



2019 Community Health Needs Assessment Summary Report

Southern Passaic County

Prepared for:
St. Joseph's University Medical Center

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Introduction



About This Assessment

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2016, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of St. Joseph's University Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of St. Joseph's University Medical Center by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey of various community stakeholders.

PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by St. Joseph's Health and PRC.

Community Defined for This Assessment

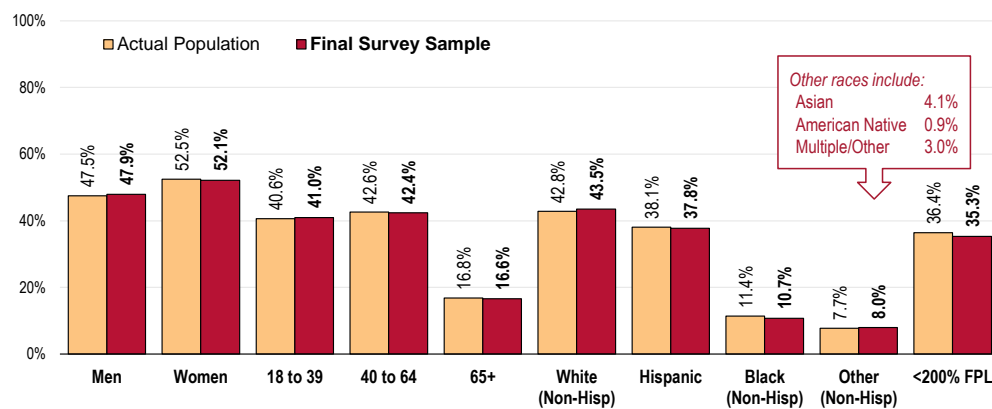
The study area for the survey effort (referred to as "Southern Passaic County" in this report) includes the following residential ZIP Codes: 07011, 07012, 07013, 07014, 07055, 07407, 07410, 07424, 07470, 07501, 07502, 07503, 07504, 07505, 07506, 07508, 07512, 07513, 07514, 07522, and 07524. This community definition represents the primary and secondary service areas of St. Joseph's University Medical Center and includes residential ZIP Codes

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the Southern Passaic County sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s healthcare needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(Southern Passaic County, 2019)



Sources:

- US Census Bureau, 2011-2015 American Community Survey.
- 2019 PRC Community Health Survey, PRC, Inc.

 Notes:

- FPL is federal poverty level, based on guidelines established by the US Department of Health & Human Services.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2019 guidelines place the poverty threshold for a family of four at \$25,750 annual household income or lower). In sample segmentation: “**low income**” refers to community members living in a household with defined poverty status or living just above the poverty level and earning up to twice (<200% of) the poverty threshold; “**mid/high income**” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by St. Joseph's Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 72 community stakeholders in Southern Passaic County took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation	
Key Informant Type	Number Participating
Physicians	10
Public Health Representatives	2
Other Health Providers	20
Social Services Providers	10
Other Community Leaders	30

Final participation included representatives of the organizations outlined below.

- St. Joseph's Health
- Clifton Health Department
- 4Cs of Passaic County
- Bangladeshi American Women's Development Initiative
- Carefinders Total Care
- Chabad Center of Passaic County
- City of Paterson
- Clifton Medical Care
- Clifton Public Schools
- Coalition on AIDS in Passaic County, Inc.
- Collaborative Support Programs of New Jersey
- Elmwood Park Senior Activity Center of Bergen Co.
- Faces of Fallen Fathers
- Family Intervention Services
- Family Promise of Bergen County
- Hamilton Partnership for Paterson
- Heart and Vascular Medical Group
- Home Care Options
- HVA Medical Group

- Internal Medicine and Geriatric Practice
- Lighthouse Pregnancy Resource Center
- M&S Psychotherapy and Counseling
- More Than Friends Cares Inc.
- New City Kids: Paterson
- NORWESCAP, Inc.
- Palestinian American Community Center
- Passaic Public Schools
- Paterson Alliance
- Paterson Community Clinic
- Paterson Division of Health
- Paterson Education Fund
- Rebuilding Together North Jersey
- RENEW Life Center
- St. Joseph's Family Medicine/Clifton
- St. Joseph's University Medical Center
- St. Paul's Church
- Straight and Narrow
- Township of Wayne
- United Methodist Church in Wayne County
- United Methodist Church
- Wanaque Borough Health Department
- Wayne Counseling and Family Services
- William Paterson University

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for Passaic County were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES) Engagement Network, University of Missouri Extension
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect Passaic County data.

Benchmark Data

Trending

A similar survey was administered in Southern Passaic County in 2016 by PRC on behalf of St. Joseph's Health. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

New Jersey Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2017 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:



- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, “significance” of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community’s health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

St. Joseph's University Medical Center made its prior Community Health Needs Assessment (CHNA) report publicly available through its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, St. Joseph's University Medical Center had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. St. Joseph's University Medical Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS Form 990, Schedule H (2018)	See Report Page
Part V Section B Line 3a <i>A definition of the community served by the hospital facility</i>	5
Part V Section B Line 3b <i>Demographics of the community</i>	41
Part V Section B Line 3c <i>Existing health care facilities and resources within the community that are available to respond to the health needs of the community</i>	153
Part V Section B Line 3d <i>How data was obtained</i>	5
Part V Section B Line 3e <i>The significant health needs of the community</i>	14
Part V Section B Line 3f <i>Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups</i>	Addressed Throughout
Part V Section B Line 3g <i>The process for identifying and prioritizing community health needs and services to meet the community health needs</i>	14
Part V Section B Line 3h <i>The process for consulting with persons representing the community's interests</i>	5
Part V Section B Line 3i <i>The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)</i>	159

Summary of Findings

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

Areas of Opportunity Identified Through This Assessment	
Access to Healthcare Services	<ul style="list-style-type: none"> ● Lack of Health Insurance ● Barriers to Access <ul style="list-style-type: none"> ○ Inconvenient Office Hours ○ Cost of Prescriptions ○ Lack of Transportation ○ Culture/Language ● Primary Care Physician Ratio ● Emergency Room Utilization ● Completion of Advance Directive Documents
Cancer	<ul style="list-style-type: none"> ● Leading Cause of Death ● Prostate Cancer Incidence
Diabetes	<ul style="list-style-type: none"> ● Kidney Disease Prevalence ● <i>Key Informants: Diabetes ranked as a top concern.</i>
Heart Disease & Stroke	<ul style="list-style-type: none"> ● Leading Cause of Death ● Stroke Prevalence ● High Blood Pressure Prevalence ● High Blood Pressure Management ● Blood Cholesterol Screening ● <i>Key Informants: Heart disease and stroke ranked as a top concern.</i>
Housing	<ul style="list-style-type: none"> ● Worry/Stress Over Rent/Mortgage
Injury & Violence	<ul style="list-style-type: none"> ● Unintentional Injury Deaths ● Violent Crime Rate ● Neighborhood Is “Slightly/Not At All Safe” ● <i>Key Informants: Injury and violence ranked as a top concern.</i>

—continued on the following page—

Areas of Opportunity (continued)	
Mental Health	<ul style="list-style-type: none"> • “Fair/Poor” Mental Health • Symptoms of Chronic Depression • Stress • Mental Health Provider Ratio • Difficulty Obtaining Mental Health Services • Sleep <7 Hours per Night • Alzheimer’s Disease Deaths • <i>Key Informants: Mental health ranked as a top concern.</i>
Nutrition, Physical Activity & Weight	<ul style="list-style-type: none"> • Fruit/Vegetable Consumption • Food Insecurity • Overweight & Obesity [Children] • Children’s Physical Activity • Access to Recreation/Fitness Facilities • <i>Key Informants: Nutrition, physical activity, and weight ranked as a top concern.</i>
Respiratory Diseases	<ul style="list-style-type: none"> • Flu Vaccination [Age 65+] • Pneumonia Vaccination [Age 65+]
Septicemia	<ul style="list-style-type: none"> • Septicemia Deaths
Sexual Health	<ul style="list-style-type: none"> • HIV/AIDS Deaths • HIV Prevalence
Substance Abuse	<ul style="list-style-type: none"> • Unintentional Drug-Related Deaths • Illicit Drug Use • <i>Key Informants: Substance abuse ranked as a top concern.</i>
Tobacco Use	<ul style="list-style-type: none"> • Exposure of Children to Environmental Tobacco Smoke • Use of Vaping Products • Smoking Cessation

Community Feedback on Prioritization of Health Needs

On October 15, 2019, St. Joseph’s University Medical Center convened a group of 15 community stakeholders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions. Finally, participants were provided an overview of the prioritization exercise that followed.

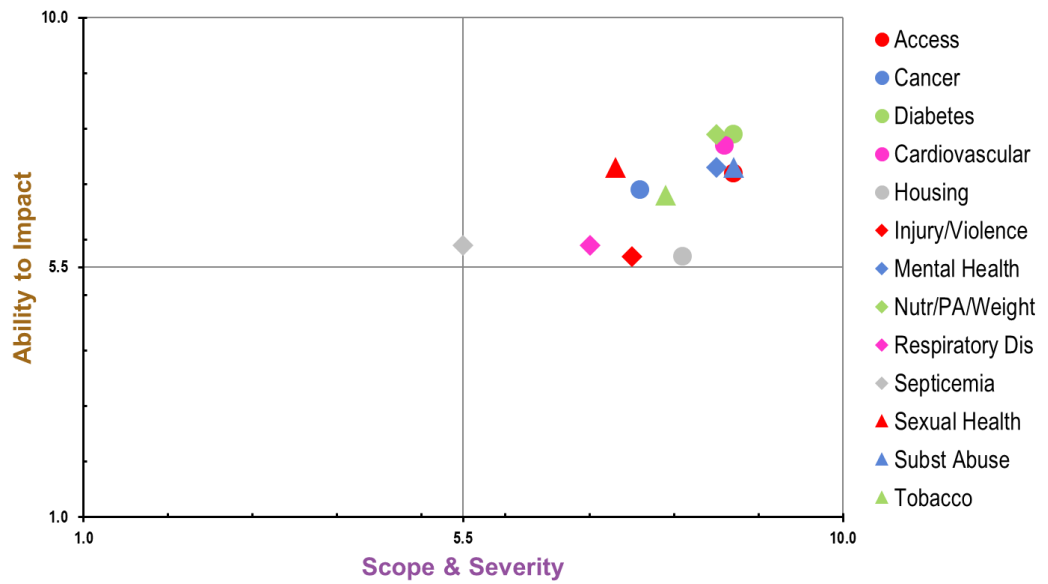
In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
 - How many people are affected?
 - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
 - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).
- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. **Diabetes**
2. **Nutrition, Physical Activity & Weight**
3. **Heart Disease & Stroke**
4. **Substance Abuse**
5. **Access to Healthcare**
6. **Mental Health**
7. **Tobacco Use**
8. **Sexual Health**
9. **Cancer**
10. **Housing**
11. **Injury & Violence**
12. **Respiratory Diseases**
13. **Septicemia**

Plotting these overall scores in a matrix illustrates the intersection of the Scope & Severity and the Ability to Impact scores. Below, those issues placing in the upper right quadrant represent health needs rated as most severe, with the greatest ability to impact.



Hospital Implementation Strategy

St. Joseph's University Medical Center will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in Southern Passaic County, grouped by health topic.

Reading the Summary Tables

■ In the following tables, Southern Passaic County results are shown in the larger, blue column. *Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.*

■ The green columns [to the left of the Southern Passaic County column] provide comparisons among the 6 communities, identifying differences for each as “better than” (☀️), “worse than” (🌧️), or “similar to” (☁️) the combined opposing areas.

■ The columns to the right of the Southern Passaic County column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2020 objectives. Again, symbols indicate whether Southern Passaic County compares favorably (☀️), unfavorably (🌧️), or comparably (☁️) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

TREND SUMMARY

(Current vs. Baseline Data)

Survey Data Indicators:













Trends for survey-derived indicators represent significant changes since 2016. Note that survey data reflect the ZIP Code-defined Southern Passaic County.














Other (Secondary) Data

Indicators: Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).







Note that secondary data reflect Passaic County data.







Disparity Among Subareas

Social Determinants	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Linguistically Isolated Population (Percent)						
Population in Poverty (Percent)						
Children in Poverty (Percent)						
No High School Diploma (Age 25+, Percent)						
Unemployment Rate (Age 16+, Percent)						
% Worry/Stress Over Rent/Mortgage in Past Year	 42.7	 51.9	 31.0	 47.6	 29.3	 33.3
% Low Health Literacy	 18.2	 29.8	 26.0	 26.1	 18.2	 17.7
<small>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</small>						































Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
10.5	 6.4	 4.4		
17.0	 10.7	 14.6		
26.3	 15.3	 20.3		
17.1	 10.8	 12.7		
3.6	 2.9	 3.4		 5.6
43.7		 30.8		 42.5
24.7		 23.3		 27.1
 better  similar  worse				













Disparity Among Subareas

Overall Health	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% "Fair/Poor" Overall Health	 20.1	 30.7	 9.7	 16.7	 11.8	 10.8
<small>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</small>						

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
19.5	 18.4	 18.1		 18.0
	 better	 similar	 worse	

Disparity Among Subareas

Access to Health Services	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% [Age 18-64] Lack Health Insurance	 9.7	 14.6	 10.8	 12.0	 9.2	 2.2
% [Insured 18-64] Have Coverage Through ACA	 10.6	 28.6	 14.6	 18.5	 7.4	 10.7
% Difficulty Accessing Healthcare in Past Year (Composite)	 40.1	 50.7	 43.3	 54.7	 58.4	 39.0
% Difficulty Finding Physician in Past Year	 20.2	 19.0	 17.5	 15.9	 9.6	 4.1
% Difficulty Getting Appointment in Past Year	 16.6	 20.0	 16.3	 20.4	 21.5	 15.1

























Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
11.2	 13.2	 13.7	 0.0	 7.7
18.1		 8.2		 12.1
49.6		 43.2		 48.0
15.7		 13.4		 14.3
19.1		 17.5		 20.8












Disparity Among Subareas

Access to Health Services (continued)	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% Cost Prevented Physician Visit in Past Year	18.2	20.1	12.9	22.6	11.0	12.7
% Transportation Hindered Dr Visit in Past Year	8.8	18.7	5.7	10.5	4.8	7.2
% Inconvenient Hrs Prevented Dr Visit in Past Year	17.6	25.1	22.7	24.6	20.9	21.3
% Language/Culture Prevented Care in Past Year	3.7	7.4	2.4	5.6	12.5	0.0
% Cost Prevented Getting Prescription in Past Year	13.4	19.2	16.1	23.8	23.1	10.1
% Skipped Prescription Doses to Save Costs	12.0	20.6	8.7	12.7	22.4	3.4
% Difficulty Getting Child's Healthcare in Past Year						
Primary Care Doctors per 100,000						
% Have a Specific Source of Ongoing Care	81.3	67.3	72.2	70.3	85.7	76.4
% Have Had Routine Checkup in Past Year	73.1	77.9	71.4	69.1	71.6	73.0

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
18.4	15.4		17.7	
11.4	8.3		10.1	
23.1	12.5		22.0	
5.7	1.2		2.9	
19.2	14.9		15.1	
14.6	15.3		15.6	
8.7	5.6		7.3	
69.8	101.6	87.8		
72.9	74.1	95.0	73.5	
72.9	76.1	68.3	74.2	

Disparity Among Subareas

Access to Health Services (continued)	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% Child Has Had Checkup in Past Year						
% Two or More ER Visits in Past Year	 5.8	 24.0	 12.2	 15.2	 4.5	 8.6
% Rate Local Healthcare "Fair/Poor"	 19.4	 13.1	 15.4	 16.8	 3.7	 10.8
% Have Completed Advance Directive Documents	 31.2	 20.1	 32.1	 18.7	 36.6	 40.5
% Expect Care at Teaching Hospital to be "Worse"	 11.8	 11.7	 8.5	 11.1	 5.4	 6.9
<small>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</small>						

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
92.5	 87.1	 87.9		
14.8	 9.3	 11.3		
14.0	 16.2	 14.1		
25.6	 34.6	 22.4		
10.2				
	 better	 similar	 worse	

Disparity Among Subareas

Cancer	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Cancer (Age-Adjusted Death Rate)						
Lung Cancer (Age-Adjusted Death Rate)						
Prostate Cancer (Age-Adjusted Death Rate)						
Female Breast Cancer (Age-Adjusted Death Rate)						
Colorectal Cancer (Age-Adjusted Death Rate)						
Cancer Incidence Rate (All Sites)						
Female Breast Cancer Incidence Rate						
Prostate Cancer Incidence Rate						
Lung Cancer Incidence Rate						
Colorectal Cancer Incidence Rate						



















Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
142.2	148.4	155.6	161.4	164.7
27.1	33.4	38.5	45.5	
18.4	17.3	18.9	21.8	
19.9	20.7	20.1	20.7	
13.9	14.0	13.9	14.5	
496.4	477.5	483.8		
117.0	133.4	124.7		
137.1	134.7	109.0		
49.6	57.3	60.2		
40.0	41.9	39.2		















Disparity Among Subareas

Cancer (continued)	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% Cancer (Other Than Skin)	9.3	4.8	7.7	5.7	10.6	7.5
% Skin Cancer	4.4	1.6	4.8	6.3	9.6	3.4
% [Women 50-74] Mammogram in Past 2 Years						
% [Women 21-65] Pap Smear in Past 3 Years						
% [Age 50-75] Colorectal Cancer Screening	68.1	73.2	71.5	73.3	54.8	77.9
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						







Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
6.7	6.4	7.1		6.3
4.6	5.1	8.5		3.8
72.8	80.7	77.0	81.1	75.7
83.5	82.1	73.5	93.0	80.1
71.2	65.1	76.4	70.5	66.7
	better	similar	worse	











Disparity Among Subareas

Diabetes	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Diabetes (Age-Adjusted Death Rate)						
% Diabetes/High Blood Sugar	 8.3	 24.2	 11.3	 12.5	 18.4	 13.2
% Borderline/Pre-Diabetes	 13.2	 11.0	 9.1	 5.7	 6.7	 10.0
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	 58.1	 49.9	 50.3	 53.6	 55.4	 51.0
<small>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</small>						

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
23.0	 17.5	 21.3	 20.5	 25.1
16.0	 11.1	 13.3		 13.2
9.0		 9.5		 8.8
52.7		 50.0		 50.4
	 better	 similar	 worse	

Disparity Among Subareas

Heart Disease & Stroke	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Diseases of the Heart (Age-Adjusted Death Rate)						
Stroke (Age-Adjusted Death Rate)						
% Heart Disease (Heart Attack, Angina, Coronary Disease)	 5.3	 9.8	 7.0	 6.6	 5.4	 4.8

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
162.1	 164.6	 166.3	 156.9	 192.1
31.3	 30.6	 37.5	 34.8	 34.7
7.1		 8.0		 5.6

Disparity Among Subareas

Heart Disease & Stroke (continued)	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% Stroke	2.5	5.3	5.6	5.5	2.0	2.5
% Blood Pressure Checked in Past 2 Years	88.8	90.8	89.9	91.3	91.1	94.6
% Told Have High Blood Pressure (Ever)	33.1	46.3	36.8	39.8	46.4	41.9
% [HBP] Taking Action to Control High Blood Pressure						
% Cholesterol Checked in Past 5 Years	86.5	87.7	86.2	86.4	91.8	90.3
% Told Have High Cholesterol (Ever)	36.4	32.9	40.5	32.3	33.0	30.1
% [HBC] Taking Action to Control High Blood Cholesterol						
% 1+ Cardiovascular Risk Factor	81.6	90.9	86.4	86.4	86.5	85.6

Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
4.5	2.5	4.7		2.8
91.1		90.4	92.6	92.6
41.5	33.0	37.0	26.9	39.7
88.5		93.8		92.4
87.6	91.1	85.1	82.1	90.6
33.5		36.2	13.5	36.6
89.2		87.3		85.0
87.1		87.2		87.5

better
 similar
 worse

Disparity Among Subareas

Infant Health & Family Planning	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
No Prenatal Care in First Trimester (Percent)						
Low Birthweight Births (Percent)						
Infant Death Rate						
Births to Adolescents Age 15 to 19 (Percent)						
Births to Adolescents Age 15 to 19 (Rate per 1,000)						
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						







Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
28.8	24.9		22.1	
8.6	8.0	8.2	7.8	8.4
3.9	4.4	5.8	6.0	4.3
5.3	3.0	5.4		9.0
34.8	21.6	36.6		39.6
	better	similar	worse	










Disparity Among Subareas

Injury & Violence	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Unintentional Injury (Age-Adjusted Death Rate)						
Motor Vehicle Crashes (Age-Adjusted Death Rate)						
[65+] Falls (Age-Adjusted Death Rate)						
% [Age 45+] Fell in the Past Year	 31.6	 33.6	 32.3	 18.2	 22.5	 22.9
Firearm-Related Deaths (Age-Adjusted Death Rate)						
Homicide (Age-Adjusted Death Rate)						
Violent Crime Rate						
% Victim of Violent Crime in Past 5 Years	 1.2	 6.9	 5.2	 3.8	 1.1	 3.6
% Victim of Domestic Violence (Ever)	 10.0	 15.5	 16.1	 14.5	 11.1	 13.3
% Perceive Neighborhood as "Slightly/Not At All Safe"	 15.4	 46.0	 9.5	 17.7	 5.6	 5.2































Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
34.1	 40.6	 46.7	 36.4	 21.1
5.9	 6.5	 11.4	 12.4	
33.9	 30.1	 62.1	 47.0	
26.1		 31.6		 26.7
5.2	 5.4	 11.6	 9.3	
4.5	 4.4	 6.0	 5.5	 4.2
451.2	 277.7	 379.7		
4.2		 3.7		 4.4
14.0		 14.2		 12.9
22.5		 15.6		 26.6












Disparity Among Subareas

Kidney Disease	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Kidney Disease (Age-Adjusted Death Rate)						
% Kidney Disease	 2.9	 10.4	 4.2	 5.3	 13.2	 5.2
<small>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</small>						

























Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
14.4	 14.0	 13.2		 15.4
7.2	 2.8	 3.8		 2.7
	 better	 similar	 worse	























Disparity Among Subareas

Mental Health	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% "Fair/Poor" Mental Health	 19.5	 21.6	 15.1	 20.3	 13.9	 10.1
% Diagnosed Depression	 15.8	 23.2	 13.7	 17.5	 14.1	 12.5
% Symptoms of Chronic Depression (2+ Years)	 32.2	 49.8	 28.4	 39.2	 30.7	 27.6
% Typical Day Is "Extremely/Very" Stressful	 14.8	 20.3	 22.2	 15.5	 17.2	 8.9
% Average <7 Hours of Sleep per Night	 32.2	 52.8	 51.7	 45.8	 38.7	 27.3

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
18.5		 13.0		 13.6
17.8	 14.8	 21.6		 17.0
38.5		 31.4		 32.8
16.8		 13.4		 15.4
44.2		 36.7		 39.4

Disparity Among Subareas

Mental Health	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Suicide (Age-Adjusted Death Rate)						
Mental Health Providers per 100,000						
% Taking Rx/Receiving Mental Health Trtmt	 12.7	 15.6	 15.2	 14.5	 13.5	 19.2
% Have Ever Sought Help for Mental Health	 32.4	 28.6	 22.9	 29.2	 27.9	 31.9
% [Those With Diagnosed Depression] Seeking Help						
% Unable to Get Mental Health Svcs in Past Yr	 11.4	 8.9	 8.3	 10.2	 11.7	 8.6
Alzheimer's Disease (Age-Adjusted Death Rate)						
% [Age 45+] Increasing Confusion/Memory Loss in Past Yr	 3.7	 13.8	 12.8	 10.4	 5.5	 13.5
<small>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</small>						

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
5.5	 7.9	 13.6	 10.2	 7.0
112.0	 175.1	 202.8		
15.1		 13.9		 12.5
29.0		 30.8		 24.8
87.1		 87.1		 82.2
9.7		 6.8		 5.3
19.2	 21.5	 30.2		 16.2
10.5		 11.2		 11.8
 better  similar  worse				

Disparity Among Subareas

Nutrition, Physical Activity & Weight	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% Food Insecure	25.9	52.4	19.8	33.7	11.6	17.3
% 5+ Servings of Fruits/Vegetables per Day	16.3	17.4	28.9	26.1	23.2	25.9
% "Very/Somewhat" Difficult to Buy Fresh Produce	23.7	27.8	18.6	19.6	14.5	11.0
% 7+ Sugar-Sweetened Drinks in Past Week	24.5	31.6	25.0	20.9	20.0	18.5
Population With Low Food Access (Percent)						
% No Leisure-Time Physical Activity	17.1	32.2	27.0	28.0	28.0	12.1
% Meeting Physical Activity Guidelines	20.6	23.3	24.3	23.9	13.7	28.9
Recreation/Fitness Facilities per 100,000						
% Healthy Weight (BMI 18.5-24.9)	36.7	25.6	26.5	30.0	37.9	27.5
% Overweight (BMI 25+)	59.2	70.3	73.5	68.8	62.1	71.0

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
33.3	27.9		32.1	
22.4	33.5		27.3	
21.0	22.1		25.2	
24.4	29.0		21.1	
13.0	23.7	22.4		
26.3	29.0	26.2	32.6	
22.9	21.9	22.8	20.1	
9.2	15.7	11.0		
29.7	36.1	30.3	33.9	
68.1	62.6	67.8	70.4	

Disparity Among Subareas

Nutrition, Physical Activity & Weight (continued)	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% [Overweights] Trying to Lose Weight	76.6	66.9	75.4	67.2	67.9	74.6
% Obese (BMI 30+)	24.2	39.0	36.4	33.5	12.7	28.9
% Medical Advice on Weight in Past Year	27.0	38.2	34.4	29.2	29.0	27.2
% [Overweights] Counseled About Weight in Past Year	39.1	43.2	40.6	35.0	37.1	34.3
% Children [Age 5-17] Healthy Weight						
% Children [Age 5-17] Overweight (85th Percentile)						
% Children [Age 5-17] Obese (95th Percentile)						
% Child [Age 2-17] Physically Active 1+ Hours per Day						

Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
69.7		61.3		
31.8	27.3	32.8	30.5	33.5
31.8		24.2		32.5
38.5		29.0		40.1
46.1		58.4		60.1
40.4		33.0		26.7
22.8		20.4	14.5	13.2
40.8		50.5		36.4











































better
 similar
 worse

Disparity Among Subareas
















Oral Health	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% Have Dental Insurance	68.4	76.7	67.7	70.8	76.6	82.5
% [Age 18+] Dental Visit in Past Year	69.7	52.4	67.7	67.3	71.9	84.7
% Child [Age 2-17] Dental Visit in Past Year						
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
73.7		59.9		72.1
65.4	73.4	59.7	49.0	68.8
83.1		87.0	49.0	80.5
	better	similar	worse	

Disparity Among Subareas

Potentially Disabling Conditions	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% Activity Limitations	 25.4	 27.4	 18.1	 25.0	 27.9	 13.1
% [50+] Arthritis/Rheumatism	 29.2	 45.0	 28.7	 34.3	 24.5	 28.9
% [50+] Osteoporosis	 13.6	 7.4	 6.3	 8.2	 14.2	 12.8
% Sciatica/Chronic Back Pain	 26.4	 22.5	 18.8	 22.4	 21.3	 25.4
% Eye Exam in Past 2 Years	 52.4	 64.6	 61.1	 64.2	 69.9	 60.8
% 3+ Chronic Conditions	 38.8	 48.3	 38.2	 38.1	 41.0	 36.1
% Caregiver to a Friend/Family Member	 28.2	 21.7	 21.1	 19.6	 25.3	 28.0

Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
24.2	 17.2	 25.0		 21.0
33.7		 38.3		 40.4
9.8		 9.4	 5.3	 10.1
22.7		 22.9		 24.6
62.8		 55.3		 63.1
41.2		 41.4		
22.7		 20.8		 22.6

 better  similar  worse

Disparity Among Subareas

Respiratory Diseases	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
CLRD (Age-Adjusted Death Rate)						
Pneumonia/Influenza (Age-Adjusted Death Rate)						
% [Adult] Currently Has Asthma	 10.6	 17.5	 12.5	 9.0	 17.2	 4.1
% [Child 0-17] Currently Has Asthma						
% COPD (Lung Disease)	 11.8	 9.7	 6.1	 8.4	 19.3	 8.0
% [Age 65+] Flu Vaccine in Past Year						
% [Age 65+] Pneumonia Vaccine Ever						
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
25.8	 28.7	 41.0		 27.9
12.0	 11.6	 14.3		 14.6
12.3	 8.6	 11.8		 10.7
10.2		 9.3		 12.1
9.9	 6.1	 8.6		 8.4
56.9	 63.4	 76.8	 70.0	 58.1
74.8	 71.6	 82.7	 90.0	 67.4
	 better	 similar	 worse	

Disparity Among Subareas

Septicemia	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Septicemia (Age-Adjusted Death Rate)						
<p>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</p>						

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
24.2	17.4	10.8		21.6
	better	similar	worse	

Disparity Among Subareas

Sexual Health	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Chlamydia Incidence Rate						
Gonorrhea Incidence Rate						
% [Unmarried 18-64] 3+ Sexual Partners in Past Year						
% [Unmarried 18-64] Using Condoms						
HIV/AIDS (Age-Adjusted Death Rate)						

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
530.0	385.3	497.3		
131.9	91.1	145.8		
13.4		13.8		10.1
36.9		39.4		41.2
4.5	3.1	2.3	3.3	

Disparity Among Subareas

Sexual Health (continued)	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
HIV Prevalence Rate						
% [Age 18-44] HIV Test in the Past Year						
<small>Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.</small>						

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
567.4	473.7	362.3		
45.4		24.7	29.3	
	better	similar	worse	

Disparity Among Subareas

Substance Abuse	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)						
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)						
% Current Drinker	59.2	48.9	64.0	57.3	60.3	65.1
% Excessive Drinker	23.3	19.6	17.7	22.9	21.1	15.8
% Drinking & Driving in Past Month	1.7	1.6	3.6	1.8	2.4	1.3
% Illicit Drug Use in Past Month	9.6	2.6	1.9	4.4	7.8	2.6
% Ever Sought Help for Alcohol or Drug Problem	3.0	7.7	6.8	3.0	4.5	4.0
% Personally Impacted by Substance Abuse	38.7	33.2	40.5	29.0	25.4	35.0

Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
16.8	21.8	16.7	11.3	4.4
8.5	7.3	10.8	8.2	9.1
56.8	57.3	55.0		55.5
20.7		22.5	25.4	21.6
1.9	2.4	5.2		3.7
4.3		2.5	7.1	3.8
5.0		3.4		3.4
32.6		37.3		29.1

better similar worse

Disparity Among Subareas

Tobacco Use	Bergen	Paterson	Northwest	Passaic/ Clifton	Southwest	Wayne/ Southwest
% Current Smoker	15.0	17.8	10.9	12.0	14.0	10.2
% Someone Smokes at Home	7.1	16.0	9.5	11.5	11.5	8.6
% [Nonsmokers] Someone Smokes in the Home	4.5	10.5	7.0	8.1	3.7	4.9
% [Household With Children] Someone Smokes in the Home						
% [Smokers] Have Quit Smoking 1+ Days in Past Year						
% [Smokers] Received Advice to Quit Smoking						
% Currently Use Vaping Products	17.0	5.7	8.9	9.3	7.9	9.7
% Use Smokeless Tobacco	1.5	4.2	1.5	2.2	6.0	0.0
% Smoke Cigars	1.5	7.7	2.7	6.6	4.5	4.9

Note: In the green section, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

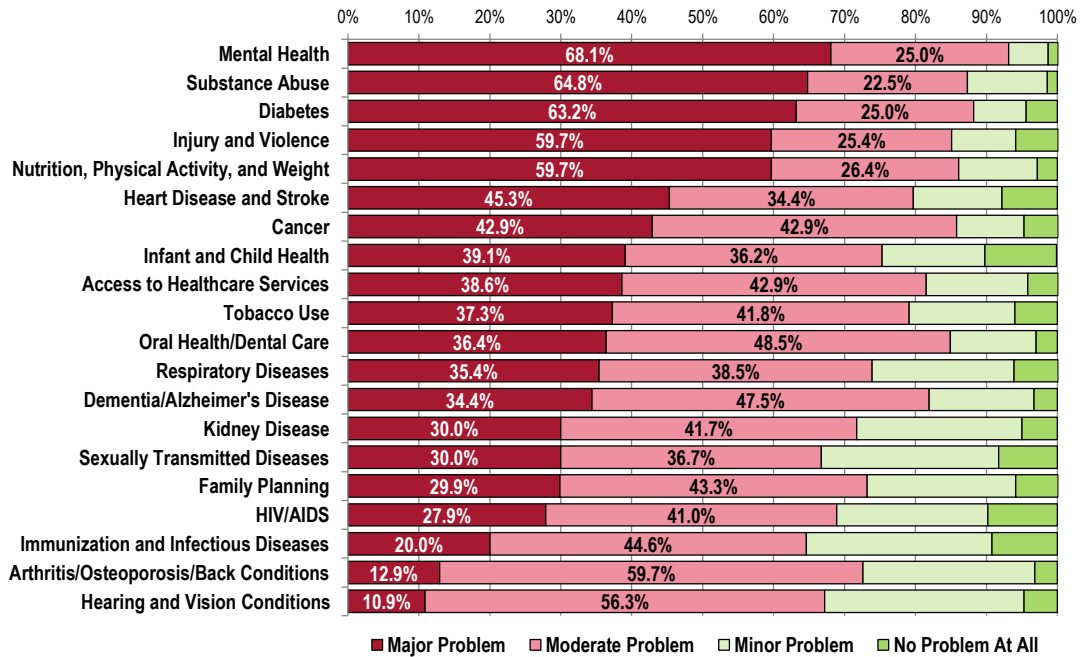
Southern Passaic County	Southern Passaic County vs. Benchmarks			TREND
	vs. NJ	vs. US	vs. HP2020	
14.0	13.7	16.3	12.0	11.2
11.9		10.7		12.3
7.5		4.0		7.1
12.9		7.2		14.4
62.1		34.7	80.0	52.2
63.4		58.0		84.2
9.0	4.4	3.8		4.8
2.8	2.1	4.4	0.2	2.5
5.6		7.5	0.3	5.2

better similar worse

Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 20 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)

Key Informants: Relative Position of Health Topics as Problems in the Community



Data Charts & Key Informant Input

The following sections present data from multiple sources, including the random-sample PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.



