2022 Community Health Needs Assessment

December 2022

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Our Commitment to Community Health

Compassion is at the heart of Deborah's Mission, reflected in its founders' motto: "There is no price on life." For 100 years, Deborah has cared for those in need, regardless of race, creed, color, national origin, nationality, ancestry, age, sex, familiar status, marital/civil union status, religion, domestic partnership status, affectional or sexual orientation, gender identity and expression, atypical hereditary, cellular or blood trait, genetic information, liability for military service, and mental or physical disability (including perceived disability, and AIDS and HIV status). We believe that no one should have to make a medical decision based on their personal financial situation. Deborah is the only hospital in the nation that treats both adults and children and that has never balance billed a patient for care provided in the hospital. Deborah is also active in our local communities and service areas, providing community-based health and wellness programs. Deborah represents the best of the traditional nonprofit hospital and serves as a regional safety net for exceptional cardiovascular and pulmonary services and care.

Our Mission and Vision

The Deborah Mission is to provide the necessary facilities, equipment, medical staff and financial resources required to deliver the highest quality inpatient and outpatient services for the diagnosis and treatment of heart, lung and vascular disease within the Center's service area. The Center realizes its obligation to provide the highest degree of patient safety and privacy and, to that end, will embrace and advocate all initiatives that enable us to attain these goals. The Center will provide these medical and surgical treatments to patients without distinction as to race, gender, sexual preference, creed, color, religion, age, national origin, handicap, or ability to pay. Inpatient and outpatient services are to be provided on a timely basis and consistent with cost-effectiveness and financial responsibility.

The Deborah Vision is to lead the Region as the premier provider of high quality innovative, compassionate and patient-focused heart, lung and vascular care, as a respected educator of the next generation of specialists, and as a thought leader in advanced clinical research.

Our Story

Deborah Heart and Lung Center is New Jersey's premier provider of high-quality heart, lung and vascular care that is innovative, compassionate, and patient-focused. The Deborah Story traces its history back to 1922 when the hospital was founded as a tuberculosis sanatorium and pulmonary center. Thousands of TB patients were medically treated and successfully cured by a heroic team of Deborah physicians driven by compassion.

With the development of antibiotic treatments like streptomycin and the eradication of TB, Deborah began expanding its focus to other chest diseases. Dr. Charles Bailey, a pioneer in heart surgery, performed the hospital's first open-heart surgeries in 1958 (one on an adult and one on a child), which were also the first procedures of their kind in New Jersey. The specialization in cardiac diseases was immediately embraced, and with a natural expansion to include vascular surgery and care, Deborah is now New Jersey's only heart, lung and vascular specialty hospital.

Today, Deborah offers leading-edge surgical techniques and non-surgical procedures for diagnosing and treating all forms of heart, lung and vascular diseases in adults, as well as congenital and acquired heart defects in adults and children.

Deborah Heart and Lung Center is proud of its alliance with the Cleveland Clinic Heart, Vascular & Thoracic Institute. Cleveland Clinic is ranked #1 in the nation for heart care since 1995 by U.S. News and World Report. This affiliation allows for the sharing of best practices, enhancing opportunities to provide new treatments and therapies to patients, as well as exploring cutting-edge technologies and techniques in cardiac care that accelerate advances in heart and vascular treatments for patients in Deborah's service area.

We believe in partnerships and collaborations with organizations that share the same commitment to improving the health of the community. This strengthens the entire continuum of care for patients from enhancing access to important services to providing patient-centered care.

Partnering with Capital Health, Cooper University Health Care, Ivy Rehab, SerenaGroup and Sidney Kimmel Medical College at Thomas Jefferson University to provide care to our patients, the Deborah campus is a health and wellness resource. We serve together to bring high-quality compassionate care close to home.

2022 Community Health Needs Assessment

Every three years, Deborah conducts a Community Health Needs Assessment (CHNA) to better understand and respond to the health and wellness concerns of our community. The 2022 CHNA builds upon previous assessments and will continue to guide our community benefit and community health improvement efforts. The CHNA also supports the many programs provided by our community health and social service partners.

To learn more about Deborah's work to improve the health of our community, visit our website or contact Cyndy Kornfeld, Director, Volunteer Services at Deborah.

2022 CHNA Executive Summary

CHNA Leadership

The development of the 2022 CHNA was managed by a planning committee comprised of representatives of Deborah Heart and Lung Center. These individuals serve in key roles at the hospital and, in some cases, as liaisons between Deborah and our community partners.

- Christine Carlson-Glazer, Vice President Government and Community Relations
- Brian Case, Vice President of Strategic Planning and Business Development
- Linda Barrientos, Director of Finance
- Cynthia Kornfeld, Director Volunteer Services
- Donna McArdle, Marketing and Public Relations Liaison

Deborah engaged Community Research Consulting (CRC) to assist with the data collection necessary for Deborah to complete its CHNA. CRC is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. Their interdisciplinary team of researchers and planners have worked with hundreds of health and human service providers and their partners to reimagine policies and achieve measurable impact.

Community Research Consulting LLC

Methodology and Community Engagement

The 2022 CHNA included quantitative research and community conversations to determine health trends and disparities affecting residents of the Deborah service area. Through a comprehensive view of statistical health indicators and community stakeholder feedback, a profile of priority areas was determined. The findings will guide Deborah in its assessment of its health improvement efforts, as well as serve as a community resource for grant making, advocacy, and to support the many programs provided by Deborah's health and social service partners.

Community engagement was an integral part of the 2022 CHNA. In assessing community health needs, input was solicited and received from persons who represent the broad interests of the community served by Deborah, as well as underserved, low-income, and minority populations. These individuals provided wide perspectives on health trends, expertise about existing community resources available to meet those needs, and insights into service delivery gaps that contribute to health disparities and inequities.

The following research methods were used to determine community health needs:

- Statistical analysis of health and socioeconomic indicators
- Electronic Key Stakeholder Survey, including health and social service providers, community and public health experts, civic and religious leaders, and policy makers and elected officials
- Electronic and paper Community Member Survey to better understand and respond to the health needs of community residents, available electronically and in paper format

- Partner Meeting conducted with community agency representatives to garner insight on community health challenges and opportunities for partnership
- Focus groups with consumers to inform community health improvement strategy

Community Health Priorities

To work on issues of health equity and improving health outcomes, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs within the community. Priorities were determined by the Deborah CHNA planning committee, taking into consideration research findings and feedback from community stakeholders.

Using feedback from community partners and stakeholders and taking into account the hospital's expertise and resources, Deborah will focus efforts on the following community health priorities as part of its 2022-2025 Community Health Improvement Plan:

- Access to care and services
- Chronic disease prevention and management
- Issues of aging and well-being

Board Approval

The 2022 CHNA was conducted in a timeline to comply with IRS Tax Code 501r requirements that a hospital conduct a CHNA every three years as set forth by the Affordable Care Act (ACA). The research findings set forth in this report will be used to guide Deborah's community benefit initiatives and will be a resource that can be used to engage local partners to collectively address identified health needs.

Deborah is committed to advancing initiatives and community collaboration to support the issues identified through the CHNA. The 2022 CHNA report was presented to the Deborah Board of Trustees and approved in accordance with its Bylaws, effective December 29, 2022.

Following the Board's approval, the CHNA report was made available to the public via the website at https://demanddeborah.org/.

Deborah's Service Area

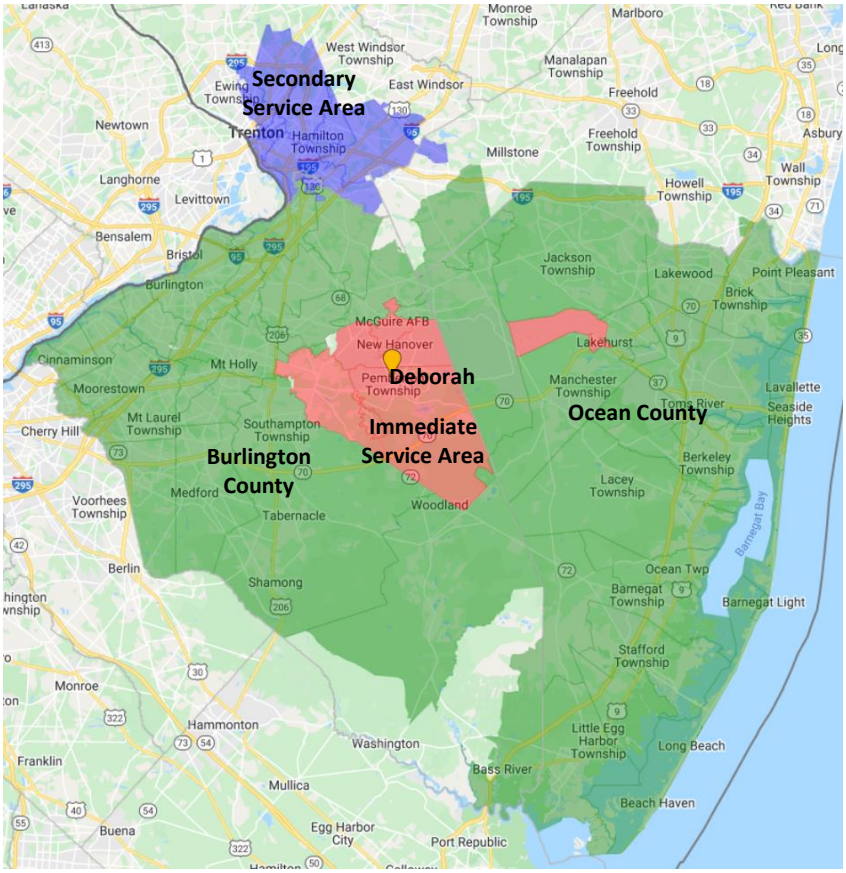
Deborah is located in Browns Mills in Burlington County, New Jersey. As a highly specialized medical provider providing care at or above national benchmarks, Deborah draws patients from every area of New Jersey and beyond. For the purposes of the 2022 CHNA, Deborah defined its service area as including three distinct geographies:

1. Immediate Service Area – the community in which Deborah is physically located, including Pemberton Township and Borough, Browns Mills, New Lisbon, Birmingham, Wrightstown, and the Joint Base McGuire-Dix-Lakehurst.

2. Primary Service Area – this is the heart of Deborah's patient population and includes the remainder of Burlington County (separate from the Immediate Service Area) and all of Ocean County.

3. Secondary Service Area – while the majority of Deborah's patient population resides within Burlington and Ocean counties, a growing number reside within neighboring Mercer County zip codes. Demographic and socioeconomic data are included for these neighboring zip codes to better understand existing social determinants of health and drivers of healthcare utilization.

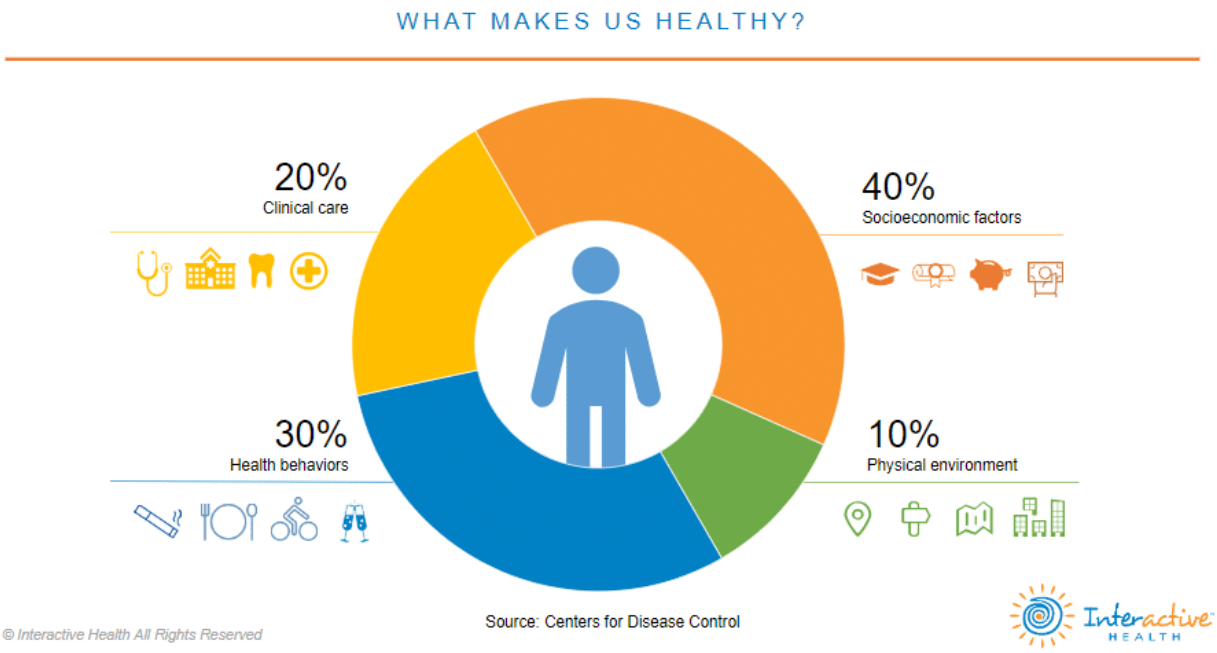
Deborah Heart and Lung Center Service Area



Social Determinants of Health: The connection between our communities and our 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 risks and outcomes. Healthy People 2030, the CDC's national benchmark for health, recognizes SDoH as central to its framework, naming "social and physical environments that promote good health for all" as one of the four overarching goals for the decade. Healthy People 2030 outlines five key areas of SDoH: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

The mix of ingredients that influence each person's overall health profile include individual behaviors, clinical care, environmental factors, and social circumstance. While health improvement efforts have historically targeted health behaviors and clinical care, public health agencies, including the US Centers for Disease Control and Prevention (CDC), widely hold that at least **50% of a person's health profile is determined by SDoH.**



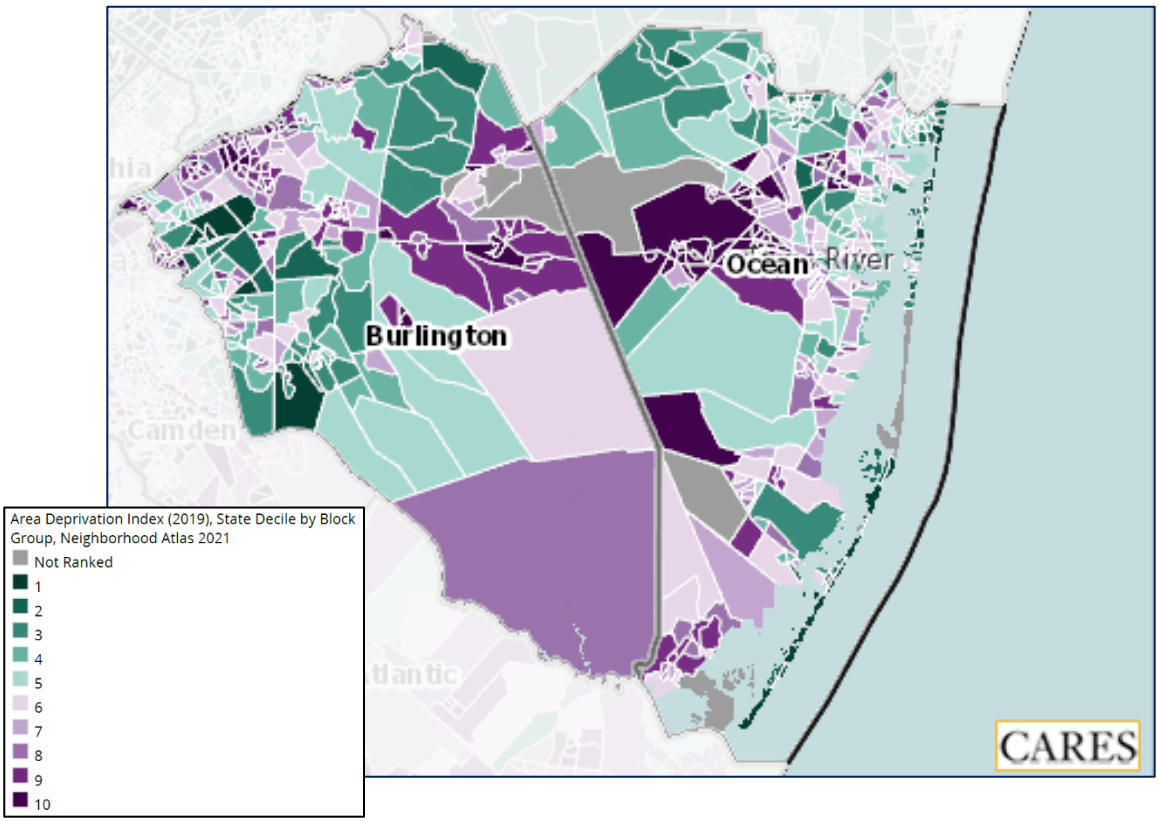
Addressing SDoH is a primary approach to achieving *health equity.* Health equity encompasses a wide range of social, economic, and health measures but can be simply defined as "a fair opportunity for every person to be as healthy as possible." In order to achieve health equity, we need to look beyond the healthcare system to dismantle systematic inequities born through racism and discrimination like power and wealth distribution, education attainment, job opportunities, housing, and safe environments, to build a healthier community for all people now and in the future.

Understanding Health Equity

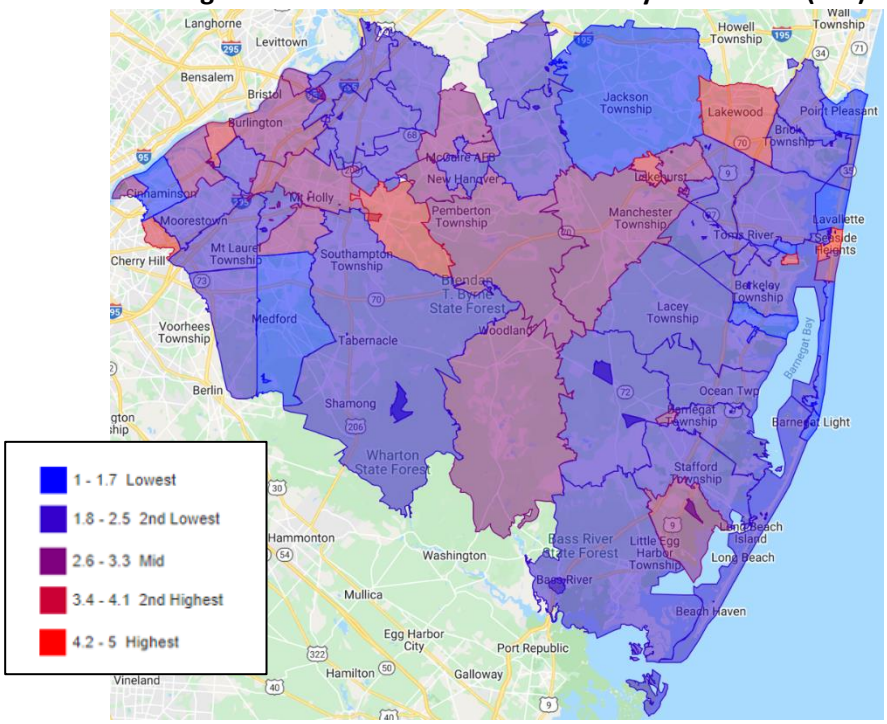
A host of indexes are available to illustrate the potential for health disparities and inequities at the community-level based on SDoH. A description of two available indices, the Area Deprivation Index and Community Need Index, is provided below followed by data visualizations of each tool that show how well residents of Deborah's service area fare compared to state and national benchmarks.

- **Area Deprivation Index (ADI)**: The ADI provides a census block group measure of socioeconomic disadvantage based on income, education, employment, and housing quality. ADI scores are displayed at the block group level on a scale from 1 (least disadvantaged) to 10 (most disadvantaged). A block group is a subdivision of a census tract and typically contains between 250 and 550 housing units.
- **Community Need Index (CNI)**: The CNI is a zip code-based index of community socioeconomic need calculated nationwide. The CNI scores zip codes on a scale of 1.0 to 5.0, with 1.0 indicating a zip code with the least need and 5.0 indicating a zip code with the most need compared to the US national average of 3.0. The CNI weights, indexes, and scores zip codes by socioeconomic barriers, including income, culture, education, insurance, and housing.

Burlington and Ocean Counties Area Deprivation Index



Burlington and Ocean Counties Community Need Index (CNI)



Zip Code	Town	CNI Score	Zip Code	Town	CNI Score
08006	Barnegat Light	1.2	08734	Lanoka Harbor	1.6
08732	Island Heights	1.2	08735	Lavallette	1.6
08055	Medford	1.4	08742	Point Pleasant Beach	1.6
08527	Jackson	1.6	08077	Riverton	1.6
08514	Cream Ridge	1.8	08722	Beachwood	2.2
08731	Forked River	1.8	08738	Mantoloking	2.2
08758	Waretown	1.8	08741	Pine Beach	2.2
08041	Jobstown	1.8	08753	Toms River	2.2
08088	Vincentown	1.8	08022	Columbus	2.2
08005	Barnegat	2.0	08036	Hainesport	2.2
08008	Beach Haven	2.0	08053	Marlton	2.2
08533	New Egypt	2.0	08057	Moorestown	2.2
08724	Brick	2.0	08721	Bayville	2.4
08755	Toms River	2.0	08723	Brick	2.4
08054	Mount Laurel	2.0	08757	Toms River	2.4
08505	Bordentown	2.0	08046	Willingboro	2.4
08554	Roebling	2.0	08515	Chesterfield	2.4
08050	Manahawkin	2.2	08641	Trenton	2.4
08087	Tuckerton	2.2	08722	Beachwood	2.2
08752	Seaside Park	2.6	08015	Browns Mills	3.0
08759	Manchester Township	2.6	08048	Lumberton	3.0
08019	Chatsworth	2.6	08065	Palmyra	3.0
08075	Riverside	2.6	08518	Florence	3.0
08092	West Creek	2.8	08016	Burlington	3.2
08060	Mount Holly	2.8	08511	Cookstown	3.2
08640	Fort Dix	2.8	08562	Wrightstown	3.2
08740	Ocean Gate	3.4	08010	Beverly	3.8
08052	Maple Shade	3.4	08733	Lakehurst	3.8
08068	Pemberton	3.6	08701	Lakewood	3.8
08751	Seaside Heights	4.2			

Lowest need

Highest need

The average CNI score for Deborah's Immediate Service Area is 3.1, indicating overall moderate need. **Lakehurst zip code 08733 in Ocean County has the highest CNI score in the immediate service area and the score increased from the 2019 CHNA, from 3.2 to 3.8.** Community need within Lakehurst is largely driven by potential language barriers, lower educational attainment, and a higher uninsured population.

Pemberton zip code 08068 has the second highest CNI score in the immediate service area, although the score declined from the 2019 CHNA from 4.0 to 3.6. Socioeconomic disparity within Pemberton is largely due to experiences of poverty and wealth inequities disproportionately affecting Black/African American residents. Black/African Americans represent nearly 30% of the Pemberton population compared to 17% countywide. Across Burlington County, Black/African Americans are nearly twice as likely to experience poverty as Whites living in the same community.

2016-2020 Social Determinants of Health by Zip Code (Deborah Immediate Service Area)

	Population in Poverty	Children in Poverty	Primary Language Other Than English	Less than HS Diploma	Without Health Insurance	CNI Score
08733, Lakehurst	7.5%	2.5%	19.4%	14.2%	8.4%	3.8
08068, Pemberton	11.4%	13.9%	13.7%	9.4%	7.6%	3.6
08015, Browns Mills	9.1%	12.1%	12.7%	10.8%	3.8%	3.0
08640, Joint Base MDL	4.5%	6.0%	26.9%	16.1%	0.7%	2.8
08641, Joint Base MDL	1.8%	2.4%	16.2%	2.6%	0.5%	2.4
08064, New Lisbon	NA	NA	4.9	13.3%	NA	NA
New Jersey	9.7%	13.0%	31.6%	9.7%	7.6%	NA

Source: US Census Bureau, American Community Survey

2016-2020 Population by Race and Ethnicity by Zip Code (Deborah Immediate Service Area)

	White	Black or African American	Asian	Other Race	Two or More Races	Latinx origin (any race)
08733, Lakehurst	70.8%	6.9%	11.6%	4.5%	6.0%	16.6%
08068, Pemberton	56.0%	29.2%	2.0%	5.1%	7.6%	14.0%
08015, Browns Mills	65.4%	22.4%	2.9%	1.4%	7.7%	13.3%
08640, Joint Base MDL	54.6%	31.1%	2.1%	2.9%	9.0%	25.1%
08641, Joint Base MDL	79.8%	7.6%	1.0%	4.6%	6.4%	23.0%
08064, New Lisbon	75.1%	20.0%	4.9%	0%	0%	0%
New Jersey	65.5%	13.4%	9.7%	6.4%	4.8%	20.4%

Source: US Census Bureau, American Community Survey

The average CNI score for Burlington and Ocean counties is 2.4, indicating lower overall need, although outcomes vary across communities. Within Burlington County, Beverly zip code 08010 has the highest CNI score of 3.8, followed by Pemberton in Deborah's immediate service area. Beverly residents are more likely to experience poverty, and children are more than twice as likely to live in poverty compared to the state benchmark. The ADI findings indicate that community need within Beverly is higher in the western portion of the zip code.

Within Ocean County, and excluding Lakehurst in Deborah's immediate service area, Seaside Heights and Lakewood have the highest CNI scores of 4.2 and 3.8, respectively. In both areas, more than 1 in 5 residents and 1 in 4 children experience poverty. As indicated previously, Lakehurst also has a high CNI score 3.8.

The following tables list the SDoH that contribute to zip code CNI scores for Burlington and Ocean county zip codes with a CNI score of 3.4 or higher.

2016-2020 Social Determinants of Health for Burlington and Ocean County Zip Codes with CNI Score ≥3.4

Zip Code (County)	Population in Poverty	Children in Poverty	Primary Language Other Than English	Less than HS Diploma	Without Health Insurance	CNI Score
08751, Seaside Heights (Ocean)	21.7%	40.6%	19.2%	10.2%	10.6%	4.2
08010, Beverly (Burlington)	14.6%	28.2%	22.0%	11.6%	9.2%	3.8
08733, Lakehurst (Ocean)	7.5%	2.5%	19.4%	14.2%	8.4%	3.8
08701, Lakewood (Ocean)	25.0%	28.8%	23.9%	11.6%	5.9%	3.8
08068, Pemberton (Burlington)	11.4%	13.9%	13.7%	9.4%	7.6%	3.6
08740, Ocean Gate (Ocean)	7.8%	10.6%	3.3%	10.1%	10.4%	3.4
08052, Maple Shade (Burlington)	8.2%	9.8%	16.3%	5.8%	7.0%	3.4
New Jersey	9.7%	13.0%	31.6%	9.7%	7.6%	NA

Source: US Census Bureau, American Community Survey

2016-2020 Population by Race and Ethnicity for Burlington and Ocean County Zip Codes with CNI Score ≥3.4

	White	Black or African American	Asian	Other Race	Two or More Races	Latinx origin (any race)
08751, Seaside Heights (Ocean)	82.0%	1.9%	0.5%	12.7%	0.3%	16.7%
08010, Beverly (Burlington)	64.2%	24.0%	0.7%	5.4%	4.4%	17.3%
08733, Lakehurst (Ocean)	70.8%	6.9%	11.6%	4.5%	6.0%	16.6%
08701, Lakewood (Ocean)	89.8%	2.5%	1.0%	5.1%	1.6%	11.4%
08068, Pemberton (Burlington)	56.0%	29.2%	2.0%	5.1%	7.6%	14.0
08740, Ocean Gate (Ocean)	94.7%	4.6%	0%	0%	0.7%	6.1%
08052, Maple Shade (Burlington)	71.2%	11.2%	8.2%	6.0%	3.0%	11.0%
New Jersey	65.5%	13.4%	9.7%	6.4%	4.8%	20.4%

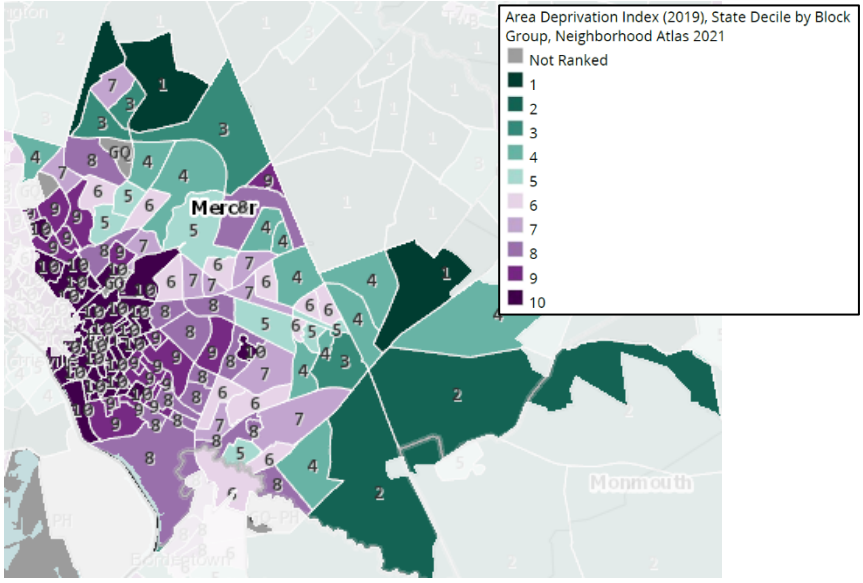
Source: US Census Bureau, American Community Survey

The Mercer County secondary service area has an average CNI score of 3.5, indicating high overall community need. Community need is largely concentrated in Trenton zip codes 08609 and 08611. Within these zip codes, more than 1 in 5 people and as many as 2 in 5 children live in poverty, and more than 20% of residents have not completed high school and/or are uninsured.

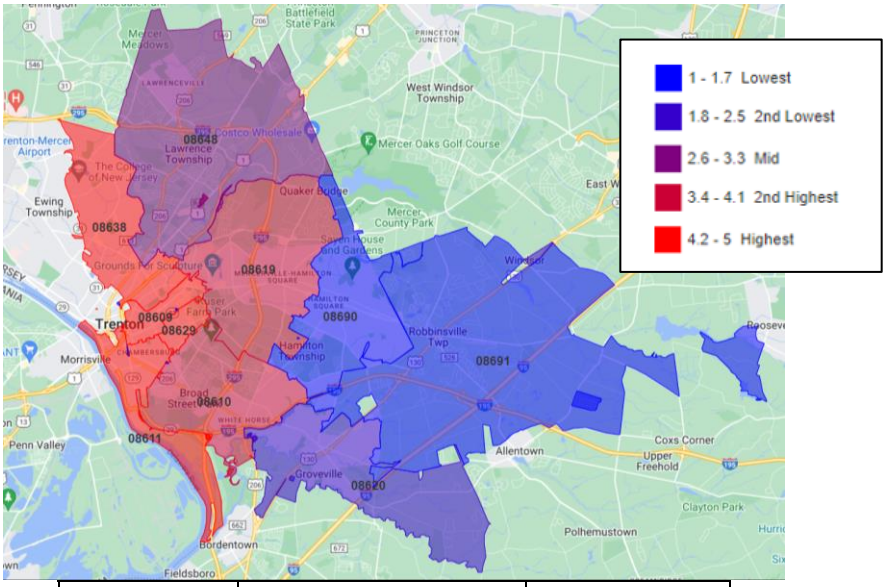
Trenton benefits from greater racial and ethnic diversity than the state with as many as 50% of residents identifying as Black/African American and/or Latinx. These communities of color have historically

experienced systemic inequities that perpetuate persistent disparities in health and social outcomes. These disparities are demonstrated in data and community feedback throughout the report.

Mercer County Secondary Service Area – Area Deprivation Index



Mercer County Secondary Service Area Community Need Index (CNI)



Zip Code	Town	CNI Score
08690	Trenton	1.6
08691	Trenton	1.6
08620	Trenton	2.0
08648	Lawrence Township	2.8
08619	Trenton	3.4
08638	Trenton	4.2
08629	Trenton	4.4
08610	Trenton	4.0
08609	Trenton	4.8
08611	Trenton	5.0

2016-2020 Social Determinants of Health by Zip Code for Mercer County Secondary Service Area

	Population in Poverty	Children in Poverty	Primary Language Other Than English	Less than HS Diploma	Without Health Insurance	CNI Score
08611, Trenton	27.1%	42.4%	55.6%	31.6%	20.4%	5.0
08609, Trenton	21.8%	22.4%	48.0%	26.2%	21.0%	4.8
08629, Trenton	11.5%	15.7%	43.4%	17.0%	12.6%	4.4
08638, Trenton	18.9%	22.3%	18.8%	13.0%	8.0%	4.2
08610, Trenton	9.9%	16.0%	36.1%	12.1%	9.2%	4.0
08619, Trenton	7.8%	11.8%	15.8%	7.8%	5.1%	3.4
08648, Lawrence Township	5.3%	1.3%	31.9%	6.9%	4.9%	2.8
08620, Trenton	6.2%	10.1%	12.8%	7.4%	3.8%	2.0
08690, Trenton	2.0%	0.5%	11.2%	4.7%	3.5%	1.6
08691, Trenton	1.8%	0.3%	25.9%	2.5%	1.2%	1.6
New Jersey	9.7%	13.0%	31.6%	9.7%	7.6%	NA

Source: US Census Bureau, American Community Survey

2016-2020 Population by Race and Ethnicity by Zip Code for Mercer County Secondary Service Area

	White	Black or African American	Asian	Other Race	Two or More Races	Latinx origin (any race)
08611, Trenton	52.3%	25.5%	1.7%	12.0%	6.8%	57.0%
08609, Trenton	29.3%	50.9%	0.4%	12.3%	5.9%	41.1%
08629, Trenton	28.8%	50.2%	1.6%	16.1%	2.5%	30.8%
08638, Trenton	45.9%	47.2%	1.2%	3.7%	1.4%	15.7%
08610, Trenton	64.0%	20.2%	3.4%	8.7%	3.7%	32.5%
08619, Trenton	79.7%	8.7%	5.7%	2.4%	3.3%	11.0%
08648, Trenton	66.1%	11.6%	14.2%	1.7%	6.3%	12.4%
08620, Trenton	82.6%	12.6%	3.6%	0.6%	0.6%	6.3%
08690, Trenton	89.8%	2.7%	4.2%	1.7%	1.7%	7.0%
08691, Trenton	69.8%	5.4%	21.9%	0.6%	2.3%	4.7%
New Jersey	65.5%	13.4%	9.7%	6.4%	4.8%	20.4%

Source: US Census Bureau, American Community Survey

Life expectancy is another measure of the impact of SDoH. **New Jersey overall reports high average life expectancy of 79.5 years, but it is not equitable across population groups.** Black/African American residents have lower average life expectancy of 74.4 years, a disparity that is also reflected in the all-cause death rate and deaths due to chronic conditions. Of note, statewide average life expectancy declined approximately one year from 2017-2019 to 2018-2020, likely due to pandemic-related factors. While Burlington and Ocean counties saw a smaller overall decline in life expectancy of 0.5 years, they saw a decline of nearly two years for Black/African American residents.

