2025
COMMUNITY HEALTH NEEDS ASSESSMENT

Old Bridge Medical Center Service Area

Prepared for
Old Bridge Medical Center

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Prepared by

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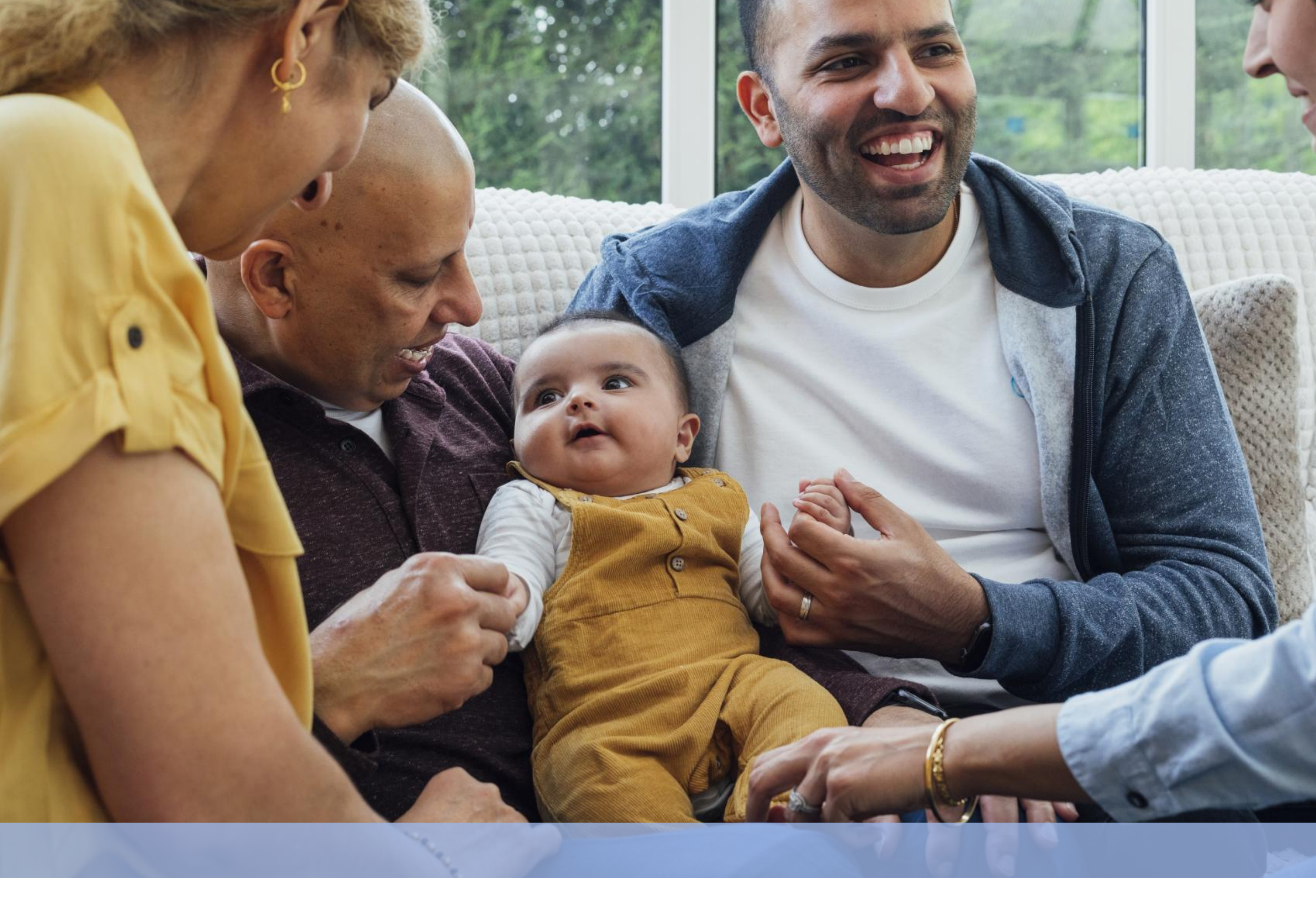
TABLE OF CONTENTS

INTRODUCTION 3
PROJECT OVERVIEW 4
Methodology 4
IRS Form 990, Schedule H Compliance 11
SUMMARY OF FINDINGS 12
DATA CHARTS & KEY INFORMANT INPUT 30
COMMUNITY CHARACTERISTICS 31
Population Characteristics 31
Social Determinants of Health 33
HEALTH STATUS 42
Overall Health 42
Mental Health 44
DEATH, DISEASE & CHRONIC CONDITIONS 51
Leading Causes of Death 51
Cardiovascular Disease 53
Cancer 59
Respiratory Disease 66
Injury & Violence 70
Diabetes 74
Disabling Conditions 78
BIRTHS 84
Prenatal Care 84
Birth Outcomes & Risks 85
Family Planning 87
MODIFIABLE HEALTH RISKS 90
Nutrition 90
Physical Activity 91
Weight Status 95
Substance Use 101
Tobacco Use 106
Sexual Health 110
ACCESS TO HEALTH CARE 113
Lack of Health Insurance Coverage 113
Difficulties Accessing Health Care 116
Emergency Room Utilization 122
Primary Care Services 124
Oral Health 127
LOCAL RESOURCES 130
Perceptions of Local Health Care Services 130
Community Education & Outreach 130
Cultural Competence 131
Resources Available to Address Significant Health Needs 133
APPENDICES 137
APPENDIX: FINDINGS FROM COMMUNITY MEMBER FOCUS GROUPS 138
APPENDIX: EVALUATION OF PAST ACTIVITIES 156



INTRODUCTION

PROJECT OVERVIEW

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 Community Health Needs Assessment — a follow-up to similar studies conducted in 2019 and 2022 — is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Old Bridge Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This assessment for Old Bridge Medical Center is part of a regional project conducted by Professional Research Consultants, Inc. (PRC) for Hackensack Meridian *Health* on behalf of its network hospitals. PRC is 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, the PRC Online Key Informant Survey, and focus groups with community members), 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.

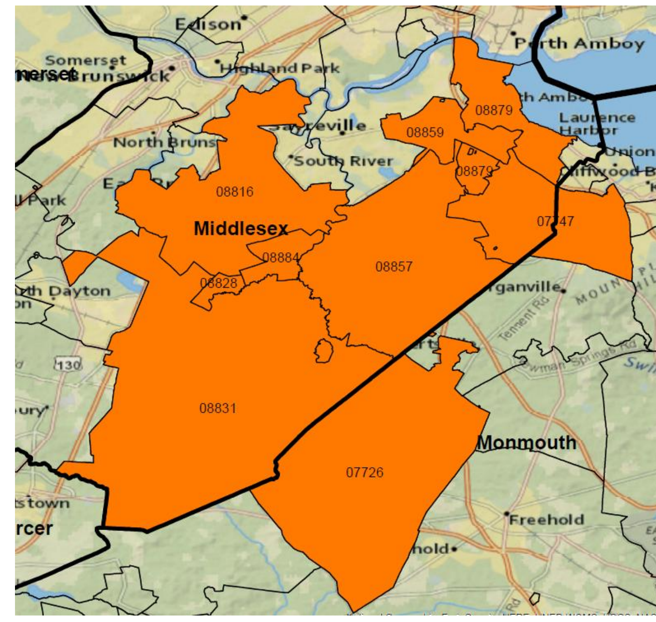
PRC Community Health Survey

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 Hackensack Meridian *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 "Old Bridge Medical Center Service Area," "OBMC Service Area," or "OBMC" in this report) is defined as each of the residential ZIP Codes comprising the primary service area of Old Bridge Medical Center. This community definition, determined based on the ZIP Codes of residence for 75% of recent patients, is illustrated in the adjacent map.



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 targeted surveys conducted by PRC via telephone (landline and cell phone) or through online questionnaires, as well as a community outreach component promoted by the study sponsors through social media posting and other communications.

> **RANDOM-SAMPLE SURVEYS** (PRC) ▶ For the targeted administration, PRC administered 309 surveys throughout the service area.

> **COMMUNITY OUTREACH SURVEYS** (Hackensack Meridian *Health*) ▶ PRC also created a link to an online version of the survey, and Hackensack Meridian *Health* promoted this link locally in order to drive additional participation and bolster overall samples. This yielded an additional 25 surveys to the overall sample.

In all, 334 surveys were completed through these mechanisms. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Old Bridge Medical Center Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

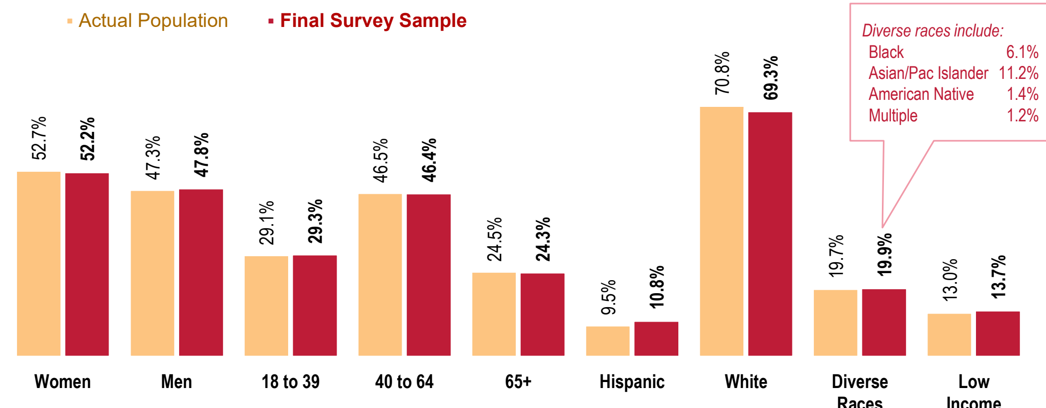
For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 334 respondents is ±5.2% at the 95 percent confidence level.

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 Old Bridge Medical Center Service Area 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
(OBMC Service Area, 2025)



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2025 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% FPL (federal poverty level, based on guidelines established by the US Department of Health & Human Services).
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

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.

PRC 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 was also implemented as part of this process. A list of recommended participants was provided by Hackensack Meridian *Health* for the network's Central Region; 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. Local participants were asked to provide input about communities in the Central Region (which includes Middlesex County); the input also included community members who work more regionally or statewide. In all, 48 community representatives in the Central Region took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	4
Public Health Representatives	8
Other Health Providers	9
Social Services Providers	6
Other Community Leaders	21

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Adult Programs East Brunswick Library
- American Cancer Society
- Bayshore Medical Center
- City of Plainfield
- Department of Family & Community Health Services – Rutgers Cooperative Extension Middlesex County
- East Brunswick Public Library
- Edison Housing Authority
- Edison Library
- Edison YMCA
- EZ Ride Deputy Director Healthy Plainfield
- Healthier Middlesex Consortium
- Highland Park Community Center
- HolaDoctor Insurance & Financial Services – Horizon NJ
- Indo-American Seniors Organization of New Jersey
- Jewish Renaissance Foundation
- JFK Johnson Rehabilitation Institute – Pediatric Rehab
- JFK Medical Center
- JFK Medical Center – Neuro
- JFK Medical Center – Family Medicine Center
- JFK Medical Center – Food & Nutrition Services

- JFK Medical Center – Radiation Oncology
- JFK Medical Center – Women's Center
- Middlesex County
- Middlesex County Office of Health Services
- Middlesex County Office of Planning NJ
- Middletown Housing Authority
- Mt Carmel Nursing Service
- Mt. Olive Baptist Church
- Old Bridge Township
- Old Bridge YMCA
- Oncology JFK Brain Tumor Center
- Paterson Division of Health
- Paterson YMCA
- Plainfield Action Services
- Priff Elementary School
- Puerto Rican Association for Human Development
- Raritan Bay Area YMCA
- Replenish
- Robert Wood Johnson University Hospital
- Saint Peter's University Hospital
- So. Amboy Administration Senior Center
- Southern Ocean Medical Center
- United Way Union County
- Woodbridge Health Department
- Woodbridge Township
- Woodbridge Township Department of Health
- Woodbridge Township Health Department
- YMCA of Metuchen, Woodbridge and South Amboy

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.

Focus Groups With Priority Populations

To supplement the other data collections, Hackensack Meridian *Health* engaged Moxley Public Health to conduct primary data collection through qualitative focus groups with community members from priority populations. The purpose of these focus groups was to gather qualitative insights into community health priorities, access to and utilization of health care services, maternal and infant health, and perspectives on health equity.

Focus groups were conducted January through April 2025, using in-person or virtual formats based on participant preference and accessibility needs. Each session was approximately one hour in length and included community members who were recruited through community networks and local organizations across North and Central New Jersey, utilizing existing meetings or events where possible.

Each focus group, with the exception of the caregivers focus group, was facilitated by a facilitator or co-facilitators from HMH Team Member Resource Groups (TMRGs). All facilitators received facilitator training, and efforts were made to ensure facilitators represented the population of the focus group they were facilitating in order to build trust and ensure participants felt comfortable. A notetaker was also present at each focus group.

Participants were thanked for their time with a $35 gift card. To ensure privacy and encourage open dialogue, no identifying information was collected, and all feedback was summarized at an aggregate level. This collaborative approach ensured that focus groups were accessible, culturally appropriate, and responsive to participant needs, creating safe spaces for diverse community voices to be heard.

The populations engaged, locations, dates, number of participants, participating organizations, and topics for each focus group can be found in the following tables.

FOCUS GROUPS WITH PRIORITY POPULATIONS				
TOPIC: HEALTH CARE ACCESS & UTILIZATION				
FOCUS GROUP	FORMAT	DATE	NUMBER OF PARTICIPANTS	PARTICIPATING ORGANIZATIONS
African American men	Virtual	February 22, 2025	25	HMH, HMH Team Member Resource Groups (TMRGs), Broreavement
Caregivers of older adults	In-person	January 10, 2025	11	HMH, HMH Alzheimer's Support Group, Ocean County Library
Latinx men	Virtual	March 4, 2025	26	HMH, HMH TMRGs, Perth Amboy YMCA
LGBTQ+ adults	Virtual	February 27, 2025	50	HMH, HMH TMRGs, Garden State Equality
TOPIC: MATERNAL & INFANT HEALTH				
FOCUS GROUP	FORMAT	DATE	NUMBER OF PARTICIPANTS	PARTICIPATING ORGANIZATIONS
African American women of childbearing age	Virtual	February 24, 2025	25	HMH, HMH TMRGs, St. Stephen AME Zion Church, Booker Family Health Center
Latinx women of childbearing age	In-person	April 24, 2025	8	HMH, HMH TMRGs, Oasis — A Haven for Women and Children

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 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, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- 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 for the Old Bridge Medical Center Service Area reflect county-level data for Middlesex County in New Jersey.

Benchmark Data

Trending

Similar surveys were administered in the service area in 2019 and 2022 by PRC on behalf of Hackensack Meridian *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.

Regional Data

Because this assessment was part of a broader, regional project conducted by Hackensack Meridian *Health* (HMH), a regional benchmark for survey indicators is available that represents all of the ZIP Codes in the primary service areas of HMH hospitals throughout central and northern New Jersey. Secondary data for the HMH Service Area are drawn from Burlington, Camden, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Somerset, Sussex, Union, and Warren counties.

New Jersey 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. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 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 findings (from various existing resources) 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.

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 US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

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

Information Gaps

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

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, 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

Old Bridge Medical Center 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, Old Bridge Medical Center had not received any written comments. However, through population surveys, community focus groups, 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. Old Bridge Medical Center will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS Form 990, Schedule H Compliance

For nonprofit 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	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	31
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	133
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)	156

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 key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access ○ Appointment Availability ○ Difficulty Finding a Physician ▪ Skipping/Stretching Prescriptions ▪ Emergency Room Utilization ▪ Focus Groups: Access to care (especially limited resources and lack of services) was identified as a top concern.
CANCER	▪ Leading Cause of Death ▪ Prostate Cancer Incidence ▪ Prostate Cancer Screening
DIABETES	▪ Prevalence of Borderline/Pre-Diabetes ▪ Key Informants: *Diabetes* ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ High Blood Cholesterol Prevalence
HOUSING	▪ Housing Conditions ▪ Key Informants: *Social Determinants of Health (including Housing)* ranked as a top concern.
INJURY & VIOLENCE	▪ Unintentional Injury Deaths ▪ Homicide Deaths
MENTAL HEALTH	▪ Diagnosed Depression ▪ Symptoms of Chronic Depression ▪ Mental Health Provider Ratio ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: *Mental Health* ranked as a top concern. ▪ Focus Groups: Mental health was identified as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Overweight & Obesity [Adults] ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Unintentional Drug-Induced Deaths ▪ Illicit Drug Use

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. Nutrition, Physical Activity & Weight
3. Housing
4. Diabetes
5. Substance Use
6. Heart Disease & Stroke
7. Cancer
8. Access to Health Care Services
9. Injury & Violence

Hospital Implementation Strategy

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

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

Summary Tables of Survey & Secondary Data: Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, Old Bridge Medical Center Service Area results are shown in the larger, gray column.

The columns to the right of the Old Bridge Medical Center Service Area column provide trending, as well as comparisons between service area data and any available regional (HMH network), state, and national findings, or Healthy People 2030 objectives. Symbols indicate whether the Old Bridge Medical Center Service Area 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 2019 (or earliest available data). Note that survey data reflect the ZIP Code-defined Old Bridge Medical Center Service Area.

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). Local secondary data reflect county-level data for Middlesex County.

SOCIAL DETERMINANTS	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	**7.6**	6.1	6.3	3.9		
Population in Poverty (Percent)	**8.5**	9.7	9.8	12.4	8.0	
Children in Poverty (Percent)	**10.4**	13.2	13.3	16.3	8.0	
No High School Diploma (Age 25+, Percent)	**10.7**	9.1	9.3	10.6		
Unemployment Rate (Age 16+, Percent)	**4.8**	4.1	4.2	3.9		
% Unable to Pay for a $400 Emergency Expense	**21.0**	27.5		34.0		17.3
% Worry/Stress Over Rent/Mortgage in Past Year	**34.2**	44.9		45.8		34.5
% Unhealthy/Unsafe Housing Conditions	**11.2**	19.3		16.4		6.5
Population With Low Food Access (Percent)	**25.0**	24.9	23.8	22.2		
% Food Insecure	**29.3**	35.1		43.3		26.4

better similar worse

OVERALL HEALTH	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	14.0	12.7	17.0	15.7		10.9

better similar worse

ACCESS TO HEALTH CARE	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	6.2	4.3	11.4	8.1	7.6	4.5
% Difficulty Accessing Health Care in Past Year (Composite)	49.9	55.4		52.5		41.2
% Cost Prevented Physician Visit in Past Year	13.4	19.5	10.8	21.6		15.4
% Cost Prevented Getting Prescription in Past Year	14.9	18.4		20.2		13.2
% Difficulty Getting Appointment in Past Year	33.8	37.1		33.4		18.9
% Inconvenient Hrs Prevented Dr Visit in Past Year	25.3	26.9		22.9		24.6
% Difficulty Finding Physician in Past Year	20.7	25.7		22.0		13.6
% Transportation Hindered Dr Visit in Past Year	10.5	17.3		18.3		7.1

ACCESS TO HEALTH CARE (continued)	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% Language/Culture Prevented Care in Past Year	**3.0**	6.1		5.0		4.0
% Written Health Info is "Seldom/Never" Easy to Understand	**8.3**	8.1		10.0		20.1
% Spoken Health Info is "Seldom/Never" Easy to Understand	**4.0**	5.4		7.5		11.7
% Stretched Prescription to Save Cost in Past Year	**16.6**	18.5		19.4		10.9
% Difficulty Getting Child's Health Care in Past Year	**8.7**	15.8		11.1		
Primary Care Doctors per 100,000	**112.6**	108.7	105.8	116.6		
% Have a Specific Source of Ongoing Care	**73.3**	65.3		69.9	84.0	78.5
% Routine Checkup in Past Year	**74.1**	76.9	79.2	65.3		70.6
% [Child 0-17] Routine Checkup in Past Year	**91.6**	80.8		77.5		88.5
% Two or More ER Visits in Past Year	**28.3**	18.1		15.6		7.6
% Rate Local Health Care "Fair/Poor"	**9.1**	9.6		11.5		8.6

better similar worse

CANCER	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000	**146.2**	161.7	166.1	182.5	122.7	157.6
Lung Cancer Deaths per 100,000	**28.6**	31.8	32.8	39.8	25.1	
Female Breast Cancer Deaths per 100,000	**23.5**	25.2	25.7	25.1	15.3	
Prostate Cancer Deaths per 100,000	**13.1**	16.6	17.0	20.1	16.9	
Colorectal Cancer Deaths per 100,000	**13.4**	14.5	15.0	16.3	8.9	
Cancer Incidence per 100,000	**452.9**	481.3	481.9	442.3		
Lung Cancer Incidence per 100,000	**45.9**	50.5	51.3	54.0		
Female Breast Cancer Incidence per 100,000	**128.5**	136.2	137.1	127.0		
Prostate Cancer Incidence per 100,000	**135.1**	143.9	143.3	110.5		
Colorectal Cancer Incidence per 100,000	**36.1**	38.4	38.7	36.5		
% Cancer	**7.4**	11.0	9.5	7.4		10.9
% [Women 50-74] Breast Cancer Screening	**86.1**	78.9		64.0	80.5	71.7

CANCER (continued)	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% [Women 21-65] Cervical Cancer Screening	**80.7**	82.4		75.4	84.3	74.4
% [Age 45-75] Colorectal Cancer Screening	**72.9**	72.9		71.5	74.4	67.9
% [Men 40+] PSA Test in Past 2 Years	**47.1**	59.3				65.0
% [Age 55-80 w/Smoking History] Low-Dose CT Scan in Past Year	**14.2**	26.4				

better similar worse

DIABETES	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000	**18.4**	21.2	22.2	30.5		18.9
% Diabetes/High Blood Sugar	**15.5**	14.9	10.5	12.8		12.5
% Borderline/Pre-Diabetes	**14.9**	19.7		15.0		9.4
Kidney Disease Deaths per 100,000	**16.1**	18.2	18.4	16.9		16.1

better similar worse

DISABLING CONDITIONS	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	38.3	37.8		38.0		39.3
% Activity Limitations	24.4	24.9		27.5		18.9
% High-Impact Chronic Pain	17.3	18.2		19.6	6.4	23.0
Alzheimer's Disease Deaths per 100,000	15.6	22.5	25.3	35.8		17.0
% Caregiver to a Friend/Family Member	23.4	25.7		22.8		20.4

better similar worse

HEART DISEASE & STROKE	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000	170.9	195.3	199.8	209.5	127.4	177.1
% Heart Disease	8.7	13.7	5.0	10.3		7.6
Stroke Deaths per 100,000	32.1	38.5	39.6	49.3	33.4	32.3
% Stroke	5.3	6.6	2.4	5.4		4.5

HEART DISEASE & STROKE (continued)	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% High Blood Pressure	**42.0**	43.2	33.4	40.4	42.6	37.9
% High Cholesterol	**46.6**	42.3		32.4		35.0
% 1+ Cardiovascular Risk Factor	**85.8**	87.9		87.8		85.8

better similar worse

INFANT HEALTH & FAMILY PLANNING	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent of Births)	**25.1**	24.4	23.5	22.3		23.7
Teen Births per 1,000 Females 15-19	**6.8**	8.8	9.0	15.5		
Low Birthweight (Percent of Births)	**8.2**	7.7	7.8	8.4		
Infant Deaths per 1,000 Births	**3.6**	4.0	4.0	5.5	5.0	3.7

better similar worse

INJURY & VIOLENCE	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000	**43.1**	51.6	53.8	67.8	43.2	31.6
Motor Vehicle Crash Deaths per 100,000	**6.3**	6.9	7.3	13.3	10.1	
[65+] Fall-Related Deaths per 100,000	**32.7**	29.9	32.5	64.0	63.4	
% [Age 45+] Fell in the Past Year	**27.0**	32.3				18.0
Homicide Deaths per 100,000	**2.7**	3.8	3.9	7.6	5.5	1.8
% Victim of Violent Crime in Past 5 Years	**2.7**	6.8		7.0		3.3
% Victim of Intimate Partner Violence	**15.7**	17.3		20.3		16.8

better similar worse

MENTAL HEALTH	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	19.9	19.1		24.4		15.7
% Diagnosed Depression	25.2	25.1	13.9	30.8		13.5
% Symptoms of Chronic Depression	42.1	41.6		46.7		23.9
% Typical Day Is "Extremely/Very" Stressful	16.2	22.1		21.1		13.7
Suicide Deaths per 100,000	6.4	7.7	7.8	14.7	12.8	7.5
Mental Health Providers per 100,000	263.6	302.1	294.8	319.4		
% Receiving Mental Health Treatment	20.1	21.4		21.9		11.2
% Unable to Get Mental Health Services in Past Year	9.2	12.9		13.2		3.9

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	**14.8**	20.3		30.0		15.4
% No Leisure-Time Physical Activity	**23.0**	25.1	24.2	30.2	21.8	19.9
% Meet Physical Activity Guidelines	**27.8**	35.1	31.3	30.3	29.7	23.7
% [Child 2-17] Physically Active 1+ Hours per Day	**40.8**	30.0		27.4		36.5
Recreation/Fitness Facilities per 100,000	**11.7**	15.9	15.8	12.3		
% Overweight (BMI 25+)	**70.2**	60.4	64.8	63.3		73.0
% Obese (BMI 30+)	**36.3**	26.9	28.9	33.9	36.0	33.7
% [Child 5-17] Overweight (85th Percentile)	**31.6**	37.3		31.8		28.8
% [Child 5-17] Obese (95th Percentile)	**18.1**	26.1		19.5	15.5	18.3

better similar worse

ORAL HEALTH	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% Have Dental Insurance	82.3	81.3		72.7	75.0	79.0
% Dental Visit in Past Year	67.8	66.0	68.3	56.5	45.0	74.3
% [Child 2-17] Dental Visit in Past Year	83.5	75.0		77.8	45.0	86.9

better similar worse

RESPIRATORY DISEASE	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000	19.2	26.7	27.7	43.5		26.4
Pneumonia/Influenza Deaths per 100,000	12.2	11.9	12.4	13.4		12.9
% Asthma	11.0	18.4	8.6	17.9		9.0
% [Child 0-17] Asthma	8.2	14.1		16.7		7.5
% COPD (Lung Disease)	5.0	11.7	4.4	11.0		8.0

better similar worse

SEXUAL HEALTH	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	309.0	475.6	449.7	386.6		
Chlamydia Incidence per 100,000	289.5	385.4	384.1	492.2		
Gonorrhea Incidence per 100,000	66.0	112.4	109.1	179.0		

better similar worse

SUBSTANCE USE	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000	7.2	8.1	8.5	15.7		5.9
% Excessive Drinking	16.5	26.8	15.7	34.3		19.9
Unintentional Drug-Induced Deaths per 100,000	24.4	29.8	30.8	29.7		14.1
% Used an Illicit Drug in Past Month	5.0	6.7		8.4		1.5
% Used a Prescription Opioid in Past Year	9.7	12.7		15.1		14.3
% Ever Sought Help for Alcohol or Drug Problem	5.4	10.1		6.8		7.4

SUBSTANCE USE (continued)	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% Personally Impacted by Substance Use	34.3	45.0		45.4		35.1

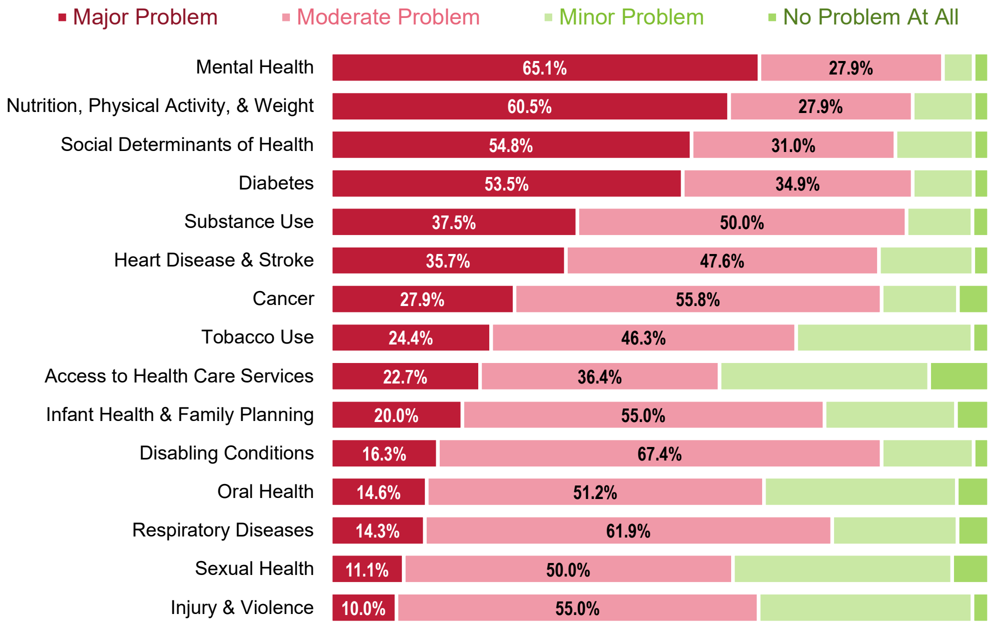
better similar worse

TOBACCO USE	OBMC Service Area	OBMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	9.6	22.8	9.1	23.9	6.1	13.6
% Someone Smokes at Home	12.5	23.0		17.7		8.5
% Use Vaping Products	10.7	19.9	6.3	18.5		7.4

better similar worse

Summary of Key Informant Input

In the Online Key Informant Survey, community representatives were asked to rate the degree to which each of 15 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 are also 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.)



