JFK Medical Center

Exceptional Care. Exceptional People.

Community Health Needs Assessment: 2015 Implementation Strategy Update

Framework for Evaluating Potential Strategic Options

- In developing JFK Medical Center's CHNA Implementation Strategy, the following framework was applied to each identified, significant community health need in order to evaluate potential strategic options:

1. Current Programs
2. New Programs
3. Partner with Existing Community Resources
4. Facilities
5. Charity Care Programs
6. Preventive Care Programs
7. Education
8. Patient Awareness and Navigation
9. Advocacy
10. Do Nothing

Significant Health Needs: Core Competency

Prioritized Health Need	Implementation Strategy	Progress Metric
2. Emergency Care Services	• Develop new Emergency Department ("ED") Pavilion on Edison campus to increase capacity and speed throughput *(Current Programs, Facilities)*	• Increase ED square footage to 54,000 • New space online by 2015 *In Progress*
	• Create separate area in ED for behavioral health patients to provide appropriate beds, equipment, and privacy while awaiting discharge and speed throughput for other patients in the ED *(New Programs, Facilities)*	• 4 dedicated treatment areas for behavioral health opened *Completed*
	• Launch Plainfield Health Initiative to identify and facilitate needed primary care relationships for Plainfield residents to reduce inappropriate utilization to free up needed ED capacity *(New Programs, Charity Care Programs, Patient Awareness & Navigation)*	• Attempt to secure funding and begin enrolling patients within three months after funding *Completed*
	• Prepare an analysis of the Satellite ED on the Muhlenberg campus to ensure it is properly sized, configured, and located to best meet the type of cases presented *(Current Programs)*	• *Analysis completed during 2014*
	• *New for 2015!* Establish an Urgent Care Center in PSA to supplement Urgent/ Emergency care access through JFK Medical Associates (Preventive Care Programs, New Programs)	• *Completed*

Prioritized Health Need	Implementation Strategy	Progress Metric
5. Weight Control Programs	• Work with physician practices to expand number of area residents serviced by JFK for Life *(Current Programs, Preventive Care Programs, Education, Patient Awareness & Navigation)*	• Increase program membership by 10% within three years. Achieved two percent annual membership growth.
	• Continue Pediatric Weight Management Program at area middle schools *(Current Programs, Preventive Care Programs, Education)*	• Maintain program funding Completed

Significant Health Needs: Core Competency

Prioritized Health Need	Implementation Strategy	Progress Metric
5. Weight Control Programs (cont.)	• Increase number of Healthy Way Program sessions *(Current Programs, Education)*	• Increase from 7 sessions per year to 10 within three years Ongoing
	• *New for 2015!* Improve access to primary care by recruiting primary care physicians that accept Medicaid to JFK Medical Associates. (Preventive Care Programs, New Programs)	• *Completed*

Prioritized Health Need	Implementation Strategy	Progress Metric
7. Physical Activity Programs	• Work with physician practices to expand number of area residents serviced by JFK for Life *(Current Programs, Preventive Care Programs, Education, Patient Awareness & Navigation)*	• Increase program membership by 10% within three years Achieved 2 percent annual membership growth.
	• Continue sponsorship of Miles for Minds 5K Race, Plainfield-Queen City Historic 5K Walk/Run for Life, and Girls on the Run	• Maintain current sponsorship levels Completed *Completed*

Prioritized Health Need	Implementation Strategy	Progress Metric
15. Mammography Screening	• Continue Maximizing Mammography program offering annual outreach to ~1,000 women, including 100 no-cost mammograms to underserved women *(Current Programs, Preventive Care Programs)*	• Maintain Susan G. Komen grant Applied for and did not receive Susan G. Komen grant renewal. Completed Strategy using other-source funds.
	• Increase number of non-Susan G. Komen grant related outreach activities *(Current Programs, Preventive Care Programs, Education, Patient Awareness & Navigation)*	• Increase from 5-6 events to 10 events annually Completed
	• Increase screening among patients at the JFK Family Medicine Center *(New Programs, Preventive Care Programs, Patient Awareness & Navigation)*	• Begin to measure screening rates to establish a baseline

