Healthier Somerset

Somerset County, NJ Community Health Improvement Plan (CHIP)

January 2016

Dear Somerset County Friends,

We are pleased to present the 2015-2018 Community Health Improvement Plan (CHIP) for Somerset County. The plan is a response to a Community Health Needs Assessment (CHNA), a process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community. The data collected in the CHNA has been reviewed, analyzed, and discussed by stakeholders across the county who comprise *Healthier Somerset,* a coalition of representatives from healthcare, government, business, education, non-profit organizations, and faith-based communities in Somerset County. The mission of the coalition is to work collaboratively to improve the health and well-being of all who live and work in Somerset County.

By sharing information and creating alliances among individuals and organizations who are working toward mutual goals, we collectively increase our efforts to create a healthier Somerset County. The health of all who live and work in Somerset County has a direct bearing upon our physical, emotional, and economic wellbeing. As a community, we embrace an agenda that identifies our greatest health needs and sets forth an action plan to address these needs.

We gratefully acknowledge the contributions and support of our partners who assisted in the development of this CHIP. Special recognition is due to Robert Wood Johnson University Hospital Somerset for its generous support for the initial research and for convening *Healthier Somerset.* We also wish to thank the public health officers of Somerset County, including the Somerset County Department of Health; Greater Somerset Public Health Partnership; Somerset County Health Officers Association; and the local health officers from across Somerset County.

As *Healthier Somerset* continues our efforts to make Somerset County the healthiest county in New Jersey, we are confident that our collective efforts will garner greater change than any one individual or organization working alone. We invite and encourage all members of the Somerset County community to join us in our mission.

Sincerely,

The Partners of Healthier Somerset

Table of Contents

EXECUTIVE SUMMARY

It is critical to understand the specific environmental factors in Somerset County -- where and how we live, learn, work, and play, and how they in turn influence our health -- in order to implement the best strategies for community health improvement. To accomplish this goal, the Robert Wood Johnson University Hospital – Somerset, NJ (RWJUH – Somerset) led a comprehensive community health planning effort with the Healthier Somerset Coalition to measurably improve the health of Somerset County residents. This effort included two major phases:

1. A community health needs assessment (CHNA) to identify the health related needs and strengths of Somerset County

2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across Somerset County

The CHNA and CHIP are essential frameworks for guiding future services, programs, and policies for healthcare and public health-serving agencies in the area overall. For nonprofit hospitals like RWJUH-Somerset, the CHNA and the hospital-based strategic implementation plan (SIP) are required to maintain nonprofit status with the IRS, form 990, and deliver community-based programming that is well aligned with and informed by community needs.

The CHNA and CHIP are also required for Somerset County health departments to earn accreditation by the Public Health Accreditation Board (PHAB), a distinction which indicates that these agencies are meeting national standards for public health system performance.

The Healthier Somerset Community Health Improvement Plan was developed over the period February, 2015 - November, 2015, using the key findings from the CHNA, which included qualitative data from focus groups, key informant interviews and a community survey; as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas. The CHNA is accessible at https://www.co.somerset.nj.us/health/Docs/Somerset%20CHA_DRAFT%20REPORT_8%2025%2015.pdf

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Healthier Somerset assessment and planning process engaged hospital leaders, local public health partners, and community based organizations through different avenues.

The Healthier Somerset Coalition, a broadly representative stakeholder group of nearly 50 organizations that included health department leaders, hospital representatives, and community-based organization leaders, was responsible for guiding, participating in, and providing feedback on all aspects of assessment and planning. Coalition members participated in at least one of the key engagement efforts below:

a. The Data Committee, comprised of health department and hospital leadership, was responsible for overseeing and providing input to the community health needs assessment
b. The Planning Committee, comprised of additional health department leaders and hospital representatives, was responsible for overseeing and providing input to the community health improvement plan, including outreach to potential participants; feedback on planning agendas; and feedback on draft components.
c. The Robert Wood Johnson University Hospital - Somerset management team and staff were responsible for convening meetings, reviewing documents and providing overall project management and oversight.

d. The CHIP Workgroups, representing subsets of the broader Healthier Somerset Coalition organized around each health priority area, were responsible for developing the goals, objectives and strategies for the CHIP.
e. The Healthier Somerset Advisory Board, comprised of 13 community representatives from Somerset County, represented diverse sectors including government, non-profit organizations and coalitions, business and industry, health, education, and community services and provided overall strategic leadership for the Coalition.

The Healthier Somerset Coalition met for two half-day, facilitated planning sessions on June 16, 2015 and September 15, 2015 to develop the core elements of the CHIP. In the first planning session, participants responded to and refined draft Vision and Values statements developed during a brainstorming session at the Coalition's CHNA-CHIP kickoff meeting on February 13, 2015. Participants also used common rating criteria and a selection tool to identify the top health priorities for the CHIP and began drafting goal statements for them. In session two, participants continued the planning process and developed objectives and evidence-based strategies for each of the goals. The output of these two half day sessions follows below:

Vision

All residents of Somerset County have an equal opportunity to pursue healthy lifestyles and achieve social, emotional, physical, and spiritual well-being.

With this vision in mind, we intend for this CHIP to provide a clear plan that empowers all who live, work, and play in Somerset County to:

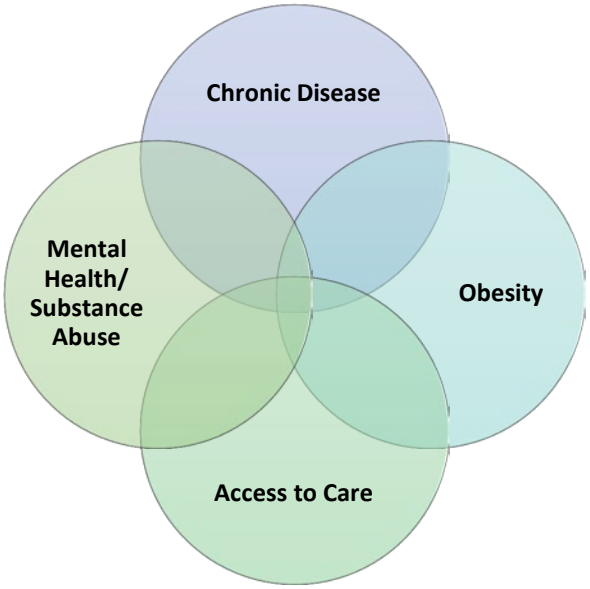
- Achieve a complete, deeper, and broader understanding of the health status of Somerset County's population
- Direct their own health and access community resources to support healthy choices
- Engage as educated, knowledgeable participants in policy, advocacy, and decision-making activities that support the advancement of the community's health

Values

1. **Integrity**: We honor the process, the data/plan itself, and are open throughout the assessment and planning process with all key stakeholders. We are unbiased, transparent, and welcome differences in opinion and approach to build and foster trust among our partners.
2. **Equity**: All community members will be included in our thought process. We will request and use community voices, experiences, and resources in our assessment, plan, and implementation. We talk about the community as a whole, although data will come from inside and outside. We work to make sure all forums and the plan itself are accessible and understandable to community stakeholders. We ensure the needs of vulnerable populations are integrated in our discussions and approaches.
3. **Effectiveness**: We will use a realistic approach and be driven toward making actual change in our community's health and well-being. We will be thoughtful in our discussions but be mindful of timely decision-making and processes. We will seek to be efficient, leveraging effort and expertise and avoiding duplicative processes whenever possible. We will be cost effective and strive to make strategic use of all available resources.
4. **Evaluation**: We will define measurable targets so we can evaluate and be accountable for our results.
5. **Collaboration**: We will foster and enhance partnerships among public health organizations and with community members and organizations. We need and value all contributions and commit to being fully participative and engaged in all assessment, planning, implementation, and evaluation activities related to improving our community's health.
6. **Innovation**: We are forward-thinking and creative in our approach, and accept that this can sometimes be disruptive or uncomfortable when we challenge our old ways of thinking and doing. We will be flexible and adaptable to new approaches and challenges as they arise.

Health Priorities

Mental Health/Substance Abuse, Obesity, Chronic Disease, and Access to Care were identified as the priority health topics for the CHIP. In addition, during the selection process and follow on discussion, participants agreed that Healthy Eating/Active Living should not be a standalone topic, but rather a cluster of related, evidence-based strategies to address three out of the four identified priorities.



Priority Area	Goal Statement
Priority Area 1: Mental Health and Substance Abuse	**Goal 1:** Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.
Priority Area 2: Obesity	**Goal 2:** Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.
Priority Area 3: Chronic Disease	**Goal 3:** Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.
Priority Area 4: Access to Care	**Goal 4:** Improve the access to and awareness of health care services for those living and working in Somerset County, including underserved populations.

Healthier Somerset, Somerset County, NJ Community Health Improvement Plan

BACKGROUND

It is critical to understand the specific environmental factors in Somerset County -- where and how we live, learn, work, and play, and how they in turn influence our health -- in order to implement the best strategies for community health improvement. To accomplish this goal, the Robert Wood Johnson University Hospital – Somerset (RWJUH – Somerset) led a comprehensive community health planning effort with the Healthier Somerset Coalition to measurably improve the health of Somerset County residents. This effort included two major phases:

1. A community health needs assessment (CHNA) to identify the health related needs and strengths of Somerset County
2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across Somerset County

The CHNA and CHIP are essential frameworks for guiding future services, programs, and policies for healthcare and public health-serving agencies in the area overall. For nonprofit hospitals like RWJUH-Somerset, the CHNA and the hospital-based strategic implementation plan (SIP) are required to maintain nonprofit status with the Internal Revenue Service (IRS), form 990, and deliver community-based programming that is well aligned with and informed by community needs.

The CHNA and CHIP are also required for Somerset County health departments to earn accreditation by the Public Health Accreditation Board (PHAB), a distinction which indicates that these agencies are meeting national standards for public health system performance.

I. OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PLAN

A. What Is a Community Health Improvement Plan?

A Community Health Improvement Plan, or CHIP, is a data-driven, collective, action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed, including strategies and measures, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.[1]

Building upon the key findings and themes identified in the Community Health Needs Assessment (CHNA), the CHIP:

- Identifies priority issues for action to improve community health
- Outlines an implementation and improvement plan with performance measures for evaluation
- Guides future community decision-making related to community health improvement

[1] As defined by the Health Resources in Action, Strategic Planning Department, 2012

The CHNA and CHIP are essential frameworks for guiding future services, programs, and policies for healthcare and public health-serving agencies in the area overall. For nonprofit hospitals like RWJUH-Somerset, the CHNA and the hospital-based strategic implementation plan (SIP) are required to maintain nonprofit status with the IRS, form 990, and deliver community-based programming that is well aligned with and informed by community needs.

The CHNA and CHIP are also required for Somerset County health departments to earn accreditation by the Public Health Accreditation Board (PHAB), a distinction which indicates that these agencies are meeting national standards for public health system performance.

B. How To Use The CHIP

A CHIP is designed to be a broad, strategic framework for community health, and should be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives so that all community groups and sectors – private and nonprofit organizations, government agencies, academic institutions, community- and faith-based organizations, and citizens – can unite to improve the health and quality of life for all people who live, work, learn, and play in Somerset County. We encourage you to review the priorities and goals, reflect on the suggested strategies, and consider how you can participate in this effort, in whole or in part, as either an independent contributor or as a member of a health-focused agency, organization, or group. Consider: How do your current plans align with the CHIP? How can your future plans align with the CHIP?

C. Relationship Between the CHIP and Other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the public health of Somerset County. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP planning process identified potential partners and resources already engaged in these efforts wherever possible. Examples include: EmPoWER Somerset, Community in Crisis, and the Regional Chronic Disease Coalition for Morris & Somerset County (RCDC), as well as local hospitals and health departments.

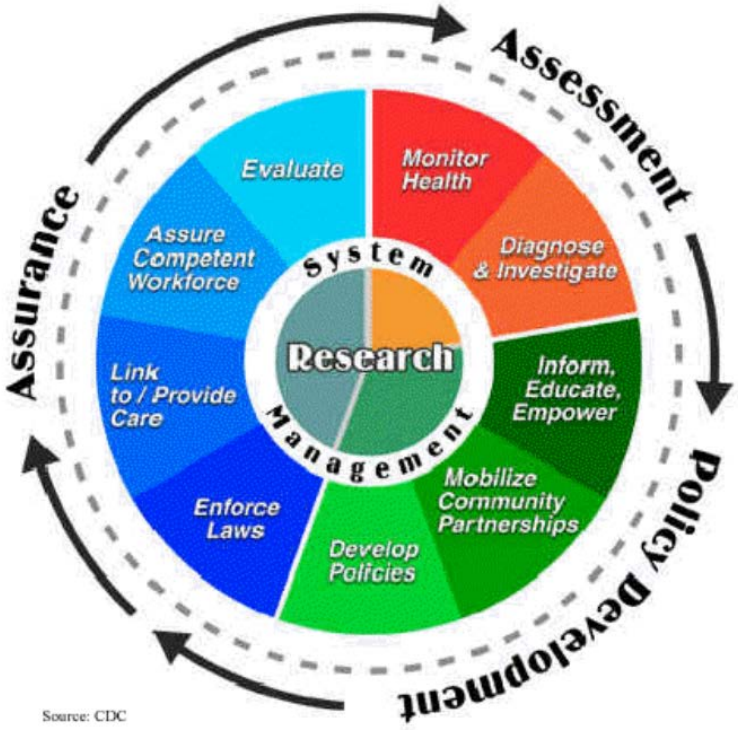
D. Methods

To develop the CHIP, RWJUH-Somerset was the convening organization that brought together community residents and the area's influential leaders in healthcare, community organizations, and other key sectors, such as transportation, mental health, local government, and social services. Following the guidelines of the National Association of County and City Health Officials (NACCHO), the community health improvement process was designed to integrate and enhance the activities of many organizations' contributions to community health improvement, building on current assets, enhancing existing programs and initiatives, and leveraging resources for greater efficiency and impact.

The assessment/planning/implementation/evaluation/reassessment process is a continuous cycle of improvement that seeks to "move the needle" on key health priorities over the course of time. The cyclical nature of the Core Public Health Functions is illustrated below in **Error! Reference source not found.**.

The next phase of the CHIP will involve broad implementation of the strategies through an annual action plan identified from the CHIP, and monitoring/evaluation of the CHIP's short-term and long-term outcome indicators through reporting on these annual plans.

Figure 1: The Cyclical Nature of the Core Public Health Functions



Source: Centers for Disease Control and Prevention (CDC), Ten Essential Public Health Services

II. PROCESS FROM ASSESSMENT TO PLANNING

The Healthier Somerset Community Health Improvement Plan was developed over the period February, 2015-November, 2015, using the key findings from the CHNA, which included qualitative data from focus groups, key informant interviews and a community survey; as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas. The CHNA is accessible at http://healthiersomerset.org/Somerset%20CHA_REPORT_090615.pdf

Similar to the process for the Community Health Needs Assessment (CHNA), the CHIP utilized a participatory, collaborative approach guided in part by elements of the Mobilization for Action through Planning and Partnerships (MAPP) process.[2] MAPP, a comprehensive, community-driven planning process for improving health, is a strategic framework that many community health coalitions across the country have employed to

[2] Advanced by the National Association of County and City Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. More information on MAPP can be found at: http://www.naccho.org/topics/infrastructure/mapp/

help direct their planning efforts. MAPP comprises rigorous assessment as the foundation for planning, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP planning/ implementation/ evaluation/ correction process allows for the periodic identification of new priorities and the realignment of activities and resources to address them.

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Healthier Somerset assessment and planning process engaged hospital leaders, local public health partners, and community based organizations through different avenues.

Healthier Somerset, a coalition of 55 organizations that includes health department leaders, hospital representatives, and community-based organization leaders, was responsible for guiding, participating in, and providing feedback on all aspects of assessment and planning. Coalition members participated in at least one of the key engagement efforts below:

a. The Data Committee, comprised of health department and hospital leadership, was responsible for overseeing and providing input to the community health needs assessment
b. The Planning Committee, comprised of additional health department leaders and hospital representatives, was responsible for overseeing and providing input to the community health improvement plan, including outreach to potential participants; feedback on planning agendas; and feedback on draft components.
c. The Robert Wood Johnson University Hospital - Somerset Management Team and staff was responsible for convening meetings, reviewing documents and providing overall project management and oversight.
d. The CHIP Workgroups, representing subsets of the broader Healthier Somerset Coalition organized around each health priority area, was responsible for developing the goals, objectives and strategies for the CHIP.
e. The Healthier Somerset Advisory Board, comprised of 13 community representatives from Somerset County, represented diverse sectors including government, non-profit organizations and coalitions, business and industry, health, education, and community services and provided overall strategic leadership for the Coalition.

In 2015, the Robert Wood Johnson University Hospital-Somerset (RWJUH-Somerset) engaged Health Resources in Action (HRiA), a non-profit public health organization located in Boston, MA, as a consultant partner to provide strategic guidance and facilitation of the CHNA-CHIP process, collect and analyze data, and develop the resulting reports and plan. HRiA has extensive experience developing health assessments and health improvement plans locally, regionally, and nationally, including state-level plans in Massachusetts, Connecticut, and New Hampshire. Over the past two years, HRiA has assisted both local and State health departments in meeting the required assessment and planning standards for Public Health Accreditation Board (PHAB) accreditation.

On February 13, 2015, HRiA facilitated a kick-off meeting with the Advisory Board and Healthier Somerset Coalition to review the assessment and planning processes, timelines, and roles; identify key stakeholders to engage in these processes; and begin brainstorming concepts for Vision and Values statements to become the strategic foundation for the CHIP.

The Healthier Somerset coalition met for two half-day planning sessions facilitated by HRiA consultants on June 16, 2015 and September 15, 2015 to develop the core elements of the CHIP. In the first planning session, HRiA presented an overview of the CHNA methodology and shared key findings from the CHNA. Participants then responded to and refined draft Vision and Values statements developed during the kickoff meeting in February. Participants used a ranking/rating selection tool with common criteria and were led through a multi-voting process with dots to identify the top health priorities for the CHIP. Session one concluded with participants self-selecting to CHIP priority area work groups and creating draft and final goal statements for their priority area, after incorporating structured feedback from other work groups (see Appendix B for a copy of the rating/ranking tool).

In the second planning session, CHIP priority area work groups continued developing draft and final objectives, and draft evidence-based strategies and potential partners, for each of the CHIP priorities. Working group participants were provided sample evidence-based strategies from a variety of resources including The Community Guide to Preventive Services, County Health Rankings, Healthy People 2020, and the National Prevention Strategy. Indicators for each objective were identified based on data available from the CHNA (including County Health Rankings and BRFSS data), using whenever possible targets outlined in Healthy People 2020 (HP2020). HP2020 is the federal government's prevention agenda for building a healthier nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. The vision of Healthy People 2020 is to have a society in which all people live long, healthy lives. CDC and the National Heart, Lung, and Blood Institute are leading a group of federal partners to track the nation's Healthy People 2020 objectives to combat heart disease and stroke. In addition to defining and tracking heart disease and stroke objectives, Healthy People 2020 includes clinical recommendations, community interventions, and consumer information related to heart disease and stroke.

The draft CHIP was completed and disseminated to subject matter experts from Healthier Somerset for review and feedback. This feedback was incorporated into the final draft of the CHIP.

III. COMMUNITY HEALTH IMPROVEMENT PLAN COMPONENTS

A. Vision and Values

The Healthier Somerset Coalition recognized that it was important to outline a compelling and inspirational vision, and to identify a set of shared values that would support the planning process and the CHIP itself. The Coalition and Advisory Body/Steering Committee participated in a brainstorming session at the CHNA-CHIP kickoff meeting in February and then refined the following Vision and Values for the CHIP:

Vision

All residents of Somerset County have an equal opportunity to pursue healthy lifestyles and achieve social, emotional, physical, and spiritual well-being.

