Appendix A: Data Tables

Data included for:

- Asthma
- Mental Health & Substance Abuse
- Nutrition & Physical Activity
- Tobacco
- Domestic Violence
- Lead
- STDs, HIV, & Reproductive Health
- Diabetes
- Surrogates of Health Including Location of Care, Insurance Status, and Barriers to Care

	New Brunswick	Middlesex County	Source	Notes
Adults who have been told by a doctor that they currently have asthma		7.5%	BRFSS 2010	
Adults who have ever been told by a doctor that they have asthma		11.6%	BRFSS 2010	
Estimated lifetime asthma among adults		12.9%	NJ Asthma 2010	2005-2009 data
Estimated current asthma among adults		8.4%	NJ Asthma 2010	2005-2009 data
Anyone in household has asthma	18%		Eagleton/NBT 2012	
Anyone in household has asthma	29.2%		Bloustein/NBT 2011	data also organized by race/ethnicity, income, and age
Has been told by a doctor, nurse, or other health professional that they had asthma?		17.3%	Hospitals 2012	
Asthma in Hospitals				
Age-adjusted rate per 10,000 residents for hospitalizations due to asthma		11.9	NJ SHAD	2011 data
Rate per 100,000 population for avoidable inpatient hospitalizations for asthma in young adults	64		CSHP Util 2013	
Rate per 100,000 population for avoidable inpatient hospitalizations for COPD/asthma in older adults	397		CSHP Util 2013	
Number of Asthma ED visits, 2009		3,665	NJ Asthma 2010	2005-2009 data
Percent of NJ asthma ED visits in 2009		6.9%		

	New Brunswick	Middlesex County	Source	Notes
HISTORIC DATA				
Asthma				
Percent of children reported with asthma (total)	10.2%		CSHP/HNB 2004	
Percent of near-poor* children reported with asthma	14.5%		CSHP/HNB 2004	*between 101% and 200% of federal poverty level
Percent of African-American children reported with asthma	14.8%		CSHP/HNB 2004	

	New Brunswick	Middlesex County	Source	Notes
Mental Health				
Anyone in household have depression, anxiety, or other mental health condition	26.4%		Bloustein/NBT 2011	data also organized by race/ethnicity, income, and age
In past 12 months, saw a provider for an emotional or mental health problem		8.1%	Hospitals 2012	
Percent of inpatient high users with mental health comorbidities	33.9%		CSHP Util 2013	
Percent of ED high users with mental health comorbidities	16.8%		CSHP Util 2013	
Alcohol Consumption Including Excessive / Heavy Drinking (multiple points)				
Believe that alcohol / drug abuse are a problem in their community		62.8%	Hospitals 2012	
Adults who reported binge drinking (<4 for women & <5 for men) on a single occasion in past 30 days		13.0%	County HR	2005-2011 data
Number of alcohol admissions	160	1692	NJ SubsAb Middlesex	2012 data
Alcohol admissions (NB Residents) as a percent of total New Brunswick SA admissions	32.0%		NJ SubsAb Middlesex	2012 data
Alcohol admissions (Middlesex County Residents) as a percent of total Middlesex County SA admissions		33.4%	NJ SubsAb Middlesex	2012 data
Alcohol admissions (NB Residents) as a percent of total Middlesex County Alcohol admissions	9.5%		NJ SubsAb Middlesex	2012 data

	New Brunswick	Middlesex County	Source	Notes
Anyone in household has drinking or alcohol issues	4.0%		Eagleton/NBT 2012	
Anyone in household have alcohol / drug problems	6.8%		Bloustein/NBT 2011	data also organized by race/ethnicity, income, and age
Heavy drinkers (Adult men having more than two drinks per day and adult women having more than one drink per day)		3.1%	BRFSS 2010	
Binge drinkers (males having five or more drinks on one occasion, females having four or more drinks on one occasion)		10.6%	BRFSS 2010	
Rate per 1000 of adult alcohol abuse treatment admissions	3.9		PRAB 2013	
Rate per 1000 of youth alcohol abuse treatment admissions	0.2		PRAB 2013	
Adults ages 18+ who reported binge drinking in past 30 days		13.3%	NJ SHAD	2008-2010 data

	New Brunswick	Middlesex County	Source	Notes
Drug Abuse				
Number of cocaine admissions	38	261	NJ SubsAb Middlesex	2012 data
Cocaine admissions (NB Residents) as a percent of total NB substance abuse admissions	7.6%		NJ SubsAb Middlesex	2012 data
Cocaine admissions (Middlesex County Residents) as a percent of total Middlesex County substance abuse admissions		5.1%	NJ SubsAb Middlesex	2012 data
Number of heroin & opiates admissions	155	2206	NJ SubsAb Middlesex	2012 data
Heroin & opiates admissions (NB Residents) as a percent of total NB substance abuse admissions	31.0%		NJ SubsAb Middlesex	2012 data
Heroin & opiates admissions (Middlesex County Residents) as a percent of total Middlesex County substance abuse admissions		43.5%	NJ SubsAb Middlesex	2012 data
Number of marijuana admissions	129	774	NJ SubsAb Middlesex	2012 data
Marijuana admissions (NB Residents) as a percent of total NB substance abuse admissions	25.8%		NJ SubsAb Middlesex	2012 data
Marijuana admissions (Middlesex County Residents) as a percent of total Middlesex County substance abuse admissions		15.3%	NJ SubsAb Middlesex	2012 data
Number of marijuana admissions	160	760	NJ SubsAb Middlesex	2012 data
Anyone in household have alcohol / drug problems	6.8%		Bloustein/NBT 2011	data also organized by race/ethnicity, income, and age

	New Brunswick	Middlesex County	Source	Notes
Rate per 1000 of adult drug abuse treatment admissions	7.8		PRAB 2013	
Rate per 1000 of youth drug abuse treatment admissions	1.1		PRAB 2013	
Believe that alcohol / drug abuse are a problem in their community		62.8%	Hospitals 2012	
Undefined Substance Abuse				
Number of other admissions	18	135	NJ SubsAb Middlesex	2012 data
Other admissions (NB Residents) as a percent of total New Brunswick substance abuse admissions	3.6%		NJ SubsAb Middlesex	2012 data
Other admissions (Middlesex County Residents) as a percent of total Middlesex County substance abuse admissions		2.7%	NJ SubsAb Middlesex	2012 data
Percent of inpatient high users with substance use disorder comorbidities	13.8%		CSHP Util 2013	
Percent of ED high users with substance use disorder comorbidities	10.3%		CSHP Util 2013	

	New Brunswick	Middlesex County	Source	Notes
Childhood Obesity				
Not overweight, ages 3-5	52%		Obesity 2010	data also organized by gender and race/ethnicity
Not overweight, ages 6-11	52%		Obesity 2010	
Not overweight, ages 12-18	56%		Obesity 2010	
Overweight, ages 3-5	19%		Obesity 2010	
Overweight, ages 6-11	20%		Obesity 2010	
Overweight, ages 12-18	19%		Obesity 2010	
Obese, ages 3-5	29%		Obesity 2010	
Obese, ages 6-11	28%		Obesity 2010	
Obese, ages 12-18	25%		Obesity 2010	
Parent's Perceptions of Child's Weight Status				data also organized by gender and race/ethnicity
Not overweight, ages 3-5	92%		Obesity 2010	
Not overweight, ages 6-11	88%		Obesity 2010	
Not overweight, ages 12-18	75%		Obesity 2010	
Slightly overweight, ages 3-5	8%		Obesity 2010	
Slightly overweight, ages 6-11	12%		Obesity 2010	
Slightly overweight, ages 12-18	22%		Obesity 2010	
Very overweight, ages 3-5	0%		Obesity 2010	
Very overweight, ages 6-11	1%		Obesity 2010	
Very overweight, ages 12-18	3%		Obesity 2010	

	New Brunswick	Middlesex County	Source	Notes
Adult Obesity				
Neither overweight nor obese (BMI ≤ 24.9)		39.7%	BRFSS 2010	
Overweight (BMI 25.0 - 29.9)		37.3%	BRFSS 2010	
Obese (BMI 30.0 - 99.8)		23.0%	BRFSS 2010	
Overweight (BMI 25.0 - 29.9)		38.0%	Hospitals 2012	Survey data
Obese (BMI 30.0 - 99.8)		28.0%	Hospitals 2012	Survey data
Overweight (BMI 25.0 - 29.9)		38.2%	NJ SHAD 2006-2008	2006-2008 data
Obese (BMI 30.0 - 99.8)		22.4%	NJ SHAD 2006-2008	2006-2008 data
Obese (BMI 30.0 - 99.8)		24.0%	County HR	2009 data
Anyone in household has obesity or weight related issues	21%		Eagleton/NBT 2012	
Anyone in household have weight problem	38.7%		Bloustein/NBT 2011	data also organized by race/ethnicity, income, and age
In the past 12 months, a doctor, nurse or other health professional gave them advice about their weight?		24.8%	Hospitals 2012	Survey data
Self perceived somewhat overweight / very overweight		60.0%	Hospitals 2012	Survey data

	New Brunswick	Middlesex County	Source	Notes
Childhood (ages 3-18) Physical Activity				
Percentage not active at least 60 minutes a day 6-7 days a week	81%		Obesity 2010	data also organized by gender and race/ethnicity
Percentage not active at least 30 minutes a day 6-7 days a week	57%		Obesity 2010	data also organized by gender and race/ethnicity
Percentage who never walk, bike, or skateboard to school	56%		Obesity 2010	data also organized by gender and race/ethnicity
Percentage who get physical activity at school 2 or fewer days per week	55%		Obesity 2010	data also organized by gender and race/ethnicity
Percentage who spend more than 2 hours a day on weekdays on TV, computer, or video games	18%		Obesity 2010	data also organized by gender and race/ethnicity
Percentage who spend more than 2 hours a day on weekend days on TV, computer, or video games	47%		Obesity 2010	data also organized by gender and race/ethnicity
Parent believe that their child gets enough physical activity				
Strongly agree	54%		Obesity 2010	data also organized by gender and race/ethnicity
Somewhat agree	36%		Obesity 2010	
Somewhat or strongly disagree	10%		Obesity 2010	

	New Brunswick	Middlesex County	Source	Notes
Adult Physical Activity / Inactivty				
During the past month, did you participate in any physical activities?		70.9%	BRFSS 2010	
Percent of adults ages 20+ reporting no leisure time physical activity		27.0%	County HR 2013	2009
Ever told by your doctor that you should exercise?				race/ethnicity, income, and age
Yes	59.9%		Bloustein/NBT 2011	
No	40.1%		Bloustein/NBT 2011	
Do you have an indoor place to exercise regularly?				data also organized by race/ethnicity, income, and age
Yes	43.2%		Bloustein/NBT 2011	
No	56.8%		Bloustein/NBT 2011	
Believe that places to exercise are a problem in their community		32.1%	Hospitals 2012	

	New Brunswick	Middlesex County	Source	Notes
Childhood (ages 3-18) Nutrition				data also organized by gender and race/ethnicity
Childhood Fruit or 100% Juice Consumption				
<1 time per day	14%		Obesity 2010	
1 to < 2 times per day	31%		Obesity 2010	
2 or more times per day	56%		Obesity 2010	
Childhood Vegetable Consumption				
<1 time per day	24%		Obesity 2010	
1 to < 2 times per day	46%		Obesity 2010	
2 to <3 times per day	19%		Obesity 2010	
3 or more times per day	12%		Obesity 2010	
Percentage who do not eat fruits and vegetable as snacks daily	53%		Obesity 2010	
Childhood Other Food Consumption				
2 or more visits to a fast-food establishment per week	12%		Obesity 2010	
Drink 2 or more sugar-sweetend beverages per day	11%		Obesity 2010	
Eat energy-dense sweet (e.g. cookies, cakes, candy or pies) snacks daily	20%		Obesity 2010	
Eat energy-dense salty (e.g. chips, Doritos or nachos) snacks daily	15%		Obesity 2010	
Percentage who do not eat breakfast daily	21%		Obesity 2010	
Parent believe that their child eats healthy				
Strongly agree	51%		Obesity 2010	
Somewhat agree	39%		Obesity 2010	

	New Brunswick	Middlesex County	Source	Notes
Somewhat or strongly disagree	10%		Obesity 2010	

	New Brunswick	Middlesex County	Source	Notes
Family Nutrition				
Programs that you or your family currently participate in?				data also organized by race/ethnicity, income, and age
Percent who receive NJ SNAP benefits	27.5%		Bloustein/NBT 2011	
Percent who participate in school breakfast and / or lunch program	22.8%		Bloustein/NBT 2011	
Percent who receive WIC benefits	17.5%		Bloustein/NBT 2011	
Percent of eligible women and children actively enrolled in NJ WIC	90.6%		NJ WIC 2014	
Believe that finding fresh fruits/veggies are a problem in their community		24.6%	Hospitals 2012	Survey data
Percent of children who receive NJ SNAP benefits		13.1%	Kids Count 2013	NJ SNAP data 2012, population data 2011
Percent of all children receiving free- or reduced-price school breakfast		6.5%	Kids Count 2013	breakfast data 2011- 2012, population data 2011
Percent of eligible children receiving free- or -reduced price school breakfast		31.2%	Kids Count 2013	
Percent of all children receiving free- or reduced-price school lunch		16.5%	Kids Count 2013	lunch data 2011- 2012, population data 2011
Percent of eligible children receiving free- or -reduced price school lunch		79.9%	Kids Count 2013	

