RWJUH Rahway & Trinitas Regional Medical Center Community Health Needs Assessment

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PREPARED BY
HEALTH RESOURCES IN ACTION

RWJBarnabas HEALTH | Robert Wood Johnson University Hospital Rahway

RWJBarnabas HEALTH | Trinitas Regional Medical Center

Acknowledgments

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Questions
For questions regarding Children's Specialized Hospital or RWJBarnabas Health, please email BHPlanning@RWJBH.org.

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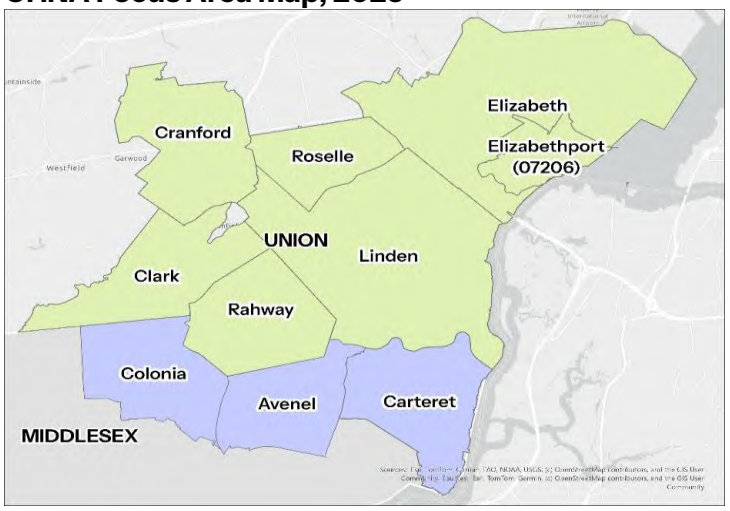
Executive Summary

Introduction

In 2025, Robert Wood Johnson University Hospital (RWJUH) Rahway and RWJBH Trinitas Regional Medical Center (TRMC) undertook a joint community health needs assessment (CHNA) process. The purpose of the CHNA was to identify and analyze community health needs and assets and prioritize those needs to inform strategies to improve community health. The CHNA fulfills the mandate for non-profit hospitals put forth by the Internal Revenue Service. The CHNA focus area encompasses the primary service area (PSA) of both facilities, which cover 10 municipalities (Avenel, Carteret, Clark, Colonia, Cranford, Elizabeth, Elizabethport, Linden, Rahway, and Roselle) over 13 zip codes in Union and Middlesex counties.

RWJUH Rahway & Trinitas Regional Medical Center CHNA Focus Area Map, 2025



DATA SOURCE: Prepared by HRiA based on NJOGIS 2023 data

Methods

While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health. Data collection was conducted using a social determinants of health framework and a health equity lens. The CHNA process utilized a mixed-methods participatory approach that engaged agencies, organizations, and community residents through different avenues. Community engagement strategies were tailored to reach traditionally medically underserved populations, including diverse immigrant and Spanish-speaking communities. The CHNA process was guided by the RWJUH Rahway and TRMC CHNA Advisory Committee, as well as other community partners. Data collection methods included:

- Reviewing existing social, economic, and health data across Union and Middlesex counties.
- Conducting a community survey that reached 1,220 Union County respondents, designed and administered by Health Resources in Action (HRiA).
- Facilitating 3 virtual focus groups with 11 participants from populations of interest, including faith-based leaders, African American men, and healthcare providers.
- Conducting 10 key informant interviews with 19 individuals from a range of sectors, including public safety, mental health, food assistance, housing services, social services, healthcare providers, local government, and others serving low-income families and immigrant communities.

Findings
The following section provides a brief overview of the key findings that emerged from this assessment.

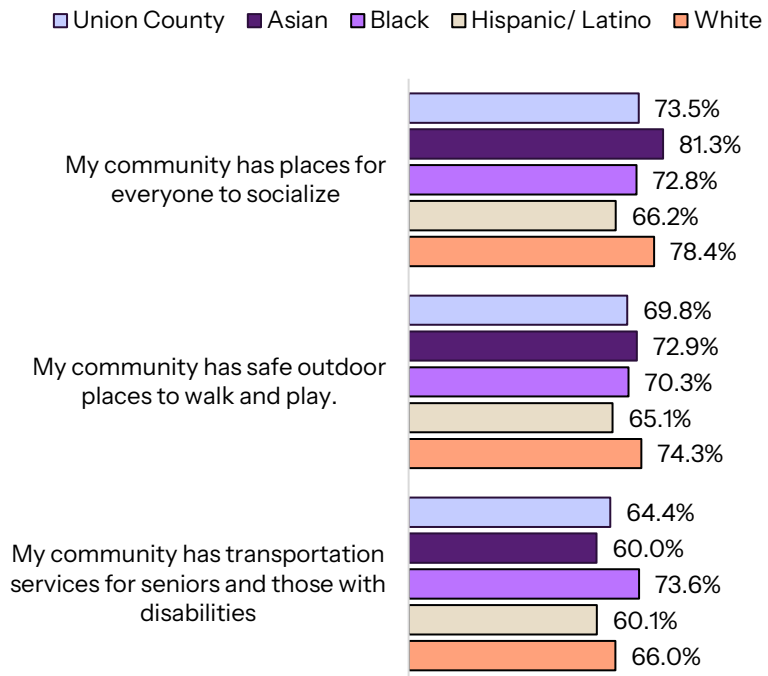
Population Characteristics

- **Demographics.** RWJUH Rahway and TRMC serve a population of 467,466 residents in 10 municipalities across two counties. Between 2014-2018 and 2019-2023, New Jersey's population grew by 4.3%, Union County's by 3.5%, and Middlesex County's by 4.2%. Among municipalities, Elizabethport (07206) experienced the highest population growth at 12.5%, while Avenel saw a population decline of 9.0%.[1]

- **Foreign-born Population.** The Rahway/Trinitas PSA is culturally diverse. While approximately one-third of residents in Union and Middlesex counties were foreign-born, the proportion was much higher in Elizabeth, where about half of the population was foreign-born. In terms of language, just under half of residents in Union County (46.7%) and Middlesex County (47.0%) spoke a language other than English at home. However, this varied widely by municipality—from a low of 13.1% in Cranford to over 75% in Elizabeth. Spanish was the most spoken language other than English in the Rahway/Trinitas PSA.[1]

- **Race/Ethnicity.** RWJUH Rahway and TRMC serve a racially and ethnically diverse population. While both Union County (41.7%) and Middlesex County (44.2%) have a majority White population, Union County has a notably larger proportion of Black (20.5%) and Latino residents (34.4%) than the state (13.0% and 21.9%, respectively). In Middlesex County, 25.1% of residents were Asian, compared to 9.9% statewide. Among municipalities, over two-thirds of Elizabeth residents were Latino, 45.6% of Roselle residents were Black, and one-quarter of Carteret residents were Asian.[1]

Union County Survey Respondents' Community Perceptions, Percent Who Agreed/Strongly Agreed, by Race/Ethnicity



DATA SOURCE: Community Health Needs Assessment Survey, 2024

[1] U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2018-2022

Community Social and Economic Environment

- **Community strengths and assets.** Focus group and interview participants valued the high level of collaboration and partnership across the different sectors and institutions that serve Union County. Participants also appreciated the convenience of having amenities nearby, including hospitals, places of worship, and recreational areas. Top strengths identified by Union County respondents to the Community Health Needs Assessment Survey in 2024 included that the community had places for everyone to socialize (73.5%), had safe outdoor places to walk and play (69.8%), and had transportation options for seniors and those with disabilities (64.4%).[2]

- **Education.** Some school districts (Clark Township, Cranford, Union County Vocational-Technical) outperformed New Jersey as a whole. However, the school districts in Rahway (80.8%) and Roselle (85.8%) had lower graduation rates in 2019-2023. In some cases, graduation rates varied across students of different racial and ethnic backgrounds. In Roselle Park, 97.5% of White students graduated, compared to 86.4% of Latino students. Union County Vocational-Technical and Linden Public Schools stand out for having very consistent graduation rates across racial/ethnic groups.[3]

- **Employment and Workforce.** Unemployment rates declined from 2014 to 2019 but experienced an uptick in 2020. They then declined rapidly post-2020 but have increased again as of 2023.[4] Overall, slightly under half (49.6%) of Union County respondents agreed that there were job opportunities in their area. White respondents were notably more positive, with 61.3% agreeing, compared to respondents from all other races/ethnicities.[5] Participants uplifted resources such as job fairs and job training events in Union County. However, they also described the challenges faced by some communities, such as returning citizens, in finding employment.

> *"If you have been incarcerated it's on your record. Even with record expungement, you are still looked upon as a negative person. Race has a lot to do with it…the darker you are they think that you're going to steal from them or that you are a gangster."*
> – Key informant interviewee

- **Income and Financial Security.** Median household income varied across communities. Union County had a median household income that was comparable to the state's, ranging from a low of $60,992 in Elizabethport to a high of $148,629 in Cranford.[6] Data on the concentration of wealth and poverty indicated large disparities. Almost 20% of households in Elizabeth (07201) had annual incomes below $25,000; in contrast, over

[2] Community Health Needs Assessment Survey, 2024
[3] New Jersey Department of Education, School Performance, 2023
[4] U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2014-2023
[5] Community Health Needs Assessment Survey, 2024
[6] U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates Subject Tables, 2018-2022

37% of households in Cranford had incomes greater than $200,000.[7] Focus group and interview participants discussed current economic challenges and financial insecurity. Participants talked about rising costs across the board: gas, housing, food, transportation, childcare, and healthcare, and shared the day-to-day challenge of affording necessities as prices continue to climb.

- **Food Insecurity and Healthy Eating.** Consistent with the prior CHNA-SIP process, participants noted food security as a top concern and discussed increasing food insecurity in Union County, which they perceived was a consequence of inflation, rising costs of living, and layoffs. Focus group and interview participants mentioned food deserts in areas of Union County as barriers to access healthy, affordable food in those communities. As of 2023, about 1 in 10 residents were considered to be food insecure, representing a steady increase since 2020.[8] Almost one-third (30.4%) of survey respondents reported that it was sometimes or often true that they worried their food would run out before they had money to buy more.[9] The situation was more dire for Latino survey respondents; 56.4% of them worried that their food would run out before they had more money to buy more and 37.0% of them relied on a food assistance program compared to 19.1% overall. Less than half (44.4%) of Union County survey respondents agreed that the schools in their community offered healthy food choices for children.

- **Affordable Housing.** Housing was described as a substantial community health challenge by focus group and interview participants who noted that the housing issues cut across race and age. Overall, under one-third (32.1%) of survey respondents in Union County agreed that there was sufficient affordable and safe housing in their community, ranging from 24.3% of Latino respondents to 37.3% of Asian respondents.[10]

> *"There's an obvious housing crisis in New Jersey. In the last couple of years, we have seen an exponential increase in average rent, so unfortunately, we have heard about displacement due to the increased rent."*
> – Focus group participant

- **Green Space and the Built Environment.** In Union County, 69.8% of survey respondents agreed or strongly agreed with the statement, "My community has safe outdoor places to walk and play." However, there were disparities by race/ethnicity. White (74.3%) and Asian (72.9%) respondents were slightly more likely than Hispanic/Latino (65.1%) respondents to agree or strongly agree with that statement.[11]

[7] U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023
[8] Feeding America, Map the Meal Gap, 2020-2022
[9] Community Health Needs Assessment Survey, 2024
[10] Community Health Needs Assessment Survey, 2024
[11] Community Health Needs Assessment Survey, 2024

- **Transportation and Walkability.** Participants indicated that some areas, including neighborhoods in Elizabeth, had public transportation. However, public transportation was limited in its reach and hours of operation. A key informant interviewee explained, *"It's typical of most cities, but the public transport is as reliable as it is. It's good, but there's not a lot of cross-town transportation. There's transportation to the port and back, to the mall and back, and then it spreads to the suburbs around the city."* Focus group members named cost and availability of transportation as barriers to accessing basic needs, such as health care and food, for those without vehicles. Overall, less than half of respondents agreed that public transportation would be easy to use for daily needs (46.9%), although Black (57.9%) and Asian respondents (53.3%) agreed with this statement at a higher rate."[12] Despite this, the majority of Union County respondents believed that their community provided transportation services for seniors and those with disabilities (64.4%), with the highest agreement among Black respondents (73.6%).

> *"Here I am, a physician, and I have been discriminated against in the healthcare system because when I present to the hospital, I present as an African American woman, and I have been treated absolutely horribly. I know how to navigate the system, I know how to talk, I know how to explain myself, and I was dismissed."*
> – Key informant interviewee

- **Violence Prevention and Safety.** Safety was something residents valued in their neighborhoods. A few focus group and interview participants identified a perceived uptick in domestic and workplace violence, particularly involving healthcare workers. More than half of Union County survey respondents (56.6%) agreed that there was not much violence in their neighborhood, such as physical fights, gang activities, stealing, or assaults. However, perceptions varied by race, with proportionately more Asian (64.7%) and White (67.9%) respondents agreeing, compared to 52.3% of Black and only 41.1% of Latino respondents. Fewer than half of survey respondents agreed that there were few issues with violence between people, like abuse within families, mistreatment of the elderly, or bullying in-person or online in their community (42.3%). Notably, bullying and community violence were among the top community concerns for children and youth, endorsed by 30.6% and 15.0% of respondents, respectively [13]

- **Systemic Racism and Discrimination.** Perceptions related to discrimination and racism varied throughout qualitative discussions. In addition to discrimination experienced based on race or ethnicity, some focus group participants also described discrimination faced by the unhoused populations, particularly when trying to access healthcare. More than one-third of Black (35.3%) respondents in Union County reported experiencing discrimination due to their race/ethnicity when receiving medical care, as did 20.7% of Asian, and 23.8% of Latino respondents. Additionally, 22.6% of LGB respondents

[12] Community Health Needs Assessment Survey, 2024
[13] Community Health Needs Assessment Survey, 2024

experienced discrimination due to their sexual orientation compared to 3.3% of heterosexual respondents.[14]

Community Health Issues

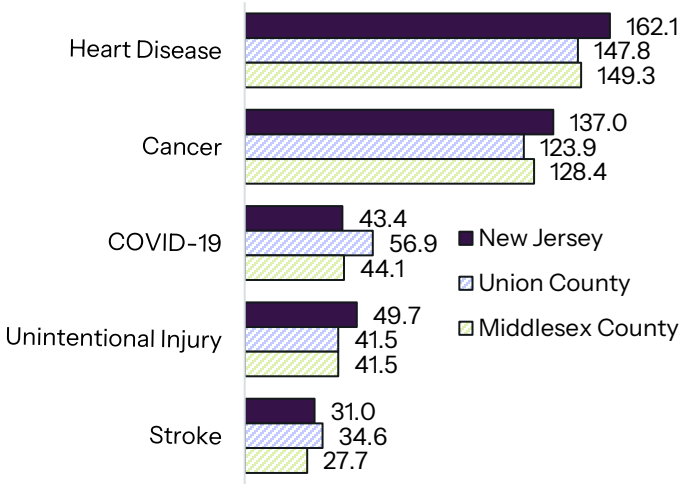
- **Community Perceptions of Health.** Interview and focus group participants highlighted how many community members were touched by social and economic issues, such as financial and food insecurity, housing, and transportation. They further emphasized how these issues were associated with chronic conditions that affected members of the community, including high blood pressure and diabetes. Participants also discussed the challenges of accessing care and the difficulties of managing chronic conditions, the increase in mental health concerns, particularly among youth, and the need for sustainable funding for services.

  Community health survey respondents in Union County ranked diabetes (37.8%), followed by cancer (31.6%), heart disease (31.4%), overweight/obesity (26.5%), and mental health issues (24.8%) as the top five health issues in their communities.

  Survey respondents also identified top health concerns regarding youth and children in the community. Respondents ranked mental health issues (35.6%), followed by bullying (30.6%), overweight/obesity (27.1%), violence and community safety (15.0%), and asthma (13.7%) as the top five health issues in their communities.[15]

- **Leading Causes of Death and Premature Mortality.** The most current mortality data from New Jersey's surveillance systems are from 2021, the second year of the COVID-19 pandemic. The leading cause of death in both Union and Middlesex counties in 2017-2021 was heart disease (147.8 and 149.3 per 100,000, respectively), followed by cancer (123.9 and 128.4 per 100,000, respectively), and COVID-19 (56.9 and 44.1 per 100,000, respectively). Of note, the mortality rate for unintentional injuries was lower in both Union and Middlesex counties than in the state overall.

Top 5 Age-Adjusted Causes of Death per 100,000, by State and County, 2017-2021



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry Department of Health, 2023

- **Chronic Disease.** As in the 2022 CHNA-SIP process, chronic disease was mentioned as a community concern by several interviewees who noted that the PSA had, like the rest of the country, high rates of diabetes, asthma, and cancer, with particular concern around chronic disease management. Data

[14] Community Health Needs Assessment Survey, 2024
[15] Community Health Needs Assessment Survey, 2024

showed racial/ethnic disparities in chronic disease burden across the PSA. Blood pressure and cholesterol screening rates differed by race/ethnicity, being lower among Latino and Black respondents.[16] While focus group and interview participants did not directly discuss heart disease, it is the leading cause of death in both Union and Middlesex counties and is closely associated with other conditions mentioned by residents, such as diabetes and overweight/obesity. Disparities exist within New Jersey and Union and Middlesex counties, with Black residents being hospitalized due to cardiovascular disease at higher rates compared to other races/ethnicities (120.3, 92.3, and 103.6 per 100,000 in New Jersey, Union County, and Middlesex County, respectively).[17] Participation in heart disease education differed by race/ethnicity, with only 11.2% of Latino residents reporting participating compared to 19.7% of Asian and 20.6% of Black residents.[18] Overall diabetes rates were higher in Middlesex County (10.0%) than in New Jersey and Union County (both at 9.0%).[19]

- **Mental Health and Behavioral Health.** Mental health was identified as a community concern in almost every interview and focus group. Participants identified depression, anxiety, stress, trauma, and suicidal ideation as mental health challenges for community residents, particularly among young people, housing-unstable populations, older adults, and some immigrant families. Among Union County survey community respondents, 1 in 4 reported experiencing 10 or more poor mental health days in the last 30 days.[20] In terms of substance use, in both Union and Middlesex counties, more than one-third of admissions to substance use treatment services were for heroin misuse (36.6% and 37.6%, respectively) and for alcohol misuse (36.6% and 37.9%, respectively).[21] Focus group participants reported insurance barriers, long wait times, language barriers, lack of culturally competent care, and a lack of providers as barriers they faced to addressing mental health and substance use. Identified as a priority also in the prior CHNA-SIP cycle, both facilities have implemented programs and worked with local partners to expand access to mental health services in their PSAs.

> *"I've never seen so much mental health, even with COVID. I don't know if it's the layoffs, if it's the undocumented status, if it's the social pressures that young individuals are going through, there's so many things, but I'm seeing so many more young adults with suicidal behavior and attempts than I ever have. Ever.*
> – Key informant interviewee

[16] Community Health Needs Assessment Survey, 2024
[17] Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023
[18] Community Health Needs Assessment Survey, 2024
[19] Behavioral Risk Factor Survey, Center for Health Statistics Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2018-2022
[20] Community Health Needs Assessment Survey, 2024
[21] Statewide Substance Use Overview Dashboard, Department of Human Services, Division of Mental Health and Addiction Services, 2024

- **Environmental Health.** Among community health survey respondents, 13.7% ranked asthma as the top concern for children and youth. Asthma was ranked among the top five concerns among children and youth by Asian (16.9%) and Latino (17.7%) respondents. While air quality was not a common theme in qualitative discussions, a participant described poor air quality in Elizabeth, particularly near the Bayway Refinery, that disproportionately impacts lower income residents. The participant explained, "*everyone knows that near Bayway [Refinery] it stinks. It's very obvious that the air quality is poor over there…Areas in Elizabeth that are better off are in the exact opposite side of the refinery and the subsidized housing is right next to it*." While lead exposure was not a common topic in many interviews and focus groups, a key informant interviewee described how lead monitoring for children remains a Union County priority. New Jersey Department of Health data from 2022 show that the percentage of children aged 1-5 with elevated blood lead levels was higher in Union County (2.3%) and lower in Middlesex County (1.5%) than in the state overall (1.9%).

- **Infectious and Communicable Diseases.** Unlike the prior CHNA, COVID-19 was not a top concern among participants. Due to vaccination, COVID-19 deaths in Union County plummeted from 1,415 in 2020 to 37 in 2023, despite high infection rates.[22] Participants discussed how COVID-19, and associated funding, had served to improve partner coordination and ability to collaborate to rapidly respond to new emergencies. However, participants were concerned that funding cuts would negatively impact their ability to identify and respond to emerging infectious diseases and outbreaks and provide care for people living with HIV. Participants were also concerned about an increase in anti-vaccination sentiments and misinformation. A key informant interviewee reported, *"Particularly for Union County, we have been pushing measles campaigns and have maybe seen a bit of an increase in vaccination rates, but as a whole, there is still some hesitancy."* Rates of HIV, chlamydia, and gonorrhea were all higher in Union County than in the state of New Jersey overall.[23] In 2017-2021, the incidence of HIV was higher among Black (32.9 per 100,000) and Latino (30.0 per 100,000) residents than the Union County average (18.2 per 100,000).

- **Maternal and Infant Health.** Maternal and infant health indicators are markers of inequity as most complications are preventable with access to quality, timely care. Teen mothers face higher risks of pregnancy complications, such as eclampsia and systemic infections, than women in their twenties. Teen pregnancy is slightly more prevalent in Union County than in the state overall. The percentage of pregnant women receiving prenatal care in the first trimester was lower in Union County (69.3%) and higher in Middlesex County (75.5%) than in New Jersey overall (74.1%).[24] There were stark differences by race/ethnicity, with Black and Latina pregnant women reporting the lowest percentages of prenatal care in the first trimester in Union County, Middlesex County, and the state overall. Black (11.3%) and Asian (8.0%) women both had higher

[22] New Jersey Department of Public Health, COVID-19 Dashboard, 2024
[23] Communicable Disease Reporting and Surveillance System (CRDSS), Communicable Disease Service, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024
[24] Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2024

percentages of low-birth-weight births compared to both county and state averages, with a similar pattern for pre-term births.[24]

Healthcare Access

- **Access and Utilization of Healthcare Services.** Discussions about access to care, including preventive, primary, and specialty care services, were prominent in interviews and focus group discussions. Several participants mentioned that the area's agencies and service providers collaborated well, which made obtaining services easier for the population. They identified the important role community health workers, mobile clinics, transportation assistance, and free health screenings and education play in improving access to services in the PSA. The top five sources of health information for Union County survey respondents were healthcare providers (80.7%), online resources (40.2%), family members (21.8%), urgent care (22.7%), and the emergency department (19.4%). Overall, 88.3% of survey respondents in Union County reported having an annual physical exam in the last two years, while 75.4% reported having a flu shot, and 79.9% receiving a dental screening.[25] Access to healthcare was identified as a top priority during the 2022 CHNA-SIP process. To address this, TRMC led numerous education sessions in English, Spanish, and Haitian Creole to improve health literacy and screenings. RWJUH Rahway developed and enhanced partnerships with local and county social service organizations to support individuals during the transition from the hospital back to the community and increased chronic disease screenings.

- **Barriers to Healthcare Access.** Participants mentioned challenges such as cost, lack of specialty and mental health providers, lack of insurance, unavailability of culturally competent care, and fear and mistrust as the main barriers to accessing healthcare. Additionally, they highlighted the need for more men to access care, including preventive care. The top barriers to access identified by survey respondents were inability to schedule an appointment at a convenient time (35.3%), long wait times (30.2%), insurance problems (22.6%), doctors not accepting new patients (22.2%), and cost of care (21.6%).[26]

> *"Many immigrant families are hesitant to seek out the services we can provide due to fear. This is happening now more than ever."*
> – Focus group participant

Community Vision and Suggestions for the Future

- **Improved access to healthcare.** Participants identified the need for improved access to healthcare providers and facilities in the PSA. Survey respondents identified difficulties scheduling appointments and long wait times as two key barriers to accessing care.[27] This was supported by quantitative data showing the ratio of primary care providers to residents in Union County being worse than in New Jersey overall.[28] Participants

[25] Community Health Needs Assessment Survey, 2024
[26] Community Health Needs Assessment Survey, 2024
[27] Community Health Needs Assessment Survey, 2024
[28] Area Health Resource File/National Provider Identifier Downloadable File as cited by County Health Rankings, 2024

expressed the need for more healthcare facilities and mobile outreach to improve access to care. They also advocated for more mental and behavioral health resources.

- **Stable funding and funding structure for healthcare, social services, and community-based organizations.** Assessment participants reported a challenging funding landscape impacting the ability of social services and community-based organizations to remain viable. The current funding landscape was also perceived to have limited local public health and healthcare organizations' ability to provide services in the community. Participants described the need for stable funding for public health as a priority.

- **Expansion of affordable housing.** Participants urged for measures to address the housing crisis. They expressed the need for more affordable units and shelters, more programs to assist with housing, and for housing policies, such as rent control. Housing was identified as a concern among community survey respondents with 19.5% of Union County residents worried about their housing stability in the next two months, with higher rates of concern among Latino (31.1%) and Black (23.2%) respondents.[29]

> *"Expanding affordable housing is critical and difficult."*
> - Key informant interviewee

- **Address food insecurity and access to healthy food.** Focus group and interview participants raised the need to address food insecurity and improve access to healthy food as priority areas. Almost 1 in 3 Union County community survey respondents worried that their food would run out before they got money to buy more; these concerns were greater among Latino (56.4%) and Black (38.8%) respondents. Survey respondents named cost (36.1%) as a main barrier to eating healthy foods.

> *"I'd like to see more to address food deserts, so that people have reasonably priced healthy food, in these underserved communities as opposed to there just being a bodega where the food is more expensive and worse."*
> - Focus group participant

- **More after-school and mentorship programs for youth and young adults.** Participants in focus group and interview discussions identified a need for more after-school and mentorship programs for youth and young adults. Participants described that while there are some programs, they often ended early, leaving youth with nothing to do after a certain time. Participants also expressed a desire for more mentorship opportunities and programs aimed at engaging youth and younger adults in deeper and more meaningful ways, something that was perceived to be lacking from some existing programs.

[29] Community Health Needs Assessment Survey, 2024

Key Themes

The following section provides an overview of the key themes that emerged from the RWJUH Rahway and TRMC CHNA process.

- **Communities in the service area are diverse, and health disparities exist.** The communities in Union and Middlesex counties vary in terms of their demographic composition, income levels, and health status. Union and Middlesex counties are racially and ethnically diverse, with many residents who speak a language other than English at home. Black residents experienced higher rates of asthma-related admissions to hospitals, higher percentages of low-birth-weight births, and cancer mortality than other groups. Latino respondents had lower preventive screening rates and experienced more barriers to accessing healthcare. A greater percentage of Black, Latino, and LGB respondents reported feeling discriminated against when receiving medical care.

- **Affordable housing and food were top community concerns.** Participants saw a need for prioritization and expansion of affordable housing. Lack of quality affordable housing was identified as a key need by survey respondents. Over 50% of renters in many Union County communities spend 30% or more of their income on housing. Food security concerns in Union County have grown over time, with participants reporting an increase in need.

- **Employment and financial security affected the well-being of many residents.** Rising costs of living threatened residents' financial security. Participants noted that there were limited employment opportunities with benefits, fixed income, and livable wages, particularly for immigrants, Black residents, and young people. In Union County, the highest unemployment rates were among people of color, with 8.2% of Black residents and 7.2% of Latino residents, being unemployed compared to 3.7% of Asian and 4.8% of White residents. Additionally, there were multiple municipalities in Union County with more than 25% of households living below the ALICE threshold.

- **Mental and behavioral health continue to be a significant concern.** Community survey respondents rated mental health as the top health concern for youth in 2024. Participants identified anxiety, depression, PTSD, and suicidality as mental health challenges for community residents, exacerbated by financial stress, fear, and isolation. The mental health of young people, older adults, and some immigrant populations was a concern. Participants noted that some immigrant groups had high levels of trauma due to past experiences, exacerbated by current attacks on some immigrant communities. Participants suggested that addressing mental health and substance misuse concerns should be a priority over the next few years. Ensuring trauma-informed care is implemented in medical facilities and schools was identified as a goal.

- **Chronic diseases were identified as prevalent.** Heart disease and cancer were among the three leading causes of death in the PSA. Black residents experienced higher cardiovascular disease and cancer mortality than other groups. Disparities were also seen in diabetes and other chronic illnesses. Participants noted that chronic diseases were linked to the social determinants of health.

- **Infectious and communicable diseases were mentioned in the context of shifting vaccination acceptance and guidance.** While COVID-19 mortality decreased dramatically following vaccination campaigns, interview and focus group participants identified increased misinformation and anti-vaccination sentiment among community members as a concern. Participants reported shifting guidance coupled with changes to funding streams as barriers to monitoring infectious and communicable diseases. Additionally, participants noted the need for increased surveillance due to the anticipated influx of international travelers for the upcoming World Cup event. A need to address stigma, mistrust, and misinformation in the healthcare system among some communities was identified as a strategy to address this gap.

- **While progress has been made toward improving environmental health conditions, disparities still exist.** Assessment participants reported that addressing lead and childhood lead exposure was a main priority and named the existence of specialized nurses and inspectors whose focus is on reducing lead exposure. Quantitative data show the percentage of children with elevated blood lead levels has decreased from 3.0% in 2016 to 2.3% in 2019 and remained consistent in Union County from 2019 to 2022. Participants noted worse air quality and more pollution in communities with more subsidized housing.

- **Access to healthcare was a prominent theme.** Interview and focus group participants and community survey respondents described various healthcare barriers such as cost and insurance challenges, insufficient specialty care providers, distance to care and transportation challenges, stigma and discrimination, fear and mistrust, and lack of knowledge and information, among others. Participants reported specific barriers for residents with limited English proficiency.

Conclusions

Based on responses gathered from key informant interviews, focus group participants, and community survey respondents, as well as social, economic, and health data from surveillance systems, ten major initial issue areas were identified for the RWJUH Rahway and TRMC service areas (listed below in alphabetical order):

- Affordable Housing
- Chronic Disease Prevention and Management
- Employment and Financial Security
- Food Insecurity and Healthy Eating
- Green Space and Built Environment
- Health and Racial Equity
- Healthcare Access
- Infectious and Communicable Disease
- Mental and Behavioral Health
- Systemic Racism and Discrimination

After a multistep prioritization process that entailed discussion with and voting by a broad group of local partners on the RWJUH Rahway-TRMC CHNA Advisory Committee, and discussion with and voting by RWJUH and TRMC leaders, the following priorities were selected:

- **TRMC Priorities (3):** 1) Food Insecurity and Healthy Eating; 2) Healthcare Access and Chronic Disease Prevention and Management; and 3) Mental Health and Behavioral Health.

- **RWJUH Rahway Priorities (4):** 1) Food Insecurity and Healthy Eating; 2) Healthcare Access; 3) Chronic Disease Prevention and Management; and 4) Mental Health and Behavioral Health.

RWJUH Rahway and TRMC will address these priority action areas as part of ongoing community engagement efforts. Health and Racial Equity and Systemic Racism and Discrimination will be included as cross-cutting themes with strategies to address health disparities.

Introduction

Community Health Needs Assessment Purpose and Goals
A community health needs assessment (CHNA) is a systematic process to identify and analyze health needs and assets and prioritize those needs to inform the implementation of strategies to improve community health. In 2025, **RWJUH Rahway and Trinitas Regional Medical Center** undertook a CHNA process using a mixed-methods and participatory approach.

RWJBarnabas Health (RWJBH) is a non-profit healthcare organization which includes 12 acute care hospitals, three acute care children's hospitals, a leading pediatric rehabilitation hospital, a freestanding acute behavioral health hospital, a clinically integrated network of ambulatory care centers, two trauma centers, a satellite emergency department, geriatric centers, the state's largest behavioral health network, ambulatory surgery centers, comprehensive home care and hospice programs, long term care facilities, fitness and wellness centers, retail pharmacy services, medical groups, diagnostic imaging centers, a clinically integrated network and collaborative accountable care organization.

RWJUH Rahway is located in Rahway, New Jersey, and is part of the RWJBH system. As one of the acute care hospitals within the system, RWJUH Rahway provided care for nearly 5,000 inpatient admissions, over 38,000 emergency room visits, and over 61,000 outpatient visits. Its campus is home to a subacute rehabilitation facility and a long-term acute care hospital. It has earned recognition as a primary stroke center and earned a hospital safety grade "A" by the Leapfrog Group in 2024.

Trinitas Regional Medical Center is a 429-licensed bed acute care hospital located in Elizabeth, New Jersey. Part of the RWJBH system, Trinitas Regional Medical Center (TRMC) cared for over 11,000 inpatients, including over 1,100 deliveries and about 3,500 same-day surgeries, as well as over 58,000 emergency department visits in 2024. It has been recognized as a high-performing hospital for maternity care by U.S. News & World Report and received the Healthgrades Labor and Delivery Excellence Award™ in 2023.

This assessment process was built upon previous assessment and planning processes conducted by RWJUH Rahway and TRMC. In developing the previous Strategic Implementation Plan (SIP) for 2023-2025, RWJUH Rahway adopted overarching goals and objectives aimed at addressing the following priority areas: Mental Health, Nutrition and Food Insecurity, Chronic Disease, and Access to Healthcare and Social Services. Meanwhile, TRMC focused on the following priorities in its prior SIP: Chronic Disease, Mental Health, Access to Healthcare and Social Services, and Food Insecurity. Progress was made towards these priorities through various partnerships, initiatives, and strategies over the last three years. See Appendix H: Outcomes and Results from Previous Implementation Plan for a more detailed description of the coalition's activities, accomplishments, and impact since 2023.

In 2024, RWJBH contracted the services of **Health Resources in Action** (HRiA), a non-profit public health consultancy organization, to support, facilitate, conduct data analysis, and develop report deliverables for the joint RWJUH Rahway and TRMC CHNA. In addition, RWJBH

contracted HRiA to carry out similar assessments across the RWJBH system, administer a community health survey, and support strategic planning processes for all RWJBH facilities.

The RWJUH Rahway and TRMC CHNA aims to gain a greater understanding of the issues that the primary service area community residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This report presents findings from the assessment process conducted in 2025.

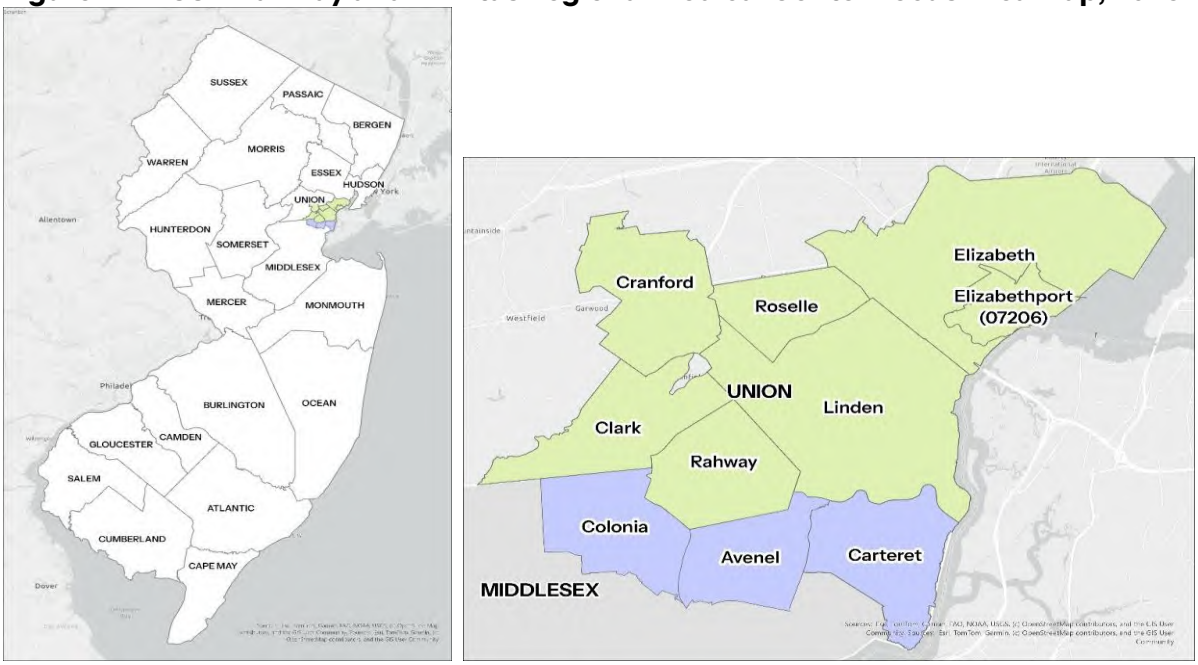
The specific goals of this CHNA are to:

- Systematically identify the needs, strengths, and resources of the community to inform future planning,
- Understand the current health status of the service area overall and its sub-populations within their social context,
- Engage the community to help determine the needs and opportunities for action, and
- Fulfill the IRS mandate for non-profit hospitals.

Area of Focus

This CHNA process aims to fulfill multiple purposes for a range of stakeholders and includes data from both facilities' primary services areas. The CHNA's focus area includes the following municipalities in Union County: Clark, Cranford, Elizabeth, Elizabethport, Linden, Rahway, and Roselle; and three municipalities in Middlesex County: Avenel, Carteret, and Colonia. The CHNA encompasses the following zip codes: 07001, 07008, 07016, 07036, 07065, 07066, 07067, 07201, 07202, 07203, 07206, 07207, and 07208. Of note, zip codes 07201, 07202, and 07208 are in Elizabeth (Figure 1).

Figure 1. RWJUH Rahway and Trinitas Regional Medical Center Focus Area Map, 2025



DATA SOURCE: NJ Office of Information Technology, Office of GIS (NJOGIS), 2023

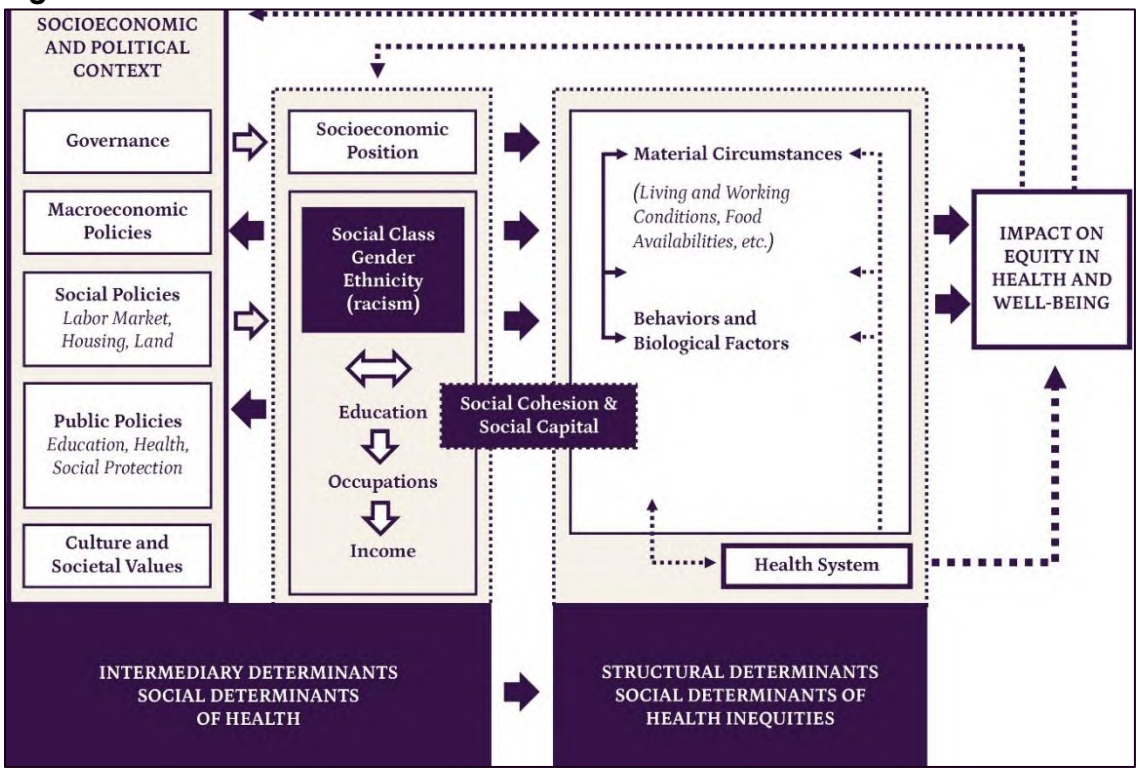
Methods

The following section describes how data for the CHNA were compiled and analyzed, as well as the broader lens used to guide this process.

Social Determinants of Health Framework
While this CHNA aimed to be comprehensive, its data collection approach focused on the social and economic upstream issues that affect a community's health.

Upstream Approaches to Health
Having a healthy population requires more than delivering quality healthcare to residents. Where a person lives, learns, works, and plays has an enormous impact on health. Health is not only affected by people's genes and lifestyle behaviors, the intermediary social determinants of health, but also by upstream factors such as employment status, quality of housing, and economic policies.

Figure 2. Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Commission on the Social Determinants of Health, A Conceptual Framework for Action on the Social Determinants of Health, 2010.

Healthcare insurers, regulators, and providers have recognized health-related social needs as those social factors that directly impact the health of individuals, such as economic strain and food availability. Healthcare sector partners can take steps to address and mitigate the impact

of the health-related social factors on health through screening and referrals to social and community-based services.[30]

The data to which we have access are often a snapshot in time, but the people represented by that data have lived their lives in ways that are constrained and enabled by economic circumstances, social context, and government policies. To this end, much of this report is dedicated to discussing the social, economic, and community context in which residents live. We hope to describe the current health status of residents and the multitude of factors that influence health to enable the identification of priorities for community health planning, existing strengths and assets upon which to build, and areas for further collaboration and coordination.

Health Equity Lens

The influences of race, ethnicity, income, and geography on health patterns are often intertwined. In the United States, social, economic, and political processes ascribe social status based on race and ethnicity, which may influence opportunities for educational and occupational advancement and housing options, two factors that profoundly affect health. Institutional racism, economic inequality, discriminatory policies, and historical oppression of specific groups are a few of the factors that drive health inequities.

The present report describes health patterns for the primary service area population overall, as well as areas of need for specific subpopulations. Understanding factors that contribute to health patterns for these groups can facilitate the identification of data-informed and evidence-based strategies to provide all residents with the opportunity to thrive and live a healthy life.

Approach and Community Engagement Process

The CHNA aimed to engage agencies, organizations, and community residents through different avenues. The CHNA process was guided by strategic leadership from the RWJBarnabas Health Community Health Needs Assessment (CHNA) Steering Committee, the RWJUH Rahway and TRMC CHNA Advisory Committee, and the community overall.

RWJBarnabas Health System Engagement

This CHNA is part of a set of CHNAs being conducted across the entire RWJBarnabas Health system. Each of these CHNAs follows a consistent framework and includes a common base set of indicators, but the approach and engagement process are tailored for each community. The RWJBH Systemwide CHNA Steering Committee, as well as the system's Social Impact and Community Investment (SICI) leadership group—both with representation across all facilities—met throughout 2024 and provided input and feedback on the assessment process, a set of common metrics across all system facilities, the content and dissemination approach of a community health survey (see next paragraph), and the planning process, including priority areas. A list of the RWJBH staff engaged can be found in the Acknowledgments section.

[30] Centers for Medicare & Medicaid Services, Social Drivers of Health and Health-Related Social Needs, 2024

In early 2024, RWJBH staff provided feedback to the community health survey. Specifically, staff made recommendations to update the content of a survey administered in the previous round of CHNAs. After changes were made by HRiA staff, RWJBH staff then reviewed, provided feedback, and approved the revised 2024 survey, which was administered in the Spring and Summer 2024. RWJBH staff also provided feedback on the community health survey mode of administration, tools, and the progress monitoring dashboard. HRiA provided weekly progress updates and technical assistance to each facility lead to increase responses and ensure the representation of key population groups.

During the entire assessment and planning process, HRiA met with RWJUH Rahway and TRMC leads, keeping them abreast of progress. RWJUH Rahway and TRMC leads provided ongoing guidance, support, and feedback. Further, they were instrumental in organizing focus groups with community residents and/or connecting HRiA to stakeholders in the community.

RWJUH Rahway and TRMC CHNA Advisory Committee Engagement

A CHNA Advisory Committee was constituted to guide the process. The Advisory Committee included about 20 partners, among them representatives from RWJBH, health departments, nonprofit organizations, communities of faith, and other organizations representing a range of relevant fields throughout the CHNA's focus areas. The CHNA Advisory Committee was engaged at critical intervals throughout this process. In April 2025, the Advisory Committee met for a kick-off meeting during which HRiA provided an overview of the assessment and strategic planning processes, and preliminary findings from the 2024 RWJBH community health survey (see survey details below). The presentations were followed by a brief Q&A and an in-depth discussion to elicit Advisory Committee members' suggestions about population groups, topic areas, and issues to focus on during the assessment process. This feedback directly informed the development of an engagement plan to guide qualitative data collection. During the data collection process, Advisory Committee members also assisted with organizing focus groups with community residents, participating in key informant interviews, and/or connecting HRiA to stakeholders in the community.

A Key Findings and Preliminary Prioritization meeting was held on September 30th, 2025, and was attended by 16 participants from the RWJUH Rahway and TRMC CHNA Advisory Committee, as well as additional hospital leadership and members of other key partner organizations. During this meeting, HRiA staff presented the findings from the CHNA process, including preliminary themes that emerged upon review of the qualitative, survey, and secondary data. Meeting participants had the opportunity to ask questions, discuss the key themes, and participate in a poll to recommend the top priorities for each of the facilities to consider when developing their respective Strategic Implementation Plans (SIP). As a second step in the prioritization process, HRiA met with a core group from each facility to finalize SIP priorities, considering ongoing programs, expertise, and capacity. A detailed description of the prioritization process can be found in the

Prioritization and Alignment Process and Priorities Selected for Planning section.

Community Engagement
Community engagement is described below under the primary data collection methods. Capturing and lifting up a range of voices, especially those not typically represented in these processes, was a core component of this initiative. Community engagement was done via virtual focus groups, interviews, and surveys, both online and in person. By engaging the community through multiple methods and in multiple languages, this CHNA aimed to depict a full and multifaced picture of current community strengths and needs. Community engagement strategies were tailored to specifically reach groups that are traditionally medically underserved, including low-income, uninsured and underinsured, and racially minoritized populations.

Secondary Data: Review of Existing Data, Reports, and Analyses
Secondary data are data that have already been collected for other purposes. Examining secondary data helps us to understand trends and identify differences by sub-groups. It also helps guide where primary data collection can dive deeper or fill in gaps.

Secondary data for this assessment were drawn from a variety of national, state, and local sources, including the U.S. Census Bureau American Community Survey (ACS), the County Health Rankings 2024, the U.S. Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), the NJ Department of Health's State Health Assessment Data (NJSHAD), the NJ Department of Health Office of Vital Statistics and Registry, the NJ State Cancer Registry, the NJ Housing and Mortgage Finance Agency's NJ Counts, the United Ways of New Jersey ALICE (Asset Limited, Income Constrained, Employed), the National Survey of Children's Health, the New Jersey Hospital Discharge Data Collection System (NJDDCS), NJ SUDORS v.01232024, Statewide Substance Use Overview Dashboard Department of Human Services, Division of Mental Health and Addiction Services, Statewide Substance Use Overview Dashboard Department of Human Services, Division of Mental Health and Addiction Services, CDC's High School Youth Risk Behavior Survey, NJ Department of Environmental Protection Bureau of GIS, Schools and Child Care Centers and Acute Care Hospitals, New Jersey Department of Education, Childhood Lead Exposure in New Jersey Annual Report Department of Public Health, Office of Local Public Health, Childhood Lead Program, the U.S. Department of Labor Bureau Statistics, Feeding America, Map the Meal Gap, CDC's ATSDR's Geospatial Research, Analysis, & Services Program (GRASP), Point-In-Time Count, U.S. EPA, National Walkability Index, and NJ Department of Law & Public Safety, Office of the Attorney General, Uniform Crime Reporting. Additionally, hospitalization data for the were provided by the respective hospitals and culled by the RWJBH system data team. The cancer appendix was prepared by the RWJBH system data team based on the CDC's State Cancer Profiles and each hospital's tumor registry.

Secondary data were analyzed by the agencies that collected or received the data. Data were downloaded from the respective websites between January and March 2025, and reflect the last year for which data were available at that time. Data are typically presented as frequencies (%) or rates per 100,000 population. The race and ethnicity categories used in this report are as reported by the respective agencies. When the narrative makes comparisons between towns,

by subpopulation, or with New Jersey overall, these are lay comparisons and not statistically significant differences. Since the U.S. Census Bureau does not recommend using the one-year ACS estimates for areas with fewer than 65,000 inhabitants, and many of the towns in the focus area fall below this population threshold, the U.S. Census Bureau ACS five-year estimates (2019-2023) were used to present the social and economic indicators. Sometimes, reporting agencies do not provide certain data points. This could be due to several reasons: the agency might not have the statistics, they might have suppressed the data because of low numbers, or the data might not have met statistical reliability standards. In any of these cases, we placed an asterisk (*) to indicate data were not available.

Primary Data Collection

Primary data are new data collected specifically for the CHNA. The goals of these data were to: 1) describe perceptions of the strengths and needs within the service area by key populations; 2) explore which issues are perceived to be most urgent; and 3) identify the gaps, challenges, and opportunities for addressing these issues more effectively. Primary data were collected using three different methods: key informant interviews, focus groups, and a community health survey. All qualitative discussions were conducted between April and June 2025.

Qualitative Discussion: Key Informant Interviews and Focus Groups

*Key Informant Int*erviews

A total of 10 key informant interview discussions were completed with 19 individuals by Zoom. Interviews lasted from 45 to 60 minutes. They were semi-structured discussions that engaged institutional, organizational, and community leaders as well as frontline staff across sectors. Discussions explored interviewees' experiences addressing community needs and priorities for future alignment, coordination, and expansion of services, initiatives, and policies. Sectors represented in these interviews included: public safety, mental health, food assistance, housing services, social services, healthcare local government, and those who work with low-income families and the most vulnerable sectors of the immigrant community. See Appendix A: Organizations Represented in Key Informant Interviews and Focus Groups for a list of sectors and organizations represented and Appendix B: Key Informant Interview Guide for the guide used.

Focus Groups

A total of 11 community residents participated in 3 virtual focus groups on Zoom conducted with specific populations of interest: faith-based leaders, African American men, and healthcare providers. Conducted in English, focus groups were up to 90-minute semi-structured conversations and aimed to delve deeply into the community's needs, strengths, and opportunities for the future and to gather feedback on priorities for action. Please see Appendix C: Focus Group Guide for the focus group facilitator's guide.

Analyses

The collected qualitative information was coded and then analyzed thematically by HRiA data analysts to identify main categories and sub-themes. The analysts identified key themes that emerged across all groups and interviews as well as the unique issues that were noted for specific populations. Throughout the qualitative findings included in this report, the term "participants" is used to refer to key informant interview and focus group participants. Unique

issues that emerged among a group of participants are specified as such. The frequency and intensity of discussions on a specific topic were the key indicators used for extracting the main themes. While differences between towns are noted where appropriate, analyses emphasized findings common across the focus area. Selected paraphrased quotes—without personal identifying information—are presented in the narrative of this report to further illustrate points within topic areas.

RWJBH Community Health Needs Assessment Survey

A community health needs assessment survey was developed with the input of a broad range of partners and administered across a large section of central and northern New Jersey from May to September 2024. The survey was piloted and validated with RWJBH Steering Committee members and key partners, as well as community residents, to support several community health needs assessment and planning processes. The survey focused on the social determinants of health and health issues that impact the community: community priorities, assets and challenges, health status and concerns, healthcare access and barriers, and mental health and substance use. The survey was administered online and by hard copy in person. It was available in eight languages (English, Spanish, Portuguese, Arabic, simplified Chinese, Haitian Creole, Hindi, and Yiddish). A shorter version of the survey was available to facilitate outreach to low-literacy, hard-to-reach groups. These strategies were specifically tailored to reach medically underserved groups, including low-income and uninsured or underinsured community members, among others.

Extensive community outreach was conducted with assistance from RWJBH staff and partner organizations. A link to the online survey was displayed on partners' web pages and social media sites. Recruitment and marketing materials, including flyers and postcards with QR codes that linked to the survey, were distributed online, in medical facility common areas, and at community-wide events. A landing site was developed where partners could download the survey and the recruitment materials in eight languages. A dashboard was created for partners to view progress toward goals in real-time. In Union County, partners disseminated the survey link and the hardcopy version at in-person events and in organizations throughout the county.

The sample presented here is based on 1,220 responses from Union County residents. Table 1 provides the sociodemographic characteristics of survey respondents. In this report, people who completed the survey are referred to as "respondents" (whereas those who were part of focus groups and interviews are referred to as "participants" for distinction).

Table 1. Characteristics of Union County Survey Respondents (N=1220)

Age (n=1112)	
18 to 24	2.8%
25 to 44	25.9%
45 to 64	43.3%
65+	28.1%
Gender (n=802)	
Woman	77.3%
Man	21.8%
Transgender woman	*
Transgender man	*
Non-binary/queer	*
Agender/I don't identify with any gender /Other	*
Other self-identified gender identity	*
Race/Ethnicity (n=1143)	
Asian	6.8%
Black/African American	23.2%
Hispanic/Latino	29.3%
Middle Eastern and North African	1.0%
Native American	*
Native Hawaiian or other Pacific Islander	*
White/Caucasian	39.6%
Other Races/Ethnicities	3.6%
Sexual Orientation (n=740)	
Straight or heterosexual	91.8%
Gay or lesbian	3.8%
Bisexual, pansexual, or queer	3.4%
Asexual or other	*

Income (n=650)	
Less than $10,000	6.0%
$10,000 to $14,999	3.2%
$15,000 to $24,999	5.4%
$25,000 to $34,999	5.5%
$35,000 to $49,999	12.3%
$50,000 to $74,999	12.0%
$75,000 to $99,999	12.9%
$100,000 to $149,999	17.4%
$150,000 to $199,999	11.5%
$200,000 or more	13.7%
Marital Status (n=748)	
Married	50.0%
Single	27.5%
Separated/divorced/widowed	17.3%
Domestic partnership/civil union/living together	5.2%
Education (n=1054)	
Less than high school	2.2%
Some high school	2.6%
High school graduate or GED	12.7%
Some college	13.9%
Associate or technical degree/certification	12.4%
College graduate	28.2%
Postgraduate or professional degree	26.4%

DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data were suppressed due to low numbers. Respondents who selected multiple race/ethnicities were assigned to each category selected.

Analyses
Frequencies were calculated for each survey question. Not all respondents answered every question; therefore, denominators in analyses reflect the number of total responses for each question, which varied. Survey data presents race and ethnicity categories as selected by respondents. The race and ethnicity categories are asked in a multiple-choice question that allows for several answers. To recognize respondents' multiple identities, the race and ethnicity categories are presented alone or in combination. For example, if someone selected "Asian" and "Black or African American" they would appear in both categories. Thus, as with other multiple-choice questions that allow for multiple responses, the percentages may not add to 100 percent. To protect respondents' privacy, an asterisk (*) is placed in any table cell with fewer than 10 responses.

Data Limitations
As with all data collection efforts, several limitations should be acknowledged when interpreting data. Numerous secondary data sources were drawn upon in creating this report and each source has its own set of limitations. Overall, it should be noted that different data sources use different ways of measuring similar variables (e.g., different questions to identify race and ethnicity). There may be a time lag for many data sources from the time of data collection to data availability, or changes in methodology that prevent year by year comparisons within data sources. Some data are not available by specific population groups (e.g., age) or at a more granular geographic level (e.g., town or municipality) due to small sub-sample sizes. In some cases, data from multiple years may have been aggregated to allow for data estimates at a more granular level or among specific groups.

The community health survey used a convenience sample. Since a convenience sample is a type of non-probability sampling strategy, there is potential selection bias in who participated or was asked to participate in the survey. Respondents' sociodemographic distribution does not represent the sociodemographic distribution of Union County residents. For example, 77.3% of the sample identified as women, compared to 51.5% of the county's population. Community health survey data should not be used to extrapolate the prevalence of a given indicator to the population of Union County as a whole. However, a range of strategies such as multiple collection sites, access points, and survey administration modalities were used to minimize selection bias (e.g., extensive community outreach at public venues and key events, and availability of survey on paper, among other strategies) and multiple population groups – patients, RWJBH employees, the community at large, and a focus on population groups typically underrepresented in surveillance data (e.g., specific language and demographic groups) were engaged to try to yield a sample that was similar to the Union County population.

Similarly, while interviews and focus groups provide valuable insights and important in-depth context, due to their non-random sampling methods and small sample sizes, results are not necessarily generalizable. Focus groups and interviews were conducted virtually, and therefore, while both video conference and telephone options were offered, some residents who lack reliable access to the internet and/or phones may have experienced difficulty participating. Further, qualitative data were collected between April and June, 2025, a period of significant transition and policy changes by the incoming federal administration. The changing landscape

posed difficulties in engaging with some stakeholders and community members —particularly those belonging to or working with some of the most vulnerable populations—in CHNA activities, who were often fearful and focused on responding to immediate challenges. Of note, those who were able to engage were eager to participate and uplifted the value of partnerships, solidarity, and collaboration to build and strengthen communities (A more detailed account of this engagement process can be found in the Primary Data Collection section). This CHNA should be considered a snapshot of the current time, which is consistent with public health best practices. Moving forward, community engagement should continue to be prioritized to understand how the identified issues may evolve and what new issues or concerns may emerge over time.

Context for Comparisons to Previous CHNA

As appropriate, comparisons are made throughout this report between the previous and the current assessment. It is important to keep in mind that these comparisons may not be as relevant given that the previous CHNA was conducted during the height of the COVID-19 pandemic and that this CHNA was conducted during early 2025, a period of transition in the federal government. Changes in the federal government at the national level can reshape federal policy priorities, funding streams, and regulatory frameworks. These factors can influence other factors that directly affect residents' health and well-being and local organizations' capacity to serve them. As federal policies continue to evolve, it remains essential to continue to understand the assets, challenges, and priorities of diverse communities, especially those with a higher burden of health inequities. Of note, in times of change, assessing the community's resilience and strengths is critically important.

Population Characteristics

Population Overview

The RWJUH Rahway and Trinitas Regional Medical Center serve a population of 467,466 across parts of Union and Middlesex counties (Table 2). In 2019-2023, the smallest municipalities by population were Clark (15,410) and Avenel (17,143), while the largest was Elizabeth (135,887). The overall population growth between 2014-2018 and 2019-2023 was 3.5% in Union County and 4.2% in Middlesex County, with Elizabeth experiencing an increase of 6.0%. Additional population tables can be found in Appendix E: Additional Data Tables and Graphs.

Table 2. Total Population and Percent Change, by State, County and Town, 2014-2023

	2014-2018	2019-2023	% change
New Jersey	8,881,845	9,267,014	4.3%
Union County	553,066	572,549	3.5%
Clark	15,614	15,410	-1.3%
Cranford	23,882	23,841	-0.2%
Elizabeth (citywide)	128,153	135,887	6.0%
Elizabeth (07201)	27,790	27,725	-0.2%
Elizabeth (07202)	41,235	44,638	8.3%
Elizabethport (07206)	27,660	31,120	12.5%
Elizabeth (07208)	31,442	32,404	3.1%
Linden	42,033	43,614	3.8%
Rahway	29,370	29,748	1.3%
Roselle	21,582	22,455	4.0%
Middlesex County	826,698	861,535	4.2%
Avenel	18,831	17,143	-9.0%
Carteret	23,682	25,187	6.4%
Colonia	17,734	18,294	3.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates Subject Tables, 2014-2018 & 2019-2023

The age distribution of Union and Middlesex counties in 2019-2023 were similar to New Jersey overall (

Figure 3). Union County had a slightly higher percentage of children under age 18 and a slightly lower percentage of residents aged 65 or older. In particular, Elizabethport had a notably younger population than other areas. Age distribution data by town can be found in Appendix E: Additional Data Tables and Graphs (Table 20. Age Distribution, by State, County and Town, 201).

Figure 3. Age Distribution, by State and County, 2019-2023

	Under 18 years	18 to 24 years	25 to 44 years	45 to 64 years	65 to 74 years	75 years and over
New Jersey	21.9%	8.4%	26.1%	26.9%	9.8%	7.0%
Union County	23.5%	8.2%	26.4%	27.0%	8.7%	6.1%
Clark	21.6%	5.6%	26.4%	23.8%	11.0%	11.6%
Cranford	22.5%	6.2%	23.8%	27.8%	9.2%	10.4%
Elizabeth (citywide)	25.5%	9.7%	28.4%	25.1%	6.7%	4.6%
Elizabeth (07201)	25.7%	8.5%	30.2%	26.1%	6.0%	3.6%
Elizabeth (07202)	25.0%	9.2%	27.7%	25.6%	7.4%	5.2%
Elizabethport (07206)	29.3%	11.1%	27.9%	22.4%	5.5%	3.9%
Elizabeth (07208)	22.5%	10.0%	28.2%	26.5%	7.7%	5.2%
Linden	20.8%	8.3%	27.7%	28.9%	9.0%	5.2%
Rahway	20.6%	8.4%	28.9%	26.4%	8.4%	7.5%
Roselle	19.2%	10.8%	28.4%	25.5%	9.3%	7.1%
Middlesex County	21.6%	9.4%	26.7%	26.5%	9.3%	6.4%
Carteret	22.2%	11.0%	24.9%	26.7%	8.6%	6.4%
Avenel	18.0%	6.2%	31.7%	31.4%	8.2%	4.3%
Colonia	21.2%	5.9%	25.0%	28.7%	11.9%	7.4%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Racial, Ethnic, and Language Diversity

Racial and Ethnic Composition

Focus group and interview participants described Union as a racially and ethnically diverse county. A key informant interviewee described, *"this [Union County] is a multicultural and multilingual county."* Participants explained that while the county overall was racially and ethnically diverse, they perceived varying demographics depending on the municipality with one participant stating, *"demographics vary widely from one end of county to the other."* Participants specifically identified Elizabeth as a city within Union County that was particularly racially and ethnically diverse.

In Union County, 41.7% of residents are White, compared to 56.9% in New Jersey overall (Table 3). Union County has a notably larger proportion of Black (20.5%) and Latino residents (34.4%) than the state. In Middlesex County, 44.2% of residents are White, and 25.1% are Asian, compared to 9.9% statewide. The diversity is not evenly distributed however, with different municipalities having varying concentrations of residents by race/ethnicity. For example, about two-thirds of Elizabeth residents are Latino, almost one-third of Rahway residents are Black, and one-quarter of Carteret residents are Asian.

Table 3. Racial and Ethnic Distribution, by State, County, and Town, 2019-2023

	American Indian	Asian	Black/African American	Hispanic/Latino	Native Hawaiian/ Pacific Islander	White	Other Race	2+ Races
New Jersey	0.5%	9.9%	13.0%	21.9%	0.0%	56.9%	9.2%	10.6%
Union County	0.3%	5.6%	20.5%	34.4%	0.0%	41.7%	19.7%	12.1%
Clark	0.2%	3.9%	2.2%	9.4%	0.0%	85.7%	1.3%	6.7%
Cranford	0.0%	3.0%	2.3%	7.4%	0.0%	85.9%	2.6%	6.1%
Elizabeth (citywide)	0.9%	1.8%	17.1%	66.8%	0.0%	24.8%	38.5%	16.9%
Elizabeth (07201)	2.3%	1.4%	20.0%	64.6%	0.0%	31.4%	25.1%	20.0%
Elizabeth (07202)	0.5%	2.1%	13.7%	70.3%	0.0%	19.3%	46.2%	18.3%
Elizabethport (07206)	0.1%	1.0%	18.5%	69.4%	0.0%	13.6%	54.4%	12.4%
Elizabeth (07208)	1.1%	2.5%	18.0%	61.2%	0.0%	37.7%	24.0%	16.7%
Linden	0.0%	3.6%	28.1%	35.6%	0.1%	37.9%	14.6%	15.6%
Rahway	0.0%	7.1%	31.3%	28.2%	0.0%	35.1%	10.9%	15.6%
Roselle	0.5%	1.2%	45.6%	36.1%	0.1%	18.5%	19.2%	14.9%
Middlesex County	0.9%	25.1%	10.4%	23.0%	0.0%	44.2%	10.5%	8.9%
Avenel	0.1%	19.9%	27.8%	21.2%	0.0%	35.9%	4.7%	11.7%
Carteret	0.6%	24.5%	17.3%	34.0%	0.1%	27.2%	12.2%	18.1%
Colonia	0.1%	14.2%	4.4%	16.6%	0.0%	65.5%	7.5%	8.4%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

NOTE: All categories except Hispanic do not include Hispanic residents. American Indian includes American Indian and Alaska Native; Black includes Black or African American; Native Hawaiian includes Native Hawaiian and Other Pacific Islander.

Foreign-Born Population

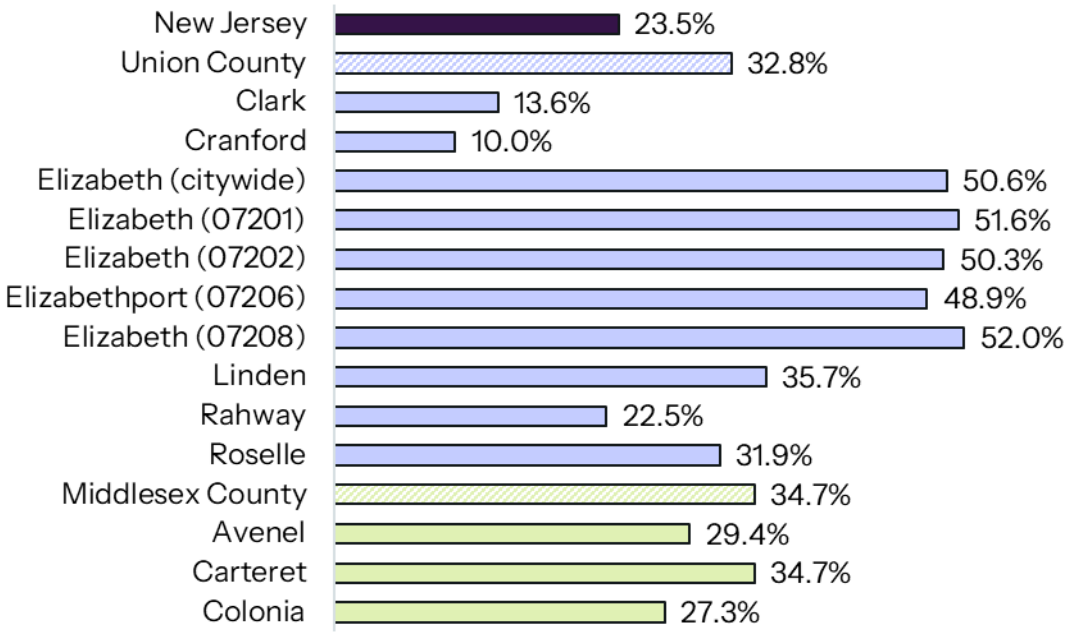
Participants described certain communities within Union County, particularly Elizabeth, as hot spots with high populations of foreign-born and immigrant communities. Interview and focus group participants described a mix of newly arrived immigrants as well as immigrant communities who have been living in Union County for generations. A key informant interviewee described, *"Elizabeth is a very large city with a large population. 50% of the population is Latino or identifies as Latino but we really are an immigrant hotspot. There is a very large portion who are new immigrants as well as immigrants who have been here for quite some time."*

Participants also perceived a potential high vulnerability and trauma some foreign-born residents experience, often believed to be associated with their journey to United States and

the experience of being in an unfamiliar place with limited friends and family. A key informant interviewee explained, *"it is often traumatizing to leave the familiar like [their] friends and families and our clients come across borders and sometimes it is dangerous for them and they are leaving, oftentimes fleeing violence behind them so they have a sense of carrying some stark burdens."*

About one in three residents of Union and Middlesex Counties were foreign-born in 2019-2023, larger proportions than the state (Figure 4). In Elizabeth, one half of residents were foreign-born. From 2014-2018, the foreign-born population has increased 2.8% in Union County and 2.0% in Middlesex County. For more details, see Table 22 in Appendix E for percentage change in foreign-born population state, county, and town

Figure 4. Percent Foreign-Born Population, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Immigrants in Union County come primarily from Colombia, the Dominican Republic, El Salvador, Ecuador, and Haiti. Immigrants in Middlesex County come primarily from India, the Dominican Republic, Mexico, China, and the Philippines (Figure 5).

Figure 5. Top 5 Places of Birth of Foreign-Born Population, by State and County, 2019-2023

	New Jersey	Union County	Middlesex County
1	India (12.6%)	Colombia (10.0%)	India (32.7%)
2	Dominican Republic (9.7%)	Dominican Republic (7.6%)	Dominican Republic (10.6%)
3	Mexico (4.8%)	El Salvador (6.9%)	Mexico (4.8%)
4	Ecuador (4.6%)	Ecuador (6.7%)	China (4.5%)
5	Colombia (4.4%)	Haiti (6.2%)	Philippines (3.6%)

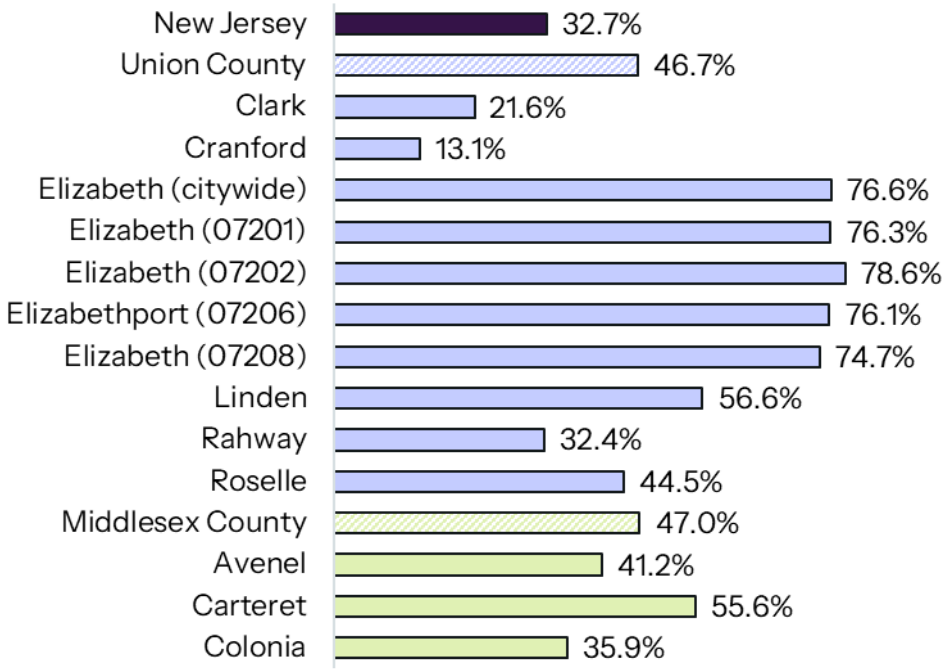
DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Language Diversity

Despite Union County being described as a multicultural and multilingual county, interview and focus group participants perceived that language was a barrier to accessing healthcare and other services in their communities. Participants described that the healthcare system is often already challenging for native English speakers and described how these challenges are amplified when trying to navigate the system in a language other than English or with limited English proficiency. A key informant interviewee described, *"getting healthcare and sustaining your health with medications and prescriptions is very challenging. Knowing where to go and what you need to bring with you in order to navigate some of those social service systems we have can be daunting if you are doing that in the local language or if you are trying to do it with the limited language you do have*."

Almost one half of Union (46.7%) and Middlesex (47.0%) County residents speak a language other than English at home, compared to 32.7% of residents statewide (Figure 6). The largest proportion is in Elizabeth, where 76.6% of residents over the age of 5 speak a language other than English at home. In contrast, a far smaller proportion of Clark (21.6%) and Cranford (13.1%) residents speak languages other than English at home.

Figure 6. Percent Population Aged 5+ Speaking Language Other than English at Home, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Spanish is the most common language other than English spoken at home in the Rahway/Trinitas PSA, with 29.6% of residents in Union County and 18.3% of residents in Middlesex County (Table 4). Elizabeth (61.5%) had the highest proportion of residents speaking Spanish at home. Notably, 8.4% of Linden residents and 7.8% of Roselle residents spoke French, Haitian, or Cajun at home, and 20.0% of Carteret residents and 14.7% of Colonia residents spoke an "other Indo-European language" at home.

Table 4. Top 5 Languages Other than English Spoken at Home, by State, County, and Town, 2019-2023

	Spanish	French, Haitian, or Cajun	Other Indo-European languages	Other Asian and Pacific Island languages	Chinese (incl. Mandarin, Cantonese)
New Jersey	17.0%	1.1%	5.5%	1.6%	1.4%
Union County	29.6%	3.4%	6.5%	0.5%	1.1%
Clark	5.4%	0.3%	8.5%	0.4%	0.2%
Cranford	3.2%	0.6%	3.5%	0.1%	0.9%
Elizabeth (citywide)	61.5%	3.6%	8.0%	0.2%	0.1%
Elizabeth (07201)	58.3%	5.2%	10.0%	0.3%	0.6%
Elizabeth (07202)	65.7%	3.2%	7.3%	0.0%	0.0%
Elizabethport (07206)	63.3%	1.6%	7.1%	0.3%	0.0%
Elizabeth (07208)	56.7%	4.7%	8.0%	0.4%	0.0%
Linden	30.1%	8.4%	6.7%	0.1%	0.5%
Rahway	18.6%	2.5%	6.0%	0.4%	0.5%
Roselle	31.0%	7.8%	1.3%	0.1%	0.0%
Middlesex County	18.3%	0.7%	13.4%	4.9%	2.7%
Avenel	16.0%	1.0%	10.3%	3.9%	0.4%
Carteret	27.3%	2.2%	20.0%	1.1%	0.1%
Colonia	9.5%	1.9%	14.7%	1.2%	1.0%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Community Social and Economic Environment

Income, work, education, and other social and economic factors are powerful social determinants of health. For example, jobs that pay a living wage enable workers to live in neighborhoods that promote health (e.g., built environments that facilitate physical activity, resident engagement, and access to healthy foods), and provide income and benefits to access health care. In contrast, unemployment, underemployment, and job instability make it difficult to afford housing, goods, and services linked with health and healthcare access, and contribute to stressful life events that affect multiple aspects of health.

