February 2020

Dear Community Partner,

I am pleased to share with you Bergen New Bridge Medical Center’s 2019 Community Health Needs Assessment (CHNA) results. This population-based assessment provides a snapshot of our local community and helps us, as the County asset and community healthcare provider, to determine the greatest needs of our neighbors and determine the best way to serve our communities.

The CHNA was made possible through a collaborative effort among the Bergen County Department of Health Services, the Community Health Partnership of Bergen County, the county’s seven hospitals, including, for the first time ever, our Medical Center.

As a result of key findings contained in the CHNA and in light of our existing service lines and areas of expertise, Bergen New Bridge leadership identified four community health priority areas to be implemented over the next three years. These areas, embodying the leading health issues and barriers to care for the residents in our service area, are:

1. mental/behavioral health and substance abuse disorder;
2. wellness, prevention, and risk factors;
3. chronic and complex conditions; and
4. social determinants of health and access to care.

In addition to examining demographic and socioeconomic factors revealed through the CHNA, we considered social determinants of health – the conditions in which people live, work, and play — that influence and define the quality of life for many in our service area. As one of New Jersey’s largest safety-net providers, we recognize how underlying conditions — such as housing, transportation, income/employment — may affect healthcare access, outcomes, and disparities. This information helped to inform our decision of where to best apply our resources.

The exciting news is that we are uniquely positioned and well-equipped to take on a significant role in addressing key community health needs and social determinants of health in collaboration with our community partners, as outlined in our three-year Implementation Strategy. Our existing partnerships with Bergen County officials, Rutgers New Jersey Medical School, Care Plus NJ, and Integrity House, for example, enable us to continue to expand our reach and deliver high quality health care and services delivered in the most efficient and compassionate manner possible.

It takes a village to care for a community — and we provide that medical village which offers a broad scope of services, diversity, and expertise of physicians and other clinical providers coupled with the commitment to care for those who need us the most. Fueled by this commitment and guided by the results of our CHNA, we will accomplish more together than we could ever do alone.

Sincerely,

Deborah Visconi, President and CEO
Bergen New Bridge Medical Center
ACKNOWLEDGMENTS

The Bergen County Community Health Needs Assessment (CHNA) and Strategic Planning process was made possible through the generous support of Bergen New Bridge Medical Center, Englewood Health, Hackensack Meridian Health Hackensack University Medical Center, Hackensack Meridian Health Pascack Valley Medical Center, Holy Name Medical Center, Ramapo Ridge Psychiatric Hospital (a part of Christian Health Care Center), and The Valley Hospital. Representatives from these seven hospitals, along with representatives of the Bergen County Department of Health Services (BCDHS) and the Community Health Improvement Partnership (CHIP) of Bergen County, worked collaboratively for more than a year to plan and execute this assessment. A Steering Committee comprised of representatives from each hospital and BCDHS guided this project. John Snow, Inc. (JSI) was hired by the Steering Committee to assist with the assessment.

Hundreds of individuals who live, work, and learn in Bergen County were engaged to participate in the assessment process. JSI administered a mail-based random household survey and received approximately 1,350 responses; the survey oversampled in areas of the County with higher percentages of Black/African American residents, Hispanic/Latino residents, and low-income households to achieve a sample that was representative of Bergen County demographics. Information was also gathered through interviews, focus groups, and community listening sessions. Finally, over 350 community residents responded to a web-based survey to capture opinions and perceptions of leading social determinants of health, barriers to care, vulnerable populations, and access to health care services.

The information gathered throughout this assessment will allow the hospitals, the BCHDS, the CHIP, and health and social service providers to gain a better understanding of health needs and barriers to care in Bergen County. The assessment results will be used to guide the development of strategic plans to address these issues and improve where, when, and how healthcare is provided. The Steering Committee would like to extend their sincere appreciation to all those who invested their time, effort, and expertise to ensure the development of a comprehensive and robust assessment.

2019 BERGEN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT STEERING COMMITTEE

Carolyn Bryan, Hackensack Meridian Health Pascack Valley Medical Center
Donnalee Corrieri, Bergen New Bridge Medical Center
Colette Cummings, The Valley Hospital
Rebecca Dauerman, Ramapo Ridge Psychiatric Hospital (part of Christian Health Care Center)
Balpreet Grewal-Virk, Hackensack Meridian Health Hackensack University Medical Center
Marianne Kennelly, Ramapo Ridge Psychiatric Hospital (part of Christian Health Care Center)
Marla Klein, Bergen County Department of Health Services
Elisabeth Lucas, The Valley Hospital
Lauren Menkes, Englewood Health
Elizabeth Rubock, Bergen County Department of Health Services
Jennifer Yanowitz, Englewood Health
Catherine Yaxley, Holy Name Medical Center
EXECUTIVE SUMMARY

OVERVIEW AND PURPOSE

Bergen New Bridge Medical Center, a clinical affiliate of Rutgers, is a 1,070-bed hospital located at 230 East Ridgewood Avenue in Paramus, NJ. Founded in 1916, the Medical Center is both the largest hospital and licensed nursing home in New Jersey and the fourth-largest publicly owned hospital in the nation. Bergen New Bridge, a not-for-profit safety net facility, provides high-quality comprehensive services, including acute care, behavioral health care, and long-term care to the greater Bergen County community. The Hospital, including its Long-Term Care Division, is fully accredited by The Joint Commission.

Bergen New Bridge is one of New Jersey’s largest safety-net providers. The Medical Center offers acute medical services, including 24/7 emergency department, surgical suites, physical rehabilitation, pharmacy, laboratory, radiologic services (including digital mammography), and more than 26 medical specialties available through its Ambulatory Care Center. Notably, the Hospital is one of the largest medical facilities providing a full continuum of care for individuals with behavioral health (mental health and substance use disorder) issues. The Medical Center is also a Veterans Choice Community Care Provider and proudly serves the healthcare needs of veterans. Bergen New Bridge is also a Leader in LGBTQ Healthcare Equality in the Human Rights Campaign Healthcare Equality Index. The Medical Center prides itself on its unique ability to address physical and behavioral health issues, the social determinants of health, and health care disparities.

This Community Health Needs Assessment (CHNA) and the associated Implementation Strategy (IS) were funded by Bergen New Bridge and the other six acute care facilities in Bergen County: Englewood Health, Hackensack Meridian Health Hackensack University Medical Center, Hackensack Meridian Health Pascack Valley Medical Center, Holy Name Medical Center, Ramapo Ridge Psychiatric Hospital (a part of Christian Health Care Center), and The Valley Hospital. Representatives from each of these entities, along with the Bergen County Department of Health Services (BCDHS) and the Community Health Improvement Partnership of Bergen County (CHIP) worked collaboratively to guide the overall assessment methods and approach and to identify priority health issues and populations for Bergen County and individual hospital service areas.

Bergen New Bridge acknowledges its role as a critical community resource, but also recognizes the value in collaborating with community partners to identify, educate, prevent, and address issues that prevent community residents from accessing the health and social services they need. This Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were done in close collaboration with the Medical Center’s leadership, staff, health and social service partners, and the community at-large. This assessment involved input from nearly 1,000 community residents, stakeholders, and service providers. This assessment, including the process that was applied to develop the Implementation Strategy, exemplifies the spirit of collaboration and community engagement that is such a vital part of Bergen New Bridge’s mission.
This CHNA provides information that will be used to make sure that the Medical Center’s services and programs are appropriately focused, are delivered in ways that are responsive to community health needs, and are conducted to address leading barriers to health and wellbeing. This CHNA and the Implementation Strategy allow Bergen New Bridge to meet federal Community Benefits requirements per the Federal Internal Revenue Service (IRS) as part of the Affordable Care Act.

APPROACH AND METHODS

The assessment began in December 2018 and was conducted in three phases, which allowed for the collection of an extensive amount of quantitative and qualitative data (Phase 1); engagement of community residents, key stakeholders, and service providers (Phase 2); and analysis and prioritization of findings for use in developing a data-driven Implementation Strategy (Phase 3).

2019 Bergen County CHNA: Project Phases

<table>
<thead>
<tr>
<th>Phase 1: Preliminary Assessment and Engagement</th>
<th>Phase 2: Targeted Engagement</th>
<th>Phase 3: Strategic Planning and Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Data Collection</td>
<td>Bergen County Random Household Survey</td>
<td>Steering Committee Prioritization Meeting</td>
</tr>
<tr>
<td>Key Informant Interviews</td>
<td>Focus Groups</td>
<td>Individual Hospital and BCHDS/CHIP Prioritization Meeting</td>
</tr>
<tr>
<td>Resource Inventory</td>
<td>Community Listening Sessions</td>
<td>Final Reporting</td>
</tr>
<tr>
<td>Steering Committee Meetings</td>
<td>Bergen County Community Health Perceptions Survey</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Steering Committee Meetings</td>
<td></td>
</tr>
</tbody>
</table>

Many individuals from across Bergen County were engaged in the assessment and planning process, including:

- Health and social service providers
- BCDHS and CHIP leadership and staff
- Faith leaders
- Community residents

- Hospital leadership, clinicians, and staff
- Health and public health officials
- Community organizers and advocates

BERGEN NEW BRIDGE MEDICAL CENTER COMMUNITY HEALTH PRIORITIES AND VULNERABLE POPULATIONS

The CHNA was designed as a population-based assessment - the goal was to identify a full range of community health issues across the demographic and socioeconomic segments of the population. The issues identified were framed in a broad context to ensure that the breadth of unmet needs and community health issues were recognized.

An integrated analysis of the assessment activities framed the leading community health issues into three priority areas: wellness, prevention, and risk factors, chronic and complex conditions\(^1\), and

---

\(^1\) Literature defines complex chronic conditions as those that “involve multiple morbidities that require the attention of multiple health care providers or facilities and possibly community (home)-based care. A patient with complex chronic disease
mental/behavioral health and substance use disorder. A crosscutting priority area was also identified: social determinants of health and access to care.

There was an effort to identify segments of the population with complex health needs or that face significant barriers to care. Seven population segments were identified: youth and adolescents, older adults, low resource individuals and families, individuals with chronic and complex conditions (including those with disabilities), racially/ethnically diverse populations and non-English speakers, veterans, and LGBTQ+.


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KEY FINDINGS/THEMES BY PRIORITY AREA

Below is a listing of key findings and themes by priority area. These findings were used as the basis for the development of Implementation Strategies for the CHIP of Bergen County and individual hospitals. For more detailed findings, data sources, and data on disparities by gender identity, race/ethnicity, income, and age, please see the full Community Health Needs Assessment report. Priority areas are listed in the order in which they are discussed in this Community Health Needs Assessment report and are not hierarchical.

