Overlook Medical Center
Community Health Needs Assessment

2019-2021

Atlantic Health System
Overlook Medical Center

ACKNOWLEDGEMENTS & CHNA COMPLIANCE

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

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

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

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

COMPLIANCE CHECKLIST: IRS FORM 990, SCHEDULE H	REPORT PAGE(S)
Part V Section B Line 1a A definition of the community served by the hospital facility	5
Part V Section B Line 1b Demographics of the community	8 and Appendix A
Part V Section B Line 1c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	80
Part V Section B Line 1d How data was obtained	Addressed Throughout
Part V Section B Line 1f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 1g The process of identifying and prioritizing community health needs and services to meet the community health need	7
Part V Section B Line 1h The process for consulting with persons representing the community's interests	7
Part V Section B Line 1i Information gaps that limit the hospital facility's ability to assess the community's health needs	None Identified

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EXECUTIVE SUMMARY

Overlook Medical Center (OMC) is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. To that end, beginning in June 2019, OMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, that encompasses portions of Union, Essex, Morris, Somerset, Hudson and Middlesex counties in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing residents of OMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

The completion of the CHNA provided OMC with a health-centric view of the population it serves, enabling OMC to prioritize relevant health issues and inform the development of future community health implementation plan(s) focused on meeting community needs. This CHNA Final Summary Report serves as a compilation of the overall findings of the CHNA process. This document is not a compendium of all data and resources examined in the development of the CHNA and the identification of health priorities for OMC's service area, but rather an overview that highlights statistics relevant to OMC's health priorities for the CHNA/CHIP planning and implementation period.

Key components of the OMC CHNA process include:

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

Overlook Medical Center, in conjunction with community partners, examined the findings of qualitative and quantitative data review to prioritize key community health issues. The following issues were identified and adopted as the key health priorities for OMC's 2019-2021 CHNA:

- Obesity / Unhealthy Weight / Food Insecurity
- Mental Health & Substance Misuse
- Heart Disease & Diabetes
- End of Life Care
- Cancer
- Stroke

Based on feedback from community partners, health care providers, public health experts, health and human service agencies, and other community representatives, Overlook Medical Center plans to focus on multiple key community health improvement efforts and will create an implementation strategy of their defined efforts, to be shared with the public on an annual basis.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Organization Overview

Overlook Medical Center, part of Atlantic Health System, is located in Summit, New Jersey and home to almost 4,000 employees and over 1,500 physicians.

Overlook Medical Center is home to some of New Jersey's top doctors, offering cutting-edge research, advanced technology and treatments in a compassionate, patient-centered environment. The Atlantic Neuroscience Institute is the region's leader in neuroscience care, offering a broad range of advanced neurological, neurosurgical and neurodiagnostic services. OMC is also certified as a Level IV Epilepsy Center and home to the Gerald J. Glasser Brain Tumor Center, where more brain tumor surgeries are performed than anywhere else in New Jersey. The CyberKnife® program is the largest and most experienced in the state, and there is a satellite emergency department in Union, NJ, which treats about 40,000 emergency cases each year. Overlook Medical Center has advanced certification from The Joint Commission for perinatal care and is designated an Advanced Comprehensive Stroke Center. Additional Joint Commission-certified services include behavioral health care, spine surgery, wound care, and primary care medical home (PCMH).

Overlook Medical Center provides emergency care that is close to home for many in northeastern New Jersey with access to high-tech specialty services available through Atlantic Health System, when needed. Atlantic Health System provides access to renowned specialists, clinical trials, innovative technology and medical treatments, and compassionate support services right here in NJ. Our vast network of hospitals and providers spans 11 counties, so patients can enter our all-encompassing community of care no matter where they live or work.

Atlantic Health System participates in and provides financial support to the North Jersey Health Collaborative (NJHC), an independent, self-governed 501(c)(3) organization with a diverse set of partners representing health care, public health, social services and other community organizations. NJHC's function is a shared process of community needs assessment and health improvement planning to identify the most pressing health issues and facilitate the development of collaborative action plans to address them. By working together NJHC partners are strategically aligning their efforts and resources to achieve collective impact on the health of our communities, accomplishing together what we could never do alone.

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

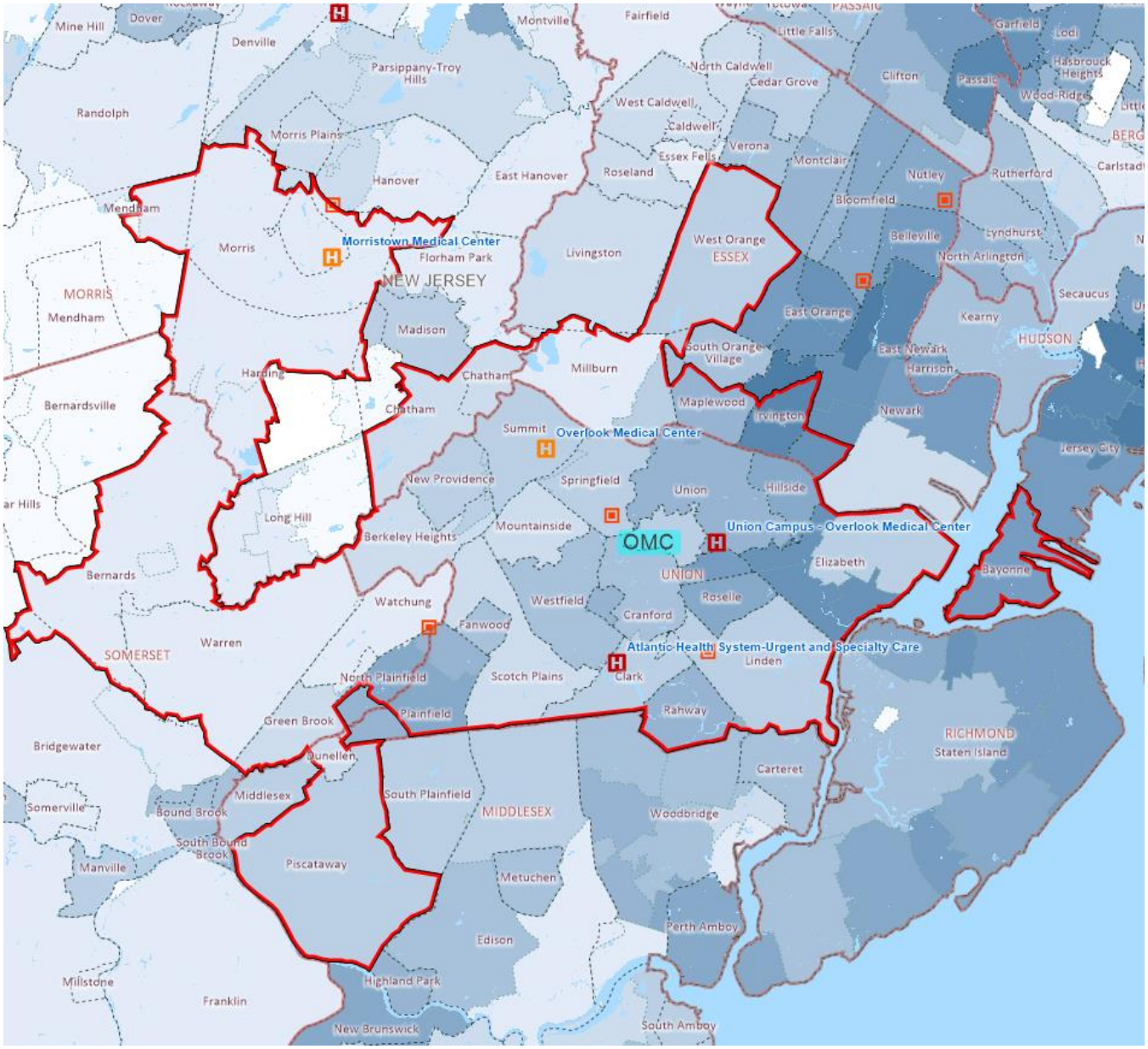
Community Overview

OMC defines the area it serves as the geographic reach from which it receives 75% of its inpatient admissions. For OMC, this represents 39 ZIP Codes, encompassing portions of Union, Morris, Essex, Hudson, Somerset and Middlesex counties in New Jersey.[1] There is broad racial, ethnic, and socioeconomic diversity across the geographic area served by OMC, from densely populated urban settings to suburban areas of the state. Throughout the service area, OMC always works to identify the health needs of the community it serves. Following are the towns and cities served by OMC.

OMC STARK SERVICE AREA					
ZIP CODE	CITY	COUNTY	ZIP CODE	CITY	COUNTY
07040	MAPLEWOOD	ESSEX	07041	MILLBURN	ESSEX
07052	WEST ORANGE	ESSEX	07078	SHORT HILLS	ESSEX
07111	IRVINGTON	ESSEX	07112	NEWARK	ESSEX
07002	BAYONNE	HUDSON	08812	DUNELLEN	MIDDLESEX
08854	PISCATAWAY	MIDDLESEX	07928	CHATHAM	MORRIS
07960	MORRISTOWN	MORRIS	07059	WARREN	SOMERSET
07069	WATCHUNG	SOMERSET	07920	BASKING RIDGE	SOMERSET
07016	CRANFORD	UNION	07023	FANWOOD	UNION
07027	GARWOOD	UNION	07033	KENILWORTH	UNION
07036	LINDEN	UNION	07060	PLAINFIELD	UNION
07062	PLAINFIELD	UNION	07065	RAHWAY	UNION
07066	CLARK	UNION	07076	SCOTCH PLAINS	UNION
07081	SPRINGFIELD	UNION	07083	UNION	UNION
07088	VAUXHALL	UNION	07090	WESTFIELD	UNION
07092	MOUNTAINSIDE	UNION	07201	ELIZABETH	UNION
07202	ELIZABETH	UNION	07203	ROSELLE	UNION
07204	ROSELLE PARK	UNION	07205	HILLSIDE	UNION
07206	ELIZABETHPORT	UNION	07208	ELIZABETH	UNION
07901	SUMMIT	UNION	07922	BERKELEY HEIGHTS	UNION
07974	NEW PROVIDENCE	UNION			

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

Geographic Area Served by Overlook Medical Center



Methodology

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

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

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

Analytic Support

Atlantic Health System's corporate Planning & System Development staff provided OMC with administrative and analytic support throughout the CHNA process. Staff collected and interpreted data from secondary data sources, collected and analyzed data from key informant surveys, provided key market insights and prepared all reports.

Community Representation

Community engagement and feedback were an integral part of the CHNA process. OMC's Community Health Department played a critical role in obtaining community input through key informant surveys of community leaders and partners and included community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

Timelines and other restrictions impacted the ability to survey all potential community stakeholders. OMC sought to mitigate these limitations by including in the assessment process a diverse cohort of representatives or and/or advocates for underserved population in the service area.

Prioritization of Needs

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

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SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to evaluate a Secondary Data Profile compiled by the North Jersey Health Collaborative and Atlantic Health System's Planning & System Development department. This county and service area-based profile is comprised of multiple data sources. Secondary data is comprised of data obtained from existing resources (see Appendix B) and includes demographic and household statistics, education and income measures, morbidity and mortality rates, health outcomes, health factors, social determinants of health, and other data points. County-level secondary data were augmented, where possible, by ZIP Code level inpatient and emergency room utilization data for the entire OMC service area and, when available AHS specific health care utilization data.

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

Demographic Overview[2]

Union County's projected growth is 2.7%, OMC's service area has a growth of 2.4%; due to projected increases in Elizabethport, 5.13%, Springfield, 4.61%, and Rahway, 3.85%. At 5,496.42 residents per square mile, Union County is the 3rd most densely populated county in New Jersey; the 21 counties range from a low of 183.02 population/sq. mile (Salem County) to a high of 14,864.40 population/sq. mile (Hudson County). OMC's service area is predominately White (Non-Hispanic). The New Jersey average for White (Non-Hispanic) is 53.9%, OMC's service area is 40.1%. Over 84% of the population, ages 5 years and older, speak English only or speak English "very well"; this is 4 percentage points lower than the New Jersey average.

For 2019, the median household income for the OMC service area was over $102,364 which was $24,381 more than the state average (Short Hills was 406% greater than the state average). There were twenty towns over $100,000 however, in 2024 there are projected twenty-four towns over $100,000. There are thirty towns projected to increase over the state average.

The state average for families below poverty was 7.8%; OMC's service area was 8.1% and Union County was 8.0%. OMC's service area and Union County both have been projected to have a larger increase in the 'number of families below poverty' compared to the state average.

Currently, there are about 8.6% of people within OMC's service area receiving food stamps/SNAP benefits which was lower than the state average, 9.3%, and lower than Union County, 9.1%. Within OMC's service area, there were eleven towns higher than the state average.

The New Jersey unemployment rate is 7.9%, OMC's service area was 8.4% and the Union County rate was 8.4%. Out of the towns in the service area, 61.5% were below the state's unemployment rate.

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

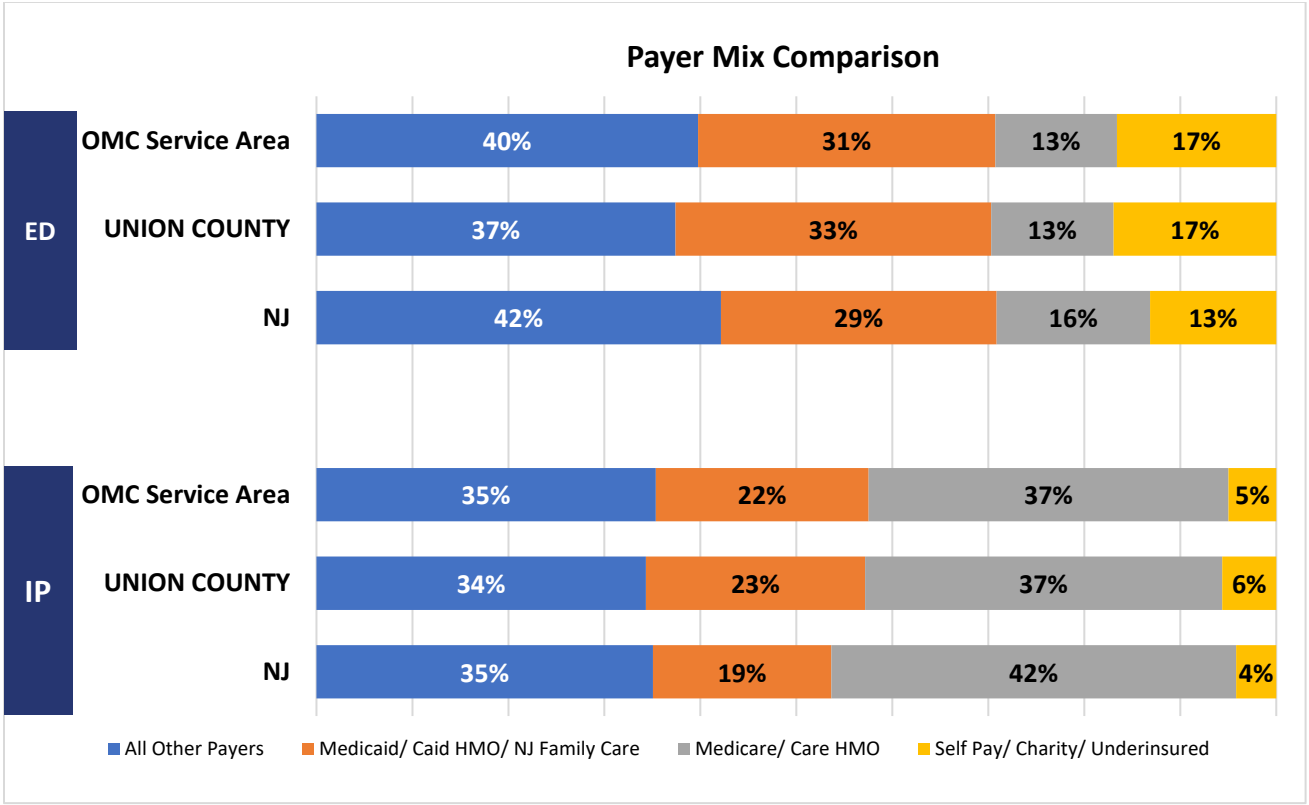
The percent of the population within OMC's service area that had 'some high school education or less' was higher than the New Jersey average; meaning that the area's population was, on average, less educated.

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

The state average for uninsured was 10.7%; however, OMC's service area and Union County were both more than 12%. Twenty-four towns in OMC's service area were less than the state average, Elizabethport had the largest uninsured percent at 28.4%.

Health insurance coverage can have a significant influence on health outcomes. Among ED visits, OMC's Service Area is approximately 31.0% Medicaid/Caid HMO/NJ Family Care with another 17.0% of Self Pay/Charity Care. The area is approximately 40.0% Commercial and 13.0% Medicare/Care HMO. From a payer mix perspective, the ED payer distribution in the Service Area is more favorable than Union County overall but has higher charity care and Medicaid proportions than the statewide distribution.

Among inpatients, OMC's Service Area is approximately 22.0% Medicaid/Caid HMO/NJ Family Care with another 5.0% of Self Pay/Charity Care. The area is approximately 35.0% Commercial and 37.0% Medicare/Care HMO. From a payer mix perspective, the inpatient payer distribution in the Service Area is marginally more favorable than Union County overall but has higher charity care and Medicaid proportions than the statewide distribution.



[3] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

Health Status Indicators[4]

A health status indicator describes an aspect of the population used to measure health or quality of life. Health indicators may include measurements of illness or disease, as well as behaviors and actions related to health. Quality of life indicators include measurements related to economy, education, built environment, social environment, and transportation. We know, from literature, that quality of life indicators may be drivers of health status - which is why both categories of data (approximately 155 indicators) are included in this analysis.

For each indicator, a county is assigned a score based on its comparison to four things: other NJ counties, whether state and national health targets have been met, and the directional trend of the indicator value over time. These four comparison scores range from 0-3, where 0 indicates the best performance and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Where comparison data is not available, a neutral score is substituted. For ease of interpretation and analysis, indicator comparison scores of concern are visually highlighted in red, showing how the county is faring in each category of comparison.

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results. The weights of each comparison in calculating the indicator scores were decided by the Data Committee of the North Jersey Health Collaborative. Specifically, this committee saw the value in comparing an indicator value against itself (the "trend") and against other local New Jersey counties, for the purposes of prioritizing interventions, which is why these two comparisons are the most heavily weighted.