Community Characteristics

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
(Estimated Population, 2013-2017)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Passaic County	510,563	186.00	2,744.92
New Jersey	8,960,161	7,355.14	1,218.22
United States	321,004,407	3,532,315.66	90.88

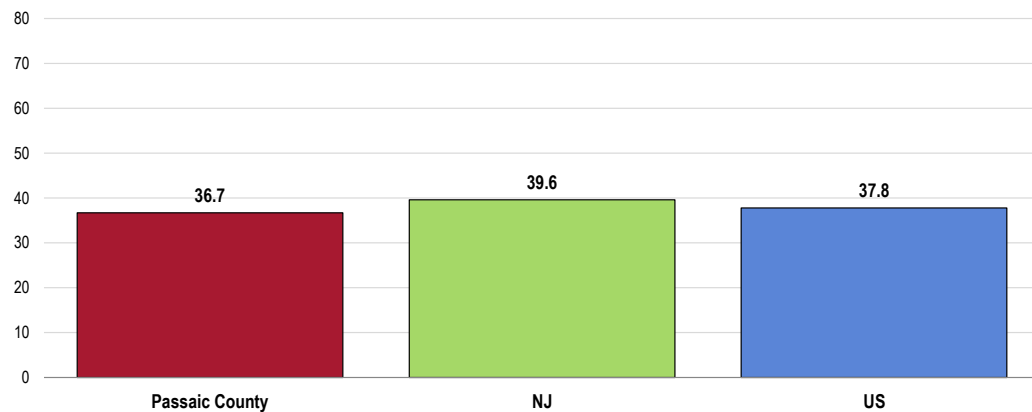
Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

Median Age
(2013-2017)



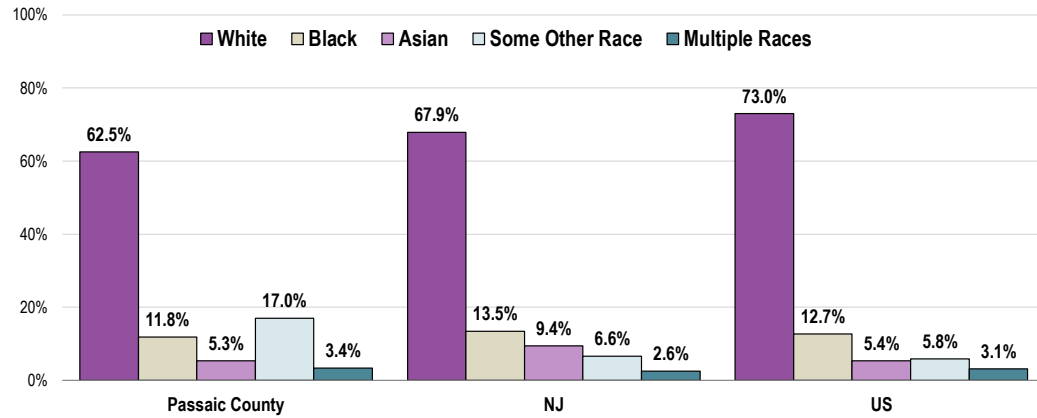
Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.

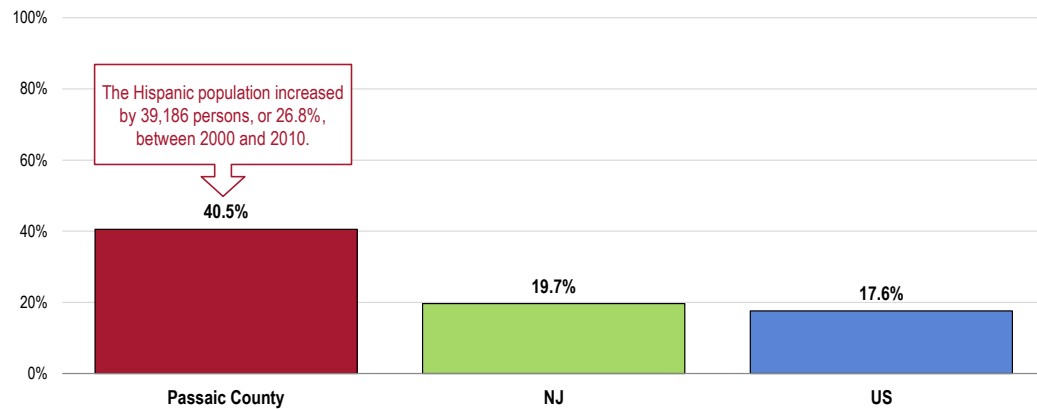
Total Population by Race Alone, Percent (2013-2017)



Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Hispanic Population (2013-2017)



Sources:

- US Census Bureau American Community Survey 5-year estimates.
- Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

 Notes:

- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

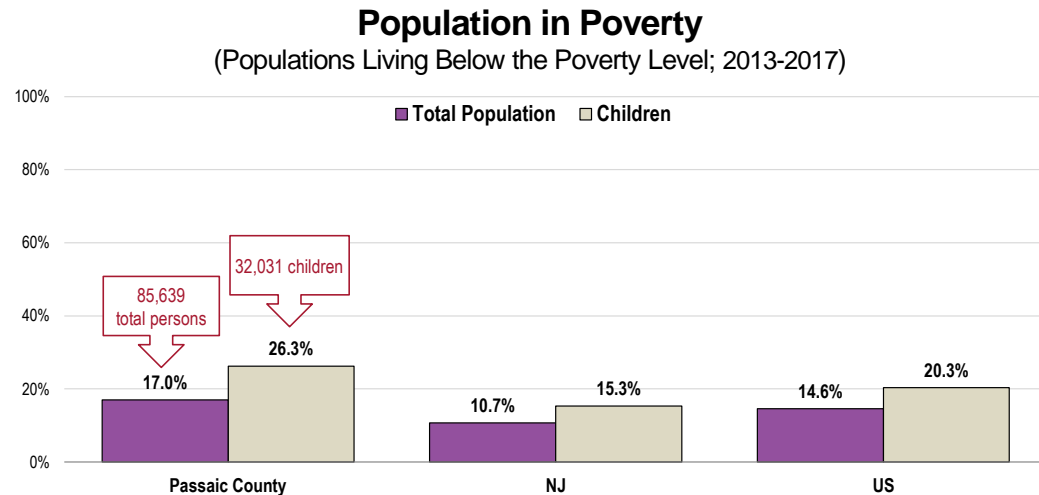
About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

— Healthy People 2020 (www.healthypeople.gov)

Poverty

The following chart outlines the proportion of our population below the federal poverty threshold, as well as below 200% of the federal poverty level, in comparison to state and national proportions.



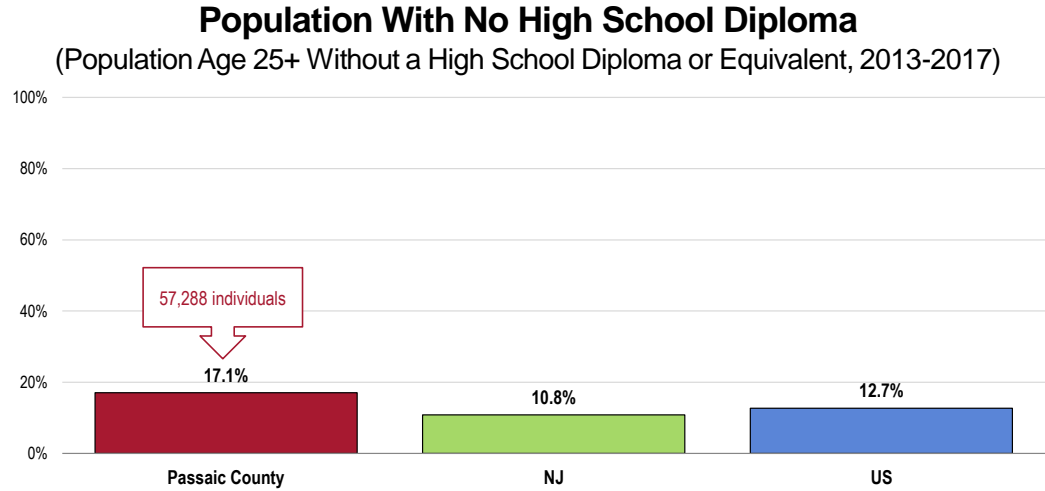
Sources: ● US Census Bureau American Community Survey 5-year estimates.

● Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Notes: ● Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Education

Education levels are reflected in the proportion of our population without a high school diploma:



Sources:

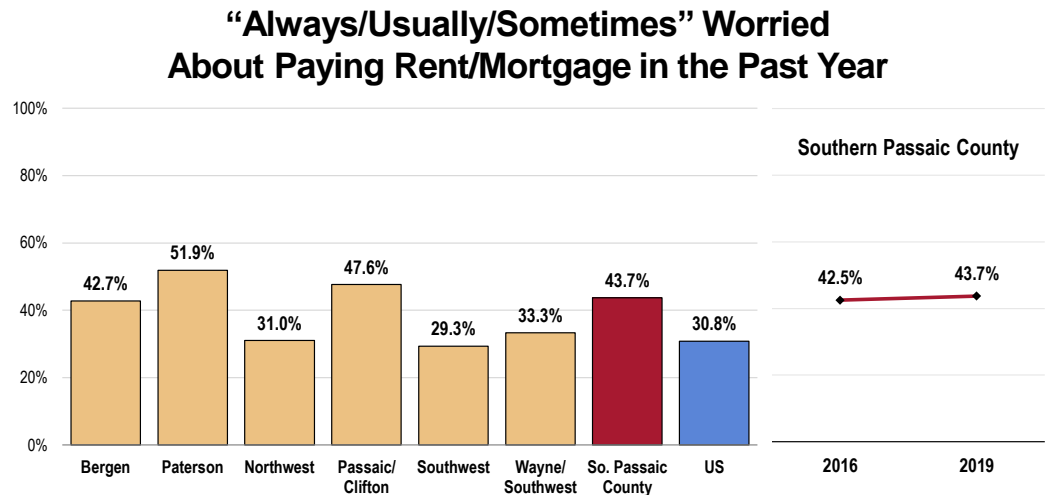
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

 Notes:

- This indicator is relevant because educational attainment is linked to positive health outcomes.

Housing Insecurity

“In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?”



Sources:

- 2019 PRC Community Health Survey, PRC, Inc. [Item 196]
- 2017 PRC National Health Survey, PRC, Inc.

 Notes:

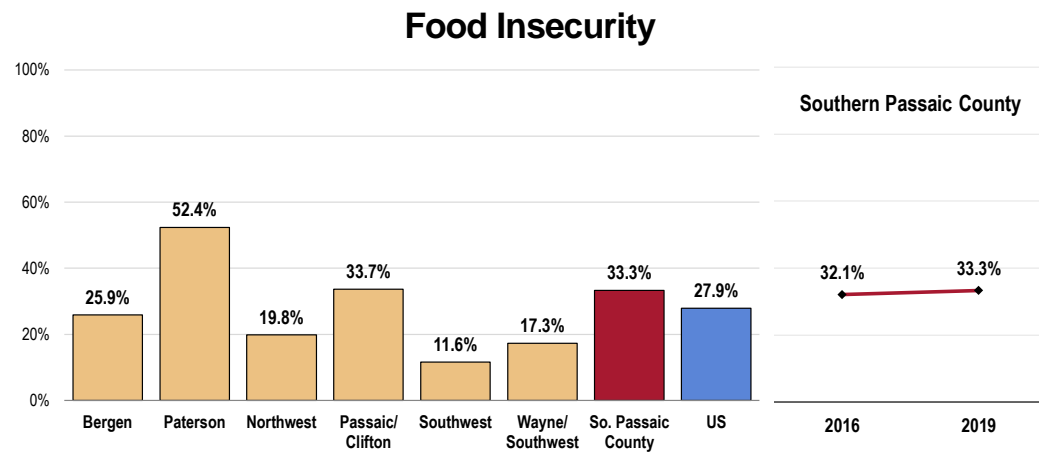
- Asked of all respondents.

Food Insecurity

“Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was ‘often true,’ ‘sometimes true,’ or ‘never true’ for you in the past 12 months.

- The first statement is: ‘I worried about whether our food would run out before we got money to buy more.’
- The next statement is: ‘The food that we bought just did not last, and we did not have money to get more.’”

Agreement with either or both of these statements (“often true” or “sometimes true”) defines food insecurity for respondents.



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 149]
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
 • Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

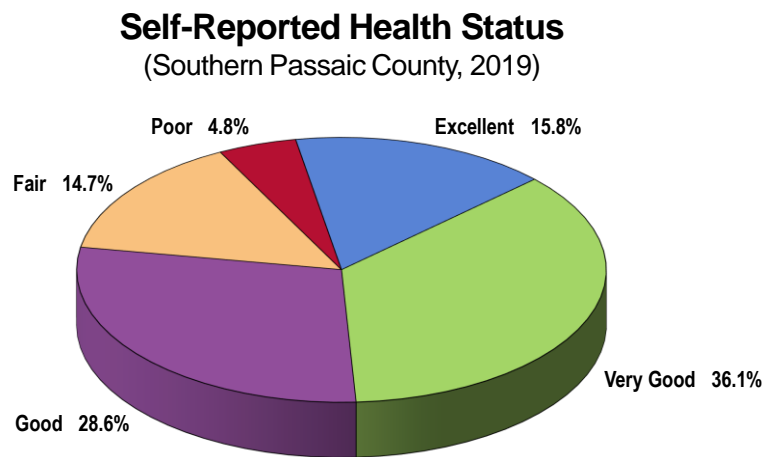
General Health Status

Overall Health Status

Self-Reported Health Status

The initial inquiry of the PRC Community Health Survey asked respondents the following:

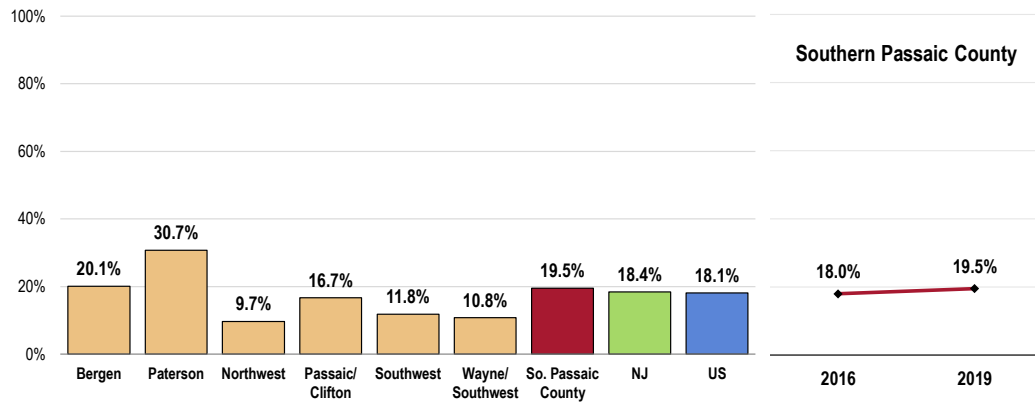
“Would you say that in general your health is: excellent, very good, good, fair, or poor?”



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

The following charts further detail “fair/poor” overall health responses in Southern Passaic County in comparison to benchmark data, as well as by basic demographic characteristics (namely by sex, age groupings, income [based on poverty status], and race/ethnicity).

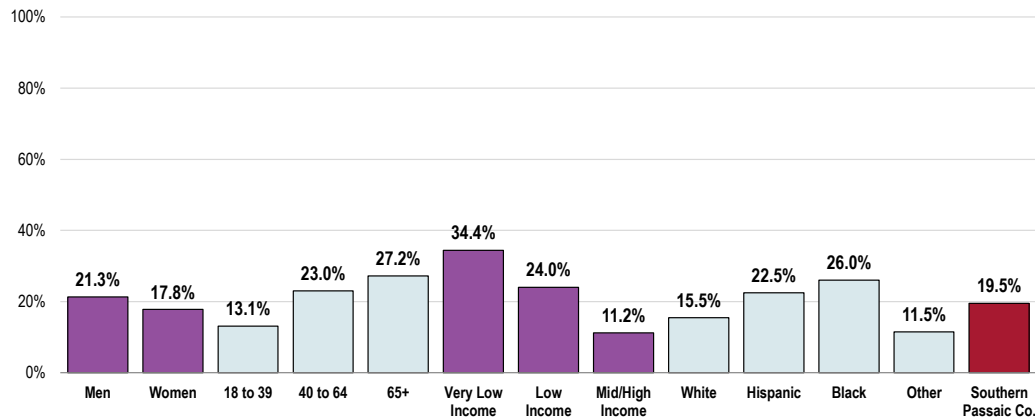
Experience “Fair” or “Poor” Overall Health



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 5]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health (Southern Passaic County, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 5]

Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Mental Health

About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

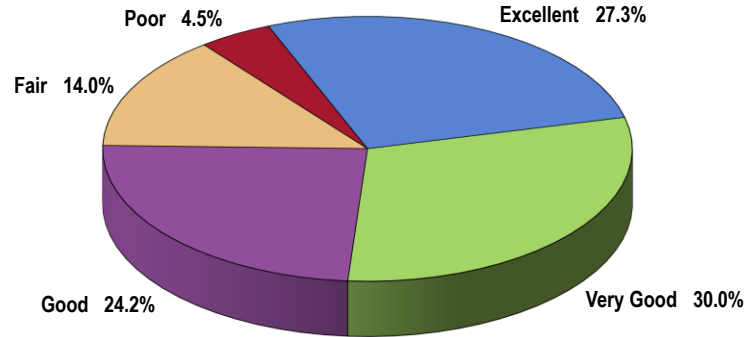
- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, and it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

— Healthy People 2020 (www.healthypeople.gov)

Self-Reported Mental Health Status

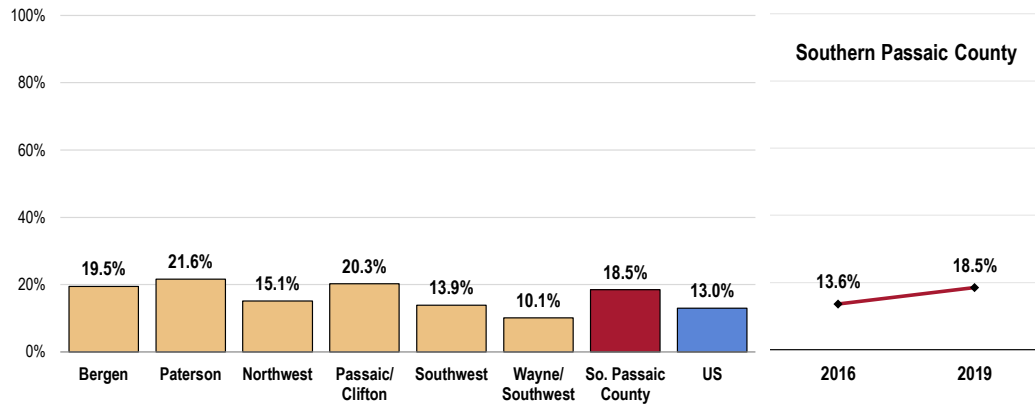
“Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?”

Self-Reported Mental Health Status (Southern Passaic County, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 99]
 Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

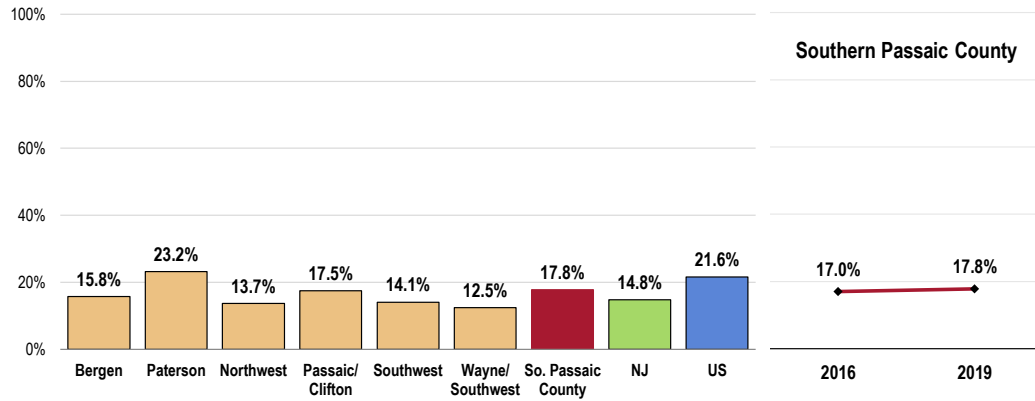


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 99]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Depression

Diagnosed Depression: “Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

Have Been Diagnosed With a Depressive Disorder

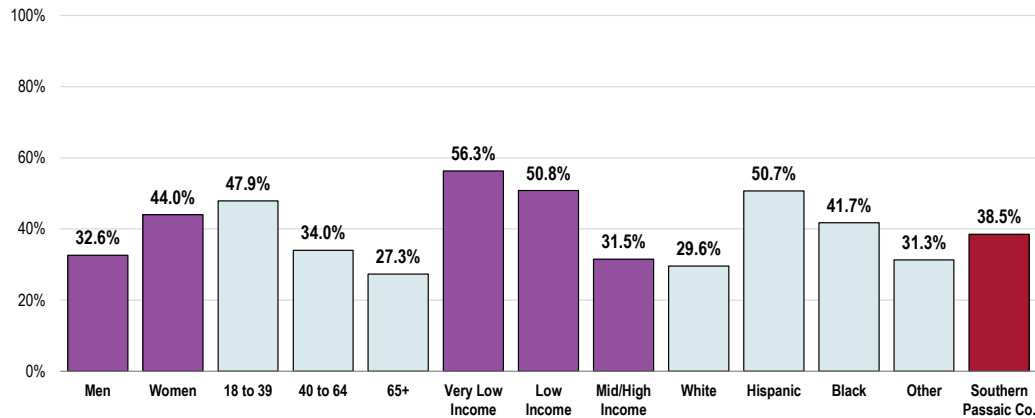


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 102]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
 • Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression: “Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?”

Have Experienced Symptoms of Chronic Depression (Southern Passaic County, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 100]

Notes: • Asked of all respondents.
 • Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

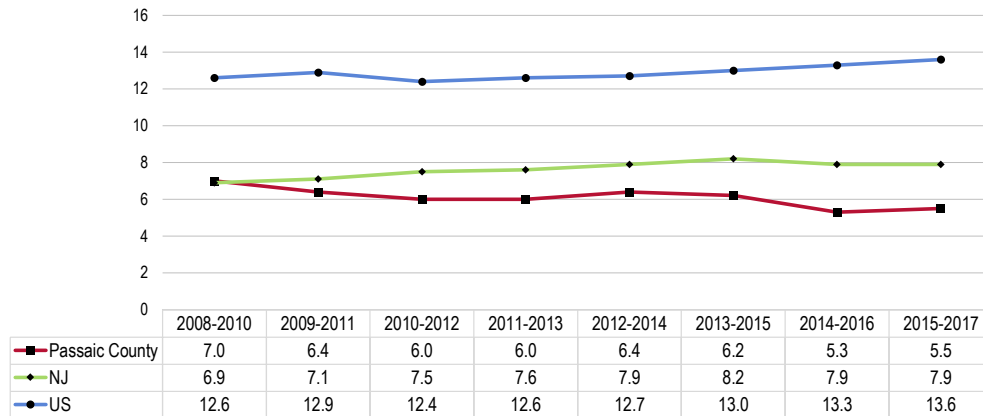
Suicide

The following chart outlines the age-adjusted mortality rates attributed to suicide in our population. (Refer to “Leading Causes of Death” for an explanation of the use of age-adjusting for these rates.)

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2020 = 10.2 or Lower

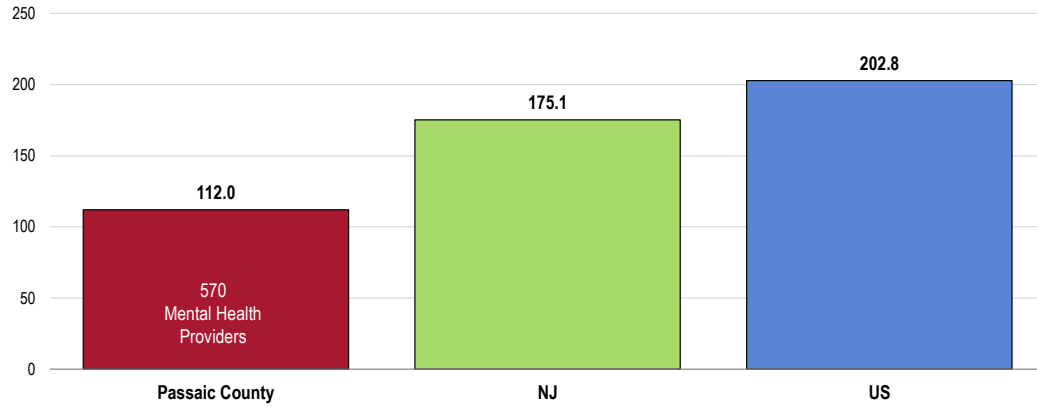


- Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MHMD-1]
- Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 - Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents.

Access to Mental Health Providers (Number of Mental Health Providers per 100,000 Population, 2018)

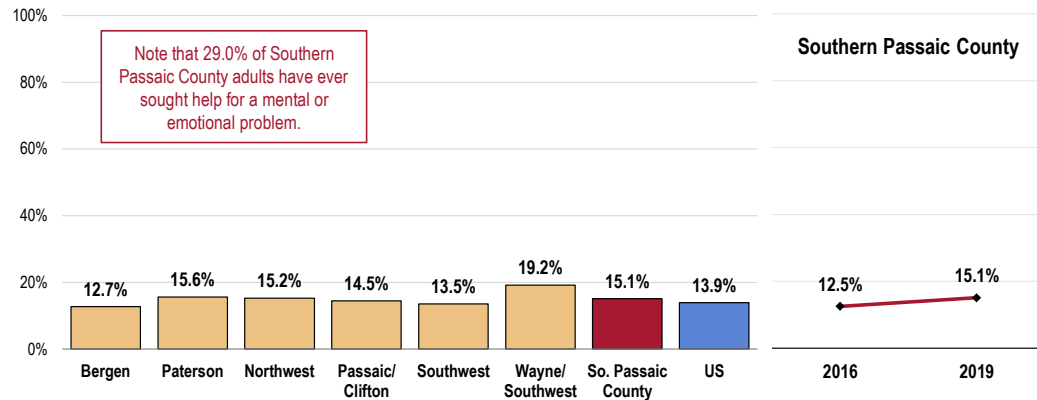


Sources: • University of Wisconsin Population Health Institute, County Health Rankings.
 • Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
 Notes: • This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

“Are you now taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?”

Have you ever sought help from a professional for a mental or emotional problem?”

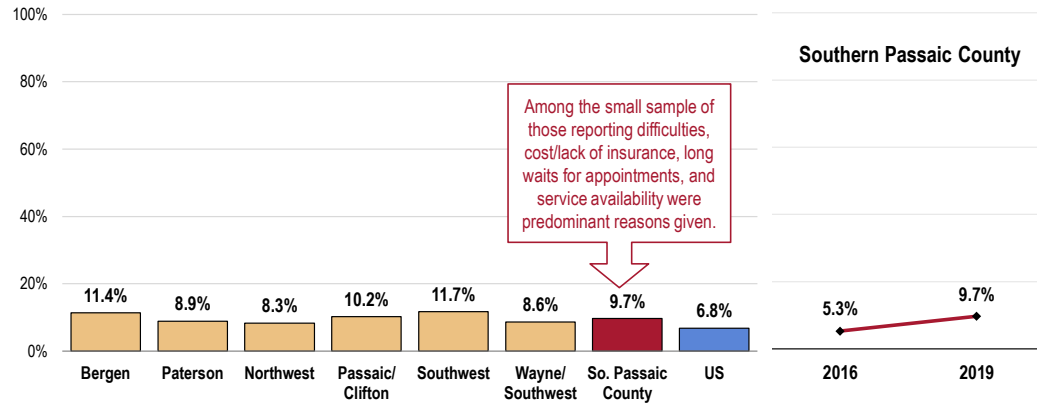
Currently Receiving Mental Health Treatment



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 103-104]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • “Treatment” can include taking medications for mental health.

“Was there a time in the past 12 months when you needed mental health services but were not able to get them?”

