Monmouth Medical Center Community Health Needs Assessment

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PREPARED BY
HEALTH RESOURCES IN ACTION

Monmouth Medical Center | RWJBarnabas HEALTH

Acknowledgements

The following partners led the Monmouth Medical Center Community Health Needs Assessment:

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CHNA Advisory Committee

The Monmouth 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 co-chaired by Jean McKinney, Regional Director, Community Health and Social Impact. The full list of Advisory Committee members can be found in Appendix A.

RWJBarnabas Health Community Health Needs Assessment Steering Committee

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- Tamara Cunningham, VP System Development/Planning, Co-Chair
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- Community Medical Center (CMC) – Brian Case, Assistant Vice President of Business Development
- Clara Maass Medical Center (CMMC) – Frank Dos Santos, MD, Chief Medical Officer
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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, Monmouth Medical Center (MMC) undertook a community health needs assessment (CHNA) process. The purpose of the CHNA was to identify and analyze community health needs, assets, and priorities that inform future health planning and fulfill the community health needs assessment mandate for non-profit institutions put forth by the IRS. MMC collaborated with three other RWJBH hospitals—Monmouth Medical Center Southern Campus (MMCSC), Community Medical Center (CMC), and Barnabas Health Behavioral Health Center (BHBHC)—to bring together community partners across the region for a joint CHNA Advisory Committee to provide input on this process.

Monmouth Medical Center CHNA Focus Area

This assessment encompassed a review and analysis of social, demographic, economic, and health indicators for communities in MMC's primary service area in Monmouth County.

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

Context

This CHNA was conducted during an unprecedented time in the United States, including the COVID-19 pandemic and the national movement for racial justice.

In particular, assessment activities coincided with the COVID-19 pandemic that, as a result, impacted both the CHNA data collection process and topics and concerns that residents raised in focus groups and key informant interviews. In addition, 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, the design of data collection instruments, and the input that was shared during focus groups, key informant interviews, and survey responses.

Methods

While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health. Data collection was conducted using a social determinants of health framework and a health equity lens. The CHNA process utilized a mixed-methods, participatory approach that engaged agencies, organizations, and community residents through different avenues. The CHNA process was guided by strategic leadership from the RWJBH Systemwide CHNA Steering Committee, a joint Monmouth-Ocean County CHNA Advisory Committee (facilitated by Monmouth Medical Center, Monmouth Medical Center Southern Campus, Community Medical Center, and Barnabas Health Behavioral Health Center), and the community overall. Methods of data collection included:

- Reviewing existing data on social, economic, and health indicators in the MMC primary service area (PSA).
- Administered a community survey to a convenient sample 976 Monmouth County residents. The survey was designed and administered by the survey firm Bruno & Ridgway.
- Facilitating four virtual focus groups with 33 participants from specific populations of interest, including residents representing persons that were Spanish-speaking, seniors or older adults, veterans and the economically vulnerable.
- Conducting eight key informant interviews with stakeholders from a range of sectors, including mental health and substance abuse, healthcare, youth services, newly arrived, faith-based, food and housing support services, disability services, and discrimination and structural racism.

Findings

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

Population Characteristics

- **Demographics**. In 2020, Monmouth County had a population size of 629,185. Towns located in Monmouth County ranged in population size. Fort Monmouth (pop. 124 residents) and Allenhurst (pop. 486) were the smallest townships. In comparison, some of the largest were Middletown (pop. 66,291), Long Branch (pop. 30,721), and Neptune (pop. 27,675).[1] Similar to the overall state, Monmouth County townships experienced minimal population decline between 2011-2015 and 2016-2020, though some experienced more substantial change. For example, Belford experienced a population increase over this time (26.2% population growth); other towns, like Deal, experienced a population decline (-43.4%).[1]

Community Social and Economic Environment

- **Community Strengths and Assets.** When asked to describe some of the strengths or assets in their community, residents, without hesitation, identified having high-quality public institutions, public spaces, and amenities such as the local school system, libraries, as well as its parks, beaches, and music venues. Additional community assets identified by participants included having access to a wealth of learning and social support services. Services highlighted were financial literacy, parenting classes, food resources, and faith-based organizations that promoted health and wellness activities, including walking clubs.

> *"We have places that encourage walkability, amenities for seniors, and good theaters. There are a lot of cultural happenings and the university. There's no end of things to do here."*
> – Focus group participant

- **Education.** Most residents considered their school to provide quality education and services. Conversely, residents also expressed concerns about the financial and emotional effects of the pandemic on children, including food and housing insecurity, the stress and anxiety brought on by isolation, and the loss of learning opportunities as school districts moved to a virtual learning format. In Monmouth County, four-year high school graduation rates hovered over 90%, with some slight variation occurring across several Monmouth County school districts. For example, compared to Monmouth County Vocational (98.4%) and Middletown Township (95.3%), both Asbury (79.3%),

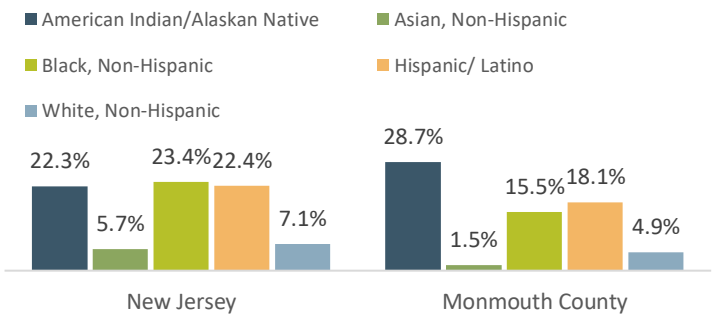
[1] DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

and Neptune (81.1%) school districts experienced lower rates of graduation.[2] Additionally, graduation rates were generally lower for Hispanic and Black high school students. Further, almost half (47.4%) of adults in Monmouth County aged 25 and older had completed a four-year degree or higher.[3]

- **Employment and Workforce.** Focus group participants and interviewees talked about employment challenges in the community caused by the COVID-19 pandemic. Job loss was considered to have increased the financial instability for families in various ways, including loss of income to pay for rent, food, water, and light and loss of employer-sponsored benefits such as health insurance. In addition, the financial and employment prospects worsened for individuals working in industries hardest hit by business closures, including restaurants, hotels, and other service-oriented jobs. Data from the Bureau of Labor Statistics show that unemployment rates in New Jersey and Monmouth County had been trending downward over the past decade before the COVID-19 pandemic, after which rates rose substantially. Additionally, town-level data from the 2016-2020 American Community Survey show that Allenhurst and Fort Monmouth experienced the highest unemployment rates, 11.1%, and 10.3%, respectively, while Shrewsbury and Oceanport experienced the lowest (both at 1.4%).[4]

- **Income and Financial Security.** Like the rest of the nation, Monmouth County experienced economic challenges due to the COVID-19 pandemic. Financial insecurity was a primary concern voiced in both focus groups and interviews, with several participants considering the loss of a job as detrimental and leading to the loss of a home, transportation, and increasing isolation, stress, and anxiety. The loss of employment and income also exacerbated already existing financial vulnerability of communities. For example, prior to the arrival of the pandemic in the U.S., American Indian/Alaskan Native, Black, and Hispanic/Latino children were more likely to live in poverty in Monmouth County.[5]

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

- **Food Access and Food Security.** In focus groups and interviews, food insecurity, like housing or transportation, rose to the top of concerns by Monmouth County residents. The undercurrent for these concerns was the economic climate and the impact felt by rises in the cost-of-living leaving little room to purchase or pay for the most basic needs, particularly food for individuals and families. For example, in Monmouth County in 2019, the population considered food insecure was 7.1%; this increased to 10.8% in 2020.[6] Further, while the percentage of the population identified as food

[2] DATA SOURCE: New Jersey Department of Education, School Performance, Adjusted Cohort Graduation Rates, 2020-2021
[3] DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020
[4] DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020
[5] 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
[6] DATA SOURCE: Feeding America, Map the Meal Gap, 2019 and 2020

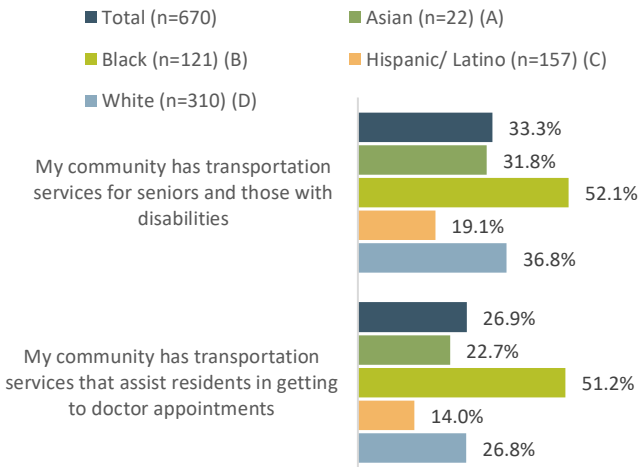
insecure in Monmouth was lower than in the state of New Jersey Monmouth County between 2019 and 2020 had a rate increase similar to the state (3.8% versus 3.7% respectively) in residents that were food insecure.[7]

- **Housing.** In focus groups and interviews, access to affordable housing was considered a significant challenge. In particular, residents voiced concerns that the lack of quality affordable housing was more likely to impact newly arrived immigrants, seniors, veterans, and economically vulnerable residents. Within Monmouth County, Deal (67.9%) and Long Branch (60.3%) had the greatest percentage of owner-occupied residents spending more than 25% of their income on housing costs, while Shrewsbury and Deal had greatest percentage of renter-occupied residents spending more than 25% of their income on housing costs (83.6% and 78.7% respectively).[8]

> *"There is no affordable housing in New Jersey and Monmouth and so what you see is that there are a lot of renters versus homeownership. But for low-income housing! It's [also just] not available. [Renting a home] is so expensive."*
> -Key informant Interviewee

- **Transportation** Focus group discussions and key informant interviews with Monmouth County residents highlighted several barriers to transportation, including rising fuel costs, having to depend on friends or coworkers for a ride, and not having a reliable public transportation system. Overall, about one-third community survey respondents agreed with statements regarding transportation services for seniors and persons that are disabled and with transportation options for medical appointments.[9] Hispanic/Latino survey respondents were much less likely to endorse statements regarding availability of transportation services. Additionally, most residents agreed that transportation barriers were more likely to be experienced by those with limited financial means.

Percent of Community Survey Respondents Who Agreed/Completely Agreed with Transportation-Related Statements about Their Community, by Race/Ethnicity (n=670), 2021



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

- **Green Space and Built Environment.** Urban environments and physical spaces can expose people to toxins or pollutants or can encourage physical activity and social interaction, affecting physical and mental health. Almost seven in ten community survey respondents agreed or completely agreed with the statement, "My community has safe outdoor places to walk and play."

[7] DATA SOURCE: Feeding America, Map the Meal Gap, 2019 and 2020
[8] DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020
[9] DATA SOURCE: Community Health Needs Assessment Survey Data, Monmouth County, Bruno & Ridgway, 2021

- **Crime and Violence.** Crime and violence and the corresponding trauma such acts can have on communities are important public health issues. While the issue of crime and violence were not major themes, a few participants mentioned the issue of domestic and family violence that they felt grew worse during the pandemic. As one participant explained, *"I know that families are going through a lot, and you see pressure and anger that can build, and so they begin to [physically] hurt those closest to them."*

- **Systemic Racism and Discrimination.** Regarding the role of systemic racism, racial injustice, and discrimination, focus group participants raised concerns regarding the exclusion or marginalization of communities based on sexual orientation, immigration status, language, and income. Amid such concerns, residents shared sentiment about finding ways to be inclusive of others and help address racism and discrimination in the community. As one resident explained, *"You know, it is just time to appreciate each other more. The diversity of our communities, whether it is veterans, LGBT, undocumented people, or people living with disabilities, you know, because we have a huge, diverse population of vulnerable populations and vulnerable people. So, I would love to see that."*

Community Health Issues

- **Perceptions of Community Health.** Many assessment participants identified obesity and chronic disease, particularly diabetes and hypertension, and mental health and substance abuse as top community concerns. Residents also relayed how these challenges can influence health behaviors and conditions such as healthy eating, physical activity, and chronic diseases. They discussed the challenges of accessing care and the increase in mental health needs in the community, especially among youth, seniors, and economically vulnerable residents. In the community survey, responses about concerns in the community varied by race/ethnicity. Overweight/obesity was the top concern among Asian, Black, and White survey respondents, followed by mental health issues for Asian and White respondents, and having adequate and affordable housing for Black respondents. Hispanic/Latino respondents noted mental health as their top concern.

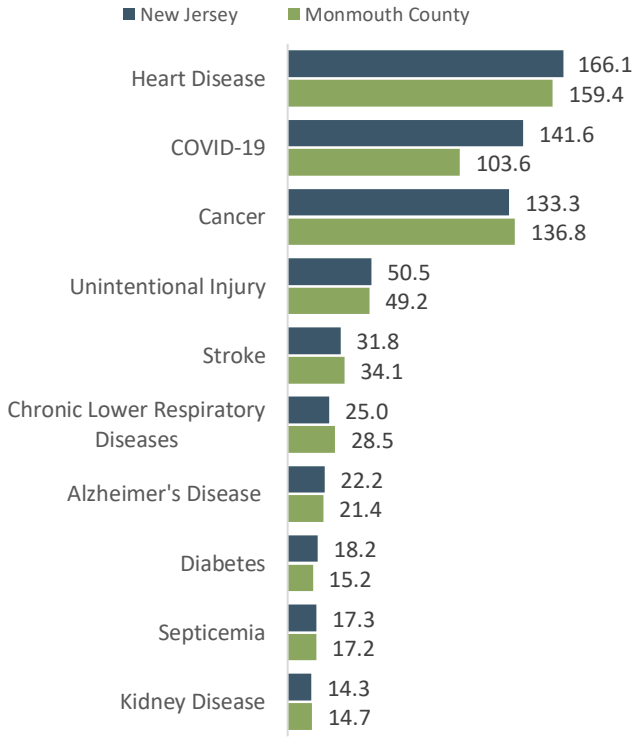
Percent of Community Survey Respondents Reporting the Top Health Issues or Concerns in Their Community, by Race/Ethnicity

	Asian (n=22) (A)	Black (n=118) (B)	Hispanic/ Latino (n=154) (C)	White (n=307) (D)
1	Overweight/ obesity (45.5%)	Overweight/ obesity (36.4%)	Mental health issues (34.4%) (B)	Overweight/ obesity (36.2%)
2	Mental health issues (31.8%)	Having adequate and affordable housing (35.6%) (ACD)	Overweight/ obesity (33.8%)*	Mental health issues (35.8%) (B)
3	Chronic heart disease (22.7%)*	Substance use, abuse or overdose (27.1%) (A)	Substance use, abuse or overdose (33.8%) (A)*	Substance use, abuse or overdose (26.7%) (A)

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. In Monmouth County, Heart disease, COVID-19, and cancer are the top three causes of death for the state and Monmouth County.[10]

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), 2019

- **Obesity, Healthy Eating, and Physical Activity.** Being overweight/obese ranked as the top health concern (after mental health) by community survey respondents. In focus groups and interviews, the issue of obesity was often interwoven into discussions regarding what participants felt were challenges with access to healthy food and food instability, and limited options for residents to participate in sports and social activities. In addition, some participants attributed the COVID-19 pandemic to an increasingly sedentary lifestyle.

- **Chronic Conditions.** In focus groups and interviews, chronic conditions were identified as some of the most pressing health concerns by residents. Several identified diabetes and hypertension as chronic conditions that were more likely to impact communities of color. Further, while 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.

- **Disability.** Several interviewees and focus group members discussed the experiences and needs of community members with disabilities, including challenges with transportation, health services and employment as well as the need for providing additional support services that could improve the health and wellbeing of persons that are disabled. The proportion of the population ages 18-64 with a disability ranged from under 4% in several towns to 16.9% in Asbury Park.[11] Additionally, almost 30% of people ages 65 and older have a disability in Monmouth County; across towns, the proportion of people ages 65 and older with a disability ranged from 0.0% in Fort Monmouth to 60.1% in Navesink.[11]

[10] 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
[11] DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

- **Mental Health and Substance Use.** The topic of mental health was prevalent in nearly all focus groups and interviews conducted for this CHNA. For example, most Monmouth residents participating in focus group discussions felt that while the COVID-19 pandemic had generally impacted the community, mental health issues were also most likely to affect the most vulnerable communities. Especially young persons, older adults, veterans, persons of color, the undocumented, and those with preexisting psychiatric conditions, including the persistently mentally ill. Beyond identifying mental health as a top community concern, 42% of community survey respondents reported that they or someone in their family has personally had trouble maintaining a good mental state and 27% reported feeling lonely or isolated from others since COVID-19 began.[12] Discussions related to mental health and substance abuse also centered around the need for coordination of mental health services tailored to meet the needs of persons experiencing severe mental illness. Residents recommended having transportation options available for seniors and those that might have physical limitations so that they could help make their mental health appointments. Interviewees also highlighted the importance of incorporating trauma-informed care as part of the services that support the community to deal more effectively with what occurred during the pandemic.

  > *"Mental Health is in tandem with substance abuse, and you can't separate these."*
  > – Focus group participant

- **Environmental Health.** In 2018, the age-adjusted asthma ED visit rate for Black residents was more than double the rate for any other racial/ethnic group in the state and in Monmouth County. The age-adjusted asthma ED visit rate was lowest among Asian, non-Hispanic residents in Monmouth County and in the state overall.[13] Additionally, risk for lead-based paint is more likely to be found in older homes built prior to 1978. In In most towns, the proportion of older housing is higher in Monmouth County than the state overall, though the county overall has a lower percentage than the state. The towns of Allenhurst and Deal have the highest proportion of older housing stock, with about 85% or more of homes built before 1980.

- **Communicable Disease.** The impact of COVID-19 was a major topic of conversation among focus group and key informant interview participants, although conversations focused primarily on the pandemic's impact on participants' mental health and well-being. As of August 2022, there had been 31,275 deaths due to COVID-19 in New Jersey. Non-Hispanic White residents account for nearly 60% of COVID deaths. Non-Hispanic Black residents account for 16.6%, Hispanic residents account for 13.8%, and Asian residents account for 4.5% of confirmed COVID-19 deaths in the state. Surveillance data identified Chlamydia as the most common sexually transmitted disease in Monmouth County, with comparatively lower rates for Gonorrhea and Hepatitis than the state of New Jersey.

- **Maternal and Infant Health.** The rate of teen births was lower in Monmouth County than the state.[14] Data across racial/ethnic groups shows that a higher proportion of non-Hispanic Black women had preterm births in both Monmouth County and the state than other races/ethnicities.

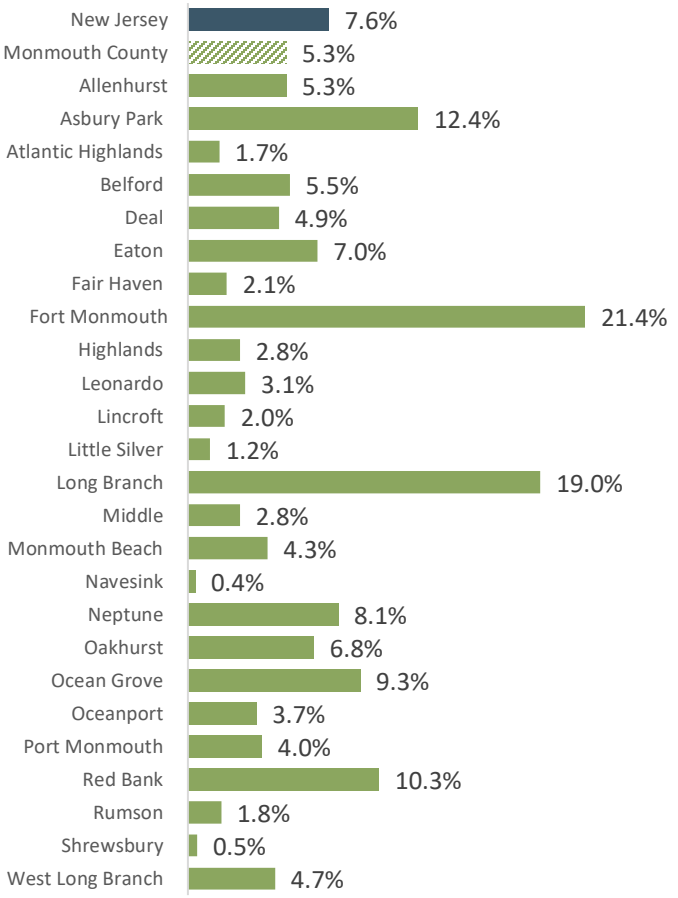
[12] Data Source: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
[13] Data Source: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020
[14] National Center for Health Statistics, Natality Files, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2014-2020

babies weighing less than 2,500 grams across all three counties and the state, followed by non-Hispanic Asian women. Non-Hispanic White women, by contrast, experienced the lowest proportion of preterm births in Monmouth County and the state. Similar patterns can be seen in the percent of low and very low birth weight births.[15]

Access to Services

- **Access to Health Services.** Several focus groups participants and interviewees identified barriers to accessing health services, including lack of insurance or limited medical coverage and access to charity care, high prescription costs, long wait times for appointments and referrals, unreliable transportation, lack of trust in the medical system including a lack of cultural awareness among providers. Health insurance can be a barrier to individuals avoiding or delaying medical care. About 7.6% of New Jersey residents and 5.3% of Monmouth County residents were uninsured in 2016-2020; however, much higher proportions of residents in Fort Monmouth (21.4%) and Long Branch (19.0%) were uninsured during this time.[16]

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



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020
Foundation, 2019

Community Vision and Suggestions for the Future

Interviewees and focus group participants were asked about their vision for the next five years, including their suggestions for future programs, services, and initiatives. The general themes that emerged based suggestions emerged.

- **Support and Advocate for Policies for Multi-Sector Approaches.** Focus group and interview participants shared their vision for the future, several mentioned the importance of bringing together city, county, and federal agencies and multi-sector community partnerships to advance legislation jointly, advocate for additional funding, and develop programs to respond to local community health issues. Participants felt that leveraging such resources would raise the visibility of key health issues, identify funding sources, and direct them to address the health needs of vulnerable populations, including persons that are persistently mentally ill, the disabled, the uninsured, and the undocumented, among others.

[15] 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

[16] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

- **Expand and Strengthen Behavioral Health Services.** Focus group and interview participants identified the need to continue addressing community mental health and substance misuse concerns. Recommendations by participants included developing and expanding efforts educate the public about the importance of mental health and destigmatizing mental health concerns, especially in communities of color, the undocumented, and those with limited English proficiency.

- **Foster Collaboration that Strengthens Coordination and Access to Services.** Interviewees overwhelmingly voiced that collaboration and partnerships were vital. This sentiment came from individuals with a shared vision of improving the health and well-being of individuals, including the newly arrived, disabled, youth, veterans, and persons with mental health and substance abuse, as well as providing general health care to the most underserved in the community. As one interview shared, no agency or organization could "go at it alone." Several interviewees also shared that Monmouth Medical Center exemplified how a hospital can advance such efforts by working closely with faith-based and community-based organizations to bring health services to the community.

- **Building Trust through Community Engagement.** Focus group participants often expressed frustration and dissatisfaction with their healthcare experience ranging from challenges in getting timely appointments or referrals to what many perceived to be little time spent with their provider to not understanding treatment for a diagnosis or the effects of medication. Interviewees agreed that while such matters were unfortunately not uncommon, efforts to engage with the community at all levels were essential to helping to foster a culture of trust as a source of health and wellness to residents.

- **Improve Outreach and Communication of Social Services and Resources.** Numerous focus group participants recommended the need for improved communication about existing local programs, especially those that focused on promoting health and wellness. Additionally, interviewees shared the importance of cities and counties working together to make the public aware of services available, including resources for older adults, the economically vulnerable, and others who might need resources or support. Recommendations included recruiting volunteers to call seniors and help keep them socially connected with what was happening as well as help connect them to local resources.

Key Themes

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 Monmouth County during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- ***The COVID-19 pandemic substantially impacted the health and wellbeing of residents in Monmouth County.*** The COVID-19 pandemic has affected all sectors of life and created substantial challenges for many. The impact of the COVID-19 pandemic and current economic conditions were a frequent topic of conversation in focus groups and interviews, and community survey respondents reported on the pandemic's negative effects, including on residents' emotional health. Participants also shared the impact of the pandemic on financial and mental well-being, education, access to healthcare, housing, transportation, and food security. Such hardship was also more likely felt by economically vulnerable residents, communities of color, the newly arrived, veterans, older adults, and persons with a disability. Like other communities, Monmouth County mobilized its partnerships

in the community to distribute and provide much-needed resources, especially to those most in need.

- ***Monmouth County residents identified mental health as a significant community health concern exacerbated by the COVID-19 pandemic.*** Among Monmouth community survey respondents, mental health issues ranked near the top (second to obesity) as a community health concern. As a result of the pandemic, unemployment, school closures, housing, and food insecurity, fear of the virus, and loss of friends and family are considered to have amplified levels of stress, anxiety, loneliness, grief, and depression, particularly among youth, people experiencing job loss, veterans, older adults, communities of color. Poverty and financial insecurity were also believed to have exacerbated mental health issues in the community. One resident observed that "economic hardships, elevated stress, social isolation, and growing behavioral health disorders [only] contributed to greater treatment needs." Additionally, residents also felt that people turned to alcohol and drugs resulting from the daily hardship, including isolation, financial hardship, and limited treatment options that resulted from ongoing public health measures to limit exposure to the coronavirus.

- ***Seniors, veterans, and persons with a disability continue to experience barriers that impact their quality of life.*** Residents highlighted the various amenities available to Monmouth County residents, including parks, libraries, beaches, and other entertainment venues, encouraging people to engage and participate in community life. However, community engagement remains a challenge for seniors, veterans, and people with a disability. In focus group discussions, a general theme emerged: the need to establish “pathways to community participation,” whether volunteering, employment, or other activities that could improve their quality of life. For example, veterans who participated in focus groups discussion shared the need to contribute productively. Some recommend the need to encourage volunteerism among agencies looking for help, especially at a time of workforce shortages. Similarly, an interviewee in disability services suggested the importance of business and other agencies looking at his clients as workers and contributors, just like anyone else. Such opportunities were also seen as a way for communities to combat the stigma associated with disability.

- ***Lack of affordable health insurance coverage, provider shortages, and transportation top list of key barriers to accessing healthcare services.*** Monmouth focus group participants and interviewees identified several barriers to accessing healthcare services in their community, including not having health insurance or having limited forms of medical coverage, administrative burdens of applying for charity care, rising prescription costs, as well as long wait times for appointments and referrals, unreliable transportation, lack of trust in the medical system including a lack of cultural awareness among providers. Among community survey respondents, health insurance was the most commonly identified barrier to healthcare. For example, focus groups and interview participants discussed the rising cost of insurance coverage, *“Having insurance is a big challenge and, in particular, having the necessary coverage to access care. "[Health insurance coverage] is a big issue, and people can keep up with costs, so you can't afford insurance.”* Residents also identified the need for more providers, in particular specialists. Among interviewees, provider shortages were considered to be a result of the staffing shortages that resulted from the COVID-19 pandemic and the current job market associated with the recruitment of healthcare professionals. Lastly, residents reported delays in accessing medical care due to affordable, reliable, and convenient transportation options, especially for those with limited mobility, seniors, and persons with limited incomes.

- ***Established network of community-based organizations are considered core assets of Monmouth County.*** Community surveys and conversations with residents highlight an array of resources and amenities in place to support the quality of life in Monmouth County. However, the arrival of COVID-19 did place unprecedented stress on the community's social and economic livelihood and residents' health and well-being. At the height of such, agencies across Monmouth County came together to provide services to residents impacted by the COVID pandemic. Whether helping to address food insecurity, housing, transportation, or other needs, residents considered these resources integral to helping support the needs of Monmouth County residents. Across interviews with various community sectors, the general theme was that people, programs, and agencies came together and organized to support the most vulnerable. Additionally, residents highlighted the need to continue to make the community aware of services available to them, the importance of coordinating services, and building awareness of the community resources available to residents, especially the most vulnerable.

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, ten initial issue areas were identified as key community needs for Monmouth and Ocean County.

These included (in no particular order):

- Unemployment
- Financial insecurity
- Food insecurity
- Housing
- Transportation
- Overweight/obesity
- Chronic disease (e.g., heart disease, cancer, diabetes)
- Mental health
- Substance use
- Access to healthcare services

After a prioritization process with the Advisory Committee and discussions within the hospital, key priority areas for MMC will include mental health, chronic health conditions, food insecurity, and substance use as it also considers its existing expertise, capacity, and experience during the development of its implementation plan 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, Monmouth Medical Center undertook a CHNA process using a mixed-methods and collaborative approach, along with multiple other hospitals and community partners.

Monmouth Medical Center (MMC) is located in Long Branch, New Jersey as part of the **RWJBarnabas Health (RWJBH)** system. RWJBH is a non-profit healthcare organization that 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. MMC is a 514-licensed-bed acute community hospital providing services, with over 22,600 admissions and delivering 6,200 births in 2021. The hospital also provided nearly 197,600 outpatient visits and more than 45,100 emergency visits.

This assessment process builds off previous assessment and planning processes conducted by MMC and RWJBH. See the Appendix for a description of the Hospital's 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. MMC collaborated with three other RWJBH hospitals—Monmouth Medical Center South Campus (MMCSC), Community Medical Center (CMC), and Barnabas Health Behavioral Health Center (BHBHC)—to bring together community partners across the region for a joint CHNA Advisory Committee to provide input on this process.

The MMC 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 MMC needs assessment process, which was conducted between April-September 2022.

The specific goals of this CHNA are to:

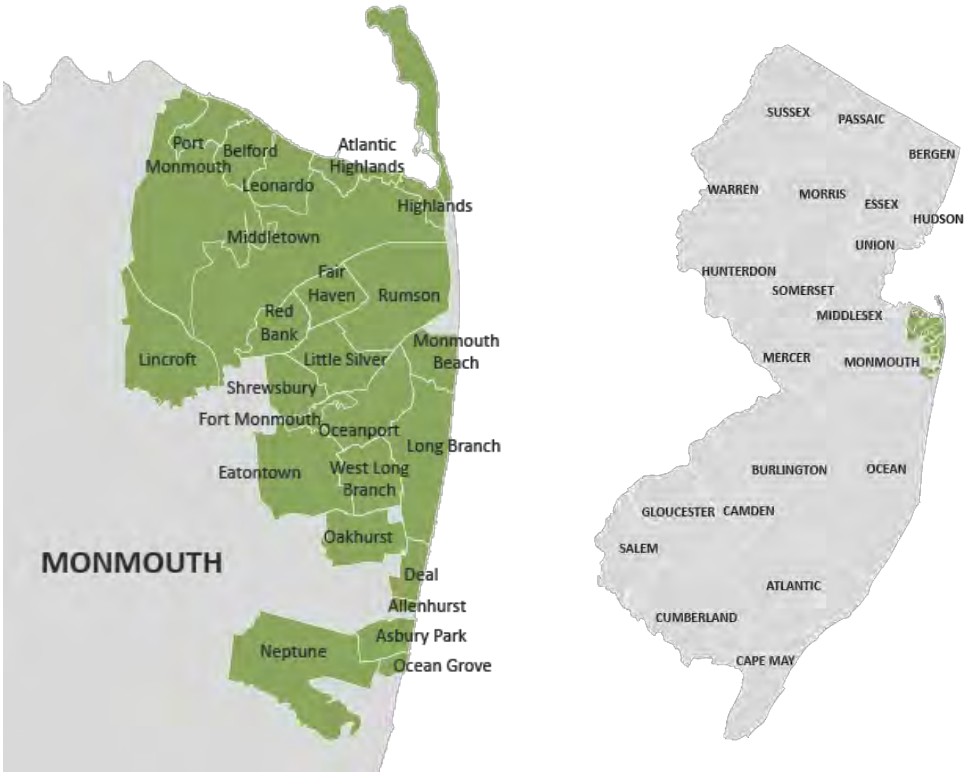
- Systematically identify the needs, strengths, and resources of the community to inform future planning,
- Understand the current health status of the service area overall and its sub-populations within their social context,
- Engage the community to help determine community needs and social determinant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

Area of Focus

This CHNA process aims to fulfill multiple purposes for a range of stakeholders. Monmouth Medical Center's primary service area (PSA) consists of twenty-five communities that are located in the following ZIP codes: 07740 (Long Branch), 07712 (Asbury Park), 07724 (Eatontown), 07753 and 07754 (Neptune), 07764 (West Long Branch), 07701 (Red Bank), 07757 (Oceanport), 07748 (Middletown), 07755 (Oakhurst), 07732(Highlands), 07716 (Atlantic Highlands), 07760 (Rumson), 07750 (Monmouth Beach), 07739 (Little Silver), 07704 (Fair Haven), 07737 (Leonard), 07723 (Deal), 07711 (Allenhurst), 07702 (Shrewsbury), 07703 (Fort Monmouth), 07738 (Lincroft), 07718 (Belford), 07758 (Port Monmouth), 07756 (Ocean Grove), and 07752 (Navesink).

MMC's service area is predominantly located in the eastern portion of Monmouth County. The MMC CHNA service area is shown in Figure 1.

Figure 1. Focused MMC CHNA Area Map



Context for the Community Health Needs Assessment

This CHNA was conducted during an unprecedented time in the United States, including the COVID-19 pandemic and the national movement for racial justice. Assessment activities coincided with the COVID-19 pandemic that, as a result, impacted both the CHNA data collection process and topics and concerns that residents raised in focus groups and key informant interviews. In addition, 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, the design of data collection instruments, and the input that was shared during focus groups, key informant interviews, and survey responses.

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 April 2022, at the beginning of this CHNA process, the COVID-19 pandemic had already been in effect for over two years. Logistically, the pandemic impacted the feasibility of convening in-person groups for the CHNA (e.g., subcommittees, focus groups, etc.) and the availability of key stakeholders and community members to participate in CHNA activities, given their focus on addressing immediate needs. Consequently, all data collection and engagement occurred in a virtual setting (e.g., telephone or video focus groups, interviews), and engagement of residents and stakeholders was challenging. (A more detailed description of this engagement process may be found in the Methods section, and COVID-19 data specific to this service area is provided in the Infectious and Communicable Disease section of this report.)

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

National protests for racial equity and justice over the killings of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, and others brought national attention to 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. 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 a 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.

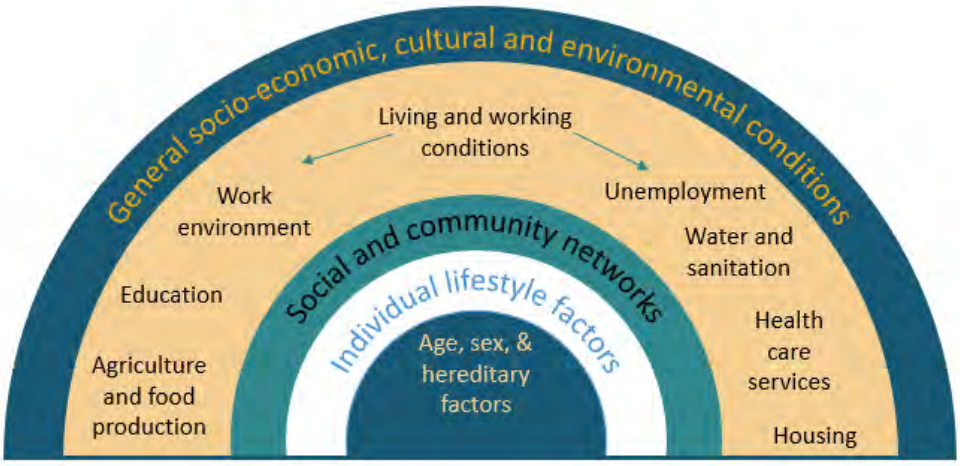
Social Determinants of Health Framework

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

Approach and Community Engagement Process

The CHNA aimed to engage agencies, organizations, and community residents through different avenues. The CHNA process was guided by strategic leadership from the RWJBH Systemwide CHNA Steering Committee, the four healthcare institutions' core team, the joint 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 Acknowledgments section.

Advisory Committee Engagement

In early 2022, four institutions--Monmouth Medical Center (MMC), Monmouth Medical Center South Campus (MMCSC), Community Medical Center (CMC), and Barnabas Health Behavioral Health Center (BHBHC)—convened a joint Advisory Committee of community and hospital partners to provide insight and guidance throughout this process. The joint Advisory Committee was engaged at critical intervals. For example, 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 Appendix A for a list of Advisory Committee members.

The Advisory Committee reconvened in late October 2022. During this meeting, HRiA staff presented the findings from the CHNA process, including the preliminary issues that emerged upon review of the qualitative and secondary data. Advisory Committee members had the opportunity to ask questions, then discuss and vote 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 the 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 including but not limited to the United Way of New Jersey's ALICE Study. Additionally, hospitalization data from the RWJBH system is also included in Appendix H. Secondary data were analyzed by the agencies that collected or received the data. Data are typically presented as frequencies (%) or rates per 100,000 population. It should be noted that when the narrative makes comparisons between towns, by subpopulation, or with NJ overall, these are lay comparisons and *not* statistically significant differences.

The 2022 MMC community health needs assessment focuses on twenty-five communities that comprise the MMC PSA. These communities are located in Monmouth County. Town-level data are provided when available. When only county-level data are available, Monmouth County is presented with the state-level data as a reference.

The U.S. Census American Community Survey (ACS) 5-year (2016-2020) estimates are the primary data source for social and economic indicators referenced in the report. Five-year estimates are considered the most reliable and comprise a relatively large sample size. Further, in the case of small population counts found in several municipalities in Monmouth County, five-year estimates provide a more precise statistical profile of the community of interest.

Quantitative data included in the report depicting racial/ethnic groups will follow standard terminology consistent with the U.S. Census unless the secondary data source utilizes different categories for race and ethnicity, which will be noted in the narrative. Qualitative data specific to racial/ethnic groups in the narrative will refer to residents using shortened terms such as White, Black, Latino, and Asian. The term communities of color may also be used when discussing themes that emerge, specifically among residents of multiple groups.

One specific area to note is that Fort Monmouth is included in the MMC primary service area. Fort Monmouth is a former U.S. Army installation that has been designated for economic redevelopment since its closure. The sociodemographic profile is based on ZIP code data from the U.S. Census. However, due to the relatively small population, estimates provided for this area must be interpreted with caution. In addition, in some instances, no information is reported for Fort Monmouth due to data not being available to derive estimates for the parameter of interest. For these reasons, Fort Monmouth indicator data (where available) are not compared with other towns in this report.

Key secondary data tables and graphs are in the body of the reported with relevant narrative. Additional tables and graphs of secondary data are located in Appendix F.

Primary Data Collection

Qualitative Discussion: Key Informant Interviews and Focus Groups

The joint Advisory Committee and core team from the four healthcare institutions were instrumental in identifying leaders, providers, and residents across the Monmouth and Ocean County region to engage in deep dive discussions. To ensure that each institution's specific CHNA is as granular as possible and aligned with its primary service area, findings from focus groups and interviews were analyzed by county, rather than across the entire region. Given MMC's primary service area, this CHNA report includes qualitative findings from residents, leaders, and providers only from Monmouth County.

Key Informant Interviews

Key informant interview discussions were completed with 8 individuals by Zoom or telephone. Interviews were 45-60-minute semi-structured discussions that engaged institutional, organizational, and community leaders as well as front-line staff across sectors. Discussions explored interviewees' experiences of addressing community needs and priorities for future alignment, coordination, and expansion of services, initiatives, and policies. Sectors represented in these interviews included mental health and substance abuse, healthcare, youth services, newly arrived, faith-based, food and housing support services, disability services, and discrimination and structural racism. See the Appendix B for the list of organizations/sectors represented by the key informant interviewees and Appendix C for the key informant interview guide.

Focus Groups

A total of 33 community residents participated in 4 virtual focus groups (telephone or video) conducted with residents representing specific populations of interest, including persons that were Spanish-speaking, seniors (65+), veterans, and those that were low-income or economically vulnerable.

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 E 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 health needs survey was developed and administered over a six-month period from early April and through the end of September 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, health 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 hospital, 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 comprised 976 respondents that self-identified as residents living in MMC's primary service area. Appendix G provides a table with the demographic composition of survey respondents. Demographically, most respondents who completed the survey were White and female, with a mean age of 50. Additionally, more than half of respondents reported having a college degree or higher (55%), with 63% reporting that they were employed full-time at the time of the survey. Throughout this report, Monmouth 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, the community survey used a convenience sample with its online administration method. 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. Therefore, results cannot be generalized to the larger population. Similarly, while interviews and focus groups provide valuable insights and important in-depth context, results are also not generalizable due to their non-random sampling methods and relatively small sample sizes.

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

Population Characteristics

Population Overview

In 2020, Monmouth County had a population size of 629,185. Towns located in Monmouth County ranged in population size. Fort Monmouth (pop. 124 residents) and Allenhurst (pop. 486) were the smallest townships. In comparison, some of the largest were Middletown (pop. 66,291), Long Branch (pop. 30,721), and Neptune (pop. 27,675). Similar to the overall state of New Jersey Monmouth County townships experienced minimal population decline between 2011-2015 and 2016-2020, though some experienced more substantial change. For example, Belford experienced a population increase over this time (26.2% population growth); other towns, like Deal, experienced a population decline (-43.4%).

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

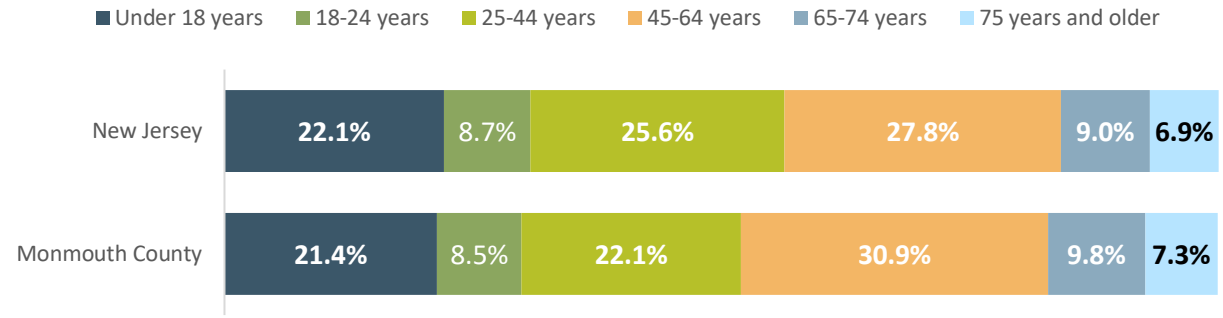
	2015	2020	% change
New Jersey	8,904,413	8,885,418	-0.2%
Monmouth County	629,185	620,821	-1.3%
Allenhurst	486	492	1.2%
Asbury Park	15,945	15,536	-2.6%
Atlantic Highlands	4,346	4,312	-0.8%
Belford	1,513	2,049	26.2%
Deal	757	528	-43.4%
Eatontown	12,298	12,195	-0.8%
Fair Haven	6,075	5,833	-4.1%
Fort Monmouth	124	117	-6.0%
Highlands	4,947	4,746	-4.2%
Leonardo	2,495	2,302	-8.4%
Lincroft	6,431	6,501	1.1%
Little Silver	5,937	5,817	-2.1%
Long Branch	30,721	30,424	-1.0%
Middletown	66,291	65,316	-1.5%
Monmouth Beach	3,258	3,226	-1.0%
Navesink	1,738	1,331	-30.6%
Neptune	27,675	27,547	-0.5%
Oakhurst	3,727	3,480	-7.1%
Ocean Grove	3,015	3,151	4.3%
Oceanport	5,800	5,715	-1.5%
Port Monmouth	3,568	3,660	2.5%
Red Bank	12,238	12,039	-1.7%
Rumson	6,993	6,757	-3.5%
Shrewsbury	3,923	4,082	3.9%
West Long Branch	7,974	7,911	-0.8%

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

Monmouth County had a similar age distribution compared to New Jersey in 2016-2020 (Figure 3), with about 22% of the population being under age 18 and over 15% being age 65+ years old. Age distribution data by town can be found in the Appendix of additional data. Children aged 18 and under made up 25% or more of residents in Fair Haven, Little Silver, Oakhurst, Rumson, and Shrewsbury in 2016-2020, and

the largest populations of adults over 65 was in Deal (36.5%) and Ocean Grove (32.4%) See Appendix F for detailed data tables.

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

According to the 2020 Census, seven in ten Monmouth County residents identified themselves as White (71.6%), followed by Hispanic/Latino (12.5%), Black (6.1%), and Asian (5.6%). However, recent population estimates (2016-2020) show that racial and ethnic distributions varied widely across towns located in Monmouth County (Table 2). For example, Asbury Park had almost two out of every three residents identified as part of a community of color, and in Long Branch and Neptune, it is one out of every two residents. During the same period, nearly all residents in Little Silver (94.8%) and Fair Haven (94.2%) identified as White. Long Branch and Red Bank had the largest Hispanic/Latino populations (27.7% and 26.8%, respectively); Asbury Park and Neptune had the largest percentage of Black residents (40.2% and 32.0% respectively), and the populations of Eatontown and Leonardo had the largest share of persons that identified as Asian (7.9% and 7.0% respectively). See Appendix F for additional data tables.

Table 2. Racial and Ethnic Distribution, by Town, 2016-2020

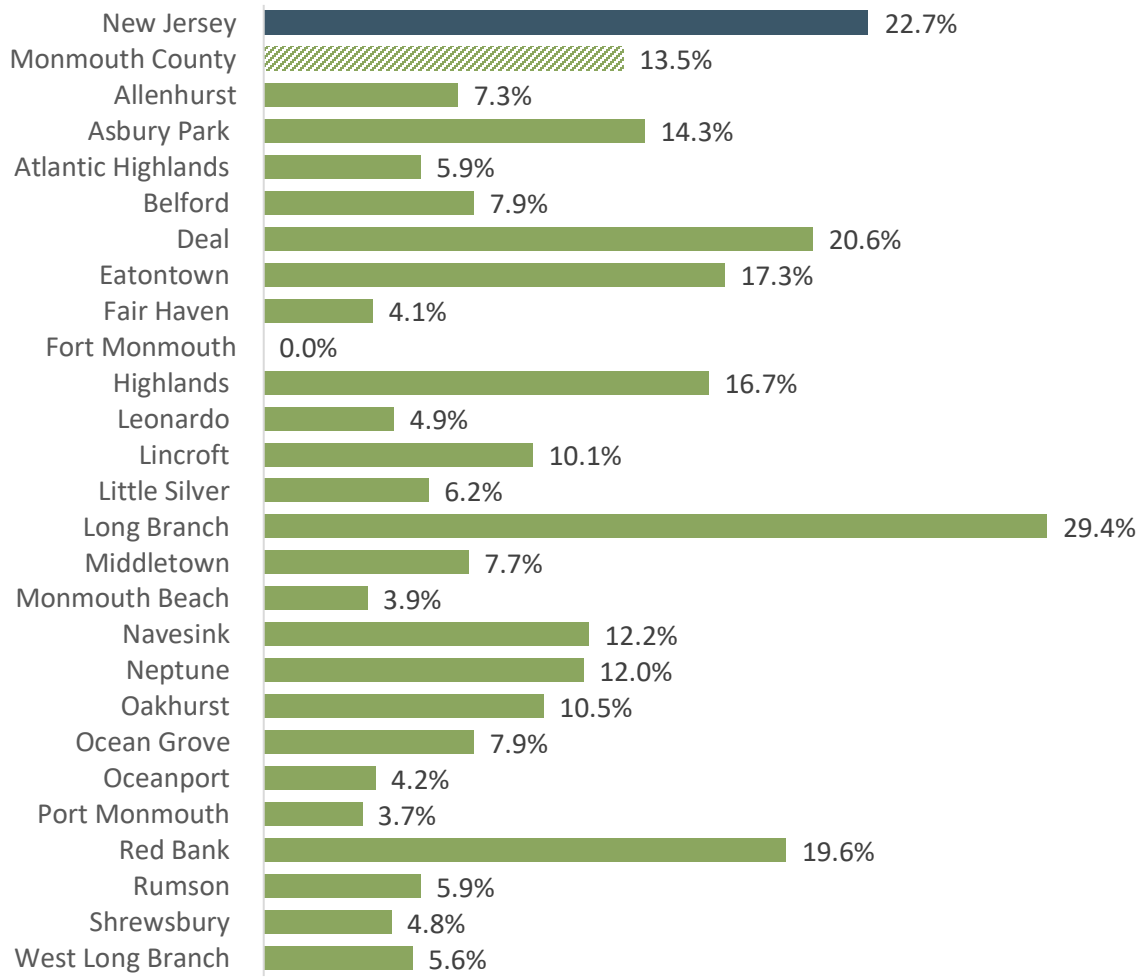
	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/ Latino	White, Non-Hispanic
New Jersey	10.2%	12.4%	21.6%	51.9%
Monmouth County	5.6%	6.1%	12.5%	71.6%
Allenhurst	0.4%	0.8%	4.7%	86.8%
Asbury Park	2.0%	40.2%	17.1%	35.3%
Atlantic Highlands	0.8%	0.0%	7.3%	91.9%
Belford	0.8%	0.0%	12.7%	84.0%
Deal	0.0%	1.5%	19.1%	79.4%
Eaton	7.9%	7.6%	12.3%	66.8%
Fair Haven	1.0%	3.0%	1.6%	94.2%
Fort Monmouth	0.0%	12.8%	0.0%	87.2%
Highlands	4.3%	1.1%	3.1%	88.1%
Leonardo	7.0%	0.0%	2.6%	90.5%
Lincroft	6.7%	0.1%	3.6%	89.1%
Little Silver	0.9%	0.0%	3.3%	94.8%
Long Branch	1.8%	11.6%	27.7%	55.7%
Middle	3.6%	1.5%	6.5%	86.8%
Monmouth Beach	0.5%	0.0%	5.7%	93.2%
Navesink	3.4%	8.5%	0.3%	86.5%
Neptune	2.2%	32.0%	11.9%	50.7%
Oakhurst	1.2%	10.4%	3.0%	84.8%
Ocean Grove	1.5%	0.6%	6.9%	90.5%
Oceanport	3.9%	0.6%	6.9%	84.1%
Port Monmouth	2.1%	2.1%	8.1%	85.2%
Red Bank	1.6%	9.1%	26.8%	61.7%
Rumson	2.7%	0.5%	3.9%	91.3%
Shrewsbury	4.3%	0.4%	1.5%	92.6%
West Long Branch	0.6%	6.2%	6.3%	84.5%

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

Foreign-Born Population

Secondary data show that there is great variation across Monmouth County in the percent of foreign-born residents in the area. In 2016-2020, the foreign-born population ranged from 3.7% in Port Monmouth to almost a third in Long Branch (29.4%) (Figure 4). According to focus group and interview participants, the communities of immigrants in Monmouth County are considered a product of the support networks instrumental for newly arrived individuals and families learning to navigate a new way of life in the United States. "*For immigrant groups especially, there is a strong sense of community and mutual support. For example, for recent Haitian immigrants, the reason they are choosing to come [to the United States is] because there was already a Haitian community there. It's piggybacking; new arrivals are finding their community and clustering. That's absolutely an asset, and social ties are so crucial to making one's way out of poverty, finding jobs, accessing resources and assistance, and getting into good schools. The sense of community, the social bond, and that mutual support and aid that happens,"* explained one interviewee. Additionally, according to the U.S. Census, Monmouth County's most common countries of origin for immigrant residents were Mexico and India, followed by China (excluding Hong Kong), Brazil, and Egypt.

Figure 4. Percent Foreign Born Population, by State and County, 2016-2020

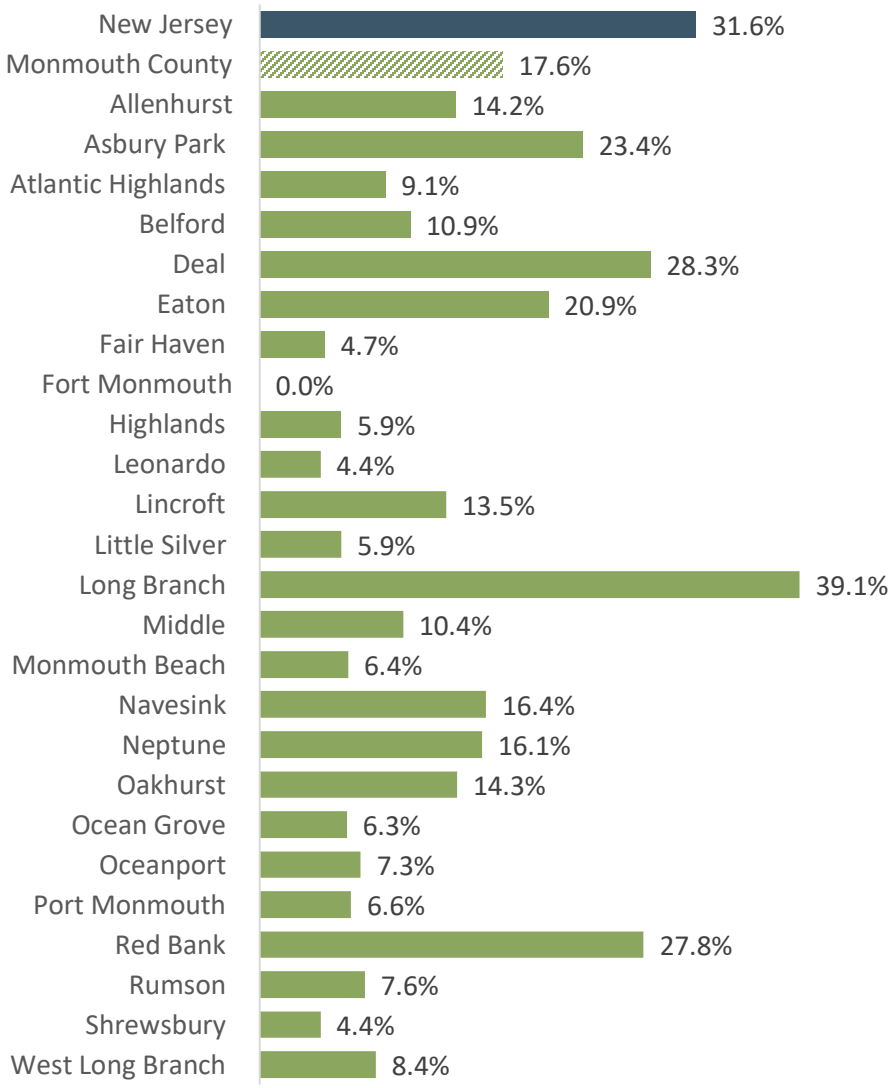


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Language Diversity

Among New Jersey residents over age five, 31.6% reported speaking a language other than English at home in 2016-2020. A variety of languages are spoken across Monmouth County, as indicated in the secondary data. For example, almost two in five residents in Long Branch speak a language other than English at home compared to 3.7% of residents in Port Monmouth (Figure 5). The most spoken languages other than English in Monmouth County are Spanish, other Indo-European languages (e.g., Portuguese, Hindi, Gujarati), Russian, Polish, or other Slavic languages, and Chinese (including Mandarin and Cantonese) (Table 3). Additional details regarding languages spoken are included in Appendix F.

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



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

Table 3. Top 5 Languages Spoken at Home, by State, County, and Town, 2016-2020

	Speak only English	Spanish	Other Indo-European languages	Russian, Polish, or other Slavic languages	Chinese (incl. Mandarin, Cantonese)
New Jersey	68.4%	16.4%	5.4%	1.7%	1.4%
Monmouth County	82.4%	7.1%	4.0%	1.5%	1.3%
Allenhust	85.8%	2.1%	8.7%	0.0%	0.0%
Asbury Park	76.6%	13.7%	0.8%	0.4%	0.0%
Atlantic Highlands	90.9%	1.7%	1.6%	0.1%	0.4%
Belford	89.1%	6.7%	2.5%	0.0%	1.4%
Deal	71.7%	14.6%	5.7%	0.0%	0.0%
Eaton	79.1%	4.6%	5.5%	1.6%	1.7%
Fair Haven	95.3%	2.7%	0.1%	0.6%	0.3%
Fort Monmouth	100.0%	0.0%	0.0%	0.0%	0.0%
Highlands	94.1%	2.4%	0.5%	0.0%	1.9%
Leonardo	95.6%	0.5%	0.0%	0.0%	0.8%
Lincroft	86.5%	2.9%	6.9%	1.6%	1.1%
Little Silver	94.1%	1.5%	1.4%	0.5%	0.6%
Long Branch	60.9%	22.2%	13.5%	0.6%	0.2%
Middle	89.6%	3.7%	3.5%	1.2%	0.7%
Monmouth Beach	93.6%	3.7%	1.2%	0.5%	0.0%
Navesink	83.6%	2.8%	8.5%	5.1%	0.0%
Neptune	83.9%	9.9%	1.0%	0.8%	0.0%
Oakhurst	85.7%	4.2%	3.2%	0.0%	0.4%
Ocean Grove	93.7%	2.5%	1.6%	0.0%	0.0%
Oceanport	92.7%	0.5%	3.6%	0.0%	0.0%
Port Monmouth	93.4%	4.6%	0.7%	0.0%	0.0%
Red Bank	72.2%	23.3%	1.6%	0.1%	0.1%
Rumson	92.4%	3.7%	1.1%	0.2%	0.9%
Shrewsbury	95.6%	0.8%	0.8%	0.1%	0.7%
West Long Branch	91.6%	2.2%	4.8%	0.7%	0.0%

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 contribute to stressful life circumstances that affect multiple aspects of health.

Community Strengths and Assets

Understanding the resources and services available in a community and their distribution helps to elucidate the assets that can be applied to address community health and any gaps that might exist. For example, when asked to describe some of the strengths or assets in their community, residents, without hesitation, identified having high-quality public institutions, public spaces, and amenities such as the local school system, libraries, as well as its parks, beaches, and music venues.

> *"We have places that encourage walkability, amenities for seniors, and good theaters. There are a lot of cultural happenings and the university. There's no end of things to do here."*
> – Focus group participant

One focus group participant described their public spaces: "*The Monmouth Park system is amazing! There are so many open spaces, and [we also have access] to the ocean and the shore."*
Another participant described the quality of life for older adults living in Monmouth County, *"Where I live, it is good for seniors and the community; they have picnics and different [social] events. These social activities help to keep the community together, and there are also lots of spaces like parks to walk."*
Additionally, the role and value of public spaces were uniformly shared by several other participants who voiced agreement that many green spaces encourage walking and running. This was followed by another participant who observed, *"Where I live, they have parks and offer recreational activities that provide a positive support system, especially for veterans."*

Additional community assets identified by participants included having access to a wealth of learning and social support services. Services that were highlighted in discussions were financial literacy trainings, parenting classes, food resources, and faith-based organizations that promoted health and wellness activities, including walking clubs. One Spanish-speaking participant highlighted a local organization's contribution to helping improve the lives of program participants. She stated, *"We have this wonderful center helping our Hispanic community and the wonderful resources, and they dedicate themselves to us becoming successful."*

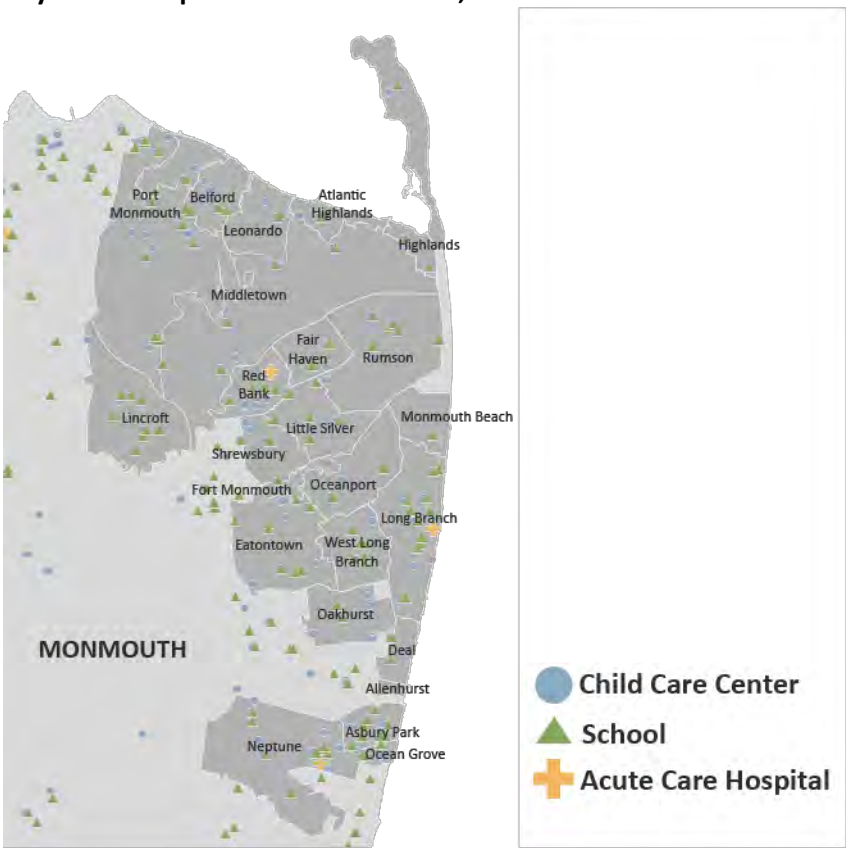
Similarly, several participants highlighted efforts by community-based organizations to help people stay informed about local issues by offering workshops and other classes benefiting individuals and families. For example, a participant described the process, "*They dedicate programming that is focused on being aware of intimate partner violence, parenting classes, and other programs to help our children in school. [These programs] help us be more aware of services*."

One participant also described the important role of community programs and services dedicated to helping residents meet their basic needs by providing free public events where possible, "*[My community] is pretty good at offering help to residents, tons of foodbanks, lots of churches, and we have whole COVID testing and everything like that, good with the community as far as kids. They [Community organizations] try to have free music at certain places and times and offer as many things as possible.*

Meanwhile, an interviewee highlighted an example of cross-sector collaboration, *"Monmouth County has been very supportive, and we are working with various organizations on health equity and wellness, including Monmouth Medical Center, Robert Wood Johnson, Hackensack-Meridian Health Center, Brookdale Community College, and others. So, collaboration is powerful, and it is about who gets acknowledged, but what services can we bring to our community."*

The map below highlights some of the institutions and services in the MMC primary service area. These include three acute care hospitals as well as 109 schools and 103 child care centers.

Community Assets Map of MMC Service Area, 2020 & 2022



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

However, while some participants discussed strengths such as sports and entertainment venues and walkability, other focus groups and interview participants described accessibility problems due to not having reliable forms of public transportation. In addition, other participants remarked about having poor roads and emphasizing challenges brought on by traffic congestion, limited housing, and a rising cost of living.

The overall themes identified across focus groups and interviews held with Monmouth community residents coincide with results gathered from community surveys administered to residents. For example, when asked how much they agreed or disagreed with statements about their community, two thirds or more agreed or completely agreed that it was easy to find fresh fruits and vegetables in their community, that their community had safe outdoor places to walk and play, and that their community was a good place to raise a family (Figure 6). This mirrors the 2019 CHNA, where community survey respondents reported that their top community strengths were: It's easy to find fresh fruits and vegetables in my community (75%), there are places to socialize (74%), it is a good place to raise a family (73%), and there are safe outdoor places to walk/play (69%). Conversely, they were less likely to endorse statements regarding transportation as a means of facilitating access for residents and affordability of housing (26.9% and 21.9% respectively).

Figure 6. Percent of Community Survey Respondents Noting Strengths in Their Community (Agree or Completely Agree with Statements (n=670), 2021

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

Education

Educational attainment is another important measure of socioeconomic position that can provide additional perspectives about a population alongside measures of income, wealth, occupation, and poverty. Further, education can shape and influence health outcomes in various ways. For example, education is considered a pathway for upward social mobility, fostering stable social relationships, and reducing the risk of uptake of unhealthy behaviors.

Educational Attainment and Opportunity

Within Monmouth County, almost half of adults 25 years and older had a four-year degree or higher (47.4%); see Appendix F. Additionally, among the towns in Monmouth County, Long Branch, Port

Monmouth, Deal, and Asbury Park reported having some of the largest populations of residents with a high school diploma or less. Additional data on educational attainment for persons aged 25 years and older by race/ethnicity are in Appendix F.

Most participants expressed pride in their school system. Parents of school-aged children enrolled in the local public school system observed that their son or daughter benefited from the local programs and services provided by the school their children attended. As one participant observed, *"I see that schools focus on the children. There are a host of programs for children."* While another resident and parent shared, *"My son is doing well in school, he has become very social, and the teachers have helped him."*

Conversely, residents also expressed concerns about the financial and emotional effects that the pandemic had on children, including food and housing insecurity, the stress and anxiety brought on by isolation, and the loss of learning opportunities as school districts moved to a virtual learning format. As one interviewee explained, "*Food insecurity is a huge challenge, and we became a* stop-gap*. We partnered with a local food bank in central New Jersey to be a distribution point, and we continue to do that at both sites."* In addition, one interviewee observed that in schools transitioning to a virtual learning format, finding a quiet place for their children to learn became a challenge, *"There was an immediate need for kids to be provided space for virtual learning. We worked with school districts and made our two non-school sites virtual learning centers so kids could do their schoolwork."*

Further, as schools began to transition back to school and try to establish some normalcy, several interviewees, particularly those involved in delivering after-school-based programs, described behavioral changes in the children they served. As one interviewee explained, *"We have noticed in our 5, 6- and 7-year-olds that we have seen a significant increase in behavioral challenges. We are not sure why but believe that COVID did not get the type of socialization, and now they are in an environment, and we are having an issue with behavior, this very pronounced."*

Graduation Rates and Educational Experiences during COVID-19

Most (92.6%) New Jersey students who began high school in 2016 completed it in four years, graduating in 2020 (Table 4). Across school districts in the primary service area, Asbury Park and Neptune had 4-year graduation rates below the statewide average. In terms of graduation rates by race and ethnicity: Black and Hispanic students generally experienced lower graduation rates than their White or Asian counterparts. Black students in the Middleton Township Public School District had the lowest graduation rate, 58.3%, for any race/ethnicity group across all the school districts.

Table 4. 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%
Monmouth County	District Wide	Asian	Black	Hispanic	White	Two+ Races
Asbury Park School District	79.3%	*	79.0%	82.8%	*	*
Long Branch Public School District	94.6%	*	96.9%	92.9%	97.4%	*
Middletown Township Public School District	95.3%	100.0%	70.6%	90.5%	96.0%	100.0%
Monmouth County Vocational School District	98.4%	100.0%	84.6%	85.0%	99.3%	*
Monmouth Regional High School	94.7%	96.3%	95.7%	83.7%	97.1%	*
Neptune Township School District	81.1%	*	81.8%	74.4%	84.4%	85.0%
Township of Ocean School District	90.5%	96.0%	80.6%	79.5%	93.9%	N

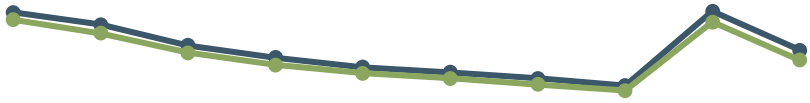
DATA SOURCE: New Jersey Department of Education, School Performance, Adjusted Cohort Graduation Rates, 2020-2021

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. Data from the Bureau of Labor Statistics show that unemployment rates in New Jersey and Monmouth County had been trending downward over the past decade prior to the COVID-19 pandemic, after which rates rose substantially (Figure 7). Town-level data from the 2016-2020 American Community Survey show that Allenhurst and Fort Monmouth experienced the highest unemployment rates, 11.1% and 10.3% respectively, while Shrewsbury and Oceanport experienced the lowest (both 1.4%) (Figure 8).