	New Brunswick	Middlesex County	Source	Notes
HISTORIC DATA				
Childhood Obesity				
At risk for overweight (children under age 19)	24.5%		CSHP/HNB 2004	
Overweight (children under age 19) (total)	24.0%		CSHP/HNB 2004	
Poor or near-poor*	30.2%		CSHP/HNB 2004	*between 101% and 200% of federal poverty level
Hispanic/Latino	35.5%		CSHP/HNB 2004	
Childhood (ages >5-18) Physical Activity				
Inadequate physicial activity or exercise (< 60 minutes per day) - total	42.6%		CSHP/HNB 2004	
Uninsured	58.4%		CSHP/HNB 2004	
Mexican	64.4%		CSHP/HNB 2004	
Adult Physical Activity / Inactivty				
Exercise every day	10.0%	14.0%	Middlesex Co. CHNA 2001	

	New Brunswick	Middlesex County	Source	Notes
Adult Smoking				
Adults Who Are Current Smokers		13.0%	County HR 2013	smokes every day or most days; 2005-2011 data
Adults Who Are Current Smokers		12.8%	BRFSS 2010	
Adults Who Are Current Smokers		12.2%	NJ SHAD	2007-2009 data
Anyone in Household that Smokes	20.9%		Bloustein/NBT 2011	data also organized by race/ethnicity, income, and
Individual Smoking Status				
Smoke everyday		10.8%	BRFSS 2010	
Some some days		2.0%	BRFSS 2010	
Former smoker		23.5%	BRFSS 2010	2005-2009 data
Never smoked		63.6%	BRFSS 2010	
Smoking Allowed in Home		10.9%	Hospitals 2012	
Abstinence from Tobacco During Pregnancy		96.3%	NJ SHAD	2007-2009 data
Related Social Indicators				
Number of licensed cigarette retailers	83		NJ SubsAb Chartbook 2013	2009 data
Rate of licensed cigarette retailers per 1000 persons	1.5		NJ SubsAb Chartbook 2013	2009 data
HISTORIC DATA				
Adult Smoking				
Currently smoke cigarettes	36.0%	25.0%	Middlesex Co. CHNA 2001	
Secondhand Smoke				
Children living with a smoker	37.6%		CSHP/HNB 2004	
Uninsured	43.7%		CSHP/HNB 2004	

	New Brunswick	Middlesex County	Source	Notes
African-American	54.3%		CSHP/HNB 2004	

	New Brunswick	Middlesex County	Source	Notes
Child Maltreatment / Abuse Reports				
Number of child maltreatment reports, 2011	989		NJ Child Abuse 2011	
Percent of child maltreatment reports that are substantiated	11.1%		NJ Child Abuse 2011	
Domestic Violence Offenses	550	5,143	NJ DV 2011	
Number of children involved, child abuse / neglect investigations		6,224	NJ Child Abuse 2011	
Substantiation rate, child abuse / neglect investigations		9.16%	NJ Child Abuse 2011	
Believe that domestic violence is a problem in their community		49.8%	Hospitals 2012	Survey data
Believe that elder abuse / neglect is a problem in their community		46.2%	Hospitals 2012	Survey data
Number of forcible rapes known to law enforcement	24		FBI Crime 2012	

	New Brunswick	Middlesex County	Source	Notes
Elevated Blood Lead Levels				
Percent of children ages 6 to 29 months with confirmed blood lead ≥ 5 µg/dL	4.5%	2.5%	NJ Lead 2012	
Percent of tested children under 6 years of age with confirmed blood lead ≥ 5µg/dL,	4.6%	2.60%	NJ Lead 2012	
Screening Levels				
Percent of children ages 6 to 29 months tested for lead poisoning	69.0%	37.0%	NJ Lead 2012	
Percent of children under 6 years of age tested for lead poisoning	40.0%	22.0%	NJ Lead 2012	
Surrogate Markers				
Number of pre-1950 housing units in New Brunswick, NJ	6,407	51,570	ACS 2012	
Percent of housing units in New Brunswick built before 1950	42.1%	17.4%	ACS 2012	
Number of pre-1950 housing units as of 2000		52,430	NJ SHAD	
HISTORIC				
Elevated Blood Lead Levels				
Percent of children with elevated blood lead levels (≥ 10µg/dL)	32.0%	7.0%	Middlesex Co. CHNA 2001	
Screening Levels				
Percent of children tested for lead poisoning under age 5	40.0%	27.0%	Middlesex Co. CHNA 2001	
Surrogate Markers				
Percent of housing units in New Brunswick built before 1979	91.6%	77.8%	Middlesex Co. CHNA 2001	

	New Brunswick	Middlesex County	Source	Notes

	New Brunswick	Middlesex County	Source	Notes
STDs				
Number of Chlamydia cases	358	1,901	NJ STD Program 2012	
Number of Gonorrhea cases	56	275	NJ STD Program 2012	
Believe that STDs are a problem in their community		40.9%	Hospitals 2012	
Chlamydia rate per 100,000 population		214.0	County HR 2013	2010 data
HIV/AIDS				
Cumulative AIDS cases (Middlesex County resident at time of diagnosis)		3,130	NJ HIV/AIDS 2012	
HIV cases, not AIDS		1,013	NJ HIV/AIDS 2012	
Cumulative HIV & AIDS cases (resident when diagnosed)	956	4,166	NJ HIV/AIDS 2012	As of December 31, 2012
Current persons living with HIV/AIDS (resident when report compiled)	384	2,036	NJ HIV/AIDS 2012	
Residents age at diagnosis (resident when diagnosed), age < 13	26	81	NJ HIV/AIDS 2012	As of December 31, 2012
Residents age at diagnosis (resident when diagnosed), ages 13-24	64	296	NJ HIV/AIDS 2012	As of December 31, 2012
Current resident, living cases of HIV/AIDS, age < 13	0	6	NJ HIV/AIDS 2012	As of December 31, 2012
Current residents, living cases of HIV/AIDS, ages 13-24	16	70	NJ HIV/AIDS 2012	As of December 31, 2012
Perinatal HIV exposures (child's HIV serostatus is negative or indeterminate)		252	NJ HIV/AIDS 2012	

	New Brunswick	Middlesex County	Source	Notes
REPRODUCTIVE HEALTH				
Prenatal Care				
Percent of women receiving early prenatal care in 2	75.4%		PRAB 2013	
Percent of women receiving early prenatal care in 2009		83.8%	Kids Count 2013	2009 data
Births receiving adequate prenatal care	64.2%		PRAB 2013	
Percent of live births with no prenatal care		0.7%	NJ SHAD	2005-2009 data
Birth Rate				
Birth rate per 1000 residents	21.1		PRAB 2013	
Birth rate per 1000 residents		13	NJ SHAD	2009 data
Percent of live births to unmarried mothers		26.5%	NJ SHAD	2007-2009 data
Birth rate per 1000 females, aged 15-17		9.0	NJ SHAD	2009 data
Birth rate per 1000 females, aged 18-19		26.4	NJ SHAD	2009 data
Percentage of births to females 10-19		4.3%	Kids Count 2013	2011 data
Number of births per 1000 female population, ages 15-19		17.0	County HR 2013	2004-2010 data
Low Birthweight				
Percentage low birth weight (weighing < than 2500 grams or 5.5 lbs at birth) infants	7.5%		PRAB 2013	
Percentage low birth weight (weighing < than 2500 grams or 5.5 lbs at birth) infants		7.9%	NJ SHAD, Kids Count 2013	2009 data
Percentage low birth weight (weighing < than 2500 grams or 5.5 lbs at birth) infants		8.3%	County HR 2013	2004-2010 data

	New Brunswick	Middlesex County	Source	Notes
HISTORIC DATA				
HIV/AIDS				
Persons living with HIV/AIDS (resident when report compiled)	354		Middlesex Co. CHNA 2001	
Pediatric infections (ages <13)	16	51	Middlesex Co. CHNA 2001	
REPRODUCTIVE HEALTH				
Birth Rate				
Birth rate per 1000 residents		13.6%	Middlesex Co. CHNA 2001	
Prenatal Care				
Percent receiving prenatal care in first trimester		84.4%	Middlesex Co. CHNA 2001	
Low Birthweight				
Percentage low birth weight (weighing < than 2000 grams or 5.5 lbs at birth) infants	6.2%	6.9%	Middlesex Co. CHNA 2001	
Percentage very low birth weight (weighing < than 1500 grams or 5.5 lbs at birth) infants	2.4%	1.6%	Middlesex Co. CHNA 2001	

	New Brunswick	Middlesex County	Source	Notes
Diabetes				
Have you ever been told by a doctor that you have diabetes? Pregnancy related excluded		9.7%	BRFSS 2010	
Anyone in household has diabetes	24.0%		Eagleton/NBT 2012	
Anyone in household has diabetes	36.9%		Bloustein/NBT 2011	data also organized by race/ethnicity, income, and age
Has been told by a doctor, nurse, or other health professional that they had diabetes?		14.0%	Hospitals 2012	
Percent of adults aged 18+ with diagnosed diabetes who had a dilated eye exam within the past 12 months		72.9%	NJ SHAD	2008-2010
Screening				
Percent of diabetic Medicare patients whose blood sugar control was screened in the past 12 months using a test of their glycated hemoglobin levels		82.0%	County HR 2013	2010
Diabetes in Hospitals				
Rate per 100,000 population for avoidable inpatient hospitalizations for DM short-term complication	57.0		CSHP Util 2013	
Rate per 100,000 population for avoidable inpatient hospitalizations for DM long-term complication	113.0		CSHP Util 2013	
Rate per 100,000 population for avoidable inpatient hospitalizations for uncontrolled DM	20.0		CSHP Util 2013	
HISTORIC DATA				
Diabetes				

	New Brunswick	Middlesex County	Source	Notes
Have a personal history of diabetes	8.0%	8.0%	Middlesex Co. CHNA 2001	

	New Brunswick	Middlesex County	Source
Location of Care			
Location Receive Medical Care			
Family doctor	56.0%		Eagleton/NBT 2012
Local clinic	19.0%		Eagleton/NBT 2012
Hospital Emergency Room	24.0%		Eagleton/NBT 2012
Take care of self / at home	2.0%		Eagleton/NBT 2012
Normally receive medical care			
Family doctor, outside NB	36.6%		Bloustein/NBT 2011
Family doctor, in NB	27.7%		Bloustein/NBT 2011
NB Clinic	17.8%		Bloustein/NBT 2011
Clinic outside NB	2.6%		Bloustein/NBT 2011
Hospital ER	9.6%		Bloustein/NBT 2011
Other	5.7%		Bloustein/NBT 2011
Ever used clinic			
Chandler			
Self	19.6%		Bloustein/NBT 2011
For child	6.6%		Bloustein/NBT 2011
For self and child	11.7%		Bloustein/NBT 2011
St. Peters			
Self	11.1%		Bloustein/NBT 2011
For child	11.2%		Bloustein/NBT 2011
For self and child	7.7%		Bloustein/NBT 2011

	New Brunswick	Middlesex County	Source
St. Johns			
Self	6.2%		Bloustein/NBT 2011
For child	2.3%		Bloustein/NBT 2011
For self and child	2.7%		Bloustein/NBT 2011
Ease of Obtaining Health Care			
Very easy	46%		Eagleton/NBT 2012
Somewhat easy	29%		Eagleton/NBT 2012
Somewhat hard	14%		Eagleton/NBT 2012
Very hard	6%		Eagleton/NBT 2012
Don't know	5%		Eagleton/NBT 2012
Went to ED ≥ 1 time in last 12 months		20.1%	Hospitals 2012
Main reason for ED visit was emergency		63.1%	Hospitals 2012
Healthcare provider visits in past 12 months			
Check-ups / preventive		80.5%	Hospitals 2012
Specialty visits		52.8%	Hospitals 2012
Other doctor visits		33.3%	Hospitals 2012
In past 12 months, made call(s) to a health care provider about own health, including medical advice, prescriptions, or test results but not scheduling		48.3%	Hospitals 2012
Rate per 100,000 population for avoidable ED visits that were primary care treatable		7829.0	CSHP Util 2013
Hospital discharge rate for ambulatory care-sensitive conditions per 1000 Medicare enrollees		65.0	County HR 2013

