Atlantic
Health System

Community Health Needs Assessment 2013

Morristown Medical Center

Newton Medical Center

Overlook Medical Center

Full Report

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Executive Summary

Atlantic Health System is a multi-hospital, comprehensive health system serving approximately 1.7 million people in Northern New Jersey. In compliance with the requirements of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148, Stat. 199), Atlantic Health System completed a Community Health Needs Assessment (CHNA) for each of its three hospitals in 2013. This report summarizes the process by which data were collected, priorities assessed, and community representatives engaged to identify and address the health needs of the community.

The Process

Atlantic Health System's approach was based on the guidelines established by the IRS and builds on best practices in Community Health Needs Assessment (CHNA) (e.g. Barnett, 2012). CHNAs are important tools for assessing current needs of populations, with an eye to health disparities, and the goal of matching community benefit resources to addressing priorities for the health of the community.

To conduct the most comprehensive assessment possible, the Community Health Alliance of Northwestern Central New Jersey (CHANC-NJ) was formed. CHANC-NJ was comprised of ten total hospitals. These included Atlantic Health System (Morristown Medical Center, Overlook Medical Center, Newton Medical Center), Saint Clare's Health System (Denville, Dover, Boonton, & Sussex), Robert Wood Johnson Rahway, Chilton Hospital, & Trinitas Regional Medical Center. The hospitals agreed to share costs in conducting the assessment and to work together to identify Community Health Needs across the region. Holleran, a national research and consulting firm, was hired to collect the primary data and some secondary data for the project.

Data were collected in three phases. First, a phone survey of residents across the region was conducted. Built from questions included in the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance Survey, these primary data we designed to provide greater understanding into the health needs of the community from a representative sample of the population. These data were matched with secondary data from multiple sources including the New Jersey Hospital Association, New Jersey Department of Health Statistics, and the Centers for Disease Control and Prevention.

After collecting the primary and secondary quantitative data, a variety of methods were used to solicit feedback from community representatives. These methods included web-based surveys, interviews, and prioritization meetings in which leaders expressed their opinions about the most pressing needs of the community. Special attention was paid to minority voices and those suffering from chronic illness. Specific lists of participating

organizations and a detailed synopsis of the process are listed in the individual reports for each hospital.

The Results

While the community health needs were identified, prioritized and will be implemented at the local hospital level, three common system-wide priorities emerged:

Behavioral Health: Approximately one in ten people reported a diagnosed mental illness, and many battled substance use behaviors that put them at risk.

Healthy Behaviors: Despite lower rates than some places, many people are at risk of developing diabetes and an unhealthy weight status due to physical inactivity and poor nutrition habits resulting in obesity, diabetes and other chronic illnesses.

Access to Care and Preventive Services: While many across the region have great medical care, disparities are prevalent between lower income individuals and Hispanic/Latinos on many indicators of access to care and utilization of preventive services. Incidentally, these groups report fewer healthy behaviors and poorer mental health status than their comparison populations.

Implementation Planning

After completing the Community Health Needs Assessment in early 2013, Atlantic Health System continued to meet with diverse workgroups of community representatives at each site to develop detailed implementation plans for each site. This process and the resulting plans are outlined in the chapter for each hospital site.

IRS Requirements

On March 23, 2010, the U.S. Congress approved the Patient Protection and Affordable Care Act. Included in section 9007(a) of this act (Pub. L. No. 111-148, 124 Stat. 119), are requirements for all tax-exempt U.S. hospitals to complete a Community Health Needs Assessment (CHNA) every three years. The requirements of this mandate state that hospitals must 1) define the community served by the facility, 2) consider input of a diverse array of persons served by the facility, 3) prioritize those needs, and 4) identify existing community resources that are available to meet the prioritized needs. An implementation strategy must be developed within the same fiscal year as the CHNA is completed and must be approved by the Board of the organization. The report herein for each AHS hospital satisfies these requirements for the fiscal year beginning January 1, 2013.

Process & Methodology

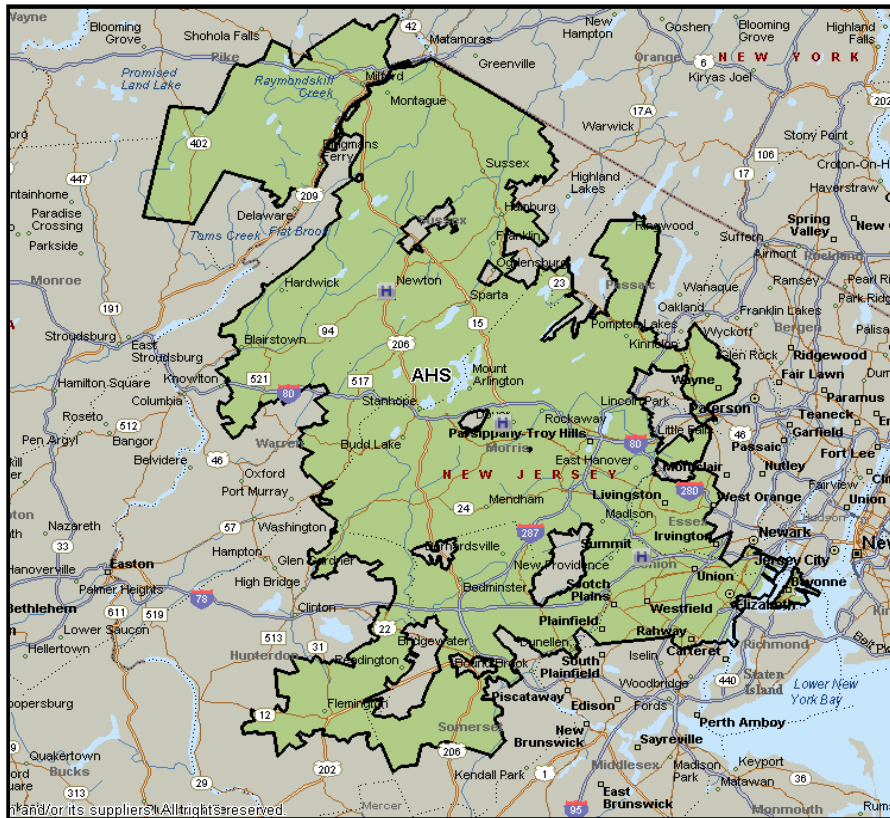
Atlantic Health System (AHS) is a comprehensive health care system serving a population of approximately 1.7 million residents. As shown in Map 1, the area served by the three AHS hospitals (Morristown Medical Center, Overlook Medical Center, Newton Medical Center) spans from urban centers near New York City to the rural counties in Northwestern New Jersey and eastern Pennsylvania. For the CHNA, the primary and secondary service areas of each hospitals were included (i.e. zip codes from which 75% of inpatient market share is drawn). While the service areas extend to parts of many counties, the three AHS hospitals chose to more narrowly define their Community Benefit Service Areas (CBSAs) as follows:

Morristown Medical Center: Morris County, NJ

Newton Medical Center: Sussex County, NJ

Overlook Medical Center: Western Union County, NJ (including the municipalities of Summit, Westfield, and Union)

Details on the communities served for each site are described in the section for each individual hospital.



Map 1. The Combined Service Areas of the Three AHS Hospitals

The AHS Community Health Needs Assessment (CHNA) was a team effort. Many individuals across the organization were involved in the development and initiation of the CHNA. The roles are responsibilities for each are outlined in Table 1.

Table 1

Roles and Responsibilities of Key AHS Personnel for CHNA

Department/Group	Role/Responsibility
AHS Corporate Department of Mission Development	• Process framework • Data Analysis • Technical assistance
Community Health Management (each site)	• Project oversight • Community Representative Engagement
AHS Staff and Physicians	• Data review and Implementation strategy • Expertise in medical care, public relations, and community engagement
Community Health Committees (each site)	• Endorsement of process and prioritized goals
Hospital Advisory Boards (each site)	• Endorsement of implementation strategy
AHS Board of Trustees	• Approval of implementation strategy

The Community Health Needs Assessment was conducted in three phases. This process was iterative with each conversation and meeting raising additional questions, leading to deeper data inquiries. The three phases were:

1. Primary Data Collection and Analysis (CHNA Phone Survey)
2. Secondary Data Analysis
3. Community Representative Engagement (meetings, interviews, and focus groups)

1. Primary Data (CHNA Phone Survey)

Primary data were collected by Holleran, a national research and consulting firm headquartered in Lancaster, Pennsylvania. Founded in 1992, Holleran is a recognized leader in health and human services and senior living, serving clients in 43 states and Canada. Working with the Alliance, Holleran provided a customized Community Health Needs Assessment based upon the service areas of the participating hospitals.

Interviews were conducted by Holleran's teleresearch center between the dates of April 18, 2012 and August 3, 2012. Interviewers contacted respondents via land-line telephone numbers generated from a random call list. Each interview lasted approximately 12 - 15 minutes depending on the criteria met and was completely

confidential. Only respondents who were at least 18 years of age and lived in a private residence were included.

The survey tool was adapted from the Center for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is the largest telephone health survey in the world. It is used nationally to identify new health problems, monitor current problems and goals, and establish and evaluate health programs and policies.

The survey tool used for this need assessment consisted of approximately 100 factors selected from the 2006, 2009, 2010 and 2011 BRFSS tools. The factors were chosen by the CHANC-NJ, a collaboration of ten hospitals in Central and Northwest New Jersey. Questions addressed 31 health-related topics ranging from general health status to childhood immunization.

All data sets utilized in the report are statistically weighted to counter for demographic imbalances (e.g. over-representation of females compared to males). All presented statistics are weighted with the exception of the demographic information.

2. Secondary Data Analysis

Secondary data were collected by Holleran and hospital staff. Several sources were identified including the New Jersey Hospital Association Countywide Profiles, existing County Health Improvement Plans, vital statistics data from the New Jersey Department of Health Statistics, County Health Rankings, the United State Census Bureau, and the Behavioral Risk Factor Surveillance Survey from the Center for Disease Control and Prevention. Secondary data were used to fill gaps not covered by the primary data and confirm or clarify data from the primary data set.

3. Community Representative Engagement

Multiple opportunities were provided for local community representatives to collaborate with the Alliance. Community members from a diverse array of organizations were invited to participate. As shown in Figure 1, the Community Wheel was used as a tool to identify partners across the spectrum including health care, government, business, education, social services, public health, law enforcement, and grassroots organizations. Invitations were made via personal conversation, email, and written letters.

On September 13, 2012, the data from the CHNA were unveiled in a meeting at Atlantic Health System Corporate in Morristown, New Jersey. This meeting was comprised of hospital representatives and community leaders including public health officers, elected officials, and non-profit organizations (i.e. the United Way). Following these meetings, a

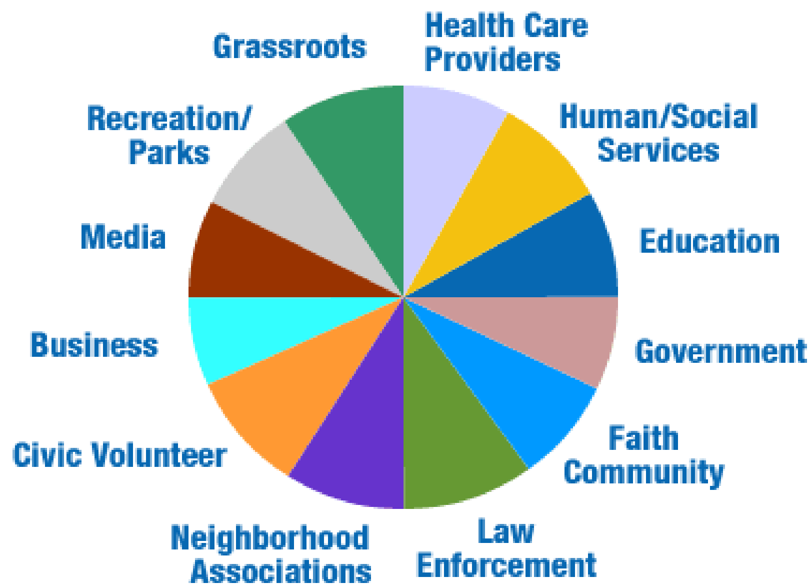


Figure 1. **The Community Wheel**

broader list of community representatives was generated by these partners and hospital staff. This extensive list of community representatives within each area (Morris County, Sussex County, Union County[1]) was invited to participate in the prioritization process. Representatives from organizations serving low-income, medically underserved, and minority populations were explicitly selected for participation. This included senior care organizations, Hispanic/Latino groups, African American faith communities, Federally-Qualified health centers, and local school districts. In addition, in-depth key informant interviews were conducted with key populations representing racial/ethnic minorities and populations with higher rates of chronic illness (e.g. Black and Hispanic/Latino leaders to further understand issues facing the minority populations in the area). In depth descriptions of the community representatives for each site are located within the individual site reports.

As described, a diverse collection of community representatives were invited to participate in the CHNA prioritization process at each site. First, they were asked to complete a brief online survey reflecting their perception of the most pressing needs of

[1] Two prioritization meetings were held in Union County. Please see additional details in Overlook's full report.

the community. Then, they were invited to Community Health Needs Prioritization Meetings at each site. Each CHNA prioritization meeting was held in October and November, 2012.

Prioritization was conducted in line with the health priorities and strategic directions outlined in the National Prevention Strategy (National Prevention Council, 2011). During this session, the primary and secondary data were presented, existing community resources were discussed, and votes were made to identify priorities. Participants voted on three criteria:

1) the prevalence of the issue and disparities between groups
2) the health and economic consequences of doing nothing
3) the ability to impact the problem given existing community resources and interest

After the initial prioritization meeting, workgroups were formed at each site to further define the needs and identify existing community resources available to address these needs. These groups met from November 2012 through the first quarter of 2013.

As data were presented and discussed with external community leaders, internal groups were consulted as well. Each AHS hospital has a Community Health Committee which serves under the local advisory board. Comprised of individuals representing local non-profit and civic organizations, these Committees were responsible for reviewing the data and providing suggestions. Additional presentations were made to groups of AHS staff, physicians, foundation boards, and other internal committees.