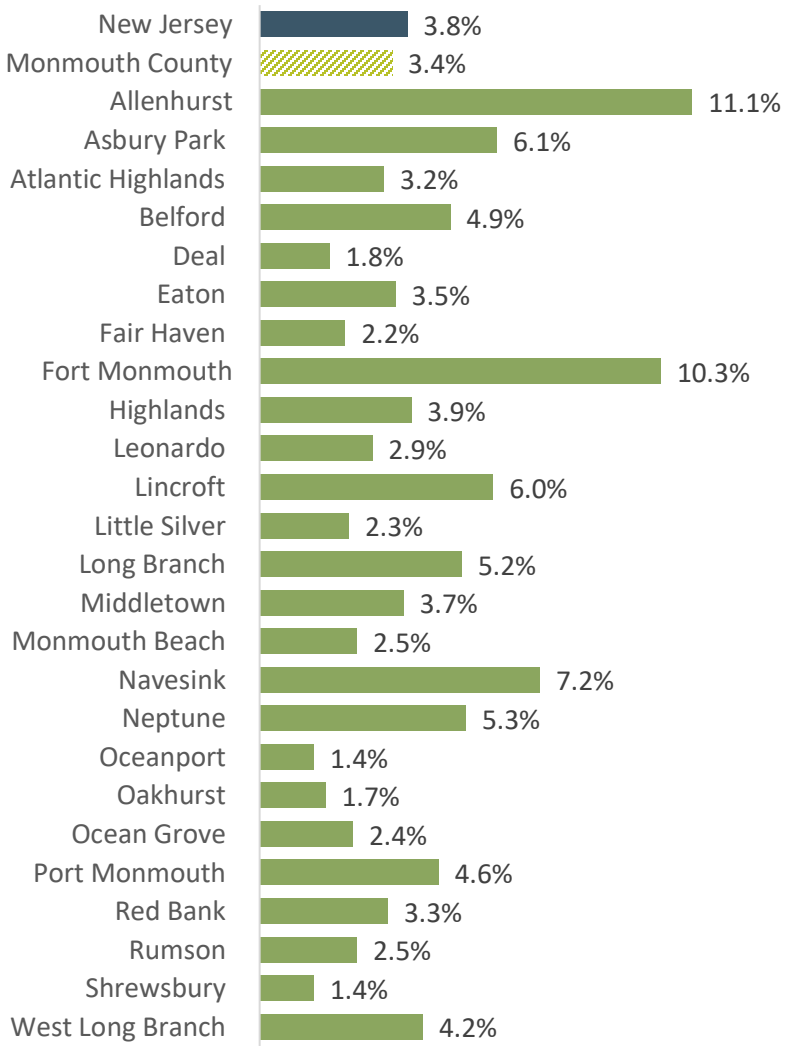
Figure 7. Unemployment Rate, by State and County, 2012-2021



	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%
Monmouth County	8.8%	7.7%	6.1%	5.1%	4.4%	4.0%	3.5%	3.0%	8.6%	5.5%

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

Figure 8. 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

Income and Financial Security

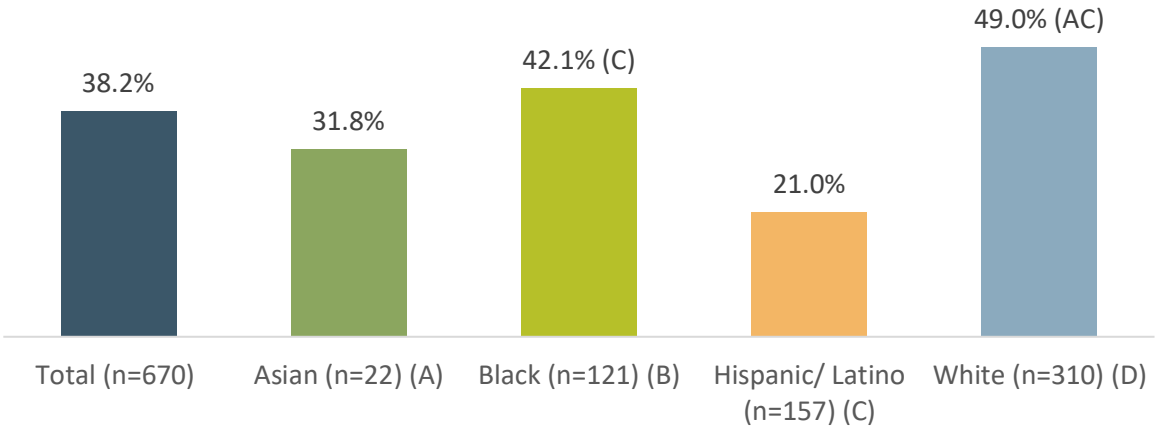
Income is a powerful social determinant of health that influences where people live and their ability to access resources, affecting health and well-being. Like the rest of the nation, Monmouth County experienced economic challenges due to the COVID-19 pandemic. The loss of employment and income also exacerbated the pre-existing financial vulnerability of individuals and communities.

Financial insecurity was a primary concern voiced in both focus groups conversations and interviews, with several participants considering the loss of a job as detrimental and leading to the loss of a home, transportation, and increasing isolation, stress, and anxiety. One participant observed, *"There is rising economic stress with a host of negative financial factors that are impacting people whether that is job loss, not making ends meet [financially], from trying to bring food home to paying your electricity."*

Additionally, residents shared experiences of people they knew who had to decide between eating and paying for essential services such as water or light and medical care. As one interviewee explained, "[*It is] Maslow's Hierarchy of Needs, health in Maslow's scale is way at the bottom. [So] if you are hungry and you also worry about feeding your kids, you are also going to get evicted, and your significant other has hurt you, and you have an appointment the next day, so you are not going to show up."* Several focus group participants also shared about the stress of having faced severe economic hardship during the pandemic and now having to face rising fuel, food, as well as costs of medication. One interviewee expressed concerns about the increasing cost of living impacting families, especially with potential benefits cuts, *"We need to think about the health equity piece to advocate for families. I see the prescription costs rising, but SNAP funds will also decrease for families."*

This was similarly highlighted in community surveys, where under two fifths of respondents agreed with the statement that people in their community could afford basic needs like food, housing, and transportation. Additionally, Hispanic/Latino (21.0%) respondents, in particular, were much less likely to agree that people in their community could afford basic needs (Figure 9).

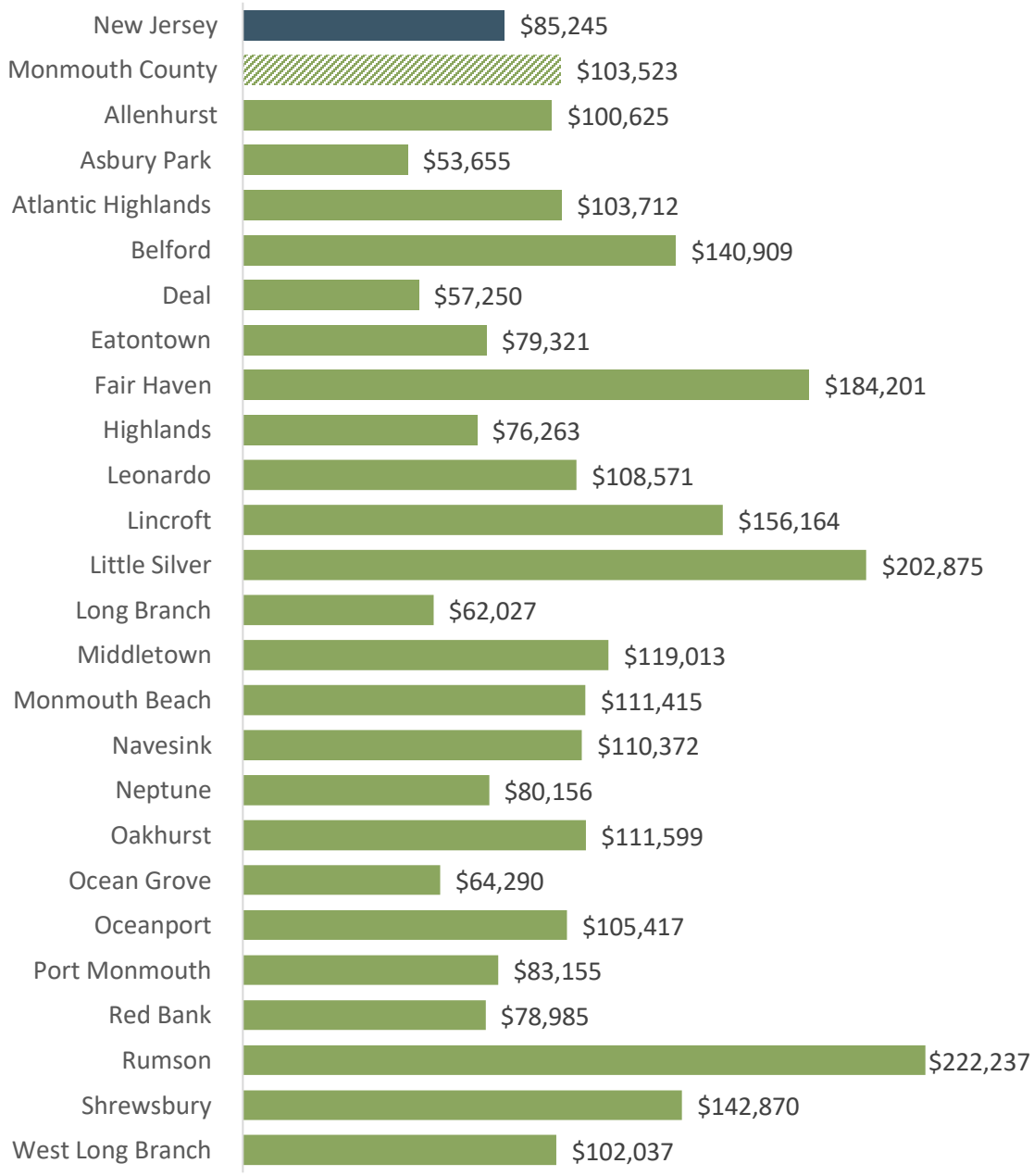
Figure 9. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement "People in my community can afford basic needs like food, housing, and transportation," by Race/Ethnicity (n=670), 2021



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.

Across the MMC service area, there is variation in household financial wellbeing. Data from the 2016-2020 American Community Survey show that median household income across communities in Monmouth County ranges from $53,655 in Asbury Park to $222,237 in Rumson, a fourfold difference (Figure 10).

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

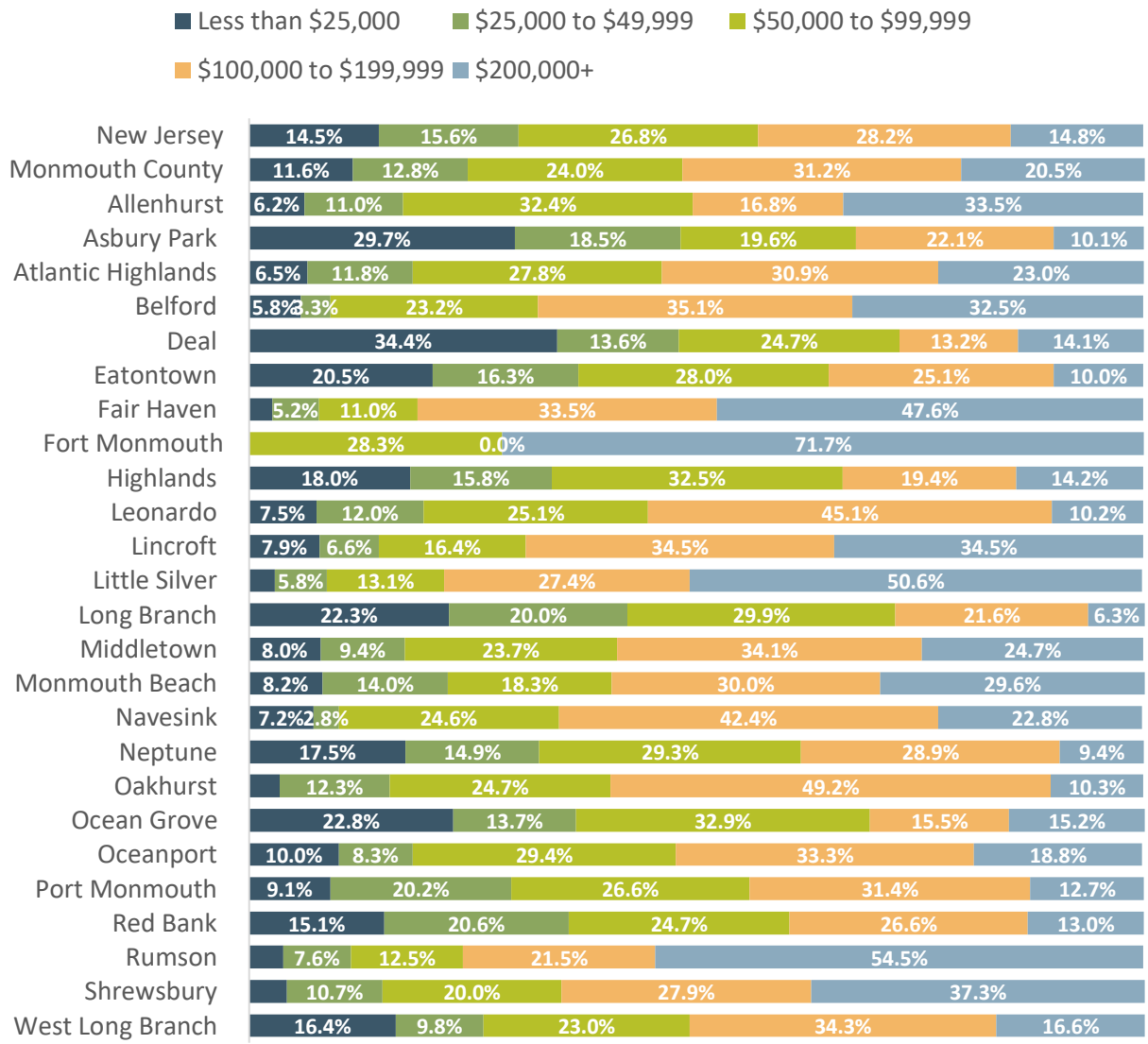


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Data on the concentration of higher and lower income earning households indicates that around 30% of households in Deal and Asbury Park have incomes less than $25,000 annually; in contrast, over 50% of

households in Fort Monmouth, Rumson, and Little Silver have incomes greater than $200,000 (Figure 11). Household incomes varied across racial and ethnic groups. Median incomes by race/ethnicity are included in Appendix F.

Figure 11. Distribution of Household Income, by State, County, and Town, 2016-2020

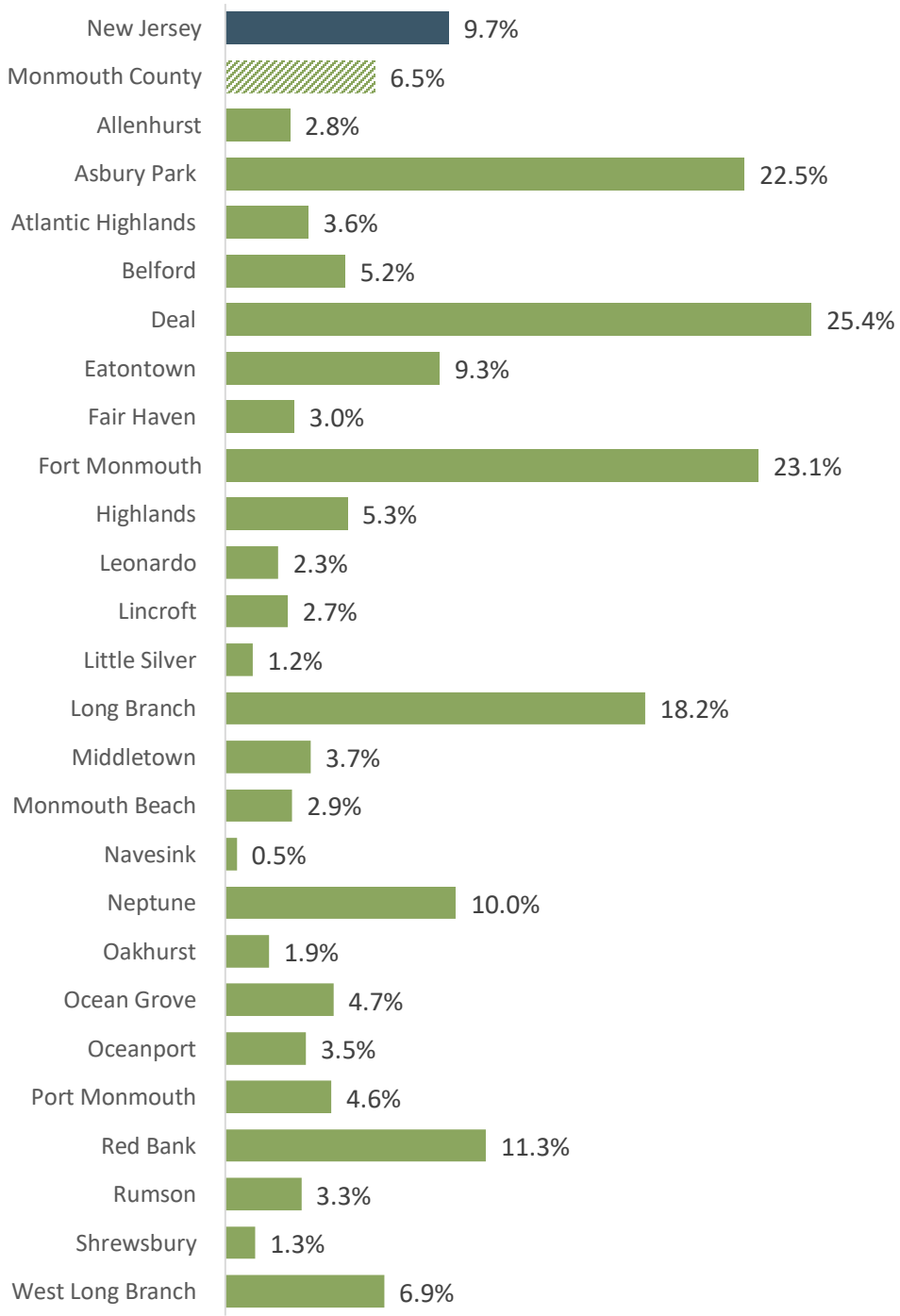


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020; percentages under 5% not labeled in graph.

The percentage of residents living below the poverty level represents the most extreme level of financial insecurity. For context, the federal poverty line is the same across the country – regardless of cost of living – but changes by household size. In 2021, individuals living alone or considered a household of one would fall below the federal poverty level at an income level of $12,880, while federal poverty level for a family of four is $26,500. While the percentage of residents of Monmouth County below the poverty level is below the state (6.5% and 9.7% respectively), this varies greatly by town (Figure 12). The percentage of residents below the poverty level range from 0.5% in Navesink to over 20% in Asbury and Deal. While Fort Monmouth reports that 23.1% of its residents live in poverty, results must be

interpreted with caution due to Fort Monmouth having only 117 residents (the poverty levels are based on the American Community Survey from the U.S. Census which uses a survey sample.)

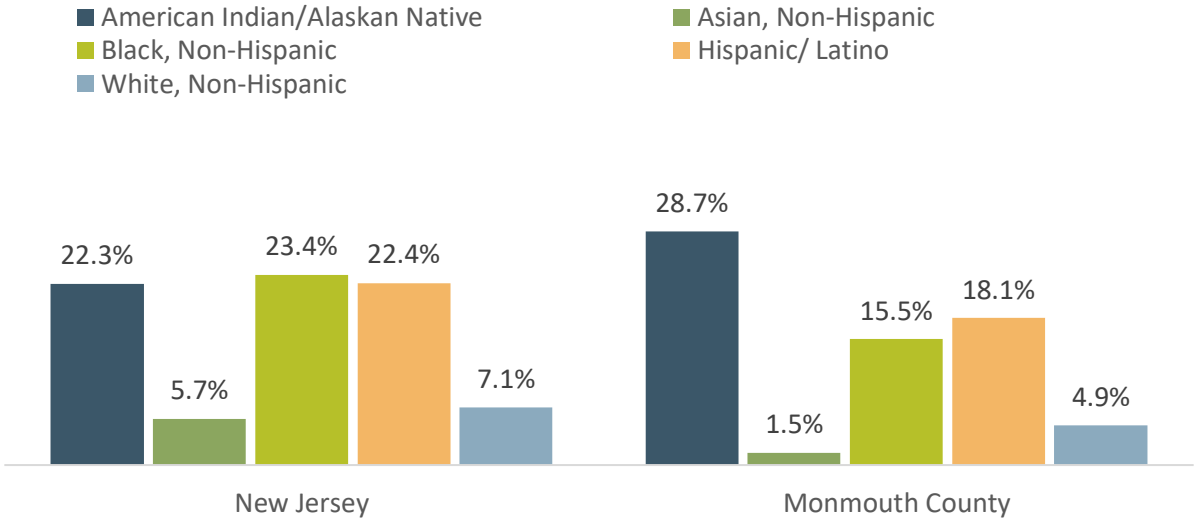
Figure 12. Individuals Below Poverty Level, by State, County, and Town, 2016-2020



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

Similar to New Jersey overall, the patterns by race/ethnicity of children in poverty in Monmouth County are dramatic (Figure 13). The percentage of Asian and White children in poverty in both New Jersey and Monmouth County was below 10% in 2019, while the percentage of Black and Hispanic/Latino children was over 15%, and up to nearly 30% for American Indian/Alaskan Native children in Monmouth County.

Figure 13. 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

Food Security

Food insecurity is often considered a condition experienced by a household with limited or uncertain access to adequate food. Additionally, the New Jersey Department of Health states that food insecurity households may often result from individuals having to tradeoff between meeting essential needs, such as light and medical care, and purchasing nutritionally adequate foods. Therefore, not having reliable access to affordable, nutritious food is directly related to financial insecurity.

> *"I think there is also this shame that can come with asking for help and food. We take pride in our work, but something happens, and you are no longer in that place to help yourself. And you are not able to access the right type of food that we need to eat to stay healthy."*
> – Key informant interviewee

Across focus groups and interviews, food insecurity, like housing or transportation, rose to the top of concerns by Monmouth County residents. The undercurrent for these concerns was the economic climate and the impact felt by rises in the cost-of-living, leaving little room to purchase or pay for the most basic needs, particularly food for individuals and families. For example, one focus group participant stated, "*There is rising economic stress that everyone is feeling, and so it is making people aware that there are certain things that they can't afford. In addition, there are negative financial factors impacting people, whether job loss, not making ends meet and other things where people now have to decide to [either] bring food home or pay your electricity.*" Additionally, some residents described barriers to purchasing affordable food, *"If you can't get transportation [to go buy affordable food at a grocery store, you have] the local convenience store [which] is overpriced. Some months I rely on places like Shore*

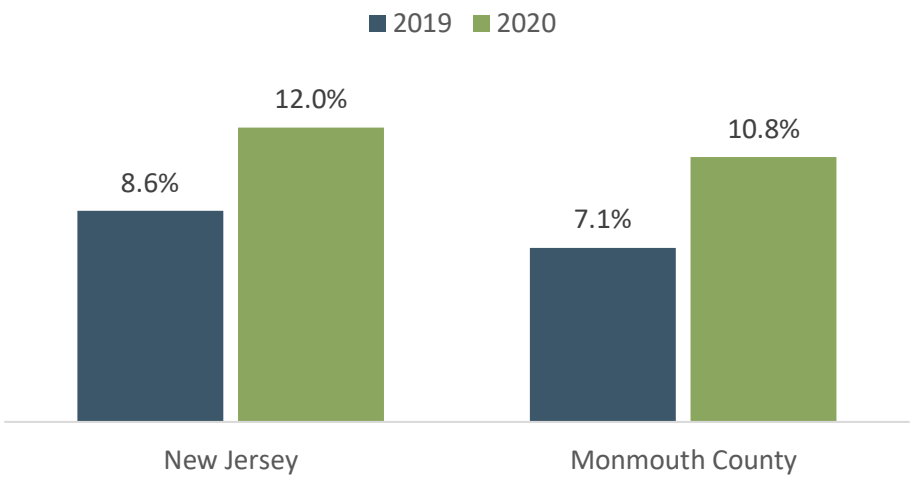
House to get food and food banks; it becomes important; otherwise, I won't eat, and I'm diabetic, so I must eat [regularly].

An interviewee also highlighted the decisions clients often make based on their financial situation, *"When someone shows up to the pantry, the most immediate need is food, but it's interrelated with other kinds of needs. People tend to sacrifice food when their budgets are stressed because they can choose lower-quality food that may be cheaper. If sacrificing in quality, you start sacrificing in quantity."*

Additionally, whether receiving or providing food assistance, residents shared that food insecurity was made more challenging by stigma. An interview shared one example of a decision to transition the food assistance program from outside distribution back to indoors*: "Immediately, pantry participation dropped. It says a lot about the power of stigma [in] keeping people away, [it is] the cloak of anonymity being something people need."* Similarly, a focus group participant reflected on a sense of feeling helpless, "*I think there is also this shame that can come with asking for help and food; we take pride in our work, but something happens, and you are no longer in that place to help yourself."*

According to data from Feeding America, Map the Meal Gap, the percent of residents in Monmouth County in 2019 considered food insecure was 7.1%; this increased to 10.8% in 2020 (Figure 14). Further, while the percent of the population food insecure in Monmouth is lower than the state of New Jersey Monmouth County between 2019 and 2020 had a rate increase that was similar to the state's in residents that were food insecure.

Figure 14. 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.

Housing

Safe and affordable housing is integral to a community's daily lives, health, and well-being. Strong and growing evidence links stable and affordable housing to health. 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. Further, 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.

> *"There is no affordable housing in New Jersey and Monmouth and so what you see is that there are a lot of renters versus homeownership. But for low-income housing. It's also just not available. Renting a home is so expensive."*
> - Key Informant Interview.

Across focus groups and interviews conducted with Monmouth residents, access to affordable housing was considered a significant challenge. In particular, residents voiced concerns that the lack of quality affordable housing was more likely to impact newly arrived immigrants, seniors, veterans, and economically vulnerable residents. However, several residents agreed that having a home was an essential source of stability and a pathway to better health. For example, one focus group participant stated, "*if they [people needing help] cannot secure proper or safe housing, then everything else doesn't matter. Without housing, it all falls apart, and when you think about this [the effects of housing on the individual], you begin to understand that housing is healthcare."*

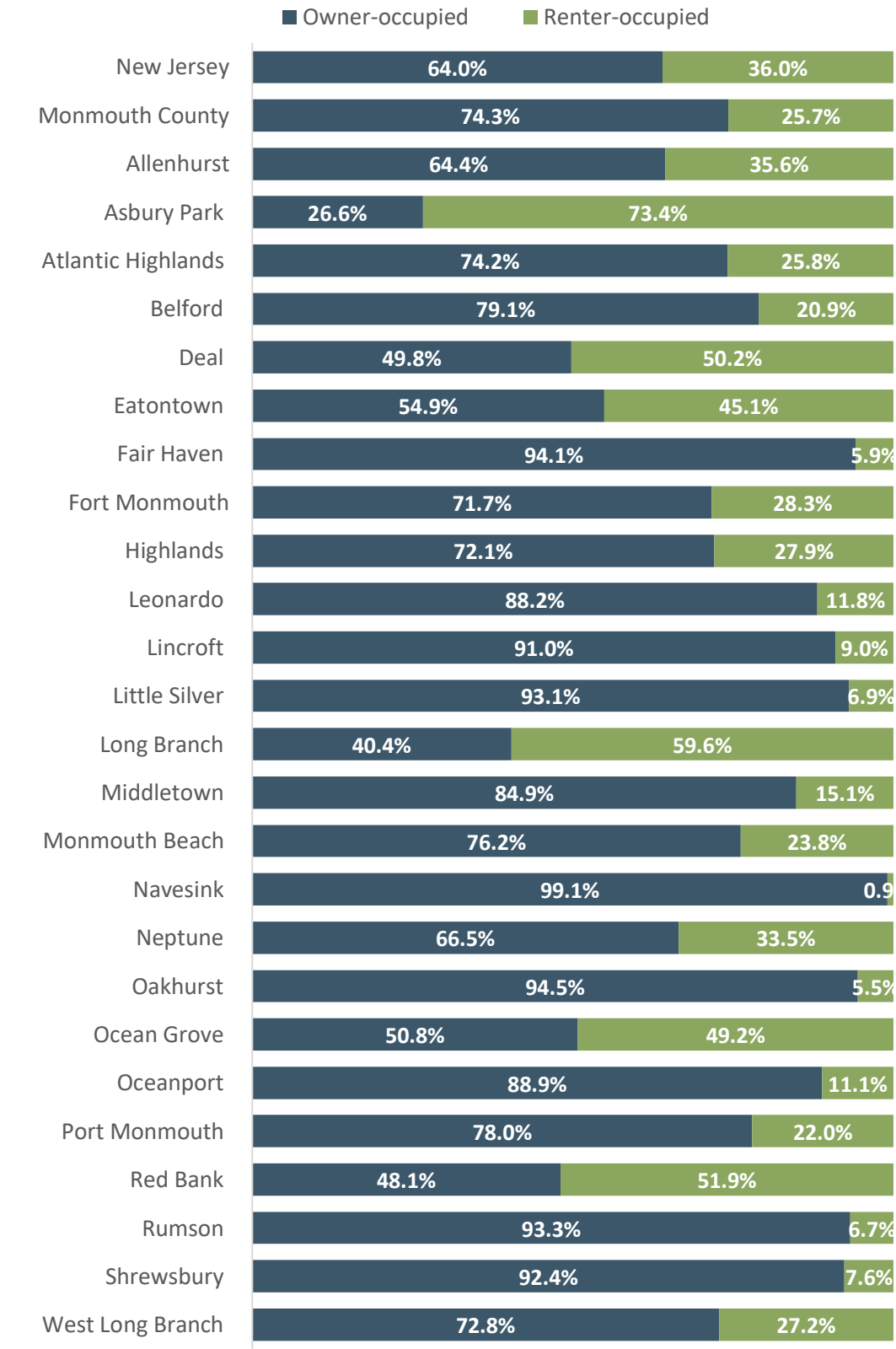
Residents also believed that housing was out of reach for many, especially for persons with limited financial means. There was general agreement among focus group participants, especially those with low incomes, that housing assistance vouchers were not keeping up with the rising cost of the rent. One interviewee working to assist low-income residents in securing housing observed, *"Social determinants such as housing are huge for people are looking for a home. They are trying to access affordable housing and get housing vouchers that don't come near fair market value. The ultimate breakdown is lack of housing and food insecurity, with changes in economy and pandemic now really coming into play, these two things are converging."* A resident and veteran similarly remarked how lack of housing and affordability can affect veterans' mental health: *"The issues that veterans must deal with, including lack of housing and rising costs, bring on anxiety, and it is especially harmful to our mental health."*

Amid the housing challenges, a network of social services and other community-based organizations in Monmouth County collaborated to address these concerns. As one interviewee observed, *"Monmouth County does a great job of identifying problems and solutions and then enacting [those] solutions. We have a lot of grass-root organizations that do not work in silos. Instead, we communicate and collaborate to help people get on a stable path – including those that need shelter, like our homeless, and people in need of a place to help them with their continuum of care [referring to those that might be discharged from the hospital or in need of emergency shelter]."*

Housing Landscape

In New Jersey 64.0% of housing units were owner-occupied versus 36.0% renter-occupied (Figure 15). In most towns in Monmouth County, owner-occupied units made up a higher percentage of housing stock than in the state overall. Home ownership rates were highest in Navesink (99.1%), Oakhurst (94.5%), and Fair Haven (94.1%). Roughly three-quarters of housing units in Asbury Park renter-occupied (73.4%).

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

Housing Affordability

Quantitative data from the 2016-2020 American Community Survey indicate that median monthly housing costs for owner-occupied households with a mortgage ranged from 1,621 in Allenhurst to $4,000+ in Monmouth Beach and Rumson (Table 5). Median monthly housing costs for renter-occupied households ranged from $559 in Lincroft to $3,500+ in Fair Haven and Little Silver.

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

	Owner-occupied	Renter-occupied
New Jersey	$2,476	$1,368
Monmouth County	$2,717	$1,437
Allenhurst	$1,621	$1,096
Asbury Park	$2,203	$1,292
Atlantic Highlands	$2,770	$1,445
Belford	$3,021	$1,758
Deal	$3,393	$1,153
Eatontown	$2,376	$1,258
Fair Haven	$3,683	3,500+
Fort Monmouth	-	-
Highlands	$2,073	$1,270
Leonardo	$2,191	$1,400
Lincroft	$3,831	$559
Little Silver	$3,429	3,500+
Long Branch	$2,339	$1,370
Middletown	$2,750	$1,382
Monmouth Beach	4,000+	$1,912
Navesink	$2,597	-
Neptune	$2,146	$1,356
Oakhurst	$2,675	-
Ocean Grove	$2,779	$1,280
Oceanport	$2,608	-
Port Monmouth	$2,236	$1,102
Red Bank	$2,475	$1,639
Rumson	4,000+	$2,236
Shrewsbury	$3,308	$2,940
West Long Branch	$2,689	$1,467

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020
NOTE: Dash (-) indicates data not available due to small sample sizes.

Consistent with conversations and interviews held with Monmouth residents, data show that Monmouth County lacks sufficient affordable housing stock. The average percent of income spent on housing costs is an important measure of an area's availability of affordable housing. 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 Monmouth County, Deal (67.9%) and Long Branch (60.3%) had the greatest percentage of owner-

occupied residents spending more than 25% of their income on housing costs. Shrewsbury (83.6%) and Deal (78.7%) had the greatest percentage of renter-occupied household with residents spending more than 25% of their income on housing costs.

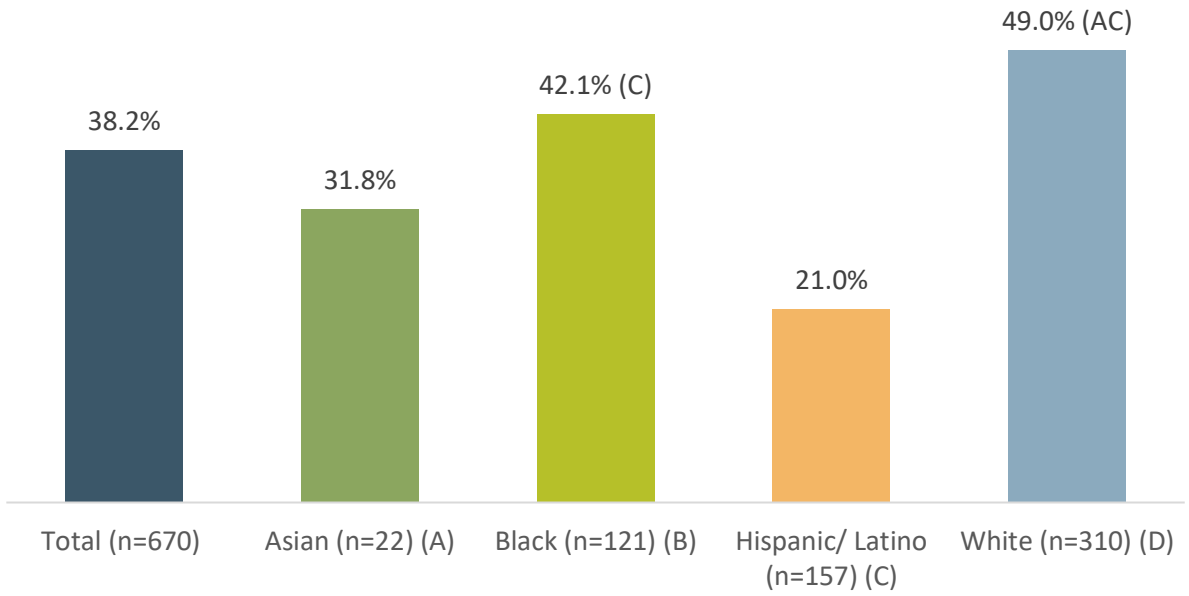
Table 6. Households whose Housing Costs are 25%+ of Household Income, by State, County, and Town, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	46.2%	62.2%
Monmouth County	44.2%	64.2%
Allenhurst	37.7%	60.7%
Asbury Park	36.5%	66.3%
Atlantic Highlands	46.8%	75.3%
Belford	31.1%	34.6%
Deal	67.9%	78.7%
Eatontown	52.5%	56.8%
Fair Haven	46.1%	64.8%
Fort Monmouth	0.0%	100.0%
Highlands	42.9%	67.3%
Leonardo	47.9%	37.0%
Lincroft	51.0%	70.3%
Little Silver	35.2%	32.5%
Long Branch	60.3%	64.1%
Middletown	42.2%	65.6%
Monmouth Beach	39.5%	73.1%
Navesink	34.0%	100.0%
Neptune	42.3%	65.9%
Oakhurst	54.7%	61.5%
Ocean Grove	43.8%	56.0%
Oceanport	48.3%	72.6%
Port Monmouth	51.2%	74.9%
Red Bank	45.4%	63.1%
Rumson	42.0%	37.4%
Shrewsbury	44.9%	83.6%
West Long Branch	50.9%	65.5%

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

Additionally, when survey respondents were asked to agree/disagree on statements about assets in their community, only 38.2% agreed completely or somewhat with the statement that there was enough affordable housing that was safe and well-kept in their community (Figure 16). Agreement with this statement was also generally lower among survey respondents from communities of color, particularly among Hispanic/Latino respondents (21.0%) and Asian respondents (31.8%).

Figure 16. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Statement "There is Enough Affordable Housing that is Safe and Well-Kept in My Community," by Race/Ethnicity (n=669), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Monmouth County, 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.

Transportation

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, or even access medical care and is therefore considered an important social determinant of health.

> *"There is public transportation but it just not very reliable. We also have a transit, but it is also just not reliable"*
> -Focus group participant

Transportation Barriers

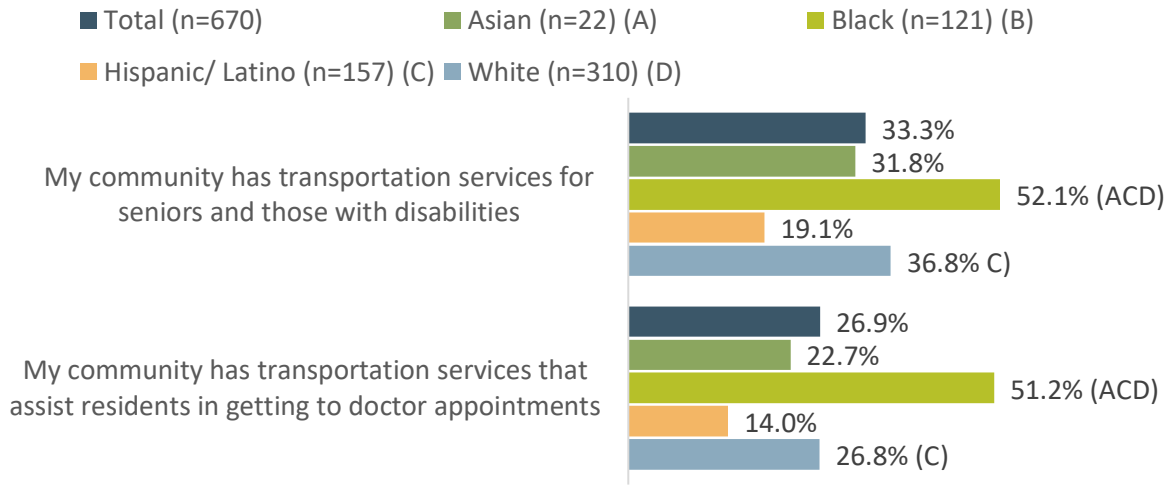
Focus group discussions and key informant interviews held with Monmouth County residents and leaders highlighted several barriers to transportation including rising fuel costs, having to depend on either friends or coworkers for a ride, and not having a reliable public transportation system. Additionally, most residents were also in agreement that transportation barriers were more likely to be experienced by those with limited financial means. As one focus group participant stated, *"In [Referencing their town] locally, you can't get anywhere without a car and gas is expensive. So, what if you don't even own a car? So, there are people who just can't afford to drive and so what happens to them? You need transportation!"* While another participant highlighted transportation as a barrier to access to medical care, stating that the *"Biggest barriers to addressing health issues include transportation to appointments."*

Perceptions of Transportation Infrastructure

Public transportation, including infrastructure and reliability, was a consistent theme across focus groups and interviews. Residents highlighted the lack of affordable and adequate transportation resources, particularly having a public transportation infrastructure that made it convenient for residents to visit friends or family, buy groceries, or make medical appointments. For example, one focus group participant observed, "*If you don't drive, it is extremely difficult because taxis and Uber are quite expensive too. I have a friend living in [another town] that would visit me but don't drive anymore, and NJ Transit [bus] routes are limited, and you never know when they will come. It also costs a lot of money to get to doctors' appointments or to get to go anywhere for entertainment."* Another participant highlighted limitations when using public transportation*, "The thing about the transportation, there are some services like Access Link and NJ Transit, but they have requirements about only 2 or 4 bags. So how do you shop [for groceries] for the week with only 2-3 bags? I can't be going back and forth; that is my only way to get what I need."*

Additionally, community surveys of Monmouth residents similarly highlighted what were considered to be limits of transportation infrastructure, especially among particular population groups. For example, as shown in Figure 17, one-third (33.3%) of survey respondents from the MMC service area agreed or completely agreed with the statement, "My community has transportation services available for seniors and those with disabilities." However, Latino respondents were less likely to agree with that statement compared to respondents in other racial and ethnic groups. Further, just over a quarter (26.9%) of survey respondents agreed/completely agreed that their community had transportation services to assist residents in getting to doctor appointments, which was much lower among Latino respondents (14.0%). Further, across both survey questions, just over half of Black respondents agreed with the transportation statements; these results were also comparatively higher than other racial and ethnic groups.

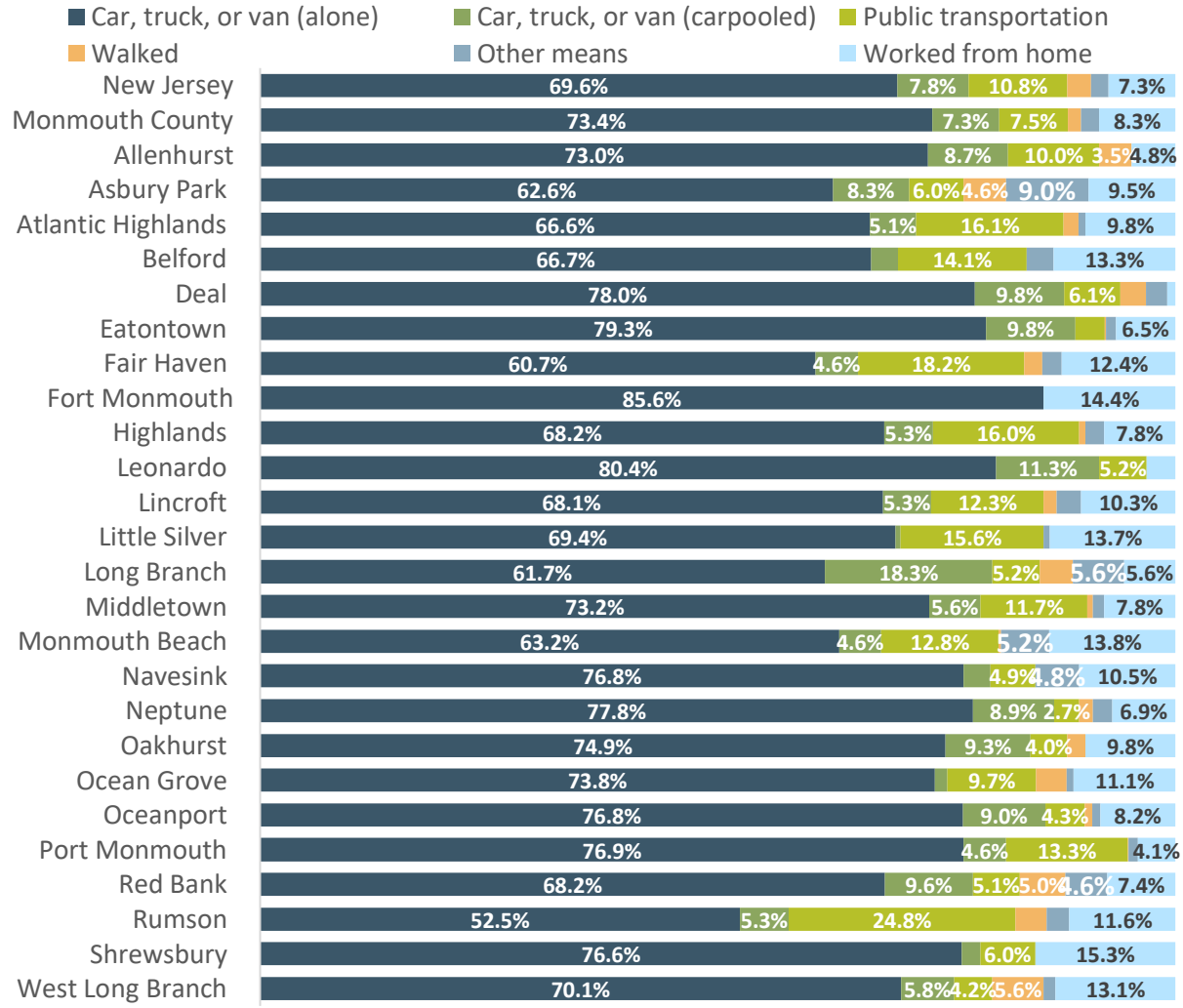
Figure 17. Percent of Community Survey Respondents Who Agreed/Completely Agreed with Transportation-Related Statements about Their Community, by Race/Ethnicity (n=670), 2021



DATA SOURCE: Community Health Needs Assessment Survey Data, Monmouth County, 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.

Secondary data support that the MMC service area is largely car dependent. U.S. Census data for 2016-2020, mainly collected prior to the COVID-19 pandemic, indicate that a higher percentage of residents aged 16+ commuted to work alone in a car, truck, or van in Monmouth County (73.4%), compared to New Jersey (69.6%) (Figure 18).

Figure 18. 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

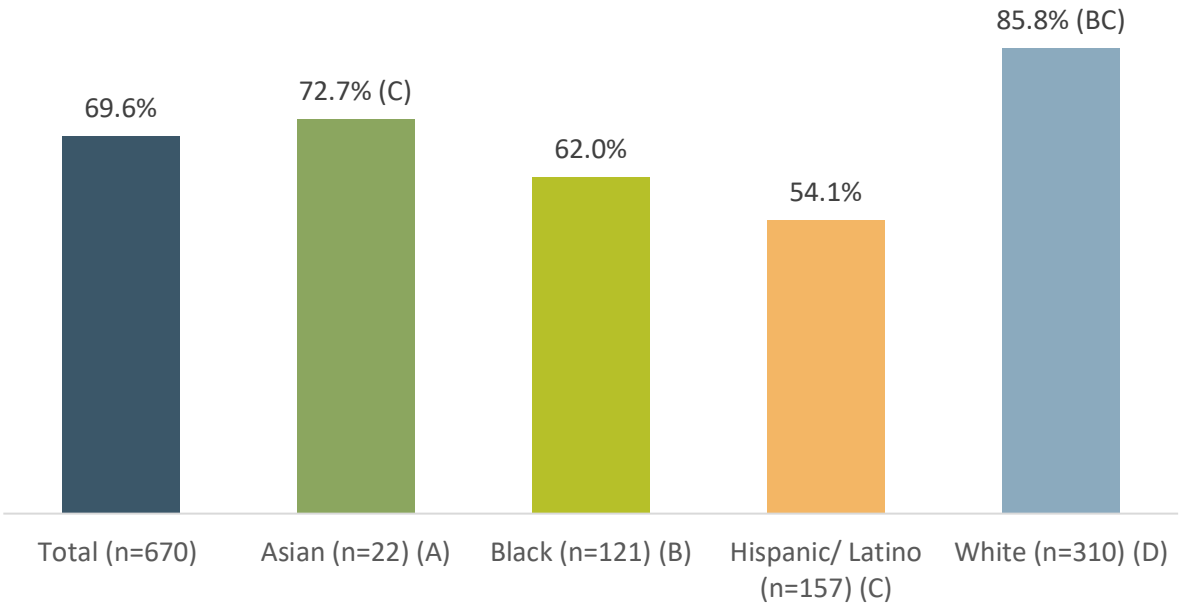
Green Space and Built Environment

Green space and the built environment influence the public's health, particularly in relation to chronic diseases. Urban environments and physical spaces can expose people to toxins or pollutants, affecting health conditions such as cancer, lead poisoning, and asthma. Physical space can also influence lifestyles. Playgrounds, green spaces, and trails as well as bike lanes and safe sidewalks and crosswalks all encourage physical activity and social interaction, which can positively affect physical and mental health. Residents highlighted Monmouth County's built environment and the amenities supporting walkability, access, and convenience. They identified the parks, recreational areas, and green spaces and

as one participant stated, *"Where I live, they have parks and recreation and a very positive support system especially for veterans."*

Community survey data from 2021 indicate that 69.6% of survey respondents from Monmouth County agreed or completely agreed with the statement, "My community has safe outdoor places to walk and play." Figure 19 presents data for the overall sample and by race/ethnicity. White respondents were more likely to agree with this statement than Black or Hispanic/Latino respondents.

Figure 19. 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=163), 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.

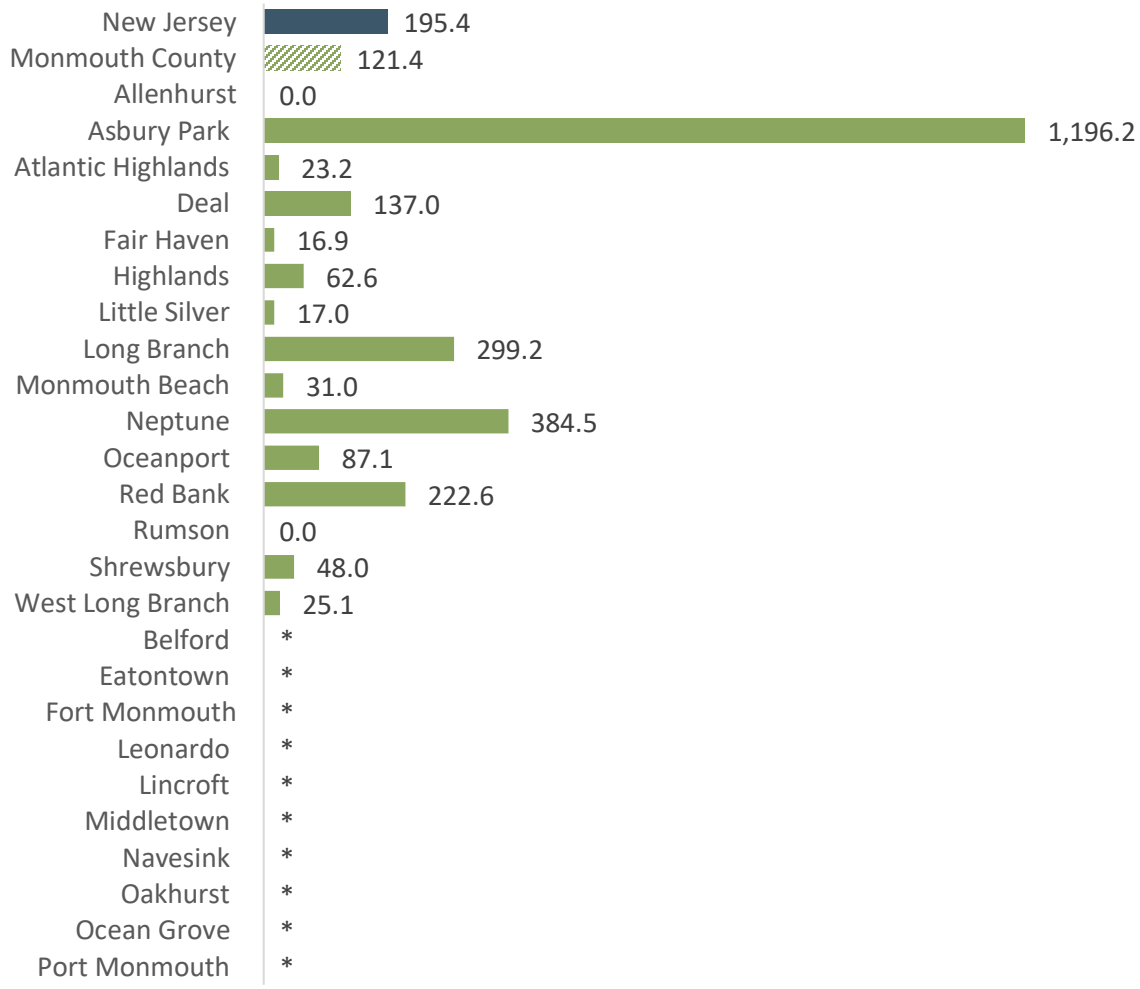
Crime and Violence

Crime and violence and the corresponding trauma that such acts can have on communities are important public health issues. Criminal and violent acts can often affect individuals' physical and mental health resulting in fear, anxiety, and depression. Additionally, people can be exposed to violence in many ways. For example, they may be victims who suffer from premature death or injuries and witness or hear about crime and violence in their community. While the issue of crime and violence were not major themes, a few participants mentioned the issue of domestic and family violence that they felt grew worse during the pandemic. As one participant explained*, "I know that families are going through a lot, and you see pressure and anger that can build, and so they begin to [physically] hurt those closest to them."*

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 in Monmouth County (Figure 20). At 1,196.2 incidents per 100,000 residents, Asbury Park had a rate over six times as high as

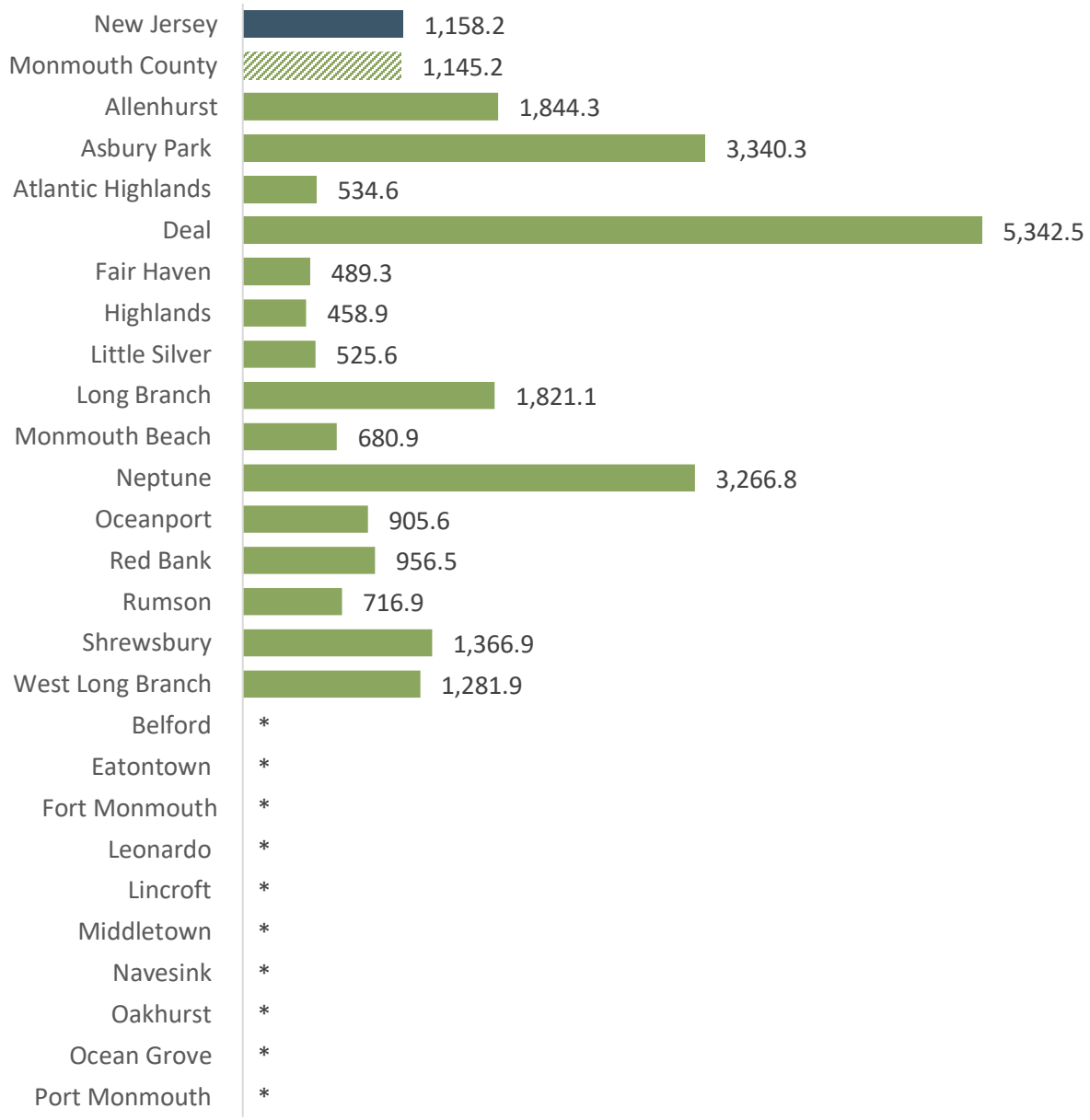
the state rate (195.4 per 100,000 residents). Other towns in the primary service area had violent crime rates lower than the state rate. Allenhurst and Rumson had the lowest rate, 0.0 per 100,000 residents. Property crime (i.e., burglary, larceny, and auto theft) is much more common than violent crime. Among towns in Monmouth County, property crime was most common in Deal (5,342.5 per 100,000 residents), Asbury Park (3,340.3 per 100,000 residents), and Neptune (3,266.8 per 100,000 residents) and least frequent in Fair Haven (489.3 per 100,000 residents) and Highlands (458.9 per 100,000 residents) (Figure 21).

Figure 20. 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.

Figure 21. 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: * Data not available for town. Property crime includes burglary, larceny, and auto theft.

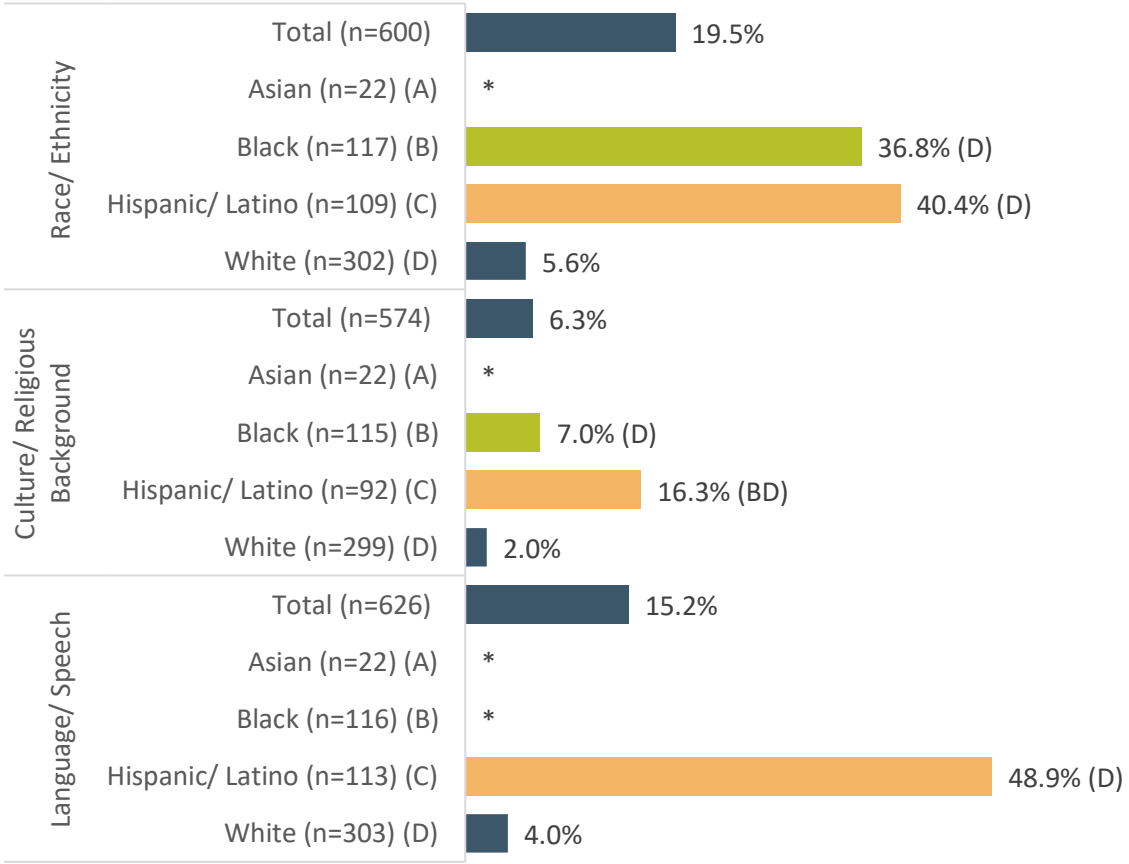
Systemic Racism and Discrimination

The issues related to systemic racism, racial injustice, and discrimination were discussed in several focus group and interview conversations. In this context, participants raised concerns regarding the exclusion or marginalization of communities based on sexual orientation, immigration status, language, and income. As one interviewee observed, *"Racial injustice has been an issue for our community; you have your "sides of the tracks," and the other has theirs. The biggest concern is the "cha-ching" [a reference to the sound of money being made] as this place is becoming more of a tourist area and so no more room*

for low-income housing… you know some people are made to feel they don't belong in a certain community – it is huge here." Amid such concerns, residents shared sentiment about finding ways to be inclusive of others and help address racism and discrimination in the community. As one resident explained, *"You know, it is just time to appreciate each other more. The diversity of our communities, whether it is veterans, LGBT, undocumented people, or people living with disabilities, you know, because we have a huge, diverse population of vulnerable populations and vulnerable people. So, I would love to see that."* Similarly, another resident shared, *"Honestly; they need to [be] proactive, because of the racial and LGBTQ stuff, all of that impacts our lives when it is so pervasive and not just in this community. The conversations and work need to continue."*

Data from the 2021 community survey provide additional insight into experiences of discrimination when receiving medical care. More than one third of Black (36.8%) and Hispanic (40.4%) survey respondents reported experiencing discrimination due to their race/ethnicity when receiving medical care compared to 19.5% of respondents overall (Figure 22). Nearly 20% of Hispanic survey respondents also reported feeling discriminated against when receiving medical care based on their culture and religious background (16.3%), and nearly half reported feeling discriminated against due to their language/speech (48.9%).

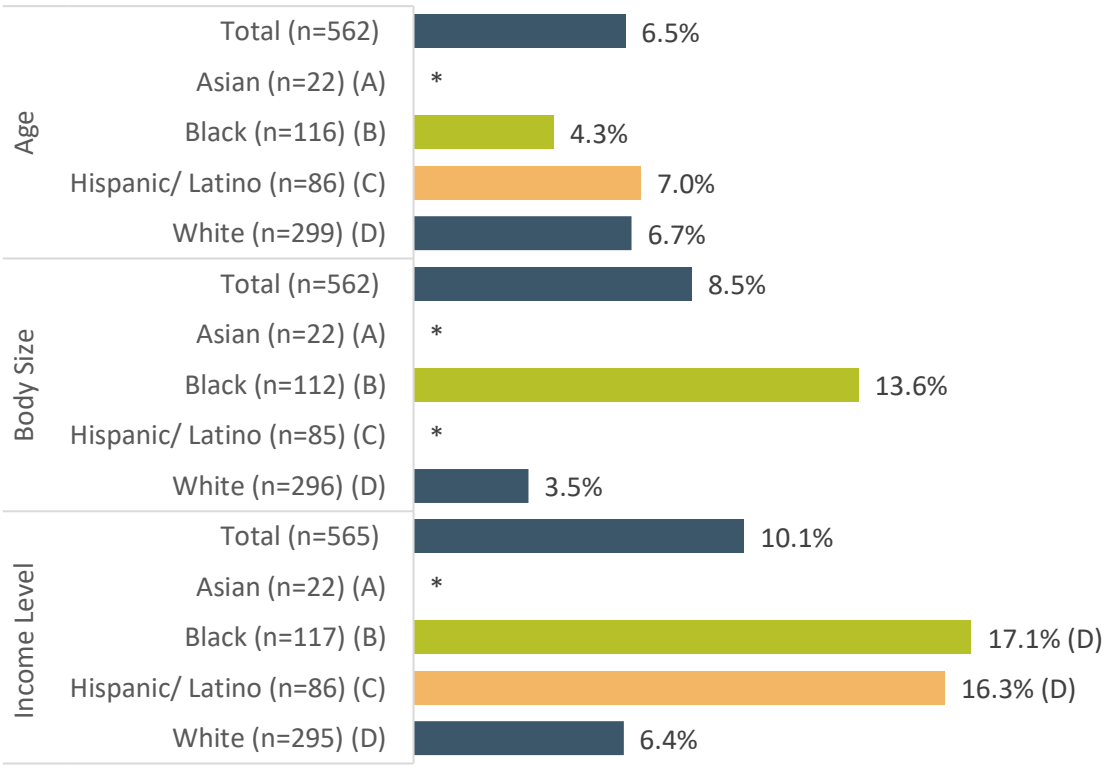
Figure 22. Percent of Community Survey Respondents Indicating Whether They Have Felt Discriminated Against When Receiving Medical Care, by Type of Characteristic and By Race/Ethnicity (n=626), 2021



In addition, about 3.6% of survey respondents indicated that they had felt discriminated against when receiving medical services because of their gender/gender identity and 3.1% reported this relative to their sexual orientation.

Around 7% of all respondents reported discrimination based on age (6.5%) and 10.1% reported discrimination based on income. Predominately Hispanic/ Latino and White respondents reported discrimination based on age, Black respondents based on body size, and Black and Hispanic/Latino respondents based on income (Figure 23).

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 (n=565), 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.

Community Health Issues

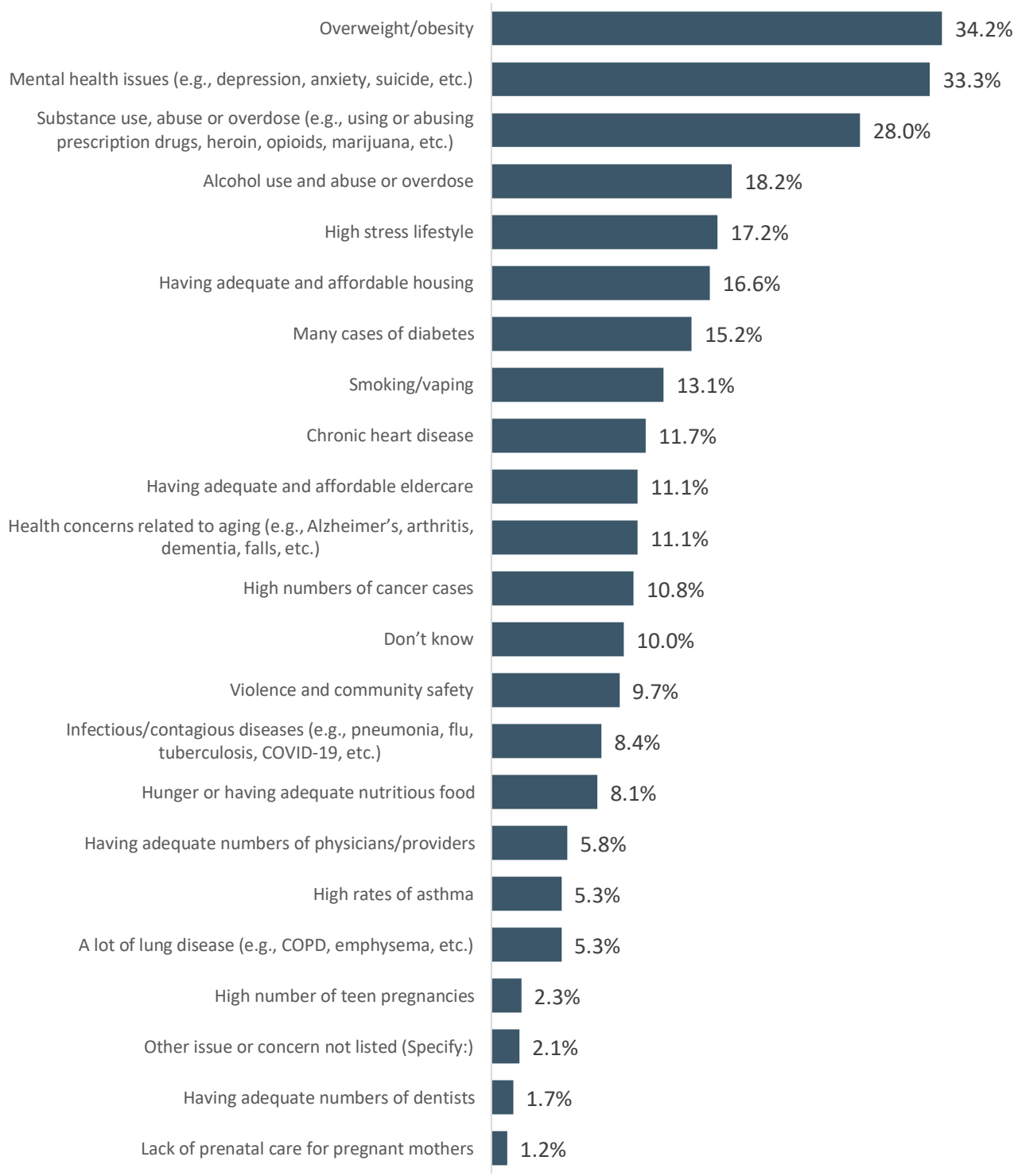
Understanding community health issues is a critical step in the CHNA process. The disparities seen in these issues mirror the historical patterns of structural, economic, and racial inequities experienced for generations across the United States.

