COMMUNITY HEALTH NEEDS ASSESSMENT

2018 Final Summary Report

Hackensack Meridian *Health*
Mountainside Medical Center

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In 2018, Hackensack Meridian *Health* Mountainside Medical Center undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area within Essex County in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing county residents. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

The completion of the CHNA enabled Mountainside Medical Center to take an in-depth look at its community. The findings from the assessment were utilized by Mountainside Medical Center to prioritize public health issues and develop a community health implementation plan focused on meeting community needs. Mountainside Medical Center is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs and an overall enhanced quality of life. This CHNA Final Summary Report serves as a compilation of the overall findings of each research component.

CHNA Components

- Secondary Data Research
- Key Informant Interviews
- Prioritization Session
- Implementation Plan

Key Community Health Issues

Mountainside Medical Center, in conjunction with community partners, examined the findings of the Secondary Data and Key Informant Interviews to select Key Community Health Issues. The following priorities (presented in alphabetical order) that were identified include:

- Access to Care
- Diabetes
- Heart Disease
- Mental Health
- Obesity

Prioritized Community Health Issues

Based on feedback from community partners, including health care providers, public health experts, health and human service agencies, and other community representatives, Mountainside Medical Center plans to focus community health improvement efforts on the following health priorities over the next three-year cycle:

- Chronic Disease Management
- Mental Health

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Organization Overview

Driven by its mission to care for, cure and nurture the sick and injured, Hackensack Meridian *Health* Mountainside Medical Center has delivered exceptional and compassionate patient care for Montclair and its surrounding New Jersey communities since 1891. The medical center has successfully transitioned from a stand-alone facility to being part of Hackensack Meridian *Health*, a leading not-for-profit health care organization that is the most comprehensive and truly integrated network in the state of New Jersey. The medical center is a joint venture between Hackensack Meridian Health and Ardent Health Services, one of the country's leading private hospital management companies.

Mountainside Medical Center operates 365 hospital beds and is staffed by world-class physicians. The medical center offers a wide array of medical services and programs ranging from its state-of-the-art emergency center to its nationally recognized weight-loss surgery program and its comprehensive cancer center. Mountainside Medical Center is designated as a Primary Stroke Center by the New Jersey State Department of Health and Senior Services. Honors include being listed as one of America's safest hospitals on Forbes.com. It has also been repeatedly recognized for outstanding customer satisfaction by Press Ganey – an organization that tracks customer satisfaction scores for hospitals.

Community Overview

Mountainside Medical Center defined its current service area based on an analysis of the geographic area where individuals utilizing its services reside. The primary service area included the following seven municipalities: Bloomfield Township, Montclair Township, Cedar Grove Township, Caldwell Borough, Nutley Township, Upper Montclair Township, and Glen Ridge Borough.

CHNA Purpose

The overall goal for Hackensack Meridian Health Mountainside Medical Center's CHNA is to gain detailed insight into the health status of the communities the medical center serves, including health assets, gaps, disparities and trends. This will allow Mountainside Medical Center to respond with the optimal mix of health and preventive services.

Summary of 2015 CHNA

In 2015, Mountainside Medical Center conducted a comprehensive community health needs assessment. After reviewing secondary source data, primary research and engaging in priority and plan development, the Steering Committee determined the Top 2 issues to be addressed in the 2015 Community Health Implementation Plan were:

1. Chronic Disease
2. Mental Health

The Committee members agreed that although these issues were highest priority, many lower ranked issues were interlaced and therefore would subsequently gain attention. Some issues, such as transportation and poverty, categorized as social determinants of health, were acknowledged but the members recognized they may be unable to impact these areas.

Since 2015, Mountainside Medical Center has provided numerous community health programs and services, including prevention, education, and wellness screenings. For a detailed list of activities and outcomes included in the Evaluation of Impact, see Appendix G.

Public Commentary on the 2015 CHNA

Mountainside Medical Center sought feedback on the previous 2015 CHNA by providing contact information on Medical Center's website. No written comments were received regarding the FY2015 CHNA.

Methodology

The CHNA was comprised of both quantitative and qualitative research components. A brief synopsis of the research components is included below with further details provided throughout the document:

- A Statistical Secondary Data Profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates, and other health statistics for Essex County, New Jersey was compiled.

- Key Informant Surveys were conducted with 23 community leaders and partners in November 2018. Key informants represented a variety of sectors, including public health and medical services, non-profit and social organizations, public schools, and the business community.

Community Representation

Community engagement and feedback were an integral part of the CHNA process. Mountainside Medical Center sought community input through an online key informant survey with community leaders and partners, and inclusion of community leaders in the prioritization and implementation planning process. Public health and health care professionals shared knowledge and expertise about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

Timeline and other restrictions may have impacted the ability to survey all community stakeholders. Mountainside Medical Center sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, Mountainside Medical Center prioritized community health issues and will develop an implementation plan to address prioritized community needs.

Questions regarding the 2018 Community Health Needs Assessment should be directed to Grettel Muscato, Director of Community Services and Volunteers at Grettel.Muscato@mountainsidehosp.com

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990 Schedule H, the following table cross-references related sections.

IRS Form 990, Schedule H	See Report Page(s)
Part V Section B Line 3a *A definition of the community served by the hospital facility*	4
Part V Section B Line 3b *Demographics of the community*	6 – 7
Part V Section B Line 3c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	33
Part V Section B Line 3d *How data was obtained*	5
Part V Section B Line 3e *The significant health needs of the community*	19
Part V Section B Line 3f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 3g *The process of identifying and prioritizing community health needs and services to meet the community health need*	19
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	29
Part V Section B Line 3i *Information gaps that limit the hospital facility's ability to assess the community's health needs*	5

SECONDARY DATA PROFILE OVERVIEW

Background

One of the initial undertakings of the CHNA was to create a Secondary Data Profile. Secondary data is comprised of data obtained from existing resources and includes demographic and household statistics, education and income measures, morbidity and mortality rates, and health indicators, among other data points. The data was gathered and integrated into a graphical report to portray the current health and socio-economic status of residents in Essex County.

Secondary data was collected from reputable sources, including the U.S. Census Bureau, Centers for Disease Control and Prevention (CDC), and New Jersey State Department of Health. A full reference list is included in Appendix A. The data represents a point in time study using the most recent data possible. When available, state and national comparisons are provided as benchmarks.

The profile details data covering the following areas:

- Demographic/Socioeconomic Statistics
- Mortality & Morbidity Statistics
- Maternal & Child Health Statistics
- Sexually Transmitted Illness & Communicable Disease Statistics
- Mental Health Statistics
- Environmental Health

Secondary Data Profile Key Findings

The following section highlights the key takeaways from the Secondary Data Profile. A full report of the findings is available through Mountainside Medical Center.

Demographic Statistics

According to U.S. Census Bureau 2012-2016 estimates, the total population in the primary service area (PSA) is 160,811, an increase of 5.90% since 2010. The vast majority of residents identify their race as White (73.4%), which closely mirrors that of the state's and the nation's racial makeup.

The racial breakdown of the primary service area provides a foundation for primary language statistics. Three-fourths of residents speak English as their primary language. As shown in Figure 1, the percentage of the population who speak a language other than English is lower in the primary service area when compared to the state, but is slightly higher than the nation.

