St Luke's
UNIVERSITY HEALTH NETWORK

2025

Warren Campus and Star Community Health Community Health Needs Assessment

Authors

Whitney E. Szmodis, Ph.D., M.Ed.
Imani Ashman, B.S.
Rajika E. Reed, Ph.D., MPH, M.Ed.

Warren Campus and Star Community Health Service Area

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Icon Legend

St. Luke's and Star Community Health Partner Quote (Key Informant Interview/Community Forum Attendee)

St. Luke's and Star Community Health Needs Assessment Data

Executive Summary

Key Findings

From our analysis of primary and secondary data, including the Community Health Needs Assessment (CHNA) key informant interviews, community forums, and work with our community partners, we see significant issues facing our communities that impede health and wellbeing. Our efforts in prevention, care transformation, research, and partnerships help support our work to advance sustainable health promotion and quality of life initiatives. While there are many issues that need to be addressed, the results from the 2025 CHNA found the top priorities for the St. Luke's University Health Network and Star Community Health include:

2025 Community Health Needs Assessment
Top Priority Outcomes
Access to Care
Workforce Development
Food Security
Obesity Reduction
Physical Activity Promotion
Mental and Behavioral Health
Opioids and Other Substance Use
Housing
Transportation

The needs discussed within the health categories outlined in this document will serve as our guide in creating a detailed network implementation plan to best address the needs of the St. Luke's University Health Network service areas using three pillars:

Wellness and Prevention	Care Transformation	Research and Partnerships

We will work collaboratively with our community and network partners to create a more equitable society with better health outcomes, especially among our most vulnerable populations such as our Hispanic communities, unhoused individuals and families, seniors, women, and children.

Introduction

Background

As part of the Patient Protection and Affordable Care Act, nonprofit hospitals are required to conduct a Community Health Needs Assessment (CHNA) every three years to maintain tax-exempt status under section 501(c)(3) of the Internal Revenue Code. The goal of the assessment is to identify critical health disparities faced by populations within St. Luke's University Health Network (SLUHN) and Star Community Health service area. The assessments state health priorities unveiled by community stakeholders, health professionals, and public health experts. Additionally, regional reports and implementation plans will be crafted to build and strengthen collaborative partnerships to determine the allocation of resources to address the specified health needs. To view the 2022 and 2025 CHNA and Annual Reports, please refer to the following link: https://www.slhn.org/community-health/community-health-needs-assessment. If you have any questions regarding these reports, contact the Department of Community Health at (484) 526-2100.

Methodology

The CHNA is comprised of both primary and secondary data. The primary data were collected through three methods. First, key informant interviews were conducted with leaders from each campus community to identify high level strengths and needs in their respective communities. A list of the interview questions can be found in Appendix A. Second, a community forum was held for each campus community with stakeholders invited to speak on behalf of those they serve. A list of organizations represented at the forum can be found in Appendix B. Quotes from key informants and community forum participants are reported throughout the assessment identified using the legend on page five. Key informant interviews were conducted through Microsoft Teams or in-person, and the community forums were conducted in person at SLUHN campuses throughout the service area. Third, 15,148 voluntary CHNA surveys were administered to adults 18 years and older throughout our fifteen campus geographic region to help establish the main priority health needs with 1,022 respondents in the Warren Campus (SLW) and Star Community Health service area. Snowball sampling was utilized to reach respondents, especially those represented in our vulnerable populations. Snowball sampling is most effective when used to reach vulnerable populations to help to shed light on the social determinants of health (SDOH) within hard-to-reach populations. To reach populations with diverse resources, surveys were completed in either paper or digital format. The survey findings document, also posted online, includes questions and responses recorded from CHNA surveys conducted in 2012, 2016, 2019, 2022, and 2025. Secondary data included the use of hospital network data as well as county, state, and national data obtained from numerous sources (e.g., U.S. Census, the University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, Vital Statistics, American Community Survey (ACS), U.S. Department of Labor, Behavioral Risk Factor Surveillance System). A resource list of all data sources can be found in Appendix C. Data were accessed directly from the resource, or through the ArcGIS (geographic information system) software Esri (Environmental Systems Research Institute). This software provides mapping and spatial analysis to help visualize, analyze, and interpret data to understand patterns, relationships, and trends. Finally, the needs identified in the interviews and community forums were supplemented by the survey data and secondary data to provide a comprehensive picture of the contributing factors and needs in the community.

····· Existing Community Assets ·····

The St. Luke's Department of Community Health prioritizes health initiatives and goals for each fiscal year in a strategic plan. These initiatives and goals are in place to help respond to the needs identified in the most recent assessment and addressing social determinants of health to improve health outcomes. The strategies St. Luke's uses to reach these goals are through prevention, care transformation, and research and partnerships. Our initiatives and goals for the 2022 CHNA addressed access to care, chronic disease, and mental and behavioral health.

St. Luke's has a sister organization, Star Community Health, a Federally Qualified Health Center Look Alike (FQHC-LA) outpatient center that provides health screenings, preventative care, care for acute illness and minor problems, care of chronic illnesses, primary care, OB/GYN, immunizations, dental, pediatric health, financial literacy services and more to the medically underserved, including the uninsured and underinsured. Other community-based St. Luke's assets, apart from the top-ranked clinical care and teaching hospital features, include community engagement efforts that support our CHNA top priorities (e.g., Lyft and Uber program, Community Health Navigation, HOPE at St. Luke's, St. Luke's Penn Foundation Mental Health Services). St. Luke's partnered with Phillipsburg School District to connect families to vaccinations, physicals, and care with Star Community Health KidsCare (Easton) and St. Luke's Coventry Family Practice in Phillipsburg. St. Luke's supported Phillipsburg Elementary School in creating their "Peace Room" to practice skills to promote emotional, mental, and physical wellness for students and families.

Within the chronic disease health priority, St. Luke's introduced Fit for Life, with the goal to promote healthy lifestyles and prevent chronic disease by increasing physical activity and fruit and vegetable consumption based on lifestyle medicine principles. Fit for Life includes Get Your Tail on the Trail, which is a partnership with the Delaware & Lehigh Corridor (D & L) to encourage overall physical activity among community residents in order to promote enjoyment of nature and reduce obesity rates. Community-based food security efforts, including mobile markets, helped to provide healthy food to families in need.

Continued partnerships with both Norwescap Food Bank and Foodshed Alliance's LocalShare provided critical food access points for community members facing food insecurity. Norwescap Food Bank donated 5,100 pounds of produce to St. Luke's Coventry Family Practice for patients in Fiscal Year 2024 (FY24). During FY24, Foodshed Alliance's LocalShare free pop-up produce markets at the St. Luke's Hillcrest Plaza distributed more than 1,000 pounds of produce and goods monthly to more than 100 families. St. Luke's Warren Campus and St. Luke's Community Health were finalists for New Jersey Hospital Association 2024 "Healthy New Jersey" award for their submission: Leveraging Strategic Partnerships and Sustainable Initiatives to Support Food Access for Underserved Communities. The Warren Campus Older Adult Meals Program is designed to provide subsidized meals to adults 65 years and older at the Warren Campus cafeteria, which served 12,830 meals during FY24.

Community Health Liaisons and Community Health Workers (CHW) employed by SLUHN build trust in the community to improve access to care, services, and resources. Established pathways strengthen connections to services for individuals and families in need (e.g., primary care, social services, food access, financial literacy, career mentoring, workforce development).

St. Luke's partners with findhelp, a free self-navigating online platform (sluhn.findhelp.com). findhelp is a social care network established to provide a comprehensive platform for people to find social services in their communities and for nonprofit and other community-based organizations to coordinate their service delivery. St. Luke's Information Technology, Quality, Case Management, and Community Health teams work collaboratively, especially with Star Community Health, with 1,246 established (i.e., claimed) community-based partners. Findhelp allows community members to search for and connect to social determinants of health (SDOH) support such as financial assistance, food pantries, medical care, transportation, and more. During FY24, there were 30,227 searches on findhelp, with the top searches including food, housing, and utilities. This platform, as well as United Way's 211, are tools that Community Health Liaisons use to assist our community members, patients, and staff to connect to vital resources.

Warm Hand Off (WHO) is an initiative to support the continuum of care for patients in need of multiple services and providers. It is a transfer of care between providers with the patient (and potentially family) present to ensure clear communication, transparency, and helps to build relationships between patients and providers. St. Luke's collaborates with local community-based organizations and local counties to support WHO efforts. At the St. Luke's Warren Campus, a total of 167 WHO were conducted for alcohol, cannabis, cocaine, opioids, and other stimulants during FY24.

When asking key informants to describe Warren County, one informant said "there is definitely a strong sense of tradition and pride in the community, and even though we've had a much more transient population than may have existed, you know, 20-30 years ago, I think many of those individuals that are even new to our community recognized the values of some of the traditions." Another said "some of our strong sense of that community spirit is historically centered around athletics. Football and wrestling are huge in this town. It's one of the few places where people from all around, whether they have kids in the school system or not, come out for scholastic sporting events...we were selected by the Cal Ripken Foundation. Cal Ripken has formed this foundation to provide high quality sports fields and turf sports fields for underserved communities. In Walters Park, the centerpiece park of our community, there is a brand-new facility we just built and opened this past summer. This turf field will be a multi-use field for football, soccer, lacrosse, baseball. Hopefully bringing tournaments to the area, but also serving our local youth sports organizations. It's going to be located right next to our brand new pool." In addition to some of the assets mentioned related to sports and recreation, one informant also said "the Lehigh Valley Chamber has been very active in supporting our downtown and trying to generate foot traffic in our downtown. The Lehigh Valley chamber is very Easton, Allentown, Bethlehem-heavy. In the last two or three years, they've made a concerted effort to really include Phillipsburg in that as kind of the far eastern end of the Lehigh Valley."

····· County Health Rankings and Roadmaps ·····

Every year the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation releases County Health Rankings and Roadmaps (CHR&R) data that compare counties to state averages, as well as U.S. top performers. There are twenty indicators evaluated for each county with the US top performers being the counties at the 90th percentile or above for the nation. SLUHN uses CHR&R to better understand the Network top priorities from a county perspective, which promotes our understanding of resource needs within the eleven counties we serve.

Indicators are color-coded using a stoplight approach: green indicates that the value is better than both state and U.S. top performers, yellow indicates that the value is in between state and U.S. top performers, and red indicates that the value is at or worse than both state and U.S. top performers. Data reported from the counties served by St. Luke's in 2024 indicates that of the 220 values, 55.9% are red (123), 25.5% are yellow (56), and 18.2% are green (40). In 2021, 60% of values were red (108), 21% were yellow (38), and 19% were green (34). From 2021 to 2024, there was a 6.8% decrease in red values, a 21.2% increase in yellow values, and a 4.3% decrease in green values. Additionally, in Warren County, there are 60% red values, 30% yellow values, and 10% green values. In 2021, there were 55% red values, 30% yellow values, and 15% green values. From 2021 to 2024, there was a 9.1% increase in red values, no change in yellow values, a 33.3% decrease in green values. Please see the following page for the CHR&R data.

*The County Health Rankings and Roadmaps report their findings as the year 2024, but many of the measures are reported from previous years. Please see https://www.countyhealthrankings.org/ for more information.

2024	U.S. Top Performers*	Pennsylvania (PA)	Berks (BR) County	Bucks (BU) County, PA	Carbon (CR) County, PA	Lehigh (LH) County, PA	Monroe (MO) County, PA	Montgomery (MT) County, PA	Northampton (NO) County, PA	Schuylkill (SC) County, PA	Luzerne County, PA	New Jersey (NJ)	Hunterdon County, NJ	Warren (WA) County, NJ
Unemployment	2.3%	4.4%	4.3%	3.8%	5.1%	4.4%	5.7%	3.5%	4.2%	5.0%	5.3%	3.7%	2.9%	3.5%
Uninsured	6%	7%	8%	5%	6%	8%	7%	5%	6%	7%	8%	8%	5%	7%
Primary care physicians	1,030:1	1,260:1	1,590:1	1,240:1	2,970:1	1,040:1	2,490:1	770:1	1,240:1	1,990:1	1,320:1	1,280:1	910:1	1,850:1
Dentists	1,180:1	1,400:1	1,790:1	1,140:1	2,420:1	1,140:1	2,700:1	930:1	1,690:1	2,020:1	1,530:1	1,160:1	1,190:1	1,400:1
Poor physical health days	3.1	3.4	3.7	2.9	3.9	3.4	3.6	3.0	3.3	3.8	3.9	3.2	2.7	3.5
Food environment index	8.9	8.5	8.6	9.1	8.3	8.4	8.5	9.2	8.7	8.3	7.9	9	9.6	8.5
Physical inactivity	20%	23%	25%	21%	27%	26%	25%	20%	23%	27%	28%	23%	18%	23%
Access to exercise opportunities	90%	86%	86%	92%	65%	85%	77%	97%	90%	75%	88%	96%	91%	90%
Adult obesity	32%	33%	36%	31%	36%	34%	33%	31%	32%	39%	37%	28%	28%	32%
Excessive drinking	13%	19%	17%	19%	17%	19%	16%	19%	19%	18%	17%	17%	20%	18%
Adult smoking	14%	15%	18%	15%	20%	17%	17%	13%	16%	21%	20%	11%	11%	14%
Poor mental health days	4.4	4.7	5	4.9	5.5	4.8	4.6	4.7	4.8	4.9	5.1	4.4	4.4	5.2
Mental health providers	230:1	370:1	560:1	330:1	1,280:1	420:1	660:1	230:1	360:1	970:1	750:1	340:1	350:1	390:1
Low birthweight	6%	8%	8%	7%	8%	8%	9%	7%	8%	9%	8%	8%	6%	8%
Teen births	9	13	18	5	15	17	8	6	9	19	20	10	2	7
Sexually transmitted infections	151.7	409.8	468.4	214.5	192.6	467.3	354.5	223.7	331.6	264.5	392.0	360.7	121.6	247.4
High school graduation	94%	87%	87%	93%	88%	86%	92%	89%	88%	91%	85%	89%	94%	89%
Children in poverty	10%	15%	14%	7%	16%	16%	16%	7%	14%	16%	21%	13%	4%	10%
Severe housing problems	8%	14%	13%	13%	14%	16%	16%	13%	13%	11%	13%	20%	12%	13%
Social associations	18	11.8	10.7	8	13.3	9.9	7.2	10.7	9.8	12.9	10.3	8.1	9.5	8.7

University of Wisconsin Population Health Institute.
County Health Rankings and Roadmaps. 2024.

KEY: At or above State/Top Perfomer | Between Top Performers and State | At or below State/Top Performer

Demographics

General Population

For the purposes of the CHNA, we define the top zip codes as those that account for 80% of the population served by the Warren Campus and Star Community Health (i.e., service area). In the Warren Campus and Star Community Health service area, 60% of the patients served reside in zip codes 08865 (Phillipsburg), 07882 (Washington), and 07823 (Belvidere). The campus service area is defined by the area covered by the top zip codes.

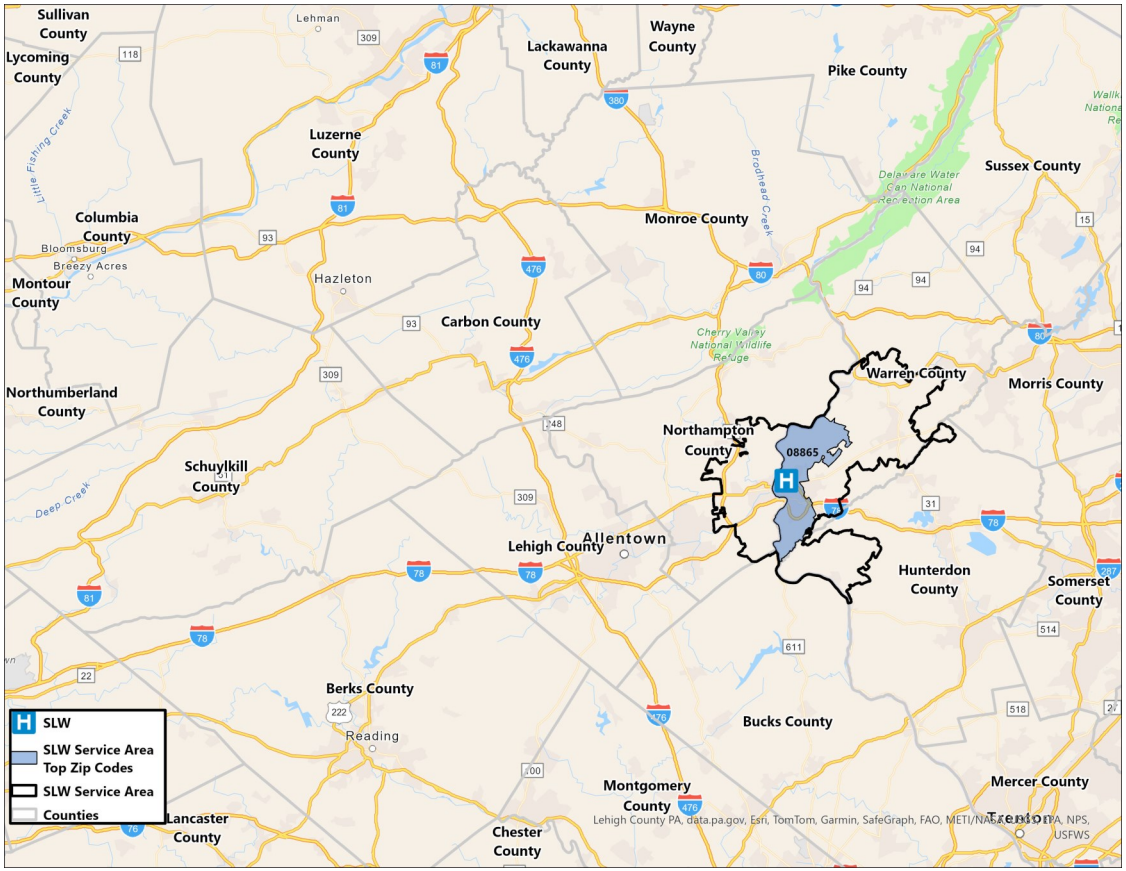
According to the ArcGIS (geographic information system) software Esri (Environmental Systems Research Institute), a total of 162,156 people live in the 232.77 square mile service area. The population density for this area is estimated at 696.64 persons per square mile.

FY23 SLW - Zip Codes Comprising Top 80% of Facility Encounters		
Zip Code	% SLW Total (n = 135,317)	% Network Total (n = 2,133,822)
08865	43%	2.7%
07882	9%	0.5%
07823	8%	0.5%
08886	6%	0.4%
18042	4%	0.3%
18040	3%	0.2%
18045	3%	0.2%
08848	2%	0.1%
07863	2%	0.1%
Total	**80%**	**5.1%**

When looking at population, we also assess the percentage of the population living in urban and rural areas. According to the 2020 Decennial Census, 57.6% of the Warren Campus and Star Community Health service area lives in an urban setting and 42.4% of the service area lives in a rural setting. Urban areas are defined by population density, count, size thresholds and the amount of impervious surface or development (i.e., areas impervious to water seeping into the ground, concrete-heavy areas). Rural areas are all other areas not defined as urban. The New Jersey percentages for urban and rural living are 94% and 6%, respectively. The United States urban and rural percentages are 78.8% and 21.2%, respectively.

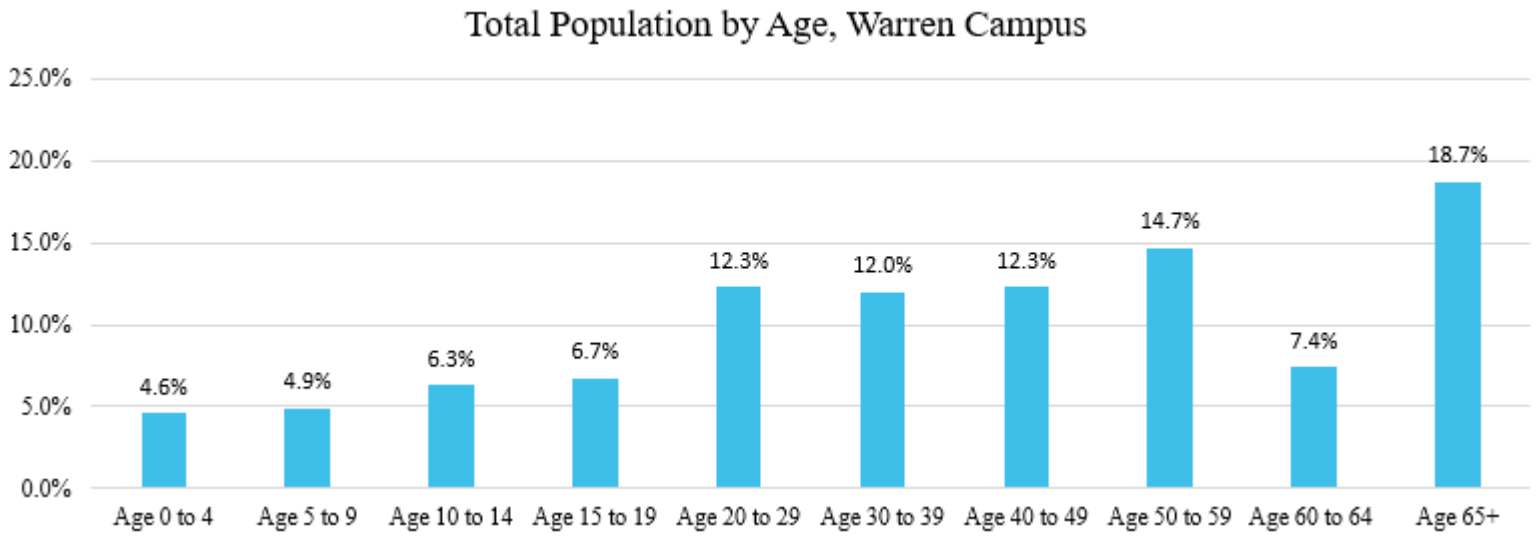
"Our community has become more diverse. We've had a much more transient population than may have existed 20 to 30 years ago, but our community maintains a strong sense of tradition and pride."

Understanding the demographics of the service area is essential to addressing need and improving upon the region's health services. The following data come from American Community Survey (ACS) 5-year estimates (2018-2022) reported in 2023 by the US Census Bureau and St. Luke's Community Health Needs Assessment (CHNA) survey data unless stated otherwise. Esri was used to access the ACS and US Census data. ACS data represents information over a 60-month period, which allows estimates to provide data for a wide range of demographic and social determinants of health for the United States population. For more information on ACS 5-year data please visit www.census.gov/data/developers/data-sets.

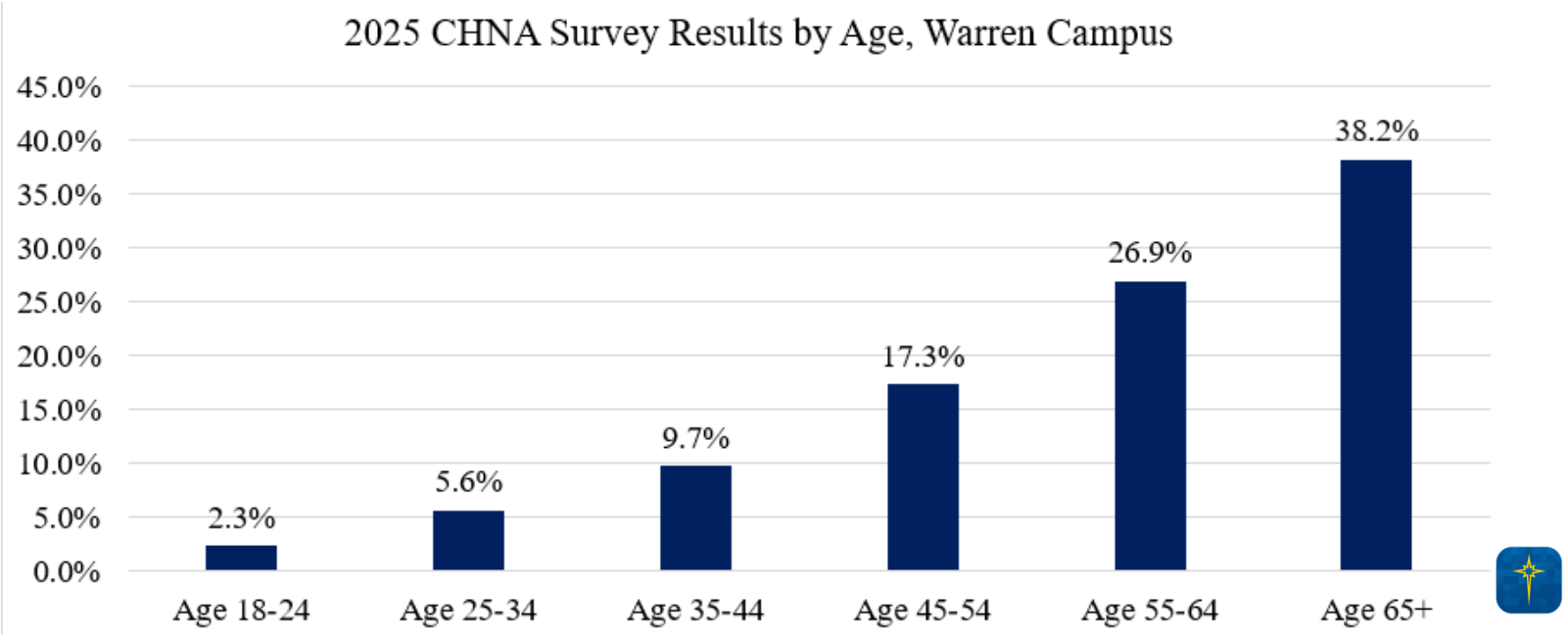


..... Age .....

The Census reports that 20.2% of the service area population are people under 18 years old and 18.7% are 65 years and older. Combined, these groups account for 38.9% of the service area population, leaving 61.1% between the ages of 18 and 64. In Warren County, 18.7% of people are under 18, 20.4% are 65 and older, and 60.9% between the ages of 18 and 64 years old. In Hunterdon County, 19% of people are under 18 years old, 21.7% are 65 and older, and 59.3% between the ages of 18 and 64 years old.



CHNA survey responses from the Warren Campus and Star Community Health service area indicated that 38.2% were 65 years and older, 26.9% were ages 55 to 64, 17.3% ages 45 to 54, 9.7% ages 35 to 44, 5.6% ages 25 to 34, and 2.3% ages 18 to 24. The CHNA survey was only administered to people 18 years and older and therefore younger ages are not reflected in the sample. The median age of respondents was 58 years old.

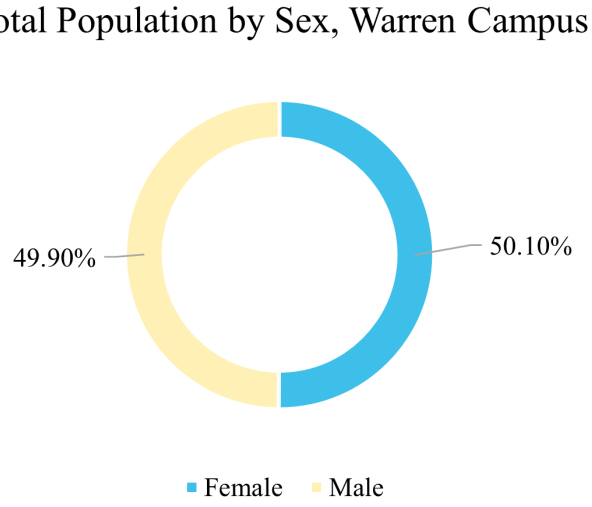


Sex at Birth

The 2022 ACS 5-year estimates asked respondents to indicate their sex (i.e., male, female) assigned at birth. The state of New Jersey has three gender options for birth certificates (i.e., male, female, undesignated/ nonbinary). Generally, the population of all SLUHN service area communities are evenly split between men and women, with women as a slightly higher percentage of the population.

According to the ACS, 50.1% of people identified as female and 49.9% identified as male in the Warren Campus and Star Community Health service area. This is similar to the national average, 50.5% and 49.5%, respectively. In Warren County, 50.9% of people identify as female and 49.1% as male. In Hunterdon County, 50.7% of people identify as female and 49.3% as male.

Of all Warren Campus and Star Community Health service area respondents to the CHNA, 64.2% were assigned female at birth compared to 35.7% assigned male at birth. Further information related to gender identification is found in the LGBTQ+ section.

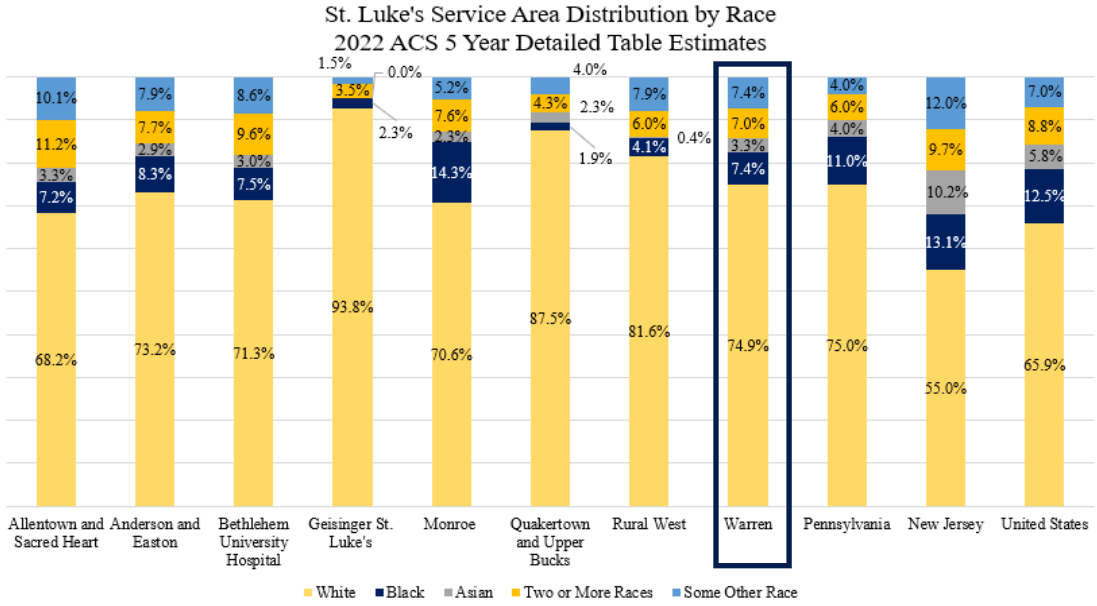


Ethnicity

Ethnicity trends in the United States have been evolving rapidly, reflecting the country's increasing diversity. Nationwide, Hispanic and Asian populations are among the fastest-growing groups as a result of both immigration and higher birth rates. These trends are also seen in New Jersey and in local communities within the SLUHN service areas.

The ACS reports that 85.1% of the Warren Campus and Star Community Health service area identifies as non-Hispanic and 14.9% identifies as Hispanic. The population in New Jersey is 78.4% non-Hispanic and 21.6% Hispanic. In Hunterdon County, 9.6% of people identify as Hispanic and 90.4% as non-Hispanic.

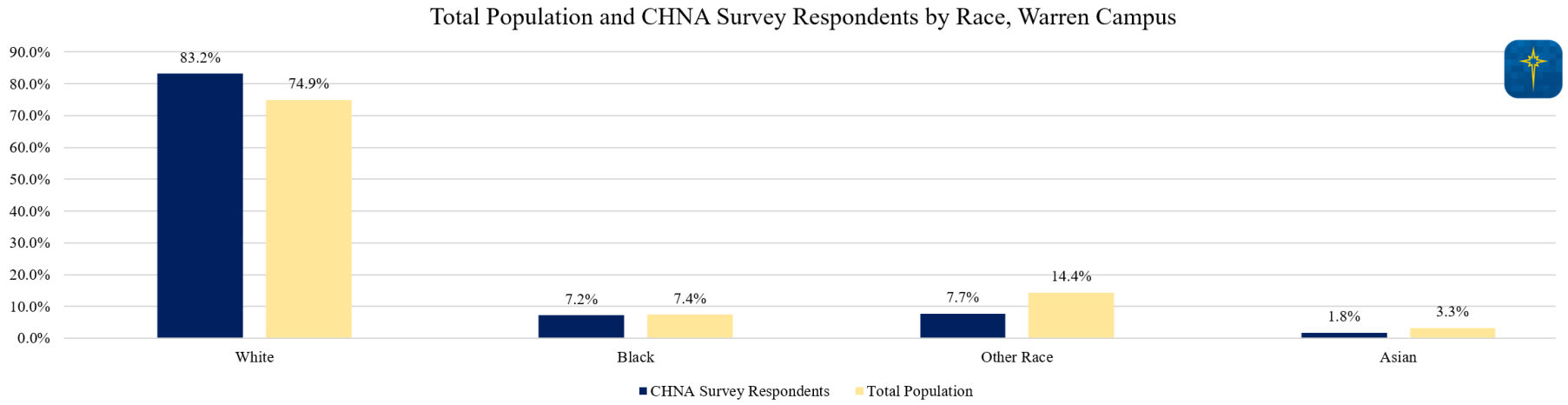
Of all Warren campus and Star Community Health service area CHNA survey respondents, 10.5% identify as Hispanic and 89.5% identify as non-Hispanic.



Race

Racial demographic trends have shifted significantly in recent years. These trends are also seen at the state level in New Jersey. The ACS reports that 76.6% of the service area identifies as White, followed by Black (7.6%), Other Race (12.2%), and Asian (3.5%). Data for individuals identifying as Native Hawaiian/Pacific Islander, Native American/Alaska Native, and Multiple Races were combined with Other Race due to small sample sizes.

The majority of CHNA survey respondents in the Warren Campus and Star Community Health service area identified as White (83.2%), 7.2% Black, 7.7% Other Race, and 1.8% Asian.



Vulnerable Populations

For the purpose of this CHNA, vulnerable populations are defined as a group or groups of individuals who experience greater obstacles and barriers to positive health outcomes and access to quality healthcare based on their economic status, racial or ethnic background, age, physical health status, mental health status, social support, geographical location, and other external factors that place them at risk of poor health outcomes. Vulnerable populations often face multiple obstacles that collectively contribute to limited access to consistent and quality care, which in turn correlates with disparities in health status due to external factors often out of the control of individuals. While these disparities are often addressed to promote a group or groups of vulnerable populations, it is important to note that many individuals face uniquely challenging circumstances that require support and services based on their personal situation. The following data was retrieved from the 5-year American Community Survey (2022), Esri estimates, and the US Census (2020) unless otherwise stated.

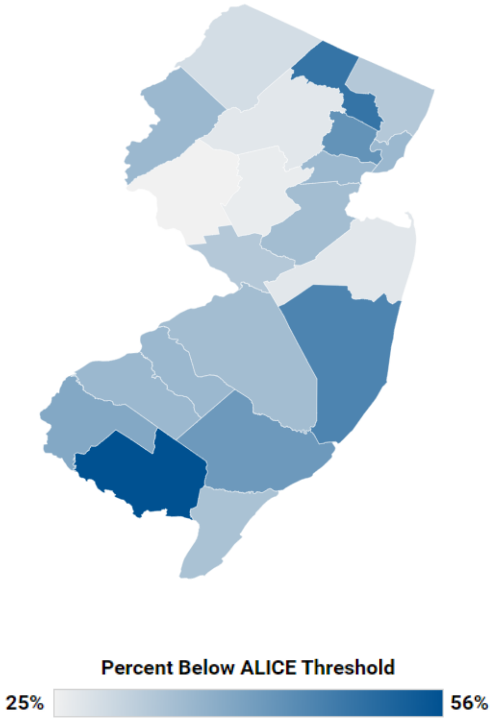
Black, Indigenous, People of Color (BIPOC)

It is important to identify the BIPOC communities within the SLUHN service area to understand the unique perspectives and experiences, which are often influenced by both historical and ongoing inequalities. For example, Indigenous peoples historically lack proper access to health resources and information and often face discrimination when accessing healthcare facilities. Black women have the highest rates of death during childbirth of any demographic, and black men have some of the highest rates of Type 2 Diabetes in the nation. It is important to recognize the specific challenges faced by BIPOC communities, including SDOH (e.g., healthcare, education, employment, housing) in order to address needs and promote education, prevention, and quality care. Disparities in access to care for BIPOC communities can be detrimental to health outcomes and generate mistrust in healthcare. In the Warren Campus and Star Community Health service area, 7.2% of survey respondents identify as Black, 1.8% Asian, 7.7% Other Race, and 13.2% of respondents identify as Hispanic. Out of the BIPOC individuals who were surveyed for the network, 5.1% identified as Black, 1.4% identified as Asian, 6.17% Other Race, and 9.25% as Hispanic.

Asset Limited Income Constrained Employed (ALICE)

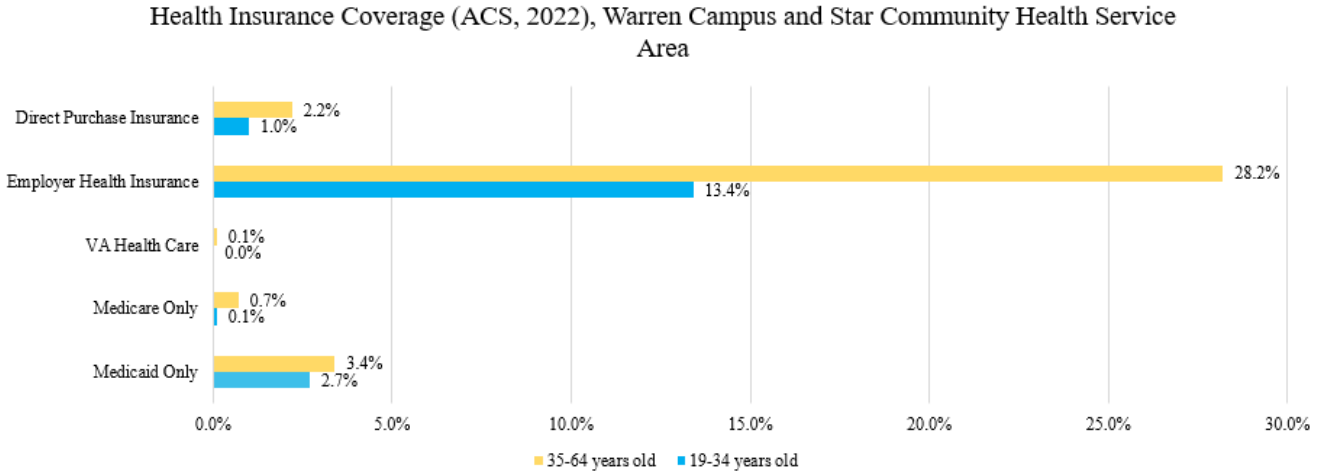
Asset Limited, Income Constrained, Employed (ALICE) are individuals and households that earn above the Federal Poverty Level, but less than the basic cost of living. ALICE households do not qualify for federal assistance and they often struggle to afford basic necessities such as healthcare, housing, food, childcare, and transportation. ALICE individuals and households are typically employed, often working multiple jobs or in positions that do not make enough to earn a living wage. Because these individuals and households earn too much to qualify for public assistance, they struggle to not only obtain financial stability in the short term, but also have little-to-no savings or assets. The basic cost of living for ALICE populations is higher than what their incomes can support, and they are often one emergency (e.g., car repair, medical emergency) away from financial crisis. The Federal Poverty Level for a family of four (2024) is $31,200.

The United Way uses the Household Survival Budget to examine the bare minimum costs for essentials in a geographic area (i.e., city, county) to understand the variance in financial constraints for individuals and households living and working within a given community. The most recent ALICE report was published in 2023 and was updated in 2024. The most recent data indicates that financial hardships in New Jersey continued to be affected by the COVID-19 pandemic, inflation, wage growth, and the expiration of public assistance provided during the pandemic. In 2022, of the 3,512,465 households in New Jersey, 36% (1,268,636) were below the ALICE threshold with 10% living in poverty. Eight percent of households in Warren County live in poverty and 27% were considered ALICE. Hunterdon County has 4% of families living in poverty and 21% were considered ALICE.



