SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

Robert Wood Johnson University Hospital | RWJBarnabas HEALTH

Middlesex and Somerset* Counties Community Health Improvement Plan

**southeast section*

September 2016

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Health Resources in Action
Advancing Public Health and Medical Research

INTRODUCTORY LETTER

Dear Middlesex and Somerset County Friends,

This project was a collaboration between Saint Peter's University Hospital (SPUH) and Robert Wood Johnson University Hospital (RWJUH), as well as, the various community partners of the Community Health Consortium for Central Jersey (CHCCJ). Our community health improvement plan could not have been done without the leadership and vision of Zachary Taylor, MEd, CHES, Coordinator of Community Health Consortium for Central Jersey; Marge Drozd, MSN, RN, APRN-BC, Director of Community Mobile Health Services at SPUH; Mariam Merced, MA, Director of Community Health Promotions Program at RWJUH; and Camilla Comer-Carruthers, MPH, Manager of Community Health Education at RWJUH.

We also want to thank the more than 65 people representing numerous community organizations that came together to establish a roadmap for the future health of individuals and families in the counties of Middlesex and Somerset*. We are pleased to present this report as a strategic framework for identifying and linking community assets, leveraging expertise and resources, and enhancing initiatives already underway to create counties which are healthy, prosperous and have a clear vision for a better future.

In this document, you will learn how the process for planning was conducted and discover key recommendations for action and partnership. You will also identify ways that you and/or your organization might participate and collaborate in the effort to improve the health of those who live, learn, work and play in Middlesex and Somerset* counties.

As we move forward to develop collaborative plans and strategies to improve the health and wellbeing of individuals and families, remember that your story builds our story. Thank you for your ongoing contributions to this important community health improvement process.

We urge you to examine the goals, objectives, strategies, and action steps outlined in this plan to determine how you may implement strategies in your own business, organization, or neighborhood to support this effort. Together, we will improve the health of individuals and families in Middlesex and Somerset*counties and lay the foundation for ongoing improvements in our region's public health outcomes.

Sincerely,

Saint Peter's University Hospital and Robert Wood Johnson University Hospital

** Refers to the southeast section of Somerset County*

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** Refers to the southeast section of Somerset County*

EXECUTIVE SUMMARY

It is critical to understand the specific environmental factors in Middlesex and Somerset* Counties -- 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, Robert Wood Johnson University Hospital (RWJUH) and Saint Peter's University Hospital (SPUH) led a comprehensive community health planning effort through the Community Health Consortium for Central Jersey (CHCCJ) to measurably improve the health of residents within their catchment area (Middlesex and Somerset* Counties). This effort included two major phases:

1. A community health needs assessment (CHNA), conducted by Rutgers University Center for State Health Policy (CSHP), to identify the health related needs and strengths of the catchment area, and

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 to address these needs.

The CHNA and CHIP are essential frameworks for guiding future services, programs, and policies for healthcare and public health-serving agencies in the catchment area. For nonprofit hospitals like RWJUH and SPUH, the CHNA and the CHIP are required to maintain nonprofit status with the IRS and deliver community-based programming that is aligned with, and informed by, community needs.

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

The 2016 Community Health Improvement Plan was developed over the period May, 2016 - August, 2016, using the key findings from the CHNA. The CHNA is accessible at:

http://www.rwjuh.edu/rwjuh/community-needs-assessment.aspx

http://www.saintpetershcs.com/saintpetersuh/community-needs-assessment/

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the community health assessment and planning processes engaged community partners through different avenues.

Community Health Consortium for Central Jersey: a diverse group of stakeholders that includes community-based organizations, health department personnel, academic institutions and hospital representatives, was responsible for guiding, participating in, and providing feedback on all aspects of the assessment and planning process. Partners provided input on the community health needs assessment, participated in planning sessions, and gave continuous feedback on draft plan components.

Leadership and staff from RWJUH and SPUH were responsible for convening meetings, reviewing documents and providing overall project management and oversight.

The Community Health Consortium for Central Jersey members, were responsible for developing the goals, objectives and strategies for the 2016 CHIP and for prioritizing objectives, strategies, and activities for year one implementation.

The CHCCJ Steering Committee, comprised of community representatives from Middlesex and Somerset Counties, 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 Consortium.

The Steering Committee met at a kick-off meeting on May 13, 2016 to review key findings from the CHNA and identify priorities for the CHIP. Steering Committee members used a voting process to identify those health needs that were both important and feasible for inclusion in the CHIP.

The full CHCCJ met for two, full-day planning sessions, in June and July 2016, to develop the core elements of the CHIP. In the first planning session, participants confirmed the priority areas for the CHIP and identified goals, objectives, evidence-based strategies and indicators to address them. In the second planning session, participants continued the planning process and developed year one action plans for CHIP implementation. The output of these two sessions follows below.

Vision

Working together to create a healthy, safe and supportive community for all.

Health Priorities

The results of the CHNA were reviewed and discussed by the Steering Committee. Utilizing an interactive voting tool, members reviewed the various CHNA areas of need and selected three key priority areas for planning: Access to Care and Services, Health Risk Factors (Prevention), and Disease Specific Issues (Chronic Disease Treatment and Management). An additional priority area (Collective Impact) was identified during the review process to ensure ongoing coordination and collaboration with the CHCCJ partners.

Given the diversity in the catchment area, as indicated by the CHNA, the CHCCJ made the conscious decision to structure this CHIP with a focus on culturally and linguistically appropriate services, programs, and activities within each priority area. Every activity outlined in the CHIP and its annual Action Plans will reflect this focus as a key component of the Consortium's broader commitment to health equity, defined as the "attainment of the highest level of health for all people (Healthy People 2020)."

Priority Area	Goal Statement
Priority 1: Collective Impact	Goal 1: Establish and sustain effective partnerships to improve equitable access to, and utilization of, culturally and linguistically appropriate community health related resources.
Priority 2: Access to Care and Services	Goal 2: Ensure access to culturally and linguistically appropriate health care, services, and resources that equitably meet the needs of the diverse populations of Middlesex and Somerset Counties.
Priority 3: Health Risk Factors (Prevention)	Goal 3: Promote healthy lifestyles through culturally and linguistically appropriate practices that reduce preventable risk factors.
Priority 4: Disease Specific (Chronic Disease Treatment and Management)	Goal 4: Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.

MIDDLESEX AND SOMERSET* COUNTIES COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

I. BACKGROUND

It is critical to understand the specific environmental factors in Middlesex and Somerset* Counties -- 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. Following the successful completion of the 2012 CHNA and 2013 CHIP, the Community Health Consortium for Central Jersey led a comprehensive community health planning effort with the Robert Wood Johnson University Hospital (RWJUH) and Saint Peter's University Hospital (SPUH) to measurably improve the health of residents within their catchment area (Middlesex and Somerset* Counties). This effort included two major phases:

1. A community health needs assessment (CHNA), conducted by Rutgers University Center for State Health Policy (CSHP), to identify the health related needs and strengths of the catchment area, and

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The CHNA and CHIP are essential frameworks for guiding future services, programs, and policies for healthcare and public health-serving agencies in the catchment area. For nonprofit hospitals like RWJUH and SPUH, the CHNA and the CHIP are required to maintain nonprofit status with the IRS and deliver community-based programming that is aligned with, and informed by, community needs.

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

II. OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PLAN

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 unifying 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 2016 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

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

- Guides future community decision-making related to community health improvement

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 Middlesex and Somerset* Counties. 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?

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 Middlesex and Somerset* Counties. 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.

Methods

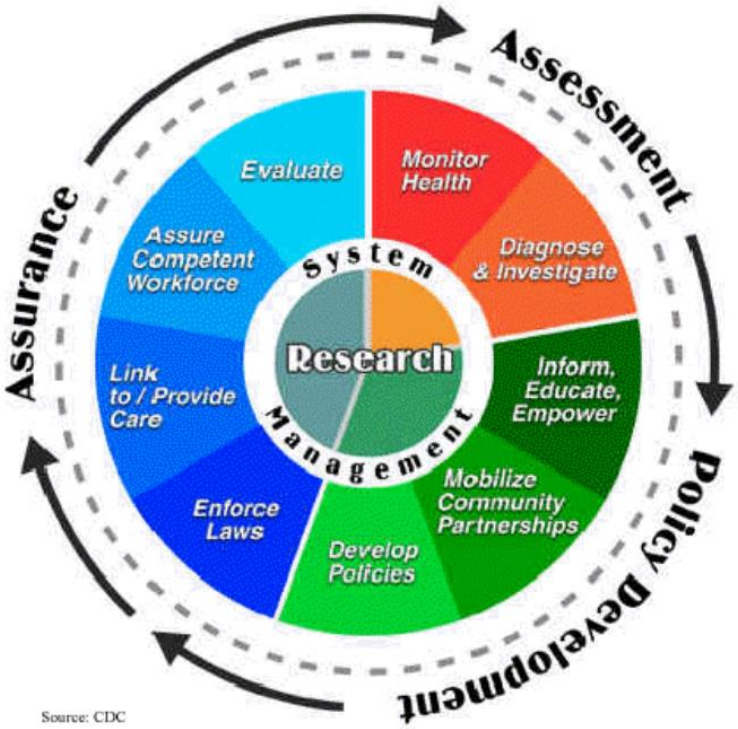
Following the guidelines of the National Association of County and City Health Officials (NACCHO), the community health improvement process was designed to integrate and enhance the activities of many organizations' contributions to community health improvement, building on current assets, enhancing existing programs and initiatives, and leveraging resources for greater efficiency and impact. To develop the CHIP, the lead partners, RJWUH and SPUH, convened the Community Health Consortium for Central Jersey as the area's cross-sector body of influential leaders in healthcare, academia, mental health, local government, social services, and other community based organizations.