Community Strengths and Assets

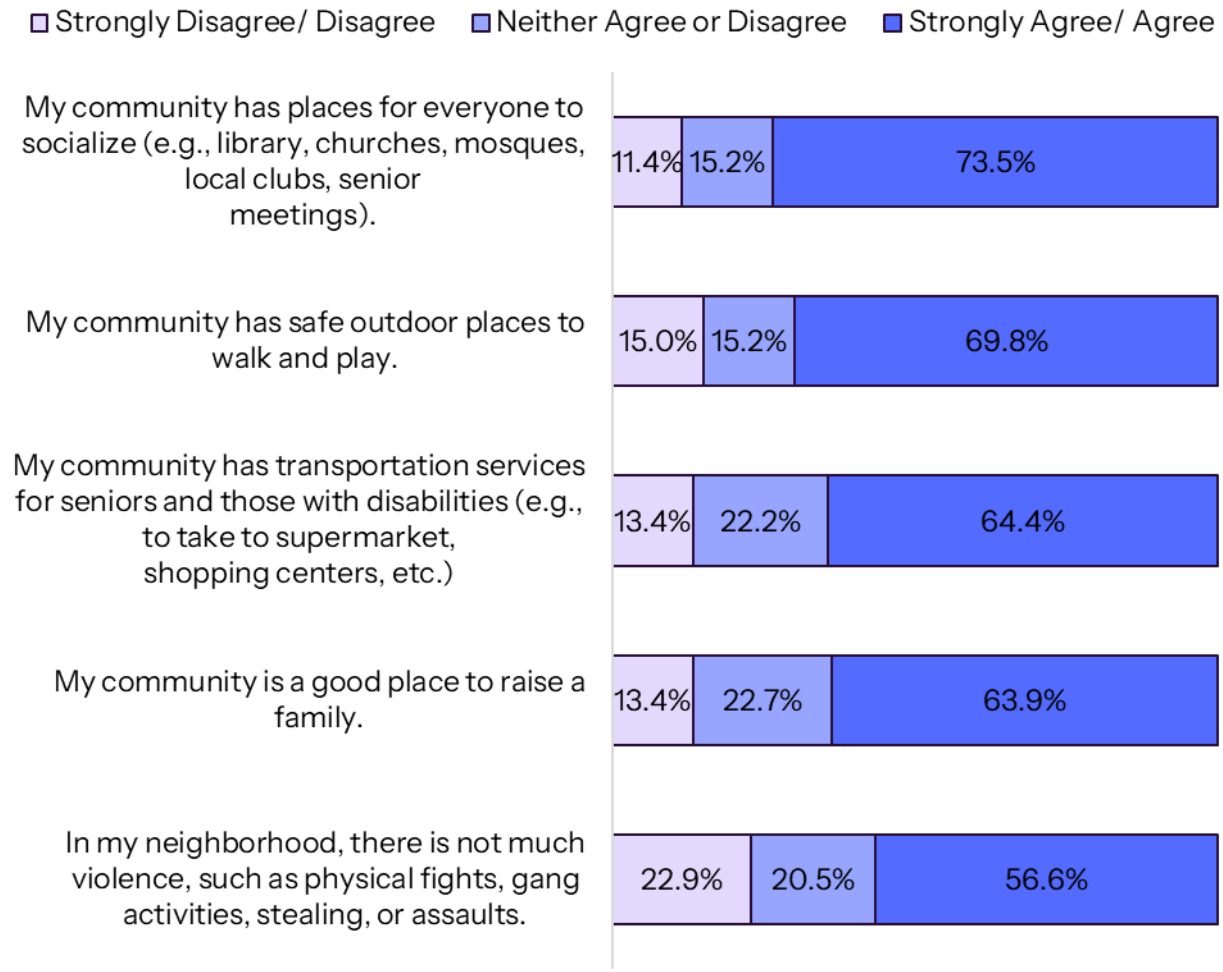
Understanding the resources and services available in a community—as well as their geographic distribution—helps to identify the assets that can be drawn upon to address community health, as well as any gaps that might exist. Interview and focus group participants identified numerous positive aspects of their communities. Residents appreciated that Union County neighborhoods have many amenities, including green areas and parks, restaurants and shops, and good schools. When describing Union County, a focus group participant explained, *"there are cultural things around whether they're art galleries or things to do [in terms of] entertainment and educational venues. [There are] things that you can do as a family as well. Definitely some good eateries and great food"* Additionally, participants described Union County as overall being quiet and peaceful, with good connection to resources.

Most participants valued and emphasized the high level of collaboration and partnership across the different sectors and institutions that serve Union County residents. One key informant described, *"There is a strong connection between different organizations, maybe because of how long they have been around, but if you go to one organization they know by name the other organizations and the leaders."*

> *"What I think that makes our community great would be, that we always try to help each other in general whether it's from agency to agency. We always try to see how best we can help them, we might not always have the funding, but we still provide the case management, and then we work with other agencies to see how best we could help."*
> – Key informant interviewee

The strengths identified by the greatest proportion of respondents were that their community had places for everyone to socialize (73.5%), had safe outdoor places to walk and play (69.8%), and had transportation options for seniors and those with disabilities (64.4%) (Figure 7).

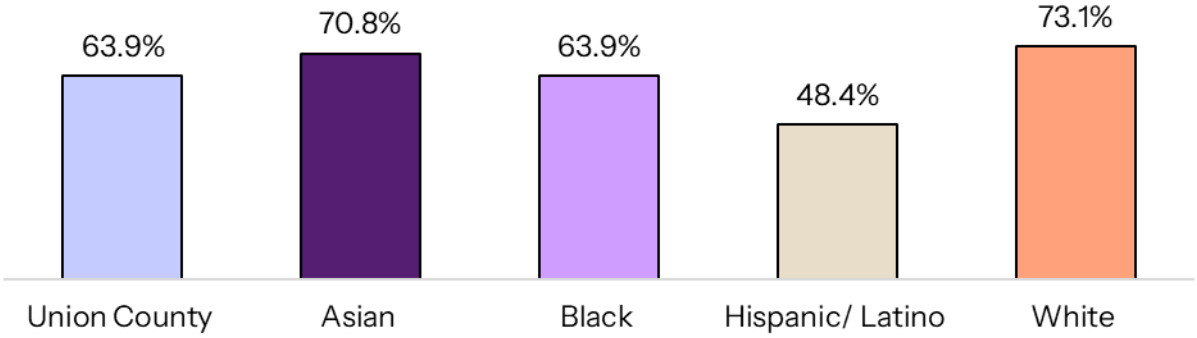
Figure 7. Community Characteristics Rated by Level of Agreement by Union County Survey Respondents, 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: The number of respondents ranged from n=686 to n=735 for the shown questions.

Of note, responses to survey questions about community characteristics varied by race/ethnicity. For example, as can be observed in Figure 8, White and Asian respondents were more likely than Latino respondents to agree or strongly agree that their community was a good place to raise a family. Of note, only about half of Latino respondents (48.4%) agreed with this statement.

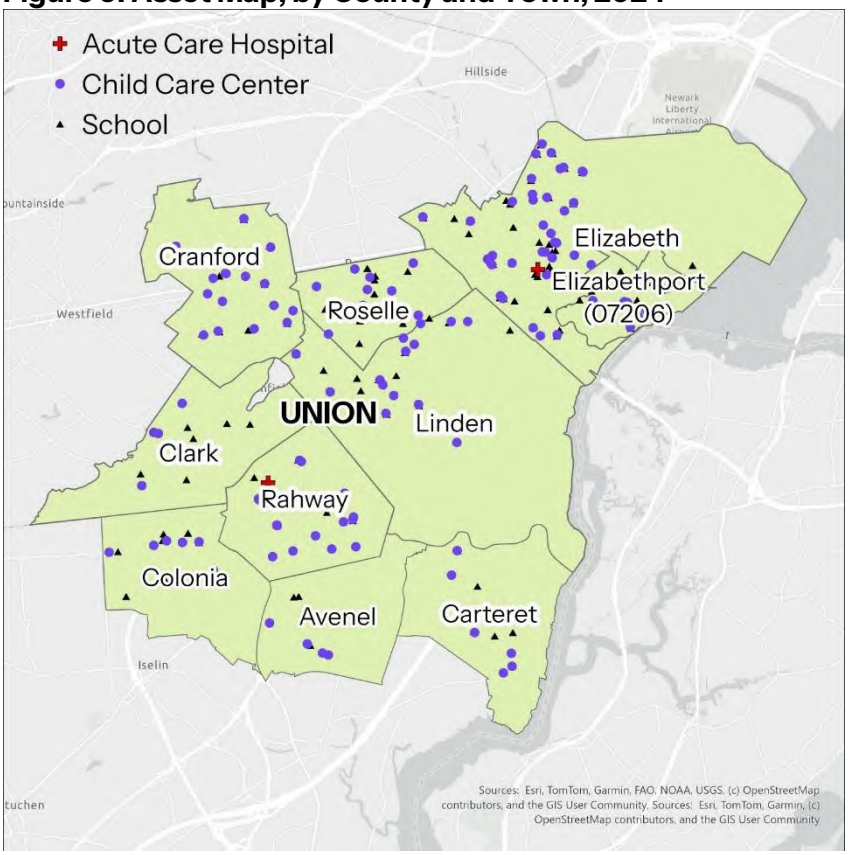
Figure 8. Percent of Union County Survey Respondents Who Agreed/Strongly Agreed with the Statement "My community is a good place to raise a family," by Race/Ethnicity, (n=686), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

The medical, educational, and childcare resources available in the Rahway/Trinitas PSA are visually presented in the map below. There are two acute care hospitals as well as 116 schools and 125 childcare centers (Figure 9). More information on assets in New Jersey can be found in Figure 92 in Appendix E: Additional Data Tables and Graphs.

Figure 9. Asset Map, by County and Town, 2024



DATA SOURCE: NJ Department of Environmental Protection Bureau of GIS, Schools and Child Care Centers and Acute Care Hospitals, 2024

Education

Focus group and interview participants viewed the education system in the Rahway/Trinitas PSA as great. They also described multiple options for tertiary schooling in the county that residents could take advantage of, which they believed made Union County a unique place to live. A key informant interviewee described, *"fortunately there is a good education system here and tertiary education here and the resources are more abundant here than in other places in the country."*

Educational attainment is an important measure of socioeconomic position that may reveal additional nuances about populations, in addition to measures of income, wealth, and poverty. NJ Department of Education data indicate that most (91.1%) New Jersey students in public schools graduated from high school (Table 5). In the Rahway/Trinitas PSA, graduation rates varied by public school district. Some school districts (Clark Township, Cranford, Union County Vocational-Technical) outperformed New Jersey as a whole. However, Rahway (80.8%) and Roselle (85.8%) had lower graduation rates in 2019-2023.

In some cases, graduation rates varied across students of different racial and ethnic backgrounds. For example, in Roselle Park, 97.5% of White students graduated, compared to 86.4% of Latino students. Union County Vocational-Technical and Linden Public Schools stand out for having very consistent graduation rates across racial/ethnic groups. Multiple school districts in the Rahway/Trinitas PSA did not have sufficient representation across racial groups to make such comparisons. More information on educational attainment can be found in Table 24 and Table 25 of Appendix E: Additional Tables and Graphs.

Table 5. Four-Year Adjusted Cohort High School Graduation Rates, by Race/Ethnicity, by State and School District, 2019-2023

		Overall	Asian, Native Hawaiian, or Pacific Islander	Black or African American	Hispanic	White
New Jersey		91.1%	96.7%	86.7%	85.8%	95.0%
Middlesex County	Carteret Public School District	91.9%	95.2%	94.7%	90.5%	92.3%
Union County	Clark Township Public School District	97.3%	*	*	100.0%	96.6%
	Cranford Public School District	96.6%	100.0%	*	95.5%	96.4%
	Elizabeth Public Schools	87.9%	86.2%	84.8%	88.7%	85.2%
	Linden Public School District	91.7%	*	91.8%	92.0%	90.5%
	Rahway Public School District	80.8%	*	79.3%	78.7%	89.7%
	Roselle Public School District	85.8%	*	86.7%	85.1%	*
	Roselle Park Public School District	91.2%	100.0%	94.7%	86.4%	97.5%
	Union County Vocational-Technical School District	99.7%	100.0%	100.0%	99.0%	100.0%

DATA SOURCE: New Jersey Department of Education, School Performance, 2023
NOTE: Asterisk (*) indicates that data are not displayed to protect student privacy.

Employment and Workforce

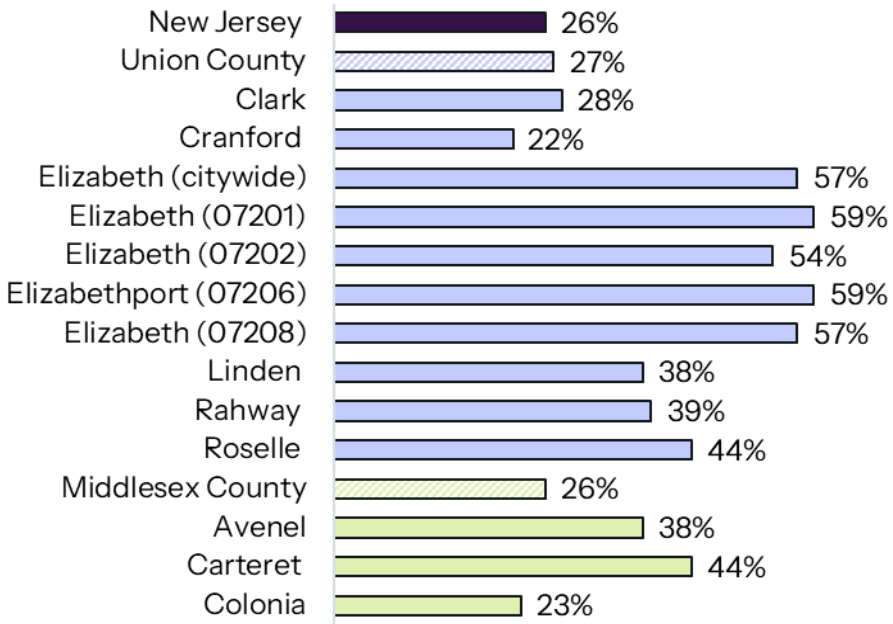
Employment was not a prominent theme in most focus groups and interviews. However, participants described the existence of multiple job fairs and job training events in Union County. A key informant interviewee described, *"the county normally sends us, any job fairs, so we get notified if there's any job fairs."*

Participants also described perceived challenges the re-entry population face finding employment. Participants identified the challenge having a criminal record had on employment opportunities overall but also described additional barriers re-entry populations face. They described stereotypes and discrimination from potential employers, and a lack of job training received while incarcerated adding additional challenges finding employment opportunities.

> *"One of the biggest is historically if you have been incarcerated it's on your record but they have record expungement now, but you are still looked upon as a negative person."*
> – Key informant interviewee

In 2022, over 1 in 5 of both Union and Middlesex counties' households were Asset Limited, Income Constrained, Employed (ALICE), meaning that although employed, they did not earn enough to support their families (Figure 10). According to United for ALICE, between 2010 and 2022, the percentage of single-headed households with children living below the ALICE threshold increased by 18% in New Jersey. Proportions ranged from lows of 22% in Cranford and 23% in Colonia, to a high of 59% in Elizabeth and Elizabethport.

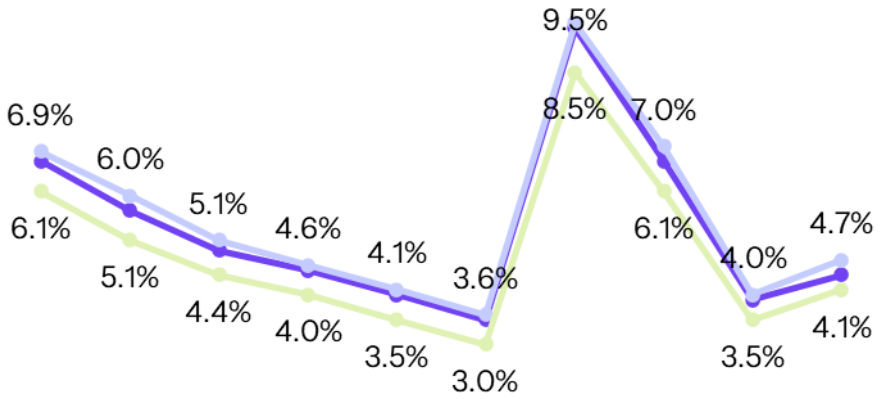
Figure 10. Percent of Households Living Below the ALICE Threshold, by State, County, and Town, 2022



DATA SOURCE: United For ALICE 2024, derived from American Community Survey, 2010-2022
NOTE: The ALICE Threshold is calculated by United Way's United For ALICE initiative. ALICE stands for Asset Limited, Income Constrained, and Employed. Households living below the ALICE threshold represent households with working adults who cannot afford basic needs (childcare, transportation, housing, food, etc.).

Data from the Bureau of Labor Statistics show that unemployment rates in Union County have consistently been slightly higher than those of New Jersey as a whole, while rates in Middlesex County have consistently been slightly lower (Figure 11). For both counties and the state, there had been a downward trend over the past decade before the COVID-19 pandemic, after which rates rose substantially. Unemployment rates then declined rapidly post-2020 but have increased again as of 2023.

Figure 11. Unemployment Rate, by State and County, 2014-2023



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
New Jersey	6.7%	5.7%	4.9%	4.5%	4.0%	3.5%	9.4%	6.7%	3.9%	4.4%
Union County	6.9%	6.0%	5.1%	4.6%	4.1%	3.6%	9.5%	7.0%	4.0%	4.7%
Middlesex County	6.1%	5.1%	4.4%	4.0%	3.5%	3.0%	8.5%	6.1%	3.5%	4.1%

DATA SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, 2014-2023

Town-level unemployment is estimated based on data from the 2019-2023 American Community Survey. Estimates showed that Elizabeth (07201) and Linden experienced the highest unemployment rates (9.2 and 8.5% respectively), while Cranford and Elizabeth (07202) experienced the lowest (3.5% and 4.2% respectively) (Table 6). Unemployment rates were also observed to vary by race/ethnicity. Residents who identify as Black had higher unemployment rates (8.2%) than other racial/ethnic groups, particularly in Linden (10.8%) while Asian residents had lower unemployment rates (3.7%) (Table 6). More detailed unemployment rates by age and gender can be found in Table 26 and Table 27 of Appendix E: Additional Data Tables and Graphs.

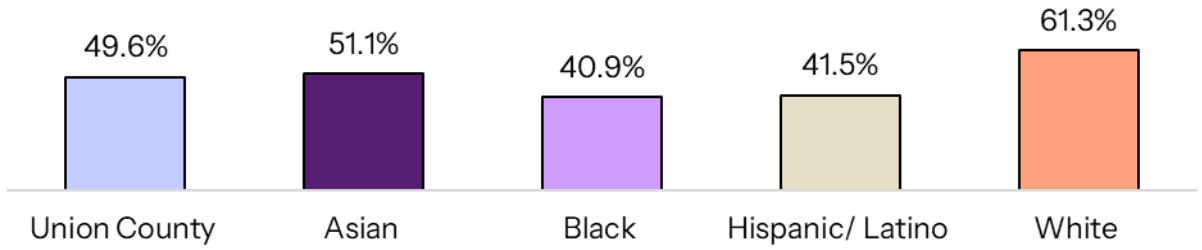
Table 6. Unemployment Rate, by Race/Ethnicity, by State, County, and Town, 2019-2023

	Overall	Asian, non-Hispanic	Black or African American, non-Hispanic	Hispanic /Latino	White, non-Hispanic	Additional Race, non-Hispanic	2+ Races
New Jersey	6.2%	4.7%	9.0%	7.2%	5.3%	7.4%	8.2%
Union County	6.3%	3.7%	8.2%	6.9%	4.8%	7.5%	7.7%
Clark	5.3%	0.0%	0.8%	2.9%	5.7%	8.3%	5.1%
Cranford	3.4%	4.6%	8.1%	5.8%	3.0%	11.9%	2.3%
Elizabeth (citywide)	6.9%	5.6%	6.5%	6.4%	6.9%	6.1%	9.2%
Elizabeth (07201)	9.7%	0.0%	5.3%	9.6%	10.9%	10.4%	12.2%
Elizabeth (07202)	4.2%	0.0%	5.3%	3.8%	2.2%	4.1%	5.9%
Elizabethport (07206)	5.2%	11.0%	7.5%	2.9%	10.7%	2.6%	7.3%
Elizabeth (07208)	9.2%	8.8%	7.9%	10.5%	6.2%	13.6%	11.5%
Linden	8.5%	1.4%	10.8%	8.2%	6.7%	8.0%	10.4%
Rahway	7.4%	1.9%	8.2%	9.6%	5.4%	9.4%	12.1%
Roselle	7.7%	4.6%	8.5%	5.6%	8.1%	8.4%	3.3%
Middlesex County	6.4%	5.1%	7.8%	7.9%	6.0%	8.7%	7.9%
Avenel	5.0%	8.4%	4.8%	3.5%	4.9%	2.2%	0.0%
Carteret	8.8%	13.2%	8.9%	7.5%	4.6%	2.4%	11.1%
Colonia	4.3%	0.0%	32.0%	2.5%	2.4%	9.6%	6.3%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Consistent with other data, many survey respondents did not believe that there were good employment opportunities in the area. Overall, slightly under half (49.6%) of Union County respondents agreed that there were job opportunities in their area (Figure 12). White respondents were notably more positive, with 61.3% agreeing, compared to respondents from all other races/ethnicities.

Figure 12. Percent of Union County Survey Respondents Who Agreed/Strongly Agreed with the Statement "There are job opportunities in my area," by Race/Ethnicity, (n=686), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Income and Financial Security

Income is a powerful social determinant of health that influences where people live and their ability to access resources that affect health and well-being.

Current economic challenges and financial insecurity were discussed in several interviews and focus groups. Participants talked about rising costs across the board: gas, housing, food, transportation, childcare, and healthcare. Focus group participants shared the day-to-day challenge of affording necessities as prices continue to climb.

Across Union County, there is variation in household financial well-being. Data from the 2019-2023 American Community Survey show that the median household income in Union County was slightly below that of New Jersey overall over that period. In addition, there were differences across communities, where the median household income ranged from a low of $60,992 in Elizabethport to a high of $148,629 in Cranford (Table 7).

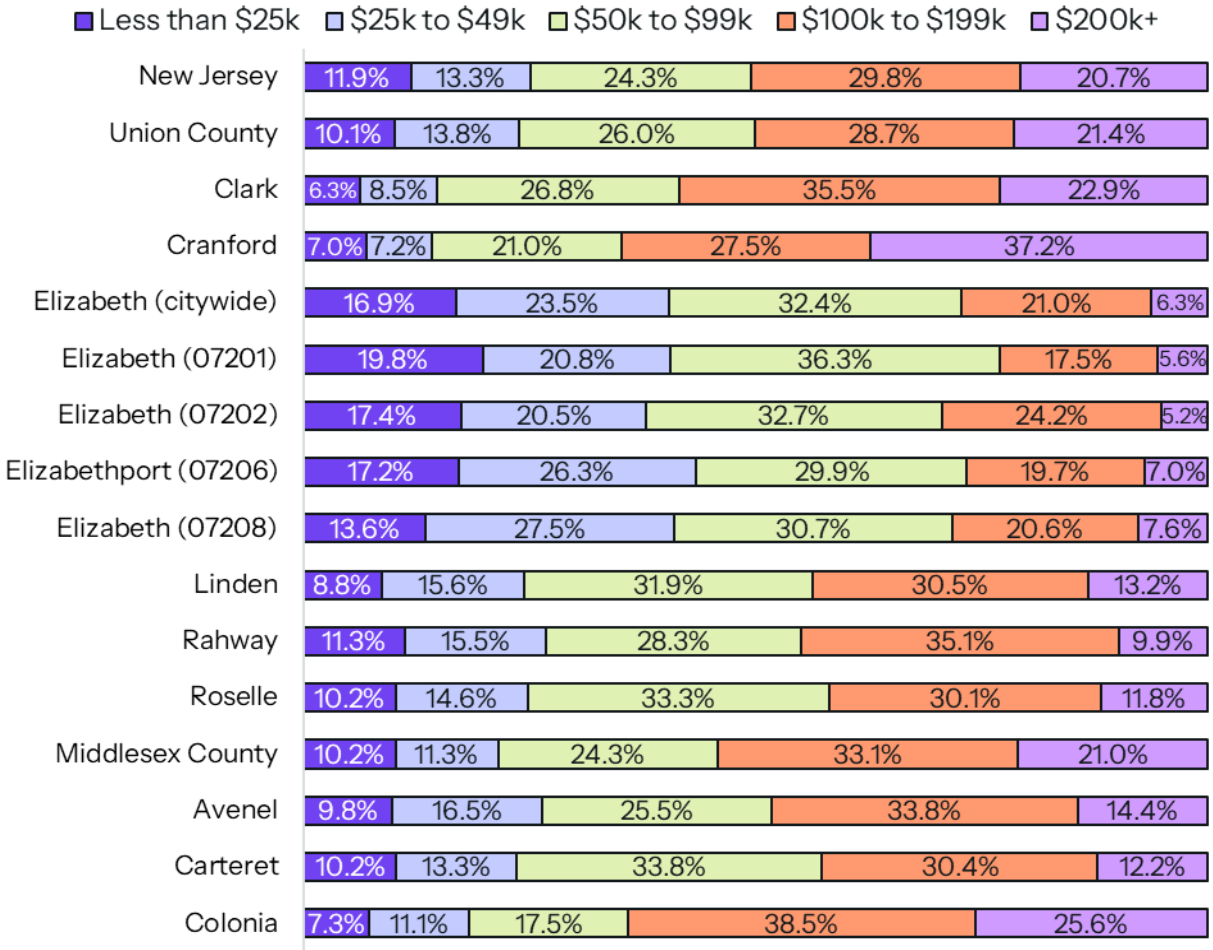
Table 7. Median Household Income, by State, County, and Town, 2019-2023

	Median income
New Jersey	$ 101,050
Union County	$ 100,117
Clark	$ 122,610
Cranford	$ 148,629
Elizabeth (citywide)	$ 63,874
Elizabeth (07201)	$ 62,026
Elizabeth (07202)	$ 68,071
Elizabethport (07206)	$ 60,992
Elizabeth (07208)	$ 61,873
Linden	$ 91,036
Rahway	$ 90,852
Roselle	$ 82,967
Middlesex County	$ 109,028
Avenel	$ 95,935
Carteret	$ 87,553
Colonia	$ 134,301

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Data on the concentration of wealth and poverty indicated large disparities. Over 19% of households in Elizabeth (07201) had annual incomes below $25,000; in contrast, over 37% of households in Cranford had incomes greater than $200,000 (Figure 13). Household incomes varied greatly across racial and ethnic groups. Among households in both Union and Middlesex Counties, residents identifying as Black, Hispanic/Latino, or other and multiple races had lower median incomes compared to residents identifying as Asian or White, non-Hispanic (for detail see Table 28 in Appendix E).

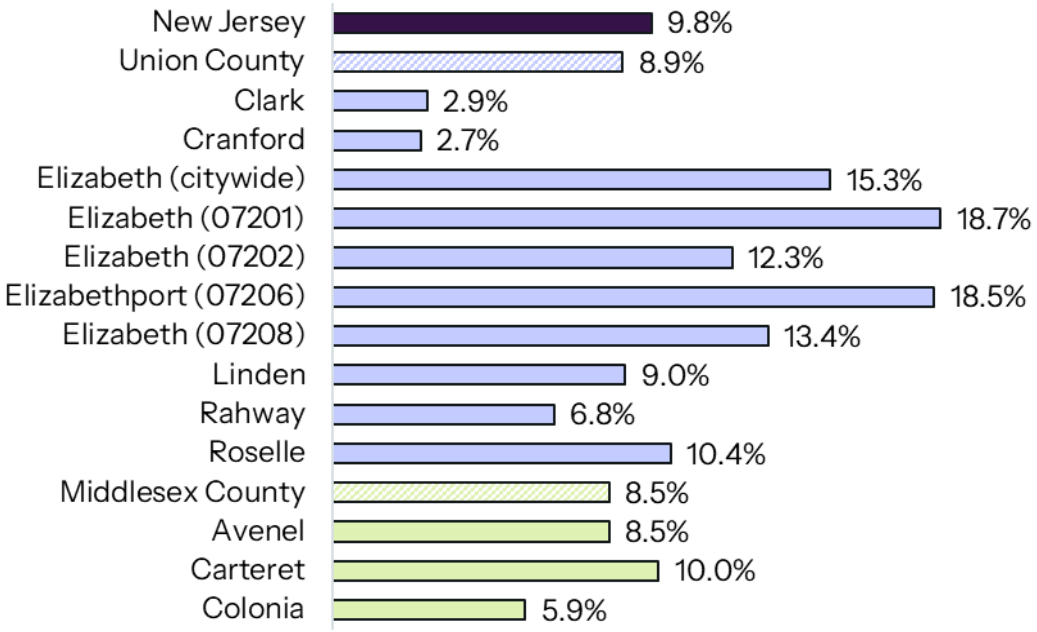
Figure 13. Distribution of Household Income, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

The percentage of Union County residents living below the poverty level represents the most extreme level of financial insecurity. For example, in 2023 an individual living alone would fall below the federal poverty line at an income level of $13,590, while the federal poverty level for a family of four was $27,750. Importantly, while the federal poverty line changes with household size, it does not increase to account for local cost of living. Figure 14 presents data on the percentage of residents falling below the federal poverty line in the state, county, and town. Both Union County (8.9%) and Middlesex County (8.5%) had percentages that were slightly below the state overall (9.8%). However, some towns had percentages that were notably higher, including Elizabeth (07201) (18.7%) and Elizabethport 18.5%). Poverty rates were lowest in Clark (2.9%) and Cranford (2.7%). For additional poverty data by race/ethnicity and among children, see Table 29, Figure 96, and Figure 97 located in Appendix E.

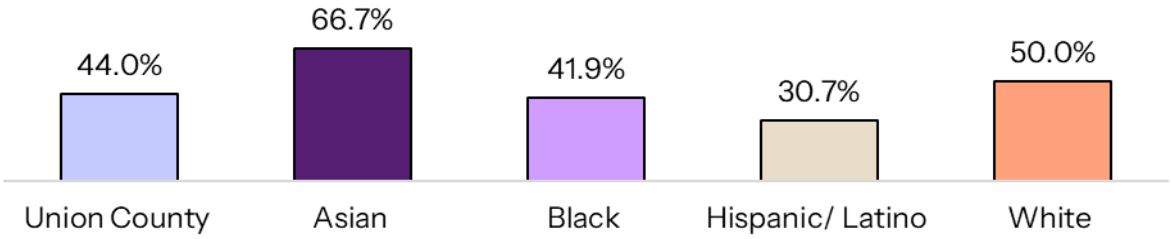
Figure 14. Individuals Below Poverty Level, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Under half (44.0%) of Union County survey respondents agreed that people in their community could afford basic needs like food, housing, and transportation (Figure 15). Among them, a greater proportion of Asian respondents agreed with this statement (66.7%), while fewer Latino (30.7%) and Black (41.9%) respondents were in agreement.

Figure 15. Percent of Union County Survey Respondents Who Agreed/Strongly Agreed with the Statement "People in my community can afford basic needs like food, housing, and transportation," by Race/Ethnicity, (n=735), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Food Insecurity and Healthy Eating

Food insecurity—not having reliable access to enough affordable, nutritious food— was a top-of-mind concern among many Rahway/Trinitas PSA residents. Several participants discussed their experiences with increasing food insecurity in Union County, which they perceived was a consequence of inflation, rising costs of living, and layoffs. A healthcare provider described, *"a*

lot of our patients are well below the poverty line. This affects anyone who's financially insecure. And what we're seeing now, more and more, as people are losing their jobs through these mass layoffs. The face of what that person looks like has changed from the stereotype of what people think and so, we will have a Mercedes-Benz pull up to the food bank."

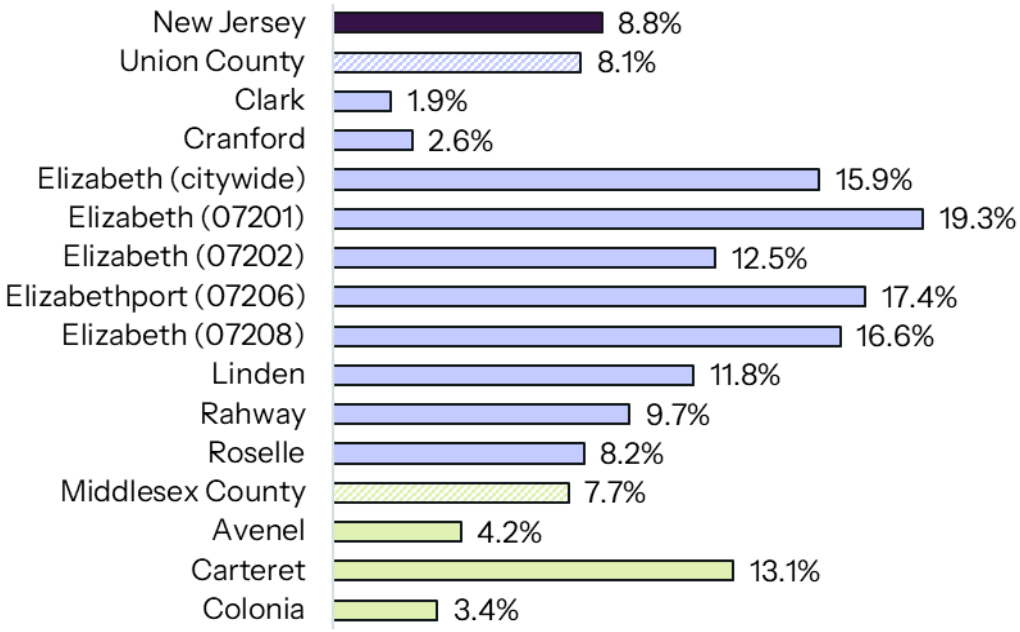
Despite food insecurity being a top community health concern, participants described multiple community-based programs offering food to low-income populations. Programs like Share My Meals, Common Market Boxes, Concrete Gardens as well as food access programs organized through the hospitals, community-based organizations, and local faith-based organizations working to improve food access in Union County.

While many food access barriers are related to income constraints, they may also be related to geography and transportation challenges. Often, these three factors intersect to inhibit food access. Focus group and interview participants perceived the existence of food deserts within Union County and described those as barriers to food access and access to healthy, affordable food for affected communities.

> *"I'd like to see more done to address food deserts, and when they do have food, having quality food not processed foods. So, addressing these with the ShopRites of the world, to put those ShopRites in these underserved communities as opposed to there just being a bodega in these communities so that people have reasonably priced healthy food. Because the food is more expensive, it's worse, and it's more expensive in these neighborhoods."*
> – Focus group participant

Consistent with interviewee and focus group perceptions, on average, between 2019-2023, 8.1% of residents in Union County and 7.7% of residents in Middlesex County received supplementary food assistance (Figure 16). The proportion of households receiving food assistance ranged from highs of 19.3% in Elizabeth (07201) and 17.4% in Elizabethport to a low of 1.9% in Clark. Food assistance data by race/ethnicity can be seen in Table 30 in Appendix E: Additional Data Tables and Graphs of this report.

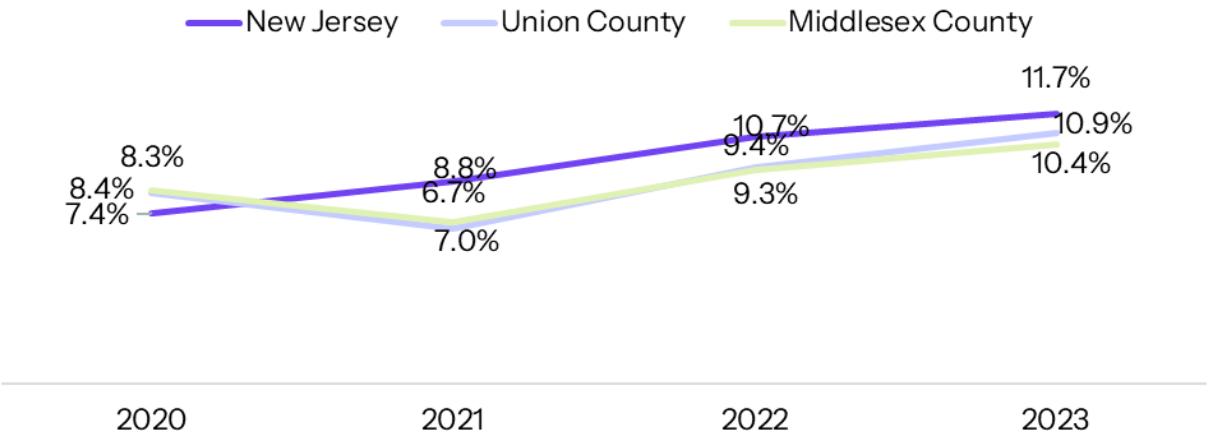
Figure 16. Households Receiving Food Stamps/SNAP, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

The percentage of the population that was food insecure has increased steadily between 2020 and 2023 in both Union and Middlesex counties and New Jersey overall (Figure 17). As of 2023, about 1 in ten residents are now considered to be food insecure.

Figure 17. Percent Food Insecure, by State and County, 2020-2023

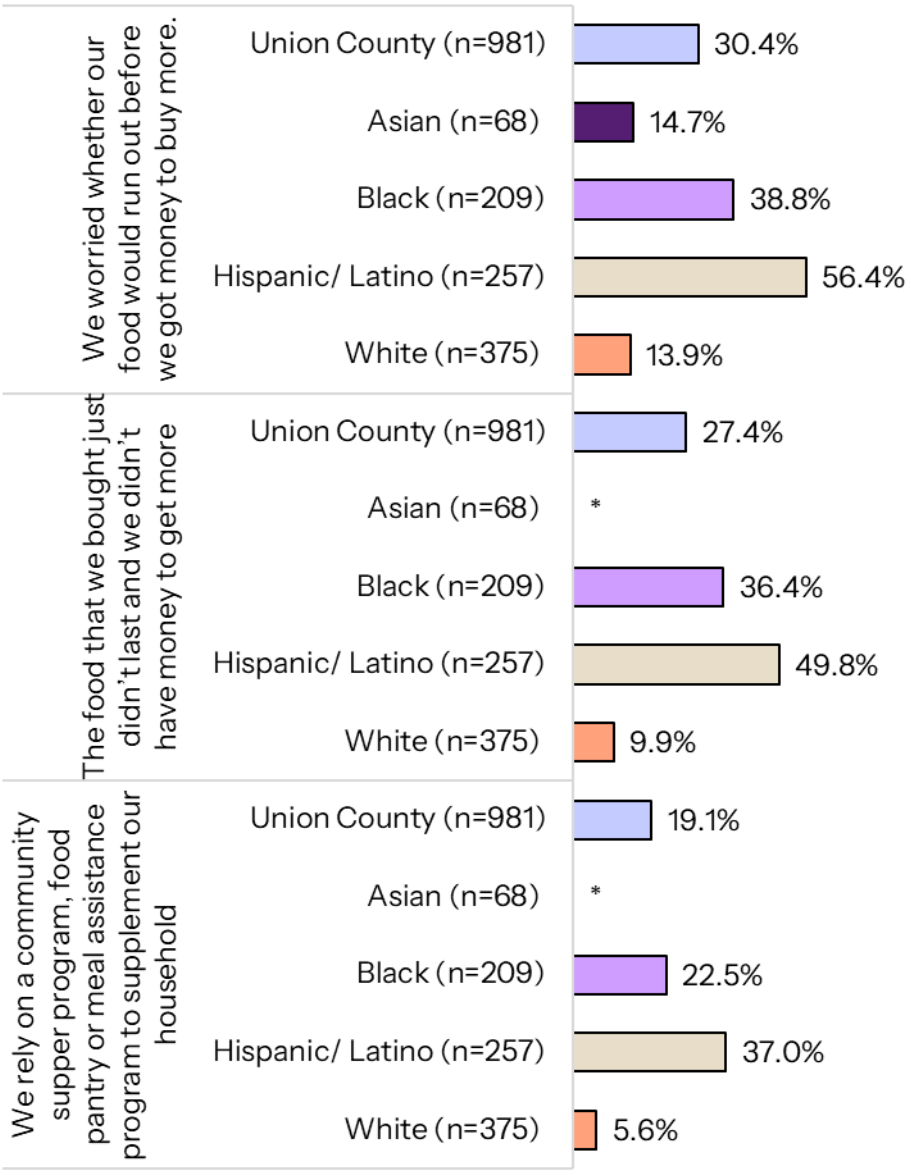


DATA SOURCE: Feeding America, Map the Meal Gap, 2020-2023

Community health survey data confirm that food security is an issue among respondents in Union County. About one-third (30.4%) of survey respondents reported that it was sometimes or often true that they worried their food would run out before they had money to buy more

(Figure 18). In addition, 19.1% of respondents reported that they relied on food assistance themselves. The situation was more dire for Latino survey respondents; 56.4% of them worried that their food would run out before they had more money to buy more and 37.0% of them relied on a food assistance program.

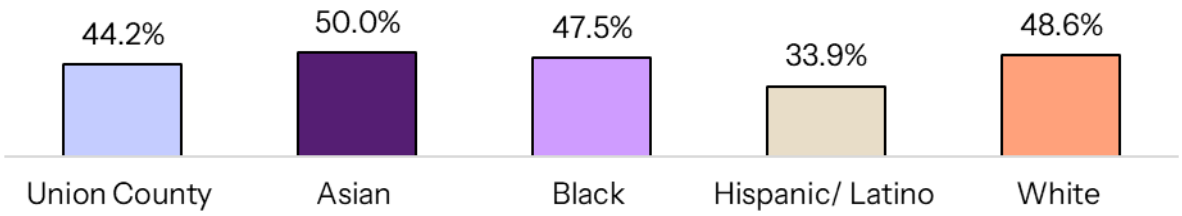
Figure 18. Household Food Situation over the Past 12 Months, Percent of Union County Survey Respondents Reporting Often or Sometimes True, by Race/Ethnicity, 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data were suppressed due to low numbers.

Many schoolchildren have school food for lunch. Schools represent an ideal opportunity to promote a healthy diet. Unfortunately, less than half of Union County survey respondents agreed that the schools in their community offered healthy food choices for children. This proportion was consistent across racial/ethnic groups (Figure 19).

Figure 19. Percent of Union County Survey Respondents Who Agreed/Strongly Agreed with the Statement "Schools in my community offer healthy food choices for children," by Race/Ethnicity, (n=686), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Food prices (36.1%) and lack of time (27.3%) were the top reasons given by respondents as barriers to maintaining a healthy diet (Table 8). The proportion of respondents indicating that the price of food kept them from a healthy diet was highest among Latino (50.0%) and Asian (40.0%) residents.

Table 8. Top 5 Reasons That Keep Respondents from Eating Foods That Are Part of a Healthy Diet among Union County Survey Respondents, by Race/Ethnicity, 2024

	Union County (n=904)	Asian (n=60)	Black (n=192)	Hispanic/ Latino (n=244)	White (n=339)
1	Nothing keeps me from eating healthy foods (41.5%)	Price of healthy foods / healthy foods cost too much money (40.0%)	Nothing keeps me from eating healthy foods (43.2%)	Price of healthy foods / healthy foods cost too much money (50.0%)	Nothing keeps me from eating healthy foods (49.0%)
2	Price of healthy foods / healthy foods cost too much money (36.1%)	Nothing keeps me from eating healthy foods (35.0%)	Price of healthy foods / healthy foods cost too much money (41.2%)	Lack of time to buy or prepare healthy meals (30.3%)	Lack of time to buy or prepare healthy meals (26.8%)
3	Lack of time to buy or prepare healthy meals (27.3%)	Lack of time to buy or prepare healthy meals (30.0%)	Lack of time to buy or prepare healthy meals (28.7%)	Nothing keeps me from eating healthy foods (27.1%)	Price of healthy foods / healthy foods cost too much money (22.4%)
4	Don't always know what foods are part of a healthy diet (11.6%)	*	Don't always know what foods are part of a healthy diet (12.5%)	Don't always know what foods are part of a healthy diet (18.4%)	Not in the mood for healthy foods (10.3%)
5	Don't like the taste or healthy foods don't fill me up (7.5%)	*	Don't know how to buy or prepare healthy foods (6.3%)	Don't know how to buy or prepare healthy foods (12.3%)	Don't like the taste or healthy foods don't fill me up (8.3%)

DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data were suppressed due to low numbers.

Nutrition and food insecurity was identified as a priority area by RWJUH Rahway and TRMC during the prior CHNA-SIP process 2022. To address this concern, over the last three years the facilities have engaged and implemented numerous strategies. For example, TRMC partnered with community-based organizations on food distribution programs providing 140 and 180 families with Thanksgiving baskets in 2024 and 2025, respectively. TRMC also partnered with Transitional Care Program to provide culturally appropriate nutritional education for families. RWJUH Rahway hosted and promoted monthly cooking classes focusing on foods among different cultural groups and targeted meals appropriate for top chronic disease states. RWJUH Rahway is a two-time recipient of the Merck grant for chronic disease education and provided diabetes and hypertension education sessions to the community in 2024 and 2025. More information and strategies and progress can be found in Appendix H.

Housing

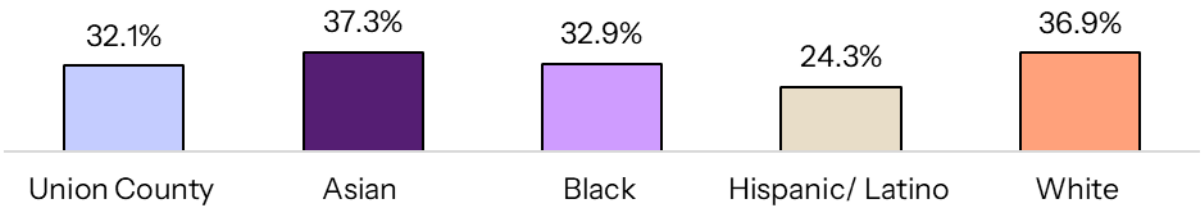
Housing Affordability

Safe and affordable housing is integral to life, health, and well-being. Housing was described as a substantial community challenge in focus groups and interviews. As is true across the nation, affordable housing in Union County is scarce. Participants reported that the housing issues cut across race and age. A community health worker described, *"another huge resource struggle that we have is housing which is the most difficult to help our patients with. There's an obvious housing crisis going on with a large lack of affordable housing in New Jersey. In last couple years we have seen an exponential increase in average rent so unfortunately, we have heard about displacement due to the increased rent."*

Participants described a perceived increase in the unhoused population and noted there are not enough shelters or housing available to meet the demand. A key informant interviewee explained, *"we do see a lot more homeless people and [there are] not enough shelters here in Union County. We in general have a lot of motels and hotels here, specifically, in Elizabeth, but a majority of the agencies that work with the homeless population are through a voucher system. So, it's very difficult to be able to place them somewhere, and as you know, the two main shelters that we have are the YMCA and the Salvation Army, and that's always at capacity with the homeless population."* Another interviewee explaining the lack of available housing-related resources described, *"even documented residents are not able to get assistance with housing, we are only halfway through the year and many of these organizations are completely out of funding. We try to put patients on lottery systems but even that is completely saturated. We had one unit available and one of our patients was 12,000th on that waiting list and lottery."*

Overall, under one-third (32.1%) of survey respondents in Union County agreed that there was sufficient affordable and safe housing in their community (Figure 20). This proportion was higher for Asian respondents (37.3%) and lower for Latino (24.3%) respondents.

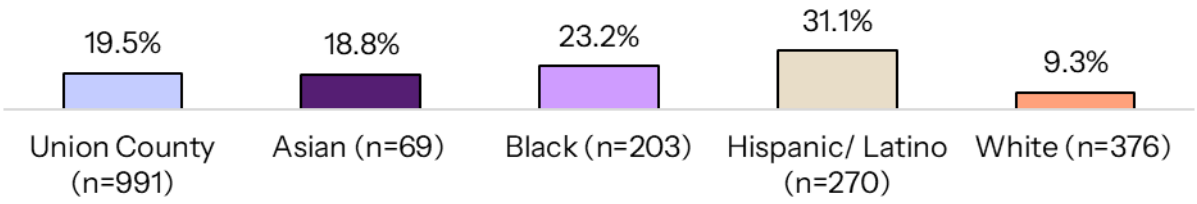
Figure 20. Percent of Union County Survey Respondents Who Agreed/Strongly Agreed with the Statement "There is enough housing that I can afford that is safe and well-kept in my community," by Race/Ethnicity, (n=735), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Echoing qualitative discussions described above, in Union County, 19.5% of survey respondents were concerned about their housing stability in the next two months (Figure 21). This concern was highest among Latino respondents (31.1%), followed by Black respondents (23.2%). In contrast, only 9.3% of White respondents shared this concern.

Figure 21. Percent of Union County Survey Respondents Reporting Concerns Regarding Their Housing Stability in the Next Two Months, by Race/Ethnicity, (n=991), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

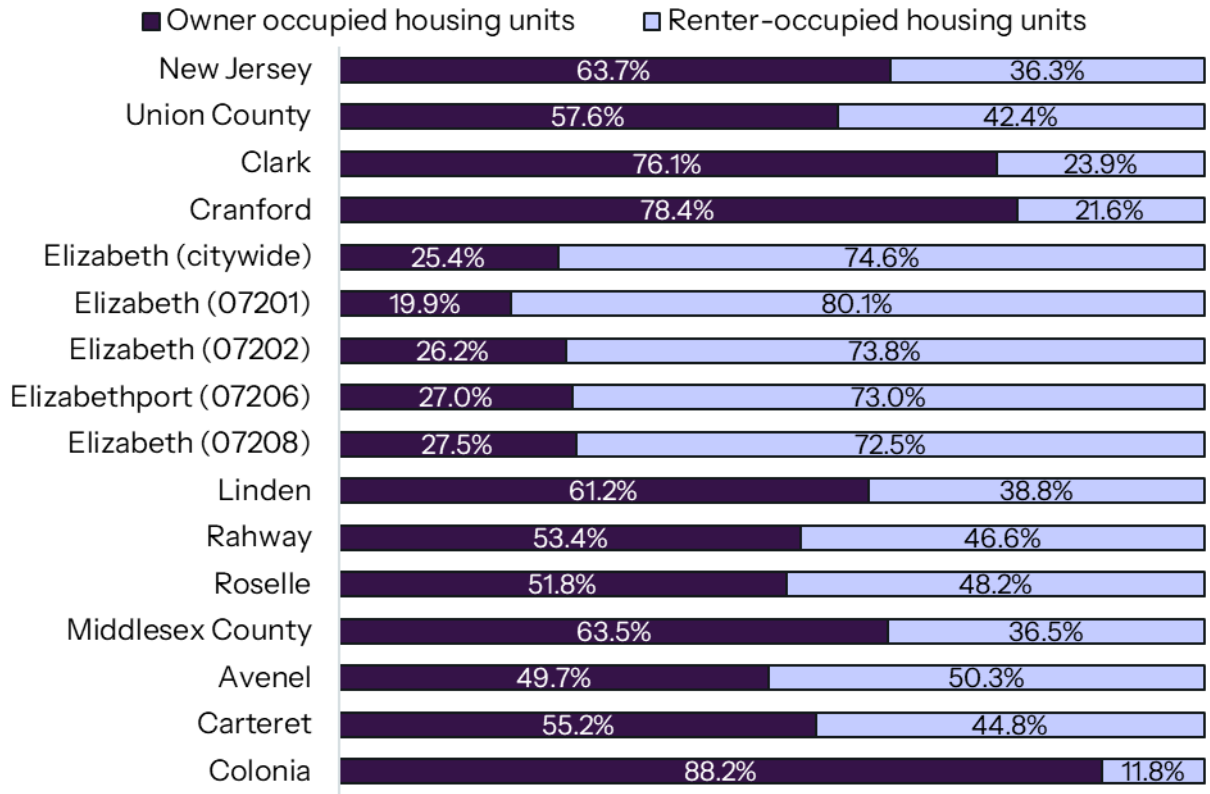
Housing Landscape

Low housing stock drives housing costs. Across Union and Middlesex Counties, the homeowner vacancy rates (4.5% and 3.5%, respectively) are lower than the state (7.9%). One town, Elizabeth (07201) had a vacancy rate that was above the state average (8.6%) (see Figure 98 in Appendix E: Additional Data Tables and Graphs).

Across New Jersey, about two-thirds of housing units are owner-occupied (63.7%), while 36.3% are renter-occupied. Both Union County (57.6% owner, 42.4% renter) and Middlesex County (63.5% owner, 36.5% renter) fall close to the state average (Figure 22). Within Union County there are notable disparities across municipalities. Both Clark (76.1%) and Cranford (78.4%) have high rates of homeownership, while Elizabeth has a much lower share, only 25.4% of housing units are owner-occupied city-wide, with rates as low as 19.9% in zip code 07201. Homeownership varied within Middlesex County as well. Colonia has a high rate of 88.2% owner-occupied units while Avenel and Carteret are more evenly split between owners and renters.

Despite the variation between owner/renter occupancy, nearly 95% of Union and Middlesex County households had an average of 1 occupant or less per room, indicating a low incidence of overcrowding (Table 32 in Appendix E: Additional Data Tables and Graphs).

Figure 22. Home Occupancy, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Monthly median housing costs for owner-occupied households with a mortgage ranged from a low of $2,462 in Avenel to a high of $3,679 in Cranford (Table 9). Monthly median housing costs for renter-occupied households ranged from a low of $1,364 in Elizabeth (07208) to a high of $2,116 in Cranford.

Table 9. Monthly Median Housing Costs, by State, County, and Town, 2019-2023

	Owner w/ Mortgage	Owner w/out Mortgage	Renter
New Jersey	$ 2,787	$ 1,205	$ 1,653
Union County	$ 3,119	$ 1,429	$ 1,664
Clark	$ 2,998	$ 1,396	$ 1,793
Cranford	$ 3,679	$ 1,500+	$ 2,116
Elizabeth (citywide)	$ 2,790	$ 1,349	$ 1,463
Elizabeth (07201)	$ 3,170	$ 1,080	$ 1,476
Elizabeth (07202)	$ 2,572	$ 1,359	$ 1,508
Elizabethport (07206)	$ 2,908	$ 1,208	$ 1,543
Elizabeth (07208)	$ 2,837	$ 1,500+	$ 1,364
Linden	$ 2,738	$ 1,262	$ 1,677
Rahway	$ 2,689	$ 1,293	$ 1,764
Roselle	$ 2,555	$ 1,318	$ 1,499
Middlesex County	$ 2,837	$ 1,208	$ 1,810
Avenel	$ 2,462	$ 1,033	$ 1,839
Carteret	$ 2,475	$ 936	$ 2,012
Colonia	$ 2,966	$ 1,293	$ 1,964

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023
NOTE: '$1500+' indicates that the median falls in the highest interval of the open-ended distribution in their respective categories.

Consistent with themes shared in focus groups and interviews, data show that Union and Middlesex Counties lack sufficient affordable housing stock. The average percentage of income spent on housing costs is an important measure of an area's availability of affordable housing. In Union County, in 2019-2023, 35.1% of owner-occupied households with a mortgage and 50.6% of renter-occupied households reported spending 30% or more of their income on housing costs (Table 10). Similarly in Middlesex County, the percentages are 32.8% of owners with a mortgage and 46.4% of renters. Across municipalities, renters generally experience a higher housing cost burden than homeowners, although the percentages were more similar in Elizabeth where over half of owners (53.6%) and renters (54.3%) are cost burdened.

Table 10. Households whose Housing Costs are 30%+ of Household Income, by State, County, and Town, 2019-2023

	Owner w/ Mortgage	Owner w/out Mortgage	Renter
New Jersey	32.4%	22.0%	50.8%
Union County	35.1%	23.0%	50.6%
Clark	35.4%	20.8%	38.1%
Cranford	27.1%	27.9%	52.6%
Elizabeth (citywide)	53.6%	24.3%	54.3%
Elizabeth (07201)	65.0%	21.8%	56.4%
Elizabeth (07202)	53.7%	26.1%	47.6%
Elizabethport (07206)	55.1%	24.9%	61.4%
Elizabeth (07208)	46.6%	23.1%	55.3%
Linden	41.2%	26.9%	50.2%
Rahway	41.0%	25.7%	51.9%
Roselle	34.5%	23.0%	50.9%
Middlesex County	32.8%	21.5%	46.4%
Avenel	32.9%	28.8%	40.3%
Carteret	33.9%	25.2%	40.9%
Colonia	32.6%	35.0%	53.9%

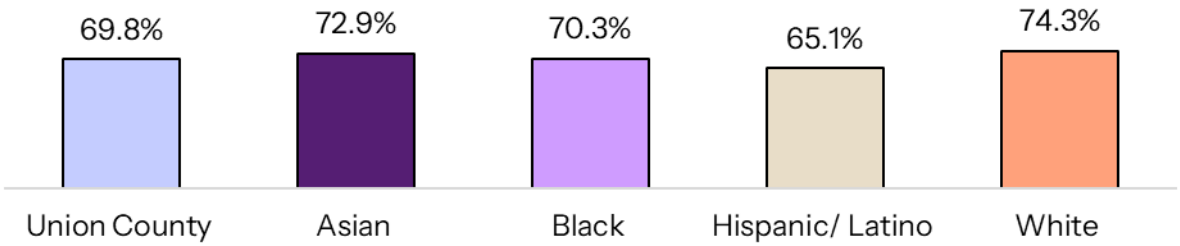
DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Green Space and Built Environment

Neighborhood characteristics, including the availability of green space and the quality of the built environment, influence the public's health, particularly in relation to chronic diseases. Urban environments and physical spaces can expose people to toxins or pollutants, increasing the incidence of health conditions such as cancer, lead poisoning, and asthma. Physical space can also influence lifestyles. Playgrounds, green spaces, and trails, as well as bike lanes, and safe sidewalks and crosswalks, all encourage physical activity and social interaction, which can positively affect physical and mental health. According to the RWJF County Rankings, all Union County residents (100%) and most Middlesex County residents (97%) and had adequate access to a location for physical activity *(*Figure 94 in Appendix E: Additional Tables and Graphs*).*

Community survey data from 2024 indicate that 69.8% of Union County respondents agreed or completely agreed with the statement, "My community has safe outdoor places to walk and play" (Figure 23). Results by race/ethnicity indicated that White (74.3%) and Asian (72.9%) respondents were slightly more likely than Hispanic/Latino (65.1%) respondents to agree or strongly agree with that statement.

Figure 23. Percent of Union County Survey Respondents Who Agreed/Strongly Agreed with the Statement "My community has safe outdoor places to walk and play," by Race/Ethnicity, (n=686), 2024



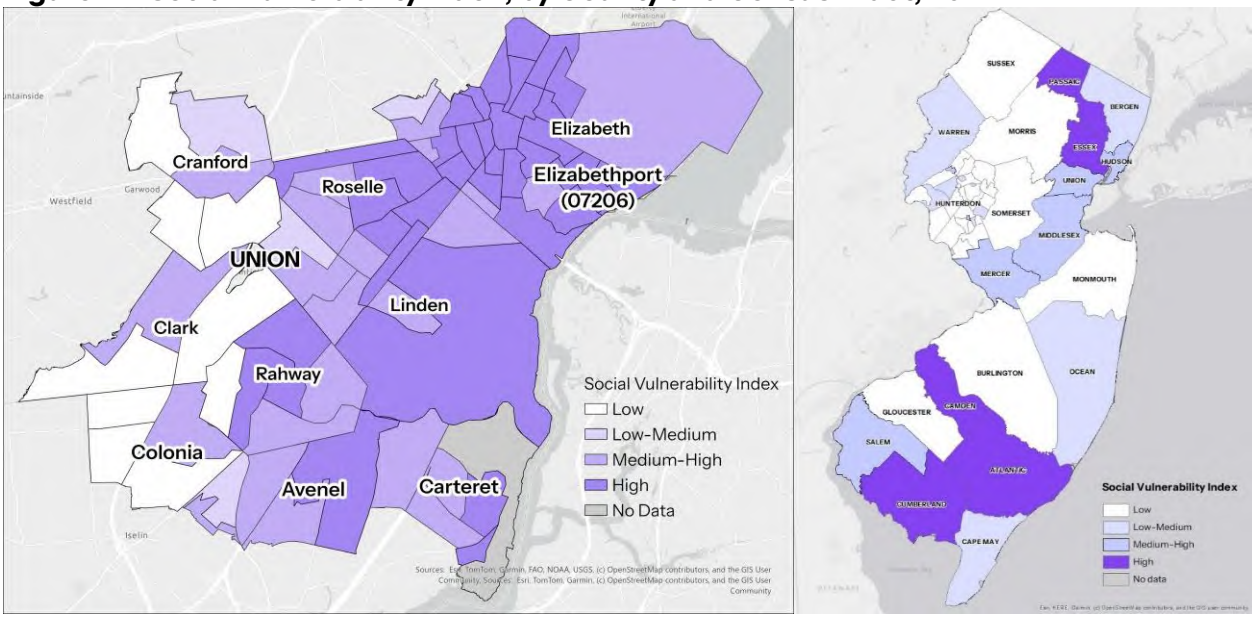
DATA SOURCE: Community Health Needs Assessment Survey, 2024

The CDC's Social Vulnerability Index (SVI) is a combined measure of factors (such as socioeconomic status, household composition, housing, and transportation) that may adversely affect residents' health and well-being. The SVI score represents the proportion of counties or census tracts that are equal to or lower than the area of interest in terms of social vulnerability. The higher the SVI, the more social vulnerability in that area, meaning that that community may need more resources to thrive.

Union County's SVI in 2022 was 0.8, which means that 80% of counties in NJ were less vulnerable than Union County and 20% were more vulnerable. Middlesex County's SVII in 2022 was 0.6 which means that 60% of counties in NJ were less vulnerable and 40% were more vulnerable (see

Table 23 in Appendix E: Additional Data Tables and Graphs). Figure 24 provides more detailed insight into the social vulnerability by census tract within Union County. Data highlights many areas of high social vulnerability within the county (SVI ≥ 0.9), including census tracts within Elizabeth, Lindon, Roselle, Rahway, Avenel, and Carteret.

Figure 24. Social Vulnerability Index, by County and Census Tract, 2022



DATA SOURCE: CDC, ATSDR's Geospatial Research, Analysis, & Services Program (GRASP), 2022
NOTE: Index categories are defined in the following way: Low 0-0.25; Low-medium 0.2501-0.5; Medium-high 0.5001-0.75; High 0.7501-1.0.

Transportation and Walkability

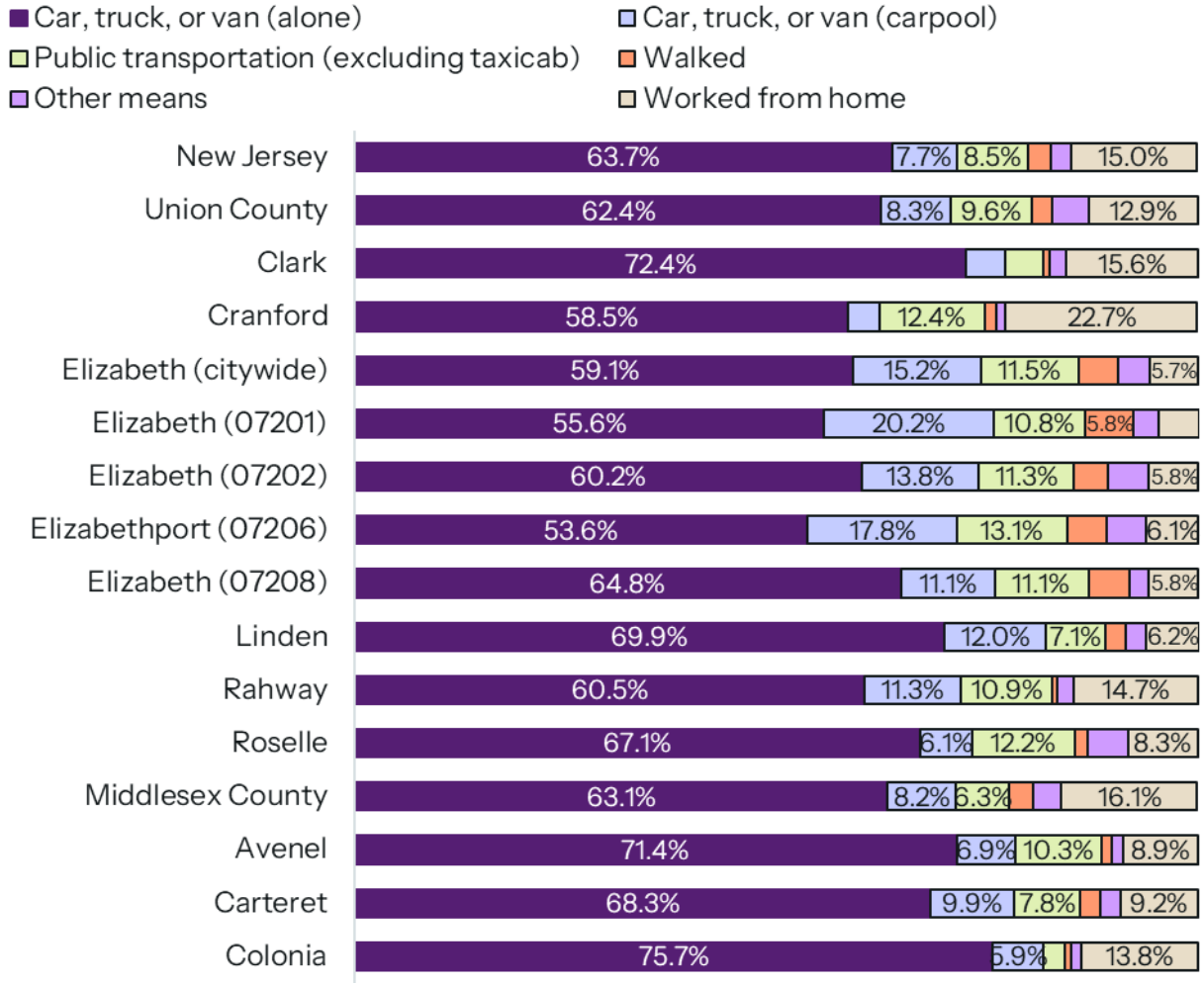
Interviewees and focus group participants shared varied perspectives on transportation in Union County. Participants indicated that some areas, including neighborhoods in Elizabeth, had public transportation available. However, public transportation was limited in its reach and hours of operation. A key informant interviewee explained, *"it's typical of most cities but the public transport is as reliable as it is. It's good but there's not a lot of cross-town transportation. Theres transportation to the port and back, to the mall and back, and then it spreads to suburbs around the city."*

Focus group members named cost and availability of transportation as barriers to accessing basic needs, such as health care and food, for those without vehicles. A health care provider noted that *"transportation, even though it's available for some individuals, [for others] even going across town is a barrier. So, I think transportation has always been one of the top issues for care."*

Consistent with qualitative data, the Walkability Index map showed pockets of walkable areas throughout Union County, primarily around the municipal centers. However, there are also extensive areas where walkability is rated as below average (See Figure 100 in Appendix E: Additional Tables and Graphs).

Quantitative data showed that most Union County residents commuted to work alone by car, truck, or van (62.4%), and fewer than 10% used public transportation (Figure 25). Findings were similar for Middlesex County. Some differences were observed across municipalities of both counties, specifically Clark (72.4%) and Colonia (75.7%) had the highest proportions of commuters who relied on private transportation while Elizabeth (07201) (20.2%) had the highest proportion of commuters who carpooled and Cranford (22.7%) had the highest proportion of residents who worked from home.

Figure 25. Means of Transportation to Work for Workers Aged 16+, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023
NOTE: Data labels under 5.0% are not shown.

As mentioned above, residents without a vehicle faced a major barrier to meeting their transportation and other basic needs. Having access to a private vehicle was not equally distributed across county residents. In Union County, 20.4% of renter-occupied households and 3.4% of owner-occupied households did not have access to a personal vehicle in 2019-2023

(Table 11). In Middlesex County, 16.2% of renter-occupied households and 3.3% of owner-occupied households lacked access to a vehicle. These percentages were comparable to those of New Jersey as a whole. Lack of vehicle access among homeowners was highest in Elizabeth (07202) (7.1%) and among renters was highest in Elizabethport (07206) (32.3%).

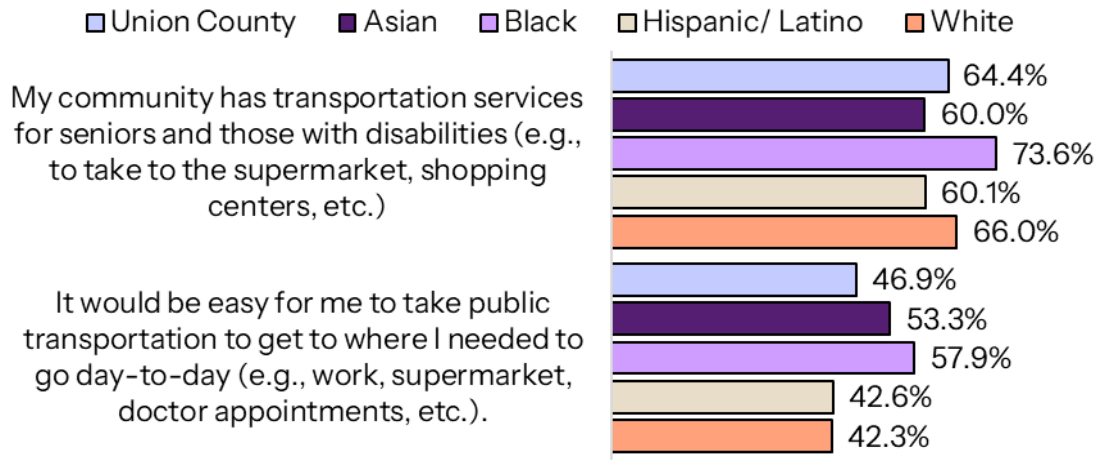
Table 11. Households (Renter vs. Owner-Occupied) Without Access to a Vehicle, by State, County, and Town, 2019-2023

	Owner occupied	Renter occupied
New Jersey	3.7%	24.6%
Union County	3.4%	20.4%
Clark	1.8%	7.9%
Cranford	3.0%	18.1%
Elizabeth (citywide)	5.9%	27.2%
Elizabeth (07201)	5.8%	29.6%
Elizabeth (07202)	7.1%	24.9%
Elizabethport (07206)	6.2%	32.3%
Elizabeth (07208)	4.4%	24.2%
Linden	5.4%	18.5%
Rahway	4.5%	16.3%
Roselle	2.2%	21.0%
Middlesex County	3.3%	16.2%
Avenel	1.2%	6.5%
Carteret	6.6%	9.9%
Colonia	2.0%	2.6%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

A majority of Union County respondents believed that their community provided transportation services for seniors and those with disabilities (64.4%), with the highest agreement among Black respondents (73.6%) (Figure 26). However, fewer respondents agreed that public transportation would be easy to use for daily needs (46.9%), although Black (57.9%) and Asian respondents (53.3%) agreed with this statement at a higher rate, than other groups.

Figure 26. Percent of Union County Survey Respondents Who Agreed/Strongly Agreed with the Statements Related to Transportation Availability, by Race/Ethnicity, (n=686), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

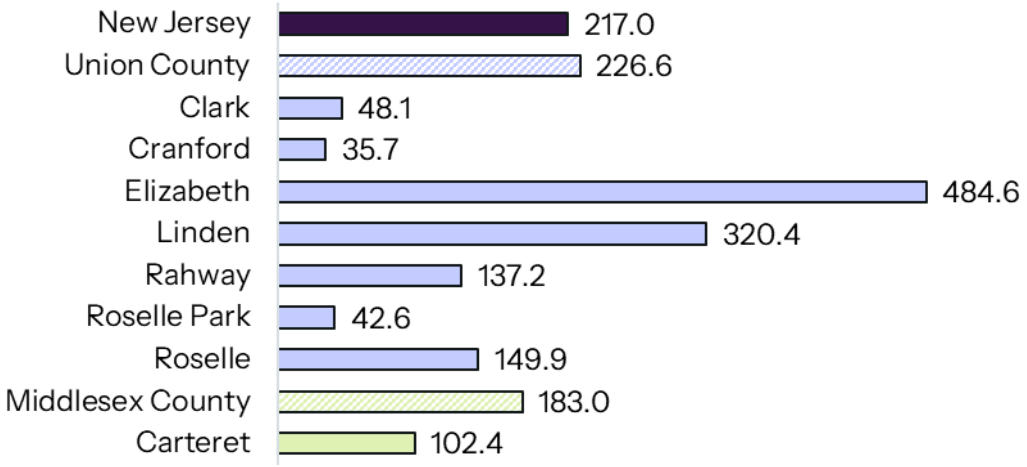
Violence Prevention and Safety

A few focus group and interview participants identified a perceived uptick in domestic violence in Union County. One participant described, *"I'm coming across a lot of females who have some type of domestic violence in their households."* Another participant supported the perceived uptick and explained that *"domestic violence and human trafficking continue to be areas we focus on."*

A few focus group participants also indicated an increase in workplace violence, particularly involving healthcare workers. A participant described, *"we are seeing increasing levels of workplace violence and assault on healthcare workers"* the participant further explained that *"fortunately most of our workplace violence is behavioral or conflict resolution and doesn't involve outright threats but escalation of argument between co-workers, patients, etc."*

Violence and trauma are important public health issues affecting physical and mental health. People can be exposed to violence in many ways: they may be victims and suffer from premature death or injuries, or witness or hear about crime and violence in their community. Data from the Uniform Crime Reporting Unit in the State of New Jersey showed that rates of violent crime (i.e., murder, rape, aggravated assault) in 2022 varied widely across municipalities in Union County (Figure 27). At 484.6 incidents per 100,000 residents, Elizabeth had a rate more than double that of the county (226.6 per 100,000 residents) and the state (217.0 per 100,000 residents).

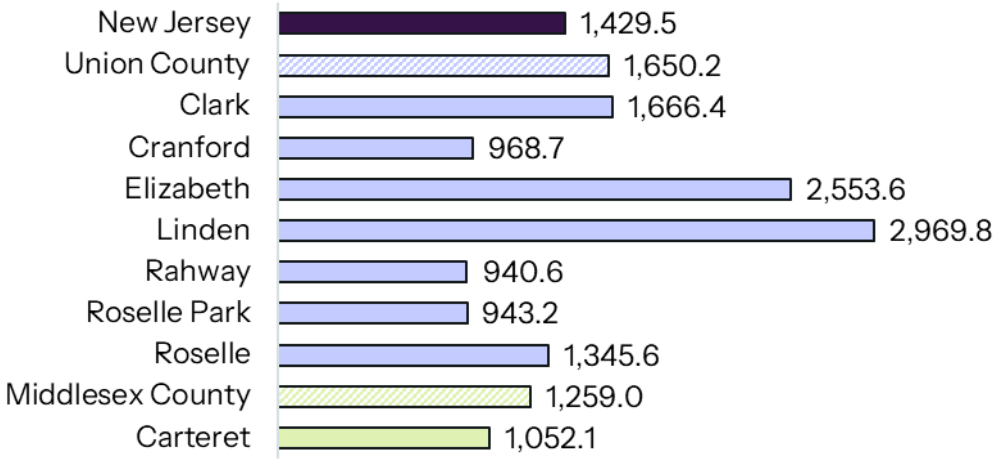
Figure 27. Violent Crime Rate per 100,000 Population, by State, County, and Town, 2022



DATA SOURCE: NJ Department of Law & Public Safety, Office of the Attorney General, Uniform Crime Reporting, 2024

Property crime (i.e., burglary, larceny, and auto theft) was much more common than violent crime in all areas (Figure 28). Rates were notably higher in Linden (2,969.8 per 100,000 residents) and Elizabeth (2,553.6 per 100,000 residents) compared to the state average of 1,429.5 per 100,000 residents).