	New Brunswick	Middlesex County	Source
Insurance Status			
Do any of your jobs provide health benefits?			
Yes	52.5%		Bloustein/NBT 2011
No	47.5%		Bloustein/NBT 2011
Do you have any other health insurance?			
Yes	41.3%		Bloustein/NBT 2011
No	58.7%		Bloustein/NBT 2011
Programs that you or your family currently participate in?			
FamilyCare	18.9%		Bloustein/NBT 2011
SCHIP	4.1%		Bloustein/NBT 2011
Medicaid	41.5%		Bloustein/NBT 2011
Medicare	46.0%		Bloustein/NBT 2011
Charity Care	10.1%		Bloustein/NBT 2011
Children receiving NJ Family Care / Medicaid		30.4%	Kids Count 2013
Children under 18 without health insurance		6.4%	Kids Count 2013
Percent of the population < 65 that has no health insurance		15.0%	County HR 2013
Main health insurance coverage			
Public		28.4%	Hospitals 2012

	New Brunswick	Middlesex County	Source
Private		64.9%	Hospitals 2012
Uninsured		6.7%	Hospitals 2012

	New Brunswick	Middlesex County	Source
Barriers to Care			
Reasons for Not Obtaining Care Including Navigation and Language Barriers			
No insurance or cannot afford it	54%		Eagleton/NBT 2012
Excessive wait / no doctors	35%		Eagleton/NBT 2012
Residency	4%		Eagleton/NBT 2012
Other	8%		Eagleton/NBT 2012
Could not get transportation		7.6%	Hospitals 2012
Could not get day care		10.7%	Hospitals 2012
No available parking at place of care		16.0%	Hospitals 2012
Unable to find provider who spoke same language		8.0%	Hospitals 2012
Hours were inconvenient		35.3%	Hospitals 2012
Had to wait too long for an appointment		34.8%	Hospitals 2012
In the past 12 months did not get or delayed getting a prescription medicine because it cost too much		15.4%	Hospitals 2012
In the past 12 months reduced or skipped dose(s) of prescription medicine to save money		11.3%	Hospitals 2012
Ever had difficulty communicating with a healthcare provider because of a difference in language			
Yes	22.8%		Bloustein/NBT 2011
No	77.2%		Bloustein/NBT 2011

	New Brunswick	Middlesex County	Source
HISTORIC DATA			
Location of Care			
Regular place of care - all children			
Private doctor	48.4%		CSHP/HNB 2004
Hospital / clinic	15.7%		CSHP/HNB 2004
Health center	21.6%		CSHP/HNB 2004
Other	6.2%		CSHP/HNB 2004
No regular source of care	8.1%		CSHP/HNB 2004
Mexican	10.6%		CSHP/HNB 2004
Near-poor*	16.4%		CSHP/HNB 2004
Uninsured	25.4%		CSHP/HNB 2004
Insurance Status			
Do you have any other health insurance?			
Yes	88.0%		Middlesex Co. CHNA 2001
No	22.0%		
Uninsured children	17.3%		CSHP/HNB 2004
Near-poor*	26.3%		CSHP/HNB 2004
Mexican	27.8%		CSHP/HNB 2004

	New Brunswick	Middlesex County	Source
HISTORIC DATA (continued)			
Barriers to Care			
Difficulty getting			
Prescription drugs	3.7%		CSHP/HNB 2004
Dental care	4.7%		CSHP/HNB 2004
Medical or surgical care	1.6%		CSHP/HNB 2004
Mental health	0.6%		CSHP/HNB 2004
Barrier is a "Major problem"			
Wait for appointment	30.2%		CSHP/HNB 2004
Language	18.4%		CSHP/HNB 2004
Finding parking	16.9%		CSHP/HNB 2004
Hours available	13.3%		CSHP/HNB 2004
Transportation	10.5%		CSHP/HNB 2004
Daycare	7.9%		CSHP/HNB 2004
* Near-poor is 101% and 200% of federal poverty level			

Appendix B: Sources and Methods for the Data Provided in the Report and Appendix A

Note: This Appendix is in alphabetical order organized by the shorthand used in the data tables (see Appendix A). For each study or assessment we provide a description as well as the formal citation used in the report.

Bloustein/NBT 2011

New Brunswick Tomorrow 2011 Needs Assessment is a mixed-mode survey research study performed for New Brunswick Tomorrow by the Bloustein Center for Survey Research, Edward J. Bloustein School of Planning and Public Policy at Rutgers, the State University of New Jersey. This 34-question survey included multiple choice and yes/no questions as well as open-ended items. Data collection included mail surveys and in-person administrations. The randomly selected mail sample of 3,330 addresses was stratified into 4 zones (1: students and commuters, 2: border area – mix of all, 3: densely populated Latino/a and 4: Latino/a and African American) and included an oversample for senior citizens. Respondents completed 724 surveys by mail for a 24.98% response rate. An additional 119 surveys were completed during site collections at the Adult Learning Center, Sharon Baptist Church, and Puerto Rican Action Board (PRAB). Total response rate for the mail and site collection surveys was 28.27%.

Report citation: Weiner, M.D., MacKinnon, T.D., & Puniello, O.T. (March 2011). *New Brunswick Tomorrow 2011 Needs Assessment*. New Brunswick, N.J.: Rutgers Edward J. Bloustein School of Planning and Public Policy, The Bloustein Center for Survey Research.

BRFSS 2010

In 1984, the Centers for Disease Control and Prevention (CDC) established the Behavioral Risk Factor Surveillance System (BRFSS), which collects state data about U.S. residents regarding their health-related risk behaviors and events, chronic health conditions, and use of preventive services. Currently, BRFSS collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year using multi-modes (mail, landline phone, and cell phone). State health departments use in-house interviewers or contract with telephone call centers or universities to administer the BRFSS surveys continuously through the year. The states use a standardized core questionnaire, optional modules, and state-added questions. See http://apps.nccd.cdc.gov/BRFSS-SMART/

Report citation: CDC – Centers for Disease Control and Prevention. (2010a). Data for Middlesex County, N.J. *Behavioral Risk Factor Surveillance System (BRFSS)*. Retrieved June 7, 2013 from http://www.cdc.gov/brfss/

County HR 2013

The *Rankings* data set is based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play.

Building on the work of America's Health Rankings, the University of Wisconsin Population Health Institute uses this model to rank the health of counties. The *County Health Rankings* measures the health of nearly all counties in the nation and ranks them within states. The *Rankings* data set is compiled using county-level measures from a variety of national and state data sources. These measures are standardized and combined using scientifically-informed weights. See http://www.countyhealthrankings.org

Report citation: University of Wisconsin, Population Health Institute and Robert Wood Johnson Foundation (2013). County Health Rankings and Roadmaps. Data for Middlesex County, N.J. retrieved June 6, 2013 from http://www.countyhealthrankings.org/app/new-jersey/2013/middlesex/county/outcomes/overall/snapshot/by-rank

CSHP/HNB 2004

The Rutgers Center for State Health Policy conducted a community health needs assessment (CHNA) of New Brunswick, N.J. for the Healthier New Brunswick 2010 initiative sponsored by New Brunswick Tomorrow and the then UMDNJ-Robert Wood Johnson Medical School. For this CHNA, the CSHP conducted focus groups, interviewed residents and community stakeholders, and administered a survey to New Brunswick residents. We used the data from this study to provide historic data for New Brunswick.

Report citations: Cantor, J.C., Guarnaccia, P., Brownlee, S., Schneider, C., & Nova, J. (April 2006). *Health and Health Care of New Brunswick's Children: A Chartbook.* New Brunswick, N.J.: Rutgers Center for State Health Policy and Healthier New Brunswick 2010. And. Guarnaccia, P., Martinez, I., Silberberg, M., Cantor, J.C., & Davis, D. (Fall 2004). Health and Health Care for the Residents of New Brunswick: Focus Group Perspectives A 'Report of the New Brunswick Community Health Assessment. New Brunswick, N.J.: Rutgers Center for State Health Policy and Healthier New Brunswick 2010.

CSHP Util 2013

Researchers used the New Jersey uniform billing (UB) data over the period 2008-2010 available from the N.J Department of Health (DOH). This hospital discharge-level database is the source of inpatient hospitalization and treat-and-release emergency department (ED) utilization by all adult (age 18 or older) hospital patients within each study area. The New Brunswick ACO area includes New Brunswick city and Franklin Township. With the assistance of the DOH Center for Health Statistics, the researchers enhanced the publicly releasable UB files to create a linked database that tracks patients over time. For calculating population-based estimates researchers use zip code level population data available from Nielsen Claritas. See http://www.cshp.rutgers.edu/Downloads/9810.pdf

Report citation: Chakravarty, S., Cantor, J.C., Tong, J., DeLia, D., Lontok, O., & Nova, J. (March 2013). *Hospital Utilization Patterns in 13 Low Income Communities in New Jersey: Opportunities for Better Care and Lower Costs*. New Brunswick, N.J.: Rutgers Center for State Health Policy.

Eagleton/NBT 2012

New Brunswick Tomorrow Final Report is a telephone fielded survey (both landlines and cellphones) designed by the Eagleton Center for Public Interest Polling in collaboration with New Brunswick Tomorrow. This 58-question survey included multiple choice and yes/no questions and open-ended items, which the researchers categorized during analysis. A total of 600 respondents completed the survey via landline and 150 via cell phone. Respondents were screened to be permanent New Brunswick residents (full time Rutgers students were not included, unless they had long-term residence in New Brunswick). Results were weighted to known parameters of the New Brunswick adult population, using U.S. Census Bureau data, based on respondent gender, race, and ethnicity.

Report Citation: Redlawsk, D.P. (October 2012). *New Brunswick Tomorrow Final Report*. New Brunswick, N.J.: Rutgers Eagleton Center for Public Interest Polling.

FBI Crime 2012

Uniform Crime Reporting (UCR) data is a collective effort of nationwide city, county, state, tribal, and federal law enforcement agencies. Participating agencies throughout the country voluntarily provide monthly reports on crimes known to the police and on persons arrested. After FBI staff members review the information for accuracy and reasonableness, they enter the data into the national database. See http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2012/crime-in-the-u.s.-2012/tables/8tabledatadecpdf/table-8-state-cuts/table_8_offenses_known_to_law_enforcement_by_new_jersey_by_city_2012.xls

Report Citation: FBI – Federal Bureau of Investigation (2012). Uniform Crime Reports. Table 8: New Jersey Offenses Known to Law Enforcement by City. *Crime in the United States 2012.* Retrieved December 5, 2013 from http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2012/crime-in-the-u.s.-2012/tables/8tabledatadecpdf/table-8-state-cuts/table_8_offenses_known_to_law_enforcement_by_new_jersey_by_city_2012.xls

Hospitals 2012

A Community Health Needs Assessment for Saint Peter's University Hospital and Robert Wood Johnson University Hospital is a random-digit dial telephone survey of non-institutionalized New Jersey adults ages 18 and over residing in Middlesex County or two zip codes in Somerset County (08873, 08823) that directly border Middlesex County. This area was previously defined by hospital staff as their main patient service area. Telephone interviews for the 231 question survey were completed for 1000 respondents; 750 of the completed interviews were conducted via landline telephone, while 250 were conducted via cellular telephone. Proportionate samples were drawn from each of the zip codes in the sampling area in order to ensure representativeness. The overall cooperation rate for the survey was 55.9%. See http://www.cshp.rutgers.edu/Downloads/9620.pdf

Report Citation: Chakravarty, S., Brownlee, S., Tong, J., Pellerano, M.B., Howard, J., Shaw, E.K., Chase, S. & Crabtree, B.F. (December 2012). *A Community Health Needs Assessment for*

Saint Peter's University Hospital & Robert Wood Johnson University Hospital: Findings from the Behavioral Risk Factor & Surveillance System (BRFSS), Hospital Discharge Data, A Community Survey, Key Informant Interviews, and Community Member Focus Groups. New Brunswick, N.J.: Rutgers Center for State Health Policy and UMDNJ-Robert Wood Johnson Medical School, Department of Family Medicine and Community Health.

Kids Count 2013

New Jersey Kids Count is a project of Advocates for Children of New Jersey. Funded by the Annie E. Casey Foundation, this annual snapshot of child well-being is intended to inform policymakers and the public of the challenges and successes New Jersey faces in ensuring the health, welfare and safety of all children. The New Jersey Kids Count 2013 Pocket Guide documents key measures of child well-being on the county and state levels.
See http://www.acnj.org/admin.asp?uri=2081&action=15&di=2514&ext=pdf&view=yes

Report Citation: Advocates for Children of New Jersey (2013). *The Pocket Guide 2013 New Jersey Kids Count: the State of Our Counties.* Newark, N.J.: Advocates for Children of New Jersey.

Middlesex County CHNA 2001

The Middlesex County Public Health Department researched and reported on the community health needs of the New Brunswick community in 2001. This report assessed the health of New Brunswick and provided information on several factors that influence health. The data in this report described health status, health risks, health care access, and other health determinants, such as housing structures and water fluoridation. The authors compared national, state, county, and municipal data to the Healthy People 2010 objectives showing health improvements that were needed.