Community Perceptions of Health

Understanding residents' perceptions of health can provide insights into health concerns, facilitators, and barriers to addressing health conditions. Community survey respondents and focus group and interview participants were asked to give their perspective on the biggest issues facing their community. Many discussed root cause issues such as financial insecurity and unemployment as issues overall. Specifically related to health, participants identified obesity and chronic disease, particularly diabetes and hypertension, as well as mental health and substance abuse as critically important, especially since they affected young and middle-aged adults. For example, one interviewee observed, *"So in terms of suicides, we seen a steady increase in middle age and elderly males that are just taking their own life through various means."* While another interviewee shared, *"At least that last two [community health] needs assessments, mental health has come up to the top of the list."* Residents also relayed how these challenges can influence health behaviors and conditions such as healthy eating, physical activity, and chronic diseases. They also discussed the challenges of accessing care and the increase in mental health needs in the community, especially among youth, seniors, and economically vulnerable residents.

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 overweight/obesity (34.2%), followed by mental health issues (33.3%), substance use, abuse, or overdose (28.0%), alcohol use and abuse, or overdose (18.2%), and a high stress lifestyle (17.2%) as the top five health issues in their communities (Figure 24). Similarly, in the 2019 CHNA, community survey respondents identified obesity (44%), substance use/abuse (43%), and mental health (34%) their top health issues or concerns.

Figure 24. Percent of Community Survey Respondents Reporting the Top Three Health Issues or Concerns in Their Community



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

There were differences in top health issues in the 2021 survey by race/ethnicity (Figure 25). Overweight/obesity was the top concern among Asian, Black, and White survey respondents, followed by mental health issues for Asian and White respondents, and having adequate and affordable housing for Black respondents. Hispanic/Latino respondents stated mental health issues as their top concern, followed by overweight/obesity. Substance use, abuse, or overdose was ranked third for Black, Hispanic/Latino and White respondents. Please note, these findings by race/ethnicity should be interpreted with caution. Given the small sub-sample sizes rankings may not be generalizable to the broader population.

Figure 25. Percent of Community Survey Respondents Reporting the Top Health Issues or Concerns in Their Community, by Race/Ethnicity

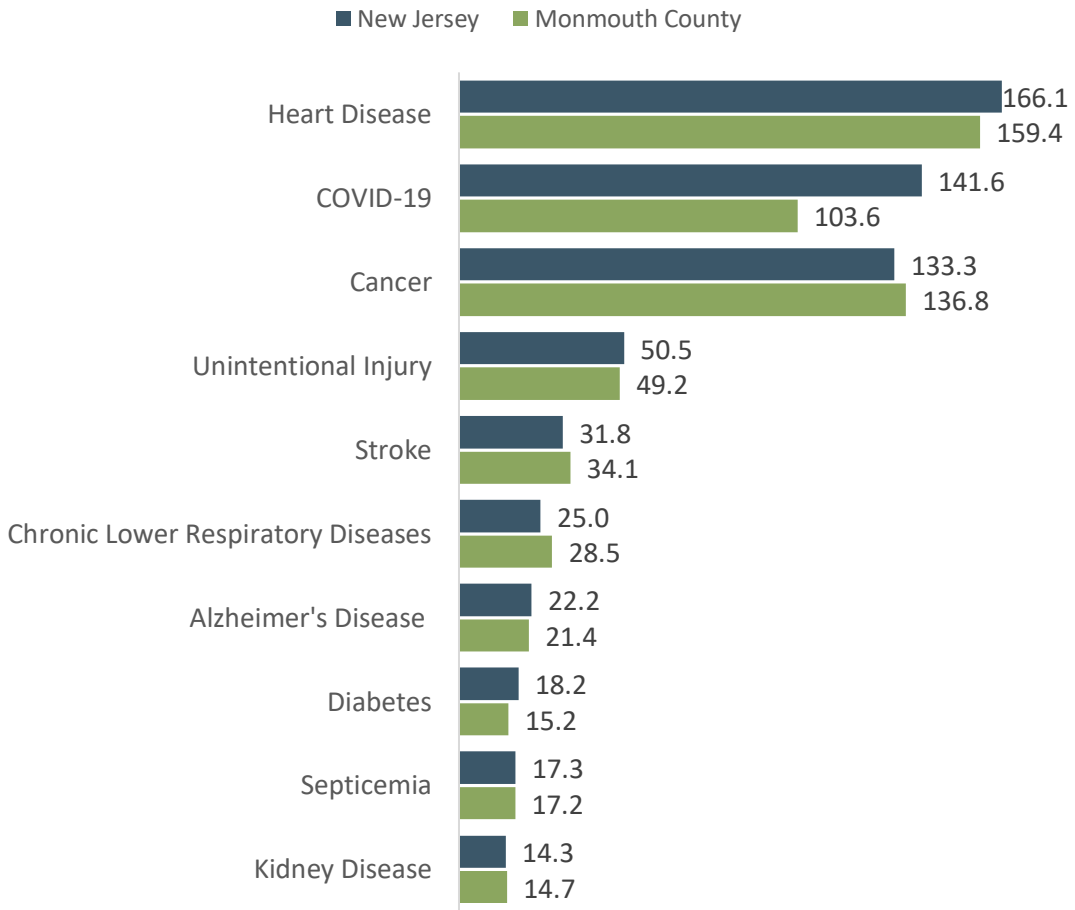
	Asian (n=22) (A)	Black (n=118) (B)	Hispanic/ Latino (n=154) (C)	White (n=307) (D)
1	Overweight/ obesity (45.5%)	Overweight/ obesity (36.4%)	Mental health issues (34.4%) (B)	Overweight/ obesity (36.2%)
2	Mental health issues (31.8%)	Having adequate and affordable housing (35.6%) (ACD)	Overweight/ obesity (33.8%)*	Mental health issues (35.8%) (B)
3	Chronic heart disease (22.7%)*	Substance use, abuse or overdose (27.1%) (A)	Substance use, abuse or overdose (33.8%) (A)*	Substance use, abuse or overdose (26.7%) (A)
4	Health concerns related to aging (22.7%) (C)*	Smoking/vaping (22.9%) (ACD)	Alcohol use and abuse or overdose (29.9%) (ABD)	High stress lifestyle (20.5%) (C)
5		Mental health issues (22.0%)	Many cases of diabetes (22.1%) (D)	Having adequate and affordable housing (13.4%) (C)

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 2020, age-adjusted mortality rates per 100,000 residents for different diseases for the state of New Jersey and Monmouth County. Heart disease, COVID-19, and cancer are the top three causes of death for the state and Monmouth County.

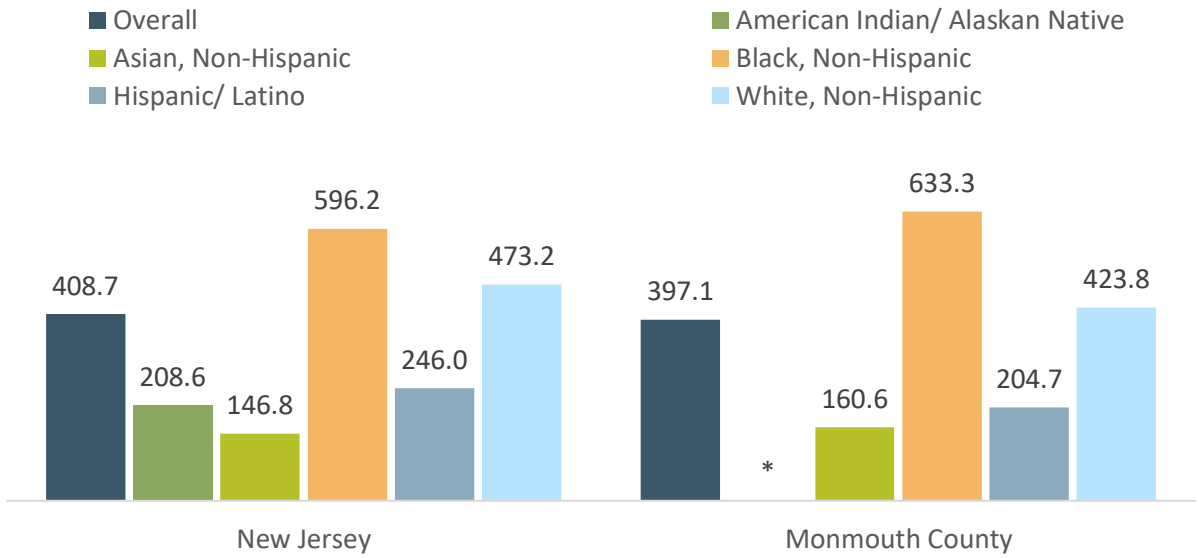
Figure 26. Top 10 Age Adjusted Mortality Rates per 100,000, by State and County, 2020



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), 2019

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 Monmouth County (397.1 per 100,000) was slightly lower than for the state (408.7). Data about premature mortality in 2018-2020 across different racial and ethnic groups show that non-Hispanic Black residents in Monmouth County experience higher rates of premature mortality than other groups across the county and the state; in many cases, these rates are at least twice as high than for other groups.

Figure 27. Premature Mortality (Deaths Before Age 75) Rate per 100,000 population, by State and County, 2018-2020



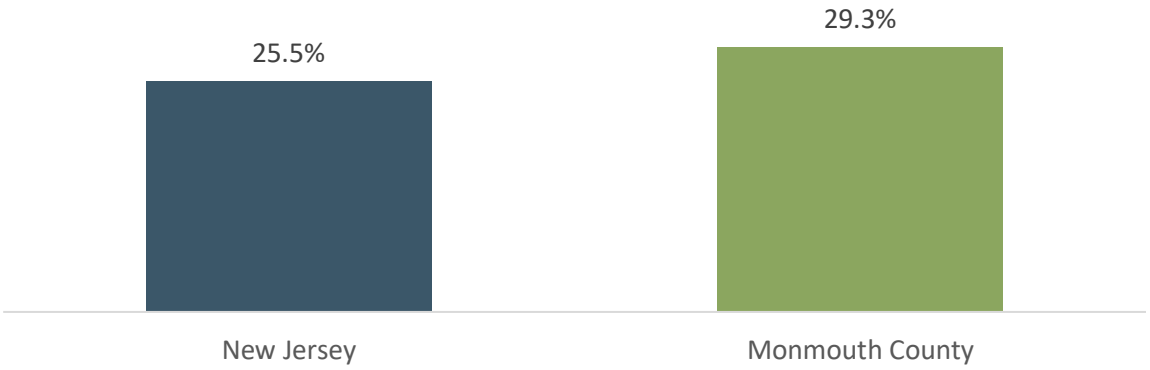
DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health as reported New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2019
NOTE: Asterisks (*) denote insufficient data to calculate 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.

Overweight and Obesity
Obesity is the second leading cause of preventable death in the United States and increases the likelihood of chronic conditions among adults and children. As discussed earlier in the Perceptions of Community Health section, in community surveys, obesity was identified as a top health concern by Monmouth residents. Overweight/obesity was identified as the top health concern by community survey respondents and was also the top concern identified in the 2019 CHNA report. Additionally, among focus groups and interviews, the issue of obesity was often interwoven into discussions regarding what participants felt were challenges with access to healthy food and food instability, and limited options for residents to participate in sports and social activities. Some participants attributed the COVID-19 pandemic to an increasingly sedentary lifestyle. One participant explained, *"I think you see more people of all ages that have gained weight; [we] were told not to go out but stay home. So, people stayed home and stopped going to the gym or parks.*" (See sections related to Food Access and the Built Environment for survey and surveillance data.)

The latest surveillance data on overweight/obesity are from 2018 and come from self-reported data about height and weight. Based on this self-report, nearly 30% of Monmouth County adults were considered obese, compared to 25.5% across the state (Figure 28).

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

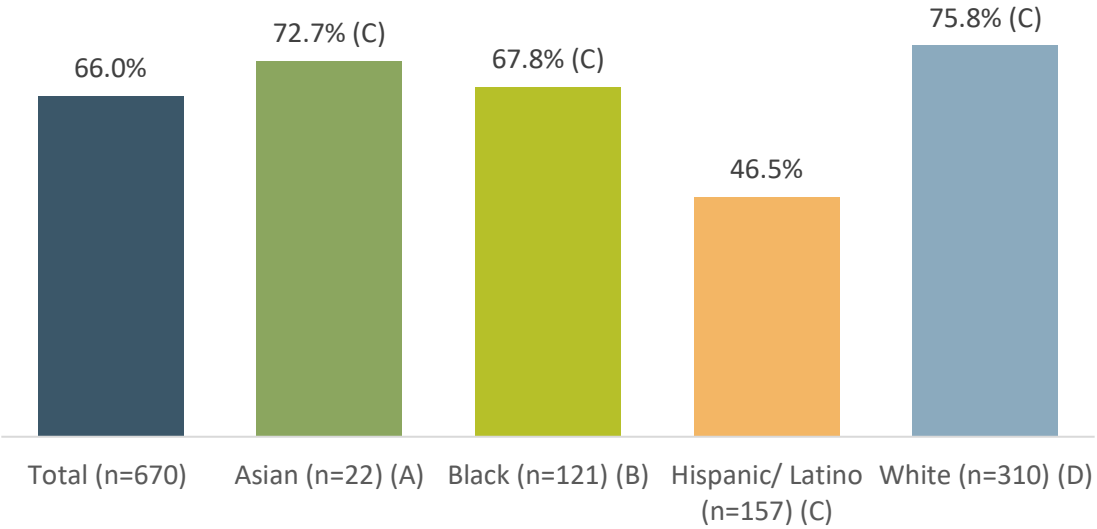


DATA SOURCE: Centers for Disease Control and Prevention (CDC), U.S. Diabetes Surveillance System, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2018

Physical Activity

Community survey respondents from Monmouth County were asked whether they were physically active. Among these respondents, 66.0% indicated that they were physically active. Figure 29 shows the overall percentage of respondents reporting they were physically active, as well as results disaggregated by race/ethnicity. White respondents had the highest percentage (75.8%) and Hispanic/Latino respondents had the lowest percentage (46.5%) indicating that they felt that they were physically active. Similar trends were seen in the 2019 CHNA, with 69% of community survey respondents saying they were physically active.

Figure 29. Percent of Community Survey Respondents Indicating that They Felt That They are Physically Active

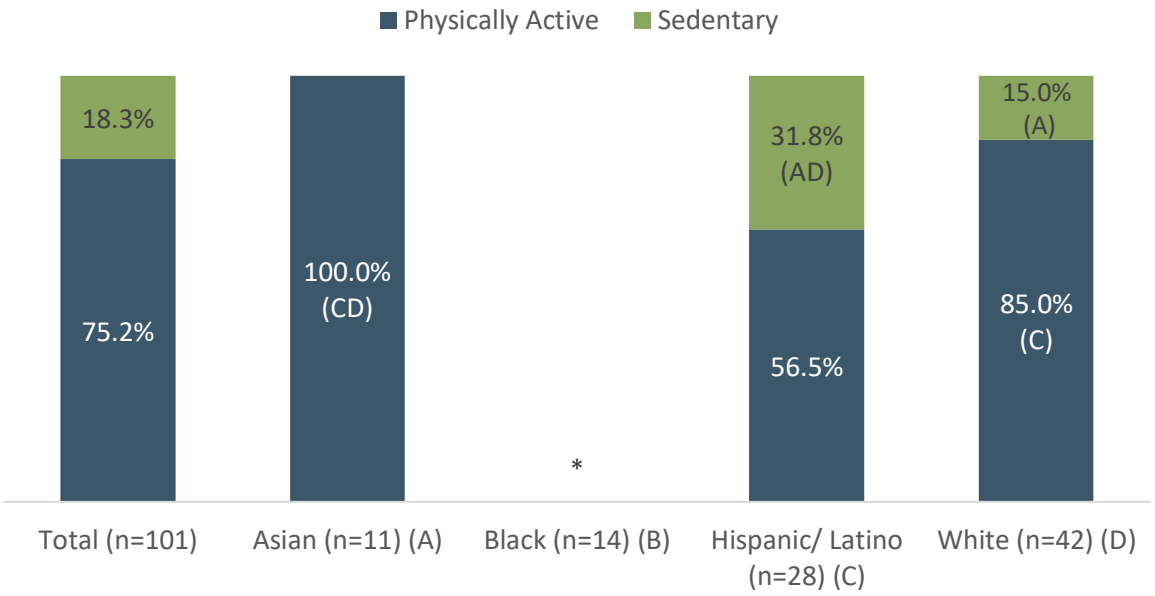


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Community survey respondents who were parents or guardians were asked whether they would describe their children as physically active or sedentary after school or on weekends. About 75% of the

101 parent survey respondents described their children as physically active during these times (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

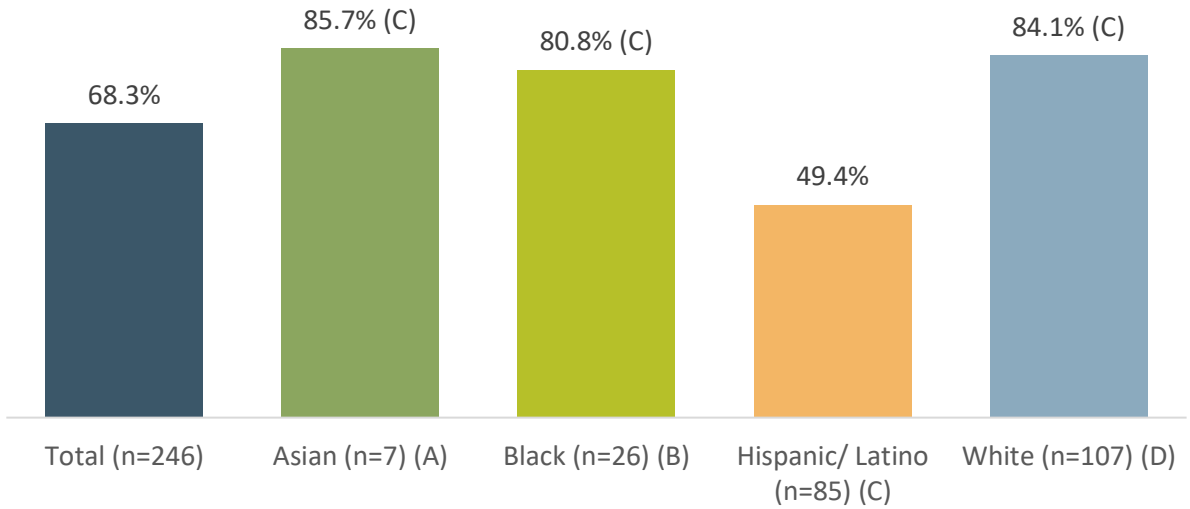


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph. * indicates n<5 in either physically active or sedentary responses.

Healthy Eating

Survey respondents who were parents or guardians were also asked whether their children eat breakfast on a daily basis. About 70% of the 246 parent survey respondents indicated that their children regularly ate breakfast (Figure 31). This was highest among Asian respondents (85.7%) and lowest among Hispanic/Latino respondents (49.4%).

Figure 31. Percent of Community Survey Respondents who are Parents or Guardians Reporting Whether Children Eat Breakfast Daily (n=246), 2021



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

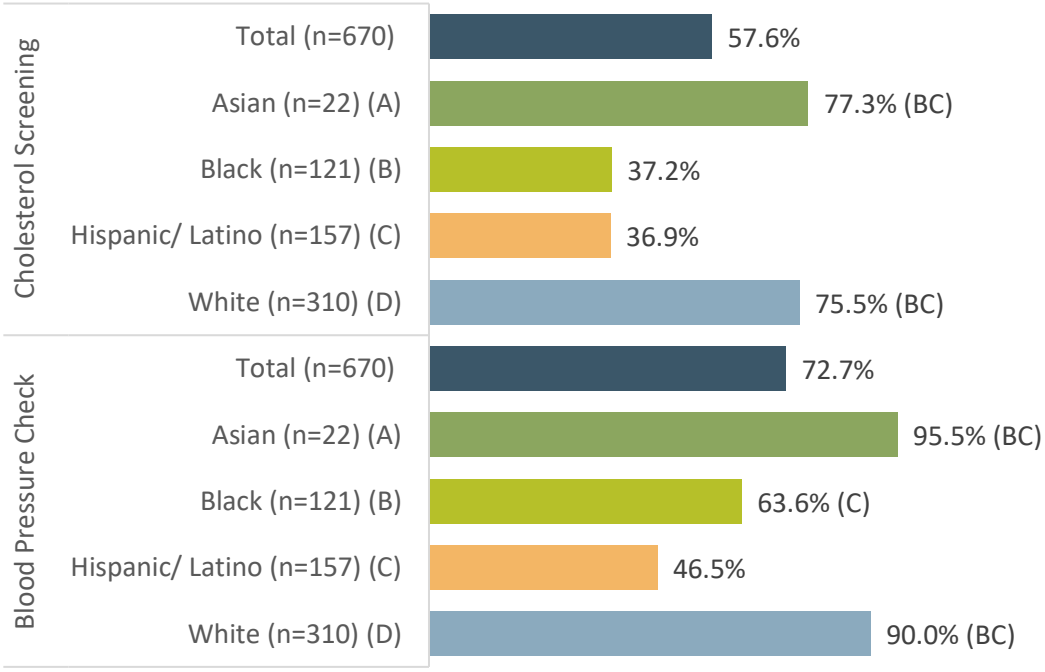
Chronic Conditions

Chronic conditions, such as heart disease, diabetes, COPD, and cancer, are some of the most prevalent in the United States, including in Monmouth County. In focus groups and interviews, chronic conditions were identified as some of the most pressing concerns. For example, one focus group participant in describing the population they work with remarked, *"Chronic disease management is huge, we see diabetic and hypertensive patients and hyperlipidemia. So, we have an enormous problem that we're seeing, which has only increased."* Similarly, one interview explained, *In the population we see, it is about 35 percent Hispanic, and 16 percent Africa-American, and chronic conditions impact our populations."* Further, while chronic diseases are among the most common and costly health problems, they are also among the most preventable through changes in behavior, such as reduced use of tobacco and alcohol and improved diet and physical activity. The following section describes the health data (e.g., screening, incidence, mortality, etc.) related to chronic conditions.

High Cholesterol and High Blood Pressure

Community survey respondents in spring/summer 2021 were asked about their participation in different types of health screenings over the past two years. Nearly three-fifths (57.6%) indicated that they had participated in a cholesterol screening and almost three-fourths participated in a blood pressure screening. Figure 32 shows overall screening participation rates, as well as rates disaggregated by race/ethnicity. A higher proportion of Asian and White respondents said that they participated in cholesterol screening and blood pressure checks than Black and Hispanic/ Latino respondents.

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=670), 2021

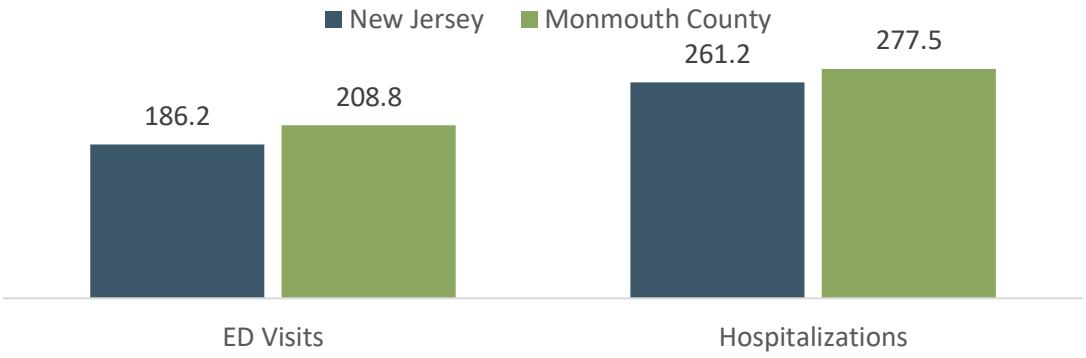


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

Heart Disease

Data from the NJ Department of Health indicate that in 2016-2020, the rate of emergency department (ED) visits (208.8 per 10,000 population) and hospitalizations (277.5 per 10,000 population) for major cardiovascular disease was higher in Monmouth County compared to NJ overall (186.2 per 10,000 and 261.2 per 10,000, respectively) (Figure 33).

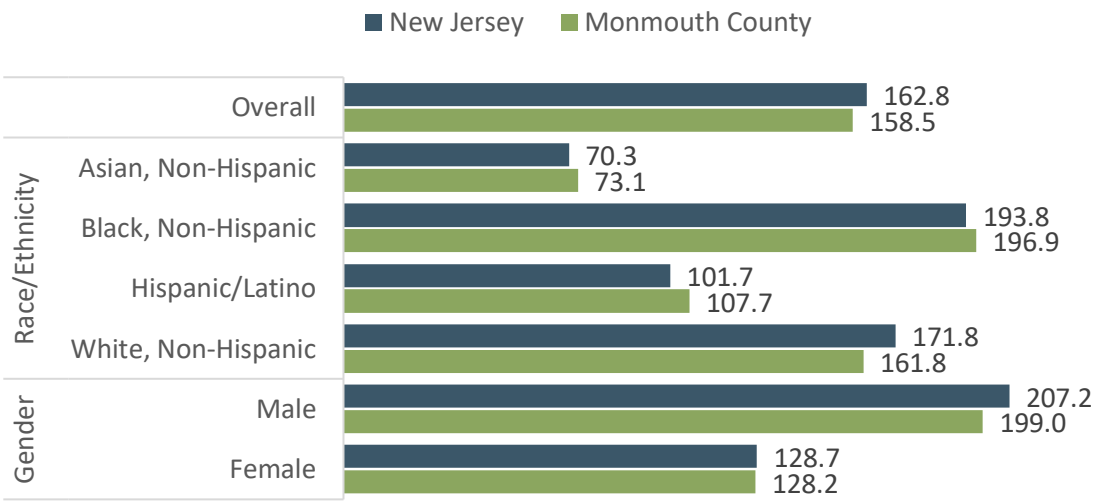
Figure 33. ED Visits and Hospitalizations for Major Cardiovascular Disease per 10,000 Population, by State and County, 2016-2020



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 for cardiovascular disease mortality per 100,000 shows that in 2016-2020 the overall mortality rate was similar between Monmouth County (158.5 per 100,000) and the state (162.8 per 100,000) (Figure 34). Across the state and Monmouth County, cardiovascular disease mortality rates were highest among non-Hispanic Black and non-Hispanic White residents. The rates were also higher among males across these geographies when compared to females.

Figure 34. Cardiovascular Disease Mortality per 100,000, by Race/Ethnicity and by Sex, by State and County, 2016-2020

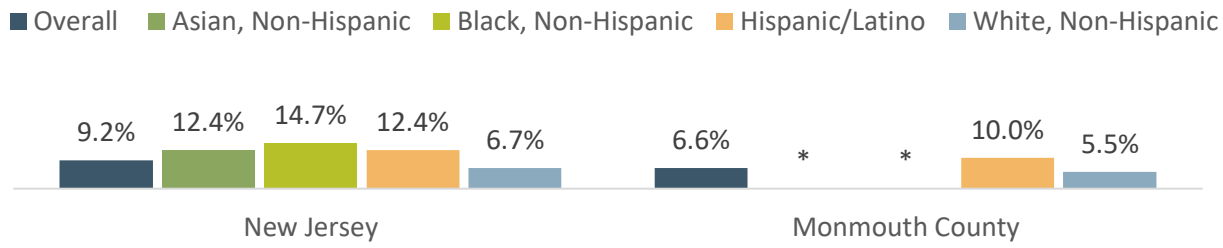


DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Diabetes

Figure 35 shows the percent of adults who reported a diagnosis of diabetes overall and by race/ethnicity from 2016-2020, the most recent years that surveillance data are available. Diabetes rates overall were lower in Monmouth County (6.6%) than statewide (9.2%). Diabetes rates were highest among non-Hispanic Black residents statewide (insufficient data were available for some racial/ethnic categories in Monmouth County). Community survey respondents identified diabetes as their seventh top health concern overall.

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



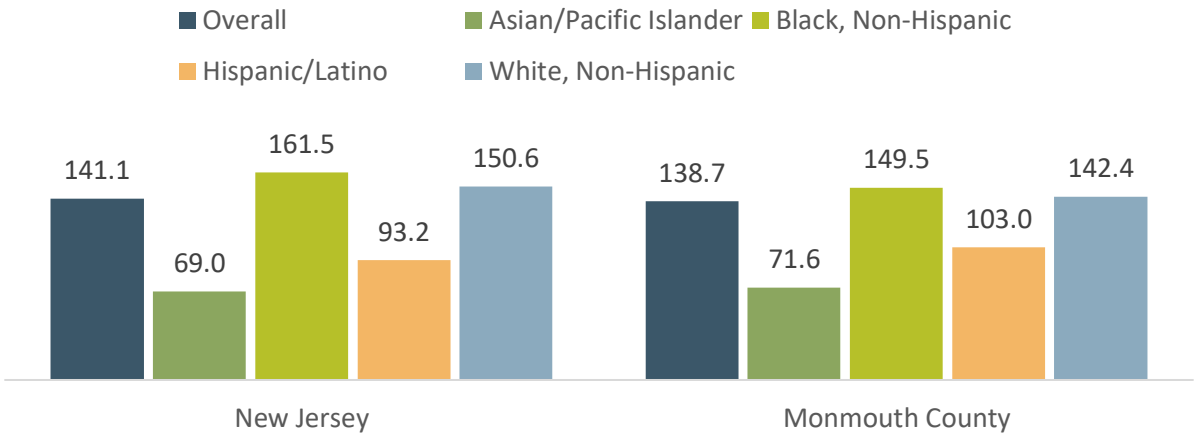
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Cancer

Despite being the second leading cause of death in Monmouth County, cancer was not a prominent theme discussed in interviews and focus groups. It was also not rated highly as a top health concern among community survey respondents. However, several veteran focus group participants expressed concern about the health effects of exposure to toxic substances and environments such as Agent Orange and burn pits during their military services. As one veteran participant stated, *"We will see certain conditions for those who work who served in the Middle East and ranging from Emphysema to multiple types of cancers."* This comment was followed by another participant who explained, "[Nodding in agreement] *There are significant medical conditions that are as a result of our veterans being exposed to Agent Orange, and so it has had an impact, and in the coming years, we are about to see similar health issues occur among the post 9/11 and Gulf War veterans. Unfortunately, these health issues we see often take decades to develop, and when you do, it will hit us, and another wave is coming."*

Death certificate data for cancer mortality rates per 100,000 in 2016-2020 show that overall cancer rates in Monmouth County are slightly lower than for the state (Figure 36), even though it is still the second leading cause of death in the county. Across the state and Monmouth County, non-Hispanic Black and non-Hispanic White residents experienced higher cancer. Appendix H contains additional cancer data including incidence and mortality data and five-year trends for all cancers across New Jersey and Monmouth County, including patient origin data for MMC's outpatient and inpatient cancer treatment population.

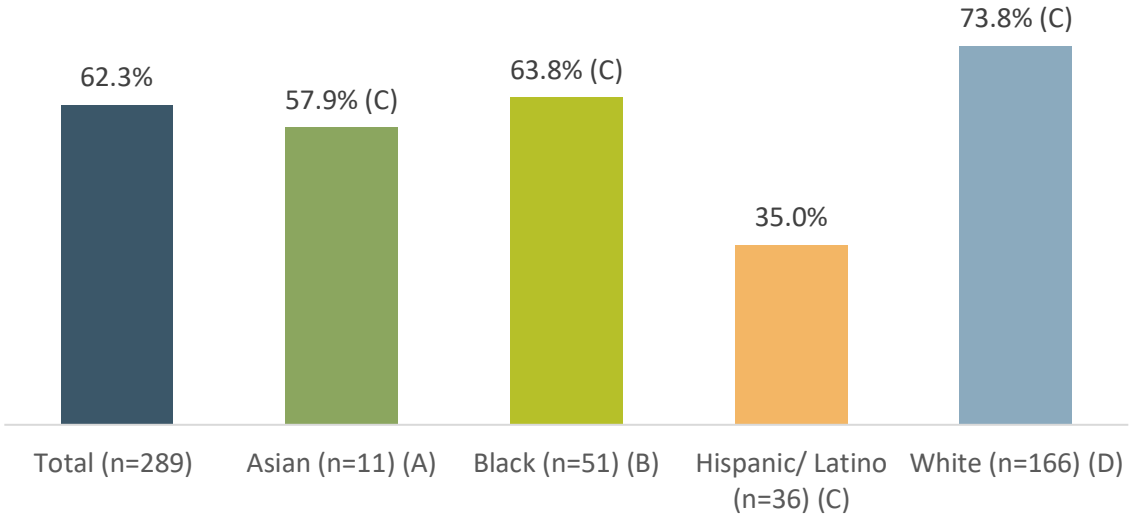
Figure 36. Cancer Mortality Rate per 100,000 population (Overall, Combined for Female Breast, Colorectal, Lung and Bronchus, Male Prostate), by State and County, 2016-2020



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

Over three-fifths (62.3%) of community survey respondents indicated that they had participated in a mammogram screening in the past two years. Figure 37 shows overall screening participation rates, as well as rates disaggregated by race/ethnicity. Please note, results by race/ethnicity should be interpreted with caution given the small sub-sample sizes.

Figure 37. Percent of Community Survey Respondents Reporting that They Have Participated in a Mammogram Screening in the Past Two Years (n=289), 2021

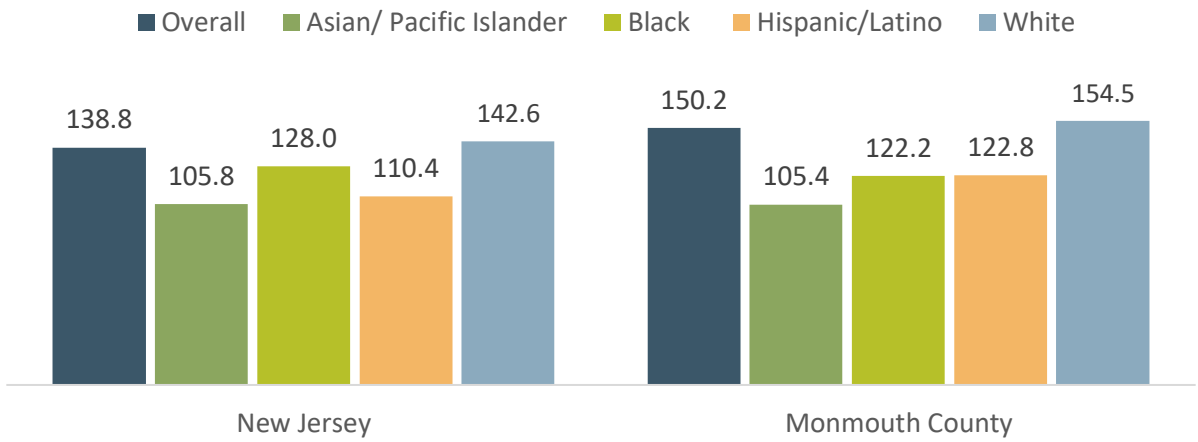


DATA SOURCE: Community Health Needs Assessment Survey Data, Bruno & Ridgway, 2021
NOTE: Statistical significance shown at 90% confidence levels. Racial/ethnic differences between groups noted by lettering next to the bars in the graph.

In 2015-2019, the age-adjusted incidence rate of female breast cancer per 100,000 population was higher in Monmouth County (150.2) than the state rate (138.8) (Figure 38). The rate of breast cancer incidence among residents who identified as White was higher than the overall rate in New Jersey and

Monmouth County. The rates of breast cancer incidence among Asian/Pacific Islander and Black residents, and residents who identified as Hispanic/Latino were lower than the overall rates statewide, and in Monmouth County. 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.

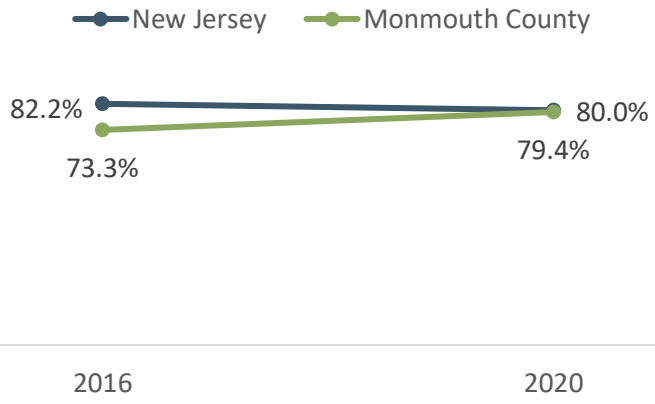
Figure 38. Age-Adjusted Female Breast Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



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.

Data about pap test screening among females ages 21-65 overall shows that rates have declined between 2016 and 2020 in the state, though the rates increased in Monmouth County (Figure 39).

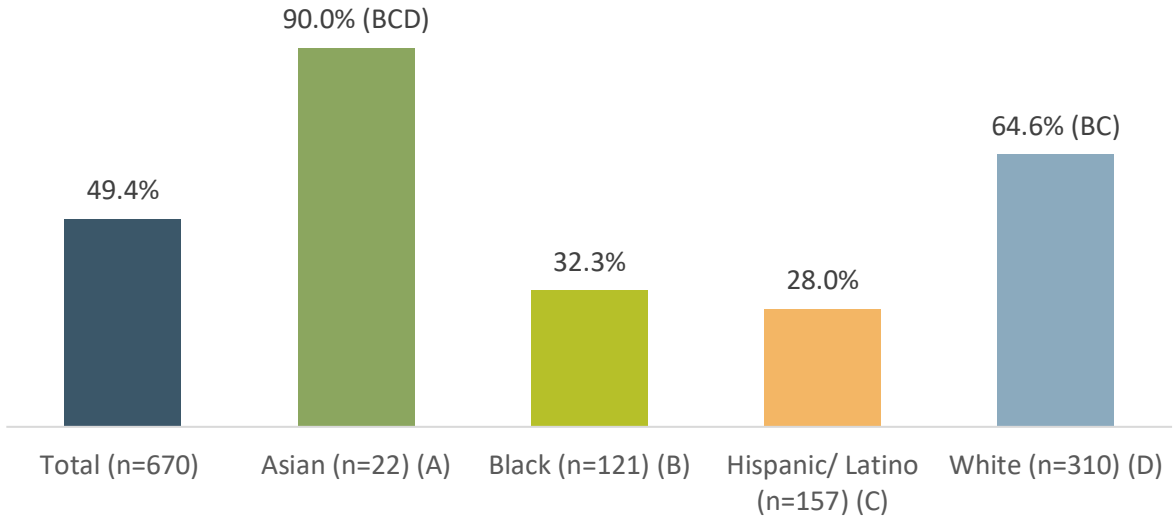
Figure 39. Percent Females Aged 21-65 Reported to Have Had a Pap Test in Past Three Years, by State and County, 2016 and 2020



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

Almost half (49.4%) of community survey respondents indicated that they had participated in a colon cancer screening in the past two years, though this appears to vary by race/ethnicity. Figure 40 shows overall screening participation rates, as well as rates disaggregated by race/ethnicity.

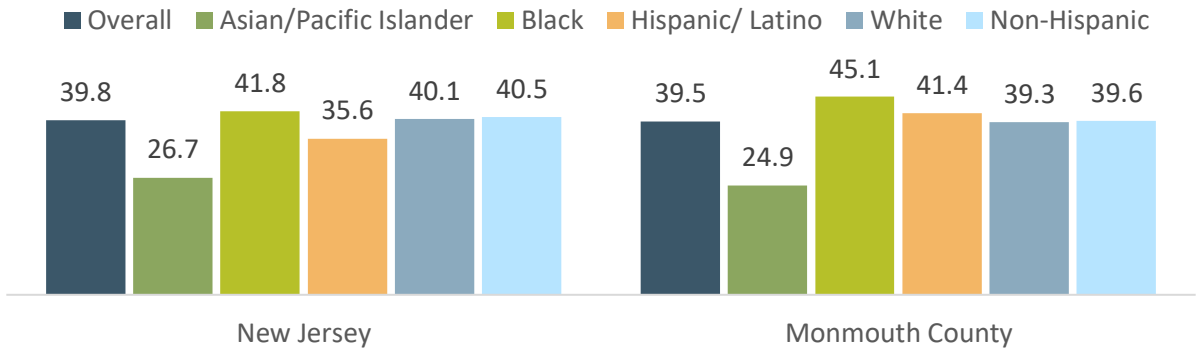
Figure 40. Percent of Community Survey Respondents Reporting that They Have Participated in a Colon Cancer Screening in the Past Two Years (n=670), 2021



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.

Cancer registry data from 2015-2019 show that the age-adjusted incidence rate of colorectal cancer is similar across New Jersey and Monmouth County, about 40 per 100,000 population (Figure 41). Incidence rates among Asian/Pacific Islander residents were lower than the overall incidence rate in the state and in Monmouth County. Incidence rates among Black and White residents were higher than the overall rate in New Jersey and Monmouth County. Incidence rates among Hispanic/Latino residents are lower in the state than overall in the state, and higher in Monmouth County than overall in Monmouth County. 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.

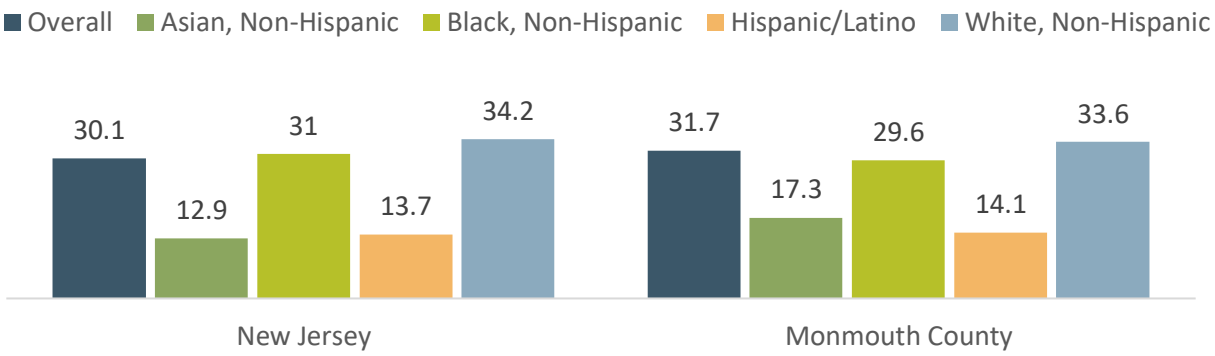
Figure 41. Age-Adjusted Colorectal Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



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.

Death certificate data about lung cancer mortality per 100,000 in 2016-2020 show that overall lung cancer death rates were similar in Monmouth County and in the state (Figure 42). Rates were higher among White and Black residents across the MMC service area and the state than among Asian and Hispanic residents.

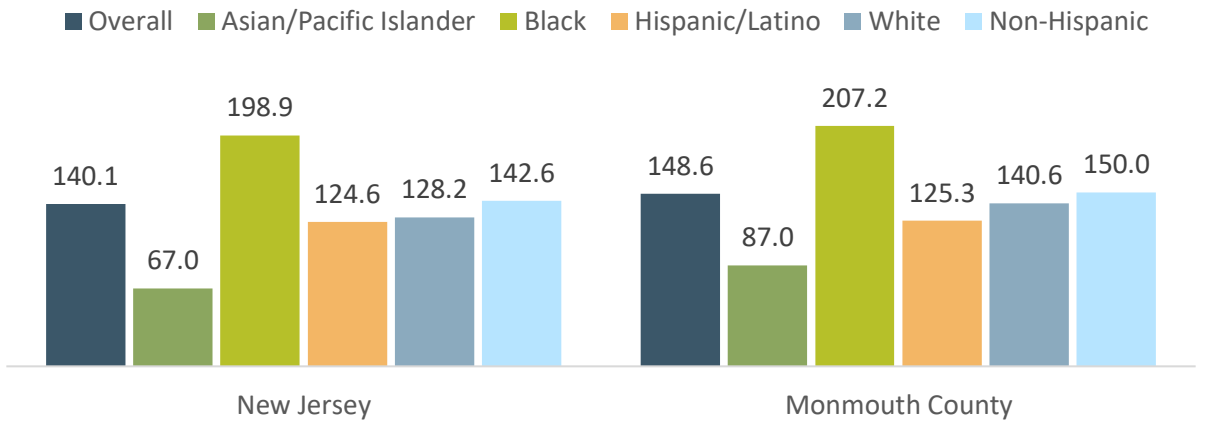
Figure 42. Lung Cancer Mortality Rate per 100,000 Population, by Race/Ethnicity, State, and County, 2016-2020



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

The age-adjusted incidence rate of prostate cancer in 2015-2019 was higher in Monmouth County (148.6) than the state (140.1) (Figure 43). Across the state and in Monmouth County, the age-adjusted incidence rate for prostate cancer was highest among Black residents, and lower among White residents, Asian/Pacific Islander residents, and residents who identified as Hispanic/Latino compared with the overall rate for the population as a whole. 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 43. Age-Adjusted Prostate Cancer Incidence Rate per 100,000 Population

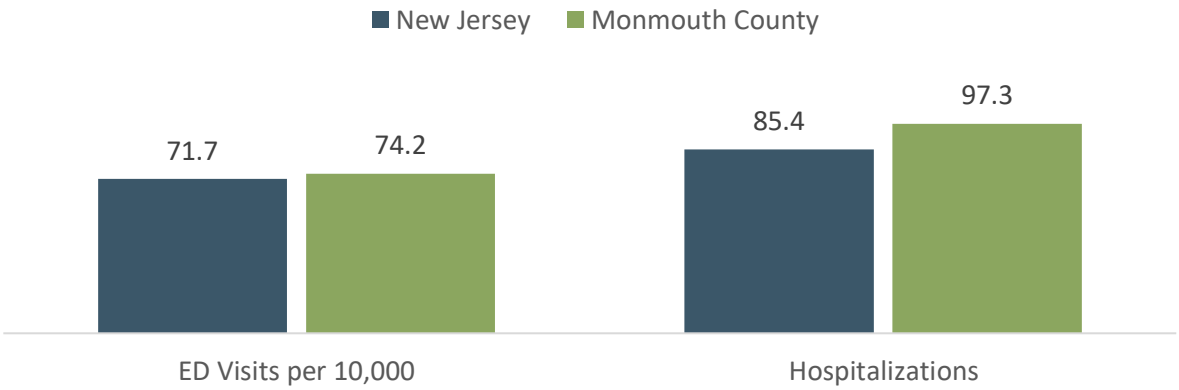


DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019
NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

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 and in Monmouth County (Figure 44). New Jersey Department of Health data from 2016-2020 show that Monmouth County had higher rates of ED visits and hospitalizations due to COPD compared to the state (Figure 44).

Figure 44. ED Visits and Hospitalizations due to COPD per 100,000, by State and County, 2016-2020



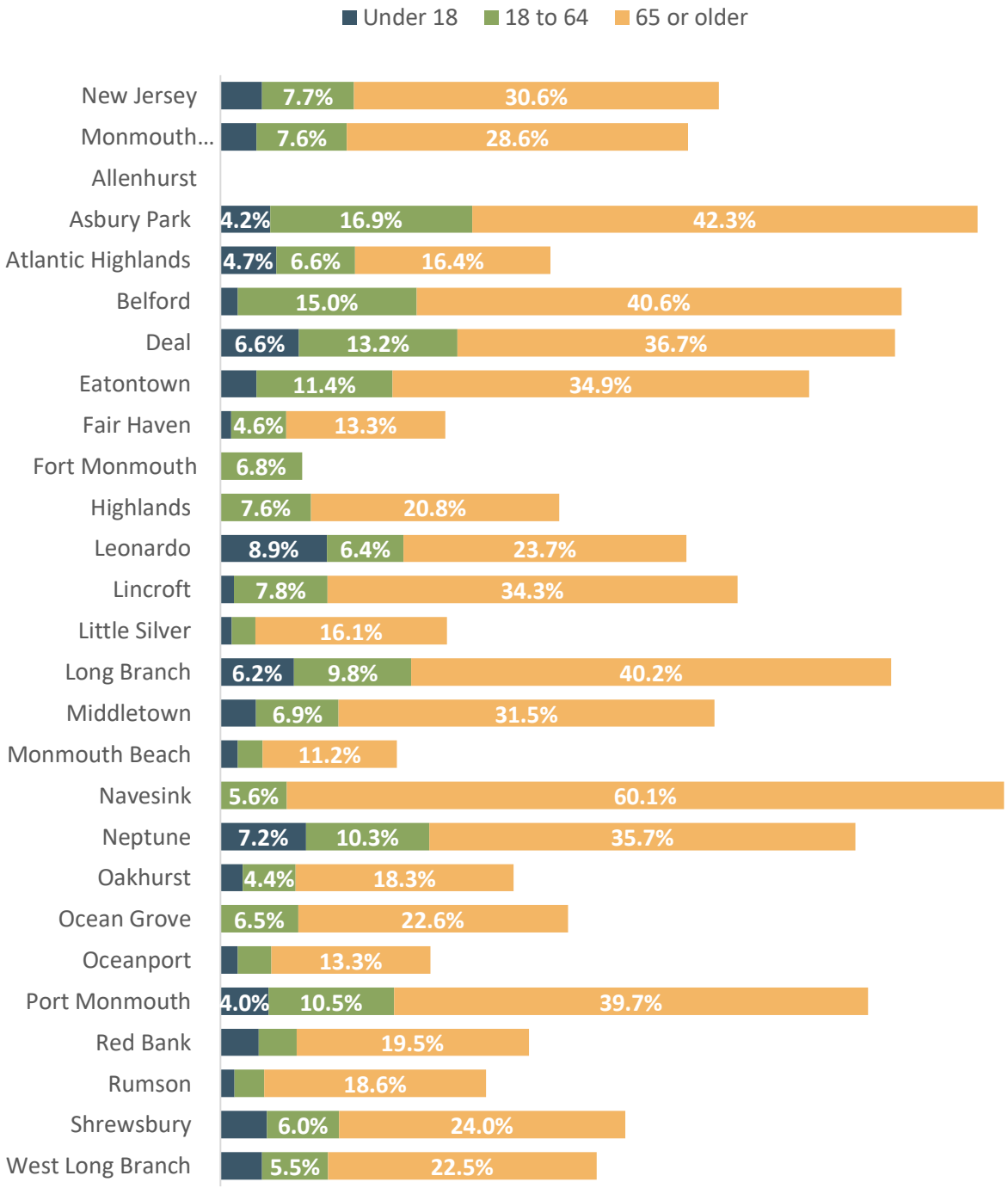
DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Disability

Residents who have some disability may have difficulty getting around, living independently, or completing self-care activities. Other disabilities, such as hearing, vision, and cognitive, may also impact residents' daily lives. Interviewees working in disability services highlighted challenges their clients faced, including limited transportation options for appointments and challenges in finding work and employment opportunities for their clients. As one interviewee explained, "*[Persons with a disability are] Very reliable workers, particularly in this labor market that we're in now. So, there's this diverse, eager, committed community of people that many businesses have not traditionally taken advantage of as far as offering opportunities for them to work. So, our folks are, you know, very eager to work."* Additionally, opportunities highlighted were finding and holding on to work staff interested in working in disability services, *"Workforce [persons working disability services] is unstable; it is trying to maintain quality staff to ensure continuity of services and support."*

American Community Survey data from 2016-2020 show that the number of people with disabilities differs across Monmouth County. The proportion of the population ages 18-64 with a disability ranged from under 4% in several towns to 16.9% in Asbury Park (Figure 45). Overall, almost 30% of people ages 65 and older have a disability in Monmouth County; across towns, the proportion of people ages 65 and older with a disability ranged from 0.0% in Fort Monmouth to 60.1% in Navesink.

Figure 45. 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
NOTE: Data under 4.0% not labeled.

Behavioral Health: Mental Health and Substance Use

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

> *"Mental Health is in tandem with substance abuse, and you can't separate these."*
> – Focus group participant

The social and economic fallout resulting from the COVID-19 pandemic significantly disrupted the day-to-day routine of individuals and communities, resulting in financial hardships, elevated stress, and social isolation and leading to a rise in mental health and substance abuse disorders. In the aftermath of the COVID-19 pandemic, national, state, and local agencies continue to report that the increased stress, depression, anxiety, and overall trauma have further elevated the demand for treatment services. Additionally, even before the pandemic, mental health and substance abuse were identified as top health issues concerns for Monmouth County, as outlined in the 2019 Community Health Need Assessment.

Mental Health

> *"As behavioral health utilization decreased, economic hardships, elevated stress, social isolation and growing behavioral health disorders contributed to greater [mental health] treatment needs."*
> –Key informant interviewee

The topic of mental health was prevalent in nearly all focus groups and interviews conducted for this CHNA. For example, most Monmouth residents participating in focus group discussions noted that while the COVID-19 pandemic had generally impacted the community, mental health issues –which were already prevalent—were most likely to be exacerbated and disproportionately affect the most vulnerable communities. These included young persons, older adults, veterans, persons of color, the undocumented, and those with preexisting psychiatric conditions, such as the persistently mentally ill. For example, one interviewee observed, *"[There is] a need for support services, especially for those with severe and president mental illness, it is a constant struggle as they struggle and are at a higher risk for morbidity and death."*

Further, several veteran focus group participants highlighted the harmful effects of the pandemic on mental health and substance abuse in veterans. One participant stated, *"The issue I see is that things were just made worse by the pandemic, violence, substance [use], and mental health and this [the pandemic] along with the lack of accessibility to social services. We see this, especially among our young men leaving the service."* In a separate conversation with residents, one focus group participant explained, *"Mental health [has crept] into so many areas, our seniors and youth who have been away from school for about two years and now are returning. For our seniors, it is not being able to see friends or family. Their social lives, which we take for granted, were taken away."*

The comments highlight a general sentiment shared by several participants - that someone or something was taken away, whether that was job loss, a loved one due to COVID-19, or the separation from friends or family. Several participants also felt that dealing with such uncertainty was exacerbated by coping with situations they had never encountered. These situations included dealing with financial insecurity, asking others for help to access basic needs, virtual schooling, social isolation, disruptions in access to care, and the general uncertainty and fear of exposure associated with the pandemic. One interviewee remarked, *"We saw trauma [in the community] occur in so many ways. People are learning to deal with so many issues all at once."*

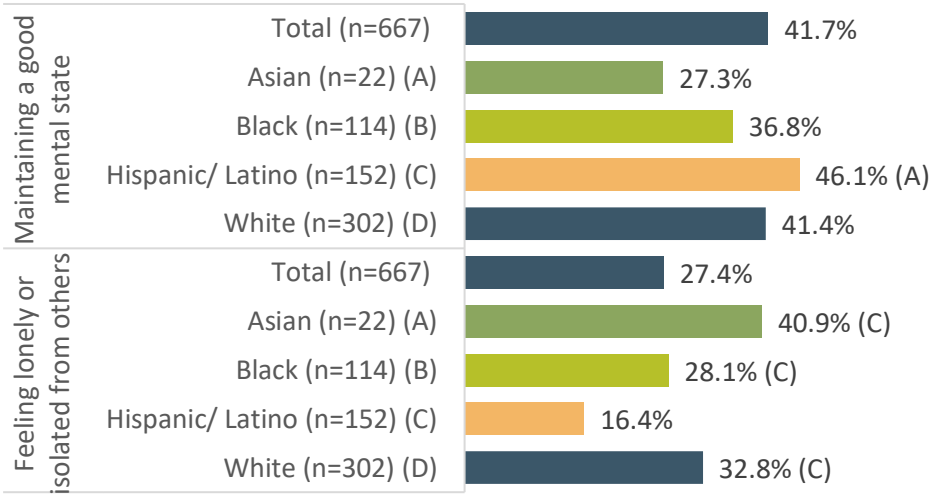
In terms of residents seeking services, interviewees discussed that the most marginalized populations also chose not to seek care due to the stigma associated with seeking help with a mental health issue. For example, as one interviewee explained, *"[Our] social services are located on the west side of town, which is Hispanic and Black, [and] we have been working hard to figure out how to best bring services to them, but they don't seek treatment because of stigma tied to mental health…the biggest challenge is stigma."* Some participants also shared that people may not seek mental health services as they either do not have medical coverage, are unaware that such services exist, or are in a situation where they cannot take time off work.

A few focus group participants also discussed that in addition to the anxiety and isolation, people were also dealing with physical pain and that in such instances of absence of support, they may choose alcohol or drug to deal with such chronic conditions. As one participant observed, *"I think there's a lot of loneliness and fear because the world's not that safe, and I think that can play with you a little bit when you're by yourself a lot, and people will medicate themselves. They get pain medication to handle physical stuff that's going on, and it's very easy to abuse that stuff. Some of us don't have family or family [are] far away, and they can't monitor [what they are doing]. It takes a village. Or people say always look for the helpers [people that can help provide mental health treatment], but we don't have enough helpers."*

Discussions related to mental health and substance abuse also centered around the need for coordination of mental health services tailored to meet the needs of persons experiencing severe mental illness. Residents also recommended having transportation options available for seniors and those that might have physical limitations so that they could help make their mental health appointments. Interviewees also highlighted the importance of incorporating trauma-informed care as part of the services that support the community to deal more effectively with what occurred during the pandemic. As one interviewee observed, *"Much of what we did was addressing trauma informally, but the pandemic provided us with an understanding of how deeply it shapes and influences our kids and their longer-term outcomes."*

Community survey data further reiterated the impact of the pandemic on the community, with 41.7% of residents reporting that they or someone in their family has personally experienced difficulty with mental health issues since COVID-19 started, and 27.4% reported feeling lonely or isolated since COVID-19 started. When looking at differences by the race and ethnicity of survey respondents, survey respondents from a Hispanic or Latino background reported higher levels of difficulty maintaining a good mental state (46.1%) while a higher percentage of Asians (40.9%) reported being lonely or isolated (40.3%) compared respondents of other backgrounds (Figure 46).

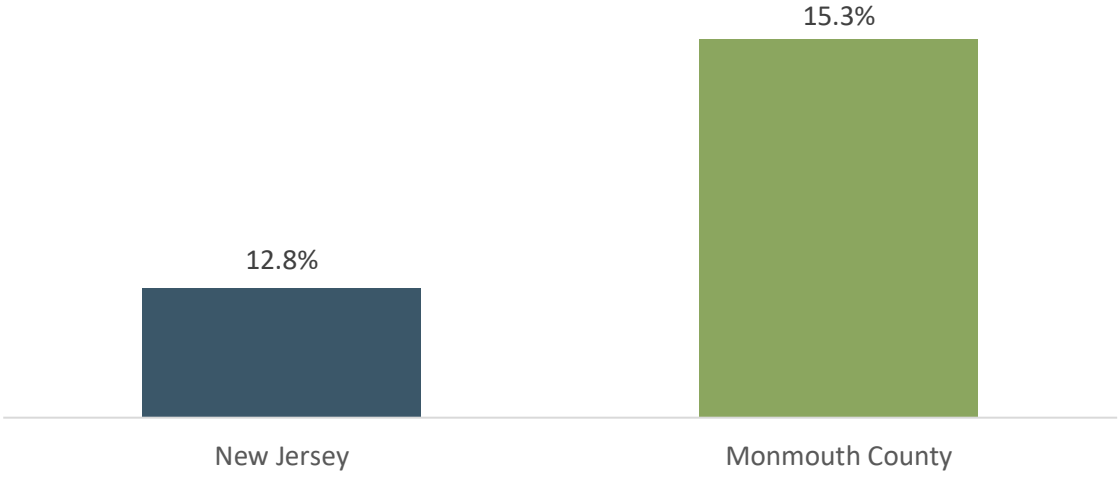
Figure 46. Percent of Community Survey Respondents Reporting that They or Someone in Their Immediate Family Has Personally Experienced Difficulty with Mental Health Issues since COVID-19 Started (n=667), 2021



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

Additionally, surveillance data from the Behavioral Risk Factor Surveillance System show that in 2020, 15.3% of Essex County adults (Figure 47).

Figure 47. Percent Adults Reported 14 or More Days of Poor Mental Health in Past Month, by State and County, 2020



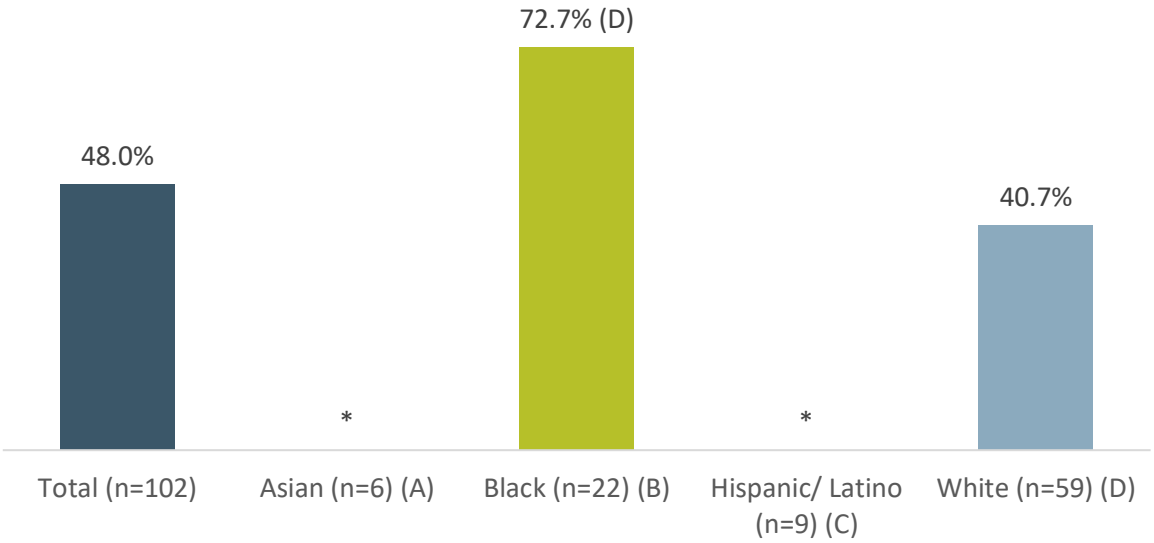
DATA SOURCE: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020

Mental Health Care and Hospitalizations

Of the 102 community survey respondents who reported that they or a household family member were ever told by a doctor or health professional that they had depression and/or anxiety, almost half of these individuals and/or their household family member (48.0%) were receiving care for one of these

conditions (Figure 48). Almost three-fourths of Black respondents (72.7%) reported they or a family member were under care.

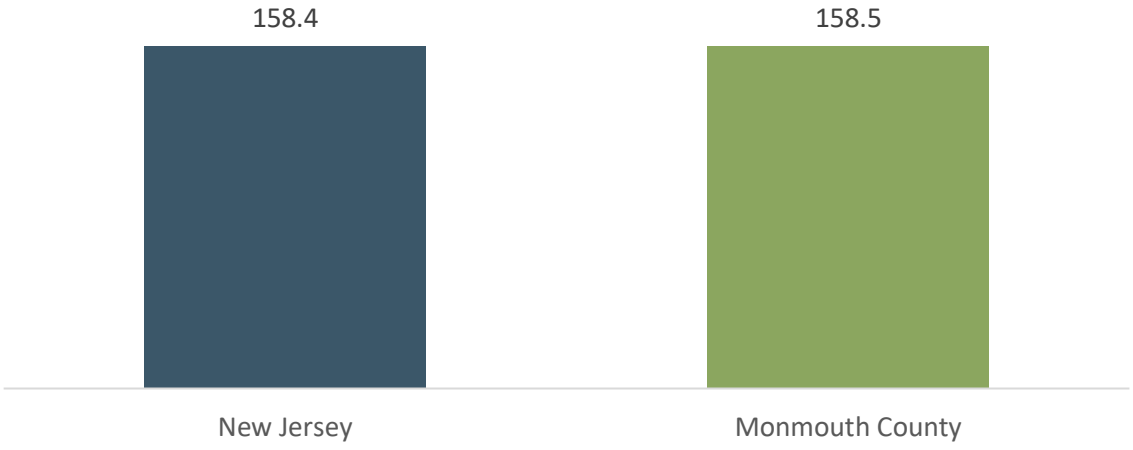
Figure 48. Of Those Told by a Doctor They Had Depression and/or Anxiety, Percent of Community Survey Respondents Reporting that They or a Family Member Are Currently Under Care for Depression or Anxiety (n=102), 2021



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.

Data on mental health admissions specific to the RWJB system can be found in Appendix f. Mental health surveillance data from 2018 show that Monmouth County's rate of ED visits due to mental health per 100,000 residents (158.5) is comparable to the statewide rate (158.4) (Figure 49).

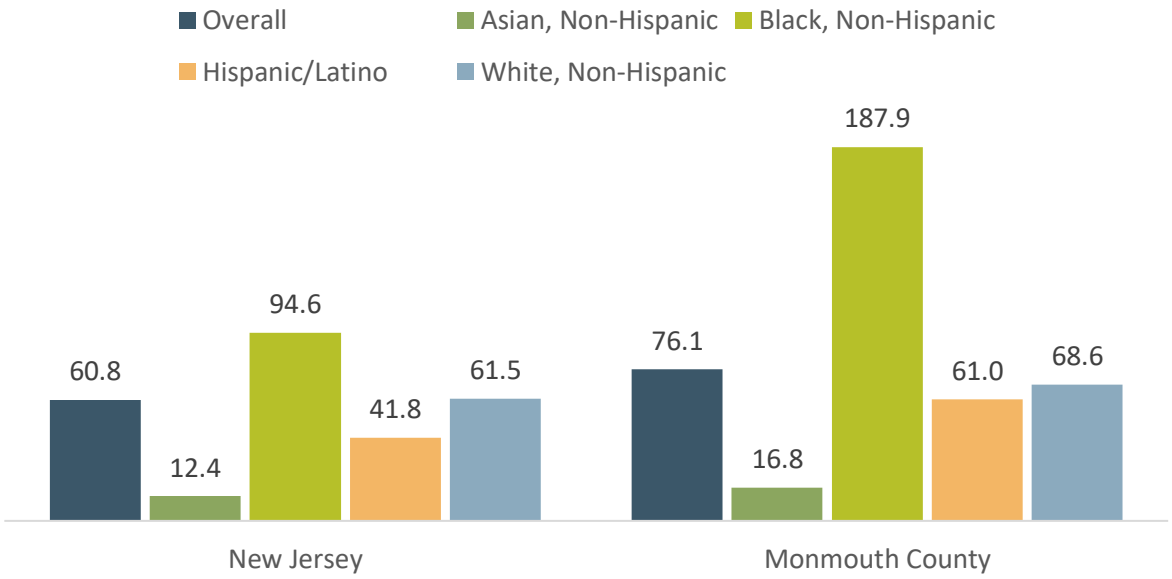
Figure 49. ED Visits due to Mental Health per 100,000, by State and County, 2020



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

Figure 50 shows that in 2020, the hospitalization rates for mental health issues were substantially higher among non-Hispanic Black residents in Monmouth County and statewide than for other racial and ethnic groups. Asian residents had the lowest hospitalization rates for mental health in 2020 across all geographies.

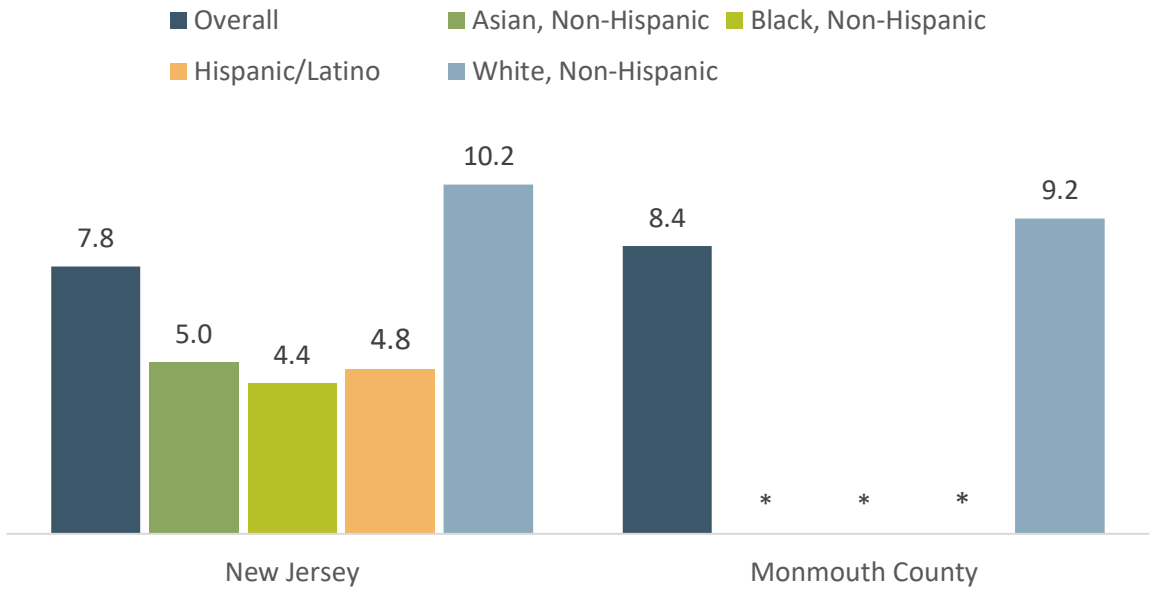
Figure 50. Hospitalizations due to Mental Health per 100,000, by Race/Ethnicity, State, and County, 2020



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 indicate that overall suicide rate in Monmouth County (8.4 per 100,000 population) is higher than the state (7.8) (Figure 51). Viewed across racial and ethnic groups, data show that suicide rates are highest among non-Hispanic White residents across the state and Monmouth County.

