Englewood Health

2020-2022 Community Health Needs Assessment

Implementation Strategy and Executive Summary

ENGLEWOOD
HEALTH

Methodology

Englewood Health (EH) offers its Community Health Implementation Strategy for 2020-2022. The implementation strategy was approved by the Board of Trustees on April 23, 2020. The Implementation Strategy is the result of Bergen County's Community Health Needs Assessment (CHNA), conducted in 2019. Through the CHNA, Englewood Health was able to identify multiple community health priority areas. These areas were identified after consideration of various criteria, including secondary data (comparison of Bergen County data to New Jersey and national data); qualitative findings from surveys, focus groups, community listening sessions, and key informant interviews; and the potential health impact within a priority area. Complete details are available within the full 2019 Englewood Health CHNA, available at englewoodhealth.org.

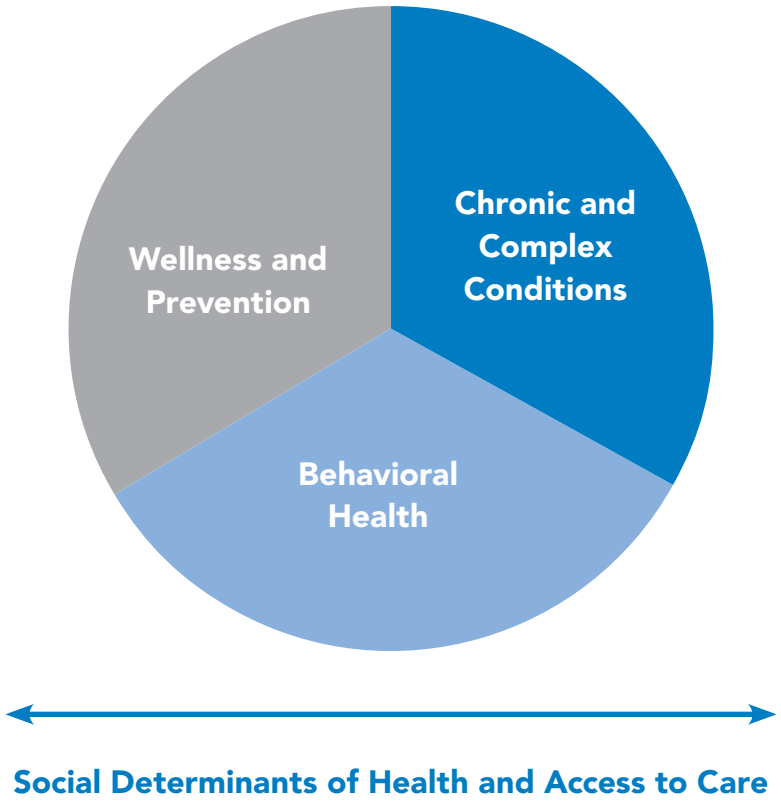
Prioritization Criteria

An evaluation of the key informant interviews, focus groups and the research data led to the identification of critical needs based on the following criteria:

1) Scope & Severity
   - What is the size of the population impacted and to what severity?
   - How does the community data compare to the state and national data, and in what areas can a resource gap be identified?
   - What is the impact trajectory of the issue and to what extent can it lead to death, disability, decreased quality of life or other health issues?

2) Ability to Impact
   - What is the perceived likelihood EH can effect change in a particular area given resources, capabilities and sphere of influence?

Englewood Health Community Priority Areas 2020-2022



Observations

While the health status of Bergen County's residents appears average when compared to that of the United States, it is important to recognize that the overall health of our country, including weight, nutrition, exercise levels and mental health, continues to decline. At this point, "average" may no longer be considered "healthy," so while we may be at or above the national average in some of these areas, there is still significant opportunity for improvement.

All populations in our community are struggling with common health issues (noted above) but it is important to recognize that solely looking at the "averages" is misleading. It disguises the significant health disparity in Bergen County. The lower one's income, the increased likelihood of disease and illness. It is critical to further analyze the data by population in order to accurately understand and address the health issues faced by the entire community.

1. Wellness and Prevention

Good nutrition is mission critical for good health. Good nutrition is not practiced for a range of reasons, including awareness, access and cost. As a result, weight-related health issues, including obesity, are pervasive and continue to contribute significantly to the spread of chronic and complex conditions (heart disease and stroke, cancer, diabetes). Physical fitness is an essential component of a healthy life. Across all populations, exercise rates are at an all-time recorded low.

2. Chronic and Complex Conditions

Conditions such as heart disease, cancer and diabetes are the leading causes of death and disability among Bergen County Residents. More than 50% of U.S. adults have at least one chronic condition. The nutrition challenges and emotional challenges of individuals who are struggling with chronic and complex conditions should be considered and addressed in the support programs and care plans for this population.

