAVITY ANDPHARYNX		**14**		**0.0%**	**0.0%**	**0.0%**	**0.0%**	**66.7%**	**66.7%**	**(6)**	**0.0**	**66.7**	**66.7**
LYMPH NODES		**13**	**11**	**40.0%**	**0.0%**	**40.0%**	**33.3%**	**0.0%**	**33.3%**	**(2)**	**(6.7)**	**0.0**	**(6.7)**
MALE GENITAL ORGANS		**138**	**70**	**0.0%**	**18.2%**	**18.2%**	**0.0%**	**11.1%**	**11.1%**	**(68)**	**0.0**	**(7.1)**	**(7.1)**
	PROSTATE GLAND	133	68	0.0%	22.2%	22.2%	0.0%	12.5%	12.5%	(65)	0.0	(9.7)	(9.7)
RESPIRATORY SYSTEM ANDINTRATORACIC ORGANS		**33**	**56**	**0.0%**	**70.8%**	**70.8%**	**6.9%**	**41.4%**	**48.3%**	**23**	**6.9**	**(29.5)**	**(22.6)**
	BRONCHUS ANDLUNG	21	50	0.0%	81.0%	81.0%	7.7%	46.2%	53.8%	29	7.7	(34.8)	(27.1)
	LARYNX	11		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(8)	0.0	0.0	0.0
SKIN		**12**		**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**(10)**	**0.0**	**0.0**	**0.0**
UNKNOWN PRIMARY SITE		**11**	**16**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**5**	**0.0**	**0.0**	**0.0**
URINARY TRACT		**42**	**40**	**0.0%**	**3.8%**	**3.8%**	**0.0%**	**0.0%**	**0.0%**	**(2)**	**0.0**	**(3.8)**	**(3.8)**
	BLADDER	39	35	0.0%	4.3%	4.3%	0.0%	0.0%	0.0%	(4)	0.0	(4.3)	(4.3)
Grand Total		**730**	**515**	**8.3%**	**21.1%**	**29.3%**	**6.2%**	**13.0%**	**19.2%**	**(215)**	**(2.1)**	**(8.1)**	**(10.1)**

Trinitas Regional Medical Center - TUMOR REGISTRY SUMMARY

In 2019, TRMC's tumor registry data showed that 7.3% and 17.5% 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: Retroperitoneum and Peritoneum (50.0%), followed by Lip and Oral Cavity (44.4%), Respiratory Systems (39.3%) and Lymph Nodes (35.7%).

Compared to 2018, there was a decrease of 31 cases (-6.0%) in 2019. The three biggest decreases in overall cases occurred in Digestive Organs (-16, -11.5%), followed by Male Genital Organs (-12, -27.3%) and Respiratory Systems (-11, -15.7%). Please note that case volume counts smaller than 10 are suppressed. Staging percentages are calculated on analytic cases only.

		Cases (both analytic and non-analytic)		2018			2019			2018 - 2019			
MainSite	SubSite	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
BONES, JOINTS and ARTICULAR CARTILAGE				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(1)	0.0	0.0	0.0
BREAST		102	107	1.1%	8.8%	9.9%	5.1%	9.1%	14.1%	5	4.0	0.3	4.3
CONNECTIVE, SUBCUTANEOUS AND OTHER SOFT TISSUES				0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4	0.0	0.0	0.0
DIGESTIVE ORGANS		139	123	10.7%	28.1%	38.8%	7.0%	24.0%	31.0%	(16)	(3.7)	(4.1)	(7.8)
	COLON	38	43	0.0%	17.6%	17.6%	2.9%	20.0%	22.9%	5	2.9	2.4	5.2
	LIVER AND INTRAHEPATIC BILE DUCTS	24	15	10.0%	30.0%	40.0%	9.1%	18.2%	27.3%	(9)	(0.9)	(11.8)	(12.7)
	PANCREAS	21	14	12.5%	31.3%	43.8%	0.0%	81.8%	81.8%	(7)	(12.5)	50.6	38.1
	RECTUM		11	33.3%	11.1%	44.4%	22.2%	11.1%	33.3%	2	(11.1)	0.0	(11.1)
	STOMACH	25	15	4.3%	39.1%	43.5%	7.7%	15.4%	23.1%	(10)	3.3	(23.7)	(20.4)
EYE, BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM		18	11	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(7)	0.0	0.0	0.0
	MENINGES	12		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(4)	0.0	0.0	0.0
FEMALE GENITAL ORGANS		30	36	14.3%	14.3%	28.6%		19.4%	22.6%	6	0.0%	5.1	(6.0)
	CORPUS UTERI	13	18	0.0%	9.1%	9.1%	0.0%	12.5%	12.5%	5	0.0	3.4	3.4
HEMATOPOIETIC AND RETICULOENDOTHELIAL SYSTEMS		42	39	3.1%	9.4%	12.5%	0.0%	2.8%	2.8%	(3)	(3.1)	(6.6)	(9.7)
LIP, ORAL CAVITY AND PHARYNX				11.1%	11.1%	22.2%	11.1%	44.4%	55.6%	1	0.0	33.3	33.3
LYMPH NODES		16	14	21.4%	14.3%	35.7%	28.6%	35.7%	64.3%	(2)	7.1	21.4	28.6
MALE GENITAL ORGANS		44	32	0.0%	36.4%	36.4%	11.5%	11.5%	23.1%	(12)	11.5	(24.8)	(13.3)
	PROSTATE GLAND	43	29	0.0%	36.4%	36.4%	8.3%	12.5%	20.8%	(14)	8.3	(23.9)	(15.5)