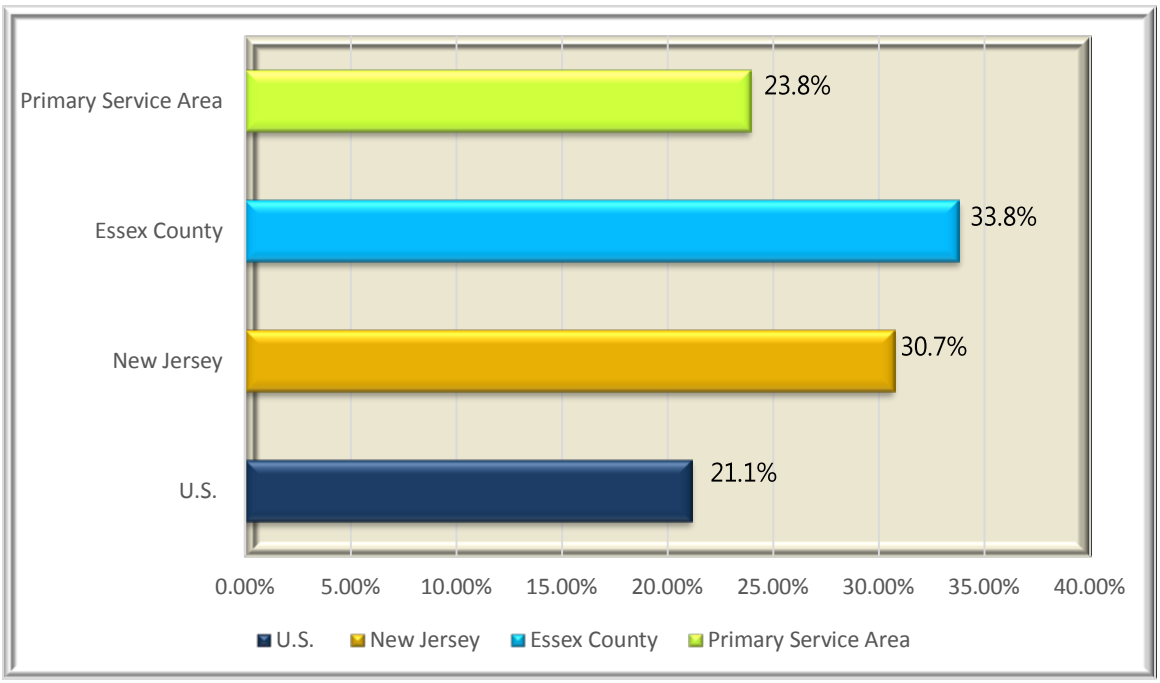


Figure 1. Percentage of population speaking a language other than English at home, 2012 – 2016

The median age in the primary service area is 41.9, indicating a slightly older population when compared to the state and the nation (40 and 37.7 respectively). In regard to marital status, residents in the primary service area, ages 15 years and over, are less likely to be separated or divorced when compared to residents across New Jersey and the nation.

Table 1. Marital Status, 15 Years and Over (2012 - 2016)

	U.S.	New Jersey	Essex County	Primary Service Area
Never married	36.2%	37.5%	45.3%	35.0%
Now married, except separated	49.8%	51.6%	42.4%	55.4%
Separated	1.8%	1.6%	2.8%	1.3%
Widowed	2.6%	2.6%	2.5%	2.8%
Divorced	9.6%	8.5%	8.7%	8.0%

Source: American Community Survey 5-Year Estimates (2012 - 2016)

The median home value in the PSA ($489,414) is significantly higher than the median value across the state ($356,300) and the national median value ($184,700). The proportion of home owners spending more than 35% of their income on housing is higher in the service area (38.1%) when compared to New Jersey (30.7%) and especially the nation (23.3%).

The average cost to rent a household in the service area ($1,404) is higher than New Jersey ($1,213) and the nation ($949). However, the percentage of renters spending more than 35% of their income on housing (36.4%) is notably lower when compared to New Jersey (44.1%) and the nation (42.0%).

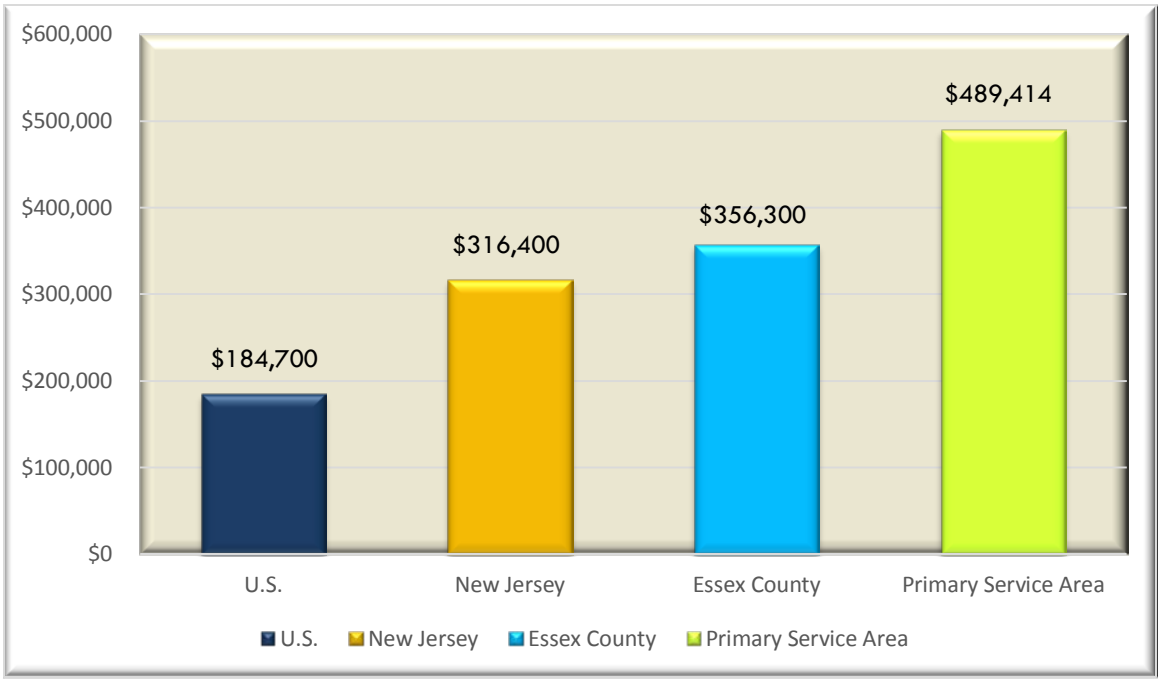


Figure 2. Median value for owner-occupied units, 2012 – 2016

The median income for households and families in the primary service area ($117,700 and $143,903 respectively) is notably higher than across all of New Jersey ($73,702; $101,634) and the nation ($55,322; $77,866). However, when comparing male and female earnings for full-time, year-round workers, the gap in the median earnings for men and women in the primary service area is notably higher than the gap in the state and the nation. The difference is highlighted in Figure 3 below.

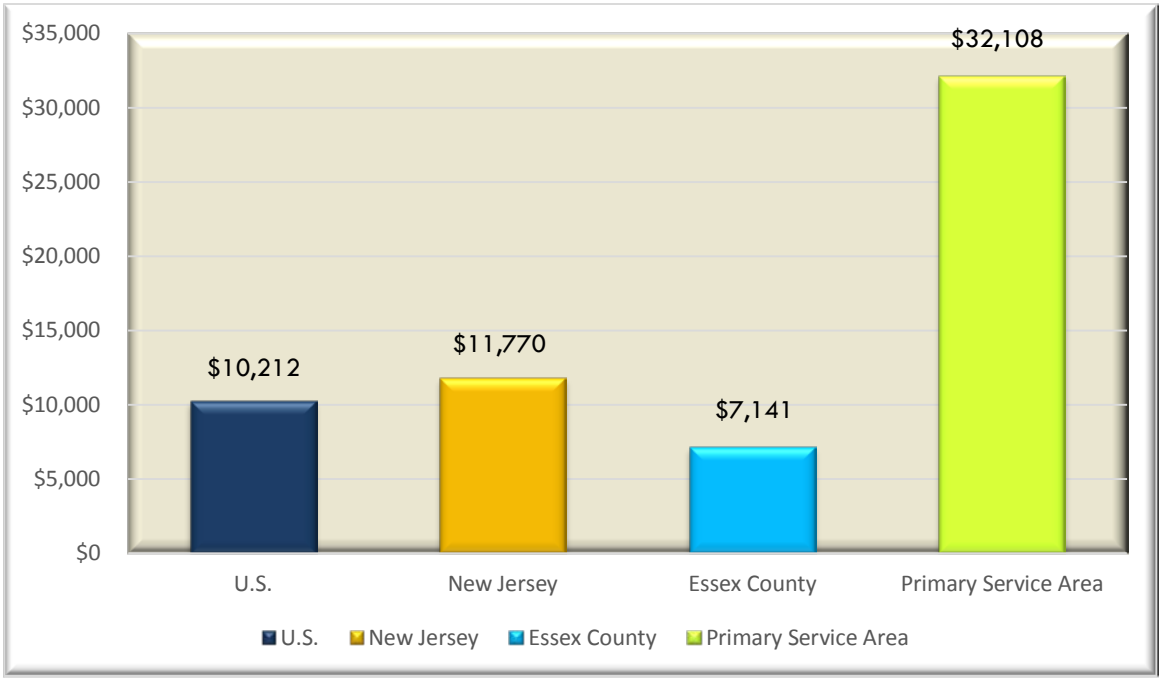


Figure 3. Median income earning gender gap, 2012 - 2016

Residents in the primary service area are less likely to live below the poverty level when compared to residents across New Jersey and the nation. In the primary service area, only 4.3% of all families and 5.6% of all people live below the poverty level, compared to 8.1% and 10.9% respectively in New Jersey and 11.0% and 15.1% respectively in the U.S. In addition, the percentage of female-headed households living below the poverty level is substantially lower in the service area than in New Jersey and the nation.