Report Citation: Middlesex PHD – Middlesex County Public Health Department (2001). *Community Health Needs Assessment for New Brunswick: A Comprehensive Report on the Health of the Residents of New Brunswick, New Jersey.* New Brunswick: Middlesex County Public Health Department.

NJ Asthma 2010

The New Jersey Department of Health and Senior Services (NJDHSS) monitors the percentage of residents with lifetime asthma and current asthma using the New Jersey Behavioral Risk Factor Survey (NJBRFS). The NJBRFS is an ongoing telephone survey that is partially funded by the Centers for Disease Control and Prevention (CDC) and is administered by the NJDHSS Center for Health Statistics. Using this system, population-based estimates are generated from interviews of non-institutionalized adults aged 18 years and older. Asthma cases reflect only those that have been diagnosed by a health care professional, as reported by survey respondents.
See http://www.nj.gov/health/fhs/asthma/asthma_resources.shtml#publications

Report Citation: New Jersey Asthma Awareness and Education Program. (November 2010).

Asthma in New Jersey. Trenton, N.J.: New Jersey Department of Health. Retrieved June 3, 2013 from http://www.state.nj.us/health/fhs/asthma/asthma_resources.shtml

NJ DCF 2011

The New Jersey State Child Abuse and Neglect Hotline, also known as the State Centralized Registry, fields an average of 15,000 phone calls per month. When a call comes into the hotline and the caller reports a child may have been abuse or neglected, one of our screening staff takes down all of that information and then reaches out to our staff in the field to conduct an investigation. As a result of that investigation, we make a finding about whether or not child abuse or neglect occurred. This report provides an overview of statistics on child abuse and neglect and family problem cases reported to the New Jersey Division of Youth and Family Services for calendar year 2011.

Report Citation: NJ DCF – State of New Jersey, Department of Children and Families. (2011). *Child Abuse and Neglect Substantiations, Calendar Year 2011.* Trenton, N.J.: State of New Jersey, Department of Children and Families.

NJ DV 2011

Pursuant to N.J.S.A. 2C:25-24, *Domestic Violence In New Jersey: For the Year Ending December 31, 2011* is the twenty-ninth annual report on domestic violence in New Jersey. The annual report is based on the domestic violence offense reports submitted to the New Jersey Uniform Crime Reporting System by every New Jersey law enforcement agency for the year 2011. See http://www.njsp.org/info/ucr2011/pdf/2011_domestic_violence.pdf

Report Citation: State Police of New Jersey, Uniform Crime Unit. (2011). *Domestic Violence in New Jersey, For the Year Ending December 31, 2011.* Trenton, N.J.: State of New Jersey, Department of Law and Public Safety, State Police of New Jersey, Uniform Crime Unit.

NJ HIV/AIDS 2012

Data in this report are based on cases that were reported to the Division of HIV, STD and TB Services (DHSTS) through June 30, 2012. A description of how these data are collected can be found in the June 2002 HIV and AIDS Surveillance Report – available on the NJDOH website at www.state.nj.us/health/aids/aidsqtr.shtml

Report Citations: NJDOH HIV – Division of HIV, STD, and TB Services-Sexually Transmitted Diseases Program. (2012a). New Brunswick Residents at Diagnosis: HIV/AIDS Cases Reported as of December 31, 2012. Retrieved June 6, 2013 from http://www.state.nj.us/health/aids/repa/allcities/documents/new_brunswick.pdf And. NJDOH HIV – Division of HIV, STD, and TB Services-Sexually Transmitted Diseases Program. (2012b). Middlesex County Residents at Diagnosis: HIV/AIDS Cases Reported as of December 31, 2012. Retrieved from June 6, 2013 http://www.state.nj.us/health/aids/repa/county/documents/middlesex.pdf

NJ SHAD

The New Jersey Department of Health's State Health Assessment Data (NJSHAD) System provides access to public health datasets and information on the health status of New Jerseyans. NJ SHAD reports various national and state data sets for each of the data points. See http://www4.state.nj.us/dhss-shad/home

Report Citations: NJ SHAD (2012a). Data for Percent of Children Tested for Lead Poisoning Before 3 Years of Age, by County, among Children Born in 2008. Retrieved June 3, 2013 from http://www4.state.nj.us/dhss-shad/indicator/view_numbers/Pb_test_cov.pcnt_co_b04.html And. NJ SHAD (2012b). Data for Percent of Tested Children under 3 Years of Age with Confirmed Blood Lead of ≥ 10 µg/dL, Children Born in 2008 by County. Retrieved June 3, 2013 from http://www4.state.nj.us/dhss-shad/indicator/view_numbers/Pb_blood_lev.Pb_GE10.html

NJ STD Program 2012

Cases of sexually transmitted diseases (STDs) reported to the New Jersey Department of Health (NJDOH). Healthcare providers, institutions (e.g., institutions of higher learning, correctional facilities, and day care centers), and laboratories are required to report STDs to NJDOH within 24 hours of diagnosis. See http://www.state.nj.us/health/std/stats.shtml

Report Citation: NJDOH STD – Division of HIV, STD, and TB Services-Sexually Transmitted Diseases Program. (2012). Reported Sexually Transmitted Diseases Morbidity in Middlesex County by Municipality for Reporting Year 2012. Retrieved November 29, 2013 from http://www.state.nj.us/health/std/stdstats/stdstats2012/middlesex.pdf

NJ SubsAb Chartbook 2013

The New Jersey Chartbook of Substance Abuse Related Social Indicators: Middlesex County is intended to identify social and health problems directly or indirectly related to substance use and to aid in the assessment of needs for treatment and prevention services. Data for the social indicators core protocol and supplemental indicators were obtained from archival sources published by the U.S. Bureau of the Census and New Jersey governmental agencies, including the Departments of Human Services, Health, and Law and Public Safety. Data are also obtained from DMHAS' Substance Abuse Monitoring System and from DMHAS sponsored needs assessment surveys. A detailed list of sources is provided in an Appendix of the Chartbook. See http://www.state.nj.us/humanservices/das/news/reports/epidemiological/Middlesex_County_Chartbook_2013.pdf

Report Citation: New Jersey Department of Human Services, Division of Mental Health and Addiction Services (May 2013). *The New Jersey Chartbook of Substance Abuse Related Social Indicators: Middlesex County.* Trenton, N.J.: New Jersey Department of Human Services.

NJ SubsAb Middlesex 2013

The *Substance Abuse Overview* publications provide statistics on substance abuse treatment for each New Jersey County for calendar year 2012. In 2012 there were 75,837 treatment admissions and 73,036 discharges reported to the New Jersey Department of Human Services, Division of Mental Health and Addiction Services by substance abuse treatment providers. These reports were submitted through the web-based New Jersey Substance Abuse Monitoring System (NJSAMS). See http://www.state.nj.us/humanservices/das/news/reports/statistical/Substance%20Abuse%20Overview%20Reports%202012/Sub_Abuse_Overview_2012_Midd.pdf

Report Citation: Zhu, L., (June 2013). *Substance Abuse Overview 2012: Middlesex County*. Trenton, N.J.: Department of Human Services, Division of Mental Health and Addiction Services. Retrieved November 20, 2013 from http://www.state.nj.us/humanservices/das/news/reports/statistical/Substance%20Abuse%20Overview%20Reports%202012/Sub_Abuse_Overview_2012_Midd.pdf

NJ WIC 2014

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides Federal grants to States for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk. Researchers developed formulas for each of the data points using information from official New Jersey vital statistics (for 2006-2008) and poverty statistics from the 2010 Census of Population. Estimates were made for 75 municipalities (with a population of 30,000 or more according to the 2010 Census of Population) and 21 counties or in the balance of a county where individual municipalities were included. See http://www.state.nj.us/health/fhs/wic/documents/2014_state_strategic_plan.pdf

Report Citation: NJDOH WIC – New Jersey Department Of Health, Public Health Services Branch, Family Health Services, WIC Services (2013). *Special Supplemental Nutrition Program For Women, Infants And Children (WIC), FFY 2014: State Strategic Plan*. Trenton, N.J.: New Jersey Department Of Health, Public Health Services Branch, Family Health Services, WIC Services.

Obesity 2010

The NJ Childhood Obesity Study was conducted by the Rutgers Center for State Health Policy (CSHP) and funded by the Robert Wood Johnson Foundation School in five cities in New Jersey (Camden, New Brunswick, Newark, Trenton, and Vineland). Rutgers CSHP obtained de-identified data from the New Brunswick Public Schools (2008-2009) and computed a BMI score and BMI percentile for each child. A random-digit-dial landline telephone sample of 208 households from New Brunswick was surveyed (as were samples from the other 4 cities) for a total of 1700 families with 3 – 18 year old children. Average survey length was 36 minutes. Worksheets and tape measures were mailed to each home to weigh and measure 3–18 year old children and the respondent. Overall response rate was 49%. For School BMI Data see http://www.cshp.rutgers.edu/Downloads/8430.pdf and for the Survey Chartbook see http://www.cshp.rutgers.edu/Downloads/8660.pdf

Report Citations: Lloyd, K., Ohri-Vachaspati, P., Brownlee, S., Yedidia, M., Gaboda, D., and Chou, J. (2010). *New Jersey Childhood Obesity Survey Chartbook: New Brunswick.* New Brunswick, N.J.: Rutgers Center for State Health Policy. And: Ohri-Vachaspati, P., Lloyd, K., Chou, J., Petlick, N., Brownlee, S., & Yedidia, M. (2010). *The New Jersey Childhood Obesity Study: New Brunswick School BMI Data.* New Brunswick, N.J.: Rutgers Center for State Health Policy.

PRAB 2012

The *Middlesex County Human Services Needs Assessment* was conducted by the Rutgers School of Social Work for PRAB, Inc. in 2012. It included three components: 1) Surveys were sent to 2,132 randomly selected households in Middlesex County regarding their human service needs. Completed surveys were received from 770 households for a 40% response rate; 2) Face-to-face interviews with 132 PRAB clients regarding their human service needs; and 3) Archival data was analyzed from a variety of national, state, and local sources. See http://www.prab.org/wp-content/uploads/2013/03/Middlesex-County-Needs-Assessment-Report-March-13-2013.pdf

Report Citation: Rutgers School of Social Work and PRAB (2013). *Middlesex County Human Services Needs Assessment.* New Brunswick, N.J.: Rutgers School of Social Work and PRAB.

US Census 2010

The U.S. Census counts every resident in the United States every 10 years. Approximately 74 percent of the households returned their census forms by mail and the remaining households were counted by census workers walking neighborhoods throughout the United States. The web-based American FactFinder provides access to data about the United States, Puerto Rico and the Island Areas. The data in American FactFinder come from several censuses and surveys. See http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Report Citation: U.S. Census Bureau, 2010. American FactFinder. Retrieved November 26 and 27, 2013 from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Appendix C: Indicator Tables with Baseline, Target, and New Brunswick Information Where Available

Table 1					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Healthy People 2020 Leading Health Indicators Topics and Objectives	**Healthy People Baseline**	**Healthy People Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Access to Health Services													
Increase the proportion of persons with medical insurance (AHS-1.1)	83.2%	100.0%	At least 52.5%	Bloustein/NBT 2011									✓
Increase the proportion of persons with a usual primary care provider (AHS-3)	76.3%	83.9%	84.2%	Bloustein/NBT 2011									✓
Clinical Preventive Services													
Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines (C-16)	52.1%	70.5%	Not available										
Increase the proportion of adults with hypertension whose blood pressure is under control (HDS-12)	43.7%	61.2%	Not available										
Reduce the proportion of persons (ages 18 and older) with diabetes with an A1c value greater than 9 percent (D-5.1)	17.9%	16.1%	Not available									✓	
Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine (PCV) (IID-8)	44.3%	80.0%	Not available										
Environmental Quality													
Reduce the number of days the Air Quality Index (AQI) exceeds 100, weighted by population and AQI (EH-1)	2,200,000,000 AQI-weighted people days exceeded 100 on the AQI	1,980,000,000 AQI-weighted people days exceeded 100 on the AQI	Not available		✓								
Reduce the proportion of children aged 3 to 11 years exposed to secondhand smoke (TU-11.1)	52.2%	47.0%	Not available		✓			✓					

Table 1					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Healthy People 2020 Leading Health Indicators Topics and Objectives	**Healthy People Baseline**	**Healthy People Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Injury and Violence													
Reduce fatal injuries (IVP-1.1)	59.2 deaths per 100,000	53.3 deaths per 100,000	12.7	NJSHAD, 2009									
Reduce homicides (IVP-29)	6.1 per 100,000	5.5 per 100,000	14.5	FBI Crime, 2012					✓				
Maternal, Infant, and Child Health													
Reduce the rate of all infant deaths (within 1 year) (MICH-1.3)	6.7 infant deaths per 1,000 live births	6.0 infant deaths per 1,000 live births	Not available										
Reduce total preterm births (MICH-9.1)	12.7 percent of live births	11.4 percent of live births	Not available								✓		
Mental Health													
Reduce the suicide rate (MHMD-1)	11.3 suicides per 100,000	10.2 suicides per 100,000	Not available			✓							
Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs) (MHMD-4.1)	8.3%	7.4%	Not available			✓							
Nutrition, Physical Activity, and Obesity													
Increase the proportion of adults who meet the objectives for aerobic physical activity and muscle strengthening activity (PA-2.4)	18.2%	20.1%	Not available				✓						
Reduce the proportion of adults who are obese (NWS-9)	33.9%	30.5%	Not available				✓						
Reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese (NWS-10.4)	16.1%	14.5%	26.7%	Obesity 2010			✓						

