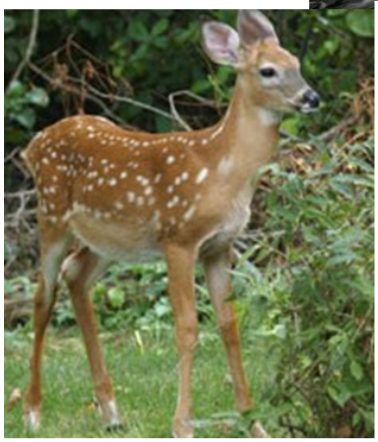
Hunterdon Medical Center

2020-2022

COMMUNITY HEALTH IMPROVEMENT PLAN



Prepared by: Kim Blanda, RN, BSN
kblanda@hhsnj.org

Introduction

Hunterdon Medical Center (HMC), part of the Hunterdon Healthcare System, is a 178-bed teaching hospital that treats more than 9,000 inpatients annually with over 32,000 Emergency Department visits and 570,000 outpatient visits per year. In addition, HHS is the largest employer in the county with approximately 2,800 full-time, part-time employees and over 600 volunteers. Since opening its doors in 1953, HMC focuses on primary care and community wellness, while emphasizing the importance of providing quality care thus achieving a high level of patient satisfaction. This philosophy is reflected in its mission and vision statements. This commitment to improve the health of the Hunterdon community has remained constant over its 60 plus year history, and will continue to do so.

> ***Mission**: Hunterdon Healthcare System delivers compassionate and exceptional care that improves the health of the community.*
>
> ***Vision**: Hunterdon Healthcare System is recognized as a national model for offering community focused health improvement that is consumer-centered and driven by a passion for excellence.*

Community Health Needs Assessment

The Hunterdon County Partnership for Health (PFH), a collaboration that includes HMC and over 70 other county agencies such as schools, government, non-profit, business, faith-based organizations, law enforcement, and healthcare completed, in June 2019, a comprehensive Community Health Needs Assessment (CHNA) to identify the health needs and issues of Hunterdon County and our bordering service areas. The CHNA identified and the PFH prioritized five needs areas: healthy weight/obesity, mental health, substance misuse, aging related issues and economic well-being. The group also committed to two overarching themes: impact of social media/technology and health equity. The complete report can be found at http://hunterdonhealthcare.org under About Us- Community Needs.

Strategies to Address Identified Priority Community Health Issues

Hunterdon Medical Center understands that collaboration is important in maintaining a healthy community. Working with other agencies enables the community to tackle complex issues more efficiently, effectively and with a broader reach. HMC is a key partner of the Partnership for Health, employing the PFH Coordinator, providing meeting space and administrative support and encouraging HMC employees to participate on Action Teams and attend quarterly meetings. HMC plans to continue its effort and collaboration with various agencies through the Partnership for Health and the Action Teams.

This Community Health Improvement Plan (CHIP) will track goals over a three year period in the areas of healthy weight, mental health, substance misuse and aging related issues. Economic well-being will be addressed by our community partners who specialize in areas surrounding affordable housing, job training and placement, social services, and other areas tied to economic well-being. HMC will serve as a referral agent to direct patients to appropriate community resources. We will receive updates through the Partnership for Health and our Clinical Liaison will serve as a communication link between the hospital and these community partners.

The Partnership for Health will continue their established Action Teams covering: healthy weight, access/economic well-being, and mental health. Our four Issue Watch Teams will work on substance misuse, Latino Access, mass violence prevention and aging-related issues. Action Team members are individuals with the expertise, passion, and knowledge to define attainable goals and objectives, and develop strategies to address. HMC will address all of the needs identified in the CHNA as indicated below.

FOCUS ON HEALTHY WEIGHT

Goal: Increase the number of Hunterdon County residents within a healthy weight range as defined by the Center for Disease Control and Prevention (CDC).

Outcome Measures:

1. Increase the percentage of patients ages 30 to 65 in our primary care practices with pre-diabetes who receive a BMI measurement and plan by 5 percentage points.

2. Increase the percentage of adults (18 and over) in our primary care practices with a BMI in the CDC defined healthy weight range by 0.5%.

3. Increase the percentage of patients age 65 and above who have been screened for food insecurity by 5 percentage points.

SUBSTANCE MISUSE

Goal: Reduce the prevalence and incidence of substance misuse in Hunterdon County and surrounding service area.

Outcome Measures:

1. Increase the percent of patients, age 18 and above, in the primary care setting with chronic opioid prescriptions (3 or more prescriptions for an opioid for over 20 pills each within the last 12 months) with a signed Controlled Substance Agreement to 92%.

2. Increase the percent of patients in the primary care setting with chronic opioid prescriptions where the physician has documented in the electronic health record (EHR) using the New Jersey Rx Monitoring Program to 96%.

3. Increase the percentage of patients ages 13 and above who have been screened for vaping by 10 percentage points.

MENTAL HEALTH

Goal: Increase the number of Hunterdon County residents being assessed for behavioral health treatment services.

Outcome Measures:

1. Increase the percentage of patients age 65 and above in the primary care setting who have been screened for depression and have a plan to address depression within the last 12 months, by 5 percentage points.

2. Increase the percentage of adolescent patients age 12 through 19 in the primary care setting who have been screened for depression by 5 percentage points..

AGING RELATED ISSUES

Goal: Increase the number of senior citizens (age 65 and above) in our service area receiving cognitive and falls risk assessments and to improve the general health of this population.

Outcome Measures:

1. Increase the percentage of patients, age 65 and above in the primary care setting who seek preventive care within the last 12 months, by 4 percentage points.

2. Increase the percentage of patients age 65 and above in the primary care setting, who have had a cognitive assessment (Mini-Cog) at their Medicare Wellness Exam within the last 12 months, by 3 percentage points.

3. Increase the percentage of patients age 65 and above in the primary care setting who have had a falls risk assessment by 3 percentage points.