A lower percentage of households in the primary service area received food stamp/SNAP benefits in the past 12 months (4.2%) when compared to the state (9.3%) and the nation (13.0%).

Table 2. Households with Supplemental Benefits in the Past 12 Months (2012 - 2016)

	U.S.	New Jersey	Essex County	Primary Service Area
Households with supplemental security income	6,355,071	142,057	19,279	1,587
Mean supplemental security income	$9,523	$9,924	$9,534	$8,302
Households with cash public assistance income	3,147,577	83,478	14,810	891
Mean cash public assistance income	$3,336	$3,568	$3,182	$2,106
Households with food stamp/SNAP benefits in the past 12 months	13.0%	9.3%	15.9%	4.2%

Source: American Community Survey 5-Year Estimates (2012-16)

According to the U.S. Census estimates (2012-16), the unemployment rate in the primary service area is 6.0%, and is slightly higher than both the state's (5.2%) and the nation's (4.7%) unemployment rate. Of the residents who are employed, the majority work in management, business, science, and arts and are private sector wage and salary workers. The average travel time to work for residents in the primary service area is 34.4 minutes.

Education is an important social determinant of health. It is well documented that individuals who are less educated tend to have poorer health outcomes. High school graduation rates and educational attainment rates for higher education in the primary service area are substantially higher than the state and nation. Approximately 94.4% of adults in the Primary Service Area have a high school diploma or higher degree while 57.8% have a bachelor's degree or higher. This is in comparison to New Jersey (88.9%; 37.5%) and the nation (87.0%; 30.3%).

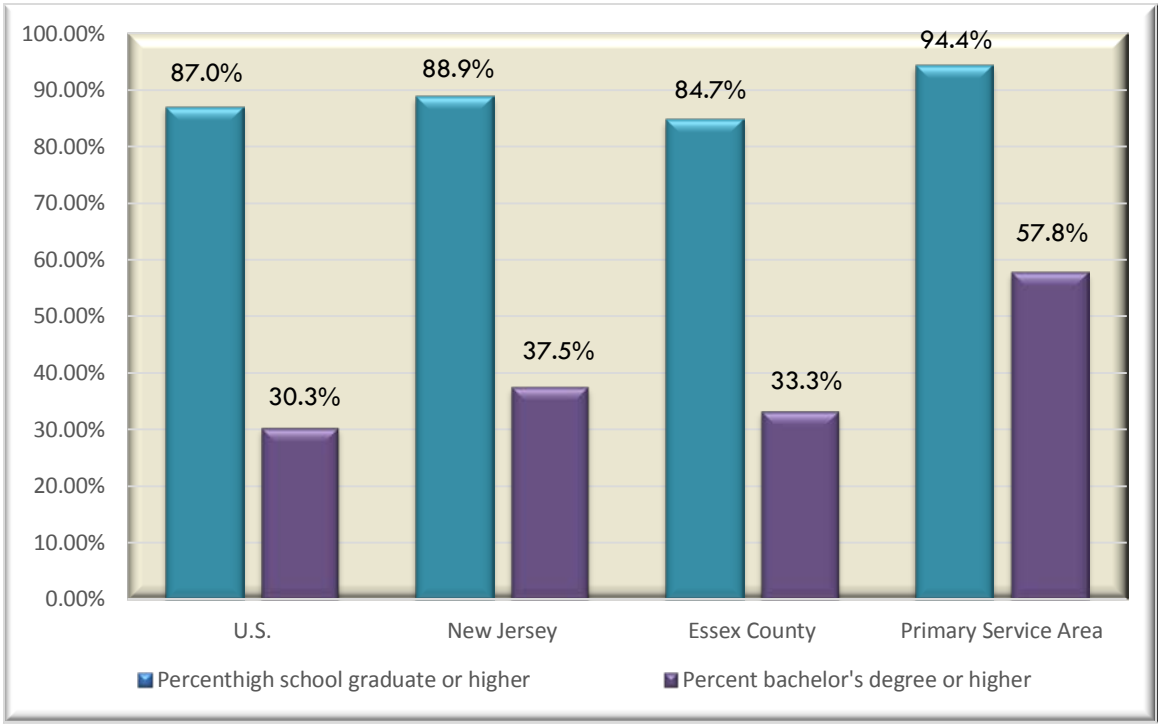


Figure 4. Educational attainment for population 25 years and older, 2012 - 2016

Health Insurance Coverage and Health Care Access

Health insurance coverage can have a significant influence on health outcomes. According to the U.S. Census Bureau (2012-16) estimates, the percentage of residents in the primary service area who have health insurance coverage (93.5%) is higher compared to New Jersey (89.3%) and the nation (88.3%).

Health Status Indicators

This section highlights existing health statistics on maternal and infant health as well as morbidity and mortality rates in the general population. However, data could not be found at the primary service area level. Therefore, comparisons have been provided at the county, state and national levels only for the remainder of the report.

Mortality Rates

The crude death rate for all causes per 100,000 is lower in Essex County (706.2) than in New Jersey (818.6) and the nation (849.3). In 2016, heart disease was the leading cause of death in Essex County, New Jersey and the nation- followed by cancer.

Maternal and Child Health

In Essex County, the overall low birth weight percentage (9.7%) is higher than that of New Jersey (8.1%), the nation (8.2%), and the Healthy People 2020 goal (7.8%). Essex County's very low birth weight percentage (2.0%) is also higher when compared to the state and the nation and falls short of the Healthy People 2020 goal of 1.4%.

Another noteworthy indicator of maternal and child health is the proportion of mothers receiving prenatal care in the first trimester, and is notably lower in Essex County (63.5%) than in New Jersey (72.1%) and the Health People 2020 goal of 77.9%.

The teen birth rate among females aged 15-17 years per 1,000 population is notably higher in Essex County (10.1) when compared to New Jersey (6.0) and the nation (11.2).

Sexually Transmitted and Communicable Diseases

The incidence of Chlamydia cases per 100,000 is notably higher in Essex County (753.7) when compared to the state (392.0) and the nation (528.8).

Cancer Statistics

Cancer Incidence and Mortality Rate

Women in Essex County are slightly less likely to be diagnosed with breast cancer (133.5) when compared to their counterparts in New Jersey (134.9), however, they are more likely when compared to the nation (124.8).

The overall cancer mortality rate is lower for Essex County (151.4) than for New Jersey (149.7) and the nation (155.8).

Chronic Conditions Statistics

Residents in Essex County are slightly more likely to report having been diagnosed with Asthma (13.4%) when compared to their counterparts in New Jersey (12.2%).

The age-adjusted rate for hospitalization due to asthma is notably higher in Essex County (12.3) when compared to the state (7.3).

Chronic Conditions among Medicare Beneficiaries

Among Medicare beneficiaries aged 65 years and over, the three most common chronic conditions among Essex County beneficiaries are hypertensions, hyperlipidemia (elevated level of lipids or fats in the blood) and diabetes. Generally speaking, the percentage of Medicare beneficiaries in Essex County with a given chronic condition is slightly higher or equitable to the state and the nation.

In addition, among the beneficiaries, 26.0% had hospital readmissions for six or more chronic conditions in Essex County, which is slightly higher when compared to the state (23.24%) and the nation (22.78%).

