



SHORE REHABILITATION INSTITUTE 2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN

INTRODUCTION

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

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

COMMUNITY HEALTH PRIORITIES AND AREAS OF OPPORTUNITY

In August 2019, SRI took part in a regional prioritization process with other Hackensack Meridian *Health* hospitals in the Southern 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 Southern 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
 - Suicide
 - Provider ratio
- Substance use
 - Alcohol misuse
 - Unintentional drug-related deaths
 - Illicit drug use
 - Secondhand smoke exposure
 - Impacts on individuals, families, and communities

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
- Unintentional injury
- Maternal and infant health

Social Determinants of Health and Access to Care, including:

- Poverty and employment
- Housing stability
- Access to healthy foods
- Violent crime
- Access to recreational facilities
- Barriers to access
- Access to routine medical care for children

- PCP ratio

COMMUNITY HEALTH PRIORITIES NOT ADDRESSED IN SRI'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 SRI's Community Health Improvement Plan given their clinical focus on rehabilitation services. SRI's CHIP will focus on the areas of Chronic & Complex Conditions, Wellness & Prevention, and Social Determinants of Health & Access to Care. SRI remains open and willing to work with hospitals across the HMM network and other public and private partners to address issues within the Behavioral Health priority area should opportunities arise.

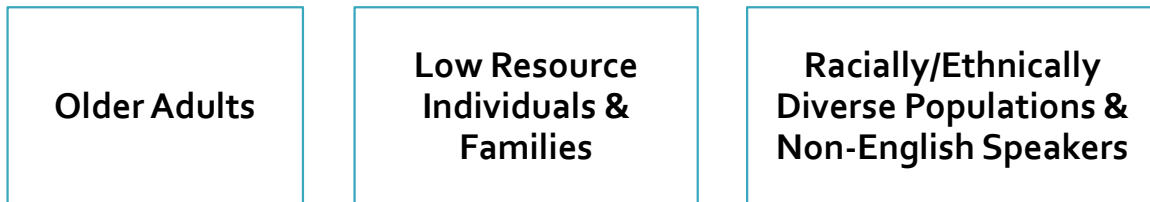
Within the three priority areas that SRI is addressing, there were sub-priorities that were not prioritized for inclusion in the Community Health Improvement Plan. Reasons for this include:

- Feasibility of SRI 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

Maternal and infant health, poverty/employment, housing stability, violent crime, and access to routine medical care for children were identified as community needs in SRI's service area, but were deemed to be outside of SRI's primary sphere of influence.

PRIORITY POPULATIONS

Shore 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. Three priority populations were identified:



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, SRI will commit direct community health program investments and in-kind resources of staff time and materials. SRI 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 increase 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

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

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*
 - *Matter of Balance*

Patient Navigation and Access to Care

- Support case management 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
 - *Stroke Support Group*
 - *Amputee 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*
 - *American Heart Association*

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 individuals engaged in case management programs
- Number of support groups offered and number of participants
- Number of task forces/coalition meetings attended

PARTNERS

- Community-based partners (e.g., 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*
 - *Stroke Prevention 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

PARTNERS

- Community-based partners (e.g., 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
- Address common barriers to accessing health care

STRATEGIES

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

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

Behavior Modification and Disease Management

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

Patient Navigation and Access to Care

- 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
- Provide cultural competency 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
- Participate in efforts to enhance access to affordable and reliable forms of transportation
 - *Free hospital transportation*
 - *Lyft partnership*

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of screenings and referrals
- Number of community partners supported and the resources/support provided to them
- Resources provided to improve access to care
- Number of cultural competency trainings and number of attendees
- Number of task forces/coalition meetings attended
- Resources devoted to transportation programs

PARTNERS

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