Atlantic Health System

Community Health Needs Assessment 2013

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

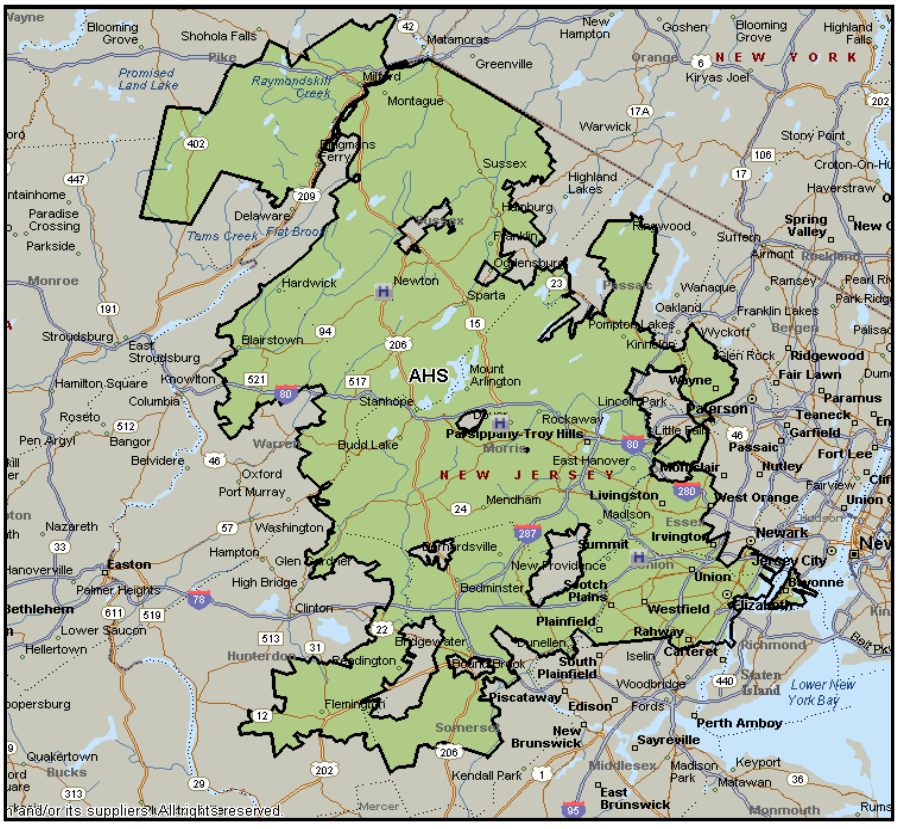
Atlantic Health System (AHS) is a comprehensive health care system serving a population of approximately 1.7 million residents. As shown in Map 1, the area served by the three AHS hospitals (Morristown Medical Center, Overlook Medical Center, Newton Medical Center) spans from urban centers near New York 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**

Overlook Medical Center
ATLANTIC HEALTH SYSTEM

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.

