Holy Name Medical Center

IMPLEMENTATION STRATEGY

TO ACCOMPANY

2019 COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA")

January, 2020

HOLY NAME MEDICAL CENTER: 2019 CHNA IMPLEMENTATION STRATEGY

INTRODUCTION

Beginning in late December 2018 and continuing into 2019, the Bergen County Department of Health Services, the Community Health Partnership of Bergen County, and Bergen's eight acute care entities – including Holy Name Medical Center ("HNMC") – conducted a comprehensive Community Health Needs Assessment ("CHNA"). This 2019 CHNA included an extensive review of quantitative data and collected qualitative information through key informant interviews, focus groups, community listening sessions, and surveys. This extensive array of assessment and engagement activities allowed the Bergen County Department of Health Services, the Community Health Improvement Partnership ("CHIP"), and the involved entities a better understanding of community health issues, vulnerable populations, and areas of opportunity in the respective service areas. Additional data addressing Holy Name's Hudson County service areas were added and the analysis extended. The final assessment findings were used as the basis for which Holy Name developed this Implementation Strategy – a plan that outlines how the Medical Center will address community health needs during 2020, 2021 and 2022 (when the next CHNA will be issued).

COMMUNITY HEALTH PRIORITY AREAS

The CHNA provided many opportunities to vet quantitative and qualitative findings. Based on these findings, Holy Name's service lines and areas of expertise, leadership and staff from Holy Name Medical Center identified three community health priority areas, which together embody the leading health issues and barriers to care for residents of the hospital's service area: chronic/complex conditions and risk factors, social determinants of health and access to care, and mental health and substance use disorders.

Chronic/Complex Conditions and Risk Factors	Social Determinants of Health and Access to Care	Mental Health and Substance Use Disorders

COMMUNITY HEALTH PRIORITIES NOT ADDRESSED IN HOLY NAME'S IMPLEMENTATION STRATEGY

It is important to note that there are community health needs that were identified through Holy Name's Community Health Needs Assessment that were not prioritized for inclusion in the Implementation Strategy. Reasons for this include:

- Feasibility of Holy Name having an impact on this issue in the short or long term
- Specific capability of the organization
- The issue is already addressed by community partners in a way that does not warrant additional support

Poverty/employment, housing stability, and certain levels of behavioral and substance abuse needs were identified as community needs, but were deemed to be outside of Holy Name Medical Center's primary sphere of influence. Holy Name remains open and willing to work with hospitals and other public and private partners to address these issues should an opportunity arise.

PRIORITY POPULATIONS

Although Holy Name is committed to improving the health status of all residents living in its service area, based on the assessment's quantitative and qualitative findings there was agreement that the Implementation Strategy should prioritize certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care. Five priority populations were identified:

Individuals with Chronic/Complex Conditions	Older Adults	Racially, Ethnically & Culturally Diverse Populations	Individuals with Limited Resources	Youth and Adolescents

COMMUNITY HEALTH IMPROVEMENT – STRATEGIC FRAMEWORK

The following defines the types of programmatic strategies and interventions that were applied in the development of the Implementation Strategy.

- **Screening and Identification:** Screening and identification programs reduce the risk of death or ill health from a specific condition by offering tests to help identify those who could benefit from treatment. A critical component of screening and referral efforts is to provide linkages to providers, treatment, and supportive services should an issue be detected.

- **Health Education and Prevention:** Initiatives that aim to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, or altering unhealthy behaviors. Programs might include targeted efforts to raise awareness about a particular condition or provide information on risk and protective factors.

- **Behavior Modification and Disease Management:** Evidence-based behavioral modification and/or chronic disease management programs that encourage individuals to manage their health conditions, change unhealthy behaviors, and make informed decisions about their health and care.

- **Care Coordination and Service Integration:** Initiatives that integrate existing services and expand access to care by coordinating health services, patient needs, and information.

- **Patient Navigation and Access to Care:** Efforts which aim to help individuals navigate the health care system and improve access to services when and where they need them.

- **Cross-Sector Collaboration and Partnership:** Includes collaborations, partnerships, and support of providers and community organizations across multiple sectors (e.g., health, public health, education, public safety, and community health).

RESOURCES COMMITTED TO COMMUNITY HEALTH IMPROVEMENT

To execute the strategies outlined in this Implementation Strategy, Holy Name Medical Center will commit direct community health program investments and in-kind resources of staff time and materials. Holy Name may also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, and on behalf of its community partners.

PRIORITY AREA: CHRONIC / COMPLEX CONDITIONS AND RISK FACTORS

Goals:
     (1) Enhance access to health education, screening and referral/treatment services

     (2) Support individuals with chronic/complex conditions and their caregivers

     (3) Enhance understanding of end-of-life needs and care

OBJECTIVES

- Screen for chronic/complex conditions and risk factors and refer to appropriate services
- Increase the number of individuals who receive education regarding chronic/complex conditions and risk factors
- Increase skills, confidence, and abilities of parents and caregivers
- Increase the number of individuals from priority populations engaged in care
- Improve coordination of care for adults with chronic/complex conditions
- Promote chronic disease management and behavioral change
- Increase healthy eating and physical activity
- Increase access to end-of-life and palliative care programs
- Decrease social isolation among older adults
- Increase the number of adults with advance healthcare directives
- Provide support for the health care of impoverished persons in Milot, Haiti

STRATEGIES

Screening and Identification

- Conduct screenings for chronic/complex conditions and risk factors in clinical and non-clinical settings

Health Education and Prevention

- Offer/support programs that provide education on healthy habits, lifestyle changes, and chronic/complex conditions
- Provide free and/or low-cost parenting and caregiver education and support programs
- Engage diverse communities through outreach initiatives
- Utilize simulation education to increase caregiver understanding of Alzheimer's disease and other conditions