Uninsured Population

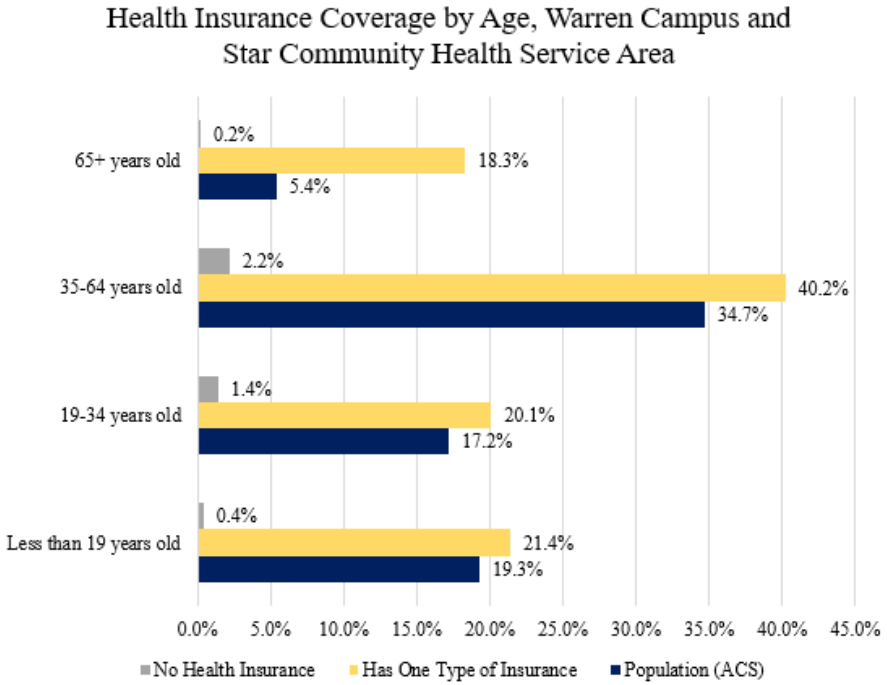
Reliable and affordable health insurance plays a vital role in ensuring that individuals and families have access to necessary medical services without overwhelming financial burden. Health insurance often covers the majority of the cost for preventative care, treatment of acute and chronic illness, and other specialty services. Access to health insurance also promotes public health, as insured populations are more likely to receive timely medical attention, vaccinations, and other care services that promote healthier communities and reduce long-term healthcare costs.



Federal programs for uninsured and underinsured individuals are available in the United States. Medicare is a federal healthcare program in the United States available to most of the population ages 65 years and older and helps to nearly eliminate the uninsured population in that age demographic. Children under the age of 18 years old are eligible for the Children's Health Insurance Program (CHIP) as part of a joint state and federal health insurance coverage for children in low-income families that earn above the Medicaid threshold but between 200-400% of the Federal Poverty Level, depending on state guidelines.

In the Warren and Star Community Health service area, only 0.2% of the 65 and older population are uninsured, 3.6% of ages 18 to 64 are uninsured, and 0.4% of children under 18 years old are uninsured. According to CHNA survey results, 7.5% of all service area respondents either have no coverage and pay cash or do not know if they have insurance. The discrepancy between this service area and CHNA survey respondents is important to note as we continue to increase our outreach efforts in the communities we serve to reach our most vulnerable populations, which includes the uninsured population.

Out of pocket health care expenditures can also be barriers to care and services. In the Warren Campus and Star Community Health service area, average healthcare expenditures within the community were $5,224 per person annually. These out of pocket expenses can include insurance payments (e.g., copays), vision care, dental care, and more.



····· Older Adults ·····

The life expectancy of older adults in the United States has rapidly increased in recent decades, requiring a greater need for elder care and older adult services. According to the 2020 U.S. Census, one in six people in the United States were 65 years and older (55.8 million individuals), which was a 38.6% increase from the previous Census in 2010. In the Warren Campus and Star Community Health service area, there were 30,482 individuals 65 years and older in 2020 (18.7% of the population). The 2024 projected estimates increased to 34,408 (20.5% of the population) and by 2029 estimates are projected to be 39,829 (23.3% of the population).

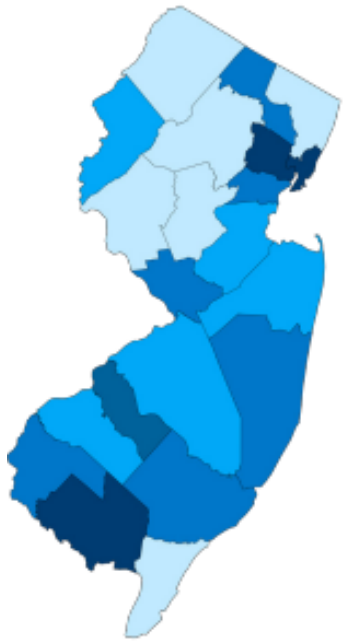
It is estimated that the 65 years and older population will outnumber the population under 18 by the year 2034. This is important as the demographics of the population shift, the needs of the population and the dependency of younger and older populations on the working-age population create diverse needs and responsibilities. Dependency ratios are calculated based on the number of children (0-14 years old) and older adults (i.e., seniors aged 65 years and older) to the working-age population (15-64 years old). These ratios help to better understand the economic, social, and other responsibilities placed on the working population to support dependents both young and old. Both child and older adult dependency ratios are calculated by dividing the number of dependents by the number of individuals in the working-age population. Age dependency ratios are a measure of the nonworking age population relative to the population of working age (18-64). This serves as a useful indicator of an area's age structure. A higher senior dependency ratio reveals that seniors represent a larger share of the dependent population. Not only do these dependency ratios impact families and communities in diverse ways (e.g., elder care, child care) but it also impacts the way healthcare systems grow and develop their services to meet the needs of the populations they serve. In the Warren Campus and Star Community Health service area, the child dependency ratio is projected to decrease from 33.0 in 2020 to 29.9 in 2029, while the senior dependency ratio is projected to increase from 30.5 in 2020 to 39.5 in 2029.

	Census 2020		2024		2029	
Total Population by Age	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
65 - 69	9,776	6.0%	10,944	6.5%	11,722	6.9%
70 - 74	7,965	4.9%	8,695	5.2%	10,271	6.0%
75 - 79	5,576	3.4%	6,669	4.0%	7,766	4.5%
80 - 84	3,391	2.1%	4,112	2.4%	5,396	3.2%
85+	3,774	2.3%	3,988	2.4%	4,674	2.7%
Child Dependency Ratio	33.0	-	31.0	-	29.9	-
Senior Dependency Ratio	30.5	-	33.8	-	39.5	-

The United Health Foundation publishes Senior Health Rankings annually with 52 measures of health to provide a comprehensive overview of the health and wellbeing of older adults in the United States. Overall, New Jersey ranked 21 out of 50 states. Metrics that have shown recent improvement have greater availability of geriatric clinicians and home healthcare workers, which increased in New Jersey. However, poverty increased 14% in New Jersey. New Jersey ranked 37 out of 50 states in physical environment health (i.e., air and water quality, housing and transit).

Older adult mental health is a growing concern in the United States. In New Jersey, 12.9% of adults 65 years and older experience depression and 10.2% experience frequent mental health distress. Overall, 9.4% of older adults in the United States experienced frequent mental distress and 15.5% experience depression. Frequent mental health distress is defined by 14 or more days of self-reported poor mental health in the past month. Factors that can contribute to frequent mental distress are the inability to afford healthcare, living alone, and activity limitations due to chronic conditions, physical disabilities, or mental health problems. One reason that the older adult population may not receive adequate mental health care is because symptoms of some mental health issues like depression or lapses in memory often get dismissed as typical aspects of aging.

Social isolation is another significant factor that can negatively impact older adult mental and physical health. Many older adults experience isolation due to multiple factors, such as reduced mobility, loss of friends or family, and geographic distance from social support networks. This isolation can lead to increased feelings of loneliness, which can increase risk of depression, anxiety, and cognitive decline. Additionally, socially isolated older adults may have limited access to healthcare services, impacting their overall well-being and potentially exacerbating existing health conditions. The United Health Foundation Health Rankings index social isolation factors to better understand the risk of social isolation for adults 65 years and older. Factors include: living in poverty; living alone; being divorced, separated, widowed; having never married; having a disability; having an independent living difficulty. Risk is assessed on a scale from 1-100, with a higher value indicating greater risk. New Jersey ranked 26th out of 50 states in social isolation.



New Jersey

1 to 33 | 34 to 38 | 39 to 44 | 45 to 50 | 51 to 100

Source: US Census Bureau, ACS 2018-2022, United Health Foundation

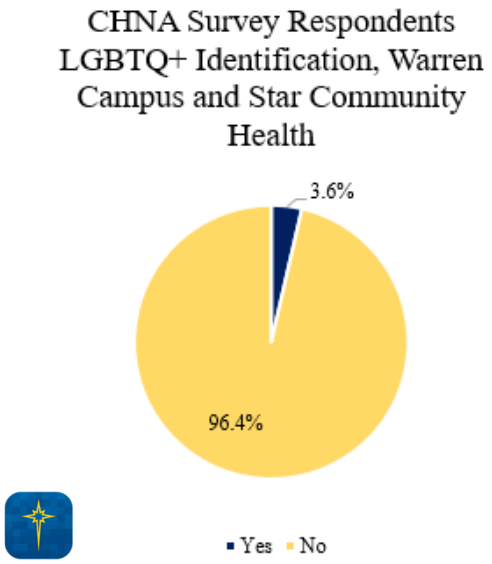
····· Lesbian, Gay, Bisexual, Transgender, Queer + (LGBTQ+) ·····

According to the University of California Los Angeles Williams Institute, 4.1% of individuals living in New Jersey identify as Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+). New Jersey ranks 24 out of the 50 states for total LGBTQ+ population. In New Jersey, 52% of the LGBTQ+ population identifies as female and 48% identify as male. Of the LGBTQ+ individuals in New Jersey, just over half (51%) identify as White, 27% as Hispanic/Latino, 13% as Black, 5% as Asian, and 4% as Other Races. The average age of LGBTQ+ individuals in New Jersey is 37 years old, with 31% of the population between the ages of 18-24 years old. The unemployment rate of New Jersey LGBTQ+ individuals is 8% compared to 7% of non-LGBTQ+ individuals. Additionally, 12% of New Jersey LGBTQ+ individuals are uninsured, 22% are food insecure, and 23% have an income less than $24,000 a year. While 41% of New Jersey LGBTQ+ individuals have a high school diploma, only 19% have a bachelor's degree.

New Jersey has implemented universal nondiscrimination laws for sexual orientation and gender identity, and conversion therapy is banned across the state. According to the Movement Advancement Project (MAP), New Jersey fairs well for LGBT policies, with New Jersey scoring 39.25 out of 44.5 for overall policies.

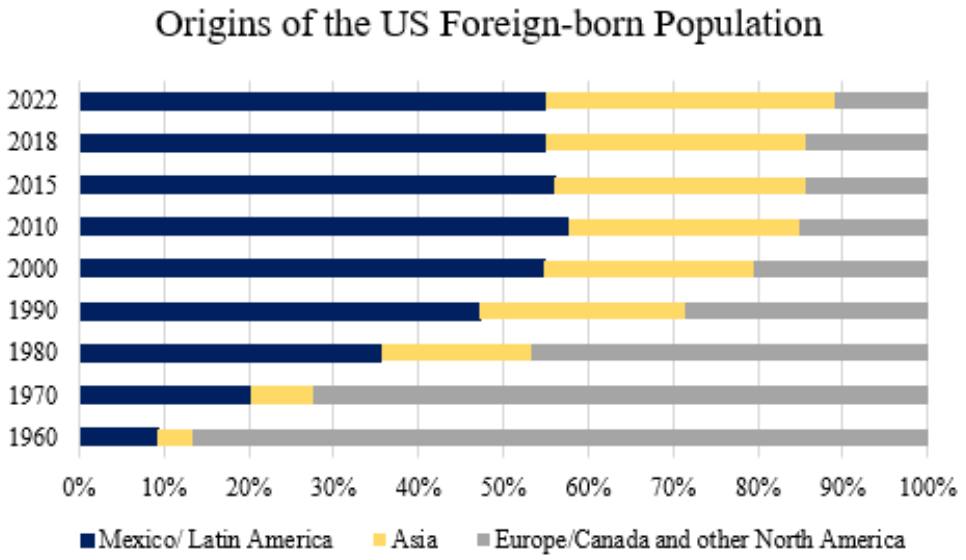
LGBTQ+ individuals are considered a vulnerable population due to the unique challenges and systemic barriers they face including discrimination, stigmatization, and a lack of legal protections that often contribute to poor health outcomes. They face depression, anxiety, and suicidal ideation at higher rates than the majority of the population, and may lack social support which can lead to social isolation and economic instability. Healthcare for LGBTQ+ individuals can face challenges and disparities that can significantly impact health outcomes. Many LGBTQ+ individuals report discrimination and stigma in healthcare settings, which can lead to mistrust of medical professionals and reluctance to seek necessary care. LGBTQ+ populations are at higher risk than the population as a whole for mental health, substance use disorders, sexually transmitted infections, and other health issues. Barriers to accessing appropriate care from healthcare providers trained in LGBTQ+ specific health concerns further exacerbates these issues, resulting in gaps in care.

From the St. Luke's CHNA survey, 3.6% of respondents from the Warren Campus and Star Community Health service area identify as LGBTQ+. Additionally, 0.36% of all respondents in the network identify as non-binary, 0.06% identify as genderqueer, 0.04% identify as gender fluid, and 0.09% identify as another gender.



····· Foreign-Born Populations ·····

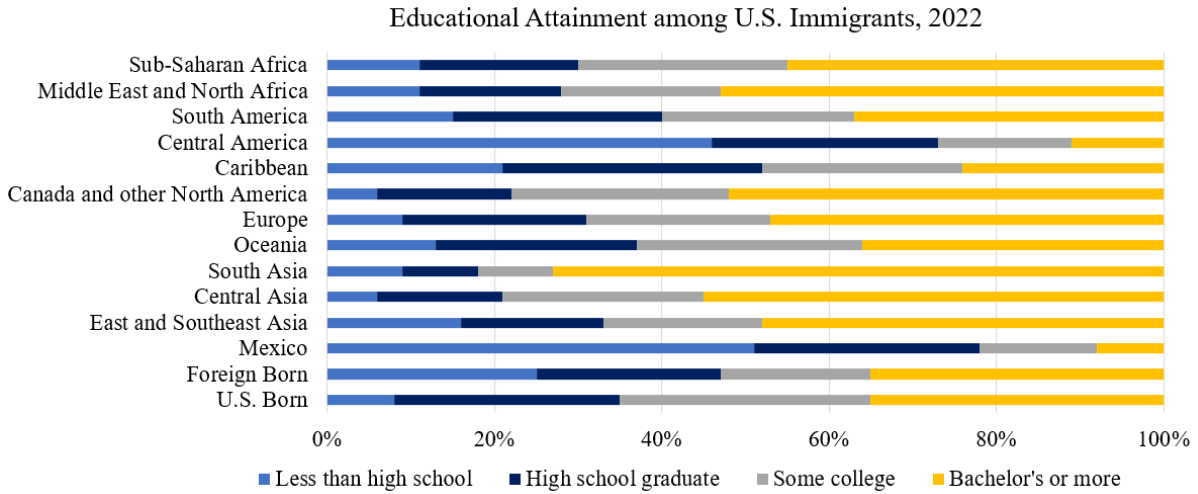
According to the 2018-2022 ACS estimates, the number of foreign-born people in the United States increased by more than 5 million over 10 years to 45.3 million or 13.7% of the nation's population. According to the US Census Bureau, foreign-born populations consist of anyone living in the United States who was not a U.S. citizen at birth, including naturalized U.S. citizens, lawful permanent residents (i.e., immigrants), temporary migrants such as foreign students, humanitarian migrants such as refugees and asylees, and unauthorized migrants. Nationally, immigrants made up over one-fifth of the population in four states: California (26.5%), New Jersey (23.2%), New York (22.6%) and Florida (21.1%). According to the U.S. Census Bureau's American Community Survey, 23.5% of New Jersey's population is foreign-born, and of those, 38.9% is of Latino origin.



Source: ACS, 2022

In 2022, educational attainment among U.S. immigrants showed notable trends. Recent immigrants, those who arrived since 2010, were more likely to have a college education compared to earlier immigrants and U.S. natives. According to the US Census, 45.2% of recent immigrants held a bachelor's degree or higher, compared to 38.0% of U.S. natives and 32.8% of immigrants who arrived in the 1990s.

Foreign-born populations often face challenges in accessing healthcare due to language barriers, cultural differences, and lack of health literacy and understanding of the healthcare system. Legal and financial obstacles (e.g., lack of health insurance, fear of deportation) further complicate these issues, making it difficult for many foreign-born populations to receive quality care. Language barriers are significant for individuals trying to access care with limited English proficiency.



Source: Pew Research Center, 2022

····· Language Diversity ·····

English is the language most widely spoken in the Lehigh Valley and surrounding areas of Pennsylvania. However, many people in the SLUHN service area may be identified as having limited English proficiency. Limited English proficiency is reported as the percentage of the population five years and older who speak a language other than English at home and speak English less than "very well." Respondents were not instructed on how to interpret the meaning of "very well." Speaking and understanding English is important in the Warren and Star Community Health service area because most health services are provided in English. Language can also be a barrier to educational attainment, higher income, employment, and accessing healthcare.

Translation and interpretation services are required in locations where either 5% of the community or over 1,000 community members speak a different language. A translator typically only translates the written word while interpreters translate orally. The Warren and Star Community Health service area zip codes that require translator or interpreter services are highlighted in red in the table found on page 22. Of the Warren and Star Community Health service area, five zip codes require language services for Spanish speakers, and one zip code requires services for other Indo-European languages (not including West Germanic and Slavic languages).

Network Service Area Languages			
Top Zip Codes	Percentage and Number of Spanish Speakers in Zip Code	Percentage and Number of Spanish Speakers in Zip Code Who Speak English Less than "Very Well"	Next Frequent Language
08865	6.5% (1,902 people)	48.7% (926 people)	Other Indo-European languages (3.2%- 933 people)
07882	6.0% (846 people)	23.5% (199 people)	Other Indo-European languages (3.5%- 497 people)
07823	3.2% (240 people)	31.3% (75 people)	Other Indo-European languages (3.8%- 280 people)
08886	3.8% (250 people)	33.6% (84 people)	Other Indo-European languages (8.2%- 540 people)
18042	15.7% (6,690 people)	37.7% (2,519 people)	Other Indo-European languages (1.7%- 736 people)
18040	6.5% (1,061 people)	27.1% (288 people)	Asian and Pacific Island languages (4.0%- 652 people)
18045	8.2% (2,307 people)	24.0% (553 people)	Other Indo-European languages (5.7%- 1,609 people)
08848	1.0% (76 people)	40.8% (31 people)	Other Indo-European languages (2.6%- 209 people)
07863	7.7% (268 people)	32.1% (86 people)	Other Indo-European languages (3.1%- 108 people)

····· Children and Adolescents ·····

Children and adolescents in the United States are a diverse and rapidly evolving segment of the population. According to the National Center for Health Statistics at the Centers for Disease Control (CDC), the birth rate in the United States has decreased by 2% annually since 2014, with an all-time low at 3,591,328 births in 2023. While birth rates are the lowest they have been in the history of the United States, the racial and ethnic diversity of children is increasing. The ACS reports that 20.2% of the Warren Campus and Star Community Health population are under 18 years old. Childhood is a crucial time for development in all aspects of life, thus it is important to study health behaviors and target initiatives towards addressing negative health patterns in youth. Routine preventative care, including vaccinations, annual well visits, and developmental screenings are crucial. Mental health services are in high demand, as many youth face challenges related to stress, anxiety, depression, and other behavioral issues. Access to proper nutrition and physical activity programs supports their physical health, while educational initiatives around health and wellness promote lifelong healthy habits. Health insurance is critical for all children to ensure they receive consistent quality care. In order to gain insight into the population, the 2021 New Jersey Youth Risk Behavior Surveillance System (YRBSS) and 2021 New Jersey Student Health Survey was used to inform trends in Warren County.

Established in 1997, the Children's Health Insurance Program (CHIP) ensures that children receive comprehensive health benefits, including routine check-ups, immunizations, doctor visits, prescriptions, dental and vision care, inpatient and outpatient hospital care, laboratory and X-ray services, and emergency services. CHIP is a state and federal partnership that provides low-cost health coverage to children in families with incomes too high to qualify for Medicaid but too low to afford private insurance. Each state administers its own CHIP program, working closely with its Medicaid program to tailor benefits and eligibility requirements to meet the needs of its residents.

In addition to covering children, some states extend CHIP benefits to pregnant women, ensuring prenatal care and reducing the risk of complications during pregnancy. The program is designed to be accessible, with families able to apply at any time of the year and coverage starting immediately upon qualification. Costs under CHIP are kept affordable, with routine well-child visits typically free and other services requiring minimal co-payments. Some states may charge a monthly premium, but it is capped at no more than 5% of a family's annual income. This structure helps ensure that children receive the necessary medical care without imposing a significant financial burden on their families.

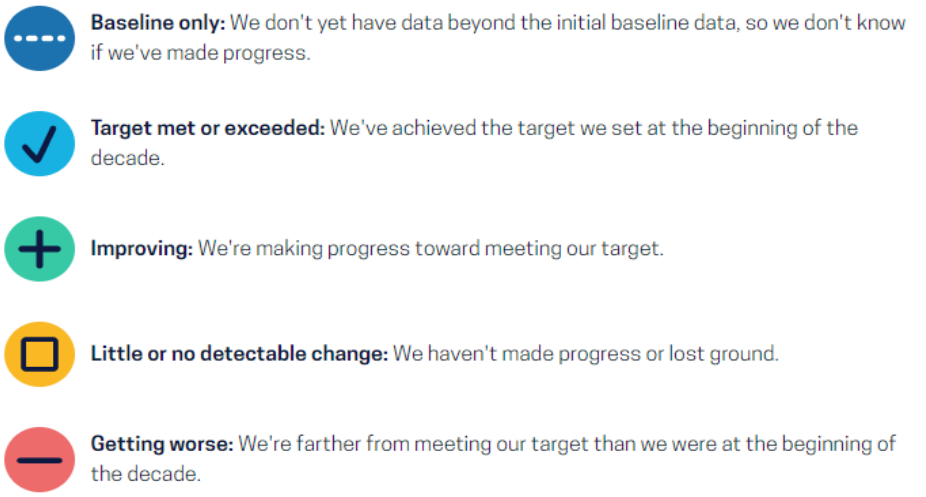
County	Number of Children enrolled in CHIP (2024)
Warren (NJ)	3,215
Hunterdon (NJ)	4,508
New Jersey	230,000
United States	7,056,520

"We have a lot of diversity in our schools, whether that is socioeconomics, race and ethnicity, or cognitive and intellectual abilities."

Education Access and Quality

Education access and quality is crucial to improving health outcomes and reducing health disparities. Quality education provides individual with the knowledge and skills to foster better community while providing greater opportunity for higher income potential. Education access and quality is a critical component of the social determinants of health, with factors intrinsically linked to health outcomes.

According to Healthy People 2030, the following objectives are related to education access and quality and are measured at the national level. Most Healthy People 2030 objectives are core, or measurable, objectives that are related to targets outlined for the decade (2020-2030). Evidence-based interventions are supported through national, state, and local initiatives. Progress is measured using a variety of data sources (e.g., US Census, ACS estimates, state and county data) and is measured using the following indicators: Baseline only, target met or exceeded, improving, little or no detectable change, getting worse (refer to chart on the right). The objectives outlined have corresponding updates at the national level as of June 2024.

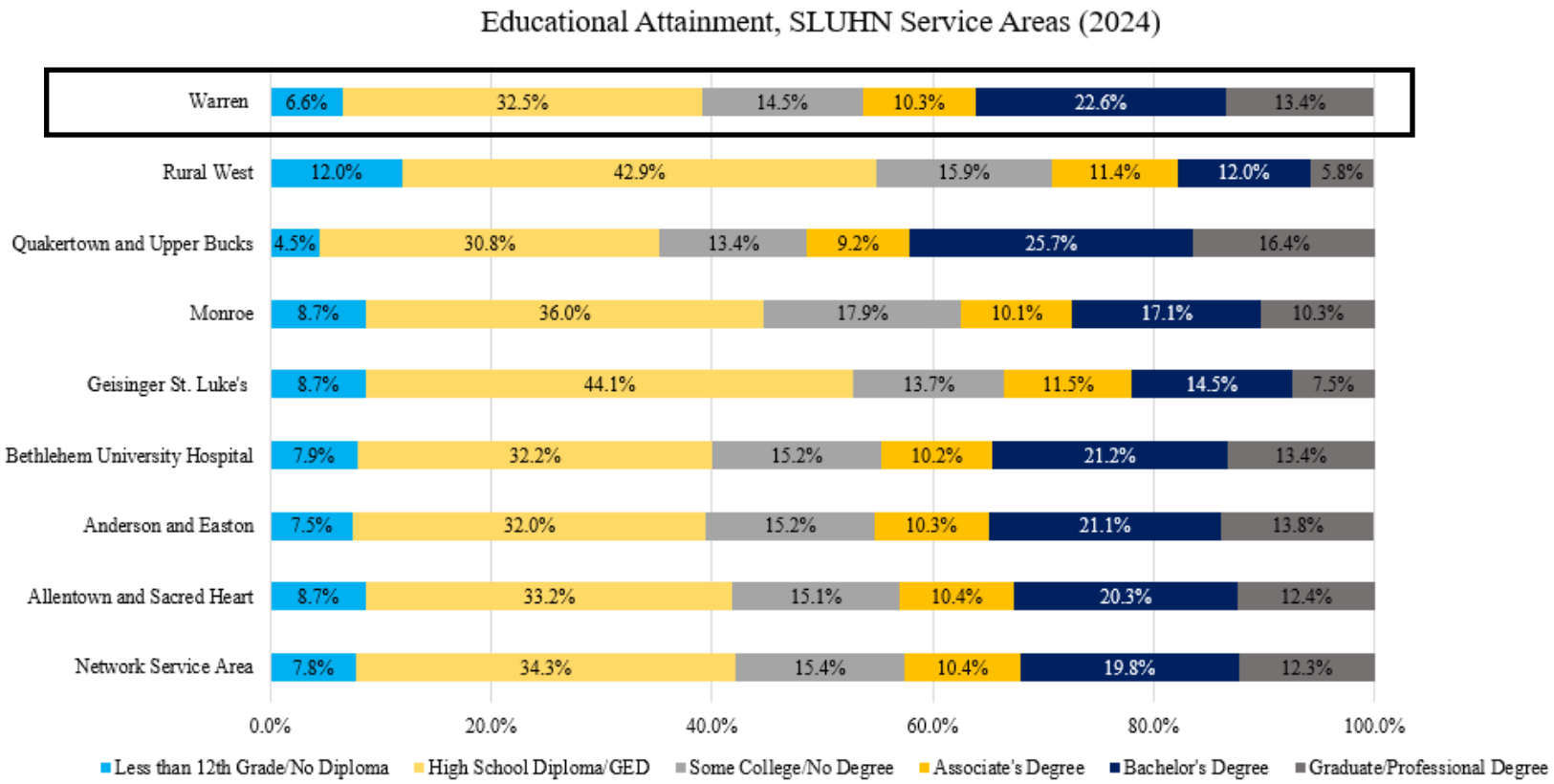


Healthy People 2030 Objectives for Education Access and Quality	Baseline	Target	Most Recent Data	Progress
Increase the proportion of high school students who graduate in four years	84.1% (2015-16)	90.7%	86.6% (2021-22)	Improving
Increase the proportion of high school graduates in college the October after graduating	69.1% (2018)	73.7%	62% (2022)	Getting worse
Increase the proportion of students with disabilities who are usually in regular education programs	63.5% (2017-18)	73.3%	66.9% (2022-23)	Improving
Increase the proportion of 4th-graders with reading skills at or above the proficient level	36.6% (2017)	41.5%	33.3% (2022)	Getting worse
Increase the proportion of 4th-graders with math skills at or above the proficient level	40.2% (2017)	43.1%	36.3% (2022)	Getting worse
Reduce the proportion of adolescents and young adults (16-24 years old) who aren't in school or working	11.5% (2017)	11.2%	10.9% (2022)	Target met or exceeded
Increase the proportion of children whose family read to them at least 4 days per week	58.3% (2016-17)	63.2%	55.1% (2020-21)	Getting worse

Education

Educational attainment is linked to income and employment, laying the building blocks for the next generation to have improved socioeconomic status and correlated positive health outcomes. Healthy People 2030 set a target goal for the percentage of students who graduate high school within four years at 90.7%. In New Jersey, 89% of people have a high school diploma or equivalent. In Hunterdon County, 94% of people have a high school diploma or equivalent and 89% in Warren County.

Of all the Warren Campus and Star Community Health survey respondents, 97.7% have a high school diploma or higher, 0.9% have less than a high school degree, and 1.4% have some high school education. Of those with a high school degree or higher, 20.3% have a high school diploma, 20.3% have some college, 19.7% have an associate's degree, 21.5% have a bachelor's degree, and 25.3% have a post college or graduate degree. CHNA survey respondents report higher educational attainment than the total population (see figure below for total population). It should be noted that people with higher levels of education are more likely to live healthier and longer lives than those with lower education levels. Healthy People 2030 states that children with less access to quality education are less likely to get safe, high-paying jobs and are more likely to develop health problems (e.g., heart disease, diabetes). This is a significant concern because it is crucial to identify and work with populations with lower access to education and healthcare to aid in healthy lifestyles and well-being.



The increasing cost of education has become a significant barrier to educational attainment, especially for vulnerable populations. Cost of education exacerbates educational and socioeconomic inequities. The National Center for Education Statistics reported that average tuition and fees in 2022–23 were $9,800 for public institutions, $18,200 for private for-profit institutions, and $40,700 for private nonprofit institutions.

School Climate and Safety

It is important for all children to feel safe at school in order to learn, socialize, and develop. Perceived lack of school safety and school violence has a negative impact on mental health outcomes and school performance. In order to gain insight into the population, the 2021 Youth Risk Behavior Surveillance System (YRBSS) was used for New Jersey High School data, and the Warren County Needs Assessment results (2023) and New Jersey Middle School Risk and Protective Factor Survey (2021) were used to inform trends in Warren County.

According to YRBSS, 26% of high school students in New Jersey reported using alcohol within the past 30 days of being surveyed and 17.3% report using marijuana in the past 30 days. In Warren County, 10.2% of middle school students reported lifetime use of alcohol and only 2.1% reported lifetime use of marijuana. Additionally, 3.7% of high school students smoke cigarettes and 36.3% have used e-cigarettes or vaped in their lifetime. In Warren County, only 0.7% of middle school students reported lifetime use of cigarettes compared to 4.6% that have vaped in their lifetime.

"Substance use is particularly affecting our youth. We need more prevention to stop use before it starts and get kids back on track."

According to the YRBSS, 12.2% of high school students in New Jersey rode with a driver who had been drinking alcohol, and 30.6% were texted or e-mailed while driving a car or other vehicle. Additionally, 11.1% of high school students missed school in the last 30 days because they felt unsafe at school or on their way to school, and 15.4% reported being electronically bullied.

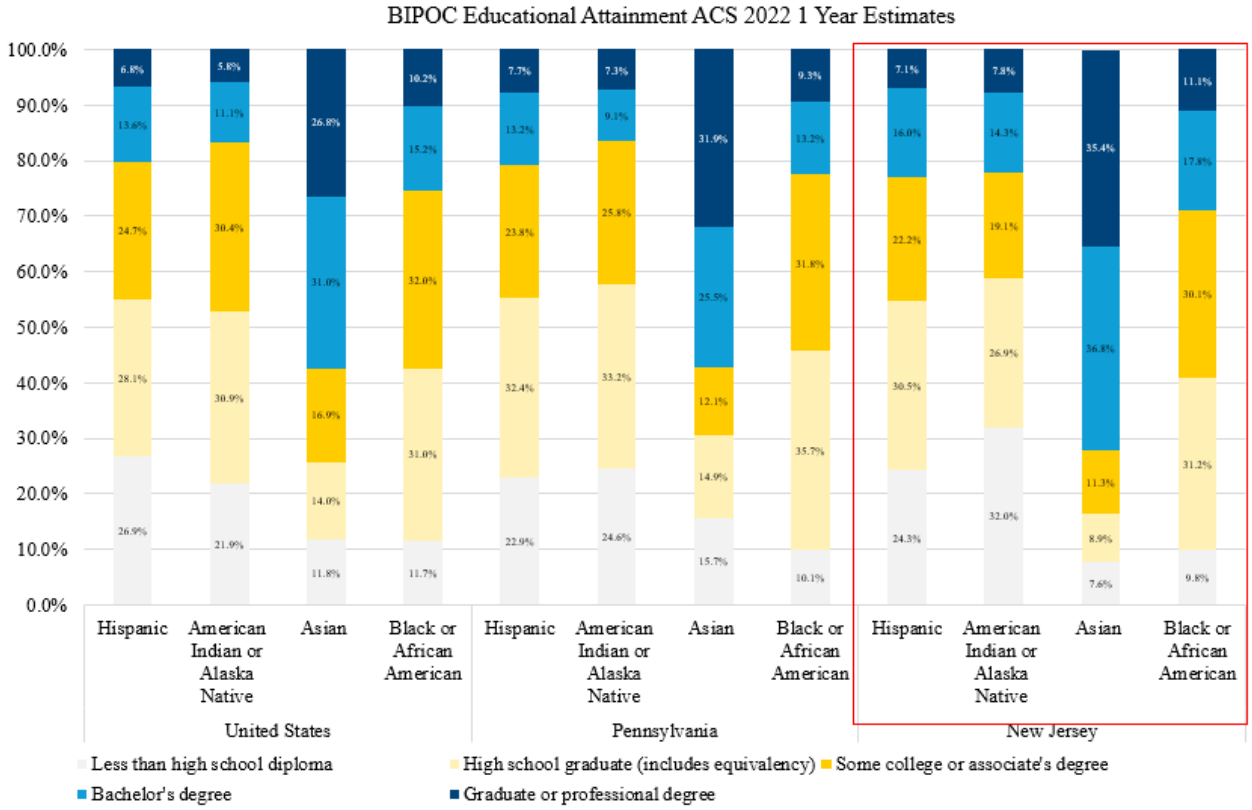
According to YRBSS, 41.5% of high school students felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the last 12 months. Additionally, 19.6% of high school students in New Jersey reported seriously considering suicide in the last 12 months, 13.1% made a plan to attempt suicide, and 9.5% attempted suicide. Current mental health issues are projected to be much higher, and the significant need for mental health providers and school support is critical as we address the mental health needs of youth in our service area.

"Many individuals in our community are struggling with substance use and mental health. This growing issue presents challenges to our police department and school system."

Many risk and protective factors come into play when understanding observed rates of drug use and mental health issues addressed in the CHNA. A risk factor is something that poses potential harm to a student's life and a protective factor is something that can help keep the student safe. The New Jersey Middle School Risk and Protective Factors Survey assessed risk and protective factors with different measures than the Pennsylvania Youth Survey (PAYS). In Warren County, the most common risk factors are low commitment to school (43%), low neighborhood attachment (36%), followed by laws and norms favorable to drug use (35%). The most common protective factors effect include school opportunities for prosocial involvement (71%), interaction with prosocial peers (61%), and school rewards for prosocial involvement (58%).

Vulnerable Populations

When looking at Black, Indigenous, and People of Color (BIPOC) communities, there are disparities in attaining higher education compared to White communities. According to the National Center for Education Statistics, Hispanic/Latino(a), Black, and American Indian/Alaska Native students have the lowest rates of undergraduate enrollment.



According to the US Census 2022 American Community Survey, 79.7% of those who identify as Hispanic/Latino(a) have less than a bachelor's degree, 83.2% of those who identify as American Indian or Alaska Native have less than a bachelor's degree, and 74.6% of those who identify as Black have less than a bachelor's degree. These rates are significantly higher when compared to their Asian (42.6%) and White (61%) counterparts.

Of the foreign-born population in the United States, 65.3% have less than a bachelor's degree according to US Census 2022 American Community Survey. In New Jersey, 58.8% of the foreign-born population have less than a bachelor's degree.

A 2021 report by the National Center of Education Statistics found the US average of 10.6% of public school students who were English language learners (ELL). New Jersey has a statewide average of 8.2% of public school students who are ELL. There was a higher percentage of English language learners for school districts in more urbanized areas (i.e., cities) and a lower percentage for less urban, rural areas. Spanish was the highest reported home language of ELL, representing the home language of 76.4% of all ELL and 8.4% of all public school students. The following eight languages were the highest reported home languages by school students (in order): Arabic, Chinese, Vietnamese, Portuguese, Russian, Haitian Creole, Hmong, and Urdu.

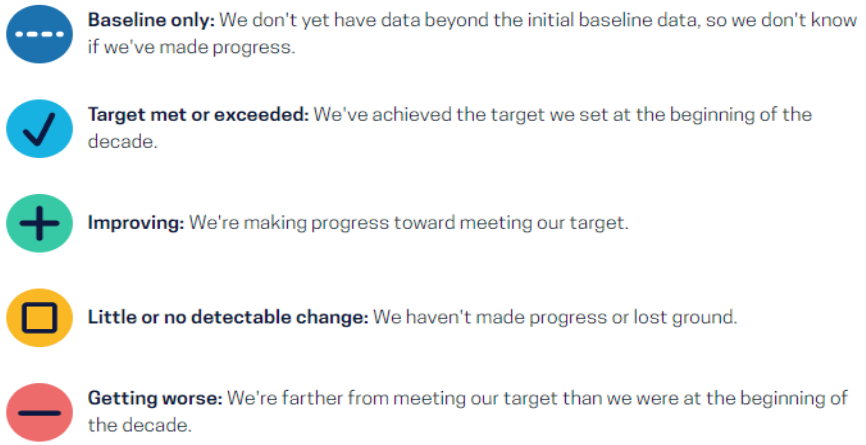
"We need more awareness of services and links to resources for English language learners."

Foreign-born Population 2022 ACS 1 Year Estimates		
Educational Attainment	United States	New Jersey
Less than high school diploma	24.9%	18.2%
High school graduate (includes equivalency)	22.1%	23.2%
Some college or associate's degree	18.3%	17.4%
Bachelor's degree	19.1%	22.9%
Graduate or professional degree	15.6%	18.4%

Economic Stability

Economic stability is a cornerstone of individual and community health, influencing access to care, education, housing, transportation, and more. Financial insecurity can lead to chronic stress, poor mental health, and limited access to healthcare, which can lead to negative health outcomes. Healthy People 2030 outlines objectives for economic stability related to these issues, including reducing poverty, increasing employment opportunities, reducing food insecurity, and improving access to affordable housing. These objectives are designed to address economic stability as a social determinant of health, recognizing that economic factors are intrinsically linked to health outcomes.

According to Healthy People 2030, the following objectives are related to economic stability and are measured at the national level. Most Healthy People 2030 objectives are core, or measurable, objectives that are related to targets outlined for the decade (2020-2030). Evidence-based interventions are supported through national, state, and local initiatives. Progress is measured using a variety of data sources (e.g., US Census, ACS estimates, state and county data) and is measured using the following indicators: Baseline only, target met or exceeded, improving, little or no detectable change, getting worse (see chart to the right). The objectives outlined have corresponding updates at the national level as of June 2024.