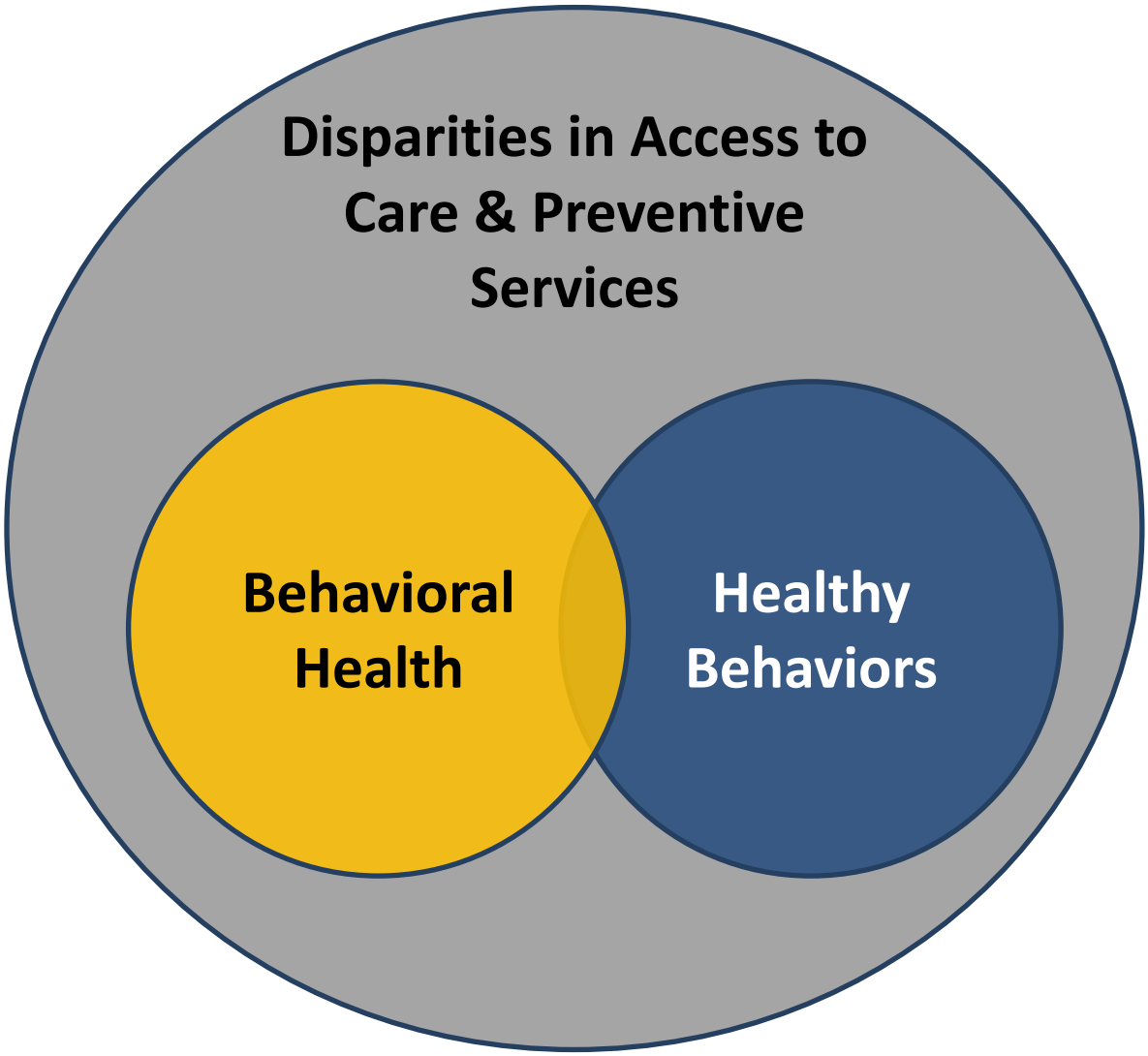


Figure 2. **System-wide Priority Health Needs**

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.