County Health Rankings

- Residents in Essex County are more likely to die prematurely (7,103 per 100,000) when compared to residents in New Jersey and the National Benchmark (5,460 and 6,700 respectively).
- The percentage of residents who report having poor or fair health in general (21%) is higher in Essex County than that of New Jersey (17%) and the National Benchmark (16%).
- The proportion of Essex County adults who were obese (29%) and physically inactive (25%) is higher in Essex County than in New Jersey and the National Benchmark.
- Essex County adults received lower rankings compared to New Jersey and the National Benchmark for physical inactivity and obesity despite having better access to exercise opportunities. Twenty-nine percent of all Essex County adults are either obese and/or not exercising.
- The percentage of uninsured individuals aged 65 and younger is higher in Essex County (14%) compared to New Jersey (10%) and the National Benchmark (11%).
- In regards to social and economic factors, Essex County has a higher percentage of children living in poverty and a notably higher percentage of children in single-parent households when compared to the state and the National Benchmark.
- Violent crime rates were substantially higher in Essex County (681 per 100,000) when compared to New Jersey (280) and the National Benchmark (55).

KEY INFORMANT SURVEY

Background

A survey was conducted among area key informants. Key informants were defined as community stakeholders with expert knowledge, including public health and health care professionals, social service providers, non-profit leaders, business leaders, faith-based organizations, and other area authorities.

Mountainside Medical Center utilized a similar Key Informant Survey Tool from the medical center's previous CHNA. This allowed the medical center to compare results from the previous CHNA Key Informant Survey and identify changes in perceived health needs among key informants. A copy of the questionnaire can be found in Appendix B. The questionnaire focused on gathering qualitative feedback regarding perceptions of community needs and strengths across three key domains:

- Key Health Issues
- Health Care Access
- Challenges & Solutions

A total of 23 key informants completed the survey between November and December 2018. The largest percentage of informants were affiliated with non-profit/Social Services/Aging Services (47.8%), followed by "other" (21.7%). Key informants serve and represent Mountainside Medical Center's service areas, but over half of respondents represented Montclair Township.

It is important to note that the results reflect the perceptions of some community leaders, but may not necessarily represent all community representatives within the service area. See Appendix C for a listing of key informant participants. The following section provides a summary of the Key Informant Interviews including key themes and select comments.

Key Health Issues

The first section of the survey focused on the key health issues facing the community. Individuals were asked to select the top six health issues that they perceived as being the most significant.
The six issues that were most frequently selected were: Mental Health/Suicide, Access to Care/Uninsured, Substance Abuse/Alcohol Abuse, Diabetes, Heart Disease, and Obesity.

The following table shows the breakdown of the percent of respondents who selected each health issue. Issues are ranked from top to bottom based on number of participants who selected the health issue.

Table 1: Ranking of the Top Six Most Pressing Key Health Issues

Rank	Key Health Issue	Percent Of Respondents Who Selected The Issue
1	Mental Health / Suicide	74%
2	Access to Care / Uninsured	65%
3	Substance Abuse / Alcohol Abuse	65%
4	Diabetes	52%
5	Heart Disease	52%
6	Overweight/Obesity	52%

An "Other" option was provided to allow respondents to select an issue that was not on the list. Other key health issues that were specified include: Medicaid, hoarders access to care, affordable housing, Alzheimer's disease, health education for the community, I/DD, environmental health and water quality.

Additionally, respondents were asked to share information regarding these issues and their reasons for ranking them this way. Verbatim summaries of responses are listed below.

Select Comments Related to Key Health Issues:

- "I would say the ones I listed are the most common I come in contact with however that does not diminish the concern for the other areas..."
- "Mental health is an ongoing issue in our service area and accounts for nearly 6-7% of the EMS monthly call volume in our primary response area. Also, returning similar results is fall victims."
- "There are few options for people who have no insurance or even who have Medicaid. Especially for psychiatric care."
- "I included access to care less for its relation to insurance coverage and more for transportation."
- "Tobacco: underage use of e-cigarettes on the rise and becoming an epidemic. Legalization of marijuana will play a role, as THC can be used in e-cigs without detection."
- "Outpatient mental health services that are covered in network are difficult to obtain on a timely basis"
- "Lack of access to oral health care for uninsured and underinsured is a huge problem in the state of NJ."
- "Over the past decade, a great deal of energy and intervention has been done in the areas of heart disease, cancer, obesity. I believe that there should now be a focus on mental health, substance abuse, Alzheimer's disease as they seem to be posing the largest future threat to population health. 2017 U.S. life expectancy stats show a decline due to substance abuse and suicide. These should be areas of concentration and prevention."
- "These are all disease states as opposed to the conditions that lead to these diseases. I would say poverty, and safe healthy housing are very important. Access to affordable mental health care, substance abuse care and wages that are high enough to keep a family intact are critical."
- "Access to care for people with intellectual and developmental disabilities who use Medicaid is almost impossible to find. Mental health and dental services for this population have limited availability as well."

Health Care Access

Availability of Services

The second set of questions concerned the ability of local residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bilingual providers. Respondents were provided with statements such as: "Residents in the area are able to access a primary care provider when needed." They were then asked to rate their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree).

As illustrated in Table 2, availability of providers accepting Medicaid and Medical Assistance, lack of mental/behavioral health providers, availability of transportation services to attend medical appointments, availability of bi-lingual health care providers garnered the lowest percentages of respondents agreeing or strongly agreeing compared to the other factors.

Table 2. Ratings of Statements about Health Care Access

Factor	Percentage of Respondents who "Agree" or "Strongly Agree"
Residents in the area are able to access a primary care provider when needed	52%
Residents in the area are able to access a medical specialist when needed (Cardiologist, Dermatologist, Neurologist, etc.)	48%
Residents are able to access a dentist when needed	39%
There is a sufficient number of providers accepting Medicaid and Medical Assistance in the area	74%
There is a sufficient number of bi-lingual providers in the area	17%
There is a sufficient number of mental/behavioral health providers in the area	17%
Transportation for medical appointments is available to area residents when needed	9%
Residents in the area are utilizing emergency department care in place of a primary care physician	22%

Barriers to Health Care Access

After rating availability of health care services, respondents were asked about the most significant barriers that keep people in the community from accessing health care when they need it. The top four barriers that were selected most frequently include:

- Inability to Navigate Health Care System
- Lack of Health Insurance Coverage
- Inability to Pay Out-of-Pocket Expenses (Co-pays, prescriptions, etc.)
- Lack of Transportation

Key informants also shared additional information regarding the barriers to accessing health care. Their verbatim responses are summarized below.

Select Comments Regarding Health Care Access and Barriers:

- "Inability to navigate the system leads to use of Emergency Dept. as primary care provider."
- "Lack of funding for small nonprofit organizations like, KinderSmile Foundation who has its boots on grounds education parents and children on oral disease prevention and oral care access. More funds and partnerships from hospitals... KSF is willing to partner with hospitals that serve same demographics. Creating community partnerships will increase oral disease awareness!"
- "I chose lack of transportation as the biggest barrier to service because many older adults, who do not drive for whatever reason (cost, inability, disability, etc.), do not have a way to get to their medical appointments. For many, incurring the medical costs alone is expensive, they do not have the money to pay for a cab to bring them to/from their medical appointments. Local county and town transportation services for older adults are limited and unreliable. Many older adults are unable to take advantage of technology and ride sharing services."
- "Our community offers many services and I believe just about everything is available within a 5-10 mile radius. However, I feel many people in the area are still struggling with access to the system in the forms of ability to pay deductibles and co-pays; the availability of transportation; the ability of single parents to take off from work to care for themselves and seek medical assistance when necessary. Health literacy is an ongoing barrier to healthcare. I am unsure what goes on in the public school systems at this point with regard to health classes, etc. but more and earlier education is needed to understand the human biological systems and how to engage in a healthy lifestyle for long term support and better quality of life. Prevention! Prevention! Prevention!"
- "Many Hispanics who are undocumented are afraid to access care even if it is available. They are also afraid to access any services with good reason since federal policy says that it may be held against them in determining whether or not they can remain in the US. Access to all of these services largely depends upon good insurance coverage and/or ability to pay. Many hourly workers cannot afford to take off to see a doctor."
- "Need more affordable options for emergencies and Medicaid people could utilize a nurse practitioner or Dr on call to determine if ER is necessary or another option is available. They need education on overuse of ER."

Underserved Populations

Informants were asked whether they thought there are specific populations who are not being adequately served by local health services. The majority of respondents (87%) indicated that there are underserved populations in the community.