The overall process, which includes assessment, planning, implementation, and evaluation, is a continuous cycle of improvement that seeks to "move the needle" on key health priorities over the course of time. This 2016 CHIP builds on and refines the work of the 2013 CHIP based on identified progress, new scenario factors, and emerging partners. The cyclical nature of the Core Public Health Functions is illustrated below in Figure 1.

The next phase of the CHIP will involve broad implementation of the strategies through an annual action plan developed from the CHIP, as well as monitoring and evaluation of the CHIP's short-term and long-term outcome indicators.

** Refers to the southeast section of Somerset County*

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



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

III. PROCESS FROM ASSESSMENT TO PLANNING

The Community Health Consortium for Central Jersey developed this CHIP over the period May, 2016 - August, 2016 using the key findings from the CHNA. The 2016 CHNA is accessible at

http://www.rwjuh.edu/rwjuh/community-needs-assessment.aspx

http://www.saintpetershcs.com/saintpetersuh/community-needs-assessment/

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 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 process allows for the periodic identification of new priorities and the realignment of activities and resources to address them.

[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/

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the community health assessment and planning processes engaged community partners through different avenues.

Community Health Consortium for Central Jersey: a diverse group of stakeholders that includes community-based organizations, health department personnel, academic institutions and hospital representatives, was responsible for guiding, participating in, and providing feedback on all aspects of the assessment and planning process. Partners provided input on the community health needs assessment, participated in planning sessions, and gave continuous feedback on draft plan components.

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The CHCCJ Steering Committee, comprised of community representatives from Middlesex and Somerset Counties, 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 Consortium.

In 2015, the Robert Wood Johnson University Hospital (RWJUH) and Saint Peter's University Hospital (SPUH) 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 CHIP process, to review and provide feedback on draft documents and output, and to develop the resulting reports and plan.

IV. COMMUNITY HEALTH IMPROVEMENT PLAN COMPONENTS

Vision and Values

The Community Health Consortium for Central Jersey confirmed and affirmed the vision from the 2013 CHIP.

Vision

Working together to create a healthy, safe and supportive community for all.

Core Values: Collaboration, commitment, communication, acceptance and respect of our differences, access to all, compassion, culturally competent care, equality, empowerment, integrity, maximize limited resources, passion, professionalism, proven interventions, respect, teamwork, transparency, trust, understanding, and unity.

Given our vision and values, the CHCCJ made the conscious decision to structure this CHIP with a focus on culturally and linguistically appropriate services, programs, and activities within each priority area. Every activity outlined in the CHIP and its annual Action Plans will reflect this focus as a key component of the Consortium's broader commitment to health equity.

Development of Data-Based, Community-Identified Health Priorities

Rutgers Center for State Health Policy (CSHP) conducted the following services for the Community Health Needs Assessment:

- Analysis of secondary data
  - 2012 Behavioral Risk Factor and Surveillance System
  - Hospital Discharge Data (2011-2013)
- Key Informant Interviews (15)

On May 13, 2016, the CHCCJ held a kick-off meeting with the Steering Committee of the Community Health Consortium for Central Jersey to review the assessment and planning processes, timelines, and roles; identify key stakeholders to engage in these processes; review and discuss key health issues identified from the CHNA; and begin identifying priorities for the CHIP. Leadership from RWJUH and SPUH presented a rating tool evaluating thematic items from the CHNA in terms of impact and feasibility and facilitated a process for prioritization of health needs. The key health issues identified by the CHNA are represented in the following tables:

Access to Care and Services
1. Cost associated barriers to care (Health Insurance)
2. Dental Access (Regular visits)
3. Emergency room misuse (Inappropriate and Overuse)
4. Health Information (Patient centered communication)
5. Healthcare Navigation (Office Hours and Appointments)
6. Medical Home (Source of care and Recent checkup)
7. Provider Diversity (Language and Culture)
8. Provider Training (Health Literacy and Cultural competency training)
9. Specialists (Access to specialty care)
10. Transportation (Parking and Public transit)

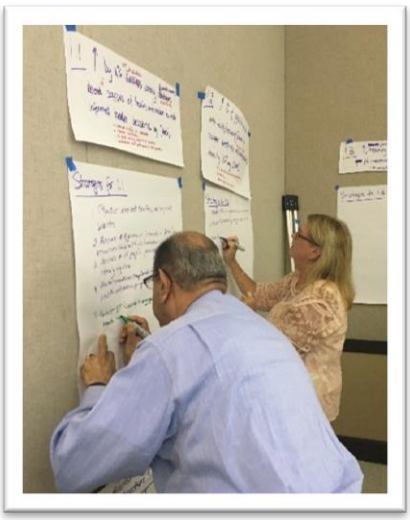
Health Risk Factors (Prevention)
1. Housing (Lack of quality housing)
2. Injury Prevention (Seat belt use and falls)
3. Nutrition (Lack of healthy food options)
4. Personal Trauma (History of abuse)
5. Physical Activity (Inactivity)
6. Screening (Testing and Early Detection)
7. Sleep (Lack of sleep)
8. Substance Use (Alcohol, Tobacco, and Other drugs)
9. Vaccinations (Flu and Pneumonia)

Disease Specific (Chronic Disease Treatment and Management)
1. Cardiac Conditions (Cardiovascular disease and Congestive heart failure)
2. Diabetes
3. Kidney Disease (Patient centered communication)
4. Mental Health
5. Obesity
6. Pulmonary Conditions (Asthma and COPD)
7. Stroke
8. Vision Problems

See Appendix A for the outcomes of the CHNA prioritization.

The results of the CHNA were reviewed and discussed by the Steering Committee. Utilizing an interactive voting tool, members reviewed the various CHNA areas of need and selected three key priority areas for planning: Access to Care and Services, Health Risk Factors (Prevention), and Disease Specific Issues (Chronic Disease Treatment and Management). An additional priority area (Collective Impact) was identified during the review process to ensure ongoing coordination and collaboration with the CHCCJ partners.

CHIP Strategic Framework and Action Plan



Following the kick-off meeting, the full Community Health Consortium for Central Jersey met for two, full-day planning sessions facilitated by HRiA consultants in June and July 2016 to develop the core elements of the CHIP. In the first planning session, participants confirmed the priority areas for the CHIP and identified goals, objectives, evidence-based strategies and indicators to address them. CHIP 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 draft CHIP was completed and disseminated to working group members from the Community Health Consortium for Central Jersey for electronic review and feedback. This feedback was incorporated into the final draft of the CHIP, which was used to guide the subsequent planning session.

In the second planning session, participants continued the planning process and developed year one action plans for CHIP implementation. An Action Plan is the Implementation Plan for the CHIP. It defines:

- Action Steps – the actions partners are going to take to execute each of the strategies for the objectives in the CHIP, as well as
- Persons Responsible
- Resources Needed
- Outcome (Products) or Results
- Timeline

The purpose of the Action Plan is to provide a realistic blueprint of activities and action steps that can be implemented and tracked as well as roles and responsibilities to which people can be held accountable.

Working group members prioritized objectives and strategies for year one implementation. Criteria for prioritization included:

- What needs to **happen first**? (Scope and sequence)
- What is **reasonable/feasible** to take on as a load for Year 1?
- Where can we have an **easy or quick success** to ensure positive momentum?
- Does it address issues of **equity and disparities**?
- Consider **budget** for implementation given limited resources and tools.
- Is this an area where we have many partners and lots of initiatives that we can connect (**critical mass**)?
- Is **my agency interested in/willing** to invest time and resources in this topic?
- Consider **timing** of other related partner initiatives.

V. 2016 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 indicators 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, Outcome Indicators, and Potential Partners/Resources for the four health priority areas outlined in the CHIP. See Appendix B for a glossary of terms used in the CHIP.

Priority Area 1: Collective Impact

Goal 1: Establish and sustain effective partnerships to improve equitable access to, and utilization of, culturally and linguistically appropriate community health related resources.

1.1: By 2019, increase effective communication among consortium partners regarding activities that impact community health priorities as outlined in the CHIP.

Outcome Indicators:

- *Awareness of partner activities that impact community health priorities in the CHIP*

Brainstormed Strategies

1.1.1 Articulate a vision for the CHCCJ. **(Year 1)**

1.1.2 Develop a communication plan for the CHCCJ partners. **(Year 1)**

1.2: By 2019, Identify and engage relevant and integral stakeholders, at both individual and organizational levels, in activities that impact community health priorities as outlined in the CHIP.

