2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Southern Ocean Medical Center Service Area

Prepared for
Southern Ocean Medical Center

Hackensack Meridian *Health*

2024-0578-02

Prepared by
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TABLE OF CONTENTS

INTRODUCTION

PROJECT OVERVIEW

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

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

This assessment for Southern Ocean Medical Center is part of a regional project conducted by Professional Research Consultants, Inc. (PRC) for Hackensack Meridian *Health* on behalf of its network hospitals. PRC is a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey, the PRC Online Key Informant Survey, and focus groups with community members), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

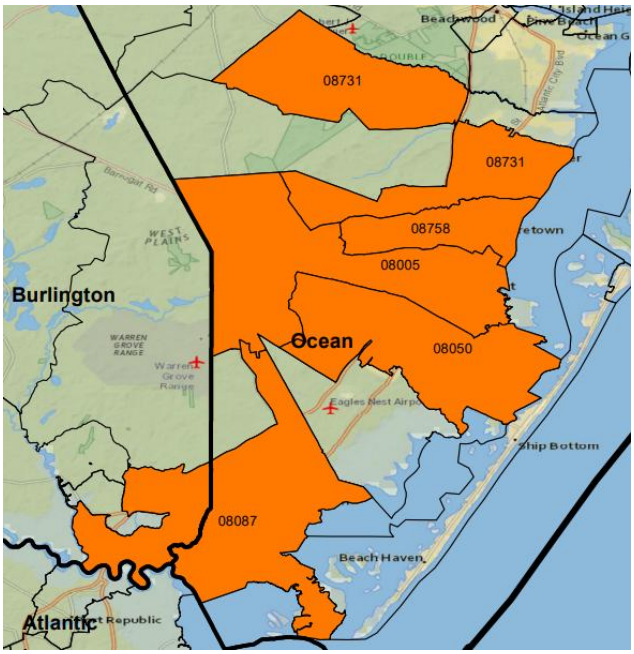
PRC Community Health Survey

Survey Instrument

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

Community Defined for This Assessment

The study area for the survey effort (referred to as "SOMC Service Area" or "SOMC" in this report) is defined as each of the residential ZIP Codes comprising the primary service area of Southern Ocean Medical Center. This community definition, determined based on the ZIP Codes of residence for 75% of recent patients, is illustrated in the adjacent map.



Sample Approach & Design

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

community outreach component promoted by the study sponsors through social media posting and other communications.

RANDOM-SAMPLE SURVEYS (PRC) ► For the targeted administration, PRC administered 286 surveys throughout the service area.

COMMUNITY OUTREACH SURVEYS (Hackensack Meridian *Health*) ► PRC also created a link to an online version of the survey, and Hackensack Meridian *Health* promoted this link locally in order to drive additional participation and bolster overall samples. This yielded an additional 32 surveys to the overall sample.

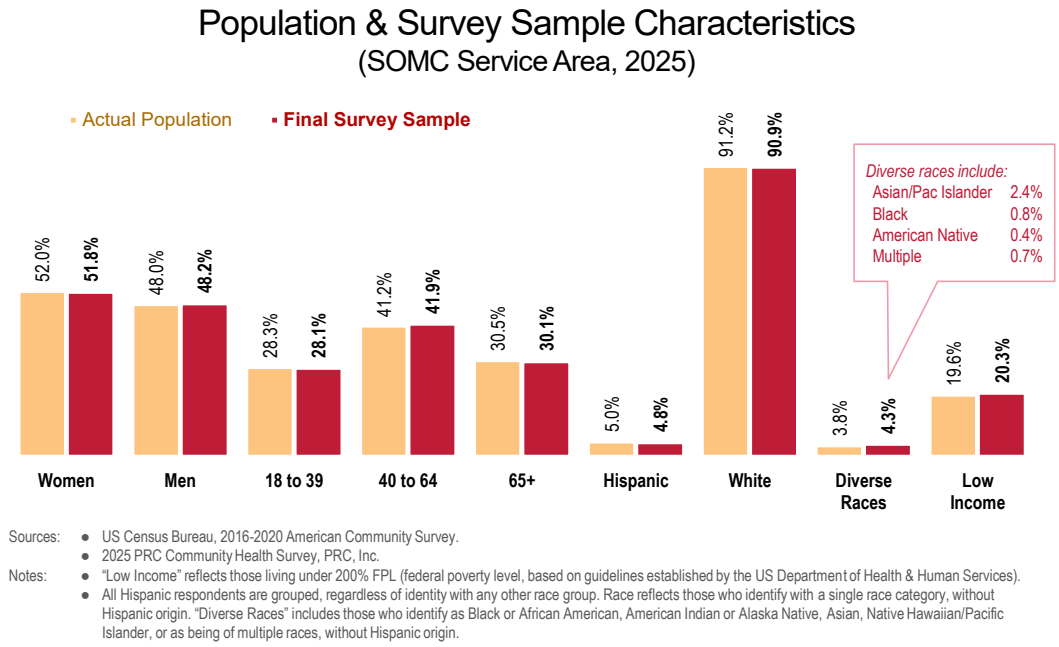
In all, 318 surveys were completed through these mechanisms. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the SOMC Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, for questions asked of all respondents, the maximum rate of error associated with a sample size of 318 respondents is ±5.7% at the 95 percent confidence level.

Sample Characteristics

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

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



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

PRC Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. Local participants were asked to provide input about communities in the South Region (which includes Ocean County); the input also included community members who work more regionally or statewide. In all, 58 community representatives in the South Region took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	1
Public Health Representatives	6
Other Health Providers	14
Social Services Providers	17
Other Community Leaders	20

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

- Asbury Park
- Camp Happiness NJ Blind Citizens Association
- Center for Health Education Medicine and Dentistry Health Center
- Central Jersey Club, National Association of Negro Business and Professional Women's Clubs, Inc.
- Circus Foodtown
- Cliffwood Elementary School
- Colts Neck Health Department
- Common Ground Grief Center
- Court Appointed Special Advocate Freehold
- Delta Sigma Theta Sorority, Inc.
- Four Seasons at Metedeconk
- Freehold Area Health Department
- Freehold Two Health Officer
- HMH George & Vita Kolber Family Health Center
- HOPE 1 Van
- Horizon Blue Cross Blue Shield of NJ
- Interfaith Health and Support Services
- Interfaith Neighbors
- Jay & Linda Grunin Foundation
- Jersey Shore University Medical Center
- Jersey Shore University Medical Center – Project Help, Empower and Lead
- Johnson Rehabilitation Institute at Ocean University Medical Center
- Little Egg Harbor Township
- Long Beach Island Health Department

- Lunch Break
- Mary's Place By the Sea
- Meals on Wheels of Ocean County
- Mercy Center – Family Resource Center
- Monmouth County Library (Manalapan)
- Monmouth County Nurses Association
- Monmouth County Office of Planning Department Infrastructure Management
- Monmouth County Sheriff's Office
- Neptune Recreation Department
- Northern Ocean Habitat for Humanity
- Ocean County Board of Social Services
- Ocean County Health Department
- Ocean County Library – Lakewood Branch
- Ocean County Library – Long Beach Island Branch
- Ocean County Office of Senior Services
- Ocean University Medical Center
- Parker Family Health Center
- Point Pleasant Beach Police Department
- Project Paul
- Red Bank Borough School District
- Red Bank Family YMCA
- Red Bank Library
- Red Bank Public Library
- Riverview Medical Center
- Senior Citizens Activities Network
- Southern Ocean Medical Center
- Southern Region RAC – NYLIFE Securities, LLC
- Special Needs Advisory Council
- United Way
- Visiting Nurse Association of Central Jersey

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

Focus Groups With Priority Populations

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

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

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

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

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

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

Public Health, Vital Statistics & Other Data

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

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data for the SOMC Service Area reflect county-level data for Ocean County in New Jersey.

Benchmark Data

Trending

Similar surveys were administered in the service area in 2019 and 2022 by PRC on behalf of Hackensack Meridian *Health*. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Regional Data

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

New Jersey Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030

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

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

Determining Significance

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

Information Gaps

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

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

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

Public Comment

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

IRS Form 990, Schedule H Compliance

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

IRS FORM 990, SCHEDULE H	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	4
Part V Section B Line 3b Demographics of the community	31
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	134
Part V Section B Line 3d How data was obtained	4
Part V Section B Line 3e The significant health needs of the community	12
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	13
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	157

SUMMARY OF FINDINGS

Significant Health Needs of the Community

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

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

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Lack of Financial Resilience ▪ Primary Care Physician Ratio ▪ Specific Source of Ongoing Medical Care ▪ Emergency Room Utilization ▪ Focus Groups: Access to care (especially limited resources and lack of services) was identified as a top concern.
CANCER	▪ Leading Cause of Death ▪ Cancer Deaths ○ Including Lung Cancer and Colorectal Cancer Deaths ▪ Cancer Incidence ○ Including Lung Cancer ▪ Cancer Prevalence
DIABETES	▪ Kidney Disease Deaths ▪ Key Informants: *Diabetes* ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Heart Disease Deaths ▪ High Blood Cholesterol Prevalence
MENTAL HEALTH	▪ Mental Health Provider Ratio ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: *Mental Health* ranked as a top concern. ▪ Focus Groups: Mental health was identified as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Children’s Physical Activity ▪ Access to Recreation/Fitness Facilities ▪ Overweight & Obesity [Adults & Children] ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
RESPIRATORY DISEASE	▪ Pneumonia/Influenza Deaths
SUBSTANCE USE	▪ Alcohol-Induced Deaths ▪ Seeking Help for Alcohol/Drug Issues
TOBACCO USE	▪ Use of Vaping Products

Community Feedback on Prioritization of Health Needs

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

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

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

Further, the **social determinants of health** are an important lens through which to understand and address all of these issues.

Hospital Implementation Strategy

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

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

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

Reading the Summary Tables

In the following tables, SOMC Service Area results are shown in the larger, gray column.

The columns to the right of the SOMC Service Area column provide trending, as well as comparisons between service area data and any available regional (HMH network), state, and national findings, or Healthy People 2030 objectives. Symbols indicate whether the SOMC Service Area compares favorably (), unfavorably (), or comparably () to these external data.

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

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

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2019 (or earliest available data). Note that survey data reflect the ZIP Code-defined SOMC Service Area.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade). Local secondary data reflect county-level data for Ocean County.

SOCIAL DETERMINANTS	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	1.5	6.1	6.3	3.9		
Population in Poverty (Percent)	10.4	9.7	9.8	12.4	8.0	
Children in Poverty (Percent)	16.4	13.2	13.3	16.3	8.0	
No High School Diploma (Age 25+, Percent)	6.7	9.1	9.3	10.6		
Unemployment Rate (Age 16+, Percent)	4.0	4.1	4.2	3.9		9.5
% Unable to Pay for a $400 Emergency Expense	26.1	27.5		34.0		11.8
% Worry/Stress Over Rent/Mortgage in Past Year	34.8	44.9		45.8		36.3
% Unhealthy/Unsafe Housing Conditions	9.7	19.3		16.4		7.4
Population With Low Food Access (Percent)	43.6	24.9	23.8	22.2		
% Food Insecure	28.9	35.1		43.3		21.8
			better	similar	worse	

OVERALL HEALTH	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	**14.2**	12.7	17.0	15.7		14.9

better similar worse

ACCESS TO HEALTH CARE	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**4.9**	4.3	11.4	8.1	7.6	6.1
% Difficulty Accessing Health Care in Past Year (Composite)	**47.1**	55.4		52.5		45.8
% Cost Prevented Physician Visit in Past Year	**14.4**	19.5	10.8	21.6		11.3
% Cost Prevented Getting Prescription in Past Year	**11.7**	18.4		20.2		18.0
% Difficulty Getting Appointment in Past Year	**29.5**	37.1		33.4		24.7
% Inconvenient Hrs Prevented Dr Visit in Past Year	**18.0**	26.9		22.9		19.5
% Difficulty Finding Physician in Past Year	**20.8**	25.7		22.0		19.4
% Transportation Hindered Dr Visit in Past Year	**10.4**	17.3		18.3		11.5

ACCESS TO HEALTH CARE (continued)	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% Language/Culture Prevented Care in Past Year	1.7	6.1		5.0		0.7
% Written Health Info is "Seldom/Never" Easy to Understand	8.6	8.1		10.0		13.4
% Spoken Health Info is "Seldom/Never" Easy to Understand	6.3	5.4		7.5		6.5
% Stretched Prescription to Save Cost in Past Year	9.2	18.5		19.4		8.3
% Difficulty Getting Child's Health Care in Past Year	6.8	15.8		11.1		4.6
Primary Care Doctors per 100,000	72.0	108.7	105.8	116.6		
% Have a Specific Source of Ongoing Care	67.4	65.3		69.9	84.0	79.1
% Routine Checkup in Past Year	75.0	76.9	79.2	65.3		74.9
% [Child 0-17] Routine Checkup in Past Year	86.2	80.8		77.5		89.9
% Two or More ER Visits in Past Year	21.7	18.1		15.6		16.0
% Rate Local Health Care "Fair/Poor"	8.7	9.6		11.5		9.6
			better	similar	worse	

CANCER	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000	**235.8**	161.7	166.1	182.5	122.7	270.4
Lung Cancer Deaths per 100,000	**54.9**	31.8	32.8	39.8	25.1	
Female Breast Cancer Deaths per 100,000	**29.5**	25.2	25.7	25.1	15.3	
Prostate Cancer Deaths per 100,000	**20.1**	16.6	17.0	20.1	16.9	
Colorectal Cancer Deaths per 100,000	**20.9**	14.5	15.0	16.3	8.9	
Cancer Incidence per 100,000	**532.8**	481.3	481.9	442.3		
Lung Cancer Incidence per 100,000	**69.8**	50.5	51.3	54.0		
Female Breast Cancer Incidence per 100,000	**135.2**	136.2	137.1	127.0		
Prostate Cancer Incidence per 100,000	**127.7**	143.9	143.3	110.5		
Colorectal Cancer Incidence per 100,000	**41.7**	38.4	38.7	36.5		
% Cancer	**14.4**	11.0	9.5	7.4		12.2

CANCER (continued)	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% [Women 50-74] Breast Cancer Screening	**73.6**	78.9		64.0	80.5	79.1
% [Women 21-65] Cervical Cancer Screening	**73.5**	82.4		75.4	84.3	64.6
% [Age 45-75] Colorectal Cancer Screening	**73.7**	72.9		71.5	74.4	76.4
% [Men 40+] PSA Test in Past 2 Years	**65.9**	59.3				61.3
% [Age 55-80 w/Smoking History] Low-Dose CT Scan in Past Year	**27.1**	26.4				

			better	similar	worse	

DIABETES	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000	**25.9**	21.2	22.2	30.5		23.6
% Diabetes/High Blood Sugar	**12.0**	14.9	10.5	12.8		14.0
% Borderline/Pre-Diabetes	**15.7**	19.7		15.0		10.9

DIABETES (continued)	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Kidney Disease Deaths per 100,000	28.3	18.2	18.4	16.9		30.9

better similar worse

DISABLING CONDITIONS	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	43.6	37.8		38.0		56.3
% Activity Limitations	30.8	24.9		27.5		35.5
% High-Impact Chronic Pain	21.5	18.2		19.6	6.4	23.3
Alzheimer's Disease Deaths per 100,000	34.5	22.5	25.3	35.8		45.2
% Caregiver to a Friend/Family Member	25.5	25.7		22.8		20.7

better similar worse

HEART DISEASE & STROKE	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000	335.5	195.3	199.8	209.5	127.4	367.1
% Heart Disease	10.0	13.7	5.0	10.3		7.5
Stroke Deaths per 100,000	51.6	38.5	39.6	49.3	33.4	50.6
% Stroke	2.1	6.6	2.4	5.4		3.2
% High Blood Pressure	44.3	43.2	33.4	40.4	42.6	47.2
% High Cholesterol	42.4	42.3		32.4		43.1
% 1+ Cardiovascular Risk Factor	89.3	87.9		87.8		86.9

better similar worse

INFANT HEALTH & FAMILY PLANNING	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
No Prenatal Care in First Trimester (Percent of Births)	22.8	24.4	23.5	22.3		22.4
Teen Births per 1,000 Females 15-19	6.4	8.8	9.0	15.5		

INFANT HEALTH & FAMILY PLANNING (continued)	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Low Birthweight (Percent of Births)	5.8	7.7	7.8	8.4		
Infant Deaths per 1,000 Births	3.6	4.0	4.0	5.5	5.0	3.3
			better	similar	worse	

INJURY & VIOLENCE	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000	57.9	51.6	53.8	67.8	43.2	52.9
Motor Vehicle Crash Deaths per 100,000	8.0	6.9	7.3	13.3	10.1	
[65+] Fall-Related Deaths per 100,000	33.8	29.9	32.5	64.0	63.4	
% [Age 45+] Fell in the Past Year	26.8	32.3				23.4
Homicide Deaths per 100,000	1.1	3.8	3.9	7.6	5.5	1.3
% Victim of Violent Crime in Past 5 Years	2.7	6.8		7.0		2.6
% Victim of Intimate Partner Violence	11.8	17.3		20.3		16.9
			better	similar	worse	

MENTAL HEALTH	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	**18.0**	19.1		24.4		17.9
% Diagnosed Depression	**22.9**	25.1	13.9	30.8		25.1
% Symptoms of Chronic Depression	**31.9**	41.6		46.7		27.4
% Typical Day Is "Extremely/Very" Stressful	**16.7**	22.1		21.1		16.8
Suicide Deaths per 100,000	**9.1**	7.7	7.8	14.7	12.8	9.8
Mental Health Providers per 100,000	**256.9**	302.1	294.8	319.4		
% Receiving Mental Health Treatment	**19.1**	21.4		21.9		18.0
% Unable to Get Mental Health Services in Past Year	**8.9**	12.9		13.2		4.1
			better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	**20.1**	20.3		30.0		21.3
% No Leisure-Time Physical Activity	**23.8**	25.1	24.2	30.2	21.8	25.3
% Meet Physical Activity Guidelines	**29.6**	35.1	31.3	30.3	29.7	26.4
% [Child 2-17] Physically Active 1+ Hours per Day	**24.2**	30.0		27.4		50.5
Recreation/Fitness Facilities per 100,000	**9.7**	15.9	15.8	12.3		
% Overweight (BMI 25+)	**69.9**	60.4	64.8	63.3		74.2
% Obese (BMI 30+)	**33.7**	26.9	28.9	33.9	36.0	33.9
% [Child 5-17] Overweight (85th Percentile)	**44.2**	37.3		31.8		28.9
% [Child 5-17] Obese (95th Percentile)	**40.6**	26.1		19.5	15.5	14.7
			better	similar	worse	

ORAL HEALTH	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% Have Dental Insurance	78.2	81.3		72.7	75.0	76.5
% Dental Visit in Past Year	66.2	66.0	68.3	56.5	45.0	70.6
% [Child 2-17] Dental Visit in Past Year	78.9	75.0		77.8	45.0	78.1
			better	similar	worse	

RESPIRATORY DISEASE	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS				
		vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000	47.4	26.7	27.7	43.5		59.2
Pneumonia/Influenza Deaths per 100,000	16.3	11.9	12.4	13.4		17.7
% Asthma	17.9	18.4	8.6	17.9		22.1
% [Child 0-17] Asthma	5.6	14.1		16.7		6.3
% COPD (Lung Disease)	8.3	11.7	4.4	11.0		10.1
			better	similar	worse	

SEXUAL HEALTH	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	**159.7**	475.6	449.7	386.6		
Chlamydia Incidence per 100,000	**174.0**	385.4	384.1	492.2		
Gonorrhea Incidence per 100,000	**23.7**	112.4	109.1	179.0		

better similar worse

SUBSTANCE USE	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000	**8.8**	8.1	8.5	15.7		6.0
% Excessive Drinking	**23.0**	26.8	15.7	34.3		25.6
Unintentional Drug-Induced Deaths per 100,000	**30.1**	29.8	30.8	29.7		27.4
% Used an Illicit Drug in Past Month	**3.0**	6.7		8.4		3.8
% Used a Prescription Opioid in Past Year	**12.3**	12.7		15.1		19.7
% Ever Sought Help for Alcohol or Drug Problem	**5.1**	10.1		6.8		10.4

SUBSTANCE USE (continued)	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% Personally Impacted by Substance Use	**39.6**	45.0		45.4		35.1

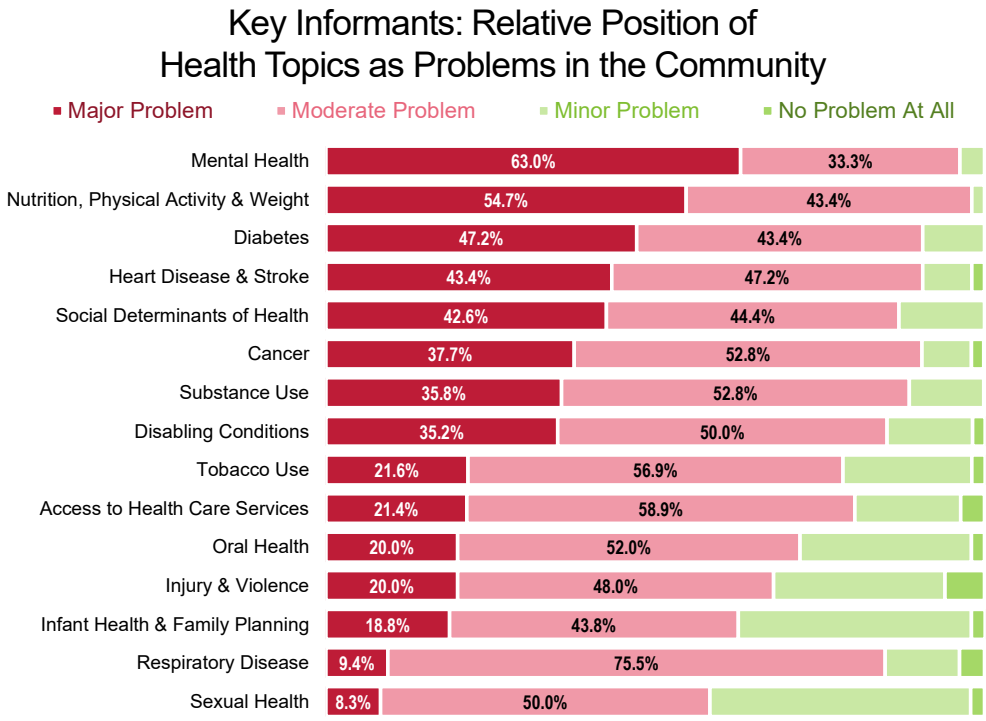
better similar worse

TOBACCO USE	SOMC Service Area	SOMC SERVICE AREA vs. BENCHMARKS vs. HMH	vs. NJ	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	**17.6**	22.8	9.1	23.9	6.1	19.1
% Someone Smokes at Home	**18.0**	23.0		17.7		17.2
% Use Vaping Products	**17.9**	19.9	6.3	18.5		5.2

better similar worse

Summary of Key Informant Input

In the Online Key Informant Survey, community representatives were asked to rate the degree to which each of 15 health issues is a problem in their own community, using a scale of "major problem," "moderate problem," "minor problem," or "no problem at all." The following chart summarizes their responses; these findings are also outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)



Summary of Community Member Focus Group Input

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

Biggest Community Health Needs:

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

Health Care Access Barriers:

- Deteriorating health outcomes (poor health outcomes, chronic conditions, mortality, worsening health conditions)
- Avoidance or delay of necessary health care (due to negative experiences and discrimination)
- Mental health deterioration (mental health strain - depression, anxiety, stress)

- Financial strain on families and individuals: financial instability due to health care costs
- Reduced quality of life

Sub-Populations with Health Care Access Barriers:

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

DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population-based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey and focus groups with priority populations.