Figure 28. Property Crime Rate per 100,000 Population, by State, County and Town, 2022

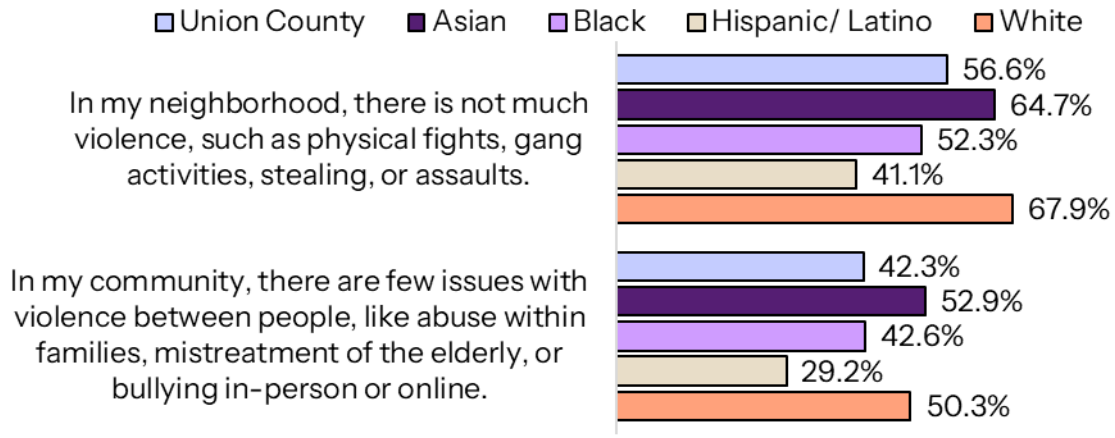


DATA SOURCE: NJ Department of Law & Public Safety, Office of the Attorney General, Uniform Crime Reporting, 2024

More than half of Union County survey respondents (56.6%) agreed that there was not much violence in their neighborhood, such as physical fights, gang activities, stealing, or assaults. However, perceptions varied by race, with proportionately more Asian (64.7%) and White (67.9%) respondents agreeing, compared to 52.3% of Black and only 41.1% of Hispanic/Latino respondents (Figure 29).

Fewer than half of survey respondents agreed that there were few issues with violence between people, like abuse within families, mistreatment of the elderly, or bullying in-person or online in their community (42.3%). Findings by race mirrored those of the prior question with agreement highest among Asian (52.9%) respondents and lowest among Black (42.6%) and Hispanic/Latino (29.2%) respondents. Notably, bullying and community violence were among the top community concerns for children and youth, endorsed by 30.6% and 15.0% of respondents, respectively (See Figure 33 below).

Figure 29.Percent of Union County Survey Respondents Who Agreed/Strongly Agreed with the Statements Related to Community Safety, by Race/Ethnicity, (n=735), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Systemic Racism and Discrimination

Perceptions related to discrimination and racism varied throughout qualitative discussions. Several interviewees and focus group participants recognized discrimination as a community issue. A focus group participant sharing a personal experience of discrimination in the healthcare setting described, *"here I am, a physician, and I have been discriminated against in the healthcare system because when I present to the hospital, I present as an African-American woman and I have been treated absolutely horribly. Right? And so, if I can be treated that way, not that I'm better than anyone, but I know how to navigate, I know how to talk, I know how to explain myself and I was dismissed. I was talked to, like, why are you even here, type of thing."*

Another focus group participant described their experience witnessing and enduring discrimination stated, *"we are not accepted. As much as we play the game, we're still not accepted in many institutions and hospitals. You have an African-American family come in, a black person coming in already they get the looks. You have a Spanish-Latino family, they're from Mexico, Central America, and they just came from work and they're dirty, but they need assistance, and they still get the look."*

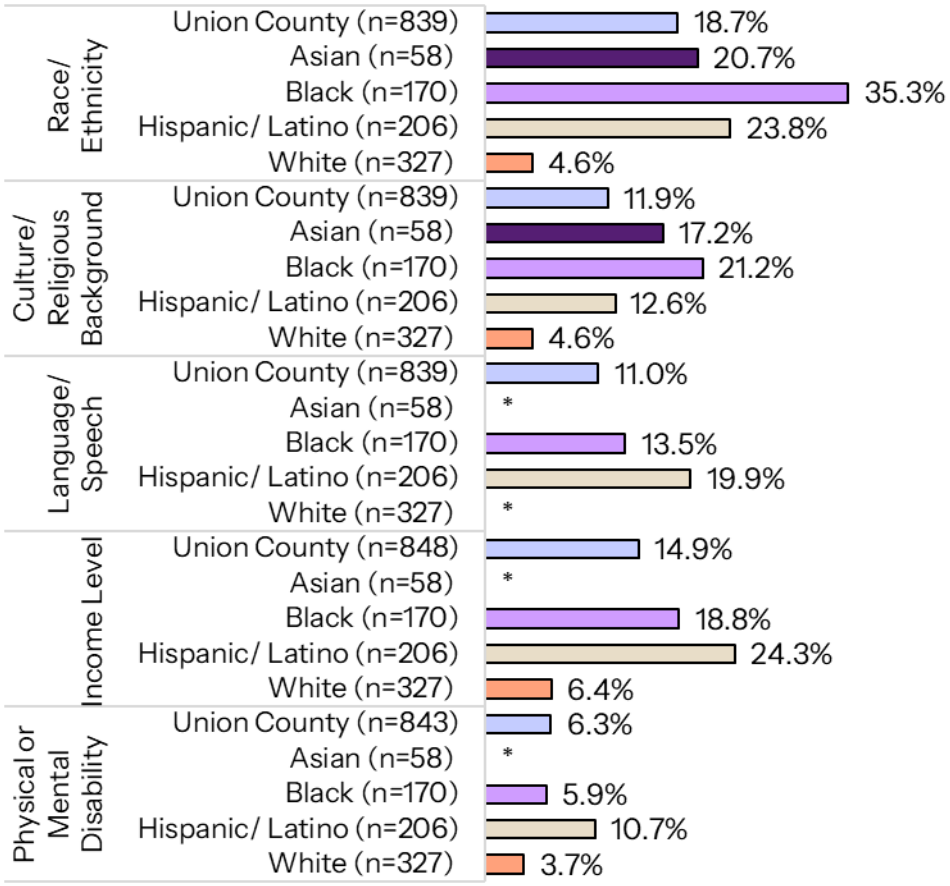
In addition to discrimination experienced based on race or ethnicity some focus group participants also described discrimination unhoused populations face, particularly when trying to access healthcare. A healthcare provider described how past negative experiences with healthcare providers and institutions can leave people reluctant to seek care when they need it.

They explained, *"most individuals on the street actually do not want to use the hospital system because of being ostracized in the past, getting inadequate care, being judged or looked down upon for whatever reason."*

Data from the 2024 community survey provide additional insight into experiences of discrimination when receiving healthcare. More than one-third of Black (35.3%) respondents in Union County reported experiencing discrimination due to their race/ethnicity when receiving medical care, as did 20.7% of Asian and 23.8% of Hispanic/Latino respondents (Figure 30).

Additionally, Hispanic/Latino (12.6%), Asian (17.2%), and Black (21.2%) survey respondents also reported feeling discriminated against when receiving medical care based on their culture and religious background. And nearly 1 in 5 Asian respondents (19.9%) also reported feeling discriminated against due to their language/speech.

Figure 30. Percent of Union County Survey Respondents Reporting Experiences of Interpersonal Discrimination while Receiving Medical Care, by Sociodemographic Characteristic, by Race/Ethnicity, 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data were suppressed due to low numbers.

Other forms of discrimination while receiving medical care also emerged from the survey. 22.6% of LGB respondents experienced discrimination due to their sexual orientation compared to 3.3% of heterosexual respondents (Figure 31).

Figure 31. Percent of Union County Survey Respondents Reporting Experiences of Interpersonal Discrimination while Receiving Medical Care due to Sexual Orientation, by Sexual Orientation, (n=844), 2024

DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: The LGB category includes gay, lesbian, bisexual, pansexual, queer, or asexual.

Community Health Issues

Understanding community health issues is a critical step in the assessment process. The disparities underscored by these issues mirror the historical patterns of systemic, economic, and racial inequities experienced for generations across the United States.

Community Perceptions of Health

Understanding residents' perceptions of health helps provide insights into lived experiences, including key health concerns, and facilitators and barriers to addressing health conditions. Focus group and interview participants were asked about top concerns in their communities. Participants identified social and economic issues such as financial and food insecurity, housing, and transportation – and how these were associated with chronic conditions that affect many members of the community, including high blood pressure and diabetes. They also discussed the challenges of accessing care and the difficulties of managing chronic conditions, the increase in mental health concerns, particularly among youth and immigrant communities. Participants discussed the need for more sustainable funding for social and health services in the context of growing demand.

Community survey respondents were presented with a list of issues and could write in others and were asked to mark the top three health concerns or issues in their community overall. Respondents in Union County ranked diabetes (37.8%), followed by cancer (31.6%), heart disease (31.4%), overweight/obesity (26.5%), and mental health issues (24.8%) as the top five health issues in their communities (Figure 32). For community survey respondents who selected "other" top health concerns in your community, write-in responses included reference to specific diseases (e.g. tick-borne illnesses, long-COVID), access to specialty services (e.g. dental care, services for disabled and older adults, LGBTQ healthcare), environmental exposures (e.g., lead and asbestos removal, air and water quality), and climate change.

Figure 32. Top Health Concerns in the Community Overall, Union County Survey Respondents, (n=1201), 2024

DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Respondents were asked to select the top three health issues or concerns in their community. Results are aggregated for all selections from all respondents.

There were differences in top health issues by race/ethnicity (Table 12). Diabetes was the top concern among Asian, Black, and Latino survey respondents. Cancer was identified as the top concern among White respondents. Heart disease was ranked as the second top concern among Asian and White respondents, with cancer and overweight/obesity ranking as the second top concerns for Black and Latino respondents, respectively.

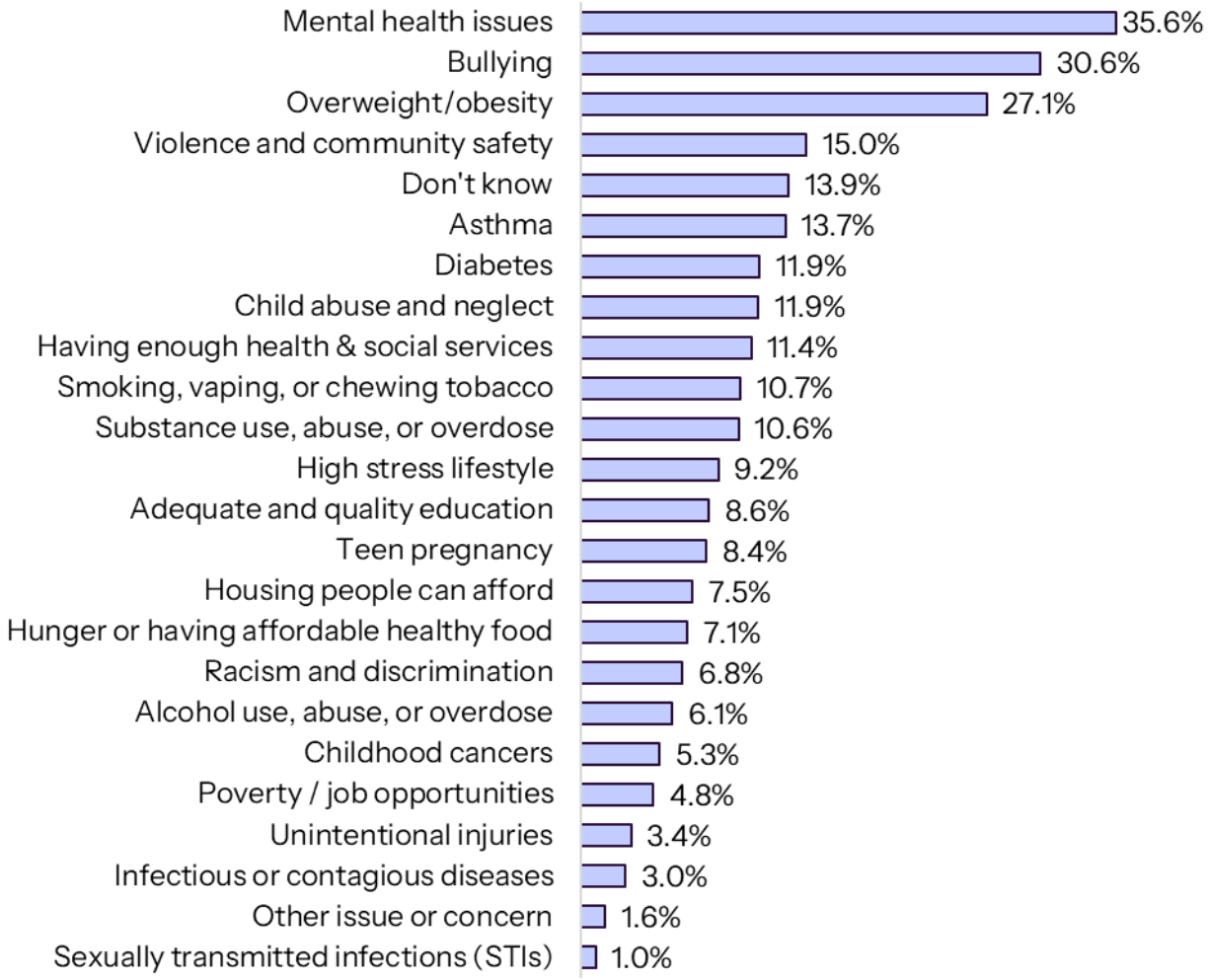
Table 12. Top Health Concerns in the Community Overall, Union County Survey Respondents, by Race/Ethnicity, (n=1201), 2024

	Union County (n=1201)	Asian (n=77)	Black (n=260)	Hispanic/ Latino (n=329)	White (n=450)
1	Diabetes (37.8%)	Diabetes (52.0%)	Diabetes (48.5%)	Diabetes (38.0%)	Cancer (38.9%)
2	Cancer (31.6%)	Heart disease (39.0%)	Cancer (33.5%)	Overweight/ obesity (27.7%)	Heart disease (35.6%)
3	Heart disease (31.4%)	Overweight/ obesity (31.2%)	Heart disease (29.2%)	Mental health issues (24.9%)	Overweight/obesity (29.3%)
4	Overweight/ obesity (26.5%)	Mental health issues (22.1%)	Mental health issues (22.3%)	Cancer (23.1%)	Diabetes (28.4%)
5	Mental health issues (24.8%)	Cancer (20.8%)	Overweight/ obesity (21.2%)	Heart disease (22.8%)	Mental health issues (26.9%)

DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Respondents were asked to select the top three health issues or concerns in their community. Results are aggregated for all selections from all respondents.

Survey respondents also identified top health concerns regarding youth and children in the community. Respondents ranked mental health issues (35.6%), followed by bullying (30.6%), overweight/obesity (27.1%), violence and community safety (15.0%), and asthma (13.7%) as the top five health issues in their communities (Figure 33) Important to note is that 13.9% of respondents answered Don't know, demonstrating a potential gap in knowledge of lived experience between adults and youth within Union County. For community survey respondents who selected "other" top health concerns for youth and children, write-in responses included concerns about social media use and extensive screen time, a lack of stable adult support and male role models for youth, opportunities and spaces to support positive youth development, support for neurodivergent children, affordable childcare, exposure to toxins and pollution, and climate change.

Figure 33. Top Health Concerns in the Community for Children and Youth, Union County Survey Respondents, (n=1097), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Respondents were asked to select the top three health issues or concerns in their community. Results are aggregated for all selections from all respondents.

As with other issues, there were notable differences by race/ethnicity (Table 13). Mental health concerns were identified as the top concern for children and youth among Black, Latino, and White respondents. Instead, Asian respondents identified bullying as the top concern for children and youth. Bullying was ranked as the second top concern for children and youth among Black, Latino, and White respondents, with Asian respondents identifying overweight/obesity as the second top concerns for children and youth.

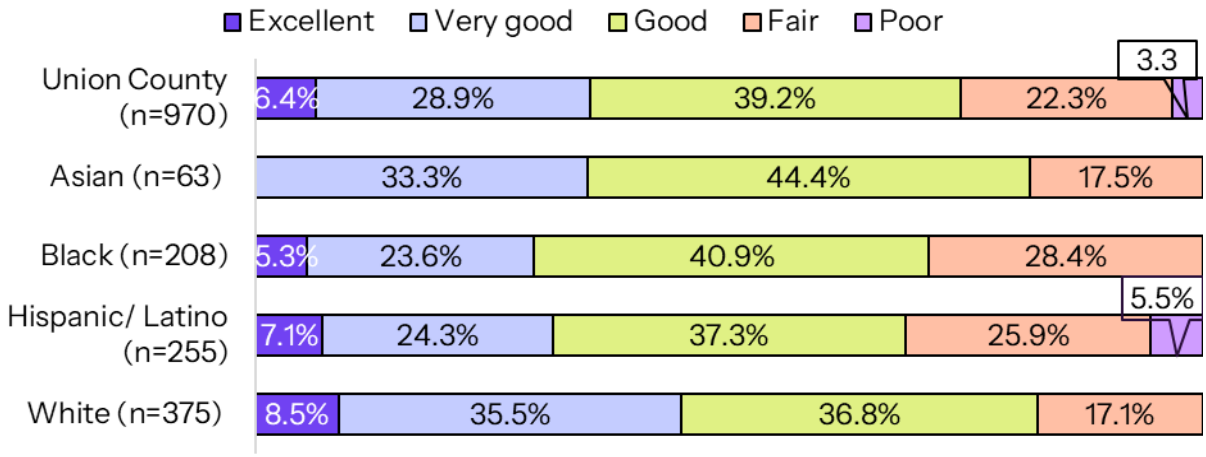
Table 13. Top Health Concerns in the Community for Children and Youth, Union County Survey Respondents, by Race/Ethnicity, (n=1097), 2024

	Union County (n=1097)	Asian (n=65)	Black (n=233)	Hispanic/ Latino (n=294)	White (n=429)
1	Mental health issues (35.6%)	Bullying (46.2%)	Mental health issues (32.6%)	Mental health issues (33.0%)	Mental health issues (43.4%)
2	Bullying (30.6%)	Overweight/ obesity (38.5%)	Bullying (26.2%)	Bullying (30.6%)	Bullying (35.2%)
3	Overweight/ obesity (27.1%)	Mental health issues (29.2%)	Overweight/ obesity (20.2%)	Overweight/ obesity (29.6%)	Overweight/ obesity (28.9%)
4	Violence and community safety (15.0%)	Asthma (16.9%)	Violence and community safety (17.2%)	Asthma (17.7%)	Having enough health & social services (15.4%)
5	Don't know (13.9%)	Smoking, vaping, or chewing tobacco (15.4%)	Don't know (16.3%)	Child abuse and neglect (16.7%)	Substance use, abuse, or overdose (15.2%) Violence and community safety (15.2%)

DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Respondents were asked to select their top three health issues or concerns in their community. Results are aggregated for all selections from all respondents.

Most survey respondents perceived their health to be good (39.2%) or very good (28.9%) (Figure 34). Proportionally more White respondents considered themselves to be in excellent and very good (44.0%) than those from other races/ethnicities.

Figure 34. Self-Assessed Overall Health Status, Union County Survey Respondents, by Race/Ethnicity, (n=970), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Some racial categories do not add to 100% because % for poor and excellent were suppressed due to n<10.

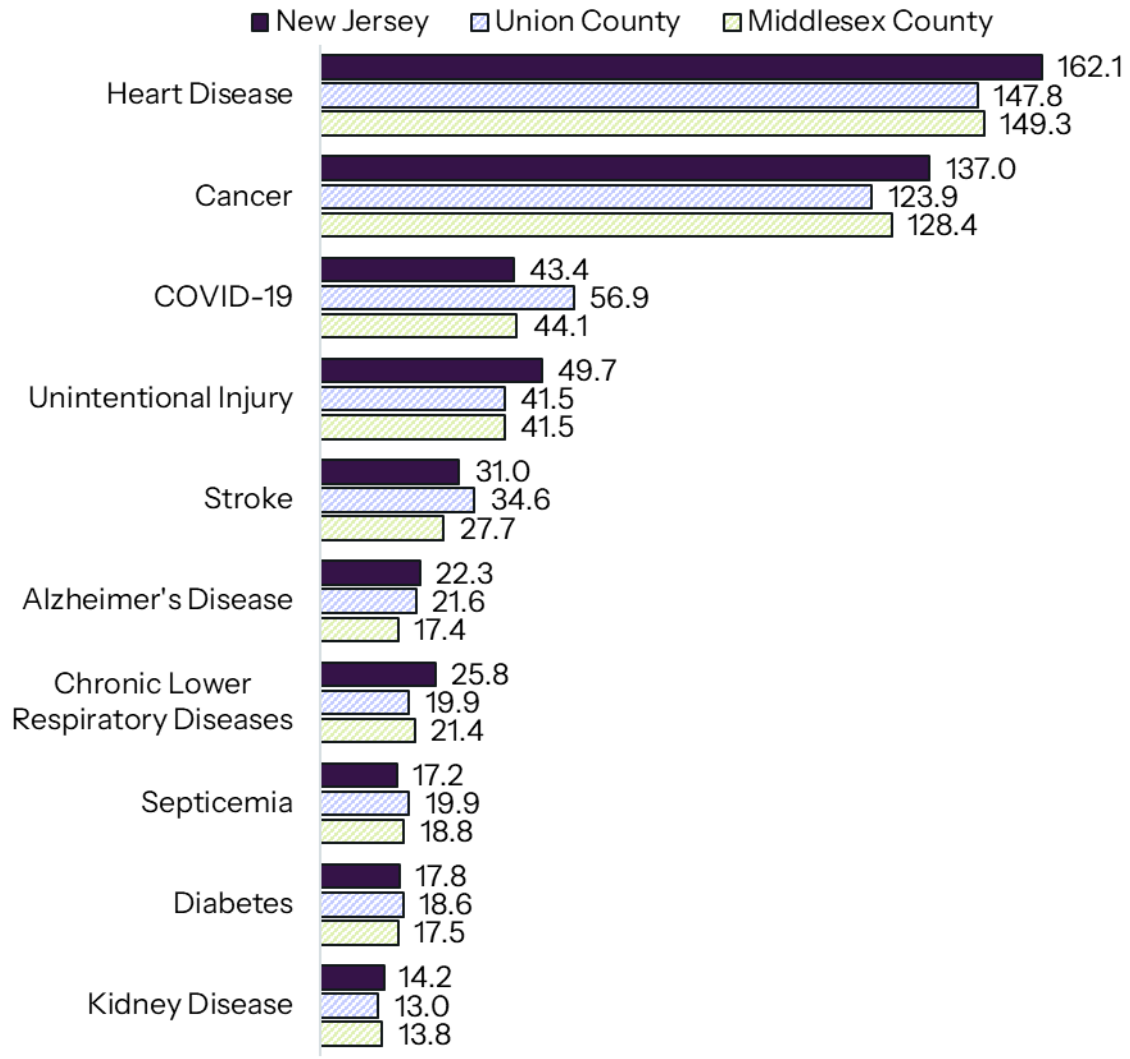
Leading Causes of Death and Premature Mortality

Mortality rates help to measure the burden and impact of disease on a population, while premature mortality data (deaths before the age of 75 years) provide a picture of preventable deaths and point to areas where additional health and public health interventions may be warranted.

The most current mortality data from New Jersey's surveillance systems are available for 2021, the second year of the COVID-19 pandemic. Figure 35 shows the age-adjusted mortality rate per 100,000 residents for the top 10 causes of death by state and county in 2021. The leading cause of death in both Union and Middlesex County in 2021 was heart disease (147.8 and 149.3 per 100,000, respectively), followed by cancer (123.9 and 128.4 per 100,000, respectively), and COVID-19 (56.9 and 44.1 per 100,000, respectively). Of note, the mortality rate for unintentional injuries was lower in both Union and Middlesex County than in the state overall. Unintentional injuries can stem from many different types of events and can include motor vehicle crashes and falls to name a few. In recent years, drug overdose has been a driver of unintentional injuries in the state.[31] More data on injury deaths and hospitalizations as well as life expectancy can be found in Appendix E: Additional Data Tables and Graphs.

[31] Healthy NJ 2020, https://www.nj.gov/health/chs/hnj2020/topics/injury-violence-prevention.shtml#ref

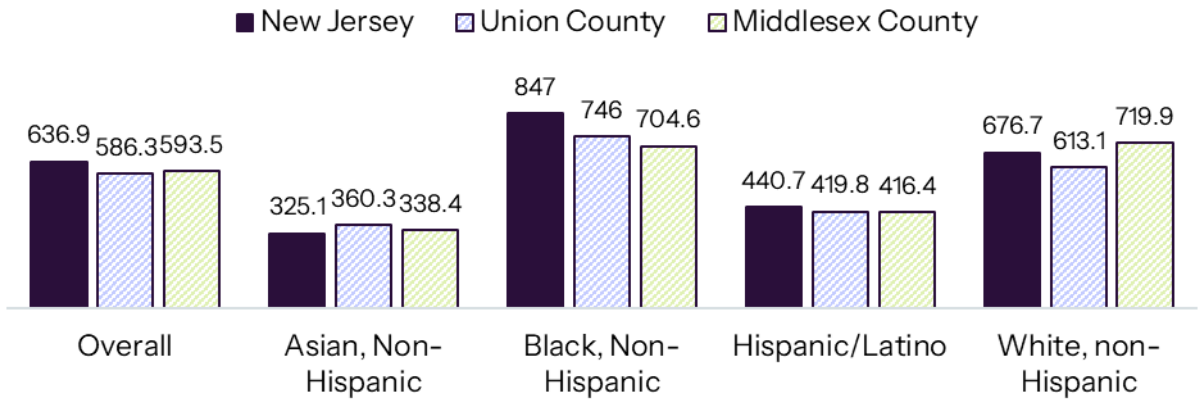
Figure 35. Top 10 Age-Adjusted Mortality Rates per 100,000, by State and County, 2017-2021



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2023

Figure 36 presents the overall age-adjusted mortality rate per 100,000 residents in 2023. Black residents had the highest age-adjusted mortality rate in both Union and Middlesex County compared to other races/ethnicities, with 746 and 704.6 per 100,000 residents, respectively, compared to the county averages of 586.3 and 593.5 per 100,000 residents, respectively.

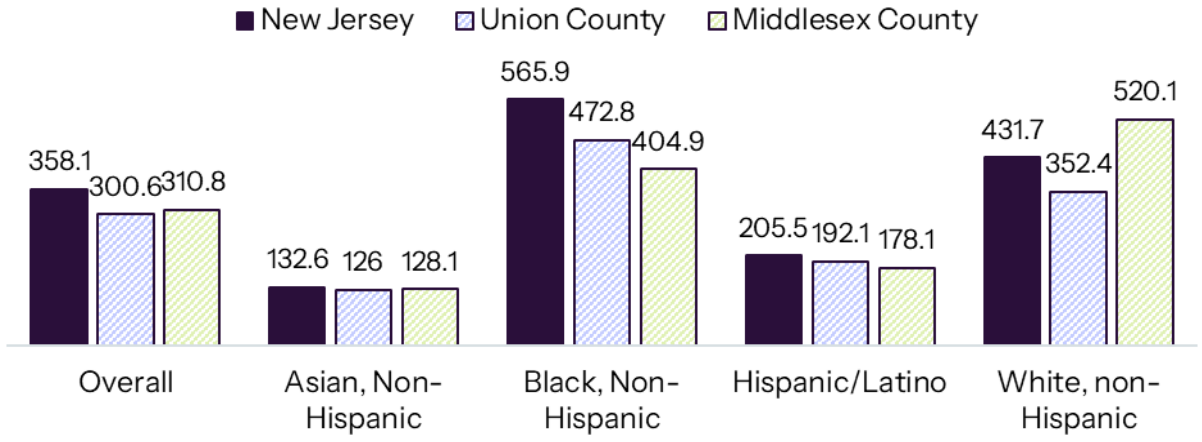
Figure 36. Age-Adjusted Mortality Rate per 100,000, by Race/Ethnicity, by State and County, 2023



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2024

Figure 37 shows premature mortality (deaths before age 75) rates per 100,000 population by state, county, and race/ethnicity. In 2023, the premature mortality rates in both Union and Middlesex County (300.6 and 310.8 per 100,000, respectively) were lower than for the state overall (358.1 per 100,000). Black residents in Union County experienced the highest premature mortality rate (746 per 100,000) compared to residents of other races/ethnicities in both Union and Middlesex, yet the rate was lower than the average premature mortality rate of Black residents in New Jersey overall (847 per 100,000).

Figure 37. Premature Mortality (Deaths Before Age 75) Rate per 100,000, by Race/Ethnicity, by State and County, 2023



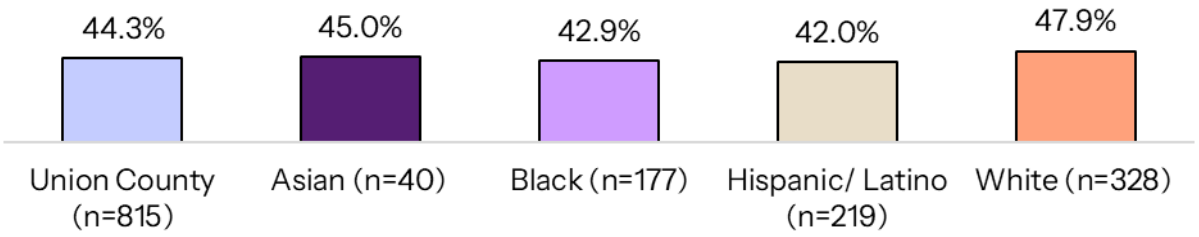
DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2024

Overweight, Obesity, and Physical Activity

Obesity is a leading cause of preventable death in the United States and increases the likelihood of chronic conditions among adults and children. While overweight/obesity was identified as the fourth top health concern by community survey respondents, and the third top health concern among children and youth, it was not a prominent theme in conversations with focus group or interview participants.

Almost half (44.3%) of survey respondents in Union County reported ever being told by a healthcare provider that they had a weight problem (Figure 38). This proportion was consistent by race/ethnicity, ranging from 42.0% of Hispanic to 47.9% of White residents. Almost half (48.4%) of respondents who were ever told they had a weight problem reported currently being under medical care to manage this condition. Figure 102 in the appendix shows 26.6% and 28.1% of Union and Middlesex County residents, respectively, self-reported being obese in 2022.

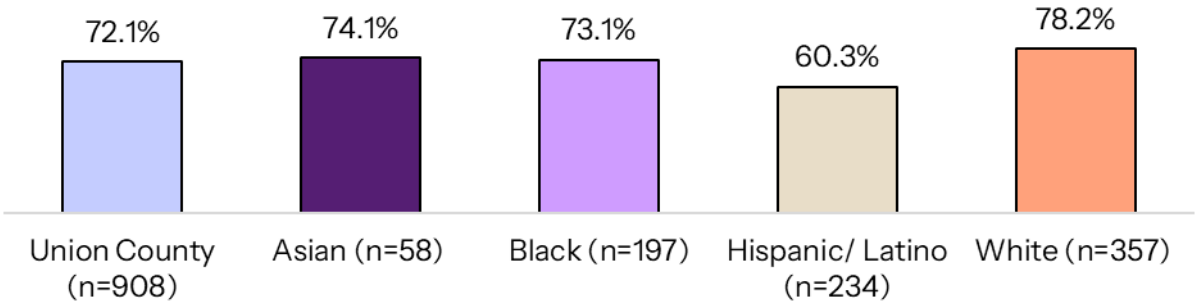
Figure 38. Union County Survey Respondents Reporting Ever Being Told They Have a Weight Problem by a Healthcare Provider, by Race/Ethnicity, (n=815), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Community survey respondents were asked if they had engaged in any physical activity in the past month. Almost 3 out of 4 Union County respondents (72.1%) indicated that they did so, ranging from 60.3% of Latino to 78.2% of White respondents (Figure 39).

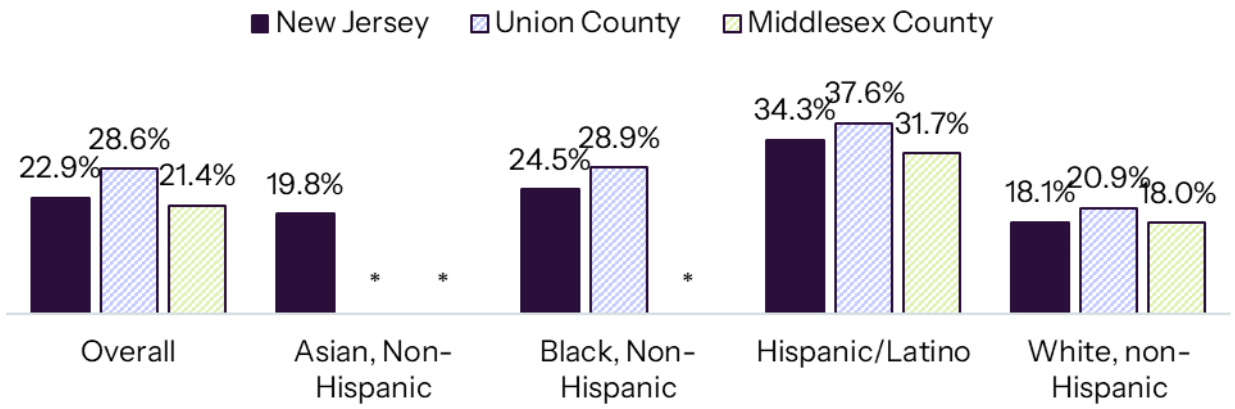
Figure 39. Union County Survey Respondents Reporting Any Physical Activity or Exercise in the Past Month, by Race/Ethnicity, (n=908), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

The built environment and availability of leisure time are two factors that affect physical activity. As mentioned in the section on community assets, focus group participants valued that there were green areas and parks to walk and play sports in their neighborhoods. Yet, many Union County residents reported not spending time on physical activity. According to the Behavioral Risk Factor Survey, in 2022, the most recent year for which these surveillance data are available, 28.6% of Union County residents reported having no leisure time for physical activity. There were differences by race and ethnicity with 28.9% of Black and 37.6% of Latino respondents reporting no leisure time compared to 20.9% of White respondents (Figure 40).

Figure 40. Percent of Adults Reporting No Leisure Time for Physical Activity, by Race/Ethnicity, by State and County, 2022



DATA SOURCE: Behavioral Risk Factor Survey, Center for Health Statistics Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024
NOTE: Asterisk (*) means that data are suppressed as the rate does not meet National Center for Health Statistics standards of statistical reliability for presentation.

Chronic Conditions

Chronic conditions, such as heart disease, diabetes, chronic obstructive pulmonary disease (COPD), and cancer, are some of the most prevalent conditions in the United States. Chronic disease was mentioned as a community concern by several interview participants who noted that the Rahway/Trinitas PSA had, like the rest of the country, high rates of diabetes, asthma, and cancer with particular concern around chronic disease management. The following section describes health data (e.g., screening, incidence, mortality, etc.) related to chronic conditions in the Rahway/Trinitas PSA.

High Cholesterol and High Blood Pressure

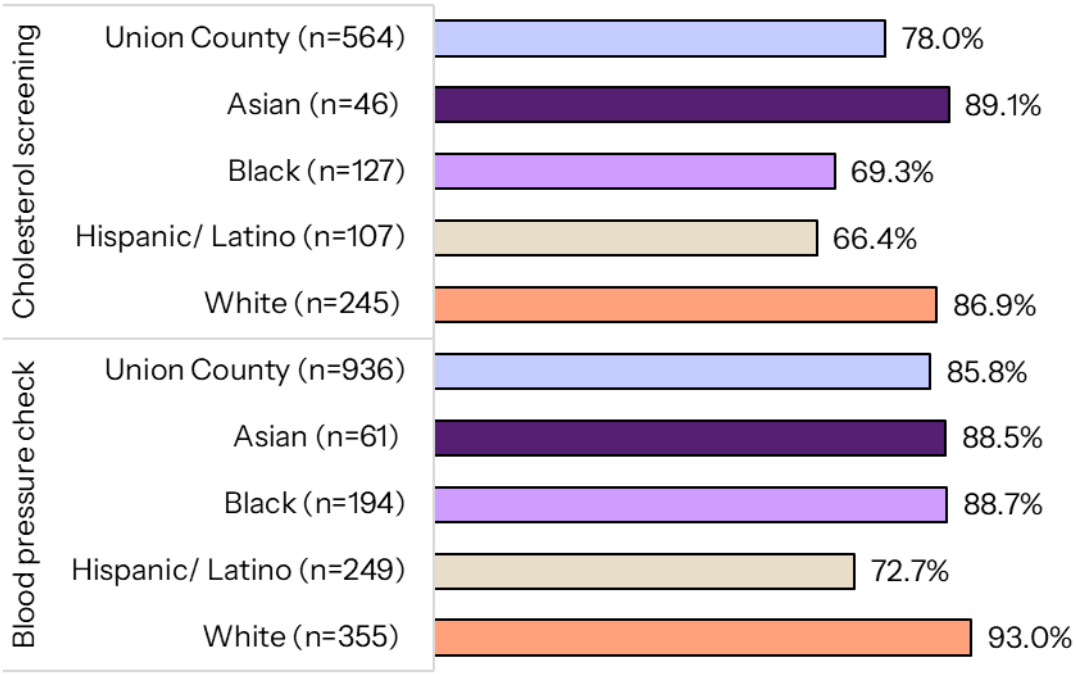
High cholesterol and high blood pressure are significant risk factors for heart disease, stroke, and other chronic diseases. There are three steps to address these conditions: prevention, screening and diagnosis, and management. Prevention based on lifestyle and behavior was discussed earlier in the sections on food insecurity and healthy eating, and on overweight, obesity, and physical activity. This section focuses on diagnosis and management.

Focus group and interview participants identified high cholesterol and high blood pressure as conditions that impact Union County residents, particularly African American and Latino

communities. A key informant interviewee when asked what communities were impacted the most by high cholesterol and high blood pressure explained, *"African Americans and the Hispanic community, just those two when it comes down to hypertension."*

Community survey respondents in 2024 were asked if they had ever received a cholesterol or blood pressure screening in the past two years. Over three-quarters (78.0%) indicated that they had participated in a cholesterol screening, and 85.8% in a blood pressure screening (Figure 41). The results differed by race/ethnicity. Only 66.4% of Latino and 69.3% of Black respondents reported being screened for cholesterol, compared to 86.3% of White and 89.1% of Asian respondents. Blood pressure checks also differed by race/ethnicity. Notably, only 72.7% of Latino respondents indicated that they had participated in blood pressure screenings compared to 93.0% of White respondents.

Figure 41. Percent of Community Survey Respondents Reporting Participation in Cholesterol and Blood Pressure Screening in the Past 2 Years, Union County Residents, by Race/Ethnicity, 2024

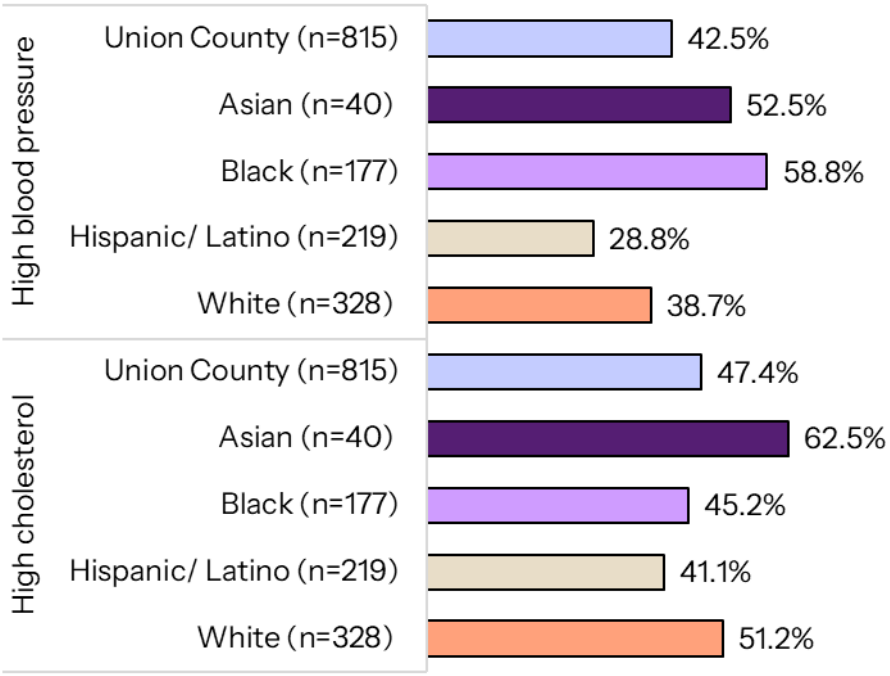


DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Percentages are calculated among those recommended for screenings by the U.S. Preventive Services Task Force. Cholesterol screening is recommended for those assigned male at birth aged 35 years and older and those assigned female at birth aged 45 years and older.

A high proportion of survey respondents reported being affected by high cholesterol and high blood pressure. Overall, 42.5% of survey respondents in Union County reported that they had high blood pressure and 47.4% that they had high cholesterol (Figure 42). Fewer Latino (28.8%) and White (38.7%) reported having been told they had high blood pressure compared to Asian (52.5%) and Black respondents (58.8%). In terms of having high cholesterol, percentages ranged from 41.4% of Latino to 62.5% of Asian respondents. These percentages should not be

interpreted as the prevalence of the conditions among survey respondents, given that this survey used a convenience sample and there are inequities in access to a healthcare provider to obtain a diagnosis.

Figure 42. Percent of Community Survey Respondents Ever Told They Had High Blood Pressure or High Cholesterol by a Provider, Union County Residents, by Race/Ethnicity, 2024



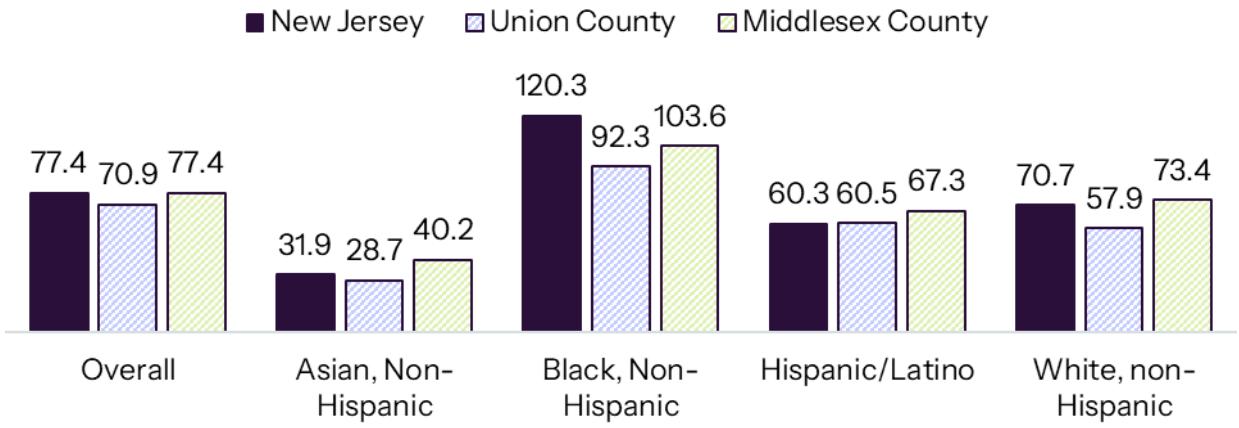
DATA SOURCE: Community Health Needs Assessment Survey, 2024

Heart Disease

While focus group and interview participants did not directly discuss heart disease, it is the leading cause of death in both Union and Middlesex County and is closely associated with other conditions mentioned by residents such as diabetes and overweight/obesity.

According to surveillance data, the rate of cardiovascular disease hospitalizations (70.9 per 10,000 population) was slightly lower in Union County compared to Middlesex County and New Jersey overall (both at 77.4 per 10,000) (Figure 43). Disparities exist within New Jersey and Union and Middlesex counties, with Black residents being hospitalized due to cardiovascular disease at the highest rates compared to the rest of race/ethnicities (120.3 per 100,000 in New Jersey, and 92.3 and 10.36 per 100,000 in Union and Middlesex County, respectively).

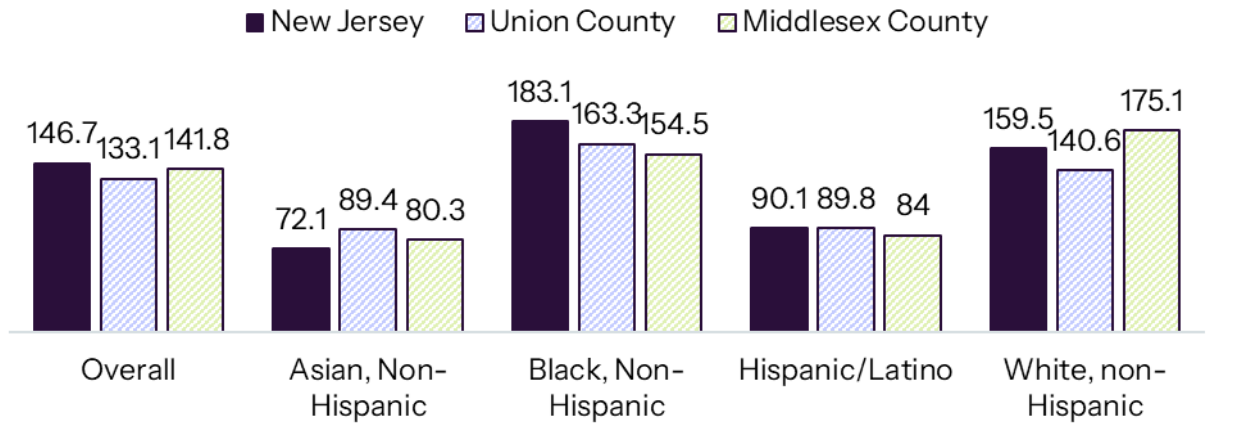
Figure 43. Age-Adjusted Inpatient Hospitalizations due to Cardiovascular Disease as Primary Diagnosis per 10,000, by Race/Ethnicity, by State and County, 2023



DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

Death certificate data show that in 2023 the heart disease mortality rates were slightly lower in Union and Middlesex County (133.1 and 141.8 per 100,000 residents, respectively) than in the state (146.7 per 100,000) (Figure 44). Heart disease mortality rates were highest among Black residents in Union County (163.3 per 100,000) and White residents in Middlesex County (175.1 per 100,000).

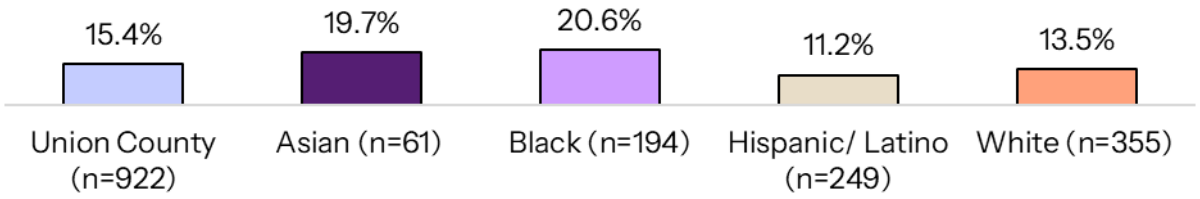
Figure 44. Age-Adjusted Cardiovascular Disease Mortality per 100,000, by Race/Ethnicity, by State and County, 2023



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

Overall, 15.4% of community survey respondents in Union County indicated receiving heart disease education in the past two years (Figure 45). Participation in heart disease education differed by race/ethnicity, with only 11.2% of Latino residents reporting participating compared to 19.7% of Asian and 20.6% of Black residents.

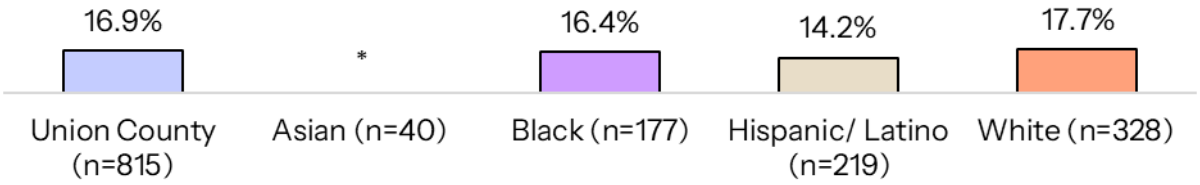
Figure 45. Percent of Community Survey Respondents Participating in Heart Disease Education in the Past 2 Years, Union County Residents, by Race/Ethnicity, (n=822), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Overall, 16.9% of community survey respondents indicated having been told by a provider that they had a heart condition (Figure 46). Minimal differences existed by race/ethnicity, with Latino respondents being the lowest (14.2%) and White respondents with the highest (17.7%) percentage.

Figure 46. Percent of Community Survey Respondents Ever Being Told They Had a Heart Condition by a Provider, Union County Residents, by Race/Ethnicity, (n=815), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data were suppressed due to low numbers.

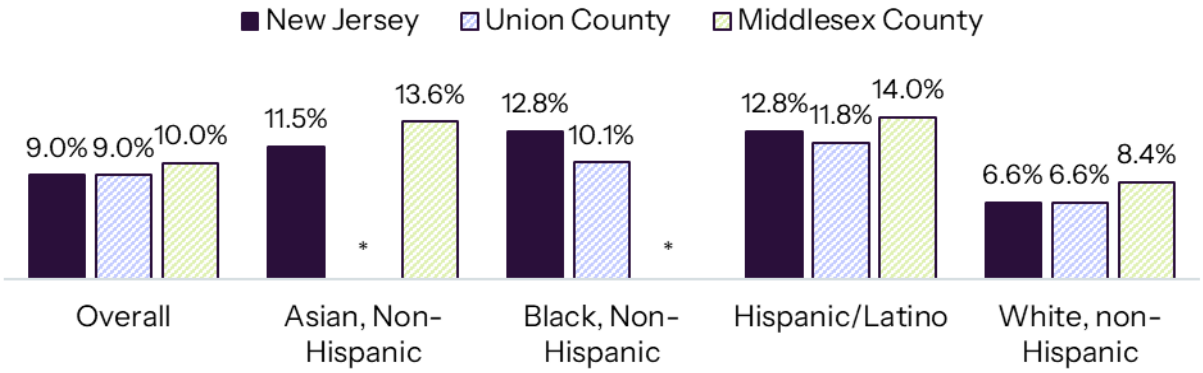
Diabetes

Participants indicated observing a perceived increase in untreated cases of diabetes in recent years and noted that diabetes was prevalent in their communities. An interviewee described how access to food may be impacting diabetes rates and explained, *"diabetes [is a problem] because it is a processed food disease and people not knowing how to eat good food or learn to live a healthy lifestyle or having access to food because they live in food deserts and all they have is processed food at the corner store bodega."* Another interviewee emphasized the challenge of managing diabetes and other chronic conditions with increasing costs of living explained, *"as people are starting to have to make more and more choices because of the economy as well. Do I pay for medicine, or do I eat? Or do I have a home? So that leaves diabetes uncontrolled, and they start to ration their medications, so that's a huge issue that we're seeing."*

Figure 47 shows the percentage of adults who reported a diagnosis of diabetes overall and by race/ethnicity from 2018 to 2022, the most recent years that surveillance data are available and aggregated over time due to small numbers. Overall diabetes rates were higher in Middlesex

County (10.0%) than in New Jersey and Union County (both at 9.0%). Community survey respondents identified diabetes as their top health concern overall.

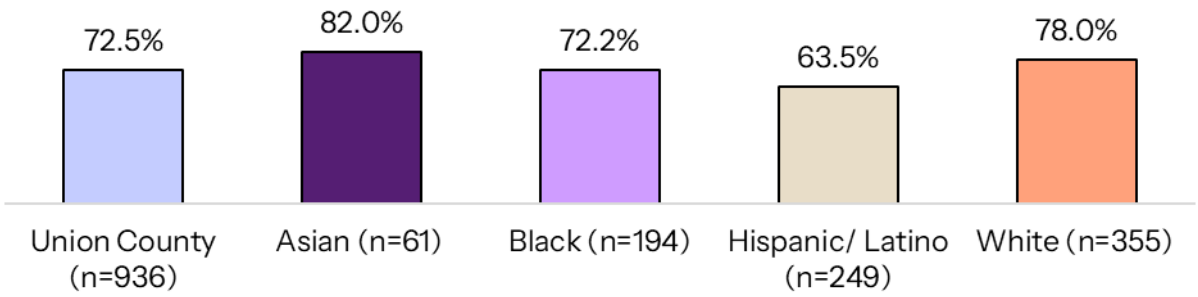
Figure 47. Percent of Adults Reporting Diabetes Diagnosis, by Race/Ethnicity, by State and County, 2018-2022



DATA SOURCE: Behavioral Risk Factor Survey, Center for Health Statistics Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2018-2022
NOTE: The asterisk (*) means that data does not meet National Center for Health Statistics standards of statistical reliability for presentation.

Community survey respondents were asked about their participation in diabetes screening or blood sugar checks in the past two years. In Union County, 72.5% of respondents were screened for diabetes (Figure 48). Participation in diabetes screenings or blood sugar checks differed by race/ethnicity, ranging from 63.5% among Latino to 82.0% among Asian respondents.

Figure 48. Percent of Community Survey Respondents Who Participated in Diabetes Screenings or Blood Sugar Checks in the Past 2 Years, Union County Residents, by Race/Ethnicity, (n=936), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

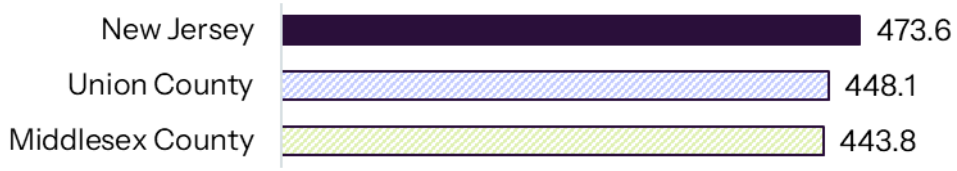
Cancer

Even though cancer is the second leading cause of death in Union County and New Jersey overall, it was not a prominent theme discussed in focus groups and interviews. However, a couple of interviewees described decreasing cancer screenings and preventative care occurring for a variety of reasons. A key informant interviewee described, *"cancer screening rates have plummeted as well. So, people not having insurance, they're going to pick and choose necessary*

things to do. So do I need to screen for something that's not a problem for me right now, and I feel fine, and I just can't deal with what's in my face right now, and I can't financially afford to do anything else." Focus group participants also explained how stigma around prostate cancer tests and screening can lead African American males in particular to avoid screening. A focus group participant explained, *"with prostate cancer there is a stigma about going back and forth to doctor and especially for prostate cancer and the tests you have to go through. I know several men who had died from prostate cancer and the lack of prevention of the disease."*

Overall, there were lower rates of cancer per 100,000 residents in both Union and Middlesex County (452.4 and 446.9, respectively) than in New Jersey (478.6) (Figure 49). Recent trends indicate that overall cancer incidence is declining (see Appendix G: Cancer Data). Figure 103 in the appendix presents additional data on cancer-related deaths.

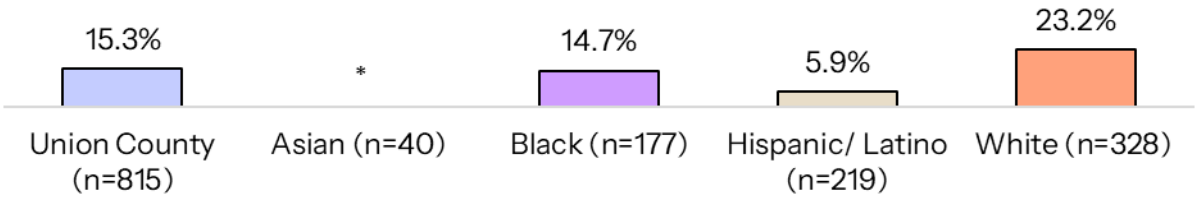
Figure 49. Age-Adjusted Invasive Cancer Incidence Rate per 100,000, by State and County, 2017-2021D



DATA SOURCE: New Jersey State Cancer Registry, 2024

Among Union County community survey respondents, 15.3% reported ever being told they had cancer by a provider (Figure 50). Percentages differed by race/ethnicity, ranging from 5.9% of Latino to 23.2% of White respondents.

Figure 50. Percent of Community Survey Respondents Ever Told They Had Cancer by a Provider, Union County Residents, by Race/Ethnicity (n=815), 2024

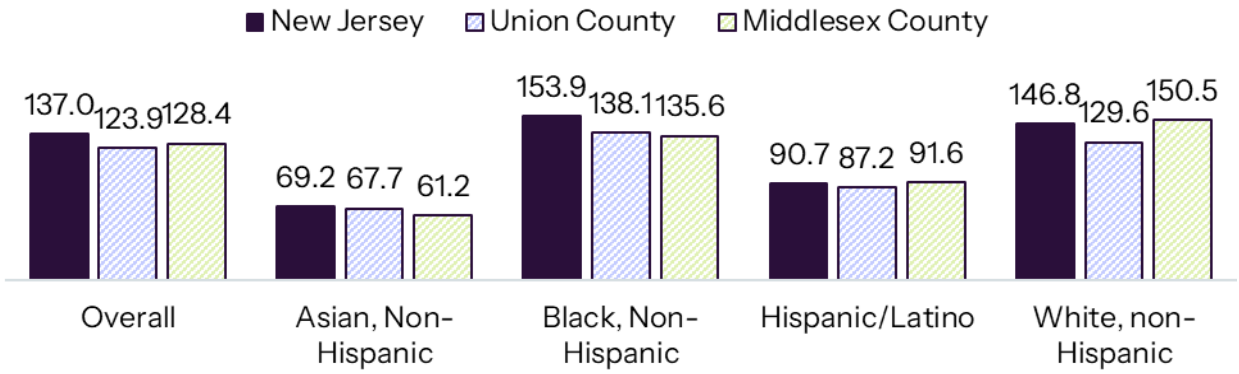


DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data were suppressed due to low numbers.

According to hospital tumor registries, in 2023, RWJUH Rahway's tumor registry data showed that 16.5 % and 16.2% of overall cases were Stage 3 and Stage 4 respectively. In TRMC, 8.4 % and 18.8% of overall cases were Stage 3 and Stage 4 respectively. The following primary sites made up more than 25% of Stage 4 cases at Rahway: Lymph Nodes (66.0%), Female Genital Organs and Lip Oral (50.0%), Digestive Organs (44.1%), and Respiratory Systems (41.7%). The following primary sites made up more than 25% of Stage 4 cases at TRMC: Respiratory Systems (58.1%), followed by Female Genital Organs (43.8%), Male Genitals (33.3%), and Lip Oral Cavity and Pharynx (28.6%) (Appendix G: Cancer Data).

In 2021, the last year for which these data were available, the overall cancer mortality rate in Union County (123.9 per 100,000) was lower than that of the state overall (137 per 100,00) (Figure 51). Black residents had a higher cancer mortality rate (138.1 per 100,000) than the county average, while Asian (67.7 per 100,000) and Latino (87.2 per 100,000) residents had the lowest cancer mortality rates of any race/ethnic group.

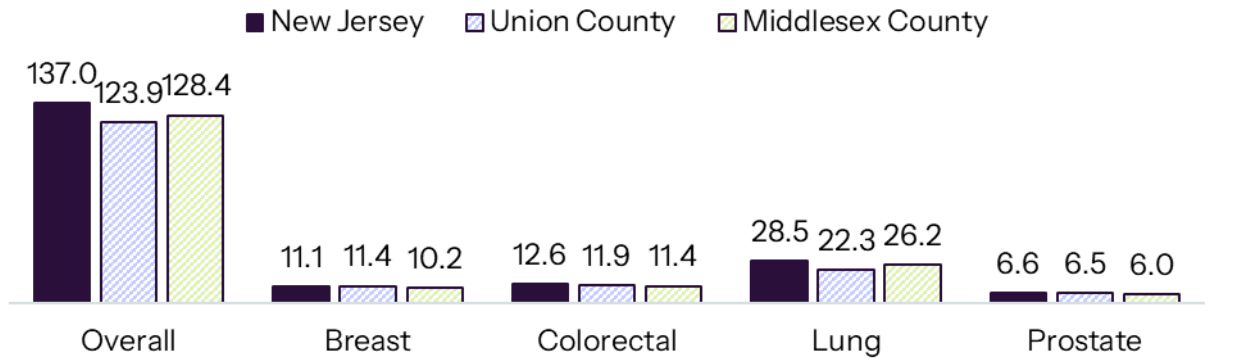
Figure 51. Age-Adjusted Deaths Due to Cancer per 100,000, by Race/Ethnicity, by State and County, 2017-2021



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

The cancers that claimed the most lives in Union and Middlesex counties were lung and bronchus cancer (22.3 and 26.2 deaths per 100,000 population, respectively), followed by colorectal (11.9 and 11.4 deaths per 100,000 population, respectively), and breast (11.4 and 10.2 deaths per 100,000 females, respectively) cancers (Figure 52). The mortality rate of these three cancers fell from 2016-2020 (Appendix G: Cancer Data).

Figure 52. Age-Adjusted Deaths Due to Cancer per 100,000, by Cancer Site, State and County, 2017-2021

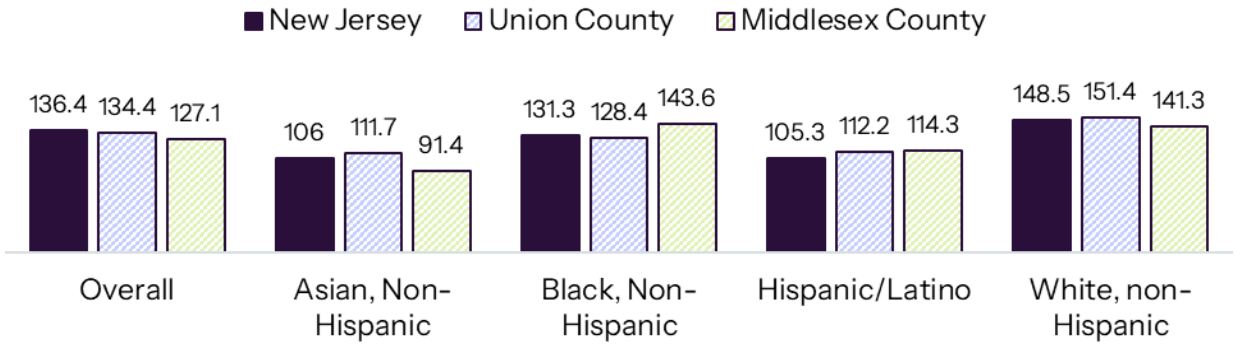


DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

Breast Cancer

Cancer registry data are presented in Figure 53 for the age-adjusted incidence rate of female breast cancer per 100,000 population in 2017-2021 across New Jersey and in Union and Middlesex County by race/ethnicity. The breast cancer incidence rates in Union and Middlesex County (134.4 and 127.1 per 100,000, respectively) were highest among White (151.4 and 141.3 per 100,000, respectively) and lowest among Asian (111.7 and 91.4 per 100,000, respectively) residents. Because race and Hispanic origin are not mutually exclusive in the New Jersey State Cancer Registry, caution should be used when comparing rates among Latino residents to rates in the different racial groups. More information on breast cancer deaths can be found in Figure 104 in Appendix E: Additional Data Tables and Graphs.

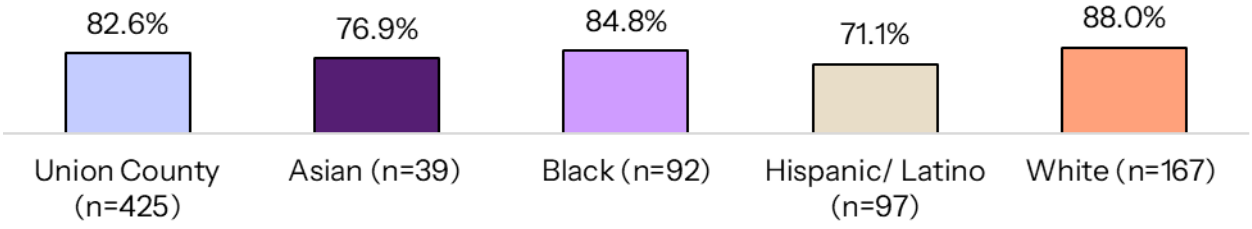
Figure 53. Age-Adjusted Rate of Female Breast Cancer per 100,000, by Race/Ethnicity, by State and County, 2017-2021



DATA SOURCE: New Jersey State Cancer Registry, 2024

Screening and early detection are critical to improved cancer-related outcomes. Community survey participants who identified as female were asked if they had participated in mammography screenings in the past two years. Overall, 82.6% of female Union County residents had a mammography in the past two years (Figure 54). However, there were differences by race/ethnicity with Latina respondents reporting participating the least (71.1%) and White respondents the most (88.0%).

Figure 54. Percent of Community Survey Respondents Who Had a Mammography or Breast Exam Screening in the Past 2 Years, Union County Residents, by Race/Ethnicity, (n=425), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Percentages are calculated among those assigned female at birth aged 40 to 74 years old.

HPV-Associated Cancers

Human papillomavirus (HPV) is a group of viruses that spread through vaginal, anal, and oral sex. HPV infections are prevalent among sexually active people. Whereas most infections resolve on their own, in some cases HPV can cause cancers such as throat (or oropharyngeal) cancer, anal cancer, penile cancer, vaginal cancer, and vulvar cancer. Throat was the most common HPV-associated cancer in both Union and Middlesex counties in 2017-2021 (9.2 and 11.4 per 100,000, respectively) (Table 14). Figure 105 in Appendix E: Additional Data Tables and Graphs presents additional data on deaths due to prostate cancer in 2020.

Table 14. Age-Adjusted Rate of HPV-Associated Cancers per 100,000, by State and County, 2017-2021

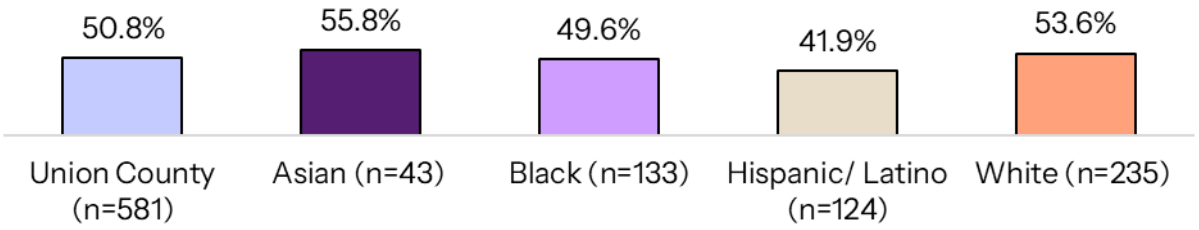
	Overall	Oral Cavity & Pharynx	Anus	Penis (Male)	Vagina (Female)	Vulva (Female)	Cervix Uterine Cavity
New Jersey	473.6	11.2	1.8	0.9	0.6	2.9	7.2
Union County	448.1	9.2	1.5	1.3	0.6*	2.8	7.1
Middlesex County	443.8	11.4	1.6	0.8	0.7	2.5	6.9

DATA SOURCE: New Jersey State Cancer Registry, 2017-2021
NOTE: Asterisk (*) means that the age-adjusted rate is not stable due to less than 15 cases.

Colon and Skin Cancer Screenings

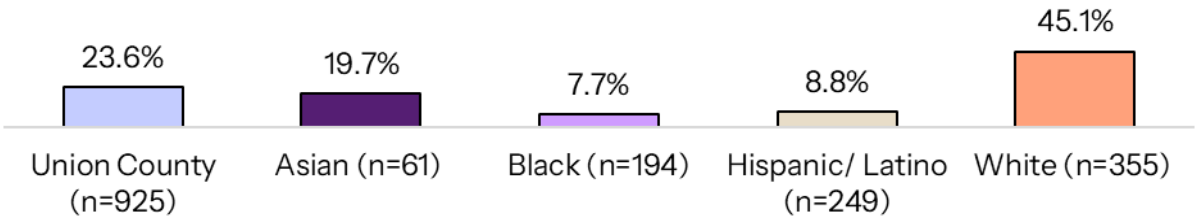
Colon and skin cancers are relatively common and may not have noticeable symptoms in their early stages. Regular cancer screenings are one of the most effective means to detect and treat it early, when treatment is easier. Community survey respondents were asked about their participation in screenings for colon and skin cancer within the past two years. About half (50.8%) of respondents reported receiving a colon cancer screening (Figure 55) and almost one-fourth (23.6%) a skin cancer screening in the last two years (Figure 56). The proportion of Asian, Black, and Latino residents screened for skin cancer was substantially lower than for White residents.

Figure 55. Percent of Community Respondents Screened for Colon Cancer in the Past Two Years, Union County Residents, by Race/Ethnicity, (n=581), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Percentages are calculated among those recommended for screenings by the U.S. Preventive Services Task Force. Colon cancer screening is recommended for adults aged 45 to 75 years old.

Figure 56. Percent of Community Respondents Screened for Skin Cancer in the Past 2 Years, Union County Residents, by Race/Ethnicity, (n=925), 2024

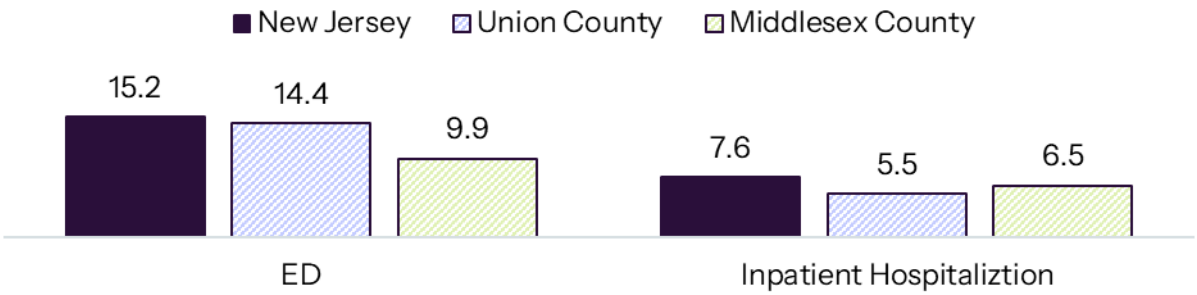


DATA SOURCE: Community Health Needs Assessment Survey, 2024

Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease (COPD) is a chronic inflammatory lung disease that causes obstructed airflow from the lungs. It is one of the main diseases in the grouping of chronic lower respiratory disease, the sixth leading cause of death in the state in 2021 (Figure 35). In 2023, both Union and Middlesex County had lower rates of emergency department (ED) visits due to COPD (14.4 and 9.9 per 10,000 population) than New Jersey overall (15.2 per 10,000) and rates of COPD-related hospitalizations to relative to the state (Figure 57). Hospital discharge rates for chronic ambulatory-care sensitive conditions, which include COPD, are presented in Appendix E: Additional Data Tables and Graphs.

Figure 57. Age-Adjusted Rate of Emergency Department (ED) Visits and Inpatient Hospitalizations due to Chronic Obstructive Pulmonary Disease as Primary Diagnosis, per 10,000, by State and County, 2023



DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

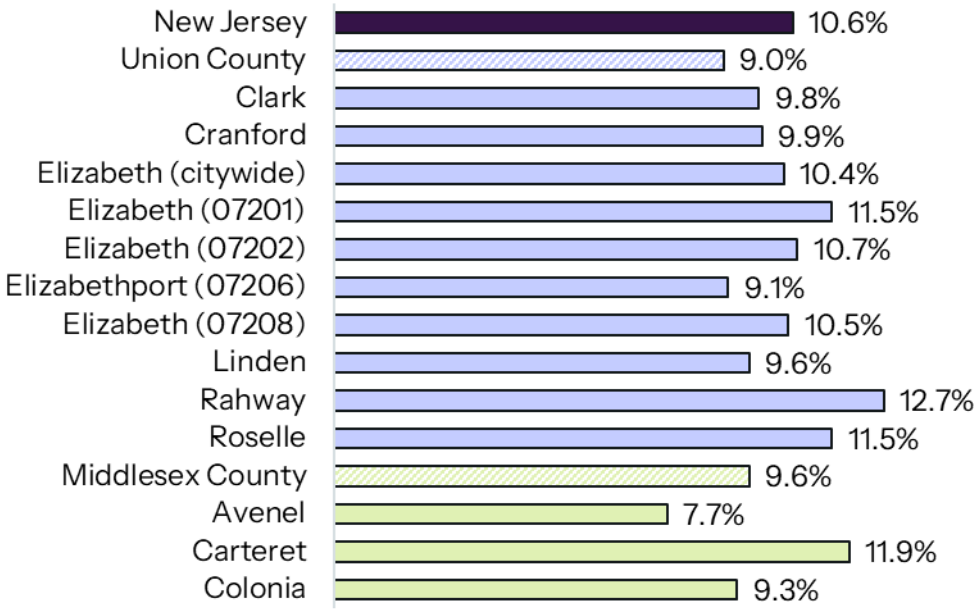
Chronic disease was identified as a priority area during the 2022 RWJUH Rahway and TRMC CHNA. To address this concern, over the last three years the systems have engaged in and implemented numerous strategies. For example, TRMC partnered with primary care providers to connect to patients struggling with compliance and medication education. TRMC also provided screening and health education to over 15,000 residents through quarterly health fairs. RWJUH-Rahway continued and expanded free support groups for individuals with chronic conditions and their caregivers. Additional information on strategies and progress can be found in Appendix H.

Disability
Disabilities, such as hearing impairment, vision impairment, cognitive impairment, and impaired mobility, impact residents' daily lives. Residents who have some type of disability may have difficulty getting around, living independently, or completing self-care activities.

