2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Southern Passaic County, New Jersey

Prepared for

ST. JOSEPH'S UNIVERSITY MEDICAL CENTER

St. Joseph's Health

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INTRODUCTION

PROJECT OVERVIEW

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2016 and 2019, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Southern Passaic County, the service area of St. Joseph's University Medical Center and St. Joseph's Health. 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 Health by PRC, a nationally recognized health care 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 multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

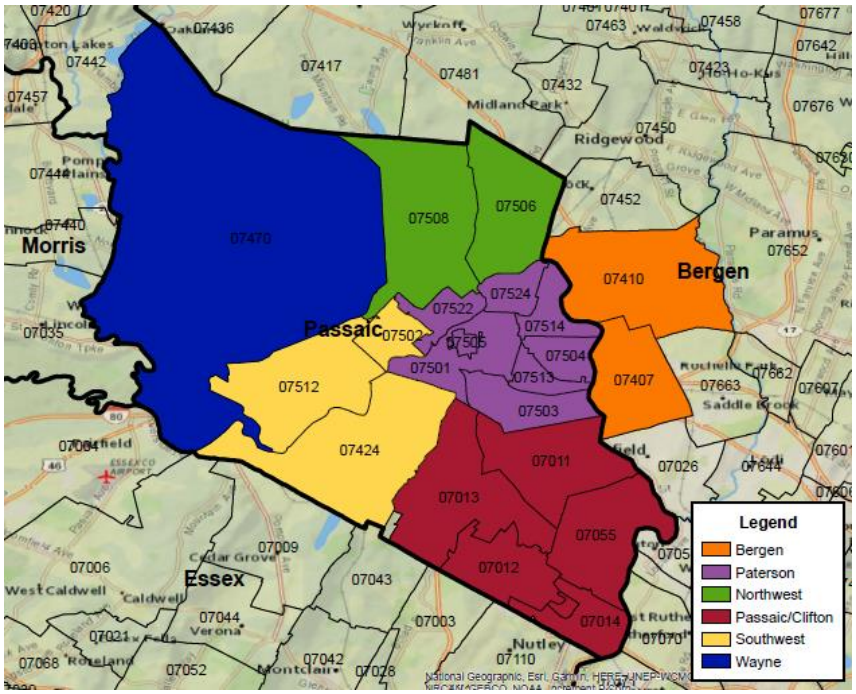
PRC Community Health Survey

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 and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the "Southern Passaic County" in this report) includes the following residential ZIP Codes: 07407, 07410, 07501, 07502, 07503, 07504, 07505, 07513, 07514, 07522, 07524, 07506, 07508, 07011, 07012, 07014, 07055, 07424, 07512, 07470, 07474. This community definition represents the primary and secondary service areas of St. Joseph's University Medical Center and St. Joseph's Wayne Medical Center and includes residential ZIP Codes that generate 85% of the hospitals' inpatient and outpatient admissions. For the purposes of data reporting, the area is further divided into six community areas (Bergen, Paterson, Northwest, Passaic/Clifton, Southwest, and Wayne/Southwest).



Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a stratified random sample of 1,006 individuals age 18 and older in the Southern Passaic County area, including 296 in Paterson, 104 in Northwest, 302 in Passaic/Clifton, 101 in Southwest, 103 in Wayne/Southwest, and 100 in nearby Bergen County ZIP Codes. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent Southern Passaic County as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 1,006 respondents is ±3.1% at the 95 percent confidence level.

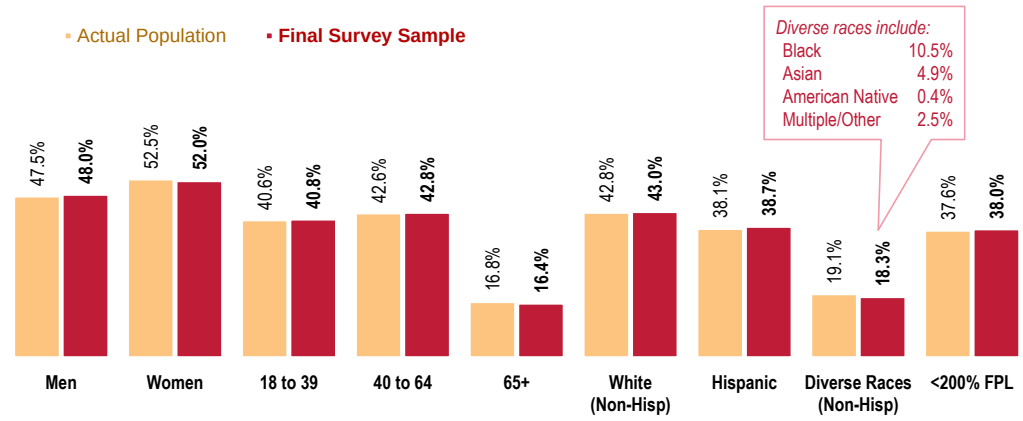
Sample Characteristics

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 health care needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics

(Southern Passaic County, 2022)



Sources:
- US Census Bureau, 2011-2015 American Community Survey.
- 2022 PRC Community Health Survey, PRC, Inc.

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

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.

INCOME & RACE/ETHNICITY

INCOME ► 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 2021 guidelines place the poverty threshold for a family of four at $26,500 annual household income or lower). In sample segmentation: "very low income" refers to community members living in a household with defined poverty status; "low income" refers to households with incomes just above the poverty level and earning up to twice (100%-199% of) the poverty threshold; and "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. All Hispanic respondents are grouped, regardless of identity with any other race group. Other race categories are non-Hispanic categorizations (e.g., "Black" reflects non-Hispanic Black respondents).

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, 69 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	15
Public Health Representatives	3
Other Health Providers	16
Social Services Providers	17
Other Community Leaders	18

Final participation included representatives of the organizations outlined below.

- 2nd Baptist Church
- 4Cs of Passaic County
- Bangladeshi American Women's Development Initiative
- CAMP YDP
- Care Finders Total Care LLC
- Catholic Charities Diocese of Paterson
- Children's Aid & Family Services–The Center for Alcohol & Drug Resources
- Circle of Care
- City Green
- City of Paterson
- City of Paterson Fire Department
- Division of Child Protection & Permanency
- Elmwood Park Senior Center
- Family Care NJ
- Family Success Center of Paterson
- Greater Paterson OIC
- Harbor House
- Health Coalition of Passaic County
- Home Care Options
- John P. Holland Charter School
- Mental Health Assoc. of Passaic County
- More Than Friends
- New Jersey Community Development Corporation
- Northeast NJ Legal Services
- NORWESCAP
- Oasis–A Haven for Women and Children
- Palestinian American Community Center
- Partnership for Maternal and Child Health of Northern NJ
- Passaic County Safe Kids
- Passaic School District
- Paterson Alliance
- Paterson Community Health Center
- Paterson Judiciary
- Paterson Public Schools
- Paterson School District
- Paterson Task Force for Community Action
- Rebuilding Together North Jersey
- Rutgers Coop Extension
- Seminary Baptist Church
- SERV Behavioral Health
- St. Paul Baptist Church
- St. Bonaventure Church
- St. Joseph's Health
- St. Joseph's WIC
- St. Paul's Episcopal
- Star of Hope Ministries
- Turning Point
- United Methodist Church, Wayne NJ
- Wayne Township
- Wayne Township Health Department
- Wayne YMCA
- William Paterson University–SBDC

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.

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 Southern 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), University of Missouri Extension, SparkMap (sparkmap.org)
- 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 county-level data for the entirety of Passaic County.

Benchmark Data

Trending

Similar surveys were administered in Southern Passaic County in 2016 and 2019 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 *2020 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 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

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, 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 Health made its prior Community Health Needs Assessment (CHNA) report publicly available on 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 Health 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 Health 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 (2019)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	33
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	146
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	12
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	13
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	154

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 HEALTH CARE SERVICES	▪ Lack of Health Insurance ▪ Barriers to Access – Inconvenient Office Hours – Cost of Prescriptions – Cost of Physician Visits – Appointment Availability – Finding a Physician – Lack of Transportation – Culture/Language ▪ Primary Care Physician Ratio ▪ Specific Source of Ongoing Medical Care ▪ Emergency Room Utilization ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death ▪ Prostate Cancer Incidence
DIABETES	▪ Prevalence of Borderline/Pre-Diabetes ▪ Prevalence of Kidney Disease ▪ Key Informants: Diabetes ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ High Blood Cholesterol Prevalence ▪ Overall Cardiovascular Risk
HOUSING	▪ Housing Insecurity ▪ Housing Conditions
INFANT HEALTH & FAMILY PLANNING	▪ Prenatal Care
INJURY & VIOLENCE	▪ Unintentional Injury Deaths – Including Falls [Age 65+] Deaths ▪ Key Informants: Injury and violence ranked as a top concern.

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AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Symptoms of Chronic Depression ▪ Mental Health Provider Ratio ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Difficulty Accessing Fresh Produce ▪ Fruit/Vegetable Consumption ▪ Access to Recreation/Fitness Facilities ▪ Overweight & Obesity [Adults] ▪ Overweight & Obesity [Children] ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
ORAL HEALTH	▪ Regular Dental Care [Adults]
POTENTIALLY DISABLING CONDITIONS	▪ Alzheimer's Disease Deaths
RESPIRATORY DISEASE	▪ Leading Cause of Death ▪ COVID-19 Mortality
SEXUAL HEALTH	▪ HIV Mortality ▪ HIV Prevalence
SUBSTANCE ABUSE	▪ Cirrhosis/Liver Disease Deaths ▪ Unintentional Drug-Related Deaths ▪ Key Informants: Substance abuse ranked as a top concern.
TOBACCO USE	▪ Smoking Cessation ▪ Use of Vaping Products ▪ Key Informants: Tobacco use ranked as a top concern.

Community Feedback on Prioritization of Health Needs

In December 2022, St. Joseph's Health convened groups of community stakeholders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss, and prioritize health issues for the community, based on findings of this Community Health Needs Assessment (CHNA). An in-person meeting was held on December 1 and an online meeting was held on December 12. Professional Research Consultants, Inc. (PRC) began each of these meetings 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), an online voting platform was used in which each participant was able to register his/her ratings using a mobile device or web browser. 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 2030 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. Mental Health
2. Access to Health Care Services
3. Substance Abuse
4. Diabetes
5. Nutrition, Physical Activity & Weight
6. Heart Disease & Stroke
7. Housing
8. Respiratory Disease (COVID-19)
9. Infant Health
10. Injury & Violence
11. Sexual Health
12. Cancer
13. Oral Health
14. Potentially Disabling Conditions
15. Tobacco Use

Hospital Implementation Strategy

St. Joseph's Health 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

Reading the Summary Tables

- In the following tables, Southern Passaic County results are shown in the larger, gray column.
- The columns to the left of the Southern Passaic County column provide comparisons among the six community subareas, 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 2030 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.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:

Trends for survey-derived indicators represent significant changes since 2016 (or earliest available data). 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 county-level data.

SOCIAL DETERMINANTS	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)							11.7	6.1	4.1		
Population in Poverty (Percent)							14.8	9.7	12.8	8.0	
Children in Poverty (Percent)							23.0	13.3	17.5	8.0	
No High School Diploma (Age 25+, Percent)							15.5	9.7	11.5		
Unemployment Rate (Age 16+, Percent)							4.9	3.6	3.9		11.0
% Unable to Pay Cash for a $400 Emergency Expense	22.4	34.0	15.4	23.8	30.1	10.7	24.6		24.6		
% Worry/Stress Over Rent/Mortgage in Past Year	35.7	54.4	37.1	40.1	38.0	22.3	40.8		32.2		42.5
% Unhealthy/Unsafe Housing Conditions	20.6	21.7	12.6	13.9	13.1	14.4	16.5		12.2		
% Food Insecure	26.5	53.6	32.1	43.4	37.4	15.1	39.0		34.1		32.1

Note: In the section above, 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.

better similar worse

OVERALL HEALTH	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	22.7	30.7	23.3	21.8	19.2	9.6	22.5	11.7	12.6		18.0

Note: In the section above, 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.

better similar worse

ACCESS TO HEALTH CARE	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	10.4	16.6	4.7	16.6	11.6	8.3	13.4	14.1	8.7	7.9	7.7
% [Insured 18-64] Have Coverage Through ACA	13.4	17.8	5.0	12.7	8.4	5.6	11.9				12.1
% Difficulty Accessing Health Care in Past Year (Composite)	46.9	51.0	51.0	49.3	39.8	47.7	48.4		35.0		48.0
% Cost Prevented Physician Visit in Past Year	13.4	17.8	14.5	19.2	15.2	8.4	16.0	10.5	12.9		17.7
% Cost Prevented Getting Prescription in Past Year	17.6	20.5	13.0	20.3	13.9	8.1	17.2		12.8		15.1
% Difficulty Getting Appointment in Past Year	26.3	26.5	26.2	21.8	19.4	29.9	24.6		14.5		20.8

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% Inconvenient Hrs Prevented Dr Visit in Past Year	19.1	28.8	18.6	20.5	17.2	29.4	**23.0**		12.5		22.0
% Difficulty Finding Physician in Past Year	18.5	19.1	11.6	15.4	12.6	11.9	**15.7**		9.4		14.3
% Transportation Hindered Dr Visit in Past Year	10.0	15.7	10.1	11.7	13.6	10.8	**12.5**		8.9		10.1
% Language/Culture Prevented Care in Past Year	2.9	6.7	3.5	5.1	4.4	1.8	**4.7**		2.8		2.9
% Skipped Prescription Doses to Save Costs	13.1	13.6	9.0	13.1	8.3	12.8	**12.3**		12.7		15.6
% Difficulty Getting Child's Health Care in Past Year							**8.1**		8.0		7.3
Primary Care Doctors per 100,000							**88.2**	107.3	106.1		
% Have a Specific Source of Ongoing Care	77.3	58.2	65.6	68.7	72.1	83.1	**68.8**		74.2	84.0	73.5
% Have Had Routine Checkup in Past Year	72.0	79.5	79.7	77.2	86.0	77.6	**78.4**	74.4	70.5		74.2
% Child Has Had Checkup in Past Year							**90.8**		77.4		87.9
% Two or More ER Visits in Past Year	14.3	20.9	20.5	14.6	14.4	6.6	**15.7**		10.1		11.3

ACCESS TO HEALTH CARE (continued)	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% Eye Exam in Past 2 Years	56.6	59.2	65.4	56.3	61.7	60.7	59.0		61.0	61.1	63.1
% Rate Local Health Care "Fair/Poor"	9.4	24.0	7.9	14.3	8.6	7.9	14.4		8.0		14.1
% Expect Teaching Hospitals to Offer "Worse" Care	10.0	9.8	7.3	10.1	6.9	6.8	9.0				10.2

Note: In the section above, 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.

better similar worse

CANCER	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)							130.2	137.1	146.5	122.7	157.4
Lung Cancer (Age-Adjusted Death Rate)							25.7	28.6	33.4	25.1	27.1
Prostate Cancer (Age-Adjusted Death Rate)							17.5	16.2	18.5	16.9	18.4
Female Breast Cancer (Age-Adjusted Death Rate)							17.9	20.1	19.4	15.3	19.9
Colorectal Cancer (Age-Adjusted Death Rate)							13.5	12.6	13.1	8.9	13.9
Cancer Incidence Rate (All Sites)							454.8	486.7	448.6		

CANCER (continued)	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
Female Breast Cancer Incidence Rate							128.9	137.2	126.8		
Prostate Cancer Incidence Rate							137.9	134.4	106.2		
Lung Cancer Incidence Rate							45.0	54.5	57.3		
Colorectal Cancer Incidence Rate							39.2	40.1	38.0		
% Cancer	8.2	4.7	10.6	8.4	5.2	10.2	7.5	9.9	10.0		
% [Women 50-74] Mammogram in Past 2 Years							80.2	78.9	76.1	77.1	75.7
% [Women 21-65] Cervical Cancer Screening							79.8	80.1	73.8	84.3	80.1
% [Age 50-75] Colorectal Cancer Screening							76.9	69.5	77.4	74.4	66.7

Note: In the section above, 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.

better similar worse

DIABETES	DISPARITY AMONG SUBAREAS: Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest	So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS: vs. NJ	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)							22.9	18.2	22.6		21.9
% Diabetes/High Blood Sugar	11.2	16.3	6.9	15.7	15.2	14.2	14.3	10.0	13.8		13.2
% Borderline/Pre-Diabetes	20.6	20.9	16.6	17.8	8.1	13.5	17.3		9.7		8.8
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	54.0	48.9	45.9	51.5	47.2	56.6	50.7		43.3		50.4

Note: In the section above, 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.

better similar worse

HEART DISEASE & STROKE	DISPARITY AMONG SUBAREAS: Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest	So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS: vs. NJ	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)							157.7	162.4	164.4	127.4	176.4
% Heart Disease (Heart Attack, Angina, Coronary Disease)	8.0	4.2	6.3	5.7	5.4	10.6	6.2	6.2	6.1		5.6
Stroke (Age-Adjusted Death Rate)							29.4	30.6	37.6	33.4	33.3
% Stroke	2.7	3.1	0.0	3.2	3.4	1.5	2.7	2.7	4.3		2.8

DISPARITY AMONG SUBAREAS

SOUTHERN PASSAIC CO. vs. BENCHMARKS

HEART DISEASE & STROKE (continued)	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest	So. Passaic County	vs. NJ	vs. US	vs. HP2030	TREND
% Told Have High Blood Pressure	44.7	40.9	42.4	35.7	34.5	39.1	38.9	33.0	36.9	27.7	39.7
% Told Have High Cholesterol	44.3	42.1	34.5	39.4	33.7	39.3	39.6		32.7		36.6
% 1+ Cardiovascular Risk Factor	85.3	90.1	85.9	87.8	96.6	81.5	88.1		84.6		87.5

Note: In the section above, 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.

better similar worse

DISPARITY AMONG SUBAREAS

SOUTHERN PASSAIC CO. vs. BENCHMARKS

INFANT HEALTH & FAMILY PLANNING	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest	So. Passaic County	vs. NJ	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent)							7.4	6.0	6.1		2.3
Low Birthweight Births (Percent)							8.7	8.0	8.2		
Infant Death Rate							3.9	4.0	5.5	5.0	3.8
Births to Adolescents Age 15 to 19 (Rate per 1,000)							19.9	10.9	19.3		

Note: In the section above, 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.

better similar worse

INJURY & VIOLENCE	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)							47.3	49.9	51.6	43.2	30.7
Motor Vehicle Crashes (Age-Adjusted Death Rate)							5.2	6.3	11.4	10.1	5.9
[65+] Falls (Age-Adjusted Death Rate)							40.1	32.1	67.0	63.4	33.9
Firearm-Related Deaths (Age-Adjusted Death Rate)							4.7	4.6	12.5	10.7	5.2
Homicide (Age-Adjusted Death Rate)							5.1	3.8	6.1	5.5	4.9
Violent Crime Rate							357.9	242.0	416.0		
% Victim of Violent Crime in Past 5 Years	1.8	7.9	3.0	5.3	3.3	2.1	4.8		6.2		4.4
% Neighborhood is “Slightly” or “Not At All” Safe	12.8	53.5	15.3	24.8	19.7	5.3	27.2				26.6
% Victim of Intimate Partner Violence	15.3	14.6	12.3	9.8	9.5	9.6	11.8		13.7		12.9

Note: In the section above, 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.

better similar worse

KIDNEY DISEASE	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)							13.8	14.3	12.8		12.7
% Kidney Disease	4.8	7.7	5.7	4.4	3.6	3.6	5.2	2.6	5.0		2.7

Note: In the section above, 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.

better similar worse

MENTAL HEALTH	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	25.1	22.7	19.0	19.3	15.4	18.1	20.3		13.4		13.6
% Diagnosed Depression	23.9	18.4	21.1	16.2	5.8	18.5	17.2	15.2	20.6		17.0
% Symptoms of Chronic Depression (2+ Years)	34.1	45.0	35.0	38.4	32.1	31.7	37.8		30.3		32.8
% Typical Day Is "Extremely/Very" Stressful	24.1	15.1	18.2	14.0	7.9	11.5	14.9		16.1		15.4
% Mental Health Has Worsened Since Pandemic	27.1	19.0	18.5	17.1	14.2	16.6	18.5				
Suicide (Age-Adjusted Death Rate)							5.6	7.8	13.9	12.8	6.0

MENTAL HEALTH (continued)	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
Mental Health Providers per 100,000							60.5	115.3	138.2		
% Taking Rx/Receiving Mental Health Trtmt	19.7	12.7	17.0	9.5	10.9	22.8	13.9		16.8		12.5
% Unable to Get Mental Health Svcs in Past Yr	7.4	5.9	8.0	8.6	4.6	9.9	7.4		7.8		5.3

Note: In the section above, 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.

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
Population With Low Food Access (Percent)							15.2	23.8	22.2		
% "Very/Somewhat" Difficult to Buy Fresh Produce	17.5	34.8	29.9	28.6	24.7	15.7	27.1		21.1		25.2
% 5+ Servings of Fruits/Vegetables per Day	17.3	16.6	37.4	16.7	32.4	19.1	20.5		32.7		27.3
% 7+ Sugar-Sweetened Drinks in Past Week	22.3	26.7	21.0	22.1	22.6	20.3	23.0				21.1
% No Leisure-Time Physical Activity	26.3	31.7	21.0	27.2	31.3	17.8	27.0	21.0	31.3	21.2	29.1

NUTRITION, PHYSICAL ACTIVITY & WEIGHT (continued)	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% Meeting Physical Activity Guidelines	21.8	22.7	25.8	23.5	19.9	32.8	24.0	21.9	21.4	28.4	25.3
% Child [Age 2-17] Physically Active 1+ Hours per Day							41.7		33.0		36.4
Recreation/Fitness Facilities per 100,000							8.8	16.6	11.9		
% Overweight (BMI 25+)	70.4	75.8	65.5	73.1	76.6	58.8	71.5	64.6	61.0		70.4
% Obese (BMI 30+)	35.8	42.9	35.3	36.4	37.2	26.6	36.8	27.7	31.3	36.0	33.5
% Children [Age 5-17] Overweight (85th Percentile)							43.1		32.3		26.7
% Children [Age 5-17] Obese (95th Percentile)							26.7		16.0	15.5	13.2

Note: In the section above, 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.

better similar worse

ORAL HEALTH	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% Have Dental Insurance	79.1	70.4	75.6	70.7	71.6	76.5	72.8		68.7	59.8	72.1
% [Age 18+] Dental Visit in Past Year	63.1	54.6	64.1	66.7	68.2	73.4	63.9	68.1	62.0	45.0	68.8
% Child [Age 2-17] Dental Visit in Past Year							80.6		72.1	45.0	80.5

Note: In the section above, 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.

better similar worse

POTENTIALLY DISABLING CONDITIONS	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	41.0	35.2	33.7	26.3	28.5	31.0	31.8		32.5		41.2
% Activity Limitations	26.3	23.3	32.0	20.0	25.3	21.9	23.4		24.0		21.0
Alzheimer's Disease (Age-Adjusted Death Rate)							24.3	22.2	30.9		15.4
% Caregiver to a Friend/Family Member	20.2	22.9	18.2	20.8	23.7	22.1	21.5		22.6		22.6

Note: In the section above, 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.

better similar worse

RESPIRATORY DISEASE	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
CLRD (Age-Adjusted Death Rate)							24.5	26.4	38.1		32.6
Pneumonia/Influenza (Age-Adjusted Death Rate)							13.0	12.5	13.4		13.0
% [Age 65+] Flu Vaccine in Past Year							80.0	64.5	71.0		58.1
COVID-19 (Age-Adjusted Death Rate)							229.2	141.6	85.0		
% [Adult] Asthma	18.7	13.8	8.1	9.8	8.6	8.5	11.4	8.7	12.9		10.7
% [Child 0-17] Asthma							8.7		7.8		12.1
% COPD (Lung Disease)	9.4	7.9	2.8	5.2	10.9	3.9	6.6	4.9	6.4		8.4

Note: In the section above, 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.

better similar worse

SEXUAL HEALTH	DISPARITY AMONG SUBAREAS: Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest	So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS: vs. NJ	vs. US	vs. HP2030	TREND
HIV/AIDS (Age-Adjusted Death Rate)							3.4	2.3	1.8		4.5
HIV Prevalence Rate							562.0	468.0	378.0		
% [Age 18-44] HIV Test in the Past Year							29.3		22.0		29.3
Chlamydia Incidence Rate							564.4	405.5	539.9		
Gonorrhea Incidence Rate							138.1	100.7	179.1		

Note: In the section above, 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.

better similar worse

SUBSTANCE ABUSE	DISPARITY AMONG SUBAREAS: Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest	So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS: vs. NJ	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)							10.4	8.4	11.9	10.9	7.3
% Excessive Drinker	16.7	17.8	17.1	13.8	11.3	19.2	15.8	17.6	27.2		21.6
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)							27.7	31.0	21.0		9.2
% Illicit Drug Use in Past Month	3.7	2.2	11.5	3.2	4.7	1.3	3.7		2.0	12.0	3.8

SUBSTANCE ABUSE (continued)	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% Ever Sought Help for Alcohol or Drug Problem	9.2	5.0	3.6	1.7	3.6	3.9	4.1		5.4		3.4
% Personally Impacted by Substance Abuse	31.8	26.6	30.8	21.3	27.4	32.7	26.8		35.8		29.1

Note: In the section above, 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.

better similar worse

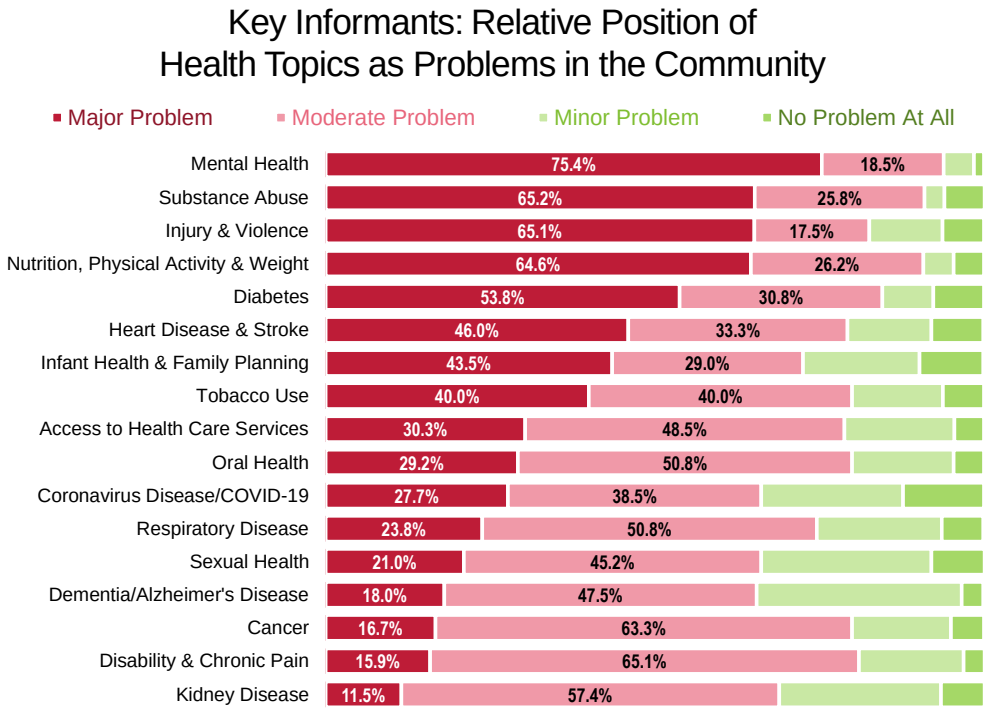
TOBACCO USE	DISPARITY AMONG SUBAREAS						So. Passaic County	SOUTHERN PASSAIC CO. vs. BENCHMARKS			
	Bergen	Paterson	North-west	Passaic/ Clifton	South-west	Wayne/ Southwest		vs. NJ	vs. US	vs. HP2030	TREND
% Current Smoker	15.5	16.0	16.0	11.3	10.2	8.7	12.9	10.8	17.4	5.0	11.2
% Someone Smokes at Home	13.2	9.2	8.9	10.7	10.4	9.3	10.2		14.6		12.3
% [Household With Children] Someone Smokes in the Home							8.8		17.4		14.4
% [Smokers] Have Quit Smoking 1+ Days in Past Year							50.7	60.4	42.8	65.7	52.2
% [Smokers] Received Advice to Quit Smoking							58.1		59.6	66.6	84.2
% Currently Use Vaping Products	5.6	11.2	11.9	7.3	8.9	6.4	8.5	5.0	8.9		4.8

Note: In the section above, 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.

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 17 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.)



DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population- based 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 Passaic County relative to size, population, and density. [COUNTY-LEVEL DATA]

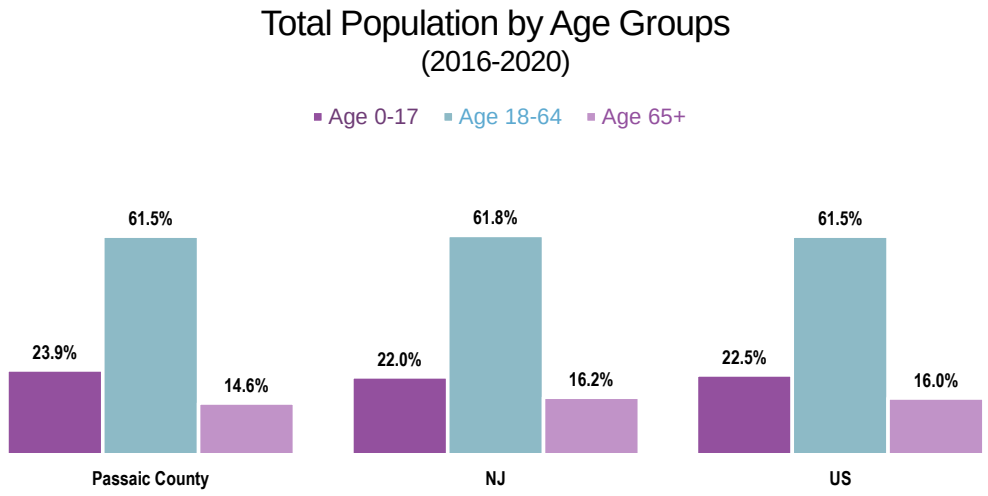
Total Population
(Estimated Population, 2016-2020)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Passaic County	**502,763**	**186.01**	**2,703**
New Jersey	8,885,418	7,354.76	1,208
United States	326,569,308	3,533,038.14	92

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).

Age

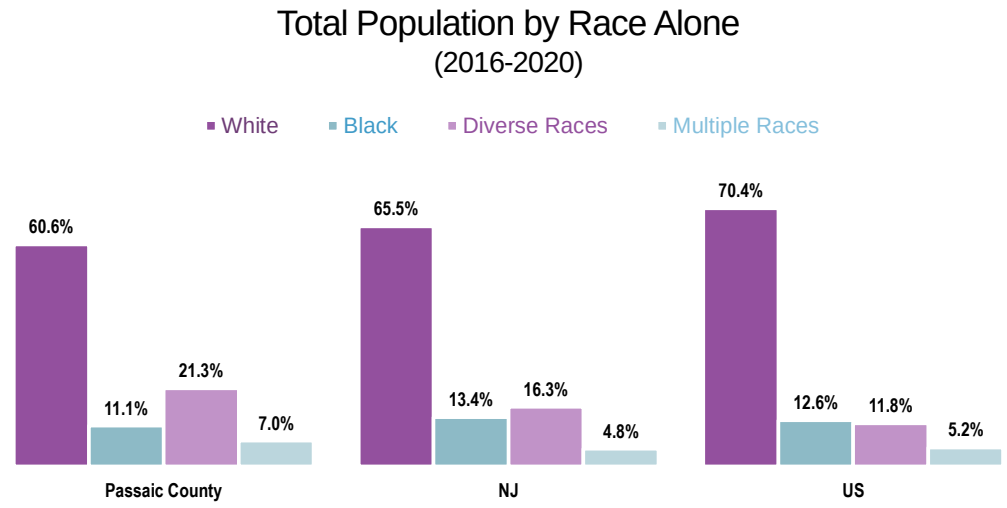
It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum. [COUNTY-LEVEL DATA]



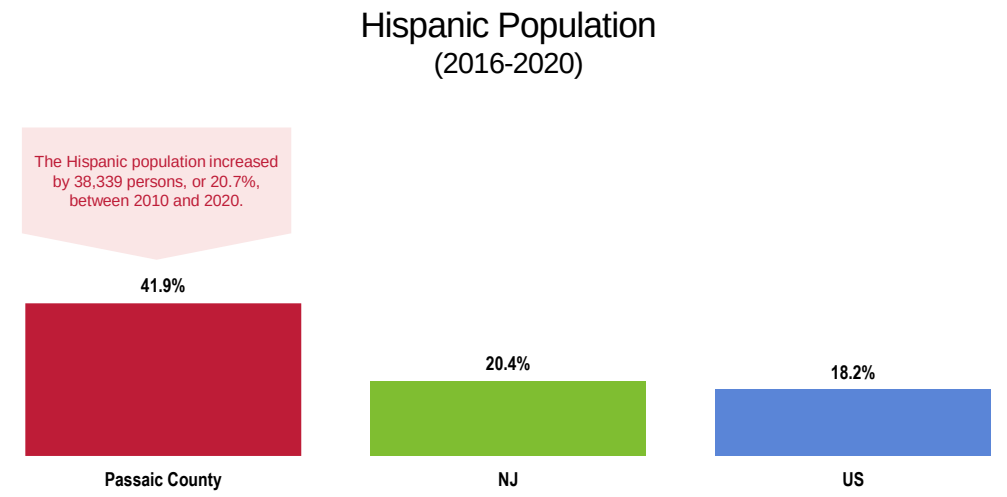
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).

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. [COUNTY-LEVEL DATA]



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.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 OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

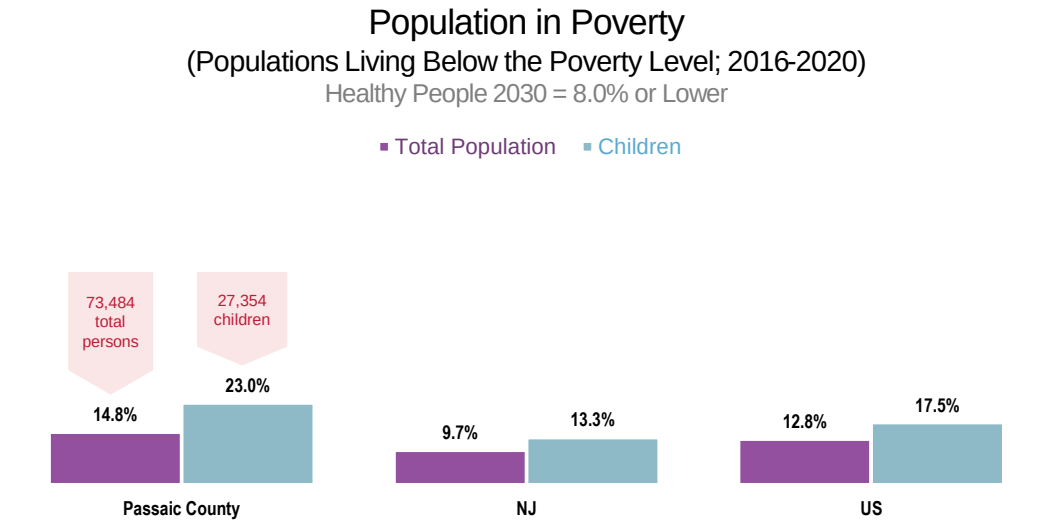
Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]



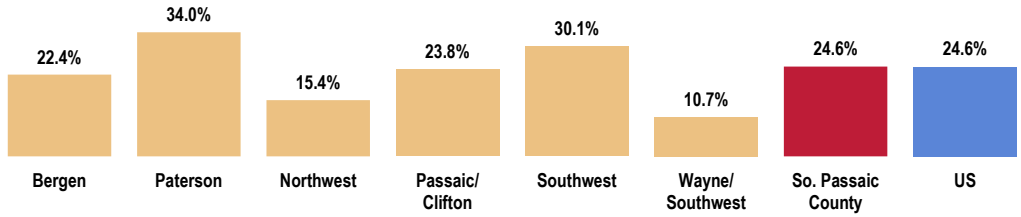
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.

