Bergen County Community Health Improvement and Implementation Plan: 2017-2019

Hospital Partners

- Christian Health Care Center – Ramapo Ridge Psychiatric Hospital
- Englewood Hospital and Medical Center
- Hackensack Meridian *Health* – Hackensack University Medical Center
- Hackensack Meridian *Health* – Pascack Valley Medical Center
- Holy Name Medical Center
- The Valley Hospital

Community Health *Improvement* Partnership
OF BERGEN COUNTY

Local Health Department Partners

- Bergen County Department of Health Services – Hansel Asmar, Director/Health Officer
- Bergenfield Health Department – David Volpe, Health Officer
- City of Hackensack Health Department – Susan McVeigh, Health Officer
- Englewood Health Department – James Fedorko, Health Officer
- Fairlawn/Village of Ridgewood Health Department – Carol Wagner, Health Officer
- Fort Lee Health Department – Stephen Wielkocz, Health Officer
- Mid-Bergen Regional Health Commission – Sam Yanovich, Health Officer
- NW Bergen Regional Health Commission – Angela Musella, Health Officer
- Palisades Park/Ridgefield Health Department – Branka Lulic, Health Officer
- Paramus Board of Health – Judy Migliaccio, Health Officer
- Teaneck Health Department – Ken Katter, Health Officer

METHODOLOGY

The Community Health Improvement Partnership of Bergen County (CHIP) offers its Community Health Needs Assessment (CHNA) Implementation Strategy for 2017-2019. The implementation strategy is the result of the department's CHNA that was presented at the annual meeting on December 13, 2016. The CHIP identified multiple Areas of Opportunity. These areas were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. Complete details are available within the Community Health Improvement Partnership of Bergen County 2016 CHNA, at http://www.healthybergen.org/.

PRIORITIZATION CRITERIA

Key informants ranked the identified needs based on two criteria:

1. Scope & Severity – the first criterion was to gauge the magnitude of the problem in consideration of the following:
    - How many people are affected?
    - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
    - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?
2. Ability to Impact – the second criterion was designed to measure the perceived likelihood of the Local Public Health Departments, hospitals and community organizations having a positive impact on each health issue

CHIP FOCUS AREAS 2017-2019

Obesity, Fitness, Nutrition and Chronic Disease

Mental Health and Substance Abuse

Access to Care

The results of this prioritization exercise are being used to inform the development of the CHIP Implementation Strategy to address the top health needs of the community in the coming years.

The area hospitals participated in the prioritization of health issues in Bergen County, however, each hospital is focusing on the health needs relevant to its local service area. Information regarding each hospital's specific priorities and implementation strategies can be found on each hospital's websites.

CHIP IMPLEMENTATION STRATEGY ACTION PLAN

The Community Health Improvement Partnership's (CHIP) Vision is that "All people in Bergen County will have access to resources that enable them to reach optimum health……Community stakeholders will collaborate to create and leverage resources to build a healthier Bergen County." The Partnership is committed to working with partners to implement the goals and strategies listed below. These partners will address obesity prevention, fitness, nutrition, chronic disease, mental health, substance abuse and access to health care. The Implementation Plan will include outreach to people most at-risk, including the elderly, low income and minority populations.