Summary of System-Wide Findings

Although the CHNAs were specific to each hospital, common themes were found across the sites. As shown in Figure 2, these system-wide priorities included 1) behavioral health (i.e. mental health and substance use/abuse), 2) healthy behaviors (i.e. physical activity and nutrition), and 3) disparities in access to care and preventive services. These similarities are important to acknowledge as they present opportunities to share resources and create greater impact in address these needs.

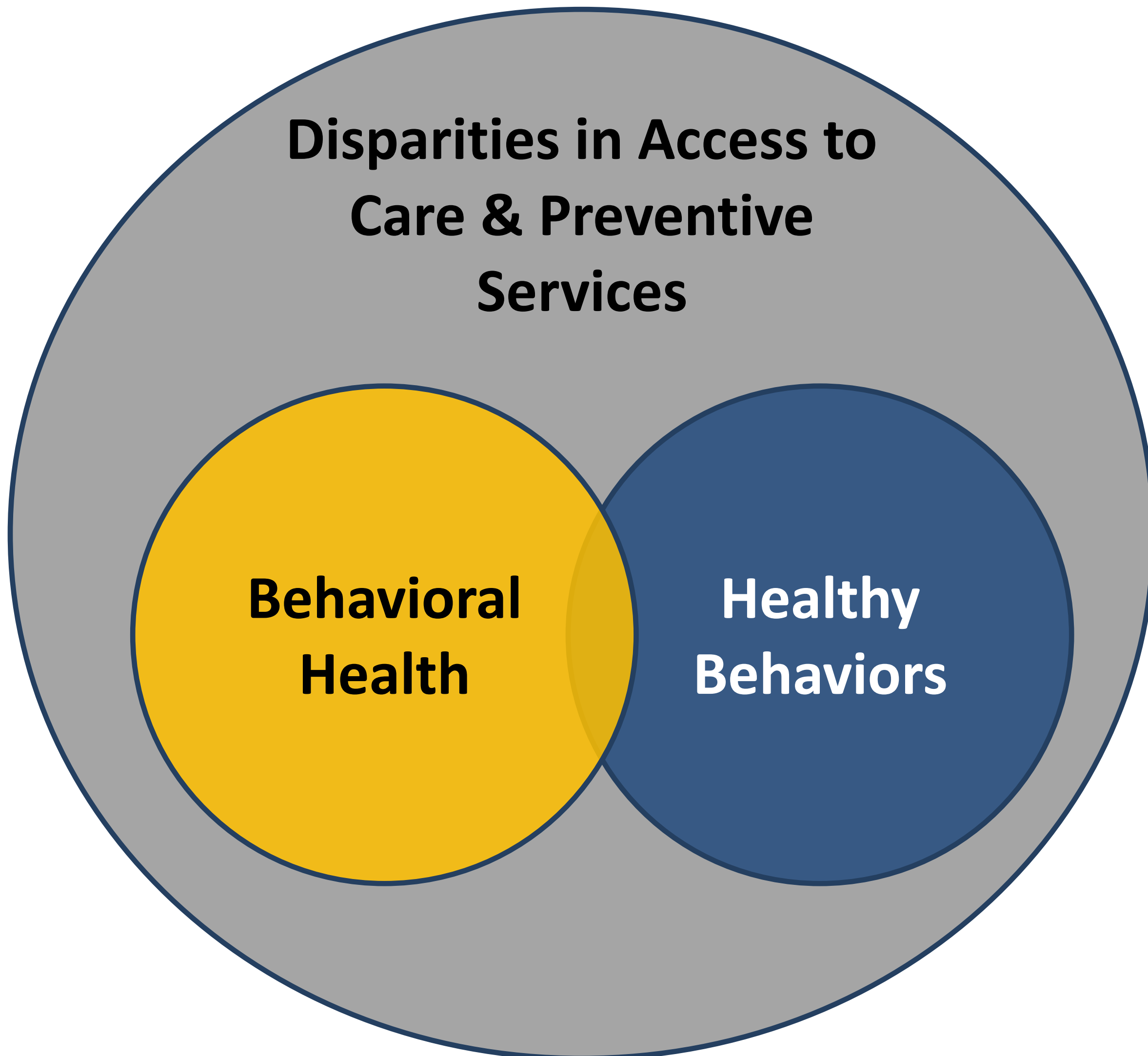


Figure 2. **System-wide Priority Health Needs**

Behavioral Health

Mental Health. While many in the area reported above average mental health status, one in ten reported poor mental health status (i.e. self-rating of poor mental health for 15 or more days in the past month). More than one in ten (10.8%) reported being diagnosed with an anxiety disorder and 11.5% with a depressive disorder. Seven percent of the population reported both illnesses. Many concerns arose around aging seniors and their caregivers. Adults between ages 45 and 64 and those who were unpaid caregivers reported higher rates of mental illness and poorer mental health status than other groups.

Substance Use/Abuse. The majority of respondents reported consuming alcohol in the past month (56.2%). This was higher than New Jersey and U.S. averages. However, rates of binge drinking[1] (15.4%) and heavy drinking[2] (1.3%) were comparable or lower than State and National norms. Similarly, while current smoking rates were lower than other places (11.3%), a large number of people in AHS' region continue to use tobacco on a regular basis. Secondary data identified a growing concern for heroin and prescription drug use across the region with particular focus on Sussex and Pike Counties (New Jersey Substance Abuse Monitoring System, 2011).

Healthy Behaviors

Despite having rates that are better than U.S. averages, the CHNA revealed that 22.7% of the population was obese, another 37.8% were overweight, and many had been diagnosed with diabetes (9.1%) or pre-diabetes (10.5%). In line with the National Prevention Strategy (National Prevention Council, 2011), the AHS hospitals chose to focus on the modifiable risk factors of physical activity and nutrition to address these trends before they lead to greater rates of chronic illness.

Primary data revealed that, while many people reported some physical activity, 16.7% were completely sedentary (i.e. no physical activity of any kind in the previous month). Further, many reported average daily consumption of less than one serving of fruits (28.1%) and vegetables (20.9%).

Interaction Between Priorities

As shown in Figure 1, behavioral health and healthy behaviors are separate, but inter-related issues. Data revealed that individuals with poor mental health status were much more likely to be physically inactive (32.4%), be obese (31.8%), and lack daily intake of

[1] Binge drinking = 5 or more drinks in a row for men/ 4 or more drinks in a row for women within the past month
[2] Heavy drinking = Average past month drinking of more than 2 daily drinks for mail or More than 1 daily drink for females

fruits (34.6%) and vegetables (27.8%). These numbers suggest the need for multi-faceted, integrated implementation strategies that affect the whole person.

Disparities in Access to Care and Preventive Services

Access to care was the third issue that emerged. While Northern New Jersey is home to some of the best healthcare in the nation and the number of insured individuals who had doctors was high, disparities were prevalent in Hispanic/Latinos and lower income populations. As shown in Figure 2, the larger context of access to care and preventive services affects both the behavioral health and healthy behaviors of individuals. Hispanics and lower income individuals (i.e. less than $75,000 in annual household income) in this sample were more likely to be uninsured, less likely to report having a doctor, and much more likely to report that they had been prohibited from visiting a doctor in the past year due to cost. This extended to preventive services with lower income individuals less likely to receive a flu shot and keep up to data with recommended mammograms, pap tests, colonoscopies/sigmoidoscopies, and other services. A sampling of the disparities between racial/ethnic and income level groups are displayed in Table 2.

Table 2

Disparities in Access to Care, Behavioral Health and Healthy Behaviors

	Hispanic	NH Black	NH White	Lower Income	Higher Income
Poor Mental Health Status	17.3%	10.5%	8.8%	12.3%	5.4%
Anxiety	14.1%	4.7%	11.8%	13.0%	9.0%
Depression	12.8%	9.5%	12.3%	15.0%	9.6%
Binge Drinking	17.7%	10.2%	10.0%	11.4%	20.5%
Cigarette Smoking	7.2%	11.1%	11.8%	14.2%	9.2%
Physical Inactivity	31.1%	20.4%	14.0%	23.6%	9.6%
No Daily Fruit	34.1%	36.5%	25.6%	29.6%	28.2%
No Daily Veggie	32.9%	30.6%	18.1%	22.6%	20.2%
Uninsured	27.4%	18.4%	6.1%	17.9%	2.0%
No Doctor	17.1%	18.5%	9.3%	7.1%	13.9%
Cost Prohibited Care	32.0%	19.3%	6.9%	19.0%	3.0%

Note: NH = Non-Hispanic; Lower income = < $75,000 annual household income; Higher income = $75,000 or more in annual household income.

Implementation Strategy

AHS is committed to "empowering our communities to be the healthiest in the nation". Following best practices, AHS developed a community-based process in which the hospitals serve as a catalyst for mobilizing change alongside a diverse array of partners and other healthcare systems. As shown in Figure 3, after completion of the data collection and prioritization process (March 2013), these community workgroups (with leadership support from AHS), developed implementation plans for each community health goal. These plans are highlighted in the reports for each site.

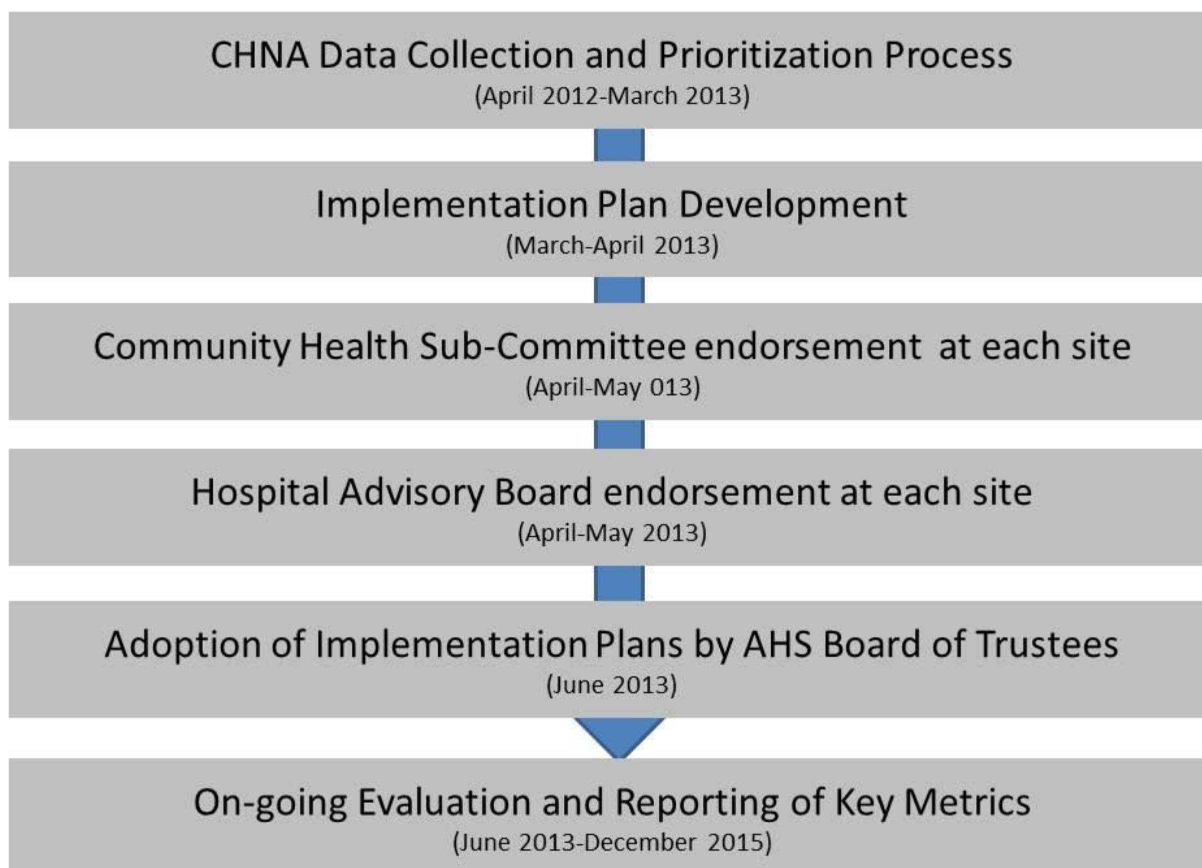


Figure 3. Implementation Plan Process

Morristown Medical Center

ATLANTIC HEALTH SYSTEM

2013 Community Health Needs Assessment

Community Served by Morristown Medical Center

Morristown Medical Center (MMC) serves a population of 1.2 million people across North-Central New Jersey. As shown in Map 2, the primary and secondary service areas of MMC (zip codes from which 75% of inpatients come) stretch across northwestern New Jersey. Due to geographical considerations, Morris County was chosen as the Community Benefit Service Area (CBSA) for MMC.

Across the service areas of MMC, the population is 49.1% male and 50.9% female. One in four residents is under age 18, and 13.2% are age 65 and older. More than seven out of 10 (71.7%) residents are White or Caucasian with 11.6% Hispanic/Latino, 8.5% Asian or Pacific Islander, and 6.4% Black or African American.