Whereas disability was not a prominent theme discussed in focus groups, it was of concern to participants working with access to services and food assistance. To illustrate this point, an interviewee described, *"the disabilities we see are primarily physical and then emotional after that. Not too much in the way of referrals out, we usually just give a heads up to the county office, but there are a few clients who express a need for resources including job training."*

American Community Survey data from 2019-2023 show that the number of people with disabilities differs slightly across the Union and Middlesex County service area. Overall, 9.0% of Union County and 9.6% of Middlesex County residents have a disability (Figure 58). More information on the percentage of residents with a disability by age can be found in Table 33 in the appendix. The proportion of people with a disability is likely higher among certain groups. For example, 47.5% of homeless people in New Jersey reported having some type of disability in 2023 according to the New Jersey Counts report.

Figure 58. Percent of Persons with a Disability, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census, American Community Survey, 5-Year Estimates, 2019-2023

Mental Health and Behavioral Health
Behavioral health is thought of as the connection between the health and well-being of the body and the mind. In the healthcare field, mental health and substance use are typically discussed under the larger framework of behavioral health.

Mental Health

Mental health was identified as a community concern in almost every interview and focus group. Participants identified anxiety, stress, trauma, PTSD, substance use, and suicidality as mental health challenges for community residents. Participants perceived an increase in mental health concerns in recent months. Poor mental health has a negative impact on overall well-being: those with mental health conditions have difficulty managing other health conditions and accessing services such as healthcare, housing, and food resources.

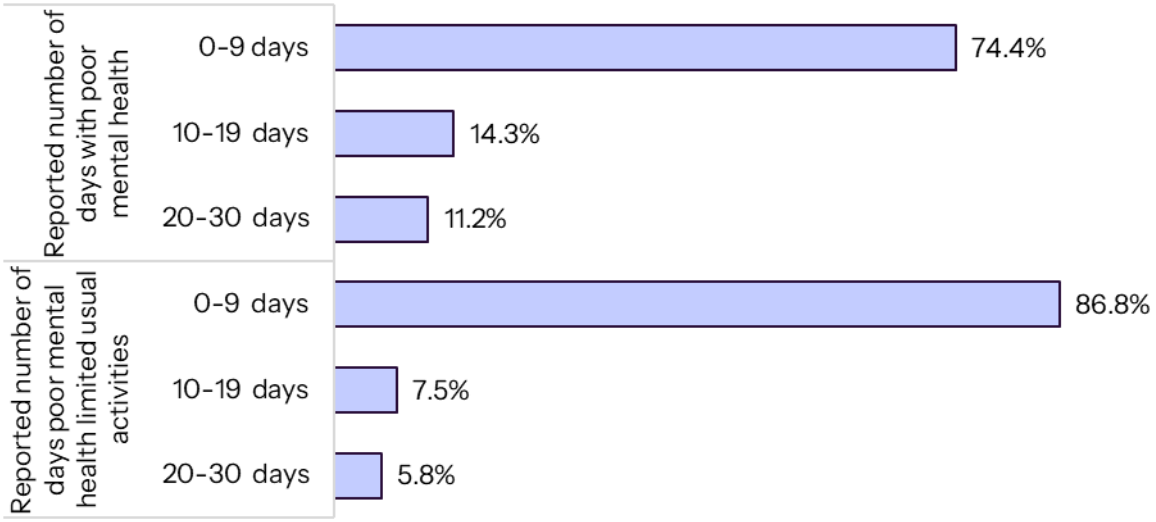
Youth and young adult mental health was of particular concern to interview and focus group participants. One interviewee working in healthcare explained, *"I've never seen so much mental health concern, even with COVID. Now, I don't know if it's just layoffs, if it's the undocumented status, if it's the social pressures that young individuals are going through that were isolated during COVID and now [they] are trying to find their way navigating social media, there's so many things, but I'm seeing so much more young adults with suicidal behavior and attempts than I ever have. Ever. Which is really wild."* One participant believed the increase in youth and young adult mental health challenges could be related to increasing socioeconomic stressors. They described, *"it's not my expertise but it's obvious it's exasperated, if not sourced from socioeconomic stressors. So, a lot of younger patients are dealing with trauma at home related to incarceration of a parent, instability with parent care, and comorbidities with substance use."*

The mental health of older adults was also mentioned as a community concern by several interview participants. Interviewees reported that older residents, many of whom experienced substantial isolation and fear during the pandemic, had high rates of depression, a condition that was more common among those who were homebound or did not have family close by. One participant described *"we are seeing a lot of older patients that are alone, that don't have family and a lot of depression. During the holiday season, they fall into a depression."*

Another community concern was the mental health of immigrants, noted by several interview and focus group participants. Participants reported that immigrant populations in the Rahway/Trinitas PSA experienced high levels of trauma and fear. One focus group participant stated, *"[there is] a lot of trauma, like PTSD has increased because of everything that is going on. There are some patients and their family members are in other countries where they live, and they're just battling because they can't be there, and they're afraid to leave because they don't think they will ever be able to come back to the States. So, you have that component. You also have some mothers that are afraid for their kids. Their kids were born here, but they weren't born here, so they're afraid that they would be separated from each other. So, it's a lot of that as well."*

Quantitative data confirm participants' perceptions. Community survey respondents identified mental health issues as the fifth top health concern in their communities and the top health concern for youth and young adults. Among Union County survey community respondents, 14.3% reported experiencing 10-19 days of poor mental health, and 11.2% reported 20-30 days of poor mental health in the last 30 days (Figure 59). Additionally, 7.5% of survey respondents reported experiencing 10-19 days in which poor mental health limited their usual activities, and 5.8% reported 20-30 days in which poor mental limited their usual activities. Prevalence of depression can be found in Figure 110 in the appendix.

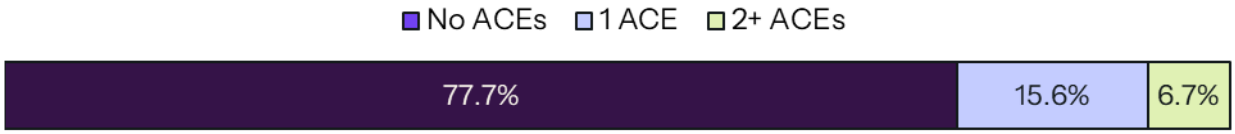
Figure 59. Percent of Union County Survey Respondents with Poor Mental Health in the Last 30 Days, (n=747), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Experiencing adverse childhood experiences (ACEs) is a strong risk factor for poor mental and physical health outcomes in childhood and adulthood. While ACEs data at the county or town level is not readily available, the National Survey of Children's Health indicates that in 2022-2023, 15.6% of children in the state of New Jersey had experienced one ACE, and 6.7% had experiences 2 or more ACEs (Figure 60).

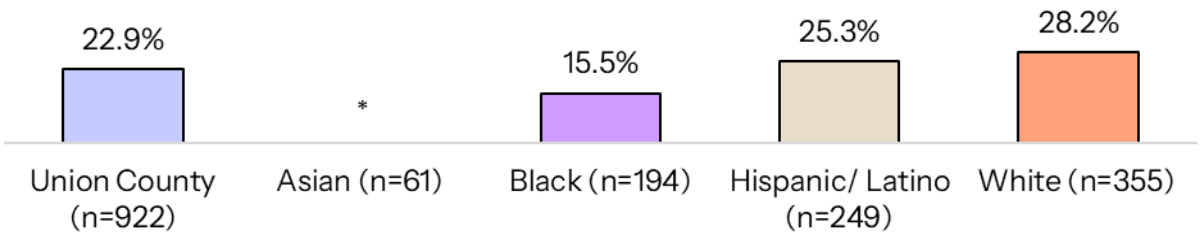
Figure 60. Percent of Children with Adverse Childhood Experiences (ACEs), by State, 2022-2023



DATA SOURCE: National Survey of Children's Health, Health Resources and Services Administration, Maternal and Child Health Bureau, 2022-2023

Almost 1 in 4 (22.9%) Union County survey respondents reported receiving mental health counseling in the past two years. Rates of participation varied by race/ethnicity. Proportionally more White (28.2%) and Black (25.3%) respondents reported receiving mental health counseling in the last two years compared to Latino (15.5%) respondents (Figure 61).

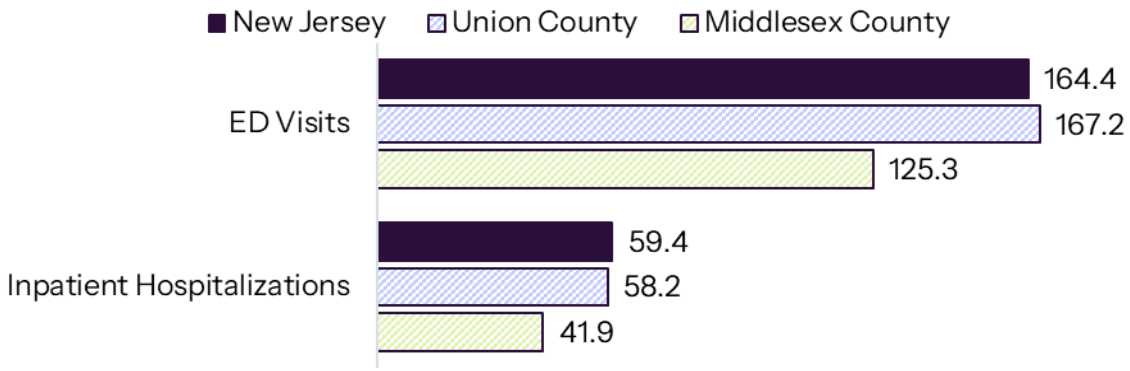
Figure 61. Percent of Union County Survey Respondents who Received Mental Health Counseling in the Past 2 Years, by Race/Ethnicity, (n=922), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Hospital discharge data from 2021 show that Union County had a relatively higher rate of emergency department (ED) visits (167.2 per 10,000) due to mental health than New Jersey (164.4 per 10,000), while Middlesex County had a lower rate (125.3 per 10,000). Both Union and Middlesex (58.2 and 41.9 per 10,000, respectively) counties had a lower rate of inpatient hospitalizations due to mental health than the state (59.4 per 10,000) (Figure 62).

Figure 62. Age Adjusted Rate of Emergency Visits and Inpatient Hospitalizations due to Mental Health per 10,000, by State and County, 2021



DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

Death Certificate Database data from 2018-2022 indicate that overall suicide rates in both Union and Middlesex County (6.0 and 6.4 per 100,000, respectively) were lower than in the state (7.3 per 100,000). White New Jersey residents had the highest rate of suicide deaths than any other racial/ethnic group (Table 15).

Table 15. Age-Adjusted Rate of Suicide Deaths per 100,000, by Race/Ethnicity, by State, 2018-2022

	Overall	Asian, non-Hispanic	Black, non-Hispanic	Hispanic/Latino	White, non-Hispanic
New Jersey	7.3	4.3	4.2	4.3	9.1
Union County	6.0	5.4	3.1	4.7	7.8
Middlesex County	6.4	3.1	3.7	4.4	8.8

DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

According to hospital discharge data, rates of pediatric hospitalization due to mental health from 2019-2023 were higher in Union County (30.7 per 10,000) than in New Jersey (28.5 per 10,000), and much lower in Middlesex County (11.4 per 10,000). In each of the 3 geographies, rates were highest among Black and White children and lowest among Asian children (Figure 63).

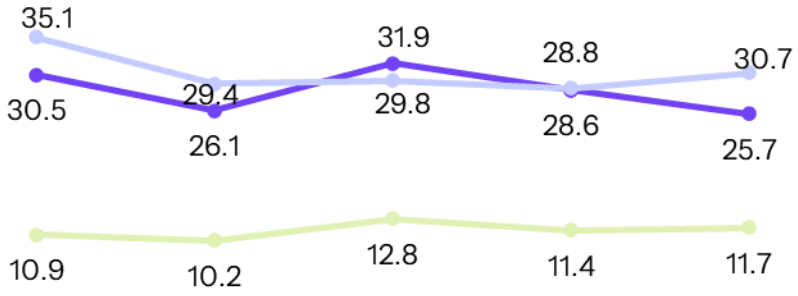
Figure 63. Rate of Pediatric Hospitalizations (Ages 19 and Under) due to Mental Health per 10,000, by Race/Ethnicity, by State and County, 2019-2023

	Overall	Asian, non-Hispanic	Black, non-Hispanic	Hispanic/Latino	White, non-Hispanic
New Jersey	28.5	7.3	38.4	19.1	27.5
Union County	30.7	6.9	31.7	26.6	32.5
Middlesex County	11.4	3.0	14.4	8.1	13.2

DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024

Pediatric hospitalizations due to mental health were consistently lower in Middlesex County compared to New Jersey between 2018 and 2022, while the rates for Union County were higher than the state in 4 out of 5 years (Figure 64). All 3 geographies experienced an increase in hospitalization rates in the aftermath of the COVID-19 pandemic.

Figure 64. Rate of Pediatric Hospitalizations (Ages 19 and Under) due to Mental Health per 10,000, by State and County, 2018-2022

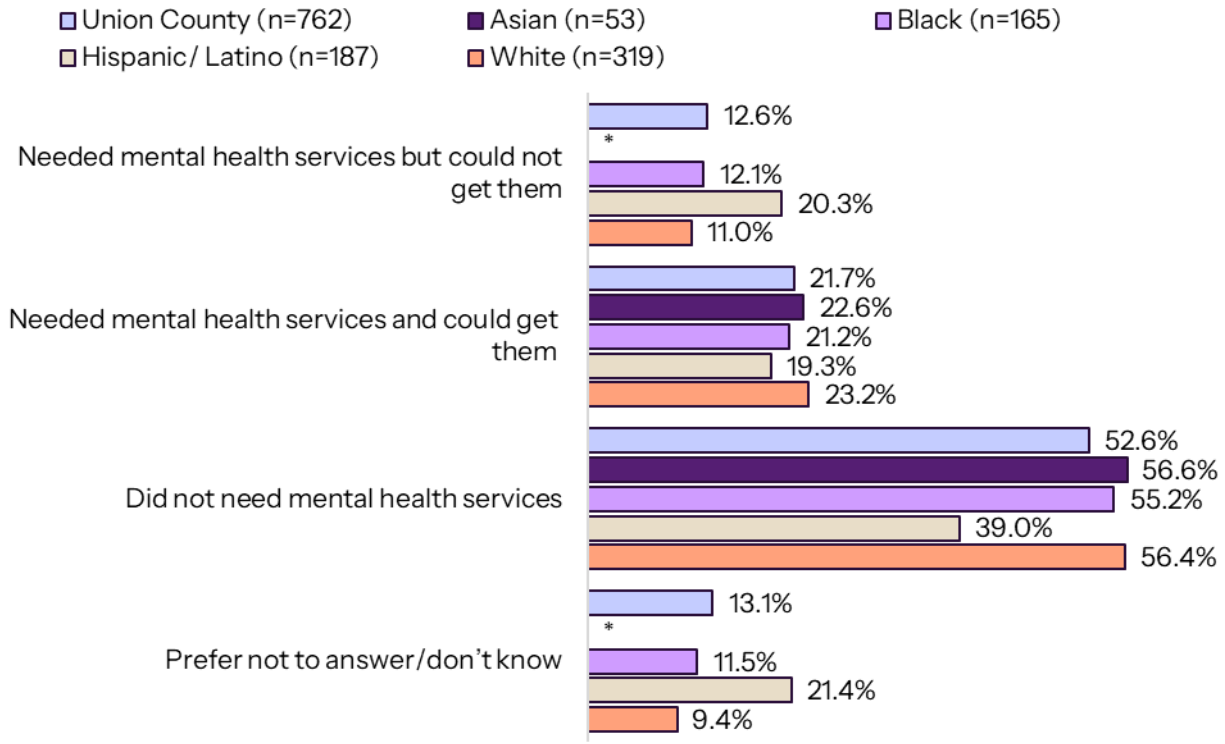


	2019	2020	2021	2022	2023
New Jersey	30.5	26.1	31.9	28.6	25.7
Union County	35.1	29.4	29.8	28.8	30.7
Middlesex County	10.9	10.2	12.8	11.4	11.7

DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024

Union County community survey respondents were asked about their experiences seeking help for mental health problems for themselves or a family member over the past two years. Overall, 12.6% of Union County respondents who reported seeking mental health services and/or treatment indicated that they could not access them (Figure 65). A higher proportion of Latino respondents (20.3%) reported not being able to access needed help. In Union County, 21.7% of respondents sought mental health services and/or treatment and accessed them in the past two years, with similar percentages by race/ethnicity.

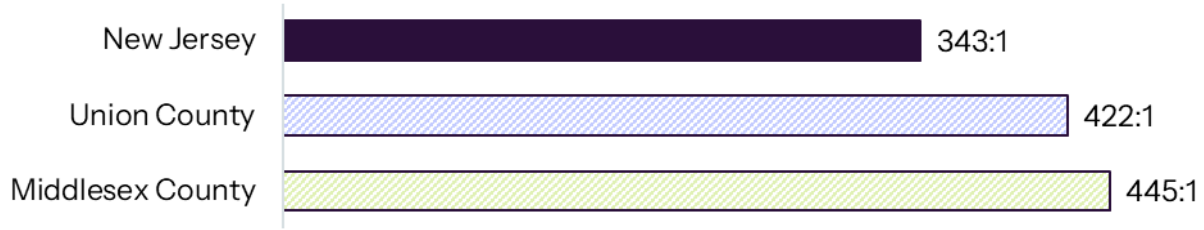
Figure 65. Community Health Survey Respondents' Experiences Accessing Help for Mental Health Problems for Respondent or a Family Member in the Past 2 Years, Union County Residents, by Race/Ethnicity, 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data are suppressed.

Mental health workforce data indicate that, in 2023, Union County and Middlesex County both had a higher population to mental health provider ratio than the state, with New Jersey at 343 people per mental health provider, and Union and Middlesex at 422 and 445, respectively. (Figure 66).

Figure 66. Ratio of Population to Mental Health Provider, by State and County, 2023



DATA SOURCE: CMS, National Provider Identification as cited by County Health Rankings, 2024

Substance Use

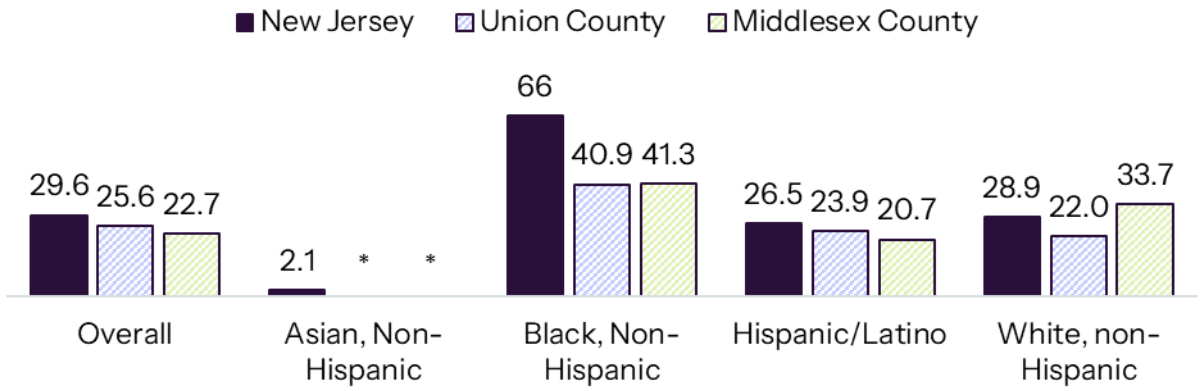
Problem substance use is the uncontrolled consumption of a substance, including alcohol, tobacco, or other psychoactive substances, despite harmful consequences. Substance misuse may impact health and affect social and economic well-being. Several interviewees and focus

group participants identified substance misuse as a problem. An interviewee stated, *"you've got the mental health and then you've got the addiction and it's often co-occurring situationally. Those are the two biggest health concerns I think."* In addition to substance use concerns, participants described increasing need for wound care associated with substance use as well.

Despite substance use being a community concern, participants mentioned a few programs and initiatives that were working to address this need. These involved the LEAD and Arrive Together programs, partnerships between treatment, health, and social service agencies for wraparound care, inpatient and outpatient treatment options, and increasing availability of Narcan leading to fewer overdose emergency calls. An interviewee described the LEAD and Arrive Together programs explaining, *"the LEAD program is engaging people with low level criminal activity and have identified mental health and substance use needs. It's an alternative to arrest and is a prearrest referral. We also engaged with Union County law enforcement as part of the arrive together initiative, so we are responding to calls with mental health screeners and law enforcement to deescalate the situation."*

Figure 67 shows the age-adjusted unintentional overdose rate per 100,000 population in 2023. Union County and Middlesex County both had lower rates of unintentional overdose mortality (25.6 and 22.7 per 100,000 population) when compared to the state rate (29.6 per 100,000 population). Most of the overdose mortality was attributable to opioids. The unintentional overdose mortality differed across race/ethnicities. The highest stratified rates in Union County and Middlesex County were among Black residents (40.9 and 41.3 per 100,000, respectively). Additional data on other substances are presented in the Mental Health and Behavioral Health section of Appendix E: Additional Data Tables and Graphs.

Figure 67. Age-Adjusted Rate of Unintentional Overdose Mortality, per 100,000 Population, by Race/Ethnicity, by State and County, 2023

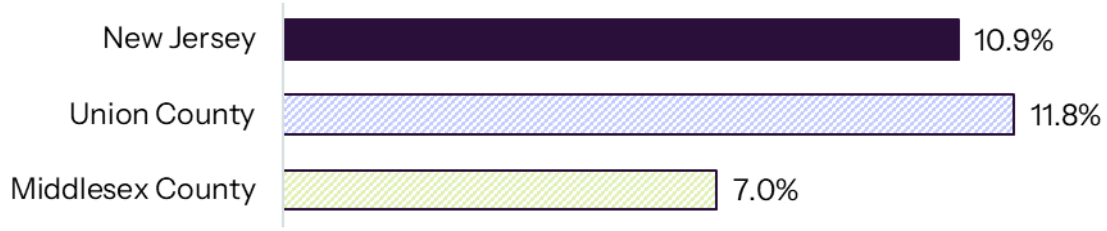


DATA SOURCE: Statewide Substance Use Overview Dashboard, Division of Mental Health and Addiction Services Department of Human Services, 2024
NOTE: Asterisk (*) means that data are suppressed, as there are fewer than 20 cases.

Tobacco is among the most consumed substances. In 2022, the percentage of adults who reported currently smoking was similar between Union County (11.8%) and the state (10.9%),

yet lower in Middlesex County (7.0%) (Figure 68). Additional data on alcohol and opioid use may be found in the appendix.

Figure 68. Percent of Adults Who Reported Current Smoking, by State and County, 2022



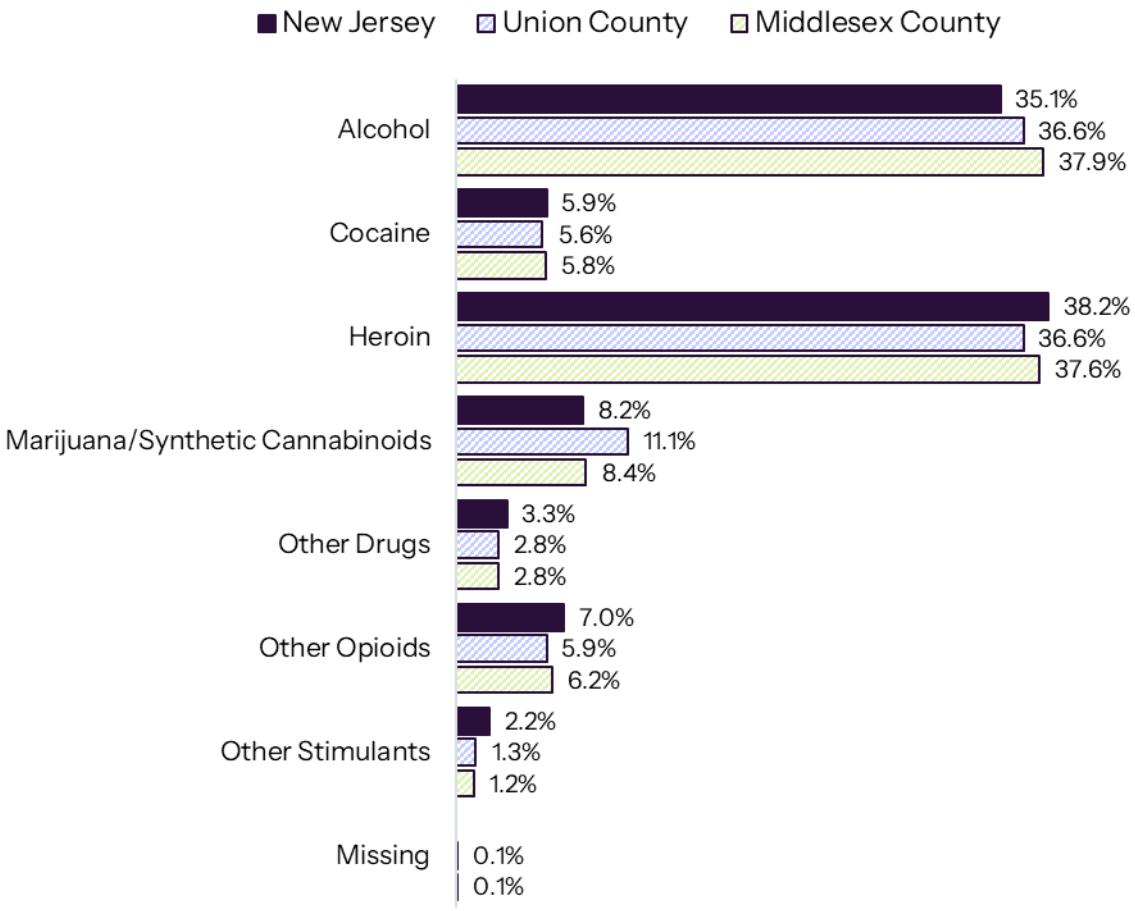
DATA SOURCE: Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health 2024

Community survey respondents were asked about their participation in any form of counseling for alcohol or drug use over the past two years. Overall, 1.7% of Union County residents reported receiving substance use counseling. Survey respondents were also asked about their participation in any programs to reduce smoking or vaping over the past two years. Overall, 2.8% of respondents indicated that they participated in such programs. Data were too low by race/ethnicity to report.

In 2024, RWJBH community survey respondents were asked about access to substance use services/treatment for themselves or a family member in Union County over the past two years. Overall, 10.0% of Union County respondents indicated that they needed substance use services and/or treatment. Nearly a third of respondents who needed services (28.9%) reported that they were not able to obtain them.

Figure 69 shows the percentage of substance use treatment admissions by primary drug from 2019-2023. Admission rates were highest for heroin and alcohol. In both Union and Middlesex County, more than one-third of admissions to substance use treatment services were for heroin misuse (36.6% and 37.6%, respectively) and for alcohol misuse (36.6% and 37.9%, respectively). Additional information on substance use treatment admission can be found in Appendix E: Additional Data Tables and Graphs.

Figure 69. Percent of Substance Use Treatment Admissions by Primary Drug, by State and County, 2019-2023



DATA SOURCE: Statewide Substance Use Overview Dashboard Department of Human Services, Division of Mental Health and Addiction Services, 2024

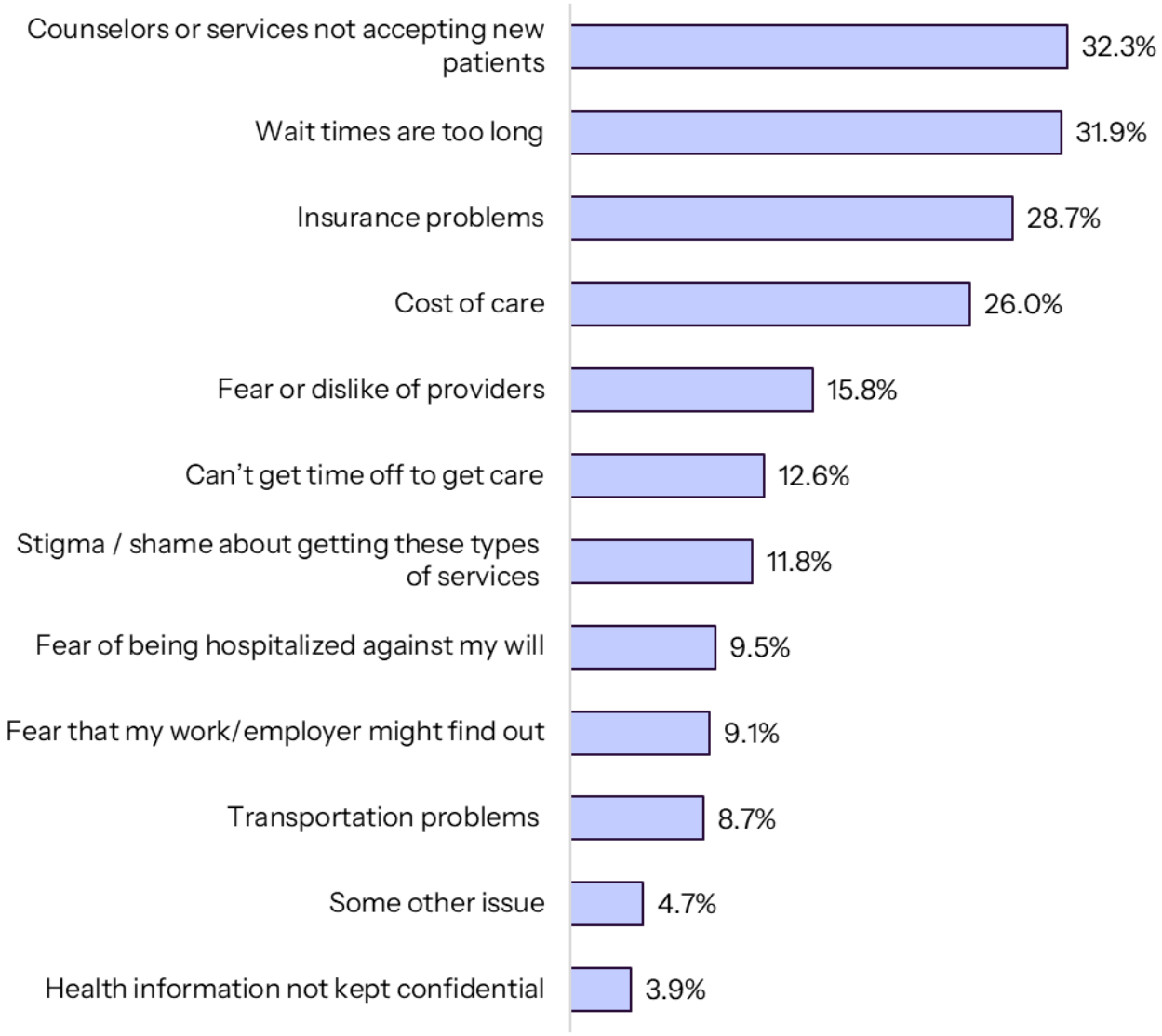
Mental and behavioral health were identified as a priority area for the prior RWJUH Rahway and TRMC CHNA-SIP process. To help address this concern in the community, over the last three years the facilities have engaged in multiple partnerships and implemented various strategies. For example, TRMC implemented the LEAD program to divert people away from the criminal justice system and connect them with case managers instead. The program began in Elizabeth, and has now expanded to Plainfield, Linden, and other municipalities in Union County. RWJUH Rahway improved linkages with community mental health resources for both inpatient and outpatient clients. The facility also increased mental health screenings and provided resources, referral information, and referrals to TRMC, Bridgeway Behavioral Health Services, and other mental health services. More information on strategies and implementation can be found in Appendix H.

Difficulties Accessing Mental Health and/or Substance Use Services

Participants stated that there were challenges accessing resources to address mental health concerns. Focus group and interview participants reported insurance barriers, long wait times, language barriers, lack of culturally competent care, and a lack of providers as barriers faced when addressing mental health and substance use. One focus group participant described the wait time for mental health services by saying, *"Trinitas has a sister hospital that focuses on mental health. Their wait list is 3 months. The undocumented population, they don't have access to Medicaid or any insurance, they have to wait 3 to 6 months to see someone just for an assessment."*

Community survey respondents were asked to list their top five reasons they had difficulty obtaining mental health or substance use services in the past two years. The main issues that Union County residents who tried to obtain mental health services listed as barriers to obtaining such services were: counselors or services not accepting new patients (32.3%), long wait times (31.9%), insurance problems (28.7%), cost of care (26.0%), and fear/dislike of providers (15.8%) (Figure 70).

Figure 70. Barriers Faced by Union County Survey Respondents when Trying to Access Mental Health or Substance Use Care for Themselves or a Family Member in the Past 2 Years, (n=254), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Responses are only among those who sought mental health services.

There were differences in top challenges for getting mental health and/or substance use services in the 2024 survey by race/ethnicity (Table 16). Counselors or services not accepting new patients was the top reason among Black (36.5%) and White (34.6%) survey respondents, and long wait times for Latino (43.7%) survey respondents. Insurance problems ranked as the second top reason among Latino (35.2%) and Black (34.6%) respondents, while White respondents (29.1%) identified long wait times as the second top reason.

Table 16. Top Five Barriers Faced by Respondents When Getting Mental Health or Substance Use Services and/or Treatment by the Respondent or a Family Member in the Past 2 Years, Union County Residents, by Race/Ethnicity, 2024

	Union County (n=254)	Asian (n=16)	Black (n=52)	Hispanic/ Latino (n=71)	White (n=110)
1	Counselors or services not accepting new patients (32.3%)	*	Counselors or services not accepting new patients (36.5%)	Wait times are too long (43.7%)	Counselors or services not accepting new patients (34.6%)
2	Wait times are too long (31.9%)	*	Insurance problems (34.6%)	Insurance problems (35.2%)	Wait times are too long (29.1%)
3	Insurance problems (28.7%)	*	Cost of care (34.6%)	Cost of care (32.4%)	Insurance problems (25.5%)
4	Cost of care (26.0%)	*	Wait times are too long (28.9%)	Counselors or services not accepting new patients (31.0%)	Cost of care (19.1%)
5	Fear or dislike of providers (15.8%)	*	*	Can't get time off to get care (19.7%)	Fear or dislike of providers (13.6%)

DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data were suppressed due to low numbers.

Environmental Health

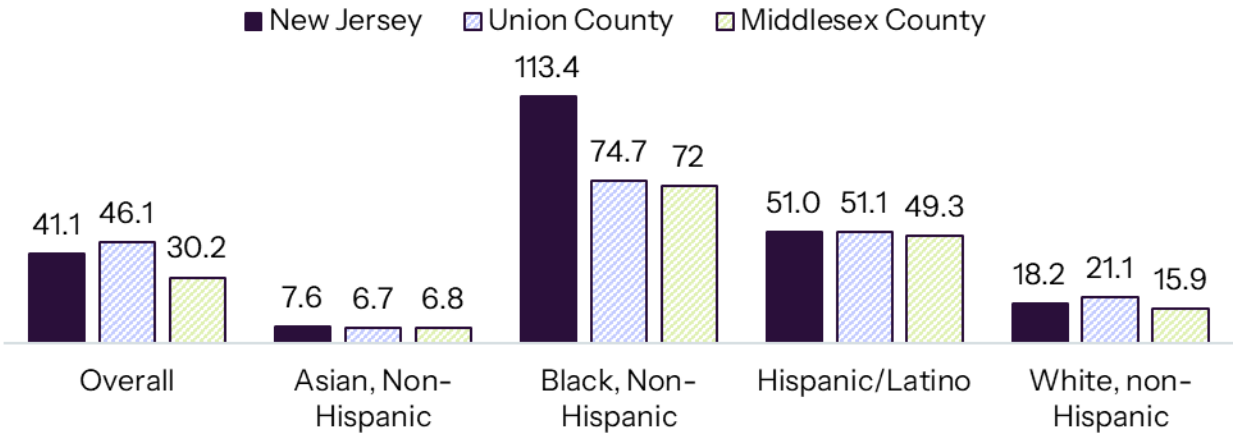
A healthy environment is associated with a high quality of life and good health. Environmental factors are various and far-reaching and include exposure to hazardous substances in the air, water, soil, or food; natural disasters and climate change; and the built environment. This section describes both environmental health factors in the Rahway/Trinitas service area and the prevalence of conditions these factors can trigger.

Asthma

While asthma is a relatively common chronic condition and disproportionately affects communities of color, it was not mentioned in the focus groups and interviews as a top concern. However, one participant noted the existence of the pediatric asthma program as one promising program working to address asthma in the Rahway/Trinitas PSA. Additionally, 13.7% of community health survey respondents ranked asthma as the top concern for children and youth. Asthma was ranked among the top five concerns among children and youth by Asian (16.9%) and Latino (17.7%) respondents. Hospital discharge data shows the age-adjusted asthma emergency department (ED) visit rate per 10,000 population by race/ethnicity in the state overall, in Union County, and in Middlesex County. In 2023, the age-adjusted asthma ED visit rate for Black residents was the highest of all races/ethnicities in Union County, Middlesex County, and the state overall (Figure 71). The age-adjusted asthma ED visit rate was lowest

among Asian residents in both Union and Middlesex County. Figure 116 in the appendix presents additional data on inpatient hospitalizations due to asthma.

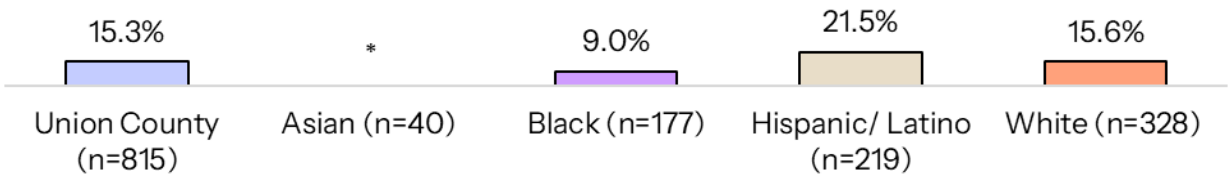
Figure 71. Age-Adjusted Rate of Asthma Emergency Department Visits per 10,000, by Race/Ethnicity, by State and County, 2023



DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024

Community survey respondents were asked if they or a member of their household had ever been told by a healthcare provider that they had asthma. In Union County, 15.3% of respondents reported ever being told by a healthcare provider that they or a household member had asthma (Figure 72).

Figure 72. Percent of Community Health Survey Respondents in Union County Ever Being Told by a Healthcare Provider that They or a Household Member Had Asthma, by Race/Ethnicity, (n=815), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data were suppressed due to low numbers.

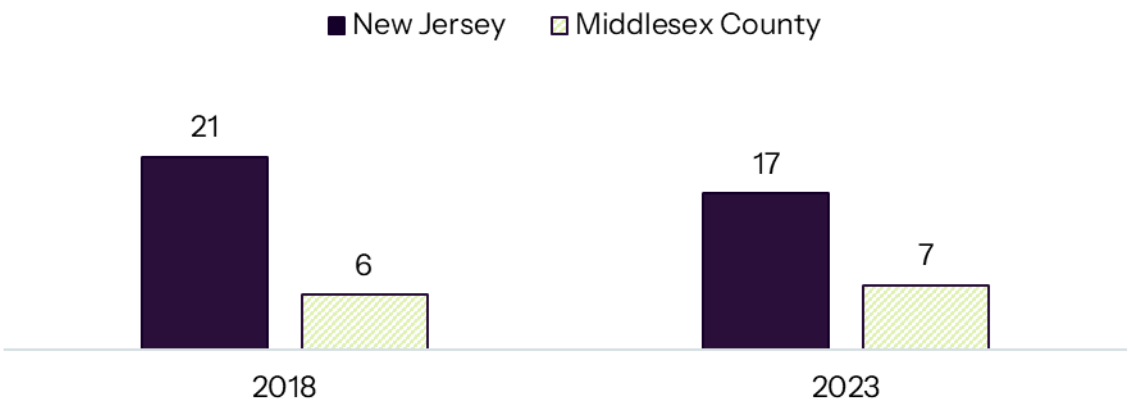
Air Quality

While air quality was not a common theme in qualitative discussions, a participant described poor air quality in Elizabeth, particularly near the Bayway Refinery that disproportionately impacted lower income residents. The participant explained, *"everyone knows that near Bayway [Refinery] it stinks. It's very obvious that the air quality is poor over there…areas in*

Elizabeth that are better off are in the exact opposite side of the refinery and the subsidized housing is right next to it."

In 2023, there were 17 days statewide in New Jersey where ozone in outdoor air exceeded the federal health-based standard for ozone levels (an eight-hour period above 0.070 ppm). Middlesex County had seven days of poor air quality in 2023, compared to 7 in 2018 (Figure 73). Union County levels are not available.

Figure 73. Days with Ozone Levels Exceeding the Federal Standard, by State and County, 2018 and 2023



DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD)
NOTE: The federal health-based standard for ozone in outdoor air is 0.070 parts per million (ppm) averaged over an 8-hour period. Not all New Jersey counties have a monitoring station for ozone. Union County does not have one.

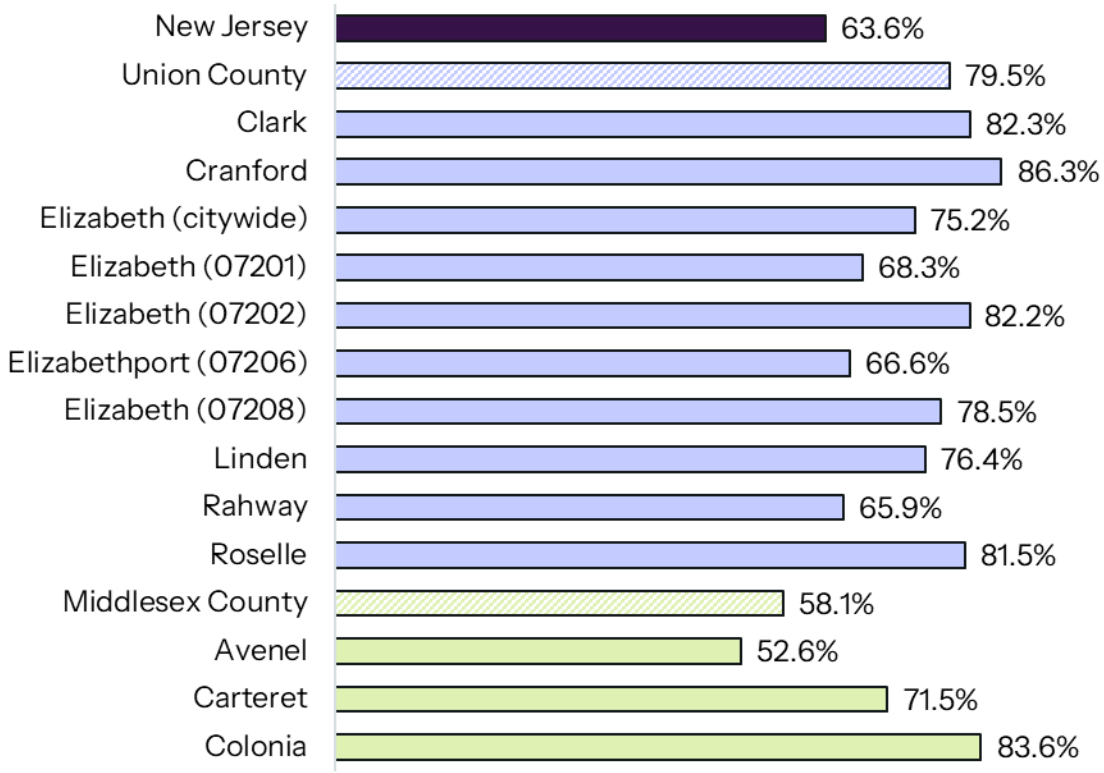
Lead

In 1978, the federal government banned consumer use of lead-based paint. Exposure to lead among young children, through touching lead dust or paint chips for example, can harm children's health, including potential damage to the brain and nervous system, slowed growth and development, and hearing and speech problems. While lead exposure was not a common topic in many interviews and focus groups, a key informant interviewee described how lead monitoring for children remains a Union County priority. They described case management and nurses available specifically to assist with lead exposure.

> *"Lead and childhood lead exposure is a big priority. We have a grant just for that and a nurse that provides case management for children who have high lead levels and helps them through the entire process. We have nurses and inspectors who look for lead dust and we follow that child and help address the exposure."*
> – Key informant interviewee

Figure 74 shows that the majority of housing in the service area was built prior to 1979, and all Union County municipalities had a higher percentage of houses built prior to 1979 than the state (63.6%). The Middlesex service area had varied percentages, with the county rate at 58.1% and municipalities ranging from 52.6% in Avenel to 83.6% in Colonia. Lead contamination in water is of grave concern to children's health. Water violations were reported in Union and Middlesex counties (Table 34 in Appendix E).

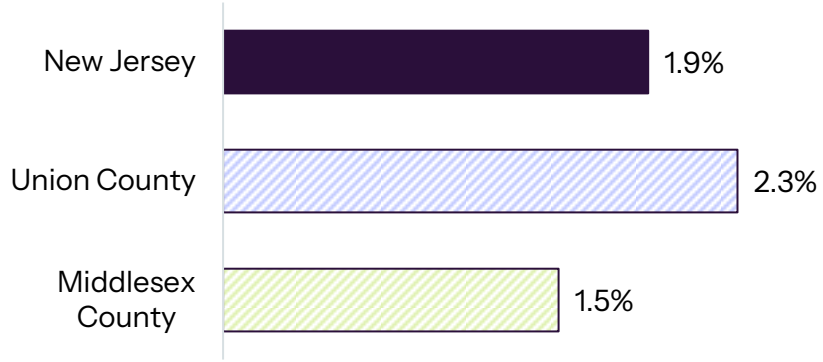
Figure 74. Percent of Houses Built Prior to 1979, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates Subject Tables, 2019-2023

New Jersey Department of Health data from 2022 show that the percentage of children aged 1-5 with elevated blood lead levels was higher in Union County (2.3%) and lower in Middlesex County (1.5%) than in the state overall (1.9%) (Figure 75).

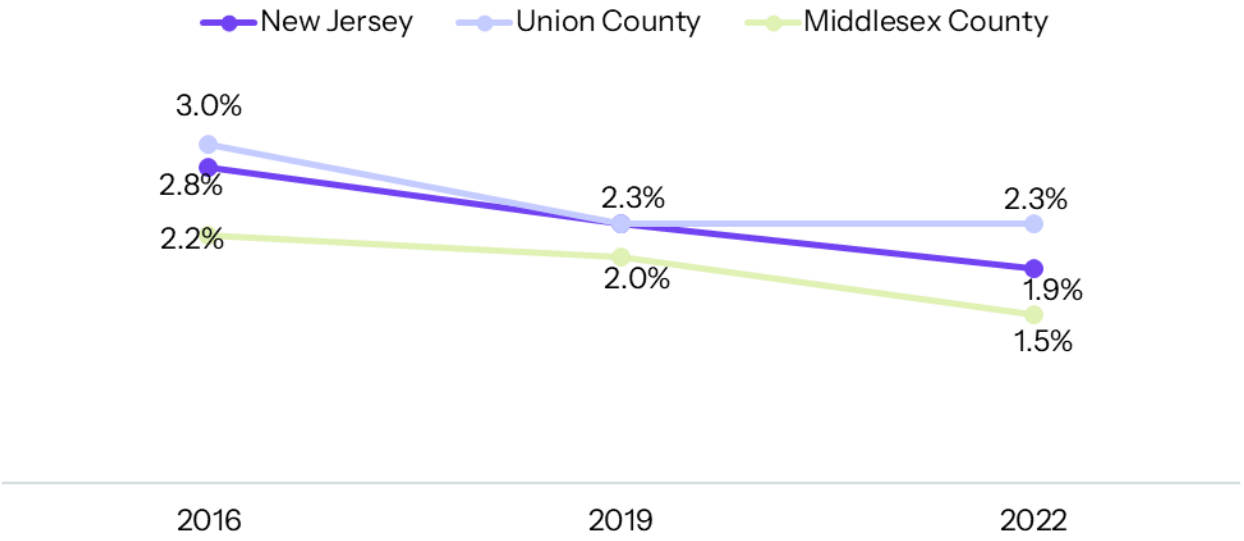
Figure 75. Percentage of Children Aged 1-5 with Elevated Blood Lead Levels, by State and County, 2022



DATA SOURCE: Childhood Lead Exposure in New Jersey Annual Report Department of Public Health, Office of Local Public Health, Childhood Lead Program, State Fiscal Year 2022
NOTE: The state of New Jersey defined elevated blood lead levels in children as at or above 5 µg/dL until 2023, and as at or above 3.5 µg/dL since 2024

Between 2016 and 2022, this percentage has gone down for the state and for both Union and Middlesex counties (Figure 76).

Figure 76. Percentage of Children Aged 1-5 with Elevated Blood Lead Levels, by State and County, 2016-2022



DATA SOURCE: Childhood Lead Exposure in New Jersey Annual Report Department of Public Health, Office of Local Public Health, Childhood Lead Program, State Fiscal Year 2016-2022
NOTE: The state of New Jersey defined elevated blood lead levels in children as at or above 5 µg/dL until 2023, and as at or above 3.5 µg/dL since 2024

Infectious and Communicable Diseases
This section discusses COVID-19 and sexually transmitted infections. Focus group and interview participants noted concerns related to reductions in funding to identify and respond to emerging infectious diseases and outbreaks; provide care for people living with HIV; and unclear vaccination guidance. Participants also reported some infectious disease surveillance data was not available at the local level and an increase in anti-vaccination sentiments and misinformation complicating preventative measures, surveillance, and response to potential outbreaks. A key informant interviewee reported, *"New Jersey as a whole is under the level of herd immunity [for measles] now so particularly for Union County we have been pushing measles campaigns and have maybe seen a bit of an increase in vaccination rates but as a whole there is still some hesitancy."*

Additionally, participants expressed growing concern about tuberculosis in Union County and the county's ability to respond to potential outbreaks particularly with the influx of international travelers anticipated for the upcoming FIFA World Cup games. One participant explained, *"luckily [we have] not seen an increase in tuberculosis cases but [there is] always potential for that when having international travelers so looking ahead to World Cup, we are looking at that."*

COVID-19
In 2025, COVID-19 was no longer a top concern among most participants who were engaged in the assessment process. However, the lasting impacts of the COVID-19 pandemic were discussed in several focus group conversations and interviews. The COVID-19 pandemic has affected all sectors of life and created substantial challenges for many. While participants shared the impact of the pandemic on mental well-being, they also shared how the pandemic was perceived to have raised awareness about mental health and well-being.

Table 17 shows the rate of COVID-19 cases per 100,000 population from 2020 to 2022. COVID-19 rates increased each year from 2020 to 2022 in the state and Middlesex County. Union County had the highest recorded rate out of the three geographies in 2021 (13,413.7 per 100,000) yet was also the only one to have a decrease between these two years.

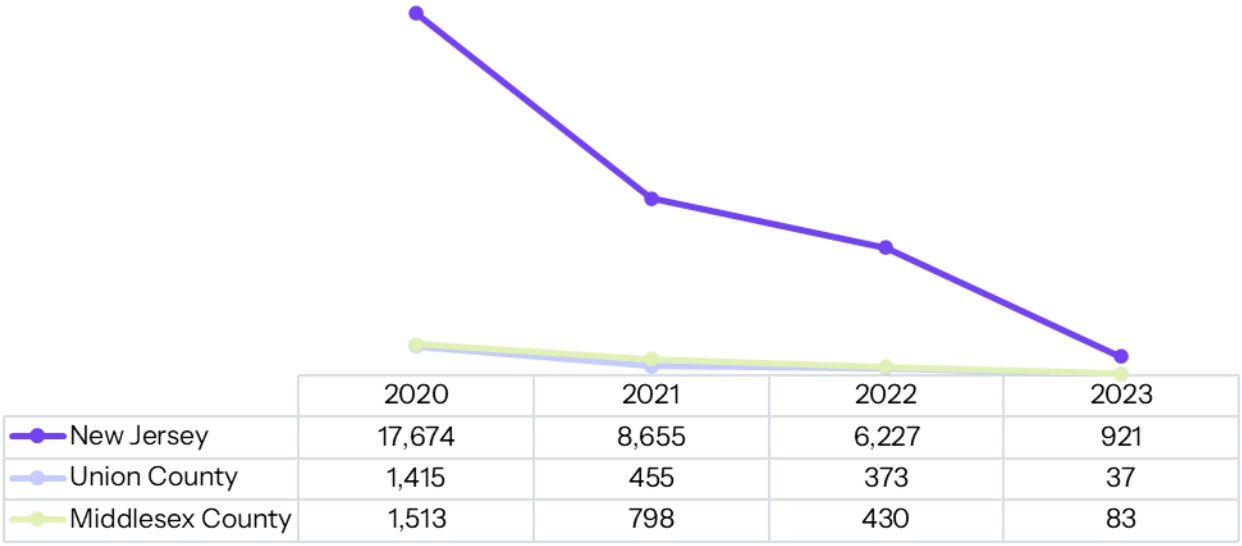
Table 17. Rate of COVID-19 Cases per 100,000, by State and County, 2020-2022

	2020	2021	2022
New Jersey	6,332.8	12,701.0	12,899.6
Union County	7,830.8	13,413.7	12,161.8
Middlesex County	6,189.9	11,913.5	13,008.4

DATA SOURCE: Communicable Disease Reporting and Surveillance System (CRDSS), Communicable Disease Service, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

Despite the increase in most COVID-19 rates over time, the number of COVID-19 deaths has decreased each year between 2020 and 2023 (Figure 77), due to successful vaccination campaigns.

Figure 77. Number of COVID-19 Confirmed Deaths, by State and County, 2020-2023



	2020	2021	2022	2023
New Jersey	17,674	8,655	6,227	921
Union County	1,415	455	373	37
Middlesex County	1,513	798	430	83

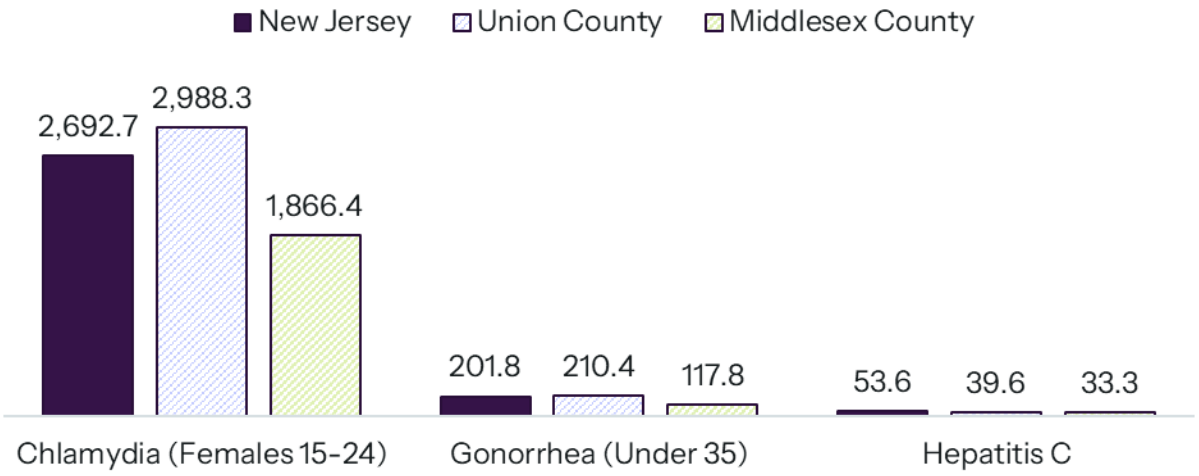
DATA SOURCE: New Jersey Department of Public Health, COVID-19 Dashboard, 2024

Sexual Health and Sexually Transmitted Infections

Sexual health and sexually transmitted infections were not commonly brought up as concerns by focus group and interview participants. However, a healthcare provider also noted a perceived increase in the number of young people between the ages of 17 and 23 who are testing positive for HIV. They stated, *"[we are seeing] a lot of new HIV patients who are between 17 and 23. There is an uptick of HIV among young individuals."*

Sexually transmitted infections are associated with adverse birth outcomes, including preterm birth and low birth weight. Chlamydia was the most common sexually transmitted disease in the state and across the service area, with more cases per 100,000 population in Union County than in the state overall (2,988.3 and 2,692.7 per 100,000, respectively) (Figure 78). More information on sexual health and sexually transmitted infections can be found in Table 35 in the appendix.

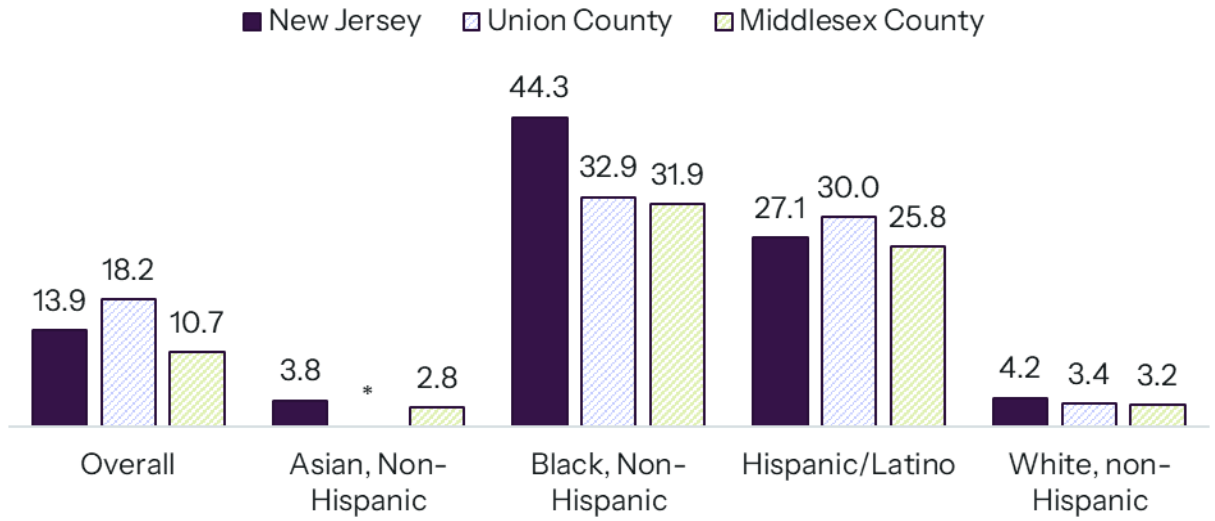
Figure 78. Incidence Rate of Chlamydia (Females Aged 15-24), Gonorrhea (Under Age 35), and Hepatitis C, per 100,000, by State and County, 2019-2023



DATA SOURCE: Communicable Disease Reporting and Surveillance System (CRDSS), Communicable Disease Service, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024

The average 5-year HIV incidence rate was 15.6 per 100,000 Union County residents and 10.7 per 100,000 Middlesex County residents in 2017-2021 (Figure 79). The HIV incidence rates were substantially higher among Black and Latino residents in each county and in the overall state rate.

Figure 79. HIV Incidence Rate per 100,000 Population (Age 13+), by Race/Ethnicity, by State and County, 2017-2021



DATA SOURCE: Enhanced HIV/AIDS Reporting System; Division of HIV/AIDS, STD, and TB Services; New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023
NOTE: Asterisk (*) means that data were suppressed.

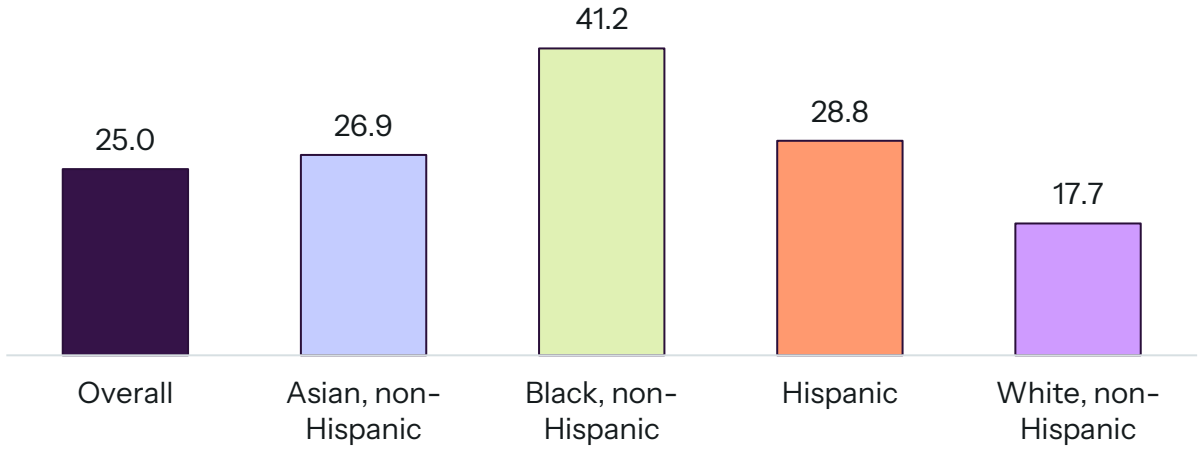
Maternal and Infant Health

The health and well-being of mothers, infants, and children are important indicators of community health. Maternal and infant health was not a prominent topic of discussion in focus groups and interviews, but a community health worker interviewed described a focus on maternal health and the creation of a community health worker specifically focused on maternal and infant health. They reported a perceived drop off in visits after the baby is born, which the maternal health community health worker aimed to address. The participant explained, *"the biggest thing we see is they take care of their needs while pregnant but once the baby is born they stop coming. Our CHWs will help them with follow-up appointments and getting them to the care."* The interviewee also reported an increase in late prenatal care and patients afraid to seek care.

Quantitative data evidence that maternal and infant health were issues of concern in Union County. Teen mothers face higher risks of pregnancy complications, such as eclampsia and systemic infections, than women in their twenties. Teen pregnancy is slightly more prevalent in Union County than in the state overall. According to the Hospital Discharge Data Collection System, in 2023, there were 3.8 births per 1,000 females ages 15-17, higher than 3.2 births per 1,000 females ages 15-17 in New Jersey (Figure 117 in Appendix E: Additional Data Tables and Graphs).

Racial and ethnic disparities exist in maternal and infant health outcomes. Birth data from the NJ Birth Certificate Database showed that Black residents in New Jersey (26.9 per 1,000) experience the highest rates of severe maternal morbidity with transfusion than other race/ethnicities, with White residents experiencing the lowest rates (17.7 per 1,000) (Figure 80).

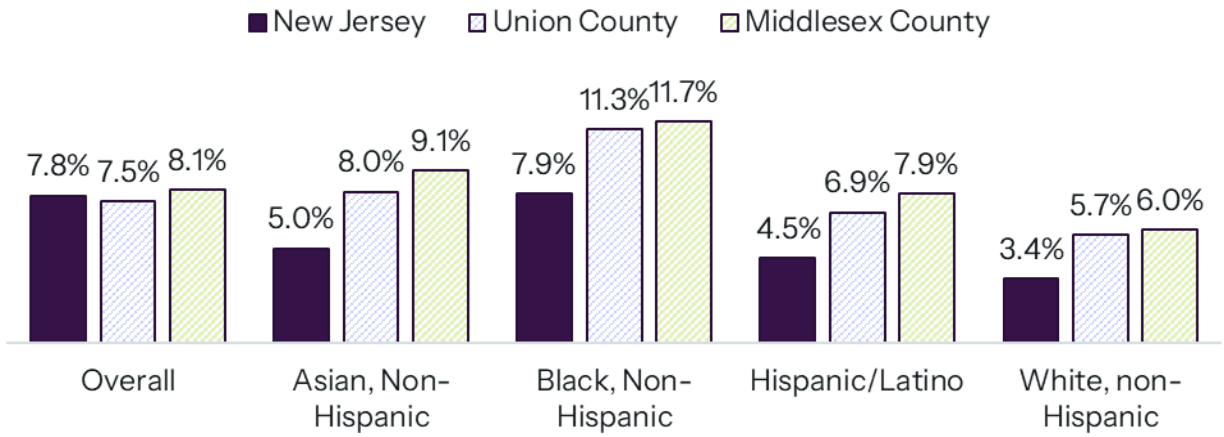
Figure 80. Severe Maternal Morbidity (SMM) with Transfusion per 1,000 Delivery Hospitalizations by Race/Ethnicity, by State, 2023



DATA SOURCE: New Jersey Electronic Birth Certificate Database (EBC), Office of Vital Statistics and Registry, New Jersey Department of Health; New Jersey Hospital Discharge Data Collections System (NJDDCS), Healthcare Quality and Informatics, New Jersey Department of Health, 2024
NOTE: Severe maternal morbidity (SMM) is a composite outcome measure that indicates serious, potentially life-threatening maternal health problems.

Union County (7.5%) had a comparable percentage of low birth weight births compared to the state overall (7.8%). Black (11.3%) and Asian (8.0%) both had higher percentages of low birth weight births compared to both county and state averages (Figure 81). A similar pattern occurred for very low birth weight outcomes (Figure 118) and preterm births (Figure 120 in Appendix E).

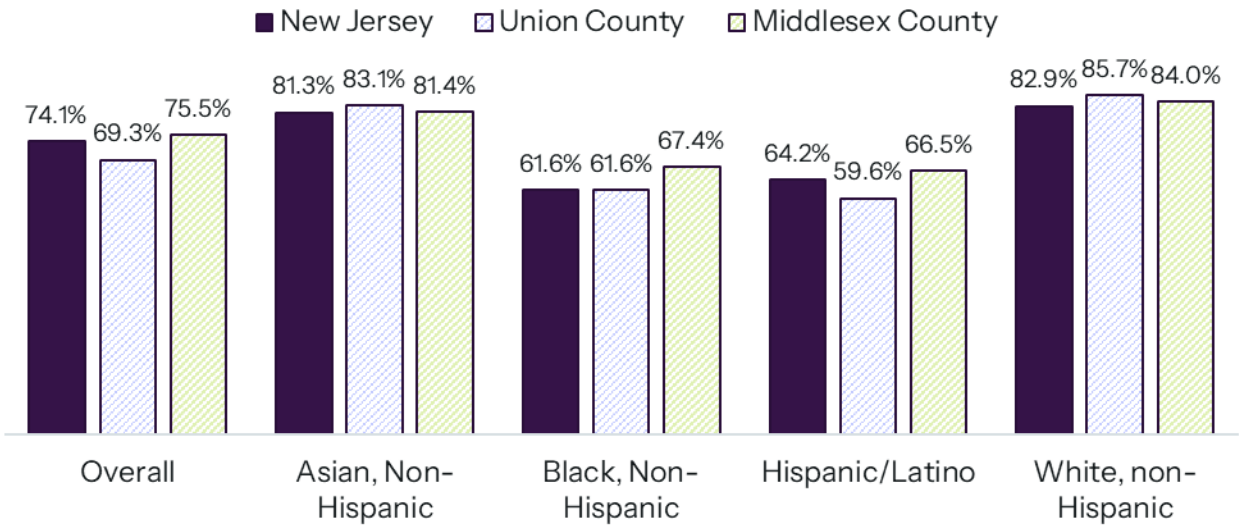
Figure 81. Percent Low Birth Weight Births, by Race/Ethnicity, by State and County, 2018-2022



DATA SOURCE: Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2024
NOTE: Low birth weight is defined as less than 2,500 grams.

Prenatal care is a critical evidence-based strategy to prevent and manage pregnancy complications and reduce poor birth outcomes. The percentage of pregnant women receiving prenatal care in the first trimester was lower in Union County (69.3%) and higher in Middlesex County (75.5%) than in New Jersey overall (74.1%). There were stark differences by race/ethnicity, with Black and Latina pregnant women reporting the lowest percentages of prenatal care in the first trimester in Union County, Middlesex County, and the state overall (Figure 82).

Figure 82. Percent of Live Births to Women Who Had Prenatal Care in the First Trimester, by Race/Ethnicity, by State and County, 2018-2022



DATA SOURCE: Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2024

In 2024, Community Health Needs Assessment Survey respondents were asked about their participation in parenting classes over the past two years. Overall, 7.8% of Union County respondents reported attending parenting classes.

Healthcare Access

This section discusses the use of healthcare and other services, barriers to accessing these services, and the health professional landscape in the region. Access to healthcare services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death.

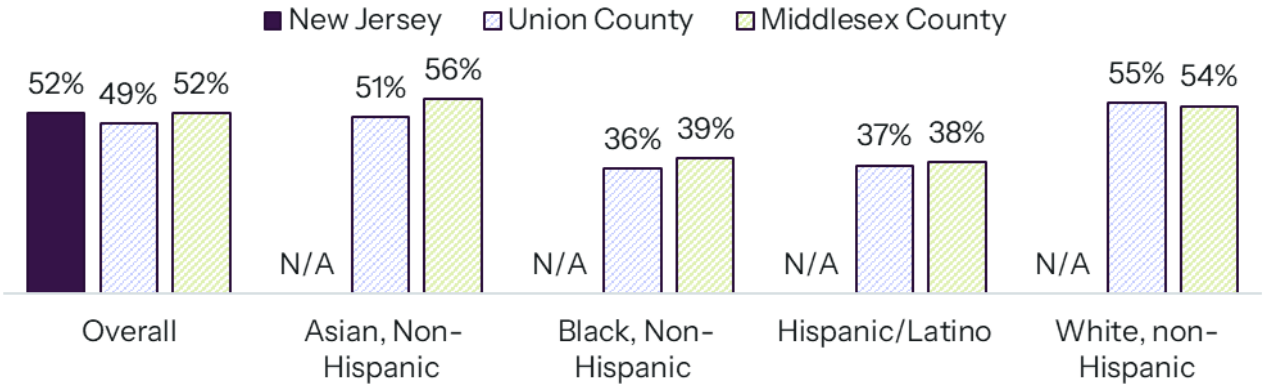
Access and Utilization of Healthcare Services

Access to services was a prominent theme in interviews and focus group discussions. Several participants mentioned that the county's agencies and service providers are very collaborative which makes attaining services easier. One participant stated, *"there is a strong connection between different organizations maybe because of how long they have been around but if you go to one organization they know by name the other organizations and the leaders. There is a lot of work being done to create one stop shops."* Additionally, focus group and interview participants discussed how trusted navigators, advocates, and providers work to improve awareness of and connection to existing services within the county. One participant said, *"[we want to increase] accessibility for low-income individuals to navigate their needs. We have*

services in our community as well, not only inside the hospital." Participants in qualitative discussions also identified the important role community health workers, mobile clinics, transportations assistance, and free health screenings and education play in improving access to services in Union County.

49% of Union County and 52% of Middlesex County residents enrolled in fee-for-service Medicare were vaccinated annually against the flu. Vaccination rates differed across race/ethnicity with Asian and White residents in both Union and Middlesex County being vaccinated at the highest percentages compared to Latino and Black residents (Figure 83).

Figure 83. Percentage of Fee-for-Service (FFS) Medicare Enrollees that Had an Annual Flu Vaccination, by Race/Ethnicity, by State and County, 2021



DATA SOURCE: Mapping Medicare Disparities Tool as cited in County Health Rankings 2023
NOTE: Racial stratifications not available at the state level.

Community survey respondents were asked what their top five sources of health information were. The top five sources of health information for Union County survey respondents overall were healthcare providers (80.7%), online resources (40.2%), family member (21.8%), urgent care (22.7%), and friends (17.4%) (Table 18). The two three sources of health information were consistent across race/ethnicity.

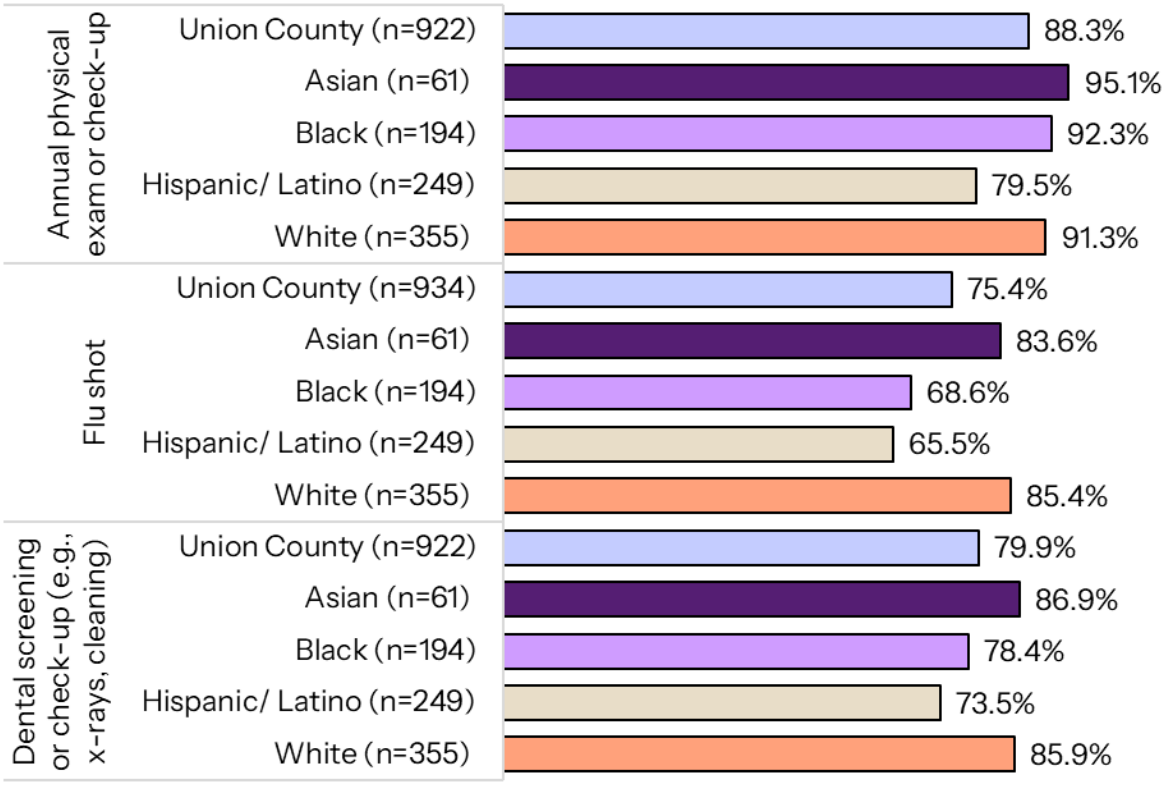
Table 18. Top 5 Sources of Health Information among Union County Survey Respondents, by Race/Ethnicity, 2024

	Union County (n=836)	Asian (n=59)	Black (n=176)	Hispanic/ Latino (n=214)	White (n=337)
1	Health care provider (80.7%)	Health care provider (89.8%)	Health care provider (84.1%)	Health care provider (66.4%)	Health care provider (86.7%)
2	Online resources (40.2%)	Online resources (42.4%)	Online resources (31.8%)	Online resources (34.6%)	Online resources (51.0%)
3	Family member (21.8%)	Family member (23.7%)	Family member (26.7%)	Hospital emergency department (21.5%)	Family member (24.6%)
4	Urgent care (20.8%)	Hospital emergency department (18.6%)	Urgent care (25.0%)	Family member (16.4%)	Urgent care (22.6%)
5	Hospital emergency department (19.4%)	Friends (17.0%)	Hospital emergency department (22.7%)	Urgent care (14.5%)	Friends (17.8%)

DATA SOURCE: Community Health Needs Assessment Survey, 2024

Respondents to the 2024 community survey were asked about their participation in various health screenings and preventive services in the last two years. Overall, 88.3% of survey respondents in the Union County service area reported having an annual physical exam in the last two years, while 75.4% reported having a flu shot, and 79.9% received dental screening (Figure 84). Latino respondents reported the lowest percentage of participation in screenings with 79.5%, 65.5%, and 73.5% of respondents reporting having a physical exam, receiving a flu shot, and receiving a dental screening, respectively in the last two years.