FOCUS AREA ONE: OBESITY, FITNESS, NUTRITION AND CHRONIC DISEASE	
Goal 1: Increase Physical Activity Throughout the Community	**Process/Outcomes Measurements**
A. CHIP Wellness/Weight Loss Challenge: Increase physical activity for adults in Bergen County through local, community-based, free and low cost exercise opportunities. B. Continue the CHIP Get Fit Bergen program: free exercises in the county parks and community locations during the year.	• # of towns and partners participating • # of community members joining the Challenge • # of mayors and town leaders participating • Evaluation through post- surveys to participants and partners; • # of participants at Get Fit exercise programs
Goal 2: Increase Healthy Eating Throughout the Community	**Process/Outcomes Measurements**
A. CHIP Wellness/Weight Loss Challenge: Increase healthy eating through multiple education programs, food demonstrations, and weekly weigh-in stations. B. Complete educational programs/trainings for professionals and community	• # of participants • # of partners • % change in biometrics data if available • Program outlines and evaluations
Goal 3: Promote Chronic Disease Management and Behavior Change	**Process/Outcomes Measurements**
A. Partner and co-host educational conferences and trainings with hospital and health care partners concerning chronic diseases for professionals and community members at risk	• # participating • results of a pre/post survey • # attending disease management programs such as Stanford CDSM, DSM, and CTS programs
Goal 4: Increase Awareness of End-of-Life and Palliative Care Resources/ Programs	**Process/Outcomes Measurements**
A. Provide outreach and education in community B. Collaborate with local hospitals to help increase access to caregiver support programs	• # of participants • # of evaluations, self-reporting of completion of Advance Directives • Increase participation • # of collaborative programs
FOCUS AREA TWO: MENTAL HEALTH AND SUBSTANCE ABUSE	
Goal 1: Reduce Depression and Isolation	**Process/Outcomes Measurements**
A. Provide educational outreach to the community B. Collaborate with local hospitals to reduce depression and isolation in the community	• # of education sessions • # of screenings • Participation levels and referrals for positive screenings • # of training sessions • # of participants trained • # of collaborative programs • # of participants
Goal 2: Reduce Anxiety and Stress	**Process/Outcomes Measurements**
A. Provide education and outreach to the community B. Collaborate with local hospitals to help reduce anxiety and stress	• # screened • # of education sessions • Participation levels and referrals for positive screenings • # of seminars • # of participants • # of collaborative programs

FOCUS AREA TWO: MENTAL HEALTH AND SUBSTANCE ABUSE	
Goal 3: Reduce Stigma Related to Mental Illness	**Process/Outcomes Measurements**
A. Provide education and outreach in the community B. Collaborate with local hospitals to help reduce the stigma related to mental illness in the community	• # of participants • Evaluations • Self-reporting • # of Stigma Free programs in town in partnership with multiple organizations • # of collaborating organizations
Goal 4: Reduce Risky and Binge Drinkers (Alcohol)	**Process/Outcomes Measurements**
A. Increase awareness in the community of available programs and services offered B. Collaborate with local hospitals to help reduce risky and binge drinkers in the community	• Survey to monitor alcohol use • # of programs • # of participants • Evaluations • # of collaborative programs
Goal 5: Reduce Prescription Drug Abuse	**Process/Outcomes Measurements**
A. Increase awareness in the community of available programs and services offered B. Collaborate with local hospitals to help reduce prescription drug abuse in the community	• # of participants in program • # of collaborative programs
Goal 6: Promote Access to and Engagement in Behavioral Health Care	**Process/Outcomes Measurements**
A. Increase awareness in the community of available programs and services offered B. Collaborate with local hospitals to help promote access to and engagement in behavioral health care	• # of collaborative programs • # of participants
FOCUS AREA THREE: ACCESS TO CARE	
Goal 1: Promote Disease Identification and Prevention	**Process/Outcomes Measurements**
A. Offer programs and screenings to the community B. Increase awareness in the community of available programs and services offered C. Collaborate with local hospitals to help promote access to and engagement in primary care in the community D. Continue to offer immunizations, vaccinations, education and outreach to the community	• # of screenings • # of referrals to health.gov, FQHC, and BVMI • Monitoring participants compliance, evaluations, decreased ER usage • # of collaborative programs • # of participants • # of immunizations/vaccinations clinics • # of immunizations/vaccinations given • # of education/outreach programs
Goal 2: Promote Care Coordination and Engagement in Primary Care	**Process/Outcomes Measurements**
A. Offer screenings and referral services B. Collaborate with local hospitals to promote care coordination and engagement in primary care in the community C. Continue to include primary care partners from FQHC, hospitals, medical practices, etc. on the CHIP Core Steering Committee and task forces	• # referred and/or screened • % change in biometrics data • # of collaborative programs • # of participants • # attending meetings, programs, and donating time and funds to CHIP related to care coordination initiatives