Unable to Get Mental Health Services When Needed in the Past Year

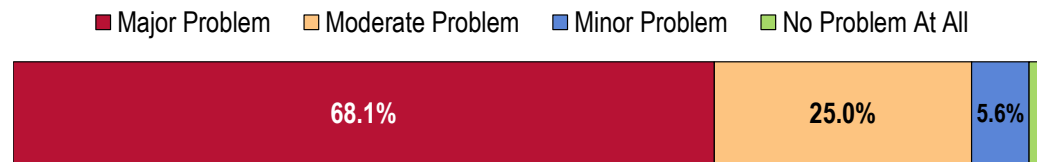


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 105-106]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental Health as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

Finding adequate care. Everyone I know with a mental health issue complains of finding a provider that they feel comfortable with. – Community/Business Leader

It seems that we have lots of unaddressed mental health issues. Getting this screened and accessed seems to be lengthy and the patient isn't always able to manage the processes. Not sure how to help them access free services. – Community/Business Leader

Access to quality mental healthcare services. – Community/Business Leader

Access to mental health services. – Community/Business Leader

Very few resources. – Community/Business Leader

The biggest challenge for people with mental health issues is access to the appropriate types of services to adequately address the need and enable people to overcome. Lack of 1:1 counseling providers who accept Medicaid and/or charity care within the community with services accessible for people when they need the service. Those in need within Paterson often have to wait for an extended period of time before they can get an appointment therefore missing the opportunity for timely service that can prevent a crisis. Many people need services for what could be considered "less severe" mental health issues such as depression, stress, anxiety, etc. They are not able to access these types of services due to lack of availability within the community, wait times, forms of acceptable payment, etc. 1:1 counseling services, if provided for patients at the time needed, could prevent escalation. Available group counseling sessions often include court-mandated participation. – Community/Business Leader

Very limited mental healthcare services, often with long waiting times and lack of affordable care. – Community/Business Leader

Rare, if any, private psychiatrist and psychologist who accepts Medicaid. Crisis center at St Joseph ER can't easily find involuntary beds in Passaic County, many times refer to other counties. Very high volume of psych patients, very high populations (compared to Bergen and neighboring counties), yet the number of private psychiatrists and psychologists are way more in neighboring counties (because of better socio-economic classes, which means patients with better insurances as opposed to the infamous state Medicaid rate of \$23 / visit for psychiatrist – do you blame them when they don't accept these patients? they end up hospitalized before they can get access to "state-run programs", addiction centers, and halfway houses, etc). – Physician

There are not enough individual mental health providers. There is a still a huge stigma associated with going to therapy, in all environments, those that have native-born Americans as well as immigrants or mixed American-born immigrant communities. I have been here a long time, but am an immigrant, and I encourage counseling all the time to people and they just don't make it a priority or don't want to make it a priority. – Community/Business Leader

Poor access to services, psychotherapy particularly. – Physician

Poor outpatient care, hard to get appointments. – Physician

Access to good treatment that is local, also more options for extensive services to include early infant mental health. More services linked to schools and head start and day care. This will allow for mental health screening and also for medical issues. We need to be more proactive so we can prevent illness and disease. – Community/Business Leader

Lack of resources, lack of understanding/ knowledge, stigma. – Community/Business Leader

One of the biggest challenges for those with mental health issues in the community is access to affordable, professional counseling. Another challenge is receiving mental health services in their primary language. With the un/under-insured it is difficult to refer any clients to resources. – Community/Business Leader

Not enough mental health clinics available in the area. Parents in our schools have difficulty getting appointments and/or there is a long wait for the clinic appointments for their children and teens. – Social Services Provider

Denial/Stigma

There is a serious stigma when it comes to acknowledging mental health or doing something to address the problem. People are ashamed to even admit any mental health issues, let alone seek out help for them, or seek out help for a family member, friend, or loved one who may be facing mental health challenges. If someone does need to get mental health support, it is usually when the situation is almost in crisis mode or the person is debilitated by their mental health issues, or someone attempts to harm themselves. If someone goes to get mental health, the truth is our mental health systems in this country are completely inaccessible even for the average person who may not be experiencing language and cultural barriers, let alone from someone who is facing both or either of these issues. Mental healthcare is inaccessible financially, and often the quality of care offered is of poor quality. The best doctors and professionals don't take Medicaid or HMOs. – Community/Business Leader

The stigma associated with mental health problems. The cost associated with getting private help. The lack of space available in agencies that can help. The ease with which individuals can sign themselves out of mental health facilities. – Other Health Provider

Their issues are either hidden or not taken seriously. – Social Services Provider

The stigma. – Community/Business Leader

Affordable Care/Services

Lack of affordable mental health services. – Public Health Representative

There is a lack of affordable services, insurance copays can be high for weekly sessions making it unaffordable or very costly. Waiting lists are common. – Other Health Provider

We have guests who seek free mental health counseling to help support their wellness and recovery. – Other Health Provider

Awareness/Education

Lack of awareness, services and the challenging laws regarding mental health issues. – Community/Business Leader

People lack knowledge and feel like a stigma attached to it. Insurance coverage is not enough. – Community/Business Leader

Lack of available information. – Other Health Provider

Diagnosis/Treatment

Based on my experience, it seems most people who have tried to get help, don't get the help they really need. Mental health treatment seems like a fast-moving revolving door. – Social Services Provider

So many people are undiagnosed, and it creates problems for the people in the community. There is a lot of fear. – Community/Business Leader

Many residents on the spectrum, undiagnosed or not receiving proper care and therapy. – Social Services Provider

Insurance Issues

Too many people lack insurance for long term care. Mental health requires more than one visit to the doctor. Medications should be administered and monitored by professionals that see mental wellbeing as an ongoing way of life. – Community/Business Leader

Insurance issues. – Physician

Homelessness

The homelessness in certain towns is an indicator of the mental health issues. Generally, a high percentage of homeless people has a mental issue that has gone undiagnosed. – Community/Business Leader

Panhandlers are taking over my community. As soon as you enter into Paterson, NJ, that's what you see. Those are people who suffer from mental illness as well as others. – Community/Business Leader

Social Isolation

Social isolation, especially among the seniors and marginalized. Children are physically alone more than in previous generations. There is a lack of community engagement and talking over the fence, fear and distrust keeps people indoors. – Social Services Provider

Lack of Providers

Shortage of licensed psychiatrists and psychologists practicing in Paterson and Passaic. – Community/Business Leader

Language/Culture

I think that finding care that is in their language and sensitive to the cultural needs as well as that accepts Medicaid or serves undocumented patients. – Social Services Provider

Poverty

Poverty, poor-health lifestyle. – Physician

Housing Issues

Housing. – Other Health Provider

Self-harm

Young girls, self-mutilation. – Physician

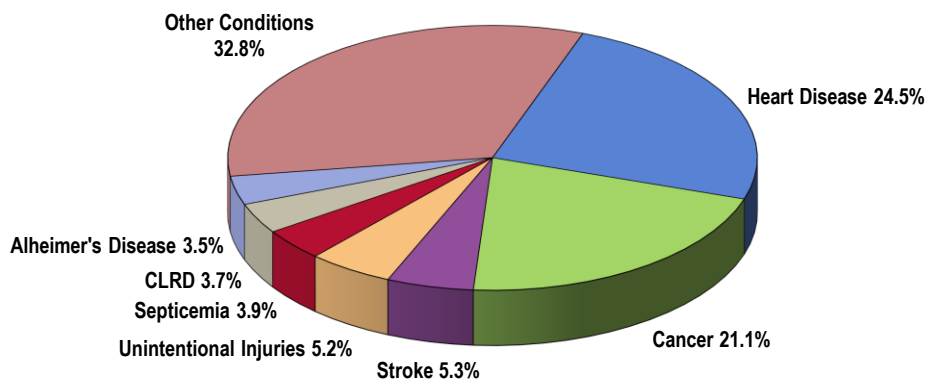
Death, Disease & Chronic Conditions

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and cardiovascular disease (heart disease and stroke) are leading causes of death in the community.

Leading Causes of Death
(Passaic County, 2015-2017)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

About Age-Adjusted Death Rates

In order to compare mortality in the region with other localities (in this case, New Jersey and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2020 objectives.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in Passaic County. (For infant mortality data, see also *Birth Outcomes & Risks* in the **Births** section of this report.)

Age-Adjusted Death Rates for Selected Causes (2015-2017 Deaths per 100,000 Population)

	Passaic County	New Jersey	US	HP2020
Diseases of the Heart	162.1	164.6	166.3	156.9*
Malignant Neoplasms (Cancers)	142.2	148.4	155.6	161.4
Unintentional Injuries	34.1	40.6	46.7	36.4
Fall-Related Deaths (65+)	33.9	30.1	62.1	47.0
Cerebrovascular Disease (Stroke)	31.3	30.6	37.5	34.8
Chronic Lower Respiratory Disease (CLRD)	25.8	28.7	41.0	n/a
Diabetes Mellitus	23.0	17.5	21.3	20.5*
Alzheimer's Disease	19.2	21.5	30.2	n/a
Drug-Induced	16.8	21.8	16.7	11.3
Kidney Diseases	14.4	14.0	13.2	n/a
Pneumonia/Influenza	12.0	11.6	14.3	n/a
Cirrhosis/Liver Disease	8.5	7.3	10.8	8.2
Motor Vehicle Deaths	5.9	6.5	11.4	12.4
Intentional Self-Harm (Suicide)	5.5	7.9	13.6	10.2
Firearm-Related	5.2	5.4	11.6	9.3
Homicide	4.5	4.4	6.0	5.5
HIV/AIDS	4.5	3.1	2.3	3.3

Sources:

- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.

- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>.

Note:

- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.

- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than \$500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

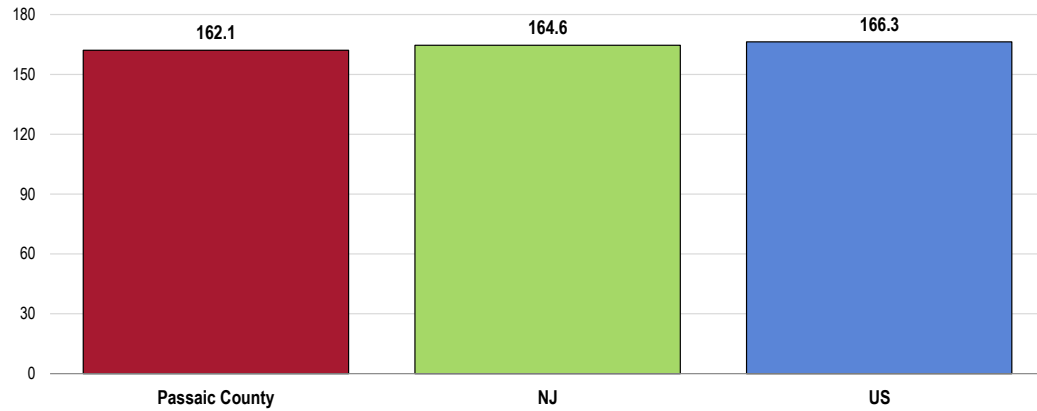
Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community.

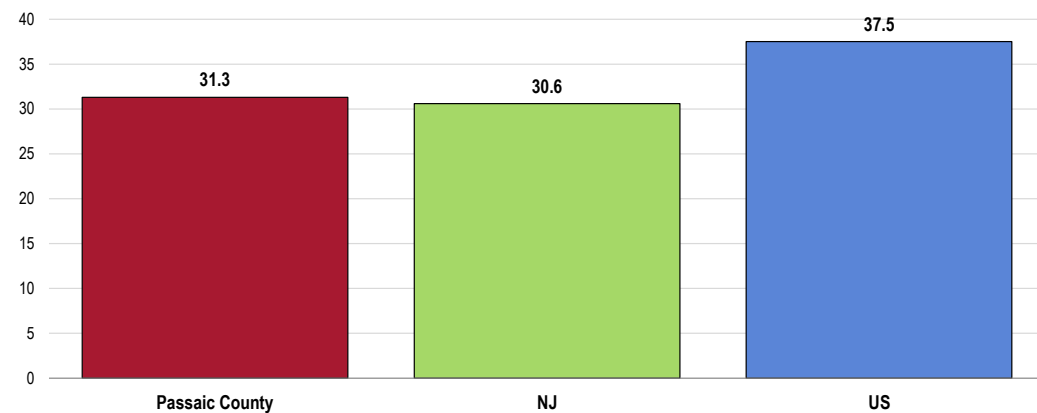
Heart Disease: Age-Adjusted Mortality (2015-2017 Annual Average Deaths per 100,000 Population) Healthy People 2020 = 156.9 or Lower (Adjusted)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-2]

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
● The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality (2015-2017 Annual Average Deaths per 100,000 Population) Healthy People 2020 = 34.8 or Lower



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective HDS-3]

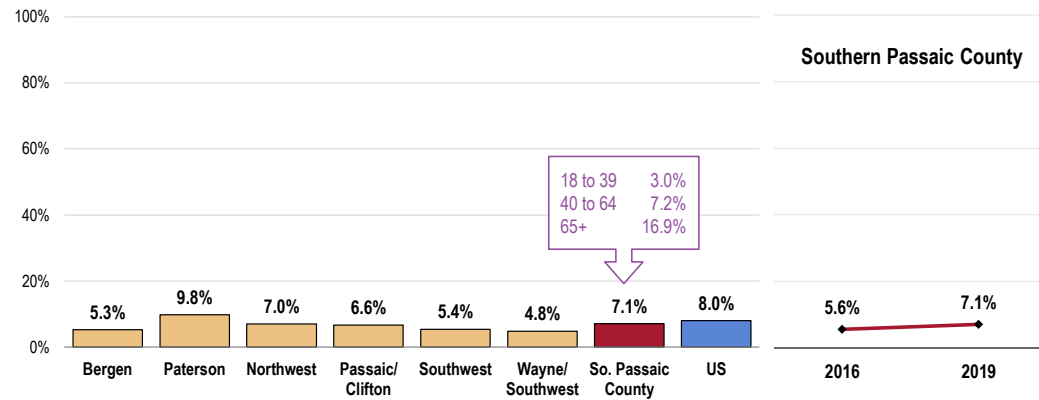
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

“Has a doctor, nurse, or other health professional ever told you that you had: a heart attack, also called a myocardial infarction; or angina or coronary heart disease?” (Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.)

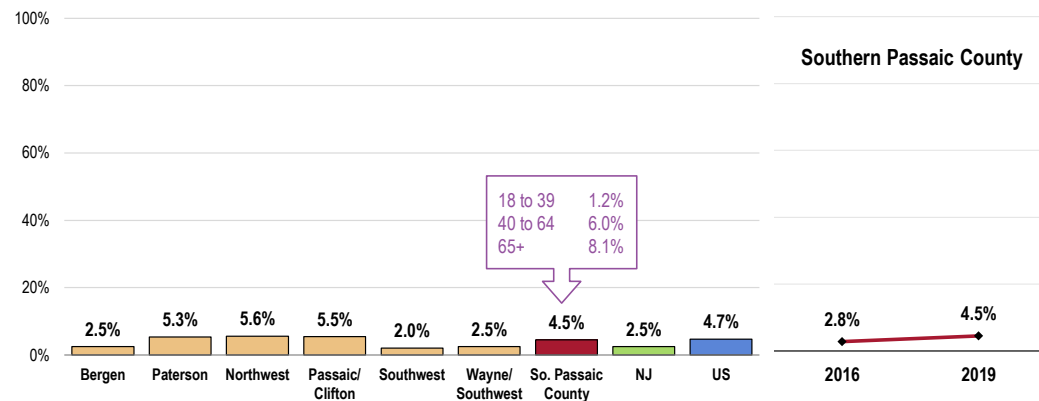
“Has a doctor, nurse, or other health professional ever told you that you had a stroke?”

Prevalence of Heart Disease



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 128]
 - 2017 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.
 - Includes diagnoses of heart attack, angina, or coronary heart disease.

Prevalence of Stroke



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 33]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 - 2017 PRC National Health Survey, PRC, Inc.
- Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

About Cardiovascular Risk

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

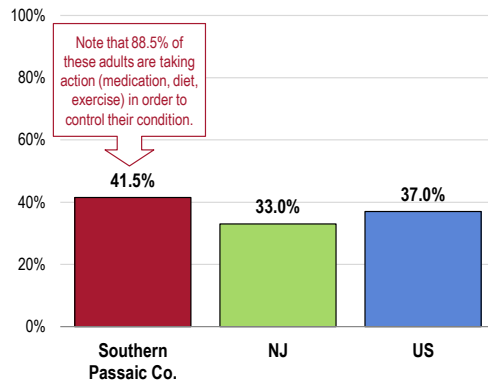
— Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure & Cholesterol Prevalence

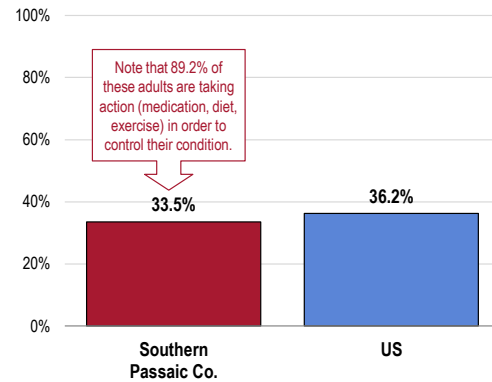
“Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?”

“Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?”

Prevalence of High Blood Pressure
Healthy People 2020 = 26.9% or Lower



Prevalence of High Blood Cholesterol
Healthy People 2020 = 13.5% or Lower



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Items 41, 44, 129-130]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 - 2017 PRC National Health Survey, PRC, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives HDS-5.1, HDS-7]
- Notes:
- Asked of all respondents.

About Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

— National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US.

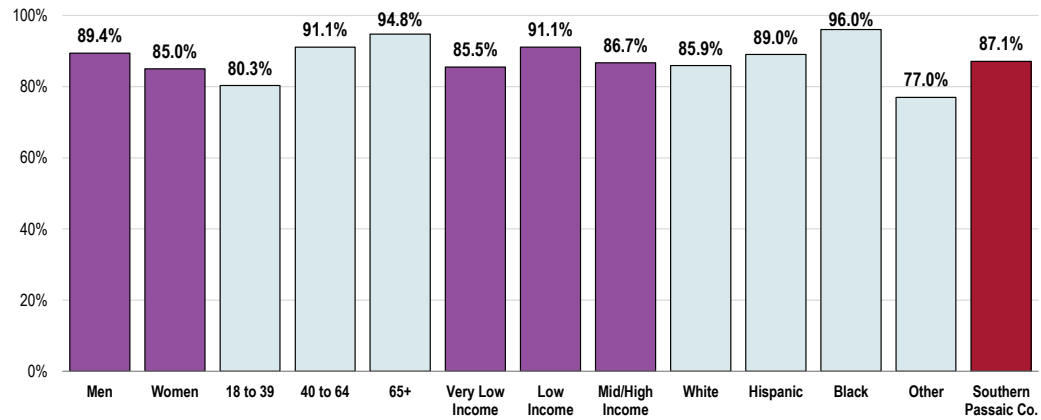
Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

— National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Total Cardiovascular Risk

The following chart reflects the percentage of adults in Southern Passaic County who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol. See also *Nutrition*, *Physical Activity*, *Weight Status*, and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

Present One or More Cardiovascular Risks or Behaviors (Southern Passaic County, 2019)

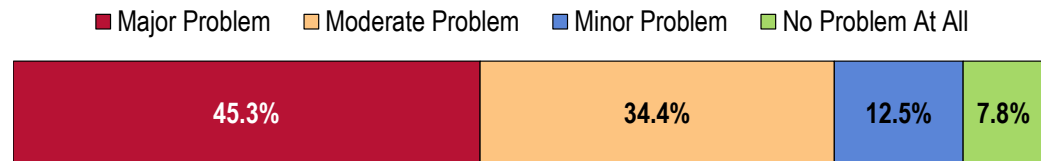


Sources: ● 2019 PRC Community Health Survey, PRC, Inc. [Item 131]
 Notes: ● Reflects all respondents.
 ● Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

Perceptions of Heart Disease and Stroke as a Problem in the Community (Key Informants, 2019)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
 Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

- Heart disease and stroke is high in the urban areas also. – Community/Business Leader
- Prevalence of the disease. – Physician
- Many people have these diseases. – Other Health Provider
- I've heard of several people who had strokes at a relatively young age. – Community/Business Leader
- High number of residents, lifestyles, lack of information. – Community/Business Leader

Contributing Factors

The access to and prioritizing of preventative healthcare and prioritizing of health before a health emergency or dire diagnosis just does not happen. Healthy diet and nutrition are also neglected in our community due to a lack of education about the importance of food choices and exercise. This couples with Paterson not always having healthy choices and safe, beautiful areas to walk around in and only exacerbates the situation. Hypertension and high blood pressure are pandemic in our community, and people may take medication after the fact, but the underlying causes of diet, exercise, stress management etc. are not being implemented or addressed. People are so busy with making ends meet, taking care of children, ensuring they have enough money to pay the bills, that prioritizing health before an emergency or the onset of heart disease just doesn't happen. This builds up until people die from stroke or heart attacks or become disabled or debilitated due to it. – Community/Business Leader

Affordability and access to healthy food options and physical activity as well as smoking, alcohol use, and rates of substance as well as cultural norms, race, ethnicity, and hereditary factors all increase risk and rates of Heart Disease and Stroke in the community. – Community/Business Leader

High stress, lack of services, poverty, fear, lack of healthy foods and nutritional knowledge, lack of exercise. – Community/Business Leader

Comorbidities

Prevalence of metabolic diseases. – Physician

Lots of people with high blood pressure, high cholesterol and obesity. – Community/Business Leader

Again, there is a correlation between diabetes and heart disease. There is a correlation between the lack of exercise and heart disease. There is a correlation between high blood pressure and strokes. I don't know that this emphasized ... especially in minority communities – Community/Business Leader

Early Diagnosis/Prevention

People are not being treated for conditions that lead up to heart disease and stroke. Poor eating habits. Not enough exercise. Lack of proper insurance and treatment. – Community/Business Leader

Access to Healthy Food

Most of the low-income individuals I deal with cannot afford a healthy diet resulting in a greater incidence of the disease. – Community/Business Leader

Lifestyle

Uneducated, poor, unhealthy lifestyle and diet with drugs and alcohol and obesity. – Physician

Genetics and lifestyle factors. – Public Health Representative

Vulnerable Populations

The demographics of the area reflect low income and minority populations that are at greater risk for heart disease and stroke. There is a lack of timely access to care and compliance with medication management among the population. Lifestyles contribute with stress, lack of exercise and smoking. – Social Services Provider

Aging Population

Wanaque has a substantial elderly population, many of whom have limited access to care, lack of transportation and financial difficulties. There is a lack of sidewalks in neighborhoods affecting activity limitations. – Other Health Provider

Nutrition

Poor dietary habits. – Other Health Provider

Cancer

About 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 five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), 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.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

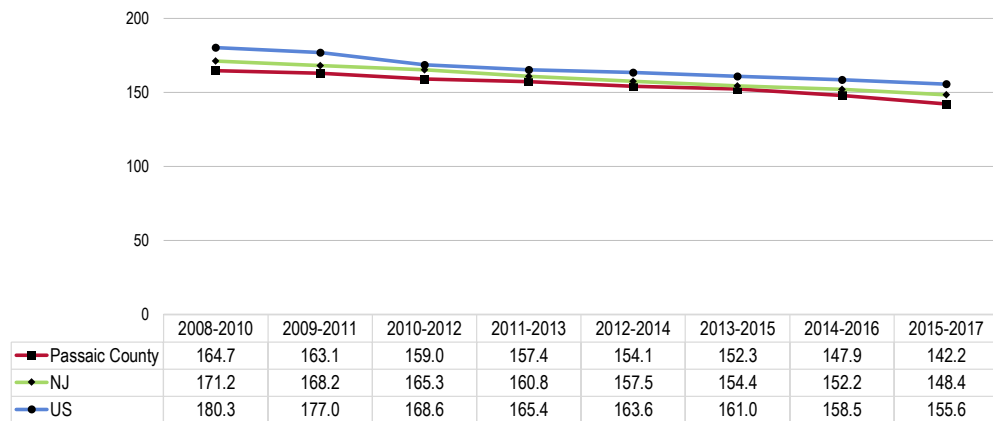
- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in Passaic County.

Cancer: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 = 161.4 or Lower



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective C-1]

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Lung cancer is by far the leading cause of cancer deaths in Passaic County. Other leading sites include breast cancer among women, prostate cancer among men, and colorectal cancer (both sexes).

Age-Adjusted Cancer Death Rates by Site (2015-2017 Annual Average Deaths per 100,000 Population)

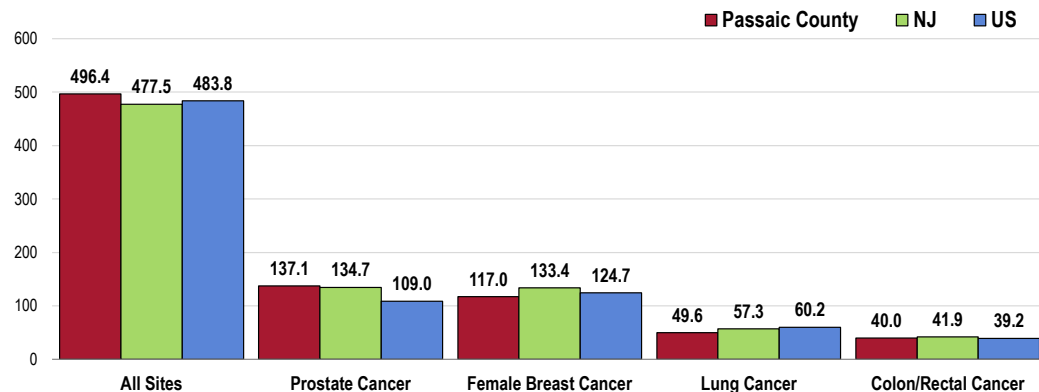
	Passaic County	New Jersey	US	HP2020
ALL CANCERS	142.2	148.4	155.6	161.4
Lung Cancer	27.1	33.4	38.5	45.5
Female Breast Cancer	19.9	20.7	20.1	20.7
Prostate Cancer	18.4	17.3	18.9	21.8
Colorectal Cancer	13.9	14.0	13.9	14.5

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov>

Cancer Incidence

Incidence rates (or case rates) reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. They usually are expressed as cases per 100,000 population per year. These rates are also age-adjusted.

Cancer Incidence Rates by Site (Annual Average Age-Adjusted Incidence per 100,000 Population, 2011-2015)



Sources: • State Cancer Profiles.
 • Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
 Notes: • This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

About Cancer Risk

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

— National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Female Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years.

Colorectal Cancer

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

— US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

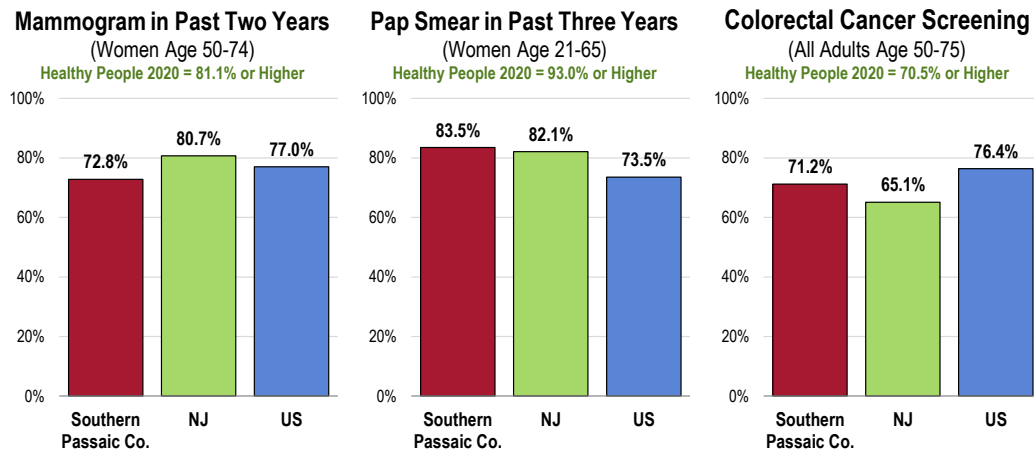
Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Breast Cancer Screening: “A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?” (Calculated here among women age 50 to 74 who indicate screening within the past 2 years.)

Cervical Cancer Screening: “A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?” (Calculated here among women age 21 to 65 who indicate screening within the past 3 years.)

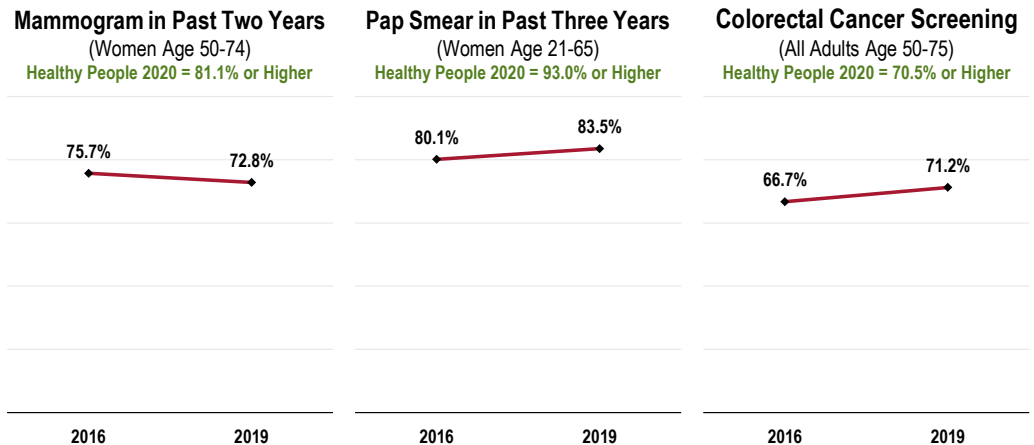
Colorectal Cancer Screening: “Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?” and “A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?” (Calculated here among both sexes age 50 to 75 who indicated fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years.)

Cancer Screenings



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 133, 134, 137]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2016 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives C-15, C-16, C-17]
 Notes: • Each indicator is shown among the gender and/or age group specified.

Cancer Screenings: Southern Passaic County Trends

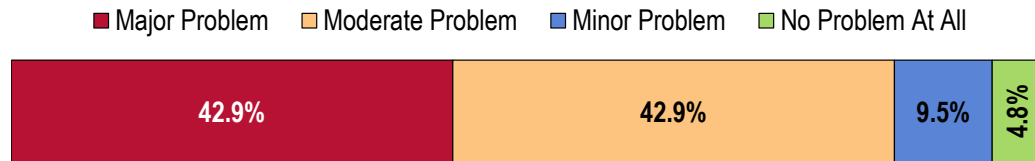


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 133, 134, 137]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objectives C-15, C-16, C-17]
 Notes: • Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The following chart outlines key informants’ perceptions of the severity of *Cancer* as a problem in the community:

**Perceptions of Cancer
as a Problem in the Community**
(Key Informants, 2019)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

- I have too many friends who have had cancer. – Other Health Provider*
- Spans a wide range of ages, occurs in many different forms. Root causes not always known, may be triggered by environmental issues over which average person has no control, frequently diagnosed at advanced stage. – Community/Business Leader*
- I personally know many people who have cancer or are in remission. I hear the treatment is expensive and so are the medications. The working poor don’t get “deals” on medicines and have to use generic or meds their insurance approves (not necessarily the ones their doctor recommends). – Other Health Provider*
- More people are diagnosed with cancer than the years prior. – Other Health Provider*
- Don’t know why, but Clifton’s breast and colorectal cancer rates are higher than the average of the national 500-Cities project. – Other Health Provider*
- Because it affects so many people, in addition, there is little programming regarding cancer prevention. It all seems to be about treatment options once the condition occurs. – Social Services Provider*
- Prevalence of cancer and treatment effects on patients and families. – Physician*

Early Diagnosis/Prevention

- Poor screening practices. – Physician*
- People are not proactive. Not diagnosed early enough. Lack of information. No healthcare coverage. – Community/Business Leader*
- Many do not receive yearly medical exams or know warning signs. The lack of female health screening for the poor and marginalized is a big concern. – Community/Business Leader*

Diagnosis/Treatment

- Our particular hospital is not good at oncology. They usually end up going to Sloan or Hackensack for their treatment and I don’t blame them. – Physician*
- I believe that quality of consistent care, education about the condition, discussion about and access to emotional support are limited. – Community/Business Leader*

Access to Care/Services

We don't have a "cancer institute" (like John Thulner Cancer center in HUMC, Bergen or Sloan, etc.) only few private, solo oncologists, overwhelmed with volume of patients. Majority of patients are Medicaid, and specialists can't afford to spend the time they need with each patient because of very low reimbursement rates and increasing overhead costs. For example, are you aware of the amount of work needed per patient to meet the "meaningful use" requirements by State of NJ? Also, Medicaid HMOs plays the game of "you bill too many high E&M codes, compared to your colleagues" – typically 18 to 36 month later, to discourage doctors of billing higher codes to make up for the time and cost they spend, ask doctor to forward records of all encounters before paying and always trying to down-code visits so that insurance can maximized their profits (this applies to all specialties and primary care). – Physician

Awareness/Education

Lack of education helps the non-importance of not knowing the importance of having doctor visits for physical checks ups could help make cancer a major problem in the community. – Other Health Provider

Nutrition

It is my belief that cancer is a major problem in the community because of poor dietary habits as well as poor living conditions that could exacerbate health issues which in turn could lead to the development of various types of cancers. – Other Health Provider

Lack of Providers

Not enough good oncologists and programs. – Other Health Provider

Tobacco Use

High level of smoking and unhealthy living habits. – Community/Business Leader

Contributing Factors

Both lifestyle, environmental, and genetic factors. – Public Health Representative

Respiratory Disease

About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

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

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

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at \$20.7 billion.

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

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

— Healthy People 2020 (www.healthypeople.gov)

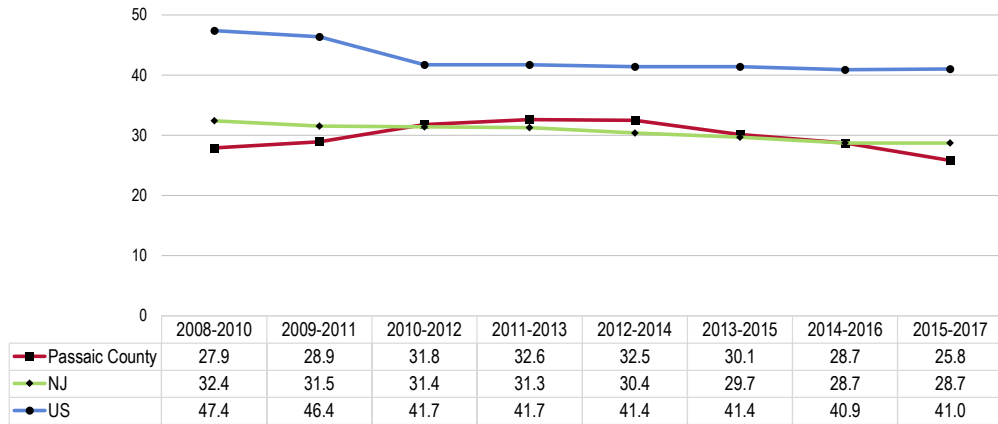
[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.