Financial Resilience

"Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"

Do Not Have Cash on Hand to Cover a $400 Emergency Expense



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

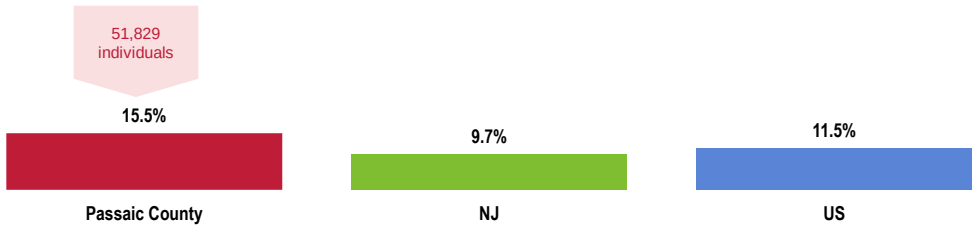
Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Education

Education levels are reflected in the proportion of our population without a high school diploma. [COUNTY-LEVEL DATA]

Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2016-2020)



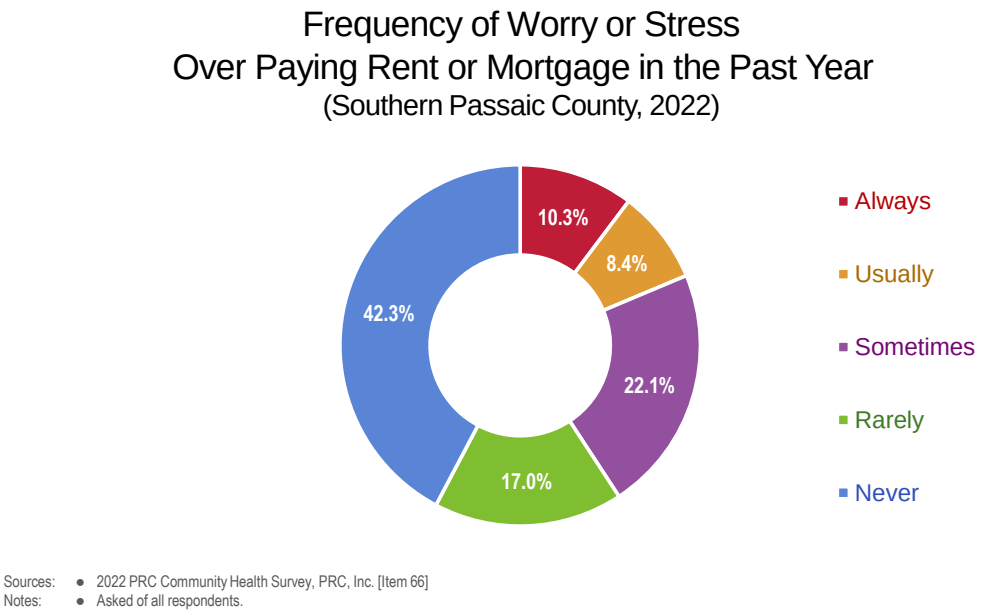
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).

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

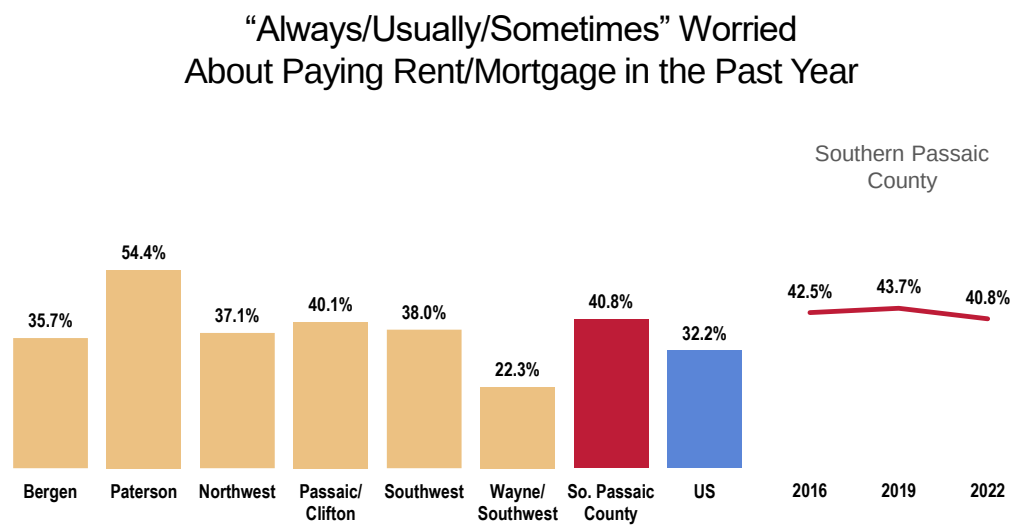
Housing

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: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

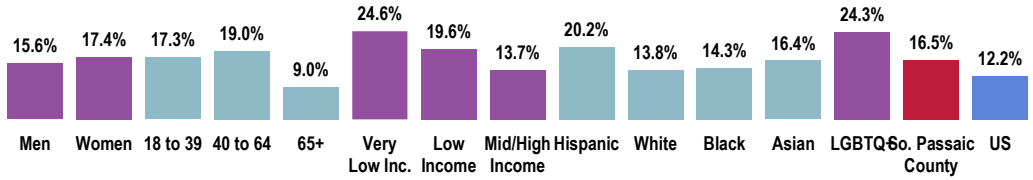


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

"Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year
(Southern Passaic County, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 65]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

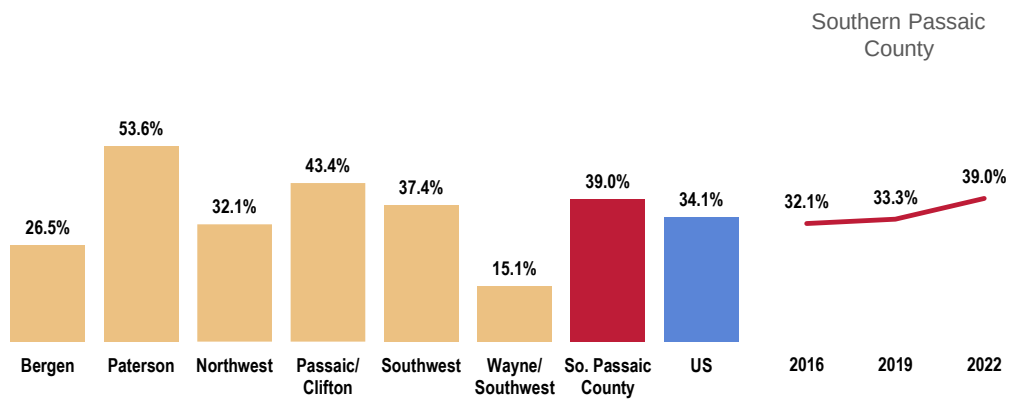
Food Insecurity

"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.

- 'I worried about whether our food would run out before we got money to buy more.'
- '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.

Food Insecurity



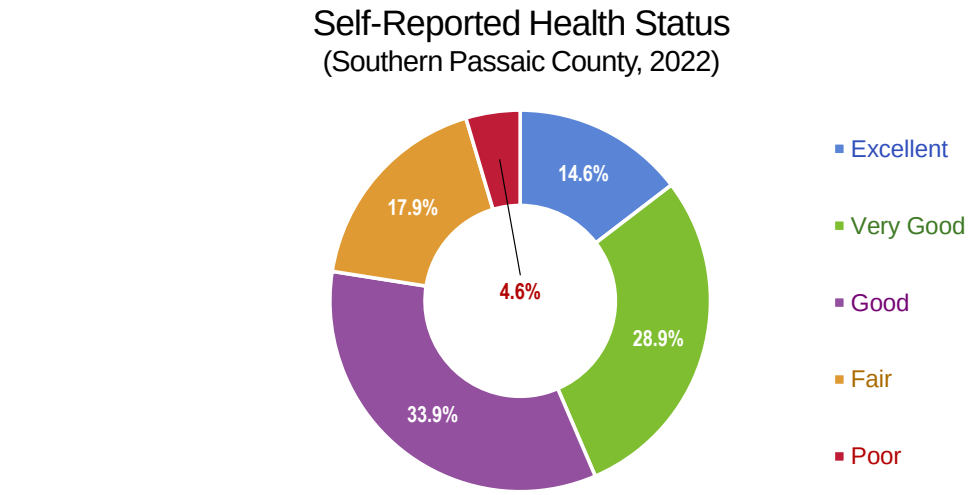
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 112]
- 2020 PRC National Health Survey, PRC, Inc.

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.

HEALTH STATUS

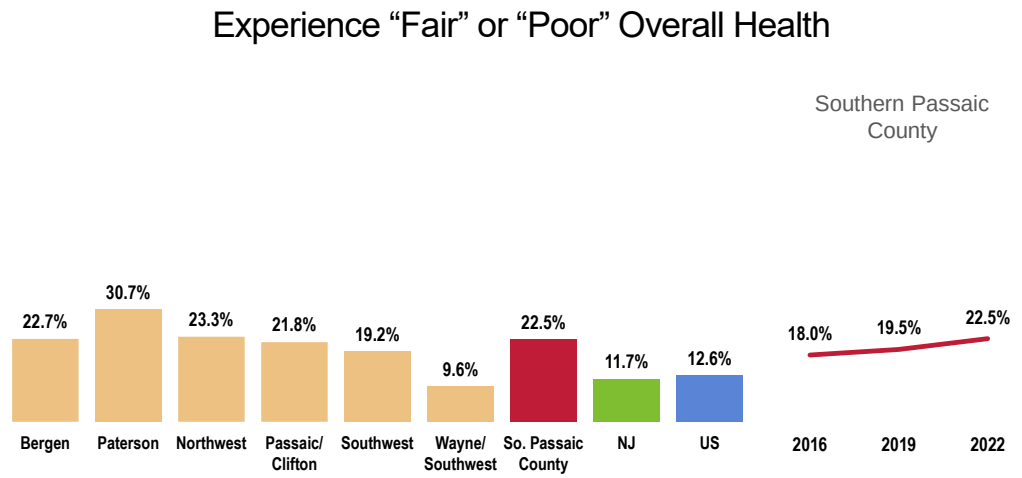
Overall Health

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



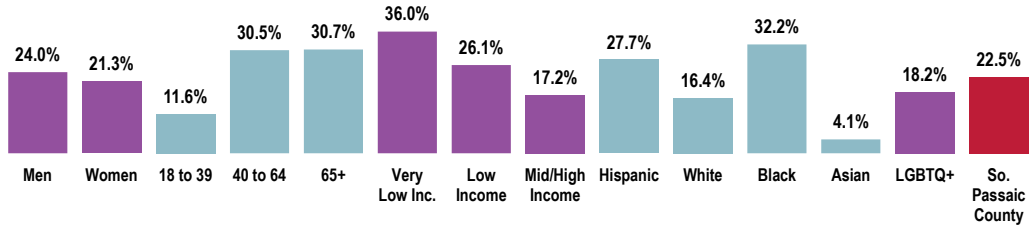
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

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], race/ethnicity, and LGBTQ+ identification).



Sources: ● 2022 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): 2020 New Jersey data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Southern Passaic County, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

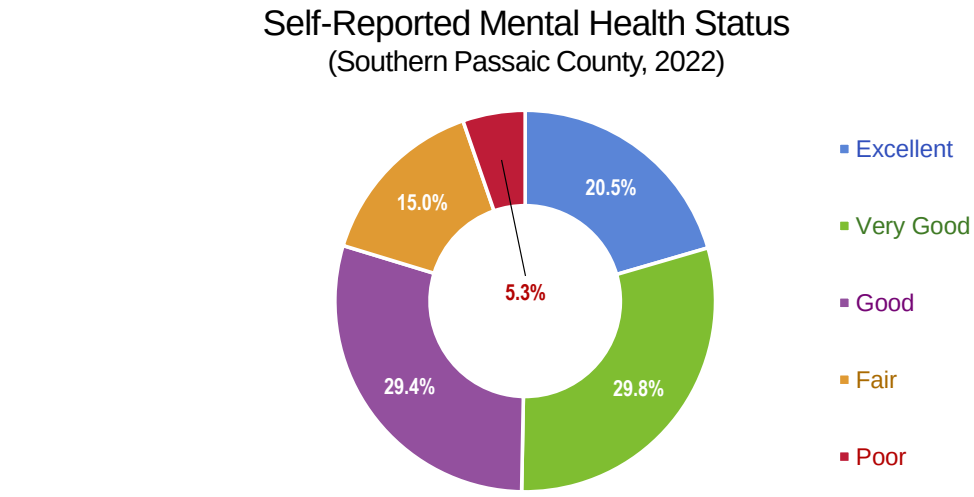
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

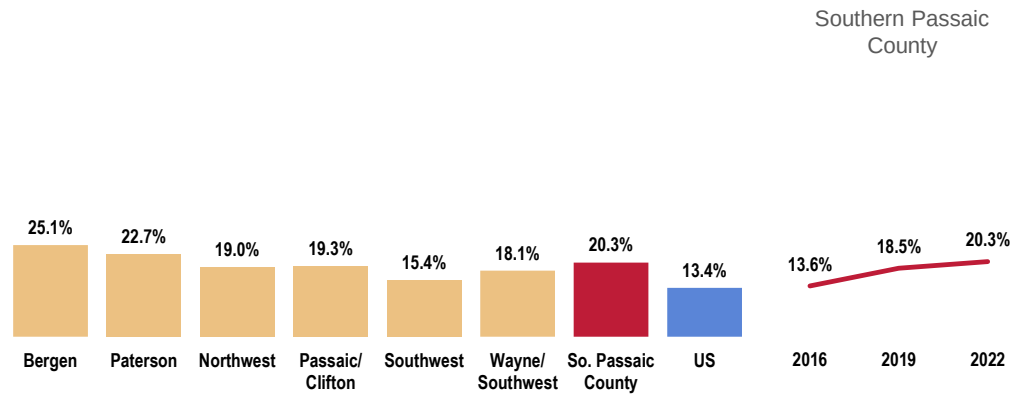
Mental Health Status

"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?"



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Mental Health



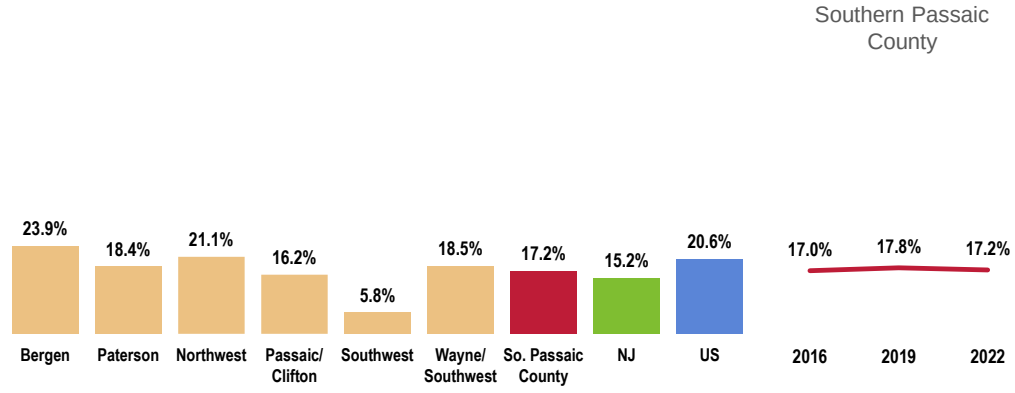
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2020 PRC National Health Survey, PRC, Inc.

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

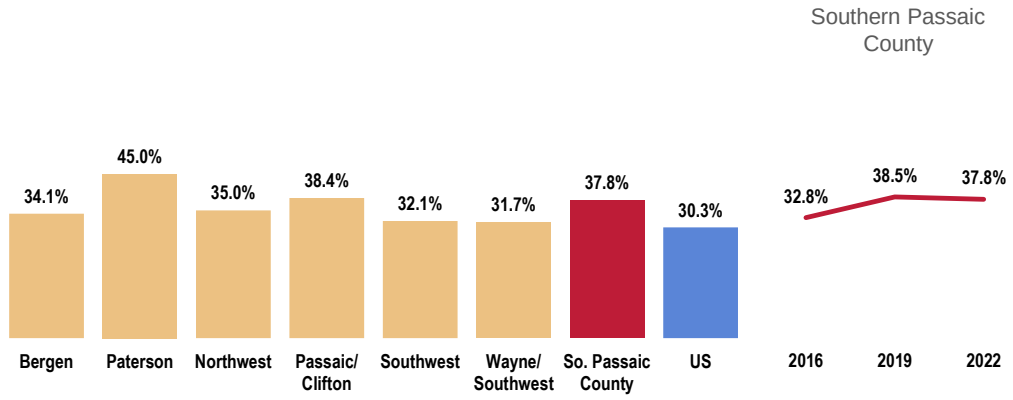


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, 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?"**

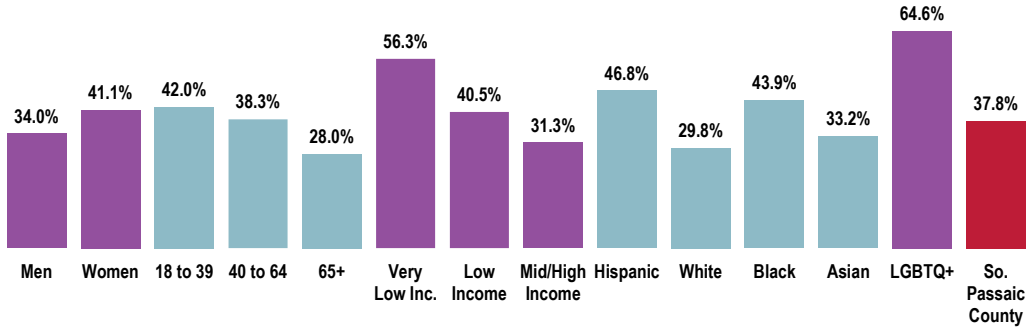
Have Experienced Symptoms of Chronic Depression



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

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.

Have Experienced Symptoms of Chronic Depression
(Southern Passaic County, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 91]

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.

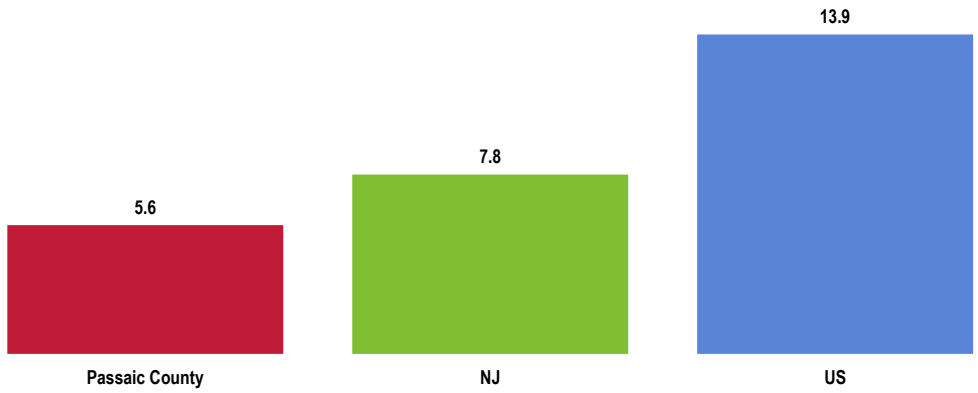
Suicide

The following charts outline the most current 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). [COUNTY-LEVEL DATA]

Suicide: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower

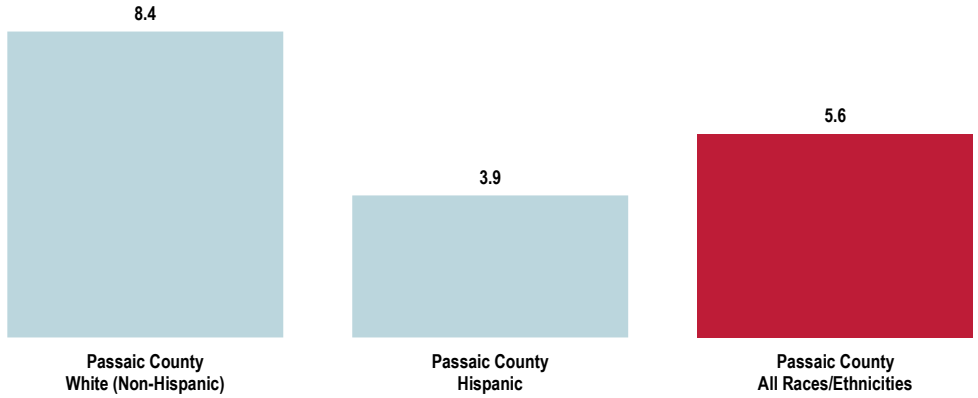


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Suicide: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower

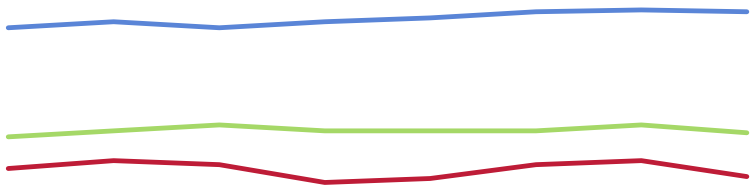


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	6.0	6.4	6.2	5.3	5.5	6.2	6.4	5.6
NJ	7.6	7.9	8.2	7.9	7.9	7.9	8.2	7.8
US	13.1	13.4	13.1	13.4	13.6	13.9	14.0	13.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

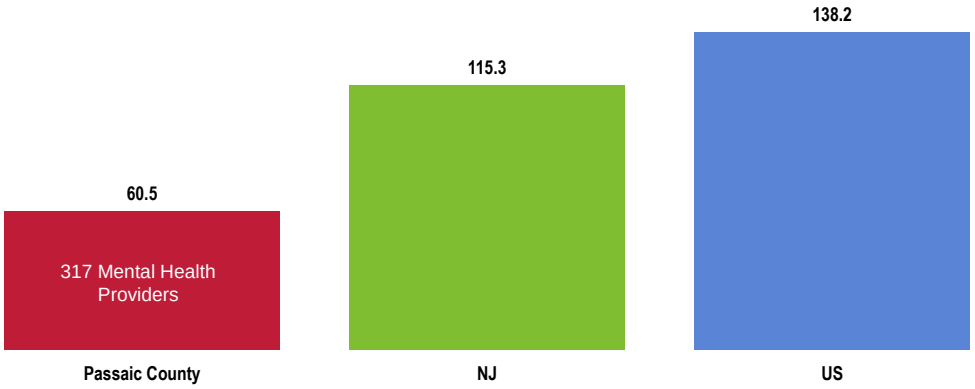
Mental Health Treatment

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

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in Passaic County and residents in Passaic County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

Access to Mental Health Providers

(Number of Mental Health Providers per 100,000 Population, 2022)



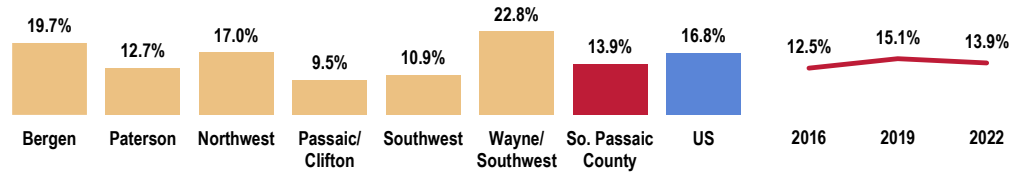
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).

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?"

Currently Receiving Mental Health Treatment

Southern Passaic County



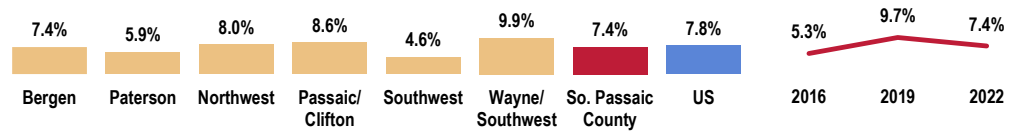
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2020 PRC National Health Survey, PRC, Inc.

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

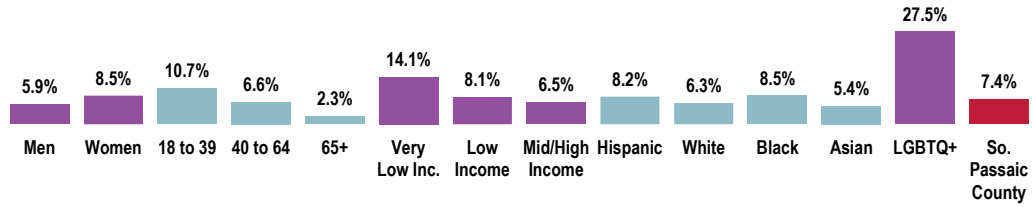
Southern Passaic County



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 95]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year
(Southern Passaic County, 2022)

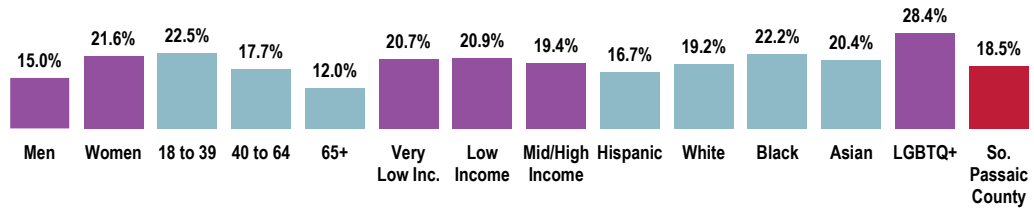


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 95]
Notes: ● Asked of all respondents.

Mental Health Impact of Pandemic

"The next question is about the coronavirus and COVID-19 pandemic that began in March of 2020. Since the start of the pandemic, would you say your mental health has improved, stayed about the same, or gotten worse?"

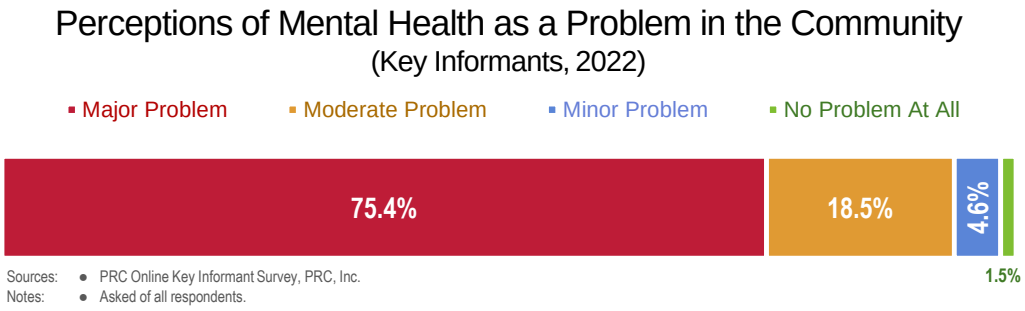
Mental Health Has Worsened Since the Beginning of the Pandemic
(Southern Passaic County, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of all respondents.
● Beginning of pandemic specified as March 2020.

Key Informant Input: Mental Health

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



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

Access to Care/Services

> Access to a mental health specialist and follow–up for their care. – Physician
>
> Lack of mental health services and local resources is the biggest challenge for our patients. – Physician
>
> Lack of available psychiatric care. – Physician
>
> It seems like people with mental health issues have trouble finding long–term health care providers, especially live–in facilities, which leads to homelessness and drug use. – Social Services Provider
>
> Lack of resources. Lack of funding for adequate resources. Police and EMS being expected to be mental health workers. – Social Services Provider
>
> Lack of mental health services. – Public Health Representative
>
> Access to services and no services on demand. – Social Services Provider
>
> There are very few places that exist to help treat the root of the issue, and not just medicate people to help with the symptoms. – Community Leader
>
> Lack of access. – Other Health Provider
>
> Finding a psychiatrist who takes their insurance and also finding an early appointment. – Physician
>
> Access to mental health care for chronic and acute illness. Post COVID mental health care. – Community Leader
>
> Available outpatient counseling services for families and students. There are times there are long waiting lists. – Community/Business Leader
>
> Access to quality services. – Community/Business Leader
>
> There are many students who exhibit mental disorders and lack the proper mental health services needed. There is an increase in CRISIS situations resulting in students going to the emergency room at St Joes due to the severity and lack of other organizations being available at all times LACK of counseling and inconsistency of services due to overwhelming amounts of cases N health insurance available for mental health services. – Social Services Provider
>
> Access to care. Many folks are uninsured. Options for Medicaid are limited. A certain percentage of the target population are undocumented, which especially limits many non–profits and other organizations in helping them due to specific policies. – Other Health Provider
>
> The ability to access mental health professionals. – Community Leader
>
> Accessing care. – Social Services Provider
>
> Access to consistent, timely and reliable help. – Physician

Affordable Care/Services

> The biggest challenges for people with mental health issues are the lack of affordable services; the limited number of agencies/professionals able to take on new clients; the limited number of mental health specialists that accept insurance, and the stigma that's still associated with asking for help and/or admitting/recognizing they have a mental health issue. In addition, some people with severe depression, anxiety, etc. need help to get help. – Public Health Representative
>
> The biggest challenges for people with mental health issues are financial instability (not being able to afford therapy/ not having health insurance) and the social stigma surrounding going to therapy. When people seek out counseling to deal with their mental health issues, they are seen as weak or crazy. – Community Leader

> Lack of access due to affordability of counseling services. Rates are incredibly high and there are very limited number of providers for Medicaid/charity care. 20% of the population in Paterson is not insured. Of the 80% who are insured, 40% are on Medicaid. Many services do not accept Medicaid and for those that do, the wait can be very long or the services offered do not meet the needs of the client (e.g., group therapy only vs individual session). – Community/Business Leader

Diagnosis/Treatment

> Seeking treatment. Ability to secure the right medication. Stigma of being mentally ill. – Other Health Provider
>
> Numerous untreated people suffering from mental health issues dot the streets of the city. Many become violent or self–harm. Challenges such as disabilities from war, excessive drug use that damages their mind, or those with poor family history. – Community Leader
>
> Proper medical care. – Community Leader

Denial/Stigma

> The stigma attached to a Mental Health diagnosis is a strong inhibitor to effective management of patients with mental health issues. In addition to that, the absence of people, that look like the people they are treating, and are aware of the culture from which they come, make ongoing intervention more difficult – Physician
>
> Wanting help and the statement that comes with it. – Social Services Provider
>
> Personal and family shame. – Community Leader

Due to COVID–19

> There are not enough mental health providers to give families and children the assistance they need. This was a concern before the COVID pandemic and has grown worse as a result of the loss of loved ones, isolation, remote learning and cutting back of many services that families need to thrive. – Community Leader
>
> Mental health issues have increased during the pandemic. – Social Services Provider
>
> This has become exacerbated by COVID–19 and the increase in social isolation and the uprooting of norms. – Social Services Provider

Awareness/Education

> Education, stigma, accessibility, affordability, knowledge of resources if any are available to get help. – Community/Business Leader

Co–Occurrences

> Depression and anxiety. – Other Health Provider

Housing

> Housing, counseling, medical support. – Community/Business Leader

Incidence/Prevalence

> Increase in mental health visits to the Emergency Department and calling community mental health agencies. – Other Health Provider

Transportation

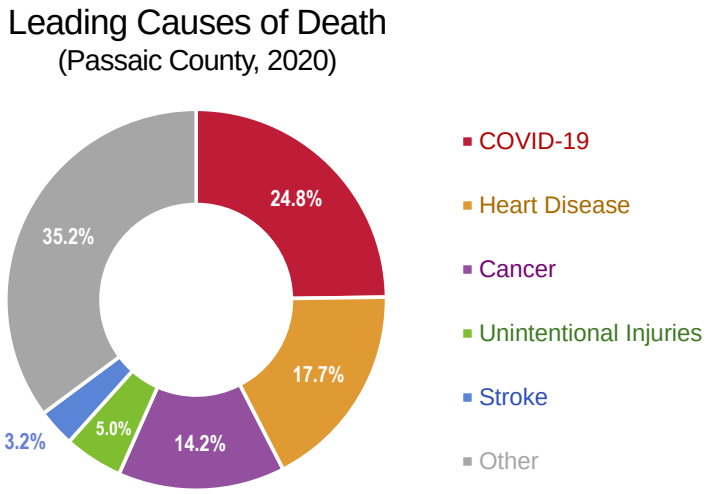
> Transportation to desired services and community resources. Affordable recreation opportunities. Affordable, safe housing. – Other Health Provider

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

COVID-19, heart disease, and cancers were leading causes of death in the community in 2020. [COUNTY-LEVEL DATA]



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

Notes: ● Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

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 2030 objectives.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in Passaic County. [COUNTY-LEVEL DATA]

Age-Adjusted Death Rates for Selected Causes
(2018-2020 Deaths per 100,000 Population)

	Passaic County	NJ	US	HP2030
Coronavirus Disease/COVID-19 [2020]	229.2	141.6	85.0	n/a
Diseases of the Heart	157.7	162.4	164.4	127.4*
Malignant Neoplasms (Cancers)	130.2	137.1	146.5	122.7
Unintentional Injuries	47.3	49.9	51.6	43.2
Fall-Related Deaths (65+)	40.1	32.1	67.1	63.4
Cerebrovascular Disease (Stroke)	29.4	30.6	37.6	33.4
Drug-Induced	27.7	31.0	21.0	n/a
Chronic Lower Respiratory Disease (CLRD)	24.5	26.4	38.1	n/a
Alzheimer's Disease	24.3	22.2	30.9	n/a
Diabetes Mellitus	22.9	18.2	22.6	n/a
Septicemia	19.3	17.3	9.8	n/a
Kidney Diseases	13.8	14.3	12.8	n/a
Pneumonia/Influenza	13.0	12.5	13.4	n/a
Cirrhosis/Liver Disease	10.4	8.4	11.9	10.9
Intentional Self-Harm (Suicide)	5.6	7.8	13.9	12.8
Motor Vehicle Deaths	5.2	6.3	11.4	10.1
Homicide	5.1	3.8	6.1	5.5
Firearm-Related	4.7	4.6	12.5	10.7
HIV/AIDS	3.4	2.3	1.8	n/a

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

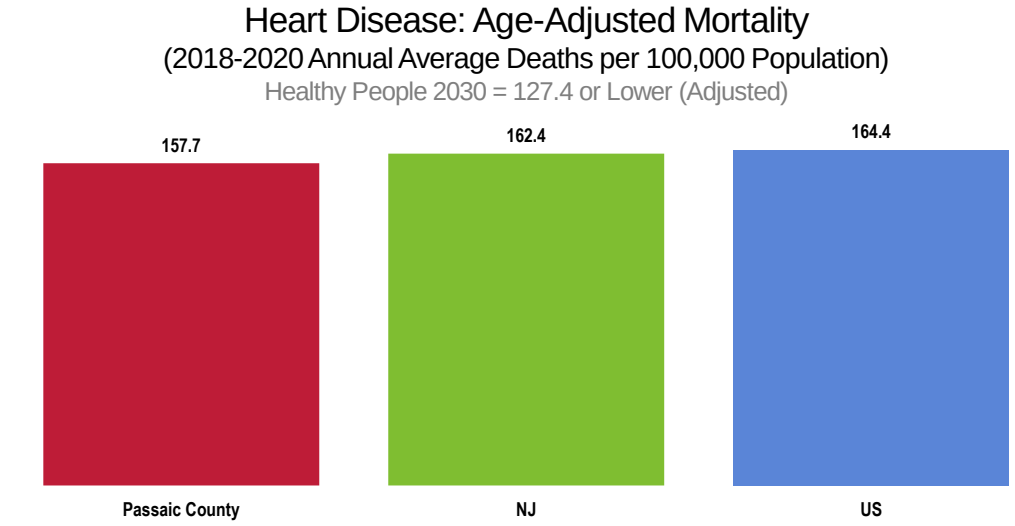
Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

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. [COUNTY-LEVEL DATA]



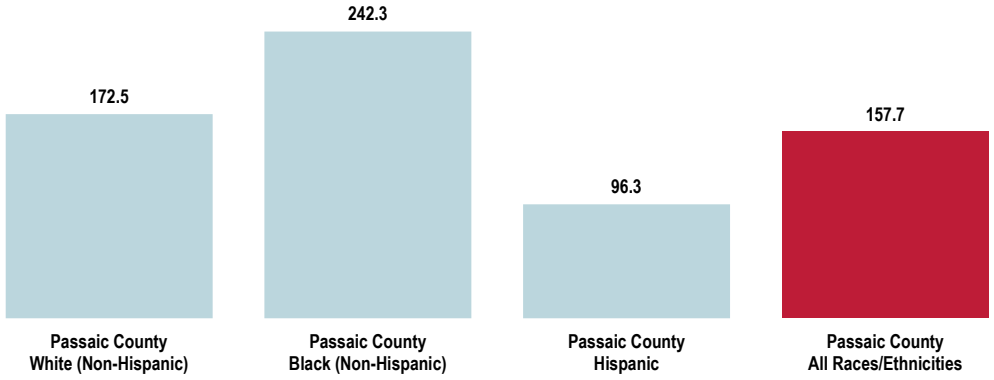
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Heart Disease: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 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 September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	176.4	175.9	171.0	167.9	162.1	158.4	156.6	157.7
NJ	172.2	169.3	167.7	165.9	164.6	163.3	161.1	162.4
US	190.6	188.9	168.9	167.5	166.3	164.7	163.4	164.4

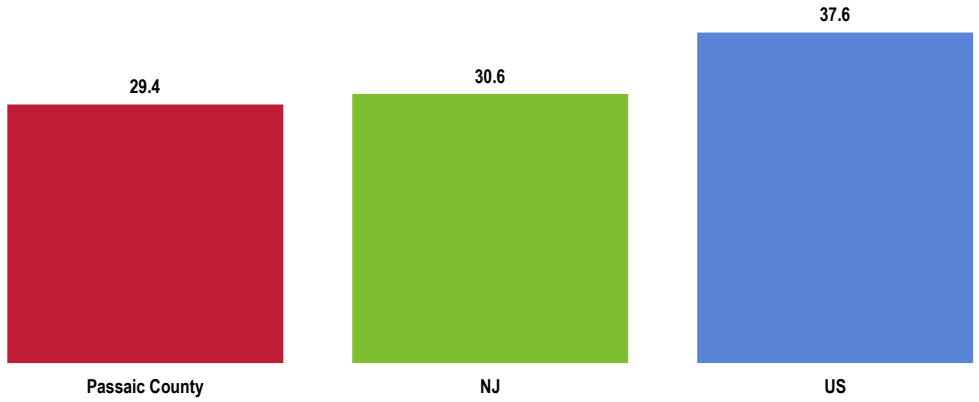
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

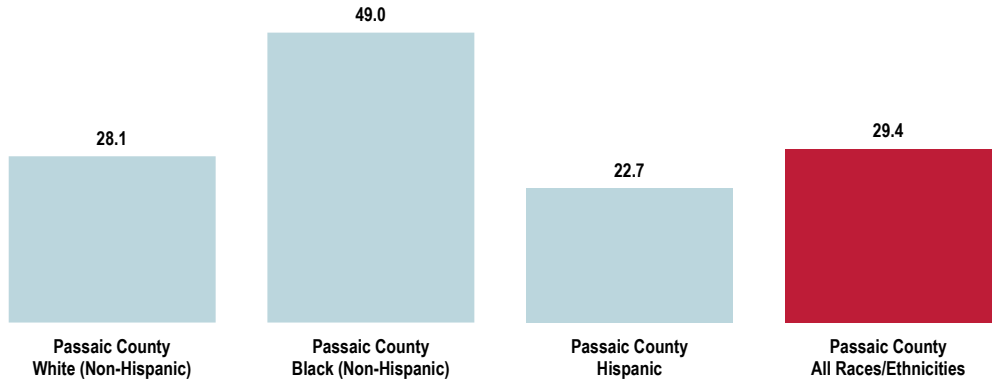


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Stroke: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

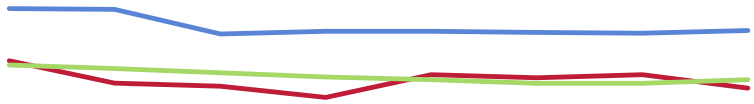


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	33.3	30.1	29.7	28.1	31.3	30.9	31.3	29.4
NJ	32.7	32.2	31.6	31.0	30.6	30.1	30.1	30.6
US	40.7	40.6	37.1	37.5	37.5	37.3	37.2	37.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

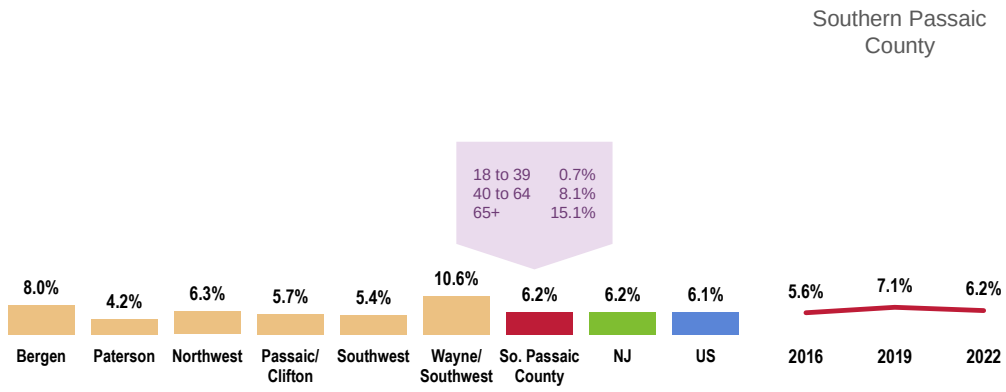
Prevalence of Heart Disease & Stroke

"Has a doctor, nurse, or other health professional ever told you that you had:

- A heart attack, also called a myocardial infarction?
- Angina or coronary heart disease?"

Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.

Prevalence of Heart Disease

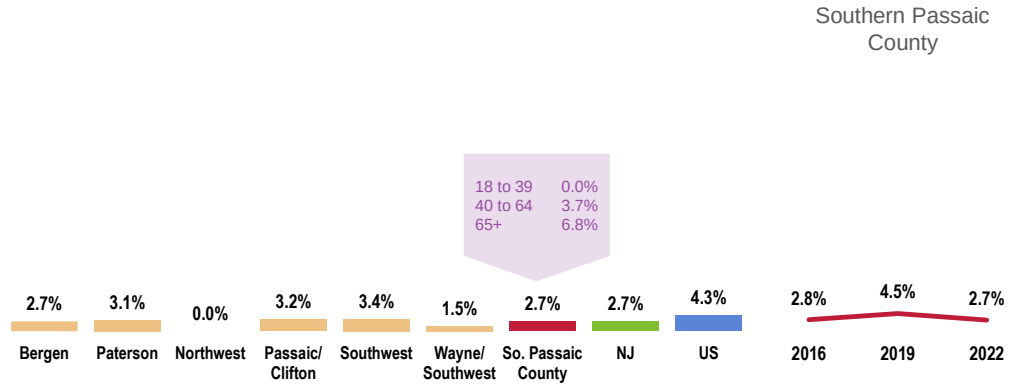


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

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

Prevalence of Stroke



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

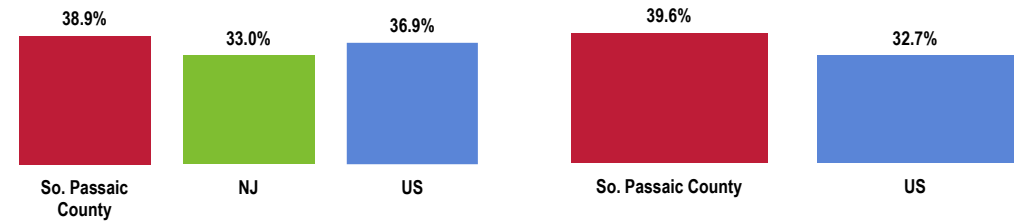
"Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

"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 2030 = 27.7% or Lower

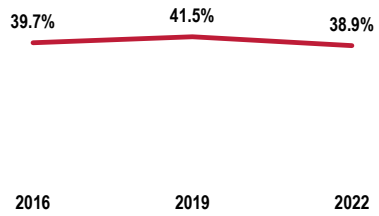
Prevalence of High Blood Cholesterol



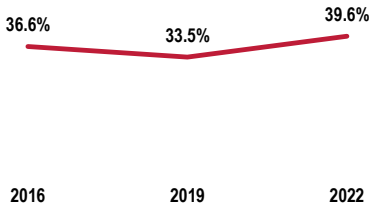
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Prevalence of
High Blood Pressure
(Southern Passaic County)
Healthy People 2030 = 27.4% or Lower



Prevalence of
High Blood Cholesterol
(Southern Passaic County)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36]
● US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

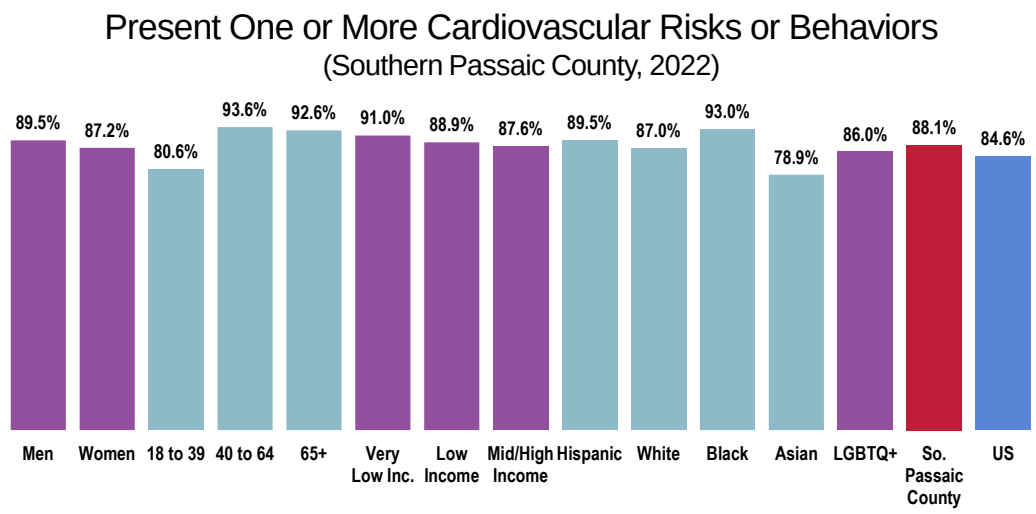
RELATED ISSUE
See also *Nutrition*, *Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

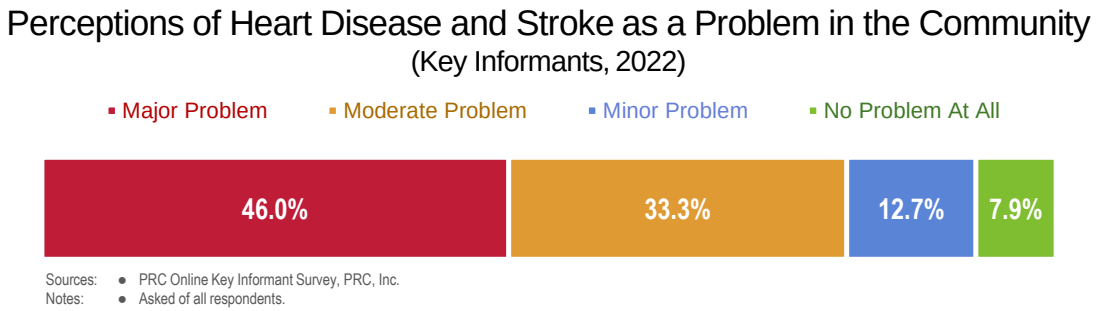
Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

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.



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:



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

Incidence/Prevalence

> As the EMS provider for the city, we see numerous cardiac issues and stroke symptoms on a daily basis. – Community Leader
>
> I continually hear of neighbors losing a loved one to heart disease. I don't have the data, but it's based on what I've seen and heard. A combination of obesity, stress and reduced access to care are all factors. – Community/ Business Leader
>
> Statistics from local hospitals indicate that heart disease and stroke are big problems in our community. – Public Health Representative
>
> State and national statistics. – Social Services Provider

Lifestyle

> Our diet is terrible. Lots of carbohydrates, fats, not enough fiber, and also not enough exercise or ability or time to exercise. – Community/Business Leader
>
> Undiagnosed heart disease due to poor access to preventive care services. Cigarette smoking, obesity, lifestyle choices, lack of exercise, etc. – Physician

> Directly connected to lack of access for good nutrition and regular physical activity. In addition, stressful environment with safety concerns, financial challenges, daily life stresses with childcare, money, work demands, many single-family households, inflation, job insecurity, gun violence, delay in care, impact of pandemic. – Community/Business Leader

Vulnerable Populations

> Not taken seriously. Prevalent in minorities. – Other Health Provider
>
> I live in a community of color, specifically African American, and the statistics are staggering. Obesity, lack of physical activity due to unsafe neighborhoods, access to high quality and nutritious foods. – Social Services Provider
>
> Heart disease and stroke are in high prevalence in the African American community. Poor living conditions, poor nutrition and fair access to care contribute as well. – Other Health Provider

Co–Occurrences

> The number of individuals with hypertension. – Community/Business Leader
>
> Continued struggles with smoking, obesity, diabetes and high blood pressure are significant in our county. – Other Health Provider
>
> High blood pressure, stress, and now COVID–19. – Other Health Provider

Obesity

> Overweight/obesity, smoking, stressful lifestyle. – Physician
>
> Obesity and poor nutrition. – Community Leader

Tobacco Use

> Heart disease and stroke are a major problem in our community because there is a high percentage of heavy smokers in our community. – Community Leader

Awareness/Education

> Lack of education to help determine warning signs. – Community Leader

Income/Poverty

> The population of much of the community is low to moderate income with a high percentage of minority populations that are prime candidates for heart disease and stroke. – Community Leader

Cancer

ABOUT CANCER

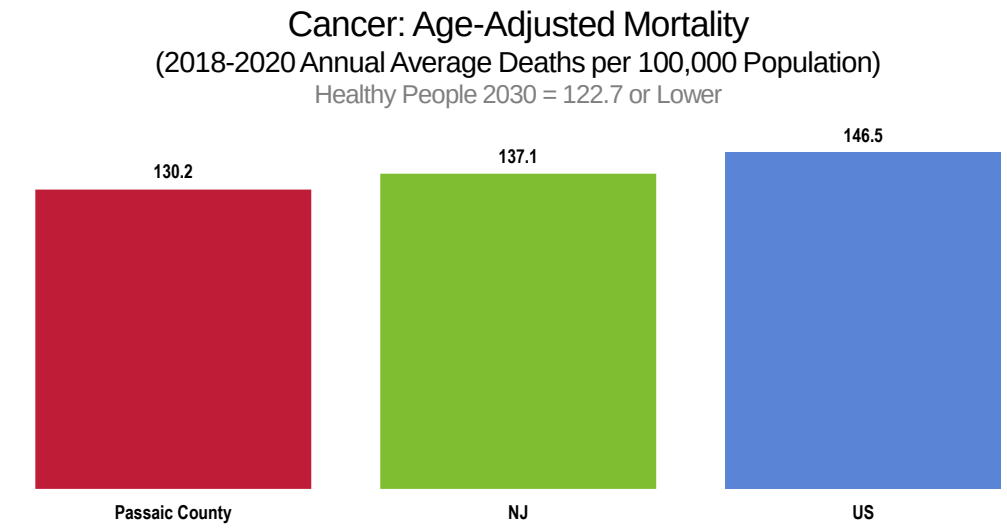
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

The following charts illustrate age-adjusted cancer mortality (all types) in Passaic County. [COUNTY-LEVEL DATA]

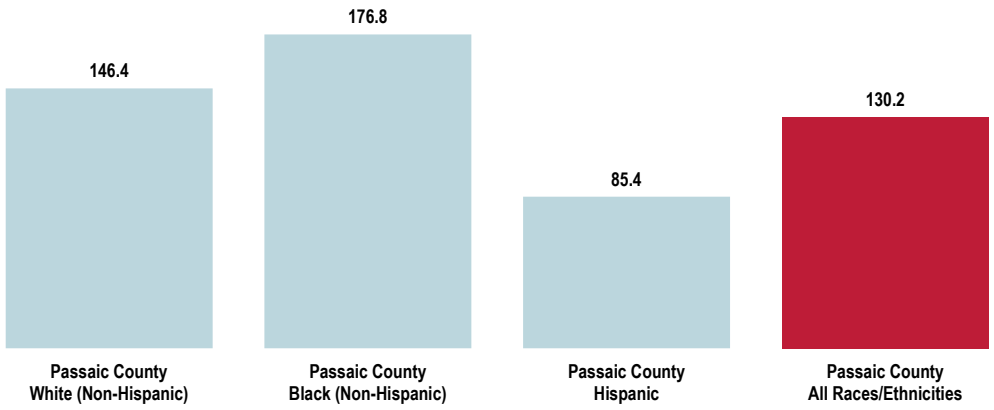


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 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 September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 122.7 or Lower

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	157.4	154.1	152.3	147.9	142.2	136.9	133.4	130.2
NJ	160.8	157.5	154.4	152.2	148.4	145.2	140.8	137.1
US	171.5	168.0	160.1	157.6	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Lung cancer is by far the leading cause of cancer deaths in Passaic County. [COUNTY-LEVEL DATA]

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

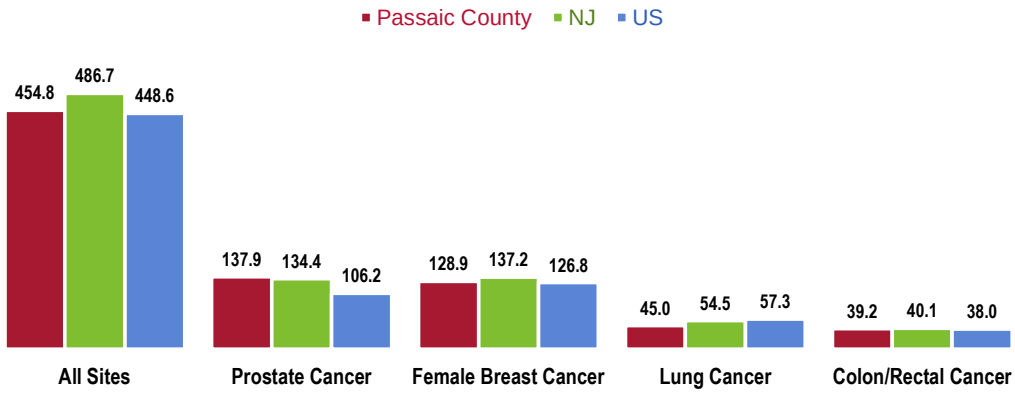
	Passaic County	NJ	US	HP2030
ALL CANCERS	**130.2**	**137.1**	**146.5**	**122.7**
Lung Cancer	**25.7**	**28.6**	**33.4**	**25.1**
Female Breast Cancer	**17.9**	**20.1**	**19.4**	**15.3**
Prostate Cancer	**17.5**	**16.2**	**18.5**	**16.9**
Colorectal Cancer	**13.5**	**12.6**	**13.1**	**8.9**

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2014-2018)



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).

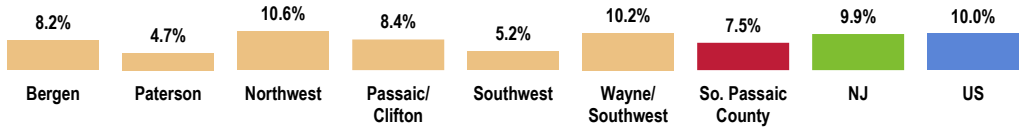
Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

"Have you ever suffered from or been diagnosed with cancer?"

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

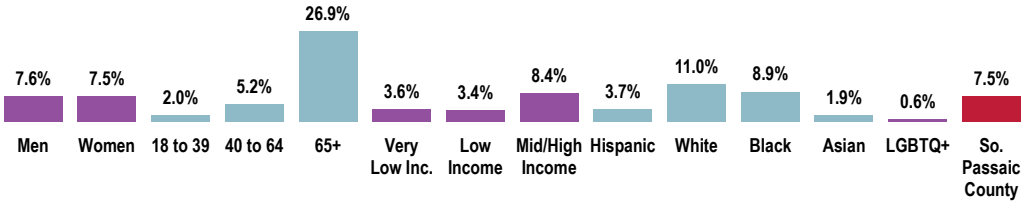
Prevalence of Cancer



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

Prevalence of Cancer
(Southern Passaic County, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 25]

Notes:
- Reflects all respondents.

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.

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) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

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.

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).

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?"**

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography 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?"**

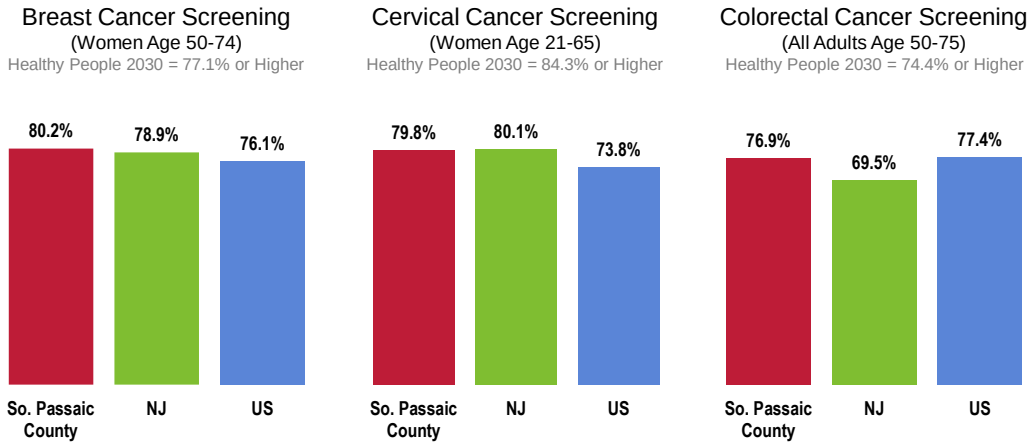
"Have you ever had a hysterectomy?"

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.

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?"**

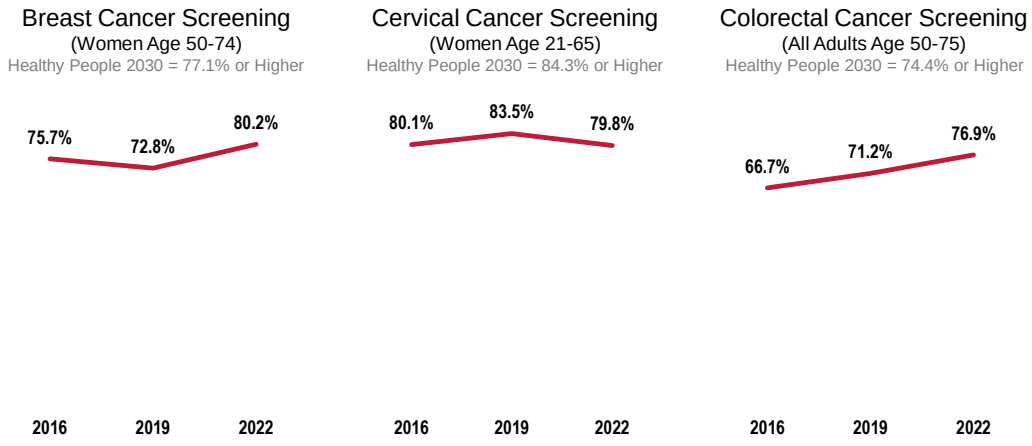
"A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" is calculated here among men and women age 50 to 75 years who have had a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

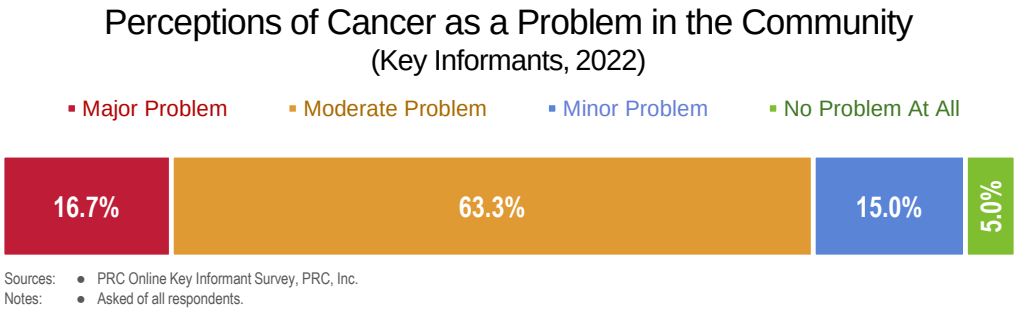


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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:



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

Access to Care

> Cancer is a major problem in our community. Since there are many low-income residents in our community, it is difficult for them to visit their doctors to do their annual screenings because of various factors such as affordability, transportation, and availability. – Community Leader
>
> Our population does not know and cannot find treatment and has no insurance. – Social Services Provider

Prevention/Screenings

> Lack of access for screening and detection. – Other Health Provider
>
> Screenings are not readily available, and treatment is costly. Lack of awareness. – Social Services Provider

Awareness/Education

> Lack of information, access to healthcare insurance for detention, especially for the immigrant community. – Other Health Provider

Incidence/Prevalence

> Many people are being diagnosed with cancer. – Community/Business Leader
>
> Knowledge of many individuals battling cancer. – Social Services Provider

Nutrition

> People are encouraged through advertisements to eat foods that contain preservatives that may have trace elements of carcinogenic toxins. The advertisements are very convincing. – Other Health Provider

Respiratory Disease

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

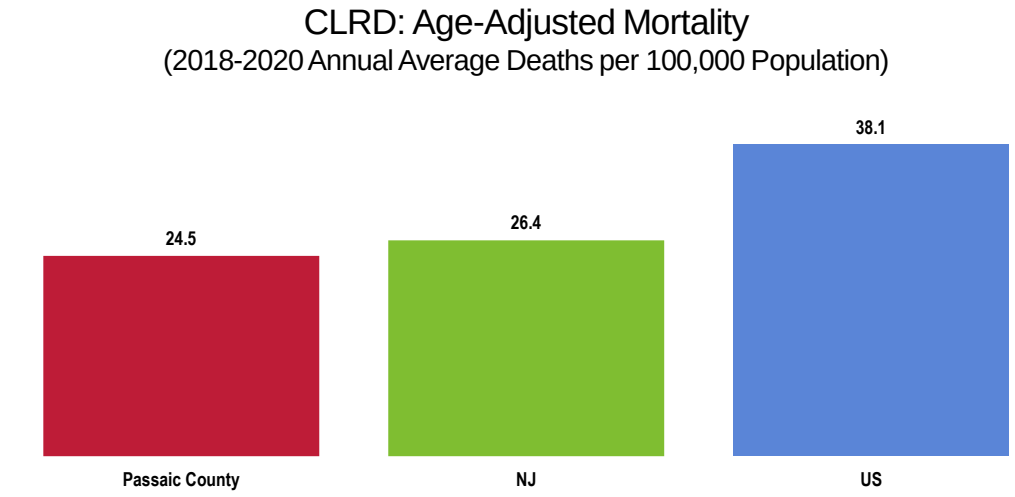
Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

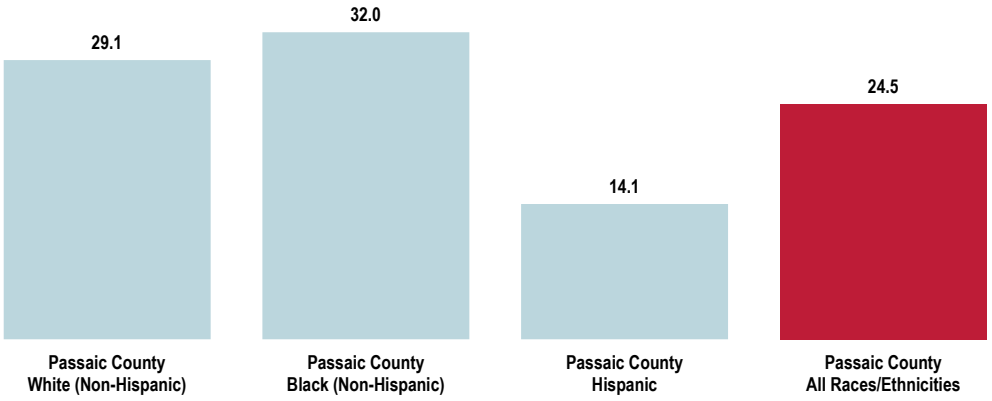
Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.

Pneumonia and influenza mortality is also illustrated. [COUNTY-LEVEL DATA]



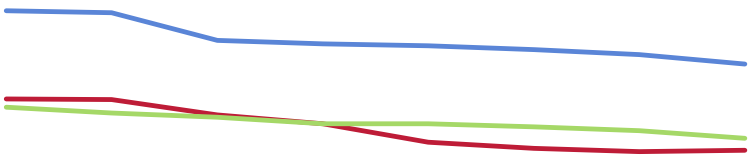
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
Notes: ● CLRD is chronic lower respiratory disease.

CLRD: Age-Adjusted Mortality by Race
(2018-2020 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 September 2022.
Notes: ● CLRD is chronic lower respiratory disease.

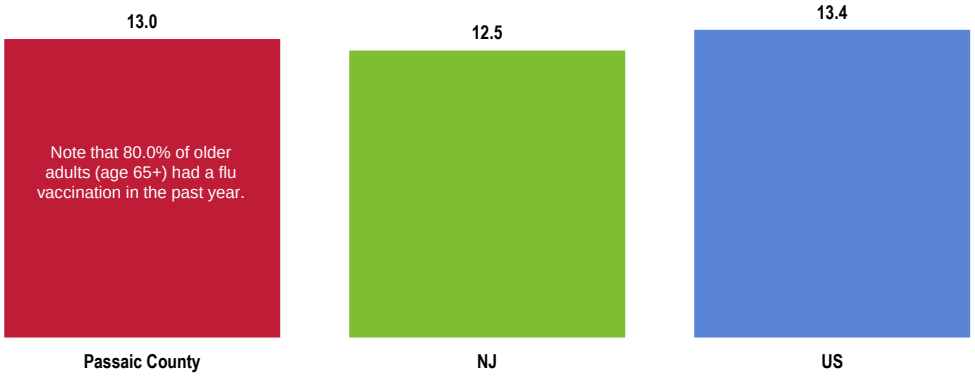
CLRD: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	32.6	32.5	30.1	28.7	25.8	24.8	24.3	24.5
NJ	31.3	30.4	29.7	28.7	28.7	28.2	27.6	26.4
US	46.5	46.2	41.8	41.3	41.0	40.4	39.6	38.1

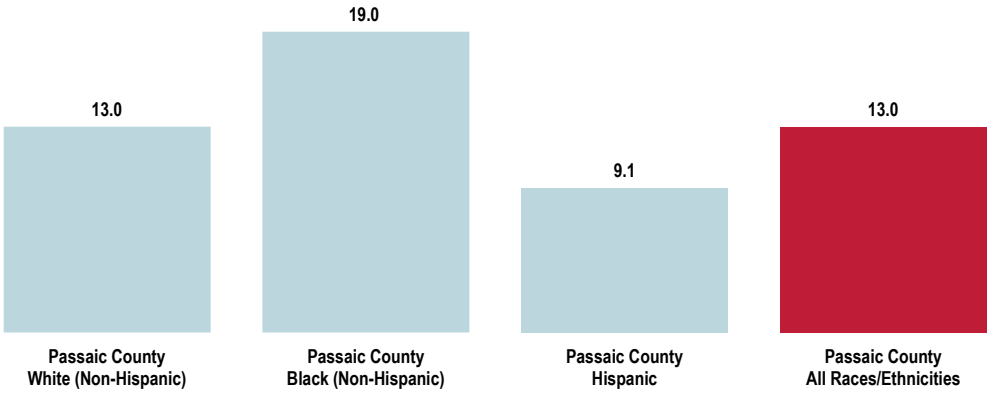
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
Notes: ● CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality
(2018-2020 Annual Average Deaths per 100,000 Population)



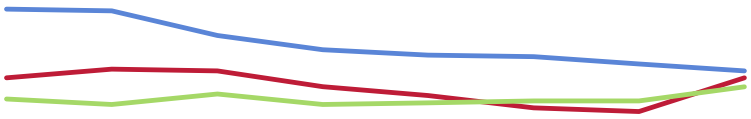
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 124]
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

Pneumonia/Influenza: Age-Adjusted Mortality by Race
(2018-2020 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 September 2022.

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	13.0	13.5	13.4	12.5	12.0	11.3	11.1	13.0
NJ	11.8	11.5	12.1	11.5	11.6	11.7	11.7	12.5
US	16.9	16.8	15.4	14.6	14.3	14.2	13.8	13.4

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

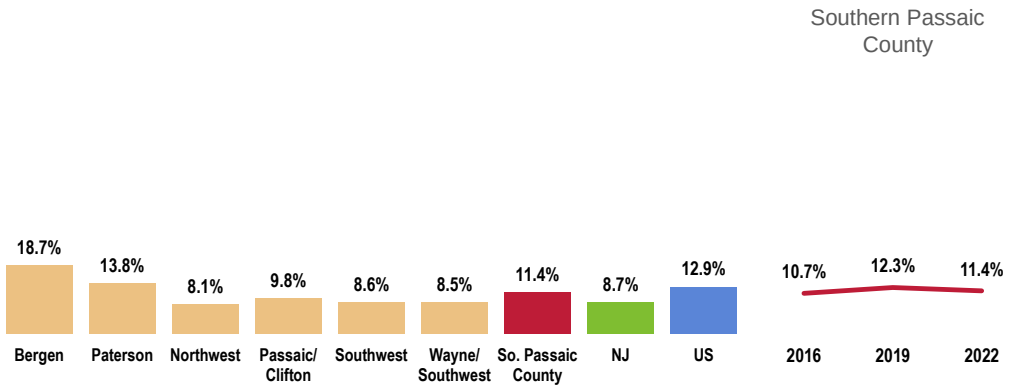
Prevalence of Respiratory Disease

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.)

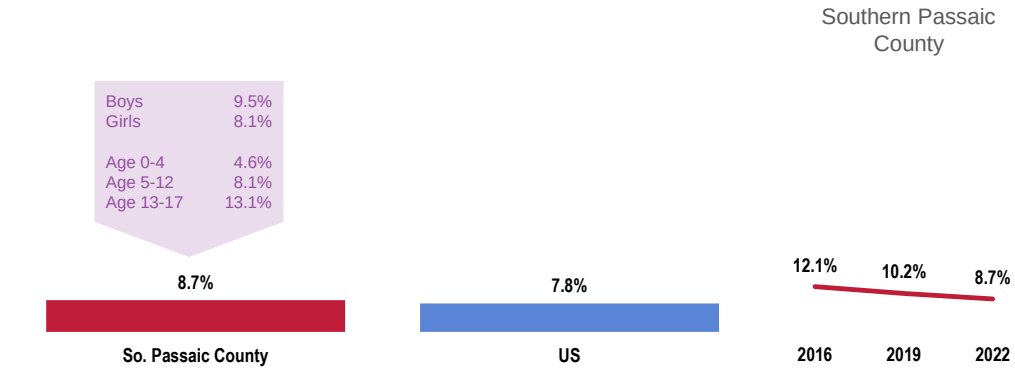
Prevalence of Asthma



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 119]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
● 2020 PRC National Health Survey, PRC, Inc.