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

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

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Health	Access to Health Services	Primary Care Provider Rate	2	1	3	3			3	2.33	
		Adults with Health Insurance	3		2	2	3			2.08	Hispanic or Latino, Other
		Adults Unable to Afford to See a Doctor	2		3	3			1	1.97	
		Mental Health Provider Rate	2	1	3	3			1	1.89	
		Non-Physician Primary Care Provider Rate	2	2	3	3			0	1.83	
		Children with Health Insurance	2		2	1	2			1.64	
		Clinical Care Ranking	2							1.58	
		Adults who have had a Routine Checkup	0		1				1	1.06	
		Dentist Rate	1	0	1	0			1	0.72	
		Preventable Hospital Stays: Medicare Population	0	0	0	0			0	0.17	
Health	County Health Rankings	Clinical Care Ranking	2							1.58	
		Health Behaviors Ranking	2							1.58	
		Morbidity Ranking	1							1.42	
		Mortality Ranking	1							1.42	
		Physical Environment Ranking	1							1.42	
		Social and Economic Factors Ranking	0							1.25	
Health	Immunizations & Infectious Diseases	Tuberculosis Incidence Rate	3		3	3	3		3	2.75	
		Chlamydia Cases							3	1.83	
		Age-Adjusted Death Rate due to Influenza and Pneumonia	2		3	1				1.75	
		Gonorrhea Cases							2	1.61	
		Lyme Disease Cases							2	1.61	
		Age-Adjusted Rate of ED Visits Due to Influenza	2							1.58	
		Syphilis Cases							1	1.39	
		Adults 50+ with Influenza Vaccination	0		1				2	1.28	
		Kindergartners with Required Immunizations	1		1				1	1.22	
		Adults with Pneumonia Vaccination	0		1				1	1.06	
Health	Wellness & Lifestyle	Insufficient Sleep	2	3	2	2				2.00	
		Self-Reported General Health Assessment: Poor or Fair	2	2	2	2				1.83	
		Morbidity Ranking	1							1.42	
		Frequent Physical Distress	2	1	2	0				1.33	
		Poor Physical Health: Average Number of Days	1	1	2	1				1.33	
		Life Expectancy	1	0	1	1				1.00	
		Limited Activity due to a Health Problem	0		0					1.00	
Health	Prevention & Safety	Severe Housing Problems	3	3	3	3			0	2.17	
		Age-Adjusted Death Rate due to Motor Vehicle Collisions	1		0				2	1.28	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Age-Adjusted Death Rate due to Unintentional Poisonings	0		0	0			3	1.08	Males; White, non-Hispanic
		Adults who were Injured in a Fall: 45+	0		0					1.00	
		Death Rate due to Drug Poisoning	0	1	0	0			3	1.00	
		Age-Adjusted Death Rate due to Unintentional Injuries	0		0	0	0		3	0.92	Males; White, non-Hispanic
Health	**Disabilities**	Persons with Disability Living in Poverty (5-year)	1	0	0	0				0.67	
		Persons with Disability Living in Poverty	1	0	0	0			1	0.56	
Health	**Heart Disease & Stroke**	Adults who Experienced a Stroke	2		3				2	1.94	
		Age-Adjusted Death Rate due to Hypertensive Heart Disease	3		3				1	1.89	Black, non-Hispanic
		Heart Failure: Medicare Population	2	3	2	3			0	1.83	
		Adults who Experienced Coronary Heart Disease	2		2					1.67	
		Adults who Experienced a Heart Attack	2		1				2	1.61	
		Hypertension: Medicare Population	1	2	1	2			2	1.61	
		Stroke: Medicare Population	0	3	1	3			1	1.56	
		Ischemic Heart Disease: Medicare Population	1	3	1	3			0	1.50	
		Atrial Fibrillation: Medicare Population	0	2	1	2			2	1.44	
		Age-Adjusted Death Rate due to Heart Attack	3						0	1.42	
		High Blood Pressure Prevalence	1		1	1	2			1.31	
		Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	2		2	0	1		1	1.25	
		Age-Adjusted Death Rate due to Heart Disease	1		1	1				1.25	Males
		Age-Adjusted Rate of Adult ED Visits for Acute Myocardial Infarction	0							1.25	
		Age-Adjusted Hospitalization Rate due to Heart Attack	1		1				1	1.22	
		Hyperlipidemia: Medicare Population	0	2	0	2				1.17	
Health	**Diabetes**	Diabetes: Medicare Population	2	3	2	3			2	2.28	
		Diabetic Monitoring: Medicare Population	1	2	2	2			1	1.56	
		Adults 20+ with Diabetes	1	0	1					1.08	
		Adults with Prediabetes	0		0					1.00	
		Age-Adjusted Death Rate due to Diabetes	1		2	0			0	0.92	Black, non-Hispanic
Health	**Exercise, Nutrition, & Weight**	SNAP Certified Stores	1	3					2	1.78	
		Farmers Market Density	2	2						1.67	
		Fast Food Restaurant Density	1	2					2	1.61	
		Adults Engaging in Regular Physical Activity	3		2	0	0			1.42	
		Adults 20+ who are Sedentary	1	1			0		2	1.28	
		Health Behaviors Ranking	0							1.25	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Food Insecure Children Likely Ineligible for Assistance	1	1	0	3			1	1.22	
		Grocery Store Density	1	0						1.17	
		Recreation and Fitness Facilities	1	0					1	1.06	
		Adults 20+ who are Obese	1	0			0			1.00	
		Children with Low Access to a Grocery Store,	0	0						1.00	
		Households with No Car and Low Access to a Grocery Store	0	0						1.00	
		Low-Income and Low Access to a Grocery Store	0	0						1.00	
		People 65+ with Low Access to a Grocery Store	0	0						1.00	
		People with Low Access to a Grocery Store	0	0						1.00	
		Food Environment Index	0	0	2	0			1	0.72	
		Access to Exercise Opportunities	0	0	1	0				0.67	
		Child Food Insecurity Rate	1	0	1	0			0	0.50	
		Food Insecurity Rate	1	0	1	0			0	0.50	
		Alzheimer's Disease or Dementia: Medicare Population	2	3	2	3			2	2.28	
		Diabetes: Medicare Population	2	3	2	3			2	2.28	
		Cancer: Medicare Population	1	3	1	3			2	1.94	
		Heart Failure: Medicare Population	2	3	2	3			0	1.83	
		Mammography Screening: Medicare Population	2	2	2	2			1	1.72	
		Chronic Kidney Disease: Medicare Population	1	2	1	1			3	1.67	
		Hypertension: Medicare Population	1	2	1	2			2	1.61	
		People 65+ Living Below Poverty Level	2	1	2	1			2	1.61	Hispanic or Latino
		Diabetic Monitoring: Medicare Population	1	2	2	2			1	1.56	
		Stroke: Medicare Population	0	3	1	3			1	1.56	
		Ischemic Heart Disease: Medicare Population	1	3	1	3			0	1.50	
		Atrial Fibrillation: Medicare Population	0	2	1	2			2	1.44	
Health	**Older Adults & Aging**	Osteoporosis: Medicare Population	1	2	1	1			2	1.44	
		Age-Adjusted Death Rate due to Alzheimer's Disease	1		1	0			3	1.42	
		Adults 50+ with Influenza Vaccination	0		1				2	1.28	
		Hyperlipidemia: Medicare Population	0	2	0	2				1.17	
		People 65+ Living Alone	1	1	1	1			1	1.06	
		Adults who were Injured in a Fall: 45+	0		0					1.00	
		People 65+ with Low Access to a Grocery Store	0	0						1.00	
		Rheumatoid Arthritis or Osteoarthritis: Medicare Population	0	1	0	1			2	0.94	
		Adults with Arthritis	0		0				1	0.89	
		Asthma: Medicare Population	0	2	0	1			1	0.89	
		Depression: Medicare Population	0	0	0	0			3	0.83	
		COPD: Medicare Population	0	0	0	0			2	0.61	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Health	Oral Health	Dentist Rate	1	0	1	0			1	0.72	
		Oral Cavity and Pharynx Cancer Incidence Rate	0	0	0	0			2	0.61	Males
Health	Environmental & Occ. Health	Lyme Disease Cases							2	1.61	
		Physical Environment Ranking	1							1.42	
		Blood Lead Levels in Children (>=5 micrograms per deciliter)	2		0				1	1.22	
		Asthma: Medicare Population	0	2	0	1			1	0.89	
		Adults with Current Asthma	0		0	0			2	0.86	
Health	Cancer	Non-Hodgkin Lymphoma Incidence Rate	2	3	2	3			3	2.50	
		Colon Cancer Screening	3		2	3	3			2.25	
		Cervical Cancer Incidence Rate	2	2	3	3	3		1	2.22	
		Breast Cancer Incidence Rate	1	3	1	2			3	2.00	
		Cancer: Medicare Population	1	3	1	3			2	1.94	
		Prostate Cancer Incidence Rate	2	3	2	3			0	1.83	Black
		Mammography Screening: Medicare Population	2	2	2	2			1	1.72	
		Pap Test in Past 3 Years: 21-65	2		2	1				1.58	
		Age-Adjusted Death Rate due to Prostate Cancer	2	1	2	2	1		1	1.50	Black
		Age-Adjusted Death Rate due to Breast Cancer	2	2	1	2	2		0	1.39	Black
		Mammogram in Past 2 Years: 50-74	1		1	1	2			1.31	
		Age-Adjusted Death Rate due to Pancreatic Cancer	1	1	1	2			1	1.22	
		Pancreatic Cancer Incidence Rate	0	2	1	2			1	1.22	
		Age-Adjusted Death Rate due to Colorectal Cancer	1	1	1	2	2		0	1.06	
		Colorectal Cancer Incidence Rate	1	1	1	2	2		0	1.06	Males
		All Cancer Incidence Rate	0	2	1	2			0	1.00	Males
		Age-Adjusted Death Rate due to Cancer	1	0	1	1	1		1	0.83	Males; Black
		Oral Cavity and Pharynx Cancer Incidence Rate	0	0	0	0			2	0.61	Males
		Liver and Bile Duct Cancer Incidence Rate	0	0	0	0			1	0.39	Males
		Lung and Bronchus Cancer Incidence Rate	0	0	0	0			1	0.39	Males
		Melanoma Incidence Rate	0	0	0	0			1	0.39	Males; White
		Age-Adjusted Death Rate due to Lung Cancer	0	0	0	0	0		1	0.22	Males
Health	Respiratory Diseases	Tuberculosis Incidence Rate	3		3	3	3		3	2.75	
		Age-Adjusted Death Rate due to Influenza and Pneumonia	2		3	1				1.75	
		Age-Adjusted Rate of Adult ED Visits for COPD	1							1.42	
		Adults 50+ with Influenza Vaccination	0		1				2	1.28	
		Adults with Pneumonia Vaccination	0		1				1	1.06	
		Asthma: Medicare Population	0	2	0	1			1	0.89	
		Adults with Current Asthma	0		0	0			2	0.86	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	0		0	0			1	0.64	
		COPD: Medicare Population	0	0	0	0			2	0.61	
		Lung and Bronchus Cancer Incidence Rate	0	0	0	0			1	0.39	Males
		Age-Adjusted Death Rate due to Lung Cancer	0	0	0	0	0		1	0.22	Males
		Chronic Kidney Disease: Medicare Population	1	2	1	1			3	1.67	
		Osteoporosis: Medicare Population	1	2	1	1			2	1.44	
Health	**Other Chronic Diseases**	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	0	1	0	1			2	0.94	
		Adults with Arthritis	0		0				1	0.89	
		Alcohol-Impaired Driving Deaths	3	2	3	2				2.17	
		Age-Adjusted Death Rate due to Hypertensive Heart Disease	3		3				1	1.89	Black, non-Hispanic
		Age-Adjusted Death Rate due to Influenza and Pneumonia	2		3	1				1.75	
		Age-Adjusted Death Rate due to Prostate Cancer	2	1	2	2	1		1	1.50	Black
		Age-Adjusted Death Rate due to Alzheimer's Disease	1		1	0			3	1.42	
		Age-Adjusted Death Rate due to Heart Attack	3						0	1.42	
		Mortality Ranking	1							1.42	
		Age-Adjusted Death Rate due to Breast Cancer	2	2	1	2	2		0	1.39	Black
Health	**Mortality Data**	Age-Adjusted Death Rate due to Motor Vehicle Collisions	1		0				2	1.28	
		Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	2		2	0	1		1	1.25	
		Age-Adjusted Death Rate due to Heart Disease	1		1	1				1.25	Males
		Age-Adjusted Death Rate	1		1				1	1.22	Males; Black, non-Hispanic, Two or More Races, non-Hispanic
		Age-Adjusted Death Rate due to Pancreatic Cancer	1	1	1	2			1	1.22	
		Age-Adjusted Death Rate due to Unintentional Poisonings	0		0	0			3	1.08	Males; White, non-Hispanic
		Age-Adjusted Death Rate due to Colorectal Cancer	1	1	1	2	2		0	1.06	
		Death Rate due to Drug Poisoning	0	1	0	0			3	1.00	
		Life Expectancy	1	0	1	1				1.00	
		Infant Mortality Rate	2		1	0	0		1	0.97	
		Age-Adjusted Death Rate due to Diabetes	1		2	0			0	0.92	Black, non-Hispanic
		Age-Adjusted Death Rate due to Unintentional Injuries	0		0	0	0		3	0.92	Males; White, non-Hispanic
		Age-Adjusted Death Rate due to Cancer	1	0	1	1	1		1	0.83	Males; Black
		Age-Adjusted Death Rate due to Suicide	0		0	0	0		2	0.69	Males; White, non-Hispanic
		Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	0		0	0			1	0.64	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		Age-Adjusted Death Rate due to Lung Cancer	0	0	0	0	0		1	0.22	Males
Health	Mental Health & Mental Disorders	Alzheimer's Disease or Dementia: Medicare Population	2	3	2	3			2	2.28	
		Mental Health Provider Rate	2	1	3	3			1	1.89	
		Age-Adjusted Death Rate due to Alzheimer's Disease	1		1	0			3	1.42	
		Age-Adjusted Rate of Emergency Department Visits due to Mood Disorder	1							1.42	
		Frequent Mental Distress	1	0	2	0				1.00	
		Adults Ever Diagnosed with Depression	0		0				1	0.89	
		Depression: Medicare Population	0	0	0	0			3	0.83	
		Age-Adjusted Death Rate due to Suicide	0		0	0	0		2	0.69	Males; White, non-Hispanic
		Poor Mental Health: Average Number of Days	0	0	1	0				0.67	
Health	Substance Abuse	Liquor Store Density	3	3	3	3			1	2.39	
		Alcohol-Impaired Driving Deaths	3	2	3	2				2.17	
		Adults who Currently Use Smokeless Tobacco	3		3				2	2.11	
		Age-Adjusted Alcohol-Related Emergency Department Visit Rate	3							1.75	
		Adults who Use Alcohol: Past 30 Days	2		2					1.67	
		Adults who Binge Drink	2		1	2	0		2	1.53	
		Age-Adjusted Rate of Substance Use Emergency Department Visits	0							1.25	
		Health Behaviors Ranking	0							1.25	
		Adults who Smoke	1	0	1	0	3			1.00	
		Death Rate due to Drug Poisoning	0	1	0	0			3	1.00	
		Opioid Treatment Admission Rate	0		0				1	0.89	
		Adults who Drink Excessively	0	1	1	1	0			0.83	
Health	Maternal, Fetal & Infant	Mothers who Received No Prenatal Care	3		3	3			3	2.58	Ages 15-17, 18-19; Black, non-Hispanic
		Mothers who Received Early Prenatal Care	3		2	3	3		2	2.36	Ages 15-17, 18-19, 20-24, 25-29; Black, non-Hispanic, Hispanic
		Teen Birth Rate: 15-17	1		3	0			1	1.31	Hispanic
		Preterm Births	1		1	0	1			1.03	Ages 40-44; Black, non-Hispanic
		Infant Mortality Rate	2		1	0	0		1	0.97	
		Very Preterm Births	0		0		0		1	0.72	Ages 40-44; Black, non-Hispanic
		Babies with Very Low Birth Weight	1		0	0	0		1	0.64	Black, non-Hispanic
		Babies with Low Birth Weight	0		0	0	0		1	0.47	Black, non-Hispanic
Health	Family Planning	Teen Birth Rate: 15-17	1		3	0			1	1.31	Hispanic
		Income Inequality	3	3	2	2				2.17	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Economy		Severe Housing Problems	3	3	3	3			0	2.17	
		Homeownership	2	2	2	2			2	1.94	
		Students Eligible for the Free Lunch Program	2	1	3	2			2	1.94	
		Cost of Licensed Child Care as a Percentage of Income	2		3					1.83	
		SNAP Certified Stores	1	3					2	1.78	
		Renters Spending 30% or More of Household Income on Rent	1	3	2	2			1	1.72	Ages 65+
		Cost of Family Child Care as a Percentage of Income	2		2					1.67	
		Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	2		2					1.67	
		Households that are Below the Federal Poverty Level	2		2					1.67	
		People 65+ Living Below Poverty Level	2	1	2	1			2	1.61	Hispanic or Latino
		Social and Economic Factors Ranking	2							1.58	
		Households with Cash Public Assistance Income	2	2	2	1			1	1.56	
		Households that are Asset Limited, Income Constrained, Employed (ALICE)	2		1					1.50	
		Unemployed Workers in Civilian Labor Force	2	1	2	1			1	1.39	
		Food Insecure Children Likely Ineligible for Assistance	1	1	0	3			1	1.22	
		People Living 200% Above Poverty Level	2	0	2	1			1	1.22	
		Low-Income and Low Access to a Grocery Store	0	0						1.00	
		Per Capita Income	1	0	2	0			1	0.89	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, Two or More Races
		Families Living Below Poverty Level	2	1	1	0			0	0.83	Black or African American, Hispanic or Latino, Other
		Median Household Income	2	0	2	0			0	0.83	Black or African American, Hispanic or Latino, Other
		Persons with Disability Living in Poverty (5-year)	1	0	0	0				0.67	
		Persons with Disability Living in Poverty	1	0	0	0			1	0.56	
		Child Food Insecurity Rate	1	0	1	0			0	0.50	
		Children Living Below Poverty Level	1	0	1	0			0	0.50	Black or African American, Hispanic or Latino, Other
		Food Insecurity Rate	1	0	1	0			0	0.50	
		People Living Below Poverty Level	1	0	1	0			0	0.50	Ages 12-17, 6-11, <6; Females; Black or African American, Hispanic or Latino, Other
		Young Children Living Below Poverty Level	2	0	0	0			0	0.50	Black or African American, Other
Education		Cost of Licensed Child Care as a Percentage of Income	2		3					1.83	
		Students Passing 4th Grade State Achievement Tests	2		2				2	1.78	
		Students Passing 8th Grade State Achievement Tests	2		2				2	1.78	
		Cost of Family Child Care as a Percentage of Income	2		2					1.67	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
		People 25+ with a High School Degree or Higher	3	2	2	2			0	1.67	Ages 65+; Males
		Student-to-Teacher Ratio	3	0	2	0			2	1.44	
		Students Passing 11th Grade State Achievement Tests	2		2				0	1.33	
		People 25+ with a Bachelor's Degree or Higher	1	0	3	0			0	0.83	Ages 65+; American Indian or Alaska Native, Black or African American, Other
Government & Politics		Voter Turnout: Presidential Election	1		1				2	1.44	
		Alcohol-Impaired Driving Deaths	3	2	3	2				2.17	
		Violent Crime Rate	2		3	1			0	1.42	
Public Safety		Age-Adjusted Death Rate due to Motor Vehicle Collisions	1		0				2	1.28	
		Substantiated Child Abuse Rate	1		0	0			1	0.81	
		Liquor Store Density	3	3	3	3			1	2.39	
		Severe Housing Problems	3	3	3	3			0	2.17	
		SNAP Certified Stores	1	3					2	1.78	
		Farmers Market Density	2	2						1.67	
		Fast Food Restaurant Density	1	2					2	1.61	
		Months of Mild Drought or Worse							2	1.61	
		Recognized Carcinogens Released into Air							2	1.61	
		Physical Environment Ranking	1							1.42	
		Annual Particle Pollution	2	1					1	1.39	
		Number of Extreme Heat Days							1	1.39	
		Number of Extreme Heat Events							1	1.39	
		Number of Extreme Precipitation Days							1	1.39	
Environment		Daily Dose of UV Irradiance	1		1					1.33	
		Blood Lead Levels in Children (>=5 micrograms per deciliter)	2		0				1	1.22	
		Grocery Store Density	1	0						1.17	
		PBT Released							0	1.17	
		Recreation and Fitness Facilities	1	0					1	1.06	
		Children with Low Access to a Grocery Store	0	0						1.00	
		Households with No Car and Low Access to a Grocery Store	0	0						1.00	
		Low-Income and Low Access to a Grocery Store	0	0						1.00	
		People 65+ with Low Access to a Grocery Store	0	0						1.00	
		People with Low Access to a Grocery Store	0	0						1.00	
		Food Environment Index	0	0	2	0			1	0.72	
		Access to Exercise Opportunities	0	0	1	0				0.67	

INDICATOR CATEGORY	INDICATOR TOPIC	INDICATOR	County Distribution		Value		Target		Trend	Score >=2	Identified Disparity
			State	US	State	US	HP 2020	Local	Trend		
Social Environment		Linguistic Isolation	3	3	3	3			1	2.39	
		Mean Travel Time to Work	2	3	1	3			3	2.33	Males
		Homeownership	2	2	2	2			2	1.94	
		Cost of Licensed Child Care as a Percentage of Income	2		3					1.83	
		Single-Parent Households	2	2	3	1			1	1.72	
		Social Associations	2	3	1	2			1	1.72	
		Cost of Family Child Care as a Percentage of Income	2		2					1.67	
		People 25+ with a High School Degree or Higher	3	2	2	2			0	1.67	Ages 65+; Males
		Within County Disparity in Life Expectancy at Birth							2	1.61	
		Social and Economic Factors Ranking	2							1.58	
		Voter Turnout: Presidential Election	1		1				2	1.44	
		Households with an Internet Subscription	2	0	2	1				1.33	
		Households with One or More Types of Computing Devices	2	0	2	1				1.33	
		People 65+ Living Alone	1	1	1	1			1	1.06	
		Per Capita Income	1	0	2	0			1	0.89	American Indian or Alaska Native, Black or African American, Hispanic or Latino, Other, Two or More Races
		Median Household Income	2	0	2	0			0	0.83	Black or African American, Hispanic or Latino, Other
		People 25+ with a Bachelor's Degree or Higher	1	0	3	0			0	0.83	Ages 65+; American Indian or Alaska Native, Black or African American, Other
		Substantiated Child Abuse Rate	1		0	0			1	0.81	
		Children Living Below Poverty Level	1	0	1	0			0	0.50	Black or African American, Hispanic or Latino, Other
		People Living Below Poverty Level	1	0	1	0			0	0.50	Ages 12-17, 6-11, <6; Females; Black or African American, Hispanic or Latino, Other
		Young Children Living Below Poverty Level	2	0	0	0			0	0.50	Black or African American, Other
		Mean Travel Time to Work	2	3	1	3			3	2.33	Males
		Solo Drivers with a Long Commute	1	3	1	3			2	1.94	
Transportation		Households with No Car and Low Access to a Grocery Store	0	0						1.00	
		Workers who Drive Alone to Work	0	0	1	0			0	0.33	Ages 45-54, 55-59, 60-64, 65+; White, non-Hispanic
		Workers Commuting by Public Transportation	0	0	1	0	0		0	0.17	Ages 60-64, 65+; Hispanic or Latino, Other

Mortality Rates[5]

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

Over the last decade, heart disease and cancer have been the number 1 and 2 causes of death in the county. For heart disease. There has been a decline of 37.2% over the past decade. For cancer, there have been a decrease of 28.4% over the last 5 years and 42.7% over the last decade. The mortality rate for unintentional injuries has increased by 10.4% over the last decade, rising to the 3rd highest mortality rate in the county. There has also been an increase in Alzheimer's disease over the last decade of 8.9%. Stroke has decreased slightly by 2.0% over the last decade.

Union County	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	5 Year Change	10 Year Change
Diseases of heart	**179.9**	**188.5**	**167.8**	**166.1**	**158.5**	**150.9**	**152.3**	**155.1**	**152.6**	**142.7**	**(15.8)**	**(37.2)**
Cancer (malignant neoplasms)	**172.1**	**154**	**163.2**	**156.1**	**157.8**	**144.4**	**154.1**	**137.9**	**141.6**	**129.4**	**(28.4)**	**(42.7)**
Unintentional injuries	**25.9**	**23.1**	**21.1**	**21.4**	**23.9**	**22.4**	**22.5**	**29.6**	**31.1**	**36.3**	**12.4**	**10.4**
Stroke (cerebrovascular diseases)	**33.9**	**35.2**	**38.8**	**30.7**	**33.5**	**33**	**35**	**28.4**	**30.8**	**31.9**	**(1.6)**	**(2.0)**
Alzheimer's disease	**14.3**	**15.2**	**12.7**	**12.1**	**12.2**	**13.9**	**14.4**	**16.2**	**21.2**	**23.2**	**11.0**	**8.9**
Chronic lower respiratory diseases (CLRD)	30.7	28	23.8	27.1	24.2	25.1	25.9	24	20	20.7	(3.5)	(10.0)
Septicemia	21.7	20.8	16.9	20.8	17.8	18.2	18.6	20.4	21.4	16.8	(1.0)	(4.9)
Diabetes mellitus	23.7	22.3	24.7	27	23.2	22.2	19.6	16.5	18.2	15.8	(7.4)	(7.9)
Influenza and pneumonia	15.4	15.2	10.9	13.9	13.5	12.6	12.1	16.4	9.8	12.1	(1.4)	(3.3)
Nephritis, nephrotic syndrome and nephrosis (kidney disease)	16.1	16.4	13.4	16.6	14.3	13.4	10.4	13.6	13.7	11.2	(3.1)	(4.9)
Essential hypertension and hypertensive renal disease	6.5	5.4	5.7	6.7	7.2	5.8	6.9	5.3	5.9	8.2	1.0	1.7
Suicide (intentional self-harm)	5.8	5.7	5.2	3.9	5.5	6.2	7.3	6.7	5.4	8	2.5	2.2
Chronic liver disease and cirrhosis	6	8.1	7.8	7.3	5.2	7.4	6.9	6.6	6.9	6.6	1.4	0.6
Parkinson's disease	6.3	4.8	4.6	4.7	5.7	4.3	5.1	6	6	5.8	0.1	(0.5)
In situ neoplasms, benign neopl. & neopl. of uncertain or unknown behavior	6.4	3.9	4.7	6.2	5.4	4.3	4.9	5.7	4.8	5.4	-	(1.0)
Pneumonitis due to solids and liquids	3.5	3.8	5.2	5.5	3.6	4.7	5.1	4.6	4.4	4.4	0.8	0.9
Homicide (assault)	5.2	**	6.2	7	5.9	5.4	4.5	4.4	4.2	4	(1.9)	(1.2)
HIV (human immunodeficiency virus) disease	5.5	6.1	5.4	3.7	**	3.1	**	**	**	3.3	N/A	(2.2)
Other than 24 Major Causes	97.3	101.2	103.1	105.9	100.7	108.6	107.7	106.8	98.8	104.6	3.9	7.3
Viral hepatitis	**	**	**	**	**	**	**	**	**	**	N/A	N/A
Anemias	**	**	**	**	**	**	**	**	**	**	N/A	N/A
Atherosclerosis	**	**	**	**	**	**	**	**	**	**	N/A	N/A
Aortic aneurysm and dissection	3.8	3.8	**	**	**	**	**	**	**	**	N/A	N/A
Certain conditions originating in the perinatal period	4.5	5	5	4.6	**	**	**	**	**	**	N/A	N/A
Congenital malformations, deformations and chromosomal abnormalities	**	**	**	**	**	**	**	**	**	**	N/A	N/A

Source: Center for Health Statistics, New Jersey Department of Health
***The value has been suppressed because it does not meet standards of reliability or precision or because it could be used to calculate the number in a cell that has been suppressed.*

SocioNeeds Index[6]

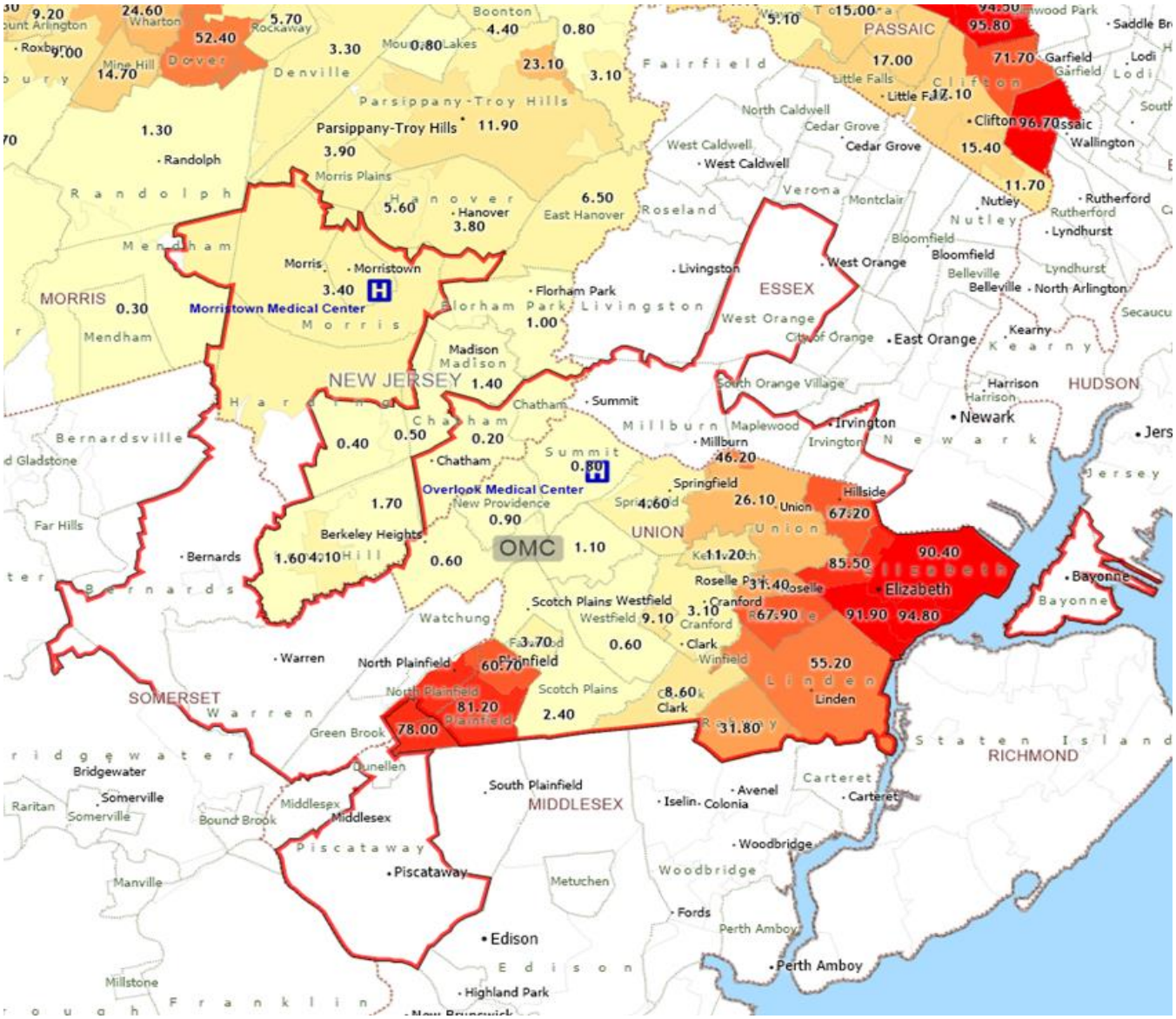
Community health improvement efforts must determine what sub-populations are most in need in order to most effectively focus services and interventions. Social and economic factors are well known to be strong determinants of health outcomes – those with a low socioeconomic status are more likely to suffer from chronic conditions such as diabetes, obesity, and cancer. The 2019 SocioNeeds Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic need that is correlated with poor health outcomes. All ZIP Codes, counties, and county equivalents in the United States are given an Index Value from 0 (low need) to 100 (high need). The index summarizes multiple socio-economic indicators into one composite score for easier identification of high need areas by ZIP Code or county.