Summary of Community Member Focus Group Input

The following presents a summation of the qualitative findings from the six focus groups that Moxley Public Health and Hackensack Meridian *Health* conducted with community members from priority populations.

Biggest Community Health Needs:

- Mental health challenges (depression, anxiety, stress) and insufficient services
- Health care access barriers (limited resources and lack of services)
- Cultural competency and discrimination issues in health care; lack of cultural sensitivity in health care
- Maternal and infant mortality, especially among Black women
- Underserved populations and health literacy concerns- inadequate support for specific populations

Health Care Access Barriers:

- Deteriorating health outcomes (poor health outcomes, chronic conditions, mortality, worsening health conditions)
- Avoidance or delay of necessary health care (due to negative experiences and discrimination)

- Mental health deterioration (mental health strain - depression, anxiety, stress)
- Financial strain on families and individuals: financial instability due to health care costs
- Reduced quality of life

Sub-Populations with Health Care Access Barriers:

- Communities of color, particularly Black/African American, other racial and ethnic minorities
- LGBTQ+ community, including transgender individuals
- Caregivers
- Elderly: people living with dementia/Alzheimer’s
- Immigrant populations, especially undocumented

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 and focus groups with priority populations.

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

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density. [COUNTY-LEVEL DATA]

Total Population
(Estimated Population, 2019-2023)

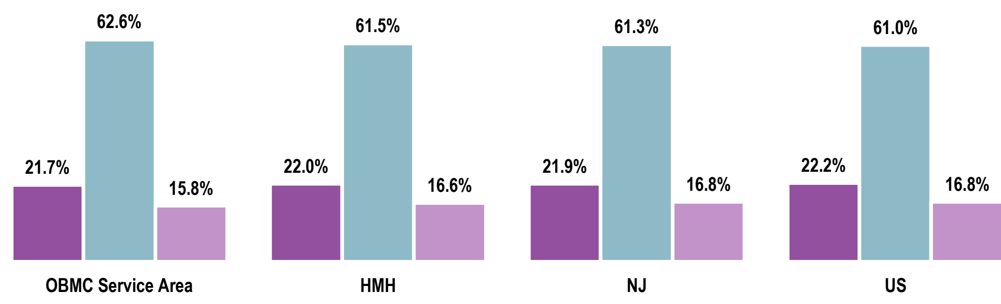
	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
OBMC Service Area	861,535	309.25	2,786
HMH Network	6,901,676	4,991.66	1,383
NJ	9,267,014	7,354.93	1,260
US	332,387,540	3,533,298.58	94

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

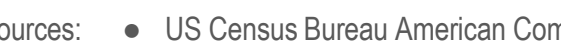
Age

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]

Total Population by Age Groups
(2019-2023)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

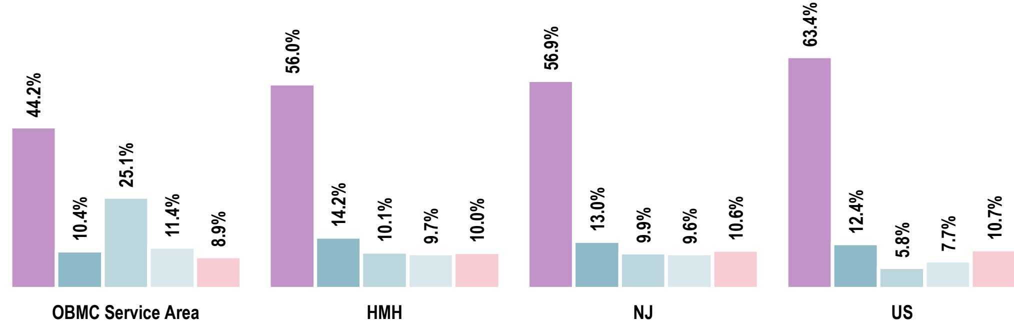


Race & Ethnicity

Race reflects those who identify with a single race category, regardless of Hispanic origin. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

The following charts illustrate the racial and ethnic makeup of our community. [COUNTY-LEVEL DATA]

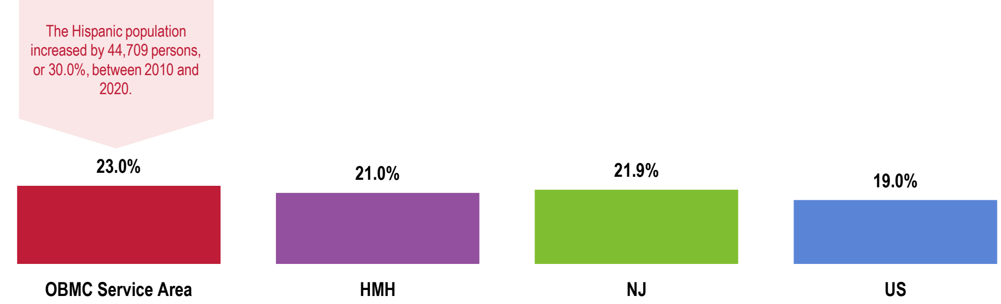
Total Population by Race Alone
(2019-2023)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- "Diverse Races" includes those who identify as American Indian or Alaska Native, Asian, or Native Hawaiian/Pacific Islander, without Hispanic origin.

Hispanic Population
(2019-2023)



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- 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)

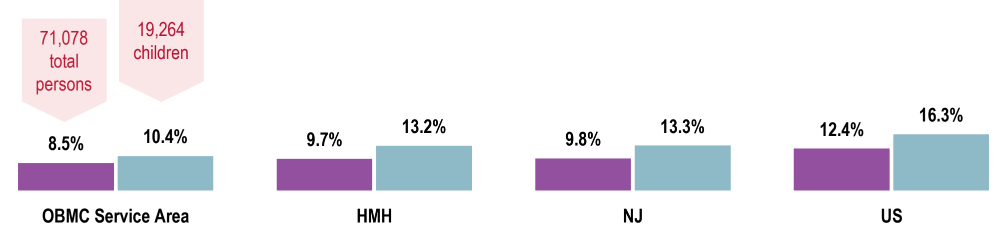
Income & Poverty

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

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

Population in Poverty
(Populations Living Below the Poverty Level; 2019-2023)
Healthy People 2030 = 8.0% or Lower

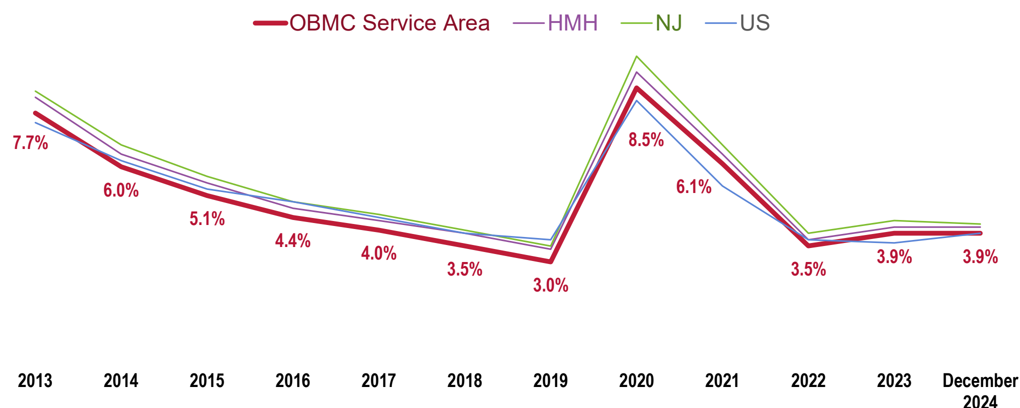


Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Employment

Note the following trends in unemployment data derived from the US Department of Labor. [COUNTY-LEVEL DATA]

Unemployment Rate



Sources: • US Department of Labor, Bureau of Labor Statistics.
• Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes: • Percent of non-institutionalized population age 16+ who are unemployed (not seasonally adjusted).

Financial Resilience

PRC SURVEY ▶ "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?"

The following details "no" responses in the Old Bridge Medical Center Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, income [based on poverty status], and race/ethnicity).

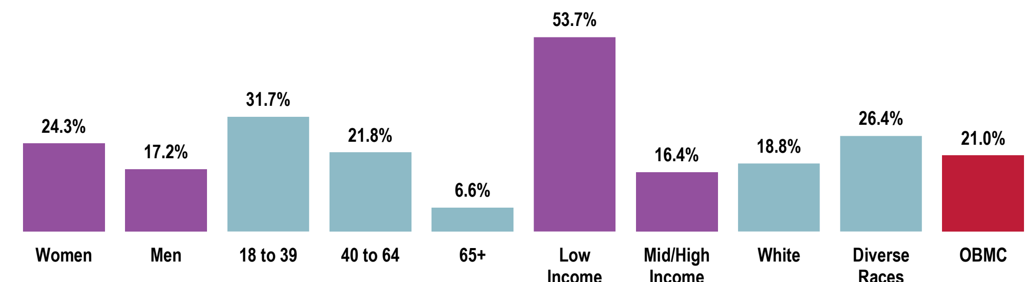
Do Not Have Funds on Hand to Cover a $400 Emergency Expense

OBMC Service Area

Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
• 2023 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.

Do Not Have Funds on Hand to Cover a $400 Emergency Expense
(OBMC Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 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.

INCOME & RACE/ETHNICITY

INCOME ► Income categories used to segment survey data 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 2024 guidelines place the poverty threshold for a family of four at $30,700 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► In analyzing survey results, mutually exclusive race and ethnicity categories are used. “White” reflects those who identify as White alone, without Hispanic origin. “Diverse Races” includes those who identify as Hispanic or as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races.

Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes. [COUNTY-LEVEL DATA]

Population With No High School Diploma
(Adults Age 25 and Older; 2019-2023)

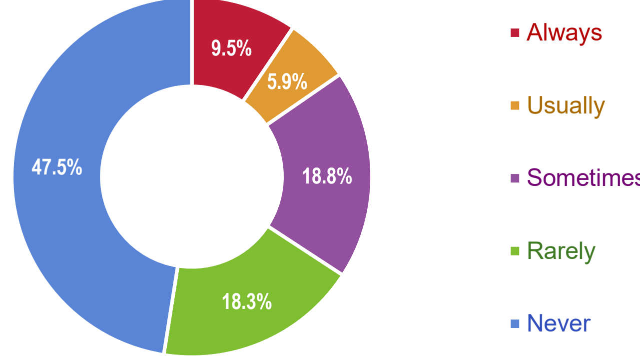
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

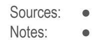
Housing

Housing Insecurity

PRC SURVEY ▶ "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?"

Frequency of Worry or Stress
About Paying Rent or Mortgage in the Past Year
(OBMC Service Area, 2025)

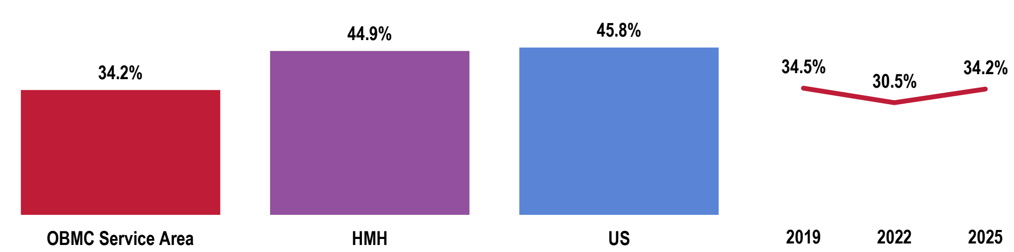




Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 56]

Notes:
- Asked of all respondents.

Always/Usually/Sometimes Worried About Paying Rent or Mortgage in the Past Year
(OBMC Service Area, 2025)

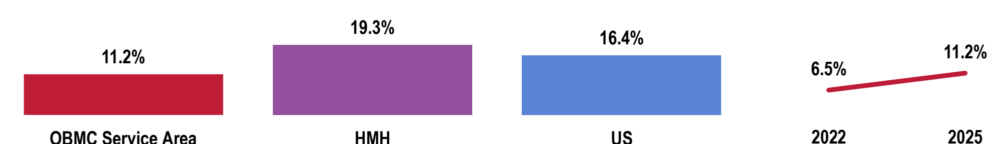


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

PRC SURVEY ▶ "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?"

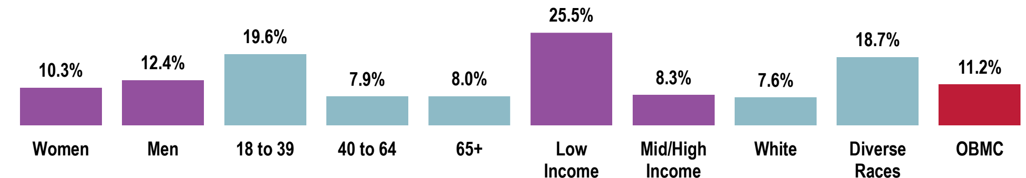
Unhealthy or Unsafe Housing Conditions in the Past Year
(OBMC Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
● 2023 PRC National Health Survey, PRC, Inc.
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.

Unhealthy or Unsafe Housing Conditions in the Past Year
(OBMC Service Area, 2025)

Among homeowners 7.8%
Among renters 11.6%



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 55]
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.

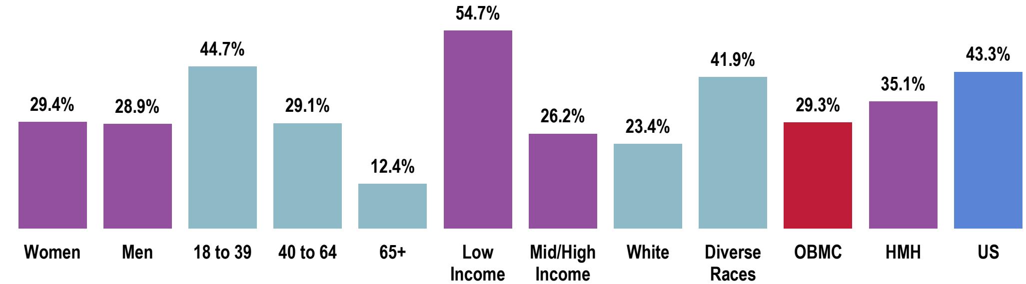
Food Insecurity

PRC SURVEY ▶ "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 Insecure
(OBMC Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 98]
• 2023 PRC National Health Survey, PRC, Inc.

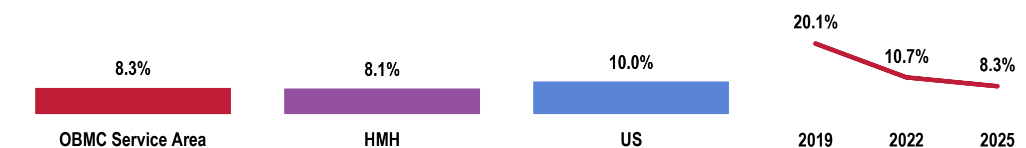
Notes: • Asked of all respondents.
• Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Health Literacy

PRC SURVEY ▶ "You can find written health information on the internet, in newspapers and magazines, on medications, at the doctor's office, in clinics, and many other places. How often is health information written in a way that is easy for you to understand? Would you say always, nearly always, sometimes, seldom, or never?"

Written Health Info is "Seldom/Never" Easy to Understand

OBMC Service Area

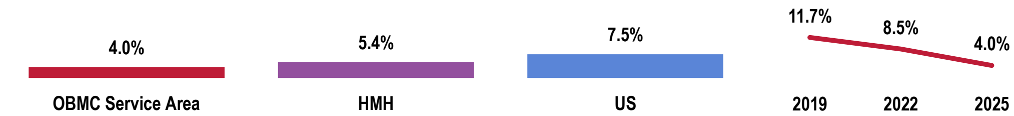


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 304]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

PRC SURVEY ▶ "How often is health information spoken in a way that is easy for you to understand? Would you say always, nearly always, sometimes, seldom, or never?"

Spoken Health Info is "Seldom/Never" Easy to Understand

OBMC Service Area

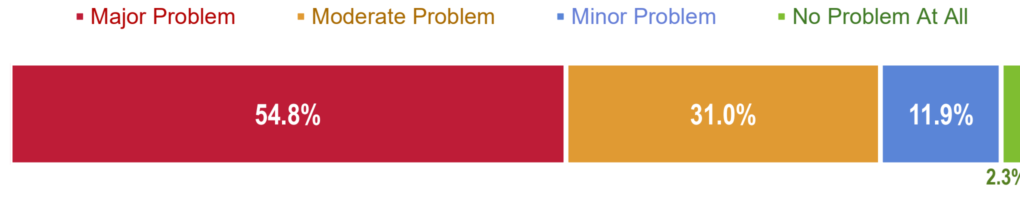


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 305]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Social Determinants of Health

The following chart outlines key informants' perceptions of the severity of *Social Determinants of Health (including Housing)* as a problem in the community:

Perceptions of Social Determinants of Health as a Problem in the Community
(Key Informants, 2025)



Sources: • 2025 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:

Housing

> Residents with limited incomes have trouble finding affordable housing. Limited housing is available for those struggling with homelessness. – Community Leader
>
> Many SDOH affecting individuals and families in the community. Housing, jobs and food insecurity are the major ones. – Public Health Representative
>
> Housing is critical for family stability. We have seen an extraordinary increase in the number of families looking for rental assistance with multiple months of rental arrears. We are concerned that this is going to continue to increase and that families are going to lose their housing. The loss of funding is going to further impact marginalized. We can lose health benefits, mental health services and further increase disparities for our most vulnerable residents. – Health Care Provider
>
> Homelessness. – Community Leader
>
> The cost of living in East Brunswick is some of the highest in the county. Salaries have not risen with the cost of apartment rentals, etc. – Community Leader
>
> Economic instability, i.e., affordable housing, healthcare, employment. – Public Health Representative
>
> Finding affordable housing for middle income residents is becoming more difficult, and what is available is overpriced almost to the point of outpacing median incomes. – Community Leader
>
> Housing should be a human right. It is a major problem because there are so many families who are unhoused. People living in Middlesex County spend upwards of 60% of their income on housing. – Community Leader
>
> We know that social determinants of health are just that--nonmedical factors that impact a person's health and longevity. Many of our community members are underserved. Without proper housing or food or income, it's very difficult for people to focus on eating healthy and exercising. If they live in a place that is susceptible to mold or other environmental toxins, this can significantly impact their health. People of color who experience discrimination whether overt or subtle, tend to have poorer health outcomes. We need to consider these factors when treating patients in our medical facilities so that we can give effective, wholistic care.
> – Health Care Provider

Impact on Quality of Life

> It effects all aspects of life and drives people to prioritize other issues aside from health. – Community Leader
>
> 80% of a person's health is dependent upon the SDOH. – Physician
>
> Social determinants of health are a major problem because they affect the person's health outcomes. Income, education, and housing, health insurance can all greatly impact their health outcomes. Limited income or low-income communities can't access health care, health foods and those with jobs probably can't take off to go to their healthcare providers. Education plays another key factor, based on their education level they may not even know how to achieve good health. – Social Services Provider

Nutrition

> We serve a diverse population where food challenges, language challenges, and financial challenges play factors in seeking health care, the ability to afford food and medications to prevent chronic disease. – Physician
>
> An increase in services provided for food insecurity, housing (rental), immigration.
> – Public Health Representative

Focus Group Input: Social Determinants of Health

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Health literacy and awareness gaps*
- *Financial barriers to care*
- *Transportation challenges*
- *Housing instability and affordability*
- *Food insecurity and access to nutrition*
- *Environmental hazards*
- *Navigation of financial systems*
- *Access to information about available services*

Maternal & Infant Health Focus Groups:

- *Housing instability and affordability*
- *Food insecurity*
- *Environmental hazards (smoking, lead exposure)*
- *Limited access to health care services*
- *Transportation barriers*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *Caregivers of individuals with dementia*
- *Low-income individuals and families*
- *Immigrants and non-English speakers*
- *Elderly individuals*
- *Men of color from foreign countries*
- *Undocumented individuals*
- *LGBTQ+ community (especially housing concerns)*

Maternal & Infant Health Focus Groups:

- *Immigrants/migrant communities*
- *Low and moderate-income households*
- *Undocumented individuals*

Key Quotes:

Access & Utilization Focus Groups:

> "I need help with resources on how to navigate financial systems. There's no one place to go to get resources." – Caregivers Focus Group
>
> "I'm unable to drive and don't have transportation." – Caregivers Focus Group
>
> "People won't engage with something they don't understand [if they have low health literacy]." – African American Men Focus Group
>
> "Low-income households: Individuals and families struggling financially often cannot afford basic necessities including health care." – African American Men Focus Group
>
> "High medical costs lead to financial instability for families, forcing them to choose between health care and basic necessities like rent, food, and utilities." – Latinx Men Focus Group
>
> "Safe and inclusive housing is still lacking—especially for trans and non-binary individuals." – LGBTQ+ Focus Group

Maternal & Infant Health Focus Groups:

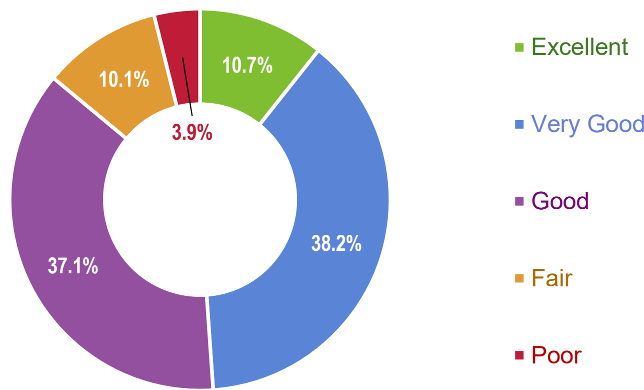
> "Shelter housing rental cost is not affordable, which means mothers and infants are not stable and moving from place to place in different environments, causing health issues." – Latinx Women Focus Group
>
> "Food insecurity, the cost of health services, and lack of stable homes are issues." – Latinx Women Focus Group
>
> "General health disparities experienced by Black women are often ignored or dismissed." – African American Women Focus Group

HEALTH STATUS

Overall Health

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

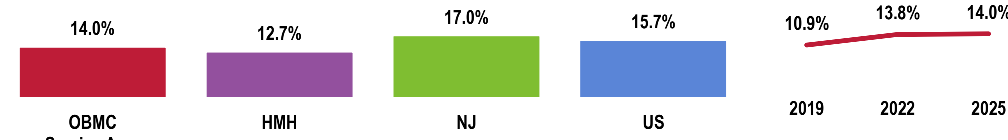
Self-Reported Health Status
(OBMC Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

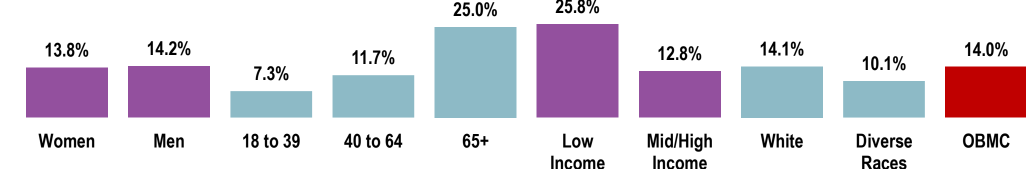
Experience "Fair" or "Poor" Overall Health

OBMC Service Area



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(OBMC Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

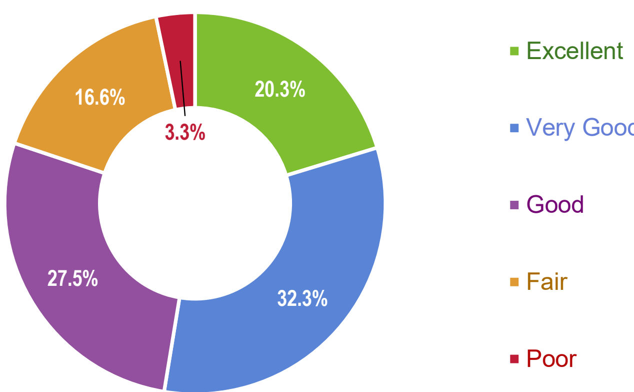
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

PRC SURVEY ▶ "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: • 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: • Asked of all respondents.

Experience "Fair" or "Poor" Mental Health

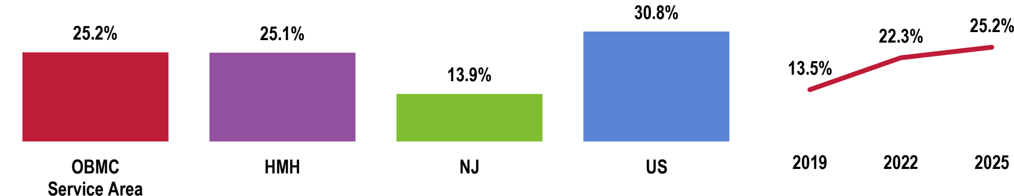
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Depression

Diagnosed Depression

PRC SURVEY ▶ "Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"

Have Been Diagnosed With a Depressive Disorder

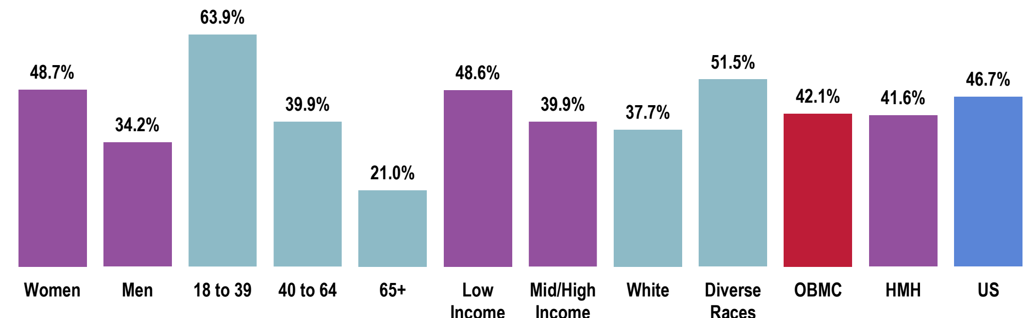


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 80]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

PRC SURVEY ▶ "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
(OBMC Service Area, 2025)



Women	Men	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Diverse Races	OBMC	HMH	US
48.7%	34.2%	63.9%	39.9%	21.0%	48.6%	39.9%	37.7%	51.5%	42.1%	41.6%	46.7%

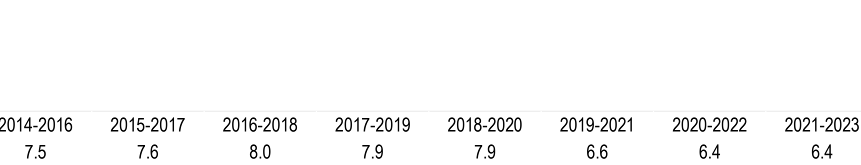
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 78]
• 2023 PRC National Health Survey, PRC, Inc.

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.

Suicide

The following chart outlines the most current mortality rates attributed to suicide in our population. [COUNTY-LEVEL DATA]

Suicide Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower



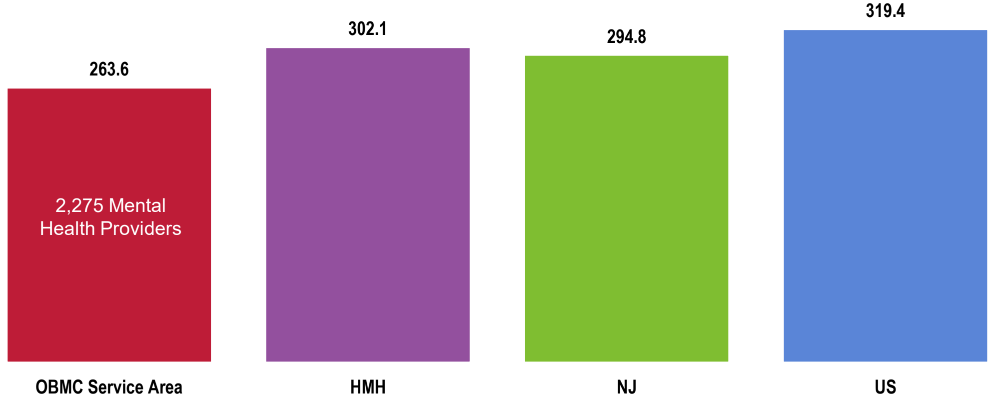
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	7.5	7.6	8.0	7.9	7.9	6.6	6.4	6.4
HMH	8.4	8.3	8.2	8.4	8.1	7.7	7.7	7.7
NJ	8.4	8.4	8.4	8.7	8.3	7.9	7.8	7.8
US	13.7	14.0	14.4	14.6	14.4	14.3	14.4	14.7

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Mental Health Treatment

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

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



Sources: ● Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 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.

