Hunterdon Health

2023-2025

Community Health Improvement Plan

Our heart has a new look,
but it's still at the center of everything we do.

INTRODUCTION

We Are Hunterdon Health

We exist to be advocates of making better healthcare a reality for our patients, their families, and our community, inspiring a healthy way of living for all.

Hunterdon Health has unveiled a refreshed look and name change as it prepares to launch a new five-year strategic plan. The new name, Hunterdon Health, acknowledges the system's deep roots in the community and its continued commitment to serving the families who live and work in Hunterdon, Somerset, Mercer, and Warren counties.

Our Promise

As partners in fulfilling the mission of Hunterdon Health, we are linked by a common calling to serve. This is our Hunterdon Health Promise:

- We promise to build positive relationships with patients, family members and each other.
- Together, we endeavor to create and maintain a collaborative work environment, recognizing an obligation to our teammates and the organization's goals, while doing everything possible to deliver safe, comfortable, high quality care on a more personal level.

Our Mission

Embrace people, elevate care and cultivate healthier communities.

Our Vision

To be distinguished for clinical excellence and seamless, personalized care.

Hunterdon Health delivers compassionate and exceptional care that improves the health of the community. A non-profit organization, Hunterdon Health provides a full range of quality, integrated services and programs that respond to the needs of the community. Hunterdon Medical Center, which treats patients in Hunterdon, Somerset, Mercer, and Warren counties, is a 178-bed teaching hospital and is a Magnet designated facility, the nursing profession's highest honor. Hunterdon Medical Center provides a full range of preventive, diagnostic, and therapeutic inpatient and outpatient hospital and community health services. Hunterdon Health treats approximately 8,000 inpatients annually with about 26,500 Emergency Department visits and over 590,000 outpatient visits per year.

The COVID-19 pandemic has been a critical focus for the past two plus years. Over the course of the pandemic, 500 individuals were admitted to the hospital with COVID-19 and over 50,000 tests were performed in both the inpatient and the outpatient setting. The entire workforce reacted quickly to ensure a sufficient number of patient rooms would be available. Two floors of the hospital were completely renovated within one week to increase bed capacity from 178 to 366 rooms. The air ventilation system was upgraded, allowing us to convert 140 patient rooms into negative pressure rooms which re-route infected air away from the rest of the hospital population. These initiatives came along with hundreds of others that were taken across the community's entire health system.

COMMUNITY HEALTH NEEDS ASSESSMENT

The Community Health Needs Assessment report included both qualitative and quantitative data, and provides an overview of the health status and health needs of the Hunterdon community as well as the towns in bordering counties of Somerset, Mercer, and Warren. Quantitative data was gathered from multiple sources, both primary and secondary, such as the 2020 US Census, County Health Rankings and Roadmaps, BRFSS, NJ Department of Health Data and others, including the Hunterdon Health electronic health record data. Qualitative data was collected from focus groups with diverse members of the community. Many sectors were represented in our focus groups including: schools, faith leaders, businesses, healthcare, social services, county employees, government, non-profit organizations, teens, senior citizens and both English and Spanish speaking residents. The Forces of Change brainstorming session with key community stakeholders drilled down the leading trends over the next 3 to 5 years that could impact health in our community.

The employees and administration at Hunterdon Health understand 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. The Hunterdon County Partnership for Health (PFH) is a local health coalition supported by Hunterdon Health and our 70 plus organizations who make up this diverse group. They are dedicated to the health and wellness of our residents and we appreciate their shared interest in the wellbeing of our community. The support and participation from our community partners has been invaluable during this process and we appreciate the continued commitment to future Community Health Needs Assessments and this 2023-2025 Community Health Improvement Plan.

Review and analysis of all data helped the members of Partnership for Health to identify the following health priorities: mental health (stress and anxiety), substance misuse (drugs and alcohol), obesity and heart disease, elder care, and access to healthcare

(including cost, language barriers and transportation). These issues were no surprise to PFH members as they were also identified in the 2019 CHNA. COVID-19 had an enormous impact on our community and the initiatives and goals we set in our last Community Health Improvement Plan (CHIP). The group unanimously voted based on the data to continue our work in these key needs areas. The current action teams: Healthy Lifestyles, Mental Health, Senior Health Coalition, Drug-free Taskforce and Latino Coalition will remain. Equity and access to care will be overarching priorities in all of the teams. Action team members are tasked to reevaluate current team goals and objectives, make necessary changes, and develop clear strategies to address these health issues. In addition, Hunterdon Health has set metrics outlined in this Community Health Improvement Plan that will be tracked from 2023 through 2025. These metrics will be monitored monthly and reported yearly in the 990 IRS report. The complete 2022 Community Health Needs Assessment is located on our website: hunterdonhealth.org.