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

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



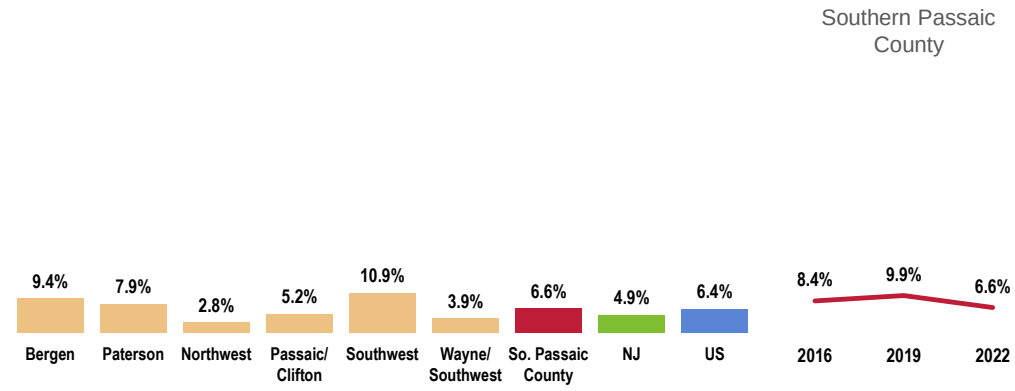
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 120]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

Chronic Obstructive Pulmonary Disease (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)

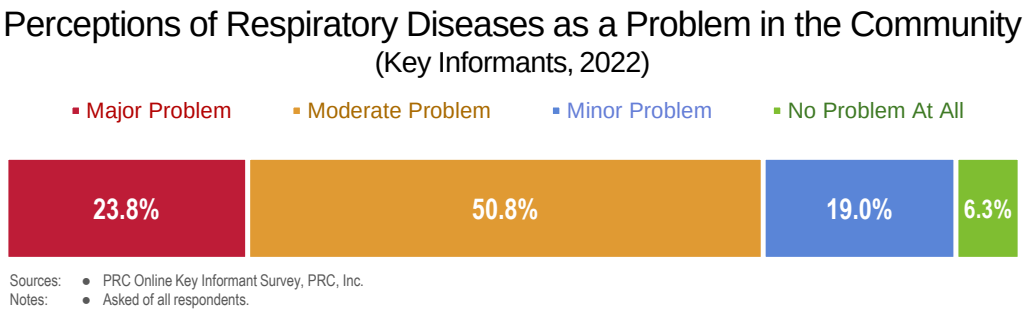


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

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



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

Built Environment

> Age of structures, rodents, dust, and mold, which all contributes to respiratory disease. – Community Leader
>
> Dense city areas seem to have high rates of asthma and respiratory issues due to old homes, pests, and not having access to their own washer/dryer, pets, and not having medical exams and being able to afford medicine exacerbates the situation. – Social Services Provider

Environmental Contributors

> Environmental issues, living in Paterson and in often unregulated and even illegal units, there can be issues with mold, ventilation, etc. – Community/Business Leader
>
> Environmental issues in the community – pollution – poor zoning – poor air quality – mold and mildew issues related to location and flooding issues. Poor housing quality – basement apartments – asthma/respiratory triggers in homes – lack of accountability by landlords and lack of code enforcement. People live where they can afford which is better than having no housing but is often filled with respiratory hazards – Community/Business Leader

Incidence/Prevalence

> Excess amounts of asthma. – Social Services Provider
>
> Asthma, emphysema, and COPD are frequent and recurring complaints that lead to ambulance calls, emergency visits, and days off work for far too many patients. – Physician

Due to COVID–19

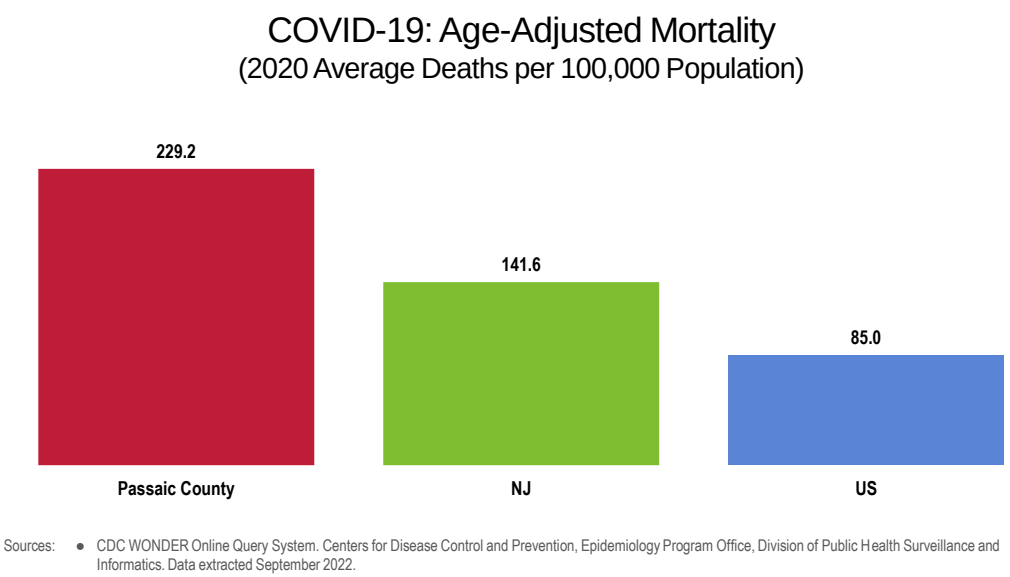
> Respiratory disease in our community is a major problem and is getting worse since the beginning of the COVID–19 pandemic. Many people who were affected by COVID–19 had a huge impact on their respiratory system. This is affecting their overall day to day activities, chores, and work. – Community Leader

Tobacco Use

> Adults who smoked for many years are experiencing related health conditions as they age. – Other Health Provider

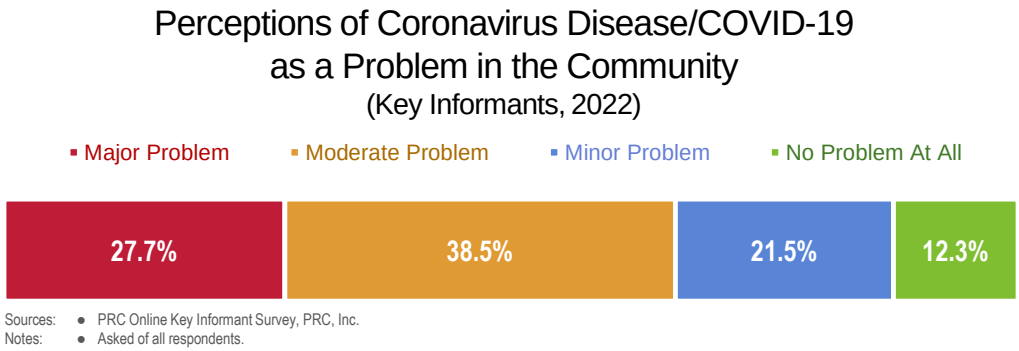
Age-Adjusted Coronavirus/COVID-19 Deaths

2020 mortality for COVID-19 is illustrated in the following chart.



Key Informant Input: Coronavirus Disease/COVID-19

The following chart outlines key informants' perceptions of the severity of *Coronavirus Disease/COVID-19* as a problem in the community:



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

Vaccination Rates

> Many families are yet to be vaccinated. They lack resources and understanding of the benefits vaccinations provide. – Social Services Provider
>
> Even though vaccination rates have increased, there is a large portion, our children under 5 that are not getting vaccinated. Furthermore, with the mask mandates, people are less careful, which can lead to another wave of infection during the upcoming months. – Other Health Provider
>
> COVID–19 is a major problem in our community because of lack of vaccination, overpopulation, and lack of access to healthcare. – Community Leader
>
> Not everyone is vaccinated. – Community Leader

Incidence/Prevalence

> Review of New Jersey Department of Health data. – Social Services Provider

> Coronavirus was a major problem within the community. Our transmission rate was among the highest in the country. It is now under control to a point. Where I believe it is a problem, is that if another pandemic were to make its way into Paterson, the result would be equally as catastrophic due to education levels, access to care and cultural/socioeconomic challenges. – Community Leader
>
> Based on the rate of transmission and positive cases as reported by the New Jersey Health CALI score. The absence of masking is encouraging the spread. – Other Health Provider
>
> Many individuals from the community were infected and died. We have a high rate of vaccinations, so that improved somewhat. – Other Health Provider

Housing

> Due to congested housing, lack of trust in the healthcare system and low immunizations. This is a problem. – Social Services Provider
>
> Overcrowding living conditions, influx of new immigrants, inability for member of our community to follow isolation guidelines are all factors in the rising rate of COVID-19 in our community. Patients with chronic medical conditions and elderly continue to be at risk. St Joseph's has been the leader in the county for COVID 19 vaccination and testing efforts, but other community resources are limited. – Physician
>
> Population congregating a lot and living in close quarters. – Physician

Lack of Adherence to Public Health Mitigation Measures

> It isn't going away, but people behave as though it has and then we have another major outbreak. People who know they are sick are still going out in public. – Social Services Provider
>
> Many people were too anxious to remove masks from their faces. – Other Health Provider

Awareness/Education

> Lack of knowledge and disbelief in science. – Community Leader
>
> Lack of awareness and understanding. – Other Health Provider

Cultural/Personal Beliefs

> There continues to be vaccine hesitancy amongst various cultural and ethnic communities. Misinformation and related rumors continue to circulate in the community. People continue to go to work despite having symptoms or positive test results out of fear of losing their jobs. – Other Health Provider

New Variants

> COVID–19 variants and vaccine costs. – Other Health Provider

Income/Poverty

> Low–income residents don't have access to sufficient PPE equipment. They are also forced to work in less stable conditions where social distancing may not be a possibility. – Social Services Provider

Injury & Violence

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

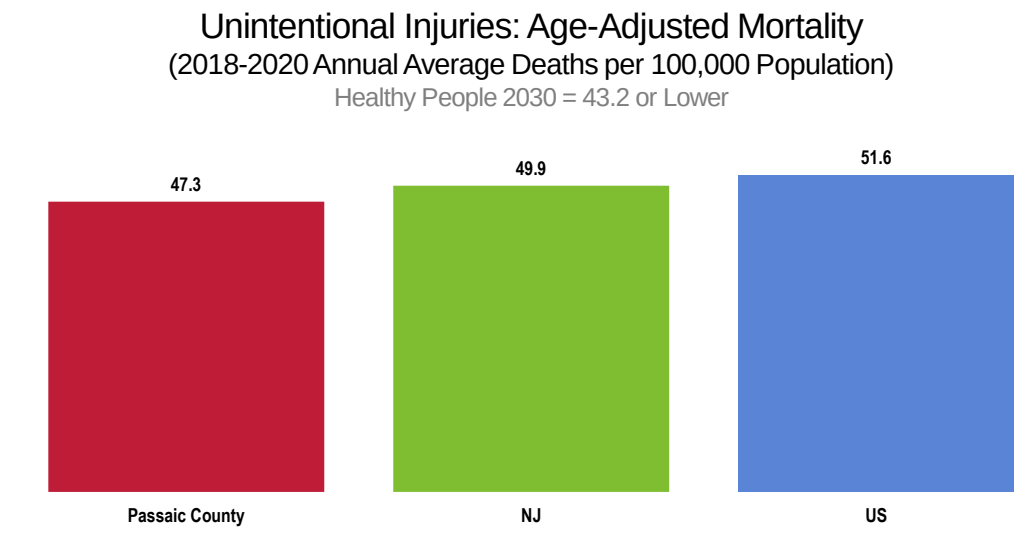
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following charts outline age-adjusted mortality rates for unintentional injury in the area. [COUNTY-LEVEL DATA]

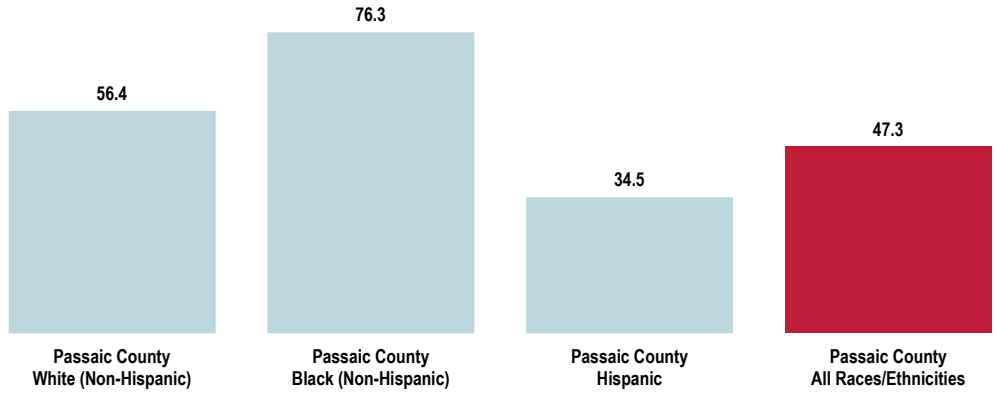


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Unintentional Injuries: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower

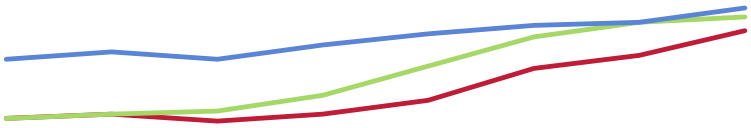


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



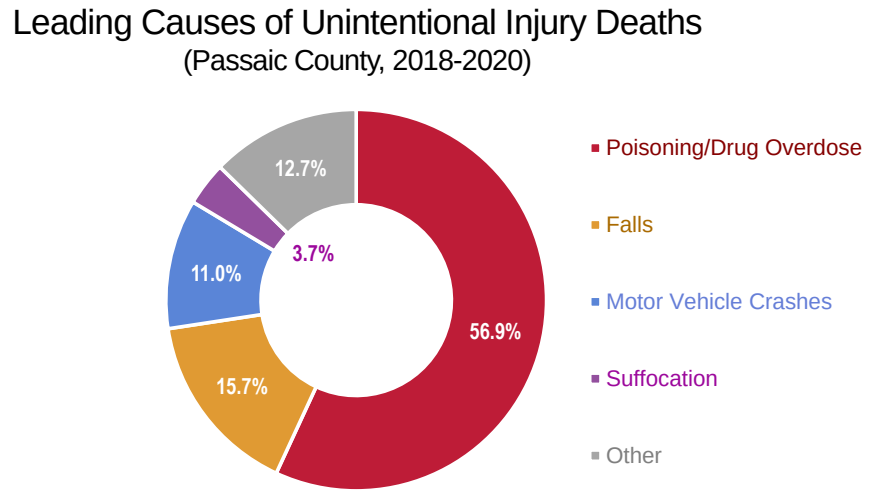
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	30.7	31.5	30.2	31.5	34.1	40.2	42.6	47.3
NJ	30.7	31.5	32.1	35.1	40.6	46.1	48.9	49.9
US	41.9	43.3	41.9	44.6	46.7	48.3	48.9	51.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Leading causes of accidental death in the area include the following: [COUNTY-LEVEL DATA]



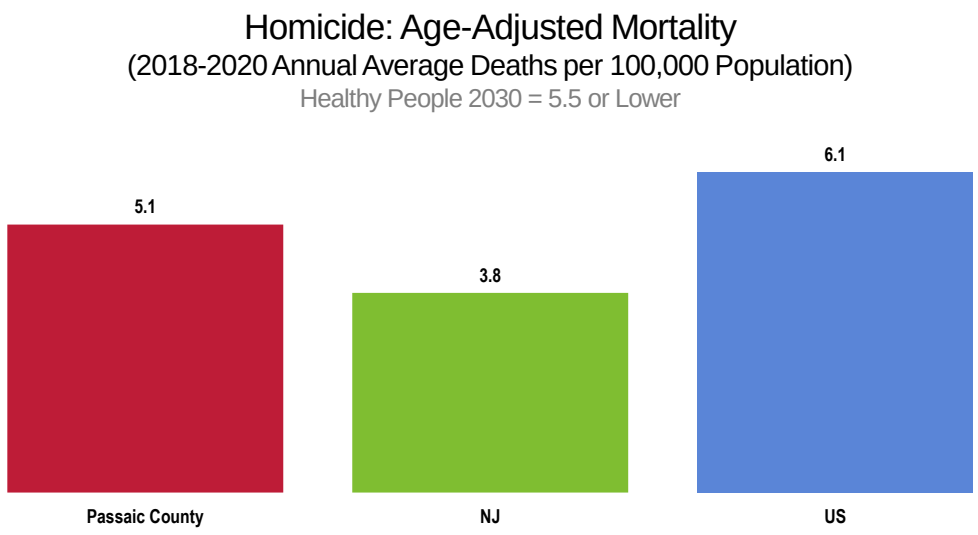
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Age-adjusted mortality attributed to homicide is shown in the following charts. [COUNTY-LEVEL DATA]

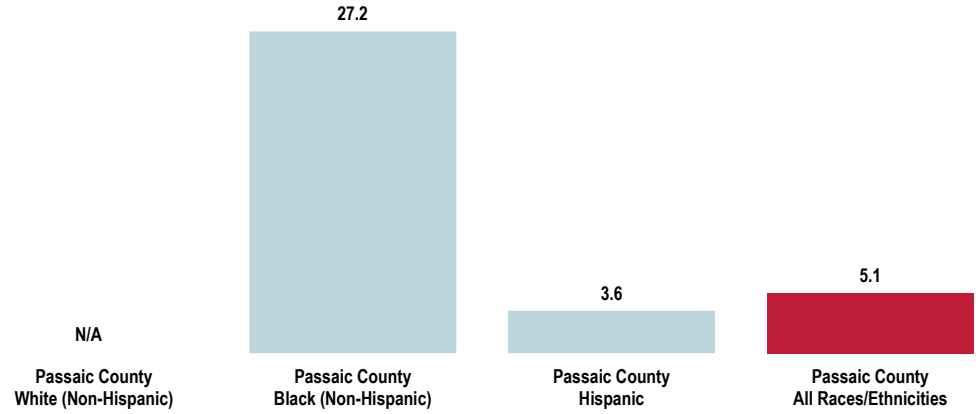


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Homicide: Age-Adjusted Mortality by Race

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 5.5 or Lower

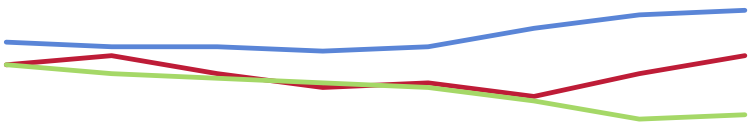


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Homicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 5.5 or Lower



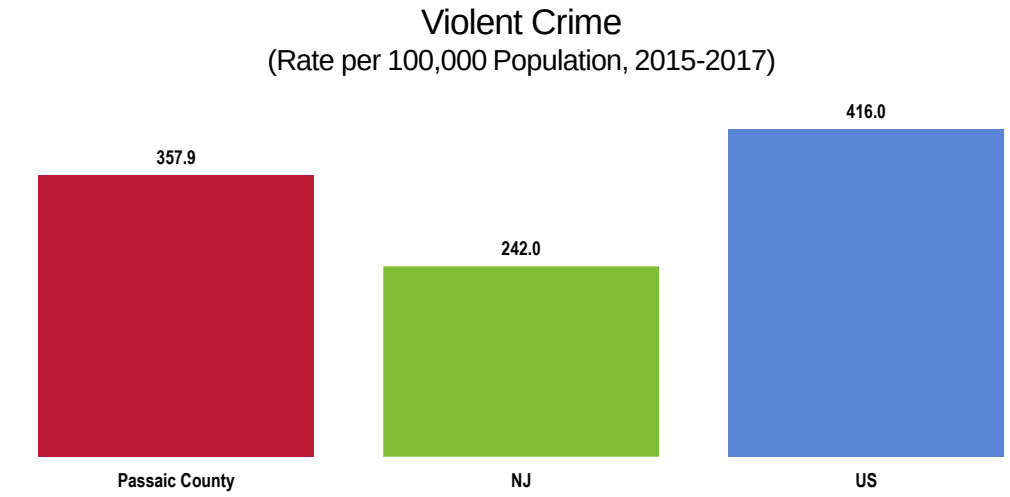
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	4.9	5.1	4.7	4.4	4.5	4.2	4.7	5.1
NJ	4.9	4.7	4.6	4.5	4.4	4.1	3.7	3.8
US	5.4	5.3	5.3	5.2	5.3	5.7	6.0	6.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

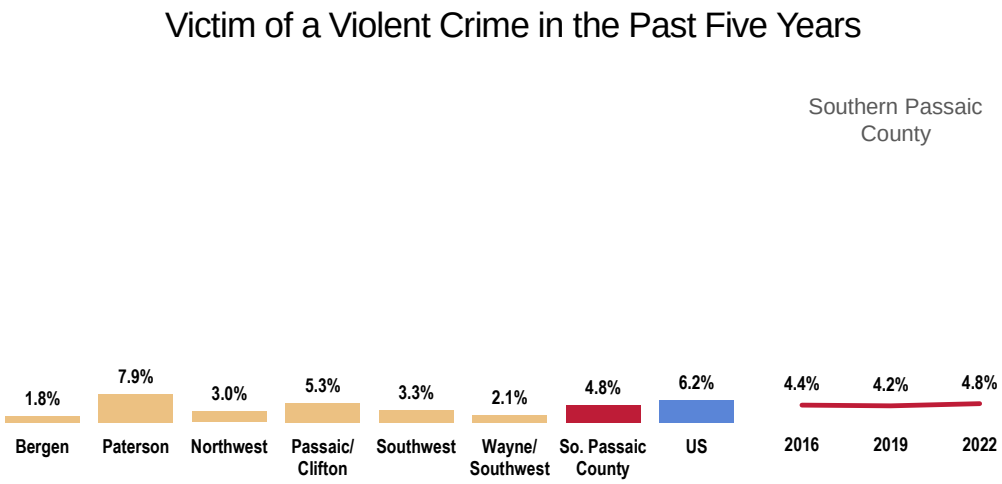
Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions. [COUNTY-LEVEL DATA]



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.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?"**

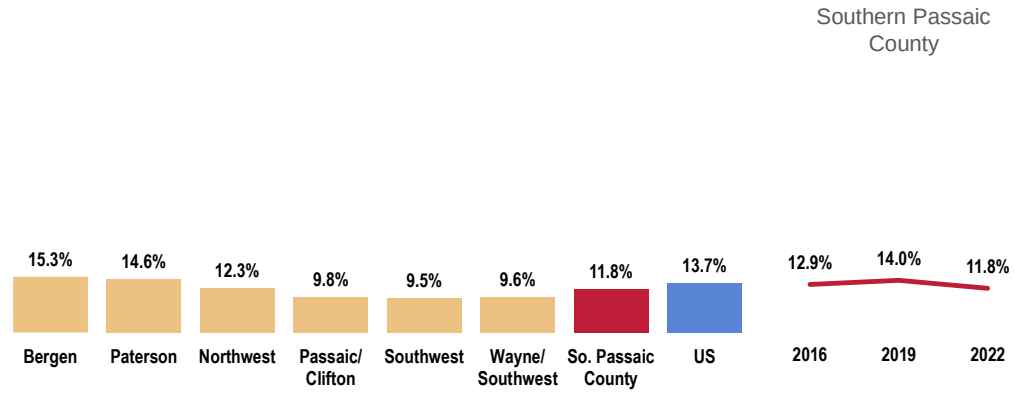


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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?"**

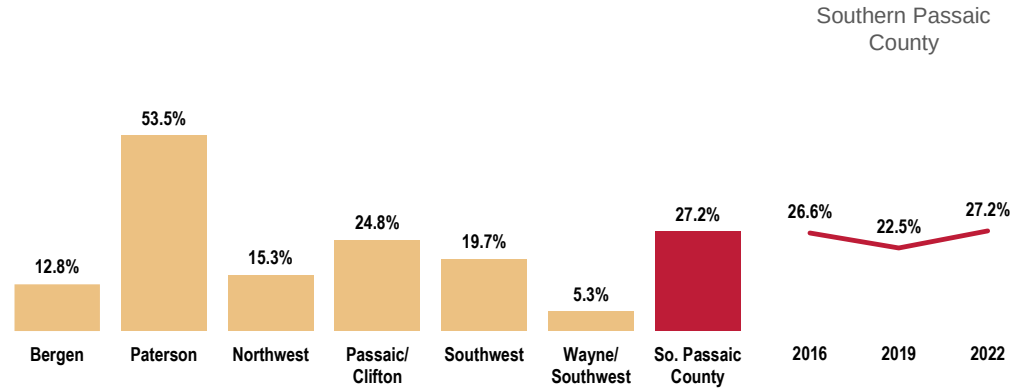
Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 39]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

NEIGHBORHOOD SAFETY ▶ **"The next question is about personal safety. How safe from crime do you consider your neighborhood to be? Would you say extremely safe, quite safe, slightly safe, or not at all safe?"**

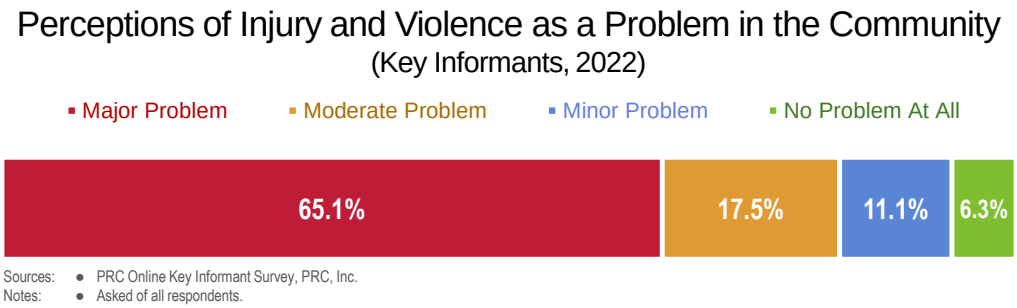
Perceive Own Neighborhood as "Slightly" or "Not At All" Safe



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 302]
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:



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

Gun Violence

> Increase in gun violence in the community. It is confirmed by the statistics. – Community/Business Leader
>
> There are shooting happening on a daily basis in Paterson, New Jersey. – Other Health Provider
>
> Random shootings almost on a daily basis. – Social Services Provider
>
> As the sole EMS provider for the city, we witness consistent shootings, stabbings, and beatings. We also witness domestic violence daily and severe injuries due to irresponsibility, like riding ATVs through the streets with no protection. – Community Leader
>
> Firearm related violence is on the rise, especially in Paterson. – Physician
>
> High rate of gun violence and drug trafficking. – Community Leader
>
> There are shootings on a regular basis in Paterson, many of which result in injury and death. I believe this is due to the poverty and lack of resources that lead to drug use and gang affiliations, which in turn lead to guns and violence. – Community Leader
>
> Gun violence has become the leading cause of premature death among children and adolescents according to a U of Minn. study and has overtaken motor vehicle accidents as a leading cause of preventable deaths. Beyond that, the fear and stress level produced in the areas heir to this violence, results in an abundance of issues including mental health problems, changes in available resources secondary to fear, and so on and so on – Physician
>
> Gun violence has traumatized the community and youth don't have positive role models and options to counteract street violence. – Community/Business Leader
>
> Frequent news about gun violence and death in the community. Gunshot wounds coming into the Emergency Room regularly as well. – Other Health Provider
>
> Gun violence is on the rise in the city and nationwide. Students in public schools are resorting to violence and are victims of physical and mental abuse. – Social Services Provider

Incidence/Prevalence

> Newspaper stories that recount the uptick in Paterson. – Social Services Provider
>
> The city is plagued with violence. – Community/Business Leader
>
> The epicenter of the population in this community is inner–city with a high prevalence of violence leading to injury. The area has an urban landscape with major roadways and a large pedestrian population leading to increased potential for motor vehicle and pedestrian related injury. Furthermore, the aging population is prone to falls these only get progressively more frequent with age and serious in relation to number and types of injuries (brain injury, bony injuries to the pelvic, hips and ribs). – Community Leader
>
> Paterson is ranked #97 for being one of the most dangerous cities in the United States, where 1 in 111 persons can be a victim. (Neighborhood Scout) – Community Leader
>
> Higher crime rates. In this line of work, I have connected with many community members who have shared that growing up and living in a community where once in a while you hear gunshots, it takes a toll on their mental health and hopefulness of a better life. – Other Health Provider
>
> Because of the news. – Social Services Provider
>
> Passaic County has had an increase in violent crime, and it is growing every day. – Other Health Provider
>
> Significant injuries and death due to violence. – Other Health Provider

> Violence due to instability in the communities. – Social Services Provider

Gang Violence

> Gangs, guns, poor relationships, and the breakdown of families. – Community Leader
>
> Gangs, domestic violence, poverty. – Physician
>
> Youth gang activity, gun violence and car thefts are increasing and impact residents' safety in their neighborhoods. – Other Health Provider
>
> Some young people belong to gangs, which replace their families. There are rivalries and arguments, which lead to injury and violence. Within families, we are taught peaceful conflict resolution, but this may not be the case in gangs. – Other Health Provider

Safe Alternatives

> Lack of opportunity for safe alternatives, lack of mentorship. – Physician

Co–Occurrences

> If you read the newspaper, you can find all the information you need about injury and violence. This is very much tied to the mental health issues that exist. It is also tied to the economic inequalities and racial issues that exist in our culture. – Community Leader

Due to COVD–19

> The amount of violence has increased during the pandemic. – Social Services Provider

Impact on Quality of Life

> Community violence, particularly in Paterson and Passaic, impact the entire community. Pervasive, chronic trauma affects everyone. – Social Services Provider

Income/Poverty

> Injury and violence are a major problem in our community because this is a low–income community with moderate crime rates. Residents living in certain areas in Clifton and Paterson are at a higher risk of various injuries such as assault, and hate crimes based on race. – Community Leader

Law Enforcement

> Lack of police involvement. – Public Health Representative

Diabetes

ABOUT DIABETES

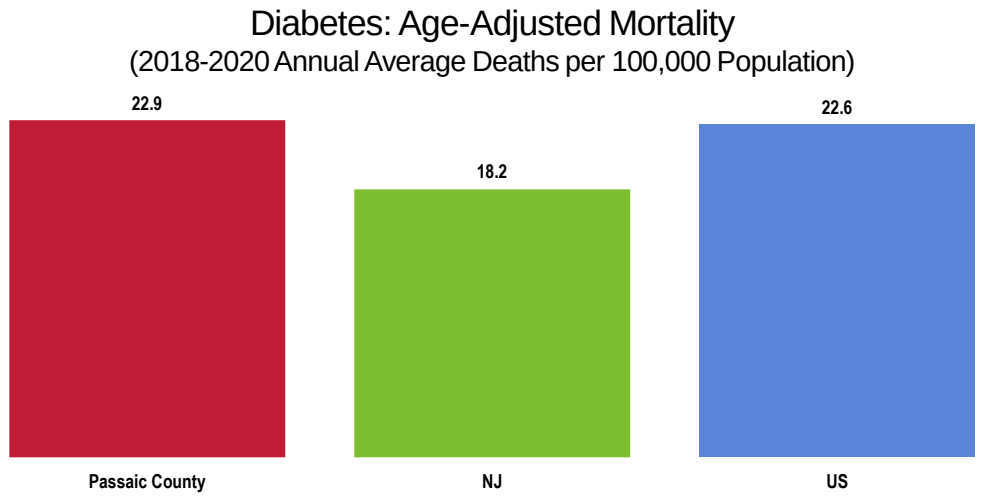
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

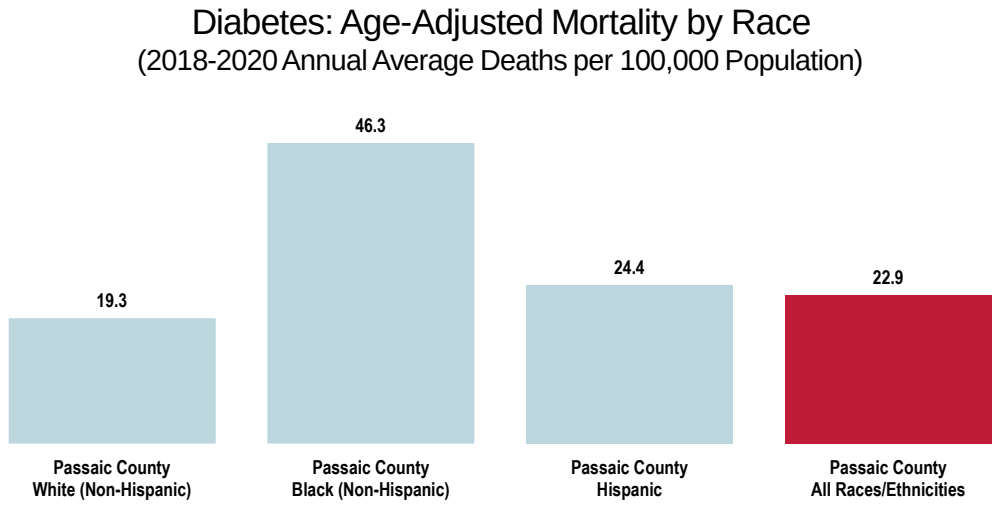
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following charts. [COUNTY-LEVEL DATA]

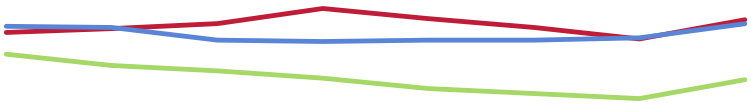


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

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



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	21.9	22.2	22.6	23.8	23.0	22.3	21.4	22.9
NJ	20.2	19.3	18.9	18.3	17.5	17.1	16.7	18.2
US	22.4	22.3	21.3	21.2	21.3	21.3	21.5	22.6

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

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?)**"**

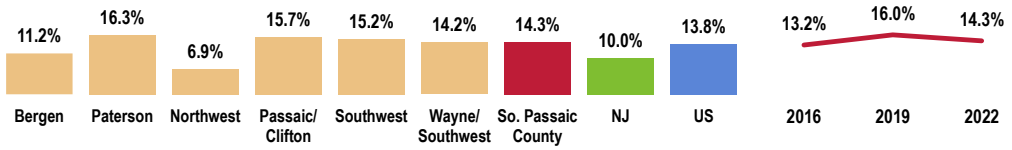
"Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)**"**

[Adults who do not have diabetes] **"Have you had a test for high blood sugar or diabetes within the past three years?"**

Prevalence of Diabetes

Another 17.3% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

Southern Passaic County

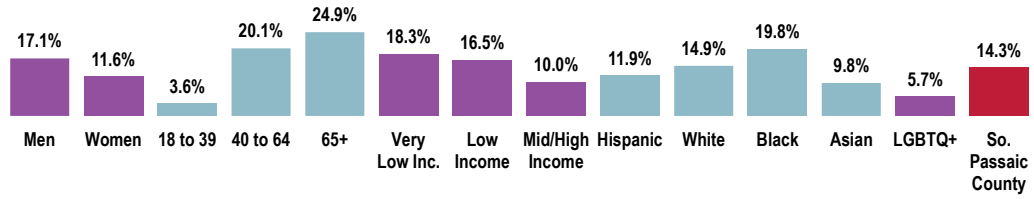


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 121]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
● 2020 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents. Excludes gestational diabetes (occurring only during pregnancy).

Prevalence of Diabetes
(Southern Passaic County, 2022)

Note that among adults who have not been diagnosed with diabetes, 50.7% report having had their blood sugar level tested within the past three years.

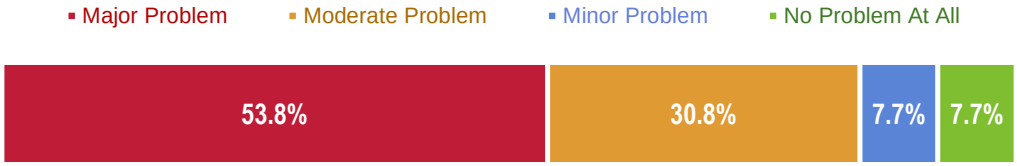


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 33, 121]
Notes: ● Asked of all respondents.
● Excludes gestational diabetes (occurring only during pregnancy).

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, 2022)



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:

Nutrition

> Diet, nutrition, and proper cooking. – Community Leader
>
> Too many advertisements advertise sugary foods. – Other Health Provider
>
> Diet and medication compliance. – Other Health Provider
>
> Diet and nutrition seem to be a major factor. Food that tends to be cheaper is also food that is full of sugar and preservatives. There is extremely limited access to healthy food options, and extremely limited knowledge of healthy food options. – Community Leader
>
> Some of the biggest challenges for people with diabetes in our community is eating healthy, especially with food desserts and a large amount of fast–food restaurants in every corner, lack of education in nutrition and eating healthy, lack of access and affordability to diabetes medications. – Community Leader
>
> Proper nutrition and medical attention and education. – Social Services Provider
>
> Access to proper diet and nutrition information, preventative health, and follow–up. – Community/Business Leader

Awareness/Education

> Education and treatment. – Social Services Provider
>
> Education and access to affordable healthy food options. – Community/Business Leader
>
> Nutritional guidelines and education. Early detection. Access and cost of healthy foods. Fresh fruits and vegetables. – Community Leader
>
> Lack of education. – Other Health Provider
>
> Knowledge and compliance with dietary habits and physical activities that support control of their diabetes. The belief that they can eat anything and the insulin and/or metformin will take care of it. – Other Health Provider
>
> Nutritional education. – Physician
>
> Education. – Community/Business Leader

Access to Affordable Healthy Food

> Lack of affordable healthy food options. – Community/Business Leader
>
> Lack of financial resources to purchase nutritious foods. – Other Health Provider
>
> Access to healthier foods in our community and education for a healthy lifestyle daily, including access to nutrition education and exercise facilities. – Community/Business Leader
>
> Diet and access to healthy food, as well as how to cook it. – Community Leader

Affordable Medications/Supplies

> Some of the challenges include the cost of purchasing healthy food and medication. Insulin is now OTC, so cost is prohibitive to some. (Where before insulin would be the cost of a copay, it is now $450+ monthly.) The availability of preferred brands of insulin. The changing of health insurance companies and/or rules forcing insulin–dependent diabetics to have to change the type of insulin that works best for them (for example pump vs no pump). Also, some people don't seem to take their diabetes diagnosis seriously enough. Since so many of their peers have it, it seems more the "norm" to have "a little sugar" (i.e., diabetes) than not. Lastly, exercise. Many of our residents seem averse to doing regular exercise. – Public Health Representative
>
> Affording the medications that are the best to treat their disease and patient education surrounding the importance to religiously take their medication. – Community Leader
>
> Cost of prescription medication. – Social Services Provider

Lifestyle

> Proper nutrition and physical activity. Latinos and African Americans are at high risk for diabetes. It does not help that in the communities they live, the groceries stores may not have healthier options. – Other Health Provider
>
> Proper nutrition and exercise. – Community Leader
>
> Lack of access/affordability/time to consume fresh fruits and veggies and opportunity for regular exercise. Safety concerns, time constraints, financial issues, all contribute. In addition, a lack of health literacy regarding many issues including diabetes prevention – Community/Business Leader

Access to Care/Services

> Lack of resources to eat healthy, lack of exercise, overweight/obesity, starting pregnancy with poor glucose control, lack of primary care providers. – Physician
>
> Lack of access to quality healthcare and medications. – Physician

Diagnosis/Treatment

> Undiagnosed individuals with the disease. – Social Services Provider

Disease Management

> Lack of compliance with care. – Physician

Kidney Disease

ABOUT KIDNEY DISEASE

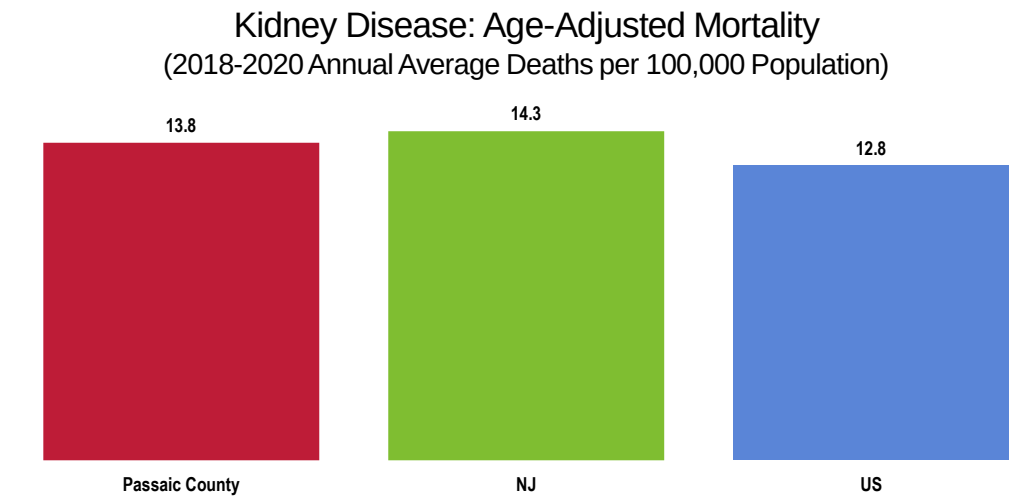
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

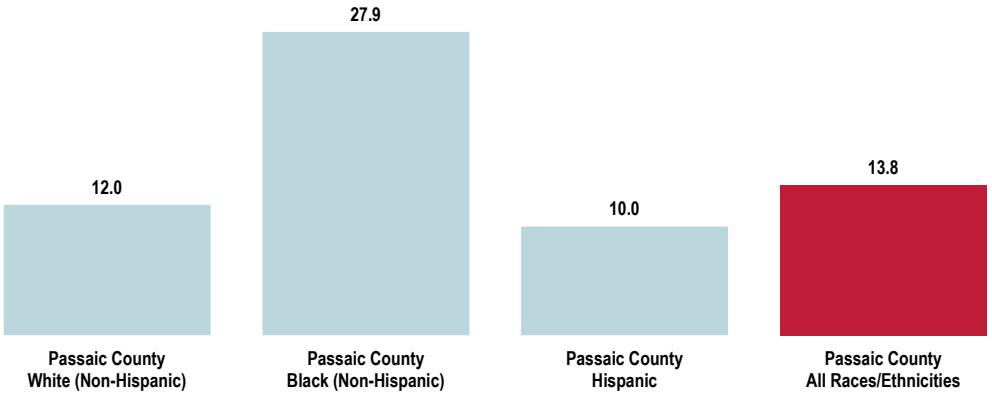
Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following charts. [COUNTY-LEVEL DATA]



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

Kidney Disease: Age-Adjusted Mortality by Race
(2018-2020 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 September 2022.

