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A Three County Community Health Needs Assessment (CHNA) in Southern New Jersey: Leveraging Partnerships and Sharing Findings with Community

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Abstract

Community Health Needs Assessment (CHNA)'s characterize community members' views on the health needs in their communities. This research focused on a three-county CHNA region in Southern New Jersey, outlining the process, methods, findings, and dissemination plan for the CHNA. We used a mixed-methods iterative strategy of data collection and analysis that combined existing publicly available-data with primary data collected from a survey with community members, focus groups with community members, and interviews with key regional health stakeholders. The largest asset in the region is depth and breadth of partnerships between institutions. Programs and partnerships across the region are geared towards preventive care, and also aim to address the social determinants of health (e.g., vaccines, food access). Across the region, barriers underscored the rising cost of living and affordability of basic needs. Cost of healthcare, as well as healthcare access issues, also arose as the barriers most noted in the data. Data spoke to a need for generating community connections and gathering in safe, and well-resourced community spaces for learning, health care, and socialization. The prevalence of chronic illness across the region also undergirds the need for preventive and follow-up care across physical and mental health conditions. Community reported solutions and recommendations across the region focused on creating new infrastructures or shifting current infrastructure towards innovative healthcare models that work for the counties, embedding more direct services and programming directly within the community, focusing on whole-person and individualized care, advocacy for the region, and continuing and maintaining partnerships. The article also discusses our dissemination strategy and offers suggestions for how other CHNAs can employ similar methods.

Keywords: community health needs assessment, community voice, mixed methods, dissemination

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Community Health Needs Assessments (CHNAs) are IRS-mandated projects that work with communities to gather information about their health needs and barriers (IRS, 2024). This CHNA was a collaboration between a research center and a local hospital, covering a three-county service region (Gloucester, Cumberland, and Salem) in Southern New Jersey. Broadly, the goal of conducting CHNAs is to provide actionable information for improving health at the community level. The main questions asked in the CHNA were: 1.) What are the health-related needs of the populations within [name of health care organization's] service area?; 2.) What are the health-related assets within [name of health care organization's] service area? And 3.) What gaps are feasible to address with intervention or additional resources? What are the solutions/recommendations available or that could be implemented to address gaps/needs? The CHNA employed a mixed methods strategy that interviewed key stakeholders, conducted focus groups with community members, and administered a community survey across the three counties.

This work was informed by community engagement principles, including shared values and goals with the main community partner – a health care organization, trusting relationships, intentionality in highlighting community assets and solutions, producing information for collective benefit, and generating accessible findings (Community Research Collaborative, 2021). These principles underscore the spectrum of community-engaged research (Key et al., 2019), from no community involvement to community-driven, with this study focusing on the areas of community-informed and community consultation.

Background on the Three County Service Region

Cumberland, Gloucester, and Salem counties are nestled in the southwest and the southernmost points of New Jersey. The region represents some of the most rural areas in New Jersey and is close to Philadelphia and Delaware.

Cumberland County is one of the most rural counties in the State of New Jersey. Nearly 25% of its population (representing approximately 23,000 residents) live in a rural area, and nearly 90% of its land area is considered rural (U.S. Census, 2023). Around 14% of adults and 5% of children do not have health insurance (County Health Rankings and Roadmaps, 2024). There are around 2,560 primary care physicians to one resident in Cumberland County, 1,560 dentists to one resident, and 760 mental health providers to one resident (County Health Rankings and Roadmaps, 2024).

Gloucester County is nearly a 50% to 50% split between rural and urban land areas as the population per square mile is 938.8 while the state rate is 1,263 per square mile (U.S. Census, 2022a). Around 7% of adults and 2% of children do not have health insurance. There are 1,020 primary care physicians to one resident, 2,240 dentists to one resident, and 640 mental health providers to one resident (County Health Rankings and Roadmaps, 2021).