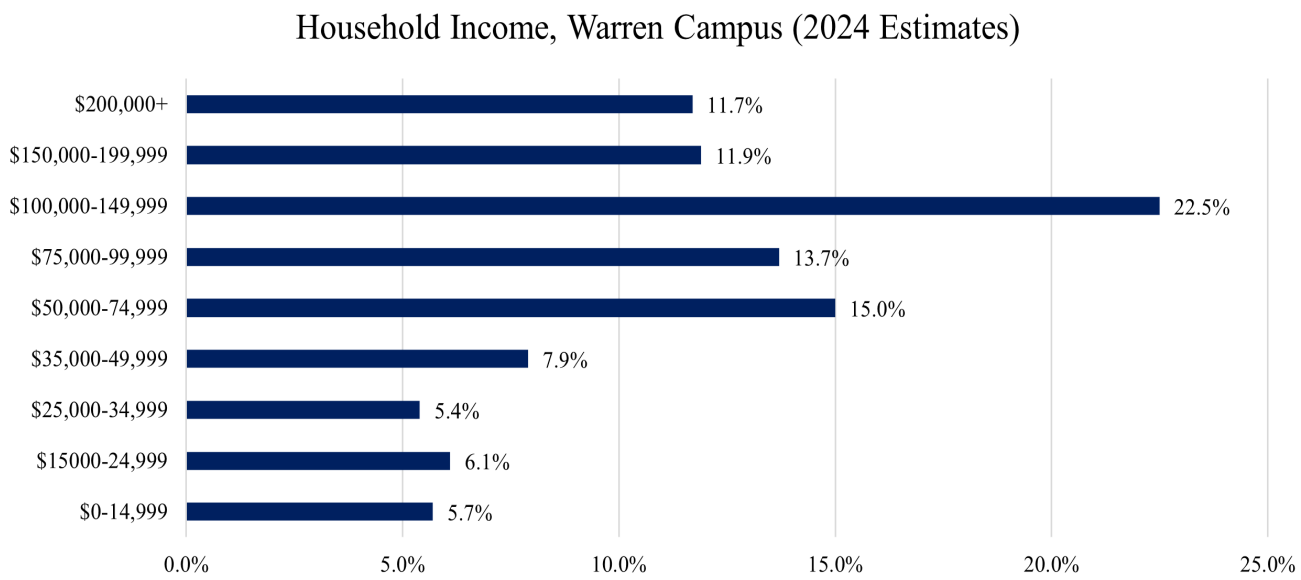
Healthy People 2030 Objectives for Economic Stability	Baseline	Target	Most Recent Data	Progress
Increase employment in working-age people (16 to 64 years old)	70.6% (2018)	75%	71.3% (2022)	Improving
Increase the proportion of children (17 years and younger) living with at least one parent who works full time	77.9% (2017)	85.1%	79.4% (2022)	Improving
Reduce the proportion of people living in poverty	11.8% (2018)	8.0%	11.5% (2022)	Little or no detectable change
Reduce the proportion of families that spend more than 30 percent of income on housing (i.e., cost-burdened)	34.6% (2017)	25.5%	35.0% (2021)	Little or no detectable change
Reduce household food insecurity and hunger	11.1% (2018)	6.0%	12.8% (2022)	Getting worse
Eliminate very low food security in children under 18 years	0.59% (2018)	0.0%	1.02% (2022)	Getting worse
Increase trips to work made by mass transit	5.0% (2017)	5.3%	5.0%	Little or no detectable change

Household Income and Poverty

Household income and poverty are interconnected, with significant implications for both individual and community wellbeing. Household income is defined as the total gross income of all members of a household, including wages, salaries, benefits, and any other earnings within a year. This can be income from employment, investments (e.g., rental properties, stocks, businesses), pensions, and government assistance programs. Household income is a key measure utilized for eligibility for social services, tax brackets, as well as understanding economic disparities within populations.

	2022 Estimates Number in Poverty	Percent in Poverty
United States	40,951,625	12.6
New Jersey	879,100	9.7
Hunterdon County	5,227	4.1
Warren County	7,628	7.0

The 2024 Federal Poverty Level (FPL) guideline is measured at $15,060 per year for one person and $31,200 for a family of four. If one person is 200% of the Federal Poverty Level, they make $30,120; if a family of four is 200% of the Federal Poverty Level, they make $62,400. In New Jersey, 9.7% of people live at or below the FPL compared to 12.6% nationwide. Hunterdon County has the least amount of people living at or below the FPL (4.1%). The ACS also reports that the median household income in Warren County is $81,307, which falls between the median household income in New Jersey ($82,545) and the United States ($62,843). The median household income in Hunterdon County is $133,534, above the median household income for New Jersey and the United States.



The majority of the respondents surveyed in the Warren Campus and Star Community Health service area have a household income of $60,000 and above (58.6%), 14.5% of respondents have a household income of less than $24,999, while 26.9% of respondents have a household income between $25,000 and $59,999. While we cannot determine how many people live below the FPL based on household size, these survey results do reveal that there are many people who could use support from food pantries, Federally Qualified Health Centers, government assistance, rent assistance, and more to supplement their income.

····· Vulnerable Populations ·····

Household income and poverty impacts vulnerable populations at higher rates than the general population. ESRI's income inequality P90-P10 ratio, which compares the income at the 90th percentile to the income at the 10th percentile, gives estimates (2024, 2029) of the income distribution within the Warren Campus and Star Community Health service area. A higher P90-P10 ratio indicates greater income inequality, while a lower rate indicates more income equality. It is estimated that in 2024, the P90-P10 ratio is 9.6, which is estimated to decrease to 8.2, indicating a trend toward more income equality within the SLUHN service area. Additionally, ESRI classifies households into tiers. The Middle Income Tier is defined as the middle 60% of earners, the top 20% of earners are defined as Upper Income Tier and the bottom 20% are defined as Low Income Tier. Households in the Low Income Tier are estimated at 16.0% in 2024, and projected to decrease to 12.9% in 2029. Households in the Middle Income Tier are projected to slightly decrease from 67.6% in 2024 to 67.4% in 2029. Households in the Upper Income Tier are projected to have the highest increase, from 16.3% in 2024 to 19.7% in 2029.

	2024		2029	
Income Inequality Measures	**Number**	**Percent**	**Number**	**Percent**
Household	65,420	100%	67,916	100%
<$15,000	3,751	5.7%	3,228	4.8%
$15,000-$24,999	3,972	6.1%	3,179	4.7%
$25,000-$34,999	3,549	5.4%	3,032	4.5%
$35,000-$49,999	5,169	7.9%	4,555	6.7%
$50,000-$74,999	9,806	15.0%	9,484	14.0%
$75,000-$99,999	8,963	13.7%	8,953	13.2%
$100,000-$149,999	14,740	22.5%	16,136	23.8%
$150,000-$199,999	7,784	11.9%	9,737	14.3%
$200,000+	7,686	11.7%	9,612	14.2%
Median Household Income	$91,573		$102,984	
Average Household Income	$116,361		$132,711	
Per Capita Income	$45,454		$52,898	
	2024		**2029**	
Households by Income	**Number**	**Percent**	**Number**	**Percent**
P90-P10 Ratio	9.6		8.2	
P90-P50 Ratio	2.3		2.1	
P50-P10 Ratio	4.3		4.0	
80-20 Share Ratio	9.5		9.7	
90-40 Share Ratio	2.4		2.5	
Households in Low Income Tier	10,499	16.0%	8,776	12.9%
Households in Middle Income	44,242	67.6%	45,791	67.4%
Households in Upper Income Tier	10,679	16.3%	13,349	19.7%

Source: ESRI 2024 Estimates, Warren Campus and Star Community Health Service Area

According to the 2022 Survey of Income and Program Participation (SIPP), there were 4.7 million older adults living in poverty in the United States in 2021. Overall, 8.3% of older adults struggle to make ends meet, and these rates are higher for adults 75 and older (42.0%) compared to adults 65-69 years old (33.8%) and 70-74 years old (24.2%). While the White population aged 65 and older is more likely to not live in poverty compared to living in poverty, Black, Asian, and Hispanic populations are more likely to live in poverty than to not live in poverty. Older adult females are also more likely to live in poverty while older adult males are less likely to live in poverty. Many older adults rely on fixed incomes from Social Security, pensions, or retirement savings, which may be insufficient due to rising healthcare costs, living expenses (e.g., rent, food), as well as possible long-term care needs (e.g., assisted living, home healthcare needs).

Children and adolescents living in poverty often lack access to essential resources including quality healthcare and education, safe and stable housing, and stable food supply which can lead to higher risk of chronic health conditions, malnutrition, and academic underachievement. Additionally, the stress of economic instability on children and adolescents can impact their mental health, resulting in increased rates of anxiety and depression. According to the 2022 New Jersey Department of Health Assessment Data, an estimated 13% of the population under age 18 is living below the poverty level.

	2022 Estimates	
	Percent of the Population in Poverty	Percent of Children in Poverty
United States	12.6	16.3
New Jersey	9.7	13
Hunterdon County	4.1	4.3
Warren County	7	9.6

Nationwide, children are more likely to live in poverty than the population as a whole, and this trend is seen in both Pennsylvania and New Jersey, as well as all of the counties in the SLUHN service area. Hunterdon County has 4.3% of children living in poverty, and Warren County has 9.6% of children living in poverty.

Employment

Stable and meaningful employment not only provides financial resources but also enhances mental and physical wellbeing by providing a sense of purpose, security, and social connection. People who work and have a livable wage are more likely to have positive health outcomes, but many people in the United States have trouble finding and keeping a job that provides them with a stable and secure income. Healthy People 2030 employment objectives include targeted efforts to promote economic stability by increasing employment rates in working-age people, especially those in marginalized and disadvantaged groups. Objectives include promoting job quality and providing safe and healthy working conditions. Quality jobs contribute to better physical and mental health by reducing work-related stress, preventing occupational injuries, and promoting social equity. Additionally, by addressing employment as a social determinant of health, other related issues (e.g., housing instability, food insecurity, lack of access to healthcare) can be mitigated through economic stability.

"As industry left and tax base began to shrink in our community, there was a reflexive move to consolidate positions and try to function more like smaller towns. There seemed to be a move to not fill positions as people left or retired. This didn't allow us to deal with many of the problems that began to set in as a result of industry leaving. We are fortunate that recently we have been able to regenerate some of our tax base through redevelopment and attracting more business to our downtown."

According to 2024 estimates, there are a total of 86,404 individuals that are employed in the Warren campus and Star Community Health service area. The healthcare sector accounts for the largest percentage of workers in the service area (14.6%), followed by manufacturing (13.5%) and retail trade (13.5%), which are all higher than the nationwide percentage distribution for those service areas.

When analyzed by civilian labor force profiles, white collar work is defined as employment that typically involves performing professional, managerial, or administrative tasks in an office setting. Blue collar work is defined as employment that typically involves manual labor or skilled trades, often performed in industrial, construction, or service environments. Service work is defined as providing assistance, support, or expertise to individuals or organizations rather than producing physical goods. Service work typically produces intangible benefits or outcomes through personal interaction, consultation, or specialized skills. Examples include healthcare roles (e.g., doctors, nurses), education (e.g., teachers), financial services (e.g., bankers) and other professional services (e.g., lawyers). In the Warren campus and Star Community Health service area, 62.5% of employed individuals are designated white collar, 21.1% blue collar, and 16.4% designated as service employed.

Workforce Distribution by Industry and Occupation, Warren Campus and Star Community Health Service Area (Esri Estimates, 2024)

Industry	Employed	Percent	US Percent
Total	86,404	100.0%	100.0%
Agriculture/Forestry/Fishing	444	0.5%	1.1%
Mining/Quarrying/Oil & Gas	38	0.0%	0.3%
Construction	4,830	5.6%	6.9%
Manufacturing	11,634	13.5%	10.0%
Wholesale Trade	2,077	2.4%	2.0%
Retail Trade	9,702	11.2%	10.5%
Transportation/Warehousing	4,641	5.4%	5.1%
Utilities	1,070	1.2%	0.9%
Information	1,772	2.1%	2.0%
Finance/Insurance	3,508	4.1%	4.8%
Real Estate/Rental/Leasing	1,230	1.4%	1.8%
Professional/Scientific/Tech	6,250	7.2%	8.3%
Management of Companies	72	0.1%	0.1%
Admin/Support/Waste Management	2,723	3.2%	4.3%
Educational Services	9,299	10.8%	9.1%
Health Care/Social Assistance	12,648	14.6%	14.1%
Arts/Entertainment/Recreation	1,782	2.1%	2.3%
Accommodation/Food Services	4,755	5.5%	6.8%
Other Services (Excluding Public)	4,136	4.8%	4.6%
Public Administration	3,793	4.4%	5.0%

Occupation	Employed	Percent	US Percent
Total	86,404	100.0%	100.0%
White Collar	53,963	62.5%	62.6%
Management	9,851	11.4%	12.1%
Business/Financial	5,482	6.3%	6.3%
Computer/Mathematical	3,638	4.2%	4.1%
Architecture/Engineering	2,592	3.0%	2.4%
Life/Physical/Social Sciences	1,220	1.4%	1.3%
Community/Social Service	1,296	1.5%	1.8%
Legal	594	0.7%	1.2%
Education/Training/Library	6,605	7.6%	6.2%
Arts/Design/Entertainment	1,544	1.8%	2.2%
Healthcare Practitioner	5,008	5.8%	6.4%
Sales and Sales Related	7,234	8.4%	8.5%
Office/Administrative Support	8,899	10.3%	10.1%
Blue Collar	18,235	21.1%	21.0%
Farming/Fishing/Forestry	176	0.2%	0.5%
Construction/Extraction	3,702	4.3%	4.9%
Installation/Maintenance/Repair	2,849	3.3%	2.9%
Production	4,524	5.2%	5.3%
Transportation/Material Moving	6,984	8.1%	7.5%
Services	14,206	16.4%	16.4%
Healthcare Support	3,004	3.5%	3.3%
Protective Service	2,099	2.4%	2.1%
Food Preparation/Serving	4,119	4.8%	5.3%
Building Maintenance	2,785	3.2%	3.2%
Personal Care/Service	2,199	2.5%	2.6%

····· Vulnerable Populations ·····

Employment is critical to access to care and services for the working population because health insurance for individuals 18-64 years old are most often not eligible for government healthcare programs (i.e., CHIP, Medicare). While Medicaid is available for individuals 18-64 years old if they qualify, the majority of the population living above the Medicaid threshold has their health insurance through their employer or through state Healthcare Marketplaces (i.e., out-of-pocket expense, self pay). The Medicaid income threshold for a single person in New Jersey (May, 2024) is $1,255 per month for Regular Medicaid/Aged Blind/Disabled individuals.

As of June 2024, the unemployment rate was 4.6% in New Jersey. In the Warren Campus and Star Community Health service area, the unemployment rate was 3.6%. Unemployment varies by age, race, and ethnicity. In the service area, the highest unemployment rate is in the 65+ population (9.1%) and the lowest unemployment rate is in the 25-54 year old population (2.4%). Black individuals 16 years and older have the highest unemployment rate by race (4.4%).

The Economic Dependency Ratio is a measure that compares the number of dependents in a population that are typically not in the labor force (e.g., children, older adults) to the number of working age who are economically productive. The higher the dependency ratio, the greater the burden on the working age population to support dependents. In the Warren Campus and Star Community Health service area, the Child Dependency Ratio is 31.8, meaning that for every 100 working age individuals, there are approximately 31.8 child dependents. The Senior Dependency Ratio is 31.7, meaning there are approximately 31.7 seniors (i.e., adults aged 65 and older) for every 100 working age individuals.

Labor Force by Age and Race, Warren Campus and Star Community Health Service Area

(Esri Estimates, 2024)

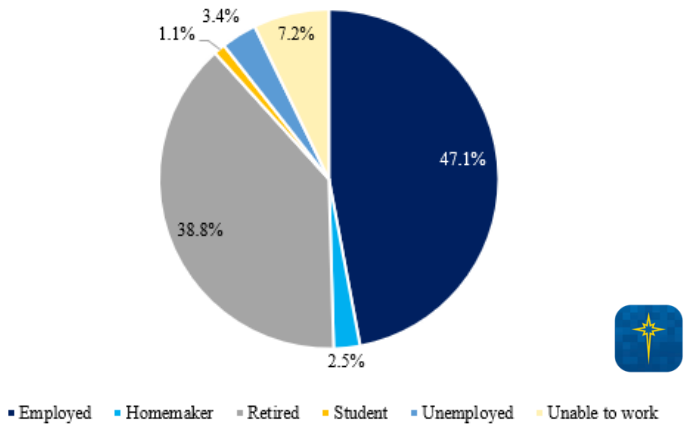
		2024 Labor Force			
Age Group	**Population**	**Employed**	**Unemployed**	**Unemployment Rate**	**Labor Force Participation Rate**
16+	140,404	86,404	3,256	3.6%	63.9%
16-24	20,741	11,766	655	5.3%	59.9%
25-54	61,129	50,679	1,223	2.4%	84.9%
55-64	24,126	17,063	689	3.9%	73.6%
65+	34,408	6,896	689	9.1%	22.0%
Male Age 16+	69,350	47,027	1,481	3.1%	69.9%
Female Age 16+	71,054	39,328	1,795	4.4%	57.9%
White Age 16+	103,383	61,499	2,283	3.6%	61.7%
Black Age 16+	12,632	8,765	405	4.4%	72.6%
American Indian Age 16+	445	287	6	2.0%	65.8%
Asian Age 16+	5,516	3,658	144	3.8%	68.9%
Pacific Islander Age 16+	60	40	0	0.0%	66.7%
Other Race Age 16+	7,561	5,084	143	2.7%	69.1%
Multiple Races Age 16+	10,807	7,052	268	3.7%	67.7%

Economic Dependency Ratio	
Total	93.3
Child (<16)	31.8
Working-Age (16-64)	29.8
Senior (65+)	31.7

Foreign-born populations in the United States often face unique challenges in the labor market, which can contribute to higher unemployment rates compared to native-born populations. Factors include language barriers, credentialing (e.g., work visas), and limited social networks. In 2023, the unemployment rate in the United States for foreign-born populations 16 years and older in the civilian labor force was 3.6%, which was also the unemployment rate for the total population. When broken down by age, younger foreign-born populations were more likely to be unemployed compared to older foreign-born populations. Race and ethnicity differences showed that Hispanic or Latino foreign-born populations had the highest unemployment rate (4.1%) and Asian foreign-born populations had the lowest unemployment rate (2.8%).

When asked about employment status, most respondents in the Warren Campus and Star Community Health service area indicated they are employed (47.1%) or retired (38.8%), followed by unable to work (7.2%), out of work/unemployed (3.4%), homemaker (2.5%) or student (1.1%).

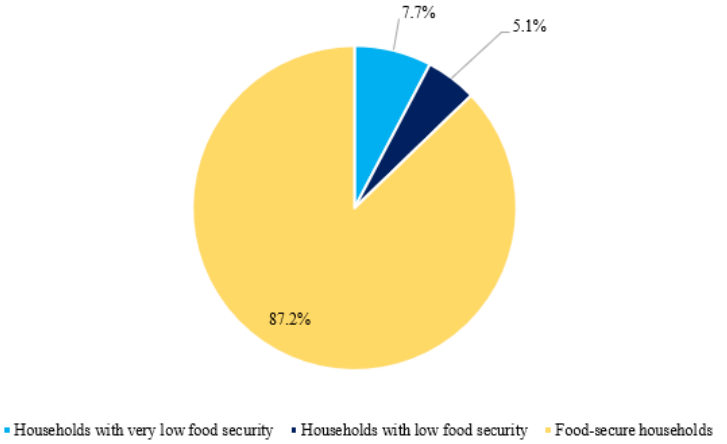
CHNA Survey Respondents by Employment Status, Warren Campus and Star Community Health Service Area



Food Security

Food insecurity, according to the United States Department of Agriculture (USDA), is the lack of consistent access to a variety of foods for a quality diet. A quality diet is one with access to foods that meet the individual's taste and nutritional needs. Very low food security (VLFS) is when normal eating patterns are disrupted and households lack money or other resources to obtain food. The USDA's annual report (2022) found that 12.8% of households nationwide are food insecure, 7.7% of which have low food security and 5.1% have VLFS. Among households with children, 17.3% are food insecure and 1.0% have VLFS. The USDA report stated that households with children facing VLFS had to skip meals or not eat for entire days due to a lack of money for food. In 2022, New Jersey had a food insecurity rate of 7.7% and VLFS rate of 3%.

U.S. Households by Food Security Status (2022)



Source: USDA

Government assistance programs aim to help reduce food insecurity through national programs. The Supplemental Nutrition Assistance Program (SNAP) provides food benefits to low-income families to supplement their food expenses. In the United States (Fiscal Year 2023), an average of 42.2 million people each month were supported with SNAP benefits. Approximately 67% of individuals that participate in SNAP are children (40%), older adults (18%), adults with a disability (9%), adults without disabilities and children in the household (20%), and adults without disabilities and no children in the household (13%). In Fiscal Year 2021, the average monthly SNAP benefit per household in New Jersey was $457.92.

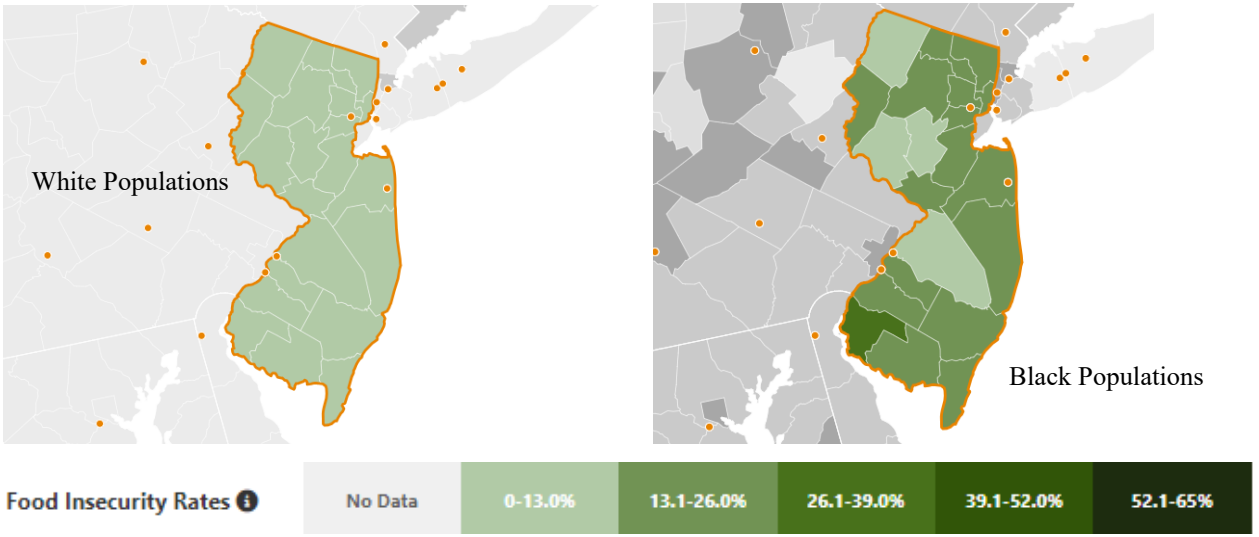
The National School Lunch Program (NSLP) was established in 1946 and is a federally assisted meal program that supports nutritious low-cost or free lunches to children each school day. To qualify for the NSLP, families must have an income at or below 130% of the poverty level. In Fiscal Year 2023, USDA's food and nutrition assistance programs totaled $166.4 billion. During the 2022-2023 school year, 36% of students in New Jersey were eligible for free or reduced lunch. In 2022-2023, 23% of students in Warren County and 9% in Hunterdon County qualified for free or reduced lunch.

Women, Infants and Children (WIC) is a federal program that supports the nutrition of low-income pregnant and postpartum women, infants, and children younger than 5 years who are at risk for poor nutrition. During Fiscal Year 2023, WIC served approximately 6.6 million qualified individuals each month, including an estimated 39% of all infants in the United States. Services include nutritious foods to supplement a healthy diet, education and information on healthy eating, including breastfeeding promotion and support, and referrals to healthcare and other social services. In New Jersey, 281,823 individuals qualified for WIC.

Vulnerable Populations

According to Feeding America, there are 994,800 people (10.4%) in New Jersey that are food insecure. Among the food insecure population, 49% are above the SNAP threshold, meaning they are ineligible for SNAP benefits. The ALICE population falls into this category, as they make too much to be eligible for services, but not enough to make ends meet. In New Jersey, almost one million individuals are food insecure (10.7%) and 55% of those individuals fall about the SNAP threshold. Children and adolescents are impacted by food insecurity at higher rates than any other demographic. Food insecurity for older adults is increasing as well, with 7.4% of the population in New Jersey aged 60 years and older being food insecure. Overall in New Jersey, 6.8% in Hunterdon County are food insecure and 9.7% in Warren County. It is also important to note that food insecurity affects vulnerable populations in significant ways. When looking at food insecurity by race and ethnicity, 16% of people that identify as Black in New Jersey are food insecure compared to 5.0% of White individuals. Of individuals in New Jersey that identify as Hispanic or Latino, 17.0% are food insecure.

Source: Feeding America



Research studies have found that stress from inconsistent access to food can play an active role in fat accumulation and chronic disease. In non-senior adults, food insecurity is associated with decreased nutrient intakes, increased rates of mental health problems, hypertension, and poor sleep outcomes. In children, food insecurity is associated with increased risks of asthma, lower nutrient intakes, cognitive problems, aggression, and anxiety. Food insecure children may also have higher risks of hospitalization, poor overall health, asthma, depression, and worsened oral health. Food deserts also play a role in food security and chronic disease. Typically, in food deserts, there is a large amount of fast food and corner stores with inexpensive, high calorie food that lacks nutritional value. Long term consumption of unhealthy food can increase likelihood of obesity, type 2 diabetes, heart disease, and other diet-related conditions.

Feeding America Food Insecurity Rates				
Geography	2022	2021	2020	2019
Warren County	9.7%	7.6%	8.9%	8.6%
Hunterdon County	6.8%	4.6%	5.5%	5.5%
New Jersey	10.7%	8.8%	7.4%	8.6%

Additionally, the percentage of SNAP benefits spent at local farmer's markets was extremely low. Increasing accessibility and educating communities about SNAP use at farmer's markets will help food insecure families to purchase healthy fruits and vegetables and to help support local farmers.

The County Health Rankings and Roadmap reports on each county's food environment index, which assess distance to a grocery store, the amount of healthy food options, and cost barriers to healthy food. The measure is ranked 0 to 10, with 10 as the best. New Jersey's overall food environment index is 9.0, while the Warren service area's is 8.5 and Hunterdon County is 9.6.

Cost-Burdened Households

According to the Department of Housing and Urban Development (HUD), a household is considered cost-burdened if 30% or more of their income goes toward their mortgage or rent. A household is severely cost-burdened if 50% or more of their income goes toward paying a mortgage or rent. Both cost-burdened and severely cost-burdened households face housing instability as well as significant financial strain, limiting their ability to afford other essentials such as food, healthcare, transportation, education, and other expenses. Vulnerable populations (e.g., children, older adults) who face housing instability and move frequently are more likely to face more severe impacts to their mental health, physical health, and overall wellbeing than the general population.

Healthy People 2030 recognizes housing instability as a social determinant of health, including negative impacts on physical and mental health. Healthy People 2030 objective to "reduce the proportion of families that spend more than 30% of income on housing" has a target of 25.5%. As of 2021, 35% of households nationwide were cost-burdened. There are a total of 69,423 housing units and 64,409 households in the Warren Campus and Star Community Health service area. Of those housing units, 67.1% are owner-occupied and 27.2% are renter-occupied, indicating a 5.8% vacancy rate, across the service area.

Of the owner-occupied housing units, 64.3% have a single mortgage, 6.4% have multiple mortgages, and 2.4% have a home equity loan without a mortgage. There are a total of 18,622 renter-occupied housing units in the Warren Campus and Star Community Health service area, with a median gross rent of $1,261. It is important to note that since the COVID-19 pandemic, housing costs have drastically increased across the nation, and as of 2024 the average rent for an one-bedroom apartment in the New Jersey was $1,654. The lack of affordable housing and low housing stock leads to increase rental and housing costs, which in turn increases the cost-burdened population.

Occupied Housing Units, Warren Campus and Star Community Health Service Area

(Esri Estimates, 2024)

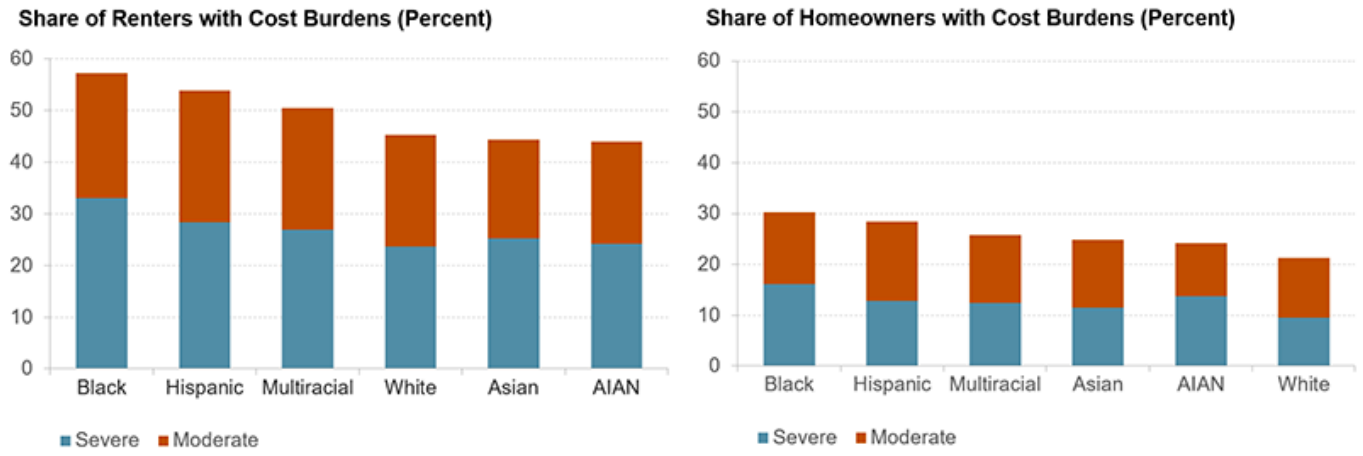
OCCUPIED HOUSING UNITS BY YEAR HOUSEHOLDER MOVED INTO UNIT			
Total	64,409	100.0%	470
Owner occupied			
Moved in 2021 or later	769	1.2%	137
Moved in 2018 to 2020	5,796	9.0%	282
Moved in 2010 to 2017	11,051	17.2%	286
Moved in 2000 to 2009	12,943	20.1%	284
Moved in 1990 to 1999	7,341	11.4%	240
Moved in 1989 or earlier	7,889	12.3%	215
Renter occupied			
Moved in 2021 or later	1,792	2.8%	188
Moved in 2018 to 2020	5,496	8.5%	235
Moved in 2010 to 2017	7,846	12.2%	248
Moved in 2000 to 2009	2,090	3.2%	245
Moved in 1990 to 1999	768	1.2%	133
Moved in 1989 or earlier	629	1.0%	195
Median Year Householder Moved Into Unit	2010		N/A

The Housing Affordability Index (HAI) measures whether a typical family earns enough income to qualify for a mortgage loan on a median-priced home. The baseline index score of 100 means that a family within the median income has exactly enough income to qualify for a mortgage on a median priced home, assuming a standard mortgage and typical interest rates. An index score above 100 indicates greater affordability, meaning that a typical family earns more that what would be necessary to purchase a median-priced home, and a score of less than 100 indicates that a typical family does not earn enough to afford a median-priced home. In the Warren Campus and Star Community Health service area, the HAI is 91, indicating that a typical family has 91% of the income needed to qualify for a mortgage on a median-priced home.

Economic stability and livable wages are intrinsically connected to housing instability and cost-burdened households. The National Low Income Housing Coalition (NLIHC) released a report on Fiscal Year 2024's housing costs and wage. Out of all states, New Jersey ranks 7th of states with the highest housing wages. In Warren County (NJ), the fair market rent for a two-bedroom apartment is $1,540, meaning the household would need to earn $38.08 per hour or $61,600 annually to afford the apartment and not be cost-burdened. An individual making minimum wage in Warren County would have to work 78 hours per week in order to afford rent. In Hunterdon County (NJ), the fair market rent for a two-bedroom apartment is $2,276, meaning the household would need to earn $43.8 per hour or $91,040 annually to afford the apartment and not be cost-burdened. An individual making minimum wage in Hunterdon County would have to work 116 hours per week in order to afford rent. With 36% of people in New Jersey renting, paying employees livable wages and providing a market of affordable housing must be addressed.

····· Vulnerable Populations ·····

According to the Joint Center for Housing Studies at Harvard University, 42 million households were cost burdened in 2022, an increase of 1.5 million households from 2021 and 4.9 million since 2019, with almost 80% of the increase since 2019 comprised of renters that were severely cost-burdened. Black and Hispanic populations are almost twice as likely to be cost-burdened compared to White households, and more than half of Black and Hispanic renters cost-burdened.



Cost-burdened housing is a large problem in the St. Luke's service area as wages and housing costs are not always aligned. This can be true for older adults with fixed incomes and retirement or pensions that no longer cover increasing rent and/or cost of living expenses (e.g., food, healthcare). According to America's Health Rankings 2024 Senior Report, of households with at least one person aged 65 years and older, 40.2% in New Jersey are cost-burdened, compared to 33.1% nationwide. Children and young adults aged 25 years and younger are the most likely to live in a cost-burdened household (50%). These rates remained relatively steady prior to the COVID-19 pandemic, but recent data and projections show drastic increases in cost-burdened households across the nation and within the service area.

Asset Limited, Income Constrained, Employed (ALICE) are individuals and households that earn above the Federal Poverty Level, but less than the basic cost of living. ALICE households do not qualify for federal assistance and they often struggle to afford basic necessities such as healthcare, housing, food, childcare, and transportation. The ALICE Household Survival Budget represents the minimum income necessary for a household to afford the basic necessities without any extras or savings. The budget includes essential costs such as housing, childcare, food, transportation, healthcare, and technology (e.g., cellular phone). In 2022, a single adult would need to spend no more than $982 per month on rent or a mortgage in New Jersey. According to the National Low Income Housing Coalition Report, the fair market rent (FMR) for a New Jersey two-bedroom apartment in 2023 was $1,742. In 2024, the FMR is $1,980, a 13.6% increase. The FMR in New Jersey for a one-bedroom apartment in 2023 was $1,448. In 2024, the FMR is $1,654, a 14.2% increase. With a lack of affordable housing, more households will become cost-burdened and face economic and housing instability. The budget for One Adult, One Child includes cost for one adult and a school-age child, The budget for One Adult, One in Child Care includes costs for an adult and a preschool-age child. The budget for Two Adults, Two in Child Care includes costs for two adults, one infant, and a preschool-age child. "Hourly Wage" shows the full-time wage needed to support each budget.

ALICE Household Survival Budget, New Jersey (2022)

Monthly Costs and Credits	Single Adult	One Adult, One Child	One Adult, One Child in Child Care	Two Adults	Two Adults, Two Children	Two Adults, Two Children in Child Care	Single Adult 65+ years old	Two Adults 65+ years old
Housing (Rent)	$982	$1,059	$1,059	$1,059	$1,314	$1,314	$982	$1,059
Housing (Utilities)	$163	$258	$258	$258	$310	$310	$163	$258
Child Care	$0	$338	$338	$0	$676	$1,827	$0	$0
Food	$532	$903	$810	$976	$1,642	$1,450	$491	$901
Transportation	$327	$464	$409	$530	$893	$784	$287	$451
Health Care	$183	$402	$402	$402	$686	$686	$598	$1,196
Technology	$86	$86	$86	$116	$116	$116	$86	$116
Miscellaneous	$227	$351	$393	$334	$564	$649	$261	$398
Tax Payments	$387	$805	$924	$500	$1,056	$1,283	$467	$845
Tax Credits	$0	($227)	($227)	$0	($452)	($453)	$0	$0
Monthly Total	$2,887	$4,439	$5,015	$4,175	$6,805	$7,966	$3,335	$5,224
ANNUAL TOTAL	$34,644	$53,268	$60,180	$50,100	$81,660	$95,592	$40,020	$62,688
Hourly Wage	$17.32	$26.63	$30.09	$25.05	$40.83	$47.80	$20.01	$31.34

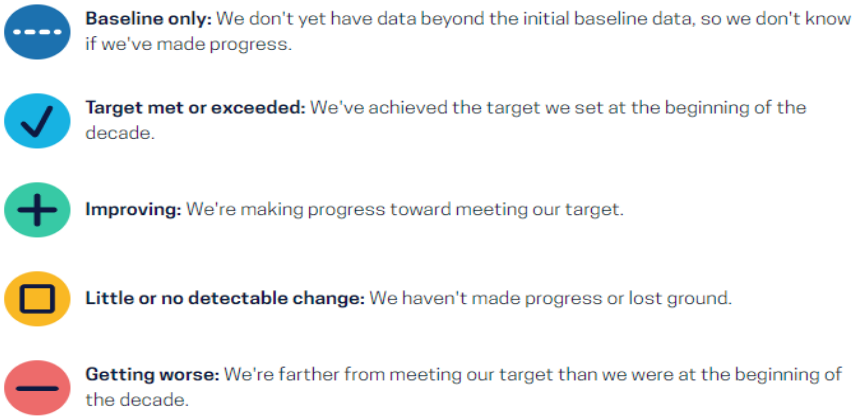
Source: 2009-2024 United Way of Northern New Jersey

"We have a lack of affordable and safe housing creating an issue for a population primarily dependent on rental housing. Additionally, a lot of that housing is quite old. Some of it could be considered substandard in many ways. Health issues could come from mold, lead, industrial sites, and pollution."

Health Care Access and Quality

Health care access and quality is a key pillar to maintaining and improving individual and community health. Accessible and equitable healthcare ensures populations receive consistent and appropriate medical care leading to early detection and management of health conditions. Healthy People 2030 outlines objectives for education access and quality related to these issues, including high quality healthcare services, preventative health measures and cost of healthcare. These objectives are designed to address health care access and quality as a social determinant of health, recognizing the economic factors are intrinsically linked to health outcomes.

According to Healthy People 2030, the following objectives are related to health care access and quality and are measured at the national level. Most Healthy People 2030 objectives are core, or measurable, objectives that are related to targets outlined for the decade (2020-2030). Evidence-based interventions are supported through national, state, and local initiatives. Progress is measured using a variety of data sources (e.g., US Census, ACS estimates, state and county data) and is measured using the following indicators: Baseline only, target met or exceeded, improving, little or no detectable change, getting worse (see chart to the right). The objectives outlined have corresponding updates at the national level as of June 2024.