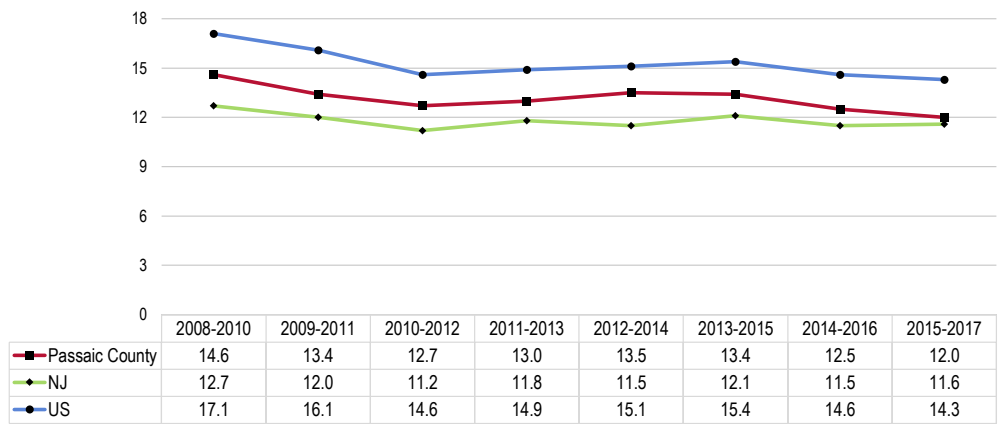
Pneumonia and influenza mortality is also illustrated.

CLRD: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



- Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
- Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
● CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)



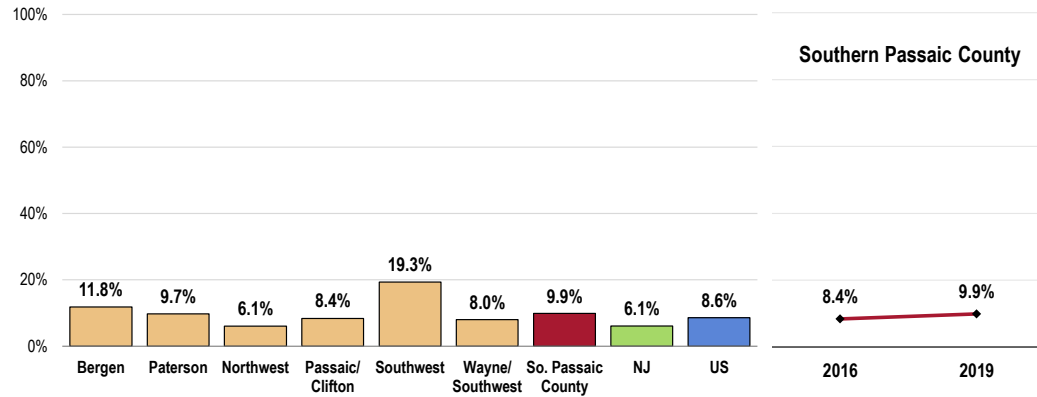
- Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
- Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Respiratory Diseases

COPD

“Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?”

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 24]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.

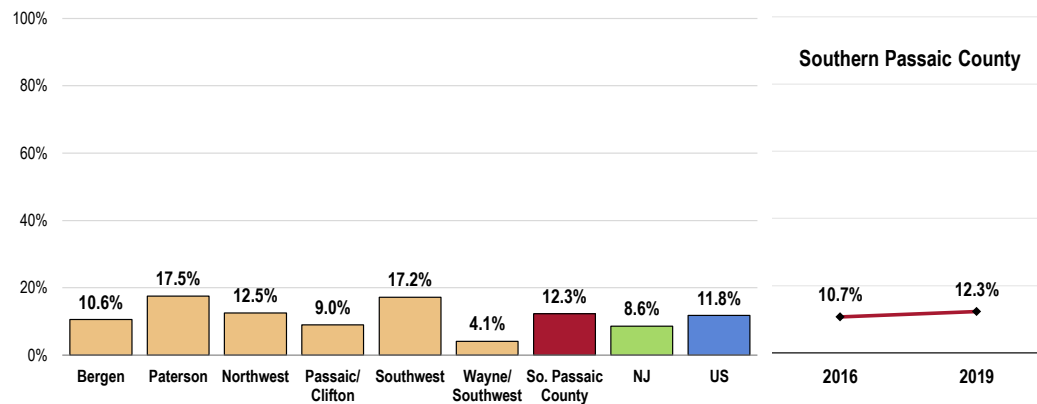
Notes: • Asked of all respondents.
 • Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.
 • Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Asthma

Adults: “Have you ever been told by a doctor, nurse, or other health professional that you had asthma?” and “Do you still have asthma?” (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

Children: “Has a doctor or other health professional ever told you that this child had asthma?” and “Does this child still have asthma?” (Calculated here as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma.)

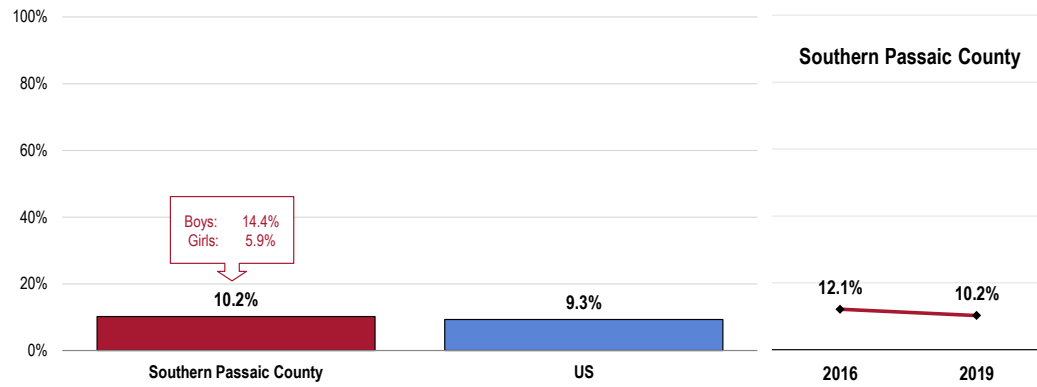
Prevalence of Asthma



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 138]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.
 • Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

Prevalence of Asthma in Children (Parents of Children Age 0-17)

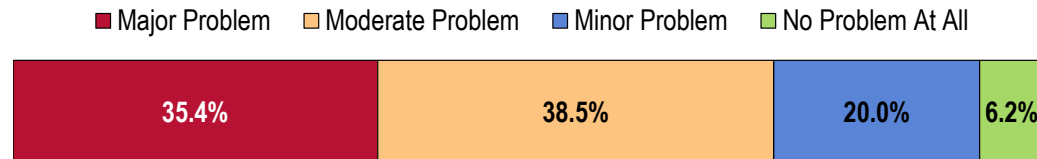


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 139]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.
 • Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

Key Informant Input: Respiratory Disease

The following chart outlines key informants’ perceptions of the severity of *Respiratory Disease* as a problem in the community:

Perceptions of Respiratory Diseases as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Environmental Contributors

- Automobile congestion and poorly ventilated heating systems or lack of temperature control. – Social Services Provider
- Air Quality. Cars and trucks, factories, insecticides. – Social Services Provider
- Environment issues such as poor air quality leads to asthma which is prevalent in urban areas. – Community/Business Leader

Pollution in Paterson and environmental toxins are probably a key part of this. Also, many men in the community smoke so that also is an issue that leads to respiratory problems. As I mentioned before there is a lack of preventative care before respiratory problems exist, so by the time someone seeks care it's usually when the health condition has already gotten pretty bad. Also, some of the homes with illegal units or units that aren't up to standards may have poor ventilation, especially if people reside in basement units or apartment units are overpopulated, which is common; multiple people can live in the same space, extended relatives often live with a family. – Community/Business Leader

Air quality in New Jersey. – Community/Business Leader

The air quality is really poor, and lots of people have asthma. – Community/Business Leader

Contributing Factors

Smoking, poor housing ventilation. – Physician

Smokers, mold, filth, poverty, insurance issues. – Physician

Access to healthcare, unhealthy homes, lead, mold, etc. Old buildings, brown areas with contamination, lead and other problems with plumbing. – Community/Business Leader

Prevalence/Incidence

So many people showing symptoms. – Social Services Provider

Data that Paterson is a known asthma corridor. – Community/Business Leader

Tobacco Use

Prevalence of smoking. – Physician

Smoking. – Community/Business Leader

Injury & Violence

About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

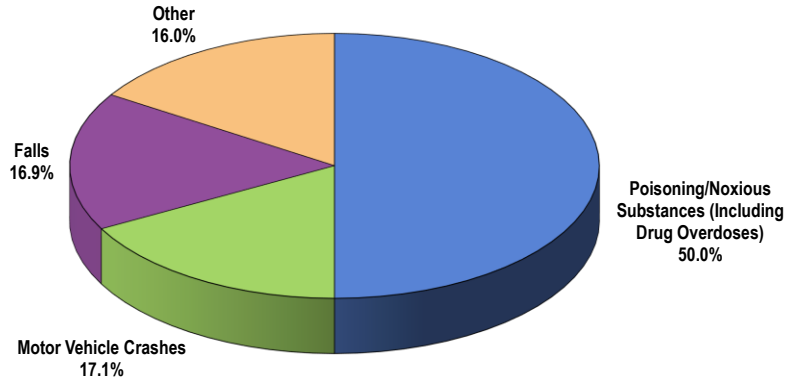
- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

— Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Leading causes of accidental death in Passaic County include the following:

Leading Causes of Unintentional Injury Deaths (Passaic County, 2015-2017)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
 Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

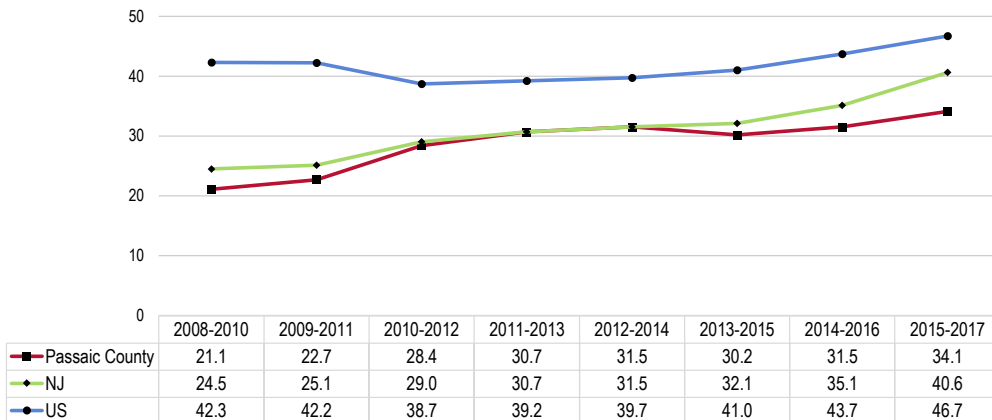
Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in Passaic County.

Unintentional Injuries: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

Healthy People 2020 = 36.4 or Lower



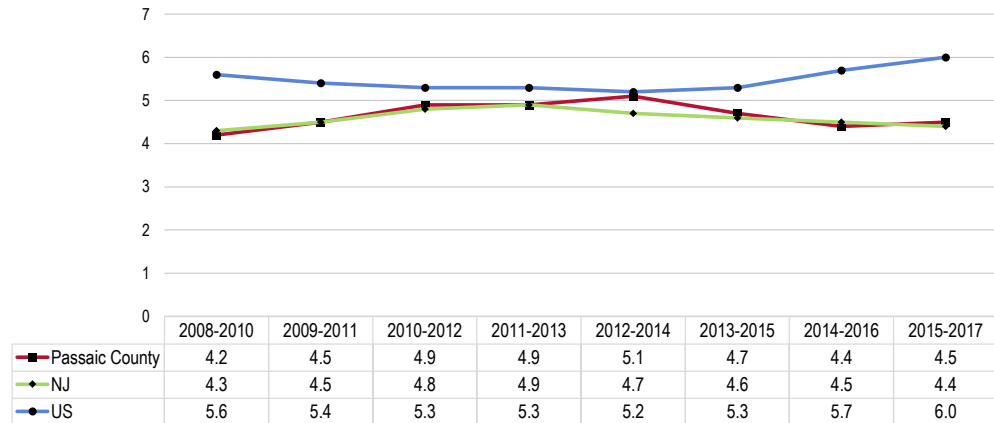
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-11]
 Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 ● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Intentional Injury (Violence)

Homicide

Age-adjusted mortality attributed to homicide is shown in the following chart.

Homicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 = 5.5 or Lower



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.

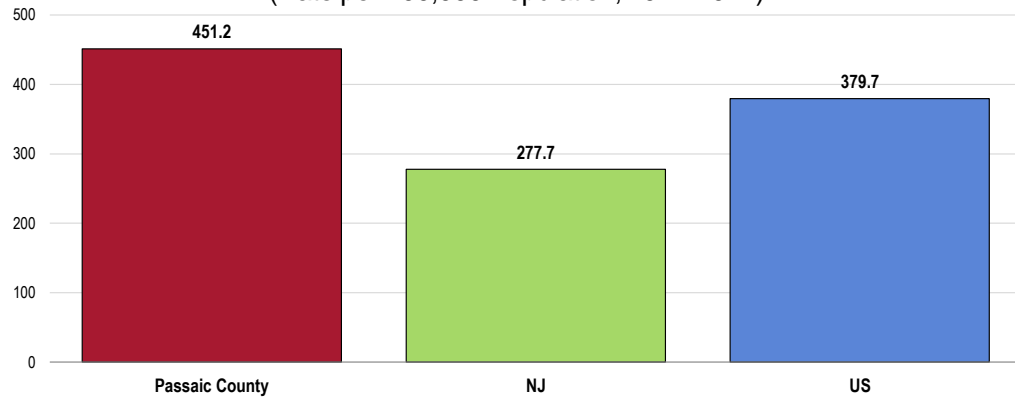
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective IVP-29]
 Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 ● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault. Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime

(Rate per 100,000 Population, 2012-2014)

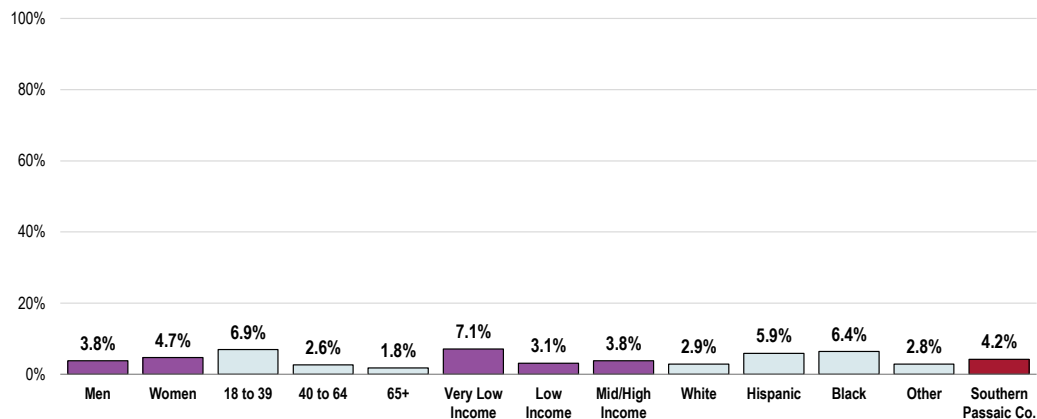


- Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
 - Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
- Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
 - Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Violent Crime Experience: “Have you been the victim of a violent crime in your area in the past 5 years?”

Victim of a Violent Crime in the Past Five Years

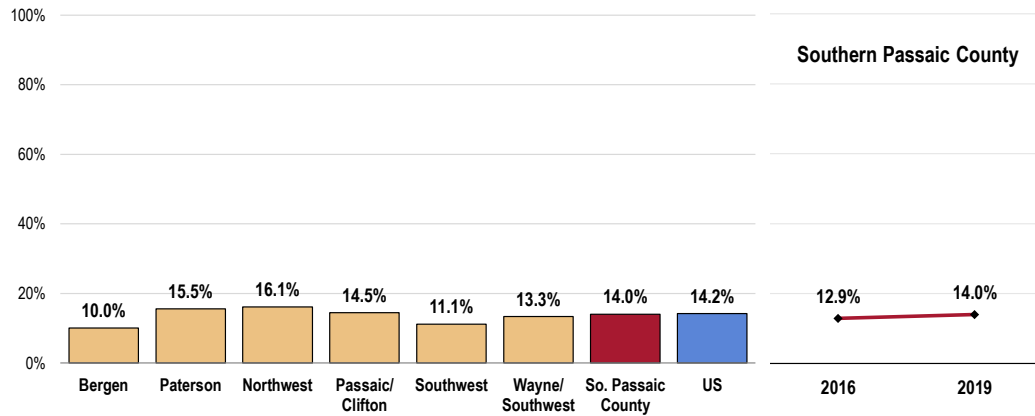
(Southern Passaic County, 2019)



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 46]
- Notes:
- Asked of all respondents.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 - Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Intimate Partner Violence: “The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?”

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

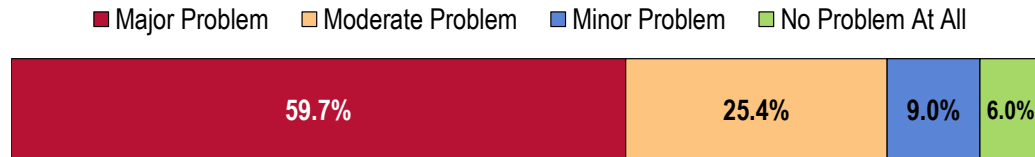


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 47]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The following chart outlines key informants’ perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury and Violence as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Gun Violence

- There are still concerns about random gun violence in the major cities. – Community/Business Leader*
- Because of the community, there is a lot of gun violence and people have become immune to it. – Community/Business Leader*
- There is major trauma in the community especially in Paterson and Passaic around violence in the community. There are many incidents of gun and other related violence claiming lives of children and adults alike. – Social Services Provider*
- I spend most of my time in Paterson, where gun violence is a regular part of everyday life. – Community/Business Leader*
- Gun Violence has become a norm in the United States and unfortunately certain towns in Passaic County are seeing an increase in gun violence. – Community/Business Leader*

Prevalence/Incidence

Media reports. – Community/Business Leader

There is domestic violence, there are fights, and gun battles among gangs. There is high incidence of violence, particularly in the city of Paterson. – Community/Business Leader

High level of crime, drug use, lack of jobs, education. – Community/Business Leader

Paterson has high rates of crime resulting in various types of violence and/or injury. Poverty rates, crime, addiction, as well as the physical environment with buildings, roads, low walkability due to poor infrastructure for sidewalks, pollution including needles, garbage, and result of homelessness all increase injury and violence conditions. – Community/Business Leader

There are many reports on social and news media. – Social Services Provider

Paterson is a violent city and highways/traffic add to injuries. – Other Health Provider

Gang Violence

High crime community, gang activity. – Community/Business Leader

Major gangs and drugs related. – Physician

In urban areas of the county, violence is a huge issue. Gangs are prevalent and take root in many poor neighborhoods. – Community/Business Leader

Contributing Factors

Access to guns is a problem, drug use, road rage, stress and trauma are prevalent while there is a lack of community supports for strengthening families, engaging communities in dialog and tolerance, political divisions exist and are validated in the news. – Social Services Provider

Poverty, drugs, lack of education. – Community/Business Leader

Drugs, gangs, violence. – Other Health Provider

Poverty

Whenever there is poverty, drugs, crime, poor education and high unemployment, there is injury and violence. Just walk into St Joseph ER in Paterson any day and see for yourself (I heard it's the 3rd busiest ER nationwide – is that true?). Overhead speakers announcing trauma codes all the time, never a dull moment in that hospital where I admit my patients – I also live in Paterson by the way. I know how bad it is. – Physician

People are not careful. People have no concern for one another. Economic despair. – Community/Business Leader

Domestic Violence

We have many guests who come who are experiencing or have experienced domestic violence. – Other Health Provider

Passaic County has a high incidence of violent crime including domestic violence. Some of the violence/injury is hidden and not disclosed to any medical or mental health professional. – Community/Business Leader

Vulnerable Populations

Low-income communities are prone to more violence. – Community/Business Leader

Violence is a problem in all communities. I don't believe this is unique to the Bengali community, but there may be more barriers to accessing support and information to leave a violent situation or address incidents of violence due to language and cultural barriers to access services. In terms of injury, there can be a concern of injuries not being adequately addressed or cared for due to a lack of access to quality healthcare or fear of high costs of hospital visits even if one does have coverage. Also, folks who may not be citizens or undocumented may fear reporting violence due to fears of being reported to ICE or being deported. – Community/Business Leader

Overcrowding

Violence and injury are a major problem because my community is overcrowded. Lots of people and nowhere for them to go, meaning the younger generation, so they stand on the corners or hang out in the chicken stores or one of the many liquor stores. The Paterson police are not learning who is in their community. – Community/Business Leader

Alcohol/Drug Use

Violent crime most related to drug abuse. – Social Services Provider

Diabetes

About Diabetes

Diabetes mellitus occurs when the body cannot produce or 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 three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

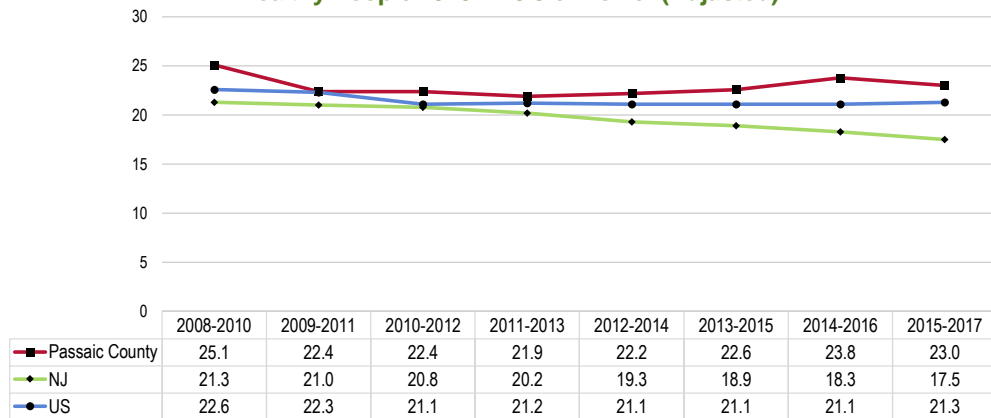
Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the county is shown in the following chart.

Diabetes: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2020 = 20.5 or Lower (Adjusted)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.

• US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective D-3]

Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

• Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

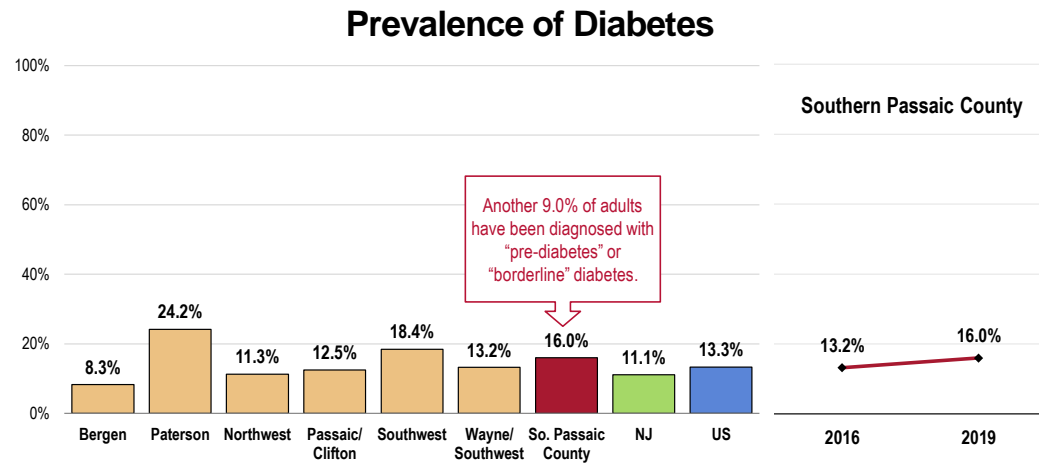
• The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

“Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)”

“Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)”

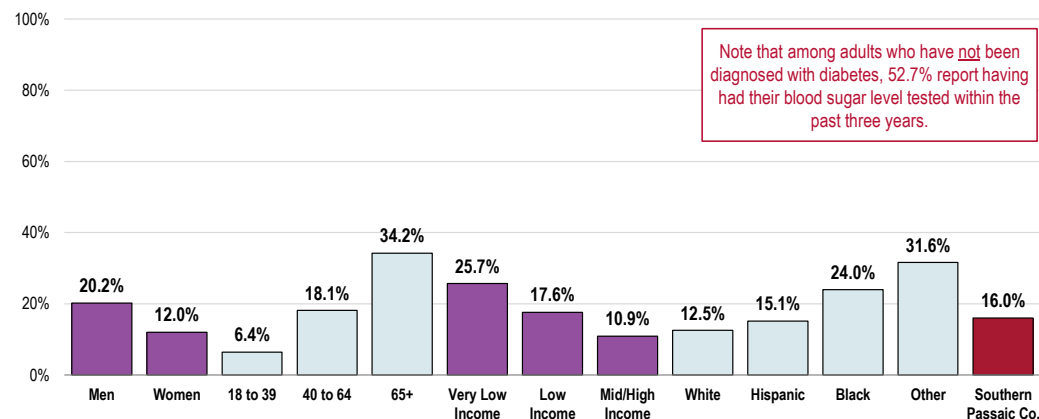
Adults who do not have diabetes: “Have you had a test for high blood sugar or diabetes within the past three years?”



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 140]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Prevalence of Diabetes (Southern Passaic County, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 37, 140]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
 • Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:

Perceptions of Diabetes as a Problem in the Community (Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Contributing Factors

Financial resources to purchase healthy food, medication copays, supplies, access to specialized care including behavioral health for depression (prevalence >50%). Medication compliance especially with polypharmacy, lack of education regarding medication administration and meaning of test results for self-monitoring of finger-stick glucose levels. There is a lack of understanding and possibly motivation to comply with recommendations for best practices and specialized care monitoring. – Social Services Provider

Many people do not know they have an issue. The lack of routine health screening, poor diets and lack of access to healthy foods contribute to this issue. – Community/Business Leader

Unhealthy foods, not educated enough to understand the cause-and-effect diabetes has on the body physically and mentally. – Community/Business Leader

Having access and means to healthy food. Resources to learn and support them of their diagnosis. – Community/Business Leader

Compliance with medication, healthy eating and living habits. – Community/Business Leader

Affordability and access to healthy food options in addition to the lack of opportunities for physical activity due to time restrictions, cultural norms, connection to community safety, housing and other Social Determinants of Health. Lower income levels and rates of pay limit choices, opportunities, and time availability for physical activities and resources to live a healthier life. – Community/Business Leader

Nutrition

Following the diet plan, eating healthy. – Community/Business Leader

Diet and genetics. – Physician

Poor dietary habits. – Other Health Provider

Good nutritional habits. Access to and affordability of healthy foods. – Community/Business Leader

Early Diagnosis/Prevention

Preventative care, early detection, nutritional education, pre-diabetes support and education, diabetes management education and support. – Community/Business Leader

People do not know they have diabetes. Not treated for condition. People do not know how serious and the effects of diabetes. Not insured so do not seek treatment. – Community/Business Leader

Losing weight, becoming physically fit. – Social Services Provider

Awareness/Education

People are not aware of how much cultural diets have an impact. They are also unaware of the importance of exercise combined with diet. Obesity is a big factor and there needs to be more public awareness and information about this. – Community/Business Leader

Education. – Physician

There are not enough programs on nutrition and the health problems around causing diabetes. Lack of education on how diabetes is contracted. Lack of information as to what effect diabetes has on body. Lack of information about sugar and diabetes. – Community/Business Leader

Prevalence/Incidence

Type 2. – Other Health Provider

High prevalence. – Other Health Provider

Diabetes in the urban area has always been high. – Community/Business Leader

Lifestyle

Changing and sticking to a healthier lifestyle, eating and exercising. Affording healthier food and medication. – Other Health Provider

Lifestyle factors, i.e.: poor nutrition and lack of physical activity. Poor access to healthy foods like fruits and vegetables. – Public Health Representative

Access to Healthy Food

Access to healthy foods, ones that are not processed. In addition, education about where to get healthy food, how to get it, and what impact it has on health. – Community/Business Leader

Access to Medications/Supplies

Insulin may be expensive; diabetes teaching is not easily accessible. – Physician

Access to Care/Services

Finding convenient, affordable healthcare. Transportation is difficult for many. – Community/Business Leader

Lack of Providers

No endocrinologist. The ones we do have take just a few of the insurances. – Physician

Kidney Disease

About Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

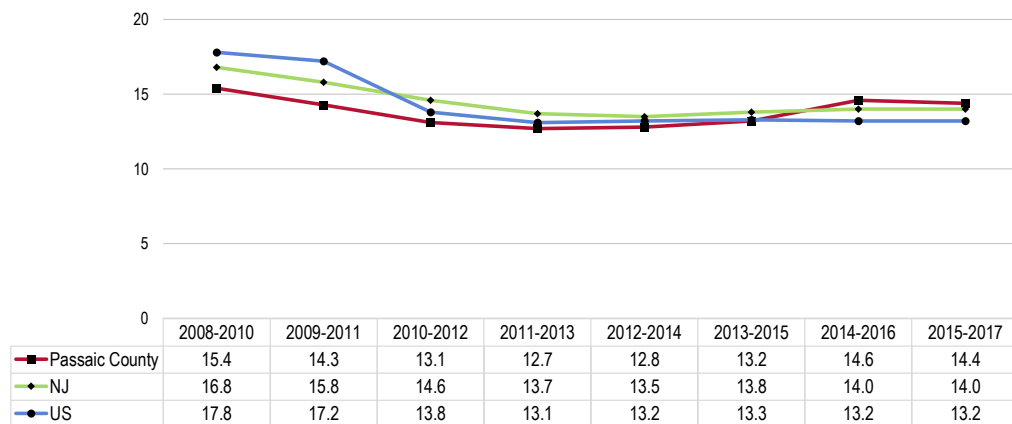
Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart.

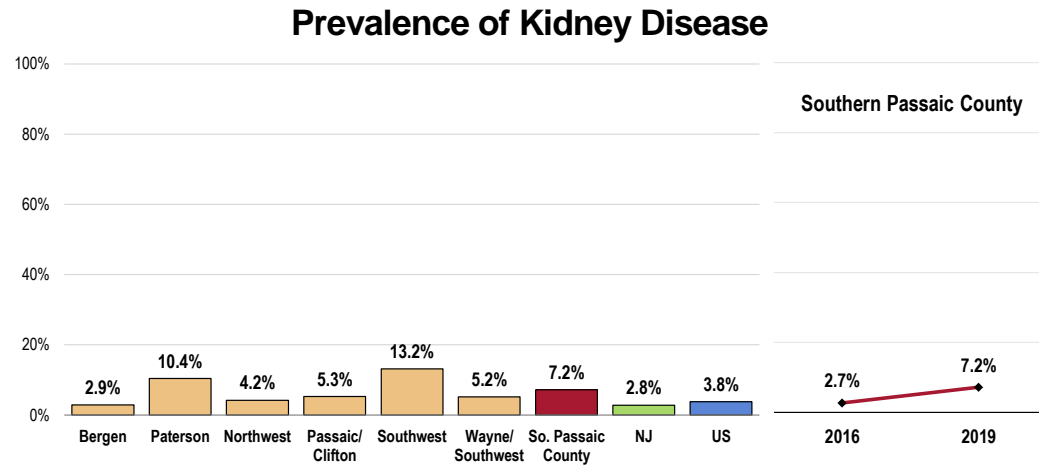
Kidney Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



- Sources: ● CDC WONDER Online Query System, Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
- Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

“Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?”