Table 1					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Healthy People 2020 Leading Health Indicators Topics and Objectives	**Healthy People Baseline**	**Healthy People Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Increase the contribution of total vegetables to the diets of the population aged 2 years and older (NWS-15.1)	0.8 cup equivalent of total vegetables per 1,000 calories	1.1 cup equivalent of total vegetables per 1,000 calories	31% of children have ≥ 2 servings per day	Obesity 2010			✓						
Oral Health													
Increase the proportion of children, adolescents, and adults who used the oral health care system in past year (OH-7)	44.5%	49.0%	Not available										✓
Reproductive and Sexual Health													
Increase the proportion of sexually experienced females aged 15 to 44 years who received reproductive health services in the past 12 months (FP-7.1)	78.6%	86.5%	Not available								✓		
Increase the proportion of persons living with HIV who know their serostatus (HIV-13)	80.6%	90.0%	Not available								✓		
Social Determinants													
Increase the proportion of students attending public schools graduated with a regular diploma 4 years after starting 9th grade (AH-5.1)	74.9%	82.4%	58.6%	NJ DOE, 2012									
Substance Abuse													
Reduce the proportion of adolescents (12-17 years old) reporting use of alcohol or any illicit drugs during the past 30 days (SA-13.1)	18.4%	16.6%	Not available			✓							
Reduce the proportion of persons engaging in binge drinking during the past 30 days - adults aged 18 years and older (SA-14.3)	27.1%	24.4%	Not available			✓							
Tobacco													
Reduce cigarette smoking by adults (TU-1.1)	20.6%	12.0%	Not available					✓					

Table 1					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Healthy People 2020 Leading Health Indicators Topics and Objectives	**Healthy People Baseline**	**Healthy People Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Reduce use of cigarettes by adolescents (past month) (TU-2.2)	19.5%	16.0%	Not available					✓					

Table 2					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Healthy New Jersey 2020 Leading Health Indicators Topics and Objectives	**Healthy New Jersey Baseline**	**Healthy New Jersey Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Access to Primary Care													
Increase the proportion of adults with a usual primary care provider	83.5%	90.0%	84.2%	Bloustein/NBT 2011									✓
Birth Outcomes													
Reduce the infant death rate	5.1 per 1,000 live births	4.8 per 1,000 live births	Not available										
Childhood Immunization													
Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and pneumococcal conjugate vaccine (PCV)	74.0%	80.0%	Not available										
Heart Disease													
Reduce the death rate due to coronary heart disease	140.1 per 100,00 population (age-adjusted)	112.1 per 100,00 population (age-adjusted)	Not available										
Obesity													
Prevent an increase in the proportion of the population that is obese - adults	23.8%	23.8%	Not available				✓						
Prevent an increase in the proportion of the population that is obese - high school students	10.3%	10.3%	24.6%	Obesity 2010			✓						

Table 3					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
National Prevention Strategy (NPS) Indicators Topics and Objectives	**NPS Baseline**	**NPS Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Goal Indicators													
Rate of infant mortality per 1,000 live births (MICH-1.3)	6.7 infant deaths per 1,000 live births	4.5 infant deaths per 1,000 live births	Not available								✓		
Proportion of Americans who live to age 25	98.3%	98.9%	Not available										
Proportion of Americans who live to age 65	83.6%	90.6%	Not available										
Proportion of Americans who live to age 85	38.6%	57.7%	Not available										
Proportion of 0 to 24 year old Americans in good or better health	97.7%	97.9%	Not available										
Proportion of 25-64 year old Americans in good or better health	88.6%	87.2%	Not available										
Proportion of 65-84 year old Americans in good or better health	77.5%	83.3%	Not available										
Proportion of 85+ year old Americans in good or better health	64.9%	71.7%	Not available										
Leading Causes of Death													
Rate of cancer deaths (C-1)	178.4 deaths per 100,000 population	160.6 deaths per 100,000 population	83.3	NJSHAD, 2009									
Rate of coronary heart disease deaths (HDS-2)	126.0 deaths per 100,000 population	100.8 deaths per 100,000 population	65.2	NJSHAD, 2009			✓						
Rate of stroke deaths (HDS-3)	42.2 deaths per 100,000 population	33.8 deaths per 100,000 population	10.9	NJSHAD, 2009			✓						
Rate of chronic lower respiratory disease deaths	40.8 deaths per 100,000 population	35.1 deaths per 100,000 population	10.9	NJSHAD, 2009									

Table 3					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
National Prevention Strategy (NPS) Indicators Topics and Objectives	**NPS Baseline**	**NPS Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Reduce unintentional injury deaths (IVP-1.1)	40.0 deaths per 100,000	36.0 deaths per 100,000	12.7	NJSHAD, 2009									
Healthy and Safe Environments													
Number of days the Air Quality Index (AQI) exceeds 100 (EH-1)	11 days	10 days	Not available		✓								
Amount of toxic pollutants released into the environment (EH-11)	1,950,000 tons	1,750,000 tons	Not available		✓								
Proportion of state public health agencies that can convene, within 60 minutes of notification, a team of trained staff who can make decisions about appropriate response and interaction with partners	84.0%	98.0%	Not available										
Proportion of children aged 5 to 17 years with asthma who missed school days in the past 12 months (RD-5.1)	58.7%	48.7%	Not available		✓								
Clinical and Community Preventive Services													
Proportion of medical practices that use electronic health records (HC/HIT-10)	25.0%	27.5%	Not available										✓
Proportion of adults aged 18 years and older with hypertension whose blood pressure is under control (HDS-12)	43.7%	61.2%	Not available				✓						
Proportion of adults aged 20 years and older with high low-density lipoprotein (LDL) cholesterol whose LDL is at or below recommended levels	33.2%	36.5%	Not available				✓						
Proportion of adults aged 50 to 75 years who receive colorectal cancer screening based on the most recent guidelines (C-16)	54.2%	70.5%	Not available										

Table 3					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
National Prevention Strategy (NPS) Indicators Topics and Objectives	**NPS Baseline**	**NPS Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Proportion of children and adults who are vaccinated annually against seasonal influenza (IID-12.1 to IID-12.5 & IID-12.7)													
6-23 months (IID-12.1)	23.0%	80.0%	Not available										
2-4 years (IID-12.2)	40.0%	80.0%	Not available										
5-12 years (IID-12.3)	26.0%	80.0%	Not available										
13-17 years (IID-12.4)	10.0%	80.0%	Not available										
18-64 years (IID-12.5)	24.9%	80.0%	Not available										
65+ years (IID-12.7)	67.0%	90.0%	Not available										
Empowered People													
Proportion of persons who report their health care providers always explained things so they could understand them (HC/HIT-2.2)	60.0%	66.0%	Not available										✓
Proportion of adults reporting that they receive the social and emotional support they need	80.0%	88.0%	Not available										
Elimination of Health Disparities													
Proportion of adults (from racial/ethnic minority groups) in fair or poor health													
African Americans	14.2%	8.8%	Not available										
Hispanics	13.0%	8.8%	Not available										
American Indian or Alaska Native	17.1%	8.8%	Not available										
Proportion of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines (AHS-6.1)	10.1%	9.0%	Not available										✓

Table 3					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
National Prevention Strategy (NPS) Indicators Topics and Objectives	**NPS Baseline**	**NPS Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Proportion of persons who report their health care provider always listens carefully (HC/HIT-2.1)	59.0%	65.0%	Not available										✓
Tobacco Free Living													
Reduce cigarette smoking by adults (TU-1.1)	20.6%	12.0%	Not available		✓			✓					
Reduce use of cigarettes by adolescents (past month) (TU-2.2)	19.5%	16.0%	Not available		✓			✓					
Reduce the proportion of children aged 3 to 11 years exposed to secondhand smoke (TU-11.1)	52.2%	47.0%	Not available		✓			✓					
Preventing Drug Abuse and Excessive Alcohol Use													
Proportion of adults aged 18 years and older who reported that they engaged in binge drinking during the past month (SA-14.3)	27.1%	24.3%	Not available			✓							
Proportion of high school seniors who binge drinking during the past two weeks (SA-14.3)	25.2%	22.7%	Not available			✓							
Proportion of persons aged 12 years or older who reported nonmedical use of any psychotherapeutic drug in the past year (SA-19.5)	6.1%	5.5%	Not available			✓							
Proportion of youth aged 12 to 17 years who have used illicit drugs in the past 30 days	10.0%	9.3%	Not available			✓							
Proportion of adults and children who are obese													
Adults 20+ years (NWS-9)	34.0%	30.6%	Not available				✓						

Table 3					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
National Prevention Strategy (NPS) Indicators Topics and Objectives	**NPS Baseline**	**NPS Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Children and adolescents 2-19 years (NWS-10)	16.2%	14.6%	26.7%	Obesity 2010			✓						
Average daily sodium consumption in the population (NWS-19)	3,641 mg	2,300 mg	Not available				✓						
Average number of infections caused by salmonella species transmitted commonly through food (FS-1.4)	15.2 cases per 100,000 population	11.4 cases per 100,000 population	Not available				✓						
Proportion of infants who are breastfed exclusively through 6 months (MICH-21.5)	14.1%	25.5%	Not available				✓						
Active Living													
Proportion of adults who meet physical activity guidelines for aerobic physical activity (PA-2.1)	43.5%	47.9%	Not available				✓						
Proportion of adolescents who meet physical activity guidelines for aerobic physical activity (PA-3.1)	18.4%	20.2%	Not available				✓						
Proportion of the nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (PA-10)	28.8%	31.7%	Not available				✓						
Proportion of commuters who use active transportation (i.e. walk, bicycle, and public transit) to travel to work (N/A)	8.7%	20.0%	Not available				✓						
Injury and Violence Free Living													
Rate of fatalities due to alcohol impaired driving (SA-17)	.40 deaths per 100 million vehicle miles traveled	.38 deaths per 100 million vehicle miles traveled	Not available			✓							

Table 3					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
National Prevention Strategy (NPS) Indicators Topics and Objectives	**NPS Baseline**	**NPS Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Rate of fall related deaths among adults aged 65 years and older (IPV-23.2)	45.3 deaths per 100,000 population	45.3 deaths per 100,000 population	Not available										
Rate of homicides (IVP-29)	6.1 per 100,000	5.5 per 100,000	14.5	FBI Crime, 2012					✓				
Rate of motor vehicle crash-related deaths (IVP-13.1)	13.8 deaths per 100,000 population	12.4 deaths per 100,000 population	1.8	NJSHAD, 2009									
Reproductive and Sexual Health													
Proportion of children born with low birth weight (LBW) and very low birth weight (VLBW)													
Low Birth Weight (MICH-8.1)	8.2%	7.8%	Not available								✓		
Very Low Birth Weight (MICH-8.2)	1.5%	1.4%	Not available								✓		
Proportion of pregnant females who received early and adequate prenatal care (MICH-10.2)	70.5%	77.6%	Not available								✓		
Pregnancy rates among adolescent females aged 15 to 19 years													
15-17 years	40.2 pregnancies per 1,000 females	36.2 pregnancies per 1,000 females	Not available								✓		
18-19 years	117.7 pregnancies per 1,000 females	105.9 pregnancies per 1,000 females	Not available								✓		
Increase the proportion of sexually experienced females aged 15 to 44 years who received reproductive health services in the past 12 months			Not available										
Females (FP-7.1)	78.9%	86.7%	Not available								✓		
Males (FP-7.2)	14.9%	16.4%	Not available								✓		

Table 3					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
National Prevention Strategy (NPS) Indicators Topics and Objectives	**NPS Baseline**	**NPS Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Proportion of persons living with HIV who know their serostatus (HIV-13)	79.0%	90.0%	Not available								✓		
Proportion of sexually active females aged 16 to 20 years and 21 to 24 years enrolled in Medicaid and commercial health insurance plans who were screened for genital Chlamydia infections during the measurement year													
16-20 year old females enrolled in Medicaid plans (STD-3.1)	52.7%	74.4%	Not available								✓		
21-24 year old females enrolled in Medicaid plans (STD-3.2)	59.4%	80.0%	Not available								✓		
16-20 year old females enrolled in commerical health insurance plans (STD-4.1)	40.1%	65.9%	Not available								✓		
21-24 year old females enrolled in commerical health insurance plans (STD-4.2)	43.5%	78.3%	Not available								✓		
Mental and Emotional Well Being													
Proportion of primary care physician office visits that screen adults and youth for depression													
Adults 19+ years (MHMD-11.1)	2.2%	2.4%	Not available			✓							
Youth, 12-18 years (MHMD-11.2)	2.1%	2.3%	Not available			✓							
Proportion of children exposed to violence within the past year, either directly or indirectly (e.g., as a witness to a violent act; a threat against their home or school) (IVP-42)	60.6%	54.5%	Not available						✓				
Rate of suicide attempts by adolescents (MHMD-2)	1.9 suicide attempts per 100	1.7 suicide attempts per 100	Not available			✓							