		Cases (both analytic and non-analytic)		2018			2019			2018-2019			
MainSite	SubSite	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
RESPIRATORY SYSTEM AND INTRATORACIC ORGANS		70	59	18.0%	41.0%	59.0%	12.5%	39.3%	51.8%	(11)	(5.5)	(1.7)	(7.2)
	BRONCHUS AND LUNG	68	54	18.6%	40.7%	59.3%	13.7%	41.2%	54.9%	(14)	(4.9)	0.5	(4.4)
RETROPERITONEUM AND PERITONEUM		[redacted]		50.0%	0.0%	50.0%	50.0%	50.0%	100.0%	0	0.0	50.0	50.0
SKIN		[redacted]		0.0%	25.0%	25.0%	0.0%	0.0%	0.0%	(1)	0.0	(25.0)	(25.0)
THYROID AND OTHER ENDOCRINE GLANDS		25	17	0.0%	4.8%	4.8%	0.0%	0.0%	0.0%	(8)	0.0	(4.8)	(4.8)
	THYROID GLAND	14	11	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(3)	0.0	0.0	0.0
UNKNOWN PRIMARY SITE		[redacted]		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0	0.0	0.0	0.0
URINARY TRACT		16	30	0.0%	30.0%	30.0%	12.0%	8.0%	20.0%	14	12.0	(22.0)	(10.0)
		Cases (both analytic and non-analytic)		2018			2019			2018 - 2019			
MainSite	SubSite	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
	BLADDER	[redacted]	14	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	6	0.0	0.0	0.0
	KIDNEY	[redacted]	11	0.0%	60.0%	60.0%	25.0%	25.0%	50.0%	5	25.0	(35.0)	(10.0)
Grand Total		537	506	7.8%	20.4%	28.2%	7.3%	17.5%	24.8%	(31)	(0.5)	(2.9)	(3.4)

Appendix H- Hospital Outcomes and Results of the Previous Implementation Plans: RWJUH Rahway and Trinitas Regional Medical Center

Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION PLAN

2019 -2021

Introduction

In 2019, Robert Wood Johnson University Hospital Rahway 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 secondary source data, a survey and meetings with local health officials and a Public Health Symposium made up of county public health officers and community representatives. The Plan can be accessed at https://www.rwjbh.org/why-rwjbarnabas-health-/community-health-needs-assessment/

Through the CHNA process, health need priorities were chosen based on the hospital's capacity, resources, competencies, and the needs specific to the populations it serves. The Implementation Plan addresses the manner in which RWJ Rahway will address each priority need and the expected outcome for the evaluation of its efforts. The implementation plan which follows is based on the three selected priority areas*:

- Nutrition Education
- Diabetes/Obesity
- Behavioral Health

**The focus areas do not represent the full extent of the hospital's community benefit activities or its support of the community's health needs. Other needs identified through the CHNA may be better addressed by other agencies/organizations or deferred to another timeframe. Other significant needs identified in the CHNA include primary care physician shortages, substance abuse, low birthweight, C-Section rate, STDs, teen pregnancy, immunization, tobacco use and community safety.*