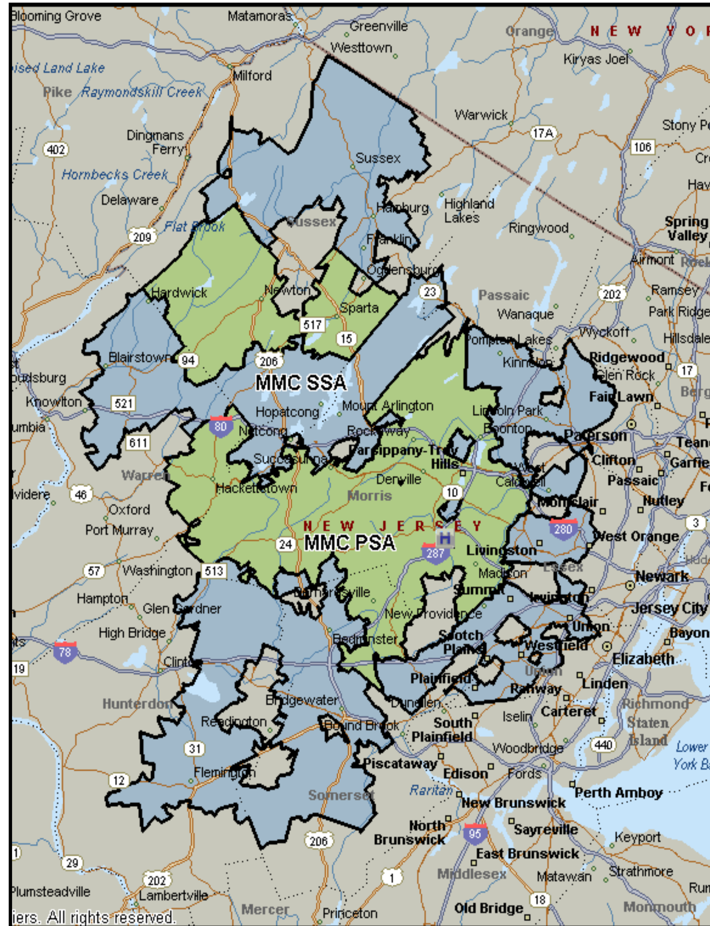
The population served by MMC is fairly affluent. Almost one in four (23.3%) households earns $150,000 per year or more, with 13.7% earning $250,000 or more each year. However, one in ten households (9.7%) subsists on less than $25,000 each year and 40.2% earned less than $75,000.

Procedure & Methodology

MMC conducted the CHNA in collaboration with nine other hospitals from the Community Health Alliance of Northern and Central New Jersey (CHANC-NJ). CHANC-NJ hired Holleran, a national research and consulting firm, to conduct a phone survey (primary data) and gather secondary data.

A sample of 1,716 individuals residing within Morristown Medical Center's service area[1] was interviewed by telephone to assess health behaviors, preventive practices, and access to health care. Individuals were randomly selected for participation based on a statistically valid sampling frame developed by Holleran. As shown in Map 2, the

[1] Defined as zip code of residence for 75% of inpatients



Map 2. **Service Area of Morristown Medical Center**[1]

sampling frame represented 71 zip codes within the New Jersey counties of Morris, Warren, Sussex, Somerset, Essex, Union, Passaic, and Hunterdon.

Secondary data were collected by Holleran and hospital staff from several sources including: the New Jersey Hospital Association Countywide Profiles, existing County Health Improvement Plans, vital statistics data from the New Jersey Department of Health Statistics, County Health Rankings, the United States Census Bureau, and the Behavioral Risk Factor Surveillance Survey from the Centers for Disease Control and Prevention.

Community Representative Engagement

MMC engaged a variety of community representatives to share the data from the CHNA, to prioritize community health needs, and to identify collaborative approaches to

[1] PSA = zip code of residence for 50% of inpatients, SSA = zip code of residents for 75% of inpatients.

improving community health. These representatives were explicitly selected to include those representing low-income, racial/ethnic minority and chronically ill populations. Representatives were engaged in an on-going process in a variety of settings as described below.

Community Health Committee. MMC's Community Health Committee serves as a sub-committee of the hospital Advisory Board. This group was instrumental throughout the process, informing the data collection process, learning from the data, and setting goals for addressing health needs. The Community Health Committee was comprised of various leaders from within MMC and a diverse array of community partners, including those representing lower-income, racial/ethnic minority, and chronic disease populations. A complete roster of members and their sponsoring organizations is listed in Table 3. In addition to monthly meetings throughout the process, the Community Health Committee completed web-based surveys on community needs and existing community resources.

Convocation. On September 13, 2012, the data from the CHNA were unveiled in a meeting at Atlantic Health System Corporate in Morristown, New Jersey. This meeting contained hospital representatives and community leaders including public health officers, elected officials, and non-profit organizations (e.g. the United Way). Representatives from Morris County included:

- Vicki Hughes: Manager, Community Health at MMC
- John Franklin, President, United Way of Northern New Jersey
- Carlos Perez, Public Health Officer, Morris County
- Mark Caputo, President, Morris Regional Public Health Partnership
- Arlene Stoller, Health Educator, Morris County Office of Health Management
- Carol DeGraw, Caregiver's Coalition, United Way of Northern NJ
- Trish O'Keefe, Chief Nursing Officer, Morristown Medical Center

Community Prioritization Meetings. A gathering of community representatives from across Morris County was convened on October 22nd to analyze data from the CHNA and prioritize community health needs. This meeting was co-sponsored by MMC, Chilton Hospital, and Saint Clare's Health System. The gathering was held at the Atlantic Health System Corporate Offices in Morristown. Forty-six community partners were present representing a broad cross-section of community organizations including:

- Caregivers Coalition
- Family Service of Morris County
- Zufall Health Center (local federally-qualified health center)
- Goryeb Children's Hospital Kid-Fit Program
- Lakeland Hills Family YMCA

- Morris County "Prevention is Key"
- Morris County Human Services
- Morris Park Commission
- Morris Regional Public Health Partnership
- Local municipal Health Officers
- Morris School District
- Morris/Somerset Regional Cancer Coalition
- Neighborhood House
- New Jersey Battered Women's Services
- United Way of Northern New Jersey

Table 3

MMC Community Health Committee Members

Name	Organization
Susan Alai	Freelance Writer/Editor/Communications Specialist
Steve Alderson, MBA, FACMPE	MMC, Business Development and Physicians Relations
Mary Buckley-O'Dell, RN, MBA, CNN	MMC, Nurse Manager, FHC and Specialty Clinics
Karen D. Carbonello	Creative Heart Work
George Foulke	Met Life Executive
John Franklin, CEO	United Way of Northern New Jersey
Michael Gerardi, MD, FAAP, FACEP	Chairman, MMC CHC
Nancy Helterman	Morris School District
Victoria Hughes, RN, MA	Manager, Community Health - MMC
Marge W. Kelly	Retired Met Life Executive
Jesse Linder	Director, Community Relations, New York Jets
Mary Lou Mauro	Community member
Joseph P. Nazzaro	Director of Leadership Morris
Valerie Olpp	Peapack Gladstone Bank
Alan S. Painter	Retired Honeywell Executive
David G. Powell	Retired Community Member
James F. Quinn	MMC Foundation
Ana Maria Riewerts	Morris County Organization for Hispanic Affairs
Reverend Robert Rogers	Church of God in Christ
Anne Rooke, RN, MSN	Chair, MMC Advisory Board
Walter D. Rosenfeld, MD	MMC, Chairman of Pediatrics
Robert Seman	AHS, Public Relations Coordinator
Rebecca Shippey, MA	MMC, Healthy Aging Coordinator
Arlene Stoller, MPH, CHES	County of Morris, Public Health Educator
Deborah D. Visconi	MMC, Director, Operations
David Walker, Esq., M.S.W	Morristown Neighborhood House, Executive Director

At this meeting, data from the CHNA were presented, participants discussed needs and resources, and voting was conducted to determine top priorities. Data were presented in accordance with the priorities and strategic directions identified in the National Prevention Strategy (National Prevention Council, 2011). As shown in Table 4, the voting process resulted in the identification of four top priorities: 1) access to care and preventive services, 2) mental health & well-being, 3) healthy behaviors (active living and healthy eating), and 4) substance use and abuse (drugs, alcohol, & tobacco). Workgroups were formed for each priority area and began meeting in January 2013 to further define the needs and identify existing community resources to meet the needs.

Table 4

Prioritized Needs List (Morris County Meeting)

Need	Scope	Severity	Ability to Impact	Overall Average
Access to Care	6.48	6.41	5.50	6.13
Mental Health & Well-Being	5.92	6.36	5.36	5.88
Active Living	5.51	5.97	5.75	5.74
Healthy Eating	5.55	5.51	5.46	5.51
Drugs & Alcohol	5.15	4.95	4.56	4.89
Reproductive & Sexual Health	3.18	3.13	4.41	3.57
Tobacco Use	3.35	3.45	3.76	3.52
Injury & Violence	3.05	3.34	3.29	3.23

* All needs rates on a 1 to 8 scale

Prioritized Health Needs

Access to Care and Preventive Services

Data. The highest priority area that was identified by the community representatives was access to care. While the Morris County area has some of the best healthcare and highest rates of insured population in the Nation, the CHNA shows that many people lack access to the basic health and preventive services they need. For example, almost one in ten residents reported that they were uninsured (9.2%), did not have a doctor (9.4%) or were prohibited from visiting a physician due to cost (9.3%). While these numbers were small compared to many places in New Jersey and the U.S., they still represent a significant number of individuals in MMC's service area.

The CHNA data revealed that the burden of limited access to care fell disproportionally on Hispanic/Latino and lower income residents (<$75 K). Almost one in three Hispanic/Latinos were unable to visit a physician in the past year due to cost concerns, and one in five reported being uninsured. Lower income individuals and those with less education were also more likely to have limited access to affordable healthcare. While access measures in the CHNA focused on cost alone, many individuals may lack

access due to transportation concerns or have difficulty accessing usable health information due to limited English ability and low health literacy.

Limited access also means that people may be unable to access preventive services, immunizations, and screenings as recommended by the U.S. Preventive Services Task Force (U.S. Preventive Services Task Force, 2013). The CHNA revealed that lower-income, Hispanic/Latino, and Black residents were less likely to complete recommended preventive screenings and immunizations including mammograms, influenza immunization, and colorectal cancer screenings.

Community Representative Engagement. To further explore these issues, MMC convened a team of local experts representing diverse social service organizations, public health, and healthcare facilities. In December 2012 and January 2013, this group of 10 community representatives met to discuss access to care issues. The group further identified lack of specialty physician services, difficulty obtaining clinic appointments, and limited health literacy as a barrier to system navigation (e.g. appointments, charity care, Medicaid applications). The team identified a comprehensive list of existing community resources to address access to care concerns as shown in Table 5.

Mental Health

Data. A second priority area was the **mental health and emotional well-being** of the population. While many in the area reported excellent mental health overall, approximately one in ten reported poor mental health status (15+ days of poor mental health per month), 10.2% reported being diagnosed with an anxiety disorder and 11.4% reported being diagnosed with depression. 6.3% reported diagnoses of both depressive and anxiety disorders.

The CHNA data also revealed disparities in mental health. Females and individuals with lower income and less education were more likely to report poor mental health status and a diagnosis of mental illness. While significant differences were not found by age group, the growing number of individuals between 45 and 64 with mental health challenges may warrant further exploration. Lower income seniors (<$75 K in annual household income) had almost twice the rate of anxiety disorders (9.7% to 5.8%) and five times the rate of depressive disorder (10.9% to 1.5%) compared to higher income seniors.

The aging of MMC's population also translates into more adults serving the role of unpaid caregiver in the life of an aging parent or family member. In the CHNA, 21.1% of participants reported they were currently a caregiver, a number that was higher than the U.S. average. These individuals cited stress and costs as key challenges. Caregivers were more likely to report poor mental health status and a diagnosis of an anxiety

disorder. This corresponds with the higher reported rates of depression (13.8%) and anxiety disorder (12.5%) among those aged 45 to 64.

Community Representative Engagement. From December 2012 to May 2013, a group of 14 community representatives (from behavioral health providers, healthcare systems-including MMC, and social service organizations) met frequently at Saint Clare's Health System in Dover to discuss priorities. The group identified a lack of funding, availability of psychiatric and residential services for lower-income, uninsured and Hispanic/Latino individuals, and mental health stigma as opportunities for improvement. A list of existing community resources was identified as shown in Table 5.

Substance Use/Abuse

The third area of community needs was **substance use and abuse**. This encompassed alcohol, tobacco, and other drugs. The CHNA revealed that people in the area were more likely to consume alcohol (59.8%), but less likely to binge drink (15.6%) or engage in heavy drinking (i.e. more than 2 daily drinks for men or more than one daily drinks for women; 1.2%) than national and New Jersey norms. At the same time, residents were less likely to have smoked across their lifetime (40.4%) and only 11.4% were current smokers. No specific questions were included in the primary data for illicit drug use, but secondary data suggest that prescription drug and heroin use may be emerging areas of concern (New Jersey Substance Abuse Monitoring System, 2011).

While White (63.5%) and higher income residents were more likely to consume alcohol in general, males of all races (18.7%) and Hispanic/Latinos (23.9%) were more likely to engage in binge drinking. While the primary data did not include information on adolescents, much of the research and funding in substance use/abuse has focused on preventing or delaying the onset of substance use behaviors. Secondary data from the most recent Youth Risk Behavior Survey (Centers for Disease Control and Prevention, 2012) showed that 69.1% of New Jersey high school students had consumed alcohol in their lifetime (14.4% of which had initiated alcohol use before age 13) and 23.7% had engaged in binge drinking within the past month. High numbers of New Jersey youth also reported lifetime usage of marijuana (21.1%), heroin (1.6%), un-prescribed prescription drugs (15.1%) and ecstasy (7.1%).

Community Representative Engagement. From December 2012 to May 2013, a group of 6 community representatives from non-profit providers, schools, and healthcare systems met regularly at Atlantic Health System to discuss priorities. The group identified significant community problems including substance use among adolescents and adults and prescription drugs across the lifespan. Challenges included:

- Lack of substance use data for youth
- Lack of resources for prevention, early intervention and treatment

- Access to care
- Insufficient treatment providers
- Needs for culturally-specific services
- Need to increase awareness of alcohol consequences among adults

A list of existing community resources was developed as shown in Table 5.

Healthy Behaviors

Data. The final priority area encompassed the mutual goals of increasing **healthy eating and active living**. Primary data revealed that while many people reported exercising regularly, 14.5% of the population was physically inactive (i.e. no exercise of any kind within the past month). One in five residents reported not eating vegetables on a daily basis, and 27.9% reported the same for fruits. Research has shown that sedentary behaviors and poor nutrition contribute to a variety of adverse health including obesity and diabetes. In the CHNA, more than one in five participants had body-mass indices (BMIs) indicating that they were obese (21.5%), and 7.7% reported been diagnosed with diabetes.