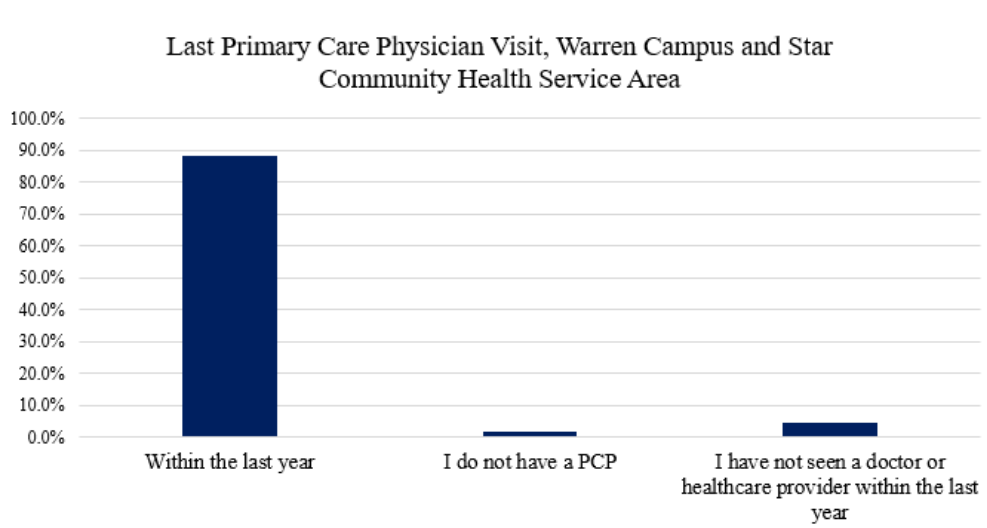


Healthy People 2030 Objectives for Healthcare Access and Quality	Baseline	Target	Most Recent Data	Progress
Increase the proportion of adolescents who had a preventative health care visit in the past year (12-17 years old)	78.7% (2016-17)	82.6%	69.6% (2020-21)	Getting worse
Increase the proportion of adults who get screened for colorectal cancer (aged 45-74 years old)	58.7% (2021)	68.3%	—	Baseline only
Increase the proportion of people with a substance use disorder who got treatment in the past year	11.1% (2018)	14.0%	12.2% (2019)	Little or no detectable change
Increase the use of the oral health care system	43.3% (2016)	45.0%	46.2% (2018)	Target met or exceeded
Reduce the proportion of people who can't get medical care when they need it	8.5% (2019)	5.9%	7.0% (2021)	Improving
Increase the proportion of people with health insurance	88.0% (2019)	92.4%	89.8% (2022)	Improving
Increase the proportion of females who get screened for breast cancer (50-74 years old)	76.2% (2019)	80.3%	75.6% (2021)	Little or no detectable change

Access to Care

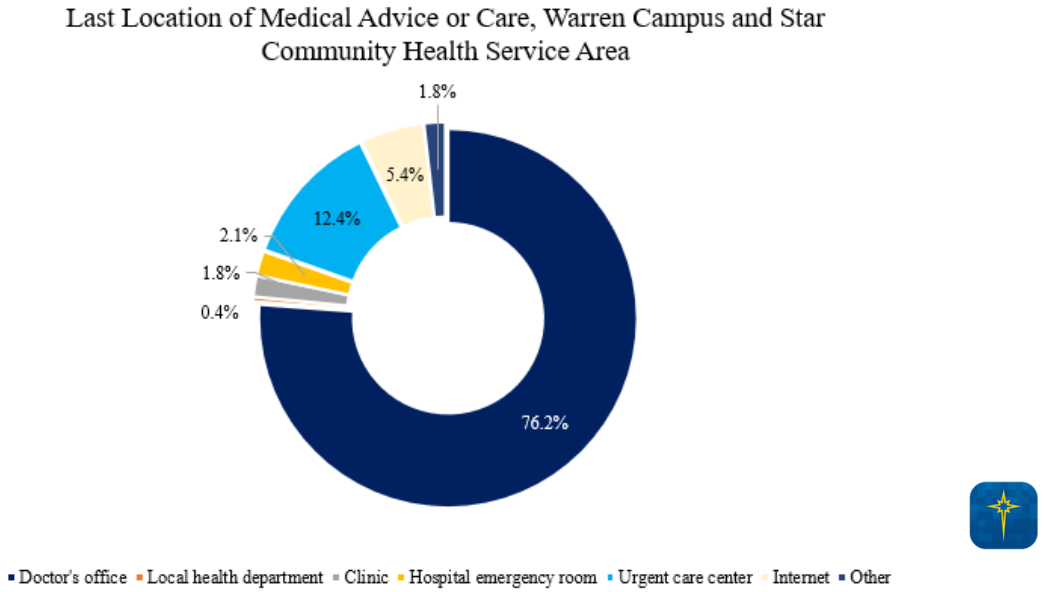
Primary Care Providers (PCPs)

Primary care providers (PCPs) are gatekeepers to the healthcare system. Often, they are a patient's first point of contact and referral to further care by specialists. The top performers in the United States (90th percentile) have a primary care indicator of 1,030:1, which denotes the ratio of individuals to PCPs. New Jersey has an overall primary care indicator of 1,280:1. This also varies dependent on location with a 1,850:1 ratio in Warren County and 910:1 ratio in Hunterdon County. To assess the frequency of visits, the CHNA survey asked respondents when they last visited their PCP. The majority of respondents (88.3%) visited their PCP within the last year in the Warren Campus and Star Community Health Service area, while 1.5% had not seen a healthcare provider in the last year and 4.3% responded that they did not have a PCP. It is also important to look at an individual's last visit to a PCP by their type of insurance. Lack of insurance or high copays may hinder individuals from seeking medical attention, which could result in worsened health conditions.



As seen in the CHNA survey results, lack of insurance did negatively impact the frequency of doctor's visits. Of respondents who do not have insurance coverage, less than half (42.8%) have seen a PCP within the past year and 48.2% do not have a PCP. This finding reinforces the need for doctors who accept a variety of insurance types and the importance of Federally Qualified Health Centers and Federally Qualified Health Center Look-Alikes (i.e., Star Community Health) that offer services on a sliding fee scale, making healthcare more affordable to patients in need.

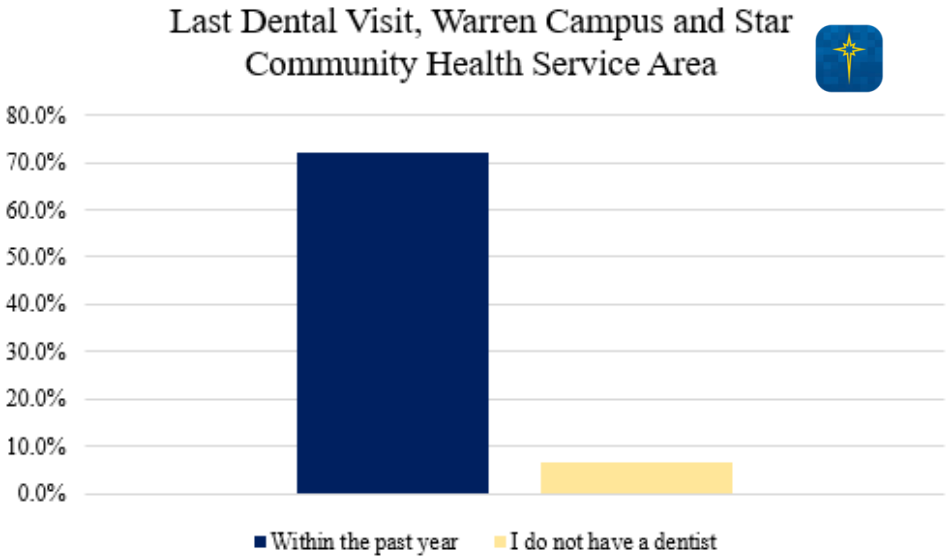
Finally, the CHNA survey asked respondents where they go most often when they are sick or in need of medical advice to get and understanding of their use of service providers. The majority of respondents go to a doctor's office (76.2%), followed by an urgent care center (12.4%), using the Internet (5.4%), and hospital emergency room (2.1%). While a majority of respondents use a doctor's office, bringing in more PCPs from diverse backgrounds and that accept many types of insurances will allow more individuals to seek care at a doctor's office rather than on the Internet.



Dentists

The Mayo Clinic refers to dental health as "a window to your overall health." Oral pain can be debilitating, and oral health can affect one's overall daily life, impacting their ability to go to work or school. Poor oral health can also lead to a host of other issues in the body, causing respiratory, digestive, and cardiovascular diseases. Top performing states in the country have an overall dental health indicator of 1,180:1, which denotes the ratio of individuals in the population to dentists. New Jersey has an overall ratio of 1,160:1 with Warren County at 1,400:1 and Hunterdon County at 1,190:1. In comparison, Pennsylvania has fewer overall dentists at a ratio of 1,400:1 and much more variation in accessibility, ranging from 2,700:1 to 930:1 in SLUHN service area counties.

In the Warren Campus and Star Community Health service area, 72.2% of respondents visited a dentist within the past year and 6.6% do not have a dentist. Additionally, 62.4% of respondents use private insurance for dental care, followed by no insurance (22.4%), Medicaid (4.9%), and Veterans Health Administration (VHA) (0.2%).



Mental Health Providers

Mental health has also been identified as a significant priority for the communities in the SLUHN service area. Additionally, the COVID-19 pandemic has greatly impacted access to mental healthcare. Access to mental health providers who take various insurance types and have availability are needed in our service areas. The ratio of population to mental health providers for the top performers in the United States is 270:1 while New Jersey has a ratio of 340:1. Warren County has a ratio of 390:1 and Hunterdon County has a ratio of 350:1.

Of the CHNA respondents in the Warren Campus and Star Community Health service area, 15.3% reported having been diagnosed with a mental health concern in the past five years and 16.7% responded that they had seen a mental health provider in the last year. More information on mental health can be found in the Health Behaviors section of this document.

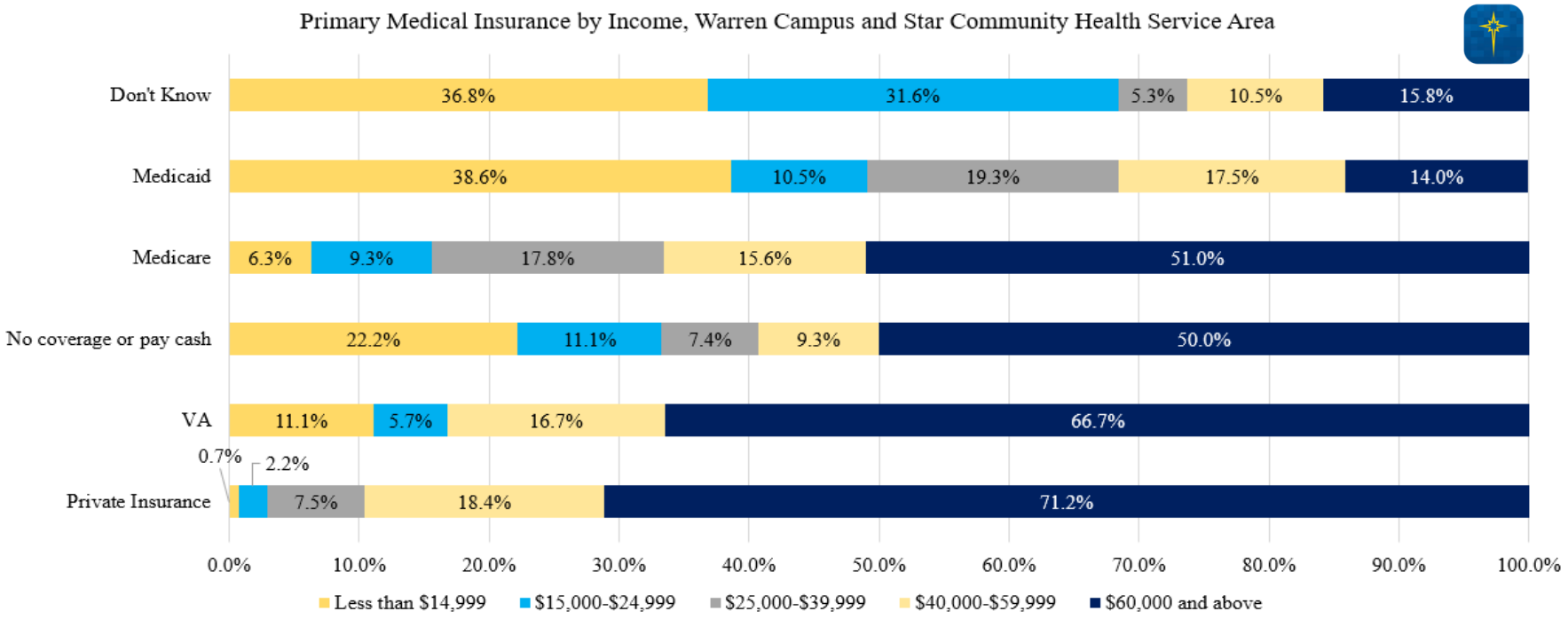
"The waitlist for mental health services is too long. A lack of staffing leads to these extremely long waitlists."

Health Insurance

Uninsured rates represent a major barrier in access to care. Often, uninsured patients do not receive preventative care and screenings and get very ill before seeking care, leading to higher medical costs. An issue that is prevalent in many areas is the lack of provider ability to take a range of insurances. Federally Qualified Health Centers (FQHC) and Federally Qualified Health Center– Look Alikes are a crucial step in treating people without insurance and insurance that has minimal coverage. The Health Resources and Services Administration (HRSA) defines a community-based health care provider as one who offers primary care services to underserved areas. FQHCs must provide services on a sliding fee scale based on the patient's ability to pay. While FQHCs are crucial to addressing health needs, knowledge that FQHCs exist and take all or no insurance needs improvement. Community Health Workers (CHW) are the next step in bridging the health care gap. CHWs are defined as "a frontline public health worker who is a trusted member and/or has an close understanding of the community served." The CHW is the liaison between health and social services and the community. They serve an important role in improving quality of services with cultural competency, increasing health knowledge in the community, and by providing advocacy. CHWs help inform people of the services available, regardless of insurance type or being uninsured, helping to increase access. They serve an important role in improving quality of services with cultural competency, increasing health knowledge in the community, and by providing advocacy for universal quality care.

Uninsured rates in Warren County stand at 7% overall. In the Warren and Star Community Health service area, only 0.2% of the 65 and older population are uninsured, 3.6% of ages 18 to 64 are uninsured, and 0.4% of children under 18 years old are uninsured. According to CHNA survey results, 7.5% of all service area respondents either have no coverage and pay cash or do not know if they have insurance. Please see the Vulnerable Populations section at the beginning of this document and the subsections throughout that explore health insurance related to other social determinants of health (SDOH).

Of the survey respondents in the Warren Campus and Star Community Health service area, those with a household income of less than $14,999 comprise the largest percent of the respondent population that use Medicaid (38.6%) or didn't know their primary insurance (36.8%). Conversely, those whose household income is $60,000 and above comprised the largest percentage of the population that use private insurance (71.2%), Veterans Administration (66.7%), and Medicare (51.0%). While respondents with a household income of $60,000 and above comprised the largest percent of the population that responded that they pay cash, the number of respondents was small and may not reflect the no coverage/pay cash population in the Warren Campus and Star Community Health Service area and is not consistent with the larger Network outcomes, which shows that 55.6% of the survey respondents across the Network that have no coverage or pay cash have an income less than $40,000. These findings reinforce the need for FQHCs in St. Luke's service areas along with doctors who accept Medicaid and uninsured patients.

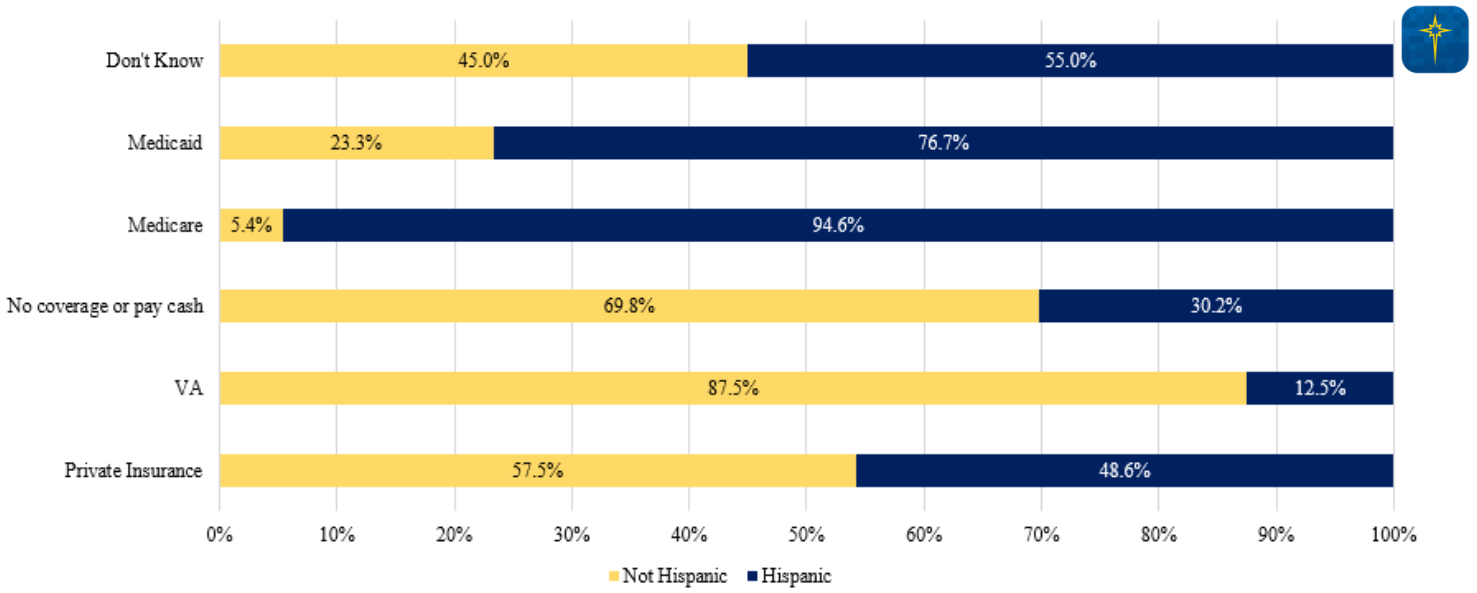


Vulnerable Populations

Access to primary care providers is pivotal for vulnerable populations. Due to the impact social determinants of health (SDOH) have on healthcare, vulnerable populations often experience greater health disparities and higher healthcare costs. The Centers for Disease Control (2021) found that mistrust of the health care system emerged as a primary barrier for BIPOC community members for seeking care in healthcare systems. Of the survey respondents in the Warren campus and Star Community Health service area who do not have a PCP, 7.1% were Black, 1.3% were American Indian or Alaskan Native, 1.9% were Asian, 0.2% Middle Eastern or North African, 0.7% Native Hawaiian or Pacific Islander, and 5.5% identified as another race.

When looking at insurance coverage by ethnicity, 9.5% of Hispanic CHNA survey respondents reported not having a PCP. Hispanic populations were more likely to have Medicaid (76.7%) coverage than Non-Hispanic populations (23.3%). Hispanic respondents are also more likely to have Medicare (94.6%), which could be explained by the age of Hispanic survey respondents in the service area, which was a mean age of 59.8 years old.

Insurance Coverage by Ethnicity, Warren Campus and Star Community Health Service Area



Financial instability also contributes as a barrier to receiving healthcare. United for ALICE found that ALICE and poverty-level families have more difficulty maintaining health behaviors and preventing illness. When basic needs for health insurance coverage and quality preventative care are not met, recovering from illness or medical emergencies are more challenging. According to 2022 The Federal Reserve Board's Survey of Household Economics and Decision making, 14% of respondents below the ALICE threshold in New Jersey faced an unexpected major medical expense that they had to pay for out of pocket because it was not completely paid for by insurance. The Updated New Jersey 2024 ALICE report emphasized how medical debt generally reflects poorer health outcomes and lower rates of health coverage. Medical debt creates a cycle of financial hardship as lower rates of health care coverage can lead to lower credit scores and additional financial hardships. Of all the survey respondents in the Warren Campus and Star Community Health service area who do not have a PCP, 18.6% had a household income of less than $15,000.

Language is also a barrier for healthcare access and quality. According to the 2022 ACS estimates, Hispanic individuals make up 19% of the total U.S. population. Of the Hispanic population in the US, nearly 70% speak Spanish at home. Additionally, 16.8% of Hispanic individuals in the United States have no insurance. Few Spanish-speaking physicians adds to existing language barriers. Only 6% of physicians identify as Hispanic and 2% of non-Hispanic physicians are Spanish-speaking. Patients facing a language barrier are more likely to experience miscommunication and less likely to follow post-appointment instructions or attend follow up appointments.

The United States Department of Health and Human Services reported on how social determinants of health affect older adults. As the population ages, health care needs can change and become more complex. According to The Administration for Community Living, risk for chronic health conditions like dementias, heart disease, type 2 diabetes, and arthritis increases with age. Most older adults have at least one chronic condition, and many have two or more. These conditions can require special care. Although older adults may have more medical needs, many older adults face barriers to getting the care. As an example, older adults living in rural areas will have to travel longer distances to see providers, including specialists. This presents an obstacle if they do not have a means of transportation. The transition from employer-sponsored health insurance plans to Medicare can complicate coverage, potentially requiring a switch in providers. In 2020, adults age 65 years and older spent an average of nearly $7,000 in out-of-pocket medical costs.

Children and adolescents also face barriers to healthcare. The shortage of pediatric physicians and subspeciality physicians creates a challenge to accessing essential healthcare services. The American Academy of Pediatrics found that there has been an increase in the number of pediatric positions offered in the National Resident Matching Program; however, the last four years have seen a significant increase in the number of unfilled pediatric positions. Children with special health care needs require trained doctors. Even with this need, pediatric subspecialities struggle to fill their positions. In New Jersey, 17% of children have special health care needs, including conditions such as cancer, down syndrome, asthma, and depression. Subspeciality shortages mean longer travel distances for families to get care, weeks or months of waiting times to meet with a subspecialist, and going without care or getting care from providers with less specific training.

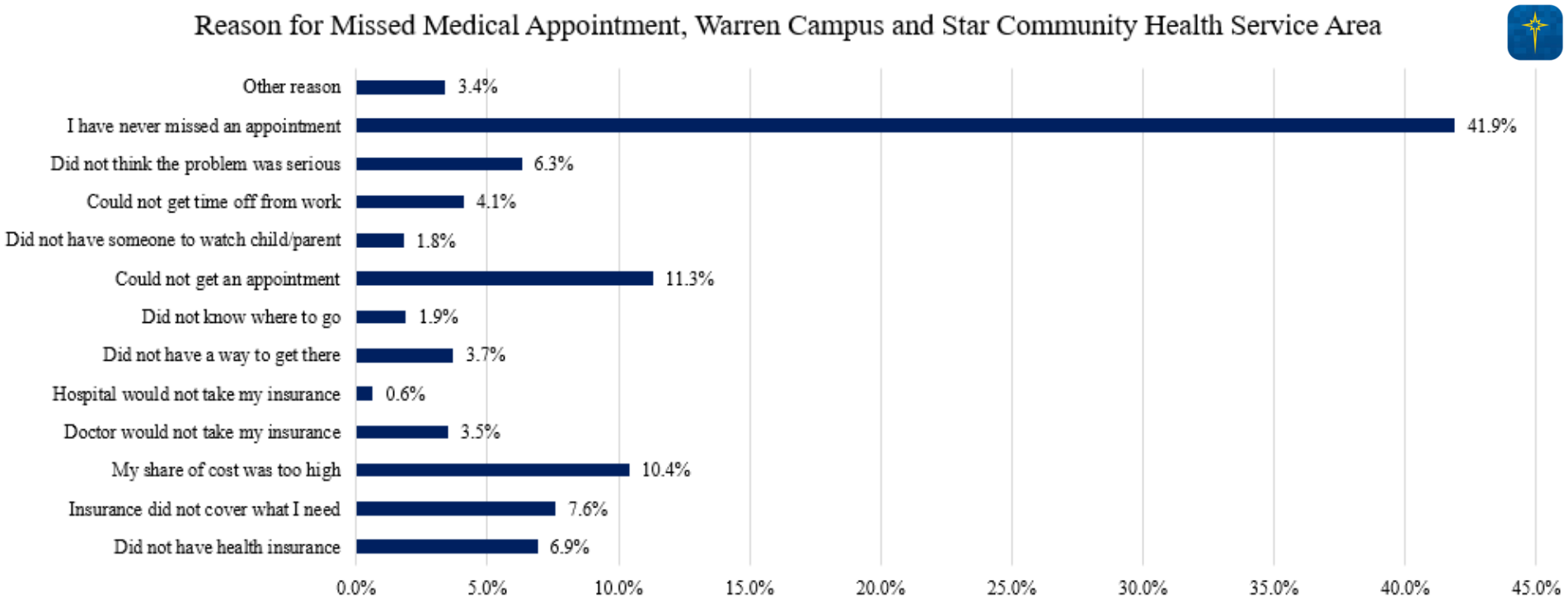
Health insurance plays a role in whether and when people get medical care and where they receive their medical care. Individuals without insurance have less access to care compared to those who are insured. Due to their lack of insurance, uninsured groups are more likely to delay or forgo treatment due to cost concerns. This creates a barrier in receiving preventative care or service for serious health conditions and chronic diseases. The cost of healthcare is increasing so when uninsured individuals seek medical care, they can encounter unaffordable medical bills. The Centers for Medicare and Medicaid Services found that nearly one in five Americans has medical debt. Out-of-pocket spending for health care has doubled in the past 20 years, from $193.5 billion in 2000 to $388.6 billion in 2020. These rising health care costs disproportionately affect vulnerable populations with less resources as mentioned previously. Of the survey respondents in the Warren Campus and Star Community Health service area, 6.9% reported that they missed a doctor's appointment because they did not have health insurance, 10.4% reported that the cost (deductible/co-pay) was too high, and 4.1% reported that the doctor/hospital did not take their insurance.

"We need more access to specialty care in the county. There is a lack of medical specialists in the area that are affordable. Many specialists in our community do not have anyone that speaks Spanish. That is a major language and contributes as a barrier to care. Another significant barrier to care is lack of health insurance."

Hospital Data

St. Luke's is one of two major health networks in the Lehigh Valley with a variety of health services ranging from behavioral health to cardiology to gastroenterology and more. St. Luke's addresses the inequities in our service area through partnerships with nonprofits, schools, and businesses. Through these partnerships we implement enhanced care, health initiatives, support, and outreach for health education, healthy lifestyles, and preventative care.

When asked to indicate reasons for any recently missed medical appointments, the top three reasons reported in the Warren Campus and Star Community Health service area were that they could not get an appointment (11.3%), their share of cost was too high (10.4%), and insurance did not cover what they need (7.6%). These findings further reinforce the need for more comprehensive health insurance and facilities that offer assistance or sliding scales to lessen the financial burden of taking care of one's health. In order to better support our service area population, St. Luke's provides charity care to help alleviate some of the financial burden. In FY23, St. Luke's reported $408 million of IRS defined community benefit spending, approximately 16% of the Network's operating expenditures.



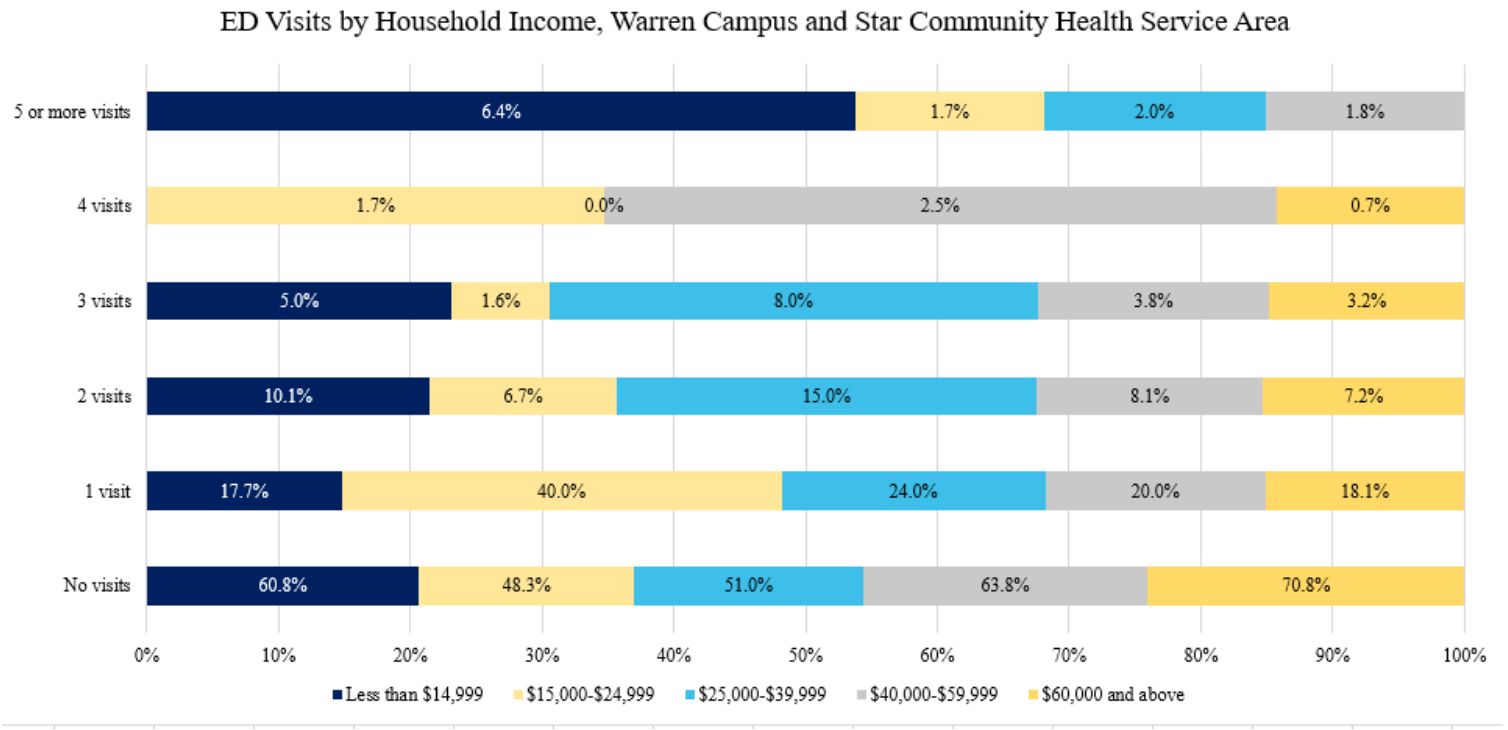
Top Reasons for Hospitalizations

Hospital data helps us to better understand the major health issues in our community. This allows us, from both a treatment and prevention perspective, to focus efforts on priority areas most affecting the health of our patient population. The top 10 reasons for hospitalization at St. Luke's Warren Campus and Star Community Health are listed below. Sepsis is the most common diagnosis during an inpatient admission, accounting for 12.7% of Warren Campus and Star Community Health total inpatient encounters.

FY23 Network Top 10 Inpatient Principal Diagnoses			
Ranking	**Principal Diagnosis**	**Inpatient Admissions**	**% of Network Total Inpatient Admissions (n=4,308)**
1	Sepsis, unspecified organism	549	12.70%
2	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	188	4.40%
3	Acute kidney failure, unspecified	105	2.40%
4	Hypertensive heart disease with heart failure	90	2.10%
5	Emergency use of U07.1 | COVID-19	88	2.00%
6	Morbid (severe) obesity due to excess calories	85	2.00%
7	Urinary tract infection, site not specified	79	1.80%
8	Other specified sepsis	78	1.80%
9	Acute and chronic respiratory failure with hypoxia	75	1.70%
10	Chronic obstructive pulmonary disease with (acute) exacerbation	59	1.40%
Total	**Total**	**1,396**	**32.40%**

Emergency Department Encounters

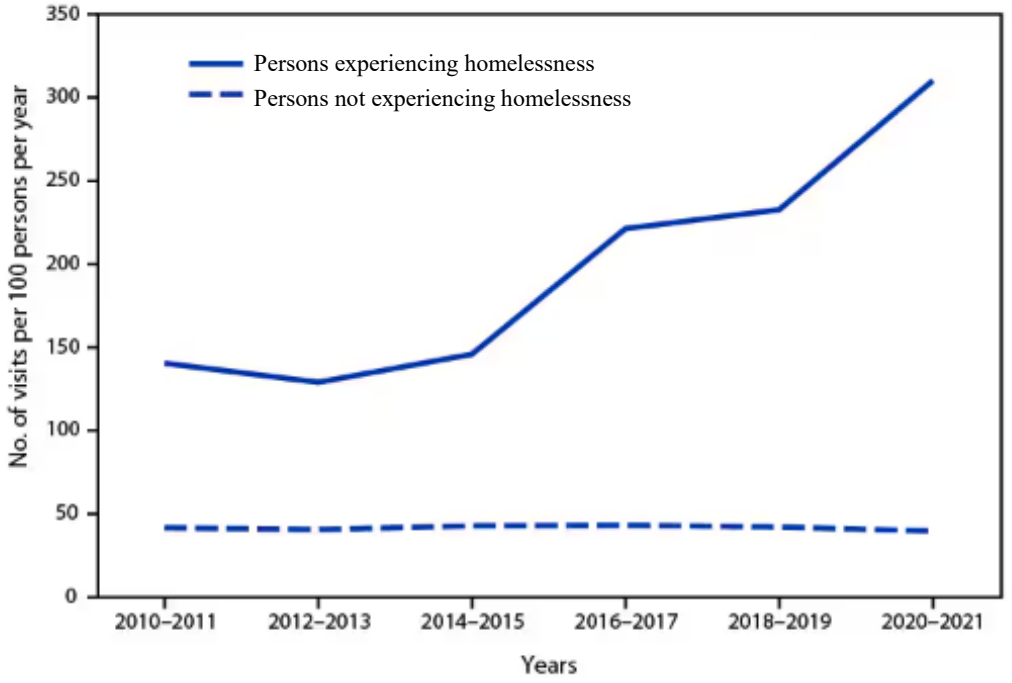
In Fiscal Year 2024, the most common type of insurance for Emergency Department (ED) encounters at the Warren Campus was Managed Medicaid, followed by Medicare and other private insurance. The most common primary treatment encounters were abdominal pain, chest pain, and falling. ED utilization can be used as an indicator to gauge lack of PCP coverage. When comparing ED visits by household income, 39.2% of survey respondents in the Warren Campus and Star Community Health service area who earn less than $15,000 visited the ED at least once compared to 29.2% of respondents who earn $60,000 and above. Additionally, respondents who earn less than $15,000 were more likely than any other income bracket to visit the ED five or more times in a year. Connection to care for low income households, especially connection to a medical home (i.e., primary care physician) is critical in reducing the overutilization of acute care settings for routine medical care.



Vulnerable Populations

Unhoused and homeless populations frequently utilize the ED as a primary source of healthcare. This is often due to lack of insurance and/or a medical home (e.g., primary care physician), lack of transportation, and unstable living conditions which can contribute to higher rates of acute and chronic health conditions. According to the Department of Housing and Urban Development (HUD, 2022) it was estimated that approximately 30% of homeless individuals had at least one emergency department visit in the last year. The National Institute of Health reports that homeless individuals are five times more likely to visit the ED than housed individuals. According to the CDC, the rate of persons not experiencing homeless has remained relatively stable at less than 50 visits per 100 persons per year compared to much higher rates in homeless populations, with drastic increases between 2010-2021. Of the CHNA respondents Network-wide that reported being homeless, 70.4% reported visiting the ED at least once in the past year compared to 91.0% of individuals living in a shelter, 32.7% of individuals who own their home, and 48.6% who rent a home or apartment. Additionally, when looking at ED utilization by hospital campus, the identified homeless population (e.g., living in a shelter, personally identified as homeless) was much more likely to utilize the ED compared to people who were not homeless.

Rate of Emergency Department Visits, by Homeless Status, United States (2010-2021)



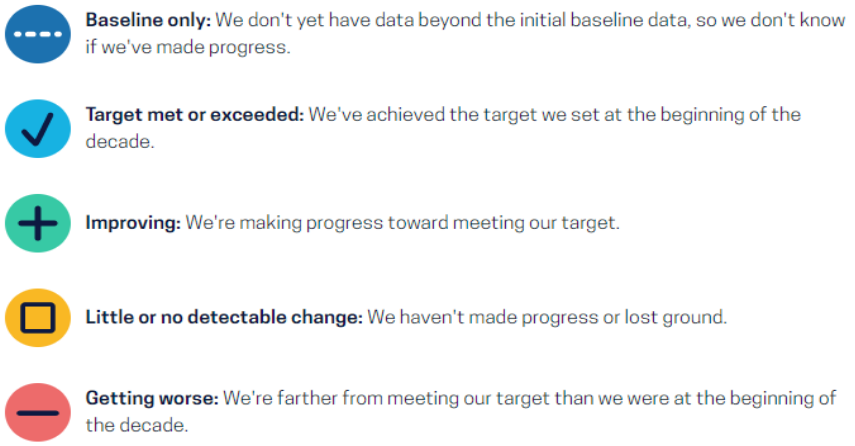
Source: CDC, 2023

Uninsured populations are especially vulnerable to high rates of hospitalizations and emergency department encounters. Emergency department visits are preventable when patients seek treatment for conditions that could have been managed in non-emergency settings or avoided with consistent and quality preventive care. Factors influencing the rate of these visits include income, education, employment, health insurance coverage, transportation access, and internet access. Utilizing emergency rooms for preventable care can lead to excess costs for taxpayers, increase the burden on healthcare providers, and reduce the quality of patient care. Of all the survey respondents in the Warren Campus and Star Community Health service area, 2.1% reported going to hospital emergency room most often when they are sick or need advice about their health.

Neighborhood and Built Environment

Neighborhood and built environment is the foundation for individual and community health, influencing access to resources, social interactions, and overall quality of life. Unsafe environments can lead to chronic stress, poor mental health, and limited access to healthcare, which can lead to negative health outcomes. Healthy People 2030 focuses on improving health and safety in the places where people are born, live, learn, work, play, worship, and age. These objectives are designed to address neighborhood and built environment as a social determinant of health, recognizing the economic and societal factors are intrinsically linked to health outcomes.

According to Healthy People 2030, the following objectives are related to neighborhood and built environment and are measured at the national level. Most Healthy People 2030 objectives are core, or measurable, objectives that are related to targets outlined for the decade (2020-2030). Evidence-based interventions are supported through national, state, and local initiatives. Progress is measured using a variety of data sources (e.g., US Census, ACS estimates, state and county data) and is measured using the following indicators: Baseline only, target met or exceeded, improving, little or no detectable change, getting worse. The objectives outlined have corresponding updates at the national level as of June 2024.



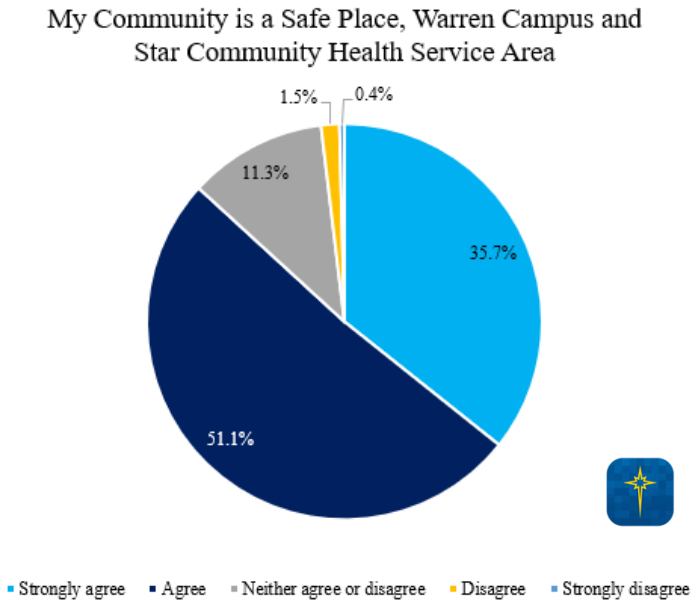
Healthy People 2030 Objectives for Neighborhood and Built Environment	Baseline	Target	Most Recent Data	Progress
Reduce the rate of minors and young adults committing violent crimes (10-24 years old)	249.0 per 100,000	199.2	249.2 (2018)	Baseline only
Reduce the proportion of families that spend more than 30 percent of income on housing	34.6% (2017)	25.5%	35.0% (2021)	Little or no detectable change
Increase the proportion of smoke-free homes	86.5% (2014-15)	92.9%	90.0% (2018-19)	Improving
Increase the proportion of people whose water supply meets Safe Drinking Water Act regulations	90.2% (2018)	92.1%	92.2% (2021)	Target met or exceeded
Reduce the number of days people are exposed to unhealthy air (Air Quality Index)	4,295,962,018 (2016-2018)	3,866,365,816	4,534,737,587 (2019-2021)	Little or no detectable change
Reduce asthma attacks	41.5% (2019)	35.1%	42.4% (2022)	Little or no detectable change
Reduce the amount of toxic pollutants released into the environment	1,970,088 tons (2017)	1,862,612 tons	1,690,240 tons (2019)	Target met or exceeded

Safety

Perceived safety is an important component of integrating into one's community. People who do not feel safe in their neighborhood are less likely to participate in outdoor activities and are more likely to isolate themselves, which can have negative impacts on both physical and mental health. Violent crime, defined as "offenses that involve face-to-face confrontation between a victim and a perpetrator, including homicide, rape, robbery, and aggravated assault" is one measure of safety. According to Federal Bureau of Investigation (2022), the U.S. rate of violent crime offenses is 380.7 per 100,000 population. New Jersey has a rate of 253 violent crimes per 100,000 population. Warren County has a higher rate of violent crimes (71 per 100,000) than Hunterdon County (42 per 100,000).