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

COMMUNITY CHARACTERISTICS

Population Characteristics

Land Area, Population Size & Density

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

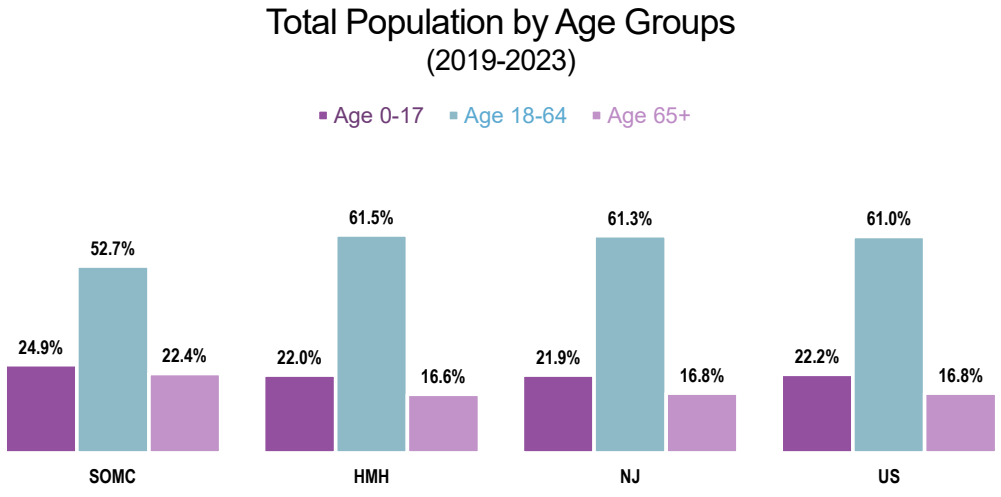
Total Population
(Estimated Population, 2019-2023)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
SOMC	646,434	628.29	1,029
HMH Network	6,901,676	4,991.66	1,383
NJ	9,267,014	7,354.93	1,260
US	332,387,540	3,533,298.58	94

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

Age

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



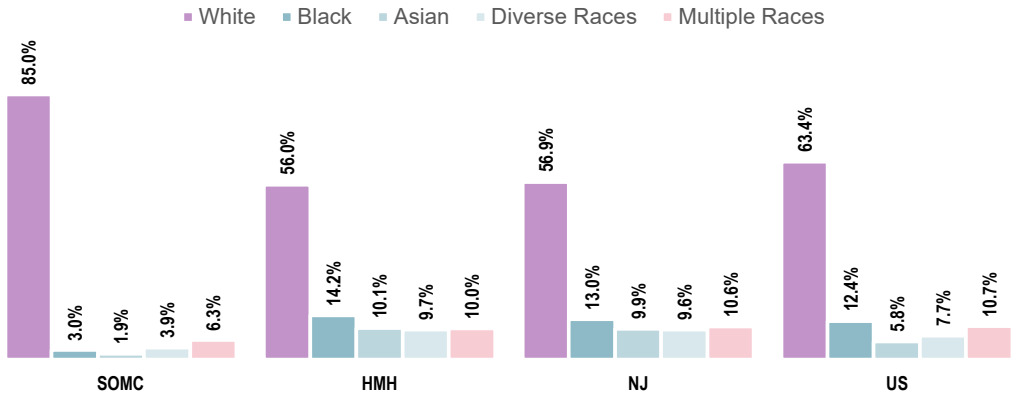
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Race & Ethnicity

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

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

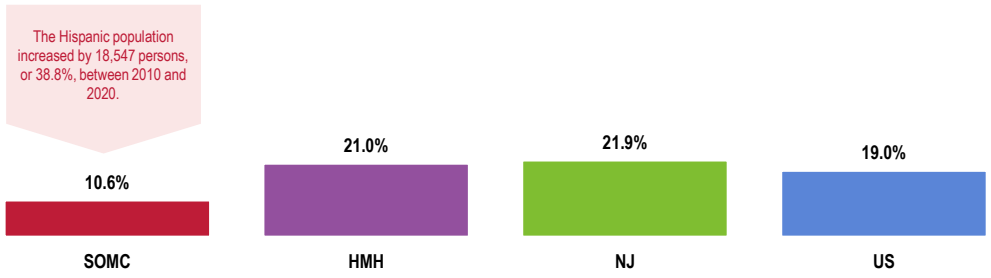
Total Population by Race Alone
(2019-2023)



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

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

Hispanic Population
(2019-2023)



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

Notes:
- People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

ABOUT SOCIAL DETERMINANTS OF HEALTH

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

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

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

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

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

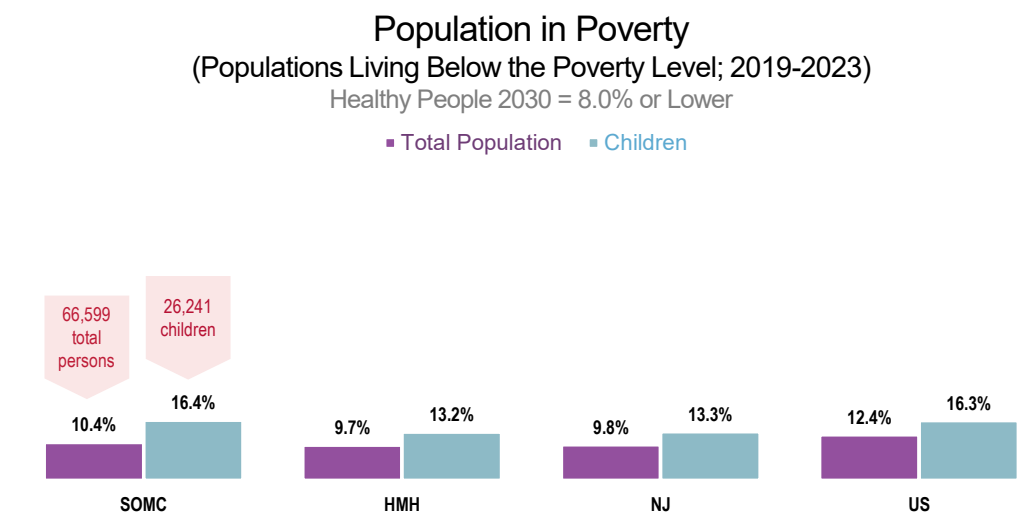
– Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

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

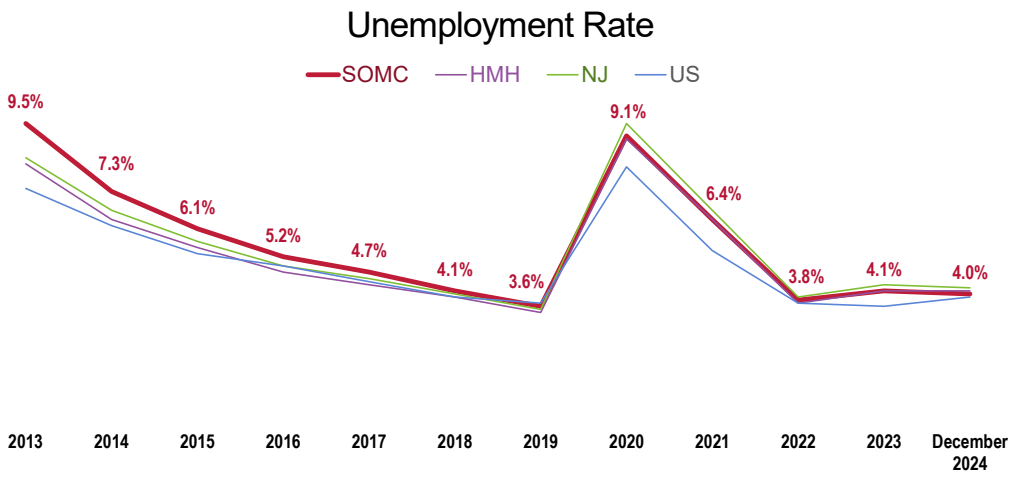
The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]



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

Employment

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



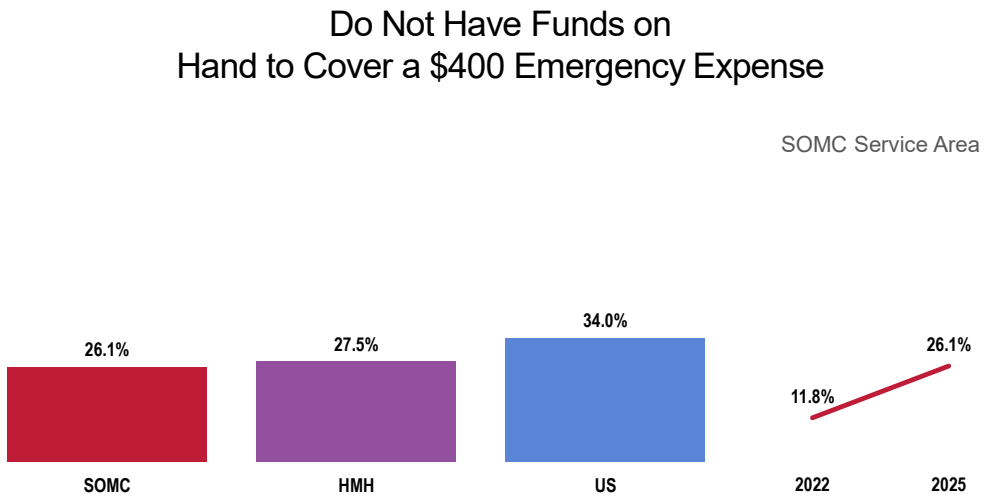
Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

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

Financial Resilience

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

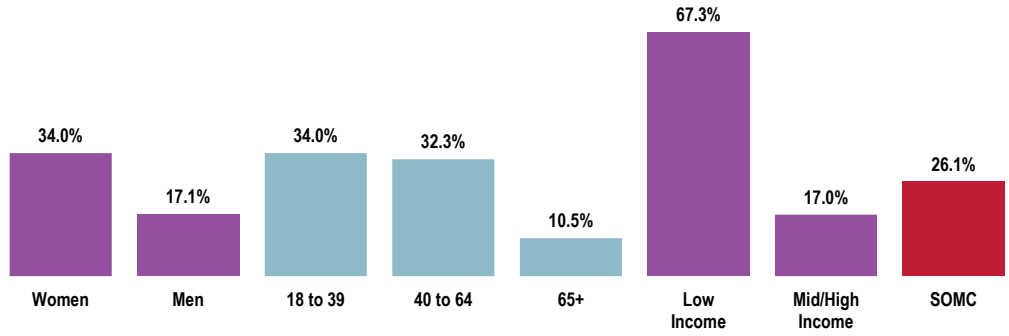
The following details "no" responses in the SOMC Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, and income [based on poverty status]).



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

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

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



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

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

INCOME & RACE/ETHNICITY

INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2024 guidelines place the poverty threshold for a family of four at $30,700 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► While the survey data are representative of the full racial and ethnic makeup of the population, samples were not of sufficient size for independent analysis by race and/or ethnicity.

Education

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

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

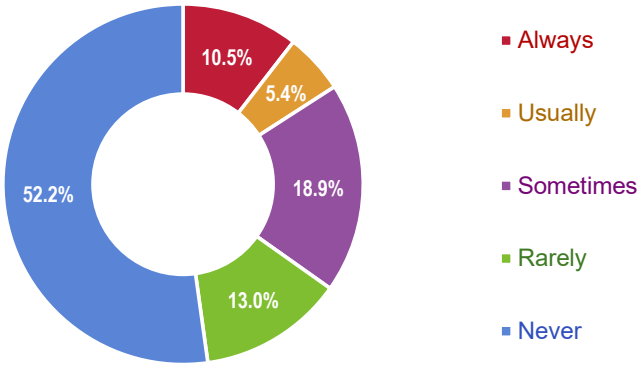
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Housing

Housing Insecurity

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

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

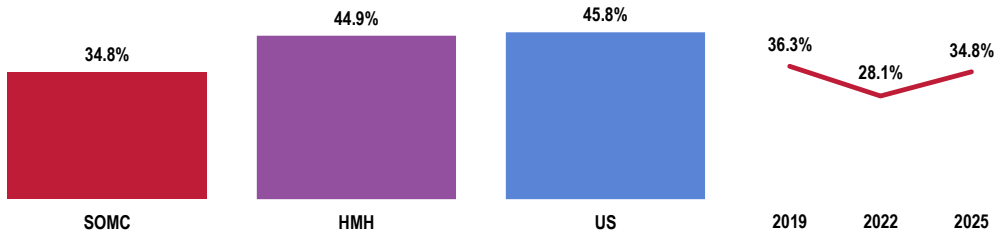


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 56]

Notes:
- Asked of all respondents.

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

SOMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 56]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Unhealthy or Unsafe Housing

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

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

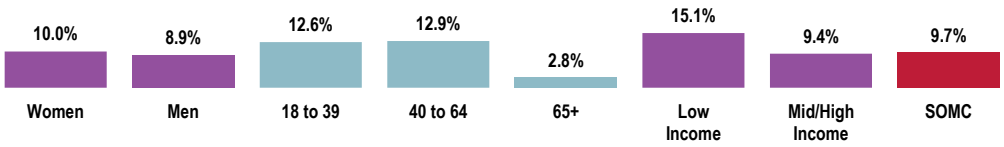
SOMC Service Area

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

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

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

Among homeowners	5.9%
Among renters	23.0%



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

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

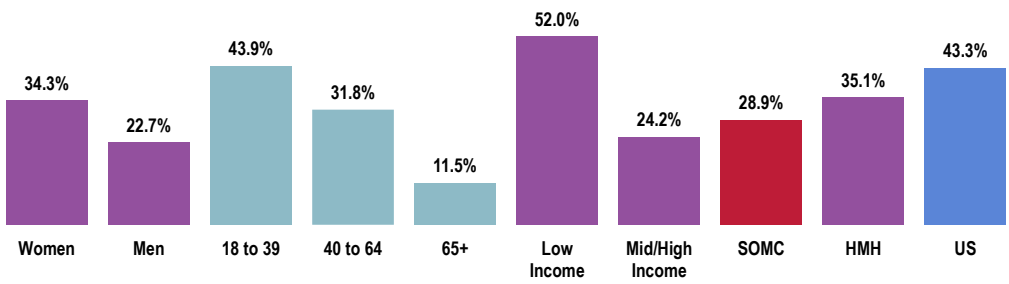
Food Insecurity

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

- 'I worried about whether our food would run out before we got money to buy more.'
- 'The food that we bought just did not last, and we did not have money to get more.'"

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

Food Insecure
(SOMC Service Area, 2025)



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

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

Health Literacy

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

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

SOMC Service Area

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

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

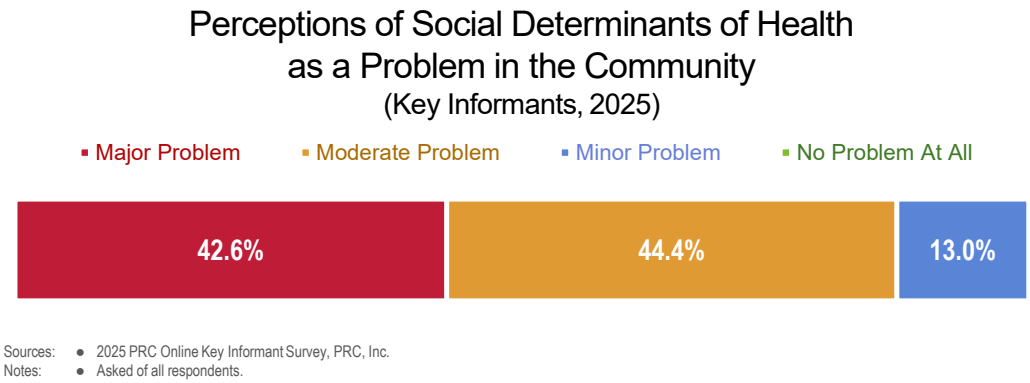
Spoken Health Info is "Seldom/Never" Easy to Understand

SOMC Service Area

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

Key Informant Input: Social Determinants of Health

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



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

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

Housing

I think there is a housing crisis in Ocean County. There is limited affordable housing. Rents are extremely high, and often income is low to moderate. – Social Services Provider

Very expensive to live in NJ. Poor future planning. – Social Services Provider

Acceptable housing is impossible to find. – Health Care Provider

Overall lack of affordable housing and rent/mortgage assistance. Significant number of ALICE households struggling to make ends meet. – Social Services Provider

Housing prices have escalated. – Health Care Provider

Affordable housing is a major detriment, and if your housing isn't stable, everything else is precarious. – Community Leader

All of these social determinants are interconnected and significantly impact an individual's health. A lack of affordable housing, overcrowded living conditions, and neglectful landlords contribute to unhealthy environments. Additionally, the level of education and marketable skills often dictate one's income. Furthermore, a person's surroundings – be it their home, community, or workplace – affect their stress levels and health. Experiences of discrimination create barriers to accessing safe communities, affordable housing, quality education, and job opportunities and increase victimization. – Social Services Provider

Housing is an issue, and affordable housing. We are seeing many more homeless elderly individuals and families. The fact the county does not have assistance for the homeless. More shelters for individuals is awful. And the lack of help one received from social services is apparent and reported by many residents. – Health Care Provider

Lack of affordable housing is probably the worst SDOH in Monmouth County. How can we all stay healthy when we can't afford to live here? – Community Leader

Increasing presence of unhoused population. Language and cultural barriers, socioeconomic factors within limited resource population. – Community Leader

Housing, transportation, income, and access to fresh fruits and vegetables are major problems in our community. These have been cited in Monmouth County's CHIP, as well as at RWJ's needs assessment. We see this throughout our entire patient population. The warming centers throughout the county are at capacity. The pantries and Fulfill and Lunch Break's numbers are increasing every year. – Health Care Provider

Income/Poverty

Low incomes, little support for public schools, youth having babies too young to go out on their own to explore career fields. – Community Leader

Ocean County is over 40% ALICE (Asset Limited, Income Constrained, Employed). Growing undocumented community unsupported. – Social Services Provider

Economics, lack of public awareness until there is a crisis, low-income communities. – Community Leader

Economic stability, access to health care, education, housing and built environment, social and community context. – Social Services Provider

Impact on Quality of Life

> The have-nots continue to struggle to live the American dream. – Social Services Provider
>
> Parents work long hours, fear of going outside, children babysitting children, food as reward, high rent, poor living conditions, at the mercy of the landlords. – Community Leader

Vulnerable Populations

> Right now, we are on tough times. People are afraid they will be deported. People would rather stay sick and go to work than go to the doctor so they can pay their rent. – Social Services Provider

Aging Population

> Social determinants of health are becoming a major problem for the senior population we serve because they are struggling to meet their basic needs in their retirement years. The average Social Security check is insufficient to meet the basic monthly needs of our seniors for food, housing, health care, and transportation. Given the fact that their fixed incomes have not kept pace with the actual cost of living, many seniors are facing housing instability, struggling to pay their utility bills, and experiencing food insecurity. Missing meals, rationing medication, experiencing utility shut-offs, and lack of transportation to/from medical offices causes stress for older adults and is impacting their overall health and well-being. – Social Services Provider

Access to Care/Services

> Lack of available services due to demand and limited resources. – Social Services Provider

Awareness/Education

> Lack of health education, lack of nutrition education. – Social Services Provider

Focus Group Input: Social Determinants of Health

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

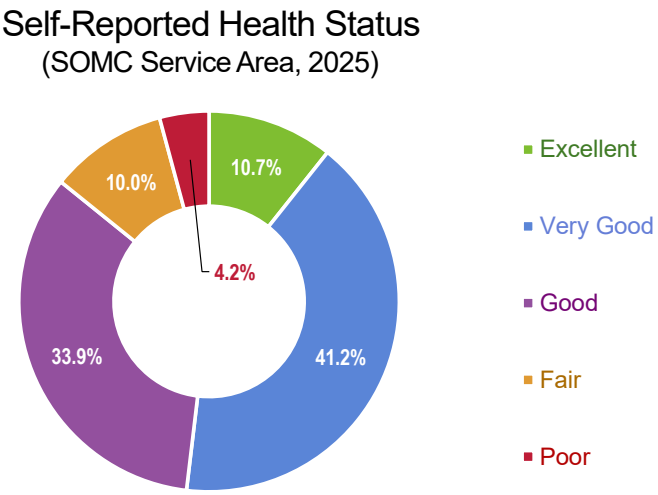
Maternal & Infant Health Focus Groups:

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

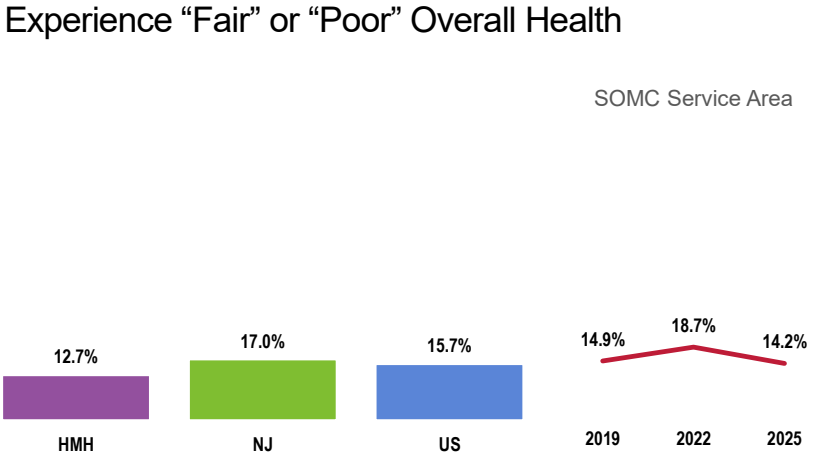
HEALTH STATUS

Overall Health

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

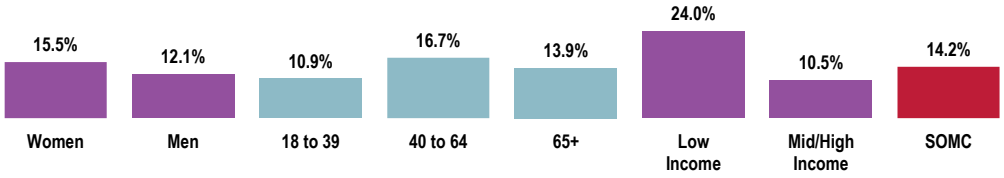


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.



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

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



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

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

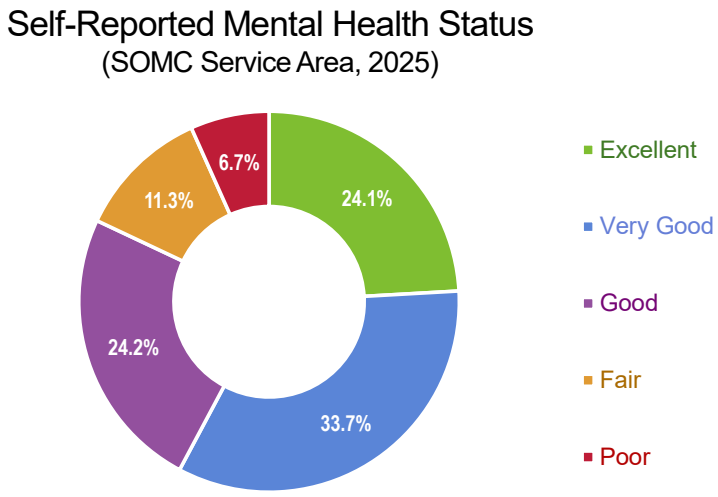
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

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

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

Mental Health Status

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



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

Experience “Fair” or “Poor” Mental Health

SOMC Service Area

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

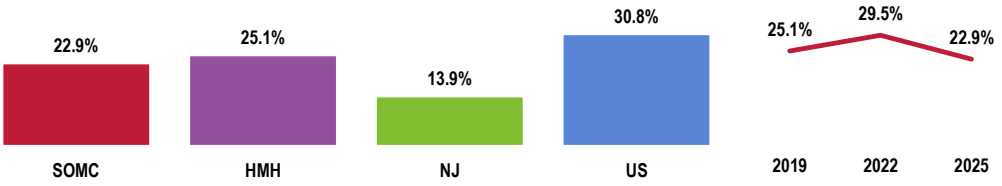
Depression

Diagnosed Depression

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

Have Been Diagnosed With a Depressive Disorder

SOMC Service Area



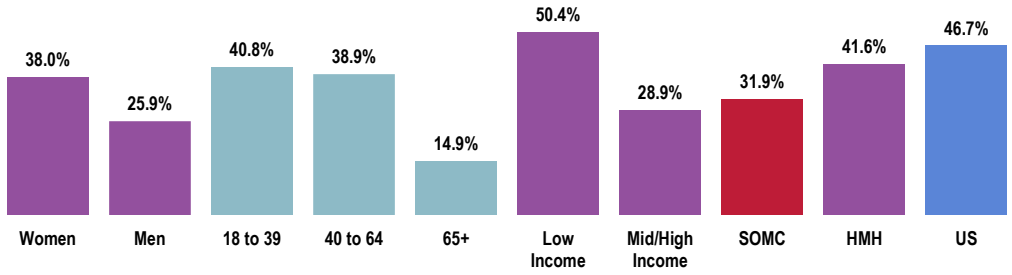
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Symptoms of Chronic Depression

PRC SURVEY ► "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"

Have Experienced Symptoms of Chronic Depression
(SOMC Service Area, 2025)



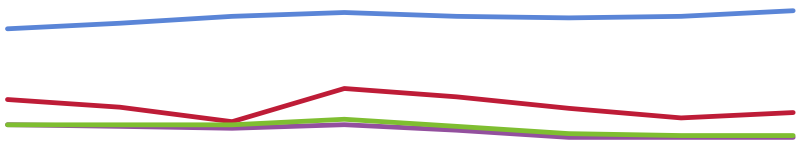
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Suicide

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

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



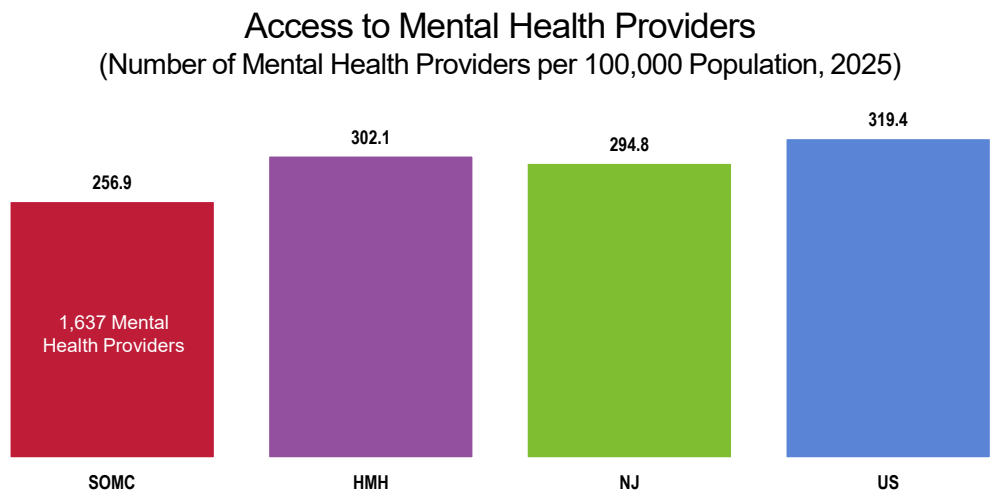
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	9.8	9.4	8.6	10.4	9.9	9.3	8.8	9.1
HMH	8.4	8.3	8.2	8.4	8.1	7.7	7.7	7.7
NJ	8.4	8.4	8.4	8.7	8.3	7.9	7.8	7.8
US	13.7	14.0	14.4	14.6	14.4	14.3	14.4	14.7

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

Mental Health Treatment

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

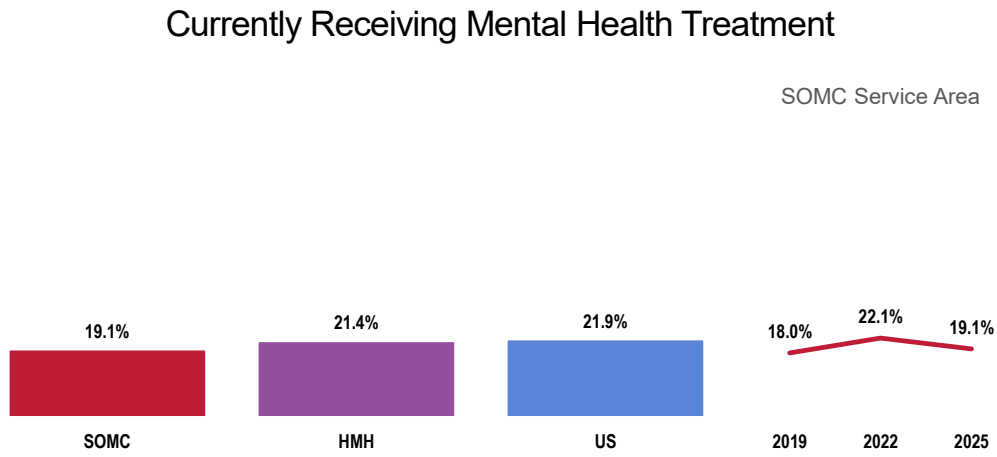
The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care) per 100,000 residents. [COUNTY-LEVEL DATA]



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

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

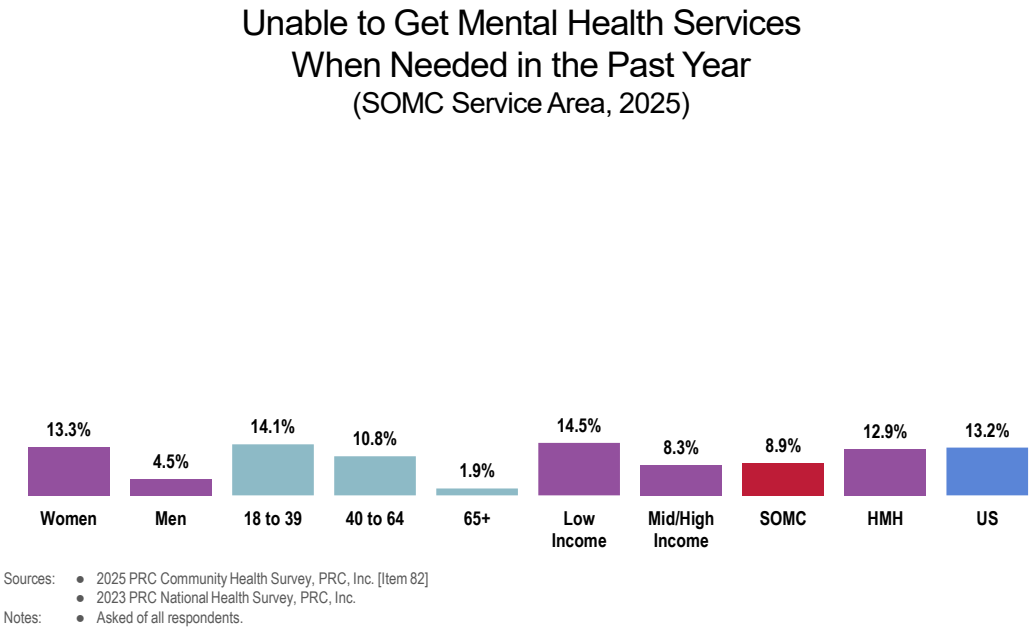
PRC SURVEY ► "Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

PRC SURVEY ► "Was there a time in the past 12 months when you needed mental health services but were not able to get them?"



