Community Health Implementation Plan 2023-2025

Valley Health System

Valley Health System is made up of Valley Hospital, Valley Home Care, and Valley Medical Group. Valley Health System serves the communities of northern New Jersey and southern New York. We're committed to keeping communities healthy through our comprehensive inpatient and outpatient programs, highly skilled home care services, community-based medical practices and wellness programs, and collaborations with some of the world's leading healthcare organizations.

We are also dedicated to providing inclusive, respectful care for everyone in our community. Initiatives such as our Social Equality Council, our LGBTQ inclusive care, and our Spiritual Care services guide our efforts to meet patients' diverse needs.

CHNA Background

In alignment with the Affordable Care Act (ACA), the Internal Revenue Service (IRS) and applicable federal requirements for not-for-profit hospitals, Valley Health System completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Valley Health System Board of Trustees on December 21, 2022.

Valley Health System 2022 CHNA was conducted by Professional Research Consultants, Inc. (PRC). While a specific CHNA was created for Valley Health System and its specific service area, Valley Health System's CHNA was conducted in partnership with the Community Health Improvement Partnership of Bergen County, a collaboration of all of the hospitals and the County Health Department serving Bergen County, New Jersey.

The assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey) and qualitative research including focus groups, key informant interviews, as well as a review of secondary data including vital statistics and other existing health indicators). The complete CHNA report can be found on the Valley Health System www.ValleyHealth.com. Included in the assessment of health indicators was an examination of the social determinants of health (SDoH) such as food insecurity, housing, transportation, education, and other factors. Furthermore, information and data learned about inequities in opportunity, access, education, and trust revealed by COVID-19 were also taken into consideration.

Community Health Implementation Plan (CHIP)

The intent of our CHIP is to respond to our community needs and expectations with an implementation plan that can be effectively executed leveraging hospital and network resources, as well as community partners.

The implementation plan is an iterative plan and should be modified as internal and external factors change, including emerging needs, availability of resources, partnerships and policies. An implementation plan should build on and leverage prior success while simultaneously adjusting strategies and actions as obstacles are encountered.

Determining Community Health Priorities

In reviewing the data from the 2022 CHNA, it is evident that the priorities previously identified in the 2019 assessment continue to be pressing needs but are now further complicated by the impact of the COVID-19 pandemic. Existing inequities in opportunity, access, and education were exacerbated by the pandemic. The inequities highlighted by the pandemic elevated health equity as a lens to be prioritized and more closely addressed in the 2022-2025 planning effort.

As part of the Community Health Improvement Partnership of Bergen County collaborative 2022 CHNA process, on October 19, 2022, Valley Health System and its partners conducted a virtual community forum with hospital representatives and key community stakeholders. During the forum, an overview of the CHNA findings was shared, followed by breakout groups to discuss and determine priority health needs. Seventy-eight people representing social agencies and institutions throughout Bergen County participated and provided diverse perspectives. The goals were reviewed with the common understanding that the social determinants of health (SDoH) have an impact on every identified area and should be incorporated throughout the complete strategic framework.

There was overwhelming support for the strategy, and ultimately participants endorsed the priority areas for 2023-2025 as **Healthy Minds, Healthy Bodies, Building Bridges**. The following graphic depicts Valley Health System's programmatic strategies and interventions, which guided the development of the implementation plan.

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The connection between our communities and our health

By focusing on removing barriers and creating vital resource connections, we can work towards building communities where all people have access to choices and tools to live their healthiest lives. One step in this process of advancing health equity is to identify and address disparities in the Social Drivers of Health.

EQUALITY:
Everyone gets the same – regardless if it's needed or right for them.

EQUITY:
Everyone gets what they need – understanding the barriers, circumstances, and conditions.

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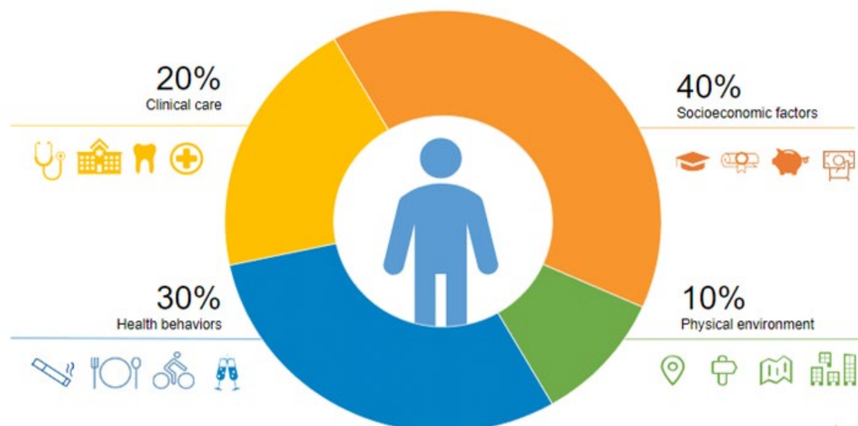
Social Drivers of Health