With this vision in mind, we intend for this CHIP to provide a clear plan that empowers all who live, work, and play in Somerset County to:

- Achieve a complete, deeper, and broader understanding of the health status of Somerset County's population
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6. **Innovation**: We are forward-thinking and creative in our approach, and accept that this can sometimes be disruptive or uncomfortable when we challenge our old ways of thinking and doing. We will be flexible and adaptable to new approaches and challenges as they arise.

B. Development of Data-Based Community Identified Health Priorities

On June 15, 2015 a summary of the CHNA findings was presented to Healthier Somerset for further discussion.

The following themes emerged most frequently from review of the available data and were considered in the selection of the CHIP health priorities:

- Active living (such as making it easier to walk, bike, and visit parks)
- Environmental issues (such as water and air quality)
- Health care access
- Healthy eating
- Issues related to aging (such as Alzheimer's or falls)
- Mental health
- Needs of caregivers
- Overweight/obesity
- Substance abuse (such as abuse of alcohol and other drugs)
- Tobacco use
- Transportation issues

HRiA presented a rating tool for prioritization populated with eleven key health issues that were identified through the health assessment. Following a group discussion, participants identified four additional key health issues.

- *Chronic Disease*
- *Infectious Disease*
- *Housing*
- *Well-being*

Participants used a rating tool to rate each health issue based on the following common criteria, where 1=low, 2=medium, 3=high, 4=very high. See Appendix B for the rating tool used.

Selection Criteria			
RELEVANCE How Important Is It?	**APPROPRIATENESS** Should We Do It?	**IMPACT** What Will We Get Out of It?	**FEASIBILITY** Can We do It?
- Burden (magnitude and severity ; economic cost; urgency) of the problem - Community concern - Focus on equity and accessibility	- Ethical and moral issues - Human rights issues - Legal aspects - Political and social acceptability - Public attitudes and values	- Effectiveness - Coverage - Builds on or enhances current work - Can move the needle and demonstrate measureable outcomes - Proven strategies to address multiple wins	- Community capacity - Technical capacity - Economic capacity - Political capacity/will - Socio-cultural aspects - Ethical aspects - Can identify easy short-term wins

Participants calculated an overall rating for each health issue by adding their four ratings and entering the total overall rating in the Total Rating column. Each participant received four sticker dots and was asked to place their dots on the four key health issues that received the four highest overall Total Ratings on their rating

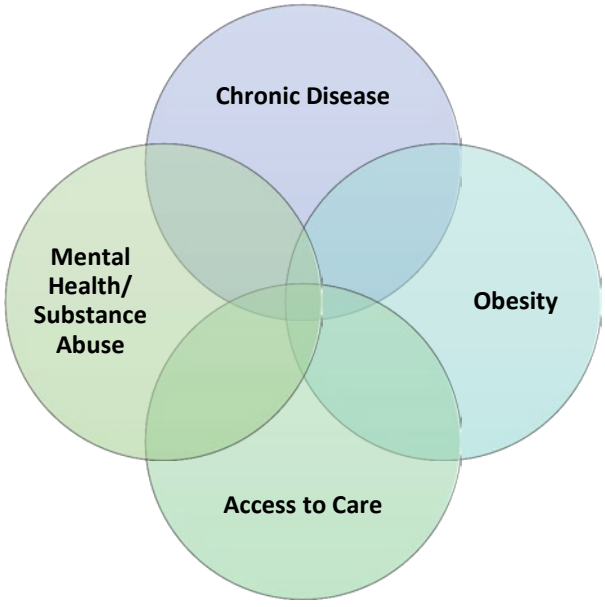
worksheet. Participants used their personal judgment to break any ties. The results of the dot voting process are depicted in the table below.

Key Health Issues	Votes
1. Tobacco use	3
2. Transportation issues	3
3. Well-being (added by participants)	3
4. Housing (added by participants)	4
5. Environmental issues (such as water and air quality)	6
6. Needs of caregivers	7
7. Infectious Disease (added by participants)	8
8. Active living (such as making it easier to walk, bike, and visit parks)	9
9. Issues related to aging (such as Alzheimer's or falls)	9
10. Overweight/obesity	**11**
11. Substance abuse (such as abuse of alcohol and other drugs)	**12**
12. Healthy eating	**13**
13. Health care access	**16**
14. Chronic Disease (management & treatment)	**19**
15. Mental health	**21**

Following group discussion, similar health issues receiving a high number of votes were combined to arrive at the four final priorities depicted below.

Somerset County Priority Areas
Priority Area 1: Mental Health and Substance Abuse
Priority Area 2: Obesity
Priority Area 3: Chronic Disease
Priority Area 4: Access to Care

Mental Health/Substance Abuse, Obesity, Chronic Disease, and Access to Care were identified as the priority health topics for the CHIP. In addition, during the selection process and follow on discussion, participants agreed that Healthy Eating/Active Living should not be a standalone topic, but rather a cluster of related, evidence-based strategies to address three out of the four identified priorities.



The June 15th planning session included a facilitated exercise where participants moved into one of four self-selected break-out groups to draft and refine goal statements for each of the priorities.

Priority Area	Goal Statement	
Priority Area 1: Mental Health and Substance Abuse	**Goal 1:**	Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.
Priority Area 2: Obesity	**Goal 2:**	Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.
Priority Area 3: Chronic Disease	**Goal 3:**	Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.
Priority Area 4: Access to Care	**Goal 4:**	Improve the access to and awareness of health care services for those living and working in Somerset County, including underserved populations.

C. CHIP Objectives, Indicators, Partners, and Strategies

On September 15th, Healthier Somerset reconvened for a four-hour planning session to develop objectives, indicators, potential partners, and strategies for each of the goals under the four priority areas of the CHIP. See Appendix A for a list of workgroup participants and affiliations.

HRiA provided sample evidence-based strategies from a variety of resources including *The Community Guide to Preventive Services, County Health Rankings*, *Healthy People 2020*, and the *National Prevention Strategy* for the strategy setting sessions.

Following the planning sessions, subject matter experts from RWJUH-Somerset, partner health departments, as well as HRiA consultants reviewed the draft output from the workgroups and edited material for clarity, consistency, and evidence base. This feedback has been incorporated into the final versions of the CHIP contained in this report.

IV. COMMUNITY HEALTH IMPROVEMENT PLAN

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of the desired future, and a clear evaluation of whether efforts are making a difference. Outcome indicators tell the story about where a community is in relation to its vision, as articulated by its related goals, objectives, and strategies. Targets for identified outcome indicator are based on *Healthy People 2020* targets using baseline data provided in the Community Health Needs Assessment. Where no data were readily available, objectives were noted as "Developmental" and a primary strategy will be to collect and analyze data and determine a baseline for successive annual comparisons.

The following pages outline the Goals, Objectives, Strategies, Potential Outcomes Indicators, and Potential Partners/Resources for the four health priority areas outlined in the CHIP. See Appendix C for a glossary of terms used in the CHIP.

A. Priority Area 1: Mental Health and Substance Abuse

Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.

Objectives and Strategies

1.1: Increase the total number of trainers able to educate the community on Mental Health First Aid* by 2017.

* *Mental Health First Aid* is a national program to teach the skills to respond to the signs of mental illness and substance use.

1.1.1 Collect and analyze data and determine a baseline for successive annual comparisons.

1.1.2 Identify and secure possible funding sources for Mental Health First Aid trainers and participants.

1.1.3 Recruit potential trainers from community-based organizations working with underserved populations (Senior Centers, Multi-cultural, etc.).

Outcome Indicator: Number of trainers able to educate the community on Mental Health First Aid

1.2: Increase the number of people trained in Mental Health First Aid by 2020 by 5%.

1.2.1 Collect and analyze data and determine a baseline for successive annual comparisons. (Year 1)

1.2.2 Design and conduct promotion and outreach to increase awareness and enrollment in training. (Year 2-3)

1.2.3 Identify and secure funding to support participation in training. (Year 2-3).

Outcome Indicator: Number of people trained in Mental Health First Aid

1.3: Increase awareness among primary care physicians of mental health/substance abuse issues by 10% by 2020.

1.3.1 Collect and analyze data and determine a baseline for successive annual comparisons. (Year 1).

1.3.2 Provide education through grand rounds and 'Do No Harm' symposiums. (Year 2).

1.3.3 Provide Primary Care Physicians with local resources and referrals for Mental Health/Substance Abuse. (Year 2-3).

1.3.4 Design and conduct outreach and education to medical schools on Mental Health/Substance Abuse. (Year 2-3).

1.3.5 Establish and promote use of a consistent Mental Health/Substance Abuse evidence-based screening tool. (Year 3).

Outcome Indicators: Level of awareness among primary care physicians.

Number of primary care physicians using a consistent Mental Health/Substance Abuse evidence-based screening tool.

1.4: Enhance municipal/health alliances to advocate for the integration of Mental Health/Substance Abuse and Primary Care by 2020.

1.4.1 Collect and analyze data and determine a baseline for successive annual comparisons. (Year 1).

1.4.2 Increase outreach to Mental Health/Substance Abuse/Primary Care to attend established alliances; convene quarterly 'think tank' meetings. (Year 1).

1.4.3 Identify and apply for grant funding that is based on collaborative partnerships. (Year 2).

1.4.4 Promote collaborative Mental Health/Substance Abuse/Primary Care best practices. (Year 2).

1.4.5 Establish advocacy work groups to promote and secure funding. (Year 3)

Outcome Indicator: Number of municipal/health alliances

1.5: Increase awareness of Mental Health/Substance Abuse services, wellness programs, and resources in Somerset County by 2017.

1.5.1 Collect and analyze data and determine a baseline for successive annual comparisons. (Year 1).

1.5.2 Design and conduct outreach to Parent Teacher Organizations (PTO) in Somerset County.

1.5.3 Establish collaboration/integration of 'No More Whispers' campaign.

1.5.4 Establish, promote and distribute signs and symptoms poster campaign in multiple languages to multiple community-based venues/sites.