[5] Source: State of New Jersey Department of Health: Measurement period: 2007-2016
[6] Healthy Communities Institute 2018. SocioNeeds Index.
http://www.njhealthmatters.org/index.php?module=indicators&controller=index&action=socioneeds

Within the community, the ZIP Codes or counties with the highest index values are estimated to have the highest socioeconomic need. The index value for each location is compared to all other similar locations (i.e. counties compare to other counties and ZIP Codes to other ZIP Codes) within the comparison area. Zip Codes are ranked using natural breaks classification, which groups the ZIP Codes into clusters based on similar index values.

The SocioNeeds Index is calculated for a community from several social and economic factors, ranging from poverty to education, that may impact health or access to care. The index is correlated with potentially preventable hospitalization rates and is calculated using Claritas estimates for 2019.

This map represents a socio-needs index for each ZIP Code within the North Jersey Health Collaborative. A higher index is indicative of poorer health outcomes and broadly, the index is designed to aid organizations in allocating efforts to a community that broadly may require more intervention. Darker shading represents a higher need index – and is relative to all ZIP Codes in the State.


Morristown Medical Center
Overlook Medical Center
OMC
MORRIS
ESSEX
HUDSON
SOMERSET
MIDDLESEX
RICHMOND
NEW JERSEY
UNION
PASSAIC
Parsippany-Troy Hills
Randolph
Morris Plains
Hanover
East Hanover
Florham Park
Madison
Chatham
Summit
New Providence
Berkeley Heights
Millburn
Maplewood
Irvington
Newark
Bayonne
Elizabeth
Linden
Roselle
Roselle Park
Union
Hillside
Springfield
Cranford
Westfield
Scotch Plains
Watchung
North Plainfield
Plainfield
Warren
Green Brook
Bridgewater
Somerville
Raritan
Bound Brook
Middlesex
Piscataway
Manville
Edison
Metuchen
South Plainfield
Woodbridge
Carteret
Avenel
Colonia
Iselin
Perth Amboy
Fords
Highland Park
Millstone
Bernardsville
Gladstone
Far Hills
Bernards
Mendham
Harrison
Kearny
East Orange
West Orange
Orange
Livingston
Roseland
Verona
Montclair
Nutley
Bloomfield
Belleville
Clifton
Passaic
Garfield
Lodi
Wallington
Rutherford
Lyndhurst
North Arlington
Saddle Br
Cedar Grove
West Caldwell
North Caldwell
Little Falls
Fairfield
Denville
Dover
Mine Hill
Roxbury
Wharton
Rockaway
Boonton
Lakes
Mountain Lakes
Hanover
Morristown
Florham Park
Livingston
Madison
Chatham
Summit
Millburn
Springfield
Union
Hillside
Irvington
Newark
Elizabeth
Linden
Roselle

Ambulatory Care Sensitive Conditions: ED & IP

ACS conditions are illnesses that can often be managed effectively on an outpatient basis and generally do not result in hospitalization if managed properly. Generally, a higher ACSC rate in Acute settings indicates a cultural acceptance of the ED as a source for Primary Care – or an area that lacks primary care providers. These conditions, if treated in a more appropriate setting, can lead to broad improvements in community health through primary care expansion, urgent care expansion, which may ultimately lead to a lower chronic disease rate in a community.

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

OVERLOOK MC SERVICE AREA: AMB CARE SENSITIVE CONDITIONS				
ACS Condition Cohort (Cell values <10 Masked)	NJE17: ED		NJS17: IP	
ENT	20,924	33.3%	103	0.8%
DEHYDRATION	7,604	12.1%	1,039	8.4%
KIDNEY/URINARY INFECTION	6,623	10.5%	1,238	10.0%
ASTHMA	5,765	9.2%	728	5.9%
CELLULITIS	3,420	5.4%	982	8.0%
DENTAL CONDITIONS	3,852	6.1%	88	0.7%
COPD	2,029	3.2%	1,808	14.7%
GASTROINSTESTINAL OBSTRUCTION	3,338	5.3%	318	2.6%
BACTERIAL PNEUMONIA	1,904	3.0%	1,353	11.0%
DIABETES	1,835	2.9%	1,279	10.4%
HYPERTENSION	2,573	4.1%	67	0.5%
CONGESTIVE HEART FAILURE	404	0.6%	1,669	13.5%
GRAND MAL STATUS/OTHER EPILEPTIC CONVULSION	939	1.5%	998	8.1%
CONVULSION	1,186	1.9%	279	2.3%
PELVIC INFLAMMATORY DISEASE	176	0.3%	54	0.4%
ANGINA	119	0.2%	100	0.8%
NUTRITION DEFICIENCIES (til 12/14 DSCHG)	**	**	112	0.9%
HYPOGLYCEMIA	82	0.1%	**	**
SKIN GRAFTS W CELLULITIS	**	**	29	0.2%
IRON DEFICIENCY ANEMIA	13	0.0%	16	0.1%
PULMONARY TUBERCULOSIS	**	**	17	0.1%
OTHER TUBERCULOSIS	**	**	14	0.1%
FAILURE TO THRIVE	**	**	10	0.1%
IMMUNIZATION RELATED PREVENTABLE	**	**	**	**
CONGENITAL SYPHILIS	**	**	**	**
Grand Total	**62,800**	**100.0%**	**12,320**	**100.0%**
ACSCs at % of Total ED or Inpatient OMC Service Area	**18.8%**		**13.7%**	

Localized Data: Disease Utilization Rate[7]

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

Heart Attack

The rate/1,000 population has increased over the period in all comparative areas. The highest rate among comparative geographies is in New Jersey overall, where the rate is at the 50th percentile. All other comparative geographies have a rate that is at or below the 40th percentile.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	1.03	0.99	0.94	0.94	1.06	1.07	0.0	30%	30%
EASTERN REGION	1.15	1.07	1.04	1.07	1.28	1.24	0.1	40%	40%
AHS REGION	1.08	1.03	1.00	1.06	1.19	1.17	0.1	40%	40%
Summit	0.39	0.87	0.91	1.55	1.16	1.02	0.6	40%	30%
Elizabeth	0.67	0.75	0.58	0.70	0.85	0.70	0.0	20%	10%
Union County	1.02	0.99	0.92	0.97	1.03	1.03	0.0	30%	30%
NEW JERSEY	1.30	1.26	1.27	1.36	1.49	1.46	0.2	50%	50%

Heart Failure

The rate/1,000 population has increased over the period across all comparative regions. The highest rate among comparative geographies is in the broader Eastern region, where the rate is at the 60th percentile. Based on a statewide rank, Summit performs extremely well with a rate/1,000 in the 10th percentile.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	2.84	2.92	2.98	2.99	3.17	3.30	0.5	50%	50%
EASTERN REGION	3.43	3.43	3.49	3.60	3.73	3.83	0.4	60%	60%
AHS REGION	2.95	2.93	2.92	3.05	3.07	3.20	0.2	50%	40%
Summit	1.57	2.21	2.29	1.85	2.14	1.62	0.0	20%	10%
Elizabeth	2.48	2.62	3.17	3.31	4.05	3.65	1.2	70%	60%
Union County	2.88	2.92	3.10	3.02	3.34	3.33	0.5	50%	50%
NEW JERSEY	3.33	3.26	3.30	3.40	3.45	3.66	0.3	60%	60%

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

Hypertension

The rate/1,000 population has increased over the period across all comparative regions, with the exclusion of Summit. The highest rate among comparative geographies is in the Eastern region, where the rate is at the 60th percentile. All other comparative geographies have a rate that is at the 50th percentile, or lower.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	100.34	99.18	102.33	109.57	109.72	110.53	10.2	40%	40%
EASTERN REGION	125.08	122.55	122.68	130.08	134.05	134.01	8.9	60%	60%
AHS REGION	104.14	104.35	105.14	109.35	113.27	114.46	10.3	50%	40%
Summit	54.09	61.30	63.51	62.70	52.83	46.67	(7.4)	0%	0%
Elizabeth	125.34	123.31	123.98	137.50	143.45	131.34	6.0	70%	50%
Union County	101.94	100.75	104.40	110.16	108.10	106.80	4.9	40%	30%
NEW JERSEY	112.08	111.11	112.34	118.03	126.14	130.76	18.7	60%	50%

Stroke/TIA

The rate/1,000 population has decreased over the period across all comparative regions, except for the OMC 75% Service Area. New Jersey's overall rate is the highest among comparative geographies and is at the 50th percentile. All other comparative regions have a rate in the 40th percentile, except for Summit, which has a rate in the 10th percentile.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	2.37	2.48	2.61	2.51	2.55	2.44	0.1	40%	40%
EASTERN REGION	2.55	2.60	2.76	2.64	2.73	2.53	(0.0)	50%	40%
AHS REGION	2.48	2.46	2.50	2.47	2.59	2.47	(0.0)	40%	40%
Summit	1.74	1.74	1.68	1.68	1.37	1.58	(0.2)	0%	10%
Elizabeth	2.50	2.30	2.32	2.68	2.73	2.43	(0.1)	50%	40%
Union County	2.40	2.52	2.72	2.53	2.54	2.38	(0.0)	40%	40%
NEW JERSEY	2.95	2.90	2.95	2.88	2.92	2.77	(0.2)	50%	50%

Diabetes

The rate/1,000 population has increased over the period in all comparative regions, except for Summit. The highest rate among comparative geographies is in Elizabeth. Except for Summit, the rate/1,000 is at or above the 50th percentile in all comparative regions.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	43.84	43.43	45.10	48.52	49.00	50.17	6.3	50%	50%
EASTERN REGION	56.49	56.38	56.95	60.61	62.61	63.33	6.8	70%	70%
AHS REGION	44.81	45.32	46.03	47.83	49.70	50.65	5.8	50%	50%
Summit	16.34	19.78	18.96	21.14	17.15	15.80	(0.5)	0%	0%
Elizabeth	61.56	61.63	62.87	68.85	71.53	66.29	4.7	80%	70%
Union County	45.33	45.02	46.82	49.73	48.83	48.64	3.3	50%	50%
NEW JERSEY	48.90	49.00	49.75	52.07	55.38	57.67	8.8	60%	60%

Obesity

The rate/1,000 population has increased over the period across all comparative regions. The highest rate among comparative geographies is in the overall New Jersey region, where the rate is at the 50th percentile. New Jersey has also seen the greatest point increase over the period.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	10.56	11.26	12.54	13.61	13.99	16.52	6.0	40%	40%
EASTERN REGION	13.92	14.16	14.98	16.01	16.74	18.98	5.1	60%	50%
AHS REGION	10.86	11.33	12.01	13.17	13.98	16.83	6.0	40%	40%
Summit	5.10	5.90	5.70	5.29	6.97	7.62	2.5	0%	0%
Elizabeth	12.06	12.83	15.01	15.99	15.77	15.75	3.7	50%	40%
Union County	10.13	10.88	12.23	13.51	13.61	15.89	5.8	40%	40%
NEW JERSEY	12.52	13.04	13.78	14.84	15.89	19.27	6.8	50%	50%

COPD & Allied Health Conditions

The rate/1,000 population has increased over the period across all comparative regions. The highest rate among comparative geographies is in New Jersey overall, where the rate is at the 50th percentile. All other comparative geographies have a rate that is at or below the 40th percentile.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	13.94	14.05	14.00	15.02	16.14	15.18	1.2	30%	30%
EASTERN REGION	16.64	16.53	16.27	17.42	20.22	18.83	2.2	50%	40%
AHS REGION	15.43	15.22	15.06	15.96	17.86	16.86	1.4	40%	40%
Summit	6.41	7.42	6.17	6.96	5.99	6.81	0.4	0%	0%
Elizabeth	15.38	15.84	17.95	18.71	20.81	18.23	2.8	50%	40%
Union County	13.55	13.28	13.60	14.23	14.92	13.80	0.3	30%	20%
NEW JERSEY	19.65	19.37	19.14	20.17	22.78	22.02	2.4	60%	50%

Asthma

The rate/1,000 population has decreased over the period across all comparative regions, with the exception of the OMC 75% Service Area and New Jersey areas. The highest rate among comparative geographies is in the broader Eastern region, where the rate is at the 80th percentile. Elizabeth also has a rate/1,000 in the 80th percentile, but the region also saw the greatest point decrease over the period.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	31.47	29.45	30.38	33.33	33.44	31.58	0.1	70%	60%
EASTERN REGION	50.66	47.63	46.72	49.96	51.60	49.82	(0.8)	80%	80%
AHS REGION	32.67	30.98	31.39	32.96	33.18	31.52	(1.2)	70%	60%
Summit	18.04	18.31	15.50	15.13	15.79	12.09	(6.0)	20%	10%
Elizabeth	51.52	45.23	46.08	53.10	54.58	43.10	(8.4)	80%	80%
Union County	30.99	28.51	30.07	32.10	31.50	27.85	(3.1)	60%	60%
NEW JERSEY	33.93	32.47	32.87	34.61	35.94	34.82	0.9	70%	70%

Pneumonia

The rate/1,000 population has increased over the period in the OMC 75% Service Area, and the boarder Eastern and AHS regions. The highest rate among comparative geographies is in Elizabeth. Summit performs extremely well, with a rate/1,000 in the 10th percentile, while the rate in all other comparative geographies is at or above the 50th percentile.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	4.99	4.48	4.01	4.17	4.86	5.18	0.2	40%	50%
EASTERN REGION	5.01	4.78	4.24	4.45	5.42	5.83	0.8	50%	60%
AHS REGION	4.88	4.48	4.11	4.22	4.93	5.00	0.1	40%	50%
Summit	3.75	3.47	2.85	3.09	2.18	2.64	(1.1)	0%	10%
Elizabeth	6.70	5.62	4.69	5.74	6.87	6.24	(0.5)	70%	70%
Union County	5.38	4.67	4.23	4.46	5.17	5.23	(0.1)	40%	50%
NEW JERSEY	5.81	5.41	4.98	5.08	5.85	5.65	(0.2)	60%	60%

Cellulitis

The rate/1,000 population has decreased over the period across all comparative regions. The highest rate among comparative geographies is in Elizabeth, where the rate is in the 70th percentile. Summit performs extremely well, with a rate/1,000 in the 10th percentile. All other comparative geographies have a rate at the 50th percentile, or higher.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	8.07	8.08	7.96	7.66	7.33	7.27	(0.8)	50%	50%
EASTERN REGION	10.21	10.07	9.86	9.52	9.09	8.76	(1.5)	60%	60%
AHS REGION	7.98	7.86	7.65	7.52	7.19	6.91	(1.1)	50%	50%
Summit	4.75	5.12	5.01	3.44	3.94	3.75	(1.0)	10%	10%
Elizabeth	12.30	12.57	12.30	11.93	11.47	10.85	(1.4)	70%	70%
Union County	8.26	8.20	8.12	7.77	7.42	7.27	(1.0)	50%	50%
NEW JERSEY	10.42	10.03	9.75	9.44	8.86	8.53	(1.9)	60%	60%

Renal Failure

The rate/1,000 population has increased over the period across all comparative regions, with the exception of Summit. The highest rate among comparative geographies is in the Eastern region. With the exception of Summit, all other comparative geographies have a rate/1,000 in either the 50th or 60th percentile.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	1.76	1.72	1.72	1.94	2.20	2.09	0.3	50%	50%
EASTERN REGION	2.22	2.17	2.06	2.33	2.61	2.60	0.4	60%	60%
AHS REGION	1.76	1.76	1.79	1.96	2.15	2.10	0.3	50%	50%
Summit	0.87	0.87	1.12	1.07	1.11	0.60	(0.3)	10%	0%
Elizabeth	1.93	2.00	1.80	2.17	2.15	2.38	0.5	50%	60%
Union County	1.77	1.77	1.63	1.90	2.14	2.11	0.3	50%	50%
NEW JERSEY	2.09	2.08	2.11	2.30	2.53	2.42	0.3	60%	60%

Mental Health (Acute Care Setting)

The rate/1,000 population has increased over the period across all comparative regions, with the exception of Elizabeth. The highest rate among comparative geographies is in Elizabeth. The rate/1,000 is in the 70th percentile in Elizabeth, but Elizabeth is also the only region among all comparative geographies that has seen a point reduction over the period.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	12.40	13.08	13.15	13.86	13.82	13.76	1.4	50%	50%
EASTERN REGION	16.13	16.81	16.61	17.16	17.60	17.33	1.2	70%	60%
AHS REGION	13.35	13.47	13.53	13.97	14.21	14.51	1.2	50%	50%
Summit	7.80	8.55	7.64	9.24	8.13	8.39	0.6	10%	10%
Elizabeth	21.07	21.02	19.74	20.44	21.32	20.40	(0.7)	80%	70%
Union County	13.41	13.81	13.38	14.35	14.31	14.15	0.7	50%	50%
NEW JERSEY	15.33	15.19	15.31	15.59	15.98	16.60	1.3	60%	60%

Substance Use Disorders (Acute Care Setting)

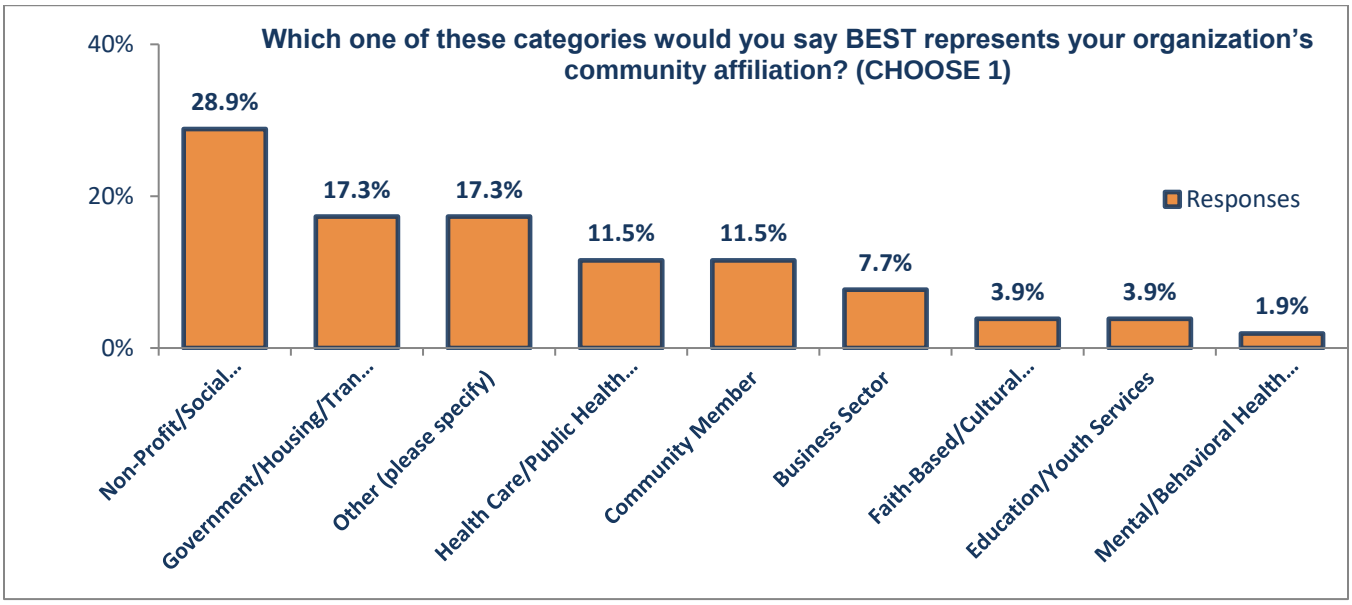
The rate/1,000 population has increased over the period across all comparative regions. The highest rate among comparative geographies is in Elizabeth, where the rate is at the 90th percentile. The rate/1,000 is at or above the 50th percentile in all comparative regions.

GEOGRAPHIC AREA	2012	2013	2014	2015	2016	2017	Rate Change '12 to '17	Statewide Percentile Rank '16	Statewide Percentile Rank '17
OMC 75% Service Area	7.86	8.28	8.45	9.62	10.79	10.64	2.8	70%	70%
EASTERN REGION	10.03	9.71	9.82	11.30	12.29	12.75	2.7	80%	80%
AHS REGION	8.02	8.06	8.25	8.97	9.23	9.46	1.4	70%	70%
Summit	6.28	7.29	6.22	6.83	6.93	7.49	1.2	50%	50%
Elizabeth	14.80	16.84	16.21	19.27	22.66	21.16	6.4	90%	90%
Union County	8.45	8.99	9.12	10.02	11.54	11.30	2.8	80%	70%
NEW JERSEY	8.63	8.66	8.77	9.56	10.08	10.22	1.6	70%	70%

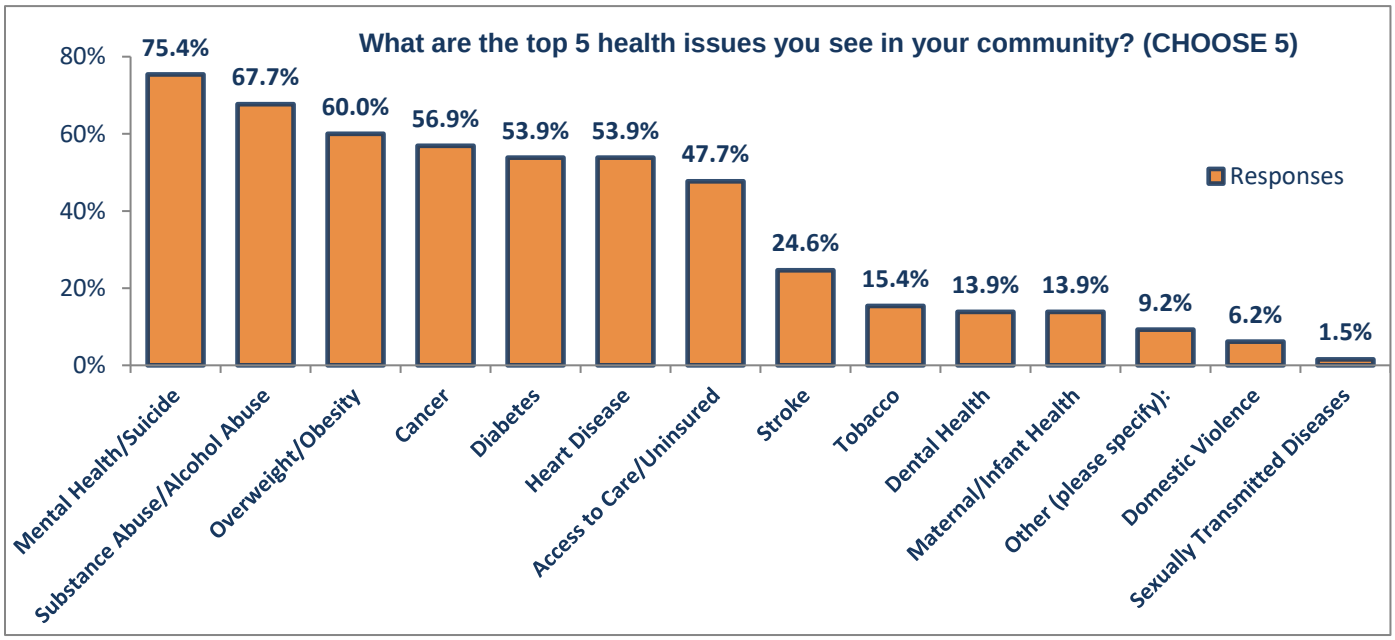
KEY INFORMANT FINDINGS

Background

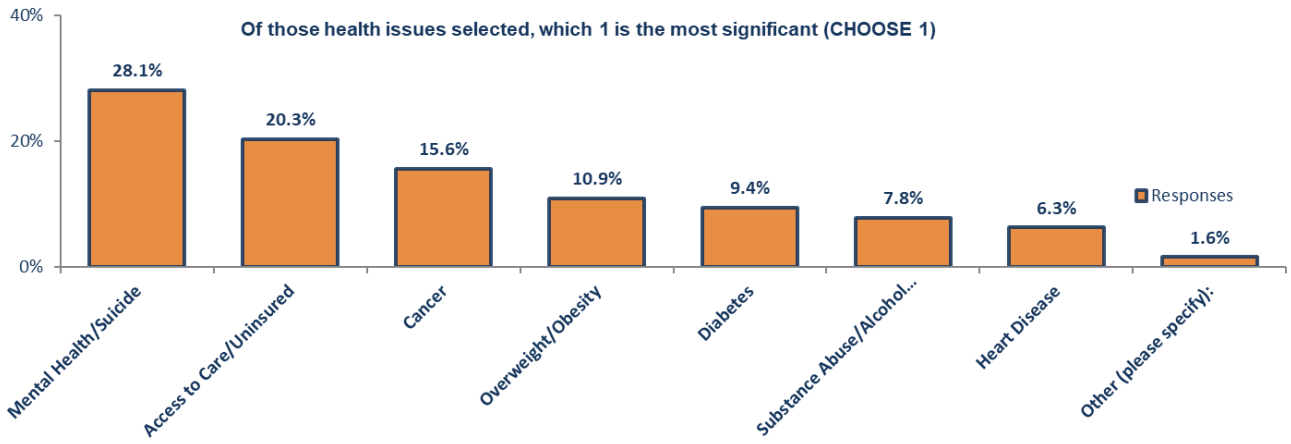
OMC received 65 responses to its community-based key-stakeholder survey, which was administered online. Below we show the breakdown of the respondents' organizational and community affiliations by category.