Salem County is the most rural county in the State of New Jersey, and the population per square mile is 195.4 while the state rate is 1,263 per square mile (U.S. Census, 2022b). 93.4% (310 square miles) of Salem County is considered rural, and 45.3% of the population lives in a rural

area. Around 8% of adults and 3% of children do not have health insurance (County Health Rankings and Roadmaps, 2021). There are around 4,070 primary care physicians to one resident in Salem County, 3,260 dentists to one resident, and 870 mental health providers to one resident (County Health Rankings and Roadmaps, 2021).

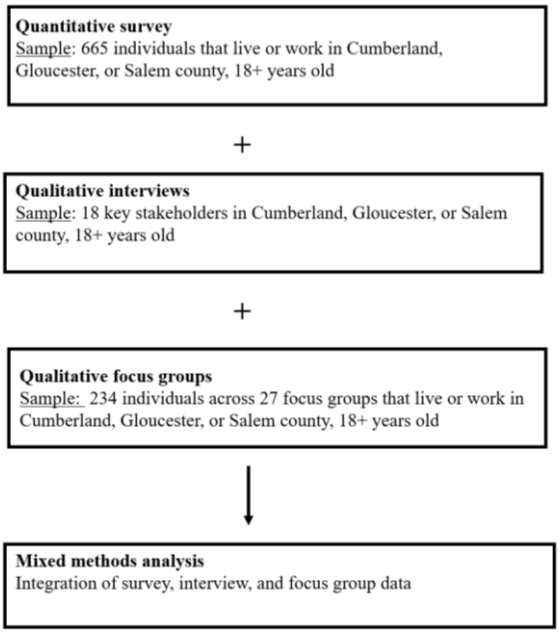
Partnership Process

Strong collaboration and mutual respect with the health care organization was critical to the success of this project. The university research team took the lead on research design, data collection and analysis, and report writing. The health care organization was critical in fostering connections to local organizations and in disseminating findings. The project team involved representatives from both organizations, and we met bi-weekly to discuss project goals, project status, any challenges, and solutions. Changes in staffing during the course of the project and shifting deadlines were addressed by transparent, respectful, and responsive communication between the principal investigator and the main project lead from the health care organization.

Methods

We conducted interviews with select leaders and staff of healthcare providers and social service agencies in Cumberland, Gloucester, and Salem Counties, as well as focus groups and surveys with community residents. The research design was primarily driven by the research team, with collaborative development of the interview protocol, focus group protocol, and survey with team members from the health care organization. Community members were not directly involved in the creation of protocols or in data analysis. All data collection processes and research protocols were approved by [name of university] Institutional Review Board (IRB). See Figure 1 for an overview of data collection methods.

Figure 1. CHNA Data Collection



Recruitment

Outreach and recruitment were done through a collaborative effort among the research center and the health care organization. Promotional materials were distributed in both English and Spanish. Surveys were distributed virtually through an anonymous link and administered in person at community locations and events in paper and QR codes/ link forms. Recruitment for the survey included on the TV screens at [health care organization's] clinical locations, outreach to community hubs (e.g., local libraries), dissemination through social media, and presence of the research team at community locations and events. Potential interview participants and focus group organizations were contacted at least three (3) times by phone and/or email. Partnering organizations put up flyers advertising focus groups in their shared spaces and distributed focus group opportunities on social media and email listservs.

Key Stakeholder Interviews

Across the region, we conducted 18 key stakeholder interviews, including Cumberland County stakeholders – four interviews (22.2%); Gloucester County stakeholders – one interview

(5.5%); Salem County stakeholders – three interviews (16.7%); and regional stakeholders – 10 interviews (55.6%). The research project's purpose was explained to potential participants, and informed consent was obtained. Interviews were conducted in person or virtually, were audio recorded, and completed using a semi-structured research instrument. Each participant was offered a $25 VISA gift card as compensation for their time. Interviews were conducted in English. The software program NVivo14 was used in the analysis.