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

Key Informant Input: Mental Health

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

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

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

Access to Care/Services

> Access to services and the stigma that is attached to those suffering from mental health issues. – Social Services Provider
>
> Lack of mental health resources. – Health Care Provider
>
> Access to resources and stigma. – Health Care Provider
>
> Access to services. Although services are available, there is a gap in accessibility. Stigma, financial restraints, and integrated care between mental health and other health care services. – Social Services Provider
>
> No availability of counseling outside of school. – Community Leader
>
> Wait time to see a doctor and psychiatrist, especially if on Medicaid or no private insurance. – Social Services Provider
>
> Getting the resources they need. Many require insurance or appointments are hard to get. – Health Care Provider

> Access to clinicians who accept insurance, and if they do accept their insurance, the copays are too expensive. Time is also a factor. Many families cannot fit in with the ongoing visits. – Community Leader
>
> Lack of resources for all age groups. Location of resources, as the lower portion of Ocean County doesn't have any. Closest location is Tom's River. – Social Services Provider
>
> Access. – Public Health Representative
>
> Having access to qualified professionals and removing the stigma of having a mental health issue. – Public Health Representative
>
> Counseling and how to find it and deciding to actually go. – Public Health Representative
>
> Access to care, finding therapists who are culturally literate and can offer therapy in the patient's primary language. – Health Care Provider

Incidence/Prevalence

> Mental health is a huge concern, especially coming out of COVID. There are so many pressures on us as individuals between work, school, family, and life. Special focus should be on youth and teaching of coping and stress management skills. – Public Health Representative
>
> Depression, anxiety, etc. – Social Services Provider
>
> Mental health is a huge issue in the area. particularly for higher-level care. We need IOPs and psychiatry that has accessibility of appointments and accepts Medicaid. – Health Care Provider
>
> Impacts large number of the population, all ages, geography, etc. Need for greater access, especially in Ocean County. – Social Services Provider

Awareness/Education

> We are never told that diet, physical activity, loneliness, and spirituality are all tied to mental health. We are given pharmaceuticals and talk therapy, which play an important role, but we are never getting to the root cause of our mental health epidemic. – Community Leader
>
> They often don't realize they have a problem. Also, they don't get the support they need from family to seek help. – Community Leader

Denial/Stigma

> Removing the stigma and creating a parallel to physical health. – Social Services Provider

Diagnosis/Treatment

> There are a lot of people who suffer from mental health issues who do not get the help they need. – Social Services Provider

Housing

> Housing and access to mental health care and helping the severely mentally ill. – Health Care Provider

Aging Population

> Most senior citizens with mental health issues frequently think that they do not need to seek treatment. Additionally, suicide, depression, and anxiety have increased in Ocean County over the past five years across all age groups, which usually stems from mental health. – Community Leader

Social Media

> Social media, stigma, access to health care, finances, and qualified therapists. – Social Services Provider

Follow-Up/Support

> Getting help/support. – Community Leader

Isolation

> Social isolation, depression, and access to support. – Community Leader

Focus Group Input: Mental Health

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Lack of mental health services and providers*
- *Stigma around mental health (especially among men)*

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

Maternal & Infant Health Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

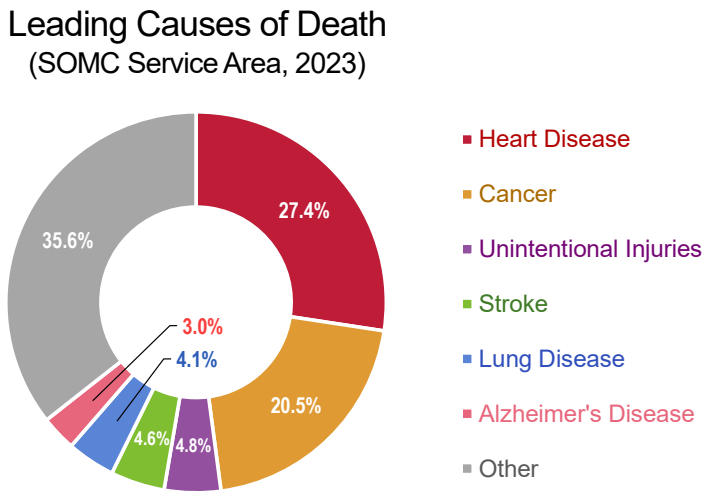
> "Depression, despair, and living with anger directly affects our health, mental health, and is reflected in our economic, family, and social well-being." – Latinx Women Focus Group
>
> "Mental health matters: It's not just about physical health. Many moms struggle with feelings like depression or anxiety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

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

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



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

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

Death Rates for Selected Causes

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

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

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

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

	SOMC	HMH	NJ	US	HP2030
Diseases of the Heart	335.5	195.3	199.8	209.5	127.4*
Malignant Neoplasms (Cancers)	235.8	161.7	166.1	182.5	122.7
Unintentional Injuries	57.9	51.6	53.8	67.8	43.2
Cerebrovascular Disease (Stroke)	51.6	38.5	39.6	49.3	33.4
Chronic Lower Respiratory Disease (CLRD)	47.4	26.7	27.7	43.5	—
Alzheimer's Disease	34.5	22.5	25.3	35.8	—
Falls [Age 65+], 2018-2020	33.8	29.9	32.5	64.0	63.4
Unintentional Drug-Induced Deaths	30.1	29.8	30.8	29.7	—
Kidney Disease	28.3	18.2	18.4	16.9	—
Diabetes	25.9	21.2	22.2	30.5	—
Pneumonia/Influenza	16.3	11.9	12.4	13.4	—
Intentional Self-Harm (Suicide)	9.1	7.7	7.8	14.7	12.8
Alcohol-Induced Deaths	8.8	8.1	8.5	15.7	—
Motor Vehicle Deaths	8.0	6.9	7.3	13.3	10.1
Homicide/Legal Intervention	1.1	3.8	3.9	7.6	5.5

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

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

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

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

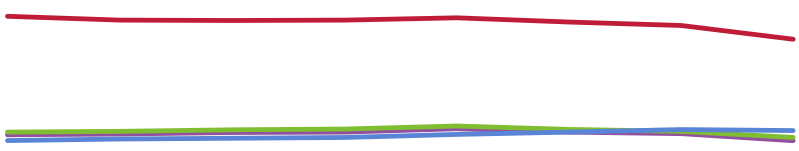
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they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

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

Heart Disease & Stroke Deaths

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

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	367.1	362.0	361.2	361.7	365.3	359.1	354.2	335.5
HMH	203.5	204.5	206.4	207.1	211.8	207.2	204.9	195.3
NJ	207.0	208.4	210.3	211.2	215.6	210.9	208.0	199.8
US	195.5	197.5	198.6	200.0	204.2	207.3	210.7	209.5

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

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

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	50.6	51.1	51.4	52.6	51.4	50.7	51.3	51.6
HMH	37.7	37.5	37.9	38.7	40.3	40.7	40.2	38.5
NJ	38.1	38.2	38.4	39.1	40.2	40.8	40.6	39.6
US	43.1	44.2	44.7	45.3	46.5	47.8	49.1	49.3

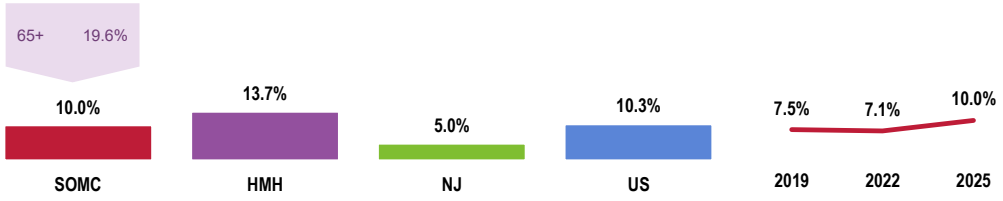
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Prevalence of Heart Disease & Stroke

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

Prevalence of Heart Disease

SOMC Service Area



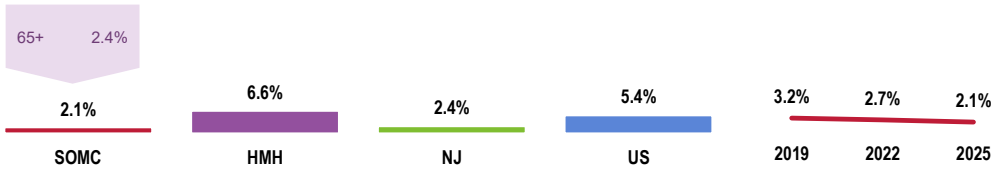
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey,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

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

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

Prevalence of Stroke

SOMC Service Area



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

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

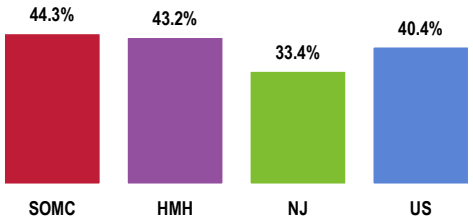
Blood Pressure & Cholesterol

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

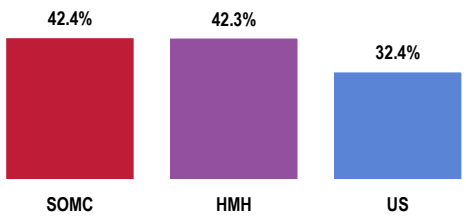
PRC SURVEY ► "Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower



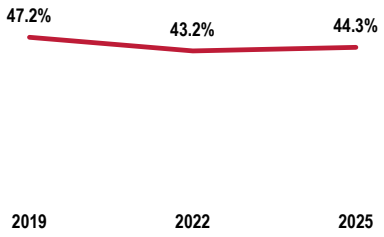
Prevalence of High Blood Cholesterol



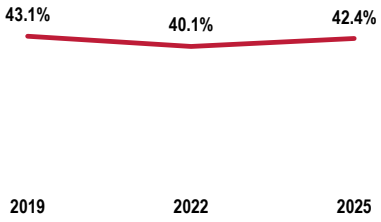
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey,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

Notes:
- Asked of all respondents.

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



Prevalence of
High Blood Cholesterol
(SOMC Service Area)



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

Total Cardiovascular Risk

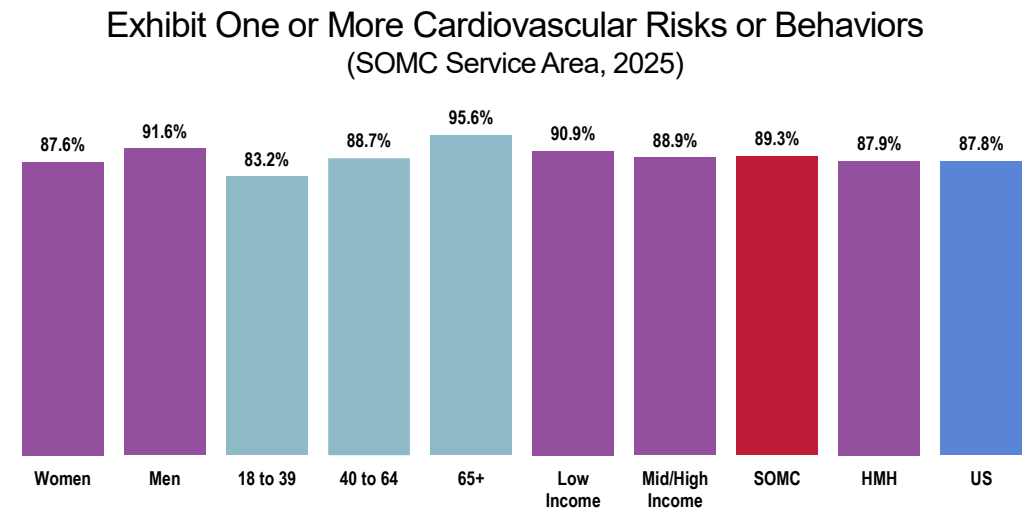
Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

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

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

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

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

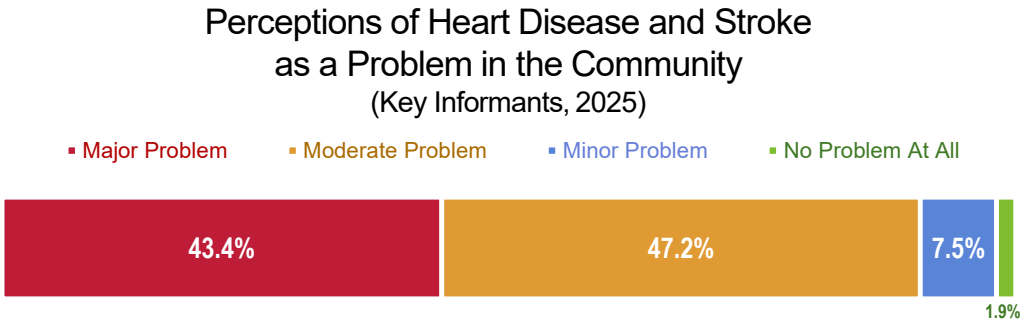


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

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

Key Informant Input: Heart Disease & Stroke

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



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

Notes:
- Asked of all respondents.

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

Incidence/Prevalence

> Heart disease and (probably) the whole CDV family of illnesses are tied together. Heart disease is the number one cause of death in New Jersey today. This is easily the largest issue financially for the health care system, and I believe that over 60% of US adults are prediabetic and/or have the precursors to CDV or are obese. Easily, the largest health care issue in the United States today with specific regard to the numbers of Americans dealing with these issues. – Public Health Representative
>
> It's the leading cause of death in our community. – Community Leader
>
> I worked for American Heart Association and am aware of the statistics in NJ. – Social Services Provider
>
> As Ocean County has an increasingly older population, and many seniors move into senior communities, heart disease and stroke become more common. – Health Care Provider

> Statistically, heart disease and stroke continue to be a major cause of mortality in Monmouth County. Health education by physicians that are close to their patients could be more effective in making a lifestyle change with them due to a trusting relationship. – Public Health Representative
>
> In my experience working with residents and stakeholders in our communities, I often hear tragic news about victims of heart attacks and strokes. I witnessed firsthand the stress and impact these events have on families and loved ones. A significant percentage of the clients we serve report that they have a family member or someone in their community who has been affected by a heart attack or stroke. There is a general lack of awareness about hereditary risk factors and education concerning cardiovascular diseases. Furthermore, there are gender-specific perceptions about the risk of heart disease. Women often do not recognize their symptoms as related to heart conditions, while men tend to dismiss their symptoms or delay seeking medical attention. – Social Services Provider
>
> Over half of the patient population we see suffer from hypertension. We have three cardiologists who are fully booked and have waitlists. – Health Care Provider
>
> The number of people hospitalized with coronary concerns. – Social Services Provider
>
> I feel like a broken record, but this is all true. Heart disease is the number one reason people in our country die. Yet the main contributor to this chronic yet reversible condition, the poor standard American diet, is hardly ever spoken about. If you are sent to a nutritionist, you are told to eat "lean" meat, dairy, sugar, etc., yet never about a plant-based diet. I have seen reversible, from a family member, who was told by a very special physician, to eat an oil-free plant-based diet after a heart attack at 60, and he is still alive at 94. Yet his regular physician told him he would die if he didn't get open-heart surgery and bypasses. How can anyone trust the health care industry when this stuff goes on? – Community Leader

Aging Population

> Large at-risk senior population. Large population engaging in high-risk, unhealthy behavior. – Public Health Representative
>
> Older population. – Health Care Provider
>
> Ocean County has a large senior population, and oftentimes with age, heart and stroke risk increases. Ocean County had the highest percentages of residents impacted by heart/stroke related issues, at 27%. – Social Services Provider
>
> Aging population, lack of physical activity, and obesity. – Public Health Representative

Lifestyle

> Eating style, inactivity, and education. – Social Services Provider
>
> Unhealthy lifestyles leading to heart disease. – Health Care Provider

Leading Cause of Death

> Leading cause of death. – Public Health Representative
>
> The number one cause of death in our area. – Health Care Provider

Access to Care/Services

> It's hard to get an appointment for the right doctor or specialist. – Social Services Provider

Prevention/Screenings

> Poor health in younger years, drugs, alcohol abuse, and mental illness, etc. – Community Leader

Focus Group Input: Heart Disease & Stroke

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Cancer

ABOUT CANCER

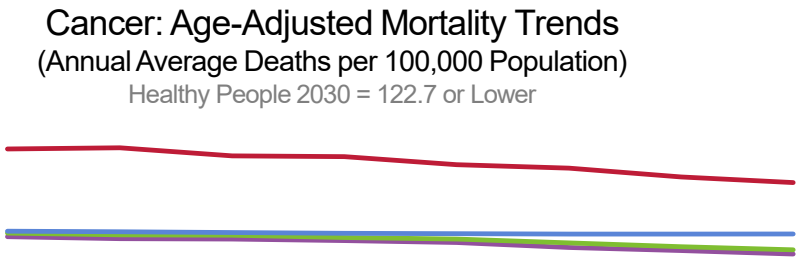
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are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

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

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

Cancer Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	270.4	271.8	263.6	262.7	254.2	250.6	241.6	235.8
HMH	179.7	177.8	177.4	175.6	173.6	168.7	165.4	161.7
NJ	183.4	181.8	181.1	179.0	177.3	173.1	169.3	166.1
US	185.4	184.8	184.1	183.3	182.9	182.6	182.6	182.5

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

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

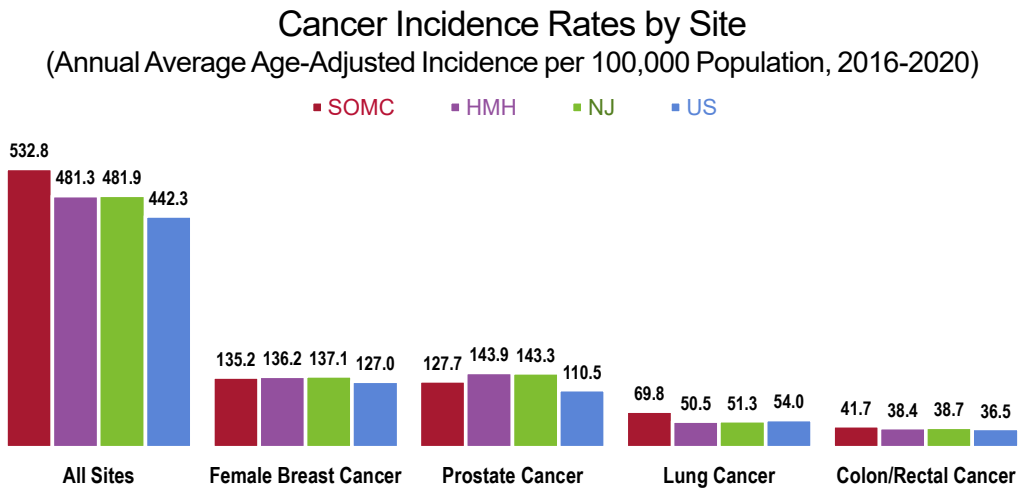
Age-Adjusted Cancer Death Rates by Site
(2021-2023 Annual Average Deaths per 100,000 Population)

	SOMC	HMH	New Jersey	US	HP2030
ALL CANCERS	**235.8**	**161.7**	**166.1**	**182.5**	**122.7**
Lung Cancer	**54.9**	**31.8**	**32.8**	**39.8**	**25.1**
Female Breast Cancer	**29.5**	**25.2**	**25.7**	**25.1**	**15.3**
Colorectal Cancer	**20.9**	**14.5**	**15.0**	**16.3**	**8.9**
Prostate Cancer	**20.1**	**16.6**	**17.0**	**20.1**	**16.9**

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

Cancer Incidence

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

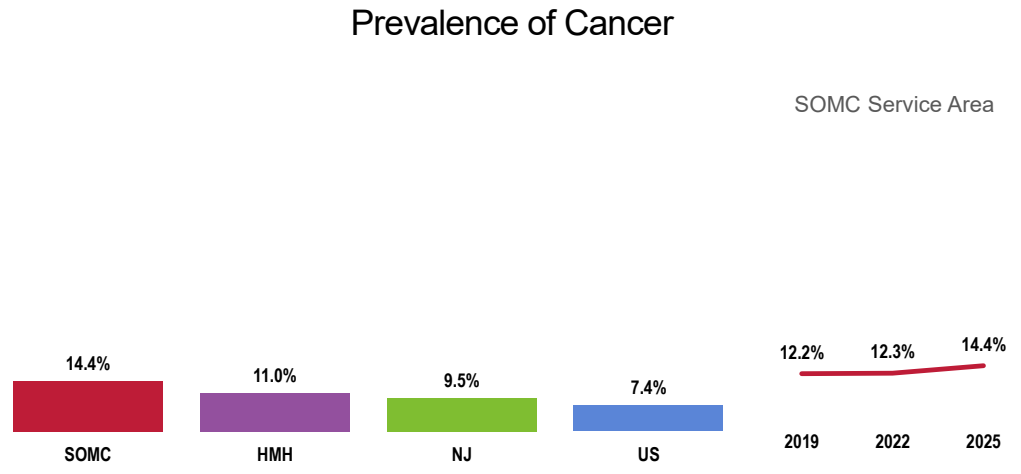


Sources:
- National Cancer Institute, State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

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

Prevalence of Cancer

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



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

Notes:
- Reflects all respondents.

Cancer Screenings

FEMALE BREAST CANCER

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

CERVICAL CANCER

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

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

PROSTATE CANCER

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

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

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

Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

Breast Cancer

PRC SURVEY ► "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

Cervical Cancer

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

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

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

Colorectal Cancer

PRC SURVEY ► "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

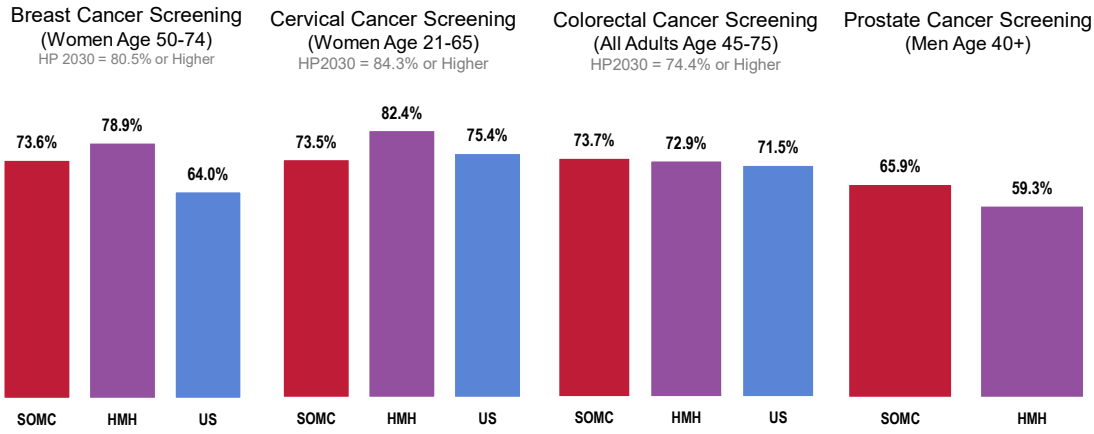
PRC SURVEY ► "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

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

Prostate Cancer

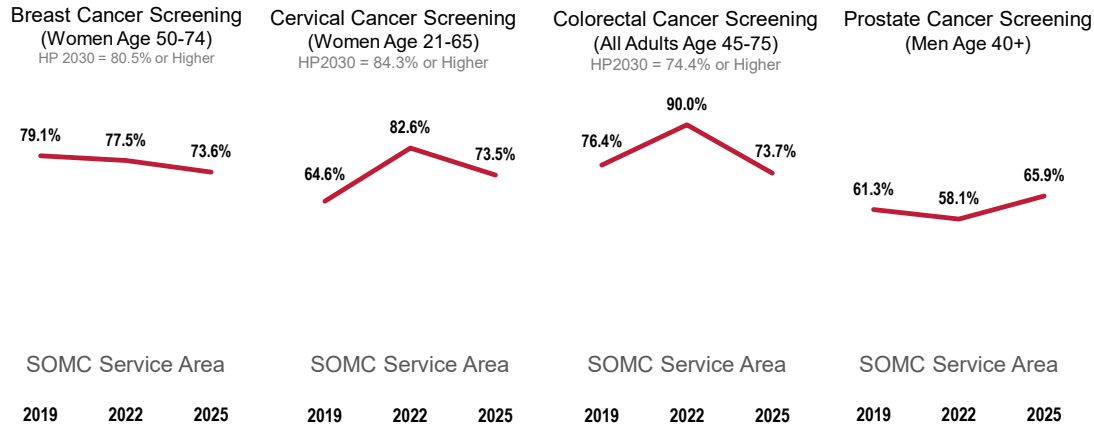
PRC SURVEY ► "A prostate-specific antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. How long has it been since you had your last PSA test?"

