Obesity:

Goal: Reduce the prevalence of obesity among Hunterdon County residents.

Measure: 1. Stop and eventually reverse the rising obesity trend

2. Increase number of participants in wellness and weight and diabetes management programs by 10%

Data Source: 1. Percentage of adults who have a BMI within the normal range (between 18.5 and 24.9) in Hunterdon Healthcare physician practices electronic health records (NextGen)

2. Number of adults participating in wellness and weight and diabetes management programs

To support community efforts we tracked the percentage of patients that have a BMI within a healthy weight range (adults and children). These numbers are shared quarterly with system administrative leadership, Boards, the Clinical Management Committee and the Population Health Committee. As part of a CMS CPCI (Comprehensive Primary Care Initiative) innovation project, seven primary care practices conducted nutrition education classes at their sites for patients identified as pre-diabetic in 2014. Ten Care Coordinators also assisted patients in addressing weight management as part of our Accountable Care programs. Static percentages across quarters in 2014 provided evidence that efforts may need to be refocused and/or expanded in 2015.

The Hunterdon Healthcare System supports the Partnership for Health (PFH), a county-wide initiative that involves more than 30 community service providers, agencies and organizations sharing a common interest in promoting and improving the health, well-being and quality of life of Hunterdon County residents. The PFH has four action teams, one concentrating on obesity. In 2014 the obesity action team participated in the Community Transformation Grant. A nutrition program was provided at 17 worksites, to approximately 200 employees throughout the county. The presentation improved awareness of healthy behaviors including portion size, increasing fruit and vegetable intake, increasing hydration, and preparing healthy lunches.

In 2014 Hunterdon Healthcare System offered employee wellness rewards to those who attended a 2 part Healthy Plate, Healthy Weight program that provided information on healthy eating strategies to approximately 150 employees. All employees can also take advantage of discount gym memberships and an on-site weight management program. A salad bar and healthy options are offered in the employee cafeteria.

The Center for Nutrition and Diabetes Management, part of the Hunterdon Healthcare System, provides nutrition education to patients with diabetes. Eighty percent of patients with diabetes are obese. In 2014, the number of individual counseling sessions increased for pediatric and adult obesity while the number of diabetes patients decreased. Although we did not reach our goal of a 10% increase in participants of the wellness and weight and diabetes management programs, we did have more people participate in 2014 than in 2013. Patient's issues with

insurance coverage, and high deductibles affect our patient volumes. We also experienced a decrease in our diabetes educator staff. The number of pre-diabetes patients counseled was relatively stable. We have established group education classes to meet the needs of diabetic patients with less nursing staff, making these services more affordable and accessible to all.

Obesity/overweight continues to be a challenge in Hunterdon County and throughout New Jersey, and the nation. Moving forward into 2015 the obesity action team is addressing four areas to make an impact on the obesity rates in Hunterdon County: worksite wellness, school wellness, food access, and breastfeeding. They will address policy change and changes in environment that they hope will provide sustainable models for reducing obesity through these venues and the county.

Substance Abuse:

Goal: Reduce the prevalence and incidence of substance abuse among Hunterdon County residents.

Measure: Reduce Substance Abuse by 5%

Data Source: Increase number of completed inpatient Addiction Treatment Consults

The number of inpatient consults conducted by Hunterdon Medical Center's Behavioral Health Practitioners was slightly lower in 2014(330 consults) as compared to 2013 (346 consults). This result is directly related to a decrease in the number of Addiction Treatment Staff during the third quarter. The staff vacancy was filled and changes made to the current staff's schedules allowed for more consult time. The 2015 numbers are on target to exceed the 2013 baseline.

Latino Health Disparity & Prenatal Care:

Goal: Reduce health disparities among the Latino population in Hunterdon County

Measure: 1. Increase number of Latino mothers attending group prenatal care program

2. Increase the proportion of Latino mothers receiving early and adequate prenatal care

3. Increase the number of Latinos participating in health education workshops

4. Increase percentage of Latinos receiving age-appropriate cancer screening

Data Source: 1. Number of Latino mothers attending the group prenatal care program at Phillips Barber

2. Percentage of pregnant Latino women receiving prenatal care in their first trimester

3. Number of adult Latinos participating in health education workshops

4. Percentage of Latinos who have had a mammogram in the past 2 years

The Latino Prenatal Group Visit program was successful this past year in providing access to care for prenatal care. The program provided transportation to Phillips Barber physician practice at no cost

(grant funded) to the participants. The number of participants nearly doubled from 2013 to 2014, from 31 to 60 mothers attending the program.