Most CHNA survey respondents in Warren Campus and Star Community Health service area agreed that their community was a safe place to live (51.1%), followed by strongly agree (35.7%), neither agree nor disagree (11.3%), disagree (1.5%), and strongly disagree (0.4%).

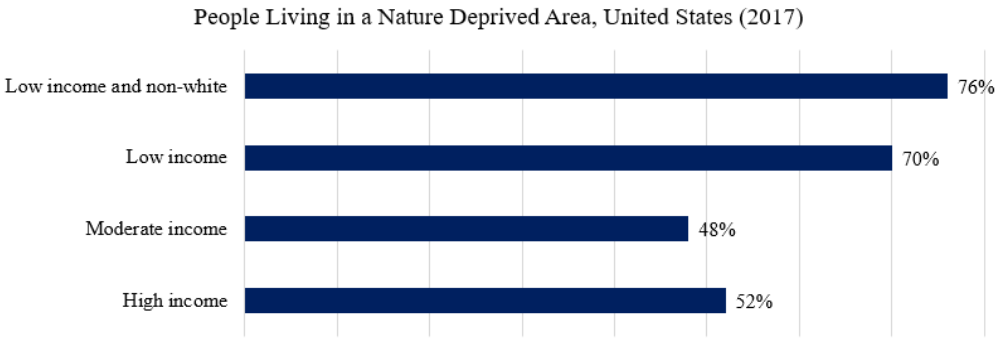
Safe parks can provide access to recreational opportunities, reduce crime, and provide environmental benefit by reducing air and water pollution. The Centers for Disease Control found that people who have more access to green environments, such as parks, and trails tend to walk and be more physically active compared to those with limited access. The closer people are to parks, the more likely they are to walk or bike there and use it for physical activity. However, location is not the only factor in accessibility to parks. People must also feel safe in their local parks and have safe streets to get there.



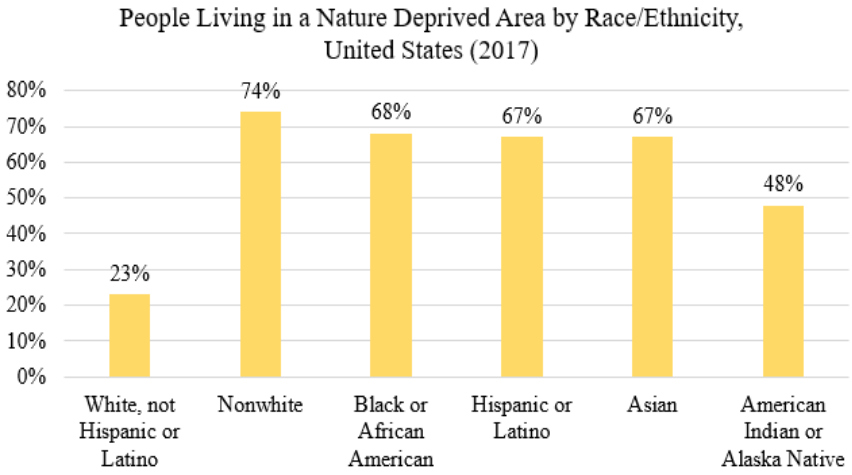
Vulnerable Populations

The National Health Foundation reported that lower-income communities and urban areas experience the most limited access to green spaces. Accessibility varies greatly across neighborhoods, income levels, and race. Having unsafe communities or far distances from local parks pushes people to travel elsewhere for recreational opportunities and environmental benefit. Finding different spaces for these opportunities creates a barrier due to cost of travel and expense of the activity. The U.S. Forest Service, National Park Service, and Fish and Wildlife Service show that although people of color make up nearly 40% of the total U.S. population, close to 70% of people who visit national forests, national wildlife refuges, and national parks are White.

Black individuals remain the most underrepresented group in these spaces. Costs of camping gear, entrance fees, lack of vacation days, and unpaid leave are factors that contribute to the difficulty families face to participate in outdoor recreation. This is especially true for BIPOC individuals who are more likely to face these economic barriers.

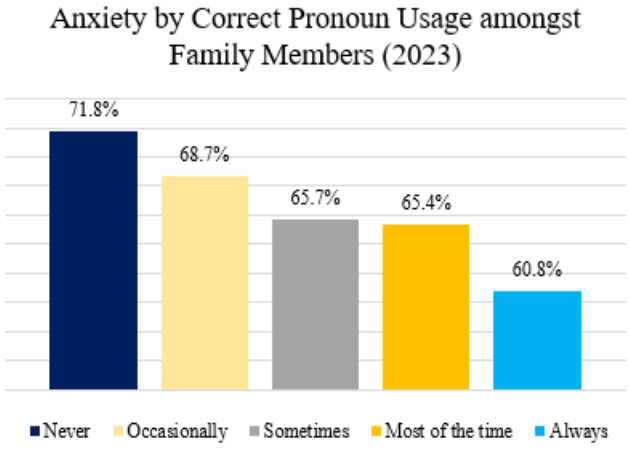


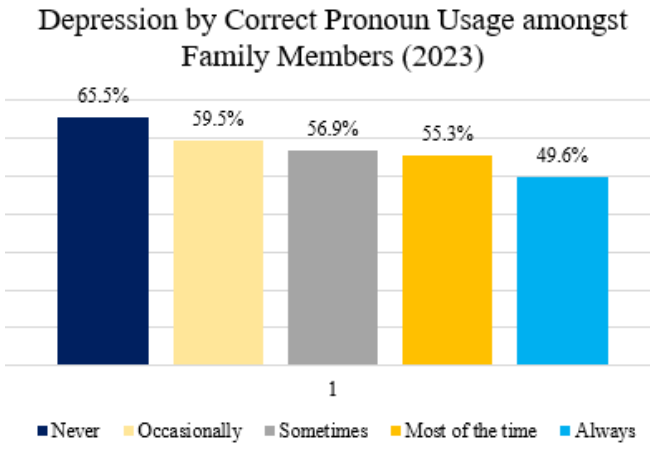
Source: National Health Foundation, 2017



Source: National Health Foundation, 2017

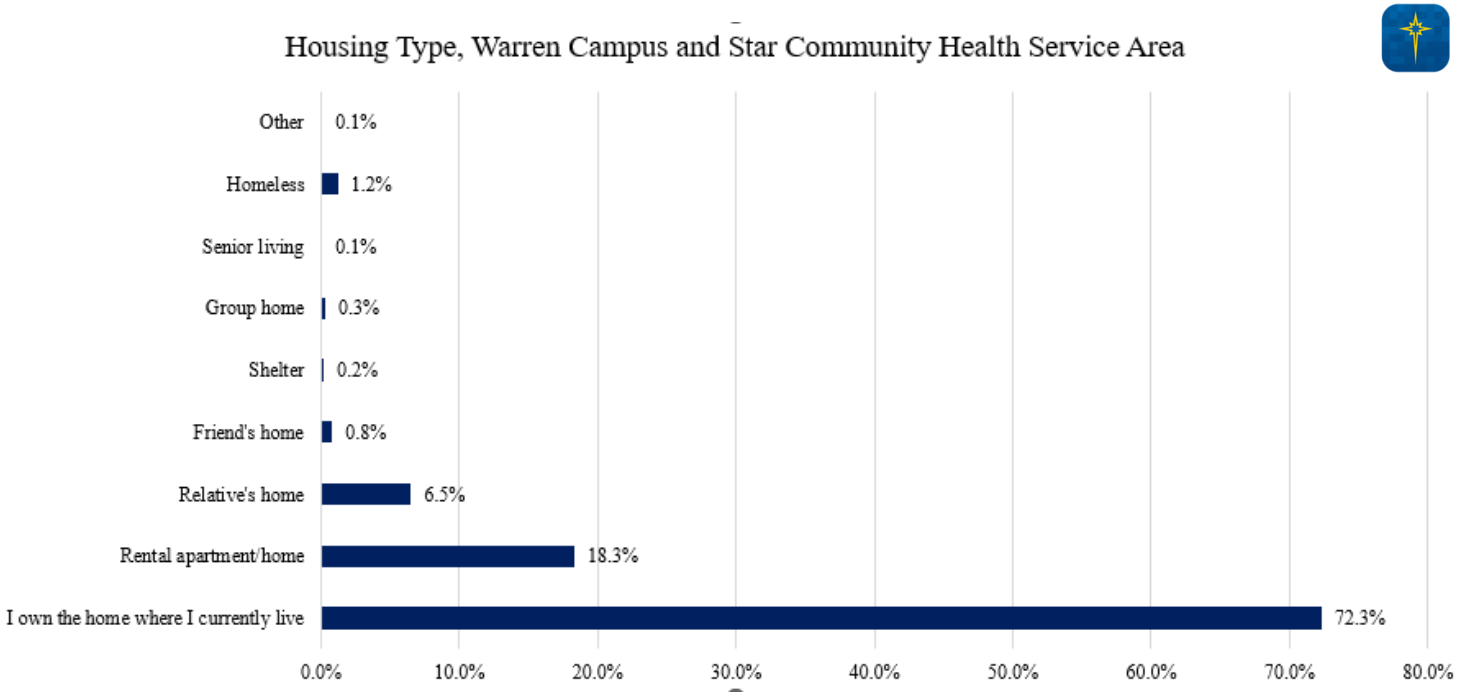
LGBTQ+ individuals can feel unsafe in their neighborhoods and built environment due to discrimination, lack of acceptance, and potential threats of violence or harassment. These circumstances can lead to feelings of isolation and vulnerability. The Human Rights Campaign (HRC) Foundation conducted a 2023 LGBTQ+ Youth Report partnered with the University of Connecticut to survey LGBTQ+ youth from across the United States. The 2023 HRC report found that 82.7% of youth surveyed have disclosed their LGBTQ+ sexual orientation and/or gender identity (SOGI) to at least one member of their immediate family. Transgender and gender expansive youth surveyed were less likely to be out to their families (67.4%) compared to their LGBQ counterparts (80.1%). Almost two-thirds (63.1%) of LGBTQ+ youth reported at least one positive experience of parental support. Seven in ten (72.1%) transgender and gender-expansive youth who report their families never refer to them with the correct name screened positive for anxiety, whereas six in ten (61.9%) of those whose families always use the correct name did so.





Housing and Blight

Stable and safe housing is an important factor that sets the foundation to achieve quality education, valuable social interactions, and access to nutritious foods. According to Healthy People 2030, safe housing is considered a social determinant of health, which are "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks". Housing affects other sectors including education, health, racial equity, economic stability, homelessness, hunger, crime, the environment, and disability rights. Over time, homeownership can help build wealth and savings, which are important in relation to health, but not everyone has had equal opportunity to homeownership. Years of discriminatory practices and inability to benefit from homeownership programs has led to a disproportionate homeownership rate between races. Healthy People 2030 has made housing a focus, including efforts to reduce the proportion of families that spend 30% or more of income on housing, increase the proportion of homeless adults who get mental health services, and to increase the proportion of homes that have an entrance without steps to make it accessible for people with disabilities. To get an understanding of how the Warren Campus and Star Community Health service area population lives, we asked respondents to indicate their housing type. There were a small number of individuals living in a shelter (0.2%), group home (0.36%), senior living (0.29%), homeless (0.22%), or other (0.8%). The majority of respondents own or have a mortgage on their home (75%), followed by renting their home (16.7%), living at a relative's home (5.9%), other (0.1%), and living at a friend's home (0.8%).



One indicator used to assess housing status is the percentage of households that are cost-burdened. According to the department of Housing and Urban Development (HUD), a household is considered cost-burdened if 30% or more of the income goes toward their mortgage or rent. A household is severely cost-burdened if 50% or more of their income goes toward paying mortgage or rent. Both situations can be detrimental to an individual's overall well-being because there is less disposable income to pay for food, healthcare costs, transportation, and other out of pocket expenses. America's Rental Housing 2024 report by Joint Center for Housing Studies found that 49.5% of all 2022 renters across the United States are moderately to severely cost-burdened meaning they spend 30-50% of their income on housing costs. The report also found that Black and Hispanic households deal with the greatest affordability challenges making them more likely to reside in inadequate housing. Please see the Economic Stability section of this CHNA for more information on cost-burdened households.

Further assessing the wage disparities, the National Low Income Housing Coalition (NLIHC) released a report on Fiscal Year 2023 housing costs and wage. Out of all states, New Jersey ranks 7th of states with the highest housing wages. In Warren and Hunterdon Counties, the fair market rent for a two-bedroom apartment ranges from $1,530 (Warren County) to $1,917 (Hunterdon County), meaning the household would need to earn $29.42 an hour or $61,200 annually to afford the apartment in Warren County and $36.87 an hour or $83,520 annually in Hunterdon County to not be cost-burdened. Based on the estimated hourly mean wage that a renter in Warren County earns ($16.40 per hour) and Hunterdon County ($19.18), they would need to work 1.8 full time jobs in Warren County or 2.1 full time jobs in Hunterdon County to afford rent. Please see the Economic Stability section of this CHNA for more information on cost-burdened households and economic stability.

Two other important factors to look at are the percentage of households that lack complete kitchens and the percentage of households that lack complete plumbing. The Robert Wood Johnson Foundation County Health Rankings measures many social determinants of health, including the percent of people living with severe housing problems. A household is considered to have a severe housing problem if one or more of these conditions are met: lacking a complete kitchen, lacking complete plumbing facilities, house is overcrowded, or the house is severely cost-burdened. A reported 20% of all households in New Jersey are considered to have severe problems, 13% in Warren County and 12% in Hunterdon County.

It is important to assess the conditions inside of houses because they give an indication of living standards and assess the quality of household facilities. According to the US Census subject definitions guide, a complete kitchen must include a sink with a faucet, a stove or range, and a refrigerator. If a household lacks any one or more of these, the household is considered to lack a complete kitchen. A complete plumbing facility must include hot and cold running water and a bathtub or shower. If a household lacks one or both of these, the house is considered to lack complete plumbing.

Without a complete kitchen, families are unable to cook nutritious meals and may rely more heavily on fast food or other ready-made food. For households lacking complete plumbing facilities, families may not be able to bathe regularly leading to worsened hygiene. According to the ACS 2022 estimates, there were 0.9% of households that lacked a complete kitchen in Hunterdon County and 1.4% in Warren County. In New Jersey, 1.4% of households lacked a complete kitchen compared to 2.1% nationwide. In Hunterdon County, 0.5% of household lack complete plumbing and 0.4% in Warren County, which are lower than New Jersey (0.7%) and the United States (1.8%). According to the Robert Wood Johnson Foundation's County Health Rankings, the lack of complete kitchen and plumbing facilities can lead to broader health issues, which is of significant concern given that lacking these facilities is more often seen in lower-income households and vulnerable populations.

	2023 ACS Estimates % Lacking a Complete Kitchen	% Lacking Complete Plumbing
United States	2.1%	1.8%
New Jersey	1.4%	0.7%
Warren County	1.4%	0.4%
Hunterdon County	0.9%	0.5%

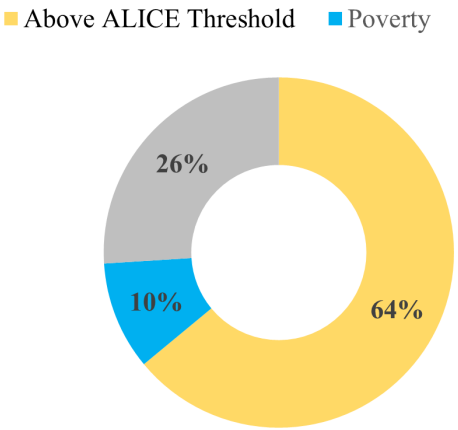
Homelessness is another important indicator when assessing housing. Each year, HUD collects homeless data across the country, also known as the Continuums of Care data. As of November 2023, New Jersey had an estimate of 6,215 people 18 years or older experiencing homelessness and of that population, 1,302 were family households, 454 were Veterans, 452 were unaccompanied young adults (ages 18-24), and 1,964 were individuals experiencing chronic homelessness. Each school year in New Jersey, the Stewart B. McKinney-Vento Education of Homeless Children and Youth Program ensures that homeless children have access to free and appropriate public education. In the 2020-21 school year, the program identified 10,542 homeless students (under 18 years old) — a decrease from the 2019-20 school year which identified 12,333 homeless students. Of the 10,542 identified homeless students in the 2020-21 New Jersey public school system, 116 were from Warren County and 13 were from Hunterdon County.

Vulnerable Populations

Black, Indigenous, and People of Color (BIPOC) communities are disproportionately affected by housing instability, neighborhood blight, and homeownership opportunities which exacerbates health and economic disparities. Federal homelessness data shows that BIPOC groups in the United States continue to experience sheltered homelessness. According to HUD's 2021 Annual Homelessness Assessment Report, people who identify as Black or African American consistently make up the largest BIPOC group experiencing sheltered homelessness. The Black and African American population represents nearly 14% of the total U.S population, but represent 37% of people experiencing sheltered homelessness. This disproportionality continues among smaller minority groups as well. Native Hawaiians and Pacific Islanders now represent 0.3% of the U.S. population but 1.8% of the sheltered homeless population. Similarly, American Indian/Alaska Natives represent 1.3% of U.S. population but 3.4 percent of the sheltered homeless population. Similarly, people identifying as Hispanic or Latino make up 19% of the U.S. population, but 24% of the sheltered homeless population. These trends are also seen in New Jersey. 2023 New Jersey Counts found that 47% of the population experiencing homelessness are Black/African American. This is a concerning number considering Black or African American make up 12% of New Jersey's total population. Of the survey respondents in the Warren Campus and Star Community Health service area, 5% Black or African American respondents reported being homeless as well as 1.0% of Hispanic respondents, and 15.4% of American Indian or Alaskan Native respondents.

ALICE individuals face significant challenges related to housing instability, neighborhood blight, and homeownership opportunities. These challenges hinder gaining financial stability. The 2024 United for Alice 2024 Report showed that a clear increasing trend in the number of ALICE households in New Jersey. Between 2010 and 2022, the total number of households in the state increased by 11%, households in poverty increased by 17%, and the number of ALICE households increased by 12%. By 2022, 10% (365,899) of all households were below the Federal Poverty Line, and 26% (902,737) of all households were ALICE. That combines to a total of 36% (1,268,636) of all households struggling to make ends meet. This rise is pushed by a growing number of households that are struggling financially and often ineligible for public assistance and undercounted through official measures.

TOTAL ALICE HOUSEHOLDS, NEW JERSEY (2024)



Source: 2009-2024 United Way of Northern New Jersey

Older adults are particularly vulnerable to the impacts of housing instability and neighborhood blight. Dealing with these challenges can negatively affect their health mobility and overall wellbeing. In January 2023, the annual Point-in-Time Count was reported by 381 Continuums of Care (CoC) conducted nation-wide. It showed, on a single night, 138,098 adults over the age of 55 were homeless. Nearly one in four people experiencing unsheltered homelessness (i.e., living in places not meant for human habitation) were over the age of 55. Prior to 2023, there had not been concrete national information on the number of older adults that are experiencing homelessness. Projections done by University of Pennsylvania's Actionable Intelligence for Social Policy estimated that homelessness among older adults is expected to nearly triple by 2030, and the population of adults aged 65 and older experiencing homelessness is anticipated to grow from 40,000 to 106,000. People experiencing homelessness often live with unmanaged chronic disease and limited access to healthcare, their health profiles are commonly associated with those of older individuals. Research done by the Gerontological Society of America shows that people experiencing homelessness in their fifties have been found to experience geriatric conditions such as memory loss, falls, and functional impairments at rates that compare to members of the general population in their seventies.

A study by the Joint Center for Housing Studies at Harvard University on immigrant access to homeownership highlighted the barriers faced when attempting to gain home ownership. Homeownership is a way for lower to middle income individuals to build wealth despite historical trends of people of color with lower home ownership. Home ownership goes beyond solely financial benefits. Home ownership fosters greater residential stability, civic engagement, and overall well-being. Home ownership is of even more impactful significance to foreign-born populations since owning a home greatly influences their settlement and life in the United States. Research shows great housing disparities among native and foreign-born households. Foreign-born households experience higher housing cost burdens and face persistently lower homeownership rates. Legal status is another major barrier unique to the foreign-born population that affects access to homeownership.

LGBTQ+ communities are particularly vulnerable to homelessness, housing instability, and blight. Discrimination, societal stigmas, and lack of support contribute to these circumstances. Research done by the Journal of Adolescent Health has shown that those who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ+) have a 120% higher risk of experiencing some form of homelessness than non-LGBTQ+ individuals. The Williams Institute found that up to 40% of the 4.2 million youth identifying as LGBTQ+ experience homelessness compared to their straight and cisgender peers experiencing homelessness (9.5%). LGBTQ+ individuals are also more likely to experience assault, trauma, depression, and suicide when compared to non-LGBTQ+ populations while also being homeless.

"Housing availability, affordability and quality are issues in our community. The town's infrastructure is older. We have a lot of challenges with our sanitary sewer system and our storm sewer system. This is especially seen in our south side of 22 which is an older, more socioeconomically distressed area that floods due to our aging storm water infrastructure."

Air and Water Quality

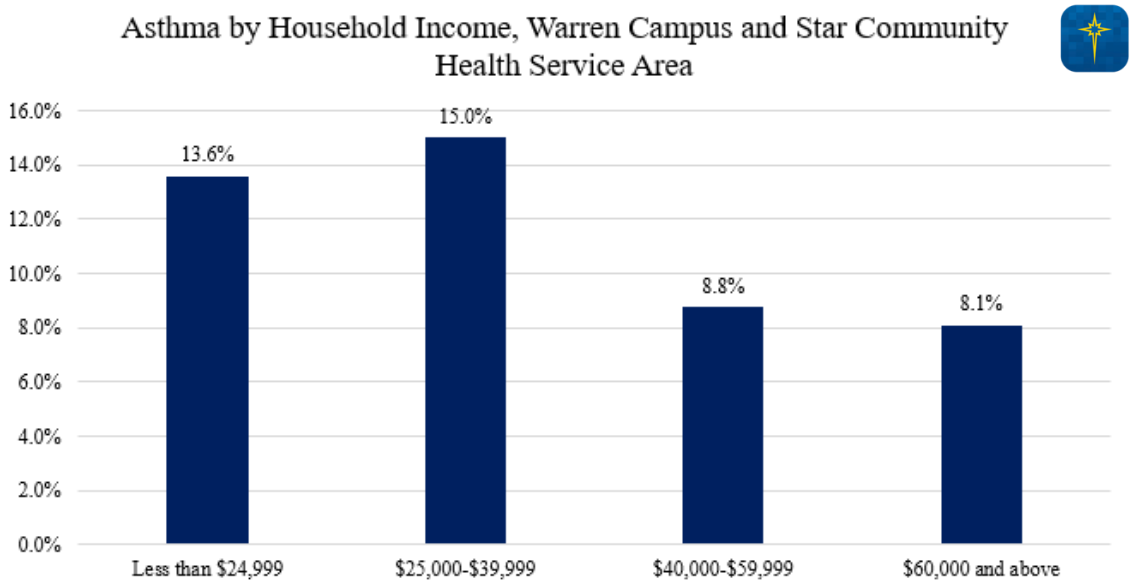
Air quality is a growing concern, especially in urbanized and industrialized areas. Poor air quality can irritate the eyes, nose, and throat, and cause long term negative health effects. Air quality is typically assessed by two components, ozone (O_3) and Particulate Matter (PM). Ozone is a gas molecule that is harmful to breathe and aggressively attacks lung tissue. Ozone is dangerous because it can be carried by wind far downstream, causing harm to people in multiple areas. Ozone can also cause premature death, acute breathing problems, long term exposure risks, and potential cardiovascular harm. PM is a particle that occupies the air we breathe but is small enough that we cannot see it unless there are large amounts of PM in one area. Large amounts of PM result in reduced visibility, or haziness in the air. PM 2.5 is the smallest particle and most dangerous size because it can easily pass through lung tissue and into the blood stream. Breathing PM can trigger illness, hospitalization, and premature death along with increasing the severity of asthma attacks in children. Both pollutants are especially dangerous in vulnerable groups like children and teens, anyone over the age of 65 years old, people with pre-existing lung diseases (e.g., asthma, COPD), and people with cardiovascular diseases. Ozone and PM can both lead to premature death, respiratory harm, and cardiovascular harm. Objectives for environmental health determined by Healthy People 2030 are to increase the proportion of people with safe water to drink, to reduce the amount of toxic pollutants in the environment, and to reduce the number of days people are exposed to unhealthy air. Ozone and PM are measured by the Environmental Protection Agency (EPA), the Department of Environmental Protection (DEP), and reported to the American Lung Association. The American Lung Association released a State of the Air (2024) report based on data collected in 2020-2022 depicting overall air quality with red days being unhealthy, purple days being very unhealthy, and orange days being unhealthy for sensitive groups.

According to the American Lung Association, Warren and Hunterdon County earned an 'A' for high ozone days for 2020-2022. The weighted average of O_3 was zero for both counties with zero orange days. Warren County earned an 'B' for PM days, with a 0.3 weight average and one orange day. Hunterdon County earned an 'A' for PM days, with a 0.0 weight average and zero orange days.

High Ozone Days				
	Weight average	Orange days	Red days	Purple Days
Berks	1.7	5	0	0
Bucks	5.3	16	0	0
Carbon	DNC	DNC	DNC	DNC
Lehigh	0.0	0	0	0
Monroe	0.0	0	0	0
Montgomery	1.7	5	0	0
Northampton	1.0	3	0	0
Schuylkill	DNC	DNC	DNC	DNC
Luzerne	0.0	0	0	0
Warren	0.0	0	0	0
Hunterdon	0.0	0	0	0

High Particulate Matter Days				
	Weight average	Orange days	Red days	Purple Days
Berks	1.0	3	0	0
Bucks	DNC	DNC	DNC	DNC
Carbon	DNC	DNC	DNC	DNC
Lehigh	0.5	0	1	0
Monroe	DNC	DNC	DNC	DNC
Montgomery	0.7	2	0	0
Northampton	1.3	4	0	0
Schuylkill	DNC	DNC	DNC	DNC
Luzerne	DNC	DNC	DNC	DNC
Warren	0.3	1	0	0
Hunterdon	0.0	0	0	0

Additionally, the CHNA survey asked respondents to indicate if they had ever been diagnosed with asthma, 9.7% of respondents in the Warren Campus and Star Community Health service area reported having asthma. When examined by income, 13.6% of respondents who earn less than $24,999 have asthma. The rates of asthma generally decrease as household income increases, with the exception of $25,000 to $39,999 income group that was slightly higher at 15.0%. This is an important trend to note as respondents with lower incomes may have substandard housing conditions (e.g., mold, dampness, inadequate ventilation), environmental triggers (e.g., higher exposure to industrial emissions), lifestyle factors (e.g., smoking), and stress, which can all exacerbate asthma and asthma attacks.



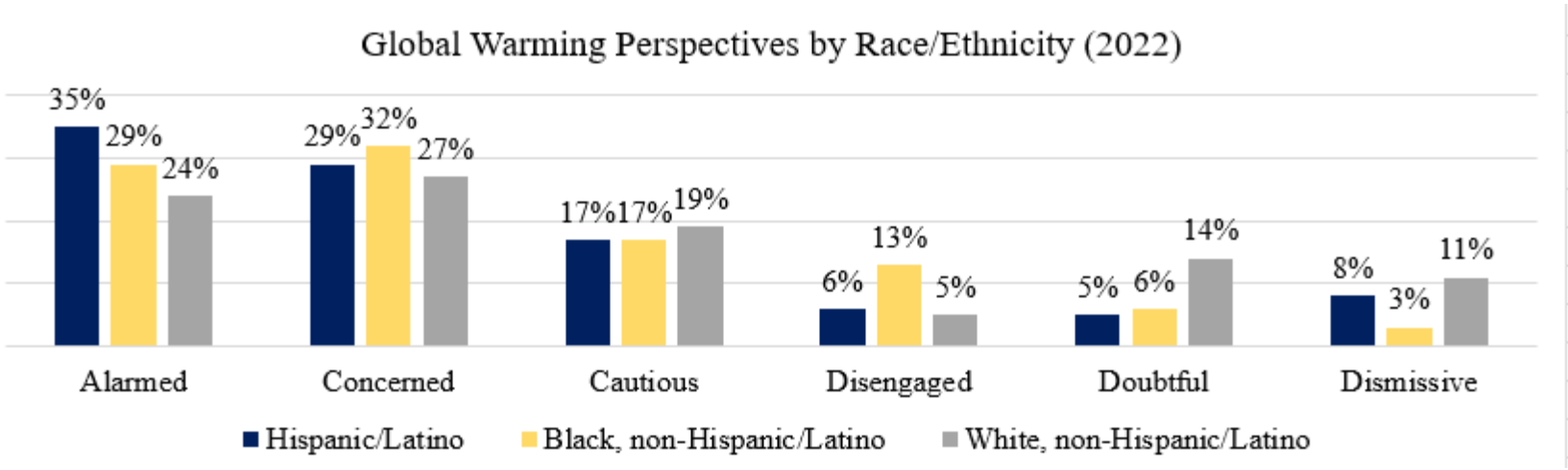
Water quality is another important aspect of the environment. Water is delivered in two ways, through wells and through municipalities. Through the Department of Environmental Protection, each municipality is required to report water quality reports each year, but well quality is difficult to track because it is typically not regulated by the state. The annual reports track violations within the Maximum Contaminant Level (MCL) which is the highest level of contaminant allowed in drinking water. The water is permitted to have some contaminants if it does not exceed the MCL. This is important to note because though a water system does not have violations, it does not necessarily mean the water is completely safe. The water report also tracks the Maximum Residual Disinfectant Level (MRDL) which limits the amount of disinfectants allowed in safe drinking water. Some of the typical contaminants tested are chlorine, fluoride, radium, turbidity, organic carbon, lead, and copper. Water contaminants can result in a variety of negative health impacts, like gastrointestinal illness, worsened nervous system or reproductive system, and a variety of diseases (e.g., cancer). The effects can also be short term or long term, while also going unseen, potentially worsening over time.

Warren and Hunterdon County serves residents through Aqua America. Warren county has five systems that service residents, four of which come from Phillipsburg and one from Port Murray. Four systems (Cliffside Park, Harkers Hollow, Riegelsville, and Phillipsburg) were in compliance with all New Jersey Maximum Containment Levels (MCLs). The Brainard system reported 88.6ppm of sodium, which exceeded the recommended upper limit of 50ppm. The typical source for high levels of sodium are erosion of natural deposits and use of sodium containing water treatments. Hunterdon County has five systems that service residents, two which come from Milford, one from Bloomsbury, Califon, and Lebanon Township. Three systems (Califon, Riegel Ridge, and Warren Glen) were in compliance with all New Jersey Maximum Containment Levels (MCLs). The Fox Hill and Bunnvale systems reported 0.71ppm and 0.51ppm respectively, which exceeded the recommended upper limit of 0.3ppm.

Vulnerable Populations

BIPOC and low-income communities are disproportionately affected by poor air and water quality. Living in areas with higher pollution levels and limited access to clean resources contributes to environmental inequities. An analysis by the United States Environmental Protection Agency (2021) showed that the most severe harm from climate change fall disproportionately upon underserved communities since they are the least able to prepare and recover from environmental events like heat waves, poor air quality, and flooding. Key findings of the report showed that Black or African American individuals are projected to feel the impacts of climate change stronger than all other demographic groups. For example, with 2°C (3.6°F) of global warming, Black or African American individuals are 34% more likely to currently live in areas with the highest projected increases in childhood asthma diagnoses and 40% more likely to currently live in areas with the highest projected increases in extreme temperature related deaths. Hispanic and Latino communities have higher participation in industries that are weather-exposed like construction and agriculture causing increased vulnerability to the effects of extreme temperatures. With 2°C (3.6°F) of global warming, Hispanic and Latino individuals are 43% more likely to currently live in areas with the highest projected reductions in labor hours due to extreme temperatures.

A research study done by Harvard T.H. Chan School of Public Health (2022) in collaboration with the Environmental Systems Research Institute, created a platform that links 17 years' worth of demographic data with data on fine particulate pollution from across the U.S. Using the platform, research was conducted on the disparities of air pollution exposure of racial/ethnic and income groups in the United States. It was found that groups that identify as Black or African American, Asian, Hispanic, and low-income populations are being exposed to higher levels of dangerous fine particulate air pollution (PM2.5) than other groups. The researchers also found that areas of the U.S. where the White and Native American populations are overrepresented have been consistently exposed to average PM2.5 levels that are lower than those in areas where Black, Asian, and Hispanic populations are overrepresented.



Source: Yale Program on Climate Change Communication

Transportation

The type of transportation a person takes to work can be a good indicator of health. Walking, biking, or taking public transportation to work promotes regular physical activity and decreases air pollution, which in turn decrease chronic diseases and obesity rates. A goal of Healthy People 2030 is to increase the amount of people using public transportation to get to work. People who drive to work are less likely to reach the recommended physical activity goal for the day. Driving to work can also have an effect on obesity, diabetes, and heart disease. However, it is not always feasible for someone to walk, bike, or take public transportation to work as many cities lack the proper infrastructure.

Below illustrates the modes of transportation used to get to work by people in Warren County, Hunterdon County, New Jersey, and the United States. For all four geographies, the majority of people drive alone to work. Warren county reported 77.7% of commuters drive alone to work, which is higher than New Jersey (65.4%) and the United States (71.7%). Carpooling to work is the next highest category for Warren County, which falls in between the percentages for New Jersey and the United States. Additionally, Warren and Hunterdon Counties have a combined 7.5% of people who walk and use public transportation to commute to work. Warren County residents have access to public transportation through the Warren County Transportation (WCT) system. The WCT offers fixed bus routes and special services to people with disabilities, veterans, low-income, and people who are 65 years and older.

Modes of Transportation to Work 2022 ACS 5 Year Estimates									
Region	Drive Alone	Carpool	Public Transportation	Taxi	Motorcycle	Bike	Walk	Other	Work From Home
Warren County	77.7%	7.0%	1.3%	0.1%	0.0%	0.2%	2.4%	1.3%	9.8%
Hunterdon County	72.3%	5.2%	2.1%	0.1%	0.1%	0.1%	1.7%	0.5%	17.9%
New Jersey	65.4%	7.6%	9.0%	0.5%	0.0%	0.3%	2.6%	1.5%	13.1%
United States	71.7%	8.5%	3.8%	0.2%	0.1%	0.5%	2.4%	1.1%	11.7%

"Transportation always pops up as a need for the community. With transportation being an issue and not having a walkable grocery store, it really does hurt our children and families."

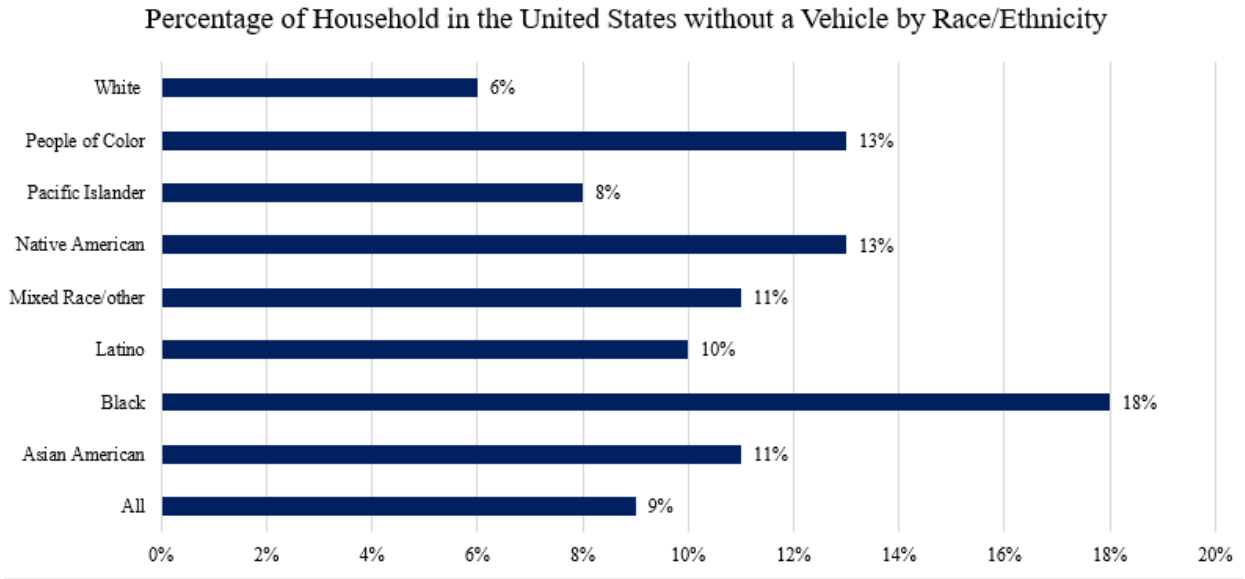
"There is a lack of transportation and off-hour transportation for the community to access employment, medical care, and other support services."

Transportation is also a key factor in access to opportunities. The World Bank described transportation as fundamental to supporting economic growth, creating jobs and connecting people to essential services like healthcare or education. Expanding sustainable and climate friendly transport options is vital, especially in low-income or vulnerable communities. Transport expansions can strengthen human development and social inclusion. Of survey respondents in the Warren Campus and Star Community Health Service Area, 4.6% reported missing or postponing medical care because they did not have a way to get there.

Vulnerable Populations

Accessible, affordable, and reliable transportation is essential, but it is not equally accessible for everyone. Transportation plays a direct role in providing access to resources. Having reliable transportation influences being able to attend job opportunities, make health care appointments, and have access to parks or places for physical activity.

Transportation inequality significantly impacts low-income individuals and marginalized racial and ethnic groups. These populations often reside in areas with limited access to reliable and affordable transportation, negatively impact access to essential services. As reported in the previous "Housing and Blight" section, Black and Hispanic households deal with the greatest affordability challenges making them more likely to live in inadequate housing. When individuals are already struggling with the cost of living, affording transportation is a need that can go unmet. The American Public Health Association released a updated Transportation Report (2021) where they found that most people consider reliable transportation as having access to a car. Car ownership can cause a burden to low-income households, as the average annual cost to own a car is $8,449.49. Without a vehicle as a means of transportation, individuals use options like public transit, walking and rolling, or biking. Not all individuals live close to public transit or have safe roadways to access those public transit. Without reliable methods of transportation, employees face being limited to working certain shifts, not being able to attend work on time, or being unable to show up altogether. People who live in auto-centric communities are more likely to fall into poverty due to transportation-related emergencies. Smart Growth America (2021) reported that people ages 50 and up, specifically those 75 years and older, are overrepresented in deaths involving pedestrians. This age group is more likely to experience challenges seeing, hearing, or moving which presents hazards when walking as a means of transportation.