Respondents were then asked to identify which populations they think are underserved. As depicted in the below (Table 3), more than half (85%) of respondents felt that Underinsured/Uninsured individuals were underserved. In addition, a considerable number of respondents believe that the low-income/poor, seniors/aging/elderly, immigrant/refugees, and the homeless are not being adequately served by local health services. Key informants also mentioned the following members of their community as being underserved: "Hoarders & those unable to navigate systems & affordable care act recipients who need a mental health or specialist" and "those who are undocumented" as being underserved.

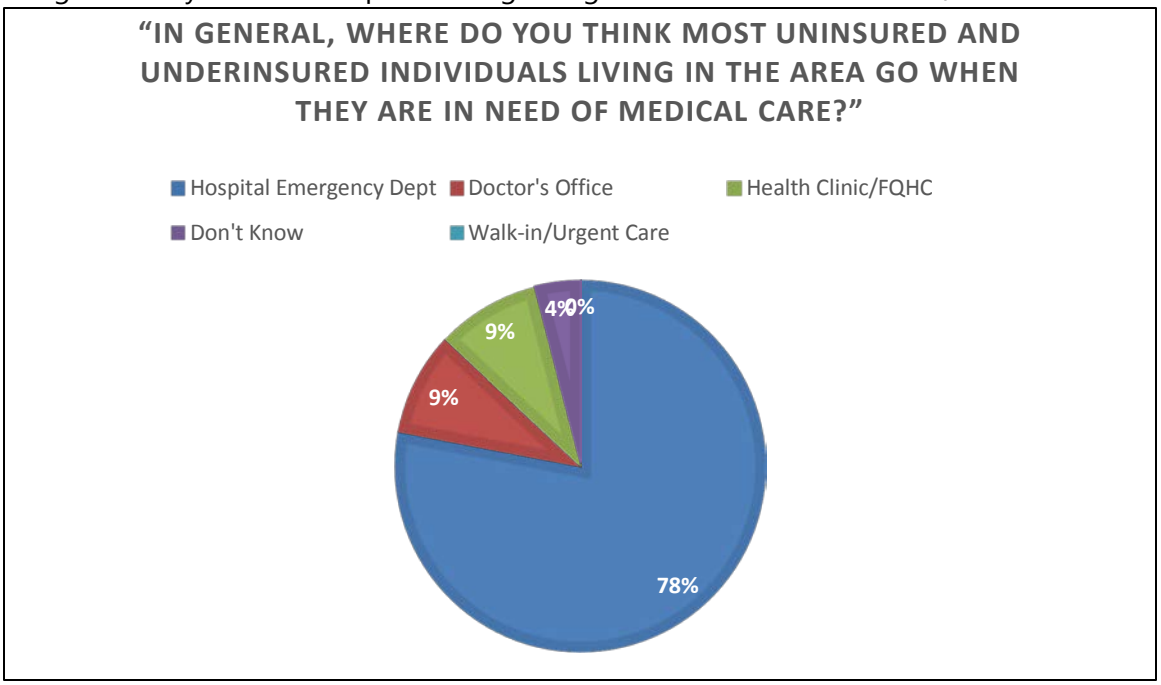
Table 3: Underserved Populations

Rank	Underserved Population	Percent Of Respondents Who Selected the Issue
1	Underinsured / Underinsured	85%
2	Low-income / Poor	75%
3	Seniors / Aging / Elderly	60%
4	Immigrant / Refugee	55%
5	Homeless	55%
6	Disabled	30%
7	Hispanic / Latino	25%
8	Black / African-American	25%
9	Children / Youth	10%
10	Young Adults	10%
11	Other - please specify	10%
12	None	0%

Health Care for Uninsured/Underinsured

Key informants were asked to identify where Uninsured/Underinsured individuals go to access health care. More than half of respondents (78.0%) indicated the Hospital Emergency Department as a primary place where uninsured or underinsured individuals go when they are in need of medical care. Key informant opinions regarding this issue are summarized in Figure 1 below.

Figure 1. Key Informant Opinions Regarding Health Care for Uninsured/Underinsured



Hackensack Meridian *Health*

Resources Needed to Improve Access

Respondents were asked to identify key resources or services they felt would be needed to improve access to health care for residents in the community. Many respondents indicated that "Free and Low Cost Medical Care," "Free and Low Cost Dental Care," "Mental Health Services," and "Transportation" are needed in their communities. "Other" responses that participants provided included "Detox Services," "Substance Abuse Detoxification for SA," "Patient Navigators/advocacy," "Geriatricians," and "Education on alternative and preventative approaches (yoga, meditation, etc.)." Table 4 includes a listing of the resources ranked by most needed to least needed.

Table 4: Listing of Resources Needed in the Community

Resources Needed	Percent of those who selected the issue
Free / Low Cost Medical Care	74%
Free / Low Cost Dental Care	57%
Mental Health Services	52%
Transportation	48%
Substance Abuse Services	39%
Bilingual Services	30%
Prescription Assistance	22%
Health Education / Information / Outreach	22%
Health Screenings	22%
Other - please specify	22%
Primary Care Providers	13%
Medical Specialists	4%
None	4%

Challenges and Solutions

Key informants were asked to identify challenges people in the community face in trying to maintain healthy lifestyles. The most salient themes that emerged in participants' responses include: Lack of health education and time, Limited opportunities for exercise in the winter months (some can't afford the YMCA or private gyms), price of healthy food and exercise facilities. Many of participants felt that most people in their communities are struggling with the basics and do not have the time or finances to support a healthy lifestyle. Comments such as the following were very common:

"Most are too busy surviving to make time or finances for their own wellbeing."
"Time and commitment while caring for other family members and attending to pressing life issues/finances."
"Many people are struggling with the basics - food, housing, heating, etc. They see healthy eating and exercise as a luxury. It's easier for their primary doctor to prescribe medication instead of encouraging a healthy lifestyle to manage chronic conditions. A lot of people also don't know where to begin eating healthy."
"Healthy food can be expensive. Overworked parents and seniors may not have the time/money/initiative to make healthy meals from scratch. Many people don't know how to

incorporate physical activity into their daily routines. Or don't think they have the time."

Responding to the question "What's being done well in the community?," respondents repeatedly mentioned their local hospital, health and education departments helping with educational and health screenings throughout the communities, local pharmacies offering flu shots and health screenings, and the access to local recreation (pools, playgrounds, tracks, parks, basketball courts) were frequently mentioned by most respondents as making a difference in their communities.

Key informants made recommendations that they felt would help improve health and quality of life in their communities. Some of the most frequently mentioned suggestions are summarized below:

- Programs for people who cannon navigate the system and are unaware of resources available to them
- Create localized partnerships with EMS and other community healthcare providers to engage the public more routinely
- More funded community programs
- More opportunities to educate people on how to live a healthier lifestyle
- Health education with a focus on prevention beginning in primary school
- Safer streets and walkways – make it safer to travel via foot or bike in areas were aggressive driving is prevalent
- Funding for communities who cannot afford healthcare insurance

Key informants made recommendations that they felt would help improve health and quality of life in their communities. Some of the most frequently mentioned suggestions are summarized below:

- Continue prevention, education and outreach efforts
- Increasing access to transportation
- Wider distribution of information and services in underserved communities
- Sustainable educational programs and health promotion activities, and
- More education and community outreach to help seniors manage chronic conditions

IDENTIFICATION OF COMMUNITY HEALTH NEEDS

Prioritization Session

Mountainside Medical Center held one session – a Community Meeting Planning Session – to review the results of the 2018 Community Health Needs Assessment (CHNA). The goal of the meeting was to discuss and prioritize the needs of their local community as identified through the CHNA and to set the stage for community health improvement initiatives and the development of the hospital's Implementation Strategy. A total of seven key informants attended a 1.5-hour prioritization session on December 11, 2018. These key informants were identified during the CHNA research process for their expertise and knowledge of the community. Among the attendees were the Director/Health Officer and Director of Nursing from the local health department, which covers several towns within the medical center's service area and Mountainside Medical Center team members from clinical and non-clinical areas including Community Health, Community and volunteer Services, Marketing, Behavioral Health and the laboratory. A full list of attendees can be found in Appendix D.