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



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

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



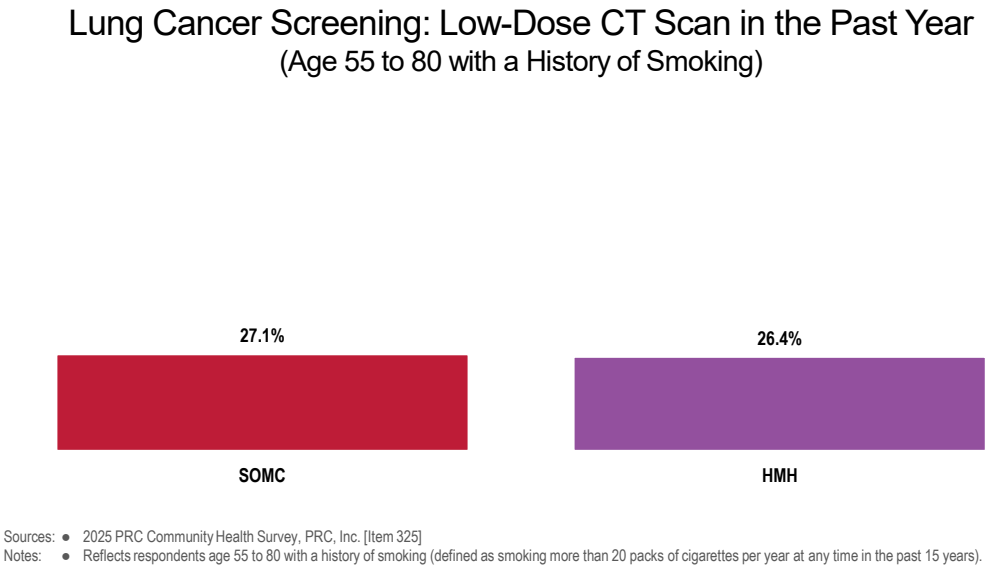
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 101-103, 326]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Lung Cancer

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

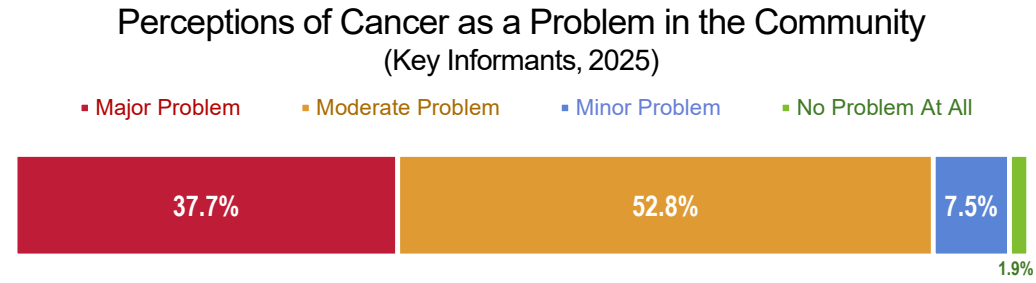
Lung cancer screening is calculated here among respondents age 55 to 80 with a history of smoking (defined as someone who smoked at least 20 packs of cigarettes per year at some point in the past 15 years).



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

Key Informant Input: Cancer

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



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

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

Incidence/Prevalence

> We are seeing an uptick in the cancer cases in the area. – Health Care Provider
>
> We have seen more patients being diagnosed with cancer, especially breast and prostate. – Health Care Provider
>
> We are seeing a shift in cancer occurring in younger members of our community. – Community Leader
>
> National problem. – Social Services Provider
>
> Cancer is the second-leading cause of death. The rise in cancers detected in young people is concerning. Cancer causes multiple burdens for patients and their families, as well as for employers. – Health Care Provider

> Rate is too high, as per DOH stats for both areas. – Health Care Provider
>
> This is my qualitative assessment, as I do not know the actual stats on different cancers. In 1970, vehicles likely averaged 10 to 12 mpg. Today, it is over 30. Today, our waste is heavily regulated at the local, state, and (sometimes) the federal level. Continuing, virtually everything is recycled. People require more permits than ever before for building and manufacturing, and this usually requires environmental inspections. We have the world's most stringent manufacturing standards, water quality standards and building materials standards. All of these improvements, yet there is still a huge cancer problem. With all of this in mind, what I hear and see is that there is virtually no family that is not touched by cancer, either directly or indirectly. Again, I could go on and on – the loss of financial stability when a breadwinner gets cancer, the loss of life, quality of life – reduced community participation, volunteerism, etc. A huge problem. – Public Health Representative
>
> The number of people I know undergoing cancer treatments. – Social Services Provider
>
> Because people die. – Community Leader
>
> So many people I know have cancer. And the health care industry is not talking about the root causes of cancer, i.e., environmental, diet, etc., only the treatment after the fact. – Community Leader
>
> The number of people I know alone has increased significantly in the last few years. – Social Services Provider
>
> Cancer is a major problem due to high incidence rates, limited access to affordable specialized health care, and environmental or lifestyle factors that contribute to the disease's prevalence. – Social Services Provider

Aging Population

> Large senior population at risk. More preventative screening and education are necessary. In addition, we need to do more about sending conflicting messages and empower residents to take control of their health through some easy actions they can take. – Public Health Representative
>
> Many seniors have cancer. It requires a person to have transportation, a caregiver, financial resources, and prepared food. Most seniors do not have these needs available to them. – Social Services Provider

Prevention/Screenings

> Many people do not seek medical guidance until they are in the critical stages of cancer, where there is no possible treatment. – Community Leader

Affordable Medications/Supplies

> People cannot afford their meds. – Social Services Provider

Focus Group Input: Cancer

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

Respiratory Disease

ABOUT RESPIRATORY DISEASE

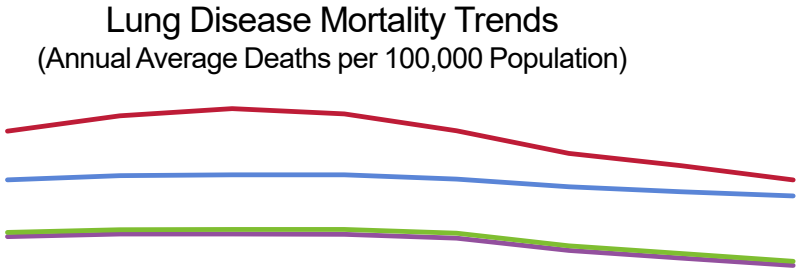
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million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

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

Respiratory Disease Deaths

Lung Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for lung disease is illustrated in the following chart. [COUNTY-LEVEL DATA]



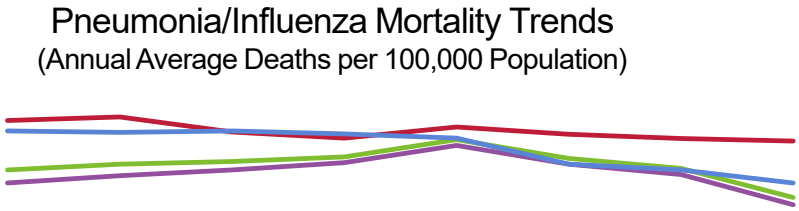
	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	59.2	62.9	64.6	63.3	59.3	53.8	50.8	47.4
HMH	33.7	34.3	34.3	34.2	33.3	30.3	28.5	26.7
NJ	34.7	35.3	35.4	35.4	34.5	31.4	29.6	27.7
US	47.4	48.4	48.6	48.6	47.6	45.7	44.5	43.5

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

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

Pneumonia/Influenza Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	17.7	18.0	16.9	16.5	17.3	16.8	16.5	16.3
HMH	13.4	13.9	14.3	14.8	16.0	14.7	14.0	11.9
NJ	14.3	14.7	14.9	15.2	16.4	15.1	14.4	12.4
US	17.0	16.9	17.0	16.8	16.5	14.7	14.3	13.4

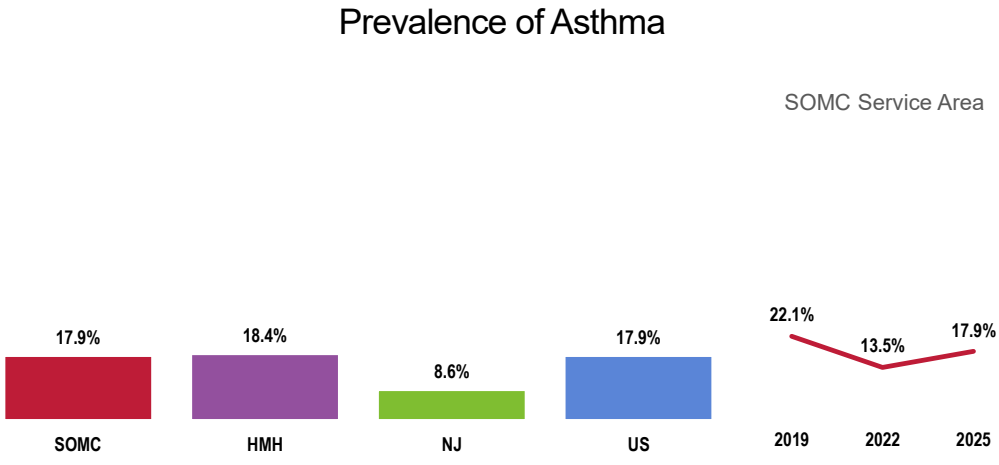
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

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

Prevalence of Respiratory Disease

Asthma

PRC SURVEY ► "Do you currently have asthma?"



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

Notes:
- Asked of all respondents.

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

PRC SURVEY ► [Among parents of children age 0-17 with a past asthma diagnosis] **"Does this child still have asthma?"**

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

SOMC Service Area

Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2023 PRC National Health Survey, PRC, Inc.

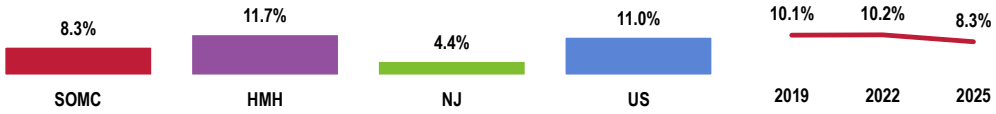
Notes:
- Asked of all respondents with children 0 to 17 in the household.
- The US percentage reflects children who have ever been diagnosed with asthma and does not specify that the child still has asthma.

Chronic Obstructive Pulmonary Disease (COPD)

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

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)

SOMC Service Area

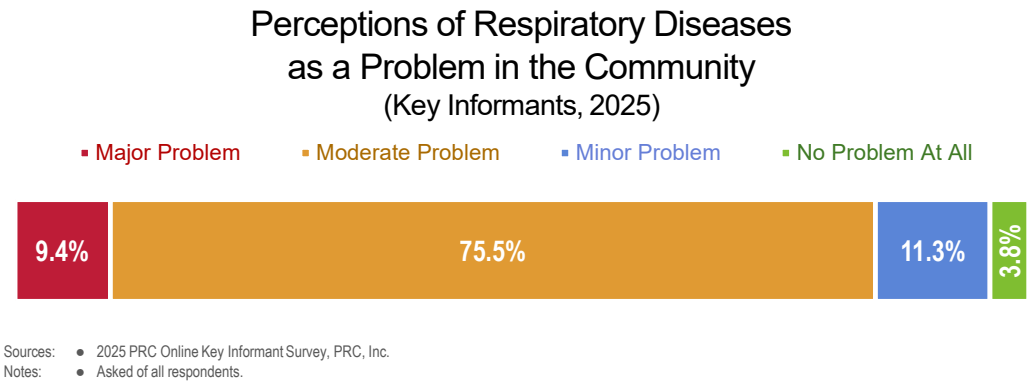


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

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



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

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

Incidence/Prevalence

> At this time, we have not seen a major surge of COVID. – Health Care Provider

Affordable Medications

> Medications are very expensive. – Social Services Provider

Alcohol/Drug Use

> Alcohol, drugs, and environment. – Community Leader

Prevention/Screenings

> People go out in public while sick. – Social Services Provider

Injury & Violence

ABOUT INJURY & VIOLENCE

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

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

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

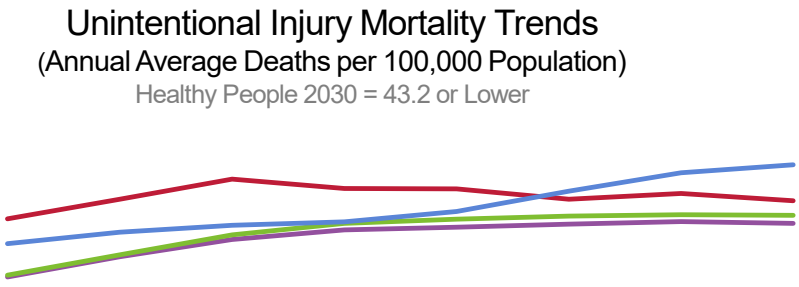
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Unintentional Injury Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	52.9	58.3	63.8	61.3	61.1	58.3	59.9	57.9
HMH	36.8	42.4	47.2	49.8	50.6	51.4	52.1	51.6
NJ	37.3	42.9	48.4	51.6	52.8	53.6	54.0	53.8
US	46.0	49.2	51.1	52.0	54.9	60.5	65.6	67.8

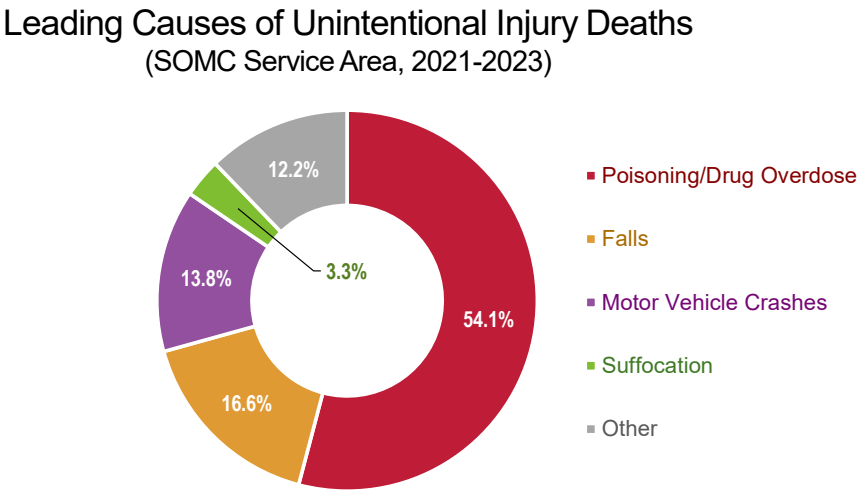
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Leading Causes of Unintentional Injury Deaths

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

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

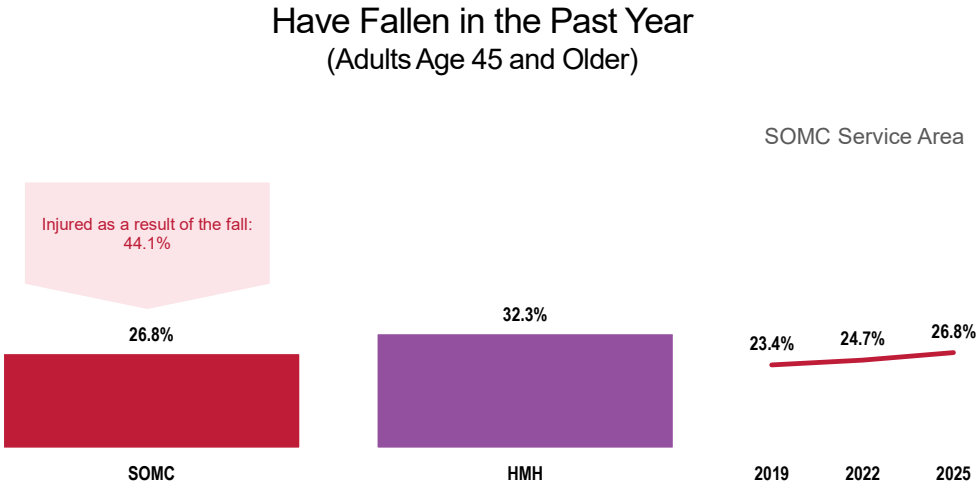


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

Falls

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

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



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

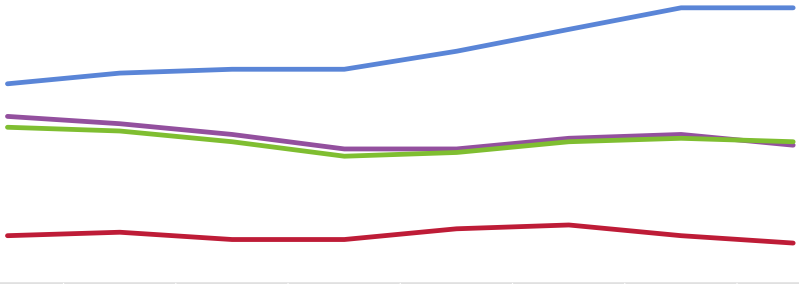
Intentional Injury (Violence)

Homicide Deaths

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

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

Homicide Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 5.5 or Lower



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	1.3	1.4	1.2	1.2	1.5	1.6	1.3	1.1
HMH	4.6	4.4	4.1	3.7	3.7	4.0	4.1	3.8
NJ	4.3	4.2	3.9	3.5	3.6	3.9	4.0	3.9
US	5.5	5.8	5.9	5.9	6.4	7.0	7.6	7.6

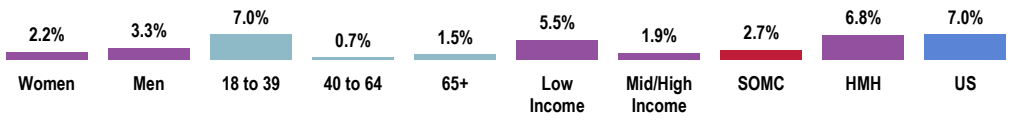
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Violent Crime Experience

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

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



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

Notes:
- Asked of all respondents.

Intimate Partner Violence

PRC SURVEY ▶ "The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

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

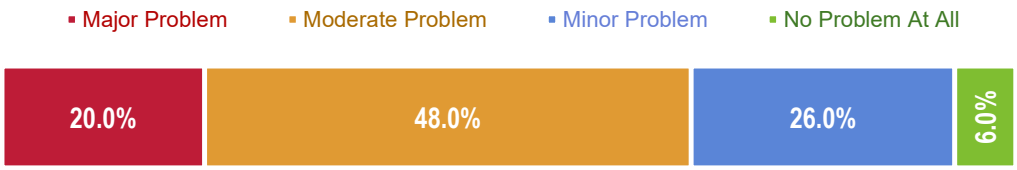
SOMC Service Area

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

Key Informant Input: Injury & Violence

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

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



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

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

Incidence/Prevalence

> Notable types of violence in the community are related to domestic, sexual, and gun violence. – Social Services Provider
>
> Too many fights, shootings, kidnappings, and violent crimes. – Community Leader
>
> Injury continues to be one of the leading causes of death of adolescents and children. – Health Care Provider
>
> Prevalence of accidental injuries are significant contributors to both hospitalizations and mortality. While my community may have a lower crime rate than urban areas, violent crimes such as assaults, domestic violence, and gun violence still present challenges. These injuries and violence place a strain on the health care system. – Social Services Provider

> Third-leading cause of death, number one from the age of 1 to 44. Leading cause of years of life lost. Roadway crashes and ped fatalities rise. This is a leading cause of death, yet an area where a limited amount of resources are allocated. We do not have funding for resources to improve survivability, such as bleeding control kits, helmets, infant car seats, or senior assistive devices. We do not have funding for per diem staff that could assist with educational outreach or classes to improve survivability, such as Stop The Bleed. The Trauma Injury Prevention Program at Jersey Shore has made a major impact despite limited resources, but there is so much more that could be done. Project HEAL has shown the value of their programs on impacting the community. These two programs have collaborated on projects that have caught the attention of the NJ district attorney and US Department of Justice. Clearly, they are both worth investing in. Expanding programs for teens and seniors is critically needed. – Health Care Provider

Income/Poverty

> Economics and mental illness. – Community Leader

Access to Care

> People lack insurance, and costs for doctors is very expensive. We need to educate the communities to help them understand the importance of appointments and checkups. – Social Services Provider

Employment

> Economy, unemployment, video game and television violence at a young age. – Social Services Provider

Gang Violence

> Increased gang activity. Lack of community trust in law enforcement and/or medical professionals. – Health Care Provider

Diabetes

ABOUT DIABETES

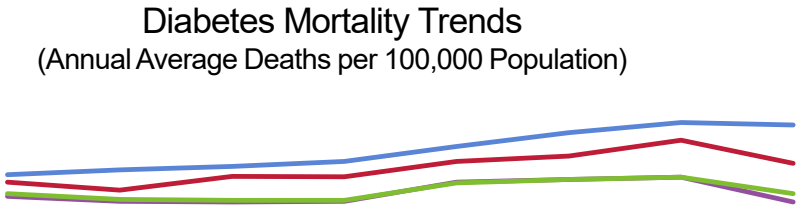
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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

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

Diabetes Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	23.6	22.6	24.3	24.2	26.1	26.7	28.7	25.9
HMH	21.9	21.3	21.2	21.3	23.6	23.9	24.2	21.2
NJ	22.2	21.5	21.4	21.4	23.5	23.9	24.2	22.2
US	24.5	25.1	25.5	26.1	27.9	29.6	30.8	30.5

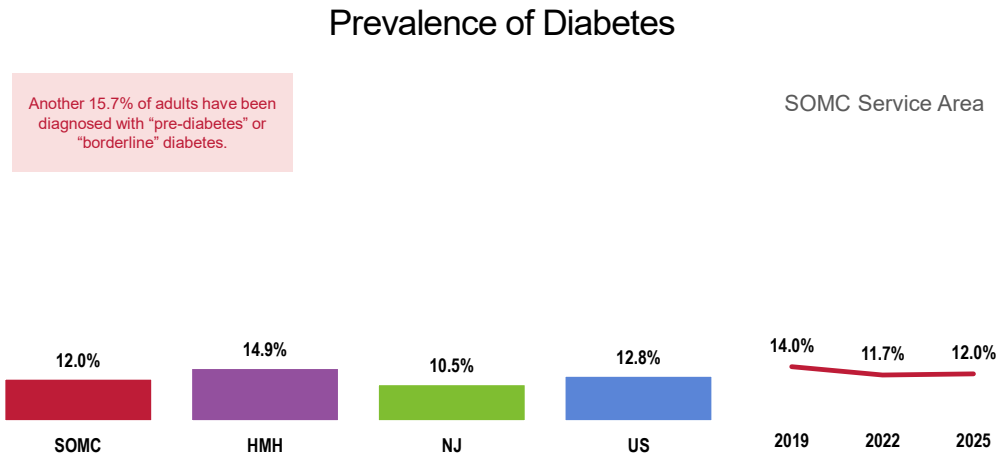
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

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

Prevalence of Diabetes

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

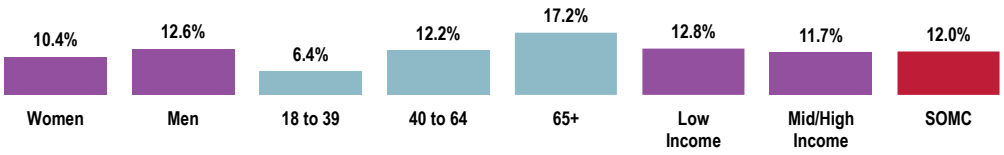
PRC SURVEY ► "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"



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

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

Prevalence of Diabetes
(SOMC Service Area, 2025)

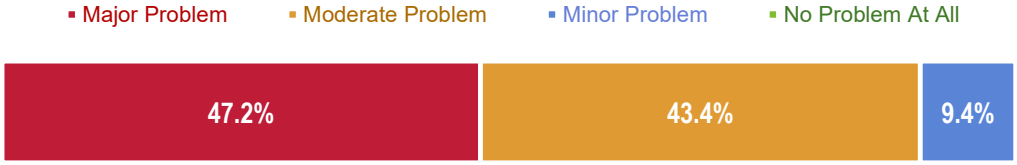


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 106]
Notes: ● Asked of all respondents.
● Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

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

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



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

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

Affordable Medications/Supplies

> Getting insulin and keeping watch on their blood sugar levels. – Social Services Provider
>
> Access to medicines and monitoring like Libre. Access to endocrinologists. – Health Care Provider
>
> Medication costs. – Social Services Provider
>
> Getting diabetes medication is difficult. – Social Services Provider
>
> Accessing medication, medical supplies, and understanding diet and exercise that can help manage diabetes. – Health Care Provider

Access to Care/Services

> The biggest challenge for people with diabetes in Ocean County is cost and self-monitoring, making sure people have the means, the access, and the support to successfully regulate their diabetes levels. – Community Leader
>
> Getting timely appointments with physicians and education on CGMs. – Health Care Provider
>
> Access to a physician. – Health Care Provider
>
> Limited availability of endocrinologists and diabetes educators. I am aware that the state average of diagnosis is 8.8%, and Monmouth County is 7%. Perhaps those living with diabetes have not been diagnosed. There are also socioeconomic factors, as well as lifestyle choices. – Social Services Provider

Awareness/Education

> Diabetes is preventable. People need to understand the consequence of unhealthy habits as it relates to diabetes and other health issues. – Public Health Representative
>
> The health care industry does not tell people that they can reverse type 2 diabetes. I have seen reversal in two weeks, from friends who were told they had to be on Metformin for the rest of their lives, from eating a plant-based diet. Yet no one is told this by their doctors, the nutritionists, etc. They are told this is genetic, so that it seems hopeless, even though there is so much evidence that lifestyle is the main factor contributing to the rise of type 2 diabetes. There are small children now with type 2 diabetes, and even they are not told it is reversible with a turn toward a plant-based diet. – Community Leader
>
> Not educated enough on what is a good vs. bad food/drink. Also, companies fake the individuals out, such as advertisement, less sugar, etc. – Health Care Provider