Table 3					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
National Prevention Strategy (NPS) Indicators Topics and Objectives	**NPS Baseline**	**NPS Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Proportion of persons who experience major depressive episode (MDE)													
Adolescents, 12 -17 years (MHMD-4.1)	8.3%	7.4%	Not available			✓							
Aduts, 18+ years (MHMD-4.2)	6.8%	6.1%	Not available			✓							

Table 4					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Kaiser Permanente Indicators by Category	**Baseline**	**Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Demographics													
Total Population			55,223	US Census 2010									
Total Population, Male			28,281	US Census 2010									
Total Population, Female			26,942	US Census 2010									
Total Population, 0-4			3,954	US Census 2010									
Total Population, 5-17			Not available										
Total Population, 18-24			Not available										
Total Population, 25-34			9,753	US Census 2010									
Total Population, 35-44			5,923	US Census 2010									
Total Population, 45-54			4,055	US Census 2010									
Total Population, 55-64			2,677	US Census 2010									
Total Population, 65+			2,853	US Census 2010									
Median Age			23.3	US Census 2010									
Change in Total Population			Not available										
Linguistically Isolated Population			Not available										
Social and Economic Factors													
Poverty Rate (<100% FPL)			27.9%	US Census 2010									
Population Uninsured			Not available										
Adults age 25+ without High School Diploma			33.3%	US Census 2010									
HS Graduation or greater			66.6%	US Census 2010									
Population Below 200% of Federal Poverty Level			Not available										
Children in Poverty			27.5%	US Census 2010									

Table 4					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Kaiser Permanente Indicators by Category	**Baseline**	**Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Unemployment Rate, Seasonally Adjusted			Not available										
School Reading Proficiency (4th Grade)			Not available										
Free and Reduced Price School Lunch Eligibility			Not available				✓						
Enrolled in Supplemental Nutrition Assistance Program			Not available				✓						
Teen Births			Not available								✓		
Violent Crime			Not available						✓				
Population Receiving Medicaid			Not available										✓
Lack of Social or Emotional Support (Adult)			Not available			✓							
Health Behaviors			Not available				✓						
Fruit/Vegetable Consumption (Adult)			Not available				✓						
Fruit/Vegetable Consumption (Youth)			Not available				✓						
Soft Drink Consumption			Not available				✓						
Heavy Alcohol Consumption (Adult)			Not available			✓							
Tobacco Usage (Adult)			Not available					✓					
Physical Activity (Adult)			Not available				✓						
Physical Activity (Youth)			Not available				✓						
Breastfeeding (an)			Not available				✓						
Breastfeeding (exclusive)			Not available				✓						
Alcohol Expenditures			Not available			✓							
Tobacco Expenditures			Not available					✓					
Fruit/Vegetable Expenditures			Not available				✓						

Table 4					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Kaiser Permanente Indicators by Category	**Baseline**	**Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Physical Environment													
Fast Food Restaurant Access			Not available				✓						
Grocery Store Access			Not available				✓						
WIC Authorized Grocery Store Access			Not available				✓						
Population Living in Food Deserts			Not available				✓						
Liquor Store Access			Not available			✓							
Park Access			Not available				✓						
Walkability			Not available				✓						
Recreation and Fitness Facility Access			Not available				✓						
Poor Air Quality (Particulate Matter 2.5)			Not available		✓								
Clinical Care - Access													
Federally Qualified Health Centers			1										✓
Population living in a HPSA			Not available										✓
Facilities Designated as HPSAs			Not available										✓
Lack of Usual Source of Primary Care			Not available										✓
Access to Primary Care			Not available										✓
Clinical Care - Delivery													
Colon Cancer Screening (Signoidoscopy/Colonoscopy)			Not available										
Pneumonia Vaccination (age 65 +)			Not available										
Diabetes Management (Hemoglobin A1c Test)			Not available									✓	
Cervical Cancer Screening (Pap Test)			Not available										
Breast Cancer Screening(Mammogram)			Not available										

Table 4					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Kaiser Permanente Indicators by Category	**Baseline**	**Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
HIV Screening			Not available								✓		
Dental Care Utilization (Adult)			Not available										
Dental Care Utilization (Youth)			Not available										
Absence of Dental Insurance Coverage			Not available										✓
Dental Care Affordability (Youth)			Not available										✓
Lack of Prenatal Care			Not available								✓		
Preventable Hospital Events			Not available										✓
Health Outcomes - Morbidity													
Asthma Incidence (Adult)			Not available		✓								
Asthma Incidence (Youth)			Not available		✓								
Obesity (Adult)			Not available				✓						
Overweight (Adult)			Not available				✓						
Obesity (Youth)			26.7%	Obesity 2010			✓						
Overweight (Youth)			19.7%	Obesity 2010			✓						
Diabetes Incidence			Not available									✓	
Diabetes Hospitalizations (Adult)			Not available									✓	
Diabetes Hospitalizations (Youth)			Not available									✓	
Heart Disease Incidence			Not available				✓						
Breast Cancer Incidence			Not available										
Cervical Cancer Incidence			Not available										
Colorectal Cancer Incidence			Not available										
Lung Cancer Incidence			Not available										

Table 4					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
Kaiser Permanente Indicators by Category	**Baseline**	**Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Prostate Cancer Incidence			Not available										
Chlamydia Incidence			Not available								✓		
HIV Prevalence			Not available								✓		
Population with Any Disability			Not available										
Low Birth Weight			Not available								✓		
Poor Dental Health (Adult)			Not available										
Poor General Health (Adult)			Not available			✓							
Poor Mental Health			Not available										
Health Outcomes - Morbidity													
Cancer Mortality			83.3 per 100,000	NJSHAD, 2009									
Premature Death			Not available										
Heart Disease Mortality			65.2 per 100,000	NJSHAD, 2009			✓						
Stroke Mortality			10.9 per 100,000	NJSHAD, 2009			✓						
Motor Vehicle Crash Death			1.8 per 100,000	NJSHAD, 2009									
Pedestrian Motor Vehicle Death			Not available										
Infant Mortality			Not available			✓					✓		
Suicide			Not available			✓							
Homicide			14.5 per 100,000	NJSHAD, 2009					✓				

					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
County Health Rankings Indicators by Category	**National Benchmark**	**Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Goal Indicators													
Mortality													
Years of potential life lost before age 75 (age-adjusted)	5,317 per 100,000		Not available										
Morbidity													
Percent of adults reporting fair or poor health (age-adjusted)	10.0%		Not available										
Average number of physically unhealthy days reported in past 30 days (age-adjusted)	2.6%		Not available										
Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	2.3%		Not available			✓							
Percent of live births with low birth weight (< 2,500 grams)	6.0%		Not available				✓						✓
Tobacco Use													
Percent of adults that report smoking ≥ 100 cigarettes and currently smoking	13.0%		Not available					✓					
Diet & exercise													
Proportion of adults that report a BMI ≥ 30	25.0%		Not available				✓						
Percent of adults aged 20 and over reporting no leisure time physical activity	21.0%		Not available				✓						

					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
County Health Rankings Indicators by Category	**National Benchmark**	**Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Alcohol & drug use													
Percent of adults that report either binge drinking (women consuming 4 or more and men consuming 5 or more alcoholic beverages on a single occasion in the past 30 days) or heavy drinking (women consuming more than 1 and men consuming more than 2 drinks per day on average)	7.0%		Not available			✓							
Motor vehicle crash deaths	10 per 100,000 population		Not available			✓							
Sexual activity and reproductive health													
Chlamydia rate	92 per 100,000 population		Not available								✓		
Teen birth rate, ages 15-19	21 per 1,000 female population										✓		
Access to Care													
Percent of population under age 65 without health insurance	11.0%		Not available										✓
Ratio of population to primary care physicians	1,067:1		Not available										✓
Ratio of population to dentists	1,561:1		Not available										✓
Quality of Care													
Hospitalization rate for ambulatory-care sensitive conditions	47 per 1,000 Medicare enrollees		Not available										✓
Percent of diabetic Medicare enrollees that receive HbA1c screening	90.0%		Not available									✓	
Percent of female Medicare enrollees that receive mammography screening	73.0%		Not available										✓

					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
County Health Rankings Indicators by Category	**National Benchmark**	**Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Education													
Percent of 9th grade cohort that graduates in 4 years	Not available												
Percent of adults aged 25-44 with some post-secondary education	70.0%												
Employment													
Percent of population age 16+ unemployed but seeking work	5.0%												
Income													
Percent of children under age 18 in poverty	14.0%		27.5%	US Census 2010									
Family & social support													
Percent of adults without social/emotional support	14.0%					✓							
Percent of children that live in household headed by single parent	20.0%												
Community safety													
Violent crime rate per 100,000 population	66 per 100,000 population								✓				
Environmental quality													
The average daily measure of fine particulate matter in micrograms per cubic meanter (PM2.5)	8.8		Not available		✓								
Percent of population exposed to water exceeding a violation limit during the past year	0.0%												

					Alliance for a Healthier New Brunswick Workgroups and Coalitions							Health Task Force	
County Health Rankings Indicators by Category	**National Benchmark**	**Target**	**New Brunswick Data (if available)**	**Source, Date**	**Asthma**	**Mental Health & Substance Abuse**	**Nutrition & Physical Activity**	**Tobacco**	**Domestic Violence**	**Lead**	**STD, HIV, & Reproductive Health**	**Diabetes**	**Access to Healthcare**
Built environment													
Rate of recreational facilities	16 per 100,000 population		Not available				✓						
Percent of population who are low-income and do not live close (< 1 mile) to a grocery store	1.0%		Not available				✓						
Percent of all restaurants that are fast-food establishments	27.0%		Not available				✓						

Appendix E: Quantitative and Qualitative Research Methods At-A-Glance

QUANTITATIVE METHODS				
Method	**Pros**	**Cons**	**Costs**	**Time to complete - data collection**
Archival research - analysis of preexisting data (e.g. U.S. Census records)	* Provides detailed information * Use to establish trends * Sometimes is fast and inexpensive * Often there is a lot of data available	* May be complicated to organize * May require specialized software to analyze (e.g. SAS)	Inexpensive to expensive depending on data design and format and analysis needs	Quick to time consuming: dependent on data and structure of output
Record review - review existing records (paper or electronic) that are not easily developed into a report (e.g. paper medical records and deeds)	* Can be objective * Mostly fast because records are existing * Does not require participants	* Sometimes data is difficult to find because different people have created the records * Records are often incomplete * Need to input data into database if records are not electronic	* Varies depending on the number of records to review and the records' complexity	* Variable depending on the number of records needing review
Self-administered surveys - surveys taken by the participant without aid of a researcher. Usually administered by mail, at point of contact, or over the Internet.	* Good for obtaining a lot of information in a non-threatening way * Can be anonymous * Usually easy to analyze especially if administered electronically *Easy to make comparisons between responses	* Results can be easily biased especially if using electronic survey (may miss populations without computer and/or Internet access) * May miss important information * Poor response rate creates a problem for analysis * Skipping questions can be incorrectly done by respondent (particularly on paper surveys) * May get a number of incomplete surveys	* Varies depending on survey administration technique (e.g. at point of contact, electronic, through the mail) and initial response rate	* Varies depending on survey administration costs and difficulty obtaining desired response rate
Face-to-face structured surveys - survey taken by participant in person with a researcher	* Good for low literacy populations * Allows questions and/or responses to be clarified	* Requires staffing and time * Scheduling people to complete surveys may be difficult * Respondents may not answer questions honestly	* Tends to be expensive because staff resources are needed	* Varies depending on method used for survey completion and how quickly people respond to request

Appendix D: Developing and Displaying an Indicator Set

This section is intended for community stakeholders as they begin to develop a shared measurement indicator set. It describes why New Brunswick has to create its own indicators separate from Middlesex County; getting the questions and methods right; categories of indicators; information accessibility; primary concerns in New Brunswick; and a suggested process for creating a long-term indicator project.

New Brunswick's Demographic Difference Makes County Data Unsatisfactory

Too often health data is only available at the geographical scale of the county, not the municipality. As we demonstrated in Section I, New Brunswick is demographically different from the county so information collected at the county level is not necessarily descriptive of New Brunswick. In order to understand our city, we need to collect data at the city level from city residents. This data needs to be collected at regular intervals (for example every two or three years) and needs to be collected in a manner that allows us to compare data from one data collection event to another.