<table>
<thead>
<tr>
<th>Priority Area: Wellness, Prevention, and Risk Factors</th>
</tr>
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<tbody>
<tr>
<td>• All-cause and premature mortality were lower in Bergen County than New Jersey overall</td>
</tr>
<tr>
<td>• One-third (33.2%) of Bergen County Random Household Survey respondents were overweight, while approximately one in five were obese (22.8%)</td>
</tr>
<tr>
<td>• Nearly a third (32.9%) of Bergen County Random Household Survey respondents reported that they did not participate in any physical activity or exercise in the past 30 days</td>
</tr>
<tr>
<td>• Over 70% of Bergen County Random Household Survey respondents reported that they had a primary care visit and a dental visit within the past year</td>
</tr>
<tr>
<td>• Individuals engaged during this assessment prioritized the risk factors associated with chronic and complex conditions (e.g., obesity, poor nutrition, sedentary lifestyle) as key issues of concern</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority Area: Chronic and Complex Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Heart disease (#1) and cancer (#2) were the leading causes of death in Bergen County</td>
</tr>
<tr>
<td>• Approximately 1 in 4 (26.5%) Bergen County Random Household Survey respondents had been diagnosed with high blood pressure</td>
</tr>
<tr>
<td>• Approximately 1 in 10 (9.7%) Bergen County Random Household Survey respondents had ever been diagnosed with cancer</td>
</tr>
<tr>
<td>• Approximately 1 in 10 (11.5%) Bergen County Random Household Survey respondents had ever been diagnosed with diabetes.</td>
</tr>
<tr>
<td>• 14.1% of Bergen County Random Household Survey respondents had been diagnosed with asthma</td>
</tr>
<tr>
<td>• Influenza and pneumonia mortality rates were significantly high in Bergen County compared to New Jersey overall</td>
</tr>
<tr>
<td>• Individuals engaged in this assessment identified older adults, especially those with multiple chronic conditions and those who lack a regular caregiver, as a vulnerable population</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority Area: Mental/Behavioral Health and Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 6.8% of Bergen County Random Household Survey respondents reported that their mental health was poor for 15 or more days in the past month</td>
</tr>
<tr>
<td>• Nearly 1 in 10 (9.7%) of Bergen County Random Household Survey respondents had ever been diagnosed with a depressive disorder</td>
</tr>
<tr>
<td>• Over 1 in 10 (12.7%) of Bergen County Random Household Survey respondents had ever been diagnosed with an anxiety disorder</td>
</tr>
<tr>
<td>• 18.9% of Bergen County Random Household Survey respondents were current smokers</td>
</tr>
<tr>
<td>• Individuals engaged in this assessment characterized e-cigarette and vaping as a critical concern, especially for youth and adolescents</td>
</tr>
<tr>
<td>• 15.4% of Bergen County Random Household Survey respondents reported binge drinking in the past 30 days</td>
</tr>
<tr>
<td>• Drug-related deaths in Bergen County have increased since 2014, from 8.8 deaths to 13.8 deaths per 100,000</td>
</tr>
<tr>
<td>• The number of suspected opioid-overdose deaths has continued to increase annually since 2014; the number of opioids dispensed has decreased annually since 2015</td>
</tr>
</tbody>
</table>
**Cross-cutting Priority Area: Social Determinants of Health and Access to Care**

- Nearly one third (30.5%) of Bergen County residents were foreign-born, and 14.5% of residents have limited English proficiency.
- Educational attainment is high and unemployment is low.
- The percentage of individuals and families in poverty is low compared to New Jersey overall. Despite this, individuals engaged in this assessment reported that there were pockets of poverty throughout Bergen County, even in affluent communities, and income, poverty, and employment were issues of concern.
- Individuals engaged in this assessment identified housing issues – including lack of housing stock and housing affordability – as a major barrier to good health and well-being.
- Individuals engaged in this assessment identified access to transportation resources, especially for older adults, low-income populations, and those without a personal vehicle as a barrier to accessing health and social services.
- Nearly one-fifth (18.5%) of respondents to the Bergen County Random Household Survey reported that it was very or somewhat difficult to buy fresh produce or vegetables.
- Less than 10% of Bergen County residents lacked health insurance. Despite this, respondents to the Bergen County Random Household Survey identified lack of health insurance as the leading social factor or barrier that limited access to care or impacted the health of those living in the community.
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BACKGROUND AND APPROACH

OVERVIEW & PURPOSE

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This CHNA provides information that will be used to make sure that Bergen New Bridge’s services and programs are appropriately focused, are delivered in ways that are responsive to community health needs, and are conducted to address leading barriers to health and wellbeing. This CHNA and the Implementation Strategy allow Bergen New Bridge to meet federal Community Benefits requirements per the Federal Internal Revenue Service (IRS) as part of the Affordable Care Act.

The primary goals for the CHNA and this report are to:

- **Assess**: Community health needs, defined broadly to include health status, social determinants, environmental factors, and service system strengths/weaknesses
- **Engage**: Members of the community, hospital staff and leadership, CHIP/BCDHS staff and leadership, local health departments, and community organizations
- **Identify**: Leading health issues/population segments most at-risk for poor health, based on a review of quantitative and qualitative evidence
- **Develop**: A three-year Implementation Strategy to address community health needs in collaboration with community partners

This CHNA may be used as a source of information and guidance to:

- Clarify issues related to community characteristics, barriers to care, existing service gaps, unmet community need and other health-related factors;
- Prioritize and promote investments in community health initiatives;
- Inform and guide a comprehensive, collaborative community health improvement planning process;
- Facilitate discussion within and across sectors regarding community need, community health improvement, and health equity;
- Serve as a resource to others working to address health inequities

Bergen New Bridge is committed to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity, the attainment of the highest level of health for all people, requires focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout the assessment process, efforts were made to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. Bergen New Bridge Medical Center’s Implementation Strategy will focus on reaching the geographic, demographic, and socioeconomic segments of the population most at-risk, as well as those with behavioral and physical health needs.
BERGEN NEW BRIDGE MEDICAL CENTER’S SERVICE AREA

All 70 municipalities in Bergen County comprise Bergen New Bridge Medical Center’s Community Benefits Service Area. Bergen New Bridge, BCDHS, the CHIP, and hospital partners made every effort to identify and consider the health needs of residents within the County, regardless of whether or not they use or have used services at the hospitals or any affiliated entities.

APPROACH & METHODS

In September 2018, a Steering Committee was formed, comprised of representatives from each hospital and staff from BCDHS. The Steering Committee hired John Snow, Inc. (JSI), a public health research and consulting firm, to support their efforts and complete this CHNA. This Committee met regularly via in-person meetings and conference calls to plan and execute project activities, vet preliminary findings, address challenges, and ensure that the assessment process was inclusive, comprehensive, and objective.

During this process, each hospital and BCDHS engaged their senior leadership and clinical staff. These individuals helped to prioritize community health issues and priority population segments for inclusion in the Implementation Strategies.

The assessment was completed in three phases. Table 1 below provides a summary of each phase and the associated activities. The community engagement index (Appendix A) includes additional information and materials related to the engagement activities/approach.

Table 1: Summary of approach and methods

<table>
<thead>
<tr>
<th>Phase 1 Preliminary Assessment and Engagement</th>
<th>Phase 2 Targeted Engagement</th>
<th>Phase 3 Strategic Planning and Reporting</th>
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</thead>
<tbody>
<tr>
<td>• Secondary Data Collection</td>
<td>• Bergen County Random Household Survey</td>
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<tr>
<td>• Key Informant Interviews</td>
<td>• Focus Groups</td>
<td></td>
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<tr>
<td>• Resource Inventory</td>
<td>• Community Listening Sessions</td>
<td></td>
</tr>
<tr>
<td>• Steering Committee Meetings</td>
<td>• Bergen County Community Health Perceptions Survey</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Steering Committee Meetings</td>
<td></td>
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</tbody>
</table>

PHASE I

The preliminary needs assessment and engagement effort relied on secondary data collected via local, state, and national sources. This information included data on the population characteristics of Bergen County, including demographics, social determinants of health, health status, and morbidity/mortality. Whenever possible, confidence intervals were analyzed to test for statistically significant differences between municipal and State of New Jersey data points. A comprehensive Data Book is included in Appendix B. In this Data Book, data points are color-coded to visualize which municipal-level data points were significantly higher or lower compared to the State overall. Relative to most states, New Jersey does an excellent job at making comprehensive data available at the state, county, and municipal levels.
through an interactive portal accessible via the New Jersey Department of Health (NJ DOH) website. The most significant limitation in regards to quantitative data was the availability of timely data related to morbidity, mortality, and service utilization. The data sets used in this report are the most up-to-date provided by NJ DOH. The data provided was valuable and allowed for identification of health needs relative to the State and specific communities. However, these data sets in some cases may not reflect recent trends in health statistics. Additionally, quantitative data was not stratified by age, race/ethnicity, income, or other characteristics, which limited the ability to identify health disparities in an objective way. The Bergen County Random Household Survey and the targeted community engagement and qualitative assessment activities allowed for exploration of these issues.

**Key informant interviews** were conducted with approximately 80 community stakeholders from throughout Bergen County. These interviews confirmed and/or refined the findings from quantitative data sources and provided valuable insight on community need, community health priorities, segments of the population most at-risk, and community health assets. Individual interviews were conducted by-phone using a structured interview guide developed by JSI and the Steering Committee. At the outset, JSI worked with the Steering Committee to identify a representative list of key informants that could provide a deep and broad perspective on the health-related needs of the County. This list included administrative and clinical representatives from each of the hospitals and BCDHS, as well as representatives from across many sectors, including health, public health, social service, academic, and business. Detailed notes were taken for each interview. For a list of interviewees, their organizational affiliations, interview dates, and the interview guide, please see Appendix A. Key themes and findings from these interviews are included in the narrative sections of this report.

During this Phase, JSI staff worked with the Steering Committee to develop a **Resource Inventory**. This inventory was meant to inform what services are available in Bergen County to address community needs as well as to determine the extent to which there are gaps in health-related services. The CHIP, BCDHS staff, and hospital partners supported this effort by providing a list of community partners and known resources from across the broad continuum of services, including clinical health care services, community health and social services, and public health resources. The Resource Inventory can be found in Appendix C.
PHASE I: PRELIMINARY ASSESSMENT AND ENGAGEMENT

SECONDARY DATA – 200+ INDICATORS

- Including:
  
  Demographics and socioeconomic status
  Social determinants of health (e.g., housing, transportation, employment)
  Risk factors
  Health status and morbidity/mortality
  Access to care and service utilization

- Municipal-level data for all cities and towns in Bergen County
- National, New Jersey, and Bergen County comparison data when possible

KEY INFORMANT INTERVIEWS – 80 PHONE AND IN-PERSON

- Interviews conducted using structured interview guide
- Representation across sectors, including:
  
  Clinicians
  Health and public health officials
  Community organizations
  Older adults/elder services
  Cultural organizations and advocates
  Hospital leadership and staff
  Faith-based community
  Schools and youth/adolescent services
  Social service providers
  Behavioral health providers and advocates

RESOURCE INVENTORY

- Identified existing Bergen County assets/resources across health-related sectors

PHASE II

Phase II included several activities aimed at further engaging community residents and stakeholders – including segments that are typically hard to reach. JSI conducted a mail-based Bergen County Random Household Survey, which captured information directly from community residents on health status and overall well-being, service utilization, and barriers to care. To generate the survey sample, a comprehensive survey was distributed to more than 4,000 randomly identified households in the County. The initial random sample of 4,000 households included an oversample of communities with large proportions of Black/African American, Hispanic/Latino, and low-income residents to ensure that enough surveys were generated from households with often under-represented segments of the population. In all, 1,372 community residents responded to the survey, representing a survey response rate of approximately 31%. Table 2 includes respondent characteristics. Detailed findings from the survey are included in the body of the report and in tabular form in Appendix B.
Table 2: Respondent characteristics (unweighted) for the Bergen County Random Household Survey (N=1,372)

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Male</th>
<th>Female</th>
<th>White</th>
<th>Black/African American</th>
<th>Hispanic/Latino</th>
<th>Asian</th>
<th>Income &lt;$50,000*</th>
<th>Over 65 years old</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respondents to survey</td>
<td>1,372</td>
<td>518</td>
<td>832</td>
<td>959</td>
<td>126</td>
<td>188</td>
<td>151</td>
<td>331</td>
<td>475</td>
</tr>
<tr>
<td>Average age</td>
<td>57</td>
<td>59</td>
<td>56</td>
<td>59</td>
<td>55</td>
<td>50</td>
<td>51</td>
<td>61</td>
<td>75</td>
</tr>
<tr>
<td>Female (%)</td>
<td>62</td>
<td>-</td>
<td>100</td>
<td>61</td>
<td>68</td>
<td>71</td>
<td>54</td>
<td>71</td>
<td>57</td>
</tr>
<tr>
<td>Less than a high school education (%)</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>12</td>
<td>1</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Advanced degree (Masters or beyond) (%)</td>
<td>25</td>
<td>28</td>
<td>23</td>
<td>27</td>
<td>20</td>
<td>16</td>
<td>23</td>
<td>4</td>
<td>23</td>
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<tr>
<td>Total Household income (%)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>&lt;$50,000</td>
<td>26</td>
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<td>100</td>
<td>36</td>
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<td>$50,000 - $124,999</td>
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<td>40</td>
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<tr>
<td>&gt;$125,000</td>
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<td>31</td>
<td>18</td>
<td>27</td>
<td>--</td>
<td>21</td>
</tr>
</tbody>
</table>

*Throughout the report, the “low-income” cohort refers to are those whose total household income was less than $50,000.