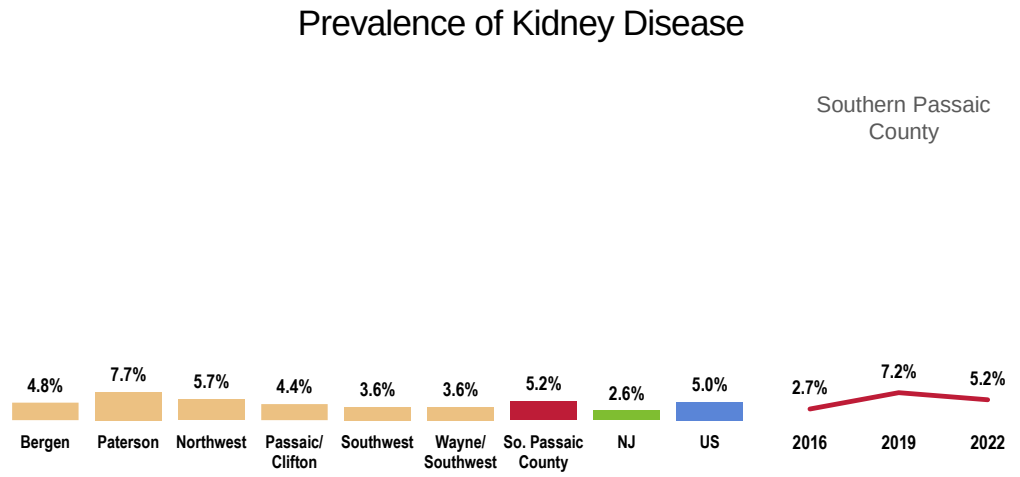
Kidney Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)

	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	12.7	12.8	13.2	14.6	14.4	14.3	13.4	13.8
NJ	13.7	13.5	13.8	14.0	14.0	14.1	14.1	14.3
US	15.3	15.3	13.3	13.3	13.2	13.0	12.9	12.8

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

Prevalence of Kidney Disease

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

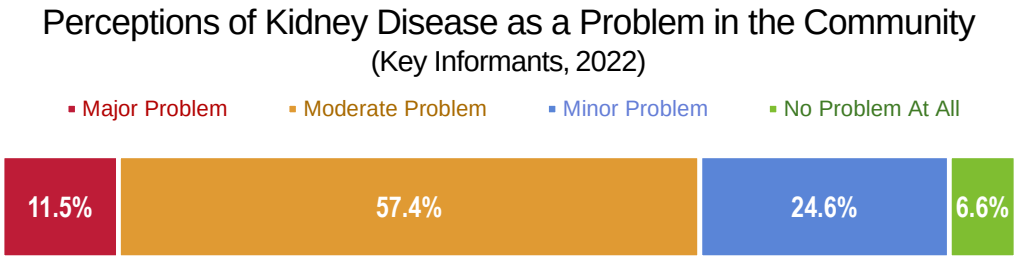


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, 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:

Co–Occurrences

> Hypertension and diabetes are major risk factors and the population we serve are at high risk for these chronic conditions. Lack of access to quality care are major risk factors. – Physician
>
> With many adults having high blood pressure, diabetes and obesity, kidney disease is inevitable. – Social Services Provider

Incidence/Prevalence

> High rates of kidney disease and dialysis. – Other Health Provider
>
> African Americans experience high rates of renal failure and are treated for it. – Social Services Provider

Potentially Disabling Conditions

Multiple Chronic Conditions

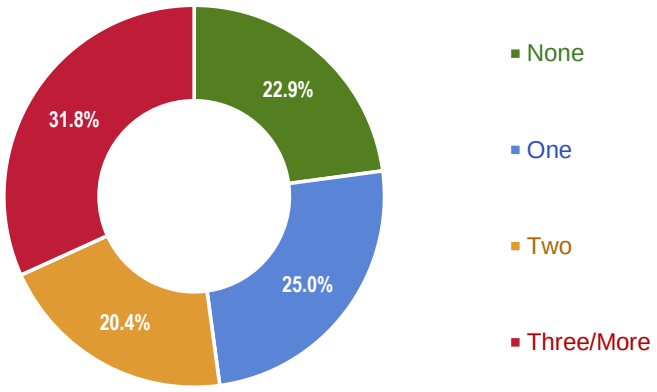
The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.

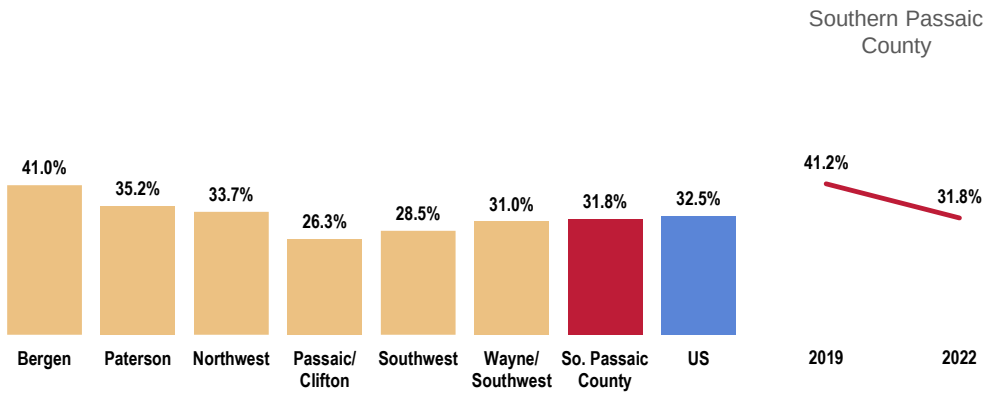
Number of Current Chronic Conditions
(Southern Passaic County, 2022)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Activity Limitations

ABOUT DISABILITY & HEALTH

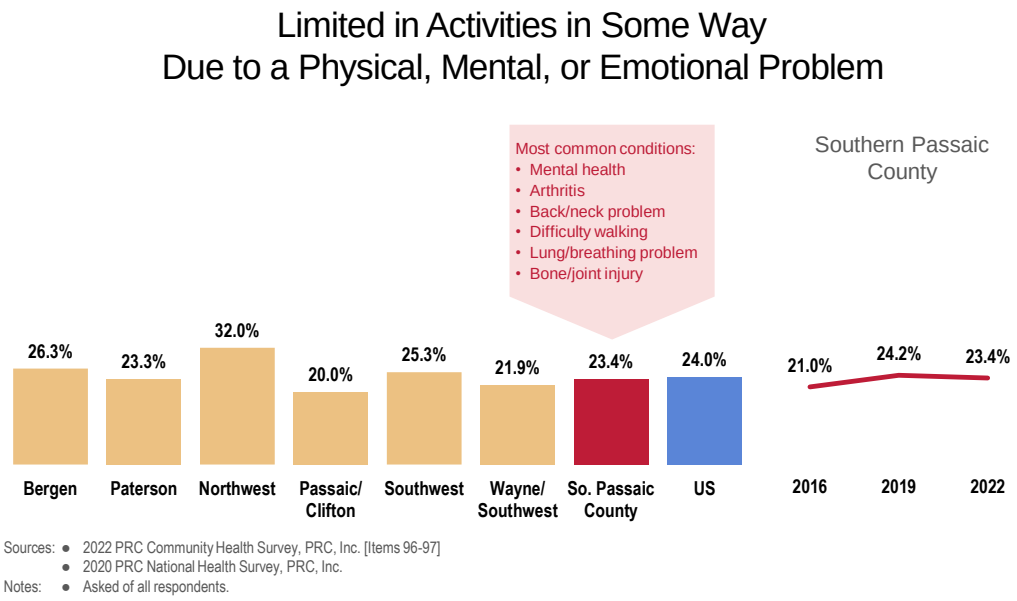
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

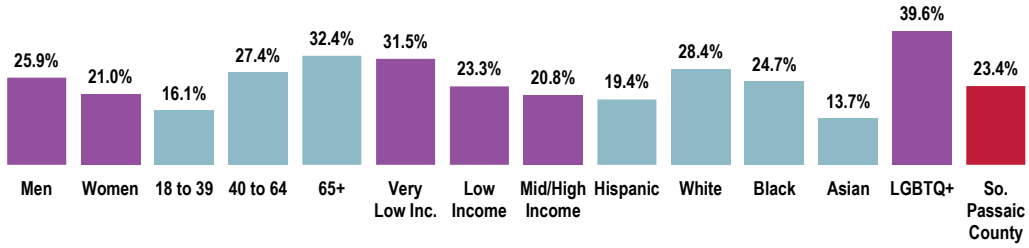
– Healthy People 2030 (https://health.gov/healthypeople)

"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
(Southern Passaic County, 2022)

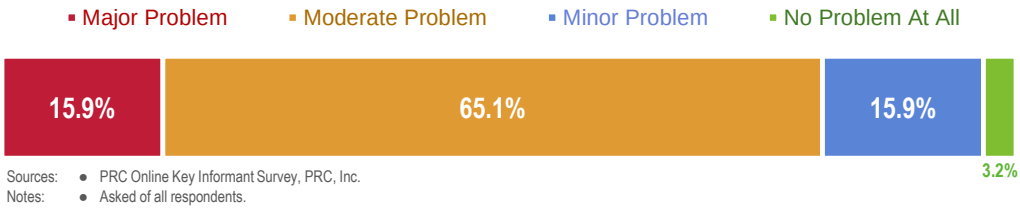


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: ● Asked of all respondents.

Key Informant Input: Disability & Chronic Pain

The following chart outlines key informants' perceptions of the severity of *Disability & Chronic Pain* as a problem in the community:

Perceptions of Disability & Chronic Pain as a Problem in the Community
(Key Informants, 2022)



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:

Aging Population

> The community has an aging population and with this comes progressive increases in the number of health disabilities, as well as chronic pain. – Community Leader
>
> Disability and chronic pain are major problems in our community especially in the older group because of the lack of physical movement at a younger age. People with chronic pain or are disabled is difficult for them to move around the neighborhood because of the lack of accessibilities and easy movement for them. – Community Leader

Diagnosis/Treatment

> Undiagnosed and untreated. – Other Health Provider
>
> Developmental and neurological disease. – Social Services Provider

Access to Care/Services

> Because my community is under resourced, this is a challenge. Quality of health coverage, cost of health coverage and transportation issues. Because of this, people may just suffer in pain instead of getting the treatment they need. – Community/Business Leader

Co–Occurrences

> High rates of homelessness, mental health, and substance use, often leads to higher rates of disability and chronic pain. Working with members of the community in this realm, you find there are many individuals in this community who are in need of such healthcare. – Other Health Provider

Incidence/Prevalence

> There are so many individuals living with pain. – Community/Business Leader

Support Groups

> There are so many people in the community that share similar problems, that are aggravated by the sense that they are alone. The need for support groups that facilitate the understanding that common problems are common, and that some of the effective coping strategies that have been found, could be shared with others in the same circumstance – Physician

Vulnerable Populations

> Management of pain is not adequately addressed in communities of color. There is a perception the members of these communities are drug seeking. – Social Services Provider

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

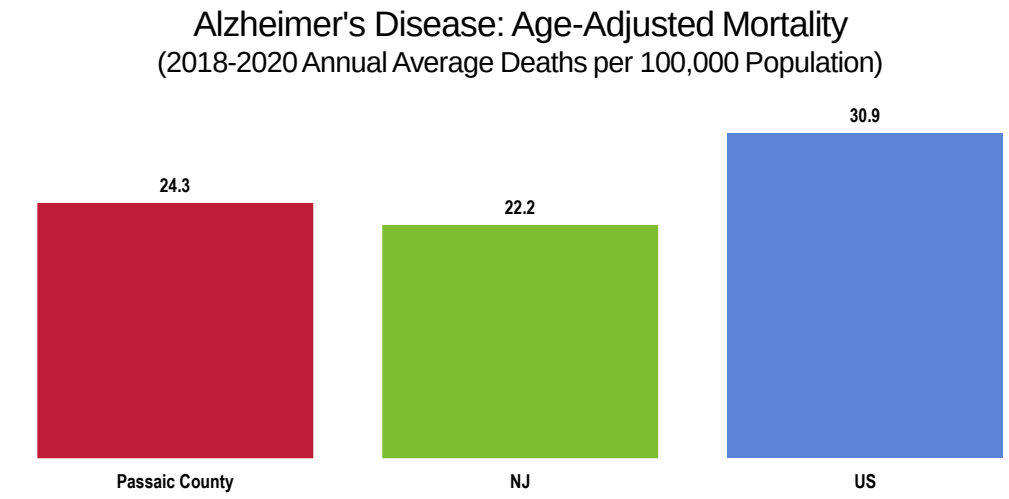
Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

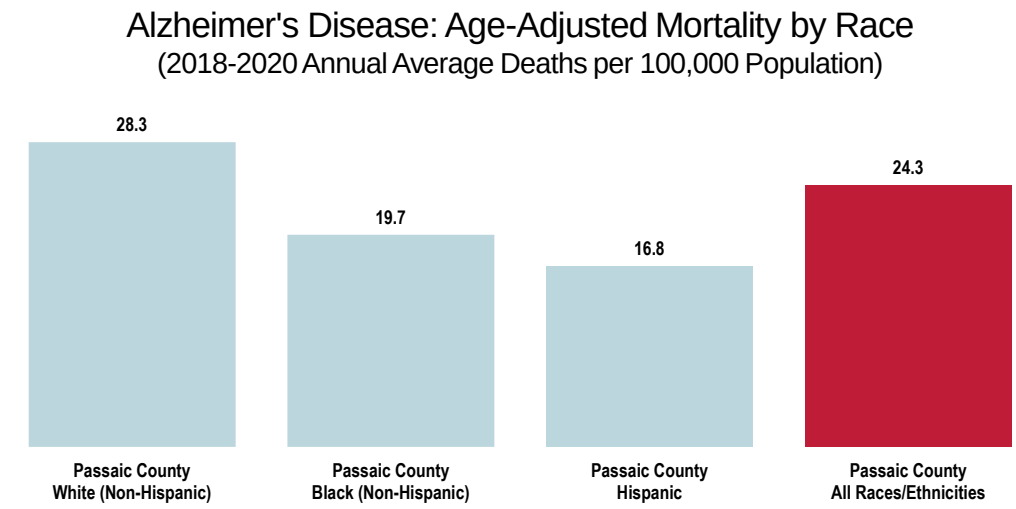
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined in the following charts. [COUNTY-LEVEL DATA]

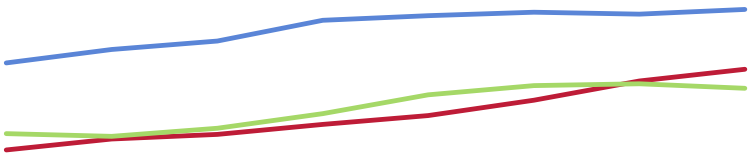


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

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



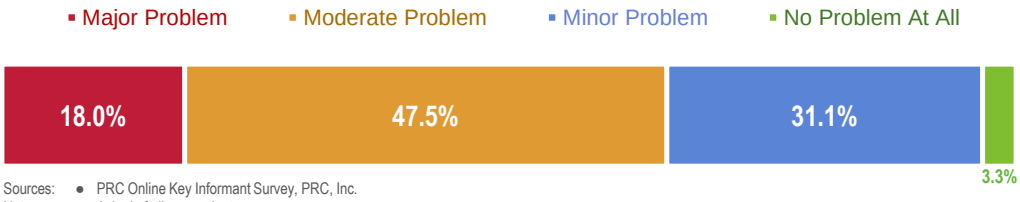
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	15.4	16.6	17.1	18.2	19.2	20.9	23.0	24.3
NJ	17.2	16.9	17.8	19.4	21.5	22.5	22.7	22.2
US	25.0	26.5	27.4	29.7	30.2	30.6	30.4	30.9

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

Key Informant Input: Dementia/Alzheimer's Disease

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

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community
(Key Informants, 2022)



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:

Incidence/Prevalence

> My community has a large senior population. I'm aware of many people who either have dementia/Alzheimer's or are caring for a family member with Alzheimer's/dementia. I also have a family member with dementia which puts me in contact with others in a similar situation. Perhaps I'm just more aware but I think it's a big problem in our community. – Public Health Representative

> The incidence of dementia and the number of vulnerable adults living alone in the community with dementia. There is a crisis regarding the lack of caregivers and the need for safe community–based care. – Other Health Provider

Affordable Care/Services

> Alzheimer's disease is a major problem in our community because it is financially destroying many people's lives. – Community Leader

Denial/Stigma

> Detention amongst many cultures. Many are in denial and do not want to seek help for their family members. On the other hand, many of our seniors are alone. As a result, checking for early signs of dementia may not be possible. – Other Health Provider

Diagnosis/Treatment

> No cure. – Physician

Impact on Caregivers/Families

> Many caretakers are overwhelmed with caretaking responsibilities and financial burden. People are often underinsured and cannot access quality services or receive assistance to care for their family members. Assisted living and memory care is often financially out of reach for families. – Other Health Provider

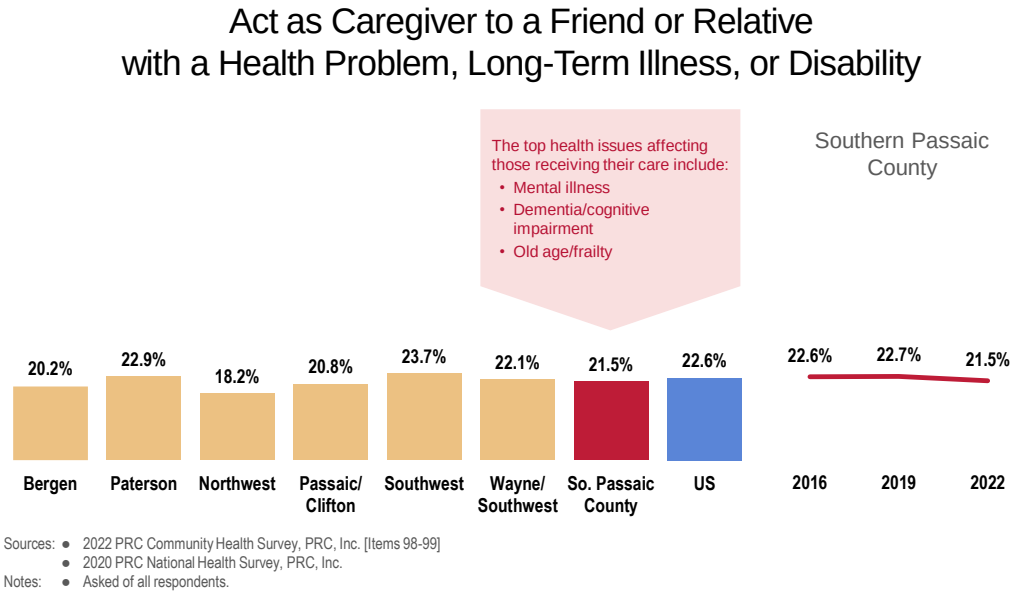
Nutrition

> We are not paying enough attention to analyzing how the foods that we eat contribute to our well–being. – Other Health Provider

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?"**



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 98-99]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

BIRTHS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

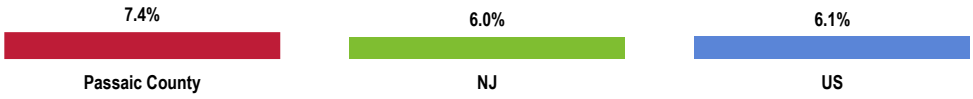
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

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 charts. [COUNTY-LEVEL DATA]

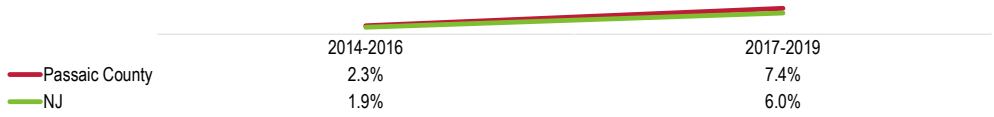
Lack of Prenatal Care in the First Trimester
(Percentage of Live Births, 2017-2019)



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2022.

Note: ● 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.

Lack of Prenatal Care in the First Trimester
(Percentage of Live Births)



	2014-2016	2017-2019
Passaic County	2.3%	7.4%
NJ	1.9%	6.0%

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2022.

Note: ● 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.

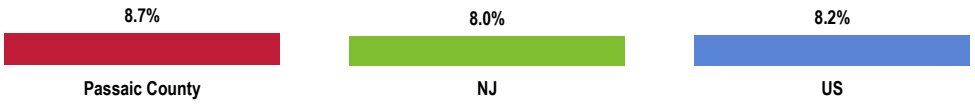
Birth Outcomes & Risks

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. [COUNTY-LEVEL DATA]

Low-Weight Births
(Percent of Live Births, 2014-2020)



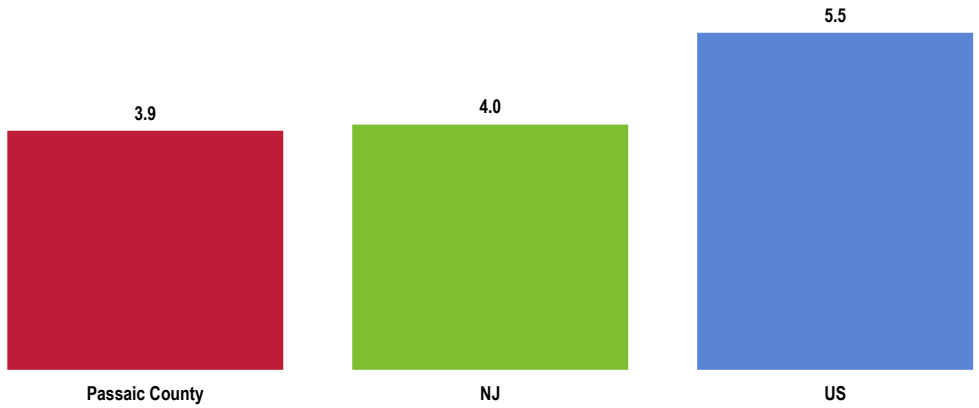
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2022.

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 charts. [COUNTY-LEVEL DATA]

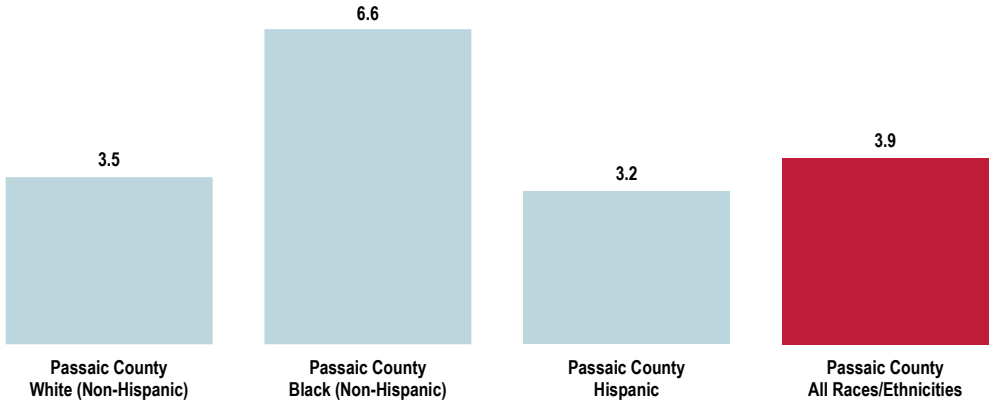
Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births, 2018-2020)
Healthy People 2030 = 5.0 or Lower



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Infant Mortality Rate by Race/Ethnicity
(Annual Average Infant Deaths per 1,000 Live Births, 2018-2020)
Healthy People 2030 = 5.0 or Lower



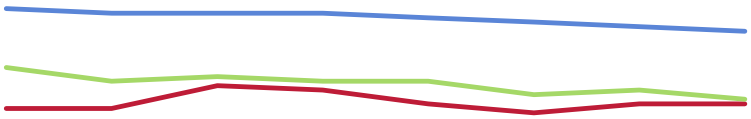
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Infant Mortality Trends

(Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2030 = 5.0 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	3.8	3.8	4.3	4.2	3.9	3.7	3.9	3.9
NJ	4.7	4.4	4.5	4.4	4.4	4.1	4.2	4.0
US	6.0	5.9	5.9	5.9	5.8	5.7	5.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2022.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

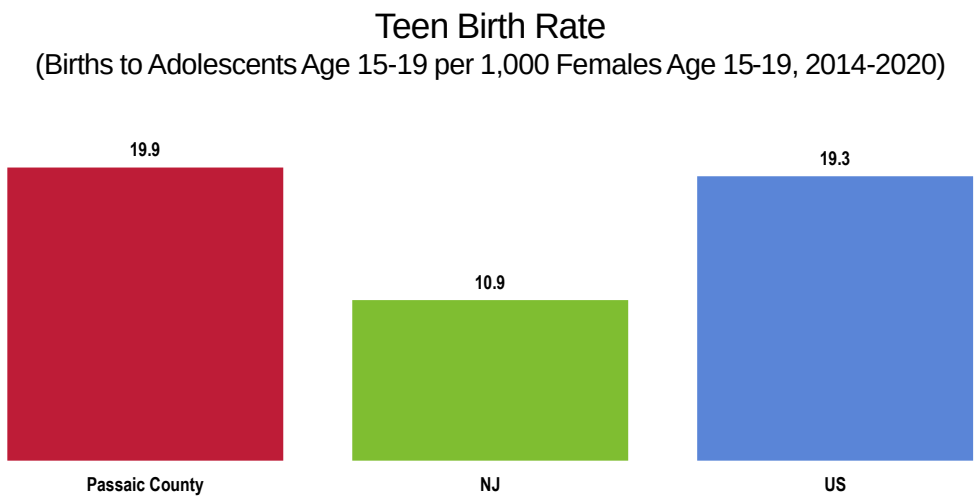
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

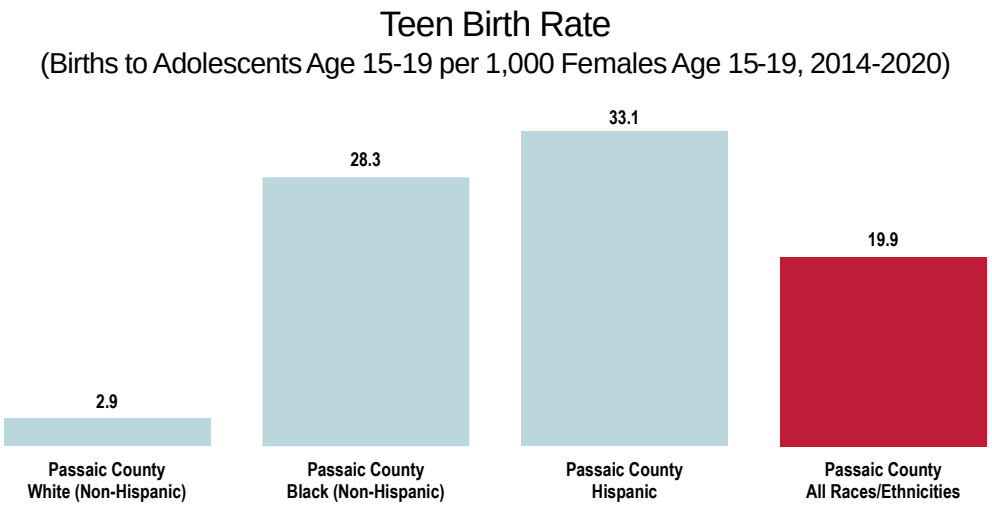
Births to Adolescent Mothers

The following charts describe births to adolescent mothers under the age of 20 years. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.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.

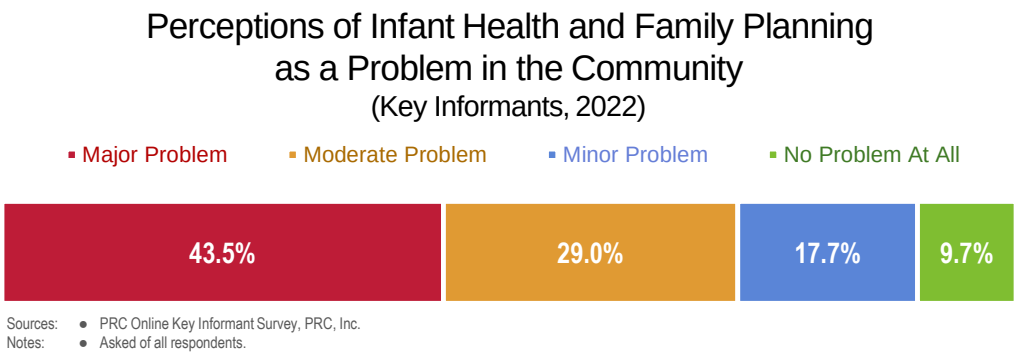


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).

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: Infant Health & Family Planning

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



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

Access to Care/Services

> Lack of family planning clinics. – Social Services Provider
>
> Lack of or late entry into prenatal care. – Physician
>
> Families in our district do not have access to pediatricians and consistent medical homes. – Social Services Provider
>
> Lack of resources to provide effective contraception counseling and product. – Physician
>
> There is not any community counseling available regarding family planning. – Social Services Provider

Awareness/Education

> All the other stated health issues begin in the infant stage. If parents aren't educated about how to raise healthy children, and empowered with access to the tools necessary, then we're going to just keep repeating the same cycles over and over. – Community Leader
>
> There is not a lot of access for young teens to learn about family planning and there is a high incidence of teen births. – Other Health Provider

Foreign-Born

> Passaic County has an abundance of low-income families that additionally do not have a legal status in this country. They are not eligible for health insurance or cannot afford to pay for health insurance. This limits them to have access to prenatal care, routine medical care for their infants and birth control. – Public Health Representative
>
> Pregnant immigrant women with no health insurance have limited knowledge about resources. – Social Services Provider

Incidence/Prevalence

> Overpopulation and prone to STDs and HIV. – Other Health Provider
>
> According to the March of Dimes, the community receives an 'F' in maternal and infant health. – Community Leader

Disease Management

> There are many families who do not follow through on their appointments. – Community Leader

Follow-Up/Support

> Mothers need support, education, and resources. – Community/Business Leader

Funding

> There is a tremendous reliance on the government to provide assistance due to a high single parent population. With that, there is little time to parent effectively and a continuous cycle of declining parental skills through generations. – Community Leader

Teen Pregnancy

> Teenage pregnancy and poor prenatal care. – Community Leader

Vulnerable Populations

> High rates of black infant and maternal mortality. – Other Health Provider

Young Families

> Infant health and family planning is a major problem in our community because there are many younger families and/or younger new parents that have a difficult time raising and taking care of a child. – Community Leader

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

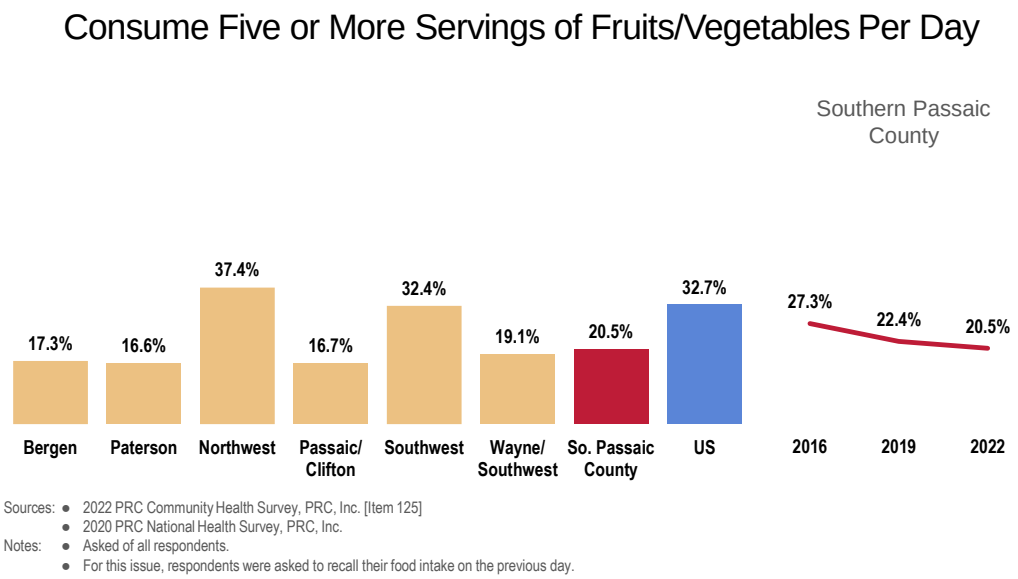
Daily Recommendation of Fruits/Vegetables

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.



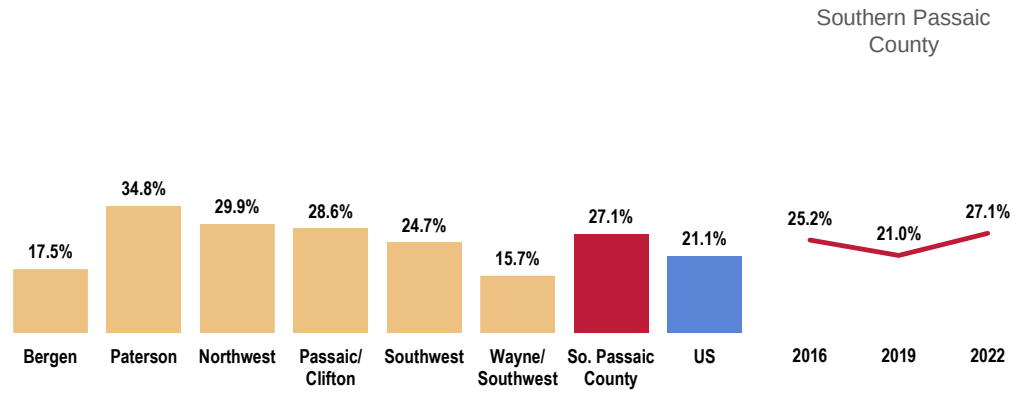
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 125]
- 2020 PRC National Health Survey, PRC, Inc.

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?"