PRC SURVEY ▶ "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"

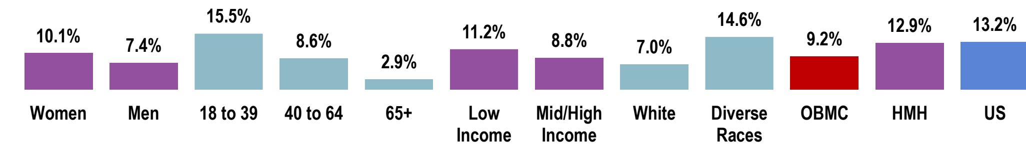
Currently Receiving Mental Health Treatment

OBMC Service Area

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC SURVEY ▶ "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
(OBMC Service Area, 2025)

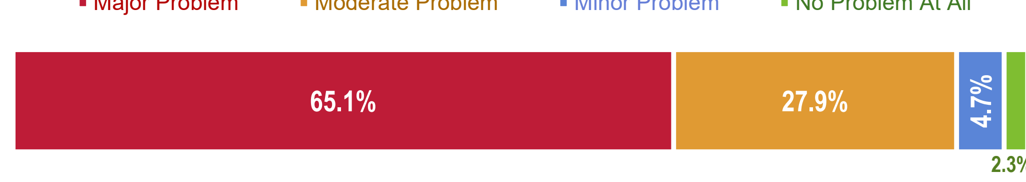


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 82]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Mental Health

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

Perceptions of Mental Health as a Problem in the Community
(Key Informants, 2025)



Sources: • 2025 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

> Access to care, lack of mental health care professionals, stigma, social and cultural factors.
> – Public Health Representative
>
> Access to mental health care, recognition of mental health needs, stigma around seeking mental health support.
> – Community Leader
>
> Access to care, social and economic challenges and physical health problems. – Public Health Representative
>
> Being able to see an appropriate mental health provider in a timely manner who accepts their insurance.- There is a shortage of mental health providers in our area- providers that do exist often have waitlists- some mental health providers accept no insurance at all and those that do very often do not accept Medicaid.
> – Health Care Provider
>
> Access to mental health care. – Physician
>
> Mental health facilities are often overcrowded but often have an underlying issue such as substance abuse.
>
> – Public Health Representative

> Programs are not available for the larger community. Outpatient, group sessions, and CBT in the hospital setting may help people in need of mental health support. No resource book for programs available is readily available. Transport and fees for these programs is an issue with the added burden of stigma to access mental health care. – Public Health Representative
>
> Accessing consistent care in the language they are most comfortable communicating in. – Community Leader
>
> Not enough resources to help them. – Community Leader
>
> Timely access to qualified mental health workers. – Physician

Denial/Stigma

> Stigma for older adults and children, lack of providers and insurance. – Community Leader
>
> Fear of speaking up about it and unfortunately the stigma that comes from being vocal about mental health challenges. – Public Health Representative
>
> Mental health is not treated as a serious medical health issue in many communities due to stigma or cultural difference. With newer food insecurity, prices of the cost of living, and the stress of the world, we see people come to the library with mental health issues and we are not trained to treat them. Our social worker intern is always booked because there is less stigma coming to the library. – Community Leader

Lack of Providers

> Lack of providers, appointments and language and culturally appropriate services.
> – Public Health Representative
>
> Lack of providers. – Health Care Provider
>
> The ability to schedule an appointment in a timely manner. Identifying practitioners who can effectively address the needs of the community. – Community Leader

Diagnosis/Treatment

> Being identified and thus seeking or receiving treatment. Far too many people have a hard time admitting they have a problem and as such don't get help. – Community Leader

Disease Management

> There are many health issues at once. Not taking medications and believing they can handle without medication.
> – Social Services Provider

Stress

> Families are over stressed and with the changes at the federal level we know that the stress levels and concerns about family stability is going to get worse. We see mostly mothers and they are coming in very stressed and in crisis. – Health Care Provider

Child & Adolescents

> Increase in child and adolescent anxiety and depression. Cultural beliefs about mental health care being a weakness. – Physician

Focus Group Input: Mental Health

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Lack of mental health services and providers*
- *Stigma around mental health (especially among men)*
- *Need for grief support*
- *Lack of caregiver mental health support*
- *Postpartum depression*
- *Anxiety and stress from housing/financial instability*
- *Mental health impacts of discrimination (LGBTQ+ community)*
- *Need for peace of mind for caregivers*

Maternal & Infant Health Focus Groups:

- *Postpartum depression*
- *Anxiety*
- *Stress from housing and financial instability*
- *Depression*
- *Lack of mental health support for new mothers*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *Caregivers for individuals with dementia*
- *LGBTQ+ community members*
- *African American men*
- *New mothers*
- *Black women*
- *Low-income families*
- *Elderly individuals*

Maternal & Infant Health Focus Groups:

- *New mothers*
- *Black women*
- *Low-income families*

Key Quotes:

Access & Utilization Focus Groups:

> "Mental health is a pressing concern…there are not enough resources available to support mental health services." – African American Men Focus Group
>
> "We need supports for caregivers to take care of themselves…meditation classes, yoga classes for caregivers that they could participate in once or twice a month…everyone needs that." – Caregivers Focus Group
>
> "When someone loses their loved ones…grief support groups have restrictive criteria, long wait times…people are grieving now and need support right away." – Caregivers Focus Group
>
> "Broreavement's grief small groups really have shown me that intentional community and brotherhood can snowball into actually facing these issues." – African American Men Focus Group
>
> "Mental health services are hard to get—people need easier access in the community." – Latinx Men Focus Group
>
> "My biggest concern is finding affirming providers, mental health stigma, and locating providers who are truly knowledgeable about how to treat LGBTQ+ people. We have an increased rate of mental health issues because a lot of us would rather not access health care services than to get there and receive embarrassing comments." – LGBTQ+ Focus Group

Maternal & Infant Health Focus Groups:

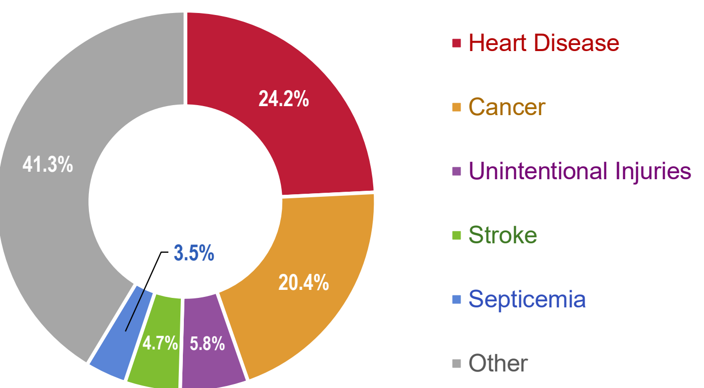
> "Depression, despair, and living with anger directly affects our health, mental health, and is reflected in our economic, family, and social well-being." – Latinx Women Focus Group
>
> "Mental health matters: It's not just about physical health. Many moms struggle with feelings like depression or anxiety after having a baby and might not get enough support for their mental health." – African American Women Focus Group
>
> "Lack of certain resources and poor economic conditions cause women to experience stress and depression." – Latinx Women Focus Group
>
> "Maternal and infant health issues lead to emotional trauma, anxiety, and depression for mothers and families." – African American Women Focus Group

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines leading causes of death in the 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 April 2025.

Notes: • Lung disease includes deaths classified as chronic lower respiratory disease.

Death Rates for Selected Causes

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

Here, deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population.

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

Death Rates for Selected Causes
(2021-2023 Deaths per 100,000 Population)

	OBMC Service Area	HMH	NJ	US	HP2030
Diseases of the Heart	170.9	195.3	199.8	209.5	127.4*
Malignant Neoplasms (Cancers)	146.2	161.7	166.1	182.5	122.7
Unintentional Injuries	43.1	51.6	53.8	67.8	43.2
Falls [Age 65+], 2018-2020	32.7	29.9	32.5	64.0	63.4
Cerebrovascular Disease (Stroke)	32.1	38.5	39.6	49.3	33.4
Unintentional Drug-Induced Deaths	24.4	29.8	30.8	29.7	—
Chronic Lower Respiratory Disease (CLRD)	19.2	26.7	27.7	43.5	—
Diabetes	18.4	21.2	22.2	30.5	—
Kidney Disease	16.1	18.2	18.4	16.9	—
Alzheimer's Disease	15.6	22.5	25.3	35.8	—
Pneumonia/Influenza	12.2	11.9	12.4	13.4	—
Alcohol-Induced Deaths	7.2	8.1	8.5	15.7	—
Intentional Self-Harm (Suicide)	6.4	7.7	7.8	14.7	12.8
Motor Vehicle Deaths	6.3	6.9	7.3	13.3	10.1
Homicide/Legal Intervention	2.7	3.8	3.9	7.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

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)

Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

The following charts outline mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]

Heart Disease Mortality Trends

(Annual Average Deaths per 100,000 Population)

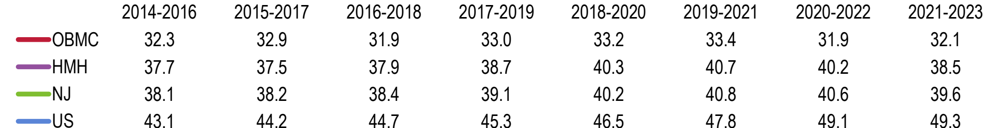
Healthy People 2030 = 127.4 or Lower (Adjusted)

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	177.1	177.4	179.9	179.6	182.3	177.1	176.6	170.9
HMH	203.5	204.5	206.4	207.1	211.8	207.2	204.9	195.3
NJ	207.0	208.4	210.3	211.2	215.6	210.9	208.0	199.8
US	195.5	197.5	198.6	200.0	204.2	207.3	210.7	209.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 33.4 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	32.3	32.9	31.9	33.0	33.2	33.4	31.9	32.1
HMH	37.7	37.5	37.9	38.7	40.3	40.7	40.2	38.5
NJ	38.1	38.2	38.4	39.1	40.2	40.8	40.6	39.6
US	43.1	44.2	44.7	45.3	46.5	47.8	49.1	49.3

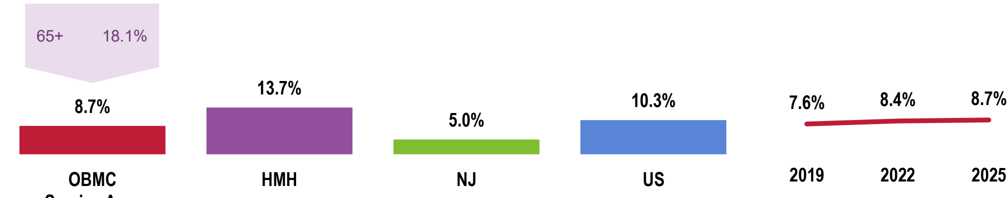
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Prevalence of Heart Disease & Stroke

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of Heart Disease

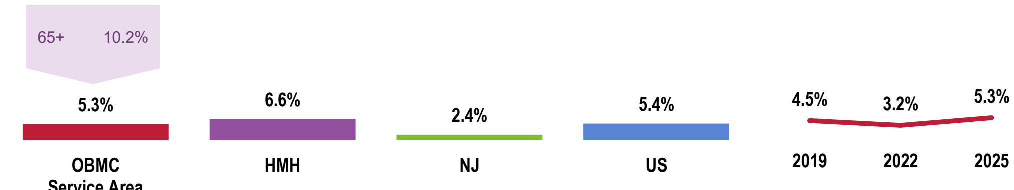
OBMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

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

PRC SURVEY ▶ "Have you ever suffered from or been diagnosed with a stroke?"



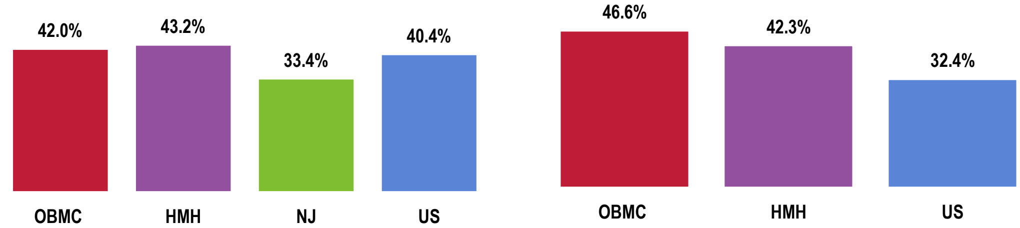
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 23]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

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

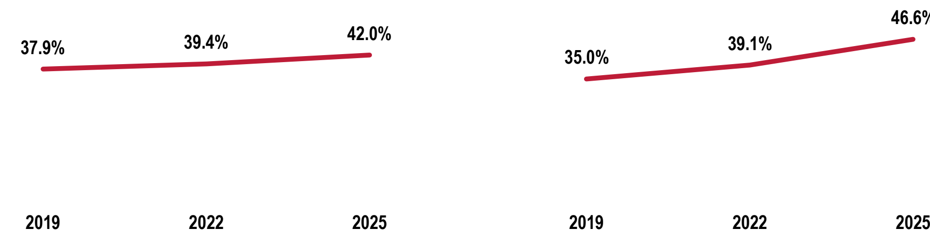
PRC SURVEY ▶ "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Prevalence of
High Blood Pressure
(OBMC Service Area)
Healthy People 2030 = 42.6% or Lower

Prevalence of
High Blood Cholesterol
(OBMC Service Area)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

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

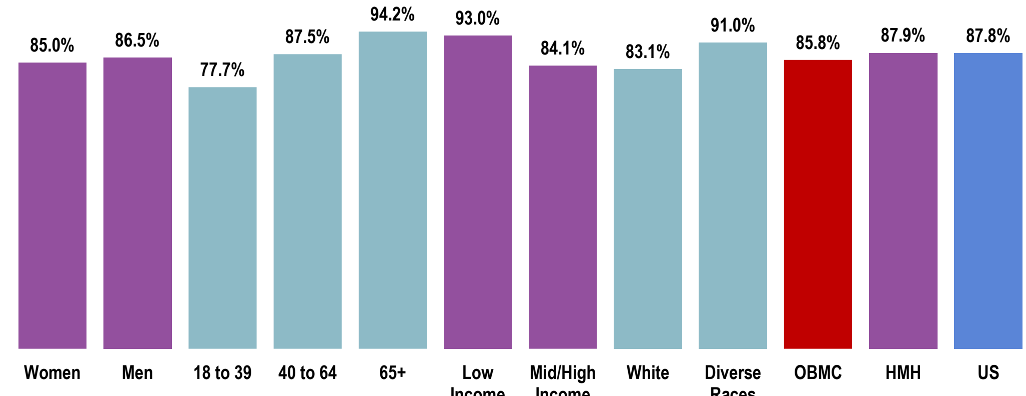
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

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

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

The following chart reflects the percentage of adults in the Old Bridge Medical Center Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

Exhibit One or More Cardiovascular Risks or Behaviors
(OBMC Service Area, 2025)



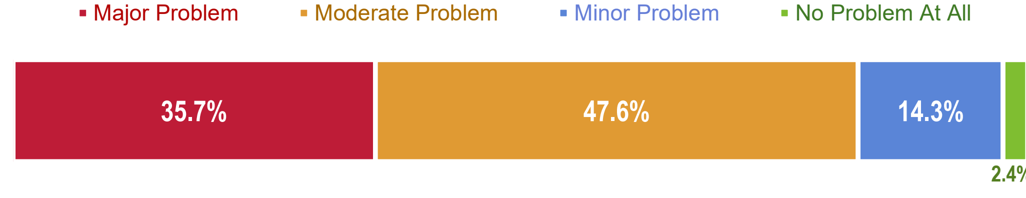
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 100]
• 2023 PRC National Health Survey, PRC, Inc.

Notes: • Reflects all respondents.
• Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

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

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2025)



Sources: • 2025 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

> The clients we work with often present with varying health problems and more often than not they share that someone in their family has heart disease. – Health Care Provider
>
> These are two of the major chronic diseases, not only in the Township, but also across the US. – Public Health Representative
>
> The number of people I speak to in the county who have it or have family/friends impacted. – Community Leader

Lifestyle

> Due to poor diet and lack of exercise and following up with doctors and medications. – Public Health Representative

Leading Cause of Death

> One of the leading causes of death in New Jersey. – Public Health Representative

Access to Care/Services

> SDOH, specifically access to healthcare, living in poverty, and education. – Public Health Representative

Obesity

> Many people in this community are overweight or obese, leading to higher incidence of heart disease and stroke (among many other health problems). Many people find it hard to follow a healthy diet and exercise regimen. Lifestyle medicine programs could really help with this. – Health Care Provider

Disease Management

> Failure to monitor and treat blood pressure, hyperlipidemia secondary to access to doctors and ability to afford medications. – Physician

Alcohol/Drug Use

> Families abuse drugs and alcohol. – Social Services Provider

Focus Group Input: Heart Disease & Stroke

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Delayed care/lack of access to primary care*
- *Poor nutrition and food insecurity*
- *Obesity*
- *Hypertension*
- *High costs of care*
- *Lack of culturally relevant health education*

Maternal & Infant Health Focus Groups:

- *Delayed care/lack of access to primary care*
- *Poor nutrition and food insecurity*
- *Obesity*
- *Hypertension.*
- *High costs of care*
- *Lack of culturally relevant health education*

Key Quotes:

Access & Utilization Focus Groups:

> "Limited access to primary and preventive care means that many residents delay seeking medical attention until conditions worsen. This leads to higher rates of chronic diseases like diabetes, hypertension, and heart disease." – Latinx Men Focus Group

Maternal & Infant Health Focus Groups:

> "Poor eating habits lead to obesity, high blood pressure, and diabetes." – Latinx Women Focus Group

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)

Cancer Deaths

The following chart illustrates cancer mortality (all types). [COUNTY-LEVEL DATA]

Cancer: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 122.7 or Lower

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	157.6	156.4	156.9	156.7	154.7	151.3	150.0	146.2
HMH	179.7	177.8	177.4	175.6	173.6	168.7	165.4	161.7
NJ	183.4	181.8	181.1	179.0	177.3	173.1	169.3	166.1
US	185.4	184.8	184.1	183.3	182.9	182.6	182.6	182.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Lung cancer is the leading cause of cancer deaths. [COUNTY-LEVEL DATA]

Age-Adjusted Cancer Death Rates by Site
(2021-2023 Annual Average Deaths per 100,000 Population)

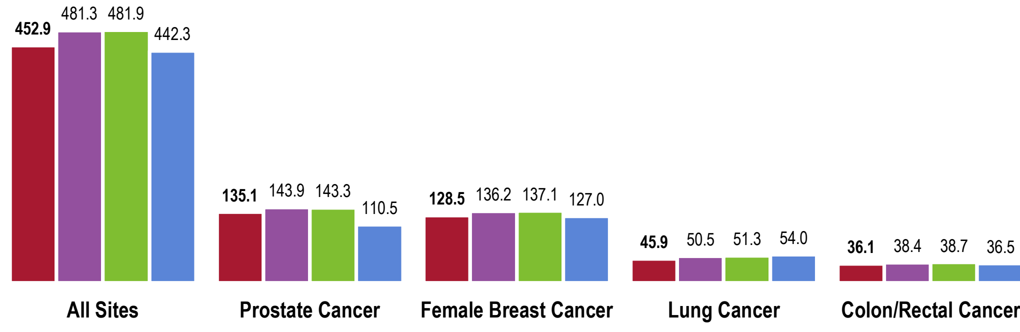
	OBMC Service Area	HMH	New Jersey	US	HP2030
ALL CANCERS	146.2	161.7	166.1	182.5	122.7
Lung Cancer	28.6	31.8	32.8	39.8	25.1
Female Breast Cancer	23.5	25.2	25.7	25.1	15.3
Colorectal Cancer	13.4	14.5	15.0	16.3	8.9
Prostate Cancer	13.1	16.6	17.0	20.1	16.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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. 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, 2016-2020)



Sources:
- National Cancer Institute, State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

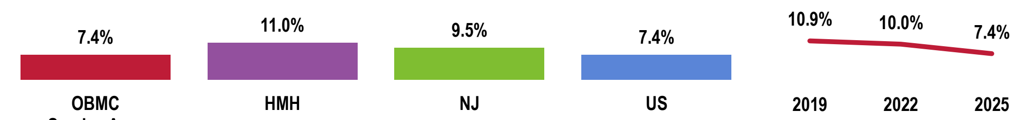
Notes:
- This indicator reports the incidence rate (cases per 100,000 population per year) for select cancers.

Prevalence of Cancer

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

Prevalence of Cancer

OBMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 24-25]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 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 age 21 to 29 years. For women age 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 45 years and continuing until age 75 years.

PROSTATE CANCER

The US Preventive Services Task Force (USPSTF) recommends that the decision to be screened for prostate cancer should be an individual one for men age 55 to 69 years. The USPSTF recommends against PSA-based screening in men age 70 and older.

– 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 the following cancer sites:

Breast Cancer

PRC SURVEY ▶ "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

PRC SURVEY ▶ "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

[If Pap test in the past five years] **"HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"**

"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.

Colorectal Cancer

PRC SURVEY ▶ “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?”

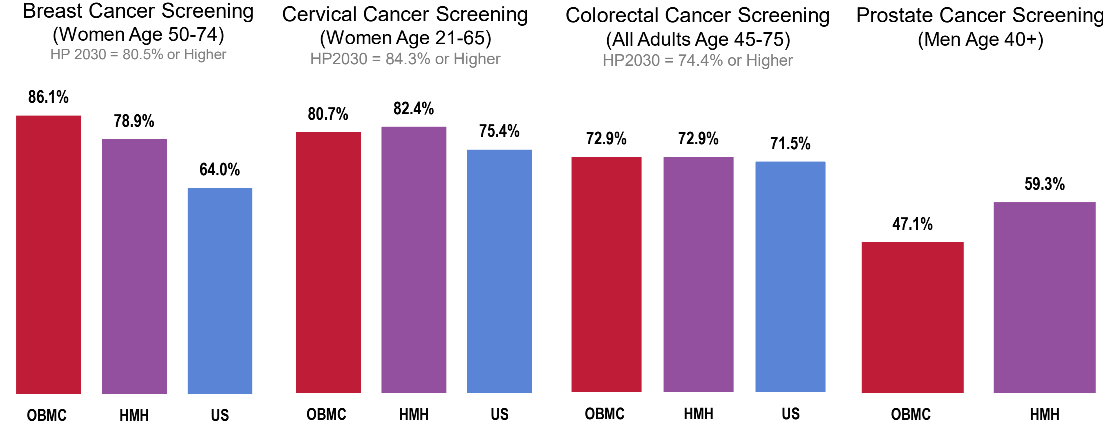
PRC SURVEY ▶ “A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?”

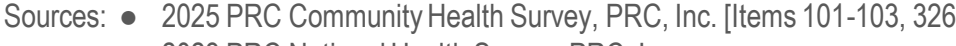
“Appropriate colorectal cancer screening” includes a fecal occult blood test among adults age 45 to 75 within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

Prostate Cancer

PRC SURVEY ▶ “A prostate-specific antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. How long has it been since you had your last PSA test?”

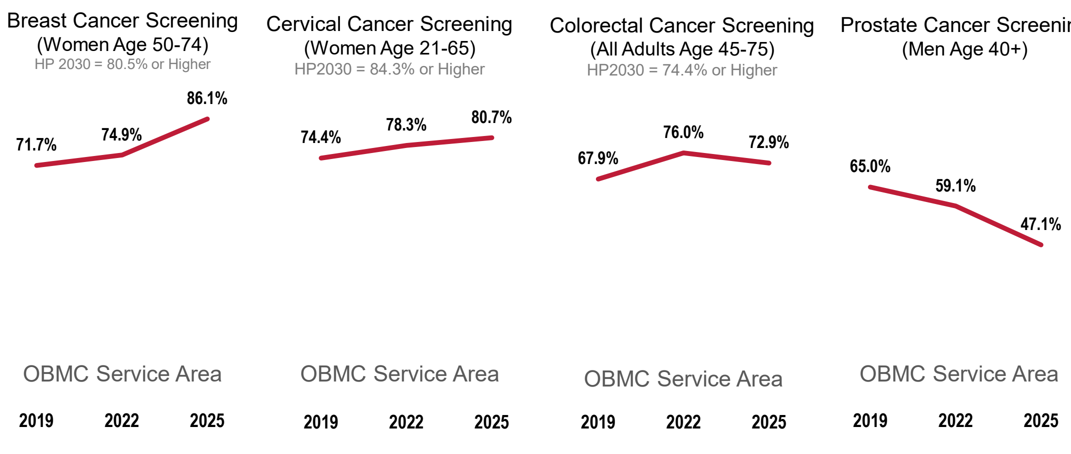
Prostate cancer screening reflects men age 40 and older who indicate a prostate-specific antigen test within the past 2 years.





Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103, 326]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that national data for colorectal cancer screening reflect adults ages 50 to 75.



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103, 326]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Lung Cancer

PRC SURVEY ▶ [Adults with a history of smoking] **"During the past 12 months, did you have a low-dose CT scan to check for lung cancer?"**

Lung cancer screening is calculated here among respondents age 55 to 80 with a history of smoking (defined as someone who smoked at least 20 packs of cigarettes per year at some point in the past 15 years).

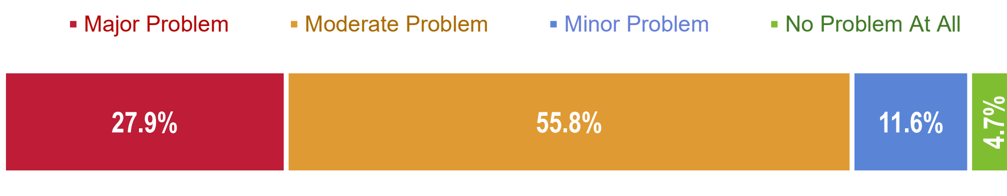
Lung Cancer Screening: Low-Dose CT Scan in the Past Year
(Age 55 to 80 with a History of Smoking)

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 325]
Notes: ● Reflects respondents age 55 to 80 with a history of smoking (defined as smoking more than 20 packs of cigarettes per year at any time in the past 15 years).

Key Informant Input: Cancer

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

Perceptions of Cancer as a Problem in the Community
(Key Informants, 2025)



Sources: ● 2025 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

> Over the past several years, instances have significantly increased that I am aware of. – Community Leader
>
> Know of too many people who have some form of cancer. – Community Leader
>
> The number of people I speak to in the county who have it or have family/friends impacted. – Community Leader
>
> One of the leading causes of death in New Jersey. – Public Health Representative
>
> Because of the high levels of cancer in the area. – Social Services Provider
>
> From hearing about it through people and their personal experiences. – Public Health Representative
>
> The number of cancer diagnoses seems to be increasing and becoming more widespread. Although services are available, it appears challenging to schedule appointments and get access to treatment. – Community Leader

Prevention/Screenings

> Cancer is a major problem due to accessing healthcare and screening services. There are known disparities, and some communities have lower access to preventative services, early detection and screenings. This would cause a rise in later stage diagnosing which can make the cancer harder to treat. – Social Services Provider
>
> Abnormal mammography follow up. Problem because of financial concerns and availability of timely care.
>
> – Health Care Provider

Focus Group Input: Cancer

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Prostate cancer screening and awareness*
- *Barriers to timely diagnosis and treatment*
- *Financial impact of cancer diagnosis*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *African American men*
- *Uninsured/underinsured individuals*

Key Quotes:

Access & Utilization Focus Groups:

> "Let people know that it's ok to go get healthy and tested, especially for the prostate. Some people don't know the prostate test is a blood test." – African American Men Focus Group
>
> "I earlier mentioned my Dad being diagnosed with prostate cancer, he was uninsured so we stalled, tried managing the symptoms until we were able to raise money and secure an appointment to meet with a specialist. By this time, other health issues popped up, kidney stones, cardiac arrest, psychological issues amongst others." – African American Men Focus Group

Respiratory Disease

ABOUT RESPIRATORY DISEASE

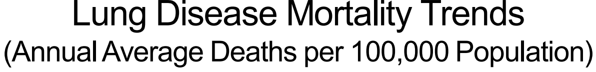
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million 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.