Social drivers of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health and quality of life outcomes. SDoH are grouped into five domains that include factors such as access to health care, safe neighborhoods, transportation options, nutritious food, and quality education. The quality and availability of these elements impact the array of healthy living choices and can be measured in rates of disease and length of life. Addressing social determinants of health is a primary approach to achieving health equity.

WHAT MAKES US HEALTHY?



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Source: Centers for Disease Control

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Priority Area: Healthy Minds

The 2022 CHNA for Valley Health System identified the following sub-priorities within the Healthy Minds priority area. Sub-priorities were determined based on areas of opportunity uncovered through the CHNA process.

Key factors:

- “Fair/Poor” Mental Health
- Diagnosed Depression
- Symptoms of Chronic Depression
- Stress
- Receiving Treatment for Mental Health
- Difficulty Obtaining Mental Health Services
- *Cirrhosis/Liver Disease Deaths
- Unintentional Drug-Related Deaths
- *Use of Marijuana
- Sought Help for Alcohol/Drug Issues
- Key Informants: Substance Abuse rated as a top concern
- Key Informants: Mental Health ranked as a top concern

Goal: All people will have access to resources needed to address mental and behavioral issues

Objectives

1. Provide behavioral health and substance abuse education resources
2. Establish appropriate treatment and level of care for all behavioral health referrals
3. Explore, strengthen and expand partnerships with community-based organizations to offer appropriate continuum of care for adult and pediatric patients

Strategies

- Expand access to information, education, resources, and services to diverse and vulnerable populations.
- Provide trainings, outreach, and education to diverse and vulnerable audiences
- Provide Tobacco Cessation programs, patches included, free of charge
- Use established triage and referral algorithm (for adults and pediatrics) which connects patients for the appropriate level of care
- Avoid medications, if possible, by utilizing psychosocial interventions, assessing SDoH, and when medication is necessary limit to monotherapy

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Priority Area: Healthy Bodies

The 2022 CHNA for Valley Health System identified the following sub-priorities within the Healthy Bodies priority area. Sub-priorities were determined based on areas of opportunity uncovered through the CHNA process.

Key factors:

- Cancer
- Diabetes
- Heart Disease and Stroke
- Tobacco Use
- *Injury and Violence
- Nutrition, Physical Activity and Weight
- Potentially Disabling Conditions
- Respiratory Disease

Goal: All people have access to the resources needed to prevent, screen, and treat disease to achieve their best life

Objectives

1. Provide education and health promotion activities and increase participation among diverse and vulnerable populations
2. Continue to engage, monitor, and coordinate care for patients with chronic/complex conditions
3. Explore, strengthen and expand partnerships with community-based organizations

Strategies

- Provide health education classes, participate in community events on various aspects of all chronic diseases.
- Conduct free screenings for pre-diabetes, diabetes and cholesterol along with education and invite participants to join pre-diabetes lifestyle class
- Leverage utilization of SDOH in the diabetic population to increase participation in chronic disease management programs.
- Conduct cancer education and/or screenings focusing on colorectal, prostate, cervical, ovarian and uterine. Will include walks, educational events, screening where appropriate, with special attention to the racial disparities.
- Increase stroke education and the importance of getting to the hospital quickly.
- Utilize metrics to identify birthing mothers with hypertension/ pre-eclampsia at risk of a cardiac episode post partem.
- Refer heart risk assessment patients to cardiologists for follow up care.
- Take findings from the Food Pharmacy pilot program to increase access to healthy food for the diabetic population.
- Conduct a baseline self-assessment to dismantle systemic racism using the Racial Equity in Healthcare Progress Report
- Respond to requests for information and collaboration from diverse organizations

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Priority Area: Building Bridges

The 2022 CHNA for Valley Health System identified the following sub-priorities within the Building Bridges priority area. Sub-priorities were determined based on areas of opportunity uncovered through the CHNA process.