Goal I: Improve Health Through Healthier Eating and Improving Access to Healthy Food

Key CHNA Findings:

- ***The community survey revealed that while 96% of respondents say they understood what healthy food is, only 84% said they eat healthy food on a regular basis.***
- ***15% say they worried whether their food would run out before they got money to buy more food.***

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
1.1	**Assure access to healthy eating programs in age of COVID through combination of virtual and in person programming.**	Goal to double number of virtual programs and increase viewership. Attract a more diverse audience through African American Churches.	Nutrition staff, Community Education	2019 Baseline: 79 in person educational/demo programs. >500 clients served. 2020: Pivoted from live cooking programs to 10 virtual cooking programs more than 200 attendance. 2021: 12 virtual healthy cooking programs 300 attended. Flood at fitness center destroyed kitchen. Relaunch to live programming in 2022. Three programs ytd. RDs provided virtual talks to support groups, senior groups and diabetes groups. 2022 ytd ten live presentations. Three Quarterly articles published on food, nutrition, aspects of nutrition in 2021-22 newsletter.
	Include healthy eating articles in community newsletter and social media.	At least 1 page per issue of dietitian-approved recipes. 1-2 pages slated.	Marketing	
	Link Frontline Appreciation, Community Groups and pantries to provide steady stream of food.	Link local community groups, Frontline Appreciation groups, vendors with Food pantries for food drives, donations.	FLAG groups, YMCA	
	Link nutritional counseling to community groups, churches, support groups and RWJ Rahway Fitness. Promotion of counseling services in various venues	Increase nutrition outreach to more support groups, church groups and others.	Nutrition staff, Community Ed	

Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

Goal I: Improve Health Through Healthier Eating and Improving Access to Healthy Food

Key CHNA Findings:

- ***The community survey revealed that while 96% of respondents say they understood what healthy food is, only 84% said they eat healthy food on a regular basis.***
- ***15% say they worried whether their food would run out before they got money to buy more food.***

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
1.2	**Hold food, supplies drive and distribution to local community food pantry**	Increase contribution by 100 pounds per month of healthy pantry staples to local food pantry, along with recipes, preparation and safety information.	Nutrition, community	In 2020, stepped up monthly food collection and distribution to local pantry. Between 100 and 200 pounds of food per month. In addition: • Collected, delivered masks, cleaning products, personal protective equipment for food pantry workers and vulnerable pantry clients. • Collected, distributed adult diapers, children's diapers, face cleanser and other personal needs. 2021 • Supplied over a ton of shelf table items, 100 frozen turkeys, plus produce through distributor Common Market. • Supplied over 200 backpacks stuffed with school supplies and holiday presents to local food pantry children. • Supplied $75 food gift cards to 12 families with special needs children through Rahway schools.

Goal II: Improve Diabetes Education, Glucose Control, Reduce Obesity

Key CHNA Findings:

- ***Percentage of Union County residents with BMI over 30 rose to 25.6% in 2016 from 23.3% in 2012.***
- ***Union County ranks in the lowest quartile in terms of percent of diabetic Medicare enrollees receiving A1C screenings.***
- ***Diabetes is 8th leading cause of death in Union County***

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
2.1	**Provide education, resources and support to the community, including food pantries, churches and libraries.** **Promote care pathways for low-income constituents who have difficulty obtaining healthy weight.**	Increase the number/types (virtually or small group) of community educational programs/demonstrations. Increase outreach to in free support/education programs, either virtually or in person , including exercise, nutrition and bariatric surgery.		Baseline Measure 2019: 60 educational programs/demos provided at various locales. 12 Professionally led diabetes support groups. 12 Professionally led bariatric support groups. 2020 5 Diabetes support groups. 10 Virtual Education/support. 12 Virtual bariatric support 2021 10 virtual bariatric support 10 in person diabetes support
2.2	**Offer a series of health screenings surrounding blood glucose and blood pressure with referral to education, counseling or physician.**	Increase the number of blood pressure and cholesterol screenings provided (Target: 15 screenings annually)		Baseline Measure: 2019 10 free screenings 2020 Goal: 0 screenings 2021 Goal: 0 screenings
2.3	**Small group workshops on prediabetes for uninsured, underinsured clients.** **Provide phone counseling, virtual workshops.**	Hold a series of small group workshops on glucose control through lifestyle, medication and activity. Promote virtual options for small group workshops.		Baseline Measure: 2019: Six, six-week class sessions. 2020: One six-week in-person session. Pivot to virtual workshops 2020-2021. 2021: Three, six-week in person programs at YMCA in late 2021. 15 people per session.

Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

Goal III: Diabetes Prevention by Promoting Healthy Eating and Exercise at Schools and Community-based Organizations.

Key CHNA Findings:

- ***Obesity/ Diabetes identified as a top issue by residents.***
- ***Identified as a top six health issue by PSA Health Officers.***

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
3.1	**Expand relationships with schools, community organizations, churches and senior facilities for healthy eating and exercise programming.** **Expanding prediabetes education virtually. Virtual prediabetes programming.**	Increase programming in largely African American churches through virtual programming.	Diabetes, Dietary staff, Gateway Family YMCA, Churches	2019 Baseline: Two prediabetes live workshops at two large churches. Four Quarterly pre-diabetes/diabetes education programs. 2020: Two virtual prediabetes programs through church-based outreach. >200 served. Pivoted to virtual education around Covid. Arranged doctors to speak at three webinar sessions reaching African American, Hispanic audiences. 2021 Pivoted to vaccine clinics in one large church, two in schools. Covid Vaccine Clinics: In addition to hospital-based vaccine clinics, established three community-based clinics: one in large church, Agape Community Worship, two in local schools. More than 290 people were vaccinated at these clinics.
3.2	**Expand programming/counseling in fitness centers, such as Gateway Family YMCA, Scotch Plains YMCA, as well as RWJ Rahway Fitness & Wellness Centers.**	Prediabetes-focused programs on lifestyle changes to avert diabetes and health safety.	Dietary, Diabetes staff, Gateway Family YMCA	2019 Baseline: 30 educational/exercise programs in fitness centers. 2020: Virtual educational programming. Conduct live/joint programs. 2021 Resumed diabetes exercise, lunch and learn program. Three in person sessions that include exercise, as well as education and group discussion. 2022 ytd Three diabetes exercise lunch and learn programs.

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Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

Goal IV: Behavioral Health

Key CHNA Findings:

- ***Union County had second highest rate of residents in the state with an inpatient hospitalization for a mental health condition***
- ***Drug overdose deaths nearly doubled from 2014 to 2016***
- ***41% of Community Survey Respondents were concerned regarding high stress lifestyle.***
- ***In 2016, 9.1% of Union County residents reported 14 of the past 30 days were not good mental health days.***

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
4.1	**Improve access to mental health services** **Promote mental health well being through support groups, referral network.** **Promote resources available in health system, county for mental health response.**	Increase the number of participants in support, educational programs through publications/social media/community linkages and speakers Use community publication and social media for stories and referral to system programs, services and support.	NAMI Union County Self Help Clearinghouse, NAMI	2019: Increased membership in NAMI group by 10-15 families 2020: Promoted virtual family training in conjunction with community partner NAMI for clients. 2020 Pivoted to virtual, professionally-led support groups for caregivers, cancer survivors, those with fibromyalgia during Covid. 2021: Facilitated and promoted family training for families caring for mentally ill family members. Held 1 family training for 2022 session.
4.2	**Develop exercise and stress management program with YMCA.**	Hold at least 2-3 programs mixing exercise/stress management.	Fitness Centers, RWJ Behavioral health, RWJ Rahway	2020: Establish targeted program for YMCA guests. Not achieved. 2021: Hold two-three programs, targeted to physical and mental wellbeing, exercise, meditation and lifestyle change. Not achieved.

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Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

Goal IV: Behavioral Health

Key CHNA Findings:

-41% of Community survey respondents were concerned regarding substance use and abuse.