Nutrition

> Type 2 diabetes caused by unhealthy eating. Inability to afford insulin. – Social Services Provider
>
> Unhealthy food habits and high cost of healthy food. Lack of local endocrinologists. – Health Care Provider
>
> Several significant challenges impact people with diabetes in this community. One of the primary concerns is suboptimal dietary habits, which are often associated with foods that are accessible and affordable for residents. Furthermore, access to health care is obstructed by various factors, including the absence of medical insurance, limited availability of medical services, and the affordability of essential medications. In addition, linguistic and cultural barriers may complicate the communication of symptoms, particularly with certain ethnic dietary practices and belief systems. Another crucial factor is the hesitance to seek medical assistance, which frequently arises from a lack of trust in the health care system. This distrust may be influenced by personal experiences or a broader sense of skepticism within the community. – Social Services Provider

Access to Affordable Healthy Food

> Limited affordable healthy food options. Limited education regarding impact of diet on one's health. – Health Care Provider
>
> After diagnosis, the cost to eat the correct foods/diet, exercise programs, and regular medical checkups. – Community Leader
>
> The cost and accessibility to healthy food and nutrition programs. Rising food costs are impacting everyone, especially those who are on Social Security disability. – Community Leader

Obesity

> Obesity. We have to be able to talk openly to our kids about obesity and not be reminded that we could be "body shaming" people. Obesity is a primary driver in diabetes, and diabetes/ancillary symptoms are the single-most costly part of our health care system. Phys ed needs to go back into the schools, regulate the ingredients in school lunches, and insist on physical activity for students every day. In senior communities, there needs to be more "active senior" programs. Our hospitals, including HMH, provide wonderful educational outreach for the public at no charge. I would like to see a systematic expansion in those programs in schools and senior communities. Education and nutrition education are the keys. – Public Health Representative
>
> Obesity often causes chronic disease, diabetes in particular. Access to health and wellness activities, prevention programs, and health education continues to be a challenge. – Community Leader

Disease Management

> Proper management and frequent readmissions. – Health Care Provider

Lack of Providers

> Endocrinologist availability. – Physician

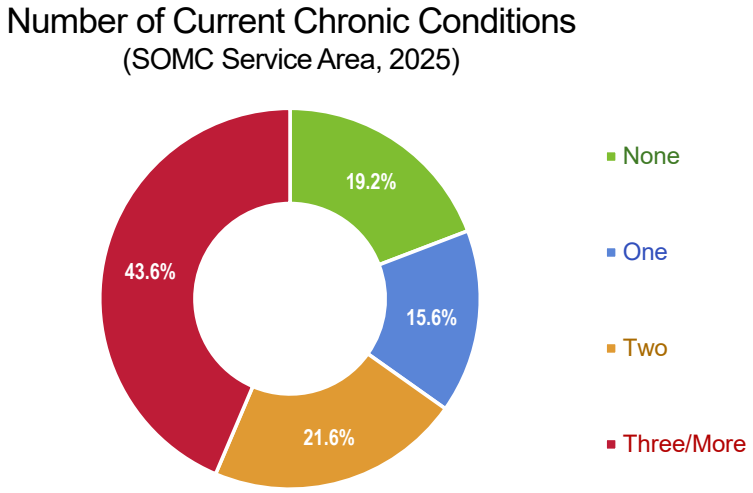
Disabling Conditions

Multiple Chronic Conditions

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

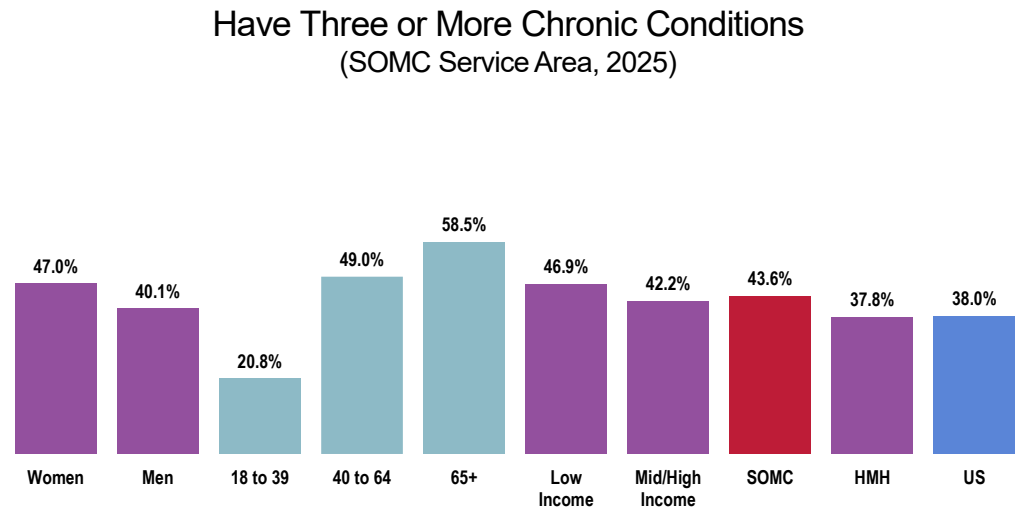
For the purposes of this assessment, chronic conditions include:

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



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]

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



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 107]
- 2023 PRC National Health Survey, PRC, Inc.

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

Activity Limitations

ABOUT DISABILITY & HEALTH

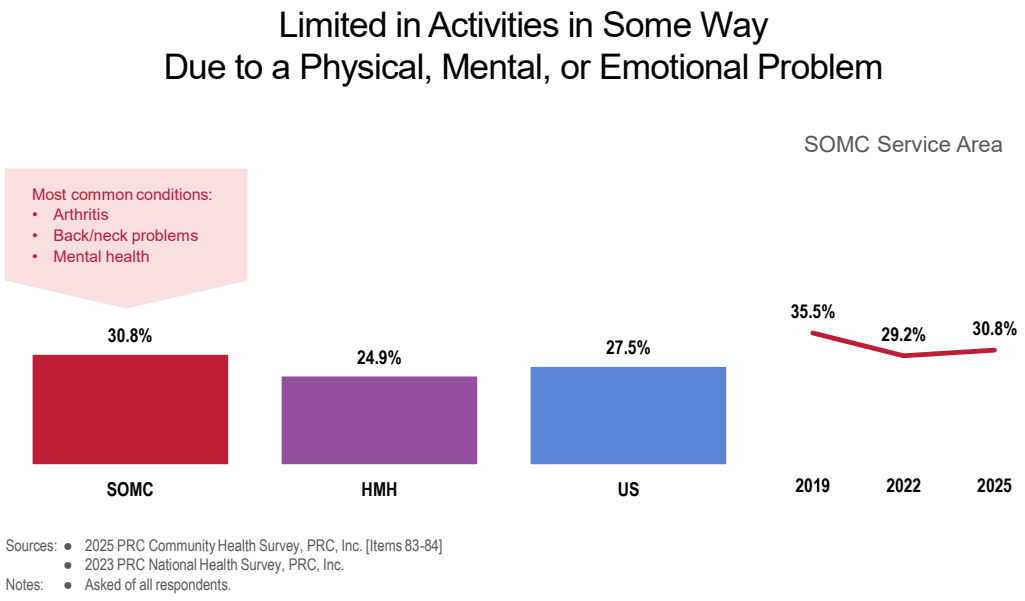
Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

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

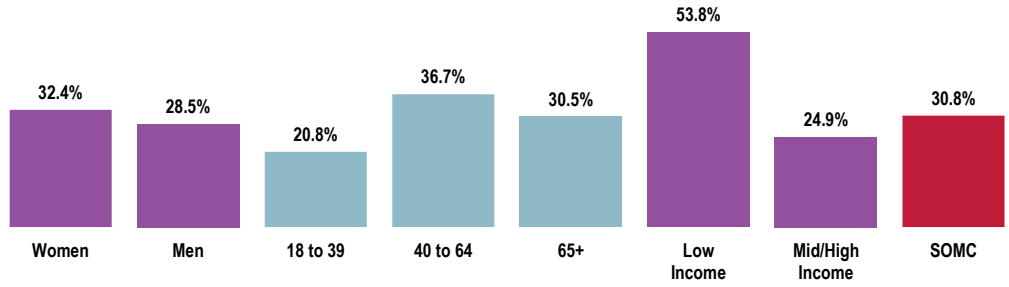
– Healthy People 2030 (https://health.gov/healthypeople)

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

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



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



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

High-Impact Chronic Pain

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

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

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

Alzheimer's Disease

ABOUT DEMENTIA

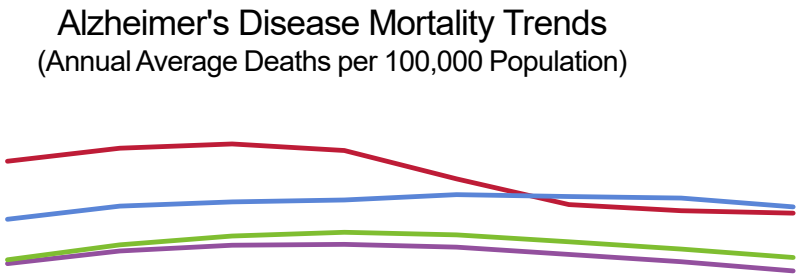
Alzheimer's disease is the most common cause of dementia…. Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

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

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

Alzheimer's Disease Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	45.2	47.9	48.8	47.4	41.5	36.2	35.0	34.5
HMH	24.0	26.6	27.8	28.0	27.4	25.9	24.4	22.5
NJ	24.8	27.9	29.7	30.5	30.0	28.5	27.0	25.3
US	33.2	35.9	36.8	37.2	38.3	37.9	37.6	35.8

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

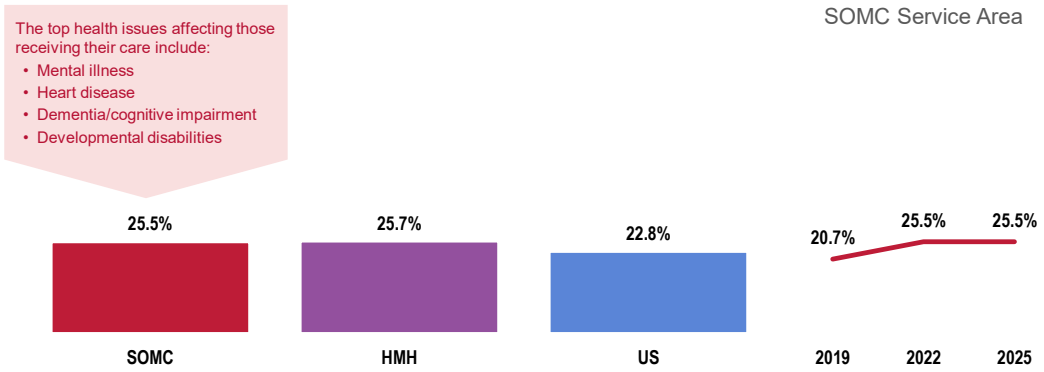
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population.

Caregiving

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

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

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

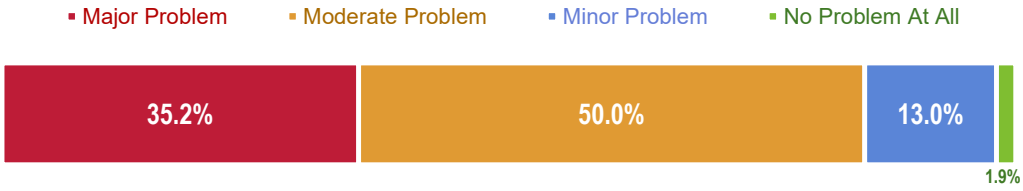


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Items 85-86]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Disabling Conditions

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

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



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

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

Aging Population

> This is a 55+ community. Many of the residents moved here over 20 years ago, when they were in their late 50s or 60s. Many of the residents are now older, in their late 70s or 80s, and suffer from physical ailments that come with age, as well as cognitive decline. Most don't drive at night, and many don't drive at all, which creates a hardship with regard to receiving medical care, going to doctor's office visits, receiving medications, engaging in social activities, etc. – Community Leader
>
> Increased age of the population in Ocean County. – Health Care Provider

> The community has a very high population of senior citizens who suffer from chronic pain and dementia, to name a few. There are community programs for people with Alzheimer's and dementia that are available – it just seems as though we have a high population of people suffering from chronic conditions. – Community Leader
>
> Ocean County is the retirement hub of New Jersey, with 93 age restricted communities and 200,000 residents over the age of 60. With increased life expectancies, our residents are living longer. With longer life spans, they face more health issues and disabling conditions, including all of the limitations listed above. The disabling conditions often result in the loss of driving privileges, creating difficulty for our residents to perform many activities of daily living, such as food shopping, banking, doctors' appointments, and pharmacy pick-ups. More importantly, it results in the loss of their independence and causes social isolation. Many of the disabling conditions make it difficult for seniors to access critical programs and services, especially with the advent of online applications causing frustration and hopelessness. – Social Services Provider
>
> We've made people live longer – but did not think about what we would do with them once they did. It is often unsafe for seniors, and others, with disabling conditions to live at home – especially if they are alone. Resources to help people to age in place are inadequate. Falls are 47% of the trauma that we see at Jersey Shore, yet fall alert devices are not covered under insurance. Few resources exist to assist with installing proper lighting, grab bars, or smart technology that could help seniors to live at home safer. Caregiver assistance costs a fortune – more than most of our community can afford. Lower-income seniors may qualify for affordable housing. Upper-income families can afford assisted living. Those in the middle are at a loss for affordable, safe living arrangements. We need to build safe senior housing affordable to that population. Local builders like Toll Brothers have construction plans approved, yet stairs are too steep, mailboxes are down the street, and alarms are out of reach. – Health Care Provider
>
> Dementia and Alzheimer’s care in the home that's affordable. – Health Care Provider

Nutrition

> Many residents do not prioritize staying healthy. Food choices are often what is least expensive. Obesity and underactivity is an issue. – Community Leader
>
> Our food has additives that are not good for our bodies. The standard American diet is flawed and contains too much processed food that damages our bodies. – Social Services Provider
>
> Again, I see so many people with inflammation and chronic pain that can be tied back to a diet high in meat, dairy, salt, sugar, and lack of exercise. etc. Yet I am aware of people who go to mainstream nutritionists, and they are never told this, only given pharmaceuticals, so never getting to the root of the problem.
> – Community Leader

Incidence/Prevalence

> A large number of our clients have these disabling conditions. – Social Services Provider
>
> After caring for my father, who was diagnosed with dementia, I became aware of the onset in my community.
> – Social Services Provider

Access to Care/Services

> It’s hard for people to get needed appointments. – Social Services Provider

Housing

> Not enough reasonably-priced housing options for people with disabilities. Many stay in their current housing situations because they feel they have no options, either because of financial issues or because they really don’t know where to turn for help. – Social Services Provider

Isolation

> I have experienced how those suffering from disabilities are homebound, suffer from isolation and local social interaction. It affects them mentally and physically. – Social Services Provider

Diagnosis/Treatment

> People wait until they have major issues to seek medical help. – Community Leader

Lack of Providers

> There are not enough specialists, and many of them do not accept Medicaid. – Community Leader

Focus Group Input: Disabling Conditions

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

BIRTHS

ABOUT INFANT HEALTH

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

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

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

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health.

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

	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	22.4%	23.1%	24.1%	24.5%	24.3%	22.8%
HMH	24.1%	24.3%	24.0%	23.8%	24.1%	24.4%
NJ	23.6%	23.7%	23.5%	23.2%	23.2%	23.5%
US	22.7%	22.5%	22.4%	22.6%	22.5%	22.3%

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

Birth Outcomes & Risks

Low-Weight Births

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

Low-Weight Births
(Percent of Live Births, 2017-2023)

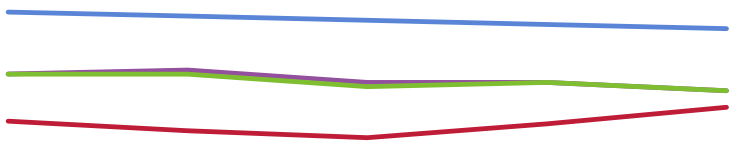
Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

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

Infant Mortality

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

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
SOMC	3.3	3.0	2.9	3.2	3.6
HMH	4.4	4.5	4.2	4.2	4.0
NJ	4.4	4.4	4.1	4.2	4.0
US	5.9	5.8	5.7	5.6	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted April 2025.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Focus Group Input: Maternal & Infant Mortality

Biggest Issues, Challenges, and Barriers:

Maternal & Infant Health Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Maternal & Infant Health Focus Groups:

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

Key Quotes:

Maternal & Infant Health Focus Groups:

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

Family Planning

ABOUT FAMILY PLANNING

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

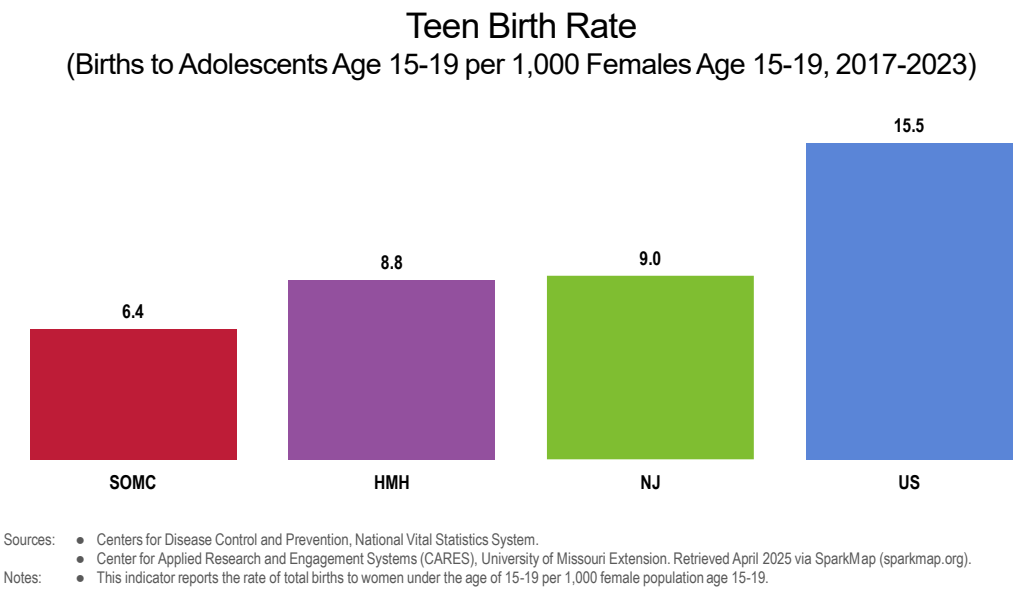
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

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

Births to Adolescent Mothers

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

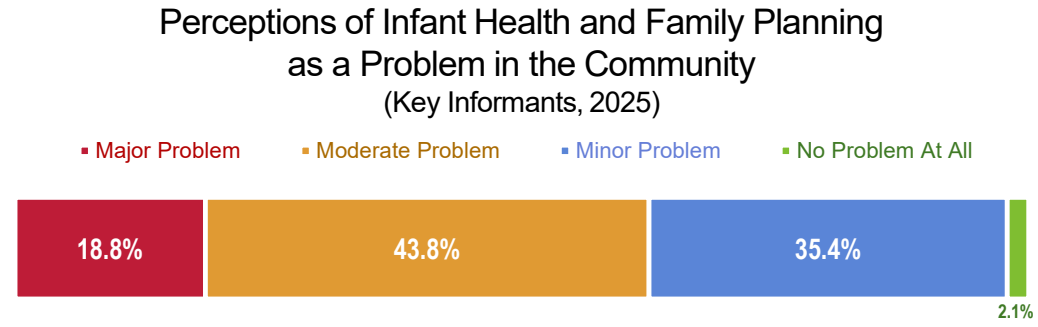
The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior. [COUNTY-LEVEL DATA]



Sources: ● Centers for Disease Control and Prevention, National Vital Statistics System.
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).
Notes: ● This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19.

Key Informant Input: Infant Health & Family Planning

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



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

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

Awareness/Education

> Education. – Social Services Provider
>
> Not enough awareness of resources and limited access to care. – Health Care Provider

Income/Poverty

> Low-income areas, lack of health education and medical coverage. – Social Services Provider

Infant Mortality

> Children are stillborn or born with health issues due to parental addictions and abuses. – Community Leader

Family Planning

> The Orthodox Jewish community in Lakewood and the surrounding areas has the second-largest birth in the world. Infant health and family planning is of vital importance in this area. – Health Care Provider

Employment

> Parents need to get the children to appointments, but sometimes they can't because of work.
> – Social Services Provider

Nutrition

> Moms and babies are eating ultra-processed foods, fed this at home and at day care, because the USDA says even this food meets regulations. – Community Leader

Children

> Those that affect children. There is so much focus on the adults when statistics and information are captured for the assessment that children are left out of the equation. There needs to be specific questions related to children, and they can be accomplished by contacting NJDOE for the surveying parents or getting de-identified information from school nurses about the health issues. Thank you. – Community Leader

Teen Pregnancy

> Having babies happens at way too young of age, pre-high school graduation. The young moms and dads, if they are in the picture, are not equipped to take care of themselves, let alone a baby. – Community Leader

Focus Group Input: Infant Health & Family Planning

Biggest Issues, Challenges, and Barriers:

Maternal & Infant Health Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Maternal & Infant Health Focus Groups:

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

Key Quotes:

Maternal & Infant Health Focus Groups:

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

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

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

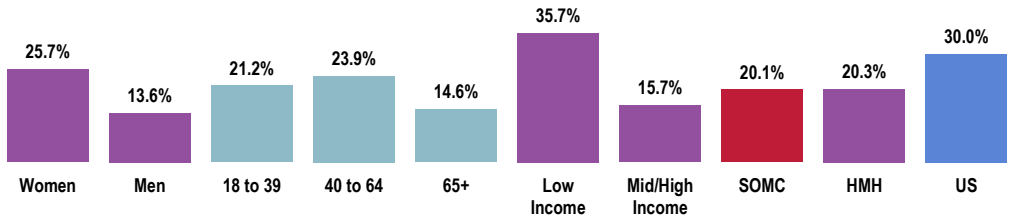
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Access to Fresh Produce

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

Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(SOMC Service Area, 2025)

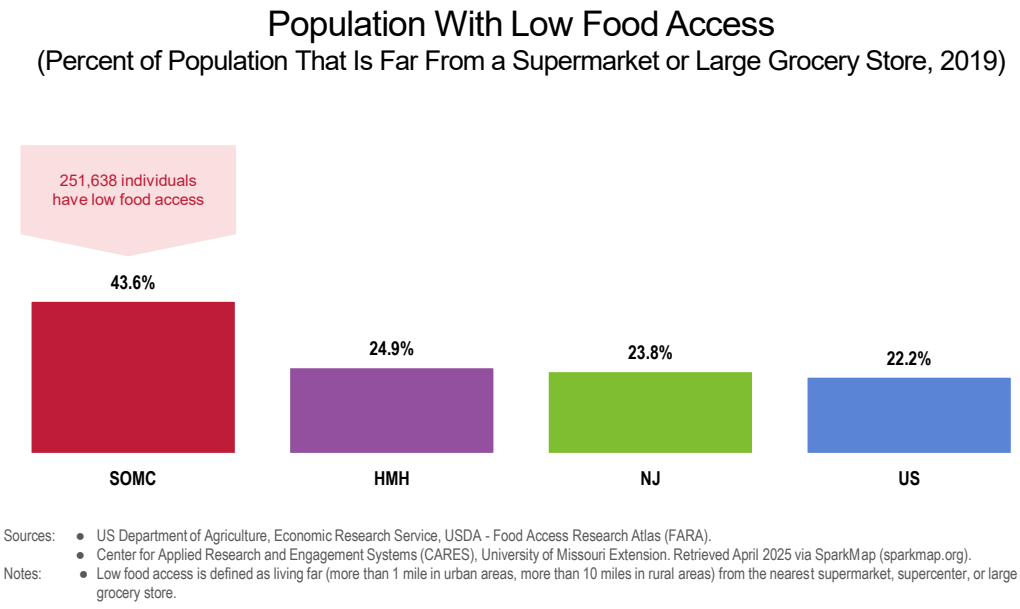


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 66]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Low Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data. [COUNTY-LEVEL DATA]



Physical Activity

ABOUT PHYSICAL ACTIVITY

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

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

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

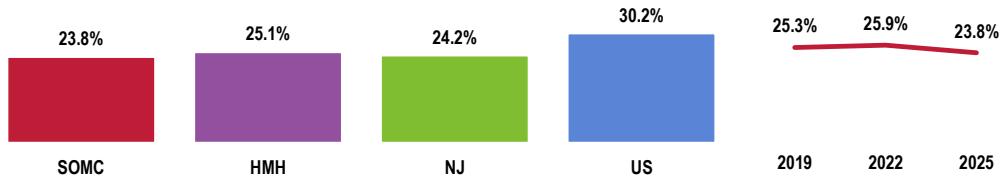
Leisure-Time Physical Activity

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

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower

SOMC Service Area



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

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

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

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

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

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

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

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

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

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

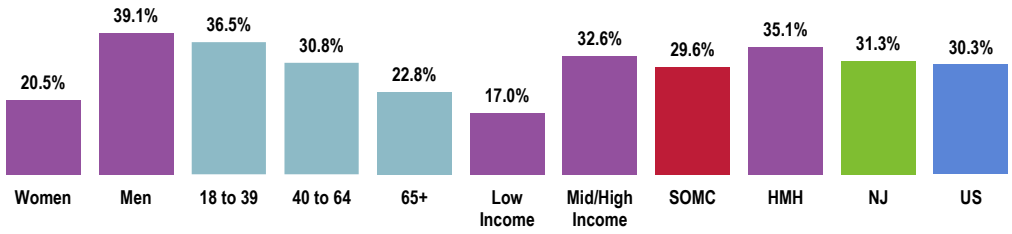
Respondents were also asked about strengthening exercises:

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

Meets Physical Activity Recommendations

(SOMC Service Area, 2025)

Healthy People 2030 = 29.7% or Higher



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

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) *and* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

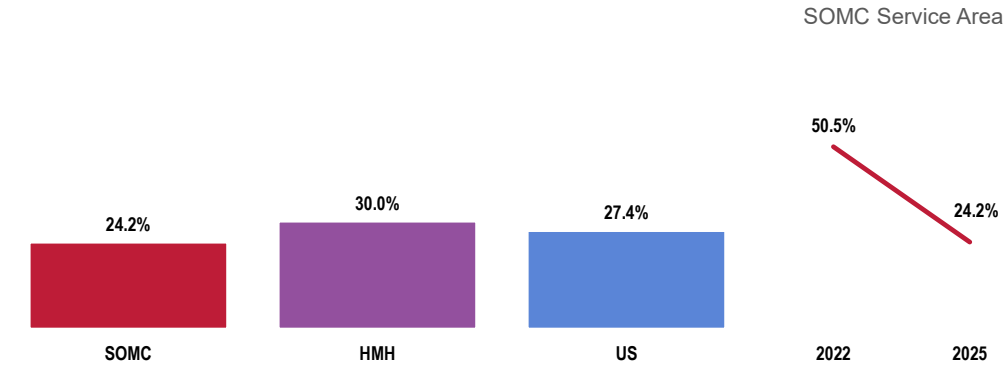
CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

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

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

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

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



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Weight Status

ABOUT OVERWEIGHT & OBESITY

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

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

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

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

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

Adult Weight Status

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

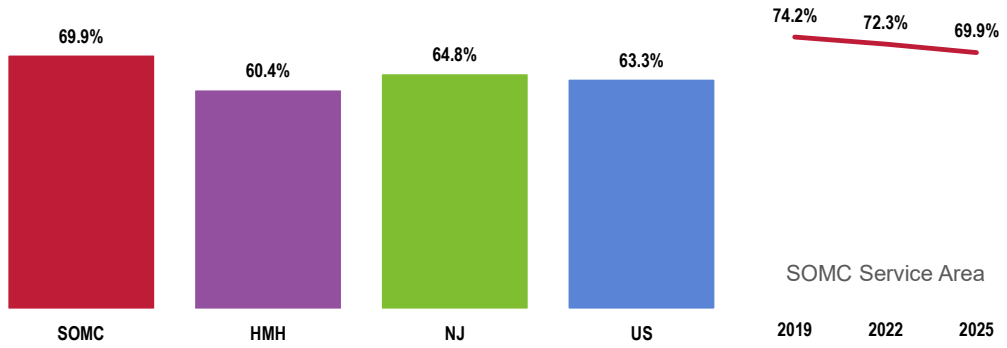
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

PRC SURVEY ► "About how much do you weigh without shoes?"

