CARRIER CLINIC
2020-2022 COMMUNITY HEALTH IMPROVEMENT PLAN

INTRODUCTION

Between September 2018 and June 2019, Hackensack Meridian *Health* Carrier Clinic, 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, Carrier Clinic 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 Carrier Clinic's 2019 CHNA Report.

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

COMMUNITY HEALTH PRIORITIES AND AREAS OF OPPORTUNITY

In August 2019, Carrier Clinic 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
  - Awareness/education
  - Denial/stigma
  - Lack of providers
  - Access to services
  - Contributing factors
- Substance abuse
  - Unintentional drug-related deaths
  - Alcohol use
  - 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:

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

Social Determinants of Health & Access to Care, including:

- Access to care
- Health literacy
- Poverty and employment
- Food insecurity
- Access to healthy foods

COMMUNITY HEALTH PRIORITIES NOT ADDRESSED IN CARRIER CLINIC'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 Carrier Clinic's Community Health Improvement Plan given their clinical focus on psychiatric and addiction treatment. Carrie Clinic's CHIP will focus on the areas of Behavioral Health and Social Determinants of Health & Access to Care. Carrier Clinic remains open and willing to work with hospitals across the HMH network and other public and private partners to address issues within the priority areas of Wellness & Prevention (Risk Factors) and Chronic & Complex Conditions should opportunities arise.

PRIORITY POPULATIONS

Although Carrier Clinic is committed to improving the health status of all residents living in its service area, community benefit activities will focus on reaching demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care. Four priority populations were identified through the CHNA:

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, Carrier Clinic will commit direct community health program investments and in-kind resources of staff time and materials. Carrier Clinic 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: 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 support initiatives that promote community education and awareness of substance use/misuse and healthy mental, emotional, and social health
- Continue to provide free mental health screenings for anxiety, depression, and alcohol dependence
- 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, and Referral)

- Continue to conduct free mental health screenings for anxiety, depression, and alcohol dependence

Health Education and Prevention

- Conduct 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.
- Offer 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
- Support tobacco, e-cigarette/vaping, and secondhand smoke control and prevention efforts

Behavior Modification and Disease Management

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

Patient Navigation and Access to Care

- Continue to partner 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

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

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of screenings offered and number of individuals screened
- 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 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

- Montgomery Rocky Hill Municipal Alliance (and associated municipal alliances statewide)
- Healthier Somerset Coalition, Healthier Middlesex Coalition, others
- County Chiefs of Police Associations
- County Health Officers
- County Prosecutors
- School Nurses Associations
- County Offices on Aging and Disabilities Services
- United Way
- YMCA
- County Business Partnerships and Regional Chambers of Commerce

PRIORITY AREA: 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
- Promote detection, education, and prevention of domestic and interpersonal violence

STRATEGIES

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

- Conduct programs that screen for the social determinants of health and make appropriate referrals to community-based resources
- Conduct screenings for domestic and interpersonal violence and provide referrals to community resources

Health Education and Prevention

- 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
- 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

SAMPLE OUTCOMES / MEASURES OF SUCCESS

- Number of individuals screened for barriers related to social determinants and number of referrals made to community resources
- Number of individuals screened for domestic violence and number of referrals to community resources
- Number of cultural competency and health literacy trainings offered
- Number of coalition/task force meetings attended

PARTNERS

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