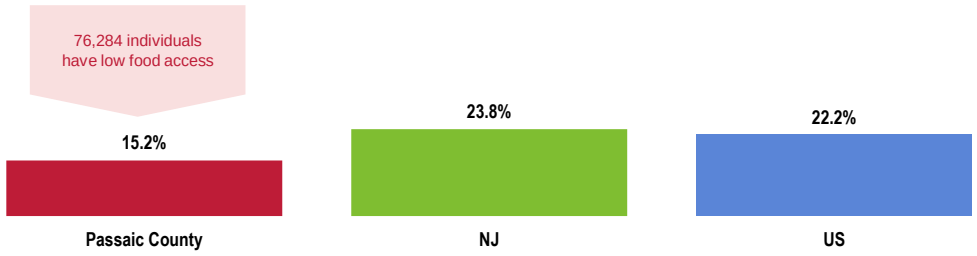
Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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. [COUNTY-LEVEL DATA]

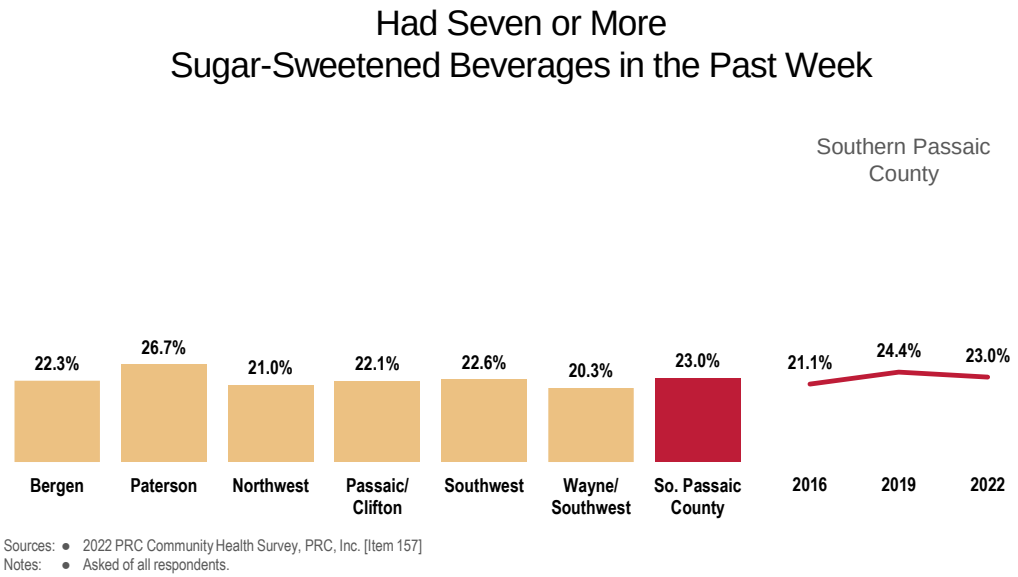
Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



Sources: ● US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.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.

Sugar-Sweetened Beverages

"During the past seven days, how many servings of sugar-sweetened beverages did you have? Please include beverages such as soda, Kool-Aid, sweetened fruit juice, sports drinks, energy drinks, or sweet tea. Do not include 'diet' drinks."



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 157]
Notes: ● Asked of all respondents.

Physical Activity

ABOUT PHYSICAL ACTIVITY

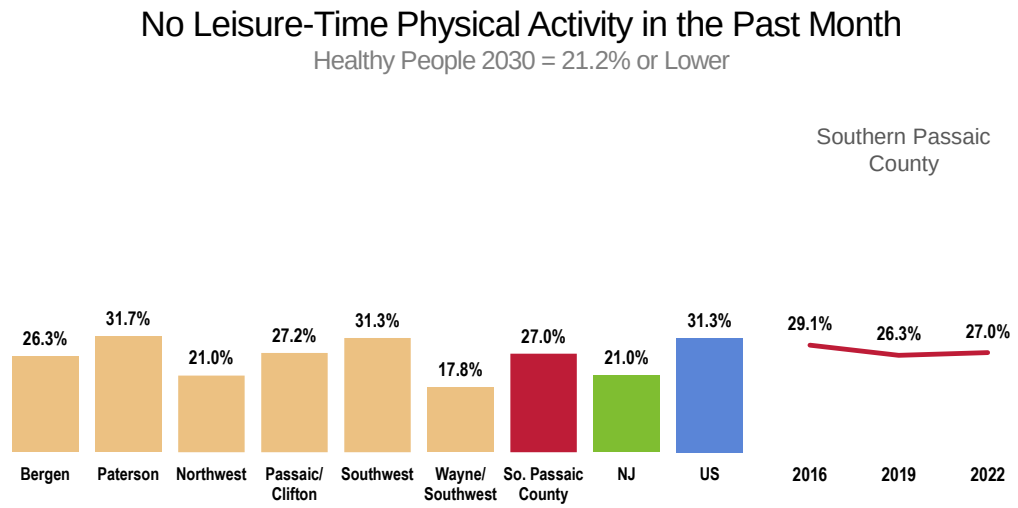
Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

"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?"



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: 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

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:

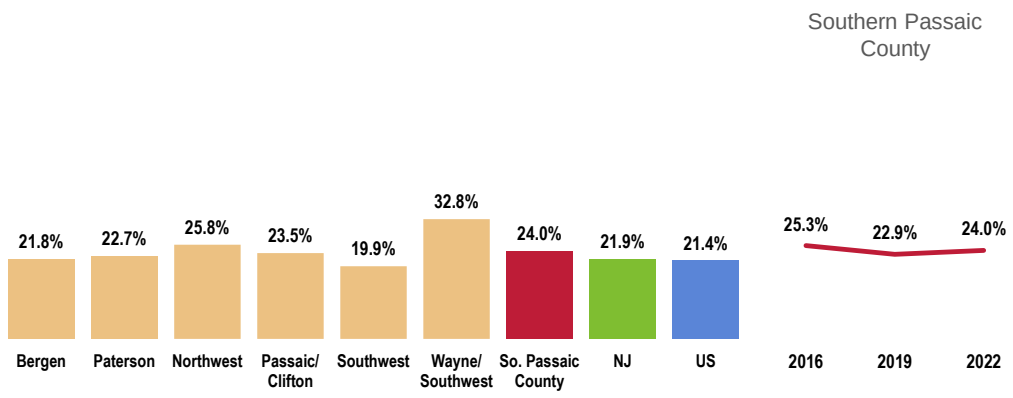
"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those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

Healthy People 2030 = 28.4% or Higher



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 126]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- 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.

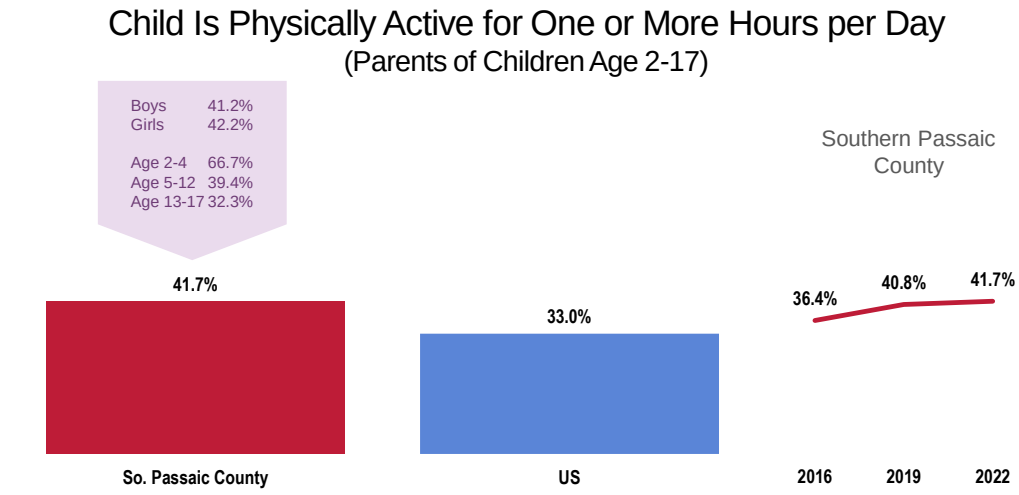
Children's Physical Activity

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

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

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



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 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

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

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 (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, 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/m^2.

– 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

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

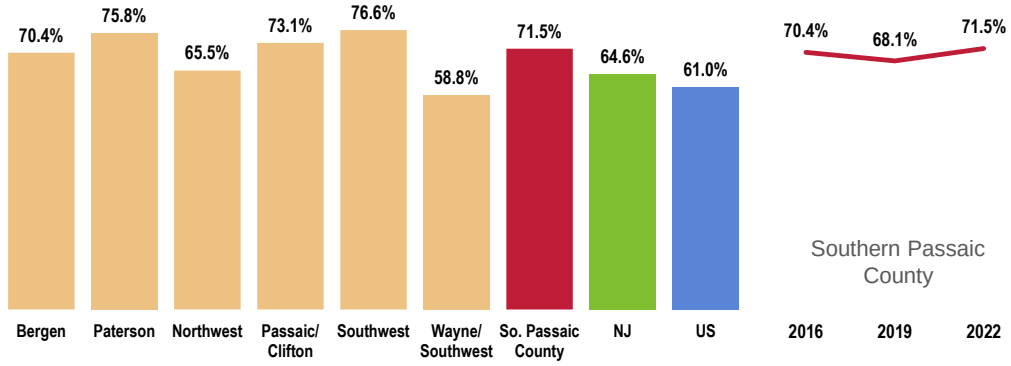
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

“About how much do you weigh without shoes?”

“About how tall are you without shoes?”

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)

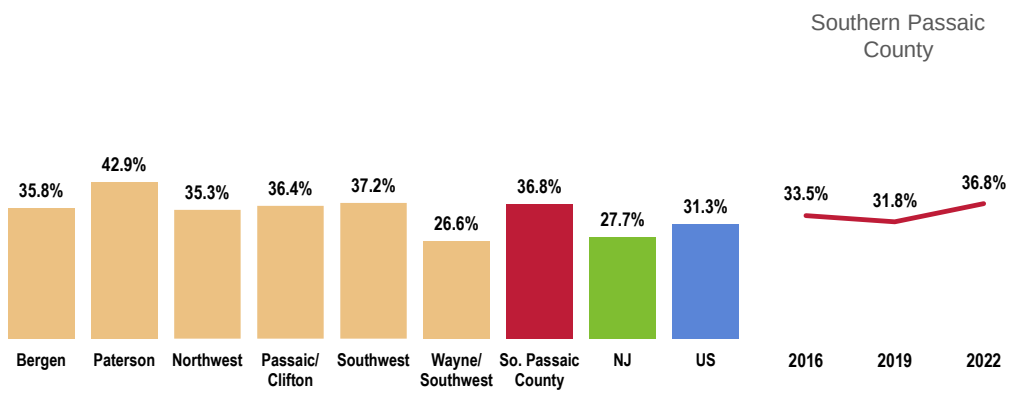


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, 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

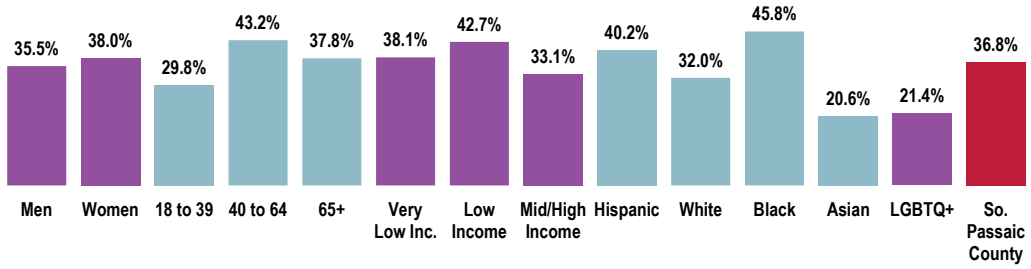
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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, 2022)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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.

Children's Weight Status

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

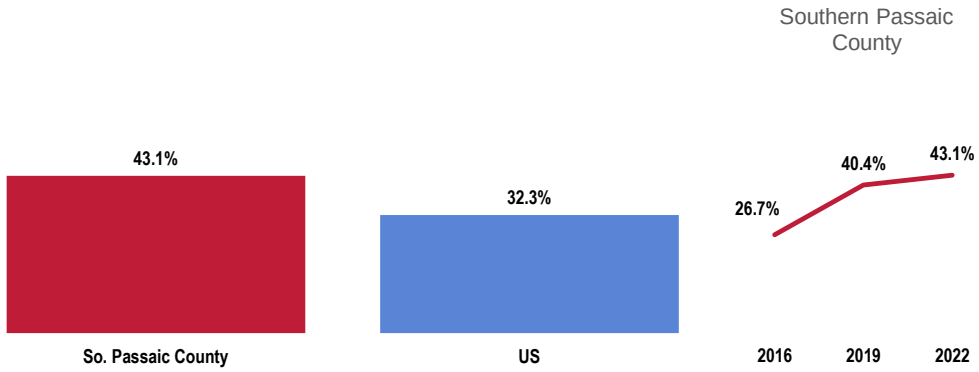
– Centers for Disease Control and Prevention

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)

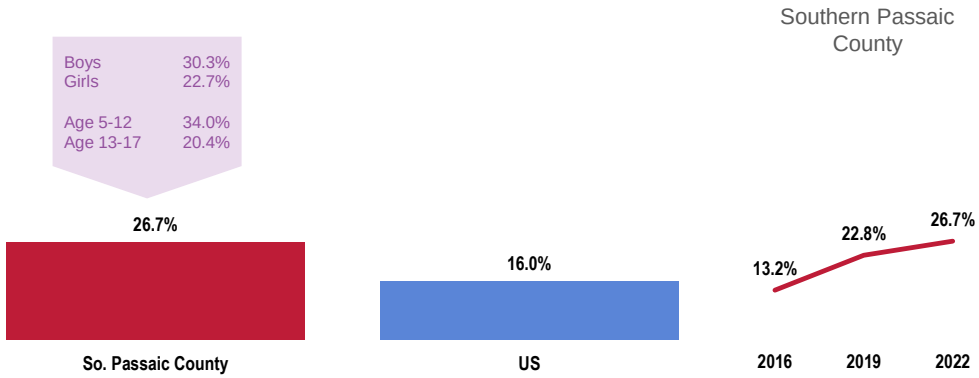


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.

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.

Prevalence of Obesity in Children
(Children Age 5-17 Who Are Obese; BMI in the 95th Percentile or Higher)

Healthy People 2030 = 15.5% or Lower

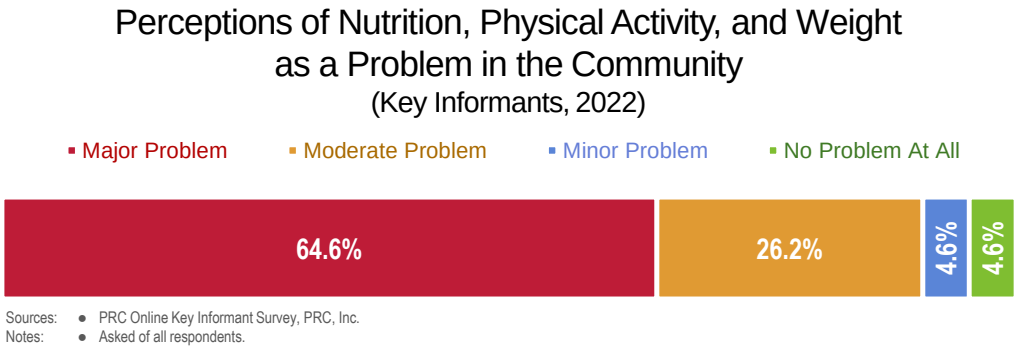


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th 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:



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

Access to Affordable Healthy Food

> Access to fresh and healthy food is challenging. – Other Health Provider
>
> Lack of healthy choices in the poorest communities, over-priced food, parks are unsafe, or not at walking distance. Not too many choices for the most vulnerable population. – Other Health Provider
>
> Eating nutritiously is expensive. The amount of time people sit on their phones/computers, sit during work, and/or sit during their commutes is excessive. Even if we offer free exercise programs people are either unable or unwilling to join. Unhealthy, sugary, high-fat foods are easily accessible and cheaper. – Public Health Representative
>
> Poor options for healthy food. Unsafe areas for physical activity. – Social Services Provider
>
> The cost of healthy food, fast food is less expensive, and that becomes the go to for residents in the community, higher calorie content, less nutrition. Children are not going outside to play, due to violence in the streets in some areas. Electronic games. – Community Leader
>
> Lack of access to healthy food. Lack of supermarkets in Paterson. Proliferation of bodegas. Lack of open space for recreation and exercise. – Social Services Provider
>
> Financial resources to purchase nutritious foods. – Other Health Provider
>
> Cost of healthy food and space for exercising. – Physician
>
> Lack of access to healthy, affordable food. Lack of access to venues to pursue physical activity, such as gyms, walking, running and bike paths. Safe streets. – Community/Business Leader
>
> Access to quality food and knowledge of how to prepare it. Lack of access or interest in public athletic programs leads to sedentary lifestyles. – Community Leader

Nutrition

> The biggest challenges related to nutrition, physical activity and weight in our community are food deserts (there are many fast-food restaurants and unhealthy food places in our community), there is a lack of advertising motivation for people to eat healthier in our community, healthier spots in our community are expensive. – Community Leader
>
> Poor diet, lack of motivation, poor upbringing. – Physician
>
> Food insecurity, physical inactivity, poor nutrition, lack of access to quality primary care, lack of green spaces and parks, community safety. – Physician
>
> People eat and drink too many sugary foods. They should also engage in more physical activity. – Other Health Provider
>
> Poor diet, food insufficiency. – Other Health Provider
>
> Poor diet, activity, and weight lead to poor health outcomes. – Physician
>
> Multitudes of individuals eating at fast food facilities that offer unhealthy, fried, high caloric foods, and/or foods with high sugar contents. Healthy food nutrition education is needed. – Social Services Provider

Awareness/Education

> Education, lack of safe, accessible, clean places to get exercise. – Community/Business Leader

> Lack of education and resources. – Community Leader
>
> Education and understanding of nutrition. Also, cost of healthy food. – Physician

Built Environment

> Poor planning, lack of pedestrian–friendly spaces, lack of places that encourage walking and biking. – Social Services Provider
>
> Unsafe neighborhoods, lack of access to quality food markets. – Social Services Provider
>
> Lack of safe green space for people to exercise. – Other Health Provider

Access to Care/Services

> Lack of resources, poor eating habits and lack of activity. – Community Leader
>
> No access to community resources. – Social Services Provider

Insufficient Physical Activity

> Lack of exercise, poor nutrition and raising rates of obesity, especially among children and adolescents. – Community Leader
>
> Students are less active and lack proper nutrition. Lack of vitamins. – Social Services Provider

Income/Poverty

> Poverty is the source of much of this. Paterson has food resources, but also many neighborhoods are food deserts, and have little or no healthy food available. Stores with healthy choices are lacking, and prices for healthy foods are expensive form many families. Recreation is also lacking – it may not be available, affordable or near enough to be useful. Many people work multiple jobs, and do not have time to do what is needed to provide families with healthy foods and opportunities for recreation. – Community Leader

Lifestyle

> Lack of time due to hourly wages and responsibilities– prioritizing the need to work extra hours or have multiple jobs to meet financial responsibilities as well as take care of family. In addition, there is significant and justifiable concern over safety in the community to walk. Joining a gym etc. is costly. – Community/Business Leader

Substance Abuse

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

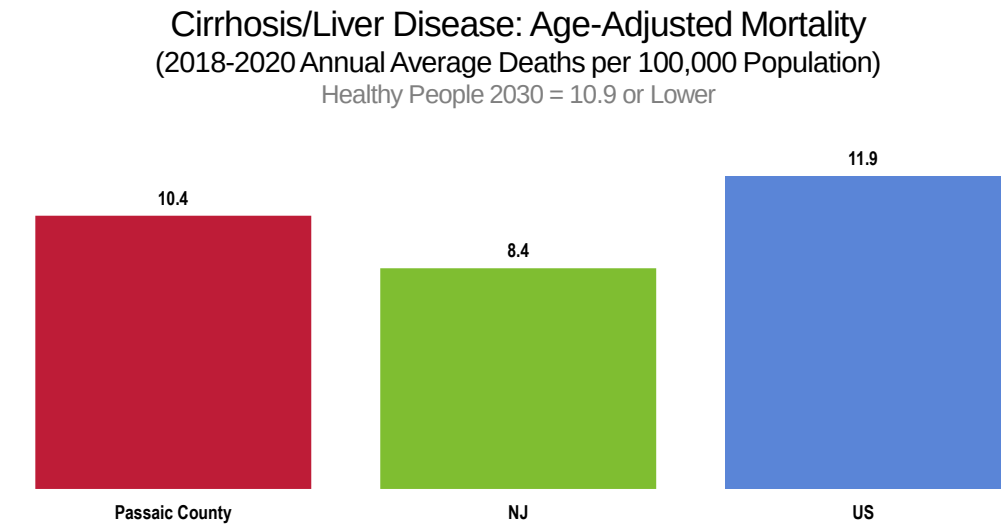
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

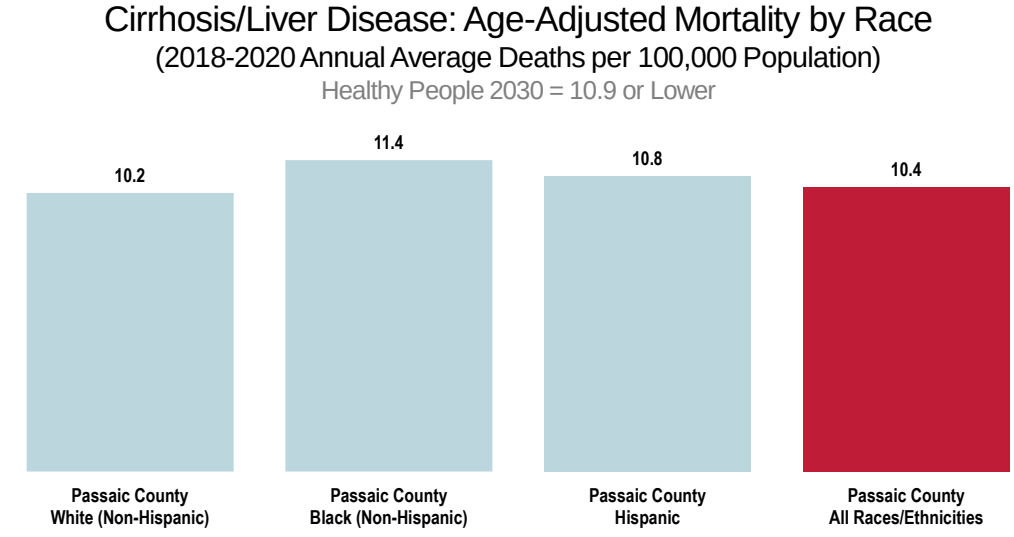
Alcohol

Age-Adjusted Cirrhosis/Liver Disease Deaths

Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following charts outline age-adjusted mortality for cirrhosis/liver disease in the area. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

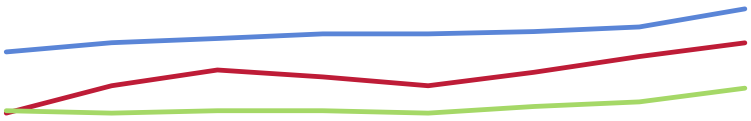


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	7.3	8.5	9.2	8.9	8.5	9.1	9.8	10.4
NJ	7.4	7.3	7.4	7.4	7.3	7.6	7.8	8.4
US	10.0	10.4	10.6	10.8	10.8	10.9	11.1	11.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Excessive Drinking

"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?"

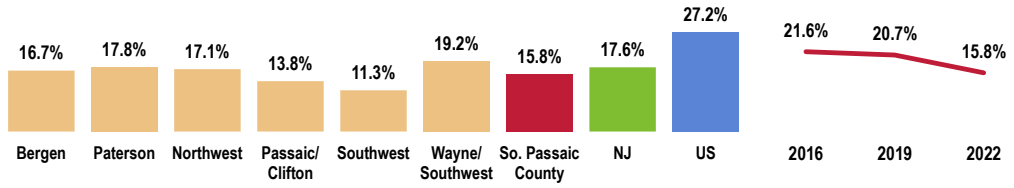
"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Excessive Drinkers

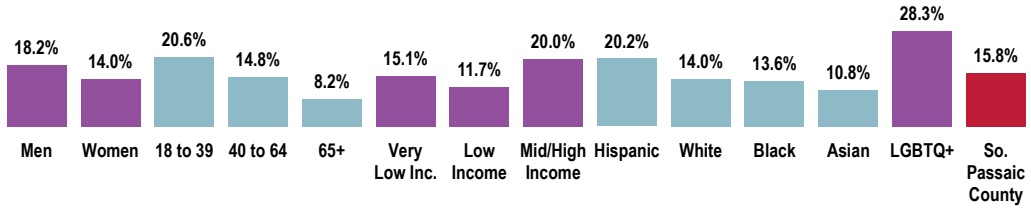
Southern Passaic County



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 136]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- 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.

Excessive Drinkers
(Southern Passaic County, 2022)



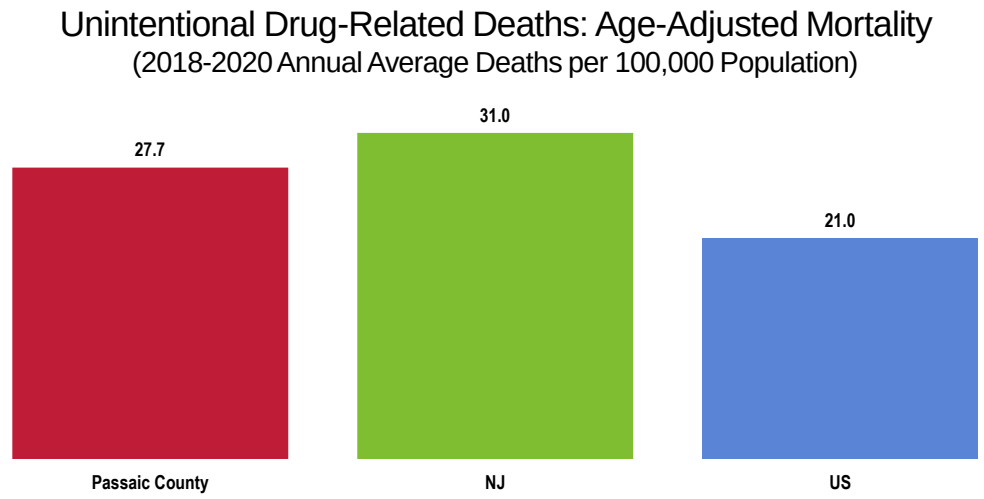
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 136]

Notes:
- Asked of all respondents.
- 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.

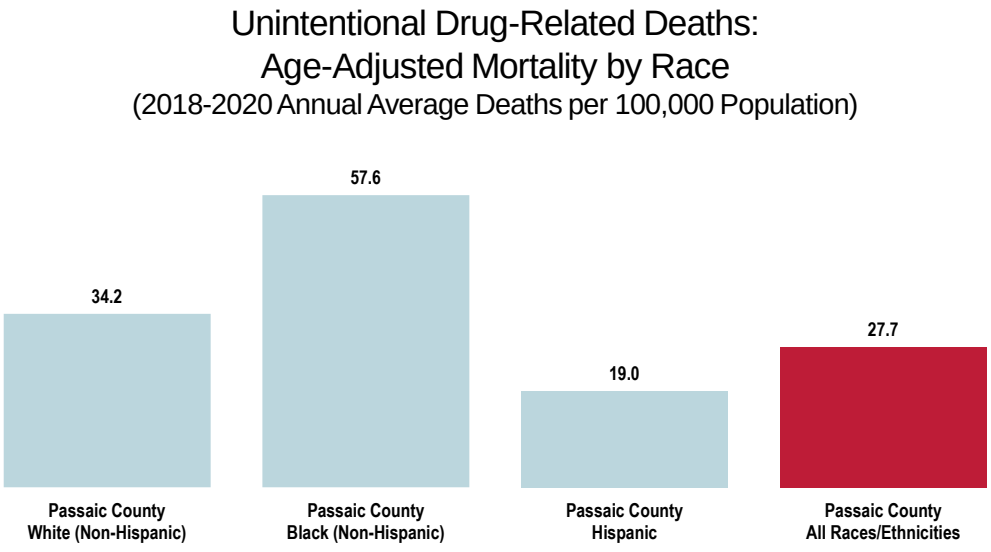
Drugs

Age-Adjusted 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 charts outline local age-adjusted mortality for unintentional drug-related deaths. [COUNTY-LEVEL DATA]



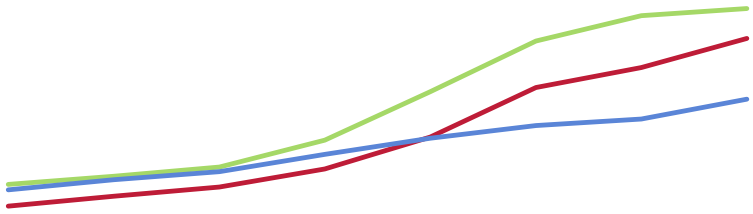
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

Unintentional Drug-Related Deaths: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Passaic County	9.2	10.3	11.3	13.3	16.8	22.3	24.5	27.7
NJ	11.6	12.5	13.5	16.5	21.8	27.4	30.2	31.0
US	11.0	12.1	13.0	14.9	16.7	18.1	18.8	21.0

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

Illicit Drug Use

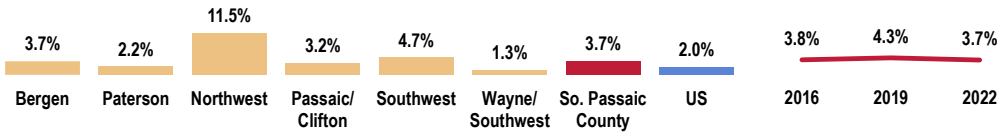
Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

"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 2030 = 12.0% or Lower

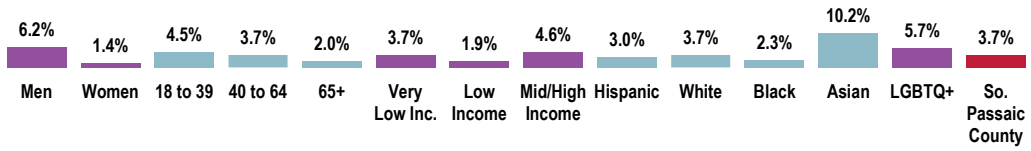
Southern Passaic County



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 49]
● 2020 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes: ● Asked of all respondents.

Illicit Drug Use in the Past Month
(Southern Passaic County, 2022)
Healthy People 2030 = 12.0% or Lower

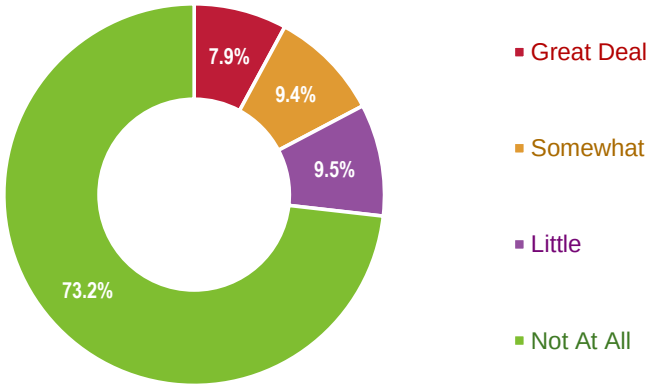


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 49]
● US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: ● Asked of all respondents.

Personal Impact From Substance Abuse

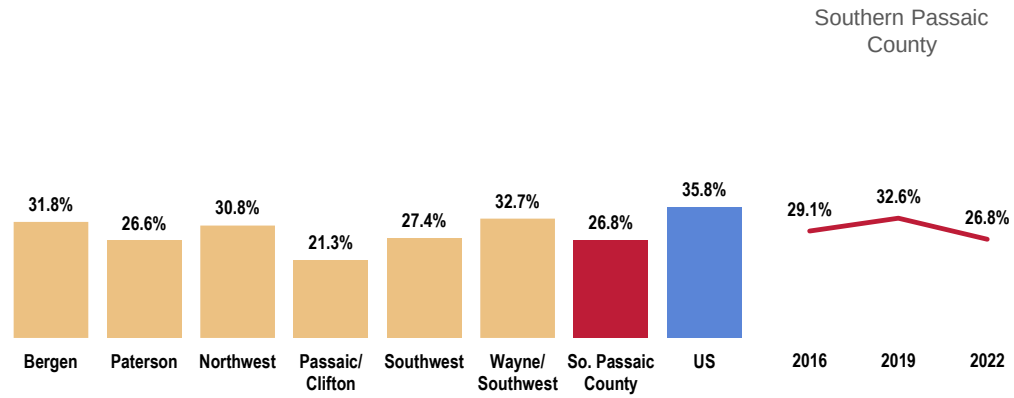
"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)
(Southern Passaic County, 2022)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: ● Asked of all respondents.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 52]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

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, 2022)

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

> Outpatient clinic and counselling services. – Physician
>
> Not enough programs. Most drug addicts that come to the area are not from the area. This has increased homelessness. – Other Health Provider
>
> The number of out of towners who fill the slots. – Community/Business Leader
>
> Availability of providers with SA credentials, access to harm reduction interventions. – Other Health Provider
>
> Availability and access to treatment centers, open beds, etc. – Public Health Representative
>
> Lack of alternatives to break the cycle. – Physician
>
> Beds and slots being utilized by residents from outside the community, as there is a lack of treatment centers in the suburbs and other counties. Therefore, not having the space for those from the local communities. – Community Leader
>
> There are not enough treatment programs or slots for the number of people who need treatment. In addition, the availability of drugs and alcohol in Paterson makes it easy for those suffering from substance abuse to get drugs and alcohol. – Social Services Provider
>
> Not enough beds for detox, treatment, or housing. – Other Health Provider

> Lack of availability, lack of motivation. – Physician
>
> Where do they go to get help? Is there long-term living-in facilities? Do they treat the substance-abuse and mental health issues? Seems there is fear about getting help, why? Cost ability to navigate systems: transportation, live-in facilities, fear? – Social Services Provider

Denial/Stigma

> In some cases, families feel there is no problem, or they are in denial. – Community/Business Leader
>
> Desire and stigma. – Social Services Provider
>
> The stigma of substance abuse, and the paucity of available resources are the primary barriers to successful intervention in substance abuse. That is of course, accepting that the recurrent nature of this problem makes treatment more of a likelihood than cure – Physician

Desire to Get Help

> People need to be ready for treatment, however many struggling with substance abuse have been through the cycle time and time again. They've often been through the system, and failed, and it just heaps failure on top of failure for people that are already struggling. As a result, they are often reticent to get themselves into just another program offering the same "surface level" solutions without truly helping to get to the bottom of their problems. – Community Leader
>
> Some of the greatest barriers related to accessing needed substance abuse treatment in our community would be lack of motivation of the individual to seek help. – Community Leader

Income/Poverty

> Substance abuse is complicated. It can begin in many ways, many related to poverty. The opioid epidemic added a layer of difficulty, as did the ease of accessing drugs. Once addicted, the brain is rewired to further the need for drugs, and the resulting pleasure/relief the drugs provide. Changing peoples need for drugs is difficult and requires constant and considerable support. – Community Leader

Access for Medicare/Medicaid Patients

> Lack of detox and treatment facilities for Medicaid and underinsured. – Other Health Provider

Awareness/Education

> Lack of awareness of services, cultural barriers, stigma associated with services, availability of substance abuse and prevention programs, transportation, and service may not meet the individual need. – Physician

Due to COVID–19

> Substance abuse agencies census are still affected by COVID guidelines with quarantine and isolation, as clients are not required to be vaccinated. – Social Services Provider

Easy Access to Drugs

> The availability of illegal drugs. – Community Leader

Incidence/Prevalence

> Significant increase in overdoses in the Emergency Room and in the community. – Other Health Provider

Insurance Issues

> Health insurance. – Public Health Representative

Teen/Young Adult Usage

> Large drug use in students. – Social Services Provider

Most Problematic Substances

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

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a “Major Problem”)	
HEROIN OR OTHER OPIOIDS	46.2%
ALCOHOL	42.3%
COCAINE OR CRACK	7.7%
MARIJUANA	3.8%

Tobacco Use

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

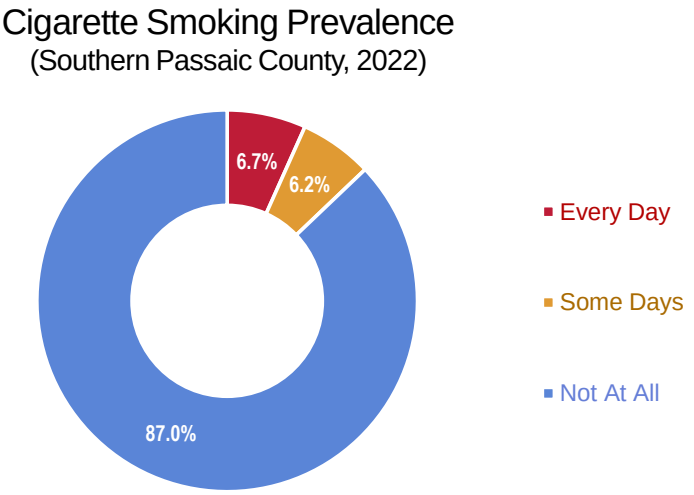
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it’s more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

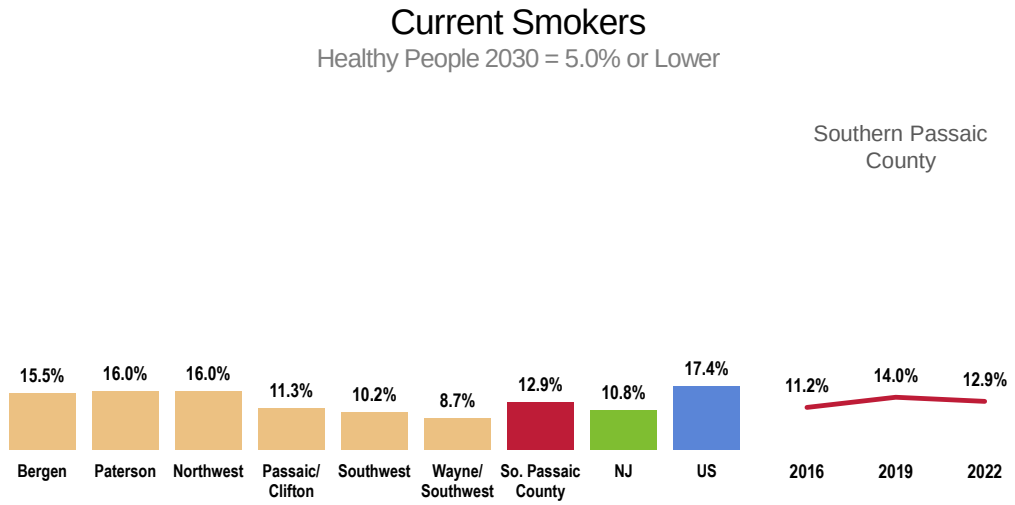
– Healthy People 2030 (https://health.gov/healthypeople)

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: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: ● Asked of all respondents.