1.5.5 Print and distribute Mental Health/Substance Abuse resources and services in multiple languages.

1.5.6 Promote synergy of mind, body wellness as a prevention mechanism.

Outcome Indicator: Number of people aware of services, wellness programs and other resources

Potential Resources/Partners

- +-*Anew Wellness, Inc.
- Carrier Clinic
- Community in Crisis
- Crisis Intervention Training for Law Enforcement
- Easter Seals
- EmPoWER Somerset
- Family support organizations
- Johnson & Johnson
- Mental Health Association of Somerset County
- Municipal Alliances
- National Alliance on Mental Illness
- Psychiatric Emergency Screening Services (PESS)
- Public and private mental health and substance abuse providers
- Richard Hall Mental Health Center
- Rutgers University Behavioral Health Care Somerset County website
- Schools (school nurses and wellness teams) involved in mental health and substance abuse
- Somerset County Department of Human Services
- United Way
- YMCA

B. Priority Area 2: Obesity

Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.

Objectives and Strategies

2.1: By 2017, increase by 10% the pounds of fresh fruit and vegetables available in food banks, food pantries and co-ops through partnerships with local producers and community gardens.

2.1.1 Create a master list of all food pantries in Somerset County.

2.1.2 Design and execute a survey to ascertain the current fresh food distribution per month.

Survey: (1) food banks, food pantries, and co-ops; and (2) local producers and community garden.

2.1.3 Recruit public health interns to provide support around conducting survey and interviews, and developing and implementing the distribution plan.

2.1.4 Conduct interviews to learn more about barriers to fresh food distribution (e.g. transportation, weight, perishability, etc.).

Interview: (1) food bank, food pantry and/ or co-op staff; and (2) local producers.

2.1.5 Develop strategies for a distribution plan from vendors to food banks / pantries / co-ops, and from food banks / pantries / co-ops to individuals. Prioritize barriers that will be addressed and define scope of distribution plan.

Outcome Indicators: Total pounds of fresh fruit available in food banks.

Total pounds of fresh fruit available in food pantries.

Total pounds of fresh fruit available in co-ops.

2.2: Increase the percentage of youth and adults who are getting the daily recommended serving of fruits and vegetables by 2019.

2.2.1 Promote the inclusion of increased fresh fruits and vegetables at food pantries.

2.2.2 Identify farmers markets for advertising/social media/vouchers.

2.2.3 Conduct community-based classes to demonstrate uses for unfamiliar fruits and vegetables.

2.2.4 Promote school and community gardens, farm to school, and offer more food tastings at school.

2.2.5 Include health information with food sources.

2.2.6 Encourage physicians to write prescriptions for fruits and vegetables and provide vouchers for purchase.

Outcome Indicators: Percentage of youth (grades 9-12) who are getting the daily recommended serving of fruits and vegetables.

Percentage of and adults (age 18 and older) who are getting the daily recommended serving of fruits and vegetables.

2.3: By 2019, increase by 5% the number of people reached by educational initiatives on healthy food choices, preparation and eating.

2.3.1 Collect and analyze data and determine a baseline for successive annual comparisons.

2.3.2 Identify and document partners (e.g. SNAP-Ed at Rutgers Cooperative, etc.) and resources for print and digital communication (e.g. newspapers, newsletters, etc.).

2.3.3 Develop a plan to coordinate sharing and tracking of information. Start with a pilot.

2.3.4 Identify opportunities for increasing reach of and sharing information about existing educational initiatives, and develop a communications plan.

Outcome Indicators: Number of people attending educational programs.

Number of newsletter recipients.

Number of website visitors.

2.4: By 2019, increase by 3% the respondents in Somerset County who participate in any physical activity.

2.4.1 Identify existing resources for worksite wellness.

2.4.2 Tap into Somerset County Business Partnership and New Jersey Department of Health. Resources / suggestions for worksite wellness might include nominating employee captains and implementing “Big Sister” mentoring (where a large business would mentor a small business around worksite wellness). Frame around cost savings.

2.4.3 Collect and re-deploy existing information on simple tips for exercise and movement. For example, collect information about helpful apps (on drinking water, stretching, etc.) and distribute this information via Pinterest and local recreation departments.

Outcome Indicator: Number of respondents who participated in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise, as identified in 2019 Community Health Needs Assessment.

2.5: By 2017, increase the awareness of the existing built environment for biking and walking (e.g. sidewalks, walking trails, Complete Streets, and biking lanes).

2.5.1 Collect and analyze data and determine a baseline for successive annual comparisons.

2.5.2 Increase signage around biking, running and walking.

2.5.3 Provide countywide education on strategies for safe, active living in population-dense places.

2.5.4 Identify all walking paths in the county (where they start, where to park, how long they are, etc.). Create a centralized information source for the entire County. Outreach to Graphic Information Systems (GIS) group that may be able to work on this, and connect with the Tourism Board regarding the ability to publicize the information through their "10 Things to do in Somerset County" e-mail.

Outcome Indicators: *Number of signs.*

Number of maps.

Knowledge of infrastructure.

Increase in use of bikes for transportation to work.

Number of municipalities that adopt Complete Streets resolution.

Potential Resources/Partners

- Coordinated school health programs
- Community gardens
- EmPoWER Somerset
- Farmers markets
- Greater Somerset Public Health Partnership
- Mayor's Wellness Campaign
- RideWise TMA
- Rutgers Cooperative Extension
- Rutgers University
- ShapingNJ
- Somerset County Business Partnership
- Somerset County Park Commission
- Somerset County Wellness Committee
- Somerset-Morris Regional Chronic Disease Coalition
- Somerset County YMCA

C. Priority Area 3: Chronic Disease

Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.

Objectives and Strategies

3.1: Increase the number of family caregivers connected to resources/support.

3.1.1 Collect and analyze data and determine a baseline for successive annual comparisons.

3.1.2 Educate general population on Caregivers Coalition (especially groups within Healthier Somerset) – need coalition support.

3.1.3 Inventory and disseminate educational materials at multiple gatherings and settings in the community.

3.1.4 Provide information cards for healthcare providers to give to patients (difficulty getting all providers to have in office).

3.1.5 Add link on hospital website.

3.1.6 Develop and conduct public service announcements and promote through the general media.

3.1.7 Develop a larger campaign to get in to doctor's offices.

3.1.8 Engage the faith-based community in promotion and support efforts.

Outcome Indicators: Number of family caregivers connected to resources/support

3.2: Increase the number of participants in educational and supportive programs by [date].

3.2.1 Collect and analyze data and determine a baseline for successive annual comparisons.

3.2.2 Identify criteria for selecting and evaluating potential educational and support programs to recommend (support groups, self-management, employee wellness, referrals to prevention alternatives).

3.2.3 Select six (6) high impact programs and promote them (strategies will differ by program).

3.2.4 Identify referral sources that channel people to those programs (doctors' offices, work sites, faith-based organizations).

3.2.5 Identify organizations for preventive care and promote.

3.2.6 Raise awareness – where do people get info, referrals and self-referral: web/social media, office of aging, disabilities, senior centers, libraries, schools.

3.2.7 Look at existing app/websites for conditions.

3.2.8 Work with programs to gather information about referrals and selection/contact (i.e., ask – how did you hear about us?).

3.2.9 Include information about programs via 211.

Outcome Indicators: Number of participants in support groups.

Number of participants in employee wellness program.

Number of participants in self-management groups.

Number of participants in prevention programs.

Number of referrals to alternative methods.

3.3: Increase the number of people who are screened for Chronic Disease risk factors and referred as appropriate.

3.3.1 Collect and analyze data and determine a baseline for successive annual comparisons.

3.3.2 Increase connections/collaborations between community settings/groups and the hospitals who do the screenings (funding as a part of it).

3.3.3 Hold annual wellness event and/or add screening to existing events.

3.3.4 Educate primary care physicians on importance of pre-"condition" results and recommending action to address them.

3.3.5 Develop and conduct a social media campaign to encourage people to get tested for chronic disease factors.

3.3.6 Collaborate with Robert Wood Johnson (RWJ) and Medical Associations to get doctors to be available for referrals from community screenings.

Outcome Indicators: Number of people screened for hypertension

Number of people screened for diabetes

Number of people screened for cholesterol

3.4: Increase healthcare providers' awareness of cultural sensitivity and diversity (beyond language).

3.4.1 Collect and analyze data and determine a baseline for successive annual comparisons.

3.4.2 Identify which agencies/organizations work with diverse populations (define cultural sensitivity and diversity. Diversity = race, gender, language, LGBT, etc. – cultural responsiveness).

3.4.3 Develop and conduct webinars for target audiences, provide incentives for providers.

3.4.4 Add presentations on cultural sensitivity to existing conferences and assign/grant. CEU's that are recognized.

3.4.5 Work with community college, residency programs, and internship programs to train diversity of students on cultural sensitivity.

3.4.6 Target pockets of "minority" populations.to increase awareness of chronic disease in their communities.

Outcome Indicators: Number of providers trained/attended.

Number of providers who access the resource list.

See also Obesity Objective 2.2 on the percentage of youth and adults who are getting the daily recommended serving of fruits and vegetables

Potential Resources/Partners

- American Diabetes Association
- Cancer Support Center of Central New Jersey
- Community gardens
- Somerset County's corporate community
- Dept. of Agriculture
- Departments of Health
- Faith-based organizations
- Family and Community Health Services (FCHS) (Rutgers)
- Food pantries
- Hospitals and Healthcare System
- Somerset County Office on Aging and Disabilities
- Public Schools
- Regional Chronic Disease Coalition for Morris & Somerset County (RCDC)
- Rutgers Coop
- Sodexo – School Food Services
- United Way Care Givers Association
- University and Colleges (Rutgers), Community Colleges

D. Priority Area 4: Access to Care

Goal 4: Improve the access to and awareness of health care services for those living and working in Somerset County, including underserved populations.

Objectives and Strategies

4.1: Increase the utilization of existing primary care services in Somerset County by 10%.

4.1.1 Work with Primary Care sites to access and analyze transportation patterns and existing transportation resources (look at patient satisfaction surveys).