3. Behavioral Health

Mental health, anxiety, stress and substance use are identified as leading health issues in our county. The impact can be seen in the increase of depression, mental health challenges, and rise in substance use and addiction. There is a gap in the ability to access support, complicated by lack of adequate supply and affordable options.

4. Social Determinants of Health

a. The overall percentage of households with insurance is misleading. Vulnerable populations have frequent "lapses" in insurance. Lack of health insurance has been identified as one of the leading barriers to health care.

b. Nearly one third of Bergen County residents are foreign born and face language-related challenges that impact understanding, navigation and access to health care.

c. Bergen County has the second highest population of adults over 65 in NJ (16.4%). This group commonly faces wellness challenges (isolation, influenza, pneumonia, falls, Alzheimer's and lack of end of life care directives).

d. Nearly 20% of all respondents to the Bergen County random household survey report they have been somewhat or very worried about food running out sometime in the past year. Percentages were highest among low income (46.8%), Hispanic/Latino (42.2%), and Black/AA (27.2%).

Key Findings

Gray boxes represent CHNA Bergen County Random Household Survey 2019 data

	Black AA	Hispanic	Low-Income	White	Bergen County	New Jersey	United States
Population 65 years of age or older					16.4%	15.1%	14.9%
Foreign-born					30.5%	22.1%	13.4%
Speaks language other than English at home					39.9%	31.0%	21.3%
Wellness and Prevention: Access							
No health insurance[1]					9.2%	9.7%	10.5%
Uninsured in past 12 Months	19.3%	20.2%	26.4%	8.5%			
Has personal doctor/primary care provider	85.1%	77.2%	79.1%	85.7%	83.9%[3]	71.9%[4]	70.5%[4]
Had primary care visit in past year					70.3%[3]	80.6%[4]	77.0%[4]
ER visit one or more times in past year	28.8%	21.7%	22.0%	20.1%			
Couldn't fill a prescription in past year due to cost	18.0%	22.4%	23.9%	12.8%			
Wellness and Prevention: Nutrition and Exercise							
Obese	30.6%	29.0%	29.2%	24.7%	23%[7]	26.0%[7]	30.9%[4]
Overweight	41.0%	34.8%	31.8%	33.6%			
Did not participate in any exercise in past 30 Days	41.6%	43.2%	47.9%	28.9%			
Met physical activity recommendations[8]					48.2%	49.3%	
Worried about food running out	27.2%	42.2%	46.8%	16.9%			
Difficult to find fresh produce	24.3%	38.4%	32.4%	18.0%			
Chronic and Complex Conditions							
Ever been told they have high blood pressure	37.5%	19.1%	32.4%	26.7%	26.5%[3]	33.0%[4]	32.3%[4]
Ever had heart attack					2.7%[3]	4.1%[4]	4.5%[4]
Ever had stroke					1.8%[3]	3.0%[4]	3.4%[4]
Ever been diagnosed with cancer					5.0%[4]	5.7%[4]	9.4%[12]
Cancer mortality (per 100,000)					180.1[10]	182.6[10]	183.9[11]
Ever had diabetes	15.7%	7.8%	16.7%	11.1%	9.6%[13]	9.9%[13]	10.9%[4]
Ever had borderline/pre-diabetes[13]	13.4%	12.8%	16.3%	10.7%	8.0%	9.4%	
Ever had asthma	19.2%	10.4%	13.7%	13.6%	7.8%[13]	12.0%[13]	14.7%[4]
Flu/pneumonia mortality (per 100,000) [10]					16.5%	14.6%	
Alzheimer's disease mortality (per 100,000)					30.6%[10]	25.2%[10]	37.3%[11]
Fallen at least once in past 3 months (people 65 or older)					14.9%[3]		
Behavioral Health							
Diagnosed with depressive disorder	10.1%	11.1%	11.6%	11.0%	9.7%[3]		9.3%[15]
Diagnosed with anxiety disorder	7.8%	11.9%	11.2%	15.6%	12.7%[3]		
Mental health provider ratio[16]					450:1	500:1	
Mental/behavioral disorder hospitalizations (per 100,000)[17]					557.3	525.1	
Adults who smoke cigarettes **(note Asians at almost 50%)**	24.3%	14.4%	28.8%	15.0%	13.0%[14]	14.0%[14]	16.1%[4]
Adults who used e-cigarette/vaping product in the past year	7.9%	8.1%	.9%	4.5%	6.0%[3]		
Adults binge/heavy drinking	12.0%	16.9%	14.1%	14.8%	16.0%[14]	17.0%[14]	
Not enough sleep 15+ days in past month	29.9%	29.4%	29.4%	23.7%			

