



Atlantic Health System

Community Health Needs Assessment 2013

Morristown Medical Center

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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 were 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

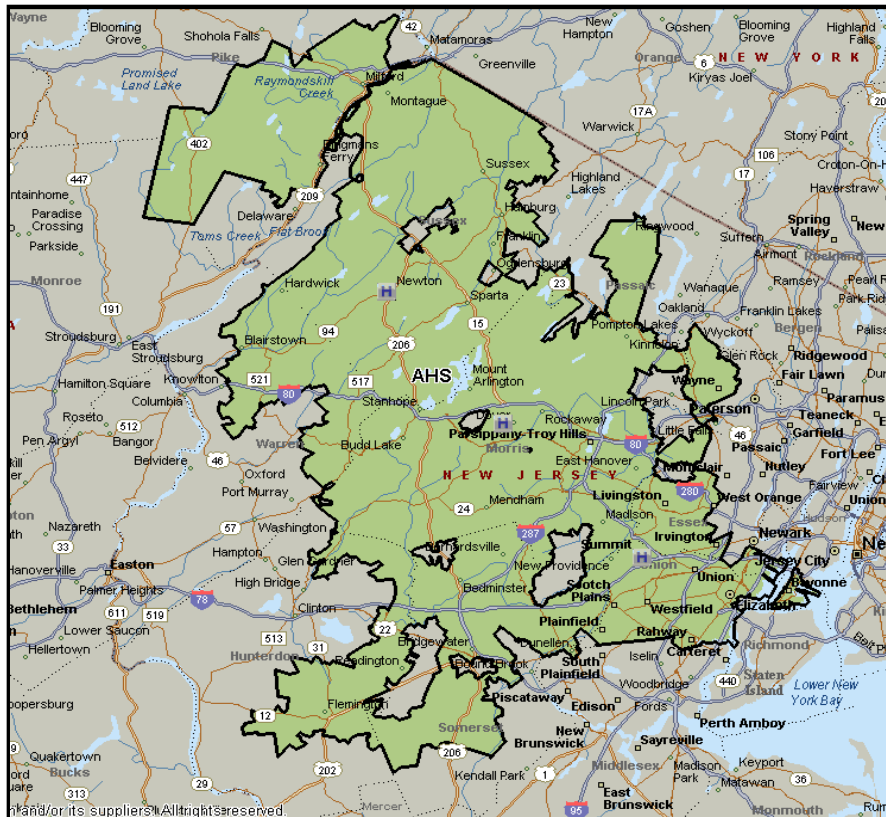
Atlantic Health System (AHS) is a comprehensive health care system serving a population of approximately 1.7 million residents. As shown in Map 1, the area served by the three AHS hospitals (Morristown Medical Center, Overlook Medical Center, Newton Medical Center) spans from urban centers near New York 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 and 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	<ul style="list-style-type: none"> • Process framework • Data Analysis • Technical assistance
Community Health Management (each site)	<ul style="list-style-type: none"> • Project oversight • Community Representative Engagement
AHS Staff and Physicians	<ul style="list-style-type: none"> • Data review and Implementation strategy • Expertise in medical care, public relations, and community engagement
Community Health Committees (each site)	<ul style="list-style-type: none"> • Endorsement of process and prioritized goals
Hospital Advisory Boards (each site)	<ul style="list-style-type: none"> • Endorsement of implementation strategy
AHS Board of Trustees	<ul style="list-style-type: none"> • 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.

