Bergen County Community Health Needs Assessment and Strategic Planning Project

Englewood Hospital and Medical Center
Community Benefit / Community Health Strategic Plan
April 2013

A. Priority Areas

The Bergen County CHNA identified the following four priority areas as the most pressing and appropriate issues for the County's health and social services providers to work collaboratively on over the next 1 to 3 years.

- Obesity, Fitness, Nutrition, and Chronic Disease
- Mental Health and Substance Abuse
- Access to Care
- Elder Health

Given Englewood Hospital and Medical Center's (EHMC) overall mission, scope of service, operational strengths, and specific service area characteristics, the hospital will focus their community benefit and community health strategy on obesity, fitness, nutrition, chronic disease, elder health, and access to care. Special emphasis will be placed on meeting the needs of low income populations and elders overall, as well as Korean, African-American/Black, and Hispanic/Latino populations specifically. The Hospital will also address mental health, substance abuse, and access to dental and behavioral health services but these issues will be secondary and will be done in partnership with other health and social service organizations.

B. Implementation Goals

<u>Leading Priorities:</u>

- **Obesity, Fitness, Nutrition, and Chronic Disease.** Implement awareness, education, and/or screening activities related to chronic disease and/or its associated risk factors in internal clinical settings (e.g., hospital emergency department, inpatient units, other hospital-based settings) and external community-based settings (e.g., Federally Qualified Health Centers, senior centers, public housing facilities, schools, faith-based organizations).
- **Obesity, Fitness, Nutrition, and Chronic Disease.** Implement follow-up and referral protocols that ensure that those with chronic disease and/or its associated risk factors engage in appropriate primary care, medical specialty care, and/or chronic disease management care.

- **Obesity, Fitness, Nutrition, and Chronic Disease.** Implement screening activities that identify those without a regular source of primary care and that ensure that they are linked to an appropriate primary care medical home.
- **Obesity, Fitness, Nutrition, and Chronic Disease.** Participate in the Bergen County Diabetes Collaborative and/or other collaborative workgroup activities in collaboration with the CHIP, the County's other hospitals, and other health/social service providers.
- **Obesity, Fitness, Nutrition, and Chronic Disease.** Support the CHIP in its efforts to expand access to chronic disease self-management and behavior change programs and promote participation in these efforts.
- **Elder Health.** Focus education, awareness, screening, follow-up and referral activities on internal hospital and external, community-based settings that serve elders (e.g., senior centers, assisted living facilities, nursing homes, etc.). Explore the possibility of developing an Elder Health Education and Prevention Center.
- **Elder Health/Access to Care.** Refine and strengthen activities that reduce hospital readmission and improve care coordination, follow-up care, and medication management after discharge, particularly for those with congestive heart failure, pneumonia, and COPD.
- **Access to Care.** Work in partnership with the CHIP, the County's other hospitals, North Hudson Community Health Center, and other community-based providers to explore how to expand access to primary care, medical specialty care, and/or chronic disease management services, particularly for low income, racial/ethnic minority, and older adult populations.

<u>Secondary Priorities:</u>

- **Obesity, Fitness, Nutrition, and Chronic Disease.** Work in partnership with the CHIP, Bergen County/local health departments to promote the development of non-clinical community health interventions such as local laws or formal policies that protect public health, improve enforcement, improve community infrastructure, or change practices in community settings such as in restaurants, grocery stores, or schools.
- **Mental Health and Substance Abuse.** Implement awareness, education, and/or screening activities related to mental health and substance abuse (e.g., depression, anxiety, alcohol) and/or its associated risk factors (e.g., obesity, fitness, nutrition, isolation) in collaboration with other Hospitals and/or other health and social service organizations in both internal clinical settings (e.g., hospital emergency department, inpatient units, other hospital-based settings)

and external community-based settings (e.g., local health departments, Federally Qualified Health Centers, senior centers, public housing facilities, schools, and faith-based organizations).

- **Access to Care.** Work in partnership with the CHIP, the County's other hospitals, and other community-based providers to explore how to expand access to dental care and behavioral health care service services.
- **Access to Care.** Advocate for improvements in public transportation and promote the development of improved transportation services in hospital and other health and social service settings

C. Desired Outcomes

Primary Outcomes:

- Reduce the prevalence of obesity and overweight
- Increase the proportion of people who get adequate exercise
- Promote healthy eating habits
- Reduce tobacco use
- Reduce the prevalence of diabetes and other chronic disease such as (heart disease, stroke, cancer, asthma, depression, anxiety)
- Expand access and facilitate engagement in appropriate primary care, medical specialty care, and chronic disease management services
- Reduce inappropriate hospital emergency department and inpatient utilization

Secondary Outcomes:

- Reduce the stigma associated with mental illness and substance abuse
- Foster better mental health and emotional well-being
- Reduce the percentage of adults who engage in "binge" drinking or "heavy" drinking
- Facilitate engagement in appropriate dental and mental health care services
- Expand access to mental health counseling services for low and moderate income populations

D. Target Populations and Conditions

Population Targets	Risk Factor Targets	Health Condition Targets
Primary Populations • Elders • Low income populations • African Americans/Blacks • Hispanics/Latinos • Koreans	Primary Risk Factor • Obesity/overweight • Lack of physical fitness • Poor nutrition • Diabetes Secondary Risk Factors • Mental health stigma	Primary Conditions • Heart disease • Hypertension • Stroke • Cancer • Asthma Secondary Conditions • Depression

	• Stress • Grief/loss • Substance abuse • Social/physical Isolation	• Anxiety

E. Primary Community Partners

Community Partners
• Community Health Improvement Partnership of Bergen County • North Hudson Community Health Center • Jewish Community Center of Bergen County • Elder and Public Housing • Faith-based Organizations • Elder Services Organizations • Public Health Departments • Other Private Primary Care Providers

F. Objectives and Strategies

Primary Objectives and Strategies

- **General Chronic Disease Health Education and Awareness Activities**. EHMC, either on its own or in Partnership with other County hospitals, local health departments, schools, and community-based organizations, will provide chronic disease health education and awareness activities in hospital and community-based settings by refining and strengthen their existing Speakers Bureau and other educational workshops, lectures, and symposia. The goal of these activities will to educate and raise awareness about chronic health conditions as well as the risk factors associated with these conditions.
- **Targeted chronic disease Health Education, Awareness, Screening, and Referral Activities.** EHMC, either on its own or in Partnership with other County hospitals, local health departments, and community-based organizations, will implement targeted chronic disease health education, awareness, and screening activities in community-based organizations and local health department settings. The goal of these activities will be to: 1) educate and raise awareness, 2) identify those with existing chronic disease, 3) identify those with chronic disease risk factors, 4) make appropriate referrals to care, and 5) follow-up to ensure that people engage in care.
- **Participation in Stamford Chronic Disease Self-Management Program.** EHMC in partnership with CHIP, other County Hospitals, and other community-

based organizations in the development of a program that identifies those with chronic disease or who are at-risk of developing a chronic disease and links them to Stamford Chronic Disease Self-Management Program, facilitated by specially trained instructors.

- **Participation in the Bergen County Chronic Disease / Diabetes Collaborative**. EHMC will participate along with the other hospitals, the CHIP, Bergen County Health Department officials, and other stakeholders in a community coalition aimed at addressing the prevalence and control of chronic disease and/or diabetes and its associated risk factors.
- **Refine / Strengthen the Hospital Efforts to Reduce Inappropriate Hospital Inpatient and Emergency Department Utilization.** EHMC, in partnership with community-based clinical and social service providers, will refine and strengthen activities to reduce inappropriate hospital inpatient and emergency department utilization. In the inpatient setting efforts will focus on improving care coordination and follow-up after discharge, improving provider-patient communication and information exchange, and assisting patients to manage their medications. Emphasis will be placed on those with congestive heart failure, pneumonia, and COPD. In the emergency department setting, efforts will focus on identifying "frequent flyers", linking those without a regular primary care provider to a primary care medical home, and helping to ensure that those with chronic medical conditions are engaged in appropriate chronic disease self-management programs.

Secondary Objectives and Strategies

- **General Health Education and Awareness Activities Related to mental health and substance abuse (e.g., depression, anxiety, alcohol abuse, mental health/substance abuse stigma)**. EHMC, either on its own or in Partnership with other County Hospitals, local health departments, and other community-based organizations will provide mental health/substance abuse education and awareness activities by refining and strengthen their existing Speakers Bureau and other educational workshops, lectures, and symposia. The goal of these activities will to educate and raise awareness about mental health and substance abuse issues and the risk factors associated with these issues.
- **Collaboration to Expand Access to Dental and Behavioral Health Care.** EHMC will work in partnership with the CHIP, the County's other hospitals, and other primary care, dental care, behavioral health care, and medical specialty care service providers to explore how to expand access to services, particularly for low income, uninsured, and older adult populations.