Community Member Focus Groups

We facilitated 27 community member focus groups, including 234 total focus group participants (214 for whom demographic information was reported). The breakdown of the participation was: Cumberland County community members - nine focus groups, 91 participants (42.54%); Gloucester County community members - seven focus groups, 43 participants (20.09%); Salem County community members - 11 focus groups, 59 participants (27.57%); and 21 other county participants (9.8%). The average age of the focus group participants was 53; 69.19% were women, and 80.84% identified as straight/heterosexual. Participants were predominantly White (40.19%) or Black (39.79%), 14.02% were Hispanic/Latinx, and 9.81% were American Indian/Alaskan Native, with 1.87% identifying as Other. See Table 1 for Community Member Focus Group Demographics.

Our focus groups consisted of a semi-structured guide and generally ranged in size from 1 to 15 participants, except for one focus group, which consisted of 38 community members. Informed consent was obtained after the purpose of the focus group was explained and before the data collection process. One research team member facilitated the focus group, and one to two additional research team members took notes in addition to recording the focus group's audio. Both Spanish and English focus groups were conducted. Each participant was given a $25 VISA gift card as compensation for their time. The software program NVivo14 was used in the analysis.

We used a pragmatic approach to qualitatively analyze interview and focus group data. We engaged in open coding of the transcripts to develop preliminary themes of assets, barriers, and recommendations/solutions, and met to discuss these themes across the region and each of the three counties. A subset of the team then engaged in a focused coding phase to code each transcript by themes aligning with assets, barriers, and recommendations/solutions specific to the region and each of the three counties (see Table 1).

We collected 665 Community Survey responses: Cumberland County Community Members - 234 respondents (35%); Gloucester County Community Members - 186 respondents (28%); Salem County Community Members - 212 respondents (32%); and Other County Community Members - 33 respondents (5%). About one-third of survey respondents were [name of health care organization] employees. The average age of respondents was 45; 71.65% were women, and 85% identified as straight/heterosexual. Most respondents were White (64%), followed by 15% Black, 9% Hispanic/Latinx, 5% American Indian/Alaskan Native, and 7% Other. See Tables 2 – 6 for

Community Member Survey Demographics

Survey data was collected through paper copies and an online Qualtrics (survey) form, and both Spanish and English surveys were used. The survey had 52 questions and took approximately 20 - 30 minutes for respondents to complete. Survey participants could opt-in for compensation for their time by entering a raffle to win a $25 VISA gift card. Twenty-one participants were mailed a gift card after the survey data collection ended. Data were analyzed using the statistical program SPSS (see Tables 2-6).

Community-report assets and solutions/ recommendations were directly generated by the data from interviews with key stakeholders and

Table 1. Community Member Focus Group Demographics (n=214)

Demographic	Regional	Cumberland	Gloucester	Salem
Works for [Name of Health Care Organization]?				
Yes	3.74% (8)	5% (5)	2% (1)	0% (0)
No	95.79% (205)	95% (86)	98% (42)	98% (58)
No answer	0.47% (1)	—	—	2% (1)
Race/Ethnicity*				
American Indian or Alaskan Native	9.81% (21)	19% (17)	7% (3)	—
Asian	1.40% (3)	—	2% (1)	3% (2)
Black or African American	38.79% (83)	25% (23)	30% (13)	61% (36)
Hispanic/Latinx	14.02%(30)	11% (10)	7% (3)	19% (11)
White	40.19% (86)	51% (46)	58% (25)	15% (9)
Other	0.47% (1)	1% (1)	—	—
No answer	1.40% (3)	—	5% (2)	2% (1)
Age (years)				
Range (Min-Max)	18 - 92	20 - 92	18 - 86	22 - 75
Average	53	60	57	44
Gender Identity*				
Man	28.16% (62)	24% (22)	23% (10)	36% (21)
Woman	69.19% (148)	73% (66)	77% (33)	63% (37)
None of these describe me	0.47% (1)	1% (1)	—	—

Prefer not to answer	0.93% (2)	1% (1)	—	2% (1)
Sexual Orientation*				
Straight/heterosexual	80.84% (173)	82% (75)	84% (36)	78% (46)
LGBTQIA+	2.80% (6)	2% (2)	2% (1)	3% (2)
None of these describe me	12.15% (26)	10% (9)	9% (4)	17% (10)
No answer	4.21% (9)	5% (5)	5% (2)	2% (1)

*Note that these percentages may tally to over 100% because respondents could select more than one option/selected all that applied.