Significant Health Needs: Core Competency

Prioritized Health Need	Implementation Strategy	Progress Metric
19. Diabetic Screening	• Develop Centering Diabetes group model of care for diabetic patients through the JFK Family Medicine Center *(New Programs, Preventive Care Programs, Education)*	• Implement and maintain program for the next three years.. Competed
	• Continue Pediatric Weight Management Program at area middle schools *(Current Programs, Preventive Care Programs, Education)*	• Maintain funding for program Completed
	• Promote screening services in outreach, advertising, and/or marketing materials *(Current Programs, Preventive Care Programs, Education, Patient Awareness & Navigation)*	• Promote at least six times per year Completed
	• Offer free blood glucose screenings at health fairs and outreach events *(Current Programs, Preventive Care Programs, Education)*	• Conduct at least 10 events annually Completed
Prioritized Health Need	**Implementation Strategy**	**Progress Metric**
20. Low Birth-weight	• Maintain gains in reducing elective inductions prior to 39 weeks *(Current Programs)*	• Keep elective inductions prior to 39 weeks below 1%. Completed
	• Continue and expand Centering Pregnancy model *(Current Programs, Education)*	• Maintain funding and reduce drop-out rate after intake to 20%. Completed
	• Continue Plainfield Connections program outreach activities to promote prenatal care *(Current Programs, Education, Preventive Care Programs)*	• Maintain funding for program. Completed
	• Begin working with Union County providers to explore adoption of Centering Pregnancy model or similar model *(Partner with Existing Community Resources, Preventive Care Programs)*	• Conduct at least two meetings. Completed

Significant Health Needs: Specialized Community Assets

20. Low Birthweight (cont.)		
	• *New for 2015!* Improve access to pre-natal care by recruiting OB/GYN's that accept Medicaid to JFK Medical Associates. (Preventive Care Programs, New Programs)	• *Completed*

Prioritized Health Need	Implementation Strategy	Progress Metric
1. Mental Health Services	• Continue providing services through the Center for Behavioral Health in Edison *(Current Programs)*	• Maintain funding Completed
	• Continue providing navigation services for behavioral health ED patients to ensure placement into the best available care setting *(Current Programs, Patient Awareness & Navigation)*	• Maintain funding for these services. Completed
	• Create separate area in ED for behavioral health patients to provide appropriate beds, equipment, and privacy for these patients *(New Programs, Facilities)*	• 4 dedicated treatment areas for behavioral health opened *Completed*
	• Provide dedicated nurse case manager for Family Medicine Center patients with depression to coordinate care *(New Programs, Patient Awareness & Navigation)*	• Implement and maintain program for the next three years Implemented in 2014 and revised to an individualized care program in 2015 to improve patient response.
	• Work with existing community mental health resources to discuss ways to ensure behavioral health patients are getting care where and when they need it *(Partner with Existing Community Resources)*	• Conduct six meetings per year with community resources. Completed
	• Meet with appropriate Federal, State, and Local officials to create awareness of existing systemic challenges in care delivery to behavioral health patients *(Advocacy)*	• Conduct four meetings per year with governmental officials . Completed

Significant Health Needs: Specialized Community Assets

Prioritized Health Need	Implementation Strategy	Progress Metric
3. Substance Abuse Services	• Continue providing services through the Center for Behavioral Health in Edison *(Current Programs)*	• Maintain funding. Completed
	• Continue providing navigation services for ED patients to ensure placement into the best available care setting *(Current Programs, Patient Awareness & Navigation)*	• Maintain funding for these services. Completed
	• Work with existing community mental health resources to discuss ways to ensure substance abuse patients are getting care where and when they need it *(Partner with Existing Community Resources)*	• Conduct six meetings per year with community resources. Completed
	• Meet with appropriate Federal, State, and Local officials to create awareness of existing systemic challenges in care delivery to substance abuse patients *(Advocacy)*	• Conduct four meetings per year with governmental officials . Completed

Significant Health Needs: Specialized Community Assets

Prioritized Health Need	Implementation Strategy	Progress Metric
6. Reproductive Services for Youth	• Continue Plainfield Connections services with area high schools *(Current Programs, Preventive Care, Education)*	• Maintain funding for program. Completed
	• Conduct outreach at area high schools through the JFK Family Medicine Residency program to provide education *(New Programs, Preventive Care Programs, Education)*	• Conduct six educational events per year. Discontinued – No longer part of Family Medicine Curriculum and Edison Twp did not renew contract.
	• Work with existing community resources to discuss ways to support education, outreach, and services to youth *(Partner with Existing Community Resources)*	• Conduct six meetings per year with community resources. Completed
	• *New for 2015!* Improve access to Reproductive Services for Youth • by recruiting OB/GYN's and PCPs that accept Medicaid to JFK Medical Associates. (Preventive Care Programs, New Programs) •	Completed

Prioritized Health Need	Implementation Strategy	Progress Metric
12. Excessive Drinking	• Continue providing services through the Center for Behavioral Health in Edison *(Current Programs)*	• Maintain funding . Completed
	• Continue providing navigation services for ED patients to ensure placement into the best available care setting *(Current Programs, Patient Awareness & Navigation)*	• Maintain funding for these services. Completed
	• Work with existing community mental health resources to discuss ways to ensure substance abuse patients are getting care where and when they need it *(Partner with Existing Community Resources)*	• Conduct six meetings per year with community resources . Completed
	• Meet with appropriate Federal, State, and Local officials to create awareness of existing systemic challenges in care delivery to substance abuse patients *(Advocacy)*	• Conduct four meetings per year with governmental officials. Completed