Getting the Questions and Methods Right

Questions

How one asks questions and the method of data collection determine the reliability of the data. Some of the questions previously asked in New Brunswick make it difficult to determine prevalence because the information gathered was not attributed to an individual within a household. When researchers do not gather information on individuals, the actual prevalence of a health problem cannot be determined. When they can, researchers prefer to use questions taken from large national surveys because such questions have been tested and validated over time on many respondents.

Methods

Collecting data to create a whole picture of a community such as New Brunswick is not a simple endeavor. There are many different data collection methods (for example surveys, focus groups, and reviews or records) each with its own strengths and weaknesses, varying costs, and time

requirements. To assist readers as they consider data collection methods, we have provided a table that compares different quantitative and qualitative methods as well as the comparative advantages, disadvantages, completion time, and costs of each (see Appendix E). Methods break down into quantitative data (quantifiable statistics that provide a snapshot in time) and qualitative data (narrative data that provides an in-depth understanding of whatever is being evaluated). As noted previously, some of the New Brunswick data could have been improved by the use of qualitative data, which allows one to understand the statistics more fully.

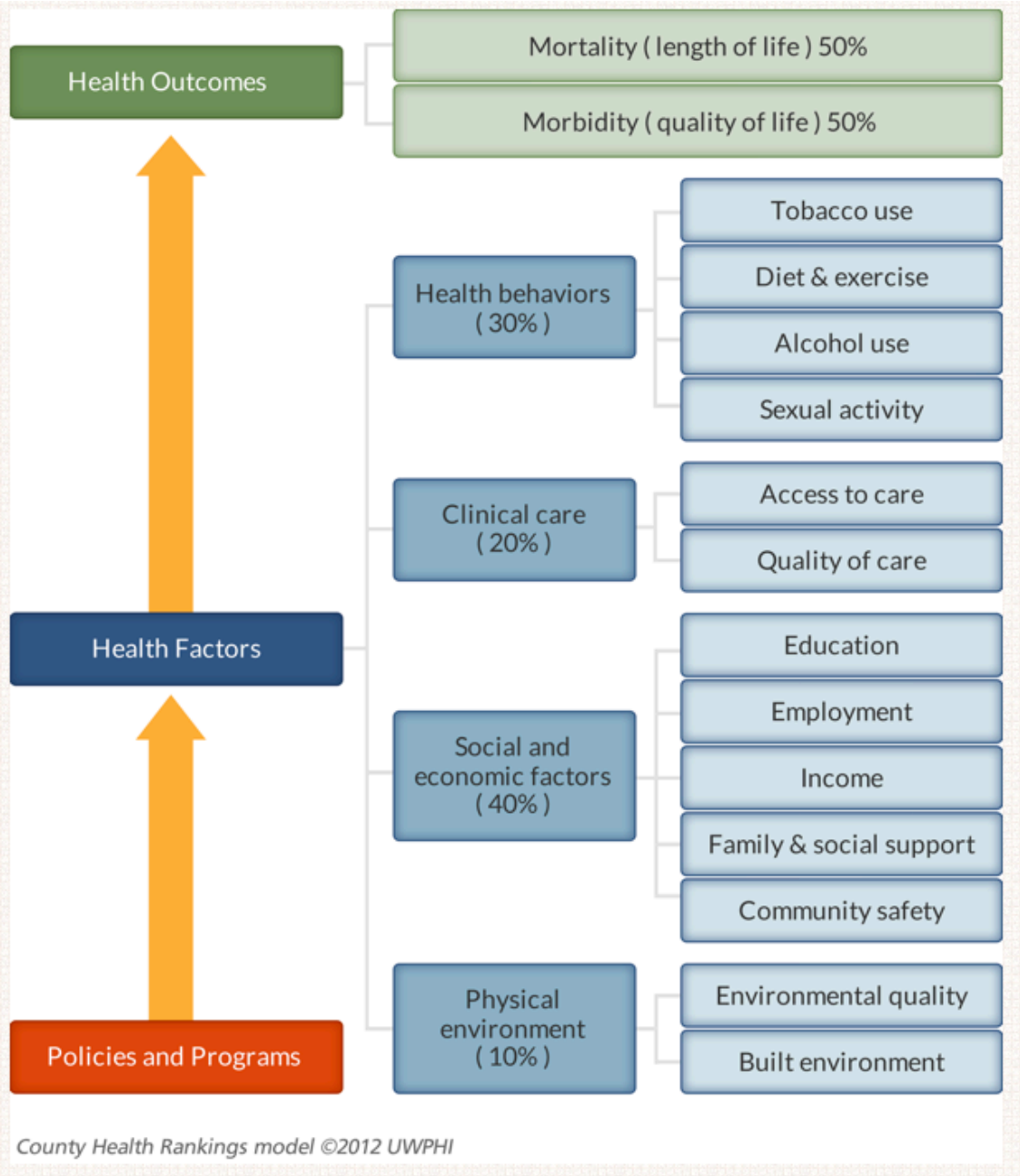
Categories of Indicators to Consider

A healthy community is described by the U.S. Department of Health and Human Services *Healthy People 2010* report as "one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential. Healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn, and play within their borders – where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options." (CDC, 2010b) Using this definition to guide the development of an indicator set means we want to include measures of demographics, health conditions and behaviors, social issues, and the local environment (natural and built). The County Health Rankings & Roadmaps indicator set (see Figure 4 best represents the Healthy People 2010 definition by capturing indicators across population health components (UWPHI, 2012).

Demographics

Demographic information allows us to see population changes over time. Demographic information is readily available because it is collected every ten years by the U.S. Census (2010) and includes social and economic data as well. For some cities, including New Brunswick, the U.S. Census estimates changes to the population more frequently than every ten years. Choices will need to be made about which demographic information we should regularly review. We can track demographics of people accessing health services in New Brunswick using data from electronic health records.

Figure 4: County Health Rankings Model



Health

Health is a very broad category that includes conditions, behaviors, and clinical care. Health conditions can include specific diseases (such as asthma, diabetes, and high blood pressure), perceptions of wellness (for example how a persons feels physically or mentally), or causes of death (for example, cancer). Health behaviors can include disease screenings (for example,

mammography or colonoscopies), personal behaviors (such as diet, exercise, or tobacco and alcohol use), and preventive care (for example immunizations and regular check ups). Clinical care includes where people obtain care, barriers to and facilitators of obtaining care (for example access to transportation and ability to pay for prescription drugs) as well as perceptions of the quality of care that they are receiving (such as how well their provider communicates). We can ascertain health information using surveys, record reviews (for example electronic health records or insurance claims data), and statistical data sets (for example death records). Some of this information is available for New Brunswick (for example birth and death data) while other information would need to be collected (for example, prevalence rate of diabetes or how many adults meet physical activity guidelines).

Social and Economic

Social and economic factors include such matters as educational status, economic status, or satisfaction with and livability of a community. Indicators about education might include educational achievement, specialized trainings, and satisfaction with education. Economic status usually includes poverty levels, individual and household income, and employment and unemployment levels but can also include percent of people who do not purchase medications because of cost or the prohibitive cost of using an emergency room for non-ambulatory conditions. Livability of the community includes satisfaction with neighborhoods, city services, local organizations and institutions, and elected officials, among other factors.

Natural and Built Environment

Indicators of the natural and built environments often are the foundation of many health-affecting activities. For example, several times each year, the State of New Jersey declares a "bad air day" for the New Brunswick area and recommends that people stay indoors or limit their outdoor activity because degraded air can exacerbate respiratory conditions such as asthma. Examples of the built environment include having maintained sidewalks and parks, which can help residents meet physical activity goals. Having easy access to stores with fresh fruits and vegetables can help residents achieve their healthy diet goals.

Information Accessibility

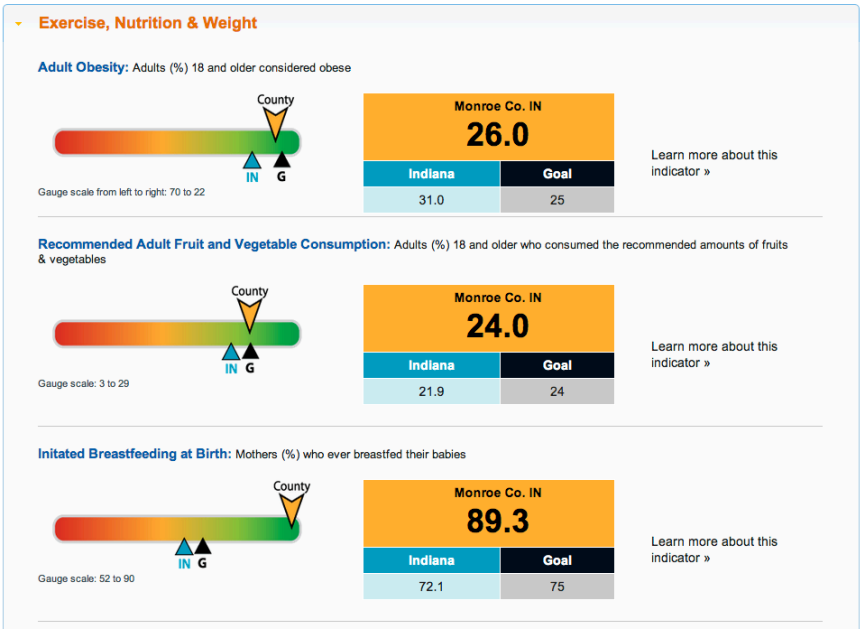
Successful shared measurement efforts for collective impact require that information be understandable and useful to community members and stakeholders. Shared measurement can be considered successful when people regularly use the information to assess progress or lack of it towards a particular goal. There are at least two ways to make information widely accessible and useful: dashboards and maps.

Dashboards

One excellent way to display progress towards a goal is to create a web-based dashboard. Similar to an automobile dashboard, a web-based dashboard organizes and presents data as a quick snapshot that is easy to understand. In the case of community health indicator dashboards, designers use a series of simple icons (for examples dials or thermometers) to display indicators important to the community. Often the dials or thermometers use green (best), yellow (needs work), and red (not meeting the target) to indicate progress towards a target. For example, in Figure 5 one can quickly see that Sonoma County, California is doing well with fruit and vegetable consumption but poorly on its teacher-to-student ratio. Many dashboards also provide comparisons to national targets set in Healthy People 2020 or state targets. For example INdicators, Indiana's Health Dashboard, uses a visual thermometer as well as a set of numbers to display how a particular county is doing compared to state goals (see Figure 6).

Figure 5: Healthy Sonoma's Community Dashboard

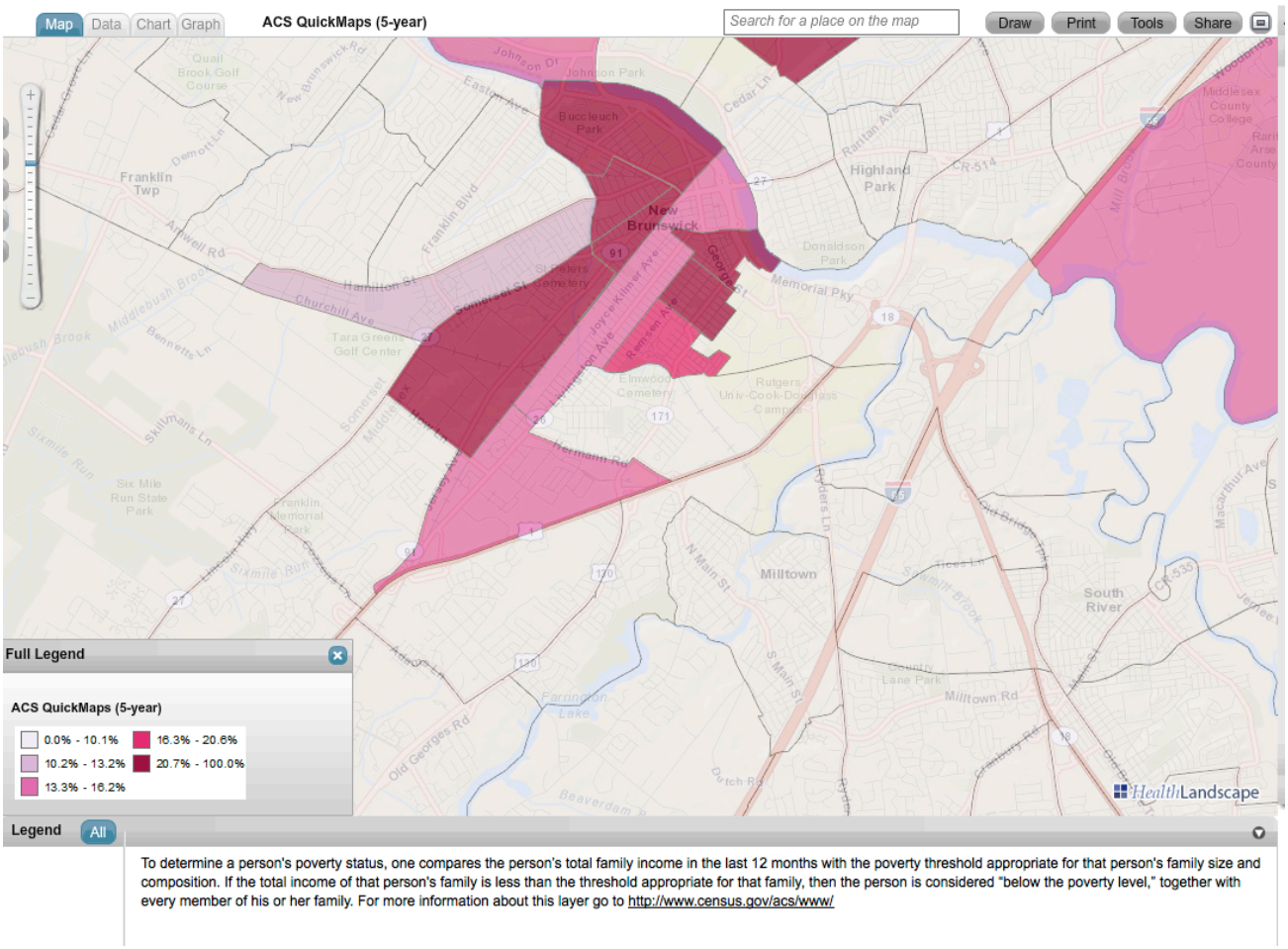
Figure 6: INdicators Dashboard



Maps

Another excellent method for visualizing information is mapping the data. Maps are very helpful to community stakeholders and policy makers because they can reveal hot spots (of a disease, for example). Maps can also reveal hidden relationships by overlaying multiple types of information (obesity and income, for example). Maps require expertise with GIS (geographical information systems) software, and of course they require relevant data to be mapped. Figure 7 is a map showing percent of persons living below poverty in different neighborhoods in New Brunswick.

