



JFK MEDICAL CENTER

2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN

INTRODUCTION

Between September 2018 and June 2019, Hackensack Meridian *Health* JFK Medical Center (JFKMC), as part of Hackensack Meridian *Health's* (HMH) network of hospitals and medical centers statewide, conducted a comprehensive Community Health Needs Assessment (CHNA). The assessment included an extensive review of quantitative data, information gathered through a robust household survey, and qualitative information from community stakeholders. During this process, JFKMC made substantial efforts to engage administrative and clinical staff, including senior leadership. A detailed review of the CHNA approach, data collection methods, community engagement activities, and findings are included in JFKMC's 2019 CHNA Report.

Once JFKMC's CHNA activities were completed, HMH facilitated a series of strategic planning sessions with community health stakeholders, community residents, and leadership/staff from JFKMC and HMH. These sessions allowed participants to:

- Review the quantitative and qualitative findings from the CHNA
- Prioritize the leading community health issues
- Discuss segments of the population most at-risk (Priority Populations)
- Discuss community health resources and community assets

After this meeting, JFKMC and HMH staff/leadership continued to work internally and with community partners to develop JFK Medical Center's 2020-2022 Community Health Improvement Plan (CHIP).

COMMUNITY HEALTH PRIORITIES AND AREAS OF OPPORTUNITY

In August 2019, JFKMC took part in a regional prioritization process with other Hackensack Meridian *Health* hospitals in the Central Region. Professional Research Consultants, Inc. (PRC) presented key findings from the CHNA, highlighting the significant health issues identified from the research for the region. Following the data review, PRC answered questions about the data findings.

Meeting attendees were then asked to help prioritize areas of opportunity in the Central Region. Using a wireless audience response system, each participant was able to register their votes for their "top 3" areas of opportunity using a remote keypad. The group identified four regional priorities:

Behavioral Health

Chronic & Complex Conditions

Wellness & Prevention (Risk Factors)

Social Determinants of Health & Access to Care

Below is a listing of sub-priorities within each priority area. Sub-priorities were determined based on areas of opportunity uncovered through the CHNA process.

Behavioral Health, including:

- Mental health
 - Stress
 - Provider ratio
- Substance abuse
 - Vaping
 - Sought help for alcohol/drug use

Chronic & Complex Conditions, including:

- Heart disease and stroke
- Diabetes and pre-diabetes
- Cancer
- Respiratory disease
- Septicemia

Wellness & Prevention (Risk Factors), including:

- Fruit/vegetable consumption
- Overweight/obese adults
- Sedentary lifestyle (children and adults)
- Oral health
- Flu vaccines
- Maternal and infant health

Social Determinants of Health & Access to Care, including:

- Language and culture
- Health literacy
- Poverty and employment
- Violent crime
- Access to recreational facilities
- Barriers to accessing care
- ER utilization

COMMUNITY HEALTH PRIORITIES NOT ADDRESSED IN JFKMC'S CHIP

It is important to note that there are community health needs that were identified through JFKMC's Community Health Needs Assessment that were not prioritized for inclusion in the Community Health Improvement Plan. Reasons for this include:

- Feasibility of JFKMC having an impact on this issue in the short or long term
- Clinical expertise of the organization
- The issue is currently addressed by community partners in a way that does not warrant additional support

Poverty/employment and violent crime were identified as community needs in JFKMC's service area, but were deemed to be outside of JFKMC's primary sphere of influence. JFKMC remains open and willing to work with hospitals across the HMH network and other public and private partners to address these issues should an opportunity arise.

PRIORITY POUPLATIONS

JFK Medical Center is committed to improving the health status of all residents living in their service area. However, based on the assessment's quantitative and qualitative findings, there was agreement that the CHIP should prioritize certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care. Four priority populations were identified:

**Children &
Families**

Older Adults

**Low Resource
Individuals &
Families**

**Racially/Ethnically
Diverse Populations
& Non-English
Speakers**

COMMUNITY HEALTH IMPROVEMENT STRATEGIC FRAMEWORK

The following defines the types of programmatic strategies and interventions that were applied in the development of the Community Health Improvement Plan.