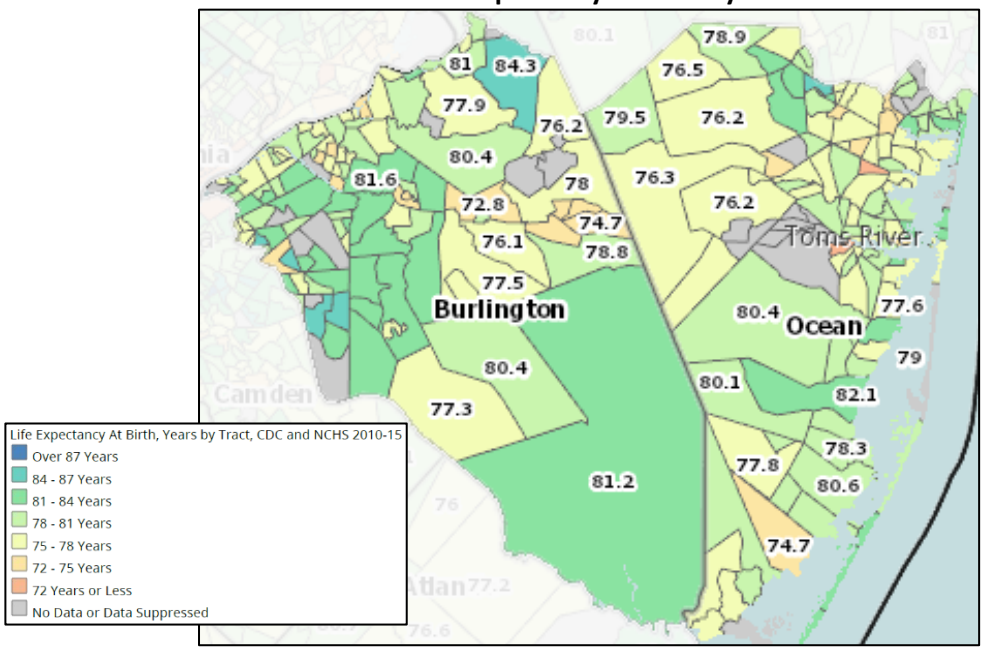
Areas of lower life expectancy in Burlington and Ocean counties generally align with areas of socioeconomic disadvantage. For example, in Deborah's immediate service area, average life expectancy in and around Pemberton, Browns Mills, and Lakehurst is as low as 75 years or less.

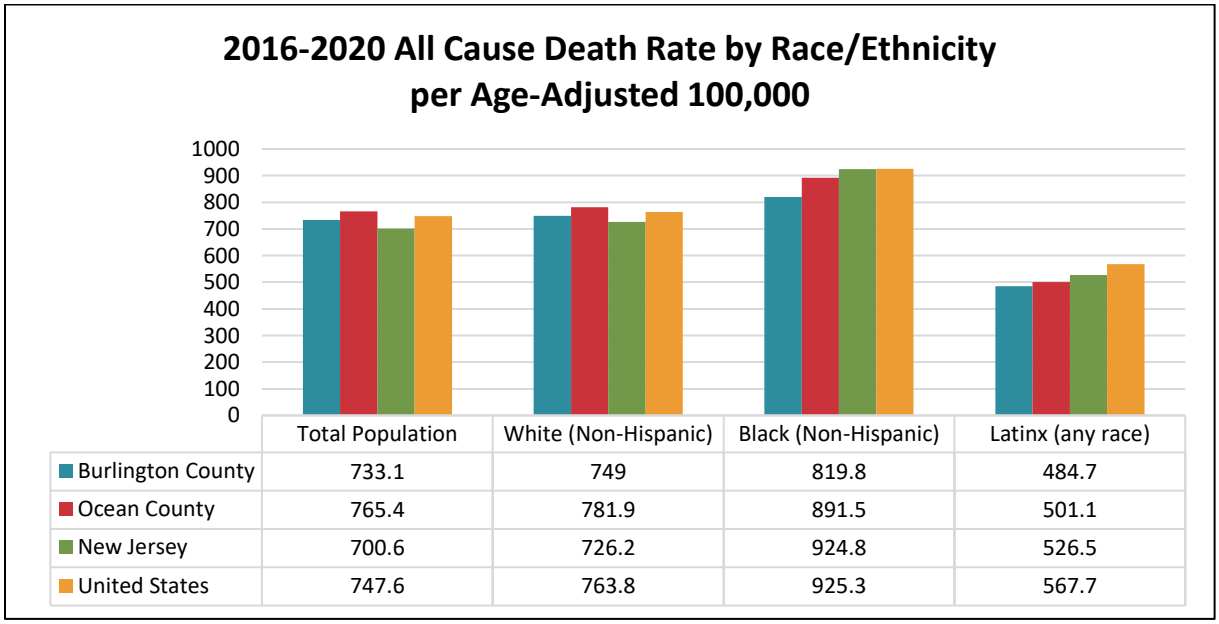
2018-2020 Life Expectancy at Birth by Race and Ethnicity

	Overall Life Expectancy	White	Black	Asian	Latinx origin (any race)
Burlington County	79.1	79.0	76.8	87.3	84.3
Ocean County	78.5	78.3	74.9	90.1	83.3
New Jersey	79.5	79.3	74.4	88.7	82.7

Source: NJSHAD, New Jersey Department of Health and National Vital Statistic 91.3

2010-2015 Life Expectancy at Birth by Census Tract





Source: Centers for Disease Control and Prevention

COVID-19 Demonstrated Inequities

The COVID-19 pandemic both highlighted and deepened socioeconomic and health inequities. The preliminary list of the leading causes of death in New Jersey during 2020 indicate that **for Black/African American, Asian, and Latinx/Hispanic people, COVID-19 became the #1 leading cause of death in 2020**, but it was #3 among White non-Hispanic New Jerseyans. Age-adjusted COVID-19 death rates suggest that the Black/African American death rate was more than double that of White and Asian New Jersey residents.

In addition to health impact, economic indicators, including unemployment and food insecurity, skyrocketed as a result of the pandemic. **Average unemployment across New Jersey more than doubled in 2020 reaching nearly 10%.** Burlington and Ocean counties had similarly high unemployment of 8.2% and 9.5% respectively. The percentage of food insecure children statewide increased from 9.9% in 2019 to 16.1% in 2020. In Ocean County in 2020, nearly 19% of children were projected to be food insecure. Food insecurity declined slightly in 2021 but continues to exceed pre-pandemic findings and will likely have long-term financial and psychological implications for residents.

As part of the Community Member Survey conducted with more than 1,300 residents, participants were asked to reflect on the impact of COVID-19 on their physical, mental, and financial health. **More than 45% of participants "agreed" or "strongly agreed" that COVID negatively impacted their mental health.** Approximately 40% of participants "agreed" or "strongly agreed" that the pandemic negatively impacted their physical and/or financial health.

Priority Health Needs

To work toward health equity, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs within our community. In determining the issues on which to focus efforts over the next three-year cycle, Deborah collected feedback from community partners and residents and sought to align with existing or planned community initiatives. Deborah will focus efforts on the following community health priorities over the next three-year cycle:

- Access to care and services
- Chronic disease prevention and management
- Issues of aging and well-being

Strategies to address the priority areas will reflect community population trends and stakeholder feedback, as highlighted below.

Mental health and substance use disorder were also identified as community health needs as part of the 2022 CHNA. While these needs were not named as priorities for the Deborah 2022-2025 Community Health Improvement Plan based on the specialty nature of the services Deborah provides and available resources, the hospital will continue to be a community partner in supporting recovery efforts. In the past, these efforts have included partnership with the Burlington County Prosecutor's Office to supply Narcan (and nasal adapters) to front line officers and EMS, and support for Hope One, a Burlington County Sheriff's Department initiative, bringing mobile addiction services directly into the community.

Community Overview and Trends

The Deborah primary service area comprises Burlington and Ocean counties in central New Jersey. Burlington County is the largest county in New Jersey by area. Ocean County is the fifth most populous county in New Jersey and one of the fastest growing counties in the state. While most residents of Burlington and Ocean counties identify as White, consistent with New Jersey overall, population growth occurred almost exclusively among non-White individuals. The multi-racial population more than doubled in Burlington County and nearly quadrupled in Ocean County from the 2010 Census.

Consistent with statewide findings, residents of Burlington and Ocean counties as a whole benefit from higher incomes and lower poverty than the nation. Residents are also more likely to attain higher education and/or own their home. These positive attributes are most evident in Burlington County, where median household income exceeds $90,000 and the proportion of all residents living in poverty is less than half the national average.

While both counties benefit from positive socioeconomic factors overall, several trends point to emerging or persistent needs. In both counties, the number of seniors living in poverty increased in 2020, a finding that may be due in part to COVID-19-related deaths and financial vulnerability among older single-person households. In Ocean County, housing cost burden and childhood poverty have improved but continue to exceed state and/or national benchmarks. Housing cost burden, defined as spending 30% or more of income on housing, affects 37% of homeowners and 60% of renters in Ocean County, a 10-point increase over national averages. Ocean County has historically had higher housing

costs than Burlington County, but lower incomes. Approximately 15% of households in Ocean County have an annual income of less than $25,000 compared to 10% in Burlington County.

Access to Care and Services

Access to care and services is a complex issue, requiring the right mix of affordability, available providers, time and convenience, cultural competence, and language resources, among other factors.

Residents of Burlington County are generally well served by health and social services, benefiting from factors like health insurance coverage and provider availability, but not all residents have the same positive experience. In Deborah's immediate service area, residents of Browns Mills and Pemberton are more likely to experience access barriers due to socioeconomic challenges and resource limitations. Approximately 1 in 10 residents live in poverty and both communities are federally designated Medically Underserved Areas with Medically Underserved Populations. These barriers, in part, reflect inequities experienced by Black/African Americans who represent a higher proportion of the area population relative to the county overall.

Ocean County residents also experience barriers to accessing care and services. While the county has a low uninsured population, healthcare provider rates are significantly lower than statewide averages. The Ocean County primary care physician rate per 100,000 population is less than half the statewide rate, and the dentist provider rate is more than 20 points lower than the statewide rate. Approximately 65% of Ocean County adults receive regular dental care compared to 71% of all New Jersey adults.

As part of the Key Stakeholder Survey, community representatives of Burlington and Ocean counties provided their recommendations on how community organizations can better serve communities to achieve health and social equity, including access to care and services. Respondents provided the following select comments:

> *"Advertisements that are more multicultural. Door to door campaigns in neighborhoods known to have many minorities."*
>
> *"Co-locating community locations, partnering with community partners to provide healthy living programs and preventative care or rehabilitative care."*
>
> *"Community outreach is key. Reaching out to established community leaders targeting marginalized groups."*
>
> *"Suggest organizational commitment to health and social equity with engagement from all stakeholders: ensure diversity of board, physicians, staff reflects the community; seek and utilize input from the community to inform services, communications, etc.; provide continuing education for physicians and staff; track, monitor, report relevant data; etc."*

Chronic Disease Prevention and Management

Chronic conditions like heart disease, cancer, and respiratory illness continue to be the leading causes of morbidity and mortality for residents across Burlington and Ocean counties, New Jersey, and the nation. This finding reflects persistent health risk factors such as smoking, physical inactivity, and high blood pressure, an aging population that is more vulnerable to chronic disease, and the impact of underlying social determinants of health and inequities.

Approximately one-quarter to one-third of adults in Burlington and Ocean counties self-report being physically inactive and/or having high blood pressure, with higher proportions in Ocean County than the state or nation overall. More than 1 in 10 adults report smoking, with a recent increase in Burlington County that should continue to be monitored. Consistent with these findings, obesity and diabetes have historically been among the leading chronic conditions for adults. In Burlington County, obesity prevalence increased nearly 10 percentage points in 2018 and diabetes prevalence increased annually since 2015. Both indicators exceed state and national benchmarks. Ocean County saw declines in both obesity and diabetes prevalence in recent years, despite higher reported risk factors.

The COVID-19 pandemic negatively impacted access to care and services for many residents, delaying preventive and maintenance care. This impact was seen in the diabetes death rate, which increased statewide, nationally, and in both counties in 2020. In Ocean County, where the diabetes death rate had been stable, the rate increased nearly 3 points in 2020. Statewide, the death rate among Black/African Americans increased more than 15 points and was nearly triple the death rate among Whites. This finding demonstrates how the pandemic both highlighted and deepened existing community inequities.

Ocean County has historically had higher rates of death due to chronic conditions like heart and lung disease than Burlington County and the state overall, a finding that may be due in part to access to care barriers, health risk factors, and socioeconomic disadvantages like poverty and housing costs. The county heart disease death rate has historically exceeded state and national death rates, and has been stable over the past decade, contrary to state and national declines. The chronic lower respiratory disease death rate also exceeds the statewide rate with marginal improvement over the past decade.

Issues of Aging and Well-Being

Burlington and Ocean counties are aging communities, and Ocean County is one of the oldest counties in the state. Approximately 17% of Burlington County residents and 23% of Ocean County residents are aged 65 or older, an increase from prior years, and higher than the national average of 16%. The Baby Boomer Generation aged 55 to 64 accounts for 13-15% of the total population in either county, suggesting that health needs and support services for older adults will continue to grow in coming years.

Older adults are among the most likely to experience chronic conditions. More than 81% of older adult Medicare beneficiaries in Ocean County and 75.5% in Burlington County have two or more chronic conditions. In Ocean County, approximately 25% of older adult Medicare beneficiaries have six or more conditions compared to 21% statewide. Compounding health concerns for older adults is an overall older demographic within Ocean County and potential social isolation. Approximately 17% of older adults in Ocean County live alone, an increasing and higher proportion than the state and nation overall.

Consistent with the state and nation, the most common chronic conditions among Burlington and Ocean county older adult Medicare beneficiaries are hypertension, high cholesterol, and arthritis. Older adults in Ocean County have a higher prevalence of nearly all reported conditions than the state and nation.

Mental Health and Substance Use Disorder

Mental health and well-being concerns were generally exacerbated during the pandemic due to experiences of stress, isolation, and loss, among other factors. Before the pandemic, approximately 18%

of adults in Burlington County and 14% of adults in Ocean County self-reported having frequent mental distress, defined as 14 or more days of poor mental health per month. Approximately 15% of older adults in both counties had been diagnosed with depression. Statewide, approximately 36% of youth reported feeling consistently sad or hopeless and 6% had attempted a suicide. Feedback by community representatives suggests these indicators worsened since the pandemic and there is a lack of sufficient resources to meet increased demand for service.

Among Community Member Survey participants, more than 45% of participants "agreed" or "strongly agreed" that COVID negatively impacted their mental health. When asked to share examples of how the pandemic impacted them, participants provided the following select comments:

> *"After working from home for a year, I became more depressed. I lost my job after the company decided to close."*
>
> *"Changed our way of life. I'm not afraid but hesitant sometimes to get together with others. I have family and friends who are petrified of getting together. Information differs from various sources. How do you know what to believe? Today read an article in the AARP newsletter, CDC does not recommend a second booster yet, and just received State of New Jersey email that says CDC recommends a second booster for over 60 years old, the population reading AARP. What's right?"*
>
> *"COVID 19 impacted my mental health the most because I was constantly exposed to positive patients for long periods of time and the worry/concern that I would bring it home to my children. My autistic son had a really hard time with the world shutting down and wearing a mask."*
>
> *"I did not get COVID, but the isolation from COVID shut down, after my husband died, was isolating me from family and friends and my church. That made my grieving process worse. Trying to talk to my family and friends was extremely hard as everyone had a strong political view on the virus and how it was handled. Even if you did not want to talk about the subject people gave their opinions. Made the whole process harder."*

Select populations within the community have historically been more at-risk for mental health concerns due to factors like trauma or inequities born through racism and discrimination. A national study of Veterans found that suicide deaths decreased among this population from 2018 to 2019 but remained 52% higher than non-Veteran adults. Among New Jersey youth, the proportion reporting an attempted suicide was more than twice as high for students identifying as Black/African American and/or lesbian, gay, or bisexual than their peers.

Related to mental health is substance use disorder. Provisional data released by the CDC predicts that 2020 and 2021 brought the highest number of overdose deaths ever in the US, largely due to pandemic-related factors. New Jersey has historically had more drug overdose deaths than the nation, and the death rate per 100,000 increased from 30.4 in 2019 to 31.0 in 2020. Ocean County has experienced more drug overdose deaths than the state overall, and the rate of deaths nearly quadrupled from 2010 to 2020. In contrast, the drug overdose death rate for Burlington County declined since 2018, including pandemic years, a finding that should be explored for potential protective factors.

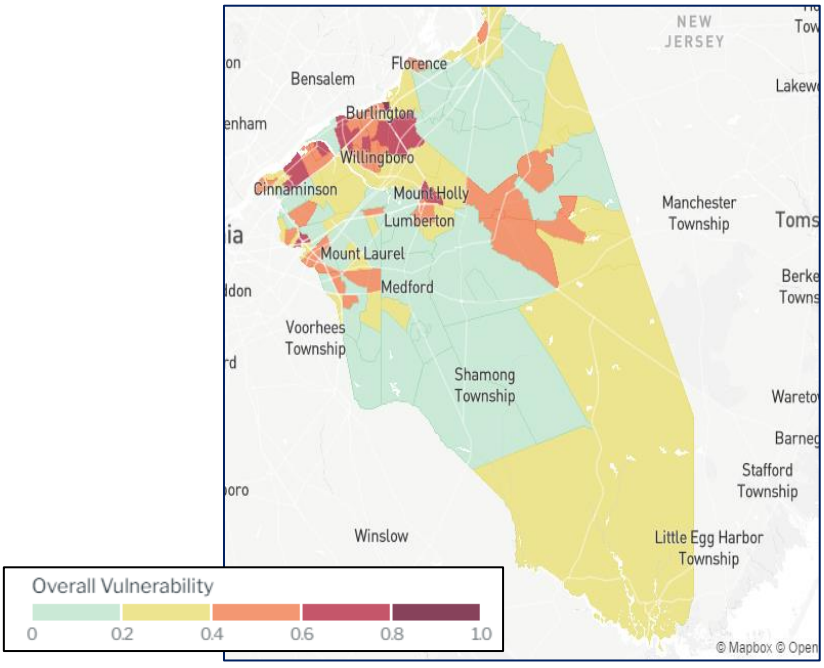
A comparison of key findings relevant to Deborah's service area as compared to New Jersey and the nation follows.

COVID-19 Impact on Communities

COVID-19 is the name of the disease caused by the SARS-CoV-2 virus. "CO" stands for corona, "VI" for virus, and "D" for disease. The number "19" refers to the year 2019 when the first case of COVID-19 was identified. COVID-19 has not impacted all people equally. Rather, certain structural issues—population density, low income, crowded workplaces, etc.—contribute to higher levels of spread and worse outcomes from COVID-19 in select communities. Surgo Ventures developed the Community Vulnerability Index to measure how well any community in the US could respond to the health, economic, and social consequences of COVID-19 without intentional response and additional support.

Using this scale, **Burlington County has "Low" vulnerability compared to other parts of the US.** Within Burlington County, the area surrounding Burlington, Cinnaminson, and Mounty Holly show higher vulnerability to COVID-19. Factors that contribute to higher vulnerability in these communities include socioeconomic status, population density, minority status and language barriers, crowded housing, transportation barriers, and/or high-risk work environments (e.g., nursing homes, prisons).

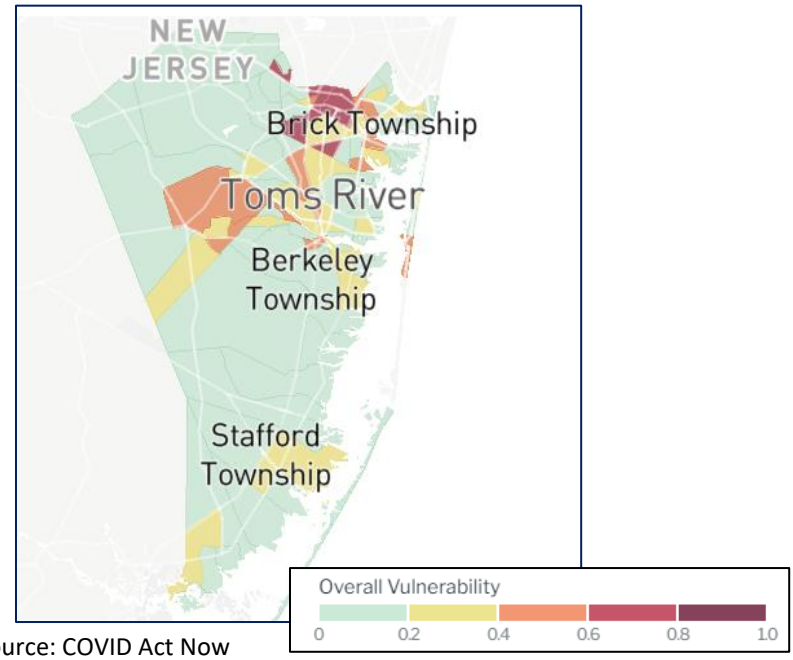
Burlington County COVID-19 Community Vulnerability Index



Source: COVID Act Now

Ocean County also has "Low" vulnerability when compared to other parts of the nation. Areas within Ocean County that have higher vulnerability to COVID-19, such as Lakewood and Lakehurst, also have higher community socioeconomic need per the Community Need Index. Other factors that contribute to higher vulnerability in these communities include crowded housing and/or transportation barriers. In Lakewood, additional factors include population density, minority status and language barriers, and healthcare system challenges. In Lakehurst, additional factors include high-risk populations such as older adults and high-risk work environments (e.g., nursing homes, prisons).

Ocean County COVID-19 Community Vulnerability Index



Source: COVID Act Now

What Makes Burlington and Ocean Counties Vulnerable to COVID-19

Burlington County		Ocean County	
Indicator	**Vulnerability**	**Indicator**	**Vulnerability**
Population density	**VERY HIGH**	Population Density	**VERY HIGH**
Minorities & non-English speakers	**HIGH**	Minorities & non-English Speakers	**HIGH**
Unemployment & low income	**MEDIUM**	Older age and health issues	**MEDIUM**
Crowded living & working areas	**LOW**	Unemployment & low income	**LOW**
Housing & transport challenges	**LOW**	Housing & transport challenges	**LOW**
Health system challenges	**LOW**	Crowded living & working areas	**VERY LOW**
Older age & health issues	**VERY LOW**	Health system challenges	**VERY LOW**

Source: COVID Act Now

COVID-19 Prevalence

The State of New Jersey tracks COVID-19 infections and deaths by race and ethnicity to identify, prevent, treat, and vaccinate communities most impacted by the disease. Although a larger number of infections, hospitalizations, and deaths occurred among Whites in New Jersey, **when the raw numbers are adjusted to reflect a standardized age distribution across racial and ethnic groups, the negative impact of COVID-19 is more significant among Black/African Americans and Latinx people.** In particular, the Black/African American death rate is more than double that of White and Asian New Jersey residents.

Age adjusting is a statistical method of making a fair comparison of two or more groups who have different age distributions. For example, in New Jersey, Black/African American and Latinx racial and ethnic groups have younger age distributions than White non-Hispanics, and younger age groups generally experience less negative outcomes such as hospitalization and death. By age adjusting, the impact of COVID-19 on groups can be compared as if they have the same age distribution.

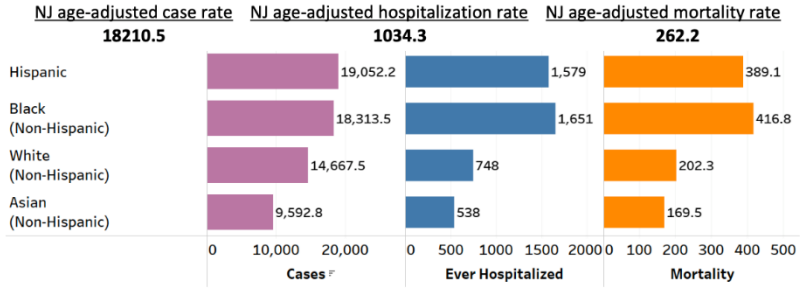
The preliminary list of the leading causes of death in New Jersey during 2020 indicate that **for Black/African American, Asian, and Latinx/Hispanic people, COVID-19 became the #1 leading cause of death in 2020**, but it was #3 among White non-Hispanic New Jerseyans.

Leading Causes of Death among New Jersey Residents by Race/Ethnicity, Preliminary 2020 Data

	White, non-Hispanic		Black, non-Hispanic		Hispanic (of any race)		Asian, non-Hispanic	
	Cause	Count	Cause	Count	Cause	Count	Cause	Count
Rank	All causes of death	65,243	All causes of death	13,623	All causes of death	10,831	All causes of death	3,795
1	Heart disease	14,585	COVID-19	2,544	COVID-19	3,505	COVID-19	947
2	Cancer	11,415	Heart disease	2,502	Heart disease	1,478	Heart disease	623
3	COVID-19	8,801	Cancer	1,867	Cancer	1,301	Cancer	610
4	Unintentional injuries	2,785	Unintentional injuries	742	Unintentional injuries	640	Stroke	168
5	Stroke	2,550	Stroke	585	Diabetes	352	Diabetes	149
6	CLRD	2,366	Diabetes	536	Stroke	305	Unintentional injuries	119
7	Alzheimer disease	2,163	Kidney disease	345	Alzheimer disease	210	Septicemia	89
8	Septicemia	1,401	CLRD	335	Influenza and pneumonia	203	Kidney disease	82
9	Diabetes	1,293	Septicemia	324	Septicemia	193	Influenza and pneumonia	80
10	Influenza and pneumonia	1,103	Essential hypertension	276	Chronic liver disease	169	Alzheimer disease	58

All data are preliminary and subject to change

Age-adjusted laboratory confirmed case, hospitalization, and mortality rates by race/ethnicity as of *February 23, 2022*, New Jersey



Age-adjusted laboratory confirmed case, hospitalization, and mortality rates by race/ethnicity per 100,000:

	Race/Ethnicity	Cases	Ever Hospitalized	Mortality
Age-adjusted rate per 100,000	White	14667.5	747.7	202.3
	Black	18313.5	1651.2	416.8
	Hispanic	19052.2	1579.1	389.1
	Asian	9592.8	537.8	169.5
Crude rate per 100,000	White	14126.6	1056.0	342.3
	Black	18363.1	1720.2	422.3
	Hispanic	18841.7	1327.1	275.4
	Asian	9691.6	529.1	147.4
Case counts	White	691200	51667	16749
	Black	211202	19785	4857
	Hispanic	346567	24410	5065
	Asian	84625	4620	1287
Case counts (%)	White	42.8%	47.6%	56.9%
	Black	13.1%	18.2%	16.5%
	Hispanic	21.5%	22.5%	17.2%
	Asian	5.2%	4.3%	4.4%
	Total cases (N)	1614942	108481	29420
Total laboratory-confirmed cases: 1,867,368 **Total hospitalized cases:** 112,000 **Total deaths:** 29,840	**Percent of total records with age and race/ethnicity data**	86.5%	96.9%	98.6%

Notes

- This report includes PCR positive records (cases, hospitalized and mortality) with known race/ethnicity and age information.
- Data are obtained from Communicable Disease Reporting and Surveillance System (CDRSS).
- COVID-19 associated deaths are identified through public health investigations (i.e., Disease Surveillance) and NJDOH's vital statistics system.
- Hospitalization data have been collected through public health investigations.
- Age-adjusted rates on cases who identify as American Indian/Alaska Native and Native Hawaiian/Pacific Islander, or Other race categories were excluded. Hispanic/Latino includes people of any race; White, Black, Asian and Other exclude Hispanic ethnicity.
- Confirmed case rates include cases who died, case and mortality data are not ***mutually exclusive***.
- Age is standardized using U.S. 2000 standard population, source: https://www-doh.state.nj.us/doh-shad/home/AARate.html
- Crude rates are calculated using 2018 NJ population estimates obtained from NJ Department of Labor.

COVID-19 Vaccines

When a large portion of a community (the herd) becomes immune to a disease, the spread of disease from person to person becomes less likely. This phenomenon is called herd immunity. Vaccines are a necessary component of reaching herd immunity. The following table shows the percentage of eligible residents either partially or fully vaccinated. **As of March 8, 2022, 53.8% of the Ocean County population was fully vaccinated compared to 63.9% of the Burlington County population.**

COVID-19 Vaccination Count and Percent by Age and Dosage as of March 8, 2022

	Burlington County		Ocean County		New Jersey	
	At Least One Dose	Fully Vaccinated	At Least One Dose	Fully Vaccinated	At Least One Dose	Fully Vaccinated
Total vaccinated	354,688	306,967	389,437	326,510	8,009,589	6,700,072
% Of Total Population	79.6%	68.9%	64.1%	53.8%	90.2%	75.4%
Population ≥ 12 Years of Age	344,793	302,942	382,712	321,165	7,684,602	6,699,873
% Of Population ≥ 12 Years of Age	89.1%	78.3%	75.4%	63.3%	95.0%	80.1%
Population ≥ 18 Years of Age	322,735	283,225	367,634	308,162	7,126,251	5,942,934
% Of Population ≥ 18 Years of Age	91.4%	80.2%	79.8%	66.9%	95.0%	85.6%
Population ≥ 65 Years of Age	79,460	69,284	133,768	110,551	1,611,925	1,362,412
% Of Population ≥ 65 Years of Age	95.0%	89.6%	95.0%	79.9%	95.0%	92.3%

Source: Centers for Disease Control and Prevention

Service Area Population Trends

Demographics

Since 2010, the Ocean County population increased by 10.5%, nearly double the statewide average of 5.7%. Ocean County is the fifth most populous county in New Jersey and one of the fastest growing counties in the state. Since 2010, Burlington County saw more moderate population growth of 2.9%.

2020 Total Population

	Total Population	Percent Change Since 2010
Burlington County	461,860	+2.9%
Ocean County	637,229	+10.5%
New Jersey	9,288,994	+5.7%
United States	331,449,281	+7.4%

Source: US Census Bureau, Decennial Census

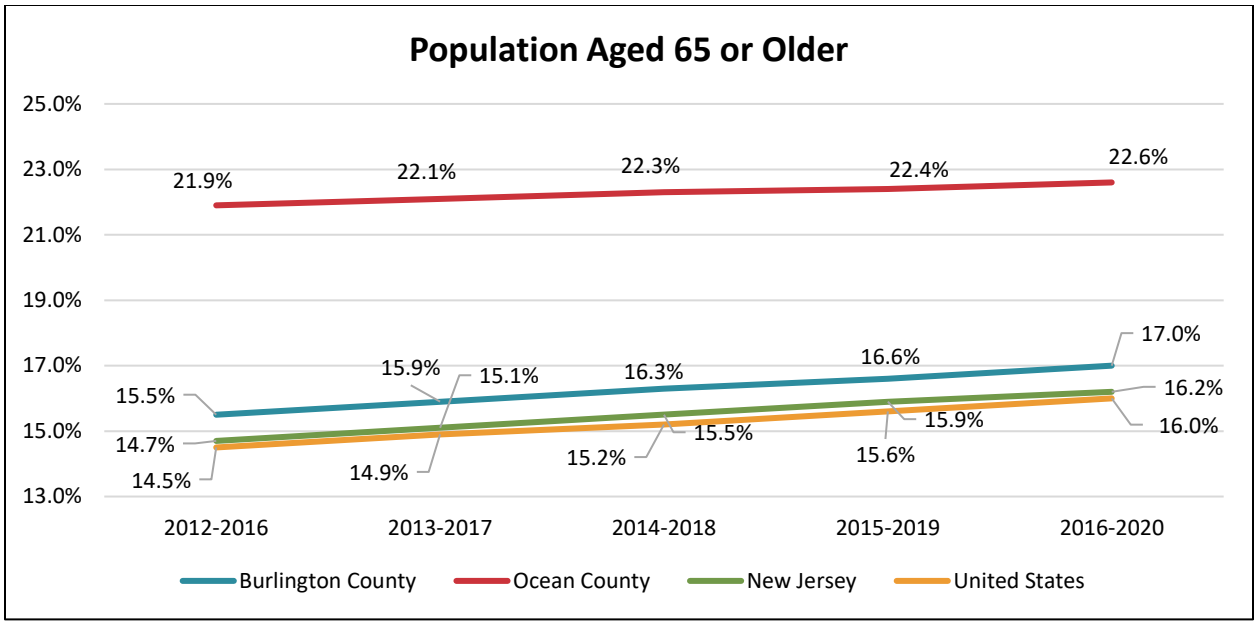
The age distribution of a community is an essential indicator of its social and healthcare needs. Both Ocean County and Burlington County have a higher median age than New Jersey and the nation. **Ocean County is unique in that it has both one of the highest proportions of seniors aged 65 or older in the state and the highest proportion of youth under age 18.** The age demographics of Burlington County more closely mirror the state overall.

The proportion of older adult residents increased across Burlington and Ocean counties, New Jersey, and the nation. Ocean County has historically had a higher proportion of older adults overall, but the Burlington County older adult population grew at a faster rate since 2012-2016.