Focus groups were conducted with population segments and health/social service provider groups to gather more precise and nuanced information on the needs of specific segments of the population or from individuals with specific expertise. Focus groups were held at locations that were considered safe and accessible for participants and were facilitated in appropriate languages to ensure full participation. JSI and co-facilitators conducted all focus groups using a guide that was similar to the one used for key informant interviews to ensure consistent data collection. JSI, the CHIP, and hospital partners worked with organizations in the County to plan these events and identify focus group participants.

JSI facilitated two community listening sessions, one in Ridgewood and one in Englewood. These sessions provided an opportunity for anyone who was interested to participate and allowed for the capture of information directly from community residents, staff from community-based organizations, and local service providers. Participants were asked to react to preliminary data findings and to share thoughts on community health needs, barriers to care, vulnerable populations, and community assets and resources. Both sessions were held in locations that were easily accessible, safe, and well known.

Finally, JSI worked with the Steering Committee to develop a web-based Bergen County Community Health Perceptions Survey to solicit additional information directly from community residents. Respondents were asked to provide their opinion and perceptions of leading social determinants of
health and barriers to care, clinical health issues, vulnerable populations, access to health care services, and opportunities for the hospital to improve community health programming. Surveys were available online, through the SurveyGizmo platform, in multiple languages. Surveys were also made available in hard copy for distribution; hard-copy surveys were collected and the responses were included in the final analysis. The CHIP, BCDHS, hospitals, and public health partners worked in close collaboration with local community organizations, businesses, and stakeholders to distribute the survey to community residents, including those who are typically hard-to-reach (e.g. non-English speakers, diverse populations). Findings from the survey are integrated into the narrative sections of this report.

**PHASE II: TARGETED ENGAGEMENT**

**BERGEN COUNTY RANDOM HOUSEHOLD SURVEY**
- County-wide sample
- Distributed via mail to 4,000 randomly selected households; oversampled in Black/African American, Hispanic/Latino, and low-income populations
- 1,372 surveys collected (31% response rate)
  - Average age of respondent = 57
  - 61% female (N=832)
  - 38% male (N=518)
  - 35% over 65 years of age (N=475)
  - 70% White (N=959)
  - 14% Hispanic/Latino (N=188)
  - 11% Asian (N=151)
  - 9% Black/African American (N=126)

**BERGEN COUNTY COMMUNITY HEALTH PERCEPTIONS SURVEY**
- County-wide sample
- Distributed via email, newsletters, social media, and other web-based sources
- 357 surveys collected

**FOCUS GROUPS**
- 60-90 minute sessions with population and provider segments
  - Black/African Americans
  - Koreans
  - Spanish-speakers
  - LGBTQ+
  - Individuals in recovery from substance use disorder
  - Mental health providers and advocates
  - Substance use disorder providers
  - Older adult health/elder services providers
  - School nurses
  - Bergen County Health Officers

**COMMUNITY LISTENING SESSIONS**
- 2-hour sessions, open to the public
  - Englewood
  - Ridgewood

**PHASE III**
Phase III included prioritization and strategic planning meetings with the Steering Committee, individual hospitals, and BCDHS/CHIP members. Meeting participants were presented with findings from the CHNA and were asked to weigh in on a set of proposed community health priorities and priority populations.
Participants were also asked to contribute information and ideas on current community and population health programs/initiatives that were working well and potential responses to identified needs. JSI used this information to finalize community health priorities and populations for the County overall and for each individual hospital.

Following the prioritization and strategic planning meetings, JSI worked with individual hospitals to draft CHNA reports and Implementation Strategies. These documents were presented for adoption to the governing bodies at each hospital in fall 2019.
POPULATION CHARACTERISTICS AND SOCIAL DETERMINANTS OF HEALTH

To understand community needs and health status for individuals in Bergen County, we begin with a description of community characteristics, including demographics, socioeconomics, and the social determinants of health. This information is critical to recognizing inequities, identifying vulnerable populations and health related disparities, and targeting strategic responses.

The social determinants of health (SDOH) are the conditions in which people live, work, learn and play. These conditions influence and define quality of life for many segments of the population in the CHNA service area. To augment the lack of quantitative data, the key informant interviews, focus groups, listening sessions, and Bergen County Community Health Perceptions Survey specifically solicited feedback on SDOH and barriers to care. A dominant theme from community engagement activities was the impact that the underlying social determinants, particularly housing, transportation, and income/employment have on the residents of Bergen County. As of one New Jersey's largest safety-net providers, Bergen New Bridge recognizes how the social determinants affect health care access, outcomes, and disparities. The Medical Center is committed to addressing the social determinants through collaborations with critical community partners.

More expansive data tables are included in the Bergen County Data Book (Appendix B).

---

AGE, RACE/ETHNICITY, AND FOREIGN BORN

- Bergen County has the second highest percentage of adults 65 and over among all counties in New Jersey. The percentage of Bergen County residents over the age of 65 (16.4%) was significantly high compared to New Jersey overall (15.1%). The median age in Bergen County (41.6) was also higher than New Jersey overall (39.6).

- Bergen County is predominantly white, though there is a large Asian population. The percentage of Asian residents in Bergen County (16.2%) was significantly high compared to the state overall (9.4%).

- The percentage of Black/African American residents in Bergen County (5.3%) was significantly low compared to the state overall (12.7%).

- The percentage of Hispanic/Latino residents in Bergen County (18.9) was similar to the state overall (19.7%).

- Nearly one-third (30.5%) of Bergen County residents were foreign-born.

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3 All statistics from US Census Bureau, American Community Survey, 2013-2017
### Table 3: Age distribution (2013-2017)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>United States</th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age (years)</td>
<td>37.8</td>
<td>39.6</td>
<td>41.6</td>
</tr>
<tr>
<td>Under 18 (%)</td>
<td>22.9</td>
<td>22.3</td>
<td>21.5</td>
</tr>
<tr>
<td>Ages 20-34 (%)</td>
<td>20.7</td>
<td>19.3</td>
<td>17.4</td>
</tr>
<tr>
<td>Ages 35-44 (%)</td>
<td>12.7</td>
<td>13.0</td>
<td>13.3</td>
</tr>
<tr>
<td>Ages 45-54 (%)</td>
<td>13.4</td>
<td>14.7</td>
<td>15.3</td>
</tr>
<tr>
<td>Ages 55-64 (%)</td>
<td>12.7</td>
<td>13.1</td>
<td>13.6</td>
</tr>
<tr>
<td>Ages over 65 (%)</td>
<td>14.9</td>
<td>15.1</td>
<td>16.4</td>
</tr>
</tbody>
</table>

*Source: US Census Bureau, American Community Survey, 2013-2017*

Shading represents statistical significance compared to the state. Data points highlighted in **orange** were statistically higher compared to the state overall, while figures highlighted in **blue** were significantly lower.

### Table 4: Race, ethnicity, and foreign-born (2013-2017)

<table>
<thead>
<tr>
<th>Race/ETHNICITY</th>
<th>United States</th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic White (%)</td>
<td>73.0</td>
<td>56.1</td>
<td>57.8</td>
</tr>
<tr>
<td>Non-Hispanic Black (%)</td>
<td>12.7</td>
<td>12.7</td>
<td>5.3</td>
</tr>
<tr>
<td>Non-Hispanic Asian (%)</td>
<td>5.4</td>
<td>9.4</td>
<td>16.2</td>
</tr>
<tr>
<td>Non-Hispanic Korean (%)</td>
<td>0.5</td>
<td>1.1</td>
<td>6.1</td>
</tr>
<tr>
<td>Hispanic or Latino of any race (%)</td>
<td>17.6</td>
<td>19.7</td>
<td>18.9</td>
</tr>
<tr>
<td>Foreign-born (%)</td>
<td>13.4</td>
<td>22.1</td>
<td>30.5</td>
</tr>
</tbody>
</table>

*Source: US Census Bureau, American Community Survey, 2013-2017*

Shading represents statistical significance compared to the state. Data points highlighted in **orange** were statistically higher compared to the state overall, while figures highlighted in **blue** were significantly lower.

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**Language**

- **Over a third of Bergen County residents speak a language other than English.** A significantly high percentage of Bergen County residents speak a language other than English in the home (39.9%) compared to the state overall (31%).
  - The percentage of these residents with limited English proficiency (LEP) – defined as speaking English “less than very well” – was also significantly high compared to the state (14.5% vs. 12.2%).

- **Over 1 in 10 Bergen County residents speak an Asian or Pacific Islander language in the home.** The percentage of Bergen County residents 5 years and older who spoke Asian and Pacific Islander languages (11.5%) was significantly high compared to the state overall.

- **Over 1 in 10 residents speak Spanish in the home.** The percentage of Bergen County residents 5 years and older who spoke Spanish in their home (14.9%) was significantly low compared to the state overall (16.1%).

---

4 All statistics from US Census Bureau, American Community Survey, 2013-2017
• **Over 1 in 10 residents speak Indo-European languages (e.g., French, Portuguese, German, Russian, Polish) in the home.** The percentage of Bergen County residents who spoke Indo-European languages (11.1%) and other languages (2.4%) were all significantly high compared to the state overall.

**Table 5: Percent of population 5+ who speak language other than English in the home (2013-2017)**

<table>
<thead>
<tr>
<th>Language other than English at home (%)</th>
<th>United States</th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language other than English at home (%)</td>
<td>21.3%</td>
<td>31.0</td>
<td>39.9</td>
</tr>
<tr>
<td>With LEP (%)*</td>
<td>8.5%</td>
<td>12.2</td>
<td>14.5</td>
</tr>
<tr>
<td>Spanish at home (%)</td>
<td>13.2%</td>
<td>16.1</td>
<td>14.9</td>
</tr>
<tr>
<td>With LEP (%)</td>
<td>5.4%</td>
<td>7.1</td>
<td>5.1</td>
</tr>
<tr>
<td>Indo-European languages (%)</td>
<td>3.6%</td>
<td>8.3</td>
<td>11.1</td>
</tr>
<tr>
<td>With LEP (%)</td>
<td>1.1%</td>
<td>2.8</td>
<td>3.6</td>
</tr>
<tr>
<td>Asian/Pacific Islander languages (%)</td>
<td>3.5%</td>
<td>4.8</td>
<td>11.5</td>
</tr>
<tr>
<td>With LEP (%)</td>
<td>1.6%</td>
<td>1.9</td>
<td>5.1</td>
</tr>
<tr>
<td>Other languages (%)</td>
<td>0.3%</td>
<td>1.7</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, American Community Survey, 2013-2017

Shading represents statistical significance compared to the state. Data points highlighted in orange were statistically higher compared to the state overall, while figures highlighted in blue were significantly lower.

**Socioeconomics**

Socioeconomic status (SES), as measured by income, employment status, occupation, education and the extent to which one lives in areas of economic disadvantage, is closely linked to morbidity, mortality and overall well-being.5

• **High educational attainment.**
  o The percentage of Bergen County residents with less than a high school diploma (8%) was significantly low compared to New Jersey overall (10.8%).6
  o The percentage of ninth-grade cohorts in Bergen that graduates in four years (95%) was higher than New Jersey overall (91%).7
  o The percentage of Bergen County adults ages 25-44 with some post-secondary education (77%) was higher than New Jersey overall (68%).8

• **Low unemployment rate.** The unemployment rate in Bergen County was significantly low compared to the state of New Jersey overall (3.4% vs. 4.6%).9

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6 US Census Bureau, American Community Survey, 2013-2017
7 County Health Rankings 2016-2017, from New Jersey Department of Education
8 US Census Bureau, American Community Survey, 2013-2017
9 US Census Bureau, American Community Survey, 2013-2017
- **Low percentage of individuals and families in poverty.** Despite this, key informant interviewees and focus group participants reported that there were pockets of poverty throughout Bergen County, even in towns that were considered affluent.
  - The percentage of Bergen County families (5.5%) and individuals (7.2%) living below the poverty level were significantly low compared to the state overall (7.9% and 10.7%, respectively).\(^\text{10}\)

- In Bergen County, the percentage of individuals with income below 200%, 300%, and 400% of the federal poverty level was lower than the state overall (Table 6).