Significant Health Needs: Specialized Community Assets

Prioritized Health Need	Implementation Strategy	Progress Metric
13. Sexually Transmitted Infections	• Continue Plainfield Connections services with area high schools *(Current Programs, Preventive Care, Education)*	• Maintain funding for program. Completed
	• Conduct outreach at area high schools through the JFK Family Medicine Residency program to provide education *(New Programs, Preventive Care Programs, Education)*	• Conduct six educational events per year. Discontinued – No longer part of Family Medicine Curriculum and Edison Twp did not renew contract.
	• Work with existing community resources to discuss ways to support education and outreach *(Partner with Existing Community Resources)*	• Conduct six meetings per year with community resources. *Completed*
	• *New for 2015!* Improve access to STD prevention care by recruiting OB/GYN's and PCPs that accept Medicaid to JFK Medical Associates. (Preventive Care Programs, New Programs)	• *Completed*

Significant Health Needs: Environmental

Prioritized Health Need	Implementation Strategy	Progress Metric
4. Services for Low Income	• Launch Plainfield Health Initiative to identify and facilitate needed primary care relationships for Plainfield residents *(New Programs, Charity Care Programs, Patient Awareness & Navigation)*	• Attempt to secure funding and begin enrolling patients within three months after funding *Completed*
	• Continue existing Family Medicine Center, charity care, and financial assistance programs *(Current Programs, Charity Care Programs)*	• Maintain policies and funding *Completed*
Prioritized Health Need	**Implementation Strategy**	**Progress Metric**
8. Violent Crime Rate	• Develop routine screening activities among JFK Medical Center patients to detect intimate partner violence *(New Programs)*	• Screening tool developed. Completed
	• Create mechanism to routinely link victims of violence presenting at JFK Medical Center with available community services *(Current Programs, Partner with Existing Community Resources, Patient Awareness & Navigation)*	• Preferred partners identified and process for linking patients developed. Completed
Prioritized Health Need	**Implementation Strategy**	**Progress Metric**
9. Inadequate Social Support	• Continue current Centering Pregnancy program, Plainfield Connections, and Rotary fund raiser *(Current Programs)*	• Maintain funding *Completed*
Prioritized Health Need	**Implementation Strategy**	**Progress Metric**
10. Fast Food Restaurants	• Participate in outreach events to promote healthy eating habits *(New Programs, Education)*	• Participate in four events per year *Completed*
Prioritized Health Need	**Implementation Strategy**	**Progress Metric**
11. Unemployment Rate	• Work with area Chambers of Commerce to foster economic development and creation of jobs in the area *(Partner with Existing Community Resources, Advocacy)*	• Attend 12 meetings per year *Completed*

Significant Health Needs: Environmental

Prioritized Health Need	Implementation Strategy	Progress Metric
14. Daily Fine Particulate Matter	• Work with political leaders and relevant governmental regulatory agencies to improve air quality standards *(Advocacy)*	• Send one letter annually to relevant bodies. Discontinued in 2016 due to new data from American Lung Association indicating "A" grade for Air Particle Pollution in Middlesex County.

Prioritized Health Need	Implementation Strategy	Progress Metric
16. Cancer Incidence	• Work with political leaders and relevant governmental regulatory agencies to improve environmental quality standards *(Advocacy)*	• Send one letter annually to relevant bodies. Completed
Prioritized Health Need	**Implementation Strategy**	**Progress Metric**
17. Children in Single Parent Home	• Continue Nursing School housing program *(Current Programs)*	• Maintain funding *Completed*
Prioritized Health Need	**Implementation Strategy**	**Progress Metric**
18. Population in Poor/Fair Health	• Continue existing Family Medicine Center, charity care, and financial assistance programs *(Current Programs, Charity Care Programs)*	• Maintain policies and funding *Completed*
	• Continue Plainfield Connections home visitation model for mothers with young children *(Current Programs, Education)*	• Maintain funding *Completed*
	• Continue Childhood Lead Poisoning program to reduce lead exposure *(Current Programs)*	• Maintain funding *Completed*
	• Continue Healthy Homes Equal Healthy Families program to reduce environmental exposures in the home *(Current Programs)*	• Maintain funding *Completed*
	• Launch Plainfield Health Initiative to identify and facilitate needed primary care relationships for Plainfield residents *(New Programs, Charity Care Programs, Patient Awareness & Navigation)*	• Attempt to secure funding and begin enrolling patients within three months after funding *Completed*