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
4.3	**Facilitate and Promote Narcan Training, Narcan Awareness to community at large, Narcotics Anonymous, All Recovery groups, Alcoholics Anonymous.**	Promote, schedule and arrange Narcan training sessions through new media platform.	Community education	Arranged/promoted 3 Narcan Training programs in 2019 Arranged/promoted 2 virtual Narcan programs 2020 Arranged/promoted 3 virtual Narcan training session 2021.
4.4	**Promote availability of all recovery support group for people with substance abuse disorders**	Use newsletters, publications, social media and other communication to promote recovery meetings. Increase participation in meetings	Community Education	2019 baseline: Weekly group increased from 19 to 25 people. 2020: Promoted Support groups, recovery groups, Narcan programs in publications, social media. 2021: Flood at fitness center closed rooms down. Unable to hold Narcan programs, recovery groups, etc.

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Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

Trinitas Regional Medical Center | RWJBarnabas HEALTH

COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION PLAN RESULTS

2019 -2021

Introduction

In 2019, Trinitas Regional Medical Center ("TRMC") 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 secondary source data, a survey and meetings with local health officials and a Public Health Symposium made up of county public health officers and community representatives. The Assessment and Plan can be accessed at https://www.rwjbh.org/trinitas-regional-medical-center/about/community-health-needs-assessment/

Through the CHNA process, health need priorities were chosen based on the hospital's capacity, resources, competencies, and the needs specific to the populations it serves. The Implementation Plan addresses the manner in which TRMC will address each priority need and the expected outcome for the evaluation of its efforts. The implementation plan which follows is based on the four selected priority areas*:

- Behavioral Health
- Cancer
- Chronic Disease
- Maternal and Child Health

**The focus areas do not represent the full extent of the hospital's community benefit activities or its support of the community's health needs. Other needs identified through the CHNA may be better addressed by other agencies/organizations or deferred to another timeframe. Other significant needs identified in the CHNA include diabetes, overweight/obesity, heart disease and stroke, substance use disorder, domestic violence, disability and respiratory disease. Top contributing factors were identified including access to healthy and fresh foods, low-income/poverty, health habits, educational attainment and health literacy, amongst others.*

Goal I: Increase access to behavioral health services.

Key CHNA Findings:

- ***Approximately 23% of Elizabeth adults report a history of depression, a higher percentage than Union County overall and the state.***
- ***Elizabeth had nine suicide deaths in 2017 and eight suicide deaths each year in 2016 and 2015.***

	Strategy/Initiative	Indicator/ Metric	Responsible Staff*	Tracking/Outcome
1.1	Reduce stigma associated with behavioral health conditions. • Provide behavioral health education and awareness programs at Trinitas and in collaboration with community organizations.	Collaborative Meetings held	Behavioral Health Program Directors	• 6 CIT trainings for law enforcement and community mental health providers, 171 people attended • School education sessions ➢ 2020/21 -9 sessions, 346 attended ➢ 2021/22- 9 sessions, 368 attended • Children's Interagency Coordinating Council- 4 mtgs, 125 people • Health Fairs- 4, 675 people • Traumatic Loss Coalition, 11 responses, 345 people • Guest speaker sessions, 7 sessions, 409 people
1.2	Identify patients that could benefit from behavior health services. • Provide hospital-wide screening of patients for substance use disorders (SUD).	Increase Screenings and Screening touch points	SAS Program Director Nursing	• Implemented AUDIT as part of screening and nursing assessment • 2021-present--secured county funding to have a Substance Use Navigator in the ED, 40 hrs/week- to link pts with SAS services after presenting to ED with alcohol or drug related ed visits • 2021- SAS director presented for Union County Alcohol Awareness Month • 2022- Union County Impact Festival-SAS table • 2022- Red Ribbon Walk-SAS table • Participated in Union County Opioid Response Task Force
1.3	Develop partnerships to provide behavioral health services to diverse populations. • Partner with the New Jersey Institute for Successful Aging to provide the Statewide Clinical Outreach Program for the Elderly (S-COPE) for older adults who experience mental health and/or behavioral crises. • Provide addiction specialists to promote treatment and supportive services among patients. • Provide Crisis Assessment Response and Enhancements Services (CARES) to improve crisis response and stabilization services for adults with intellectual and developmental disabilities.	Increase Awareness and competencies	Behavioral Health S-Cope Director CARES Director	S-COPE director • 2020 – 590 new intakes, 565 Face-to-face interventions, 2665 Phone Consultations, 156 Diverts from potential inpatient/hospitalization, 69 individualized trainings for facility health care workers, 8 trainings provided with Continuing Education Unit Credits for health care professionals, Overall 88 percent of client's maintained community placement in 2020 • 2021 – 616 new intakes, 790 Face-to-face interventions, 1732 Phone Consultations, 159 Diverts from potential inpatient/hospitalization, 121 individualized trainings for facility health care workers, 10 trainings provided with Continuing Education Unit Credits for health care professionals, Overall 90 percent of client's maintained community placement in 2021 • Addiction specialists provided – see Initiative 1.2

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Medical Center

RWJBarnabas HEALTH

Goal I: Increase access to behavioral health services.