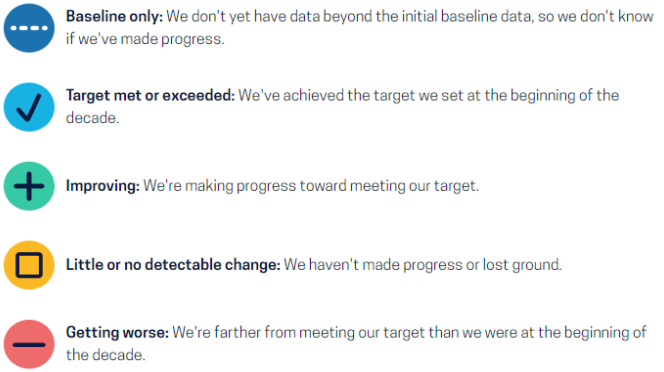


Source: Smart Growth America, 2021

Health Behaviors

Health Behaviors are actions taken by individuals that affect their health. These actions can be positive, negative, or have little impact and can include a wide range of choices and activities such as diet, physical activity, smoking alcohol consumption, and adherence to medical advice and care plans. In the United States, health behaviors vary across different regions and populations, reflecting the diversity and complex nature of external influences (e.g., culture, access, financial and social context). Despite local, state, and national efforts in health education and promotion, many people living in the United States continue to engage in unhealthy behaviors (e.g., smoking, substance use, poor dietary habits).

According to Healthy People 2030, the following objectives are related to health behaviors and are measured at the national level. Most Healthy People 2030 objectives are core, or measurable, objectives that are related to targets outlined for the decade (2020-2030). Evidence-based interventions are supported through national, state, and local initiatives. Progress is measured using a variety of data sources (e.g., US Census, ACS estimates, state and county data) and is measured using the following indicators: Baseline only, target met or exceeded, improving, little or no detectable change, getting worse. The objectives outlined have corresponding updates at the national level as of June 2024. Selected objectives are included based on their alignment with SLUHN CHNA survey questions and primary data outcomes.



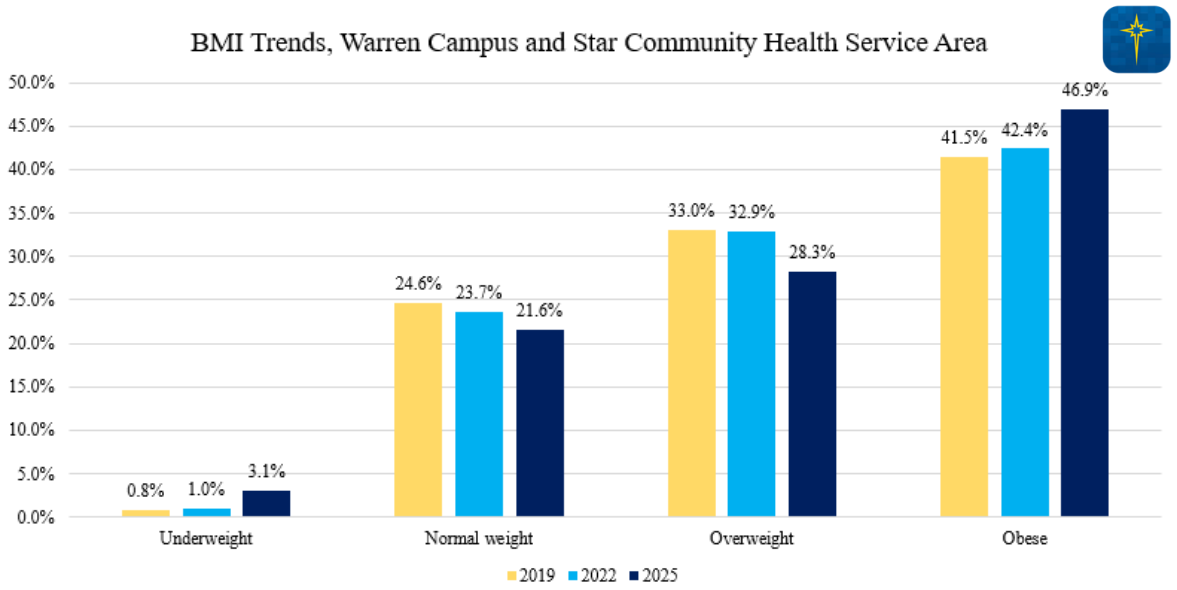
Healthy People 2030 Objectives for Health Behaviors	Baseline	Target	Most Recent Data	Progress (June 2024)
Increase fruit consumption by people aged 2 years and over	0.51 cups per 1,000 calories (2013-16)	0.56	0.49 (2017-20)	Little or no detectable change
Increase vegetable consumption by people aged 2 years and over	0.76 cups per 1,000 calories (2013-16)	0.84	0.73 (2017-20)	Little or no detectable change
Reduce the proportion of people living with obesity	38.6% (2013-16)	36.0%	41.8% (2017-20)	Getting worse
Reduce the proportion of people aged 21 years and over who engaged in binge drinking in the past month	26.6% (2018)	25.4%	26.0% (2019)	Little or no detectable change
Reduce the proportion adults who used drugs in the last month	12% (2018)	12%	13.4% (2019)	Getting worse
Reduce drug overdose deaths	20.7 per 100,000 (2018)	20.7 per 100,000	32.6 per 100,000 (2022)	Getting worse
Increase the proportion of adults who get enough sleep	72.3% (2020)	73.3%	69.9% (2022)	Getting worse
Reduce the proportion of adults who do no physical activity in their free time	26.1% (2020)	21.8%	26.3% (2022)	Little or no detectable change

Obesity

Obesity is a medical condition characterized by an excess accumulation of body fat that can contribute to poor health and increased risk for developing heart disease, diabetes, cancer, stroke, and more. Obesity is typically measured by Body Mass Index (BMI), which is a ratio of weight to height (i.e., weight in kilograms divided by the square of height in meters). County Health Rankings and Roadmaps assess obesity by measuring the percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m^2. A BMI under 18.5 is considered underweight, normal is 18.5-24.9, overweight is 25-29.9, and obese is 30 and above.

County Health Rankings and Roadmaps (2024), reported that 28% of adults in New Jersey are obese. Warren County reports that 32% of adults in the county are obese. Hunterdon County has the lowest percentage of adults living with obesity (28%) of all SLUHN service areas, which falls below the Healthy People 2030 target of 36.0%. A 2024 report by the New Jersey Hospital Association found that the proportion of all ED visits with an obesity/overweight diagnosis increased by approximately 126% from 2017 to 2022 (from 1.0 to 2.3 percent, representing over 30,000 visits in 2017 and over 68,000 visits in 2022). According to the CDC, obesity accounts for nearly $173 billion in medical expenditures in 2019. Obesity-related medical costs are estimated to be $1,861 higher per person than the medical costs of an individual whose BMI falls into the normal weight category. For adults living with severe obesity (BMI greater than 35), the excess costs were $3,097 per person. Many factors play a role in the obesity epidemic and its rapid increase over several decades including: lack of vegetable consumption, lack of physical activity, poor portion control, and poor access to outdoor recreational activities and healthy foods.

Results from the 2025 CHNA survey show that in the Warren Campus and Star Community Health service area, 3.1% of respondents are underweight, 21.6% are normal weight, 28.3% are overweight, and 46.9% are obese according to BMI. While the 2025 results are trending in a similar direction as 2022, there is a more significant difference, with a 4.6% decrease in overweight respondents and a 4.5% increase in obesity. It is also concerning that there is a 2.1% increase in underweight individuals and a 2.1% decrease in the normal weight population. There is a significant need to target education and health promotion as it relates to obesity and the health complications and comorbidities associated with obesity.

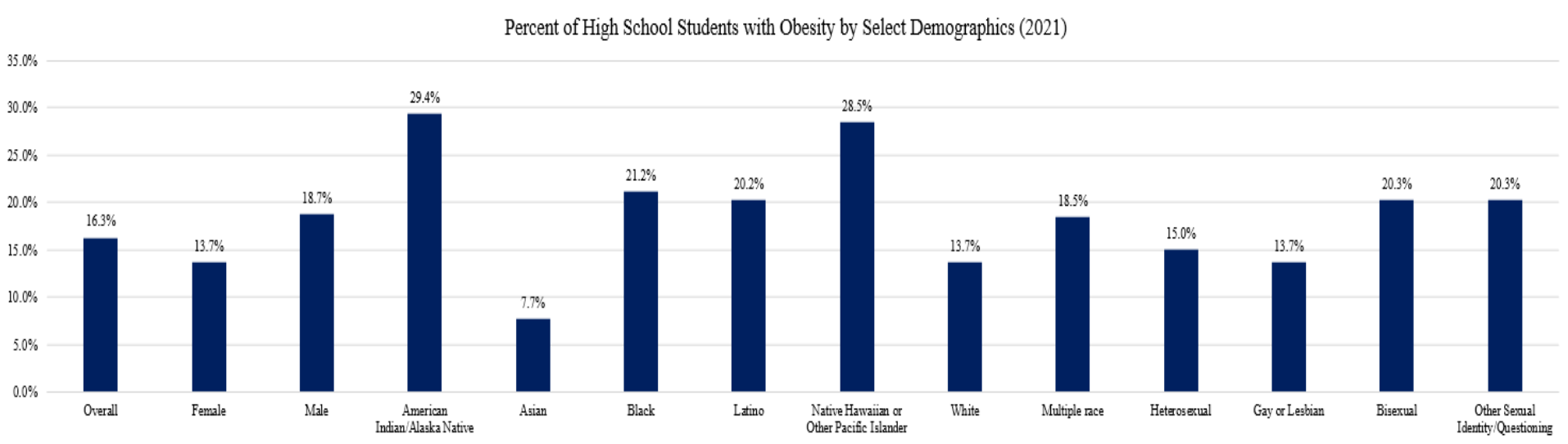


Stigma toward people living with obesity is common. This can lead to social and psychological challenges, including bullying, low self-esteem, social isolation, avoidance of healthcare services, decreased physical activity, increased mental health needs, and more. Addressing obesity requires a multifaceted approach that increase health education and promotion and supportive environments that model non-biased behaviors.

····· Vulnerable Populations ·····

In 2023, Trust for America's Health (TFAH) reported that, "socioeconomic factors such as poverty and discrimination have contributed to higher rates of obesity among certain racial and ethnic populations. Black adults have the highest level of adult obesity nationally at 49.9%; that rate is driven in large part by an adult obesity rate among Black women of 57.9%." New Jersey ranks 42 out of 51 states (including Washington, DC) for percentage of adults with obesity and ranks 41 for adults who are overweight. The age bracket with the highest percentage of adults with obesity in New Jersey is also 45-64 years old, accounting for 33.9% of adults who are overweight. TFAH did not report any adult obesity data by race/ethnicity for New Jersey.

According to the CDC, one in five children and adolescents are living with obesity. Childhood obesity is more likely to affect children living in low-income households, Hispanic children, non-Hispanic Black children, and adolescents 10-17 years old. A child is considered obese if their BMI is at or above the 95th percentile.



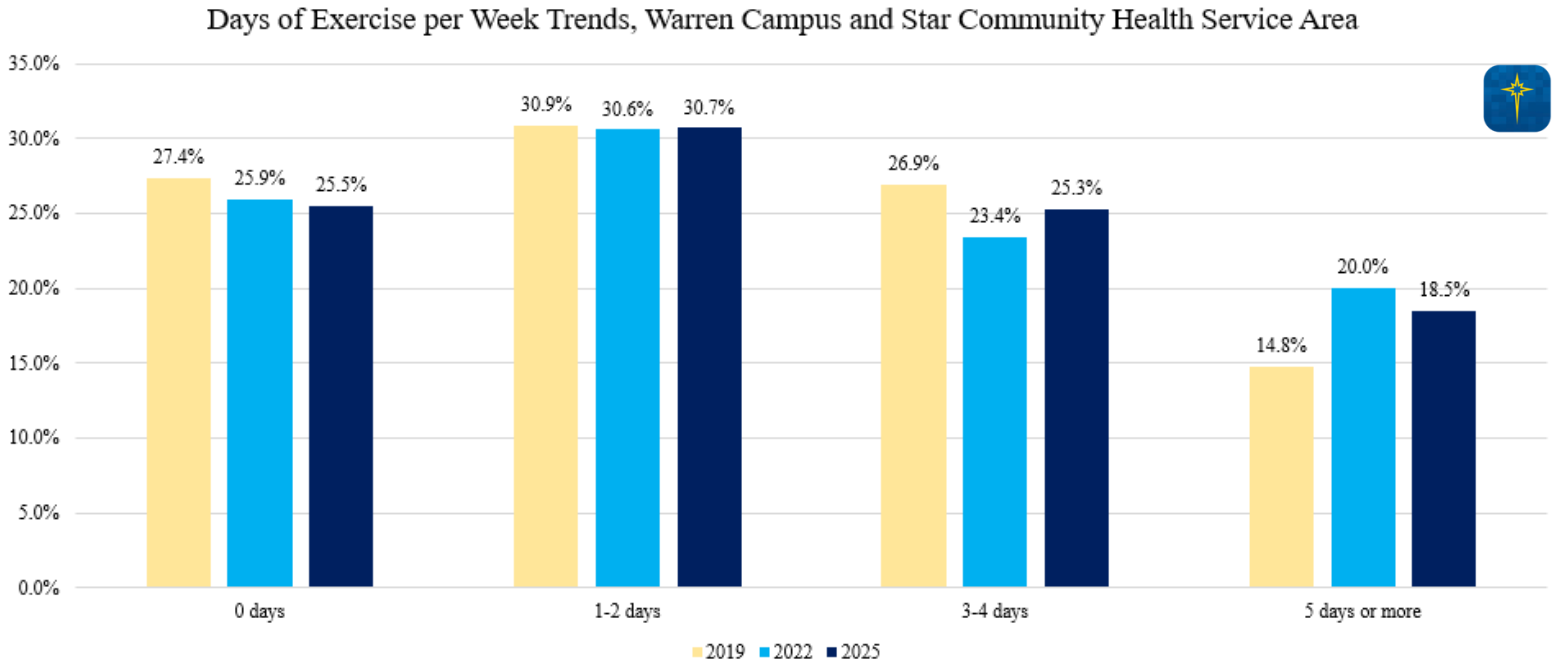
The prevalence of childhood obesity has increased dramatically in recent years, with other comorbidities increasing in children living with diabetes (e.g., diabetes, hypertension). The most recent TFAH (2022) report found that 15.4% of children ages 2-4 and 13.8% of children ages 10-17 are obese in New Jersey.

Physical Activity

According to Healthy People 2030, physical activity and exercise contribute to a healthy lifestyle and can help to prevent disease, disability, injury, and premature death. Physical activity includes any movement that expends energy, including daily tasks, recreational activities, and occupational tasks. Exercise refers to planned, structured, and repetitive movements aimed at improving or maintaining physical fitness. Regular physical activity and exercise can enhance cardiovascular health, strengthen muscles and bones, improve mental health, and help individuals maintain a healthy weight. Healthy People 2030 aims to reduce the proportion of adults who "engage in no leisure-time physical activity" and increase the proportion of adults who meet current physical aerobic physical activity recommendations of exercising 5 or more days a week for 30 minutes. The target goal by 2030 is 21.8 percent, and as of 2022 the nation was at 26.3 percent of individuals that did not participate in physical activity in their free time. This aligns with the CDC data that shows fewer than one in four children get enough physical exercise and one in five adults meet physical activity guidelines.

The County Health Rankings and Roadmaps (2024) measure physical inactivity as the percentage of adults 20 years old and over reporting no leisure-time physical activity. New Jersey has 23% of adults who report no leisure-time physical activity. Hunterdon County has 18% of adults that report no leisure-time physical activity and Warren County has 23% of adults reporting no leisure-time physical activity.

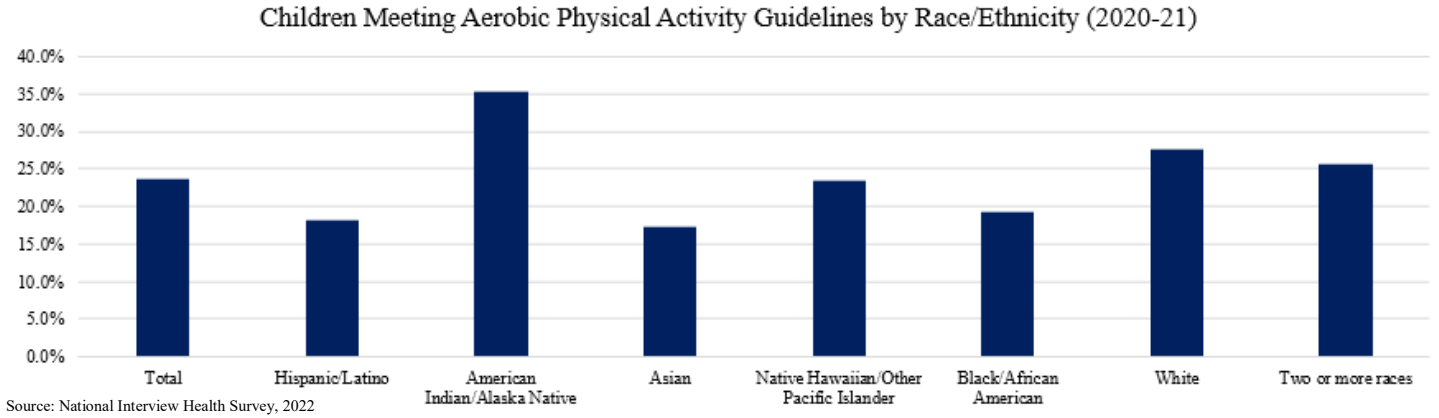
In the CHNA survey, 25.5% of respondents reported no physical activity, a decrease from 2022 and 30.7% of respondents reported 1-2 days, which remained consistent with 2022. Changes in the trend occurred mostly between respondents who reported 3-4 days of physical activity per week and those with five or more, with a decrease of 1.5% in respondents that reported meeting the Healthy People 2030 recommendation of five or more days. This is a concerning trend, as physical activity is important for both disease prevention and a healthy lifestyle.



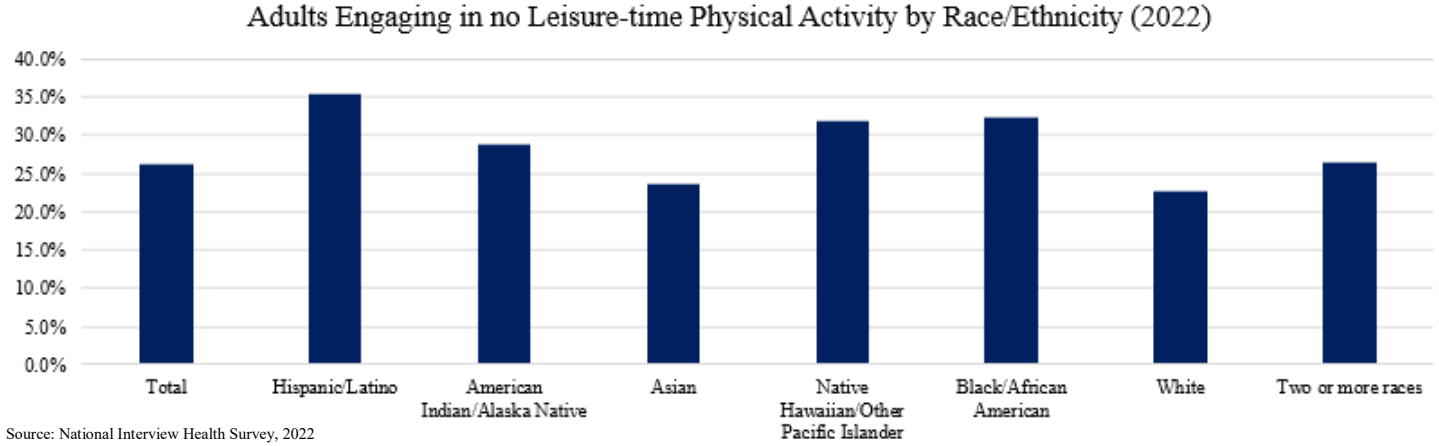
····· Vulnerable Populations ·····

Physical activity levels vary greatly across different populations based on socio-economic, cultural, and environmental factors (e.g., age race. ethnicity, socioeconomic status). Minority populations, including Black and African American, Hispanic, and American Indian or Alaska Native populations are the least likely to engage in leisure-time physical activity, while White and Asian populations are the most likely to engage in leisure-time physical activity. According to Americas Health Rankings Senior Report (2024), 29.5% of older adults in fair or good health in New Jersey were physically inactive compared to 30.9% nationwide.

Healthy People 2030 objective to increase the proportion of children who do enough aerobic physical activity has a target goal of 30.4%, meaning that by 2030 30.4% of children should meet the current aerobic physical guideline of at least 60 minutes of physical activity per day. The most recent data (2021) reports that only 23.6% of children meet that goal, and the trend is decreasing. When analyzed by race, American Indian and Alaska Native children were the most likely to meet the goal (35%) and Asian children were the least likely (17.2%). For adults, Black (32.3%) and Hispanic (35.3%) populations were the least likely to engage in leisure-time physical activity and White (22.8%) and Asian (23.7%) were the most likely to engage in leisure-time physical activity.



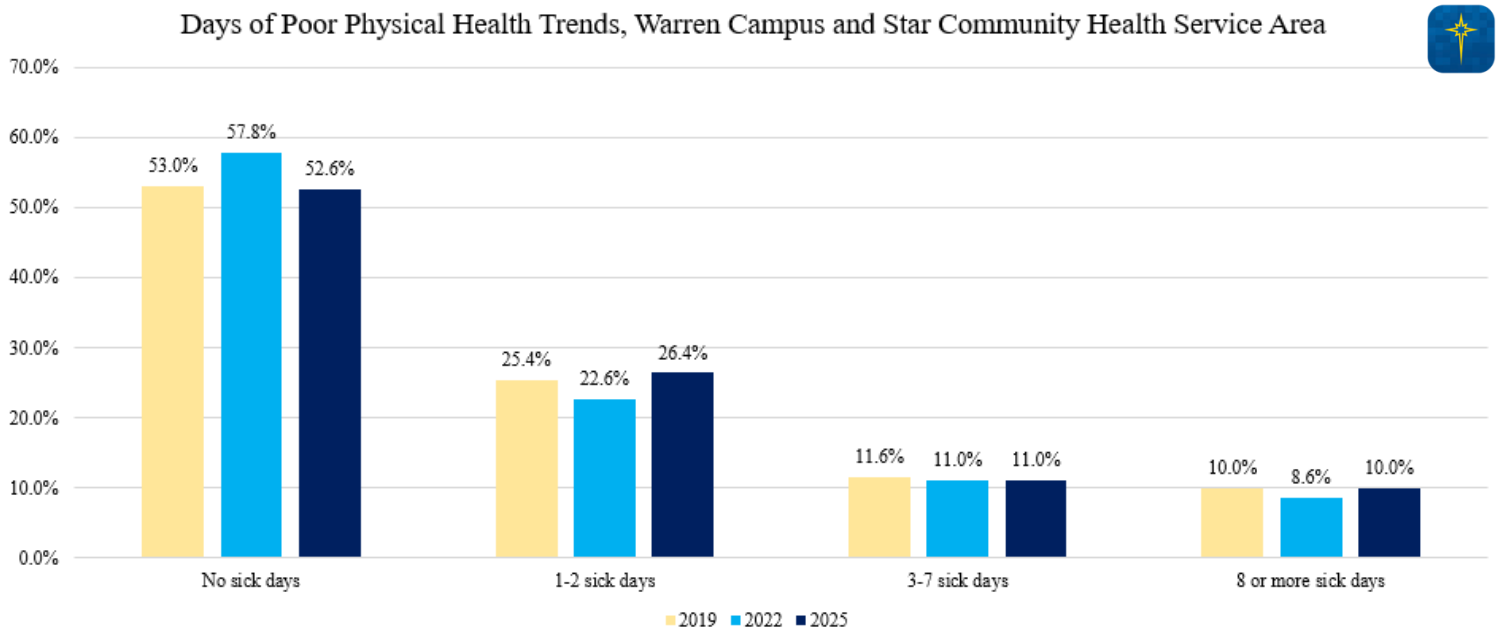
Source: National Interview Health Survey, 2022



Source: National Interview Health Survey, 2022

Days of Poor Physical Health

According to Healthy People 2030, daily physical activity can prevent disease, disability, injury, and premature death. County Health Rankings and Roadmaps (CHR&R) assesses the number of poor physical health days people experience since it can be a predictor for negative outcomes associated with health such as unemployment, poverty, and mortality. The poor physical health days question is measured by the average number of physical unhealthy days in the past 30 days. In New Jersey, the average is 3.2 unhealthy days with an average of 2.7 in Hunterdon county and 3.5 in Warren County. The majority of respondents indicated no sick days in the past 30 days (52.6%), but with a 5.2% decrease from 2022. The increasing trend shows that 3.8% more respondents reported 1-2 sick days (26.4%) and 1.4% reported eight or more sick days (10.0%). Respondents reporting 3-7 sick days remained the same as 2022.

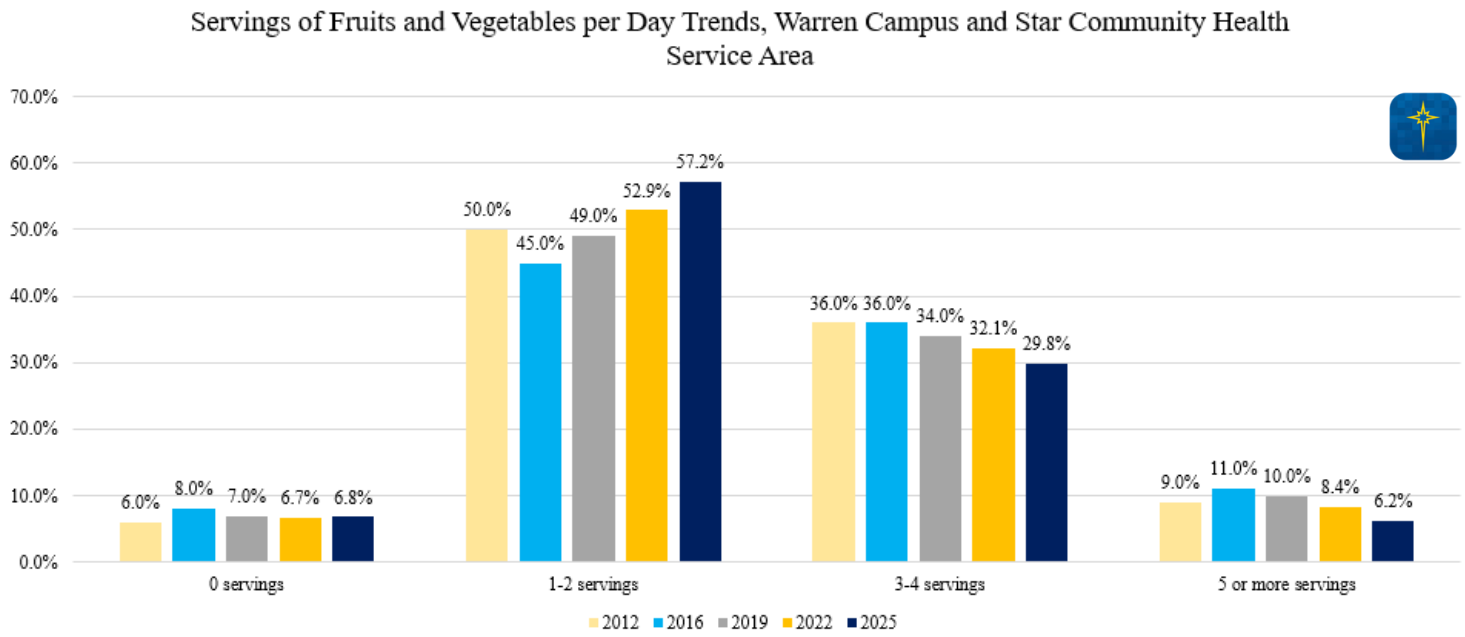


Diet

Diet (i.e., fruit and vegetable consumption) plays a large role in overall health and reducing chronic disease. The CDC states that eating a diet filled with a variety of fruits and vegetables can reduce the risk of type 2 diabetes, certain cancers, and cardiovascular disease, all of which play a role in the top leading causes of death nationally.

Released in February 2021, the CDC surveyed adults 20 years and older, finding that the majority of adults consumed a serving of fruit (67.3%) or vegetable (95%) on a given day, with more women reporting eating a serving of a fruit and vegetable on a given day than men. Additionally, America's Health Rankings surveyed adults across the country asking respondents to indicate consuming two or more servings of fruit and three or more servings of vegetables daily (five servings total). In New Jersey, 11.4% of adults consume two or more servings of fruit and three or more servings of vegetables daily compared to 7.4% of adults in the U.S.

In the 2025 CHNA survey, only 6.2% of respondents eat the recommended five or more servings of fruits and vegetables a day, a 2.2% decrease from 2022. The majority of respondents eat 1-2 servings a day (57.2%), a 4.3% increase from 2019. Additionally, only 0.8% of respondents consumed 7 or more vegetables a day, which was combined with 5-7 servings a day as this answer choice was not given on the previous surveys. Furthermore, looking at fruits and vegetable consumption by income shows that serving size increases with income. Of respondents who earn less than $14,999, 88.7% do not consume any vegetables or have 1-2 servings of fruits and vegetables a day. The majority of respondents in each income bracket consume 1-4 servings of fruits and vegetables a day.



Vulnerable Populations

Healthy People 2030 set two general goals, as well as numerous targeted goals (e.g., reduce iron deficiency in children aged one to two years old) related to nutrition and healthy eating. The two general goals, increase fruit consumption by people aged two and over and increase vegetable consumption by people aged two and over, are used to help understand general eating patterns and behaviors for the population. The goal for fruit consumption is 0.56 cup equivalents per 1,000 calories and vegetables is 0.84 cup equivalents per 1,000 calories. As of 2020, data shows that only 0.49 cup equivalents of fruit per 1,000 calories and 0.73 cup equivalents of total vegetables per 1,000 calories were being consumed, indicating little or no detectable change. According to America's Health Rankings Senior Report, 12.2% in New Jersey have adequate fruit and vegetable consumption, compared to 7.3% nationwide.

Sexual Activity

Healthy People 2030 reports that there are more than 20 million new cases of preventable sexually transmitted infections (STI) in the United States each year. Healthy People 2030 objectives are to increase knowledge and education of sexual education across adolescents and adults and decrease the rate of STIs and sexually transmitted diseases (STDs). Adolescents may experience developmental changes that affect physical and mental health, potentially increasing risky behaviors. Risky behaviors increase the chances of STIs and teen pregnancy. Healthy People 2030 objectives for teen pregnancy are to reduce pregnancies in adolescents, increase the percentage of adolescents using effective birth control, and to increase the proportion of adolescents who receive formal sexual education before 18 years old.

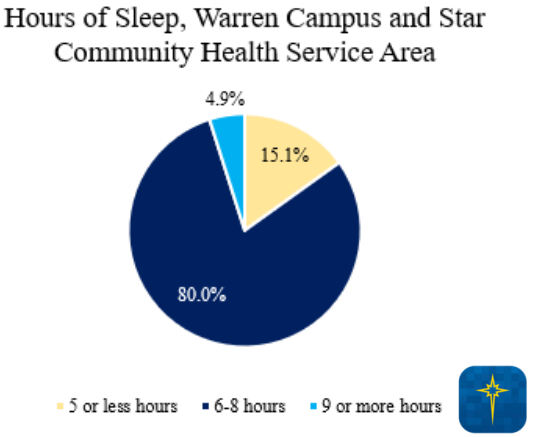
The Robert Wood Johnson Foundation's County Health Rankings and Roadmaps assess two sexual activity measures: STI and teen births. The 2024 rankings use STI data that reflects the number of new chlamydia cases per 100,000 population. These rates are important to assess because chlamydia is the "most common bacterial sexually transmitted infection (STI) in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain." The CDC reports that rates of chlamydia and gonorrhea are highest among females during their adolescent and young adult years in New Jersey, the rate of new cases is 360.7 per 100,000 population with 247.4 in Warren County and 121.6 in Hunterdon County.

There are also strong connections between teen birth and poor socioeconomic and/or mental health outcomes. County Health Rankings also found that teenage mothers who give birth are less likely to achieve an education level beyond high school and are more likely to experience psychological distress. The measure is represented by the number of births per 1,000 female population ages 15-19 years. In New Jersey, the rate is 10 teen births per 1,000 population with a rate of seven in Warren County and two in Hunterdon County. In addition to the impact of teen pregnancy on mothers, the prevalence of low birthweight in teen pregnancy is significant. Low birthweight is when a baby is born weighing less than 5 pounds, 8 ounces. Approximately 8% of babies in the United States are born with low birthweight. A low birthweight may have significant complications, including birth defects, infections, trouble eating, and trouble gaining weight. Teen mothers (and mothers over 40) are most likely to have a low birthweight child. Hunterdon County has a lower rate of low birthweight (6%) compared to New Jersey's rate of low birthweight of 8%. Warren County has a 8% rate of low birthweight.

Sleep

Sleep is an important part of a healthy lifestyle and a lack of sleep can have serious and negative health effects. Healthy People 2030 reports that approximately 1 in 3 adults do not get enough sleep. Ongoing sleep deficiency has been linked to numerous health conditions such as heart disease, stroke, depression, and anxiety. Objectives for Healthy People 2030 include the reduction of motor vehicle crashes due to drowsy driving, to increase the proportion of children who get sufficient sleep, and to increase the proportion of adults who get sufficient sleep. The County Health Rankings and Roadmaps assessed the percent of adults who report less than an average of seven hours of sleep per night, with 32% in New Jersey, 30% in Warren County, and 29% in Hunterdon County.

When asked to indicate, on average, the number of hours they sleep in a 24-hour period, the majority of respondents in the Warren Campus and Star Community Health service area reported 6-8 hours of sleep (80.0%), 4.9% of respondents get nine or more hours, and 15.1% of respondents get five hours or less.



Mental Health

Mental health has been an increasing issue during the last decade, with significant increases since 2020, in part due to the COVID-19 pandemic. Mental health disorders can affect people of all age and racial groups, but some populations have disproportionately higher rates of diagnosis. Mental health disorders (e.g., anxiety, depression) can affect a person's ability to take part in healthy behaviors and result in physical health problems making it harder for them to get treatment for mental health disorders. Goals related to improving mental health for Healthy People 2030 are to increase the proportion of people with substance use and mental health disorders who get treatment for both, increase the proportion of children and adolescents with symptoms of trauma who get treatment, increase quality of life for cancer survivors, reduce the suicide rate, and increase the proportion of public schools with a counselor, social worker, and psychologist. To help reach, educate, and connect people with mental health disorders to care, there is a local National Alliance on Mental Illness (NAMI) or related chapter in each St. Luke's service area; NAMI Warren county.

According to the State of Mental Health in America 2024 Report, 23% of adults (60 million people) experiences a mental illness in the past year, compared to 19.86% of adults in 2022. One in four adults with frequent mental distress could not see a doctor due to cost, a 2% increase since 2022 and 5% of adults reported experiencing thoughts of suicide. In 2022, the number of deaths by suicide was recorded in the United States.

The report ranks states on their prevalence rates and access to mental health care for adults and youth. States ranked 1-13 have lower prevalence and higher access to care, while 40-51 (including The District of Columbia) have higher prevalence rates and lower access to care. For overall adult rankings, New Jersey ranks 5th and Pennsylvania ranks 10th. For adult rankings, New Jersey ranks 2nd and Pennsylvania ranks 7th. For overall youth ranking, New Jersey ranks 10th and Pennsylvania ranks 13th. States ranked 1-13 have a lower prevalence of mental illness and higher rates of access to care. Contrarily, states that are ranked 39-51 indicate a higher prevalence of mental illness and lower rates of access to care. The 2024 report indicated that 23% of Americans report experiencing any mental illness (AMI) which is characterized as having a diagnosable mental, behavioral, or emotional disorder other than a developmental or substance use disorder. New Jersey ranks 2nd with a 16.4% prevalence rate and Pennsylvania ranks 18th with a 19.7% prevalence rate. The Access to Care ranking indicates how much access to mental healthcare exists within a state (e.g., access to insurance, access to treatment, quality and cost of insurance, access to special education, mental health workforce availability). A high access ranking indicates that a state provides relatively more access to mental healthcare than those ranked 39-51. New Jersey is ranked 21st and Pennsylvania is ranked 10th.

State of Mental Health in America (2022), State Adult Rankings			
	NJ%	NJ Rank	United States
Adults with any Mental Illness (AMI)	16.4%	1	19.9%
Adults with Substance Use Disorder in the past year	6.7%	6	7.7%
Adults with serious thoughts of suicide	3.8%	1	4.6%
Adults with AMI who are uninsured	10.6%	25	11.1%
Adults with AMI who do not receive treatment	57.1%	38	55.9%
Adults with AMI reporting an unmet need	21.6%	6	24.7%
Adults with cognitive disability who could not see a doctor due to costs	25.2%	18	29.7%

····· Depression and Anxiety ·····

Depression is a significant issue facing the U.S. and the residents of our service area. The National Institute of Mental Health (NIMH) define depression as a mood disorder that causes "severe symptoms [that] affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks." Some signs of depression are, but not limited to: persistent sad mood; feelings of hopelessness or pessimism; decreased energy or fatigue; difficulty concentrating, remembering, or making decisions; and thoughts of death or suicide. Depression can happen at any age but is more common in adulthood.

In midlife or older adults, depression can co-occur with other serious medical illnesses like diabetes, cancer, heart disease, and Parkinson's disease. Some risk factors include personal or family history of depression, major life changes, trauma, or stress, and certain physical illnesses and medications. Depression can be treated with medications, psychotherapy (counseling), or a combination of both. The New Jersey Department of Health reported in 2021 that 18.2% of people in the state were diagnosed with depression, with 22.0% of Warren County residents and 28.9% of Hunterdon County residents diagnosed.

Anxiety is another common mental disorder that affects people across the country. Anxiety is a normal part of life, but for a disorder, it is more than temporary worry or fear. The NIMH says "for a person with an anxiety disorder, the anxiety does not go away and can get worse over time. The symptoms can interfere with daily activities such as job performance, schoolwork, and relationships." Risk factors for anxiety disorders differ for each disorder, but generally include temperamental traits of shyness or behavioral inhibition in childhood, exposure to a stressful or negative life or environmental events in early childhood or adulthood, a history of anxiety in relatives, and some health conditions. Anxiety disorders can be treated with psychotherapy, medication, or a combination. Generalized Anxiety Disorder (GAD) displays excessive anxiety or worry, most days for at least 6 months, about a number of things, causing significant problems in areas of life like social interactions, school, and work. In 2022, the Anxiety and Depression Association of America (ADAA) found that GAD affects 3.1% of the U.S. population, however only 43.2% of those affected are receiving treatment.

····· Suicide ·····

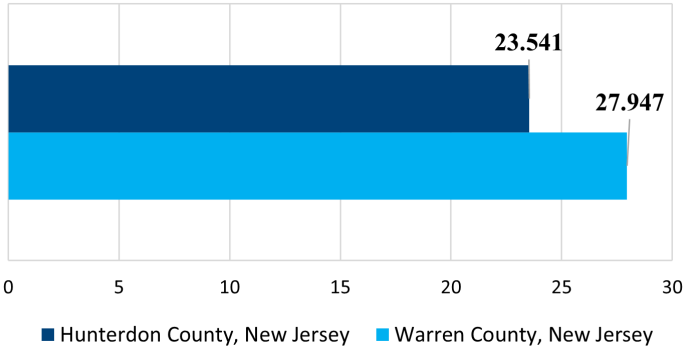
Suicide is a serious public health issue the United States and affects individuals of all ages, genders, cultures, races, and backgrounds. While some populations are statistically at higher risk than others (e.g., LGBT+, veterans, adolescents), there are many factors that contribute or are correlated with suicide, including mental health disorders (e.g., depression, anxiety), substance use, traumatic experiences, and socio-economic stressors.