- **Identification of Those At-Risk (Outreach, Screening, Assessment, and Referral):** Screening and assessment programs reduce the risk of death or ill health from a specific condition by offering tests to help identify those who could benefit from treatment. A critical component of screening and referral efforts is to provide linkages to providers, treatment, and supportive services should an issue be detected.
- **Health Education and Prevention:** Initiatives that aim to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, or altering unhealthy behaviors. Programs might include targeted efforts to raise awareness about a particular condition or provide information on risk and protective factors.

- **Behavior Modification and Disease Management:** Evidence-based behavioral modification and/or chronic disease management programs that encourage individuals to manage their health conditions, change unhealthy behaviors, and make informed decisions about their health and care.
- **Care Coordination and Service Integration:** Initiatives that integrate existing services and expand access to care by coordinating health services, patient needs, and information.
- **Patient Navigation and Access to Care:** Efforts which aim to help individuals navigate the health care system and improve access to services when and where they need them.
- **Cross-Sector Collaboration and Partnership:** Includes collaborations, partnerships, and support of providers and community organizations across multiple sectors (e.g., health, public health, education, public safety, and community health).

RESOURCES COMMITTED TO COMMUNITY HEALTH IMPROVEMENT

To execute the strategies outlined in this CHIP, JFKMC will commit direct community health program investments and in-kind resources of staff time and materials. JFKMC may also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, and on behalf of its community partners.

PRIORITY AREA 1: BEHAVIORAL HEALTH

Goal: A community where all residents have access to high quality behavioral health care, and experience mental wellness and recovery

OBJECTIVES

- Support efforts to reduce stigma associated with mental health and substance use issues
- Continue to provide community education and awareness of substance use/misuse and healthy mental, emotional, and social health
- Support opportunities to prevent and reduce the misuse of drugs and alcohol
- Strengthen existing – and explore new – community partnerships to address mental health and substance use

STRATEGIES

Identification of Those at-Risk (Outreach, Screening, Assessment, Referral)

- Support efforts to conduct mental health screenings and provide referrals in primary care settings

Health Education and Prevention

- Support Mental Health First Aid trainings in targeted community-based settings to raise awareness, reduce stigma, and educate residents and service providers about mental health and substance use
- Support Stigma Free Communities to raise awareness and reduce the stigma associated with mental health and substance use issues
- Organize free lectures and educational seminars, conducted by hospital clinical and non-clinical staff, related to mental health and substance use issues in targeted community-based settings

Behavior Modification and Disease Management

- Implement and support evidence-based prevention and cessation programs geared toward reducing vaping and e-cigarette use

Patient Navigation and Access to Care

- Support mental health and substance use support groups for those with or recovering from mental health or substance use and their family/friends/caregivers

Cross-Sector Collaboration and Partnership

- Participate in local and regional health coalitions and taskforces to promote collaboration, share knowledge, and coordinate community health improvement activities
 - *Healthy Plainfield*
 - *Healthier Middlesex*
 - *Middlesex County Health and Wellness Council*
 - *Metuchen, Edison, Woodbridge, South Amboy YMCA*
 - *Jewish Community Center (JCC)*

- Support drug take back efforts with local law enforcement and other community-based partners

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of mental health screenings and referrals
- Number of Mental Health First Aid trainings and number of attendees
- Number of lectures/seminars offered and number of attendees
- Number of tobacco/e-cigarette prevention and cessation efforts and number of individuals reached
- Number of support groups offered and number of attendees
- Number of coalition/task force meetings attended
- Number of drug take back efforts and amount collected

PARTNERS

- Community-based partners (e.g., schools, senior centers, social services, providers)
- Municipal and County leadership
- Municipal and County departments focused on behavioral health
- Law enforcement
- Local task forces, coalitions, and community health partnerships

PRIORITY AREA 2: CHRONIC & COMPLEX CONDITIONS

Goal: All residents will have access to chronic disease education, screening, and management services to achieve an optimal state of wellness

