IMPLEMENTATION PLAN
– 2014 –

Raritan Bay Medical Center

Advancing care every day

INTRODUCTION

In 2014, Raritan Bay Medical Center ("RBMC") conducted and adopted its Community Health Needs Assessment ("CHNA") which consisted of a detailed review of secondary source data, a community health survey of service area residents, meetings with local health officials, community and civic organizations, and providers to discuss and prioritize the healthcare needs of the region. The RBMC Community Health Needs Assessment can be accessed at www.rbmc.org.

Through the CHNA process, health need priorities were chosen based on the Medical Center's capacity, resources, competencies, and the needs specific to the populations it serves. The Implementation Plan addresses the manner in which RBMC will address each priority need and the expected outcome and timeframe for the evaluation of its efforts. The implementation plan which follows is based on the five selected priority areas:

- ✓ Healthy Nutrition/Obesity
- ✓ Mental Health and Substance Abuse
- ✓ Heart Disease
- ✓ Diabetes
- ✓ Cancer

RBMC works with the Middlesex County Health Department, other providers and community organizations to improve the health and welfare of its communities. The five priority areas do not represent the full extent of the Medical Center's community benefit activities or its support of the community's health needs. Other needs identified through the CHNA may be better addressed by other agencies/organizations or deferred to another timeframe.

RARITAN BAY MEDICAL CENTER

Implementation Plan

GOAL 1: ENHANCE COMMUNITY AWARENESS OF HEALTHY NUTRITION AND REDUCE THE INCIDENCE OF OBESITY IN ADULTS AND CHILDREN.

Community Need Addressed: Healthy Nutrition/Obesity

	Initiative	Indicator	Review Period	Comments
1.1	Continue to work with employees to reduce BMI, and achieve weight management through diet and exercise.	• Obtain baseline data on the number of employees participating in weight management program through Bravo Wellness. • Investigate potential to lower cost or increase incentives for employees to participate in gym/weight loss program. • Increase the percentage of employees engaged in weight management programs by 5%.	2015 2015 2017	
1.2	Continue to promote healthy nutrition at Health Fairs throughout the region.	• Work with community groups (schools, employers, churches) to provide a site for at least 1 health fair per Quarter.	Annual	
1.3	Work with town recreational departments or YMCA to assist in developing outdoor walking program.	• Explore potential sponsors. • Initiate program.	2015 2016	

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GOAL 1: ***ENHANCE COMMUNITY AWARENESS OF HEALTHY NUTRITION AND REDUCE THE INCIDENCE OF OBESITY IN ADULTS AND CHILDREN.***

Community Need Addressed: Healthy Nutrition/Obesity

	Initiative	Indicator	Review Period	Comments
1.4	Expand community efforts aimed at adult and childhood obesity.	• Explore the potential to add a full-time dietician to work on outreach efforts (1.3 & 1.4) and provide services in the weight management program.	1st Quarter 2015	
	• Continue to work with local Girl & Boy Scout Troops on healthy nutrition and body changes.	• Provide educational services to 3 troops each year.	Annual	
	• Investigate opportunities to work with Perth Amboy schools on programs to reduce childhood obesity via exercise and healthy eating.	• Contact schools and initiate discussions.	2nd Quarter 2015	
		• If interested, identify work group to explore potential projects and funding sources.	3rd Quarter 2015	
	• Increase education on breast feeding exclusively.	• Provide Moms-to-be during hospital site visits/childbirth classes information on benefits of breast feeding and its impact on reducing childhood obesity.		

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GOAL 1: ***ENHANCE COMMUNITY AWARENESS OF HEALTHY NUTRITION AND REDUCE THE INCIDENCE OF OBESITY IN ADULTS AND CHILDREN.***

Community Need Addressed: Healthy Nutrition/Obesity

	Initiative	Indicator	Review Period	Comments
1.5	Continue to offer a range of options to decrease obesity. • Offer a bariatric surgery program. • Offer a program of weight loss and nutritional counseling for children 8 and above, and adults.	• Track weight loss progress of patients in bariatric and weight management programs at 6 months, 1 year and 2 year intervals. • Provide services to 50 people.	Annual 2017	
1.6	Provide discharged patients with a diagnosis or comorbidity of obesity information on weight loss and healthy nutrition.	• Identify process and materials to be provided. • Track number of referrals and patients participating in weight loss programs. • Established targets for participation for 2017.	2015 2016 2016	

GOAL 2: IMPROVE ACCESS TO MENTAL HEALTH/ALCOHOL AND SUBSTANCE ABUSE SERVICES FOR THE COMMUNITY.

