Obesity:

**Goal:** Reduce the prevalence of obesity among Hunterdon County residents.

**Measure:** 1. Stop and eventually reverse the rising obesity trend

2. Increase number of participants in wellness and weight and diabetes management programs by 10%

**Data Source:** 1. Percentage of adults who have a BMI within the normal range (between 18.5 and 24.9) in Hunterdon Healthcare physician practices electronic health records (NextGen)

2. Number of adults participating in wellness and weight and diabetes management programs

To support community efforts we tracked the percentage of patients that have a BMI within a healthy weight range (adults and children). These numbers are shared quarterly with system administrative leadership, Boards, the Clinical Management Committee and the Population Health Committee. As part of a CMS CPCI (Comprehensive Primary Care Initiative) innovation project, seven primary care practices conducted nutrition education classes at their sites for patients identified as pre-diabetic in 2014. Ten Care Coordinators also assisted patients in addressing weight management as part of our Accountable Care programs. Static percentages across quarters in 2014 provided evidence that efforts needed to be expanded. In 2015 the percentage of adult patients within a healthy weight range was shared quarterly with the Hunterdon County Partnership for Health.

The Hunterdon Healthcare System supports the Partnership for Health (PFH), a county-wide initiative that involves more than 50 community service providers, agencies and organizations sharing a common interest in promoting and improving the health, well-being and quality of life of Hunterdon County residents. The PFH has four action teams, one concentrating on obesity. In 2015 the obesity action team worked with food pantries to solicit healthier donations with an emphasis on low-sodium and low-sugar options. They also provided cooking demonstrations and recipes so that food pantry patrons could learn how to incorporate the available fresh produce donated by local farmers into their family meals. This was particularly helpful when the patrons were not used to eating certain vegetables or their culture was not familiar with how to cook them.

The Obesity Action Team also started conversations with the Hunterdon County Chamber of Commerce to work on a workforce wellness program. This Healthy Hunterdon Workforce Initiative will help to bring the concept of “making the healthy choice the easy choice” to businesses throughout the county. By stressing how small changes can make a big impact on health, we hope to improve the health of employees throughout the workforce. The program rolled out in January of 2016.

In 2015, Hunterdon Healthcare System offered employee wellness rewards to those who attended a 2 part Healthy Plate, Healthy Weight program that provided information on healthy eating strategies to approximately 175 employees. In addition, employees had access to
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an on-site Weight Watchers program conducted during the lunch hour. If employees exercised at least 3 times per week in at least 30-minute increments, they would also qualify for wellness rewards. All employees can also take advantage of discount gym memberships and an on-site weight management program, in addition to a campus Walking Map, which outlines a variety of "trails" employees can walk around campus during their lunch break. A salad bar and healthy options are offered in the employee cafeteria.

The Center for Nutrition and Diabetes Management, part of the Hunterdon Healthcare System, provides nutrition education to patients with diabetes. Eighty percent of patients with diabetes are obese. In 2015, the number of diabetes patients increased while the number of pediatric and adult obesity patients decreased. Although we did not reach our goal to maintain the number of total referrals in 2015, 1541 referrals were made to our center resulting in 4.190 appointments which include both diabetes patients and nutrition patients. Patient issues with insurance coverage and high deductibles continue to affect our patient volume as well as the retirement of a part time 21 hour per week nurse educator who was replaced with a per diem nurse educator. The number of prediabetes patients continues to remain consistent but we are seeing an increase in commercial insurances that are beginning to cover a prediabetes diagnosis. We continue to offer and fill diabetes group education classes to meet the needs of patients with diabetes with less nursing staff, making these services more accessible to all.

Obesity/overweight continues to be a challenge in Hunterdon County, New Jersey and the nation. Moving forward in 2016, our center will continue to be involved in the Partnership for Health specifically the Lifestyle/Behavior Action Team.

Substance Abuse:

**Goal:** Reduce the prevalence and incidence of substance abuse among Hunterdon County residents.

**Measure:** Reduce Substance Abuse by 5%

**Data Source:** Increase number of completed inpatient Addiction Treatment Consults

The number of inpatient consults conducted by Hunterdon Medical Center’s Behavioral Health Practitioners was higher in 2015 (517 consults) as compared to 2014 (330 consults). This result is directly related to an increase in the number of Addiction Treatment Staff. The staff vacancies from 2014 were filled and changes made to the current staff’s schedules allowed for more consult time.

Latino Health Disparity & Prenatal Care:

**Goal:** Reduce health disparities among the Latino population in Hunterdon County

**Measure:** 1. Increase number of Latino mothers attending group prenatal care program

   2. Increase the proportion of Latino mothers receiving early and adequate prenatal care

   3. Increase the number of Latinos participating in health education workshops
4. Increase percentage of Latinos receiving age-appropriate cancer screening

**Data Source:**
1. Number of Latino mothers attending the group prenatal care program at Phillips Barber
2. Percentage of pregnant Latino women receiving prenatal care in their first trimester
3. Number of adult Latinos participating in health education workshops
4. Percentage of Latinos who have had a mammogram in the past 2 years

The Latino Prenatal Group Visit program was successful this past year in providing access to care for prenatal care. The program provided transportation to Phillips Barber physician practice at no cost (grant funded) to the participants. In 2015, the number of Latino women receiving prenatal care during their first trimester and delivering at Hunterdon Medical Center was 72% compared to 70% in 2014. The designation of Phillips Barber as a Centering Pregnancy site and the diligent work of our Public Health Nurses, Social Services, WIC, and the medical director of this program and her staff have made tremendous strides in this area. Their services are well known throughout the community. However, the current trend of pregnant Latino women arriving to the community later in their pregnancies is a factor that may decrease our percentages moving forward.