Below we show the breakdown of the percent of respondents who selected each health issue in the 2019 survey. Issues are ranked on the number of participants who selected the issue. Each respondent chose 5. This year, the top ranked issues were mental health/suicide, substance abuse/alcohol abuse, overweight/obesity, cancer, and diabetes and heart disease, which were both tied as the 5th most frequently selected health issues.



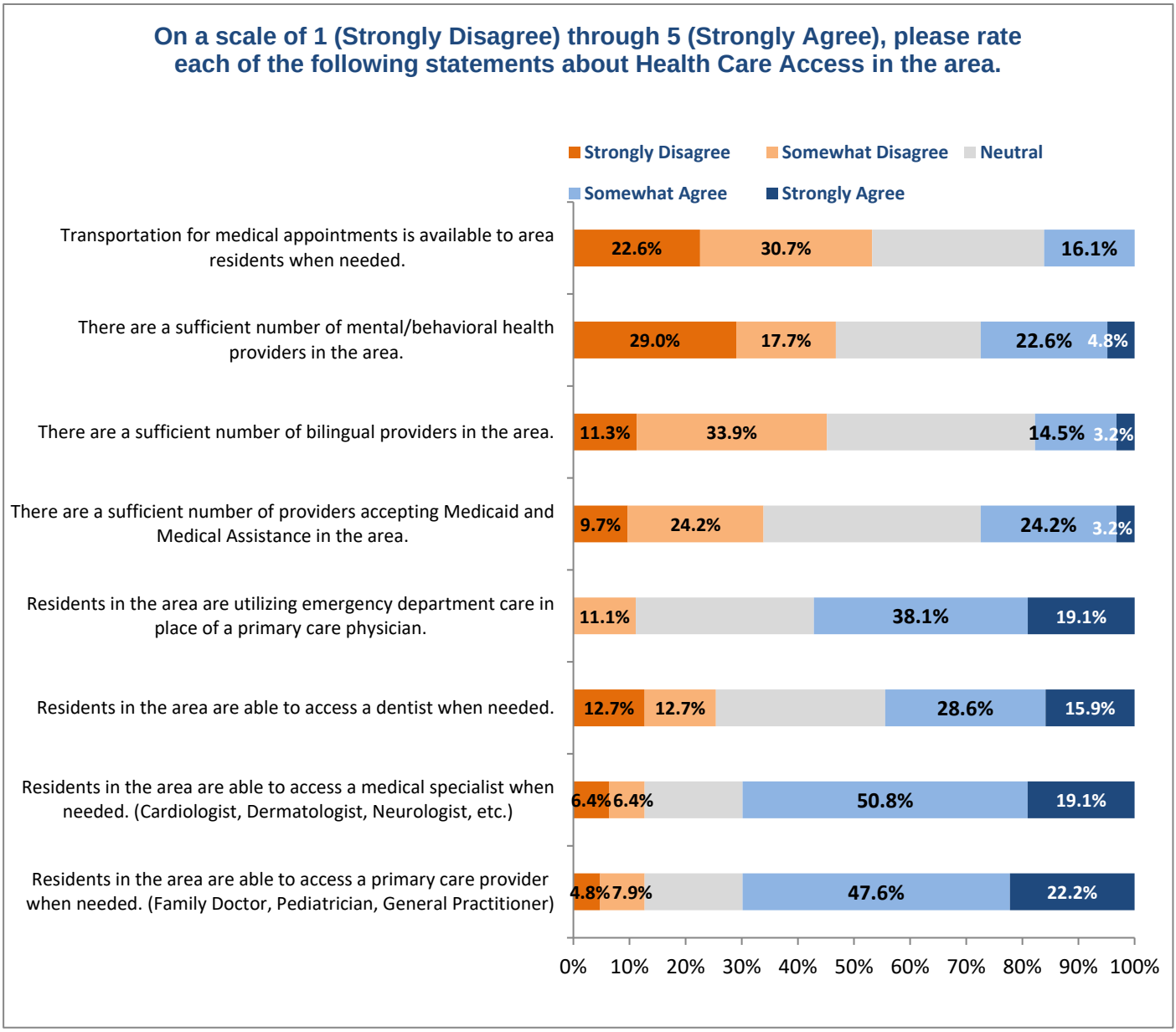
The respondents' top significant health issue in 2019 is mental health/suicide, followed by access to care/uninsured and cancer.



Select Stakeholder Comments: Top Health Issue

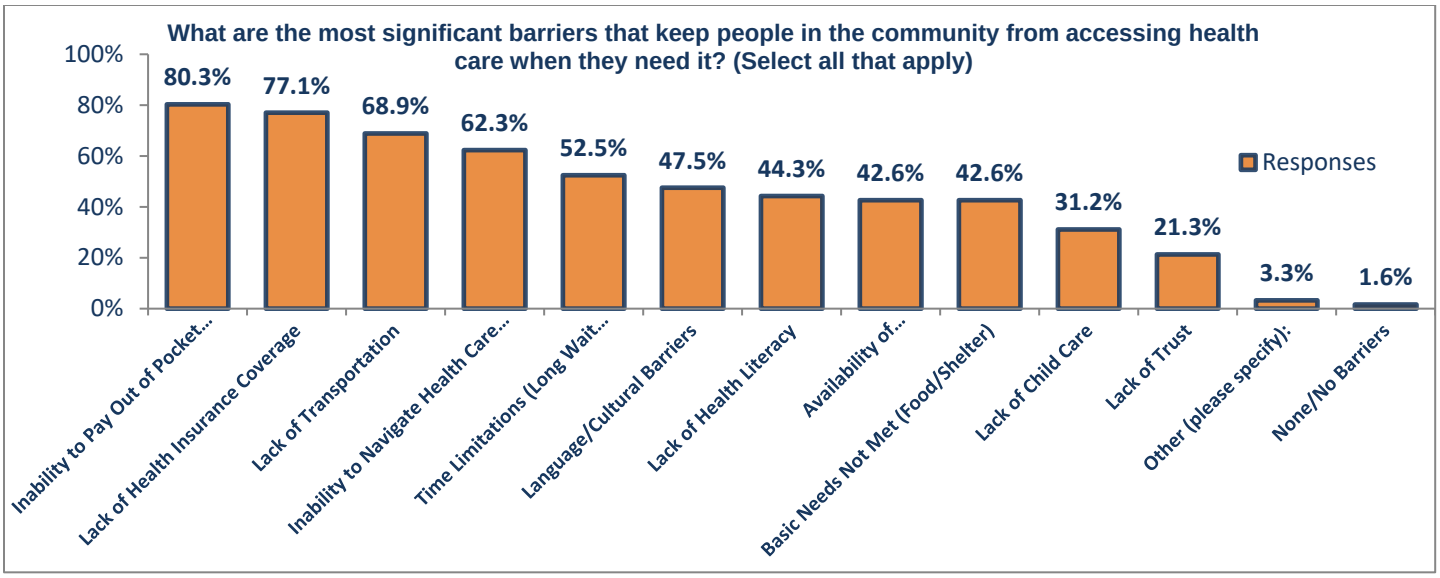
- *Uninsured are often afraid to seek care at FQHCs or other centers that offer charity care. There is fear of incurring a bill and there is fear of providing proof of citizenship.*
- *Mental health is so important and so often those who need care do not receive it, either because of lack of insurance, money, or stigma.*
- *Knowledge of how to obtain care and access to care is the gatekeeper to any solution of health issues.*
- *Mental health is the root cause of so many ills facing our society.*
- *Access to care/uninsured and mental health are actually a tie in my book. Mental health is highly under-served, and the stigma of mental health illness doesn't help.*
- *As a parent I see kids in our community struggling with stress, anxiety and depression. I see my adult friends facing the challenge of finding good care and advice about how to care for their kids and themselves. People need better access to support and resources.*

The second set of questions concerned the ability of residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bi-lingual providers. Respondents were provided with statements such as: "Residents in the area are able to access a primary care provider when needed." They were then asked to rate their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree).



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

In 2019, Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.) was rated by participants as the most significant barrier (80.3%), followed by Lack of Health Insurance Coverage at 77.1%. Other barriers that were rated by participants as being the most significant included Lack of Transportation, Inability to Navigate Health Care System, and Time Limitations (Long Wait Times, Limited Office Hours, Time off Work).



When respondents were asked for their choice of top significant barrier, Inability to Pay Out of Pocket Expenses was identified (32.8%). Lack of Health Insurance Coverage and Inability to Navigate the Healthcare System followed. After selecting the most significant barriers, informants were asked to share any additional information regarding these barriers.

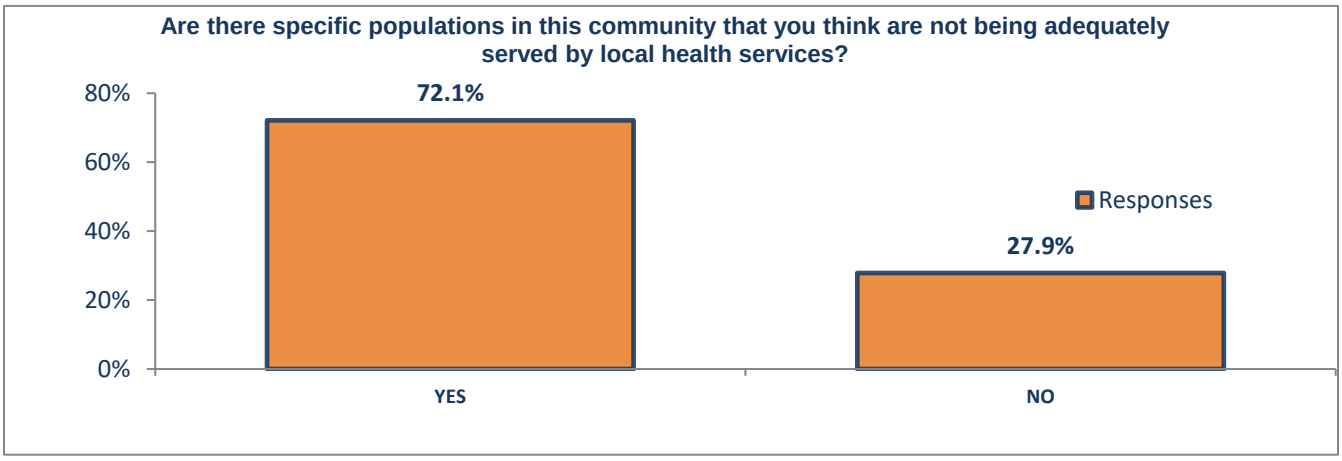
After selecting the most significant barriers, informants were asked to share any additional information regarding the barriers to accessing health care.

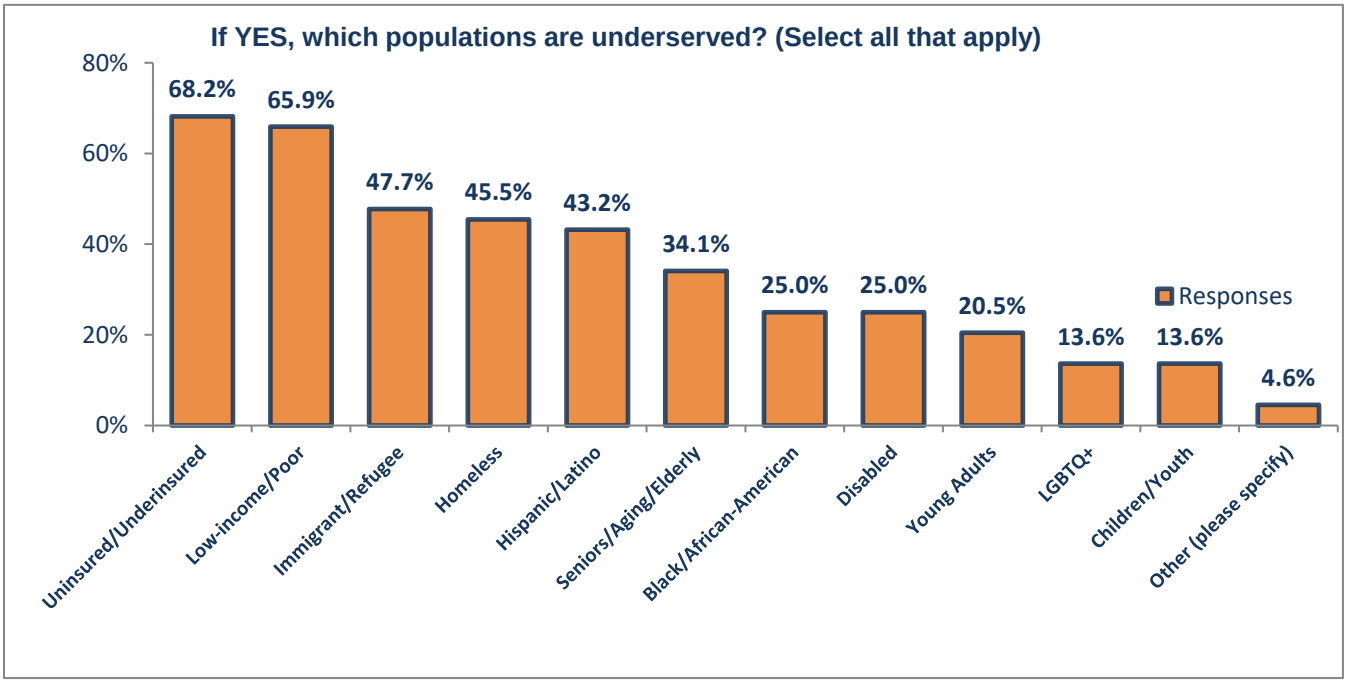
Select Stakeholder Comments: Healthcare Access & Barriers

- *In addition to the barriers listed previously, there are also cultural barriers and lack of knowledge in the Latino community as to how to navigate the healthcare system.*
- *Mental health issues such as depression get in the way of people being able to take action.*
- *The healthcare system is extremely complicated. Even the well-educated can have problems navigating it.*
- *People think about what care will cost them before they assess their willingness to find care.*
- *Patients need to know that there is help in finding health care.*
- *Transportation is a challenge for seniors.*

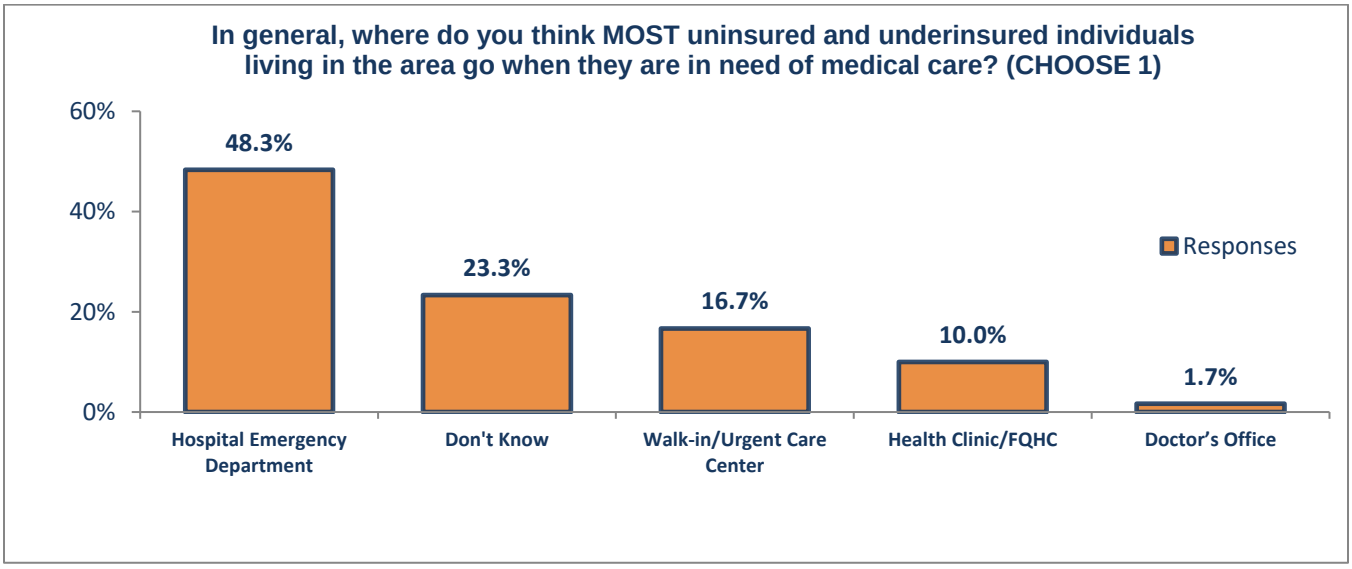
The top three population groups identified by key informants as being underserved when compared to the general population in this current survey were:

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

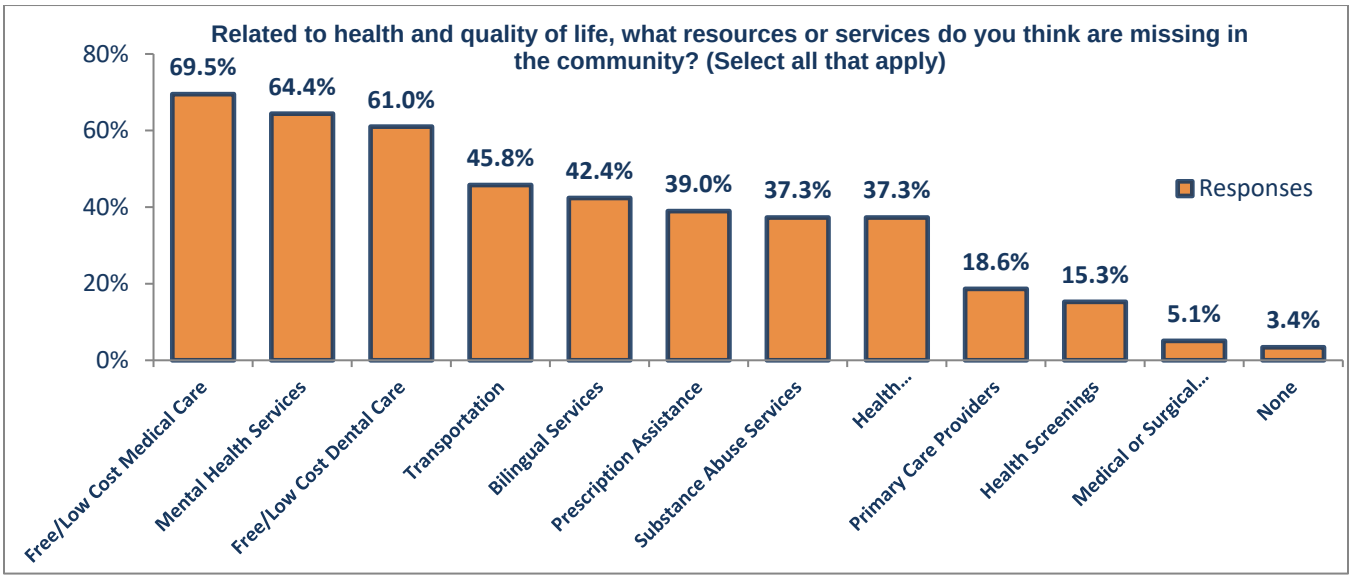




48.3% of key informants indicated hospital emergency departments as the primary place where uninsured/underinsured individuals go when they need medical care.



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



IDENTIFICATION OF COMMUNITY HEALTH NEEDS

Prioritization

Following a review of secondary data and key informant findings, a select group of providers, community health agency representatives and other community stakeholders were asked to participate in a health issue prioritization survey. The prioritization survey included 11 health issues or concerns, which were identified during the primary and secondary analysis phases of the community health needs assessment. For each of the 11 health issues included in the survey, participants in this prioritization process were asked to respond to six statements related to the extent to which the health-related disparity or concern impacts the community served by Overlook Medical Center or can be positively impacted by community health improvement efforts directed by OMC. In completing their responses, prioritization survey participants were asked to provide their perspective based on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree) for six criteria for each of the 11 identified health issues. Respondents to the stakeholder survey were given the option to abstain from offering a ranking on any individual criteria.

The six prioritization criteria used to evaluate each issue were:

- Number of people impacted
- The risk of morbidity and mortality associated with the problem
- Impact of the problem on vulnerable populations
- Availability of resources to address the problem
- Relationship of issue to other community issues
- Is within the organization's capability/ competency to impact

The 11 issues identified for prioritization in the area served by OMC were:

- Barriers to Healthcare Access
- Cancer
- Dental Health
- Diabetes
- Heart Disease
- Maternal and Child Health
- Mental Health
- Obesity / Unhealthy Weight
- Stroke
- Substance Misuse
- Tobacco Use & Vaping

Weighted averages for each impact on an issue were calculated. For each of the six potential impacts on an issue, the weighted averages were combined to create an overall weighted average for each issue (the overall ranking). The most impactful factor for each issue had the highest weighted average of the seven impacts for that issue, the least impactful factor had the lowest weighted average for that issue. These results were presented to the Overlook Medical Center Community Health Committee, who in partnership with hospital administration and the medical center's Community Advisory Board recommended the adoption of the following priority areas for inclusion in the 2019-2021 CHNA for OMC.

- Obesity / Unhealthy Weight / Food Insecurity
- Mental Health & Substance Misuse
- Heart Disease & Diabetes
- End of Life Care
- Cancer
- Stroke

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

IDENTIFIED HEALTH PRIORITIES

Obesity / Unhealthy Weight / Food Insecurity

In the area served by Overlook Medical Center, there are identified health concerns or disparities among the population that are related to obesity, unhealthy weight or food insecurity.

Each year, the *State of Obesity: Better Policies for a Healthier America* report, issued by the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF), highlights the latest obesity trends as well as strategies, policies, programs, and practices that can reverse the epidemic. State of Obesity also demonstrates the level of commitment necessary to effectively fight obesity on a large scale and includes key recommendations for specific action.

New studies documenting national obesity rates and trends from the past year reinforce what we already know: obesity rates are alarmingly high; sustained, meaningful reductions have not yet been achieved nationally except possibly among our youngest children in low-income families; many populations continue to see steady increases in obesity; and racial, ethnic, and geographic disparities are persistent. Therefore, addressing the obesity epidemic remains imperative for ensuring the health of the nation.

According to the most recent National Health and Nutrition Examination Survey (NHANES), 18.5 percent of children and 39.6 percent of adults had obesity in 2015–2016. These are the highest rates ever documented by NHANES. There were no statistically significant changes in youth or adult rates compared with the 2013–2014 survey, but rates have increased significantly since 1999–2000, when 13.9 percent of children and 30.5 percent of adults had obesity.

The severity of racial, ethnic, and geographic disparities remains striking. Black and Latino children and adults continue to have higher obesity rates than Whites and Asians. The Youth Risk Behavior Survey, which is based on self-reported data, found that 14.8 percent of U.S. high school students had obesity in 2017. That survey also reported persistent inequities–18.2 percent of Black and Latino high schoolers had obesity compared to12.5 percent of their White peers. Two other studies found that adults and children who live in rural areas have higher rates of severe obesity.

Accelerating progress to address obesity will require collaboration, sufficient resources, and sustained efforts, including by federal, state, and local agencies and the private sector. For decades, experts at CDC, National Institutes of Health (NIH), U.S. Department of Agriculture (USDA), U.S. Department of Education, the Administration for Children and Families, and the Food and Drug Administration (FDA) have been researching and developing strategies to prevent and address obesity. Over the past 15 years, policymakers have taken significant steps to implement new approaches through the WIC program, the Supplemental Nutrition Assistance Program, the National School Lunch and Breakfast Programs, updated menu labeling rules, and an updated Nutrition Facts label. Some of these efforts were delayed or weakened, preventing full implementation and thus denying researchers the ability to effectively study which efforts best help people maintain a healthy weight.

For instance, a USDA rule published in November 2017 scaled back key nutrition standards for school breakfast and lunch programs that went into effect in 2012. The question is whether schools will continue the healthy changes that they already implemented. In 23 states, 100 percent of school food agencies were compliant as of September 2016 and at least 90 percent of agencies were compliant in every state. FDA requirements for food retailers and restaurants to post calorie information on menus and elsewhere went into effect in May 2018, more than eight years after becoming law and after several unnecessary delays. Recent federal budget proposals include

deep cuts to key health programs such as the CDC's National Center for Chronic Disease Prevention and Health Promotion. This cut would eliminate dedicated funding for addressing nutrition, physical activity, and obesity.

Limiting policies and funding for obesity prevention efforts at a moment when the enormity and intractability of this public health problem is so pressing, will have adverse consequences for the country and its residents. After all, Americans' health is directly tied to national security and the U.S. economy.

In response to ongoing high levels of obesity, the United States must be bold enough to find and test new strategies, and resolute enough to intensify evidence-based solutions that are already making a difference. This means communities, governments, and other institutions need to work across sectors and levels to support policies, practices, and programs that work. Over time, these investments can pay off—in lives saved and in reduced healthcare costs.