Some groups were at greater risk for unhealthy behaviors. While females (17.4%) were more likely than males (12.1%) to report being physically inactive, males reported worse nutrition (36.5% with no daily vegetables). Asian participants reported the best health behaviors overall (only 8.3% physically inactive and 21.6% without daily vegetables), with higher rates of physical inactivity among Hispanics (25.7%). Socioeconomic indicators showed that lower income (< $75 K in annual household income) and lower education (less than a 4-year college degree) participants were more likely to be physically inactive, diabetic, and obese.

At the October Community Needs Prioritization meeting, much of the discussion around physical activity and nutrition focused on helping children get a strong start in life by addressing programs and policies at young families. Secondary state-level data show that New Jersey has one of the highest rates of pre-school child obesity among low-income children (National Center for Chronic Disease Prevention and Health Promotion, 2009). While the primary data did not directly survey children on their health behaviors, we can derive a great deal of information by looking at the behaviors of parents. Parents of children 18 and under in the sample had behaviors that were similar to the overall population: 11.6% were physically inactive, 28.4% did not eat fruit on a daily basis, and 19.0% did not eat vegetables on a daily basis.

Community Representative Engagement. From December 2012 to May 2013, a group of 12 community representatives from public health, parks and recreation, healthcare –including representation from MMC-- met regularly to discuss priorities

related to healthy eating/active living. The group identified a target population of working with low-income, predominantly Spanish-speaking families with children in child care/preschool. Community resources were identified as shown in Table 5.

Existing Community Resources

As shown in Table 5, the community representatives at the multiple gatherings held between October 2012 and May 2013 helped to identify key resources within the community that could address the priority needs within the priority populations. The broad coalition of community partners identified the possibility of collaboration within the local community as a key asset.

Table 5

List of Existing Resource by Need Area

Access to Care	MMC Family Health Center, MMC Financial Counseling Services, Zufall Health, Morris County Office of Hispanic Affairs (MCOHA), United Way of Northern NJ, Local Health Departments, Morris Area Transportation Services, Partnership for Healthy Families
Mental Health & Well-Being	MMC Behavioral Health, Saint Clare's Outpatient Behavioral Health Services, Zufall Health, New Bridge Services, Family Service of Morris County, Hope House, MCOHA, Mental Health Association, Housing Alliance, Morris County Department of Human Services, Morris County Prevention is Key, Morris View Nursing Home, Community Hope, Inc., Family Intervention Services
Substance Use/Abuse	MMC Crisis Intervention Program, Morris County Prevention is Key, Municipal Alliances, Morristown High School, Carrier Clinic, Day Top, High Focus, Hope House, Treatment Dynamics, St. Clare's Adolescent Psych Unit, Summit Oaks, Hope House (Dover), Cura (Newark)
Healthy Eating/Active Living	Goryeb Children's Hospital kidFIT program, Child and Family Resources, Zufall Health Center's Healthy Weight Collaborative, Neighborhood House, PreSchool Advantage, YMCA's CATCH, United Way of Northern New Jersey, Municipal Recreation Departments, Grow it Green Morristown, Headstart, NJ Family Care, WIC, Interfaith Food Pantry.

Implementation Plan

In partnership with the community representatives described previously, MMC developed an implementation plan to respond to each community need: Access to Care and Preventive Services, Behavioral Health (combing the needs of mental health and substance use/abuse), and Healthy Eating/Active Living. The plan was created between April and June 2013. The complete logic model for each plan is displayed in Tables 6 through 8.

Access to Care & Preventive Services

As shown in Table 6, MMC and our partners identified three strategies for improving access to care.

1. **Increase access to specialists for lower-income residents**

   Many clinic patients find it difficult to access specialists for health care. To increase this, ***MMC will work with MMC sites to increase visits by Zufall Health Center patients by 20%***

2. **Establish a comprehensive list of available resources to secure and fund healthcare**

   For uninsured (or underinsured) patients, navigating the healthcare system can be challenging. ***MMC and our partners will create and distribute 5,000 resource wallet cards with information on area health clinics, transportation, and payment options.***

3. **Build awareness of health literacy among health professionals**

   Thousands of studies have shown that healthcare communication is too complex for the average person and that many aversive health outcomes a related to limited health literacy. To build awareness among providers, ***MMC, in partnership with Zufall Health, will 1) provide health literacy training to 100 health professionals and 2) run a health literacy photovoice project that will build awareness of the importance of clear communication among healthcare providers across the County.***

Behavioral Health

In response to the mental health and substance abuse needs of the community, MMC identified four strategies for implementation as outlined in Table 7.

1. **Decrease the number of narcotics being prescribed**

   Secondary needs assessment data revealed that treatment admissions for heroin use have risen in Morris County. This has been attributed, in part, to an increase in the number of class 2 narcotics being prescribed. To address this issue, ***MMC and our partners will provide educational programs about the dangers of over-prescribing and best practices in narcotic management to 300 pharmacists and prescribers (doctors, nurses, etc.).***

2. **Increase usage of Prescription Monitoring Program.**

   The New Jersey Prescription Monitoring Program is a statewide database that was created to "halt the abuse and diversion of prescription drugs." Unfortunately, many practitioners are not fully utilizing the program. To address this issue, ***MMC and our partners will provide education and training on the program to 300 pharmacists and prescribers in MMC's service area.***

3. **Increase awareness of underage drinking among health care providers, parents, and community members.**

   Underage drinking has been shown to be a serious problem in MMC's service area. To address this issue, we will work to educate providers, parents, and community members on the process. ***MMC and our partners will train 150 healthcare providers and reach an additional 200 with information. For parents and the general public, we will provide five educational programs with 250 attendees and reach 1,000 adults with information on the topic.***

4. **Decrease mental health stigma**

   The CHNA revealed that mental illness is widespread in our communities. Much of this illness goes untreated due to many factors including mental health stigma. ***MMC and our partners will work to decrease stigma in our community by training professionals and increasing public awareness. We will train 6 people in Mental Health First Aid, an evidence-based program designed to equip people with knowledge about mental illness. These 6 individuals will provide the Mental Health First Aid program to at least 300 participants over three years***. In conjunction, ***MMC and our partners will reach at least 50,000 people with a public awareness campaign designed to promote anti-stigma messages.***

Healthy Eating/Active Living

As shown in Table 8, MMC and our partners identified four strategies for improving the healthy behaviors in our communities.

1. **Promote healthy eating and active living in schools.**

   Schools are an important location for affecting student health. In partnership with area school districts, ***MMC's Goryeb Children's Hospital will launch a kid-FIT Cup program designed to promote healthy eating and active living in area schools with a target of 50 schools participating over three years.***

2. **Increase availability of affordable fruits and vegetables in lower-income areas in Morris County.**

   Many lower-income and Hispanic/Latino residents reported in the CHNA that they were not consuming fruits and vegetables on a daily basis. ***MMC will work with community partners to support three community gardens and one farmer's market to lower-income areas of Morris County.***

3. **Work with childcare providers to increase healthy eating and active living in centers.**

   Childcare centers are important settings for affecting child health. ***Working with Child & Family Resources, we will increase by 10% the number of area child care providers completing Nutritional and Physical Activity Self-Assessments for Child Care (NAP-SACC) assessments*****.**

4. **Support environmental change initiatives**

   The environment in which we live has a tremendous effect on our health. ***MMC and our partners will support two projects that increase access to parks and "Complete Streets" in lower-income areas around the county.***

Identified Community Needs that are not addressed

As shown previously, almost all of the health needs identified by the data and prioritized by the diverse array of community representatives are addressed by the preceding implementation plan. In MMC's service area, data did not reveal many significant areas in which the community was worse than other areas. However, by choosing to priorities related to prevention (and in line with the National Prevention Strategy (National Prevention Council, 2011), MMC chose to affect a broad range of health factors and outcomes before they cause significant problems in the future.

Two issues were not fully addressed by this plan. First, the high number of caregivers (more than one in five adults) was of great concern. While the Mental Health First Aid program will affect these adults, additional programs were not added at this time. The United Way of Northern New Jersey has done a tremendous job establishing a Caregiver's Coalition in the area with broad participation and support. This effort is being supported by MMC (with funds and staff participation), and it was determined that the need was already being addressed by this Coalition.

Second, one of the identified challenges around mental health and emotional welling was the lack of behavioral health treatment options especially for lower-income, Spanish-speaking residents. After much discussion, it was determined that this was a concern that could not be adequately addressed at this time due to funding limitations. Instead, the workgroup chose to focus on prevent (in line with the National Prevention Strategy), including the establishment of Mental Health First Aid training. As a byproduct of this process, communication and collaboration between providers has increased and will help make the most of the existing resources in this arena.

Table 6

Implementation Plan for Access to Care and Preventive Services (MMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When?	What?	3 Years	10 Years
Many lower-income residents have limited access to physician specialists	Increase access to specialists for lower-income residents	Identify opportunities to refer Zufall patients to MMC Resident specialists	MMC Community Health, MMC Specialty Clinics, Zufall Health Center	2013 Q3	Increase visits in Zufall patients to MMC specialists by 20%	Decrease health disparities with respect to Specialty MD services by 10%	Decrease health disparities with respect to Specialty MD services by 20%
Many residents have limited understanding of where to seek available health and health insurance resources	Establish a comprehensive list of resources to secure and fund health care	Create a resource card with information on health care access	MMC Community Health, Patient Financial Services, and Clinics, Saint Clare's Health System, Chilton Hospital, Zufall Health	2014 Q2	Distribute at least 5,000 resource cards	Decrease percentage of lower income and Hispanic/Latino adults unable to afford care by 20%	Decrease health disparities in Hispanic/Latino and lower income populations by 10%
36% of U.S. population has limited HL[1], with higher numbers among racial/ethnic minorities, seniors, and low SES populations leading to poor health outcomes	Build Awareness of health literacy among health professionals	Provide health literacy training to staff at Health clinics and local Health Departments	MMC Community Health and Family Health Center, Zufall Health, Local Health Departments	2014 Q1	100 health professionals trained	Increase health literacy for the H/L and low income community	Decrease health disparities in Hispanic/Latino and lower income populations by 10%
		Run Health Literacy Photovoice Project	MMC Community Health, Atlantic Health System, Zufall Health	2013 Q4	Photos shared with 500 people		

[1] National Center for Education Statistics, 2003

Table 7

Implementation Plan for Behavioral Health (MMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When?	What?	3 Years	10 Years
Rates of heroin substance abuse prescriptions have grown in Morris County. This has been linked to opiate and prescription drug use	Decrease number of narcotics being prescribed	Provide educational programs to providers	MMC Community Health, Morris County Prevention is Key (MCPIK), Saint Clare's, Farleigh Dickinson School of Pharmacy, DEA	2013 Q4	300 pharmacists and prescribers will be trained	Decrease in the number of prescriptions written for class 2 narcotics by 10%.	Decrease substance abuse treatment admissions for heroin by 10%
	Increase usage of Prescription Monitoring Program	Provide training for prescribers and pharmacist on how and why to maximize the use of the PMP system.	MMC Community Health, MCPIK, , Morris County Municipal Alliances, Saint Clare's	2014 Q1	300 pharmacists and prescribers will be trained	Increase utilization of PMP by 75%	
Drinking has increased among adults and adolescents	Increase awareness of underage drinking among health care providers, parents, and community members	Provide tools and educate providers on alcohol screening	MMC Community Health & Goryeb Children's Hospital, MCPIK, Morris County Municipal Alliances, Saint Clare's, Morris County schools	2014 Q3	150 providers trained 200 reached with information	25 providers will participate	Decrease alcohol use among adolescents by 10%
		Provide community programs for parents and community members		2014 Q2	5 programs 250 attendees 1,000 people reached with information	Awareness of underage drinking will increase	
While more than one in ten residents report suffering from mental illness in our area, national data suggests that much of mental illness is untreated.[1] Stigma has been cited as a key inhibitor of seeking treatment	Decrease mental health stigma	Launch Mental Health First Aid training program: Youth and Adult	MMC Community Health, Saint Clare's, Chilton, YMCA, Mental Health Association	2013 Q4	6 trainers trained 300 participants	Decrease stigma around mental illness.	Decrease untreated mental illness.
		Launch public awareness campaign	MMC Community Health, Saint Clare's, Chilton	2014 Q1	Reach 50,000 people		

[1]Kessler et al., 2001

Table 8

Implementation Plan for Healthy Eating/Active Living (MMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When?	What?	3 Years	10 Years
One in five residents reported no daily consumption of vegetables. 14.9% of residents reported physical inactivity These numbers were higher for lower-income (<$75K annual household income) and Hispanic/Latino populations New Jersey has one of the highest rates of obesity in low-income children ages 2 to 5[1]	Promote physical activity in schools	Launch kid-FIT Cup for area schools	Goryeb Children's Hospital, AHS, School Districts	2013 Q3	50 schools participate	50% of Morris County kids will have an hour of physical activity per day	Reduce childhood obesity in lower income and Hispanic/Latino children by 10%
	Increase availability of affordable fruits and vegetables in lower income areas in Morris County.	Support the creation of community gardens and farmer's markets in Dover and Morristown	MMC Community Health, Grow It Green Morristown, Zufall Health	2014 Q3	Support 3 community gardens and 1 farmer's market	Increase community gardens by 10%	
	Work with childcare providers to increase healthy eating and active living in centers	Provide NAP-SACC training to identified child care centers and home child care providers	MMC Community Health, Morris Area Wellness Partnership, Child & Family Resources, Family Success Center, Morris County Office of Hispanic Affairs, Dover Head Start	2014 Q2	Increase in child care providers implementing NAP-SACC by 10%	Increase participating child care providers nutrition guidelines by 25% Increase participating child care providers with 1 hour or more physical activity by 25%	
	Support environmental change initiatives	Support the creation of parks and Complete Streets.	MMC Community Health, Morris County Park Commission, Morris Area	2015 Q4	Complete 2 projects	Decrease physical inactivity in lower-income adult population by 5%	Decrease physical inactivity in lower-income adult population by 10%