4.1.2 Train primary care physician site staff on available transportation resources.

4.1.3 Educate at the community level by giving up to date transportation and health services information to 211.

Outcome Indicators: *Proportion of persons with a usual primary care provider.*

Proportion of persons of all ages who have a specific source of ongoing care.

4.2: Create a network of Community Health Workers who represent the diverse populations in our community.

4.2.1 Define Community Health Worker title and job description.

4.2.2 Assess existing community health workers (CHWs) (use existing survey), including volunteer, lay health workers, etc. for coverage, satisfaction level, training needs, etc.

4.2.3 Identify gaps in services and geographic areas.

4.2.4 Identify partners (work group).

4.2.5 Identify funding to support development of network.

Outcome Indicators: *Number of Community Health Workers*

Diversity of Community Health Workers

4.3: Increase opportunities to address barriers to health insurance navigation for underserved community members.

4.3.1 Collect and analyze data and determine a baseline for successive annual comparisons.

4.3.2 Identify key barriers to health insurance navigation for targeted populations (focus groups, survey, other).

4.3.3 Educate community members on resources and supports

4.3.4 Conduct marketing promotion/media (radio, billboards, and social media).

4.3.5 Identify funding opportunities and grants.

4.3.6 Identify key policy and systems barriers; form advocacy group(s) to address them.

Outcome Indicators: Number of resources to improve health insurance navigation for underserved community members.

Potential Resources/Partners

- Catholic Charities
- First Baptist Church of Lincoln Gardens, Somerset NJ
- Franklin Township Food Bank
- Jewish Family Services
- Martin Luther King Jr Youth Center
- Matheny Developmental Services
- Pharmaceutical assistance programs
- Resource Center of Somerset County
- Richard Hall Mental Health Center
- Robert Wood Johnson University Hospital- Somerset
- Samaritan Homeless Interim program (SHIP)
- Somerset County Office of Human Services
- Somerset County Food Bank Network
- Somerset County Office on Aging and Disabilities
- United Way of Northern New Jersey
- Zarephath
- Zufall Health Services

V. NEXT STEPS

The components included in this report represent the strategic framework for a data-driven, Community Health Improvement Plan. Healthier Somerset, including the core agencies, CHIP workgroups, partners, stakeholders, and community residents, will continue finalizing the CHIP by prioritizing objectives and related strategies for the first year of implementation, developing specific 1-year action steps, assigning lead responsible parties, and identifying resources for each priority area (see Appendix D for Action Plan Template). An annual CHIP progress report will illustrate performance and will guide subsequent annual implementation planning.

VI. SUSTAINABILITY

As part of the action planning process, partners and resources will be solidified to ensure successful CHIP implementation and coordination of activities and resources among key partners in Somerset County. The Advisory Board will continue to serve as the executive oversight for the improvement plan, progress, and process.

VII. ACKNOWLEDGEMENTS

The dedication, expertise, and leadership of the following agencies and people made the 2015 Robert Wood Johnson University Hospital - Somerset Community Health Improvement Plan a collaborative, engaging, and substantive plan that will guide our community in improving the health and wellness for the residents of Somerset County. Special thanks to all of you.

CHIP community member and agency workgroup members: Your insight, dedication, and expertise are unparalleled. We look forward to our continued partnership.

We are deeply appreciative of the dedication, expertise, and leadership of the people and agencies that contributed to the 2015 Healthier Somerset Community Health Improvement Plan. Our efforts to build a lasting Culture of Health in Somerset County would not be possible without your ongoing enthusiasm and support.

Appendices

APPENDIX A: PARTICIPANTS IN THE CHIP PROCESS

Healthier Somerset Advisory Board 2015

Serena Collado, RWJ Somerset, Convener
Valerie Barber, Verizon Wireless Worksite Wellness task force co-chair
Stephanie Carey, Somerset County Health Officers Association
Erica Ferry, Sanofi US
Laura Forgione, Greater Somerset Public Health Partnership
Paul Grzella, The Courier News
Mike Kerwin, Somerset County Business Partnership
Mary Lacoff, RWJ Somerset, Worksite Wellness task force co-chair
Paul Masaba, Health Officer, Somerset County, NJ
Rebecca Perkins, Healthier Somerset Project Manager
Linda Rapacki, RideWise Policy task force co-chair
Kristen Schiro, Schools task force chair
Lucille Talbot, Policy task force co-chair
Hon. Patricia Walsh, Somerset County Freeholder

Planning Session Participants

Priority Area	Participants	6/15/15	9/15/15
Priority Area 1: Mental Health and Substance Abuse	Tim Wolf	x	
	Zach Taylor	x	
	Mariam Merced	x	
	Priscilla Schmitt	x	
	Pat Walsh	x	
Priority Area 2: Obesity	Cheryl Komline	x	x
	Kristin Schiro	x	
	Ruth Prothero	x	x
	Linda Rapacki	x	x
	Valerie Barber	x	x
	Carolyn Seracka	x	
	Erika Lannaman	x	
	Stephanie Carey	x	
	Sarah Walker	x	x
	Theresa Hanntz	x	x
	Ben Strong	x	
	Lucy Forgione		x

Priority Area	Participants	6/15/15	9/15/15
Priority Area 3: Chronic Disease	Erica Ferry	x	
	Debbie McGarity	x	
	Stephanie Howland	x	x
	Karen Isky	x	
	Paul Masaba	x	x
	Caitlin Witucki	x	x
	Audrey Taffet	x	
	Lucille Young-Talbot	x	
	Linda Frey	x	
	Lux Maria Gomer		x
	Peter Ruccione		x
	Sean Tyndall		x
	Daryl Minch		x
	Stephanie Carey		x
	Allison Lacko		x
Priority Area 4: Access to Care	Michéle Samarya-Timm	x	x
	Phyllis Friedman	x	
	Paulann Pierson	x	
	Mary Lacoff	x	
	Takeena Deas	x	
	Ben Strong		x
	Zach Taylor		x
	Isharni Amin		x
	Siobhan Spano		x
	Fran Palm		x

Subject Matter Expert Reviewers

Greater Somerset Public Health Partnership
Middle-Brook Regional Health Commission
Somerset County Department of Health
Somerset County Heath Officers Association

Consultant Advisors

Health Resources in Action, Inc.

Community Partners/Hosts

Robert Wood Johnson University Hospital - Somerset

APPENDIX B: PRIORITIZATION TOOL

Step 1: Rate Priorities Using the following Criteria

Instructions:Rate each health issue based on how well it meets each of the criteria provided:
1=low, **2**=medium, **3**=high, **4**=very high

Health Resources in Action
Advancing Public Health and Medical Research

Key Health Issues	Selection Criteria				Total Rating
	RELEVANCE *How Important Is It?*	APPROPRIATENESS *Should We Do It?*	IMPACT *What Will We Get Out of It?*	FEASIBILITY *Can We do It?*	**Step 2:** Add the four ratings to determine the total rating
	- Burden (magnitude and severity ; economic cost; urgency) of the problem - Community concern - Focus on equity and accessibility	- Ethical and moral issues - Human rights issues - Legal aspects - Political and social acceptability - Public attitudes and values	- Effectiveness - Coverage - Builds on or enhances current work - Can move the needle and demonstrate measureable outcomes - Proven strategies to address multiple wins	- Community capacity - Technical capacity - Economic capacity - Political capacity/will - Socio-cultural aspects - Ethical aspects - Can identify easy short-term wins	
1. Active living (such as making it easier to walk, bike, and visit parks)					
2. Environmental issues (such as water and air quality)					
3. Health care access					
4. Healthy eating					
5. Issues related to aging (such as Alzheimer's or falls)					
6. Mental health					
7. Needs of caregivers					
8. Overweight/obesity					
9. Substance abuse (such as abuse of alcohol and other drugs)					
10. Tobacco use					
11. Transportation issues					
Added by participants:					
1. Chronic Disease					
2. Infectious Disease					
3. Housing					
4. Well-being					

APPENDIX C: GLOSSARY OF TERMS

Built Environment: Man-made surroundings that include buildings, public resources, land use patterns, the transportation system, and design features.

Community Health Improvement Plan (CHIP): Action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed.

Complete Streets: Streets that are designed and operated to enable safe access for all users, including pedestrians, bicyclists, motorists and transit riders of all ages and abilities.

Cultural Competence: Set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework

Evidence-based Method: Strategy for explicitly linking public health or clinical practice recommendations to scientific evidence of the effectiveness and/or other characteristics of such practices

Goals: Identify in broad terms how the efforts will change things to solve identified problems

Health Equity/Social Justice: When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstances.

Health Literacy: Degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.

Mental Health First Aid is a national program to teach the skills to respond to the signs of mental illness and substance use.

Objectives: Measurable statements of change that specify an expected result and timeline, objectives build toward achieving the goals

Percentages: All percentages are relative; absolute change as a percentage of the baseline value

Performance Measures: Changes that occur at the community level as a result of completion of the strategies and actions taken

Priority Areas: Broad issues that pose problems for the community

Strategies: Action-oriented phrases to describe how the objectives will be approached

Action Planning Terms

Resources Needed: Include all resources needed for this strategy. (Examples: funding, staff time, space needs, supplies, technology, equipment, and key partners)

Monitoring/Evaluation Approaches: The approaches you will use to track and monitor progress on strategies and activities (e.g., quarterly reports, participant evaluations from training)

Action Steps: The activities outline the steps you will take to achieve each strategy. It is best to arrange activities chronologically by start dates.

Organization(s) Responsible: Identify by name the key person(s) or organization(s) that will lead, manage, and implement the activities for each strategy, including initiating the activity, providing direction for the work, and monitoring progress.

Outcome (Products) or Results: Describe the direct, tangible and measurable results of the activity (e.g., a product or document, an agreement or policy, number of participants).