Process

The prioritization meeting was facilitated by Grettel Muscato, Director of Community and Volunteer Services at Mountainside Medical Center. The meeting began with an abbreviated research overview. This overview presented the results of the secondary data research and the key findings of the CHNA.
Following the research overview, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, initiatives to the hospital's annual plan, and other aspects of health improvement planning, such as goal setting and developing strategies. In an open group format, attendees were then asked to openly share what they perceived to be the needs and areas of opportunity in the community. The discussion encouraged attendees to share if their perceived needs of the community aligned with the needs as found through the CHNA. Participants confirmed their experience matched the identified needs and areas of opportunity found in the community.
Through facilitated discussion, the group identified multiple areas of defined health needs that would later be consolidated to four broad areas of potential focus. The "master list" of community priorities (presented in alphabetical order) includes:

- Access to Care
- Diabetes
- Heart Disease
- Mental Health
- Obesity

Key Community Health Issues: Identified Health Priorities

Once the master list was compiled, the group had an open discussion to prioritize the issues based on two criteria: the services available at Mountainside Medical Center, and the group's ability to impact the issues collaboratively. Ultimately, the following two priorities were adopted:

- Mental health
- Chronic disease management

The priority areas that were perceived as the most serious were mental health, followed by heart disease, diabetes, obesity, and then access to health.
In the discussion, it was revealed that mental health and access to care directly correlated with the aging

population of the Montclair and surrounding communities, therefore it was decided that we will tackle mental health focusing on seniors, and connecting seniors with the transportation resources available in the community.
Because heart disease, diabetes and obesity have direct correlations with one another, it was determined that they would be addressed directly under the umbrella of chronic disease management through health education and outreach programs.

Chronic Disease Management

Community partners identified that while the community as a whole provides a large number of resources to assist people in managing their chronic diseases, there is a clear disconnect between the availability of services and the area residents utilizing those services. This can be due to lack of awareness of these services, and the potential costs of services provided, such as health screenings.
Community partners suggested strategies to address this need included the following:

- Possibly provide health screenings (either quarterly or 2x/year) through collaborative efforts by local health departments and the hospital at no cost
- Collaborate with local not-for-profit groups, health departments, providers, and others to gather funds and resources needed to create a community based meal-planning education series
- Continue providing screenings and lectures throughout the community

Mental Health

Similar to chronic disease management, the group identified many resources available to the members of the community. It was noted that Mountainside Medical Center has made great strides over the last 3+ years to partner with agencies, senior housing and local universities and schools to help streamline the processes for those requiring mental health services at Mountainside Medical Center, as well as Mountainside's now available resource book created to help individuals connect with their needed services.
One primary challenge the group identified was trying to navigate available age-specific resources, particularly transportation for seniors. Participants recommended the following strategies:

- Improving access to senior groups
- Linking seniors to transportation services such as the shuttle services provided by their municipalities
- Linking seniors to discounted transportation options that may be available to them
- Participation in School Counselor meetings on a quarterly basis
- Further connect with colleges and universities (Bloomfield College and Essex County Community College-Caldwell Campus)
- Increase awareness of available senior support groups
- Continue community meetings with senior groups hosted by a clinical expert

Appendix A. Secondary Data Sources

Annie E. Casey Foundation. (2018) *Kids Count Data Center*. Retrieved from https://datacenter.kidscount.org/data#NJ/2/0/char/0

Centers for Disease Control and Prevention. (2018). *CDC wonder*. Retrieved from https://wonder.cdc.gov/

Centers for Disease Control and Prevention. (2018). *National vital statistics reports*. Retrieved from http://www.cdc.gov/nchs/nvss.htm

Centers for Medicare & Medicaid Services. (2018). *County reports*. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/chronic-conditions-county/cc_county_dashboard.html

County Health Rankings & Roadmaps. (2018). *Santa Clara County*. Retrieved from http://www.countyhealthrankings.org/app/newjersey/2018/rankings/essex/county/outcomes/overall/snapshot

Feeding America (2018). *Map The Meal Gap Data*. Retrieved from https://www.feedingamerica.org/research/map-the-meal-gap/by-county

New Jersey State Department of Health. *Reports and Statistics*. Retrieved from https://www-doh.state.nj.us/doh-shad/community/highlight/index/GeoCnty/7.html

U.S. Department of Health and Human Services. (2018). *Healthy People 2020*. Retrieved from http://www.healthypeople.gov/2020/default.aspx

U.S. Department of Health and Human Services. (2018). *The 2018 HHS poverty guidelines*. Retrieved from https://www.payingforseniorcare.com/longtermcare/federal-poverty-level.html#title2

Appendix B. Key Informant Survey Tool

INTRODUCTION: As part of its ongoing commitment to improving the health of the communities it serves, Mountainside Medical Center is spearheading a comprehensive Community Health Needs Assessment.

You have been identified as an individual with valuable knowledge and opinions regarding community health needs, and we appreciate your willingness to participate in this survey.

The survey should take about 10-15 minutes to complete. Please be assured that all of your responses will go directly to Hackensack Meridian *Health* and will be kept strictly confidential.
Please note that while your responses, including specific quotations, may be included in a report of this study, your identity will not be directly associated with any quotations.

When answering the questions, please consider the community and area of interest to be the communities surrounding Mountainside Medical Center including Bloomfield, Montclair, Cedar Grove, Caldwell, Nutley, Upper Montclair and Glen Ridge.

KEY HEALTH ISSUES

When answering the questions, please consider the communities of Bloomfield, Montclair, Cedar Grove, Caldwell, Nutley, Upper Montclair and Glen Ridge.

1. What are the top **5** health issues you see in your community? (CHOOSE 5)

☐ Access to Care/Uninsured	☐ Overweight/Obesity
☐ Cancer	☐ Sexually Transmitted Diseases
☐ Dental Health	☐ Stroke
☐ Diabetes	☐ Substance Abuse/Alcohol Abuse
☐	☐
☐ Maternal/Infant Health	☐ Other (specify):
☐ Mental Health/Suicide	☐

2. Of those health issues mentioned, which **1** is the most significant? (CHOOSE 1)

☐ Access to Care/Uninsured	☐ Overweight/Obesity
☐ Cancer	☐ Sexually Transmitted Diseases
☐ Dental Health	☐ Stroke
☐ Diabetes	☐ Substance Abuse/Alcohol Abuse
☐ Heart Disease	☐ Tobacco
☐ Maternal/Infant Health	☐ Other (specify):
☐ Mental Health/Suicide	☐

3. Please share any additional information regarding these health issues and your reasons for ranking them this way in the box below:

ACCESS TO CARE

When answering the questions, please consider the communities of Bloomfield, Montclair, Cedar Grove, Caldwell, Nutley, Upper Montclair and Glen Ridge.

4. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about **Health Care Access** in the area.

	Strongly disagree ← → Strongly agree
Residents in the area are able to access a primary care provider when needed. (Family Doctor, Pediatrician, General Practitioner)	1 ☐2 ☐3 ☐4 5
Residents in the area are able to access a medical specialist when needed. (Cardiologist, Dermatologist, Neurologist, etc.)	1 ☐2 ☐3 ☐4 ☐5
Residents in the area are able to access a dentist when needed.	1 ☐2 ☐3 ☐4 ☐5
Residents in the area are utilizing emergency department care in place of a primary care physician.	1 ☐2 ☐3 ☐4 ☐5
There are a sufficient number of providers accepting Medicaid and Medical Assistance in the area.	1 ☐2 ☐3 ☐4 ☐5
There is a sufficient number of bilingual providers in the area.	1 ☐2 ☐3 ☐4 ☐5
There are a sufficient number of mental/behavioral health providers in the area.	1 ☐2 ☐3 ☐4 ☐5
Transportation for medical appointments is available to area residents when needed.	1 ☐2 ☐3 ☐4 ☐5

5. What are the most significant barriers that keep people in the community from accessing health care when they need it? (Select all that apply)

☐ Availability of Providers/Appointments
☐ Basic Needs Not Met (Food/Shelter)
☐ Inability to Navigate Health Care System
☐ Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
☐ Lack of Child Care
☐ Lack of Health Insurance Coverage
☐ Lack of Transportation
☐ Lack of Trust
☐ Language/Cultural Barriers
☐ Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)

☐ None/No Barriers
☐ Other (specify):

6. Of those barriers mentioned, which **1** is the most significant? (CHOOSE 1)

☐ Availability of Providers/Appointments
☐ Basic Needs Not Met (Food/Shelter)
☐ Inability to Navigate Health Care System
☐ Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
☐ Lack of Child Care
☐ Lack of Health Insurance Coverage
☐ Lack of Transportation
☐ Lack of Trust
☐ Language/Cultural Barriers
☐ Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
☐ None/No Barriers
☐ Other (specify):

7. Please share any additional information regarding barriers to health care in the box below:

8. Are there specific populations in this community that you think are not being adequately served by local health services?