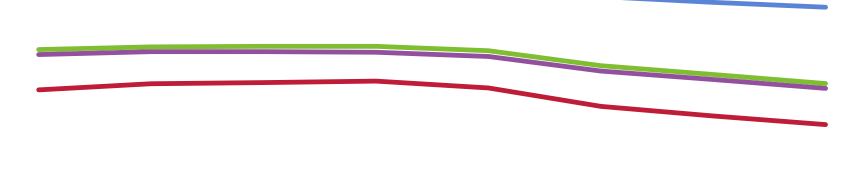
– Healthy People 2030 (https://health.gov/healthypeople)

Respiratory Disease Deaths

Lung 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 lung disease is illustrated in the following chart. [COUNTY-LEVEL DATA]





	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	26.4	27.7	27.9	28.2	26.8	23.0	21.0	19.2
HMH	33.7	34.3	34.3	34.2	33.3	30.3	28.5	26.7
NJ	34.7	35.3	35.4	35.4	34.5	31.4	29.6	27.7
US	47.4	48.4	48.6	48.6	47.6	45.7	44.5	43.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Pneumonia/Influenza Deaths

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

Pneumonia/Influenza Mortality Trends
(Annual Average Deaths per 100,000 Population)

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	12.9	13.3	14.4	15.1	16.0	14.7	13.9	12.2
HMH	13.4	13.9	14.3	14.8	16.0	14.7	14.0	11.9
NJ	14.3	14.7	14.9	15.2	16.4	15.1	14.4	12.4
US	17.0	16.9	17.0	16.8	16.5	14.7	14.3	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 April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

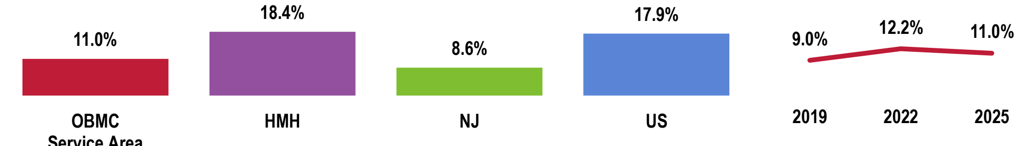
Prevalence of Respiratory Disease

Asthma

PRC SURVEY ▶ "Do you currently have asthma?"

Prevalence of Asthma

OBMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

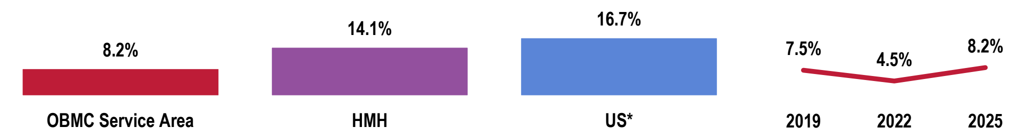
Notes:
- Asked of all respondents.

PRC SURVEY ▶ [Among parents of children age 0-17] **"Has a doctor, nurse, or other health professional ever told you that this child had asthma?"**

PRC SURVEY ▶ [Among parents of children with a past asthma diagnosis] **"Does this child still have asthma?"**

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

OBMC Service Area



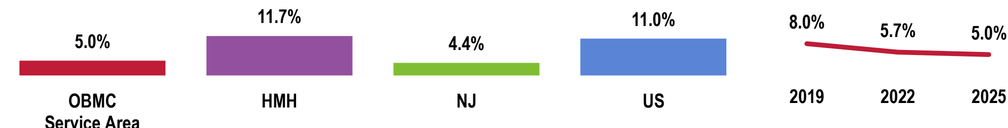
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 105]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.
● The US percentage reflects children who have ever been diagnosed with asthma and does not specify that the child still has asthma.

Chronic Obstructive Pulmonary Disease (COPD)

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

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)

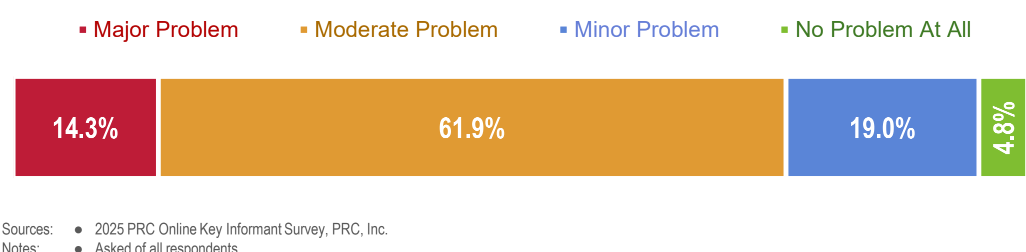
OBMC Service Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes conditions such as chronic bronchitis and 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:



Sources: • 2025 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

> There are high numbers of respiratory diseases throughout the state, including flu and COVID-19. – Public Health Representative
>
> We have a lot of people still sick with respiratory issues even though we are in February. – Community Leader

Tobacco Use

> We continue to see high use of nicotine and with the increase in stress we are concerned about an increase in use of cigarettes and vaping products. – Health Care 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.

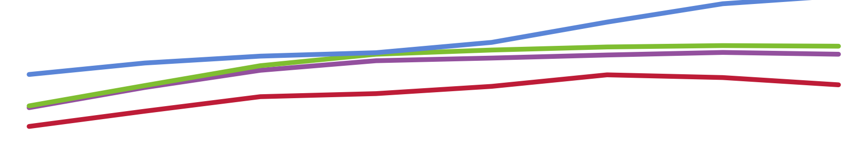
– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Unintentional Injury Deaths

The following chart outlines mortality rates for unintentional injury in the area. [COUNTY-LEVEL DATA]

Unintentional Injury Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 43.2 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	31.6	35.8	39.9	40.7	42.7	45.9	45.1	43.1
HMH	36.8	42.4	47.2	49.8	50.6	51.4	52.1	51.6
NJ	37.3	42.9	48.4	51.6	52.8	53.6	54.0	53.8
US	46.0	49.2	51.1	52.0	54.9	60.5	65.6	67.8

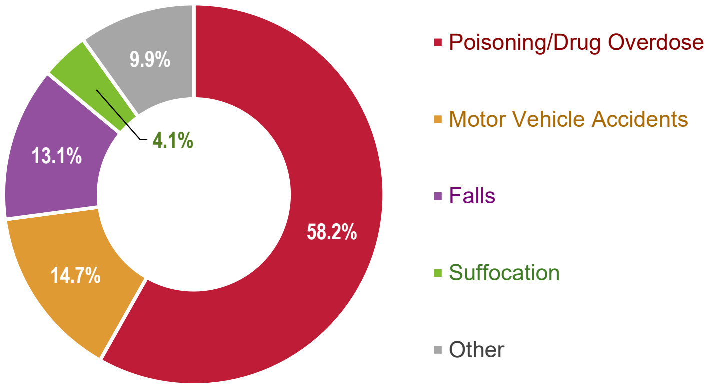
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Leading Causes of Unintentional Injury Deaths

The following outlines leading causes of accidental death in the area. [COUNTY-LEVEL DATA]

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

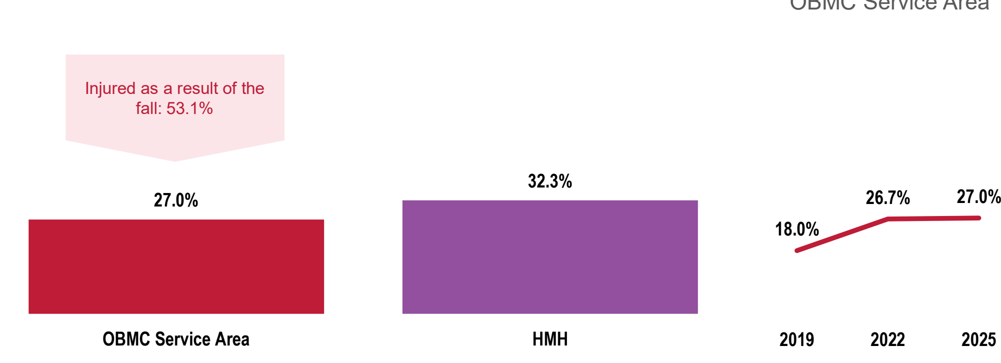


Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Falls

PRC SURVEY ▶ [Adults age 45 and older] **"In the past 12 months, how many times have you fallen?"**

PRC SURVEY ▶ [Adults Age 45 and older who have fallen] **"In the past 12 months, were you injured as the result of a fall?"**



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Items 308-309]
Notes: • Among respondents age 45 and older.

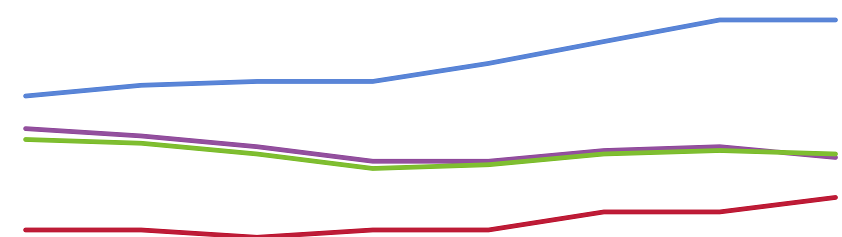
Intentional Injury (Violence)

Homicide Deaths

Mortality attributed to homicide is shown in the following chart. [COUNTY-LEVEL DATA]

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

Homicide Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	1.8	1.8	1.6	1.8	1.8	2.3	2.3	2.7
HMH	4.6	4.4	4.1	3.7	3.7	4.0	4.1	3.8
NJ	4.3	4.2	3.9	3.5	3.6	3.9	4.0	3.9
US	5.5	5.8	5.9	5.9	6.4	7.0	7.6	7.6

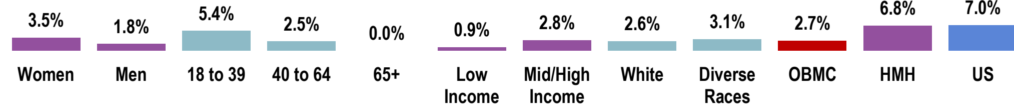
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Violent Crime Experience

PRC SURVEY ▶ "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"

Victim of a Violent Crime in the Past Five Years
(OBMC Service Area, 2025)



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 32]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Intimate Partner Violence

PRC SURVEY ▶ "The next question is about 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

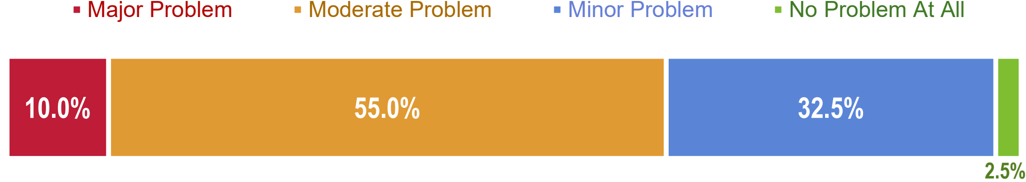
OBMC Service Area

Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 33]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

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

Perceptions of Injury and Violence as a Problem in the Community
(Key Informants, 2025)



Sources: • 2025 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

> Motor vehicle injury. Some communities in Middlesex County have more violence than others. Our service area included two small cities, Plainfield and Perth Amboy, with more violence than others. – Physician
>
> We see significant violet crime in the JFK SED. In addition, there is more violence at health care facilities between patients and caregivers. – Physician

Access to Care

> There is not a specific program that addresses community violence only for domestic and sexual violence. People that are hurt in the community due to stabbing, gunshot wounds, and robbery can't find support/ services in the community. Many immigrants are experiencing trauma and are suffering in silence.
> – Public Health Representative

Diabetes

ABOUT DIABETES

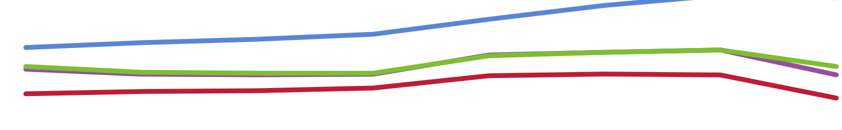
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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)

Diabetes Deaths

Diabetes mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	18.9	19.2	19.3	19.6	21.1	21.3	21.2	18.4
HMH	21.9	21.3	21.2	21.3	23.6	23.9	24.2	21.2
NJ	22.2	21.5	21.4	21.4	23.5	23.9	24.2	22.2
US	24.5	25.1	25.5	26.1	27.9	29.6	30.8	30.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Prevalence of Diabetes

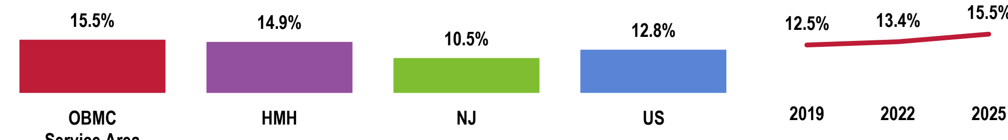
PRC SURVEY ▶ “Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?”

PRC SURVEY ▶ “Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?”

Prevalence of Diabetes

Another 14.9% of adults have been diagnosed with “pre-diabetes” or “borderline” diabetes.

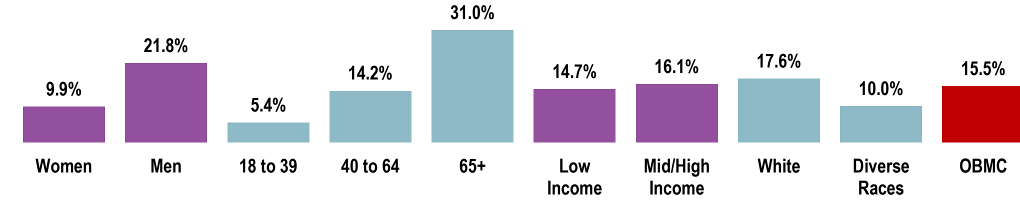
OBMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Prevalence of Diabetes
(OBMC Service Area, 2025)

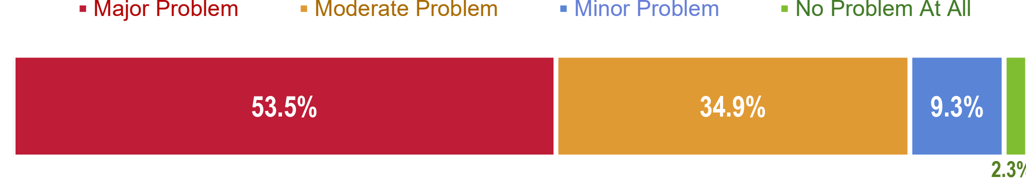


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 106]

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:



Sources: • 2025 PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

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

Awareness/Education

> Having access to programs to learn how to make lifestyle changes to reduce or reverse their pre-diabetes and/or diabetes diagnosis, rather than only getting medications to treat / control diabetes. I was diagnosed with being pre-diabetic but on the border of diabetic and prescribed Jardiance and told to "eat healthier." A year and a half later after making modifications to my diet and losing some weight, my A1C was still not where it should be. Through my work medical insurance, I was offered a program through Virta Health. Six months after starting the program, my A1C is normal, my glucose is under control and have lost 45lbs. There should be more programs available like this, or doctors should be more aware of available programs to guide their patients to.
> – Community Leader
>
> Lack of understanding the correlation between food and their health is one of two big barriers. Affordability of healthy food is the second big problem. Access to low quality food is easier due to cost and accessibility.
>
> – Health Care Provider
>
> Health literacy and health education that can address their chronic condition in their native language and also food traditions and practices. They also need access to healthy food and places they can exercise.
> – Public Health Representative
>
> Education and support around how to combat diabetes. Support groups and organizations that support pre-diabetes programming. – Community Leader
>
> No understanding how to eat healthy. Resources to buy the appropriate food. – Social Services Provider

Nutrition

> Their diet, culturally, and lack of awareness of nutrition and exercise. – Community Leader
>
> Access to proper nutrition and foods that meet dietary restrictions. – Community Leader
>
> Overcoming the prevalent use of ingredients that increase diabetes in everyday food sales. Continuing encouragement of exercise, nutrition, and responsible weight loss and maintenance of targets for body weight.
>
> – Community Leader

Affordable Medications/Supplies

> The cost of medication and cost of eating to maintain a diet to benefit diabetes. – Public Health Representative
>
> Access to needed medications for all patients. – Physician
>
> The biggest challenges are for those who are undocumented being able to get medication on a regular basis. Now more than ever, accessing care where they feel safe. – Community Leader
>
> Keeping their diabetes under control with an affordable medicine. – Social Services Provider

Obesity

> The overweight problem is causing a lot of people suffering from diabetes. – Social Services Provider
>
> Many people in this community are overweight or obese, leading to higher incidence of diabetes (among many other health problems). Many people don't fully understand their condition, its management, and find it hard to follow a diet and exercise regimen. Lifestyle medicine programs could really help with this.
> – Health Care Provider

Access to Care/Services

> Access to care, healthy foods, and education. – Public Health Representative

Access to Affordable Healthy Food

> Access to healthy food, if food insecure or culturally not taught to cook healthy foods. – Community Leader

Aging Population

> Senior disabled population. Don't always eat or cook healthy. – Social Services Provider

Follow-Up/Support

> Ability to follow up on their blood sugars and to afford medications. Access to providers. – Physician

Lifestyle

> Changing their lifestyle which includes exercise, healthy eating, and following up with the right medications and physicians. – Public Health Representative

Disabling Conditions

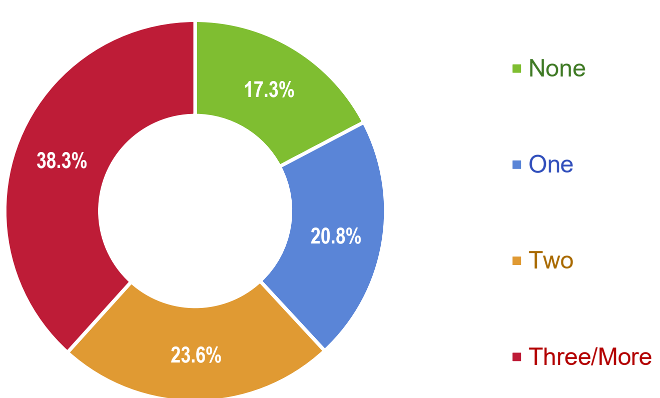
Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

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

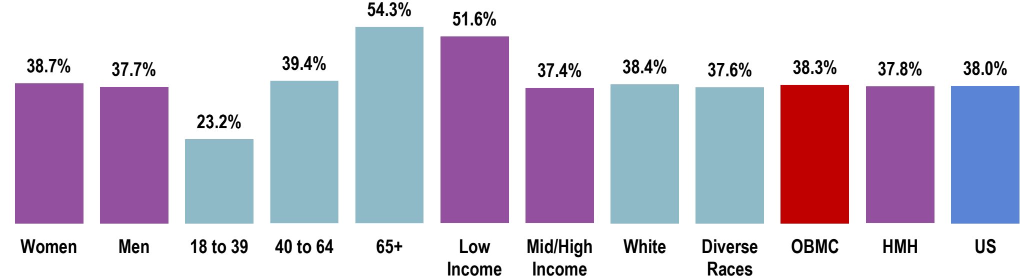
The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

Number of Current Chronic Conditions
(OBMC Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: ● Asked of all respondents.
● In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.

Currently Have Three or More Chronic Conditions
(OBMC Service Area, 2025)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 107]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and/or stroke.

Activity Limitations

ABOUT DISABILITY & HEALTH

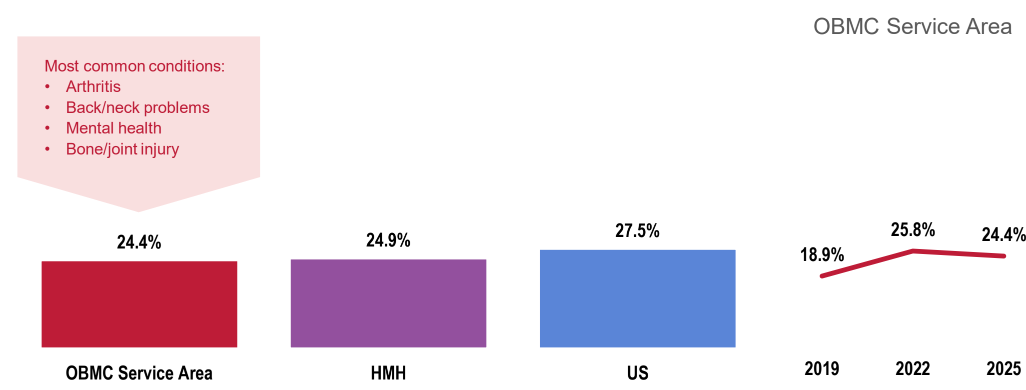
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

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)

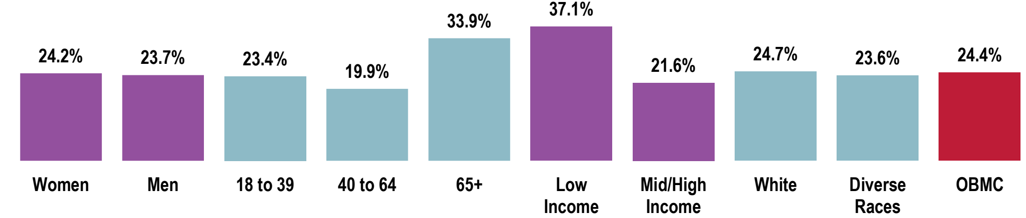
PRC SURVEY ▶ **"Are you limited in any way in any activities because of physical, mental, or emotional problems?"**

PRC SURVEY ▶ [Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem
(OBMC Service Area, 2025)

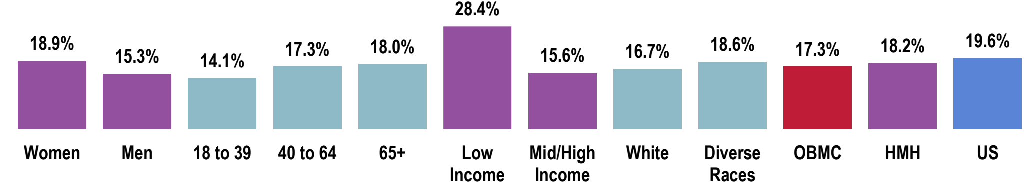


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: • Asked of all respondents.

High-Impact Chronic Pain

PRC SURVEY ▶ "Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?" (Reported here among those responding "most days" or "every day.")

Experience High-Impact Chronic Pain
(OBMC Service Area, 2025)
Healthy People 2030 = 6.4% or Lower



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 31]
• 2023 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Asked of all respondents.
• High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Alzheimer's Disease

ABOUT DEMENTIA

Alzheimer's disease is the most common cause of dementia…. 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.

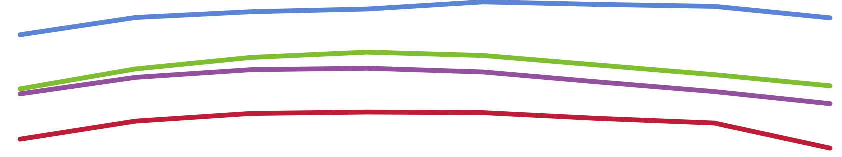
While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address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

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

Alzheimer's Disease Deaths

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

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	17.0	19.8	21.0	21.2	21.1	20.2	19.5	15.6
HMH	24.0	26.6	27.8	28.0	27.4	25.9	24.4	22.5
NJ	24.8	27.9	29.7	30.5	30.0	28.5	27.0	25.3
US	33.2	35.9	36.8	37.2	38.3	37.9	37.6	35.8

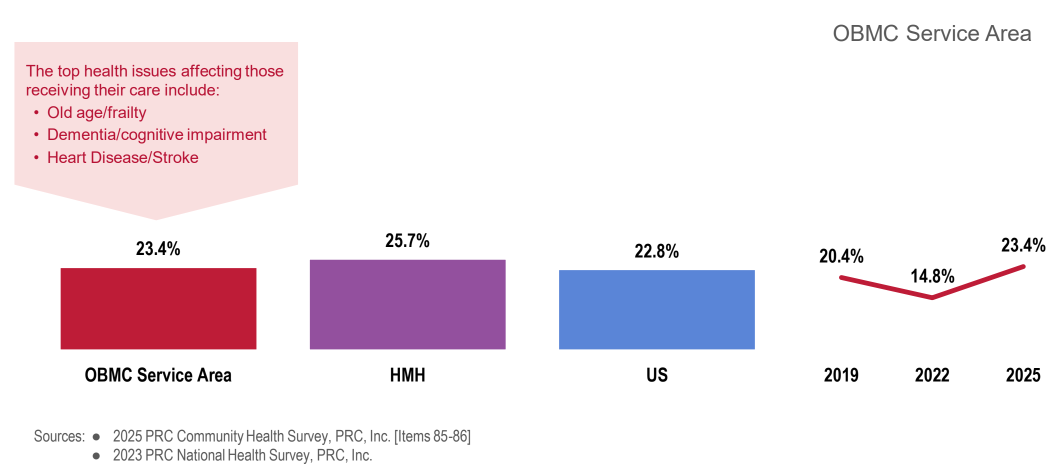
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Caregiving

PRC SURVEY ▶ "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?"

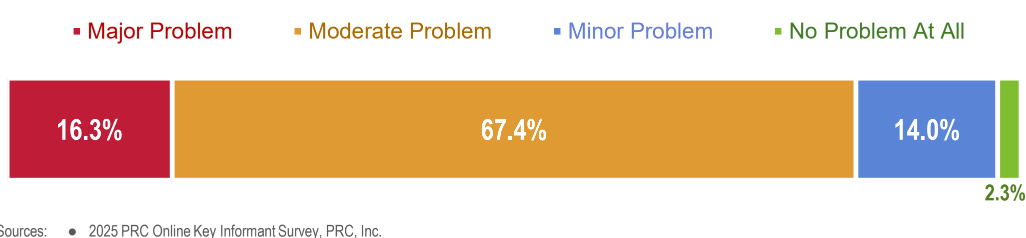
PRC SURVEY ▶ [Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 85-86]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Disabling Conditions

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



Sources: ● 2025 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

> With a growing senior population, these issues have become more pronounced in recent years. – Public Health Representative
>
> 80% of the elderly population has a major problem with self-care due to the disability. Causes multiple falls with injury, increasing the communication with dementia. I see residents discharged from hospital, send home by taxi and dying on the steps or corridor. – Health Care Provider

Access to Care/Services

> Volume of them and limited resources to care for them. – Physician

Incidence/Prevalence

> Dementia and Alzheimer's seems to be becoming more and more prevalent. – Community Leader

Built Environment

> Our community would benefit accessibility to buildings, stores, and especially homes. – Social Services Provider

Focus Group Input: Disabling Conditions

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Dementia care and support*
- *Support for individuals with disabilities*
- *Caregiver burden*
- *Respite care needs*
- *Fear and uncertainty about disease progression*
- *Caregivers unable to leave loved ones*
- *Behavior issues with dementia patients*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *Elderly individuals with dementia*
- *Caregivers*
- *LGBTQ+ individuals with disabilities*
- *Neurodivergent individuals*

Key Quotes:

Access & Utilization Focus Groups:

> "My husband was diagnosed [with dementia] in July…there are lots of things happening with him…we talk about disease process and fear of the unknown, what's happening down the road." – Caregivers Focus Group
>
> "Respite is a big thing…people come to the house and provide relief, help with grocery shopping, get prescriptions." – Caregivers Focus Group
>
> "With disabilities, sometimes you're even ignored by some health care providers…probably to them you're not that important." – LGBTQ+ Focus Group
>
> "We need support for dementia patients as they are diagnosed." – Caregivers Focus Group
>
> "Caregivers that can't leave their loved one [face challenges]." – Caregivers Focus Group
>
> "Caregivers want to bring their loved ones with dementia to support groups, and they can't." – Caregivers Focus Group
>
> "People with dementia may have behavior issues, being on the bus and acting out, fear of where they are going, it can be dangerous. Caregivers can't get away and there is a lot of stress and a big impact on mental health." – Caregivers Focus Group
>
> "People with disabilities may face barriers related to inaccessible health care facilities, communication barriers, and lack of disability-specific care." – LGBTQ+ Focus Group
>
> "There's a fear of the unknown…we don't know how long people [with dementia] have and just go day by day." – Caregivers Focus Group

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.

This indicator reports the percentage of women who did not receive prenatal care during their first trimester of pregnancy. This indicator can signify a lack of access to preventive care, a lack of health knowledge, or other barriers to services. [COUNTY-LEVEL DATA]

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

	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	23.7%	24.1%	23.0%	23.2%	23.6%	25.1%
HMH	24.1%	24.3%	24.0%	23.8%	24.1%	24.4%
NJ	23.6%	23.7%	23.5%	23.2%	23.2%	23.5%
US	22.7%	22.5%	22.4%	22.6%	22.5%	22.3%

Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Note: • This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy.