Figure 7: New Brunswick: Percent of Persons Below Poverty Level



Creating a Shared Measurement Data Set for Collective Impact in New Brunswick

This paper is intended to lay the groundwork for community partners to work together to develop a set of indicators in support of New Brunswick's healthy communities project – Healthier New Brunswick. As Kate Besleme and Megan Mullin noted in 1997, healthy community projects cultivate a sense of shared responsibility for community health and well-being by bridging the gap between government and citizens, building coalitions within communities, and attempting to draw attention to problems and negative trends before they become damaging to the community.

This section reviews what we know about resident's concerns about the New Brunswick community, describes a process for developing community health indicators in New Brunswick, and offers a suggested list of indicators to help meet the goals of Healthier New Brunswick.

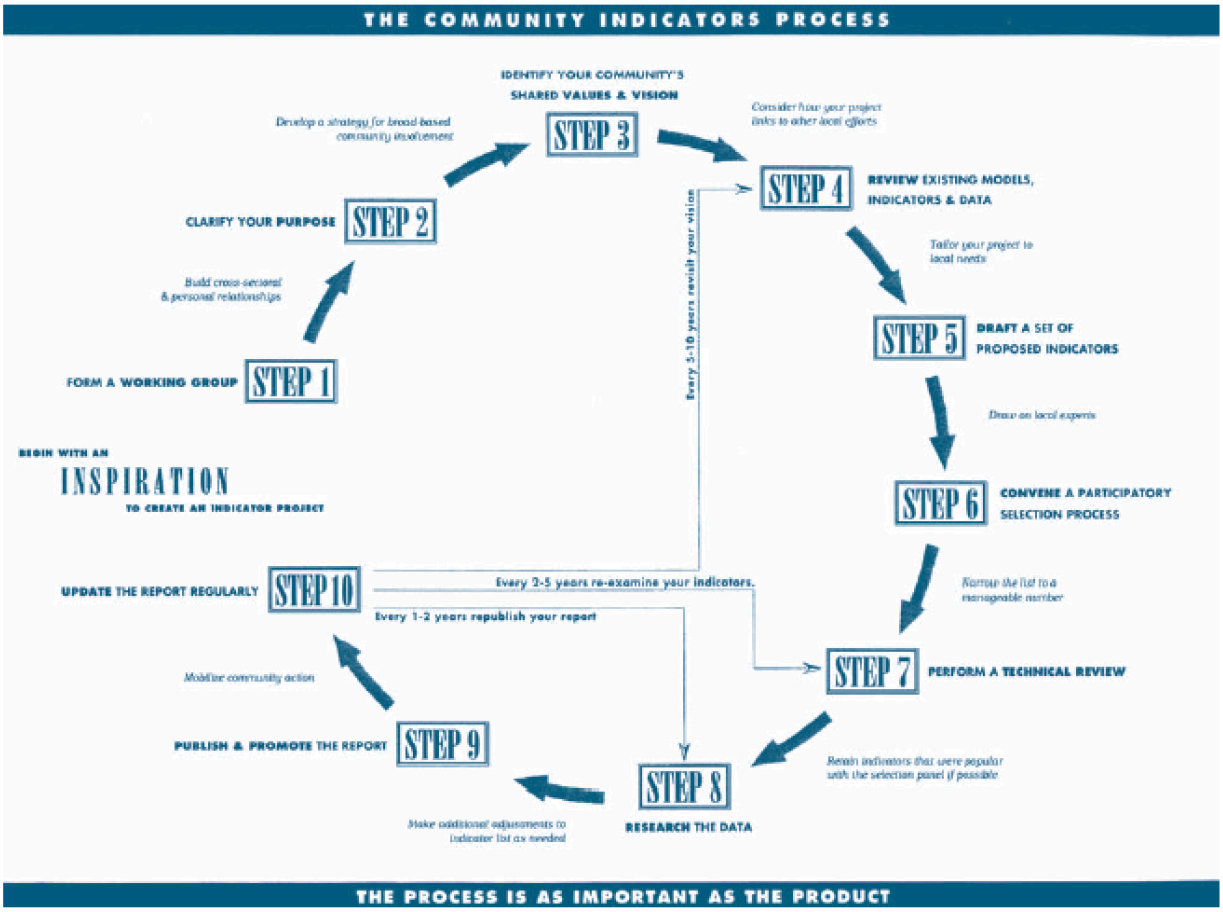
Social and Economic Determinants of Health in New Brunswick

We have detailed many health conditions, health behaviors, and clinical care issues in New Brunswick in "Section II – What do we know about the health of New Brunswick residents?" There are a number of social and economic conditions in New Brunswick that impact the health outcomes of residents. For example, people's perceptions of safety affect whether or not they let their children play outside. We will not detail these concerns in this report but instead refer you to the 2011 and 2012 surveys conducted for New Brunswick Tomorrow (Weiner et al., 2011 and Redlawsk, 2012). Together, these two surveys provide insight into some of the most pressing social and economic issues in New Brunswick. We have included some of these indicators where appropriate in our suggested set of indicators. For example, we have included neighborhood safety in as a suggested indicator for Nutrition & Physical Activity.

Community Indicators Process

The American Planning Association (APA) outlines a ten-step process for developing community indicators (APA-PAS, 2003), which is included as Figure 8. The APA recognizes that an indicator process is long-term and its "scope and breadth requires a far-sighted and far-reaching timeline" (APA-PAS, 2003).

Figure 8: Community Indicators Process as Published by APA-PAS



With the completion of this report, the Healthier New Brunswick Initiative is half way through the community indicators process (see Table 6).

Table 5: HNB Progress Towards Community Indicators Process

Step	HNB Progress
Step 1: Form a working group. (*Build cross-sectional & personal relationships.*)	Completed – HNB work is accomplished through the Alliance for a Healthier New Brunswick and the Health Task Force.
Step 2: Clarify your purpose. (*Develop a strategy for broad-based community involvement.)*	Mission of HNB – Improve the health and healthcare of New Brunswick residents through community-based partnerships.
Step 3: Identify your community's shared values & vision. (*Consider how*	HNB Vision – HNB envisions a city where all stakeholders work together to improve health and wellness for all New Brunswick residents. The work of

your project links to other local efforts.)	HNB, through our community partners, is a model of excellence in public and private partnerships, where a culture of health and wellness is produced. The process is inclusive of all stakeholders and residents and dedicated to maximizing community health efforts and the continuous improvements in the quality and value of services. Ultimately, HNB assists city residents lead active, healthier lifestyles and have greater positive health outcomes.
Step 4: Review existing models, indicators & data. (*Tailor your project to local needs.*)	This report fulfills this step.
Step 5: Draft a set of proposed indicators. (*Draw on local experts.*)	This report fulfills this step.
Step 6 Convene a participatory selection process. (*Narrow the list to a manageable number.*)	Future action.
Step 7: Perform a technical review. (*Retain indicators that were popular with the selection panel if possible.*)	Future action.
Step 8: Research the data. (*Make additional adjustments to indicator list as needed.*)	Future action.
Step 9: Publish & promote the report. (*Mobilize community action.*)	Future action.
Step 10: Update the report regularly. (*Every 1-2 years republish your report* and *Every 3-5 years re-examine your indicators.)*	Future action.

Appendix E: Quantitative and Qualitative Research Methods At-A-Glance

QUANTITATIVE METHODS				
Method	**Pros**	**Cons**	**Costs**	**Time to complete - data collection**
Archival research - analysis of preexisting data (e.g. U.S. Census records)	* Provides detailed information * Use to establish trends * Sometimes is fast and inexpensive * Often there is a lot of data available	* May be complicated to organize * May require specialized software to analyze (e.g. SAS)	Inexpensive to expensive depending on data design and format and analysis needs	Quick to time consuming: dependent on data and structure of output
Record review - review existing records (paper or electronic) that are not easily developed into a report (e.g. paper medical records and deeds)	* Can be objective * Mostly fast because records are existing * Does not require participants	* Sometimes data is difficult to find because different people have created the records * Records are often incomplete * Need to input data into database if records are not electronic	* Varies depending on the number of records to review and the records' complexity	* Variable depending on the number of records needing review
Self-administered surveys - surveys taken by the participant without aid of a researcher. Usually administered by mail, at point of contact, or over the Internet.	* Good for obtaining a lot of information in a non-threatening way * Can be anonymous * Usually easy to analyze especially if administered electronically *Easy to make comparisons between responses	* Results can be easily biased especially if using electronic survey (may miss populations without computer and/or Internet access) * May miss important information * Poor response rate creates a problem for analysis * Skipping questions can be incorrectly done by respondent (particularly on paper surveys) * May get a number of incomplete surveys	* Varies depending on survey administration technique (e.g. at point of contact, electronic, through the mail) and initial response rate	* Varies depending on survey administration costs and difficulty obtaining desired response rate
Face-to-face structured surveys - survey taken by participant in person with a researcher	* Good for low literacy populations * Allows questions and/or responses to be clarified	* Requires staffing and time * Scheduling people to complete surveys may be difficult * Respondents may not answer questions honestly	* Tends to be expensive because staff resources are needed	* Varies depending on method used for survey completion and how quickly people respond to request

Method	Pros	Cons	Costs	Time to complete - data collection
Telephone surveys - survey administered by calling participants on the telephone (using landline or cell phone) Researcher often uses computer assistance to administer the survey.	* Allows you to target a wider area * Good for low literacy populations * Computer assistance allows for skipping non-relevant questions	* Requires staffing and time * Misses people without phones * Sometimes hard to reach the correct residents if calling cell phones (phone number often does not indicate geographic location of residence)	* Expensive particularly if many people in targeted population only have cell phones	* Varies depending on collection method and response rate
QUALITATIVE METHODS				
Focus groups - explore a topic in depth using a group discussion	* Can obtain information quickly * Efficient way to get range and depth of information in a short time *Can use to convey information to participants	* Recruitment and scheduling sometimes difficult * Needs to be well-facilitated to get useful information * Time consuming to analyze responses	Inexpensive if run, transcribed, and analyzed in-house; more expensive if using professional facilitators and transcribers	Quick: Each focus group generally takes 1.5 hours
Observation - gather information in real time by observing and taking notes	* Can view a process as it is occurring * Can adapt to events if necessary	* Requires a well-trained observer * Sometimes observations are difficult to categorize * Can influence behaviors of people being observed * If notes not written within 24 hours of observation - key data may be lost	Expensive if using trained, non-interested party observers	Quick - Long Time: dependent on how many observations, process length, and availability of both the observer and the group being observed
Interviews - multiple questions on one subject designed to get detailed impressions, experiences, or information. Can be structured or unstructured.	* Get a full range of information * Researcher can develop relationships with subjects * Can be flexible	* Can take a lot of time * Can be hard to analyze or compare * Interviewer can bias responses by theway they ask questions * Analysis of multiple interviews takes time	* Cost depends on number of interviews and length of interviews	* Individual interviews usually take an hour to complete
Case study - a comprehensive examination of a particular person, group, or situation over a period of time. Sometimes compared to another person, group, or situation.	* Gather in-depth information * Fully depicts experience of subject * Powerful way to portray strategy or process to outsiders	* Usually very time-consuming to collect, organize, and describe * Requires experienced researchers * Sometimes of limited widespread use	* Usually expensive but is dependent on the complexity of the case study	* Usually long