PALISADES MEDICAL CENTER
2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN

INTRODUCTION

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

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

COMMUNITY HEALTH PRIORITIES AND AREAS OF OPPORTUNITY

In August 2019, PMC took part in a regional prioritization process with other Hackensack Meridian *Health* hospitals in the Northern 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 Northern 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
  - Stress
  - Provider ratio
- Substance abuse
  - Excessive drinking
  - Binge drinking

Chronic & Complex Conditions, including:

- Heart disease and stroke
- Diabetes and pre-diabetes
- Cancer
- HIV/AIDS prevalence and death
- Septicemia

Wellness & Prevention (Risk Factors), including:

- Fruit/vegetable consumption
- Overweight/obesity
- Sedentary lifestyle (children)
- Maternal and infant health

Social Determinants of Health & Access to Care, including:

- Language and culture
- Poverty and employment
- Education
- Food insecurity
- Housing stability
- Access to recreational facilities
- Violent crime

- Emergency room utilization
- Access to ongoing medical care
- PCP ratio

COMMUNITY HEALTH PRIORITIES NOT ADDRESSED IN PMC'S CHIP

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

- Feasibility of PMC 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, housing stability, access to recreational facilities, and the ratio of primary care physicians were identified as community needs, but were deemed to be outside of PMC's primary sphere of influence. PMC 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

Although Palisades Medical Center is committed to improving the health status of all residents living in its service area, based on the assessment's quantitative and qualitative findings there was agreement that PMC's 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, Palisades Medical Center will commit direct community health program investments and in-kind resources of staff time and materials. PMC 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)

- Conduct targeted mental health screenings in community-based settings

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

- Support partnerships with local health departments, substance use providers, and clinical providers to continue peer recovery coach programs

- Support programs that reduce older adult depression and isolation in community-based settings

- Support evidence-based prevention and 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

- Participate in hospital-based bridge programs with clinical and non-clinical partners to enhance access to 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

- Number of mental health screenings
- 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 older adults engaged in programming
- Resources devoted to bridge programs and integrated behavioral health services
- Number of support groups offered and number of attendees
- Number of coalition/task force meetings attended

PARTNERS

- 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

- 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, BMI)*
    - *A1C screenings for Latino population*
    - *Peak flow screening*
    - *HIV/AIDS screening*

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 in patient-care and community-based setting on septicemia prevention, identification, and treatment

Behavior Modification and Disease Management

- Conduct or 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*
    - *A Matter of Balance*

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

- 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 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, 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*

- Provide free or low-cost parenting and/or caregiver education and support programs to enhance knowledge, skills, and confidence
  - *Breastfeeding/Lactation programs*

Behavior Modification and Disease Management

- Support active living programs that provide 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 BMI screenings offered and number of individuals counseled
- Number of prevention, wellness, and educational programs offered and number of attendees
- Number of parenting/caregiver education and support 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)
- Food pantries, grocery stores, and other food-related community organizations
- 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

- Participate in efforts to promote violence prevention and community cohesion

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

- Provide information on where and how to access community resources

Behavior Modification and Disease Management

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

Patient Navigation and Access to Care

- Continue to offer health insurance enrollment counseling/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

- Provide cultural competency and health literacy training 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
    - *North Hudson Community Action*
    - *Local municipal departments*
    - *Supplemental Nutrition Assistance Program (SNAP)*

- Participate in collaborative efforts to promote violence prevention and community cohesion

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of individuals screened for social determinants and number of referrals made
- Number of individuals counseled regarding enrollment in health insurance or public assistance programs
- Number of individuals connected to community resources
- 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, providers)
- Municipal and County leadership
- Municipal and County departments focused on social determinants of health and access to care
- Local task forces and coalitions