Suicide involves dynamic interactions between national and community issues, families and relationships, and individual health and/or well-being. It has become a growing concern and was the 11th leading cause of death among all ages in the United States in 2021. The CDC found the provisional number of suicides in 2022 (49,449) was 3% higher than the final 2021 number. Provisional data provides an early estimate of deaths before the release of final data. Suicide rates increased 37% between 2000-2018 and decreased 5% between 2018-2020. After the pandemic, rates returned to their peak for 2022 (14.2 per 100,000). While the long-term effects of the pandemic on the general population, the economy, and vulnerable groups is still unknown in many ways, the impact on mental health and suicide risk is trending in a negative direction. Therefore, responses to suicide should target the whole population, focusing on particular risk factors like financial stressors, alcohol consumption, isolation, and access to care.

A CDC Suicide Mortality report in the United States from 1999-2021 was released April 2023, outlining the suicide rate during a 10-year period. The age-adjusted rate in 2021 was 14.1 per 100,000 people, which is slightly lower than the rate in 2020 (13.5). In 2021, the National Hospital Ambulatory Medical Care Survey (NHAMCS) reported 660,000 emergency visits for self-harm. Mental Health America data (2023) indicates that, in New Jersey, Warren County had 27.947 per 100,000 individuals reporting suicidal ideation and Hunterdon County had the lowest of all SLUHN service areas with 23.541 per 100,000.

In response to the growing suicide rates, New Jersey made state suicide prevention plans. New Jersey's prevention plan was released for 2014-2017 with ten goals, including awareness that suicide is preventable; to improve and expand surveillance systems; and to develop and implement strategies to reduce the stigma.

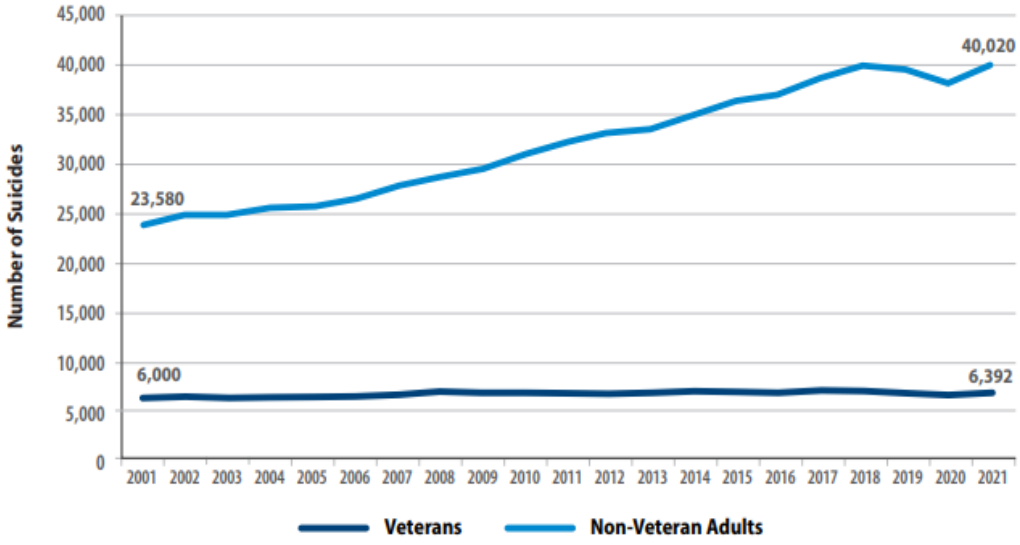
Number of People Reporting Frequent Suicidal Ideation per 100K of County Population



Source: CDC Suicide Mortality Report 2023

Vulnerable Populations

Another population particularly vulnerable to suicide is Veterans. A 2023 National Veteran Suicide Prevention Report by the U.S. Veterans Affairs found that in 2021, 6,923 veterans died by suicide, an increase of 114 from 2020. When looking at age-adjusted and sex-adjusted suicide rates, veterans suicide rates increased 11.6% between 2020 and 2021, compared to 4.5% for the general population. In 2021, suicide was the 13th leading cause of death for veterans overall, and the second leading cause of death for Veterans under 45 years old. The unadjusted suicide rate was 19.7 per 100,000 for Veterans with Hispanic ethnicity, compared to 33.4 per 100,000 for other Veterans. Suicide rates in veterans tend to be affected by economic disparities, homelessness, unemployment, disability status, community connection, and personal health and well-being. Veterans served by the Veterans Health Administration (VHA) who die by suicide are more likely to have sleep disorders, traumatic brain injuries, or a mental health disorder diagnosis. These suicide rates tend to be higher in individuals who live in rural areas and individuals who are isolated.



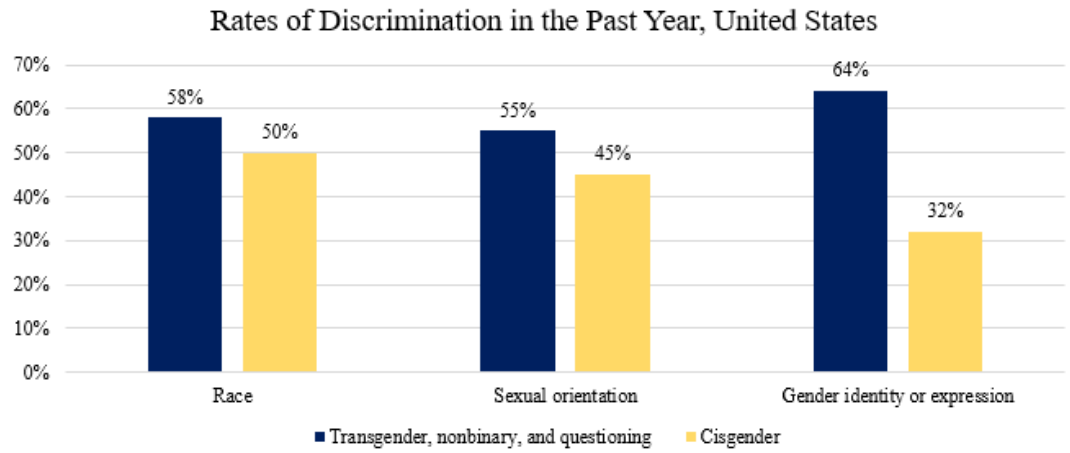
The 2024 State of Mental Health in America Report also ranked states by youth measures, with 20% of youth ages 12-17 reporting they suffered from at least one major depressive episode in the past year, up from 15.08% in 2022. A major depressive episode is "a period of two weeks or longer in which a person experiences certain symptoms of major depression: feelings of sadness and hopelessness, fatigue, weight gain or weight loss, changes in sleeping habits, loss of interest in activities, or thoughts of suicide." Additionally, 53.7% of youth in Pennsylvania and 56.4% of youth in New Jersey dealt with a major depressive episode in the last year with an unmet need for treatment, compared to 48.3% nationwide. Of youth nationwide not receiving care, 86.9% reported that they should have been able to handle their mental healthcare on their own.

State of Mental Health in America 2022 State Youth Rankings			
	NJ%	NJ Rank	US
Youth with at least one Major Depressive Episode (MDE) in the past year	12.71%	3	15.08%
Youth with Substance Use Disorder in the past year	3.33%	4	4.08%
Youth with severe MDE	8.4%	9	10.6%
Youth with MDE who did not receive mental health services	57.1%	38	55.9%
Youth with severe MDE who recived some consistent treatment	28.4%	25	27.2%

Suicide is the third leading cause of death for New Jersey youth between 10 and 24 years of age. In 2023, the National Vital Statistics Report and CDC released a 2022 provisional estimate of suicide by demographic characteristics in the United States. The number of suicides for males increased 2% from 38,358 in 2021 to 39,255 in 2022. The number of suicide for females increased 4% from 9,825 to 10,194. Of the races presented in the report (Hispanic, Non-Hispanic American Indian and Alaska Native, Asian, Black, and White) the highest rate was American Indian and Alaska Native people at 26.7 deaths per 100,000 standard population. All of the female groups increased in suicide rates from 2021-2022, with a significant increase for only White females (3% increase from 7.1 to 7.3).

The Movement Advancement Project (MAP), as mentioned in the Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) section, 4.1% of individuals living in New Jersey identify as LGBTQ+. LGBTQ+ individuals are considered a vulnerable population due to the unique challenges and systemic barriers they face due to discrimination, stigmatization, and a lack of legal protections that often contribute to poor health outcomes. The Trevor Project's 2021 National Survey of LGBT+ Youth Mental Health revealed that 19.0% of LGBT+ youth aged 13–18 and 8.3% of those aged 19–24 reported attempting suicide in the past year. When these rates are applied to the estimated number of LGBT+ youth in the U.S., it translates to approximately 503,073 youth aged 13–18 and 209,917 youth aged 19–24, totaling 712,990 LGBT+ youth aged 13–24 who attempted suicide in the past year.

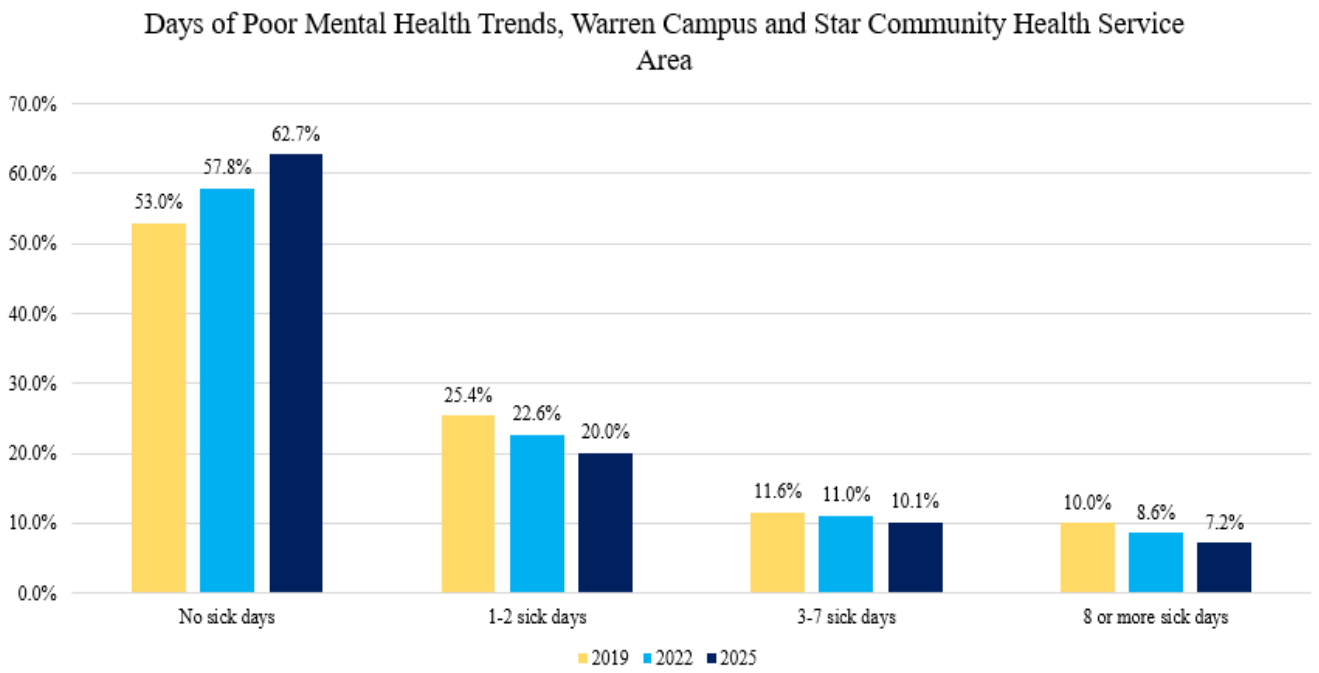
Additionally, over one in five (21%) Black transgender, nonbinary, or questioning young people reported attempting suicide in the past year. This rate is more than double that of Black cisgender LGBT+ young people (8%). More than one-third (32%) of Black cisgender LGBT+ young people seriously considered suicide in the past year, compared to just over half (51%) of Black transgender, nonbinary, or questioning young people.



Source: Trevor Project, 2021

Days of Poor Mental Health

Poor mental health days is important to assess because it can be a good indicator for overall well-being. The County Health Rankings and Roadmaps assesses poor mental health days by the average number of mentally unhealthy days in the past 30 days. The poor mental health days question is measured by the average number of mentally unhealthy days in the past 30 days. The New Jersey overall average is 4.4 unhealthy days with 5.2 in Warren County and 4.4 in Hunterdon County. The majority of CHNA respondents indicated no mentally unhealthy days in the past 30 days (62.7%), which is trending in a positive direction with 4.9% more respondents reporting no sick days. There were 20.0% respondents that indicated 1-2 sick days, 10.1% indicated 3-7 sick days, and 7.2% indicated eight or more sick days in the past 30 days, which is a slight decrease from 2022.



Substance Use

According to Healthy People 2030, more than 20 million adults and adolescents in the United States experienced a substance use disorder (SUD) in 2023. SUD can involve illicit drugs, prescription medications, or alcohol, with opioid use disorders causing an epidemic across the country. These disorders are associated with numerous health issues (e.g., mental health, cancer, heart attack, stroke), and overdoses often result in emergency department visits and fatalities. Healthy People 2030 aims to prevent drug and alcohol misuse and ensure that individuals with substance use disorders receive the necessary treatment. There are numerous targeted goals (e.g., reduce the proportion of people who used heroin in the past year) and other more general goals. The general goals help to encompass large populations and support preventative measures to reduce SUD. The goal is to reduce drug overdose deaths by 2030 is 20.7 per 100,000. As of the most recent update (2021), drug overdose deaths were 32.4 per 100,000 with deaths projected to increase. The goal to reduce the proportion of adults who used drugs in the last month has a goal of 12%, meaning that by 2030 the goal would be to have 12% or less of adults 18 years and over who reported use of illicit drugs in the past 30 days. The most recent data from Healthy People 2030 (2019), shows that 13.4% of individuals 18 years and older reported use of illicit drugs in the past 30 days, indicating a trend in a negative direction.

In 2022, New Jersey Drug and Alcohol Abuse Treatment did a Substance Abuse Overview of their counties. There were 85,266 treatment admissions and 84,437 discharges reports to the New Jersey Department of Human Services, Division of Mental Health and Addiction services by substance abuse treatment providers. In Warren County, there were 977 substance use admissions with the primary substance being alcohol (384) followed by heroin (345). Hunterdon County had 731 substance admissions with the primary substance being alcohol (314) followed by heroin (253). Overall in New Jersey, there were 81,042 substance use admissions with the primary substance being heroin (30,413) followed by alcohol (29,295). Of the recent admissions, 30.9% were female and 69.1% were male. Of people admitted, 59% were White, 25% were Black, 15% were Hispanic, and 1% identified as another race.

SUD affects an individual's health, relationships, and are complex and highly specific to the individual. Although effective treatments for substance use disorders exist, a significant number of individuals do not receive the care they need. Emphasis should be placed on implementing strategies to prevent substance use, especially among adolescents, and facilitating access to treatment can help reduce drug and alcohol misuse, associated health problems, and deaths. A substance use and suicide study done by Substance Abuse and Mental Health Services Administration (SAMHSA) in 2023 found that one in four adults in the U.S. used illicit drugs in the past year. Of the 70.5 million people living in America that used illicit drugs in 2023, 61.8 million used marijuana and 8.8 million used other drugs. Approximately 1 in 30 individuals misused central nervous system stimulants (e.g., cocaine, methamphetamines), with 1.4 million individuals misusing prescription CNS stimulants, a decrease from 1.5 million individuals in 2022. According to the SAMHSA Nation Substance Use and Mental Health Services Survey, there were 388 facilities in New Jersey that supported 35,227 clients. Of the clients supported in New Jersey, 85.6% of clients had both alcohol and other substance use disorders, compared to 82.6% nationwide.

..... Alcohol .....

Alcohol misuse refers to drinking alcohol in a situation, amount, or frequency that could cause harm to the person who drinks or to those around them (e.g., binge drinking, heavy drinking, alcohol use disorder). These patterns of drinking can lead to numerous health issues, including liver disease, heart problems, and increased risk of accident and injury.

Prevalence, Risks, and Consequences of Alcohol Use, United States (2022)		
	Total	Percent of the Population
Past-Year Alcohol Use	174,339,000	62.3%
DSM-5 Alcohol Use Disorder (AUD)	29,544,000	10.6%
Emergency Department Visits (all alcohol-related visits	4,936,690	1.8%
Alcohol-Related Deaths	140,557	0.1%

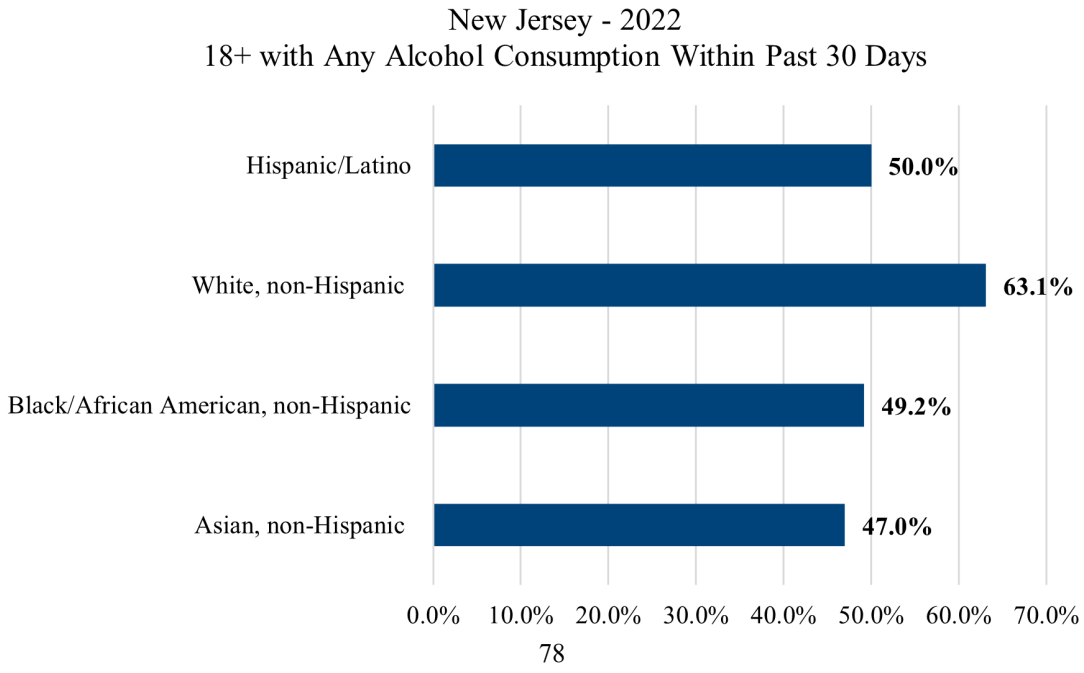
The National Institute on Alcohol and Alcoholism (2022) reported that 221.3 million people (78.5% in this age group) reported that they drank alcohol at some point in their lifetime. Of adults 18 years and older, 84.1% reported drinking alcohol at some point in their lifetime. Men aged 18 years and older are more likely to have consumed alcohol (85.9%) compared to women (82.4%). White adults (89.1%) are the most likely to have consumed alcohol at some point in their lives, compared to Mixed Race populations (84.6%), Hispanic or Latino (79.7%), Black or African American (75.8%), American Indian or Alaska Native (74.2%), and Asian (64.2%).

New Jersey's crude rate for alcohol-induced deaths was 7.9 per 100,000. New Jersey performs a Behavioral Risk Factor Surveillance System (BRFSS) to assess their states risk factors. Binge drinking is "defined as a pattern of drinking that brings a person's blood alcohol concentration (BAC) to 0.08 g/dl or above. This typically happens when men consume 5 or more drinks or women consume 4 or more drinks in about 2 hours." The CDC reports that binge drinking is the most common, costly, and deadly pattern of excessive alcohol use in the United States. Binge drinking can be associated with unintentional car crashes, violence, sexually transmitted diseases, fetal alcohol spectrum disorders, cancer, and more. Chronic drinking is when someone drinks more than the recommended one (women) or two (men) drinks a day, and more than seven (women) and fourteen (men) drinks in a week.

New Jersey's 2022 BRFSS used the term episodic heavy drinking (binge drinking) in last 30 days; 16.7% of New Jersey, 15.7% of Warren County, and 28.2% of Hunterdon County had episodic heavy drinking. Episodic heavy drinking is measured by "proportion of adults consuming at least 4 alcoholic drinks (females) or at least 5 alcoholic drinks (males) on a single occasion at least once during the past month". In New Jersey, 5.2% and 14.5% in Warren County are chronic heavy drinkers. Chronic heavy drinkers is measured by the "proportion of adults consuming more than 30 alcoholic drinks (females) or 60 alcoholic drinks (males) during the past month." When asked how many binge drinking episodes a respondent has had in the past month, 84.4% of respondents in the Warren campus and Star Community Health service area indicated no episodes. However, 5.8% have had 1-2 episodes in the past month and 9.8% had 3 or more episodes.

In 2022, the Census Bureau released a County Business Patterns (CBP) report. One of the businesses assessed were liquor stores. Liquor store access reports on places primarily engaged in retailing liquor and packaged alcoholic beverages, like beer and wine. This excludes places preparing alcohol for consumption (e.g., bars, restaurants) or places that sell alcohol as a secondary retail product (e.g., gas stations, grocery stores). Increased access to liquor stores gives individuals easier access and poses a higher risk of developing alcohol use and/or a substance use disorder. The number of liquor stores is reported per 10,000 population. Warren County has 8 liquor stores per 10,000 population, and Hunterdon County has 13 per 10,000 population.

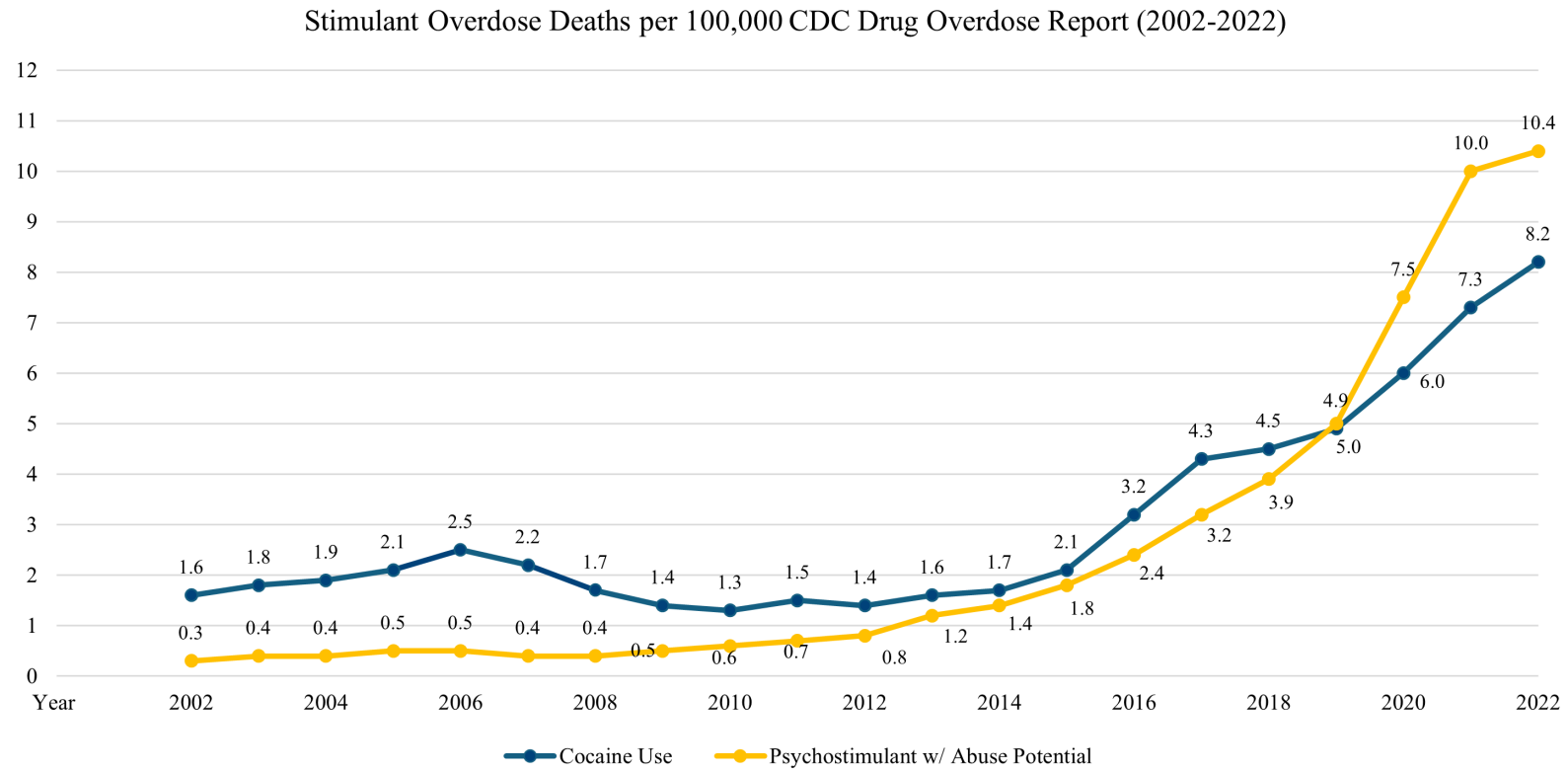
The Robert Wood Johnson Foundation released 2024 County Health Rankings on excessive drinking and alcohol impaired driving deaths. Excessive drinking measures the percentage of the county's adult population that reports binge or heavy drinking in the past 30 days. New Jersey reported 17% of the state's population excessively drinks, 18% in Warren county, and 20% in Hunterdon County. The US Department of Transportation National Highway Traffic Safety released a 2022 report assessing alcohol-impaired driving. Drivers are considered to be alcohol-impaired when their blood alcohol concentrations (BACs) are .08 grams per deciliter (g/dL) or higher. Alcohol reduces brain function and impairs thinking, which can hinder driving. Of total traffic fatalities in New Jersey, 26.0% were alcohol-impaired-driving traffic fatalities. Drivers 21-24 years old caused 29% of all alcohol impaired deaths. According to the 2022 BRFSS, White, non-Hispanic populations were the most likely to have had at least one drink in the past 30 days and Hispanic populations were the least likely to have had at least one drink the past 30 days.



..... Stimulants .....

The CDC Drug Overdose Report (2002-2022) indicates that the age-adjusted rate of drug overdose deaths increased from 8.2 deaths per 100,000 standard population in 2002 to 32.6 in 2022. The age-adjusted rate of drug overdose deaths involving cocaine increased from 1.6 deaths per 100,000 standard population in 2002 to 8.2 in 2022. It is important to note that the rate in 2022 was 12.3% higher than the rate in 2021 (7.3%). The age-adjusted rate of drug overdose deaths involving psychostimulants increased more than 34 times from 2002 (0.3%) to 2022 (10.4%).

Stimulants are dangerous and easily abused because they increase alertness, attention, and energy. An overdose of stimulants can result in symptoms such as rapid breathing, aggression, hallucinations, and overactive reflexes. The SAMHSA (Substance Abuse and Mental Health Services Administration) 2023 National Survey on Drug Use and Health reported that 1.8% of people in the United States 12 years and older used cocaine in the past year. This is highest among 26-29 years (3.7%) and 21-25 years (3.6%). An estimated 7.0% of people 12 years and older reported misuse of prescription stimulants in the past year. This is highest among people 26-29 years (4.2%) and 21-25 years (3.7%)



..... Tobacco .....

SAMHSA's 2023 National Survey on Drug Use and Health indicated that 61.2% of the population 12 years and older used any type of tobacco product. The New Jersey BRFSS found that 10.9% of New Jersey adults currently smoke cigarettes.

Percent of Adults who are Current Smokers	
Region	Percent
Warren	14%
Hunterdon	11%
New Jersey	11%
United States	15%

The Robert Wood Johnson 2024 County Health Rankings report on adult smoking using data from 2021. Cigarette smoking is an important data point to capture because it has been identified as a cause of various cancers, cardiovascular disease, and other adverse health outcomes. Measuring tobacco use can help St. Luke's and other health networks identify needs for smoking cessation and other smoking reduction programs. Adult smoking is measured as the percent of the adult population that report currently smoking every day or most days and have smoked at least 100 cigarettes in their lifetime.

In 2023, the CDC reported on youth tobacco use including data from the 2023 National Youth Tobacco Survey. CDC reports that tobacco use typically starts and is established during adolescence. Nearly 9 out of 10 adults who smoke cigarettes daily try smoking for the first time by age 18. In 2023, about 1 of every 100 middle school students (1.1%) reported that they had smoked cigarettes in the past 30 days and nearly 2 of every 100 high school students (1.9%) reported that they had smoked cigarettes in the past 30 days. For other tobacco products, 1.1% of middle school students reported using cigars, 0.7% reported using smokeless tobacco, 1.0% reported using hookah, 0.8% reported using heated tobacco products, and 0.4% reported using pipe tobacco. There were1.8% of high school students reported using cigars, 1.5% reported using smokeless tobacco, 1.1% reported using hookah, 1.7% reported using nicotine pouches, 1.0% reported using heated tobacco products, and 0.6% reported using pipe tobacco.

When asked about smoking, 20.8% of CHNA respondents in the Warren Campus and Start Community Health indicated they smoke. Of those who smoke, marijuana is the most common (5.0%), followed by cigarettes (4.9%), CBD (3.5%), vape (2.7%), cigars (2.0%), e-cigarettes (0.9%), hookahs (0.4%). Less than 0.3% of respondents used chewing tobacco, snuff, snus, or pipes. There was an increase in marijuana use in the Warren Campus and Star Community Health service area from the previous 2022 CHNA, which could be related to the legalization and decriminalization of marijuana in New Jersey in 2021.

..... Vape .....

Vaping is another form of smoking nicotine, a highly addictive substance that is especially harmful to children and adolescents. Vapes, also known as e-cigarettes or electronic cigarettes, are "electronic devices that heat a liquid and produce an aerosol or mix of small particles in the air."

Nicotine is most harmful for children and adolescents because the substance hinders brain development, which does not occur until approximately 25 years old. Particularly, nicotine impacts attention, learning, mood, and impulse control, all of which are built in and refined through childhood. The CDC found that flavorings in tobacco products can make them more appealing to youth. In 2021, 80.2% of high school students and 74.6% of middle school students who used tobacco products in the past 30 days reported using a flavored tobacco product during that time.

In 2023, these numbers increased with 90.3% of high school students and 87.1% of middle school students having used a flavored tobacco product during that time. When looking at overall electronic cigarette use — including unflavored products, the CDC and National Youth Tobacco survey reported about 1 out of every 22 middle school students (4.6%) have used electronic cigarettes in the past 30 days. Additionally, 1 of every 10 high school students (10.0%) report that they had used electronic cigarettes in the past 30 days.

According to the 2021 New Jersey Youth Risk Behavior Survey (YRBSS), 36% of New Jersey high school students have ever used electronic vapor products, 18% currently use electronic vapor products, 7.3% use electronic vapor products frequently, and 5.0% use them daily. Additionally, 6.8% reported they usually get their electronic vapor products by buying the products themselves in a convenience store, supermarket, discount store, or gas station.

Marijuana

Marijuana is a psychotropic drug that is commonly used throughout the United States. In the short-term, marijuana can alter senses, change mood, impair memory, and impair body movement. In the long-term, marijuana can affect thinking, memory, and learning functions crucial to brain development. Marijuana can also have physical effects which result in breathing problems and increased heart rate. On February 22, 2021 New Jersey changed the legal status of marijuana by regulating cannabis and decriminalizing unregulated marijuana and hashish for non-distribution offenses through the New Jersey Cannabis Regulatory, Enforcement, Assistance, and Marketplace Modernization Act.

SAMHSA's 2023 National Survey on Drug Use and Health indicated that 21.8% of people 12 years and older used marijuana in the past 12 months during 2023. Marijuana use was highest among people 21-25 (38.1%) followed by people 26-29 (29.6%).

In the Warren Campus and Star Community Health service area, 5.0% indicated use of marijuana, which is a 1.0% increase from respondents to the 2022 CHNA survey. Usage was similar between male (5.2%) and female respondents (5.6%), and highest in respondents that reported very good or good overall health (71.2%) compared to poor health (25%) or excellent health (2.8%). When looking at marijuana by age group, only 3% of respondents aged 65 years and older reported using marijuana, compared to 8.2% of 18-24 year olds, 15.3% of respondents aged 25-34 years, 4% of respondents aged 35-44 years, and 5.5% of respondents aged 55-64 years.

Opioids

The CDC reports that the opioid epidemic has occurred in three phases. First, prescription opioids increased in the 1990s with overdose deaths continually increasing since 1999. The second phase began around 2010 with increased overdoses involving heroin. Heroin is an alternative to prescription opioids due to its similar effect on the body. The third phase began in 2013 with the introduction of synthetic opioids (e.g., illicitly manufactured fentanyl). The CDC provides descriptions on the most commonly used opioids: prescription opioids, fentanyl, and heroin. Prescription opioids can be used to treat pain and are often prescribed following surgery, an injury or to manage a disease like cancer. However, there has been a dramatic increase in the prescription of opioids for chronic pain such as back pain or osteoarthritis, "despite serious risks and the lack of evidence about their long-term effectiveness." Prescription opioids are highly addictive and incredibly difficult to stop using. As many as one in four patients receiving long-term opioid therapy in a primary care setting struggle with an opioid addiction. Common prescription opioids are Methadone, Oxycodone (OxyContin), Hydrocodone (Vicodin), and Benzodiazepines such as Alprazolam (Xanax) and Diazepam (Valium).

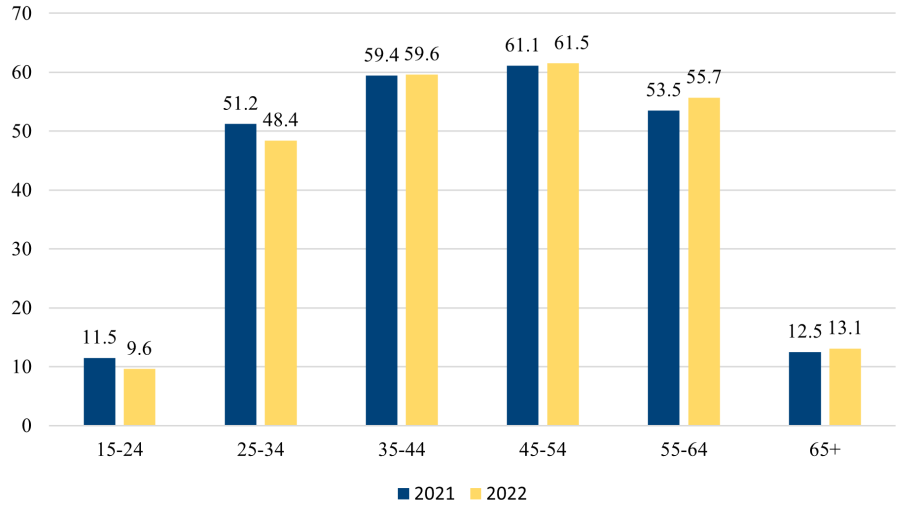
Fentanyl produced pharmaceutically is a synthetic opioid used to treat severe pain. It is 50 to 100 times more potent than morphine. However, the increase in overdose has been linked to illegally made fentanyl which has a heroin-like effect. According to CDC National Vital Statistics System, rates of overdose deaths involving synthetic opioids other than methadone, which includes fentanyl and fentanyl analogs, increased from 2002 (0.4 per 100,000 population) to 2022 (22.7 per 100,000 population). More than four out of five (81.8%) of deaths involved at least one opioid. Heroin is an illegal and highly addictive drug that is typically injected, and heroin use increases the risk of serious infections like HIV, Hepatitis C, Hepatitis B, and bacterial infections. Over 7% of all opioid overdose deaths in 2022 involved heroin. The number of heroin overdose deaths in 2021 was 3 times more than 2010.

Opioid use while pregnant can have severe negative outcomes for the child, potentially resulting in Neonatal Abstinence Syndrome (NAS). NAS births occur "in a newborn who was exposed to addictive substances while in the mother's womb. The most common opiate drugs that are associated with NAS are heroin, codeine, oxycodone (oxycontin), methadone and buprenorphine". The effects of NAS usually occur within 48-72 hours of birth, suffering from withdrawal, low birth weight, tremors, vomiting, fever and more. New Jersey Department of Health reported a rate of 45.3 NAS cases per 10,000 births in 2022.

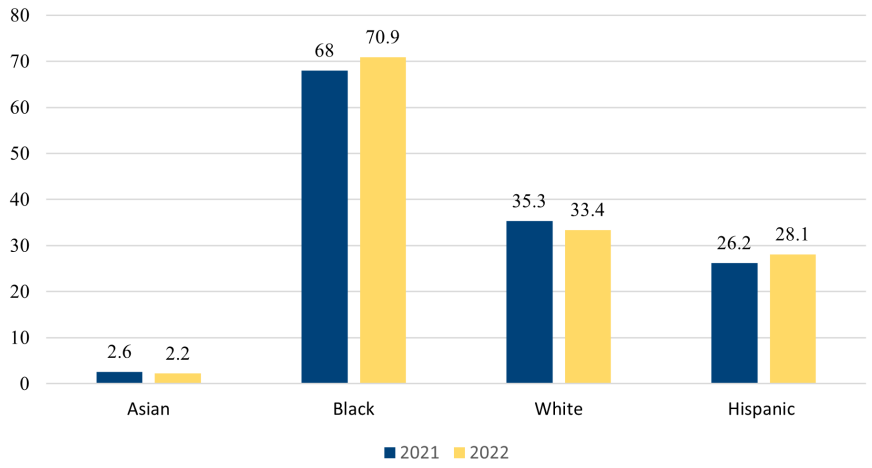
Overdose

Overdose is inextricably linked to substance use disorders, and is a growing concern with increasing prevalence rates, especially during the pandemic. Drug overdose deaths are the leading contributor to premature death and are largely preventable. According to CDC National Vital Statistics System, the age-adjusted rate of drug overdose deaths nearly quadrupled from 8.2 deaths per 100,000 in 2002 to 32.6 deaths per 100,000 in 2022. The NORC, National Opinion Research Center, reports on drug overdose deaths in the United States. From 2018-2021, there has been a rate of 46.9 drug overdose deaths per 100,000 people in the New Jersey, 44.5 in Warren County, and 21.2 in Hunterdon County.

Rate of Drug Overdose Deaths by Age, New Jersey



Rate of Drug Overdose Deaths, by Race and Hispanic Origin, New Jersey



Source: CDC State Unintentional Drug Overdose Reporting System

····· Stigma ·····

Stigma is another important component to substance use disorder regarding usage and receiving or accessing help. The Cambridge Dictionary defines stigma as "a strong feeling of disapproval that most people in a society have about something." Stigma may be a barrier to seeking help for people suffering from substance use disorders due to shame or fear of disapproval from family, friends, or others. Public stigma can lead to self-stigma, where individuals with substance use disorders internalize negative stereotypes from society, making these views part of their self-identity. Those with opioid use disorder often come to believe they are not valued members of society, which can cause feelings of guilt, self-loathing, shame, and despair. This self-stigma can result in various negative mental and physical health outcomes, such as increased anxiety and depression, a lower quality of life, and reluctance to seek social support or substance use treatment.

New Jersey has prioritized stigma reduction as part of its behavioral health initiatives. The New Jersey Department of Health has integrated behavioral health into its State Health Improvement Plan, focusing on reducing stigma through public education and community programs. One example is Stigma-Free Zones, which "means making a commitment to creating a safe, welcoming environment based on principles of tolerance and acceptance, without fear of ridicule, harassment, and bullying," as defined by Stigma Free Society (www.stigmafreesociety.com).