			Wellness Partnership				

[1]National Center for Chronic Disease Prevention and Health Promotion, 2009

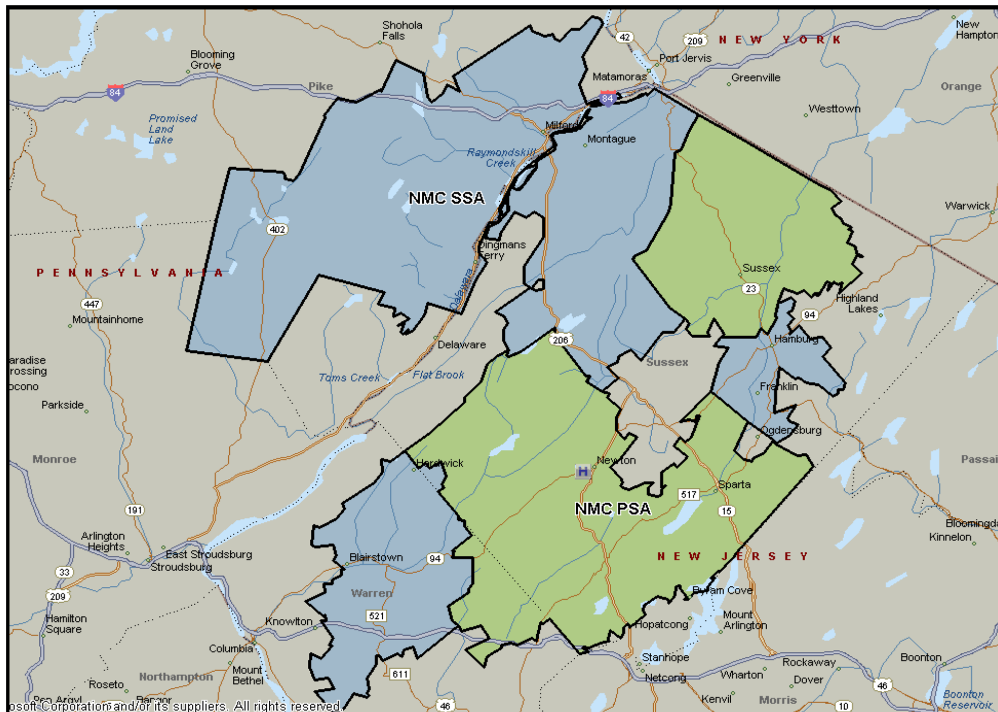
Newton Medical Center

ATLANTIC HEALTH SYSTEM

2013 Community Health Needs Assessment

Community Served by Newton Medical Center

Newton Medical Center (NMC) serves a population of 149,265 in 11 zip codes in its primary and secondary service areas (zip codes from which 75% of inpatients come). As shown in Map 2, NMC's service area encompasses most of Sussex County, Pike and Monroe County in Pennsylvania and surrounding areas, including the municipalities of Newton, Sussex, and Sparta.



Map 3. **Service Area of Newton Medical Center**

The residents of NMC's service area were slightly more female (50.5%) than male (49.5%). Almost one in four residents were under 18 years of age (23.9%), and 12.2% were aged 65 and older. Almost nine out of ten residents in Newton's service area were

White, 6.1% were Hispanic/Latino, and smaller percentages are Asian (1.8%) or Black (1.7%). One half of households in the county earned over $75,000 in annual household income with 6.5% earning $250,000 per year or more. Conversely, almost one in three residents (29.3%) earns less than $50,000 year. For the purposes of the Community Health Needs Assessment, NMC defined its Community Benefit Service Area (CBSA) as Sussex County, New Jersey.

Procedure & Methodology

NMC conducted the CHNA in collaboration with nine other hospitals from the Community Health Alliance of Northern and Central New Jersey (CHANC-NJ). CHANC-NJ hired Holleran, a national research and consulting firm to conduct a phone survey (primary data) and gather secondary data.

A sample of 739 individuals who reside within Newton Medical Center's service area was interviewed by telephone to assess disease prevalence, health behaviors, preventive practices, and access to health care. Individuals were randomly selected for participation based on a statistically valid sampling frame developed by Holleran. The sampling frame represented 23 zip codes within the New Jersey counties of Warren and Sussex and the Pennsylvania county of Pike.

Secondary data were collected by Holleran and hospital staff from several sources including: the New Jersey Hospital Association Countywide Profiles, existing County Health Improvement Plans, vital statistics data from the New Jersey Department of Health Statistics, County Health Rankings, the United State Census Bureau, and the Behavioral Risk Factor Surveillance Survey from the Centers for Disease Control and Prevention

Community Representative Engagement

NMC engaged a variety of community representatives to share the data from the CHNA, to prioritize community health needs, and to identify collaborative approaches to improving community health.

Community Health Committee. NMC's community health committee was instrumental throughout the process. This group was involved in informing the data collection process, learning from the data, and setting goals for addressing health needs. The Community Health Committee was comprised of various leaders from within NMC and other community organizations. A comprehensive roster of members is listed in Table 9.

Table 9

NMC Community Health Committee Members

Name	Organization
Barbara Adolphe	Center for Prevention and Counseling
Becky Carlson	Center for Prevention and Counseling
Alma Dhuyvetter	Sussex County YMCA
Mary Emilius	United Way of Northern New Jersey
Paulette Hussey	Neighborhood Health Center
Dr. Jean Paul Bonnet	Practicing Physician
Dr. Christian Robertozzi	Chief of Staff at NMC, Practicing Podiatrist
Roger Cherney	NMC Behavioral Health
Maureen Cianci	NMC Community Health
Debra Berry-Toon	Project Self-Sufficiency
Carol DeGraw	United Way of Northern New Jersey
Tania Dikun	NMC Volunteer Office
Kathleen Fitzpatrick	NMC Community Health/Diabetes Education
Judy Beardsley	NMC Community Health/Diabetes Education
Anne Foster	NJ State First Aid Council 12th district
Susan Frost	NMC Marketing
Jennifer Gardner	Sussex County YMCA
Richard Gorab	Sussex County YMCA
Stephen Gruchacz	Sussex County Department of Human Services
Helen Homeijer	Sussex County Dept. of Environmental & Public Health Services
Matt Lifschultz	Fairview Lake YMCA
Lori Reich	Sussex County Superior Court
Analyn Nieuzytek	NMC Case Management
Randy Parks	NMC Chaplin
Emick Seabold	Sussex Cty. Dept. of Environmental and Public Health Services
Tracy Storms-Mazzucco	Sussex Cty. Dept. of Environmental & Public Health Services
Diane Tulig	NMC Community Health
Yvonne Quinones Syto	Hopatcong Health Advisory Counsel
Loretta Ritter	NMC Rehab Services
Leigh Kramer	NMC Diabetes/Nutrition/Community Health
Carrie Parmelee	Saint Clare's Family Intensive Services
Nancy Hess	Skylands RSVP, Norwescap
Melissa Latronica	Sussex County Division of Community and Youth Services
Ellen Phelps	Sussex Cty. Dept. of Environmental & Public Health Services
Ralph D'Aries	Sussex Cty. Dept. of Environmental & Public Health Services
Darla Williams	WIC Program
Pamela Madzy	Blessed Kateria, Migrant Ministry

Convocation. On September 13, 2012, the data from the CHNA was unveiled in a meeting at Atlantic Health System Corporate in Morristown, New Jersey. This meeting contained hospital representatives and community leaders including public health

officers, elected officials, and non-profit organizations (i.e. the United Way). Representatives from NMC included:

- Tom Senker, President, NMC
- Chris Orr, Manager, Community Health, NMC
- Dr. Paul Owens, Medical Director NMC
- Ardelle Bigos, Chief Nursing Officer, NMC
- Loretta Ritter, Manager, Rehabilitative Services, NMC
- Deborah McCarren, Coordinator, Behavioral Health, NMC
- Maureen Cianci, Coordinator, Community Health, NMC
- Randy Parks, Manager, Chaplain Services, NMC

Community Prioritization Meeting. Representatives from across the community were invited to participate in a prioritization meeting on October 25, 2012 at Newton Medical Center. The gathering was conducted in collaboration with the Sussex campus of Saint Clare's Health System. Eighteen total community partners were present representing:

- Sussex County YMCA
- Center for Prevention and Counseling
- United Way of Northern New Jersey
- Neighborhood Health Center
- Project Self-Sufficiency
- NJ State First Aid Council 12th district
- Sussex County Department of Human and Health Services
- Sussex County Department of Environmental and Public Health Services
- Sussex County Superior Court
- Hopatcong Health Advisory Counsel
- Norewescap

At this meeting, data from the CHNA were presented, participants discussed needs and resources, and voting was conducted to determine top priorities. Data were presented in accordance with the priorities and strategic directions identified in the National Prevention Strategy (National Prevention Council, 2011). As shown in Table 10, the voting process identified three combined areas of need: 1) behavioral health (mental health & substance use/abuse), 2) healthy behaviors (including active living and nutrition), and 3) access to care.

These community representatives and others were invited back to subsequent meetings in December 2012 through May 2013. During these meeting, specific challenges within each priority area were discussed and comprehensive lists of existing community resources were identified. Each of these needs is discussed in depth below.

Table 10

Prioritized Needs List (Sussex County Meeting)

Need	Scope	Severity	Ability to Impact	Overall Average
Mental Health & Well-Being	6.10	6.17	5.13	5.80
Drugs & Alcohol	6.00	5.83	5.41	5.75
Active Living	5.39	5.17	5.46	5.34
Healthy Eating	5.38	5.07	5.36	5.27
Access to Care	5.46	5.41	3.90	4.92
Tobacco Use	4.21	4.43	4.41	4.35
Injury & Violence	3.60	3.52	4.03	3.72
Reproductive & Sexual Health	3.46	3.21	4.00	3.56

* All needs rates on a 1 to 8 scale

Prioritized Health Needs

Behavioral Health

Data. The results of the CHNA confirm that mental illness and substance use/abuse are widespread throughout the Sussex County area. Almost one in ten people reported poor mental health status (i.e. 15 or more days of “poor mental health” in the past month). For diagnosed mental illness, 8.8% of the respondents reported that they had been diagnosed with either an anxiety or depressive disorder, with 7.1% reporting diagnosis with both illnesses.

At the same time, 14.6% of respondents reported recent binge drinking (5 or more drinks in a row for men/ 4 or more drinks in a row for women) and 14.1% were current smokers. While illicit drugs were not included in the primary data, secondary data along with the reports of many community representatives suggested that Sussex County was subject to growing rates of prescription drug and heroin use (New Jersey Substance Abuse Monitoring System, 2011).

The data also identified alarming disparities in behavioral health. Women were more likely than men to report poor mental health status (12.4%) and anxiety disorder diagnosis (15.2%), while men were more likely to be current smokers (16.2%). Hispanic/Latinos were more likely to report binge drinking (22.2%). The largest disparities, however, were found on socioeconomic indicators. Lower income residents reported poorer mental health status (12.5%) and higher rates of anxiety disorder (16.4%), depressive disorder (14.3%), disability (33.2%), and experiences of intimate partner violence (19.1%). Similarly, individuals without a Bachelor’s degree reported greater rates of poor mental health (11.0%), anxiety disorder (14.7%) and lifetime cigarette use (53.9%). Among individuals reporting poor mental health status, 14.9%

were uninsured, 12.0% did not have a doctor, and 20.5% reported that they had needed to visit the doctor in the past year, but could not do so because of cost.

Community Representative Engagement. From December 2012 to May 2013, a diverse group of community representatives (including those representing lower-income, racial/ethnic minority, and chronic disease populations) met regularly at NMC. They worked together to discuss the data from the CHNA and identified challenges in reducing narcotic consumption and decreasing mental health stigma. As shown in Table 11, the community representatives developed a list of existing community resources for addressing behavioral health concerns.

Healthy Behaviors

Data. The second priority area that was identified by the group of community leaders was healthy behaviors. These include physical activity and nutrition, and their relationship to health outcomes including obesity and diabetes. In the Sussex area, the needs assessment found that one in four respondents were obese, another four in ten were overweight, and many suffered from chronic illnesses including diabetes (8.5%), heart disease (4.7%), stroke (1.9%), and COPD (6.1%).

As research has consistently shown, many of these illnesses can be traced back to the physical activity and nutrition habits of individuals. While many respondents in the needs assessment reported exercising regularly and eating adequate fruits and vegetables, 15.6% reported no exercise of any kind in the previous month, with a significant number of lower-income individuals reporting no daily consumption of fruits (29.9%) or vegetables (14.2%).

Similar to behavioral health, disparities were prevalent in health behaviors and associated outcomes. While males were less likely to report physical inactivity (i.e. no exercise of any kind in the past 30 days), they reported significantly higher rates of poor nutrition (no daily fruit (32.4%) and vegetable (17.5%) intake), were more likely to be obese (29.3%) and reported almost twice the rate of diabetes diagnosis (10.9%). Disparities were also found based on socioeconomic indicators. Lower-income and non-college educated individuals were more likely to report poor physical health, to be physically inactive, and to suffer from obesity and/or diabetes. While no differences were found on fruit consumption, lower income individuals were less likely to consume vegetables on a daily basis.

Community Representative Engagement. From December 2012 to May 2013, a diverse group of community representatives (including those representing lower-income, racial/ethnic minority, and chronic disease populations) met regularly at NMC to discuss healthy behaviors. Key projects were identified to promote physical activity

collaboratively across the county and by using resources at NMC. This group developed a list of existing resources for addressing healthy behaviors as shown in Table 11.

Access to Care

Data. The final priority area identified by the community representatives was access to care and preventive services. The CHNA revealed that, while many people had insurance and access to physicians, disparities were found among Hispanic/Latinos and individuals of lower socioeconomic status. Individuals earning less than $75,000 per year (annual household income) and those without a college education were much more likely to be uninsured, to not have a doctor, and to have been inhibited from visiting a doctor in the past year due to cost. Similar disparities were found between Hispanic and non-Hispanic residents. Lack of access to care also translated into lack of preventive services. Residents with less household income were less likely to get their annual flu shot and to meet the recommendations for preventive screenings, including mammograms and colonoscopies.

Community Representative Engagement. Community representatives met through May 2013 to develop a list of existing community resources as shown in Table 11. This group built on this list and identified additional opportunities for addressing access to care issues in Sussex County. Four major barriers were identified: 1) transportation 2) cost of care, 3) awareness of available services, and 4) health literacy.