Outcome Indicators

- *New and relevant stakeholders participating in consortium*

Brainstormed Strategies

1.2.1 Develop and implement an outreach strategy to connect and engage relevant and integral stakeholders in activities to effectively achieve the CHIP objectives. **(Year 1)**

1.3: By 2019, increase coordination and collaboration among partners related to CHIP objectives.

Outcome Indicators

- *Increased number of collaborations to meet CHIP objectives*

Brainstormed Strategies

1.3.1 Develop forums for partners to discuss targeted programming plans. **(Year 1)**

1.3.2 Develop a forum for partners to discuss funding opportunities. **(Year 1)**

Priority Area 2: Access to Care and Services

Goal 2: Ensure access to culturally and linguistically appropriate health care, services, and resources that equitably meet the needs of the diverse populations of Middlesex and Somerset* Counties.

2.1: By 2019, increase the utilization of sources of health information among individuals to make informed health decisions.

Outcome Indicators:

- *Increased internet traffic on websites*
- *Increased number of pieces of literature distributed*
- *Increased number of people making inquiries to libraries*
- *Positive evaluations from participants of information programs*

Brainstormed Strategies

2.1.1: Reach out to the National Library of Medicine for information on cultural and linguistically appropriate health information and other available services and resources. **(Year 1)**

2.1.2: Organize a symposium between health libraries of all types (hospital, academic, public) to foster networking and awareness of resources and to brainstorm on new ways that librarian talent can be leveraged to promote health literacy and culturally competency. **(Year 1)**

2.1.3: Recruit 5+ libraries in CHIP catchment area to engage in providing culturally and linguistically appropriate health information to consumers. **(Year 1)**

2.1.4: Collaborate with the Middlesex County Mayor's Council to secure funding to recruit additional librarians in under-resourced libraries (e.g., those that lack adequate public funding to develop their own health literacy initiative) to provide health information.

2.1.5: Outreach/collaborate with community and business fairs to provide health information and education.

2.1.6: Reach out to local businesses (pharmacy, food places) to disseminate health education/information.

2.1.7: Expand the collaboration with faith-based organizations for information sharing.

2.1.8: Utilize transportation to disseminate health information in culturally and linguistically appropriate formats (e.g., posters on buses, trains, and other modes of transportation).

2.1.9: Seek ways to identify/address the health information needs of at-risk communities through grant funding of **a "regional health hub**" and training by East Brunswick Public Library's consumer health librarians to other libraries in Middlesex/Somerset Counties.

Partners and Resources

- *Community Health Consortium for Central Jersey*
- *County Health Rankings apps, website and coach*
- *East Brunswick Public Library*
- *Hospitals in the catchment area*
- *Local, county and state department of health*
- *Managed care organizations*
- *New Jersey Hospital Association*
- *NJ State Library*
- *National Network of Libraries of Medicine, Middle Atlantic Region (NN/LM MAR)*
- *Office of Minority Heath*
- *Rutgers Health Sciences Library (Healthynj.org)*
- *United Way of Central Jersey*
- *Universal Signage resources (e.g., Hablamos Juntos - http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp*
- *Other Public Libraries and Cultural Centers*

2.2: By 2019, increase the percentage of the population that is provided with tools, resources, and guidance to navigate healthcare resources and providers by 20%.

Outcome Indicators:

- *Increased number of new enrollees to various programs*
- *Increased number of referrals by navigation personnel and care providers*
- *Increased number of navigation services provided*

Brainstormed Strategies

2.2.1: Utilize business and civic groups to disseminate navigation tools.

2.2.2: Utilize social media/marketing around navigation (where to find services and care books).

2.2.3: Equip care providers (e.g., family medicine, internal medicine, and other primary care clinicians (including behavioral health providers) to provide

referrals to health information programs for their patients and monitor referrals to programs for health information.

2.2.4: Create a website with tutorials on how to use the health info portals/resources and track the usage of the tools.

2.2.5: Assess learnings and strategies for connecting systems from ACO's (for those with Medicare, Medicaid, and other insurance).

Partners and Resources

- *In addition to MedlinePlus (www.medlineplus.gov) consumer health information website, there are two local sites: Rutgers Health Sciences Libraries' HealthyNJ (www.healthynj.org) and East Brunswick Public Library's "Just For The Health of It" (http://www.wellinks.org/).*

2.3: By 2019, increase provider training about culturally and linguistically appropriate services (CLAS), health equity, and patient-centered care.

Outcome Indicators:

- *Increased number of trainings*
- *Increased number of providers trained*
- *Positive patient feedback*

Brainstormed Strategies

2.3.1: Integrate training about CLAS and health equity into health professions, residency, and continuing education (CEU) programs.
  - Offer free live, online, and "blended" training programs. The course content is already under development as part of the 2013 CHIP initiative.

2.3.2: Collaborate with the New Jersey Statewide Network for Cultural Competence (NJSNCC) and other cultural competence agencies in sharing information, resources, training.

2.3.3: Conduct CLAS training for other "providers" (e.g., librarians, EMT's, other interdisciplinary teams).

Partners and Resources

- *Free online programs developed by the DHHS OMH and HRSA.*
  https://www.thinkculturalhealth.hhs.gov/
  https://www.train.org/DesktopShell.aspx

Medical Interpreters

2.4: By 2019, increase the utilization of current transportation services to meet the needs of patients.

Outcome Indicators:

- *Increased utilization of current transportation services.*
- *Increased funding/investment in public transportation.*
- *Identified areas of transportation needs and limitations.*

Brainstormed Strategies

2.4.1: Approach businesses and organizations to increase investments in public transportation in alignment with county or state priorities and their related campaigns. **(Year 1)**

2.4.2: Promote multimodal transportation options. **(Year 1)**

2.4.3: Charity care funding specific to medical transportation.

2.4.4: Multi-lingual transportation information in public areas of facilities (e.g., bus schedule, rates, etc.).

2.4.5: Evaluation of current routes and utilization and change schedules and routes to meet the needs.

2.4.6: Education/training to care coordinators on available transportation options and services (Keep Middlesex Moving).

2.4.7: Explore the establishment of a municipal partnership with ride share companies (e.g., Uber, Lyft).

Partners and Resources

- *County Transportation*
- *Hospitals in the catchment area*
- *Keep Middlesex Moving*
- *NJ Transit Access Line*
- *RideWise*
- *Seniors Centers*

2.5: By 2019, reduce the number avoidable emergency department visits in area hospitals.

Outcome Indicators:

- *Readmission rate to emergency departments*

Brainstormed Strategies

2.5.1: Implement 24-hour Phone-a-Doc/RN Calling Center.

2.5.2: Increase physician office hours to accommodate patients who work and patients who work off standard shifts.

2.5.3: Increase the number of urgent care centers.

2.5.4: Increase urgent care centers' hours (nights/weekends).

2.5.6: Expand the pilot for patient-centered medical home referral identification at emergency department registration with opening and assigning appointments.

2.5.7: Provide bed-side education on follow-up care to increase Rx and Dx education and ensure patient understanding of compliance and risks for non-compliance.

2.5.8: Form follow up teams for patients discharged to assist and increase continuity of care and decrease repeat emergency department returns/readmissions.

2.5.9: Provide care navigators for discharged patients.

2.5.10: Develop “A Roadmap for Better Care and a Healthier You”, a guide for patients for follow-up care after hospital stay.

2.5.11: Increase the number of Community Health Workers (CHWs) in the catchment area.

2.5.12: Facilitate use of care coordinators by the insured population (through accountable care organizations ACOs).

Priority Area 3: Health Risk Factors (Prevention)

Goal 3: Promote healthy lifestyles through culturally and linguistically appropriate practices that reduce preventable risk factors.

3.1: By 2019, increase the number of people engaged in obesity prevention programs.

Outcome Indicators:

- *Increase in the number of obesity prevention programs*

Brainstormed Strategies

3.1.1: Identify and support multi-component, integrated, obesity prevention interventions (nutrition, physical activity, behavior change, policy, systems, and environmental factors) in local communities. **(Year 1)**

3.1.2: Utilize the data to target populations and communities most at risk.

3.1.3: Advocate for multi-component, integrated, obesity prevention interventions (nutrition, physical activity, behavior change, policy, systems, and environmental factors) in local communities.

3.2: By 2019, reduce substance use among school-aged youth.

Outcome Indicators:

- *Reduced alcohol abuse among middle school students*
- *Reduced marijuana use among middle school students*
- *Reduced tobacco use among middle school students*
- *Reduced prescription drug misuse among middle school students*
- *Reduced alcohol abuse among high school students*
- *Reduced marijuana use among high school students*
- *Reduced tobacco use among high school students*
- *Reduced prescription drug misuse among high school students*

Brainstormed Strategies

3.2.1: Advocate for policy to increase enforcement of existing alcohol, tobacco point of sale laws and prescription drug ordinances. **(Year 1)**

3.2.2: Coordinate mental and behavioral health services with ED visit as a point of referral for treatment.

3.2.3: Work with community partners to increase number of medicine drop boxes in catchment area to limit inappropriate access to prescription drugs.

3.3: By 2019, reduce preventable injuries related to falls among the elderly.