---

**Figure 2: Percentage of residents below 200% of the federal poverty level, by municipality**


---

\(^{10}\) US Census Bureau, American Community Survey, 2013-2017
Table 6: Unemployment and poverty (2013-2017)

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment rate (%)</td>
<td>4.1</td>
<td>4.6</td>
<td>3.4</td>
</tr>
<tr>
<td>Individuals with income below the federal poverty level (%)</td>
<td>14.6</td>
<td>10.7</td>
<td>7.2</td>
</tr>
<tr>
<td>Families with income below the federal poverty level (%)</td>
<td>10.5</td>
<td>7.9</td>
<td>5.5</td>
</tr>
<tr>
<td>Individuals with income &lt;200% of federal poverty level</td>
<td>32.7</td>
<td>24.1</td>
<td>17.6</td>
</tr>
<tr>
<td>Individuals with income &lt;300% of federal poverty level</td>
<td>49.1</td>
<td>37.1</td>
<td>28.3</td>
</tr>
<tr>
<td>Individuals with income &lt;400% of federal poverty level</td>
<td>62.6</td>
<td>48.9</td>
<td>39.1</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, American Community Survey, 2013-2017

Shading represents statistical significance compared to the state. Data points highlighted in orange were statistically higher compared to the state overall, while figures highlighted in blue were significantly lower.

HOUSING

- **Housing issues** – including lack of housing stock and affordability – were identified as barriers to health and well-being. Many key informants and focus group/forum participants expressed concern over the limited options for affordable housing throughout Bergen County. This was particularly an issue for older adults, who often bear the burden of household costs (e.g. taxes, maintenance, adaptabilities) while living on fixed incomes.
  - The percentage of owner-occupied units in which ownership costs exceed 35% of total household income, representing a major financial burden, was significantly high in Bergen (31.3%) compared to New Jersey overall (29.3%).\(^{11}\)
  - The percentage of renter-occupied households whose gross rent exceeded 35% of total household income was significantly low (41.1%) compared to New Jersey overall (43.6%).\(^{12}\)
  - Over one-fifth of households (22%) had at least one severe housing problem (overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing) - the same as New Jersey overall.\(^{13}\)

11 US Census Bureau, American Community Survey, 2013-2017
12 US Census Bureau, American Community Survey, 2013-2017
13 Comprehensive Housing Affordable Strategy (US Department of Housing and Urban Development), 2011-2015, from County Health Rankings
**FOOD INSECURITY**

- The percentage Bergen County’s population who lacked adequate access to food (8%) was slightly lower than New Jersey overall (10%). However, this number equates to 70,200 individuals who reported that they did not have access to a reliable source of food during the past year.\(^{14}\)

- Nearly one-fifth of all respondents to the Bergen County Random Household Survey reported that they had been somewhat or very worried about food running out sometime in the past year (19%).
  - Percentages were highest among low-income (46.8%) and Hispanic/Latino (42.2%) respondents.

- Nearly one-fifth of all respondents to the Bergen County Random Household Survey reported that it was very or somewhat difficult to buy fresh produce or vegetables (18.5%).
  - Percentages were highest among Hispanic/Latino (38.4%) and low-income (32.4%) respondents.

**Figure 3: Bergen County Random Household Survey – Very or Somewhat Worried About Food Running Out Sometime During Past Year (%)**

![Bar chart showing the percentage of respondents worried about food running out, categorized by gender, race, income, and age.](chart)

*Total annual household income less than $50,000. This group is described as the “low-income” cohort throughout this report.*

\(^{14}\) Map the Meal Gap, 2016, from County Health Rankings
**CRIME & VIOLENCE**

- **Violent crime and property crime rates were low.**
  - The violent crime rate (e.g., murder/non-negligent manslaughter, forcible rape, robbery, aggravated assault) in Bergen County was significantly low compared to New Jersey overall (228.6). \(^{15}\)
  - The property crime rates (e.g., burglary, larceny/theft, motor vehicle theft, arson) in Bergen County (966.9) was significantly low compared to New Jersey overall (1537.9). \(^{16}\)

- **6% of Bergen County Random Household Survey respondents reported that they had experienced intimate partner violence.**
  - Percentages were highest among female (8.7%) and Hispanic/Latino (8.0%) respondents.

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\(^{15}\) FBI Uniform Crime Reporting: Offenses Known to Law Enforcement 2017

\(^{16}\) FBI Uniform Crime Reporting: Offenses Known to Law Enforcement 2017
Figure 5: Bergen County Random Household Survey – Had Experienced Intimate Partner Violence (%)
KEY FINDINGS: WELLNESS, PREVENTION, AND RISK FACTORS

At the core of the CHNA process is understanding leading risk factors and the extent to which individuals participate in certain risky behaviors. This information is critical to assessing health status, clarifying health-related disparities and identifying health priorities. The CHNA captures a wide range of quantitative data from federal and municipal data sources and from the Bergen County Random Household Survey. Qualitative information gathered from key informant interviews, focus groups, listening sessions, and the web-based Community Health Perceptions Survey informed the key findings sections of this report by providing perspective on the confounding and contributing factors of illness, health priorities, barriers to care, service gaps and possible strategic responses to the issues identified.

OVERALL HEALTH STATUS

- **Overall health status among Bergen County residents was good.**
  - Among all Bergen County Random Household Survey respondents, 87% reported that their general health was excellent, very good, or good. Only 13% reported their health status as fair or poor. Over one fourth (25.3%) of low-income respondents reported fair or poor health status.
  - 19.7% of respondents to the Bergen County Random Household Survey responded that they are limited in some way because of a physical, mental, or emotional problem. Percentages were highest among low-income respondents (31.9%), respondents over 65 (31.1%), and Black/African American respondents (27.7%).

- **All-cause mortality and premature mortality was lower than the state overall.**
  - The all-cause mortality rate was significantly lower in Bergen County (760) than New Jersey overall (810.7).\(^{17}\)
  - The premature mortality rate – or the years of life lost before age 75 – was lower in Bergen County (3,800) than the state overall (5,700).\(^{18}\)
  - The average age of death in Bergen County (78.2) was significantly higher than New Jersey overall (75.0).\(^{19}\)

\(^{17}\) Deaths per 100, New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017

\(^{18}\) Years of potential life lost before age 75 per 100,000 (age-adjusted); National Center for Health Statistics – Mortality Files, 2015-2017

\(^{19}\) New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017
Figure 6: Bergen County Random Household Survey - Self Reported Health Status as Fair or Poor (%)

Figure 7: Bergen County Random Household Survey - Limited in Some Way Due to Physical, Mental, or Emotional Problems (%)
NUTRITION & WEIGHT

- One-third (33.2%) of all respondents to the Bergen County Random Household Survey were overweight, while 22.8% were obese.
  - 41% of Black/African American respondents reported being overweight, and 30.6% reported as obese. These percentages were highest among all racial/ethnic cohorts.
  - Obesity percentages were also high among low-income (29.25%) and Hispanic/Latino (29%) respondents.

Figure 8: Bergen County Random Household Survey - Overweight (%)

Figure 9: Bergen County Random Household Survey - Obese (%)

Bergen New Bridge Medical Center: Community Health Needs Assessment 2019 || Page 27
• 75.4% of Bergen County Random Household Survey respondents reported that, on average, they had less than three servings of fruit per day in the past month. Daily fruit consumption was lowest among Asian (86.6%) and Hispanic/Latino (85.9%) respondents.

• 78.8% of survey respondents reported that, on average, they had less than three servings of vegetables per day in the past month. Percentages were highest among Hispanic/Latino (83.1%) and Asian (83.1%) respondents.

**Figure 10: Bergen County Random Household Survey – Less Than 3 Servings of Fruit a Day (%)**

**Figure 11: Bergen County Random Household Survey – Less Than 3 Servings of Vegetables a Day (%)**
• 19.1% of survey respondents reported drinking sugar sweetened drinks (e.g., Kool-Aid, lemonade, sweet tea, sports drinks, energy drinks) on more than 5 days in the past week.
  o Percentages were nearly double among Hispanic/Latino (37.4%) and Black/African American (37.3%) survey respondents.

Figure 12: Bergen County Random Household Survey – Has Sugar Sweetened Drinks 5+ Days a Week (%)

PHYSICAL ACTIVITY

• The Bergen County Random Household Survey revealed disparities in regular physical activity. 32.9% of all respondents reported that they did not participate in any physical activity or exercise, outside of their normal job, in the past 30 days; only 18.6% reported moderate exercise in the past 30 days.
  o Low-income respondents (47.9%), Hispanic/Latino respondents (43.2%), Black/African American respondents (41.6%), and Asian (41.2%) respondents reported less exercise than other cohorts.

The Bergen County Community Health Perceptions Survey asked people to name the issues they thought prevented people from living a healthy life. “Physical inactivity or sedentary lifestyle” was the second most common response (44.5%).
ROUTINE HEALTH VISITS

- **Primary care providers.** Among all respondents to the Bergen County Random Household Survey, 83.9% reported that they had one person they considered their personal care doctor or primary care provider. Percentages were lowest among Hispanic/Latino respondents (77.2%).
• **Primary care visits.** Among all respondents to the Bergen County Random Household Survey, 70.3% reported that they had a primary care visit within the last year. Percentages were similar across racial/ethnic cohorts. Percentages were highest among respondents over 65 years old (87.4%).

**Figure 15: Bergen County Random Household Survey – Had Primary Care Visit within Past Year (%)**

- All: 70.3%
- Male: 68.7%
- Female: 72%
- White: 70.3%
- Black/Af. Amer: 70.8%
- Hisp./Lat.: 67.1%
- Asian: 73.6%
- Income <$50K: 70.6%
- Over 65: 87.4%

• **Disparities in dental visits.** Approximately 70% of respondents reported having been to the dentist within the past year. Percentages were lowest among low-income respondents (54.1%) and Black/African American respondents (55.9%).

**Figure 16: Bergen County Random Household Survey – Had Dental Visit within Past Year (%)**

- All: 70.6%
- Male: 71%
- Female: 70.3%
- White: 73.8%
- Black/Af. Amer: 55.9%
- Hisp./Lat.: 65.1%
- Asian: 70.1%
- Income <$50K: 54.1%
- Over 65: 68.5%
KEY FINDINGS: CHRONIC AND COMPLEX CONDITIONS

Chronic and complex conditions such as heart disease, cancer, stroke, Alzheimer’s disease, and diabetes are the leading causes of death and disability in the United States, and are the leading drivers of the nation’s $3.3 trillion annual healthcare costs. Over half of American adults have at least one chronic condition, while 40% have two or more. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

This section discusses specific conditions in approximate order of how they were prioritized in the assessment process. Age-specific findings (older adult health/healthy aging and maternal and infant health) follow the discussion of specific conditions.

CARDIOVASCULAR & CEREBROVASCULAR DISEASES

- **Heart disease was the leading cause of death in Bergen County in 2017**, representing 25.7% of all deaths.22
- Cardiovascular and cerebrovascular disease mortality, inpatient hospitalization, and emergency discharge rates were significantly low in Bergen County compared to the state overall. Despite this, key informants, focus group/listening session participants, and community residents identified these issues as priorities.

The Bergen County Community Health Perceptions Survey asked respondents what health issues they think people in their community struggle with the most. Despite significantly low mortality, hospitalization, and emergency room discharge rates, “Cardiovascular conditions (e.g., high blood pressure/hypertension, heart disease) was the most common response (49.2%).

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21 CDC, *Chronic Diseases in America*
Table 7: Cardiovascular and cerebrovascular disease mortality, inpatient hospitalizations, and emergency room discharges (crude rates per 100,000)

<table>
<thead>
<tr>
<th></th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>207.3</td>
<td>199.3</td>
</tr>
<tr>
<td>Inpatient hospitalizations*</td>
<td>1082.6</td>
<td>871.1</td>
</tr>
<tr>
<td>Emergency department discharges*</td>
<td>303.6</td>
<td>252.5</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mortality</td>
<td>38.3</td>
<td>36.7</td>
</tr>
<tr>
<td>Inpatient hospitalizations*</td>
<td>243.0</td>
<td>206.3</td>
</tr>
<tr>
<td>Emergency department discharges*</td>
<td>38.0</td>
<td>19.2</td>
</tr>
</tbody>
</table>

**Source:** New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017


Shading represents statistical significance compared to the state data point. Figures highlighted in **orange** were significantly higher compared to the state overall, while figures highlighted in **blue** were significantly lower.