2016-2020 Population by Age

	Gen Z/ Gen C	Gen Z	Millennial	Millennial / Gen X	Gen X	Boomers	Boomers/ Silent	Median Age
	Under 18 years	18-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65 years and over	
Burlington County	20.8%	8.3%	12.5%	12.4%	14.3%	14.6%	17.0%	41.6
Ocean County	24.1%	7.4%	10.9%	10.1%	11.6%	13.4%	22.6%	42.4
New Jersey	22.0%	8.6%	12.9%	12.8%	13.9%	13.6%	16.2%	40.0
United States	22.4%	9.3%	13.9%	12.7%	12.7%%	12.9%	16.0%	38.2

Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

New Jersey is a more racially and ethnically diverse community than the nation. Burlington and Ocean counties differ from the state with less racial and ethnic diversity, particularly in Ocean County. Nearly 84% of Ocean County residents identify as White compared to 55% statewide, and contrary to state and national trends, the White population as a proportion of the total population increased from 2010 to 2020. Burlington County racial population trends mirror the nation with population growth occurring exclusively among non-White residents. Both counties are home to fewer residents identifying as Latinx than the state or nation.

Consistent with the state and nation, the multiracial population is the fastest growing population in Burlington and Ocean counties. The Ocean County multiracial population grew nearly 400% from 2010 to 2020, representing an increase of nearly 34,000 individuals. The Burlington County multiracial population nearly doubled with an increase of more than 24,000 individuals.

2020 Population by Race and Ethnicity

	White	Black or African American	Asian	Other Race*	Two or More Races	Latinx origin
Burlington County	65.5%	16.8%	5.7%	4.7%	8.1%	8.7%
Ocean County	83.8%	3.0%	1.8%	3.8%	6.6%	10.4%
New Jersey	55.0%	13.1%	10.2%	11.9%	9.7%	21.6%
United States	61.6%	12.4%	6.0%	9.8%	10.2%	18.7%

Source: US Census Bureau, American Community Survey

*Includes American Indian, Native Hawaiian, and Some Other Race together

Population Change among Prominent Racial and Ethnic Groups, 2010 to 2020

	White	Black or African American	Asian	Other Race*	Two or More Races	Latinx origin
Burlington County	-8.5%	+4.4%	+35.3%	+68.4%	+185.1%	+40.1%
Ocean County	+1.8%	+5.0%	+14.3%	+98.1%	+399.1%	+38.8%
New Jersey	-15.2%	+1.2%	+30.9%	+86.4%	+276.0%	+28.8%
United States	-8.6%	+5.6%	+35.5%	+43.2%	+275.7%	+23.0%

Source: US Census Bureau, American Community Survey

*Other race includes American Indian, Native Hawaiian, and Some Other Race.

Compared to New Jersey and the Unites States, Burlington and Ocean counties are home to proportionally fewer immigrant residents. Consistent with this finding, both counties have fewer residents who speak a primary language other than English. Among foreign-born residents, nearly 40% in Burlington County immigrated from Asian. In Ocean County, a similarly high proportion of foreign-born residents immigrated from Latin America or Europe.

2016-2020 Nativity and Citizenship Status

	US citizen, born in the US	US citizen by naturalization	Not a US citizen	Speak Primary Language Other Than English
Burlington County	87.5%	6.8%	3.4%	13.6%
Ocean County	90.7%	5.1%	2.7%	12.0%
New Jersey	74.9%	13.0%	9.7%	31.6%
United States	84.9%	6.9%	6.6%	21.5%

Source: US Census Bureau, American Community Survey

2016-2020 Foreign-Born Population by Region of Birth

	Latin America	Europe	Asia	Africa	Other
Burlington County	29.1%	17.5%	39.9%	12.0%	1.5%
Ocean County	39.1%	34.0%	20.0%	4.0%	2.8%
New Jersey	45.9%	14.6%	32.5%	5.9%	1.0%
United States	50.0%	10.8%	31.3%	5.4%	2.5%

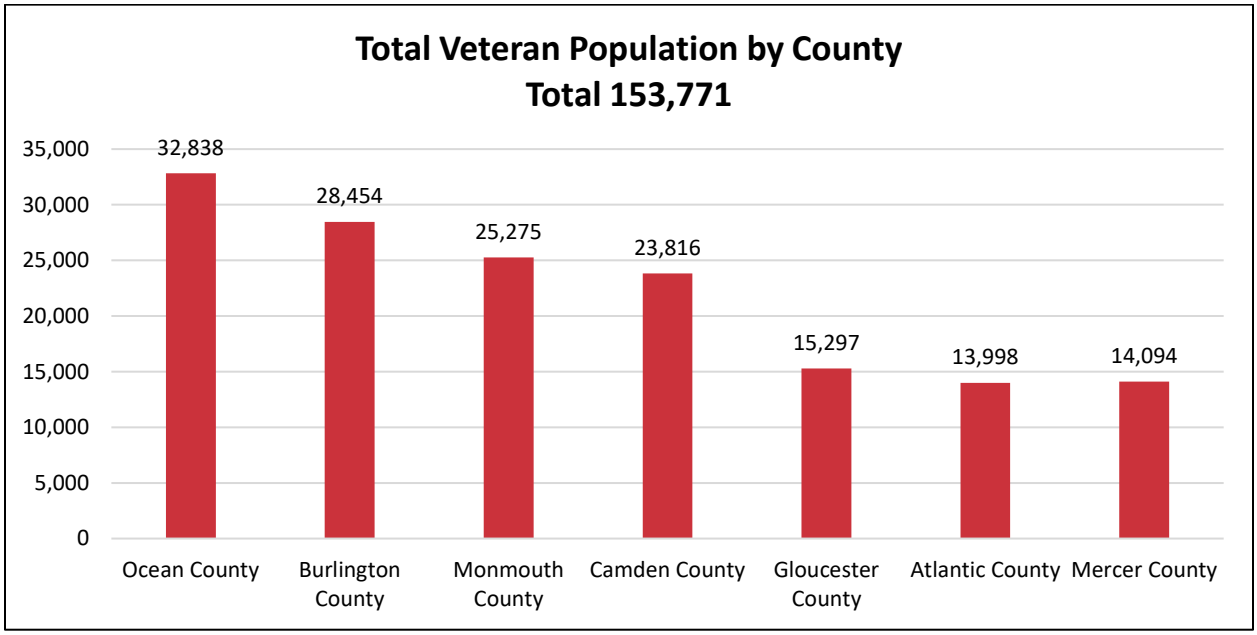
Source: US Census Bureau, American Community Survey

Joint Base McGuire-Dix-Lakehurst – Active Military, Dependents, Retirees and Veterans

On October 1, 2009, three adjacent military bases (McGuire Air Force Base, the Army's Fort Dix, and the Navy's Naval Air Engineering Station Lakehurst) merged to form JB MDL, the nation's only tri-service Joint Base.

Straddling the two largest counties in New Jersey – Burlington and Ocean, JB MDL encompasses 42,000 contiguous acres spanning more than 20 miles from east to west. Deborah is uniquely situated as its immediate and primary service areas encompass JB MDL. With Deborah located just 1.3 miles from Browns Mills Gate on the Dix-side, Deborah is committed to serving those who have served for us.

There are more than 61,000 military Veterans living in Burlington and Ocean counties, and more than 150,000 Veterans living in the seven-county region.



Source: VA Predictive Analytics and Actuary Service, September 30, 2020

Joint Base McGuire-Dix-Lakehurst provides non-emergent, primary care medical services as part of the 87th Medical Group. Emergency services are generally provided at the Emergency Department located on the Deborah campus. Patients requiring specialty medical care and many diagnostic services are referred to providers in the surrounding communities. Of note, **Browns Mills and Pemberton Township border JB MDL and are federally designated as Medically Underserved Areas (MUAs) for low-income individuals.** This finding likely affects access to medical professionals and services for all area residents, including those at JB MDL.

Many Veterans receive care through the Veteran's Administration (VA). The following tables show average wait times in days for new and returning primary and specialty care patients for VA clinics located in proximity to Deborah. This data is updated weekly and based on a rolling 30-day average.

Average VA Wait Times for New and Returning Primary Care Patients

	Location	New Patient	Returning Patient
Burlington County VA Clinic	Marlton, NJ	No new patients	3 days
James J. Howard Veterans' Clinic	Brick, NJ	53 days	8 days

Source: US Department of Veterans Affairs, September 25, 2022

Average VA Wait Times for New and Returning Specialty Care Patients*

	James J. Howard Veterans' Outpatient Clinic	Gloucester County VA Clinic	Corporal Michael J. Crescenz Department of VA Medical Center	Lyons VA Medical Center	Wilmington VA Medical Center	East Orange VA Medical Center
Location	Brick, NH	Sewell, NJ	Philadelphia, PA	Lyons, NJ	Wilmington, DE	East Orange, NJ
Cardiology						
New patient	11	NA	17	NA	10	24
Returning patient	109	NA	60	NA	59	79
Dermatology						
New patient	**	0	12	7	7	4
Returning patient	13	5	58	29	32	21
Gastroenterology						
New patient	NA	NA	16	15	12	17
Returning patient	NA	NA	42	47	41	38
GI Procedures						
New patient	NA	NA	57	NA	16	42
Returning patient	NA	NA	104	NA	32	68
Mental Health						
New patient	NA	3	5	NA	14	15
Returning patient	NA	**	24	NA	14	31
Neurology						
New patient	NA	NA	20	NA	17	5
Returning patient	NA	NA	35	NA	221	34
Oncology						
New patient	NA	NA	2	4	4	2
Returning patient	NA	NA	30	45	44	25
Ophthalmology						
New patient	NA	NA	10	NA	7	14
Returning patient	NA	NA	51	NA	61	69
Orthopedics						
New patient	NA	NA	25	NA	9	8
Returning patient	NA	NA	39	NA	46	27
Physical Therapy						
New patient	6	NA	10	9	10	17
Returning patient	15	NA	19	7	29	15
Podiatry						
New patient	12	NA	7	3	14	7
Returning patient	38	NA	26	26	116	66
Pulmonology						
New patient	NA	111	28	13	1	7
Returning patient	NA	**	40	49	14	33
Sleep Medicine						
New patient	NA	3	23	NA	1	16
Returning patient	NA	9	36	NA	107	67

Source: US Department of Veterans Affairs, September 26, 2022

*"NA" reflects that the service is not provided at the VA location.

**There were zero new or return appointments scheduled at the clinic in the previous month.

Studies consistently show the need for mental health services for military personnel and Veterans due to the unique stressors experienced by these populations. Data presented in the above table indicate that four of the six VA clinics located in proximity to Deborah offer mental health services. Appointment wait times for these services average 3-15 days for new patients and 14-31 days for returning patients.

Stress is a risk factor for Post-Traumatic Stress Disorder (PTSD) and/or suicide attempts. The 2021 National Veteran Suicide Prevention Annual Report, issued by the US Department of Veterans Affairs, noted the following key data points:

- Veteran suicide decreased from 2018 to 2019 (399 fewer suicide deaths among Veterans)
- The rate of suicide was 52.3% times higher among Veterans compared to non-Veteran adults
- The rate of suicide was 38.8 (per 100,000) for male Veterans and 15.4 (per 100,000) for female Veterans
- White Veterans had a suicide rate of 33.6 (per 100,000) which is more than double the suicide rate among Black/African American Veterans. Latinx Veterans had the highest suicide rate (31.5 per 100,000) among racial minority groups.

2019 Veterans Unadjusted Suicide Rates by Race and Ethnicity per 100,000

White	Black or African American	American Indian/Alaskan Native	Asian, Native Hawaiian or Other Pacific Islander	Latinx (any race)
33.6	14.5	30.1	28.3	31.5

Source: US Department of Veterans Affairs

Income and Work

Overall poverty in Burlington and Ocean counties declined since the 2019 CHNA, and fewer residents live in poverty when compared to the nation.

Since the 2019 CHNA, the median household in Burlington and Ocean Counties increased by approximately $6,300 and $8,900 respectively. The Burlington County median household income is higher than the state and the nation, while Ocean County has a lower median household income than the state. Of note, while overall poverty in Ocean County is consistent with the state and declined from prior assessments, it affects 10% of all residents and 15% of children. **The percentage of children living in poverty in Ocean County is double the percentage for Burlington County.**

COVID-19's economic disruptions caused a substantial increase in child poverty in 2020. Nationally, 17.5% of children were living in poverty in 2020 compared to 15.7% in 2019. Child poverty rates disproportionately increased among Latinx and Black/African American children and children of female-headed households, while remaining flat for White and Asian children. In response to these trends, the federal government launched a larger, more periodic child tax credit (CTC) in July 2021. While the new CTC is not anticipated to extend into 2022, it had a significant impact in 2021, keeping millions of children out of poverty. This impact is reflected in projected child food insecurity rates, which declined significantly from 2020 to 2021 across the nation, New Jersey, and Burlington and Ocean counties.

COVID-19 also had a significant impact on unemployment rates across the nation. **By the end of 2020, average unemployment for the US, New Jersey, and Burlington and Ocean counties was more than double what it was at the beginning of the year.** Unemployment declined in 2021, falling to pre-pandemic levels, but the potential economic and social impacts from higher unemployment during the pandemic should continue to be monitored.

Since the 2019 CHNA, the proportion of Burlington and Ocean county residents living in poverty declined across racial and ethnic groups. **Notably, in Ocean County, Black/African Americans living in poverty decreased approximately 7 percentage points, from 19.1% to 11.9%.** Despite these improvements, economic inequities persist, particularly in Burlington County, where Black/African American, multiracial, and Latinx residents are at least two times as likely to live in poverty as White residents.

Economic Indicators

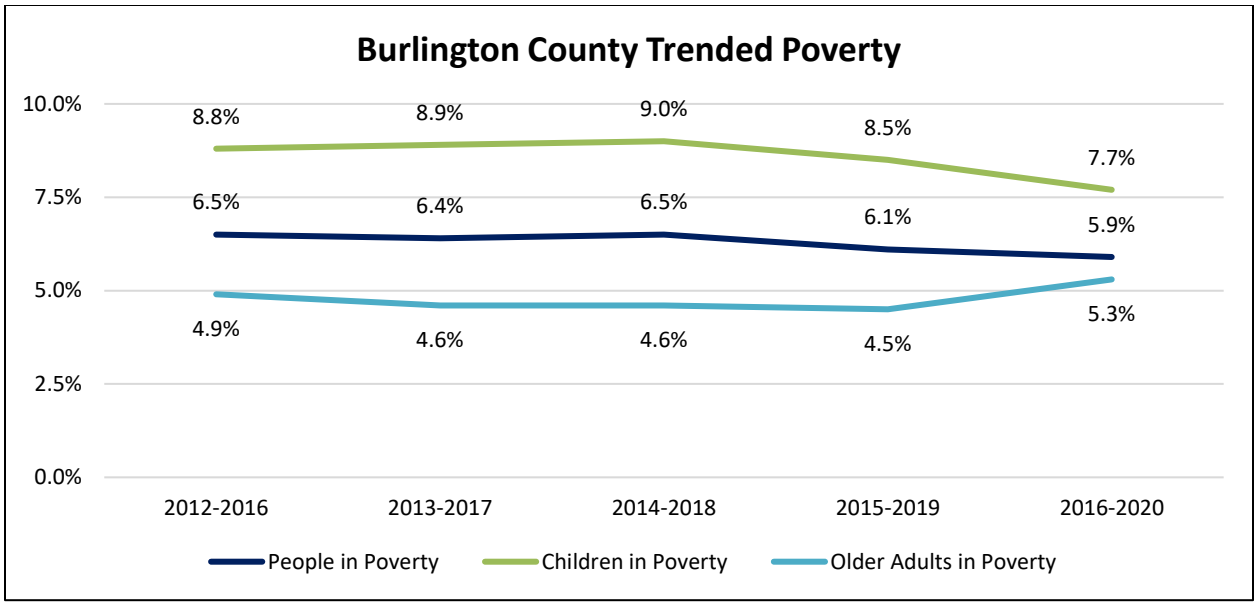
	Burlington County	Ocean County	New Jersey	United States
Income and Poverty (2016-2020)				
Median household income	$90,329	$72,679	$85,245	$64,994
People in poverty	5.9%	9.9%	9.7%	12.8%
Children in poverty	7.7%	15.3%	13.0%	17.5%
Older adults (65+) in poverty	5.3%	6.7%	8.4%	9.3%
Households with SNAP* Benefits	5.1 %	5.8%	8.4%	11.4%
Unemployment				
January 2020	3.6%	4.5%	4.0%	4.0%
2020 average	8.2%	9.5%	9.5%	8.1%
February 2022	3.6%	4.4%	4.4%	4.1%

Source: US Census Bureau, American Community Survey & US Bureau of Labor Statistics
*Supplemental Nutrition Assistance Program.

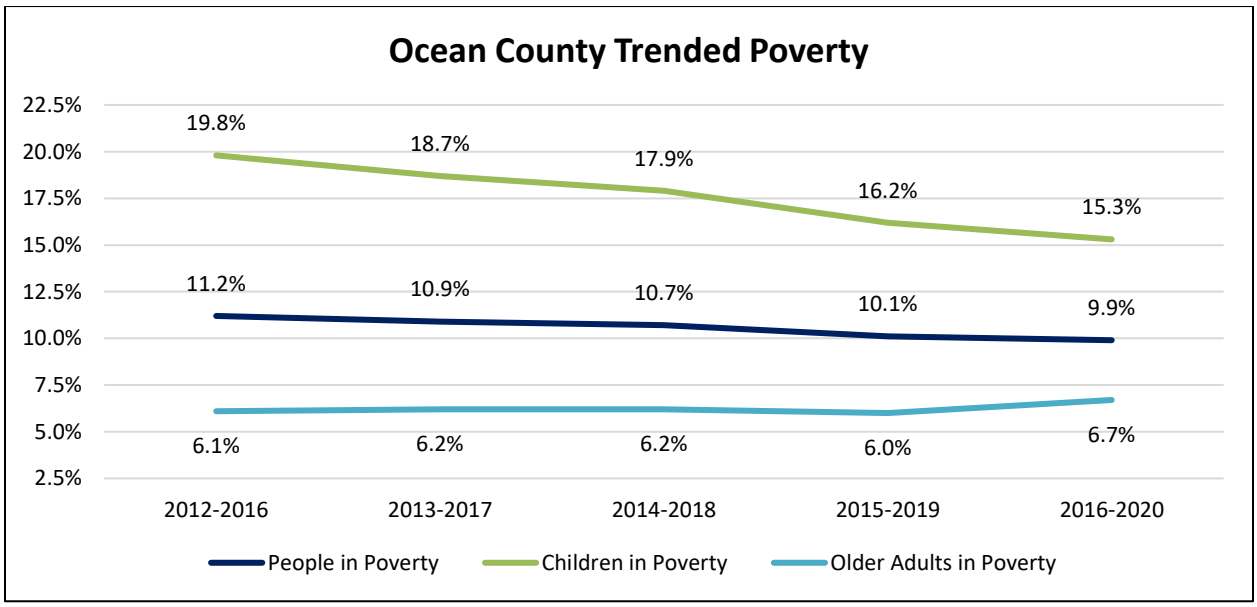
2016-2020 People in Poverty among Prominent Racial and Ethnic Groups

	White	Black / African American	Asian	Two or More Race	Latinx origin (any race)
Burlington County	4.8%	8.7%	3.6%	11.8%	11.7%
Ocean County	9.6%	11.9%	8.8%	12.0%	11.5%
New Jersey	7.6%	16.4%	6.3%	12.6%	16.9%
United States	10.6%	22.1%	10.6%	15.1%	18.3%

Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Food Insecurity

Food insecurity is defined as not having reliable access to a sufficient amount of nutritious, affordable food. Food insecurity is associated with lower household income and poverty, as well as poorer overall health status. Similar to poverty and unemployment rates, COVID-19 had a profound impact on food insecurity, particularly among children. **From 2019 to 2020, food insecurity among children was projected to increase 6 to 7 percentage points across New Jersey and Burlington and Ocean counties.** Prior to 2020, food insecurity among all residents and children was declining statewide and nationally.

Consistent with having slightly higher child poverty rates, Ocean County has a higher proportion of children experiencing food insecurity than Burlington County, estimated at 17.3%. Approximately 30% of Ocean County students participate in the free or reduced-price lunch program.

Trended and Projected Food Insecurity

	Burlington County	Ocean County	New Jersey	United States
All Residents				
2021 (projected)	**9.7%**	**12.2%**	**11.7%**	**12.9%**
2020 (projected)	**10.0%**	**12.9%**	**12.0%**	**13.9%**
2019	6.6%	9.0%	8.6%	10.9%
Children				
2021 (projected)	**14.1%**	**17.3%**	**15.3%**	**17.9%**
2020 (projected)	**14.8%**	**18.8%**	**16.1%**	**19.9%**
2019	8.8%	11.7%	9.9%	14.6%

Source: Feeding America

2020-2021 School Year Students Enrolled in Free or Reduced-Price Lunch Program

	Total Student Enrollment	Participation in Free Lunch Program	Participation in Reduced-Price Lunch Program
Burlington County	66,788	21.1%	4.5%
Ocean County	66,723	25.0%	4.8%
New Jersey	13,43,440	31.0%	4.4%

Source: New Jersey Department of Education

Education

High school graduation is one of the strongest predictors of longevity and economic stability. Adult residents of Burlington and Ocean counties are more likely to have completed high school when compared to the state and the nation. Consistent with the state overall, a higher proportion of Burlington County residents attain higher education, estimated at nearly 39%. Ocean County more closely mirrors the nation with 31% of residents attaining higher education.

Consistent with state and national trends, Burlington and Ocean county adults of Asian descent are the most likely of any other population group to attain higher education. **Black/African American and Latinx residents of both counties are just as likely or more likely to attain higher education when compared to their peers nationwide but experience educational disparity relative to other racial groups living in the same community**.

2016-2020 Population (Age 25 or Older) by Educational Attainment

	Less than high school diploma	High school graduate (includes GED)	Some college or associate's degree	Bachelor's degree	Graduate or professional degree
Burlington County	6.3%	27.9%	27.4%	24.9%	13.6%
Ocean County	7.6%	33.5%	27.6%	20.7%	10.7%
New Jersey	9.7%	26.7%	22.8%	24.8%	15.9%
United States	11.5%	26.7%	28.9%	20.2%	12.7%

Source: US Census Bureau, American Community Survey

2016-2020 Population with a Bachelor's Degree or Higher by Prominent Racial and Ethnic Group

	White	Black / African American	Asian	Two or More Race	Latinx origin (any race)
Burlington County	39.8%	29.7%	59.2%	31.2%	24.6%
Ocean County	31.5%	23.4%	57.6%	27.4%	16.9%
New Jersey	41.9%	25.2%	71.0%	34.0%	20.6%
United States	34.4%	22.6%	55.0%	29.7%	17.6%

Source: US Census Bureau, American Community Survey

Housing

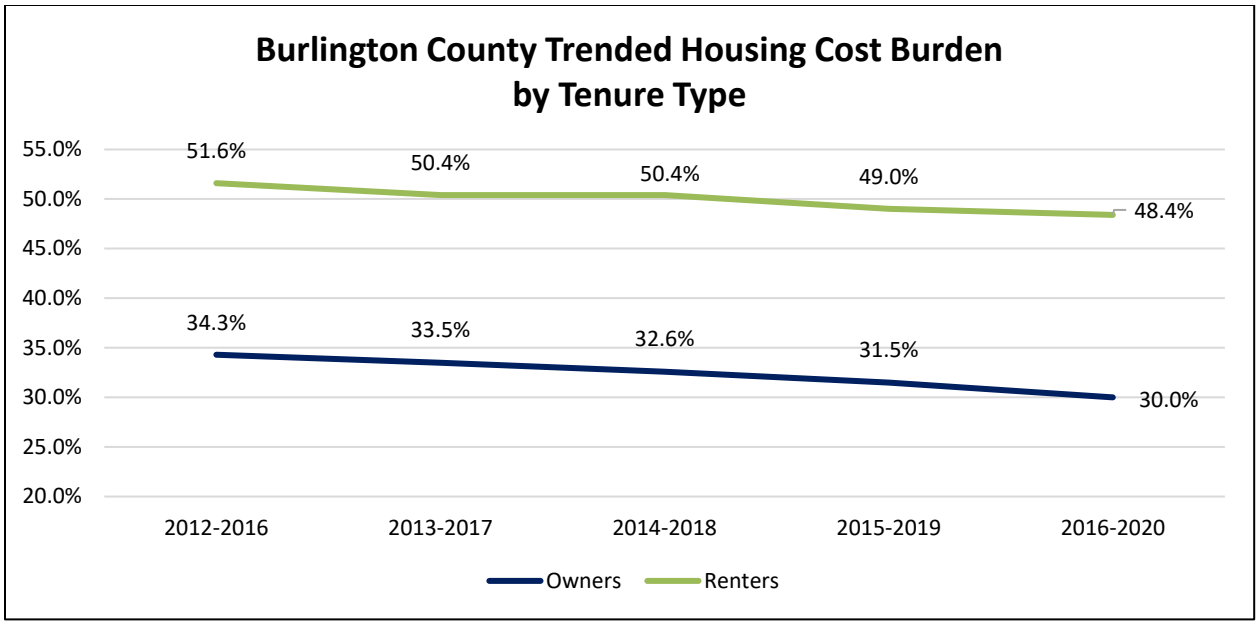
Housing is the largest single expense for most households and should represent 30% of a household's monthly income. While the median home value in Burlington and Ocean counties is generally less expensive than home values statewide, 30% or more of homeowners are housing cost burdened. Approximately 50% of more renters in either county are rent cost burdened. **Housing cost burden is higher in Ocean County, affecting nearly 37% of homeowners and 60% of renters.** Median household income in Ocean County is nearly $18,000 less than income in Burlington County, but median home value is nearly $30,000 higher. In both counties, housing cost burden declined slightly from prior years.

2016-2020 Housing Indicators

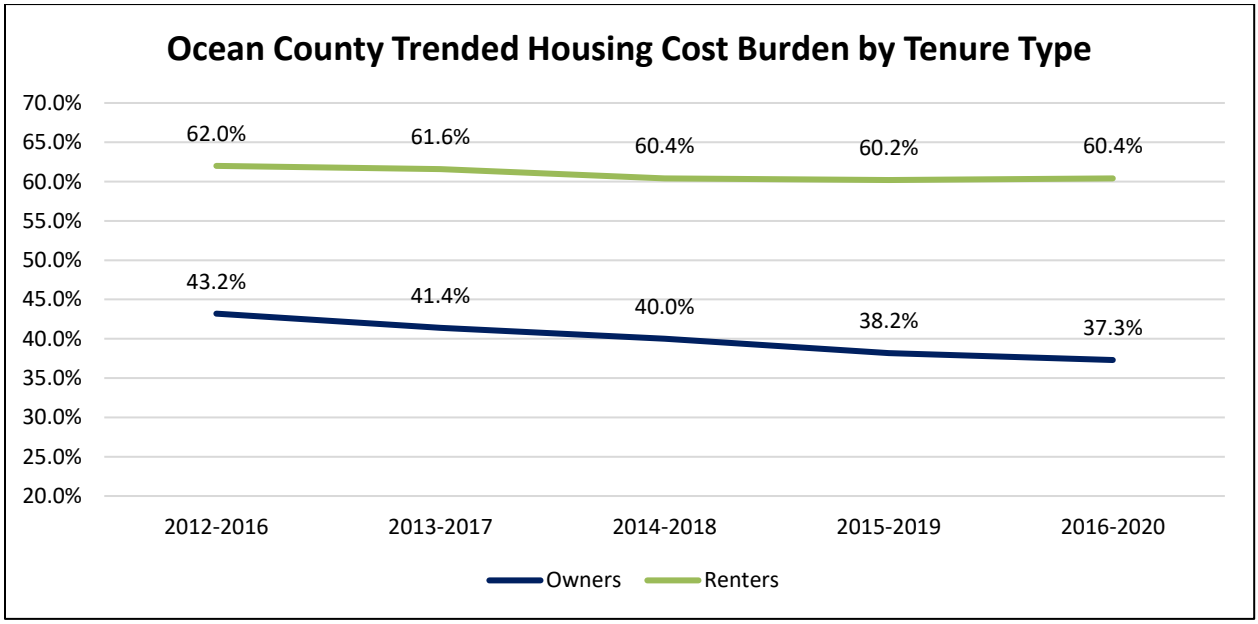
	Owners			Renters		
	Occupied Units	Median Home Value	Cost-Burdened*	Occupied Units	Median Rent	Cost-Burdened*
Burlington County	75.1%	$259,600	30.0%	24.9%	$1,388	48.4%
Ocean County	80.3%	$286,700	37.3%	19.7%	$1,459	60.4%
New Jersey	64.0%	$343,500	34.1%	36.0%	$1,368	50.6%
United States	64.4%	$229,800	27.4%	35.6%	$1,096	49.1%

Source: US Census Bureau, American Community Survey

*Defined as spending 30% or more of household income on rent or mortgage expenses.



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

New Jersey has older housing stock than the nation overall. Approximately 13% of housing statewide were built after 1999 compared to nearly 20% nationwide. Burlington County housing age closely mirrors statewide trends, while Ocean County has newer housing stock. Nearly 7% of housing units in Ocean County were built after 2009 compared to 4% of units statewide and 6% nationally.

2016-2020 Housing by Year Built

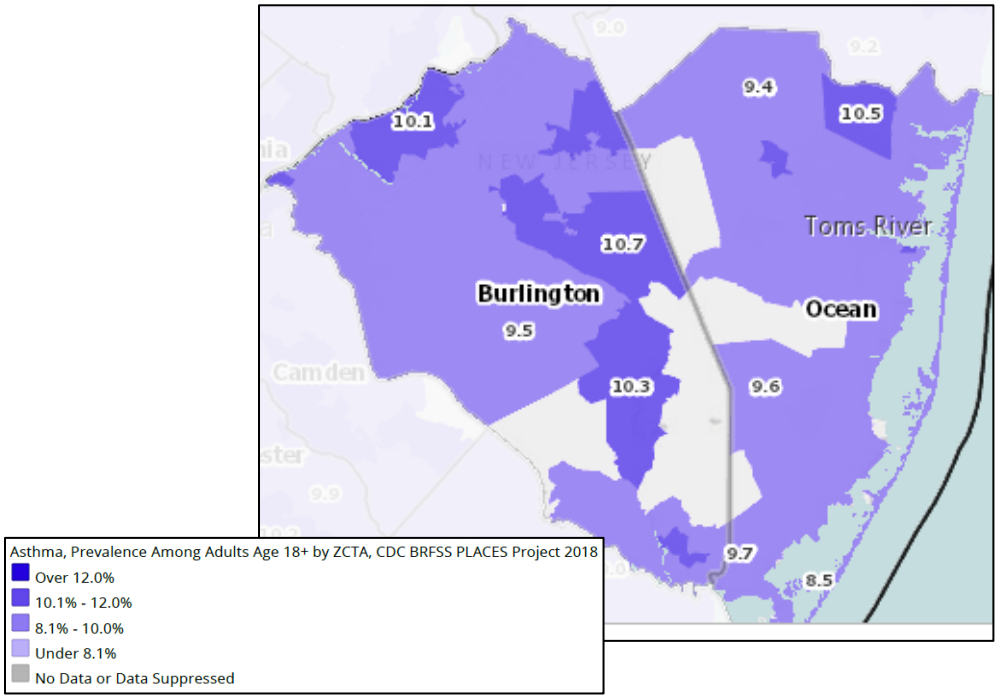
	Before 1980	1980-1999	2000-2009	2010-2013	2014 or Later
Burlington County	57.1%	28.6%	10.7%	1.8%	1.8%
Ocean County	49.3%	30.8%	13.2%	2.5%	4.1%
New Jersey	65.7%	21.5%	8.8%	1.8%	2.2%
United States	52.9%	27.2%	13.6%	2.7%	3.5%

Source: US Census Bureau, American Community Survey

Quality housing has a direct impact on health. Housing built before 1979 may contain lead paint and other hazardous materials like asbestos and can put residents at risk of health issues including lead poisoning, asthma, injury, and other chronic diseases.

Approximately 9.5% of Burlington County adults and 9.7% of Ocean County adults have been diagnosed with asthma compared to 8.3% of adults statewide and 9.6% nationally. The following map depicts adult asthma prevalence by zip code as available. Asthma prevalence is slightly higher, at approximately 11%, in zip codes 08010, Beverly and 08046, Willingboro. This finding is consistent with overall older housing in these communities, which generally have a median build year of before 1966.

2018 Adult Asthma Prevalence by Zip Code



Asthma is the most common chronic condition among children, and a leading cause of hospitalization and school absenteeism. As of 2019, 22.9% of New Jersey high school students had an asthma diagnosis, a similar proportion as the nation overall. Contrary to national trends, asthma prevalence among New Jersey youth is generally consistent across racial and ethnic groups.

2019 High School Students Ever Diagnosed with Asthma

	New Jersey	United States
Total	22.9%	21.8%
Race and Ethnicity		
Asian	19.5%	22.6%
Black or African American	23.8%	29.2%
Latinx origin (any race)	22.0%	21.0%
White	23.6%	19.8%

Source: Centers for Disease Control and Prevention, YRBS

Related to housing concerns is access to computers and internet service. Termed the "digital divide," there is a growing gap between the underprivileged members of society—especially poor, rural, elderly, and disabled populations—who do not have access to computers or the internet and the wealthy, middle-class and young Americans living in urban and suburban areas who have access.

Burlington and Ocean county residents generally have similar digital access as the state, although access is higher in Burlington County than Ocean County. This finding likely reflects the older demographic of Ocean County and digital preferences among older adults.

2016-2020 Households by Digital Access

	With Computer Access			With Internet Access	
	Computer Device	Desktop / Laptop	Smartphone	Internet Subscription	Broadband Internet
Burlington County	94.3%	85.6%	85.3%	91.0%	90.8%
Ocean County	90.5%	81.3%	77.2%	84.4%	84.0%
New Jersey	92.9%	82.1%	84.9%	88.1%	87.9%
United States	91.9%	78.3%	83.7%	85.5%	85.2%

Source: US Census Bureau, American Community Survey

Homelessness

The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness, which is mandated by the U.S. Department of Housing and Urban Development (HUD) in every community nationwide. Sheltered locations include emergency shelters and transitional housing. Unsheltered locations include cars, streets, parks, etc. PIT data provides insight into the numbers of people experiencing homelessness in communities and service gaps. Monarch Housing Associates conducts the PIT count for all of New Jersey.