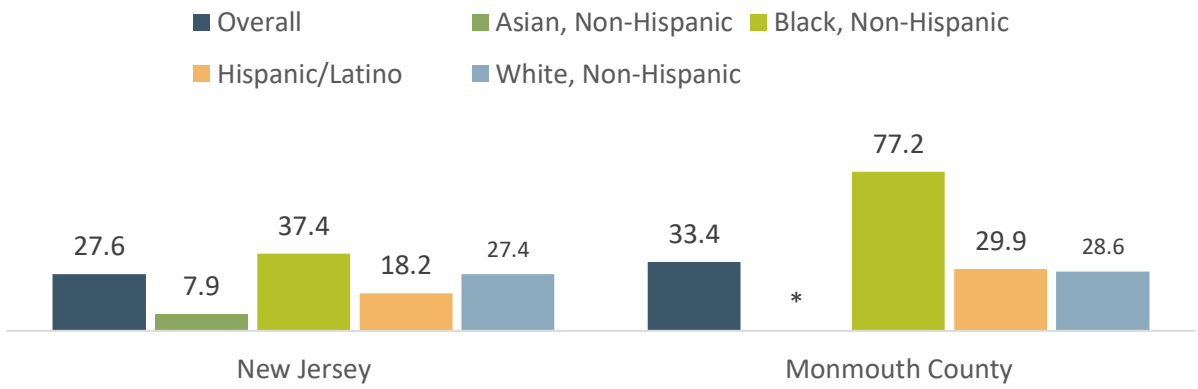
Figure 51. Suicide Rate per 100,000 Population (Age-Adjusted), by State and County, 2016-2020



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

Recent data on pediatric hospitalizations due to mental health shows that hospitalization rates are higher in Monmouth County than statewide (Figure 52). The hospitalization rate for mental health issues among non-Hispanic Black children in Monmouth County (77.2 per 100,000) is more than two times the rate of hospitalizations among non-Hispanic Black children statewide (37.4 per 100,000) and is higher than any other racial/ethnic categories.

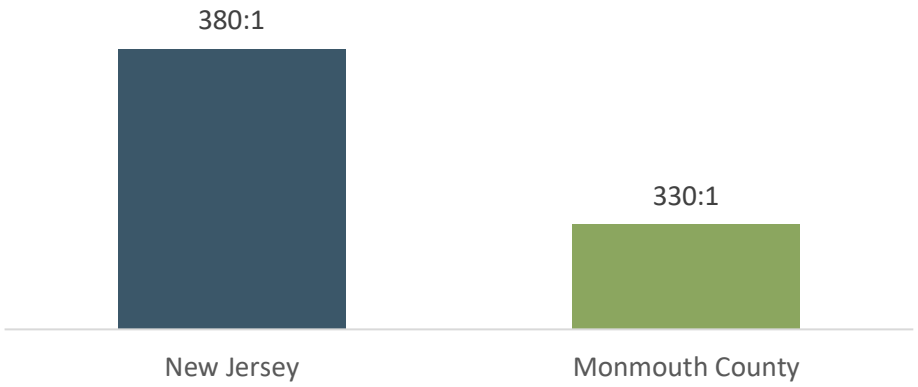
Figure 52. Pediatric Hospitalizations (Ages 19 and under) due to Mental Health per 100,000, by Race/Ethnicity, State, and County, 2020



DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Data about the mental health workforce from the Centers for Medicare and Medicaid Services indicate that in 2021, Monmouth County had 330 people for every mental health provider, a rate slightly lower than the state (380:1) (Figure 53).

Figure 53. Ratios of Population to Mental Health Provider, 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

Between 2017-2020 binge drinking rates were slightly higher in Monmouth County (20.6%) than statewide (16.9%) (Figure 54). Across racial and ethnic groups, binge drinking rates were highest among non-Hispanic White residents statewide and Monmouth County and lowest among non-Hispanic Asian and non-Hispanic Black residents.

Figure 54. Percent Adults Reported Binge Drinking in the Last 30 Days, by State and County, 2017-2020

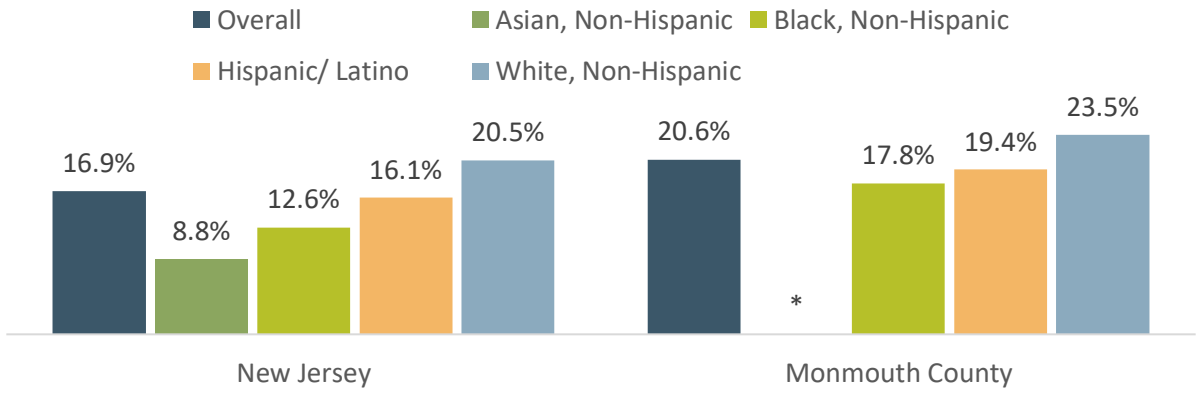
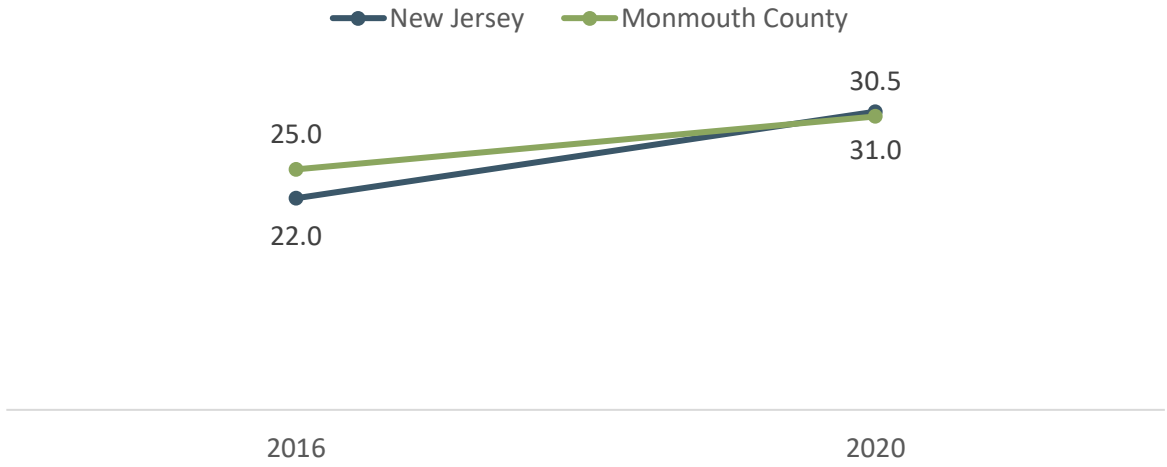


Figure 55 shows the age-adjusted drug poisoning mortality rate per 100,000 population in 2016 and 2020. Over this time period, mortality rates increased in Monmouth County and statewide.

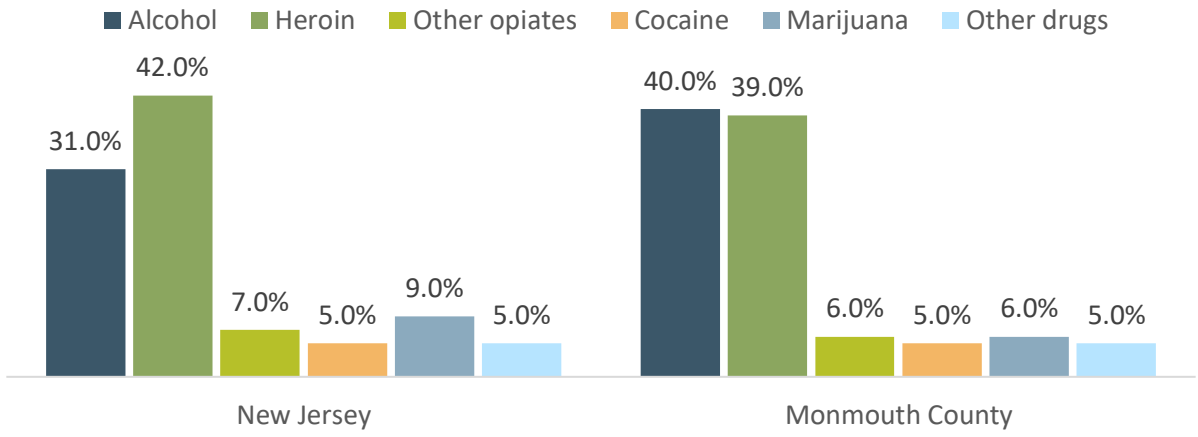
Figure 55. Age-Adjusted Unintentional Drug Induced Poisoning Mortality Rate per 100,000 Population, by State and County, 2016 and 2020



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2020 on CDC WONDER Online Database, 2016 and 2020
DATA SOURCE: Drug Deaths for 2019, New Jersey Office of the State Medical Examiner

Figure 56 shows the percentage of substance use treatment admissions by primary drug in 2020. Across geographies, admission rates were highest for alcohol and heroin. In Monmouth County, two-fifths of admissions to substance use treatment services were for alcohol misuse and nearly two-fifths were for heroin misuse.

Figure 56. 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

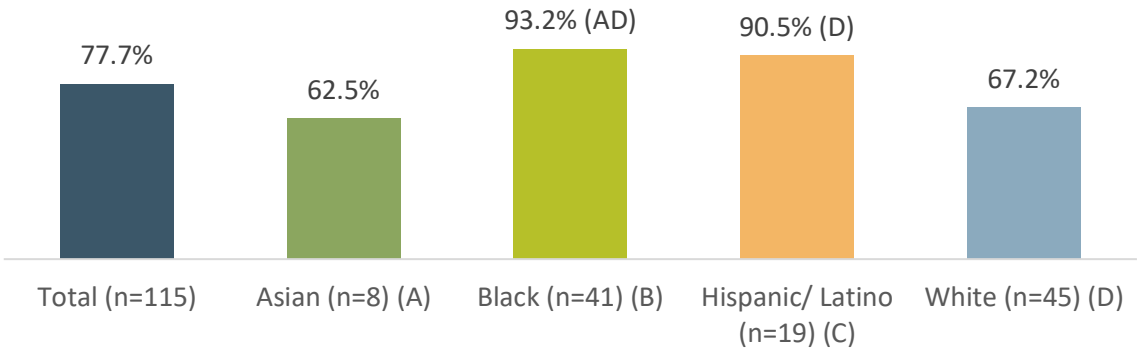
Environmental Health

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.

Asthma

Among the 115 community survey respondents who reported that they or a household family member were ever told by a doctor or health professional that they had asthma, 77.7% indicated they or a household member were receiving treatment (Figure 57). Among Black and Hispanic/Latino respondents, the percentage was over 90 (93.2% and 90.5% respectively).

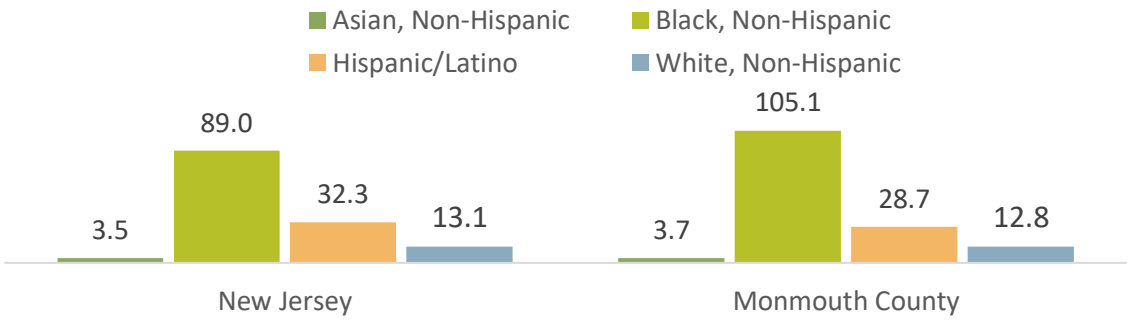
Figure 57. Of Those Told by a Doctor They Had Asthma, Percent of Community Survey Respondents Reporting that They or a Family Member Are Under Care for Asthma (n=115), 2021



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

Figure 58 shows the age-adjusted asthma emergency department visit rate per 10,000 population by race/ethnicity in the state overall and in Monmouth County. In 2018, the age-adjusted asthma ED visit rate for Black residents was more than double the rate for any other racial/ethnic group in the state and in Monmouth County. The age-adjusted asthma ED visit rate was lowest among Asian, non-Hispanic residents in Monmouth County and in the state overall.

Figure 58. Age-Adjusted Asthma Emergency Department Visit Rate per 10,000 Population by Race/Ethnicity, by State and County, 2018

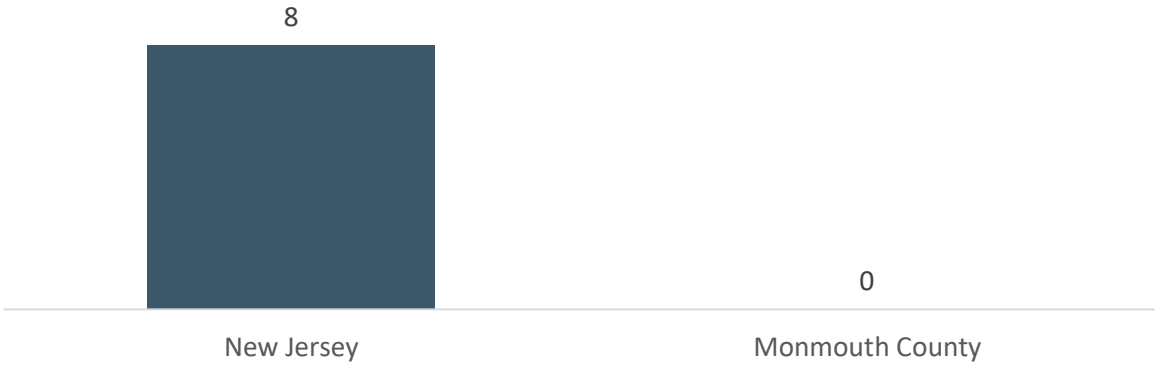


DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018
NOTE: Data includes ED visits where asthma was primary diagnosis

Air Quality

In 2020, there were eight days statewide in New Jersey where ozone in outdoor air exceeded the federal health-based standard for ozone (eight-hour period above 0.070 ppm). Monmouth County had zero days of poor air quality (Figure 59).

Figure 59. Ozone in Outdoor Air, Number of Days Ozone Exceeded the National Ambient Air Quality Standards for Ozone (8-hour above 0.070 ppm), 2020



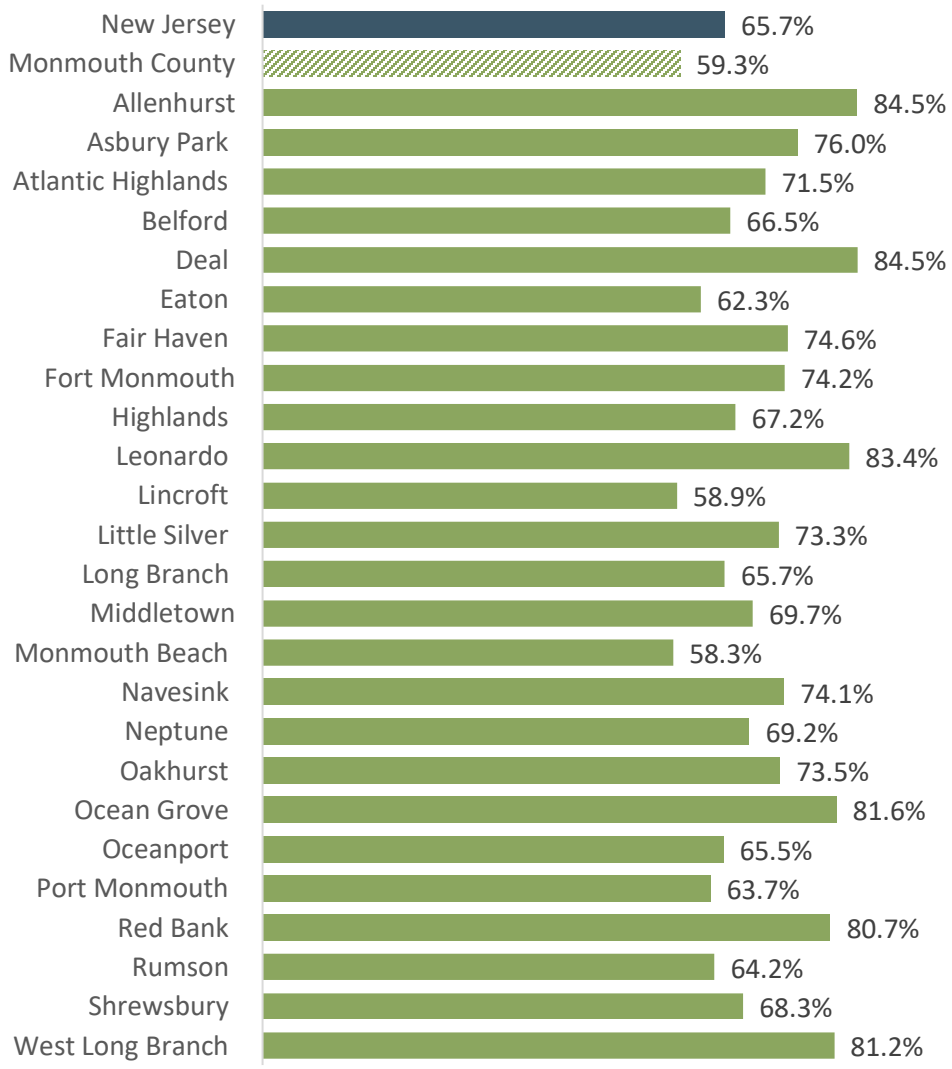
DATA SOURCE: Bureau of Air Monitoring, New Jersey Department of Environmental Protection, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Lead

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.

Figure 60 shows that the majority of housing in Monmouth County was built prior to 1980. In most towns, the proportion of older housing is higher in Monmouth County than the state overall, though the county overall has a lower percentage than the state. The towns of Allenhurst and Deal have the highest proportion of older housing stock, with about 85% or more of homes built before 1980. The towns of Monmouth Beach and Lincroft have the lowest proportion of older housing stock, with 58.3% and 58.9% of homes built before 1980, respectively.

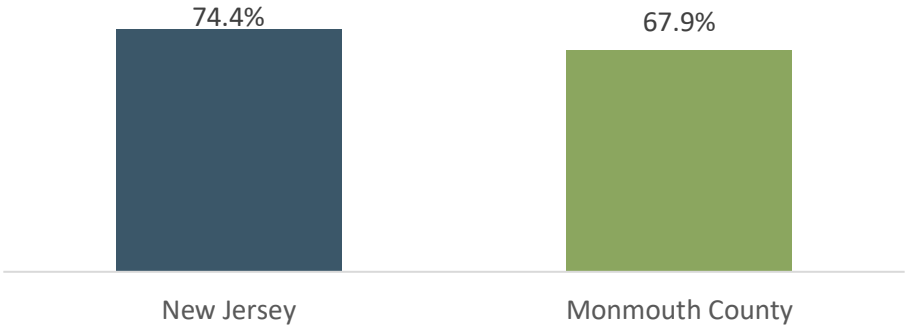
Figure 60. Percent of Housing Stock Built Pre-1980, by State, County, and Town, 2016-2020



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

New Jersey Child Health Program data from 2022 shows that the proportion of children tested for lead exposure before 36 months of age is lower within Monmouth County than the state overall (Figure 61). In Monmouth County, almost 70% of children born in 2014 were tested for led before their third birthdays.

Figure 61. 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

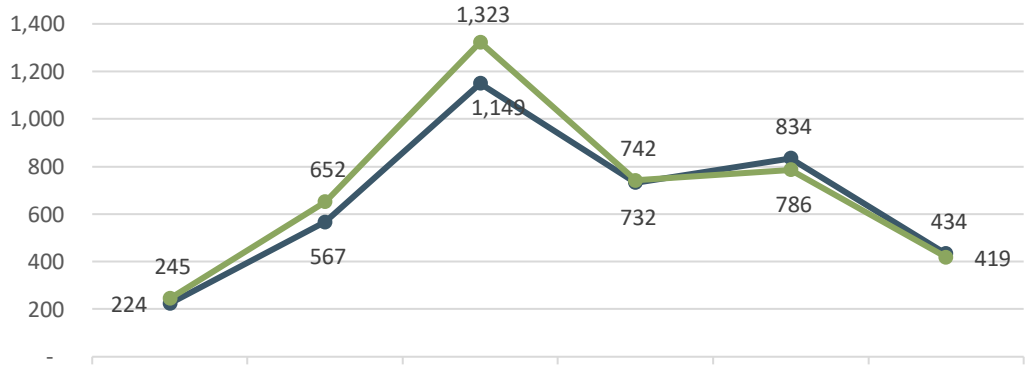
Infectious and Communicable Disease

This section discusses COVID-19 and sexually transmitted infections.

COVID-19

Figure 62 shows new confirmed cases of COVID-19 per 100,000 population in New Jersey as a whole, and in Monmouth County between March – August 2022. In all localities the rate of new cases was lowest in March 2022 and peaked in May 2022. The rate of new cases in Monmouth County was similar to the state overall. It was consistently slightly higher than the state rate until July 2022, when it dropped below the state rate.

Figure 62. New COVID-19 Cases per 100,000 population, by State and County, 2020-2022

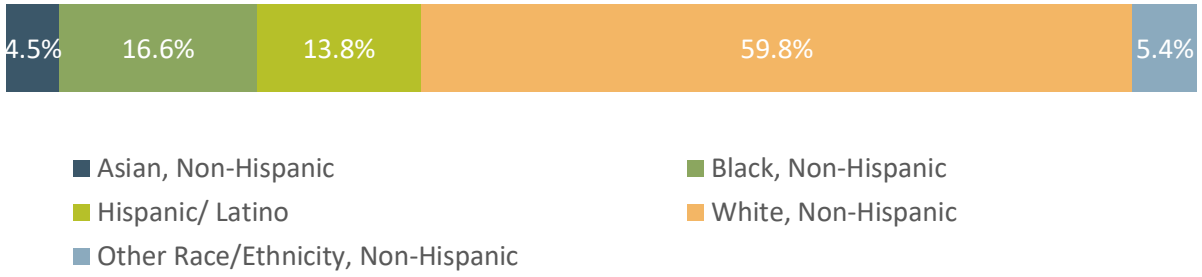


	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
New Jersey	224	567	1,149	732	834	434
Monmouth County	245	652	1,323	742	786	419

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

As of August 2022, there had been 31,275 deaths due to COVID-19 in New Jersey. Non-Hispanic White residents account for nearly 60% of COVID deaths. Non-Hispanic Black residents account for 16.6%, Hispanic residents account for 13.8%, and Asian residents account for 4.5% of confirmed COVID-19 deaths in the state (Figure 63).

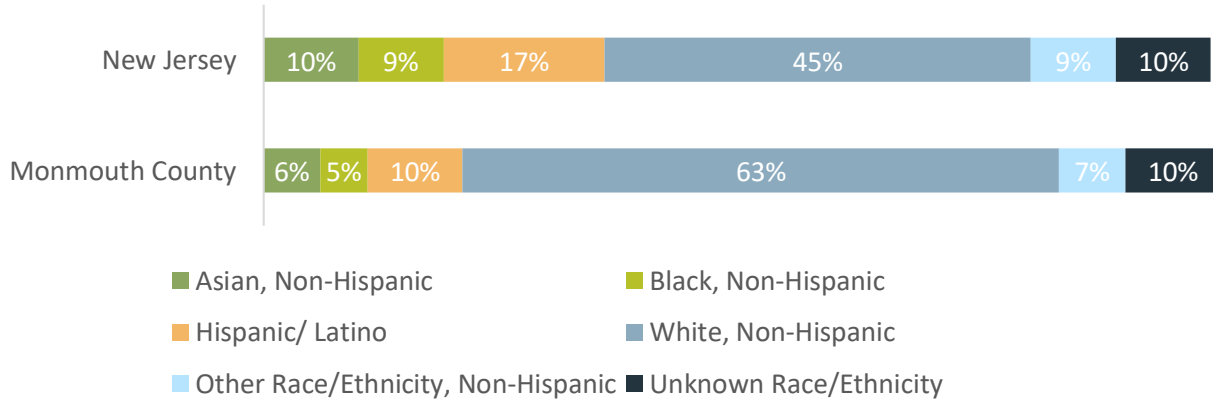
Figure 63. Percent of COVID-19 Deaths by Race/Ethnicity in New Jersey 2022



DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022
NOTE: Counts are up to date as of August 10th 2022.

As of July 27, 2022, 6,795,708 individuals in New Jersey and 453,571 in Monmouth County had been fully vaccinated against COVID-19. Of which, a majority were non-Hispanic White (63%) followed by Hispanic (10%), Asian (6%) and Black (5%) (Figure 64). This generally mirrors the racial/ethnic distribution within Monmouth County overall.

Figure 64. Percent Distribution of Persons Fully Vaccinated for COVID-19, by Race/Ethnicity, State, and County, 2022



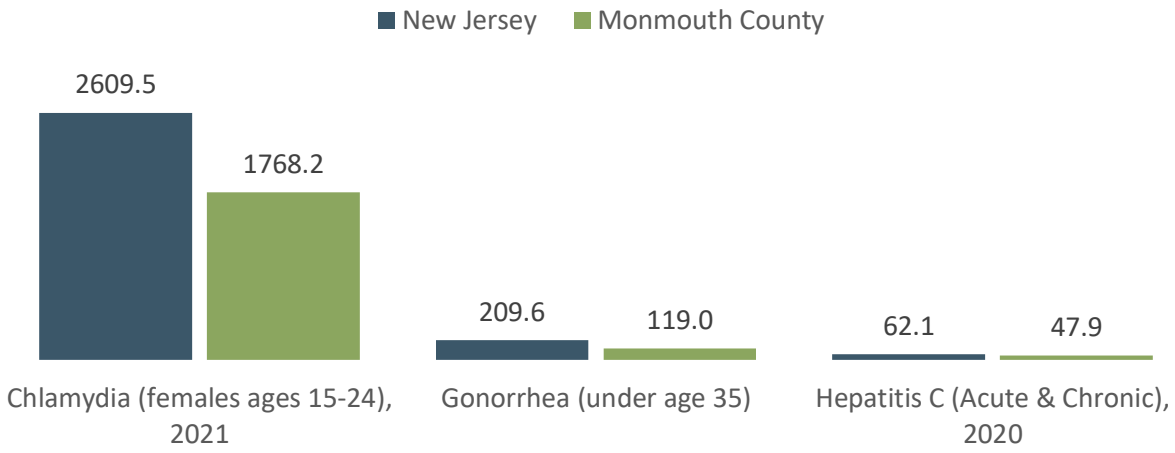
DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2022
NOTE: Racial/ethnicity data does not include those vaccinated out of state and by federal programs.

Sexual Health and Sexually Transmitted Diseases

Chlamydia was the most common sexually transmitted disease in the state and in Monmouth County; the rate of Chlamydia was lower in Monmouth County at 1,768.2 cases per 100,000 population

compared to the state at 2,609.5 per 100,000 (Figure 65). Rates of Gonorrhea and Hepatitis C were also lower in Monmouth County compared to the state.

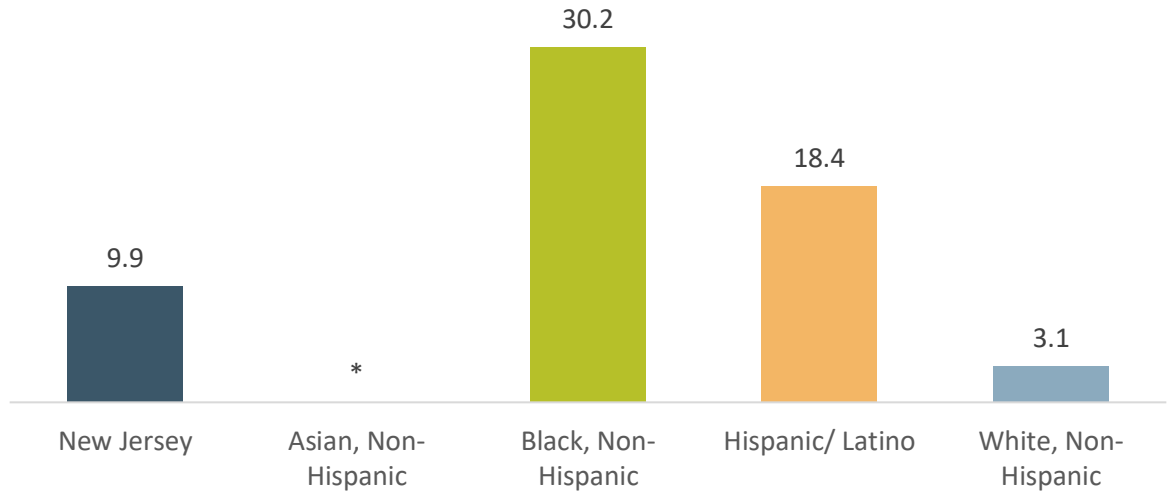
Figure 65. Chlamydia, Gonorrhea, and Hepatitis C Incidence per 100,000 Population, by State and County, by Most Recent Data Available



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

HIV transmission data were only available at the state level. The rate of HIV transmission for Black residents in New Jersey was 30.2 per 100,000 persons, which was ten times the rate of transmission for White residents (3.1 per 100,000) and three times the rate for all New Jersey residents (9.9 per 100,000) (Figure 66). Hispanic/Latino residents had an HIV transmission rate of 18.4 per 100,00 persons, almost twice as high as the state rate.

Figure 66. HIV Transmission per 100,000 Population (Age 13 and Older), by State and Race/Ethnicity, 2020

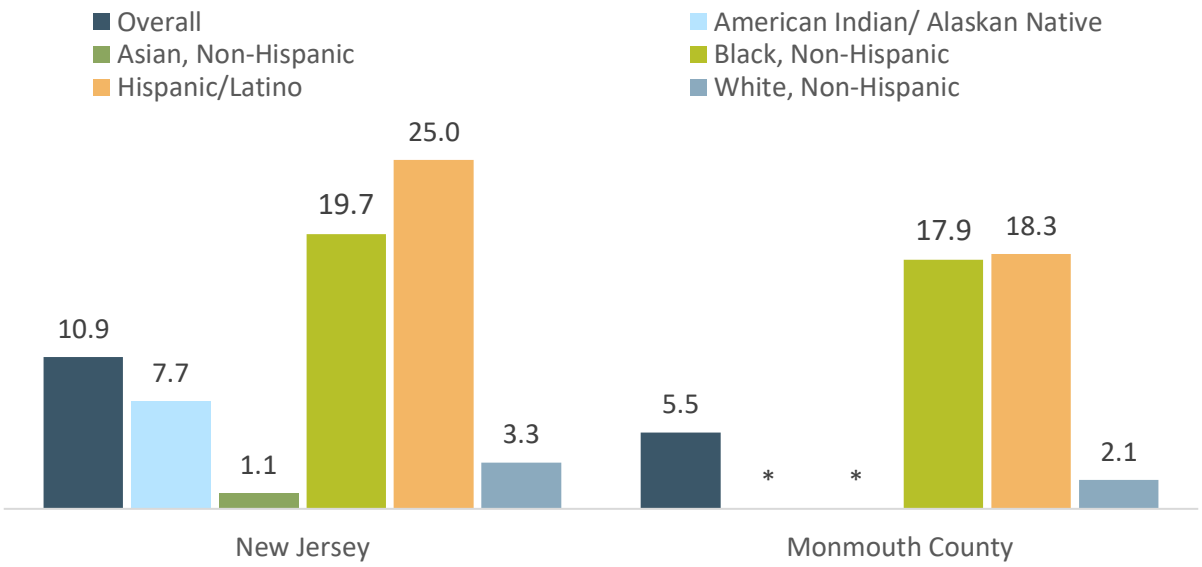


DATA SOURCE: Enhanced HIV/AIDS Reporting System (eHARS), Division of HIV/AIDS, STD, and TB Services, as reported by the New Jersey Health Assessment Data (NJSHAD), 2019
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Maternal and Infant Health

The health and well-being of mothers, infants, and children are important indicators of community health. Figure 67 shows the number of teen births per 1,000 female population from 2014 to 2020, by race/ethnicity, state, and county. The rate of teen births was lower in Monmouth County (5.5 per 1,000 female population ages 15-19) than statewide (10.9 per 1,000 population). Across the geographies, the rate of teen births was higher among non-Hispanic Black and Hispanic females compared to the rate in the population overall.

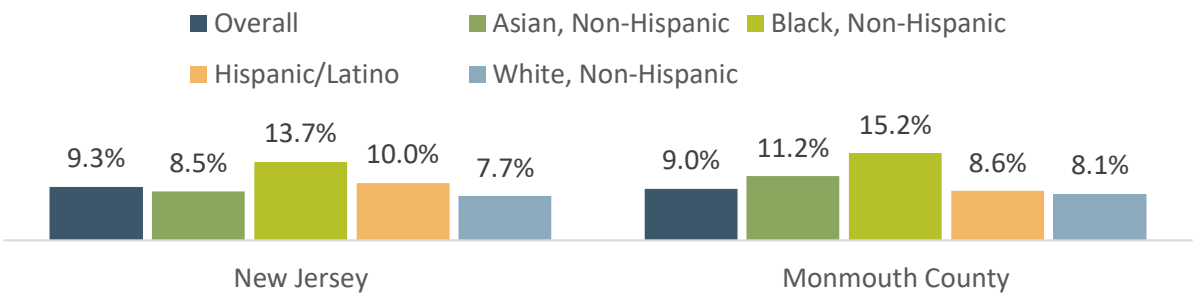
Figure 67. Number of Births per 1,000 Female Population Ages 15 to 19, by Race/Ethnicity, State, and County, 2014-2020



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

Birth data from the NJ Birth Certificate Database show that Monmouth County (9.0%) had a similar proportion of preterm births to the state (9.3%) in 2020 (Figure 68). Data across racial/ethnic groups shows that a higher proportion of non-Hispanic Black women had preterm births in both Monmouth County and the state than other races/ethnicities. babies weighing less than 2,500 grams across all three counties and the state, followed by non-Hispanic Asian women. Non-Hispanic White women, by contrast, experienced the lowest proportion of preterm births in Monmouth County and the state. Similar patterns can be seen in the percent of low and very low birth weight births (see Appendix F for additional data.)

Figure 68. Percent Preterm Births, by Race/Ethnicity, State, and County, 2020



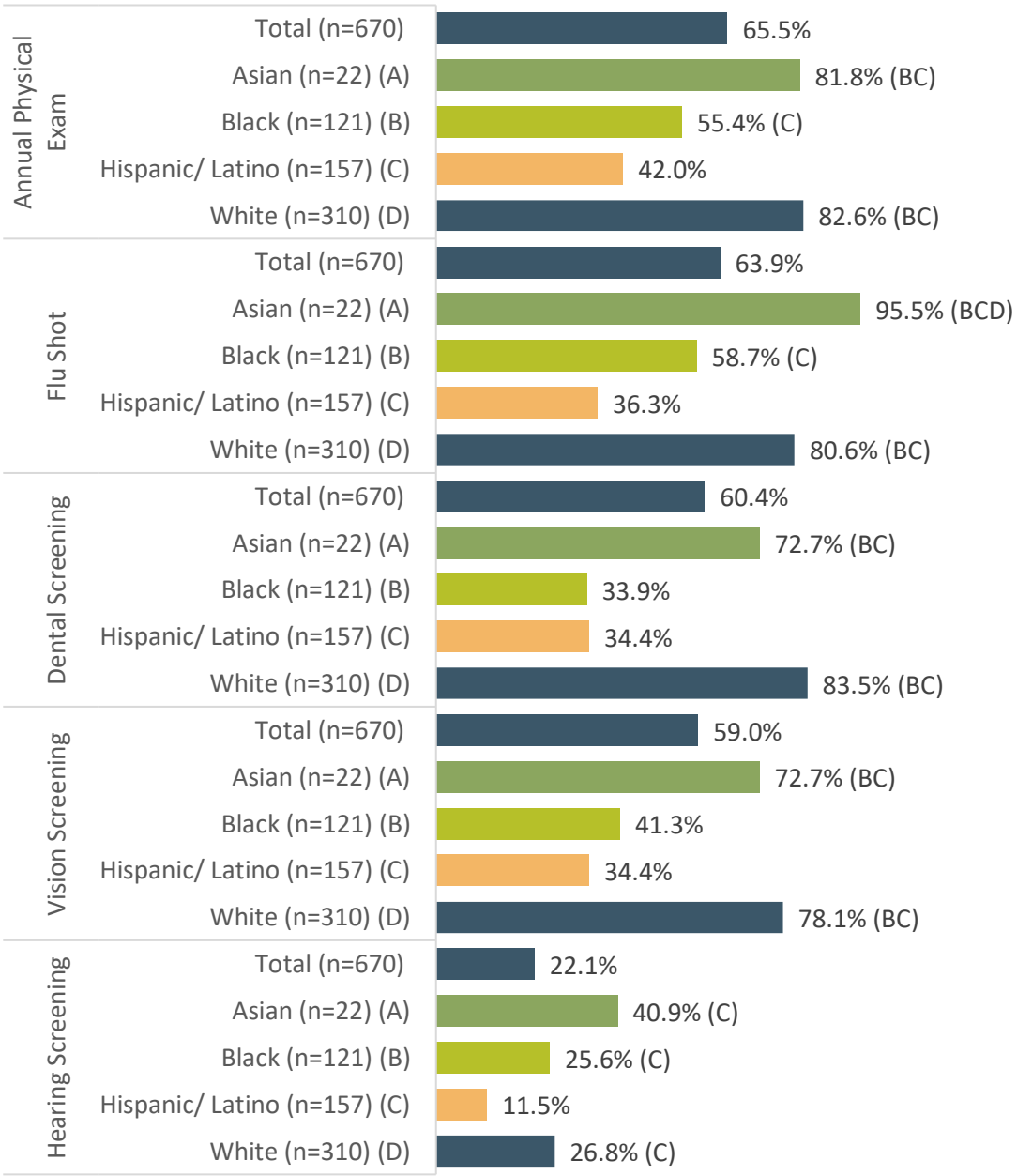
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2020
NOTE: Preterm is defined as less than 37 weeks gestation

Access to Services

Access to healthcare services is important for promoting and maintaining health, preventing, and managing disease, and reducing the chance of premature death.

The 2021 community survey asked respondents about their participation in various healthcare screenings, including preventive services. Approximately two thirds of survey respondents from the MMC service area reported having an annual physical exam (65.5%), while around 60% reported that they have had their flu shot and received a dental and vision screening. Around one fifth (22.1%) reported receiving a hearing screening (Figure 69). In the 2019 CHNA, surveillance data showed that in 2016, 54.9% of residents Monmouth County had received a flu shot.

Figure 69. Percent of Community Survey Respondents Reporting that They Have Participated in a General Preventive Services and Screenings in the Past Two Years



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

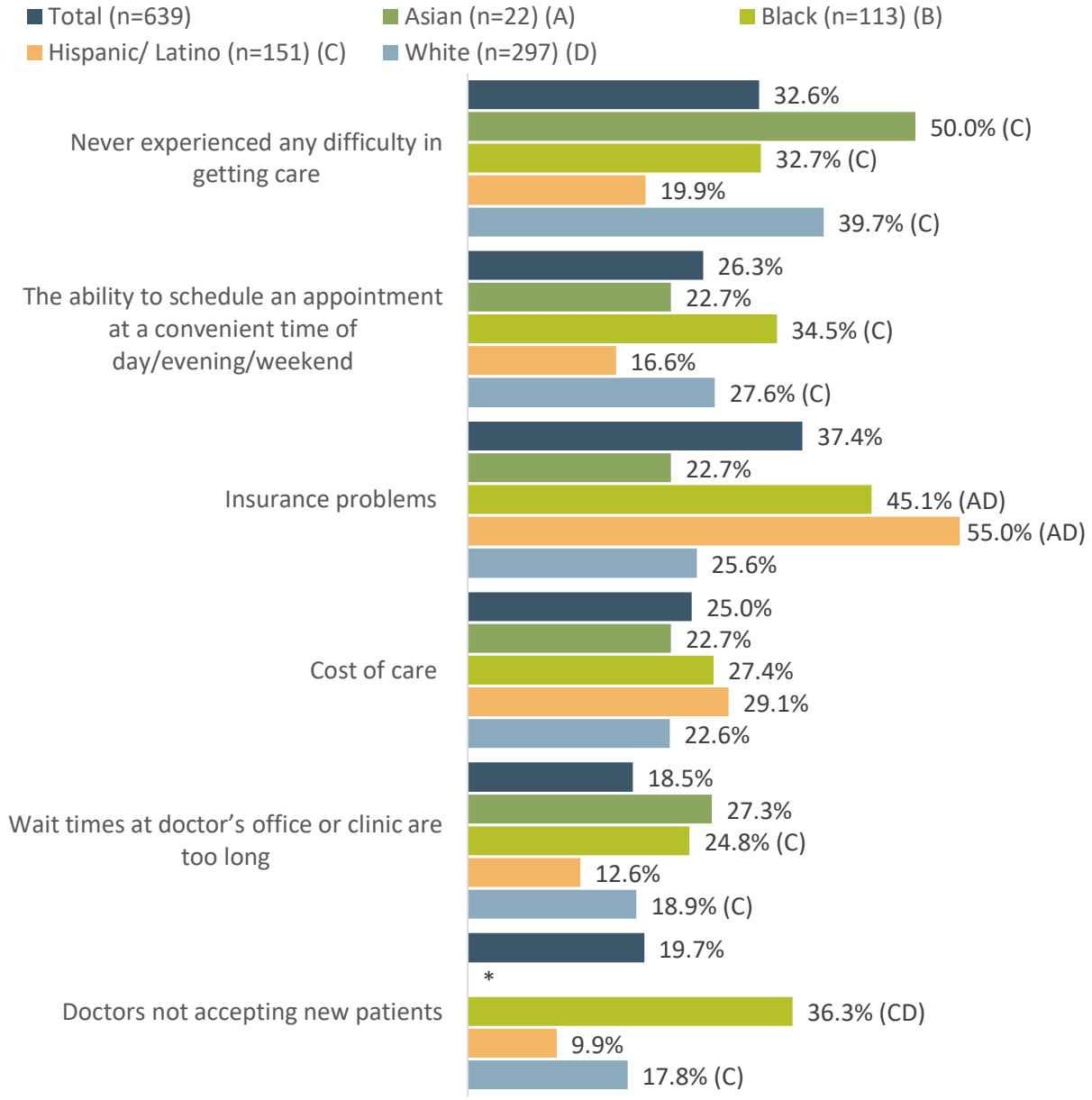
In the United States, access to timely, affordable, high-quality health care remains out of reach to many Americans. Many choose not to seek medical care for various reasons, including being uninsured, not having access to a medical provider, or not having the resources to purchase prescription medication.

> "[Not accessing care] *this again, was exacerbated by COVID, so people weren't taking their meds because they couldn't afford them, or they were rationing their meds and again, what do you do? Do you put food on the table, or do you go pay for your medicines? You're gonna put food on the table."*
> - Focus group participant

Similarly, focus groups participants and interviewees identified barriers to accessing healthcare services that included lack of insurance or limited medical coverage and access to charity care, high prescription costs, long wait times for appointments and referrals, unreliable transportation, lack of trust in the medical system including a lack of cultural awareness among providers. As one focus group participant explained, *"No [medical] insurance exacerbates the issue. I have a friend who is an ophthalmologist, and he told me that no matter what happens, the insurance company will get their money, but who is deciding on what type of care they can provide? So, there are some limitations based on health insurance coverage."* While another participant touched on the challenge of trying to see a medical provider, *"Hard to see doctors, booking appointments – in my case, it's something relatively new [that I am experiencing], but a lot of people must see doctors. But when it comes to [trying to see a] specialist, that's where the problem is."*

While reported participation in screenings among survey respondents was high, respondents also indicated several issues that made it difficult for them or a family member to get medical treatment or care when needed. Importantly, it should be noted that a minority of respondents, about one-third (33%), indicated that they have never experienced difficulty in getting healthcare. The top issue survey respondents identified overall was insurance problems (Figure 70). Challenges differed by racial/ethnic groups. A comparison of these survey results to community survey results shared in the 2019 CHNA reveal similar barriers. In 2019, the top health care barriers noted by respondents were insurance (39%), cost of care (32%), scheduling appointments (27%), and doctors not taking new patients (23.0%). Additionally, 30.0% of respondents reported that they did not experience any difficulties getting care in 2019.

Figure 70. 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=639), 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.

Insurance

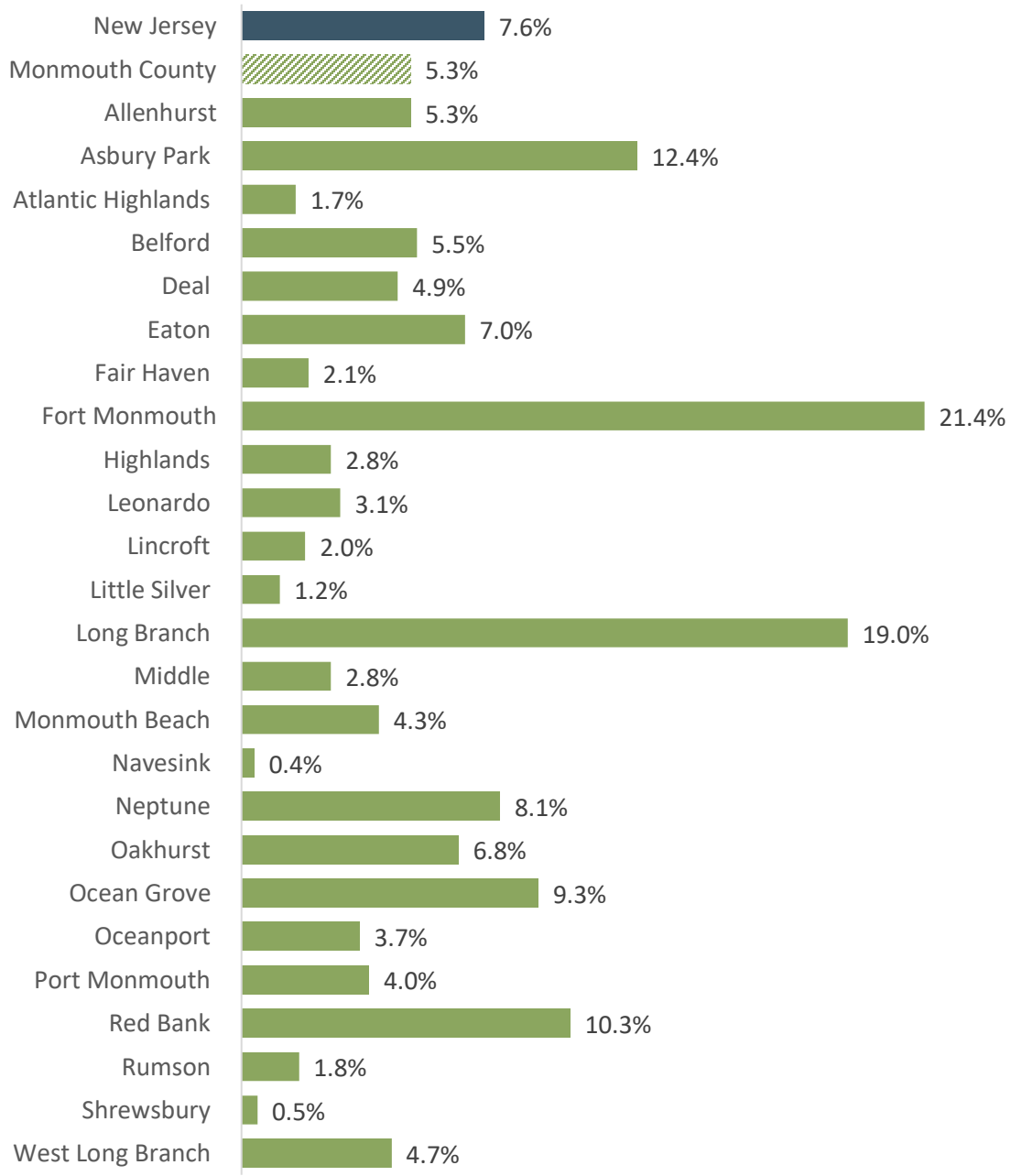
As noted, survey data indicate that insurance was the most reported barrier to accessing care. Many focus group and interview participants discussed the rising cost of insurance coverage, *"Having insurance is a big challenge and, in particular, having the necessary coverage to access care. "[Health insurance coverage] is a big issue, and people can keep up with costs, so you can't afford insurance. So, it is so challenging,"* explained one focus group participant. In addition, to concerns about insurance affordability was the process of individuals navigating charity care. Charity care is considered free or discounted medically necessary health care that many hospitals offer to people who cannot afford to pay for treatment otherwise. It includes both inpatient and emergency room services.

Additionally, even persons with health insurance may qualify for charity care to pay the amount of their hospital bill that their insurance doesn't cover. However, one interviewee observed, *"Going through the charity care application takes time, and if a patient needs surgery [or] needs diagnostic testing, they cannot pay out of pocket. [Then] They too have to go through the charity care process, which is definitely a challenge. So, we try to work with the hospitals to get the application from them [hospitals] to help the patient go through that application.*" As a potential solution, the interviewee recommended that efforts be made to incorporate presumptive eligibility for patients to help reduce waiting time for patients needing services but waiting for approval of their applications.

Data from the American Community Survey indicate that barriers related to health insurance coverage vary by town. About 7.6% of New Jersey residents and 5.3% of Monmouth County residents were uninsured in 2016-2020; however, much higher proportions of residents in Fort Monmouth (21.4%) and Long Branch (19.0%) were uninsured during this time (Figure 71). There are fewer uninsured residents in Navesink (0.4%) and Shrewsbury (0.5%).

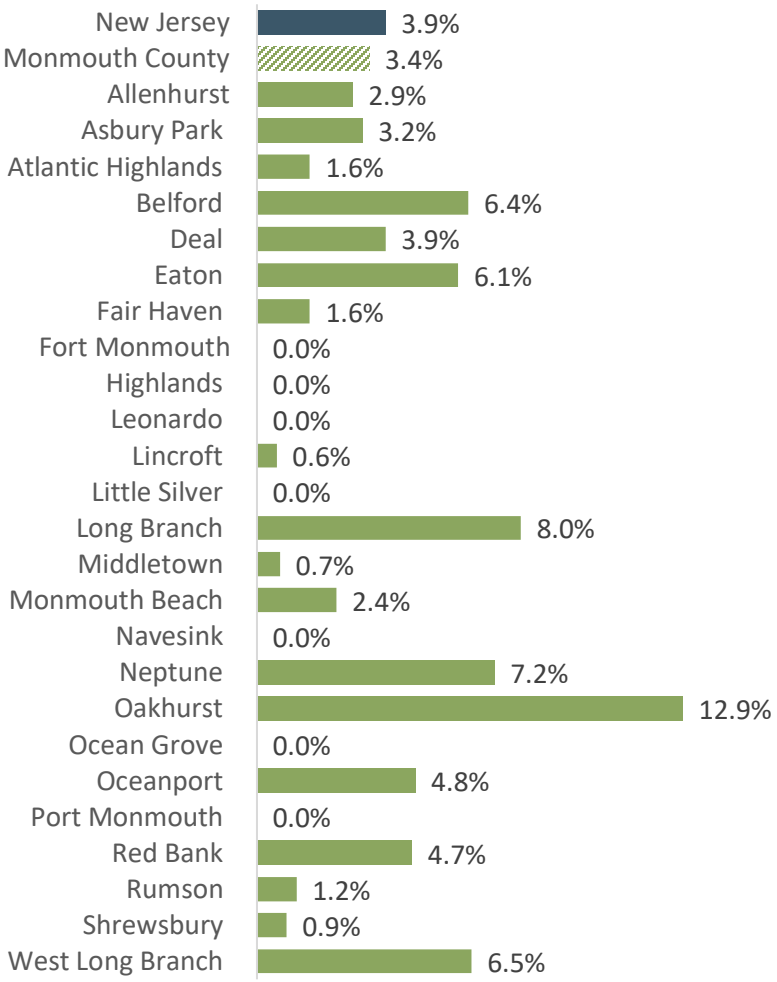
Patterns are slightly different when looking at the population under 19 years old without insurance (Figure 72). Nearly 13% of children and adolescents in Oakhurst do not have health insurance, while approximately 6-8% of children under 19 years old in Long Branch, Neptune, Belford, West Long Branch, and Eaton do not have health insurance.

Figure 71. Percent Population Uninsured, by State, County, and Town, 2016-2020



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

Figure 72. 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

Availability of Providers

When focus group participants discussed barriers to accessing care, providers' availability was another issue of concern. Specifically, participants described a need for more primary care providers and, mainly, specialists, *"[It is] Hard to see doctors [and there are a] lot of people who have to see doctors. But when it comes to a specialist, that's where the problem is,"* observed one focus group participant. While another participant stated, *"Monmouth County doesn't have specialists; you have to go outside of the county to see a specialist; I don't know why that is, but I find that to be a big concern when you want to see someone specialized, and there is no one nearby."* The concern raised by focus group participants regarding access to specialists was considered to be the result of workforce shortages that, like other industries, health care continues to encounter. *The workforce [shortage] is huge, and this is universal; we can't find nurses or doctors."* Data on the ratio of the population per providers can be found in Appendix F, which shows a slightly more positive ratio in Monmouth County (840:1 primary care providers, 330:1 mental health providers) compared to New Jersey overall.

Community Vision and Suggestions for the Future

Interviewees and focus group participants were asked about their vision for the community for the next five years, including their suggestions for future programs, services, and initiatives. Several suggestions emerged, the most frequently discussed included supporting multi-sector approaches to community health, expanding, and strengthening behavioral health services, fostering collaboration that strengthens coordination and access to services, building trust through community engagement, and improving outreach and communication of social services and resources for residents.

Support and Advocate for Policies for Multi-Sector Approaches

When focus group and interview participants shared their vision for the future, several mentioned the importance of bringing together city, county, and federal agencies and multi-sector community partnerships to advance legislation jointly, advocate for additional funding, and develop programs to respond to local community health issues. Participants discussed that leveraging such resources would raise the visibility of key health issues, identify funding sources, and direct them to address the health needs of vulnerable populations, including persons that are persistently mentally ill, the disabled, the uninsured, and the undocumented, among others.

Expand and Strengthen Behavioral Health Services

Focus group and interview participants identified the need to continue addressing community mental health and substance misuse concerns. For example, participants recognized the importance of recruitment and retention of mental health providers working with the persistently mentally ill. Participants also recommended that efforts focus on improving care coordination for the dually diagnosed (mental health and substance abuse) and mental health outreach to youth in schools to help address the isolation and loss of normalcy resulting from the COVID-19 pandemic. Additional recommendations included developing and expanding efforts educate the public about the importance of mental health and destigmatizing mental health concerns, especially in communities of color, the undocumented, and those with limited English proficiency.

Foster Collaboration that Strengthens Coordination and Access to Services

Interviewees overwhelmingly voiced that collaboration and partnerships were vital. This sentiment came from individuals with a shared vision of improving the health and well-being of individuals, including the newly arrived, disabled, youth, veterans, and persons with mental health and substance abuse, as well as providing general health care to the most underserved in the community. As one interviewee shared, no agency or organization could "*go at it alone*." Additionally, several interviewees noted that the COVID-19 pandemic had forced a recognition that the virus did not recognize "*political turfs*." One interviewee also expressed the need to work together and "*play to each other's strengths*." Several interviewees shared that MMC was an example of a hospital working closely with faith-based and community-based organizations to bring health services to the community. Additional recommendations include uniformly adopting presumptive eligibility for charity care to reduce the administrative burden placed on patients waiting to have their application reviewed for eligibility and facilitate coordination of care between health providers. Finally, the shared sentiment was also seen as a need not to duplicate services but to coordinate accordingly, especially as funding sources were finite.

Build Trust through Community Engagement

Focus group participants often expressed frustration and dissatisfaction with their healthcare experience ranging from challenges in getting timely appointments or referrals to what many perceived to be little time spent with their provider to not understanding treatment for a diagnosis or the effects

of medication. Further, the administrative issues of dealing with health insurance coverage were also commonly a key point of frustration for participants. Interviewees agreed that while such matters were unfortunately not uncommon, efforts to engage with the community at all levels were essential to helping to foster a culture of trust as a source of health and wellness to residents. Additionally, interviewees highlighted that innovative efforts such as Monmouth ACTS (Assisting Communities Through Services) were essential to successfully build goodwill and trust between residents and health and community service providers. As one interviewee stated, *"It is all about building bridges."* Interviewees also highlighted the importance of working with a faith-based organization and community agencies to establish the community as a key source for feedback on what is and what is not working well and collaborate on solutions. As one interviewee expressed, *"it is critical to understand their challenges and where people are coming from."*

Improve Outreach and Communication of Social Services and Resources

Numerous focus group participants recommended the need for improved communication about existing local programs, especially those that focused on promoting health and wellness. Participants also highlighted the importance of using technology to share recreational opportunities with the public, encouraging residents to take advantage of local amenities, including parks and beaches. One focus group participant referenced a local website, *BizEturtle*, dedicated to highlighting local community events and activities in Monmouth County. Additionally, interviewees shared the importance of cities and counties working together to make the public aware of services available, including resources for older adults, the economically vulnerable, and others who might need resources or support. Recommendations included recruiting volunteers to call seniors and help keep them socially connected with what was happening as well as help connect them to local resources. One example highlighted by several veteran focus group participants was the importance of having a social worker housed at a local library branch in Long Branch. This was considered an essential resource for helping veterans and the general public with connecting to local social service agencies and resources.

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 Monmouth County during an unprecedented time given the COVID-19 pandemic and the national movement for racial justice. Several overarching themes emerged from this synthesis:

- ***The COVID-19 pandemic substantially impacted the health and wellbeing of residents in Monmouth County.*** The COVID-19 pandemic has affected all sectors of life and created substantial challenges for many. The impact of the COVID-19 pandemic and current economic conditions were a frequent topic of conversation in focus groups and interviews, and community survey respondents reported on the pandemic's negative effects, including on residents' emotional health. Participants also shared the impact of the pandemic on financial and mental well-being, education, access to healthcare, housing, transportation, and food security. Such hardship was also more likely felt by economically vulnerable residents, communities of color, the newly arrived, veterans, older adults, and persons with a disability. Like other communities, Monmouth County mobilized its partnerships in the community to distribute and provide much-needed resources, especially to those most in need.

- ***Monmouth County residents identified mental health as a significant community health concern exacerbated by the COVID-19 pandemic.*** Among Monmouth community survey respondents,

mental health issues ranked near the top (second to obesity) as a community health concern. As a result of the pandemic, unemployment, school closures, housing, and food insecurity, fear of the virus, and loss of friends and family are considered to have amplified levels of stress, anxiety, loneliness, grief, and depression, particularly among youth, people experiencing job loss, veterans, older adults, communities of color. Poverty and financial insecurity were also believed to have exacerbated mental health issues in the community. As one resident observed, *"economic hardships, elevated stress, social isolation, and growing behavioral health disorders [only] contributed to greater treatment needs."* Additionally, residents also noted that people turned to alcohol and drugs to cope with daily hardships such as isolation and financial loss. The limited treatment options, especially during the height of the pandemic to limit exposure to the coronavirus, made this situation even more challenging.

- ***Seniors, veterans, and persons with a disability continue to experience barriers that impact their quality of life.*** Focus group participants, interviewees, and community survey respondents highlighted the various amenities available to Monmouth County residents, including parks, libraries, beaches, and other entertainment venues, encouraging people to engage and participate in community life. However, community engagement remains a challenge for seniors, veterans, and people with a disability. In focus group discussions, a general theme emerged: the need to establish "pathways to community participation," whether volunteering, employment, or other activities that could improve their quality of life. For example, veterans who participated in focus groups discussion shared the need to contribute productively. Some recommend the need to encourage volunteerism among agencies looking for help, especially at a time of workforce shortages. As one veteran explained, *"[We need to] think about ways that we can engage and involve veterans to 'return to service' for their community, including volunteer opportunities so that we don't sit around and drink or eat, which leads to other issues. We need to feel that we can continue to help and volunteer."* Similarly, an interviewee in disability services discussed the importance of businesses and other agencies looking at persons with disability not as persons with a limitation but as workers and contributors, just like anyone else. Such opportunities were also seen as a way for communities to combat the stigma associated with disability.

- ***Lack of affordable health insurance coverage, provider shortages, and transportation top list of key barriers to accessing healthcare services.*** Monmouth focus group participants and interviewees identified several barriers to accessing healthcare services in their community, including not having health insurance or having limited forms of medical coverage, administrative burdens of applying for charity care, rising prescription costs, as well as long wait times for appointments and referrals, unreliable transportation, lack of trust in the medical system including a lack of cultural awareness among providers. Among community survey respondents, health insurance was the most commonly identified barrier to healthcare. For example, focus groups and interview participants discussed the rising cost of insurance coverage, *"Having insurance is a big challenge and, in particular, having the necessary coverage to access care. [Health insurance coverage] is a big issue, and people can keep up with costs, so you can't afford insurance."* Residents also identified the need for more providers, in particular specialists. Among interviewees, provider shortages were considered to be a result of the staffing shortages that resulted from the COVID-19 pandemic and the current job market associated with the recruitment of healthcare professionals. Lastly, residents reported delays in accessing medical care due to affordable, reliable, and convenient transportation options, especially for those with limited mobility, seniors, and persons with limited incomes.

- ***Established network of community-based organizations are considered core assets of Monmouth County.*** Community surveys and conversations with residents highlight an array of resources and amenities in place to support the quality of life in Monmouth County. However, the arrival of COVID-19 did place unprecedented stress on the community's social and economic livelihood and residents' health and well-being. At the height of such, agencies across Monmouth County came together to provide services to residents impacted by the COVID pandemic. Whether helping to address food insecurity, housing, transportation, or other needs, residents considered these resources integral to helping support the needs of Monmouth County residents. Across interviews with various community sectors, the general theme was that people, programs, and agencies came together and organized to support the most vulnerable. Additionally, residents highlighted the need to continue to make the community aware of services available to them, the importance of coordinating services, and building awareness of the community resources available to residents, especially the most vulnerable.

Prioritization Process and Priorities Selected for Planning

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

Criteria for Prioritization

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

Prioritization Criteria

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

Prioritization Process

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

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

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

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

- Unemployment
- Financial insecurity
- Food insecurity
- Housing
- Transportation
- Overweight/obesity

- Chronic disease (e.g., heart disease, cancer, diabetes)
- Mental health
- Substance use
- Access to healthcare services

Step 2: Data-Informed Voting via a Prioritization Meeting

On October 26, 2022, a 90-minute virtual community meeting was held with the Monmouth and Ocean County CHNA Advisory Committee Meeting (see Appendix A for members), so Advisory Committee members could discuss and vote on preliminary priorities for action. During the virtual prioritization meeting on Zoom, attendees heard a brief data presentation on the key findings from the CHNAs conducted across Monmouth and Ocean County.

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

At the end of the meeting, using Zoom's polling tool, participants were asked to vote for up to four of the ten priorities identified from the data and based on the specific prioritization criteria (Burden, Equity, Impact, Systems Change, Feasibility, Collaboration/Critical Mass, and Significance to Community). A total of thirty-four Advisory Committee members voted during the Community Prioritization Meeting.

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

	Percentage	Vote #s
Mental health	76.5%	26/34
Chronic disease	58.8%	20/34
Food insecurity	50.0%	17/34
Transportation	47.1%	16/34
Financial insecurity	47.1%	16/34
Housing	41.2%	14/34
Substance use	32.4%	11/34
Unemployment	23.5%	8/34
Access to healthcare services	20.6%	7/34
Overweight/obesity	11.8%	4/34

Key priority areas for the hospital will include mental health, chronic health conditions, food insecurity, and substance use as it also considers its existing expertise, capacity, and experience during the development of its implementation plan in 2023.

APPENDICES

Appendix A – Monmouth and Ocean County Advisory Committee Members
Appendix B – Organizations & Sectors Represented in Key Informant Interviews
Appendix C – Key Informant Interview Guide
Appendix D – Focus Group Guide
Appendix E – Resource Inventory
Appendix F – Additional Data Tables
Appendix G – Hospitalization Data
Appendix H – Cancer Data
Appendix I – Results and Outcomes Report of the Previous Implementation Plan

Appendix A- Advisory Committee Members

Name	Organization
Bahiyyah Abdullah	Toms River Area NAACP
Dorothy Amedu	Long Branch Housing Authority
Shari Beirne	RWJBarnabas Health Behavioral Health Center
Maureen Bowe MSN,RN	Monmouth Medical Center
Ty-Kiera	Family & Children's Services, Monmouth County
Enrico Cabredo	Monmouth County Health Department
Dr. Virginia Carreira	Long Branch Public School District
Allison Cerco	Hackensack Meridian Health
Michael Ciavolino	SCAN/Senior Citizens Activities Network
Joe Cuffari	RWJBH Behavioral Health Center
Peter Curatolo	Ocean County Health Department
Kelly DeLeon	Monmouth Medical Center Southern Campus
Jennifer Delgado	Visiting Nurse Association Group
Wendy DePedro	Mental Health Association of Monmouth County
Phillip Duck	Project Search
Suzanne Dyer	Parker Family Health Center
Doug Eagles	Boys & Girls Clubs of Monmouth County
George Echeverria	Monmouth County Health Department
Angelica Espinal-Garcia	Freehold Area Health Department
Kristine Fields	Community Medical Center
Margaret Fisher, MD	New Jersey Department of Health & Monmouth Medical Center
Marli Gelfand	Monmouth Medical Center
Robert Graebe, MD	OB/GYM Monmouth Medical Center
Ben Heinemann	BP Print Group & MMC/MMCSC Board of Trustees
David Henry	Monmouth County Regional Health Commission
Gretchen Insole	Ocean County YMCA
Margy Jahn	Monmouth County Health Department
Janet Jimenez	Monmouth Medical Center, Monmouth Medical Center Southern Campus
Kanesha Jones	Central Jersey Club
Pastor John Jones	Greater Bethel Church of God in Christ Lakewood
Dorothea Jones	Greater Bethel Church of God in Christ
Rabbi Yehudah Kaszirer	Bikur Cholim of Lakewood
Mike Kowal	City of Long Branch Health Department

Name	Organization
Dr. Teri Kubiel	Community Medical Center, Monmouth Medical Center Southern Campus
Marybeth Kwapniewski	SCAN/Senior Citizens Activities Network
Maria La Face	Ocean County Office of Senior Services
Zach Lewis	Lewis Consulting Group & MMC/MMCSC Board of Trustees
Sharon Lichter	Monmouth Medical Center, Monmouth Medical Center Southern Campus
Elliott Liebling	RWJBH Institute for Prevention and Recovery
Erna Alfred Liousas	U*Realized
Michael Litterer	RWJBH Institute for Prevention and Recovery
Pamela Major	Monmouth County CIACC
Jean McKinney	Monmouth Medical Center, Monmouth Medical Center Southern Campus
Christopher Merkel	Monmouth County Health Dept
Chaplain Barbara Miles	Sadie Vickers Community Resource
Emily Morales	CHEMED Health Center
Colleen Nelson	Visiting Nurse Association
Michaela Novo	Monmouth County Regional Health Commission
Beatriz Oesterveld	Community Affairs Resource Center
Debbie Patti	Community Medical Center
David Perez	Long Branch Free Public Library
SSG Christopher Petrizzo	New Jersey National Guard Counter Drug Task Force
Tanya Randall, MD	Central Jersey Club of the National Association of Negro Business and Professional Women's Clubs, Inc.
Daniel Regenye	Ocean County Health Department
Ashley E. Riker	Community Medical Center
Danny Rivera	Boys & Girls Club of Monmouth County
Betty Rod	NAALP
Johanna Rosario	Monmouth Medical Center
Sargent Melissa Rose	Ocean County Prosecutors Office
Maria Roussos	Ocean County Dept of Human Services
Brian Rumpf	Ocean County Health Department
Ashley Scardigno	Soldier On
Chaim Sender	Monmouth Medical Center Southern Campus
Robert Sickel	Pine Belt Enterprises Inc., MMC/MMCSC Board of Trustees
Marta Silverberg	Monmouth Family Health Center
Reverand Ronald Sparks	Bethel AME Church & SCAN/Senior Citizens Activities Network Board Chair
Triada Stampas	Fulfill

Name	Organization
Sarah Sternbach	Lakewood Resource and Referral Center
Patricia Thomas	Monmouth County Health Department
Abigail Thompson	LiveWell Center, Monmouth Medical Center
Deanna Tiggs	Monmouth Medical Center, Monmouth Medical Center Southern Campus
Christopher Tomaszewicz	Monmouth County Health Department
Kristina Veintimilla	Monmouth County Health Department
Anita Voogt	Brookdale Community College & Long Branch City Council
Shelby Voorhees	Ocean County Youth Services Commission
Tracy Walsh, PhD, MSN, RN	Ocean County College
Chedva Werblowsky	CHEMED Health Center
Deonna Williams-Square	Monmouth Medical Center
Sean Wright	Ocean County Department of Human Services
Phil Zimmerman	Ocean County Veteran Services Bureau

Appendix B- Organizations & Sectors Represented in Key Informant Interviews

Organization	Population/Sector
Bethel African Methodist Episcopal Church (Freehold, NJ)	Leaders in the faith community
Mental Health Association of Monmouth County (Trinton Falls, NJ)	Mental health providers/substance abuse prevention and treatment
Monmouth Family Health Center (Long Branch, NJ)	Healthcare providers
Boys & Girls Clubs of Monmouth County (Asbury & Redbank, NJ)	Public school staff/Those working in in youth-serving organizations (YSOs)
Parker Family Health Center (Redbank, New Jersey)	Those providing services to the newly arrived
Family Resources Associates (Red Bank & Brick, New Jersey)	Those working persons that are disabled/disability services
Family and Children Services, Monmouth County (Long Branch, NJ)	Those working to address discrimination and structural racism
HABCore, Inc (RedBank, NJ)	Those working food assistance and food insecurity/housing

Appendix C- Key Informant Interview Guide

Health Resources in Action
Monmouth & Ocean County
2022 Community Health Needs Assessment
Virtual Key Informant Interview Guide (May 6, 2022)

Goals of the key informant interview

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

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

I. BACKGROUND (5 MINUTES)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today.

- The Monmouth and Ocean County is a group of hospitals and community partners working together on a community health assessment effort to better understand residents' health 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 various community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future.