- **Racial/ethnic, age, and income disparities.** The Bergen County Random Household Survey revealed disparities in the percentage of residents who had been told by a doctor that they had high blood pressure, had a heart attack, or had a stroke.
  - Approximately 1 in 4 Bergen County Random Household Survey respondents had been diagnosed with high blood pressure by a physician (26.5%).
    - Percentages were highest among respondents over 65 (57.8%) and Black/African American respondents (37.5%).
  - 2.7% of Bergen County Random Household Survey respondents had experienced a physician-diagnosed myocardial infarction (heart attack).
    - Percentages were highest among respondents over 65 (8.1%) and male respondents (4.0%).
  - 1.8% of Bergen County Random Household Survey respondents had experienced a stroke.
    - Percentages were highest among respondents over 65 (6.1%), Black/African American respondents (4.0%), and low-income respondents (3.8%).
Figure 17: Bergen County Random Household Survey – Has Physician-Diagnosed High Blood Pressure (%)

Figure 18: Bergen County Random Household Survey – Has Had a Physician-Diagnosed Heart Attack (%)
CANCER

SCREENINGS

- **Low-income respondents reported less frequent mammograms.** Among respondents to the Bergen County Random Household Survey, a smaller percentage of low-income women over 40 reported having had a recent mammogram (57.3%) compared to all female respondents over 40 (68.1%).

- **Disparities for recent PSA tests among men over 40.** Among men over 40 who responded to the Bergen County Random Household Survey, 44.9% reported a recent prostate antigen test (PSA). Percentages were lowest among low-income respondents (31.7%) and Hispanic/Latino respondents (33.5%).

- **Disparities in sigmoidoscopies/colonoscopies.** Among individuals over 50 who responded to the Bergen County Random Household Survey, 70.4% reported having ever had a sigmoidoscopy/colonoscopy. Percentages were lowest among Hispanic/Latino respondents (55.0%) and low-income respondents (56.7%).

- **Disparities in recent Pap tests.** Among women over 18 who responded to the Bergen County Random Household Survey, 58.9% reported having had a recent Pap test. Percentages were lowest among Asian respondents (39.2%) and low-income respondents (40.0%).
The Prostate-Specific Antigen (PSA) test is primarily used to screen for prostate cancer.

---

2 The Prostate-Specific Antigen (PSA) test is primarily used to screen for prostate cancer.
Figure 22: Bergen County Random Household Survey – Ever Had Sigmoidoscopy/Colonoscopy among Men and Women Over 50(%)*

*Sigmoidoscopies and colonoscopies are the two main procedures to screen for colorectal cancer

Figure 23: Bergen County Random Household Survey – Recent Pap among Women Over 18 (%)**

**The Papanicolaou (Pap) test is a method of cervical screening used to detect potentially precancerous and cancerous processes in the cervix.
DIAGNOSES

- Approximately 1 in 10 Bergen County Random Household Survey respondents had ever been diagnosed with cancer (9.7%). The percentage was higher among respondents over 65 (26.5%) and White respondents (12.0%).

**Figure 24: Bergen County Random Household Survey – Ever Been Diagnosed With Cancer (Any Type) (%)**

MORTALITY

- Cancer was the second leading cause of death in Bergen County in 2017, representing 22.6% of all deaths. 23
- Cancer mortality rates similar to New Jersey. Across all-types of cancer, breast cancer, colorectal cancer, lung cancer, and prostate cancer, mortality rates were similar to New Jersey overall (Figure 25).

### Figure 25: Cancer Mortality (crude rates per 100,000), 2013-2017

![Cancer Mortality Graph](image)

**Source:** New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017

### DIABETES

- **Over 10% of survey respondents reported that they had diabetes.**
  - Among respondents to the Bergen County Random Household Survey, 11.5% reported that they had been diagnosed with diabetes.
    - Percentages were highest among respondents over 65 (22.1%), low-income respondents (16.7%), and Black/African American respondents (15.7%).
  - 11.2% Bergen County Random Household Survey respondents reported that a physician had told them that they had borderline or pre-diabetes.
    - Percentages were highest among respondents over 65 (19.8%) and low-income respondents (16.3%).

---

**Key informants and focus group/listening session participants prioritized many of the risk factors for diabetes — poor nutrition, physical inactivity, and obesity — and discussed the need for diabetes management and support services for those affected.**
Figure 26: Bergen County Random Household Survey – Ever Been Diagnosed With Diabetes (%)

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Diabetic (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1372</td>
<td>11.5</td>
</tr>
<tr>
<td>Male</td>
<td>518</td>
<td>12.2</td>
</tr>
<tr>
<td>Female</td>
<td>832</td>
<td>10.9</td>
</tr>
<tr>
<td>White</td>
<td>959</td>
<td>11.1</td>
</tr>
<tr>
<td>Black/Af. Amer</td>
<td>126</td>
<td>15.7</td>
</tr>
<tr>
<td>Hisp./Lat.</td>
<td>188</td>
<td>7.8</td>
</tr>
<tr>
<td>Asian</td>
<td>151</td>
<td>12.1</td>
</tr>
<tr>
<td>Income &lt;$50K</td>
<td>331</td>
<td>16.7</td>
</tr>
<tr>
<td>Over 65 yrs old</td>
<td>475</td>
<td>22.1</td>
</tr>
</tbody>
</table>

Figure 27: Bergen County Random Household Survey – Ever Been Told They Had Borderline/Pre-Diabetes (%)

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Pre-Diabetic (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>1372</td>
<td>11.2</td>
</tr>
<tr>
<td>Male</td>
<td>518</td>
<td>11.3</td>
</tr>
<tr>
<td>Female</td>
<td>832</td>
<td>11.3</td>
</tr>
<tr>
<td>White</td>
<td>959</td>
<td>10.7</td>
</tr>
<tr>
<td>Black/Af. Amer</td>
<td>126</td>
<td>13.4</td>
</tr>
<tr>
<td>Hisp./Lat.</td>
<td>188</td>
<td>12.8</td>
</tr>
<tr>
<td>Asian</td>
<td>151</td>
<td>11.9</td>
</tr>
<tr>
<td>Income &lt;$50K</td>
<td>331</td>
<td>16.3</td>
</tr>
<tr>
<td>Over 65 yrs old</td>
<td>475</td>
<td>19.8</td>
</tr>
</tbody>
</table>
Diabetes mortality, inpatient hospitalizations, and emergency discharges significantly low.
  - In Bergen County, the diabetes mortality rate (17.9) was significantly low compared to New Jersey overall (22.1).\textsuperscript{24}
  - In Bergen County, the rates of inpatient hospitalizations (105.6) and emergency department discharges (100.4) due to diabetes were significantly low compared to New Jersey overall (177.1 and 189.9, respectively).

**Table 8: Diabetes mortality, inpatient hospitalizations, and emergency department visits**

<table>
<thead>
<tr>
<th></th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes mortality</td>
<td>22.1</td>
<td>17.9</td>
</tr>
<tr>
<td>Diabetes inpatient hospitalizations*</td>
<td>177.1</td>
<td>105.6</td>
</tr>
<tr>
<td>Diabetes emergency room visits*</td>
<td>189.9</td>
<td>100.4</td>
</tr>
</tbody>
</table>

*Source: Crude rates per 100,000; New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017
*Source: New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, 2016. Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

**ASTHMA**

- 14.1\% of respondents to the Bergen County Random Household Survey reported that a doctor had told them that they had asthma. Percentages were highest among Black/African American (19.2\%) respondents.

**Figure 28: Bergen County Random Household Survey — Ever Been Told They Had Asthma (%)**

\textsuperscript{24} New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017
INFECTIONIOUS DISEASE

- **Pneumonia/Influenza** - The Influenza/pneumonia mortality rate was significantly high in Bergen County (16.5) compared to New Jersey overall (14.6).\(^{25}\)
  - Over half of Bergen County residents had not received a flu vaccination within the past 12 months.\(^{26}\)

- **Sexually transmitted diseases** – Chlamydia, gonorrhea, and syphilis case counts were significantly low in Bergen County compared to New Jersey overall (Table 9).

### Table 9: Sexually Transmitted Diseases

<table>
<thead>
<tr>
<th></th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia cases</td>
<td>355</td>
<td>189.6</td>
</tr>
<tr>
<td>Gonorrhea cases</td>
<td>86</td>
<td>29.4</td>
</tr>
<tr>
<td>Syphilis cases</td>
<td>15</td>
<td>9.5</td>
</tr>
</tbody>
</table>

*Source: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, 2013-2017*

Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

- **Other communicable diseases** - Hepatitis B and Tuberculosis incidence in Bergen County was similar to New Jersey overall. Incidence of Hepatitis C, in all forms, was significantly lower than the state. HIV prevalence was lower than the state (Table 10).

### Table 10: Communicable Diseases

<table>
<thead>
<tr>
<th></th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>4.2</td>
<td>4.3</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>85.5</td>
<td>40.9</td>
</tr>
<tr>
<td>HIV prevalence</td>
<td>474</td>
<td>222</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>3.3</td>
<td>3.7</td>
</tr>
</tbody>
</table>

*Source: Communicable Disease Reporting and Surveillance System, New Jersey Department of Health, 2013-2017*

\(^{25}\) New Jersey Death Certificate Database, Office of Vital Statistics and Registry, crude death rate per 100,000 2013-2017

\(^{26}\) New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health, age-adjusted rates per 100,000 (2012-2016)
OLDER ADULT HEALTH/HEALTHY AGING

Additional information on the health of older adults is included throughout this report, where data is stratified by age.

- **Falls** – 14.9% of Bergen County Random Household Survey respondents 65 or older reported that they had fallen at least once in the past 3 months.

- **Advanced Directives/End of Life Care** – 58.7% of Bergen County Random Household Survey respondents 65 or older reported that they had no legal documents that provide end of life instructions (e.g., medical power of attorney, health care proxies, and advanced directives).

- **Social and emotional support** – 12.7% of Bergen County Random Household Survey respondents 65 or older reported that they rarely or never get the social and emotional support they need.
  - Within this same age cohort, 32% reported that they do not regularly participate in activities that allow them to socialize.

- **Neurological and memory disorders.**
  - The Alzheimer’s disease mortality rate was significantly high in Bergen County (30.6) compared to New Jersey overall (25.2).
  - The Parkinson’s disease mortality rate in Bergen County was similar to the state overall.

<table>
<thead>
<tr>
<th>Alzheimer's Disease mortality (crude rate per 100,000)</th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.2</td>
<td>30.6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parkinson’s disease mortality (crude rate per 100,000)</th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.3</td>
<td>9.5</td>
<td></td>
</tr>
</tbody>
</table>

Source: Crude rates per 100,000; New Jersey Death Certificate Database, Office of Vital Statistics and Registry, 2013-2017

The Berg County Community Health Perceptions Survey asked people to name the populations with the greatest health needs. “Older adults (65+)” was the most common response (66.2%).

Many key informants and focus group/listening session participants were concerned about social isolation and depression for older adults, especially those that are frail, live alone, and lack a regular caregiver.

Table 11: Alzheimer’s and Parkinson’s Disease Mortality

Shading represents statistical significance compared to the state data point. Figures highlighted in **orange** were significantly higher compared to the state overall, while figures highlighted in **blue** were significantly lower.
MATERNAL & INFANT HEALTH

- **Teen births** – The adolescent birth rate was significantly low in Bergen County (4.0) compared to the state overall (12.0).

- **Adequate prenatal care** – Approximately 66% of individuals in Bergen County received adequate prenatal care. 27

- **Low birthweight and preterm births** – The percentage of low birthweight (<2500 g) infants and preterm births (<37 weeks) in Bergen County were lower than New Jersey overall.