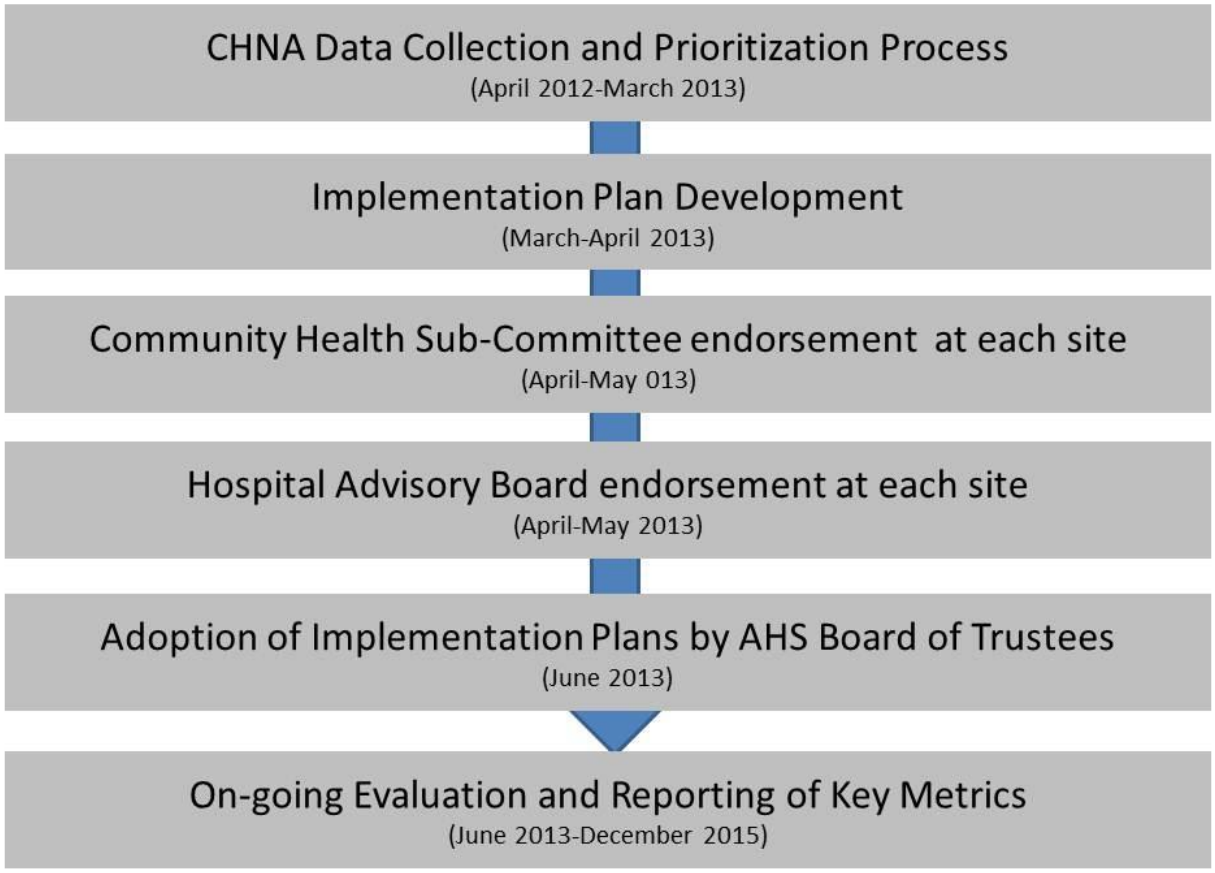
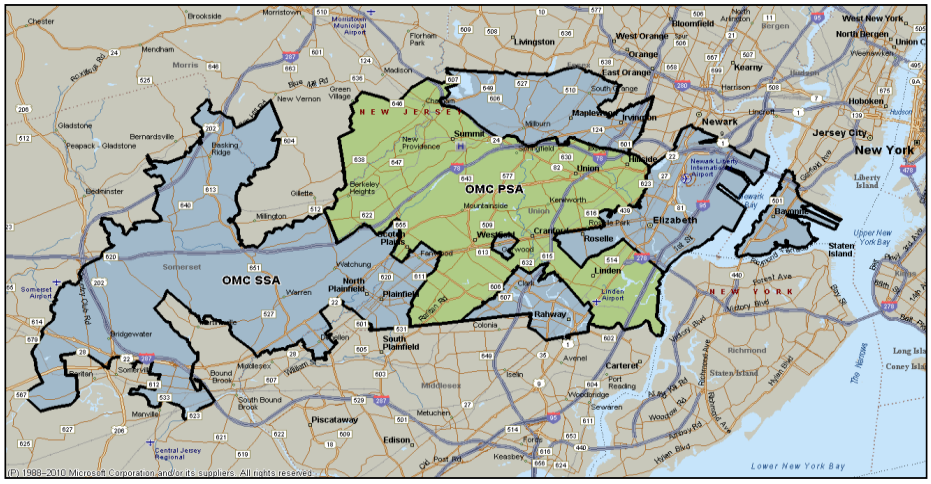


Figure 3. Implementation Plan Process

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 2. **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.

Procedures & 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 3

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 4

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 5

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 6

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 7

Implementation Plan: Behavioral Health- Seniors

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 8

Implementation Plan: Behavioral Health- Resilience

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 9

Implementation Plan: Physical Activity and Nutrition

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 10

Implementation Plan: Access to Care and Preventive Services

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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