Table 2. Community Member Survey – [Health care organization] Employee (n=664)

County	Yes	No
Cumberland	40% (94)	32% (139)
Gloucester	34% (80)	25% (106)
Salem	18% (43)	39% (169)
Other	8% (18)	3% (15)
Regional	35% (235)	65% (429)

Table 3. Community Member Survey – Race/Ethnicity (n=617)

Race/ Ethnicity	Cumberland	Gloucester	Salem	Total (#)
American Indian or Alaska Native	7% (17)	6% (12)	3% (7)	5% (36)
Asian	3% (9)	2% (3)	2% (5)	3% (17)
Black or African American	16% (42)	9% (17)	20% (43)	15% (102)
Hispanic / Latino	13% (34)	7% (14)	7% (14)	9% (62)
Native Hawaiian or Pacific Islander	2% (4)	2% (4)	1% (3)	2% (11)
White	58% (151)	73% (141)	64% (137)	64% (429)
Other	2% (4)	2% (3)	2% (4)	2% (11)

*Note that these percentages may tally to over 100% because respondents could select more than one option/selected all that applied.

Table 4. Community Member Survey – Age (n=665)

Age group (in years)	Cumberland	Gloucester	Salem	Other	Total (#)
18-24	7% (16)	5% (9)	5% (11)	3% (1)	6% (37)
25-34	29% (68)	33% (61)	17% (37)	36% (12)	27% (178)
35-44	29% (69)	23% (43)	15% (32)	21% (7)	23% (151)
45-54	15% (34)	15% (27)	8% (16)	18% (6)	12% (83)
55-64	26 (11%)	28 (15%)	17 (8%)	5 (15%)	11% (76)
65-74	6% (14)	6% (12)	12% (*26)	6% (2)	8% (54)
75-84	0% (0)	2% (4)	12% (*26)	0% (0)	5% (30)
Older than 85	0%(0)	0% (0)	7% (*14)	0% (0)	2% (14)
N/A	3% (7)	1% (2)	16% (33)	0% (0)	6% (42)

Table 5. Community Member Survey – Gender Identity (n=656)

Gender Identity	Cumberland	Gloucester	Salem	Other	Total (#)
Man	31% (74)	24% (44)	23% (46)	6% (2)	25.30% (166)
Woman	66% (156)	73% (137)	75% (149)	85% (28)	71.65% (470)
Non-binary	0.84% (2)	1 (0.53%)	0.50% (1)	0% (0)	0.61% (4)
Transgender	0.84% (2)	0.53% (1)	0% (0)	3% (1)	0.61% (4)
Questioning of exploring	0.42% (1)	0% (0)	0% (0)	3% (1)	0.30% (2)
Prefer not to answer	0.84% (2)	2% (4)	1.51% (3)	3% (1)	1.52% (10)

*Note that these percentages may tally to over 100% because respondents could select more than one option/selected all that applied.

Table 6. Community Member Survey – Sexual Orientation (n=645)

Sexual Orientation	Cumberland	Gloucester	Salem	Other	Total (#)
Gay	5% (12)	1% (1)	2% (3)	0% (0)	2% (16)
Lesbian	3% (7)	1% (2)	0% (0)	0% (0)	1% (9)
Straight	81% (186)	91% (168)	87% (172)	77% (24)	85% (550)
Bisexual	5% (11)	5% (9)	4% (8)	6% (2)	5% (30)
Questioning or exploring	1% (2)	0% (0)	1% (1)	3% (1)	1% (4)
None of these describe me	6% (13)	3% (5)	7% (14)	13% (4)	6% (36)

*Note that these percentages may tally to over 100% because respondents could select more than one option/selected all that applied.

focus groups with community members for each county and regionally. Community-reported barriers/needs were generated by thoroughly reviewing all the data across interviews, focus groups, and interviews for each county and regionally (IRS, 2024).