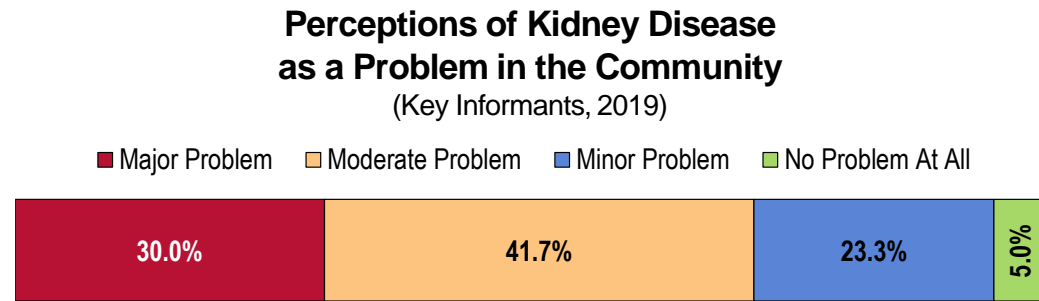


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 30]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Key Informant Input: Kidney Disease

The following chart outlines key informants’ perceptions of the severity of *Kidney Disease* as a problem in the community:



Sources: • PRC Online Key Informant Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

- Because it appears as though there are a lot of people who require dialysis. – Social Services Provider
- Too much. – Physician
- There is a very high incidence in the diverse populations, Latino, African American, Arab. – Other Health Provider

The amount of dialysis centers in the area is an indicator. In addition, acute diseases that lead to kidney disease are high, hypertension, HBP, diabetes, etc. – Community/Business Leader

Kidney disease is very prominent in the African-American community and senior community. There is a large population of people that require dialysis. – Community/Business Leader

Comorbidities

The high rate of hypertension and diabetes caused by poor diet and wellness care. – Social Services Provider

People do not understand that high blood pressure and diabetes can affect your kidneys. Lack of treatment and knowledge regarding cause of kidney disease. – Community/Business Leader

Very high rates of diabetes and pre-diabetic conditions lead to kidney disease. – Community/Business Leader

High number of residents with diabetes. – Community/Business Leader

More at-risk patients, diabetics, hypertensive are surviving longer, poor follow-up practices. – Physician

Disease Management

Compliance and transportation to the dialysis centers are ongoing issues. – Physician

Alcohol/Drug Use

A large sum of the community abuses alcohol. – Other Health Provider

Nutrition

Poor dietary habits. – Other Health Provider

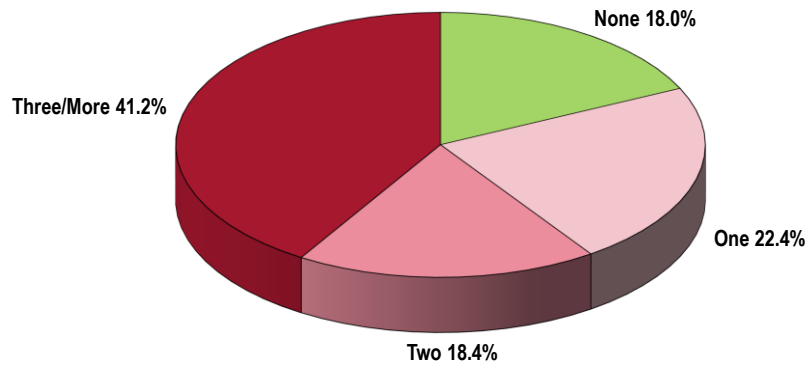
Potentially Disabling Conditions

Multiple Chronic Conditions

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

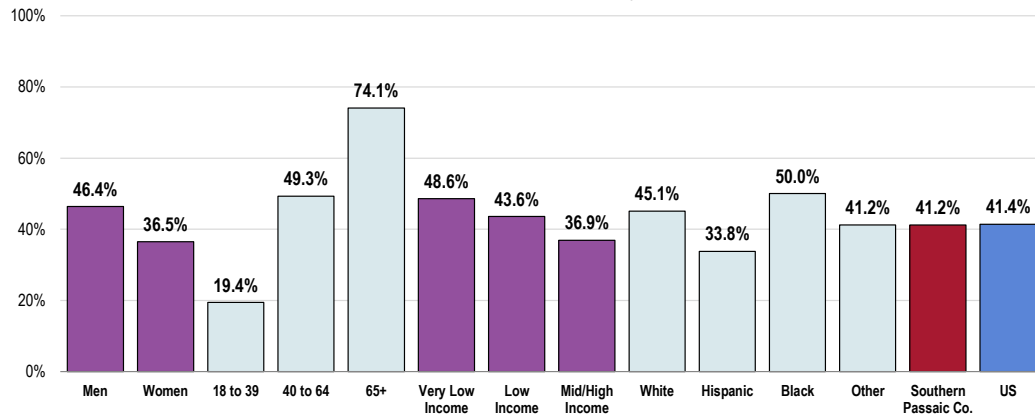
In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Number of Current Chronic Conditions
(Southern Passaic County, 2019)



- Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 143]
 Notes: • Asked of all respondents.
 • In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(Southern Passaic County, 2019)



- Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 143]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • In this case, chronic conditions include lung disease, arthritis, sciatica, cancer, osteoporosis, kidney disease, heart attack, angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, obesity, and/or diagnosed depression.

Activity Limitations

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

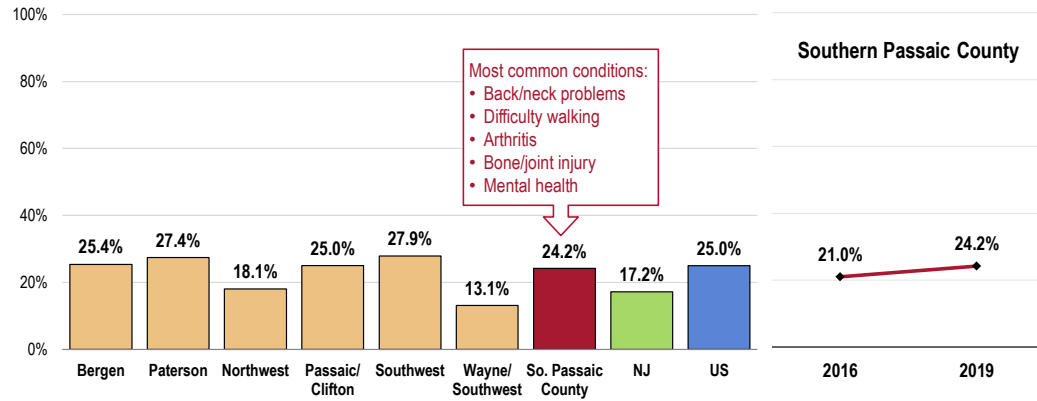
- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

— Healthy People 2020 (www.healthypeople.gov)

“Are you limited in any way in any activities because of physical, mental, or emotional problems?”

Adults with activity limitations: “What is the major impairment or health problem that limits you?”

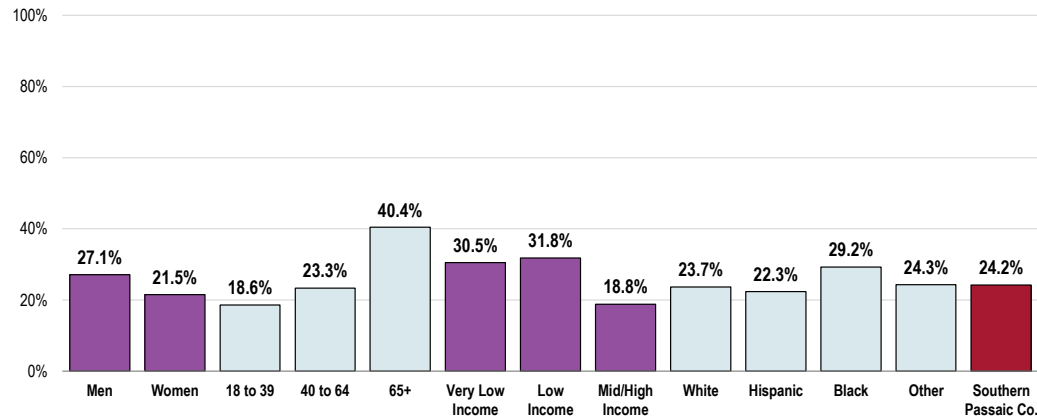
Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 109-110]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2016 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem (Southern Passaic County, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 109]

Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Arthritis, Osteoporosis & Chronic Back Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than \$128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least \$50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

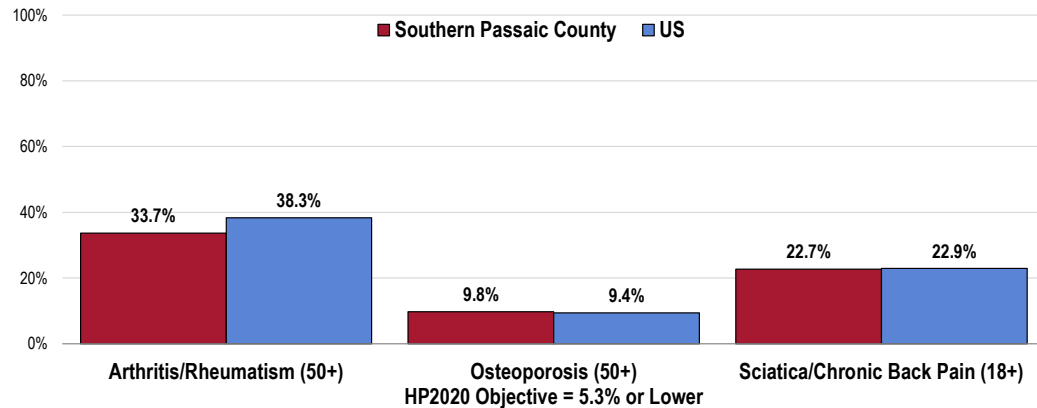
— Healthy People 2020 (www.healthypeople.gov)

“Would you please tell me if you have ever suffered from or been diagnosed with arthritis or rheumatism?” (Reported here among only those here 50+.)

“Would you please tell me if you have ever suffered from or been diagnosed with osteoporosis?” (Reported in the following chart among only those age 50+.)

“Would you please tell me if you have ever suffered from or been diagnosed with sciatica or chronic back pain?” (Reported here among all adults age 18+.)

Prevalence of Potentially Disabling Conditions

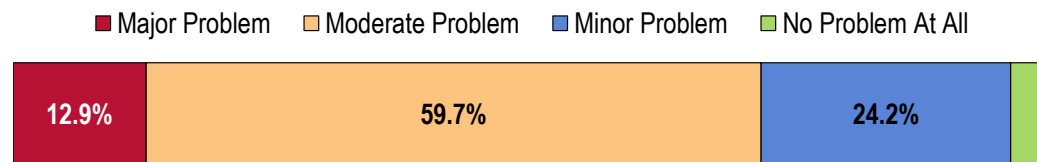


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 26, 141-142]
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AOCBC-10]
 Notes: • The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

The following chart outlines key informants’ perceptions of the severity of *Arthritis*, *Osteoporosis* & *Chronic Back Conditions* as a problem in the community:

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

No good pain management doctors (who are willing to prescribe and monitor narcotic prescriptions) and also accepts Medicaid. No private spine surgeons who accepts Medicaid or even commercial insurance. All good surgeons are out of network. Wait time to see a rheumatologist is 4 to 5 months in some case, only handful left. – Physician

Limited access to ortho/PT. Increase in aging population. – Physician

Aging Population

Because of age. – Other Health Provider

A lot of seniors with knee problems and other arthritis condition, not properly maintained or cared for. No insurance. – Community/Business Leader

Diagnosis/Treatment

A lot of my patients have had back surgeries and have not gotten any better and perhaps worse. The ortho won't see them anymore usually because the insurance won't reimburse them enough to see the patient, so they end up in my office looking for pain meds. That happens on a daily basis. – Physician

Contributing Factors

Mix genetics population, obesity, lack of exercise. – Physician

Vision & Hearing Impairment**About Vision**

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

— Healthy People 2020 (www.healthypeople.gov)

About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

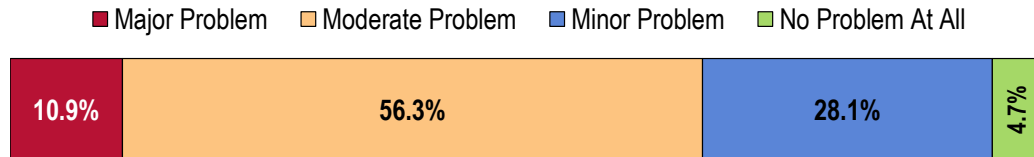
As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

— Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Vision & Hearing

The following chart outlines key informants' perceptions of the severity of *Vision & Hearing* as a problem in the community:

Perceptions of Vision and Hearing as a Problem in the Community
(Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Early Diagnosis/Prevention

Most people do not pay attention to the importance of regular hearing and vision check up and do not go to see the specialist until they have serious problems. The financial aspect might be a contributing factor. – Community/Business Leader

Affordable Care/Services

Hearing aids are expensive. Insurance won't cover it at times, patients are poor and can't afford it. – Physician

Access to Care/Services

Poor access to specialty/subspecialty clinics to serve aging population. – Physician

Insurance Issues

Most people's insurance doesn't provide coverage. – Social Services Provider

Alzheimer's Disease

About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

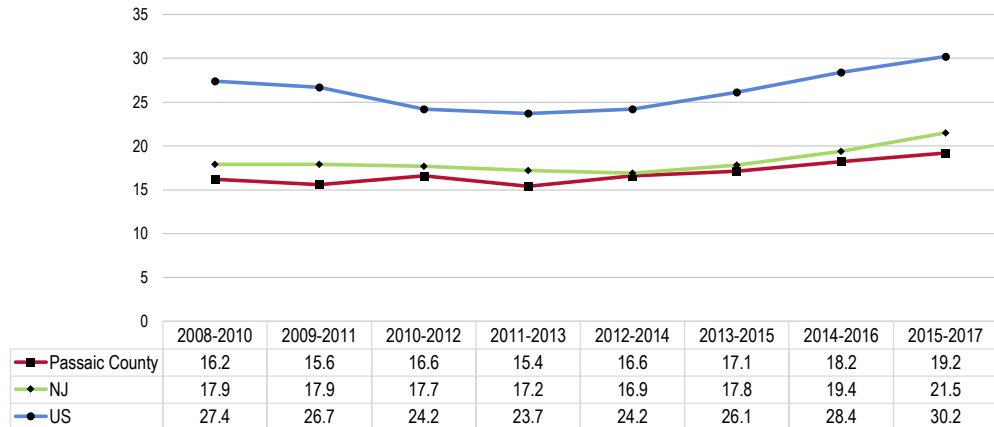
Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

— Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined in the following chart.

Alzheimer's Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population)

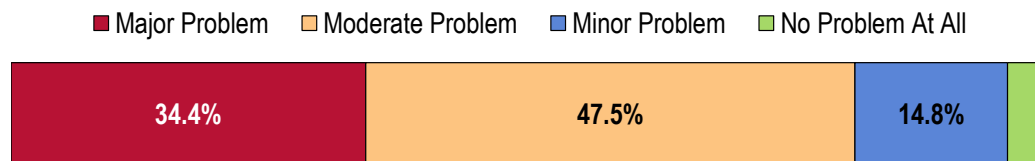


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
 Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 ● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Dementias, Including Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementias, Including Alzheimer's Disease* as a problem in the community:

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community (Key Informants, 2019)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
 Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Affordable Care/Services

Caregivers are expensive to hire, and families often cannot manage. – Social Services Provider

No programs, except money. – Physician

I work with seniors and their caretakers quite often. The biggest complaint is the lack of safe, affordable care for those with dementia/Alzheimer's disease. – Other Health Provider

Many of our guests have memory or early dementia and free resources would be helpful. – Other Health Provider

The lack of affordable services leaves individuals and families scrambling for care or simply doing without. Early intervention is also lacking especially in low-income populations. – Community/Business Leader

Contributing Factors

Diet and mental illness. – Other Health Provider

The aging population in the community is increasing in the over-85 age group and this age cohort often lives alone without a caregiver. Overall the comorbidity of dementia is present in the majority of seniors served in the community. The caregivers when present are overwhelmed by the role and are reluctant to purchase services to assist them for fear of a lack of resources for their own future care needs.

There are insufficient publicly funded community resources for this population and the caregivers are socially isolated due to geographic barriers, mobility, or inadequate senior transportation systems.

Often the individual with dementia is the head of household supporting 1 or 2 younger generations.

There is a significant gap of legal information and services available. Care planning and provision requires hours of one-on-one services that is very costly per person. The individual with dementia's safety is compromised due to inadequate care, unprepared caregivers and environment. – Social Services Provider

Aging Population

Aging population. – Physician

Seeing more of it in the older population. – Other Health Provider

Access to Care/Services

No psychometrics availability. – Physician

Lack of community services. – Other Health Provider

Prevalence/Incidence

Many people are dealing with parents with this condition. – Community/Business Leader

Awareness/Education

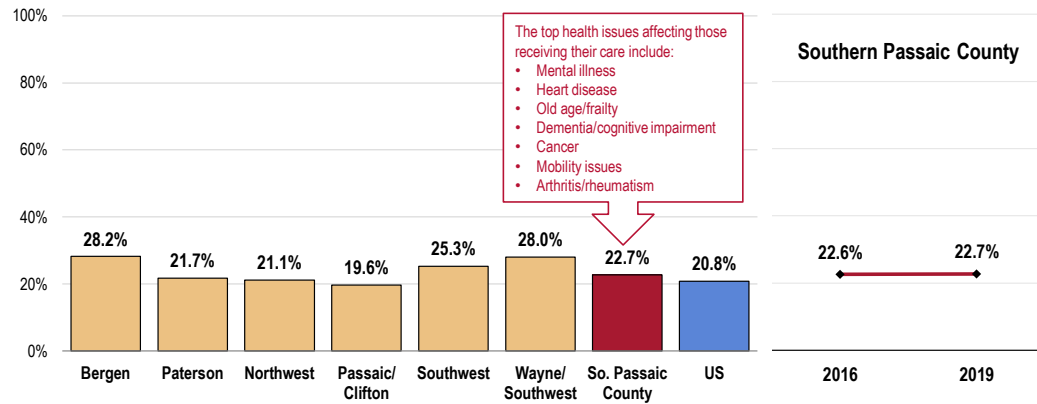
People lack understanding and are not being treated early on. Not enough help for family members. – Community/Business Leader

Caregiving

“People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?”

Among those providing care: “What is the main health problem, long-term illness, or disability that the person you care for has?”

Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability



Sources: ● 2019 PRC Community Health Survey, PRC, Inc. [Items 111-112]
 ● 2017 PRC National Health Survey, PRC, Inc.
 Notes: ● Asked of all respondents.

Infectious Disease

About Immunization & Infectious Diseases

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by \$9.9 billion.
- Saves \$33.4 billion in indirect costs.

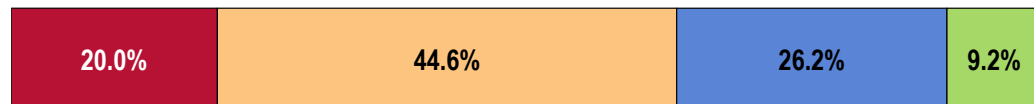
— Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Immunization & Infectious Diseases

The following chart outlines key informants' perceptions of the severity of *Immunization & Infectious Diseases* as a problem in the community:

Perceptions of Immunization and Infectious Diseases as a Problem in the Community (Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Alcohol/Drug Use

Due to needle use amongst addicts and junkies who have become prostitutes to pay for their addiction.
– Social Services Provider

Awareness/Education

Lack of information/education, especially regarding adult immunizations, influenza, pneumococcal vaccine. – Physician

Cultural/Personal Beliefs

More and more people are choosing not to get vaccinated. The recent measles outbreaks are of concern and many of the people I speak with don't understand how dangerous infectious diseases can be. – Other Health Provider

Overcrowding

30K students in school district with only eight square miles in city. Major issue. – Community/Business Leader

Diagnosis/Treatment

Not properly treated. People not cautious enough. – Community/Business Leader

Births

About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

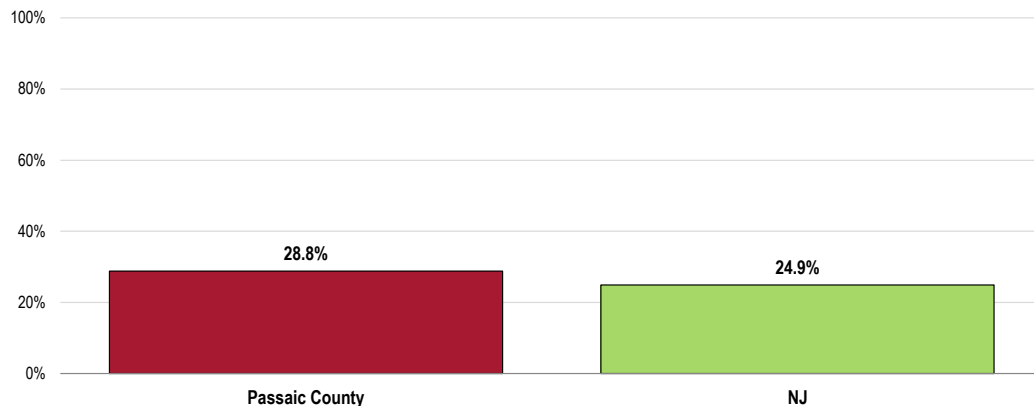
Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

— Healthy People 2020 (www.healthypeople.gov)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health. Lack of timely prenatal care (care initiated during the first trimester of pregnancy) is outlined in the following chart.

Lack of Prenatal Care in the First Trimester (Percentage of Live Births, 2016-2017) Healthy People 2020 = 22.1% or Lower



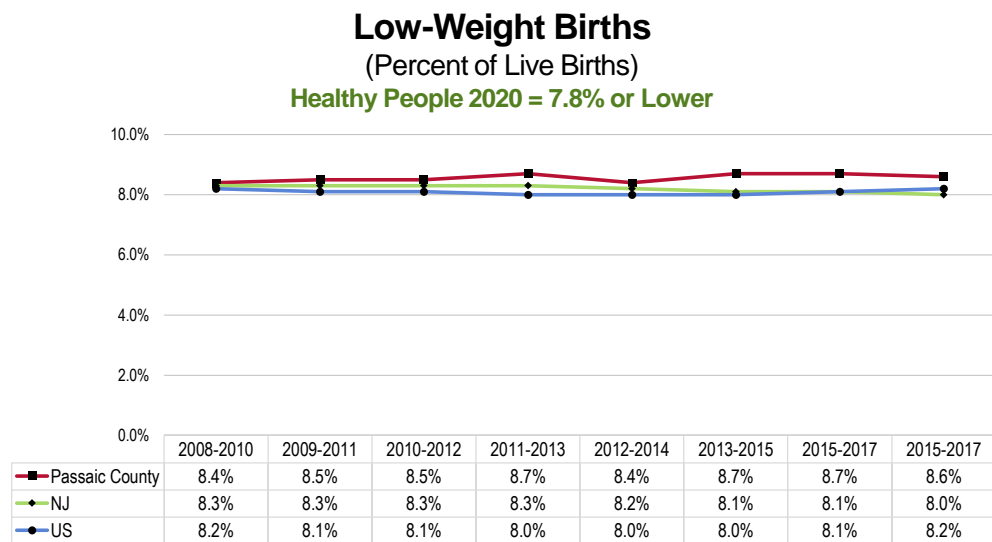
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics.
• Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Note: • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-10.1]
• This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. Births of low-weight infants are described in the following chart.



Sources:

- CDC WONDER Online Query System, Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics.
- Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-8.1]

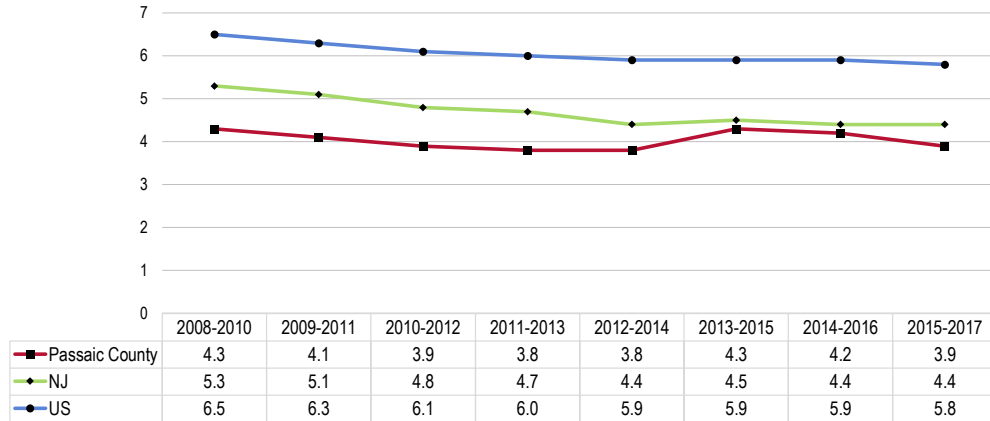
Note:

- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart.

Infant Mortality Trends (Annual Average Infant Deaths per 1,000 Live Births) Healthy People 2020 = 6.0 or Lower

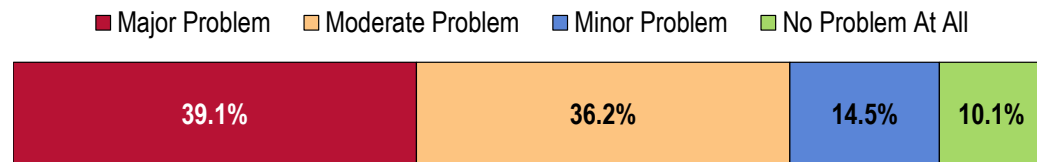


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted July 2019.
 ● Centers for Disease Control and Prevention, National Center for Health Statistics.
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective MICH-1.3]
 Notes: ● Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Key Informant Input: Infant & Child Health

The following chart outlines key informants' perceptions of the severity of *Infant & Child Health* as a problem in the community:

Perceptions of Infant and Child Health as a Problem in the Community (Key Informants, 2019)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
 Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Contributing Factors

- *Babies having babies. Not insured. Lack of information.* – Community/Business Leader
- *This is a statewide problem. Poor healthcare during pregnancy and limited, affordable infant and children healthcare services.* – Community/Business Leader

I think infant and child health is linked to decreased or inadequate family planning in the county: my own observation has led me to believe that Passaic County has a higher-than-average rate of youth pregnancy, and this in turn leads to higher infant and child health problems (because many youth are not equipped to properly care for a child). Additionally, poverty in the county creates worse infant and child health outcomes as poverty causes families to have inadequate nutrition and inadequate amounts of medical check-ups (especially when families cannot afford pre- or post-natal check-ups). – Community/Business Leader

Our community does prioritize infant and child health because there is a concern about putting children first, especially for mothers to do this (often at the expense of their own health and needs). However, similar to as I mentioned prior, there are language and cultural barriers when parents may seek care for their infants and children, so the proper health information and education may not be getting to them like it needs to. Also there is a major concern regarding environmental hazards such as lead in water and lead in the walls that can be very harmful and have lasting effects on young children which are not addressed, in part due to a lack of education and due to the fact that many buildings in Paterson where the community lives are not up to code, may be illegal units and have lead in the pipes and building without it being addressed. Getting rid of illegal units is also not an easy answer because this can make housing unaffordable. Also fears of parents who are undocumented. – Community/Business Leader

Lack of funds, resources, poverty. Lack of knowledge about children's development. – Community/Business Leader

Awareness/Education

Insufficient information in childhood immunization, nutrition. – Physician

Lack of awareness, education and access to quality doctors. – Community/Business Leader

I believe that racial issues contribute negatively to how infant and child health issues are addressed. Lack of education about what is a real problem and accessible ways of getting this information to mothers is a problem. – Community/Business Leader

Lack of focus on the importance of women's health in the community including importance of good nutrition and physical activity throughout women's life and the relation to a healthy pregnancy and healthy child. Late access to pre-natal care for a variety of reasons and the effect on birth outcomes and infant/child health in general. Nutrition, Lead, physical activity, and exposure to unhealthy behaviors – Community/Business Leader

Vulnerable Populations

Infant Mortality is high within the African American community. – Community/Business Leader

Community of color, immigrant community, trust barriers for infant care. – Community/Business Leader

Minority and low-income communities tend not to visit doctor on a regular basis and therefore do not have access to important pre-natal care. Lack of education and insurance. – Community/Business Leader

Affordable Care/Services

Parents not being able to afford doctor's visits. – Social Services Provider

Lack of affordable healthcare. – Public Health Representative

Lead Poisoning

Lead poisoning. – Community/Business Leader

Child lead; so many buildings built prior to 1978 and in such an ethnically diverse community, there are many cultural practices, food, and housewares that may involve lead. – Other Health Provider

Teen Pregnancies

Underage parents. Babies having babies. – Social Services Provider

Family Planning

Births to Adolescent Mothers

About Adolescent Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents.

Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately \$3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

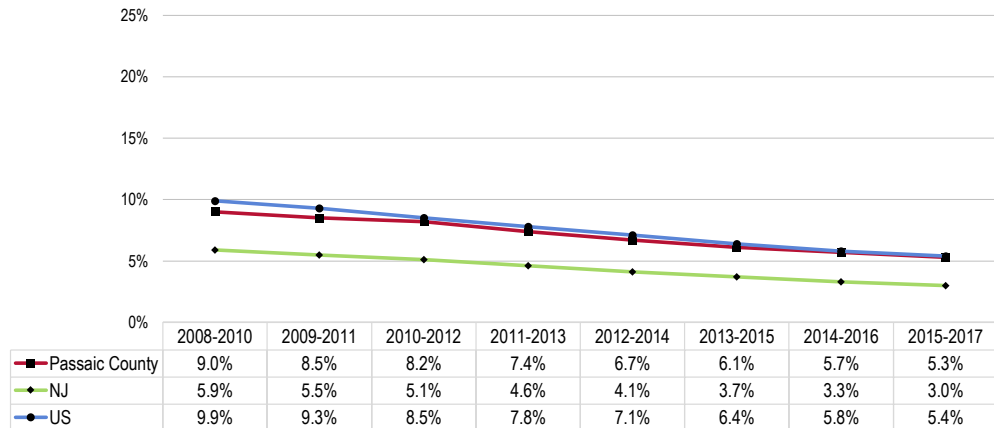
Similarly, early fatherhood is associated with lower educational attainment and lower income.

Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

— Healthy People 2020 (www.healthypeople.gov)

The following chart describes births to adolescent mothers age 15 to 19 years old.

Adolescent Birth Trends
(Percentage of Births to Adolescents Age 15-19)



Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.

• Retrieved from CARES Engagement Network at <https://engagementnetwork.org>.

Notes: • This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

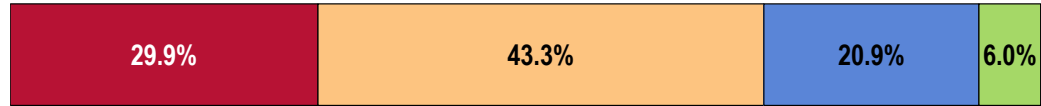
Key Informant Input: Family Planning

The following chart outlines key informants' perceptions of the severity of *Family Planning* as a problem in the community:

Perceptions of Family Planning as a Problem in the Community

(Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
 Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Awareness/Education

Lack of education mainly among African American and Hispanic population. – Physician
Parenting classes would benefit our guests who struggle with mental health. – Other Health Provider
Not as much sex education as should be, culturally conservative communities don’t talk about issues as much. – Community/Business Leader
Lack of education. – Community/Business Leader

Access to Care/Services

Services in this area are limited and the last seven years the funding for this service was severely cut on the state level. – Community/Business Leader
I am aware of one Planned Parenthood center in Paterson. Others in the county aren’t known to me. – Community/Business Leader

Contributing Factors

Family planning is a major problem in my community because the majority don’t sit down at the dinner table or plan ahead. Some have no vision. Some children are kicked out before the age of 15 years old for whatever reasons. Family planning and talking is a step ahead; to me it called communication. To plan is a major step in life. – Community/Business Leader

Teenage Pregnancy

Sometimes working with youth, I see that many youth in Passaic County have children – I believe the statistics I have seen show that the county has a higher rate of youth pregnancies. Couple this with the attacks on family planning and reproductive rights at a national level and we have a major issue with family planning in Passaic County – youth are not getting the proper sexual education they deserve, access to birth control is difficult for many, etc. – Community/Business Leader

Unplanned Pregnancy

Passaic County is home to the third largest city in the state. The percentage of children born to unwed mothers is also very high for the state. Under and Uninsured persons have a very difficult time accessing appropriate family planning services. – Community/Business Leader

Affordable Care/Services

Finding convenient, affordable healthcare is difficult for many. Lack of financial resources is a hindrance as well. – Community/Business Leader

Vulnerable Populations

High mortality rate amongst minorities. Not enough engagement pre-, during, and post-pregnancy. Lack of doctor who can relate to patient’s situation. – Community/Business Leader

Modifiable Health Risks

Nutrition, Physical Activity & Weight

Nutrition

About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include: knowledge and attitudes; skills; social support; societal and cultural norms; food and agricultural policies; food assistance programs; and economic price systems.