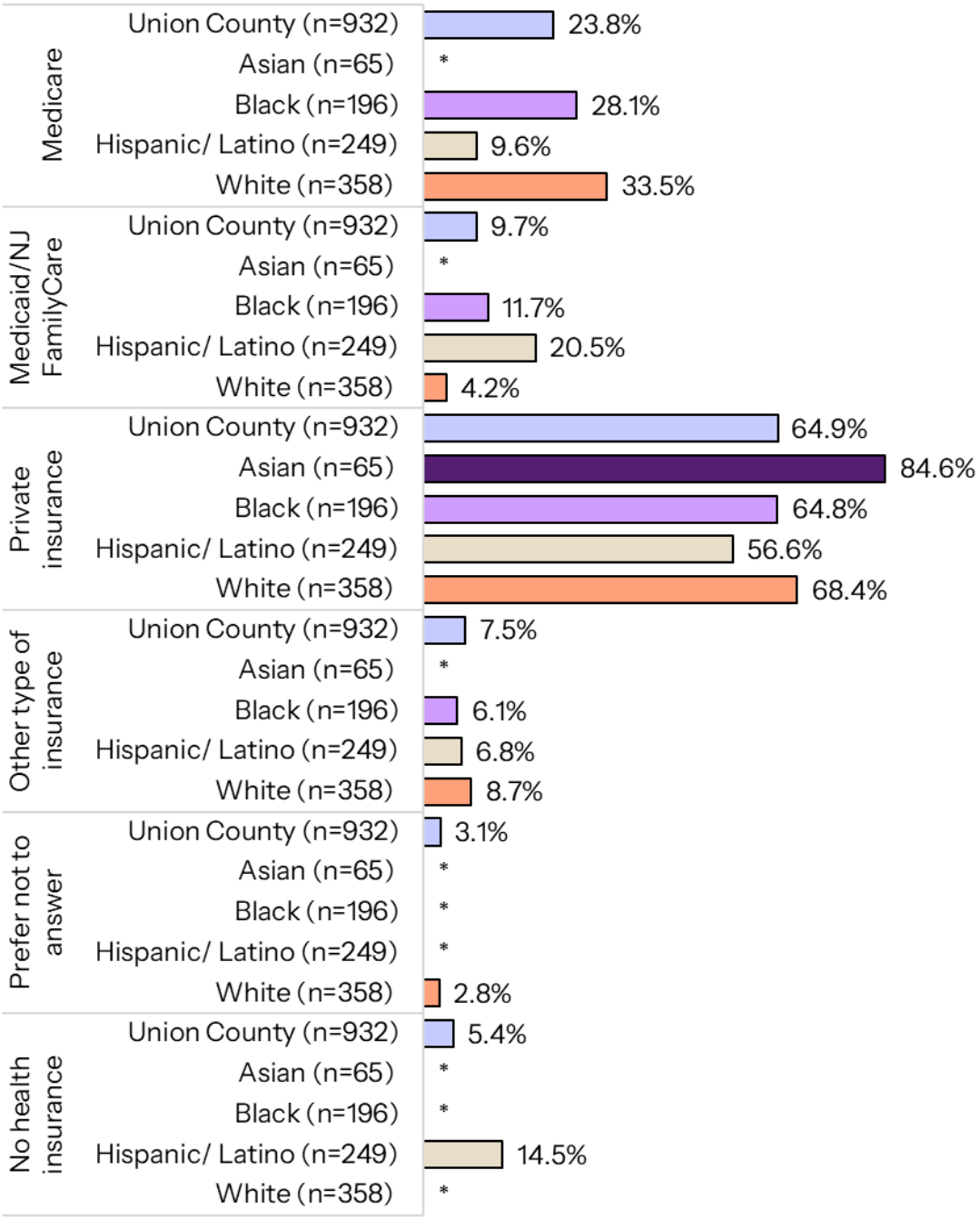
Figure 84. Participation in Selected Preventive Services in the Past 2 Years, Union Survey County Respondents, by Race/Ethnicity, 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024

Community survey respondents were asked about their health insurance coverage. Overall, 23.8% of survey respondents in the Union County service area reported having Medicare, 9.7% reported having Medicaid/NJ FamilyCare, 64.9% reported having private insurance, and 7.5% reported having some other type of insurance (Figure 85).

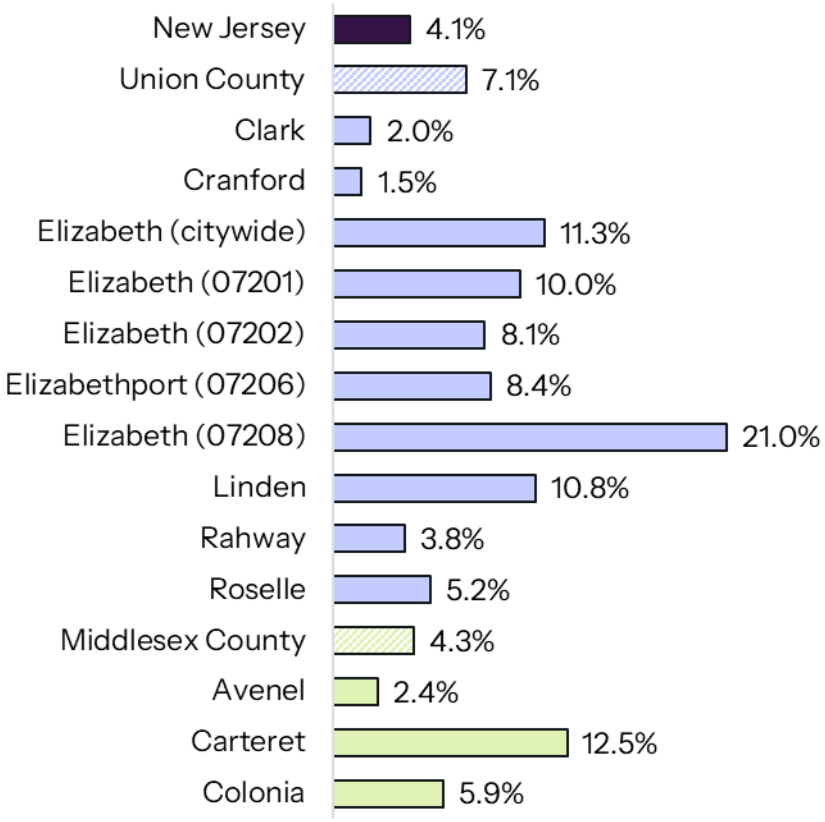
Figure 85. Type of Health Insurance, Union County Survey Respondents, by Race/Ethnicity, 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data are suppressed.

U.S. Census data show the percentage of uninsured population from 2019-2023. Overall, both Union and Middlesex County (7.1% and 4.3%, respectively) have a higher percentage of uninsured population than New Jersey (4.1%). Differences exist across towns in Union and Middlesex County, with the highest municipalities being Elizabeth 07208 (21.0% population uninsured) and Carteret (12.5% of population uninsured) (Figure 86). More information on health insurance rates and uninsured populations can be found in Figure 122 and Table 37 in Appendix E.

Figure 86. Percent Uninsured, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023

Barriers to Healthcare Access

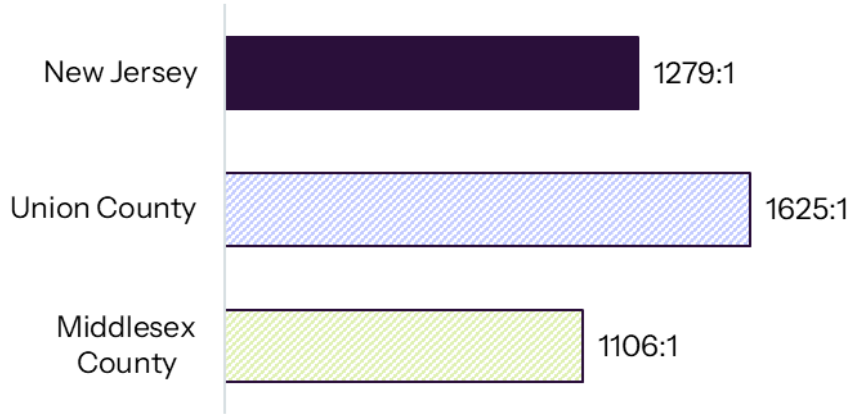
Interview and focus group participants shared that Union County residents faced barriers to accessing healthcare. Challenges such as cost, lack of specialty and mental health providers, lack of insurance, language and transportation barriers, lack of culturally competent care, fear and mistrust, a lack of knowledge and education, and stigma or bias were among the main barriers identified. A focus group participant describing the lack of healthcare providers stated there was a *"massive shortage of providers in the healthcare system across the board. [It is] alarming of where we are in the healthcare system."* Another focus group participant described an increasing hesitancy and fear leading to a decrease in certain communities seeking services.

They described, *"many families come into the country and are hesitant to seek out the services we can provide due to fear of what is happening in society and now more than ever."*

Additionally, interview and focus group participants perceived a lack of services for men overall as well as a lack of men attending health fairs and participating in preventative screening. A key informant interviewee described, *"most places don't address men's needs no matter where you go on a consistent basis."* A focus group participant described a lack of preventative health screening and preventative health measures in men by stating, *"for prostate cancer, there is a stigma around going back and forth to doctor and especially for prostate cancer and the tests you have to go through. I know several men who have died from prostate cancer and the lack of prevention of the disease."*

Data from the 2024 County Health Rankings show the ratio of population to primary care providers in 2021. Union County has a larger ratio at 1625:1 compared to New Jersey overall with 1279:1 (Figure 87) indicating a relative lack of primary care providers compared to the state average. Middlesex County has the lowest ratio compared to the state and Union County at 1106:1. Figure 123 in Appendix E provides a ratio of population to mental health provider by state and county in 2022.

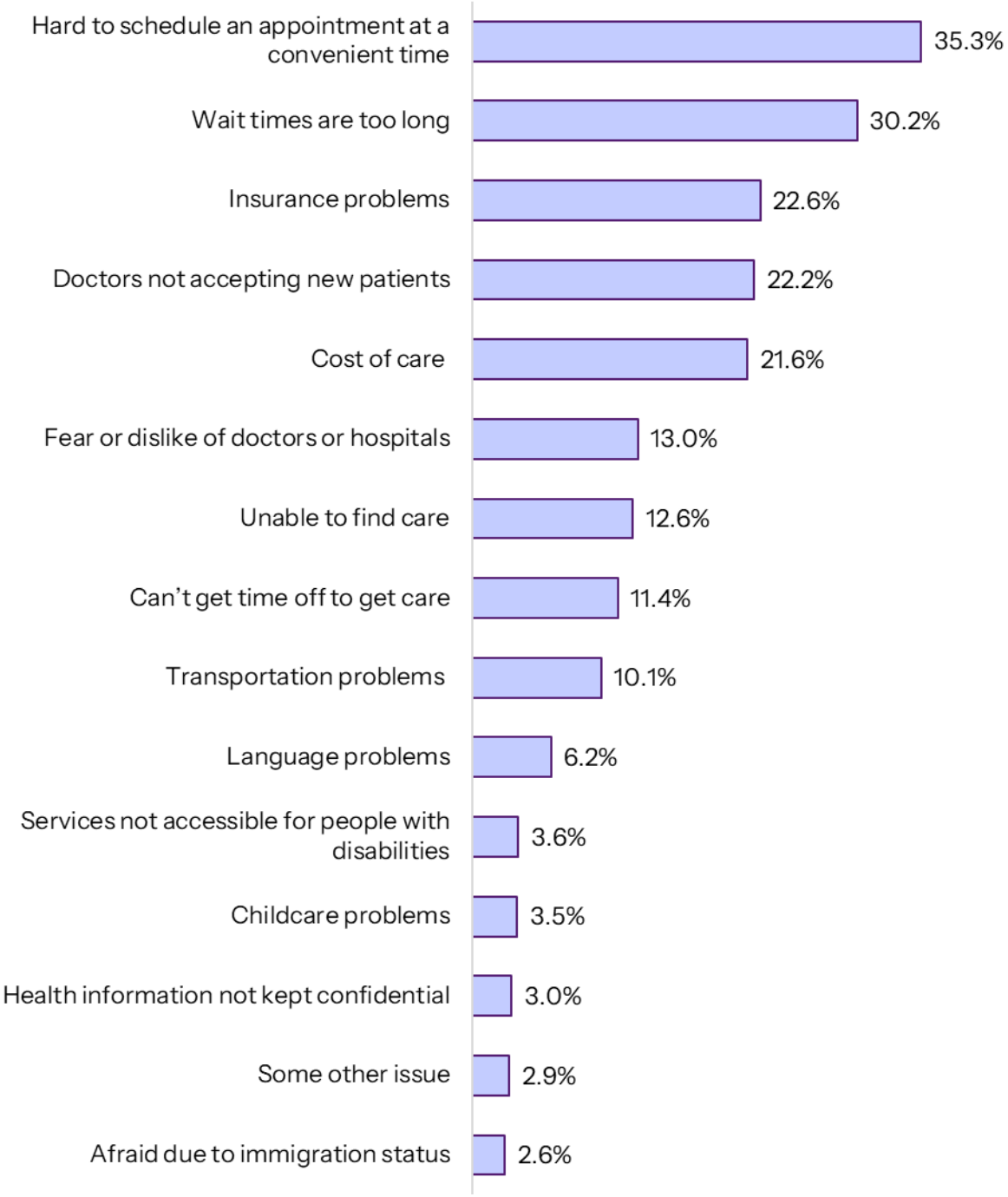
Figure 87. Ratio of Population to Primary Care Provider, by State and County, 2021



DATA SOURCE: Area Health Resource File/National Provider Identifier Downloadable File as cited by County Health Rankings, 2024

Community survey respondents were asked to identify the issues that made it harder for them or a family member to get medical care or treatment when needed. The full list of barriers is graphed below (Figure 88). The top issues survey respondents identified overall were inability to schedule an appointment at a convenient time (35.3%), long wait times (30.2%), insurance problems (22.6%), doctors not accepting new patients (22.2%), and cost of care (21.6%).

Figure 88. Health Care Access Barriers Reported by Community Health Survey Respondents in Union County, by Race/Ethnicity, (n=860), 2024



DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Responses are only among survey respondents who reported seeking specialty care.

Table 19 below presents the top five challenges by racial/ethnic groups. Latino and White respondents had named their top barrier as the difficulty of scheduling an appointment at a convenient time, while Asian respondents named long wait times (35.5%) and Black respondents named cost of care (30.9%)

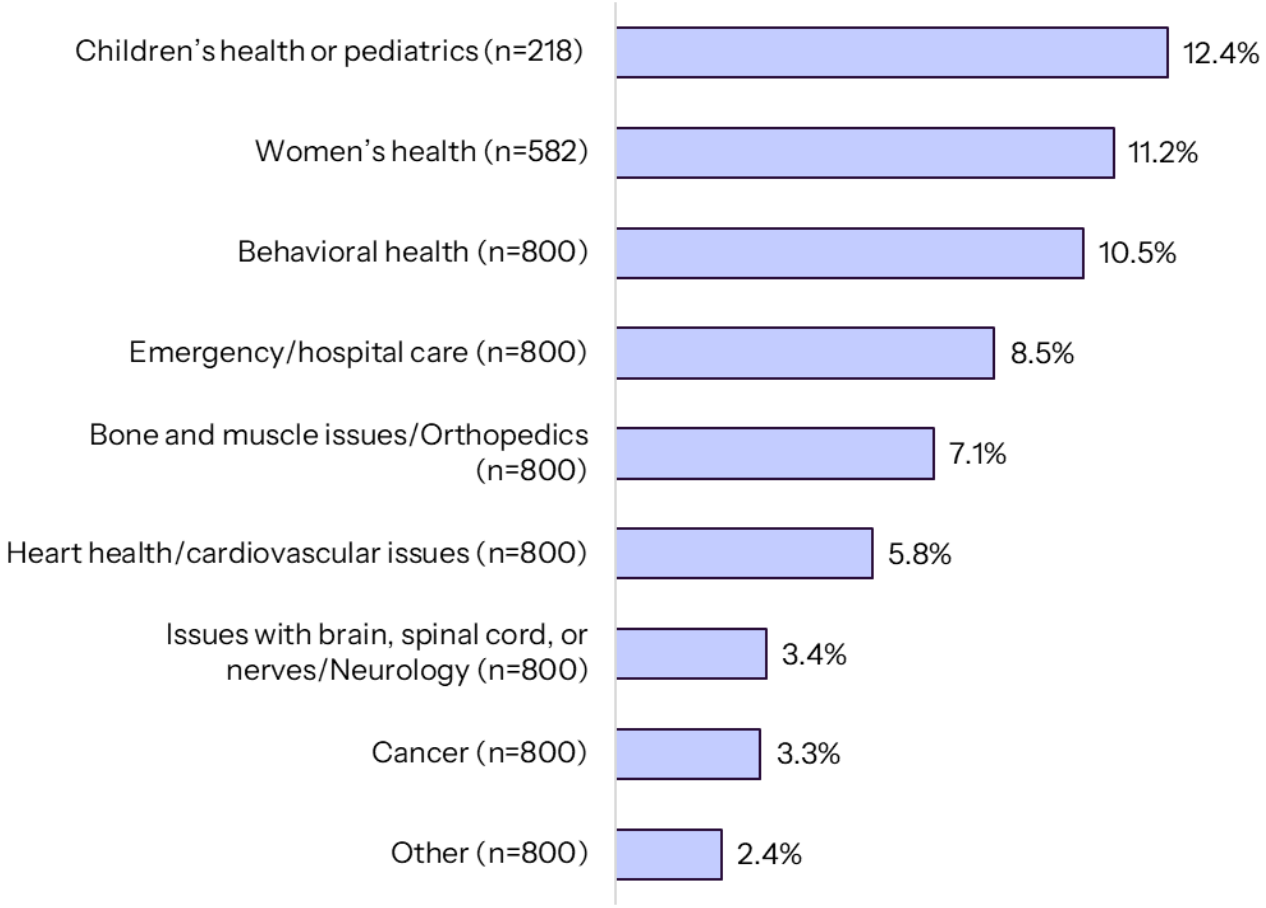
Table 19. Top 5 Health Care Access Barriers, Union County Survey Respondents, by Race/Ethnicity, 2024

	Union County (n=860)	Asian (n=62)	Black (n=188)	Hispanic/ Latino (n=221)	White (n=342)
1	Hard to schedule an appointment at a convenient time (35.3%)	Wait times are too long (35.5%)	Cost of care (30.9%)	Hard to schedule an appointment at a convenient time (40.3%)	Hard to schedule an appointment at a convenient time (37.4%)
2	Wait times are too long (30.2%)	Hard to schedule an appointment at a convenient time (32.3%)	Wait times are too long (29.8%)	Wait times are too long (37.6%)	Wait times are too long (26.6%)
3	Insurance problems (22.6%)	Insurance problems (19.4%)	Hard to schedule an appointment at a convenient time (29.8%)	Insurance problems (29.9%)	Doctors not accepting new patients (25.4%)
4	Doctors not accepting new patients (22.2%)	*	Insurance problems (22.9%)	Cost of care (28.1%)	Insurance problems (20.2%)
5	Cost of care (21.6%)	*	Doctors not accepting new patients (20.7%)	Doctors not accepting new patients (23.1%)	Cost of care (13.2%)

DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Asterisk (*) means that data were suppressed due to low numbers.

Below is the percentage of community survey respondents from Union County who reported needing specialist care and not being able to access such care, by type of care (Figure 89). The greatest proportion of respondents facing difficulties in accessing care were for those needing pediatric care (12.4%), women's health care (11.2%), and behavioral health care (10.5%).

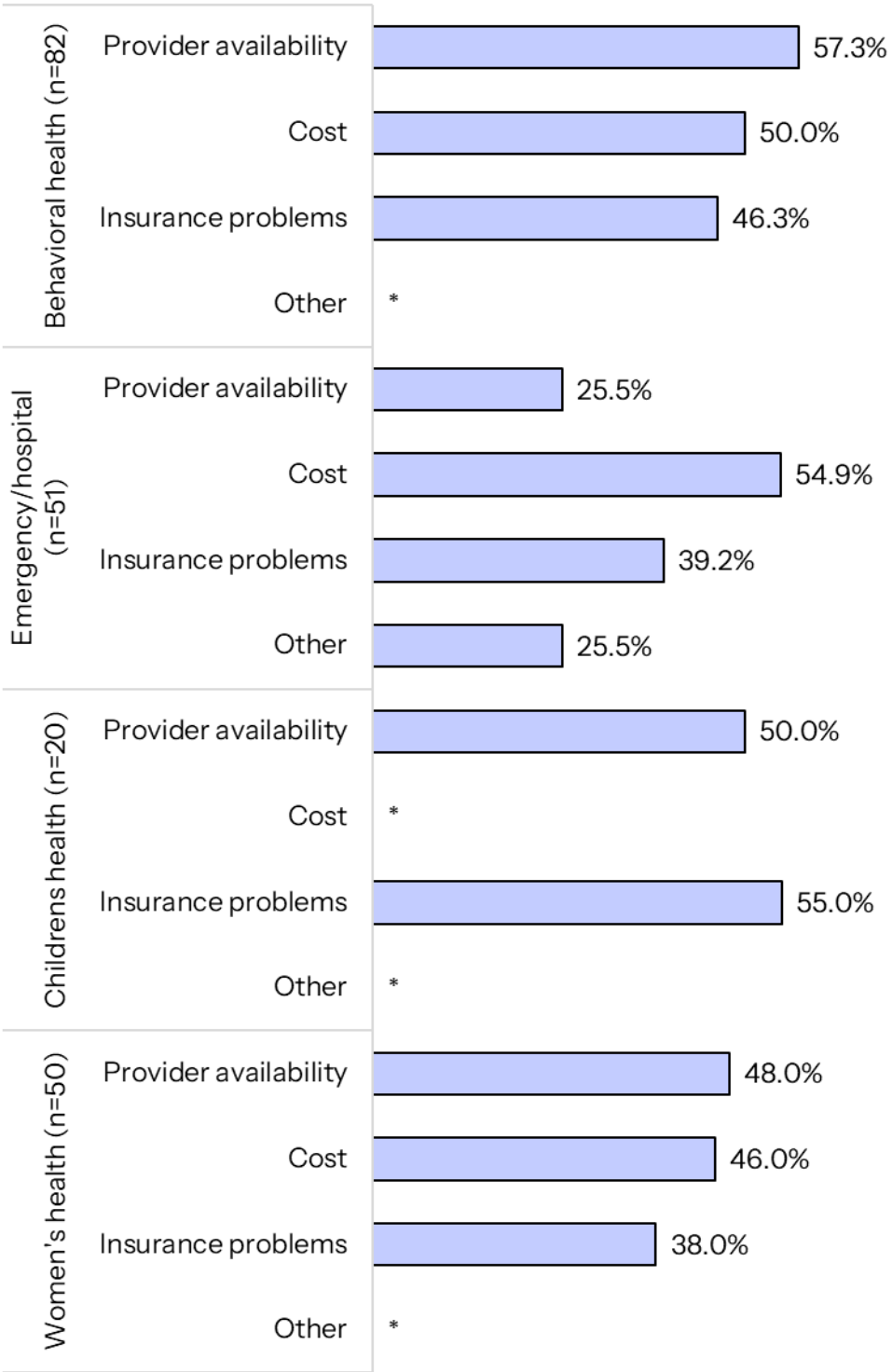
Figure 89. Percent of Community Survey Respondents in Union County Who Reported Needing Specialist Care and Not Being Able to Go, by Type of Care Needed, 2024

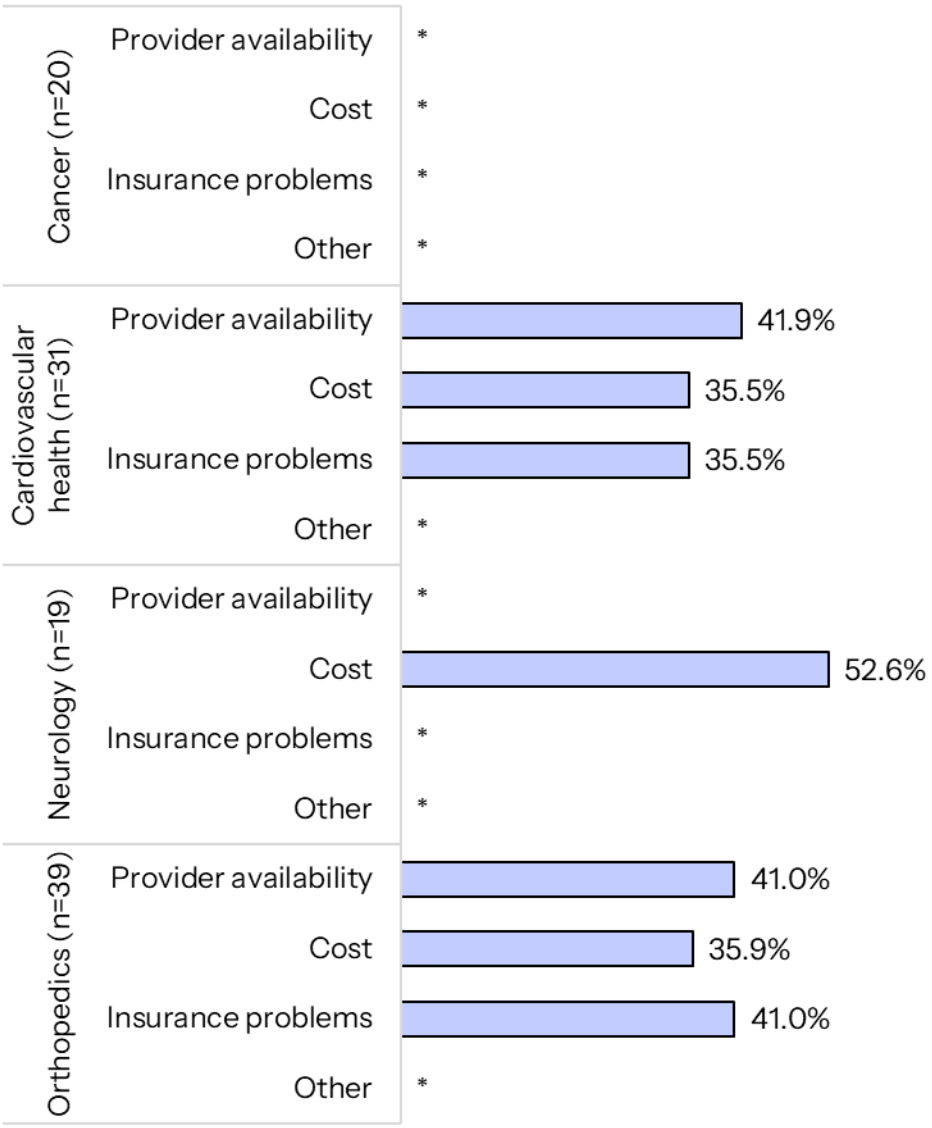


DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Responses are only among survey respondents who reported needing specialty care. Percentages are calculated for "Children's health or pediatrics" only among respondents reporting having any children under age 18. Percentages are calculated for "Women's health" only among those assigned female at birth.

The largest barrier to seeking care for behavioral health (57.3%), women's health (48.0%), and cardiovascular health (41.9%) was provider availability (Figure 90). Cost was the highest barrier to emergency/hospital care (54.9%) and neurological care (52.6%). Insurance problems were the highest barrier to children's health care (55.0%) (Figure 90).

Figure 90. Factors Preventing Community Survey Respondents from Obtaining Specialist Care, Union County Survey Respondents, by Provider Type, 2024





DATA SOURCE: Community Health Needs Assessment Survey, 2024
NOTE: Percentages are calculated for "Children's health or pediatrics" only among respondents reporting having any children under age 18. Percentages are calculated for "Women's health" only among those assigned female at birth. Asterisk (*) means that data were suppressed due to low numbers.

Access to healthcare was identified as a priority area for the prior RWJUH Rahway and TRMC CHNA. Over the last three years the facilities have engaged in and implemented multiple initiatives and partnerships to address these concerns. For example, TRMC conducted education in the community around primary and preventive care to improve health literacy and access to screenings. Education programs were conducted in English, Spanish, and Haitian Creole. RWJUH Rahway developed and enhanced partnerships with local social service organizations to support individuals transitioning from the hospital back to the community and increased chronic disease screenings. Additional information can be found in Appendix H.

Community Vision and Suggestions for the Future

Focus group and interview participants were asked for their suggestions for addressing community needs and their vision for the future of their communities. Community participants included organizational leaders from different health and social service sectors (e.g., housing, community health workers, women's health), mental and behavioral health providers, health officers and administrators, and Rahway/Trinitas PSA residents at large belonging to specific population groups, including Black men. The following section summarizes the assessment participants' recommendations for future consideration.

Improved access to healthcare in the service area. Community participants identified the need for improved access to healthcare providers and facilities in the Rahway/Trinitas PSA. Community survey respondents identified difficulties scheduling appointments and long wait times as two key barriers to accessing care and services in Union County (Table 19). This was supported by quantitative data showing the ratio of primary care providers to residents in Union County being worse than New Jersey overall (Figure 87). Additionally, focus group and interview participants identified a shortage of healthcare providers and expressed a desire for more healthcare facilities and mobile outreach to improve access to care. Focus group and interview participants also advocated for more mental and behavioral health resources available in the service area. A focus group participant explained, *"for me resources for those who are experiencing mental health issue is the biggest thing I would like to see more of in the future."*

Stable funding and funding structure for healthcare, social services, and community-based organizations. Assessment participants reported a challenging funding landscape impacting the ability of social services and community organizations to remain viable community options. Participants described the need for more stable funding infrastructure in the community, local public health, healthcare, and shelters as areas for improvement in the future. Funding was described by participants as a primary barrier preventing community-based organizations from being able to provide more services to the community. A focus group participant explained, *"the uncertainty in the funding sources and that affects our healthcare facilities ability to do outreach and maintain the programs [we offer]."*

Expansion of affordable housing. Another vision for the future among participants was expanding affordable housing. Housing was identified as a concern among community survey respondents with 19.5% of Union County residents worried about their housing stability in the next two months (Figure 21). These concerns were greater among Latino and Black respondents, with 31.1% and 23.2%, respectively, worried about their housing stability in the next two months. Focus group and interview participants also identified the need to address the housing crisis when asked about their vision for the future. Participants explained the need for more affordable housing units and a need for more policies to assist with housing, such as rent control. A key informant interviewee explained, *"expanding affordable housing is critical and*

difficult. A lot of houses are privately-owned and I heard a patient say she was on month to month lease and every two months the landlord raised the rent to try to get her to leave."

Address food insecurity and access to healthy food. Addressing food insecurity and access to healthy food was another vision for the future. Nearly 1 in 3 (30.4%) Union County community survey respondents reported that they worried that their food would run out before they got money to buy more (Figure 18). These concerns were greater among Latino (56.4%) and Black (38.8%) respondents. Community survey respondents also named the price of healthy foods (36.1%) as one of the top five reasons that keeps them from eating healthy foods (Table 8). A focus group participant described, *"I'd like to see more done to address food deserts, and when they do have food, quality food, not processed foods…put those Shop Rites in these underserved communities as opposed to there just being a bodega in these communities so that people have reasonably priced healthy food, because the food is more expensive and worse in these neighborhoods."*

More after school and mentorship programs for youth and young adults. Participants in focus group and interview discussions identified a need for more after school and mentorship programs for youth and young adults in the Rahway/Trinitas PSA. Participants explained that existing programs often end early, leaving youth with nothing to do after they close. A focus group participant described, *"we don't have enough [programs] for the 14-18 age group within that junior high/high school demographic. These youth don't have anything to do after 7/8pm when some of the rec centers are winding down."* Participants also expressed a desire for more mentorship opportunities and programs aimed at engaging youth and young adults in deeper and more meaningful ways. A focus group participant explained, *"a lot of times in the work I do with young people, especially young people who are going through the system or who may or may not have a father figure, is they all say they don't have one person in their life who cared about them. When thinking about mentorship, it needs to be something genuine, consistent, and that connects at the basic level with young people. We have these social programs that can do a lot of things but not provide the meaningful connections that people are looking for."*

Key Themes and Conclusions

Through a review of the secondary social, economic, and epidemiological data; a community survey; and discussions with community residents and stakeholders, this assessment examined the current health status of residents in the service area. Several key themes emerged from this synthesis:

Communities in the service area are diverse, and health disparities exist. The communities served vary in terms of their demographic composition, income levels, and health status. Union and Middlesex counties are racially and ethnically diverse, with many residents who speak a language other than English at home. Data show health disparities between subpopulations. Black residents experienced higher rates of asthma-related hospital admissions, low birth weight births, and cancer mortality than other racial/ethnic groups. Proportionally fewer Latino community health survey respondents had had preventive screenings and annual physical exams in the last two years compared to respondents of other racial/ethnic groups; they also experienced more barriers to accessing healthcare than other groups. A greater percentage of Black and Latino respondents reported feeling discriminated against when receiving medical care and experiencing food insecurity compared to other respondents.

Affordable housing and food access were top community concerns. Housing challenges in the Rahway/Trinitas PSA were a frequent theme in interview and focus group participants. Lack of quality affordable housing was identified as a key gap in the county by community survey respondents. Residents in many communities spent 30% or more of their income on housing. Participants saw a need for prioritization and expansion of affordable housing. Participants indicated that food security concerns have grown in recent months. Just under a third of community survey respondents reported worried that their food would run out.

Employment and financial security affected the well-being of many residents. Rising costs of living threatened residents' financial security. Participants noted that there were limited well-paid employment opportunities, with benefits, fixed income, and livable wages particularly for immigrants, Black residents, and young people. In Union County, the highest unemployment rates were among people of color, with 8.2% of Black residents and 7.2% of Latino residents, being unemployed compared to 3.7% of Asian and 4.8% of White residents. Additionally, there were multiple municipalities in the service area with more than 25% of households living below the ALICE threshold.

Behavioral health continues to be a significant concern in the Rahway/Trinitas PSA. Mental health was identified as a community concern in many interviews and focus groups. Community survey respondents rated mental health as the fifth top health concern for adults and the top health concern for youth in 2024. Participants identified anxiety, depression, PTSD, and suicidality as key mental health challenges for community residents and noted that these all have been exacerbated due to financial stress, fear, isolation and loneliness. The mental health of young people and older adults was of particular concern. Participants expressed that many older adults have struggled with isolation and depression since the pandemic, while indicating an uptick in suicidality among youth and young adults presenting to healthcare providers.

Another community of concern were immigrant populations in the county. Participants noted that some immigrant groups had high levels of trauma due to past experiences and trauma has been exacerbated by current attacks on some immigrant communities. Difficulty accessing mental health services was a theme in focus group and interview conversations, with more provider availability and services in languages other than English needed. While substance use was identified less often, use of substances is closely correlated with mental health issues, and the need for more wound care associated with substance use was noted as a growing concern. Participants suggested that addressing mental health and substance misuse concerns should be a priority over the next few years. Ensuring trauma-informed care is implemented in medical facilities and schools was identified as a goal for addressing mental and behavioral health in the county.

Chronic diseases were identified as prevalent. Heart disease and cancer were among the three leading causes of death in Union and Middlesex counties. Black residents experienced higher cardiovascular disease and cancer mortality than other groups. Disparities were also seen in diabetes and other chronic illnesses. Participants noted in the county noted that chronic diseases were linked to the social determinants of health, such as an unhealthy diet, unstable housing, unsafe/polluted neighborhoods, lack of leisure time, and exacerbated by the rising cost of living.

Infectious and communicable diseases were mentioned in the context of shifting vaccination acceptance and guidance. While COVID-19 mortality decreased dramatically in the service area following vaccination campaigns, interview and focus group participants identified increased misinformation and anti-vaccination sentiment among community members as a concern. Participants reported shifting guidance coupled with changes to funding streams as barriers to monitoring infectious and communicable diseases. Additionally, participants noted the need for increased surveillance due to the anticipated influx of international travelers for the upcoming World Cup event. A need to address stigma, mistrust, and misinformation in the healthcare system among some communities was identified as a strategy to address this gap.

While progress has been made toward improving environmental health conditions, disparities still exist. Assessment participants reported addressing lead and childhood lead exposure was a main priority for the service area and named the existence of specialized nurses and inspectors whose focus is reducing lead exposure as a key asset. Quantitative data show the percentage of children with elevated blood lead levels has decreased from 3.0% in 2016 to 2.3% in 2019 and remained consistent in Union County from 2019 to 2022. However, participants noted there was worse air quality and increased pollution in communities with subsidized housing.

Access to healthcare was a prominent theme in discussions with interview and focus group participants. Interview and focus group participants and community survey respondents described various healthcare barriers such as cost and insurance challenges, insufficient specialty care providers, distance to care and transportation challenges, stigma and discrimination, fear and mistrust, and a lack of knowledge and information, among others. Participants reported additional barriers for residents with limited English proficiency when

accessing care, particularly when seeking mental health resources in languages other than English.

Conclusions

Based on responses gathered from key informant interviews, focus group participants, and community survey respondents, as well as social, economic, and health data from surveillance systems, ten major initial issue areas were identified for the RWJUH Rahway and TRMC service areas (listed below in alphabetical order):

- Affordable Housing
- Chronic Disease Prevention and Management
- Employment and Financial Security
- Food Insecurity and Healthy Eating
- Green Space and Built Environment
- Health and Racial Equity
- Healthcare Access
- Infectious and Communicable Disease
- Mental and Behavioral Health
- Systemic Racism and Discrimination

Prioritization and Alignment Process and Priorities Selected for Planning

Prioritization allows hospitals, organizations, and coalitions to target and align resources, leverage efforts, and focus on achievable goals and strategies for addressing priority needs. Priorities for this process were identified by examining data and themes from the CHNA findings utilizing a systematic, engaged approach. This section describes the approach and outcomes of the prioritization process.

Criteria for Prioritization
A high-level set of prioritization criteria, defined by the RWJBH CHNA Steering Committee for the system, were used to guide conversations to refine the priorities:

- **Burden**: How much does this issue affect health in the community?
- **Equity**: Will addressing this issue substantially benefit those most in need?
- **Impact**: Can working on this issue achieve both short-term and long-term changes? Is there an opportunity to enhance access/accessibility?
- **Systems Change**: Is there an opportunity to focus on/implement strategies that address policy, systems, and environmental change?
- **Feasibility**: Can we take steps to address this issue given the current infrastructure, capacity, and political will?
- **Collaboration/Critical Mass**: Are existing groups across sectors already working on or willing to work on this issue together?
- **Significance to Community**: Was this issue identified as a top need by a significant number of community members?

Prioritization and Alignment Process
The prioritization process was multifaceted and aimed to be inclusive, participatory, and data-driven. Following an extensive process to gather input from community members and stakeholders via primary data collection, the following steps were taken to prioritize action areas among those identified as part of the CHNA process.

Key Findings Presentation and SIP Preliminary Prioritization (Step 1)
On September 30th, 2025, a 120-minute virtual Key Findings Presentation and SIP Preliminary Prioritization meeting was held with RWJUH Rahway-TRMC CHNA Advisory Committee members, hospital leadership, and key community partners to present and discuss the preliminary findings and conduct a poll on the preliminary priorities for action.

During the meeting, attendees heard a data presentation on the preliminary key findings from the assessment. Next, meeting participants discussed the data as a group and offered their

perspectives and feedback on the various issues. Participants noted that the themes presented resonated with their own experiences and perceptions.

Then, using the polling platform Mentimeter, meeting participants were asked to select up to four of the eight priorities identified from the data and based on the high-level prioritization criteria. The other two, Health and Racial Equity and Systemic Racism and Discrimination, were recommended to be considered as cross-cutting themes, leaving eight key themes for consideration as potential priority areas. Preliminary polling results identified the following four potential priority areas:

- Mental Health and Behavioral Health
- Chronic Disease Prevention and Management
- Healthcare Access
- Food Insecurity and Healthy Eating.

Facility-Specific Key Findings and SIP Prioritization Sessions (Step 2)
On September 14th and September 15th, 2025, two separate 60-minute virtual meetings took place with TRMC and RWJUH Rahway leadership and key partners, respectively. Following a brief recap of the CHNA findings, facility leadership reviewed the polling results from the Step 1 meeting and discussed priorities for their respective Strategic Implementation Plans (SIPs). TRMC discussions resulted in combining Chronic Disease Prevention & Management and Healthcare Access into one priority area. RWJUH Rahway discussions resulted in leadership approving the four priority areas suggested by the RWJUH Rahway-TRMC CHNA Advisory Committee polling results.

It is noted that the needs prioritized and selected by the facilities for improvement planning are in line with the New Jersey State Health Improvement Plan 2020, which addresses strategies for improvement of Health Equity, Mental Health/Substance Use, Nutrition, Physical Activity, and Chronic Disease (additional focus areas include Birth Outcomes, Immunizations and Alignment of State and Community Health Improvement Planning). Further, actions for the prioritized areas support and are in line with the four broad Health New Jersey 2030 topic areas that represent the key elements that influence health: 1) Access to Quality Care; 2) Healthy Communities; 3) Health Families; and 4) Healthy Living.

Priorities Selected for Planning
Based on the assessment findings as well as existing initiatives, expertise, capacity, and experience:

- **TRMC Priorities (3):** 1) Food Insecurity and Healthy Eating; 2) Healthcare Access and Chronic Disease Prevention and Management; and 3) Mental Health and Behavioral Health.

- **RWJUH Rahway Priorities (4):** 1) Food Insecurity and Healthy Eating; 2) Healthcare Access; 3) Chronic Disease Prevention and Management; and 4) Mental Health and Behavioral Health.

RWJUH Rahway and TRMC will address these priority action areas as part of ongoing community engagement efforts. Health and Racial Equity and Systemic Racism and Discrimination will be included as cross-cutting themes with strategies to address health disparities.

RWJUH Rahway & Trinitas Regional Medical Center Community Health Needs Assessment: Appendix

November 2025

PREPARED BY
HEALTH RESOURCES IN ACTION

RWJBarnabas HEALTH | Robert Wood Johnson University Hospital Rahway

RWJBarnabas HEALTH | Trinitas Regional Medical Center

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Appendix A: Organizations Represented in Key Informant Interviews and Focus Groups

Organization	Sector
ARRIVE TOGETHER	Public Safety & Mental Health
RWJUH-Rahway Public Safety	
Trinitas Regional Medical Center Public Safety	
The National Alliance on Mental Illness (NAMI)	Mental Health
RWJBH Community Health Workers	Community Health Workers
SNAP & WIC Program Representatives	Food Assistance & Food Insecurity
Local Health Department Officials	Local Health Department
Union County Health Department	County Health Department
Union County Fatherhood Initiative Coalition	African American Men
Josephine's Place	Women's Health
RWJB Community Outreach	Latinx Community Perspectives
RWJUH-Rahway Pastoral Care	Faith Based Leaders
AME Ebenezer Church of Rahway	
Neighborhood Health Services Corporation	Healthcare Providers
Trinitas Regional Medical Center	

Appendix B: Key Informant Interview Guide

Health Resources in Action
RWJUH-Rahway & Trinitas Regional Medical Center
Health Resources in Action
Virtual Key Informant Interview Guide 7.28.24

Goals of the key informant interview
- To determine perceptions of the strengths and needs of the community
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively
- To understand the priorities for action

I. BACKGROUND (5 MINUTES)

- Hello, my name is _____, and I work for _____. Thank you for taking the time to talk with me today.

- RWJUH-Rahway & Trinitas Regional Medical Center are conducting a community health assessment to gain a greater understanding of the needs of the community, how those needs are currently being addressed, and whether there might be opportunities to address these issues more effectively

- Our interview will last about 45 – 60 minutes. After all the data is collected, we will summarize the key themes that have emerged during these discussions into a report. In this report we will be including quotes, but will not include any names or identifying information. Nothing you say here will be directly tied to you.

- [NOTE IF TRANSCRIBING] We plan to transcribe these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the note-taking. No one but the analysts at Health Resources in Action, who are writing the report, will be reviewing the transcription. Do you have any concerns with me turning on the transcription now?

- Do you have any questions before we begin?

II. INTRODUCTION (5 MINUTES)

1. Can you tell me a bit about yourself and the work that your organization does?

[PROBE: What is your organization's mission/services? What communities do you work in? Who are your main clients/audiences?]

III. COMMUNITY ASSETS AND CONCERNS (20 minutes)

Now, we're going to shift gears and talk about the community.

2. What makes your community great? What are it's biggest strengths?

3. What are some of the biggest problems or concerns in your community? What are neighbors worried about?

    a. [PROBE ON SOCIAL DETERMINANTS OF HEALTH – FOOD INSECURITY / HEALTHY EATING; HOUSING AFFORDABILITY, ECONOMIC SECURITY/EMPLOYMENT; TRANSPORTATION; STIGMA/DISCRIMINATION]

    b. [IF NOT ADDRESSED ABOVE] What do you think are the most pressing *health* concerns in your community? (EX. MENTAL HEALTH, CHRONIC DISEASE MANAGEMENT, SUBSTANCE USE, ETC.)

4. How do these issues affect your/ residents' day-to-day life? [PROBE ON SDOH AND HEALTH ISSUES]
    a. Are there groups in the community that are more impacted by these concerns than others? If yes, which groups? (PROBE: New Immigrants, Youth, Seniors, Low-Income Residents)

IV. PRIORITIES (18 minutes)

5. Can you tell me about some promising initiatives in your community to tackle the issues we've discussed?

6. Can you describe existing partnerships and collaborations that are helping to strengthen the community? What health issue are they tackling? Who are they serving? What have been the main accomplishments?

7. What are the gaps in existing services? Are there groups or populations that are not being reached? What do you see as some of the biggest challenges for your community to tackle this issue or make improvements?

V. VISION FOR THE FUTURE (10 MINUTES)

8. If you had one major takeaway call to action, need, or issue for us to address urgently, what would that be, and why? In other words, what change needs to happen to address the main issues in this community?

9. I'd like you to think about the future of your community. When you think about the community 3 years from now, what would you like to see? What's your vision?

    a. What are the next steps to help this vision become a reality?

VI. CLOSING (2 MINUTES)

Thank you so much for your time and sharing your opinions. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today? Thank you again. Your feedback is valuable, and we greatly appreciate your time.

Appendix C: Focus Group Guide

Health Resources in Action
RWJUH-Rahway & Trinitas Regional Medical Center
Virtual Focus Group Guide 7.28.24

Goals of the focus group:
- To determine perceptions of the strengths and needs of the community
- To understand residents' current experiences and challenges
- To identify the gaps, challenges, and opportunities for addressing community needs more effectively

I. BACKGROUND (5 minutes)

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization based in Boston that works throughout the US. I'd also like to introduce my colleague _____. They work with me on this project and are here to take notes during our discussion, so I can give you my full attention. Thank you for taking the time to talk with me today.

- RWJUH-Rahway and Trinitas Regional Medical Center are conducting a community health assessment to gain a greater understanding of the needs of the community, how those needs are currently being addressed, and whether there might be opportunities to address these issues more effectively.

- As part of the community health assessment process, we are conducting interviews with leaders in the community and focus groups with residents to understand different people's perspectives on these issues. The findings from these conversations will inform decisions around future investments to improve the community. We greatly appreciate your feedback, insight, and honesty.

- We're going to be having a focus group today. Has anyone here been part of a focus group before?

- You are here because we want to hear from you. There are no right or wrong answers. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share what you think, both positive and negative. If I ask a question that you don't feel comfortable answering it's okay for us to skip and move on to the next questions.

- This discussion will last about 60-90 minutes. Please turn on your video, if possible, so that we can all see each other speaking. As a reminder, please keep yourself on MUTE until you want to speak.

- When we are done collecting data, we will write a report on the key themes that came up during these discussions. We will include quotes, but we will not share any names or

identifying information. Nothing that you say here will be connected directly to you in our report.

- [NOTE IF AUDIORECORDING/TRANSCRIBING] We'd like to audio record/transcribe this conversation to ensure we have captured the main points of the discussion. No one but the analysts at Health Resources in Action, who are writing the report, will be listening to the audio recordings/reading the transcript. Does anyone have any concerns with me turning the recorder/transcription on now? [Only turn transcript on if nobody objects]

- Does anyone have any questions before we begin?

II. INTRODUCTIONS (5 minutes)

First, let's spend some time getting to know one another. When I call your name, please unmute yourself and tell us:

1) Your first name
2) What city or town you live in
3) One thing you love about where you live. [MODERATOR STARTS THEN ALL PARTICIPANTS INTRODUCE THEMSELVES]

III. COMMUNITY ASSETS AND CONCERNS (20 minutes)

Now, we're going to shift gears and talk about the community that you live in.

1. If someone was thinking about moving into your neighborhood, what would you say are the biggest strengths of your community - or the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

2. What are some of the biggest problems or concerns in your community? What are neighbors worried about?

    a. [PROBE ON SOCIAL DETERMINANTS OF HEALTH – FOOD INSECURITY / HEALTHY EATING; HOUSING AFFORDABILITY, ECONOMIC SECURITY/EMPLOYMENT; TRANSPORTATION; STIGMA/DISCRIMINATION, ETC.]

    b. [IF NOT ADDRESSED ABOVE] What do you think are the most pressing *health* concerns in your community? (EX. MENTAL HEALTH, CHRONIC DISEASE MANAGEMENT, SUBSTANCE USE, ETC.)

3. How do these issues affect your/ residents' day-to-day life? [PROBE ON SDOH AND HEALTH ISSUES]

a. Are there groups in the community that are more impacted by these concerns than others? If yes, which groups? (PROBE: New Immigrants, Youth, Seniors, Low-Income Residents)

IV. PRIORITIES (14 minutes) [You can use the question pool to tailor this section]
I've heard in our conversation today that NAME ISSUES are a top concern for the community. [NAME THE MAJOR 2-3 ISSUES MENTIONED IN THE DISCUSSION– FOOD INSECURITY/HEALTHY EATING; ACCESS TO HEALTHCARE; MENTAL HEALTH; BEHAVIORAL HEALTH; CHRONIC DISEASE; TRANSPORTATION; SOCIAL; ECONOMIC; ETC.]

4. Do you agree with this list as the major concerns/issues in your community? Is there a major issue that is missing?

Now let's talk about some of these issues in more detail [Moderator to select one major issue discussed.]

5. From your perspective, what are the main issues related to this [ISSUE]? What are the main factors affecting [ISSUE] in your community? [PROBE: Barriers and facilitators to access, Service Coordination, Social/Economic Factors, Discrimination, Etc.; Population groups most affected]

6. What do you see as some of the biggest challenges for your community to tackle this issue or make improvements?

7. What services or programs currently exist to address [ISSUE]?

8. What are the main gaps in existing services? Do the existing services work for everyone? [PROBE: Groups not being reached, neighborhoods less served, etc.]

[REPEAT Q5-Q8 FOR 1-2 OTHER MAJOR ISSUES THAT WERE DISCUSSED]

V. VISION OF COMMUNITY HEALTH IMPROVEMENT AND INVOLVEMENT (14 minutes)

9. I'd like you to think ahead about the future of your community. When you envision the community 3 years from now, what change would you like to see happen?

10. What is one action or investment that should happen in the community to improve health and wellness? Why?

VI. CLOSING (2 minutes)
Thank you so much for your time and for sharing your opinions with us. Your perspective about the communities you work with will be a great help in determining how to improve the systems that affect the health of this population.

Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier?

Thank you again. Your feedback is valuable, and we greatly appreciate your time and sharing your opinion.

Appendix D: Resource Inventory

Health Resources for Union County

Part 1: Acute and Long Term Care Facilities

Acute Care Facilities Resource Union County

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
AMBULATORY CARE FACILITY	22518	UNIVERSITY RADIOLOGY AT TRINITAS, LLC (NJ22518)	415 MORRIS AVENUE ELIZABETH, NJ 07208	ELIZABETH	NJ	07208	UNION	(908) 351-7600	(908) 351-4406	University Radiology At Trinitas, L.L.C.
AMBULATORY CARE FACILITY	23061	NJIN OF CRANFORD (NJ23061)	25 SOUTH UNION AVENUE CRANFORD, NJ 07016	Cranford	NJ	07016	UNION	(908) 709-1323	(908) 709-1329	The New Jersey Imaging Network Llc
AMBULATORY CARE FACILITY	23213	NJIN OF UNION (NJ23213)	445 CHESTNUT STREET UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 687-6054	(908) 688-1131	The New Jersey Imaging Network Llc
AMBULATORY CARE FACILITY	23294	DYNAMIC MEDICAL IMAGING-DMI, INC (NJ23229)	950 WEST CHESTNUT STREET UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 687-2552	(908) 687-6552	Dynamic Medical Imaging, Llc
AMBULATORY CARE FACILITY	23473	UNIVERSITY RADIOLOGY GROUP, LLC (NJ23473)	210 W ST GEORGES AVENUE LINDEN, NJ 07036	LINDEN	NJ	07036	UNION	(908) 587-0035	(908) 587-0035	University Radiology Group, Llc
AMBULATORY CARE FACILITY	24038	RAHWAY REGIONAL CANCER CENTER (NJ24038)	892 TRUSSLER PLACE RAHWAY, NJ 07065	RAHWAY	NJ	07065	UNION	(732) 382-5550	(732) 382-2407	Rahway Radiation Oncology Associates, P.C.
AMBULATORY CARE FACILITY	24811	SUMMIT MEDICAL GROUP PA (NJ24811)	574 SPRINGFIELD AVENUE WESTFIELD, NJ 07091	WESTFIELD	NJ	07091	UNION	(908) 673-7257	(908) 673-7179	Summit Medical Group, Pa
AMBULATORY CARE FACILITY	24872	WOMEN'S HEALTHCARE IMAGING CENTER (NJ24872)	1896 MORRIS AVENUE UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 964-0004	(908) 964-0034	Women'S Healthcare Imaging, Corp
AMBULATORY CARE FACILITY	24977	AQ MODERN DIAGNOSTIC IMAGING (NJ24977)	315 ELMORA AVENUE ELIZABETH, NJ 07208	ELIZABETH	NJ	07208	UNION	(856) 524-1559	(856) 210-1888	Aq Modern Diagnostic Imaging, Inc.
AMBULATORY CARE FACILITY	25059	SUMMIT MEDICAL GROUP (NJ25059)	1 DIAMOND HILL ROAD, SUITE LG-601 BERKELEY HEIGHTS, NJ 07922	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 273-4300		Summit Medical Group, Pa
AMBULATORY CARE FACILITY	25089	BIRTH CENTER OF NEW JERSEY, LLC (THE) (NJ25089)	1945 US 22 WEST UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 627-4455	(908) 624-9632	The Birth Center Of New Jersey, Llc
AMBULATORY CARE FACILITY	25233	ATLANTIC IMAGING SERVICES AT CLARK (NJ25233)	140 CENTRAL AVENUE, SUITE 600 CLARK, NJ 07066	CLARK	NJ	07066	UNION	(732) 943-5030	(732) 943-5031	Atlantic Imaging Services, L.L.C.
AMBULATORY CARE FACILITY	25167	BACK AND BODY PAIN RELIEF, LLC (NJ25167)	355 US - 22 EAST SPRINGFIELD, NJ 07081	SPRINGFIELD	NJ	07081	UNION	(908) 325-3000	(908) 325-3232	Back And Body Pain Relief, Llc
AMBULATORY CARE FACILITY - SATELLITE	72038	PLANNED PARENTHOOD OF NORTHERN, CENTRAL & SOUTHERN (NJ72038)	1171 ELIZABETH AVENUE ELIZABETH, NJ 07201	ELIZABETH	NJ	07201	UNION	(973) 879-1306	(908) 353-6822	Planned Parenthood Of Ncsnj

AMBULATORY SURGICAL CENTER	22724	GARDEN STATE ENDOSCOPY AND SURGERY CENTER (31DUMMY22001)	200 SHEFFIELD STREET STE 101 MOUNTAINSIDE, NJ 07092	MOUNTAINSIDE	NJ	07092	UNION	(908) 241-8900	(908) 241-8933	Morris Avenue Endoscopy, Llc

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
AMBULATORY SURGICAL CENTER	24093	SUMMIT MEDICAL GROUP PA (NJ24093)	1 DIAMOND HILL ROAD, SUITE 1B-142 BERKELEY HEIGHTS, NJ 07922	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 273-4300	(908) 673-7382	Summit Medical Group, Pa
AMBULATORY SURGICAL CENTER	24207	UNION SURGERY CENTER, LLC (NJ24207)	1000 GALLOPING HILL ROAD UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 239-4545	(908) 258-7654	Union Surgery Center, Llc
AMBULATORY SURGICAL CENTER	R24650	PRISM SURGERY CENTER AT UNION (NJ31C0001030)	855 Lehigh Avenue, Suite 203 UNION, NJ 07083	UNION	NJ	07083	UNION	(201) 216-1700	(201) 216-1800	Pavonia Surgical Center, Llc
AMBULATORY SURGICAL CENTER	R24498	Endo-Surgi Center, PA (NJ31C0001068)	1201 MORRIS AVENUE UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 686-0066	(908) 686-5388	Endo Surgi Center Pa
AMBULATORY SURGICAL CENTER	22511	GASTRO-SURGI CENTER OF NEW JERSEY, THE (NJ31C0001111)	1132 SPRUCE DRIVE MOUNTAINSIDE, NJ 07092	MOUNTAINSIDE	NJ	07092	UNION	(908) 317-0071	(908) 317-0103	The Gastro-Surgi Center Of New Jersey, Llc
AMBULATORY SURGICAL CENTER	R24579	LINDEN SURGICAL CENTER, LLC (NJ31C0001125)	210 WEST ST GEORGE AVENUE LINDEN, NJ 07036	LINDEN	NJ	07036	UNION	(908) 587-1888	(908) 587-9545	Linden Surgical Center, Llc
AMBULATORY SURGICAL CENTER	22987	CENTER FOR AMBULATORY SURGERY, LLC (NJ31C0001135)	1450 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092	MOUNTAINSIDE	NJ	07092	UNION	(908) 233-2020	(908) 233-9322	Center For Ambulatory Surgery, Llc
AMBULATORY SURGICAL CENTER	23028	UNION COUNTY SURGERY CENTER, LLC (NJ31C0001161)	950 WEST CHESTNUT STREET UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 688-2700	(908) 688-7424	Union County Surgery Center, L.L.C.
AMBULATORY SURGICAL CENTER	R24726	NEW JERSEY INTERVENTIONAL ASSOCIATES LLC (NJR24726)	1050 GALLOPING HILL ROAD, SUITE 102 UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 686-1350	(908) 686-1382	New Jersey Interventional Associates, Llc
AMBULATORY SURGICAL CENTER ASC-ST	R24592	CCG MEDICAL GROUP LLC (NJR24592)	433 CENTRAL AVENUE - 2ND FLOOR WESTFIELD, NJ 07090	WESTFIELD	NJ	07090	UNION	(973) 759-9000	(973) 759-2487	Ccg Medical Group Llc
AMBULATORY SURGICAL CENTER ASC-ST	R24840	SPRINGFIELD SURGERY CENTER, LLC (NJR24840-2)	105 MORRIS AVENUE, FIRST FLOOR SPRINGFIELD, NJ 07081	SPRINGFIELD	NJ	07081	UNION	(973) 718-5550	0	Springfield Surgery Center, Llc
AMBULATORY SURGICAL CENTER ASC-ST	25276	MUHLENBERG ASC, LLC (NJ252761)	1280 RANDOLPH ROAD, STE 301 MUHLENBERG, NJ 07060	MUHLENBERG	NJ	07060	UNION	(973) 429-7900	0	Muhlenberg Asc Llc
COMPREHENSIVE OUTPATIENT REHAB	23133	QUALCARE THERAPY CENTER INC (NJ23133)	2333 MORRIS AVENUE, SUITE B-210 UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 688-3366	(908) 688-8115	Diagnostic Solutions, Inc

END STAGE RENAL DIALYSIS	22289	FRESENIUS MEDICAL CARE KENILWORTH (NJ22289)	131 SOUTH 31ST STREET KENILWORTH , NJ 07033	KENILWORTH	NJ	07033	UNION	(908) 241-0453	(908) 241-5731	Nna Saint Barnabas, Llc
END STAGE RENAL DIALYSIS	22318	SUMMIT DIALYSIS (NJ22318)	1139 SPRUCE DRIVE MOUNTAINSIDE, NJ 07092	MOUNTAINSIDE	NJ	07092	UNION	(908) 232-7800	(908) 232-9188	Dva Renal Healthcare, Inc.
END STAGE RENAL DIALYSIS	23228	NNA OF ELIZABETH (NJ23026)	595 DIVISION STREET, SUITE B ELIZABETH, NJ 07201	ELIZABETH	NJ	07201	UNION	(908) 436-3007	(908) 436-3008	Nna Of Elizabeth

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
END STAGE RENAL DIALYSIS	23079	PLAINFIELD DIALYSIS (NJ23079)	1200 RANDOLPH ROAD PLAINFIELD, NJ 07060	PLAINFIELD	NJ	07060	UNION	(908) 757-6030	(908) 757-6282	Kidney Life, Llc
END STAGE RENAL DIALYSIS	24065	HILLSIDE DIALYSIS (NJ24065)	1529 NORTH BROAD STREET HILLSIDE, NJ 07205	HILLSIDE	NJ	07205	UNION	(973) 474-1199	(973) 474-1198	Kidney Life, Llc
END STAGE RENAL DIALYSIS	24459	FRESENIUS MEDICAL CARE LINDEN (NJ24459)	630 WEST ST GEORGES LINDEN, NJ 07036	LINDEN	NJ	07036	UNION	(908) 925-5161	(908) 925-5197	Fresenius Medical Care Linden Llc
END STAGE RENAL DIALYSIS	24924	RAHWAY DIALYSIS (NJ24924)	800 HARRISON STREET RAHWAY, NJ 07065	RAHWAY	NJ	07065	UNION	(732) 680-0373	(732) 680-0376	Gebhard Dialysis, Llc
END STAGE RENAL DIALYSIS	25179	ELMORA DIALYSIS (NJ25179)	547 MORRIS AVENUE ELIZABETH, NJ 07208	ELIZABETH	NJ	07208	UNION	(908) 436-9201	(908) 436-9206	Pinson Dialysis, Llc
END STAGE RENAL DIALYSIS	42001	BIO-MEDICAL APPLICATIONS OF HILLSIDE (NJ42001)	879 RAHWAY AVENUE UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 378-6387	(908) 688-7108	Fresenius Medical Care
FEDERALLY QUALIFIED HEALTH CENTERS	22271	NEIGHBORHOOD HEALTH CTR PLAINFIELD (NJ311809)	1700 MYRTLE AVENUE PLAINFIELD, NJ 07063	PLAINFIELD	NJ	07063	UNION	(908) 753-6401	(908) 753-7570	Neighborhood Health Services Corporation
GENERAL ACUTE CARE HOSPITAL	12005	OVERLOOK MEDICAL CENTER (NJ12005)	99 BEAUVOIR AVENUE SUMMIT, NJ 07901	SUMMIT	NJ	07901	UNION	(908) 522-2000	(908) 273-5134	Ahs Hospital Corp.
GENERAL ACUTE CARE HOSPITAL	12006	ROBERT WOOD JOHNSON UNIVERSITY HOSPITAL AT RAHWAY (NJ310024)	865 STONE ST RAHWAY, NJ 07065	RAHWAY	NJ	07065	UNION	(732) 381-4200	(732) 499-6337	Robert Wood Johnson University Hospital At Rahway
GENERAL ACUTE CARE HOSPITAL	12007	TRINITAS REGIONAL MEDICAL CENTER (NJ310027)	225 WILLIAMSON STREET ELIZABETH, NJ 07207	ELIZABETH	NJ	07207	UNION	(908) 994-5000	(908) 994-5756	Trinitas Regional Medical Center
HOME HEALTH AGENCY	22301	Bayada Home Health Care, Inc. (NJ317020)	354 Union Avenue Elizabeth, NJ 07208	ELIZABETH	NJ	07208	UNION	9083525694	9083522475	Bayada Home Health Care, Inc.
HOSPICE CARE - INPATIENT	20C101	PEGGY COLONEY'S HOUSE AT HOPE VILLAGE (NJ20C101)	1900 RARITAN ROAD SCOTCH PLAINS, NJ 07076	SCOTCH PLAINS	NJ	07076	UNION	(908) 889-7780	(908) 889-5172	Center For Hope Hospice
HOSPICE CARE - INPATIENT	82468	FATHER HUDSON HOUSE (NJ82468)	111 DEHART PLACE ELIZABETH, NJ 07202	ELIZABETH	NJ	07202	UNION	(908) 353-6060	(908) 353-4504	Center For Hope Hospice

HOSPICE CARE PROGRAM	22782	CENTER FOR HOPE HOSPICE AND PALLIATIVE CARE (NJ22782)	1900 RARITAN ROAD SCOTCH PLAINS, NJ 07076	SCOTCH PLAINS	NJ	07076	UNION	(908) 889-7780	(908) 889-5172	Center For Hope Hospice
HOSPICE CARE PROGRAM	23391	HOMESIDE HOSPICE LLC (NJ23391)	67 WALNUT AVENUE, SUITE 205 CLARK, NJ 07066	CLARK	NJ	07066	UNION	(732) 381-3444	(732) 381-3445	Journey Investments Llc
HOSPICE CARE PROGRAM	24987	SWAN HOSPICE (NJ24987)	1777 Avenue of the States Suite 106 Lakewood, NJ 08701	LAKEWOOD	NJ	08701	UNION	(908) 818-1700	(732) 377-6624	First Response Hospice Care, Inc.