___Yes ___ No

9. **If yes**, which populations are underserved? (Select all that apply)

☐ Uninsured/Underinsured
☐ Low-income/Poor
☐ Hispanic/Latino
☐ Black/African-American
☐ Immigrant/Refugee
☐ Disabled
☐ Children/Youth
☐ Young Adults
☐ Seniors/Aging/Elderly
☐ Homeless
☐ None
☐ Other (specify):

10. In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care? (CHOOSE 1)

☐	Doctor's Office
☐	Health Clinic/FQHC
☐	Hospital Emergency Department
☐	Walk-in/Urgent Care Center
☐	Don't Know
☐	Other (specify):

11. Please share any additional information regarding Uninsured/Underinsured Individuals & Underserved Populations in the box below:

12. Related to health and quality of life, what resources or services do you think are missing in the community? (Select all that apply)

☐	Free/Low Cost Medical Care
☐	Free/Low Cost Dental Care
☐	Primary Care Providers
☐	Medical Specialists
☐	Mental Health Services
☐	Substance Abuse Services
☐	Bilingual Services
☐	Transportation
☐	Prescription Assistance
☐	Health Education/Information/Outreach
☐	Health Screenings
☐	None
☐	Other (specify):

CHALLENGES & SOLUTIONS

When answering the questions, please consider the communities of Bloomfield, Montclair, Cedar Grove, Caldwell, Nutley, Upper Montclair and Glen Ridge.

13. What challenges do people in the community face in trying to maintain healthy lifestyles like exercising and eating healthy and/or trying to manage chronic conditions like diabetes or heart disease?

14. In your opinion, what would make it easier for residents of the communities you serve to maintain healthy eating habits and an active lifestyle?

15. In your opinion, what is being done ***well*** in the community in terms of health and quality of life? (Community Assets/Strengths/Successes)

16. What recommendations or suggestions do you have to improve health and quality of life in the community?

CLOSING

When answering the questions, please consider the communities of Bloomfield, Montclair, Cedar Grove, Caldwell, Nutley, Upper Montclair and Glen Ridge.

Please answer the following demographic questions.

17. **Name & Contact Information:** (Note: Your name and organization is required to track survey participation. Your identify WILL NOT be associated with your responses.)

Name:
Title:
Organization:
Email Address:

18. Which one of these categories would you say BEST represents your organization's community affiliation? (CHOOSE 1)

☐ Health Care/Public Health Organization
☐ Mental/Behavioral Health Organization
☐ Non-Profit/Social Services/Aging Services
☐ Faith-Based/Cultural Organization
☐ Education/Youth Services
☐ Government/Housing/Transportation Sector
☐ Business Sector
☐ Community Member
☐ Other (specify):

19. Please indicate which town(s) your organization serves or represents(Select all that apply):

☐ Bloomfield
☐ Caldwell
☐ Cedar Grove
☐ Glen Ridge
☐ Montclair
☐ Nutley
☐ Upper Montclair

20. Which one of these groups would you say BEST represents the race/ethnicity of the clients you serve? (CHOOSE 1)

☐ White/Caucasian
☐ Black/African American
☐ Hispanic/Latino
☐ Asian/Pacific Islander
☐ Other (specify):

21. Which one of these groups would you say BEST represents the age of the clients you serve? (CHOOSE 1)

☐	Newborn - 18 years
☐	19 – 35 years
☐	36 – 64 years
☐	65 years and over

22. Mountainside Medical Center and its partners will use the information gathered through this survey in guiding their community health improvement activities. Please share any other feedback you may have for them below:

Thank you! That concludes the survey.

Appendix C. Key Informant Survey Participants

Name	Title	Agency
Linda Wanat	Township Clerk of Montclair	Township of Montclair
Everett Schlam	Doctor	Family Medicine
Patricia Cruz	Public Health Nurse	Township of Nutley
Sue Seidenfield	Executive Director	COPE Center, Inc.
Damian Luke	Reverend	Glen Ridge
Nicole McGrath	President	KinderSmile, Inc.
Katie York	Project Director	Lifelong Montclair
Stefanie Grove	Director	RSVP Center of Essex and Hudson Counties
Peggy Brodowski	Director of Nursing	Montclair Health Department
Pamela Scott	Executive Director	Partners for Health
Jose Flores	Doctor	Family Medicine
Robert Gorman	Doctor	Family Medicine
Michele Kroeze	Business Manager	Salvation Army
Dawn Diamond	Director	NJ Center for Healthy Living
James Simpson	Chief	Montclair Ambulance Unit
Sue Portuese	Montclair Health Officer	Township of Montclair
Maria Mados	Director	VanDyk Manor Nursing Home
Al Brunetti	Pharmacist in Charge	Brookdale ShopRite
Erin Bunger	Senior Research	Montclair State University
Robert Jackson	Mayor of Montclair	Township of Montclair
Emma Justice	Executive Director	Interfaith Hospitality Network
Linda Lucas	Executive Director	ARC of Essex County
Kathy Smith	Grants Program Director	Partners for Health

Appendix D. Prioritization Session Participants

Name	Title	Agency
Margaret Brodowski, R.N., MA, CSN	Director of Nursing	Montclair Department of Health and Human Services
Florey Cruz-Cerpa	Community Health Manager	Mountainside Medical Center
JoLynn Ferante	Lab Coordinator	Mountainside Medical Center
Susan Portuese, M.A., B.S.	Health Officer, Department Director	Montclair Department of Health and Human Services
Chiara Marababol, M.P.H. , CHES	Marketing Manager	Mountainside Medical Center
Grettel Muscato, M.P.A.	Director of Community Services and Volunteers	Mountainside Medical Center
Shavonda Sumter, M.B.A.	AVP – Behavioral Health	Mountainside Medical Center

Appendix E. Community Resource Inventory

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to the public to address the significant health needs identified in this report. This list is not exhaustive but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

Health Departments:

Caldwell – (973) 403-4623
Clifton – (973) 470-5773
Bloomfield – (973) 680-4058
Nutley – (973)-284-4976
Montclair (serves Glen Ridge, Cedar Grove, Verona and Montclair) – (973) 509-4974

KinderSmile Foundation (Pediatric Dental Services) – (973) 744-7003
Zufall (Community Health Center- Medical and Dental) – (973) 325-2266

Transportation Services

Access Link NJ Transit – 800-955-2321 (TTY 800-955-6765)
Belleville Dial -A- Ride (Belleville and Nutley only) – (973)-450-3402
Bloomfield Dial-A-Ride (Essex County) – (973)-566-7194
Easton Coach Company – (908)-454-4044 or 866-594-4044
Essex County Transportation (973)-618-1280 or EZ Ride (973)-961-6941

Mental Health and Substance Abuse Services

COPE Counseling Center – (973) 783-6655
Mental Health Association of Essex and Morris – (973) 509-9777
Al-Anon Family Groups (12-Step) – (973)-744-8686; Spanish-speaking (973)-268-1260.
Alcoholics Anonymous (BILINGUAL) 12-Step – (1-800)245-1377; Spanish-speaking (973)-824-0555
Chapter 9 Couples In Recovery Anonymous 12-Step – (862)-215-6470
Double Trouble (for people living with HIV/AIDS) – (973)483-1065 or (973)483-3444
Double Trouble in Recovery (for persons in dual recovery from a mental illness and a substance or alcohol addiction) – (973)677-7700
Families Anonymous (12-Step) – (201)396-6701

Food and Nutrition Services

Human Needs Food Pantry – (973)746-4669
Salvation Army Montclair Citadel – (973)744-3312
St Rocco's outreach Project – (973) 371-5266
St Anne's Church Food Pantry – (973) 642-5553
The Apostle House – (973) 482-0625
Toni's Kitchen – (973)860-0768

God's Love We Deliver – 1(800) 747-2023
Human Needs Food Pantry – (973) 624 – 2528
Newark Emergency Services for Families – (973) 643 – 5727
Meals on Wheels – (contact your local municipality or County for more information)
Farmer's Markets (that accept WIC, Senior Checks, EBT and Food Stamps)
City Green (Veggie Mobile stops in Clifton, Passaic and Montclair) – (973)-869-4086
Montclair Farmer's Market
Montclair Community Farms – (973) 744-1796

Local Pharmacies with Delivery Services

Grove Pharmacy – (973) 744-5550
CVS (Broad Street Bloomfield – (973) 743-8100
North Center Drugs (Bloomfield) – (973) 748-1299
Terry Drugs (Bloomfield) – (973) 338-7300
Walgreens (Fairfield) – (862) 210-3980
Little Falls Pharmacy – (973) 638-1561
CVS (West Orange) – (973)736-8408

Appendix G. Evaluation of Impact

Behavioral Health Goals for Improvement

Behavioral Health Services are comprehensive with an ease to emergency assessments and accessibility to appropriate levels of care 24 hours a day, 7 days a week, 365 days a year. There are sufficient clinical resources aligned with the community and hospital priorities. Acute programming is available with strong referral relations and education programs.
Adult Population for Essex County- 510,027; Average length of stay on the inpatient acute unit is 8 days.