The 2021 PIT count methodology was greatly affected by the COVID-19 pandemic and does not reflect the same data collected in previous years. As a result, the 2021 counts are not comparable to previous PIT counts and prior years of data were excluded from the following findings.

In 2021, there were 604 individuals in Burlington County and 366 individuals in Ocean County experiencing homelessness. Among individuals experiencing homelessness in Burlington County, 19%

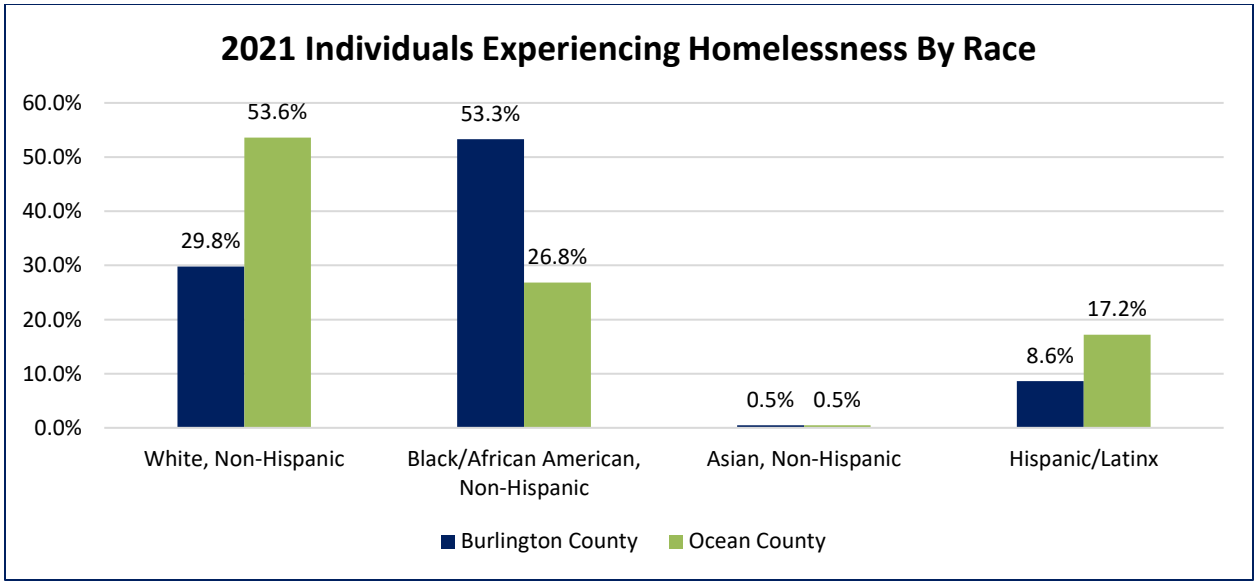
were chronically homeless and 35% were children under the age of 18. Among individuals experiencing homelessness in Ocean County, 18% were chronically homeless and 32% were children under the age of 18. Chronically homelessness is defined as individuals continuously homeless for a year or longer.

In comparing the racial breakdown of those experiencing homelessness to the racial breakdown in the general population, disparate impacts along racial lines are evident. According to the 2020 Census, **Black/African Americans comprise approximately 17% of the Burlington County total population and 3% of the Ocean County total population, but 53% of those experiencing homelessness in Burlington County and 27% of those experiencing homelessness in Ocean County**. Similarly, in Ocean County, Latinx comprise 10% of the total population, but 17% of those experiencing homelessness.

2021 Point-in-Time Homeless Count

	Persons Experiencing Homelessness		
	New Jersey	Burlington County	Ocean County
Total Individuals	8,097	604	366
Total Households	6,210	370	239
Individual Characteristics			
Chronic homeless	1,493	117	67
Veterans	442	4	18
Young adults (age 18-24)	528	31	23
Children (under age 18)	1,660	207	116
Shelter Type			
Emergency Shelter	5,823	547	296
Transitional Housing	1,432	49	55
Unsheltered	835	8	15

Source: Monarch Housing Associates



Source: Monarch Housing Associates

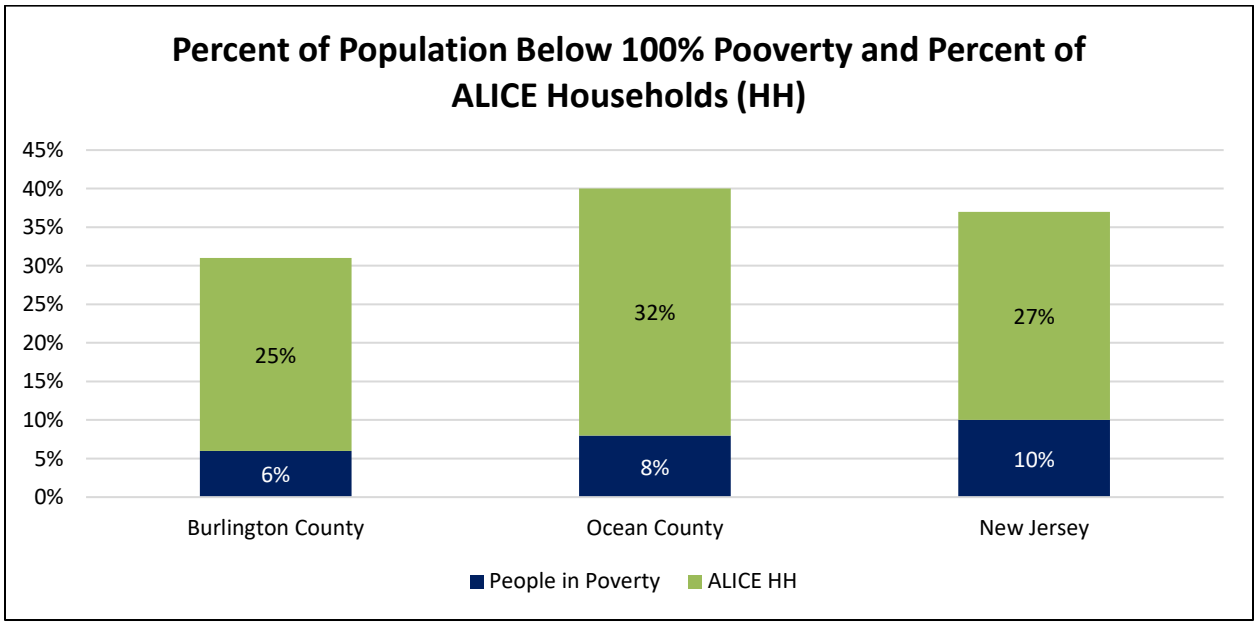
Illuminating Health Inequities

Health inequities refer to the systematic differences in opportunities that population groups have to achieve optimal health, which lead to unfair and avoidable differences in health outcomes. Without addressing inequities and supporting initiatives aimed at providing a healthy start, access to opportunity for improvement, and a tangible pathway to a better life, interventions focused only on individual behavior change often do not have enough social and environmental soil to take root and create lasting positive change. By addressing inequities in our communities, we can more effectively work towards a healthier community for all people now and in the future.

Asset Limited Income Constrained Employed (ALICE)

The ALICE threshold is an index that measures the minimum income level required to meet all basic needs for an average sized household, based on localized cost of living and local average household sizes. The ALICE index captures the percent of households whose income is above the federal poverty level, but below the threshold necessary to meet all basic needs. These households are often a paycheck or two away from acute financial strife.

While the proportion of people living below the poverty level is relatively low across Burlington and Ocean counties, one-quarter to one-third of households met the ALICE threshold of working but not being able to make ends meet ***before the start of the COVID-19 pandemic.*** While the data regarding these measures during the pandemic are not yet available, anecdotal information suggests it is likely that the proportion of struggling households has increased during more recent years.



Source: United for ALICE,2018

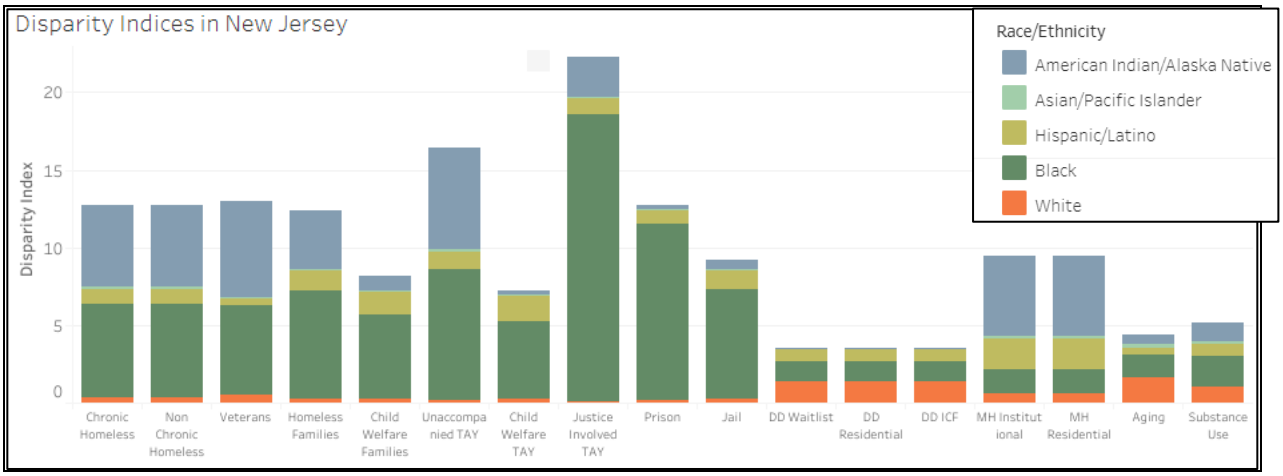
Racial Disparities and Disproportionality Index (RDDI)

The RDDI was developed by the Corporation for Supportive Housing (CSH) to assess unique systems and measure whether a racial and/or ethnic group's representation in a particular public system is

proportionate to, over, or below their representation in the overall population. Public systems include homelessness, veterans, prison/justice systems, child welfare, developmental disabilities, mental health institutions, aging population and substance use.

The index can be viewed as the likelihood of one group experiencing an event, compared to the likelihood of another group experiencing that same event. An index of 1 signifies equal representation; an index below 1 signifies underrepresentation and an index above 1 signifies overrepresentation in a system. Results are provided on a state-by-state basis.

Across New Jersey, Black/African Americans have the highest RDDI score of 6.00, indicating overrepresentation in public systems. American Indian/Alaska Native residents have the second highest index score of 5.26. In New Jersey, Black/African Americans are most overrepresented in prison and justice systems. This finding is consistent with systemic issues of racism within the nation's criminal justice system that leads to disproportionate incarceration and sentencing among people of color. American Indian/Alaska Native residents are most overrepresented among individuals experiencing homelessness and mental health institutions.



Source: Corporation for Supportive Housing
*TAY: Transition-age youth; DD: Developmental Disability; MH: Mental Health

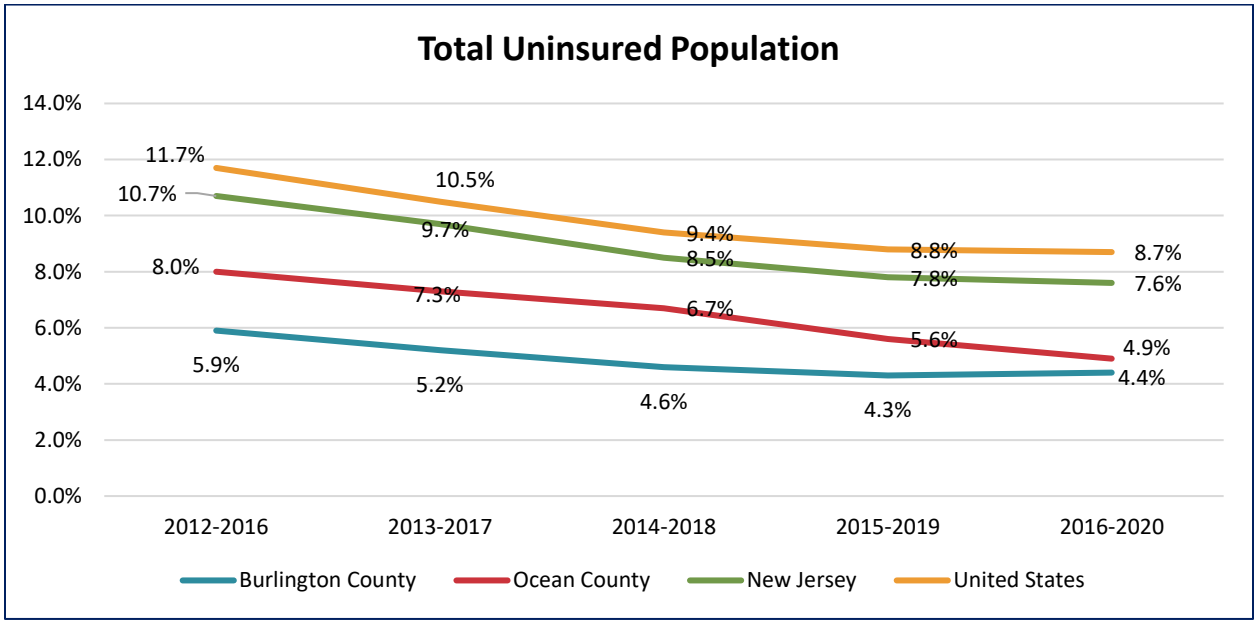
The Health of Our Community

Access to Healthcare

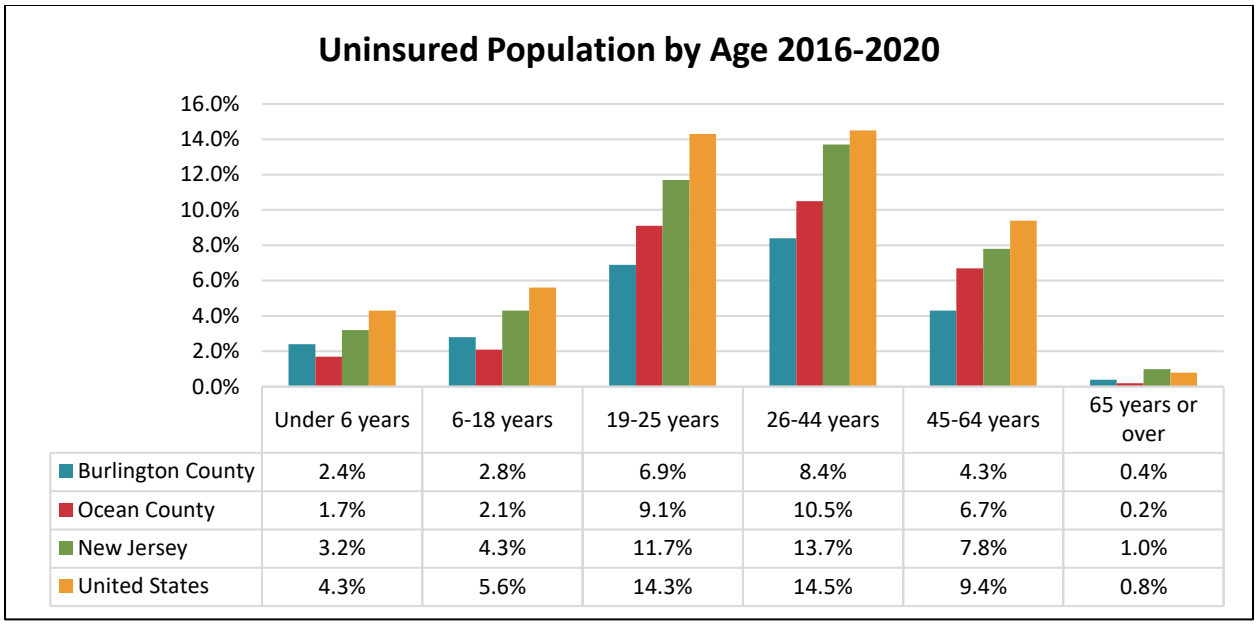
Burlington and Ocean counties continue to have a lower percentage of uninsured residents than New Jersey and the US overall. As of 2016-2020, both counties have a similar overall uninsured percentage, although Ocean County has a higher proportion of uninsured working-age adults than Burlington County.

While Burlington and Ocean counties have a lower proportion of uninsured residents overall, outcomes vary by community. **In both counties, individuals identifying as non-White have higher uninsured rates.** This disparity is most evident in Ocean County, where 24% of other race, 16% of Latinx, and 9% of Black/African American individuals are uninsured compared to 4% of Whites.

Among individuals with health insurance, nearly 70% in Burlington County and 60% in Ocean County have employer-based insurance. Burlington County has a higher proportion of individuals with employer-based insurance than the state and nation. Consistent with an aging population, nearly 1 in 4 insured residents in Ocean County are Medicare insured compared to 17% statewide.

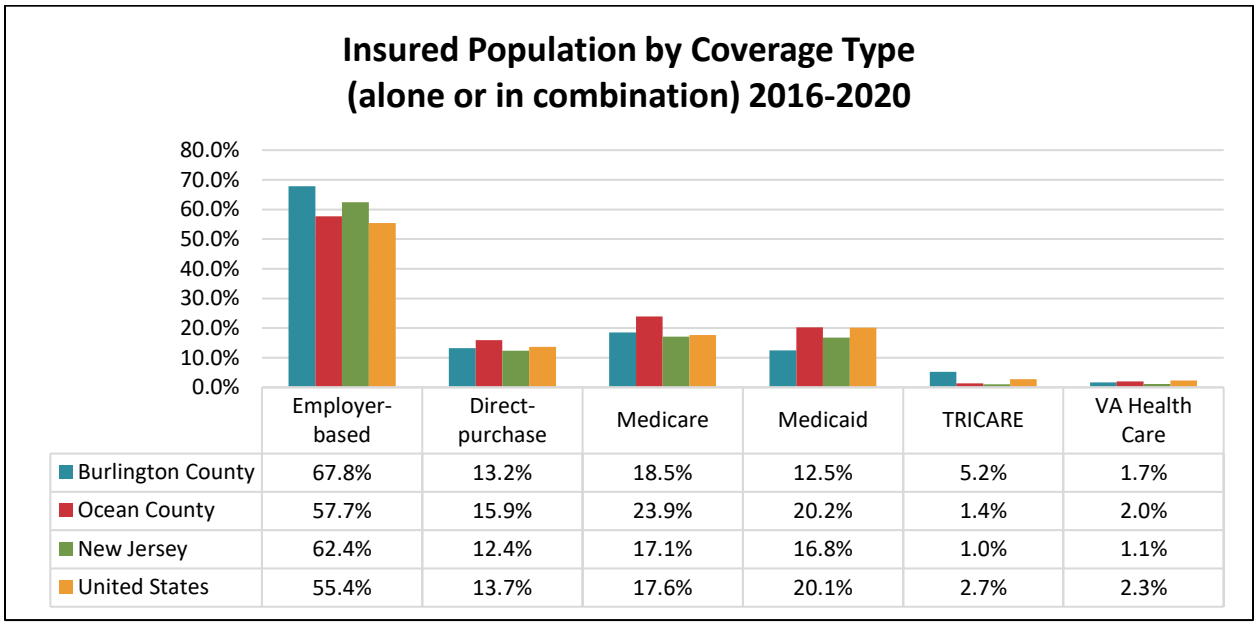


Source: US Census Bureau, American Community Survey



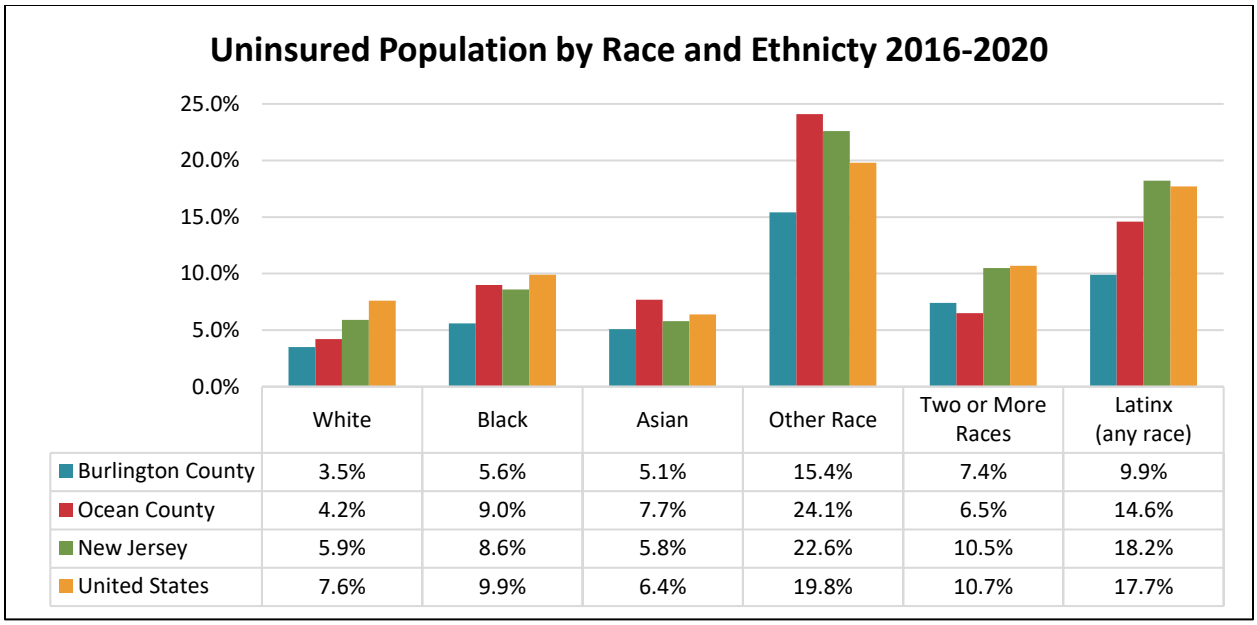
	Under 6 years	6-18 years	19-25 years	26-44 years	45-64 years	65 years or over
Burlington County	2.4%	2.8%	6.9%	8.4%	4.3%	0.4%
Ocean County	1.7%	2.1%	9.1%	10.5%	6.7%	0.2%
New Jersey	3.2%	4.3%	11.7%	13.7%	7.8%	1.0%
United States	4.3%	5.6%	14.3%	14.5%	9.4%	0.8%

Source: US Census Bureau, American Community Survey, 2016-2020



	Employer-based	Direct-purchase	Medicare	Medicaid	TRICARE	VA Health Care
Burlington County	67.8%	13.2%	18.5%	12.5%	5.2%	1.7%
Ocean County	57.7%	15.9%	23.9%	20.2%	1.4%	2.0%
New Jersey	62.4%	12.4%	17.1%	16.8%	1.0%	1.1%
United States	55.4%	13.7%	17.6%	20.1%	2.7%	2.3%

Source: US Census Bureau, American Community Survey, 2016-2020



	White	Black	Asian	Other Race	Two or More Races	Latinx (any race)
Burlington County	3.5%	5.6%	5.1%	15.4%	7.4%	9.9%
Ocean County	4.2%	9.0%	7.7%	24.1%	6.5%	14.6%
New Jersey	5.9%	8.6%	5.8%	22.6%	10.5%	18.2%
United States	7.6%	9.9%	6.4%	19.8%	10.7%	17.7%

Source: US Census Bureau, American Community Survey, 2016-2020

Availability of healthcare providers also impacts access to care and health outcomes. New Jersey overall has more primary care providers than the nation as indicated by the rate of providers per 100,000 population. Burlington County mirrors the state, while Ocean County has less than half the rate of primary care providers as the state. **Despite having fewer physicians per population, the percentage of Ocean County adults accessing routine care is similar to adults in Burlington County, although both fall below state and national averages.**

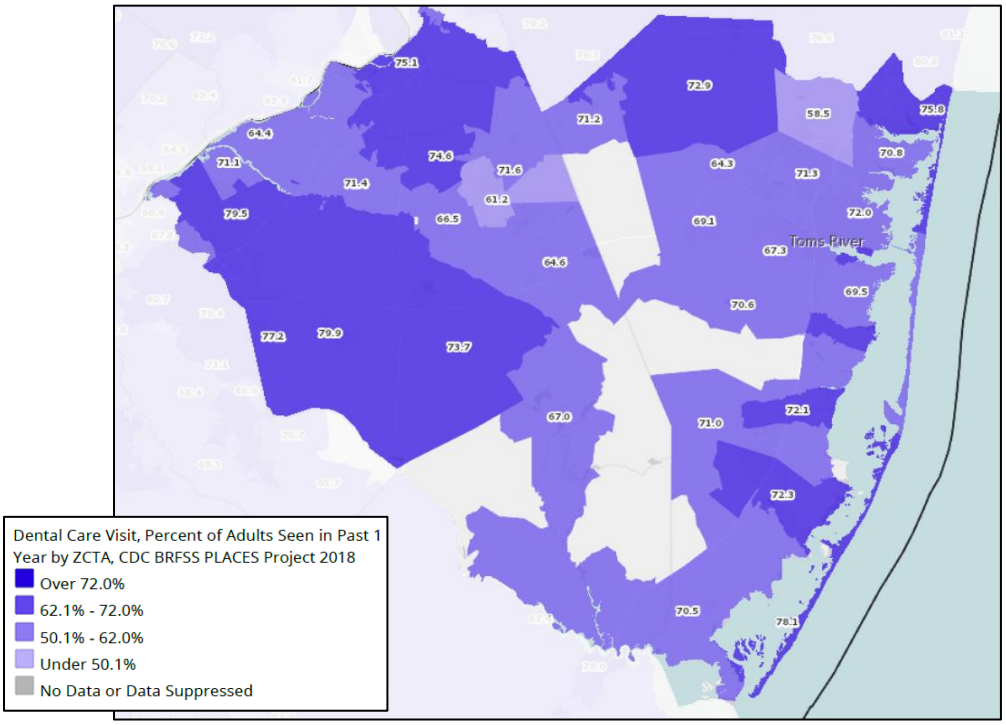
Ocean County also has fewer dental providers than Burlington County, the state, and the nation, and fewer adults accessing dental care. **Approximately 65% of Ocean County adults received recent dental care compared to 75% of Burlington County adults.** Areas of disparity in dental care access exist across Ocean County and are most evident in communities experiencing socioeconomic disadvantage, including Lakehurst, Lakewood, and Manchester Township.

Primary and Dental Provider Rates and Adult Healthcare Access

	Primary Care		Dental Care	
	Physicians per 100,000 Population (2019)	Routine Checkup within Past Year (2018)*	Dentists per 100,000 Population (2020)	Dental Visit within Past Year (2018)*
Burlington County	86.7	73.1%	75.5	74.7%
Ocean County	41.8	71.7%	62.0	64.9%
New Jersey	84.7	79.2%	88.1	71.3%
United States	76.3	75.0%	71.4	66.2%

Source: Health Resources and Services Administration & Centers for Disease Control and Prevention, BRFSS
*Data are reported as age-adjusted percentages.

2018 Adults with an Annual Dental Visit by ZIP Code



Health Risk Factors and Chronic Disease

Consistent with having better overall access to care, New Jerseyans as a whole are healthier than their peers nationally, with generally lower prevalence and mortality due to chronic disease. Despite this finding, health risk factors are prevalent among New Jersey adults. More than one-quarters of adults in Burlington and Ocean counties reported not exercising in the past 30 days, and nearly 1 in 5 adults reported smoking. While Burlington County smoking rates exceed state and national benchmarks, this finding is contrary to past CHNA findings and should continue to be monitored.

2018 Age-Adjusted Adult Physical Health Outcomes

	No Leisure-Time Physical Activity in Past 30 Days	Current Smokers
Burlington County	25.7%	17.3%
Ocean County	31.2%	14.9%
New Jersey	27.9%	13.5%
United States	23.6%	15.9%

Source: Centers for Disease Control and Prevention, PLACES & BRFSS and New Jersey Department of Health

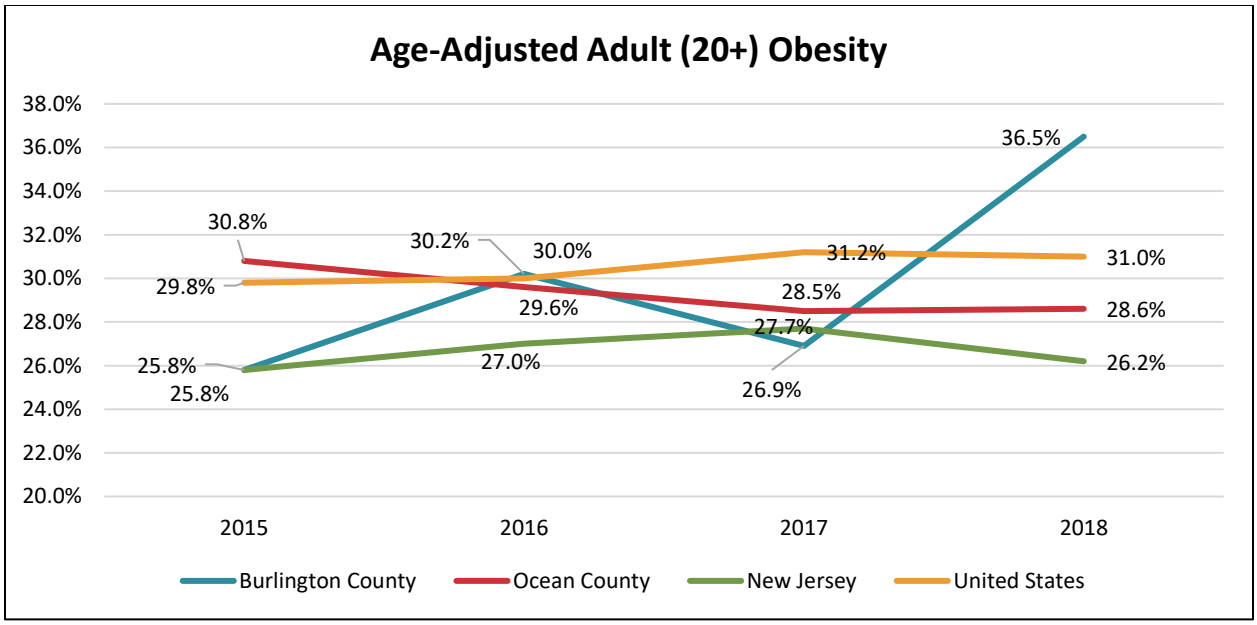
Obesity and Diabetes

Historically, New Jersey adults have a lower prevalence of obesity compared to national benchmarks, although a similar prevalence of diabetes. Burlington and Ocean counties have seen unique trends related to these conditions. **In Burlington County, the prevalence of adult obesity increased nearly 10 percentage points from 2017 to 2018, and the prevalence of diabetes increased annually since 2015**,

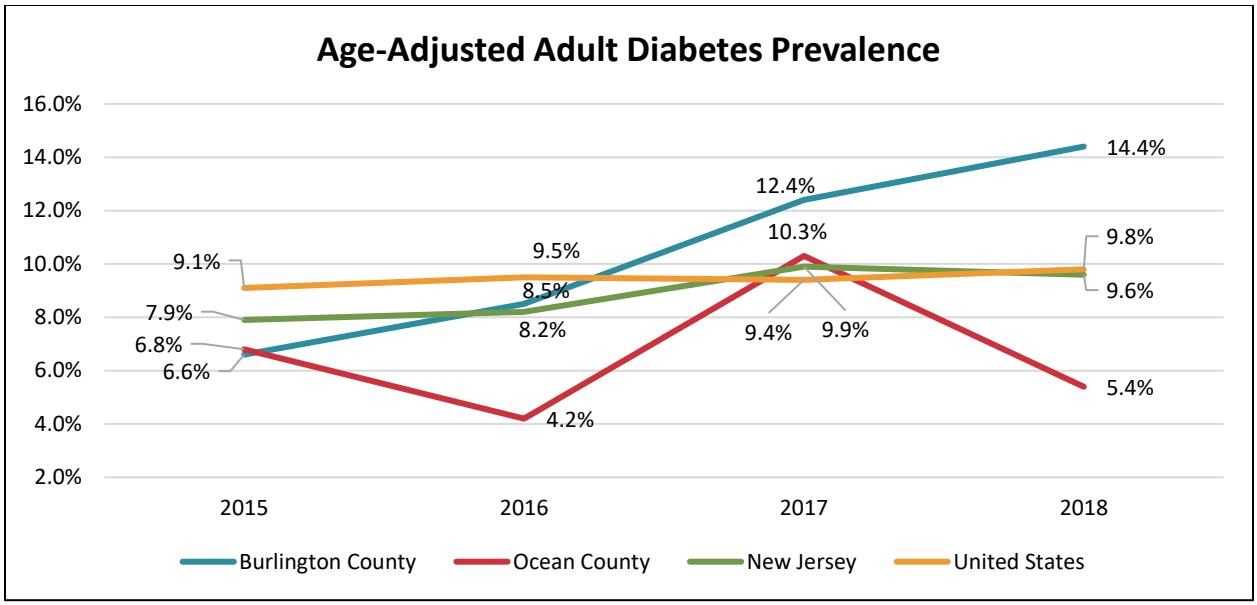
exceeding state and national benchmarks. Obesity prevalence in Ocean County generally declined, but it exceeds the statewide average. Diabetes prevalence in Ocean County has been variable, and generally lower than state and national benchmarks.

Overall, **New Jersey has a lower rate of diabetes death than the nation, although the rate increased from 2019 to 2020, likely due in part to the pandemic and related healthcare access barriers**. Burlington and Ocean counties also saw an increase in diabetes-related deaths in 2020 but continue to have a lower rate of death than the state and nation.