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

— Healthy People 2020 (www.healthypeople.gov)

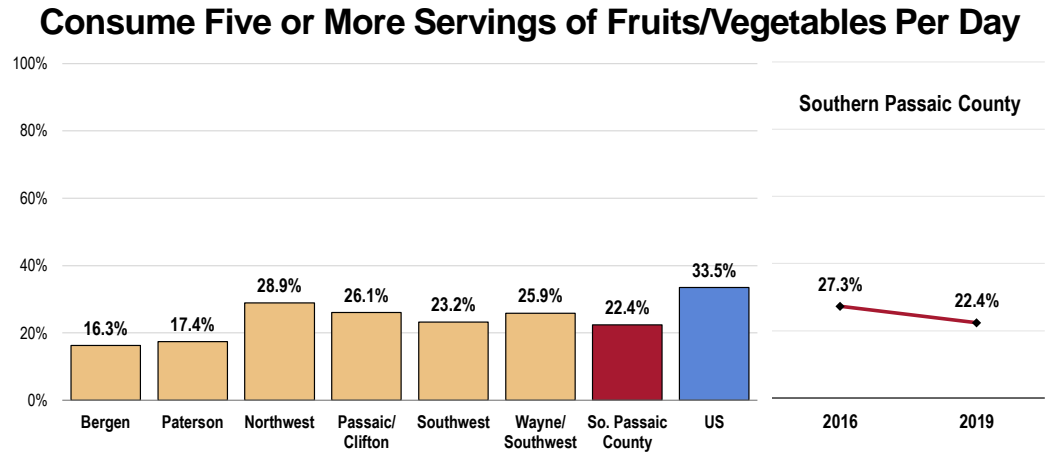
Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

“Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?”

“How many servings of vegetables did you have yesterday?”

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.

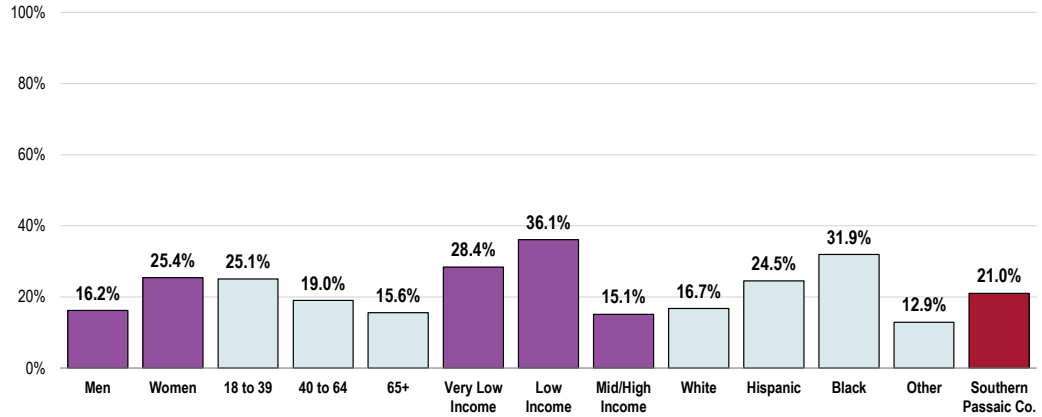


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 148]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.
 • For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

“How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?”

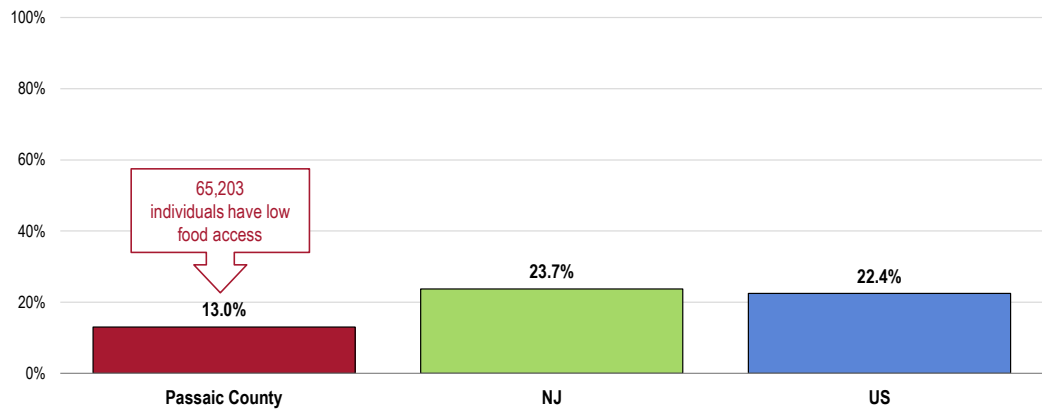
Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce (Southern Passaic County, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 189]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This related chart is based on US Department of Agriculture data.

Population With Low Food Access (Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2015)



Sources: • US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
 • Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.
 Notes: • This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

— Healthy People 2020 (www.healthypeople.gov)

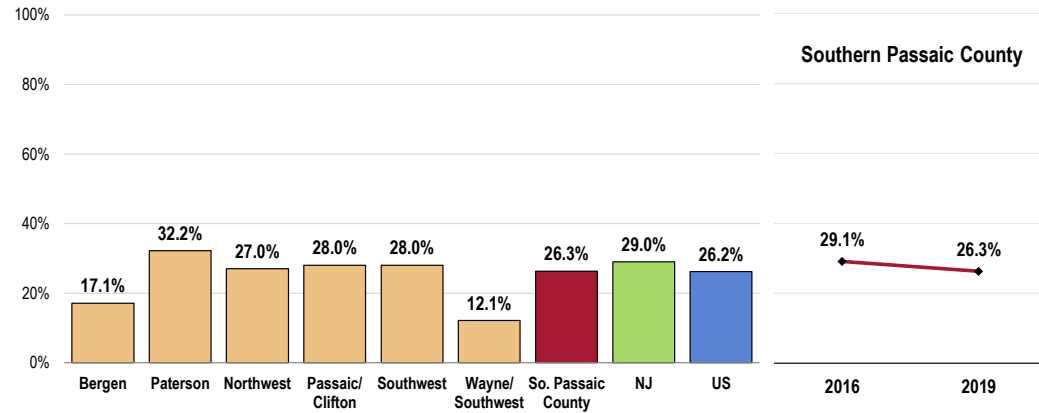
Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

“During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?”

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 = 32.6% or Lower



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 89]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-1]

Notes: • Asked of all respondents.

Recommended Levels of Physical Activity

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do muscle-strengthening activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

— 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Meeting Physical Activity Recommendations

To measure physical activity frequency, duration and intensity, respondents were asked:

“During the past month, what type of physical activity or exercise did you spend the most time doing?”

“And during the past month, how many times per week or per month did you take part in this activity?”

“And when you took part in this activity, for how many minutes or hours did you usually keep at it?”

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

“During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands.”

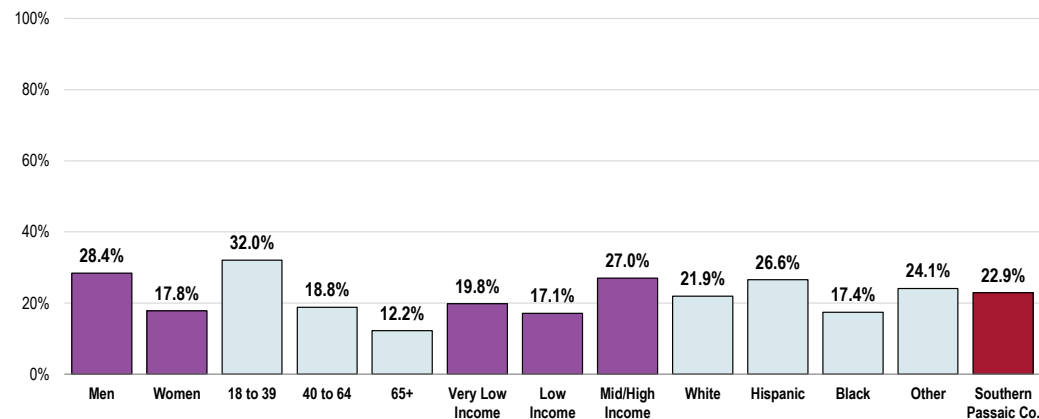
“Meeting physical activity recommendations” includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations

(Southern Passaic County, 2019)

Healthy People 2020 = 20.1% or Higher

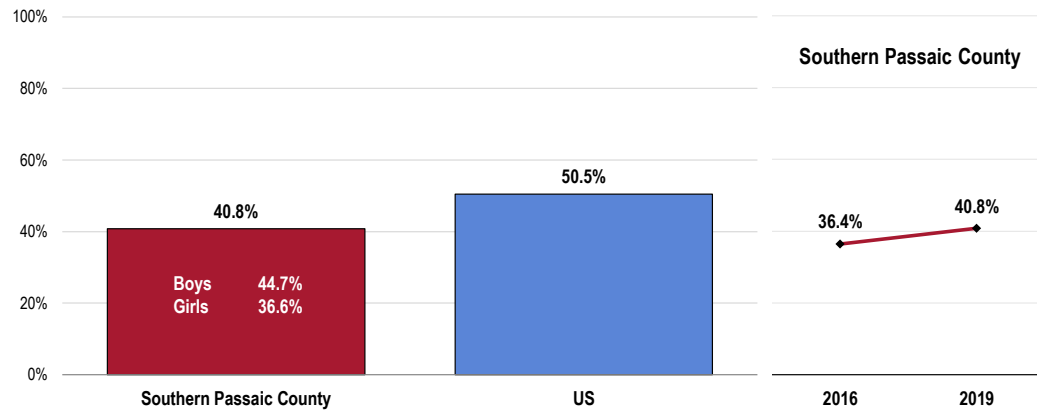


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 152]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective PA-2.4]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

“During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?”

Child Is Physically Active for One or More Hours per Day
(Parents of Children Age 2-17)



- Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 124]
 • 2017 PRC National Health Survey, PRC, Inc.
- Notes: • Asked of all respondents with children age 2-17 at home.
 • Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Weight Status

About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

— Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m²). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches²)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m² and obesity as a BMI ≥30 kg/m². The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m². The increase in mortality, however, tends to be modest until a BMI of 30 kg/m² is reached. For persons with a BMI ≥30 kg/m², mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m².

— Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Classification of Overweight and Obesity by BMI	BMI (kg/m ²)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight, not Obese	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

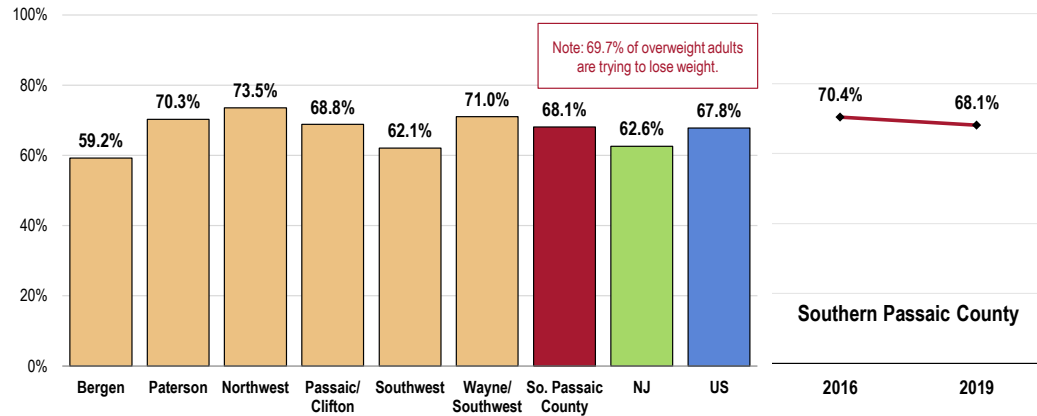
“About how much do you weigh without shoes?”

“About how tall are you without shoes?”

“Are you now trying to lose weight?”

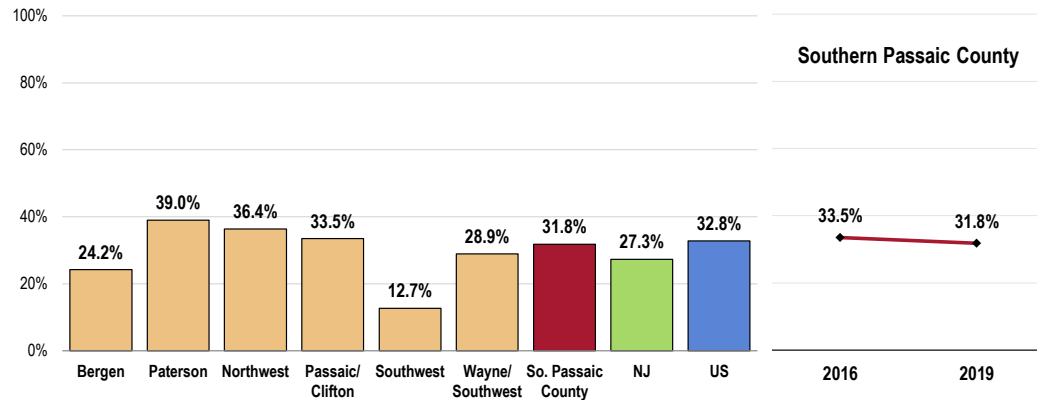
Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight and Obese)



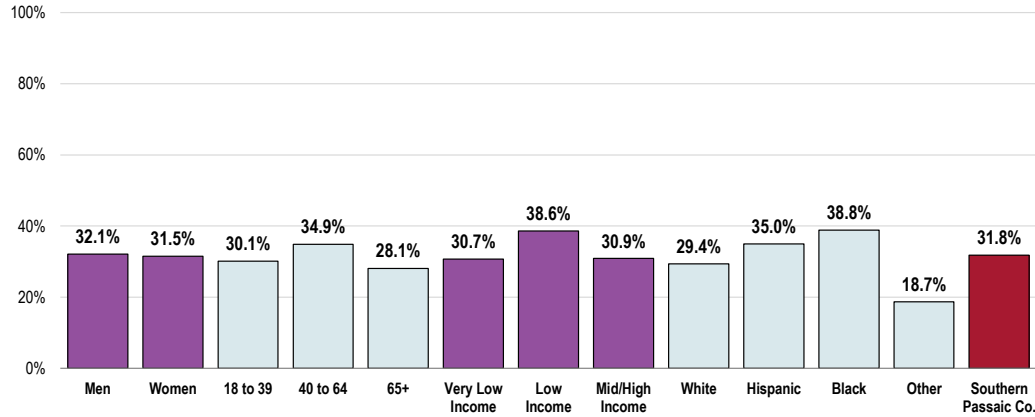
- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Items 155, 191]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 - 2017 PRC National Health Survey, PRC, Inc.
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity
 Healthy People 2020 = 30.5% or Lower



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 154]
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 - 2017 PRC National Health Survey, PRC, Inc.
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]
- Notes:
- Based on reported heights and weights, asked of all respondents.
 - The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
 (Southern Passaic County, 2019)
 Healthy People 2020 = 30.5% or Lower



Sources:

- 2019 PRC Community Health Survey, PRC, Inc. [Item 154]
- US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective NWS-9]

 Notes:

- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Childhood Overweight & Obesity

About Weight Status in Children & Teens

In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

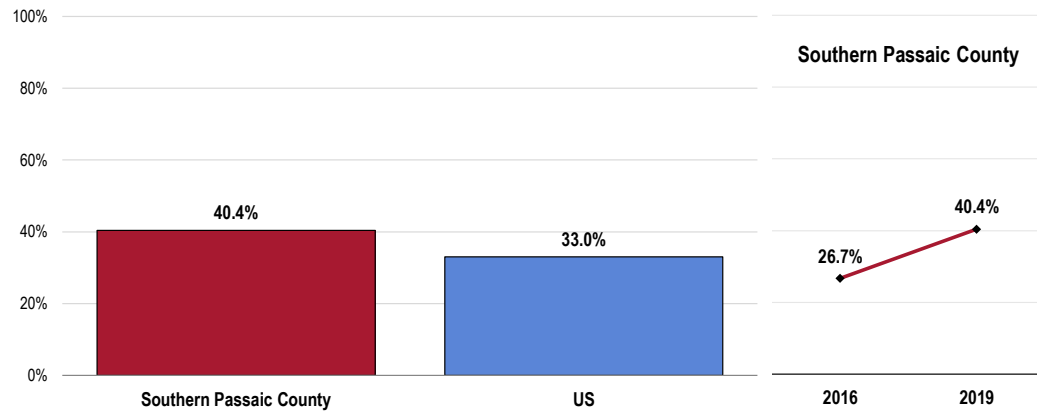
— Centers for Disease Control and Prevention

The following questions were used to calculate a BMI value (and weight classification as noted above) for each child represented in the survey:

“How much does this child weigh without shoes?”

“About how tall is this child?”

Prevalence of Overweight in Children (Parents of Children Age 5-17)

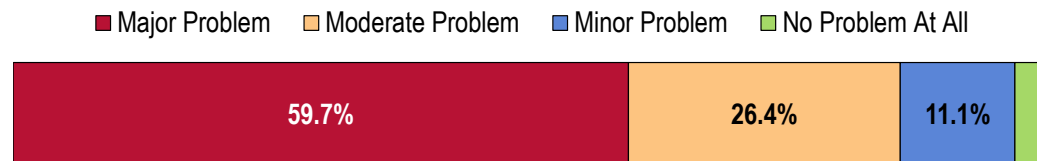


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 192]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents with children age 5-17 at home.
 • Overweight among children is determined by children’s Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants’ perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Contributing Factors

- *Lack of knowledge, access to healthy foods, lack of physical activity, fear of going outside. – Community/Business Leader*
- *Lack of affordable healthy food options, education, access to grocery stores. Cost of purchasing healthy foods. – Community/Business Leader*
- *Poverty, lack of education, welfare money spent on junk food. – Physician*

Variations in obesity rates in various census tracts. Survey showed below average time spent in physical activity. The built environment assessment suggested walkability as possibly contributing to physical inactivity, but the city has a lot of city parks accessible to a large number of people. However, transportation beyond the city itself may mostly lead to only other urban areas. There's access to large grocery stores but could use more affordable farmer's market type of options to reach vulnerable populations. There are corner stores, but the quality & availability of foods could be improved. – Other Health Provider

The biggest challenges are a lack of information about proper nutrition for good health (meaning eating less fried foods that are high in fat, high amounts of starch and carbohydrates in the diet, incorporating more fresh fruits and vegetables in the diet). Due to this weight goes up, especially weight around the belly for men and women. Our culture also doesn't really have a tradition of exercise, especially for women, so there is almost zero physical activity which further exacerbates health problems. Paterson, especially the area with a high population of Bengali people, has broken sidewalks, lots of litter, and generally does not have safe areas to walk or get exercise especially when it gets dark. People don't feel motivated to spend time outdoors because it's not safe, clean nor aesthetically pleasing. There are parks in Paterson, but are they safe and clean? Are they well maintained? – Community/Business Leader

With the prevalence of "fast food" chains in the area (Paterson), the increase of technology, lack of safe outdoor space, the discrepancy of pricing between healthy and unhealthy food and its accessibility, obesity and poor nutrition is seen in every classroom and in the community. – Community/Business Leader

Very unhealthy eating habits. Eating healthy is expensive, most local supermarkets don't accept manufacturer coupons so they can save money on their grocery shopping. Most people stay indoors and most moms keep kids indoor due to crime/violence. Parks are often unappealing. – Community/Business Leader

I often hear people say they're exhausted after the long hours they work to pay their bills, which leaves them too tired to exercise. They also say healthy, fresh food is expensive and the food they can afford or that they get from the local food pantry is usually starchy and less healthy. – Other Health Provider

Obesity

Children are getting fat and are less active (somewhat due to technology) and communities do not have structured and supervised activities. Also, some communities are dangerous and families do not let their children out to play. There also needs to be more access to healthy affordable food – not fast food or white processed garbage that is genetically modified. Healthy clean food that is affordable. – Community/Business Leader

Obesity leads to the other issues such as high blood pressure, Type 2 diabetes, etc. – Community/Business Leader

Increasing obesity and the sequelae of this condition. – Physician

Obesity and poor diet, no life skills. – Social Services Provider

Awareness/Education

Education and information stressing the benefits of physical activity. Programs should also stress and highlight the detriment of the absence of balanced diet and obesity. – Community/Business Leader

Insufficient education on appropriate weight goals, diet. – Physician

Healthy food advice and access. – Community/Business Leader

Lack of knowledge about good nutrition. Lack of support to get into and stick to a program that gets them on the right path. – Community/Business Leader

Lifestyle

Children and adults who appear to be unhealthy. Overweight and underweight citizens. No one wants to be active really. – Community/Business Leader

Lifestyle factors, poor access to nutritious foods, unsafe neighborhoods. – Public Health Representative

Nutrition

Most people don't pay attention to what they eat and do not exercise on regular basis. – Community/Business Leader

Access to Healthy Food

Regular, affordable, nutritious food. Poor diets contribute to so many health issues. – Community/Business Leader

Healthy food is often expensive. – Social Services Provider

Prevalence/Incidence

This is a national problem. – Physician

Biggest problem in Passaic. – Other Health Provider

Poverty

Time and economic resources. This is a low-income area and individuals and families are struggling. They are unable to plan when they are focused on where they will sleep or where their next meal is coming from. – Community/Business Leader

Early Diagnosis/Prevention

Many guests come in our respite wanting to work on their physical health and wellness. – Other Health Provider

Comorbidities

Cardiovascular disease, diabetes. – Community/Business Leader

Substance Abuse

About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

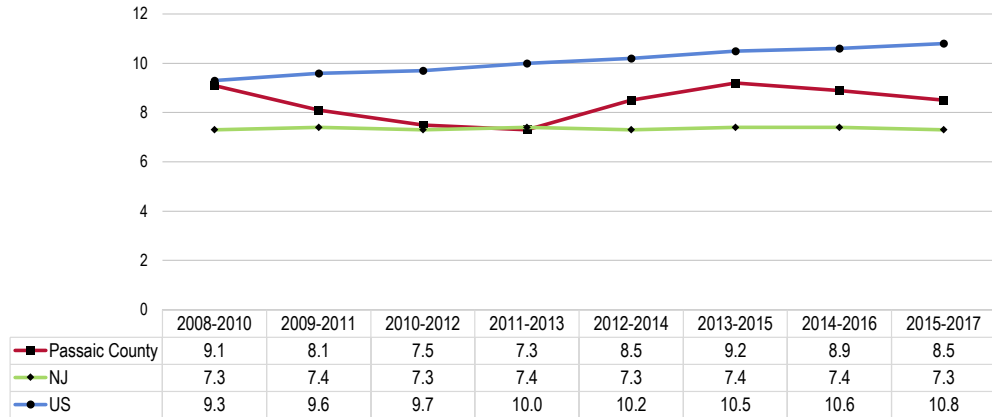
— Healthy People 2020 (www.healthypeople.gov)

Alcohol

Cirrhosis/Liver Disease

Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in the county.

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 = 8.2 or Lower



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-11]

Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Excessive Drinking

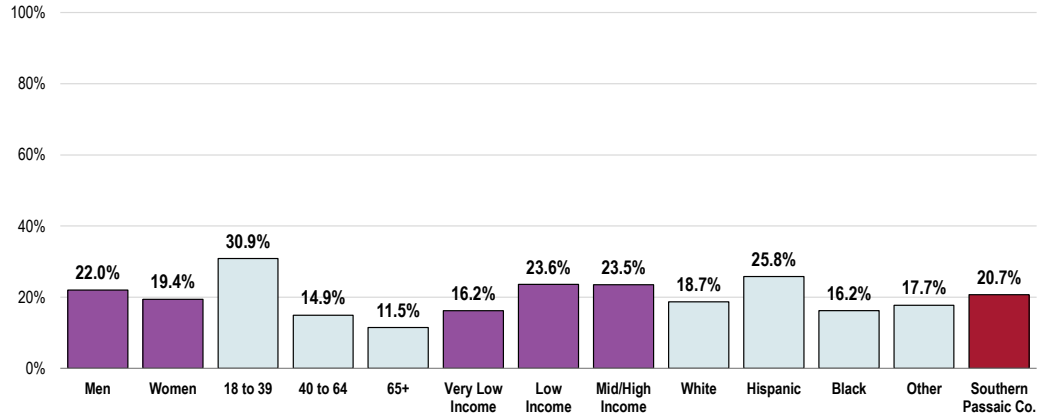
Excessive drinking reflects the number of adults (age 18+) who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women), or who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

“During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?”

“On the day(s) when you drank, about how many drinks did you have on the average?”

“Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?”

Excessive Drinkers (Southern Passaic County, 2019) Healthy People 2020 = 25.4% or Lower



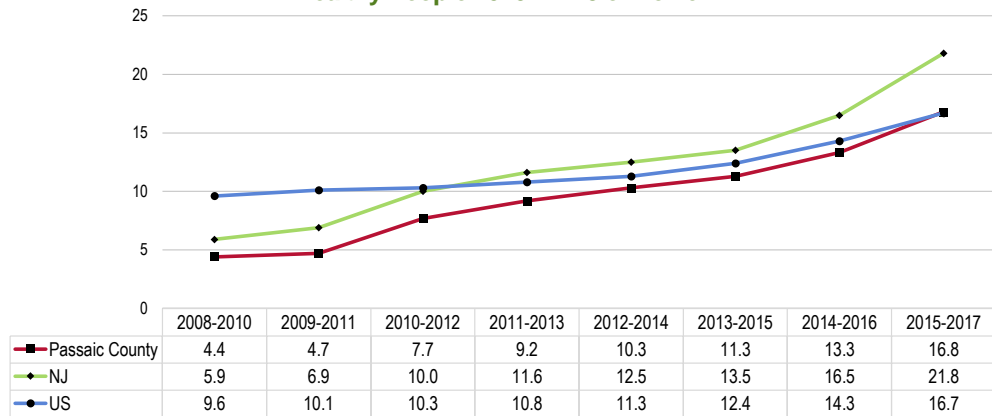
Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 168]
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-15]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level. "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) or who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Unintentional Drug-Related Deaths

Unintentional drug-related deaths include all deaths, other than suicide, for which drugs are the underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-related deaths.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends (Annual Average Deaths per 100,000 Population) Healthy People 2020 = 11.3 or Lower



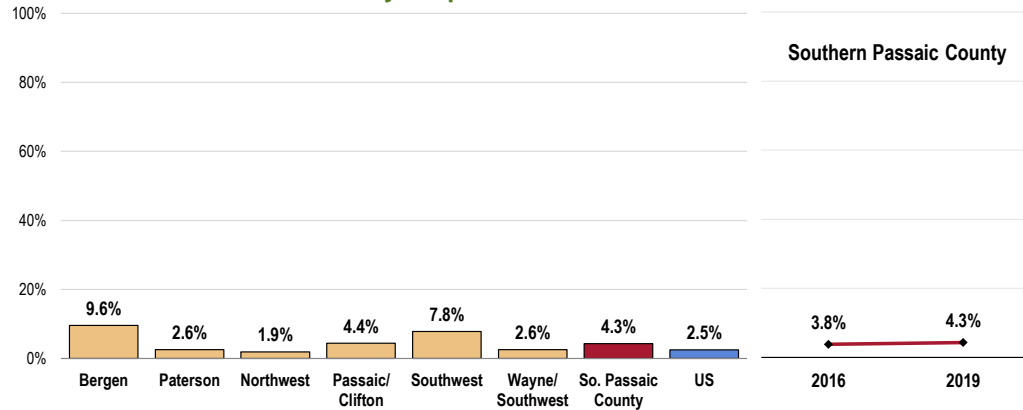
Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted July 2019.
 • UD Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-12].
 Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
 • Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Illicit Drug Use

“During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?”

Illicit Drug Use in the Past Month

Healthy People 2020 = 7.1% or Lower

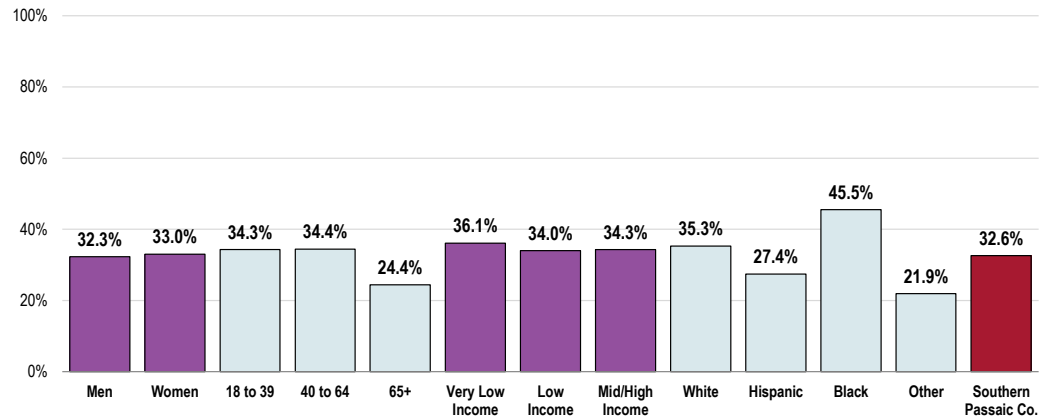


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 59]
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective SA-13.3]
 Notes: • Asked of all respondents.

Personal Impact of Substance Abuse

“To what degree has your life been negatively affected by your own or someone else’s substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?”

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
 (Southern Passaic County, 2019)

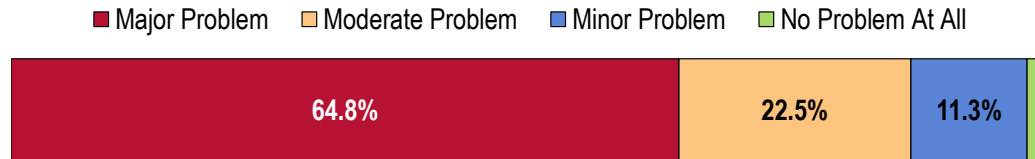


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 195]
 Notes: • Asked of all respondents.
 • Includes response of “a great deal,” “somewhat,” and “a little.”
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., “White” reflects non-Hispanic White respondents).
 • Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Substance Abuse

The following chart outlines key informants’ perceptions of the severity of *Substance Abuse* as a problem in the community:

**Perceptions of Substance Abuse
as a Problem in the Community**
(Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

- Heroin leader in area. – Community/Business Leader*
- Substance abuse is prevalent across most cities in Passaic County. Route 23 has been dubbed Heroin Highway. The accessibility of cheap drugs is on the rise. – Community/Business Leader*
- Paterson is a drug center, too many people come here to access drugs. We need more effective programs, policing, education. – Community/Business Leader*
- I see the trading, use and aftereffects of drugs on the streets every day. – Community/Business Leader*
- Opioid problem is growing, not shrinking. – Other Health Provider*

Access to Care/Services

- Getting people to treatment and for treatment facilities to be more understanding of the rate of failure as part of the treatment process. – Community/Business Leader*
- Not enough beds in NJ to properly provide care in this specific area, many families who can afford go out of state. – Community/Business Leader*
- The number of open beds for treatment. – Other Health Provider*
- Same as behavioral health. Also, very high rates of relapses because of the limited outpatient psych services/practices. Poor social support. Lower socioeconomic classes, education levels, access to good jobs. – Physician*
- Poor availability of treatment facilities. – Physician*

Disease Management

- Depends on the age group, the willingness of the patient, the facilities cost and the lack of insurance. – Community/Business Leader*
- Effective programs must be 24/7 with strong aftercare. The cost of these programs is excessive and since most of our city is drug addicted, residents/inhabitants are not from Paterson. There needs to be a way to access their town of origin for their care. – Social Services Provider*
- Lack of willingness to address the situation. You have non-residents who are invading the communities because of access to drugs. The cities do not have the funds to address this issue on a large scale. – Community/Business Leader*
- Lack of patient motivation, difficulty in overcoming the disease. – Physician*

Contributing Factors

Stigma is still a major issue when it comes to drug use. Income is another issue; many individuals simply cannot afford substance use treatment and their insurance may not cover it at all. Additionally, individuals fear legal repercussions of admitting to using substances, especially in areas that are highly policed for substance use (such as Paterson and Passaic City). – Community/Business Leader

Stigma and admitting one needs help. – Social Services Provider

Awareness/Education

Knowledge and money. – Community/Business Leader

Many Guests would like to continue to work on their sobriety and don't know where to seek free services. – Other Health Provider

It's an epidemic. There's no single organization reaching out to inner city to provide education. – Physician

Early Diagnosis/Prevention

Substance abuse is a problem, but treatment, as described in this question, is not the only need. Access to prevention service as well as treatment are equally needed, yet often the focus is only on treatment. – Community/Business Leader

Easily Accessible

There are young men and women hanging on the street corners every day. It's easy to access in my community. – Community/Business Leader

Denial/Stigma

Stigma. Failure to recognize substance abuse as a disease. – Social Services Provider

Affordable Care/Services

Cost, not enough services. – Public Health Representative

Most Problematic Substances

Key informants (who rated this as a “major problem”) clearly identified **alcohol** and **heroin/other opioids** as the most problematic substance abused in the community, followed by **marijuana**, **cocaine/crack**, and **prescription medications**.