Time Line: Check off the projected quarter of completion for each activity

APPENDIX D: ACTION PLAN TEMPLATES

Year 1 Action Plan			
PRIORITY AREA 1: Mental Health and Substance Abuse			
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.			
Objective 1.1: Increase the total number of trainers able to educate the community on Mental Health First Aid* by 2017. * *Mental Health First Aid* is a national program to teach the skills to respond to the signs of mental illness and substance use.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of trainers able to educate the community on Mental Health First Aid	Developmental	50% over baseline	Surveys
Partners for This Objective:			
• Anew Wellness, Inc. • Carrier Clinic • Community in Crisis • Crisis Intervention Training for Law Enforcement • Easter Seals • EmPoWER Somerset • Family support organizations • Johnson & Johnson • Mental Health Association of Somerset County • Municipal Alliances • National Alliance on Mental Illness • Psychiatric Emergency Screening Services (PESS) • Public and private mental health and substance abuse providers • Richard Hall Mental Health Center • Rutgers University Behavioral Health Care Somerset County website • Schools (school nurses and wellness teams) involved in mental health and substance abuse • Somerset County Department of Human Services • United Way • YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan											
PRIORITY AREA 1: Mental Health and Substance Abuse											
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.											
Objective 1.1: Increase the total number of trainers able to educate the community on Mental Health First Aid* by 2017. * *Mental Health First Aid* is a national program to teach the skills to respond to the signs of mental illness and substance use.											
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
1.1.1	Collect and analyze data and determine a baseline for successive annual comparisons.									
1.1.2	Identify and secure possible funding sources for Mental Health First Aid trainers and participants.									
1.1.3	Recruit potential trainers from community-based organizations working with underserved populations (Senior Centers, Multi-cultural, etc.).									

Year 1 Action Plan			
PRIORITY AREA 1: Mental Health and Substance Abuse			
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.			
Objective 1.2: Increase the number of people trained in Mental Health First Aid by 2020 by 5%.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of people trained in Mental Health First Aid	Developmental	5% over baseline	Surveys
Partners for This Objective:			
• Anew Wellness, Inc. • Carrier Clinic • Community in Crisis • Crisis Intervention Training for Law Enforcement • Easter Seals • EmPoWER Somerset • Family support organizations • Johnson & Johnson • Mental Health Association of Somerset County • Municipal Alliances • National Alliance on Mental Illness • Psychiatric Emergency Screening Services (PESS) • Public and private mental health and substance abuse providers • Richard Hall Mental Health Center • Rutgers University Behavioral Health Care Somerset County website • Schools (school nurses and wellness teams) involved in mental health and substance abuse • Somerset County Department of Human Services • United Way • YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan										
PRIORITY AREA 1: Mental Health and Substance Abuse										
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.										
Objective 1.2: Increase the number of people trained in Mental Health First Aid by 2020 by 5%.										
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
1.2.1	Collect and analyze data and determine a baseline for successive annual comparisons. (Year 1)									
1.2.2	Design and conduct promotion and outreach to increase awareness and enrollment in training. (Year 2-3)								x	x
1.2.3	Identify and secure funding to support participation in training. (Year 2-3).								x	x

Year 1 Action Plan			
PRIORITY AREA 1: Mental Health and Substance Abuse			
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.			
Objective 1.3: Increase awareness among primary care physicians of mental health/substance abuse issues by 10% by 2020.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Level of awareness among primary care physicians	Developmental	10% over baseline	Surveys
• Number of primary care physicians using a consistent Mental Health/Substance Abuse evidence-based screening tool	Developmental	10% over baseline	Surveys
Partners for This Objective:			
• Anew Wellness, Inc. • Carrier Clinic • Community in Crisis • Crisis Intervention Training for Law Enforcement • Easter Seals • EmPoWER Somerset • Family support organizations • Johnson & Johnson • Mental Health Association of Somerset County • Municipal Alliances • National Alliance on Mental Illness • Psychiatric Emergency Screening Services (PESS) • Public and private mental health and substance abuse providers • Richard Hall Mental Health Center • Rutgers University Behavioral Health Care Somerset County website • Schools (school nurses and wellness teams) involved in mental health and substance abuse • Somerset County Department of Human Services • United Way • YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan										
PRIORITY AREA 1: Mental Health and Substance Abuse										
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.										
Objective 1.3: Increase awareness among primary care physicians of mental health/substance abuse issues by 10% by 2020.										
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
1.3.1	Collect and analyze data and determine a baseline for successive annual comparisons. (Year 1).									
1.3.2	Provide education through grand rounds and 'Do No Harm' symposiums. (Year 2).								x	
1.3.3	Provide Primary Care Physicians with local resources and referrals for Mental Health/Substance Abuse. (Year 2-3).								x	x
1.3.4	Design and conduct outreach and education to medical schools on Mental Health/Substance Abuse. (Year 2-3).								x	x
1.3.5	Establish and promote use of a consistent Mental Health/Substance Abuse evidence-based screening tool. (Year 3).									x

Year 1 Action Plan			
PRIORITY AREA 1: Mental Health and Substance Abuse			
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.			
Objective 1.4: Enhance municipal/health alliances to advocate for the integration of Mental Health/Substance Abuse and Primary Care by 2020			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of municipal/health alliances	Twenty	Twenty-one	Surveys
Partners for This Priority Area:			
• Anew Wellness, Inc. • Carrier Clinic • Community in Crisis • Crisis Intervention Training for Law Enforcement • Easter Seals • EmPoWER Somerset • Family support organizations • Johnson & Johnson • Mental Health Association of Somerset County • Municipal Alliances • National Alliance on Mental Illness • Psychiatric Emergency Screening Services (PESS) • Public and private mental health and substance abuse providers • Richard Hall Mental Health Center • Rutgers University Behavioral Health Care Somerset County website • Schools (school nurses and wellness teams) involved in mental health and substance abuse • Somerset County Department of Human Services • United Way • YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan										
PRIORITY AREA 1: Mental Health and Substance Abuse										
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.										
Objective 1.4: Enhance municipal/health alliances to advocate for the integration of Mental Health/Substance Abuse and Primary Care by 2020										
Strategies	**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y 2**	**Y3**
				Q 1	**Q 2**	**Q 3**	**Q 4**		
1.4.1 Collect and analyze data and determine a baseline for successive annual comparisons. (Year 1).									
1.4.2 Increase outreach to Mental Health/Substance Abuse/Primary Care to attend established alliances; convene quarterly 'think tank' meetings. (Year 1).									
1.4.3 Identify and apply for grant funding that is based on collaborative partnerships. (Year 2).								x	
1.4.4 Promote collaborative Mental Health/Substance Abuse/Primary Care best practices. (Year 2).								x	
1.4.5 Establish advocacy work groups to promote and secure funding. (Year 3)									x

Year 1 Action Plan			
PRIORITY AREA 1: Mental Health and Substance Abuse			
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.			
Objective 1.5: Increase awareness of Mental Health/Substance Abuse services, wellness programs, and resources in Somerset County by 2017.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of people aware of services, wellness programs and other resources	Developmental	20% over baseline	Surveys
Partners for This Priority Area:			
• Anew Wellness, Inc. • Carrier Clinic • Community in Crisis • Crisis Intervention Training for Law Enforcement • Easter Seals • EmPoWER Somerset • Family support organizations • Johnson & Johnson • Mental Health Association of Somerset County • Municipal Alliances • National Alliance on Mental Illness • Psychiatric Emergency Screening Services (PESS) • Public and private mental health and substance abuse providers • Richard Hall Mental Health Center • Rutgers University Behavioral Health Care Somerset County website • Schools (school nurses and wellness teams) involved in mental health and substance abuse • Somerset County Department of Human Services • United Way • YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan											
PRIORITY AREA 1: Mental Health and Substance Abuse											
Goal 1: Improve comprehensive services for mental health and/or substance abuse through timely, affordable and appropriate access for all residents.											
Objective 1.5: Increase awareness of Mental Health/Substance Abuse services, wellness programs, and resources in Somerset County by 2017.											
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y 3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
1.5.1	Collect and analyze data and determine a baseline for successive annual comparisons. (Year 1).									
1.5.2	Design and conduct outreach to Parent Teacher Organizations (PTO) in Somerset County.									
1.5.3	Establish collaboration/integration of 'No More Whispers' campaign.									
1.5.4	Establish, promote and distribute signs and symptoms poster campaign in multiple languages to multiple community-based venues/sites.									
1.5.5	Print and distribute Mental Health/Substance Abuse resources and services in multiple languages.									
1.5.6	Promote synergy of mind, body wellness as a prevention mechanism.									

Year 1 Action Plan
PRIORITY AREA 2: Obesity

Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.			
Objective 2.1: By 2017, increase by 10% the pounds of fresh fruit and vegetables available in food banks, food pantries and co-ops through partnerships with local producers and community gardens.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Total pounds of fresh fruit and vegetables available in food banks			Countywide survey
• Total pounds of fresh fruit and vegetables available in food pantries			Countywide survey
• Total pounds of fresh fruit and vegetables available in co-ops			Countywide survey
Partners for This Objective:			
• Coordinated school health programs • Community gardens • EmPoWER Somerset • Farmers markets • Greater Somerset Public Health Partnership • Mayor's Wellness Campaign • RideWise TMA • Rutgers Cooperative Extension • Rutgers University • ShapingNJ • Somerset County Business Partnership • Somerset County Park Commission • Somerset County Wellness Committee • Somerset-Morris Regional Chronic Disease Coalition • Somerset County YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan										
PRIORITY AREA 2: Obesity										
Goal 2:	**Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.**									
Objective 2.1:	**By 2017, increase by 10% the pounds of fresh fruit and vegetables available in food banks, food pantries and co-ops through partnerships with local producers and community gardens.**									
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
2.1.1	Create a master list of all food pantries in Somerset County.									
2.1.2	Design and execute a survey to ascertain the current fresh food distribution per month. Survey: (1) food banks, food pantries, and co-ops; and (2) local producers and community garden.									
2.1.3	Recruit public health interns to provide support around conducting survey and interviews, and developing and implementing the distribution plan.									
2.1.4	Conduct interviews to learn more about barriers to fresh food distribution (e.g. transportation, weight, perishability, etc.). Interview: (1) food bank, food pantry and/ or co-op staff; and (2) local producers.									
2.1.5	Develop strategies for a distribution plan from vendors to food banks / pantries / co-									

Year 1 Action Plan									
PRIORITY AREA 2: Obesity									
Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.									
Objective 2.1: By 2017, increase by 10% the pounds of fresh fruit and vegetables available in food banks, food pantries and co-ops through partnerships with local producers and community gardens.									
	ops, and from food banks / pantries / co-ops to individuals. Prioritize barriers that will be addressed and define scope of distribution plan.								