Outcome Indicators:

- *Decreased unintentional fall death rate ages 65+ years*
- *Decreased hospital stays for non-fatal, unintentional falls ages 65+ years*
- *Decreased emergency department visits for non-fatal, unintentional falls ages 65+*

Brainstormed Strategies

3.3.1: Collaborate with community-based institutions (e.g., libraries, Y's, community centers) to distribute Home Safety checklists in paper and online versions to educate families on fall prevention safety for the elderly.

3.3.2: Implement evidence-based fall prevention program in senior centers and senior housing facilities.

3.4: By 2019, reduce preventable injuries related to transportation.

Outcome Indicators:

- *Decreased injuries and fatalities due to non-seatbelt use*
- *Decreased pedestrian injuries due to transportation*

Brainstormed Strategies

3.4.1: Enhance pedestrian safety awareness campaigns. **(Year 1)**

3.4.2: Implement and support seat belt and restraint use campaign including print and online media.

3.4.3: Collaborate with local police departments on enforcement initiatives (e.g. "Click it or Ticket" and "Drive Sober or Get Pulled Over").

3.5: By 2019, increase the number of families receiving home health and safety education.

Outcome Indicators:

- *Increased number of families receiving healthy housing education*

Brainstormed Strategies

3.5.1: Build partnerships with nonprofit community based organizations that are engaged in advancing housing initiatives that will result in improved health and well-being. **(Year 1)**

3.5.2 Recruit and provide education to increase the number of healthy housing initiatives.

3.6: By 2019, increase the number of children receiving the CDC recommended series of vaccinations

Outcome Indicators:

- *Increased number of children receiving CDC recommended vaccinations*

Brainstormed Strategies

3.6.1: In communities with low vaccination rates, implement education programs to increase the level of awareness about the importance of vaccines and dispel myths.

3.6.2: Educate and increase awareness about available resources, especially for patients without insurance.

3.6.3: Advocate for patient education policies in clinical care settings.

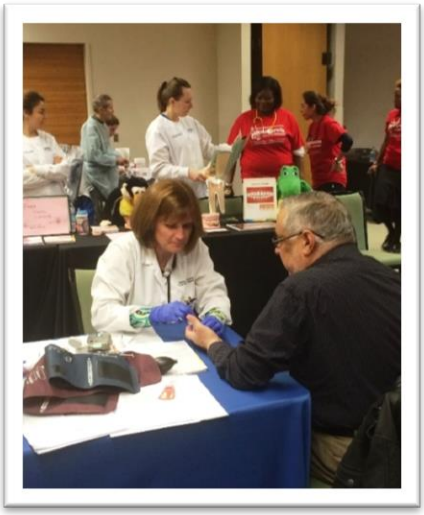
3.6.4 Educate providers on how to talk to patients and patients' family about the benefits and risks of vaccines.

3.6.5: Implement community-based vaccination opportunities to increase access.

Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)

Goal 4: Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.

4.1: By 2019 increase the number of individuals engaging in diabetes programs.



Outcome Indicators:

- *Increased number of participating programs*
- *Increased number of participants in programs*

Brainstormed Strategies

4.1.1: Recruit individuals to participate in CDSMP (Chronic Diseases Self-Management Program) and DSMP (Diabetes Self-Management Program) through community outreach to senior center, libraries, faith based organizations, and community centers.

4.1.2: Recruit healthcare professionals to join the LINCS system (Local Information Network Communications) to share information and coordinate with one another and with education programs to aid in getting patients into programs, according to HIPAA and interoperability requirements (i.e., Who's doing the testing and what are the results? Incorporate into Electronic Medical Records (EMR)). **(Year 1)**

4.1.3: Increase education and awareness of programs available at the community level through outreach to Community-Based (CBO) and Faith-Based Organizations (FBO's). **(Year 1)**

4.1.4: Increase the number of individuals routinely tested/screened for diabetes/prediabetes using HbA1C levels (long term blood sugar screening test).

4.1.5: Increase capacity of programs to meet demand (e.g., more diabetes educators, support groups (in multiple programs), virtual diabetes programs to those who have computer access, programs in multiple languages).

4.1.6: Increase utilization of diabetes focused Patient Centered Medical Home (PCMH).

** Refers to the southeast section of Somerset County*

4.2: By 2019, increase the number of individuals engaging in cardiovascular health initiatives.

Outcome Indicators:

- *Decrease blood pressure*
- *Decrease BMI*
- *Decrease cholesterol levels*
- *Decrease tobacco use*

Brainstormed Strategies

4.2.1: Create system for awareness of existing cardiovascular health promotion and intervention programs.

4.2.2: Support existing programs and increase the number of clinically- and community-based nutrition programs designed for targeted populations. **(Year 1)**

4.2.3: Increase the number of clinically- and community-based exercise programs/walking programs for targeted populations.

4.2.4 Increase the number of health risk behavior screenings in community based settings (e.g., BP, BMI, and cholesterol screenings). **(Year 1)**

4.2.5: Increase PCP (primary care providers) awareness of evidence-based community resources to increase referrals (e.g., QuitLine for tobacco cessation, Chronic Disease Self-Management Program (CDSMP) to learn about nutrition and exercise)

4.2.6: Advocate for system change and policy regarding tobacco sales and use through NJ Prevention Network.

4.3: By 2019, increase number of individuals engaging in respiratory health initiatives.

Outcome Indicators:

- *Number of schools implementing "Open Airways" or similar programs*
- *Number of visits to ER by children for asthma related conditions*

Brainstormed Strategies

4.3.1: Promote Open Airways or similar programs within schools. **(Year 1)**

4.3.2: Outreach to providers, community-based and faith-based organizations to coordinate asthma and COPD support groups in clinical and community-based settings.

4.3.3: Support treatment compliance for COPD (medication, behavior (smoking)) through follow up calls by care providers, referrals to rehabilitation services and support groups, etc.

4.3.4: Implement teacher/parent asthma education workshops at pre-schools regarding triggers; prevention of exacerbations; "school walk-through"; asthma friendly zones, and assistance available through Special Child Health Services.

4.3.5: Increase awareness of Special Child Health Services among community members and providers to increase referrals about respiratory health issues.

See also Objective 2.4 (Healthy Homes).

4.4: By 2019, increase number of community members/organizations engaging in mental health and awareness training and education.

Outcome Indicators:

- *Number of people trained in Mental Health First Aid*
- *Number of people trained in trauma-informed care*
- *Number of people referred to mental health and supportive services*

Brainstormed Strategies

4.4.1: Provide and disseminate best practices related to mental health awareness training for healthcare providers.

4.4.2: Utilize online training and state training for mental health first aid.

4.4.3: Increase community awareness regarding mental health needs and existing programs by public campaigns and other methods [e.g., outreach to mental health providers to present at community health fairs, increasing the number of Peer Support Specialists available at community health events or initiatives, providing lists of available programs and where to get help, etc.]. **(Year 1)**

4.4.4: Increase mental health screening across health care settings by promoting the incorporation of user-friendly and evidence-based screening tools at Community Wellness Centers (ex. Robert Wood Health and Wellness center), and also hospital mobile units (ex. CMHS at SPUH).

4.4.5: Outreach to providers, community-based and faith-based organizations to coordinate support groups on general and specific mental health topic areas (e.g., migration, grief, stress, and depression). **(Year 1)**

4.5: By 2019, increase the number of individuals who undergo HIV testing.

Outcome Indicators:

- *Number of people tested for HIV*

Brainstormed Strategies

4.5.1: Advocate as state mandates (already in regulations) and as CDC recommends at 15 years old, to include HIV testing in routine screening of adolescents (with cholesterol).

4.5.2: Outreach to diverse communities in alignment with NJ CLAS Standards for HIV (e.g., African-Americans, Latinos, LGBTQ) to increase awareness regarding the importance of routine HIV testing to minimize

the spread of disease and determine appropriate treatment for management of the disease. **(Year 1)**

4.5.3 Coordinate classes for PCPs, with a focus on cultural competencies to enhance communications with diverse populations regarding the importance of HIV testing.

4.5.4: Use community-based participatory research (CBPR) methods to identify barriers as to why people are not getting screened.

4.5.5: Set up programs that offer affordable health insurance, by collaborating with insurance companies, and non-profit organizations that provide insurance to low income individuals.

Partners and Resources

- *Rutgers Health Care Center*
- *Local health agencies*
- *Hyacinth Foundation – mobile services*
- *Cultural Competency Resources:*
  http://www.state.nj.us/health/aids/rapidtesting/documents/njclas_implementation_guide.pdf
  https://www.careacttarget.org/library/besafe-cultural-competency-model-african-americans
  http://dh.howard.edu/cgi/viewcontent.cgi?article=1001&context=nmaetc_pubs
  https://www.careacttarget.org/library/besafe-cultural-competency-model-asians-and-pacific-islanders
  http://www.aidsetc.org/resource/be-safe-cultural-competency-model-american-indians-alaska-natives-and-native-hawaiians

VI. NEXT STEPS

The components included in this report represent the strategic framework for a data-driven, Community Health Improvement Plan. The Community Health Consortium of Central Jersey, including the core agencies, CHIP workgroups, partners, stakeholders, and community residents, will continue finalizing, implementing, and tracking CHIP progress over the coming year. A progress report will illustrate performance and will guide subsequent annual implementation planning.