Existing Community Resources

As shown in Table 11, the community representatives at the multiple gatherings held between October 2012 and May 2013 helped to identify key resources within the community that could address the priority needs within the priority populations. The broad coalition of community partners identified the possibility of collaboration within the local community as a key asset.

Table 11

List of Existing Sussex County Resources by Area of Need

Behavioral Health	NMC Behavioral Health, Behavioral Health Care LLC, Bridgeway Rehabilitation Services, Inc., Capitol Care, Inc., Center for Prevention and Counseling, Advance Housing, Community Hope, Project Self-Sufficiency, Sussex County Mental Health Board and Professional Advisory Committee, Self Help/A Way to Freedom, DBSA, NAMI
Healthy Behaviors	NMC Health Education Events, Local YMCAs, Hopactong Health Advisory Council, Norwescap, Sussex County Dept. of Human Services, Sussex Cty. Dept. of Environmental & Public Health Services, United Way of Northern New Jersey, WIC
Access to Care	NMC Community Health, NMC Adult Clinic, Sussex Transportation Services, the "Monday clinic", Neighborhood Health Center, Saint Clare's, faith–based communities, schools, sheriff's office, senior services, WIC, Norwescap, CIRCLES

Implementation Plan

In partnership with the community representatives described previously, NMC developed an implementation plan to respond to each community need: Behavioral Health, Healthy Behaviors, and Access to Care and Preventive Services. The complete logic model for each plan is displayed in Tables 12 through 14.

Behavioral Health

In response to the mental health and substance abuse needs of the community, NMC identified four strategies for implementation as outlined in Table 12.

1. Decrease the number of narcotics being prescribed

Secondary needs assessment data revealed that treatment admissions for heroin use have risen in Sussex County. This has been attributed, in part, to an increase in the number of class 2 narcotics being prescribed by physicians. To address this issue, ***NMC and our partners will provide educational programs about the dangers of over-prescribing and best practices in narcotic management to 100 pharmacists and prescribers (doctors, nurses, etc.) over three years.***

2. Increase usage of New Jersey Prescription Monitoring Program.

The New Jersey Prescription Monitoring Program is a statewide database that was created to "halt the abuse and diversion of prescription drugs." Unfortunately, many practitioners are not fully utilizing the program. To address this issue, ***NMC and our partners will provide education and training on the program to 100 pharmacists and prescribers in MMC's service area over three years.***

3. Decrease mental health stigma

The CHNA revealed that mental illness is widespread in our communities. Much of this illness goes untreated due to many factors including mental health stigma. We will work to decrease stigma in our community by training professionals and increasing public awareness. ***NMC and our partners will train 10 professionals to be trainers in Mental Health First Aid***, an evidence-based program designed to equip people with knowledge about mental illness. These 10 individuals ***will provide the Mental Health First Aid program to at least 300 participants over three years***. In conjunction, we will reach at least 10,000 people with a public awareness campaign to promote anti-stigma messages.

4. **Promote usage of prescription drop boxes in the community**

   Many of the prescription drugs involved in addiction are not prescribed to the person taking them. Unused prescriptions drugs are dangerous and can be accessed by children and youth. To reduce the number of unused prescriptions in the community, ***NMC and our partners will reach 10,000 people with a public awareness campaign to promote usage of the available drop boxes.***

5. **Reduce Tobacco Use in Public Places**

   To reduce the number of smokers in the community and limit exposure to secondhand smoke, ***NMC will work with our partners and local communities to establish 15 smoke-free parks in the NMC service area within three years.***

Healthy Behaviors

As shown in Table 13, NMC and our partners identified four strategies for improving the healthy behaviors in our communities.

1. **Launch the We Can! Program in Sussex County**

   We Can! is a nationally-recognized program for promoting physically activity and nutrition in communities. In partnership with a wide range of community organizations, Sussex County will become New Jersey's first We Can! County. Using the evidenced-based resources, ***NMC and our partners will hold 15 programs and reach at least 500 people over three years.***

2. **Create easy-to-understand information for healthy behaviors.**

   Statistics on health literacy suggest that many people lack the basic information they need to successfully manage their health. To address this concern, ***NMC and our partners will create a "Roadmap to Healthy Living in Sussex County" and distribute to at least 5,000 people over three years.***

3. **Conduct Healthy Cooking classes**

   Many people lack the basic knowledge of how to prepare healthy foods. In partnership with the YMCA and local schools, ***NMC and our partners will provide healthy cooking classes for 150 people over three years.***

4. **Host the “Dinner and a Lecture” series**

   The “Dinner and Lecture” series provides health education and healthy foods to community members at NMC’s campus. To address the need for healthy behaviors, ***NMC will host 30 “Dinner and a Lecture” programs over three years.***

Access to Care & Preventive Services

As shown in Table 14, NMC and our partners identified three strategies for improving access to care.

1. **Partner with community organizations to increase screenings and health education events.**

   Health screenings and health education events are essential for lower-income populations to get access to the care and preventive services they need. To increase the number of people completing recommended screenings, ***NMC will hold 30 community-based screenings, reaching 420 people over the next three years.***

2. **Build New Jersey 2-1-1 into a viable resource for the region**

   New Jersey 2-1-1 is a resource that provides phone and internet access to resources. The community representatives in Sussex County revealed that few professionals are aware of the service and that the service is not up to date with all existing resources in the county. To better utilize this resource, ***NMC will work with our partners to increase the percentage of Sussex County resources listed in the 2-1-1 database by 15%.***

3. **Create tools for community/patient to better understand their health**

   Thousands of studies have shown that healthcare communication is too complex for the average person, and that many aversive health outcomes result from limited health literacy. To build awareness among providers, ***NMC will a) develop a patient checklist for guiding patient-provider interaction (5,000 people reached), and b) develop easy-to-use health education tools for the population with limited health literacy (5,000 people reached).***

4. **Create a “Using Clinics in Sussex County Guide”**

   For populations with limited income and no health insurance, finding access to care is challenging, resulting in significant disparities in these populations. To

address this need, ***NMC and our partners will create a "Using Clinics in Sussex County" guide and distribute it to at least 5,000 people***

Identified Community Needs that are not addressed

As shown previously, the health needs identified by the data and prioritized by the diverse array of community representatives are all addressed by the preceding implementation plan. By choosing to priorities related to prevention (and in line with the National Prevention Strategy (National Prevention Council, 2011), we have the opportunity to affect a broad range of health factors and outcomes affecting the Sussex County population even in areas where the residents compared favorably to national and state norms.

One key challenge was cited that was not addressed. In discussing access to care and utilization of preventive services, transportation was identified as a key barrier to receiving treatment. Despite mutual agreement as to this need and discussions with all partners, it was agreed that providing direct transportation or increasing routes was outside of the current capabilities for the hospital and the participating community partners. However, the creation of resource cards with transportation information will help many residents know where and how to find medical care.

Table 12

Implementation Plan for Behavioral Health (NMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When?	What?	3 Years	10 Years
17% of Sussex County residents report poor mental health status and approximately one in ten report diagnosis with a mental illness. 14.6% of Sussex County residents report binge drinking, one of the highest counties in the state Rates of heroin and prescription drug use are rising in the county. Sussex County is the #2 county in New Jersey for Heroin use (New Jersey Substance Abuse Monitoring System, 2011)	Rates of heroin substance abuse prescriptions have grown in Sussex County. This has been linked to opiate and prescription drug use	Decrease number of narcotics being prescribed by providing educational programs to providers	NMC Community Health, Skylands Medical Group, Saint Clare's, Center for Prevention and Counseling (CPAC)	2013 Q3	100 pharmacists and prescribers trained	Decrease the number of prescriptions written for class 2 narcotics by 10% Decrease number of pills in each written prescription by 10%	Decrease substance abuse treatment admissions for heroin by 10%
		Increase usage of Prescription Monitoring Program by Provide training for prescribers and pharmacists on how and why to maximize the use of the PMP system.	NMC Community Health, Skylands Medical Group, Saint Clare's, CPAC, Community Pharmacies	2014 Q2	100 pharmacists and prescribers trained	Increase the number of physicians and pharmacists participating by 50%	
	Decrease Mental Health Stigma	Launch Mental Health First Aid Training	NMC Community Health, Saint Clare's, SC Mental Health Board, YMCA, Hopatcong Health Alliance, SC Dept. of Health, SC Dept. of Human Services, Local mental health providers, CPAC	2013 Q4	Train 10 trainers Reach 300 participants	Decrease stigma around mental illness in Sussex County	Decrease untreated mental illness
		Public Awareness Campaign		2014 Q1	10,000 people reached		
	Reduce Unused Prescriptions in the Community by using drop boxes	Promote usage of prescription drop boxes in the community	NMC Community Health and Marketing/PR, Police Departments, CPAC	2014 Q1	10,000 of people reached	Increase pounds of medication in drop boxes by 20%	Decrease substance abuse admissions for prescription drugs by 30%

	Reduce Tobacco Use in Public	Promote “Smoke Free Parks”	NMC Community Health, SC Dept. of Health, CPAC	2014 Q3	15 smoke-free parks	Decrease the percentage of current smokers by 5%	Decrease the percentage of current smokers by 10%?

Table 13

Implementation Plan for Healthy Eating, Active Living (NMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When?	What?	3 Years	10 Years
15.6% of Sussex County residents reported being physically inactive (i.e. no exercise of any kind) in the previous month 30% of Sussex County residents reported no daily consumption of fruits and 14.2%% reported no daily consumption of vegetables 64.8% of county residents were overweight or obese	*We Can!* Program	Train Key Personnel Launch Curriculum	NMC Community Health, Saint Clare’s, YMCA, Hopatcong Health Alliance, SC Dept. of Health, SC Dept. of Human Services, Norwescap, WIC, Project Self-Sufficiency	2013 Q3	15 programs held 500 people participants	Increase consumption of daily fruits and vegetables by 10% Increase daily physical activity by 10%	Decrease rate of obesity by 1%
	Create Easy-to-Understand Information for Healthy Behaviors	Create Roadmap to Healthy Living in Sussex County brochure		2013 Q4	5,000 of Brochures distributed		
	Health Education and Screenings	Conduct Healthy Cooking Classes	NMC Community Health, YMCA Hardyston Middle School	2014 Q1	150 people trained		
		Host the “Dinner and a Lecture” series	NMC Community Health, Staff Physicians	2013 Q3	30 programs completed	Conduct pre and post evals to identify 20% change in specific habit related to talk	
		Health Screenings in Community (see goal under Access to Care)					

Table 14

Implementation Plan for Access to Care (NMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When?	What?	3 Years	10 Years
Financial Access							
Lower-income Sussex County residents cannot afford care and are less likely to complete recommended preventive screenings	Conduct recommended screenings in community settings	Partner with community organizations to increase screenings and health education events	NMC Community Health, Blessed Kateria Migrant Ministry Hopatcong Health Alliance, SC Dept. of Health, SC Dept. of Human Services, Norwescap, WIC, Project Self-Sufficiency	2013 Q3	30 screenings to 420 people	5% increase in the number of who have completed recommended preventive screenings	Decrease health disparities in lower income population
Educational Access (Health Literacy)							
Many in Sussex County report being unaware of existing resources.	Establish unified resource portal for community	Build 2-1-1 into a viable resource for the region	NMC Community Health, United Way of NNJ, , Saint Clare's, Hopatcong Health Alliance, SC Dept. of Health, SC Dept. of Human Services, Norwescap, WIC, Project Self-Sufficiency	2013 Q4	Increase resources listed in 2-1-1 by 15%	Increase 2-1-1 usage by 10%	Increase participation in community programs by 15%
36% of U.S. population has limited HL[1],with higher numbers among racial/ethnic minorities, seniors, and low SES populations; H/L and lower income population less likely to complete well visits and receive preventive services	Create Tools for Community/Patient to Better Understand their Health	Develop web/mobile/paper patient checklist for guiding patient-provider communication	Atlantic Health System, Atlantic ACO	2014 Q3	5,000 people reached	5% increase in recommended preventive care in total population	Increase utilization of preventive services by 20%
		Develop health education tools for low HL population	NMC Community Health, SC Dept. of Health	2014 Q1	5,000 people reached		
Physical Access (Transportation)							
Many in Sussex County lack adequate transportation to get to medical appointments.	Inform the public about options for clinics and transportation	Create a "Using Clinics in Sussex County" guide	NMC Community Health, Saint Clare's, Sussex County Department	2013 Q4	5,000 people reached	Increase usage of clinics and awareness of transportation	Reduce the number of people unable to attend medical appointments due

			Env. Services			services	to cost

[1]National Center for Education Statistics, 2003

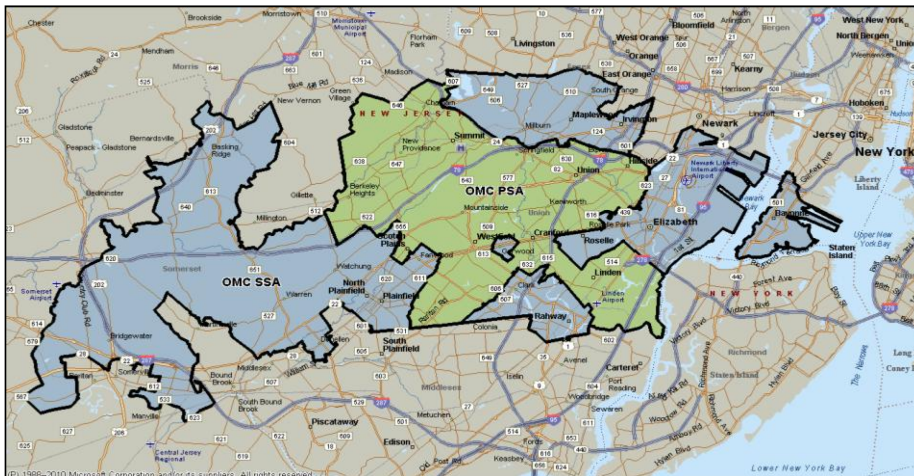
Overlook
Medical Center

ATLANTIC HEALTH SYSTEM

2013 Community Health Needs Assessment

Community Served by Overlook Medical Center

Overlook Medical Center (OMC) in Summit, New Jersey serves a population of 304,088 residents from 14 zip codes in Central New Jersey in its primary service area[1], with an additional 555,953 residents from 24 zip codes in its secondary service area[2]. As shown in Map 2, the primary service area of OMC ranges from Linden and Union to Chatham and Berkley Heights, with high concentrations in Summit and Westfield.