The annual State of Obesity reports have documented how, over the past 15 years, a series of evidenced-based policies and programs have helped Americans eat healthier and provided more opportunities for physical activity in their homes, schools, and communities. These initiatives have taken root at the local, state, and federal levels, with participation from the private sector.

A renewed commitment to obesity prevention policies and programs, and continued innovation at the state and local levels is critical to achieving success among more children and adults in our country. Effective obesity prevention efforts also require substantial investment to support multifaceted, multi-sector collaborations; merging multiple sources of public and private funding can best ensure that these efforts are sustainable as a long-term enterprise. This is particularly important for populations that have elevated risk.

TFAH and RWJF recommend three guiding principles regarding obesity prevention:

1) Promote policies and scale programs that take a multi-sector approach. Multi-sector aligned initiatives—collaborations that involve, for example, health departments, schools, transportation departments, local businesses, and other agencies—are more likely to achieve results.
2) Adopt and implement policies that help make healthy choices easy. Federal, state, and local governments can create conditions in schools, communities, and workplaces that make healthy eating and active living accessible, affordable, and convenient.
3) Invest in programs that level the playing field for all individuals and families. While obesity affects all populations, some have significantly higher levels than others—often due to social and economic factors largely beyond their control, such as racism, poverty, and lack of access to healthcare. Carefully designed initiatives, that are informed by community input and address these challenges, are critically important. Investing in these programs requires not only adequate funding, but also staffing, public promotion, and other community resources.

TFAH and RWJF offer the following specific recommendations to Healthcare System and Providers:

- Hospitals should no longer sell or serve sugary drinks on their campuses; they should also improve the nutritional quality of meals and promote breastfeeding.
- Nonprofit hospitals should prioritize childhood obesity prevention programs as they work to meet their community benefit requirements.
- All public and private health plans should cover the full range of obesity-prevention, treatment, and management services, including nutritional counseling, medications, and behavioral health consultation.

- Medicare should encourage eligible beneficiaries to enroll in obesity counseling as a covered benefit and evaluate its use and effectiveness. Health plans, medical schools, continuing medical education, and public health departments should raise awareness about the need and availability of these services.
- The healthcare system should extend programs that are effective in terms of costs and performance, such as the Diabetes Prevention Program (DPP) and the community health worker–clinical coordination models. Providers and payers should allocate resources to educating and referring patients to DPP and other covered benefits as appropriate.
- Public and private payers should cover value-based purchasing models that incorporate health outcome measures that incentivize clinicians to prioritize healthy weight.

Mental Health & Substance Misuse

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

Mental Health

Need for Mental Health Providers[8]

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

Expanding the workforce by allowing advanced practice registered nurses to practice to the full extent of their training, broadening the scope of practice of psychologists to prescribe some medications, and educating more advanced practice registered nurses and psychiatric-mental health physician assistants, are examples of strategies to address the shortage. Tele-mental health is widely accepted as a mechanism that can address shortages in some geographic areas. One in five counties also has a shortage of non-prescriber mental health professionals, defined as psychologists, advanced practice psychiatric nurses, social workers, licensed professional counselors, and marriage and family therapists. Also, there are categories of mental health service providers, including licensed professional counselors and marriage and family therapists, whose services are not eligible for reimbursement by Medicare. Peer support can play an important role in a functioning mental health system and should be included as a part of a full continuum of services, whenever possible. Peer support services have been demonstrated to promote recovery and resiliency through the generation of hope, engagement in treatment services, and activation for improved health outcomes. Youth and family peer support services have also generated notable outcomes in this area.

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

Most states report insufficient psychiatric crisis response capacity as well as insufficient numbers of inpatient psychiatric hospital beds. It is critical that every state have adequate bed capacity to respond to the needs of people experiencing both psychiatric crises and those who need longer periods of inpatient care, such as people in forensic care (care that is provided because of involvement in the criminal or juvenile justice systems). In many areas, bed shortages have led to long delays in gaining access to treatment and an increase in individuals waiting for competency restoration services needed to restore competency to participate in legal proceedings. A report by the National Association of State Mental Health Program Directors Research Institute found that most states (35 of the 46 who responded) have shortages of psychiatric hospital beds. The configuration of available beds and the number of beds per 100,000 population varies substantially across states, but few states report they have adequate numbers of inpatient beds to meet needs. Use of a variety of strategies, such as building psychiatric respite bed capacity, may help to address these capacity issues.

- The workforce is too few, aging into retirement, inadequately reimbursed, inadequately supported and trained and facing significant changes affecting practice, credentialing, funding, and ability to keep up with changes in practice models driven by changing science, technologies and systems.
- Shortages of qualified workers, recruitment and retention of staff and an aging workforce have long been cited as problems.
- Lack of workers in rural/frontier areas and the need for a workforce more reflective of the racial and ethnic composition of the U.S. population create additional barriers to accessing care for many.
- Recruitment and retention efforts are hampered by inadequate compensation, which discourages many from entering or remaining in the field.
- The misperceptions and prejudice surrounding mental and substance use disorders and those who experience them are imputed to those who work in the field.
- Pre-service education and continuing education and training of the workforce have been found wanting, as evidenced by the long delays in adoption of evidence-based practices, underutilization of technology, and lack of skills in critical thinking. These education and training deficiencies are even more problematic with the increasing integration of primary care and mental or substance use disorder treatment, and the focus on improving quality of care and outcomes.
- Of additional concern, the current workforce is unprepared to meet the mental and substance use disorder treatment needs of the rapidly growing population of older adults.

Several themes emerged as common factors that are influencing workforce trends across the country.[9]

- The Affordable Care Act and Medicaid expansion: The Patient Protection and Affordable Care Act (ACA) and accompanying reforms expanded access to SUD treatment to millions of Americans. Treatment agencies need more staff to treat more clients. Many existing SUD staff need to complete additional coursework or pursue master's level degrees.
- Clinical supervision: In many states, clinical supervision is also required when implementing evidence-based practices. Organizations that invest in their staff by providing good clinical supervision may have greater success with workforce recruitment and retention.
- Healthcare integration: The movement to integrate mental health and SUD treatment with primary care has had an impact on the workforce. SUD professionals are under increasing pressure to acquire skills that allow them to work in integrated healthcare settings, and primary care physicians, nurses, and other medical professionals are beginning to play larger roles in SUD treatment and recovery services.

[9] SAMHSA. (2017, September). ATTC: Network Coordinating Office. National Workforce Report 2017. From http://attcnetwork.org/documents/ATTC_Network_Natl_Report2017_single.pdf (

- The opioid epidemic: No state in the country has been spared from the devastation of the opioid epidemic. Building the capacity of the SUD workforce to provide effective evidence-based treatment for opioid use disorders has been a top priority.

What are some strategies to increase the size of the workforce to better provide evidence-based mental health services and supports?[10]

- HRSA has taken several steps to address these workforce challenges as part of its mission to prepare a diverse workforce and improve the workforce distribution to increase access for underserved communities. Among its many programs, HRSA awards health professional and graduate medical education training grants and operates scholarship and loan repayment programs.
- Of note is the National Health Service Corps, where, as of September 2015, roughly 30 percent of its field strength of 9,683 was composed of behavioral health providers, meeting service obligations by providing care in areas of high need.
- HRSA is also putting increased emphasis on expanding the delivery of medication-assisted treatment, increasing SBI, and coordinating RSS. The development of the workforce qualified to deliver these services and services to address co-occurring medical and mental disorders will have significant implications for the national workforce's ability to reach the full potential of integration.

What are SAMHSA and other Federal agencies doing to address the workforce crisis and enhance recovery supports as an integral part of the solution?[11]

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

What is the best way to ensure the behavioral health workforce has access to the information they need to remain current in advancing technologies in prevention, treatment and recovery support? [12]

- Strong health IT systems improve the organization and usability of clinical data, thereby helping patients, health care professionals, and health system leaders coordinate care, promote shared decision-making, and engage in quality improvement efforts. These systems have the capacity to easily provide information

[10] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.
[11] SAMHSA. Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018
[12] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

in multiple languages and to put patients in touch with culturally appropriate providers through telehealth.

What kinds of training programs or strategies might BH managers adopt to enhance staff retention?[13]

- Members of the behavioral health workforce benefit from continued training and clinical supervision to maintain high-quality services. In addition, these practices and other organizational factors may prevent staff from experiencing burnout and may assist in overcoming challenges in retention of qualified workers.
- For example, clinical supervision has been shown to serve as a protective factor in substance abuse treatment counselors' turnover, emotional exhaustion, and job satisfaction. In the substance abuse treatment field, staff turnover has been found to be as high as 50 percent in some contexts, with average annual estimates around 32 percent for counselors. Substance abuse treatment facilities can play a key role in supporting their workforce through training and supervision practices.

What are initiatives that increase access to providers in underserved areas and integrate behavioral health and primary care?

- The National Network to Eliminate Disparities (NNED) in Behavioral Health is dedicated to promoting equality in behavioral health services for individuals, families, and communities. NNED, with help from SAMHSA and the National Alliance for Multi-Ethnic Behavioral Health Associations, builds coalitions of racial, ethnic, cultural, and sexual minority communities and groups dedicated to removing disparities in behavioral health care.[14]
- The Minority Fellowship Programs (MFP) increase the knowledge of issues related to mental health conditions and addictions among minorities, and to improve the quality of mental health services and substance abuse prevention and treatment delivered to ethnic minority populations. SAMHSA provides grants to encourage and facilitate the doctoral and post-doctoral development of nurses, psychiatrists, social workers, psychologists, marriage and family therapists, and professional counselors by providing funding to organizations which oversee the fellowship opportunities.
- Graduate Psychology Education (GPE) Program: HRSA grants in the GPE program support interdisciplinary training for health service psychologists to provide mental and behavioral health care services to underserved populations, such as those in rural areas, older adults, children, chronically ill or disabled persons, and victims of abuse or trauma, including returning military personnel.
- HRSA's National Health Service Corps are health professionals who provide primary health care services in underserved communities in exchange for either loan repayment assistance or scholarships to help pay the costs of their medical education.
- SAMHSA's cooperative agreement with Historically Black Colleges and Universities supports a Center for Excellence in Substance Abuse and Mental Health which provides student internships at minority serving institutions.[15]
- CMS is providing technical and program support to states to introduce policy, program, and payment reforms to identify individuals with substance use disorders, expand coverage for effective treatment, expand access to services, and develop data collection, measurement, and payment mechanisms that promote better outcomes.

[13] Sherman, Laura, Lynch, Sean, et. al. Behavioral Health Workforce: Quality Assurance Practices in Substance Abuse Treatment Facilities. The CBHSQ Report. SAMHSA.
[14] SAMHSA. (n.d.). Serving the Needs of Diverse Populations.
[15] SAMHSA. (2013, January 24). Report to Congress on Nation's Substance Abuse and Mental Health Workforce Issues.

- Medicaid is also encouraging the trend to integration in other ways, including supporting new models for delivering primary care, expanding the role of existing community-based care delivery systems, enacting mental health and substance use disorder parity for Medicaid and Children's Health Insurance Program (CHIP) as included in the final rule that CMS finalized in March 2016.[16]

Substance Use Disorders

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Following are overviews of the most common substance use disorders in the United States.

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

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

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

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

In 2014, an estimated 913,000 people ages 12 and older had a stimulant use disorder because of cocaine use, and an estimated 476,000 people had a stimulant use disorder as a result of using other stimulants besides

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

methamphetamines. In 2014, almost 569,000 people in the United States ages 12 and up reported using methamphetamines in the past month.

Symptoms of stimulant use disorders include craving for stimulants, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use stimulants, and withdrawal symptoms that occur after stopping or reducing use, including fatigue, vivid and unpleasant dreams, sleep problems, increased appetite, or irregular problems in controlling movement.

Marijuana is the most-used drug after alcohol and tobacco in the United States. According to SAMHSA data:

- In 2014, about 22.2 million people ages 12 and up reported using marijuana during the past month.
- Also, in 2014, there were 2.6 million people in that age range who had used marijuana for the first time within the past 12 months. People between the ages of 12 and 49 report first using the drug at an average age of 18.5.

In the past year, 4.2 million people ages 12 and up met criteria for a substance use disorder based on marijuana use.

Marijuana's immediate effects include distorted perception, difficulty with thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure to cancer-causing compounds. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Some symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use.

According to the CDC, more than 480,000 deaths each year are caused by cigarette smoking. Tobacco use and smoking do damage to nearly every organ in the human body, often leading to lung cancer, respiratory disorders, heart disease, stroke, and other illnesses.

In 2014, an estimated 66.9 million Americans aged 12 or older were current users of a tobacco product (25.2%). Young adults aged 18 to 25 had the highest rate of current use of a tobacco product (35%), followed by adults aged 26 or older (25.8%), and by youths aged 12 to 17 (7%).

In 2014, the prevalence of current use of a tobacco product was 37.8% for American Indians or Alaska Natives, 27.6% for Whites, 26.6% for Blacks, 30.6% for Native Hawaiians or other Pacific Islanders, 18.8% for Hispanics, and 10.2% for Asians.

Excessive alcohol use can increase a person's risk of developing serious health problems in addition to those issues associated with intoxication behaviors and alcohol withdrawal symptoms. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use causes 88,000 deaths a year.

Data from the National Survey on Drug Use and Health (NSDUH) show that in 2014, slightly more than half (52.7%) of Americans ages 12 and up reported being current drinkers of alcohol. Most people drink alcohol in moderation. However, of those 176.6 million alcohol users, an estimated 17 million have an AUD. Many Americans begin drinking at an early age. In 2012, about 24% of eighth graders and 64% of twelfth graders used alcohol in the past year.

The definitions for the different levels of drinking include the following:

- Moderate Drinking—According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.
- Binge Drinking—SAMHSA defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 drinks for women and 5 drinks for men over a 2-hour period.
- Heavy Drinking—SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Excessive drinking can put you at risk of developing an alcohol use disorder in addition to other health and safety problems. Genetics have also been shown to be a risk factor for the development of an AUD.

To be diagnosed with an AUD, individuals must meet certain diagnostic criteria. Some of these criteria include problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

Hallucinogens can be chemically synthesized (as with lysergic acid diethylamide or LSD) or may occur naturally (as with psilocybin mushrooms, peyote). These drugs can produce visual and auditory hallucinations, feelings of detachment from one's environment and oneself, and distortions in time and perception.

In 2014, approximately 246,000 Americans had a hallucinogen use disorder. Symptoms of hallucinogen use disorder include craving for hallucinogens, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, use in risky situations like driving, development of tolerance, and spending a great deal of time to obtain and use hallucinogens.

Heart Disease & Diabetes

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

Heart Disease[17]

Heart disease currently stands as the leading cause of death in the United States, with more than 600,000 Americans dying of heart disease and related conditions each year.[18] This amounts to one in every four deaths in the United States annually. Several health conditions, your lifestyle, and your age and family history can increase your risk for heart disease. About half of all Americans (47%) have at least one of the three key risk factors for heart disease: high blood pressure, high cholesterol, and smoking. Some of the risk factors for heart disease cannot be controlled, such as your age or family history. But you can take steps to lower your risk by changing the factors you can control.

[17] https://www.cdc.gov/heartdisease/about.htm
[18] www.cdc.gov/nchs/ data/nvsr/nvsr60/nvsr60_03.pdf

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

Coronary artery disease (CAD) is the most common type of heart disease in the United States. For some people, the first sign of CAD is a heart attack. CAD is caused by plaque buildup in the walls of the arteries that supply blood to the heart (called coronary arteries) and other parts of the body. Plaque is made up of deposits of cholesterol and other substances in the artery. Plaque buildup causes the inside of the arteries to narrow over time, which could partially or totally block the blood flow. This process is called atherosclerosis.
Too much plaque buildup and narrowed artery walls can make it harder for blood to flow through your body. When your heart muscle doesn’t get enough blood, you may have chest pain or discomfort, called angina. Angina is the most common symptom of CAD. Over time, CAD can weaken the heart muscle. This may lead to heart failure, a serious condition where the heart can’t pump blood the way that it should. An irregular heartbeat, or arrhythmia, also can develop. Being overweight, physical inactivity, unhealthy eating, and smoking tobacco are risk factors for CAD. A family history of heart disease also increases your risk for CAD.
Heart Attack, also called a myocardial infarction, occurs when a part of the heart muscle doesn’t receive enough blood flow. The more time that passes without treatment to restore blood flow, the greater the damage to the heart muscle. Learn more about the signs and symptoms of a heart attack.
Every year, about 790,000 Americans have a heart attack. Of these cases, 580,000 are a first heart attack and 210,000 happen to people who have already had a first heart attack. One of 5 heart attacks is silent—the damage is done, but the person is not aware of it. Coronary artery disease (CAD) is the main cause of heart attack. Less common causes are severe spasm, or sudden contraction, of a coronary artery that can stop blood flow to the heart muscle.

Other related conditions include:

- Acute coronary syndrome: a term that includes heart attack and unstable angina.
- Angina: asymptom of coronary artery disease, is chest pain or discomfort that occurs when the heart muscle is not getting enough blood. Angina may feel like pressure or a squeezing pain in the chest. The pain also may occur in the shoulders, arms, neck, jaw, or back. It may feel like indigestion.
- Stable angina: happens during physical activity or under mental or emotional stress.
- Unstable angina: chest pain that occurs even while at rest, without apparent reason. This type of angina is a medical emergency.
- Aortic aneurysm and dissection: conditions that can affect the aorta, the major artery that carries blood from the heart to the body. An aneurysm is an enlargement in the aorta that can rupture or burst. A dissection is a tear in the aorta. Both conditions are medical emergencies.
- Arrhythmias: irregular or unusually fast or slow heartbeats. Arrhythmias can be serious. One example is called ventricular fibrillation. This type of arrhythmia causes an abnormal heart rhythm that leads to death unless treated right away with an electrical shock to the heart (called defibrillation). Other arrhythmias are less severe but can develop into more serious conditions, such as atrial fibrillation, which can cause a stroke.
- Atherosclerosis: occurs when plaque builds up in the arteries that supply blood to the heart (called coronary arteries). Plaque is made up of cholesterol deposits. Plaque buildup causes arteries to narrow over time.
- Atrial fibrillation: a type of arrhythmia that can cause rapid, irregular beating of the heart’s upper chambers. Blood may pool and clot inside the heart, increasing the risk for heart attack and stroke.
- Cardiomyopathy: occurs when the heart muscle becomes enlarged or stiff. This can lead to inadequate heart pumping (or weak heart pump) or other problems. Cardiomyopathy has many causes, including

family history of the disease, prior heart attacks, uncontrolled high blood pressure, and viral or bacterial infections.

- Congenital heart defects: problems with the heart that are present at birth. They are the most common type of major birth defect. Examples include abnormal heart valves or holes in the heart's walls that divide the heart's chambers. Congenital heart defects range from minor to severe.
- Heart failure: often called congestive heart failure (CHF) because of fluid buildup in the lungs, liver, gastrointestinal tract, and the arms and legs. Heart failure is a serious condition that occurs when the heart can't pump enough blood to meet the body's needs. It does not mean that the heart has stopped but that muscle is too weak to pump enough blood. The majority of heart failure cases are chronic, or long-term heart failures. The only cure for heart failure is a heart transplant. However, heart failure can be managed with medications or medical procedures.
- Peripheral arterial disease (PAD): occurs when the arteries that supply blood to the arms and legs (the periphery) become narrow or stiff. PAD usually results from atherosclerosis, the buildup of plaque and narrowing of the arteries. With this condition, blood flow and oxygen to the arm and leg muscles are low or even fully blocked. Signs and symptoms include leg pain, numbness, and swelling in the ankles and feet.
- Rheumatic heart disease is damage to the heart valves caused by a bacterial (streptococcal) infection called rheumatic fever.

Diabetes[19]

Diabetes mellitus (DM) occurs when the body cannot produce enough insulin or cannot respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications.

Many forms of diabetes exist. The 3 common types of DM are:

- Type 2 diabetes, which results from a combination of resistance to the action of insulin and insufficient insulin production
- Type 1 diabetes, which results when the body loses its ability to produce insulin
- Gestational diabetes, a common complication of pregnancy. Gestational diabetes can lead to perinatal complications in mother and child and substantially increases the likelihood of cesarean section. Gestational diabetes is also a risk factor for the mother and, later in life, the child's subsequent development of type 2 diabetes after the affected pregnancy.

Effective therapy can prevent or delay diabetic complications. However, about 28 percent of Americans with DM are undiagnosed, and another 86 million American adults have blood glucose levels that greatly increase their risk of developing type 2 DM in the next several years. Diabetes complications tend to be more common and more severe among people whose diabetes is poorly controlled, which makes DM an immense and complex public health challenge. Preventive care practices are essential to better health outcomes for people with diabetes.

DM affects an estimated 29.1 million people in the United States and is the 7th leading cause of death. Diagnosed DM:

- Increases the all-cause mortality rate 1.8 times compared to persons without diagnosed diabetes

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

- Increases the risk of heart attack by 1.8 times
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness
- In addition to these human costs, the estimated total financial cost of DM in the United States in 2012 was $245 billion, which includes the costs of medical care, disability, and premature death.
- The number of DM cases continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with DM, and possibly earlier onset of type 2 DM, there is growing concern about:

    - The possibility of substantial increases in prevalence of diabetes-related complications in part due to the rise in rates of obesity
    - The possibility that the increase in the number of persons with DM and the complexity of their care might overwhelm existing health care systems
    - The need to take advantage of recent discoveries on the individual and societal benefits of improved diabetes management and prevention by bringing life-saving discoveries into wider practice
    - The clear need to complement improved diabetes management strategies with efforts in primary prevention among those at risk for developing type 2 DM

Four “transition points” in the natural history of diabetes health care provide opportunities to reduce the health and economic burden of DM:

- Primary prevention: Movement from no diabetes to diabetes
- Testing and early diagnosis: Movement from unrecognized to recognized diabetes
- Access to care for all persons with diabetes: Movement from no diabetes care to access to appropriate diabetes care
- Improved quality of care: Movement from inadequate to adequate care
  Disparities in diabetes risk:
- People from minority populations are more likely to be affected by type 2 diabetes. Minority groups constitute 25 percent of all adult patients with diabetes in the United States and represent most children and adolescents with type 2 diabetes.
- African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians and other Pacific Islanders are at particularly high risk for the development of type 2 diabetes.
- Diabetes prevalence rates among American Indians are 2 to 5 times those of whites. On average, African American adults are 1.7 times as likely and Mexican Americans and Puerto Ricans are twice as likely to have the disease as non-Hispanic whites of similar age.
  Barriers to progress in diabetes care include:
- Systems problems (challenges due to the design of health care systems)
- The troubling increase in the number of people with diabetes, which may result in a decrease in the attention and resources available per person to treat DM

Evidence is emerging that diabetes is associated with additional comorbidities including:

- Cognitive impairment
- Incontinence
- Fracture risk
- Cancer risk and prognosis

The importance of both diabetes and these comorbidities will continue to increase as the population ages. Therapies that have proven to reduce microvascular and macrovascular complications will need to be assessed considering the newly identified comorbidities.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals. Based on this, new public health approaches are emerging that may deserve monitoring at the national level. For example, the Diabetes Prevention Program research trial demonstrated that lifestyle intervention had its greatest impact in older adults and was effective in all racial and ethnic groups. Translational studies of this work have also shown that delivery of the lifestyle intervention in group settings at the community level are also effective at reducing type 2 diabetes risk. The National Diabetes Prevention Program has now been established to implement the lifestyle intervention nationwide.

Another emerging issue is the effect on public health of new laboratory-based criteria, such as introducing the use of A1c for diagnosis of type 2 diabetes or for recognizing high risk for type 2 diabetes. These changes may impact the number of individuals with undiagnosed diabetes and facilitate the introduction of type 2 diabetes prevention at a public health level.

Several studies have suggested that process indicators such as foot exams, eye exams, and measurement of A1c may not be sensitive enough to capture all aspects of quality of care that ultimately result in reduced morbidity. New diabetes quality-of-care indicators are currently under development and may help determine whether appropriate, timely, evidence-based care is linked to risk factor reduction. In addition, the scientific evidence that type 2 diabetes can be prevented or delayed has stimulated new research into the best markers and approaches for identifying and referring high-risk individuals to prevention programs in community settings.

Finally, it may be possible to achieve additional reduction in the risk of type 2 diabetes or its complications by influencing various behavioral risk factors, such as specific dietary choices, which have not been tested in large randomized controlled trials.

End of Life Care[20,21]

A recent survey found that 92% of people believe talking about end-of-life care and decision making is important, but only 32% have done so. Knowing where to begin is often the hardest part. At the end of life, each story is different. Death comes suddenly, or a person lingers, gradually fading. For some older people, the body weakens while the mind stays alert. Others remain physically strong, but cognitive losses take a huge toll. Although everyone dies, each loss is personally felt by those close to the one who has died.

End of life care is the term used to describe the support and medical care given during the time surrounding death. Such care does not happen only in the moments before breathing ceases and the heart stops beating. Older people often live with one or more chronic illnesses and need a lot of care for days, weeks, and even months before death.

When a doctor says something like, “I’m afraid the news is not good. There are no other treatments for us to try. I’m sorry,” it may close the door to the possibility of a cure, but it does not end the need for medical support. Nor does it end the involvement of family and friends.