Problematic Substances as Identified by Key Informants				
	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Alcohol	27.6%	39.3%	18.5%	24
Heroin or Other Opioids	51.7%	17.9%	11.1%	23
Marijuana	3.4%	7.1%	29.6%	11
Cocaine or Crack	6.9%	17.9%	11.1%	10
Prescription Medications	3.4%	10.7%	11.1%	7
Methamphetamines or Other Amphetamines	3.4%	3.6%	7.4%	4
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	3.4%	3.6%	3.7%	3
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	0.0%	3.7%	1
Inhalants	0.0%	0.0%	3.7%	1

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General’s report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

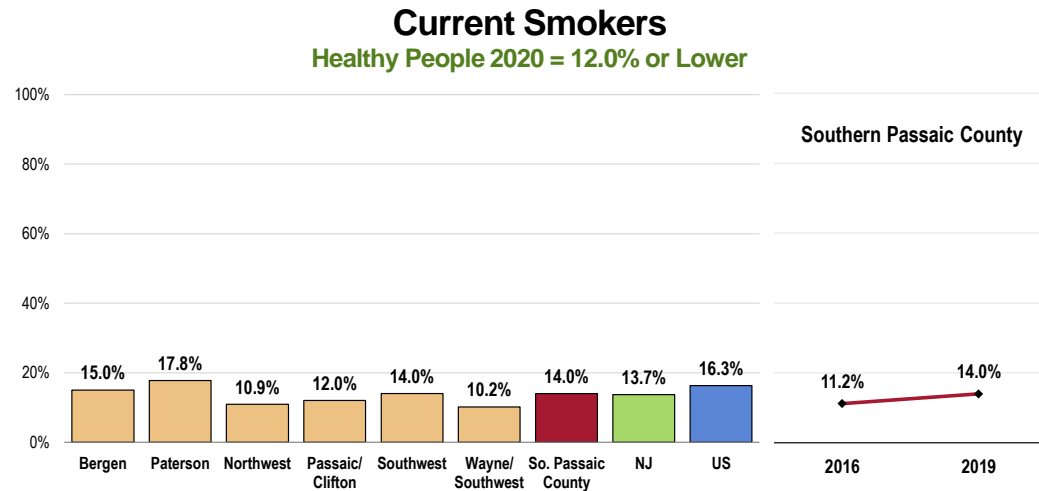
There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

— Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

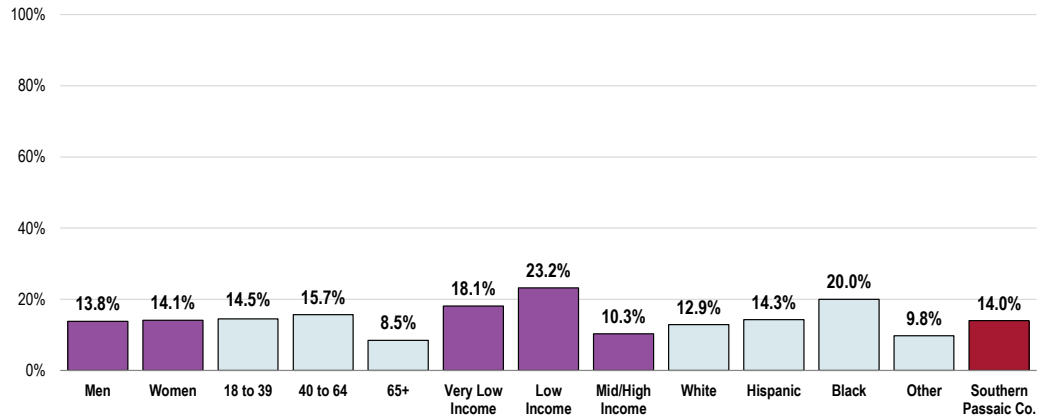
“Do you now smoke cigarettes every day, some days, or not at all?” (“Current smokers” include those smoking “every day” or on “some days.”)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 193]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]

Notes: • Asked of all respondents.
 • Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers (Southern Passaic County, 2019) Healthy People 2020 = 12.0% or Lower



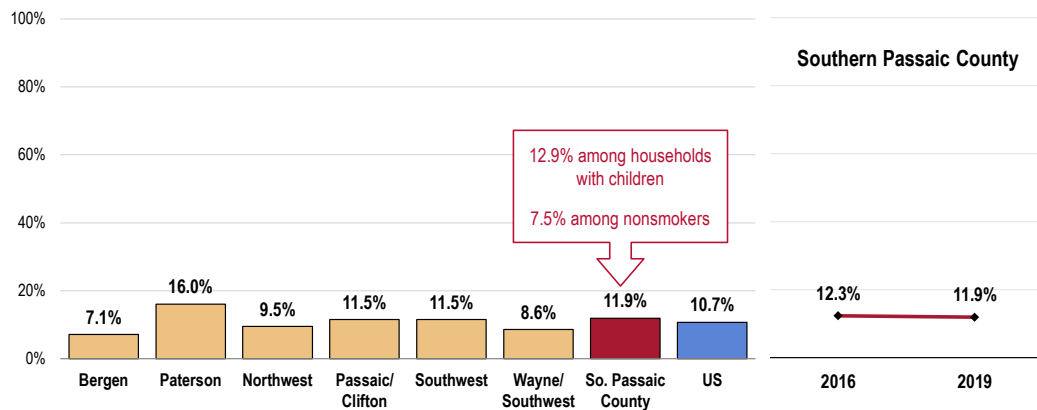
Sources: ● 2019 PRC Community Health Survey, PRC, Inc. [Item 193]
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective TU-1.1]
 Notes: ● Asked of all respondents.
 ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 ● Includes regular and occasion smokers (every day and some days).

Exposure to Tobacco Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).

Member of Household Smokes at Home



Sources: ● 2019 PRC Community Health Survey, PRC, Inc. [Items 52, 161-162]
 ● 2017 PRC National Health Survey, PRC, Inc.
 Notes: ● Asked of all respondents.
 ● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

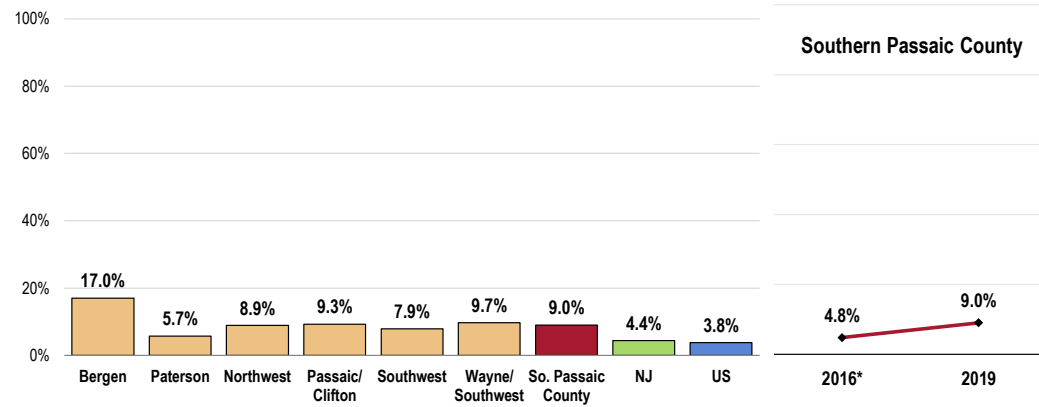
Use of Vaping Products

“The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?”

“Do you now use electronic vaping products, such as e-cigarettes, "every day," "some days," or "not at all"?”

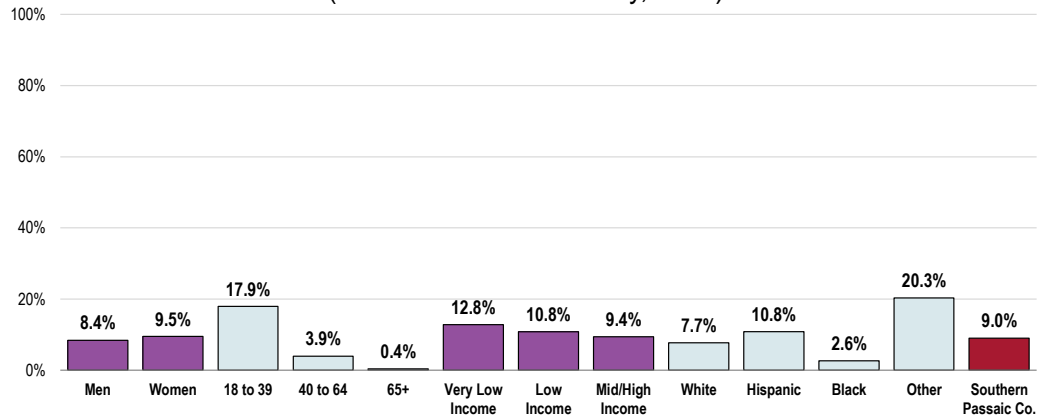
“Current use” includes use “every day” or on “some days.”

Currently Use Vaping Products (Every Day or on Some Days)



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 194]
 - 2017 PRC National Health Survey, PRC, Inc.
 - Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
- Notes:
- Asked of all respondents.
 - Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).
 - Note that in 2016, respondents were asked about electronic cigarettes; in 2019, this wording was changed to "vaping products" to include the expanding types of products that can be used for "vaping."

Currently Use Vaping Products (Southern Passaic County, 2019)

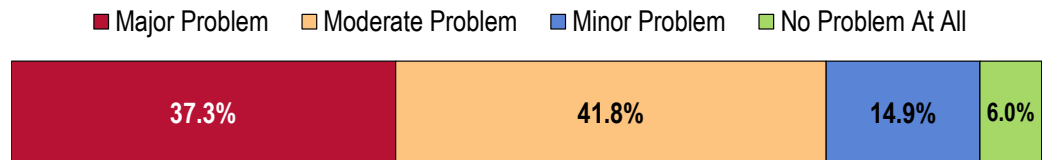


Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 194]
 Notes: • Asked of all respondents.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
 • Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use as a Problem in the Community (Key Informants, 2019)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

Cigarette smoking and doing hookah is a big problem in our community. – Community/Business Leader

All the butts of Black & Mild and cigarettes all over the ground everywhere you walk or drive, as well as seeing people smoke. – Community/Business Leader

You cannot walk down a street without someone smoking cigarettes, Black and Mild's, or vaping. – Community/Business Leader

Contributing Factors

Lack of education, knowledge regarding tobacco use. Often associated with drug use and mental health issues. – Community/Business Leader

Access. Addiction to nicotine, lack of cessation services. – Public Health Representative

Easy access to tobacco, poor teenager education programs. – Physician

E-Cigarettes

Younger people are straying away from traditional cigarette use to vaping because they think it is safer. The vaping companies have not been very upfront of the dangers of vaping and how it is worse than smoking a cigarette. – Community/Business Leader

There is an acceptance of tobacco use due to e-cigarettes. – Social Services Provider

Youth Usage

Youth use. – Community/Business Leader

Early age smoking and drug addiction in teens-young adults. Peer group pressures, stress, lack of recreational facility, i.e. YMCA, Boys & Girls clubs for after-school access. – Other Health Provider

Vulnerable Populations

Low-income communities tend not to recognize the danger of tobacco. Tobacco industry continues to use advertising methods to fool public without mentioning downside. – Community/Business Leader

Access to Care/Services

Lack of resources/support for those planning to quit. – Physician

Sexual Health

HIV

About Human Immunodeficiency Virus (HIV)

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

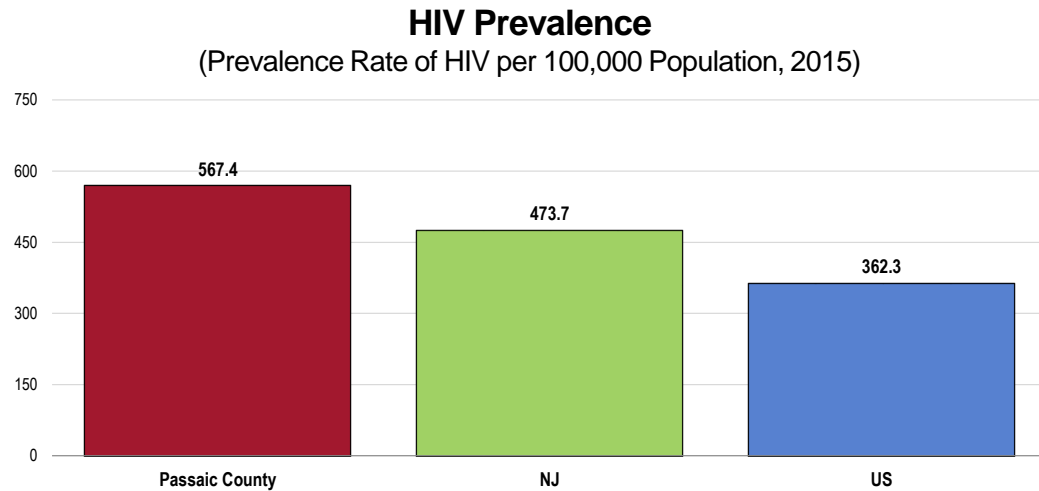
- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

— Healthy People 2020 (www.healthypeople.gov)

HIV Prevalence

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the county.



Sources:

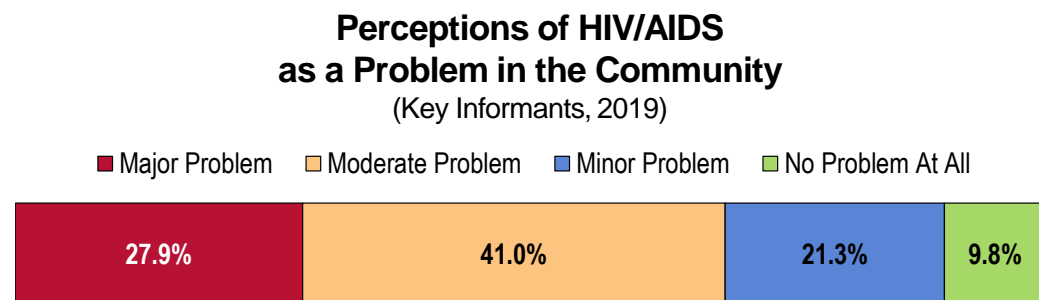
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

Notes:

- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

Key Informant Input: HIV/AIDS

The following chart outlines key informants' perceptions of the severity of *HIV/AIDS* as a problem in the community:



Sources:

- PRC Online Key Informant Survey, PRC, Inc.

Notes:

- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

I saw a recent statistic that HIV/AIDS cases are highest in Passaic County. – Community/Business Leader

Paterson has the third-highest incidence rate of HIV diagnoses in the state of New Jersey, and other cities in Passaic County have larger-than-average HIV incidence rates as well (such as Passaic City). I believe that this is an issue due to many reasons, including a lack of comprehensive sexual education, unawareness of safer sex resources, and high rates of injection drug use. – Community/Business Leader

Denial/Stigma

Stigma attached to it. People fearful to get diagnosed. Lack of insurance. People not taking proper precaution. – Community/Business Leader

HIV/AIDS is no longer discussed as openly as the first outbreak in the 80's. I believe there is still a lot of shame associated with this disease. Due to lack of insurance and shame, most people don't have access to doctors that treat this type of immune condition. – Community/Business Leader

Risky Behavior

Unprotected sex. – Other Health Provider

Transmission through unsafe sexual and substance abuse practices. – Community/Business Leader

Awareness/Education

Since awareness campaigns have declined, there has been a slow increase in cases. – Community/Business Leader

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic, and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

— Healthy People 2020 (www.healthypeople.gov)

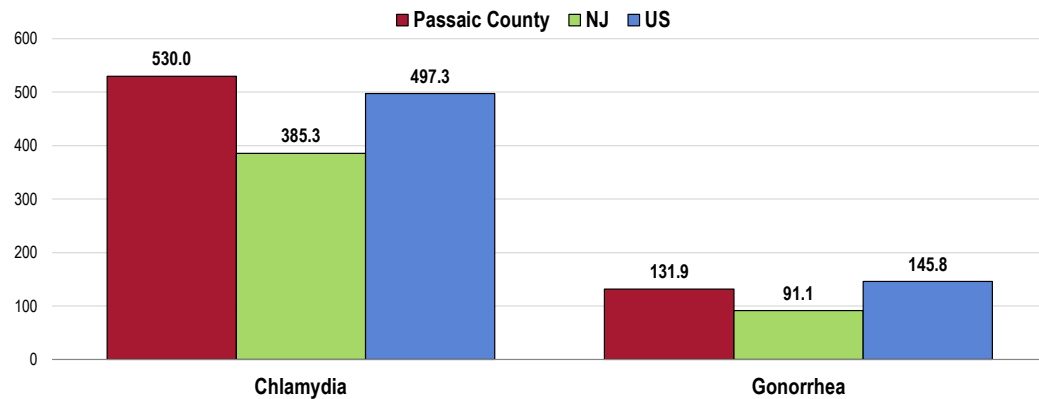
Chlamydia & Gonorrhea

Chlamydia. Chlamydia is the most commonly reported STD in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

Gonorrhea. Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STDs.

Chlamydia & Gonorrhea Incidence (Incidence Rate per 100,000 Population, 2016)



Sources:

- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

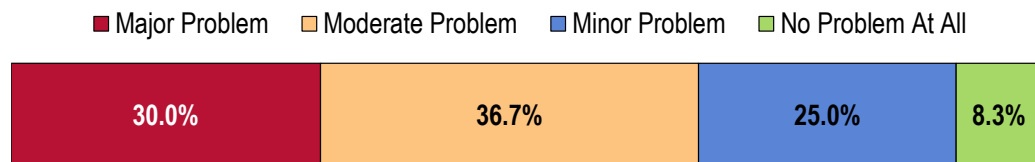
 Notes:

- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexually Transmitted Diseases

The following chart outlines key informants' perceptions of the severity of *Sexually Transmitted Diseases* as a problem in the community:

Perceptions of Sexually Transmitted Diseases as a Problem in the Community (Key Informants, 2019)



Sources:

- PRC Online Key Informant Survey, PRC, Inc.

 Notes:

- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

Statistics at the board of health explain this. – Community/Business Leader

The rate of STD/STIs in the county is steadily increasing among both males and females. Chlamydia and gonorrhea are two STIs that are easily treated with antibiotics. – Community/Business Leader

Syphilis diagnoses rose by 40% between 2016 and 2017; couple this with the fact that Paterson ranks as the city with the third-highest incidence of HIV diagnoses in New Jersey, and you can see there is a problem with STDs in the county. I think this is due to many things, including a lack of comprehensive sexual education in schools, a lack of awareness of safer sex resources, and a high use of injection drugs in the county. – Community/Business Leader

Access to Care/Services

*The Planned Parenthood close to our community closed and it's quite a ride to the one in Paterson. –
Other Health Provider*

Awareness/Education

Lack of education, cultural beliefs and practices. – Public Health Representative

Access to Health Services

Lack of Health Insurance Coverage (Age 18 to 64)

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

“Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?”

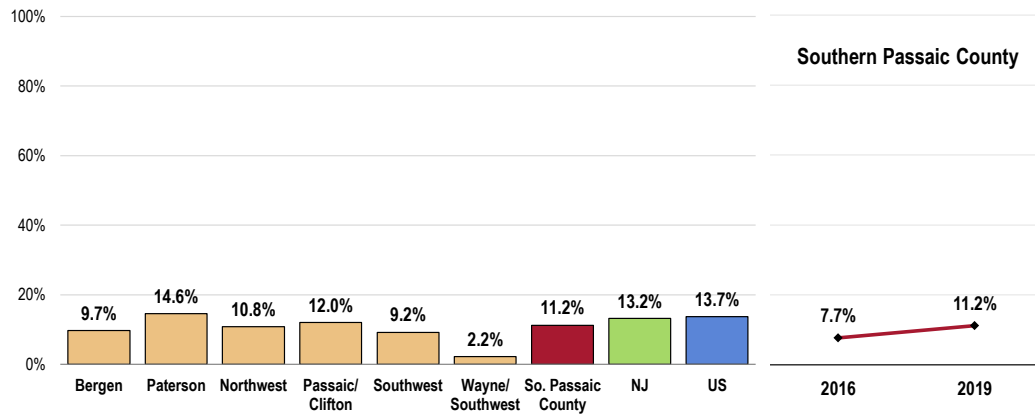
“Do you currently have: health insurance you get through your own or someone else’s employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?”

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Lack of Healthcare Insurance Coverage

(Adults Age 18-64)

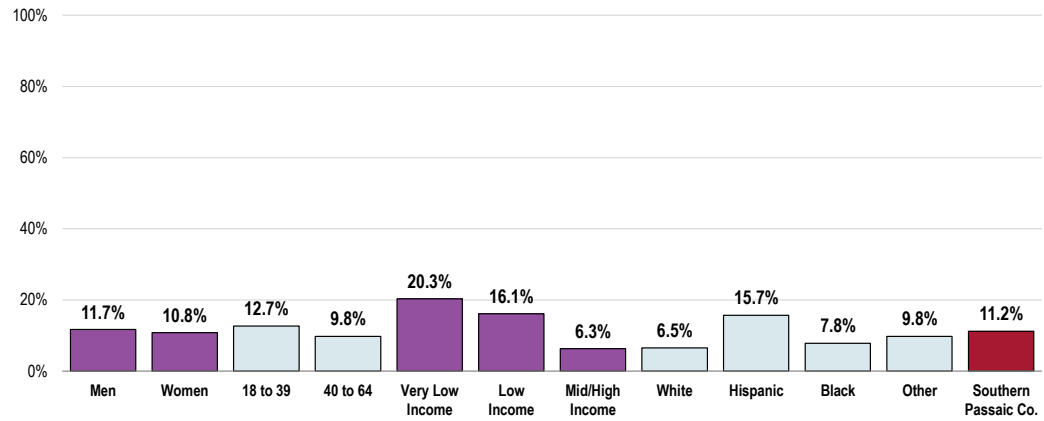
Healthy People 2020 = 0.0% (Universal Coverage)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 169]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.
 • US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]

Notes: • Asked of all respondents under the age of 65.

Lack of Healthcare Insurance Coverage (Adults Age 18-64; Southern Passaic County, 2019) Healthy People 2020 = 0.0% (Universal Coverage)



- Sources:
- 2019 PRC Community Health Survey, PRC, Inc. [Item 169]
 - US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective AHS-1]
- Notes:
- Asked of all respondents under the age of 65.
 - Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 - Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

— Healthy People 2020 (www.healthypeople.gov)

Barriers to Healthcare Access

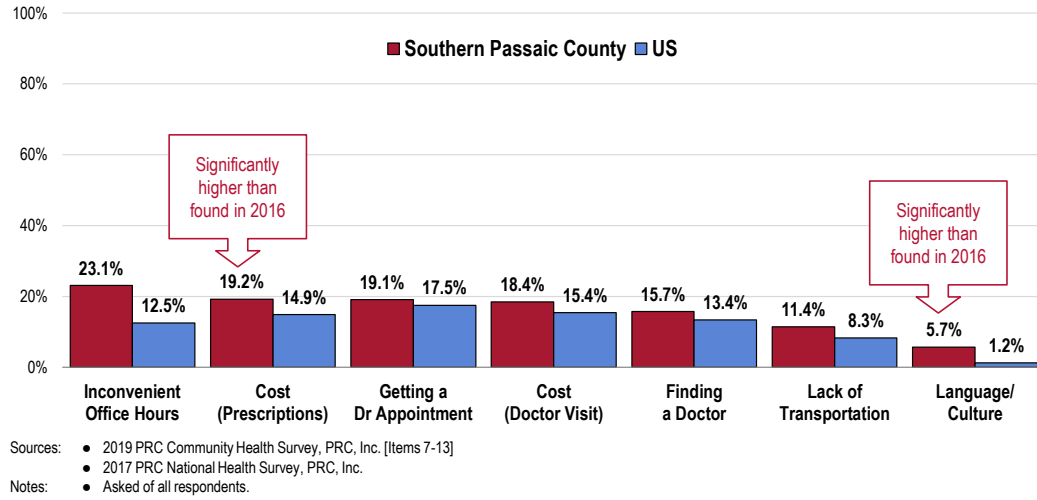
To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

“Was there a time in the past 12 months when...

- ... you needed medical care, but had **difficulty finding a doctor?**”
- ... you had difficulty getting an **appointment** to see a doctor?”
- ... you needed to see a doctor, but could not because of the **cost?**”
- ... a **lack of transportation** made it difficult or prevented you from seeing a doctor or making a medical appointment?”
- ... you were not able to see a doctor because the **office hours were not convenient?**”
- ... you needed a **prescription medicine**, but did not get it because you could not afford it?”
- ... you were not able to see a doctor due to **language or cultural differences?**”

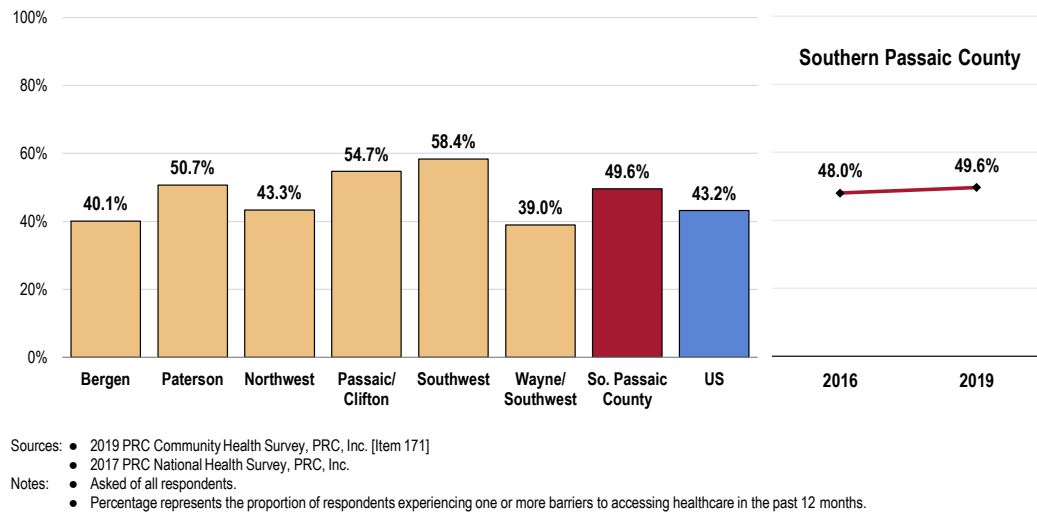
The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year

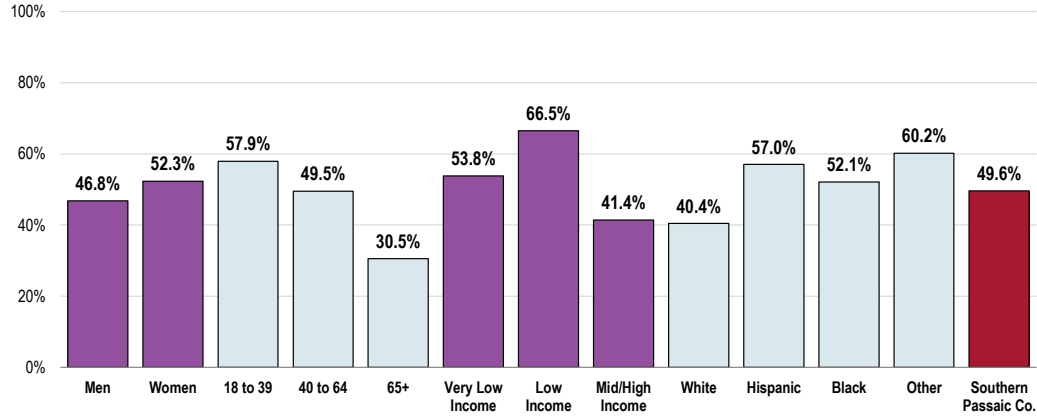


The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year



Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (Southern Passaic County, 2019)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 171]
 Notes: • Asked of all respondents.
 • Percentage represents the proportion of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
 • Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
 • Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

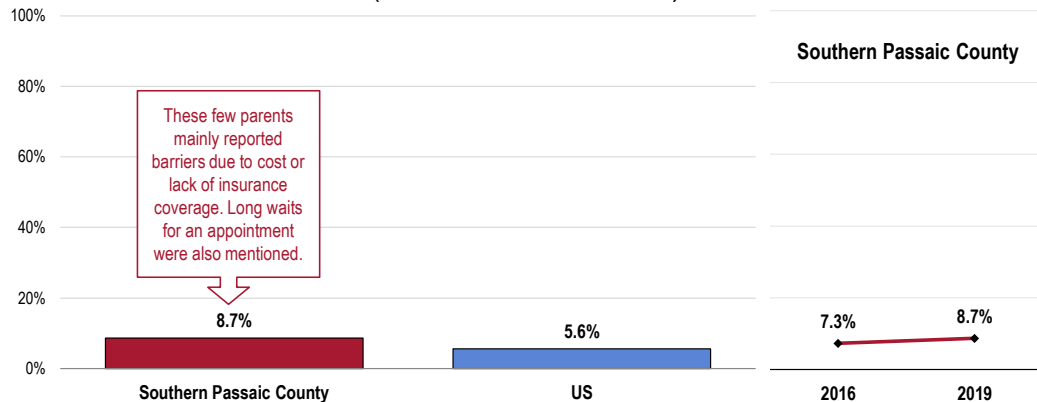
Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

“Was there a time in the past 12 months when you needed medical care for this child, but could not get it?”

“What was the main reason you could not get medical care for this child?”

Had Trouble Obtaining Medical Care for Child in the Past Year (Parents of Children 0-17)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Items 118-119]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Healthcare Services

The following chart outlines key informants’ perceptions of the severity of *Access to Healthcare Services* as a problem in the community:

**Perceptions of Access to Healthcare Services
as a Problem in the Community**

(Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

Ease of access, transportation, direct link to location, need for satellite facilities. – Social Services Provider

I think there are several barriers including lack of resources for underserved populations be it for financial reasons, for cultural sensitivity reasons, for immigration concerns, etc. – Social Services Provider

Inability for families to miss work, transportation challenges, money, and education on what services are available and where. – Community/Business Leader

Not enough doctors with evening hours to accommodate the working families. So kids have to miss days of school to go to the doctor. – Community/Business Leader

Lack of availability of appointments at specialty clinics. – Physician

Not enough people have healthcare and use the Emergency Room as their healthcare service.