Key factors:

- Inconvenient Office Hours
- Appointment Availability
- Finding a Physician
- *Lack of Transportation
- Routine Medical Care (Children)
- *Emergency Room Utilization

Goal: Achieve whole, healthy communities through availability and coordination of healthy living services and resources for all people

Objectives

1. Promote utilization of community care clinic
2. Respond to requests for financial support from community organizations
3. Provide inclusive health education with special attention to the Latino, Black and LGBTQ populations.
4. Use SDoH metrics to determine patient barriers to accessing care and maintaining healthy behaviors
5. Strengthen cultural competency training for team members and physicians
6. Reduce common barriers to care
7. Embrace opportunities for collaborative action with diverse community partners
8. Expand Public Health commitments in the community

Strategies

- Create awareness for community care clinic using various educational and marketing vehicles with focus on diverse and vulnerable populations.
- Continue to promote Valley's Community Foundation Grants.
- Leverage community partners to connect with diverse and vulnerable populations
- Provide support and training for REaL and SOGI data collection tools, methods, usage
- Maintain HRC HEI Certification for LGBTQ Community
- Increase implicit bias and cultural competency training amongst all team members
- Explore best practice options to increase appointment availability and hours of operation
- Provide health insurance enrollment and assistance and financial assistance with treatment costs
- Seek opportunities to provide support for other agencies serving the same geographic area
- Collaborate with NW Bergen Health Commission.

*Key Factors Valley Health System Defers to Community Leadership

Valley Health System acknowledges the wide range of issues that emerged from the CHNA process and determined it could effectively focus on those health needs which are the most pressing, under-addressed, and within its ability to influence. Valley Health System will continue to lead efforts in support of the prioritized needs related to Healthy Minds, Healthy Bodies, and Building Bridges. Valley Health System will collaborate with our community partners, where possible, in addressing key contributing factors outside of the clinical expertise and scope of the organization. Specific examples of these key contributing factors are marked with an *asterisk. These factors include, Injury and Violence, Use of Marijuana, Cirrhosis/Liver Disease Deaths, Lack of Transportation, Emergency Room Utilization. Valley Health System remains open and willing to explore opportunities and partnerships across our service area to address issues impacting health and wellbeing.

Alignment with New Jersey State Health Improvement Plan

Health needs identified in the CHNA research were confirmed by community stakeholders and refined through collaborative discussion. Local concerns were then aligned with the statewide health priorities in the **New Jersey State Health Improvement Plan (2020)**. This approach ensures priority areas reflect local concerns and community-generated strategies for action while establishing a connection to statewide initiatives. The table below shows the identified health needs in the New Jersey State Health Improvement Plan and the alignment of these issues with priorities with Valley Health priorities.

New Jersey State Health Improvement Plan Priorities
Health Equity
Mental Health and Substance Use
Nutrition, Physical Activity and Chronic Disease
Immunizations
Birth Outcomes
Alignment of State and Local Health Improvement Planning

Valley Health System Priorities	
Equity Informed Approach	Enhance competency / health equity commitment to patients and community and increase communication on this topic.
Healthy Minds	All people will have access to resources needed to address mental and behavioral issues.
Healthy Bodies	All people have access to the resources needed to prevent, screen, and treat disease to achieve their best life.
Building Bridges	Achieve whole, healthy communities through availability and coordination of healthy living services and resources for all people.

Next Steps

Community health improvement requires collaboration among community-based organizations, policy makers, funders, and many other partners. Valley Health System's Community Health Improvement Plan is an active document, designed to serve as a guide to engage community partners towards collective impact, and to measure progress. Valley Health System invites opportunities to advance health equity for all. For more information about Valley Health System's Community Health Implementation Plan and community benefit activities, or to get involved, please visit our website https://www.ValleyHealth.com/services/community-health

Our Research Partners:

A New Jersey certified Small Business Enterprise (SBE) and Women-owned Business Enterprise (WBE), 35th Street Consulting specializes in transforming data into action that advances health and social equity through practical and impactful strategies. Our interdisciplinary team of community development experts, health planners, researchers, and data analysts have worked with hundreds of healthcare providers, payors, public health departments, government agencies, health and human service providers, and other community-based organizations to direct action and funding to reimagine policies and achieve realistic, measurable social impact.

We use quantitative and qualitative research methods to conduct studies and develop solutions to address community health, housing, socioeconomic disparities, capacity-building, population health management, and similar challenges. We specialize in transforming research into action through strategic planning, policy change, and collective impact.

Professional Research Consultants (PRC) is a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.