Behavior Modification and Disease Management

- Support programs that enhance access to opportunities for free or low cost physical activity
- Support programs that provide education and demonstration related to weight management, healthy foods, and food preparation
- Support efforts that engage individuals in evidence-based behavior change and self-management programs

Patient Navigation and Access to Care

- Provide free flu vaccinations in community-based settings
- Engage individuals with chronic/complex conditions and their caregivers in case management and patient navigation programs
- Offer support groups for individuals with chronic/complex conditions, those affected by the loss of a loved one, and caregivers

Cross-Sector Collaboration and Partnership

- Participate in collaborative regional and local efforts to address issues around wellness, risk factors, and chronic/complex conditions

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of screenings offered and number of individuals screened/referred to services
- Number of educational programs provided or supported
- Number of parenting/caregiver education/support programs offered and number of individuals engaged
- Number of individuals engaged in care through outreach initiatives
- Resources provided for programs that enhance access to nutritious/affordable foods
- Number of individuals engaged in behavior change/self-management programs
- Number of free flu vaccinations provided
- Number of individuals engaged in case management and patient navigation programs
- Number of support groups offered and number of participants
- Results of pre- and post- tests to measure changes in knowledge, attitudes, behaviors, and health outcomes (when available)
- Participation in regional/local collaborative efforts and any resources committed
- Number of Advance Directives completed
- Number of persons/families appropriately referred for palliative care

PARTNERS

- Community-based partners (e.g., senior centers, other providers, community centers)
- Municipal and County leadership and departments focused on chronic/complex conditions and risk factors
- Local community health partnerships and collaboratives (e.g., CHIP of Bergen County)

PRIORITY AREA: SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO CARE

Goals: **(1) Address the social determinants of health and access to care issues that inhibit the ability of individuals to lead happy, healthy, and productive lives**

(2) Reduce health disparities

OBJECTIVES

- Support programs and policies that address the social determinants of health
- Address common barriers to accessing health care
- Promote care coordination and engagement in primary care
- Promote cultural competency, health literacy, and linguistically appropriate care to reduce health disparities and to increase access to services
- Reduce inappropriate use of the emergency room and hospital readmissions
- Reduce transportation barriers

STRATEGIES

Screening and Identification

- Implement or support programs that screen for/identify the social determinants of health and make appropriate referrals to community-based resources

Behavior Modification and Disease Management

- Support community partners that address barriers associated with social determinants of health

Patient Navigation and Access to Care

- Provide information that links individuals to community-based organizations that address the social determinants of health
- Support innovative solutions that address the leading barriers to care
- Provide cultural competency/health literacy education and training for hospital clinicians and staff
- Provide resources that reduce barriers related to health literacy, cultural issues/needs, and language

Cross-Sector Collaboration and Partnership

- Participate in collaborative regional and local efforts to address issues around the social determinants of health and access to care
- Participate in national models of care (e.g., CMS and other payers) that seek to improve outcomes, reduce cost and provide coordinated, better care.

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of community partners supported and the resources/support provided to them
- Resources provided to improve access to care
- Number of cultural competency/health literacy trainings and number of attendees
- Resources devoted to reducing barriers related to health literacy/language
- Participation in regional/local collaborative efforts and any resources committed
- Participation in national and regional models of care that provide measured results

PARTNERS

- Community-based partners (e.g., social service agencies, senior centers)
- Municipal and County leadership and departments focused on mental health and substance use disorder
- Local community health partnerships and collaboratives (e.g., CHIP of Bergen County)

PRIORITY AREA: MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

Goal: Support and/or implement strategies that promote mental, emotional, and social well-being

OBJECTIVES

- Enhance identification of individuals with undiagnosed mental/behavioral health conditions
- Support efforts that aim to reduce the stigma associated with mental/behavioral health and substance use disorder
- Support initiatives that promote healthy mental, emotional, and social behaviors
- Expand access to behavioral health screening, treatment, and supportive services
- Collaborate with clinical and community-based partners to address mental/behavioral health and substance use disorder
- Reduce use of opioids, especially opioid prescriptions issued by HNMC and its affiliates

STRATEGIES

Screening and Identification

- Screen individuals for undiagnosed mental health issues

Health Education and Prevention

- Support mental health First Aid trainings in community-based settings
- Support the *Stigma Free Communities* initiative
- Offer lectures and educational seminars related to mental, social, and emotional health in community-based settings
- Support efforts that provide education on the harmful effects of tobacco and e-cigarette/vaping products

Behavior Modification and Disease Management

- Support peer recovery coach programs through collaborations with local health departments, substance use providers, and clinicians
- Support evidence-based tobacco and e-cigarette/vaping cessation programs

Cross-Sector Collaboration and Partnership

- Participate in collaborative regional and local efforts to address issues around mental/behavioral health and substance use disorder
- Collaborate with local law enforcement and community partners on drug take back efforts
- Provide free *Narcan* replacement kits to first responders

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of screenings and number of individuals referred to treatment/supportive services
- Number of mental health First Aid trainings and number of attendees
- Resources committed to supporting *Stigma Free* initiatives
- Number of lectures and seminars offered and number of attendees
- Number of tobacco/e-cigarette prevention, education, and cessation efforts and number of individuals engaged
- Participation in regional/local collaborative efforts and any resources committed
- Number of *Narcan* replacement kits provided
- Number of opioid prescriptions written in ER

PARTNERS

- Community-based partners (e.g., community centers, law enforcement, other providers)
- Bergen New Bridge Medical Center (Paramus, NJ)
- Municipal and County leadership and departments focused on mental health and substance use disorder
- Local community health partnerships and collaboratives (e.g., CHIP of Bergen County)

APPROVED

Holy Name Medical Center Board of Trustees

January 23, 2020