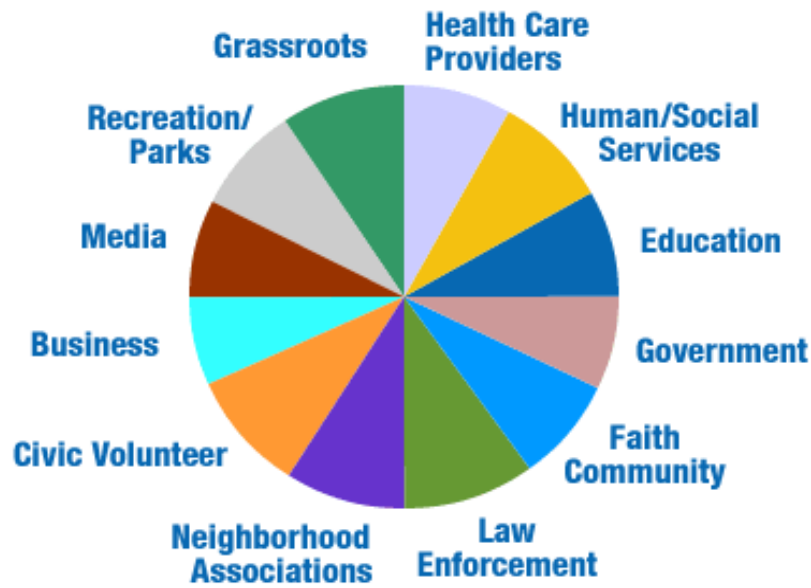
2. Secondary Data Analysis

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



The Community Wheel

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 County¹) 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.