[20] http://www.sageeldercare.org/services/yourdecisionsmatter/
[21] https://www.nia.nih.gov/health/providing-comfort-end-life#what

There are many ways to provide care for an older person who is dying. Being a caregiver for someone at the end of life can be physically and emotionally exhausting. In the end, accept that there may be no perfect death, just the best you can do for the one you love. And, the pain of losing someone close to you may be softened a little because, when you were needed, you did what you could.

There are ways to make a person who is dying more comfortable. Discomfort can come from a variety of problems. For each, there are things you or a healthcare provider can do, depending on the cause. For example, a dying person can be uncomfortable because of:

- Pain
- Breathing problems
- Skin irritation
- Digestive problems
- Temperature sensitivity
- Fatigue

Complete end-of-life care also includes helping the dying person manage mental and emotional distress. Someone who is alert near the end of life might understandably feel depressed or anxious. It is important to treat emotional pain and suffering. Encouraging conversations about feelings might help. You might want to contact a counselor, possibly one familiar with end-of-life issues. If the depression or anxiety is severe, medicine may help.

- A dying person may have some specific fears and concerns. He or she may fear the unknown or worry about those left behind. Some people are afraid of being alone at the very end. This feeling can be made worse by the understandable reactions of family, friends, and even the medical team. For example, when family and friends do not know how to help or what to say, sometimes they stop visiting. Or, someone who is already beginning to grieve may withdraw.

- Doctors may feel helpless because they can't cure their patient. Some seem to avoid a dying patient. This can add to a dying person's sense of isolation.

- The simple act of physical contact—holding hands, a touch, or a gentle massage—can make a person feel connected to those he or she loves.

- Try to set a comforting mood. Remember that listening and being present can make a difference.

- Some experts suggest that when death is very near, music at a low volume and soft lighting are soothing. In fact, near the end of life, music therapy might improve mood, help with relaxation, and lessen pain. Listening to music might also evoke memories those present can share. For some people, keeping distracting noises like televisions and radios to a minimum is important.

- Often, just being present with a dying person is enough. It may not be necessary to fill the time with talking or activity. A quiet presence can be a simple and profound gift for a dying family member or friend.

People nearing the end of life may have spiritual needs as important as their physical concerns. Spiritual needs include finding meaning in one's life and ending disagreements with others, if possible. The dying person might find peace by resolving unsettled issues with friends or family. Visits from a social worker or a counselor may also help.

- Many people find solace in their faith. Others may struggle with their faith or spiritual beliefs. Praying, talking with someone from one's religious community (such as a minister, priest, rabbi, or imam), reading religious texts, or listening to religious music may bring comfort.

- Family and friends can talk to the dying person about the importance of their relationship. For example, adult children can share how their father has influenced the course of their lives. Grandchildren can let their grandfather know how much he has meant to them. Friends can relate how they value years of support and companionship. Family and friends who can't be present could send a recording of what they would like to say or a letter to be read out loud.

- Sharing memories of good times is another way some people find peace near death. This can be comforting for everyone. Some doctors think it is possible that even if a patient is unconscious, he or she might still be able to hear. It is probably never too late to say how you feel or to talk about fond memories.

- Always talk to, not about, the person who is dying. When you come into the room, it is a good idea to identify yourself, saying something like, "Hi, Juan. It's Mary, and I've come to see you." Another good idea is to have someone write down some of the things said at this time—both by and to the person who is dying. In time, these words might serve as a source of comfort to family and friends. People who are looking for ways to help may welcome the chance to aid the family by writing down what is said.

- There may come a time when a dying person who has been confused suddenly seems clear-thinking. Take advantage of these moments, but understand that they might be only temporary, not necessarily a sign he or she is getting better. Sometimes, a dying person may appear to see or talk to someone who is not there. Try to resist the temptation to interrupt or say they are imagining things. Give the dying person the space to experience their own reality.

In partnership with *SAGE Eldercare*, Atlantic Health System's Overlook and Chilton Medical Centers bring an important conversation directly to the community through an initiative that offers workshops in familiar spots both in the communities served by the medical centers. SAGE Eldercare was awarded a 3-year grant from Atlantic Health System's Overlook and Chilton Medical Centers' Community Advisory Boards to develop this community outreach program. The project is a community-based initiative to engage the public in conversations about end-of-life care and decision making while helping to normalize the topic. The Your Decisions Matter initiative is aware of various cultures and beliefs and recognizes that all wishes are not alike, but all are respected. The outreach program -- 'Your Decisions Matter' -- is designed to engage the public in conversations about end-of-life care and decision making, hosted in familiar places throughout the community.

Through its partnership with Sage Eldercare, OMC works to identify innovative and effective methods to educate the public and providers about end of life issues across all age groups.

OMC continues to develop and work with an end of life care task force, involving academic institutions, research organizations, clergy, and OMC staff. The task force is charged with identifying appropriate ways to implement end of life care, approach conversations between care givers and families about end of life care, and ways to expand awareness and recognition of the need for appropriate conversations among family members.

OMC is working to implement provider education for end of life are at all Atlantic Health System acute care sites and approximately 30 Atlantic Medical Group practice locations and works with other AHS departments and sites to develop system-wide approach to palliative care.

Cancer

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

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in 5 years, yet cancer remains a leading cause of death in the United States, second only to heart disease.[22]

Many cancers are preventable by reducing risk factors such as:

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

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

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

For cancers with evidence-based screening tools, early detection must address the continuum of care from screening to appropriate follow-up of abnormal test results and referral to cancer treatment.[23]

However, while scientific advances and medical breakthroughs in cancer treatment options and their efficacy, the benefits of these health improvements have thus far been felt disproportionately by only a small, sub-section of the population. To explain this phenomenon, researchers have pointed to the complex and interrelated factors, which contribute to the risk of developing cancer, and to the observed disparities in cancer incidence and death among racial, ethnic, and underserved groups.[24]

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

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

[22] https://www.healthypeople.gov/2020/topics-objectives/topic/cancer
[23] Zapka, J. G., et al. (2003). A framework for improving the quality of cancer care: the case of breast and cervical cancer screening. Cancer Epidemiology and Prevention Biomarkers, 12(1), 4-13.
[24] https://www.healthypeople.gov/2020/topics-objectives/topic/cancer

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

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

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

Recently, overweight and obesity have emerged as new risk factors for developing certain cancers, including but not limited to colorectal, breast, uterine corpus (endometrial), pancreas, and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.[25]

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

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

In the coming decade, as the number of cancer survivors is expected to increase by more than 30% to 18 million, understanding survivors' health status and behaviors will become increasingly important.[26]

Stroke[27]

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

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

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

[25] http://seer.cancer.gov
[26] De Moor, J. S., et al. (2013). Cancer survivors in the United States: prevalence across the survivorship trajectory and implications for care. Cancer Epidemiology and Prevention Biomarkers, 22(4), 561-570.
[27] https://www.stroke.org/en/about-stroke

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

- Ischemic stroke occurs when a vessel supplying blood to the brain is obstructed. It accounts for about 87 percent of all strokes. Fatty deposits lining the vessel walls, called atherosclerosis, are the main cause for ischemic stroke. Fatty deposits can cause two types of obstruction:

    - Cerebral thrombosis is a thrombus (blood clot) that develops at the fatty plaque within the blood vessel.

    - Cerebral embolism is a blood clot that forms at another location in the circulatory system, usually the heart and large arteries of the upper chest and neck. Part of the blood clot breaks loose, enters the bloodstream and travels through the brain's blood vessels until it reaches vessels too small to let it pass. A main cause of embolism is an irregular heartbeat called atrial fibrillation. It can cause clots to form in the heart, dislodge and travel to the brain.

- Hemorrhagic strokes make up about 13 percent of stroke cases. It's caused by a weakened vessel that ruptures and bleeds into the surrounding brain. The blood accumulates and compresses the surrounding brain tissue. The two types of hemorrhagic strokes are intracerebral (within the brain) hemorrhage or subarachnoid hemorrhage. A hemorrhagic stroke occurs when a weakened blood vessel ruptures. Two types of weakened blood vessels usually cause hemorrhagic stroke: aneurysms and arteriovenous malformations (AVMs).

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

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

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

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

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

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

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

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

APPENDIX A: DEMOGRAPHIC TABLES

Current and Forecasted Population

POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES						
ZIP Code	ZIP Code Name	Population of Base Yr (2010)	Population of Current Yr (2019)	Population of Forecast Yr (2024)	Population Growth: Base Yr to Current Yr (%)	Population Growth: Current Yr to Forecast Yr (%)
07040	MAPLEWOOD	23,987	24,766	25,289	3.25%	2.11%
07041	MILLBURN	6,955	7,205	7,368	3.59%	2.26%
07052	WEST ORANGE	46,633	48,297	49,251	3.57%	1.98%
07078	SHORT HILLS	13,104	13,330	13,506	1.72%	1.32%
07111	IRVINGTON	54,174	54,430	54,912	0.47%	0.89%
07112	NEWARK	26,331	27,243	27,842	3.46%	2.20%
07002	BAYONNE	63,083	67,415	69,507	6.87%	3.10%
08812	DUNELLEN	14,411	15,062	15,425	4.52%	2.41%
08854	PISACATAWAY	55,966	58,510	59,853	4.55%	2.30%
07928	CHATHAM	18,884	18,265	18,117	-3.28%	-0.81%
07960	MORRISTOWN	43,833	44,908	45,583	2.45%	1.50%
07059	WARREN	15,677	16,210	16,558	3.40%	2.15%
07069	WATCHUNG	6,483	6,780	6,956	4.58%	2.60%
07920	BASKING RIDGE	27,529	28,338	28,908	2.94%	2.01%
07016	CRANFORD	22,690	24,201	24,941	6.66%	3.06%
07023	FANWOOD	7,333	7,826	8,079	6.72%	3.23%
07027	GARWOOD	4,299	4,544	4,671	5.70%	2.79%
07033	KENILWORTH	7,993	8,435	8,666	5.53%	2.74%
07036	LINDEN	42,028	43,957	44,968	4.59%	2.30%
07060	PLAINFIELD	44,107	44,779	45,299	1.52%	1.16%
07062	PLAINFIELD	13,450	13,825	14,033	2.79%	1.50%
07065	RAHWAY	27,375	30,166	31,328	10.20%	3.85%
07066	CLARK	14,442	15,652	16,244	8.38%	3.78%
07076	SCOTCH PLAINS	23,682	25,239	26,023	6.57%	3.11%
07081	SPRINGFIELD	15,550	17,140	17,931	10.23%	4.61%
07083	UNION	53,641	56,558	58,036	5.44%	2.61%
07088	VAUXHALL	3,422	3,620	3,725	5.79%	2.90%
07090	WESTFIELD	30,295	31,482	32,115	3.92%	2.01%
07092	MOUNTAINSIDE	6,813	7,116	7,278	4.45%	2.28%
07201	ELIZABETH	26,820	28,230	28,970	5.26%	2.62%
07202	ELIZABETH	40,207	43,465	45,081	8.10%	3.72%
07203	ROSELLE	20,986	21,790	22,216	3.83%	1.96%
07204	ROSELLE PARK	13,194	13,765	14,069	4.33%	2.21%
07205	HILLSIDE	21,452	22,550	23,129	5.12%	2.57%
07206	ELIZABETHPORT	26,569	29,813	31,341	12.21%	5.13%
07208	ELIZABETH	31,058	32,252	32,896	3.84%	2.00%
07901	SUMMIT	22,744	23,745	24,267	4.40%	2.20%
07922	BERKELEY HEIGHTS	12,300	12,895	13,207	4.84%	2.42%
07974	NEW PROVIDENCE	11,896	12,556	12,900	5.55%	2.74%
	OMC SERVICE AREA	**961,396**	**1,249,525**	**1,264,843**	**4.7%**	**2.4%**
	UNION COUNTY	**557,564**	**589,509**	**605,700**	**5.7%**	**2.7%**
	NEW JERSEY	**8,791,914**	**9,043,262**	**9,195,645**	**2.9%**	**1.7%**

Population Density

POPULATION DENSITY: ZIP CODES AND COMPARATIVE GEOGRAPHIES		
ZIP Code	ZIP Code Name	Population / Square Mile
07040	MAPLEWOOD	6,948.70
07041	MILLBURN	5,345.09
07052	WEST ORANGE	3,953.87
07078	SHORT HILLS	2,027.73
07111	IRVINGTON	18,172.55
07112	NEWARK	14,680.83
07002	BAYONNE	11,347.10
08812	DUNELLEN	2,840.89
08854	PISACATAWAY	3,083.43
07928	CHATHAM	2,128.89
07960	MORRISTOWN	1,266.50
07059	WARREN	824.20
07069	WATCHUNG	1,071.55
07920	BASKING RIDGE	1,215.72
07016	CRANFORD	4,928.33
07023	FANWOOD	5,767.90
07027	GARWOOD	6,689.41
07033	KENILWORTH	3,852.73
07036	LINDEN	3,980.00
07060	PLAINFIELD	8,797.30
07062	PLAINFIELD	7,383.39
07065	RAHWAY	7,574.44
07066	CLARK	3,506.03
07076	SCOTCH PLAINS	2,744.51
07081	SPRINGFIELD	3,250.12
07083	UNION	6,469.33
07088	VAUXHALL	8,260.82
07090	WESTFIELD	4,616.25
07092	MOUNTAINSIDE	1,743.12
07201	ELIZABETH	4,201.73
07202	ELIZABETH	18,585.17
07203	ROSELLE	8,062.57
07204	ROSELLE PARK	11,005.93
07205	HILLSIDE	8,077.61
07206	ELIZABETHPORT	18,235.28
07208	ELIZABETH	18,022.21
07901	SUMMIT	3,687.33
07922	BERKELEY HEIGHTS	2,292.98
07974	NEW PROVIDENCE	3,047.55
	OMC SERVICE AREA	**3,895.43**
	UNION COUNTY	**5,496.42**
	NEW JERSEY	**1,303.47**

Race & Hispanic[28]

POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES											
		White (Non-Hispanic)		Hispanic (of Any Race)		Asian (Non-Hispanic)		Black (Non-Hispanic)		Another Race (Non-Hispanic)	
ZIP Code	ZIP Code Name	2019	2024	2019	2024	2019	2024	2019	2024	2019	2024
07040	MAPLEWOOD	50.4%	48.8%	7.9%	8.6%	3.9%	4.4%	34.2%	34.3%	3.6%	3.9%
07041	MILLBURN	63.1%	56.6%	7.5%	8.7%	22.8%	27.1%	3.4%	3.8%	3.2%	3.7%
07052	WEST ORANGE	40.0%	35.3%	19.0%	20.8%	9.0%	9.6%	29.4%	31.6%	2.6%	2.7%
07078	SHORT HILLS	69.6%	64.5%	3.1%	3.5%	23.6%	27.8%	1.0%	1.1%	2.7%	3.1%
07111	IRVINGTON	2.1%	1.7%	12.8%	14.1%	1.0%	1.0%	82.6%	81.7%	1.7%	1.5%
07112	NEWARK	1.3%	1.5%	7.8%	9.0%	0.3%	0.3%	88.6%	87.1%	2.0%	2.0%
07002	BAYONNE	47.4%	42.5%	31.1%	33.7%	10.1%	11.7%	8.8%	9.3%	2.6%	2.8%
08812	DUNELLEN	49.1%	41.9%	23.5%	26.7%	16.3%	18.9%	9.2%	10.6%	1.9%	2.0%
08854	PISACATAWAY	25.0%	20.8%	13.6%	14.9%	37.6%	40.2%	20.2%	20.4%	3.5%	3.7%
07928	CHATHAM	83.7%	81.4%	5.5%	6.2%	7.1%	7.8%	1.2%	1.5%	2.6%	3.0%
07960	MORRISTOWN	63.0%	60.8%	21.6%	23.5%	5.4%	5.8%	8.0%	7.7%	2.0%	2.2%
07059	WARREN	69.5%	65.4%	6.8%	7.7%	20.0%	22.8%	1.9%	2.1%	1.9%	2.0%
07069	WATCHUNG	64.3%	59.6%	9.8%	11.1%	16.4%	18.4%	6.4%	7.5%	3.1%	3.4%
07920	BASKING RIDGE	71.3%	66.8%	4.9%	5.4%	19.3%	22.6%	2.2%	2.5%	2.4%	2.7%
07016	CRANFORD	82.0%	79.1%	9.4%	11.2%	3.6%	4.1%	2.9%	3.0%	2.2%	2.7%
07023	FANWOOD	73.9%	70.2%	8.8%	10.3%	9.1%	10.6%	5.2%	5.3%	2.9%	3.6%
07027	GARWOOD	80.9%	77.2%	12.8%	15.4%	2.7%	3.0%	1.5%	1.9%	2.1%	2.5%
07033	KENILWORTH	67.3%	62.0%	22.2%	26.4%	5.1%	5.6%	3.3%	3.6%	2.1%	2.4%
07036	LINDEN	36.0%	30.1%	32.3%	37.0%	2.9%	3.1%	26.6%	27.6%	2.1%	2.1%
07060	PLAINFIELD	11.5%	9.2%	54.3%	58.4%	2.8%	2.9%	29.6%	27.7%	1.8%	1.8%
07062	PLAINFIELD	10.0%	8.1%	34.9%	39.3%	1.5%	1.6%	50.7%	47.9%	2.8%	3.0%
07065	RAHWAY	30.3%	25.0%	31.3%	35.6%	5.1%	5.5%	30.8%	31.3%	2.5%	2.6%
07066	CLARK	81.8%	78.3%	11.2%	13.6%	4.6%	5.2%	1.2%	1.5%	1.2%	1.4%
07076	SCOTCH PLAINS	68.4%	65.4%	9.5%	11.3%	8.6%	9.2%	10.7%	10.8%	2.8%	3.3%
07081	SPRINGFIELD	65.3%	59.3%	14.3%	17.3%	10.2%	11.6%	8.1%	9.3%	2.1%	2.5%
07083	UNION	33.6%	26.4%	20.4%	23.2%	12.9%	13.9%	30.7%	33.9%	2.5%	2.6%
07088	VAUXHALL	7.4%	7.1%	10.2%	11.8%	4.6%	5.3%	75.1%	73.3%	2.7%	2.6%
07090	WESTFIELD	80.4%	77.6%	6.9%	8.3%	7.4%	8.4%	2.8%	2.7%	2.5%	3.0%
07092	MOUNTAINSIDE	79.7%	75.9%	9.0%	10.8%	6.8%	7.8%	2.7%	3.1%	1.9%	2.3%
07201	ELIZABETH	12.5%	10.7%	60.9%	64.7%	1.4%	1.5%	22.7%	20.9%	2.4%	2.2%
07202	ELIZABETH	13.4%	10.0%	70.7%	74.0%	2.3%	2.1%	12.3%	12.6%	1.4%	1.3%
07203	ROSELLE	10.9%	8.2%	33.2%	36.9%	2.2%	2.1%	51.6%	50.7%	2.0%	2.0%
07204	ROSELLE PARK	41.0%	33.4%	39.0%	44.9%	10.8%	11.4%	7.5%	8.7%	1.6%	1.6%
07205	HILLSIDE	18.9%	15.4%	20.3%	21.9%	2.5%	2.4%	55.7%	57.7%	2.6%	2.6%
07206	ELIZABETHPORT	7.8%	6.0%	69.4%	71.2%	1.2%	1.4%	20.1%	20.0%	1.5%	1.4%
07208	ELIZABETH	17.4%	14.0%	58.2%	61.9%	2.9%	2.8%	19.8%	19.7%	1.7%	1.6%
07901	SUMMIT	68.3%	64.4%	15.9%	17.8%	8.6%	9.8%	4.5%	4.7%	2.7%	3.3%
07922	BERKELEY HEIGHTS	76.4%	72.9%	6.7%	7.8%	13.0%	14.6%	1.7%	1.9%	2.2%	2.8%
07974	NEW PROVIDENCE	74.3%	70.3%	9.4%	11.3%	12.3%	13.8%	1.6%	1.8%	2.3%	2.7%
	OMC SERVICE AREA	**40.1%**	**36.4%**	**25.6%**	**28.0%**	**8.7%**	**9.6%**	**23.4%**	**23.6%**	**2.3%**	**2.4%**
	UNION COUNTY	**38.0%**	**34.2%**	**33.5%**	**36.6%**	**5.4%**	**5.9%**	**20.9%**	**21.0%**	**2.1%**	**2.3%**
	NEW JERSEY	**53.9%**	**50.9%**	**21.0%**	**22.8%**	**10.0%**	**11.0%**	**12.8%**	**12.8%**	**2.3%**	**2.5%**

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

Language Spoken at Home[29]

POPULATION 5 YEARS AND OVER: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Speak English only or speak English "very well"	Speak English less than "very well"	% Speak English less than "very well"
07040	MAPLEWOOD	20,877	1,680	7.4%
07041	MILLBURN	6,174	682	9.9%
07052	WEST ORANGE	38,174	6,417	14.4%
07078	SHORT HILLS	11,465	502	4.2%
07111	IRVINGTON	42,201	7,870	15.7%
07112	NEWARK	22,858	877	15.5%
07002	BAYONNE	53,071	8,343	13.6%
08812	DUNELLEN	11,497	1,980	14.7%
08854	PISACATAWAY	48,160	6,440	11.8%
07928	CHATHAM	17,543	730	4.0%
07960	MORRISTOWN	38,003	4,673	10.9%
07059	WARREN	14,298	932	6.1%
07069	WATCHUNG	5,521	421	7.1%
07920	BASKING RIDGE	24,492	1,556	6.0%
07016	CRANFORD	21,384	1,019	4.5%
07023	FANWOOD	6,676	337	4.8%
07027	GARWOOD	3,756	309	7.6%
07033	KENILWORTH	6,831	981	12.6%
07036	LINDEN	33,001	7,668	18.9%
07060	PLAINFIELD	29,669	12,998	30.5%
07062	PLAINFIELD	10,742	1,361	11.2%
07065	RAHWAY	22,771	3,994	14.9%
07066	CLARK	13,710	988	6.7%
07076	SCOTCH PLAINS	21,395	1,033	4.6%
07081	SPRINGFIELD	14,469	1,699	10.5%
07083	UNION	44,310	7,440	14.4%
07088	VAUXHALL	3,005	26	8.0%
07090	WESTFIELD	27,426	1,064	3.7%
07092	MOUNTAINSIDE	6,253	301	4.6%
07201	ELIZABETH	13,224	10,953	45.3%
07202	ELIZABETH	22,579	16,021	41.5%
07203	ROSELLE	17,092	3,519	17.1%
07204	ROSELLE PARK	10,670	2,143	16.7%
07205	HILLSIDE	17,401	3,101	15.1%
07206	ELIZABETHPORT	14,894	10,634	41.7%
07208	ELIZABETH	17,578	11,680	39.9%
07901	SUMMIT	19,767	2,032	9.3%
07922	BERKELEY HEIGHTS	11,038	656	5.6%
07974	NEW PROVIDENCE	10,578	673	6.0%
	OMC SERVICE AREA	**732,352**	**138,097**	**15.9%**
	UNION COUNTY	**429,378**	**5,503**	**5.2%**
	NEW JERSEY	**7,365,008**	**1,021,939**	**12.2%**

[29] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

Median Household Income[30]

CURRENT AND PROJECTED MEDIAN HOUSEHOLD INCOME: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	2019 HH INCOME Median HH Income	2024 HH INCOME Median HH Income	% Change Median HH Income – Projected
07040	MAPLEWOOD	$122,282	$132,342	8.2%
07041	MILLBURN	$117,271	$125,269	6.8%
07052	WEST ORANGE	$107,726	$116,332	8.0%
07078	SHORT HILLS	$316,414	$349,366	10.4%
07111	IRVINGTON	$39,994	$42,917	7.3%
07112	NEWARK	$35,521	$38,479	8.3%
07002	BAYONNE	$62,597	$69,611	11.2%
08812	DUNELLEN	$98,355	$108,392	10.2%
08854	PISACATAWAY	$97,120	$106,690	9.9%
07928	CHATHAM	$177,298	$195,774	10.4%
07960	MORRISTOWN	$120,751	$131,559	9.0%
07059	WARREN	$155,276	$175,309	12.9%
07069	WATCHUNG	$140,014	$156,574	11.8%
07920	BASKING RIDGE	$149,729	$169,039	12.9%
07016	CRANFORD	$131,293	$145,989	11.2%
07023	FANWOOD	$123,941	$140,278	13.2%
07027	GARWOOD	$91,230	$101,997	11.8%
07033	KENILWORTH	$109,357	$122,823	12.3%
07036	LINDEN	$72,774	$81,177	11.5%
07060	PLAINFIELD	$63,635	$69,703	9.5%
07062	PLAINFIELD	$72,870	$79,838	9.6%
07065	RAHWAY	$76,932	$85,619	11.3%
07066	CLARK	$102,364	$113,999	11.4%
07076	SCOTCH PLAINS	$125,995	$140,091	11.2%
07081	SPRINGFIELD	$118,404	$133,239	12.5%
07083	UNION	$91,782	$101,947	11.1%
07088	VAUXHALL	$66,706	$73,526	10.2%
07090	WESTFIELD	$171,945	$191,594	11.4%
07092	MOUNTAINSIDE	$153,594	$172,973	12.6%
07201	ELIZABETH	$48,012	$54,228	12.9%
07202	ELIZABETH	$46,496	$51,448	10.7%
07203	ROSELLE	$55,696	$62,599	12.4%
07204	ROSELLE PARK	$76,389	$86,138	12.8%
07205	HILLSIDE	$70,789	$77,859	10.0%
07206	ELIZABETHPORT	$48,158	$52,934	9.9%
07208	ELIZABETH	$51,996	$57,767	11.1%
07901	SUMMIT	$166,017	$188,412	13.5%
07922	BERKELEY HEIGHTS	$168,421	$190,028	12.8%
07974	NEW PROVIDENCE	$159,348	$180,408	13.2%
	OMC SERVICE AREA	**$ 102,364**	**$ 113,999**	**11.4%**
	UNION COUNTY	**$84,617**	**$94,043**	**11.1%**
	NEW JERSEY	**$77,983**	**$ 85,857**	**10.1%**