VII. SUSTAINABILITY

The Community Health Consortium for Central Jersey, including the core agencies RWJUH and SPUH, CHIP workgroups, partners, stakeholders, and community residents, will continue the process by refining the specific annual action steps, assign lead agencies and personnel, and identify resources for each priority area.

The Steering Committee will provide executive oversight for the improvement plan, progress, and process. The Consortium will expand agency membership to match the scope of the CHIP's four priority areas, identifying additional partners that are integral to success of the plan. Community dialogue sessions and forums will occur in order to engage residents in the implementation where appropriate, share progress, solicit feedback, and strengthen the CHIP. Regular communication through presentations, meetings and via hospital websites to community members and stakeholders will occur throughout the implementation. New and creative ways to feasibly engage all parties will be explored at the aforementioned engagement opportunities.

VIII. ACKNOWLEDGEMENTS

The dedication, expertise, and leadership of the following agencies and people made the 2016 Community Health Consortium of Central Jersey CHIP a collaborative, engaging, and substantive plan that will guide our community in improving the health and wellness for the residents of Middlesex and Somerset* County. Special thanks to all of you:

Steering Committee

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Jaymie Santiago	President, New Brunswick Tomorrow
Gina Stravic	Executive Director, Raritan Valley YMCA
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Veronica Barone	JFK Medical Center
Adam Beder	JFK Medical Center
Catherine Biondi	Edison Township
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Taran Sayal	Rutgers University
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Susan Stephenson-Martin	Rutgers, Cooperative Extension
Gina Stravic	Raritan Valley YMCA
Robert Takash	Edison Greenways Group
Zachary Taylor	Community Health Consortium for Central Jersey
Andrew Thomas	Robert Wood Johnson University Hospital
Jeanette Valentine	Rutgers, Greater New Brunswick Community Health Collaborative
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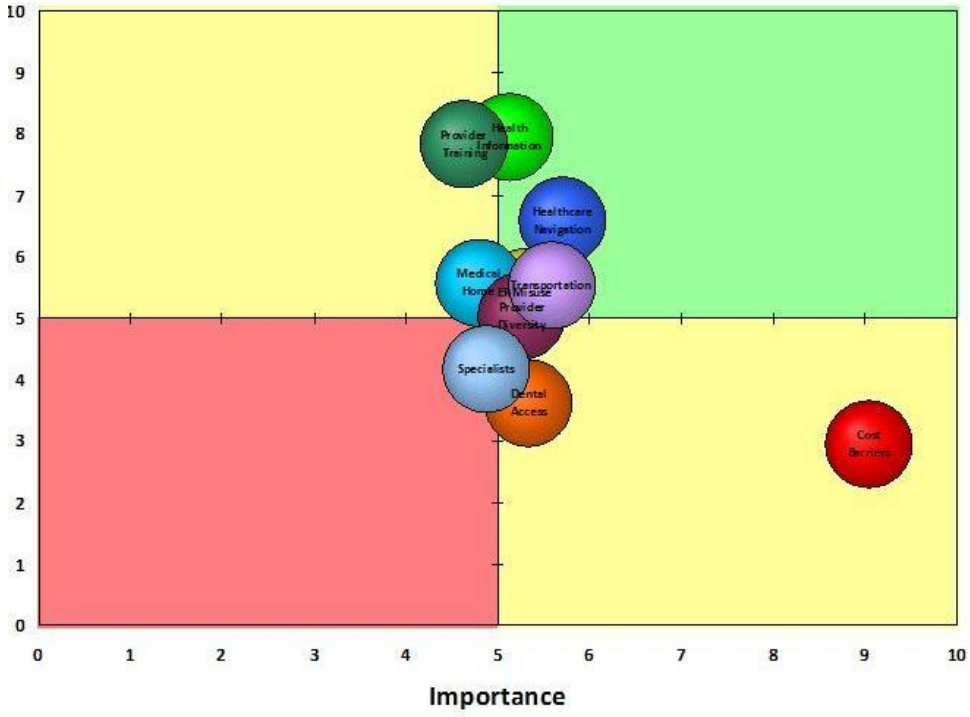
Cheri Wilson	Robert Wood Johnson University Hospital
Yingting Zhang	Rutgers, RWJMS - Health Sciences Library

Consultant Advisors

Health Resources in Action, Inc.

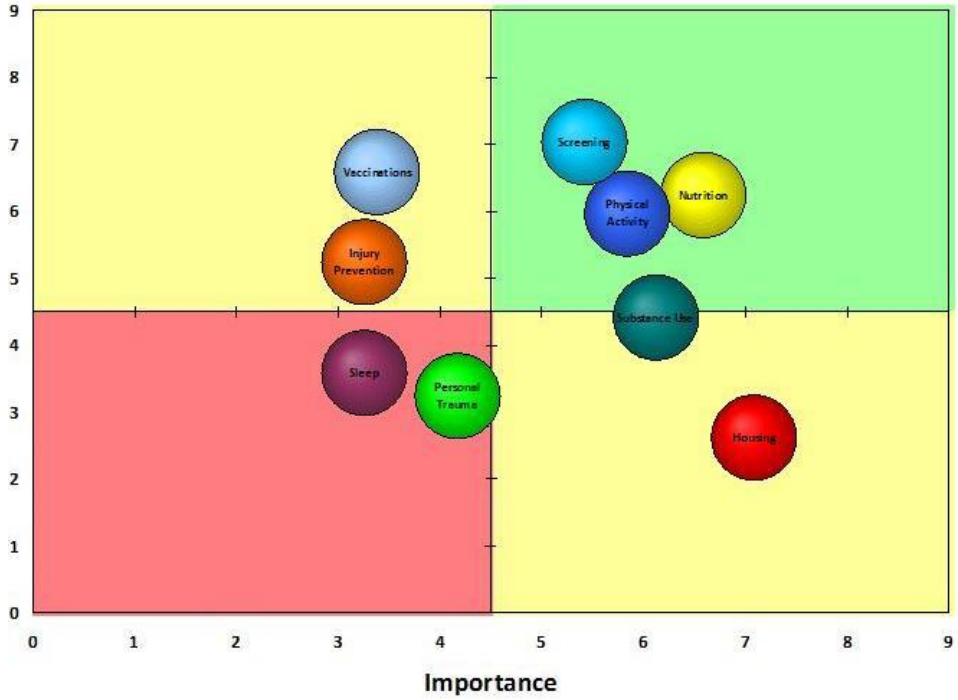
APPENDIX A: CHNA PRIORITIZATION OUTCOMES

Prioritization of Access to Care Issues



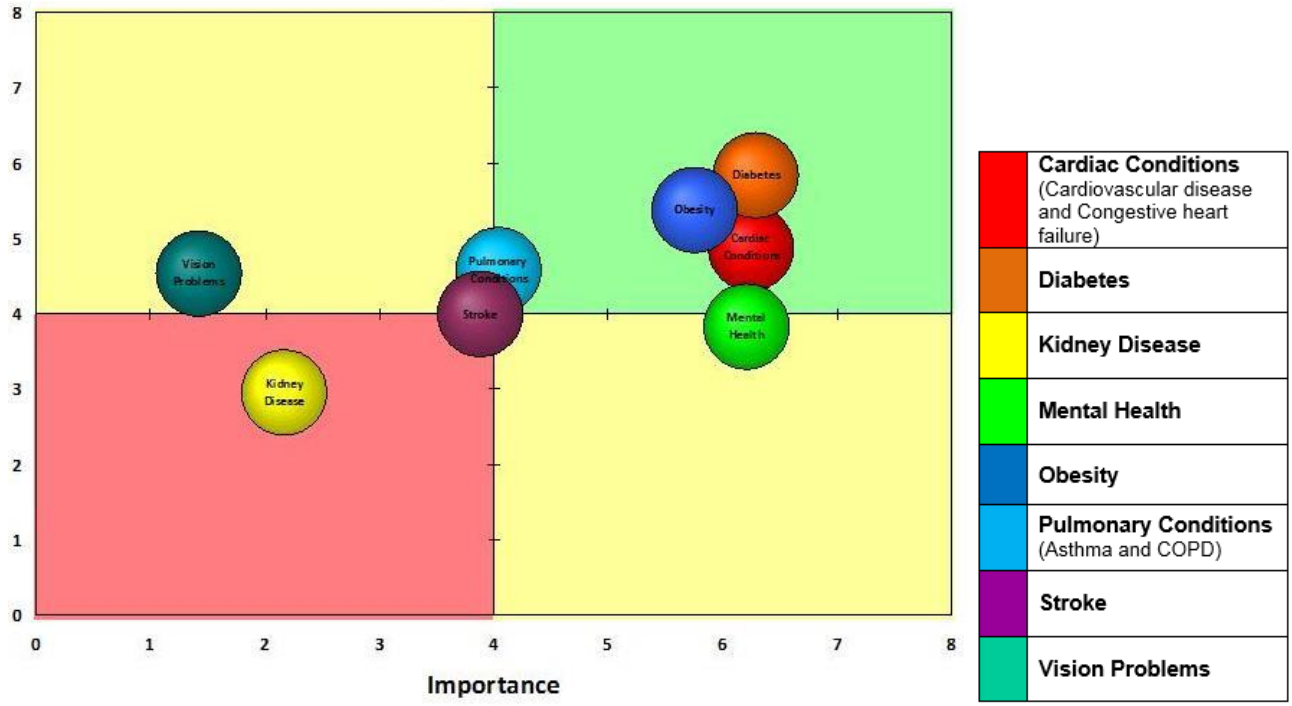
- **Cost Barriers** (Health Insurance)
- **Dental Access** (Regular visits)
- **ER Misuse** (Inappropriate and Overuse)
- **Health Information** (Patient centered communication)
- **Healthcare Navigation** (Office hours and Appointments)
- **Medical Home** (Source of care and Recent checkup)
- **Provider Diversity** (Language and Culture)
- **Provider Training** (Health literacy and Cultural competency training)
- **Specialists** (Access to specialty care)
- **Transportation** (Parking and Public transit)