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, 2017-2023)

Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

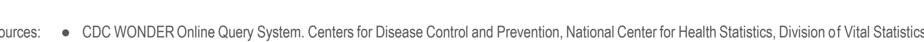
Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than 1 year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health. [COUNTY-LEVEL DATA]

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

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
OBMC	3.7	3.5	3.6	3.6	3.6
HMH	4.4	4.5	4.2	4.2	4.0
NJ	4.4	4.4	4.1	4.2	4.0
US	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 April 2025.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- This indicator reports deaths of children under 1 year old per 1,000 live births.

Focus Group Input: Maternal & Infant Mortality

Biggest Issues, Challenges, and Barriers:

Maternal & Infant Health Focus Groups:

- *Maternal mortality (especially for Black women)*
- *Infant mortality*

Sub-Populations with Health Care Access Barriers:

Maternal & Infant Health Focus Groups:

- *Black women and infants*
- *Low-income populations*

Key Quotes:

Maternal & Infant Health Focus Groups:

> "African American women/infants face higher mortality rates than those of other races." – African American Women Focus Group
>
> "I was terrified to go to a hospital in NYC to have baby and receive prenatal care…I had heard horror stories of what has happened to women in NYC." – African American Women Focus Group
>
> "The high maternal and infant mortality rates have social, emotional and economic consequences. The trauma, family and economic strain and erosion of trust in institutions have a huge impact." – African American Women Focus Group

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

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior. [COUNTY-LEVEL DATA]

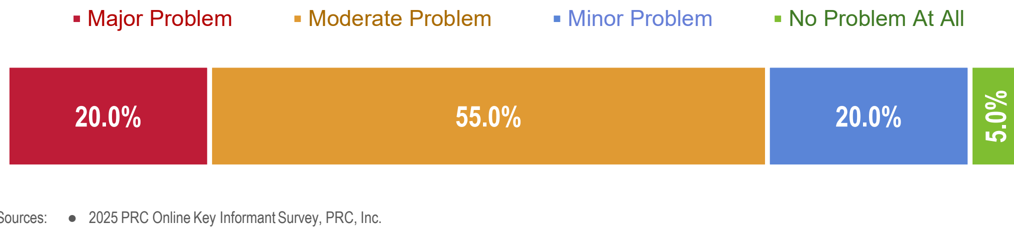
Teen Birth Rate
(Births to Adolescents Age 15-19 per 1,000 Females Age 15-19, 2017-2023)

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 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.

Key Informant Input: Infant Health & Family Planning

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



Sources: • 2025 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

> Limited access to care for infants, immunizations and limited family planning care available. – Physician
>
> I believe family planning is a major problem in the community because not all families are familiar with all of their options and are used to more hospitalized settings. Access to prenatal care can sometimes be difficult as well as ultrasound and appointments leading up to birth. – Public Health Representative

Vulnerable Populations

> We have a large population of new Americans with limited access to services and we need to continue providing these critical services to all. – Health Care Provider

Income/Poverty

> We serve a low income area who has difficulty accessing care, sometimes their own choice/unwillingness and an inability to understand/afford prenatal care. – Physician

Childhood Screenings

> Infant health is the foundation for a child's development. If an infant does not receive the medical services they need early on, overall development can be impacted negatively setting the stage for developmental delays/issues. – Health Care Provider

Affordable Care/Services

> Access to affordable and timely family planning services. – Public Health Representative

Focus Group Input: Infant Health & Family Planning

Biggest Issues, Challenges, and Barriers:

Maternal & Infant Health Focus Groups:

- *Limited access to prenatal care*
- *Premature births*
- *Breastfeeding challenges*
- *Lack of specialized care for high-risk pregnancies*
- *Postpartum preeclampsia*
- *Limited postpartum care*

Sub-Populations with Health Care Access Barriers:

Maternal & Infant Health Focus Groups:

- *Black mothers and infants*
- *Undocumented immigrants*
- *Low-income families*

Key Quotes:

Maternal & Infant Health Focus Groups:

> "So many peers end up with postpartum preeclampsia…it's just way too prevalent." – African American Women Focus Group
>
> "Breastfeeding support and resources may be limited in some communities, contributing to lower breastfeeding rates, which is an infant health concern." – African American Women Focus Group
>
> "Premature births are a significant concerns, particularly in communities with limited access to prenatal care and other resources." – African American Women Focus Group
>
> "I believe it's important to have specialized care readily available for newborn babies, childbirth education, and care for high risk pregnancies." – African American Women Focus Group
>
> "Many women, especially in underserved populations, face barriers to receiving timely and continuous care which can lead to complications during pregnancy, labor, and recovery, as well as challenges in the postpartum period." – African American Women Focus Group
>
> "If trained nurses or therapists can visit families at home to provide medical care, guidance and support for families with premature or high risk babies, it'll be better and help navigate challenges they face and ensure the best possible outcomes for their little ones." – African American Women Focus Group
>
> "We need a more consistent midwife team." – African American Women Focus Group

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.

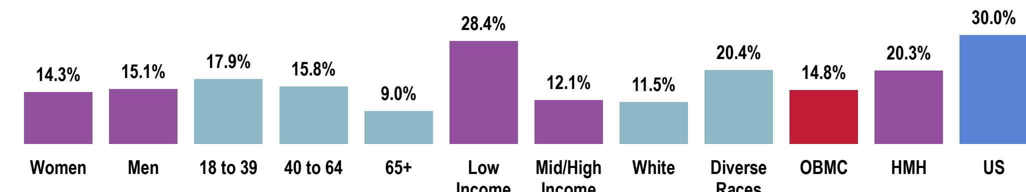
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Access to Fresh Produce

PRC SURVEY ▶ "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
(OBMC Service Area, 2025)



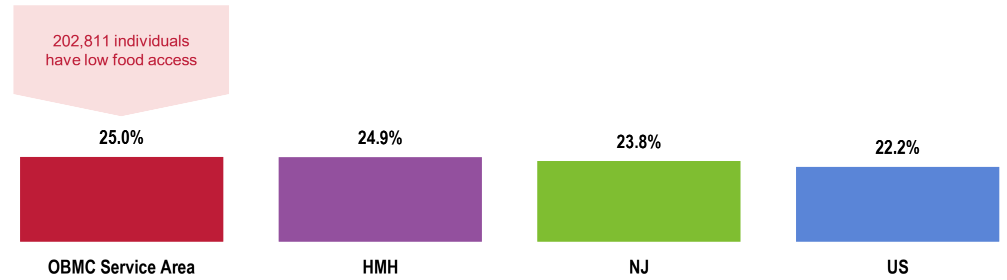
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Low Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). 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 April 2025 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living far (more than 1 mile in urban areas, more than 10 miles in rural areas) from the nearest supermarket, supercenter, or large grocery store.

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.

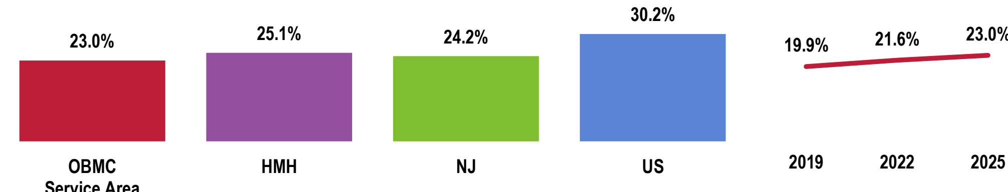
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

PRC SURVEY ▶ "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

"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.

– 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:

PRC SURVEY ▶ "During the past month, what type of physical activity or exercise did you spend the most time doing?"

PRC SURVEY ▶ "And during the past month, how many times per week or per month did you take part in this activity?"

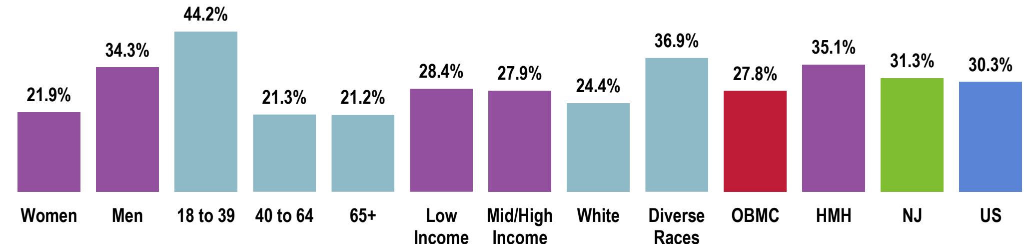
PRC SURVEY ▶ "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

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:

PRC SURVEY ▶ "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."

Meets Physical Activity Recommendations
(OBMC Service Area, 2025)
Healthy People 2030 = 29.7% or Higher



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): BRFSYR ST8 data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

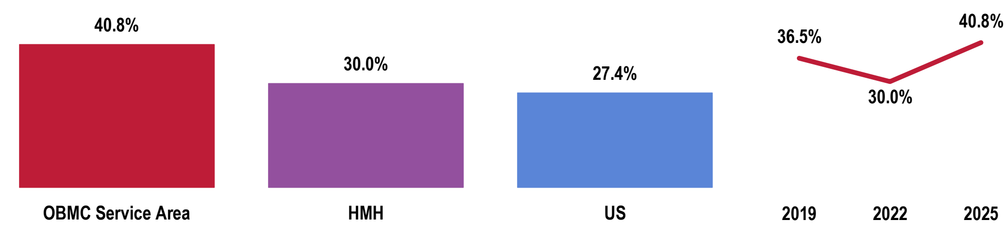
CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

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

PRC SURVEY ▶ [Among parents of children age 2-17] **"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"**

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



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 94]
● 2023 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
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

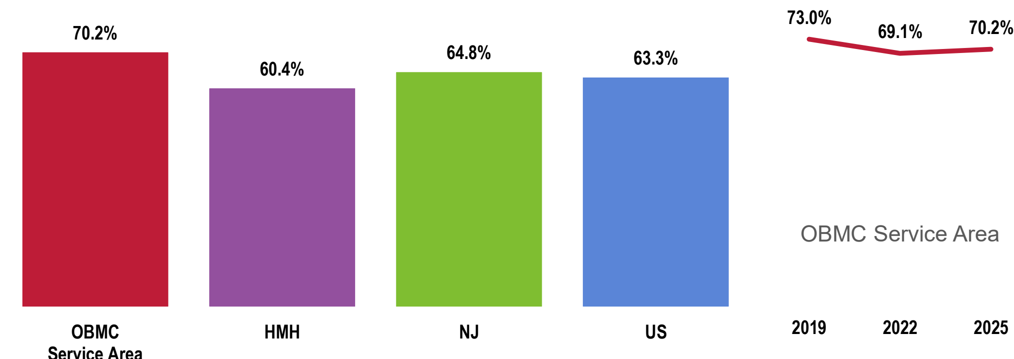
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

PRC SURVEY ▶ “About how much do you weigh without shoes?”

PRC SURVEY ▶ “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)



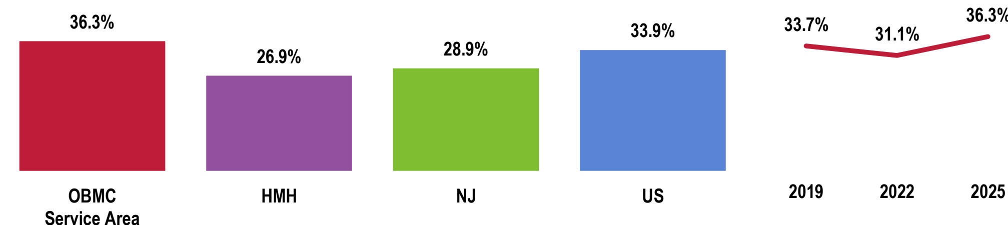
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, 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. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

Healthy People 2030 = 36.0% or Lower

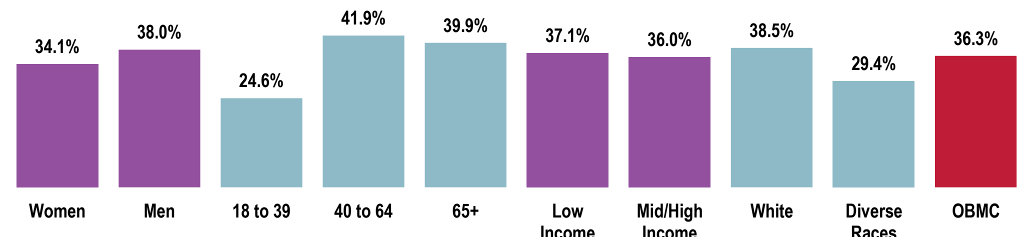
OBMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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.

Prevalence of Obesity
(OBMC Service Area, 2025)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

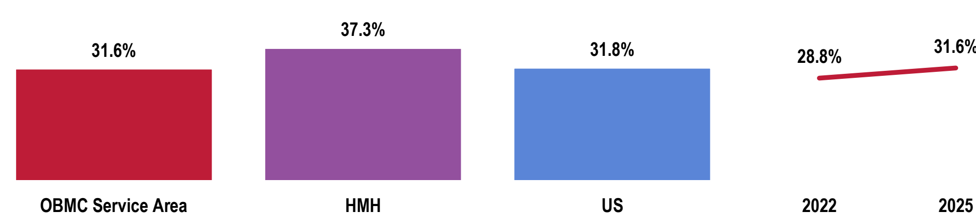
– Centers for Disease Control and Prevention

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

PRC SURVEY ▶ [Among parents of children age 5-17] **"How much does this child weigh without shoes?"**

PRC SURVEY ▶ [Among parents of children age 5-17] **"About how tall is this child?"**

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



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 5-17 at home.
● Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

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

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, 2025)

Sources: ● 2025 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:

Obesity

Many people in this community are overweight or obese, leading to higher incidence of heart disease and stroke, diabetes, hypertension, hyperlipidemia, etc. Many people find it hard to follow a healthy diet and exercise regimen because of cost, struggles with motivation for change, psychological factors, or other social factors. There needs to be more of a push for lifestyle change as a means of prevention and reversal of many health concerns in our community. Physicians need to be trained in this, community stakeholders need to support lifestyle medicine changes, and HMH should consider starting a Lifestyle Medicine Programs in this county. – Health Care Provider

National issue of obesity. Poor dietary habits and sedentary lifestyle. – Physician

We continue to see residents who are obese but limited resources makes it difficult for families to have access to nutritionist and access to health affordable food. – Health Care Provider

Increased weight, increases in BMI are prevalent leading to a host of diseases starting with metabolic syndrome. Lack of physical activity is definitely a contributor, but food choices and availability are issues common as well. – Community Leader

Obesity and diabetes are very common. – Physician

Childhood and adolescent obesity and I believe this is due to the internet, overuse of cell phones, and poor eating habits. – Public Health Representative

Nutrition

> Cooking healthy, regular access to nutritious foods. There are pockets in the county that have great access and others that do not, care and medications to address obesity, free physical activities on a consistent basis.
> – Community Leader
>
> The Indian diet is high in fatty, fried foods. Lots of dairy and sauces/oils. Some are also mostly vegetarian and not getting protein with each meal. We have many people who come into the Y without eating before workout. They are not aware of nutrition guidelines. – Community Leader
>
> Community unable to afford nutritious, whole foods. Lack of free adult physical activity resources.
> – Community Leader
>
> Everything that is healthy is expensive. Also not knowing the difference. – Social Services Provider
>
> There are many factors that create challenges related to nutrition, physical activity, and weight for people. One of them is accessibility to healthy foods as well as fitness options. They may have limited access to fresh produce, supermarkets and maybe can't afford it even if they were accessible. As for the physical activity, this can be a financial challenge for low income families. – Social Services Provider

Awareness/Education

> Misinformation related to nutrition. More tabling events by the hospital and workshops for the public for nutrition topics may be helpful. Safe spaces for activity, especially in the winter months. Weight loss programs /Lifestyle change programs for chronic disease prevention and support groups must be offered.
> – Public Health Representative
>
> The lack of educating young people to take better care of themselves. – Community Leader

Cultural/Personal Beliefs

> Different cultures here have different ways of cooking that are not considered healthy. Activity in a sedentary society is harder, especially if you do not have the funds to go to a gym, nutritionist, etc. – Community Leader
>
> Culture and what people eat in certain culture, a heavier weight being a sign of better health in some cultures and lack of physical activity due to a sedentary lifestyle. – Public Health Representative

Insufficient Physical Activity

> Lack of mobility, lack of healthy food products due to cost and lack of gym membership due to cost.
> – Public Health Representative

Lifestyle

> Getting people to be willing to invest time in nutrition and exercise programs, as well as having the determination to get involved in these. – Public Health Representative

GLP-1 Medications

> Access to weight loss medications that are covered by insurance. NJ Family Care/Medicaid does not cover any weight loss medication for even those who are morbidly obese. – Community Leader

Disease Management

> Willingness to seek help and access to too many unhealthy food choices. – Community Leader

Focus Group Input: Nutrition, Physical Activity & Weight

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Access to healthy food*
- *Affordability of nutritious options*
- *Sodium content in processed foods*
- *Connections between nutrition and chronic disease*
- *Poor eating habits*
- *Obesity*

Maternal & Infant Health Focus Groups:

- *Limited access to healthy foods*
- *Poor eating habits*
- *Obesity*
- *Need for education on nutrition*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *Latinx community members*
- *Low-income individuals*
- *Families reliant on food assistance*

Maternal & Infant Health Focus Groups:

- *Low-income families*
- *Families reliant on food assistance*

Key Quotes:

Access & Utilization Focus Groups:

> "Processed foods and high sodium [are an issue]." – Latinx Men Focus Group
>
> "[Unhealthy eating is] linked to chronic diseases." – Latinx Men Focus Group
>
> "Affordability of healthy food [is an issue]." – Latinx Men Focus Group
>
> "What would it look like if we had access to these healthier foods?" – Latinx Men Focus Group
>
> "Our ancestors didn't have access to 'junk'...we eat less healthily compared to what they are used to." – Latinx Men Focus Group

Maternal & Infant Health Focus Groups:

> "As moms, we set the example. If we had better access and education, we could model healthier habits for our kids." – Latinx Women Focus Group
>
> "[We need] education for better eating, better Eating Habits, Environmental." – Latinx Women Focus Group
>
> "Poor eating habits lead to obesity, high blood pressure, and diabetes." – Latinx Women Focus Group
>
> "Obesity, high blood pressure, anxiety, depression, and lead poisoning [are issues]." – Latinx Women Focus Group

Substance Use

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.

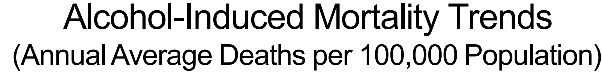
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

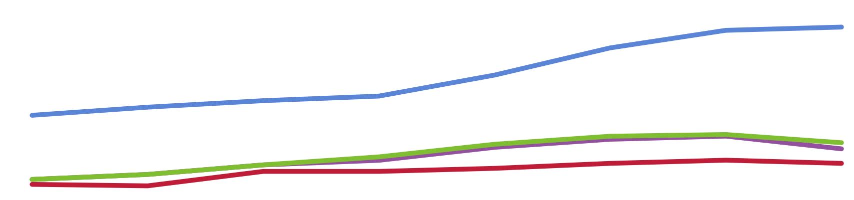
– Healthy People 2030 (https://health.gov/healthypeople)

Alcohol

Alcohol-Induced Deaths

The following chart outlines alcohol-induced mortality in the area. [COUNTY-LEVEL DATA]





	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	5.9	5.8	6.7	6.7	6.9	7.2	7.4	7.2
HMH	6.2	6.5	7.1	7.4	8.2	8.7	8.9	8.1
NJ	6.2	6.5	7.1	7.6	8.4	8.9	9.0	8.5
US	10.2	10.7	11.1	11.4	12.7	14.4	15.5	15.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Excessive Drinking

PRC SURVEY ▶ "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?"

PRC SURVEY ▶ "On the day(s) when you drank, about how many drinks did you have on average?"

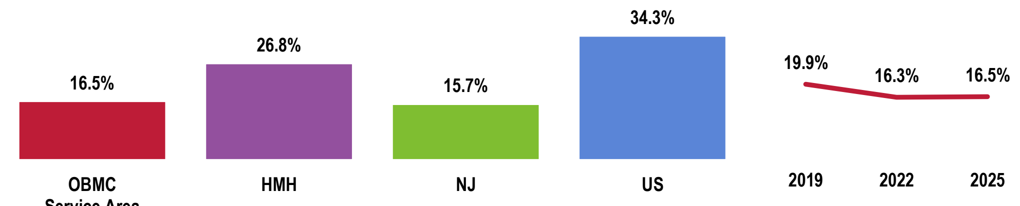
PRC SURVEY ▶ "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive drinking includes heavy and/or binge drinkers:

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

Engage in Excessive Drinking

OBMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

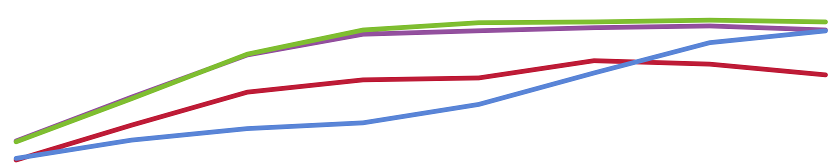
Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drugs

Unintentional Drug-Induced Deaths

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

Unintentional Drug-Related Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
OBMC	14.1	18.3	22.3	23.8	24.0	26.1	25.7	24.4
HMH	16.4	21.7	26.8	29.3	29.7	30.1	30.3	29.8
NJ	16.3	21.5	26.9	29.8	30.7	30.8	31.0	30.8
US	14.3	16.5	17.9	18.6	20.8	24.6	28.3	29.7

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
Notes: • Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
• Rates are per 100,000 population.

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.

PRC SURVEY ▶ "During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

PRC SURVEY ▶ "Have you ever sought professional help for an alcohol or drug-related problem?"

Illicit Drug Use in the Past Month

5.4% of respondents report that they have sought professional help for an alcohol or drug-related problem at some point in their lives.

OBMC Service Area

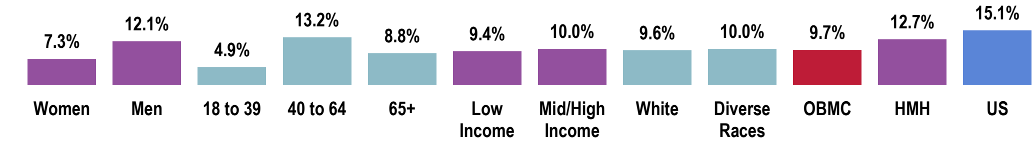
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Items 40, 42]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

PRC SURVEY ▶ "Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"

Used a Prescription Opioid in the Past Year
(OBMC Service Area, 2025)

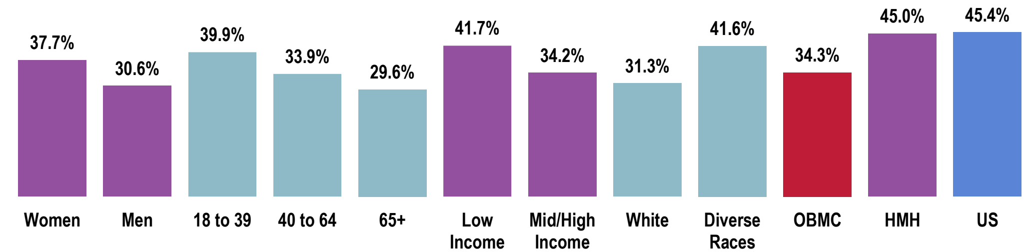


Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 41]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Personal Impact From Substance Use

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

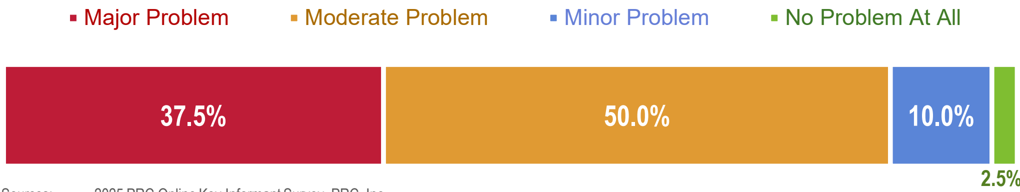
Life Has Been Negatively Affected
by Substance Use (by Self or Someone Else)
(OBMC Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
• 2023 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.
• Includes response of "a great deal," "somewhat," or "a little."

Key Informant Input: Substance Use

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



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

Access to Care/Services

> Cost, stigma and lack of support systems. – Public Health Representative
>
> The demand for services exceeds the available supply. – Community Leader
>
> Limited resources. – Physician
>
> They are sometimes overcrowded and sometimes people need to have health insurance or pay for facilities. – Public Health Representative

Denial/Stigma

> Stigma, lack of harm reduction resources, drug adulterants such as fentanyl and xylazine. – Public Health Representative
>
> Possibly the stigma associated with people using them, as well as transportation to these resources. – Public Health Representative

Lack of Providers

> Barrier of getting the person that they need the help. – Health Care Provider
>
> Limited providers. – Physician

Alcohol/Drug Use

> Amount of illegal drugs in the community. – Community Leader

Focus Group Input: Substance Use

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Substance abuse treatment accessibility*
- *Insurance coverage for substance abuse treatment*
- *Lack of LGBTQ+-friendly substance abuse services*
- *Stigma surrounding substance use*
- *Environmental exposure to substances*

Maternal & Infant Health Focus Groups:

- *Environmental exposure to substances*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *African American men*
- *LGBTQ+ individuals*
- *Low-income individuals*

Key Quotes:

Access & Utilization Focus Groups:

> "There are a lot of complications with insurance coverage and substance abuse inpatient programs." – African American Men Focus Group
>
> "Drug and substance abuse is neglected in health care systems." – African American Men Focus Group
>
> "Expand substance abuse treatment programs, including harm reduction initiatives and rehabilitation services." – LGBTQ+ Focus Group
>
> "We need LGBTQ+-friendly substance abuse treatment: substance abuse treatment programs that cater to the LGBTQ+ individual, addressing issues like addiction, trauma, and mental health." – LGBTQ+ Focus Group
>
> "The lack of substance use treatment options and stigma surrounding these issues contributes to homelessness, crime, and public health concerns." – Latinx Men Focus Group
>
> "One thing that we need is substance abuse services." – Latinx Men Focus Group
>
> "Many people struggle with depression, anxiety, trauma, and substance use, but LGBTQIA friendly services are limited…improving mental health and substance use services would be great." – LGBTQ+ Focus Group

Maternal & Infant Health Focus Groups:

> "The environment where we live, people smoke, and there are all kinds of substances on the street." – Latinx Women Focus Group

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.

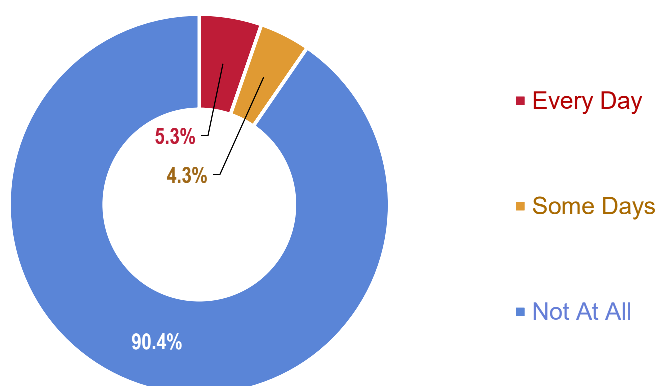
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

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

Cigarette Smoking

PRC SURVEY ▶ "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")

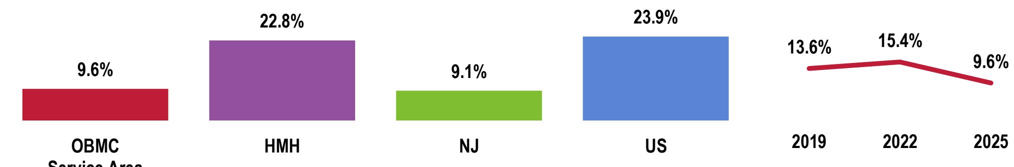
Cigarette Smoking Prevalence
(OBMC Service Area, 2025)



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: • Asked of all respondents.

Currently Smoke Cigarettes
Healthy People 2030 = 6.1% or Lower

OBMC Service Area



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
• 2023 PRC National Health Survey, PRC, Inc.
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Asked of all respondents.
• Includes those who smoke cigarettes every day or on some days.

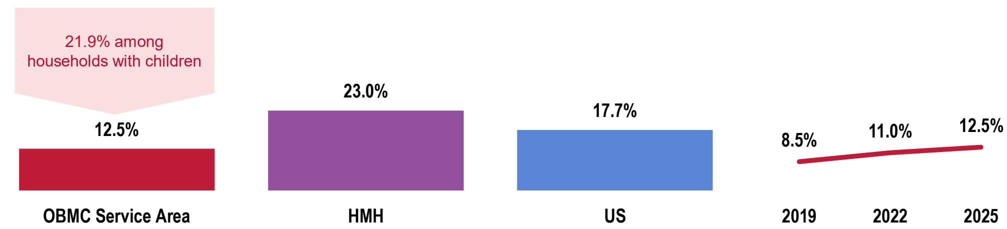
Environmental Tobacco Smoke

PRC SURVEY ▶ "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

OBMC Service Area



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
● 2023 PRC National Health Survey, PRC, Inc.