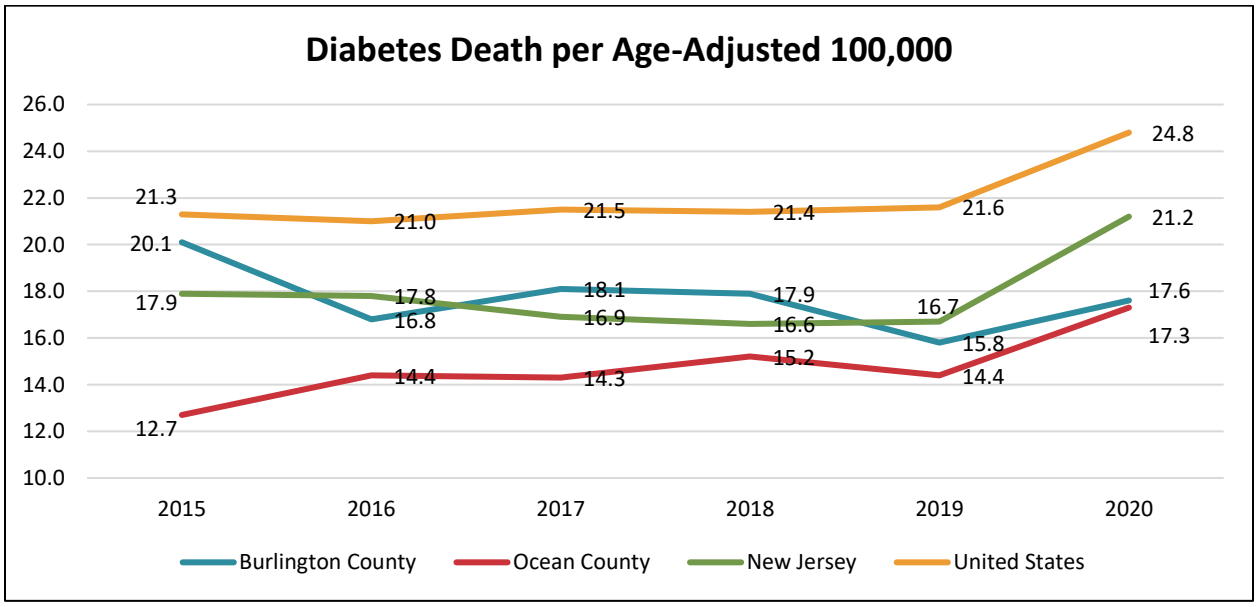
Nationally, the diabetes death rate for Black/African Americans is double the death rate for Whites. This difference is consistent across New Jersey and Burlington County. Death rates for non-White residents of Ocean County are not reportable due to low counts. Latinx residents of New Jersey also have a higher rate of death relative to the White population.



Source: Centers for Disease Control and Prevention, BRFSS and New Jersey Department of Health



Source: Centers for Disease Control and Prevention, US Diabetes Surveillance System & BRFSS



Source: Centers for Disease Control and Prevention

2020 Diabetes Death Rate per Age-Adjusted 100,000 by Race and Ethnicity

	Total Population	White, Non-Hispanic	Black or African American, Non-Hispanic	Latinx origin (any race)
Burlington County	17.6	13.4	37.0	NA (n=≤10)
Ocean County	17.3	17.5	NA (n=≤10)	NA (n=≤10)
New Jersey	21.2	16.5	47.8	25.4
United States	24.8	21.1	46.8	30.9

Source: Centers for Disease Control and Prevention

Heart Disease

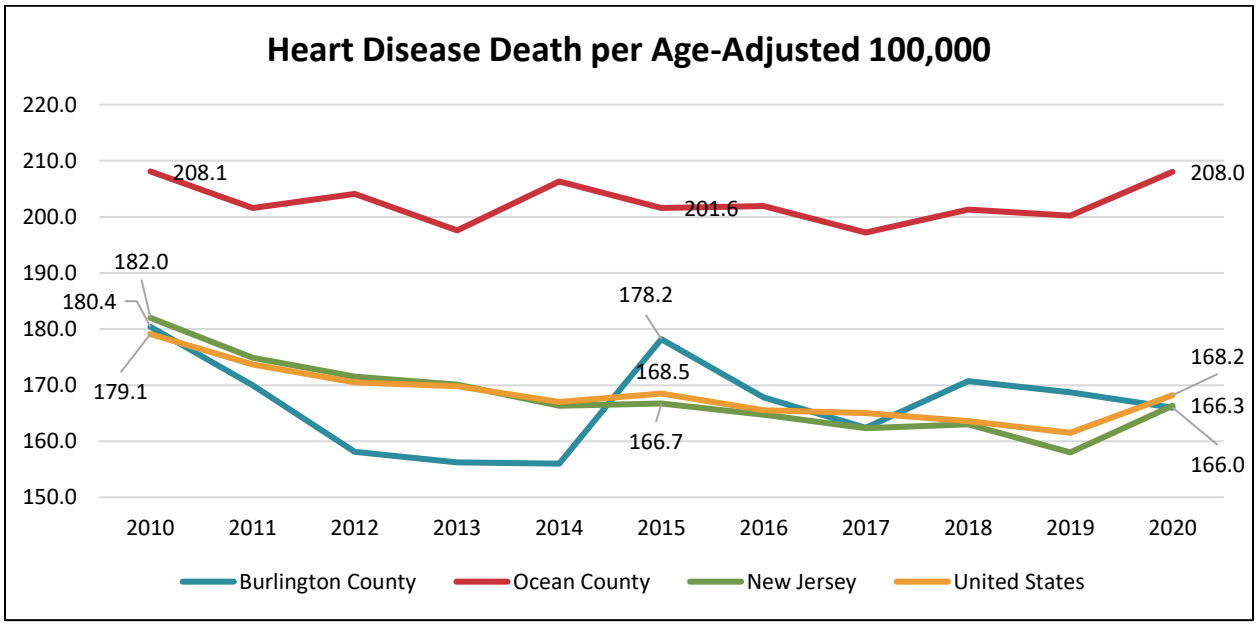
Heart disease is the leading cause of death nationally. High blood pressure and cholesterol are two of the primary causes of heart disease and can be preventable. Both Burlington and Ocean County have a higher proportion of adults with high blood pressure and/or high cholesterol than the state. **With more than one-third of adults reporting high blood pressure and/or cholesterol, Ocean County exceeds both state and national benchmarks. Overall, Ocean County has a higher rate of death due to heart disease** than Burlington County, New Jersey, and the US.

Across the nation, the heart disease death rate is higher for Black/African Americans than other racial or ethnic groups. This is consistent in Ocean County and New Jersey overall. In Ocean County, the heart disease death rate for Black/African Americans is 277.6 per 100,000 compared to 165.6 per 100,000 in Burlington County.

2017 Age-Adjusted Adult (Age 18+) Heart Disease Risk Factors Prevalence

	Adults with High Blood Pressure	Adults with High Cholesterol
Burlington County	31.7%	29.7%
Ocean County	35.7%	36.6%
New Jersey	30.2%	31.7%
United States	29.7%	29.3%

Source: Centers for Disease Control and Prevention, PLACES & BRFSS, New Jersey Department of Health



Source: Centers for Disease Control and Prevention

2020 Heart Disease Death Rate per Age-Adjusted 100,000, by Race and Ethnicity

	Total Population	White, Non-Hispanic	Black or African American, Non-Hispanic	Latinx origin (any race)
Burlington County	166.0	172.6	165.6	N/A (n=17)
Ocean County	208.0	211.8	277.6	130.5
New Jersey	166.3	173.7	219.2	113.7
United States	168.2	165.8	221.9	122.7

Source: Centers for Disease Control and Prevention

Cancer

Cancer is the second leading cause of death nationally. Overall, **Burlington and Ocean counties report higher cancer incidence than the state and nation, but comparable death rates.** This finding can indicate overall higher disease prevalence, as well as better screening, detection, and follow-up treatment of cancers. Analysis of the four most common cancer types (female breast, colorectal, lung, and prostate) illuminates the following cancer-related trends:

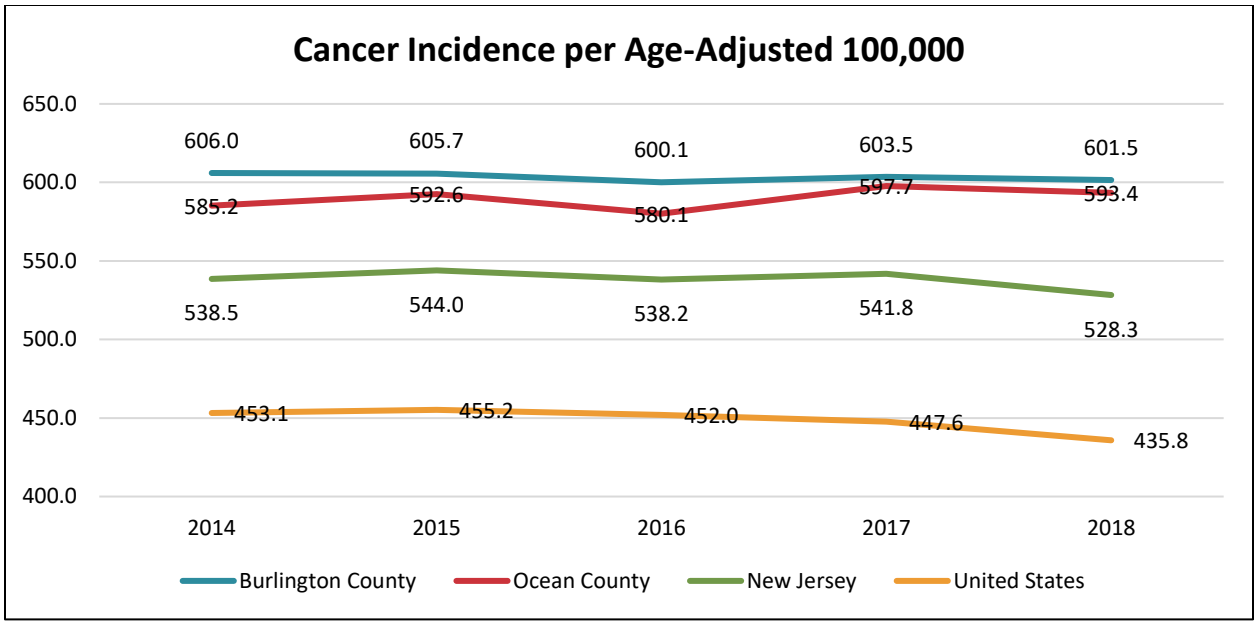
- Burlington County has higher incidence and death rates due to female breast and male prostate cancers than the state and nation, despite overall better screening practices
- Both Burlington and Ocean counties have slightly higher incidence and death rates due to colorectal cancer than the state and nation
- While both Burlington and Ocean counties have higher incidence and death rates due to lung cancer than the state and nation, rates are notably higher in Ocean County, likely due in part to historically higher smoking rates

Neither county meets the Healthy People 2030 goal for cancer-related deaths: 122.7 per 100,000. Nationally, Black/African Americans have disproportionately higher rates of cancer death compared to other racial and ethnic groups. **In Burlington County, Black/African Americans have the highest cancer incidence and death rates among racial and ethnic minorities**. Though Black/African Americans in Ocean County have similar or lower cancer incidence rates as other racial and ethnic groups, they have the highest cancer death rate that exceeds the total Ocean County population death rate: 184.9 per 100,000 versus 162.8 per 100,000.

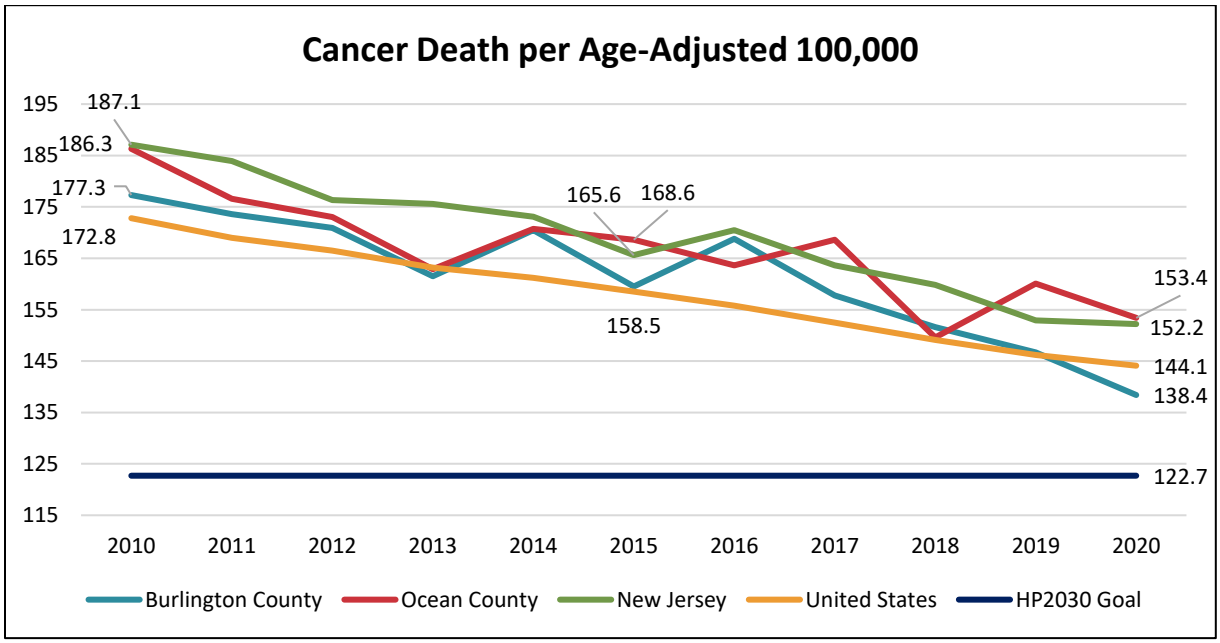
2018 Age-Adjusted Adult Cancer Incidence and Screening Practices

	Invasive Cancer Incidence Rate per 100,000	Mammogram in the Past 2 Years (50-74 years)	Cervical Cancer Screening 2 years (21-65 years)	Colon Cancer Screening (50-74 years)
Burlington County	537.9	80.5%	74.6%	73.6%
Ocean County	537.7	83.2%	86.6%	65.4%
New Jersey	479.8	80.0%	81.5%	66.7%
United States	436.8	77.8%	85.5%	65.0%
Healthy NJ Target	NA	87.5%	93.6%	70.2%

Source: New Jersey Cancer Registry & Centers for Disease Control and Prevention, United States Cancer Statistics



Source: New Jersey Cancer Registry & Centers for Disease Control and Prevention, United States Cancer Statistics

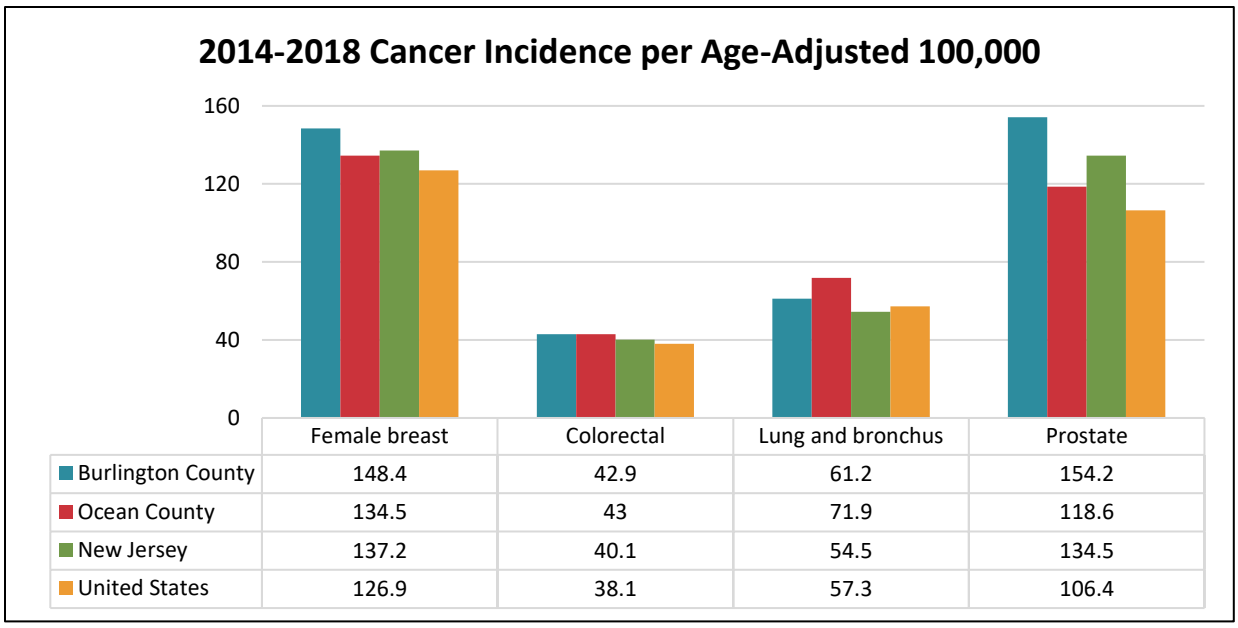


Source: Centers for Disease Control and Prevention

2014-2018 Age-Adjusted Cancer Incidence and Death per 100,000 Population by Race and Ethnicity

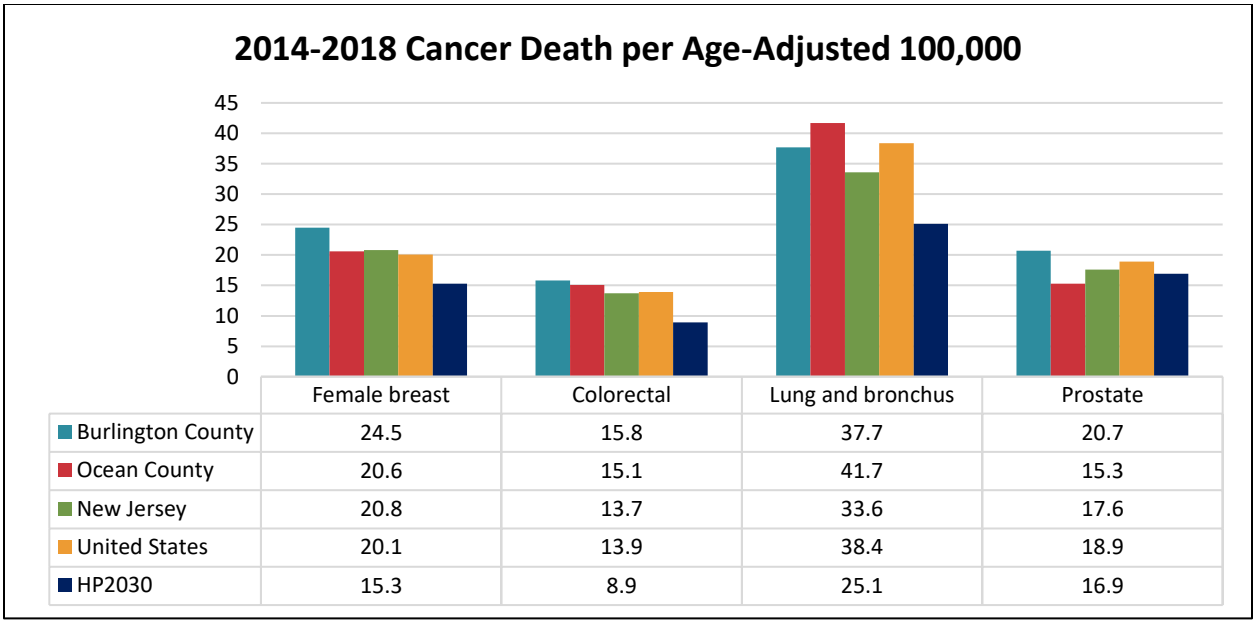
	Burlington County	Ocean County	New Jersey	United States
Cancer Incidence				
Total Population	530.2	527.9	487.0	449.0
White	541.0	523.2	499.1	451.3
Black or African American	490.8	467.5	450.7	445.4
Asian	304.0	285.5	282.5	291.5
Latinx origin (any race)	469.8	484.2	392.9	345.5
Cancer Death				
Total Population	162.1	162.8	148	155.6
White	166.4	163.9	152.1	156.4
Black or African American	163.1	184.9	167.1	177.6
Asian	79.1	66.5	74.8	97.4
Latinx origin (any race)	109.7	99.3	97.7	111.3

Source: Centers for Disease Control and Prevention, United States Cancer Statistics: Data Visualizations



	Female breast	Colorectal	Lung and bronchus	Prostate
Burlington County	148.4	42.9	61.2	154.2
Ocean County	134.5	43	71.9	118.6
New Jersey	137.2	40.1	54.5	134.5
United States	126.9	38.1	57.3	106.4

Source: Centers for Disease Control and Prevention, United States Cancer Statistics



	Female breast	Colorectal	Lung and bronchus	Prostate
Burlington County	24.5	15.8	37.7	20.7
Ocean County	20.6	15.1	41.7	15.3
New Jersey	20.8	13.7	33.6	17.6
United States	20.1	13.9	38.4	18.9
HP2030	15.3	8.9	25.1	16.9

Source: Centers for Disease Control and Prevention, United States Cancer Statistics

Respiratory Disease

Chronic lower respiratory disease (CLRD) includes several chronic conditions of the respiratory tract, including asthma and chronic obstructive pulmonary disease (COPD). The prevalence of adult asthma and COPD in Burlington County is more than double that of Ocean County, the state, and the nation, a finding that is consistent with higher reports of adult smoking in the county for 2018. Nationally, Whites have higher rates of CLRD death than other racial or ethnic groups. Burlington County and New Jersey mirror this finding. Consistent with other death rate disparities seen among Black/African Americans living in Ocean County, the CLRD death rate is higher for this population than Whites.

2018 Age-Adjusted Adult Respiratory Disease Prevalence

	Adults with Current Asthma Diagnosis	Adults with COPD
Burlington County	16.1%	14.0%
Ocean County	7.2%	2.7%
New Jersey	8.4%	5.2%
United States	9.1%	6.2%

Source: Centers for Disease Control and Prevention, PLACES & New Jersey Department of Health

2018-2020 CLRD Death Rate per Age-Adjusted 100,000, by Race and Ethnicity

	Total Population	White, Non-Hispanic	Black or African American, Non-Hispanic	Asian or Pacific Islander	Latinx origin (any race)
Burlington County	25.8	28.2	20.9	NA	NA
Ocean County	33.5	34.4	39.5	NA	NA (N=17)
New Jersey	26.4	30.0	28.2	6.5	12.9
United States	38.1	43.2	29.8	10.9	16.3

Source: Centers for Disease Control and Prevention

Aging Population

The populations of Burlington and Ocean counties are aging at a faster rate than the state and nation overall. **Ocean County has one of the highest proportions of seniors aged 65 or older in New Jersey, and these seniors are generally less healthy than their peers statewide and nationally.** According to Centers for Medicare & Medicaid Services data, approximately 81% of senior Medicare beneficiaries in Ocean County have two or more chronic conditions and 25% have six or more chronic conditions. In comparison to the 2019 CHNA, the proportion of older adult Medicare beneficiaries with multiple chronic conditions increased in both counties by 1-2 percentage points.

In addition to having higher chronic disease prevalence, older adults are more likely to experience disability. Consistent with the state and nation, approximately one-third of older adults in Burlington and Ocean counties have a disability. The most common disability among older adults is ambulatory (walking), followed by independent living and hearing. Without appropriate support services, disabilities can impede disease management and treatment efforts and further exacerbate poorer health outcomes.

2018 Chronic Condition Comorbidities among Medicare Beneficiaries 65 Years or Older

	0 to 1 Condition	2 to 3 Conditions	4 to 5 Conditions	6 or More Conditions
Burlington County	24.5%	31.2%	25.3%	19.0%
Ocean County	18.8%	28.4%	27.7%	25.1%
New Jersey	24.4%	29.4%	25.3%	20.9%
United States	29.7%	29.4%	22.8%	18.2%

Source: Centers for Medicare & Medicaid Services

2016-2020 Older Adult Population by Disability Status

	Burlington County	Ocean County	New Jersey	United States
Total population	11.8%	13.0%	10.3%	12.7%
65 years or older	30.5%	32.5%	30.6%	34.0%
Ambulatory	19.8%	21.4%	20.5%	21.5%
Hearing	12.1%	12.7%	11.0%	14.1%
Independent living	12.6%	12.1%	13.6%	14.0%
Cognitive	7.9%	6.6%	7.3%	8.4%
Vision	4.8%	5.3%	5.4%	6.2%

Source: US Census Bureau, American Community Survey

Older adult healthcare utilization and costs increase significantly with a higher number of reported chronic diseases. Tracking these indicators helps plan allocation of resources to best anticipate and serve need in the community. When compared to the nation, New Jersey overall has fewer ED visits and lower per capita spending among older adult Medicare beneficiaries. Burlington County largely mirrors the state for these findings, while **Ocean County reports fewer ED visits and lower per capita spending.**

This finding should be explored for positive healthcare management practices among Ocean County older adults.

2018 Per Capita Standardized Spending* for Medicare Beneficiaries Age 65 Years or Older

	0 to 1 Condition	2 to 3 Conditions	4 to 5 Conditions	6 or More Conditions
Burlington County	$1,890	$5,312	$10,062	$29,912
Ocean County	$2,045	$5,143	$9,480	$27,527
New Jersey	$1,921	$5,263	$9,787	$29,229
United States	$1,944	$5,502	$10,509	$29,045

Source: Centers for Medicare & Medicaid Services

*Standardized spending takes into account payment factors that are unrelated to the care provided (e.g. geographic variation in Medicare payment amounts).

2018 ED Visits per 1,000 Medicare Beneficiaries Age 65 Years or Older

	0 to 1 Condition	2 to 3 Conditions	4 to 5 Conditions	6 or More Conditions
Burlington County	95.6	269.3	564.1	1679.5
Ocean County	112.0	258.9	483.9	1,463.4
New Jersey	102.1	257.5	510.0	1,558.2
United States	122.6	318.4	621.1	1,719.1

Source: Centers for Medicare & Medicaid Services

Nationally, the most common chronic conditions among older adult Medicare beneficiaries, in order of prevalence, are hypertension, high cholesterol, and arthritis. This finding is consistent across New Jersey and Burlington and Ocean counties.

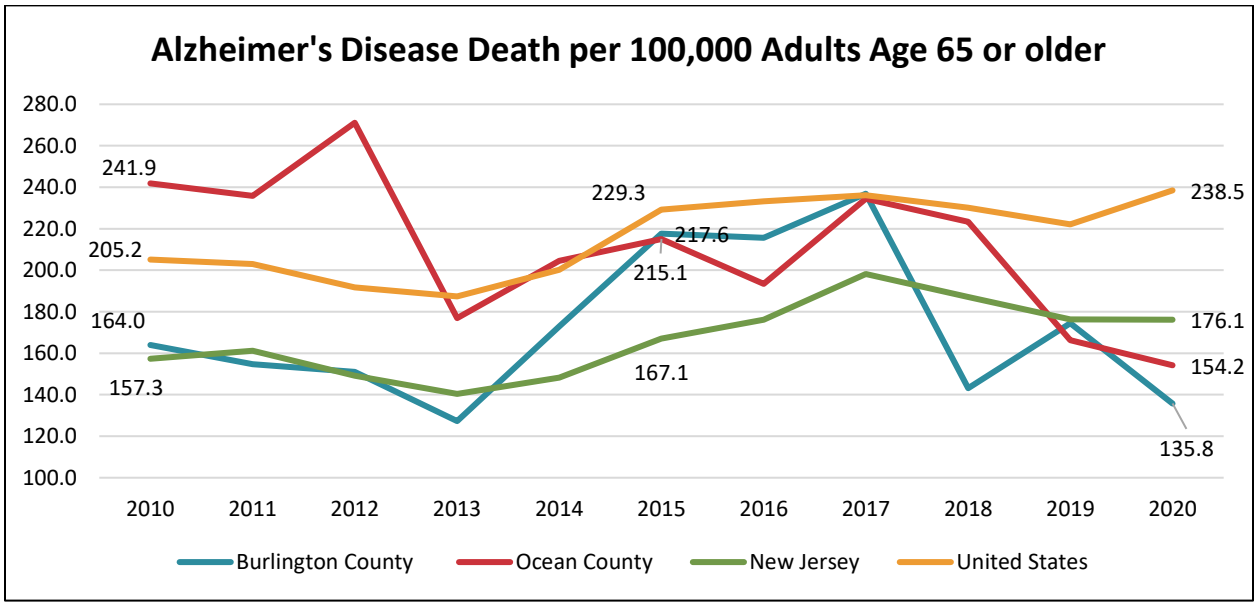
Consistent with having overall higher prevalence of chronic disease, older adults in Ocean County have a higher prevalence of all reported chronic conditions than the state and the nation, excluding Alzheimer's disease and depression. Chronic disease prevalence in Burlington County is generally consistent with the state.

Older adults in Burlington and Ocean County have a similar prevalence of Alzheimer's disease as the state and nation, but lower death rates in recent years. This finding indicates potentially improved management of Alzheimer's disease across the counties.

2018 Chronic Condition Prevalence among Medicare Beneficiaries Age 65 Years or Older

	Burlington County	Ocean County	New Jersey	United States
Alzheimer's Disease	12.2%	12.4%	12.8%	11.9%
Arthritis	36.2%	41.2%	36.3%	34.6%
Asthma	5.7%	5.7%	5.3%	4.5%
Cancer	10.9%	11.7%	10.7%	9.3%
Chronic Kidney Disease	25.8%	28.4%	25.5%	24.9%
COPD	10.5%	15.7%	11.1%	11.4%
Depression	14.4%	15.1%	14.5%	16.0%
Diabetes	28.9%	33.6%	31.5%	27.1%
Heart Failure	13.2%	17.9%	15.8%	14.6%
High Cholesterol	59.3%	67.0%	59.2%	50.5%
Hypertension	66.0%	71.1%	65.2%	59.8%
Ischemic Heart Disease	29.2%	39.1%	33.5%	28.6%
Stroke	4.9%	5.4%	5.1%	3.9%

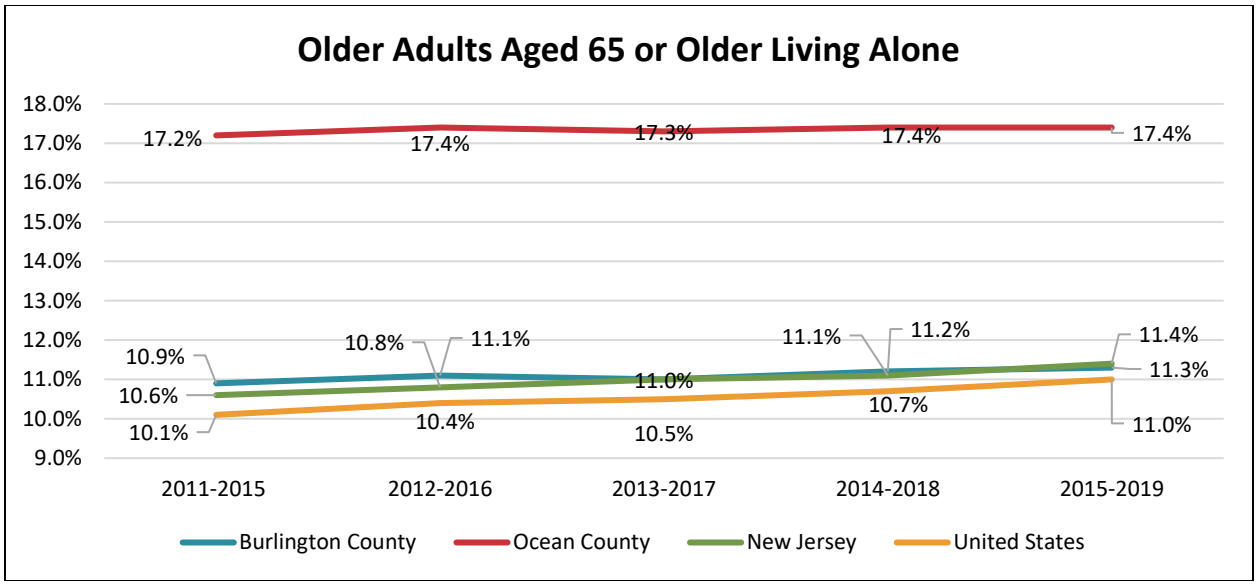
Source: Centers for Medicare & Medicaid Services



Source: Centers for Disease Control and Prevention

In older adults, chronic illness often leads to diminished quality of life and increased social isolation. Social isolation may also impede effective chronic illness management and accelerate the negative impact of chronic diseases. One indicator of social isolation among older adults is the percentage of adults aged 65 years or older who live alone.

Consistent with the nation, the proportion of older adults living alone increased across New Jersey and Burlington and Ocean counties. **Older adults in Ocean County are more likely to live alone when compared to older adults across New Jersey and the US, a finding of significance due to the high proportion of Ocean County older adults and those managing chronic illness.**

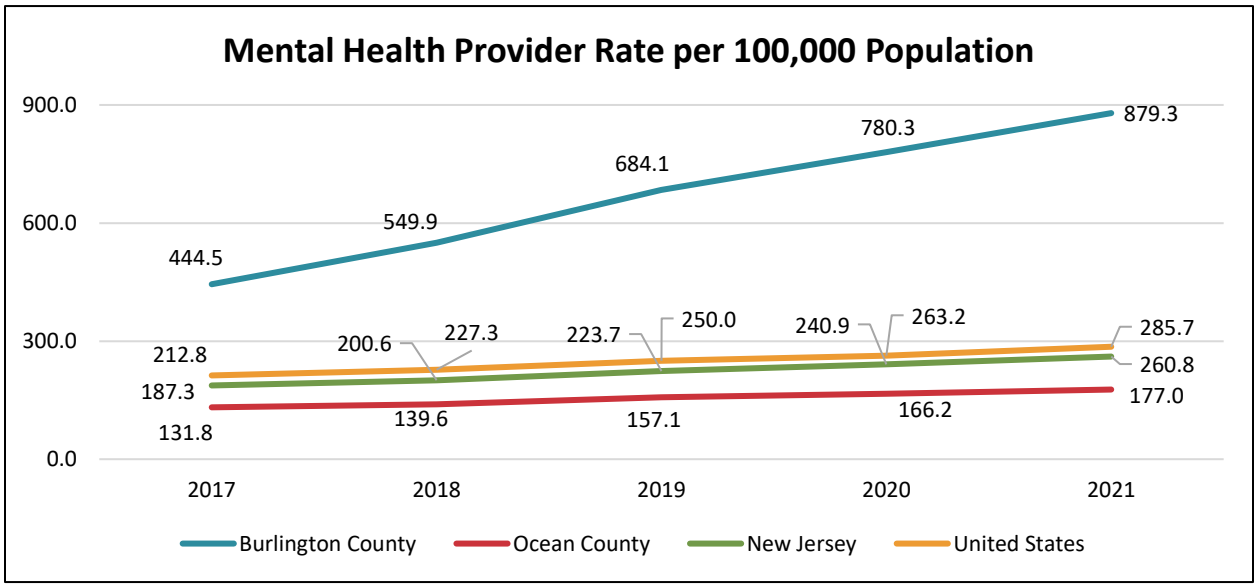


Source: US Census Bureau, American Community Survey

Mental Health and Substance Use Disorder

New Jersey overall has similar access to mental health providers as the nation, as indicated by a consistent rate of providers per 100,000. The availability of mental health providers has increased nationally and across New Jersey. **Burlington County continues to have a high rate of mental health providers that is more than triple the statewide rate.** Consistent with having overall lower provider availability, Ocean County has a lower mental health provider rate than the state and nation.