Prioritization of Health Risk Factors



- **Housing** (Lack of quality housing)
- **Injury Prevention** (Seat belt use and Falls)
- **Nutrition** (Lack of healthy food options)
- **Personal Trauma** (History of abuse)
- **Physical Activity** (Inactivity)
- **Screening** (Testing and Early Detection)
- **Sleep** (Lack of sleep)
- **Substance Use** (Alcohol, Tobacco, and Other drugs)
- **Vaccinations** (Flu and Pneumonia)

Prioritization of Disease Specific Issues



APPENDIX B: 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 C: ACTION PLAN TEMPLATES

Priority Area 1: Collective Impact

Year 1 Action Plan Priority Area 1: Collective Impact			
Goal 1: To establish and sustain effective partnerships to improve equitable access to, and utilization of, culturally and linguistically appropriate community health related resources.			
Objective 1.1: By 2019, increase effective communication among consortium partners regarding activities that impact community health priorities as outlined in the CHIP.			
Outcome Indicators			
Awareness of partner activities that impact community health priorities in the CHIP			
Potential Partners for this Objective			
• CHCCJ Steering Committee and Members			
Monitoring/Evaluation Approaches			
•			

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
1.1.1 Articulate a vision for the CHCCJ.	a. Update/Create the mission, visions, purpose and name	Steering Committee	Clear mission, visions, purpose and name
	b. Approve the mission, visions, purpose and name	Steering Committee	Steering committee acceptance and endorsement of mission, visions, purpose, name
	c. Communicate mission/vision/etc. to Consortium partners	Steering Committee	Mission/vision communicated to partners
1.1.2 Develop a communication plan for the CHCCJ partners.	a. Determine how the consortium communicates amongst partners: -meeting announcements -agendas and action items -consortium business	Steering Committee	Mechanism for partner communication has been established
	b. Develop white paper method for workgroup meetings for Consortium distribution	Workgroup Leads	White paper method developed
	c. Hold update webinars or conference calls periodically for member communication	Coordinator	Update webinars/calls held
	d. Create annual report on CHIP outcomes and targets	Steering Committee	Annual Report

Year 1 Action Plan Priority Area 1: Collective Impact			
Goal 1: To establish and sustain effective partnerships to improve equitable access to, and utilization of, culturally and linguistically appropriate community health related resources.			
Objective 1.2: By 2019, identify and engage relevant and integral stakeholders, at both individual and organizational levels, in activities that impact community health priorities as outlined in the CHIP.			
Outcome Indicators			
New and relevant stakeholders participating in consortium			
Potential Partners for this Objective			
• To be determined			
Monitoring/Evaluation Approaches			
• Track number of participants and participation rate			

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
1.2.1 Develop and implement an outreach strategy to connect and engage relevant and integral stakeholders in activities to effectively achieve the CHIP objectives.	a. Identify sectors that are relevant and integral to effective implementation of the action plan	Steering committee/ consortium members	List of sectors
	b. Identify which sectors are present on the consortium and those that are missing	Steering committee/ consortium members	List of targeted sectors
	c. Identify the sectors (from the list) that need to be represented at the steering committee level	Steering committee	Steering committee
	d. Utilizing existing SC members, develop and implement an outreach strategy to engage stakeholders who are missing from the consortium	Steering committee	Assign outreach duties/cultivating relationships (accountability)

Year 1 Action Plan Priority Area 1: Collective Impact			
Goal 1: To establish and sustain effective partnerships to improve equitable access to, and utilization of, culturally and linguistically appropriate community health related resources.			
Objective 1.3: By 2019, increase coordination and collaboration among partners related to CHIP objectives.			
Outcome Indicators			
Increased number of collaborations to meet CHIP objectives			
Potential Partners for this Objective			
• Community Health Consortium for Central Jersey			
Monitoring/Evaluation Approaches			
• Number of collaborative engagements			

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
1.3.1 Develop forums for partners to discuss targeted programming plans.	a. Identifying methods and tools for information sharing/programming.	Steering Committee	Tools and methods identified
	b. Cross-collaboration	Consortium	Cross collaboration documented
1.3.2 Develop a forum for partners to discuss funding opportunities.	a. Identify capacity needs of partners to implement provisions of the CHIP	Consortium	List of CHIP activities
	b. Develop a resource strategic plan including a forum for partners to collaboratively share and approach funding opportunities	Consortium	Resource strategic plan developed

Priority Area 2: Access to Care and Services

Year 1 Action Plan Priority Area 2: Access to Care & Services			
Goal 2: Ensure access to culturally and linguistically appropriate health care, services, and resources that equitably meet the needs of the diverse populations of Middlesex and Somerset* Counties.			
Objective 2.1: By 2019, increase the utilization of sources of health information among individuals to make informed health decisions.			
Outcome Indicators			
Increased internet traffic on websites			
Increased number of pieces of literature distributed			
Increased number of people making inquiries at libraries			
Positive Evaluations from participants of info group			
Potential Partners for this Objective			
• Rutgers Health Sciences Library, healthynj.org, United Way of CJ, NJ State Library, CHCCJ, EB Library, NN/LM, MAR, Public Libraries & Cultural Centers			
Monitoring/Evaluation Approaches			
• Symposium to be held in 2017, number of people using libraries as health information			

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
2.1.1 Reach out to national library of medicine for information on cultural and linguistically appropriate health information and other available services and resources.	a. Increase awareness of CLAS & relevance to public libraries by promoting through CHCCJ channels and partners	HL/CC Work Group/Pub Health Intern/Library Intern	Number of libraries engaged w NLM
	b. Obtain culturally & linguistically appropriate info National Libraries of Medicine etc.	Local libraries	Have programs available
	c. Recruit and select Public Health Intern (#1) & Library Intern (#1)	CMHS and EBPL	Obtain Interns
	d. Distribute culturally & linguistically appropriate info to community & library patrons	Librarian	Number Of distributed literature & CLAS programs
	e. Develop and publicize a listing of resources (web based, application based)	Interns	List of resources

Resources Required (human, partnerships, financial, infrastructure, or other)
• County health rankings apps & website and coach

Year 1 Action Plan Priority Area 2: Access to Care & Services			
Goal 2:	**Ensure access to culturally and linguistically appropriate health care, services, and resources that equitably meet the needs of the diverse populations of Middlesex and Somerset* Counties.**		
Strategies	**Action Steps**	**Organization(s) Responsible**	**Outcome (Product) or Results**
2.1.2 Organize a symposium between health libraries of all types (hospital, academic, public) to foster networking and awareness of resources and to brainstorm on new ways that librarian talent can be leveraged to promote health literacy and culturally competency.	a. Establish planning committee	HL/CC Work Group & PH Intern	Contact List of committee members
	b. Fall planning session	HL/CC Work Group & PH Intern, LMXAC, NJ State Library, NLM	Meeting held & planning begins. Clear goals and timeline
	c. Promotion of Event	Planning Committee & CHCCJ,	Attendance
	d. Event held	Planning Committee & CHCCJ,	Attendance
	e. Evaluation	Attendees & Planning Committee	Evaluation results
	f. Identify and recruit community members & faith based groups , potential healthcare providers & champions, leaders of other workgroups	HL/CC Work Group	List of participants recruited
Resources Required (human, partnerships, financial, infrastructure, or other)			
• SPUH room , United Way, EB Library, hospitals, managed care, local, county & state depts. of health, NJHA, Department of Mental Health, OMM			
Strategies	**Action Steps**	**Organization(s) Responsible**	**Outcome (Product) or Results**
2.1.3 Recruit 5+ libraries in CHIP catchment area to engage in providing culturally and linguistically appropriate health information to consumers.	a. Engage National Library of Medicine	Identified libraries	Connection w NLM made
	b. Survey to determine how/where resources are being used in order to promote use of library services (see 1.1.3)	HL/CC Work Group	List of libraries
	c. Outreach to those prospects	HL/CC Work Group	Calls/contacts made
Resources Required (human, partnerships, financial, infrastructure, or other)			
• CHCCJ, NLM, LMX, NJ State Library			