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
HOSPICE CARE PROGRAM	22841	ASCEND HOSPICE (NJ311541)	65 Jackson Drive, Suite 103 Cranford, NJ 07016	Cranford	NJ	07016	UNION	(908) 931-9080	(908) 931-0174	Care Alternatives, Inc.
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1503	TRINITAS CRANFORD DIALYSIS (NJ25096)	205 BIRCHWOOD AVENUE CRANFORD, NJ 07016	Cranford	NJ	07016	UNION	(908) 994-6660	(908) 994-5134	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1040	RENAL DIALYSIS SATELLITE (NJ313503)	10 NORTH WOOD AVENUE LINDEN, NJ 07036	LINDEN	NJ	07036	UNION	(908) 862-7400	(908) 862-5245	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY	1041	TRINITAS RENAL DIALYSIS SATELLITE (NJ313519)	200 WILLIAMSON STREET, SUITE 210 ELIZABETH, NJ 07206	ELIZABETH	NJ	07206	UNION	(908) 994-7011	(908) 994-7025	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1027	TRINITAS HOSPITAL DOROTHY B HERSH CLINIC (NJ1027)	655 EAST JERSEY STREET ELIZABETH, NJ 07208	ELIZABETH	NJ	07208	UNION	(908) 994-5112	(908) 994-5574	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1042	TRINITAS COMPREHENSIVE CANCER CENTER (NJ1042)	225 WILLIAMSON STREET ELIZABETH, NJ 07202	ELIZABETH	NJ	07202	UNION	(908) 994-8000	(908) 994-8748	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1048	TRINITAS HIV CLINIC (NJ1048)	655 LIVINGSTON STREET ELIZABETH, NJ 07206	ELIZABETH	NJ	07206	UNION	(908) 994-7605	(908) 994-7301	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1049	TRINITAS SUBSTANCE ABUSE CLINIC (NJ1049)	655 EAST JERSEY STREET ELIZABETH, NJ 07206	ELIZABETH	NJ	07206	UNION	(908) 994-7438	(908) 994-7191	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1050	TRINITAS ADULT PSYCHIATRIC CLINIC (NJ1050)	654 EAST JERSEY STREET ELIZABETH, NJ 07206	ELIZABETH	NJ	07206	UNION	(908) 994-7552	(908) 994-7054	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1051	TRINITAS CHILD AND ADOLESCENT PSYCHIATRIC CLINIC (NJ1051)	655 EAST JERSEY STREET ELIZABETH, NJ 07206	ELIZABETH	NJ	07206	UNION	(908) 994-7354	(908) 994-7247	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1177	TRINITAS HOSPITAL ADDICTION SERVICES (NJ1177)	654 EAST JERSEY STREET ELIZABETH, NJ 07206	ELIZABETH	NJ	07206	UNION	(908) 994-7556	(908) 994-7170	Trinitas Regional Medical Center

HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1210	OVERLOOK MEDICAL CENTER-UNION CAMPUS (NJ1210)	1000 GALLOPING HILL ROAD UNION, NJ 07083	UNION	NJ	07083	UNION	(973) 522-6300	(908) 964-2160	Overlook Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1242	JFK MEDICAL CENTER-MUHLENBERG CAMPUS (NJ1242)	PARK AVENUE AND RANDOLPH ROAD PLAINFIELD, NJ 07061	PLAINFIELD	NJ	07061	UNION	(732) 321-7000	(732) 549-8532	Hmh Hospitals Corporation
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1279	TRINITAS REGIONAL MEDICAL CENTER SLEEP (NJ1279)	2 JACKSON DRIVE, HOMEWOOD SUITES CRANFORD, NJ 07016	Cranford	NJ	07016	UNION	(908) 994-8694	(908) 351-8697	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1404	TRINITAS AMBULATORY SURGERY CENTER (NJ1404)	225 WILLIAMSON STREET ELIZABETH, NJ 07202	ELIZABETH	NJ	07202	UNION	(908) 994-8944	(908) 994-8349	Trinitas Regional Medical Center

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	City	State	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1425	WOUND HEALING PROGRAM AT UNION CAMPUS (NJ1425)	1000 GALLOPING HILL ROAD UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 522-6300		Overlook Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1479	TRINITAS REGIONAL MEDICAL CENTER PRIMARY CARE (NJ1479)	654 EAST JERSEY STREET ELIZABETH, NJ 07206	ELIZABETH	NJ	07206	UNION	(908) 994-7271	(908) 994-6054	Trinitas Regional Medical Center
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1526	CHILDREN'S SPECIALIZED HOSPITAL CENTER AT UNION (NJ1526)	2840 MORRIS AVENUE UNION, NJ 07083	UNION	NJ	07083	UNION	(732) 258-7000	(732) 258-7210	Children'S Specialized Hospital
HOSPITAL-BASED, OFF-SITE AMBULATORY CARE FACILITY STHSPOFF	1233	OVERLOOK HEALTH SERVICES AT ONE SPRINGFIELD AVENUE (NJ24153)	1 SPRINGFIELD AVENUE SUMMIT, NJ 07901	SUMMIT	NJ	07901	UNION	(908) 934-6651	(908) 273-0104	Overlook Medical Center
PSYCHIATRIC HOSPITAL	52006	SUMMIT OAKS HOSPITAL (NJ52006)	19 PROSPECT ST SUMMIT, NJ 07901	SUMMIT	NJ	07901	UNION	(908) 522-7000	(908) 522-7098	Summit Oaks Hospital
SPECIAL HOSPITAL	23268	KINDRED HOSPITAL NEW JERSEY - RAHWAY (NJ23268)	865 STONE STREET RAHWAY, NJ 07065	RAHWAY	NJ	07065	UNION	(732) 669-8200	(732) 669-8229	Kindred Hospitals East, Llc
SPECIAL HOSPITAL - PSYCHIATRIC	22001	MOUNTAINVIEW BEHAVIORAL HOSPITAL (NJ22001A)	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 771-5857	(908) 771-5820	County Of Union
SPECIAL HOSPITAL HOSP-LT	24426	CARE ONE AT TRINITAS REGIONAL MEDICAL CENTER (NJ23098)	225 WILLIAMSON ST 7 NORTH ELIZABETH, NJ 07207	ELIZABETH	NJ	07207	UNION	(908) 994-5412	(908) 994-8860	The Rehabilitation Hospital At Raritan Bay Medical
SURGICAL PRACTICE	R24618	MED FEM AESTHETIC CENTER (NJ24618)	33 OVERLOOK ROAD, SUITE 302 SUMMIT, NJ 07901	SUMMIT	NJ	07901	UNION	(908) 522-1777	(908) 522-3051	Med Fem Aesthetic Center

SURGICAL PRACTICE ASC-P-C	R24587	WESTFIELD PLASTIC SURGICAL CENTER (NJR24587)	955 SO SPRINGFIELD AVENUE, BLDG A, SUITE 105 SPRINGFIELD, NJ 07081	SPRINGFIELD	NJ	07081	UNION	(908) 654-6540	(908) 654-6504	Westfield Plastic Surgical Center, Llc

Reference: New Jersey Department of Health, Health Facilities search, downloaded July 31, 2025

Long-Term Care Facilities Resource Union County

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	CITY	STATE	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
ADULT DAY HEALTH SERVICES FACILITY	18202	SARAHCARE AT WATCHUNG SQUARE (NJ18202)	1115 GLOBE AVENUE MOUNTAINSIDE, NJ 07092	MOUNTAINSIDE	NJ	07092	UNION	(908) 561-8888	(908) 222-3481	Sarahcare @ Watchung Square, Llc
ADULT DAY HEALTH SERVICES FACILITY	20004	TOWN SQUARE ADULT MEDICAL DAY CARE CENTER (NJ20004)	1155 EAST JERSEY STREET ELIZABETH, NJ 07201	ELIZABETH	NJ	07201	UNION	(908) 787-0980	(908) 787-0983	Town Square Adult Medical Day Care Center Inc
ADULT DAY HEALTH SERVICES FACILITY	908110	SAGE SPEND A DAY (NJ908110)	290 BROAD STREET SUMMIT, NJ 07901	SUMMIT	NJ	07901	UNION	(908) 598-5520	(908) 598-5545	Sage Eldercare, Inc.
ADULT DAY HEALTH SERVICES FACILITY	908112	FIVE STAR ADULT MEDICAL DAY CARE CENTER (NJ908112)	1201 DEERFIELD TERRACE LINDEN, NJ 07036	LINDEN	NJ	07036	UNION	(908) 486-5750	(908) 486-3325	Five Star Adult Medical Day Care Center Llc
ADULT DAY HEALTH SERVICES FACILITY	908113	DAYBREAK ADULT DAYCARE AT ELIZABETH (NJ908113)	712 NEWARK AVENUE ELIZABETH, NJ 07208	ELIZABETH	NJ	07208	UNION	(908) 353-3530	(908) 353-3529	Daybreak Adult Daycare At Elizabeth Llc
ADULT DAY HEALTH SERVICES FACILITY	908115	CEDAR HARBOR MEDICAL DAY CARE CENTER (NJ908115)	545 EAST 1ST AVENUE ROSELLE, NJ 07203	ROSELLE	NJ	07203	UNION	(908) 298-8588	(908) 298-8511	Cedar Harbor Medical Day Care Center, Llc
ADULT DAY HEALTH SERVICES FACILITY	908116	2ND HOME SWEET HOME OPERATIONS, LLC (NJ908116)	550 NORTH BROAD STREET ELIZABETH, NJ 07208	ELIZABETH	NJ	07208	UNION	(908) 994-0050	(908) 994-0056	Home Sweet Home Operations, Llc
ADULT DAY HEALTH SERVICES FACILITY	908117	SENIOR SPIRIT OF ROSELLE PARK (NJ908117)	430 EAST WESTFIELD AVENUE ROSELLE PARK, NJ 07204	ROSELLE PARK	NJ	07204	UNION	(908) 241-9393	(908) 241-5622	Senior Spirit Of Roselle Park, Llc
ADULT DAY HEALTH SERVICES FACILITY	NZDOUG	2ND HOME SPRINGFIELD (NJNZDOUG)	40 STERN AVENUE SPRINGFIELD, NJ 07081	SPRINGFIELD	NJ	07081	UNION	(973) 376-4004	(973) 376-8060	2Nd Home Springfield Llc
ADULT DAY HEALTH SERVICES in a LONG-TERM CARE FACILITY	908300	ARISTACARE AT NORWOOD TERRACE (NJ908300)	40-44 NORWOOD AVENUE PLAINFIELD, NJ 07060	PLAINFIELD	NJ	07060	UNION	(908) 769-1400	(908) 769-8092	Norwood Terrace Nursing And Rehabilitation Center
ASSISTED LIVING PROGRAM	90A100	CENTER FOR HOPE HOSPICE INC (NJ90A100)	1900 RARITAN ROAD SCOTCH PLAINS, NJ 07076	SCOTCH PLAINS	NJ	07076	UNION	(908) 889-7780	(908) 288-9151	Center For Hope Hospice
ASSISTED LIVING RESIDENCE	AL20001	ARBOR TERRACE MOUNTAINSIDE (NJ20A013)	1050 SPRINGFIELD AVENUE MOUNTAINSIDE, NJ 07092	MOUNTAINSIDE	NJ	07092	UNION	(908) 760-0599		Csh Mountainside Licensee, Llc
ASSISTED LIVING RESIDENCE	20A014	SUNRISE OF SUMMIT (NJ20A014)	26 RIVER ROAD SUMMIT, NJ 07901	SUMMIT	NJ	07901	UNION	(908) 673-1400	(908) 673-1401	Summit Opco, Llc
ASSISTED LIVING RESIDENCE	20A105	CONTINUING CARE AT LANTERN HILL (NJ20A015)	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974	NEW PROVIDENCE	NJ	07974	UNION	(908) 516-9300	(908) 516-9325	Lantern Hill, Inc.
ASSISTED LIVING RESIDENCE	90122	BRIGHTON GARDENS OF MOUNTAINSIDE (NJ90122)	1350 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092	MOUNTAINSIDE	NJ	07092	UNION	(908) 654-4460	(908) 654-4467	Prime Care One, Llc
ASSISTED LIVING RESIDENCE	90144	SUNRISE ASSISTED LIVING OF WESTFIELD (NJ90144)	240 SPRINGFIELD AVENUE WESTFIELD, NJ 07090	WESTFIELD	NJ	07090	UNION	(908) 317-3030	(908) 789-5778	Szr Westfield Assisted Living, Llc
ASSISTED LIVING RESIDENCE	90A000	MIRA VIE AT FANWOOD (NJ90A000)	295 SOUTH AVENUE FANWOOD, NJ 07023	FANWOOD	NJ	07023	UNION	(908) 654-5200	(908) 789-0451	Mira Vie At Fanwood Opco Llc
ASSISTED LIVING RESIDENCE	90a001	BRANDYWINE LIVING AT SUMMIT (NJ90A001)	41 SPRINGFIELD AVENUE SUMMIT, NJ 07901	SUMMIT	NJ	07901	UNION	(908) 522-8852	(908) 522-8862	Csl Summit, Llc
ASSISTED LIVING RESIDENCE	90A120	AMBER COURT OF ELIZABETH, LLC (NJ90A120)	1155 EAST JERSEY STREET ELIZABETH, NJ 07201	ELIZABETH	NJ	07201	UNION	(908) 352-9200	(908) 352-8026	Amber Court Of Elizabeth, Llc
COMPREHENSIVE PERSONAL CARE HOME	20C003	BIRCHWOOD SQUARE AT CRANFORD (NJ20C003)	205 BIRCHWOOD AVENUE CRANFORD, NJ 07016	Cranford	NJ	07016	UNION	(908) 272-6660	(908) 276-2424	Crnc Operating, Llc
COMPREHENSIVE PERSONAL CARE HOME	82472	ATRIA CRANFORD (NJ82472)	10 JACKSON DRIVE CRANFORD, NJ 07016	Cranford	NJ	07016	UNION	(908) 709-4300	(908) 709-1460	Wg Cranford Sh, Llc
COMPREHENSIVE PERSONAL CARE HOME	90C000	ARISTACARE AT PARKSIDE (NJ90C000)	400 WEST STIMPSON AVENUE LINDEN, NJ 07036	LINDEN	NJ	07036	UNION	(908) 862-3399	(908) 862-6967	Linden Garden Estates Llc
HOSPITAL BASED - LONG TERM CARE FACILITY SNF/NF	12001L	TRINITAS HOSPITAL (NJ12001L)	655 EAST JERSEY STREET ELIZABETH, NJ 07206	ELIZABETH	NJ	07206	UNION	(908) 994-7525	(908) 994-7047	Trinitas Regional Medical Center
HOSPITAL BASED - LONG TERM CARE FACILITY SNF/NF	22249L	CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE (NJ22249L)	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092	MOUNTAINSIDE	NJ	07092	UNION	(908) 233-3720	(908) 301-5587	Children'S Specialized Hospital
LONG TERM CARE FACILITY	12006L	CARE CONNECTION RAHWAY (NJ12006L)	865 STONE STREET RAHWAY, NJ 07065	RAHWAY	NJ	07065	UNION	(732) 499-6460	(732) 388-4111	Care Connection Rahway, Llc
LONG TERM CARE FACILITY	20016	CONTINUING CARE AT LANTERN HILL (NJ20016)	537 MOUNTAIN AVENUE NEW PROVIDENCE, NJ 07974	NEW PROVIDENCE	NJ	07974	UNION	(908) 516-9400	(908) 516-9425	Lantern Hill, Inc.
LONG TERM CARE FACILITY SNF/NF	22001L	RUNNELLS CENTER FOR REHABILITATION & HEALTHCARE (NJ22001L)	40 WATCHUNG WAY BERKELEY HEIGHTS, NJ 07922	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 771-5700	(908) 771-9654	Runnells Operating Llc
LONG TERM CARE FACILITY SNF/NF	32003	ELMORA HILLS HEALTH & REHABILITATION CENTER (NJ32003)	225 W JERSEY STREET ELIZABETH, NJ 07202	ELIZABETH	NJ	07202	UNION	(908) 353-1220	(908) 353-0102	Elmora Hills Health & Rehabilitation Center, Llc

LONG TERM CARE FACILITY SNF/NF	602030	PLAZA HEALTHCARE & REHABILITATION CENTER (NJ602030)	456 RAHWAY AVENUE ELIZABETH, NJ 07202	ELIZABETH	NJ	07202	UNION	(908) 354-1300	(908) 629-9610	Plaza Healthcare & Rehabilitation Center, Llc
LONG TERM CARE FACILITY SNF/NF	062002	ASHBROOK CARE & REHABILITATION CENTER (NJ62002)	1610 RARITAN ROAD SCOTCH PLAINS, NJ 07076	SCOTCH PLAINS	NJ	07076	UNION	(908) 889-5500	(908) 889-6573	Ashbrook Care & Rehabilitation Center, Llc

FACILITY_TYPE	LIC#	LICENSED_NAME	ADDRESS	CITY	STATE	ZIP	COUNTY	TELEPHONE	FAXPHONE	LICENSED_OWNER
LONG TERM CARE FACILITY SNF/NF	062004	CORNELL HALL CARE & REHABILITATION CENTER (NJ62004)	234 CHESTNUT STREET UNION, NJ 07083	UNION	NJ	07083	UNION	(908) 687-7800	(908) 687-1417	Cornell Hall Care & Rehabilitation Center, Llc
LONG TERM CARE FACILITY SNF/NF	062005	CRANFORD PARK CARE (NJ62005)	600 LINCOLN PARK EAST CRANFORD, NJ 07016	Cranford	NJ	07016	UNION	(908) 276-7100	(908) 276-0173	Cranford Operating, Llc
LONG TERM CARE FACILITY SNF/NF	062006	BIRCHWOOD REHABILITATION AND HEALTHCARE CENTER (NJ62006)	205 BIRCHWOOD AVE CRANFORD, NJ 07016	Cranford	NJ	07016	UNION	(908) 272-6660	(908) 276-2424	Cranford Snf Llc
LONG TERM CARE FACILITY SNF/NF	62007X	ELIZABETH NURSING AND REHAB (NJ62007X)	1048 GROVE STREET ELIZABETH, NJ 07202	ELIZABETH	NJ	07202	UNION	(908) 354-0002	(908) 354-0033	Bracha, Inc.
LONG TERM CARE FACILITY SNF/NF	062008	SPRING GROVE REHABILITATION AND HEALTHCARE CENTER (NJ62008)	144 GALES DRIVE NEW PROVIDENCE, NJ 07974	NEW PROVIDENCE	NJ	07974	UNION	(908) 464-8600	(908) 464-3969	Spring Grove Operator, Llc
LONG TERM CARE FACILITY SNF/NF	062009	COMPLETE CARE AT PLAINFIELD LLC (NJ62009)	1340 PARK AVE PLAINFIELD, NJ 07060	PLAINFIELD	NJ	07060	UNION	(908) 754-3100	(908) 754-3418	Complete Care At Plainfield, Llc
LONG TERM CARE FACILITY SNF/NF	062013	COMPLETE CARE AT WESTFIELD, LLC (NJ62013)	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090	WESTFIELD	NJ	07090	UNION	(908) 233-9700	(908) 233-4266	Complete Care At Westfield, Llc
LONG TERM CARE FACILITY SNF/NF	062016	AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS (NJ62016)	35 COTTAGE STREET BERKELEY HEIGHTS, NJ 07922	BERKELEY HEIGHTS	NJ	07922	UNION	(908) 897-1000	(908) 425-4546	Bheights Associates, Llc
LONG TERM CARE FACILITY SNF/NF	062017	ARISTACARE AT PARKSIDE (NJ62017)	400 W STIMPSON AVE LINDEN, NJ 07036	LINDEN	NJ	07036	UNION	(908) 862-3399	(908) 862-6967	Linden Garden Estates Llc
LONG TERM CARE FACILITY SNF/NF	062018	ADROIT CARE REHABILITATION AND NURSING CENTER (NJ62018)	1777 LAWRENCE STREET RAHWAY, NJ 07065	RAHWAY	NJ	07065	UNION	(732) 499-7927		Rahway Garden Group Llc
LONG TERM CARE FACILITY SNF/NF	062020	ARISTACARE AT NORWOOD TERRACE (NJ62020)	40 NORWOOD AVENUE PLAINFIELD, NJ 07060	PLAINFIELD	NJ	07060	UNION	(908) 769-1400	(908) 769-8092	Norwood Terrace Nursing And Rehabilitation Center
LONG TERM CARE FACILITY SNF/NF	062021	MOUNTAINSIDE SKILLED NURSING AND REHAB (NJ62021)	1180 US HIGHWAY 22 MOUNTAINSIDE, NJ 07092	MOUNTAINSIDE	NJ	07092	UNION	(908) 654-0020	(800) 504-0270	Manor Care Of Mountainside Nj, Llc
LONG TERM CARE FACILITY SNF/NF	062022	COMPLETE CARE AT WOODLANDS (NJ62022)	1400 WOODLAND AVE PLAINFIELD, NJ 07060	PLAINFIELD	NJ	07060	UNION	(908) 753-1113	(908) 753-9558	Complete Care At Woodlands Llc
LONG TERM CARE FACILITY SNF/NF	062023	SOUTH MOUNTAIN HC (NJ62023)	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088	VAUXHALL	NJ	07088	UNION	(908) 688-3400	(908) 964-7502	South Mountain Rehabilitation Center Llc
LONG TERM CARE FACILITY SNF/NF	062211	COMPLETE CARE AT CLARK LLC (NJ62026)	1213 WESTFIELD AVENUE CLARK, NJ 07066	CLARK	NJ	07066	UNION	(732) 396-7100	(732) 396-1924	Clark Nursing & Rehabilitation Center, Llc

Reference: New Jersey Department of Health, Health facility search download July 17, 2025

Health Resources for Union County

Part 2: Mental Health Services

UNION COUNTY

Acute Care Family Support
Mental Health Association in NJ 88
Pompton Avenue
Verona, NJ 07044
(973) 571-4100

Early Intervention Support Service (EISS) Bridgeway
Crisis Intervention Services - Union Bridgeway
Behavioral Health
615 North Broad Street
Elizabeth, NJ 07202
(908) 469-6517

Integrated Case Management Services
Mt. Carmel Guild Behavioral Healthcare
505 South Avenue East
Cranford, NJ 07016
(908) 497-3927

Involuntary Outpatient Commitment
Trinitas Regional Medical Center
654 East Jersey Street
Elizabeth, NJ 07206
(908) 994-7543

Outpatient
Trinitas Regional Medical Center - Dept. of Psychiatry 655
East Jersey Street
Elizabeth, NJ 07201
(908) 994-7278

Outpatient
UCPC Behavioral Healthcare
117-119 Roosevelt Avenue
Plainfield, NJ 07060
(908) 756-6870 (press #4)

Partial Care
UCPC Behavioral Healthcare
117-119 Roosevelt Avenue
Plainfield, NJ 07060
(908) 756-6870 (press #3), (908) 686-0560 or (973)
571-4100

County Mental Health Board
Union County Administration Building
Elizabethtown Plaza
Elizabeth, NJ 07207
(908) 527-4844

Homeless Services (PATH)
Bridgeway Rehabilitation Services
265 West Grand Street Elizabeth,
NJ 07202
(908) 249-4100

Intensive Family Support Services
Mental Health Association in NJ
361-363 Monroe Avenue
Kenilworth, NJ 07033
(908) 272-5309

Intensive Outpatient Treatment and Support Services (IOTSS) TLC Program at Trinitas Regional Medical Center
654 East Jersey Street
Elizabeth, NJ 07206
(908) 994-7278
(908) 994-7131 (after hours)

Justice Involved Services (JIS)
Trinitas Regional Medical Center
654 East Jersey Street
Elizabeth, NJ 07206
(908) 994-7278 or (908) 994- 7131

Outpatient
Mt. Carmel Guild Behavioral Healthcare 108
Alden Street
Cranford, NJ 07016
(908) 497-3968

Partial Care
Mt. Carmel Guild Behavioral Healthcare
1160 Raymond Boulevard
Newark, NJ 07102
(973) 596-3971 or (908) 497-3968

Partial Care
Trinitas Regional Medical Center - Dept. of Psychiatry 655
East Jersey Street
Elizabeth, NJ 07201
(908) 497-3968 or call center (908) 994-7131

UNION COUNTY (Continued)

Partial Care
Bridgeway House
567 Morris Avenue
Elizabeth, NJ 07208
(908) 355-7200

PRIMARY SCREENING CENTER for UNION
Trinitas Regional Medical Center
655 East Jersey Street
Elizabeth, NJ 07201
HOTLINE: (908) 994-7131

Emergency Services - Affiliated w/Screening Center
Overlook Hospital
99 Beavior @ Silvan Road
Summit, NJ 07901
HOTLINE: (201) 841-8078

Program of Assertive Community Treatment (PACT)
Bridgeway Rehabilitation, Inc.
313 E. Front Street
Plainfield, NJ 07060
(908) 791-0505 (PACT II)

Residential Services
Volunteers of America
205 West Milton Avenue
Rahway, NJ 07065
(732) 827-2444

Residential Services
SERV Centers of NJ
130 Dermody Street
Cranford, NJ 07016
(908) 276-0490

Partial Care
Bridgeway House
567 Morris Avenue
Elizabeth, NJ 07208
(908) 355-7200

Emergency Services - Affiliated w/Screening Center
RWJ University Hospital Rahway
865 Stone Street
Rahway, NJ 07065
HOTLINE: (732) 499-6165 or (732) 381-4949

Program of Assertive Community Treatment (PACT)
Bridgeway Rehabilitation, Inc.
96 W. Grand Street
Elizabeth, NJ 07202
(908) 352-0242 (PACT I)

Program of Assertive Community Treatment (PACT)
Bridgeway Rehabilitation, Inc.
1023 Commerce Avenue
Union, NJ 07083
(908) 688-5400 (PACT III)

Self-Help/Wellness Center
Park Avenue CWC
333 Park Avenue Plainfield, NJ 07060 (908)
757-1350

Esperanza
lsantana@mhanj.org
(973) 571-4100
(Spanish-speaking staff)

Short Term Care Facility (STCF)
Trinitas Regional Medical Center
655 East Jersey Street
Elizabeth, NJ 07201
(908) 994-7205 / 7202
HOTLINE: (908) 351-6684

UNION COUNTY (Continued)

Short Term Care Facility Trinitas Regional Medical Center 655 East Jersey Street Elizabeth, NJ 07026 (908) 994-7275	**Supported Education** Bridgeway Behavioral Health Services 373 Clermont Terrace Union, NJ 07083 (908)687-9666
Supported Employment Services Bridgeway Behavioral Health Services 373 Clermont Terrace Union, NJ 07083 (908) 686-2956	**Community Support Services** Advance Housing, Inc. 100 Hollister Road - Suite 203 Teterboro, NJ 07608 (201) 498-9140
Community Support Services & Medically Enhanced Community Support Services Bridgeway House 265 West Grand Street Elizabeth, NJ 07208 (908) 249-4100	**Systems Advocacy** Community Health Law Project 65 Jefferson Street, Suite 402 Elizabeth, NJ 07201 (908) 355-8282
Voluntary Unit Trinitas Regional Medical Center 655 East Jersey Street Elizabeth, NJ 07206 (908) 994-7205	**Systems Advocacy** United Family & Children's Society 305 West 7th Street Plainfield, NJ 07060 (908) 755-4848

Reference: Department of Human Services, Division of Mental Health and Addiction Services. Directory of Mental Health Services (DHMAS contracted providers only), updated March 2025 and downloaded July 31, 2025

Appendix E. Additional Data Tables and Graphs
Population Overview

Table 20. Age Distribution, by State, County and Town, 2019-2023

	Under 18 years	18 to 24 years	25 to 44 years	45 to 64 years	65 to 74 years	75 years and over
New Jersey	21.9%	8.4%	26.1%	26.9%	9.8%	7.0%
Union County	23.5%	8.2%	26.4%	27.0%	8.7%	6.1%
Clark	21.6%	5.6%	26.4%	23.8%	11.0%	11.6%
Cranford	22.5%	6.2%	23.8%	27.8%	9.2%	10.4%
Elizabeth (citywide)	25.5%	9.7%	28.4%	25.1%	6.7%	4.6%
Elizabeth (07201)	25.7%	8.5%	30.2%	26.1%	6.0%	3.6%
Elizabeth (07202)	25.0%	9.2%	27.7%	25.6%	7.4%	5.2%
Elizabethport (07206)	29.3%	11.1%	27.9%	22.4%	5.5%	3.9%
Elizabeth (07208)	22.5%	10.0%	28.2%	26.5%	7.7%	5.2%
Linden	20.8%	8.3%	27.7%	28.9%	9.0%	5.2%
Rahway	20.6%	8.4%	28.9%	26.4%	8.4%	7.5%
Roselle	19.2%	10.8%	28.4%	25.5%	9.3%	7.1%
Middlesex County	21.6%	9.4%	26.7%	26.5%	9.3%	6.4%
Carteret	22.2%	11.0%	24.9%	26.7%	8.6%	6.4%
Avenel	18.0%	6.2%	31.7%	31.4%	8.2%	4.3%
Colonia	21.2%	5.9%	25.0%	28.7%	11.9%	7.4%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Table 21. Age Distribution, by Race/Ethnicity, by State and County, 2019-2023

		Asian, non-Hispanic			Black, non-Hispanic		
	Total Population	**Under 18 years**	**18 to 64 years**	**65 years and over**	**Under 18 years**	**18 to 64 years**	**65 years and over**
New Jersey	9,267,014	2.1%	6.7%	1.4%	2.8%	8.1%	1.8%
Union County	572,549	1.3%	3.8%	0.8%	4.4%	12.8%	3.1%
Middlesex County	861,535	6.0%	16.7%	3.2%	2.4%	7.1%	1.4%
		Hispanic/Latino			**White, non-Hispanic**		
	Total Population	**Under 18 years**	**18 to 64 years**	**65 years and over**	**Under 18 years**	**18 to 64 years**	**65 years and over**
New Jersey	9,267,014	6.4%	14.1%	2.1%	8.9%	29.7%	12.1%
Union County	572,549	9.9%	22.0%	3.3%	6.6%	20.3%	8.0%
Middlesex County	861,535	6.9%	15.1%	2.1%	5.1%	21.9%	9.8%
		Additional Race, non-Hispanic			**2+ Races**		
	Total Population	**Under 18 years**	**18 to 64 years**	**65 years and over**	**Under 18 years**	**18 to 64 years**	**65 years and over**
New Jersey	9,267,014	2.7%	6.9%	0.9%	2.7%	5.5%	4.1%
Union County	572,549	6.2%	13.8%	1.2%	2.6%	5.2%	5.0%
Middlesex County	861,535	3.4%	8.4%	1.2%	2.2%	3.9%	3.1%

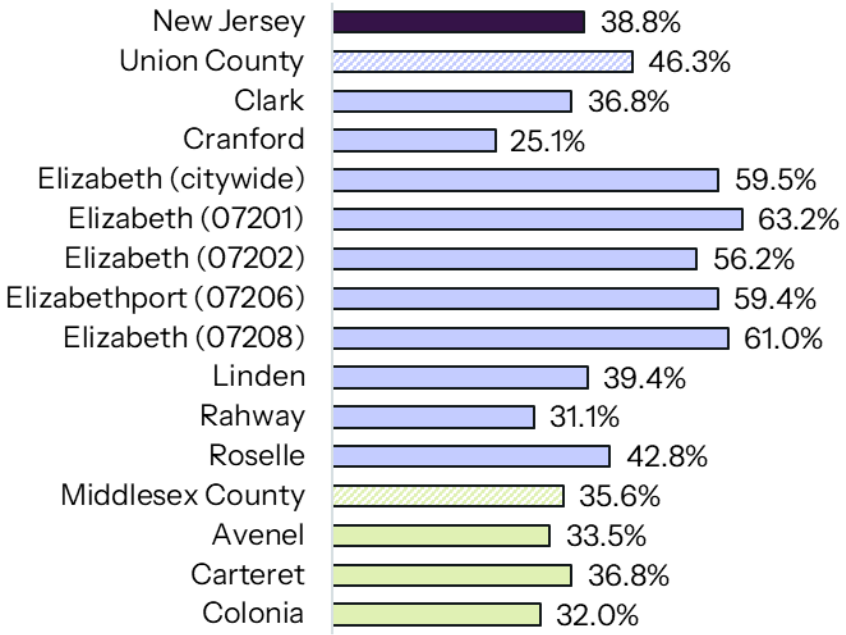
DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-202

Table 22. Percent Change in Foreign-Born Population, by State, County, and Town, 2014-2023

	2014-2018	2019-2023	% change
New Jersey	22.2%	23.5%	1.3%
Union County	30.0%	32.8%	2.8%
Clark	16.5%	13.6%	-2.9%
Cranford	10.8%	10.0%	-0.8%
Elizabeth (citywide)	46.2%	50.6%	4.4%
Elizabeth (07201)	47.8%	51.6%	3.8%
Elizabeth (07202)	49.1%	50.3%	1.2%
Elizabethport (07206)	42.6%	48.9%	6.3%
Elizabeth (07208)	44.1%	52.0%	7.9%
Linden	34.0%	35.7%	1.7%
Rahway	26.0%	22.5%	-3.5%
Roselle	29.8%	31.9%	2.1%
Middlesex County	32.7%	34.7%	2.0%
Avenel	31.5%	29.4%	-2.1%
Carteret	32.0%	34.7%	2.7%
Colonia	23.4%	27.3%	3.9%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2014-2018 and 2019-2023

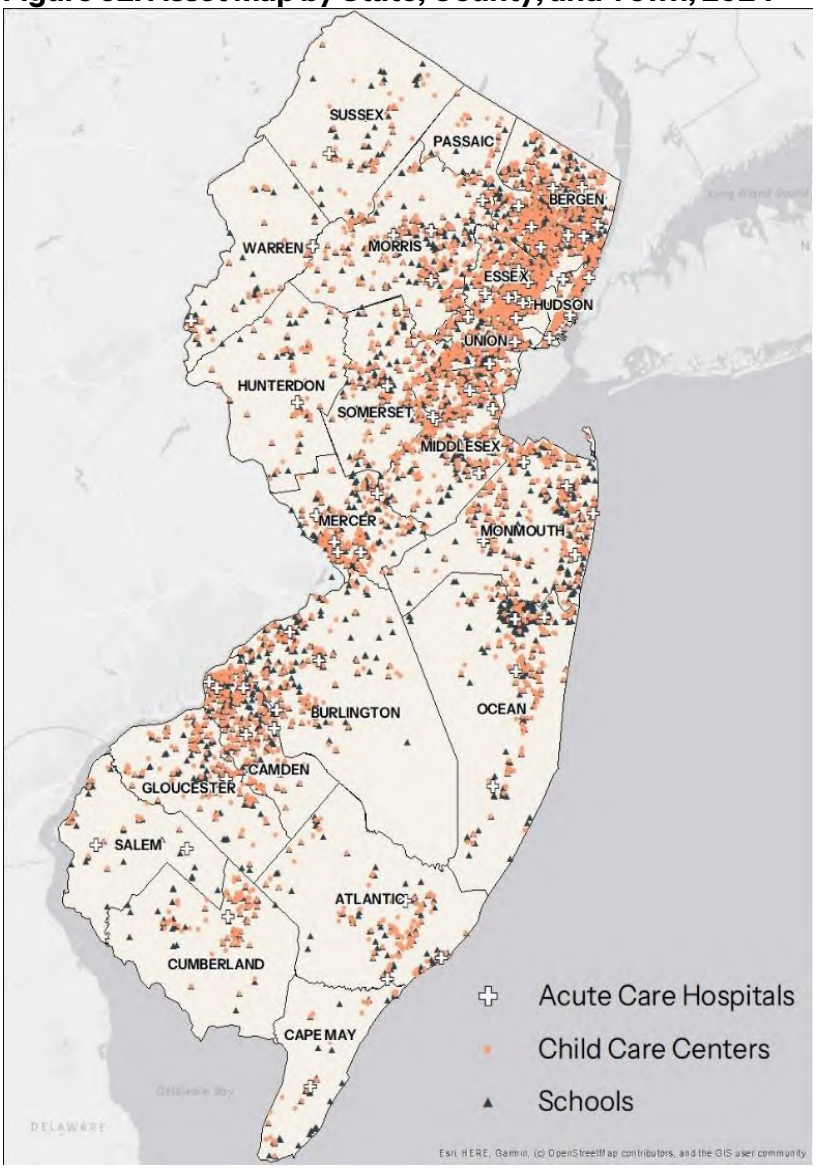
Figure 91. Percent Population Lacking English Proficiency (Out of Population Who Speak a Language Other than English at Home), by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Green Space and Built Environment

Figure 92. Asset Map by State, County, and Town, 2024



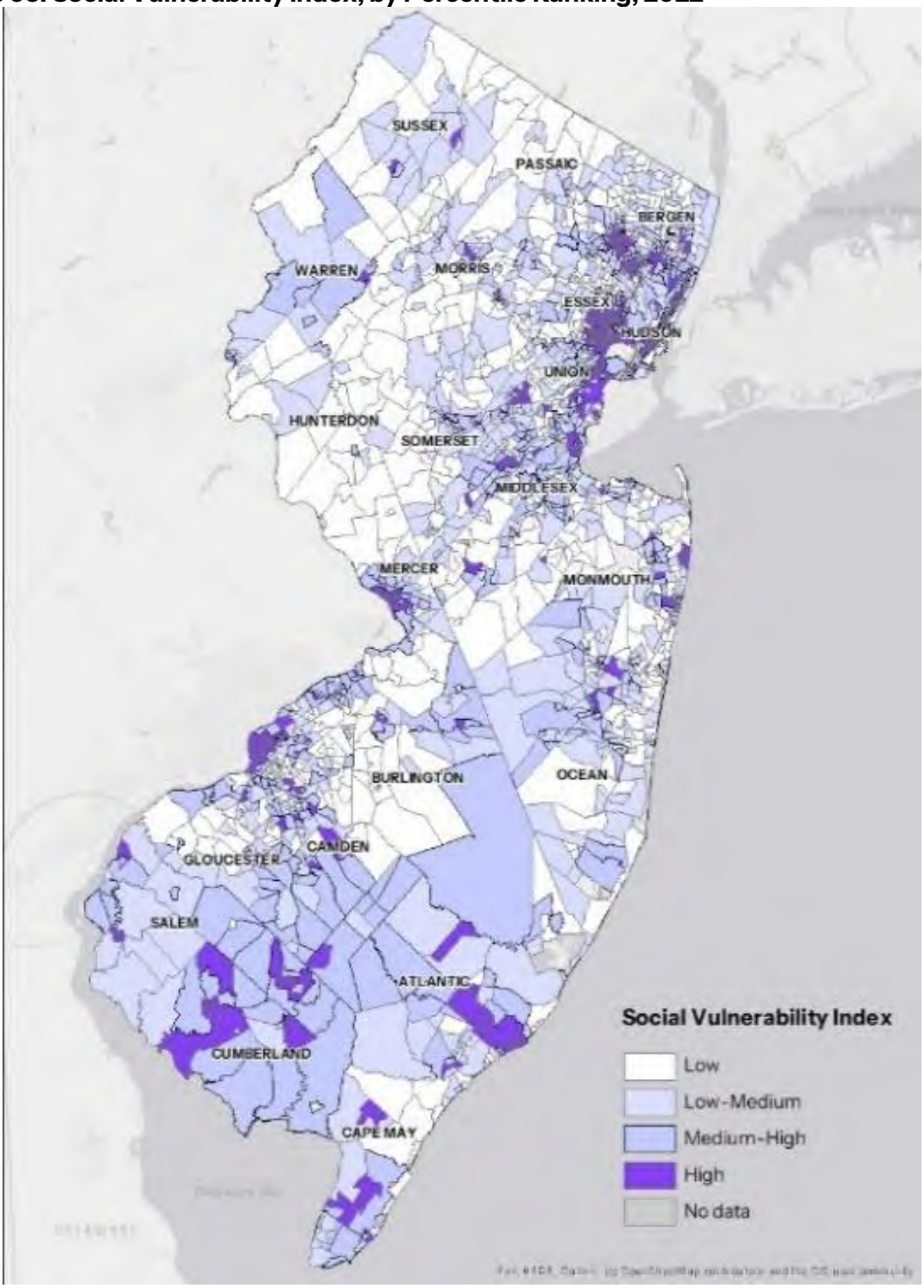
DATA SOURCE: NJ Department of Environmental Protection Bureau of GIS, Schools and Child Care Centers and Acute Care Hospitals, 2024

Table 23. Social Vulnerability Index, by State and County, 2022

	Overall SVI
New Jersey	0.5
Union County	0.8
Middlesex County	0.6

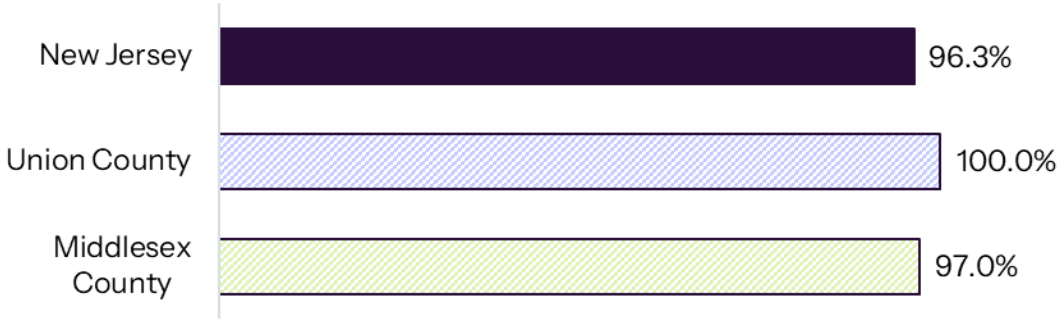
DATA SOURCE: CDC, ATSDR's Geospatial Research, Analysis, & Services Program (GRASP), 2022
NOTE: A percentile ranking represents the proportion of tracts (or counties) that are equal to or lower than a tract (or county) of interest in terms of social vulnerability. For example, a CDC/ATSDR SVI ranking of 0.85 signifies that 85% of tracts (or counties) in the state or nation are less vulnerable than the tract (or county) of interest and that 15% of tracts (or counties) in the state or nation are more vulnerable.

Figure 93. Social Vulnerability Index, by Percentile Ranking, 2022



DATA SOURCE: CDC, ATSDR's Geospatial Research, Analysis, & Services Program (GRASP), 2022
NOTE: A percentile ranking represents the proportion of tracts (or counties) that are equal to or lower than a tract (or county) of interest in terms of social vulnerability.

Figure 94. Percent Population with Adequate Access to Location for Physical Activity, by State and County, 2020-2023



DATA SOURCE: Business Analyst, Delorme map data, ESRI, & U.S. Census Files, as cited by RWJF-County Health Rankings 2020-2023

Education

Table 24. Educational Attainment of Adults Aged 25+, by State, County, and Town, 2019-2023

	High school graduate or higher	Bachelor's degree or higher
New Jersey	90.7%	42.9%
Union County	86.3%	38.6%
Clark	95.2%	46.4%
Cranford	97.2%	64.8%
Elizabeth (citywide)	74.3%	14.2%
Elizabeth (07201)	75.0%	15.0%
Elizabeth (07202)	75.7%	12.6%
Elizabethport (07206)	63.7%	7.8%
Elizabeth (07208)	81.0%	21.2%
Linden	85.3%	23.3%
Rahway	89.6%	35.6%
Roselle	85.4%	26.1%
Middlesex County	89.3%	45.1%
Avenel	87.7%	29.4%
Carteret	84.6%	27.7%
Colonia	91.7%	46.5%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

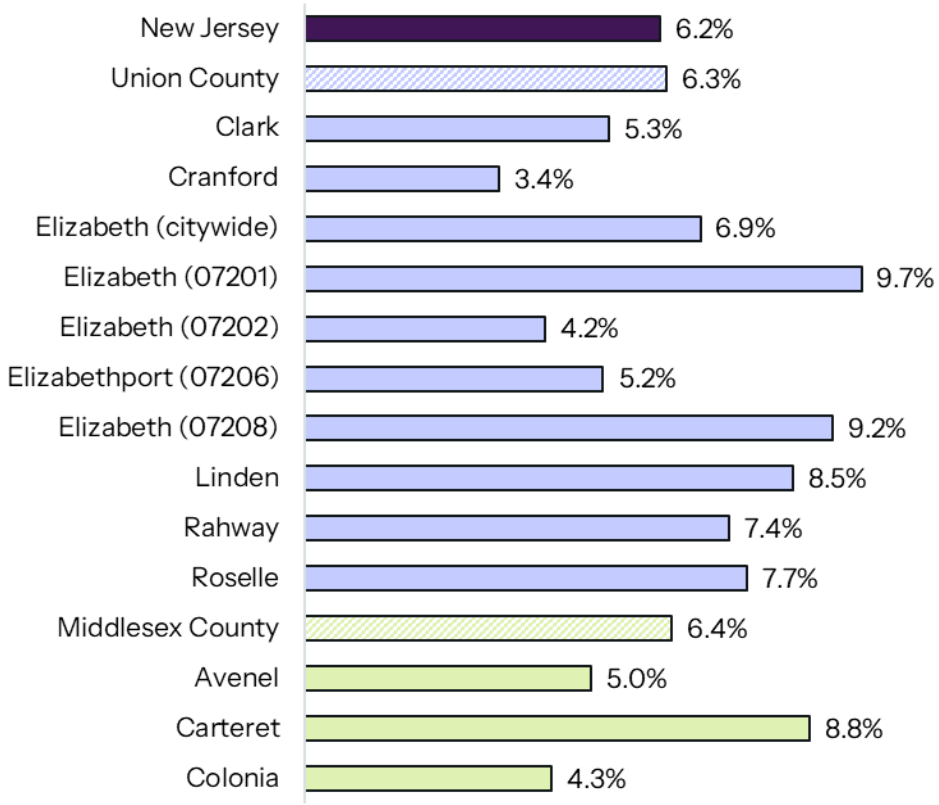
Table 25. Educational Attainment of Adults Aged 25+, by Race/Ethnicity, by State, County, and Town, 2019-23

	Asian, Non-Hispanic		Black, Non-Hispanic		Hispanic/Latino		White, Non-Hispanic		Additional Race Category, Non-Hispanic		2+ Races	
	HS	BA/BS+	HS	BA/BS+	HS	BA/BS+	HS	BA/BS+	HS	BA/BS+	HS	BA/BS+
New Jersey	92.8%	72.0%	89.9%	28.0%	76.2%	22.5%	95.4%	47.9%	71.3%	18.0%	84.4%	32.4%
Union County	94.6%	72.0%	91.0%	28.4%	71.8%	18.7%	93.8%	54.5%	65.8%	13.4%	83.1%	30.2%
Clark	93.4%	69.0%	96.2%	75.6%	88.4%	42.7%	95.8%	45.2%	96.4%	31.4%	92.4%	40.0%
Cranford	100.0%	73.1%	74.9%	12.8%	94.9%	54.6%	97.9%	66.5%	97.0%	55.5%	94.2%	62.1%
Elizabeth (citywide)	99.5%	45.6%	86.6%	12.9%	69.3%	11.7%	77.4%	21.4%	66.5%	7.5%	73.8%	19.6%
Elizabeth (07201)	97.2%	63.3%	81.1%	16.0%	72.0%	13.5%	78.1%	16.8%	71.3%	11.3%	74.2%	19.3%
Elizabeth (07202)	100.0%	30.7%	92.7%	11.9%	72.1%	11.1%	73.5%	14.5%	69.0%	6.8%	75.3%	20.2%
Elizabethport (07206)	100.0%	38.9%	79.2%	6.6%	56.6%	4.2%	67.0%	21.6%	56.1%	2.6%	72.8%	15.3%
Elizabeth (07208)	100.0%	51.9%	91.4%	16.2%	75.1%	18.2%	85.7%	31.6%	76.9%	16.2%	72.2%	21.6%
Linden	88.8%	56.3%	85.6%	23.1%	79.5%	17.9%	89.8%	26.0%	74.5%	15.5%	85.9%	17.9%
Rahway	97.3%	80.4%	90.9%	28.9%	81.3%	24.4%	94.6%	40.1%	77.0%	18.7%	85.9%	37.0%
Roselle	70.7%	42.8%	96.5%	25.0%	68.9%	20.6%	85.6%	37.9%	61.0%	14.0%	81.9%	27.1%
Middlesex County	91.8%	74.0%	92.5%	35.7%	73.2%	18.8%	94.4%	42.8%	68.9%	17.1%	84.2%	30.4%
Avenel	92.8%	58.6%	86.9%	29.1%	80.9%	16.4%	89.6%	23.0%	74.1%	34.5%	90.4%	11.3%
Carteret	75.8%	40.4%	95.7%	29.6%	81.4%	19.0%	88.0%	24.9%	75.5%	14.9%	87.4%	20.5%
Colonia	90.0%	65.1%	94.4%	63.9%	90.0%	38.0%	93.7%	43.7%	66.5%	25.6%	94.6%	42.4%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023
NOTE: HS = High School degree or GED completed; BA/BS+ = Bachelor's degree or above obtained.

Employment and Workforce

Figure 95. Unemployment Rate, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Table 26. Unemployment Rate, by Age, by State, County, and Town, 2019-2023

	16 to 19 years	20 to 24 years	25 to 29 years	30 to 34 years	35 to 44 years	45 to 54 years	55 to 59 years	60 to 64 years	65 to 74 years	75 years and over
New Jersey	15.9%	11.6%	7.0%	5.5%	4.9%	4.7%	5.0%	5.2%	5.9%	5.7%
Union County	22.5%	14.0%	7.1%	4.9%	5.3%	4.8%	4.8%	3.4%	5.5%	2.8%
Clark	24.0%	31.1%	1.1%	0.0%	0.7%	7.4%	6.9%	1.1%	2.2%	0.0%
Cranford	10.5%	8.6%	5.8%	1.3%	2.9%	2.9%	4.1%	2.1%	0.0%	0.0%
Elizabeth (citywide)	17.2%	10.7%	8.0%	4.4%	5.5%	6.7%	5.5%	2.9%	12.5%	3.5%
Elizabeth (07201)	19.1%	15.2%	9.6%	9.5%	8.5%	12.0%	2.2%	3.1%	11.3%	18.3%
Elizabeth (07202)	6.3%	11.4%	4.2%	1.8%	3.2%	3.2%	4.8%	1.5%	7.4%	0.0%
Elizabethport (07206)	26.2%	0.0%	4.7%	3.7%	6.2%	3.4%	5.4%	0.0%	17.7%	0.0%
Elizabeth (07208)	22.3%	14.2%	15.0%	3.7%	5.1%	9.0%	10.4%	5.7%	16.1%	0.0%
Linden	25.9%	21.4%	6.7%	4.9%	9.7%	6.9%	5.9%	6.1%	1.1%	0.0%
Rahway	42.9%	6.1%	12.7%	3.6%	13.4%	1.2%	1.7%	7.6%	2.9%	0.0%
Roselle	32.5%	11.8%	11.7%	6.4%	5.1%	7.8%	2.2%	2.9%	4.7%	5.6%
Middlesex County	15.1%	11.9%	8.0%	5.3%	5.2%	4.7%	4.4%	5.3%	8.2%	11.3%
Avenel	6.2%	18.5%	0.6%	5.9%	2.4%	5.6%	1.3%	5.6%	5.4%	13.6%
Carteret	4.4%	27.8%	1.3%	1.2%	11.1%	0.7%	0.0%	8.7%	24.9%	0.0%
Colonia	9.2%	3.9%	11.5%	7.8%	1.0%	3.9%	5.4%	0.4%	6.8%	8.9%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Table 27. Unemployment Rate, by Gender, by State, County, and Town, 2019-2023

	Overall	Male	Female
New Jersey	6.2%	5.7%	6.0%
Union County	6.3%	5.6%	6.2%
Clark	5.3%	5.3%	4.4%
Cranford	3.4%	4.0%	2.8%
Elizabeth (citywide)	6.9%	5.1%	7.7%
Elizabeth (07201)	9.7%	4.9%	15.2%
Elizabeth (07202)	4.2%	3.6%	4.5%
Elizabethport (07206)	5.2%	4.0%	4.2%
Elizabeth (07208)	9.2%	8.2%	8.7%
Linden	8.5%	7.7%	9.4%
Rahway	7.4%	5.3%	8.3%
Roselle	7.7%	8.8%	5.4%
Middlesex County	6.4%	5.4%	6.5%
Avenel	5.0%	5.7%	4.1%
Carteret	8.8%	11.2%	4.6%
Colonia	4.3%	2.2%	5.7%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Income and Financial Security

Table 28. Median Household Income, by Race/Ethnicity, by State, County, and Town, 2019-2023

	Overall	Asian, non-Hispanic	Black or African American, non-Hispanic	Hispanic /Latino	White, non-Hispanic	Additional Race, non-Hispanic	2+ Races
New Jersey	$101,050	$154,105	$68,457	$74,331	$113,091	$70,457	$84,641
Union County	$100,117	$165,686	$86,179	$77,613	$131,368	$73,125	$95,098
Clark	$122,610	$206,992	$91,738	$137,159	$121,667	$126,250	$134,375
Cranford	$148,629	$100,000	$71,618	$145,667	$155,053	$191,324	$159,861
Elizabeth (citywide)	$63,874	$69,427	$56,802	$62,077	$74,935	$64,128	$72,290
Elizabeth (07201)	$62,026	$90,469	$53,567	$64,641	$65,379	$65,354	$70,135
Elizabeth (07202)	$68,071	-	$67,724	$68,120	$67,864	$66,567	$79,685
Elizabethport (07206)	$60,992	-	$50,612	$58,795	$86,054	$64,188	$86,431
Elizabeth (07208)	$61,873	$99,224	$56,211	$54,110	$99,531	$56,724	$60,840
Linden	$91,036	$117,524	$88,524	$96,593	$82,989	$95,064	$102,887
Rahway	$90,852	$163,074	$78,075	$81,574	$100,421	$91,995	$106,801
Roselle	$82,967	$112,792	$79,221	$98,539	$81,232	$79,236	$107,143
Middlesex County	$109,028	$160,165	$91,149	$81,447	$106,034	$80,821	$91,185
Avenel	$95,935	$140,592	$103,666	$80,043	$85,993	$91,588	$80,234
Carteret	$87,553	$110,000	$110,407	$80,078	$72,788	$67,229	$80,102
Colonia	$134,301	$176,304	$142,125	$160,069	$121,599	$94,286	$105,536

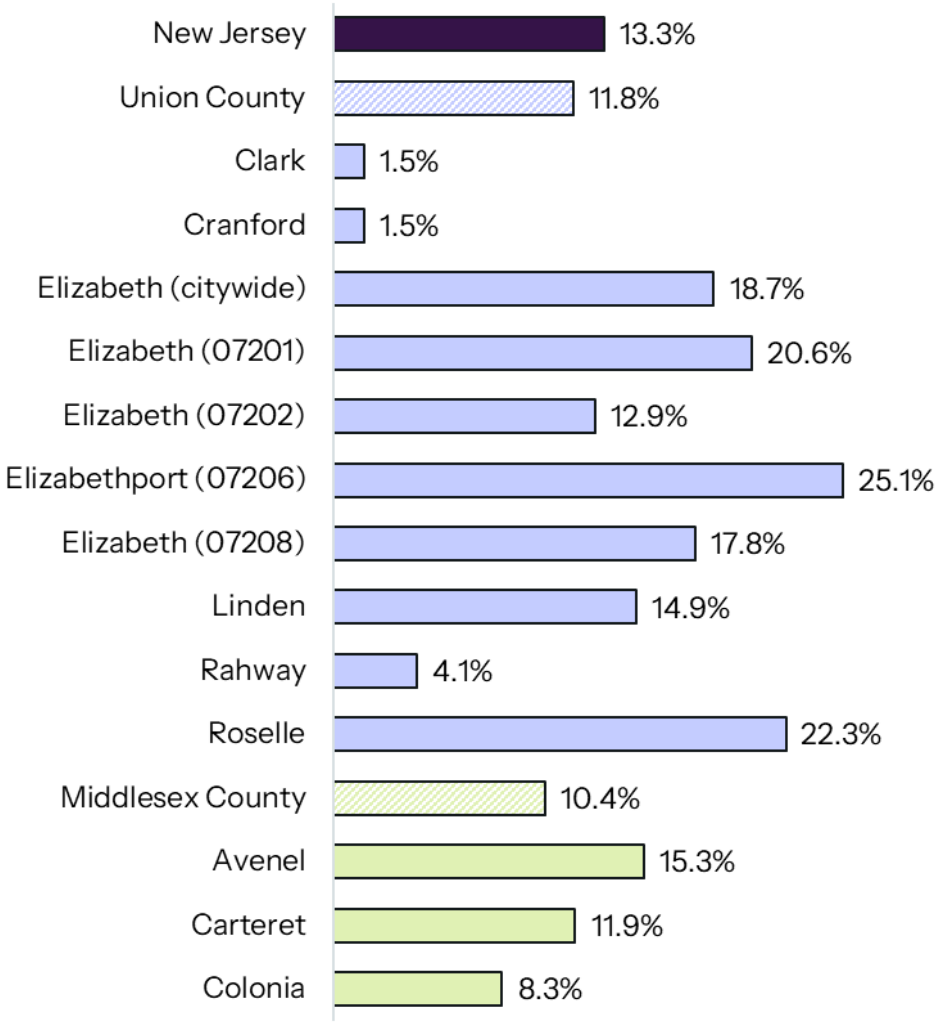
DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023
NOTE: A DASH (-) means that data are suppressed.

Table 29. Individuals Below Poverty Level, by Race/Ethnicity, by State, County, and Town, 2019-2023

	Overall	Asian, non-Hispanic	Black or African American, non-Hispanic	Hispanic or Latino origin (of any race)	White, non-Hispanic	Additional Races, non-Hispanic	2+ Races
New Jersey	9.8%	5.7%	16.3%	16.1%	6.3%	17.9%	13.0%
Union County	8.9%	5.3%	10.4%	13.2%	4.9%	15.7%	7.9%
Clark	2.9%	0.0%	4.6%	2.5%	2.8%	2.4%	3.2%
Cranford	2.7%	11.2%	2.8%	0.8%	2.6%	1.3%	1.3%
Elizabeth (citywide)	15.3%	23.9%	17.5%	15.7%	12.3%	16.9%	10.4%
Elizabeth (07201)	18.7%	24.6%	20.1%	20.5%	11.3%	25.6%	15.8%
Elizabeth (07202)	12.3%	36.2%	18.1%	11.6%	9.3%	12.0%	8.3%
Elizabethport (07206)	18.5%	22.7%	19.1%	17.2%	31.8%	18.4%	3.0%
Elizabeth (07208)	13.4%	10.7%	12.9%	16.2%	7.5%	18.6%	13.1%
Linden	9.0%	3.3%	7.1%	9.3%	11.6%	14.8%	4.7%
Rahway	6.8%	0.0%	9.0%	6.8%	5.2%	6.5%	9.6%
Roselle	10.4%	5.2%	5.8%	12.0%	12.2%	18.8%	7.1%
Middlesex County	8.5%	4.6%	9.4%	16.5%	6.1%	17.1%	13.1%
Avenel	8.5%	1.1%	12.4%	20.2%	5.6%	16.8%	14.4%
Carteret	10.0%	3.3%	6.7%	16.5%	10.9%	21.7%	15.3%
Colonia	5.9%	2.9%	10.7%	11.2%	4.0%	31.5%	2.7%

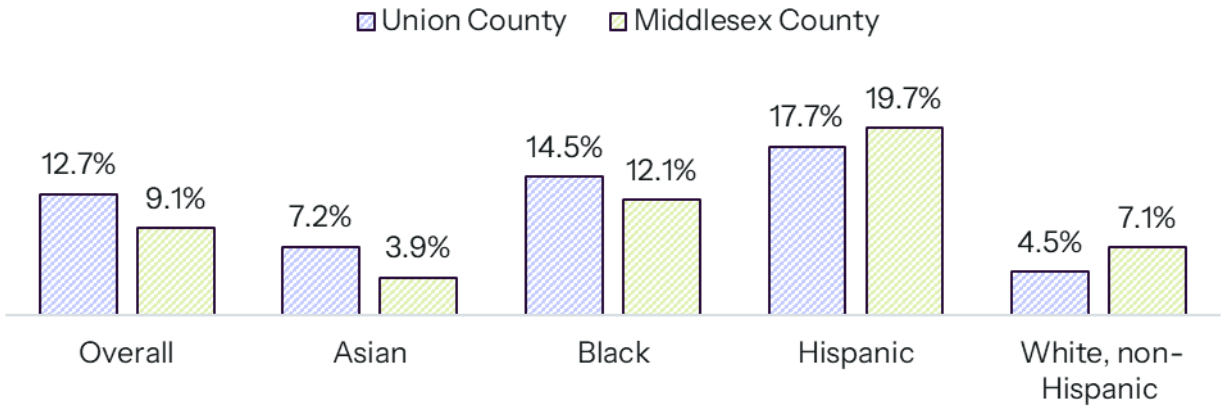
DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Figure 96. Percentage of Children Living Below the Poverty Line, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Figure 97. Percent Children Living Below the Poverty Line, by Race/Ethnicity, by County, 2022



DATA SOURCE: U.S. Census Bureau, Small Area Income and Poverty Estimates, as reported by County Health Rankings, University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, 2024

Food Access and Food Insecurity

Table 30. Households Receiving Food Stamps/SNAP, by Race/Ethnicity of Householder, by State, County, and Town, 2019-2023

	Overall	Asian alone	Black or African American alone	Hispanic or Latino origin (of any race)	White alone, not Hispanic or Latino	Some other race alone	Two or more races
New Jersey	8.8%	5.6%	27.3%	37.7%	27.7%	16.3%	14.9%
Union County	8.1%	3.5%	33.5%	48.9%	13.6%	23.1%	17.5%
Clark	1.9%	0.0%	0.0%	17.9%	53.6%	17.9%	28.6%
Cranford	2.6%	15.7%	0.0%	0.0%	82.7%	0.0%	1.6%
Elizabeth (citywide)	15.9%	2.7%	28.7%	61.7%	9.2%	26.0%	17.5%
Elizabeth (07201)	19.3%	0.0%	37.1%	62.7%	7.2%	15.3%	16.4%
Elizabeth (07202)	12.5%	8.2%	20.8%	62.8%	9.2%	27.3%	20.7%
Elizabethport (07206)	17.4%	1.3%	35.4%	52.1%	10.5%	36.1%	10.1%
Elizabeth (07208)	16.6%	1.2%	23.2%	67.6%	9.9%	26.8%	21.3%
Linden	11.8%	1.7%	34.0%	50.0%	12.9%	17.8%	29.8%
Rahway	9.7%	1.6%	53.4%	39.0%	8.5%	3.0%	26.6%
Roselle	8.2%	0.0%	54.7%	21.2%	16.6%	8.0%	15.2%
Middlesex County	7.7%	14.1%	18.0%	42.5%	25.1%	22.9%	9.0%
Avenel	4.2%	0.0%	48.1%	49.8%	10.5%	14.8%	13.5%
Carteret	13.1%	32.0%	9.4%	45.0%	12.4%	30.8%	14.3%
Colonia	3.4%	30.3%	20.7%	24.5%	19.2%	21.6%	5.3%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

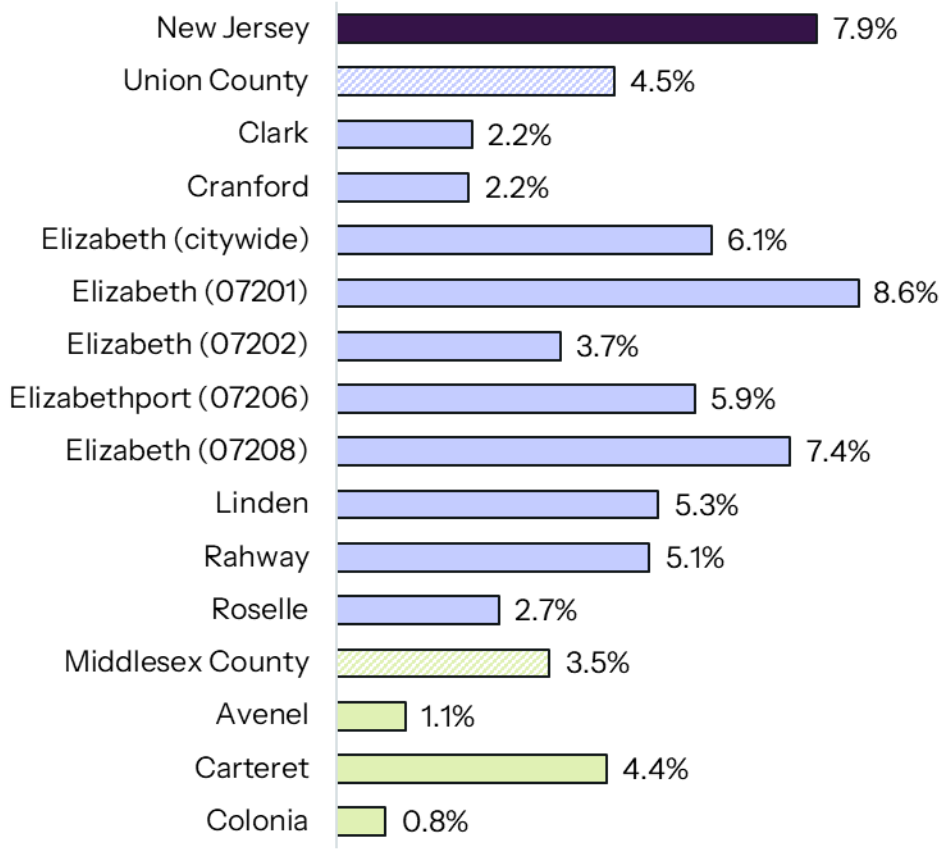
Table 31. Food Desert Factor Score, by Designated Food Desert Communities, 2022

	Municipality	Population Weighted Avg FDF Score	Avg Food Desert Low Access Score (supermarket)	Food Desert Population (2020)
Union County	Elizabeth city	49.6	66.3	69,264
	Linden/Roselle	31.5	43.1	36,659

DATA SOURCE: New Jersey Economic Development Authority, 2022
NOTE: Food Desert Factor Score ranges from 0 to 100. Higher scores indicate more factors consistent with being a Food Desert Community. Not every community has a food desert score.

Housing

Figure 98. Homeowner Vacancy Rate, by State, County, and Town, 2019-2023



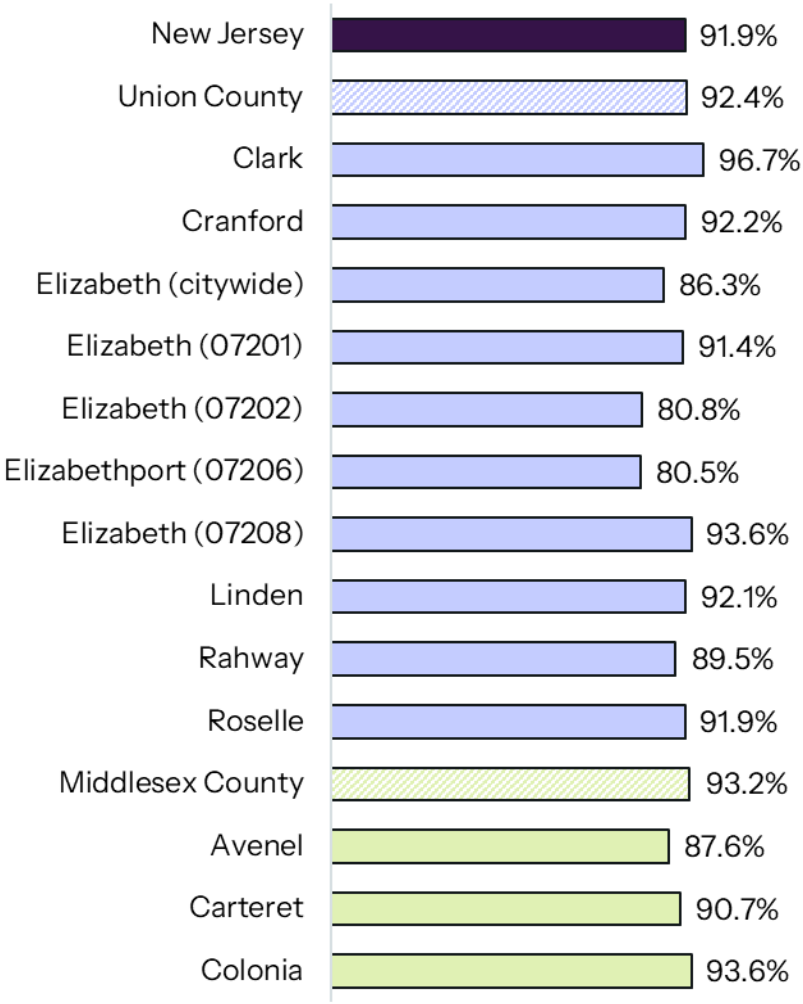
DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Table 32. Household Occupants per Room, by State, County, and Town, 2019-2023

	1.00 or less	1.01 to 1.50	1.51 or more
New Jersey	96.3%	2.4%	1.3%
Union County	94.6%	3.5%	1.9%
Clark	98.5%	1.1%	0.4%
Cranford	98.5%	0.4%	1.1%
Elizabeth (citywide)	89.4%	7.6%	3.0%
Elizabeth (07201)	89.5%	9.2%	1.3%
Elizabeth (07202)	89.4%	6.0%	4.5%
Elizabethport (07206)	88.1%	9.7%	2.2%
Elizabeth (07208)	90.1%	6.9%	3.0%
Linden	96.1%	2.7%	1.2%
Rahway	96.5%	2.6%	0.9%
Roselle	96.6%	2.5%	0.9%
Middlesex County	94.9%	3.6%	1.5%
Avenel	94.4%	3.6%	2.0%
Carteret	89.2%	8.6%	2.2%
Colonia	98.3%	0.9%	0.8%

DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

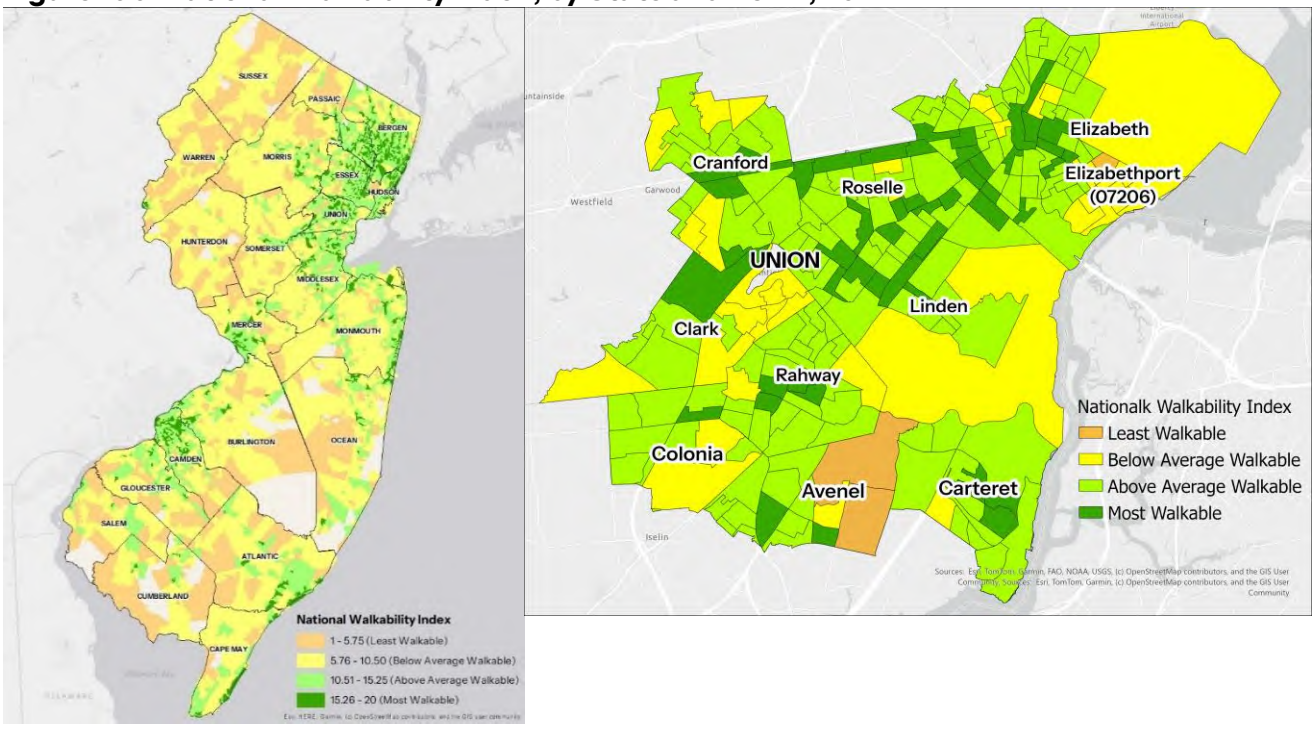
Figure 99. Households with Internet, by State, County, and Town, 2019-2023



DATA SOURCE: U.S. Census Bureau. American Community Survey, ACS 5-Year Estimates Subject Tables, 2019-2023

Transportation

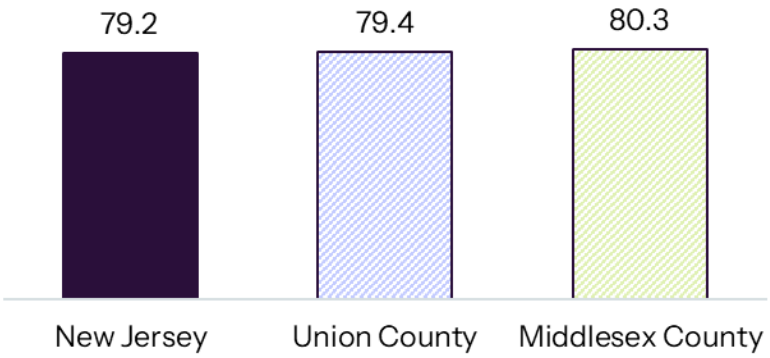
Figure 100. National Walkability Index, by State and Town, 2021



DATA SOURCE: U.S. EPA, National Walkability Index, 2021

Leading Causes of Death and Premature Mortality

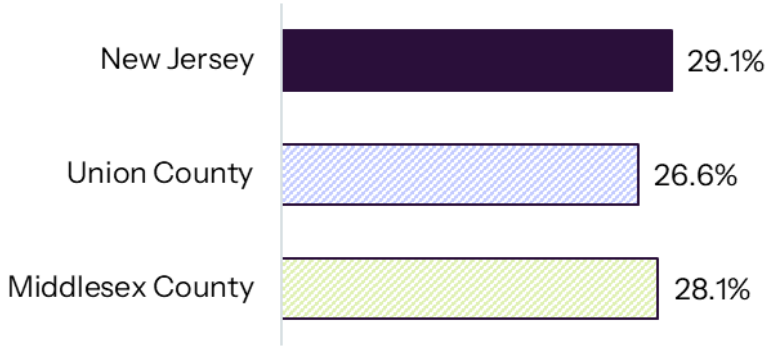
Figure 101. Life Expectancy in Years, by State and County, 2021



DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2024

Obesity and Physical Activity

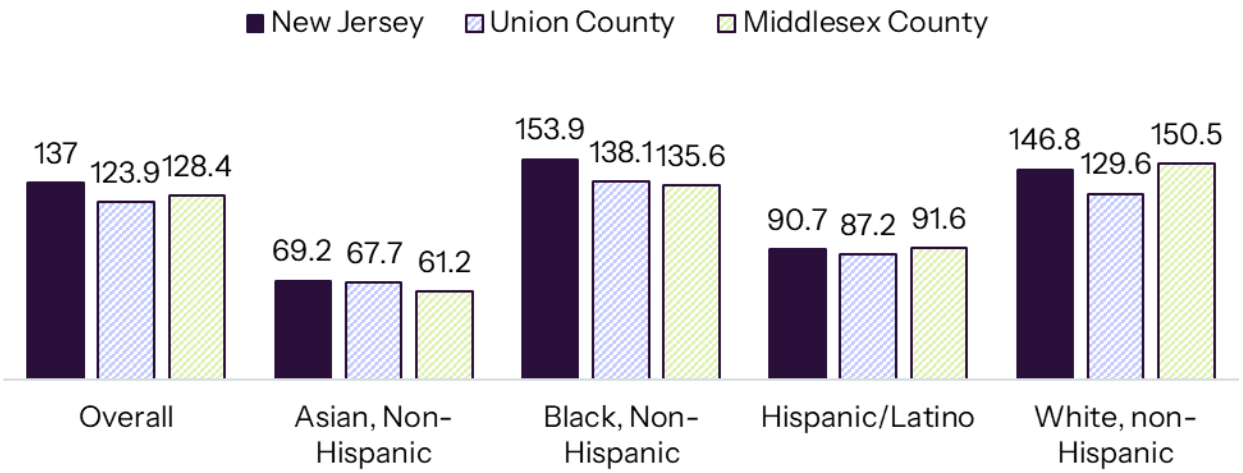
Figure 102. Percent Adults Self-Reported Obese, by State and County, 2022



DATA SOURCE: Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health 2024

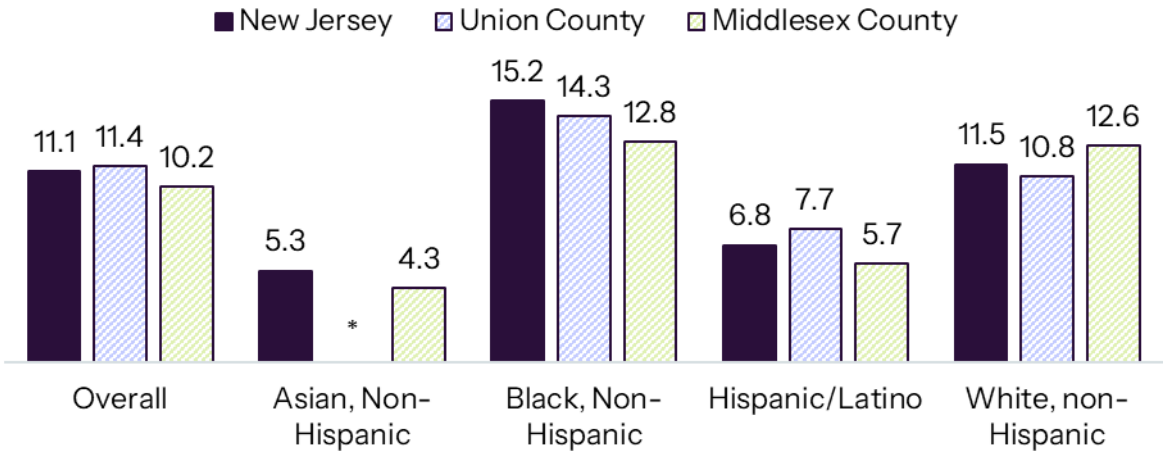
Cancer and Chronic Disease

Figure 103. Age-Adjusted Rate of Deaths due to Cancer per 100,000, by Race/Ethnicity, by State and County, 2017-2021



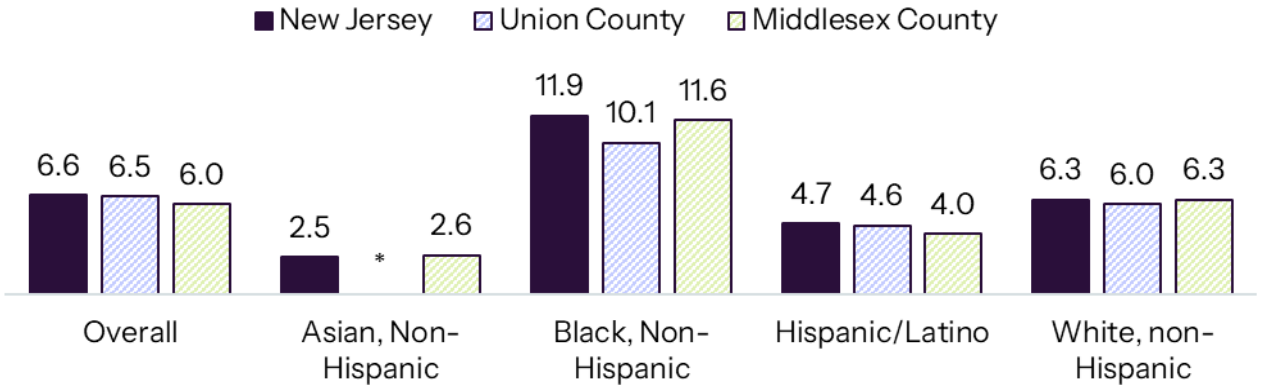
DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

Figure 104. Age-Adjusted Rate of Deaths due to Breast Cancer per 100,000, by Race/Ethnicity, by State and County, 2017-2021



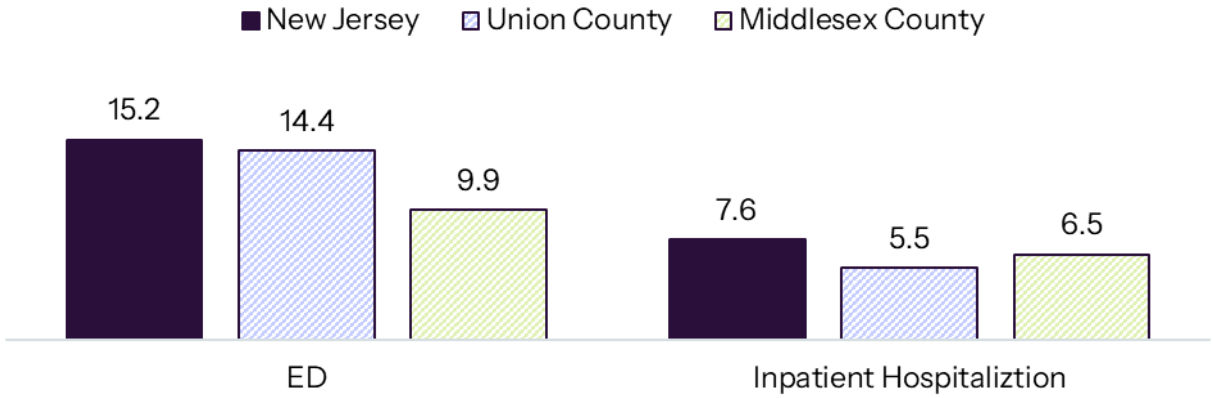
DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023
NOTE: Asterisk (*) means that data are suppressed, as the rate does not meet National Center for Health Statistics standards of statistical reliability for presentation.

Figure 105. Age-Adjusted Rate of Deaths due to Prostate Cancer per 100,000, by Race/Ethnicity, by State and County, 2017-2021



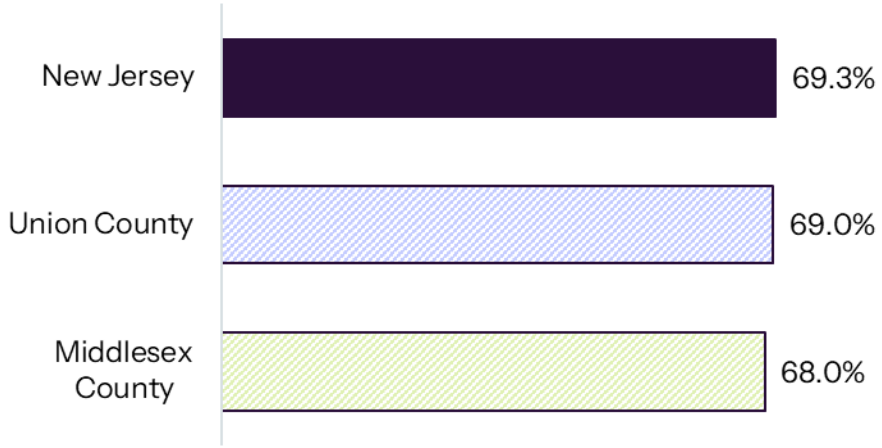
DATA SOURCE: Death Certificate Database, Office of Vital Statistics and Registry Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023
NOTE: Asterisk (*) means that data are suppressed, as the rate does not meet National Center for Health Statistics standards of statistical reliability for presentation.