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

Poverty[31]

CURRENT AND PROJECTED MEDIAN HOUSEHOLD INCOME: SERVICE AREA & COMPARATIVE GEOGRAPHIES						
ZIP Code	ZIP Code Name	2019 # Families Below Poverty	2019 % Families Below Poverty	2024 # Families Below Poverty	2024 % Families Below Poverty	% Change 2019-2014
07040	MAPLEWOOD	313	4.8%	328	4.9%	4.79%
07041	MILLBURN	58	3.0%	66	3.3%	13.79%
07052	WEST ORANGE	660	5.4%	680	5.4%	3.03%
07078	SHORT HILLS	75	2.0%	88	2.3%	17.33%
07111	IRVINGTON	2,651	20.2%	2,669	20.1%	0.68%
07112	NEWARK	1,436	21.5%	1,468	21.4%	2.23%
07002	BAYONNE	2,098	12.1%	2,171	12.1%	3.48%
08812	DUNELLEN	228	6.0%	222	5.8%	-2.63%
08854	PISACATAWAY	730	5.4%	753	5.4%	3.15%
07928	CHATHAM	55	1.1%	70	1.5%	27.27%
07960	MORRISTOWN	498	4.7%	527	4.8%	5.82%
07059	WARREN	92	2.0%	94	2.0%	2.17%
07069	WATCHUNG	26	1.4%	27	1.4%	3.85%
07920	BASKING RIDGE	182	2.5%	193	2.6%	6.04%
07016	CRANFORD	78	1.2%	100	1.5%	28.21%
07023	FANWOOD	47	2.1%	55	2.4%	17.02%
07027	GARWOOD	46	3.9%	57	4.7%	23.91%
07033	KENILWORTH	103	4.7%	101	4.5%	-1.94%
07036	LINDEN	880	8.0%	890	7.9%	1.14%
07060	PLAINFIELD	1,375	14.2%	1,370	14.1%	-0.36%
07062	PLAINFIELD	428	12.9%	427	12.8%	-0.23%
07065	RAHWAY	293	3.9%	327	4.3%	11.60%
07066	CLARK	119	2.8%	134	3.0%	12.61%
07076	SCOTCH PLAINS	180	2.6%	201	2.9%	11.67%
07081	SPRINGFIELD	206	4.5%	219	4.6%	6.31%
07083	UNION	786	5.6%	825	5.7%	4.96%
07088	VAUXHALL	76	8.4%	79	8.5%	3.95%
07090	WESTFIELD	140	1.7%	157	1.8%	12.14%
07092	MOUNTAINSIDE	53	2.7%	56	2.8%	5.66%
07201	ELIZABETH	843	13.1%	850	12.9%	0.83%
07202	ELIZABETH	1,642	16.3%	1,659	16.0%	1.04%
07203	ROSELLE	474	9.1%	484	9.1%	2.11%
07204	ROSELLE PARK	160	4.6%	168	4.7%	5.00%
07205	HILLSIDE	563	9.7%	571	9.6%	1.42%
07206	ELIZABETHPORT	1,180	17.2%	1,212	16.9%	2.71%
07208	ELIZABETH	1,112	14.5%	1,114	14.3%	0.18%
07901	SUMMIT	175	2.9%	186	3.0%	6.29%
07922	BERKELEY HEIGHTS	113	3.3%	113	3.2%	0.00%
07974	NEW PROVIDENCE	131	3.8%	138	3.9%	5.34%
	OMC SERVICE AREA	**20,305**	**8.1%**	**20,849**	**8.1%**	**2.7%**
	UNION COUNTY	**12,486**	**8.0%**	**12,799**	**8.0%**	**2.9%**
	NEW JERSEY	**179,302**	**7.8%**	**182,371**	**7.8%**	**1.71%**

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

Food Stamps / SNAP[32]

ESTIMATED TOTAL HOUSEHOLDS: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Total Households (HH)	HH receiving food stamps/SNAP	% of HH Receiving SNAP
07040	MAPLEWOOD	8,170	233	2.9%
07041	MILLBURN	2,551	54	2.1%
07052	WEST ORANGE	16,375	664	4.1%
07078	SHORT HILLS	3,983	17	0.4%
07111	IRVINGTON	20,220	3,606	17.8%
07112	NEWARK	9,089	2,228	24.5%
07002	BAYONNE	25,377	3,482	13.7%
08812	DUNELLEN	4,593	272	5.9%
08854	PISACATAWAY	16,253	605	3.7%
07928	CHATHAM	6,479	47	0.7%
07960	MORRISTOWN	17,222	649	3.8%
07059	WARREN	5,115	85	1.7%
07069	WATCHUNG	1,954	16	0.8%
07920	BASKING RIDGE	9,685	145	1.5%
07016	CRANFORD	8,480	143	1.7%
07023	FANWOOD	2,519	-	0.0%
07027	GARWOOD	1,750	57	3.3%
07033	KENILWORTH	2,675	75	2.8%
07036	LINDEN	14,854	1,344	9.0%
07060	PLAINFIELD	14,460	2,048	14.2%
07062	PLAINFIELD	4,037	724	17.9%
07065	RAHWAY	10,508	1,072	10.2%
07066	CLARK	5,661	61	1.1%
07076	SCOTCH PLAINS	8,387	237	2.8%
07081	SPRINGFIELD	7,148	308	4.3%
07083	UNION	19,220	999	5.2%
07088	VAUXHALL	1,272	110	8.6%
07090	WESTFIELD	10,551	228	2.2%
07092	MOUNTAINSIDE	2,360	-	0.0%
07201	ELIZABETH	8,076	1,592	19.7%
07202	ELIZABETH	13,385	2,402	17.9%
07203	ROSELLE	8,028	922	11.5%
07204	ROSELLE PARK	4,946	127	2.6%
07205	HILLSIDE	7,252	404	5.6%
07206	ELIZABETHPORT	7,673	1,586	20.7%
07208	ELIZABETH	10,853	2,227	20.5%
07901	SUMMIT	8,333	265	3.2%
07922	BERKELEY HEIGHTS	4,051	12	0.3%
07974	NEW PROVIDENCE	4,057	43	1.1%
	OMC SERVICE AREA	**337,602**	**29,082**	**8.6%**
	UNION COUNTY	**194,211**	**17,586**	**9.1%**
	NEW JERSEY	**3,195,014**	**298,642**	**9.3%**

[32] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

Unemployment Rate[33]

POPULATION 16 YEARS AND OVER: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Employed	Unemployed	% Unemployed
07040	MAPLEWOOD	18,008	1,171	6.5%
07041	MILLBURN	5,389	269	5.0%
07052	WEST ORANGE	37,694	2,601	6.9%
07078	SHORT HILLS	9,043	434	4.8%
07111	IRVINGTON	42,233	7,560	17.9%
07112	NEWARK	19,815	4,458	22.5%
07002	BAYONNE	52,807	3,644	6.9%
08812	DUNELLEN	11,486	666	5.8%
08854	PISACATAWAY	48,461	3,925	8.1%
07928	CHATHAM	14,064	563	4.0%
07960	MORRISTOWN	37,289	1,641	4.4%
07059	WARREN	12,580	629	5.0%
07069	WATCHUNG	5,043	116	2.3%
07920	BASKING RIDGE	20,754	830	4.0%
07016	CRANFORD	19,109	1,051	5.5%
07023	FANWOOD	5,506	396	7.2%
07027	GARWOOD	3,526	205	5.8%
07033	KENILWORTH	6,588	303	4.6%
07036	LINDEN	35,249	3,349	9.5%
07060	PLAINFIELD	36,160	2,784	7.7%
07062	PLAINFIELD	10,096	1,050	10.4%
07065	RAHWAY	23,207	2,065	8.9%
07066	CLARK	12,774	766	6.0%
07076	SCOTCH PLAINS	18,932	1,022	5.4%
07081	SPRINGFIELD	14,156	694	4.9%
07083	UNION	45,053	3,604	8.0%
07088	VAUXHALL	2,915	303	10.4%
07090	WESTFIELD	22,734	1,205	5.3%
07092	MOUNTAINSIDE	5,442	365	6.7%
07201	ELIZABETH	20,126	2,073	10.3%
07202	ELIZABETH	32,010	3,393	10.6%
07203	ROSELLE	17,463	2,410	13.8%
07204	ROSELLE PARK	10,825	1,083	10.0%
07205	HILLSIDE	17,660	2,614	14.8%
07206	ELIZABETHPORT	19,681	1,693	8.6%
07208	ELIZABETH	25,052	2,681	10.7%
07901	SUMMIT	17,511	823	4.7%
07922	BERKELEY HEIGHTS	9,605	231	2.4%
07974	NEW PROVIDENCE	8,986	404	4.5%
	OMC SERVICE AREA	**775,032**	**65,072**	**8.4%**
	UNION COUNTY	**451,124**	**37,749**	**8.4%**
	NEW JERSEY	**7,143,654**	**566,878**	**7.9%**

[33] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

Education Attainment[34]

CURRENT AND PROJECTED EDUCATION LEVEL (AGE 25+): SERVICE AREA & COMPARATIVE GEOGRAPHIES						
ZIP Code	ZIP Code Name	2019 Some High School or Less	2019 % Some High School or Less	2024 Some High School or Less	2024 % Some High School or Less	% Point Change 2019-2014
07040	MAPLEWOOD	884	5.6%	942	5.8%	0.20%
07041	MILLBURN	145	3.1%	167	3.4%	0.30%
07052	WEST ORANGE	2,618	7.8%	2,703	7.9%	0.09%
07078	SHORT HILLS	153	1.9%	174	2.1%	0.17%
07111	IRVINGTON	5,792	15.9%	5,876	16.0%	0.06%
07112	NEWARK	2,299	13.0%	2,404	13.1%	0.09%
07002	BAYONNE	5,748	12.1%	5,993	12.2%	0.01%
08812	DUNELLEN	1,072	10.2%	1,119	10.2%	0.01%
08854	PISACATAWAY	2,700	7.2%	2,805	7.3%	0.12%
07928	CHATHAM	259	2.3%	275	2.4%	0.13%
07960	MORRISTOWN	2,526	7.9%	2,616	8.0%	0.12%
07059	WARREN	555	5.0%	600	5.1%	0.08%
07069	WATCHUNG	264	5.4%	280	5.5%	0.05%
07920	BASKING RIDGE	611	3.2%	659	3.3%	0.08%
07016	CRANFORD	767	4.6%	832	4.8%	0.18%
07023	FANWOOD	127	2.5%	143	2.8%	0.23%
07027	GARWOOD	187	5.5%	202	5.8%	0.25%
07033	KENILWORTH	713	11.7%	745	11.7%	0.03%
07036	LINDEN	4,098	13.0%	4,271	13.0%	0.04%
07060	PLAINFIELD	7,878	26.4%	7,998	26.4%	-0.01%
07062	PLAINFIELD	1,532	16.4%	1,565	16.5%	0.06%
07065	RAHWAY	2,145	9.9%	2,249	9.9%	-0.01%
07066	CLARK	820	7.2%	873	7.3%	0.06%
07076	SCOTCH PLAINS	714	4.2%	761	4.3%	0.10%
07081	SPRINGFIELD	614	5.0%	645	5.0%	0.02%
07083	UNION	4,615	11.5%	4,820	11.6%	0.04%
07088	VAUXHALL	236	9.4%	254	9.6%	0.17%
07090	WESTFIELD	511	2.6%	547	2.6%	0.08%
07092	MOUNTAINSIDE	176	3.6%	188	3.7%	0.12%
07201	ELIZABETH	5,099	27.5%	5,213	27.4%	-0.07%
07202	ELIZABETH	7,298	24.8%	7,536	24.7%	-0.13%
07203	ROSELLE	1,992	13.2%	2,052	13.2%	0.05%
07204	ROSELLE PARK	847	8.6%	892	8.8%	0.14%
07205	HILLSIDE	1,981	12.7%	2,065	12.7%	0.07%
07206	ELIZABETHPORT	6,590	36.3%	6,918	36.0%	-0.28%
07208	ELIZABETH	4,298	19.6%	4,366	19.5%	-0.05%
07901	SUMMIT	857	5.7%	899	5.7%	0.06%
07922	BERKELEY HEIGHTS	345	4.0%	371	4.1%	0.11%
07974	NEW PROVIDENCE	300	3.7%	319	3.8%	0.12%
	OMC SERVICE AREA	**80,366**	**11.8%**	**83,337**	**11.8%**	**0.04%**
	UNION COUNTY	**61,445**	**14.2%**	**63,479**	**14.2%**	**-0.01%**
	NEW JERSEY	**675,582**	**10.8%**	**692,826**	**10.8%**	**0.00%**

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

Health Insurance Coverage / Health Care Access[35]

CIVILIAN NONINSTITUTIONALIZED POPULATION: SERVICE AREA & COMPARATIVE GEOGRAPHIES				
ZIP Code	ZIP Code Name	Insured	Uninsured	% Uninsured
07040	MAPLEWOOD	22,679	1,740	7.1%
07041	MILLBURN	7,140	305	4.1%
07052	WEST ORANGE	41,218	4,932	10.7%
07078	SHORT HILLS	12,663	103	0.8%
07111	IRVINGTON	42,562	11,523	21.3%
07112	NEWARK	21,350	4,126	16.2%
07002	BAYONNE	56,590	9,154	13.9%
08812	DUNELLEN	12,918	1,335	9.4%
08854	PISACATAWAY	52,835	4,464	7.8%
07928	CHATHAM	18,610	619	3.2%
07960	MORRISTOWN	39,698	3,790	8.7%
07059	WARREN	15,092	797	5.0%
07069	WATCHUNG	5,644	481	7.9%
07920	BASKING RIDGE	25,919	450	1.7%
07016	CRANFORD	22,103	1,192	5.1%
07023	FANWOOD	7,284	167	2.2%
07027	GARWOOD	4,175	140	3.2%
07033	KENILWORTH	7,693	436	5.4%
07036	LINDEN	36,539	6,283	14.7%
07060	PLAINFIELD	32,866	12,479	27.5%
07062	PLAINFIELD	10,537	2,455	18.9%
07065	RAHWAY	25,444	3,311	11.5%
07066	CLARK	14,229	932	6.1%
07076	SCOTCH PLAINS	22,862	1,046	4.4%
07081	SPRINGFIELD	16,215	1,103	6.4%
07083	UNION	49,740	4,408	8.1%
07088	VAUXHALL	2,473	763	23.6%
07090	WESTFIELD	29,332	938	3.1%
07092	MOUNTAINSIDE	6,568	54	0.8%
07201	ELIZABETH	19,092	7,148	27.2%
07202	ELIZABETH	30,360	9,906	24.6%
07203	ROSELLE	18,067	3,440	16.0%
07204	ROSELLE PARK	12,179	1,372	10.1%
07205	HILLSIDE	18,318	3,392	15.6%
07206	ELIZABETHPORT	20,201	8,001	28.4%
07208	ELIZABETH	24,960	6,550	20.8%
07901	SUMMIT	21,501	1,696	7.3%
07922	BERKELEY HEIGHTS	11,455	470	3.9%
07974	NEW PROVIDENCE	11,584	427	3.6%
	OMC SERVICE AREA	**850,695**	**121,928**	**12.5%**
	UNION COUNTY	**486,641**	**81,122**	**14.3%**
	NEW JERSEY	**7,868,933**	**938,966**	**10.7%**

[35] Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

APPENDIX B: SECONDARY DATA SOURCES

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

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

APPENDIX C: SECONDARY DATA INDICATORS[36]

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

PRIMARY TOPIC	INDICATOR
Economy	Cost of Family Child Care as a Percentage of Income
	Cost of Licensed Child Care as a Percentage of Income
Economy / Employment	Unemployed Workers in Civilian Labor Force
Economy / Government Assistance Programs	Households with Cash Public Assistance Income
	Students Eligible for the Free Lunch Program
Economy / Homelessness	Homelessness by County
Economy / Homeownership	Homeownership
Economy / Housing Affordability & Supply	Renters Spending 30% or More of Household Income on Rent
	Severe Housing Problems
Economy / Income	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold
	Households that are Asset Limited, Income Constrained, Employed (ALICE)
	Households that are Below the Federal Poverty Level
	Income Inequality
	Median Household Income
	Median Household Income by Age - 25-44
	Median Household Income by Age – 45-64
	Median Household Income by Age – 65+
	Median Household Income by Age – Under 25
	Median Income Per Individual Worker
	Median Income Per Individual Worker- Female
	Median Individual Worker Income - Male
	Per Capita Income
Economy / Poverty	Children Living Below Poverty Level
	Children Under 5 Years Old Living in Poverty
	Families Living Below Poverty Level
	Households Receiving SNAP with Children
	People 65+ Living Below Poverty Level
	People Living 200% Above Poverty Level
	People Living Below Poverty Level
	Utility Assistance for Low-Income Households
	Young Children Living Below Poverty Level
Education / Educational Attainment in Adult Population	People 25+ with a bachelor's degree or Higher
	People 25+ with a High School Degree or Higher

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

PRIMARY TOPIC	INDICATOR
Education / School Resources	Student-to-Teacher Ratio
Education / Student Performance K-12	Students Passing 11th Grade State Achievement Tests
	Students Passing 4th Grade State Achievement Tests
	Students Passing 8th Grade State Achievement Tests
Environment / Air	Annual Ozone Air Quality
	Annual Particle Pollution
	Recognized Carcinogens Released into Air
Environment / Built Environment	Access to Exercise Opportunities
	Children with Low Access to a Grocery Store
	Farmers Market Density
	Fast Food Restaurant Density
	Food Environment Index
	Grocery Store Density
	Households with No Car and Low Access to a Grocery Store
	Liquor Store Density
	Low-Income and Low Access to a Grocery Store
	People 65+ with Low Access to a Grocery Store
	People with Low Access to a Grocery Store
	Recreation and Fitness Facilities
	SNAP Certified Stores
Environment / Toxic Chemicals	PBT Released
	Risk factor for childhood lead exposure: Pre-1950 Housing
Environment / Weather & Climate	Daily Dose of UV Irradiance
	Months of Mild Drought or Worse
	Number of Extreme Heat Days
	Number of Extreme Heat Events
	Number of Extreme Precipitation Days
	Weeks of Moderate Drought or Worse
Government & Politics / Elections & Voting	Voter Turnout: Presidential Election
Health	Age-Adjusted Years of Potential Life Lost
Health / Access to Health Services	Adults Unable to Afford to See A Doctor
	Adults who enrolled in the health insurance marketplace
	Adults who have had a Routine Checkup
	Adults with at least one primary care provider
	Adults with Health Insurance
	Adults with Health Insurance: 18-64
	Children with Health Insurance
	Children with Health Insurance: 0-17
	Medicare Healthcare Costs
	Non-Physician Primary Care Provider Rate

PRIMARY TOPIC	INDICATOR
	Persons with Private Health Insurance Only
	Persons with Public Health Insurance Only
	Preventable Hospital Stays: Medicare Population
	Primary Care Provider Rate
Health / Cancer	Age-Adjusted Death Rate due to Breast Cancer
	Age-Adjusted Death Rate due to Cancer
	Age-Adjusted Death Rate due to Colorectal Cancer
	Age-Adjusted Death Rate due to Lung Cancer
	Age-Adjusted Death Rate due to Pancreatic Cancer
	Age-Adjusted Death Rate due to Prostate Cancer
	All Cancer Incidence Rate
	Breast Cancer Incidence Rate
	Cancer: Medicare Population
	Cervical Cancer Incidence Rate
	Colon Cancer Screening
	Colorectal Cancer Incidence Rate
	Liver and Bile Duct Cancer Incidence Rate
	Lung and Bronchus Cancer Incidence Rate
	Mammogram in Past 2 Years: 50-74
	Mammography Screening: Medicare Population
	Melanoma Incidence Rate
	Non-Hodgkin Lymphoma Incidence Rate
	Oral Cavity and Pharynx Cancer Incidence Rate
	Pancreatic Cancer Incidence Rate
	Pap Test in Past 3 Years: 21-65
	Prostate Cancer Incidence Rate
Health / County Health Rankings	Clinical Care Ranking
	Health Behaviors Ranking
	Morbidity Ranking
	Mortality Ranking
	Physical Environment Ranking
	Social and Economic Factors Ranking
Health / Diabetes	Adults 20+ with Diabetes
	Adults with Prediabetes
	Age-Adjusted Death Rate due to Diabetes
	Diabetes: Medicare Population
	Diabetic Monitoring: Medicare Population
Health / Disabilities	Persons with a Cognitive Difficulty
	Persons with a Disability
	Persons with a Disability (5-year)
	Persons with a Hearing Difficulty
	Persons with a Self-Care Difficulty
	Persons with a Vision Difficulty

PRIMARY TOPIC	INDICATOR
	Persons with an Ambulatory Difficulty
	Persons with Disability Living in Poverty
	Persons with Disability Living in Poverty (5-year)
Health / Environmental & Occupational Health	Blood Lead Levels in Children (>5 micrograms per deciliter)
Health / Exercise, Nutrition, & Weight	Adults 20+ who are Obese
	Adults 20+ who are Sedentary
	Adults Engaging in Regular Physical Activity
	Child Food Insecurity Rate
	Food Insecure Children Likely Ineligible for Assistance
	Food Insecurity Rate
Health / Family Planning	Teen Birth Rate: 15-17
Health / Heart Disease & Stroke	Adults who Experienced a Heart Attack
	Adults who Experienced a Stroke
	Adults who Experienced Coronary Heart Disease
	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)
	Age- Adjusted Death Rate due to Heart Attack
	Age-Adjusted Death Rate due to Heart Disease
	Age-Adjusted Death Rate due to Hypertensive Heart Disease
	Age-Adjusted Hospitalization Rate due to Heart Attack
	Atrial Fibrillation: Medicare Population
	Heart Failure: Medicare Population
	High Blood Pressure Prevalence
	Hyperlipidemia: Medicare Population
	Hypertension: Medicare Population
	Ischemic Heart Disease: Medicare Population
	Stroke: Medicare Population
Health / Immunizations & Infectious Diseases	Adults 50+ with Influenza Vaccination
	Adults with Pneumonia Vaccination
	Age-Adjusted Death Rate due to Influenza and Pneumonia
	Age-Adjusted Rate of ED Visits Due to Influenza
	Chlamydia Cases
	First Grade Students with Required Immunizations
	Gonorrhea Cases
	Hepatitis C Cases
	HIV/AIDS Prevalence Rate
	Kindergartners with Required Immunizations
	Lyme Disease Cases
	Pre-Kindergarten Students with Required Immunizations
	School-Aged Children that are Unvaccinated Due to Religious Exemption
	Sixth Grade Students with Required Immunizations
	Syphilis Cases
	Transfer Children with Required Immunizations
	Tuberculosis Incidence Rate

PRIMARY TOPIC	INDICATOR
Health / Maternal, Fetal & Infant Health	Babies with Low Birth Weight
	Babies with Very Low Birth Weight
	Infant Mortality Rate
	Mothers who Received Early Prenatal Care
	Mothers who Received No Prenatal Care
	Preterm Births
	Very Preterm Births
Health / Mental Health & Mental Disorders	Adults Ever Diagnosed with Depression
	Age-Adjusted Death Rate due to Suicide
	Depression: Medicare Population
	Frequent Mental Distress
	Inadequate Social Support
	Mental Health Provider Rate
	Poor Mental Health: Average Number of Days
Health / Mortality Data	Age-Adjusted Death Rate
Health / Older Adults & Aging	Adults 65+ with a Disability
	Adults 65+ with a Hearing Difficulty
	Adults 65+ with a Self-Care Difficulty
	Adults 65+ with a Vision Difficulty
	Adults 65+ with an Independent Living Difficulty
	Adults who were Injured in a Fall: 45+
	Adults with Arthritis
	Age-Adjusted Death Rate due to Alzheimer's Disease
	Alzheimer's Disease or Dementia: Medicare Population
Health / Oral Health	Dentist Rate
Health / Other Chronic Diseases	Age Adjusted Death Rate due to Chronic Kidney Disease
	Chronic Kidney Disease: Medicare Population
	Osteoporosis: Medicare Population
	Rheumatoid Arthritis or Osteoarthritis: Medicare Population
Health / Prevention & Safety	Age-Adjusted Death Rate due to Unintentional Injuries
	Age-Adjusted Death Rate due to Unintentional Poisonings
Health / Respiratory Diseases	Adults with Current Asthma
	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases
	Age-Adjusted Rate of Adult ED Visits for COPD
	Asthma: Medicare Population
	COPD: Medicare Population
Health / Substance Abuse	Adults who Binge Drink
	Adults who Currently Use Smokeless Tobacco
	Adults who Drink Excessively
	Adults who Smoke
	Adults who Use Alcohol: Past 30 Days
	Age-Adjusted Rate of Substance Use Emergency Department Visits
	Death Rate due to Drug Poisoning

PRIMARY TOPIC	INDICATOR
	Opioid Treatment Admission Rate
Health / Wellness & Lifestyle	Frequent Physical Distress
	Insufficient Sleep
	Life Expectancy
	Limited activity due to a Health Problem
	Poor Physical Health: Average Number of Days
	Self-Reported General Health Assessment: Poor or Fair
Public Safety / Crime & Crime Prevention	Violent Crime Rate
Public Safety / Transportation Safety	Age-Adjusted Death Rate due to Motor Vehicle Collisions
	Alcohol-Impaired Driving Deaths
Social Environment	Households with Internet Subscription
	Households with One or More Types of Computing Devices
Social Environment / Children's Social Environment	Substantiated Child Abuse Rate
Social Environment / Demographics	Within County Disparity in Life Expectancy at Birth
Social Environment / Family Structure	Single-Parent Households
Social Environment / Neighborhood/Community Attachment	Linguistic Isolation
	People 65+ Living Alone
	Social Associations
Social Environment / Social & Civic Involvement	Civic Engagement Ranking
Transportation / Commute to Work	Mean Travel Time to Work
	Solo Drivers with a Long Commute
	Workers Commuting by Public Transportation
	Workers who Drive Alone to Work

APPENDIX E: KEY INFORMANT SURVEY TOOL

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

Overlook Medical Center (OMC) is undertaking a comprehensive community health needs assessment (CHNA) to re-evaluate the health needs of individuals living in the hospital service area. The purpose of the assessment is to gather current statistics and qualitative feedback on the key health issues facing service area residents. The completion of the CHNA will enable OMC to take an in-depth look at its community and the findings will be utilized to prioritize public health issues and develop a community health implementation plan focused on meeting community needs.