<table>
<thead>
<tr>
<th></th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent (15-19) birth rate</td>
<td>12.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Adequate prenatal care (%)</td>
<td>67.1</td>
<td>66.4</td>
</tr>
<tr>
<td>Low birthweight (%)</td>
<td>8.1</td>
<td>7.9</td>
</tr>
<tr>
<td>Preterm births &lt;37 weeks (%)</td>
<td>9.6</td>
<td>9.7</td>
</tr>
</tbody>
</table>


Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

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27 The Kotelchuck Index, also called the Adequacy of Prenatal Care Utilization (APNCU) Index, uses two crucial elements obtained from birth certificate data—when prenatal care began (initiation) and the number of prenatal visits from when prenatal care began until delivery (received services). The Kotelchuck Index classifies the adequacy of initiation as follows: pregnancy months 1 and 2, months 3 and 4, months 5 and 6, and months 7 to 9, with the underlying assumption that the earlier prenatal care begins the better. To classify the adequacy of received services, the number of prenatal visits is compared to the expected number of visits for the period between when care began and the delivery date. A ratio of observed to expected visits is calculated and grouped into four categories—Inadequate (received less than 50% of expected visits), Intermediate (50%-79%), Adequate (80%-109%), and Adequate Plus (110% or more). The final Kotelchuck index measure combines these two dimensions into a single summary score. The profiles define adequate prenatal care as a score of 80% or greater on the Kotelchuck Index.
KEY FINDINGS:
MENTAL/BEHAVIORAL HEALTH AND
SUBSTANCE USE DISORDER

Information on access to mental health and substance use disorder treatment and support services is included in the “Social Determinants of Health and Access to Care” section of this report.

MENTAL/BEHAVIORAL HEALTH

- Mental and behavioral health have an impact on all population segments, though emphasis was on youth/adolescents, isolated older adults, and immigrants.
  - **Youth/Adolescents**: Depression, stress, and anxiety are mental health issues affecting youth and adolescents. Several individuals cited increased pressure to succeed in school and extracurricular activities, the impacts of social media, and increased social isolation due to use of technology as contributing factors.
  - **Older Adults**: Many key informants and focus group/listening session participants identified social isolation as an issue for older adults. Participants suggested several reasons for this isolation — a lack of friends or family, inability to leave the home due to frailty or limited access to transportation, or unwillingness to leave the home for unknown reasons. While there are many active senior centers and Councils on Aging in Bergen County, participants reported that it was difficult for some older adults to attend activities or utilize services because of transportation or mobility issues.
  - **Immigrants and non-English speakers**: In a focus group with Koreans in Bergen County — many of whom were older adults — social isolation was identified as a significant issue. Participants spoke about the loneliness that comes along with being a new immigrant, a non-English speaker, or someone who doesn’t identify with a particular culture. Participants also noted that mental health issues have historically been considered taboo in Korean culture — many individuals do not feel comfortable speaking about these issues with family, friends, or health care providers.

Mental health, including depression, anxiety, stress, and other conditions — was overwhelmingly identified by key informants, focus group/listening session participants, and stakeholders as one of the leading health issue for residents of Bergen County.
- 6.8% of respondents to the Bergen County Random Household Survey reported that their mental health was poor for 15 or more days in the past month.
  - Percentages were highest among low-income (13.3%), Black/African American (10.9%), and Hispanic/Latino (9.5%) respondents.

- 7.5% of Bergen County Random Household Survey respondents reported that they had felt sad, blue, or depressed for more than 15 days within the past month. Percentages were highest among low-income (13.2%) and Hispanic/Latino (10.3%) respondents.
  - Nearly 1 in 10 with diagnosed depression. 9.7% of respondents had been diagnosed with a depressive disorder. Percentages were higher among female (11.9%) and low-income respondents (11.6%).

Figure 29: Bergen County Random Household Survey – Sad, Blue, Depressed More Than 15 Days in Last Month (%)

![Figure 29: Bergen County Random Household Survey – Sad, Blue, Depressed More Than 15 Days in Last Month (%)](image-url)
• 13.9% of respondents reported that they had felt worried, tense, or anxious for more than 15 days within the past month. Percentages were highest among low-income (22.4%), female (16.1%), and Hispanic/Latino (15.8%) respondents.
  
  o **Over 1 in 10 with anxiety.** 12.7% of respondents to the Bergen County Random Household Survey reported that they had been diagnosed with an anxiety disorder. Percentages were highest among white (15.6%) and female (15.2%) respondents.
Figure 32: Bergen County Random Household Survey – Ever Been Diagnosed With Anxiety Disorder (%)

- **Mental and behavioral disorder inpatient hospitalization rate significantly high.** The rate of mental and behavioral disorder inpatient hospitalizations was significantly high in Bergen County (557.3) compared to New Jersey overall (525.1).

Table 13: Mental and behavioral disorder hospitalizations and emergency department discharges

<table>
<thead>
<tr>
<th></th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental and behavioral disorder inpatient hospitalizations</td>
<td>525.1</td>
<td>557.3</td>
</tr>
<tr>
<td>Mental and behavioral disorder emergency department discharges</td>
<td>1122.9</td>
<td>651.4</td>
</tr>
</tbody>
</table>

Source: Crude rates per 100,000; New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment, New Jersey Department of Health, 2016

Shading represents statistical significance compared to the state data point. Figures highlighted in orange were significantly higher compared to the state overall, while figures highlighted in blue were significantly lower.

**SUBSTANCE USE**

**TOBACCO USE AND E-CIGARETTE/VAPING**

- **18.9% of Bergen County Random Household Survey respondents were smokers.**
  - Nearly half of all Asian respondents (49%) smoked. The percentage was also high among low-income respondents (28.8%).
6.0% of Bergen County Random Household Survey respondents reported having used an e-cigarette or vapor product within the past 12 months. It should be noted that the Bergen County Random Household Survey was aimed at reaching individuals over 18, thus the small percentage represents use among adult respondents only. According to the 2018 National Youth Tobacco Survey, e-cigarette use among high school students increased by a staggering 78% from 2017 to 2018.28

- Among the Bergen County Random Household Survey respondents who reported using an e-cigarette/vapor product in the past 12 months, 24.7% reported that they used it to help them quit smoking.

**Figure 33: Bergen County Random Household Survey — Current Cigarette Smokers (%)**

ALCOHOL USE

- **Risky/heavy drinking** - 5.0% of respondents to the Bergen County Random Household Survey reported heavy/risky drinking in the past 30 days – defined as having more than one alcoholic beverage per day on average (7 drinks per week) for women, and more than two alcoholic beverages per day on average (14 drinks per week) for men.

- **Binge drinking** - 15.4% of respondents to the Bergen County Random Household Survey reported binge drinking in the past 30 days – defined as more than four alcoholic beverages at any one sitting for women, and five alcoholic beverages at any one sitting for men. Percentages were highest among male (19.2%) respondents.
ILLEGAL DRUG USE

- **7.8% of Random Household Survey respondents reported having used drugs (e.g., heroin, cocaine, crack, painkillers like Percocet, Dilaudid, Demerol, Vicodin, and OxyContin) within the past 12 months.** It should be noted that individuals who responded that they used painkillers did not define whether these substances were used as-prescribed or for recreational purposes.

- **Opioid overdose deaths have increased every year since 2013.**

- **The number of Naloxone (Narcan) administrations — to rapidly reverse an opioid overdose — have increased every year since 2015.**

- **Prescriptions dispensed decreased.** Since 2015, the number of opioid prescriptions dispensed has steadily decreased. Approximately 47,000 fewer opioid prescriptions were dispensed in 2018 than in 2017.
Figure 36: Suspected Opioid Overdose Deaths in Bergen County

Source: NJCares, Office of the New Jersey Coordinator for Addiction Responses and Enforcement Strategies; State of New Jersey Office of the Attorney General

Figure 37: Naloxone (Narcan) Administrations in Bergen County

Source: NJCares, Office of the New Jersey Coordinator for Addiction Responses and Enforcement Strategies; State of New Jersey Office of the Attorney General
MARIJUANA USE

- 11% of Random Household Survey respondents reported that they currently use marijuana.
  - Percentages were highest among male (14.6%) and white (13.1%) respondents.

Figure 39: Bergen County Random Household Survey – Currently Uses Marijuana (%)

Source: NJCares, Office of the New Jersey Coordinator for Addiction Responses and Enforcement Strategies; State of New Jersey Office of the Attorney General
KEY FINDINGS: SOCIAL DETERMINANTS AND ACCESS TO CARE

PERCEIVED BARRIERS TO CARE
Just as it is important to understand and characterize disease burden, it is important to understand whether individuals are able to access health care services when they want them, where they want them, and how they want them. Throughout the assessment, key informants, focus/group listening session participants, and key stakeholders described the common barriers to care people face when trying to access care in Bergen County. Many of these barriers are associated with the social determinants of health – inability to pay for needed services or health insurance, lack of transportation, and linguistic/cultural barriers. Other barriers were related to issues within the health service system – lack of providers, inability to find appointments, and fragmented service systems.

- **Receiving all needed medical services** - 10.1% of Bergen County Random Household Survey respondents reported that they did not receive all of the medical services they needed in the past 12 months. Percentages were highest among low-income (14.4%) respondents.
  - Among those who did not receive needed care (of any kind) within the past 12 months, 4.1% of respondents reported that it was because of the high cost of care; 2.2% reported that it was because they had no health insurance.

- **Factors that limit access to care and impact health** - Bergen County Random Household Survey respondents were asked to identify the leading social factors or barriers that limit access to care or impact the health of those living in the community.
  - Lack of health insurance, poverty/low wages/limited job opportunities, lack of social support and social isolation, limited transportation, limited education/health literacy, and lack of affordable and/or safe housing were the top six responses.
HEALTH INSURANCE

Whether an individual has health insurance—and the extent to which it helps to pay for needed acute services and access to a full continuum of high-quality, timely and accessible preventive and disease management or follow-up services—has been shown to be critical to overall health and well-being.29

- **Percent uninsured significantly low** - In Bergen County, the percentage of the population that was uninsured (9.2) was significantly low compared to New Jersey overall (9.7).30
  - The percentage with public insurance (e.g., Medicaid, Medicare) in Bergen County (24.3%) was also significantly low compared to New Jersey overall (29.7%).
  - The percentage of the population with private insurance (76.4%) was significantly high compared to New Jersey overall (71.6%).

---


30 US Census Bureau, American Community Survey, 2013-2017
### Table 14: Health Insurance (2013-2017)

<table>
<thead>
<tr>
<th>Health Insurance Details</th>
<th>New Jersey</th>
<th>Bergen County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured (%)</td>
<td>9.7</td>
<td>9.2</td>
</tr>
<tr>
<td>Public health insurance (e.g., Medicaid, Medicare) (%)</td>
<td>29.7</td>
<td>24.3</td>
</tr>
<tr>
<td>Private health insurance (%)</td>
<td>71.6</td>
<td>76.4</td>
</tr>
</tbody>
</table>

*Source: US Census Bureau, American Community Survey, 2013-2017*

Shading represents statistical significance compared to the state. Figures highlighted in orange were significantly high compared to the state overall, while figures highlighted in blue were significantly low.

- Among respondents to the Bergen County Random Household Survey, 10.9% reported that they had been uninsured sometime within the past year.
  - Percentages were highest among low-income (26.4%), Hispanic/Latino (20.2%), and Black/African American (19.3%) respondents.

**Figure 41: Bergen County Random Household Survey – Uninsured Sometime Within Past Year (%)**

![Chart showing percentages of uninsured individuals by demographic groups.]

**SERVICE UTILIZATION**

- 20.2% of Bergen County Random Household Survey respondents reported that they had visited the emergency room one or more times in the past year.
  - Percentages were highest among Black/African American respondents (28.8%) and those over 65 (24.9%).
- 9.3% of Bergen County Random Household Survey respondents reported that they had stayed in a hospital overnight for care of observation one or more times in the past year.
  - Percentages were highest among respondents over 65 (18.0%) and low-income respondents (14.8%).

**Figure 42: Bergen County Random Household Survey — Visited Emergency Room At Least Once in Past Year (%)**

One of the major themes of this assessment was that individuals struggle to access behavioral healthcare services, including psychiatry, inpatient/outpatient mental health treatment, substance use detoxification and rehabilitation, outpatient substance use treatment, and medication-assisted treatment. Many of the individuals engaged during this assessment reported that hospitals and community partners were working to fill service gaps and address the needs of individuals and the community at-large, yet people continue to face delays or barriers to care due to limited providers and specialists, limited treatment beds, and social determinants that impede access to care (e.g., insurance coverage, transportation, employment, health literacy). Many participants also discussed the co-morbidity that often occurs between mental health and substance use issues, which complicates treatment options.