Challenges in getting doctors’ appointments and transportation. Lack of awareness regarding regular check-ups. – Community/Business Leader

Cost of services and transportation issues. – Social Services Provider

Affordable care, education to prevent more serious illnesses. Lack of trust. – Community/Business Leader

The biggest challenges are affordable insurance and affordable co-pays and/or deductibles. For those with Medicare or Medicaid the biggest complaint I hear is they need transportation to and from the doctor’s office and/or they’d like bigger selection of doctors to choose from. – Other Health Provider

Language/Culture

Clifton is 3rd most linguistically diverse city in the nation, with 1/2 of the residents speaking something other than English. Communicating about available services is hugely challenging. Large number of immigrants who may not be eligible for insurance and may lack transportation; variations in walkability, increasing homelessness. – Other Health Provider

There are major cultural and language barriers for the Bangladeshi community in the Paterson/Passaic County area. Though some in the community can speak the Bengali language and the county does provide some Bengali language interpretation, many in the community speak a distinct dialect of Bengali, called Syhleti, which is very different from colloquial Bengali and very difficult to navigate if that language interpretation is not available. There is also a big gap in access to preventative health services. Too often our community only goes in when there's a health emergency, instead of cultivating good health practices to prevent health issues down the road, such as high blood pressure, diabetes, hypertension and diabetes. So cultural and language access gaps, lack of access to preventative healthcare and a lack of comfort and education on prioritizing one's health. Also, environmental health issues are also a concern (i.e., lead poisoning, asthma, environmental impacts on health). – Community/Business Leader

Insurance Issues

No insurance or underinsured. – Community/Business Leader

People who are unemployed or underemployed are not provided with adequate insurance and won't go to the doctors until it is too late. – Community/Business Leader

Lack of adequate healthcare insurance coverage. – Other Health Provider

Not having insurance coverage. – Other Health Provider

Contributing Factors

Lack of insurance, lack of transportation, fear and distrust. – Public Health Representative

Transportation and education of the community make it difficult for residents to understand the issues and obtain adequate care. – Community/Business Leader

Awareness/Education

Lack of education. – Other Health Provider

People are unaware of how to access healthcare outside of the Emergency Room. – Community/Business Leader

Vulnerable Populations

Transition-related healthcare: several clients I have worked with in my social service agency identify as transgender. While transgender individuals represent only around 1-2% of our client base, our transgender clients experience many negative health outcomes related to their transgender identity and healthcare. For example, many of our transgender clients are unable to afford transition-related care and their health insurance does not cover certain related procedures, which leads these clients to seek cheaper procedures from unlicensed practitioners and ultimately leads to health concerns. Some clients have also expressed being denied care due to their gender identity, despite their gender not being related to the issue they are seeking care for. – Community/Business Leader

Poverty

The patients are poor and uneducated and therefore very sick. They have the worst insurances, so they do not get the treatment that they need. Insurance companies won't pay for the procedures and medicines they need, and so the doctors won't even see them because the reimbursement is so low for actually taking care of a patient that it's not worth the time and energy or the risk that comes with taking on a new patient that is very sick, has lots of needs, and lousy insurance. – Physician

Affordable Medication

Affordability of medications for chronic diseases for people who have been diagnosed. – Physician

Co-Occurrences

Guests seeking mental health help as well as substance use. – Other Health Provider

Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) most often identified behavioral health and substance abuse treatment as the most difficult to access in the community.

Medical Care Difficult to Access as Identified by Key Informants				
	Most Difficult	Second-Most Difficult	Third-Most Difficult	Total Mentions
Behavioral Health	36.8%	27.8%	12.5%	14
Substance Abuse Treatment	36.8%	16.7%	6.3%	11
Primary Care	21.1%	0.0%	6.3%	5
Specialty Care	0.0%	0.0%	31.3%	5
Dental Care	0.0%	22.2%	0.0%	4
Elder Care	0.0%	11.1%	12.5%	4
Chronic Disease Care	0.0%	5.6%	12.5%	3
Urgent Care	5.3%	5.6%	6.3%	3
Prenatal Care	0.0%	5.6%	6.3%	2
Palliative Care	0.0%	0.0%	6.3%	1
Pain Management	0.0%	5.6%	0.0%	1

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

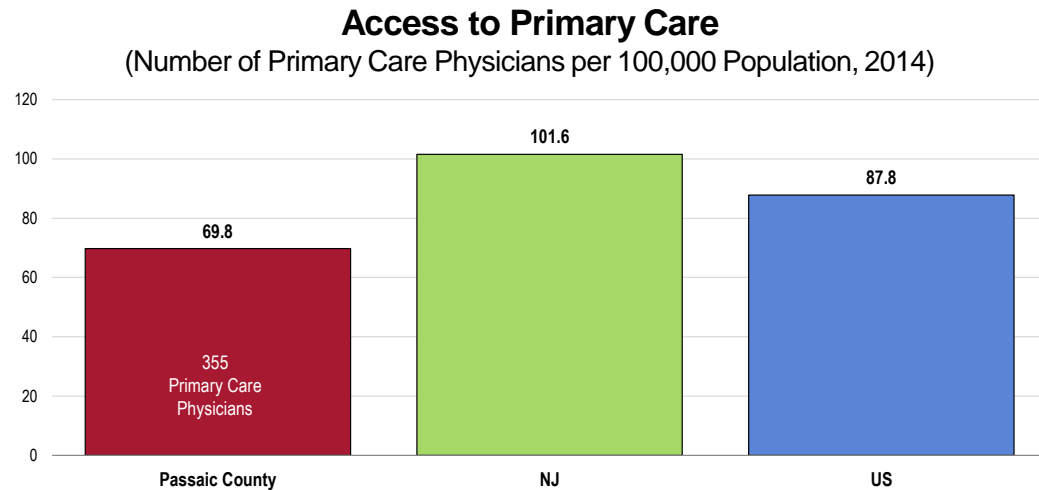
- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

— Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.



Sources: • US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
 • Retrieved July 2019 from CARES Engagement Network at <https://engagementnetwork.org>.

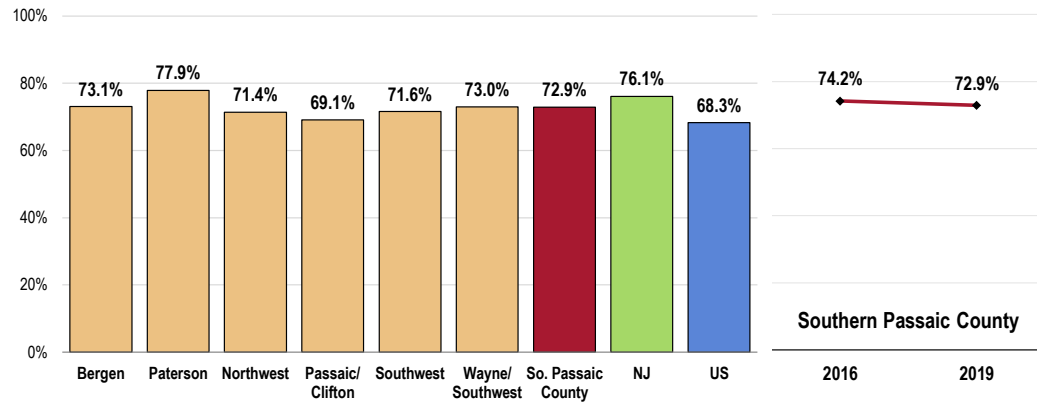
Notes: • Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Utilization of Primary Care Services

Adults: “A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?”

Children: “About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?”

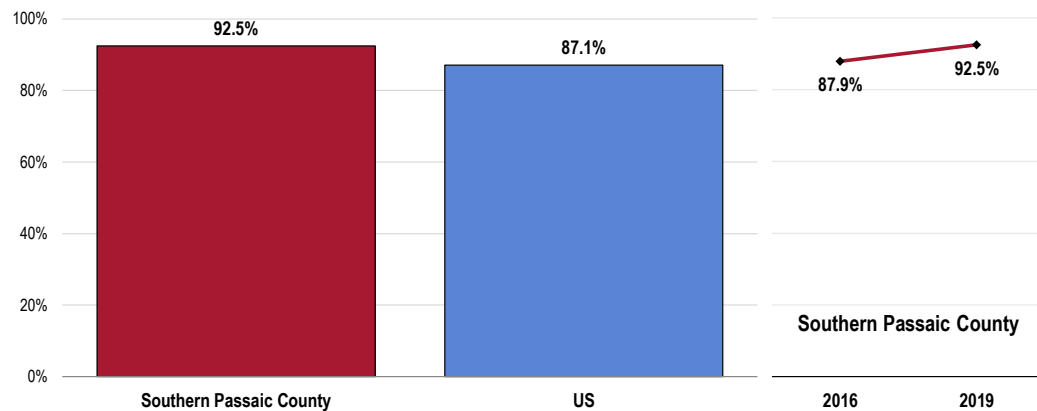
Have Visited a Physician for a Checkup in the Past Year



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 18]
 • Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2017 New Jersey data.
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents.

Child Has Visited a Physician for a Routine Checkup in the Past Year (Parents of Children 0-17)



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 120]
 • 2017 PRC National Health Survey, PRC, Inc.

Notes: • Asked of all respondents with children 0 to 17 in the household.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use**; **excessive alcohol use**; and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

— Healthy People 2020 (www.healthypeople.gov)

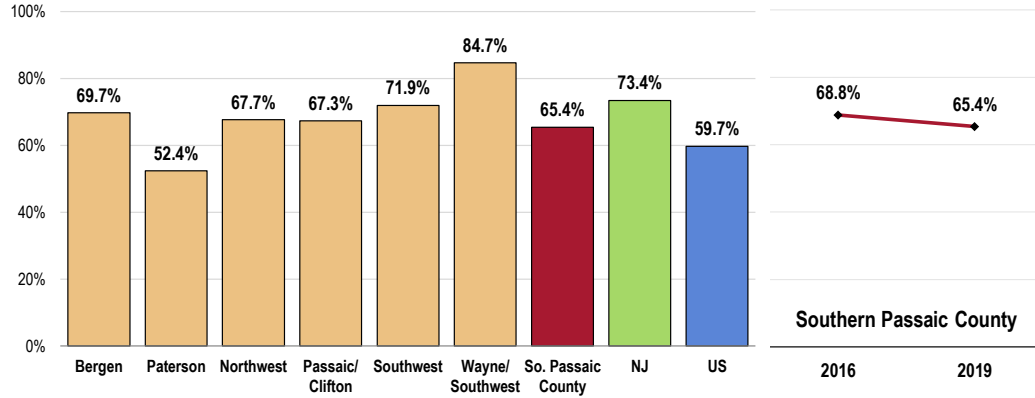
Dental Care

Adults: “About how long has it been since you last visited a dentist or a dental clinic for any reason?”

Children Age 2-17: “About how long has it been since this child visited a dentist or dental clinic?”

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2020 = 49.0% or Higher

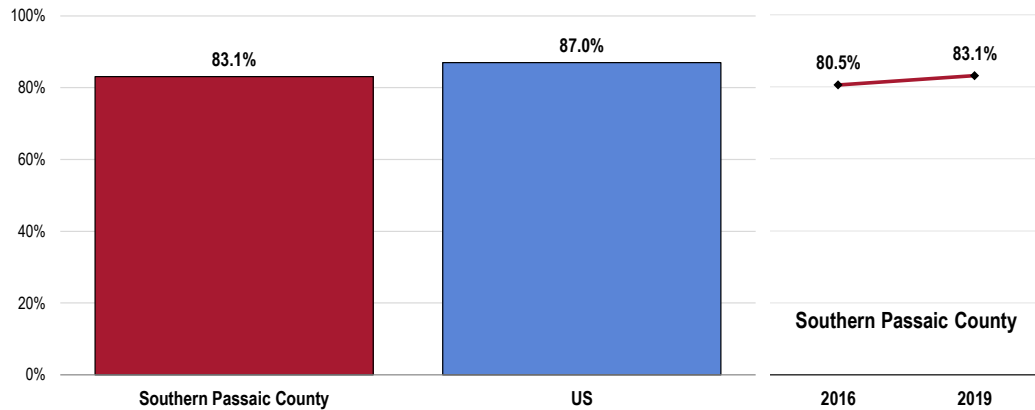


Sources: ● 2019 PRC Community Health Survey, PRC, Inc. [Item 20]
 ● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC); 2016 New Jersey data.
 ● 2017 PRC National Health Survey, PRC, Inc.
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]

Notes: ● Asked of all respondents.

Child Has Visited a Dentist or Dental Clinic Within the Past Year (Parents of Children Age 2-17)

Healthy People 2020 = 49.0% or Higher



Sources: ● 2019 PRC Community Health Survey, PRC, Inc. [Item 123]
 ● 2017 PRC National Health Survey, PRC, Inc.
 ● US Department of Health and Human Services. Healthy People 2020. December 2010. <http://www.healthypeople.gov> [Objective OH-7]

Notes: ● Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:

Perceptions of Oral Health as a Problem in the Community (Key Informants, 2019)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Care/Services

- The Clifton Board of Health provides a dental clinic once a month. Not enough time for preventive care for our children. – Social Services Provider*
- Lack of access to dental care. – Physician*
- Affordability, lack of education, awareness regarding dental hygiene. – Community/Business Leader*
- Not enough providers and adequate insurance and free coverage. – Other Health Provider*

Prevalence/Incidence

- People are obviously in need of dental care and/or in pain. – Social Services Provider*
- People with rotten teeth and lack of teeth. – Social Services Provider*
- I noticed a lot of people with missing teeth, built up plaque as well as major cavities. – Community/Business Leader*

Insurance Issues

- Lack of dental insurance. – Public Health Representative*
- Insurance issues, not enough providers to take the lousy insurances. – Physician*
- High percentage of uninsured. – Community/Business Leader*

Access for Medicaid/Medicare Patients

- Very few dentists accept Medicaid. Hospital clinic is packed! Patients go as early as 5 a.m. to get in the line, wait all day. Insurances barely cover the basics, very expensive to see a dentist and pay out of pocket. Medicare does not cover dental. Commercial insurances have too many exclusions. What to cover and what not to cover. Having good dental care is a luxury reserved to more influential and richer counties – as for Passaic, we can't afford these luxuries at this time. – Physician*

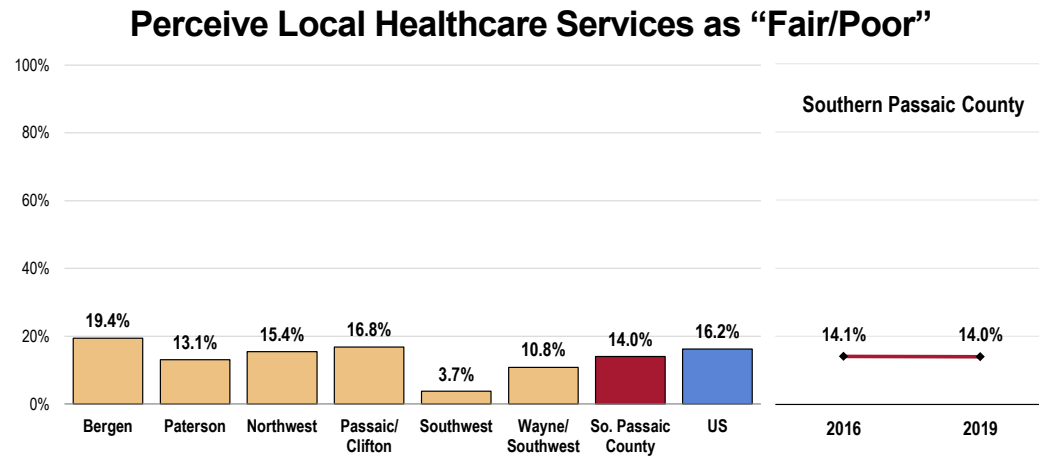
Contributing Factors

- In some cases, there can be a direct correlation between the lack of dental hygiene and heart disease. – Community/Business Leader*
- Generally dental care is secondary to physical care. Most dentists do not take Medicaid or Medicare. – Community/Business Leader*

Local Resources

Perceptions of Local Healthcare Services

“How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?”



Sources: • 2019 PRC Community Health Survey, PRC, Inc. [Item 6]
 • 2017 PRC National Health Survey, PRC, Inc.
 Notes: • Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access Problems

- 4Cs of Passaic County
- Access Link
- Aging and Disability Resources
- Barnert Hospital
- Care Plus
- Center for Family Services
- Charity Care
- Clifton Health Department
- County Transportation
- Doctor's Offices
- Eva's Village
- Evelyn's Place
- Horizon
- M&S Psychotherapy and Counseling

- Mental Health Association of Passaic County
- New Jersey Cancer Education and Early Detection (NJCEED)
- New Jersey Community Development Corporation
- North Hudson Community Action Corporation
- North Hudson Federally Qualified Health Center
- North Jersey Health Collaborative
- Oasis: A Haven for Women and Children
- Options Counseling
- Paratransit
- Passaic County Human Services
- Passaic Wellness Respite
- Paterson Community Health Center

Paterson Health Department
Paterson Public Schools
Perform Care
Ryde4Life
Senior Transportation
St. Joseph's Health
St. Mary's Hospital
Straight and Narrow

Arthritis/Osteoporosis/Back Conditions

Charity Care
Doctor's Offices
Hospitals
Pain Management

Cancer

American Cancer Association
American Cancer Society
Charity Care
Doctor's Offices
Hackensack University Medical Center
Health Department
Memorial Sloan Kettering
Mountainside Hospital
New Jersey Cancer Education and Early Detection (NJCEED)
Paterson Community Health Center
Pharmaceutical Assistance to the Aged and Disabled (PAAD)
Quit Center Grant Program
Sisters Network Passaic/Bergen Counties
St. Joseph's Health
St. Mary's Hospital

Chronic Kidney Disease

Community Education
Davita
Fresenius
Good Shepherd Mission Alcohol and Drug Recovery
Hospitals

Dementia/Alzheimer's Disease

Act Now Foundation
Adult Day Care
Alzheimer's Association
Alzheimer's of New Jersey
Caregiver Support Groups
CARES Program
Geriatric Psychiatry
Home Care Options
Hospitals
Legal Services
Passaic County Senior Services
St. Joseph's Health

Diabetes

American Diabetes Association Bergen Chapter
Charity Care
Chilton Hospital
CUMAC Food Pantry
Diabetes Education and Nutrition Center
Diabetes Foundation
Diabetic Services
Doctor's Offices
Federally Qualified Health Centers
Hackensack University Medical Center
Health Coalition of Passaic County
Health Department
John Victor Machuga Center
Mountainside Hospital
Nutrition Services
Paterson Community Health Center
Paterson Public Schools
Pharmaceutical Assistance to the Aged and Disabled (PAAD)
Pharmacies
St. Joseph's Health
St. Mary's Hospital
St. Paul's Food Pantry

Family Planning

Charity Care
Community Education
Healthy Mothers, Healthy Babies
Hyacinth

Lighthouse Pregnancy Resource Center
Partnership for Maternal and Child Health
Paterson Community Health Center
Paterson Division of Health
Planned Parenthood
RENEW Life Center
School System

Heart Disease and Stroke

American Heart Association
Blood Pressure Screenings
City Green
Doctor's Offices
Federally Qualified Health Centers
Health Department
Health Fairs
Lifeline Screening
Parks and Recreation
Paterson Community Health Center
St. Joseph's Health

HIV/AIDS

Coalition on AIDS
Doctor's Offices
HIV/AIDS Programs
Hospitals
Hyacinth
Passaic Alliance
Passaic Bergen HIV Health Screening Services
Paterson Counseling Center
Project COPE

Immunization/Infectious Disease

12 Steps
Barnett Drug and Liquor Addiction After Care
Doctor's Offices
Eva's Village
Health Department
Hospitals
Paterson Community Health Center
Paterson Division of Health
Pharmacies

St. Joseph's Health

Infant and Child Health

4Cs of Passaic County
CAMP Youth Development Program
Doctor's Offices
Eva's Village
Federally Qualified Health Centers
Healthy Mothers, Healthy Babies
Hospitals
Infant and Mortality Organizations
Lighthouse Pregnancy Resource Center
New Destiny Family Success Center
North Porch Women and Infant Children
Oasis - A Haven for Women and Children
Partnership for Maternal and Child Health
Paterson Community Health Center
School System
St. Joseph's Health
WIC

Injury and Violence

Bronze Shield
Cease Fire
Churches
County Sheriff's Community Programs
Court Sanctioned Anger Management Programs
Eva's Village
Fallen Soldiers
Help Lines
Hospitals
Kintock Group
M&S Psychotherapy and Counseling
Manavi, Inc.
Municipal Alliances
My Sister's Keeper
New Destiny Family Success Center
Oasis: A Haven for Women and Children
Passaic County Women's Shelter
Paterson Family Court
Paterson Police
Paterson's Community Policing Programs
Perform Care
Police Violence Prevention Program

Safe City Street Program
 Safe Transaction Areas
 Sanitation Department
 Scared Straight
 School System
 Sheriff's Department
 St. Joseph's Health
 St. Paul's CDC

Doctor's Offices
 Federally Qualified Health Centers
 Fitness Centers/Gyms
 Food Pantry
 Habitat for Humanity
 Health Department
 Hospitals
 New Destiny
 Nutrition Services
 Parks and Recreation
 Passaic County Food Coalition
 Passaic County Food Policy Council
 Paterson Public Schools
 Planet Fitness
 ShopRite
 St. Joseph's Health
 WIC
 YMCA

Mental Health Issues

Bergen Regional Hospital
 Charity Care
 Clifton Behavioral Healthcare
 Community Education
 Eva's Village
 Family Intervention Services
 Harbor House
 Jewish Family Services
 Long-Term Health Clinics
 M&S Psychotherapy and Counseling
 Mental Health Association of Passaic County
 New Jersey Association of Mental Health and Addiction Agencies
 North Jersey Health Collaborative
 Oasis – A Haven for Women and Children
 Options Counseling
 Passaic County Division of Mental Health
 Passaic County Human Services
 Passaic County Program of Assertive Community Treatment (PACT)
 Passaic Wellness Respite
 Paterson Public Schools
 Pathways Counseling
 Perform Care
 Performance Children's Behavioral Health
 St. Joseph's Health
 St. Mary's Hospital
 Straight and Narrow
 True Care

Oral Health/Dental Care

Clifton Board of Health
 Dentist's Offices
 Doctor's Offices
 Eva's Village
 Federally Qualified Health Centers
 Health Department
 Park Avenue Dental
 Rutgers Dental School
 Smile Dental Group
 St. Joseph's Health

Respiratory Diseases

4th Ward CPTED
 Clean Air Initiatives
 Doctor's Offices
 Greater Bergen Community Action
 Habitat for Humanity
 Hospitals
 Rebuilding Together North Jersey
 Smoking Cessation Programs

Nutrition, Physical Activity, and Weight

Boys and Girls Club
 City Green

Sexually Transmitted Diseases

Coalition on AIDS
Doctor's Offices
Federally Qualified Health Centers
Hospitals
Lighthouse Pregnancy Resource Center
Passaic County Board of Health
Paterson Community Health Center
Paterson Division of Health
Paterson Health Department
Planned Parenthood
Project COPE

Hospitals
Municipal Alliances
New Bridge Services
Options Counseling
Passaic County Division of Addiction Services
Paterson Counseling Center
Short-term Care Facilities
St. Joseph's Health
Straight and Narrow
Turning Point
United for Prevention in Passaic County (UPinPC)

Substance Abuse

12 Steps
Anonymous Support Groups
Coalition on AIDS
Doctor's Offices
Drug Monitoring Programs
Eva's Village
High Focus

Tobacco Use

American Cancer Society
Doctor's Offices
Hackensack's Tobacco Quit Centers
Municipal Alliances
Quit Lines
United for Prevention

Appendix



Evaluation of Past Activities: St. Joseph's University Medical Center

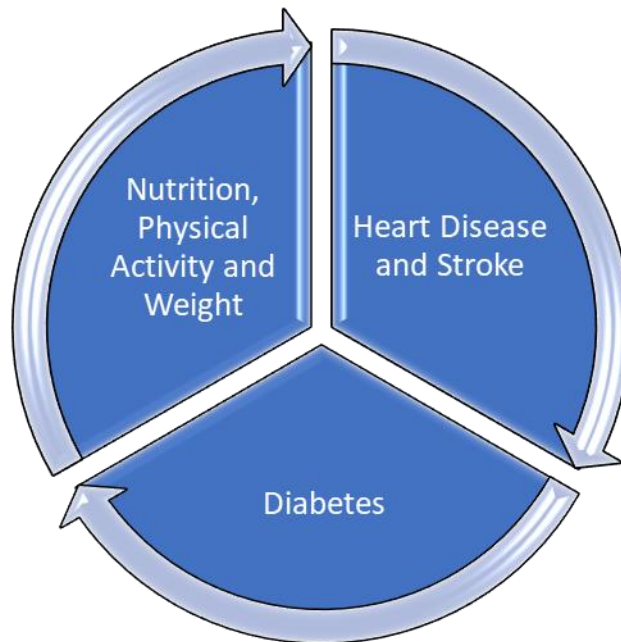
St. Joseph's Healthcare System

2016 Community Health Needs Assessment

Implementation Strategy Evaluation 2019

In 2016, St. Joseph's Healthcare System (System) conducted a Community Health Needs Assessment (CHNA) and created an implementation strategy plan. The System includes St. Joseph's University Medical Center (SJUMC), a quaternary state-designated trauma center and state-designated St. Joseph's Children's Hospital (651 adult and pediatric beds) on the Paterson campus; St. Joseph's Wayne Medical Center (229 beds), an acute care community hospital on the Wayne campus; St. Joseph's Healthcare and Rehab Center (151 beds), Cedar Grove; Visiting Health Services of NJ, Totowa; and more than 30 North Jersey community-based facilities. For purposes of this evaluation, only SJUMC is included in this implementation strategy assessment. The System CHNA process identified three priority areas outlined in **Figure 1** as the most important priority issues for SJUMC to work on over the next three-years.

Figure 1. SJUMC Priority Areas



With the assistance of Strategy Solutions, Inc., the Erie, PA-based consulting group engaged by PRC to assist with the System CHNA, an evaluation of the implementation strategies undertaken since the completion of the 2016 CHNA was conducted. Although the measurable population health outcomes for most county level indicators did not move substantially over the three-year period, the partners are working individually and collaboratively to improve the health of the community. Overall population health improvements are expected over time.

It is important to note that SJUMC is actively involved in the community providing educational sessions on a variety of topics, supporting local community events, offering wellness and preventative screenings and helping to address the social determinates of health especially as they relate to access. The numbers in this chapter are only those related to the priority areas

and do not fully represent the depth and breadth of community outreach, programming and screenings provided by SJUMC. Participation was not tracked at all events and educational sessions nor were the specific priority area noted for all. Events and education sessions may cover multiple topics and therefore the numbers cannot be totaled to provide an unduplicated account of number of events, educational sessions, screenings or participants. The data presented in this chapter is based on information available. As SJUMC looks to develop its 2020 Implementation Strategy there will be a focus on defining relevant metrics and working to implement a more standard process for data tracking.



Nutrition, Physical Activity and Weight

Goal: Improve the wellbeing of community residents through increased knowledge about and access to healthy foods and participation in physical activity programs

SJUMC continues to provide community education and outreach throughout the community with a focus on nutrition, physical activity and weight. Through partnerships and participation in local events SJUMC has reached over 69,016 residents through 173 outreach programs and events.

Since the 2016 CHNA, SJUMC has:

- Partnered with the Health Coalition of Passaic County to:
 - Provide 5 bi-lingual Healthy Women Build Healthy Communities programs in the highest risk zip codes for pre-term births
 - Enroll and conduct care coordination for 26 diabetic clients with at least 50% of participants with a reduction in Biometric benchmarks
 - Conduct 1 Diabetes Self-Management program
 - Recruit and launch 12 Faith in Prevention Programs
- Partnered with Straight and Narrow Family Success Center to provide an opportunity to expose second year medical residents to the community during their Community Advocacy rotation:
 - Residents had the opportunity to observe and facilitate a workshop at Straight and Narrow Family Success Center. This year they conducted 4

- workshops at Straight and Narrow Family Success Center, with each having between 8-10 participants for a total of 32-40 participants
- Focused educational outreach in the community through participation in health fairs and through educational outreach and programming:
 - Participated in 40 local health fairs, school and community events (with a specific focus on physical activity and nutrition) reaching over 39,000 residents
 - Offered 10 educational programs in the community on a variety of topics related to health, nutrition and physical activity reaching almost 70 residents
 - Provided quarterly bariatric seminars with over 1,000 participants in addition to hospital wide programs on obesity, nurse education on bariatrics for the pediatric and me/surge units and a program on obesity offered at a local church
 - Offered 4 educational outreach events (focused on physical activity and nutrition) to the faith-based community with over 350 participants
 - Provided 6 educational outreach sessions (focused on physical activity and nutrition) to area corporations
 - Partnered with the YMCA to host 2 educational outreach events (focused on physical activity and nutrition) with 530 participants
 - Participated in National Nutrition month by offering 2 nutritional education sessions in the cafeteria as well as staff education on providing nutritious meals to children with approximately 250 individuals participating in events during the month
 - Offered support groups as well as education at support groups across service lines:
 - Bariatric support groups were offered two times per month (1 in English and 1 in Spanish) with a total of 723 participants
 - Bariatric pre-op classes were also offered two times per month (1 in English and 1 in Spanish) with a total of 1,053 participants
 - Participated in 35 health fairs, community events and educational sessions in neighboring communities reaching almost 26,000 residents

Heart Disease and Stroke

Goal: Improve health status through chronic disease and care management across the continuum for heart disease and stroke

SJUMC continues to provide community education and outreach throughout the community and develop programs related to heart disease and stroke. SJUMC has earned disease specific certification in Primary Stroke from Det Norske Veritas and has been designated by the State of New Jersey, Department of Health and Senior Service as a Comprehensive Stroke Center. The stroke program has been recognized by the American Heart Association/American Stroke Association's "Get With The Guidelines" Program and has received the Gold Plus Award for quality stroke care. All educational programs and services provided align with recognized best practices. SJUMC has developed the Community Medicine-Ambulatory Medicine Program and Cardiovascular Fellowship Program as well as begun using Nurse Navigators to follow up with post-stroke care. They have also partnered with area schools to teach and certify students in CPR.

Since the 2016 CHNA, SJUMC has:

- Focused educational outreach in the community related to heart disease prevention and risk factors through partnerships with the American Heart Association and other community organizations:
 - Participated in 39 local health fairs where hospital focused on heart health reaching over 1,000 residents
 - Offered blood pressure screenings at 18 events screening over 1,000 residents. Those who had high blood pressure at the time of the screening were encouraged to follow up with their primary care provider, Community Medicine or Community Health Center at Paterson.

- Increased awareness of life-saving programs in the community through Hands Only CPR and AED trainings:
 - Worked with local paramedics to offer a program at Harp Academy and Mary Help with a total of 41 students participating, of which 25 are CPR certified
 - Provided CPR and defibrillator training to 20 employees at Kontos
- Offered community education programs through partnerships with health care providers, employers and the community at large to increase public awareness of the value for early patient engagement for heart attack care and hands only CPR:
 - Developed the Community Medicine – Ambulatory Medicine Program and the Cardiovascular Disease Fellowship Program – Continuity Clinic Experience which utilize 40 medical residents
 - *Community Medicine-Ambulatory Medicine Program.* This program provides residents a broad exposure of practice in 2 components: 1) the general internal medicine in the ambulatory settings. Each resident is assigned a panel of patients throughout the three years of residency. A total of 8 weeks a year. The faculty only duty is to provide residents education and oversee resident patient care. The Faculty-Resident practice encompasses a multidisciplinary team including social worker, community health nursing, etc. 2.) Includes Community Centered rotations such as a rotation at Straight and Narrow Family Success Center.
 - *Cardiovascular Disease Fellowship Program- Continuity Clinic Experience.* In this program fellows rotate once a week for three years in 3 outpatient clinics. Fellows will see two new patients and four return patients under the supervision of a single faculty physician assigned to the continuity clinic for the weeks. Patients are referrals and present a variety of cardiac diseases including routine management, pre-op evaluations, evaluations for revascularization procedures, discharged patients, medical records, lab results and radiology results are easily accessed via the updated electronic medical records that facilitates, monitoring, tracking, and integration of longitudinal health integration facilitating quality and preventing redundancy of healthcare services. The second component of this program is the Ambulatory Billoci rotations.
- Continued educational outreach in the community:
 - Provided stroke education and awareness of the connection strokes have to drug use, smoking and obesity at 29 community venues
 - Provided 3 general education sessions on stroke and heart health to residents of all ages with 95 participants
- Provided post-stroke care through Nurse Navigators:
 - A Nurse Navigator conducts follow up calls for up to 90 days post discharge with a focus on follow up appointments, stroke education, medication adherence, patient and family engagement and readmission prevention. For Medicare clients there were 91 episodes with a readmission rate of 19.8%
- Provided 44 educational sessions or attend health fairs focused on heart health and stroke education and offered blood pressure screenings at 16 events in neighboring communities reaching almost 1,000 residents and providing blood pressure screenings to over 750 residents

Diabetes

Goal: Improve health status through chronic disease and care management across the continuum for diabetes

SJUMC continues to provide community education and outreach throughout the community and develop programs related to diabetes. SJUMC has developed the Community Medicine Diabetes Management by Pharmacist Program which has lowered patients HbA1C.

Since the 2016 CHNA, SJUMC has:

- Implemented the Community Medicine Diabetes Management by Pharmacist Program:
 - Program includes: Medication reconciliation, adherence assessment and intervention, optimization of pharmacologic therapy, diabetes education, resolution of medication access and immunizations
 - Since 2017 approximately 500 patients have been diagnosed with diabetes mellitus with the patients in the program showing a decrease in average HbA1C from baseline following post-pharmacist management
- Provided education on juvenile diabetes to 15 childcare providers and 600 individuals at an area school
- Provided diabetes education at 4 events in neighboring communities to 570 residents