Hackensack Meridian *Health*

JFK JOHNSON REHABILITATION INSTITUTE
2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN

INTRODUCTION

Between September 2018 and June 2019, Hackensack Meridian *Health* JFK Johnson Rehabilitation Institute (JFKJRI), 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, JFKJRI 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 JFKJRI's 2019 CHNA Report.

Once JFKJRI's CHNA activities were completed, HMH facilitated a series of strategic planning sessions with community health stakeholders, community residents, and leadership/staff from JFKJRI 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, JFKJRI and HMH staff/leadership continued to work internally and with community partners to develop JFK Johnson Rehabilitation Institute's 2020-2022 Community Health Improvement Plan (CHIP).

COMMUNITY HEALTH PRIORITIES AND AREAS OF OPPORTUNITY

In August 2019, JFKJRI 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
  - Depression and other diagnoses
  - Provider ratio
  - Impacts on individuals, families, and communities
- Substance use
  - Vaping
  - Impacts on individuals, families, and communities

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/obesity
- Sedentary lifestyle (children and adults)
- Maternal and infant health
- Oral health

Social Determinants of Health & Access to Care, including:

- Language and culture
- Health literacy
- Poverty and employment
- Barriers to access
- Access to routine medical care (adults and children)
- Access to recreational facilities

COMMUNITY HEALTH PRIORITIES NOT ADDRESSED IN JFKJRI'S CHIP

It is important to note that there were community health needs that were identified through the CHNA that were not prioritized for inclusion in JFKJRIs Community Health Improvement Plan given their clinical focus on rehabilitation services. JFKJRI's CHIP will focus on the areas of Chronic & Complex Conditions, Wellness & Prevention, and Social Determinants of Health & Access to Care. JFKJRI remains open and willing to work with hospitals across the HMH network and other public and private partners to address issues within the Behavioral Health priority area should opportunities arise.

Within the three priority areas that JFKJRI is addressing, there were sub-priorities that were not prioritized for inclusion in the Community Health Improvement Plan. Reasons for this include:

- Feasibility of JFKJRI 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

Oral health and maternal and infant health were identified as community needs in JFKJRI's service area, but were deemed to be outside of JFKJRI's primary sphere of influence.

PRIORITY POPULATIONS

JFK Johnson Rehabilitation Institute 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, JFKJRI will commit direct community health program investments and in-kind resources of staff time and materials. JFKJRI 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: 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
    - *Hearing screenings*
    - *Balance 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

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
    - *Aphasia Support Group*
    - *Laryngectomy Support Group*
    - *Amputee Support Group*
    - *Parkinson's 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
    - *Brain Injury Alliance of New Jersey*
    - *Healthy Plainfield*
    - *Healthier Middlesex*
    - *Middlesex County Health and Wellness Council*

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 2: 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

STRATEGIES

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

- Provide screenings and risk identification assessments to prevent injury
    - *Balance screenings*

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
    - *Fall and injury prevention*

Behavior Modification and Disease Management

- Support active living programs that promote opportunities for individuals to be active

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

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of screenings/assessments offered and number of individuals reached
- Number of prevention, wellness, and educational programs offered and number of attendees
- Number of individuals engaged in active living programs
- 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 3: 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 workforce development programs
- Address common barriers to accessing health care

STRATEGIES

Behavior Modification and Disease Management

- Support community partners that address barriers associated with the social determinants of health
- Support workforce development and pipeline programs to provide job and career opportunities for individuals with disabilities

Patient Navigation and Access to Care

- Provide information on where and how to access community resources
- Maintain a health resources inventory for residents and community organizations that identifies resources to address social determinants of health
- Continue to provide free transportation
- Provide cultural competency and health literacy trainings for hospital clinicians and staff

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*

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of community partners supported and the resources/support provided to them
- Resources devoted to workforce/pipeline programs 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
- Number of food bank/food insecurity programs supported and the resources/support provided to them

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