Note: The mental health provider rate includes psychiatrists, psychologists, licensed clinical social workers, counselors, and mental health providers that treat alcohol and other drug abuse, among others. It does not account for potential shortages in specific provider types.



Source: Centers for Medicare and Medicaid Services

Mental health and substance use disorder concerns are growing nationally and have historically affected New Jerseyans at a higher rate than their peers across the US. In Burlington County, approximately 1 in 5 adults have been diagnosed with depression and/or experience frequent mental distress. While Ocean County has lower reported prevalence of adult mental health concerns, these findings should be interpreted with some caution as Ocean County has fewer mental health providers to diagnose concerns.

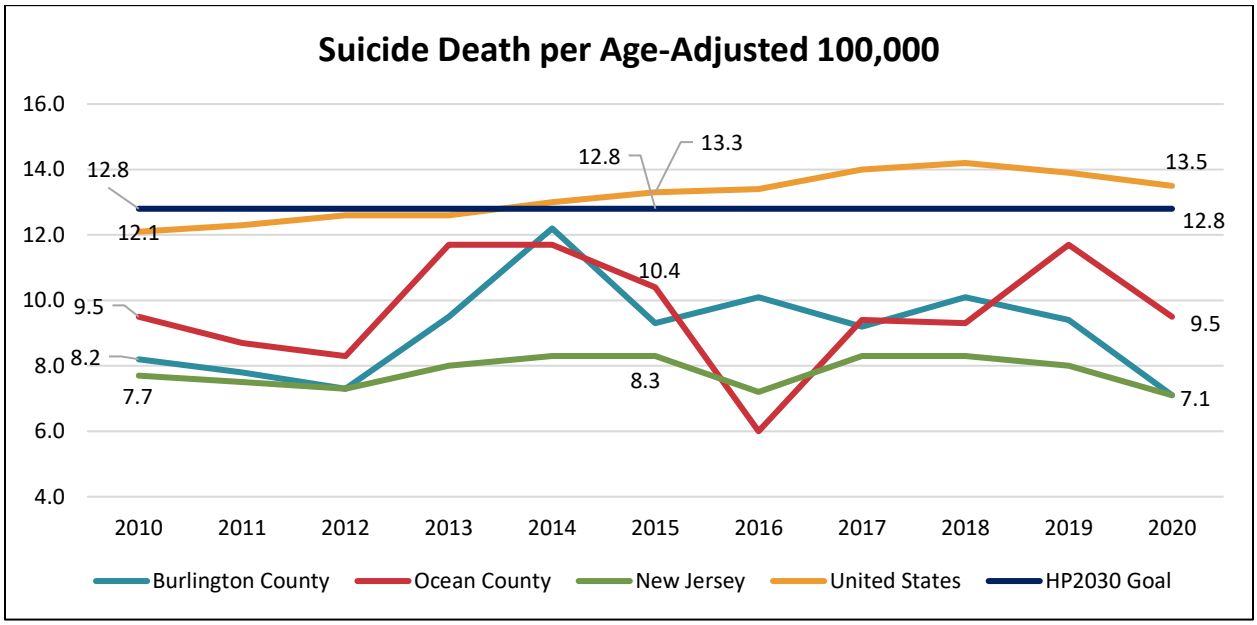
Frequent mental distress and depression are risk factors for suicide. Overall, New Jersey had a lower rate of suicide death than the nation over the past decade and it decreased slightly in recent years. **Burlington and Ocean counties have historically had a higher rate of suicide death than the state, but a lower rate than the nation that meets the Healthy People 2030 goal**. The rate of death declined in both counties from 2019 to 2020.

Statewide in 2020, men were approximately three times as likely to suffer a suicide death than women. Among racial and ethnic groups, White residents were approximately twice as likely to suffer a suicide death as other populations.

2018 Age-Adjusted Adult (Age 18+) Poor Mental Health Days

	Diagnosed With Depression	Frequent Mental Distress: 14 or More Poor Mental Health Days per Month
Burlington County	22.0%	18.4%
Ocean County	8.7%	13.9%
New Jersey	11.7%	16.7%
United States	NA	12.9%

Source: Centers for Disease Control and Prevention, BRFSS and New Jersey Department of Health



Source: Centers for Disease Control and Prevention

2020 Statewide Suicide Deaths, Demographic Characteristics

	Suicide Deaths	Age-Adjusted Rate per 100,000
Gender		
Female	154	3.4
Male	525	12.1
Age*		
15-24	75	6.9
25-34	114	9.9
35-44	85	7.4
45-54	114	9.7
55-64	131	10.7
65-74	85	9.9
75-84	41	9.1
Race and Ethnicity		
White, Non-Hispanic	507	10.4
Black/African American, Non-Hispanic	54	4.5
Asian, Non-Hispanic	49	5.3
Latinx origin (any race)	69	3.7

Source: Centers for Disease Control and Prevention
*Rates by age category are not age-adjusted.

Substance use disorder affects a person's brain and behaviors and leads to an inability to control the use of substances which include alcohol, marijuana, and opioids, among others. Alcohol is the most prevalent addictive substance used among adults.

In Burlington and Ocean counties, nearly 20% of adults report binge or heavy drinking compared to approximately 16% across New Jersey. Binge drinking includes males having five or more drinks on one occasion and females having four or more drinks on one occasion. Of note, the proportion of driving deaths due to alcohol impairment increased in Ocean County for the most recent reporting years, accounting for 1 in 4 driving-related deaths. From 2016-2020, a total of 43 alcohol-impaired driving deaths occurred in Burlington County and 52 occurred in Ocean County.

Alcohol Use Disorder Indicators

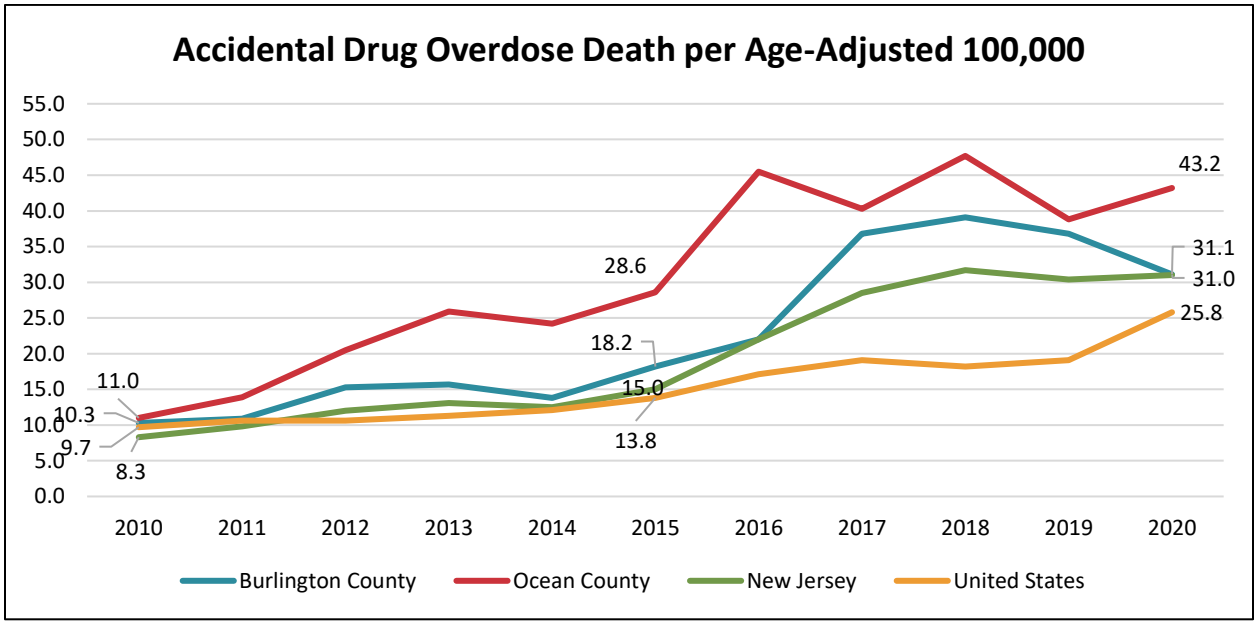
	2019 Adults Reporting Binge or Heavy Drinking (age-adjusted)	2016-2020 Driving Deaths due to Alcohol Impairment (%, count)
Burlington County	19.8%	19.9%
Ocean County	19.4%	25.7%
New Jersey	16.0%	22.8%
United States	20.0%	27.0%

Source: Centers for Disease Control and Prevention, BRFSS

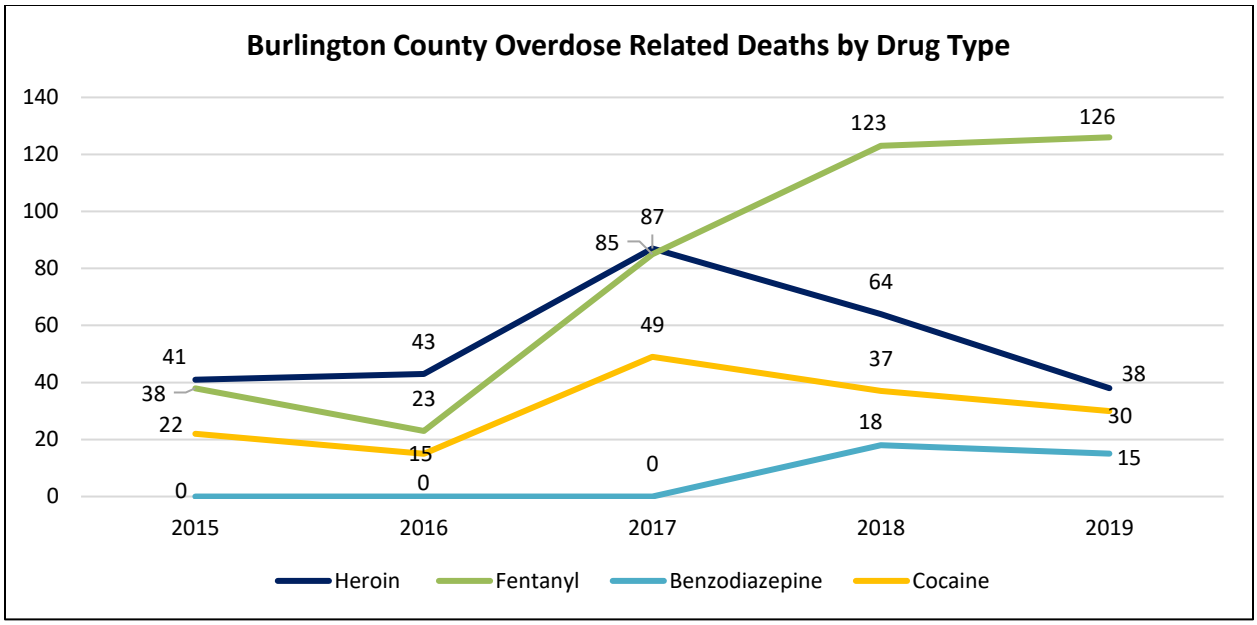
Provisional data released by the CDC predicts that 2020 and 2021 brought the highest number of overdose deaths ever in the US. Nationally, from 2019 to 2020, the accidental drug overdose death rate per 100,000 increased from 19.1 to 25.8. New Jersey has historically had more drug overdose deaths than the nation but saw a smaller death rate increase from 2019 to 2020 of 30.4 to 31.0.

Ocean County has experienced more accidental drug overdose deaths than the state, and the rate of deaths nearly quadrupled from 2010 to 2020. The accidental drug overdose death rate for Burlington County has declined since 2018 and is on par with the state. In 2020, a total of 139 accidental drug overdose occurred in Burlington County and 217 deaths occurred in Ocean County.

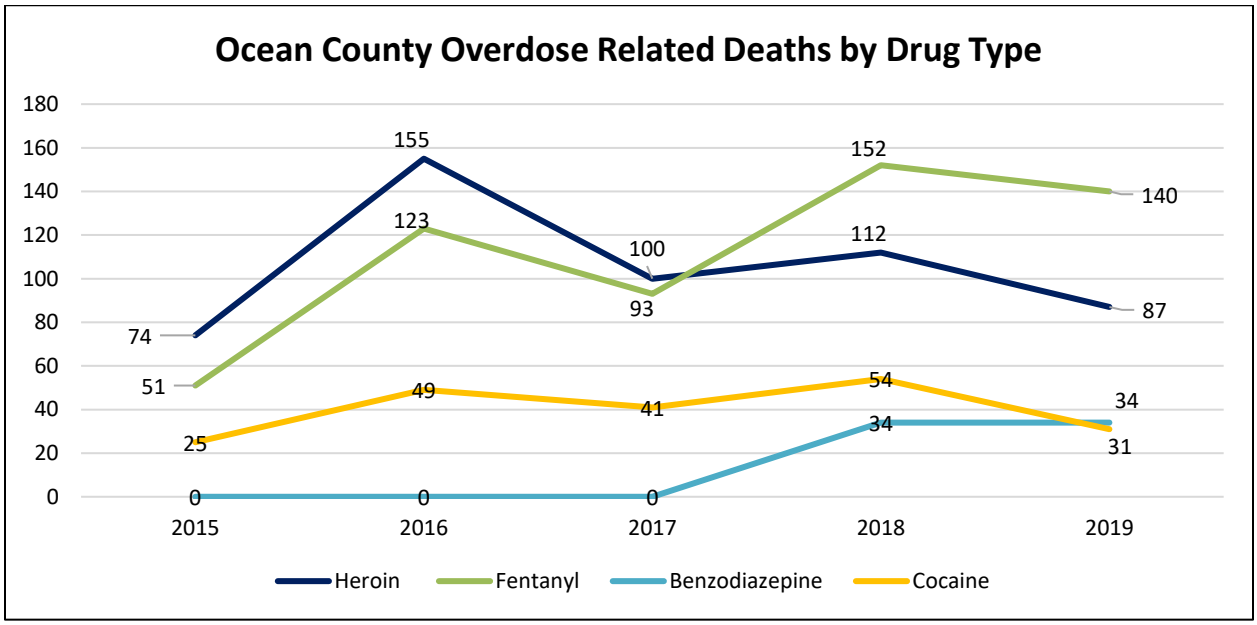
Consistent with prior year trends, heroin- and prescription opioid-involved deaths declined nationally and across New Jersey, while synthetic opioid-involved deaths (primarily fentanyl) increased. Synthetic opioids are laboratory produced and have similar effects as natural opioids, but can have far greater potency, increasing the risk for overdose and death. **An analysis of overdose-related deaths occurring among Burlington and Ocean county residents in 2019 found that approximately 50-60% of deaths involved fentanyl.**



Source: Centers for Disease Control and Prevention

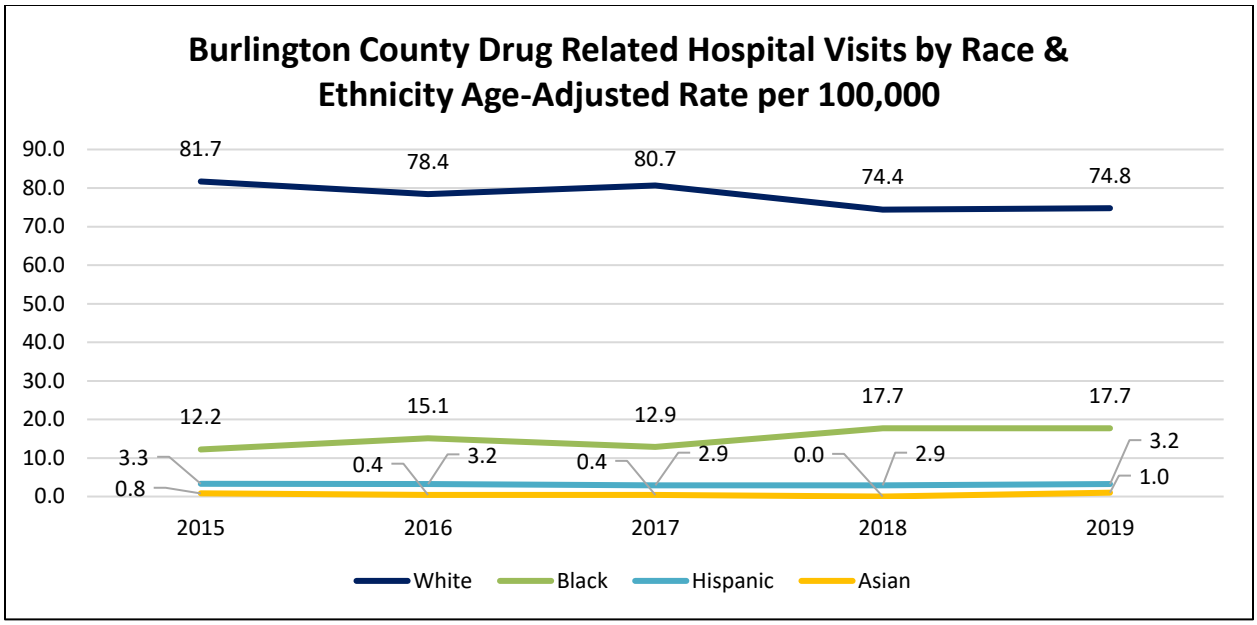


Source: New Jersey Department of Health, Population Health

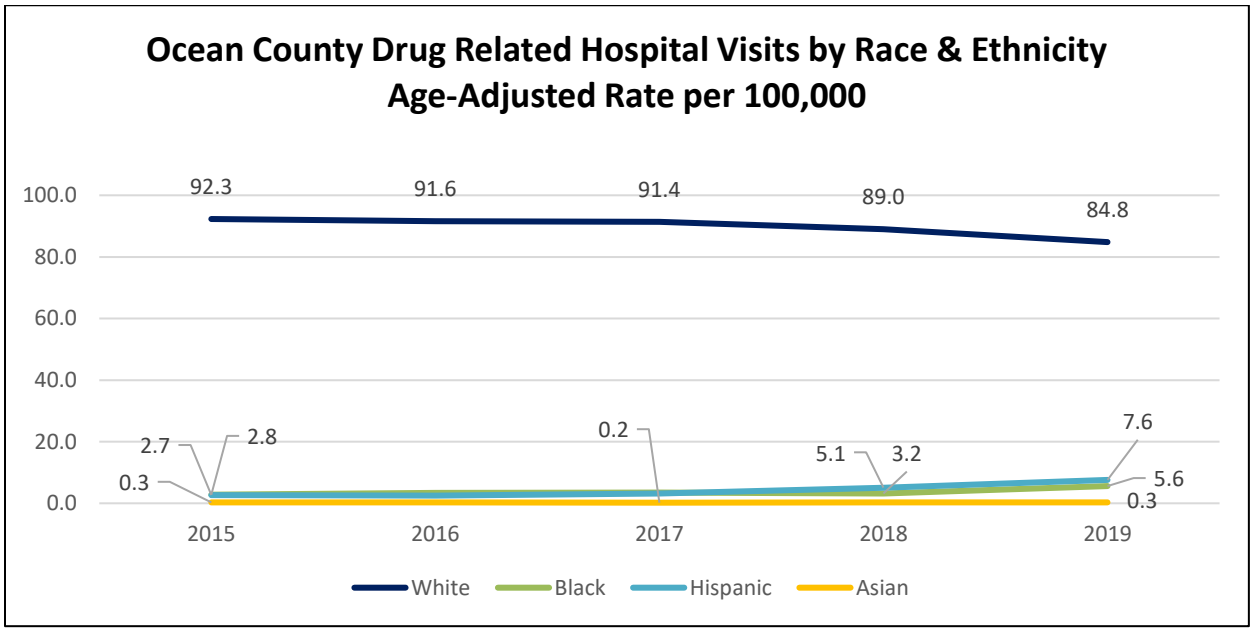


Source: New Jersey Department of Health, Population Health

When compared to other racial and ethnic groups, White residents of Burlington and Ocean counties have a higher rate of drug-related hospital visits, although the rate has declined. Of note, in Burlington County, Black/African Americans have the second highest drug-related hospital visit rate and it increased from 2015 to 2019.



Source: New Jersey Department of Health, Population Health



Source: New Jersey Department of Health, Population Health

Youth Health

The Youth Risk Behavior Survey (YRBS) is conducted by the CDC every two years to monitor health-related behaviors that contribute to the leading causes of death and disability among youth and adults. The survey is conducted nationally for public and private school students in 9th through 12th grades. The following is a summary of YRBS results for New Jersey students.

Overweight and Obesity

Childhood obesity is a persistent and significant threat to the long-term health of today's youth. The CDC reports that children who have obesity are more likely to have high blood pressure and high cholesterol; glucose intolerance, insulin resistance and type 2 diabetes; breathing problems like asthma and sleep apnea; joint and musculoskeletal problems; and psychological and social problems, such as anxiety, depression, low self-esteem, and bullying; among other concerns.

When compared to the nation, fewer New Jersey high school students have obesity, although the percentage increased from 2013 to 2019. The most at-risk populations for youth obesity in New Jersey are males (13.9%), Black/African Americans (19.9%), and students identifying as lesbian, gay, or bisexual (LGB) (20%).

High School Students with Obesity

	2013	2015	2017	2019
New Jersey	8.7%	N/A	N/A	11.9%
United States	13.7%	13.9%	14.8%	15.5%

Source: Centers for Disease Control and Prevention, YRBS

*New Jersey data are not reported for 2015 and 2017.

2019 High School Students with Obesity

	New Jersey	United States
Gender		
Female	9.9%	11.9%
Male	13.9%	18.9%
Race and Ethnicity		
White	10.4%	13.1%
Black or African American	19.9%	21.1%
Latinx origin (any race)	15.2%	19.2%
Sexual Identity		
Lesbian, Gay, Bisexual (LGB)	21.0%	21.0%
Straight	10.7%	14.4%

Source: Centers for Disease Control and Prevention, YRBS

Behavioral Health

Historically, New Jersey has reported fewer high school students attempting suicide than the nation, and suicide attempts decreased from 2013 to 2019, contrary to national increases. Though reported suicide attempts decreased, the percentage of students who reported feeling consistently sad or helpless has consistently increased.

When considered by subgroup, attempted suicide is highest among students identifying as LGB and/or Black/African Americans in New Jersey. This finding is consistent nationwide. **In 2019, New Jersey students identifying as LGB were more than four times as likely to report an attempted suicide as straight identifying students.**

Overall, teenage death by accident, homicide, or suicide is lower in New Jersey than the US. In 2019, the death rate in New Jersey was 23 per 100,000 versus 34 per 100,000 across the nation.

High School Students Reporting an Attempted Suicide

	2013	2015	2017	2019
New Jersey	9.9%	N/A	N/A	5.9%
United States	8.0%	8.6%	7.4%	8.9%

Source: Centers for Disease Control and Prevention, YRBS
*New Jersey data are not reported for 2015 and 2017.

2019 High School Students Reporting an Attempted Suicide

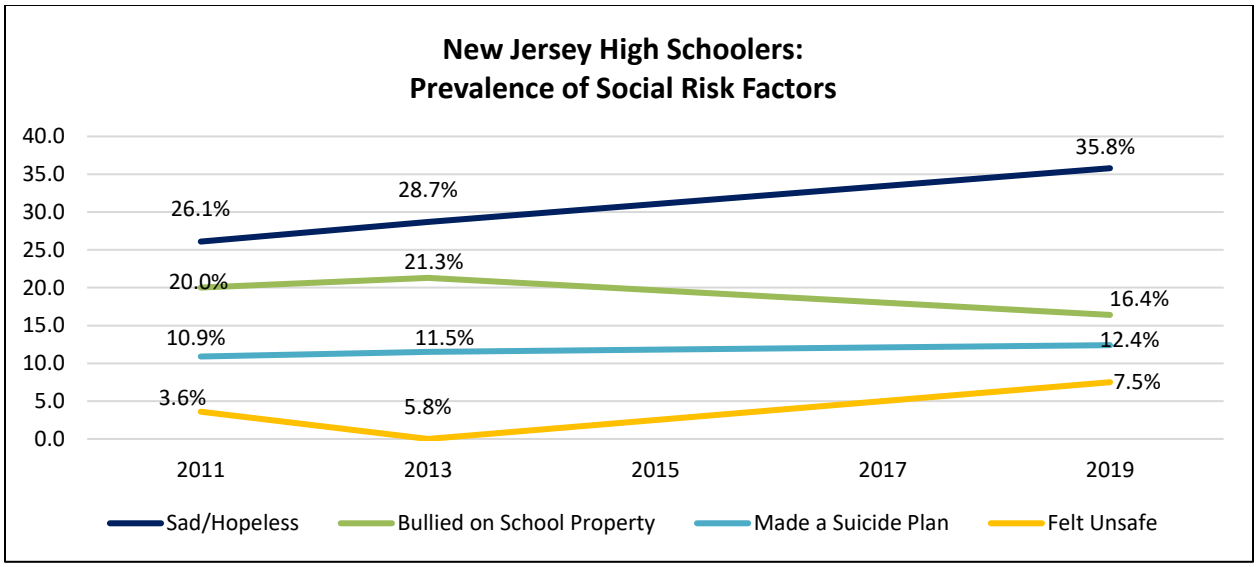
	New Jersey	United States
Gender		
Female	6.9%	8.9%
Male	4.8%	6.6%
Race and Ethnicity		
Asian	4.5%	7.7%
Black or African American	11.3%	11.8%
Latinx origin (any race)	5.3%	8.9%
White	4.9%	7.9%
Sexual Identity		
Lesbian, Gay, Bisexual (LGB)	13.2%	23.4%
Straight	4.8%	6.4%

Source: Centers for Disease Control and Prevention, YRBS

Teenage Deaths by Accident, Homicide, and Suicide Rate per 100,000

	2015	2016	2017	2018	2019
New Jersey	21	23	24	17	23
United States	36	38	39	37	36

Source: Annie E. Casey Foundation Kids Count Data Center



Source: Centers for Disease Control and Prevention, YRBS

*New Jersey data are not reported for 2015 and 2017.

Substance Use (Tobacco, Alcohol, Drugs)

New Jersey high school students are less likely to use e-cigarettes compared to the nation, although more than 1 in 4 students report recent use. Consistent with the nation, e-cigarette use is highest among White students and students who identify as LGB. The prevalence of alcohol use among New Jersey high school students steadily decreased since 2011, while marijuana use has been stable.

High School Students Reporting Current (within past 30 days) E-Cigarette Use

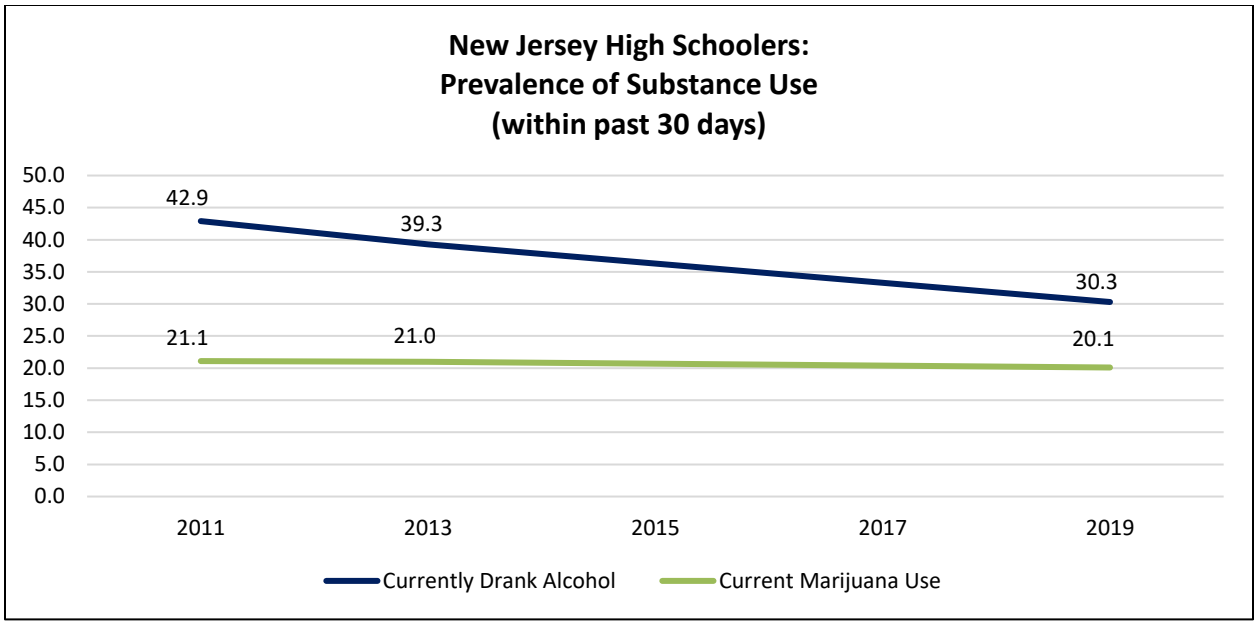
	2015	2017	2019
New Jersey	N/A	N/A	27.6%
United States	24.1%	13.2%	32.7%

Source: Centers for Disease Control and Prevention, YRBS

2019 High School Students Reporting Current (within past 30 days) E-Cigarette Use

	New Jersey	United States
Gender		
Female	26.7%	33.5%
Male	28.3%	32.0%
Race and Ethnicity		
Asian	17.8%	13.0%
Black or African American	18.4%	19.7%
Latinx origin (any race)	28.0%	31.2%
White	31.6%	38.3%
Sexual Identity		
Lesbian, Gay, Bisexual (LGB)	29.9%	34.1%
Straight	27.6%	32.8%

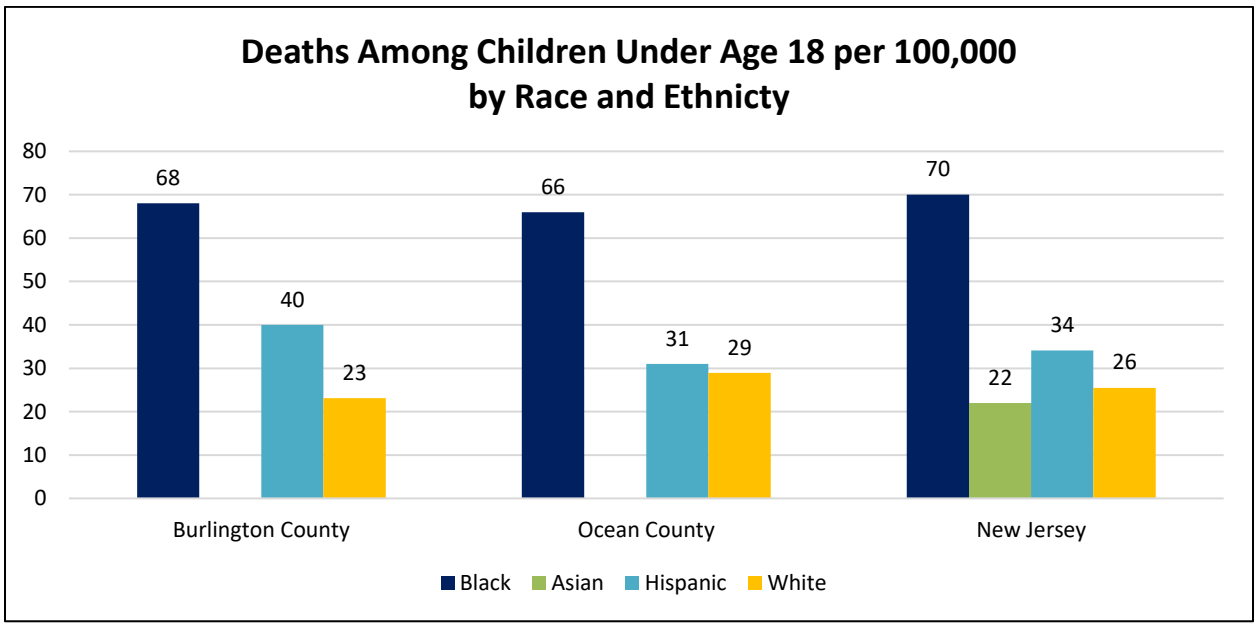
Source: Centers for Disease Control and Prevention, YRBS



Source: Centers for Disease Control and Prevention, YRBS
*New Jersey data are not reported for 2015 and 2017.

Child Fatality

Consistent with the state, Black/African American children in Burlington and Ocean counties have higher death rates than other racial or ethnic groups. **In both counties, the death rate for young Black/African American children is approximately three times as high as the death rate for young White children.** In Burlington County, there is also a significant disparity in deaths among young Latinx children compared their White counterparts, estimated as nearly twice as high.



Source: National Center for Health Statistics – Mortality Files, 2017-2020
*Data not available for Asian children of Burlington and Ocean counties.

Maternal and Infant Health

New Jersey overall reports better birth outcomes than the nation, including fewer teen births, earlier access to prenatal care, fewer premature and low birth weight births, and lower tobacco use during pregnancy. Burlington and Ocean counties have similar or better outcomes as the state, and metrics have generally improved in recent years.

Nationally, Black/African Americans experience poorer birth outcomes than other racial or ethnic groups. Approximately 68% of Black/African Americans receive first trimester prenatal care compared to nearly 83% of Whites, and Black/African American babies are approximately twice as likely to be born with low birth weight and/or preterm. This finding is consistent across New Jersey, including Burlington and Ocean counties. These disparities are reflected in infant and maternal death rates. In Burlington County, the infant death rate for Black/African Americans is 6.9 per 1,00 live births compared to 3.7 per 1,000 live births for White babies.