Year 1 Action Plan			
PRIORITY AREA 2: Obesity			
Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.			
Objective 2.2: Increase the percentage of youth and adults who are getting the daily recommended serving of fruits and vegetables by 2019.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Percentage of youth (grades 9-12) who are getting the daily recommended serving of fruits and vegetables (5 or more)	19% 19.2% for NJ		Youth Risk Behavior Survey (YRBS) 2013 Student Health Survey 2011
• Percentage of adults (age 18+) who are getting the daily recommended serving of fruits and vegetables (5 or more)	26.1% for NJ		Behavioral Risk Factor Surveillance System (BRFSS), State --> county data 2009
Partners for This Objective:			
• Coordinated school health programs • Community gardens • EmPoWER Somerset • Farmers markets • Greater Somerset Public Health Partnership • Mayor's Wellness Campaign • RideWise TMA • Rutgers Cooperative Extension • Rutgers University • ShapingNJ • Somerset County Business Partnership • Somerset County Park Commission • Somerset County Wellness Committee • Somerset-Morris Regional Chronic Disease Coalition • Somerset County YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
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Monitoring/Evaluation Approaches			
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Year 1 Action Plan											
PRIORITY AREA 2: Obesity											
Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.											
Objective 2.2: Increase the percentage of youth and adults who are getting the daily recommended serving of fruits and vegetables by 2019.											
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
2.2.1	Promote the inclusion of increased fresh fruits and vegetables at food pantries.									
2.2.2	Identify farmers markets for advertising/social media/vouchers.									
2.2.3	Conduct community-based classes to demonstrate uses for unfamiliar fruits and vegetables.									
2.2.4	Promote school and community gardens, farm to school, and offer more food tastings at school.									
2.2.5	Include health information with food sources.									
2.2.6	Encourage physicians to write prescriptions for fruits and vegetables and provide vouchers for purchase.									

Year 1 Action Plan			
PRIORITY AREA 2: Obesity			
Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.			
Objective 2.3: By 2019, increase by 5% the number of people reached by educational initiatives on healthy food choices, preparation and eating.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of people attending educational programs	Developmental		
• Reach of communications (number of newsletter recipients, website hits, etc.)	Developmental		
Partners for This Objective:			
• Coordinated school health programs • Community gardens • EmPoWER Somerset • Farmers markets • Greater Somerset Public Health Partnership • Mayor's Wellness Campaign • RideWise TMA • Rutgers Cooperative Extension • Rutgers University • ShapingNJ • Somerset County Business Partnership • Somerset County Park Commission • Somerset County Wellness Committee • Somerset-Morris Regional Chronic Disease Coalition • Somerset County YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
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Year 1 Action Plan										
PRIORITY AREA 2: Obesity										
Goal 2:	**Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.**									
Objective 2.3:	**By 2019, increase by 5% the number of people reached by educational initiatives on healthy food choices, preparation and eating.**									
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
2.3.1	Collect and analyze data and determine a baseline for successive annual comparisons.									
2.3.2	Identify and document partners (e.g. SNAP-Ed at Rutgers Cooperative, etc.) and resources for print and digital communication (e.g. newspapers, newsletters, etc.).									
2.3.3	Develop a plan to coordinate sharing and tracking of information. Start with a pilot.									
2.3.4	Identify opportunities for increasing reach of and sharing information about existing educational initiatives, and develop a communications plan.									

Year 1 Action Plan			
PRIORITY AREA 2: Obesity			
Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.			
Objective 2.4: By 2019, increase by 3% the respondents in Somerset County who participate in any physical activity.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Respondents who participated in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise	71.3% indicated "Yes"	74.3%	2015 Somerset County community health assessment survey question that asked Future: Behavioral Risk Factor Surveillance System (BRFSS)
Partners for This Objective:			
• Coordinated school health programs • Community gardens • EmPoWER Somerset • Farmers markets • Greater Somerset Public Health Partnership • Mayor's Wellness Campaign • RideWise TMA • Rutgers Cooperative Extension • Rutgers University • ShapingNJ • Somerset County Business Partnership • Somerset County Park Commission • Somerset County Wellness Committee • Somerset-Morris Regional Chronic Disease Coalition • Somerset County YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
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Monitoring/Evaluation Approaches			
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Year 1 Action Plan										
PRIORITY AREA 2: Obesity										
Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.										
Objective 2.4: By 2019, increase by 3% the respondents in Somerset County who participate in any physical activity.										
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
2.4.1	Identify existing resources for worksite wellness.									
2.4.2	Tap into Somerset County Business Partnership and New Jersey Department of Health. Resources / suggestions for worksite wellness might include nominating employee captains and implementing “Big Sister” mentoring (where a large business would mentor a small business around worksite wellness). Frame around cost savings.									
2.4.3	Collect and re-deploy existing information on simple tips for exercise and movement. For example, collect information about helpful apps (on drinking water, stretching, etc.) and distribute this information via Pinterest and local recreation departments.									

Year 1 Action Plan			
PRIORITY AREA 2: Obesity			
Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.			
Objective 2.5: By 2017, increase the awareness of the existing built environment for biking and walking (e.g. sidewalks, walking trails, Complete Streets, and biking lanes).			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of signs	Developmental		Audit of signage
• Number of maps	Developmental		
• Knowledge of infrastructure	Developmental		Survey about knowledge of what infrastructure exists
• Increase in use of bikes for transportation to work	Developmental		US Department of Commerce, Bureau of the Census, American Fact Finder, 2009 - 2013 American Community Survey
• Number of municipalities that adopt Complete Streets resolution	8/21 municipalities		
Partners for This Objective:			
• Coordinated school health programs • Community gardens • EmPoWER Somerset • Farmers markets • Greater Somerset Public Health Partnership • Mayor's Wellness Campaign • RideWise TMA • Rutgers Cooperative Extension • Rutgers University • ShapingNJ • Somerset County Business Partnership • Somerset County Park Commission • Somerset County Wellness Committee • Somerset-Morris Regional Chronic Disease Coalition • Somerset County YMCA			
Resources Required (human, partnerships, financial, infrastructure or other)			
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Year 1 Action Plan										
PRIORITY AREA 2: Obesity										
Goal 2: Prevent and reduce the severity of obesity through education and strategies that promote healthy eating, active living, and behavioral change.										
Objective 2.5: By 2017, increase the awareness of the existing built environment for biking and walking (e.g. sidewalks, walking trails, Complete Streets, and biking lanes).										
Monitoring/Evaluation Approaches										
•										
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
2.5.1	Collect and analyze data and determine a baseline for successive annual comparisons.									
2.5.2	Increase signage around biking, running and walking.									
2.5.3	Provide countywide education on strategies for safe, active living in population-dense places.									
2.5.4	Identify all walking paths in the county (where they start, where to park, how long they are, etc.). Create a centralized information source for the entire County. Outreach to Graphic Information Systems (GIS) group that may be able to work on this, and connect with the Tourism Board regarding the ability to publicize the information through their “10 Things to do in Somerset County” e-mail.									

Year 1 Action Plan			
PRIORITY AREA 3: Chronic Disease			
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.			
Objective 3.1: Increase the number of family caregivers connected to resources/support.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of family caregivers connected to resources/support	Developmental		
Partners for This Objective:			
• American Diabetes Association • Cancer Support Center of Central New Jersey • Community gardens • Somerset County's corporate community • Dept. of Agriculture • Departments of Health • Faith-based organizations • Family and Community Health Services (FCHS) (Rutgers) • Food pantries • Hospitals and Healthcare System • Somerset County Office on Aging and Disabilities • Public Schools • Regional Chronic Disease Coalition for Morris & Somerset County (RCDC) • Rutgers Coop • Sodexo – School Food Services • United Way Care Givers Association • University and Colleges (Rutgers), Community Colleges			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
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Year 1 Action Plan											
PRIORITY AREA 3: Chronic Disease											
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.											
Objective 3.1: Increase the number of family caregivers connected to resources/support.											
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
3.1.1	Collect and analyze data and determine a baseline for successive annual comparisons.									
3.1.2	Educate general population on Caregivers Coalition (especially groups within Healthier Somerset) – need coalition support.									
3.1.3	Inventory and disseminate educational materials at multiple gatherings and settings in the community.									
3.1.4	Provide information cards for healthcare providers to give to patients (difficulty getting all providers to have in office).									
3.1.5	Add link on hospital website.									
3.1.6	Develop and conduct public service announcements and promote through the general media.									
3.1.7	Develop a larger campaign to get in to doctor's offices.									
3.1.8	Engage the faith-based community in promotion and									

Year 1 Action Plan									
PRIORITY AREA 3: Chronic Disease									
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.									
Objective 3.1: Increase the number of family caregivers connected to resources/support.									
support efforts.									

