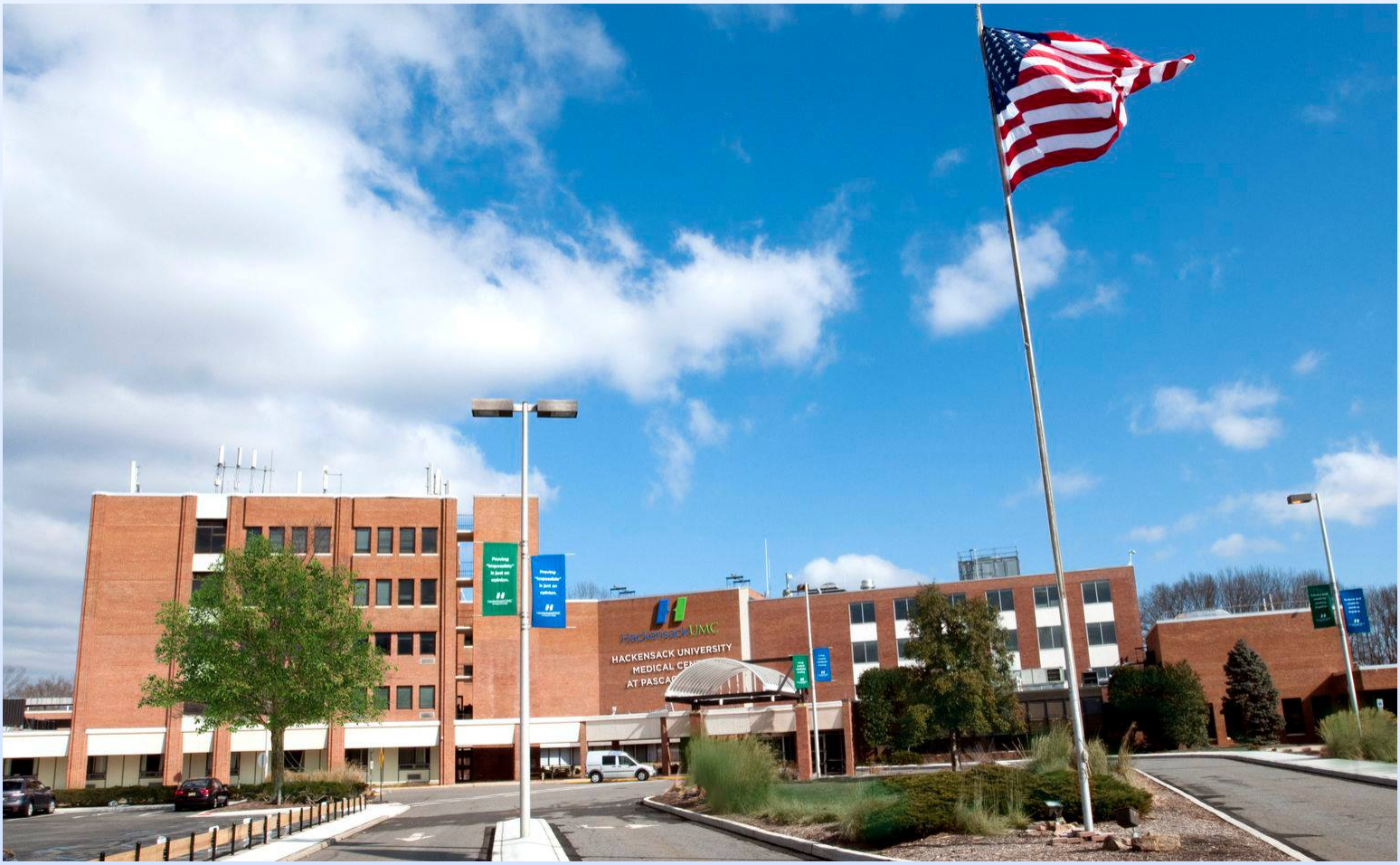

Community Health Needs Assessment
Implementation Strategy Executive Summary
2017-2019

Hackensack
Meridian *Health*
Pascack Valley Medical Center

METHODOLOGY

Pascack Valley Medical Center (PVMC) offers its Community Health Needs Assessment (CHNA) Implementation Strategy for 2017-2019. The implementation strategy is the result of the hospital's CHNA adopted by the PVMC Board of Directors on November 16, 2016. The PVMC CHNA identified twenty-nine (29) 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 PVMC 2016 CHNA, which may be viewed at http://www.hackensackumc.org/assets/1/7/2016_PRC_CHNA_Report_-_HUMC.pdf.

PRIORITIZATION CRITERIA

Key informants ranked the identified needs based on two criteria:

1. Scope & Severity – the first rating 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 – a second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue given available resources, competencies, and spheres of influence.