Key CHNA Findings:

- ***Approximately 23% of Elizabeth adults report a history of depression, a higher percentage than Union County overall and the state.***
- ***Elizabeth had nine suicide deaths in 2017 and eight suicide deaths each year in 2016 and 2015.***

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
1.3 Continued	Develop partnerships to provide behavioral health services to diverse populations. • Partner with the New Jersey Institute for Successful Aging to provide the Statewide Clinical Outreach Program for the Elderly (S-COPE) for older adults who experience mental health and/or behavioral crises. • Provide addiction specialists to promote treatment and supportive services among patients. • Provide Crisis Assessment Response and Enhancements Services (CARES) to improve crisis response and stabilization services for adults with intellectual and developmental disabilities.	Collaborative Meetings Held Increase Awareness and competencies	CARES Director	SCOPE director, continued • 2022- Year to Date 08/31/2022- 745 New intakes, 995 Face-to-face interventions, 1127 Phone Consultations, 159 Diverts from potential inpatient/hospitalization, 86 individualized trainings for facility health care workers, 4 trainings provided with Continuing Education Unit Credits for health care professionals- with 7 CEU trainings pending, 8 EHCO Trainings • ED Navigator funding secured and position filled CARES program director • 2020 979 new intakes, 179 collaborative mtgs with system partners, 10 ECHO trainings, 10 ECHO Learning Collaborative sessions, 141 specialized trainings for agencies/families • 2021 1249 new intakes, 297 collaborative mtgs, 12 ECHO trainings, 12 ECHO learning collab sessions, 176 specialized trainings for agencies/families • 2022 year to date 1387 new intakes, 8 ECHO trainings, collaboration with state in rollout of 988 specfic to DD population Worked with clinical trials for long acting anti-psychotic agents for inpatients to transition to outpatient services with higher success.

Goal II: Reduce death from cancers and improve quality of life for patients living with cancer

Key CHNA Findings:
-Cancer remains a leading cause of death, but if detected early, can often be effectively treated.
- New Jersey and Union County have a higher incidence of cancer than the nation

	Strategy/Initiative	Indicator/ Metric	Responsible Staff*	Tracking/Outcome
2.1	Increase the number of adults who receive recommended cancer screenings. • Provide cancer education and screening programs at Trinitas and in collaboration with community organizations.	Increase Community Touch Points and screenings	Medical Oncology	Increased early detection and treatment though working with imaging centers to navigate patients for enhanced diagnostic treatment. • Navigated patients from University Radiology Group – Morris Ave resulting in an increased # of patients having breast biopsies to increase early identification of cancer • Worked with Jersey Diagnostic Imaging (from Linden) to increase breast biopsies performed – 17 patients Jan-Dec 2021) Screenings were limited as we were unable to participate in Health Fairs due to the COVID Pandemic for 2020 and 2021
2.2	Reduce disparities among low-income, at-risk, and minority populations. • Provide free, comprehensive screening services for breast, cervical, prostate, and colorectal cancers in partnership with the New Jersey Cancer Education and Early Detection (NJCEED) program.	Increase Community Screenings for BIPOC and underinsured	Medical Oncology	Worked to reduce risks by Improving patients safety in the home and community during the Pandemic; provided Protection Kits to our patients that include masks, hand sanitizer wipes, thermometers and information magnets. Partnered with Pharmaceutical companies to obtain medications for the uninsured and underinsured populations. Screenings were limited due to COVID. Breast and Cervical Screening provided to over 300. Colon cancer screening education provided. Resources were channeled for COVID prevention and treatment.
2.3	Increase caregiver and patient support. • Provide psychosocial services for patients and their families to assist with counseling, community resources, and other social needs.	Increase numbers of psychosocial and other support encounters	Medical Oncology	• Support program provided for 15 patients with mastectomy and lymphedema products. • Conducted “Made for Me” boutique for cancer patient wigs • Zoom educational programs 1. HPV and Head & Neck Cancer 2. Breast Health 101 Supports were limited due to COVID.