OBJECTIVES

- Continue to screen adults for chronic and complex conditions and risk factors in community-based settings, and refer those at-risk to appropriate services
- Continue to support community education and awareness of chronic and complex conditions
- Continue to monitor and coordinate care for adults with chronic/complex conditions

STRATEGIES

Identification of Those At-Risk (Outreach, Screening, Assessment, Referral)

- Conduct or support chronic/complex conditions screening programs in clinical and non-clinical settings through wellness fairs or stand-alone screening events
 - *Wellness screenings (Blood pressure, pulse, total cholesterol, total glucose, BMI, stroke risk assessment)*
 - *Vascular screenings (Blood pressure, BMI, ABI, AAA measurement, EKG, carotid ultrasound)*
 - *Diabetic retinopathy screenings*
 - *Memory screenings*
 - *Cancer screenings (Skin, colorectal, lung)*
 - *Visual acuity screenings*
 - *Bone density screenings*
 - *Hearing screenings*
 - *Balance screenings*
 - *Pediatric asthma screenings*

Health Education and Prevention

- Support free lectures and educational seminars, conducted by hospital clinical and non-clinical staff, related to chronic/complex conditions in targeted community-based settings
- Support faith-based outreach initiatives that focus on engaging diverse communities through wellness fairs and educational programs
- Provide education on septicemia prevention, identification, and treatment in patient-care and community-based settings

Behavior Modification and Disease Management

- Support evidence-based behavior change and self-management support programs
 - *Take Control of Your Health – Diabetes Self-Management, Tomando Control de su Salud, Cancer Thriving and Surviving*

Patient Navigation and Access to Care

- Support case management and patient navigation programs to support those with chronic/complex conditions and their caregivers
- Offer support groups for individuals with chronic/complex conditions, those affected by the loss of a loved one, and caregivers
 - *Parkinson’s Support Group*
 - *Caregiver Support Group*
 - *Living with Cancer*
 - *Epilepsy Support Group*
 - *Brain Injury Support Group*
 - *Stroke Support Group*
 - *Breast Cancer Support Group*
 - *Insulin Pump Therapy Support*
 - *Brain Tumor Support Group*

Cross-Sector Collaboration and Partnership

- Participate in local and regional health coalitions and task forces to promote collaboration, share knowledge, and coordinate community health improvement activities related to chronic/complex conditions
 - *Healthy Plainfield*
 - *Healthier Middlesex*
 - *Middlesex County Health and Wellness Council*
 - *Metuchen, Edison, Woodbridge, South Amboy YMCA*
 - *Jewish Community Center (JCC)*

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of screenings events held and number of individuals screened
- Number of individuals referred to treatment or support after screening
- Number of lectures/seminars offered and number of attendees
- Number of faith-based outreach initiatives and number of individuals engaged
- Number of behavior change/self-management programs offered and number of attendees
- Number of individuals engaged in case management and patient navigation programs
- Number of support groups offered and number of participants
- Number of task forces/coalition meetings attended
- Results of pre- and post- tests to measure changes in knowledge, attitudes, behaviors, and health outcomes

PARTNERS

- Community-based partners (e.g., schools, churches, senior centers, social services, providers)
- Municipal and County leadership
- Municipal and County departments focused on chronic and complex conditions
- Local task forces, coalitions, and community health partnerships

PRIORITY AREA 3: WELLNESS & PREVENTION (RISK FACTORS)

Goal: All residents will have the tools and resources to recognize and address risk factors that impact health and wellbeing

OBJECTIVES

- Continue to provide education and counseling regarding wellness, health promotion, risk factors, and healthy behaviors
- Support efforts to improve maternal and infant health

STRATEGIES

Identification of Those At-Risk (Outreach, Screening, Assessment, Referral)

- Promote screening for BMI along with counseling for physical activity and nutrition