- We recognize this is a unique time we are in. Given the COVID-19 pandemic, an assessment of the community's needs and strengths is even more important than ever.

- Our interview will last about 45 – 60 minutes. After all the interview and focus group discussions are completed, we will be writing a summary report of the general themes that have emerged during these discussions. We will not include any names or identifying information in that report. All names and responses will remain confidential. Nothing sensitive that you say here will be connected directly to you in our report.

- Do you 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, for us to skip and move on to the next questions.

Do you have any questions before we begin?

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]

   [PROBE ON ORGANIZATION: What is your organization's mission/services? What communities do you work in? Who are the main clients/audiences?]

2. What are some of the biggest challenges your organization faces in conducting your work in the community?
   a. How have these changed during COVID-19? What new challenges do you anticipate going forward?

COMMUNITY PERCEPTIONS AND SOCIAL/ECONOMIC FACTORS (10 MINUTES)

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

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

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

6. 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; financial stress; food security; violence; employment; cultural understanding; language access; impacts of environmental problems and climate change, etc.] REPEAT QUESTIONS FOR DIFFERENT ISSUES]

7. What populations (geography, age, race, gender, income/education, etc.) do you see as being most affected by these issues?

   b. How has [ISSUE] affected their daily lives?

   c. How have these issues changed during/since COVID-19?

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

HEALTH ISSUES (10 MINUTES)

8. What do you think are the most pressing health concerns in the community/among the residents you work with? Why? [PROBE ON SPECIFICS. PROBE FOR HEALTH ISSUES NOT DIRECTLY RELATED TO COVID-19, OR ISSUES THAT HAVE CHANGED BECAUSE OF COVID-19]

   d. How has [HEALTH ISSUE] affected the residents you work with? [PROBE FOR DETAILS: IN WHAT WAY? CAN YOU PROVIDE SOME EXAMPLES?]
   e. From your experience, what are peoples' biggest challenges to addressing [THIS ISSUE]?

9. 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.]

10. 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?

***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 in Financial Instability, Employment, and Workforce Development

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

For Interviewees Working with Communities where Discrimination is a Concern

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

For Interviewees Working with Seniors/Older Adults

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

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

- Are there particular structural, institutional, or policy-related barriers that have affected the communities you work with in this region before the pandemic – and now?

- How has the pandemic impacted community members regarding substance use and mental health? *mention other KIIs have brought up suicide in youth; isolation in older populations
- What are your major concerns for the future? What has been going "right" that could be built on going forward?

For Interviewees Working with 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?

VISION FOR THE FUTURE (10 MINUTES)

11. 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?

    f. What do you see as the next steps in helping this vision become reality?

    g. We talked about a number of strengths or assets in the community. [MENTION POTENTIAL STRENGTHS- Community resilience, diversity, number of organization/services available, community engagement, etc.] How can we build on or tap into these strengths to move us towards a healthier community?

12. As you think about your vision, what do you think needs to be in place to support <u>sustainable</u> change?

    h. How do we move forward with lasting change across <u>organizations and systems</u>?

    i. Where do you see yourself or your organization in this?

13. We talked about a lot of issues today, if you had to narrow down the list to 3 or so issues – thinking about what would make the most impact, who is most affected by the issues, and how realistic it is to make change: What do you think are the 3 highest priority issues for future action? If there were greater investments made in your community, what 3 issues should receive this funding?

    OTHER

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

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?

Appendix D- Focus Group Guide

Health Resources in Action
Monmouth & Ocean County
2022 Community Health Needs Assessment
Focus Group Guide (Updated July 7, 2022)

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

I. BACKGROUND (5-10 minutes)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today. I hope you and your families are fine during these uncertain times.

- This discussion will last about 60 minutes. [DEPENDING ON FORMAT OF FOCUS GROUP] Please turn on your video, if possible, so that we can all see each other speaking. As a reminder, please keep yourself on MUTE until you want to speak.

NORMALLY, WE WOULD BE DOING THIS IN-PERSON AS A GROUP.

- 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.

- The Monmouth and Ocean County is a group of hospitals and community partners working together on a community health assessment effort to better understand residents' health 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 various 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 AUDIORECORDING] We plan to audio record these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the 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 concerns with me turning the recorder on now?
- Does everyone feel comfortable 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 questions. Please nod or unmute to communicate that you consent to be part of this focus group.

- 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 its <u>biggest strengths about your community - or the most positive things</u> 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 <u>biggest problems or concerns</u> 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 <u>you</u> deal with on a day-to-day basis? [PROBE ON ISSUES IF NEEDED – TRANSPORTATION, HOUSING AFFORDABILITY, ECONOMIC SECURITY, HEALTH CONCERNS, ETC.]

    b. How have these changed during COVID-19?

    c. What <u>specific population groups</u> do you think have been most at-risk for these issues in your community?

3. **In the past year, there has been <u>more national dialogue around racial injustice, inequity, and structural racism</u>.** 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 ***<u>health</u>*** concerns in your community?**

    a. How did these health issues affect your community? In what way?

        i. How have these changed during COVID-19?

    b. What <u>specific population group</u> are most at-risk for these issues?

5. Thinking about health and wellness, what makes it <u>easier</u> to be healthy in your community?

        i. What supports your health and wellness?

    b. What makes it <u>harder</u> 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.

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

7. Let's talk about [ISSUE]. *(Moderator to select one major issue discussed.)* What are some of the barriers or challenges residents face in dealing with [ISSUE]? [PROBE: BARRIERS TO SERVICES, ASSISTANCE, COORDINATION, SOCIAL/ECONOMIC FACTORS, DISCRIMINATION, ETC.]

    a. Thinking about your larger community environment – the services and resources available, your state and local policies or practices, etc. -- what do you see as some of the biggest challenges for your community to tackle this issue or make improvements?

    b. What do you think should happen in the community to address this issue? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

[REPEAT Q6 FOR 1-2 OTHER MAJOR ISSUES THAT WERE DISCUSSED]

V. VISION OF COMMUNITY HEALTH IMPROVEMENT AND INVOLVEMENT (10 minutes)

8. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see? What is your vision for the future?

    a. What do you think needs to happen in the community to make this vision a reality?

    b. Who should be involved in this effort?

9. We talked about a lot of things today. Thinking about what would make the most impact, who is most affected by the different issues we talked about, and how realistic it is to make change: **What do you think are the most important areas of action to improve health in your community?** If organizations and agencies are going to work together to tackle the community's biggest issues, what should they put at the top of the list?

VI. OTHER

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

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. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Have a good afternoon. [TALK ABOUT NEXT STEPS OF THE PROCESS, SPECIFICALLY HOW PARTICIPANTS CAN GET INVOLVED FURTHER OR RECEIVE THE FINAL REPORT OR SUMMARY OF THE REPORT.]

Appendix E- Resource Inventory

Monmouth County

Acute, Long Term Care and Medical Ambulatory Services

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
ADULT DAY HEALTH CARE SERVICES	13008	Active Day Adult Services	20 JACKSON STREET, 1-A	FREEHOLD	NJ	07728	MONMOUTH	(732) 845-3332	(732) 845-3339	ACTIVE DAY ADULT SOCIAL SERVICES, LLC
ADULT DAY HEALTH CARE SERVICES	556215	All In A Day Medical Daycare Center	104 PENSION ROAD	ENGLISHTOWN	NJ	07726	MONMOUTH	(732) 792-2273	(732) 792-2322	ALL IN A DAY ADULT MEDICAL DAY CARE, LLC
ADULT DAY HEALTH CARE SERVICES	83010	Allaire Care	1979 ROUTE 34 SOUTH	WALL	NJ	07719	MONMOUTH	(732) 974-7666	(732) 974-2261	R.H.C. ADC, INC
ADULT DAY HEALTH CARE SERVICES	13016	Caring Tree Adult Medical Daycare	51 JAMES WAY	EATONTOWN	NJ	07724	MONMOUTH	(732) 542-0363	(732) 542-0372	CARING TREE ADULT MEDICAL DAYCARE LLC
ADULT DAY HEALTH CARE SERVICES	558113	Golden Age Care	209 COMMERCIAL COURT	MORGANVILLE	NJ	07751	MONMOUTH	(732) 583-9999	(732) 583-3883	GOLDEN AGE CARE, LLC
ADULT DAY HEALTH CARE SERVICES	13001	Golden Years Care	108 WOODWARD ROAD	MANALAPAN	NJ	07726	MONMOUTH	(732) 851-6640	(732) 446-6898	GOLDEN YEARS CARE, LLC
ADULT DAY HEALTH CARE SERVICES	558100	Jersey Shore Adult Day Health Care Center	600 MAIN STREET	ASBURY PARK	NJ	07712	MONMOUTH	(732) 869-9090	(732) 988-2803	FIRST HEALTHCARE ASBURY PARK LLC
ADULT DAY HEALTH CARE SERVICES	13022	Matawan Adult Day Care	3996 COUNTY ROAD 516	MATAWAN	NJ	07747	MONMOUTH	(732) 391-8100	(732) 810-0291	MATAWAN ADULT DAY CARE LLC
ADULT DAY HEALTH CARE SERVICES	13009	Monroe Adult Day Care	24 DUGANS GROVE ROAD	MILLSTONE TWP	NJ	08535	MONMOUTH	(732) 851-6720	(732) 851-7925	24 DUGANS GROVE LLC
ADULT DAY HEALTH CARE SERVICES	13018AD	Neptune Adult Day Health Center, Inc	3405 ROUTE 33	NEPTUNE	NJ	07753	MONMOUTH	(732) 918-0663	(732) 922-0759	NEPTUNE ADULT DAY HEALTH CENTER, INC.
ADULT DAY HEALTH CARE SERVICES	FNP72Z	Royal Senior Care	1041 (500) HIGHWAY 36	ATLANTIC HIGHLANDS	NJ	07716	MONMOUTH	(732) 291-0710		FIVE STAR DAY CARE LLC
ADULT DAY HEALTH CARE SERVICES	AD13001	Senior Comfort Adult Medical Day Care	3 PARAGON WAY, SUITE 150	FREEHOLD	NJ	07728	MONMOUTH	(732) 984-6380	(732) 984-6424	SENIOR COMFORT LLC
ADULT DAY HEALTH CARE SERVICES	13007	We Care Adult Care, Inc	552A HIGHWAY 35 SOUTH	RED BANK	NJ	07701	MONMOUTH	(732) 741-7363	(732) 741-9188	WE CARE ADULT CARE, INC
ADULT DAY HEALTH CARE SERVICES	558110	Young at Heart of Eatontown	139 GRANT AVENUE	EATONTOWN	NJ	07724	MONMOUTH	(732) 578-1888	(732) 935-7509	RIVAARON LLC
AMBULATORY CARE FACILITY	23955	ATLANTIC MEDICAL IMAGING WALL TOWNSHIP	2399 NORTH HIGHWAY 34	MANASQUAN	NJ	08736	MONMOUTH	(732) 292-9980	(732) 292-9950	ATLANTIC MEDICAL IMAGING
AMBULATORY CARE FACILITY	23176	ATRIUM DIAGNOSTIC IMAGING. L.L.C.	224 TAYLORS MILLS ROAD, SUITE 108	MANALAPAN	NJ	07726	MONMOUTH	(732) 431-7600	(732) 431-1606	ATRIUM DIAGNOSTIC IMAGING, LLC
AMBULATORY CARE FACILITY	24878	BEACON OF LIFE	1075 STEPHENSON AVENUE	OCEANPORT	NJ	07757	MONMOUTH	(732) 592-3400	(732) 592-5401	ACUTECARE HEALTH SYSTEM, LLC
AMBULATORY CARE FACILITY	24429	CARDIOLOGY ASSOCIATES OF OCEAN COUNTY	2414 HIGHWAY 35 NORTH	MANASQUAN	NJ	08736	MONMOUTH	(732) 223-1170	(732) 223-1199	CARDIOLOGY ASSOCIATES OF OCEAN COUNTY
AMBULATORY CARE FACILITY	1511	CENTRAL JERSEY WOUND TREATMENT CENTER	1001 WEST MAIN STREET, SUITE B	EAST FREEHOLD	NJ	07728	MONMOUTH	(732) 637-6300	(732) 409-1364	CENTRASTATE MEDICAL CENTER, INC

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
AMBULATORY CARE FACILITY	22832	HEALTH VILLAGE IMAGING AT WALL	1975 HIGHWAY 34, BUILDING D	WALL	NJ	07719	MONMOUTH	(732) 974-8060	(732) 974-8038	HEALTH VILLAGE IMAGING, L.L.C.
AMBULATORY CARE FACILITY	24938	HER SPACE WOMEN'S HEALTH	300 STATE ROUTE 35 SOUTH	EATONTOWN	NJ	07724	MONMOUTH	(732) 571-9100	(732) 571-9650	BREAST IMAGING AND BIOPSY SPECIALISTS, LLC
AMBULATORY CARE FACILITY	23108	HOLMDEL IMAGING, LLC	100 COMMONS WAY, SUITE 110	HOLMDEL	NJ	07733	MONMOUTH	(732) 671-6618	(732) 671-7353	HOLMDEL IMAGING, LLC
AMBULATORY CARE FACILITY	24295	HUDSON LITHOTRIPSY LLC	331 NEWMAN SPRINGS RD - BLDG 1, 4TH FLR, STE 143	RED BANK	NJ	07701	MONMOUTH	(800) 852-5695	(800) 751-3655	HUDSON LITHOTRIPSY, L.L.C.
AMBULATORY CARE FACILITY	24303	JERSEY SHORE IMAGING LLC	2100 CORLIES AVENUE	NEPTUNE	NJ	07753	MONMOUTH	(732) 988-1234	(732) 988-8769	JERSEY SHORE IMAGING LLC
AMBULATORY CARE FACILITY	22709	MIDDLETOWN MEDICAL IMAGING	1275 ROUTE 35 NORTH	MIDDLETOWN	NJ	07748	MONMOUTH	(732) 275-0999	(732) 275-0979	MIDDLETOWN VENTURES ASSOCIATES, LLC
AMBULATORY CARE FACILITY	25146	MONMOUTH PAIN AND REHABILITATION, INC	1985 HIGHWAY 34 SOUTH, BUILDING A	WALL	NJ	07719	MONMOUTH	(732) 345-1377	(848) 469-8858	MONMOUTH PAIN AND REHABILITATION, INC
AMBULATORY CARE FACILITY	24296	NOTTINGHAM SURGICAL SERVICES LLC	125 HALF MILE ROD, SUITE 200	RED BANK	NJ	07701	MONMOUTH	(800) 852-5695	(800) 751-3655	NOTTINGHAM SURGICAL SERVICES, LLC
AMBULATORY CARE FACILITY	25099	OCEAN HEALTH INITIATIVES, INC	20 JACKSON STREET, SUITE E	FREEHOLD	NJ	07728	MONMOUTH	(732) 363-6655		OCEAN HEALTH INITIATIVES, INC.
AMBULATORY CARE FACILITY	23997	PERSONAL CARE MOLECULAR IMAGING	1514 HIGHWAY 138	WALL	NJ	07719	MONMOUTH	(732) 681-2700	(732) 681-2701	PCMI PERSONAL CARE MOLECULAR IMAGING
AMBULATORY CARE FACILITY	71370	PLANNED PARENTHOOD OF NCSNJ	69 EAST NEWMAN SPRINGS ROAD	SHREWSBURY	NJ	07702	MONMOUTH	(973) 879-1306	(973) 539-0180	PLANNED PARENTHOOD OF NCSNJ
AMBULATORY CARE FACILITY	24187	PRINCETON RADIOLOGY ASSOCIATES, PA	176 ROUTE 9 NORTH	ENGLISHTOWN	NJ	07726	MONMOUTH	(732) 577-2750	(732) 536-0805	PRINCETON RADIOLOGY ASSOCIATES
AMBULATORY CARE FACILITY	22464	PRINCETON RADIOLOGY ASSOCIATES, PA	901 WEST MAIN STREET	FREEHOLD	NJ	07728	MONMOUTH	(732) 462-4844	(732) 462-9482	PRINCETON RADIOLOGY ASSOCIATES
AMBULATORY CARE FACILITY	23457	PROFESSIONAL ORTHOPAEDIC ASSOCIATES	776 SHREWSBURY AVENUE SUITE 205	TINTON FALLS	NJ	07724	MONMOUTH	(732) 530-4949	(732) 345-8027	PROFESSIONAL ORTHOPAEDIC ASSOCIATES
AMBULATORY CARE FACILITY	25003	SHORE HEART GROUP-KEYPORT OFFICE	1 HIGHWAY 35	KEYPORT	NJ	07735	MONMOUTH	(732) 360-6333		SHORE HEART GROUP, P.C.
AMBULATORY CARE FACILITY	24021	SHREWSBURY DIAGNOSTIC IMAGING LLC	1131 BROAD STREET	SHREWSBURY	NJ	07702	MONMOUTH	(732) 578-9640	(732) 578-9649	MONMOUTH DIAGNOSTICS JOINT VENTURE LLC
AMBULATORY CARE FACILITY	24076	SLEEP DYNAMICS	2240 HIGHWAY 33, SUITE 114	NEPTUNE CITY	NJ	07753	MONMOUTH	(732) 455-3030	(732) 960-6611	SLEEP DYNAMICS, LLC
AMBULATORY CARE FACILITY	24976	SLEEP DYNAMICS	1000 HIGHWAY 35, SUITE 102	MIDDLETOWN	NJ	07748	MONMOUTH	(732) 455-3030	(732) 960-6611	SD MIDDLETOWN, L.L.C.

Mental Health Services

Acute Care Family Support
Monmouth Medical Center
300 Second Avenue
Long Branch, NJ 07740
(732) 923-6999

Early Intervention Support Services (Crisis Intervention Services)
Monmouth Medical Center
West Side Plaza
3301 Highway 66 - Building B, 1st Floor Neptune, NJ 07753
(732) 922-1042

Integrated Case Management Services
CPC Behavioral Healthcare 10 Industrial Way East Eatontown, NJ 07724
(732) 780-2012

Involuntary Outpatient Commitment
Legacy Treatment Center 68 Culver Rd
Monmouth, NJ 08852
(609)667 7526

Outpatient
Jersey Shore Medical Center
Parkway 100
3535 Rt. 66 – Building 5
Neptune, NJ 07753
(732) 643-4400

Outpatient
CPC Behavioral Healthcare
270 Highway 35
Red Bank, NJ 07701
(732) 842-2000

Outpatient
CPC Behavioral Healthcare
Aberdeen Counseling Center
1088 Highway 34
Aberdeen, NJ 07747
(732) 290-1700

Partial Care
Monmouth Medical Center
75 North Bath Avenue
Long Branch, NJ 07740
(732) 923-6500

County Mental Health Board
Monmouth Co. Div. of Mental Health & Addiction Services
3000 Kozloski Road
Freehold, NJ 07728
(732) 431-6451

Homeless Services (PATH)
Mental Health Association of Monmouth County
119 Ave @ the Commons - Suite 5
Shrewsbury, NJ 07701
(732) 542-6422

Intensive Family Support Services
Mental Health Association of Monmouth County
119 Avenue at the Common - Suite 5
Shrewsbury, NJ 07702
(732) 542-6422

Outpatient
Monmouth Medical Center
75 North Bath Avenue
Long Branch, NJ 07740
(732) 923-6500

Outpatient
Riverview Medical Center
Booker Behavioral Health
661 Shrewsbury Avenue
Shrewsbury, NJ 07702
(732) 345-3400

Partial Care
Riverview Medical Center
Booker Behavioral Health
661 Shrewsbury Avenue
Shrewsbury, NJ 07702
(732) 345-3400

Partial Care
CPC Behavioral Healthcare
1088 Highway 34
Aberdeen, NJ 07747
(732) 290-1700

PRIMARY SCREENING CENTER for MONMOUTH
Monmouth Medical Center
300 Second Avenue
Long Branch, NJ 07740
HOTLINE: (732) 923-6999

Emergency Services - *Affiliated w/Screening Center*
Centra State Medical Center
901 West Main Street
Freehold, NJ 07728
(732) 294-2595

Program of Assertive Community Treatment (PACT)
CPC Behavioral Healthcare
270 Highway 35
Red Bank, NJ 07701
(732) 842-2000

Self-Help Center
Freehold Self-Help Center
17 Bannard St., Suite 22
Freehold, NJ 07728
(732) 625-9485

Short Term Care Facility
Centra State Medical Center
901 West Main Street
Freehold, NJ 07728
(732) 294-2858

Supported Education
Preferred Behavioral Health
725 Airport Rd
Lakewood, NJ 08701
(732) 367-5439

Partial Care
Jersey Shore Medical Center
1011 Bond Street
Asbury Park, NJ 07712
(732) 869-2760 732-345-3400

Emergency Services - *Affiliated w/Screening Center Jersey Shore University Medical Center*
1945 Corlies Avenue, Route 33
Neptune, NJ 07753
(732) 776-4555

Emergency Services - *Affiliated w/Screening Center Riverview Medical Center*
1 Riverview Plaza
Red Bank, NJ 07701
(732) 450-2870

Residential Services
Easter Seal Society of NJ
615 Hope Road
Victoria Plaza
Eatontown, NJ 07712
(732) 380-0390

Self-Help Center
The C.A.R.E. Center
80 Steiner Ave.
Neptune City, NJ 07753
(732) 455-5358

Short Term Care Facility
Monmouth Medical Center/St. Barnabas 300 Second Avenue
Long Branch, NJ 07740
(732) 923-6901

Supported Employment Services
CPC Behavioral Healthcare
1088 Highway 34
Aberdeen, NJ 07747
(732) 290-1700

Community Support Services
CPC Behavioral Healthcare
1088 Highway 34
Aberdeen, NJ 07747
(732) 290-1700

Community Support Services
Mental Health Association of Monmouth 119 Ave @ the Commons –
Suite 5 Shrewsbury, NJ 07702
(732) 542-642

Community Support Services
Collaborative Support Programs of NJ (CSP)
11 Spring Street
Freehold, NJ 07728
(732) 780-1175

Community Support Services
Triple C Housing, Inc.
1 Distribution Way
Monmouth Junction, NJ 08852
(732) 297-5840

Systems Advocacy
City of Asbury Park
1 Municipal Plaza
Asbury Park, NJ 07712
(732) 502-5731

Voluntary Unit
Centra State Medical Center
901 West Main Street
Freehold, NJ 07728
(732) 294-2850

Voluntary Unit
Riverview Hospital
1 Riverview Plaza (Lower Level 1)
Red Bank, NJ 07701
(732) 530-2478

Community Support Services
Easter Seal Society of NJ
615 Hope Road - Building 3 - 1st Floor
Eatontown, NJ 07724
(732) 380-0390

Community Support Services
Declarations
223 Taylors Mills Road
Manalapan, NJ 07726
(732) 792-6990

Community Support Services
RHD Coastal Wellness
6 Industrial Way West
Suite F-17
Eatontown, NJ 07724
(732) 361-5845

Systems Advocacy
Community Health Law Project
One Main Street. Suite 413
Eatontown, NJ 07724
(732) 380-1012

Voluntary Unit
Monmouth Medical Center
300 Second Avenue
Long Branch, NJ 07740
(732) 923-6909

Voluntary Unit
Jersey Shore Medical Center
Rosa II
1945 Rt. 33
Neptune, NJ 07753
(732) 776-4369

Addiction Health Services

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

STATE OF NEW JERSEY
Department of Human Services
Division of Mental Health and Addiction Services

ADDICTION SERVICES TREATMENT DIRECTORY

Carole Johnson
Commissioner
Department of Human Services
(DHS)

Valerie Mielke
Assistant Commissioner
Division of Mental Health and Addiction Services
(DMHAS)

License No: 2000896 Agency Type: Non-Profit Phone No: 8665697233	**Services:** ○ Co-Occurring Treatment Services ○ Outpatient Treatment	**Address:** 1 INDUSTRIAL WAY WEST BUILDING A SUITE D EATONTOWN NJ 07724 **County:** Monmouth
Advanced Health and Education, LLC License No: 2000450 Agency Type: Non-Profit Phone No: 7329822674	**Services:** ○ Co-Occurring Treatment Services ○ Intensive Outpatient Treatment ○ Outpatient Treatment ○ Partial Care *IDRC affiliated:* **Yes**	**Address:** 3 Corbett Way Eatontown NJ 07724 **County:** Monmouth
Alexander Goldberg MD/DO NPI Number: 1952371734 Phone No: 732-577-1066	**Services:** ○ Medication-Assisted Treatment	**Address:** 224 Taylors Mills Rd 112 Manalapan New Jersey 07726 **County:** Monmouth
American Day CD Centers, LLC d/b/a/ High Focus Centers License No: 2000535 Agency Type: Profit Phone No: 7324747447	**Services:** ○ Intensive Outpatient Treatment ○ Outpatient Treatment *IDRC affiliated:* **Yes**	**Address:** 6 PARAGON WAY SUITE 104 FREEHOLD NJ 07728 **County:** Monmouth
Center for Network Therapy License No: 2000811 Agency Type: Profit Phone No: 7324315800	**Services:** ○ Ambulatory Withdrawal Management ○ Co-Occurring Treatment Services ○ Intensive Outpatient Treatment ○ Partial Care *IDRC affiliated:* **Yes**	**Address:** 20 GIBSON PLACE FREEHOLD NJ 07728 **County:** Monmouth
Community Rehab, Inc. License No: 2000533 Agency Type: Profit	**Services:** ○ Co-Occurring Treatment Services	**Address:** 3443 Rte 9 Suite 9

Phone No: 7324625553

- Intensive Outpatient Treatment
- Outpatient Treatment
- Partial Care

IDRC affiliated: **Yes**

Freehold NJ 07728
County: Monmouth

CPC Aberdeen Counseling Center
License No: 2000651
Agency Type: Non-Profit
Phone No: 7329352250

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

IDRC affiliated: **Yes**

Address:
1088 HIGHWAY 34
ABERDEEN NJ 07747
County: Monmouth

CPC Behavioral Healthcare, Inc.
License No: 2000332
Agency Type: Non-Profit
Phone No: 7328422000

Services:
- Ambulatory Withdrawal Management
- Co-Occurring Treatment Services
- Intensive Outpatient Treatment
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
270 HIGHWAY 35
RED BANK NJ 07701
County: Monmouth

CPC Freehold Counseling Center
License No: 2000659
Agency Type: Non-Profit
Phone No: 7327807387

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

IDRC affiliated: **Yes**

Address:
22 COURT STREET
FREEHOLD NJ 07728
County: Monmouth

CPC Howell Counseling Center
License No: 2000679
Agency Type: Non-Profit
Phone No: 7329878200

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

IDRC affiliated: **Yes**

Address:
4535, 4537 & 4539 US HIGHWAY 9
HOWELL NJ 07731
County: Monmouth

Crossroads of N.J. Management , LLC d/b/a Crossroads Treatment Center of Neptune
License No: 2000825

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

Address:
2040 SIXTH AVENUE
SUITE C & D
NEPTUNE NJ 07753
County: Monmouth

Agency Type: Non-Profit
Phone No: 7328073600

- Outpatient Treatment

IDRC affiliated: **Yes**

Diana Alavi
NPI Number: 1700276680
Phone No: 7327412700

Services:
- Medication-Assisted Treatment

Address:
1 Riverview Plz
Red Bank New Jersey 07701
County: Monmouth

Diana Alavi
NPI Number: 1700276680
Phone No: 7327870568

Services:
- Medication-Assisted Treatment

Address:
100 Main street
Keansburg New Jersey 07734
County: Monmouth

Diana Alavi
NPI Number: 1700276680
Phone No: 7327395000

Services:
- Medication-Assisted Treatment

Address:
727 North Beers Street
Holmdel New Jersey 07733
County: Monmouth

Discovery Institute for Addictive Disorder
License No: 2000037
Agency Type: Non-Profit
Phone No: 7329469444

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

IDRC affiliated: **Yes**

Address:
80 Conover Rd
Marlboro NJ 07746
County: Monmouth

Discovery Institute for Addictive Disorders, Inc.
License No: 1000051
Agency Type: Non-Profit
Phone No: 7329469444

Services:
- Co-Occurring Treatment Services
- Long Term Residential Substance Abuse Treatment
  Beds Capacity: 5 Available:3
- Short Term Residential Substance Abuse Treatment
  Beds Capacity: 95 Available:4
- Inpatient Withdrawal Management
  Beds Capacity: 20 Available:2

IDRC affiliated: **Yes**

Address:
80 CONOVER RD
MARLBORO NJ 07746
County: Monmouth

Epiphany House
License No: 2000336
Agency Type: Non-Profit
Phone No: 7327757020

Services:
- Co-Occurring Treatment Services
- Intensive Outpatient

Address:
1110 GRAND AVE
ASBURY PARK NJ 07712
County: Monmouth

Treatment
- Outpatient Treatment
- Partial Care

IDRC affiliated: **Yes**

Epiphany House, Inc.-Long Branch
License No: 1000105
Agency Type: Non-Profit
Phone No: 7327750720

Services:
- Co-Occurring Treatment Services
- Halfway House Substance Abuse Treatment
  Beds Capacity: 15 Available:0

Address:
373 BRIGHTON AVE
LONG BRANCH NJ 07740
County: Monmouth

IDRC affiliated: **Yes**

Francine Dygulski NP
NPI Number: 1831501618
Phone No: 908-391-0768

Services:
- Medication-Assisted Treatment

Address:
1 Riverview Plz
Red Bank New Jersey 07701
County: Monmouth

Gateway Day Treatment Program
License No: 2000285
Agency Type: Non-Profit
Phone No: 7329220591

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

Address:
1 CENTER ST
OCEAN NJ 07712
County: Monmouth

IDRC affiliated: **Yes**

Habit Opco, Inc. d/b/a Central Jersey Comprehensive Treatment Center
License No: 2000490
Agency Type: Non-Profit
Phone No: 7327272555

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

Address:
111 HIGHWAY 35, SUITE 7
CLIFFWOOD NJ 07721
County: Monmouth

IDRC affiliated: **Yes**

Harbor Wellness & Recovery Center, LLC
License No: 2000800
Agency Type: Unknown
Phone No: 8556983554

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

Address:
2139 HIGHWAY 35 N., SUITE 120
HOLMDEL NJ 07733
County: Monmouth

IDRC affiliated: **Yes**

HMH Hospitals Corporation - Jersey Shore University Medical Center
License No: 2000673
Agency Type: Unknown
Phone No: 7326434400

Services:
- Intensive Outpatient Treatment
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
1200 JUMPING BROOK RD.
NEPTUNE NJ 07753
County: Monmouth

HMH Hospitals Corporation - Riverview Medical Center
License No: 2000672
Agency Type: Unknown
Phone No: 7323453400

Services:
- Intensive Outpatient Treatment
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
661 SHREWSBURY AVE
SHREWSBURY NJ 07702
County: Monmouth

Jewish Family and Children's Service of Greater Monmouth County
License No: 2000519
Agency Type: Non-Profit
Phone No: 7327746886

Services:
- Intensive Outpatient Treatment
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
705 SUMMERFIELD AVE
ASBURY PARK NJ 07712
County: Monmouth

JSAS Healthcare, Inc.
License No: 2000316
Agency Type: Non-Profit
Phone No: 7329888877

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

IDRC affiliated: **Yes**

Address:
685 NEPTUNE BLVD
NEPTUNE NJ 07754
County: Monmouth

Middletown Medical, LLC
License No: 2000404
Agency Type: Non-Profit
Phone No: 7327061300

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

IDRC affiliated: **Yes**

Address:
600 State Hwy 35
Middletown NJ 07748
County: Monmouth

Morning Glory Behavioral Health Partial Care Program, LLC
License No: 2000694
Agency Type: Unknown
Phone No: 7329189905

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

IDRC affiliated: **Yes**

Address:
645 Neptune Boulevard
Neptune NJ 07753
County: Monmouth

Morris Antebi MD
NPI Number: 1578532404
Phone No: 6096458884

Services:
- Medication-Assisted Treatment

Address:
108 Main St
Oceanport New Jersey 07757
County: Monmouth

Muhammad Abbas MD/DO
NPI Number: 1396955951
Phone No: 732-840-5266

Services:
- Medication-Assisted Treatment

Address:
1011 Bond St
Asbury Park New Jersey 07712
County: Monmouth

New Hope Foundation, Inc.
License No: 1000053
Agency Type: Non-Profit
Phone No: 7329463030

Services:
- Co-Occurring Treatment Services
- Short Term Residential Substance Abuse Treatment
  Beds Capacity: 68 Available:8
- Inpatient Withdrawal Management
  Beds Capacity: 34 Available:3

IDRC affiliated: **Yes**

Address:
80 Conover Road
Marlboro NJ 07746
County: Monmouth

New Hope Foundation, Inc., Epiphany House, Inc.
License No: 1000058
Agency Type: Profit
Phone No: 7327750720

Services:
- Co-Occurring Treatment Services
- Halfway House Substance Abuse Treatment
  Beds Capacity: 18 Available:7

IDRC affiliated: **Yes**

Address:
300 FOURTH AVENUE
ASBURY PARK NJ 07712
County: Monmouth

New Hope Foundation, Inc., Phillips House Outpatient Services
License No: 2000110
Agency Type: Non-Profit
Phone No: 7328708500

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

IDRC affiliated: **Yes**

Address:
190 CHELSEA AVE
LONG BRANCH NJ 07740
County: Monmouth

New Hope Foundations's Phillip House Halfway House
License No: 1000020
Agency Type: Non-Profit
Phone No: 7328708500

Services:
- Co-Occurring Treatment Services
- Halfway House Substance Abuse Treatment
  Beds Capacity: 20 Available:1

Address:
190 CHELSEA AVE
LONG BRANCH NJ 07740
County: Monmouth

IDRC affiliated: **Yes**

New Hope Outpatient Services
License No: 2000307
Agency Type: Non-Profit
Phone No: 7323080113

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

IDRC affiliated: **Yes**

Address:
2 MONMOUTH AVE
FREEHOLD NJ 07728
County: Monmouth

Preferred Behavioral Health of NJ
License No: 2000648
Agency Type: Non-Profit
Phone No: 7326631800

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

IDRC affiliated: **Yes**

Address:
1405 HIGHWAY 35
OCEAN NJ 07712
County: Monmouth

Recovery Innovations, Inc.
License No: 2000002
Agency Type: Unknown
Phone No: 7323807061

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

IDRC affiliated: **Yes**

Address:
1 Corbett Way
Eatontown NJ 07724
County: Monmouth

Relevance, LLC
License No: 2000820
Agency Type: Profit
Phone No: 7327022242

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

IDRC affiliated: **Yes**

Address:
61 WEST MAIN STREET
FREEHOLD NJ 07728
County: Monmouth

RESA Treatment Center, LLC
License No: 2000640
Agency Type: Unknown
Phone No: 7324951474

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

IDRC affiliated: **Yes**

Address:
199 MAIN STREET 2A
KEANSBURG NJ 07734
County: Monmouth

Seabrook Shrewsbury

Services:

Address:

License No: 2000853
Agency Type: Unknown
Phone No: 7328893900

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

IDRC affiliated: **Yes**

21 WHITE STREET
SHREWSBURY NJ 07702
County: Monmouth

Seacrest Recovery Center North Jersey, LLC
License No: 2000701
Agency Type: Unknown
Phone No: 7328373323

Services:

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

IDRC affiliated: **Yes**

Address:
162 Route 35
Eatontown NJ 07724
County: Monmouth

Stress Care of New Jersey
License No: 2000593
Agency Type: Profit
Phone No: 7326794500

Services:

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

IDRC affiliated: **Yes**

Address:
4122 Route 516
Matawan NJ 07747
County: Monmouth

Stress Care of New Jersey, LLC
License No: 2000645
Agency Type: Profit
Phone No: 7326794500

Services:

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

IDRC affiliated: **Yes**

Address:
500 PARK AVENUE
MANALAPAN NJ 07726
County: Monmouth

SUSAN GENTILE NP
NPI Number: 1689792210
Phone No: 7323603522

Services:

- Medication-Assisted Treatment

Address:
195 ROUTE 9 STE 106
ENGLISHTOWN New Jersey 07726
County: Monmouth

The Counseling Center at Clark at Monmouth Junction
License No: 2000692
Agency Type: Unknown
Phone No: 7328824639

Services:

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

Address:
1110 CORNWALL ROAD
SUITE 111
MONMOUTH JUNCTION NJ 08852
County: Monmouth

IDRC affiliated: **Yes**

The Counseling Center of Freehold
License No: 2000454
Agency Type: Non-Profit
Phone No: 7324315300

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

IDRC affiliated: **Yes**

Address:
4345 Rte 9
Freehold NJ 07728
County: Monmouth

Township of Middletown Inc., Crossroads
License No: 2000506
Agency Type: Unknown
Phone No: 7326152277

Services:
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
730 Newman Springs Road
Lincroft NJ 07738
County: Monmouth

Unity Place of Monmouth County, LLC
License No: 2000616
Agency Type: Profit
Phone No: 8482082636

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

IDRC affiliated: **Yes**

Address:
1075 STEPHENSON AVENUE
OCEANPORT NJ 07757
County: Monmouth

Wall Youth Center and Community Services Department
License No: 2000192
Agency Type: Non-Profit
Phone No: 7326811375

Services:
- Intensive Outpatient Treatment
- Outpatient Treatment

IDRC affiliated: **Yes**

Address:
1824 S M ST
WALL NJ 07719
County: Monmouth

YMCA of Greater Monmouth County Family Services
License No: 2000341
Agency Type: Unknown
Phone No: 7322909040

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

IDRC affiliated: **Yes**

Address:
166 Main Street
Matawan NJ 07747
County: Monmouth

Appendix F- Additional Data Tables

Table 7. Survey Respondent Characteristics (n=669)

Age		Income	
Under 30	12.4%	Under $25,000	16.8%
30 to 49	37.1%	$25,000 to $50,000	24.7%
50 to 64	31.5%	$50,001 to $100,000	23.3%
65+	19.1%	$100,001 to $125,000	8.7%
Gender		$125,001 to $150,000	8.5%
Female	71.5%	$150,001 to $200,000	0.0%
Male	28.0%	Over $200,000	18.0%
Additional Gender Category/ Transgender	0.5%*	**Employment**	
Race/Ethnicity		Employed full-time	63.4%
African American/ Black	4.1%	Employed part-time	12.3%
Asian	18.4%	Student	2.4%
Hispanic/ Latino, Latino(a)	23.9%	Homemaker	3.3%
Multiracial	3.4%	Disabled	3.4%
White/ Caucasian	47.3%	Retired	11.1%
Other	2.9%	Unemployed	4.2%
Sexual Orientation		**Marital Status**	
Heterosexual	94.1%	Married	50.8%
Homosexual	2.1%	Single	26.8%
Bisexual	2.4%	Separated/divorced/widowed	14.2%
Additional Sexual Orientation	1.4%	Domestic partnership/civil union/living together	8.1%
Education			
Less than high school graduate or GED	5.4%		
High school graduate or GED	15.9%		
Some college	17.5%		
Associate or technical degree/certification	11.3%		
College graduate	25.3%		
Post graduate or professional degree	24.6%		

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

Table 8. Percent Change in Racial and Ethnic Distribution in New Jersey 2011-2020

	New Jersey			Monmouth County		
	2015	2020	% change	2015	2020	% change
Asian	9.0%	9.6%	0.6%	5.3%	5.4%	0.1%
Black or African American	12.7%	12.6%	-0.1%	6.7%	6.5%	-0.2%
Hispanic/ Latino, any race	19.0%	20.4%	1.4%	10.3%	10.9%	0.6%
White, non-Hispanic	57.2%	54.7%	-2.5%	75.9%	75.0%	-0.9%
Other	0.5%	0.6%	0.1%	0.2%	0.3%	0.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2020
NOTE: "Other" is represents those who identify as American Indian and Alaska Native, Native Hawaiian and Other Pacific Islander, and those identifying as another race or more than one race.

Table 9. Percent Change in Racial and Ethnic Distribution, by Town, 2011-2020

	Asian			Black or African-American		
	2015	2020	% change	2015	2020	% change
Allenhurst	1.9%	0.4%	-1.5%	0.0%	0.8%	0.8%
Asbury Park	0.3%	2.0%	1.7%	41.5%	40.2%	-1.3%
Atlantic Highlands	1.2%	0.8%	-0.4%	2.9%	0.0%	-2.9%
Belford	2.9%	0.8%	-2.1%	0.0%	0.0%	0.0%
Deal	0.8%	0.0%	-0.8%	0.3%	1.5%	1.2%
Eatontown	8.4%	7.9%	-0.5%	10.9%	7.6%	-3.3%
Fair Haven	1.0%	1.0%	0.0%	2.4%	3.0%	0.6%
Fort Monmouth	0.0%	0.0%	0.0%	13.7%	12.8%	-0.9%
Highlands	0.9%	4.3%	3.4%	1.9%	1.1%	-0.8%
Leonardo	0.5%	7.0%	6.5%	0.0%	0.0%	0.0%
Lincroft	8.4%	6.7%	-1.7%	0.8%	0.1%	-0.7%
Little Silver	1.3%	0.9%	-0.4%	0.4%	0.0%	-0.4%
Long Branch	2.4%	1.8%	-0.6%	12.7%	11.6%	-1.1%
Middletown	3.2%	3.6%	0.4%	0.9%	1.5%	0.6%
Monmouth Beach	0.3%	0.5%	0.2%	0.0%	0.0%	0.0%
Navesink	0.0%	3.4%	3.4%	9.8%	8.5%	-1.3%
Neptune	2.4%	2.2%	-0.2%	34.6%	32.0%	-2.6%
Oakhurst	2.6%	1.2%	-1.4%	1.2%	10.4%	9.2%
Ocean Grove	2.3%	1.5%	-0.8%	2.3%	0.6%	-1.7%
Oceanport	1.8%	3.9%	2.1%	1.8%	0.6%	-1.2%
Port Monmouth	1.6%	2.1%	0.5%	0.1%	2.1%	2.0%
Red Bank	2.2%	1.6%	-0.6%	13.3%	9.1%	-4.2%
Rumson	1.0%	2.7%	1.7%	0.7%	0.5%	-0.2%
Shrewsbury	1.1%	4.3%	3.2%	0.4%	0.4%	0.0%
West Long Branch	2.1%	0.6%	-1.5%	2.3%	6.2%	3.9%

	Hispanic/ Latino			White, NH			Other Race, NH		
	2015	2020	% change	2015	2020	% change	2015	2020	% change
Allenhurst	4.5%	4.7%	0.2%	90.5%	86.8%	-3.7%	0.0%	1.2%	1.2%
Asbury Park	32.1%	17.1%	-15.0%	24.0%	35.3%	11.3%	0.6%	0.8%	0.2%
Atlantic Highlands	3.8%	7.3%	3.5%	88.7%	91.9%	3.2%	0.7%	0.0%	-0.7%
Belford	9.9%	12.7%	2.8%	84.3%	84.0%	-0.3%	0.7%	0.0%	-0.7%
Deal	5.8%	19.1%	13.3%	93.1%	79.4%	-13.7%	0.0%	0.0%	0.0%
Eatontown	14.5%	12.3%	-2.2%	64.0%	66.8%	2.8%	0.3%	0.1%	-0.2%
Fair Haven	3.2%	1.6%	-1.6%	92.6%	94.2%	1.6%	0.0%	0.0%	0.0%
Fort Monmouth	33.9%	0.0%	-33.9%	44.4%	87.2%	42.8%	0.0%	0.0%	0.0%
Highlands	6.9%	3.1%	-3.8%	87.9%	88.1%	0.2%	0.9%	0.0%	-0.9%
Leonardo	7.9%	2.6%	-5.3%	90.6%	90.5%	-0.1%	0.6%	0.0%	-0.6%
Lincroft	3.6%	3.6%	0.0%	86.7%	89.1%	2.4%	0.0%	0.1%	0.1%
Little Silver	2.4%	3.3%	0.9%	94.7%	94.8%	0.1%	0.0%	1.0%	1.0%
Long Branch	30.6%	27.7%	-2.9%	51.5%	55.7%	4.2%	0.5%	0.9%	0.4%
Middletown	6.4%	6.5%	0.1%	88.2%	86.8%	-1.4%	0.2%	0.2%	0.0%
Monmouth Beach	5.2%	5.7%	0.5%	92.0%	93.2%	1.2%	0.0%	0.2%	0.2%
Navesink	7.0%	0.3%	-6.7%	82.3%	86.5%	4.2%	0.0%	0.0%	0.0%
Neptune	10.0%	11.9%	1.9%	49.6%	50.7%	1.1%	0.5%	0.7%	0.2%
Oakhurst	2.2%	3.0%	0.8%	92.7%	84.8%	-7.9%	0.0%	0.0%	0.0%
Ocean Grove	8.0%	6.9%	-1.1%	87.1%	90.5%	3.4%	0.0%	0.0%	0.0%
Oceanport	4.2%	6.9%	2.7%	90.7%	84.1%	-6.6%	0.0%	0.0%	0.0%
Port Monmouth	14.3%	8.1%	-6.2%	83.3%	85.2%	1.9%	0.0%	0.2%	0.2%
Red Bank	32.9%	26.8%	-6.1%	51.0%	61.7%	10.7%	0.0%	0.0%	0.0%
Rumson	3.2%	3.9%	0.7%	94.1%	91.3%	-2.8%	0.4%	0.0%	-0.4%
Shrewsbury	4.8%	1.5%	-3.3%	93.0%	92.6%	-0.4%	0.0%	0.0%	0.0%
West Long Branch	6.1%	6.3%	0.2%	87.8%	84.5%	-3.3%	0.2%	0.6%	0.4%

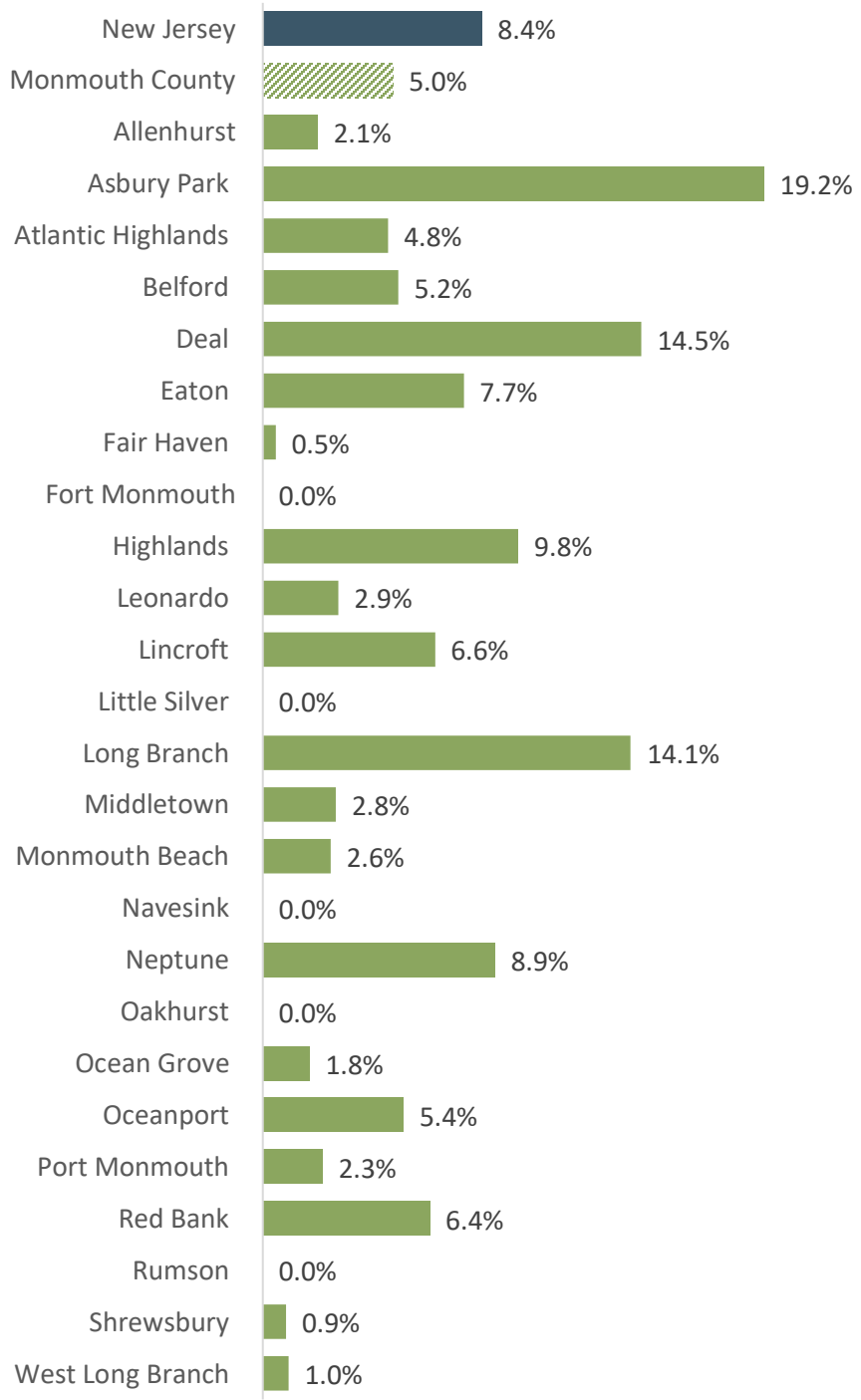
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2011-2015 and 2016-2020

Table 10. 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%
Monmouth County	48.7%	51.3%	48.7%	51.3%	0.0%	0.0%
Allenhurst	52.3%	47.7%	49.2%	50.8%	-3.1%	3.1%
Asbury Park	50.2%	49.8%	47.7%	52.3%	-2.5%	2.5%
Atlantic Highlands	47.5%	52.5%	53.7%	46.3%	6.2%	-6.2%
Belford	48.6%	51.4%	50.4%	49.6%	1.8%	-1.8%
Deal	50.3%	49.7%	46.8%	53.2%	-3.5%	3.5%
Eatontown	48.7%	51.3%	46.5%	53.5%	-2.2%	2.2%
Fair Haven	48.3%	51.7%	50.0%	50.0%	1.7%	-1.7%
Fort Monmouth	74.2%	25.8%	55.6%	44.4%	-18.6%	18.6%
Highlands	52.2%	47.8%	58.1%	41.9%	5.9%	-5.9%
Leonardo	45.9%	54.1%	49.0%	51.0%	3.1%	-3.1%
Lincroft	50.6%	49.4%	51.0%	49.0%	0.4%	-0.4%
Little Silver	46.7%	53.3%	48.5%	51.5%	1.8%	-1.8%
Long Branch	48.7%	51.3%	49.1%	50.9%	0.4%	-0.4%
Middletown	49.0%	51.0%	50.0%	50.0%	1.0%	-1.0%
Monmouth Beach	48.3%	51.7%	48.4%	51.6%	0.1%	-0.1%
Navesink	49.3%	50.7%	46.3%	53.7%	-3.0%	3.0%
Neptune	47.7%	52.3%	49.5%	50.5%	1.8%	-1.8%
Oakhurst	47.1%	52.9%	48.9%	51.1%	1.8%	-1.8%
Ocean Grove	40.3%	59.7%	44.3%	55.7%	4.0%	-4.0%
Oceanport	51.6%	48.4%	47.6%	52.4%	-4.0%	4.0%
Port Monmouth	52.6%	47.4%	43.2%	56.8%	-9.4%	9.4%
Red Bank	48.4%	51.6%	48.1%	51.9%	-0.3%	0.3%
Rumson	50.0%	50.0%	52.2%	47.8%	2.2%	-2.2%
Shrewsbury	45.7%	54.3%	46.7%	53.3%	1.0%	-1.0%
West Long Branch	45.1%	54.9%	43.9%	56.1%	-1.2%	1.2%

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

Figure 73. Households Receiving Food Stamps/SNAP, by State, County, and Town, 2016-2020



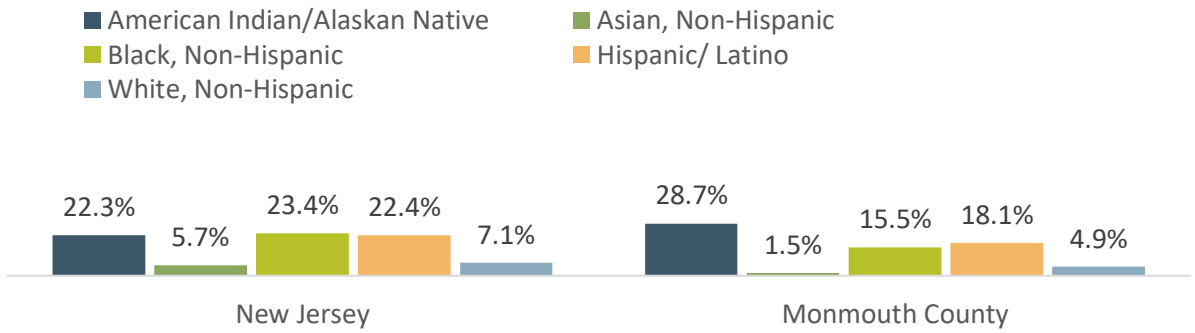
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 11. 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%
Monmouth County	3.4%	13.0%	14.9%	4.8%	21.9%
Allenhurst	0.0%	0.0%	0.0%	3.3%	0.0%
Asbury Park	10.1%	27.2%	26.2%	14.7%	40.8%
Atlantic Highlands	0.0%	100.0%	9.5%	3.2%	1.8%
Belford	0.0%	-	11.2%	4.5%	-
Deal	-	87.5%	30.7%	22.9%	30.4%
Eatontown	5.3%	8.0%	3.7%	8.8%	4.1%
Fair Haven	0.0%	0.0%	7.6%	2.9%	0.0%
Fort Monmouth	-	46.7%	-	19.6%	-
Highlands	9.3%	0.0%	5.4%	5.4%	100.0%
Leonardo	0.0%	-	0.0%	2.5%	-
Lincroft	9.2%	0.0%	0.0%	2.4%	0.0%
Little Silver	0.0%	-	0.0%	1.2%	0.0%
Long Branch	0.2%	19.1%	27.9%	13.2%	30.0%
Middletown	4.7%	1.2%	6.3%	3.6%	15.5%
Monmouth Beach	0.0%	-	0.0%	3.2%	0.0%
Navesink	0.0%	0.0%	0.0%	0.5%	-
Neptune	13.9%	15.7%	15.1%	4.2%	5.4%
Oakhurst	0.0%	0.3%	0.0%	2.2%	-
Ocean Grove	0.0%	0.0%	5.5%	4.8%	0.0%
Oceanport	0.0%	18.9%	0.0%	4.0%	-
Port Monmouth	44.2%	0.6%	0.0%	4.3%	0.0%
Red Bank	23.7%	10.9%	23.1%	5.7%	22.2%
Rumson	0.0%	19.4%	12.2%	2.6%	10.0%
Shrewsbury	0.0%	0.0%	36.7%	0.8%	0.0%
West Long Branch	0.0%	10.1%	3.4%	6.1%	0.0%

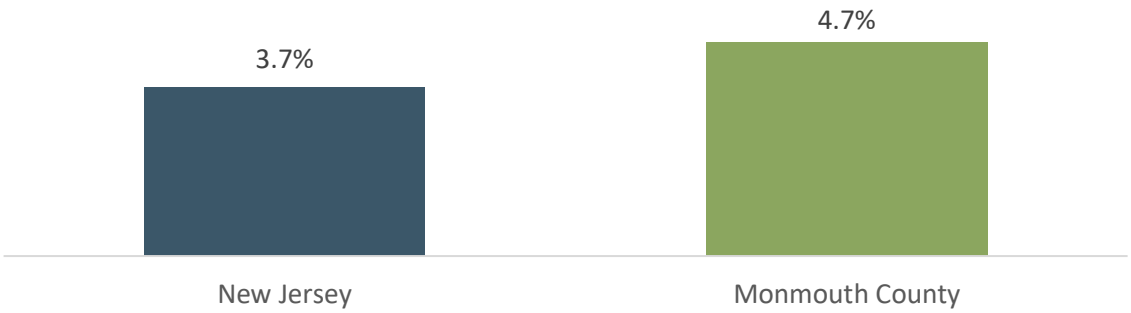
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 74. Children in Poverty, by State and County, 2019



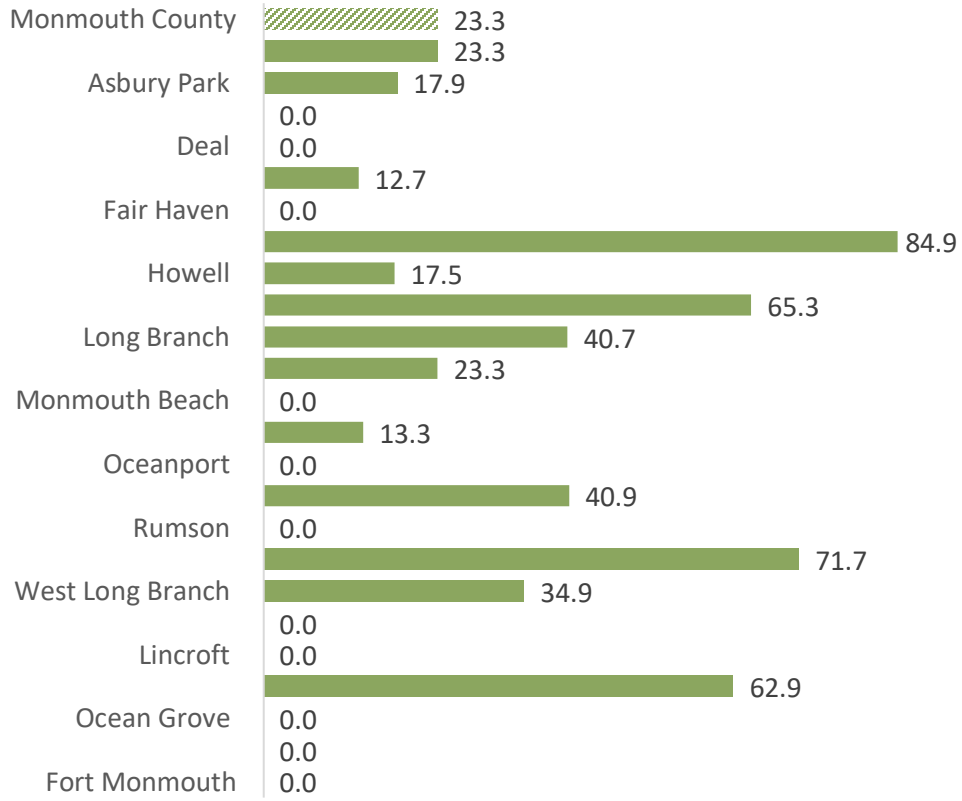
DATA SOURCE: U.S. Census Bureau, Small Area Income and Poverty Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Figure 75. Food Desert Among Residents, by State and County, 2019



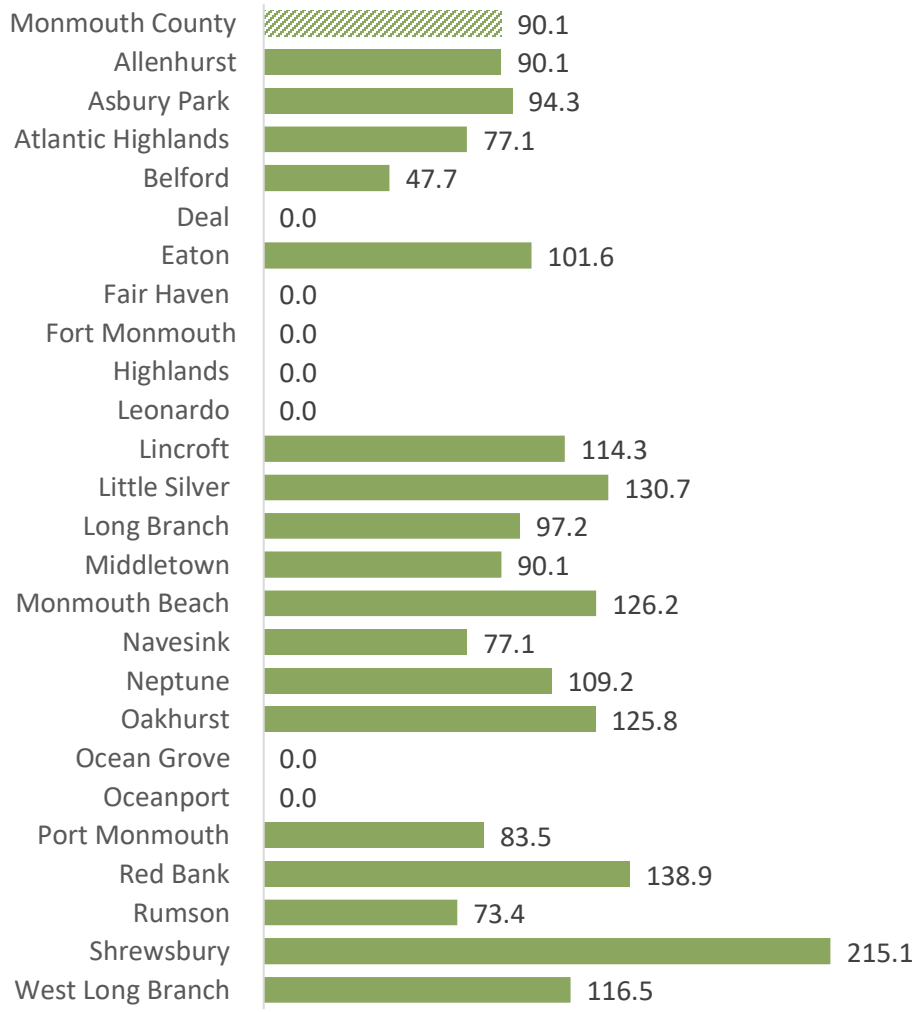
DATA SOURCE: U.S. Department of Agriculture, Economic Research Service, Food Access Research Atlas, 2019 , as reported by, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2022
NOTE: 2020 data are estimated projections based on available employment and poverty data, and were revised in March 2021; therefore data are subject to change.