Year 1 Action Plan Priority Area 2: Access to Care & Services			
Goal 2: Ensure access to culturally and linguistically appropriate health care, services, and resources that equitably meet the needs of the diverse populations of Middlesex and Somerset* Counties.			
Objective 2.4: By 2019, increase the utilization of current transportation services to meet the needs of patients.			
Outcome Indicators			
Increased utilization of current transportation services			
Increased funding/investment in public transportation			
Identified areas of transportation needs			
Potential Partners for this Objective			
• KMM, NJDOT, RideWise			
Monitoring/Evaluation Approaches			
• Annual report from KMM, NJDOT, RideWise			

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
2.4.1 Approach businesses and organizations to increase investments in public transportation in alignment with county or state priorities and their related campaigns.	a. Connect coalitions and organizations to KMM and other transportation services	KMM and Coordinator	Shared vision between organizations
	b. Develop comprehensive list of transportation for healthcare	Voorhees Transportation	List
	c. Develop plan for symposium to address healthcare transportation	KMM and CMHS	Plan developed
	d. Get tracking information from individual agencies that provide transit and identify which areas need more transportation assistance	KMM, Workgroup	Information obtained

Resources Required (human, partnerships, financial, infrastructure, or other)
• Hospitals, Managed Care, NJ Transit Access Line, Senior Centers, County Transportation, RideWise, KMM

Year 1 Action Plan Priority Area 2: Access to Care & Services			
Goal 2:	**Ensure access to culturally and linguistically appropriate health care, services, and resources that equitably meet the needs of the diverse populations of Middlesex and Somerset* Counties.**		
Strategies	**Action Steps**	**Organization(s) Responsible**	**Outcome (Product) or Results**
2.4.2 Promote multimodal transportation options.	a. Identify populations and geographic areas with limited transportation options for targeted outreach	Workgroup	Targeted intervention sites
	b. Provide/publicize alternative transportation options from available services at conferences and events	Person holding event	Increased ride share & other options
	c. Educate organizations to access KMM's website for transportation alternatives	KMM	Number of organizations spoken to
	d. Engage public libraries to run programs on different transportation resources and services at multiple sites	KMM and EBPL	Number of libraries engaged
Resources Required (human, partnerships, financial, infrastructure, or other)			
• Colleagues from other groups			

Priority Area 3: Health Risk Factors (Prevention)

Year 1 Action Plan Priority Area 3: Health Risk Factors (Prevention)			
Goal 3: Promote healthy lifestyles through culturally and linguistically appropriate practices that reduce preventable risk factors.			
Objective 3.1: By 2019, increase the number of people engaged in obesity prevention programs			
Outcome Indicators	**Baseline**	**Target**	**Data Source**
Increase in the number of obesity prevention programs	Number of current obesity prevention programs	5% above baseline	HP2020
Potential Partners for this Objective			
• Health department, school systems, YMCA, family success center, hospitals, FQHCs, mayors wellness, health communities grant, shaping NJ Rutgers			
Monitoring/Evaluation Approaches			
• Qualtrics questionnaire			
Strategies	**Action Steps**	**Organization(s) Responsible**	**Outcome (Product) or Results**
3.1.1 Identify and support multi-component, integrated, obesity prevention interventions (nutrition, physical activity, behavior change, policy, systems, and environmental factors) in local communities.	a. Identify criteria to be used in obesity prevention programs in Middlesex /Somerset counties.	Department of Health interns	Criteria
	b. Department of health to develop an assessment of existing programs supporting reduction of behaviors that cause weight gain	Departments of Health	Questionnaire
	c. Issue the questionnaire to community partners and stakeholders via email submission	Qualitrics	Report
	d. Interns will analyze/report outreach efforts to assess the programmatic needs in Middlesex /Somerset	Interns	Report
	e. Once agencies/programs are identified, reach out to outreach workers, stakeholders, grantees to increase the number of programs being offered.	Interns	Programmatic increase
	f. Support agency resources by providing established indirect educational opportunities	Departments of Health, SNAP Ed existing agencies with supportive materials	Written materials, poster, social media
Resources Required (human, partnerships, financial, infrastructure, or other)			
• Collaboration, interns, partnership with stakeholders/grants, potential staff position,			

Objective 3.2: By 2019, reduce substance use among school-aged youth.			
Outcome Indicators	**Baseline**	**Target**	**Data Source**
Reduced tobacco use among middle school students	YRBS, YTS	Decrease 5%	HP2020 and Coalition for healthy communities
Reduced tobacco use among high school students	YRBS, YTS	Decrease 5%	HP2020 and Coalition for healthy communities
Reduced alcohol use among middle school students	YRBS	Decrease 5%	HP2020 and Coalition for healthy communities
Reduced alcohol use among high school students	YRBS	Decrease 5%	HP2020 and Coalition for healthy communities
Reduction of prescription drugs among middle school students	YRBS	Decrease 5%	HP2020 and Coalition for healthy communities
Reduction of prescription drugs among high school students	YRBS	Decrease 5%	HP2020 and Coalition for healthy communities

Potential Partners for this Objective

- NJPN (New Jersey prevention network), regional chronic disease coalition, wellspring, Middlesex mayor's wellness council. Healthier Somerset, empower Somerset, Coalition for healthy communities
- nurses, SACs, municipal alliance

Monitoring/Evaluation Approaches

- Tobacco free for health NJ database, drug free NJ (private property ordinance list)

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
3.2.1 Advocate for policy to increase enforcement of existing alcohol, tobacco point of sale laws and prescription drug ordinances.	a. Collect data and info for all alcohol and tobacco products including e-cig, vaping, marijuana, snuff	Partner	Data collected
	b. Conduct literature review to determine the effectiveness of municipal policies	Partner	Best practices
	c. Identify municipalities with and without policies	Partner	List of municipalities
	d. Create report of collected data	NJPN	Report
	e. Advocate/educate stakeholders, including parent education about underage alcohol consumption	NJPN	Action plan
	f. Develop objectives, goals, strategies to effect local policy change	NJPN	Policy change

Resources Required (human, partnerships, financial, infrastructure, or other)

- Tobacco free for a healthy NJ, drug free NJ (point of sale resource), YRBS

Year 1 Action Plan
Priority Area 3: Health Risk Factors (Prevention)

Goal 3: Promote healthy lifestyles through culturally and linguistically appropriate practices that reduce preventable risk factors.

Objective 3.4: By 2019, reduce preventable injuries related to transportation.

Outcome Indicators	Baseline	Target	Data Source
Decrease pedestrian injuries due to transportation			NJDHTS

Potential Partners for this Objective

- KMM, MC Comprehensive traffic safety program, local police departments, RWJ injury prevention, Rutgers Voorhees transportation department, managed care plans, HL/CC workgroup, KMM, USDA and DO H-NJ, libraries, healthy NJ website, cooperative extensions, worksites

Monitoring/Evaluation Approaches

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Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
3.4.1 Enhance pedestrian safety awareness campaigns	a. Identify existing pedestrian partners safety campaigns (and their effectiveness)	KMM, MCTSP, local police department, (Consortium workgroup?)	List of current campaigns
	b. Gather existing data to identify problem areas	MC Transportation Safety	Database - problem areas
	c. Compare data to identify gaps	MC Transportation Safety	List of problem areas ranked by risk
	d. Develop plan for engaging communities with needs	Partners	Plan
	e. conduct a training for county and municipal decision-makers about state and federal resources to improve pedestrian safety through infrastructure improvements and policies	Partners	Training Conducted
	f. Enhance access for communities with identified need to already existing pedestrian campaigns/concepts	Partners	Plan to bring effective programs to communities in need

Resources Required (human, partnerships, financial, infrastructure, or other)

- Rutgers - Plan for safety, coordinate awareness campaign as part of healthy homes initiative and as part of community awareness campaigns. CAIT Rutgers data re pedestrian accidents

Year 1 Action Plan Priority Area 3: Health Risk Factors (Prevention)			
Goal 3: Promote healthy lifestyles through culturally and linguistically appropriate practices that reduce preventable risk factors.			
Objective 3.5: By 2019, increase the number of families receiving home health and safety education.			
Outcome Indicators			
Number of families receiving healthy homes education			
Potential Partners for this Objective			
• State and county health departments, home visitation workers, child care providers, local Ys, libraries, CBOs, FBOs, municipal alliances, managed care plans, HL/CC workgroup, KMM, USDA and DO H-NJ, libraries, healthy NJ website, cooperative extensions, worksites • partner with EPA, CDC, fire and public safety code officials			
Monitoring/Evaluation Approaches			
• Increase in communities engaged in pedestrian safety campaigns.			