In 2014 the number of Latino women receiving prenatal care during their first trimester and delivering at Hunterdon Medical Center was 70% compared to 82% in 2013. There are many factors that may have been the reason for this decrease. One of the factors is the increase of Latino mothers arriving to the country and our area later in their pregnancies. This is a general shift in the demographics of the Latino population in our area.

The designation of Phillips Barber as a Centering Pregnancy site and the diligent work of our Public Health Nurses, Social Services, WIC, and the medical director of this program and her staff have made tremendous strides in this area. Their services are well known throughout the community. However, the current trend of pregnant Latino women arriving to the community later in their pregnancies is a factor that has and will decrease our percentages.

The Hunterdon Regional Cancer Center at Hunterdon Medical Center facilitates the Hunterdon NJ CEED (Cancer Education and Early Detection) program. The successes of this program were achieved due to the commitment of CEED staff to provide Breast, Cervical, Colorectal, and Prostate Cancer education and screening enrollment to Hunterdon County's uninsured and underinsured Latino residents. The CEED staff is linguistically and culturally competent providing bilingual education programs. Through collaboration with local businesses, non-profit organizations, healthcare providers, local government agencies and faith-based organizations they were able to increase participation in the Latino health education workshops to 303 people in 2014 compared with 198 in 2013. They will continue to work with many community organizations in order to further engage the Latino community.

Aging Related Issues:

Goal: Improve the health, function and quality of life of seniors living in Hunterdon County

Measures: 1. Increase the percentage of seniors who seek preventive care.

2. Increase the percentage of seniors who have completed an Advanced Directive.

3. Increase hospice utilization.

4. Increase average daily census of Briteside Adult Day Center.

Data Source:

1. Percentage of adults 65 years and older who receive an Annual Wellness Visit or Annual Physical Exam

2. Percentage of adults 65 years and older who have a scanned Advanced Directive in their EHR.

3. Number of completed hospice consults

4. Number of enrolled Briteside clients

1. **Adult Wellness Exams/Annual Physicals**

In 2014 all primary care practices were using our CareSentry population management technology. This software enabled physicians to receive status reminders real-time during the patient appointment. For example, if they were due for an annual physical or a flu shot this would come up as an alert. Patients age 65 and above were encouraged to schedule wellness visits and address preventative care. Pre-visit planners reached out to patients prior to those visits to stimulate patient engagement. While in the waiting room, patients are provided a Pre-visit Health Review that includes their status for a wellness visit. Patients are provided Adult Wellness Visit(AWV) and Annual Physical forms prior to a scheduled visit. The Director of Population Health talked about keeping healthy and the Medicare Annual Wellness visit during a radio show in February of 2014. With all of these efforts the percentages of patients 65 and over having an Adult Wellness Visit or Annual Physical increased from a baseline of 28% in 2013 to 37% by the end of 2014. Efforts will be expanded in 2015 to include additional age categories and methods of patient engagement.

2. Advance Directives

The percentage of patients age 65 and above with a scanned Advance Directive in the out-patient electronic health records system was tracked and included on the newly created Population Health Dashboard. The Dashboard was shared with system administrative leadership, Boards, the Clinical Management Committee and the Population Health Committee. A Pre-visit Planning Worksheet was developed in 2014 that includes Advance Directives. If no document is present in the EHR, an Advanced Directive template is provided to the patient during the well visit. During 2014 the percentage of scanned Advance Directives increased from 6% to 10%. Efforts in 2015 will focus on expanded educational opportunities for physicians on methods to address advanced illness planning.

3. Hospice Utilization

Hunterdon Hospice Inc, a member of the Hunterdon Healthcare System, increased hospice utilization from 344 admissions in 2013 to 376 admissions in 2014. The increase in admissions is related to an increase in physician referral as well as family self-referral. Although we saw an increase in referrals, short lengths of stay are associated with late physician referral and family hesitancy. As we move forward we are developing an online tool kit for physicians to utilize while meeting with patients and families to aide in the discussions regarding end of life care and help facilitate the referral process.

4. Briteside Census

Briteside fell slightly under goal in terms of participant volume in 2014 primarily due to two factors: transportation and increased discharges. Hunterdon is a rural county and transportation is a challenge for many people but especially seniors. Securing affordable and appropriate transportation is not always feasible. Public transportation is a particular hardship for our clients who suffer from Dementia and Alzheimer's. We have recently secured private funding to purchase a van and provide our clients with door to door transportation. This should address our transportation issue moving forward.

Briteside also experienced a shorter length of stay. While "Welcome Visits" and enrollments remained relatively steady, the discharge rate increased. The trend in 2014 was that families were waiting until closer to "crisis mode" to enroll their loved one at Briteside. Therefore, the length of time that they were appropriate for Briteside or within the criteria for social day care was shorter. Through continuing efforts to educate the community about our services and the benefits of earlier enrollment we hope to increase our census.