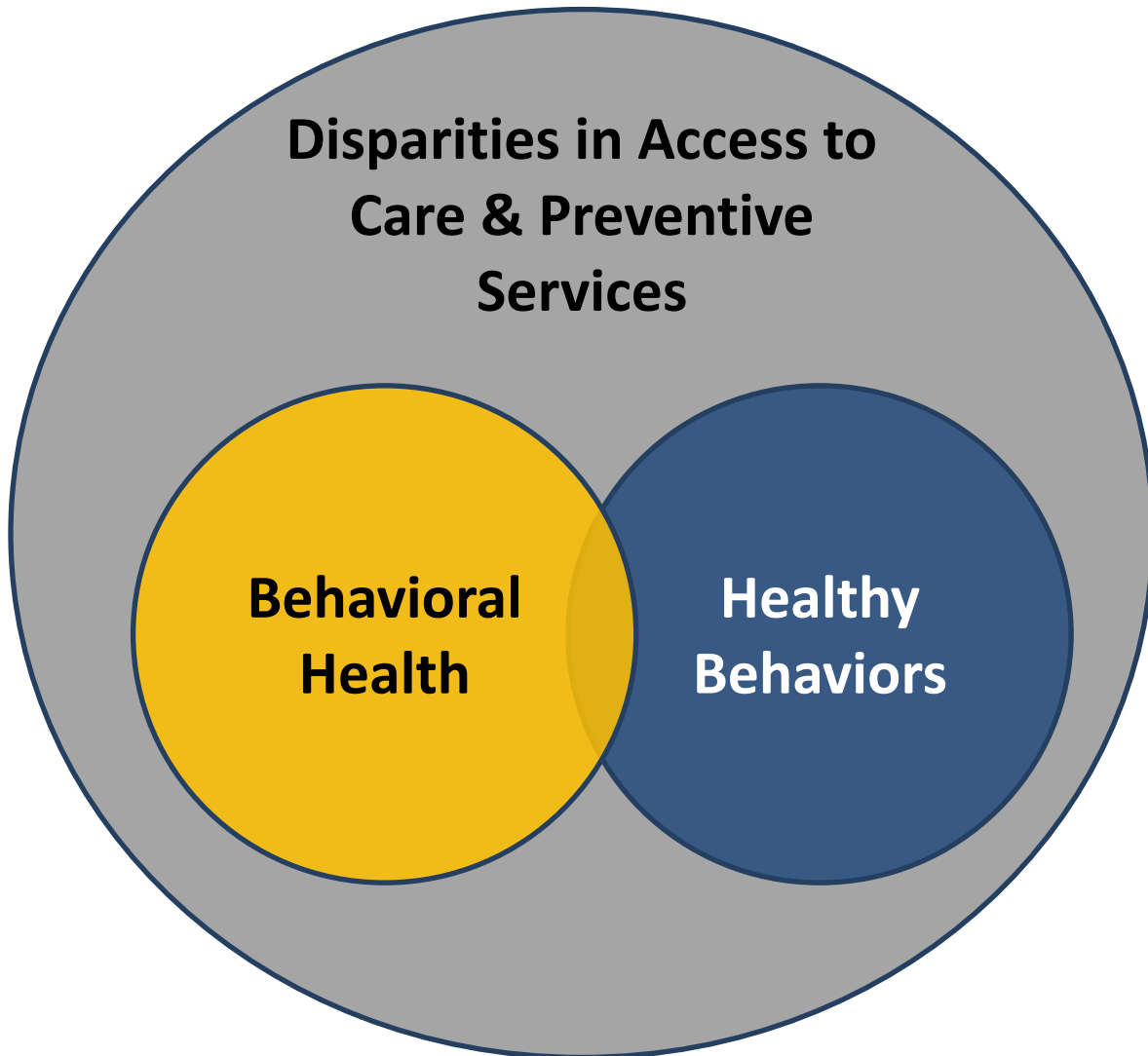


Figure 2. System-wide Priority Health Needs

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 drinking¹ (15.4%) and heavy drinking² (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.

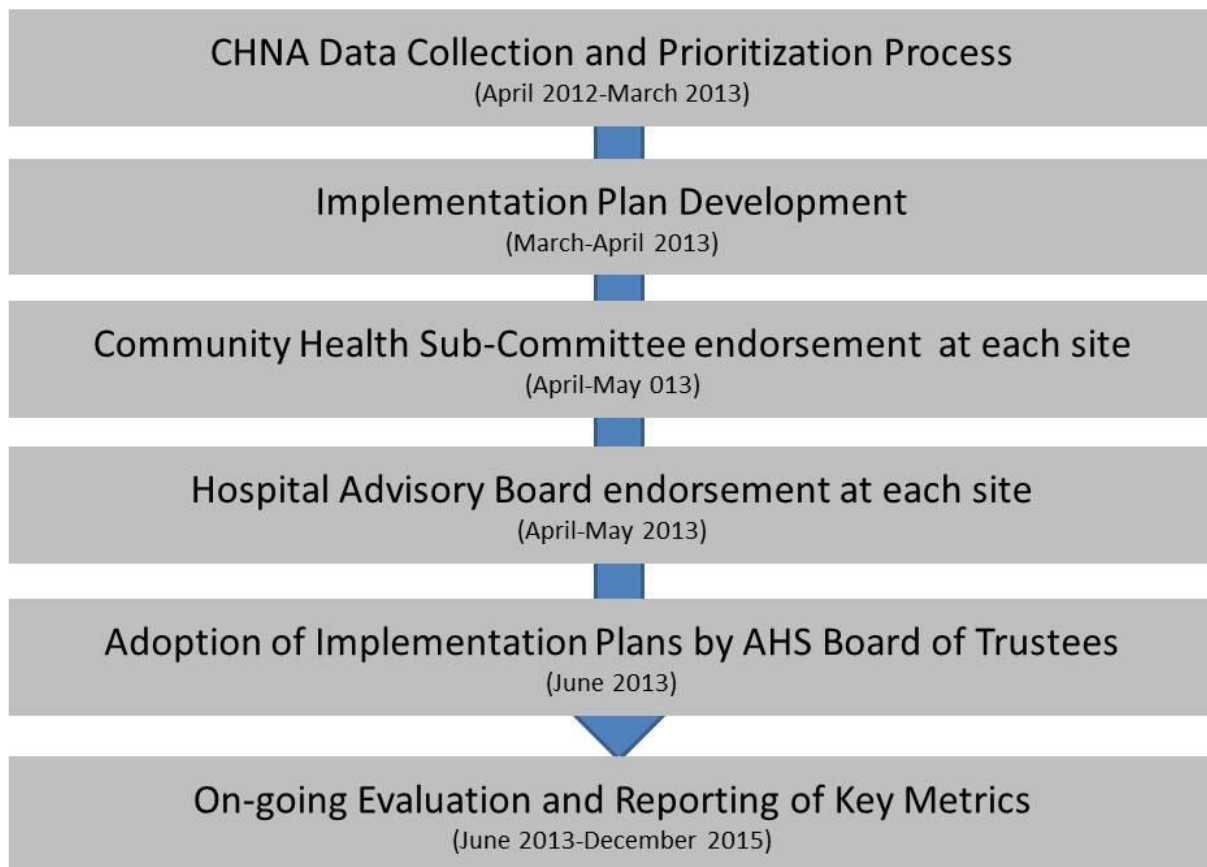


Figure 3. Implementation Plan Process



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.