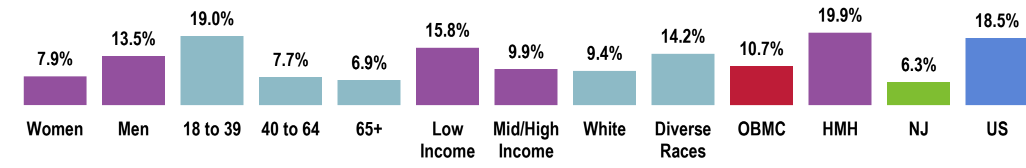
Notes: ● Asked of all respondents.
● "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Use of Vaping Products

PRC SURVEY ▶ "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

Currently Use Vaping Products
(OBMC Service Area, 2025)



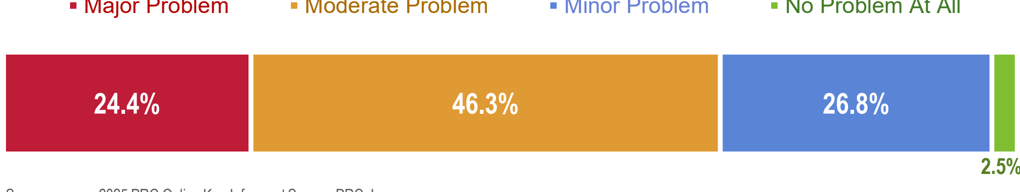
Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 36]
● 2023 PRC National Health Survey, PRC, Inc.
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): BRFSYR ST8 data.

Notes: ● Asked of all respondents.
● Includes those who use vaping products every day or on some days.

Key Informant Input: Tobacco Use

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

Perceptions of Tobacco Use as a Problem in the Community
(Key Informants, 2025)



Sources: • 2025 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:

Young People

> A lot of young people moving from tobacco products to vaping products. – Health Care Provider
>
> Vaping in youths. Vaping, e-cigarettes, in youth in New Jersey was higher than the National statistics. https://truthinitiative.org/research-resources/smoking-region/tobacco-use-new-jersey-2023. – Public Health Representative

Easy Access

> In addition to being able to purchase tobacco products at convenience stores, several Vape and Smoke shops have opened. Middle schoolers are being suspended for vaping in school. Vaping is so prevalent that government buildings have had to update their smoking policies to include vaping as a prohibited activity on government property. Vaping is not safer than "traditional" methods of using tobacco but that's the vibe.
>
> – Community Leader

Cancer

> We see a significant number of people who are high risk for lung cancer. – Physician

Incidence/Prevalence

> Many smokers in the area. – Social Services Provider

Income/Poverty

> Increase in stress and anxiety due to the current financial climate of our country. – Health Care Provider

Co-morbidities

> A leading cause of preventable illness. – Physician

Focus Group Input: Tobacco Use

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Environmental exposure to smoking*

Maternal & Infant Health Focus Groups:

- *Environmental exposure to smoking*

Key Quotes:

Maternal & Infant Health Focus Groups:

> "The environment where we live, people smoke, and there are all kinds of substances on the street." – Latinx Women Focus Group

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).

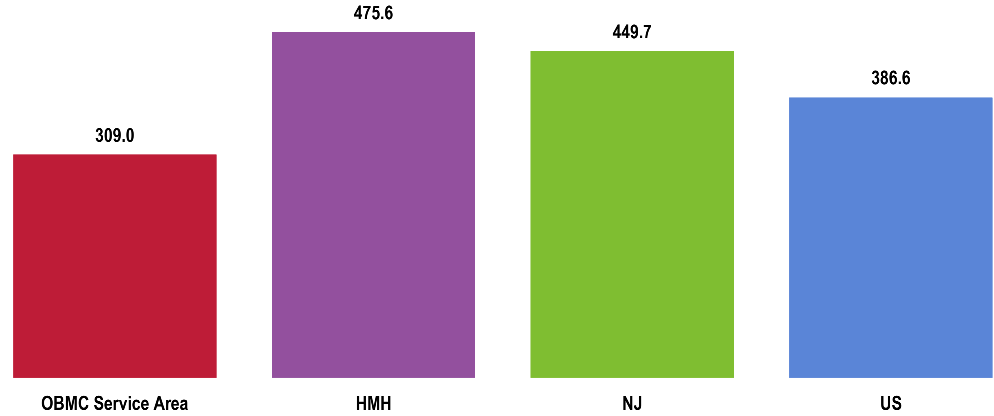
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

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

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



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 April 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

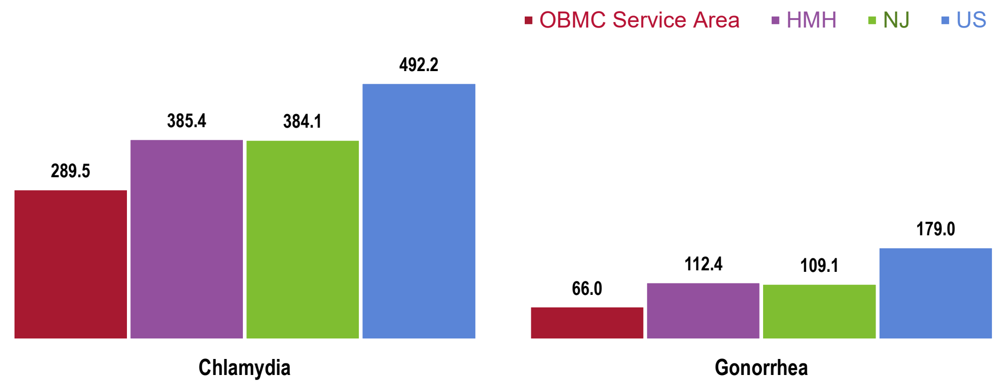
Chlamydia

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.

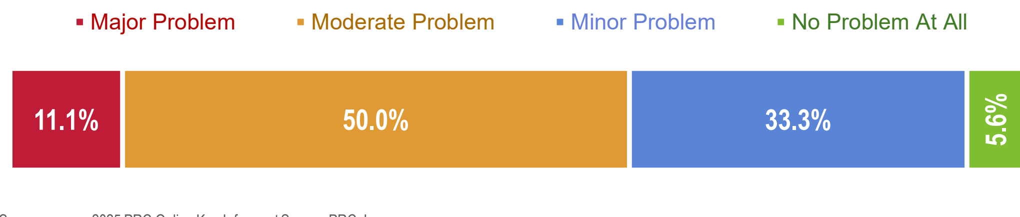
The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]



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 April 2025 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

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



Sources:
- 2025 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Awareness/Education

> Need for sexual health education for young people, STD's cases are growing. – Public Health Representative

Access to Care/Services

> STD and HIV treatment can be difficult to find. – Physician

Focus Group Input: Sexual Health

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Discomfort discussing sexual health*
- *Stigma surrounding LGBTQ+ sexual health*
- *Fear of discrimination when seeking sexual health services*
- *Need for culturally competent sexual health providers*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *LGBTQ+ individuals*
- *Men of color*
- *African American men*

Key Quotes:

Access & Utilization Focus Groups:

> "People don't feel comfortable speaking about sexual health." – African American Men Focus Group
>
> "Sexual health is only talked about briefly [in health care settings]." – African American Men Focus Group
>
> "I often book appointments with sexual health doctors and also gain emotional support from LGBTQ+ community support groups." – LGBTQ+ Focus Group
>
> "I'm scared of discrimination and the stigma like when the nurses expect that as a Black gay man, I'm likely an HIV patient." – LGBTQ+ Focus Group

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

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 health care services – neither private insurance nor government-sponsored plans.

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

PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?"

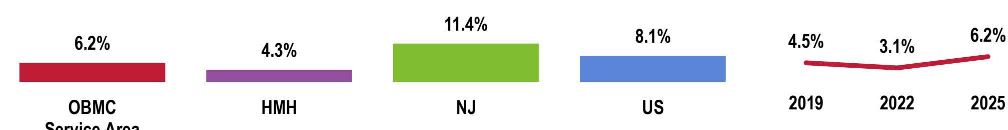
PRC SURVEY ► "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay entirely on your own?"

Lack of Health Care Insurance Coverage

(Adults Age 18-64)

Healthy People 2030 = 7.6% or Lower

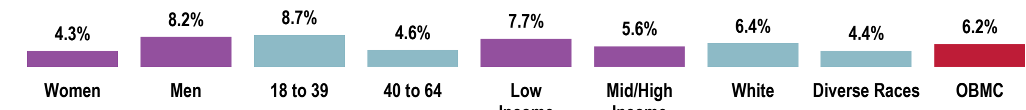
OBMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage
(Adults 18-64; OBMC Service Area, 2025)
Healthy People 2030 = 7.6% or Lower



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
• US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: • Reflects respondents age 18 to 64.

Focus Group Input: Health Insurance Coverage

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Lack of insurance or inadequate coverage*
- *Complicated documentation requirements*
- *Insufficient coverage for specialized needs*
- *Barriers to transition-related care*
- *Transportation coverage issues*
- *High cost of health insurance*
- *Difficulty obtaining Medicaid*
- *Denial of coverage for mothers and children*

Maternal & Infant Health Focus Groups:

- *High cost of health insurance*
- *Difficulty obtaining Medicaid through Social Services*
- *Challenges with insurance accepting providers*
- *Denial of coverage for mothers and children*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *Low-income individuals*
- *LGBTQ+ individuals, particularly transgender people*
- *Caregivers and elderly*
- *Immigrants and undocumented individuals*

Maternal & Infant Health Focus Groups:

- *Immigrants*
- *Low-income families*
- *Undocumented individuals*

Key Quotes:

Access & Utilization Focus Groups:

> "We have to get documentation from insurance company for everything, and see what will be covered…only sometimes will transportation to health care be covered by health insurance. Can there be more transportation options that are covered by insurance? If the transportation company doesn't give me the right information to get it covered and then I can't get it covered. that's an internal admin thing for people to be made aware of." – Caregivers Focus Group
>
> "We need to push for insurance coverage of gender-affirming care and mental health services." – LGBTQ+ Focus Group
>
> "As a transgender person, I face discrimination and insurance barriers to transition-related care." – LGBTQ+ Focus Group
>
> "There should be increased outreach and enrollment efforts to ensure eligible community members are enrolled in Medicaid." – LGBTQ+ Focus Group
>
> "I wish I could have a very affordable health insurance package that's all-encompassing, and very flexible." – Latinx Men Focus Group
>
> "Insurance coverage [is a key barrier]." – African American Men Focus Group

Maternal & Infant Health Focus Groups:

> "Health coverage is expensive. Employer health insurance is expensive. Medicaid through the Board of Social Services denies coverage to people (mothers and children) all the time." – Latinx Women Focus Group
>
> "The barriers in health including maternal and infant care stems from the insurance and the coverage that people may have." – African American Women Focus Group
>
> "If a child has Medicare/Medicaid, some doctors don't take that or want to take that, so then they have to switch so much so then kids are left without proper care." – African American Women Focus Group
>
> "We are getting charged $150-$200 for physicals in order to play sports." – African American Women Focus Group
>
> "Health insurance should be given to families in need with fewer health issues and concerns." – Latinx Women Focus Group

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care 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.

PRC SURVEY ▶ "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"

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

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

PRC SURVEY ▶ "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?"

PRC SURVEY ▶ "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?"

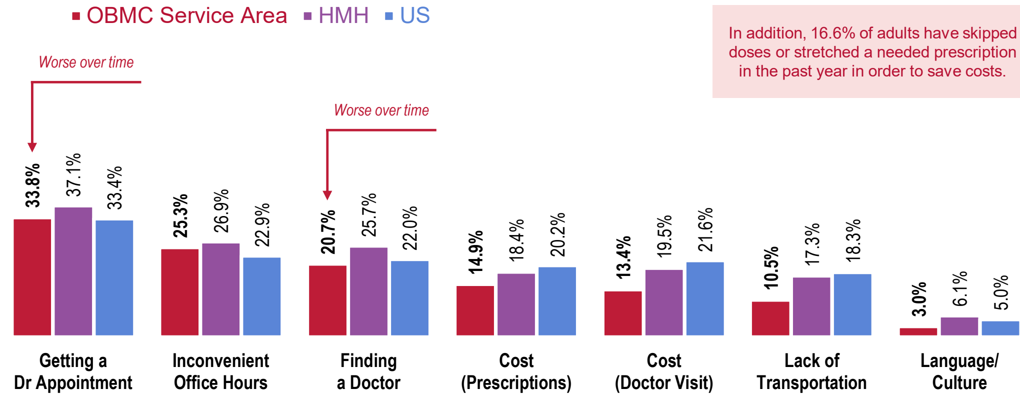
PRC SURVEY ▶ "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

PRC SURVEY ▶ "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

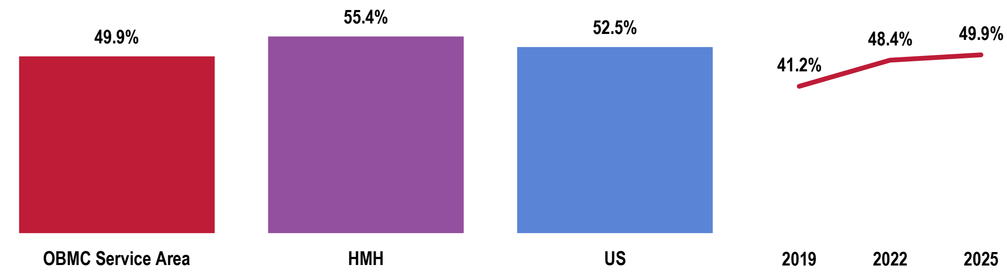
Also:

PRC SURVEY ▶ "Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"

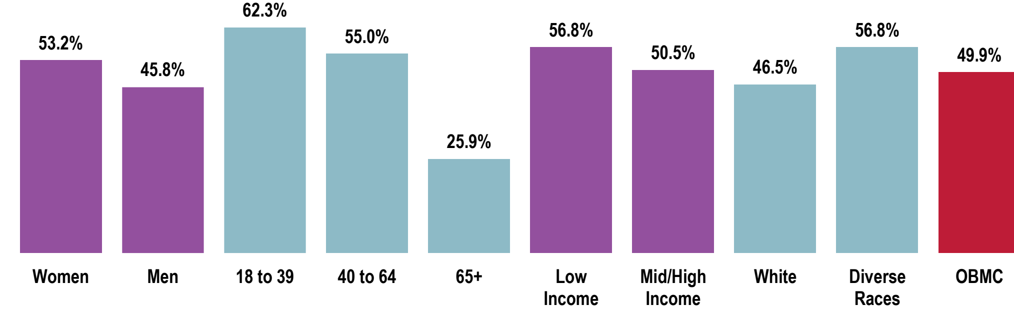
The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.



The following charts reflect the composite percentage of the total population experiencing problems accessing health care in the past year (indicating one or more of the aforementioned barriers), again regardless of whether they needed or sought care.



Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 119]
• 2023 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.



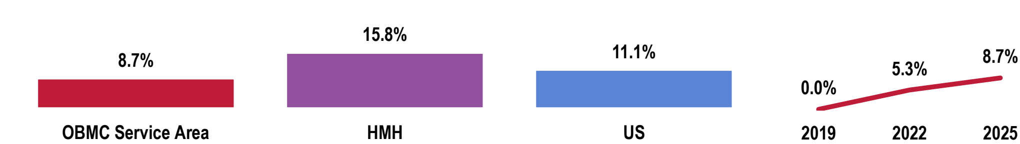
Sources: • 2025 PRC Community Health Survey, PRC, Inc. [Item 119]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

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.

PRC SURVEY ▶ [Among parents of children age 0-17] **"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)

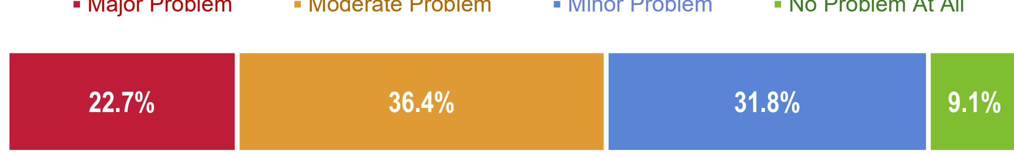


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 90]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children age 0 to 17 in the household.

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:

Perceptions of Access to Health Care Services as a Problem in the Community
(Key Informants, 2025)



Sources: ● 2025 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 for Uninsured/Underinsured

> Access to charity care for those who cannot afford insurance. There is a large population who either can't afford insurance, don't qualify given legal status, or make just enough money where obtaining insurance is cost prohibitive. Needing the access to charity care to become a smoother and more transparent process for people who speak all languages as well as cohesion amongst the various healthcare facilities such as with Hackensack and RWJ. – Physician
>
> Lack of health insurance, trust in the system, immigration status, a complicated health system that is difficult to navigate, lack of transportation, language differences and childcare availability are the biggest challenges for certain groups in the community when accessing healthcare services. – Public Health Representative
>
> Lack of insurance, transportation, locating available/accessible services for particular needs.
> – Public Health Representative

Affordable Care/Services

Costs. Unemployment. Lack of knowledge how to apply for many of the senior population. – Community Leader

Affordability, insurance, transportation and not enough providers to meet the need. – Community Leader

Access to Specialty Care

Physio therapy. – Community Leader

Individuals with autism have a difficult time finding medical providers as they transition from pediatric services to adult services, e.g. from a pediatrician to an adult primary doctor. – Health Care Provider

Lack of Cultural Competency

There is a lack of cultural competency in the health industry where clients are made to feel unwelcomed. There needs to be a shift on how families of all ethnicities are engaged for services. The community doesn't know about the services available to them. – Health Care Provider

Lack of culturally competent medical professionals who speak the language of the community. – Health Care Provider

Access to Care/Services

Accessing health care services in different areas of New Jersey can present a variety of challenges, particularly in some communities. Some of the challenges I see are those of health disparities in health outcomes due to different racial and ethnic groups. Minority groups such as Black and Latino populations tend to have worse health outcomes and least access to quality care. We also can look at health insurance coverage, we see those particularly in low-income or immigrant communities who are uninsured or underinsured which makes access to healthcare services a challenge for continuity of care. Another challenge I see is the difference in access based on geographic location for instance rural vs urban. Rural may have challenges in transportation options available to them or healthcare facilities locations and this can pose as a difficulty. – Social Services Provider

Transportation

Transportation. In conversations with all of the health care facilities and with HMCS, transportation is a key reason why people do not make it to or home from appointments. Transportation is infrequent and gaps exist everywhere - even in areas with a lot of transit. – Community Leader

Access for Medicare/Medicaid Patients

Patients with Medicaid are generally forced to seek their health care services at a hospital based program. Very few private practices/providers accept Medicaid. Some services, particularly those for children with special needs, have waitlists - often 6-9 months or longer. With NJ being one of the states with the highest rate of autism, a family here may have to wait months to see a developmental specialist and get a diagnosis for their child. Some services for children with autism are not accessible until the child actually has a dx. of autism. These months of waiting on a waitlist are precious time in the life of a young child and cannot be gotten back. Overall this problem is due to a scarcity of developmental specialists here in NJ and throughout the country. – Health Care Provider

Insurance Issues

Insurance, knowledge of systems and services and cultural differences. – Community Leader

Awareness/Education

Knowing how and where to access health care services, insurance coverage, scheduling an appointment and transportation. – Public Health Representative

Income/Poverty

I believe the biggest challenges are economic barriers as a lot of Middlesex County population has a median household income below the state average. – Public Health Representative

Incidence/Prevalence

Family health and senior health concerns are highly challenging in our community. – Social Services Provider

Focus Group Input: Access to Health Care Services

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Discrimination in health care settings*
- *Provider shortages and lack of specialists*
- *Long wait times for appointments*
- *Transportation barriers*
- *Health care navigation challenges*
- *Cultural and language barriers*
- *Lack of LGBTQ+ competent providers*
- *Racism in health care*

Maternal & Infant Health Focus Groups:

- *Language barriers*
- *Immigration status fears*
- *Cost barriers*
- *Transportation issues*
- *Lack of awareness about available services*
- *Discrimination/racism in health care*
- *Need for culturally congruent care*
- *Limited access to providers of color*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *LGBTQ+ individuals*
- *Racial and ethnic minorities*
- *Elderly individuals*
- *Caregivers*
- *Immigrants and non-English speakers*
- *Low-income individuals*
- *Rural communities*
- *Black women*

Maternal & Infant Health Focus Groups:

- *Black women*
- *Immigrants*
- *Non-English speakers*
- *Low-income individuals*

Key Quotes:

Access & Utilization Focus Groups:

> "Sometimes I'm addressed in a way I wouldn't like to be addressed, wrong pronouns.Their [health care providers] comments and treatment are often very downgrading and it makes us not feel accepted." – LGBTQ+ Focus Group
>
> "There is a large lack of specialists in the community - all of the specialties need to be enhanced." – Caregivers Focus Group
>
> "We need respite services [for caregivers]." – Caregivers Focus Group
>
> "My concerns are about being outed or having one's LGBTQ+ status disclosed without consent, particularly in health care settings." – LGBTQ+ Focus Group
>
> "I wish we didn't have to wait forever till when we no longer see the need to see the medical team because we've somehow found a way to manage symptoms." – LGBTQ+ Focus Group
>
> "For most doctors, you can't get appointments in general. We need additional physicians in the community to support." – Caregivers Focus Group
>
> "We don't really have neurologists here (6 months to get a dementia diagnosis is a very long time)." – Caregivers Focus Group
>
> "There is a need for a navigator/liaison general to the health care system, help with getting appointments, takes forever." – Caregivers Focus Group

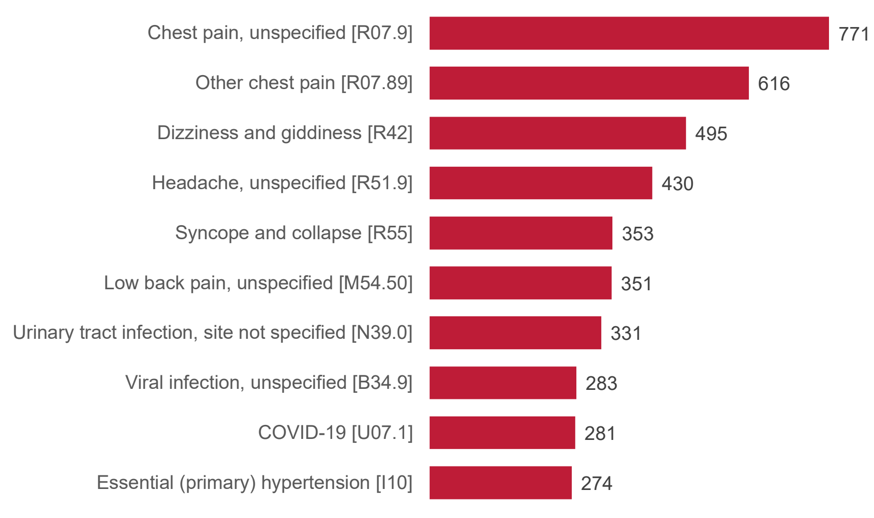
> "Many people work during the day so hours are hard." – African American Men Focus Group
>
> "Perceived biases within the health care system can erode trust, leading to decreased engagement of health care services." – African American Men Focus Group
>
> "There are racial and ethnic disparities in health care access, quality, and outcomes—particularly among African Americans." – African American Men Focus Group
>
> "We need access to affordable, effective, and reliable health care." – Latinx Men Focus Group
>
> "There is outdated health care infrastructure and technology." – Latinx Men Focus Group

Maternal & Infant Health Focus Groups:

> "African American women tend to be sidelined in health care and not given the care that they need...there are general disparities in care." – African American Women Focus Group
>
> "i want to see someone that looks at me and doesn't brush off the pains that I have. What we have to go through to prove we're actually in pain is an issue itself, there are so many biases and stereotypes for Black women." – African American Women Focus Group
>
> "There are language barriers at the hospital." – Latinx Women Focus Group
>
> "Accessibility of services for some people is very concerning." – Latinx Women Focus Group
>
> "The migrant population, primarily undocumented people, is the most vulnerable." – Latinx Women Focus Group

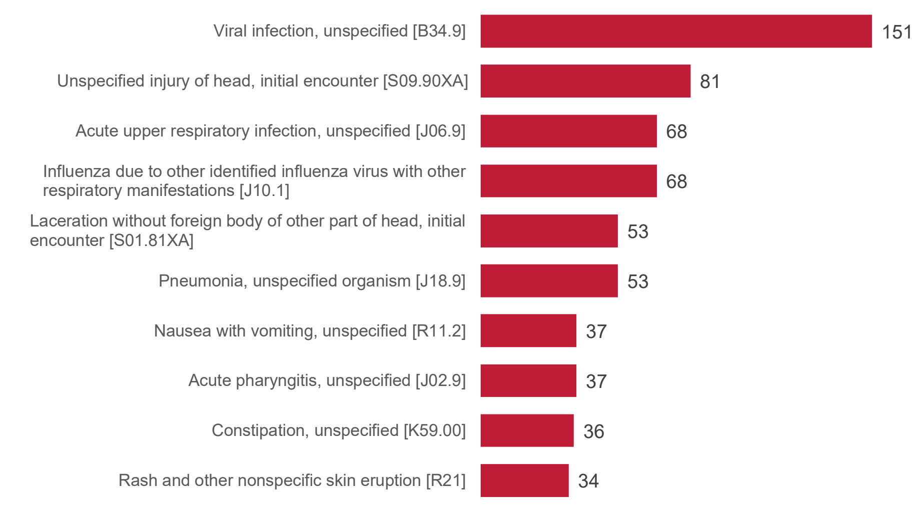
Emergency Room Utilization

The following charts outline the top diagnoses of adults and children visiting the Old Bridge Medical Center emergency department in the 2024 calendar year.



Notes:
- Includes diagnosis and diagnostic codes for ED visits to Old Bridge Medical Center during the 2024 calendar year.
- Includes adults age 18 and older.

Sources:
- Hackensack Meridian Health.



Notes:
- Includes diagnosis and diagnostic codes for ED visits to Old Bridge Medical Center during the 2024 calendar year.
- Includes children under 18.

Sources:
- Hackensack Meridian Health.

Focus Group Input: Emergency Room Utilization

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Use of ER as primary care*
- *High costs of emergency services*
- *Slow emergency services response*
- *Reluctance of some groups to call 911*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *Low-income individuals*
- *Uninsured populations*
- *Immigrants (fear of utilizing services)*
- *Those without access to primary care*

Key Quotes:

Access & Utilization Focus Groups:

> "Many people rely on emergency rooms for basic health care needs due to difficulty finding or affording primary care providers." – Latinx Men Focus Group
>
> "Delayed care from providers, it's hard to access services. We have slow EMS services." – African American Men Focus Group
>
> "Immigrants are stigmatized and afraid to call 911 or any other emergency services." – African American Men Focus Group
>
> "The ambulance bills are crazy." – African American Men Focus Group
>
> "People rely on the ER, but we have overburdened emergency services. Many use ERs for primary care due to lack of access to regular providers, increasing health care costs and straining hospital resources." – African American Men Focus Group

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.

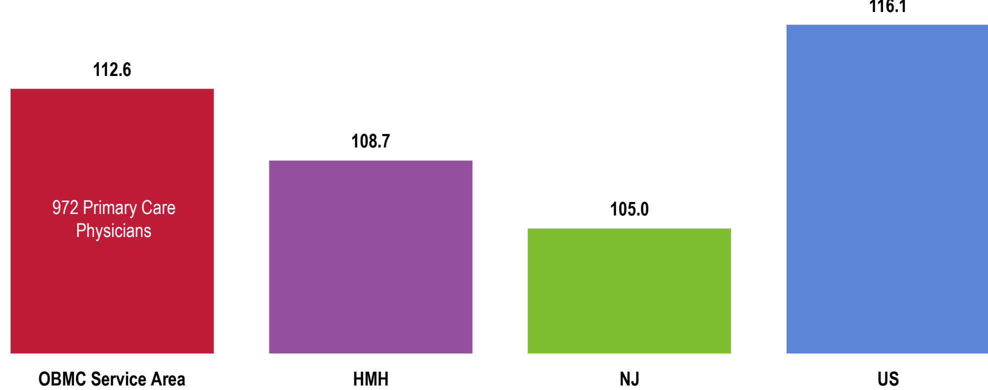
– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. [COUNTY-LEVEL DATA]

Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population, 2025)



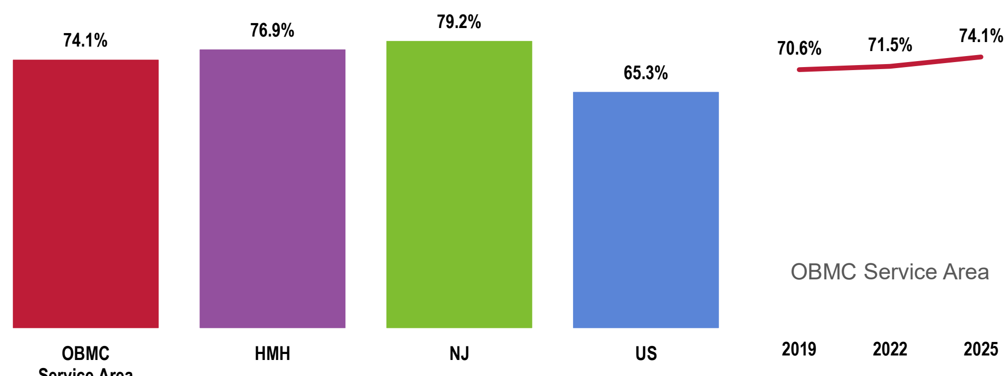
Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

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.