Findings

Community-Reported Existing Assets – Regional

By far, the largest asset in the region is the depth and breadth of partners between institutions, many of which include specific [name of health care organization] backing and support. Programs and partnerships across the region are geared towards preventive care and also aim to address the social determinants of health (e.g., vaccines, food access). Regional efforts focused on targeting emerging public health trends and provided resources to certain areas and populations as needed, responding quickly and flexibly. Data spoke to the multiple ways organizations kept their ear to the ground about what was going on and what is needed in their service areas. One organization shared how they have monthly listening sessions with organizations and rotate counties where they do the sessions, which are often held at one of the 200 out of 300 partners of that organization that are food pantries.

Community-Reported Barriers/Needs - Regional

Cost of living

Many individuals spoke about how their basic needs (e.g., food, shelter, employment, and transportation) were not always being met, and meeting these needs often took precedence over meeting specific healthcare needs. When asked about the top community-based health issues, cost of living was the most common, with just under 80% (75.9%; 471 of 620) of survey takers selecting cost of living as a top barrier. As one person shared, "With the economy where it is now, those who are working two jobs that can barely make rent are the ones we're seeing the most in need…It's really those who are struggling. A single-parent family struggling to pay for childcare and work really puts them in a bind. With the federal programs that have gone away, SNAP benefits, and so forth, we have really seen an uptick in need." (Regional Stakeholder).

Cost and availability of healthcare

While reliability of, distance to, and availability of health care varied across the three counties - the high cost of health care was perceived as a critical barrier across the region. When asked, "During the past 12 months, have you delayed or not gotten medical care because of cost?," almost one-third (30.6%) of all survey takers across the region said yes (197 of 643). While New Jersey has high insurance coverage rates, even those with insurance coverage encountered barriers of high copays or doctors and specialists in their area not accepting their instance. Costs were also not always incurred at the point of care but often happened in the process of making time to get and travel to care (e.g., transportation, unpaid work time off, time and distance, childcare).

Chronic illnesses

The top chronic health issues discussed in the data were cardiovascular-related diseases, high blood pressure/hypertension, diabetes, obesity, asthma, and mental illness. As one person shared, "Having patients coming in with no insurance or underinsured, sometimes they don't necessarily maybe come to us when they're being first diagnosed by some of this chronic conditions…usually what you're going to see a lot here is patients coming in with hypertension, with diabetes, with asthma, with COPD, and those chronic illnesses." (Regional Stakeholder)

Community connections and spaces

When asked about missing community health resources, the top missing one (with the most responses) was 36.1% (218 of 604) community social support services/programs connecting with other people (e.g., social clubs, hobby interest groups). Individuals we spoke with sought a sense of belonging/ community

engagement and a "third space" where they could connect with neighbors formally and/or informally.

Administrative barriers

Across the region, multiple administrative and structural barriers were noted as critical to health: staffing challenges, challenging funding requirements, mismatched infrastructure to population needs, and challenges associated with rural designations (or lack thereof). Stakeholders discussed the barriers of having large hospitals in the service area when smaller outpatient clinics may be better suited for the population. Related data spoke to the nuances of rural barriers - both in attracting people to work, live, and play in the state's most rural places and barriers to obtaining and sustaining funding. Regarding funding, one person said, "The challenges we have in South Jersey is that we are located and we're sandwiched in between lots of metropolitan areas, and so it makes it hard to fully advocate for us as a rural area, especially those areas as rural areas because of their proximity. Salem - its proximity to Wilmington [Delaware], Philadelphia, and Camden puts it in a predicament where, federally, we don't meet some of the definitions. Even though we meet the state definition of rural, we don't meet the federal one more often than not. What ends up happening is that there's just federal grants and programs that we can't tap into, and we can't formally say, 'Yes, we're rural, even though we know we are.'" (Regional Stakeholder)