What did we do?

1. Increase mental health collaborations throughout Essex County
    a. Affiliation agreements with Community providers throughout Essex County that include:
        i. Essex County Mental Health Association
        ii. Essex County Mental Health Hospital
        iii. Care Plus
        iv. Assisted Living Facilities
        v. Nursing Homes
        vi. Home Care Agencies
        vii. Hospice Service
2. Create a resource that can be used easily for mental health information, resources, and referrals
3. Develop campaign messages to promote peer advocates. (Messages may include identifying the indicators of mental illness and local resources available)
    a. 1 Page Flyer of Services and Contact Information
    b. Magnet for the Geriatric Services
    c. Installed a Geriatric Service Helpline (staffed 24/7/365)
    d. Maintain a Crisis Phone line (staffed 24/7/365)
    e. Created a web based video of the service experience for providers and families to view
    f. Memory Loss blog post
    g. Balancing Mental Health and Academics media article
4. Increase the proportion of adults and children with mental health disorders who receive treatment
    a. Maintain an Outpatient Mental Health Services that provides treatment to children
    b. Developing a clinical relationship with Montclair State University to provide treatment to children with specialty diagnosis

5. Increase mental health screenings by primary care providers
    a. Affiliation agreement with Vanguard Medical Group to coordinate BH and Primary Care Services
    b. Annual information mailer to over 50 primary care providers

Key Indicators

1. Community meetings and educational sessions held on the mental health topic
    a. Caregiver Coalition
    b. Professional Providers
    c. Senior Blue Book
    d. Essex County Regional Ethics Committee

e. Health Fairs
f. NJ Care Network
g. Lifelong Montclair Senior AMA

2. Number of community members and community health volunteers who serve as informal referral agents and mental health champions for increasing awareness
    a. Internship/volunteer opportunities throughout the Behavioral Health Services
    b. Educational Clinical Rotations with Social Work, Recreation Therapists, Nursing and Physicians

3. Number/Percentage of Emergency Department patients presenting with mental health issues who are transferred to inpatient or outpatient facilities
4. Number/Percentage of primary care providers screening for and providing mental health treatment referrals
5. Number of mental health and/or substance/ alcohol abuse community outreach programs conducted and number of participants.

Intended Outcomes

1. Increased number of people using a mental health hotline and attending mental health education sessions
2. Increased number of at-risk residents who can identify coping mechanisms during crisis/emergent events and resources available to them.

For the Year of 2018 January through October there were 1665 emergency department patients presenting with mental health issues.

2018	
January 2018: Inpatient: 55 Outpatient: 16 Total: 71/168=42%	**June 2018:** Inpatient: 77 Outpatient: 11 Total: 88/198=44%
February 2018: Inpatient: 62 Outpatient: 8 Total: 70/172=40%	**July 2018:** Inpatient: 71 Outpatient: 8 Total: 79/197=40%
March 2018: Inpatient: 72 Outpatient: 9 Total: 81/189=42%	**August 2018:** Inpatient: 66 Outpatient: 11 Total: 77/166=46%
April 2018: Inpatient: 68 Outpatient: 15 Total: 83/180=46%	**September 2018:** Inpatient: 66 Outpatient: 20 Total: 86/170=50%
May 2018: Inpatient: 58 Outpatient: 12 Total: 70/177= 39%	**October 2018:** Inpatient: 65 Outpatient: 14 Total: 79/167=47%
2017	
June 2017: Inpatient: 74 Outpatient: 10 Total: 84/ 174= 48%	**October 2017:** Inpatient: 73 Outpatient: 18 Total: 91/194= 46%
July 2017: Inpatient: 69 Outpatient: 13 Total: 82/157=52%	**November 2017:** Inpatient: 74 Outpatient: 14 Total: 88/176=50%
August 2017: Inpatient: 84 Outpatient: 16 Total: 100/188=53%	**December 2017:** Inpatient: 52 Outpatient: 11 Total: 63/151=35%
September 2017: Inpatient: 81 Outpatient: 16 Total: 97/195=49%	

Chronic Disease Management

Data revealed that **45.38%** of residents receive chronic disease screenings to maximize treatment options and participate in behaviors/programs that reduce risk factors for chronic disease.

What did we do?

- Increased the number of health promotion activities targeting high-risk populations by 15.72%
- Number of screenings and referrals to address early detection for 2016 and 2017 were 252 with a decrease of 13% in 2018*
- Number of individuals participating in health education programs increased by 120%
- Number/Percentage of patients who report incorporating healthy lifestyle behaviors and techniques and/or increased knowledge of the components of healthy living/lifestyles increased by 120%
- Increased the number of health screenings and lunch & learn lectures at corporate locations by 112.50%
- Increased access to fresh fruits and vegetables by implementing monthly Veggie Mobile stops, nutrition education and health screenings in the South End Section of Montclair.
- Implemented immediate medical referrals/appointments to the outpatient clinics, as needed in order to decrease the number of ER visits for chronic conditions.

**The decrease in number of screenings for 2018 has been identified as the low to no enrollment in the clinical health screenings offered to our local health departments' client population. Our goal for 2019 is to identify alternative locations and partners and further continue to offer these much needed screenings.*

Community Partnerships:

Below is a list of some of our current partners. Our nursing staff provides one to one health screenings and educates the participant once results are ready. If results are borderline or abnormal, the staff refers participant to their primary care physician (if they have one) or they make an appointment for participant to our outpatient clinics, if needed. Documentation is given to the participant to take to their upcoming appointment. We also provide lectures, if the location's space permits.

- Brookdale (Bloomfield), Nutley and West Caldwell Shop Rite sites- Customers within our targeted service areas
- Montclair YMCA- Children and Adults- Members and low income and underserved families
- Succeed2gether Afterschool program- Low income families
- Human Needs Food Pantry- Low income adults and children
- Tony's Kitchen (soup kitchen) - Low income adults and children
- City Green's Veggie Mobile- Low income adults and children
- Harris, Inc. – Corporation's team members

FINDINGS

Mountainside Medical Center has been providing world-class health care in a community setting since our founding in 1891.

Our first Community Health Implementation Plan, created in 2015, highlighted the two areas of need in our communities - behavioral health and chronic health management - and the number of programs and ways to which we worked to improve health and access to care for the people in the communities we serve.

It is clear that between 2015 and 2018, Mountainside Medical Center's community health improvement efforts made a great impact in our community. Mountainside Medical Center successfully increased the number of health promotion activities for chronic disease management and attendance to these activities, as well implemented a way to immediately refer community members to necessary resources. Additionally, we created a much needed resource for Behavioral Health Resources Booklet for patients, as well as strengthening our community partnerships through education.

We recognize that the impact of our implementation plan was limited by our community relationships, reach, resources and community awareness of the resources available to them at Mountainside Medical Center. This is evidenced by the decline in enrollment for clinical health screenings offered by Mountainside to local health departments.

It is evident that in order to build off of the successes and limitations of our Community Health Needs Assessment Plan for both Behavioral Health and Chronic Disease Management, Mountainside must continue to strengthen current community relationships, while also building new relationships with organizations within our community, and with the members of the community. Specifically for Chronic Disease Management, Mountainside must establish a protocol for patient follow-up after event or screening attendance to measure the effectiveness of our outreach efforts.