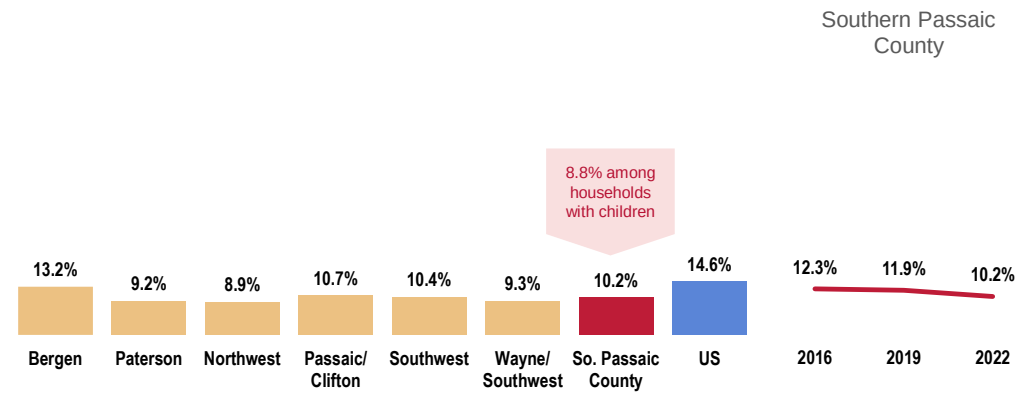
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
● 2020 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov
Notes: ● Asked of all respondents.
● Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Environmental 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:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
- 2020 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

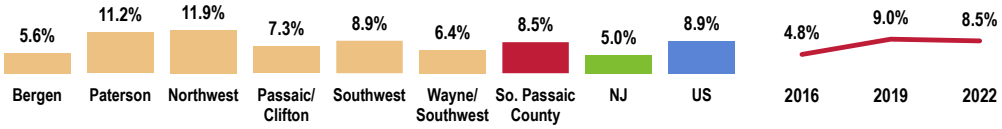
"The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces 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)

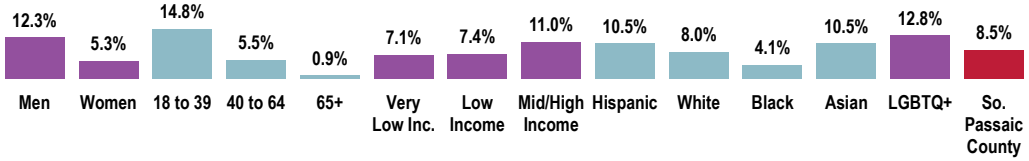
Southern Passaic County



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 135]
- 2020 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): 2020 New Jersey data.

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

Currently Use Vaping Products
(Southern Passaic County, 2022)

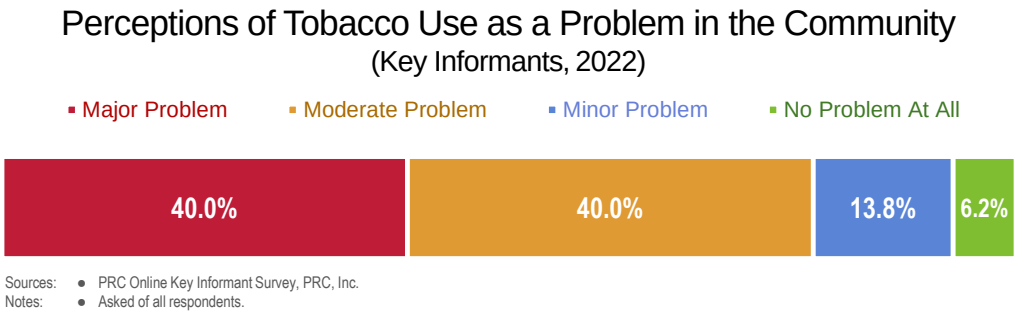


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 135]

Notes:
- Asked of all respondents.
- 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:



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

Impact on Quality of Life

> The incidence of heart and respiratory illness linked to tobacco use. – Social Services Provider
>
> Tobacco is a major problem in our community because it is one of the main causes of leading health problems in the United States. It is also affecting the health and well–being of individuals around them and affecting the environment. – Community Leader
>
> This seems like an obvious question...the Surgeon General has been saying for decades that tobacco use is detrimental to our health. It's a proven fact. You can see it with all the smoke shops seemingly on every corner. It's hard to walk down the street without smelling a puff of smoke somewhere along the way. – Community Leader
>
> Because it results in cancer. – Community Leader

E–Cigarettes

> Vapes are excessive in the schools. – Social Services Provider
>
> Vaping/tobacco use is preventable cause of death and chronic disease. Smoking is a major cause of cardiovascular disease, stroke, and type 2 diabetes. Also, 80 to 90 % of lung cancer deaths are due to smoking. Lung cancer is the leading cause of death due to cancer in NJ. – Physician

Incidence/Prevalence

> Significant tobacco uses and high heart disease. – Other Health Provider
>
> Every corner has people smoking. – Physician

Easy Access

> Number-one cause of cancer in underserved community, because of availability. – Physician

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

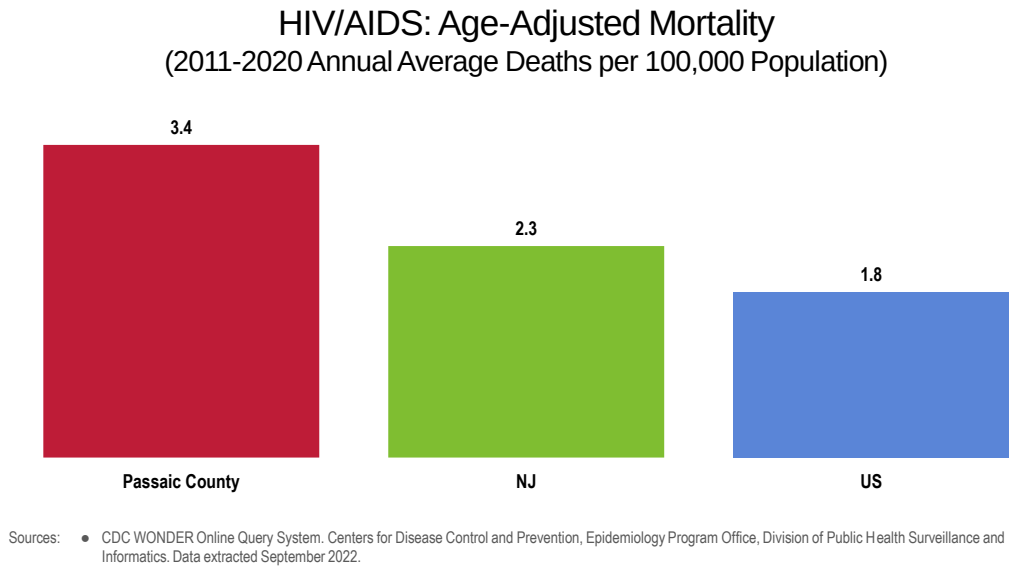
Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

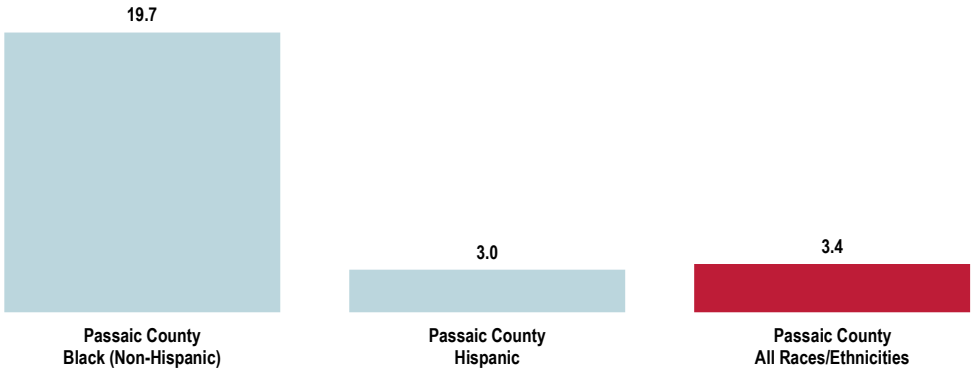
Age-Adjusted HIV/AIDS Deaths

The following charts outline annual average age-adjusted HIV/AIDS mortality rates per 100,000 population in the area. [COUNTY-LEVEL DATA]



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

HIV/AIDS: Age-Adjusted Mortality by Race
(2011-2020 Annual Average Deaths per 100,000 Population)

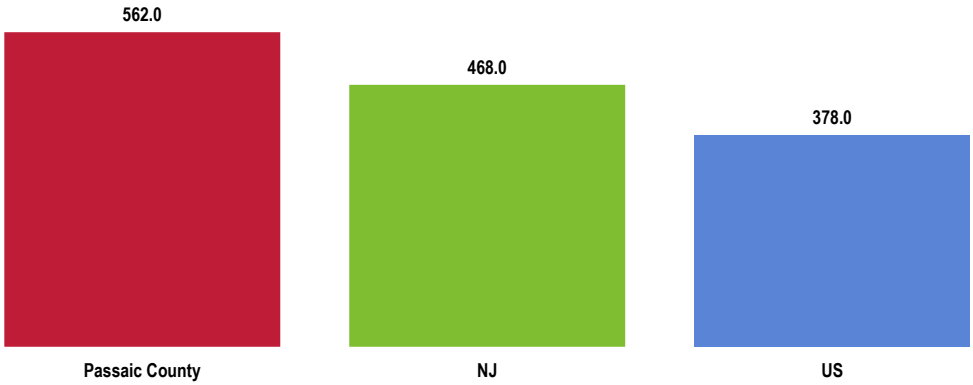


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2022.

HIV Prevalence

The following charts outline prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area. [COUNTY-LEVEL DATA]

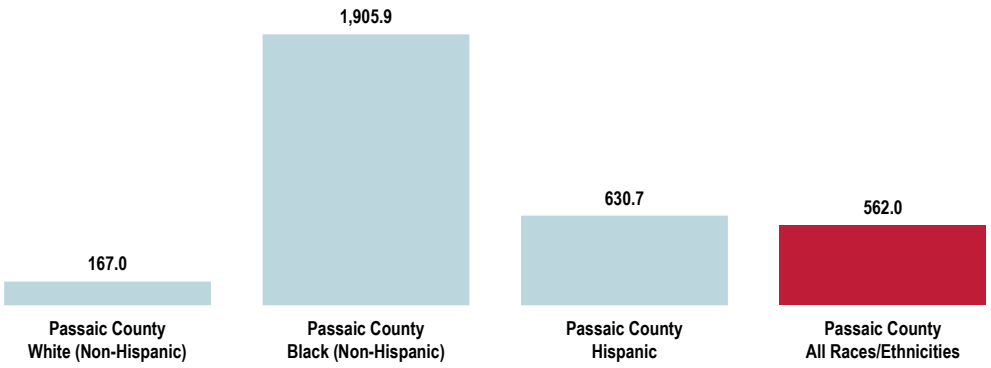
HIV Prevalence
(Prevalence Rate of HIV per 100,000 Population, 2019)



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.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.

HIV Prevalence by Race/Ethnicity
(Rate per 100,000 Population, 2019)



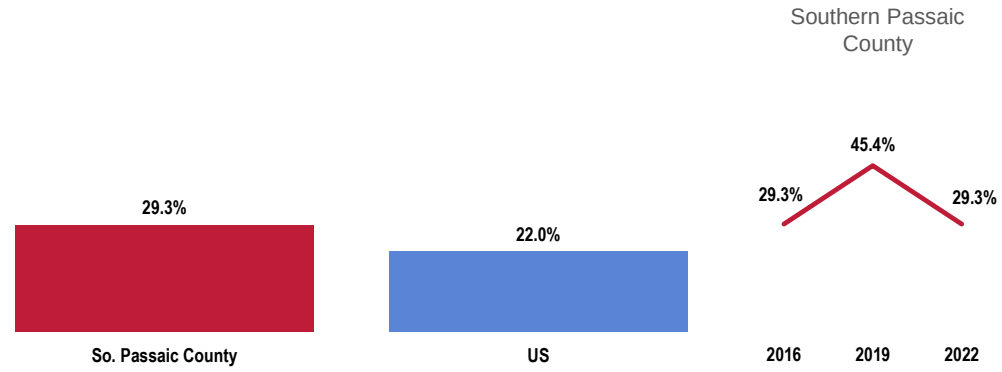
Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).

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.

HIV Testing

[Age 18-44] **"Not counting tests you may have had when donating or giving blood, when was the last time you were tested for HIV?"**

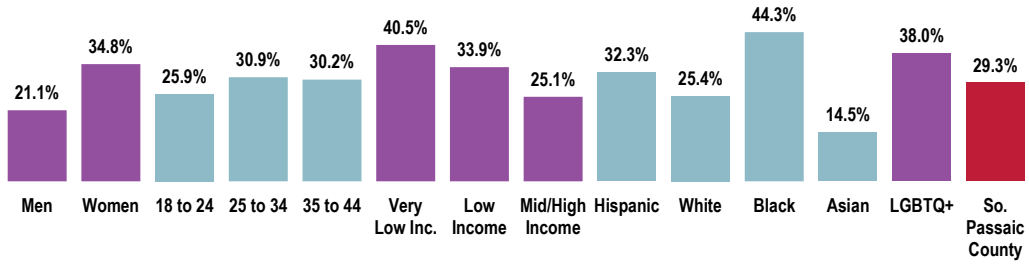
Tested for HIV in the Past Year
(Adults Age 18-44)



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 158]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents age 18 to 44.

Tested for HIV in the Past Year
(Age 18-44; Southern Passaic County, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 158]
Notes: • Asked of all respondents age 18 to 44

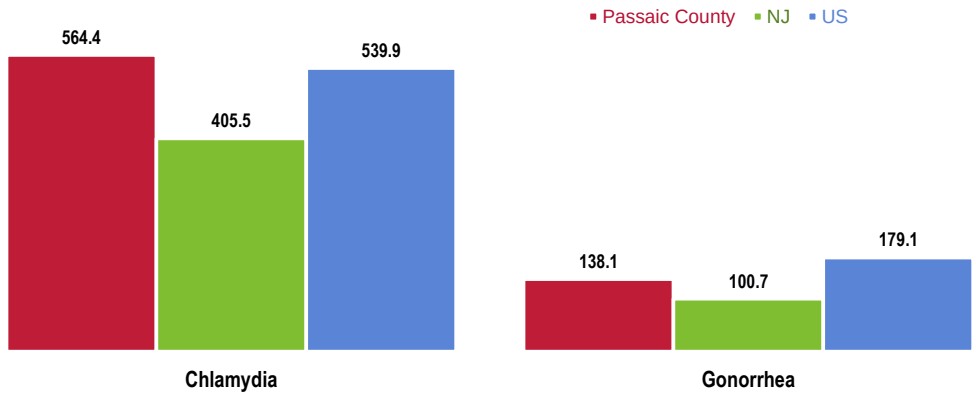
Sexually Transmitted Infections (STIs)

CHLAMYDIA ► Chlamydia is the most commonly reported STI 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 STIs. [COUNTY-LEVEL DATA]

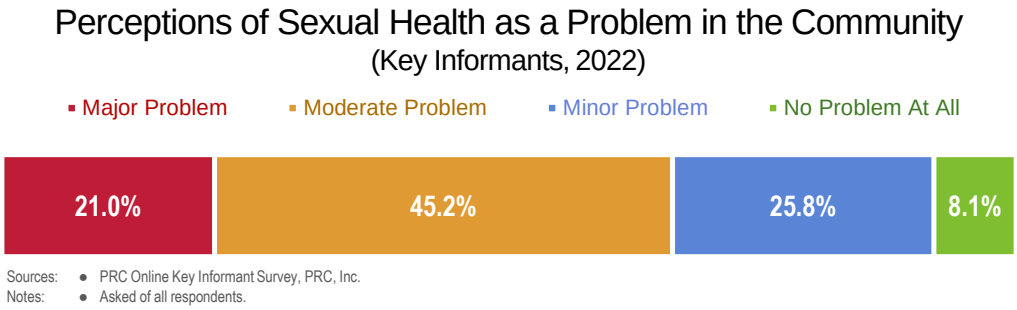
Chlamydia & Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2018)



Sources: • Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.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: Sexual Health

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



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

Awareness/Education

> Sexual health is a major problem in our community because there are many teens and younger individuals who don't have the proper sexual education. There are many cases of young teen pregnancies and diseases caused by unsafe sex so there ate higher rates of STIs and HIVs. – Community Leader

Incidence/Prevalence

> STIs, such as chlamydia, gonorrhea and syphilis, continue to be rising, as well as newly diagnosed HIV patients. Need for more free, confidential testing and education in the community. – Physician

Lifestyle

> Promiscuity and lack of self-value. – Physician

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

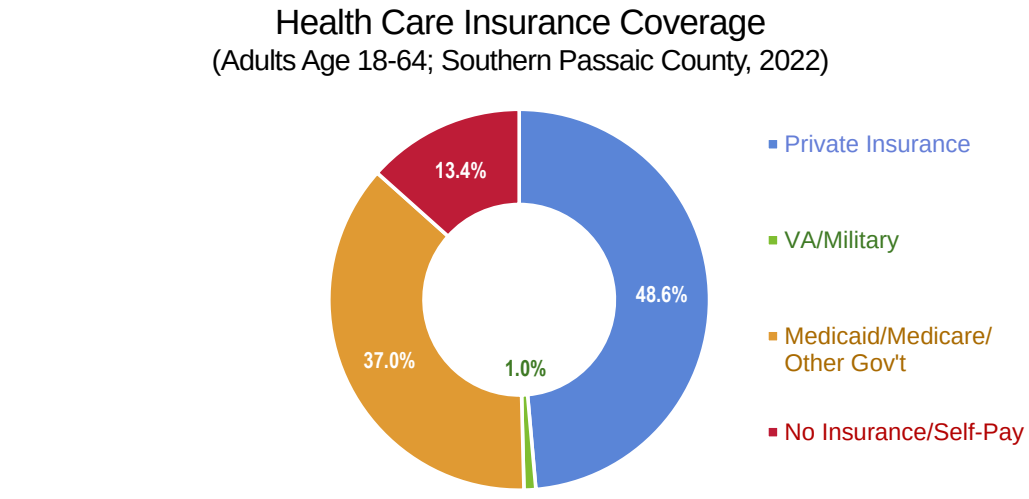
Lack of Health Insurance Coverage

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?"

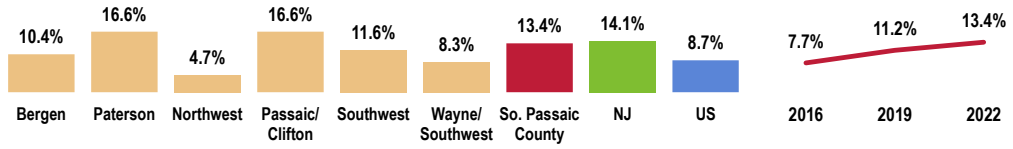
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
Notes: ● Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults Age 18-64)
Healthy People 2030 = 7.9% or Lower

Southern Passaic County



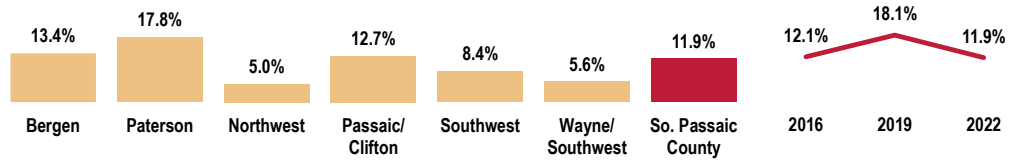
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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

[Adults Age 18-64 with private insurance or Medicaid] **"Did you sign up for this coverage under the Affordable Care Act, sometimes also referred to as Obamacare? You may have signed up through a health insurance exchange navigator, a state-sponsored health insurance exchange website, or the Healthcare.gov website."**

Insurance Was Secured
Under the Affordable Care Act / "Obamacare"
(Adults Age 18-64 With Private Insurance or Medicaid, By Type of Coverage)

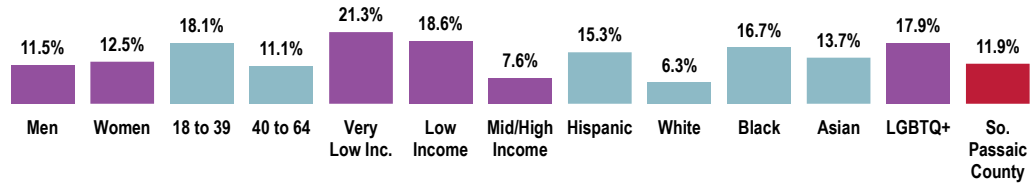
Southern Passaic County



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 303]

Notes:
- Asked of all respondents under 65 with private insurance or Medicaid.

Insurance Was Secured
Under the Affordable Care Act / "Obamacare"
(Adults Age 18-64 With Private Insurance or Medicaid; Southern Passaic County, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: • Asked of all respondents under 65 with private insurance or Medicaid.

Difficulties Accessing Health Care

Barriers to Health Care 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?"

"Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

"Was there a time in the past 12 months when you needed to see a doctor, but could not because of the cost?"

"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

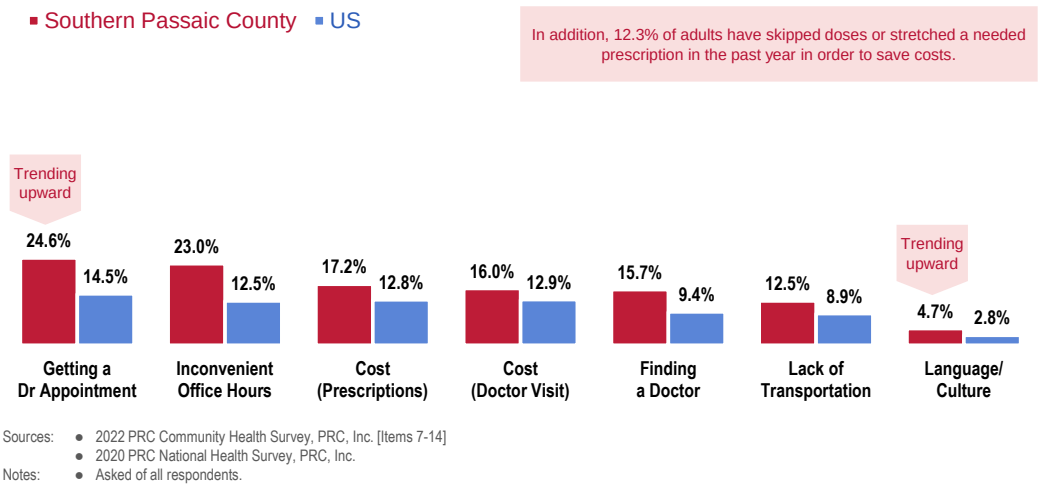
"Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

"Was there a time in the past 12 months when you needed a prescription medicine, but did not get it because you could not afford it?"

"Was there a time in the past 12 months when 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

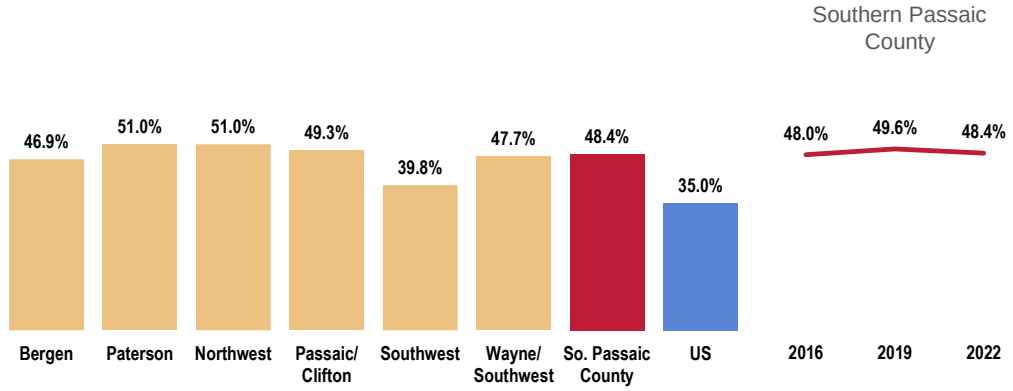


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 7-14]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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.

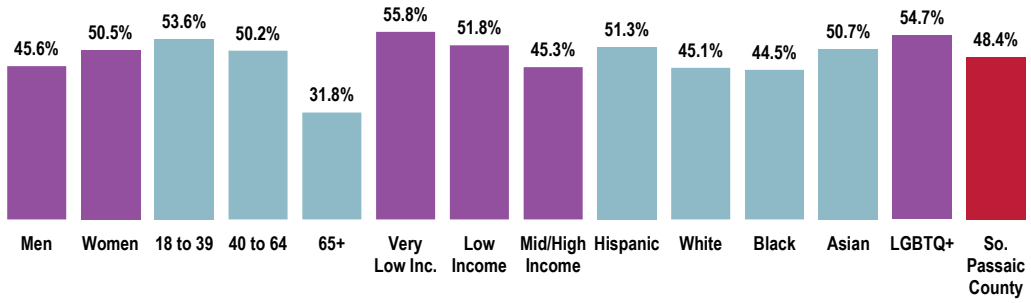
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Southern Passaic County, 2022)



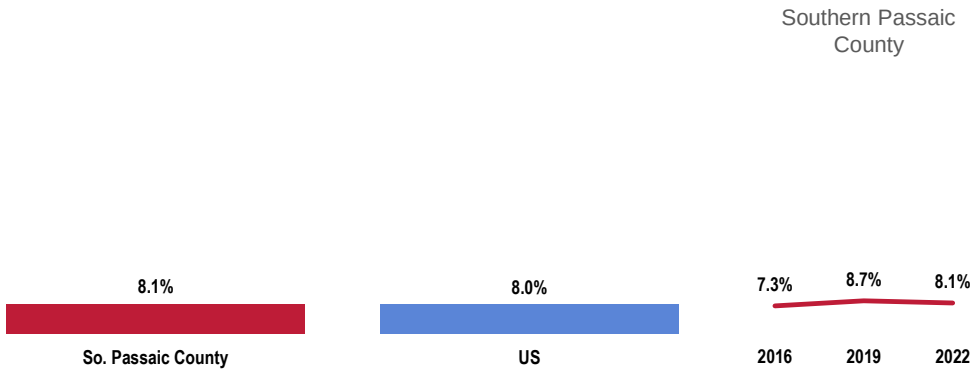
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
Notes: ● Asked of all respondents.
● Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Accessing Health Care 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?"

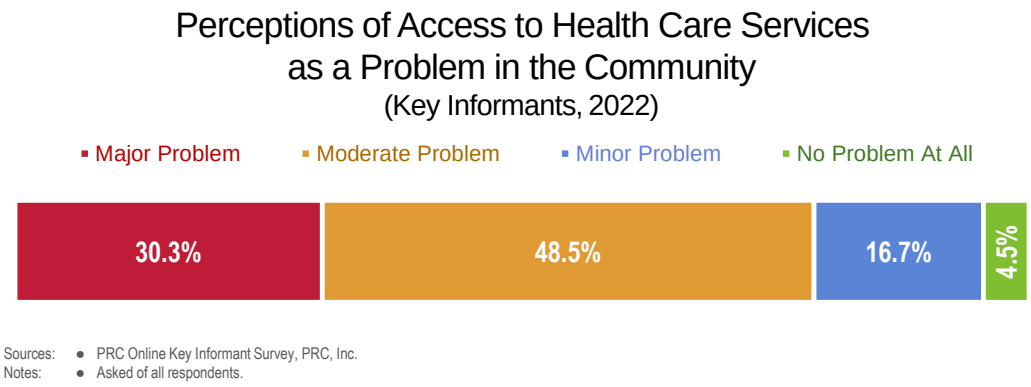
Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 104]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* 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:

Access to Care/Services

> Often the only services that people in need are able to access are sub–par services. They are not able to access the higher level of medical and health services that are available other places. This is a gross injustice. In addition, gaining access to doctors, nurses, and medical services that are willing to dive deep to the root of the issues rather than treating symptoms with pharmaceuticals is almost non–existent in our cities. – Community Leader
>
> Language barriers, government apathy, location sites for access and affordability. – Community Leader
>
> Preventative health care access is a big issue, education, and information before a major health problem or crisis arises is also an issue. Some of the other challenges are reliable, accessible and affordable transportation, and language barriers because many in my community speak a dialect of Bengali called Sylheti and there are often a lack of language accessibility when it comes to that. – Community/Business Leader
>
> General health and regular checkups. – Social Services Provider
>
> Many of our families do not have a medical home. They lack consistency with wellness checkups. This is an outcome of Health care and information. The services are not easily accessible and at times difficult for our families due to language barriers and costs. – Social Services Provider
>
> All the resources are located in one concentrated area, which can be a challenge to get to for people who live outside that area. – Social Services Provider
>
> Transportation, free clinics, lack of knowledge, language barrier. – Social Services Provider
>
> Transportation to quality health providers. Access to services for uninsured or underinsured persons. Limited providers that accept Medicaid, making for long wait lists for services, such as mental health. – Social Services Provider
>
> Ease of access in a timely manner. Barriers include patients being unaware of services, lack of insurance and transportation. – Physician
>
> Within the city of Paterson, the hospital is used as an 'urgicenter'. If families do not have primary care physicians, this is where they go for 'normal' health care. Additional medical facilities are needed throughout the community. – Community Leader
>
> Currently missing are the services that were provided by the Paterson Community Health Center on Broadway for pediatric healthcare services and referrals for new to the country students with no insurance and low–income families with low income insurances. – Other Health Provider
>
> Undocumented and uninsured have limited options for health care and thus do not pursue preventative care. – Community/Business Leader
>
> Uninsured and homeless individuals. There are limited resources for uninsured, but these are slowly increasing. It is still an issue though, particularly for the homeless population, as they often get disqualified from certain services that require proof of address. – Other Health Provider

Affordable Care/Services

> Some of the biggest challenges related to accessing health care services in our community would be poor financial status, many people in our community can't afford the expensive healthcare services so they avoid visiting their doctors for annual checkups and screenings and for emergencies. Another issue would be transportation barriers, limited education and/ or lack of awareness about healthcare services near them, language barriers. – Community Leader
>
> I hear people say they use the hospital's Emergency Room instead of seeing a doctor proactively. Health care costs are too high. – Community/Business Leader
>
> Access to affordable health care. – Social Services Provider

Income/Poverty

> Poverty and transportation. – Community/Business Leader

Insurance Issues

> Lack of insurance coverage, lack of knowledge of what a disease is, lack of knowledge that there is a treatment for the above. – Physician

Lack of Primary Care Providers

> The paucity of primary care options as well as the virtual absence of specialty care practices in urban locations easily accessed on public transportation make it difficult to obtain consistent, continuous healthcare. Added to that is the need for capacity to address the wide range of payment options/requirements as well as to overcome some of the language barriers. – Physician

Lack of Trust

> Mistrust from people of color with the medical system. – Other Health Provider

Primary Care Services

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

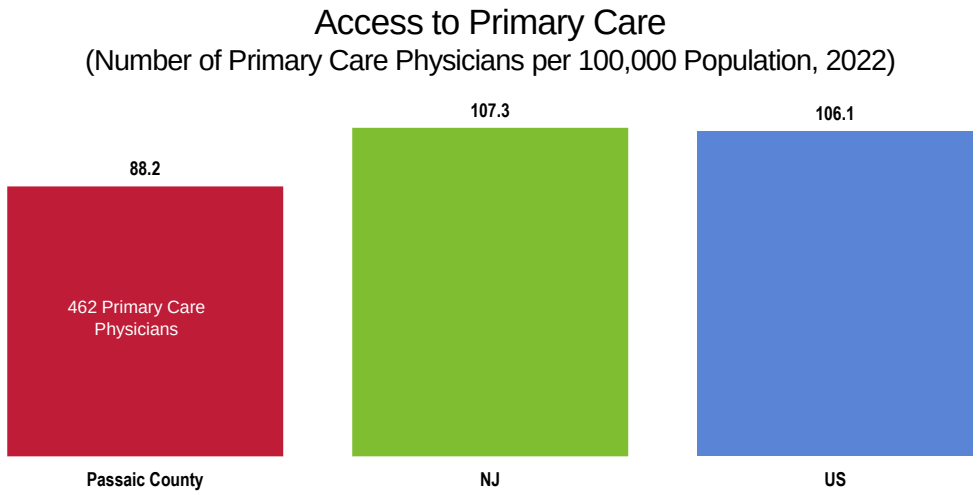
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.



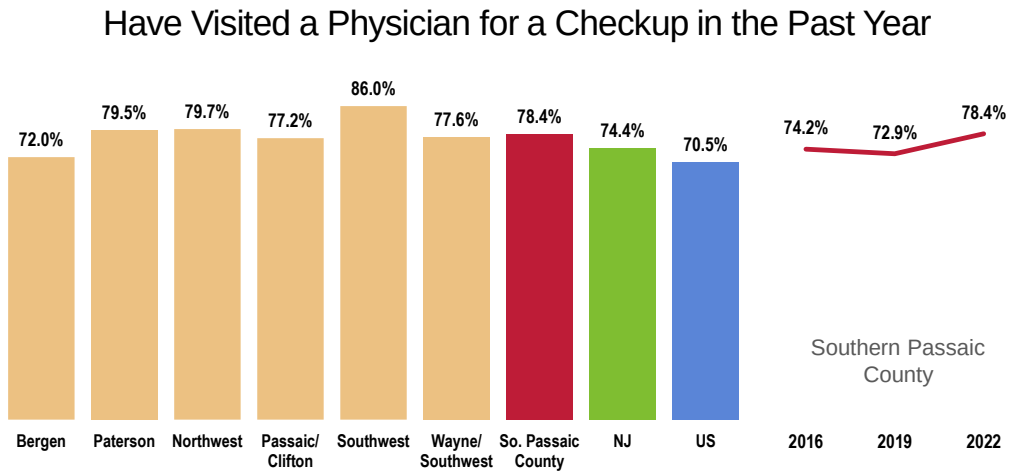
Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2022 via SparkMap (sparkmap.org).