Map 4. **Primary Service Area of Overlook Medical Center[1]**

[1] PSA = zip code of residence for 50% of inpatients, SSA = zip code of residents for 75% of inpatients.

Fifty-one percent of residents in OMC's primary and secondary service areas were female. One-fourth (24.9%) of residents are under 18 years of age, 12.4% are age 65 and older. Race/ethnicity for population is 47.0% White, 21.5% Black, 23.1% Hispanic/Latino, and 6.4% Asian.

OMC's service area is also subject to wide ranges in socioeconomic status. Forty-five percent of the population reported more than $75,000 in annual household income, and 9.5% earned more than $250,000 per year. Conversely, almost one in five (17.5%) households earned less than $25,000 per year.

For the purposes of the Community Health Needs Assessment, OMC identified a Community Benefit Service Area (CBSA) comprised by its primary service area (highlighted in green in Map 2). In addition, OMC agreed to collaborate with hospitals and community groups in OMC's secondary service area (including Elizabeth, Rahway, Bridgewater, and Basking Ridge) on specific projects to address unique needs of that region.

Procedure & Methodology

OMC conducted the CHNA in collaboration with nine other hospitals from the Community Health Alliance of Northern and Central New Jersey (CHANC-NJ). CHANC-NJ hired Holleran, a national research and consulting firm to conduct a phone survey (primary data) and gather secondary data.

A sample of 879 individuals who reside within Overlook Medical Center's service area were interviewed by telephone to assess their health behaviors, preventive practices, and access to health care. Individuals were randomly selected for participation based on a statistically valid sampling frame developed by Holleran. The sampling frame represented 38 zip codes within the New Jersey counties of Union, Morris, Hudson, Essex, Somerset, and Middlesex. The data were statistically weighted to counter for demographic imbalances (e.g. over-representation of females compared to males).

Secondary data were collected by Holleran and hospital staff from several sources including: the New Jersey Hospital Association Countywide Profiles, existing County Health Improvement Plans, vital statistics data from the New Jersey Department of Health Statistics, County Health Rankings, the United State Census Bureau, and the Behavioral Risk Factor Surveillance Survey from the Centers for Disease Control and Prevention.

Community Representative Engagement

OMC engaged a variety of community representatives to share the data from the CHNA, to prioritize community health needs, and to identify collaborative approaches to improving community health. These individuals represented organizations in many sectors (social services, government, public health, education, etc.) and included those serving lower-income, racial/ethnic minority, and chronic disease populations. Additional representatives were invited throughout the process as needs were identified and ideas formulated.

Community Health Committee. OMC's Community Health Committee, a sub-committee of the hospital Advisory Board, was instrumental throughout the process. This group was involved in informing the data collection process, learning from the data, and setting goals for addressing health needs. The Community Health Committee was comprised of various leaders from within OMC and other community organizations. A comprehensive roster of members is listed in Table 15. In addition to monthly meetings throughout the process, the Community Health Committee completed web-based surveys on community needs and existing community resources.

Convocation. On September 13, 2012, the data from the CHNA was unveiled in a meeting at Atlantic Health System Corporate in Morristown, New Jersey. This meeting contained hospital representatives and community leaders including public health officers, elected officials, and non-profit organizations (i.e. the United Way of Northern New Jersey). Representatives from OMC included:

- Joyce Passen, Manager, Community Health
- Vincent Ursino, Chair, Community Health Committee
- William Neate, Director Gagnon Cardiovascular Institute
- Jane Rubin, Director Overlook Neuroscience
- Mary Pat Sullivan, RN, Chief Nursing Officer
- Susan Kaye MD, Medical Director, Overlook Family Practice
- Jeanne Kerwin, Coordinator, Overlook Palliative Care
- Joanne Williams, Past Nurse Manager Vauxhall Community Health Center

Community Prioritization Meetings. Two meetings were held to prioritize community health needs. On October 14th, the first meeting was held for residents of OMC's primary service area. The gathering was held at the Summit Area YMCA. A total of 16 community partners were present representing:

- Summit Mayor's Office
- Summit Area YMCA
- SAGE Eldercare
- Junior League of Summit

Table 15

OMC Community Health Committee Members

Name	Organization
Lisa Marie Arieno	American Heart Association
Megan Avalone	Westfield Regional Health Officer
Janice Baker, MD	OMC Family Practice
Monica Cattano, RN	Summit School District
Ellen Dickson	Mayor of Summit
Margaret Dolan	Westfield School District
Rosalind Dorlen, Ph.D.	OMC Psychologist
Annette Dwyer	Shaping Summit
Mark Elasser	Westfield YMCA
Paul Fernandez	Summit Oaks Hospital
Mirela Feurdean	Vauxhall Health Center
Carolyn Giaccio	Summit Public Health Nurse
Gerald Glasser	OMC Foundation Board
Amy Gole	OMC Parent Education
Baxter Graham	Community Liaison
John Gregory, MD	OMC Palliative Care
Peggy Hagen	The Connection for Women and Families
Janina Hecht	OMC Public Relations
Christine Hodde	Summit Red Cross
Darrell Johnson	Summit Area YMCA
Judith Leblein Josephs	Summit Recreation
Kris Luka	Community Liaison
Dee MacKaey-Kaufmann	Westfield Recreation
Rev. James Mahoney	Corpus Christi Parish
Janet Maulbeck	Interweave
Ellen McNally	Sage Eldercare
Mixon Marin	Summit Downtown
Nathan Parker	Summit School District
Joanne Oppelt	Contactwecare
Anna Pence	AHS Government Relations
Joyce Passen	OMC Community Health
Augustine Pushparaj	Community Liaison
Nancy Raymond	Clark Health Officer
Brigitte Richter-Hajduk	TD Bank
Mary Robinson	Imagine
Jessica Rosenzweig	Sage Eldercare
Joseph Tribuna, MD	OMC Family Practice
Vince Ursino	Chair
Darielle Walsh	Westfield Community Member
Rosemary Walsh	AHS Behavioral Health
JoAnne Williams	Physician Practice

- Summit School Nurses
- Summit Public Health Nursing
- Regional Health Officer
- Hispanic Community Liaison
- Westfield School District
- The Connection for Women and Families
- Corpus Christi Church, Chatham

At this meeting, data from the CHNA were presented, participants discussed needs and resources, and voting was conducted to determine top priorities. Data were presented in accordance with the priorities and strategic directions identified in the National Prevention Strategy (National Prevention Council, 2011). The community representatives voted, and the results, as displayed in Table 16, identified three predominant areas of need: 1) mental health & well-being, 2) healthy eating and active living, and 3) drugs and alcohol. An emphasis was made on the interconnectedness of the three areas, suggesting the need for holistic, integrative interventions that affect the whole person.

Table 16

Prioritized Needs List (Western Union County Meeting)

Need	Scope	Severity	Ability to Impact	Overall Average
Mental Health & Well-Being	6.50	6.79	5.71	6.33
Healthy Eating	5.38	5.07	5.20	5.22
Active Living	4.33	4.33	4.57	4.41
Drugs & Alcohol	4.20	4.36	4.27	4.28
Reproductive & Sexual Health	3.43	4.00	3.64	3.69
Injury & Violence	2.53	2.67	2.64	2.61
Tobacco Use	1.93	2.47	2.43	2.28

* All needs rates on a 1 to 7 scale

The second prioritization meeting was held in collaboration with two other Union County hospitals: Robert Wood Johnson Rahway and Trinitas Regional Medical Center. This session was help at the Union YMCA and was facilitated by Holleran, a national consulting and research firm. Approximately 20 individuals attended from organizations across Union County including:

- Westfield YMCA
- YMCA Eastern Union County
- United Way of Union County
- Contact We Care
- Kean University Health Services
- Clark Township Health Department

- Bridgeway
- Elizabeth Police Department
- Proceed
- Union County Family & Child Services
- Public Relations, Overlook Medical Center
- Behavior Health, Overlook Medical Center

In this session participants listened to data for Union County as a whole, created a collaborative list of community health needs, and then voted on those needs based upon their seriousness and ability to impact. The results of the vote are shown in Table 17. As shown, the needs identified at this meeting (obesity, diabetes, mental health, cancer, access to care/health disparities) clearly match those identified in the Western Union County Meeting (mental health, healthy eating/active living, access to care).

Table 17

Prioritized Needs List (Union County Meeting)

Master List	Seriousness	Impact	Overall Average
Obesity	4.70	4.05	4.38
Diabetes	4.39	4.11	4.25
Mental Health	4.30	3.60	3.95
Cancer	4.40	3.35	3.88
Latino/Hispanic Disparities	4.25	3.35	3.80
Access to Care	4.25	2.95	3.60
Drugs & Alcohol	4.05	3.15	3.60
Stroke	3.55	3.05	3.30
Single Mothers	3.30	2.70	3.00
Asthma	2.90	2.20	2.55

Key Informant Interviews

To ensure that all voices of low-income and minority citizens were heard, a number of key informant interviews were conducted with leaders. These included:

- Reverend Ronald Allen, Pilgrim Baptist Church of Summit
- Joanne Williams, Past Nurse Manager Vauxhall Community Health Center
- Luis Arias, The Migrant Ministry, Diocese of Paterson

- Celine Benet, Summit resident, Teacher and Hispanic Liaison for Summit Board of Education
- Monica Roldan, Pathways, Social Services
- Teresa Usme, Summit resident
- Janet Maulbeck, Summit resident, President Interweave
- Luz Marina Bazalar, Summit resident, Director of the San Jose Community at the Shrine of St**.** Joseph

Key themes from these interviews included:

- Access to Care
- Chronic Disease Management
- Health Literacy
- Healthy Eating

These themes were used to provide deeper explanation of the identified disparities found in the data and to inform implementation strategies.

Prioritized Community Health Needs

After considering all the data and input from community representatives, OMC identified three intersection elements of community need: 1) behavioral health (including mental health and substance use/abuse, 2) healthy behaviors (as preventive factors for obesity, diabetes, and cancer) and 3) disparities in access to care. These needs are considered to be inter-related and all fit within the context of access to care.

Behavioral Health

Mental Health & Well-Being. Mental health is a key indicator that is both affected by and influences health behaviors that contribute to chronic illness and injury. More than one in ten residents reported battling mental illness (10.0% anxiety disorder, 10.4% depressive disorder) and 11.5% reported having 15 or more days of poor mental health in the previous month. These individuals were less likely to eat vegetables daily (38.4% to 23.7%), more likely to be physically inactive (32.8% to 16.0%), and more likely to smoke cigarettes (20.3% to 8.9%). Comorbidities between depression, anxiety disorder and chronic illnesses (e.g. COPD, Heart Disease, Diabetes) were also found.

Substance Use/Abuse. The use and abuse of substances is one of the leading causes of death and chronic illness across the United States. The primary data revealed that more than half of the respondents reported drinking alcohol with 16.0% binge drinking in the previous month (i.e. 5 or more drinks in a row for a male, 4 or more for a female). In addition, alcohol treatment admissions were higher than the New Jersey average. More

than one-third of respondents had smoked cigarettes at one point in their life (35.9%) and 10.2% were current smokers. Rates of substance abuse treatment admissions for heroin and marijuana were also higher than New Jersey averages, but no questions on illicit drugs were included in the primary data survey (New Jersey Substance Abuse Monitoring System, 2011).

The Community Representatives identified two target populations in which to address the identified behavioral health needs: 1) youth and 2) senior adults. The foundation for preventing mental illness and risk behaviors is established in the skills and habits learned during the formative school years. The key informant interviews, including those with Middle School students themselves, revealed that many challenges were present in schools (e.g. bullying) that affected students' ability to thrive. Secondary data revealed that too many New Jersey adolescents were unhealthy and/or engaged in risky behaviors.

At the same time, the population of New Jersey and the United States continues to get older, and this presents unique needs in the community. Older adults were more likely to report depression, poor mental health, and physical inactivity. As the population begins to age, more people are becoming informal caregivers for their aging family members. One out of five (20.6%) of respondents reported providing care. These individuals were much more likely to report being diagnosed with an anxiety or depressive disorder.

Physical Activity & Nutrition

Physical activity and nutrition are modifiable factors that are linked to obesity and chronic illness. Almost one out of every five participants reported being physically inactive (i.e. no physical activity at all in the previous month) and more than one in four reported no daily vegetable intake. While many in the area did report adoption of these healthy behaviors, 59.6% were either overweight or obese, 10.2% reported having diabetes, and the age-adjusted diabetes death rates (26.9 per 100,000) was no better than New Jersey or U.S. averages.

One emphasis of the Community Representatives was the need to start early, providing every child with a strong start to life. Research shows that what happens in the first years of life can have a dramatic impact on health throughout childhood and into adulthood. This includes positive birth outcomes and lower rates of child obesity. Seven percent of babies are born with low birth weight in OMC's service area, and 9.2% are born prematurely. Of two to five year olds across the nation, 26.7% are overweight or obese. New Jersey has one of the worst rates of child obesity, especially among low-income children.

In the CHNA, six out of ten adults were overweight or obese, and approximately one in four reported no daily consumption of fruits and vegetables. These numbers were no different for parents, suggesting that many parents may not be providing the active and nutritious environments that their young children need to thrive. This is especially true for females without a college education who were more likely to be physically inactive and suffer from depression.