PRC SURVEY ► "About how tall are you without shoes?"

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

Prevalence of Total Overweight (Overweight and Obese)

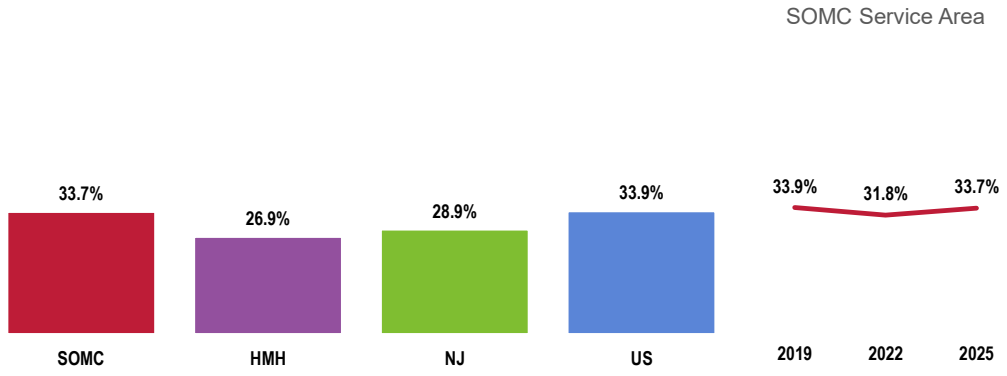


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey,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

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

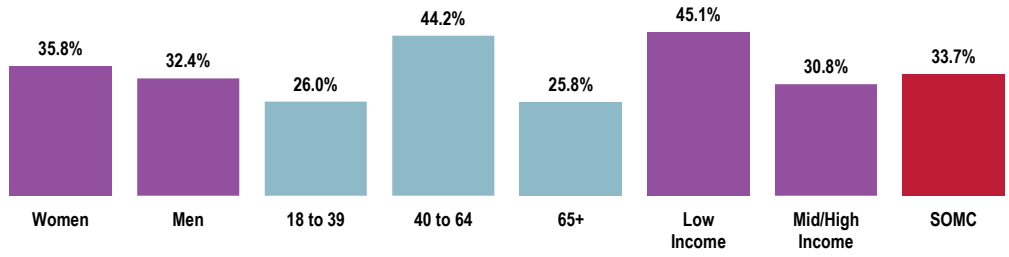
Healthy People 2030 = 36.0% or Lower



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

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

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



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

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

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

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

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

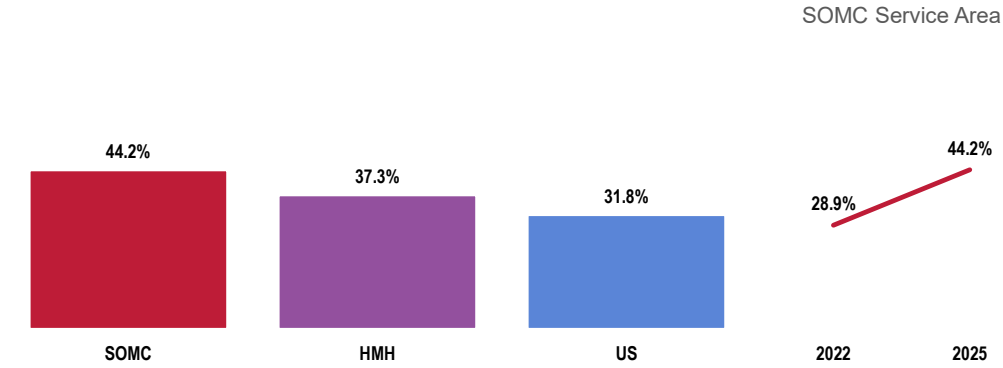
– Centers for Disease Control and Prevention

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

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

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

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



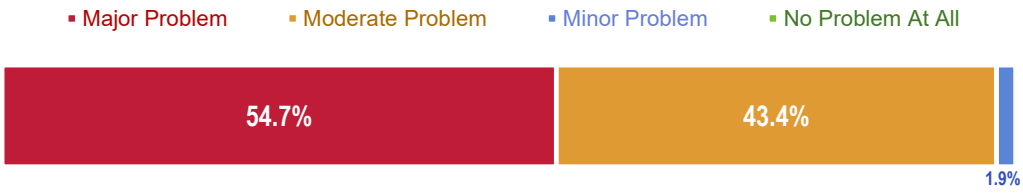
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 113]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

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

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



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

Notes:
- Asked of all respondents.

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

Nutrition

> Eating the right food. – Social Services Provider
>
> The sugar and other additives in our processed foods. Not every family can buy/cook clean foods. They may not have access to them, or if they do, they can't afford them. Also, knowing how to prepare foods that may be foreign or unusual for them. – Community Leader
>
> Nutrition and physical activity and weight play a huge role in the overall health and well-being of people. Ocean County statistics are not favorable for these indicators. – Public Health Representative
>
> The biggest challenges related to nutrition, physical activity, and weight are related to limited access to affordable fresh fruits, vegetables, and meats, coupled with a reliance on fast food, which presents a significant challenge. Comfort foods are often processed and high in sodium, fats, sugar, and carbohydrates. Furthermore, low-income housing complexes frequently lack safe recreational spaces, contributing to sedentary lifestyles. This is compounded by certain jobs and recreational activities, such as watching TV and playing video games, which can lead to socially compulsive behaviors. – Social Services Provider
>
> Limited access to healthy food options. Public spaces may not be safe for physical activities.
> – Health Care Provider
>
> Cost of healthy food and lack of knowledge as to how to cook low-cost healthy meals. – Social Services Provider

Awareness/Education

> Physical and nutritional education are the keys to long-term success and reduced health care costs, as well as healthier lives for people across the age continuum, if they are implemented at a young age. This should be part of standard NJ curriculum in schools across the board, even for just 15 minutes per day.
> – Public Health Representative
>
> Lack of education/awareness. – Health Care Provider
>
> Education and convincing/motivating individuals to make a positive lifestyle change.
> – Public Health Representative
>
> Again, we are never told that a plant-based diet is the best diet to stay healthy and live long lives. We are constantly bombarded with ads for meat, dairy, sugar, etc., and nutritionists provide "healthy" recipes full of this garbage. Our children are exposed to sugar in the womb and given sugar at day care, school, after school, summer programs, etc. I once saw 32 grams of sugar in an after-school meal at the Boys and Girls Club. Then children react to this garbage and are put into a "calming room," and this is considered ADD/ADHD, etc. No one ever connects the garbage the "experts" say is healthy, that is given to them, as one of the roots causes of "poor" behavior in children. – Community Leader

Obesity

> Obesity is on the rise, in conjunction with diabetes. Culturally, it is an issue for many of the local populace.
> – Health Care Provider
>
> Obesity throughout our country. – Social Services Provider

Aging Population

> The biggest challenge related to nutrition in the senior population is their Social Security checks have not kept pace with the rising cost of food and increased cost of living. Living on a fixed income, seniors have had to make their monthly checks go further, and the one thing they have some control over is food costs. This often means not having sufficient food to sustain them for the month or turning to cheaper options as opposed to fresh fruits and vegetables. Seniors who lose their driver's licenses are less able to get out and about to socialize, which contributes to depression and results in a lack of motivation to engage in physical activity. Physical activity may also be limited to due medical conditions, mobility issues, or something as simple as bladder control issues that cause seniors to avoid interaction and physical activity. – Social Services Provider
>
> Older population, access to gyms, and finances. – Health Care Provider

Affordable Care/Services

> Access to affordable health and wellness locations and health education services. – Community Leader
>
> Cost and time, along with lack of knowledge on how to make lifestyle changes. – Health Care Provider

Income/Poverty

> Finances, education, kitchen skills, and inactivity. – Social Services Provider
>
> Economics and family challenges. – Community Leader

Access to Care/Services

> Not enough easily accessible or affordable services, lack of education, and support for community as whole to help with individua barriers to following a healthy lifestyle and/or lack of motivation of individuals to seek out and use programs/services to support a healthy lifestyle. – Community Leader

Insufficient Physical Activity

> Inactivity and transportation. – Community Leader

Lifestyle

> Inability to access sports/physical activity. Parents working a lot, not aware of available resources, recreation, parks, and lack of education. – Community Leader

Transportation

> Many of the residents don't drive, so they can't get to the grocery store. Many of the residents have mobility issues and need a cane or walker to get around, resulting in a lack of physical activity. Weight is an issue for many of the residents, as they don't have access to fresh produce and don't have the ability to cook healthy meals for themselves. – Community Leader

Lack of Providers

> There are not many nutritionists in the area or dieticians. This is always a very popular topic that our population asks for information about. – Public Health Representative

Attitudes

> Poor attitudes and not believing in any government systems. – Health Care Provider

Focus Group Input: Nutrition, Physical Activity & Weight

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Substance Use

ABOUT DRUG & ALCOHOL USE

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

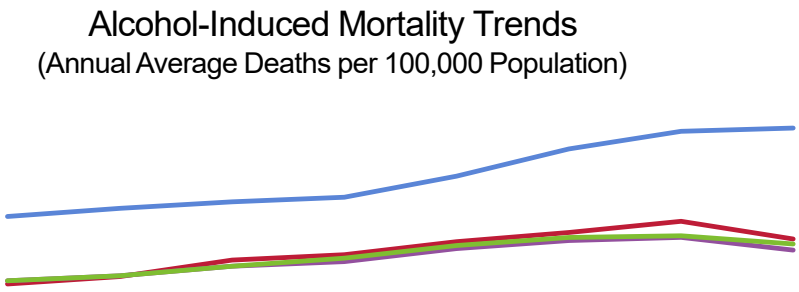
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

Alcohol

Alcohol-Induced Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	6.0	6.5	7.5	7.8	8.6	9.2	9.9	8.8
HMH	6.2	6.5	7.1	7.4	8.2	8.7	8.9	8.1
NJ	6.2	6.5	7.1	7.6	8.4	8.9	9.0	8.5
US	10.2	10.7	11.1	11.4	12.7	14.4	15.5	15.7

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

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

Excessive Drinking

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

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

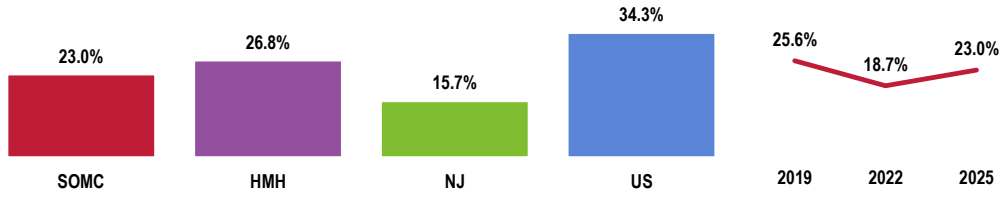
PRC SURVEY ► "Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)**/4** (if female) **or more drinks on an occasion?"**

Excessive drinking includes heavy and/or binge drinkers:

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

Engage in Excessive Drinking

SOMC Service Area



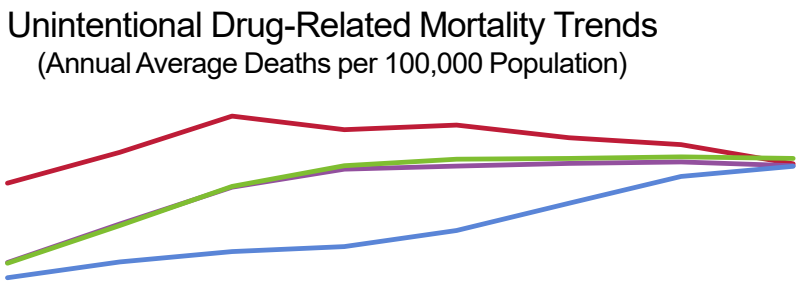
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey,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

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

Drugs

Unintentional Drug-Induced Deaths

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



	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020	2019-2021	2020-2022	2021-2023
SOMC	27.4	31.6	36.6	34.7	35.4	33.6	32.7	30.1
HMH	16.4	21.7	26.8	29.3	29.7	30.1	30.3	29.8
NJ	16.3	21.5	26.9	29.8	30.7	30.8	31.0	30.8
US	14.3	16.5	17.9	18.6	20.8	24.6	28.3	29.7

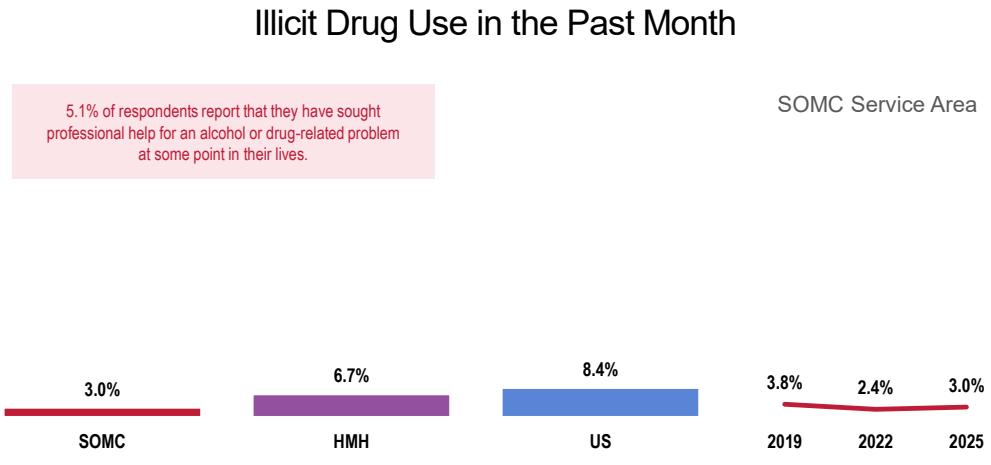
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted April 2025.

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

Illicit Drug Use

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

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



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 40, 42]
- 2023 PRC National Health Survey, PRC, Inc.

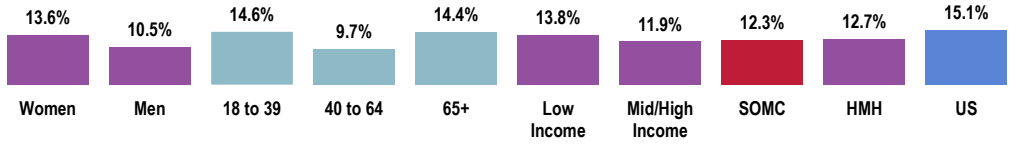
Notes:
- Asked of all respondents.

Use of Prescription Opioids

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

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

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



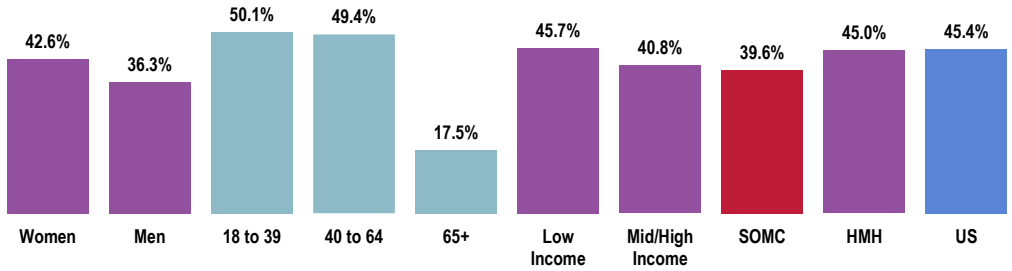
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 41]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Personal Impact From Substance Use

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

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

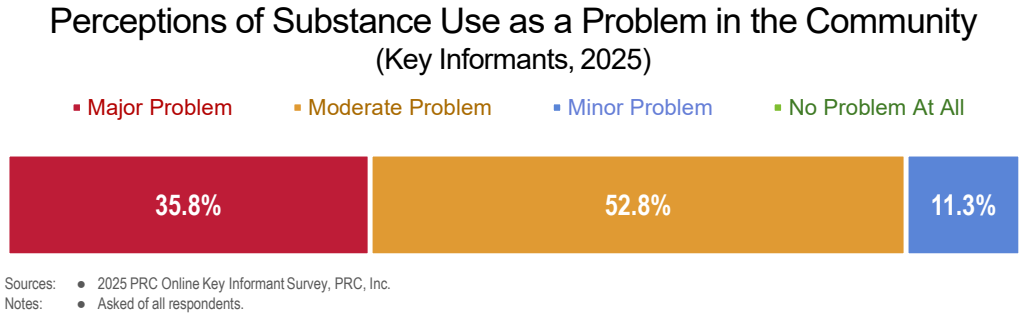


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 43]
- 2023 PRC National Health Survey, PRC, Inc.

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

Key Informant Input: Substance Use

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



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

Denial/Stigma

> Stigma, denial, and financial constraints. – Community Leader
>
> Stigma and availability, especially for those without private insurance. – Social Services Provider
>
> Individuals realizing they need treatment and following up once help is offered. – Community Leader
>
> People's desire to stop. Finances to get help in a hospital. The person has to be intoxicated; they can't just ask for help. – Social Services Provider
>
> Stigma and medication-assisted treatment is not accepted at the Mission homeless shelter. – Health Care Provider

Easy Access

> Accessibility, new substances constantly being introduced into the community, people starting to use younger, and cost. – Public Health Representative
>
> Legal marijuana is used by minors all different times of the day or at different locations. – Health Care Provider

Transportation

> Transportation and family support. – Community Leader
>
> In my opinion, transportation to treatment programs and payment for treatment services are both crucial factors that need to be addressed. – Social Services Provider

Awareness/Education

> Big misconception that alcohol is OK to consume in excess of a social drink every now and then. Substance use (including alcohol, drugs, marijuana, tobacco, etc.) put people in positions that they act outside their normal character. Sometimes, the consequences are very difficult or impossible to overcome. Substance use has a major impact on overall health and quality of life. Mixed messages are sent that these are OK to consume. – Public Health Representative

Attitudes

> Appreciating and valuing equality of opportunities. – Social Services Provider

Co-Occurrences

> Mental health deficits cause turn to drugs. Ease of access. – Social Services Provider

Language Barrier

> Language barrier. – Social Services Provider

Focus Group Input: Substance Use

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

- *Environmental exposure to substances*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Tobacco Use

ABOUT TOBACCO USE

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

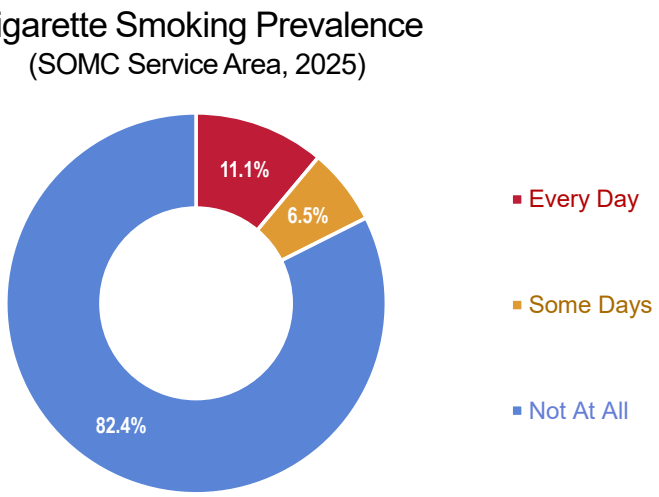
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including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

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

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

Cigarette Smoking

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

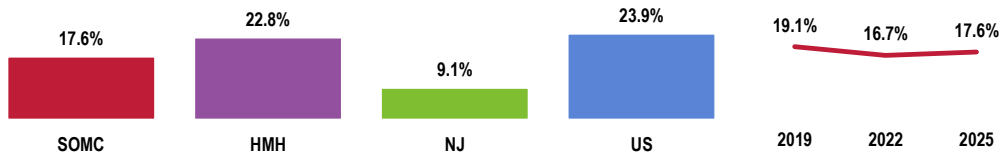


Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: ● Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower

SOMC Service Area



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 34]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Includes those who smoke cigarettes every day or on some days.

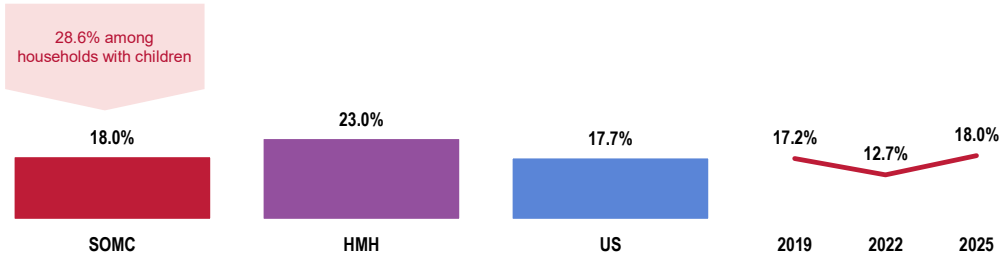
Environmental Tobacco Smoke

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

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

Member of Household Smokes at Home

SOMC Service Area



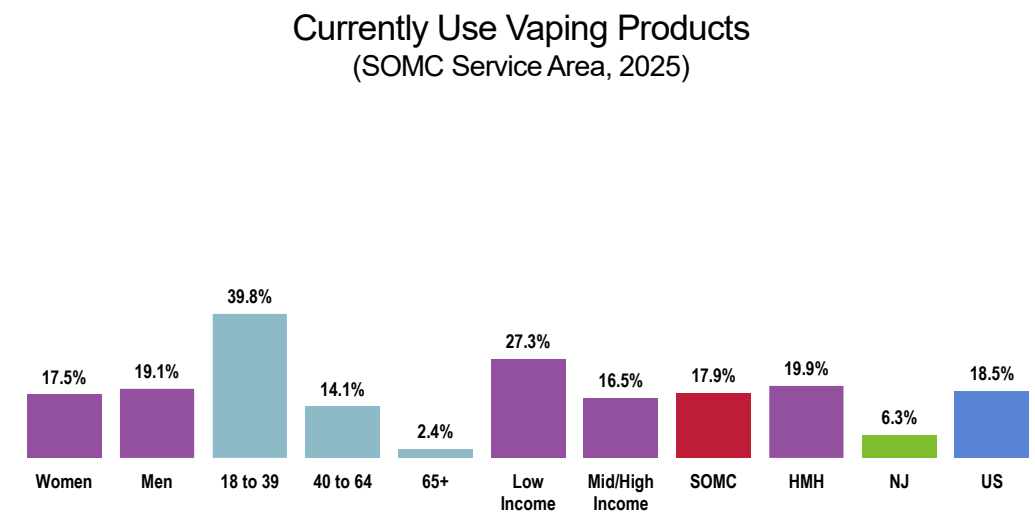
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 35, 114]
- 2023 PRC National Health Survey, PRC, Inc.

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

Use of Vaping Products

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

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

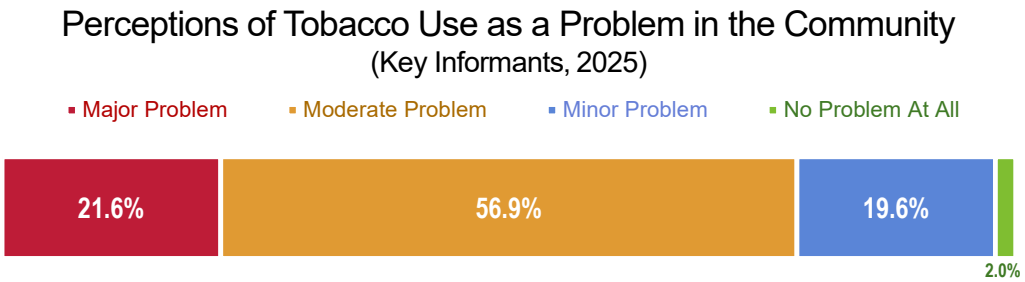


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2023 New Jersey data.
- 2023 PRC National Health Survey,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

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

Key Informant Input: Tobacco Use

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



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

Notes:
- Asked of all respondents.