Figure 106. Age-Adjusted Rate of Emergency Department Visits & Inpatient Hospitalizations due to Chronic Obstructive Pulmonary Disease as Primary Diagnosis, per 10,000, by State and County, 2023



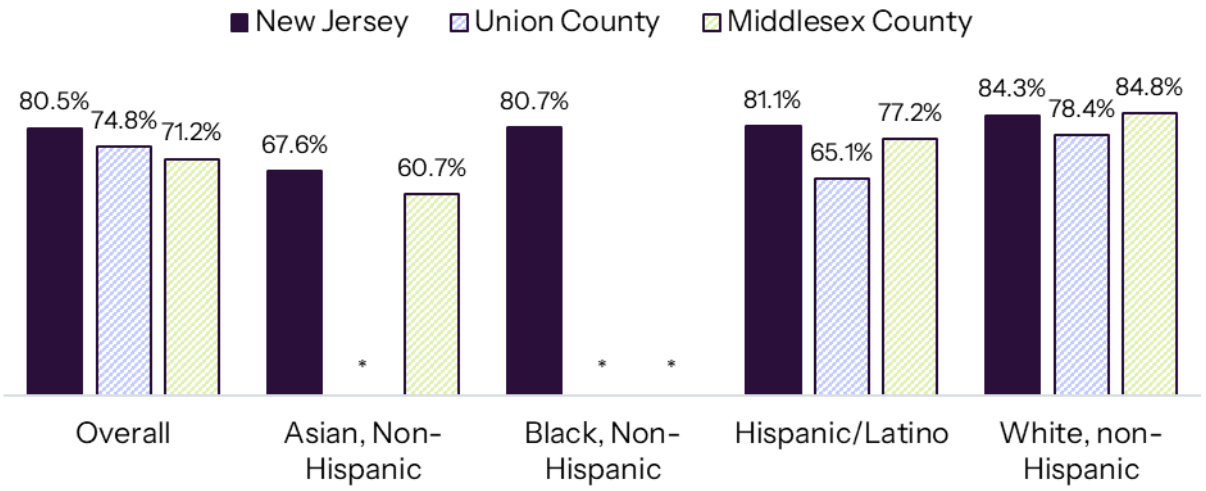
DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

Figure 107. Percent with a Mammography Screening Within the Past Two Years (Age 40-74), by State and County, 2022



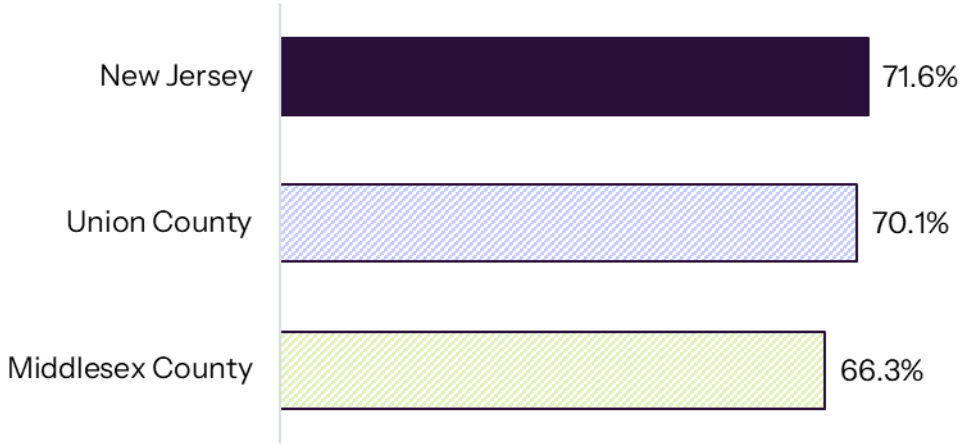
DATA SOURCE: Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024

Figure 108. Percent of Females Aged 21-65 Self-Reported to Have Had a Pap Test in Past Three Years, by Race/Ethnicity, by State and County, 2017-2020



DATA SOURCE: Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024
NOTE: Asterisk (*) means that data are suppressed, as the rate does not meet National Center for Health Statistics standards of statistical reliability for presentation.

Figure 109. Percent of Adults 50+ Meeting Current Guidelines for Colorectal Cancer Screening, by State and County, 2020



DATA SOURCE: Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024

Disability

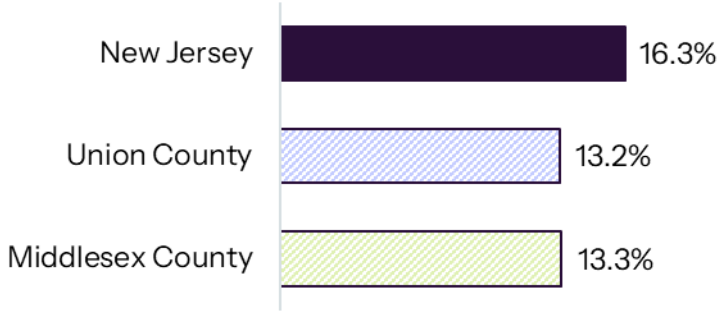
Table 33. Percent with Disability, by Age, by State, County, and Town, 2019-2023

	Under 5 years	5 to 17 years	18 to 34 years	35 to 64 years	65 to 74 years	75 years and over
New Jersey	0.4%	4.9%	5.7%	9.2%	20.1%	43.2%
Union County	0.7%	3.9%	5.0%	7.7%	16.8%	43.8%
Clark	1.2%	2.3%	4.2%	9.0%	11.4%	35.1%
Cranford	0.0%	4.2%	3.5%	4.7%	13.7%	55.2%
Elizabeth (citywide)	0.6%	5.3%	4.7%	11.5%	24.8%	46.5%
Elizabeth (07201)	0.0%	10.5%	4.4%	11.0%	27.5%	65.6%
Elizabeth (07202)	1.1%	3.7%	4.3%	12.0%	26.5%	47.1%
Elizabethport (07206)	0.0%	3.8%	5.0%	13.4%	19.5%	27.7%
Elizabeth (07208)	1.1%	4.9%	5.3%	9.7%	24.5%	47.0%
Linden	0.0%	3.8%	3.1%	10.4%	18.3%	45.4%
Rahway	0.0%	2.6%	12.0%	8.7%	21.8%	56.2%
Roselle	0.0%	2.5%	5.1%	14.0%	16.6%	38.9%
Middlesex County	0.5%	5.1%	4.7%	7.9%	18.7%	44.7%
Avenel	0.0%	5.5%	1.1%	6.1%	14.7%	60.1%
Carteret	3.4%	2.4%	3.7%	11.1%	25.0%	59.7%
Colonia	0.0%	5.2%	3.7%	8.0%	12.6%	38.7%

DATA SOURCE: U.S. Census, American Community Survey, 5-Year Estimates, 2019-2023

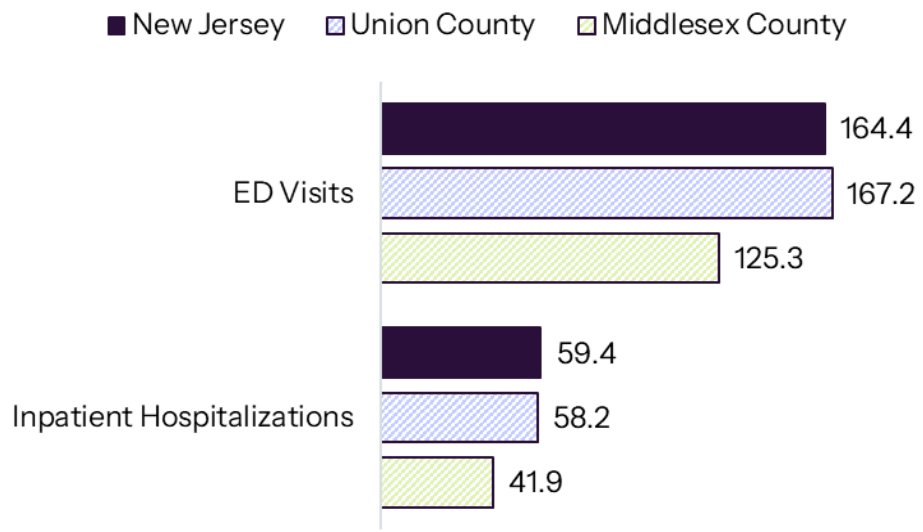
Mental Health and Behavioral Health

Figure 110. Percent Adults Ever Diagnosed with Depression, 2020-2022



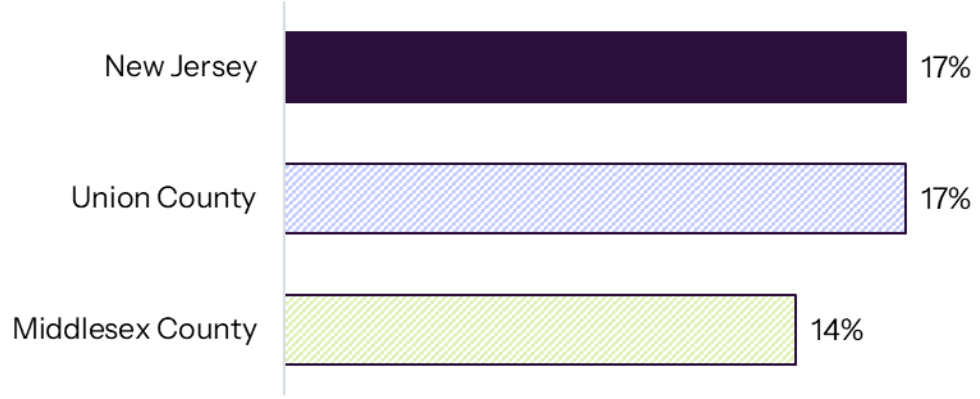
DATA SOURCE: Behavioral Risk Factor Survey, Center for Health Statistics Department of Health 2023

Figure 111. Age-Adjusted Rate of Emergency Visits & Inpatient Hospitalizations due to Mental Health per 10,000, by State and County, 2023



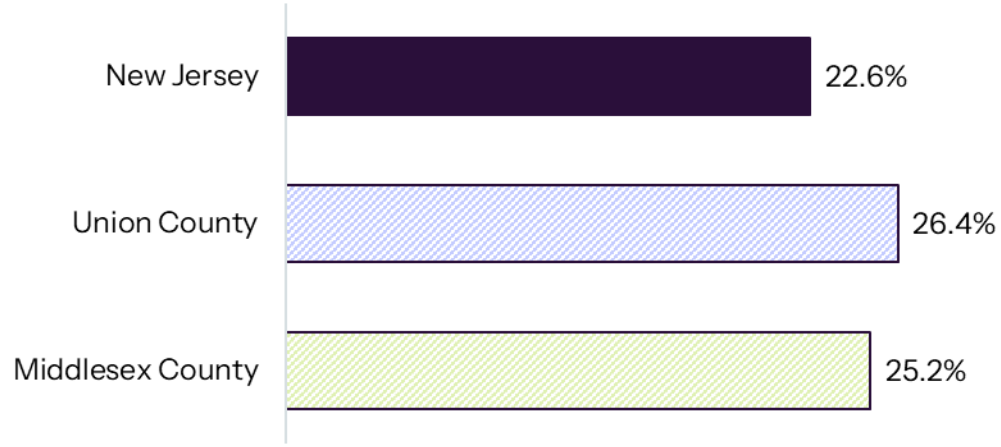
DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2023

Figure 112. Percent Adults Reported Excessive Drinking, by State and County, 2024



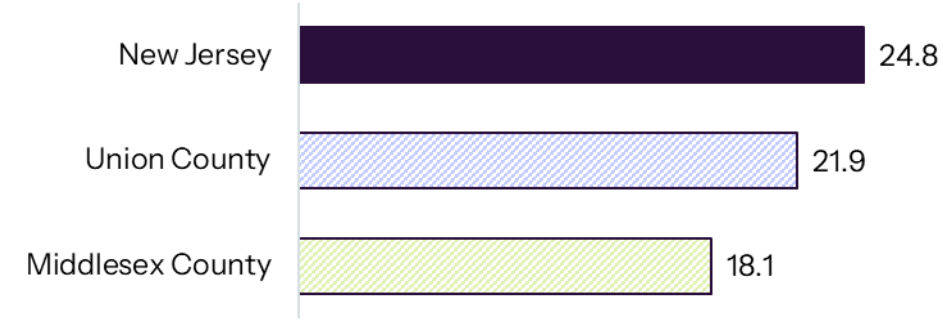
DATA SOURCE: Behavioral Risk Factor Surveillance System as cited by County Health Rankings, 2024
NOTE: Excessive drinking refers to heavy drinking (adult men having more than 14 drinks per week and adult women having more than 7 drinks per week)) or binge drinking (4 or more drinks on one occasion within a two-hour window for women and 5 or more drinks on one occasion within a two-hour window for men).

Figure 113. Percent Driving Deaths with Alcohol Involvement, by State and County, 2020-2024



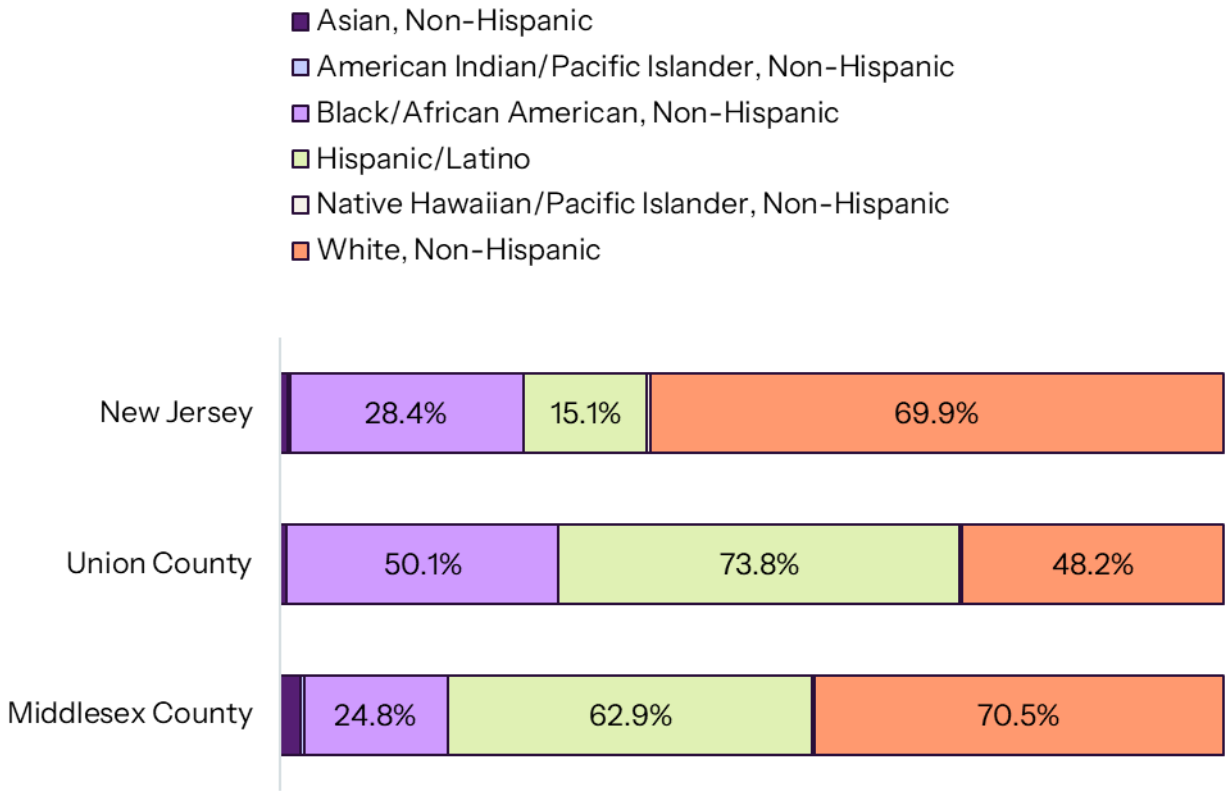
DATA SOURCE: Fatality Analysis Reporting System as cited by County Health Rankings, 2024

Figure 114. Age-Adjusted Rate of Opioid-Related Overdose Mortality per 100,000, by State and County, 2023



DATA SOURCE: Statewide Substance Use Overview Dashboard, Division of Mental Health and Addiction Services Department of Human Services, 2024

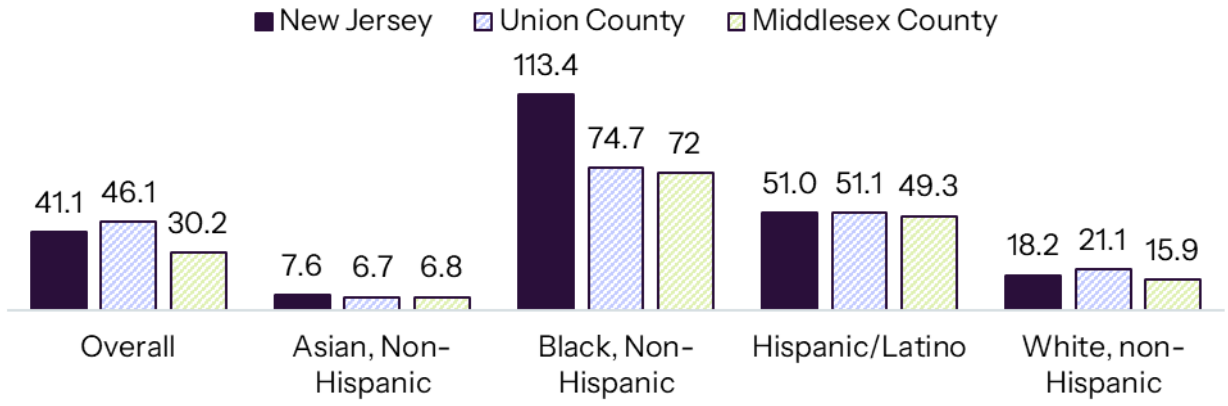
Figure 115. Substance Use Treatment Admissions by Race/Ethnicity, by State and County, 2019-2023



DATA SOURCE: Statewide Substance Use Overview Dashboard Department of Human Services, Division of Mental Health and Addiction Services, 2024
NOTE: Data labels under 5.0% are not shown.

Environmental Health

Figure 116. Age-Adjusted Asthma Inpatient Hospitalization Rate per 10,000 Population by Race/Ethnicity, by State and County, 2023



DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD) 2023

Table 34. Presence of Drinking Water Violations, by County, 2022

	Presence of Water Violation
Union County	No
Middlesex County	Yes

DATA SOURCE: Safe Drinking Water Information System as cited by County Health Rankings, 2024

Infectious and Communicable Disease

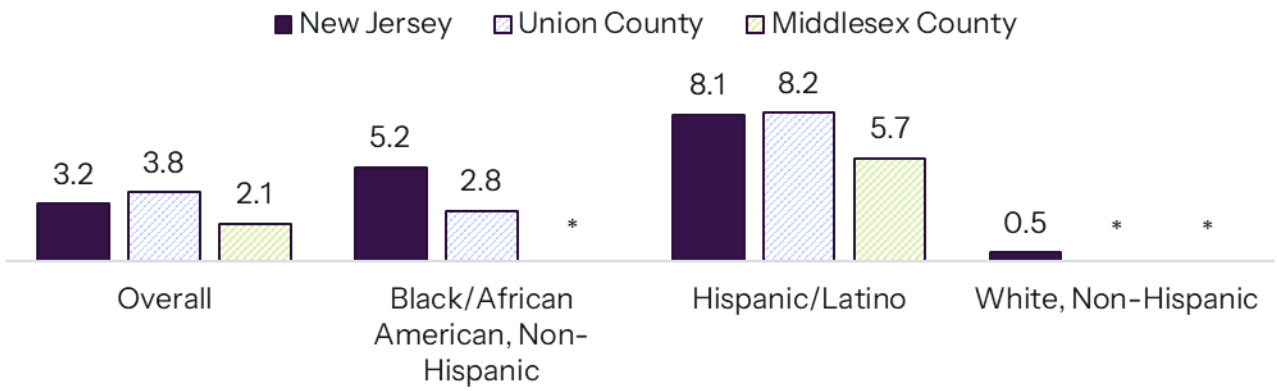
Table 35. Crude Rate of Primary/Secondary Syphilis per 100,000, by Race/Ethnicity, by State and County, 2019-2023

	Overall	Asian/Pacific Islander, Non-Hispanic	American Indian/Alaska Native, Non-Hispanic	Black/African American, Non-Hispanic	Hispanic /Latino	White, Non-Hispanic
New Jersey	8.9	2.6	*	26.8	12.1	4.2
Union County	11.5	*	*	19.0	15.1	4.9
Middlesex County	6.3	2.8	*	13.6	9.8	4.8

DATA SOURCE: Communicable Disease Reporting and Surveillance System (CRDSS), Communicable Disease Service, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024
NOTE: An asterisk (*) means that the data was suppressed, as the rate does not meet the National Center for Health Statistics standards of statistical reliability for presentation.

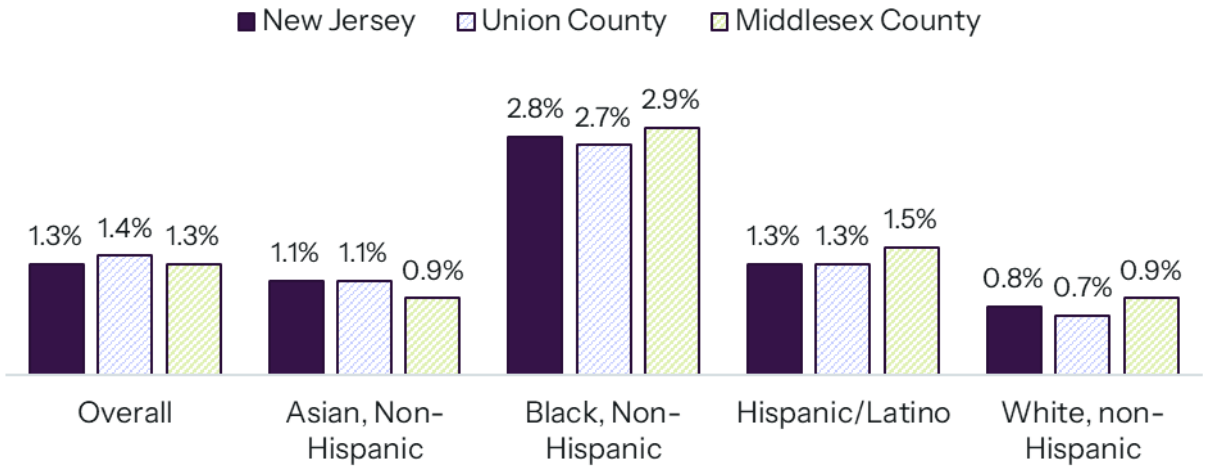
Maternal and Infant Health

Figure 117. Live Births per 1,000 Female Population Aged 15-17, by State and County, 2020-2023



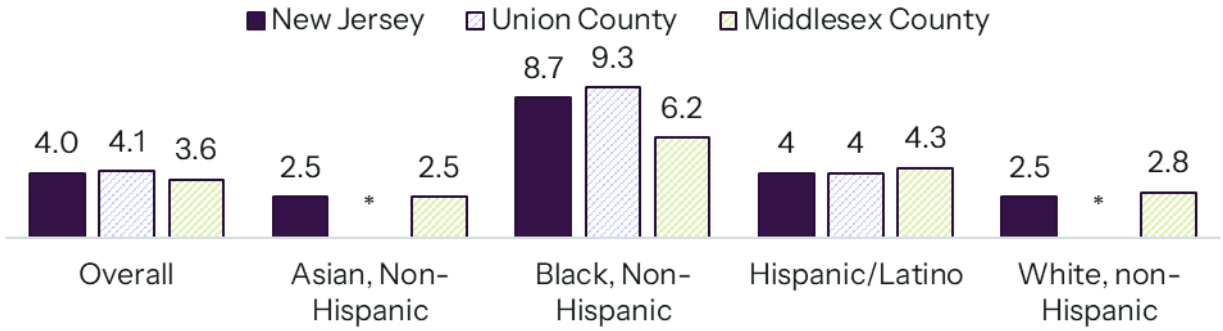
DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment Department of Health via New Jersey State Health Assessment Data (NJSHAD) 2024

Figure 118. Percent Very Low Birthweight Births, by State and County, 2018-2022



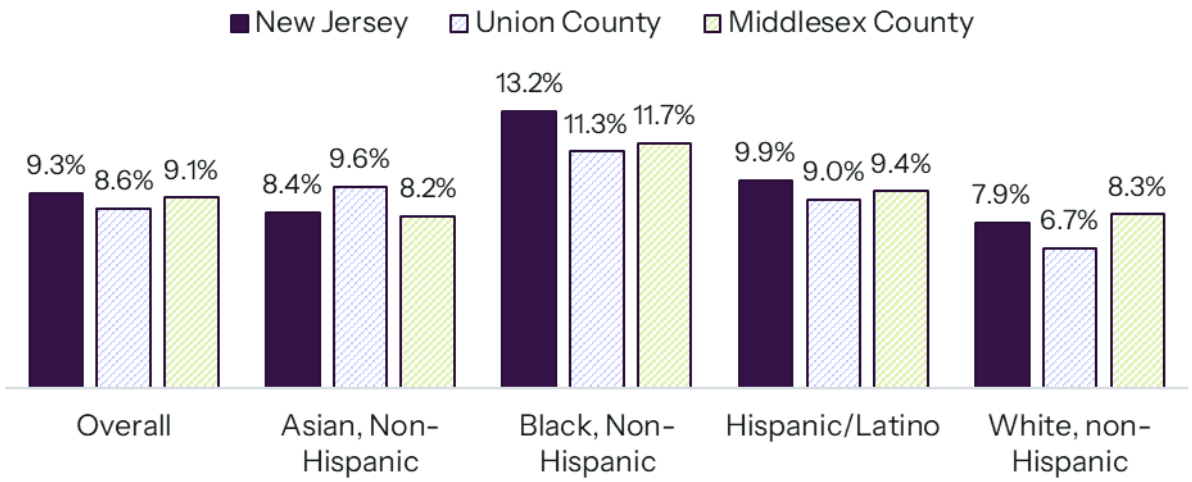
DATA SOURCE: Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2024
NOTE: Very low birth weight is defined as less than 1,500 grams.

Figure 119. Infant Mortality Rate per 1,000 Births, by State and County, 2017-2021



DATA SOURCE: Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2024
NOTE: Asterisk (*) means that data are suppressed, as the rate does not meet National Center for Health Statistics standards of statistical reliability for presentation.

Figure 120. Percent Preterm Births, by State and County, 2021-2022



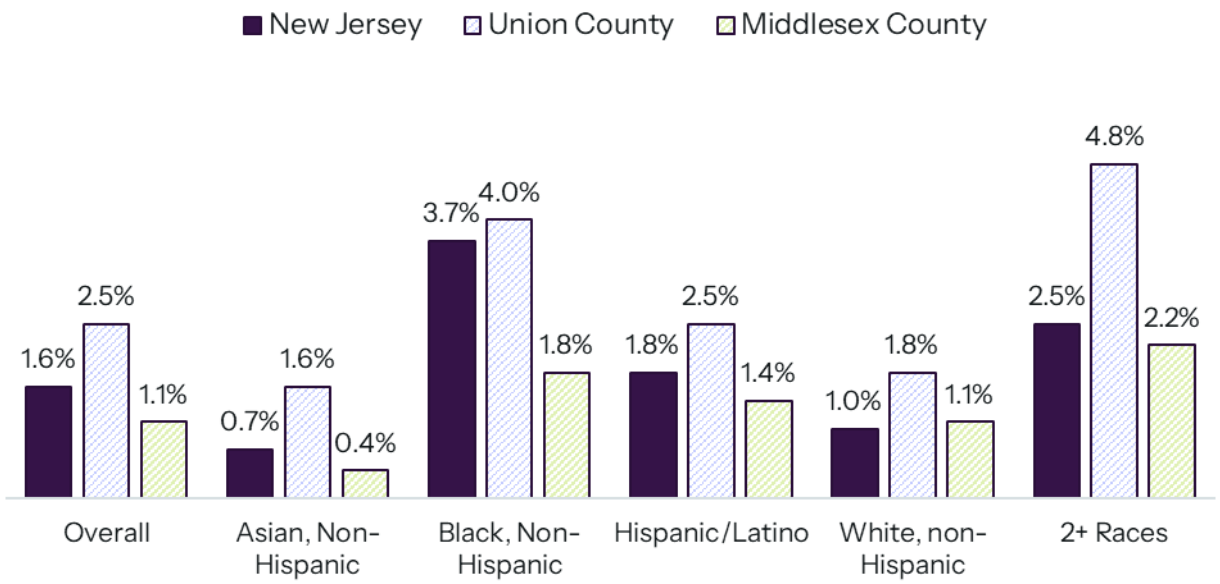
DATA SOURCE: Birth Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health, 2024
NOTE: Preterm births are defined as live births before 37 weeks of gestation based on obstetric estimate.

Table 36. Percent Immunized Children, by State, 2020

	Overall
United States	70.5%
New Jersey	68.7%

DATA SOURCE: National Immunization Survey, Center for Disease Control and Prevention via New Jersey State Health Assessment Data (NJSHAD), 2024

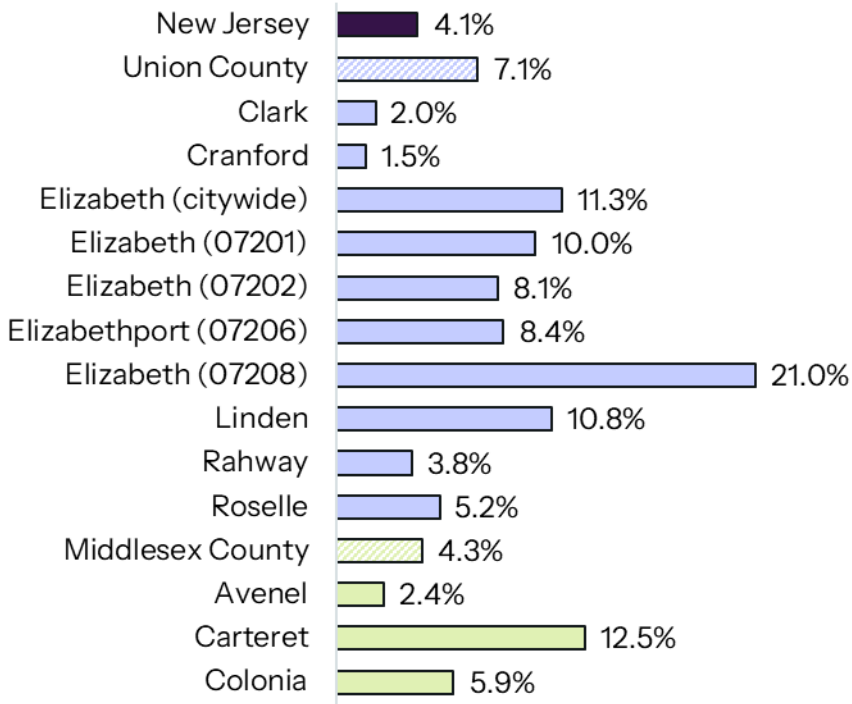
Figure 121. Percent of Live Births to Women Who Had No Prenatal Care, By Race/Ethnicity, by State and County, 2018-2022



DATA SOURCE: Birth Certificate Database, Office of Vital Statistics and Registry, Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024

Access to Care

Figure 122. Percent of Population under 19 Uninsured, by Town, by State and County, 2019-2023



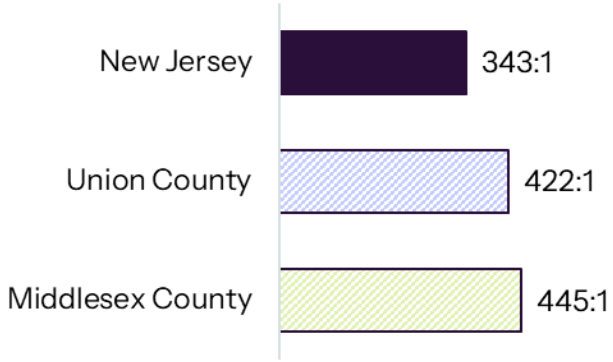
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, 2019-2023

Table 37. Percent of Population with Private Health Insurance, by State, County, and Town, 2019-2023

	Overall
New Jersey	71.1%
Union County	65.3%
Clark	84.6%
Cranford	87.9%
Elizabeth (citywide)	40.5%
Elizabeth (07201)	36.1%
Elizabeth (07202)	45.0%
Elizabethport (07206)	35.4%
Elizabeth (07208)	43.1%
Linden	64.0%
Rahway	71.1%
Roselle	64.5%
Middlesex County	74.0%
Avenel	77.4%
Carteret	66.9%
Colonia	81.6%

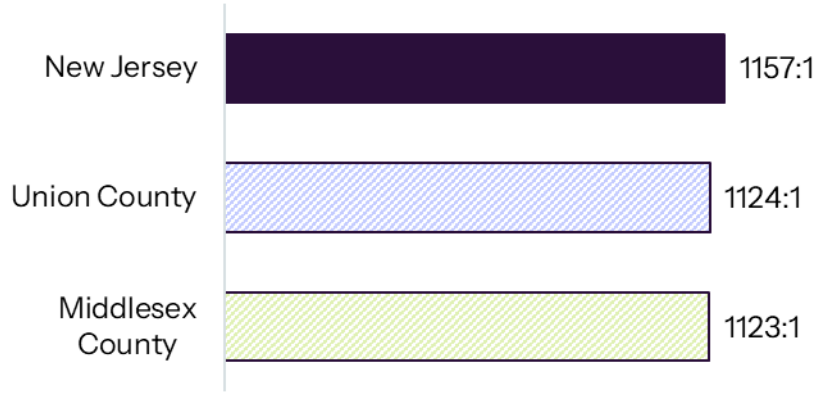
DATA SOURCE: Source: U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates, 2019-2023

Figure 123. Ratio of Population to Mental Health Provider, by State and County, 2023



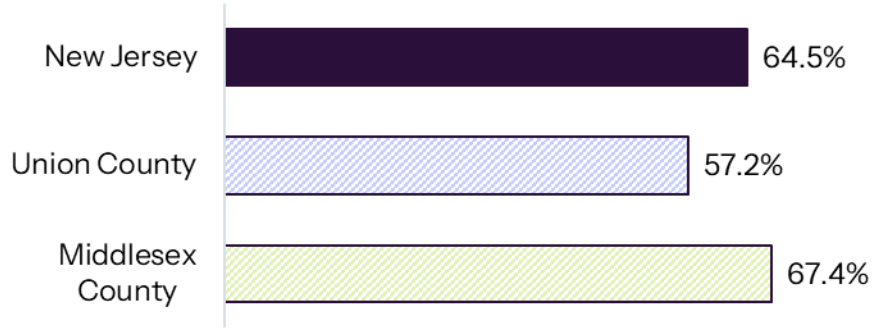
DATA SOURCE: CMS, National Provider Identification as cited by County Health Rankings, 2024

Figure 124. Ratio of Population to Dentist, by State and County, 2022



DATA SOURCE: Area Health Resource File/National Provider Identifier Downloadable File as cited by County Health Rankings, 2024

Figure 125. Percentage of Adults Reporting Ever Receiving a Pneumococcal Vaccination, 65 and Older, by State and County, 2020-2022



DATA SOURCE: Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024

Injury

Table 38. Age-Adjusted Rate of Hospital Emergency Department Visits per 10,000 for Injury, Poisoning, and Other External Causes, by State, 2023

	Rate
New Jersey	597.7
Union County	572.9
Middlesex County	479.8

DATA SOURCE: Hospital Discharge Data Collection System (NJDDCS), Health Care Quality and Assessment, New Jersey Department of Health via New Jersey State Health Assessment Data (NJSHAD), 2024

Table 39. Injury Deaths per 100,000 Population, by State and County, 2017-2021

	Rate
New Jersey	65.5
Union County	55.8
Middlesex County	53.5

DATA SOURCE: National Center for Health Statistics - Mortality Files as cited by County Health Rankings, 2024

Appendix F. Hospitalization Data

Table 40. Emergency Room Treat and Release Rates per 1,000 Population, by Age, State, County, and Primary Service Area (PSA), 2022

Age	New Jersey	Middlesex County	Union County	Rahway PSA	Trinitas PSA
Total	304.6	250.5	330.1	290.2	475.0
Under 18	67.4	280.8	367.5	304.3	526.5
18-64	185.6	242.4	323.6	286.7	468.5
65 and over	51.6	242.1	300.0	285.1	396.3

DATA SOURCE: RWJBarnabas Health System, 2022

Table 41. Emergency Room Treat and Release Rates per 1,000 Population, by Race/Ethnicity, State, County, and Primary Service Area, 2022

Race/Ethnicity	New Jersey	Middlesex County	Union County	Rahway PSA	Trinitas PSA
Total	304.6	250.5	330.1	290.2	475.0
Asian	90.7	78.4	90.2	111.5	104.8
Black	546.9	341.6	417.6	375.1	466.1
Hispanic	373.3	383.1	395.4	331.2	423.7
White	219.3	185.4	199.2	164.8	279.9

DATA SOURCE: RWJBarnabas Health System, 2022

Table 42. Hospital Admission Rates per 1,000 Population, by Race/Ethnicity, State, County, and Primary Service Area, 2022

	Race/Ethnicity	Total	Acute	Chronic	Diabetic
New Jersey	Overall	8.1	3.8	2.5	1.8
	Asian	1.6	2.2	1.5	0.9
	Black	13.1	5.0	4.3	3.9
	Hispanic	5.8	2.7	1.5	1.6
	White	8.2	4.1	2.6	1.5
Middlesex County	Overall	7.8	3.7	2.4	1.7
	Asian	2.7	1.3	0.8	0.5
	Black	9.8	3.8	3.2	2.9
	Hispanic	6.7	3.3	1.7	1.7
	White	9.0	4.3	3.1	1.7
Union County	Overall	7.2	3.2	2.2	1.8
	Asian	0.1	0.1	0.0	0.0
	Black	10.4	4.1	3.1	3.1
	Hispanic	5.5	2.5	1.5	1.5
	White	6.4	3.1	2.0	1.3
Rahway PSA	Overall	7.8	3.5	2.5	1.8
	Asian	3.2	1.7	0.8	0.7
	Black	9.9	3.9	3.2	2.8
	Hispanic	5.5	2.7	1.6	1.2
	White	6.2	3.0	1.9	1.3
Trinitas PSA	Overall	8.0	3.2	2.2	2.6
	Asian	3.3	1.0	2.0	0.3
	Black	10.8	3.8	2.9	4.0
	Hispanic	5.7	2.3	1.5	1.9
	White	6.4	2.5	1.9	2.0

DATA SOURCE: RWJBarnabas Health System, 2022

Table 43. Hospital Admission Rates per 1,000 Population, by Condition, by State, County, and Primary Service Area, 2022

	Total	Obesity	Obstetrics	Cardiac	Mental Health	Substance Use
New Jersey	75.8	1.1	10.7	10.7	3.4	1.5
Middlesex County	70.1	1.3	10.1	10.2	1.9	1.1
Union County	70.7	1.3	12.3	9.3	3.6	1.2
Rahway PSA	73.0	1.5	11.1	11.0	2.8	1.0
Trinitas PSA	73.0	1.6	12.8	8.5	4.6	1.9

DATA SOURCE: RWJBarnabas Health System, 2022

Table 44. Hospital Admission Rates per 1,000 Population, by Age, Race/Ethnicity, State, County, and Primary Service Area, 2022

	Age	Race /Ethnicity	Total	Obesity	Obstetrics	Cardiac	Mental Health	Substance Use
New Jersey	Total	Total	75.8	1.1	10.7	10.7	3.4	1.5
		Asian	30.8	0.1	8.6	3.6	0.9	0.2
		Black	103.3	1.8	11.3	15.7	6.1	2.4
		Hispanic	57.0	1.5	13.1	5.5	2.3	1.1
		White	77.5	0.9	8.4	12.2	3.1	1.5
	Under 18	Total	2.8	0.0	0.1	0.0	0.3	0.0
		Asian	1.4	0.0	0.0	0.0	0.1	0.0
		Black	4.3	0.0	0.1	0.0	0.6	0.0
		Hispanic	3.9	0.0	0.2	0.1	0.3	0.0
		White	1.7	0.0	0.0	0.0	0.3	0.0
	18-64	Total	39.5	1.1	10.6	3.6	2.6	1.4
		Asian	17.4	0.1	8.6	1.2	0.7	0.2
		Black	65.8	1.8	11.2	7.9	5.1	2.2
		Hispanic	38.8	1.5	12.9	2.5	1.8	1.1
		White	33.1	0.9	8.4	3.1	2.3	1.4
	65 and over	Total	33.4	0.0	0.0	7.1	0.4	0.1
		Asian	12.0	0.0	0.0	2.4	0.1	0.0
		Black	33.3	0.0	0.0	7.8	0.5	0.2
		Hispanic	14.3	0.0	0.0	3.0	0.2	0.0
		White	42.7	0.1	0.0	9.1	0.5	0.2
Middlesex County	Total	Total	70.1	1.3	10.1	10.2	1.9	1.1
		Asian	29.9	0.1	9.0	3.6	0.4	0.1
		Black	75.3	1.8	9.7	11.4	2.5	1.2
		Hispanic	60.1	1.8	13.7	6.0	1.5	1.2
		White	79.5	1.3	6.5	14.3	2.2	1.4
		Total	16.3	0.0	0.2	0.2	0.6	0.0

	Age	Race /Ethnicity	Total	Obesity	Obstetrics	Cardiac	Mental Health	Substance Use
	Under 18	Asian	8.2	-	-	0.1	0.1	-
		Black	19.7	-	0.2	0.2	0.7	-
		Hispanic	16.9	0.0	0.6	0.2	0.5	-
		White	14.9	0.0	0.1	0.1	0.8	-
	18-64	Total	58.1	2.0	16.1	5.4	2.3	1.6
		Asian	26.9	0.2	14.1	1.9	0.5	0.2
		Black	71.5	2.6	14.6	8.8	3.1	1.7
		Hispanic	65.5	2.8	21.4	4.5	2.0	1.8
		White	53.4	2.0	10.8	6.0	2.6	2.1
	65 and over	Total	185.5	0.2	0.0	41.4	2.0	0.6
		Asian	87.8	-	-	19.1	0.3	0.0
		Black	210.2	0.3	-	49.7	3.0	0.7
		Hispanic	168.5	0.2	-	37.6	1.2	0.6
		White	182.9	0.2	-	43.3	2.3	0.7
Union County	Total	Total	70.7	1.3	12.3	9.3	3.6	1.2
		Asian	33.6	0.1	10.2	3.6	0.9	0.1
		Black	82.2	1.7	9.9	13.5	4.4	1.6
		Hispanic	61.3	1.5	15.8	5.3	2.6	0.9
		White	66.2	0.9	9.1	10.5	4.0	1.1
	Under 18	Total	16.8	0.0	0.4	0.3	2.1	0.0
		Asian	8.5	-	-	-	0.1	-
		Black	19.9	-	0.5	0.2	2.5	0.0
		Hispanic	17.2	-	0.7	0.5	2.3	0.0
		White	11.3	0.0	0.0	0.0	1.7	0.0
	18-64	Total	65.4	2.1	19.9	5.6	4.5	1.7
		Asian	30.7	0.1	15.8	1.6	1.1	0.1
		Black	77.1	2.6	15.1	10.3	5.5	2.4
		Hispanic	67.5	2.4	24.9	3.8	2.9	1.4
		White	50.9	1.4	15.4	4.6	5.2	1.7
	65 and over	Total	173.5	0.2	-	37.9	2.5	0.6
		Asian	84.5	-	-	18.4	0.9	-
		Black	191.8	0.2	-	46.3	2.0	0.7
		Hispanic	155.2	0.1	-	31.0	2.0	0.7
		White	158.6	0.2	-	36.3	2.8	0.6
Rahway PSA	Total	Total	73.0	1.5	11.1	11.0	2.8	1.0
		Asian	36.2	0.2	11.3	4.6	0.9	0.3
		Black	77.0	1.7	10.3	13.3	3.1	1.0
		Hispanic	58.1	1.6	12.9	5.9	2.1	0.9

	Age	Race /Ethnicity	Total	Obesity	Obstetrics	Cardiac	Mental Health	Substance Use
		White	61.8	1.3	7.3	11.3	2.7	1.1
	Under 18	Total	15.9	0.0	0.2	0.1	1.4	0.0
		Asian	7.0	0.0	0.0	0.0	0.3	0.0
		Black	22.3	0.0	0.1	0.2	2.0	0.0
		Hispanic	14.7	0.0	0.3	0.2	1.4	0.0
		White	8.6	0.1	0.1	0.1	1.1	0.0
	18-64	Total	63.1	2.4	17.7	6.3	3.4	1.5
		Asian	32.5	0.3	17.5	1.8	1.1	0.4
		Black	71.1	2.7	15.9	10.0	4.0	1.5
		Hispanic	61.8	2.7	20.7	4.0	2.4	1.4
		White	46.7	2.0	11.8	5.1	3.3	1.5
	65 and over	Total	185.9	0.2	0.0	43.4	2.2	0.6
		Asian	97.5	0.0	0.0	24.3	0.8	0.4
		Black	182.9	0.0	0.0	47.1	0.5	0.3
		Hispanic	166.2	0.0	0.0	35.3	2.2	0.2
		White	153.6	0.2	0.0	40.0	2.3	0.7
Trinitas PSA	Total	Total	73.0	1.6	12.8	8.5	4.6	1.9
		Asian	34.1	0.3	5.4	5.0	1.3	0.0
		Black	74.7	1.2	10.0	12.2	6.0	3.1
		Hispanic	60.2	1.7	13.4	5.5	3.1	1.1
		White	53.4	0.5	5.1	8.3	4.4	1.6
	Under 18	Total	18.3	0.0	0.4	0.4	3.3	0.1
		Asian	5.6	0.0	0.0	0.0	0.0	0.0
		Black	18.3	0.0	1.1	0.4	2.8	0.2
		Hispanic	15.9	0.0	0.3	0.5	3.1	0.0
		White	7.7	0.0	0.0	0.0	1.9	0.1
	18-64	Total	75.4	2.6	20.1	6.2	5.4	2.7
		Asian	29.3	0.5	8.2	3.1	2.1	0.0
		Black	78.5	1.6	14.3	10.8	7.4	4.1
		Hispanic	64.1	2.6	20.8	3.9	3.2	1.6
		White	49.0	0.8	8.6	5.0	5.9	2.6
	65 and over	Total	181.6	0.1	0.0	39.6	2.9	1.0
		Asian	126.9	0.0	0.0	27.9	0.0	0.0
		Black	177.1	0.4	0.0	49.1	3.8	2.6
		Hispanic	164.2	0.1	0.0	31.4	2.3	0.7
		White	120.0	0.0	0.0	28.4	2.4	0.3

DATA SOURCE:RWJBarnabas Health System, 2022
NOTE: Dash (-) means that data were suppressed by the reporting agency.

Appendix G. Cancer Data

APPENDIX G1: CANCER INCIDENCE RATE REPORT: CANCER PATIENT ORIGIN UNION COUNTY 2023

Almost sixty nine percent of RWJ-R's cancer inpatients and 67.2% of cancer outpatients resided in the Primary Service Area. In total, 69.3% of inpatients and 69.0% of outpatients resided in Union County. Rahway (07065) and Linden (07036) represent the largest segment of RWJ-R's inpatient cancer patients. Similarly, Linden (07036) and Roselle (07203) represent the largest segments of RWJ-H's outpatient cancer patients. The health factors and outcomes explored in the CHNA bear relevance to the oncology services and its review of specific cancer needs for the community.

CANCER PATIENT ORIGIN	2023 RWJ RAH IP PATIENTS	%	2023 RWJ RAH OP PATIENTS	%
Union County	312	69.3%	40	69.0%
Primary Service Area	310	68.9%	39	67.2%
Secondary Service Area	53	11.8%	8	13.8%
Out of Service Area (NJ)	77	17.1%	11	19.0%
Out of State	10	2.2%	0	0.0%
TOTAL	**450**	**100.0%**	**58**	**100.0%**
Linden (07036)	98	21.8%	14	24.1%
Rahway (07065)	69	15.3%		
Roselle (07203)			8	13.8%

Source; Decision Support; IP volume includes cases with ICD10 principal or secondary codes C00 thru D49.9 (Neoplasms); OP volume includes cases with ICD10 principal or secondary codes Z51.0 or Z51.11 (Chemo and Radiation Therapy).

APPENDIX G2: CANCER INCIDENCE RATE REPORT: UNION COUNTY 2016-2020

INCIDENCE RATE REPORT FOR UNION COUNTY 2016-2020				
Cancer Site	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trend
All Cancer Sites	446.4	2,875	falling	-1
Bladder	18.9	122	falling	-2
Brain & ONS	5.7	34	stable	-0.9
Breast	132.6	451	stable	0.3
Cervix	8	25	stable	-0.8
Colon & Rectum	36.3	232	falling	-3
Esophagus	3.4	22	stable	-1.7
Kidney & Renal Pelvis	14.5	93	stable	0.6
Leukemia	14.7	91	stable	0.3
Liver & Bile Duct	7.5	50	rising	2.3
Lung & Bronchus	37.9	245	falling	-5.8
Melanoma of the Skin	14.2	92	stable	-1.5
Non-Hodgkin Lymphoma	18.8	120	stable	-0.3
Oral Cavity & Pharynx	8.6	55	stable	0
Ovary	11.6	39	falling	-1.9
Pancreas	13.3	86	stable	0.4
Prostate	154.8	478	rising	5
Stomach	8.8	56	stable	-0.9
Thyroid	14.8	87	stable	3.8
Uterus (Corpus & Uterus, NOS)	31.1	113	stable	1.1

The Source for G2 and following tables G3, G4, G5 and G6 is : https://statecancerprofiles.cancer.gov

APPENDIX G3: CANCER INCIDENCE DETAILED RATE REPORT: UNION COUNTY 2016-2020 SELECT CANCER SITES: RISING INCIDENCE RATES

		Liver & Bile Duct	Prostate
INCIDENCE RATE REPORT FOR UNION COUNTY 2016-2020 All Races (includes Hispanic), All Ages	Age-Adjusted Incidence Rate(†) - cases per 100,000	7.5	154.8
	Average Annual Count	50	478
	Recent Trend	rising	rising
	Recent 5-Year Trend (‡) in Incidence Rates	2.3	5
White Non-Hispanic, All Ages	Age-Adjusted Incidence Rate(†) - cases per 100,000	6.4	130.6
	Average Annual Count	22	219
	Recent Trend	rising	rising
	Recent 5-Year Trend (‡) in Incidence Rates	2.3	5.1
Black (includes Hispanic), All Ages	Age-Adjusted Incidence Rate(†) - cases per 100,000	8.1	214.2
	Average Annual Count	11	129
	Recent Trend	stable	falling
	Recent 5-Year Trend (‡) in Incidence Rates	1.7	-3.4
Asian or Pacific Islander (includes Hispanic), All Ages	Age-Adjusted Incidence Rate(†) - cases per 100,000	9.7	89.9
	Average Annual Count	3	14
	Recent Trend	stable	stable
	Recent 5-Year Trend (‡) in Incidence Rates	-1.2	-0.5
Hispanic (any race), All Ages	Age-Adjusted Incidence Rate(†) - cases per 100,000	9.4	134.7
	Average Annual Count	13	85
	Recent Trend	stable	falling
	Recent 5-Year Trend (‡) in Incidence Rates	1.6	-3.6
MALES	Age-Adjusted Incidence Rate(†) - cases per 100,000	11	154.8
	Average Annual Count	34	478
	Recent Trend	stable	rising
	Recent 5-Year Trend (‡) in Incidence Rates	1.4	5
FEMALES	Age-Adjusted Incidence Rate(†) - cases per 100,000	4.5	n/a
	Average Annual Count	16	n/a
	Recent Trend	rising	n/a
	Recent 5-Year Trend (‡) in Incidence Rates	3.1	n/a

** Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).*

APPENDIX G4: CANCER MORTALITY RATE REPORT: UNION COUNTY 2016-2020

MORTALITY RATE REPORT: UNION COUNTY 2016-2020					
Cancer Site	Met Healthy People Objective of ***?	Age-Adjusted Mortality Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trend
All Cancer Sites	No	130.4	843	falling	-2.2
Bladder	***	3.8	25	falling	-1.1
Brain & ONS	***	3.5	22	falling	-1.1
Breast	No	21.6	79	falling	-2.1
Cervix	Yes	1.8	6	falling	-2.9
Colon & Rectum	Yes	12.4	81	falling	-3.1
Esophagus	***	2.6	17	falling	-2.5
Kidney & Renal Pelvis	***	2.6	17	falling	-2.4
Leukemia	***	5.3	34	falling	-1.2
Liver & Bile Duct	***	5.5	36	stable	1
Lung & Bronchus	Yes	24.2	156	falling	-6.9
Melanoma of the Skin	***	1.3	9	falling	-1.7
Non-Hodgkin Lymphoma	***	4.4	28	falling	-2.4
Oral Cavity & Pharynx	***	1.5	10	falling	-2.8
Ovary	***	5.8	22	falling	-2.5
Pancreas	***	10.5	69	stable	-0.4
Prostate	Yes	16.4	42	falling	-3.6
Stomach	***	3.6	23	falling	-3.3
Thyroid	***	0.6	4	*	*
Uterus (Corpus & Uterus, NOS)	***	6	22	stable	0.8

*** No Healthy People 2030 Objective for this cancer.*

* Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).*

APPENDIX G5: CANCER MORTALITY DETAILED RATE REPORT (Highest Volume): UNION COUNTY 2016-2020

		Lung & Bronchus	Colon & Rectum	Breast
MORTALITY RATE REPORT FOR UNION COUNTY 2016-2020 All Races (includes Hispanic), All Ages	Met Healthy People Objective	Yes	Yes	No
	Age-Adjusted Death Rate - per 100,000	24.2	12.4	21.6
	Average Annual Count	156	81	79
	Recent Trend	falling	falling	falling
	Recent 5-Year Trend in Death Rates	-6.9	-3.1	-2.1
White Non-Hispanic, All Ages	Met Healthy People Objective	No	Yes	No
	Age-Adjusted Death Rate - per 100,000	27.6	13	20.1
	Average Annual Count	100	47	41
	Recent Trend	falling	falling	falling
	Recent 5-Year Trend in Death Rates	-7.3	-3	-2.4
Black (includes Hispanic), All Ages	Met Healthy People Objective	No	No	No
	Age-Adjusted Death Rate - per 100,000	27.1	15.6	29.5
	Average Annual Count	35	21	23
	Recent Trend	falling	falling	falling
	Recent 5-Year Trend in Death Rates	-7.3	-2.8	-1.6
Asian or Pacific Islander (includes Hispanic), All Ages	Met Healthy People Objective	Yes	***	No
	Age-Adjusted Death Rate - per 100,000	11.5	*	20
	Average Annual Count	4	3 or fewer	3
	Recent Trend	*	*	*
	Recent 5-Year Trend in Death Rates	*	*	*
Hispanic (any race), All Ages	Met Healthy People Objective	Yes	Yes	No
	Age-Adjusted Death Rate - per 100,000	14	8.8	15.4
	Average Annual Count	17	11	12
	Recent Trend	falling	stable	*
	Recent 5-Year Trend in Death Rates	-1.9	1.6	*
MALES	Met Healthy People Objective	No	No	n/a
	Age-Adjusted Death Rate - per 100,000	28.2	13.6	n/a
	Average Annual Count	78	37	n/a
	Recent Trend	falling	falling	n/a
	Recent 5-Year Trend in Death Rates	-8.2	-3.4	n/a
FEMALES	Met Healthy People Objective	Yes	No	No
	Age-Adjusted Death Rate - per 100,000	21.5	11.7	21.6
	Average Annual Count	79	44	79
	Recent Trend	falling	falling	falling
	Recent 5-Year Trend in Death Rates	-6.7	-2.8	-2.1

**** No Healthy People 2030 Objective for this cancer.*

** Data has been suppressed to ensure confidentiality and stability of rate estimates. Counts are suppressed if fewer than 16 records were reported in a specific area-sex-race category. If an average count of 3 is shown, the total number of cases for the time period is 16 or more which exceeds suppression threshold (but is rounded to 3).*

APPENDIX G6 : CANCER INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
All Cancer Sites: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	481.9	53,389	falling	-0.5
US (SEER+NPCR)	442.3	1,698,328	stable	-0.3
Cape May County	559	900	stable	-0.4
Gloucester County	533.7	1,930	stable	-0.2
Ocean County	532.8	4,817	stable	1.5
Monmouth County	526.4	4,389	rising	1
Burlington County	519.4	3,025	stable	-0.3
Camden County	517.6	3,187	stable	-0.3
Sussex County	512	979	falling	-0.5
Salem County	510.2	436	stable	0
Warren County	507.5	740	stable	-0.4
Cumberland County	504	891	stable	0.1
Mercer County	491.4	2,165	falling	-0.5
Atlantic County	490.4	1,755	falling	-0.7
Morris County	484.4	3,134	falling	-0.6
Hunterdon County	474.7	836	stable	-0.2
Bergen County	465.8	5,678	stable	-0.4
Passaic County	455.7	2,624	falling	-0.6
Somerset County	453	1,882	falling	-0.6
Middlesex County	452.9	4,432	falling	-0.7
Essex County	452.5	4,014	stable	-0.3
Union County	446.4	2,875	falling	-1
Hudson County	398.2	2,679	stable	0.3
Bladder: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	22	2,487	falling	-1.1
US (SEER+NPCR)	18.9	74,016	falling	-2
Cape May County	29.8	50	falling	-4.1
Ocean County	27.6	276	stable	5.2
Hunterdon County	25.6	46	stable	0.2
Sussex County	25.5	49	stable	-0.3
Monmouth County	25.1	216	stable	-0.2
Gloucester County	24.7	89	falling	-5.2

Burlington County	24.5	146	stable	-0.3

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Cumberland County	24	43	stable	-0.4
Salem County	23.9	22	stable	0.2
Warren County	23.9	37	stable	-1
Atlantic County	23.1	85	falling	-4.5
Morris County	22.8	152	falling	-1.4
Camden County	22	136	stable	-1.2
Middlesex County	21.4	210	falling	-1.1
Mercer County	21.2	94	falling	-3.2
Bergen County	20.9	266	falling	-1.5
Passaic County	20.2	118	stable	-1.3
Somerset County	19.7	82	stable	-1.1
Union County	18.9	122	falling	-2
Essex County	16.8	147	falling	-1.4
Hudson County	15.5	99	falling	-1.8
Brain & ONS: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	6.8	689	falling	-0.4
US (SEER+NPCR)	6.4	22,602	falling	-0.7
Gloucester County	8.4	27	stable	1.2
Ocean County	8.2	60	stable	0.2
Somerset County	7.9	29	stable	-0.2
Cape May County	7.7	11	stable	-1
Monmouth County	7.5	57	stable	-0.8
Bergen County	7.4	80	stable	-0.2
Sussex County	7.3	12	stable	-1.4
Burlington County	7.2	38	stable	0.7
Passaic County	7.2	38	stable	-0.2
Mercer County	6.9	28	stable	-0.5
Hunterdon County	6.8	11	stable	-0.9
Camden County	6.8	39	stable	-0.7
Salem County	6.7	5	*	*
Morris County	6.5	39	falling	-3.4

Middlesex County	6.3	58	stable	-0.8
Warren County	6.2	8	stable	1.1
Atlantic County	6	20	stable	-1.7

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Cumberland County	5.8	9	stable	-1.5
Union County	5.7	34	stable	-0.9
Hudson County	5.7	39	stable	-0.6
Essex County	5.6	47	stable	-0.3
Breast: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	137.1	7,854	rising	0.6
US (SEER+NPCR)	127	249,750	rising	0.5
Burlington County	151	454	rising	1.4
Monmouth County	150.9	650	stable	0.3
Morris County	146.7	483	stable	0.2
Hunterdon County	146.2	130	stable	0.5
Gloucester County	145.4	279	rising	1.8
Bergen County	144	896	rising	0.9
Cape May County	143.9	112	stable	0.2
Somerset County	142.5	309	stable	0.2
Sussex County	141	139	stable	0
Camden County	138.7	450	stable	0.6
Ocean County	135.2	616	stable	0.9
Passaic County	134.9	402	rising	1.5
Mercer County	132.7	302	stable	0
Union County	132.6	451	stable	0.3
Warren County	132.3	99	stable	-0.2
Essex County	130.6	625	rising	1.4
Atlantic County	130.3	239	stable	0.2
Middlesex County	128.5	651	stable	-0.1
Salem County	122.7	53	stable	0.5
Cumberland County	120.8	111	stable	0.8
Hudson County	112.5	403	stable	0.5
Cervix: All Races (includes Hispanic), Both Sexes, All Ages				

New Jersey	7.4	365	falling	-1.7
US (SEER+NPCR)	7.5	12,553	stable	-0.4
Cumberland County	10.9	9	stable	-2
Cape May County	9.5	5	stable	1
Passaic County	9.5	24	stable	-1.5

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Essex County	9.1	40	stable	3
Hudson County	8.3	29	falling	-2.4
Atlantic County	8.1	12	stable	-1.7
Union County	8	25	stable	-0.8
Middlesex County	7.9	37	stable	-1.1
Mercer County	7.6	15	stable	6.1
Burlington County	7.4	18	stable	-1
Camden County	7.4	21	falling	-2.4
Ocean County	7	23	stable	-1.3
Gloucester County	6.8	11	stable	-1
Warren County	6.8	3	stable	-1.2
Morris County	6.7	19	stable	-0.9
Hunterdon County	6.3	4	stable	21.6
Monmouth County	6.2	22	stable	-1.4
Somerset County	5.8	11	stable	2.3
Bergen County	5.3	30	stable	-1.3
Sussex County	5.1	4	falling	-3.7
Salem County	*	3 or fewer	*	*
Colon & Rectum: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	38.7	4,270	falling	-1.5
US (SEER+NPCR)(1)	36.5	138,021	falling	-1.1
Cape May County(7)	45.1	71	stable	-0.2
Gloucester County(7)	44.3	158	falling	-2.5
Salem County(7)	44.1	36	falling	-1.9
Sussex County(7)	43.8	82	stable	0
Camden County(7)	43.2	263	stable	-2
Cumberland County(7)	42.7	74	stable	-1.6

Warren County(7)	42.5	62	stable	0
Ocean County(7)	41.7	378	stable	-1.6
Burlington County(7)	40.6	234	falling	-2.4
Passaic County(7)	39.6	227	stable	-0.5
Essex County(7)	38.7	340	stable	-1.1
Monmouth County(7)	38.6	319	stable	-1.8

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Atlantic County(7)	38.5	136	falling	-3.4
Bergen County(7)	37.3	460	stable	-0.4
Hudson County(7)	37	247	falling	-2.7
Morris County(7)	36.5	239	stable	0.4
Union County(7)	36.3	232	falling	-3
Middlesex County(7)	36.1	353	falling	-2.9
Mercer County(7)	35.1	154	falling	-3.3
Hunterdon County(7)	34.9	61	falling	-2.3
Somerset County(7)	34.7	145	falling	-2.8
Esophagus: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	4.2	486	falling	-1.2
US (SEER+NPCR)(1)	4.5	17,922	stable	-0.1
Cape May County(7)	6.3	11	stable	0.8
Ocean County(7)	6	57	stable	-0.3
Warren County(7)	5.6	9	stable	0
Hunterdon County(7)	5.6	11	stable	-0.8
Gloucester County(7)	5.4	20	stable	1.4
Camden County(7)	5.3	34	stable	-0.7
Cumberland County(7)	5.3	9	stable	0
Sussex County(7)	5.2	11	stable	-1.1
Atlantic County(7)	4.9	18	stable	-1.5
Morris County(7)	4.6	31	stable	-0.3
Monmouth County(7)	4.5	39	stable	-1
Burlington County(7)	4.3	26	stable	-1.4
Passaic County(7)	4.1	24	stable	-0.8
Mercer County(7)	3.8	17	falling	-3.2

Middlesex County(7)	3.7	38	stable	-1.5
Union County(7)	3.4	22	stable	-1.7
Bergen County(7)	3.4	42	falling	-1.8
Essex County(7)	3.4	30	falling	-3.1
Hudson County(7)	3	21	stable	-2.1
Somerset County(7)	2.8	12	stable	-1.1
Salem County(7)	*	3 or fewer	*	*

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	**Age-Adjusted Incidence Rate - cases per 100,000**	**Average Annual Count**	**Recent Trend**	**Recent 5-Year Trending Incidence Rates**
Kidney & Renal Pelvis: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	16.2	1,785	stable	0.6
US (SEER+NPCR)(1)	17.2	65,490	rising	1.2
Salem County(7)	21	17	stable	1.3
Camden County(7)	19	116	stable	0.2
Burlington County(7)	18.8	109	stable	-0.2
Mercer County(7)	18.6	81	rising	2.5
Cape May County(7)	18.4	28	stable	1.8
Gloucester County(7)	18.2	68	stable	0.3
Ocean County(7)	17.9	156	rising	1.6
Warren County(7)	17.6	25	stable	1
Cumberland County(7)	17	30	falling	-6.6
Atlantic County(7)	16.5	58	stable	-0.2
Bergen County(7)	16.3	200	stable	0.6
Monmouth County(7)	15.8	132	rising	1.1
Middlesex County(7)	15.8	155	stable	0.3
Hunterdon County(7)	15.6	26	stable	0.3
Passaic County(7)	15.4	90	stable	0.7
Morris County(7)	15.3	99	stable	0.8
Sussex County(7)	15	30	stable	-0.5
Union County(7)	14.5	93	stable	0.6
Essex County(7)	14	124	stable	0.7
Hudson County(7)	13.7	94	rising	1
Somerset County(7)	13.3	56	stable	0

Leukemia: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	15.8	1,686	rising	1
US (SEER+NPCR)(1)	13.9	51,518	falling	-1.9
Sussex County(7)	23.3	39	rising	3.6
Monmouth County(7)	18.7	149	rising	1.8
Hunterdon County(7)	18.2	31	stable	0.3
Morris County(7)	17.9	111	rising	1.5
Mercer County(7)	17.4	74	rising	2.1
Gloucester County(7)	17.3	59	stable	1
Ocean County(7)	17.3	157	stable	0.8

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Warren County(7)	16.6	23	stable	1.4
Burlington County(7)	16.3	92	stable	1
Middlesex County(7)	16	147	stable	0.3
Cape May County(7)	15.5	24	stable	-0.6
Camden County(7)	15.2	90	stable	0.6
Bergen County(7)	15	176	stable	-2.4
Somerset County(7)	14.8	59	stable	-0.2
Union County(7)	14.7	91	stable	0.3
Essex County(7)	14.1	123	stable	0.8
Cumberland County(7)	13.9	24	stable	-8.9
Atlantic County(7)	13.8	47	stable	0
Passaic County(7)	13.6	75	stable	-9.3
Hudson County(7)	12.6	83	stable	0.6
Salem County(7)	11.9	9	stable	-1
Liver & Bile Duct: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	8	935	stable	0.5
US (SEER+NPCR)(1)	8.6	34,900	stable	0
Cumberland County(7)	11.9	21	rising	4.1
Cape May County(7)	11	19	rising	4.5
Atlantic County(7)	10.5	40	stable	2.2
Camden County(7)	9.2	61	stable	-4.4
Hudson County(7)	9	62	rising	2.8

Ocean County(7)	8.9	86	rising	3.6
Salem County(7)	8.7	8	rising	4
Essex County(7)	8.3	77	stable	1.1
Mercer County(7)	8.2	38	rising	1.8
Passaic County(7)	7.8	47	stable	0.9
Bergen County(7)	7.7	98	rising	1.4
Middlesex County(7)	7.7	78	rising	2.1
Sussex County(7)	7.6	16	stable	1.9
Union County(7)	7.5	50	rising	2.3
Burlington County(7)	7.5	46	rising	2.1
Gloucester County(7)	7.3	28	rising	1.7
Monmouth County(7)	7.2	63	rising	2

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Morris County(7)	7	47	rising	2.2
Warren County(7)	6.9	10	stable	1.5
Somerset County(7)	6.4	28	rising	2.2
Hunterdon County(7)	5.3	10	rising	2.2
Lung & Bronchus: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	51.3	5,849	falling	-1.9
US (SEER+NPCR)(1)	54	215,307	falling	-1.8
Salem County(7)	77.9	70	stable	1.4
Cape May County(7)	70.8	125	stable	-0.8
Ocean County(7)	69.8	702	stable	0.7
Gloucester County(7)	68.8	251	falling	-4.9
Cumberland County(7)	66.2	120	falling	-0.9
Warren County(7)	63.9	96	stable	-0.6
Atlantic County(7)	63.5	236	falling	-1.5
Camden County(7)	60.4	382	falling	-1.4
Burlington County(7)	57.4	346	falling	-1.1
Sussex County(7)	57	113	falling	-1.4
Monmouth County(7)	55.6	480	falling	-1.5
Mercer County(7)	50.5	228	falling	-1.5
Middlesex County(7)	45.9	453	falling	-2

Bergen County(7)	45.4	576	falling	-1.6
Morris County(7)	44.4	295	falling	-1.9
Passaic County(7)	43.4	254	falling	-1.9
Essex County(7)	42.9	379	falling	-2.2
Somerset County(7)	39.6	166	falling	-1.9
Hudson County(7)	39.2	257	falling	-2.4
Hunterdon County(7)	38.6	72	falling	-12.5
Union County(7)	37.9	245	falling	-5.8
Melanoma of the Skin: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	21	2,295	stable	0.4
US (SEER+NPCR)(1)	22.5	83,836	stable	1.5
Cape May County(7)	50.1	79	stable	1.9
Hunterdon County(7)	34.7	61	stable	1.6
Ocean County(7)	31.6	274	stable	-0.2

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Monmouth County(7)	29.9	245	stable	-1.3
Sussex County(7)	28.6	53	stable	0.4
Gloucester County(7)	28.2	99	stable	1
Atlantic County(7)	26.9	94	rising	1.7
Morris County(7)	26.1	166	stable	0.3
Warren County(7)	25.7	37	stable	0.6
Burlington County(7)	25.6	146	stable	0.6
Somerset County(7)	24.8	102	stable	0.4
Salem County(7)	23.7	20	stable	-0.5
Camden County(7)	22.6	135	stable	0.5
Mercer County(7)	21.8	96	stable	0.4
Cumberland County(7)	17.5	30	stable	1.6
Bergen County(7)	16.8	202	falling	-1.5
Middlesex County(7)	15.4	149	falling	-5.5
Union County(7)	14.2	92	stable	-1.5
Passaic County(7)	12.3	70	stable	-0.3
Essex County(7)	10.4	92	stable	-0.6
Hudson County(7)	7.7	53	stable	-0.7

Non-Hodgkin Lymphoma: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	21.3	2,323	stable	0
US (SEER+NPCR)(1)	18.6	70,394	falling	-1.3
Monmouth County(7)	24.2	200	stable	1.7
Morris County(7)	23.6	151	stable	-0.1
Sussex County(7)	23.5	44	stable	-0.3
Warren County(7)	23.3	34	stable	-0.4
Somerset County(7)	22.8	93	stable	0.3
Bergen County(7)	22.6	271	stable	0.2
Mercer County(7)	22.5	97	stable	0
Camden County(7)	22.3	135	stable	0.3
Ocean County(7)	22.1	202	stable	0.6
Burlington County(7)	21.8	125	stable	-0.2
Middlesex County(7)	21.5	207	stable	-0.1
Cumberland County(7)	20.8	36	stable	0.2
Passaic County(7)	20.6	117	stable	0.4

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Atlantic County(7)	20.6	73	stable	-0.2
Gloucester County(7)	20.5	72	stable	-4.8
Union County(7)	18.8	120	stable	-0.3
Hunterdon County(7)	18.5	34	stable	-0.8
Essex County(7)	17.8	154	falling	-1.8
Salem County(7)	17.2	15	stable	-0.9
Hudson County(7)	17.1	113	stable	-0.5
Cape May County(7)	16.9	28	stable	-0.4
Oral Cavity & Pharynx: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	11.4	1,298	rising	0.9
US (SEER+NPCR)	11.9	46,507	stable	0
Cape May County	15.8	25	stable	0.5
Salem County	15	14	stable	0.7
Cumberland County	14.5	26	rising	2.2
Sussex County	14.2	27	stable	1.5
Ocean County	13.9	124	stable	2.6

Atlantic County	12.8	48	rising	1.4
Monmouth County	12.8	110	stable	0.8
Camden County	12.6	79	rising	1.6
Warren County	12.3	18	stable	2
Gloucester County	12	45	stable	0.9
Middlesex County	11.6	115	rising	1.9
Morris County	11.4	75	stable	1.6
Burlington County	11.2	68	stable	1.1
Somerset County	11.1	48	stable	0.4
Passaic County	11	65	stable	2.3
Hunterdon County	10.9	21	stable	1.3
Mercer County	10.7	49	rising	8.2
Essex County	10.7	96	stable	-2.3
Bergen County	9.8	123	stable	0.2
Hudson County	9.4	66	stable	-0.7
Union County	8.6	55	stable	0
Ovary: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	11.3	654	falling	-2

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	**Age-Adjusted Incidence Rate - cases per 100,000**	**Average Annual Count**	**Recent Trend**	**Recent 5-Year Trending Incidence Rates**
US (SEER+NPCR)	10.1	19,863	falling	-3.3
Warren County	15	11	stable	0.9
Cape May County	14.7	11	stable	-0.2
Somerset County	12.6	27	falling	-2
Mercer County	12.3	29	stable	-0.9
Atlantic County	12.3	22	stable	-2.4
Cumberland County	11.9	11	stable	-1.2
Burlington County	11.8	35	stable	-0.9
Hudson County	11.8	42	stable	-0.8
Union County	11.6	39	falling	-1.9
Camden County	11.6	38	falling	-2.1
Hunterdon County	11.5	10	falling	-2.5
Sussex County	11.2	11	falling	-3.1
Middlesex County	11.2	58	falling	-2.3

Ocean County	11.1	52	falling	-1.3
Essex County	10.9	51	falling	-1.7
Bergen County	10.7	68	stable	-1
Monmouth County	10.6	47	falling	-2
Gloucester County	10.5	20	falling	-2.9
Passaic County	10.4	32	falling	-2.5
Morris County	10.2	36	falling	-3.1
Salem County	*	3 or fewer	*	*
Pancreas: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	14.8	1,687	rising	1.2
US (SEER+NPCR)(1)	13.2	52,045	rising	1
Ocean County(7)	16.8	162	rising	1.6
Salem County(7)	16.7	15	stable	1.8
Camden County(7)	16.4	103	rising	1.4
Cumberland County(7)	16.4	30	stable	1.6
Sussex County(7)	15.7	30	rising	3.1
Atlantic County(7)	15.6	58	rising	1.4
Burlington County(7)	15.6	92	rising	1.7
Gloucester County(7)	15.4	57	stable	1.1

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	**Age-Adjusted Incidence Rate - cases per 100,000**	**Average Annual Count**	**Recent Trend**	**Recent 5-Year Trending Incidence Rates**
Mercer County(7)	15.3	69	rising	1.9
Morris County(7)	15.2	102	rising	1.5
Warren County(7)	14.9	22	stable	-13.4
Essex County(7)	14.7	130	stable	0.8
Monmouth County(7)	14.6	127	rising	1.1
Bergen County(7)	14.3	182	stable	0.4
Passaic County(7)	14.2	84	stable	0.6
Hudson County(7)	14.2	93	stable	3.3
Hunterdon County(7)	14.1	26	stable	1.7
Somerset County(7)	13.4	59	rising	1.4
Middlesex County(7)	13.4	134	stable	0.9
Union County(7)	13.3	86	stable	0.4
Cape May County(7)	13	23	stable	0

Prostate: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	143.3	7,783	stable	3.6
US (SEER+NPCR)	110.5	212,734	rising	2.5
Essex County	167.5	690	stable	4.7
Burlington County	165.9	480	stable	2.8
Mercer County	158.4	337	falling	-1.9
Cape May County	158	135	falling	-1.5
Gloucester County	156.5	284	falling	-1.5
Union County	154.8	478	rising	5
Camden County	151.9	456	falling	-1.6
Monmouth County	150.2	636	rising	6.3
Cumberland County	148.6	128	stable	-0.2
Passaic County	145.8	405	falling	-2.2
Morris County	142.4	463	falling	-2.6
Salem County	142.2	63	stable	-1.6
Bergen County	137.3	823	stable	-1.6
Somerset County	136	277	falling	-2.2
Middlesex County	135.1	645	rising	4.8
Hunterdon County	130	124	rising	7.5
Atlantic County	127.9	231	falling	-2.2
Ocean County	127.7	563	stable	6.6

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Sussex County	124.7	128	falling	-3.7
Warren County	120	92	falling	-3.1
Hudson County	114.1	344	stable	1.3
Stomach: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	7.5	832	falling	-1
US (SEER+NPCR)(1)	6.2	23,883	falling	-1
Passaic County(7)	10.4	59	stable	-0.1
Essex County(7)	9.2	81	falling	-1.3
Cumberland County(7)	8.8	15	stable	-1.5
Union County(7)	8.8	56	stable	-0.9
Hudson County(7)	8.4	56	falling	-1.9

Camden County(7)	8.3	51	stable	0.4
Bergen County(7)	8.2	101	stable	-0.7
Atlantic County(7)	7.7	28	stable	-0.8
Middlesex County(7)	7	69	falling	-2.2
Somerset County(7)	7	29	stable	-1.3
Monmouth County(7)	6.8	59	stable	6.5
Mercer County(7)	6.8	30	stable	-0.9
Sussex County(7)	6.6	13	stable	-0.6
Burlington County(7)	6.5	39	stable	-0.2
Gloucester County(7)	6	22	stable	-1.7
Morris County(7)	6	39	falling	-1.7
Ocean County(7)	5.9	54	stable	-0.8
Warren County(7)	5.7	9	stable	-0.1
Salem County(7)	5.3	4	stable	-0.5
Hunterdon County(7)	5.3	10	stable	0.1
Cape May County(7)	5.2	9	stable	-1.7
Thyroid: All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey(7)	17.5	1,673	falling	-2.2
US (SEER+NPCR)(1)	13.3	44,551	falling	-2.3
Monmouth County(7)	24.3	165	stable	0.2
Ocean County(7)	23.4	146	stable	0.1
Gloucester County(7)	21.7	67	rising	3.1
Warren County(7)	20.6	25	rising	2.2

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Salem County(7)	20	13	stable	2.8
Hunterdon County(7)	19.2	26	rising	4.6
Bergen County(7)	18.8	191	stable	-0.6
Camden County(7)	18.6	100	falling	-6.1
Mercer County(7)	18.3	73	falling	-14.3
Burlington County(7)	17.8	88	falling	-3.8
Middlesex County(7)	17.1	151	stable	-1.7
Morris County(7)	16.9	91	stable	-2.6
Sussex County(7)	16.8	26	rising	3.4

Atlantic County(7)	16.2	46	stable	0.2
Somerset County(7)	16.1	57	falling	-6.1
Passaic County(7)	15	79	stable	-1.1
Cape May County(7)	14.9	15	stable	-3.2
Union County(7)	14.8	87	stable	3.8
Hudson County(7)	13.7	98	stable	-0.6
Essex County(7)	13.1	111	stable	-0.4
Cumberland County(7)	11.2	18	stable	-0.4
Uterus (Corpus & Uterus, NOS): All Races (includes Hispanic), Both Sexes, All Ages				
New Jersey	31.9	1,967	rising	0.8
US (SEER+NPCR)	27.4	56,871	rising	1.2
Warren County	39.2	31	stable	1.4
Cumberland County	38	36	stable	1.6
Hunterdon County	37.7	37	rising	4.5
Sussex County	36.6	40	stable	0.4
Camden County	35.9	124	stable	0
Mercer County	33.1	83	rising	1.5
Ocean County	33	163	stable	0.3
Middlesex County	32.5	175	stable	0.6
Monmouth County	31.8	147	stable	0
Cape May County	31.7	27	stable	-12.7
Burlington County	31.7	103	stable	1.1
Essex County	31.6	160	rising	1.6
Morris County	31.4	113	stable	0.4

INCIDENCE RATE REPORT: ALL COUNTIES 2016-2020				
County	Age-Adjusted Incidence Rate - cases per 100,000	Average Annual Count	Recent Trend	Recent 5-Year Trending Incidence Rates
Union County	31.1	113	stable	1.1
Atlantic County	31	62	stable	-8
Somerset County	30.9	73	stable	0.1
Gloucester County	30.9	64	stable	1
Hudson County	30	112	rising	1.4
Bergen County	29.3	199	stable	0.1
Salem County	28.5	14	stable	0.3
Passaic County	28.5	91	stable	0.2

APPENDIX G7: RWJ Rahway - TUMOR REGISTRY SUMMARY

In 2023, RWJ-R's tumor registry data showed that 16.5 % and 16.2% of overall cases were Stage 3 and Stage 4 respectively. The following primary sites were made up of more than 25% of Stage 4 cases: Lymph Nodes (66.0%) followed by Female Genital Organs and Lip Oral (50.0%), Digestive Organs (44.1%), and Respiratory Systems (41.7%).