OUTCOMES AND IMPACT WILL BE MEASURED BY:

- Increased ease of access to care
- Events and educational outreach programs and services provided
- Participation in screening events
- Referrals for services, interventions, or higher levels of care based on screening outcomes
- Improvement in chronic disease management
- Increase in community's knowledge base and intent to change behavior
- Creation of protocols for certain programs
- Participation in clinics

PRIORITIZATION OF RESULTS

- Substance Abuse
- Mental Health
- Diabetes
- Nutrition, Physical Activity and Weight
- Access to Healthcare Services
- Heart Disease and Stroke
- Dementias, Including Alzheimer's Disease
- Immunization & Infectious Diseases
- Cancer
- Potentially Disabling Conditions

While the hospital will likely not implement strategies for all the prioritized health issues, the results of this prioritization exercise will be used to inform the development of PVMC Implementation Strategy to address the

KEY DATA FINDINGS: COMPARISONS TO BENCHMARK DATA

	Service Area	vs. Bergen County	vs. NJ	vs. US	vs. HP 2020
Access to Health Services					
% [Age 18-64] Lack Health Insurance	**3.8**	5.6	15.0	10.1	0.0
% Difficulty Accessing Healthcare in Past Year (composite)	**37.9**	40.7		35.0	
% Inconvenient Hrs Prevented Dr Visit in Past Year	**19.1**	21.5		14.4	
% Cost Prevented Getting Prescription in Past Year	**11.4**	8.7		9.5	
% Cost Prevented Physician Visit in Past Year	**15.3**	15.5		11.5	
% Difficulty Getting Appointment in Past Year	**18.7**	19.2		15.4	
% Difficulty Finding Physician in Past Year	**9.7**	11.5		8.7	
% Transportation Hindered Dr Visit in Past Year	**8.1**	6.5		5.0	
% Difficulty Getting Child's Healthcare in Past Year	**8.5**	8.3		3.9	
Cancer					
Prostate Cancer incidence per 100,000	**149.0**		157.3	131.7	
Female Breast Cancer Incidence per 100,000	**134.1**		130.2	123.0	
% [Women 40+] Mammogram in Past 2 Years	**65.1**	66.6	74.4	74.4	
% [Women 50-74] Mammogram in past 2 Years	**70.1**	72.2	78.2	80.3	81.1
% [Women 21-65] Pap Smear in Past 3 Years	**74.9**	74.5	83.8	84.8	93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	**74.2**	75.4	67.7	75.6	
% [Age 50-75] Colorectal Cancer Screening	**70.5**	72.8	65.0	74.5	70.5
Diabetes					
% Borderline/Pre-Diabetes	**9.4**	8.6	1.4	5.7	
Heart Disease & Stroke					
% Stroke	**3.1**	3.4	2.6	2.6	
% Blood Pressure Checked in Past 2 Years	**89.5**	90.1		93.6	92.6
% Told Have High Blood Pressure (Ever)	**36.6**	36.9	31.1	36.5	26.9
% Told Have High Cholesterol (Ever)	**42.9**	39.6		33.5	13.5
Mental Health & Mental Disorders					
% Diagnosed Depression	**12.0**	11.4	13.4	17.9	
% Symptoms of Chronic Depression(2+ years)	**27.9**	26.6		29.9	
% Typical Day Is "Extremely/Very" Stressful	**15.8**	14.4		11.7	
Nutrition, Physical Activity & Weight					
% Children [Age 5-17] Obese (95th Percentile)	**26.0**	18.6		9.5	14.5
% No Leisure-Time Physical Activity	**29.3**	23.4	23.3	27.9	32.6
% Meeting Physical Activity Guidelines	**21.1**	25.7	21.6	23.6	20.1
% Child [Age 2-17] Physically Active 1+ Hours per Day	**31.9**	33.6		47.9	
Substance Abuse					
% Current Drinker	**64.5**	68.8	56.3	59.7	
% Ever Sought Help for Alcohol or Drug Problem	**2.0**	2.4		4.1	

IMPLEMENTATION STRATEGY ACTION PLAN

PVMC is committed to achieving the "triple aim:" improved health through better quality of care at lower costs. To address the needs of the community, PVMC is committed to the strategies outlined below. PVMC has allocated resources in the form of staff, facilities, programs and financial support over the next three years to ensure the achievement of the implementation strategy goals outlined here in order to provide the necessary education and services to the community.

Goal 1: Improve Health Status Through Chronic Disease and Care Management Across the Continuum by Increasing Participation in Education and Wellness, Focusing on Cardiovascular Disease, Diabetes, Obesity and Stroke

A. Focus on educational outreach to the community through participation in community events, such as health fairs, speaking engagements, and Be Well lectures across the continuum for those residents with cardiovascular disease, obesity and stroke
B. Increase educational outreach to those with prediabetes and diabetes through community events

Goal 2: Ensure Local Access to Primary and Specialty Care

A. Focus outreach efforts to ensure easier access to primary and specialty care for those in our community through education on primary and specialty care services available and by offering the means to schedule appointments at events through the hospital website
B. Increase focus on Women's Health through education about services offered, as well as providing a means for women to make appointments on hospital website and at events
C. Increase focus on prediabetes and diabetes through education about services offered, as well as providing a means for women to make appointments on hospital website and at events

Goal 3: Promote Prevention and Increase Screening Services for Chronic Disease, Mental Health and Substance Abuse

A. Focus on prevention by offering screenings throughout the community that include but are not limited to:
    a. Cancer screenings that include either conducting at events or setting up appointments for: breast cancer, colorectal cancer and prostate cancer
    b. Blood glucose screenings
    c. High blood pressure screenings
    d. Cholesterol screenings
    e. Depression screenings
B. In partnerships with area schools, offer concussion awareness classes at the beginning of each sporting season for coaches, parents, and athletic trainers
C. Collaborate with organizations and institutions specifically addressing mental health and substance abuse in the community