Disparities in Access to Care & Preventive Services

Health disparities are "differences in the health status or health care that are measurable, unnecessary, preventable, and unjust" (Carter-Pokras & Baquet, 2002). Primary data revealed that certain populations were at greater risk for poor mental health and unhealthy behaviors. Education level played a major role. Adults without a 4-year college degree reported twice the rates of depression and poor mental health compared to those with a Bachelor's degree or more. This effect is especially pronounced among females. Disparities were also found for Hispanic/Latinos who reported higher rates of anxiety disorder and poor mental health status than White and Black groups. At the same time, Hispanic/Latinos were less likely exercise, eat vegetables, and were three times as likely to report being unable to go to the doctor because of cost. Community representatives linked these disparities to affordability, accessibility, and limited health literacy.

Existing Community Resources

From October 2012 to May 2013, the community representatives in OMC's Community Health Community met to discuss the data and identify existing resources. As shown in Table 18, a list of resources was developed via meetings and an online survey for community representatives.

Table 18

List of Existing Resource by Need Area

Behavioral Health (Youth)	OMC Behavioral Health & Goryeb Children's Center, School Harassment, Bullying, Intimidation (HIB) Teams, Girls on the Run Program, SAGE Eldercare,The Connection, Summit Department of Community Programs, Summit Connection, Shaping Summit together, Summit Board of Education, NJ Psychological Association bullying initiative, CONTACT WE CARE, The Westfield Area and Summit Area YMCAs, Bridgeway Catholic Charities, local behavioral psychologists
Behavioral Health (Seniors)	OMC gerontology and caregivers services, Senior Service Center of the Chatham, SAGE Eldercare, The Connection For Women And Families, Summit and Westfield YMCAs, Summit Public Health Services, Summit Department of Community Programs, Senior Citizen Centers, Olmstead Initiative, Ombudsman, Jewish Family Services, Contactwecare, "We care" ring program
Healthy Behaviors (A Strong Start for Every Child)	OMC HealthStart Clinic, Union County Immunization Clinic, The Connection for Women and Families (preschool programs), Gateway Maternal Health Consortium, Planned Parenthood, Teen Success, NJ Family, Child health conferences (local health departments), March of dimes, Prenatal/ postpartum classes at OMC, Westfield YMCA, Women, infants & children (WIC) clinics, YMCA Catch and 7th grade programs
Access to Care and Preventive Services	OMC Community Health Screenings, Healthy Avenues Van, and Overlook Downtown, OMC Health Navigators, Vauxhall Community Health Center, Local Public Health Departments, Family Practice Offices, New Jersey Family Care, Union County CEED Program, Faith Communities and Parish Nurses, Union/Middlesex County on Chronic Disease Committee, Union County United Way, Red Cross, Susan G. Komen North Jersey Affiliate, UTCAO (Union Township Community Action Organization), Union County Para-Transit, Union County Health Educators

Implementation Plan

In partnership with the community representatives described previously, OMC developed an implementation plan to respond to the needs of the community within the four goal areas. The complete logic model for each plan is display in Tables 19 through 22.

Behavioral Health

In response to the mental health and substance abuse needs of the community, OMC and our partners set two goals for improving the behavioral health of our populations. Two target populations were identified: seniors (and their caregivers) and adolescents. The first goal is to ***"empower seniors to live happy, healthy lives***". We chose four strategies to accomplish this (Table 19):

1. Increase opportunities for social interaction among isolated seniors

   Using our Overlook Downtown location and partnering with SAGE Eldercare and other groups, OMC will provide opportunities for 500 seniors to connect socially and break the isolation that contributes to poor mental and physical health

2. Create access to resources for seniors and senior-serving organizations. ***OMC will transform its Community Health website to include listings of all resources available to seniors in our communities***. In addition, ***OMC will produce a printed resource guide that will be distributed to 1,000 seniors via the internet, community events, and upon discharge from the hospital.***

3. ***OMC will host a "summit" for senior-serving organizations in which 50 people will be represented***. This will be an opportunity to identify new strategies and resources for finding and serving isolated seniors in our communities.

In addition to the needs of seniors, the OMC needs assessment revealed that many people are providing unpaid care to friends and family members and that these individuals are more likely to suffer from mental illness and poor mental health status. OMC will provide resources and support to these caregivers by:

1. ***Supporting existing caregiver events*** in partnership with SAGE Eldercare, faith communities, and the OMC Department of Palliative Care
2. ***Providing caregiver resource guides to 250 caregivers***.

The second goal for improving behavioral health was to "***build resilience in our communities",*** with a focus on the adolescent population. OMC and our partners developed two key strategies (Table 20):

1. Teach resilience skills to youth in schools

   OMC will partner with area school districts to develop and provide resilience training to all 6th grade students in Summit and Westfield schools. This strengths-based curriculum will build skills necessary to cope with life's obstacles in a positive manner. Resilience assessments will also be conducted to measure progress.

2. Provide "Mental Health First Aid" training to professionals

   Mental Health First Aid is an internationally-recognized, evidence-based program designed to train people on the signs and symptoms of mental illness. The youth component of the program will be revealed in 2013. ***OMC will train at least 25 people per year from Western Union County in this program***.

3. Launch Anti-Stigma Public Awareness Campaign

   In addition to building skills in youth and professional staff, ***OMC will reach 5,000 people in the general public with a marketing campaign designed to reduce stigma and encourage treatment of mental illness and substance abuse problems.***

Physical Activity and Nutrition

OMC and our partners chose to promote physical activity and nutrition with the goal of ***"providing a strong start for every child"*** Two strategies were identified (Table 21):

1. **Provide education to parents of children 10 and under**

   Parents, particularly those from lower-income populations, need resources that will help them raise healthy children both before and after the child is born. To accomplish this goal, ***OMC will a) hold more than 30 bilingual education classes led by medical residents, b) provide education to 500 parents at local PTOs and other organizations, c) distribute 5,000 easy-to-understand parent education materials, and d) support the planting community gardens at local schools and other organizations, including on the OMC campus***.

2. **Provide education on proper hospital utilization to parents of children (10 and under)**

OMC will a) hold bilingual classes led by medical residents and b) provide parent education tools designed to educate parents about the right time to visit the doctor, go to the emergency room, or stay at home.

Access to Care & Preventive Services

OMC and our partners identified the goal of "***providing affordable, accessible and understandable care and preventives services to all residents of Western Union County***" To accomplish this goal, three strategies were identified (Table 22):

1. Conduct recommended screenings in community settings to reach Hispanic/Latino and lower income populations.

   The CHNA revealed that many lower income and Hispanic/Latino residents were not receiving preventive services with cost being a key issue. Over the next three years, ***OMC will 1) partner with faith communities to reach over 600 Hispanic/Latinos with screenings and events, 2) use the Healthy Avenues Van at 100 screenings in key geographic areas to reach the lower-income and Hispanic/Latino residents, and 3) disseminate information on health care reform (e.g. exchanges, Medicaid expansion) to 10,000 people.***

2. Establish a unified resource portal for the community.

   Being able to access health services requires the ability to know about what services are available. The CHNA revealed that even professionals are often unaware of existing programs in the community. Over the next three years, ***OMC and our partners will develop a repository of local resources to be housed on the OMC Community Health website, increasing web traffic by 300% over this time***.

3. Create tools for Community/Patient to better understand their health

OMC will create tools and information that will empower patients to control their own health. In the next three years, ***OMC will create and disseminate easy-to-use patient checklists and "how-to" guides to 5,000 residents***, helping them have greater control of their health and healthcare. In addition, ***OMC will expand health education classes/events targeted at lower income and Hispanic/Latino residents***.

Identified community needs that are not addressed

As shown previously, almost all of the health needs identified by the data and prioritized by the diverse array of community representatives are addressed by the preceding implementation plan. In OMC's primary service area, data did not reveal many significant areas in which the community was worse than other areas. However, by choosing to priorities related to prevention (and in line with the National Prevention Strategy (National Prevention Council, 2011), OMC chose to affect a broad range of health factors and outcomes before they cause significant problems in the future.

Table 19

Implementation Plan: Behavioral Health- Seniors (OMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When?	What?	3 Years	10 Years
Senior Mental Health							
15% of adults 65+ report poor mental health status. Isolation and chronic illness are cited as significant causes[1]	Increase opportunities for social interaction among isolated seniors	Use Overlook Downtown location for senior interaction and services	SAGE Eldercare; Summit Community Health; OMC Community Health; Faith Communities	2013 Q4	500 seniors will attend	Decrease the percentage of adults 65+ with poor mental health status by 10%	Decrease the percentage of adults 65+ with poor mental health status by 50%
	Create access to resources for seniors and senior-serving organizations	Establish website with resources	OMC	2014 Q2	Increase hits by 300%		
		Create print guide and distribute to all seniors upon discharge		2014 Q3	Distribute to 1,000 seniors		
	Host "summit" for senior-serving organizations	Identify resources and new programs for isolated seniors	OMC, SAGE, Summit Community Health	2013 Q4	50 people in attendance		
Caregivers							
20.6% of adults are providing unpaid care. They cite stress and greater rates of mental illness[1]	Provide resources and support to caregivers	Support caregivers events	OMC Palliative Care, SAGE, OMC Community Health, Faith Communities	2013 Q3	Increase attendance at caregiver events by 10%	Reduce the percentage of caregivers with poor mental health status by 1%	Reduce the percentage of caregivers with poor mental health status by 5%
		Provide resource guides for caregivers	OMC	2013 Q3	Distribute materials to 250 caregivers		

[1] OMC 2013 Community Health Needs Assessment

Table 20

Implementation Plan: Behavioral Health: Resilience (OMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When to Start?	What?	3 Years	10 Years
Youth							
Reports of bullying and poor mental health in youth were cited by community representatives as key components in health today and affecting rates of mental illness, substance abuse, and poor physical health in the future.	Teach resilience skills to youth in schools	Assess Youth Resilience	Schools; OMC Community Health	2015 Q1	Assess and administer program to all 6th graders at Summit and Westfield schools	Reduce HIB incidence in area schools by 10%	Reduce rates of mental illness and substance abuse in young adults by 10%
		Develop "Resilience" training program and materials		2014 Q2			
Mental Health Stigma							
Many people with a diagnosable mental illness do not receive treatment[1]. Many community representatives report being unaware of how to handle situations involving mentally-ill persons	Increase awareness and understanding of mental illness	Provide youth "Mental Health First Aid" training to professionals	Schools; OMC Community Health, Behavioral Health	2013 Q4	Train 25 people per year from Western union County	Increase the number of professionals aware of the signs and symptoms of mental illness	Decrease untreated mental illness
		Launch marketing campaign		2014 Q2	Reach 50,000 people		

[1]Kessler et al., 2001

Table 21

Implementation Plan: Physical Activity and Nutrition (OMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When?	What?	3 Years	10 Years
Healthy Start							
33% of kids in Summit Schools are overweight or obese[1]	Provide education to parents (prenatal through 10 years)	Bilingual Education by Health Start Residents	OMC Family Practice, Health Start Clinic	2013 Q3	Hold events 1-2 afternoons per month	Reduce the percentage of obese and overweight elementary school kids by 10%	Reduce the percentage of obese and overweight elementary school kids by 25%
		Present to PTO and other parent groups	OMC, Schools	2014 Q1	Reach 500 parents at events		
		Distribute Parent Education Materials and Classes through partner organizations	OMC HealthStart, Parent Ed., Comm. Health; WIC	2014 Q2	5,000 tools distributed		
		Support the development of community gardens	YMCA, School Districts, OMC	2013 Q3	Increase the number of community gardens in the area by 100%		
Hospitalization							
In 2012, 14,103 children 10 and under visited OMC Emergency Department[2]	Provide education to parents (prenatal through 10 years)	Bilingual Education by Health Start Residents	OMC Family Practice, Health Start Clinic	2013 Q3	Hold events 1-2 afternoons per month	Reduce preventable ED visits for children by 10%	Reduce preventable ED visit for children by 25%
		Distribute Parent Education Materials and Classes through partner organizations	OMC HealthStart, Parent Ed., Comm. Health; WIC	2014 Q2	5,000 tools distributed		

[1] *BMI Data from Summit Public Schools* ; [2] *OMC ED Utilization Data*

Table 22

Implementation Plan: Access to Care and Preventive Services (OMC)

Community Need	Strategies	Activities	Partners	Timeframe	Outputs	Outcomes	
	How?	How, specifically?	Who?	When?	What?	3 Years	10 Years
Financial Access							
30.5% of Hispanic/Latinos in OMC's service area could not afford a doctor's visit in the past year Lower income residents (<$75K annual household income) and Hispanic/Latinos were less likely to complete many recommended preventive screenings 11.7% of lower income residents had not been to a doctor in over 2 years[1]	Conduct recommended screenings in community settings to reach Hispanic/Latino and lower income populations	Partner with faith communities to hold screenings and health education events	OMC Community Health; Faith Communities	2013 Q3	4 events per year reaching 200 (Y1), 225 (Y2), 250 (Y3)	10% increase the number of H/L's and lower income residents who have completed recommended preventive screenings 10% increase in Hispanic/Latino and lower income individuals with doctor visit in past two years	5% decrease health disparities in H/L and lower income population
		Use Healthy Avenues Van to conduct screenings in Key Areas	OMC Community Health; Businesses; Union Wellness Center; Neighborhoods	2013 Q3	100 screenings/events per year targeted at Hispanic/Latino and lower income population		
		Provide information on Health Care Reform	OMC Community Health; Schools; Public Health; Non-Profits; Businesses	2013 Q4	Disseminate information to 10,000 people		
Educational Access (Health Literacy)							
36% of U.S. population has limited HL[2], with higher numbers among racial/ethnic minorities, seniors, and low SES populations leading to poor health outcomes	Increase awareness of available resources in the community	Build an AHS Community Health Website with Resource Listings	OMC, Atlantic Health System	2013 Q4	Increase hits to page by 300%	Improve awareness of resources among community partners	5% average decrease in health disparities for H/L and lower income population
	Create tools and events to empower our communities to manage their health	Develop web/mobile/paper patient checklists and how-to guiles	OMC Community Health	2014 Q3	Disseminate to 5,000 people	Increase patient engagement and usage of preventive services	
		Increase health education programming	OMC Community Health	2014 Q1	Hold 200 health education events	Build health literacy in vulnerable populations	

[1] OMC 2013 Community Health Needs Assessment; [2] National Center for Education Statistics, 2003

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