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

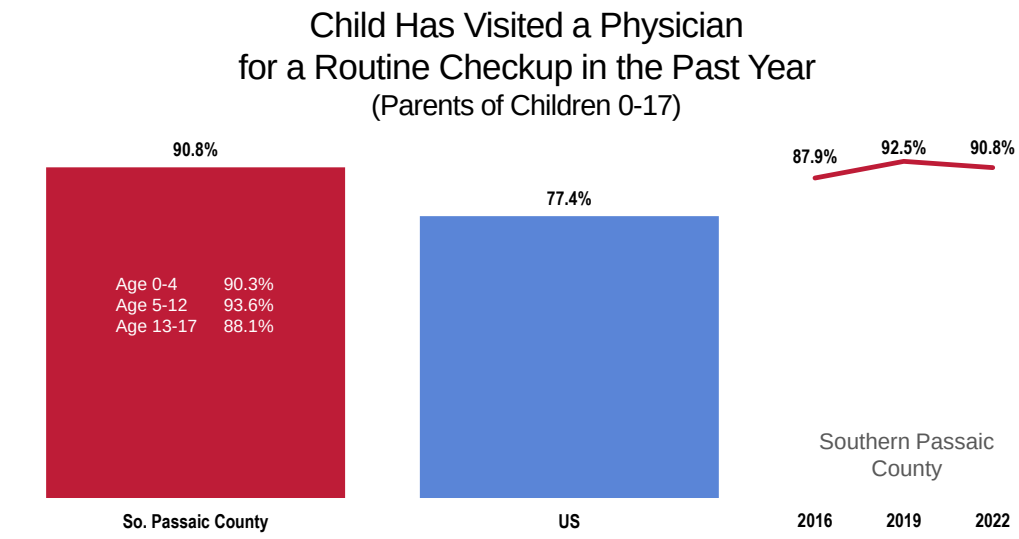
ADULTS ► **"A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"**

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?"**



Sources:
- 2022 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): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 105]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

Oral Health

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Care

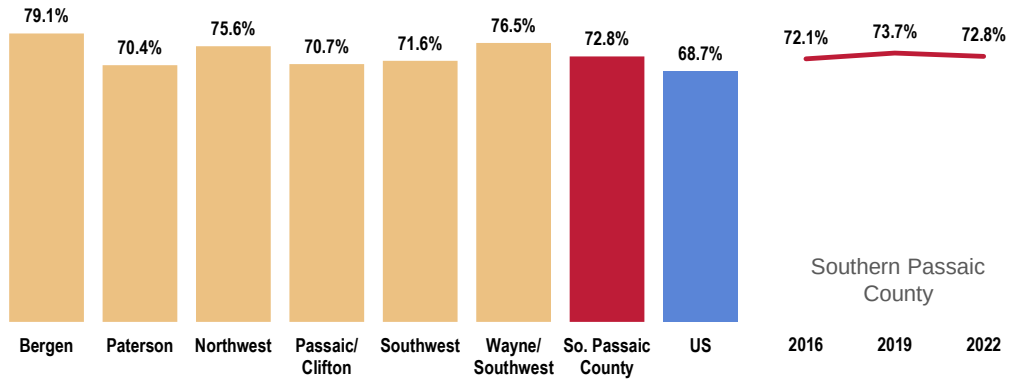
ADULTS ► **"About how long has it been since you last visited a dentist or a dental clinic for any reason?"**

"Do you currently have any health insurance coverage that pays for at least part of your dental care?"

CHILDREN AGE 2-17 ► **"About how long has it been since this child visited a dentist or dental clinic?"**

Have Insurance Coverage That Pays All or Part of Dental Care Costs

Healthy People 2030 = 59.8% or Higher

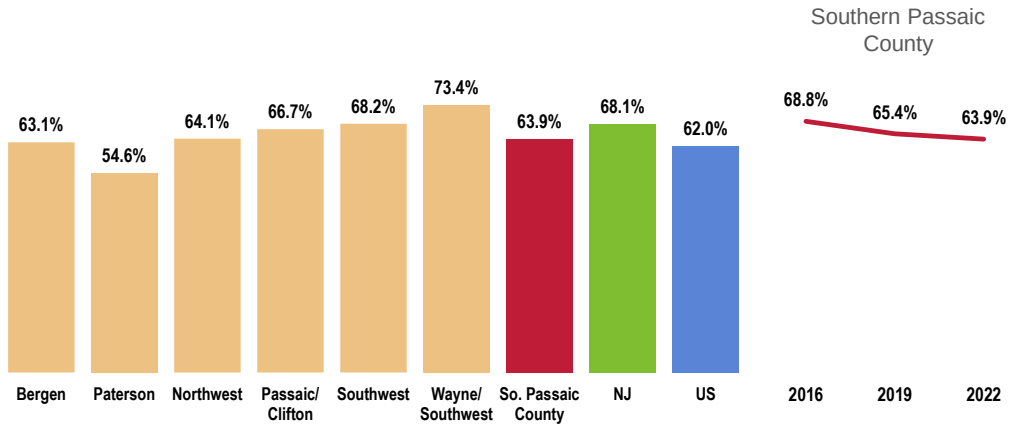


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 21]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



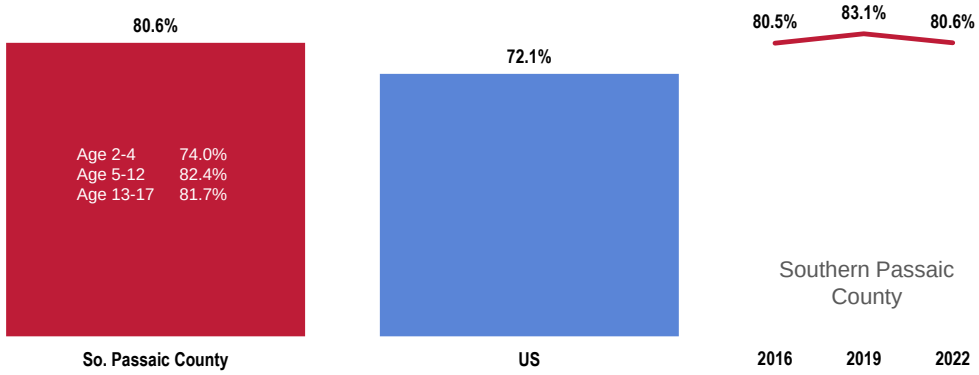
Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2020 New Jersey data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

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 2030 = 45.0% or Higher



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 108]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

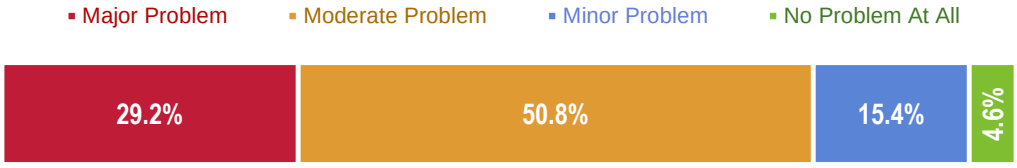
Notes:
- Asked of all respondents with children age 2 through 17.

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, 2022)



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

> Many people have inadequate dental coverage or no dental coverage. Major services such as extractions, crowns, dentures, implants, orthodontics are not adequately covered. – Other Health Provider
>
> Lack of services. – Community Leader
>
> Lack of dental health coverage, eating too many sweets. – Community/Business Leader
>
> The cost if you do not have insurance. Even if you have insurance, the cost can be prohibitive. The access to dentists and emergency dental. – Community Leader

Affordable Care/Services

> Dental care is expensive and dental insurance is expensive and usually provides limited coverage. – Public Health Representative
>
> Cost. – Social Services Provider
>
> Not affordable. – Social Services Provider

Diagnosis/Treatment

> When school students are referred to school nurses, often times there is severe decay. – Social Services Provider

Lack of Providers

> Not enough providers and the population is not knowledgeable about how and when to access available services. – Social Services Provider

Prevention/Screenings

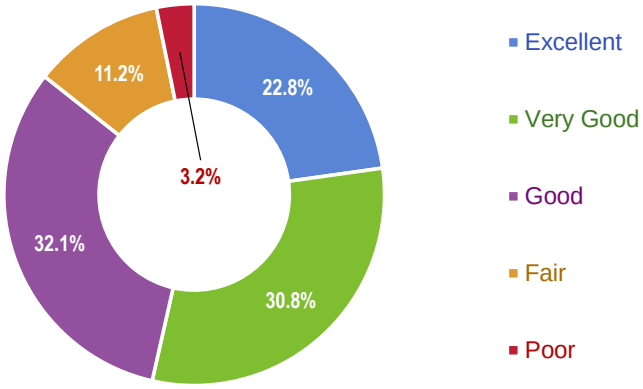
> Lack of preventive care. No dental insurance. – Social Services Provider

LOCAL RESOURCES

Perceptions of Local Health Care Services

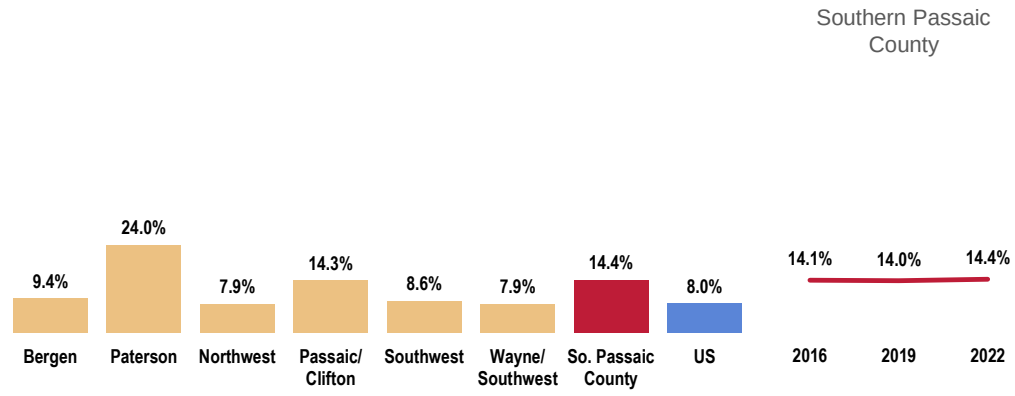
"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"

Rating of Overall Health Care Services Available in the Community
(Southern Passaic County, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: • Asked of all respondents.

Perceive Local Health Care Services as "Fair/Poor"



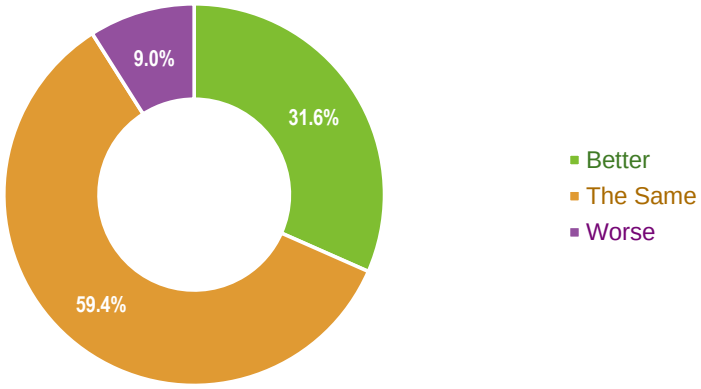
Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 6]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Perceptions of Teaching Hospitals

In a teaching hospital, medical students are trained to be future doctors, and research/ clinical trials are conducted.

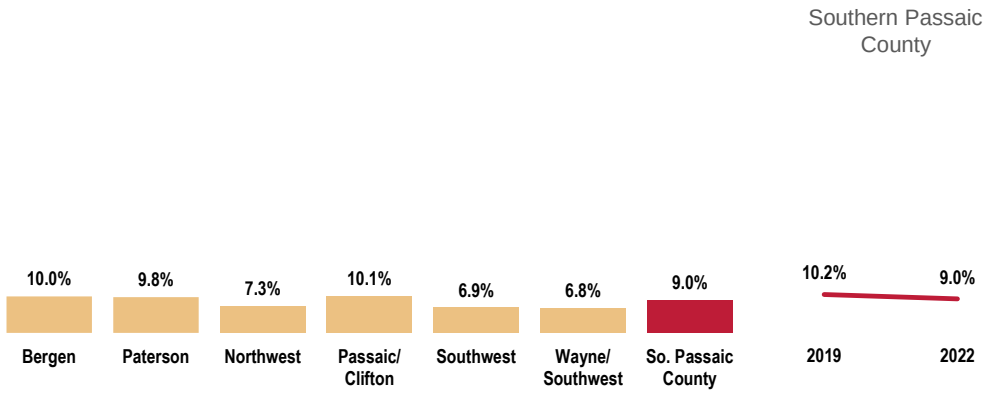
"In general, do you feel the medical care you would receive at a teaching or university hospital would be better, the same, or worse than at a non-teaching hospital?"

Expectations of Medical Care Received at Teaching Hospitals vs. Non-Teaching Hospital
(Southern Passaic County, 2022)



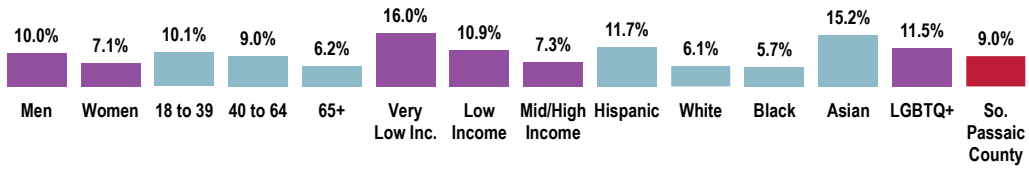
Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: ● Asked of all respondents.

Expect Medical Care at Teaching Hospitals to be "Worse" Than at Non-Teaching Hospitals



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: ● Asked of all respondents.

Expect Medical Care at Teaching Hospitals to be "Worse" Than at Non-Teaching Hospitals
(Southern Passaic County, 2022)



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
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 to Health Care Services

- 4 C's
- Barnet Hospital Center
- Celebrating Seniors
- Clifton Family Medicine
- Collaborative Support Programs of New Jersey Peer Respite
- Community Development Corporation
- Community Education
- Community Fairs
- Depaul Pediatrics
- Doctor's Offices
- Drug Rehabilitation and Detox Sites
- Eva's Village
- Faith-Based Organizations
- Family Health Center
- Father English Food Bank
- Federally Qualified Health Centers
- Go Go Grandparent
- Health Centers
- Health Coalition of Passaic County
- Holistic Care
- M&S Counseling
- Medicare/Medicaid Vans
- Mental Health Association of New Jersey
- Mental Health Center of Passaic
- Mutual Aid Events
- Naturopathy
- New Bridge Services
- NJ Community Development Corporation-Paterson
- North Hudson Community Action
- North Hudson Community Health Center
- Nutrition Services
- Oasis
- Passaic County Social Services
- Passaic Mental Health Clinic
- Paterson Board of Health
- Paterson Community Health Center
- Paterson Department of Health
- Performance Care
- Programs for Teaching English
- School System
- SERV's Community Behavioral Health Clinic
- SMILE for Charity
- St. Joseph's Community Outreach Efforts
- St. Joseph's DePaul Clinics
- St. Joseph's Health
- St. Joseph's Hospital
- St. Joseph's Medical Center
- St. Mary's Hospital
- Support Groups
- Uber Health
- Urgi Center
- Walgreens
- Women, Infants & Children

Cancer

- American Cancer Society
- Health Coalition of Passaic County
- Horizon NJ Health
- Mayor of Passaic
- Rainbows of Hope
- Shop Rite
- St. Joseph's Health
- St. Joseph's Hospital

Coronavirus Disease/COVID-19

- American Red Cross
- Center of United Methodist Aid to the Community
- Churches
- City of Paterson
- Clifton Health Department
- Community Education
- Community Health Centers
- County of Passaic
- CVS
- Doctor's Offices
- Eva's Village
- Faith-Based Organizations
- Federal HHS and CDC
- Free Covid Test Kits
- Health Coalition of Passaic County

- Health Department
- Hospitals
- Local Agencies
- Mask Mandates in Businesses
- Medicaid
- Mobile Vaccine Unit
- New Destiny Family Success Center
- New Jersey Department of Health
- NJ Community Development Corporation-Paterson
- Oasis
- Outreach Groups
- PACC
- Passaic County Health
- Paterson Board of Health
- Paterson Counseling Center
- Paterson Department of Health
- Paterson Fire/EMS
- Pharmacies
- Riverside Medical Group
- School System
- Sheefa Pharmacy
- Social Services
- St. Joseph's Health
- St. Joseph's Hospital
- St. Joseph's Medical Center
- Vaccination Sites
- Walgreens

Dementia/Alzheimer's Disease

- Alzheimer's Association
- Department of Senior Services
- More Than Friends
- Preakness Health System
- Senior Services Department
- St. Mary's Hospital

Diabetes

- American Diabetes Association
- City Green
- Center of United Methodist Aid to the Community
- Clifton Family Medicine
- Community Education
- Community Health Centers
- Diabetes Education
- Doctor's Offices
- Endocrinology at Willowbrook and Totowa
- Eva's Village
- Family Health Center
- Federally Qualified Health Center
- Fitness Centers/Gyms
- Food Assistance
- Food Pantry
- Health Coalition of Passaic County
- Health Department
- High Risk Obstetric Clinic
- Horizon NJ Health
- Hospitals
- Local Agencies
- More Than Friends
- North Hudson Community Health Center
- Oasis
- Outreach Groups
- Parks and Recreation
- Paterson Community Health Center
- Paterson Health
- Pharmacies
- School System
- Shop Rite
- St. Joseph's DePaul Clinics
- St. Joseph's Health
- St. Joseph's Hospital
- St. Joseph's Medical Center

Disability & Chronic Pain

- Doctor's Offices
- Hospitals
- St. Joseph's Health

Heart Disease & Stroke

- American Heart Association
- Clifton Family Medicine
- Community Education
- Doctor's Offices
- Family Health Center
- Health Coalition of Passaic County
- Health Department
- Hospitals
- St. Joseph's Health
- St. Joseph's Hospital
- St. Joseph's Medical Center
- Young Men’s Christian Association

Infant Health & Family Planning

- Center for Maternal Health
- Clifton Health Department
- Community Health Centers
- Eva's Village
- Hospitals
- Lighthouse Pregnancy Resource Center
- Maternal Health Care

- Mi Casa Tu Puebla
- New Destiny Family Success Center
- Oasis
- Partnership for Maternal and Child Health
- Passaic Municipal Alliance
- Passaic Pediatrics
- Paterson Board of Health
- Paterson Community Health Center
- Paterson Human Services
- Planned Parenthood
- School System
- St. Joseph's Community Health Center
- St. Joseph's Health
- St. Joseph's Hospital
- St. Joseph's Medical Center
- Women, Infants, & Children
- Women's Shelters

Injury & Violence

- Adult Mentors
- Anti-Violence Community Events
- Boy Scouts/Girl Scouts
- Care Management Organization
- Cease Fire
- Churches
- Eva's Village
- Grandmothers Helping Grandchildren
- Law Enforcement
- Local Agencies
- Men Stand UP
- Mother's Demanding Action
- New Destiny Family Success Center
- New Jersey Community Development Corporation
- NJ Community Development Commission
- Oasis
- Parks and Recreation
- Paterson Education Fund
- Paterson Healing Collective
- Paterson Police Department
- Police Department
- Prisoner Re-Entry Program
- Resources/Activities for Youth and Young Adults
- School System
- Sisters Helping Sisters
- St. Joseph's Health
- St. Joseph's Medical Center
- Street Keepers
- Support Groups
- Young Men’s Christian Association

Kidney Disease

- Davita Dialysis
- Doctor's Offices
- National Kidney Foundation
- New Jersey Department of Health
- St. Joseph's Health
- St. Joseph's Hospital

Mental Health

- Boonton Hospital
- Catholic Charities
- Center for Family Services
- Chosen Generation
- Circle of Care
- Community Health Centers
- Counseling Centers
- Doctor's Offices
- Eva's Village
- Guide to Mental Health Services in Passaic County
- Habor House
- Hospitals
- Local Agencies
- M&S Counseling
- Mental Health Association in Passaic County
- Mental Health Association of New Jersey
- Mental Health Centers
- Mental Health Services
- National Alliance for the Mentally Ill
- New Bridge Services
- Outreach Groups
- Passaic Mental Health Clinic
- Paterson Healing Collective
- Performance Care
- Performed Care
- School System
- Self Help Centers
- Shelters
- Small Groups
- Social Services
- St. Joseph's Clinic
- St. Joseph's Crisis Intervention Center
- St. Joseph's Health
- St. Joseph's Health Community Mental Health Center
- St. Joseph's Hospital
- St. Joseph's Medical Center
- St. Mary's Mental Health Clinic
- St. Paul's CDC

Nutrition, Physical Activity & Weight

- 4 C's
- Boys and Girls Club
- City Green
- Community Education
- Community Health Centers
- Compassionate Use Medical Cannabis Act
- Depaul
- Doctor's Offices
- Food Pantry
- Hospitals
- Local Agencies
- Medicaid
- Oasis
- Parks and Recreation
- Passaic County Food Policy Council
- School System
- Senior Nutrition Programs
- St. Joseph's Health
- St. Joseph's Hospital
- Supplemental Nutrition Assistance Program
- United Way
- Weight Watchers
- Women, Infants, & Children
- Young Men’s Christian Association

Oral Health

- Dental Offices
- Health Department
- Paterson Board of Health
- Paterson Community Health Center
- School System

Respiratory Disease

- Fitness Centers/Gyms
- Health Coalition of Passaic County/HCPC
- St. Joseph's Health

Sexual Health

- AIDS Prevention and Intervention Program
- Community Health Centers
- Faith-Based Organizations
- Local Agencies
- New Jersey Department of Health
- North Hudson Community Health Center
- Planned Parenthood

Substance Abuse

- AA/NA
- CarePlus
- Catholic Charities
- Chosen Generation
- Churches
- Community Health Centers
- Counseling Centers
- Crossroads
- Eva's Village
- Father English Community Center
- Hospitals
- Local Agencies
- MAT Programs
- Paterson Coalition Against Substance Abuse
- Rehabilitation Programs
- Salvation Army
- School System
- St. Joseph's Health
- St. Paul's
- Straight and Narrow
- Turning Point

Tobacco Use

- American Lung Association
- Community Health Centers
- Doctor's Offices
- Hospitals
- New Jersey Department of Health
- Quit Hotline
- Small Groups
- St. Joseph's Health

APPENDIX

EVALUATION OF PAST ACTIVITIES: ST. JOSEPH'S HEALTH

Community Benefit

Over the past three years, St. Joseph's Health has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Over $459,867,149 in community benefit, excluding uncompensated Medicare.
- More than $833,656,220 in charity care and other financial assistance programs.

Our work also reflects a focus on community health improvement, as described below.

Addressing Significant Health Needs

St, Joseph's Health conducted its last CHNA in 2019 and reviewed the health priorities identified through that assessment. Taking into account, the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that St. Joseph's Health would focus on developing and/or supporting strategies and initiatives to improve:

- Nutrition, Physical Activity and Weight
- Heart Disease and Stroke
- Diabetes

Strategies for addressing these needs were outlined in St. Joseph's Health's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by St. Joseph's Health to address these significant health needs in our community.

Evaluation of Impact

Priority Area: Heart Disease and Stroke	
Community Health Need	**Improve Health Status Through Chronic Disease and Care Management Across the Continuum for Heart Disease and Stroke**
Goal(s)	***Prioritized Goal: Heart Disease*** • Focus educational outreach in the community based on requests related to heart disease prevention and risk factors through partnership with the American Heart Association and other community organizations • Increase awareness of life-saving programs in the community through Hands On Only CPR and AED trainings • Expand Cardiac and Pulmonary Rehab at both hospital campuses • Focus educational outreach in the community based on requests to offer heart health initiatives targeting women ***Prioritized Goal: Stroke*** • Focus educational outreach in the community based on requests related to stroke prevention and risk factors through partnership with the American Heart Association and other community organizations • Educate the medical community on stroke awareness through outreach to nursing homes and primary care physician offices in order to decrease the time from the onset of a stroke to medical treatment

Strategy: Build local capacity of community clinics to provide primary and preventive cardiovascular disease healthcare services.	
Strategy Was Implemented?	**YES**
Target Population(s)	Low-income residents in the several locations of southern Passaic County
Partnering Organization(s)	**Black Life Matter (BLM)-Diversity, Equality and Inclusion Committee, Straight & Narrow Family Success Center. St. Josephs residents/Fellows/Physicians**
Results/Impact	• Provided monthly health education and blood pressure/glucose screenings to approximately 25 participants. An average of 875 Blood pressure/glucose screenings. • Community Medicine-Ambulatory Medicine Program. Residents provided monthly virtual rotation sessions at Straight and Narrow Family Success Center. Thirty-five virtual sessions are provided to an average of 10-15 patients per session. In addition, the residents participate in virtual health fairs approximately 2 per year. • Cardiovascular Disease Fellowship Program Continuity Clinic Experience. Fellows rotate once a week for three years in 3 outpatient clinics. 156 rotations. A team of physicians and Fellows provides comprehensive and integrated patient-centered healthcare services. They see two new patients and four return patients under the supervision of a faculty physician assigned to the clinic. Patients are referrals and present multiple cardiovascular comorbidities and cardiac diseases. Services include routine pre-op evaluations, evaluations for revascularization procedures, discharged patients, medical records lab, radiology results, and referrals as needed. The integrated electronic medical records facilitate tracking, monitoring, and integrating health care, supporting quality and preventing redundancy of healthcare services.

Strategy: Expand cardiac and pulmonary rehabilitation services and providers to the community by adding additional services and access points to enable improved healthcare outcomes.	
Strategy Was Implemented?	**YES**
Target Population(s)	Adults and Seniors throughout the entire St. Joseph's Health service area.
Partnering Organization(s)	Internal: Community Outreach, Cardiac Rehabilitation, Pulmonary Rehabilitation, Respiratory Therapy External: American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), American Heart Association, American Stroke Association
Results/Impact	• Cardiac and pulmonary rehabilitation outpatient services at the Paterson University Medical Center and St. Joseph's Wayne Medical Center became nationally AACVPR Certified, Paterson 2020, and Wayne 2022. • Integrated Healthy heart prevention, promotion, and management events held in supermarkets, recreation centers, corporate, community fairs, and hospitals 141+ 203+ 200=544 events 2020-2022 • Health education, promotion, prevention, treatment, and management, including cardiopulmonary rehabilitation services, sleep studies, driver rehabilitation, healthcare providers and services, contact information based on blood pressure screenings, risk assessments, and identification of a need, 80% of all community events from 2020-2022-112818+178,658 2921, 243781=422439

Strategy: Launch a hospital-wide initiative on the importance of stroke awareness and preventive care by providing blood pressure screenings and stroke health education through various collaborative community initiatives.	
Strategy Was Implemented?	**YES**
Target Population(s)	Adults and Seniors throughout the St. Joseph's Health service area in Passaic County.
Partnering Organization(s)	I**nternal**: Community Outreach, Cardiac Rehabilitation, Pulmonary Rehabilitation, Respiratory Therapy, PT/OT Rehabilitation Services, Family Medicine, Nursing, Stroke Team, Sleep Studies, Driver Rehabilitation, Diabetes Program **External**: local, public, and private organizations, corporate, county, state, and national organizations. Women and Families Ascending Association (WAFAA), Boys and Girls Club, New Destiny Family Success Center, Senior Resource Group, YMCA of Paterson & Wayne, ShopRite of Wayne Hills, St. George's University, BP, BAE, Sax LLP, The Islamic Center of Passaic County, Calvary Baptist Church, Community Charter School of Paterson, New Jersey Jackals, Senior Resource Group, Wayne Parks and Recreation, Wayne Public Library, Hawthorne Library, Bloomingdale Senior Center, Immigration and American Citizenship Organization (IACO), Borough of Woodland Park, Borough of Totowa, Wayne Township, Borough of Prospect Park, Borough of Hawthorne, Borough of Pompton Lakes, City of Paterson, Clifton Passaic County Department of Health.
Results/Impact	• Provided blood pressure screenings to approximately 264,000 community participants in events hosted and attended by the St. Joseph's Health System. • Hosted 46 health fairs and events in collaboration with the YMCAs in Passaic County during monthly health initiatives from 2020-2022. • Participated in summer city/town days for approximately seven different municipalities in Passaic County, offering health resources and education regarding cardiovascular disease prevention. • Sponsored and participated at Township and county events to provide the community with resources, referrals, healthcare providers' contact information, latest evidence-based health education, promotion, treatment, and management in English and Spanish facilitating access to cardiovascular disease prevention, promotion, treatment, management, services, and screening tools, 2020-2022. 29 organizations • Expand blood pressure screening, health education, and outreach by hosting stroke awareness events in four St. Joseph's Health. **Individuals seen =** 422,439

Strategy: Produce, adapt and tailor educational services and resources based on evidence-based, language, culture, and level of education that stresses early identification of signs of a stroke, risks and susceptibilities, and steps that promote timely access to preventive and management of stroke.	
Strategy Was Implemented.	**YES**
Target Population(s)	
Partnering Organization(s)	**Internal**: Community Outreach Department, Stroke Team, multidisciplinary departments, dietician, behavioral services, endocrinology, primary care and cardiovascular services. St. Joseph's University Medical Center and Wayne Hospital Medical Center are External: American Heart Association, American Stroke Association
Results/Impact	• St. Joseph's University Medical Center and St. Joseph's Wayne Medical Center are primary and Comprehensive Stroke-Certified Centers. Recognized by the Get With The Guidelines-Heart Failure by the American Heart Association/American Stroke Association (AHA/ASA). Provided stroke awareness education, risk assessments, and recognition in 100% of community events promoting cardiovascular disease prevention from 2020-2022. • Participated in 40 cardiovascular disease prevention events consisting of blood pressure screenings and educational resources throughout American Heart and Stroke Association Month in February and Stroke Awareness Month in May from 2020-2022. • Collaborated with public, private, corporate organizations, senior, assisted living, corporations, living apartments, and nursing homes to provide heart healthy and stroke awareness education, risk assessment, and outreach to diverse and most susceptible populations, including Hispanics and Black Americans. Worked with 60 organizations.

Priority Area: Diabetes	
Community Health Need	**Improve Health Status Through Chronic Disease and Care Management Across the Continuum for Diabetes**
Goal(s)	• Focus educational outreach in the community based on requests related to diabetes prevention and risk factors through partnership with the American Diabetes Association and other community organizations • Expand Diabetes Education Program on the Wayne campus and expand services to the Paterson community • Share experiences and learnings from SJH internal Diabetes awareness and prevention program with community partners • Offer Pre-Diabetes / Diabetes Prevention awareness education to primary care physicians/residents on health lifestyle changes program • Share experiences and learnings from SJH internal Pre-diabetes and Diabetes Prevention

Strategy: Conduct outreach activities with community-based partners and provide nutritional information and diabetes education at places where people live and go to school, church, and others, such as markets, parks, schools, workplaces, and recreation facilities in Passaic County.

Strategy Was Implemented?	**YES**
Target Population(s)	Adolescents, Adults, and Seniors utilizing high traffic areas with healthy benefits in southern Passaic County.
Partnering Organization(s)	Internal: Community Outreach, The Victor Machuga Diabetes and Nutrition Center, Food and Nutrition External: American Diabetes Association, American Endocrinologist Association.
Results/Impact	• Medical doctors, nutritionists, and support staff committed 155 hours in National Nutrition Month and Farmers' Market community events in collaboration with the YMCA, ShopRite, and Townships in 2022 -- 32 events. • Distributed nutritional health education and diabetes awareness information to approximately 51,675 community participants during National Nutrition Month, Farmers' Market, fairs, and workplace events in 2022. • Hosted 10 Hispanic Heritage Month celebrations in the hospital consisting of healthy recipes from different cultures and diabetes education, 2020-2022.

Strategy: Utilize a standard pre-diabetes risk test and offer test score awareness for the community to assess and analyze individual risks and the need for further testing, reduction of risk factors, and intervention.	
Strategy Was Implemented?	**YES**
Target Population(s)	Adolescents, pregnant women, Adults, and Seniors
Partnering Organization(s)	Internal: Community Outreach, The Victor Machuga Diabetes and Nutrition Center, Food and Nutrition, endocrinologists External: American Diabetes Association, Ad Council, American Medical Association, Center for Disease Control and Prevention, National Diabetes Prevention Program.
Results/Impact	• Provided pre-diabetes risk tests (English, Spanish & Arabic) to community members in 100% of community events aimed toward pre-diabetes knowledge increase, awareness, education, prevention and diabetes management from 2020-2022. • Developed community toolkit consisting of a pre-diabetes risk test, medication safety, and health benefits of music and dance programming. • Developed visual/written health information on the understanding of the Hemoglobin A1C blood test for individuals, referrals, resources supporting identification and need of lifestyle changes, counseling, and access to services. • Committed 266 hours in National Diabetes Month regarding education in pre-diabetes prevention and diabetes management for community events in Passaic County from 2020-2022.

Strategy: Increase community awareness by Collaborating with interdisciplinary providers and local community-based organizations to offer diabetes comprehensive, diabetes and self-management education, and incorporating healthy diet, physical activity, and medication safety to promote management of diabetes.	
Strategy Was Implemented.	**YES**
Target Population(s)	Adolescents, Adults, and Seniors
Partnering Organization(s)	Internal: Community Outreach, The Victor Machuga Diabetes and Nutrition Center, Food and Nutrition, Family Medicine, Cardiac Rehabilitation, Bariatric, OB clinic, SJHP Clinical Integrated Network ER SjRMC, ACO/Bundle team. Ambulatory Pharmacy led Diabetes Management External: Ramapo College, Black Lives Matter Organization, William Paterson University, Women and Families Ascending Association (WAFAA), Boys and Girls Club, New Destiny Family Success Center, Senior Resource Group, YMCA of Paterson & Wayne, ShopRite of Wayne Hills, St. George's University, Calvary Baptist Church, Community Charter School of Paterson, New Jersey Jackals, Immigration and American Citizenship Organization (IACO), Borough of Woodland Park, Borough of Totowa, Wayne Township, Borough of Prospect Park, Borough of Hawthorne, City of Paterson, St. Elizabeth's College, DaVita
Results/Impact	• Monthly Diabetes Support Group to the public offer in the daytime and evening dates are listed on the SJH website, 2020-2022. • Diabetes Awareness lectures, interdisciplinary department referrals, and collaborative self-management diabetes management. • Ambulatory Care Clinical Pharmacist and Certified Diabetes Care and Education Specialist. Self-management, Hypertension and SCVD risk reduction, referral to podiatrist, ophthalmology, and others. An average of 31/weekly encounters, appointments 45-60 minutes. • 2020, 705 visits, 175 patients, new referrals, 41 A1C 11.8%, 19, 8.7%, and 5, 9.2%. • 2021 669 visits, 171 patients. New referrals, 59 A1C 10.2%, 40, 9%, 18, 8.8%, and 4, 7.6%.

Priority Area: Nutrition, Physical Activity & Weight	
Community Health Need	**Improve the Wellbeing of Community Residents Through Increased Knowledge About and Access to Healthy Foods and Participation in Physical Activity Programs**
Goal(s)	• Partner with the Passaic County Health Coalition and area organizations to promote health and wellness in the community related to nutrition, physical and healthy weight activities • Focus educational outreach in the community based on requests related to nutrition, physical activity and healthy weight initiatives • Continue to offer nutritional and wellness education to monthly support groups across service lines, such as heart health, stroke and diabetes support groups

Strategy: Launch a Health Recipes Page on the St. Joseph's Health Website.	
Strategy Was Implemented?	**YES**
Target Population(s)	Individuals of all ages in St. Joseph's Health service area.
Partnering Organization(s)	Internal: Food and Nutrition, Information Technology, St. Joseph's Health Affinity Groups External:
Results/Impact	• Provided an easily accessible online webpage for individuals to access healthy recipes and nutrition facts of meals from most common cultures. • Website is accessible via: https://www.stjosephshealth.org /recipes?highlight=YToxOntpOjA7czo3OiJyZWNpcGVzIjt9

Strategy: Establish a Meal Distribution Program to benefit community members facing food insecurity.	
Strategy Was Implemented?	**YES**
Target Population(s)	Families and individuals in primary, secondary, service areas experiencing food insecurity.
Partnering Organization(s)	Internal: Community Outreach, Foundation, Health Coalition of Passaic County, St. Joseph's WIC. External: Madison Rotary Club, Catholic Charities, Heart of Hannah Women's Center, St. Mary's, Boys and Girls, Neighborhood Assistance Office, Circle of Care, Power of One Coaching and Outreach.
Results/Impact	• Distributed 100,000 meals. • Sharing, integrating, communicated, and disseminated access to food resources among diverse vulnerable communities

Strategy: Provide a meal program for frontline workers and their families during the COVID-19 Omicron variant surge of Winter 2022.	
Strategy Was Implemented?	**YES**
Target Population(s)	Families, individuals, and frontline healthcare workers in our primary, secondary, service area experiencing food insecurity.
Partnering Organization(s)	Internal: Health Coalition of Passaic County, Community Outreach, Foundation, Nursing, Nutrition Services. External: Catholic Charities, Father English Food Pantry, Paterson Housing Authority, Ministerio Restauración Cristiana, Paterson Healing Collective, New Destiny Family Success Center, Boys and Girls Club of Passaic County
Results/Impact	• Distributed 24,430 meals in three months as part of the “Feeding the Frontlines and those in Need” program. • St. Joseph’s staff and residents contributed a total of 189 hours after their shifts to serve restaurant quality hot meals to the frontlines and their families.