Community-Reported Solutions and Recommendations - Regional

Data also highlighted recommendations and solutions offered by participants we spoke with, including creating new infrastructures or shifting current infrastructure towards innovative healthcare models that work for these counties; embedding well-rounded services directly within communities; focusing on individualized and whole-person care; continuing to build partnerships, and advocating for the region's needs and its residents. Many stakeholders discussed the uniqueness of South Jersey and the need for both funding and shifting and flexible infrastructures to work with the three-county region. Participants also discussed the potential for preventative care models for overall well-being and using one-stop healthcare centers, which some organizations already do. Across all places and spaces, data suggested ways to create partnerships and meet people where they are - for health and social programming. Data spoke to the continued solution of coordinating activities, sharing information widely with partners and organizations, especially in the most rural places, and ensuring that people have both awareness of and access to those community connection opportunities and health resources. Lastly, data spoke to the need for advocacy and leadership. Stakeholders discussed the recommendation to connect [health care organization's] health priorities and CHNA findings to direct funding opportunities and to state legislator attention.

County Findings

Cumberland County

Community-reported assets across Cumberland County included community centers and organizations. Additionally, data spoke to the various partnerships across sectors in the area as an asset. Data around barriers from Cumberland County highlighted the importance of making life more affordable for residents. While access to care and services remains a challenge, it has become evident that addressing affordability is the most pressing concern. Additionally, people expressed a desire to feel safe in their community and when receiving care. Community-reported solutions and recommendations across Cumberland County included the need for more programs and resources that help people navigate existing resources and information in both healthcare and social services. Data also spoke to the importance of services being delivered by people who are from the communities in which they exist.

Gloucester County

Community-reported assets across Gloucester County included the collaboration

across local governments, nonprofit agencies, and faith-based organizations to promote public health through resource sharing and programming. Participants also remarked on the presence of healthcare, recreation and leisure activities in the County and its proximity to Philadelphia's many providers and specialists. Barriers centered on the burden of the rising cost of living and healthcare. Participants also voiced the continued need for specialists within the county, greater access to healthy foods, and opportunities to build community. Community members' perception of the healthcare system as confusing and expensive was tied to a sense of distrust in providers, the inability to separate valid and false health information, and the need for reliable advocates and safe spaces for community outreach. Community-reported solutions and recommendations across Gloucester County included nurturing trust within the community. Participants recommended ensuring consistency between messaging and programming to increase trust in public health authorities and health care providers and leaning on well-regarded community entities to adapt communications and make them accessible to all community members. There was also an emphasis on increasing the availability of public spaces and public events to promote healthy habits, health education, and community building. Participants also suggested engaging businesses and academic institutions in the area to invest in the community through their participation and sponsorship of community programming.

Salem County

Community-reported assets across Salem County included local programs, organizations, and community-wide partnerships. Residents were grateful for the services offered to targeted populations, especially the youth. Community partners were also considered collaborative and invested in helping the community. Data around barriers from Salem County highlighted the lack of existing infrastructure and the overarching impact this has on residents. The absence of local, well-resourced institutions limits residents' access to fresh and affordable foods, healthcare, transportation, employment, and recreational activities. Participants expressed that the barriers they face are often intertwined and connected due to missing infrastructure. For instance, the lack of local medical specialists and accessible public transportation makes it difficult for some to access health care for chronic conditions. Community-reported solutions and recommendations across Salem County included creating more local infrastructure. People suggested increasing local medical health professionals and facilities, grocery stores, employers, community spaces, recreational activities, and public transportation, suggesting co-locating some of these services. Data spoke to the importance of said institutions treating people with dignity, respect, and free of internalized bias. Furthermore, recommendations included increasing information sharing (about community activities, local health programs, and events), through both digital and print media to inform residents.

Discussion: Communicating Back to Community

Across the region, barriers underscored the rising cost of living and affordability of basic needs. The cost of healthcare and healthcare access issues also arose as large barriers in the data. While the overall cost of living and basic needs (e.g., food, transportation, housing) were more deeply reflected in Cumberland Gloucester counties, Salem County barriers highlighted a lack of infrastructure to support these needs and housing, transportation, and employment. Data spoke to a need for generating community connections and gathering in safe and well-resourced community spaces for learning, health care, and socialization. The prevalence of chronic illness across the region also undergirds the need for preventive and follow-up care across physical and mental health conditions. Overall, the findings suggest maintaining partnerships and figuring out creative ways to reduce costs associated with healthcare and social determinants of health. See Figure 2 for a breakdown of assets, barriers, and recommendations/solution across the region and the three counties.