METRICS

FOCUS ON HEALTHY WEIGHT

Goal: Increase the number of residents in our service area within a healthy weight range as defined by the Center for Disease Control and Prevention.

1. Increase the percentage of patients in NextGen, ages 40-60 in our primary care practices, who move from no physical activity (“none”) to a higher level of activity and have it documented in their electronic record (NextGen) as low, medium or high by 3 percentage points from 2023 to 2025.

*Definitions for activity levels

None - You are not physically active and spend most of your time sitting or resting.
Low - You are physically active 1 to 2 days per week.
Medium - You are physically active 3 to 4 days per week.
High - You are physically active 5 or more days per week

2. Increase awareness and screening for “food insecurity” documented at least once in the past 12 months, in the electronic health record (NextGen), in the primary care setting, for patients 65 and above by 4 percentage points from 2023 to 2025.

3. Increase the percentage of hispanic adults in the electronic health record (NextGen), ages 35-50 in our primary care practices, with a BMI in the healthy weight range within the past 12 months by 2.25 percentage points from 2023 to

2025. Patients in the denominator will have ethnicity recorded as “hispanic” or “latino” or Spanish entered as their preferred language.

SUBSTANCE MISUSE

Goal: Reduce the prevalence and incidence of substance abuse in our service area.

1. Maintain or exceed the current percentage of patients age 13+ being screened for “vaping” in the past 24 months, in the primary care setting, documented in our electronic health record (NextGen) at 68% or higher from 2023 to 2025.

2. Increase the percentage of patients, age 18 and above in the primary care setting, with a prescription for stimulants with a signed Controlled Substance Agreement, in our electronic health record (NextGen) to 75% from 2023 to 2025.

3. Increase the percentage of patients age 21 and over with a prescription (3 or more prescriptions of at least 30 pills/prescription in the past 12 months) for a benzodiazepine screened for alcohol, in our primary care practices, in our electronic health record (NextGen), by 3 percentage points from 2023 to 2025.

MENTAL HEALTH

Goal: Increase the number of residents in our service area being assessed, and if necessary, treated for behavioral health treatment services.

1. Increase the percentage of patients, age 65 and above in the primary care setting, in our electronic health record (NextGen), who have been screened for depression and if positive have a plan to address depression within the last 12 months, by 3 percentage points from 2023 to 2025.

2. Increase the percentage of adolescent patients, in our electronic health record (NextGen), age 12-19 in the pediatric and primary care setting with depression screen and plan by 3 percentage points from 2023 to 2025.

3. Increase the percentage of pts 65+ on medicare, in our electronic health record (NextGen), in the primary care setting who answer “hardly ever” to the question on the AWV questionnaire, “How often do you feel isolated from others?” by 4 percentage points.

AGING-RELATED ISSUES

Goal: Reduce barriers and increase the number of Senior (age 65+) residents in our service area receiving preventive care.

1. Increase the percentage of patients, age 65 and above in the primary care setting, in our electronic health record (NextGen), with a Falls Risk Assessment by 2 percentage points from 2023 to 2025.

2. Increase the percentage of patients, age 65 and above in the primary care setting, in our electronic health record (NextGen), who seek preventive care within the last 12 months, by 3 percentage points from 2023 to 2025.

ACCESS TO CARE/SOCIAL DETERMINANTS (DRIVERS) OF HEALTH

Goal: Collect data to inform strategies to reduce barriers to care for residents in our service area.

1. Collect data on the number of people the bilingual Community Health Worker connects to community resources.

2. Collect data on the number of Spanish-speaking patients the bilingual Community Health Worker helps navigate the healthcare system.

3. Collect data on transportation reported as a barrier for those receiving assistance navigating the healthcare system by the bilingual Community Health Worker.