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

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

2. Of those health issues selected, which 1 is the most significant? (CHOOSE 1)

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

3. Please share any additional information regarding these health issues and your reasons for ranking them this way in the box below:

_____
_____
_____
_____
_____
_____
_____
_____

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

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

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

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

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

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

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

_____
_____
_____
_____
_____
_____
_____
_____

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

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

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

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

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

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

11. In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care? (CHOOSE 1)

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

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

_____
_____
_____
_____
_____
_____

13. Related to health and quality of life, what resources or services do you think are missing in the community? (Select all that apply)

- ☐ Free/Low Cost Medical Care
- ☐ Free/Low Cost Dental Care
- ☐ Primary Care Providers
- ☐ Medical or Surgical Specialists
- ☐ Mental Health Services
- ☐ Substance Abuse Services
- ☐ Bilingual Services
- ☐ Transportation
- ☐ Prescription Assistance
- ☐ Health Education/Information/Outreach
- ☐ Health Screenings
- ☐ None
- ☐ Other (please specify):

14. What challenges do people in the community face in trying to maintain healthy lifestyles, like exercising and eating healthy and/or trying to manage chronic conditions, like diabetes or heart disease?

_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

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

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

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

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

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

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

20. Overlook Medical Center will use the information gathered through this survey in guiding their community health improvement activities. Please share any other feedback you may have for them below:

_____
_____
_____
_____

APPENDIX E: KEY INFORMANT SURVEY PARTICIPANTS

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

Organization	Organization
Academy of Clinical and applied Psychoanalysis	Our Lady Of Peace
Assemblyman Jamel C. Holley	Overlook Medical Center Auxiliary
Atlantic Health System	Overlook Medical Center Family Medicine
Autumn Lake Healthcare	Overlook Medical Center Community Health Committee
Berkeley Heights Public Library	Pathways to learning Institute
Boys & Girls Clubs of Union County	Pilgrim Baptist Church
Bridges Outreach, Inc.	Plainfield Public Library
C R Bard Foundation Inc	Rabbi Stuart Gershon
Caring Contact	Rabbi William B. Horn
City of Plainfield	Rahway Public Library
City of Rahway	SAGE Eldercare
City of Summit Health Department	Scotch Plains Public Library
City of Summit Police Department	Somerset County Library System
Community Access Unlimited	Springfield Public Library
Congregation Beth Hatikvah	Summit Area Public Foundation
Corpus Christi Parish	Summit Area YMCA
Curemonos	Summit Downtown, Inc
Elizabeth Public Library	Summit Library
EZ Ride Transportation Services	Summit Public Schools
Family Promise Union County	TD Bank
Fanwood Public Library	The Arc of Union County
Fanwood-Scotch Plains YMCA	The Borough of Roselle Park
Garwood Public Library	The Connection
Gateway Regional Chamber of Commerce	The Gateway Family YMCA
GRACE	Township of Cranford Health Department
Health Department	Township of Cranford Library
Hillside Public Library	Township of Maplewood
Imagine	Township of Union
Jewish Community Housing Corporation	Township of Union Public School District
Kriegman & Smith, Inc	TransOptions
Lakeland Bancorp, Inc.	Trinitas Regional Medical Center
Liberty Drug	Union County Office of Health Management
Linden Public Library	Union Township Community Action Organization
Livingston Health Department	Union Township Public Library
LMxAC	United Way of Greater Union County

Organization	Organization
Maplewood Public Library	Wakefern Food Corp (ShopRite)
Millburn Public Library	Wallace Chapel AME Zion Church
Mountainside Public Library	Westfield Area YMCA
New Providence Memorial Library	Westfield Memorial Library
NJ Department of Human Services	Westfield Public School District
NJ Red Cross	Westfield Regional Health Department

APPENDIX F: PRIORITIZATION PARTICIPANTS

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

Organization
Academy of Clinical and Applied Psychoanalysis
C R Bard Foundation Inc
Clark Health Department
Corpus Christi Parish
Curemonos
NJ Department of Human Services
Family Promise Union County
Gateway Regional Chamber of Commerce
GRACE
Imagine
Kenilworth Public Library
Maplewood Health Department
Overlook Medical Center Auxiliary
Overlook Medical Center Family Medicine
Overlook Medical Center Administration
Overlook Medical Center Community Health Committee
Pathways to Learning Institute
Pilgrim Baptist Church
SAGE Eldercare
Shop Rite
Summit Area Public Foundation
Summit Public Schools
The Connection for Women and Families
TransOptions
Trinitas Regional Medical Center
Union Health Department
Wallace Chapel AME Zion Church
Westfield Regional Health Office
YMCA

APPENDIX G: UNION COUNTY LICENSED HEALTH FACILITIES[37]

Facility	Type/Services
Cornerstone Behavioral Health Hospital of Union County 40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922 (908)-771-5857	Special Hospital
Summit Medical Group 1 DIAMOND HILL ROAD BERKELEY HEIGHTS, NJ 07922 (908)-273-4300	Ambulatory Care Facility
Homeside Hospice LLC 67 WALNUT AVENUE, SUITE 205 CLARK, NJ 07066 (732)-381-3444	Hospice
First Response Hospice Care, Inc. 57 BRANT AVENUE, SUITE 100 CLARK, NJ 07066 (908)-818-1700	Hospice
Hackensack Meridian Health JFK at Home 100 WALNUT AVENUE CLARK, NJ 07066 (732)-317-5777	Home Health Agency
Trinitas Regional Medical Center Sleep 2 JACKSON DRIVE, HOMEWOOD SUITES CRANFORD, NJ 07016 (908)-994-5226	Hospital-based, Off-site Ambulatory Care Facility
Trinitas Cranford Dialysis 205 BIRCHWOOD AVENUE CRANFORD, NJ 07016 (908)-994-5649	Hospital-based, Off-site Ambulatory Care Facility
NJIN of Cranford 25 SOUTH UNION AVENUE CRANFORD, NJ 07016 (908)-709-1323	Ambulatory Care Facility
NJU CANCER TREATMENT CENTERS 570 SOUTH AVENUE CRANFORD, NJ 07016 (908)-603-4200	Ambulatory Care Facility
Trinitas Hospital Dorothy B Hersh Clinic 655 EAST JERSEY STREET ELIZABETH, NJ 07208 (908)-994-5754	Hospital-based, Off-site Ambulatory Care Facility
Trinitas Health Center - Jefferson Avenue 65 JEFFERSON AVENUE ELIZABETH, NJ 07201 (908)-994-5754	Hospital-based, Off-site Ambulatory Care Facility
Trinitas Renal Dialysis Satellite 629 LIVINGSTON STREET ELIZABETH, NJ 07206 (908)-994-5754	Hospital-Based, Off-site Ambulatory Care Facility
Trinitas Comprehensive Cancer Center 225 WILLIAMSON STREET ELIZABETH, NJ 07202 (908)-994-5754	Hospital-based, Off-site Ambulatory Care Facility

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

Facility	Type/Services
Trinitas HIV Clinic 655 LIVINGSTON STREET ELIZABETH, NJ 07206 (908)-994-5754	Hospital-based, Off-site Ambulatory Care Facility
Trinitas Substance Abuse Clinic 655 EAST JERSEY STREET ELIZABETH, NJ 07206 (908)-994-5754	Hospital-based, Off-site Ambulatory Care Facility
Trinitas Adult Psychiatric Clinic 654 EAST JERSEY STREET ELIZABETH, NJ 07206 (908)-994-5754	Hospital-based, Off-site Ambulatory Care Facility
Trinitas Child and Adolescent Psychiatric Clinic 655 EAST JERSEY STREET ELIZABETH, NJ 07206 (908)-994-5754	Hospital-based, Off-site Ambulatory Care Facility
Trinitas Hospital Addiction Services 654 EAST JERSEY STREET ELIZABETH, NJ 07206 (908)-994-5754	Hospital-based, Off-site Ambulatory Care Facility
Trinitas Regional Medical Center 225 WILLIAMSON STREET ELIZABETH, NJ 07207 (908)-994-5000	General Acute Care Hospital
Trinitas Ambulatory Surgery Center 225 WILLIAMSON STREET ELIZABETH, NJ 07202 (908)-994-8936	Hospital-based, Off-site Ambulatory Care Facility
Trinitas Regional Medical Center Primary Care Satellite 654 EAST JERSEY STREET ELIZABETH, NJ 07206 (908)-994-7271	Hospital-based, Off-site Ambulatory Care Facility
HOLY REDEEMER HOME CARE/ HOSPICE 354 UNION AVENUE ELIZABETH, NJ 07208 (908)-352-5694	Home Health Agency Hospice
University Radiology at Trinitas, LLC 415 MORRIS AVENUE ELIZABETH, NJ 07208 (908)-351-7600	Ambulatory Care Facility
Neighborhood Health Services Corporation 178-184 FIRST STREET ELIZABETH, NJ 07206 (908)-355-4459	Ambulatory Care Facility - Satellite
National Nephrology Associates, Inc 595 DIVISION STREET, SUITE B ELIZABETH, NJ 07201 (908)-436-3007	Ambulatory Care Facility
Aids Resource Foundation for Children/St. Clares Elizabeth 643 PEARL STREET ELIZABETH, NJ 07202 (908)-351-8746	Pediatric Community Transitional Homes
Care One at Trinitas 225 WILLIAMSON STREET, 7 NORTH ELIZABETH, NJ 07207 (732)-324-6090	Special Hospital
AQ Modern Diagnostic Imaging	Ambulatory Care Facility

Facility	Type/Services
315 ELMORA AVENUE ELIZABETH, NJ 07208 (856)-524-1559	
Planned Parenthood of Northern, Central and Southern New Jersey, Inc. 1171 ELIZABETH AVENUE ELIZABETH, NJ 07201 (908)-353-0283	Ambulatory Care Facility- Satellite
Hillside Dialysis 1529 NORTH BROAD STREET HILLSIDE, NJ 07205 (973)-474-1199	Ambulatory Care Facility
Fresenius Medical Care-Kenilworth 131 SOUTH 31ST STREET KENILWORTH, NJ 07033 (908)-241-0453	Ambulatory Care Facility
Garden State Endoscopy and Surgery Center 1700 GALLOPING HILL ROAD KENILWORTH, NJ 07033 (908)-241-8900	Ambulatory Care Facility
Renal Dialysis Satellite 10 NORTH WOOD AVENUE LINDEN, NJ 07036 (908)-862-7400	Hospital-based, Off-site Ambulatory Care Facility
Linden Imaging LLC 210 W ST GEORGES AVENUE LINDEN, NJ 07036 (908)-587-0035	Ambulatory Care Facility
Fresenius Medical Care Linden 630 WEST ST GEORGES LINDEN, NJ 07036 (908)-925-5161	Ambulatory Care Facility
Linden Surgical Center, LLC 210 WEST ST GEORGE AVENUE Linden, New Jersey 07036 (908)-587-1888	Surgical Practice
Summit Dialysis 1139 SPRUCE DRIVE MOUNTAINSIDE, NJ 07092 (908)-232-7800	Ambulatory Care Facility
Gastro-Surgi Center Of New Jersey, The 1132 SPRUCE DRIVE MOUNTAINSIDE, NJ 07092 (908)-317-0071	Ambulatory Care Facility
Center for Ambulatory Surgery, LLC 1450 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092 (908)-233-2020	Ambulatory Care Facility
JFK Medical Center-Muhlenberg Campus PARK AVENUE AND RANDOLPH ROAD PLAINFIELD, NJ 07061 (732)-321-7000	Hospital-based, Off-site Ambulatory Care Facility
Neighborhood Health Center Plainfield 1700 MYRTLE AVENUE PLAINFIELD, NJ 07063 (908)-753-6401	Ambulatory Care Facility
Neighborhood Health Center the Healthy Place 427 DARROW AVENUE	Ambulatory Care Facility- Satellite

Facility	Type/Services
PLAINFIELD, NJ 07063 (908)-731-4288	
Plainfield Dialysis 1200 RANDOLPH ROAD PLAINFIELD, NJ 07060 (908)-757-6030	Ambulatory Care Facility
Planned Parenthood of Northern, Central and Southern New Jersey, Inc. 123 PARK AVENUE PLAINFIELD, NJ 07060 (908)-756-3736	Ambulatory Care Facility- Satellite
Robert Wood Johnson University Hospital at Rahway 865 STONE ST RAHWAY, NJ 07065 (732)-381-4200	General Acute Care Hospital
ASCEND HOSPICE 1600 ST GEORGE AVENUE, SUITE 312 RAHWAY, NJ 07065 (908)-931-9080	Hospice
Kindred Hospital New Jersey-Rahway 865 STONE STREET RAHWAY, NJ 07065 (732)-669-8200	Special Hospital
Rahway Regional Cancer Center 892 TRUSSLER PLACE RAHWAY, NJ 07065 (732)-382-5550	Ambulatory Care Facility
Rahway Dialysis 800 HARRISON STREET RAHWAY, NJ 07065 (732)-381-0973	Ambulatory Care Facility
Center for Hope Hospice and Palliative Care 1900 RARITAN ROAD SCOTCH PLAINS, NJ 07076 (908)-889-7780	Hospice
Overlook Medical Center 99 BEAUVOIR AVENUE SUMMIT, NJ 07902 (908)-522-2000	General Acute Care Hospital
Overlook Health Services at One Springfield Avenue 1 SPRINGFIELD AVENUE SUMMIT, NJ 07901 (908)-934-6651	Hospital-based, Off-site Ambulatory Care Facility
Summit Oaks Hospital 19 PROSPECT ST SUMMIT, NJ 07901 (908)-522-7027	Psychiatric Hospital
Westfield Plastic Surgical Center 955 SO SPRINGFIELD AVENUE, BLDG A, SUITE 105 Springfield, New Jersey 07081 (908) -654-6540	Surgical Practice
Springfield Surgery Center, L.L.C. 105 MORRIS AVENUE, FIRST FLOOR Springfield, New Jersey 07081 (973) -718-5550	Surgical Practice
Med Fem Aesthetic Center 33 OVERLOOK ROAD, SUITE 302 Summit, New Jersey 07901	Surgical Practice

Facility	Type/Services
(908)-522-1777	
Overlook Medical Center-Union Campus 1000 GALLOPING HILL ROAD UNION, NJ 07083 (973)-522-6300	Hospital-based, Off-site Ambulatory Care Facility
Wound Healing Program at Union Campus 1000 GALLOPING HILL ROAD UNION, NJ 07083 (908)-522-6300	Hospital-based, Off-site Ambulatory Care Facility
Union County Surgery Center, L.L.C. 950 WEST CHESTNUT STREET UNION, NJ 07083 (908)-688-2700	Ambulatory Care Facility
Qualcare Therapy Center Inc & Sleep Diagnostics of NJ 2333 MORRIS AVENUE, SUITE B-210 UNION, NJ 07083 (908)-688-3366	Ambulatory Care Facility
NJIN of Union 445 CHESTNUT STREET UNION, NJ 07083 (908)-687-6054	Ambulatory Care Facility
Dynamic Medical Imaging L.L.C. 950 WEST CHESTNUT STREET UNION, NJ 07083 (908)-687-2552	Ambulatory Care Facility
UNION SURGERY CENTER, LLC 1000 GALLOPING HILL ROAD UNION, NJ 07083 (908)-258-7666	Ambulatory Care Facility
Advanced Spine and Outpatient Surgery Center, LLC 855 LEHIGH AVENUE, SUITE 203 UNION, NJ 07083 (908)-557-9420	Ambulatory Care Facility
Women's Healthcare Imaging Center 1896 MORRIS AVENUE UNION, NJ 07083 (908)-964-0004	Ambulatory Care Facility
The Birth Center of New Jersey, LLC 1945 US 22 WEST UNION, NJ 07083 (908)-624-9665	Ambulatory Care Facility
Bio-Medical Applications of Hillside 879 RAHWAY AVENUE UNION, NJ 07083 (908)-964-5606	Ambulatory Care Facility
Endo-Surgi Center, PA 1201 MORRIS AVENUE UNION, NJ 07083 (908)-686-0066	Ambulatory Care Facility
Access Care Physicians of NJ L.L.C. 2401 MORRIS AVENUE, SUITE W-112 Union, New Jersey 07083 (908)-686-0123	Surgical Practice
New Jersey Interventional Associates LLC 2401 MORRIS AVENUE, SUITE W-111 Union, New Jersey 07083 (908)-686-1350	Surgical Practice

Facility	Type/Services
Summit Medical Group, P.A. 574 SPRINGFIELD AVENUE WESTFIELD, NJ 07091 (908)-673-7257	Ambulatory Care Facility
Cardiovascular Care Group, The 433 CENTRAL AVENUE Westfield, New Jersey 07090 (973)-759-9000	Surgical Practice
2nd Home Sweet Home Operations, LLC 550 North Broad Street Elizabeth, NJ07208 (908)-994-0050	Adult Day Health Care Services
Amber Court of Elizabeth, LLC 1155 East Jersey Street Elizabeth, NJ07201 (908)-352-9200	Assisted Living Residence
The Chelsea at Fanwood 295 South Avenue Fanwood, NJ07023 (908)-654-5200	Assisted Living Residence
Circle of Friends, LLC 40 Stern Avenue Springfield, NJ07081 (973)-376-4004	Adult Day Health Care Services
The Woodlands 1400 Woodland Ave Plainfield, NJ07060 (908)-753-1113	Long Term Care Facility
Alaris Health at Riverton 1777 Lawrence Street Rahway, NJ07065 (732)-499-7927	Long Term Care Facility
Arbor Terrace Mountainside 1050 Springfield Avenue Mountainside, NJ07092 (908)-760-0599	Assisted Living Residence
ARISTACARE AT DELAIRE 400 W Stimpson Ave Linden, NJ07036 (908)-862-3399	Long Term Care Facility Comprehensive Personal Care Home
AristaCare at Norwood Terrace 40 Norwood Avenue Plainfield, NJ07060 (908)-769-1400	Long Term Care Facility Adult Day Health Care Services
Ashbrook Care & Rehabilitation Center 1610 Raritan Road Scotch Plains, NJ07076 (908)-889-5500	Long Term Care Facility
Atria Cranford 10 Jackson Drive Cranford, NJ07016 (908)-709-4300	Comprehensive Personal Care Home
Autumn Lake Healthcare at Berkeley Heights 35 Cottage Street Berkeley Heights, NJ07922 (908)-897-1000	Long Term Care Facility
Aveanna Healthcare	Pediatric Day Health Care Services

Facility	Type/Services
316 West Westfield Avenue Roselle Park, NJ07204 (908)-259-3330	
Birchwood Square at Cranford 205 Birchwood Avenue Cranford, NJ07016 (908)-272-6660	Comprehensive Personal Care Home
Brighton Gardens of Mountainside 1350 Route 22 West Mountainside, NJ07092 (908)-654-4460	Assisted Living Residence
Care Connection Rahway 865 Stone Street Rahway, NJ07065 (732)-499-6460	Long Term Care Facility
Cedar Harbor Medical Day Care Center 545 East 1st Avenue Roselle, NJ07203 (908)-298-8588	Adult Day Health Care Services
Center for Hope Hospice Inc. 1900 Raritan Road Scotch Plains, NJ07076 (908)-889-7780	Assisted Living Program
Children's Specialized Hospital 150 New Providence Road Mountainside, NJ07092 (908)-233-3720	Long Term Care Facility
Clark Nursing and Rehabilitation Center 1213 Westfield Avenue Clark, NJ07066 (732)-396-7100	Long Term Care Facility
Continuing Care at Lantern Hill 537 Mountain Avenue New Providence, NJ07974 (908)-516-9400	Long Term Care Facility Assisted Living Residence
Cornell Hall Care & Rehabilitation Center 234 Chestnut Street Union, NJ07083 (908)-687-7800	Long Term Care Facility
Cranford Park Rehabilitation & Healthcare Center 600 Lincoln Park East Cranford, NJ07016 (908)-276-7100	Long Term Care Facility
Cranford Rehab & Nursing Center 205 Birchwood Ave Cranford, NJ07016 (908)-272-6660	Long Term Care Facility
Daybreak Adult Daycare at Elizabeth 712 Newark Avenue Elizabeth, NJ07208 (908)-353-3530	Adult Day Health Care Services
Elizabeth Nursing and Rehab Center 1048 Grove Street Elizabeth, NJ07202 (908)-354-0002	Long Term Care Facility
Elmora Hills Health & Rehabilitation Center 225 W Jersey Street	Long Term Care Facility

Facility	Type/Services
Elizabeth, NJ07202 (908)-353-1220	
FATHER HUDSON HOUSE 111 Dehart Place Elizabeth, NJ07202 (908)-353-6060	Comprehensive Personal Care Home
Five Star Adult Medical Day Care Center 1201 Deerfield Terrace Linden, NJ07036 (908)-486-5750	Adult Day Health Care Services
JFK Hartwyck At Cedar Brook 1340 Park Ave Plainfield, NJ07060 (908)-754-3100	Long Term Care Facility
Manor Care Health Services Mountainside 1180 Route 22 West Mountainside, NJ07092 (908)-654-0020	Long Term Care Facility
Peggy Coloney's House at Hope Village 1900 Raritan Road Scotch Plains, NJ07076 (908)-889-7780	Comprehensive Personal Care Home
Plaza Healthcare & Rehabilitation Center 456 Rahway Avenue Elizabeth, NJ07202 (908)-354-1300	Long Term Care Facility
Runnells Center for Rehabilitation & Healthcare 40 Watchung Way Berkeley Heights, NJ07922 (908)-771-5700	Long Term Care Facility
SAGE Spend A Day 290 Broad Street Summit, NJ07901 (908)-273-5550	Adult Day Health Care Services
SarahCare At Watchung Square 1115 Globe Avenue Mountainside, NJ07092 (908)-561-8888	Adult Day Health Care Services
Senior Spirit of Roselle Park 430 East Westfield Avenue Roselle Park, NJ07204 (908)-241-9393	Adult Day Health Care Services
South Mountain Healthcare & Rehabilitation 2385 Springfield Avenue Vauxhall, NJ07088 (908)-688-3400	Long Term Care Facility
Spring Grove Rehabilitation and Healthcare Center 144 Gales Drive New Providence, NJ07974 (908)-464-8600	Long Term Care Facility
Spring Meadows Summit 41 Springfield Avenue Summit, NJ07901 (908)-522-8852	Assisted Living Residence
Sunrise Assisted Living of Westfield 240 Springfield Avenue	Assisted Living Residence

Facility	Type/Services
Westfield, NJ07090 (908)-317-3030	
Town Square Adult Medical Day Care Center 1155 East Jersey Street Elizabeth, NJ07201 (908)-787-0980	Adult Day Health Care Services
Trinitas Hospital 655 East Jersey Street Elizabeth, NJ07206 (908)-994-7525	Long Term Care Facility
Westfield Center 1515 Lamberts Mill Road Westfield, NJ07090 (908)-233-9700	Long Term Care Facility

PREPARED FOR

OVERLOOK MEDICAL CENTER

BY

ATLANTIC HEALTH SYSTEM
PLANNING & SYSTEM DEVELOPMENT

Atlantic Health System

Overlook Medical Center