- 9.3% of Random Household Survey respondents that they received counseling, treatment, or medicine for mental health or substance use issues within the last 12 months. Percentages were highest among low-income (11.2%) respondents.
  - 17.8% of Bergen County Random Household Survey respondents reported that they never or rarely get the social/emotional help they need. Percentages were highest among Asian (34.3%), low-income (25.6%), and male (23.5%) respondents.
• **16.5% of respondents reported that they did not receive needed mental health care in the past year.** Percentages were highest among Black/African American (20.2%) and white (17.7%) respondents.

• **7.0% of respondents reported that they did not receive needed substance use treatment in the past year.** Percentages were highest among low-income (10.8%) and Asian (9.0%) respondents.

**Figure 43: Bergen County Random Household Survey – Received Counseling, Treatment, or Medicine for Mental Health/Substance Use Issue in Past Year (%)**

**Figure 44: Bergen County Random Household Survey – Did Not Receive Needed Mental Health Treatment (%)**
Figure 45: Bergen County Random Household Survey – Did Not Receive Needed Substance Use Treatment (%)

Figure 46: Bergen County Random Household Survey – Never or Rarely Get Social/Emotional Help They Need (%)

Bergen New Bridge Medical Center: Community Health Needs Assessment 2019 || Page 59
SUMMARY IMPLEMENTATION STRATEGY

This section provides a summary of the planning principles applied to the development of Bergen New Bridge Medical Center’s Implementation Strategy. Below is also a discussion of the priority populations that the Implementation Strategy aims to reach, and goals, objectives, and strategies within each identified priority area. A full Implementation Strategy, with goals, objectives, strategies, sample measures, and potential community partners may be found in Appendix D.

IMPLEMENTATION STRATEGY PLANNING PRINCIPLES

The following defines the types of programmatic strategies and interventions that were applied in the development of the Implementation Strategy.

- **Identification of those At-risk (Outreach, Screening, Assessment and Referral):** Screening and assessment programs reduce the risk of death or ill health from a specific condition by offering tests to help identify those who could benefit from treatment. A critical component of screening and referral efforts is to provide linkages to providers, treatment, and supportive services should an issue be detected.

- **Health Education and Prevention:** Initiatives that aim to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, or altering unhealthy behaviors. Programs might include targeted efforts to raise awareness about a particular condition or provide information on risk and protective factors.

- **Behavior Modification and Chronic Disease Management:** Evidence-based behavioral modification and/or chronic disease management programs that encourage individuals to manage their health conditions, change unhealthy behaviors, and make informed decisions about their health and care.

- **Care Coordination and Service Integration:** Initiatives that integrate existing services and expand access to care by coordinating health services, patient needs, and information.

- **Patient Navigation and Access to Care:** Efforts which aim to help individuals navigate the health care system and improve access to services when and where they need them.

- **Cross-Sector Collaboration and Partnership:** Includes collaborations, partnerships, and support of providers and community organizations across multiple sectors (e.g., health, public health, education, public safety, and community health).
PRIORITY POPULATIONS

Bergen New Bridge is committed to improving the health status and well-being of all residents living in Bergen County - certainly all geographic, demographic, and socioeconomic segments of the population face challenges that may impede their ability to access care or maintain good health. Regardless of age, race/ethnicity, income, family history, or other characteristics, everyone is impacted in some way by health-related disparities. With this in mind, the Medical Center’s Implementation Strategy includes activities that will support all residents, across all segments of the population. However, based on the assessment’s quantitative and qualitative findings, there was broad agreement that the Implementation Strategy should prioritize certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care, service gaps, or adverse social determinants of health, which put them at greater risk. The assessment identified the following priority populations:

**Figure 47: Bergen New Bridge Medical Center Priority Populations 2020-2022**

**YOUTH & ADOLESCENTS**

Individuals that were engaged during this assessment identified children as one of the most vulnerable and at-risk populations in the region. Participants’ reasons for believing this group should be prioritized varied, but centered on the prevalence and impact of mental health and substance use. Children and adolescents are both in critical formative and transitional period that include biological and developmental milestones that are important to establishing long-term identity and independence. Although adolescents are generally healthy, they do struggle with health and social issues, such as obesity (e.g., poor nutrition and lack of physical activity), mental health (e.g., depression, anxiety, stress), substance use (e.g., cigarettes/vaping, marijuana, alcohol, opiates), sexually transmitted infectious, and injuries due to accidents. In order to thrive children and adolescents need strong, supportive families and/or other support networks to guide them through the early stages of life.

**OLDER ADULTS**

The challenges faced by older adults came up in nearly every interview and focus group. Chronic disease, social isolation/lack of family support, living on fixed incomes, affordable housing, and
transportation were identified as significant issues. In the U.S. and New Jersey, older adults are among the fastest growing age groups.

Older adults experience a higher risk of chronic and complex conditions such as heart disease, cancer, stroke, diabetes, and neurological disorders (e.g., dementia, Alzheimer’s, Parkinson’s disease). These conditions contribute to the leading causes of death for older adults and may affect an individual’s quality of life, especially for those who manage two or more chronic conditions.31

Significant proportions of this group experience hospitalizations, are admitted to nursing homes, and receive home health services and other social supports in home and community settings. Addressing these concerns demands a service system that is robust, diverse, and responsive.

**LOW RESOURCE INDIVIDUALS & FAMILIES**
Key informants, focus group participants, and hospital leadership discussed the challenges that individuals and families face when they are forced to decide between housing, food, heat, health care services, childcare, transportation, and other essentials. These choices often lead to missed care or delays in care, due to either the direct costs of care (co-pays and deductibles) or the indirect costs of transportation, childcare, or missed wages. There was near consensus that lack of affordable housing was a leading issue in the region. Participants also spoke of the intense challenges that many moderate income individuals and families face due to the high cost of living in Bergen County, combined with the fact that most of those in middle-income cohorts are not eligible for subsidized public programs like Medicaid, food stamps, and Healthy Start.

**INDIVIDUALS WITH CHRONIC AND COMPLEX CONDITIONS (INCLUDING DISABILITIES)**
Though substance use and mental health were the focus for many key informants, providers, and residents, one cannot ignore that heart disease and cancer were the leading causes of death in New Jersey and in Bergen County. Along with other conditions, including asthma and diabetes, these conditions are considered to be chronic and complex and may strike early in one’s life, possibly ending in premature death. It is important to note that the risk and protective factors for many chronic/complex conditions are the same, including lack of physical activity, poor nutrition, obesity, and substance misuse. Individuals with chronic/complex conditions often face significant barriers to care (e.g., transportation, lack of health literacy, fragmented care). These issues are exacerbated for frail elders, individuals without caregivers, those with limited mobility, and those who lack financial resources. Many key informants cited a need for care management, navigation, and care coordination for these populations. Several individuals also suggested a need for caregiver support programs and resources.

**RACIALLY/ETHNICALLY DIVERSE POPULATIONS & NON-ENGLISH SPEAKERS**
Many engaged during this assessment reported that many racial, ethnic, and cultural minorities and non-English speakers experiences disparities with respect to the social determinants (e.g. housing, income and employment, access to transportation), health care access (e.g. navigation of health system,

31 “Older Adults.” HealthyPeople.gov, Office of Disease Prevention and Health Promotion, https://www.healthypeople.gov/2020/topics-objectives/topic/older-adults
access to primary care), and overall health status. Information gathered from the assessment, supported by findings from academic literature, highlight the disparities that these segments face. These segments may also experience adverse health outcomes due to stress, racism, and discrimination.32

**VETERANS**
Veterans are a population with distinct cultural values and unique health issues. They experience substance use disorders, mental health disorders (including depression, post-traumatic stress disorder and serious mental illnesses), traumatic brain injuries, chronic pain and serious bodily injuries at disproportionate rates compared to civilians. These factors coalesce to produce a complicated set of issues that make it difficult for some veterans to reintegrate successfully into civilian life, exacerbating existing health issues and creating instability in personal and professional lives. According to the U.S. Census Bureau, approximately 30,000 veterans reside in Bergen County; they are overwhelmingly male and nearly one-third of veterans are disabled. Though not mentioned often during the assessment, veterans were identified as a priority population by numerous focus group and forum participants, as well as by the Medical Center’s senior leadership. The Medical Center is a Veterans Choice Community Care Provider and proudly serves the healthcare needs of veterans.

**LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING+ (LGBTQ)**
While societal acceptance of the LGBTQ+ community has increased greatly over the past several decades, these populations still experience discrimination and health disparities. The LGBTQ+ community continues to face issues of disproportionate violence, socioeconomic inequality, and health disparities.

The LGBTQ population is large and diverse; though there is a tendency to view LGBTQ+ as a monolithic identify, some experience greater disparities than others do. For example, transgender and gender-nonconforming individuals are more likely to be unemployed, uninsured, overweight, and depressed compared with cisgender adults.33 LGBTQ individuals engaged in this assessment expressed a need for comprehensive and coordinated health care programs that allow individuals to coordinate and manage all aspects of care, from primary care and prescriptions to specialty care and diagnostics. They also reported a need for programs and services for aging LGBTQ individuals. Bergen New Bridge is committed to improving health outcomes and addressing barriers to care for this population; the Medical Center is a Leader in LGBTQ Healthcare Equality in the Human Rights Campaign (HRC) Healthcare Equality Index.

**GOALS AND OBJECTIVES BY PRIORITY AREA**
The goal of the CHNA was to engage the community and compile quantitative and qualitative information to identify the leading health-related issues affecting individuals in the County. The priorities that were identified have been framed broadly to ensure that the full breadth of unmet needs and community health issues are recognized. These priorities were identified through an integrated and

33 Carl G. Streed, Jr., Ellen P. McCarthy, and Jennifer S. Haas. “Association Between Gender Minority Status and Self-Reported Physical and Mental Health in the United States.” *JAMA Internal Medicine*, 2017; 177(8): 1210-1212
A thorough review of all of the quantitative and qualitative information captured for the assessment. The priorities have been identified to maximize impact, reduce disparities, and promote collaboration and cross-sector partnership.

During the later stages of the CHNA process, significant efforts were made to vet the priority issues with the Steering Committee, hospital staff and leadership, and representations from BCDHS and the CHIP. Based on the findings from the breadth of CHNA activities, leadership opted to prioritize the following community health issues (in order of how they are discussed in the Community Health Needs Assessment): wellness, prevention and risk factors, chronic and complex conditions, mental/behavioral health and substance use disorder, and the cross-cutting priority area of social determinants of health and access to care.

**Figure 48: Bergen New Bridge Medical Center Community Health Priority Areas 2020-2022**
**PRIORITY AREA: MENTAL/BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| (1) Support and/or implement strategies that promote mental, emotional, and social well-being | • Support efforts that aim to reduce the stigma associated with mental/behavioral health and substance use disorder  
• Support initiatives that provide education on how to achieve and maintain healthy mental, emotional, and social health  
• Expand access to behavioral health screening, treatment, and supportive services  
• Collaborate with clinical and community-based partners to address mental/behavioral health and substance use disorder |

**PRIORITY AREA: WELLNESS, PREVENTION, AND RISK FACTORS**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objectives</th>
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| (1) Enhance access to health education, screening, and referral services | • Provide education and counseling regarding wellness, health promotion, risk factors, and healthy behaviors  
• Support initiatives that reduce barriers to physical activity and accessing healthy foods |

**PRIORITY AREA: CHRONIC AND COMPLEX CONDITIONS**

<table>
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<tr>
<th>Goal</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| (1) Support individuals with chronic/complex conditions and their caregivers | • Screen individuals for chronic and complex conditions and refer those at-risk to appropriate services  
• Support community education and awareness of chronic and complex conditions  
• Monitor and coordinate care for adults with chronic/complex conditions |

**PRIORITY AREA: SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO CARE**

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| (1) Address the social determinants of health and access to care issues that inhibit the ability of individuals to lead happy, healthy, productive lives  
(2) Reduce health disparities | • Support programs and policies that address the social determinants of health  
• Address common barriers to accessing health care  
• Support efforts to reduce domestic and interpersonal violence |
COMMUNITY HEALTH NEEDS NOT PRIORITIZED BY BERGEN NEW BRIDGE MEDICAL CENTER

It is important to note that there are community health needs that were identified through Bergen New Bridge’s assessment that were not prioritized for inclusion in the Implementation Strategy. Reasons for this include:

- Feasibility of Bergen New Bridge Medical Center having an impact in the short- or long-term
- Clinical expertise of the organization
- The issue is currently being addressed by community partners in a way that does not warrant additional support

Poverty/employment, housing stability, and transportation were identified as community needs, but were deemed to be outside of the Medical Center’s primary sphere of influence. Bergen New Bridge Medical Center remains open and willing to work with hospitals and other public and private partners to address these issues should an opportunity arise.
INTRODUCTION

Between December 2018 and July 2019, the Bergen County Department of Health Services, the Community Health Partnership of Bergen County, and Bergen’s seven acute care hospitals – including Bergen New Bridge Medical Center – conducted a comprehensive Community Health Needs Assessment (CHNA). This CHNA included an extensive review of quantitative data and collected qualitative information through key informant interviews, focus groups, community listening sessions, and surveys. This extensive array of assessment and engagement activities allowed BCDHS, the CHIP, and hospitals to better understanding community health issues, vulnerable populations, and areas of opportunity in Bergen County. Assessment findings were used as the basis for which Bergen New Bridge developed this Implementation Strategy – a three-year plans that outlines how the Medical Center will address community health needs and the social determinants of health in collaboration with community partners.