Community Need Addressed: Mental Health and Substance Abuse

	Initiative	Indicator	Review Period	Comments
2.1	Continue to work with the Perth Amboy and Old Bridge school district to provide behavioral health screening and evaluation services for adolescents.	• Number of individuals served.	Annual	
2.2	Work with Bay Medical Practices to identify patients in need of both medical and behavioral health services.	• Identify referral sources. • Initiate use of screening tools for depression/ anxiety. • Provide referrals to appropriate providers.	2nd Quarter 2015 3rd Quarter 2015 3rd Quarter 2015	

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GOAL 2: IMPROVE ACCESS TO MENTAL HEALTH/ALCOHOL AND SUBSTANCE ABUSE SERVICES FOR THE COMMUNITY.

Community Need Addressed: Mental Health and Substance Abuse

	Initiative	Indicator	Review Period	Comments
2.3	Work with community-based providers to initiate school-based programs and public service billboards with information directed towards adolescent suicide prevention.	• Identify suicide prevention hotline provider.	1st Quarter 2015	
		• Work with Police and EMS on a school-based program on bullying and suicide prevention.	2015	
		• Develop and implement PSA signage at key locations. Use members of Students Against Destructive Decisions (SADD) in the development of the messaging.	3rd Quarter 2015	
		• Work with churches, especially those with teen programs.	2016	
		• Decrease the number of adolescents referred to Crisis Center by 2%.	2017	
2.4	Research and identify grant funding to provide crisis intervention services to adolescents in the ED.	• Conduct research regarding crisis intervention services.	1st Quarter 2015	

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GOAL 2: IMPROVE ACCESS TO MENTAL HEALTH/ALCOHOL AND SUBSTANCE ABUSE SERVICES FOR THE COMMUNITY.

Community Need Addressed: Mental Health and Substance Abuse

	Initiative	Indicator	Review Period	Comments
2.5	Identify opportunities to work with Perth Amboy and other town alliances focused on under-age drinking.	• Assign hospital staff to serve on municipal committees.	4th Quarter 2015	
2.6	Investigate ways to work with the V.A. to assist patients presenting with PTSD/homelessness.	• Work with representatives of the Hispanic Nurses Association to meet with officials of the V.A. to determine formal referral process to assist patients with PTSD or other behavioral health issues and those who are homeless. • Track number of referrals made.	3rd Quarter 2015 Begin 4th Quarter 2015	
2.7	Work with local municipalities on Veterans Affairs issues, including absenteeism maintaining employment by ensuring access to PTSD services.	• Track number of referrals.	3rd Quarter 2015	

GOAL 3: ***IMPROVE OUTCOMES FOR CARDIOVASCULAR DISEASE THROUGH EDUCATION AND OUTREACH EFFORTS AND IMPROVEMENTS IN CARE TRANSITIONS.***

Community Need Addressed: Heart Disease

	Initiative	Indicator	Review Period	Comments
3.1	Reduce cardiac risk factors for employees through employer-sponsored behavioral risk assessment and screening services.	• Increase participation in programs by 2% per year. • Reduce high cholesterol levels among participants by 10% • Reduce hypertension rates among employees by 5%.	2015-2017 2015 2016	
3.2	Expand work with community providers to offer cardiovascular risk screenings and preventive education services. • Participate in Health Fairs aimed at cardiac disease prevention. • Provide high blood pressure screenings throughout the year. • Provide cardiovascular education/testing programs. ♦ Signs and symptoms of heart attack, congestive heart failure, stroke. ♦ Controlling high blood pressure; high cholesterol. ♦ Stress testing. • Provide stroke education and outreach to local EMS squads.	• Participate in at least 2 additional health Fairs. • Provide 25 high blood pressure screenings and cardiovascular education programs at 20 sites each year. • Provide at least 10 high blood pressure/cholesterol programs each year. • Provide at least 20 stress tests per year. • Provide 15 classes per year.	Annual	

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GOAL 3: IMPROVE OUTCOMES FOR CARDIOVASCULAR DISEASE THROUGH EDUCATION AND OUTREACH EFFORTS AND IMPROVEMENTS IN CARE TRANSITIONS.