Please note that case volume counts smaller than 10 are suppressed. Staging percentages are calculated on analytic cases only.

MainSite	SubSite	Cases (both analytic and non-analytic) - 2023	% Stage 3	% Stage 4	Total % Stage 3 & 4
BREAST		**42**	**15.4%**	**15.4%**	**30.8%**
DIGESTIVE ORGANS		**74**	**14.7%**	**44.1%**	**58.8%**
	COLON	15	33.3%	66.7%	100.0%
	LIVER AND INTRAHEPATIC BILE DUCTS	11	0.0%	25.0%	25.0%
	PANCREAS	16	14.3%	57.1%	71.4%
	STOMACH	12	20.0%	20.0%	40.0%
EYE, BRAIN AND OTHER PARTS OF CENTRAL NERVOUS SYSTEM		**13**	**0.0%**	**0.0%**	**0.0%**
FEMALE GENITAL ORGANS		**24**	**25.0%**	**50.0%**	**75.0%**
	CORPUS UTERI	11	0.0%	0.0%	0.0%
HEMATOPOIETIC AND RETICULOENDOTHELIAL SYSTEMS		**36**	**0.0%**	**0.0%**	**0.0%**
	HEMATOPOIETIC AND RETICULOENDOTHELIAL SYSTEMS	36	0.0%	0.0%	0.0%
LIP, ORAL CAVITY AND PHARYNX		**11**	**0.0%**	**50.0%**	**50.0%**
LYMPH NODES		**18**	**0.0%**	**60.0%**	**60.0%**
	LYMPH NODES	18	0.0%	60.0%	60.0%
MALE GENITAL ORGANS		**168**	**22.0%**	**7.3%**	**29.4%**
	PROSTATE GLAND	166	22.0%	7.3%	29.4%
RESPIRATORY SYSTEM AND INTRATORACIC ORGANS		**43**	**16.7%**	**41.7%**	**58.3%**
	BRONCHUS AND LUNG	38	16.7%	41.7%	58.3%
THYROID AND OTHER ENDOCRINE GLANDS		**10**	**0.0%**	**0.0%**	**0.0%**
URINARY TRACT		**45**	**20.0%**	**10.0%**	**30.0%**
	BLADDER	28	15.0%	0.0%	15.0%
	KIDNEY	13	28.6%	42.9%	71.4%
Grand Total		**501**	**16.9%**	**16.5%**	**33.3%**

APPENDIX G8: CANCER INCIDENCE RATE REPORT: CANCER PATIENT ORIGIN UNION COUNTY 2023

A little over sixty-one percent of TRMC's cancer inpatients and 54.8% of cancer outpatients resided in the Primary Service Area. In total, 88.2% of inpatients and 85.7% of outpatients resided in Union County. Elizabeth (07202) and Elizabeth (07201) represent the largest segment of TRMC's inpatient cancer patients. Similarly, Elizabeth (07202) and Elizabeth (07208) represent the largest segments of TRMC's outpatient cancer patients. The health factors and outcomes explored in the CHNA bear relevance to the oncology services and its review of specific cancer needs for the community.

CANCER PATIENT ORIGIN	2023 TRMC IP PATIENTS	%	2023 TRMC OP PATIENTS	%
Union County	986	88.2%	478	85.7%
Primary Service Area	685	61.3%	306	54.8%
Secondary Service Area	327	29.2%	179	32.1%
Out of Service Area (NJ)	87	7.8%	73	13.1%
Out of State	19	1.7%	0	0.0%
TOTAL	**1,118**	**100.0%**	**558**	**100.0%**
Elizabeth (07202)	233	20.8%	93	16.7%
Elizabeth (07201)	193	17.3%		
Elizabeth (07208)			90	16.1%

Source; Decision Support; IP volume includes cases with ICD10 principal or secondary codes C00 thru D49.9 (Neoplasms); OP volume includes cases with ICD10 principal or secondary codes Z51.0 or Z51.11 (Chemo and Radiation Therapy).

Appendix H. Outcomes and Results from Previous Implementation Plan

Robert Wood Johnson University Hospital-Rahway 2023-2025 Strategic Implementation Plan

May 2023

PREPARED BY
HEALTH RESOURCES IN ACTION

Robert Wood Johnson University Hospital Rahway | RWJBarnabas HEALTH

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Executive Summary

This executive summary provides an overview of the Robert Wood Johnson University Hospital Rahway (RWJUH Rahway) 2022 Community Health Needs Assessment (CHNA) and 2023-2025 Strategic Implementation Plan (SIP).

Improving the health of a community is essential to enhancing the quality of life for residents in the region and supporting future social and economic well-being. RWJUH Rahway engaged in a rigorous planning process to improve the health of residents in its primary service area of Union County (towns of Clark, Cranford, Linden, Rahway, and Roselle), and three communities in Middlesex County (Avenel, Carteret, and Colonia), fulfilling the requirements under the Affordable Care Act and continuing this best practice in community health. This effort included two phases: (1) a CHNA to identify the health-related needs and strengths of the region and (2) a SIP to identify major health priorities, develop goals, select strategies, and identify partners to address these priority issues across the region.

Impact of COVID-19 & Related Considerations

The 2022 CHNA was conducted during an unprecedented time due to the novel coronavirus (COVID-19) pandemic and the national movement for racial justice. The COVID-19 pandemic coincided with the activities of this assessment and impacted both the CHNA data collection process, as well as topics and concerns that residents raised in focus groups and key informant interviews. A wave of national protests for racial equity in 2020 highlighted how racism is embedded in systems across the US. The national movement informed the content of this report including the data collection processes, design of data collection instruments, and the input that was shared during focus groups, key informant interviews, and through survey responses.

Health Equity Approach

RWJUH Rahway utilized the social determinants of health framework to guide the CHNA and SIP processes. This framework examines how individual health outcomes are influenced by upstream social and economic factors such as housing, educational opportunities, food access, and economic stability. The CHNA describes social and economic determinants and reviews key health outcomes among residents of the RWJUH Rahway service area. The SIP prioritizes addressing these upstream factors to promote health equity, the principle that all people have a fair and just opportunity to be healthy.

Methods

To identify the health needs of the service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in Union and Middlesex Counties; conducting a community survey with 443 resident responses; facilitating four focus groups with a total of 50 residents from specific populations of interest (e.g., residents identifying as Haitian with the interview conducted in Haitian Creole, residents identifying as African American, volunteers providing food access to economically vulnerable and unhoused residents, and Spanish-speaking low-income residents seeking food and/or housing assistance with the interview conducted in Spanish); and conducting key informant interviews with 19 community stakeholders representing various sectors including the faith community, school health services, mental health services, community services, and those who serve/work with specific populations (e.g., immigrant communities, economically vulnerable populations, youth, and senior populations). The CHNA and SIP processes were guided by the RWJBH Systemwide CHNA Steering Committee, RWJUH Rahway-TRMC CHNA Advisory Committee, and the RWJUH Rahway SIP Planning Committee. Both the CHNA and SIP committees included

community stakeholders who contributed suggestions and feedback regarding health and social challenges in their area and recommendations for how to address these concerns.

CHNA Key Findings and Prioritization

During the survey, focus groups and interviews, assessment participants were asked for input on the top priorities for action in their communities. Participants were asked about the most pressing concerns in their communities, and their highest priorities for future action and investment. Secondary data at the state, county, and town-level were also reviewed for key concerns related to social, environmental, and health issues.

In synthesizing social, economic, and epidemiological statistical data with community perspectives and discussions, the 2022 CHNA identified several key priority areas for action related to community health improvement, including:

- Systemic Racism and Injustice
- Financial Insecurity and Employment
- Nutrition and Food Insecurity
- Housing
- Transportation
- Chronic Disease (e.g., heart disease, cancer, diabetes)
- Mental Health
- Substance Use
- COVID-19
- Access to Healthcare and Social Services

On November 4, 2022, a 90-minute virtual community meeting was held with the 15-member RWJUH Rahway-Trinitas Regional Medical Center (TRMC) CHNA Advisory Committee, so Advisory Committee members could discuss and vote on preliminary priorities for action. During the virtual prioritization meeting on Zoom, attendees heard a brief data presentation on the key findings from the CHNA conducted across the RWJUH Rahway-TRMC primary service areas. Meeting participants were then divided into small groups to reflect on and discuss the data and offer their perspectives and feedback on the various issues. At the end of the meeting, using Zoom's polling tool, participants were asked to vote for up to four of the ten priorities identified from the data, based on the specific prioritization criteria (Burden, Equity, Impact, Systems Change, Feasibility, Collaboration/Critical Mass, and Significance to Community).

As a result of these facilitated discussions, the following priorities were selected to be the focus for the RWJUH Rahway SIP:

- **Mental Health**
- **Nutrition and Food Insecurity**
- **Chronic Disease**
- **Access to Healthcare and Social Services**

In addition, RWJUH Rahway decided that all priorities be addressed with an overarching focus on **racism and discrimination**.

The CHNA can be accessed at Community Health Needs Assessment | Hospitals in Rahway NJ (rwjbh.org). The document provides a more in-depth discussion of the communities served and the methods, participants, and findings leading to the selected priorities. While there were other significant needs that were identified in the

CHNA, the hospital has limited resources and needs to focus on prioritized needs to be most successful in its improvement efforts for the SIP. The SIP does not include all activities that are or may be undertaken by the hospital, but those developed to achieve specific objectives within the mission of Community Benefit.

Process for Developing the Strategic Implementation Plan

Following the prioritization discussion, Health Resources in Action (HRiA) facilitated a one-hour virtual kickoff meeting, followed by one, three-hour virtual SIP planning session in April 2023 that included mapping current and emerging programs and initiatives against priority areas identified in the CHNA. Most areas highlighted by the 2022 CHNA are being addressed at different levels within the 2023-2025 SIP (e.g., priority level, goal, and/or cross-cutting strategic themes/strategic initiatives). This plan is meant to be reviewed regularly and adjusted to accommodate emerging issues that merit attention.

Vulnerable Populations Addressed by this SIP

- Residents identifying as Haitian
- African American residents
- Spanish-speaking, low-income residents
- Economically vulnerable and unhoused residents
- Youth
- Seniors
- Immigrants, undocumented

Social Determinants of Health Issues Addressed by this SIP

- Access to Healthcare Services and Social Services
- Food Access
- Transportation

Partnership Development & Ongoing Collaborations

RWJUH Rahway continues to build and maintain relationships with partner organizations in the community to ensure their community health improvement work is carried out collaboratively. Residents, social service organizations, and faith communities are highly invested in community health and in deepening the partnership between communities and healthcare providers.

RWJUH Rahway Strategic Implementation Plan

Strategic Implementation Plan Snapshot

Priority Area	Goal
Priority Area 1: Mental Health	Goal: Provide access to the holistic, ongoing mental health services people need regardless of ability to pay or documentation status.
Priority Area 2: Nutrition & Food Insecurity	Goal: Provide health and nutrition education and resources for all community members to have access to healthy and culturally appropriate foods to meet individual nutritional needs and maintain a healthy lifestyle.
Priority Area 3: Chronic Disease	Goal: Ensure access to accurate, early diagnosis; treatment; and supportive care for chronic disease that honors patients' values and lived experiences and promotes holistic wellness regardless of insurance status to prevent unnecessary ED utilization.
Priority Area 4: Access to Healthcare and Social Services	Goal: Ensure community members have access to quality and equitable health and social services at the time of need.

Priority 1: Mental Health

Priority Area 1: Mental Health **Goal: Provide access to the holistic, ongoing mental health services people need regardless of ability to pay or documentation status.**						
Outcome Indicators					**Baseline**	**Target**	**Tracking/Outcome**
Number of community partners as referral sources (a, d, i)					3 sources	6 sources	Exceeded target
Number of referrals to Trinitas outpatient program from patients presenting to the ED in crisis (b, g, h)					0	100%	Met target
Number of community outreach and education events (c, i)					0	2 annually	Exceeded target
Number of patients referred by hospitalists/intensivists for appropriate outpatient mental health service (g)					0	100%	**Pending**
Number of patients screened through existing hospital outpatient programs and referred to mental health services (g, h, i)					0	100%	Met target
Strategic Initiatives	**Current/New Initiative?**	**Person(s) Responsible (Dept./Name)**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**		**Successes/ Challenges**
a. Expand linkage to community mental health resources for inpatient and outpatient population; and continue follow-up process for all patients referred for PES (Psychiatric Emergency Services) and discharged into the community, regardless of insurance type, until appropriate link is obtained.	Current	Tina Butler	Y1-Y3	FT Clinical Coordinator, calls, documentation, out-reach time	DMHAS Peer Support Funding (potential)		Hired and trained Community Education Coordinator with onboarding and orientation to RWJBH and partnering mental health and social service programs Direct link to Trinitas inpatient and outpatient facility for direct referrals when needed

Priority Area 1: Mental Health Goal: Provide access to the holistic, ongoing mental health services people need regardless of ability to pay or documentation status.						
b. Put into practice, use of standing drop-in appointments, at Trinitas Outpatient Behavioral Health and/or Bridgeway Services for patients discharged from PES.	New	Linda Reynolds, Tina Butler	Y1	Clinical staff time	TBD	Expanded community linkages by distributing information about Trinitas Outpatient Behavioral Health, Bridgeway Services and/or NAMI mental health alliance at each health fair, speaking engagement or event participated.
c. Provide new Community Education Coordinator with onboarding and orientation to mental health and social service programs offered by the hospital system to reach Rahway's most vulnerable patient populations.	New	Tina Butler, Christina Manata	Y1	Staff time	TBD	Became active member of the Union County Opioid Task Force to identify and assist with fund allocation providing addiction services to vulnerable populations. Became active member of the Union County Health Officers meeting to assist with services needed within Union County municipalities.
d. Collaborate with community partners that have created resource directories to share comprehensive resources with patients and hospital staff; cross market and share these resources among all community partners.	Current	Christina Manata, Community Ed Coordinator	Y1	Staff time, printing resources	Resources from NAMI, Bridgeway, RWJBH, etc.	Work closely with the Psych Services at Rahway and Trinitas to keep current materials on hand and remain up-to-date on community needs/trends.

Priority Area 1: Mental Health Goal: Provide access to the holistic, ongoing mental health services people need regardless of ability to pay or documentation status.						
Strategic Initiatives	**Current/New Initiative?**	**Person(s) Responsible (Dept./Name)**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**	**Successes/ Challenges**
e. Facilitate ongoing inter-agency opportunities for service-providers (MD/NP) to build relationships, share resources, and expand the sharing of Behavioral Health guides with medical providers.	New	Community Ed Coordinator Service-Providers	Y1-Y3	Staff time, printing resources	Trinitas, Union County, City of Rahway, Bridgeway, etc.	Referred patients with support group needs to the monthly National Alliance on Mental Illness (NAMI) or support groups.
f. Explore providing professional development opportunities for hospital staff to build their skills and knowledge to provide services and resources for patients with social determinants of health needs.	New	Tina Butler, Diversity and Inclusion Director, Trinitas Behavioral Health and Bridgeway	Y1-Y3	Staff time	TBD	Ongoing work with Case Management and Community Health Workers for patient referrals to outpatient programs.
g. Partner with hospitalists, intensivists, and other admitting providers to screen patients under their management for Insomnia/Depression and Anxiety/NIDA and refer to Trinitas, Bridgeway or other mental health outpatient service.	New	Tina Butler, Dr. Carol Ash, Dr. Ghanefar, Dr. Kodadhala, Medical Staff	Y1-Y3	Staff Time, printed resources	TBD	Ongoing work with Case Management and Community Health Workers for patient referrals to outpatient programs.
h. Educate and support outpatient programs on screening guidelines as an addition to the patient intake form. Patients presenting to Transitions of Care Clinic, Bariatric program, and other outpatient programs, will be screened for Depression and Anxiety, and referred to Trinitas, Bridgeway or other mental health services.	New	Tina Butler, Christina Manata, Community Ed Coordinator, Dr. Howard Levitt, Dr. Anish Nihalani	Y1-Y3	Staff time, printed resources	TBD	Ongoing work with Case Management, Chronic Disease Navigators and Community Health Workers for patient referrals to outpatient programs.

Priority Area 1: Mental Health **Goal: Provide access to the holistic, ongoing mental health services people need regardless of ability to pay or documentation status.**						
i. Include mental health screenings in the planning of other coordinated community events and provide resources and referral information for outpatient services for vulnerable populations.	New	Christina Manata, Community Ed Coordinator, Lisa Gomez, Karen Vargas, etc.	Y1-Y3	Staff time, Printed resources	TBD	Community Education Coordinator invites CHW's to confirmed events to further expand our reach and support for local vulnerable patient populations
j. Participate on Union County Opioid Task Force to identify and assist with fund allocation providing addiction services to vulnerable populations.	New	Dr. Carol Ash, Christina Manata, Community Ed Coordinator	Y1	Staff time	Union County Behavioral Health Services	Currently a member of the Union County Opioid Task Force.

Monitoring/Evaluation Approach	**Approaches Used**
Follow ups conducted and outcomes tracked by excel spreadsheet on every MH Discharge from ED within 72 hours Conduct patient survey, provider survey and chart audit for compliance with screenings and referrals	Epic tracking used by PES Epic tracking used by CHW's
Potential Partners	**Partners Engaged**
• Bridgeway Community Programs • Case management (Bernie Valenzuela • Coalition for the Homeless • Jenna McCook, Outpatient Program Director for Adults • Pat Roman, NAMI • Patient Experience Department	Connected with each partner as needed and developed strong relationship with Trinitas due to the Coordinator position shared between us.

Priority 2: Nutrition and Food Insecurity

Priority Area 2: Nutrition and Food Insecurity **Goal: Provide health and nutrition education and resources for all community members to have access to healthy and culturally appropriate foods to meet individual nutritional needs and maintain a healthy lifestyle.**			
Outcome Indicators	**Baseline**	**Target**	**Tracking/Outcome**
• Number of annual cooking classes offered through RWJ Rahway (a)	1x/month	1x/month	Exceeded target
Number of diabetes education series annually (b, d, f, k)	3 series/year	4 series/year	Exceeded target
Quantity of food distributed locally via partnership with Rahway Food for Friends (e)	20 vegetable boxes/month 100 turkeys at Thanksgiving	30 vegetable boxes/month 100 turkeys at Thanksgiving	Exceeded target
Quantity of food collected and donated monthly to food bank (e)	85 lbs.	100 lbs.	Exceeded target
Number of community collaborative efforts to increase knowledge of healthy eating (a, b, d, f, g, h, i, k)	0	2 annually	Exceeded target
Developed patient resource guide and education on chronic disease management (d)	0	1	Met target
Number of Walk-with-a doc events where information and recipes are distributed (k)	0	2 annually	1 event

Priority Area 2: Nutrition and Food Insecurity Goal: Provide health and nutrition education and resources for all community members to have access to healthy and culturally appropriate foods to meet individual nutritional needs and maintain a healthy lifestyle.						
Strategic Initiatives	**Current/New Initiative?**	**Person(s) Responsible (Dept./Name)**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**	**Successes/ Challenges**
a. Host and promote monthly cooking classes at the RWJ fitness center and other primary market locations, focusing on foods among different cultural groups and for varied disease states, and targeting meals appropriate for top chronic disease states.	Current/New	Mary Beth Puschak	Y1-Y3	Staff time Cost of food used in cooking classes	Possible "guest chef" series	• Fulfilled monthly cooking classes at the RWJ fitness center focusing on foods among different cultural groups and for varied disease states, and targeting meals appropriate for top chronic disease states • Fulfilled senior center cooking demos • Fulfilled City of Rahway employee cooking demos
b. Increase diabetes awareness and nutrition information to vulnerable populations by organizing and participating in the Community Diabetes Education Series at Rahway YMCA; coordinate additional series for upcoming years as grant permits.	Current	Lauren Bernstein, Christina Manata, Community Ed Coordinator	Y1-Y3	Staff/Provider/ Pharm time	Renew grant from Merck?	Two-time recipient of Merck grant for chronic disease education. Organized Diabetes Education Series at Rahway YMCA. Added hypertension sessions to the curriculum for 2024 and 2025.

Priority Area 2: Nutrition and Food Insecurity Goal: Provide health and nutrition education and resources for all community members to have access to healthy and culturally appropriate foods to meet individual nutritional needs and maintain a healthy lifestyle.						
c. Participate in various support groups (e.g., breast cancer, bariatric support groups, fibromyalgia support groups) at the RWJ fitness center to share nutrition education and resources for specific disease states.	Current	Mary Beth Puschak	Y1-Y3	Staff time	TBD	Hosted/Participated in monthly breast cancer, bariatric and fibromyalgia support groups to bring nutrition education and resources to patients
Strategic Initiatives	**Current/New Initiative?**	**Person(s) Responsible (Dept./Name)**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**	**Successes/ Challenges**
d. Provide lectures and virtual programs as requested by various community groups (e.g., church group, senior citizen groups) on nutrition education, and include resources on disease management in each instance.	Current	Christina Manata and Andrea Alvare	Y1-Y3	Staff time	TBD	• Hosted senior center cooking demos in Rahway and Westfield each year as requested • Fulfilled City of Rahway employee cooking demo requests as needed and in conjunction with Paint Rahway Pink initiative • Participate in annual Food for Friends Day, providing screening, healthy eating demos and recipes

Priority Area 2: Nutrition and Food Insecurity Goal: Provide health and nutrition education and resources for all community members to have access to healthy and culturally appropriate foods to meet individual nutritional needs and maintain a healthy lifestyle.						
e. Provide nutrition-driven healthy donation suggestions or monetary donation access for ongoing employee food drive. Continue to Provide food and/or gifts (*e.g., vegetable boxes, turkeys on Thanksgiving, gifts around the holidays*) to community members through Food for Friends or City of Rahway annually.	Current/New	LaToyah Washington (Rahway Food for Friends) Christina Manata, Community ed coordinator	Y1-Y3	Staff time Provided donations (food and gifts)	Other organizations to provide money and/or gifts	Provided annual healthy donations to Food-for-Friends food bank (monthly canned goods and non-perishables, co-op *vegetable boxes, Thanksgiving turkeys and Christmas turkeys and hams)* Hosted supplemental drive upon SNAP benefits stoppage in 2025, resulting in more than 900 lbs of goods delivered.
f. Distribute nutrition-driven recipes relevant to top diagnosis to improve the management of chronic disease states to hospital outpatients and patients being discharged. Provide emphasis on hypertension, COPD, CHF, obesity and diabetes (within Transitions of Care, Bariatric and other forums as appropriate), and ensure recipes are low cost and culturally appropriate for each instance.	New	Mary Beth Puschak and Christina Manata	Y1-Y3	Staff time	TBD	Provided dietitian created, nutrition-driven, disease specific recipes at each program, added to each curated food delivery and included in YMCA and health fair packets annually.

Priority Area 2: Nutrition and Food Insecurity Goal: Provide health and nutrition education and resources for all community members to have access to healthy and culturally appropriate foods to meet individual nutritional needs and maintain a healthy lifestyle.						
g. Engage local restaurants and chefs to assist with eating modification efforts, including low cost, culturally appropriate recipes for the top chronic diseases, and collaboration on menu options for dining out locally; offer coupons if applicable.	New	Mary Beth Puschak and Christina Manata	Y1-Y3	Staff time	Review Social Impact list of local, diverse owned, restaurants and eateries willing to participate	Engaged with Rahway owned business during Paint Rahway Pink events to potentially modify menu items. Ongoing effort to engage even after Paint Rahway Pink events have ended.
h. Work with local nurseries to assist with nutrition modification efforts, including identifying vegetables, herbs and other food groups that align with chronic disease management and result in healthy food choices.	New	Mary Beth Puschak and Christina Manata	Y1-Y3	Staff time	TBD	Utilized Rahway employed, registered dietitians each instance.
Strategic Initiatives	**Current/New Initiative?**	**Person(s) Responsible (Dept./Name)**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**	**Successes/ Challenges**
i. Work with local supermarkets and dollar stores to identify healthy shopping resources and promote “shop the outside perimeter” campaigns, to encourage healthy shopping behaviors that align with chronic disease management resulting in healthy disease choices for vulnerable patient populations to improve behaviors including food choices, food preparation and access.	New	Mary Beth Puschak, Community Outreach Coordinator	Y1-Y3	Staff time	TBD	Ongoing effort with local supermarkets

Priority Area 2: Nutrition and Food Insecurity Goal: Provide health and nutrition education and resources for all community members to have access to healthy and culturally appropriate foods to meet individual nutritional needs and maintain a healthy lifestyle.						
j. Partner with Pharma and non-profit partners to provide patient resources and education on chronic disease management.	New	Mary Beth Puschak, Christina Manata and pharma and non-profit representatives and staff	Y1-Y3	Staff time	TBD	Ongoing collaborative relationship with Boehringer Ingelheim for chronic disease specific resources for both inpatients and outpatients.(CHF, COPD and CKD)
k. Elevate awareness of healthy food behaviors, selection and preparation, via the launch of the RWJ Rahway chapter of national Walk-with-a Doc program to encourage physical activity and reduce the effects of a sedentary lifestyle. Information, recipes and resources will be distributed via group walks.	New	Community Outreach Coordinator, Mary Beth Puschak and select providers	Y2-Y3	Staff time	Possible partnership with NBI and Trinitas to expand provider opportunities	Ongoing efforts to bridge this program with the Surgical weight-loss program at Rahway.

Priority Area 2: Nutrition and Food Insecurity **Goal: Provide health and nutrition education and resources for all community members to have access to healthy and culturally appropriate foods to meet individual nutritional needs and maintain a healthy lifestyle.**	
Monitoring/Evaluation Approach	**Approaches Used**
• Registration and attendance records for cooking classes, education series, support groups, programs • Survey or open focus group for participants to share their feedback and what changes participants might make (e.g., eating more vegetables)	Recorded in CBISA, each instance Real-time responses captured and implemented with approval from registered dietitians, each instance
Potential Partners	**Partners Engaged**
• Communities in Cooperation (Linden, NJ) • Community Food Bank (assist in getting people SNAP program) • County Division of Social Services • Gateway Family YMCA - Rahway Branch • JFK Community Center • Local grocery stores and bodegas • Rahway Community Action Organization • Rahway Food for Friends • Rahway Non-profit Alliance • United Way • Behringer Ingelheim • The American Heart Association	• Strong relationship with many partners listed. • Increased partnerships with local clergy who also connect with residents for food insecurity.

Priority 3: Chronic Disease

Priority Area 3: Chronic Disease
Goal: Ensure access to accurate, early diagnosis; treatment; and supportive care for chronic disease that honors patients' values and lived experiences and promotes holistic wellness regardless of insurance status to prevent unnecessary ED utilization.

Outcome Indicators	Baseline	Target	Tracking/Outcome
• Number of support groups and screening events for chronically ill patients (c, d, g)	0	8 annually	Exceeded target
• Number of physicians participating in volunteer activities in community (e)	1x month	3X month	Met target
• Number of patients and caregivers referred to support groups/community events (c, d)	1 per month	4 per month	Met target
• Number of educational events for community health workers who are recently released, formerly incarcerated individuals (b)	0 meetings	1 meeting	Met target
• Number of total attendees (support groups, awareness/screening events) (c, d)	4 registered	7 registered	Exceeded target
• Number of policy educational events (e.g., medical-legal symposium) (g)	0	1 event	Ongoing referrals to County of Union

Strategic Initiatives	Current/New Initiative?	Person(s) Responsible (Dept./Name)	Timeline (Y1, Y2, Y3)	Hospital Contribution	Other Source	Successes/ Challenges
a. Continue free pulmonary-cardiac clinic, which includes diagnostic testing, therapy, and education.	Current	Paul Sonder and Bill Debois (Admin), Dr. Carol Ash, Dr. Deb Gandy	Y1 – Y3	Staff time, facility space, equipment, funding	NBIMC facility space (program spans both campuses)	• Collaborating with Medical Group for outpatient cardiology and pulmonology services on-site. New space allotment for 2026. • Utilization of RSI grant for UberHealth transportation needs

Priority Area 3: Chronic Disease Goal: Ensure access to accurate, early diagnosis; treatment; and supportive care for chronic disease that honors patients' values and lived experiences and promotes holistic wellness regardless of insurance status to prevent unnecessary ED utilization.						
b. Engage HR in discussion to overcome policy barriers to launching community health worker program employing recently released, formerly incarcerated individuals.	New	Sheila Buthe, Director of HR and Lawyer	Y1 – Y3	Staff time, funding	Rutgers Health, American Medical Assoc. (poss. grant funding), Merck (poss. grant funding)	Community health workers began at Rahway in 2025 as part of Population Health initiative. Referrals to the Union County Community Health Law project or Union County expungement clinic as needed.
c. Continue free support groups for individuals with chronic disease and expand support groups for caregivers, including diabetes education at Gateway YMCA, bariatric support group, and interstitial lung disease (ILD) support group at Rahway.	Current/New	Christina Manata, Community Ed Coordinator	Y1 – Y3	Staff time, facility space	Gateway YMCA (facility space), Bridgeway FQHC (space/referrals), Neighborhood Health FQHC (space/referrals)	Continued free monthly support groups for individuals with chronic disease. Expanded support group participation for caregivers, diabetes education, bariatrics, lung disease and breast cancer survivors.

Priority Area 3: Chronic Disease Goal: Ensure access to accurate, early diagnosis; treatment; and supportive care for chronic disease that honors patients' values and lived experiences and promotes holistic wellness regardless of insurance status to prevent unnecessary ED utilization.						
Strategic Initiatives	**Current/New Initiative?**	**Person(s) Responsible (Dept./Name)**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**	**Successes/ Challenges**
d. Conduct provider education about support groups offered; transportation support available; and creating virtual, in-person, and hybrid options for participation.	Current/New	Bernie Valenzuela	Y2 – Y3	Staff time, facility space	Gateway YMCA (facility space), Bridgeway FQHC (space/referrals), Neighborhood Health FQHC (space/referrals)	Introduced support groups to on-site Medical Group and outpatient practices. Frequently provide materials for patient participation. Navigators and CHW's refer to support groups as needed.
e. Assess clinician burnout, using online surveys, before event launch. Educate providers and prove correlation in reduction in clinician burnout, as a result of engaging in community volunteerism through the launch of in-person and virtual, free Walk-with-a-Doc program in RWJUH Rahway service area.	New	Carol Ash, Wil McCullars, and Christina Manata	Y1 – Y3	Staff time, educational resources, funding	TBD	• Refer providers to system resources tailored to physician burnout. • Limit Medical Advisory Panel providers to 2 engagement opportunities annually to reduce volunteer related burnout.

Priority Area 3: Chronic Disease Goal: Ensure access to accurate, early diagnosis; treatment; and supportive care for chronic disease that honors patients' values and lived experiences and promotes holistic wellness regardless of insurance status to prevent unnecessary ED utilization.						
f. Continue free community screening and awareness events, such as Running with the Devils event, led by Rahway staff, and expand screening and awareness events by developing relationships with local nonprofit organizations, businesses, faith communities, pastoral care networks, and other non-traditional partners.	Current	Carol Ash, Wil McCullars, and Christina Manata, Father Luigi Hargain (community member)	Y1 – Y3	Staff time, educational resources	TBD	Conducted increased number of health screenings and awareness events throughout 2023-2025; taking BP and glucose levels at each community event, where applicable. Increased NJCEED screenings with breast cancer and cervical screenings.
g. Explore opportunities to support external policy change to create employment of community members, as community health workers, with a history of incarceration who will improve access for chronic disease management among residents. Implement opportunities to support policy change to improve participation of the legal system to address civil health obstacles.	New	Sheila Buthe, Judges Vincent Leblon and Travis Francis (community members), Carol Ash	Y1 – Y3	Staff time	TBD	• Worked within system guidelines for recruitment and employment. • Partnered with HR for 2 on-site interview events resulting in real time interviews for community members.

Priority Area 3: Chronic Disease Goal: Ensure access to accurate, early diagnosis; treatment; and supportive care for chronic disease that honors patients' values and lived experiences and promotes holistic wellness regardless of insurance status to prevent unnecessary ED utilization.						
Strategic Initiatives	**Current/New Initiative?**	**Person(s) Responsible (Dept./Name)**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**	**Successes/ Challenges**
h. Develop partnerships with legal entities (e.g., law schools, state and county bar associations, law firms) to provide free legal clinics or other events, for individuals who have been denied health care services or insurance claims; cross market these initiatives to enhance number of attendees and ensure diversity of attendees at policy education events in terms of sectors represented.	New	Sheila Buthe, Judges Vincent Leblon and Travis Francis (community members), Carol Ash	Y1 – Y3	Staff time, facility space	Middlesex County Bar Foundation (poss. grant funding), NJ State Bar Association Foundation, NJ Law Schools	Refer patients to the Union County Community Health Law project or the Union County expungement clinic as needed. Exploring new partnership opportunity with Bridgeway Justice involved services.
i. Promote linkages to primary care providers from ED by working with Chair of ED Service Line to identify need, increase meet and greet opportunities, and/or share expanded medical neighborhood of both Medical Group and JV practices with ED staff.	New	Christina Manata, Maryann Serra	Y1-Y3	Staff time, provider time	Medical Group and JV practices	• Worked within system guidelines for referrals through Epic. • Introduced Trinitas and Medical Group providers to Hospitalists, intensivists and ED providers as needed for increased patient care and keepage.

Priority Area 3: Chronic Disease **Goal: Ensure access to accurate, early diagnosis; treatment; and supportive care for chronic disease that honors patients' values and lived experiences and promotes holistic wellness regardless of insurance status to prevent unnecessary ED utilization.**	
Monitoring/Evaluation Approach	**Approaches Used**
• Attendance records (support groups, awareness/screening events) • Audits with prescribing MDs • Employment records for CHW's • Identification of community partnerships • Calendar of events • ED data on readmissions, repeat admissions • Surveys (caregiver satisfaction, clinician burnout, patient satisfaction)	• Recorded in CBISA, as needed • Real-time reporting captured via Epic.

Priority Area 3: Chronic Disease **Goal: Ensure access to accurate, early diagnosis; treatment; and supportive care for chronic disease that honors patients' values and lived experiences and promotes holistic wellness regardless of insurance status to prevent unnecessary ED utilization.**	
Potential Partners:	**Partners Engaged**
• American Academy for Respiratory Care *(educational resources and practice guidelines)* • American Academy for Sleep Medicine *(educational resources and practice guidelines)* • American Association of Cardiovascular and Pulmonary Rehab *(educational resources, practice guidelines)* • American Heart Association *(educational resources and practice guidelines)* • American Medical Association *(possible grant funding, free educational support for hypertension management)* • Baxter (Life 2k) *(equipment donation: ventilator for pulmonary rehab)* • Boehringer-Ingelheim Pharmaceutical Company *(assistance with chronic disease management, ILD, connection to other funding sources)* • Bridgeway FQHC *(space/referrals for community awareness and screening programs)* • Durable Medical Equipment providers *(equipment donation)* • Gateway YMCA *(space/referrals for community awareness and screening programs)* • Merck *(possible grant funding for a medical assistant to improve access to care for recently released, formerly incarcerated individuals)* • Middlesex County Bar Foundation *(possible grant funding for legal clinic/services)* • Middlesex Legal Services *(possible grant funding for legal clinic/services)* • Neighborhood Health FQHC *(space/referrals for community awareness and screening programs)* • New Jersey State Bar Foundation *(possible grant funding for legal clinic/services)* • New Jersey State Dept. of Corrections *(referrals to transitions to care network)* • New Jersey State Judiciary *(partner in medical-legal symposium, policy education event)* • Newark Beth Israel Medical Center *(NCIMC – pulmonary cardiac clinic)* • Rutgers Health *(grant funding for proposal for transitions to care network for formerly incarcerated individuals)* • Union County Reentry Task Force *(coalition of faith-based, mental health, probation, parole, and FQHC stakeholders…support for transitions to care network)* • Wescoe Foundation *(screening/awareness events focusing on pulmonary disease prevention/management)* • Transitions Clinic Network (TCN) • TMIT Consulting, LLC	• Existing relationship with many partners listed. • Continue to expand opportunities to partner throughout Union and Middlesex Counties

Priority 4: Access to Healthcare and Social Services

Priority Area 4: Access to Healthcare and Social Services **Goal: Ensure community members have access to quality and equitable health and social services at the time of need.**						
Outcome Indicators					**Baseline**	**Target**	**Tracking/Outcome**
• Number of community outreach events to improve community health literacy about chronic disease, chronic disease management and local social services (a, b, e, h, i)					1 per month	2 per month	Exceeded target
• Number of community screening opportunities and education on preventative health care visits (b, i)					1 per month	2 per month	Exceeded target
• Number of sessions educating adults on access to online medical record/health information (e)					0 sessions	1 session	Exceeded target
• Number of community health works with incarceration history, employed and trained. (F) • Number of existing community programs servicing formerly incarcerated individuals that are successfully linked to a medial legal partnership. (g)					0 0 0	1 1	Refer to Union County, each instance
• Number of symposia with Union County to educate residents on social service resources available (c, h)					0	1 event	Met target
Strategic Initiatives	**Current/New Initiative?**	**Person(s) Responsible (Dept./Name)**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**		**Successes/ Challenges**
a. Improve health related education and literacy through hospital-sponsored community informational sessions, community outreach events, cooking demonstrations, etc.	Current	Pastor Marti, Ebenezer Church, Community Ed Coordinator	Y1-Y3	Staff time	Rahway senior center, Rahway Public Housing		Improved health related education and literacy through informational sessions, outreach events, cooking demonstrations, etc

Priority Area 4: Access to Healthcare and Social Services Goal: Ensure community members have access to quality and equitable health and social services at the time of need.						
b. Increase chronic disease screening opportunities through outreach to the community, ensuring access to primary care through various community referral sources (FQHC's, other resources).	Current	Case Management Department, Bernie Valenzuela	Y1-Y3	Staff time	TBD	• Increased chronic disease screening by offering screening opportunities at every event possible. • Ensured access to primary care through direct referrals to Medical Group and Joint Venture practices. • Navigators and CHW's refer as per hospital protocol. • Partner with local companies for wellness day events (L'Oreal/Covient)
c. Become an active member of the Human Services Advisory Council (Union County and Middlesex County) to coordinate health and social services for our most vulnerable patient population.	New	Dalton Laluces, Union County Department of Human Services, Case Management Department, Bernie Valenzuela, Middlesex County (specific group TBD)	Y1-Y3	Staff time	TBD	• Active participant on the Union County Health Officers Association meetings • Active participant on the Union County Community Networking Association

Priority Area 4: Access to Healthcare and Social Services Goal: Ensure community members have access to quality and equitable health and social services at the time of need.						
Strategic Initiatives	**Current/New Initiative?**	**Person(s) Responsible (Dept./Name)**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Source**	**Successes/ Challenges**
d. Develop and enhance partnerships with local and county run Social Services and other community-based organizations to support individuals during the transition from the hospital into the community.	New	Case Management Department, Bernie Valenzuela, Dalton Laluces, Union County Department of Human Services	Y1-Y3	Staff time	TBD	As needed, Case Managers, Navigators and CHW's refer to Union County Department of Human Services for support or resources for patients upon discharge
e. Increase adult access to EPIC and/or other EMR portals via education at other outreach events, to expand patient knowledge of any diagnosed chronic disease states. • Host Zoom sessions for patients with demonstration on how to access the EPIC portal and retrieve protected health information as part of the "know your numbers" campaign. • Host Zoom program for front end office staff to educate on the practice benefits of educating patients on medical chart access.	New	HIM, IT, Christina Manata, Maryann Serra, Community Outreach Coordinator	Y2-Y3	Staff time, printed resources, advertising	Community Practices	• Increase resident access to EPIC My Chart via educational material distributed at outreach events, YMCA classes or directly with patient upon discharge and follow up. • Link Medical Group and community provider offices to Epic for training and access to hyperspace and knowledge of MyCart for patient education.

Priority Area 4: Access to Healthcare and Social Services Goal: Ensure community members have access to quality and equitable health and social services at the time of need.						
f. Work with members of the clergy and local community groups to identify community members with prior incarceration history. Working with transitions of care network, to create the process to allow for appropriate employment to identify previous incarcerated community members appropriate for employment who will serve as community health workers to improve access to healthcare to recently released incarcerated patients.	NEW	Community Outreach Coordinator, Local clergy, Hospital HR Dept.	Y2-Y3	Staff time		• Refer patients to the Union County Community Health Law project or the Union County expungement clinic as needed. • Exploring new partnership opportunity with Bridgeway Justice involved services.
g. Identify members of the legal community to address and provide services to those with civil legal health needs.	NEW	Dr. Carol Ash, Christina Manata, Judges LeBlon and Francis	Y2-Y3	Staff time		• Refer patients to the Union County Community Health Law project or the Union County expungement clinic as needed. • Exploring new partnership opportunity with Bridgeway Justice involved services.

Priority Area 4: Access to Healthcare and Social Services Goal: Ensure community members have access to quality and equitable health and social services at the time of need.						
h. Partner with Union County Resources for educational symposium for both hospital and local officials to identify partnership opportunities; cross market these initiatives to enhance number of attendees and ensure diversity of attendees at policy education events in terms of sectors represented.	New	Dalton Laluces, Union County Department of Human Services, Case Management Department, Bernie Valenzuela, Community Ed Coordinator	Y2-Y3		TBD	• Partner annually with Union County Commissioners on health events in Warinenco Park (back to school wellness event, house music festival, etc.) • Partner annually with City of Rahway for both Paint Rahway Pink breast cancer awareness event and Rahway Day health event
i. Partner with local pastoral care leaders to address common disease states and opportunities to bring information to the people; increase partnership opportunities with local churches to improve health of community and congregation members; and conduct chronic disease health screenings (CHF, Diabetes, HTN, Depression, Insomnia).	New	Local Houses of worship, Community Ed Coordinator	Y1-Y3		TBD	• Increased partnerships with local clergy for screening events and lectures to congregations about chronic disease • Hosted Wellness Road Spirituality event, inviting clergy and their congregations to learn about chronic disease, healthy eating and behavioral health concerns.

Priority Area 4: Access to Healthcare and Social Services Goal: Ensure community members have access to quality and equitable health and social services at the time of need.						
J. Reduce number of preventable hospital admissions by instructing ED staff on how to implement chronic disease resources to patients presenting to ED to educate patient population and educate on the self-prevention of hospital readmissions.	New	Community Ed Coordinator, Dr. Ramnarine, Dr. Trattner	Y1-Y3		Use of resources and COPD card where applicable	Hired Community Health Navigators to monitor and reduce preventable hospital admissions. Working closely with Hospitalists, ED staff and Medical Group providers on providing resources to patients and provide patient education on the self-prevention of hospital readmissions. Link patients to Charity Care as needed.
Monitoring/Evaluation Approach						**Approaches Used**
• Evaluation Surveys (Robert Wood Johnson)-includes identification of individuals needs • Demographics/healthcare information Tool (Robert Wood Johnson) • Quarterly reports (# person attended session, who attended) • Patient satisfaction survey						Recorded in CBISA, as needed Real-time reporting captured via Epic. Monitor press ganey

Priority Area 4: Access to Healthcare and Social Services Goal: Ensure community members have access to quality and equitable health and social services at the time of need.	
Potential Partners	**Partners Engaged**
• Bridgeway Behavioral Health Services • CEAS/CoC (Subcommittee of HSAC) • Department of Corrections • Federally Qualified Healthcare Centers (FQHC's) • Human Services Advisory Council (Union County and Middlesex County) • Legal Associations in Middlesex and Union Counties • Local police • Rahway Food for Friends (Pat Carter) • Rahway Nonprofit Alliance • Robert Wood Johnson University Hospital • Rutgers Cancer Institute of New Jersey • YMCA-Rahway location (Shannon Frank, CEO)	• Existing relationship with many partners listed. • Continue to expand opportunities to partner throughout Union and Middlesex Counties

Appendices

Appendix 1: SIP Planning Committee Lead

Name	Organization	Title
Christina Manata, MPA	RWJUH Rahway	Director, Physician Relations & Community Health Services RWJUH Rahway

Appendix 2: RWJUH Rahway SIP Planning Participants

Priority 1: Mental Health	Priority 2: Nutrition & Food Insecurity	Priority 3: Chronic Disease	Priority 4: Access to Healthcare & Social Services
Tina Butler Bethany Joseph Christina Manata Linda Reynolds	Andrea Alvare Pat Carter Mary Beth Puschak Christina Topolosky	Dr. Carol Ash Deb Gandy Behringer Ingelheim Wilbur McCullers Leeanne Muller Helen Peare Dr. Carlos Remolina Ann Marie Shears Dr. Lauren Trattner	Mary Jackson Dalton Laluces Vincent LeBlon, Esq. Father Robin Pierre Pastor Marti Robinson Bernie Valenzuela Kamili Williams

Appendix 3: Acronyms

CEAS/CoC	Comprehensive Emergency Assistance System/Continuum of Care
CHNA	Community Health Needs Assessment
CHF	Congestive Heart Failure
CHW	Community Health Worker
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus Disease of 2019
ED	Emergency Department
EMR	Electronic Medical Record
FQHC	Federally Qualified Health Center
HTN	Hypertension
ILD	Interstitial Lung Disease
MH	Mental Health
NAMI	National Alliance on Mental Illness
NIDA	National Institute on Drug Abuse
PES	Psychiatric Emergency Services
RWJBH	RWJBarnabas Health Hospital System
SIP	Strategic Implementation Plan
TBD	To Be Determined

Appendix 4: Glossary of Terms

Burden: How much does this issue affect health in the community?

Collaboration/Critical Mass: Are existing groups across sectors already working on or willing to work on this issue together?

Community Benefit: Programs, initiatives, or activities developed in collaboration with community representatives that address a need identified in the hospital's Community Health Needs Assessment and serve the needs of a Target Population identified in the hospital's Implementation Strategy.

Essential Services: All wrap-around and support services required for maintaining optimal physical and mental health.

Equity: Will addressing this issue substantially benefit those most in need?

Feasibility: Can we take steps to address this issue, given the current infrastructure, capacity, and political will?

Goal: The projected state of affairs/result that a person or system intends to achieve.

Health Equity: Everyone has a fair and just opportunity to be as healthy as possible.

Impact: Can working on this issue achieve both short-term and long-term changes? Is there an opportunity to enhance access/accessibility?

Outcome Indicator: Measures used to track the progress/success/impact of a series of strategies on improving population health.

Potential Partners: Individuals and agencies/organizations who can implement and/or support strategies identified in the SIP.

Priority Area: Topic area of focus.

Significance to Community: Was this issue identified as a top need by a significant number of community members?

Social Determinants of Health: The economic and social conditions in which people are born, grow, live, work and age that influence health outcomes.

Strategies/Initiatives: An approach to getting things done; a statement of HOW a Goal/Objective will be achieved.

Systems Change: Is there an opportunity to focus on/implement strategies that address policy, systems, and environmental change?

Vulnerable Populations: Groups and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political, and environmental resources, as well as limitations due to illness or disability.

RWJBarnabas HEALTH | Trinitas Regional Medical Center

COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION PLAN RESULTS 2023-2025

Introduction

In 2022, RWJBH/Trinitas Regional Medical Center ("TRMC") conducted and adopted its Community Health Needs Assessment ("CHNA") which consisted of a community health needs survey of residents in our service area, a detailed review of secondary source data, focus groups and key informant interviews. The process included a local committee to oversee the process that was inclusive of community representatives. The Plan and a full discussion of methods can be accessed here.

Through the CHNA process, significant health needs were identified and select priorities were chosen for development of improvement strategies based on the Medical Center's capacity, resources, competencies, and the needs specific to the populations it serves. The Implementation Plan addresses the manner in which TRMC addressed each priority need and the expected outcome for the evaluation of its efforts. The implementation plan which follows is based on the selected priority areas*:

- **Chronic Disease**
- **Mental Health**
- **Access to Healthcare and Social Services**
- **Food Insecurity**

TRMC participates and works with its Network Partners, its Patient-Family Advisory Council and many local private, non for Profit, Municipal and Governmental organizations on health issues including discussing and prioritizing needs, coordinating services, providing education and specialty knowledge, and supporting local health promotions. These community touch points provide the hospital with additional valuable external insights regarding community need.

**The focus areas do not represent the full extent of the Medical Center's community benefit activities nor its support of the community's health needs. Other needs identified through the CHNA may be better addressed by other agencies/organizations, deferred to another timeframe or have additional activities that are not reported as part of this plan. Other significant needs identified in the CHNA include Unemployment and financial insecurity, food insecurity, housing, transportation, chronic diseases (heart, diabetes, cancer), COVID-19 and access to healthcare/social services.*

Goal 1: Prevent and reduce impact of chronic disease through improvement in culturally relevant medical education, and access to healthcare.

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
1.1	Increase community partnerships with a focus on cultural organizations		Manager of Community Outreach	Multiple faith-based entities including people of Haitian, Hispanic and Portuguese cultures; Public Library, City of Elizabeth, Union County special programs
1.2	Establish methods of outreach for health information (social media, newsletters, etc.)		AVP Marketing	Outreach used to distribute health information include Face Book, Instagram and Linked In
1.3	Partner with PCP's to connect us to patients struggling with compliance and medication education (blood pressure, glucometer, insulin administration, foot checks, etc.).	• Increased compliance with medical appointments • Decrease the # of re-admissions	APP Director of Transitional Care	Transitional Care team through home visits connects PCC with patients in the community
1.4	Increase frequency of Patient/Family Advisory Group to meet at least monthly.		VP/Chief Nursing Officer	Patient/Family Advisory Group meets 2 times a year
1.5	Investigate and promote education programs focused on diet and food choices with dietitians		Director of Transitional Care, Director of Dialysis Services VP Mission Integration, Manager of Community Outreach	Transitional Care clinical, educational programs; collaboration with Public Library and churches and faith-based groups to provide on nutrition education programs & dietary management Thrive Program educates and assists ERD and Dialysis patients A comprehensive plan in progress to establish an overarching Food & Healthy Nutrition program to include collaboration with RWJBH to establish Food Farmacy, Planet Harvest provision of weekly health food to mothers with children under 5 yrs, food pantries and distribution through OP clinics and services, Common Market Food boxes annually from The System and a Green Garden on site
1.6	Investigate funding sources to support community outreach initiatives, including those that focus on men's health services.		Manager of Community Outreach	Education and screening programs in collaboration with Fatherhood Initiative Coalition, PSA and other health screenings in the municipal and county communities through Trinitas Community Outreach program

Goal 1: Prevent and reduce impact of chronic disease through improvement in culturally relevant medical education, and access to healthcare (Continued)

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
1.7	Implement quarterly health fairs in partnership with local communities with screening, education and connection to support systems.	• # of patients screened at health fairs • Decrease the # of re-admissions	Manager of Community Outreach In collaboration with Cancer Center Team, Respiratory Care Team, and Cardiac Care MDs and Nurses Attending Physicians & Medical Residents & APPs presenting on various health issues at community venues	# of Patients educated in health fairs in partnership with local communities 15,005; Major presentations by MDs on Cardiac Care, Respiratory disease, Breast and Colon cancer screened medically Presentations on Cardiac Care, Respiratory disease , Breast , Prostate and Cancer prevention with specific attention to Breast, Prostate, Colorectal and cancer prevention in general
1.8	Work with transitional care services to identify surplus medications available in the community for patients who are struggling with access.			
1.9	Promote Charity Care clinic in multiple languages to increase awareness and utilization and develop signage in multiple languages throughout the Center (English, Spanish, Creole/French).	• Decrease the # of re-admissions		Under consideration
1.10	Promote existing chronic disease support groups to patients.	• Decrease the # of re-admissions • Increased frequency of and attendance at support groups	Dir. Of Transitional Care, Dir. Of Dialysis Dir. Of Respiratory care services	Transitional care support groups for Cardiac Disease, Thrive groups - Dialysis support group program including ERD, Lung and Respiratory Disease group, and Cancer Center Breast Cancer group
1.11	Explore opportunities to promote and increase smoking cessation programs and resources.	• Decrease the # of re-admissions	Manager Of Community Outreach	County, Municipal and faith-based preventive health screening and education programs include Respiratory health

Goal 2: Work with community partners to improve equitable access to comprehensive mental health services that include prevention, crisis response, and integrated care to address the barriers experienced by those with mental health challenges.

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
2.1	Continue further development of crisis response teams, such as Arrive Together and the Peer Recovery program, to address those experiencing a mental health or substance use-related crisis and avoiding unnecessary ED admissions. (IN PROCESS TO LAUNCH)	• # crisis management cases brought to ED that are voluntary vs. involuntary • # people linked to Peer Recovery Specialists, case managers, and other specialty programs • Knowledge/competency change	Screening Center Director Director of Institute for Prevention and Recovery	Community education programs presenting MH programs including suicide and violence prevention; depression screening; establishment and strengthening of the Arrive Together program; HIV outreach program for confidential testing Peer recovery specialists provide additional support to patients in crisis and recovery
2.2	Implement LEAD program, a nationally recognized model that diverts people from criminal justice system by connecting them with case managers trained in harm reduction strategies and assisting them with root causes of low-level criminal offenses (poverty, unemployment, homelessness, MH/SU, etc.). (IN PROCESS TO LAUNCH)	• # crisis management cases brought to ED that are voluntary vs. involuntary • # people linked to Peer Recovery Specialists, case managers, and other specialty programs • Knowledge/competency change	Director of LEAD Senior Director of Behavioral Health	Implementation and oversite of the LEAD Program in collaboration with the police departments in Elizabeth and nearby municipalities. Presently expanding from Elizabeth to Plainfield & Linden and then throughout Union County
2.3	Implement annual collaborative educational opportunities on integrated care for staff to bridge the divide between the Medical campus and Behavioral Health campus. (ONGOING)	• Knowledge/competency change • # trainings/events • # participants at trainings/events	Chair of Psychiatry Chair of Medicine	Plans in process to have psych residents collaborate with Street Medicine Program
2.4	Provide education to hospital staff, community groups, police, and EMS on assessing patient needs/best places to bring those experiencing a mental health or substance use-related crisis. (ONGOING)	• # crisis management cases brought to ED that are voluntary vs. involuntary • Knowledge/competency change • # trainings/events • # participants at trainings/events	Sr. Director of Behavioral Health	Partnering with City of Elizabeth Re-Entry Program, the Elizabeth Police and Fire Departments

Goal 2: Work with community partners to improve equitable access to comprehensive mental health services that include prevention, crisis response, and integrated care to address the barriers experienced by those with mental health challenges. (continued)

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
2.5	Provide staff education on cultural competence to better understand diverse patients' needs and responses to care in our ever-changing community; clarify cultural education related to special interest groups (e.g., LBGTQ+, Haitian). (ONGOING)	• Knowledge/competency change • # trainings/events • # participants at trainings/events	Director of Education	A Haitian volunteer Program provides added assistance and support to Haitian Patients and Families BRGs (Business Related Groups for Black, Hispanic, Asian and Pacific Islanders, LGBTQIA, and Emerging Leaders) developed to enhance cultural education and involvement in planning for care and services
2.6	Identify, recruit, deploy, and retain bilingual staff (especially Spanish and Haitian) who can support clinical services for mental health diagnosis and treatment, especially in the outpatient setting. (NEW)	• # bilingual staff, retention rate for bilingual staff • Knowledge/competency change	HR Director Sr. Director of Behavioral Health	Development and implementation of new recruitment events in process
2.7	Continue supporting the inpatient and outpatient staff with best practices for safe and compassionate service delivery to the LGBTQ+ population, including staff education, IT/registration, etc. (ONGOING)	• Knowledge/competency change	BRG BRG Lead Executive Sponsor, VP Psychiatry and Behavioral Health	An LGBTQIA Board level committee was established in 2023. Activities included developing appropriate practices and policies, changing individual toilets to all gender for a more welcoming environment, and development of basic staff education programs to address LGBTQ special needs and culturally appropriate practices. Transgender Day of Visibility – education for 300 persons
2.8	Expand educational trainings and informational sessions in schools, and with primary care providers, police, other community service providers on navigating the mental health system; specific services/needs; and risk factors and wellness supports. (RE-START)	• # people linked to Peer Recovery Specialists, case managers, and other specialty programs • Knowledge/competency change • # trainings/events • # participants at trainings/events	Directors of School Based programs Peer Recovery Specialists	Education and depression screening programs provided to Police through the LEAD and ARRIVE TOGETHER programs Mandatory training for Trauma Informed Care and De-escalation Skills for all staff Education programs on suicide prevention, screening for depression and available MH services provided for school faculties and staff

Goal 2: Work with community partners to improve equitable access to comprehensive mental health services that include prevention, crisis response, and integrated care to address the barriers experienced by those with mental health challenges. (continued)

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
2.9	Participate in system-wide, trauma-informed care initiative focused on training all staff in all roles to understand and interact appropriately with consumers, colleagues, and others in the work setting who have experienced trauma.(NEW)	• Knowledge/competency change • # trainings/events • # participants at trainings/events	Hospital wide Educator Sr. Director of Behavioral Health	Trauma Informed Care Training developed and mandated for all staff. Currently in process
2.10	Continue participation in EPIC workgroups in preparation for Trinitas implementation (early identification for prevention/early intervention for mental health crises). (NEW)	• Knowledge/competency change • # trainings/events • # participants at trainings/events	AVP IT Chief Medical Officer Chief Nursing Officer	Completed Continuing to build knowledge of Epic reports, develop data base for tracking trends, needs and to develop directions

Goal 3: Provide equitable access to primary care to improve appropriate use of health care services at Trinitas.

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
3.1	Conduct education sessions in the community around primary and preventative care to improve health literacy (see food insecurity, potential cross-cutting with CD)	• Improvement in health literacy and understanding of the value of primary care	Community Outreach Manager, Director of Cancer Center	Outreach education and screening programs including Women's health (breast cancer, cervical, (in English, Spanish, Haitian Creole), Blood Drives, Colorectal Health Chat
3.2	Educate registration staff in the ED and Women's Health Clinic to support enrollment, Medicaid, Medicare Advantage Plan, and the Affordable Care Act, in partnership with health plans.	• Increased enrollment in health plans	Administrative Management Team, SNAP Navigator	In progress
3.3	Partner with RWJ UH Rahway to develop and implement an educational campaign on the benefits of primary care via local media (e.g., podcasts, cable tv, social media, etc.)	• Improvement in health literacy and understanding of the value of primary care		
3.4	Explore the feasibility of establishing a Bridge Clinic at Trinitas using the RWJ UH New Brunswick (Healthier Middlesex) model – discharged to be followed by the clinic for 30 days; clinic will find primary care for them, assists with enrollment, etc. (nurse practitioner, pharmacist, social worker)	• Improvement in health literacy and understanding of the value of primary care • Decision on feasibility of new programs	Admin. Management Team	Under consideration
3.5	Explore the feasibility of providing free community-based health assessment and guidance to facilitate appropriate care interventions (e.g., Virtual and site-based practitioners)	• Decision on feasibility of new programs	Chief Medical Officer, VP Foundation	Grant support obtained for Street Medicine clinical and educational program

Goal 3: Provide equitable access to primary care to improve appropriate use of health care services at Trinitas. (continued)

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
3.6	Provide staff education on cultural competence to improve understanding of diverse patient needs and responses to care (see mental health).	• Improvement in understanding of cultural competence	Nursing Educator and Team All Departments Dir. Of Office of People, Belonging & Impact to Patient Access, CEO & Admin.	BRGs focus: Black, Hispanic, Asian & Pacific Islands, LGBTQIA and Emerging Leaders MLK Day of Service & completion of first night kits SR. Barbara Conroy Lecture series: Leadership Development for Emerging Leaders – enhancing understanding of leadership and managing diverse needs
3.7	Conduct SDOH screenings in all clinical settings to assess basic needs (e.g., Insurance, medication, food, housing, transportation, etc.) (see mental health, food insecurity, potentially chronic disease) and reinforce access to affordable medication	• SDOH data collected to inform interventions	Chief Medical Officer, Dir. Of Quality & Infection Control	Epic data collection implementation required as element of patient intake; to be used toward program development
3.8	Partner with community organizations to conduct outreach and offer free screenings on-site (e.g., Blood pressure, blood glucose, breast exams, blood tests) and referrals for free preventative screenings in clinical settings (e.g., mammogram, lung cancer, colorectal cancer, etc.) (potential cross-cutting with chronic disease) • Mobile clinics (Nurse Practitioner, Pharmacist and Social Worker) – bringing health care out to community	• Increase in preventative screenings	Mgr. of Community Outreach Directors of Medical specialties/ departs	Extensive partnering with parishes, churches, special interest groups, City of Elizabeth, Union County and state groups for outreach screening with referrals for TX : Blood pressure & Blood Sugar, Diabetes, PSA, Stroke, Nursing Education, HIV, Sleep Study, Trauma, Good & Nutrition and Community Health, Smoking Cessation Health Fairs at Elizabeth Coalition to House the Homeless, St. John Vianney, O'Donnell Senior Center, ST. Joseph's Social Service, New Zion Baptist Church, Eliz. Public Library, Delta Sigma Theta Sorority, City of Elizabeth, Washington Community School, Josephine's Place, TWSP Scotch Plains, Plainfield BD Education, Fidelis Care, Gateway YMCA, ST. John Baptist, Jose Marti & Juan Pablo Duarte School, Mickey Walker Center, Lenny Cathart House Music Festival, Jersey Gardens, Fatherhood Initiative Coalition and various community festivals, etc.
3.9	Continue participation in EPIC workgroups in preparation for migration to EPIC system.	• SDOH data collected to inform interventions	Chief Medical Officer, IT Director at Trinitas	Completed. Work continues to develop new, dimensions for reports and data collection to further support emerging patient care, prevention needs and outreach for access

Goal 4: Enhance access, affordability, and consumption of healthy food.

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
4.1	Improve referrals, screenings, sharing resources between clinics and partner organizations (e.g., through Wellness Wednesdays at St. Josephs, shelters, and outreach for the homeless census).	• Number of partnerships with community-based organizations	Community Outreach Mgr., Directors of TRAC, TRAC Samsa Programs, Transitional Care Program	In process
4.2	Continue promoting enrollment and engagement with WIC and SNAP services, (e.g., Groundwork Elizabeth program, connections to the senior farmers market nutrition program, and by exploring the feasibility of hosting SNAP navigators and other outreach activities on site)	• Number of gift cards and other benefits to supplement food access distributed • Number of partnerships with community-based organizations • Increase in the number of screenings and referral of eligible patients to WIC and SNAP services	SNAP Navigator Community Outreach Workers Mgr. of Community Outreach VP Foundation	Ongoing promotion and expansion of 'WIC; designated SNAP Navigator at Trinitas; Groundwork Elizabeth partnering to further hospital Green Garden (Rootin For You); connecting seniors and chronically ill with food sources and nutrition through Transitional Care Program, TRAC food distribution in BH OP Clinics,
4.3	Improve patient data collection and referrals between clinics and food pantries/ other resources using the EPIC system.		AVP IT Trinitas Chief Medical Officer	In Progress
4.4	Continue participation in the EPIC workgroups in preparation for migration to EPIC system.			Completed
4.5	Seek resources and assess feasibility of replicating the food prescription program at TRMC.	• Number of gift cards and other benefits to supplement food access distributed	VP Mission Integration RWJBH SVP of Social Impact and Community Investment,	Food Farmacy funding obtained through RWJBH System to begin second quarter 2026, increase in Common Market Food Boxes to @675 in 2024-2025, Implementation of Planet Harvest 200 15# boxes of fresh food and staples weekly for women with children under 5 yrs.

Goal 4: Enhance access, affordability, and consumption of healthy food. (continued)

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
4.6	Continue providing and explore feasibility of partnering, expanding, and streamlining eligibility/distribution of Thanksgiving baskets, food drives, meals on wheels, and provision of food cards for patients in need.	• Number of gift cards and other benefits to supplement food access distributed • Number of partnerships with community-based organizations	VP of Foundation, VP of Mission Integration	Food distribution programs partnering with community-based orgs: Share My Meals with Covenant House Elizabeth, Planet Harvest, Food Farmacy, Green Garden with Behavioral Health Teen Residents and Groundwork Elizabeth. Thanksgiving baskets for 140 families in 2024 and 180 in 2025. Shop Rite Food Cards distribution
4.7	Explore the feasibility of providing, expanding, and sustaining collaborations around community education, meal planning, and summer events that utilize food grown locally, in partnership with Groundwork, local greenhouses and community gardens, the YMCA, and other partners that focus on locally grown food	• Number of partnerships with community-based organizations • Number of educational events with a focus on food provided to community members and schools • Attendance and number of participants at educational events	VPs of Foundation and Mission Integration, Manager of Community Outreach	Drives to meet special needs included: Christmas Toy Drive, A children's coat Drive, Feminine Hygiene Drive, various food drives Formal connections with Foundation donors, NP groups community based and Institutional Partners
4.8	Partner with community organizations to promote and implement culturally appropriate nutrition and cooking education classes that include a focus on affordability.	• Number of partnerships with community-based organizations • Number of educational events with a focus on food provided to community members and schools • Attendance and number of participants at educational events	APP Dir. Of Transitional Care, Mgr. Community Outreach	Transitional Care Program provides culturally appropriate nutrition education for families in need in collaboration with Churches, Public Library and NFP special interest groups
4.9	Continue and strengthen education sessions with schools to improve knowledge of healthy foods, increasing variety of fruit and vegetables consumed, and meal prep with families and students	• Number of partnerships with community-based organizations • Number of educational events with a focus on food provided to community members and schools • Attendance and number of participants at educational events	Directors of School Based Programs	Nutrition education & involvement of Elizabeth HS Students in food pantry development & provision of food to hospital food pantries; St. Vincent de Paul sandwich project (employee volunteers during work time have made @2000 sandwiches distributed through local Social Service agencies.

Goal 4: Enhance access, affordability, and consumption of healthy food. (continued)

	Strategy/Initiative	Indicator/Metric	Responsible Staff*	Tracking/Outcome
4.10	Explore the feasibility of adapting emergency department intake and screening processes to identify men presenting with food needs and establish referrals and partnerships to connect them to food services.	• Number of gift cards and other benefits to supplement food access distributed • Number of partnerships with community-based organizations	Director of Emergency Services CEO/Admin staff/VP Mission Integration	In process
4.11	Explore the feasibility of partnering with local organizations (e.g., Shelters, rehabilitation centers, Union County and Elizabeth re-entry programs, county probation programs, and local faith organizations) to help connect men with food services and help reduce unnecessary emergency department visits.	• Number of partnerships with community-based organizations	CEO, VP Mission Integration Manager of Community Outreach and Hospital Staff as appropriate Manager of Community Outreach, VP Foundation	Plans in process for establishing a Warming/Cooling Center for homeless men; Health screenings, education and supports for Elizabeth Re-entry programs; Corporate/Community Orgs – Shop Rite, Village Supermarkets, Elizabethtown Health Care Foundation, Wakefern, Elizabeth Coalition to House the Homeless, City of Elizabeth Depts, Coalition for Homeless, St Joseph's SS, Josephine's Place, Jefferson Park Min, multiple churches and faith-based orgs, Public Library, Gateway YMCA, Jersey Gardens Mall, BD of Education/Public schools, Chamber of Commerce, RE-Entry Program, Fatherhood Initiative Coalition…
4.12	Enhance partnership with the food bank and local farms in the region to expand access to local and fresh foods.	• Number of gift cards and other benefits to supplement food access distributed • Number of partnerships with community-based organizations	VP Mission Integration in Collaboration with RWJBH SVP of Social Impact & Community Investment, VP Trinitas Foundation	Collaboration with RWJBH to distribute Common Market boxes of fresh food and protein from NJ farmers to St Joseph's SS, Josephine's Place for Women, Jefferson Park Ministries (Haitian Community)
4.13	Continue partnership with the Women's Wellness Pantry to connect patients with food and services.	• Number of gift cards and other benefits to supplement food access distributed • Number of partnerships with community-based organizations	VP Mission Integration, Administrative Director of Women and Children's Health, SVP of Social Impact & Community Investment, SVP Community Health	Partnering with RWJBH and Trinitas Woman & Children's Services to provide Planet Harvest weekly food boxes for women with a child under 5 years