Year 1 Action Plan			
PRIORITY AREA 3: Chronic Disease			
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.			
Objective 3.2: Increase the number of participants in educational and supportive programs by [date].			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of participants in support groups	Developmental		
• Number of participants in employee wellness program	Developmental		
• Number of participants in self-management groups	Developmental		
• Number of participants in prevention programs	Developmental		
• Number of referrals to alternative methods	Developmental		
Partners for This Objective:			
• American Diabetes Association • Cancer Support Center of Central New Jersey • Community gardens • Somerset County's corporate community • Dept. of Agriculture • Departments of Health • Faith-based organizations • Family and Community Health Services (FCHS) (Rutgers) • Food pantries • Hospitals and Healthcare System • Somerset County Office on Aging and Disabilities • Public Schools • Regional Chronic Disease Coalition for Morris & Somerset County (RCDC) • Rutgers Coop • Sodexo – School Food Services • United Way Care Givers Association • University and Colleges (Rutgers), Community Colleges			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
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Year 1 Action Plan										
PRIORITY AREA 3: Chronic Disease										
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.										
Objective 3.2: Increase the number of participants in educational and supportive programs by [date].										
Strategies	**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
				Q 1	**Q 2**	**Q 3**	**Q 4**		
3.2.1 Collect and analyze data and determine a baseline for successive annual comparisons.									
3.2.2 Identify criteria for selecting and evaluating potential educational and support programs to recommend (support groups, self-management, employee wellness, referrals to prevention alternatives).									
3.2.3 Select six (6) high impact programs and promote them (strategies will differ by program).									
3.2.4 Identify referral sources that channel people to those programs (doctors' offices, work sites, faith-based organizations).									
3.2.5 Identify organizations for preventive care and promote.									
3.2.6 Raise awareness – where do people get info, referrals and self-referral: web/social media, office of aging, disabilities, senior centers, libraries, schools.									
3.2.7 Look at existing app/websites									

Year 1 Action Plan										
PRIORITY AREA 3: Chronic Disease										
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.										
Objective 3.2: Increase the number of participants in educational and supportive programs by [date].										
	for conditions.									
3.2.8	Work with programs to gather information about referrals and selection/contact (i.e., ask – how did you hear about us?).									
3.2.9	Include information about programs via 211.									

Year 1 Action Plan			
PRIORITY AREA 3: Chronic Disease			
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.			
Objective 3.3: Increase the number of people who are screened for Chronic Disease risk factors and referred as appropriate			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of people screened for hypertension	Developmental		
• Number of people screened for diabetes	Developmental		
• Number of people screened for cholesterol	Developmental		
Partners for This Objective:			
• American Diabetes Association • Cancer Support Center of Central New Jersey • Community gardens • Somerset County's corporate community • Dept. of Agriculture • Departments of Health • Faith-based organizations • Family and Community Health Services (FCHS) (Rutgers) • Food pantries • Hospitals and Healthcare System • Somerset County Office on Aging and Disabilities • Public Schools • Regional Chronic Disease Coalition for Morris & Somerset County (RCDC) • Rutgers Coop • Sodexo – School Food Services • United Way Care Givers Association • University and Colleges (Rutgers), Community Colleges			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan										
PRIORITY AREA 3: Chronic Disease										
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.										
Objective 3.3: Increase the number of people who are screened for Chronic Disease risk factors and referred as appropriate										
Strategies	**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
				Q 1	**Q 2**	**Q 3**	**Q 4**		
3.3.1 Collect and analyze data and determine a baseline for successive annual comparisons.									
3.3.2 Increase connections/collaborations between community settings/groups and the hospitals who do the screenings (funding as a part of it).									
3.3.3 Hold annual wellness event and/or add screening to existing events.									
3.3.4 Educate primary care physicians on importance of pre-“condition” results and recommending action to address them.									
3.3.5 Develop and conduct a social media campaign to encourage people to get tested for chronic disease factors.									
3.3.6 Collaborate with Robert Wood Johnson (RWJ) and Medical Associations to get doctors to be available for referrals from community screenings.									

Year 1 Action Plan			
PRIORITY AREA 3: Chronic Disease			
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.			
Objective 3.4: Increase healthcare providers' awareness of cultural sensitivity and diversity (beyond language).			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of providers trained/attended	Developmental		Survey (existing)?
• Number of providers who access the resource list	Developmental		Survey (existing)?
Partners for This Objective:			
• American Diabetes Association • Cancer Support Center of Central New Jersey • Community gardens • Somerset County's corporate community • Dept. of Agriculture • Departments of Health • Faith-based organizations • Family and Community Health Services (FCHS) (Rutgers) • Food pantries • Hospitals and Healthcare System • Somerset County Office on Aging and Disabilities • Public Schools • Regional Chronic Disease Coalition for Morris & Somerset County (RCDC) • Rutgers Coop • Sodexo – School Food Services • United Way Care Givers Association • University and Colleges (Rutgers), Community Colleges			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan										
PRIORITY AREA 3: Chronic Disease										
Goal 3: Reduce the impact of chronic disease through prevention, management, and education to improve quality of life.										
Objective 3.4: Increase healthcare providers' awareness of cultural sensitivity and diversity (beyond language).										
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
3.4.1	Collect and analyze data and determine a baseline for successive annual comparisons.									
3.4.2	Identify which agencies/organizations work with diverse populations (define cultural sensitivity and diversity. Diversity = race, gender, language, LGBT, etc. – cultural responsiveness).									
3.4.3	Develop and conduct webinars for target audiences, provide incentives for providers.									
3.4.4	Add presentations on cultural sensitivity to existing conferences and assign/grant. CEU's that are recognized.									
3.4.5	Work with community college, residency programs, and internship programs to train diversity of students on cultural sensitivity.									
3.4.6	Target pockets of "minority" populations.to increase awareness of chronic disease in their communities.									

Year 1 Action Plan			
PRIORITY AREA 4: Access to Care			
Goal 4: Improve the access to and awareness of health care services for those living and working in Somerset County, including underserved populations.			
Objective 4.1: Increase the utilization of existing primary care services in Somerset County by 10%.			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Proportion of persons with a usual primary care provider.			Medical Expenditure Panel Survey (MEPS); Agency for Healthcare Research and Quality (AHRQ).
• Proportion of persons of all ages who have a specific source of ongoing care.			National Health Interview Survey (NHIS), CDC/NCHS
Partners for This Objective:			
• Catholic Charities • First Baptist Church of Lincoln Gardens, Somerset NJ • Franklin Township Food Bank • Jewish Family Services • Martin Luther King Jr Youth Center • Matheny Developmental Services • Pharmaceutical assistance programs • Resource Center of Somerset County • Richard Hall Mental Health Center • Robert Wood Johnson University Hospital- Somerset • Samaritan Homeless Interim program (SHIP) • Somerset County Office of Human Services • Somerset County Food Bank Network • Somerset County Office on Aging and Disabilities • United Way of Northern New Jersey • Zarephath • Zufall Health Services			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan										
PRIORITY AREA 4: Access to Care										
Goal 4: Improve the access to and awareness of health care services for those living and working in Somerset County, including underserved populations.										
Objective 4.1: Increase the utilization of existing primary care services in Somerset County by 10%.										
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
4.1.1	Work with Primary Care sites to access and analyze transportation patterns and existing transportation resources (look at patient satisfaction surveys).									
4.1.2	Train primary care physician site staff on available transportation resources.									
4.1.3	Educate at the community level by giving up to date transportation and health services information to 211.									

Year 1 Action Plan			
PRIORITY AREA 4: Access to Care			
Goal 4: Improve the access to and awareness of health care services for those living and working in Somerset County, including underserved populations.			
Objective 4.2: Create a network of Community Health Workers who represent the diverse populations in our community			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of Community Health Workers	Developmental		Survey (existing)
• Diversity of Community Health Workers	Developmental		Survey (existing)
Partners for This Objective:			
• Catholic Charities • First Baptist Church of Lincoln Gardens, Somerset NJ • Franklin Township Food Bank • Jewish Family Services • Martin Luther King Jr Youth Center • Matheny Developmental Services • Pharmaceutical assistance programs • Resource Center of Somerset County • Richard Hall Mental Health Center • Robert Wood Johnson University Hospital- Somerset • Samaritan Homeless Interim program (SHIP) • Somerset County Office of Human Services • Somerset County Food Bank Network • Somerset County Office on Aging and Disabilities • United Way of Northern New Jersey • Zarephath • Zufall Health Services			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan										
PRIORITY AREA 4: Access to Care										
Goal 4: Improve the access to and awareness of health care services for those living and working in Somerset County, including underserved populations.										
Objective 4.2: Create a network of Community Health Workers who represent the diverse populations in our community										
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
4.2.1	Define Community Health Worker title and job description.									
4.2.2	Assess existing community health workers (CHWs) (use existing survey), including volunteer, lay health workers, etc. for coverage, satisfaction level, training needs, etc.									
4.2.3	Identify gaps in services and geographic areas.									
4.2.4	Identify partners (work group).									
4.2.5	Identify funding to support development of network.									

Year 1 Action Plan			
PRIORITY AREA 4: Access to Care			
Goal 4: Improve the access to and awareness of health care services for those living and working in Somerset County, including underserved populations.			
Objective 4.3: Increase opportunities to address barriers to health insurance navigation for underserved community members			
Selected Outcome Indicators:	**Baseline**	**2020 Target**	**Data Source**
• Number of resources to improve health insurance navigation for underserved community members	Developmental		
Partners for This Objective:			
• Catholic Charities • First Baptist Church of Lincoln Gardens, Somerset NJ • Franklin Township Food Bank • Jewish Family Services • Martin Luther King Jr Youth Center • Matheny Developmental Services • Pharmaceutical assistance programs • Resource Center of Somerset County • Richard Hall Mental Health Center • Robert Wood Johnson University Hospital- Somerset • Samaritan Homeless Interim program (SHIP) • Somerset County Office of Human Services • Somerset County Food Bank Network • Somerset County Office on Aging and Disabilities • United Way of Northern New Jersey • Zarephath • Zufall Health Services			
Resources Required (human, partnerships, financial, infrastructure or other)			
•			
Monitoring/Evaluation Approaches			
•			

Year 1 Action Plan											
PRIORITY AREA 4: Access to Care											
Goal 4: Improve the access to and awareness of health care services for those living and working in Somerset County, including underserved populations.											
Objective 4.3: Increase opportunities to address barriers to health insurance navigation for underserved community members											
Strategies		**Action Steps**	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products)** or Results	**Year 1**				**Y2**	**Y3**
					Q 1	**Q 2**	**Q 3**	**Q 4**		
4.3.1	Collect and analyze data and determine a baseline for successive annual comparisons.									
4.3.2	Identify key barriers to health insurance navigation for targeted populations (focus groups, survey, other).									
4.3.3	Educate community members on resources and supports									
4.3.4	Conduct marketing promotion/media (radio, billboards, and social media).									
4.3.5	Identify funding opportunities and grants.									
4.3.6	Identify key policy and systems barriers; form advocacy group(s) to address them.									