COMMUNITY HEALTH PRIORITY AREAS

The CHNA provided many opportunities to vet quantitative and qualitative findings. Based on these findings, and Bergen New Bridge Medical Center’s service lines and areas of expertise, leadership and staff identified four community health priority areas, which together embody the leading health issues and barriers to care for residents of the hospital’s service area: mental/behavioral health and substance use disorder; wellness, prevention, and risk factors; chronic and complex condition; and social determinants of health and access to care.

COMMUNITY HEALTH PRIORITIES NOT ADDRESSED IN BERGEN NEW BRIDGE MEDICAL CENTER’S IMPLEMENTATION STRATEGY

It is important to note that there are community health needs that were identified through the Community Health Needs Assessment that were not prioritized for inclusion in the Implementation Strategy. Reasons for this include:

- Feasibility of Bergen New Bridge Medical Center having an impact on this issue in the short or long term
- Clinical expertise of the organization
- The issue is currently addressed by community partners in a way that does not warrant additional support

Poverty/employment, housing stability, and transportation were identified as community needs, but were deemed to be outside of the Medical Center’s primary sphere of influence. Bergen New Bridge Medical Center remains open and willing to work with hospitals and other public and private partners to address these issues should an opportunity arise.
**PRIORITY POPULATIONS**

Although the Medical Center is committed to improving the health status of all residents living in its service area, based on the assessment’s quantitative and qualitative findings there was agreement that the Implementation Strategy should prioritize certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care. Seven priority populations were identified:

- **Youth & Adolescents**
- **Older Adults**
- **Low Resource Individuals and Families**
- **Individuals with Chronic/Complex Conditions (including disabilities)**
- **Racially/Ethnically Diverse Populations and Non-English Speakers**
- **Veterans**
- **LGBTQ+**

**COMMUNITY HEALTH IMPROVEMENT – STRATEGIC FRAMEWORK**

The following defines the types of programmatic strategies and interventions that were applied in the development of the Implementation Strategy.

- **Screening and Identification:** Screening and assessment programs reduce the risk of death or ill health from a specific condition by offering tests to help identify those who could benefit from treatment. A critical component of screening and referral efforts is to provide linkages to providers, treatment, and supportive services should an issue be detected.

- **Health Education and Prevention:** Initiatives that aim to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, or altering unhealthy behaviors. Programs might include targeted efforts to raise awareness about a particular condition or provide information on risk and protective factors.

- **Behavior Modification and Disease Management:** Evidence-based behavioral modification and/or chronic disease management programs that encourage individuals to manage their health conditions, change unhealthy behaviors, and make informed decisions about their health and care.

- **Care Coordination and Service Integration:** Initiatives that integrate existing services and expand access to care by coordinating health services, patient needs, and information.

- **Patient Navigation and Access to Care:** Efforts which aim to help individuals navigate the health care system and improve access to services when and where they need them.

- **Cross-Sector Collaboration and Partnership:** Includes collaborations, partnerships, and support of providers and community organizations across multiple sectors (e.g., health, public health, education, public safety, and community health).
RESOURCES COMMITTED TO COMMUNITY HEALTH IMPROVEMENT

Bergen New Bridge Medical Center will commit direct community health program investments and in-kind resources of staff time and materials to carry out the activities in this Implementation Strategy. Bergen New Bridge may also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, and on behalf of its community partners.
**PRIORITY AREA: MENTAL/BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER**

**Goal:** Support and/or implement strategies that promote mental, emotional, and social well-being

**OBJECTIVES**

- Support efforts that aim to reduce the stigma associated with mental/behavioral health and substance use disorder
- Support initiatives that provide education on how to achieve and maintain healthy mental, emotional, and social health
- Expand access to behavioral health screening, treatment, and supportive services
- Collaborate with clinical and community-based partners to address mental/behavioral health and substance use disorder

**STRATEGIES**

**Screening and Identification**
- Screen individuals for undiagnosed mental health issues

**Health Education and Prevention**
- Support Mental Health First Aid trainings in community-based settings
- Support the Stigma Free Communities initiative
- Offer lectures and educational seminars related to mental, social, and emotional health in community-based settings

**Behavior Modification and Disease Management**
- Support evidence-based tobacco prevention and cessation programs

**Patient Navigation and Access to Care**
- Support a peer recovery coach program
- Provide patient navigation services for individuals with mental/behavioral health issues and/or substance use disorder
- Host and/or support mental health and substance use disorder support groups

**Care Coordination and Service Integration**
- Provide case management services for individuals with mental/behavioral health issues and/or substance use disorders
Cross-Sector Collaboration and Partnership

- Participate in collaborative regional and local efforts to address issues around mental/behavioral health and substance use disorder
- Offer free Narcan, and training/education on its use, to community residents
- Provide Narcan to local emergency medical service personnel

Sample Outcomes / Measures of Success

- Number of screenings offered and number of individuals screened
- Number of individuals connected to resources after screening
- Number of Mental Health First Aid trainings and number of attendees
- Number of lectures/seminars offered and number of attendees
- Number of tobacco cessation programs offered and number of individuals reached
- Number of support groups offered and number of attendees
- Number of coalition/task force meetings attended and any resources committed
- Number of Narcan trainings
- Amount of Narcan distributed

Partners

- Integrity House
- Care Plus NJ
- YWCA Northern New Jersey
- Children’s Aid and Family Services
- Bergen’s Promise
- National Alliance on Mental Illness
- Community-based organizations
- Primary care providers
- Municipal and Bergen County leadership
- Municipal and Bergen County departments focused on mental/behavioral health and substance use disorder
- Local community health partnerships and collaboratives (e.g., CHIP of Bergen County, Stigma Free initiative)
PRIORITY AREA: WELLNESS, PREVENTION, AND RISK FACTORS

Goal: Enhance access to health education, screening, and referral services

OBJECTIVES

- Provide education and counseling regarding wellness, health promotion, risk factors, and healthy behaviors
- Support initiatives that reduce barriers to physical activity and accessing healthy foods

STRATEGIES

Screening and Identification
- Promote screening for major risk factors (obesity, high blood pressure, high cholesterol)

Health Education and Prevention
- Offer and support prevention, education, and wellness programs that educate individuals on lifestyle changes and make referrals to appropriate community resources

Behavior Modification and Disease Management
- Support programs that enhance access to opportunities for free or low cost physical activities
- Support programs that provide education and demonstration related to weight management, healthy foods, and food preparation

Patient Navigation and Access to Care
- Offer free flu vaccinations in community-based settings
- Offer free screenings and vaccinations for measles

Cross-Sector Collaboration and Partnership
- Participate in collaborative regional and local efforts to address issues around wellness, prevention, and risk factors

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of screenings offered and number of individuals counseled
- Number of prevention, wellness, and educational programs offered and number of attendees
- Number of individuals engaged in active living programs
- Resources provided for programs that enhance access to nutritious/affordable foods
- Number of cooking demonstrations/workshops and number of attendees
- Number of free vaccinations provided
- Number of task forces/coalition meetings attended
- Results of pre- and post-tests to measure changes in knowledge, attitudes, behaviors, and health outcomes
PARTNERS

- YWCA Northern New Jersey
- NJ Mobile Health
- Rutgers New Jersey Medical School
- Community-based organizations
- Primary care providers
- Municipal and Bergen County leadership
- Municipal and Bergen County departments focused on mental/behavioral health and substance use disorder
- Local community health partnerships and collaboratives (e.g., CHIP of Bergen County)
PRIORITY AREA: CHRONIC AND COMPLEX CONDITIONS

Goal: Support individuals with chronic/complex conditions and their caregivers

OBJECTIVES

• Screen individuals for chronic and complex conditions and refer those at-risk to appropriate services
• Support community education and awareness of chronic and complex conditions
• Monitor and coordinate care for adults with chronic/complex conditions

STRATEGIES

Screening and Identification
• Conduct or support chronic/complex conditions screening programs in clinical and non-clinical settings

Health Education and Prevention
• Support free lectures and educational seminars, conducted by hospital clinical and non-clinical staff, related to chronic/complex conditions in community-based settings. Lectures and seminars intend to reach the general public and priority populations (e.g., LGBTQ+, veterans, etc.)

Behavior Modification and Disease Management
• Conduct or support evidence-based behavior change and self-management support programs

Patient Navigation and Access to Care
• Support case management and patient navigation programs to support those with chronic/complex conditions and their caregivers

Cross-Sector Collaboration and Partnership
• Participate in collaborative regional and local efforts to address issues around chronic/complex conditions

SAMPLE OUTCOMES / MEASURES OF SUCCESS

• Number of screenings events held and number of individuals screened
• Number of individuals referred to treatment or support after screening
• Number of lectures/seminars offered and number of attendees
• Number of behavior change/self-management programs offered and number of attendees
• Number of individuals engaged in case management and patient navigation programs
• Number of task forces/coalition meetings attended and any resources committed
• Results of pre- and post-tests to measure changes in knowledge, attitudes, behaviors, and health outcomes
PARTNERS

- YWCA Northern New Jersey
- Rutgers New Jersey Medical School
- NJ Mobile Health
- Alzheimer’s of New Jersey
- Community-based organizations (senior centers, VFWs, etc.)
- Primary care providers
- Municipal and Bergen County leadership
- Municipal and Bergen County departments focused on mental/behavioral health and substance use disorder
- Local community health partnerships and collaboratives (e.g., CHIP of Bergen County)
PRIORITY AREA: SOCIAL DETERMINANTS OF HEALTH & ACCESS TO CARE

Goal:
(1) Address the social determinants of health and access to care issues that inhibit the ability of individuals to lead happy, healthy, and productive lives
(2) Reduce health disparities

OBJECTIVES

- Support programs and policies that address the social determinants of health
- Address common barriers to accessing health care
- Support efforts to reduce domestic and interpersonal violence

STRATEGIES

**Screening and Identification**
- Implement or support programs that screen for the social determinants of health and make appropriate referrals to community-based resources
- Support programs that screen for domestic and interpersonal violence and provide referrals to community resources

**Behavior Modification and Disease Management**
- Support community partners that address barriers associated with the social determinants of health

**Patient Navigation and Access to Care**
- Provide information that identifies resources to address social determinants of health
- Support innovative solutions to address leading barriers to care (e.g., telehealth)
- Provide cultural competency and training for hospital clinicians and staff
- Provide resources that reduce barriers related to health literacy (e.g., interpretation, translation)

**Cross-Sector Collaboration and Partnership**
- Participate in collaborative regional and local efforts to address issues around the social determinants of health and health disparities

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of community partners supported and the resources/support provided to them
- Number of screenings for domestic/interpersonal violence and number of referrals made
- Resources provided to improve access to care
- Number of cultural competency/health literacy trainings and number of attendees
- Number of individuals who received resources to overcome barriers related to health literacy
- Number of task forces/coalition meetings attended and any resources committed

**PARTNERS**

- YWCA Northern New Jersey
- Community-based organizations
- Municipal and Bergen County leadership
- Municipal and Bergen County departments focused on mental/behavioral health and substance use disorder
- Local community health partnerships and collaboratives (e.g., CHIP of Bergen County)