Utilization of Primary Care Services

PRC SURVEY ▶ "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?"

Have Visited a Physician for a Checkup in the Past Year

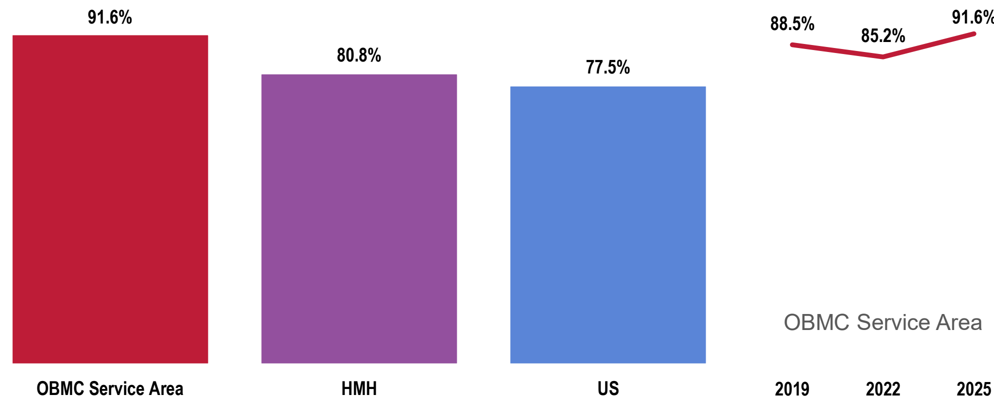


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 16]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
● 2023 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.

PRC SURVEY ▶ [Among parents of children age 0-17] **"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?"**

Child Has Visited a Physician for a Routine Checkup in the Past Year (Parents of Children 0-17)



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 91]
● 2023 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents with children age 0 to 17 in the household.

Focus Group Input: Primary Care Services

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Shortage of primary care providers*
- *Over-reliance on emergency services for primary care*
- *Reluctance to seek preventative care*
- *Distrust of health care system*
- *Geographic barriers to accessing care*
- *Limited access to primary care doctors*

Maternal & Infant Health Focus Groups:

- *Limited access to primary care doctors*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *Men, especially men of color*
- *Rural and semi-urban communities*
- *Low-income individuals*
- *Individuals without reliable transportation*
- *Children with Medicaid*

Maternal & Infant Health Focus Groups:

- *Children with Medicaid*

Key Quotes:

Access & Utilization Focus Groups:

> "Many areas, especially rural or semi-urban regions, lack well-equipped hospitals and clinics, forcing people to travel long distances for medical care." – Latinx Men Focus Group
>
> "We don't take preventive measures for health care, men don't normalize this and there is no maintenance for men to go to the doctor regularly." – African American Men Focus Group
>
> "We need more doctors, geriatricians, and neurologists." – Caregivers Focus Group
>
> "For most doctors, you can't get appointments in general. We need additional physicians in the community to support." – Caregivers Focus Group
>
> "There is a lack of access to primary health care…they need to be closer to the community." – Latinx Men Focus Group
>
> "Limited access to primary and preventive care means that many residents delay seeking medical attention until conditions worsen." – Latinx Men Focus Group
>
> "You should feel safe to talk to your own doctor." – LGBTQ+ Focus Group

Maternal & Infant Health Focus Groups:

> "I use resources at Oasis, WIC, and my pediatrician." – Latinx Women Focus Group
>
> "I would like for there to be more options for more doctors that specialize in individualizing care for patients needs." – African American Women Focus Group
>
> "I think doctors should have a good bedside manner and caring spirit." – African American Women Focus Group
>
> "Lack of primary care doctors and the high costs of urgent care create major barriers." – African American Women Focus Group

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)

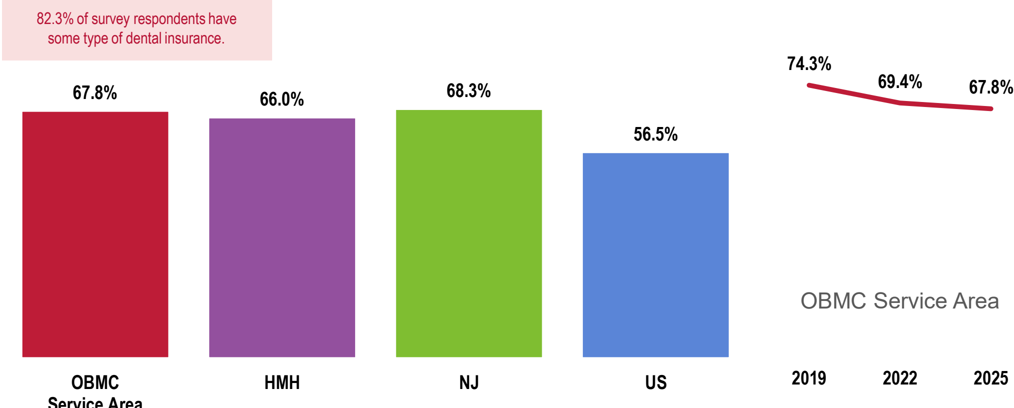
Dental Care

PRC SURVEY ▶ "About how long has it been since you last visited a dentist or a dental clinic for any reason?"

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

Have Visited a Dentist or Dental Clinic Within the Past Year

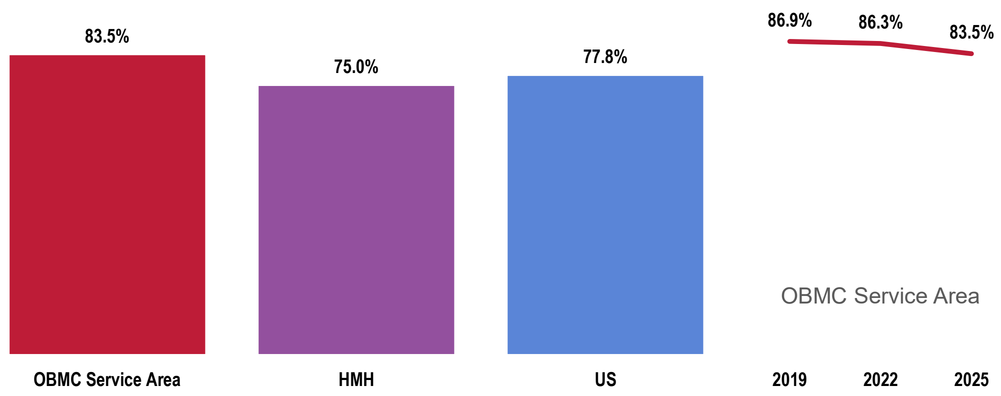
Healthy People 2030 = 45.0% or Higher



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 17-18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

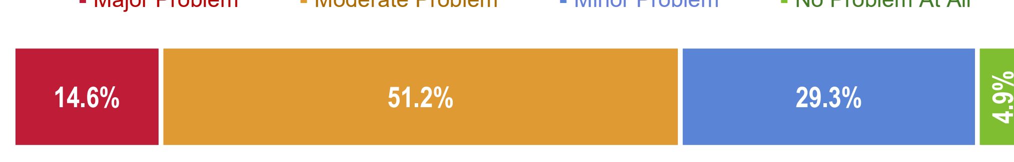
PRC SURVEY ▶ [Among parents of children age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 93]
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
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:



Sources: ● 2025 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:

Insurance Issues

> Dental insurance is not very good or families do not have coverage. Oral and vision care are the last considerations for families in terms of budget. – Community Leader

Income/Poverty

> Families with extremely limited resources do not have the resources for consistent oral health. When prioritizing needs, oral health is not a priority. – Health Care Provider

Affordable Care/Services

> Shortage of dentistry for lower income population. – Physician

Focus Group Input: Oral Health

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Lack of dental care*
- *Limited dental insurance coverage*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *Low-income individuals*
- *African American community*
- *LGBTQ+ community*

Key Quotes:

Access & Utilization Focus Groups:

> "Mental health, dental health, health literacy, and building trust with health care organizations are needed." – African American Men Focus Group
>
> "Dental care services [are needed]." – LGBTQ+ Focus Group

LOCAL RESOURCES

Perceptions of Local Health Care Services

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

Perceive Local Health Care Services as "Fair/Poor"

OBMC Service Area

Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Community Education & Outreach

Focus Group Input: Community Education & Outreach

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Need for better awareness of available resources*
- *Workshops and education programs*
- *In-person, word-of-mouth delivery of information*
- *Need for accessible information formats*

Maternal & Infant Health Focus Groups:

- *Need for better awareness of available resources*
- *Workshops and education programs*
- *In-person, word-of-mouth delivery of information*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *Low-income communities*
- *Non-English speakers*
- *Elderly*
- *Caregivers*
- *Individuals with limited technological access*

Key Quotes:

Access & Utilization Focus Groups:

> "We rely on community events or word of mouth for health info—if it's not shared that way, most won't know." – African American Men Focus Group
>
> "Community outreach programs which offer free or low cost educational programs and events on adult initiatives and health education are helpful." – African American Men Focus Group
>
> "It would be very helpful to have info on services that exist." – Caregivers Focus Group
>
> "We need more outreach to tell our community what services are truly LGBTQ+-friendly, because a lot of us have been burned and don't trust the system anymore." – LGBTQ+ Focus Group

Maternal & Infant Health Focus Groups:

> "We need more workshops or better marketing promotions to show where we can go to get health care or resources." – Latinx Women Focus Group
>
> "We need more programs to teach us what's available and how to access it." – Latinx Women Focus Group
>
> "We need in-person, word-of-mouth delivery of information on services." – African American Women Focus Group
>
> "We need more workshops or events to connect people." – Latinx Women Focus Group
>
> "I think an Enlightenment program should be carried out for members of the community to get familiar with their health care resources." – African American Women Focus Group

Cultural Competence

Focus Group Input: Cultural & Racial Aspects of Care

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Racism/discrimination in health care*
- *Need for more providers of color*
- *Historical trauma and fear of medical system*
- *Need for culturally congruent care*
- *Limited culturally competent providers*
- *Few providers of color*

Maternal & Infant Health Focus Groups:

- *Racism/discrimination in health care*
- *Need for more providers of color*
- *Historical trauma and fear of medical system*
- *Need for culturally congruent care*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

- *African American/Black communities*
- *Immigrants*
- *Non-English speakers*
- *LGBTQ+ individuals*

Key Quotes:

Access & Utilization Focus Groups:

> "Providers don't look like patients of color." – African American Men Focus Group
>
> "Health care disparities among minority populations: racial and ethnic disparities in health care access, quality, and outcomes—particularly among African Americans." – African American Men Focus Group
>
> "There is decreased trust in the health care system which is a negative experience, and perceived biases within the health care system can erode trust, leading to decreased engagement of health care services." – African American Men Focus Group
>
> "We need more affordable and culturally sensitive health care services, expanded mental health support, and accessible education on preventive care." – Latinx Men Focus Group
>
> "I'm scared of discrimination and the stigma—like when the nurses expect that as a Black gay man, I'm likely an HIV patient." – LGBTQ+ Focus Group

Maternal & Infant Health Focus Groups:

> "There is so much fear that goes back historically for African Americans…we carry that when we go to the doctor." – African American Women Focus Group
>
> "There should be professionals that are people of color as well. I feel a lot more comfortable when I meet people that are my color too because they're more considerate and not racist. – African American Women Focus Group
>
> "There's much racism so I think there should be a better way of solving this especially in the health care sector because this has led to a lot of lives being lost in the process of the maternal journey." – African American Women Focus Group
>
> "There are traumatic stories passed down through generations...we can do better to not inflict fear on younger generations, highlight not only challenges but also successes." – African American Women Focus Group
>
> "For me personally, I'd love to see people who would welcome me and make me feel better and comfortable to let them know whatever I feel. I'll need people who I can be vulnerable to, without feeling hurt by their comments." – African American Women Focus Group
>
> "I had the experience of a male doctor going off on me for how I was taking a medication when I was just doing what I knew... some can be against traditional medicine and don't understand your needs." – African American Women Focus Group
>
> "Language barriers at the hospital and fear about immigration status make it hard to get care." – Latinx Women Focus Group

Resources Available to Address 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

- American Cancer Society
- Charity Care
- Community Base Organizations
- Community Health Workers
- Doctors' Offices
- Federally Qualified Health Centers
- Free Screenings
- Hospitals
- JFK University Medical Center
- Keep Middlesex Moving
- Maternal Care Information
- Mental Health
- Middlesex County Center for Environmental Exposures and Disease
- Middlesex County Department of Community Services
- Middlesex County Department of Public Safety and Health
- Middlesex County Department of Transportation
- Middlesex County RIDE Program
- Middlesex County Services Locator
- New Jersey Department of Health
- New Jersey Human Services
- Public Health Events
- Regional Chronic Disease Coalition Middlesex Union Co
- School System
- State Health Insurance Program
- Uber Health
- United Way of Greater Union County
- Woodbridge Mobile Health

Cancer

- American Cancer Society
- Astera Cancer Care
- Cancer Center
- Cancer.org
- Center for Environmental Exposures and Disease Program
- Doctors' Offices
- Edison Jewish Community Center
- Healthier Middlesex
- Hospitals
- Just for the Health of It
- Middlesex County Center for Environmental Exposures and Disease
- New Jersey Department of Health
- New Jersey Center for Environmental Exposures and Disease
- Regional Chronic Disease Coalition Middlesex Union Co
- Road to Recovery
- Rutgers Cancer Institute of New Jersey
- YMCA

Diabetes

- Diabetes Center
- Diabetes Self-Management and Support Program
- Diabetes Seminars
- Dieticians/Nutritionists
- Doctors' Offices
- Federally Qualified Health Centers
- Food Banks/Pantries
- Hackensack Meridian Health
- Hospitals
- JFK Family Medicine
- JFK Pharmacy of Hope
- JFK University Medical Center
- Just for the Health of It
- Lunch Break
- Meals on Wheels
- Middlesex County Department of Public Safety and Health
- Middlesex County Office of Health Services
- My Choice Store
- Pediatric Endocrinology Specialty Clinic
- Pharmacies
- Robert Wood Johnson University Hospital
- School System
- Senior Programs
- Success Centers
- Supplemental Nutrition Assistance Program
- Visiting Nurse Association

- We Feed Food Pantry
- Woodbridge Mobile Health
- YMCA

Disabling Conditions

- Doctors' Offices
- Federally Qualified Health Centers
- JFK University Medical Center
- Middlesex County Human Resources
- Mobile Health Unit
- Raritan Bay Medical Center
- Robert Wood Johnson University Hospital
- Senior Services
- Senior Transportation
- Veterans Services

Heart Disease & Stroke

- American Heart Association
- Doctors' Offices
- Healthier Middlesex
- JFK Stroke and Neurovascular Center
- JFK University Medical Center
- JRI
- Just for the Health of It
- Middlesex County Department of Public Safety and Health
- New Jersey Quits
- Nursing Division and Mobile Health Unit
- Pharmacies
- Pharmacy Assistance Programs
- Regional Chronic Disease Coalition Middlesex Union Co
- Robert Wood Johnson University Hospital
- Rutgers
- Rutgers University
- School System
- St. Peter's
- Success Centers
- Tobacco Free New Jersey
- Transportation
- Woodbridge Mobile Health

Infant Health & Family Planning

- County Immunization Clinics
- Eric B Chandler Health Center
- Federally Qualified Health Centers
- JFK Family Medicine
- JFK Laborist Program
- JFK SED
- Partnership for Maternal and Child Health of North New Jersey
- Plainfield Health Connection
- Planned Parenthood
- Robert Wood Johnson University Hospital

Injury & Violence

- Catholic Charities
- JFK Behavioral Health Center
- PRAB
- Robert Wood Johnson University Hospital
- Women's Shelter

Mental Health

- 988
- Alliance for Healthier New Brunswick
- Carrier Clinic
- Catholic Charities
- CCDOM.org
- Churches
- CMO
- Collaborative Support Programs of New Jersey
- Community Based Organizations
- Division of Mental Health and Addiction Services
- Doctors' Offices
- George J Otlowski Senior Center for Mental Health
- Hospitals
- JFK Behavioral Health Center
- JRF Community Health Center
- Just for the Health of It
- Medicaid
- Meditation Centers
- Middlesex County Addictions and Mental Health Planning
- Middlesex County Department of Community Services
- Middlesex County Mental Health Resource Directory
- Middlesex County Services Locator
- Middlesex County Stigma Program
- National Alliance on Mental Illness
- New Life Recovery Center
- Passion Care
- Perform Care
- Private Pay Counselors
- Raritan Bay Medical Center
- Rutgers Behavioral Health
- Rutgers University
- School System

- Senior Services
- Success Centers
- Temples
- Therapists
- Township Health Department
- University Hospital
- Woodbridge Behavioral Health
- Working Progress

Nutrition, Physical Activity & Weight

- American Cancer Society
- Dieticians/Nutritionists
- Doctors' Offices
- Family Success Center
- Fitness Centers/Gyms
- Food Banks/Pantries
- Grocery Stores
- Hackensack Meridian Health
- Health Education Flyers
- Health Fairs
- Hospitals
- JFK University Medical Center
- JRF Community Health Center
- Just for the Health of It
- Meals on Wheels
- Middlesex County
- Mobile Health Unit
- New Jersey Department of Health
- Nutrition Counseling
- Parks and Recreation
- Rutgers Center Metabolic Health and Weight Management
- School System
- Supplemental Nutrition Assistance Program
- Walk With a Doc
- Woodbridge Community Center
- Woodbridge Senior Centers
- YMCA
- Youth Groups

Oral Health

- Central Jersey Health
- Dental Offices
- Federally Qualified Health Centers
- JFK University Medical Center
- JRF Community Health Center

Respiratory Diseases

- Insurance Companies
- Just for the Health of It
- Nursing Vaccination Programs
- Pharmacies
- Rutgers
- St. Peter's
- Transportation

Sexual Health

- Empower Somerset
- JFK Family Medicine
- JFK University Medical Center
- Planned Parenthood
- Robert Wood Johnson University Hospital

Social Determinants of Health

- 211
- Access Link
- Affordable Housing
- American Cancer Society
- Cancer.org
- Coming Home
- Community Based Organizations
- Community Health Workers
- East Brunswick Library
- Federally Qualified Health Centers
- Food Banks/Pantries
- Garden State Home
- Healthy Food Access Map
- Hospitals
- JFK University Medical Center
- JRF Family Assistance Center
- Just for the Health of It
- Middlesex Co Housing, Community Develop, Social Services
- Middlesex County
- Middlesex County Board of Social Services
- Middlesex County Department of Transportation
- Middlesex County Human Services Advisory Council
- Middlesex County Replenish
- Middlesex County Services Locator
- New Brunswick Tomorrow
- New Jersey Department of Health
- PRAB
- PROCEED
- Success Centers
- Town and County Resources

- Translation Services
- Triple C Housing
- Unite Us
- Urban League

Substance Use

- AA/NA
- Addiction Services and Recovery
- Catholic Charities
- Housing for Behavioral Health Individuals
- JFK Behavioral Health Center
- Kiosks/Vending Machines
- Making Over Substance Abuse Interventions on Campus
- Middlesex County
- Middlesex County Addictions and Mental Health Planning
- Middlesex County Blue Cares
- Middlesex County Department of Community Services
- Middlesex County Overdose Fatality Review Team
- New Jersey State Police
- Raritan Bay Medical Center
- University Hospital
- Woodbridge Behavioral Health
- Woodbridge Peer Recovery Coaches

Tobacco Use

- JFK Behavioral Health Center
- JFK University Medical Center
- Rutgers
- St. Peter's

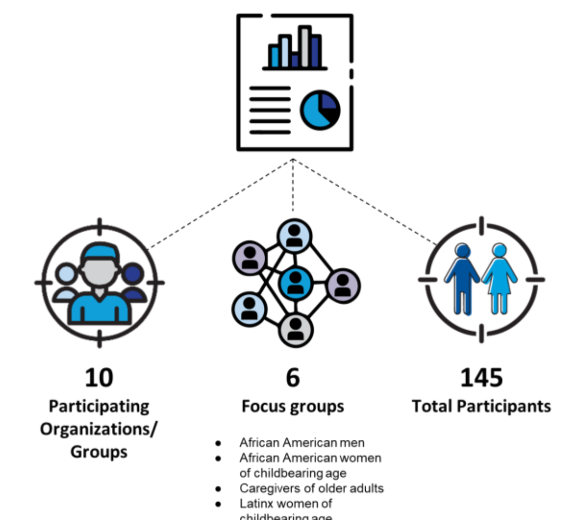
APPENDICES

APPENDIX: FINDINGS FROM COMMUNITY MEMBER FOCUS GROUPS

The 2025 HMH Community Health Needs Assessment involved a variety of primary and secondary data collection methods including secondary (existing) data collection, a community survey, key informant interviews, and focus groups with priority populations. This appendix will focus on the data collection completed by Moxley Public Health, who was hired as an external consultant by HMH to complete the qualitative focus groups with community members.

The Community Health Needs Assessment (CHNA) focus groups were made possible thanks to the collaborative efforts of Hackensack Meridian *Health*, community partners, local stakeholders, and community residents. Their contributions, expertise, time, and resources played a critical part in the completion of this important community engagement. Moxley Public Health would like to recognize the following organizations/groups for their contributions to the focus groups:

- Booker Family Health Center
- Broreavement
- Garden State Equality
- Hackensack Meridian *Health*
- Hackensack Meridian *Health* Alzheimer's Support Group
- Hackensack Meridian *Health* Team Member Resource Groups (TMRGs)
- Oasis — A Haven for Women and Children
- Ocean County Library
- Perth Amboy YMCA
- St. Stephen AME Zion Church



Overarching Focus Group Questions (Access & Utilization)

The following questions were asked for the **African American men, caregivers, Latinx men,** and **LGBTQ+** focus groups.

1. What are your biggest concerns/issues in our community (related to access to and utilization of health care)?
2. How do these health care access and utilization concerns/issues impact our community?
3. What are some populations/groups in our community that face barriers to accessing health and utilizing health care services?
4. What existing health care resources/services do you use in our community to address your health needs?
5. What health care resources do you think are lacking in our community?
6. Do you have any ideas for how to improve access to and utilization of health care in our community?
7. Do you have any other feedback/thoughts to share with us?

Overarching Focus Group Questions (Maternal & Infant Health)

The following questions were asked for the **African American women** and **Latinx women** focus groups.

1. What are your biggest concerns/issues in our community (related to maternal and Infant health)?
2. How do these maternal and infant health concerns/issues impact our community?
3. What are some populations/groups in our community that face barriers to maternal and infant health?
4. What existing health care resources/services do you use in our community to address maternal and infant health?
5. What maternal and infant health resources do you think are lacking in our community?
6. Do you have any ideas for how to improve maternal and infant health in our community?
7. Do you have any other feedback/thoughts to share with us?

Data Analysis

Moxley Public Health synthesized and analyzed data from focus groups using thematic qualitative analysis techniques. Analysis was done manually by reading through focus group notes and creating codes based on key themes. Key quotes were also extracted. Analysis was done separately for each focus group to understand the findings of each, as well as the extraction of relevant data for each health need being assessed. Finally, data was synthesized into a summary of the findings and recommendations across all focus groups.

Consolidated Summary of Focus Group Input

The following present an overall summary of the qualitative findings from the six focus groups that Moxley Public Health and Hackensack Meridian *Health* conducted with community members from priority populations. Findings are organized into a summary of what focus group participants love about the community overall, focus group findings, findings from the access & utilization focus groups, and findings from the maternal & infant health focus groups.

Things People Love About The Community

The top things focus group participants love about their community are:

- Strong community bonds and support systems
- Cultural diversity and inclusion
- Safety and peaceful environment
- Family-friendly atmosphere with a sense of belonging
- Natural beauty and outdoor recreational spaces

"We are a very passionate community. As neighbors, we like to know what's going on with each other and supporting each other emotionally, financially, or any other ways."

- LGBTQ+ Focus Group

"I love the diverse community with a mix of cultures and backgrounds."

- African American Women Focus Group

"It feels safe and comfortable."

- Latinx Men Focus Group

"It feels safe and comfortable."

- Latinx Men Focus Group

"I love my community because it feels like home."

- African American Women Focus Group

"I love the great spots for relaxation, walks, and outdoor activities. The Hackensack river also adds to the city's natural beauty."

- Latinx Men Focus Group

"Despite being a city, Hackensack has a strong sense of community, with local businesses, farmers' markets, and family -friendly events."

- Latinx Men Focus Group

"I love that my identity is celebrated and not just tolerated."