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

Cancer

> Number of cancer cases diagnosed from smoking. – Community Leader
>
> Tobacco use can increase the risk of many types of cancers and other diseases. – Community Leader

E-Cigarettes

> People go from cigarettes to vapes. Still hurting lungs. – Social Services Provider
>
> E-cigarettes have unfortunately made tobacco use acceptable and used in an increasingly young population. – Health Care Provider

Incidence/Prevalence

> Seeing an increase in use, and it is an unhealthy activity link to many chronic diseases as we age.
> – Public Health Representative

Focus Group Input: Tobacco Use

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

- *Environmental exposure to smoking*

Maternal & Infant Health Focus Groups:

- *Environmental exposure to smoking*

Key Quotes:

Maternal & Infant Health Focus Groups:

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

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

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

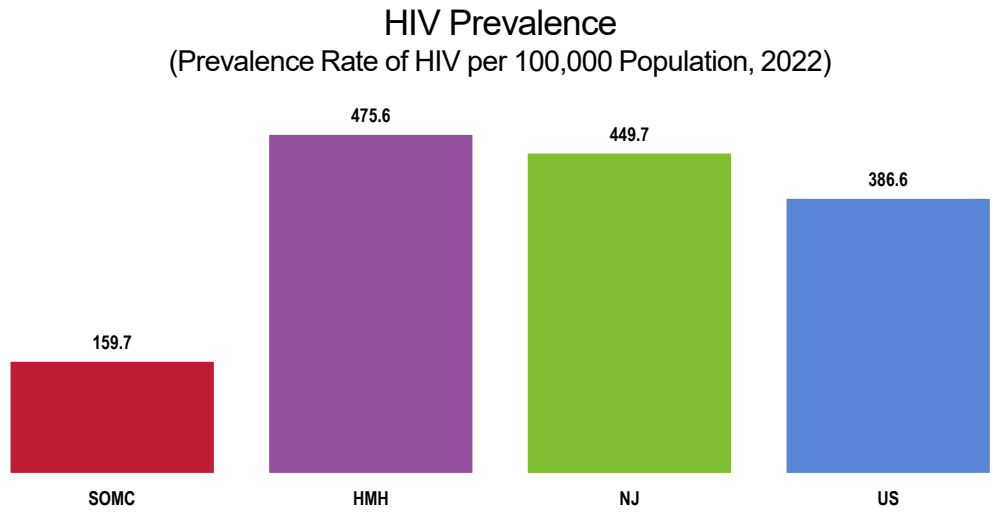
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

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

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

HIV

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



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

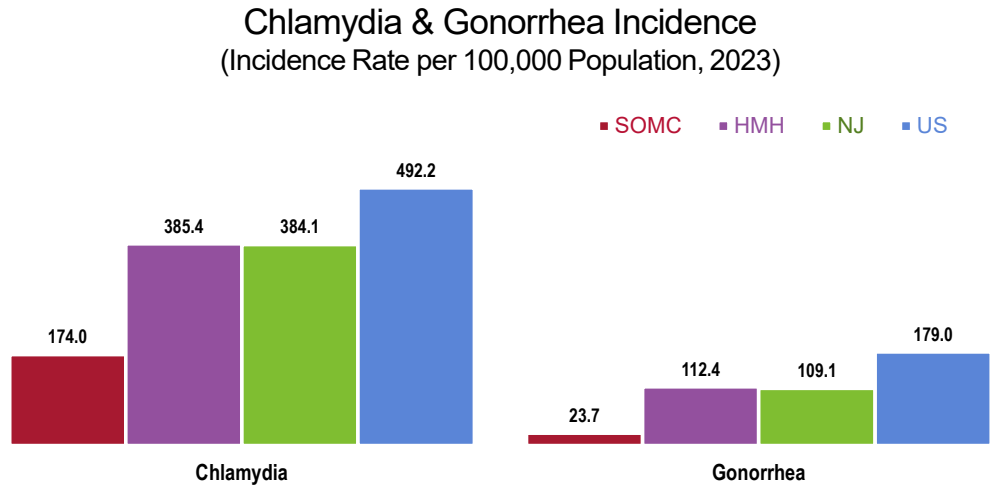
Chlamydia

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

Gonorrhea

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

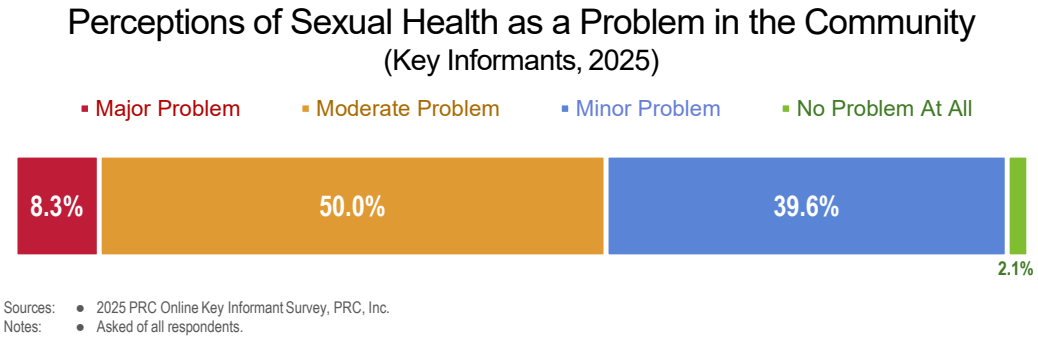
The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

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



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

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

Incidence/Prevalence

> Increasing rates of STDs. – Public Health Representative
>
> Rise in STDs and HIV. – Social Services Provider

Awareness/Education

> Education. – Social Services Provider

Aging Population

> Seniors living in age-restricted communities. – Social Services Provider

Alcohol/Drug Use

> Drug abuse, incest, and economics. – Community Leader

Denial/Stigma

> Fear of finding out you contracted a disease. – Social Services Provider

Focus Group Input: Sexual Health

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

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

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

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

Lack of Health Insurance Coverage

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

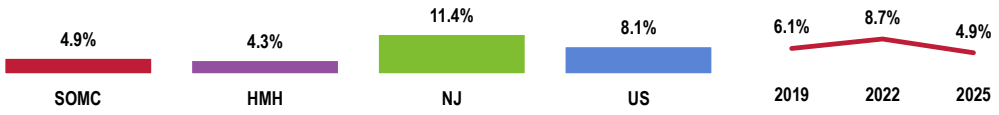
Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

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

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

Lack of Health Care Insurance Coverage
(Adults Age 18-64)
Healthy People 2030 = 7.6% or Lower

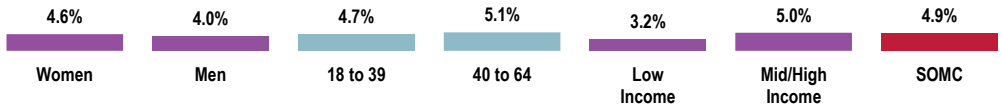
SOMC Service Area



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

Notes:
- Reflects respondents age 18 to 64.

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



Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Focus Group Input: Health Insurance Coverage

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

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

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

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

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

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

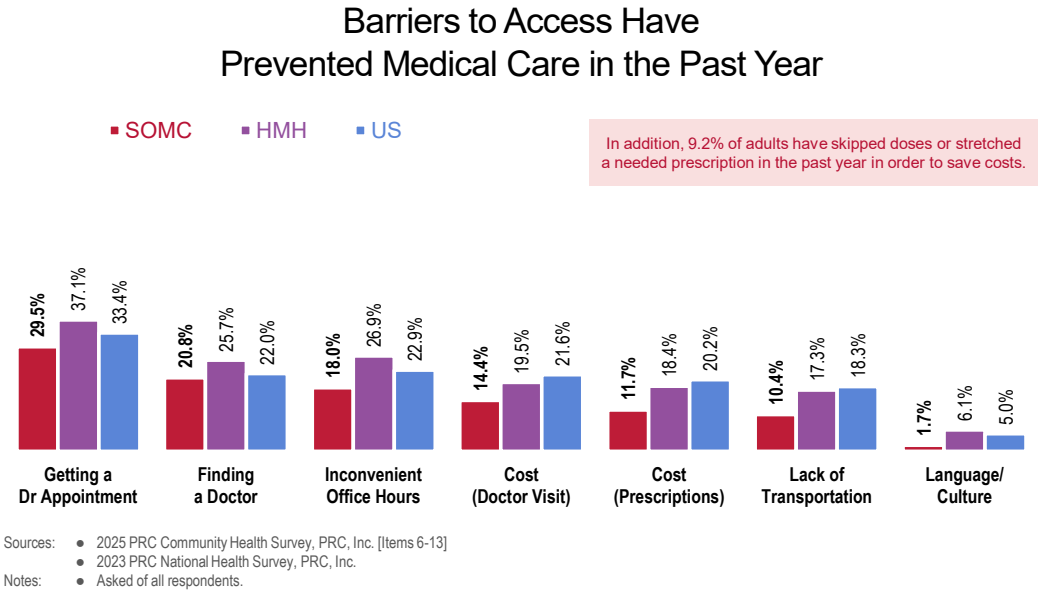
PRC SURVEY ► "Was there a time in the past 12 months when you needed a prescription medicine but did not get it because you could not afford it?"

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

Also:

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

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



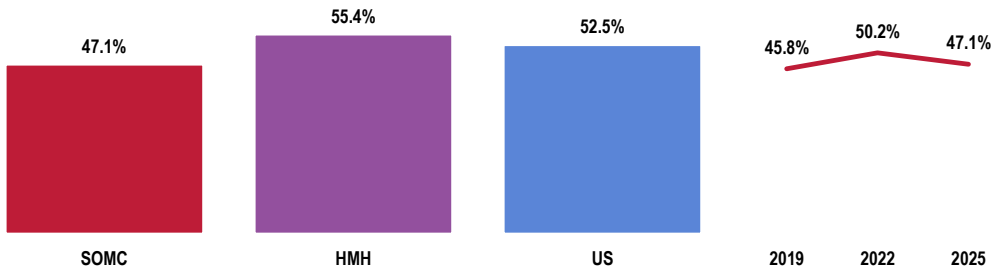
Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

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

SOMC Service Area

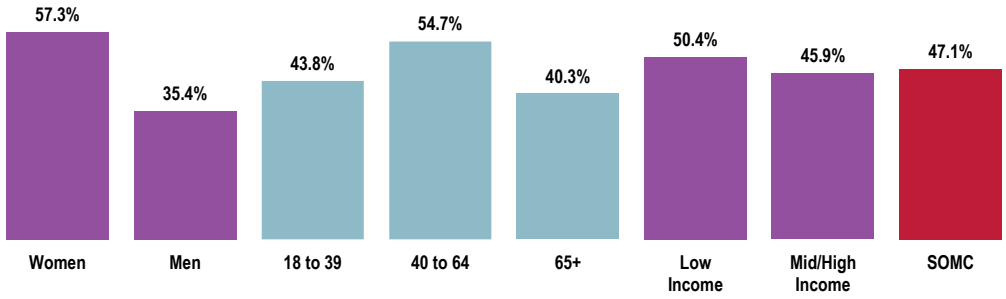


Sources:
- 2025 PRC Community Health Survey, PRC, Inc. [Item 119]
- 2023 PRC National Health Survey, PRC, Inc.

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

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

(SOMC Service Area, 2025)



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

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

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

PRC SURVEY ▶ [Among parents of children age 0-17] **"Was there a time in the past 12 months when you needed medical care for this child but could not get it?"**

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

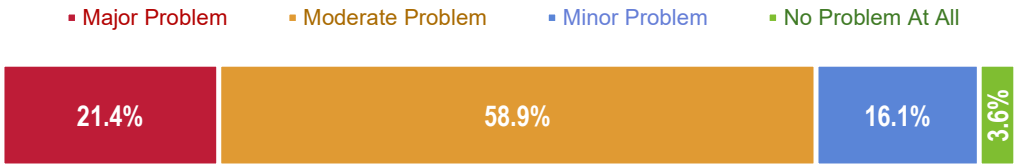
SOMC Service Area

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

Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:

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



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

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

Access to Care/Services

> Access to health care/providers, Ocean County. – Social Services Provider
>
> Limited primary and specialty services. Limited dental services, especially for Medicaid and uninsured patients. – Health Care Provider
>
> Getting timely appointments with physicians. – Social Services Provider

Transportation

> Transportation and finances are major obstacles to accessing health care. Language is an additional challenge. – Health Care Provider
>
> Transportation is inadequate in Ocean County. – Social Services Provider

> Transportation. – Social Services Provider

Affordable Care/Services

> Finances, transportation, and senior assistance. Copays and amounts due before deductibles can be very difficult for many families. People with college-age children are burdened if their child needs health care while at school. A student in need of PT is forced to pay out-of-network costs, when clearly it is impossible for the student to come home three times a week for needed PT. Transportation to providers' offices can be costly for those who do not have a vehicle or for seniors who are no longer able to drive. I have seen patients miss appointments strictly because they do not have transportation. The EZ Ride program exists, but many community members, patients, and families are unaware that the program exists. The "sandwich generation" struggles, as they often are still providing for their children due to the high costs of college and housing. In addition, they are assisting senior loved ones. They struggle to balance work while trying to assist seniors to get to their medical appointments. – Health Care Provider
>
> My biggest challenge in accessing health care services in my community is affordable health care. I currently have Get Covered health insurance, and I pay $700 per month. The coverage is minimal. In 2024, I owe over $7,000 for out-of-pocket health care costs. Due to the out-of-pocket expense, I'm scared to go to urgent care or the ER. – Community Leader

Access to Care for Uninsured/Underinsured

> People that do not have insurance are afraid to see the doctor. It's getting better or paying my rent.
> – Social Services Provider
>
> Many residents without medical insurance or using the hospital for visits that could be handled at an urgent care.
> – Community Leader

Access to Specialty Care

> Specialists, language barrier even with translator, and too many hoops. – Community Leader
>
> Access to neurology, endocrinology, and dermatology. – Physician

Awareness/Education

> Inability to access the systems due to computer literacy challenges. Inability to complete the applications, collect the resources needed to understand what is available. Access and transportation to health care services.
> – Community Leader
>
> Health education, access to doctors, Keansburg and local environment are low-income areas. A large medical bus used to come from the hospital, but that stopped a while ago. – Social Services Provider

Insurance Issues

> Acquiring insurance or knowing how to use what they have. – Social Services Provider

Need More Collaboration

> We need more collaboration; stop mixed messages. We cannot be everything for everybody. We need to stay in our lane and do the best we can with the resources we have to help those who want help.
> – Public Health Representative

Focus Group Input: Access to Health Care Services

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

- *Language barriers*
- *Immigration status fears*
- *Cost barriers*

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

> "Sometimes I'm addressed in a way I wouldn't like to be addressed, wrong pronouns.Their [health care providers] comments and treatment are often very downgrading and it makes us not feel accepted." – LGBTQ+ Focus Group
>
> "There is a large lack of specialists in the community - all of the specialties need to be enhanced." – Caregivers Focus Group
>
> "We need respite services [for caregivers]." – Caregivers Focus Group
>
> "My concerns are about being outed or having one's LGBTQ+ status disclosed without consent, particularly in health care settings." – LGBTQ+ Focus Group
>
> "I wish we didn't have to wait forever till when we no longer see the need to see the medical team because we've somehow found a way to manage symptoms." – LGBTQ+ Focus Group
>
> "For most doctors, you can't get appointments in general. We need additional physicians in the community to support." – Caregivers Focus Group
>
> "We don't really have neurologists here (6 months to get a dementia diagnosis is a very long time)." – Caregivers Focus Group
>
> "There is a need for a navigator/liaison general to the health care system, help with getting appointments, takes forever." – Caregivers Focus Group
>
> "Many people work during the day so hours are hard." – African American Men Focus Group
>
> "Perceived biases within the health care system can erode trust, leading to decreased engagement of health care services." – African American Men Focus Group
>
> "There are racial and ethnic disparities in health care access, quality, and outcomes—particularly among African Americans." – African American Men Focus Group
>
> "We need access to affordable, effective, and reliable health care." – Latinx Men Focus Group
>
> "There is outdated health care infrastructure and technology." – Latinx Men Focus Group

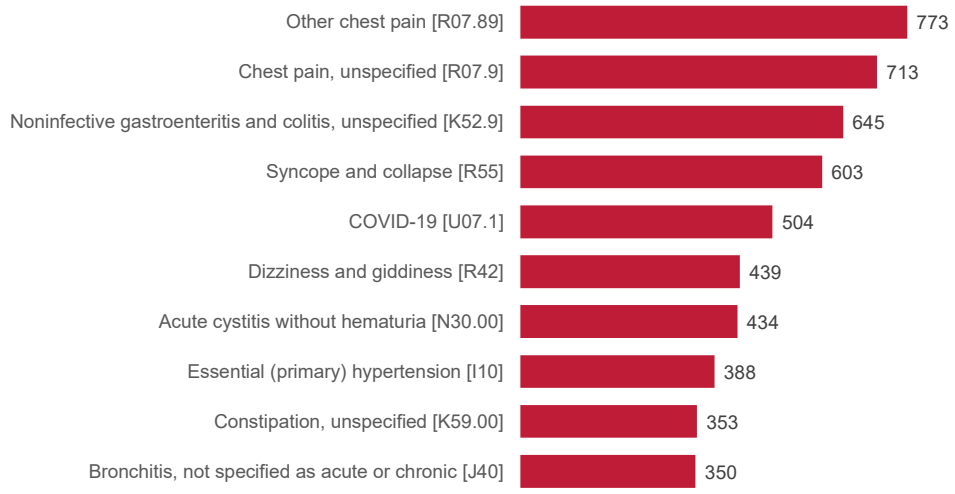
Maternal & Infant Health Focus Groups:

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

Emergency Room Utilization

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

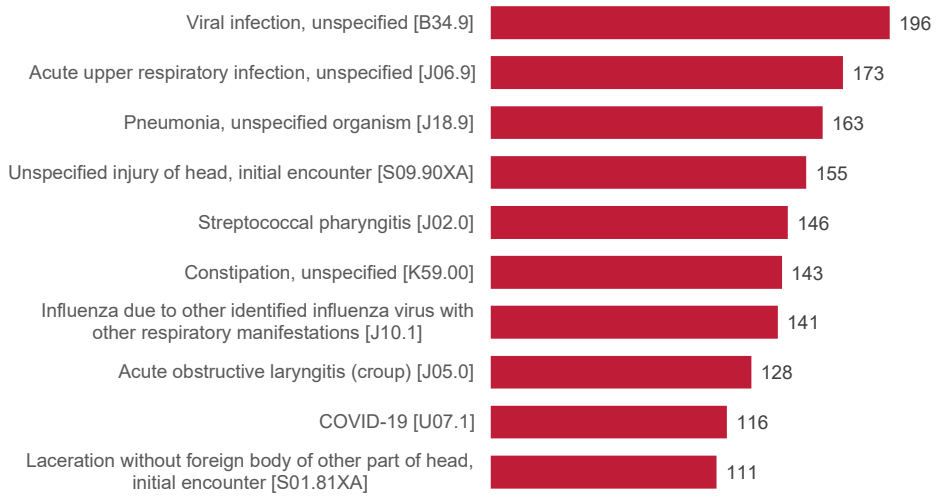
Top 10 Primary Diagnoses of Emergency Department Visits: Adults
(Number of Visits to Southern Ocean Medical Center by Diagnosis, 2024)



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

Sources:
- Hackensack Meridian Health.

Top 10 Primary Diagnoses of Emergency Department Visits: Children
(Number of Visits to Southern Ocean Medical Center by Diagnosis, 2024)



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

Sources:
- Hackensack Meridian Health.

Focus Group Input: Emergency Room Utilization

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

Primary Care Services

ABOUT PREVENTIVE CARE

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

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

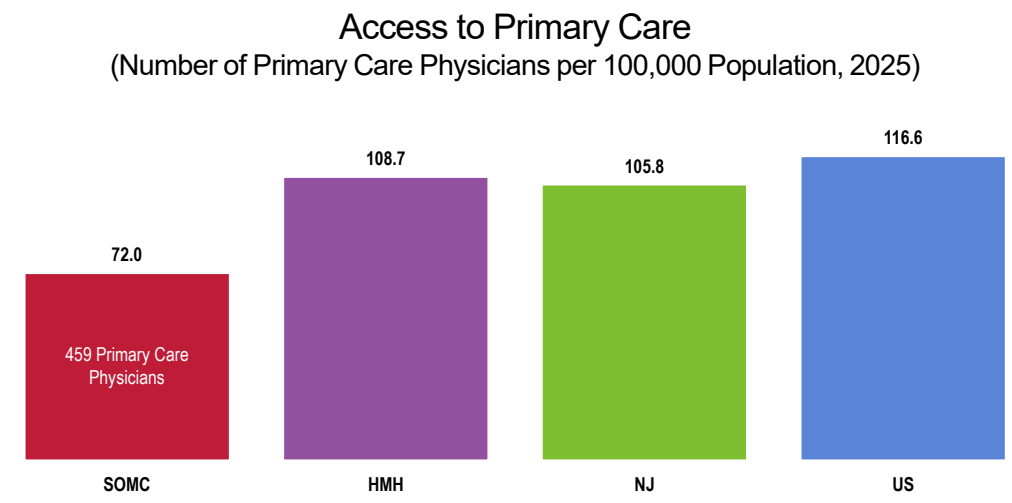
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

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

Access to Primary Care

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

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

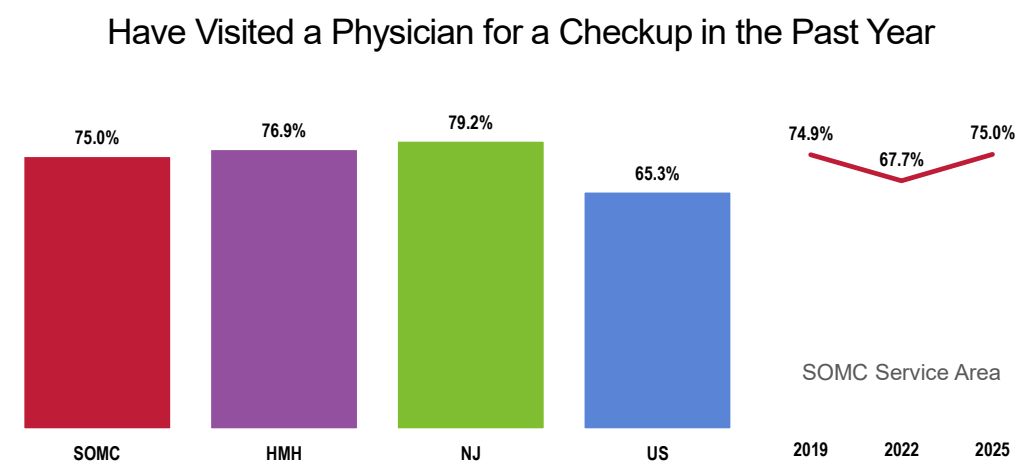


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved April 2025 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

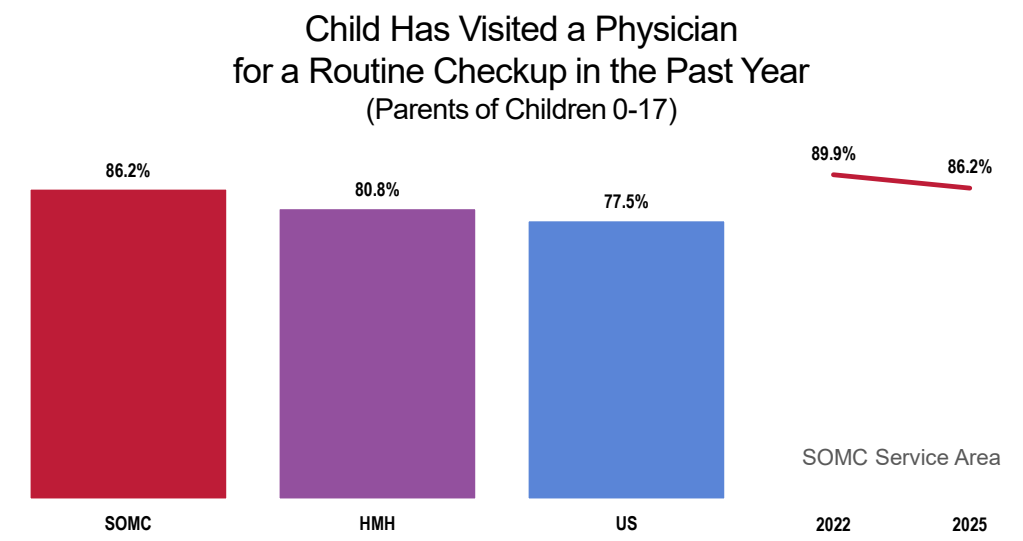
PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



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

Notes:
- Asked of all respondents.

PRC SURVEY ► [Among parents of children age 0-17] **"About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"**



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

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

Focus Group Input: Primary Care Services

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

- *Limited access to primary care doctors*

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

- *Children with Medicaid*

Key Quotes:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Oral Health

ABOUT ORAL HEALTH

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

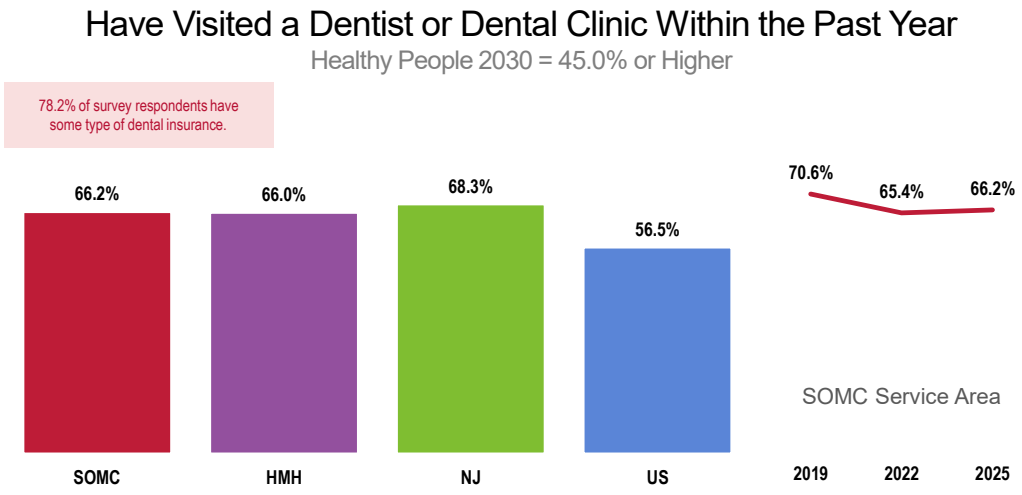
Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching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

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

Dental Care

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

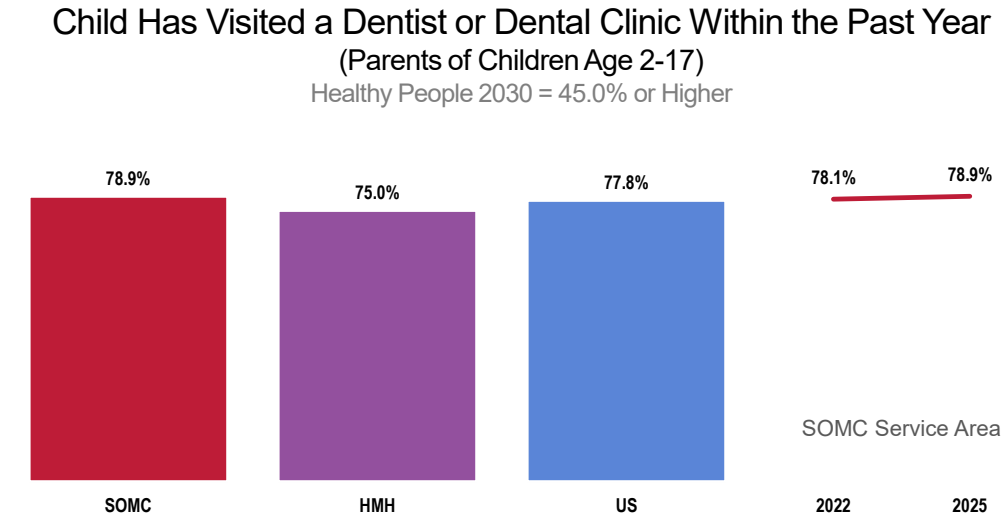
PRC SURVEY ► "Do you currently have any health insurance coverage that pays for at least part of your dental care?"