While the elements of this CHNA mirror many aspects from other CHNAs, the tri-county region provided additional considerations for reaching out to the community during the data collection stages and for dissemination of findings. We took multiple steps to communicate findings back to community members and organizations. Other CHNAs can employ similar strategies to disseminate their findings.

Foremost, the health care organization has created its Community Health Implementation Plan (CHIP) that outlines how it intends to address some of the findings from the CHNA. Data from the CHNA directly informed the CHIP. The CHIP highlighted the health care organization's specific programs and partnerships that do and will address each of the barriers identified in the CHNA. Specifically, these included alleviating financial burdens by improving access to affordable food, housing, and transportation; enhancing access to affordable and comprehensive health care services; improving the management and prevention of chronic illnesses, fostering community engagement; and streamlining administrative processes and addressing staffing challenges. We created four accessible reports and four executive summaries that live on the websites of our research center and the healthcare organization. We also made a one-page flyer with links and QR codes to the website for residents to learn more. We wrote a blog post highlighting the takeaways from the CHNA and how the healthcare organization will use the highly applicable findings to inform its future work, which was shared on socials. Survey respondents were able to check a box on the survey if they would like to receive a copy of the report once finalized, and a copy of the report will be sent to those who selected "yes," and who provided an email address. These survey respondents and the individuals and organizations we reached out to participate in data collection were emailed copies of the reports and supporting information. We organized four community presentations – one in each county and one with a regional host– to share the findings in an informal presentation and discussion style. These presentations were hybrid where feasible to promote accessibility. We also held two "drop-in" virtual sessions geared towards practitioners to come learn about the findings and ask questions in an informal setting. In partnership with the health care organization, these presentations were promoted in the same ways we recruited for data collection – we emailed all the individuals we reached out to for interviews and all the organizations for focus groups – asking them to attend and share with their networks and community folks.

We are still learning how best to communicate back research project findings to the community in ways that are most approachable and accessible to community members. Our website received a huge uptick in visitors following the report(s) release, and the reports were often downloaded. Feedback to date expressed appreciation for the hybrid options, and partners we spoke with enjoyed the informative and casual nature of the "drop-in" sessions. Ideally, we would have had more time to space out the community presentations (e.g. over three months as opposed to one month), and offer more community presentation time slots (e.g., AM and PM on the same day). Dissemination back to the community is an important component of the project budget that other researchers should consider. Funds should be allocated for the creation (e.g., graphic design, translation) and publication of publicly accessible and readable materials (e.g., one-pagers, blog posts, summaries) and for in-person engagements (e.g., travel time, refreshments, printed materials). Additionally, other researchers should offer multiple avenues for interested parties to engage with the findings. Multiple formats (e.g., online presentation, in-person town hall, one pager, social media posts) will support people engaging with the findings in ways that are most approachable to them.

Limitations

There are multiple limitations to the current study that can inform future CHNAs. The goal of this study was to highlight the needs of the health care provider's service region, and

the findings are descriptive in nature. Although we engaged with over 600 survey respondents, the sample was a cross-sectional convenience sample and may not be representative of the population of these counties; it is not generalizable. Bias may have been introduced by respondents when answering questions related to their health, both in surveys and in the focus groups and interviews. Additionally, while we attempted to engage with multiple special populations (e.g., LGBTQIA+ individuals, older adults, people experiencing homelessness) we were unable to capture the breadth and depth of experience across all groups of special populations. Future CHNAs can work to ensure representative samples as well as engage in focused studies with populations of interest. Despite these limitations, this study amassed a substantial amount of actionable data that can inform health care practice and social service delivery in Southern New Jersey.

Conclusion

This CHNA spanned three counties and highlighted the barriers residents face in accessing basic needs and health care due to rising costs. Community-reported solutions and recommendations focused on maintaining and increasing regional partnerships in bringing programming, funding, and advocacy to the region. Specific health care takeaway highlight the need for individualized, whole-person care, supported through co-locating services and attentive staff.

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