Figure 76. Grocery Stores and Supermarkets per 100,000 by State, County, and Town, 2020



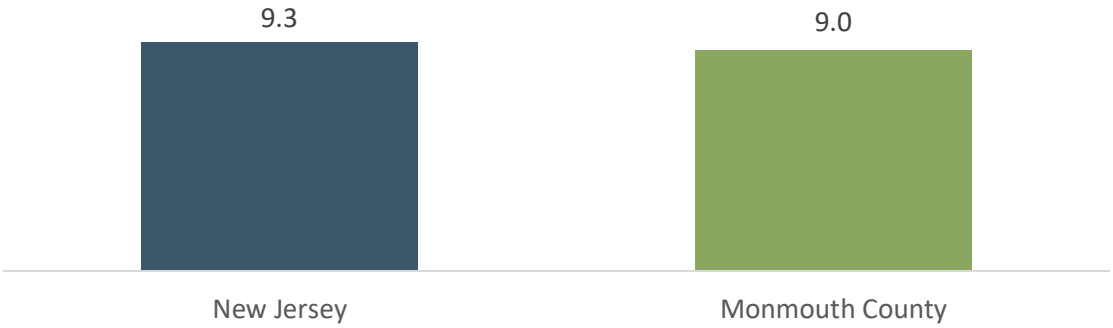
DATA SOURCE: Community Commons, Census County Business Patterns, analyzed by Center for Applied Research and Engagement Systems (CARES), 2020

Figure 77. 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

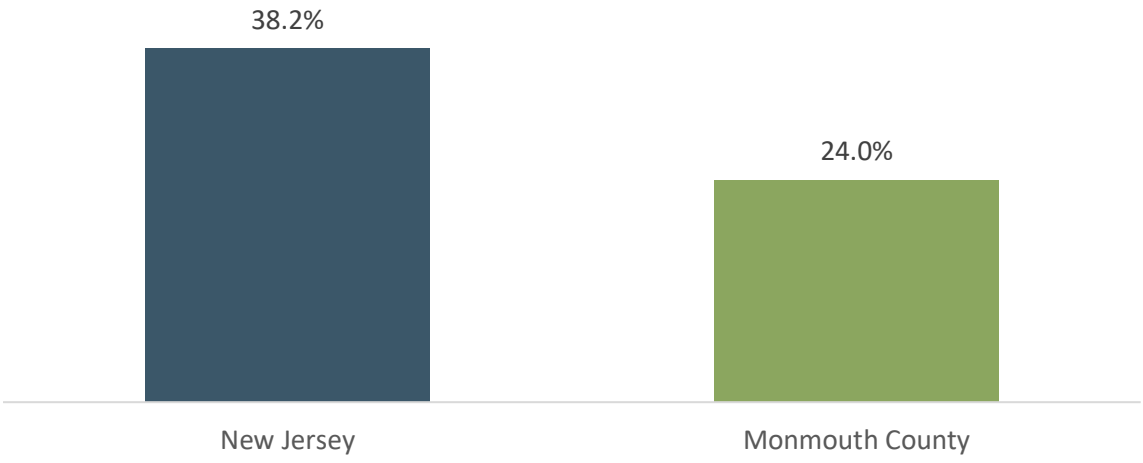
Figure 78. Food Environment Index, by State and County, 2019



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



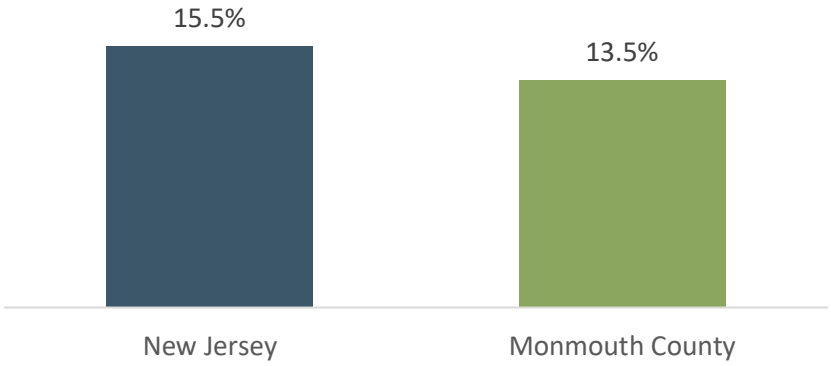
DATA SOURCE: National Center for Education Statistics, 2019-2020 from University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2021

Table 12. Age-Adjusted Mortality Rate per 100,000 population, by State and County, 2018-2020

	2018-2020
New Jersey	722.2
Monmouth County	710.0

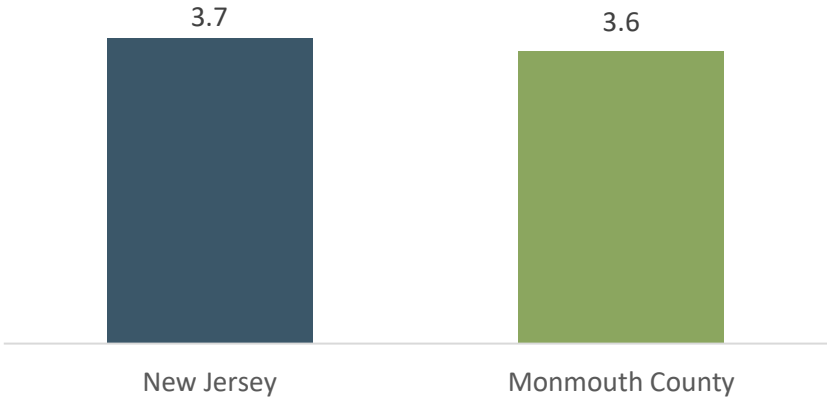
DATA SOURCE: New Jersey Department of Health, New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2018-2020

Figure 80. Percent Poor or Fair Health, by State and County, 2018



DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018

Figure 81. Poor Physical Health Days by State and County, 2018



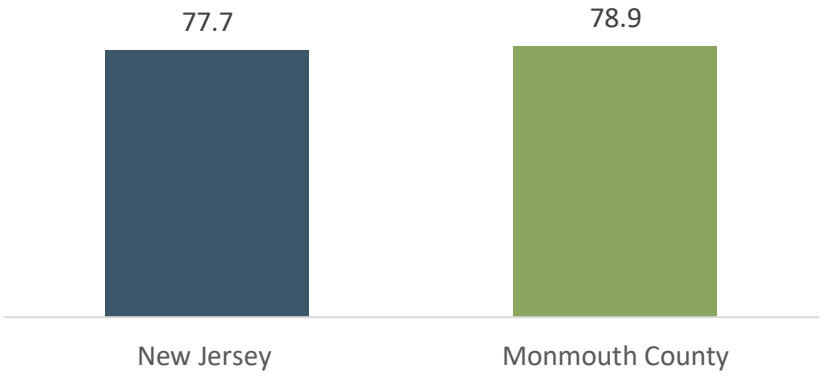
DATA SOURCE: Behavioral Risk Factor Surveillance System, as reported University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, 2018

Table 13. Community Need Index, by Zip Code in Counties, 2021

	Monmouth
Highest Need in County	Asbury Park, Keansburg, Long Branch (4.2)
Lowest Need in County	Allenwood (1)

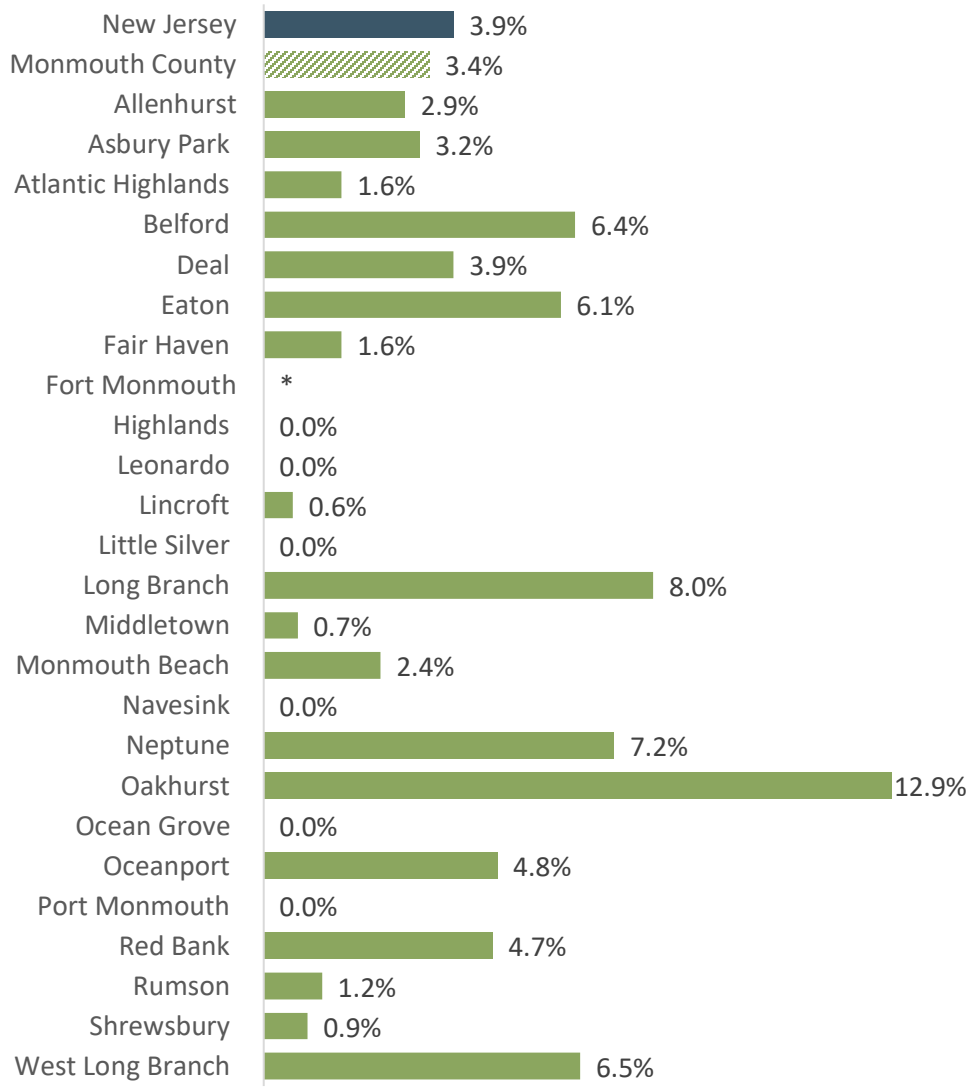
DATA SOURCE: Truven Health Analytics, 2021; Insurance Coverage Estimates, 2021; The Nielson Company, 2021; and Community Need Index, 2021.

Figure 82. Life Expectancy by State and County, 2020



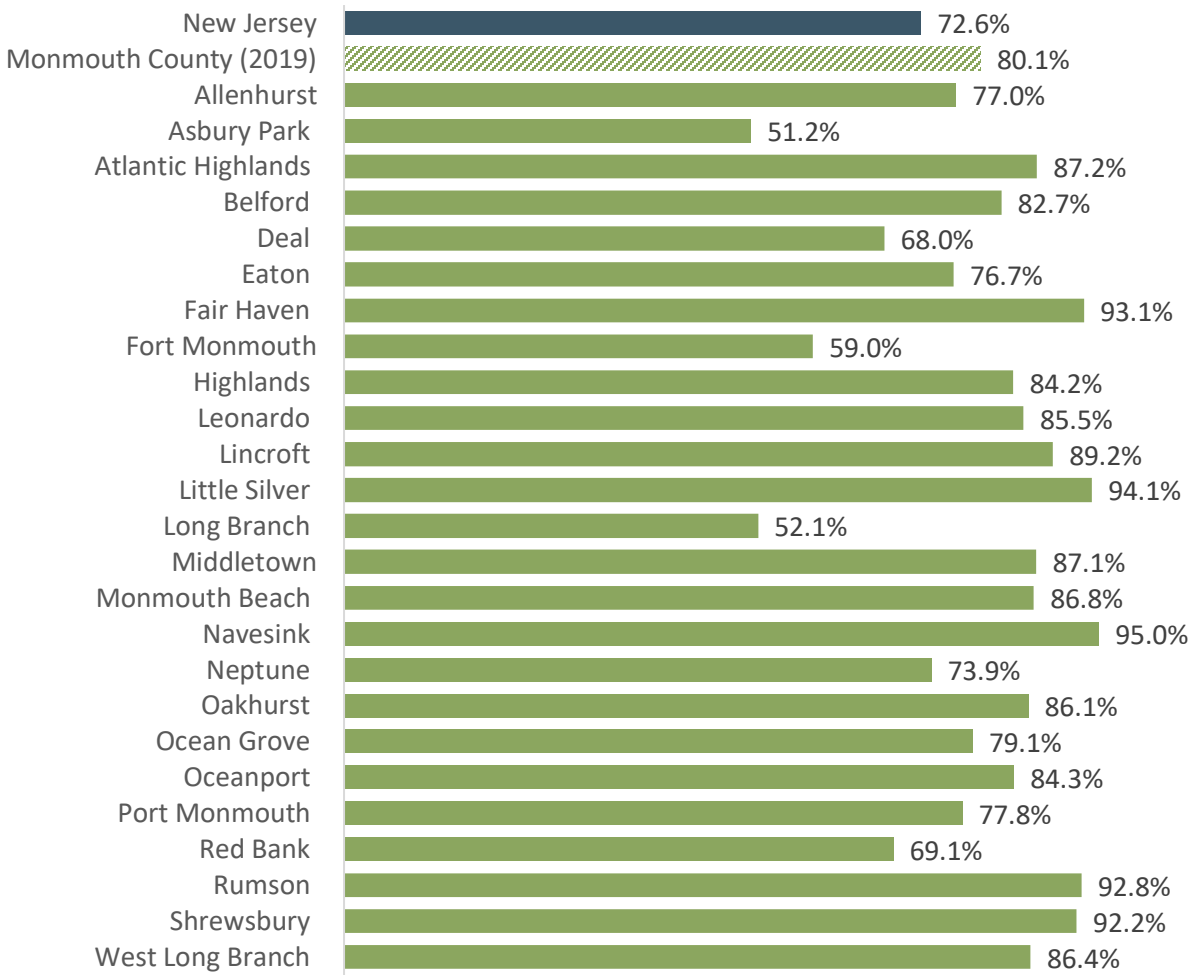
DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health 2020

Figure 83. Population Under 19 with No Health Insurance, by State, County, and Town, 2016-2020



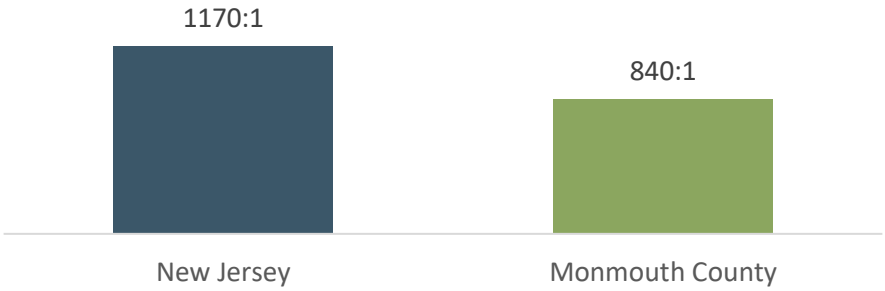
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable estimate

Figure 84. Population with Private Insurance, by State, County and Town, 2016-2020



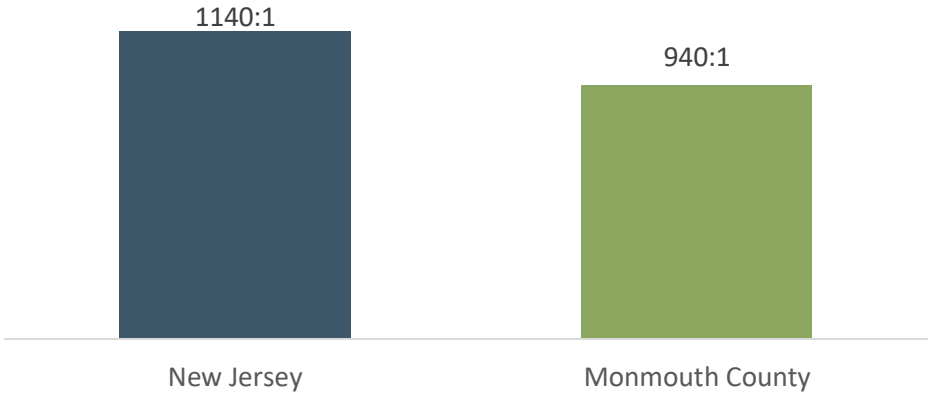
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020
NOTE: Data for Monmouth County is not available via 2016-2020 estimates. Data shown is a 2015-2019 estimate.

Figure 85. Ratio of Population to Primary Care Physicians, by State and County, 2019



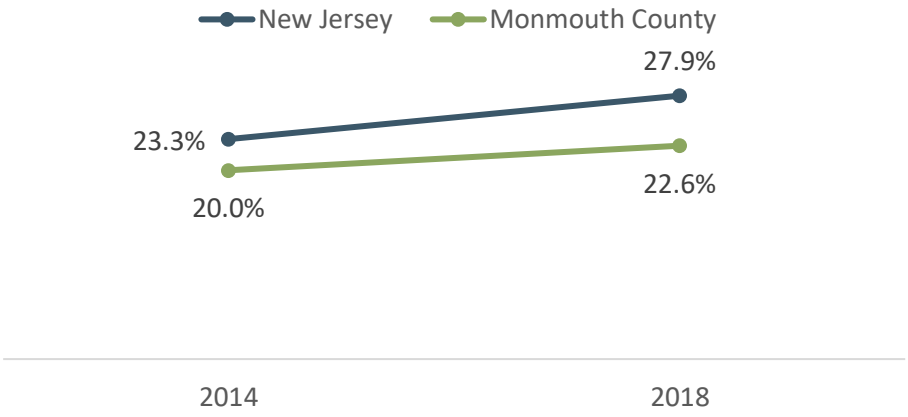
DATA SOURCE: American Medical Association, Area Health Resource File, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Figure 86. Ratio of Population to Dentists, by State and County, 2020



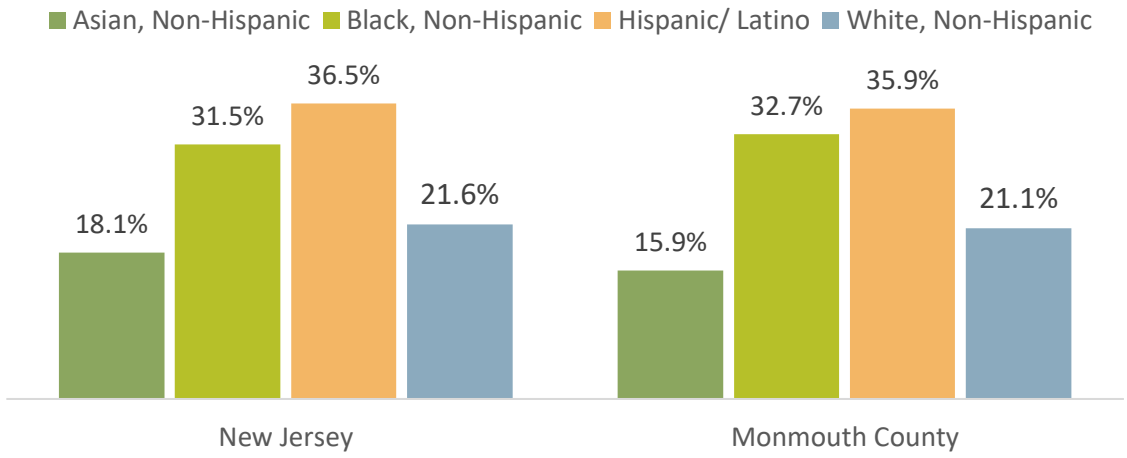
DATA SOURCE: National Provider Identification file, Centers for Medicare and Medicaid Services, Area Health Resource File, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2020

Figure 87. Percent Adults Reported to Have Had No Leisure Time Physical Activity, by State and County, 2014 and 2018



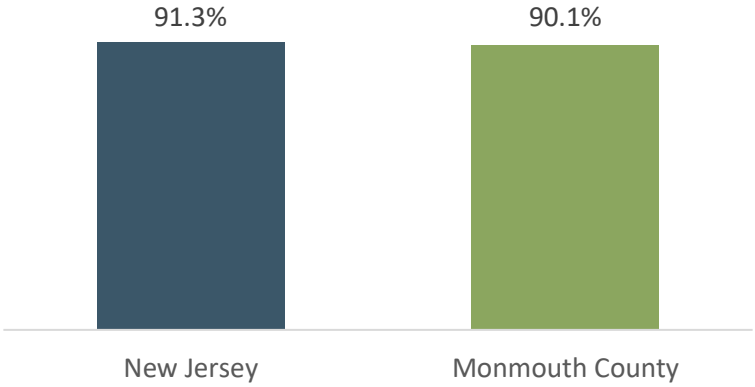
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2014 and 2018

Figure 88. Percent Adults Reported to Have Had No Leisure Time Physical Activity by Race/Ethnicity, by State and County, 2016-2020



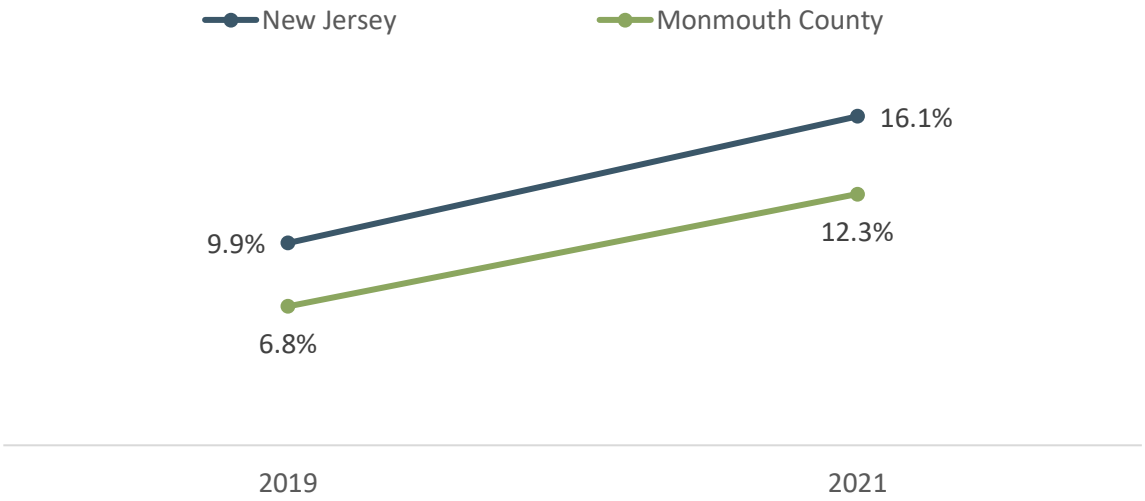
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Figure 89. Population with adequate access to location for physical activity, by State and County, 2010 and 2021



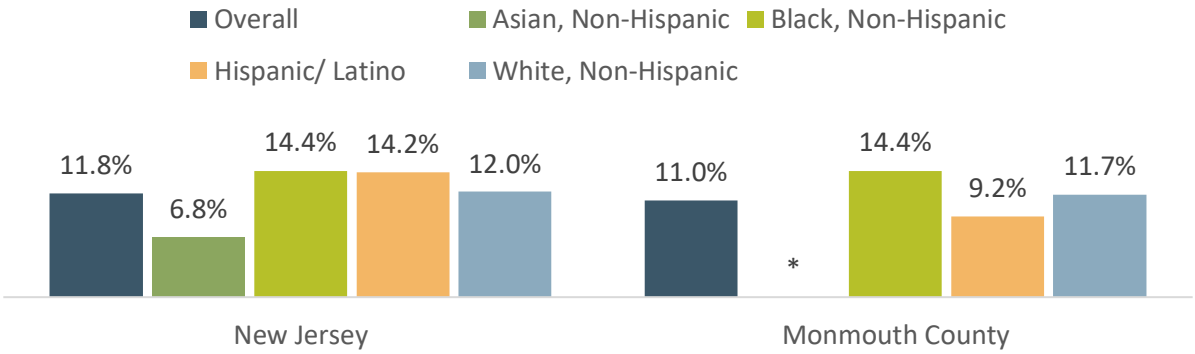
DATA SOURCE: ESRI & U.S. Census Tigerline Files, Business Analyst, Delorme map data, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2010 & 2021

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



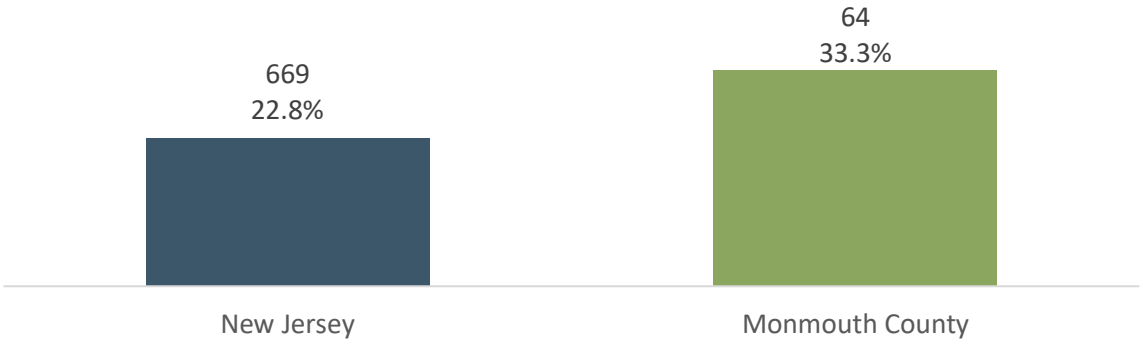
DATA SOURCE: Feeding America, Map the Meal Gap 2021
NOTE: 2021 data are projections of food insecurity levels in response to projected changes to annual unemployment and poverty due to COVID-19.

Figure 91. Percent Adults Reported Current Smokers, by State and County, 2017-2020



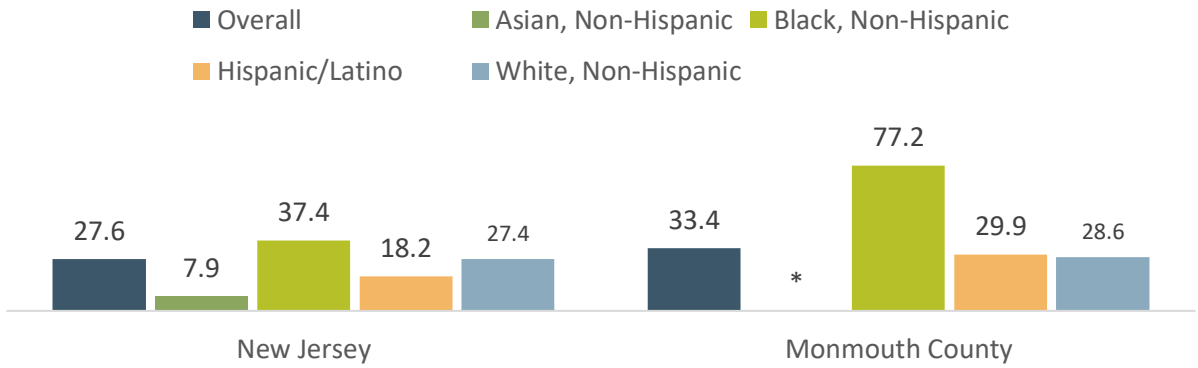
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2017-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 92. Alcohol-impaired Driving Deaths, by State and County, 2016-2020



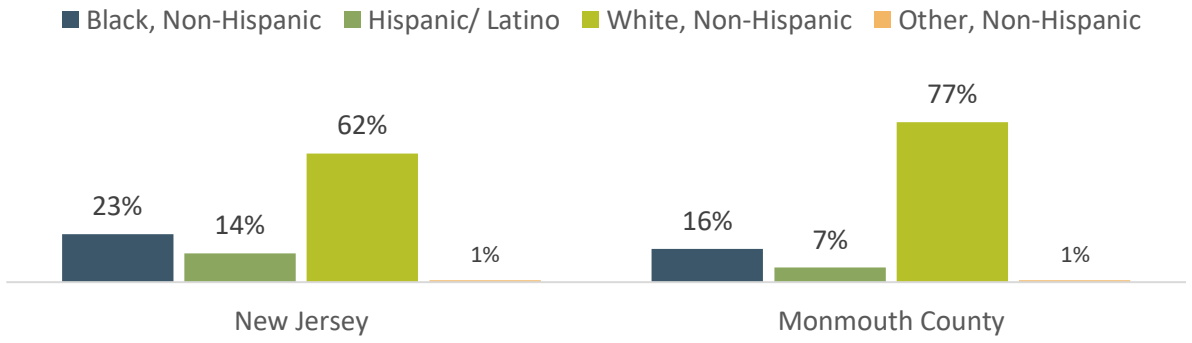
DATA SOURCE: Fatality Analysis Reporting System as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020

Figure 93. Pediatric Hospitalizations (Ages 19 and under) due to Mental Health per 10,000, by Race/Ethnicity, State, and County, 2020



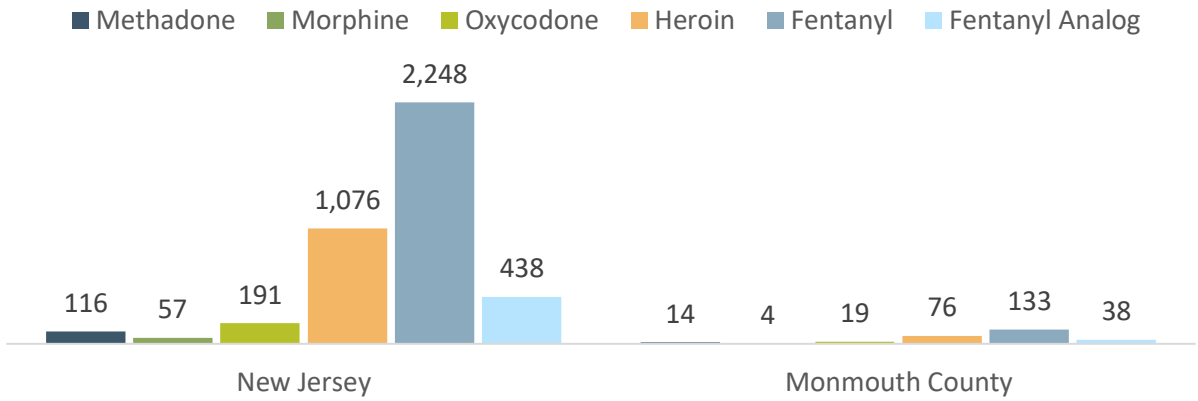
DATA SOURCE: New Jersey Department of Health, Office of Health Care Quality Assessment, New Jersey Data Collection System, as reported by New Jersey State Health Assessment Data (NJSHAD), 2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 94. Substance Use Treatment Admissions by Race/Ethnicity, by State and County, 2020



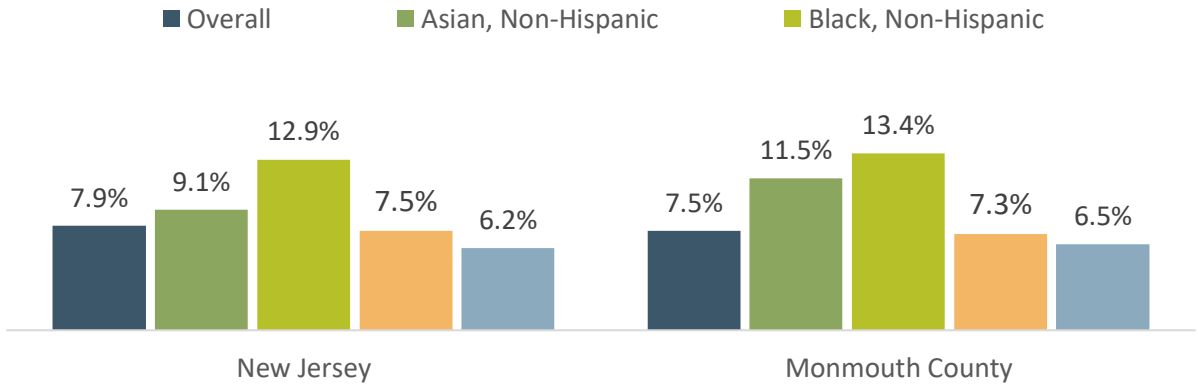
DATA SOURCE: New Jersey Department of Human Services, Division of Mental Health and Addiction Services, New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview, 2020

Figure 95. Count of Opioid Related Deaths by Drug, by State and County, 2019



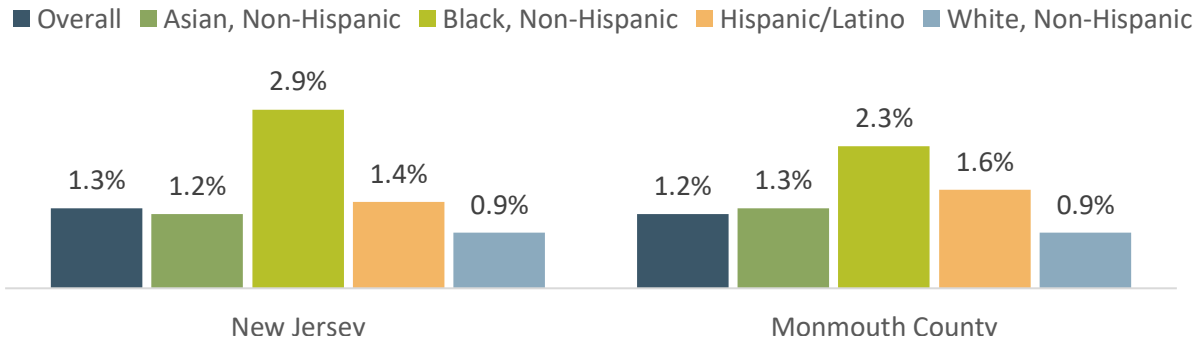
DATA SOURCE: Drug Deaths for 2019, New Jersey Office of the State Medical Examiner

Figure 96. Percent Low Birth Weight Births by Race/Ethnicity, by State and County, 2016-2020



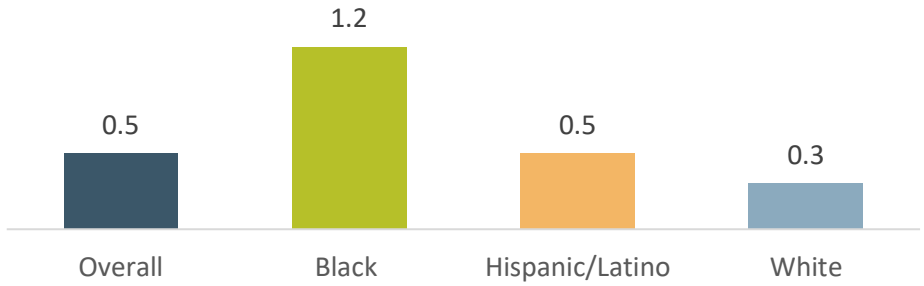
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020
NOTE: Low birth weight as defined as less than 2,500 grams

Figure 97. Percent Very Low Birth Weight Births by Race/Ethnicity, by State and County, 2016-2020



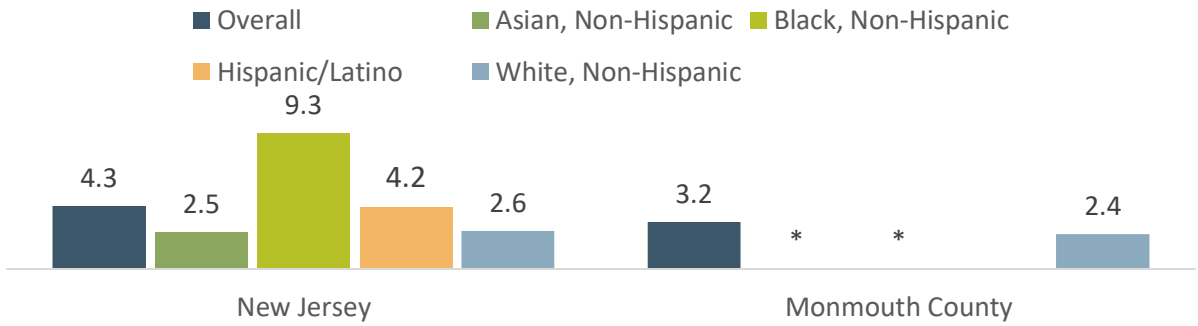
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018
NOTE: Very low birth weight is defined as less than 1,500 grams

Figure 98. Maternal mortality rate per 100,000 population, by State and Race/Ethnicity, 2015-2019



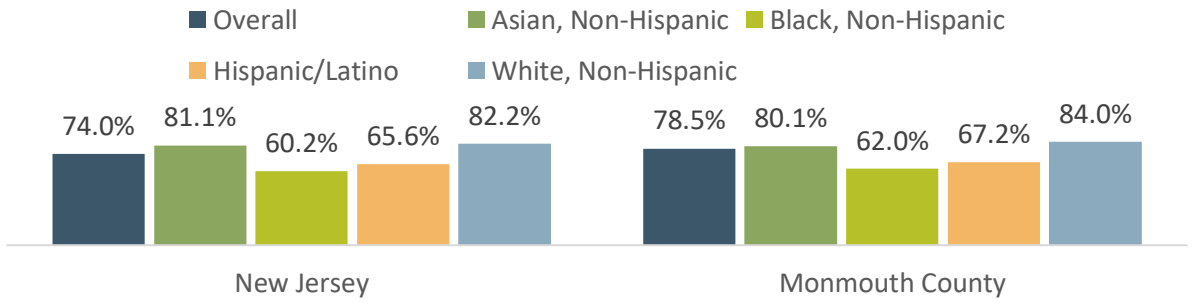
DATA SOURCE: New Jersey Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2015-2019

Figure 99. Infant Mortality Rate per 1,000 Births by Race/Ethnicity, by State, 2015-2019



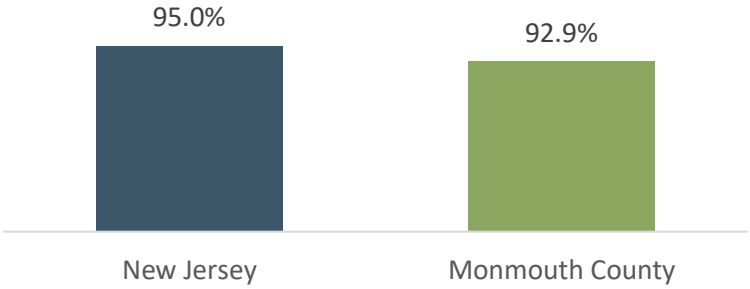
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2015-2019
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 100. Percent Births with Prenatal Care in First Trimester by Race/Ethnicity, by State, 2016-2020



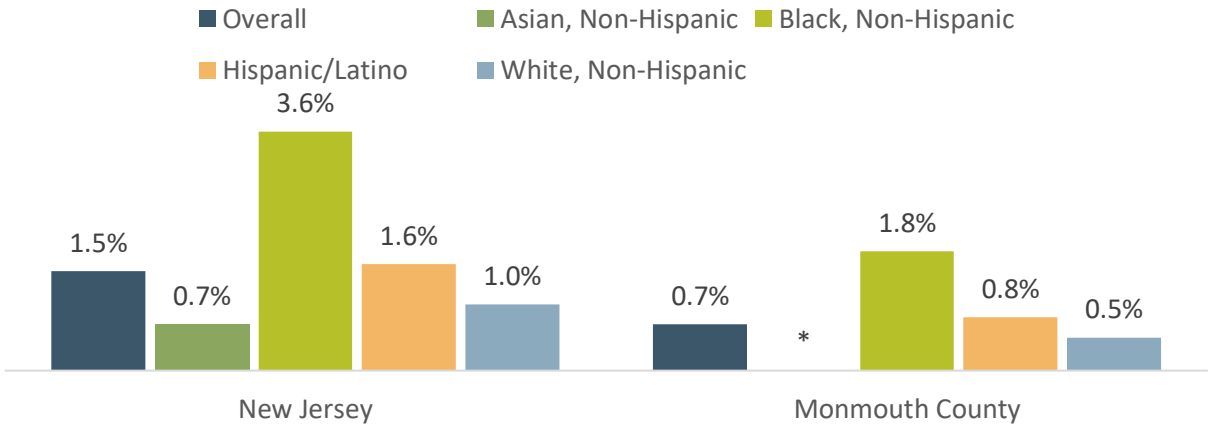
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020

Figure 101. Percent of Immunized Children, by State and County, 2017-2018



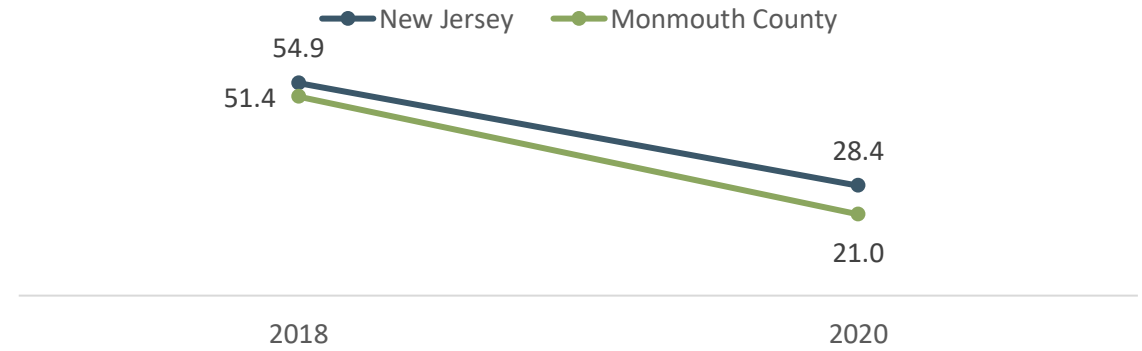
DATA SOURCE: Annual Immunization Status Reports, Communicable Disease Service, New Jersey Department of Health, as reported by New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2017-2018
NOTE: Includes childcare/preschool, Kindergarten/Grade 1 (entry level), Grade 6, and transfer students in any grade

Figure 102. Percent Births with No Prenatal Care Overall by Race/Ethnicity, by State, 2016-2020



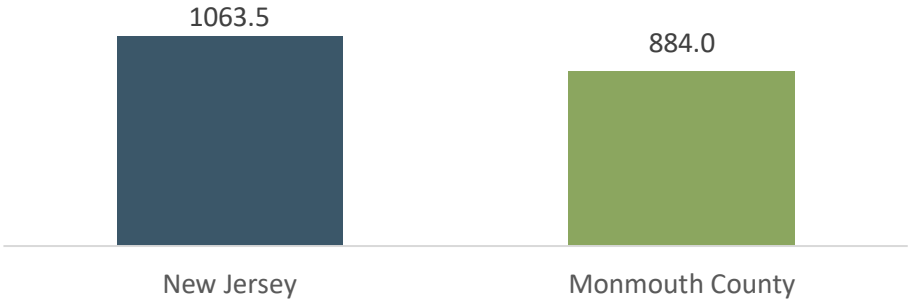
DATA SOURCE: New Jersey Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2016-2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 103. Age-Adjusted Asthma Emergency Department Visit Rate per 10,000 Population, by State and County, 2018 and 2020



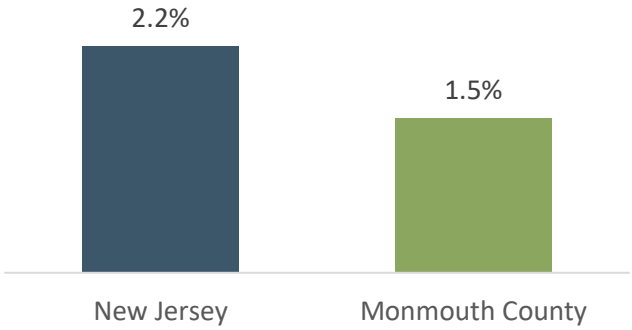
DATA SOURCE: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, New Jersey State Health Assessment Data (NJSHAD), 2018 and 2020
NOTE: Data includes ED visits where asthma was primary diagnosis

Figure 104. Age-Adjusted Rate of Asthma Hospitalizations, by State and County, 2020



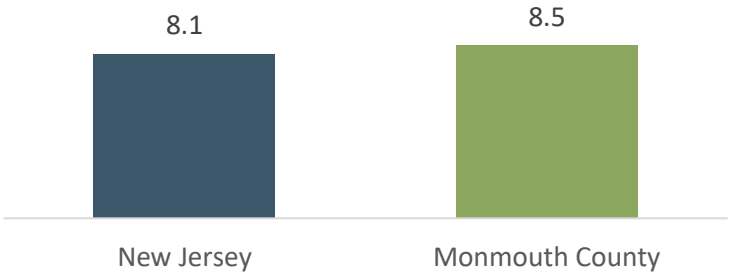
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2020
NOTE: Includes all asthma diagnoses, including primary, secondary, and other diagnoses.

Figure 105. Percent of Children Aged 1 -5 Years With Elevated Blood Lead Level (>= 5mcg/dL), by State and County, 2019



DATA SOURCE: Childhood Lead Exposure in New Jersey Annual Report, New Jersey Department of Public Health, Office of Local Public Health, Childhood Lead Program, State Fiscal Year 2019

Figure 106. Air pollution- particulate matter by State and County, 2018



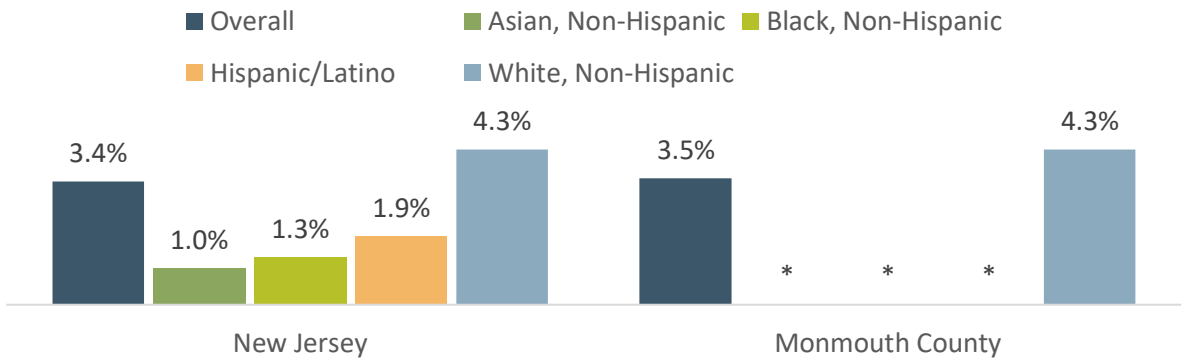
DATA SOURCE: Center for Disease Control and Prevention (CDC), Environmental Public Health Tracking Network, as reported by, County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2018

Table 14. Drinking Water Violations by County, 2020

	Z-score	Presence of Water Violation
Monmouth County	-1.75	No

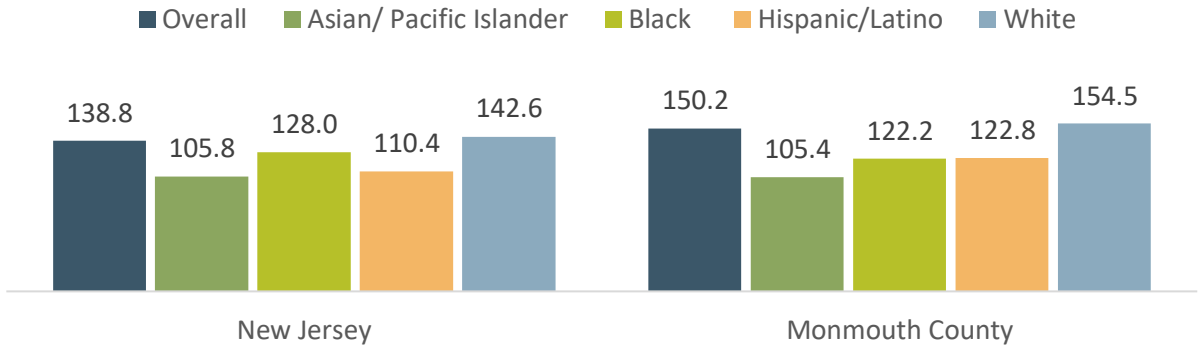
DATA SOURCE: Environmental Protection Agency, Safe Drinking Water Information System, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2020
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 107. Adults reporting angina or coronary heart disease, by State and County, by Race/Ethnicity, 2020



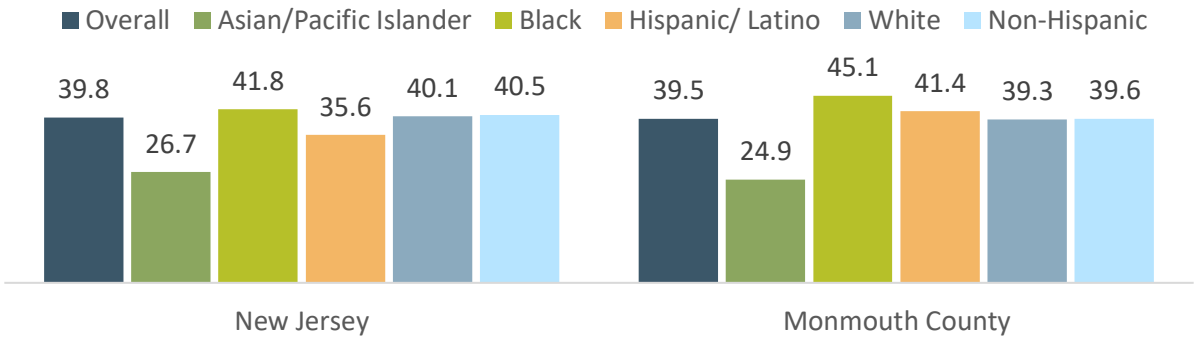
DATA SOURCE: New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2018
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 108. Age-Adjusted Female Breast Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



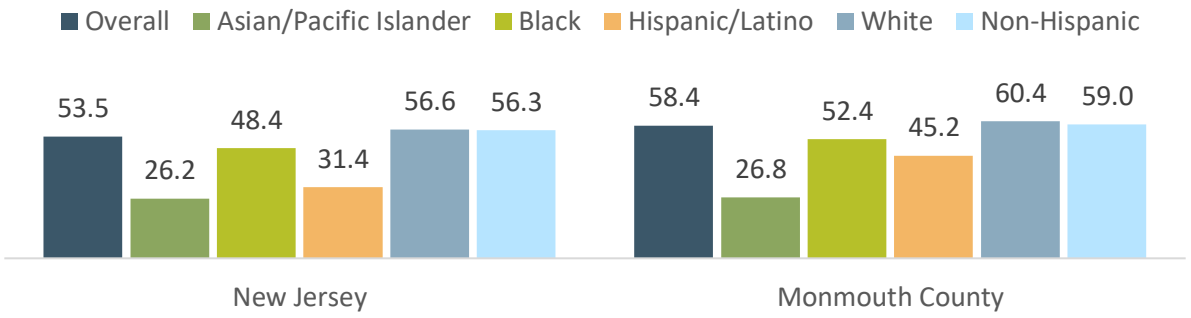
DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019
NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Figure 109. Age-Adjusted Colorectal Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



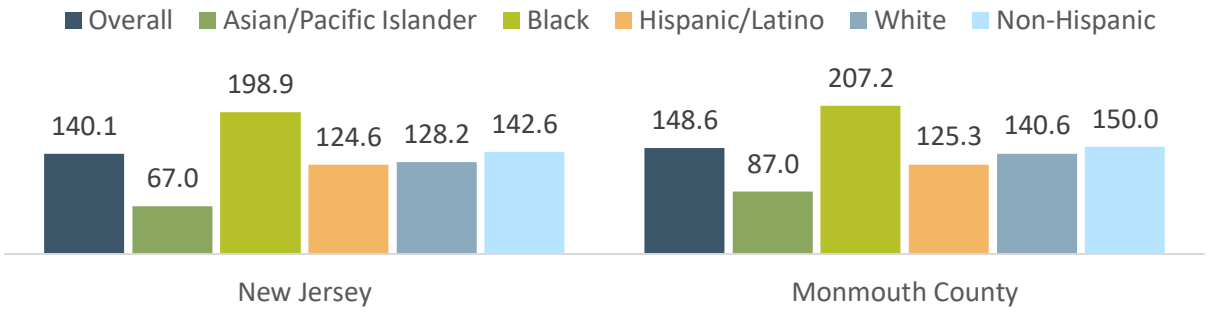
DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019
NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Figure 110. Age-Adjusted Lung Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



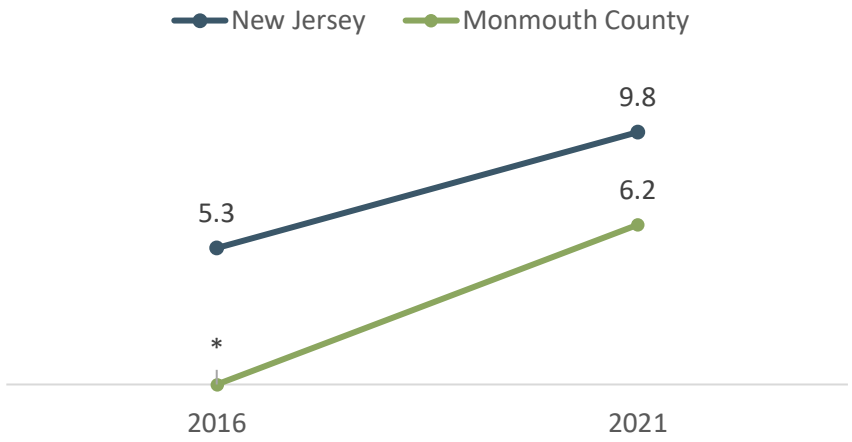
DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019
NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Figure 111. Age-Adjusted Prostate Cancer Incidence Rate per 100,000 Population, by State and County, 2015-2019



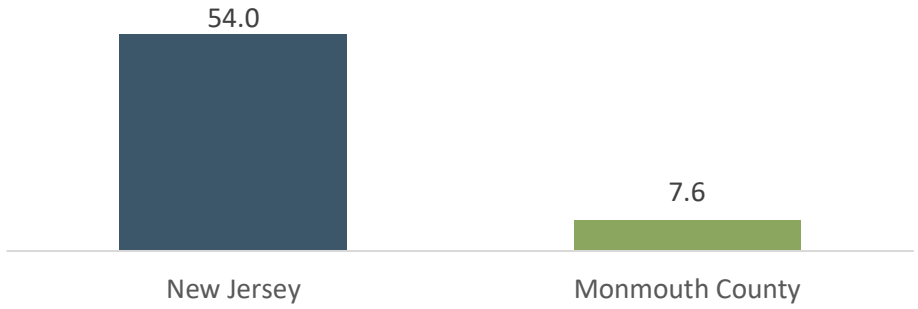
DATA SOURCE: New Jersey State Cancer Registry, New Jersey Department of Health, 2015-2019
NOTE: Persons of Hispanic ethnicity may be of any race or combination of races. The categories of race and ethnicity are not mutually exclusive.

Figure 112. Syphilis Incidence Rate per 100,000 Population, by State and County, 2016 and 2021



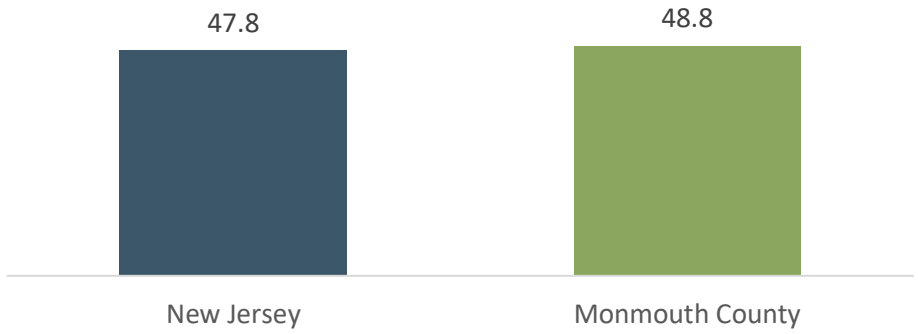
DATA SOURCE: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, Division of HIV, STD, and TB Services, 2016 and 2021
NOTE: Includes primary and secondary syphilis. Crude rate.
NOTE: Asterisks (*) denote insufficient data to calculate reliable rate

Figure 113. ED visits due to unintentional injury (age adjusted) per 10,000, by State and County, 2016-2020



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

Figure 114. 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

Figure 115. 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

Figure 116. Percent Colorectal Cancer Screening (Adults Aged 50-75), by State and County, 2020

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

Figure 117. 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 118. 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

Table 15. Age Distribution and Percent Change, by Town, 2011-2015, 2016-2020

	Under 18 years			18-24 years			25-44 years		
	2011-2015	2016-2020	%change	2011-2015	2016-2020	%change	2011-2015	2016-2020	%change
Allenhurst	17.1%	18.1%	1.0%	4.1%	9.3%	5.2%	25.1%	15.2%	-9.9%
Asbury Park	23.1%	20.7%	-2.4%	10.5%	9.3%	-1.2%	31.3%	31.8%	0.5%
Atlantic Highlands	20.8%	18.4%	-2.4%	6.7%	7.9%	1.2%	20.5%	19.8%	-0.7%
Belford	23.5%	24.7%	1.2%	9.6%	10.4%	0.8%	23.4%	26.5%	3.1%
Deal	10.7%	16.8%	6.1%	11.0%	10.6%	-0.4%	16.2%	15.8%	-0.4%
Eatontown	18.2%	19.4%	1.2%	7.9%	7.2%	-0.7%	29.2%	26.1%	-3.1%
Fair Haven	31.5%	34.6%	3.1%	4.7%	4.7%	0.0%	19.0%	18.3%	-0.7%
Fort Monmouth	4.0%	0.0%	-4.0%	57.3%	0.0%	-57.3%	26.6%	28.2%	1.6%
Highlands	12.8%	11.3%	-1.5%	6.3%	7.1%	0.8%	25.7%	19.7%	-6.0%
Leonardo	18.3%	19.8%	1.5%	11.2%	10.9%	-0.3%	22.4%	24.3%	1.9%
Lincroft	26.6%	24.4%	-2.2%	6.6%	6.8%	0.2%	19.1%	21.9%	2.8%
Little Silver	29.2%	27.2%	-2.0%	5.0%	5.0%	0.0%	18.1%	16.1%	-2.0%
Long Branch	24.3%	22.0%	-2.3%	9.0%	9.3%	0.3%	28.3%	28.8%	0.5%
Middletown	23.3%	21.9%	-1.4%	7.6%	8.1%	0.5%	21.3%	21.4%	0.1%
Monmouth Beach	19.9%	16.6%	-3.3%	5.9%	7.7%	1.8%	16.1%	13.6%	-2.5%
Navesink	33.5%	21.6%	-11.9%	3.5%	3.9%	0.4%	21.4%	22.0%	0.6%
Neptune	19.7%	16.9%	-2.8%	7.6%	8.8%	1.2%	24.8%	24.3%	-0.5%
Oakhurst	25.5%	25.8%	0.3%	6.9%	7.0%	0.1%	17.7%	16.2%	-1.5%
Ocean Grove	9.3%	2.2%	-7.1%	3.2%	5.0%	1.8%	27.3%	21.8%	-5.5%
Oceanport	22.6%	17.6%	-5.0%	7.4%	7.2%	-0.2%	22.8%	17.3%	-5.5%
Port Monmouth	22.4%	23.1%	0.7%	10.1%	7.6%	-2.5%	21.3%	22.5%	1.2%
Red Bank	21.6%	22.2%	0.6%	6.5%	6.1%	-0.4%	34.7%	34.9%	0.2%
Rumson	30.8%	32.5%	1.7%	8.9%	6.1%	-2.8%	13.0%	14.2%	1.2%
Shrewsbury	27.5%	26.8%	-0.7%	6.7%	5.3%	-1.4%	16.6%	16.2%	-0.4%
West Long Branch	18.7%	21.0%	2.3%	23.1%	21.6%	-1.5%	17.1%	18.5%	1.4%

	45-64 years			65-74 years			75 years and older		
	2011-2015	2016-2020	%change	2011-2015	2016-2020	%change	2011-2015	2016-2020	%change
Allenhurst	33.3%	39.2%	5.9%	12.0%	11.2%	-0.8%	8.4%	6.9%	-1.5%
Asbury Park	24.4%	26.2%	1.8%	5.7%	7.2%	1.5%	4.9%	4.8%	-0.1%
Atlantic Highlands	34.7%	35.2%	0.5%	11.3%	11.9%	0.6%	6.1%	6.8%	0.7%
Belford	33.6%	26.9%	-6.7%	5.0%	7.1%	2.1%	5.0%	4.4%	-0.6%
Deal	28.8%	20.4%	-8.4%	16.3%	19.7%	3.4%	17.0%	16.8%	-0.2%
Eatontown	29.3%	32.4%	3.1%	9.1%	8.1%	-1.0%	6.3%	6.7%	0.4%
Fair Haven	33.2%	31.1%	-2.1%	7.6%	6.9%	-0.7%	3.9%	4.4%	0.5%
Fort Monmouth	7.3%	71.8%	64.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Highlands	41.0%	43.0%	2.0%	9.9%	9.7%	-0.2%	4.3%	9.1%	4.8%
Leonardo	38.2%	32.5%	-5.7%	5.6%	9.6%	4.0%	4.3%	2.9%	-1.4%
Lincroft	29.6%	27.9%	-1.7%	8.7%	10.9%	2.2%	9.3%	8.1%	-1.2%
Little Silver	30.7%	32.2%	1.5%	9.2%	9.5%	0.3%	7.6%	10.0%	2.4%
Long Branch	25.3%	25.1%	-0.2%	7.9%	9.1%	1.2%	5.3%	5.8%	0.5%
Middletown	32.5%	30.8%	-1.7%	8.5%	10.1%	1.6%	7.0%	7.8%	0.8%
Monmouth Beach	40.1%	34.9%	-5.2%	10.0%	17.7%	7.7%	7.9%	9.7%	1.8%
Navesink	31.2%	30.2%	-1.0%	7.0%	18.8%	11.8%	3.5%	3.3%	-0.2%
Neptune	31.1%	30.2%	-0.9%	8.6%	10.6%	2.0%	8.1%	9.1%	1.0%
Oakhurst	33.4%	30.5%	-2.9%	7.2%	13.3%	6.1%	9.2%	7.1%	-2.1%
Ocean Grove	33.0%	38.4%	5.4%	15.1%	20.5%	5.4%	12.0%	11.9%	-0.1%
Oceanport	29.9%	36.6%	6.7%	9.8%	13.2%	3.4%	7.6%	8.2%	0.6%
Port Monmouth	35.1%	33.8%	-1.3%	7.0%	6.3%	-0.7%	4.1%	6.8%	2.7%
Red Bank	23.1%	22.2%	-0.9%	7.4%	7.4%	0.0%	6.7%	7.1%	0.4%
Rumson	36.2%	35.2%	-1.0%	6.7%	7.0%	0.3%	4.2%	5.0%	0.8%
Shrewsbury	30.9%	29.4%	-1.5%	11.7%	11.3%	-0.4%	6.7%	11.1%	4.4%
West Long Branch	27.0%	24.5%	-2.5%	6.8%	8.2%	1.4%	7.3%	6.3%	-1.0%

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

Table 16. Age Distribution, by Gender, State, and County, 2016-2020

	Under 18 years		18-24 years		25-44 years	
	Male	Female	Male	Female	Male	Female
New Jersey	23.0%	21.0%	9.0%	8.2%	26.5%	25.0%
Monmouth County	22.2%	20.3%	8.8%	8.0%	22.6%	21.7%
Allenhurst	21.5%	14.8%	15.3%	3.6%	12.4%	18.0%
Asbury Park	19.5%	17.7%	9.0%	8.3%	35.8%	32.4%
Atlantic Highlands	17.8%	23.4%	7.1%	5.6%	20.9%	18.4%
Belford	27.1%	27.4%	10.8%	3.7%	24.9%	28.3%
Deal	21.5%	13.5%	13.4%	26.3%	18.5%	13.9%
Eatontown	18.9%	21.4%	8.8%	6.6%	28.0%	28.8%
Fair Haven	33.1%	36.7%	7.6%	3.1%	17.6%	18.3%
Fort Monmouth	0.0%	0.0%	0.0%	0.0%	32.3%	23.1%
Highlands	12.0%	15.2%	10.3%	2.7%	22.8%	20.8%
Leonardo	27.4%	12.8%	7.8%	9.1%	22.3%	28.3%
Lincroft	26.8%	21.4%	3.3%	7.5%	26.8%	19.8%
Little Silver	30.8%	24.6%	4.5%	4.4%	18.2%	19.1%
Long Branch	24.1%	20.2%	10.5%	11.3%	27.5%	27.6%
Middletown	24.7%	18.6%	6.5%	7.9%	22.5%	20.0%
Monmouth Beach	15.3%	10.6%	12.6%	7.0%	9.3%	11.6%
Navesink	11.5%	27.4%	2.4%	3.6%	27.2%	13.6%
Neptune	15.1%	15.9%	11.2%	7.0%	24.9%	22.2%
Oakhurst	29.9%	25.0%	6.6%	7.8%	17.6%	19.1%
Ocean Grove	2.7%	3.0%	1.4%	3.8%	26.4%	23.5%
Oceanport	23.0%	15.7%	6.6%	7.3%	16.4%	18.9%
Port Monmouth	21.7%	16.9%	4.0%	11.5%	17.7%	18.6%
Red Bank	20.1%	19.6%	5.5%	4.0%	37.8%	31.5%
Rumson	28.8%	30.9%	14.4%	4.4%	11.8%	16.4%
Shrewsbury	30.6%	27.6%	4.8%	5.3%	19.3%	16.4%
West Long Branch	19.8%	16.2%	18.9%	22.2%	19.1%	19.1%

	45-64 years		65-74 years		75 years and older	
	Male	Female	Male	Female	Male	Female
New Jersey	27.3%	27.7%	8.6%	9.7%	5.7%	8.4%
Monmouth County	30.4%	30.7%	9.9%	10.5%	6.0%	8.9%
Allenhurst	36.8%	41.6%	10.8%	11.6%	3.3%	10.4%
Asbury Park	27.2%	27.1%	6.2%	8.3%	2.4%	6.4%
Atlantic Highlands	36.5%	33.7%	9.2%	10.8%	8.4%	8.3%
Belford	30.4%	28.0%	3.4%	8.5%	3.4%	4.0%
Deal	17.0%	18.8%	16.6%	12.4%	13.0%	14.9%
Eatontown	31.9%	26.0%	6.7%	8.2%	5.8%	8.8%
Fair Haven	33.1%	30.0%	5.1%	7.2%	3.5%	4.8%
Fort Monmouth	67.7%	77.0%	0.0%	0.0%	0.0%	0.0%
Highlands	29.7%	42.1%	4.8%	11.6%	20.4%	7.6%
Leonardo	28.7%	35.1%	10.5%	12.4%	3.2%	2.4%
Lincroft	23.9%	32.8%	13.3%	9.7%	6.1%	8.9%
Little Silver	34.0%	32.1%	7.0%	10.8%	5.5%	9.0%
Long Branch	23.0%	23.6%	8.1%	9.0%	6.8%	8.3%
Middletown	30.6%	33.6%	9.7%	11.0%	6.0%	8.8%
Monmouth Beach	35.9%	35.5%	17.5%	21.7%	9.3%	13.5%
Navesink	35.8%	29.2%	21.9%	20.2%	1.1%	5.9%
Neptune	30.1%	33.5%	12.1%	11.7%	6.7%	9.8%
Oakhurst	26.8%	30.1%	11.7%	12.0%	7.3%	6.1%
Ocean Grove	48.0%	49.9%	17.0%	10.0%	4.6%	9.7%
Oceanport	33.5%	33.9%	10.3%	17.1%	10.1%	7.2%
Port Monmouth	41.4%	32.5%	9.8%	10.9%	5.3%	9.6%
Red Bank	22.6%	20.8%	8.4%	11.0%	5.7%	13.2%
Rumson	32.9%	35.3%	7.4%	8.1%	4.8%	4.8%
Shrewsbury	26.1%	25.3%	9.1%	14.7%	10.3%	10.5%
West Long Branch	26.9%	24.2%	11.3%	7.3%	4.0%	11.0%

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

Table 17. Racial and Ethnic Distribution, by Town, 2020

	Asian, Non-Hispanic	Black, Non-Hispanic	Hispanic/ Latino	White, Non-Hispanic	Other Race/ Ethnicity, Non-Hispanic
Monmouth County					
Allenhurst	0.6%	0.8%	4.0%	92.2%	0.0%
Asbury Park	1.1%	33.3%	26.9%	34.8%	0.6%
Atlantic Highlands	1.8%	1.2%	8.2%	84.9%	0.1%
Belford	2.9%	1.4%	10.6%	81.5%	0.4%
Deal	0.7%	0.7%	13.3%	81.2%	1.6%
Eatontown	9.7%	12.1%	14.7%	55.7%	1.7%
Fair Haven	1.5%	1.1%	3.8%	90.3%	0.3%
Fort Monmouth	-	-	-	-	-
Highlands	1.2%	1.7%	7.4%	85.0%	0.7%
Leonardo	0.6%	1.0%	9.2%	86.5%	0.3%
Lincroft	4.3%	0.6%	5.6%	87.0%	0.3%
Little Silver	2.3%	0.4%	4.3%	89.8%	0.2%
Long Branch	1.9%	10.0%	32.6%	41.5%	5.0%
Middletown	2.8%	1.2%	7.6%	85.2%	0.4%
Monmouth Beach	1.1%	0.3%	3.8%	91.6%	0.8%
Navesink	2.0%	3.9%	5.2%	84.5%	0.6%
Neptune	2.7%	33.6%	14.4%	44.8%	0.6%
Oakhurst	3.5%	1.5%	9.1%	81.1%	1.0%
Ocean Grove	1.0%	3.7%	6.6%	85.3%	0.5%
Oceanport	1.1%	1.4%	9.9%	83.8%	0.9%
Port Monmouth	2.6%	2.4%	11.1%	79.8%	0.6%
Red Bank	1.8%	7.5%	37.8%	49.9%	0.4%
Rumson	1.4%	0.3%	4.2%	90.4%	0.5%
Shrewsbury	2.3%	1.5%	3.9%	88.4%	0.8%
West Long Branch	1.7%	3.2%	9.0%	79.4%	1.8%

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

Table 18. Foreign-Born Population by Top Countries of Origin, by State and County, 2016-2020

	New Jersey		Monmouth County	
1	India	13.1%	Mexico	11.1%
2	Dominican Republic	9.1%	India	9.5%
3	Mexico	5.1%	China, excluding Hong Kong and Taiwan	5.1%
4	Colombia	4.3%	Brazil	4.8%
5	Ecuador	4.1%	Egypt	3.8%

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

Table 19. Educational Attainment among Adults 25 Years and Older, by State, County, and Town, 2016-2020

	Less than 9th grade	9th to 12th grade, no diploma	High school graduate/ GED	Some college, no degree	Associate's degree	Bachelor's degree	Graduate or professional degree
New Jersey							
Monmouth County	2.4%	3.8%	22.7%	16.2%	7.4%	28.8%	18.6%
Allenhurst	0.0%	3.1%	14.0%	19.3%	4.8%	38.4%	20.4%
Asbury Park	4.3%	9.1%	25.0%	17.6%	4.3%	26.0%	13.7%
Atlantic Highlands	0.3%	2.1%	20.7%	16.6%	10.4%	30.5%	19.4%
Belford	1.6%	5.6%	24.5%	17.9%	12.2%	28.6%	9.6%
Deal	6.7%	8.5%	24.5%	27.0%	2.7%	25.2%	5.5%
Eatontown	2.6%	4.9%	28.6%	13.7%	8.2%	24.3%	17.6%
Fair Haven	0.4%	2.2%	7.1%	11.7%	3.6%	45.8%	29.2%
Fort Monmouth	0.0%	6.0%	13.7%	0.0%	30.8%	10.3%	39.3%
Highlands	1.4%	4.7%	17.2%	24.2%	6.2%	19.5%	26.8%
Leonardo	0.0%	4.9%	30.1%	22.0%	7.2%	27.9%	7.9%
Lincroft	0.2%	1.7%	16.8%	16.7%	5.6%	33.3%	25.6%
Little Silver	0.5%	0.6%	10.4%	12.8%	6.4%	40.4%	28.9%
Long Branch	9.9%	8.9%	30.2%	17.2%	5.6%	16.8%	11.5%
Middletown	1.4%	3.1%	25.0%	16.7%	7.6%	30.4%	15.9%
Monmouth Beach	0.0%	1.0%	14.6%	13.1%	8.1%	33.0%	30.3%
Navesink	0.0%	8.7%	13.5%	20.0%	10.3%	29.8%	17.7%
Neptune	4.2%	4.5%	24.0%	21.4%	8.4%	24.9%	12.6%
Oakhurst	2.8%	3.7%	20.6%	27.3%	6.3%	24.2%	15.1%
Ocean Grove	2.5%	2.1%	7.0%	13.3%	5.7%	35.7%	33.8%
Oceanport	1.0%	4.1%	15.8%	16.2%	8.3%	32.2%	22.3%
Port Monmouth	1.1%	4.5%	42.3%	22.7%	9.8%	14.2%	5.5%
Red Bank	5.1%	5.7%	21.5%	13.3%	8.8%	24.6%	21.0%
Rumson	0.0%	0.5%	8.4%	11.4%	4.4%	42.3%	33.0%
Shrewsbury	1.0%	1.4%	16.7%	10.0%	6.1%	37.6%	27.3%
West Long Branch	1.9%	8.5%	20.7%	17.7%	5.0%	30.5%	15.6%

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

Table 20. Educational Attainment among Adults 25 Years and Older, by Race/Ethnicity and Town, 2016-2020

	Asian, NH		Black, NH		Hispanic/ Latino	
	HS+	BA/BS+	HS+	BA/BS+	HS+	BA/BS+
New Jersey	92.8%	71.0%	88.6%	25.2%	75.6%	20.6%
Monmouth County	93.6%	70.0%	86.8%	23.9%	76.6%	24.8%
Allenhurst	100.0%	100.0%	100.0%	75.0%	85.7%	0.0%
Asbury Park	93.9%	88.1%	82.8%	15.8%	69.8%	18.9%
Atlantic Highlands	100.0%	77.1%	100.0%	0.0%	94.9%	33.2%
Belford	50.0%	50.0%	-	-	94.3%	63.9%
Deal	-	-	12.5%	0.0%	69.1%	25.5%
Eatontown	90.7%	56.2%	96.3%	37.7%	67.7%	23.5%
Fair Haven	100.0%	90.2%	81.8%	14.5%	81.6%	63.3%
Fort Monmouth	-	-	53.3%	0.0%	-	-
Highlands	61.9%	61.9%	100.0%	44.0%	85.8%	14.2%
Leonardo	50.0%	50.0%	-	-	68.4%	26.3%
Lincroft	90.8%	52.2%	0.0%	0.0%	100.0%	30.4%
Little Silver	100.0%	100.0%	-	-	100.0%	58.7%
Long Branch	88.4%	48.2%	86.9%	16.9%	59.2%	7.0%
Middletown	89.6%	60.6%	69.5%	22.6%	87.9%	34.2%
Monmouth Beach	100.0%	56.3%	-	-	74.7%	17.2%
Navesink	100.0%	100.0%	77.0%	47.8%	0.0%	0.0%
Neptune	97.4%	52.9%	88.9%	21.2%	68.0%	16.1%
Oakhurst	100.0%	55.9%	100.0%	33.2%	100.0%	59.3%
Ocean Grove	100.0%	52.1%	100.0%	100.0%	52.1%	10.6%
Oceanport	100.0%	78.0%	81.1%	59.5%	75.2%	61.4%
Port Monmouth	81.8%	66.2%	98.7%	0.0%	100.0%	13.0%
Red Bank	100.0%	100.0%	90.9%	26.5%	63.8%	5.3%
Rumson	100.0%	70.3%	100.0%	76.5%	99.4%	53.5%
Shrewsbury	80.6%	56.5%	66.7%	66.7%	100.0%	18.4%
West Long Branch	100.0%	27.3%	40.9%	18.8%	91.3%	30.4%

	White, NH		Other race, NH	
	HS+	BA/BS+	HS+	BA/BS+
New Jersey	94.6%	45.1%	71.4%	15.3%
Monmouth County	96.2%	50.3%	67.4%	13.2%
Allenhurst	97.2%	59.1%	100.0%	100.0%
Asbury Park	94.8%	62.0%	58.0%	7.5%
Atlantic Highlands	97.8%	51.1%	53.6%	0.0%
Belford	93.0%	32.6%	-	-
Deal	90.3%	32.6%	41.4%	0.0%
Eatontown	94.4%	43.1%	54.3%	12.6%
Fair Haven	98.4%	78.1%	100.0%	0.0%

Fort Monmouth	100.0%	56.9%	-	-
Highlands	96.5%	47.2%	0.0%	0.0%
Leonardo	97.2%	35.4%	-	-
Lincroft	99.0%	60.5%	0.0%	0.0%
Little Silver	98.9%	70.4%	100.0%	0.0%
Long Branch	88.0%	37.7%	59.3%	3.7%
Middletown	96.6%	46.8%	75.5%	23.9%
Monmouth Beach	100.0%	65.3%	100.0%	0.0%
Navesink	93.2%	45.8%	-	-
Neptune	96.0%	49.7%	47.8%	9.2%
Oakhurst	92.5%	39.4%	-	-
Ocean Grove	98.8%	74.3%	32.5%	2.6%
Oceanport	95.6%	53.7%	-	-
Port Monmouth	94.4%	19.2%	100.0%	0.0%
Red Bank	97.1%	59.1%	46.9%	4.5%
Rumson	99.5%	76.3%	0.0%	0.0%
Shrewsbury	98.6%	66.0%	100.0%	0.0%
West Long Branch	93.3%	49.1%	93.2%	0.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

Table 21. Unemployment Rate among Workers 16 Years and Above, 2016-2020

	2016-2020
New Jersey	5.8%
Monmouth County	5.1%
Allenhurst	7.6%
Asbury Park	8.3%
Atlantic Highlands	4.8%
Belford	6.9%
Deal	3.6%
Eatontown	5.0%
Fair Haven	3.2%
Fort Monmouth	11.8%
Highlands	5.7%
Leonardo	4.1%
Lincroft	9.5%
Little Silver	3.9%
Long Branch	7.9%
Middletown	5.6%
Monmouth Beach	4.4%
Navesink	9.2%
Neptune	7.9%
Oakhurst	2.9%
Ocean Grove	3.5%
Oceanport	2.3%
Port Monmouth	6.9%

Red Bank	4.5%
Rumson	4.3%
Shrewsbury	2.4%
West Long Branch	6.7%

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

Table 22. 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%
Monmouth County	3.9%	7.6%	5.8%	4.7%	1.2%	0.0%	6.0%
Allenhurst	0.0%	0.0%	0.0%	12.5%	-	0.0%	-
Asbury Park	0.0%	12.1%	2.3%	4.0%	0.0%	0.0%	0.0%
Atlantic Highlands	0.0%	-	17.8%	3.9%	100.0%	-	0.0%
Belford	0.0%	-	17.2%	4.8%	-	-	-
Deal	-	-	0.0%	4.8%	-	-	0.0%
Eatontown	1.2%	6.1%	2.9%	4.6%	-	-	12.7%
Fair Haven	0.0%	1.0%	2.9%	3.4%	-	-	0.0%
Fort Monmouth	-	0.0%	-	12.8%	-	-	-
Highlands	16.0%	0.0%	0.0%	5.8%	-	-	-
Leonardo	28.1%	-	0.0%	1.3%	-	-	-
Lincroft	16.0%	0.0%	7.9%	9.0%	-	-	0.0%
Little Silver	0.0%	-	0.0%	4.1%	-	-	-
Long Branch	8.5%	10.5%	6.1%	8.4%	0.0%	-	7.3%
Middletown	13.2%	13.6%	6.3%	5.1%	0.0%	-	9.5%
Monmouth Beach	0.0%	-	0.0%	4.7%	-	-	-
Navesink	0.0%	29.2%	0.0%	6.3%	-	-	-
Neptune	7.2%	9.1%	4.0%	8.2%	0.0%	-	0.4%
Oceanport	0.0%	0.0%	4.4%	2.4%	-	-	-
Oakhurst	0.0%	1.2%	0.0%	3.1%	-	-	-
Ocean Grove	0.0%	-	0.0%	4.0%	-	-	0.0%
Port Monmouth	0.0%	0.0%	0.0%	7.3%	-	-	0.0%
Red Bank	0.0%	3.9%	8.4%	3.1%	0.0%	-	9.0%
Rumson	0.0%	57.1%	0.9%	4.4%	100.0%	-	-
Shrewsbury	0.0%	0.0%	0.0%	1.9%	-	-	0.0%
West Long Branch	0.0%	10.3%	2.1%	6.9%	-	-	0.0%

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

Table 23. Unemployment Rate by Gender, State, County, and Town, 2016-2020

	Female	Male
New Jersey	5.6%	5.4%
Monmouth County	5.1%	4.5%
Allenhurst	12.4%	13.3%
Asbury Park	6.8%	8.8%
Atlantic Highlands	1.0%	8.4%
Belford	6.2%	8.3%
Deal	0.0%	7.5%
Eatontown	3.1%	5.5%
Fair Haven	4.9%	2.0%
Fort Monmouth	26.7%	0.0%
Highlands	5.9%	6.7%
Leonardo	0.0%	8.1%
Lincroft	3.2%	13.2%
Little Silver	2.5%	4.8%
Long Branch	9.6%	5.3%
Middletown	4.3%	5.9%
Monmouth Beach	4.1%	6.8%
Navesink	0.0%	10.3%
Neptune	9.8%	5.3%
Oakhurst	1.2%	4.6%
Ocean Grove	3.2%	4.7%
Oceanport	2.1%	3.2%
Port Monmouth	5.8%	6.8%
Red Bank	5.6%	3.1%
Rumson	4.5%	5.3%
Shrewsbury	1.9%	2.2%
West Long Branch	4.4%	10.0%

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

Table 24. Unemployment Rate by Age, State, and County, 2016-2020

	16 to 19 years	20 to 24 years	25 to 29 years	30 to 34 years	35 to 44 years
New Jersey	17.2%	11.4%	6.5%	5.2%	4.6%
Monmouth County	12.1%	11.1%	5.0%	4.4%	3.6%
Allenhurst	0.0%	33.3%	10.5%	0.0%	0.0%
Asbury Park	17.3%	19.7%	2.2%	6.6%	6.0%
Atlantic Highlands	0.0%	0.0%	5.1%	0.8%	20.3%
Belford	0.0%	0.0%	10.9%	3.9%	9.1%
Deal	0.0%	0.0%	22.2%	0.0%	0.0%
Eatontown	29.5%	11.7%	1.7%	3.1%	1.1%
Fair Haven	6.9%	23.5%	0.0%	6.9%	1.3%
Fort Monmouth	-	-	0.0%	100.0%	0.0%
Highlands	0.0%	0.0%	0.0%	18.4%	10.5%
Leonardo	0.0%	50.0%	0.0%	0.0%	0.0%
Lincroft	27.8%	27.3%	21.9%	0.0%	10.0%
Little Silver	0.0%	12.4%	34.5%	7.4%	0.0%
Long Branch	19.9%	13.3%	7.8%	9.3%	7.1%
Middletown	13.9%	11.4%	5.9%	2.0%	3.2%
Monmouth Beach	0.0%	35.2%	0.0%	0.0%	0.0%
Navesink	0.0%	0.0%	0.0%	23.8%	0.0%
Neptune	26.0%	12.3%	5.4%	7.2%	8.8%
Oakhurst	0.0%	27.0%	0.0%	0.0%	2.6%
Ocean Grove	0.0%	0.0%	0.0%	0.0%	6.3%
Oceanport	0.0%	16.9%	0.0%	9.9%	0.7%
Port Monmouth	12.8%	7.3%	0.0%	0.0%	8.9%
Red Bank	6.3%	17.7%	4.9%	6.2%	4.1%
Rumson	0.0%	14.7%	1.9%	14.4%	5.8%
Shrewsbury	9.1%	0.0%	15.8%	0.0%	0.0%
West Long Branch	6.8%	3.9%	0.0%	7.3%	0.0%

	45 to 54 years	55 to 59 years	60 to 64 years	65 to 74 years	75 years and over
New Jersey	4.6%	4.5%	4.4%	4.8%	4.2%
Monmouth County	3.6%	5.0%	4.4%	5.2%	3.2%
Allenhurst	0.0%	51.1%	0.0%	0.0%	0.0%
Asbury Park	4.5%	11.7%	17.7%	13.6%	0.0%
Atlantic Highlands	2.1%	8.3%	0.0%	0.0%	9.2%
Belford	0.0%	33.6%	0.0%	0.0%	0.0%
Deal	0.0%	0.0%	0.0%	0.0%	28.6%
Eatontown	6.5%	6.8%	1.9%	15.0%	0.0%
Fair Haven	2.5%	2.4%	0.0%	0.0%	0.0%
Fort Monmouth	0.0%	-	0.0%	-	-
Highlands	8.9%	0.0%	5.3%	0.0%	0.0%
Leonardo	2.6%	0.0%	0.0%	10.3%	0.0%

Lincroft	2.4%	10.8%	0.0%	0.0%	0.0%
Little Silver	1.3%	8.1%	3.2%	6.9%	0.0%
Long Branch	3.1%	7.3%	4.6%	14.1%	0.0%
Middletown	4.6%	6.1%	5.6%	7.1%	1.6%
Monmouth Beach	0.0%	3.4%	9.0%	0.0%	0.0%
Navesink	0.0%	0.0%	45.2%	25.3%	-
Neptune	2.5%	14.0%	3.0%	3.9%	0.0%
Oakhurst	0.2%	0.0%	0.0%	3.9%	0.0%
Ocean Grove	7.9%	3.7%	4.4%	0.0%	0.0%
Oceanport	0.0%	0.0%	3.3%	0.0%	0.0%
Port Monmouth	1.3%	11.4%	20.1%	15.8%	0.0%
Red Bank	0.7%	0.0%	0.0%	5.6%	5.6%
Rumson	1.8%	8.6%	0.0%	0.0%	0.0%
Shrewsbury	0.0%	0.0%	8.3%	0.0%	0.0%
West Long Branch	9.4%	18.9%	3.3%	3.2%	0.0%

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

Table 25. Population Employed by Industry Type, State, County, and Town, 2016-2020

	Agriculture, forestry, fishing and hunting, and mining	Construction	Manufacturing	Wholesale trade	Retail trade
New Jersey	0.3%	5.9%	8.1%	3.3%	10.7%
Monmouth County	0.3%	7.1%	5.8%	2.9%	10.8%
Allenhurst	0.0%	2.7%	5.5%	7.4%	19.1%
Asbury Park	0.1%	6.1%	9.5%	2.2%	9.8%
Atlantic Highlands	0.0%	3.6%	10.2%	2.8%	13.6%
Belford	0.8%	9.4%	4.7%	2.9%	10.8%
Deal	0.0%	15.3%	6.0%	6.0%	8.8%
Eatontown	0.1%	9.1%	5.1%	2.7%	11.7%
Fair Haven	0.0%	5.3%	5.8%	3.6%	5.1%
Fort Monmouth	0.0%	8.9%	0.0%	76.7%	0.0%
Highlands	0.9%	8.0%	1.2%	3.5%	10.5%
Leonardo	0.8%	10.3%	3.3%	2.6%	19.5%
Lincroft	0.2%	8.9%	5.7%	7.4%	6.0%
Little Silver	0.0%	7.0%	5.5%	6.3%	6.2%
Long Branch	0.6%	17.6%	3.2%	2.0%	11.5%
Middletown	0.3%	6.6%	5.4%	2.9%	10.5%
Monmouth Beach	0.0%	2.4%	8.1%	4.4%	4.9%
Navesink	1.2%	2.9%	7.8%	1.6%	1.6%
Neptune	0.7%	6.1%	4.5%	3.2%	12.3%
Oakhurst	0.0%	11.8%	5.6%	5.6%	5.1%

Ocean Grove	2.6%	6.5%	2.0%	5.2%	7.2%
Oceanport	1.2%	6.8%	5.7%	5.3%	8.5%
Port Monmouth	0.0%	7.4%	5.3%	2.8%	19.5%
Red Bank	0.0%	6.8%	7.4%	1.5%	12.0%
Rumson	0.0%	3.1%	5.1%	1.5%	8.3%
Shrewsbury	0.7%	2.1%	4.5%	2.0%	7.5%
West Long Branch	0.0%	8.0%	6.9%	3.5%	11.8%

	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
New Jersey	6.4%	2.6%	8.5%	13.7%
Monmouth County	4.8%	3.1%	10.2%	14.3%
Allenhurst	0.0%	2.0%	14.1%	21.9%
Asbury Park	5.2%	3.0%	4.8%	11.5%
Atlantic Highlands	5.4%	2.7%	12.2%	12.8%
Belford	15.0%	3.0%	8.1%	20.2%
Deal	5.6%	1.4%	16.7%	10.7%
Eatontown	4.5%	5.2%	6.9%	15.0%
Fair Haven	1.6%	4.5%	23.0%	17.1%
Fort Monmouth	0.0%	0.0%	0.0%	14.4%
Highlands	0.7%	7.4%	2.8%	21.5%
Leonardo	5.2%	1.5%	3.2%	14.8%
Lincroft	1.6%	2.0%	12.7%	10.8%
Little Silver	3.0%	1.2%	19.1%	23.9%
Long Branch	4.3%	1.3%	7.3%	12.4%
Middletown	5.4%	2.9%	12.1%	16.7%
Monmouth Beach	9.1%	6.6%	9.2%	11.7%
Navesink	1.6%	1.7%	2.1%	33.8%
Neptune	5.5%	3.2%	5.3%	12.0%
Oakhurst	3.1%	2.5%	9.0%	20.1%
Ocean Grove	1.4%	4.5%	8.9%	12.0%
Oceanport	1.1%	2.6%	8.7%	11.2%
Port Monmouth	3.7%	0.8%	7.8%	14.2%
Red Bank	3.5%	4.2%	9.6%	13.5%
Rumson	2.5%	2.5%	26.4%	16.4%
Shrewsbury	3.7%	5.3%	20.8%	16.4%
West Long Branch	3.9%	2.0%	8.5%	13.3%

	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	24.1%	7.8%	4.2%	4.4%
Monmouth County	24.4%	8.2%	3.6%	4.5%
Allenhurst	18.8%	3.9%	1.2%	3.5%
Asbury Park	24.6%	16.1%	4.4%	2.5%
Atlantic Highlands	24.5%	7.2%	2.3%	2.8%
Belford	9.5%	10.9%	1.2%	3.5%
Deal	11.2%	8.8%	4.2%	5.1%
Eatontown	26.6%	5.8%	3.6%	3.6%
Fair Haven	19.5%	9.4%	2.7%	2.5%
Fort Monmouth	0.0%	0.0%	0.0%	0.0%
Highlands	18.7%	17.1%	3.2%	4.5%
Leonardo	16.2%	16.9%	3.5%	2.2%
Lincroft	19.8%	8.5%	4.5%	11.8%
Little Silver	19.0%	5.1%	2.4%	1.1%
Long Branch	20.0%	11.2%	5.5%	3.2%
Middletown	21.5%	8.4%	3.4%	4.0%
Monmouth Beach	24.2%	13.3%	1.1%	5.0%
Navesink	28.3%	6.4%	4.9%	6.2%
Neptune	29.4%	8.5%	2.0%	7.1%
Oakhurst	24.0%	6.5%	3.7%	3.0%
Ocean Grove	27.7%	14.5%	3.4%	4.0%
Oceanport	30.6%	11.0%	1.6%	5.9%
Port Monmouth	19.0%	9.6%	5.1%	4.8%
Red Bank	24.5%	10.3%	5.0%	1.6%
Rumson	19.8%	6.7%	1.8%	5.9%
Shrewsbury	22.1%	9.7%	0.6%	4.5%
West Long Branch	25.0%	6.1%	4.0%	7.0%

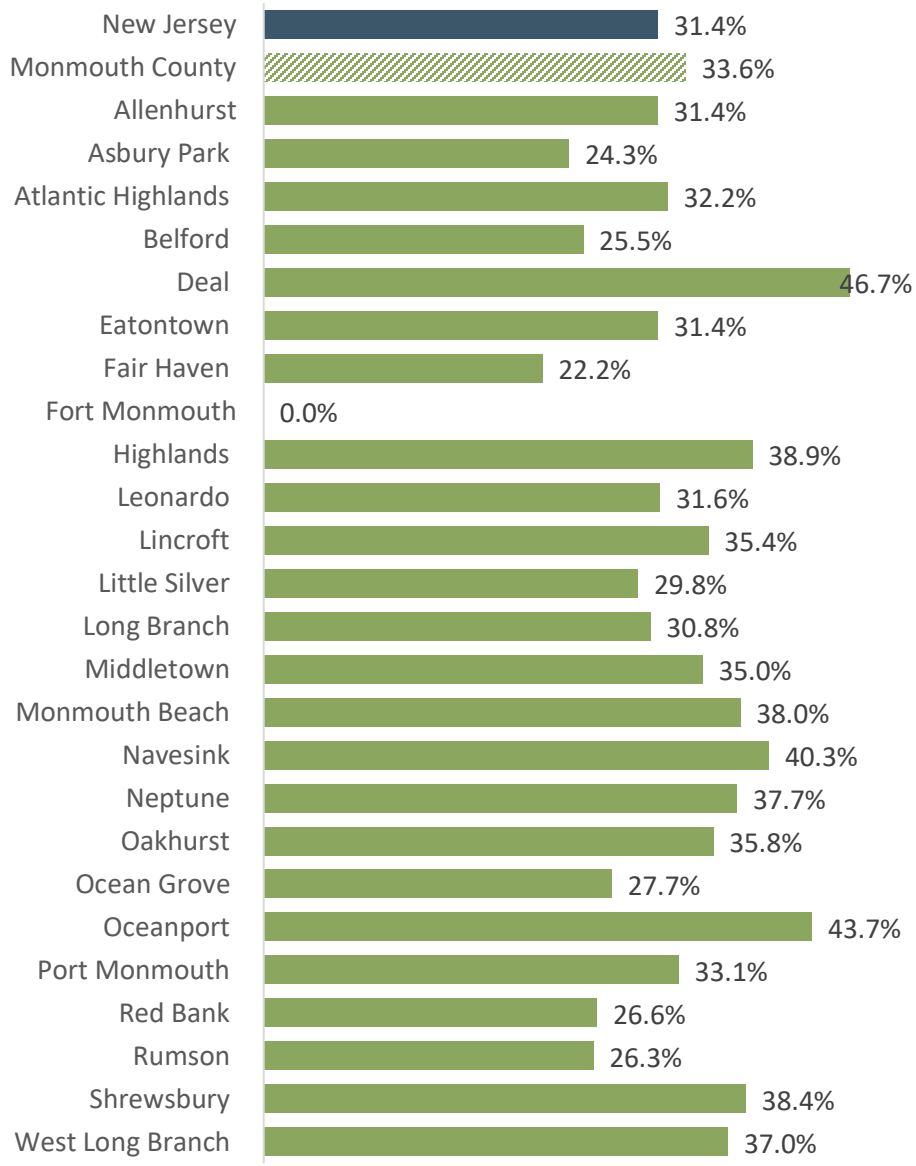
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 26. 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
Monmouth County	$157,700	$57,466	$74,759	$108,111	-	-	$56,862
Allenhurst	-	-	-	$93,750	-	-	-
Asbury Park	$200,820	$33,972	$42,845	$75,132	-	-	$31,129
Atlantic Highlands	-	-	$102,904	$106,875	-	-	-
Belford	-	-	$189,432	$125,000	-	-	-
Deal	-	-	-	$56,500	-	-	-
Eatontown	$86,964	$57,165	$100,703	$81,614	-	-	-
Fair Haven	-	-	-	$186,250	-	-	-
Fort Monmouth	-	-	-	-	-	-	-
Highlands	$169,531	-	-	$76,310	-	-	-
Leonardo	-	-	-	$110,017	-	-	-
Lincroft	$185,165	-	-	$163,397	-	-	-
Little Silver	-	-	250,000+	$199,969	-	-	-
Long Branch	$57,008	$44,382	$61,620	$63,448	-	-	$64,042
Middletown	$110,125	$53,834	$101,389	$121,325	$88,289	-	-
Monmouth Beach	-	-	$45,050	$112,426	-	-	-
Navesink	-	-	-	$122,552	-	-	-
Neptune	$135,329	$68,841	$103,533	$81,277	-	-	-
Oakhurst	-	-	-	$112,857	-	-	-
Ocean Grove	-	-	$50,605	$68,265	-	-	$49,759
Oceanport	-	-	250,000+	$101,389	-	-	-
Port Monmouth	-	-	$122,386	$84,821	-	-	-
Red Bank	-	$71,038	$39,232	$90,375	-	-	$38,679
Rumson	$250,000+	-	-	$221,974	-	-	-
Shrewsbury	-	-	$187,857	$143,472	-	-	-
West Long Branch	-	$13,693	$74,219	$121,875	-	-	$73,750

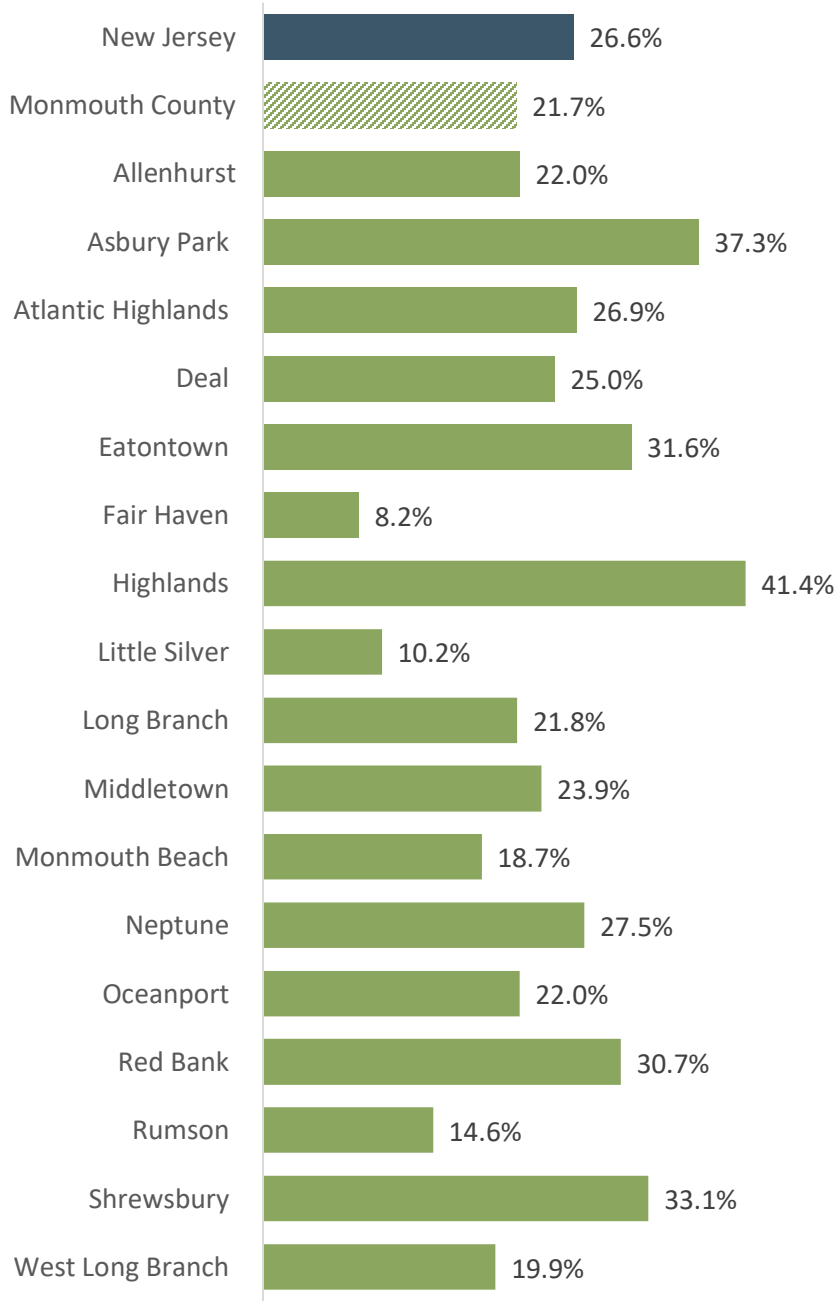
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 119. Percent Households Receiving Social Security Income, by State, County, and Town, 2016-2020



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

Figure 120. Percent Households Falling into ALICE Population, by State and County, 2018

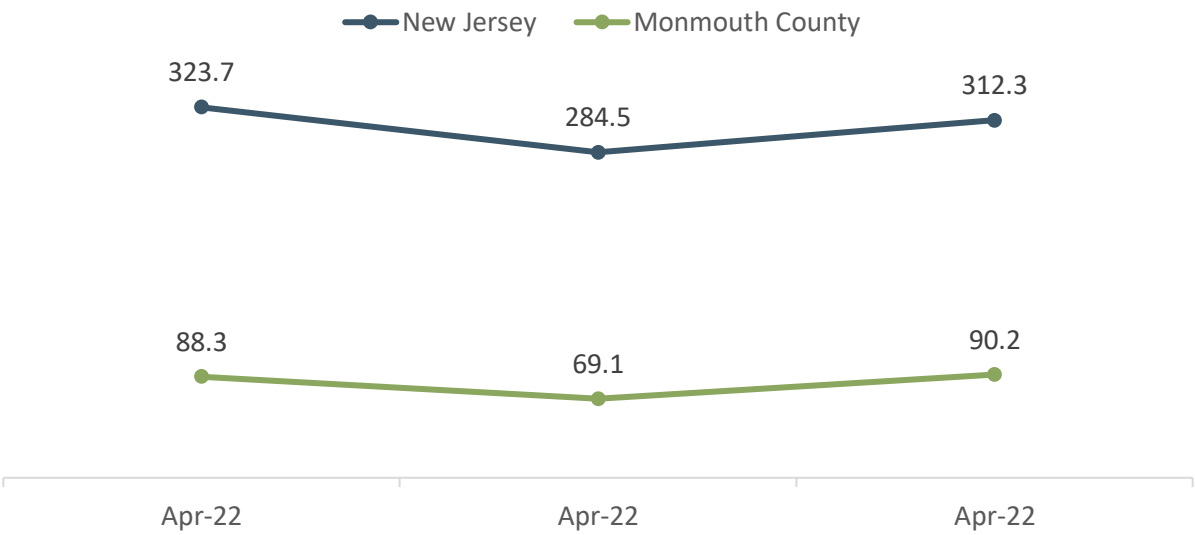


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2014-2018 as reported by United Ways of New Jersey Alice in New Jersey: A Financial Hardship Study, 2020
NOTE: ALICE refers to the population in our communities that are Asset Limited, Income Constrained, Employed. The ALICE 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 121. Income Inequality (80th to 20th Percentile Income Ratio), by State and County, 2016-2020

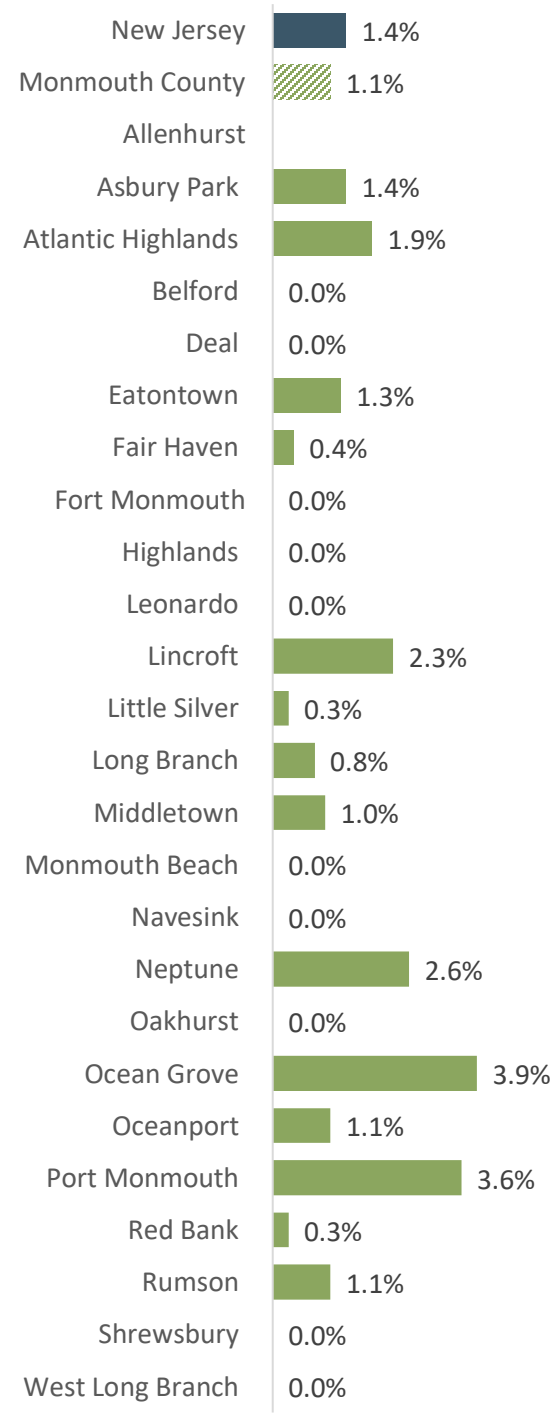
DATA SOURCE: U.S. Census Bureau, American Community Survey as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2016-2020
NOTE: The ratio of household income at the 80th percentile to that at the 20th percentile, where the incomes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

Figure 122. Number of Participating Persons, Adults, and Children Receiving WFNJ/TANF per 100,000, by County, 2021



DATA SOURCE: New Jersey Department of Human Services, Division of Family Development, Current Program Statistics 2020-2022
DATA SOURCE: Current Program Statistics, Division of Family Development, New Jersey Department of Human Services, 2020-2021

Figure 123. Homeowner Vacancy Rate, by State and County, 2016-2020



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

Table 27. Household Occupants per Room, by State and County, 2016-2020

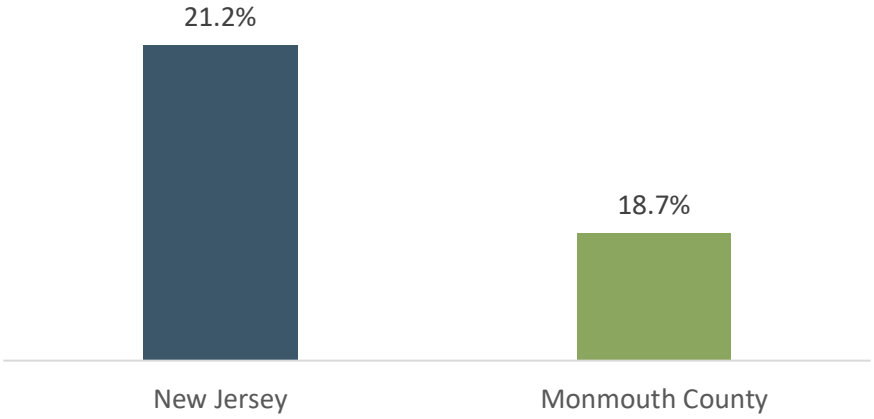
	1.00 or less	1.01 to 1.50	1.51 or more
New Jersey	96.7%	2.1%	1.1%
Monmouth County	98.5%	1.1%	0.5%
Allenhurst	96.7%	2.2%	1.1%
Asbury Park	94.8%	2.9%	2.4%
Atlantic Highlands	99.3%	0.7%	0.0%
Belford	97.0%	3.0%	0.0%
Deal	93.8%	3.1%	3.1%
Eatontown	98.0%	2.0%	0.0%
Fair Haven	99.9%	0.1%	0.0%
Fort Monmouth	100.0%	0.0%	0.0%
Highlands	100.0%	0.0%	0.0%
Leonardo	100.0%	0.0%	0.0%
Lincroft	99.2%	0.0%	0.8%
Little Silver	100.0%	0.0%	0.0%
Long Branch	94.9%	3.5%	1.6%
Middletown	99.4%	0.4%	0.2%
Monmouth Beach	100.0%	0.0%	0.0%
Navesink	100.0%	0.0%	0.0%
Neptune	97.6%	2.3%	0.1%
Oakhurst	100.0%	0.0%	0.0%
Ocean Grove	97.9%	2.1%	0.0%
Oceanport	98.9%	0.0%	1.1%
Port Monmouth	99.3%	0.7%	0.0%
Red Bank	98.9%	0.7%	0.5%
Rumson	100.0%	0.0%	0.0%
Shrewsbury	100.0%	0.0%	0.0%
West Long Branch	99.9%	0.0%	0.1%

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

Figure 124. Percentage of children that live in a household headed by a single parent by State and County, 2016-2020

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

Figure 125. 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.

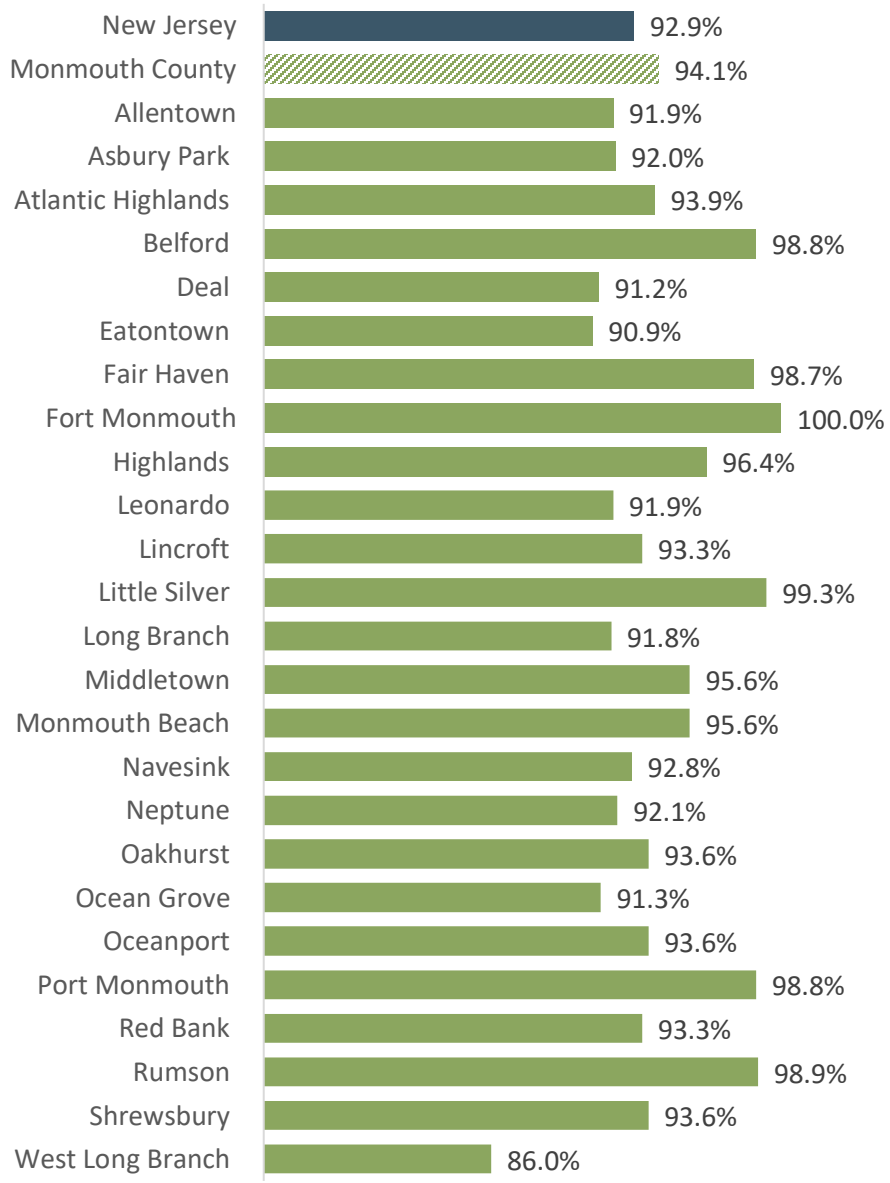
Table 28. Households (Renter v. Owner-Occupied) Without Access to a Vehicle, by State and County, 2016-2020

	Owner-occupied	Renter-occupied
New Jersey	3.6%	24.8%
Monmouth County	2.8%	18.4%
Allenhurst	1.6%	0.0%
Asbury Park	5.5%	24.9%
Atlantic Highlands	0.5%	16.8%
Belford	0.0%	6.7%
Deal	8.8%	12.3%
Eatontown	2.8%	9.7%
Fair Haven	1.2%	0.0%
Fort Monmouth	0.0%	0.0%
Highlands	2.8%	16.2%
Leonardo	3.5%	0.0%
Lincroft	0.6%	32.8%
Little Silver	0.8%	0.0%
Long Branch	4.0%	14.8%
Middletown	1.5%	17.4%
Monmouth Beach	2.9%	17.8%
Navesink	0.0%	0.0%
Neptune	3.2%	24.3%
Oakhurst	4.1%	0.0%
Ocean Grove	6.0%	17.8%
Oceanport	0.0%	15.6%

Port Monmouth	2.9%	50.5%
Red Bank	7.7%	26.2%
Rumson	1.9%	18.4%
Shrewsbury	5.5%	0.0%
West Long Branch	4.5%	12.7%

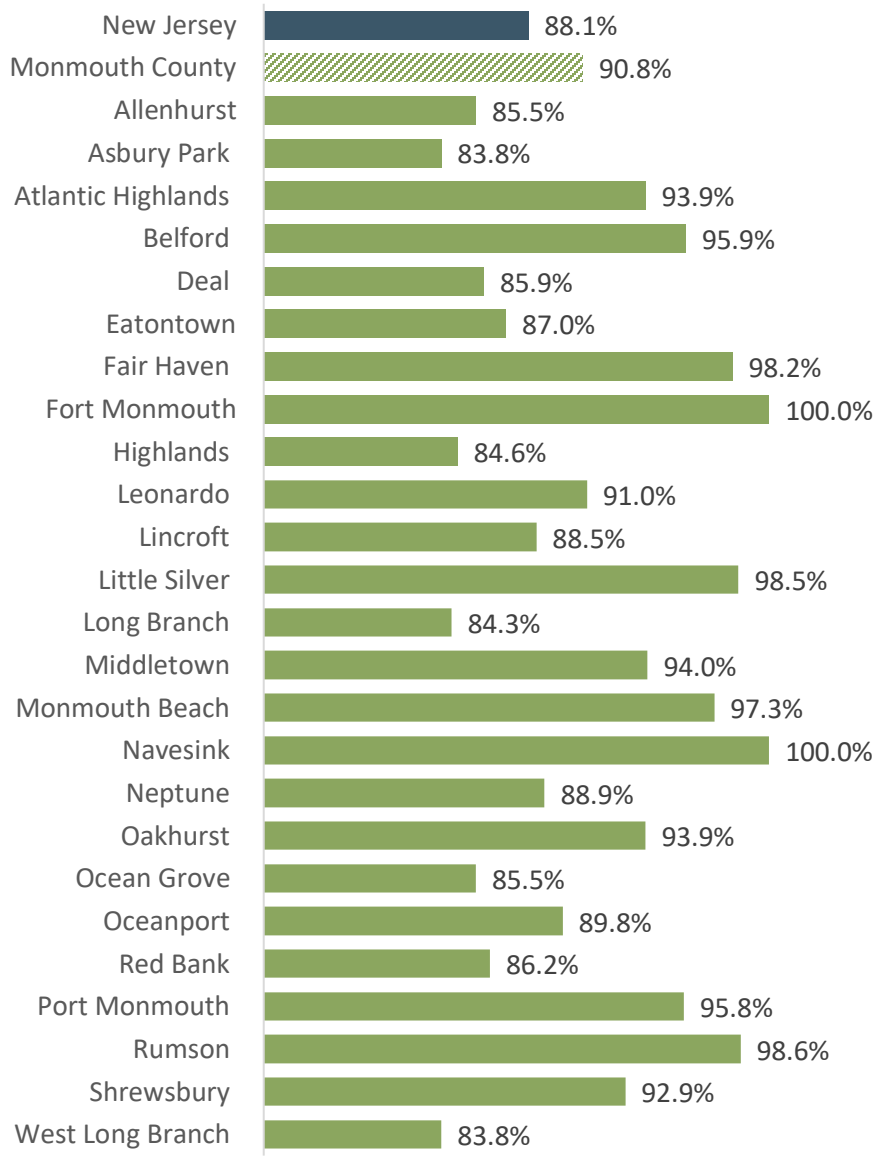
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 126. 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

Figure 127. Households with Internet, by State, County, and Town, 2016-2020



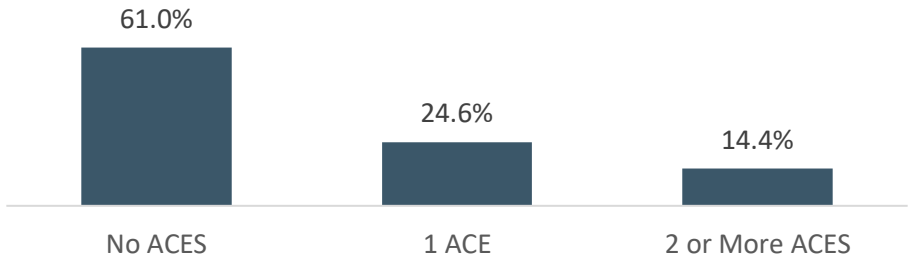
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Table 29. Domestic Violence Offenses, by State, 2019

	2019
New Jersey	59,645

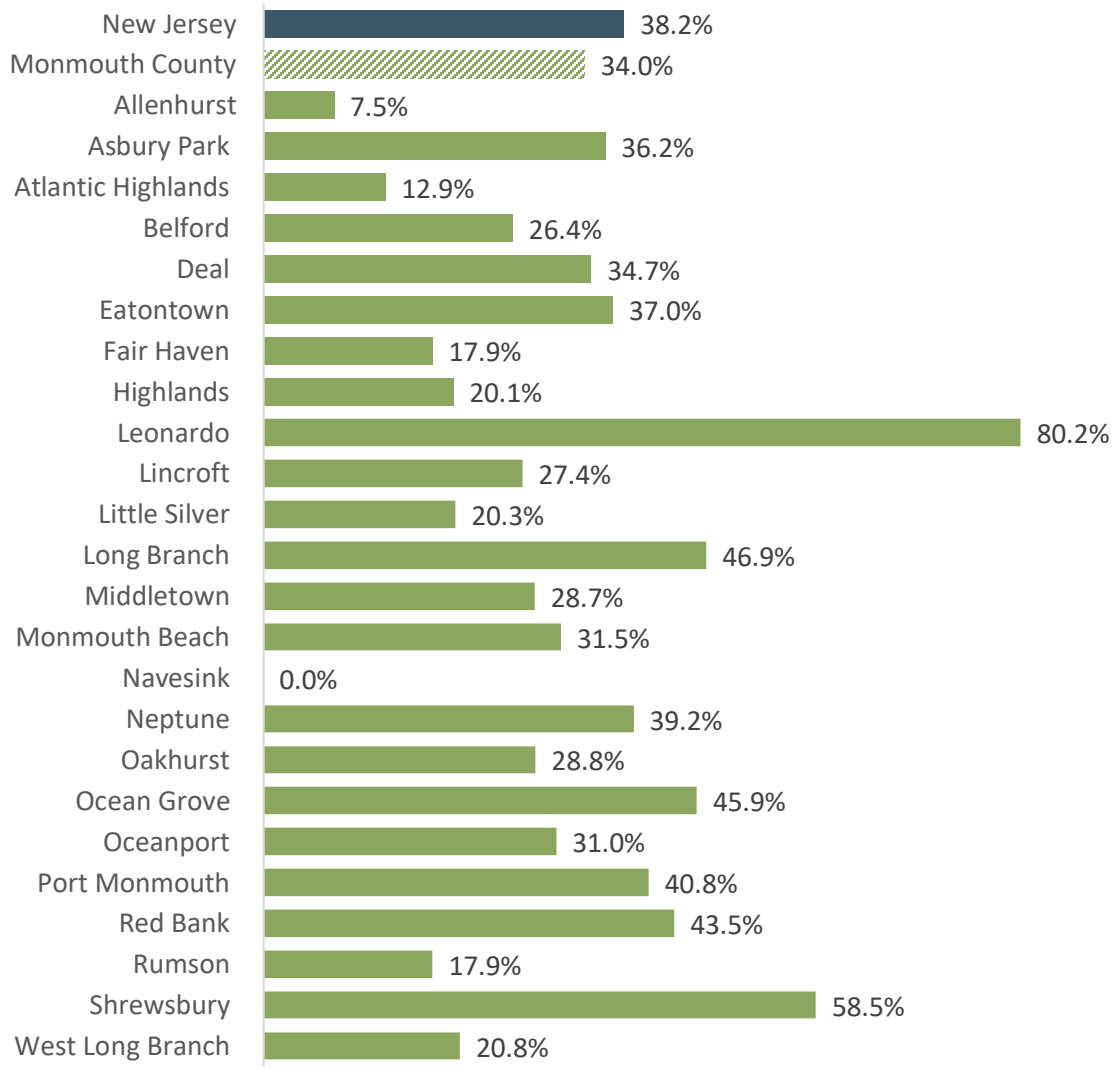
DATA SOURCE: State of New Jersey Department of Law and Public Safety, Uniform Crime Reporting Unit, Uniform Crime Report, 2019

Figure 128. 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

Figure 129. 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
NOTE: Towns (Fort Monmouth) with missing data not represented.

Table 30. Top Languages Spoken at Home, by State, County, and Town, 2016-2020

	Speak only English	Spanish	French, Haitian, or Cajun	German or other West Germanic languages	Russian, Polish, or other Slavic languages
New Jersey	68.4%	16.4%	1.1%	0.3%	1.7%
Monmouth County	82.4%	7.1%	0.8%	0.3%	1.5%
Allenhurst	85.8%	2.1%	1.3%	0.6%	0.0%
Asbury Park	76.6%	13.7%	7.5%	0.4%	0.4%
Atlantic Highlands	90.9%	1.7%	0.0%	4.4%	0.1%
Belford	89.1%	6.7%	0.0%	0.0%	0.0%
Deal	71.7%	14.6%	0.0%	1.2%	0.0%
Eaton	79.1%	4.6%	1.5%	0.3%	1.6%
Fair Haven	95.3%	2.7%	0.1%	0.0%	0.6%
Fort Monmouth	100.0%	0.0%	0.0%	0.0%	0.0%
Highlands	94.1%	2.4%	0.7%	0.0%	0.0%
Leonardo	95.6%	0.5%	1.1%	0.0%	0.0%
Lincroft	86.5%	2.9%	0.0%	0.0%	1.6%
Little Silver	94.1%	1.5%	0.0%	0.5%	0.5%
Long Branch	60.9%	22.2%	0.4%	0.1%	0.6%
Middle Monmouth Beach	89.6%	3.7%	0.2%	0.4%	1.2%
Navesink	93.6%	3.7%	0.5%	0.3%	0.5%
Neptune	83.6%	2.8%	0.0%	0.0%	5.1%
Oakhurst	83.9%	9.9%	2.5%	0.4%	0.8%
Ocean Grove	85.7%	4.2%	3.8%	0.5%	0.0%
Oceanport	93.7%	2.5%	0.6%	0.4%	0.0%
Port Monmouth	92.7%	0.5%	0.4%	0.0%	0.0%
Red Bank	93.4%	4.6%	0.0%	0.0%	0.0%
Rumson	72.2%	23.3%	0.5%	0.6%	0.1%
Shrewsbury	92.4%	3.7%	0.4%	0.4%	0.2%
West Long Branch	95.6%	0.8%	0.4%	0.0%	0.1%

	Other Indo-European languages	Korean	Chinese (incl. Mandarin, Cantonese)	Vietnamese
New Jersey	5.4%	0.9%	1.4%	0.2%
Monmouth County	4.0%	0.2%	1.3%	0.1%
Allenhurst	8.7%	0.0%	0.0%	0.0%
Asbury Park	0.8%	0.4%	0.0%	0.0%
Atlantic Highlands	1.6%	0.0%	0.4%	0.0%

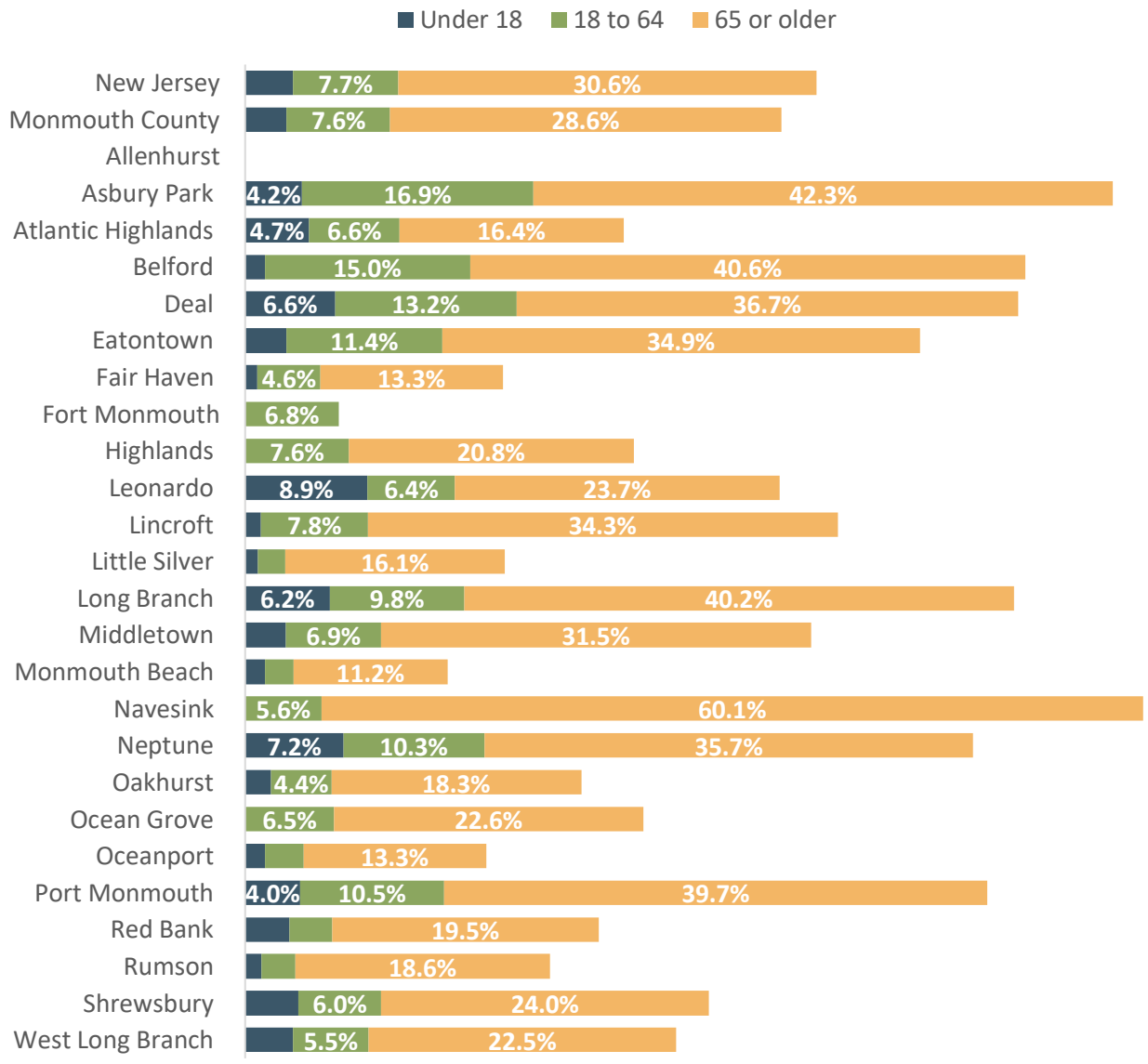
Belford	2.5%	0.0%	1.4%	0.0%
Deal	5.7%	0.0%	0.0%	0.0%
Eaton	5.5%	1.1%	1.7%	2.0%
Fair Haven	0.1%	0.3%	0.3%	0.0%
Fort Monmouth	0.0%	0.0%	0.0%	0.0%
Highlands	0.5%	0.0%	1.9%	0.3%
Leonardo	0.0%	0.0%	0.8%	2.0%
Lincroft	6.9%	0.0%	1.1%	0.0%
Little Silver	1.4%	0.0%	0.6%	0.0%
Long Branch	13.5%	0.2%	0.2%	0.0%
Middle	3.5%	0.0%	0.7%	0.1%
Monmouth Beach	1.2%	0.2%	0.0%	0.0%
Navesink	8.5%	0.0%	0.0%	0.0%
Neptune	1.0%	0.0%	0.0%	0.0%
Oakhurst	3.2%	0.0%	0.4%	0.0%
Ocean Grove	1.6%	0.0%	0.0%	0.0%
Oceanport	3.6%	2.8%	0.0%	0.0%
Port Monmouth	0.7%	0.0%	0.0%	0.0%
Red Bank	1.6%	0.1%	0.1%	0.0%
Rumson	1.1%	0.0%	0.9%	0.0%
Shrewsbury	0.8%	0.7%	0.7%	0.0%
West Long Branch	4.8%	0.0%	0.0%	0.0%

	Tagalog (incl. Filipino)	Other Asian and Pacific Island languages	Arabic	Other and unspecified languages
New Jersey	0.9%	1.5%	0.9%	1.0%
Monmouth County	0.4%	0.7%	0.6%	0.5%
Allenhurst	0.0%	0.0%	0.0%	1.5%
Asbury Park	0.0%	0.0%	0.0%	0.1%
Atlantic Highlands	0.0%	0.9%	0.0%	0.0%
Belford	0.3%	0.0%	0.0%	0.0%
Deal	0.0%	2.8%	0.8%	3.3%
Eaton	0.7%	1.4%	0.0%	0.7%
Fair Haven	0.0%	0.3%	0.0%	0.3%
Fort Monmouth	0.0%	0.0%	0.0%	0.0%
Highlands	0.0%	0.0%	0.0%	0.0%
Leonardo	0.0%	0.0%	0.0%	0.0%
Lincroft	0.0%	1.0%	0.0%	0.0%
Little Silver	0.0%	0.0%	0.0%	1.4%
Long Branch	0.2%	0.1%	0.6%	1.0%
Middle	0.2%	0.2%	0.1%	0.2%
Monmouth Beach	0.0%	0.0%	0.0%	0.0%
Navesink	0.0%	0.0%	0.0%	0.0%
Neptune	0.8%	0.3%	0.2%	0.2%
Oakhurst	0.0%	0.0%	0.0%	2.2%

Ocean Grove	0.0%	0.7%	0.0%	0.4%
Oceanport	0.0%	0.0%	0.0%	0.0%
Port Monmouth	1.0%	0.0%	0.0%	0.3%
Red Bank	0.1%	0.8%	0.0%	0.6%
Rumson	0.0%	0.0%	0.0%	0.9%
Shrewsbury	0.6%	0.0%	0.2%	0.0%
West Long Branch	0.1%	0.2%	0.0%	0.1%

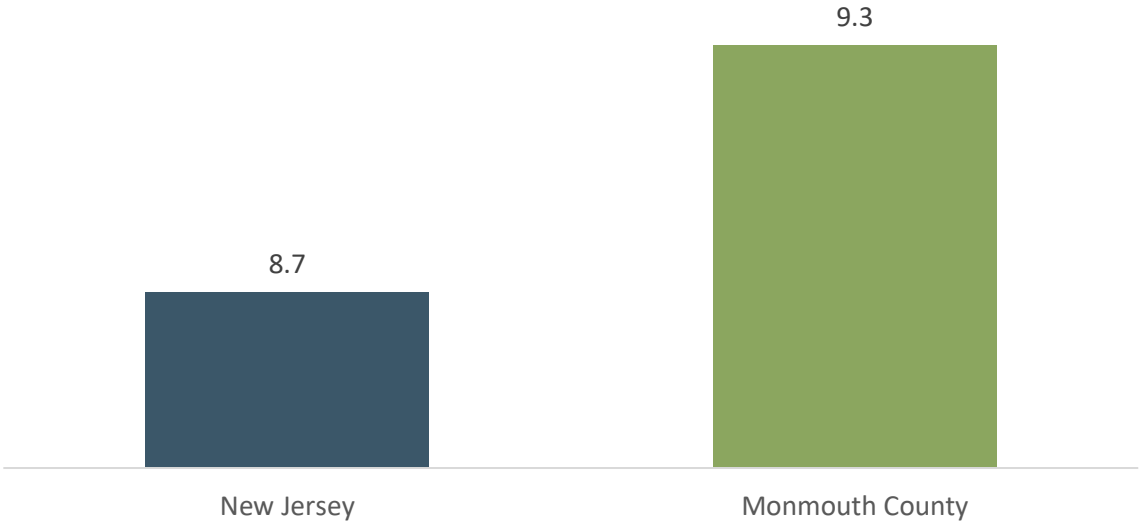
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2016-2020

Figure 130. 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

Figure 131. Membership in Social Associations, by State and County, 2019



DATA SOURCE: County Business Patterns as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2019

Appendix G- Hospitalization Data

Figure 132. 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	Monmouth County	New Jersey	Monmouth County
2017	0-17	690,506	41,712	334.4	277.5
	18-44	1,259,377	70,911	416.8	394.8
	45-64	757,159	50,995	302.2	264.4
	65+	450,704	35,433	320.4	335.4
	All Ages	3,157,746	199,051	350.9	316.7
2018	0-17	673,100	40,740	343.2	310.5
	18-44	1,217,047	69,492	394.5	357.0
	45-64	748,821	51,441	301.1	270.0
	65+	463,456	36,879	322.9	340.9
	All Ages	3,102,424	198,552	345.9	317.9
2019	0-17	658,207	38,402	334.6	297.3
	18-44	1,219,299	65,530	392.2	336.6
	45-64	760,293	49,375	305.8	259.5
	65+	489,485	36,974	330.6	331.8
	All Ages	3,127,284	190,281	345.8	304.2

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

Figure 133. Emergency Room Treat & Release Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	142,919	69.2
	18-44	242,892	80.4
	45-64	139,427	55.6
	65+	82,129	58.4
	All Ages	607,367	67.5
2018	0-17	145,643	74.3
	18-44	239,710	77.7
	45-64	139,051	55.9
	65+	82,293	57.3
	All Ages	606,697	67.6
2019	0-17	142,215	72.3
	18-44	238,051	76.6
	45-64	141,147	56.8
	65+	88,005	59.0
	All Ages	609,418	67.4

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

Figure 134. Emergency Room Treat & Release Counts and Rates per 1,000 Population of Monmouth County Resident Patients Treated at MMC by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	10,173	67.7
	18-44	12,980	72.3
	45-64	7,773	40.3
	65+	5,083	48.1
	All Ages	36,009	57.3
2018	0-17	10,311	78.6
	18-44	12,706	65.3
	45-64	7,995	42.0
	65+	5,033	46.5
	All Ages	36,045	57.7
2019	0-17	9,943	77.0
	18-44	12,096	62.1
	45-64	7,991	42.0
	65+	5,444	48.9
	All Ages	35,474	56.7

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

Figure 135. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in MMC's Primary Service Area Treated in New Jersey by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	21,923	384.9
	18-44	37,747	440.5
	45-64	24,799	315.5
	65+	16,187	341.8
	All Ages	100,656	374.8
2018	0-17	21,954	391.1
	18-44	36,726	433.6
	45-64	25,311	326.0
	65+	17,085	354.2
	All Ages	101,076	379.0
2019	0-17	20,537	369.7
	18-44	34,379	407.6
	45-64	24,469	315.3
	65+	17,145	348.7
	All Ages	96,530	362.0

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

Figure 136. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in MMC's Primary Service Area Treated at MMC, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	9,288	163.1
	18-44	11,878	138.6
	45-64	7,120	90.6
	65+	4,793	101.2
	All Ages	33,079	123.2
2018	0-17	9,284	165.4
	18-44	11,593	136.9
	45-64	7,322	94.3
	65+	4,732	98.1
	All Ages	32,931	123.5
2019	0-17	8,964	161.4
	18-44	11,071	131.3
	45-64	7,284	93.9
	65+	5,144	104.6
	All Ages	32,463	121.7

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

Figure 137. 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	Monmouth County	New Jersey Residents	Monmouth County
2017	American Indian or Alaska Native	6,530	175	201.1	126.9
	Asian	80,692	3,667	92.2	98.5
	Black or African American	780,645	34,742	628.0	739.6
	Hawaiian & Pacific Islander	3,949	127	985.5	569.5
	Other Race	610,721	21,495	935.3	1034.4
	Two or More Races	11,014	1,002	38.6	69.5
	White	1,563,896	137,843	264.8	263.3
	All Race/Ethnicities	3,057,447	199,051	340.0	126.9
2018	American Indian or Alaska Native	6,035	175	185.4	129.0
	Asian	80,655	3,926	90.3	103.5
	Black or African American	755,704	33,922	608.9	723.2

		Count		Rate per 100,000 Population	
Year	Race/Ethnicity	New Jersey Residents	Monmouth County	New Jersey Residents	Monmouth County
	Hawaiian & Pacific Islander	8,405	135	2,031.7	602.7
	Other Race	633,209	22,527	961.3	1071.2
	Two or More Races	11,395	983	39.5	67.2
	White	1,509,245	136,884	258.0	263.9
	All Race/Ethnicities	3,004,648	198,552	335.0	129.0
2019	American Indian or Alaska Native	5,360	205	164.0	156.1
	Asian	81,556	3,731	89.8	99.7
	Black or African American	754,534	31,930	600.1	684.2
	Hawaiian & Pacific Islander	4,203	126	1,005.3	512.2
	Other Race	683,104	22,304	1,012.6	1054.1
	Two or More Races	11,025	935	37.5	63.2
	White	1,486,019	131,050	253.0	251.9
	All Race/Ethnicities	3,025,801	190,281	334.6	156.1

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

Figure 138. 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

Year	Race/Ethnicity	Count	Rate per 1,000
	Two or More Races	1,745	6.0
	White	219,439	37.5
	All Race/Ethnicities	592,206	-
2019	American Indian or Alaska Native	593	18.1
	Asian	18,706	20.6
	Black or African American	195,413	155.4
	Hawaiian & Pacific Islander	480	114.8
	Other Race	162,149	240.4
	Two or More Races	1,946	6.6
	White	215,469	36.7
	All Race/Ethnicities	594,756	-

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

Figure 139. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in MMC'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	81	105.7
	Asian	1,277	146.6
	Black or African American	27,516	872.9
	Hawaiian & Pacific Islander	73	598.4
	Other Race	16,549	1390.1
	Two or More Races	529	74.6
	White	54,631	262.0
	All Race/Ethnicities	100,656	374.8
2018	American Indian or Alaska Native	71	93.2
	Asian	1,368	155.7
	Black or African American	26,681	853.4
	Hawaiian & Pacific Islander	86	661.5
	Other Race	17,117	1425.5
	Two or More Races	552	76.9
	White	55,201	267.2
	All Race/Ethnicities	101,076	379.0
2019	American Indian or Alaska Native	87	118.0
	Asian	1,233	143.6
	Black or African American	24,862	799.6
	Hawaiian & Pacific Islander	81	582.7
	Other Race	16,896	1402.0
	Two or More Races	470	65.0
	White	52,901	255.8

Year	Race/Ethnicity	Count	Rate per 1,000 Population
	All Race/Ethnicities	96,530	362.0

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

Figure 140. Emergency Room Treat and Release Counts and Rates per 1,000 Population of Patients Residing in MMC's Primary Service Area Treated at MMC by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	32	41.8
	Asian	380	43.6
	Black or African American	6,799	215.7
	Hawaiian & Pacific Islander	18	147.5
	Other Race	9,727	817.1
	Two or More Races	50	7.1
	White	16,073	77.1
	All Race/Ethnicities	33,079	123.2
2018	American Indian or Alaska Native	38	49.9
	Asian	375	42.7
	Black or African American	6,491	207.6
	Hawaiian & Pacific Islander	24	184.6
	Other Race	10,100	841.1
	Two or More Races	78	10.9
	White	15,825	76.6
	All Race/Ethnicities	32,931	123.5
2019	American Indian or Alaska Native	38	51.6
	Asian	361	42.0
	Black or African American	6,293	202.4
	Hawaiian & Pacific Islander	35	251.8
	Other Race	10,052	834.1
	Two or More Races	93	12.9
	White	15,591	75.4
	All Race/Ethnicities	32,463	121.7

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

Figure 141. 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	
Year	Age	New Jersey	Monmouth County	New Jersey	Monmouth County
2017	0-17	24,837	1397	12.0	9.3
	18-44	91,990	5553	30.4	30.9
	45-64	55,496	3694	22.1	19.2
	65+	10,688	883	7.6	8.4
	All Ages	183,011	11,527	20.3	18.3
2018	0-17	26,241	1801	13.4	13.7
	18-44	90,808	6061	29.4	31.1
	45-64	55,715	4342	22.4	22.8
	65+	11,055	932	7.7	8.6
	All Ages	183,819	13,136	20.5	21.0
2019	0-17	25,172	1640	12.8	12.7
	18-44	90,172	5592	29.0	28.7
	45-64	54,046	3779	21.7	19.9
	65+	11,851	923	8.0	8.3
	All Ages	181,241	11,934	20.0	19.1

