



## RARITAN BAY MEDICAL CENTER 2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN

### INTRODUCTION

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Between September 2018 and June 2019, Hackensack Meridian *Health* Raritan Bay Medical Center (RBMC), 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, RBMC 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 RBMC's 2019 CHNA Report.

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

### COMMUNITY HEALTH PRIORITIES AND AREAS OF OPPORTUNITY

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In August 2019, RBMC 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
  - Provider ratio
  - Seeking help
- Substance abuse
  - Vaping

### **Chronic & Complex Conditions**, including:

- Heart disease and stroke
- Diabetes and pre-diabetes
- Cancer
- Respiratory disease
- Potentially disabling conditions
- Septicemia

### **Wellness & Prevention (Risk Factors)**, including:

- Overweight/obesity
- Sedentary lifestyle (children)
- Oral health (children and adults)
- Flu/pneumonia vaccinations
- Maternal and infant health

### **Social Determinants of Health & Access to Care**, including:

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

## COMMUNITY HEALTH PRIORITIES NOT ADDRESSED IN RBMC'S CHIP

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

- Feasibility of RBMC 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 and employment were identified as community needs in RBMC's service area, but were deemed to be outside of RBMC's primary sphere of influence. RBMC 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 POPULATIONS

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Raritan Bay 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

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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

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To execute the strategies outlined in this CHIP, RBMC will commit direct community health program investments and in-kind resources of staff time and materials. RBMC 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

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- 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

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#### ***Health Education and Prevention***

- 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
- Conduct and support tobacco and e-cigarette/vaping control and prevention efforts

#### ***Behavior Modification and Disease Management***

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

#### ***Care Coordination and Service Integration***

- Support integrated behavioral health services (mental health and substance use) in primary care and other specialty care settings for those with or at-risk of mental health issues, including screening, assessment, and treatment

#### ***Patient Navigation and Access to Care***

- Support partnerships with clinical and non-clinical partners to enhance access to around-the-clock treatment for those with substance use disorders

- 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

### **SAMPLE OUTCOMES / MEASURES OF SUCCESS**

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- Number of lectures/seminars offered and number of attendees
- Number of tobacco/e-cigarette prevention and cessation efforts and number of individuals reached
- Resources supporting integrated behavioral health services
- Number of support groups offered and number of attendees
- Number of coalition/task force meetings attended

### **PARTNERS**

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- Community-based partners (e.g., schools, senior centers, social services, providers)
- Municipal and County leadership
- Municipal and County departments focused on behavioral health
- 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

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- 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

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#### ***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*

#### ***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

### ***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

## **SAMPLE OUTCOMES / MEASURES OF SUCCESS**

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- 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**

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- 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

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

### STRATEGIES

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#### ***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*
  - *Stop the Bleed*
  - *Are You Getting a Good Night's Sleep?*
  - *Pawsitive Action Team*
- Provide free or low-cost parenting and/or caregiver education and support programs to enhance knowledge, skills, and confidence
  - *SafeSitter*
  - *Support groups*
  - *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*
- Support programs in community-based settings that enhance access to nutritious and affordable foods
  - *Local Farmer's Markets*
  - *The Learning Garden (Perth Amboy)*

- 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 free influenza vaccinations
- Explore partnerships to increase 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
  - *Healthier Perth Amboy*
  - *Healthier Middlesex*
  - *Middlesex County Health and Wellness Council*
  - *Raritan Bay Area YMCA*
  - *Jewish Renaissance*
  - *Puerto Rican Association for Human Development, Inc. (PRAHD)*

## **SAMPLE OUTCOMES / MEASURES OF SUCCESS**

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- 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
- Resources provided to support programs that enhance access to nutritious/affordable foods
- Number of cooking demonstrations/workshops offered and number of attendees
- Number of influenza vaccinations provided
- Resources devoted to increasing 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**

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- Community-based partners (e.g., schools, senior centers, social services, providers)
- Municipal and County leadership
- Municipal and County departments focused on wellness and prevention

## 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

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

### STRATEGIES

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#### ***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)*
- 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
  - *Healthier Perth Amboy*
  - *Healthier Middlesex*
  - *Middlesex County Health and Wellness Council*
  - *Raritan Bay Area YMCA*
  - *Jewish Renaissance*
  - *Puerto Rican Association for Human Development, Inc. (PRAHD)*

### **SAMPLE OUTCOMES / MEASURES OF SUCCESS**

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- 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**

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- 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