Trinitas Regional Medical Center
RWJBarnabas HEALTH

Goal III: Reduce health disparities for chronic disease.

Key CHNA Findings:

- ***While Union County and Elizabeth residents in general have lower death rates due to heart disease and cancer, rates among African American residents are 10-20 points higher than White residents.***
- ***The diabetes death rate among African Americans is double the death rate for Whites.***

	Strategy/Initiative	Indicator/ Metric	Responsible Staff*	Tracking/Outcome
3.1	Reduce risk factors for chronic disease and improve chronic disease management through increased access to healthy foods. • Partner with the New Jersey Corner Store Initiative to improve healthy food access in neighborhood stores. • Support Groundwork Elizabeth's Come Grow With Us! community gardening program. • Support local farmers' markets and food pantries.	Increase promotion and education of healthy food choices	Transitions in Care Cardiac Services, Dietary and other TRMC Team members	• Transitional care dietician visit patients at home assess their needs for meals and connect them with the local meals on wheels program. • Educated patients on proper food choices by taking them food shopping • Encourage healthy food choices by reading food labels. • Conducted education on "Benefits of Fiber" to help address prevention and underlying conditions of chronic disease • Provided Thanksgiving Baskets to food insecure persons
3.2	Initiate early stage interventions for individuals at high risk for chronic disease. • Offer a diabetes prevention program in partnership with The Gateway Family YMCA. • Provide chronic disease education and screening programs at Trinitas and in collaboration with community organizations. • Support Shaping Elizabeth initiatives to address health disparities related to chronic disease.	Increase Education and Screenings for chronic diseases – Heart, Diabetes	Transitions in Care Cardiac Services TRMC Team members	• Offered diabetes prevention program in partnership with the New Jersey diabetes association. • Nurse Practitioners providing chronic disease education and screening programs at Trinitas • Support St Joseph Social services to address health disparities related to chronic disease. • Heart Walks held annually (Park in Elizabeth coordinated with Mayor; NNJ) • BP screenings in community (Elizabeth, Crown Bank) • Women and Heart Disease education (the Garden, Westfield Catholic Church, Go Red Women's Health Zoom Lecture) • Heart month • Employee Calendar - food and recipes, suggested activities • TRMC team members participated in chronic disease coalition. 2021 – 2022 conducted stroke and diabetes educations. Screenings were limited due to pandemic. Resources were channeled for COVID and Vaccine education and vaccination clinics at Hospital, home visits and community (Elizabeth HS).
3.3	Increase the number of residents who have a medical home. • Identify a medical home for all patients at discharge and provide a "warm handoff." • Use care navigators to follow up with patients to ensure connection with medical home.	Improve transition to Community	Transitions in Care Discharge Planning	Agreement with FQHCs and VNA to promote effective care transitions.

Note: Trinitas Medical Center provided COVID education and vaccinations to over 26,800 persons in 2021 alone.

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Trinitas Regional Medical Center

RWJBarnabas HEALTH

Goal III: Reduce health disparities for chronic disease (continued).

Key CHNA Findings:

- ***While Union County and Elizabeth residents in general have lower death rates due to heart disease and cancer, rates among African American residents are 10-20 points higher than White residents.***
- ***The diabetes death rate among African Americans is double the death rate for Whites.***