Figure 142. 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	
Year	Race/Ethnicity	New Jersey	Monmouth County	New Jersey	Monmouth County
2017	American Indian or Alaska Native	334	17	10.3	12.3
	Asian	3,380	145	3.9	3.9
	Black or African American	44,153	3,826	35.5	81.4
	Hawaiian & Pacific Islander	187	5	46.7	22.4
	Other Race	22,769	362	34.9	17.4
	Two or More Races	490	21	1.7	1.5
	White	106,929	5,539	18.1	10.6
	All Race/Ethnicities	178,242	9,915	19.8	15.4
2018	American Indian or Alaska Native	350	46	10.8	33.9
	Asian	3,497	158	3.9	4.2
	Black or African American	44,282	3,522	35.7	75.1
	Hawaiian & Pacific Islander	187	6	45.2	26.8
	Other Race	24,682	366	37.5	17.4
	Two or More Races	651	41	2.3	2.8
	White	104,601	5,211	17.9	10.0

	All Race/Ethnicities	178,250	9,350	19.9	14.6
2019	American Indian or Alaska Native	322	44	9.8	33.5
	Asian	3,466	135	3.8	3.6
	Black or African American	43,789	3,166	34.8	67.8
	Hawaiian & Pacific Islander	187	5	44.7	20.3
	Other Race	27,076	495	40.1	23.4
	Two or More Races	609	39	2.1	2.6
	White	99,593	5,142	17.0	9.9
	All Race/Ethnicities	175,042	9,026	19.4	14.1

Figure 143. 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	Monmouth County	New Jersey	Monmouth County
2017	0-17	131,591	7,830	63.7	52.1
	18-44	231,158	14,076	76.5	78.4
	45-64	226,349	16,506	90.3	85.6
	65+	363,285	27,978	258.2	264.8
	All Ages	952,383	66,390	105.8	105.6
2018	0-17	130,739	7,831	66.7	59.7
	18-44	225,360	14,027	73.0	72.1
	45-64	221,118	16,308	88.9	85.6
	65+	364,459	29,208	254.0	270.0
	All Ages	941,676	67,374	105.0	107.9
2019	0-17	127,024	7,480	64.6	57.9
	18-44	218,270	13,498	70.2	69.3
	45-64	215,320	15,813	86.6	83.1
	65+	368,288	29,326	248.7	263.2
	All Ages	928,902	66,117	102.7	105.7

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

Figure 144. Inpatient Discharge Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	32,923	15.9
	18-44	50,878	16.8
	45-64	44,240	17.7
	65+	68,104	48.4
	All Ages	196,145	21.8
2018	0-17	32,768	16.7

	18-44	49,365	16.0
	45-64	43,076	17.3
	65+	67,477	47.0
	All Ages	192,686	21.5
2019	0-17	32,107	16.3
	18-44	48,316	15.5
	45-64	41,662	16.8
	65+	67,539	45.6
	All Ages	189,624	21.0

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

Figure 145. Inpatient Discharge Counts and Rates per 1,000 Population of Monmouth County Resident Patients Treated at MMC, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	2,578	17.2
	18-44	3,617	20.1
	45-64	2,600	13.5
	65+	3,520	33.3
	All Ages	12,315	19.6
2018	0-17	2,457	18.7
	18-44	3,586	18.4
	45-64	2,436	12.8
	65+	3,554	32.8
	All Ages	12,033	19.3
2019	0-17	2,474	19.2
	18-44	3,410	17.5
	45-64	2,414	12.7
	65+	3,343	30.0
	All Ages	11,641	18.6

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

Figure 146. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in MMC's Primary Service Area Treated in New Jersey by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	3,806	66.8
	18-44	6,922	80.8
	45-64	7,215	91.8
	65+	12,304	259.8
	All Ages	30,247	112.6
2018	0-17	3,739	66.6
	18-44	6,790	80.2
	45-64	7,316	94.2

	65+	12,941	268.3
	All Ages	30,786	115.4
2019	0-17	3,606	64.9
	18-44	6,436	76.3
	45-64	6,985	90.0
	65+	12,748	259.3
	All Ages	29,775	111.7

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

Figure 147. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in MMC's Primary Service Area Treated at MMC, by Age, 2017-2019

Year	Age	Count	Rate per 1,000 Population
2017	0-17	1,809	1,665
	18-44	2,719	2,391
	45-64	2,053	1,964
	65+	3,099	2,968
	All Ages	9,680	8,988
2018	0-17	1,644	29.3
	18-44	2,595	30.6
	45-64	1,951	25.1
	65+	3,181	66.0
	All Ages	9,371	35.1
2019	0-17	1,665	30.0
	18-44	2,391	28.3
	45-64	1,964	25.3
	65+	2,968	60.4
	All Ages	8,988	33.7

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

Figure 148. Inpatient Discharge Counts and Rates per 1,000 Population of Patients 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	Monmouth County	New Jersey	Monmouth County
2017	American Indian or Alaska Native	1913	66	58.9	47.9
	Asian	40,158	1,451	45.9	39.0
	Black or African American	164,073	7,012	132.0	149.3
	Hawaiian & Pacific Islander	1438	48	358.9	215.2
	Other Race	135,193	4,500	207.0	216.5
	Two or More Races	1733	120	6.1	8.3
	White	607,875	53,193	102.9	101.6

Year	Race/Ethnicity	Count		Rate per 1,000 Population	
		New Jersey	Monmouth County	New Jersey	Monmouth County
	All Race/Ethnicities	952,383	66,390	268.3	-
2018	American Indian or Alaska Native	1689	73	51.9	53.8
	Asian	40,286	1,612	45.1	42.5
	Black or African American	160,752	7,179	129.5	153.1
	Hawaiian & Pacific Islander	2146	71	518.7	317.0
	Other Race	146,436	4,664	222.3	221.8
	Two or More Races	1929	125	6.7	8.5
	White	588,438	53,650	100.6	103.4
	All Race/Ethnicities	941,676	67,374	267.7	-
2019	American Indian or Alaska Native	1559	55	47.7	41.9
	Asian	38,291	1,666	42.2	44.5
	Black or African American	156,678	7,083	124.6	151.8
	Hawaiian & Pacific Islander	1442	65	344.9	264.2
	Other Race	152,844	4,520	226.6	213.6
	Two or More Races	1767	155	6.0	10.5
	White	576,321	52,573	98.1	101.1
	All Race/Ethnicities	928,902	66,117	262.7	-

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

Figure 149. Inpatient Discharge Counts and Rates per 1,000 Population of New Jersey Resident Patients Treated at RWJBH Hospitals, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rater per 1,000
2017	American Indian or Alaska Native	207	6.4
	Asian	8,753	10.0
	Black or African American	45,498	36.6
	Hawaiian & Pacific Islander	188	46.9
	Other Race	33,999	52.1
	Two or More Races	255	0.9
	White	107,245	18.2
	All Race/Ethnicities	196,145	55.2
2018	American Indian or Alaska Native	181	5.6
	Asian	8,850	9.9
	Black or African American	45,635	36.8
	Hawaiian & Pacific Islander	199	48.1
	Other Race	34,880	53.0

	Two or More Races	250	0.9
	White	102,691	17.6
	All Race/Ethnicities	192,686	54.8
2019	American Indian or Alaska Native	244	7.5
	Asian	8,642	9.5
	Black or African American	44,186	35.1
	Hawaiian & Pacific Islander	200	47.8
	Other Race	34,415	51.0
	Two or More Races	339	1.2
	White	101,598	17.3
	All Race/Ethnicities	189,624	53.6

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

Figure 150. Inpatient Discharge Counts and Rates per 1,000 Population of Monmouth County Resident Patients Treated at MMC, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rater per 1,000 Population
2017	American Indian or Alaska Native	21	15.2
	Asian	245	6.6
	Black or African American	1,653	35.2
	Hawaiian & Pacific Islander	13	58.3
	Other Race	1,906	91.7
	Two or More Races	10	0.7
	White	8,467	16.2
	All Race/Ethnicities	12,315	15.2
2018	American Indian or Alaska Native	26	19.2
	Asian	200	5.3
	Black or African American	1,607	34.3
	Hawaiian & Pacific Islander	27	120.5
	Other Race	2,056	97.8
	Two or More Races	12	0.8
	White	8,105	15.6
	All Race/Ethnicities	12,033	19.2
2019	American Indian or Alaska Native	16	12.2
	Asian	229	6.1
	Black or African American	1,514	32.4
	Hawaiian & Pacific Islander	19	77.2
	Other Race	1,960	92.6
	Two or More Races	25	1.7
	White	7,878	15.1
	All Race/Ethnicities	11,641	12.2

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

Figure 151. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in MMC'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	28	36.6
	Asian	518	59.5
	Black or African American	5,185	164.5
	Hawaiian & Pacific Islander	20	163.9
	Other Race	2,832	237.9
	Two or More Races	64	9.0
	White	21,600	103.6
	All Race/Ethnicities	30,247	112.6
2018	American Indian or Alaska Native	25	32.8
	Asian	478	54.4
	Black or African American	5,256	168.1
	Hawaiian & Pacific Islander	34	261.5
	Other Race	2,906	242.0
	Two or More Races	54	7.5
	White	22,033	106.7
	All Race/Ethnicities	30,786	115.4
2019	American Indian or Alaska Native	20	27.1
	Asian	526	61.2
	Black or African American	5,099	164.0
	Hawaiian & Pacific Islander	36	259.0
	Other Race	2,756	228.7
	Two or More Races	77	10.6
	White	21,261	102.8
	All Race/Ethnicities	29,775	111.7

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

Figure 152. Inpatient Discharge Counts and Rates per 1,000 Population of Patients Residing in MMC's Primary Service Area Treated at MMC, by Race/Ethnicity, 2017-2019

Year	Race/Ethnicity	Count	Rate per 1,000 Population
2017	American Indian or Alaska Native	13	17.0
	Asian	172	19.7
	Black or African American	1,502	47.6
	Hawaiian & Pacific Islander	-	65.6
	Other Race	1,584	133.1
	Two or More Races	-	1.0
	White	6,394	30.7
	All Race/Ethnicities	9,680	36.0
2018	American Indian or Alaska Native	14	18.4
	Asian	137	15.6
	Black or African American	1,420	45.4
	Hawaiian & Pacific Islander	15	115.4
	Other Race	1,648	137.2
	Two or More Races	-	0.7
	White	6,132	29.7
	All Race/Ethnicities	9,371	35.1
2019	American Indian or Alaska Native	11	14.9
	Asian	151	17.6
	Black or African American	1,351	43.5
	Hawaiian & Pacific Islander	15	107.9
	Other Race	1,576	130.8
	Two or More Races	15	2.1
	White	5,869	28.4
	All Race/Ethnicities	8,988	33.7

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

Figure 153. Hospital Admission Rates per 1,000 Population, by Race/Ethnicity, New Jersey and MMC, 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
MMC	Asian	5.1	1.9	3.3	0.7
	Black	21.4	3.9	17.5	5.5
	Hispanic	5.6	1.6	4.1	2.0
	White	10.1	3.2	6.9	1.5
	All Race/Ethnicities	11.4	3.2	8.2	2.1

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

Figure 154. Hospital Admission Rates per 1,000 Population by Reason for Admission, by Race/Ethnicity, New Jersey and MMC, 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
MMC	Asian	46.9	7.9	1.9	0.3
	Black	138.4	21.7	10.6	3.6
	Hispanic	61.0	4.7	3.5	2.6
	White	84.7	14.1	5.0	2.2
	All Race/Ethnicities	93.6	14.6	5.8	2.6

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

Figure 155. Hospital Admission and Emergency Department Visit Rates per 1,000 Population, by Age and Race/Ethnicity, New Jersey and MMC, 2019

		Admission Rate per 1,000 Population					Emergency Department Visits per 1,000 Population				
	Age	Asian	Black	Hispanic	White	All Race/ Ethnicities	Asian	Black	Hispanic	White	All Race/ Ethnicities
New Jersey	All	5.2	26.1	10.3	17.2	18.6	108.8	682.4	430.2	271.2	403
	Under 18	0.4	1.9	1.4	1.1	1.6	99.8	477.1	497.4	181.7	344
	18 to 64	3.5	26.5	9.3	12	15	91.4	760.5	392.4	248	396.6
	65+	25.3	73.3	46.6	48.7	54.8	233.8	698.1	548.2	428.5	505.8
MMC	All	46.9	138.4	61.0	84.7	93.6	169.3	894.4	552.1	301.1	429.5
	Under 18	7.7	19.3	21.5	9.8	14.2	150.0	583.9	740.4	207.1	379.9
	18 to 64	32.8	145.7	67.0	61.6	77.6	129.4	1,031.0	467.2	269.6	412.8
	65+	188.9	308.4	186.8	221.5	236.0	423.7	865.5	638.6	479.8	540.6

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

Figure 156. 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	Monmouth County	New Jersey	Monmouth County
2017	73,005	6,006	8.1	9.6
2018	69,282	5,871	7.7	9.4
2019	65,610	5,533	7.3	8.8

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

Figure 157. 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	Monmouth County	New Jersey	Monmouth County
2017	126,968	9,464	14.1	15.1
2018	125,886	9,803	14.0	15.7
2019	126,198	10,115	14.0	16.2

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

Figure 158. Inpatient Discharge Counts and Rates per 1,000, Residents of Monmouth County Treated at MMC, 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	2,032	1,836	1,755	3.2	2.9	2.8
Diseases and Disorders of the Circulatory System	948	1,001	929	1.5	1.6	1.5

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

Appendix H- Cancer Data

APPENDIX H1: CANCER INCIDENCE RATE REPORT: CANCER PATIENT ORIGIN MONMOUTH COUNTY 2020

Almost sixty eight percent of MMC's cancer inpatients and 67.7% of cancer outpatients resided in the Primary Service Area. In total, 80.6% of inpatients and 80.0% of outpatients resided in Monmouth County. Long Branch (07740) and Eatontown represent the largest segment of MMC's inpatient cancer patients. Similarly, Long Branch (07740) and Asbury Park (07712) represent the largest segments of MMC'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 MMC IP PATIENTS	%	2020 MMC OP PATIENTS	%
Monmouth County	909	80.6%	813	80.0%
Primary Service Area	765	67.8%	688	67.7%
Secondary Service Area	126	11.2%	100	9.8%
Out of Service Area (NJ)	224	19.9%	215	21.2%
Out of State	13	1.2%	13	1.3%
TOTAL	**1,128**	**100.0%**	**1,016**	**100.0%**
Long Branch (07740)	223	19.8%	194	19.1%
Eatontown (07724)	104	9.2%		
Asbury Park (07712)			117	11.5%

Source; Decision Support; IP volume includes cases with ICD10 principal or secondary codes C00 thru D49.9 (Neoplasms); OP volumeincludes cases with ICD10 principal or secondary codes Z51.0 or Z51.11 (Chemo and Radiation Therapy).

APPENDIX H2: CANCER INCIDENCE RATE REPORT: MONMOUTH COUNTY 2013 2017

INCIDENCE RATE REPORT FOR MONMOUTH 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	523.2	4160	stable	0.4
Bladder	25.5	206	stable	-0.3
Brain & ONS	6.8	50	*	*
Breast	146.2	616	stable	0.1
Cervix	6.1	21	stable	-2.3
Colon & Rectum	40.9	325	falling	-3.3
Esophagus	4.3	36	falling	-2
Kidney & Renal Pelvis	16.7	133	rising	0.9
Leukemia	17.4	134	rising	1.5
Liver & Bile Duct	7.6	64	rising	2.4
Lung & Bronchus	59.7	482	falling	-1.5
Melanoma of the Skin	32.1	249	rising	1.6
Non-Hodgkin Lymphoma	24.3	188	stable	0
Oral Cavity & Pharynx	12.9	105	rising	1
Ovary	11	48	falling	-2.2
Pancreas	14.5	121	rising	1.3
Prostate	139.3	549	falling	-2.2
Stomach	6.7	56	falling	-1.5
Thyroid	26.8	182	stable	1.4
Uterus (Corpus & Uterus, NOS)	30.8	140	stable	-0.2

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

APPENDIX H3: CANCER INCIDENCE DETAILED RATE REPORT: MONMOUTH COUNTY 2013-2017 SELECT CANCER SITES: RISING INCIDENCE RATES

		Kidney & Renal Pelvis	Leukemia	Liver & Bile Duct	Melanoma of the Skin	Oral Cavity & Pharynx	Pancreas
INCIDENCE RATE REPORT FOR MONMOUTH COUNTY 2013-2017 All Races (includes Hispanic), AllAges	Age-Adjusted Incidence Rate - casesper 100,000	16.7	17.4	7.6	32.1	12.9	14.5
	Average Annual Count	133	134	64	249	105	121
	Recent Trend	rising	rising	rising	rising	rising	rising
	Recent 5-Year Trend in IncidenceRates	0.9	1.5	2.4	1.6	1	1.3
White Non-Hispanic, All Ages	Age-Adjusted Incidence Rate - casesper 100,000	17.4	17.1	7.1	37.5	13.5	14.5
	Average Annual Count	115	109	50	237	92	102
	Recent Trend	rising	stable	rising	rising	rising	rising
	Recent 5-Year Trend in IncidenceRates	0.8	1	2.7	1.7	1.5	1.4
Black (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - casesper 100,000	14.2	9.3	12.5	*	6.1	15.6
	Average Annual Count	7	5	7	3 or fewer	3	9
	Recent Trend	stable	stable	stable	*	falling	stable
	Recent 5-Year Trend in IncidenceRates	2.5	2.1	1.7	*	-5.7	-1
Asian or Pacific Islander (includes Hispanic), All Ages	Age-Adjusted Incidence Rate - casesper 100,000	*	*	*	*	9.4	12.8
	Average Annual Count	3 or fewer	3 or fewer	3 or fewer	3 or fewer	4	4
	Recent Trend	*	*	*	*	stable	*
	Recent 5-Year Trend in IncidenceRates	*	*	*	*	-0.6	*
Hispanic (any race), All Ages	Age-Adjusted Incidence Rate - casesper 100,000	16.6	19.7	12.2	9.3	10.8	17.6
	Average Annual Count	8	9	5	4	5	6
	Recent Trend	stable	stable	*	stable	stable	*
	Recent 5-Year Trend in IncidenceRates	0.8	0.7	*	-1.3	-2.4	*
MALES	Age-Adjusted Incidence Rate - casesper 100,000	23.9	22.1	12.1	40.9	19	16.3
	Average Annual Count	88	77	47	144	72	59
	Recent Trend	rising	rising	rising	rising	rising	stable
	Recent 5-Year Trend in IncidenceRates	1.4	1.4	2.8	1.7	1.4	0.8
FEMALES	Age-Adjusted Incidence Rate - casesper 100,000	10.8	13.7	3.9	25.7	7.8	13.1
	Average Annual Count	45	56	18	105	33	62
	Recent Trend	stable	stable	stable	stable	stable	rising
	Recent 5-Year Trend in IncidenceRates	0.2	1.3	1.3	1.3	-0.2	1.7

** 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).*

APPENDIX H4: CANCER MORTALITY RATE REPORT: MONMOUTH COUNTY 2014-2018

MORTALITY RATE REPORT: MONMOUTH COUNTY 2014-2018					
Cancer Site	Met Healthy People Objective?	Age-Adjusted Mortality Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trend in Mortality Rates
All Cancer Sites	***	143.3	1,187	falling	-2.7
Bladder	***	4.6	39	stable	-0.3
Brain & ONS	***	4.2	34	*	*
Breast	***	21.1	99	falling	-2.3
Cervix	***	1.6	7	falling	-2.9
Colon & Rectum	***	11.4	94	falling	-4.8
Esophagus	***	3.5	31	falling	-1.4
Kidney & Renal Pelvis	***	3	25	falling	-2.1
Leukemia	***	6.2	49	falling	-1
Liver & Bile Duct	***	5.2	44	stable	0.6
Lung & Bronchus	***	34.8	287	falling	-3.4
Melanoma of the Skin	***	2.7	23	falling	-1.6
Non-Hodgkin Lymphoma	***	5.4	44	falling	-3.7
Oral Cavity & Pharynx	***	1.9	16	falling	-3.4
Ovary	***	6.3	29	falling	-2.3
Pancreas	***	10.2	86	stable	-0.5
Prostate	***	17.3	56	falling	-3.6
Stomach	***	2.1	18	falling	-4.5
Thyroid	***	0.6	5	stable	0
Uterus (Corpus & Uterus, NOS)	***	5.1	24	stable	0.3

**** No Healthy People 2020 Objective for this cancer.*

** Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).*

APPENDIX H5: CANCER MORTALITY DETAILED RATE REPORT (Highest Volume): MONMOUTH COUNTY 2014-2018

		Liver & Bile Duct	Pancreas
MORTALITY RATE REPORT FOR MONMOUTH COUNTY 2014-2018 All Races (includes Hispanic), All Ages	Met Healthy People Objective	***	***
	Age-Adjusted Death Rate - per 100,000	5.2	10.2
	Average Annual Count	44	86
	Recent Trend	stable	stable
	Recent 5-Year Trend in Death Rates	0.6	-0.5
White Non-Hispanic, All Ages	Met Healthy People Objective	***	***
	Age-Adjusted Death Rate - per 100,000	5.1	10
	Average Annual Count	36	72
	Recent Trend	stable	stable
	Recent 5-Year Trend in Death Rates	0.5	-0.4
Black (includes Hispanic), All Ages	Met Healthy People Objective	***	***
	Age-Adjusted Death Rate - per 100,000	6.6	15.3
	Average Annual Count	4	8
	Recent Trend	*	stable
	Recent 5-Year Trend in Death Rates	*	-0.6
Asian or Pacific Islander (includes Hispanic), All Ages	Met Healthy People Objective	***	***
	Age-Adjusted Death Rate - per 100,000	*	11.1
	Average Annual Count	3 or fewer	4
	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	*	*
	Average Annual Count	3 or fewer	3 or fewer
	Recent Trend	*	*
	Recent 5-Year Trend in Death Rates	*	*
MALES	Met Healthy People Objective	***	***
	Age-Adjusted Death Rate - per 100,000	8.3	11.2
	Average Annual Count	30	42
	Recent Trend	stable	stable
	Recent 5-Year Trend in Death Rates	0.5	-0.7
FEMALES	Met Healthy People Objective	***	***
	Age-Adjusted Death Rate - per 100,000	2.8	9.3
	Average Annual Count	13	44
	Recent Trend	stable	stable
	Recent 5-Year Trend in Death Rates	0.5	-0.4

**** 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 morewhich exceeds suppression threshold (but is rounded to 3).*

APPENDIX H6: CANCER INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
All Cancer Sites: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	485.9	51,689	falling	-0.8
US (SEER+NPCR)	448.7	1,673,102	falling	-1
Cape May County	564.6	881	stable	-0.2
Salem County	554.1	462	stable	0
Gloucester County	541.6	1,853	stable	-0.2
Burlington County	527.8	2,956	falling	-0.4
Camden County	524.6	3,123	falling	-0.4
Monmouth County	523.2	4,160	stable	0.4
Ocean County	521.2	4,511	falling	-0.6
Cumberland County	512	895	stable	0.1
Sussex County	510.3	932	falling	-0.8
Warren County	506.4	706	falling	-0.8
Mercer County	503.9	2,138	falling	-0.6
Atlantic County	495.8	1,699	falling	-0.8
Morris County	487.9	3,030	falling	-0.9
Hunterdon County	475.1	794	stable	-0.4
Bergen County	472.4	5,571	falling	-1
Somerset County	463.3	1,827	falling	-0.8
Essex County	462.1	3,930	falling	-0.7
Middlesex County	460.8	4,293	falling	-0.9
Union County	453.7	2,802	falling	-1.2
Passaic County	451.6	2,510	falling	-0.8
Hudson County	403.5	2,607	falling	-1.2
Bladder: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	23.1	2,487	falling	-1.1
US (SEER+NPCR)	20	74,787	falling	-1.9
Cape May County	30.9	51	stable	-0.3
Warren County	27.2	39	stable	-0.4
Gloucester County	27.1	90	stable	0
Atlantic County	26.8	93	stable	-0.6
Salem County	26.5	23	stable	0.6
Burlington County	26.5	151	stable	-0.2
Sussex County	25.9	48	stable	0

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5- Year Trending Incidence Rates
Hunterdon County	25.9	43	stable	0.5
Monmouth County	25.5	206	stable	-0.3
Camden County	25	148	stable	-0.8
Cumberland County	25	43	stable	-0.7
Morris County	24.2	152	falling	-1.5
Ocean County	23.9	231	falling	-2.2
Middlesex County	22.8	211	falling	-1
Bergen County	22.6	277	falling	-1.6
Passaic County	22.2	124	stable	-1
Mercer County	20.7	88	falling	-1.4
Union County	20.4	127	falling	-2
Somerset County	20.1	79	stable	-1.2
Essex County	18.4	154	falling	-1.4
Hudson County	17.6	108	falling	-1.6
Brain & ONS: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	6.8	673	*	*
US (SEER+NPCR)	6.5	22,781	*	*
Salem County	9.6	7	*	*
Warren County	9.1	12	*	*
Hunterdon County	8.6	12	*	*
Sussex County	7.9	13	*	*
Gloucester County	7.8	25	*	*
Burlington County	7.7	39	*	*
Ocean County	7.7	54	*	*
Mercer County	7.3	29	*	*
Bergen County	7.2	77	*	*
Morris County	7.2	40	*	*
Atlantic County	6.9	22	*	*
Cumberland County	6.9	11	*	*
Camden County	6.9	38	*	*
Middlesex County	6.8	60	*	*
Monmouth County	6.8	50	*	*
Passaic County	6.7	35	*	*
Somerset County	6.5	23	*	*
Cape May County	5.8	7	*	*
Hudson County	5.7	38	*	*
Union County	5.6	33	*	*

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5- Year Trending Incidence Rates
Essex County	5.5	46	*	*
Breast: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	136.6	7,668	rising	0.5
US (SEER+NPCR)	125.9	244,411	rising	0.3
Morris County	148.1	480	stable	0
Burlington County	147	433	rising	1.3
Hunterdon County	146.2	129	stable	0.2
Monmouth County	146.2	616	stable	0.1
Gloucester County	144.3	267	stable	0.3
Somerset County	144.2	306	stable	0.1
Mercer County	141.9	316	stable	0.2
Camden County	141	450	stable	0.6
Bergen County	140.8	865	stable	0.5
Essex County	137.4	641	rising	1.9
Union County	136.7	454	stable	0
Cape May County	135.7	106	stable	-0.1
Sussex County	135.6	129	stable	-0.2
Ocean County	132.9	586	stable	-0.2
Atlantic County	131.4	238	stable	0.2
Salem County	130.6	56	stable	0.1
Middlesex County	129.7	639	stable	-0.1
Warren County	125.9	92	stable	-0.7
Passaic County	124.4	367	rising	1.1
Cumberland County	118.9	108	stable	0.6
Hudson County	111.1	389	stable	0.5
Cervix: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.7	382	falling	-1.9
US (SEER+NPCR)	7.6	12,833	stable	0.3
Cumberland County	15.3	11	stable	-1.4
Cape May County	11.7	5	stable	0.8
Salem County	10.6	3	*	*
Hudson County	9.4	33	falling	-2.2
Union County	9.3	29	stable	-0.3
Atlantic County	9.2	14	stable	-1.1
Essex County	9.2	40	falling	-3
Passaic County	8.6	23	stable	-2.1
Ocean County	8.2	27	stable	-1.5

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5- Year Trending Incidence Rates
Camden County	8.1	23	falling	-2.7
Warren County	8	4	stable	-0.5
Somerset County	7.5	13	stable	4.7
Gloucester County	6.9	12	stable	-0.8
Middlesex County	6.9	32	stable	-1.5
Bergen County	6.8	36	stable	-0.9
Burlington County	6.4	16	stable	12.6
Morris County	6.3	18	stable	-1.1
Mercer County	6.2	12	falling	-3.9
Monmouth County	6.1	21	stable	-2.3
Sussex County	5.9	5	stable	-2.7
Hunterdon County	5.1	3	falling	-4
Colon & Rectum: All Races (includes Hispanic), Both Sexes, AllAges				
New Jersey	40.8	4,342	falling	-1.6
US (SEER+NPCR)	38.4	142,225	falling	-1.4
Salem County	48.4	40	falling	-2.6
Cape May County	46.5	72	falling	-2.8
Cumberland County	46.3	80	falling	-2.5
Gloucester County	44.8	151	falling	-2.7
Burlington County	44.7	249	stable	-1
Ocean County	43.7	393	falling	-1.8
Camden County	43.7	256	falling	-2.9
Warren County	42.8	61	falling	-3
Sussex County	42.1	74	falling	-3.4
Essex County	42.1	354	stable	-0.1
Monmouth County	40.9	325	falling	-3.3
Atlantic County	40.4	138	falling	-3.6
Hudson County	40.3	259	falling	-2.9
Middlesex County	39.6	370	falling	-3
Passaic County	39.5	220	stable	-0.8
Union County	39.1	243	falling	-3.2
Bergen County	39	464	stable	1.1
Hunterdon County	37.7	62	falling	-2.6
Mercer County	37.3	158	falling	-3.3
Morris County	37.1	233	falling	-3.4
Somerset County	35.2	139	falling	-3.4

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5- Year Trending Incidence Rates
Esophagus: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	4.3	469	falling	-1.3
US (SEER+NPCR)	4.5	17,419	falling	-1.1
Warren County	7	10	stable	-0.1
Gloucester County	6.4	23	rising	2.2
Cape May County	6.4	10	stable	1.4
Sussex County	6.1	12	stable	-1.1
Ocean County	5.7	52	stable	-0.7
Cumberland County	5.1	9	stable	-0.3
Camden County	5	31	stable	-0.8
Hunterdon County	4.7	8	stable	-1.8
Salem County	4.7	4	stable	-3.4
Morris County	4.6	30	stable	-0.4
Passaic County	4.5	25	stable	-0.3
Burlington County	4.4	25	stable	-0.9
Atlantic County	4.3	15	falling	-2.1
Monmouth County	4.3	36	falling	-2
Mercer County	4.2	18	falling	-2.8
Essex County	3.7	32	falling	-3
Union County	3.7	23	stable	-1.9
Middlesex County	3.6	34	falling	-2
Bergen County	3.2	39	falling	-1.4
Hudson County	3.2	20	falling	-2.8
Somerset County	3.2	13	stable	-1.6
Kidney & Renal Pelvis: All Races (includes Hispanic), Both Sexes,All Ages				
New Jersey	16.3	1,736	rising	0.8
US (SEER+NPCR)	16.8	62,705	rising	0.6
Cumberland County	21	36	stable	-10.5
Burlington County	19.6	110	stable	1.3
Camden County	19.6	116	rising	2
Gloucester County	18.6	65	stable	0.4
Ocean County	17.8	147	rising	1.5
Mercer County	17.7	76	rising	2
Salem County	17.7	15	stable	0.2
Atlantic County	17.4	60	stable	0.2
Cape May County	17.3	26	stable	2.1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5- Year Trending Incidence Rates
Monmouth County	16.7	133	rising	0.9
Warren County	16.5	22	stable	0.8
Bergen County	16.4	194	stable	0.5
Passaic County	15.8	88	stable	0.9
Morris County	15.7	98	stable	0.7
Middlesex County	15.7	146	stable	0
Sussex County	15.4	31	stable	-0.4
Union County	15	93	stable	0.2
Somerset County	14.6	58	stable	-0.1
Hunterdon County	13.8	23	stable	-0.7
Essex County	13.4	115	stable	0.6
Hudson County	12.8	84	stable	0.5
Leukemia: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	15.7	1,610	rising	0.8
US (SEER+NPCR)	14.2	51,227	falling	-2.1
Sussex County	19.4	32	rising	2.9
Monmouth County	17.4	134	rising	1.5
Gloucester County	17.4	58	stable	1.2
Ocean County	16.9	145	stable	0.6
Morris County	16.8	101	rising	1.2
Mercer County	16.6	68	rising	1.8
Cape May County	16.5	23	stable	-1.2
Burlington County	16.3	88	stable	0.9
Cumberland County	16.1	28	rising	1.7
Warren County	16	21	stable	0.4
Union County	15.7	93	stable	1
Bergen County	15.6	182	stable	1.3
Passaic County	15.6	83	stable	1
Somerset County	15.4	57	stable	-0.5
Middlesex County	15.4	139	stable	0.3
Camden County	15.3	88	stable	0.4
Hunterdon County	14.7	23	stable	-0.8
Essex County	14.2	117	stable	0.5
Atlantic County	13.7	45	stable	-0.2
Salem County	13.7	10	stable	-1.1
Hudson County	11.5	72	stable	0

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5- Year Trending Incidence Rates
Liver & Bile Duct: All Races (includes Hispanic), Both Sexes, AllAges				
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, AllAges				
New Jersey	55.3	5,950	falling	-1.6
US (SEER+NPCR)	58.3	221,568	falling	-2
Salem County	85.4	73	rising	2.5
Cape May County	76.3	130	stable	-0.8
Gloucester County	74.6	252	falling	-1.2
Ocean County	70.8	672	falling	-1.1
Cumberland County	69.2	123	falling	-0.8
Camden County	67.2	404	falling	-1.4
Atlantic County	64.7	226	falling	-1.9
Warren County	63.8	91	stable	-1
Sussex County	62.5	114	falling	-1.3

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
Burlington County	61.8	350	falling	-1
Monmouth County	59.7	482	falling	-1.5
Mercer County	56.7	242	falling	-1.5
Middlesex County	49.7	459	falling	-2.1
Bergen County	49.4	598	falling	-1.7
Hunterdon County	48.6	81	stable	-1.2
Morris County	47.7	300	falling	-2
Essex County	46.9	393	falling	-2.4
Passaic County	44.8	250	falling	-5.8
Somerset County	44	173	falling	-1.8
Hudson County	43.7	273	falling	-2.5
Union County	43.1	262	falling	-2.2
Melanoma of the Skin: All Races (includes Hispanic), Both Sexes,All Ages				
New Jersey	22.2	2,335	stable	0.5
US (SEER+NPCR)	22.3	81,226	rising	1.8
Cape May County	51.3	77	rising	3.3
Hunterdon County	39.8	65	stable	1.9
Ocean County	34	283	stable	0.2
Salem County	32.4	26	stable	-16.8
Monmouth County	32.1	249	rising	1.6
Sussex County	31.9	56	rising	3.1
Gloucester County	27.2	91	stable	0.7
Atlantic County	27.1	92	rising	1.6
Morris County	26.7	164	stable	0.2
Burlington County	26.4	146	stable	0.5
Warren County	25.7	34	stable	0.1
Somerset County	24.4	97	stable	0.2
Camden County	21.7	128	stable	0.3
Mercer County	21.1	88	stable	0.4
Middlesex County	18.1	167	stable	1
Bergen County	18	212	falling	-1.3
Cumberland County	16.4	28	stable	1.3
Union County	15.7	97	stable	0.2
Passaic County	14.3	77	stable	0.2
Essex County	12.2	103	stable	-0.1
Hudson County	8.2	53	stable	-0.7

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
Non-Hodgkin Lymphoma: All Races (includes Hispanic), BothSexes, All Ages				
New Jersey	21.8	2,272	stable	0
US (SEER+NPCR)	19.3	70,661	falling	-1.5
Warren County	24.9	34	stable	-0.2
Monmouth County	24.3	188	stable	0
Morris County	23.7	145	stable	-0.3
Somerset County	23.7	92	stable	0.3
Sussex County	23.5	41	stable	-0.5
Atlantic County	23.2	78	stable	0
Bergen County	23.1	268	stable	0.1
Mercer County	22.6	94	stable	0
Ocean County	22.5	196	stable	0.4
Gloucester County	22.1	73	rising	0.9
Middlesex County	22.1	202	stable	-0.1
Cumberland County	22	37	stable	-0.1
Union County	21.1	129	stable	-6.5
Burlington County	21.1	117	stable	-0.5
Salem County	20.8	17	stable	-0.5
Hunterdon County	20.6	35	stable	-0.3
Camden County	20.6	122	stable	-0.4
Passaic County	20.4	109	stable	0.4
Essex County	18.4	153	stable	-0.7
Cape May County	18.3	29	stable	-0.3
Hudson County	17.1	110	stable	-0.4
Oral Cavity & Pharynx: All Races (includes Hispanic), Both Sexes,All Ages				
New Jersey	11.1	1,204	rising	0.8
US (SEER+NPCR)	11.8	45,129	stable	0
Salem County	16.1	14	stable	1.2
Cape May County	14.6	23	stable	0.2
Atlantic County	14.4	51	rising	1.5
Cumberland County	14	25	rising	2.3
Monmouth County	12.9	105	rising	1
Ocean County	12.8	108	rising	1.7
Sussex County	12.7	25	stable	1.7
Camden County	12.2	75	stable	1.2
Warren County	11.7	17	stable	2.1

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5- Year Trending Incidence Rates
Gloucester County	11.5	41	stable	0.8
Hunterdon County	11.4	21	stable	1.9
Morris County	11.4	74	rising	1.7
Burlington County	11.2	65	stable	1.3
Middlesex County	10.7	100	rising	1.6
Essex County	10.7	92	rising	8.2
Somerset County	10.5	43	stable	0.4
Passaic County	10.1	57	stable	-0.2
Bergen County	9.5	115	stable	-0.1
Mercer County	9.4	42	falling	-1.2
Union County	9	57	stable	-0.1
Hudson County	8.3	55	stable	-1.3
Ovary: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	11.8	679	falling	-2.1
US (SEER+NPCR)	10.9	21,338	falling	-3.1
Cape May County	17.1	13	stable	0.2
Somerset County	13.6	29	falling	-2.1
Camden County	13.4	42	falling	-1.6
Mercer County	13.2	30	stable	-0.9
Burlington County	12.8	39	stable	-0.9
Warren County	12.5	9	stable	0.2
Atlantic County	12.3	22	falling	-2.7
Gloucester County	12.3	23	falling	-2.9
Ocean County	12	55	stable	-1.1
Hunterdon County	11.9	11	falling	-2.7
Middlesex County	11.8	59	falling	-2.1
Hudson County	11.7	41	stable	-1.1
Morris County	11.4	38	falling	-2.5
Bergen County	11.3	72	falling	-3.9
Essex County	11.3	54	falling	-1.8
Passaic County	11.2	34	falling	-2.7
Monmouth County	11	48	falling	-2.2
Union County	10.6	36	falling	-2.4
Cumberland County	10.4	9	stable	15.6
Sussex County	10.2	10	falling	-3.3
Salem County	9.3	4	stable	-2.1
Pancreas: All Races (includes Hispanic), Both Sexes, All Ages				

INCIDENCE RATE REPORT: ALL COUNTIES 2013-2017				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5- Year Trending Incidence Rates
New Jersey	14.4	1,556	rising	1.1
US (SEER+NPCR)	12.9	48,832	rising	0.8
Warren County	17	24	stable	1.8
Mercer County	16.1	69	rising	2.3
Salem County	15.9	14	stable	1.5
Burlington County	15.9	91	rising	2
Ocean County	15.7	148	rising	1.5
Hunterdon County	15.4	27	rising	2.2
Camden County	15.1	91	rising	1.1
Gloucester County	14.7	50	stable	0.8
Cape May County	14.7	25	stable	0.4
Monmouth County	14.5	121	rising	1.3
Essex County	14.2	120	stable	0.7
Atlantic County	14.2	50	stable	1.3
Bergen County	14.1	171	stable	0.3
Morris County	14	90	rising	1.3
Hudson County	14	87	rising	2.1
Passaic County	13.5	76	stable	0
Sussex County	13.5	25	stable	2.3
Cumberland County	13.4	24	stable	0.6
Union County	13.4	82	stable	0.5
Middlesex County	12.9	121	stable	0.8
Somerset County	12.8	51	stable	1.1
Prostate: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	131.3	6,723	falling	-2.9
US (SEER+NPCR)	104.5	192,918	stable	-0.4
Essex County	153.1	593	falling	-3.2
Cape May County	152.9	122	falling	-1.9
Mercer County	148.1	300	falling	-2.3
Burlington County	147.9	407	falling	-3.1
Camden County	142.3	405	falling	-1.8
Gloucester County	140.7	236	falling	-1.8
Monmouth County	139.3	549	falling	-2.2
Salem County	139.3	58	stable	-1.7
Passaic County	136.2	359	falling	-2.5
Union County	134.6	390	falling	-3.7
Cumberland County	129.8	109	stable	-0.6

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
Bergen County	128.6	729	falling	-3.3
Morris County	127.6	392	falling	-3.3
Middlesex County	124.1	555	stable	1.2
Somerset County	122	232	falling	-2.9
Warren County	120	85	falling	-3.5
Sussex County	119.2	117	falling	-4.3
Atlantic County	117.7	203	falling	-2.5
Hudson County	112.7	319	falling	-3.9
Ocean County	112.1	466	falling	-3.6
Hunterdon County	108	94	rising	9.1
Stomach: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	7.9	847	falling	-1.1
US (SEER+NPCR)	6.5	24,190	falling	-1.1
Passaic County	10.4	58	stable	-0.2
Union County	9.7	59	stable	-0.8
Hudson County	9.5	60	falling	-1.7
Essex County	9	76	falling	-2
Cumberland County	8.8	15	stable	-2
Camden County	8.7	51	stable	0.3
Bergen County	8.6	104	stable	-0.9
Mercer County	8.1	34	stable	-0.5
Atlantic County	7.7	26	stable	-1
Middlesex County	7.5	70	falling	-2.5
Sussex County	7.5	14	stable	0.3
Burlington County	7	40	stable	-0.4
Ocean County	7	62	stable	-0.7
Somerset County	7	28	falling	-1.8
Gloucester County	6.7	23	stable	-0.9
Monmouth County	6.7	56	falling	-1.5
Morris County	6.4	41	falling	-1.7
Salem County	5.9	5	stable	0
Hunterdon County	5.7	9	stable	-0.1
Warren County	5.6	8	stable	0.7
Cape May County	5.1	8	stable	-1.6
Thyroid: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	19.3	1,840	stable	-0.3
US (SEER+NPCR)	14.3	48,211	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
Monmouth County	26.8	182	stable	1.4
Gloucester County	24.4	76	rising	4
Mercer County	24.1	96	rising	4
Ocean County	24	147	rising	5.4
Camden County	22	118	rising	2.7
Burlington County	20.8	102	rising	2.4
Bergen County	20.3	207	stable	0.3
Salem County	20.2	13	rising	4
Somerset County	19.8	71	falling	-12.1
Middlesex County	19.2	169	stable	-0.9
Morris County	19.1	102	stable	-3.9
Sussex County	18	29	rising	3.9
Warren County	17	20	stable	1.6
Atlantic County	16.9	48	stable	0.9
Passaic County	16.2	85	stable	-7.6
Cape May County	16	17	rising	2.4
Union County	15.8	92	falling	-8.9
Hudson County	15.1	107	stable	-0.1
Cumberland County	14.6	24	stable	0.5
Hunterdon County	14.4	20	rising	3.6
Essex County	13.7	113	rising	4.3
Uterus (Corpus & Uterus, NOS): All Races (includes Hispanic), BothSexes, All Ages				
New Jersey	31.9	1,913	rising	0.8
US (SEER+NPCR)	27	55,004	rising	1.2
Warren County	39.3	30	stable	1.2
Cumberland County	39.1	37	rising	1.9
Cape May County	38.2	32	rising	3.1
Sussex County	36.3	38	stable	0.9
Camden County	35.3	119	rising	2.1
Mercer County	34.3	82	rising	1.6
Hunterdon County	34.3	31	stable	-1
Gloucester County	33.7	66	stable	1.2
Salem County	33.7	16	stable	1.1
Essex County	33.5	165	rising	1.7
Morris County	32.8	115	stable	0.3
Atlantic County	32.4	61	stable	1.2

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
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

APPENDIX H7: MONMOUTH MEDICAL CENTER - TUMOR REGISTRY SUMMARY

In 2019, MMC's tumor registry data showed that 9.7% and 13.1% 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, Oral Cavity and Pharynx (27.3%), Lymph Nodes (39.1%), and Respiratory System (45.2%).

Compared to 2018, there was a decrease of 13 cases (-1.17%) in 2019. The two biggest decreases in overall cases occurred in Female Genital System (-28, -26.7%), followed by Skin (-13, -43.3%). 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**
BREAST		301	304	5.1%	4.4%	9.6%	2.2%	4.0%	6.1%	3	(3.0)	(0.4)	(3.4)
DIGESTIVE ORGANS		163	166	24.0%	25.6%	49.6%	22.9%	18.3%	41.2%	3	3	(1.1)	(7.3)
	ANUS AND ANAL CANAL		14	33.3%	16.7%	50.0%	22.2%	11.1%	33.3%	4	(11.1)	(5.6)	(16.7)
	COLON	50	53	25.6%	18.6%	44.2%	17.4%	13.0%	30.4%	3	(8.2)	(5.6)	(13.8)
	LIVER AND INTRAHEPATIC BILE DUCTS	16		9.1%	63.6%	72.7%	0.0%	20.0%	20.0%	(7)	(9.1)	(43.6)	(52.7)
	PANCREAS	27	26	5.0%	40.0%	45.0%	4.5%	45.5%	50.0%	(1)	(0.5)	5.5	5.0
	RECTUM	30	24	50.0%	13.6%	63.6%	60.0%	13.3%	73.3%	(6)	10.0	(0.3)	9.7
	STOMACH	14	16	9.1%	18.2%	27.3%	7.7%	15.4%	23.1%	2	(1.4)	(2.8)	(4.2)
EYE, BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM		54	51	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(3)	(3)	0.0	0.0
	BRAIN	24	18	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(6)	0.0	0.0	0.0
	MENINGES	21	22	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1	0.0	0.0	0.0
FEMALE GENITAL ORGANS		105	77	21.8%	5.7%	27.6%	12.1%	10.6%	22.7%	(28)	(28)	(9.7)	4.9
	CERVIX UTERI	19		6.7%	0.0%	6.7%	12.5%	12.5%	25.0%	(10)	5.8	12.5	18.3
	CORPUS UTERI	55	41	20.8%	2.1%	22.9%	10.5%	5.3%	15.8%	(14)	(10.3)	3.2	(7.1)
	OVARY	15	15	46.2%	23.1%	69.2%	16.7%	33.3%	50.0%	0	(29.5)	10.3	(19.2)
HEMATOPOIETIC AND RETICULOENDOTHELIAL SYSTEMS		40	51	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11	11	0.0	0.0
LIP, ORAL CAVITY AND PHARYNX		28	35	18.2%	22.7%	40.9%	9.1%	27.3%	36.4%	7	(9.1)	4.5	(4.5)
LYMPH NODES		29	32	0.0%	20.0%	20.0%	26.1%	39.1%	65.2%	3	26.1	19.1	45.2
MALE GENITAL ORGANS		146	142	15.2%	8.9%	24.1%	15.6%	8.3%	24.0%	(4)	0.4	(0.5)	(0.1)
	PROSTATE GLAND	140	137	16.0%	9.3%	25.3%	16.3%	8.7%	25.0%	(3)	0.3	(0.6)	(0.3)
RESPIRATORY SYSTEM AND INTRATORACIC ORGANS		109	115	17.8%	43.3%	61.1%	12.9%	45.2%	58.1%	6	6	(4.9)	1.8
	BRONCHUS AND LUNG	99	106	16.0%	46.9%	63.0%	11.9%	48.8%	60.7%	7	(4.1)	1.9	(2.2)
SKIN		30	17	7.4%	7.4%	14.8%	9.1%	0.0%	9.1%	(13)	1.7	(7.4)	(5.7)
THYROID AND OTHER ENDOCRINE GLANDS		39	38	0.0%	0.0%	0.0%	0.0%	3.8%	3.8%	(1)	0.0	3.8	3.8

		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
	OTHER ENDOCRINE GLANDS	20	17	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	(3)	0.0	0.0	0.0
	THYROID GLAND	18	18	0.0%	0.0%	0.0%	0.0%	6.3%	6.3%	0	0.0	6.3	6.3
URINARY TRACT		59	56	5.8%	11.5%	17.3%	2.3%	6.8%	9.1%	(3)	(3.5)	(4.7)	(8.2)
	BLADDER	27	35	0.0%	9.1%	9.1%	0.0%	3.3%	3.3%	8	0.0	(5.8)	(5.8)
	KIDNEY	28	17	11.5%	11.5%	23.1%	9.1%	18.2%	27.3%	(11)	(2.4)	6.6	4.2
Grand Total		1,115	1,102	11.4%	12.9%	24.3%	9.7%	13.1%	22.8%	(13)	(1.7)	0.2	(1.5)

Appendix I- Outcomes and Results Report of the Previous Implementation Plan

Monmouth Medical Center | RWJBarnabas HEALTH

2019
COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION PLAN
for years 2020 – 2022 as of 9/8/22

Introduction

In 2019, Monmouth Medical Center (MMC) 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 and a survey of local health officials and community agencies. The Plan can be accessed at www.rwjbarnabashealth.org/.aspx.

Through the CHNA process, health need priorities were chosen based on the Medical Center's capacity, resources, competencies, and the needs specific to the populations it serves. The Implementation Plan addresses the manner in which MMC 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*:

- Prevention and Treatment of Obesity & Associated Chronic Diseases such as Diabetes, Heart Disease, Cancer
- Reduce Substance Abuse
- Improve Access to Care for Behavioral Health Patients

MMC participates in the Health Improvement Coalition of Monmouth County which is made up of key stakeholders in the county (government, civic, community-based organizations and healthcare providers) who are focused on improving the health of community members. MMC will continue to work with the Health Improvement Coalition of Monmouth County, other providers and community organizations to improve the health and welfare of our communities.

**The three focus areas do not represent the full extent of the Medical Center's community benefit activities or its support of the community's health needs. Other needs identified through the CHNA may be better addressed by other agencies/organizations or deferred to another timeframe.*

Goal 1: Prevention, Early Detection and Treatment of Obesity & Associated Chronic Diseases such as Diabetes, Heart Disease & Cancer

Key CHNA Findings:

- Obesity is the leading contributor for chronic diseases for both men and women of most ethnicities and leads to premature death and disability. Long Branch has the highest incident rate for Obesity and Diabetes.

- Over 80% of Adults have at least one risk factor for cardiovascular disease. Heart disease and cancer has historically been the top causes of death in Monmouth County with a respective increase of 7.1% and a decrease of 4.8% since 2013. Percentage of residents with high cholesterol in Monmouth County was higher that statewide rate.

- Cancer is the 2nd leading cause of death in the nation, New Jersey and Monmouth County. Monmouth County rates of Breast, Prostate, Melanoma, Lung and Colon/Rectum Cancer were higher than statewide figures. Cancer incidence is substantially higher in Monmouth County than State.

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
1.1	Improve knowledge scores of students participating in the evidenced based Kids Fit nutrition program in the 21st Century After-School program in Long Branch School District	• ↑ % if improvement in change in behavior scores		2019 38% improvement in scores 2020 Suspended – COVID

**Responsible Staff for internal purposes only; Not published on final document*

Goal 1: Prevention, Early Detection and Treatment of Obesity & Associated Chronic Diseases such as Diabetes, Heart Disease & Cancer

Key CHNA Findings:

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- Cancer is the 2nd leading cause of death in the nation, New Jersey and Monmouth County. Monmouth County rates of Breast, Prostate, Melanoma, Lung and Colon/Rectum Cancer were higher than statewide figures. Cancer incidence is substantially higher in Monmouth County than State.

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
1.2	Increase # of pediatric and adult patients seen in the FQHC for 1:1 nutrition and weight management	• ↑ # of pediatric and adult patients – completed visits • ↓ % lower BMI		<u>2019 at FQHC</u> 186 patient visits 62% BMI reduction <u>2020 Q1-Q2 at FQHC</u> suspended program at FQHC due to pandemic 42 unique patients <u>2020 Q-3-Q4 – launched at MMC Diabetes Center</u> 93 patient visits (38 adults, 55 pediatrics) 52.11% BMI reduction <u>2021 MMC Diabetes Center</u> 234 patient visits (74 adults, 160 pediatrics) 58.6% BMI reduction <u>2021 MMC Diabetes Center (YTD 8/31)</u> 234 patient visits (147 adults, 19 pediatrics) BMI reduction – calculated at year end

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Goal 1: Prevention, Early Detection and Treatment of Obesity & Associated Chronic Diseases such as Diabetes, Heart Disease & Cancer

Key CHNA Findings:

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	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
1.3	Provide nutrition and weight management education and screenings for community members at risk for obesity and diabetes	• # of educational events and # serve • # of individuals screened for BMI		<u>2019</u> 79 programs 3,343 served 57 BMI screenings <u>2020</u> 9 programs 280 served 65 BMI screenings <u>2021</u> 5 Programs 98 served 0 BMI screening <u>2022 (YTD 7-30)</u> 54 Programs * 456 served * 0 BMI screening * Opened LiveWell Center 5/1/22 for free community health & nutrition programs with full time RD & demonstration kitchen

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1.4	Advance the implementation of the Long Branch Walking Club through collaboration with MMC clinical and non-clinical employees	• # of participants per session		2019 (fall session) = 30 walkers 2020 spring session = suspended pandemic fall session = 57 walkers 2021 spring session = 53 walkers fall session = suspended to surge 2022 spring session = 33 walkers fall session =

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1.5	Establish a reoccurring health program in community settings (barbershops, hair salons, food pantries, etc.) in Long Branch that serve high risk populations	• # of participants • # of BP referrals • # of lung, breast, colon screenings booked		2020 establish baseline 36 participants – halted to pandemic 2021 – shifted efforts to vaccination education through flyers 2022 – challenges finding male RN's, Med Techs, etc. of color
1.6	Establish a Maternal Health education program with the Women's Health Center to educate pregnant women on healthy lifestyle behaviors with an emphasis on hypertension, gestational diabetes and breastfeeding.	• # of participants • # of participants that are breast feeding at discharge		2020 establish baseline Initiative never launched due to pandemic

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1.7	Improve participation and outcomes for patients taking part in the Outpatient Diabetic Self Management Program	• ↑ # of patient consults
		• 80 % of participants will achieve within a 6 month period
		  • A1c reduction of 1% or >
		  • Weight reduction of 3.5% or >
		  • Participation in 10 hours of comprehensive diabetic management education
				<u>2019</u>
				patient consults 1,141
				A1c 68%
				Weight reduction 70%
				Class participation 80%
				
				<u>2020</u>
				patient consults 1,080
				A1c 55%
				Weight reduction 75%
				Class participation 80% (Jan & Feb) halted group classes due to pandemic
				
				<u>2021</u>
				patient consults 1,214
				A1c reduction 72%
				Weight Reduction 68%
				Class Participation (no group classes in 2021 due to surge)
				
				<u>2022 (YTD 8/15)</u>
				patient consults 682
				A1c & Weight Management – calculated at end of year
				Class participation resuming 10/5/22

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	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
1.8	Improve care transitions for patients with chronic cardiovascular disease through the use of multidisciplinary team rounding, APN assessment during hospital admission, and standardized clinical pathway order sets.	↓ Medicare 30-day readmission rate/100 people for: • AMI to 13.17 • Heart Failure to 17.8 • COPD to 16.3 • PN to 13.96		<u>2019</u> AMI 10.00 Heart Failure 17.36 COPD 15.38 PN 18.26 <u>2020</u> AMI 9.09 Heart Failure 11.27 COPD 15.63 PN 14.89 <u>2021</u> AMI 6.25 Heart Failure 10.89 COPD 6.52 PN 15.07 <u>2022 (YTD 5/31)</u> AMI 0.00 Heart Failure 3.85 COPD 35.71 PN 18.75

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1.9	Partner with VNAHG to provide ongoing communication, education, and monitoring of patients to identify early changes in health status	• ↑ # of new patients enrolled in Healthy Lives Program • ↑ # of completed patient follow-up appointments		<u>2019</u> New Patients = 88 Follow-up appointments =2,292 COPD New Patients = 22 COPD follow-up appointments = 119 <u>2020</u> New Patients = 117 Follow-up appointments = 1972 COPD New Patients = 5 COPD follow-up appointments = 20 <u>2021</u> New Patients = 85 Follow-up appointments = 2,275 COPD New Patients = 10 COPD follow-up appointments = 40 <u>2022 (YTD 8/15)</u> New Patients = 63 Follow-up appointments = 1,461 COPD New Patients = 3 COPD follow-up appointments = 44

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1.10	Eliminate racial/ethnic disparities in 30 day readmits	• ↓ % 30 day readmission with no exclusion		<u>2019</u> Black or African American, non-Hispanic = 15% White, non-Hispanic = 11% Hispanic = 12% <u>2020</u> Black or African American, non-Hispanic = 115/833 = 13.81% White, non-Hispanic = 376/5559 = 6.76% Hispanic = 50/787 = 6.35% <u>2021</u> Black or African American, non-Hispanic =130/788 = 16.50% White, non-Hispanic = 422/5858 = 7.20% Hispanic = 52/832 = 6.25% <u>2022 Q1-Q2</u> Black or African American, non-Hispanic = 34/373 = 9.12% White, non-Hispanic = 195/2567 = 7.60% Hispanic = 28/381 = 7.35%

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	Strategy/Initiative	Indicator/Metric	Responsible	Tracking/Outcome
1.11	Improve racial/ethnic disparities in communication	• Improve quality at discharge with instructions		2019 Black or African American 87.8/48% White 90.6/78% Hispanic 91.3/83% 2020 Black or African American 91.1/84% White 88.0/59% Hispanic 90.5/80% 2021 Black or African American 90.1/83% White 90.2/84% Hispanic 93.9/95% 2022 (YTD 8/31) Black or African American 90.9/87% White 89.1/76% Hispanic 100/99%
1.12	Provide cultural competency education to employees to improve racial/ethnic disparities in communication	• ↑ Increase the % of employees completing the training		2019 = 70% 2020 = 448 employees 2021 = 829 (489 new hires & 220 staff) 2022 = 552 (355 new hires, 93 staff training, 42 physician/resident, 62 management)

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1.13	Increase participation in the Lung Cancer Screening Program for high-risk individuals. Establish referral program to PCP for individuals with incidental lung nodule findings for appropriate radiologic follow-up. Enhance our referrals to our smoking cessation program. Reduce the incidence of late-stage diagnosis for lung cancer	# of participants that complete a low-dose CT for lung cancer screening 2019 = 207 2020 target - Low-dose CT = 228 (10% increase) # of referrals to PCP for Incidental Lung Nodule Program Feb 2020 Initiation 2020 target - Incidental Lung Nodule Referrals = 600 (50/month) # of new lung cancers detected through low-dose CT for lung cancer screening 2019 = 3 2020 target - New cancers detected through low-dose CT for lung cancer screening = 5 (2%) % of patients w/ late stage (stage 4) diagnosis of lung cancer Jan – Jun 2019 = 57% 2020 target - % of patents w/ late stage diagnosis (stage 4) of lung cancer = decrease to 52%		<u>2020</u> 187 participants completing low-dose CT (82% of goal) 351 referrals to PCP -Incidental Lung Nodule Program (59% of goal) 1 new lung cancers detected through low-dose CT for lung cancer screening (0.5%) (20% of goal) 45% patients w/ late stage (stage 4) lung cancer diagnosis from Jan-June 2020 <u>2021</u> 275 participants completing low-dose CT referrals to PCP -Incidental Lung Nodule Program-ended 2021 3 new lung cancers detected through low-dose CT for lung cancer screening 51% patients w/ late stage (stage 4) lung cancer diagnosis <u>2022 Q1-Q2</u> 188 participants completing low-dose CT referrals to PCP -Incidental Lung Nodule Program-ended 2021 3 new lung cancers detected through low-dose CT for lung cancer screening 48% patients w/ late stage (stage 4) lung cancer diagnosis as of March 2022

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1.14	• Continue to provide access to MMC's Cancer Support Community • Established Integrated Oncology Psychotherapy program in support of treatment plans (Oct 2019)	• # participants in Cancer Support Community Programs (2019 - MMC 2,443) • # patients w/increased anxiety due to cancer dx seeking individual therapy (2019 = 7)		<u>2020</u> Participants in Cancer Support Community Programs • MMC 1,748 • Patients w/increased anxiety due to cancer dx seeking individual therapy = 15 <u>2021</u> • Participants in Cancer Support Community Programs • MMC 935 • Patients w/increased anxiety due to cancer dx seeking individual therapy = 24 <u>2022 (YTD 7/30)</u> • Participants in Cancer Support Community Programs • MMC 530 • patients w/increased anxiety due to cancer dx seeking individual therapy = 27

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1.15	Continue to provide community outreach emphasizing screening and early detection for populations at risk / provide navigation to screening for uninsured patients 1. Breast cancer screening Establish navigation process for screening of <u>uninsured patients:</u> 1. Lung cancer screening 2. Colorectal cancer screening	# of at- risk and/or uninsured patients navigated to complete screening <u>2019</u> 421 uninsured patients navigated for breast screening services 398 mammograms 12 breast cancers detected <u>2020 Targets</u> <u>Breast</u> • 465 navigated to breast screening • 445 mammograms completed • 13 breast cancers detected (3%) <u>Lung</u> • 30 low-dose CT for lung cancer screening completed <u>Colon</u> • 50 FIT kits distributed • 25 FIT kits returned		**2020:** <u>Breast</u> 346 navigated to breast screening (74% of goal) 336 mammograms completed (75% of goal) 4 breast cancers detected (1%) (30% of goal) <u>Lung</u> 0 low-dose CT for lung cancer screening completed <u>Colon</u> 24 FIT kits distributed (48% of goal) 14 FIT kits returned (56% of goal) **2021:** <u>Breast</u> 612 navigated to breast screening 610 mammograms completed 8 breast cancers detected (1.3%) <u>Lung</u> 3 low-dose CT for lung cancer screening completed <u>Colon</u> 67 FIT kits distributed 36 FIT kits returned **2022 Q1&2:** <u>Breast</u> 282 navigated to breast screening 215 mammograms completed 3 breast cancers detected (1.4%) <u>Lung</u> – grant not received yet for 2022 # low-dose CT for lung cancer screening completed <u>Colon</u> grant not received yet for 2022 # FIT kits distributed # FIT kits returned

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Goal 2: Reduce Substance Use

Key CHNA Findings:

- Opioid epidemic and non-medical Rx drug use continues to rise. Total substance use treatment admissions were higher than the State and Narcan administrations were up 63% between 2015 & 2016. In Monmouth County and New Jersey, age-adjusted drug induced deaths increased between 2007 and 2013.

- Emergency Department utilization rates in MMC's Service Area were higher (9.0/1,000) than the county rate (6.85/1,000) and the State rate (7.84/1,000).

- Binge drinking increased 17.5 to 22.7% in Monmouth County and New Jersey. 22.7% of adults in Monmouth County reported binge drinking, higher than the State & Ocean County.

- 20% county residents are smokers, higher than the state, Ocean County, County Health Ranking benchmark & Health People 2020. Tobacco use remains the leading cause of preventable disease, disability, and death. E-cigarette use among middle and high school students has increased alarmingly since 2017.

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
2.1	Expand Monmouth Medical Center's Peer Recovery Program (PRP) beyond those individuals reversed from an opioid overdose to include any individuals who accept follow-up care to address drug addiction	• ↑ # and % of individuals who receive emergency care for substance use disorder who subsequently accept follow-up care through the OORP		2019 79.7% (1,113 of 1,397 individuals 2020 86.8% (1,062 of 1,224 individuals) 2021 78.3% (775 of 990 individuals) 2022 Q1-Q2 78.2% (388 of 496 individuals)
2.2	Track recovery status of individuals who received follow-up care through OORP	• ↑ # and % of individuals in recovery at 6 and 12 month intervals		2019 5.8% (7 of 121 individuals) 2020 4.8% (44 of 909 individuals) 2021 6.2% (31 of 499 individuals) 2022 Q1 – Q2 2.9% (6 of 204 individuals)
2.3	Improve awareness and access to services to support those suffering from addiction and their families	• ↑ # of individuals attending the All Recovery Support Group		2020 establish baseline 4,169 attendees 2021 5,360 2022 Q1 – Q2 1,651

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	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
2.4	Conduct screening for and provide education regarding alcohol use	• ↑ *# of patients with an AUDIT score of 8-15 who receive education from a Recovery Specialist*		2020 67 patients 2021 197 patients 2022 (Q1-Q2) 80 patients
2.5	Prevent initiation of tobacco use among youth and young adults and to promote cessation and tobacco users to quit	• ↑ # of schools that implemented non-clinical educational program (ASPIRE) • ↑ expand the # of community educators for adult to adult and adult to children training on vaping education • # of referrals to Nicotine and Tobacco Recovery Services • ↑ # of educational events and # served		2019 • 59 Don't Get Vaped In trainers trained • 5 schools implemented ASPIRE • 157 referrals to Nicotine and Tobacco Recovery Services 2020 • 18 Don't Get Vaped In trainers trained • 1 schools implemented ASPIRE • 152 referrals to Nicotine and Tobacco Recovery Services • 7 of educational events & 25 served 2021 • 0 Don't Get Vaped In trainers trained • 0 schools implemented ASPIRE • 257 referrals to Nicotine and Tobacco Recovery Services • 23 of educational events & 108 served 2022 Q1-Q2 • 0 Don't Get Vaped In trainers trained • 0 schools implemented ASPIRE • 121 referrals to Nicotine and Tobacco Recovery Services • 14 of educational events & 195 served

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Goal 3: Improve Access to Care for Behavioral Health Patients

Key CHNA Findings:

- Individuals with a behavioral health condition are at greater risk of developing a wide range of physical health problems (e.g., chronic diseases).

- Average life expectancy for a person with serious mental illness is at least 25 years less than those without.

- Monmouth County had a higher rate of residents with an inpatient hospitalization (7.10/1,000) for Mental Health Conditions than NJ (4.81/1,000) in 2016.

- Suicide and suicidal ideation is one if most pressing issues with particular concern in the decrease in age of onset. Stress and trauma seen as underlying causes.

-- Monmouth County's suicide rate (8.2/100,000) was higher than the State (7.7/100,000).

- Monmouth County's ED visit rate for Mental Health Conditions increased between 2012 (8.90/1,000) and 2016 (9.33/1,000).

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
3.1	Maintain Integrated Health Home (IHH) for the seriously mentally ill wait time and first appointment adherence in the outpatient setting and after readmission (transition of care)	• % of patients seen within 7 days of IHH referral • % of patients first appointment adherence/no-show rate		2019 100% patients seen within 7 days of referral 100% adherence to first appointment 2020 IHH program discontinued after March 100% patients seen within 7 days of referral 91.65% adherence to first appointment
3.2	Reduce readmission within 30 days of IHH enrollment through focused patient management and navigation	• ↓ % of patients readmitted within 30 days of IHH program		2019 Re-admissions within 30 days of IHH program=5.3% 2020 IHH program discontinued after March Re-admissions within 30 days of IHH program = 0%
3.3	Improve patient satisfaction with IHH program	• ↑ Patient satisfaction scores		2019 Patient Satisfaction with IHH program 92.75% 2020 IHH program discontinued in March 2020

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	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
3.4	Reduce inpatient psychiatric readmissions, increase follow-up after mental health, substance abuse, alcohol or mental health after ED visits, and the initiation & engagement for automatic referrals to IFPR peer recovery specialists for treatment. (in alignment with State Quality Improvement Program goals)	BH1: 30-Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization BH2: Follow-Up After Hospitalization for Mental Illness - 30-Days Post Discharge BH3: Follow-Up After Emergency Department (ED) Visits for Alcohol and Other Drug - 30-Days BH4: Follow-Up After ED Visits for Mental Illness 30-Days BH5: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment BH6: Engagement in Alcohol and Other Drug Abuse or Dependence Treatment BH7: Preventative Care: Depression Screening & Follow Up BH8: Substance Use Screening and Intervention Composite BH11: Standardized Screen Tool for SDOH (Report Only)		<u>2021 Launched 7/1/2021 to 12/31/21</u> BH1 – 16.98% (met goal) BH2 – 47.13% (met target) BH3 – 35.56% (met goal) BH4 – 53.06% (missed target) BH5 – 65.56% (met goal) BH6 – 32.45% (met goal) BH7: 25.64% (met metric) BH8: 0% (missed target) BH11: Reported <u>2022 Outcomes not reported by state yet</u>

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	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
3.4	Provide education for suicide awareness for prevention intervention to identify risk factors and warning signs	• # of educational events • # served		2020 establish baseline 2 educational events 45 served 2021 2 educational events 413 served 2022 (YTD 9/8) 1 event: Role of a Trusted Adult w/Society of Teen Suicide scheduled for 10 served

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