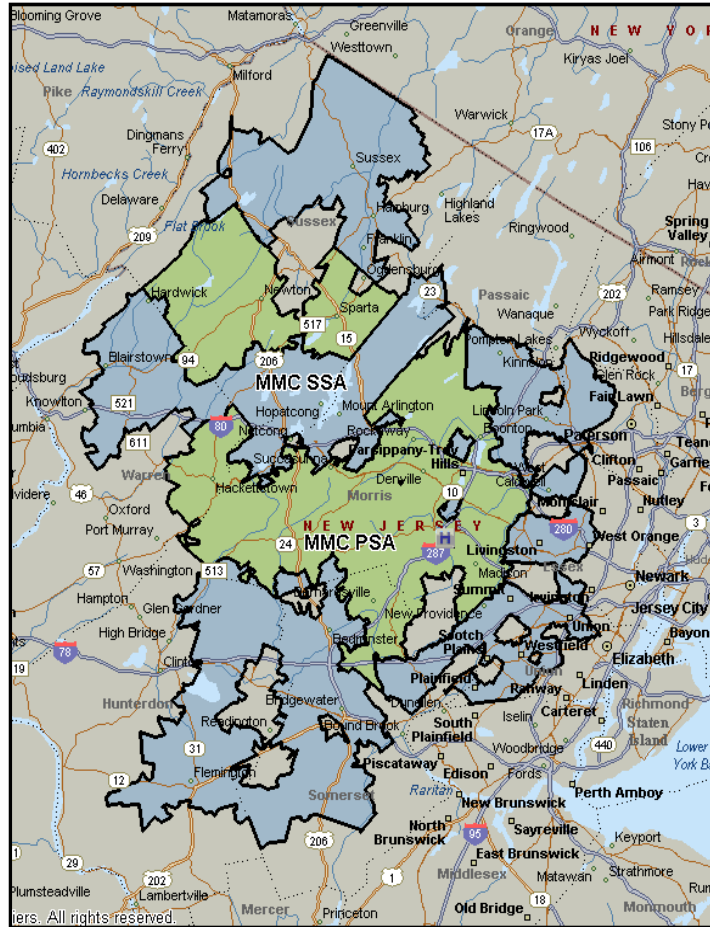
The population served by MMC is fairly affluent. Almost one in four (23.3%) households earns \$150,000 per year or more, with 13.7% earning \$250,000 or more each year. However, one in ten households (9.7%) subsists on less than \$25,000 each year and 40.2% earned less than \$75,000.

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 area¹ 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 Center¹

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 disproportionately 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 <u>resource card</u> 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		

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 pharmacists 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		

¹Kessler 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
<p>One in five residents reported no daily consumption of vegetables.</p> <p>14.9% of residents reported physical inactivity</p> <p>These numbers were higher for lower-income (<\$75K annual household income) and Hispanic/Latino populations</p> <p>New Jersey has one of the highest rates of obesity in low-income children ages 2 to 5¹</p>	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	<p>Reduce childhood obesity in lower income and Hispanic/Latino children by 10%</p>
	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%	<p>Increase participating child care providers nutrition guidelines by 25%</p> <p>Increase participating child care providers with 1 hour or more physical activity by 25%</p>	
	Support environmental change initiatives	Support the creation of parks and Complete Streets.	MMC Community Health, Morris County Park Commission, Morris Area Wellness Partnership	2015 Q4	Complete 2 projects	<p>Decrease physical inactivity in lower-income adult population by 5%</p> <p>Decrease physical inactivity in lower-income adult population by 10%</p>	

¹National Center for Chronic Disease Prevention and Health Promotion

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