2020 Maternal and Infant Health Indicators by Race and Ethnicity

	First Trimester Prenatal Care	Premature Births	Low Birth Weight Births	Non-Smoking during Pregnancy
Burlington County	**79.1%**	**8.9%**	**6.9%**	**94.9%**
Asian	79.6%	10.7%	9.7%	99.7%
Black/African American, non-Hispanic	68.7%	10.9%	10.9%	95.5%
White, non-Hispanic	84.6%	7.7%	5.0%	94.1%
Latinx origin (any race)	73.7%	8.8%	7.4%	94.7%
Ocean County	**74.5%**	**7.1%**	**6.0%**	**98.0%**
Asian	77.6%	8.2%	7.1%	98.8%
Black/African American, non-Hispanic	68.1%	14.4%	13.5%	96.9%
White, non-Hispanic	75.1%	6.3%	5.5%	98.1%
Latinx origin (any race)	71.1%	10.2%	7.8%	98.8%
New Jersey	75.5%	9.3%	7.7%	97.1%
Asian	83.5%	8.6%	8.8%	99.7%
Black/African American, non-Hispanic	62.4%	13.7%	13.2%	95.7%
White, non-Hispanic	83.4%	7.6%	5.9%	95.5%
Latinx origin (any race)	66.5%	10.0%	7.4%	97.8%
United States	77.7%	10.1%	8.2%	94.4%
Asian	NA	NA	NA	NA
Black/African American, non-Hispanic	68.4%	14.4%	14.2%	95.4%
White, non-Hispanic	82.8%	9.1%	6.8%	91.8%
Latinx origin (any race)	72.3%	9.8	7.4%	98.6%
HP2030 Goal	80.5%	9.4%	NA	95.7%

Source: New Jersey Department of Health & Centers for Disease Control and Prevention

2020 Teenage Births by Race and Ethnicity

	Teen (15-17) Birth Percentage	Teen (18-19) Birth Percentage
Burlington County	NA (n=19)	15.7
Ocean County	2.6	15.5
New Jersey	3.6	18.3
Black/African American, non-Hispanic	6.3	27.6
White, non-Hispanic	0.4	4.9
Latinx origin (any race)	9.2	41.3
United States	6.3	26.5
Black/African American, non-Hispanic	10.9	44.1
White, non-Hispanic	3.4	17.9
Latinx origin (any race)	10.5	43.3

Source: New Jersey Department of Health & Centers for Disease Control and Prevention

2015-2019 Infant Deaths per 1,000 Live Births

	Infant Deaths per 1,000 Live Births
Burlington County	**5.0**
White, Non-Hispanic	3.7
Black/African American, Non-Hispanic	6.9
Asian	NA (n=8)
Latina (any origin)	NA (n=10)
Ocean County	**3.1**
White, Non-Hispanic	2.5
Black/African American, Non-Hispanic	NA (n=18)
Asian	NA (n=5)
Latina (any origin)	NA (N=9)
New Jersey	6.1
White, Non-Hispanic	2.6
Black/African American, Non-Hispanic	9.3
Asian	2.5
Latina (any origin)	4.2
HP2030 Goal	5.0

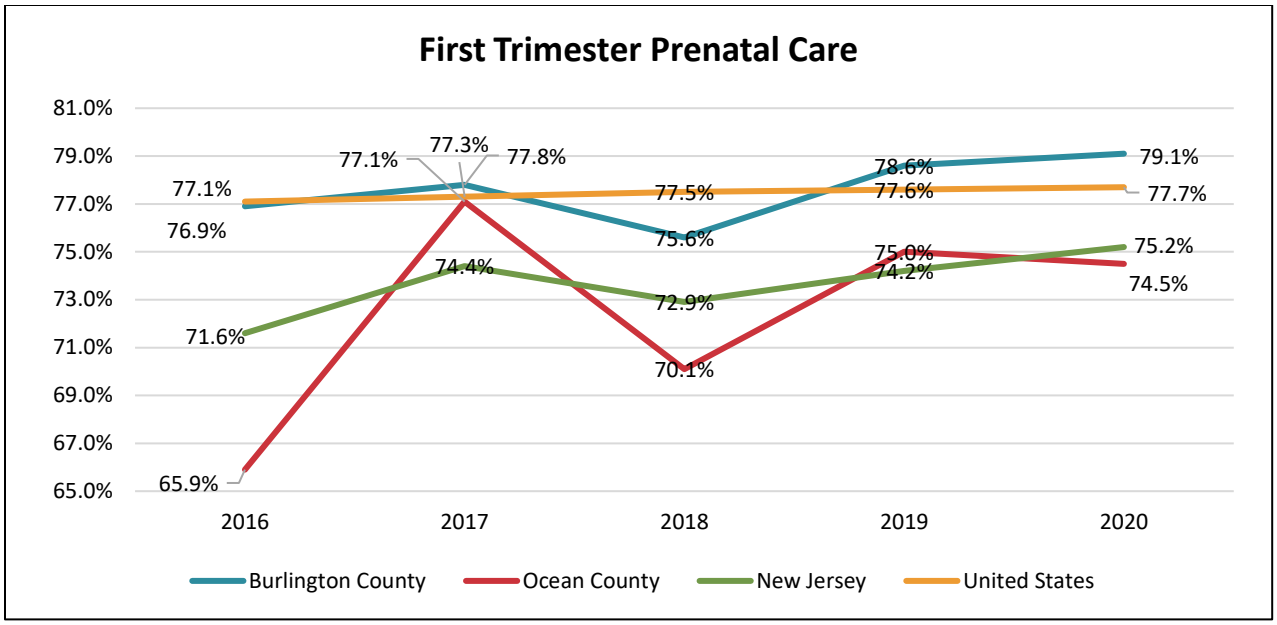
Source: New Jersey Department of Health & Centers for Disease Control and Prevention

2018 Maternal Deaths* per 100,000 Live Births

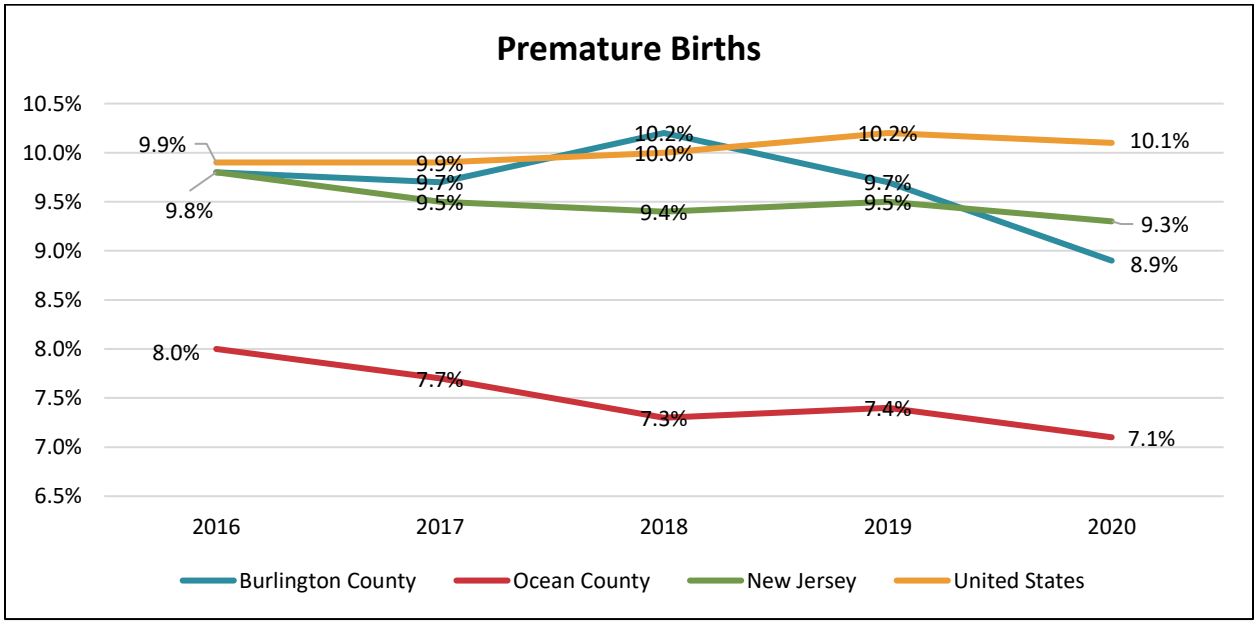
	Total Deaths	Total Death Rate	Black Death Rate	White Death Rate	Latina Death Rate
New Jersey	27	26.7	N/A	N/A	N/A
United States	658	17.4	37.1	14.7	11.8
HP2030 Goal	--	15.7	--	--	--

Source: Centers for Disease Control and Prevention

*Maternal deaths include deaths of pregnant people or within 42 days of termination of pregnancy, from any cause related to pregnancy or its management.



Source: New Jersey Department of Health & Centers for Disease Control and Prevention



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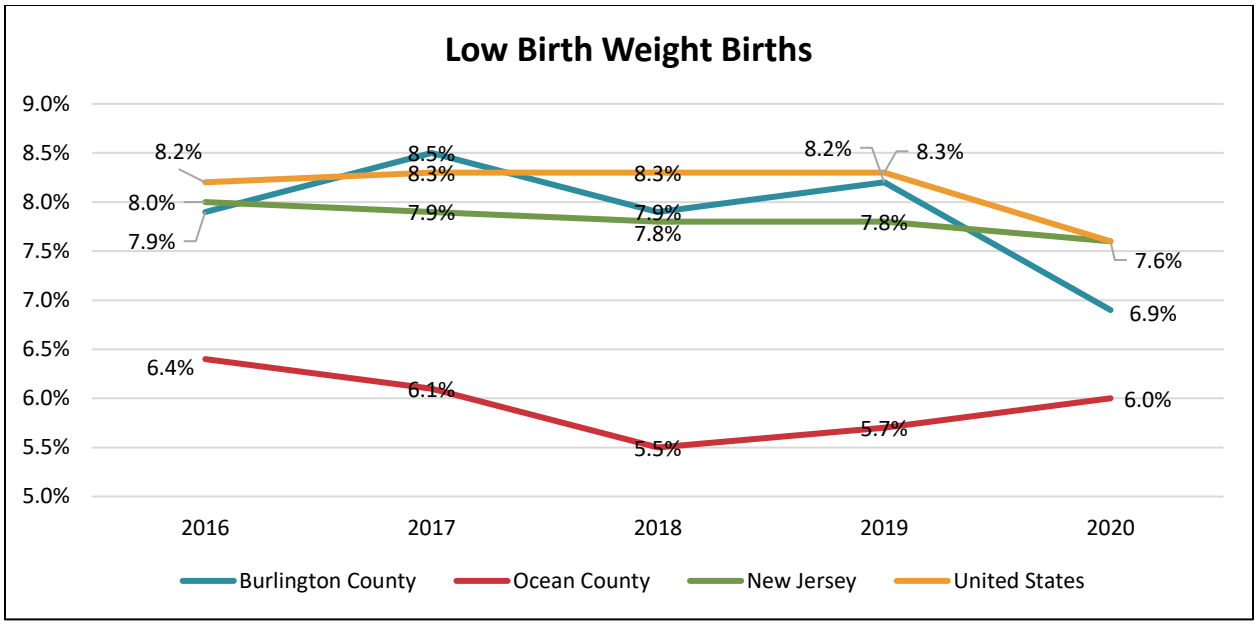

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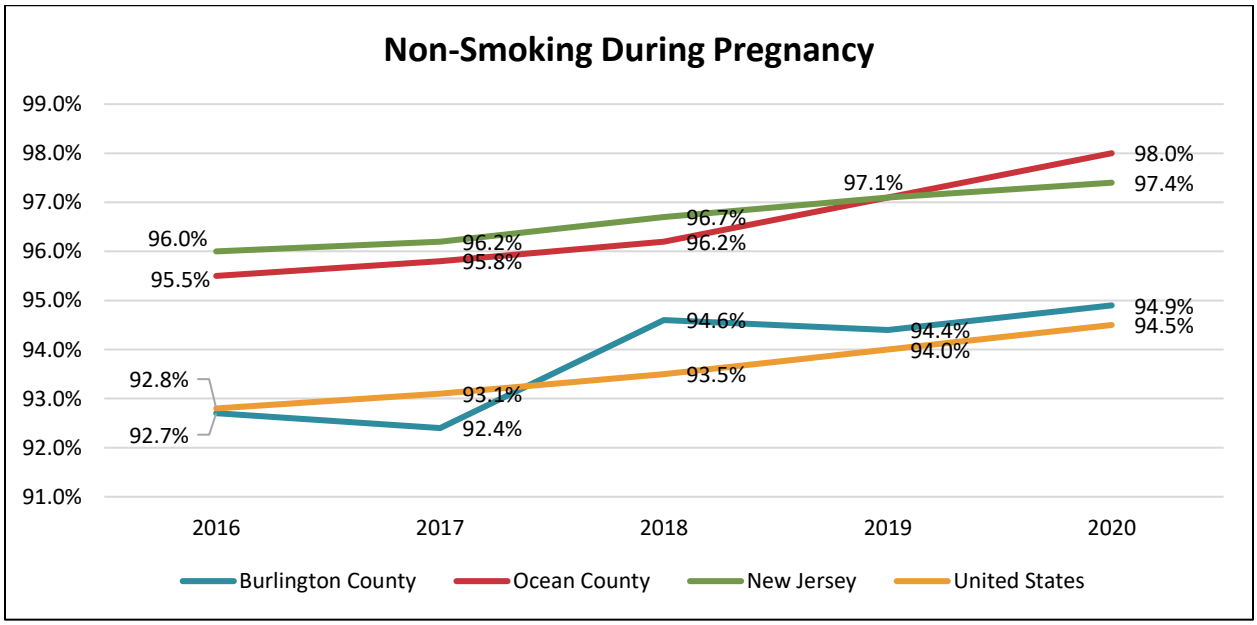


Source: New Jersey Department of Health & Centers for Disease Control and Prevention

Research findings from secondary data analysis were compared to qualitative research findings to compare perceptions to statistical data, identify root causes, and contextualize data trends and contributing factors for identified health needs.

Key Stakeholder Survey

Background

An online Key Stakeholder Survey was conducted with community representatives of Burlington and Ocean counties to solicit information about local health needs and opportunities for improvement. Community representatives included healthcare and social service providers; public health experts; civic, social, and faith-based organizations; policy makers and elected officials; and others representing diverse community populations.

A total of 30 individuals responded to the survey. A list of the represented community organizations and the participants' respective titles is included in Appendix B.

Approximately 67% of stakeholders served Burlington County, 7% served Ocean County, and 20% served all of New Jersey. Other geographies served by stakeholders included surrounding counties, including Atlantic, Camden, Gloucester, and Mercer. Nearly 57% of stakeholders served all populations. Among stakeholders who served specific population groups, the most served populations were children or youth and people with low incomes.

Primary Populations Served by Key Stakeholder Survey Participants

	Number of Participants	Percent of Total
No specific focus-serve all populations	17	56.7%
Children or Youth	7	23.3%
People with low incomes	6	20.0%
Active military members and/or their families	5	16.7%
People who are uninsured or underinsured	5	16.7%
African American/Black	4	13.3%
Older adults/Seniors	4	13.3%
People with disabilities	4	13.3%
Religious Community	4	13.3%
Hispanic/Latinx	3	10.0%
Young adults (age 19-24)	3	10.0%
People or families experiencing homelessness	3	10.0%
Other	3	10.0%
American Indian/Alaska Native	2	6.7%
Asian/South Asian	2	6.7%
Pacific Islander/Native Hawaiian	2	6.7%
LGBTQ+ community	2	6.7%
Immigrant or refugee communities	2	6.7%

Key stakeholders were asked a series of questions about perceived health priorities, perspectives on emerging health trends, including COVID-19, and recommendations to advance community health improvement strategies. A summary of their responses follows.

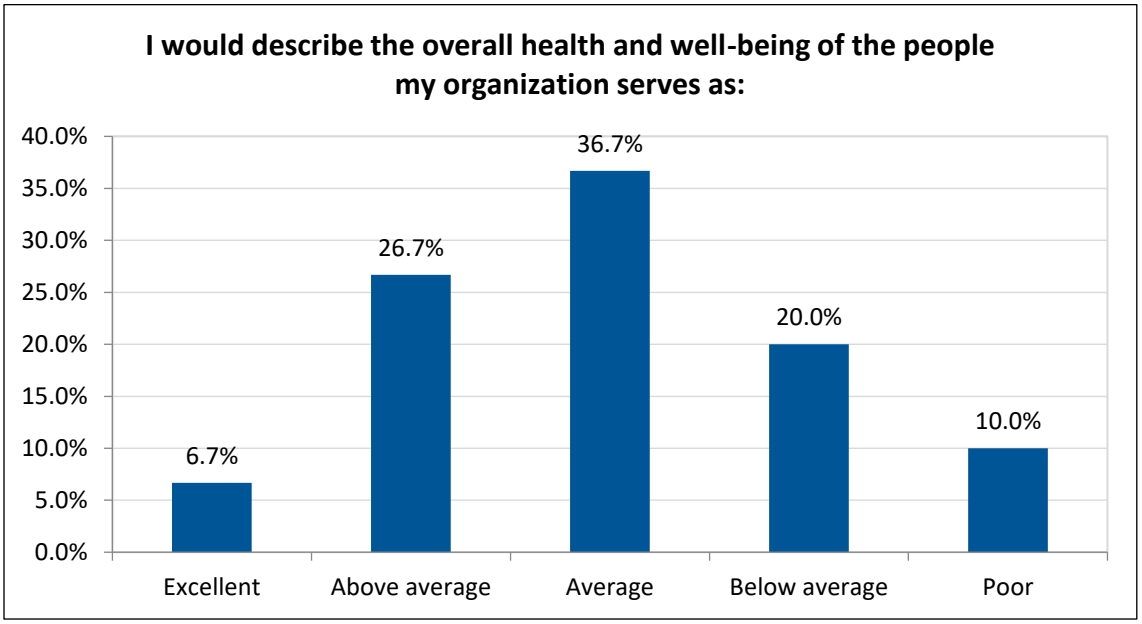
Survey Findings

Thinking about the people their organization serves, key stakeholders were asked to describe the overall health and well-being of individuals and the most pressing concerns affecting them. Key stakeholders rank ordered up to five issues, selecting from a wide-ranging list of options. An option to "write in" any issue not included on the list was provided.

Stakeholders were divided on their perceptions of the overall health and well-being of the individuals they serve. Approximately 37% described overall health and well-being as "average," while 33% described it as "above average" or "excellent" and 30% described it as "below average" or "poor."

When asked to identify the most pressing concerns affecting the people their organization serves, the largest proportion of key stakeholders selected access to healthcare as both the #1 issue (32.1%) and a top five issue (50%). Approximately half of key stakeholders also selected chronic diseases and mental health as top five concerns.

Key stakeholders were asked to list any pressing concerns that were not included in the provided list. Responses largely expanded upon the top identified concerns and included access to affordable medication and vaccinations; heart disease, stroke, and diabetes; and mental health of youth following COVID-19 isolation. Other responses included healthcare disparities due to nebulous funding, services and support for children with learning differences, timely access to palliative and hospice care, stigma, and workforce issues.



What are the most pressing concerns among people that your organization serves?
Top Key Stakeholder Selections.

	Selected as #1 Issue		Selected as a Top 5 Issue	
	Number of Participants	Percent of Total	Number of Participants	Percent of Total
Access to healthcare	9	32.1%	14	50.0%
Chronic disease conditions	6	21.4%	14	50.0%
Mental health	2	7.1%	13	46.4%
Access to social services	2	7.1%	9	32.1%
Housing access and affordability	2	7.1%	5	17.9%
Education attainment and learning loss	2	7.1%	2	7.1%
Economic security and employment	1	3.6%	12	42.9%
Substance use (alcohol, opiates, etc.)	1	3.6%	10	35.7%
Transportation	1	3.6%	8	28.6%
Food security/hunger	1	3.6%	8	28.6%
Childcare (access and affordability)	1	3.6%	2	7.1%
Discrimination (racial, ethnic, gender, sex, etc.)	0	0.0%	8	28.6%

Key stakeholders were asked to share their ideas for what needs to be done differently to address the most pressing concerns. Select verbatim comments by stakeholders are included below.

- *"Access to healthy living and youth-focused and family programs co-located in our facilities."*
- *"Continued access to appropriate physicians at convenient locations and to the latest health information."*
- *"Educate physicians, staff, patients, families about palliative and hospice care."*
- *"Health education plays a large role. Diabetes/Cardiovascular and cerebrovascular health are large components in our Ocean County Community Health Improvement Plan."*
- *"More community outreach by community-based organizations."*
- *"Partnerships with organizations to create greater access to mental health resources, and resources for children with learning differences."*
- *"Provide higher Medicaid rates for treatment facilities."*
- *"Reduce unemployment and increase access to food, healthcare, and medications."*
- *"The state should require all physicians who participate in Medicare to take a portion of Medicaid, so patients have access to care within a reasonable distance from their home. This is a state concern, not specific to Deborah."*

In a follow-up question, key stakeholders were asked to rate the quality of the SDoH within the community their organization serves, focusing on the five key domains identified by Healthy People 2030: economic stability, education access and quality, healthcare access and quality, neighborhood and

built environment, and social and community context. Ratings were provided using a scale of (1) “very poor” to (5) “excellent.”

The mean score for each SDoH domain and related community factors is listed in the table below in rank order. Educational opportunity was seen as the strongest community SDoH with the highest overall mean score and 47.1% of stakeholders rating it as “good” or “excellent.” Within the educational opportunity domain, early childhood education and development was seen as a top strength for the community with 43.5% rating it as “good” or “excellent.”

Economic stability was seen as the weakest SDoH with the lowest overall mean score and 15.8% of stakeholders rating it as “very poor” or “poor.” Within the economic stability domain, food security was seen as a top area of opportunity with 25% rating it as “very poor” or “poor.” Other top areas of opportunity across the SDoH domains were health literacy and understanding, transportation options, accessible primary and preventive care, sense of community or social connection, health insurance coverage, and discrimination and racism.

Ranking of Social Determinants of Health by Domain and in Descending Order by Mean Score

	Mean Score
Educational Opportunity	**3.41**
Early childhood education and development	3.52
Quality of Schools	3.39
Post-secondary school enrollment (Trade, College, University)	3.09
Social and Community Context	**3.26**
Community engagement	3.22
Discrimination and racism	3.04
Sense of community, social connection	3.00
Neighborhood and Built Environment	**3.21**
Places for recreation	3.32
Safe neighborhoods	3.09
Transportation options	2.65
Health and Healthcare	**3.21**
Accessible COVID testing and vaccination	3.83
Health insurance coverage	3.00
Accessible primary and preventive care	2.83
Health literacy and understanding	2.59
Economic Stability	**3.05**
Employment	3.17
Housing	3.09
Food Security	2.96

Key stakeholders were asked to share their thoughts on SDoH areas they marked as "very poor" or "excellent." Select verbatim comments are included below. Feedback by stakeholders largely acknowledged availability of public recreation spaces as a community strength and transportation as a persistent challenge, particularly in Burlington County.

- *"Burlington County has a lot of open space and parks in all the municipalities. Transportation continues to be a struggle in many parts of the county."*
- *"I do believe that Ocean County has ample places/locations for recreation and, with Ocean Ride, our transportation system throughout Ocean County is vast and accessible."*
- *"I feel there is not enough agencies/organizations available to do the work."*
- *"Public transit is virtually non-existent in our area. Should a community member need a doctor or care not available locally, private transportation is required. Not everyone in our area has reliable transportation."*
- *"The transportation service companies available have terrible organization within their company, which results in sick patients being abandoned for hours at doctors' offices with no assistance. They should be held to a standard and audited more frequently by the state."*
- *"Throughout Burlington County, public transportation can be hard to navigate or come by, as it is a rural area. Many of our clients find getting to work or a program one of the biggest barriers to entry."*

Approximately 37.5% of key stakeholders stated that their organization currently screens the people their organization serves for the needs related to SDoH. Stakeholders were asked to share their thoughts on key success factors for screening and responding to the needs related to social determinants. Select verbatim comments are included below.

- *"Care management and integrated records among community providers."*
- *"Consistent publicity and presence of CHWs to inform, advocate, and promote services available in communities."*
- *"Ensure screening tool is equitable; use input from patients, families, community members; establish connections with providers and community and faith-based organizations to meet needs; monitor needs/responses; provide assistance as needed and consistent follow-up."*
- *"It is important to have the proper resources to provide individuals that are deemed appropriate for social services. It is also important to have a dedicated social worker that can follow through with these individuals."*
- *"Making screening no cost to individuals who do not have insurance. Go out into the community to offer free screening days. Partner with local government/organizations for events that will draw people in for free screenings."*

Lastly, key stakeholders were asked to share recommendations for how community organizations, including Deborah, can better serve priority populations (Black, indigenous, people of color, LGBTQ+, and others) to achieve health and social equity. Select verbatim comments by stakeholders are included below.

- *"Advertisements that are more multicultural. Door to door campaigns in neighborhoods known to have many minorities."*
- *"Co-locating community locations, partnering with community partners to provide healthy living programs and preventative care or rehabilitative care."*
- *"Community outreach is key. Reaching out to established community leaders targeting marginalized groups."*
- *"Deborah is an amazing organization that provides access to top quality healthcare that many individuals in the community would not have otherwise. That being said, Deborah needs the support of community organizations to continue to build on its mission. If community organizations want a partner that is truly service-oriented and delivers the highest caliber of healthcare, there is no better choice than Deborah."*
- *"I believe that it is a matter of outreach. You have to meet people where they are. This may include virtual or in-person outreach at a community center and or the expanding of clinics in underserved areas."*
- *"Suggest organizational commitment to health and social equity with engagement from all stakeholders: ensure diversity of board, physicians, staff reflects the community; seek and utilize input from the community to inform services, communications, etc.; provide continuing education for physicians and staff; track, monitor, report relevant data; etc."*
- *"We need to do a better job at engaging trusted leaders within the various communities."*

Community Member Survey

Background

A Community Member Survey was conducted from April to June 2022 to solicit individual experiences and perceptions of health and social needs. The survey was made widely available as an electronic link and in paper format. The survey was shared across the community via print ads, local outreach, email, and social media advertising. The survey was not intended to be a representative sample of the greater community, but rather provide general insights into respondents' perceptions and health status.

Respondent Demographics

A total of 1,315 residents aged 18 or over completed the survey. Respondents represented both Ocean (48.6%) and Burlington (41%) county residents. The top zip codes of residence for respondents were Manchester Township in Ocean County and Browns Mills in Burlington County.

Respondents represented nearly equal proportions female (50.7%) versus male (47.5%). The largest proportion of respondents were White (87.3%). The most represented age groups were and 65-74 (36.1%) and 75 or older (30.1%). More than 1 in 10 respondents were caregivers for an older adult.

Educational attainment varied among respondents with nearly 47% earning a high school diploma and 49% attaining higher education. Household income also varied among respondents with approximately 21% earning less than $35,000; 29% earning $35,000-$74,999; and 27% earning $75,000 or more.

County of Residence

	Respondents	Percent of Total
Ocean County	551	48.6%
Burlington County	464	41.0%
Other*	118	10.4%

*Top responses: New Jersey (87), Mercer County (4), Atlantic County (3).

Top 10 Zip Codes of Residence

	Respondents	Percent of Total
08759, Manchester Township	173	15.6%
08015, Browns Mills	169	15.3%
08757, Toms River	73	6.6%
08088, Vincentown	49	4.4%
08005, Barnegat	37	3.3%
08753, Toms River	37	3.3%
08050, Manahawkin	36	3.3%
08087, Tuckerton	36	3.3%
08068, Pemberton	36	3.3%
08016, Burlington	33	3.0%

Respondent Demographics (as provided)

	Respondents	Percent of Total*
Gender Identity		
Female	572	50.7%
Male	536	47.5%
Non-binary	0	0.0%
Race and Ethnicity		
White	986	87.3%
Black	51	4.5%
Hispanic/Latinx	28	2.5%
Asian	22	2.0%
Other race	14	1.2%
Native American/Alaska Native	14	1.2%
Multiracial	9	0.8%
Native Hawaiian/Pacific Islander	3	0.3%
Age		
18-24	3	0.3%
25-34	26	2.3%
35-44	59	5.2%
45-54	67	5.9%
55-64	208	18.4%
65-74	407	36.1%
75 or older	340	30.1%
Other Characteristics		
Caregiver of older adult	148	13.2%
Active-duty military (self of immediate family member)	58	5.2%

*Percentages may not total 100%. Participants had the option to select “prefer not to answer.”

Respondent Socioeconomic Indicators (as provided)

	Respondents	Percent of Total*
Education		
High school diploma or GED	266	23.6%
Some college, but no degree	261	23.1%
Bachelor's degree	243	21.5%
Associate's degree	131	11.6%
Graduate degree	122	10.8%
Technical school	56	5.0%
Some high school (did not finish)	25	2.2%
Annual Household Income		
Less than $20,000	72	6.4%
$20,000 to $34,999	164	14.6%
$35,000 to $49,999	143	12.7%
$50,000 to $74,999	186	16.5%
$75,000 to $99,999	129	11.5%
$100,000 to $149,999	115	10.2%
$150,000 to $199,999	40	3.6%
$200,000 or more	20	1.8%

*Percentages may not total 100%. Participants had the option to select "prefer not to answer."

Survey Findings

Community Experience

Survey respondents were asked to provide their experience related to a number of socioeconomic factors and environmental conditions that affect health and quality of life. Their responses are depicted in the table below. The table is rank ordered by the percentage of respondents who "disagreed" or "strongly disagreed" that they had sufficient resources in the indicated area.

The majority of respondents reported positive socioeconomic and environmental conditions, including access to digital devices and services, safe and stable housing, affordable transportation, and social supports. Approximately 77% or more of respondents "agreed" or "strongly agreed" that they had sufficient resources in these areas.

Economic security was a concern for some respondents. Approximately 1 in 10 respondents "disagreed" or "strongly disagreed" that they felt confident they could continue to afford their housing and/or had enough money to pay their bills each month. Another 1 in 10 respondents "neither agreed nor disagreed" with these statements.

Please tell us your level of agreement or disagreement with the following statements.

	Disagree / Strongly Disagree	Neither Agree nor Disagree	Agree / Strongly Agree	Doesn't Apply
I have enough money to pay my bills every month.	12.2%	12.5%	72.6%	2.7%
I feel confident that I can continue to afford my housing.	11.2%	10.3%	74.6%	3.9%
I can get the foods I want to eat.	9.2%	7.5%	74.5%	8.8%
I have social support (family, friends) in my community.	9.2%	9.4%	76.7%	4.8%
I have affordable transportation options.	9.0%	7.6%	79.0%	4.3%
I have reliable internet service.	9.0%	6.4%	79.8%	4.9%
I have safe and appropriate recreation spaces.	8.1%	10.8%	72.3%	8.8%
I have safe, stable housing that meets my needs.	7.1%	3.2%	86.3%	3.5%
I have a device (computer, smartphone) to access the internet.	5.6%	1.6%	89.3%	3.5%
I have quality, affordable childcare.	2.6%	5.7%	7.0%	84.7%

Healthcare Access and Experience

More than 97% of respondents had health insurance. Consistent with respondent demographics, respondents were most likely to have Medicare insurance. Among respondents who were uninsured, the top reason for not having health insurance was being unemployed or between jobs.

Health Insurance Coverage

	Respondents	Percent of Total
Medicare	862	65.6%
Private insurance (employer-provided or self-pay)	589	44.8%
Tricare/military health insurance	105	8.0%
Medicaid	102	7.8%
VA healthcare coverage	74	5.6%
I do not have health insurance	31	2.4%
Don't know	12	0.9%

What is the reason you do not have health insurance?

	Respondents	Percent of Total
I am unemployed or between jobs	14	50.0%
I cannot afford to buy my own insurance (self-pay)	13	46.4%
I do not qualify for Medicaid or other reduced cost coverage	11	39.3%
Other	9	32.1%
I receive services at a low-cost or free clinic	8	28.6%
My job doesn't offer health insurance	6	21.4%
I do not want health insurance	6	21.4%
My job offers insurance, but it is too expensive	5	17.9%
I do not know how to get health insurance	5	17.9%
I was denied health insurance	4	14.3%

Approximately 92.6% of respondents had a regular healthcare provider and 91.5% of respondents visited a healthcare provider within the year prior to the survey for a routine checkup. The percentage of respondents who had visited a dentist for a routine checkup was lower at 67.7%.

Nearly 25% of respondents stated that there was a time in the past 12 months when they needed to see a healthcare provider but didn't for one or more reasons. The top reasons for not receiving care were fear of getting COVID-19 and/or inability to afford it (copayment, deductible). "Other" reasons for not receiving care largely captured barriers related to COVID-19 closures and lack of available or convenient appointment times. Other less commonly stated reasons included lack of providers accepting insurance and/or feeling healthy.

Routine Care Access

	Last Visit to a Healthcare Provider for a Routine Checkup		Last Visit to a Dentist for a Routine Checkup	
	Respondents	Percent of Total	Respondents	Percent of Total
Within the last 6 months	952	75.0%	657	51.8%
Within the last 12 months	210	16.5%	201	15.9%
Within the past 24 months	46	3.6%	118	9.3%
More than 2 years ago	48	3.8%	221	17.4%
Don't know	14	1.1%	71	5.6%

Was there a time in the past 12 months when you needed to see a healthcare provider but didn't because of one or more of the following reasons?

	Respondents	Percent of Total
None/Not applicable	936	75.2%
I was afraid of getting COVID	102	8.2%
I couldn't afford it (copayment, deductible)	95	7.6%
Other	79	6.4%
I didn't have health insurance	56	4.5%
I didn't have transportation	45	3.6%
I couldn't get off work	35	2.8%
I didn't have childcare	21	1.7%

A total of 54.3% of respondents stated that they used telehealth (virtual video or phone call visits) to access healthcare during the COVID-19 pandemic. When asked about their willingness to use telehealth in the future, 55.3% of respondents stated they were "willing" or "somewhat willing" to use it and 17.9% were undecided. Respondents who were unwilling to use telehealth in the future largely stated a preference for in-person visits and perceptions of lower quality of care.

What is the reason you are unwilling to use telehealth in the future? Check all that apply.

