Christian Health Care Center
2019-2022 CHNA
Implementation Strategy

Priority Area	Goal	Community Collaboration	Strategy	Performance Metrics	Outcome
					Impact
			What specific programs will we do to meet the goal	*What do we want to evaluate/ measure? What will change?*	*What is the target? (2019-2022)*
Behavioral Health (Mental Health and Substance Use Disorders)	*Supprot and/or implement strategies that promote mental, emotional and social well-being*	Valley Medical Group Bergen County Mental Health Board	**Screening and Identification**: Collaborate with community partners to support universal mental health screenings	# of VMG practices with CHCC MH Services collaboration	3 practices *one per year (2020, 2021, 2022)
				# of referrals received annually as a result of + MH screening in PCP office	120 per year
				# of referrals scheduled	90 per year
				% of referrals seen for OP level of care annually as a result of + MH screening in PCP office	75% per year
		The Valley Hospital	**Health Education and Prevention**: Continue to participate in outreach programs through affiliation with Wyckoff Stigma Free	2 CHCC Representatives	100%
		Wyckoff Sitgma Free		# of community events supported	2 annually (1 fall/1 spring event)
		Community Health (CHIP of Bergen County)	**Cross-sector Collaboration and Partnership**	Co-Host Angst presentation with The Valley Hospital Community Health Department	1 presentation
Chronic/Complex Conditions and Risk Factors	*Enhance access to health education, screening, and referral services*	The Valley Hospital	**Screening and Identification**: Continue to screen for major chronic disease risk factors (i.e. obesity, HTN, diabetes) upon admission and refer for additional services as needed	% compliance with admission screening during nursing assessment for RRPH	100%
	Support individuals with chronic/complex conditions	Valley Medical Group	**Health Education and Prevention**: Sponsor conference for clinical providers to address issues related to mental health and chronic and complex conditions	Annual MH Conference	1 Conference annually
	Support caregivers of individuals with chronic/complex conditions	Community Health (CHIP of Bergen County)		# of participants	75
		Bergen County Mental Health Board	**Behavior Modification and Disease Management**: provide evidence based patient and caregiver education related to dementia	# of education sessions provided	48 annually
			Cross Sector Collaboration	Continue to achieve TJC Disease Specific Certification in the Management of Dementia	Re-Certification achieved
Social Determinants of Health and Health Disparities		Bergen County Mental Health Board Community Health (CHIP of Bergen County) Wyckoff Stigma Free	**Screening and Identification**: screen for issues related to the social determinants of health that may be a barrier to a successful discharge and refer to community-based partners for assistance	# of readmissions to RRPH due to lack of linkage to community based services	0
	Reduce health disparities		**Patient Navigation and Access to Care**: provide annual cultural competency training for RRPH SW and provide resources to reduce barriers to health literacy and primary language	% of SW who complete annual cultural competency education	100%
				% of individuals served at RRPH who received interpretation services to overcome barriers to health literacy and language	100%