*Footnotes appear on next page

[1]US Census Bureau, 2013-2017; [2]Healthy People 2020 Objectives; [3]Bergen County Random Household Survey 2019; [4]Behavioral Risk Factor Surveillance Survey 2018; [5]Centers for Medicare and Medicaid Services 2016; [6]New Jersey Department of Health, Office of Health Care Quality Assessment (age-adjusted rate); [7]National Diabetes Surveillance System 2015; [8]New Jersey Behavioral Risk Factor Surveillance Survey 2013-2017 (odd years); [9]Feeding American First 2016; [10]New Jersey Death Certificate Database 2013-2017; [11]Centers for Disease Control and Prevention 2017; [12]Centers for Disease Control and Prevention 2018; [13]New Jersey Behavioral Risk Factor Surveillance Survey 2017; [14]New Jersey Behavioral Risk Factor Surveillance Survey 2016; [15]Centers for Disease Control and Prevention 2016; [16]Center for Medicaid Services National Provider Identification Registry 2018; [17]New Jersey Discharge Data Collection System, Office of Health Care Quality Assessment 2016

Implementation Strategy

Englewood Health is committed to achieving improved health through better quality care at lower costs. To address the needs of our community, Englewood Health is allocating significant resources to achieve the goals set forth in this Implementation Strategy. Englewood Health's Population Health Department, which includes both clinical and community support services, will lead this effort. Englewood Health is dedicated to being the healthcare leader for our community.

1 **Priority Area:** Wellness and Prevention
Goal: Increase access to health education, screening, and prevention services

Objectives/Strategies:

1. Provide education and intervention regarding wellness, health promotion, prevention efforts, risk factors, and healthy behaviors (nutritional, physical, and emotional health / wellness)
2. Conduct screenings for chronic disease risk factors (e.g., cancer, high blood pressure, cholesterol, BMI) and provide referrals to appropriate treatment or services
3. Implement programs and events with local and regional collaboratives that address issues related to wellness, prevention, and risk factors
4. Expand upon our system-wide care management program

Sample Process/Outcome Measurements:

- Number of education/counseling programs and number of participants
- Pre and post tests to measure changes in attitude, knowledge, and health outcomes
- Number of screenings and number of referrals to treatment/services
- Resources devoted to collaborative efforts

2 **Priority Area:** Chronic and Complex Conditions
Goal: Improve health status through chronic disease and care management

Objectives/Strategies:

1. Provide programs that promote education and awareness of chronic and complex conditions
2. Promote chronic disease management programs (diabetes, cardiovascular, stroke and cancer)
3. Provide linkage to care, with increased access to providers and navigation within physician network
4. Create customized care plans to manage patients with complex conditions

Sample Process/Outcome Measurements:

- Number of educational programs and number of participants
- Number of individuals engaged in chronic disease management programs
- Pre and post tests to measure changes in attitude, knowledge, and health outcomes
- Resources devoted to maintaining Commission on Cancer accreditation and Joint Commission Disease Specific Certification for stroke
- Number of resources devoted to care management; number of patients with care plans

3 **Priority Area:** Behavioral Health
Goal: Promote positive mental, social, and emotional health

Objectives/Strategies:

1. Expand efforts to reduce stigma
2. Continue to offer behavioral health educational programs and screenings in community-based settings, with a focus on priority populations
3. Expand behavioral health care services in the Englewood Health Physician Network
4. Improve access to behavioral health treatment
5. Collaborate with local and regional partners to address behavioral health issues

Sample Process/Outcome Measurements:

- Number of screenings and number of individuals referred to treatment or supportive services
- Number of educational programs offered and number of participants
- Pre and post tests to measure changes in attitude, knowledge, and health outcomes
- Resources devoted to behavioral health integration across the continuum

4 **Priority Area:** Social Determinants of Health and Access To Care

Goal: Address issues that prevent or delay individuals from accessing care and resources

Objectives/Strategies:

1. Develop innovative solutions for improving access to care, for the community at-large and patients attributed to the Englewood Health Physician Network
2. Implement navigation services that remove barriers to care (language, age/ transportation)
3. Expand programs and policies that screen for and address the social determinants of health, with a focus on nutrition and food security
4. Implement local and regional efforts to address social determinants of health and access to care issues

Sample Process/Outcome Measurements:

- Resources provided to improving access to care
- Number of screenings for social determinants of health and referrals to additional resources
- Resources devoted to collaborative efforts