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
3.5.1 Build partnerships with nonprofit community based organizations that are engaged in advancing housing initiatives that will result in improved health and well-being.	a. Identify all existing healthy housing initiatives and their target	Consortium	List of initiatives
	b. Determine the capacity of existing housing initiatives	Consortium	Assessment to capacity report
	c. Identify the resource needs to implement healthy housing initiatives and expand the reach	Consortium	Needs and resource comparison
Resources Required (human, partnerships, financial, infrastructure, or other)			
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Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)

Year 1 Action Plan Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)			
Goal 4: Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.			
Objective 4.1: By 2019, increase the number of individuals engaging in diabetes programs.			
Outcome Indicators			
Increase number of participating programs			
Increase number of participants in programs			
Potential Partners for this Objective			
• Office of Health Services			
Monitoring/Evaluation Approaches			
• CDSMP Data Collection			

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
4.1.2 Recruit individuals to participate in CDSMP (Chronic Diseases Self-Management Program) and DSMP (Diabetes Self-Management Program) through community outreach to senior center, libraries, faith based organizations, and community centers.	a. Collect data	Health Dept.	CDSMP Data
	b. Identify target locations and contacts.	Participating orgs.	List of locations and contacts
	c. Develop inventory of trained bilingual staff.	MC Office of Health Services	List of trained bilingual staff
	d. Develop and implement awareness campaign(s).	Participating orgs.	Number of awareness initiatives
	e. Implement Client Tracking system.	MC Office of Health Services	Number of individuals completing program
Resources Required (human, partnerships, financial, infrastructure, or other)			
• Partnerships (CBO, FBO, FQHC)			

Year 1 Action Plan Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)			
Goal 4: Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.			
Strategies	**Action Steps**	**Organization(s) Responsible**	**Outcome (Product) or Results**
4.1.3 Increase education and awareness of programs available at the community level through outreach to Community-Based (CBO) and Faith-Based Organizations (FBO's).	a. Identify existing programs and list of potential community organizations.	CHIP Workgroup	List of existing programs List of community orgs.
	b. Recruit trained program facilitators.	CHIP Workgroup; MCOHS	Increased number of facilitators
	c. Define facilitator competencies.	CHIP Workgroup; MCOHS	List of facilitator competencies
	d. Select trained program facilitators.	CHIP Workgroup; MCOHS	List of facilitators
	e. Assess capacity of existing and potential community orgs.	CHIP Workgroup	List of community orgs. with capacity
	f. Identify resources to implement new programs.	CHIP Workgroup	Increased resources to implement programs
Resources Required (human, partnerships, financial, infrastructure, or other)			
• Financial (sponsorships), physical space			

Year 1 Action Plan Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)			
Goal 4: Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.			
Objective 4.2: By 2019, increase the number of individuals engaging in cardiovascular health initiatives.			
Outcome Indicators			
Decrease blood pressure			
Decrease BMI			
Decrease cholesterol level			
Decrease tobacco use			
Potential Partners for this Objective			
Monitoring/Evaluation Approaches			
• TBD by Workgroup			

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
4.2.2 Support existing programs and increase the number of clinically- and community-based nutrition programs designed for targeted populations.	a. Identify and assess existing programs	CHIP Workgroup	List of community orgs.
	b. Identify barriers to success of existing programs and to the population	CHIP Workgroup	List of barriers (culture, stigma)
	c. Identify resources to implement new programs	CHIP Workgroup	Increased resources to implement programs
	d. Identify potential community orgs.	CHIP Workgroup	List of community orgs.
	e. Assess capacity of existing and potential community orgs.	CHIP Workgroup	List of community orgs. with capacity
Resources Required (human, partnerships, financial, infrastructure, or other)			
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** Refers to the southeast section of Somerset County*

Year 1 Action Plan Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)			
Goal 4: **Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.**			
Strategies	**Action Steps**	**Organization(s) Responsible**	**Outcome (Product) or Results**
4.2.4 Increase the number of health risk behavior screenings in community based settings (e.g., BP, BMI, and cholesterol screenings).	a. Identify community-based providers providing screenings.	CHIP Workgroup; hospitals	List of community-based providers providing screenings
	b. Identify potential community-based providers to provide screenings.	CHIP Workgroup; hospitals	List of potential community-based providers to provide screenings
	c. Create and implement outreach strategy to include new community-based providers.	CHIP Workgroup	Increased number of community-based providers providing screenings
	d. Assess capacity of existing and potential community-based providers.	CHIP Workgroup; hospitals	List of community orgs. with capacity
	e. Determine high-risk target populations to be screened.	CHIP Workgroup; hospitals	List of high-risk target populations per screen
	f. Determine whether screenings are reaching the respective target populations.	CHIP Workgroup; hospitals	Number of target populations screened
Resources Required (human, partnerships, financial, infrastructure, or other)			
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** Refers to the southeast section of Somerset County*

Year 1 Action Plan
Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)

Goal 4: Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.

Objective 4.3: By 2019, increase the number of individuals engaging in respiratory health initiatives.

Outcome Indicators			
Number of schools implementing "Open Airways" or related programs			
Number of visits to ER by children for asthma related conditions			

Potential Partners for this Objective

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Monitoring/Evaluation Approaches

- TBD by Workgroup

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
4.3.1 Promote Open Airways or similar programs within schools.	a. Determine schools already providing Open Airways or related programs.	Alliance for a Healthier New Brunswick	List of schools providing OA or related programs
	b. Identify incentives for schools to provide Open Airways or related programs.	Alliance for a Healthier New Brunswick	Incentives available for interested schools to provide OA or related programs
	c. Outreach to schools not providing Open Airways or related programs.	Alliance for a Healthier New Brunswick	Increased schools interested in providing OA & related programs
	d. Provide training for Open Airways or similar programs to identified schools.	Alliance for a Healthier New Brunswick	Identified schools trained to provide OA or related programs
	e. Identify additional partners (i.e., ALA, PACNJ, etc.)	Alliance for a Healthier New Brunswick	Partners partnering in promoting OA and related programs
	f. Identify asthma-related resources to use in OA or related programs.	Alliance for a Healthier New Brunswick	List of available asthma-related resources

Resources Required (human, partnerships, financial, infrastructure, or other)

- Financial, partnerships, schools

** Refers to the southeast section of Somerset County*

Year 1 Action Plan
Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)

Goal 4: Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.

Objective 4.4: By 2019, increase the number of community members/organizations engaging in mental health and awareness training and education.

Outcome Indicators			
Number of people trained in Mental Health First Aid			
Number of people trained in trauma-informed care			
Number of people referred to mental health and supportive services			

Potential Partners for this Objective

- Workgoup Mental health services and caregivers

Monitoring/Evaluation Approaches

- Mental Health First Aid reporting

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
4.4.3 Increase community awareness regarding mental health needs and existing programs by public campaigns and other methods [e.g., outreach to mental health providers to present at community health fairs, increasing the number of Peer Support Specialists available at community health events or initiatives, providing lists of available programs and where to get help, etc.].	a. Identify existing mental health programs.	CHIP Workgroup	List of existing mental health programs
	b. Implement communications strategy to disseminate info.	CHIP Workgroup	Increased awareness of available mental health needs and services
	c. Connect at-risk populations to mental health resources at community events and other venues.	CHIP Workgroup	Increased participation in mental health programs
	d. Identify number of peer support specialists.	CHIP Workgroup	List of peer support specialists

Resources Required (human, partnerships, financial, infrastructure, or other)

- Existing country online list: department of human services mental health providers, libraries

** Refers to the southeast section of Somerset County*

Year 1 Action Plan Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)			
Goal 4: **Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.**			
Strategies	**Action Steps**	**Organization(s) Responsible**	**Outcome (Product) or Results**
4.4.5 Outreach to providers, community-based and faith-based organizations to coordinate support groups on general and specific mental health topic areas (e.g., migration, grief, stress, and depression).	a. Connect with agencies involved in mental health services and support.	CHIP Workgroup	List of agencies
	b. Identify community resources providing mental health-related support groups.	CHIP Workgroup	List of community resources providing mental health-related support groups
	c. Implement communications strategy to disseminate info	CHIP Workgroup	Increased awareness of available mental health support groups
	d. Identify gaps in mental health-related support services.	CHIP Workgroup	List of identified gaps in mental health-related support services
Resources Required (human, partnerships, financial, infrastructure, or other)			
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** Refers to the southeast section of Somerset County*

Year 1 Action Plan Priority Area 4: Disease Specific (Chronic Disease Treatment and Management)			
Goal 4: Decrease the prevalence and severity of leading chronic health conditions affecting Middlesex and Somerset* counties through culturally and linguistically appropriate strategies that improve overall well-being.			
Objective 4.5: By 2020, increase the number of individuals who undergo HIV testing.			
Outcome Indicators			
Number of people tested for HIV			
Potential Partners for this Objective			
• International AIDS Society			
Monitoring/Evaluation Approaches			
• State and County level HIV testing rates			

Strategies	Action Steps	Organization(s) Responsible	Outcome (Product) or Results
4.5.2 Outreach to diverse communities in alignment with NJ CLAS Standards for HIV (e.g., African-Americans, Latinos, LGBTQ) to increase awareness regarding the importance of routine HIV testing to minimize the spread of disease and determine appropriate treatment for management of the disease.	a. Identify communities at-risk for HIV/AIDS and correlate with testing centers.	CHIP Workgroup	Communities at-risk for HIV/AIDS identified and mapped against testing centers
	b. Create population-specific outreach plans for at-risk communities.	CHIP Workgroup	Population-specific outreach plans for at-risk communities created
	c. Implement population-specific outreach plans for at-risk communities using standards/strategies from national HIV/AIDS work plan.	CHIP Workgroup	Population-specific outreach plans for at-risk communities implemented

Resources Required (human, partnerships, financial, infrastructure, or other)
• Financial, human, partnerships

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