	Respondents	Percent of Total
I prefer in-person visits	205	70.2%
I do not think I receive the same quality of care	152	52.1%
I am not comfortable using telehealth technology	95	32.5%
I am concerned about my security or privacy	43	14.7%
I have trouble seeing or hearing healthcare providers	30	10.3%
I do not have reliable internet	18	6.2%
I do not know how much it costs	16	5.5%
I do not have a computer or smart phone device	12	4.1%
I had a bad experience using telehealth	7	2.4%
Other (e.g., technology difficulty, lower quality of care)	3	1.0%

Survey respondents were asked to share their relationship experience with their healthcare provider. Using a scale of "strongly disagree" to "strongly agree," respondents rated a number of statements related to communication and respect for individual preferences and identities. Their responses are depicted in the table below.

Respondents had overall positive perceptions of their relationship with their healthcare provider. The majority of respondents "agreed" or "strongly agreed" that their healthcare provider communicated in their preferred language and respected their individual identities (race, culture, gender, sexual) and religious preferences. Approximately 5% or fewer respondents "disagreed" or "strongly disagreed" with these statements.

Please tell us your level of agreement with the following statements.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Doesn't Apply
I can communicate with my healthcare provider(s) in my preferred language.	4.6%	0.7%	2.2%	32.2%	56.6%	3.7%
My healthcare provider(s) respect my racial identity.	2.7%	0.7%	9.7%	26.4%	40.6%	19.9%
My healthcare provider(s) respect my cultural identity.	2.4%	0.8%	11.1%	26.2%	38.2%	21.3%
My healthcare provider(s) respect my gender identity.	2.1%	0.3%	9.1%	27.1%	37.9%	23.6%
My healthcare provider(s) respect my sexual identity.	2.1%	0.8%	10.0%	25.5%	35.2%	26.5%
My healthcare provider(s) respect my religious preferences.	2.1%	0.4%	12.2%	24.9%	33.9%	26.5%

COVID-19 Experience

Survey respondents were asked to identify the sources that they relied on most for COVID-19 information. Respondents could choose up to three responses. An option to "write in" any source not included on the list was provided.

Participant responses reflected wide use of reliable sources of COVID-19 information, including the Centers for Disease Control and Prevention (CDC) and New Jersey Department of Health. Approximately one-quarter to one-third of respondents also relied on local or national news sources. "Other" responses included other medical practitioners and institutions, internet research, common sense, and local health departments, among others.

What source(s) have you relied on most for information about COVID-19?

	Respondents	Percent of Total
Centers for Disease Control and Prevention (CDC)	52.5%	621
New Jersey Department of Health	49.9%	591
National news sources	37.0%	438
Local news sources	27.1%	321
Other healthcare provider	17.1%	202
My family or friends	16.0%	189
Deborah Heart and Lung Center	14.6%	173
Other	8.7%	103
My work	6.1%	72
Social media (Facebook, Twitter, Instagram, etc.)	4.8%	57
Political leaders	1.4%	17

A total of 24.8% of respondents had contracted COVID-19 at the time of the survey. Among respondents who had contracted COVID-19, 7.4% (n=78) had continuing health problems (also known as long COVID) and 2.5% (n=28) were being treated for long COVID.

Respondents were asked to share how the pandemic impacted their health, regardless of whether or not they had contracted COVID-19. It is worth noting that 40.3% of respondents "agreed" or "strongly agreed" that the pandemic had a negative impact on their mental health, and approximately 37-40% "agreed" or "strongly agreed" that it had a negative impact on their physical and/or financial health.

Please tell us your level of agreement or disagreement with the following statements. The COVID-19 pandemic had a negative impact on my:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Doesn't Apply
Financial health	8.9%	17.8%	27.0%	22.9%	13.8%	9.6%
Mental health	9.4%	14.8%	23.8%	32.8%	12.7%	6.5%
Physical health	9.7%	17.3%	26.2%	30.3%	10.0%	6.6%

Survey respondents were asked to share free-form feedback on how COVID-19 impacted their health and well-being and what they need to recover from the pandemic. Select verbatim comments are included below by impact on financial, mental, and/or physical health.

Financial Impact

- *"Employers have taken advantage of the situation. Much like price gouging, many were fired and then rehired losing their benefits, accrued seniority, lower salary.....etc."*
- *"Financial impact. We were furloughed from work."*
- *"Financially lost work time. Every time I stepped outside my door to find food or necessities and waited on lines for food or if someone came closer than 6 feet to me, I was in fear of contracting the covid. I am alone and would not be able to care for myself or go out to get meds."*
- *"Forced into retirement by work provider."*
- *"I have had to quit a part time job, which impacted my financial and mental health. The PACS (post-acute COVID-19 syndrome) has affected me greatly. It has also affected me socially and mentally."*
- *"I have had to support family members who could not work during the pandemic and didn't get unemployment help from state of New Jersey."*
- *"I lost my job."*
- *"Lost my job & health insurance due to covid and being locked down. Became sedentary and gained a lot of weight."*
- *"My employer's insistence to quarantine due to allergy symptoms has caused me to use all of my sick time and family sick time. This is unacceptable."*

Mental Health Impact

- *"A constant worry, especially with all the TV coverage."*
- *"After working from home for a year, I became more depressed. I lost my job after the company decided to close."*
- *"Am always sad and withdrawn. Having hard time being social again. Wearing a mask makes me hyper. Don't know how to recover. Most of my friends have either moved, are sick or died last 3 years. I feel hopeless."*
- *"Cease of social and religious activity was depressing. Certain bogus supply chain issues caused frustrations."*
- *"Changed our way of life. I'm not afraid but hesitant sometimes to get together with others. I have family and friends who are petrified of getting together. Information differs from various sources. How do you know what to believe? Today read an article in the AARP newsletter, CDC does not recommend a second booster yet, and just received State of NJ email that says CDC recommends a second booster for over 60 years old, the population reading AARP. What's right?"*

- *"Continued mental stress. I need self-care and access to accurate information from healthcare providers."*
- *"COVID 19 impacted my mental health the most because I was constantly exposed to positive patients for long periods of time and the worry/concern that I would bring it home to my children. My autistic son had a really hard time with the world shutting down and wearing a mask."*
- *"Depression that I can't shake."*
- *"I did not get Covid but the isolation from COVID shut down, after my husband died, was isolating me from family and friends and my church. That made my grieving process worse. Trying to talk to my family and friends was extremely hard as everyone had a strong political view on the virus and how it was handled. Even if you did not want to talk about the subject people gave their opinions. Made the whole process harder."*
- *"I had to work during the pandemic at my previous job and the stress nearly killed me. I started going to therapy to help me cope. I also was denied a raise or bonus despite being told I would receive hazard pay. Being in therapy and getting a new job have greatly helped my recovery."*
- *"The isolation, feeling of not being in control caused stress and anxiety. The impact is still with me today."*

Physical Health Impact

- *"As a senior Covid impacted not only me but my wife also, residual effects still continue with difficulty breathing and brain fog."*
- *"Brain fog, partial loss of smell & taste, fatigue."*
- *"Continued fatigue, inability to complete tasks, focusing issues."*
- *"Covid lasted about 6 weeks. It took me about two whole months to feel like myself again."*
- *"Daily fatigue 3 months later. Hair loss and shedding continues 3 months later."*
- *"I had it twice. It mainly affected my fibromyalgia. So I was in extreme pain. The 2nd time, I had the pain and was very sick for a long time. It hasn't been good, mentally and physically for me."*
- *"I have ongoing breathing issues."*
- *"I lost 40% of my hearing in one ear."*
- *"Lack of contact with others started feeling sad and lonely. Started to gain weight. Noticed loss of my usual strength and mobility."*
- *"Less chance to get out and about with friends or go to the gym. I gained weight."*

Community Conversations

As part of the CHNA, Deborah hosted a Partner Meeting and Focus Groups on July 11, 2022. The Partner Meeting convened 18 people representing health and social service agencies, senior services, and civic organizations. A list of participants and their respective organization is included in Appendix C. The Focus Groups convened a total of 27 community residents of Burlington and Ocean counties. Focus Group participant names are withheld for confidentiality.

The objective of the Partner Meeting was to share data from the CHNA and garner feedback on community health priorities. Group dialogue was facilitated to discuss research findings and new or innovative opportunities for cross-sector collaboration to support recovery efforts.

Two Focus Groups were conducted, one each in Burlington and Ocean counties. The objectives of the Focus Groups were to assess COVID-19 impact on health and social needs; understand individual perceptions and experiences in accessing healthcare during the pandemic; and identify available and needed community resources to support recovery efforts.

Feedback collected as part of the Partner Meeting and Focus Groups reflected consistent concerns and complementary recommendations. A combined summary of key discussion takeaways follows.

Challenges Brought About by COVID

- Community division, largely along political lines, and mistrust in government entities
    - "I don't want them shoving the vaccine down my throat. It's my body."
    - "I'm angry. We could have avoided a lot of loss if people had treated this seriously."
    - "Stuff that was basic all along, like sanitation, was devalued, no longer believed."
    - "We still have over two million unvaccinated in New Jersey. How do we rebuild?"
- Community economic challenges brought on by early retirements and the great resignation
    - "People are just fed up."
    - "The township suffered not being able to lease the building or generate revenue from services."
    - "We lost managers and leaders that we depend on for guidance, historical perspectives, expertise, knowledge."
- Confusion and strain on families due to inconsistent guidelines from national, state, and local entities
    - "The CDC and school systems are not on the same page. There are different guidelines on when to come or not to come to school and how long to quarantine. If kids come to school with a cough, they have to go home, bringing parents out of work."
    - "We need a common language and policies for COVID, particularly as we get ready for the fall."

- Getting people back on track with routine preventive care, and the higher acuity that will come from not having caught conditions in earlier stages
    - "I didn't trust going to the hospital, and they were telling you not to come in."
    - "We weren't eating right or exercising. Nobody was going to the doctor."
- Lost learning among youth contributing to delays in academics and social emotional learning; children at-risk for educational disparities before the pandemic were most affected
    - "Discipline issues we used to see in the sixth grade, we're now seeing in fourth grade. Everything has been pushed forward, in a bad way."
    - "Prior to the pandemic, there were problems in schools. It exacerbated them. Especially in the beginning when they couldn't get access to Wi-Fi. Kids were left behind."
    - "Some of my first-grade students had never stepped into a school. Some of them did fine, but it depended on the student and the parent. It wasn't necessarily money that made it easier, but the right environment and emotional support."
    - "We're seeing kids dropping out at higher rates, not engaged in class."
- Negative impact on mental health, and lack of providers to meet service demands
    - Key words describing resident experience: "anger," "anxiety," "depression," "fear," "isolation," "loss of life," "trauma"
    - "Anxiety levels are rising as people go back to school and work. Schools don't have providers to address the need and parents are compensating."
    - "I got COVID and was home alone, with just the dogs."
    - "Medication management is a gap. Primary care providers will do it for a little bit, but then they pass it off."
    - "Not being able to see loved ones when it was needed most was hard."
    - "There is a lot of PTSD among healthcare providers."

Redirecting Resources to Respond to COVID and other Community Challenges

- Build awareness of available community services and promote co-location of services
    - "Don't hold events, piggyback on others."
    - "Get community involved in the planning of events and promote word of mouth advertising."
    - "How do we know what services are available to share with community? How have they changed with the pandemic? We want to know so we can be the conduit for the people who need them. What are we doing to make sure we (providers) are aware of services?"
    - "The true question is how we connect and create bridges between healthcare and social services. Patient navigators are vital. We need to leverage trusted community resources (e.g., houses of worship and food banks) to embed navigators."

- "We should have QR codes at community sites that connect people with services."

- Conduct community-based services and outreach to address social barriers, partner with known community entities and trusted representatives
  - "During the pandemic, apartment complexes helped with sharing resources and filling out paperwork for assistance."
  - "Instead of telehealth, we need mobile health. Take it to the people."
  - "Send people out into the community who are trusted."
  - "The Pinelands Family Success Center is awesome, anything from resume writing to grabbing a cup of coffee."
- Continue to address healthcare challenges, particularly related to transportation and older adults and their caregivers
  - "Transportation is the killer. You have to beg, borrow, or steal a car."
  - "I've heard of people using OceanRide who sit at appointments for four hours waiting to be picked up, or who show up for a 1pm appointment at 2:30pm."
  - "The density of older people in Ocean County is a strain on healthcare and support services. Stop building retirement communities."
  - "I'm a caregiver for my dad. There are very few days that I've missed going to see him. If there's help, I haven't found it."
  - "There's so much to juggle as a caregiver. You need to have an outlet."
- Leverage telehealth as a convenient option for some residents, but recognize limitations and negative perceptions by others
  - "It's good for prescription refills or follow up, like clarifying instructions or understanding lab results."
  - "Telehealth was like treating myself. It wasn't as effective."
  - "Telehealth was only there for those with the technology. The VA did not have the infrastructure."
- Rebuild sense of community and trust, particularly among historically marginalized communities
  - "People are zoomed out. We need to get back together. We need community events."
  - "Recreation and extracurriculars are the first things to get cut from funding, but we are the heart of the community. We are the mayor's wellness campaign."
  - "There is a history of mistreatment and poor care for Black/African Americans. Rebuilding trust requires following through on what you say you will do."
  - "We all used to know each other and look out for each other. We don't have community villages now because people are afraid of everything."
  - "We lost funding for things like afterschool programming and tutoring in communities that need these the most."

Evaluation of Health Impact: 2019-2022 Community Health Improvement Plan Progress

In 2019, Deborah completed a CHNA and developed a supporting three-year Implementation Plan for community health improvement. The Implementation Plan outlined our strategies for measurable impact on identified priority health needs, including Linkages to Care, Chronic Disease Management, and Issues of Aging. Within six months of the release of the 2019 Implementation Plan, the COVID-19 pandemic shifted the priorities of our community and Deborah adapted our work to respond to the emergent needs of residents. The following sections outline our work to impact the priority health needs and respond to COVID-19 in our communities.

Linkages to Care

Partnering to Deliver Access to Emergency Services

To complement Deborah's specialty services, since 2010 Deborah has partnered with a licensed acute care hospital to bring emergency services to the campus. Deborah successfully navigated a smooth transition during a change in acute care partner in 2019 with no disruption in access to emergency services. The emergency department (ED) at Deborah has provided a vital emergency medical link for the residents of northwestern Burlington County, southeastern Mercer County, and southwestern Ocean County. This New Jersey "triangle" region previously had no close access to emergency services, and the ED has provided a valuable lifeline for many families, including those who live in Deborah's primary service area, which is federally designated as a medically underserved community. The ED is also located one-mile from Joint Base McGuire-Dix-Lakehurst and is a cornerstone of emergency care for active-duty military and their dependents stationed on the Base.

Partnering to Meet Other Healthcare Needs

To meet other outstanding healthcare needs in our community, Deborah partnered with Landmark Healthcare Facilities, LLC who constructed a medical office building (MOB) on the Deborah campus. Deborah leadership worked with representatives of Landmark, and community leaders, to identify providers to occupy the building and to meet community healthcare needs. The MOB opened in mid-2018, offering state-of-the-art space to attract new providers and services previously unavailable in our community.

Medical services available in the MOB:

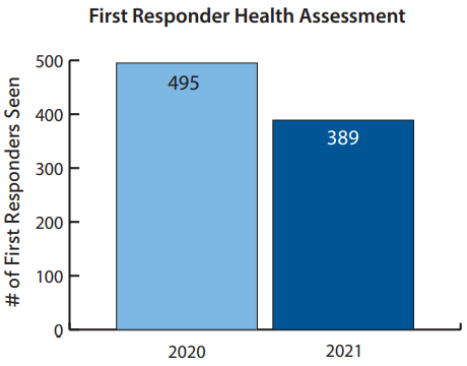
- Urgent care *(provided by Central Jersey Urgent Care)*
- Primary care *(provided by Capital Health)*
- OB/Gyn services *(provided by Capital Health)*
- Outpatient pharmacy (provided by Georgie's Pharmacy)
- Physical therapy (provided by Ivy Rehab) in partnership with Deborah
- Cardiac rehab (provided by Deborah Heart and Lung Center)
- Podiatry services (provided by Ocean County Foot and Ankle Surgical Services)
- Pain management (provided by Corda Pain Management)
- Sleep center (provided by Deborah)
- Pulmonary rehabilitation (provided by Deborah)

Expanding Access Locations in the Community

To improve access to healthcare throughout the region, Deborah supports the development of a non-profit specialty practices – Deborah Specialty Physicians – that operate practice locations in Burlington, Ocean, and Atlantic Counties. The practice brings high-tech specialty heart, lung, and vascular care into communities that may not have ready access to these specialties. Deborah's partnership with DSP includes their commitment to expand access to uninsured and underinsured and to provide education to the community. The goal is to encourage the best and most cost-efficient use of healthcare resources by having healthier patients seek routine care closer to home, while at the same time, educating them to the resources available at tertiary centers, such as Deborah. The continued growth of these practices demonstrates the need for these services in the community.

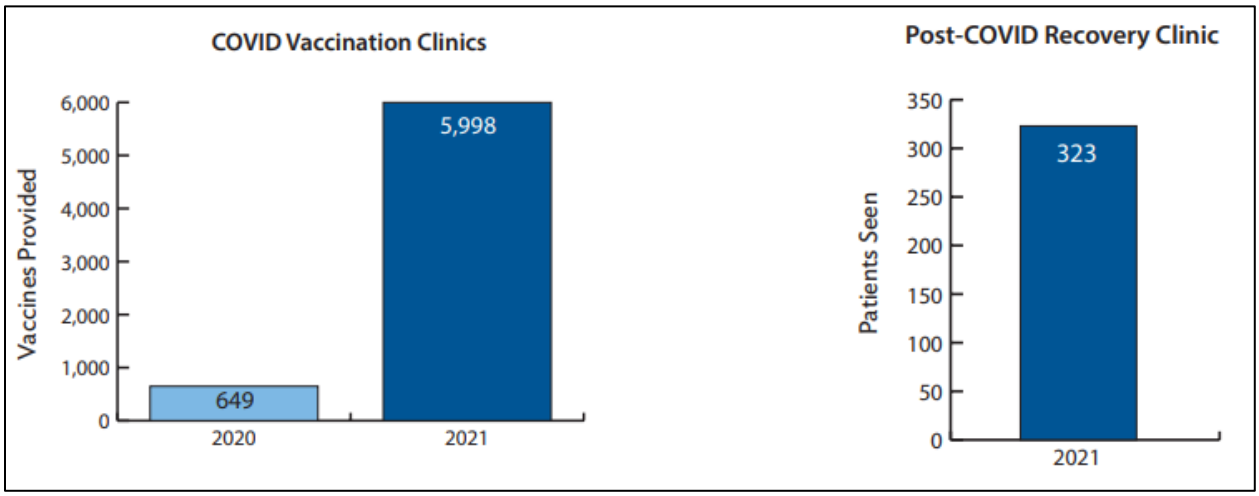
Targeting First Responder Health

To provide early detection and intervention, Deborah developed an evidence-based First Responder Health Assessment Program which provides comprehensive exams and appropriate testing specifically for firefighters, police officers, EMTs, and other front line emergency workers who are at a higher risk of cardiovascular and respiratory diseases. The United States Fire Administration estimates that 47% of line-of-duty firefighter deaths are cardiac related, and the National Center for Biotechnology Information (NCBI) reports that police officers have the poorest cardiovascular disease profile of any occupation.



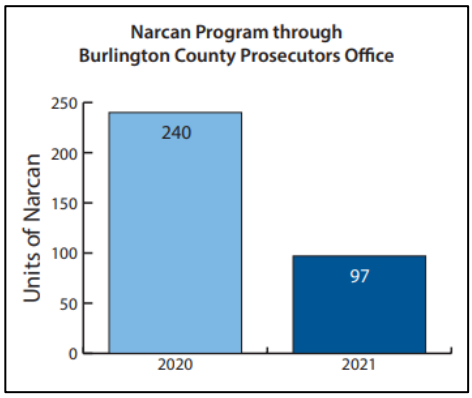
Prioritizing COVID-19 Healthcare Response

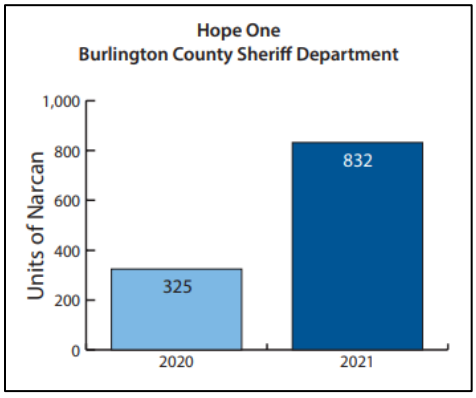
In 2020, in direct response to the coronavirus pandemic, and the urgency for unified response for community health initiatives, Deborah quickly pivoted on two key areas of particular concern: administering vaccinations to the public and launching a Post-COVID Recovery Program for long-haulers experiencing symptoms months after infection. These have played a vitally important regional role, in both helping to suppress the virus and addressing the long-term health impacts that COVID-19 is having on our regional population.



Assisting in Managing Mental Health and Substance Use Disorders

Although Deborah's primary medical focus does not include a segment specific to mental health or substance abuse, Deborah recognizes its community role in assisting with these issues. Since 2015, Deborah has worked in partnership with the Burlington County Prosecutor's Office to supply Narcan (and nasal adapters) quarterly to front line officers and EMS personnel who directly respond to emergency overdose calls in the community. Deborah continues to financially support this program which unfortunately grew during the pandemic when addiction issues skyrocketed. Emergency intervention by the officers' administering Narcan continues to save lives.





Deborah also partnered with Hope One, a Burlington County program for addressing substance abuse. Administered through the Burlington County Sheriff's Department, Hope One is a mobile van that brings addiction services directly into the community with treatment referrals, a host of other needed health services tailored to those with substance abuse issues, and Narcan kits, which are distributed with instructions on how to use them in an overdose emergency. Deborah contributes to the purchase of the Narcan.

Reducing Transportation Barriers to Healthcare

In direct response to resident surveying that identified transportation as a community need, since 2018 Deborah has contracted with Stout Transportation Services to provide medical transportation for patients in need of rides to and from their appointments at Deborah and its' affiliated practices.

Round-Trip Rides Provided by Deborah by Patient County Residence

	2020	2021
Atlantic	14	33
Burlington	736	605
Camden	76	80
Gloucester	47	10
Mercer	138	213
Monmouth	39	67
Ocean	1,013	940
Other	14	518
Cooper*	132	135
Total	**2,209**	**2,601**

*Additional patient rides sent to Cooper University Health Care as part of HeroCare Connect™

Fostering and Deepening Community Partnerships

In order to prevent subsequent emergency room visits post-hospitalization, Deborah's robust rehab programs play a critical role. Patients who enroll in – and are compliant with – their physical, occupational, and especially cardiac rehabilitation programs, are more likely to manage the health conditions that landed them in the ED to begin with. Working one-on-one with patients and carefully monitoring their progress and following up with them has enabled many of these patients to avoid a repeat visit to the ED.

Improving Early Detection of Lung Cancer and Increasing Access to Care

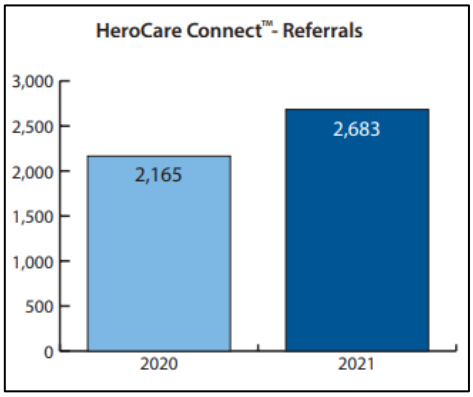
Deborah's Multi-Disciplinary Oncology Clinic Program offers collaborative personalized outpatient appointments for case management of patients with tumors. The integrated team includes an oncologist, radiologist, pulmonologist, pathologist, surgeon, administrative director and other care team staff to provide an efficient approach to the evaluation of lung tumors, employing state-of-the-art technology like Endobronchial Ultrasound (EBUS) and PET scans. Additionally low-dose CT scans offered as part of a lung cancer screening program for current or former smokers offers early detection, leading to quicker treatment with better outcomes.

Supporting the Health Needs of the LGBTQ+ Community

Building on Deborah's previous three-year CHIP, which brought expert professionals to begin educating Deborah's staff on protocols and sensitivities surrounding sex and gender expression in healthcare, Deborah began the research and committee formulation to actively seek Healthcare Equality Index certification. Tasks and responsibilities were identified to begin the formal process, and internal stakeholders were identified as key to beginning the certification process.

Growing and Expanding Care for the Military Community

Deborah has continued to build on its HeroCare Connect™ program launched in 2017 in partnership with Cooper University Health Care. Designed to improve access to healthcare for active duty military, retirees, veterans and their dependents, the HeroCare Connect program draws on Deborah's close proximity to Joint Base McGuire-Dix-Lakehurst, and Cooper's long-standing relationship with the military, as well as providing a critical healthcare link for the close to 17,000 veterans served by the Philadelphia, East Orange, and Wilmington VA hospitals who are waiting over 30 days for specialty care services (as of 1/28/21, VHA Patient Access data).



The program's concierge navigators share the goal of providing non-routine specialty visits within 24-48 hours with priority access for the military to medical appointments in over 75 specialties and locations throughout the region.

Chronic Disease Management

Providing Complimentary Screenings for Chronic Disease

Deborah provides complimentary screenings for residents across the age span, both at community events and in partnership with community organizations. Even during the pandemic, Deborah continued virtual outreach events to reinforce to residents the need to stay on top of their healthcare.

Community Outreach Data

	2020	2021
Blood Pressure	137	8
Body Fat Analysis	27	0
On-site Temperature Screenings	62	30
Peripheral Artery Disease	0	30
Pulmonary Function Testing	49	0
Pulse Ox	103	8
Sleep Apnea	31	0
Speaking Events	11	12

Providing Community Education and Resources

In addition to outreach activities in the community, Deborah manages support groups, community self-check health machines, hosts educational podcasts, schedules speaking engagements, and distributes a health e-newsletter. All of these efforts reinforce the education needed for managing chronic disease, as well as providing outlets for sharing and seeking more detailed information.

Support Groups and Counseling

	2020	2021
Zipper Club for Heart Surgery Patients	14	0
Nutrition Counseling – Adolescent	23	24
Nutrition Counseling – Adult	305	340
Malnutrition Screening – Pulmonary	238	172
Tobacco Cessation	6	4
Cardiology Clinical Support	600 hours	1,320 hours
EP Clinical Support	330 hours	660 hours

Deborah Self Check Machines

	2020	2021
Blood Pressure	6,751	11,349
Sleep Assessment	274	618
Peripheral Artery Disease	227	447
Heart Disease Risk Assessment	0	67
Total	**7,252**	**12,681**

Podcast/Speaker Engagements

	2020	2021
Hurley in the Morning	12	12
KWY Podcast	6	7
PHL-17	6	12
ABC 6 News – Facebook Live	1	N/A
Grand Rounds	20	16

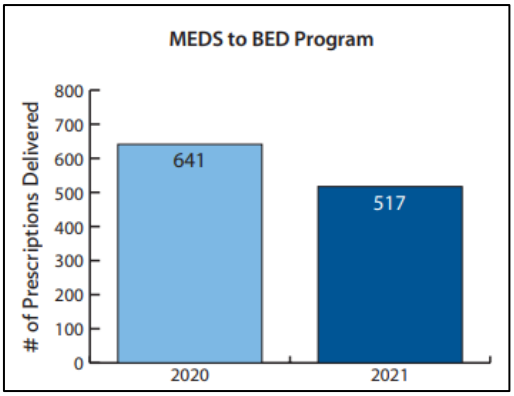
Addressing Social Determinants of Health

Deborah has established a number of successful partnerships to improve the health of community members. These partnerships have led to greater community health outreach, and membership in coalitions and alliances to collectively impact chronic disease-related needs.

Partnerships

- American Heart Association – Southern NJ
- Aspen Hills Healthcare Center
- Burlington County Health Department
- Burlington County Prosecutor's Office
- Burlington County Sheriff's Department
- Capital Health System
- Carbon Health Urgent Care
- Cleveland Clinic Heart, Vascular & Thoracic Institute
- Center for Medicare and Medicaid Services
- Cooper University Health Care
- DNV GL Healthcare
- Garden State Equality
- Georgies Family Pharmacy
- Humana Military
- Ivy Rehab Network
- Joint Base McGuire-Dix-Lakehurst
- Landmark Healthcare Facilities, LLC
- The LeapFrog Group
- Maryville Addiction Treatment Center
- Ocean County Health Department
- New Lisbon Partnership
- New Jersey Department of Health
- New Jersey Department of Human Services
- New Jersey Department of Military and Veterans Affairs
- NJHA Veteran Navigators
- Ocean County Foot and Ankle Surgical Associates
- Pemberton Community Library
- Pinelands Family Success Center
- Serena Group
- Society of Thoracic Surgeons
- Veterans Administration

Reducing Readmissions



In order to help keep patients compliant and on top with their prescriptions, Deborah has partnered with Georgies Pharmacy in 2019 to initiate a MEDS to BED program. This program allows Deborah providers to submit electronic prescription requests to the pharmacy, which are then filled and delivered to patient homes. The pharmacy further provides medication education and two follow-up calls to ensure patient adherence to medication instructions. In addition, several new remote monitoring programs – including remote monitoring for COPD and daily monitoring for Bluetooth-enabled heart devices, allow for a quick feedback loop to the medical team in case of worsening conditions that can be addressed prior to the need for readmission.

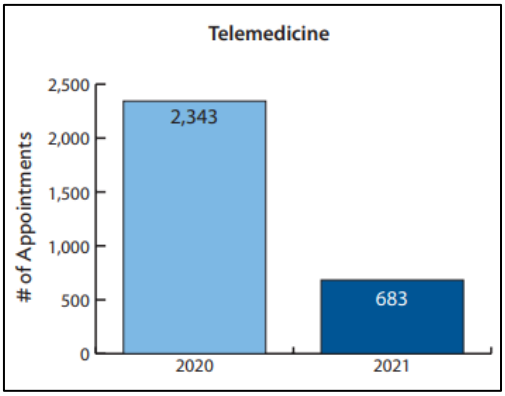
Remote Programs

	2020	2021
HGE Program – COPD Monitoring	0	28
Alzbetter Program Jan-Mar 2021 – Cardiac Monitoring	0	356
Spring Hills Program Apr 2021-present – Cardiac Monitoring	0	982
Anticoagulation Clinic	671	616

Issues of Aging

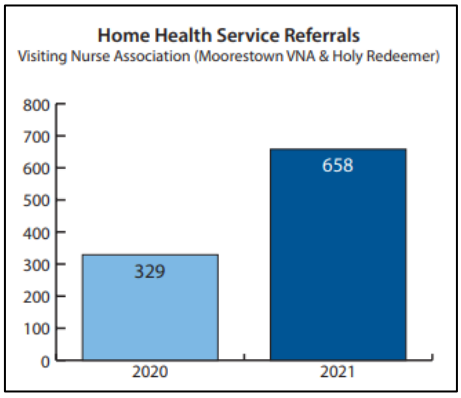
Offering Community Education and Programs

In an effort to ensure that our patients were able to access healthcare during the COVID-19 pandemic, Deborah arranged for telemedicine appointments for willing patients, providing continuing care for patients during the lockdown.



Developing a Network for In-Home, Person-Centered Care

Deborah partners with several organizations to ensure that upon discharge, patients are able to continue to receive in-home care and monitoring of their medical issues.



Building on Deborah's previous CHIP, the hospital's physicians use available resources to identify potential problems for seniors that might impede their ability to effectively manage their healthcare in their homes. Working with Deborah's case management team, Deborah's providers ensure that a strong in-home network (family, friends, spouses) are available to support the patient.

Appendix A: Public Health Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

- American Heart Association-Southern New Jersey, Director of Development
- Aspen Hills Healthcare Center, Transitional Care Manager
- Burlington County Eye Physicians, Administrator
- Burlington County Health Department, Health Officer
- Burlington County Military Affairs Committee (BCMAC), Chair
- Burlington County Regional Chamber of Commerce, President / CEO
- Burlington Township Health and Wellness Campaign, Event Coordinator
- Capital Health, Emergency Department Medical Director
- Complete Care Burlington Woods, Director Marketing & Admissions
- Girl Scouts of Central and Southern NJ, CEO
- Greater Philadelphia YMCA, President and CEO
- Joint Base McGuire-Dix-Lakehurst 87th Medical Group, Commander
- Maryville Inc, CEO
- Occupational Training Center (OTC), Outreach Coordinator
- Ocean Healthcare/Aspen Hills Healthcare Center, Director of Admissions
- Office of Senator Singleton, Chief of Staff
- Pemberton Branch of the Burlington County Library, Manager
- Pemberton Township High School, Teacher/Nurse
- Pemberton Township Schools, Media Services Coordinator
- Pinelands Family Success Center, Director
- Rowan College at Burlington County, Executive Director of Strategic Communications and Marketing
- Saints Memorial Community Church, Member/ health information Women's ministry
- Samaritan Healthcare & Hospice, Chief Marketing & Public Affairs Officer
- Sisterhood Inc, Community Health Worker
- SisterHood Inc, Program Director
- SisterHood Inc, Community Health Worker Supervisor
- Township, Local leadership
- Township of Pemberton, Mayor
- Virtua Health, Emergency Management Coordinator

Appendix C: Partner Meeting Attendees

- Aspen Hills Healthcare Center, Administrator
- Aspen Hills Healthcare Center, Transitional Care Manager
- Burlington County Community Action Partnership, Specialist
- Burlington County Health Department. Health Officer
- Center for Family Services, Navigator
- Capital Health, Emergency Department Medical Director
- Ivy Rehab, Regional Director of Business Development
- JB MDL 87th Medical Group, Chief Medical Officer
- JB MDL, 87th Medical Group, Chief Administrator
- JB MDL 87th Medical Group, RN Case Manager Warrior Clinic
- JB MDL 87th Medical Group, Exceptional Family Member Program
- National Coalition of 100 Black Women, Inc. Director, Southern NJ Chapter
- Ocean County Health Department, Coordinator, Community Health Services Division
- Ocean County Health Department, Public Health Coordinator/Health Officer
- Pemberton Township, Business Administrator
- Pinelands Family Success Center, Family Partner
- Samaritan, Chief Marketing & Public Affairs Officer
- Sisterhood, Inc., Program Director
- Sisterhood, Inc., Community Health Worker