The Hunterdon Cancer Education and Early Detection (CEED) Grant program is located at the Hunterdon Regional Cancer Center at Hunterdon Medical Center. One of the program’s initiatives is educating community members on prevention and early detection of Breast, Cervical, Colorectal, and Prostate Cancer, specifically to populations who are uninsured or under insured. During 2015, CEED staff partnered with local community based organizations, healthcare providers, local government agencies and businesses to provide linguistically and culturally competent programs to 346 Latino residents. This outreach increased from our 2014 efforts where 303 Latino residents attended. Moving into 2016, the CEED program will continue to work with many community organizations in order to further engage the Latino community.

**Aging Related Issues:**

**Goal:** Improve the health, function and quality of life of seniors living in Hunterdon County

**Measures:**
1. Increase the percentage of seniors who seek preventive care.
2. Increase the percentage of seniors who have completed an Advanced Directive.
3. Increase hospice utilization.
4. Increase average daily census of Briteside Adult Day Center.

**Data Source:**
1. Percentage of adults 65 years and older who receive an Annual Wellness Visit or Annual Physical Exam
2. Percentage of adults 65 years and older who have a scanned Advanced Directive in their EHR.
3. Number of completed hospice consults
4. Number of enrolled Briteside clients

1. **Adult Wellness Exams/Annual Physicals**

   In 2015 all primary care practices continue to use CareSentry population management technology. This software enabled physicians to receive status reminders real-time during the patient appointment. For example, if they were due for an annual physical or a flu shot this would come up as an alert. Patients age 65 and above were encouraged to schedule wellness visits and address preventative care. Pre-visit planners reached out to patients prior to those visits to stimulate patient engagement. While in the waiting room, patients are provided a Pre-visit Health Review that includes their status for a wellness visit. Patients are provided Adult Wellness Visit (AWV) and Annual Physical forms prior to a scheduled visit. With all of these efforts the percentages of patients 65 and over having an Adult Wellness Visit or Annual Physical increased from a baseline of 37% in 2014 to 48% by the end of 2015.

2. **Advance Directives**

   The percentage of patients age 65 and above with a scanned Advance Directive in the outpatient electronic health records system was tracked and included on the newly created Population Health Dashboard. The Dashboard was shared with system administrative leadership, Boards, the Clinical Management Committee and the Population Health Committee. A Pre-visit Planning Worksheet was developed in 2014 that includes Advance Directives. If no document is present in the EHR, an Advanced Directive template is provided to the patient during the well visit. During 2015 the percentage of scanned Advance Directives increased from 10% to 11%. Efforts in 2015 focused on expanding educational opportunities for physicians on methods to address advanced illness planning. An End-of-Life Summit was held on March 11, 2015 and an End-Of-Life Tool Kit was created to assist physicians and other health care workers become more comfortable with end of life discussions.

3. **Hospice Utilization**

   In 2015, Hunterdon Hospice, Inc. a member of the Hunterdon Healthcare System, experienced a 12% increase in utilization over 2014. Although the number of admissions decreased from 376 in 2014 to 322 in 201, patient’s length of stay was longer so overall utilization increased. An End of Life summit held by Hunterdon Medical Center in March 2015 led to the identification of barriers experienced by Hunterdon Health care System physicians in accessing hospice services. Barriers include “not having the words” to have a conversation with a family and not knowing when to refer to hospice services and having difficulty knowing the differences between hospice and palliative care. Hunterdon Hospice, Inc., a member of the Hunterdon Healthcare System helped create an on-line tool kit for physicians to utilize while meeting with patients and families to aide in the discussions regarding end of life care as well as having guidelines as to when to refer a patient for an evaluation or admission to hospice. As we move forward, Hunterdon Hospice staff is actively involved in educating physicians about this new tool and facilitating the referral process.
4. Briteside Census

Briteside fell slightly under goal in terms of participant volume in 2015 primarily due to increased discharges. Securing the Briteside van and providing transportation has helped us to reach those in rural areas and add participants that would not otherwise be able to attend. However, even with the van we are still experiencing a shorter length of stay. New client “welcome visits”, did increase from the year prior by 12%, meaning admissions into Briteside increased compared to 2014, but families are now waiting until a crisis to take advantage of our service. This means their length of stay tends to be shorter, making for a high turnover at Briteside.

We are unable to sustain advanced care. Our bathroom stalls are not suited for assistance, therefore any participant who is non-weight bearing or needs assistance with toileting must be discharged. We do not offer shower service for incontinence, which is also a challenge for seniors. Our rate of discharge was increasing thus surpassing our admission rate. Participants fell out of criteria and eligible for discharge primarily due to staff inability to tend to care needs in our current location.