- LGBTQ+ Focus Group

Overall Summary

Biggest Community Health Needs:

- Mental health challenges (depression, anxiety, stress) and insufficient services
- Health care access barriers (limited resources and lack of services)
- Cultural competency and discrimination issues in health care; lack of cultural sensitivity in health care
- Maternal and infant mortality, especially among Black women
- Underserved populations and health literacy concerns- inadequate support for specific populations

Health Care Access Barriers:

- Deteriorating health outcomes (poor health outcomes, chronic conditions, mortality, worsening health conditions)
- Avoidance or delay of necessary health care (due to negative experiences and discrimination)
- Mental health deterioration (mental health strain - depression, anxiety, stress)
- Financial strain on families and individuals: financial instability due to health care costs
- Reduced quality of life

Sub-Populations with Health Care Access Barriers:

- Communities of color, particularly Black/African American, other racial and ethnic minorities
- LGBTQ+ community, including transgender individuals

- Caregivers
- Elderly: people living with dementia/Alzheimer's
- Immigrant populations, especially undocumented

Existing Community Resources:

- Virtual health care and telemedicine
- Veterans' health care services
- Alzheimer's Caregivers' Support Group
- Parker Family Health Center
- Primary care and insurance

Lacking Community Resources:

- Mental health services and supports
- Specialty health care providers, particularly neurologists and geriatricians
- Culturally competent and diverse health care providers: LGBTQ+ trained health care providers
- Support groups for various populations, particularly caregivers
- Health education and resource awareness

Ideas for Community Health Improvement:

Improve Access and Affordability of Health care Services:

- *Expand walk-in, evening, and telehealth options.*
- *Increase availability of primary and specialist care.*
- *Reduce wait times and improve continuity of care.*
- *Make insurance and medical care more affordable.*
- *Provide financial assistance for uninsured individuals.*

Enhance Transportation and Navigation Support:

- *Expand community transportation options to clinics and hospitals.*
- *Simplify insurance processes for transportation.*
- *Create health care navigator and peer support roles to support access to services.*

Expand Culturally Competent, Inclusive, and Respectful Care:

- *Hire more diverse, culturally-competent providers.*
- *Improve language access and translation services.*
- *Increase access to LGBTQ+-inclusive and gender-affirming care.*
- *Provide anti-discrimination and sensitivity training for health care workers*

Strengthen Mental Health, Caregiver, and Family Supports:

- *Expand maternal mental health and caregiver wellness programs.*
- *Provide grief and parenting support groups with respite services.*
- *Promote equitable sharing of caregiving responsibilities in families.*
- *Include fathers and extended family in maternal/infant care systems.*

Address Social Determinants of Health Through Housing, Nutrition, and Education:

- *Increase access to affordable, stable, and inclusive housing.*
- *Improve access to healthy foods and nutrition education.*
- *Integrate health literacy programs into schools and communities.*
- *Promote physical activity through community-based wellness initiatives.*

Key Quotes:

> "We need more walk-in and evening appointments—people can't always take time off work to get care." – African American Men Focus Group
>
> "Shelter housing rental cost is not affordable, which means mothers and infants are not stable and moving from place to place in different environments, causing health issues." – Latinx Women Focus Group
>
> "If someone has a bad experience—like being misgendered, dismissed, or treated unfairly—they might never go back to the doctor, even if they really need help." – LGBTQ+ Focus Group
>
> "Caregivers are on their own with no support, going through a challenging time with their loved ones." – Caregivers Focus Group
>
> "African American women and infants face higher mortality rates than those of other races." – African American Women Focus Group
>
> "We need more programs to teach us what's available and how to access it." – Latinx Women Focus Group
>
> "We need more affordable and culturally sensitive health care services, expanded mental health support, and accessible education on preventive care." – Latinx Men Focus Group
>
> "We don't take preventative measures for health care—men don't normalize this and there is no maintenance for men to go to the doctor regularly." – African American Men Focus Group

Individualized Focus Group Findings: African American Men (Access & Utilization)

Biggest Community Health Needs:

- Mental health:
  - *Cultural and societal stigmas*
  - *Insufficient services*
  - *Untreated mental health issues due to barriers*
- Substance abuse:
  - *Neglected in health care systems*
  - *High rates among African Americans and vulnerable populations*
  - *Insurance complications with inpatient programs*
- Prostate health:
  - *Delayed diagnosis due to lack of insurance leading to cascading health problems*

Health Care Access Barriers:

- Health literacy:
  - *Providers don't give full details*
  - *Not enough time allowed with providers*
  - *Difficulty navigating health care system*
- Health care disparities:
  - *Racial and ethnic disparities in access, quality, and outcomes*
  - *Particular impact on African Americans*
- Provider issues:
  - *Insufficient number of health care professionals*
  - *Providers don't look like patients of color (representation gap)*
  - *Insurance coverage*
- Emergency room overuse :
  - *Many use ERs for primary care*
  - *Increased health care costs*
  - *Strained hospital resources*
- Scheduling conflicts:
  - *Working hours make it difficult to access services*
  - *Transportation limitations*

Sub-Populations with Health Care Access Barriers:

- Undocumented individuals
- Immigrants
- LGBTQIA+ communities
- Elderly people
- Men of color
- Low-income households
- African Americans
- Uninsured and underinsured individuals
- African Diaspora men

Existing Community Resources:

- Hackensack Meridian *Health* urgent care

- Churches
- Primary health care services
- Telehealth
- Broreavement grief support
- Community outreach programs
- Jamaican program with Patrick Reid
- Mental health services
- Support groups and well-being services
- Specialist services (cardiologists, endocrinologists, physical therapists)

Lacking Community Resources:

- Education dissemination
- Programs for youth
- Health care services specifically for men of color
- Support groups
- Swift emergency medical services

Ideas for Community Health Improvement:

- Preventative care:
  - *Normalize regular check-ups for men.*
  - *Promote prostate health testing.*
- Community engagement:
  - *Meet men where they are and partner with existing groups.*
  - *Use barbershops for health information.*
  - *Offer incentives for participation.*
- Activity integration:
  - *Combine health discussions with activities men enjoy.*
  - *Partner with recreational centers and sports leagues.*
  - *Create integrated facilities (e.g., gyms within hospitals).*
- Accessibility improvements:
  - *Provide virtual meeting options.*
  - *Expand telehealth for rural/underserved communities.*
- Workforce development:
  - *Recruit diverse health care providers.*
  - *Send health care professionals to community events.*
- Educational initiatives:
  - *Improve health literacy.*
  - *Engage with schools through assemblies.*
  - *Include male youth in programs and develop targeted curricula.*

Other Feedback:

- Pursue grants and funding opportunities for Black men's health.
- Develop hiring and training programs for men of color.
- Provide culturally sensitive support and navigation services.
- Focus on intentional community building.
- Emphasize that "people won't engage with something they don't understand".

Key Quotes:

> "Many people work during the day so hours [of health care services] are hard." – African American Men Focus Group
>
> "Providers don't look like patients of color." – African American Men Focus Group
>
> "African American men often face cultural and societal barriers to seeking mental health services leading to untreated mental health issues." – African American Men Focus Group
>
> "People rely on the ER for care." – African American Men Focus Group
>
> "Health care disparities exist among minority populations: Racial and ethnic disparities in health care access, quality and outcomes particularly among African American people." – African American Men Focus Group
>
> "We don't take preventive measures for health care…men don't normalize this and there is no maintenance for men to go to the doctor regularly." – African American Men Focus Group
>
> "There is decreased trust in the health care system due to negative experiences, and perceived biases within the health care system can erode trust, leading to decreased engagement of health care services." – African American Men Focus Group
>
> "Health care disparities and inadequate access to care can contribute to reduced life expectancy among African Americans." – African American Men Focus Group

Individualized Focus Group Findings:
African American Women (Maternal & Infant Health)

Biggest Community Health Needs:

- Higher mortality rates for African American women and infants compared to other racial/ethnic groups
- Prevalence of postpartum preeclampsia among peers in the community
- Mental health challenges affecting new mothers (depression, anxiety) with insufficient support
- Limited breastfeeding support and resources in some communities
- Higher rates of premature births, particularly in communities with limited access to prenatal care
- Pregnant women's health concerns not being taken seriously enough
- Maternal/infant health being a taboo topic in some cultures/communities (particularly mentioned in Muslim community)
- Traumatic birth stories passed down through generations creating fear

Health Care Access Barriers:

- African American women being "sidelined in health care" and not receiving adequate care
- Insurance challenges (many doctors not accepting Medicaid/Medicare)
- High costs for basic services
- Weak health systems overall
- Lack of awareness about available resources
- Not knowing where to go for care
- Racial bias in health care (having to "prove" pain is real)
- Historical fears affecting care-seeking behaviors among African Americans
- Lack of continuity with midwife teams
- Lack of providers who understand cultural backgrounds and traditional approaches

Sub-Populations with Health Care Access Barriers:

- African American women

Existing Community Resources:

- Community health centers (Parker Family Health Center, Monmouth Family Health Center)
- Visiting Nurse Association
- WIC program
- Midwives of New Jersey (though limited African American midwives in Monmouth County)
- Various free or sliding fee scale services (though awareness is limited)

Lacking Community Resources:

- School-based health clinics with APRNs and dental services
- Maternal health education programs
- Specialized care for newborns and high-risk pregnancies
- Care coordination programs for seamless transition between prenatal, delivery, and postpartum care
- Health care providers of color, especially Black midwives and doulas
- Easily accessible health services
- Information about available resources
- Private clinics and maternity homes offering personalized care

- Home visiting nurses or therapists for families with premature or high-risk babies

Ideas for Community Health Improvement:

- Increase racial diversity among health care providers (“wanting to see someone who looks like us”).
- Improve awareness of existing resources in the community.
- Create education and awareness programs about available health care resources.
- Increase access to quality prenatal care services.
- Partner with local organizations and schools to disseminate health information.
- Expand community health centers, mobile health units, and telehealth services.
- Deliver information in-person at trusted community locations (e.g., food banks).
- Address racism in health care settings.
- Create more friendly, welcoming health care environments.
- Establish specialized care for newborns and high-risk pregnancies.

Other Feedback:

- There is an appreciation for community diversity, supportive neighbors, and family orientation.
- There is a desire for health care environments where patients feel welcome, understood, and respected.
- Maternal/infant health issues lead to emotional trauma and increased health care costs.
- Compassionate care throughout the childbirth journey is important.
- There is a need to address fear created by historical and generational trauma.

Key Quotes:

> “African American women and infants face higher mortality rates than those of other races.” – African American Women Focus Group
>
> “Maternal/infant/women’s health can be a taboo topic in some cultures/communities.” – African American Women Focus Group
>
> “It’s important to maintain continuity of care with midwives and other providers—changing providers disrupts trust and outcomes.” – African American Women Focus Group
>
> “General health disparities experienced by Black women are often ignored or dismissed.” – African American Women Focus Group
>
> “The pandemic made it harder to access care during pregnancy—it was isolating and scary.” – African American Women Focus Group
>
> “There are a lot of resources, but people just don’t know about them or how to access them.” – African American Women Focus Group
>
> “Lack of primary care doctors and the high costs of urgent care create major barriers.” – African American Women Focus Group
>
> “Community members often don’t know where to go for care, especially when using Medicaid or Medicare.” – African American Women Focus Group

Individualized Focus Group Findings: Caregivers Of Older Adults (Access & Utilization)

Biggest Community Health Needs:

- Support Group Access and Awareness:
  - *Lack of adequate support groups for caregivers of people with dementia*
  - *Existing support groups are poorly advertised, especially to elderly without internet access*
  - *Caregivers cannot bring their loved ones with dementia to support meetings*
- Specialist Shortages:
  - *Severe shortage of neurologists (6+ month waits for dementia diagnosis)*
  - *Lack of geriatricians specifically trained for elderly care*
  - *General physician shortages leading to long appointment wait times*
- Caregiver Support and Resources:
  - *Financial burden of caregiving ($10,000/month for memory care)*
  - *Need for respite care services to provide relief for caregivers*
  - *Fear and uncertainty about disease progression*
  - *Lack of centralized resource information*
- Grief Support:
  - *Insufficient grief support groups with restrictive criteria*
  - *Long wait times for grief services when immediate support is needed*

Health Care Access Barriers:

- Information and Awareness Barriers:
  - *Lack of awareness about available services for elderly*
  - *No centralized source of information for caregivers*
  - *Limited outreach to communities where elderly live*
- Financial Barriers:
  - *High costs of caregiving services and private care*
  - *Concerns about affording long-term care*
  - *Insurance documentation challenges for coverage*
- Transportation Barriers:
  - *Transportation difficulties for those who cannot drive*
  - *Limited availability of insurance-covered transportation options*

Sub-Populations with Health Care Access Barriers:

- Caregivers of people with dementia who cannot leave their loved ones
- Elderly populations:
  - *Those with limited technology access*
  - *Those with mobility limitations*
  - *Senior communities like Rebriar*
- Uninsured or underinsured individuals
- People without transportation or unable to drive
- Rural/remote community members with limited access to specialists

Existing Community Resources:

- Veterans Administration (VA) services
- Bay Avenue Respite Center
- Caregiver support groups (described as “very helpful for peace of mind”)
- Educational seminars at nursing homes

- Palliative care nurse speakers

Lacking Community Resources:

- Professional Care Options:
  - *Shortage of respite care services and volunteers*
  - *Lack of in-between options between home care and nursing homes*
  - *Insufficient availability of specialists, especially neurologists and geriatricians*
- Support Services:
  - *More caregiver-specific wellness programs (yoga, meditation)*
  - *Financial planning assistance for long-term care*
  - *Legal guidance for caregivers*
- Information Resources:
  - *Centralized information about available services*
  - *Resources in non-digital formats for elderly without internet access*

Ideas for Community Health Improvement:

- Community Outreach:
  - *Advertise services through church bulletins, Meals on Wheels, and flyers.*
  - *Outreach to 55+ communities with dementia resources.*
  - *Improve communication about available services.*
- Enhanced Support System:
  - *Create health care navigator/liaison positions to help people access care.*
  - *Develop more caregiver support groups with convenient timing.*
  - *Offer wellness activities specifically for caregivers.*
- Professional Services:
  - *Recruit more specialists to the area, particularly geriatricians and neurologists.*
  - *Create programs with financial and legal experts to help with planning.*
  - *Simplify insurance documentation processes.*

Other Feedback:

- Caring for loved ones with dementia is emotionally and financially taxing, particularly in terms of balancing caregiving responsibilities with caregivers' needs for support.
- There is a strong desire for continued support groups.
- There is a need for more doctors, particularly geriatricians, in the area.

Key Quotes:

> "Caregivers are on their own with no support, going through a challenging time with their loved ones." – Caregivers Focus Group
>
> Not enough support groups (particularly for caregivers for those with dementia) and lack of awareness of support groups." – Caregivers Focus Group
>
> "Wait lists for care and supports are 6 months or more—it's too long when you're caring for someone who needs help now." – Caregivers Focus Group
>
> "There are folks out there who need a navigator to help them through the system." – Caregivers Focus Group
>
> "Navigating the system is too complicated for caregivers who spend all their time caring for their loved one." – Caregivers Focus Group
>
> "There are no doctors in the hospital when needed, and you can't get appointments—it's exhausting." – Caregivers Focus Group
>
> "Finances are a burden for caregivers—we don't qualify for help but can't afford care either." – Caregivers Focus Group
>
> "Support groups are very helpful for peace of mind for caretakers, but they need to be easier to access." – Caregivers Focus Group

Individualized Focus Group Findings: Latinx Men (Access & Utilization)

Biggest Community Health Needs:

- Health literacy and education gaps were frequently mentioned as significant concerns.
- Mental health services were identified as a critical need in the community.
- High health care costs creating barriers to timely care.
- Limited access to affordable and culturally sensitive health care.
- Substance abuse services were noted as lacking.
- Chronic diseases are linked to nutrition and lifestyle factors.

Health Care Access Barriers:

- Financial constraints: High costs of medical services, medications, and diagnostic tests
- Language and cultural barriers affecting health care engagement
- Limited transportation options to medical facilities, particularly affecting elderly and disabled residents
- Outdated health care infrastructure and technology
- Limited health care facilities in certain areas, requiring long-distance travel
- Low awareness about available health care services and preventive care options

Sub-Populations with Health Care Access Barriers:

- Latinx community members, particularly men
- Men of color from foreign countries
- Low-income individuals and families living in poverty
- Rural communities
- Seniors/elderly population
- Individuals facing mental health issues
- Disabled residents who struggle with transportation to medical facilities

Existing Community Resources:

- Emergency rooms (often used for basic health care needs due to lack of primary care)
- Primary health care centers
- Hackensack University Medical Center (HUMC)
- Community health fairs for screenings and vaccinations
- Mental Health ER Center
- Local clinics for routine check-ups and urgent care
- Bereavement/grief support groups through Emergence Church in Totowa

Lacking Community Resources:

- Mental health services
- Dental health services
- Health literacy programs
- Culturally competent care providers
- Substance abuse treatment options
- Affordable health care options
- Trust with health care organizations

- Preventive care education and outreach

Ideas for Community Health Improvement:

- Reduce health care costs to make services more affordable.
- Implement telehealth services to increase access to specialty care.
- Expand community health initiatives including health fairs and free medical check-ups.
- Employ health care access coordinators to connect patients with available resources.
- Increase primary care providers and promote preventative health education.
- Create mobile health units for underserved neighborhoods.
- Develop culturally sensitive health care services.
- Enhance transportation options to medical facilities.
- Increase funding for home health care programs for seniors and disabled residents.
- Improve vaccination programs.
- Build stronger partnerships between schools and health care providers.
- Meet community members “where they are”.

Other Feedback:

- Participants emphasized the importance of:
  - *Virtual health care access options that are affordable*
  - *Early intervention with younger generations that could positively impact entire families.*
  - *Community-based and intentional brotherhood groups*
  - *Addressing social determinants of health (housing, education, employment, food security)*
  - *Regular evaluation and improvement of community health initiatives*
  - *Bereavement and grief small groups in building community and addressing health issues*

Key Quotes:

> “We need more affordable and culturally sensitive health care services, expanded mental health support, and accessible education on preventive care.” – Latinx Men Focus Group
>
> “Limited access to primary and preventive care means that many residents delay seeking medical attention until conditions worsen. This leads to higher rates of chronic diseases like diabetes, hypertension, and heart disease.” – Latinx Men Focus Group
>
> “I believe that the cost of medical services is a major challenge as well.” – Latinx Men Focus Group
>
> “High medical costs lead to financial instability for families, forcing them to choose between health care and basic necessities like rent, food, and utilities.” – Latinx Men Focus Group
>
> “There’s a lot of health inequity due to lack of education.” – Latinx Men Focus Group
>
> “Mental health services are hard to get—people need easier access in the community.” – Latinx Men Focus Group
>
> “Outdated health care infrastructure and technology make care less effective and harder to access.” – Latinx Men Focus Group
>
> “People won’t engage with something they don’t understand—health literacy is a major barrier.” – Latinx Men Focus Group

Individualized Focus Group Findings: Latinx Women (Maternal & Infant Health)

Biggest Community Health Needs:

- Poor nutrition and eating habits
- Unstable housing leading to frequent moves and environmental health issues (i.e. lead exposure, spread of infectious diseases)
- Diabetes
- Obesity
- High blood pressure
- Limited access to health services
- Exposure to smoking and other substances
- Food insecurity
- Mental health strain (stress, anxiety, and depression)

Sub-Populations with Access Barriers:

- Immigrants, especially undocumented people, who are described as "the most vulnerable"
- Low and moderate-income households where "funds get in the way of purchasing food or even health care"
- People facing language barriers at hospitals and health care facilities

Existing Community Resources:

- Participants reported using various resources to address maternal and infant health needs:
- Oasis (A Haven for Women and Children)
- WIC (Women, Infants, and Children)
- Pediatricians
- Employer health insurance (described as "expensive")
- Medicaid (through Board of Social Services, though with noted difficulties)
- Horizon Health care
- SNAP
- Private organizations offering affordable health services
- New Destiny, Lighthouse, and Healthy Mothers Healthy Babies programs
- North Hudson Community Clinic

Lacking Community Resources:

- Health coverage due to denials from Passaic County Board of Social Services (specifically mentioned as giving families "a hard time getting health insurance").
- Paternal health resources in addition to maternal health.
- Affordable prenatal vitamins for those with financial constraints.
- More community education and workshops about available resources.

Ideas for Community Health Improvement:

- Hold more workshops and do better marketing to increase awareness of health care resources.
- Expand health insurance coverage for families in need.
- Do more community engagement focusing on maternal health.
- Increase group sessions, table settings, and social media outreach.

- Hold me events to connect people.
- Create support groups promoting family unity in parenting and household responsibilities.
- Develop programs for entire families, not just mothers, to include fathers in the support system.
- Create mental health support groups where “mothers have a safe space to share, learn, and feel supported”.
- Promote a cultural shift to better distribute family responsibilities: “In my culture, men are the financial caretakers and women carry the emotional and physical weight of the home. We need to support each other more and shift some of those expectations.”

Key Quotes:

> “Shelter housing rental cost is not affordable, which means mothers and infants are not stable and moving from place to place in different environments, causing health issues.”
> -Latinx Women Focus Group
>
> “If the parents are not stable, it can affect the kids.” – Latinx Women Focus Group
>
> “As moms, we set the example. If we had better access and education, we could model healthier habits for our kids.” – Latinx Women Focus Group
>
> “Many women live in basements or crowded homes due to high rent, leading to issues like lead exposure.” – Latinx Women Focus Group
>
> “Limited access to health services. Food insecurity, the cost of health services, and lack of stable homes are issues.” – Latinx Women Focus Group
>
> “Worrying about these problems causes stress, anxiety, and depression.” – Latinx Women Focus Group
>
> “We need more programs to teach us what’s available and how to access it.” – Latinx Women Focus Group
>
> “We lack community programs that support families with affordable health care.” – Latinx Women Focus Group
>
> “Language barriers at the hospital and fear about immigration status make it hard to get care.” – Latinx Women Focus Group

Individualized Focus Group Findings: LGBTQ+ Adults (Access & Utilization)

Biggest Community Health Needs:

- Discrimination in health care settings was the most frequently cited concern.
- Inadequate treatment from medical professionals due to lack of training and sensitivity is common.
- There is poor health education and awareness specific to LGBTQ+ needs.
- Mental health issues require specialized care.
- Cost barriers to accessing health care exist, especially for those who can't afford private services.
- There are long wait times for appointments and care.

Sub-Populations with Health Care Access Barriers:

- LGBTQ+ community members, especially transgender and non-binary individuals
- People with intersectional identities facing multiple disadvantages:
  - *LGBTQ+ people of color*
  - *LGBTQ+ individuals with disabilities*
  - *Low-income LGBTQ+ individuals*
  - *Immigrant and refugee LGBTQ+ individuals*
  - *Neurodivergent LGBTQ+ individuals*
- Uninsured individuals
- Formerly incarcerated people

Existing Community Resources:

- Local health care facilities:
  - *Community health clinics*
  - *Free clinics*
  - *Urgent care centers*
  - *Planned Parenthood (mentioned specifically for hormone replacement therapy)*
- LGBTQ+ specific services:
  - *LGBTQ-friendly primary care providers*
  - *LGBTQ+ mental health services*
  - *Transgender health programs (e.g., at Robert Wood Johnson University Hospital)*
- Online/virtual health care options:
  - *Telehealth services*
  - *Online resources and hotlines*
  - *Virtual health care programs*
  - *Support groups and community-based health services*

Lacking Community Resources:

- Financial support and insurance coverage:
  - *Affordable health insurance*
  - *Coverage for gender-affirming care*
- Specialized care:
  - *Mental health and counseling services*
  - *Substance abuse treatment*
  - *Dental care services*
  - *Transgender and non-binary specific health services*
  - *Gender-affirming health care*
- Housing resources:
  - *LGBTQ+ specific housing services*

- *Homelessness support*
- *Affordable housing initiatives*

- Education and training resources:
  - *Preventive health education*
  - *Resources addressing social and economic disparities*
  - *Safe spaces for LGBTQ+ health discussions*

Ideas for Community Health Improvement:

- Increase provider training and competence:
  - *Cultural competency training for health care providers*
  - *LGBTQ+ specific training*
- Expand service delivery options:
  - *More virtual consultations/telehealth*
  - *Mobile clinics to reach underserved areas*
  - *Walk-in appointment availability*
- Improve health care affordability:
  - *Insurance coverage of gender-affirming care*
  - *Sliding-scale services*
  - *Medicaid enrollment assistance*
- Enhance community involvement:
  - *Community outreach and engagement*
  - *Surveys to hear LGBTQ+ opinions on health care*
  - *Partnerships between LGBTQ+ centers and other organizations*
- Develop peer navigator programs to help coordinate care and navigate insurance.
- Improve transportation to health care facilities.

Other Feedback:

- Participants emphasized the importance of:
  - *Partnerships between LGBTQ+ centers and autism/neurodiversity organizations*
  - *Increasing health care providers in high-concern areas*
  - *Creating peer navigator programs for care coordination*
  - *Developing mobile health units specifically for LGBTQ+ and neurodivergent individuals*
  - *Mental health services*
  - *Addressing challenges for families with financial limitations*
  - *Easier access and appointment availability*
  - *Local medical centers, urgent care, health fairs, and mobile services*

Key Quotes:

> "There is a high level of discrimination and unfair treatment from the health care providers." – LGBTQ+ Focus Group
>
> "If someone has a bad experience—like being misgendered, dismissed, or treated unfairly—they might never go back to the doctor, even if they really need help.
> " – LGBTQ+ Focus Group
>
> "My biggest concern is finding affirming providers—mental health stigma too, and locating providers who are truly knowledgeable about how to treat LGBTQ+ people." – LGBTQ+ Focus Group
>
> "For me, I'll say that my greatest concern is the fact that my identity is always questioned… that makes me feel unseen." – LGBTQ+ Focus Group
>
> "Sometimes I'm addressed in a way I wouldn't like to be addressed—wrong pronouns." – LGBTQ+ Focus Group
>
> "My concerns are about being outed or having one's LGBTQ+ status disclosed without consent, particularly in health care settings." – LGBTQ+ Focus Group
>
> "Most service providers are not LGBTQ+-friendly. There is intentional discrimination and it creates a bridge of trust." – LGBTQ+ Focus Group
>
> "I don't even see the need to visit the hospital because—who will I confide in when I'm being discriminated against?" – LGBTQ+ Focus Group

APPENDIX:
EVALUATION OF PAST ACTIVITIES

Old Bridge Medical Center
2023-2025 Evaluation of Impact Report

Background

In 2022, Hackensack Meridian *Health* Old Bridge Medical Center completed a Community Health Needs Assessment (CHNA) and developed a supporting Community Health Improvement Plan (CHIP) to address identified health priorities. The strategies implemented to address the health priorities reflect Hackensack Meridian Health's mission and commitment to improving the health and well-being of the community.

Guided by the findings from the 2022 CHNA and input from key community stakeholders, Hackensack Meridian Health leadership identified the following priorities to be addressed by the CHIP:

- Mental Wellbeing
- Healthy Living
- Access to Care

The following sections outline our work to impact the priority health needs and respond to any emerging public health concerns in our area since implementing the 2023-2025 Community Health Improvement Plan.

Priority Area: Mental Wellbeing		
Goal: A community where all people have access to high quality behavioral health care, and experience mental wellness and recovery		
	Objectives	**Activity/ Impact Measures**
Prevention and Awareness	▪ **Provide universal behavioral health screenings for patients** ▪ **Continue behavioral health education and increase participation among diverse and vulnerable populations** ▪ **Support public health in local prevention and emergency initiatives**	• 612 patients screened for suicide risk via the Patient Safety Screener-3 (PSS-3) and Ask Suicide-Screening Questions (ASQ) tool who were referred for follow-up • 22 behavioral health related lectures *Topics include: depression, coping with stress, meditation, mindfulness, and much more* ○ 522 community members educated • 47 Narcan replacement kits distributed to first responders, free of cost. *This program has ended as of September 1, 2023, as first responders can now order Naloxone in bulk from the NJ State Department of Human Services.* • In partnership with HMH Hospitality Services, local law enforcement, and the NJ Harm Reduction Coalition, HMH Pharmacy is hosting its first network-wide drug take-back day on April 27, 2025. This collaborative initiative aims to provide safe medication disposal and naloxone access to communities across the HMH network as part of the system's commitment to combating the opioid crisis.
Build Capacity	▪ **Expand care delivery methods for behavioral healthcare**	• 4-bed crisis unit built in Old Bridge Medical Center's Emergency Room, as part of expansion • 96 Behavioral Health patients served through HMH's First Thirty Program *The First Thirty Transitions of Care program, developed by HMH, is a groundbreaking initiative addressing the critical needs for underserved, underinsured, and uninsured behavioral and maternal health patients in New Jersey.* *Launched in 2020, the program offers comprehensive support during the crucial time when patients leave the hospital and addresses physical and mental health needs while reducing hospital readmissions and improving follow-up care.* *The First Thirty program provides interventions such as care coordination and access to essential resources, including medications, transportation, and food assistance, while addressing cultural and health literacy barriers to ensure equitable and effective postpartum care.*

Priority Area: Healthy Living		
Goal: All people will have access to chronic disease education, screening, and management services to achieve an optimal state of wellness		
	Objectives	**Activity/Impact Measures**
Prevention and Awareness	▪ **Continue to provide education and health promotion and increase participation among diverse and vulnerable populations** ▪ **Support public health departments in local prevention and emergency initiatives**	● 6,091 wellness screenings provided to community members & 2,126 abnormal results detected. Individuals received counseling on their results and were referred for follow up care as needed. ● 138 health education lectures provided by physicians and health care providers that focus on wellness, prevention, chronic and complex conditions, educating 5,841 community members *Topics include: healthy eating, heart failure, stroke risk factors, the benefits of exercise, and so much more.* RSV, FLU & COVID-19 Campaign: The Community Outreach & Engagement team launched a network-wide community education and awareness campaign, tackling the rise in preventable visits to our emergency department (ED) for RSV, flu and other respiratory infections, especially among our pediatric population. The goal was to educate the public about the signs and symptoms of these infections and when and where to seek care. In addition, our health educators distributed 10 reusable digital thermometers to families in need in the OBMC service area.
Build Capacity	▪ **Continue to engage, monitor and coordinate care for patients with chronic/complex conditions**	● 64 patients supported through Hospital Prevention program The *Hospital Prevention program is for Medicare patients who are at risk of readmission and who do not meet the Medicare guidelines of traditional home care. Patients are provided with 1 free home visit by an RN, providing education on discharge medications, signs and symptoms of their illness, and more.*
Strengthen Community Partnerships	▪ **Increase, strengthen and evaluate partnerships with community-based organizations**	● Participated in 60 coalition/task force meetings to promote collaboration, share knowledge, and coordinate community health improvement activities related to chronic and complex conditions

Priority Area: Access to Care		
Goal: All people will have the opportunity to be as healthy as possible, regardless of where they live, work or play		
	Objectives	**Activity/Impact Measures**
Prevention and Awareness	▪ **Reduce common barriers to accessing health care for diverse and vulnerable populations** ▪ **Strengthen cultural competency training for team members and physicians**	• 65,929 patients screened for social determinants of health and referred to community-based resources via UniteUs, a referral platform. • 508 patients assisted in Medicaid health insurance enrollment • 41,584 discharge patients who received free prescriptions through our Meds to Bed program • 1.803 Lyft rides provided to patients in need, free of charge • 92.50% Unconscious Bias in the Workplace e-learnings completed for new hire hospital clinicians and staff
Build Capacity	▪ **Develop and leverage alternative care delivery models to improve access to care for all**	• 15,172 telehealth appointments conducted in 2023-2024
Strengthen Community Partnerships	▪ **Increase, strengthen and evaluate partnerships with community-based organizations**	• Participated in 60 coalition/task force meetings to promote collaboration, share knowledge, and coordinate community health improvement activities related to access to care • 3,020 community organizations and 14,714 programs available through the UniteUS database, including those sourced through our collaborative efforts