Community Need Addressed: Heart Disease

	Initiative	Indicator	Review Period	Comments
3.3	Implement HF Transitions in Care Program.	• 10% reduction in the readmission rate for all chronic cardiac conditions based on a phased approach by focusing on CHF first and then expanding to the other chronic cardiac conditions to achieve an overall reduction in cardiac conditions.	DSRIP Pilot program began Oct. 2014. DSRIP program implementation begins March 2015. Ongoing Quarterly Monitoring of DSRIP Program Outcomes through March 2017.	
3.4	Investigate the potential of working with Sayreville's Take Control of Your Health Program for chronic disease management.	• Initiate discussions with the Sayreville Take Control of Your Health Program. • If successful, integrate with other efforts to improve care transitions, reduced readmissions and ED visits. • Measure impact on cardiac-related readmissions and ED visits.	1st Quarter 2015 2016 2017	

GOAL 3: IMPROVE OUTCOMES FOR CARDIOVASCULAR DISEASE THROUGH EDUCATION AND OUTREACH EFFORTS AND IMPROVEMENTS IN CARE TRANSITIONS.

Community Need Addressed: Heart Disease

3.5	Continue to provide classes in cardiopulmonary resuscitation for medical professionals and the general public.	• Provide at least 25 programs annually. • Track number of individuals trained per year.	Annual Annual	

GOAL 4: IMPROVE COMMUNITY'S UNDERSTANDING AND CONTROL OF DIABETES AND REDUCE UNNECESSARY ED VISITS AND ADMISSIONS.

Community Need Addressed: Diabetes

	Initiative	Indicator	Review Period	Comments
4.1	Continue to provide diabetes discussion groups each month. • Expand promotion among Hispanic community via church bulletins and other outreach means. • Ensure discharge patients receive information about support groups.	• Maintain one group each month; with one held in Spanish every other month. • Develop information packet for patients discharged with diabetes.	Annual 2015	
4.2	Investigate potential to add an ADA diabetes education program on the Perth Amboy campus.	• Develop a business plan to assess feasibility.	2015-2016	
4.3	Continue to work with Sanafi Aventis diabetes educator.	• Track number of referrals. • Identify potential to track number of patients trained who have controlled A1c levels.	2015 2016	

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GOAL 4: ***IMPROVE COMMUNITY'S UNDERSTANDING AND CONTROL OF DIABETES AND REDUCE UNNECESSARY ED VISITS AND ADMISSIONS.***

Community Need Addressed: Diabetes

	Initiative	Indicator	Review Period	Comments
4.3	Continue to work with community groups to sponsor programs in diabetes awareness. • Work with Primary Care Physicians to distribute information regarding diabetes in their offices and to refer appropriate patients for consultations/ screenings, HbA1 testing, eye and foot exams. • Investigate potential of working with existing diabetes self-management program as a training site.	• Provide individual counseling at all Health Fairs and screenings. • Physician liaison to begin working with Bay Medical Practices' Physicians and tracking activity on referrals. • Provide at least two community lectures annually, via Speakers Bureau. • Initiate discussions with at least 2 community groups that provide diabetes self-management programs.	Annual 2015 Annual 1st Quarter 2015	

GOAL 5: IMPROVE HEALTH OUTCOMES FOR CANCER PATIENTS THROUGH EARLY DETECTION AND SCREENING.

Community Need Addressed: Cancer

	Initiative	Indicator	Review Period	Comments
5.1	Investigate potential to work with Middlesex County Health Department to provide free breast, cervical, colorectal and prostate cancer screenings.	• Initiate discussion with Middlesex County CEED Program. • Identify needs. • Initiative program.	2014 1st Quarter 2015 2nd Quarter 2015	
5.2	Continue to provide smoking cessation assistance to employees and community residents seeking assistance.	• Track number of employees participating in smoking cessation program through Bravo Wellness. • Track number of community residents seeking smoking cessation assistance. • Aim for 5% increase by 2016.	2015 2015 2016	
5.3	Continue to provide pulmonary function screenings and referrals to smoking cessation services.	• Number of individuals referred.	Annual	