····· Naloxone ·····

Naloxone is a drug that can quickly reduce the effects of an opioid overdose. The National Institute of Drug Abuse define naloxone as "an opioid antagonist meaning that it binds to opioid receptors and can reverse and block the effects of other opioids. It can very quickly restore normal respiration to a person whose breathing has slowed or stopped because of overdosing with heroin or prescription opioid pain medications." Naloxone is safe and can be administered in three ways: injected, auto injected, or as a nasal spray. It is important to train people in numerous contexts (e.g., healthcare workers, community members, first responders, family members) to understand how to administer naloxone as it can quickly save someone's life. In response to opioid use and substance use, The New Jersey Department of Health signed a standing order for all residents to get Naloxone from their local pharmacies without a personal prescription. Both New Jersey and Pennsylvania have a mail-to-home Naloxone program, allowing individuals to receive medication after a short online training.

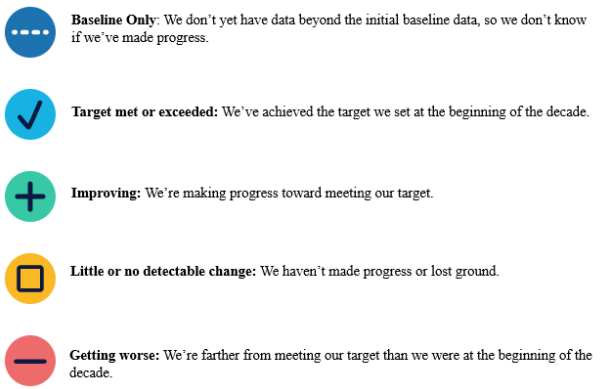
····· Warm Hand Off (WHO)·····

WHO is an initiative to support the continuum of care for patients in need of multiple services and providers. It is a transfer of care between providers with the patient (and potentially family) present to ensure clear communication, transparency, and helps to build relationships between patients and providers. St. Luke's collaborates with local community-based organizations and local county to support WHO efforts. During 2024 at SLUHN Hospitals, a total of 1,776 WHO were conducted for alcohol, cannabis, cocaine, opioids, and other stimulants. In the Warren Hospital, a total of 167 WHO were conducted for alcohol, cannabis, cocaine, opioids, and other stimulants during FY24.

Social and Community Context

Social and community context is the basis for people's relationships and interactions with family, friends, co-workers, and community members. Negative social and community context can lead to unsafe neighborhoods, discrimination, chronic stress, poor mental health, and limited access to healthcare, which can lead to negative health outcomes. Healthy People 2030 focuses on improving health and safety in the places where people are born, live, learn, work, play, worship, and age. These objectives are designed to address social and community context as a social determinant of health, recognizing the economic and societal factors are intrinsically linked to health outcomes.

According to Healthy People 2030, the following objectives are social and community context and are measured at the national level. Most Healthy People 2030 objectives are core, or measurable, objectives that are related to targets outlined for the decade (2020-2030). Evidence-based interventions are supported through national, state, and local initiatives. Progress is measured using a variety of data sources (e.g., US Census, ACS estimates, state and county data) and is measured using the following indicators: Baseline only, target met or exceeded, improving, little or no detectable change, getting worse. The objectives outlined have corresponding updates at the national level as of June 2024.



Healthy People 2030 Objectives for Social and Community Context	Baseline	Target	Most Recent Data	Progress (June 2024)
Increase the proportion of adults who talk to family or friends about their health	86.9% aged 18+ years (2017)	92.3%	79.6% (2022)	Getting worse
Reduce the proportion of children with a parent or guardian who has served time in jail or prison	7.7% 17 years and younger (2016-17)	5.2%	6.5% (2020-21)	Improving
Increase the proportion of adolescents who have an adult they can talk to about serious problems	79.0% aged 12-17 years (2018)	82.9%	78.3% (2019)	Little or no detectable change
Increase the proportion of people with diabetes who get formal diabetes education	51.7% aged 18+ years (2017)	55.2%	48.0% (2022)	Little or no detectable change
Increase the proportion of children and adolescents who communicate positively with their parents	68.5% aged 6-17 years (2016-17)	73.0%	62.0% (2020-21)	Getting worse
Increase the proportion of adults whose health care provider checked their understanding	26.6% aged 18+ years (2017)	32.2%	26.3% (2021)	Little or no detectable change
Increase the proportion of local jurisdictions that have a health improvement plan	67.2% (2016)	71.8%	65.0% (2022)	Little or no detectable change

Social Associations

Social association is a measure of the emotional and social support available to an individual. Social associations are often an organized group of individuals who come together based on shared interests, goals, or purposes. These groups typically have a structured system with rules, leadership, and membership. They can include professional, cultural, recreational, or political organizations and play a vital role in building community bonds and fostering collective action. Examples from County Health Rankings and Roadmaps include: activity programs for older adults, community arts programs, community centers, cross-age youth mentoring programs, extracurricular activities for social engagement, grocery/housing/utilities cooperatives, intergenerational communities, intergenerational mentoring and activities, land return for tribal restitution, neighborhood associations, and more.

Limited social interactions and minimal community involvement are linked to higher rates of illness and premature death. Studies indicate that the health risks of social isolation are comparable to those of smoking. Additionally, social support networks are strong predictors of health behaviors, with individuals lacking a robust social network being less likely to adopt healthy lifestyle choices. People in areas with high social trust are less likely to report poor health compared to those in areas with low social trust. It is suggested that social trust is bolstered when individuals participate in voluntary groups and organizations, as these memberships foster trust among group members.

One-Person Households by Age and Sex
U.S. Census Current Population Survey (2024)

Age	Male	Female
15-64 years	30.9%	27.6%
65-74 years	8.6%	12.6%
75+ years	6.1%	14.2%

The social associations indicator from County Health Rankings and Roadmaps measures the number of membership associations per 10,000 population. According to 2024 County Health Rankings, U.S. top performers scored 18 for social associations, while New Jersey social associations were 8.1 —falling below U.S. performers and bringing to light the need for more social supports and community building in our service areas. Hunterdon County social associations was 9.5 and Warren County social associations was 8.7.

The U.S. Census Bureau, Current Population Survey, released a 2024 report on America's Families and Living Arrangements from 1970 to 2022. In 2022, men aged 15-64 made up the largest share of one-person households (30.9%) while females were the most likely to be in a one-person household aged 75 years and older. The report also highlighted that the proportion of households consisting of a single person has increased significantly over the decades, with about 28% of all households being one-person households in 2022. Additionally, the data revealed that the number of young adults aged 18-24 living with their parents has risen, with 57% of men and 55% of women in this age group residing in their parental homes. According to the Pew Research Center (2019), economic factors such as rising housing costs and student debt have made it more challenging for young adults to afford independent living. This trend reflects broader changes in economic conditions and social norms over the past few decades, including delayed marriage and extended education becoming more common, leading to more young adults staying in their parental homes longer. While this can lead to positive social associations within multigenerational households, it can also limit social associations for young adults through increased family household connectedness and expectations.

Social Vulnerability

Social vulnerability refers to the demographic and socioeconomic factors that can negatively affect communities. The CDC Social Vulnerability Index (SVI) is a tool designed to help public health officials and emergency response planners identify communities that may need support before, during, or after disasters. By using sixteen U.S. Census variables, the SVI assesses the resilience of communities when confronted with external stresses on human health, such as natural disasters or disease outbreaks. The index ranks each community on a scale from zero to one, with higher values indicating greater vulnerability. This ranking helps prioritize resources and interventions to the most at-risk populations, ensuring that aid is distributed effectively and equitably.

The SVI is divided into four major themes, each encompassing specific indicators:

Socioeconomic Status: This theme includes indicators such as poverty, unemployment, income, and education level. These factors influence a community's ability to prepare for, respond to, and recover from disasters.

Household Composition and Disability: This theme considers variables like age (e.g., elderly and children), single-parent households, and disability status. These groups may require additional assistance during emergencies due to physical or logistical challenges.

Minority Status and Language: This theme encompasses racial and ethnic minority status and English language proficiency. Language barriers and systemic inequalities can affect access to resources and information during a crisis.

Housing Type and Transportation: This theme looks at housing structures (e.g., multi-unit structures, mobile homes), crowding, and access to transportation. These factors can impact evacuation processes and the ability to shelter in place safely or to seek refuge when faced with a natural disaster or other emergency.

Hunterdon County has the lowest overall social vulnerability in the counties served by SLUHN, with an 0.03 index, while Warren County has a social vulnerability index of 0.22. Understanding SVI is important because it helps to identify demographic groups and geographic locations with higher vulnerability to environmental and public health hazards. Reducing social vulnerability can minimize the impacts of stressors and disasters, decreasing human suffering and economic loss.

Social Vulnerability Index
CDC, 2022

County	SVI
Berks	0.62
Bucks	0.08
Carbon	0.3
Lehigh	0.63
Luzerne	0.61
Monroe	0.31
Montgomery	0.2
Northampton	0.29
Schuylkill	0.45
Hunterdon, NJ	0.03
Warren, NJ	0.22

Domestic Violence

The CDC defines domestic violence, or intimate partner violence, as the "physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner." CDC's National Intimate Partner and Sexual Violence Survey indicate about 41% of women and 26% of men experienced contact sexual violence, physical, or stalking by an intimate partner during their lifetime and reported a related impact. New Jersey Courts Family Practice Division conducted a report on the Prevention of Domestic Violence Act. In 2021, there were 20,635 Municipal Court case originations of domestic violence complaints for a restraining order. The Municipal Court hears motor vehicle and minor criminal cases, as well as county and municipal ordinance cases. There were also 14,531 Superior Court case originations of domestic violence complaints for a restraining order. The Superior Court conducts criminal, civil, and family law cases. The number of domestic violence filings increased by 17.6% from 2022 and 76.8% of plaintiffs filed for a domestic violence restraining order.

Of Warren Campus and Star Community Health service area CHNA survey respondents, 8.0% reported ever being hit, slapped, kicked, or otherwise physically hurt by their partner or someone important to them. Of those respondents, 15.7% reported that it was their spouse, 29.2% their ex-spouse, 11.2% their partner, 4.5% a stranger, and 39.3% reported being physically hurt by someone else. Additionally, 21.9% of respondents reported being emotionally abused by their partner or someone they care about. These results indicate an important need in the community, and care, both physical and mental support, should be available to support victims of domestic violence.

Sex Trafficking

According to the 2023 Trafficking In Persons Report by the US Department of State, sex trafficking includes activities involved when a trafficker uses force, fraud, or coercion to compel another person to engage in a commercial sex act or causes a child to engage in a commercial sex act. There are three elements that are required to establish a sex trafficking crime: "acts," "means," and "purpose". "The "acts" element of sex trafficking is met when a trafficker recruits, harbors, transports, provides, obtains, patronizes, or solicits another person to engage in commercial sex. The "means" element of sex trafficking occurs when a trafficker uses force, fraud, or coercion. The "purpose" element is a commercial sex act." These three elements apply to all sex trafficking crimes except in cases of child sex trafficking where "the means are irrelevant". The National Human Trafficking Hotline reported 480 signals received by the hotline in 2023 from New Jersey, and 105 of those signals were from victims or survivors of human trafficking. In 2023 there were 170 cases of human trafficking involving 246 victims that were identified. The Human Trafficking Hotline has received 6,668 signals from New Jersey since its inception in 2007.

Health Outcomes

Morbidity, Mortality, and Life Expectancy

Morbidity, mortality, and life expectancy are key health outcomes that help determine the overall health of the populations we serve. According to the National Vital Statistics System, the average life expectancy in the U.S. is 77.5 years old and the age adjusted death rate in 2022 was 798.8 per 100,000. The life expectancy is 77.7 years in New Jersey with the range of life expectancy being 75.3-83.5 years. As of 2023, there is an age adjusted rate of 636.3 deaths per 100,000 standard population in New Jersey, 709.8 deaths per 100,000 in Warren County, and 507.8 deaths per 100,000 in Hunterdon County.

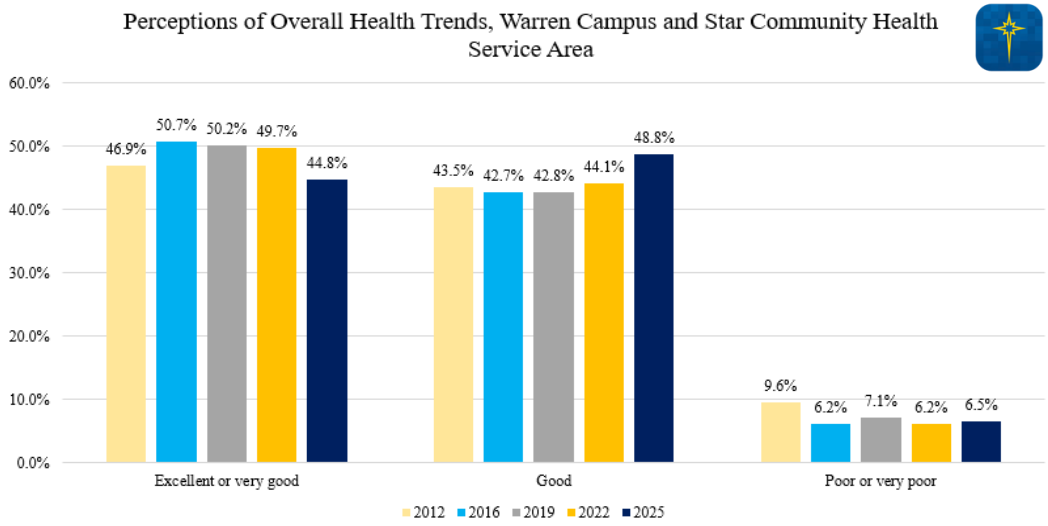
In 2023, the ten leading causes of death made up 73.8% of all deaths in the United States. The CDC reported the top ten leading causes of death (in order): heart disease; cancer; accidents (unintentional injuries); stroke (cerebrovascular diseases); chronic lower respiratory diseases; Alzheimer's disease; diabetes; nephritis, nephrotic syndrome, and nephrosis; chronic liver disease and cirrhosis; COVID-19.

County Health Rankings and Roadmaps reports a premature death health outcome, which measures the age-adjusted years of potential life lost before age 75 per 100,000 population. Years of potential life lost rate in New Jersey is 6,500 deaths per 100,000. and 6,000 deaths for U.S. top performers.

Low birthweight is another health outcome that can contribute to life expectancy. Low birthweight is measured by the percentage of live births who are under 2,500 grams (5 pounds, 8 ounces), which can be an indicator for future health problems such as cardiovascular disease, respiratory conditions, and visual, auditory, intellectual, and developmental impairments. The overall low birthweight percentage is 8% in New Jersey, Warren County at 8% and Hunterdon County at 6%. The low birthweight percentage for U.S. top performers is 6%.

Perceptions of Health

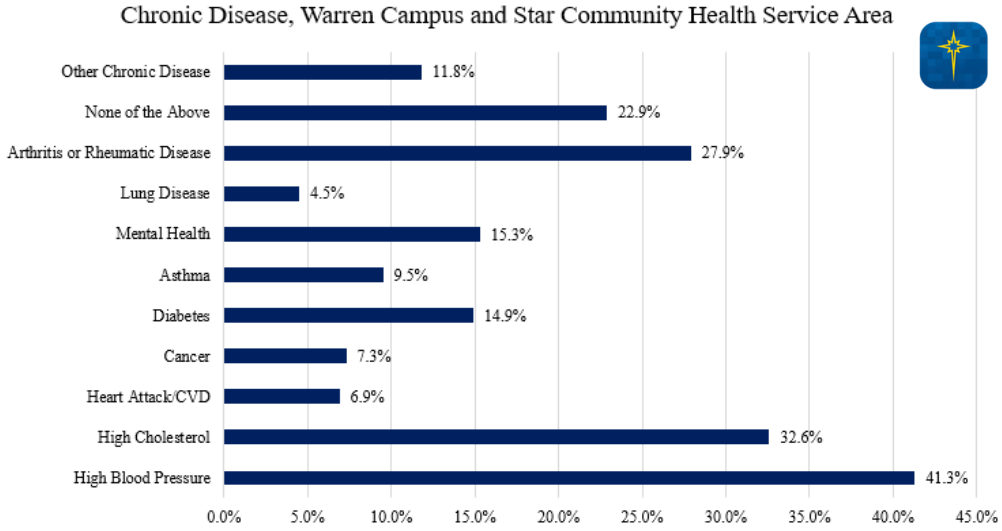
It is important to assess a community's perceived sense of health status to interpret their overall well-being, as well as highlight areas where health education would benefit the community. According to the CHNA survey, most individuals in the Warren Campus and Star Community Health service area reported good health (48.8%), followed by excellent or very good (44.3%), and poor or very poor (6.5%). While there was not a significant change in the respondents that reported poor or very poor health since 2022, there was a 4.9% decrease in respondents that reported excellent or very good health and a 4.7% increase in good health, indicating that there was a decrease in overall health for the population by approximately 5% of respondents. This indicates the importance of health promotion, education, and prevention to support the overall health needs of the community.



Chronic Disease

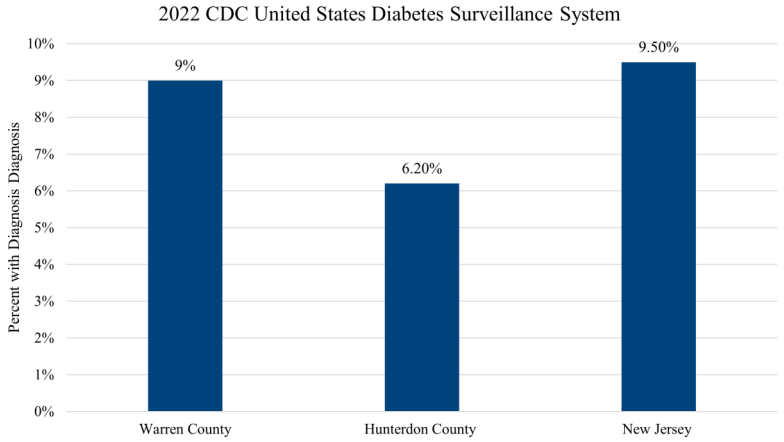
The CDC defines chronic disease as “conditions that last one year or more and require ongoing medical attention and limit activities of daily living or both.” Chronic diseases like heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Chronic diseases are also the leading drivers of the nation's $4.5 trillion in annual health care costs. Chronic diseases can be prevented by limiting risk behaviors like smoking, poor nutrition, physical inactivity, and excessive alcohol use.

The 2025 CHNA survey results indicated that 41.3% of Warren Campus and Star Community Health service area respondents have high blood pressure, followed by high cholesterol (32.6%), and arthritis or a rheumatic disease (27.9%). Of respondents 45 years and older, 80.4% have one or more chronic disease.



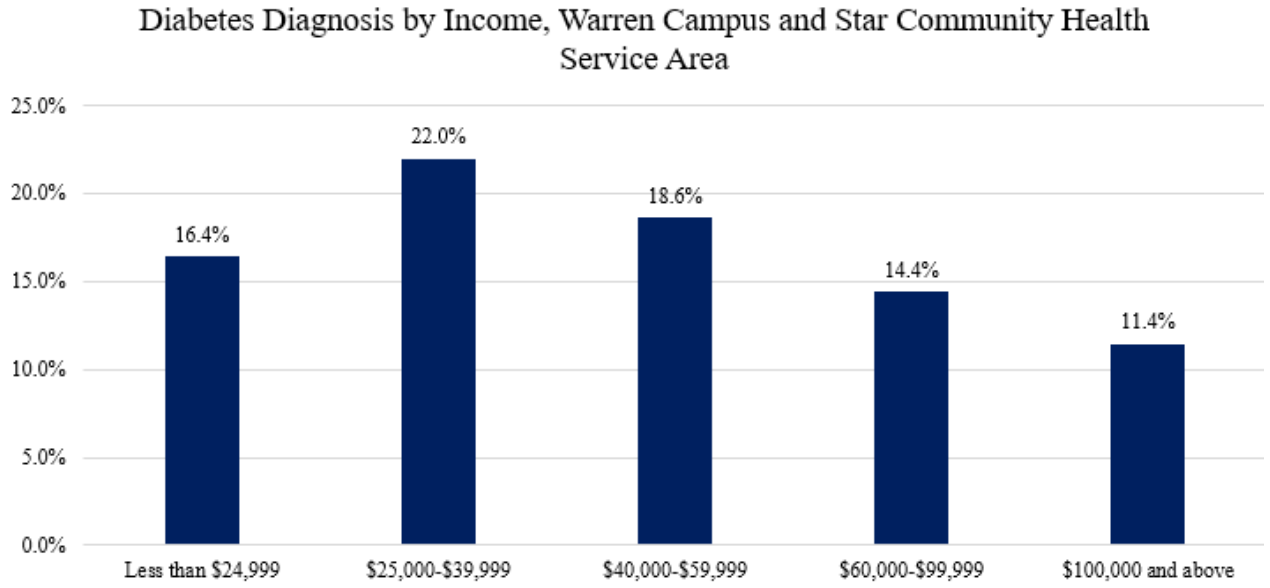
Diabetes

According to the 2022 CDC National Diabetes Statistics Report, an estimated 38 million Americans have diabetes, with 90-95% of all diagnoses classified as type 2 diabetes. Approximately 98 million Americans have prediabetes, and more than 8 in 10 adults with prediabetes do not know they have it, which is more than 78 million individuals across the country. Of U.S. adults diagnosed with diabetes, 89.0% were either overweight or obese. The total medical cost, lost work and wages for people with diagnosed diabetes is $413 billion annually, with medical costs for people with diabetes twice as high as for people without diabetes. Type 2 diabetes, once called adult-onset diabetes, because it was previously a rare diagnosis in youth, has increased significantly in ages 10-19 since 2002. In 2016, diabetes was responsible for 16 million ER visits and 7.8 million hospital discharges nationally.



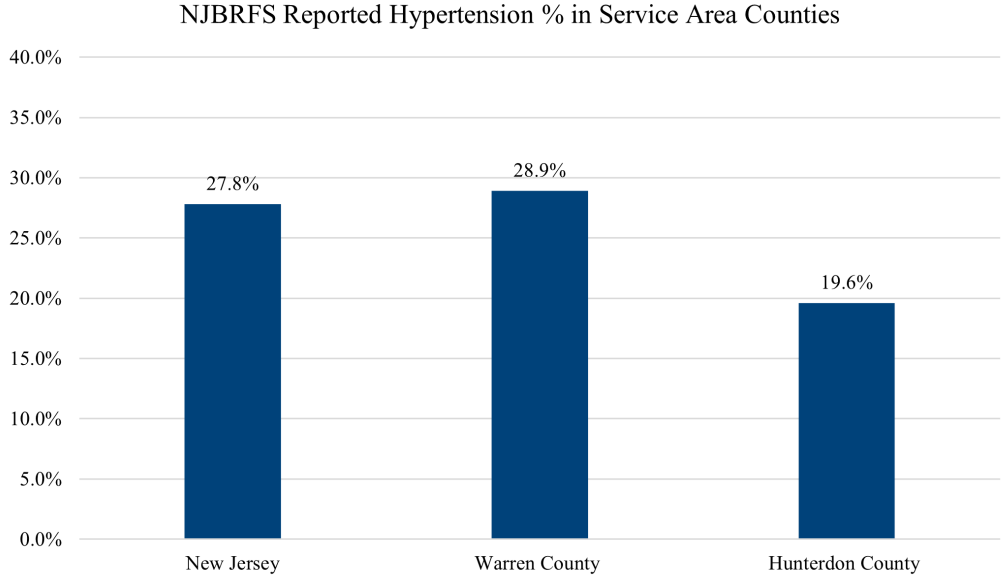
The CDC’s National Diabetes Statistics Report showed disparities in diabetes exist among racial and ethnic groups. The highest rate among any race or ethnicity group was American Indian/ Alaska Natives (13.6%), followed by 12.1% of non-Hispanics Black adults and 11.1% of adults of Hispanic origin. Asians and White non-Hispanics have the lowest prevalence of diabetes at 9.1% and 6.9% respectively. These disparities also exist on an educational level: those with less than a high school education have a diabetes prevalence of 12.6%, while those with more than high school education have a diabetes prevalence of 7.2%.

From our previous question of chronic disease presence, we know that 14.9% of respondents in the Warren Campus and Star Community Health service area reported having been diagnosed with diabetes. Our survey also looks at the relationship between diabetes and income as it can give more insight into the contributing factors to incidence rates. In the Warren Campus and Star Community Health service area, 22% of individuals earning $25,000-$39,999 had diabetes, the highest rate of the income brackets and the $60,000 and above bracket has the lowest (11.4%).



Hypertension

The Center for Disease Control (CDC) defines hypertension as having a blood pressure that is at or above a systolic value of 130 mm Hg, which measures the pressure in your arteries when your heart beats, and a diastolic value of 80 mm Hg, which measures the pressure in your arteries when your heart rests between beats. In comparison, a normal blood pressure is less than 120/80 mmHg. Data regarding hypertension also includes individuals who are taking medications for hypertension that would otherwise be uncontrolled. According to the CDC (2021), nearly half of adults have high blood pressure with a prevalence of 48.1% (119.9 million). These numbers are even more alarming because they are likely underreported. The CDC estimates that one in four adults with high blood pressure do not know they have this condition. Poorly controlled hypertension is a serious condition that can affect many bodily systems over time including the heart, kidneys, vision, and blood vessels. According to the American Heart Association, hypertension can increase risk for heart attack, stroke, and kidney failure among other complications. Due to the serious impacts it can have on health, hypertension contributes to an increased burden on our healthcare system, with hypertension accounting for 1.3 million emergency department visits each year in the U.S. alone.

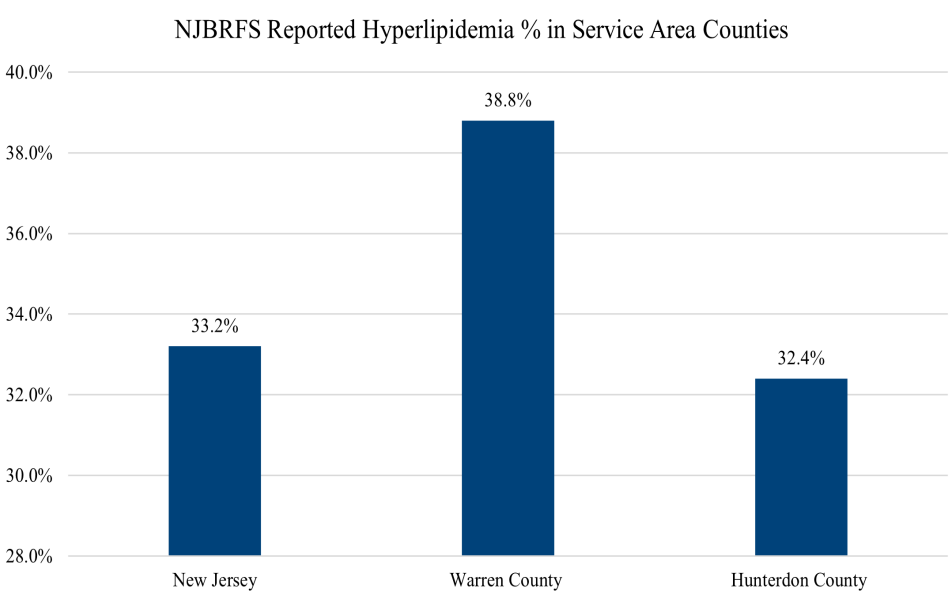


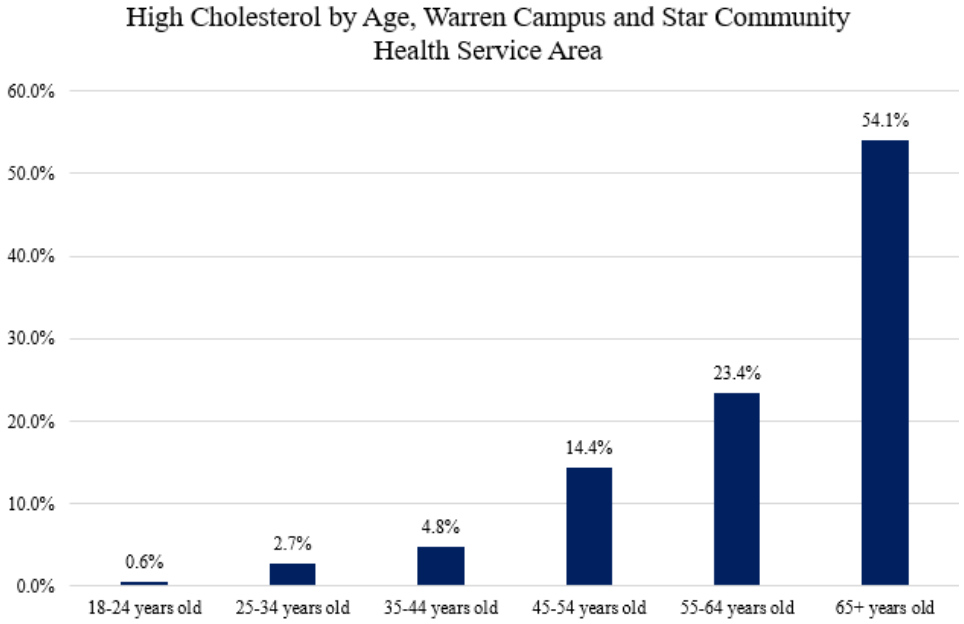
The New Jersey hypertension rate is 27.8%, with a slightly higher rate in Warren County (28.9%) and a much lower rate in Hunterdon County (19.6%). In the Warren Campus and Star Community Health service area, 41.3% of CHNA survey respondents report they have been diagnosed with high blood pressure. When looking at hypertension by income, 60.0% of survey respondents with an income between $25,000-$39,999 reported having hypertension compared to 35.6% of respondents with an income of $100,000 or more. While there are disparities in diagnosis by income, it is important to note that all income categories are high.

····· Hyperlipidemia ·····

Hyperlipidemia, or high cholesterol, is defined as a total serum cholesterol at or above 240 mg/dL, which stands for milligrams per deciliter and is a unit of measure that shows the concentration of a substance in a fluid. Data regarding hyperlipidemia also includes individuals who are taking medications to control their high cholesterol. According to the 2023 report from the American Heart Association, 26.7% of U.S. adults aged 20 and over have been diagnosed with hyperlipidemia; more than one in four U.S. adults. This has been steadily increasing in most recent decades, with only one in five U.S. adults having hyperlipidemia in the 1995 CDC report. High cholesterol can lead to plaque buildup in one's blood vessels, which can lead to increased risk of carotid artery disease, coronary heart disease, heart attack and stroke among other complications. In addition to adults, 7.4% of all U.S. children and adolescents have high total cholesterol. The risk of high total cholesterol significantly increases with a risk factor of obesity, and 6.3% of children 6-19 years old have high cholesterol at a healthy weight compared to 11.6% at a weight that is considered obese.

The New Jersey hyperlipidemia rate is 33.2%, with a higher rate in Warren County (38.8%) and a lower rate in Hunterdon County (32.4%). In the Warren Campus and Star Community Health service area, 32.6% of respondents reported having hyperlipidemia. Of those respondents, 54.1% were 65 years or older. Only 0.6% of respondents with hyperlipidemia were 18-24 years old, and the increasing trend shown is reflective of the larger population and hyperlipidemia diagnoses that increase with age and other comorbidities (e.g., diabetes, hypertension).





Cancer

The CDC reported that 1.7 million people in the U.S. are diagnosed with cancer each year and the estimated health care cost of cancer (e.g., diagnosis, care, treatment) is expected to reach more than $240 billion by 2030. Cancer is the second leading cause of death nationally with over half a million deaths each year. According to the National Cancer Institute, cancer incidence in the U.S. is 458.3 per 100,000. Pennsylvania and New Jersey have a cancer incidence of 415.1 per 100,000 and 473.6 per 100,000 respectively. There are certain risk factors that increase the risk of getting cancer, including obesity, smoking, secondhand smoke exposure, exposure to sun and tanning beds, excessive alcohol use, and some infectious diseases. These health behaviors have been discussed in earlier sections of this document.

In addition to certain health behaviors, access to care can play a significant role in cancer screening, diagnosis, and mortality rates. Early versus late-stage detection can impact cancer mortality, and we observe that uninsured patients and Medicaid recipients have a much lower rate of early detection than their privately insured counterparts.

The National Cancer Institute (NCI) showed that, for many cancers, Black men and women have higher mortality rates. For example, the American Cancer Society shows that Black women have a 40% higher chance of mortality from breast cancer than White women despite comparable levels of incidence. Black men are twice as likely to die of prostate cancer than White men and continually have the highest prostate cancer mortality rates among US racial and ethnic groups. Educational attainment, regardless of race or ethnicity, also appears to play a role in cancer mortality for certain cancers.

In order to be considered up to date with screenings, CHNA survey respondents must have had a screening date fall in the recommended time frame for their screening type and age. If a respondent was missing an answer to one of the questions, their screening status was marked "Unknown." Survey respondents were asked to indicate their most recent colorectal cancer screening if they reported being 45-74 years old. Of the Warren Campus and Star Community Health service area respondents, 65.4% have been screened, 32.5% have not been screened, and 2.1% do not know.

The CHNA survey also assesses colorectal cancer screening by insurance type to uncover any disparities and perhaps see if insurance is a barrier to cancer screenings. Only 51.8% of respondents that do not have insurance/pay cash reported being screened for colon cancer, compared to 65.8% of respondents with private insurance and 77.3% of respondents with Medicare. Additionally, 58.7% of respondents who use Medicaid have never been screened. Since colon cancer can be prevented or caught early with screenings, this is a large gap in care.

The CHNA survey also asks respondents about breast cancer screening and compares breast cancer screenings by insurance. In the Warren Campus and Star Community Health service area, 74.3% of respondents ages 40-74 years old had a mammogram, 25.4% have not, 0.15% do not know. When looking at breast cancer screening by insurance, 75.9% of respondents with private insurance had a mammogram in the last two years, compared to 81.4% of respondents with Medicare and only 59.5% of respondents with Medicaid.

While a significant portion of respondents aged 40-74 years old have undergone mammograms, the data reveals notable differences based on insurance type. Those with Medicare show the highest screening rates, followed by those with private insurance, and lastly, those with Medicaid. These findings underscore the need for targeted interventions to improve breast cancer screening accessibility and uptake, particularly among Medicaid recipients.

Unintentional Injury

According to the National Vital Statistics System, in 2022, the United States had 68.1 unintentional injury deaths per 100,000 population, which was the third ranked cause of death. In 2021, there were 25.5 million visits to the emergency room for unintentional injuries. Unintentional injuries are unplanned and preventable when using proper safety precautions; they are also a substantial contributor to premature death. When broken down further for the United States, there were 14 per 100,000 population unintentional fall deaths, 13.4 per 100,000 population motor vehicle traffic deaths, and 30.9 per 100,000 population unintentional poisoning deaths. In New Jersey, there were 49.67 unintentional deaths per 100,000. Since unintentional injury deaths are so prominent, Healthy People 2030 has set objectives for injury deaths, some of which are to reduce unintentional injury deaths, reduce deaths involving opioids, reduce emergency department visits for non-fatal injuries and unintentional injuries.

Unintentional Injury Deaths 2022 via CDC Wonder	
Region	Rate per 100,000 population
Warren	59.75
Hunterdon	45.60
NJ	49.67
US	64.03

Conclusion

Through this extensive review of the primary and secondary data, it is evident that there are significant needs to address within our communities. For the upcoming three-year (2025-2028) cycle, St. Luke's University Health Network will continue to work toward addressing the health priorities identified network-wide to improve the community's overall health and well-being with targeted community specific initiatives. The three main priorities identified include: access to care; preventing chronic disease; and improving mental and behavioral health.

To analyze our findings in these areas, SLUHN has adopted the Healthy People 2030 framework, including goals and objectives. The social determinants of health shape the status of a person's health and provide guidance for community health priorities. When addressing the priority health needs, it is crucial to consider the social determinants of health and lifestyle behaviors to effectively tackle the service area's health disparities. Some significant survey findings, which are consistent with trends seen widely, are related to health outcomes and income, access to care for minority and marginalized populations, healthy eating (i.e., fruit and vegetable consumption), diabetes and other chronic illnesses, the opioid epidemic, and other substance use disorders.

From our analysis of primary and secondary data, as well as the key CHNA informant interviews and work with our community members, we see significant issues facing our communities that impede healthy lifestyles. Our efforts in prevention, care transformation, research, and partnerships help support our work to promote sustainable programs and opportunities for our reach to focus on a wide range of health promotion and quality of life initiatives.

While there are many that need to be addressed, the results from the 2025 CHNA found the most pressing needs to be specifically in areas related to:

- Access to Care
- Workforce Development
- Food Security
- Obesity Reduction
- Physical Activity Promotion
- Opioids and other Substance Use
- Mental Health
- Housing
- Transportation

The needs discussed within the health categories outlined in this document will serve as our guide in creating a detailed campus-specific implementation plan to best address the specific needs of the St. Luke's Network service area using the three pillars of: wellness and prevention; care transformation; and research and partnerships. We will work collaboratively with our community and network partners to create a more equitable society with better health outcomes, especially among our most vulnerable populations.

Appendix A

2024 CHNA Key Informant Interview

St. Luke's University Health Network (SLUHN) is a nationally recognized non-profit health network that has facilities serving counties in both Pennsylvania (Lehigh, Northampton, Carbon, Schuylkill, Bucks, Berks, Monroe, Luzerne) and New Jersey (Warren and Hunterdon). As part of the Patient Protection and Affordable Care Act, all non-profit hospitals are required to conduct a Community Health Needs Assessment (CHNA) every three years. In order to accomplish our goals, St. Luke's is conducting key informant interviews to identify health needs within the community. Since you are a vital member of our community, you are being asked for your feedback to assist us in data collection. Your answers will be compiled by St. Luke's to determine health needs in the community.

Please note that your name will not be associated with your responses.

1. Name:
2. Title:
3. Organization:
4. How long have you been a part of this community and in what capacities?
5. When thinking about others you interact with here, do you feel a sense of community?
6. How would you describe your community?
7. What are the major needs/challenges within this community?
8. What are some of the challenges specific to your organization?
9. How do you feel this community has been successful in meeting its needs?
10. What improvements in policy and community infrastructure would assist you in meeting community needs?
11. Who are some of the key players in your community and what organization do they belong to?
12. What are some of the strengths and resources of your community?
13. Do you feel these strengths are shared and evenly distributed throughout the community? Please explain.
14. What are some concrete examples of strengths and challenges across the lifespan related to the following topics in your community?
    1. Health disparities/Access to care (example: access to medical, mental, dental and vision care)
    2. Chronic Disease (example: diabetes, heart disease, physical activity, diet, and cancer)
    3. Mental/Behavioral Health (example: substance misuse/use disorder, depression, and anxiety)
15. What are the **top three issues** that need to be addressed in your community?
16. Any additional comments?

Appendix B

2024 CHNA Community Forum Invited Organizations– Warren Campus and Star Community Health

- Abilities on Northwest Jersey
- Catholic Charities-Diocese of Metuchen
- Center for Family Services
- Community Visiting Nurse Association-New Jersey
- Domestic Abuse & Sexual Assault Crisis Center of Warren County
- Family Promise of Warren County
- Foodshed Alliance-Local Share
- Norwescap Food Bank
- Norwescap-Health Connections
- Norwescap Traditions Family Success Center
- NJ Department of Child Protection & Permanency
- Phillipsburg Elementary School
- Phillipsburg Free Public Library
- Phillipsburg Housing Authority
- Phillipsburg Law Enforcement Assisted Diversion
- Phillipsburg Early Childhood Learning Center
- River of Life-Food Party
- Rutgers New Jersey Medical School-The CARE Center
- Star Community Health
- The Firth Youth Center
- Warren County Department of Human Services-Mental Health
- Warren County Department of Human Services-Transportation
- Warren County-Division of Temporary Assistance & Social Services
- Warren County Health Department
- Warren County Technical School
- Zufall Health Center-Rural Health

Appendix C

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