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
3.4	Ensure patients can receive medications, treatments, follow up appointments, and other needed healthcare. • Explore partnership opportunities for ride services to medical appointments. • Explore partnership opportunities with pharmacies for home delivery. • Use CRNPs, paramedics to provide home visits, transitions of care with high priority patients post discharge.	Identify transportation resources Increase Home Check Visits for high risk patients	Transitions of Care	• The use of UBER health to follow up appointments and other community events. • Partnership with community pharmacies who has been delivering medications to the patients at the hospital before and after discharge. • Nurse practitioners and community health workers provide high-quality care for patients with chronic disease post-discharge. • Partnership with the Division of the Blind for the safety of our disabled patient's post discharge. • Collaboration with pharmaceutical industries for free medication through the patient assistance program.
3.5	Identify and address social services needs of patients. • Develop partnerships with social service agencies for warm handoff to services, e.g., housing caseworkers. • Develop protocols to screen for social determinants of health. • Develop resource directory for staff and protocols for "on demand" response. • Partner with community organizations to reach priority populations.	Identify SDOH screening tools and opportunities Resource Directory developed	Transitions of Care	• Our transitions of care Social workers make home visits to patients after discharge to address social needs. • Ongoing partnership with St Joseph social services to help our patients and their families with social difficulties to reduce healthcare disparities in the communities. • Connecting patients to the resources in the community for a better outcome. • Partnered with FQHCs

Note: Trinitas Medical Center provided COVID education and vaccinations to over 26,800 persons in 2021 alone.

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Trinitas Regional Medical Center

RWJBarnabas HEALTH

Goal IV: Optimize pregnancy and birth outcomes for women and children.

Key CHNA Findings:

- ***Prenatal care is less accessible for women in Union County with 67.9% receiving care in the first trimester compared to 74.7% statewide.***
- ***Elizabeth lags behind the county with only 56.1% of women receiving first trimester care, which is the second lowest ranking in the county, behind Plainfield.***

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
4.1	Increase the proportion of pregnant women who receive early and adequate prenatal care. • Collaborate with organizations that serve target populations to advocate for and advance access to prenatal care. • Explore opportunities to sponsor nationally recognized maternal programs like Nurse Family Partnership and Healthy Beginnings Plus. • Provide culturally competent and diverse midwifery, doula, and prenatal services.	Connections with community established Implement monitoring for Moms returning for post delivery check-up	OB Nursing / Ambulatory Services	• Engaged with the Hasidic Community of Linden/Union to enable those OB/GYN patients to access prenatal care early in their pregnancies. Partnering with Nurse Family Partnership. • Monitoring Post-partum patients for their completion of post delivery appointments. Implemented strategies to schedule the post partum visit PRIOR to discharge from the hospital. Follow-up for no show appointments has been implemented. • Multi-cultural prenatal team in place.
4.2	Reduce disparities in birth outcomes. • Participate in or host free community health fairs (e.g. Baby Shower) targeting underserved communities. • Provide education and counseling in nutrition, exercise, physiological and emotional changes, and sexuality. • Provide lactation education and counseling for all new mothers and postpartum follow up. • Provide substance use disorder counseling and services for pregnant women.	Participate and/or host community programs Increased educational programming for wellness and breastfeeding	WIC Services Dietician Midwives	• Participate in several community based programs such as farmer's market. • All prenatal patients are seen by a dietitian initially and also gestational diabetes mothers are followed closely by Providers, dietitian and maternal fetal medicine. • All patients are rounded on by CNM's especially those that are exclusive breastfeeding. We also provide breastfeeding follow-up visits with our APN's and CNM's on an outpatient basis to support those mom's post partum. • Partnered with Women's addiction services at NPC.

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Goal IV: Optimize pregnancy and birth outcomes for women and children (continued).

Key CHNA Findings:

- ***Prenatal care is less accessible for women in Union County with 67.9% receiving care in the first trimester compared to 74.7% statewide.***
- ***Elizabeth lags behind the county with only 56.1% of women receiving first trimester care, which is the second lowest ranking in the county, behind Plainfield.***

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
4.3	Decrease teenage pregnancies. • Partner with schools, community organizations, faith based institutions, and other CBOs to collaborate on initiatives. • Provide education and mentoring for young women to increase self-esteem.	Provide education and counseling programs	OB Nursing / Ambulatory Services	Currently we are not partnered with any school services due to staffing issues and re-allocations and changes due to COVID
4.4	Increase number of teen mothers who earn a high school diploma. • Explore opportunities to sponsor nationally recognized maternal programs like Nurse Family Partnership and Healthy Beginnings Plus. • Partner with schools, community organizations, faith based institutions, and other CBOs to collaborate on initiatives. • Provide education and mentoring for young women to increase self-esteem.	Provide education and counseling programs	OB Nursing / Ambulatory Services	• Partnered with Nurse Family Partnership • Partnered with Hasidic community of Linden/Union, Planned Parenthood and E-Port

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