Valley Hospital Implementation Plan 2020-2022

Improve health status through education and screening for chronic diseases: Cardiovascular, Cerebrovascular, Diabetes, Cancer, Cognitive Decline/ Dementia and other needs as identified.

Identify an individual's risk for developing cardiovascular disease.

- Provide free heart risk assessments assessing for gender specific and emerging risk factors. ***750 people***
- Provide on-site cardiac education and screening to the black/African American community. ** ***3-5 programs***
- Identify people at risk for stroke by offering comprehensive community stroke screenings. ***6 events/ 450 people***

Explore evidence-based practices to identify people (who are not aware) of their risk for pre-diabetes and diabetes.

- Increase free screening opportunities for pre-diabetes, diabetes and cholesterol. ***300 people***
- Invite screening participants to join pre-diabetes lifestyle classes. ***60% of participants will lower A1C, 50% will lower cholesterol***
- Provide Diabetes Self-Management Program to individuals with diabetes diagnosis. ***80% of participants lower their A1C after 6 months***

Increase and maintain mammography screening rates above HEDIS benchmark for primary care patient population.

- Identify patients with existing orders, utilize payer claims data, host screening events. ***Increase 1% a year to achieve 75th percentile***

Provide health education classes, participate in community events and presentations

- Offer monthly programs on various aspects of all chronic diseases. ***70% attendees express intent to change behavior***
- Fulfill requests for Community Speaker's Bureau programs on chronic diseases. ***Fulfill at least 100 program requests***

Assist individuals with chronic disease to maintain their functional status.

- Continue to offer Transitions in Care program. ***Maintain 30-day readmission rate-Transition's patients below 10%, from TVH to below National Average***
- Offer Delay the Disease program through Lifestyles. ***TBD.***

Increase awareness of end of life decision making and completion of advance directives

- Educate about end of life decision making and completion of advanced directives. ***15 programs***

Promote mental health and prevent substance abuse: Depression, Anxiety, Stress, Isolation, Access to Care, Stigma, Opioids, Vaping/ smoking.

Provide community awareness and education on common mental health issues, and intervention and referral options and on medication safety, drug awareness, vaping and smoking

- Provide behavioral health support groups focused on promoting positive mental health. ***4,000 people***
- Host special education events on relevant topics. ***5 events***
- Continue to meet the requests from first responders and municipal alliances for narcan and drug abuse training. ***300 people***
- Continue smoking and vaping cessation programs. Of people who completed the program, 50% remain smoke free after 6 weeks. ***Vaping 20 programs***

Improve mental health and medical outcomes for VMG adult patients (age 18+) for depression

- Screen all new Community Care patients and current patients annually. ***Baseline 95% of new patients and 90% follow up. 3 year impact, 1% each year for both goals***
- Screen all VMG adult patients (age 18+) for depression. ***87% of patients***
- Pilot mental health services program through partnership with Ramapo Ridge at VMG locations. ***TBD***

Increase access to care for underserved populations

Become HRC HEI Certified for the LGBTQ community

- Address deficiencies identified during the initial analysis. ** ***100% score***

Continue to offer a community care clinic

- Continue to offer primary and specialty care at no cost to children and adults who are covered by Medicare, Medicaid and Charity Care. ** ***7,000 patient visits annually***

Assist patients in identifying programs to address healthcare costs

- Improve patient access to cancer treatment through monitoring the patient's therapy, insurance coverage, liability and need for assistance.** ***Increase number of patients supported by 5%***

Increase access to care for underserved populations

- Continue to provide research and counseling on medication assistance programs ** ***5% increase in patient savings***

Provide health education and screenings targeting ethnically underserved populations

- Work with area religious organizations to plan and implement programming targeting identified health needs. ** ***15 programs***
- Partner with CEED to provide PSA screenings targeting underserved populations. ** ***50-75 people***
- Continue to provide mammography screening and PAP tests in partnership with CEED. ** ***300 screenings/ tests***

Improve and/ or prevent chronic disease by teaching and provide access to healthy lifestyle habits such as nutrition and exercise.

Increase nutrition education

- Work with area schools to provide healthy eating education. ***50 classes***
- Continue breastfeeding classes, breastfeeding support groups and lactation classes to provide continuity of care and have moms increase exclusive breastfeeding rates. ***10% increase in attendees***
- Work with Community Meals, Inc. program by supplying healthy meals.** ***22,000 meals annually***

Increase opportunities for exercise

- Partner with local library to continue walking program. ***7,000 miles walked, % of people who increase their daily exercise.***
- Begin walking program for young moms. ***20-30 new moms, % of people who increased their daily exercise***
- Continue to educate the community on falls, arthritis, osteoporosis and joint replacement. ***75 programs***

Build community while promoting health

- Hold weekly "Walk with a Doc" to encourage exercise and provide health education. ***TBD***

Encourage healthy community initiatives

- Continue community weight loss challenges in 2 communities. ***2,000 lbs. lost, 35% participants reduction in A1C***
- Work with community partners to establish a Paramus Healthy Coalition. ***TBD***

Increase flu vaccination rate

- Vaccinate community care pediatric patients (6 months - 17 years) ***82% annually***
- crease access by adding ability to bill insurances. ***TBD***

** Indicate Social Determinant of Health

Bold indicates 3-year impact unless otherwise noted