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

Notes:
- Asked of all respondents.

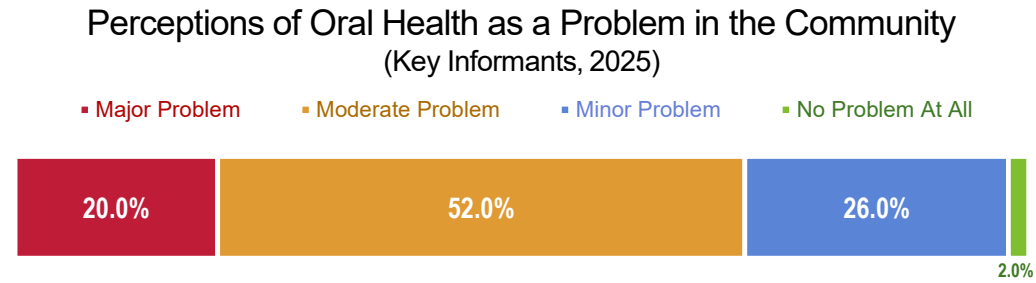
PRC SURVEY ▶ [Among parents of children age 2-17] **"About how long has it been since this child visited a dentist or dental clinic?"**



Sources: ● 2025 PRC Community Health Survey, PRC, Inc. [Item 93]
● 2023 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

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



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

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

Insurance Issues

> Many adults don't have access to dental providers. They may not have insurance, or they cannot find a provider that accepts Medicaid. Many parents who don't have a history of oral health don't bring their children to the dentist. Many immigrant families don't have the knowledge to navigate those services until the problem gets so bad that it is an oral emergency. – Community Leader
>
> Lack of access to affordable dental insurance premiums and comprehensive coverage for dental procedures. – Social Services Provider
>
> Lack of dental coverage, and dentists are expensive. – Social Services Provider
>
> Over a third of those living in Monmouth County do not have dental insurance. Dental care is expensive, and the cost is a barrier to care. The cost of care and transportation are major obstacles for those members of our community who are under-resourced. – Health Care Provider

Income/Poverty

> Economics and lack of general education about the importance of oral health. – Community Leader

Affordable Care/Services

> People need more dental appointments without breaking the bank. – Social Services Provider

Aging Population

> Oral health is a major problem for our senior population because Medicare doesn't cover dental, and many seniors need but cannot afford dental care. Ultimately, their poor oral health ends up contributing to other health-related issues. – Social Services Provider

Fear

> Fear of pain, finances. Poor oral health leads to heart disease and malnutrition. – Social Services Provider

Nutrition

> Unhealthy food and high sugar consumption are prevalent, lending to increased caries. Lack of easy accessibility to dental care makes treatment options hard to find. – Health Care Provider

Focus Group Input: Oral Health

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

LOCAL RESOURCES

Perceptions of Local Health Care Services

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

Perceive Local Health Care Services as "Fair/Poor"

SOMC Service Area

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

Community Education & Outreach

Focus Group Input: Community Education & Outreach

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Cultural Competence

Focus Group Input: Cultural & Racial Aspects of Care

Biggest Issues, Challenges, and Barriers:

Access & Utilization Focus Groups:

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

Maternal & Infant Health Focus Groups:

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

Sub-Populations with Health Care Access Barriers:

Access & Utilization Focus Groups:

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

Key Quotes:

Access & Utilization Focus Groups:

> "Providers don't look like patients of color." – African American Men Focus Group
>
> "Health care disparities among minority populations: racial and ethnic disparities in health care access, quality, and outcomes—particularly among African Americans." – African American Men Focus Group

> “There is decreased trust in the health care system which is a negative experience, and perceived biases within the health care system can erode trust, leading to decreased engagement of health care services.” – African American Men Focus Group
>
> “We need more affordable and culturally sensitive health care services, expanded mental health support, and accessible education on preventive care.” – Latinx Men Focus Group
>
> “I’m scared of discrimination and the stigma—like when the nurses expect that as a Black gay man, I’m likely an HIV patient.” – LGBTQ+ Focus Group

Maternal & Infant Health Focus Groups:

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

Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Bayshore Medical Center
- Black Concerned Nurses
- Caregiver Volunteers of Central Jersey
- Central Jersey Club
- County Health Services
- County Transportation
- EZ Ride Program
- Federally Qualified Health Centers
- Hackensack Meridian Health
- Monmouth Medical Center
- Neighbor Helping Neighbor
- Neighborhood Connections to Health
- Ocean Ride
- Parker Clinic
- Parker Family Health Center
- Riverview Medical Center
- School System
- Senior Community Bussing
- Social Services
- Uber Health
- Urgent Cares
- Visiting Nurse Association

Cancer

- American Cancer Society
- Bikur Cholim of Lakewood
- Center for Environmental Exposures and Disease Program
- CentraState Medical Center
- Charity Care
- Chia Lifeline
- Doctors' Offices
- Emergency Services
- Grocery Stores
- Hackensack Meridian Health
- Health Department
- Hospitals
- Jersey Shore University Medical Center
- Leon Hess Cancer Center
- Mary's Place
- Memorial Sloan Kettering Cancer Center
- New Jersey Caregivers
- Nonprofit Community
- Ocean County Health Department
- Ocean Ride
- Paint the Town Pink
- Rofeh Cholim Cancer Society
- Riverview Medical Center
- Rutgers
- RWJ
- Sloan Kettering
- Supplemental Nutrition Assistance Program
- Support Groups
- Town BOH
- University of Pennsylvania
- Visiting Nurse Association
- Walk-In Facilities
- YMCA

Diabetes

- Bayshore Medical Center
- Caroline Huber Holistic Wellness Center
- Community Services Inc of Ocean County
- Diabetes Foundation
- Dispensary of Hope
- Doctors' Offices
- Federally Qualified Health Centers
- Fitness Centers/Gyms
- Food Banks/Pantries
- Fulfill
- Hackensack Meridian Health
- Health Department
- HM Jersey Medical Center
- Hospitals
- Jane Booker Family Health Center
- Juvenile Diabetes Research Foundation
- Libre
- Lunch Break
- Monmouth Medical Center
- New Jersey 211 Diabetes Prevention and Management Programs
- Nutrition Counseling
- Ocean County Health Department

- Ocean Health Incentive
- Online Resources
- Pharmaceutical Assistance to the Aged and Disabled
- Parker Family Health Center
- Ritesh Shah Charitable Pharmacy
- RWJ
- School System
- State Pharmaceutical Supplemental Programs
- Visiting Nurse Association
- Walk-In Facilities
- YMCA

Disabling Conditions

- Alzheimer's Association
- Alzheimer's New Jersey
- Caregiver Volunteers of Central Jersey
- Central Jersey Caregivers
- Chronic Pain Management
- Clubhouses
- Doctors' Offices
- Farmers' Markets
- Federally Qualified Health Centers
- Hands for All
- Handy Andy
- Home Care Services
- Hospitals
- Jersey Shore University Medical Center
- Just Believe
- Meals on Wheels
- Monmouth County Human Services Department
- Monmouth Medical Center
- New Jersey Human Services
- Northern Ocean Habitat for Humanity
- Ocean County Library
- Ocean Inc
- Ocean Ride
- Outpatient Rehab Facilities
- Parks and Recreation
- Return to Driving Programs
- Saint Francis Center
- Senior Centers
- Senior Services
- State Chapters of National Topics
- Support Groups
- Visiting Angels

Heart Disease & Stroke

- American Heart Association
- Cardiac Care
- CentraState Medical Center
- Charity Care
- Doctors' Offices
- Farmers' Markets
- Hackensack Meridian Health
- Heart Specialists of New Jersey
- Hospitals
- ImageCare
- Jersey Shore
- Jersey Shore Meridian Health
- Jersey Shore University Medical Center
- JRI
- Library
- Monmouth Cardiology
- Monmouth Medical Center
- Neptune Aquatic Center
- New Jersey Department of Health
- Ocean County Health Department
- Parker Family Health Center
- Parks and Recreation
- Pharmacy Assistance Programs
- PHB Classes
- Ritesh Shah Charitable Pharmacy
- RWJ
- Screenings Through Community Based Organizations
- Subacute Facilities
- Support Groups
- Visiting Nurse Association
- YMCA

Infant Health & Family Planning

- Bayshore Medical Center
- Doctors' Offices
- Family Planning Centers
- Federally Qualified Health Centers
- Hospitals
- Jane Booker Family Health Center
- School System
- Visiting Nurse Association

Injury & Violence

- 180 Turning Lives Around
- Community Affairs and Resource Center
- CPC Integrated Health
- Drug and Gun Take Back Programs
- Family Planning Centers
- Family Resource Centers
- Jersey Shore University Medical Center
- Law Enforcement
- Mercy Center

- Monmouth Child Advocacy Center
- Monmouth County Domestic Violence Program
- Monmouth County Prosecutor Office
- Monmouth Medical Center
- Pediatric Trauma Injury Prevention
- Project Heal
- School System
- Trauma Injury Prevention
- Turning Lives Around
- Unemployment Offices

Mental Health

- 988
- Behavioral Health Resource Book
- Bright Harbor
- Catholic Charities
- Community Based Organizations
- County Department of Mental Health
- County Division of Behavioral Health Resources
- County Programs
- CPC Behavioral
- CPC Integrated Health
- CredibleMinds
- Crest
- Doctors' Offices
- EAP
- Employee Assistance Programs
- Federally Qualified Health Centers
- Hackensack Meridian Health
- High Focus
- Jersey Shore
- Jersey Shore University Medical Center
- LBI Health Department
- Mental Health Association
- Mental Health Association of Monmouth County
- Monmouth County
- National Alliance on Mental Illness
- NJ4S - Compass
- Ocean County Health Department
- Ocean County Mental Health Board
- Ocean Mental Health Services
- Parker Family Health Center
- Perform Care
- Preferred Behavioral
- Private Therapists
- Psychiatric Emergency Screening Services
- PULSE
- Relief Resources
- RWJ
- Sliding Scale Therapy Offices
- Society for the Prevention of Teen Suicide
- Telehealth
- Visiting Nurse Association
- Work First New Jersey
- YMCA

Nutrition, Physical Activity & Weight

- Boardwalk
- Boys and Girls Clubs
- CentraState Medical Center
- Clubhouses
- Coupon Clubs
- Farmers' Markets
- Federally Qualified Health Centers
- Fitness Centers/Gyms
- Food Banks/Pantries
- Hackensack Meridian Health
- Health Department
- Hospitals
- Insurance Companies
- Lunch Break
- Meals on Wheels
- Media
- Mercy Center
- Monmouth County
- Nutrition Counseling
- Ocean County Health Department
- Outpatient Rehab Facilities
- Parker Clinic
- Parks and Recreation
- PHB Classes
- Riverview Medical Center
- RWJ
- Saint Francis Center
- School System
- Southern Ocean Medical Center
- Supplemental Nutrition Assistance Program
- Therapists
- Visiting Nurse Association
- YMCA

Oral Health

- Dental Offices
- Dental Schools
- Federally Qualified Health Centers
- Hospitals
- Mobile Health Unit
- Monmouth Medical Center
- Ocean Health Initiatives

- Shore Pediatric Dental
- Visiting Nurse Association

Respiratory Diseases

- Federally Qualified Health Centers
- Visiting Nurse Association

Sexual Health

- Doctors' Offices
- Federally Qualified Health Centers
- Health Department
- National Council on Aging
- Ocean County Health Department
- Visiting Nurse Association

Social Determinants of Health

- Affordable Housing
- AP Housing Authority
- Catholic Charities
- Civic Organizations
- Collaborative Support Programs of New Jersey
- Community Affairs and Resource Center
- Faith Communities
- Food Banks/Pantries
- Freehold Open Door
- Fulfill
- Government
- Habcore
- Hackensack Meridian Health
- Hope Center
- HOPE Sheds Light
- Lakewood Resource and Referral
- League of Women Voters
- Lunch Break
- Medicaid
- Monmouth County Division of Social Services
- Northern Ocean Habitat for Humanity
- Ocean County Board of Social Services
- Ocean County College
- Office of Senior Services
- Parker Family Health Center
- Resource Center
- Salvation Army
- School System
- Supplemental Nutrition Assistance Program
- Trinity
- United Methodist Church Backpack Crew
- United Way of Monmouth and Ocean Counties
- Visiting Nurse Association
- Workforce Development Programs

Substance Use

- County Transportation
- CPC Integrated Health
- Discovery Institute
- Doctors' Offices
- High Focus
- HOPE Sheds Light
- Jersey Shore University Medical Center
- Jewish Family Services of Metro West
- Local Programs and Workshops
- Maryville
- Meridian Addiction Recovery Services
- Municipal Alliances
- New Hope Foundation
- Ocean County Health Department
- Private Facilities
- Quantum Outpatient Addiction Treatment Center
- Recover Revolution
- School System
- Sunrise Detox Center
- Support Team for Addiction Recovery
- Visiting Nurse Association
- Work First New Jersey
- YMCA

Tobacco Use

- American Cancer Society
- Municipal Alliances
- New Jersey Quits
- Ocean County Health Department
- RWJ
- School System
- Visiting Nurse Association

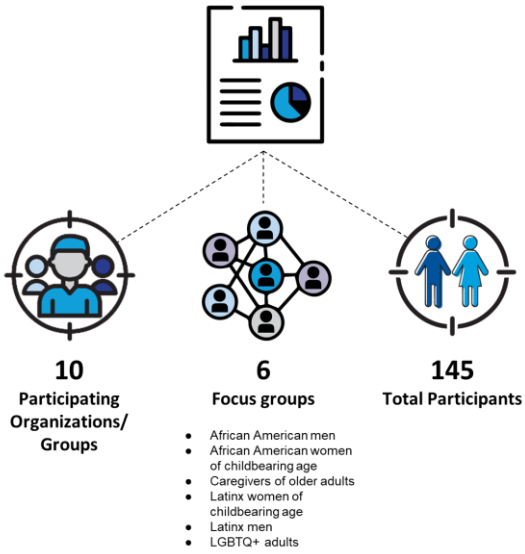
APPENDICES

APPENDIX: FINDINGS FROM COMMUNITY MEMBER FOCUS GROUPS

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

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

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



Overarching Focus Group Questions (Access & Utilization)

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

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

Overarching Focus Group Questions (Maternal & Infant Health)

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

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

Data Analysis

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

Consolidated Summary of Focus Group Input

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

Things People Love About The Community

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

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

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

"I love the diverse community with a mix of cultures and backgrounds."
- African American Women Focus Group

"It feels safe and comfortable."
- Latinx Men Focus Group

"It feels safe and comfortable."
- Latinx Men Focus Group

"I love my community because it feels like home."
- African American Women Focus Group

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

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

"I love that my identity is celebrated and not just tolerated."
- LGBTQ+ Focus Group

Overall Summary

Biggest Community Health Needs:

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

Health Care Access Barriers:

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

Sub-Populations with Health Care Access Barriers:

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

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

Existing Community Resources:

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

Lacking Community Resources:

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

Ideas for Community Health Improvement:

Improve Access and Affordability of Health care Services:

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

Enhance Transportation and Navigation Support:

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

Expand Culturally Competent, Inclusive, and Respectful Care:

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

Strengthen Mental Health, Caregiver, and Family Supports:

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

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

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

Key Quotes:

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

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

Biggest Community Health Needs:

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

Health Care Access Barriers:

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

Sub-Populations with Health Care Access Barriers:

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

Existing Community Resources:

- Hackensack Meridian *Health* urgent care

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

Lacking Community Resources:

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

Ideas for Community Health Improvement:

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

Other Feedback:

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

Key Quotes:

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

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

Biggest Community Health Needs:

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

Health Care Access Barriers:

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

Sub-Populations with Health Care Access Barriers:

- African American women

Existing Community Resources:

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

Lacking Community Resources:

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

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

Ideas for Community Health Improvement:

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

Other Feedback:

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

Key Quotes:

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

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

Biggest Community Health Needs:

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

Health Care Access Barriers:

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

Sub-Populations with Health Care Access Barriers:

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

Existing Community Resources:

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

- Palliative care nurse speakers

Lacking Community Resources:

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

Ideas for Community Health Improvement:

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

Other Feedback:

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

Key Quotes:

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

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

Biggest Community Health Needs:

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

Health Care Access Barriers:

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

Sub-Populations with Health Care Access Barriers:

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

Existing Community Resources:

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

Lacking Community Resources:

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

- Preventive care education and outreach

Ideas for Community Health Improvement:

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

Other Feedback:

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

Key Quotes:

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

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

Biggest Community Health Needs:

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

Sub-Populations with Access Barriers:

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

Existing Community Resources:

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

Lacking Community Resources:

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

Ideas for Community Health Improvement:

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

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

Key Quotes:

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

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

Biggest Community Health Needs:

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

Sub-Populations with Health Care Access Barriers:

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

Existing Community Resources:

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

Lacking Community Resources:

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

- *Homelessness support*
- *Affordable housing initiatives*

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

Ideas for Community Health Improvement:

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

Other Feedback:

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

Key Quotes:

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

APPENDIX:
EVALUATION OF PAST ACTIVITIES

Southern Ocean Medical Center
2023-2025 Evaluation of Impact Report

Background

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

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

- Mental Wellbeing
- Healthy Living
- Access to Care

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

<table>
<tr><th colspan="3">Priority Area: Mental Wellbeing</th></tr>
<tr><th colspan="3">Goal: A community where all people have access to high quality behavioral health care, and experience mental wellness and recovery</th></tr>
<tr><th></th><th>Objectives</th><th>Activity/ Impact Measures</th></tr>
<tr><td>Prevention and Awareness</td><td>Provide universal behavioral health screenings for patients

Continue behavioral health education and increase participation among diverse and vulnerable populations

Support public health in local prevention and emergency initiatives</td><td>● 3,206 patients screened for suicide risk via the Patient Safety Screener-3 (PSS-3) and Ask Suicide-Screening Questions (ASQ) tool who were referred for follow-up
● 25 behavioral health related lectures
Topics include: depression, coping with stress, meditation, mindfulness, and much more
○ 542 community members educated
● 167 Narcan replacement kits distributed to first responders, free of cost. This program has ended as of September 1, 2023, as first responders can now order Naloxone in bulk from the NJ State Department of Human Services.
In partnership with HMH Hospitality Services, local law enforcement, and the NJ Harm Reduction Coalition, HMH Pharmacy is hosting its first network-wide drug take-back day on April 27, 2025. This collaborative initiative aims to provide safe medication disposal and naloxone access to communities across the HMH network as part of the system's commitment to combating the opioid crisis.
● 461 Society for the Prevention of Teen Suicide Mental Health Crisis Toolkits provided to parents of teens</td></tr>
</table>

		Project AWARE: Hackensack Meridian *Health* Southern Ocean Medical Center and Stafford Intermediate School partnered along with local police department L.E.A.D officers (formerly D.A.R.E) and local anti-abuse leaders to present Project Aware, a dramatic presentation that informs and educates sixth-graders about the dangers of drug and alcohol abuse. Through realistic, dramatic presentations of real-life details that connect with students' lives and experiences, students learn the consequences of making bad choices and discover that they have the power to make smart decisions. The one-of-a-kind theatrical program began at the Stafford Theater Arts Center in Manahawkin and continued at the medical center's Emergency Department. The event concluded with a debriefing session in the Beach Plum Conference Room at Southern Ocean Medical Center. ○ **739** students participated ● **400 local students** viewed HMH's **Project Crash,** a Drinking and Driving ED program in collaboration with the Flight Team *Project Crash is an impactful program performed by the Hackensack Meridian Health Air Medical Team, Local Police, Fire and EMS to educate graduating seniors on the devastating consequences of drinking and driving. The demonstration features four high school seniors participating in a realistic, staged drunk driving accident.* *The scene depicts one student killed and two others critically injured, requiring EMS and fire rescue teams to extricate them from the vehicles. To enhance the realism, the student actors wear prom attire and are fully moulaged with lifelike injuries.* *All police, fire, and victim participants have microphones on, allowing the audience of students to hear the raw and emotional communication that occurs during real-life emergency responses. This immersive experience provides a powerful and unforgettable lesson on the dangers of impaired driving.* ● **123** uninsured/underinsured Behavioral Health patients served through HMH's First Thirty Program *The First Thirty Transitions of Care program, developed by HMH, is a groundbreaking initiative addressing the critical needs for underserved, underinsured, and uninsured behavioral and maternal health patients in New Jersey.* *Launched in 2020, the program offers comprehensive support during the crucial time when patients leave the hospital and addresses physical and mental health needs while reducing hospital readmissions and improving follow-up care.* *The First Thirty program provides interventions such as care coordination and access to essential resources, including medications, transportation, and food assistance, while addressing cultural and health literacy barriers to ensure equitable and effective postpartum care.*

Build Capacity	Expand care delivery methods for behavioral healthcare	• **50** peer recovery specialists deployed to patients' bedside *The program provides peer-to-peer bedside counseling with the goal of getting individuals who have been reversed by Narcan into an appropriate treatment program following an opioid overdose*
Strengthen Community Partnerships	Increase, strengthen and evaluate partnerships with community-based organizations	• Participated in **32** coalition/task force meetings to promote collaboration, share knowledge, and coordinate community health improvement activities related to behavioral health issues impacting the community

Priority Area: Healthy Living		
Goal: All people will have access to chronic disease education, screening, and management services to achieve an optimal state of wellness		
	Objectives	**Activity/Impact Measures**
Prevention and Awareness	Continue to provide education and health promotion and increase participation among diverse and vulnerable populations Support public health departments in local prevention and emergency initiatives	• **6,555** wellness screenings provided to community members & **2,098** abnormal results detected. Individuals received counseling on their results and were referred for follow up care as needed. • **174** health education lectures provided by physicians and health care providers that focus on wellness, prevention, chronic and complex conditions, educating **4,743** community members. *Topics include: healthy eating, heart failure, stroke risk factors, the benefits of exercise, and so much more.* • **47** individuals given the knowledge and tools to manage their disease through ***Take Control of Your Health,*** an evidence-based 6-week chronic disease self management program • **1,045** sharp containers dispensed and collected for Diabetes patients through the Syringe Disposal Program **RSV, FLU & COVID-19 Campaign:** The Community Outreach & Engagement team launched a network-wide community education and awareness campaign, tackling the rise in preventable visits to our emergency department (ED) for RSV, flu and other respiratory infections, especially among our pediatric population. The goal was to educate the public about the signs and symptoms of these infections and when and where to seek care. In addition, our health educators distributed **450** reusable digital thermometers to families in need in the SOMC service area.
Build Capacity	Continue to engage, monitor and coordinate care for patients with chronic/complex conditions	• **2** uninsured, indigent patient receiving ongoing treatment through the outpatient Hemodialysis Relief Program • **4** indigent, uninsured patients that received a Cardiac Life Vest upon discharge • **55** support groups held for various topics ○ **507** patients, family members and caregivers supported • **179** uninsured/underinsured Maternal Health patients served through HMH's First Thirty Program *The First Thirty Transitions of Care program, developed by HMH, is a groundbreaking initiative addressing the critical needs for underserved, underinsured, and uninsured behavioral and maternal health* patients *in New Jersey.*

		Launched in 2020, the program offers comprehensive support during the crucial time when patients leave *the hospital and addresses physical and mental health needs while reducing hospital readmissions and improving follow-up care.* *The First Thirty program provides interventions such as care coordination and access to essential resources, including medications, transportation, and food assistance, while addressing cultural and health literacy* barriers *to ensure equitable and effective postpartum care.*
Strengthen Community Partnerships	Increase, strengthen and evaluate partnerships with community-based organizations	• Participated in **58** coalition/task force meetings to promote collaboration, share knowledge, and coordinate community health improvement activities related to chronic and complex conditions

Priority Area: Access to Care		
Goal: All people will have the opportunity to be as healthy as possible, regardless of where they live, work or play		
	Objectives	**Activity/Impact Measures**
Prevention and Awareness	Reduce common barriers to accessing health care for diverse and vulnerable populations Strengthen cultural competency training for team members and physicians	• **101,519** patients screened for social determinants of health and referred to community-based resources via UniteUs, a referral platform. • **548** patients assisted in Medicaid health insurance enrollment • **54,203** discharge patients who received free prescriptions through our Meds to Bed program • **353** RXs provided through the Dispensary of Hope The *Dispensary of Hope provides free prescriptions to discharged patients who do not have pharmacy benefits and are 300% below the poverty line. SOMC had its first patient in the first quarter of 2023.* • **32** Lyft rides provided to patients in need, free of charge • **94.37%** Unconscious Bias in the Workplace e-learnings completed for new hire hospital clinicians and staff
Build Capacity	Develop and leverage alternative care delivery models to improve access to care for all	• **11,321** telehealth appointments conducted in 2023-2024 • **5** Mini Medical School sessions offered to High School students to learn about career options in health care ○ **45** high school students educated
Strengthen Community Partnerships	Increase, strengthen and evaluate partnerships with community-based organizations	• Participated in **5** coalition/task force meetings to promote collaboration, share knowledge, and coordinate community health improvement activities related to access to care • **3,020** community organizations and **14,714** programs available through the UniteUS database, including those sourced through our collaborative efforts