Health Education and Prevention

- Continue to offer and support prevention, education, and wellness programs that educate individuals on lifestyle changes and make referrals to appropriate community resources
 - *Healthy cooking demonstrations*
 - *Pawsitive Action Team*
- Provide free or low-cost parenting and/or caregiver education and support programs to enhance knowledge, skills, and confidence
 - *Car Seat Safety*
 - *Support groups*
 - *Bike Helmet Safety*
 - *Breastfeeding and New Moms Support Group*

Behavior Modification and Disease Management

- Support active living programs that promote opportunities for individuals to be active
 - *Safe Routes to School*
 - *YMCA Healthy Kids Day*
 - *Senior fitness events*
- Continue to offer cooking demonstrations and workshops that educate people on healthy eating and food preparation

Patient Navigation and Access to Care

- Offer and promote influenza vaccinations at family health centers
- Provide access to low-cost dental care

Cross-Sector Collaboration and Partnership

- Participate in local and regional coalitions and task forces to promote collaboration, share knowledge, and coordinate community health improvement activities related to wellness and prevention
 - *Healthy Plainfield*
 - *Healthier Middlesex*
 - *Middlesex County Health and Wellness Council*
 - *Metuchen, Edison, Woodbridge, South Amboy YMCA*
 - *Jewish Community Center (JCC)*
 - *Give Kids A Smile*

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of BMI screenings offered and number of individuals counseled
- Number of prevention, wellness, and educational programs offered and number of attendees
- Number of parenting/caregiver educational programs offered and number of attendees
- Number of individuals engaged in active living programs
- Number of cooking demonstrations/workshops offered and number of attendees
- Number of influenza vaccinations provided
- Resources devoted to providing access to low-cost dental care
- Number of task forces/coalition meetings attended
- Results of pre- and post- tests to measure changes in knowledge, attitudes, behaviors, and health outcomes

PARTNERS

- Community-based partners (e.g., schools, senior centers, social services, providers)
- Municipal and County leadership
- Municipal and County departments focused on wellness and prevention
- Local task forces, coalitions, and community health partnerships

PRIORITY AREA 4: SOCIAL DETERMINANTS OF HEALTH & ACCESS TO CARE

Goal: All individuals will have the opportunity to be as healthy as possible, regardless of where they live, work, or play

OBJECTIVES

- Support plans, programs, and policies that address barriers to achieving optimal health
- Support individuals to enroll in health insurance and public assistance programs
- Address common barriers to accessing health care

STRATEGIES

Identification of Those At-Risk (Outreach, Screening, Assessment, Referral)

- Implement or support programs that screen for the social determinants of health and make appropriate referrals to community-based resources

Health Education and Prevention

- Conduct targeted outreach to diverse populations and non-English speakers to engage them in care, programs, and services

Behavior Modification and Disease Management

- Support community partners that address barriers associated with the social determinants of health

Patient Navigation and Access to Care

- Provide information on where and how to access community resources
- Continue to offer health insurance enrollment counseling and assistance and patient navigation support services
- Maintain a health resources inventory for residents and community organizations that identifies resources to address social determinants of health
- Support innovative solutions to address leading barriers to care
 - *Convenient care (Urgent Care, RediClinic, telehealth)*
 - *Co-located clinics*
 - *Family Health Centers*
 - *Plainfield Health Connections*
 - *Satellite ED*

Cross-Sector Collaboration and Partnership

- Participate in local and regional health coalitions and taskforces to promote collaboration, share knowledge, and coordinate community health improvement activities
 - *Healthy Plainfield*
 - *Healthier Middlesex*
 - *Middlesex County Health and Wellness Council*
 - *Metuchen, Edison, Woodbridge, South Amboy YMCA*
 - *Jewish Community Center (JCC)*

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of community partners supported and the resources/support provided to them
- Number of outreach efforts and number of individuals engaged
- Number of individuals counseled regarding enrollment in health insurance or public assistance programs
- Resources provided to improve access to care
- Number of cultural competency/health literacy trainings and number of attendees
- Number of task forces/coalition meetings attended

PARTNERS

- Community-based partners (e.g., schools, senior centers, food banks, clinics)
- Municipal and County leadership
- Municipal and County departments focused on social determinants of health and access to care
- Local task forces and coalitions