G. Process and Outcome Measures

Sample Process Measures

Target Area	Description of Measure	Baseline	Goal	Actual Number	Timeframe

Education and Awareness	Number of educational events thought the Speakers Bureau	Unknown	TBD	Track in 2013/14	2014
Education and Awareness	Number of participants involved in speakers bureau events	Unknown	TBD	Track in 2013/14	2014
Education, Screening, and Referral	Number of more targeted community-based education, screening, and referral events in churches, meals on wheels, and other community-based settings.	Unknown	TBD	Track in 2013/14	2014
Education, Screening, and Referral	Number of participants involved in more targeted community-based education, screening, and referral events in churches, meals on wheels, and other community-based settings.	Unknown	TBD	Track in 2013/14	2014
Education, Screening, and Referral	Number of participants screened in more targeted community-based education, screening, and referral events in churches, meals on wheels, and other community-based settings.	Unknown	TBD	Track in 2013/14	2014
Education, Screening, and Referral	Number of participants referred to care through more targeted community-based education, screening, and referral events in churches, meals on wheels, and other community-based settings.	Unknown	TBD	Track in 2013/14	2014
Reduction of Hospital Utilization	Number / Rate of Hospital admissions for the Leading Inpatient and Emergency Department Admission Types	Unknown	TBD	Track in 2013/14	2014

Sample Outcome Measures

Target Area	Description of Measure	Baseline[1]	Goal[2]	HP 2020 Goal[3]	Timeframe
Reduce the Prevalence of Health Related-Risk Factors					
Overweight/ Obesity	Reduce the proportion of persons (18+) who are either overweight or obese (BRFSS)	58%	52.2%	NA	By 2016
Obesity	Reduce the proportion of persons (20+) who are obese (HP 2020)	22%	19.8%	30.5	By 2016
Adequate Physical Exercise	Reduce the proportion of persons (18+) who engage in no leisure-time physical activity (BRFSS)	30%	27%	32.6%	By 2016
Healthy Diet	TBD	TBD	TBD	TBD	By 2016
Alcohol Consumptio	Reduce the proportion of persons (18+) engaging in binge drinking during	22%	19.8%	NA	By 2016

n	the past 30 days (BRFSS)				
Depression	Reduce the percentage of the population who reports being sad or blue more than 15 days per month	10%	6%	NA	By 2016
Anxiety	Reduce the percentage of the population who reports being Tense or Anxious more than 15 days per month	17%	10%	NA	By 2016

Target Area	Description of Measure	Baseline[1]	Goal[2]	HP 2020 Goal[3]	Timeframe
Reduce the Prevalence of Disease and Health Related-Risk Factors					
Diabetes	Reduce the proportion of persons (18+) who have been told by their doctor that they have diabetes (BRFSS)	10%	9%	NA	By 2016
Hypertension	Reduce the proportion of persons (18+) who have been told by their doctor that they have hypertension (BRFSS) (HP 2020)	28%	25.2%	26.9%	By 2016
High Cholesterol	Reduce the proportion of persons (18+) who have been told by their doctor that they have high cholesterol (BRFSS) (HP 2020[4])	36%	32.4%	13.5%[4]	By 2016
Promote Proper Control and Disease Management for Those with Chronic Conditions					
Diabetes	Increase the proportion of adults with diabetes who have had their HbA1c levels tested at least twice in the past 12 months (HP 2020)	TBD	TBD	71.1%	BY 2016
Hypertension	Increase the proportion of adults with hypertension who are on medication for their condition (HP 2020)	87%	90%	69.5%	By 2016
High Cholesterol	Increase the proportion of persons (18+) with high Cholesterol who are on medication for their condition (BRFSS)	60%	66%	NA	By 2016

Access to Care and Care Coordination					
Target Area	**Description of Measure**	**Baseline[1]**	**Goal[2]**	**HP 2020 Goal[3]**	**Timeframe**
Primary Medical Care	Increase the proportion of persons (18+) with a usual source of primary care medical services (BRFSS)	83%	91.3%	89.4%	By 2016
Primary Medical Care	Increase the proportion of persons who have had a regular check-up or preventive services in the past 12 mos. (BRFSS)	68%	74.8%	NA	By 2016

Dental Care	Increase the proportion of persons who have had a regular dental check-up or seen the dentist in the past 12 mos. (BRFSS)	63%	69.3%	NA	By 2016
Behavioral Health Care	Increase the number of primary care practice sites that offer co-located behavioral health services or have enhanced referral relationships with community-based mental health providers	NA	10 Clinic Sites	NA	By 2016
Medical Specialty Care	Increase the number of medical specialty care providers who serve Medicaid insured or uninsured patients on a discounted basis.	NA	TBD	NA	By 2016
Medical Specialty Care	Increase the proportion of those in racial/ethnic minority populations who access a specialty care provider in the past 12 mos.	34% - 51%	40% - 56.1	NA	By 2016
Cultural/ Linguistic Competence	TBD	TBD	TBD	TBD	By 2016
Health Literacy	TBD	TBD	TBD	TBD	By 2016
Transportation	TBD	TBD	TBD	TBD	By 2016

[1] Baseline data drawn from the Bergen County Community Health Needs Assessment Survey, 2012

[2] Goals reflect a 10% improvement over baseline

[3] HP 2020 Targets are drawn from the HP 2020 website: http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx