Middlesex and Somerset* Counties Community Health Improvement Plan

**southeast section*

September 2013

Submitted to:

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

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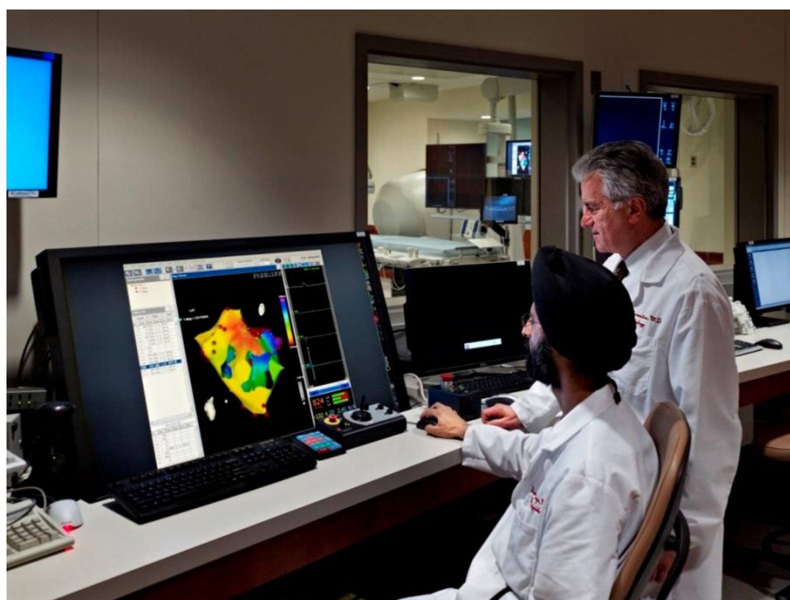
This project was a collaboration between Saint Peter's University Hospital (SPUH) and Robert Wood Johnson University Hospital (RWJUH) and was funded through the Robert Wood Johnson Foundation's New Jersey Health Initiative Program. This community health improvement plan could not have been done without the leadership and vision of 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 individuals 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, 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.



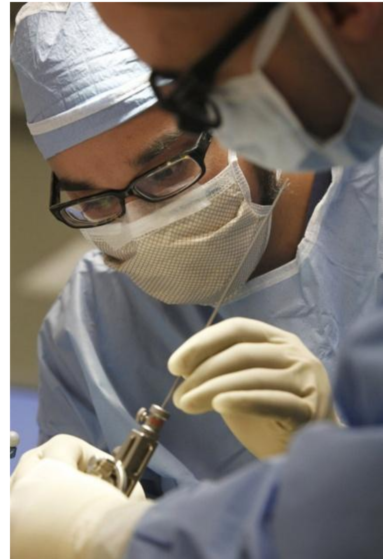
When we refer to the Somerset County we are only referring to the southeast section of Somerset County.

Executive Summary

Where and how we live, work, play, and learn affects our health. Understanding how these factors influence health is critical for developing the best strategies to address them. To accomplish these goals, Saint Peter's University Hospital and Robert Wood Johnson University Hospital, along with local health departments, federally qualified health centers, government agencies, and numerous community and non-profit organizations serving Middlesex and Somerset* counties, led a comprehensive regional health planning effort comprised of two phases:

1. A community health needs assessment (CHNA) to identify the health-related needs and strengths of Middlesex and Somerset* counties
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 Middlesex and Somerset* counties

In addition to guiding future services, programs, and policies for these agencies and the area overall, the CHNA and CHIP are also required prerequisites for the health department to earn accreditation, and for hospitals to maintain their not-for-profit status.



The 2013 Saint Peter's University Hospital and Robert Wood Johnson University Hospital CHIP was developed over the period of April 2013 – August 2013, using the key findings from the CHNA, which included qualitative data from focus groups and key informant interviews that were conducted locally, as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas. The CHNA was developed by Rutgers University Center for State Health Policy (CSHP) and the University of Medicine & Dentistry of New Jersey-Robert Wood Johnson Medical School (UMDNJ-RWJMS) Department of Family Medicine and Community Health, Research Division.

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Middlesex and Somerset*planning process engaged community members and Local Public Health System (LPHS) Partners through different avenues:

a. the Steering Committee was responsible for overseeing the community health assessment, identifying the health priorities, and overseeing the development of the community health improvement plan, and
b. the CHIP Workgroups, which represented broad and diverse sectors of the community, were formed around each priority area to develop the goals, objectives, strategies, action steps, and potential partners for the CHIP.

The CHIP Workgroup members developed a compelling and inspirational vision that would support the planning process and the CHIP itself.

Vision

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

The results of CHNA research were reviewed by the Steering Committee, and from this review and group discussion, three key priority areas were selected for planning at the county level. An additional priority area was identified during the review process to ensure ongoing coordination and collaboration with local public health system partners.

The final four priority areas are:

Priority Area 1: **Coordination and Communication**
Goal 1: Strengthen coordination and communication among community health partners.

Priority Area 2: **Access to Care and Health Information**
Goal 2: To ensure that every person has access to health and wellness services that meet the culture and language needs of Middlesex and Somerset*counties.

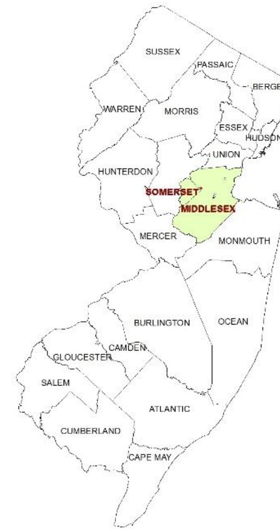
Priority Area 3: **Promoting Healthy Behaviors**
Goal 3: To build a community that promotes, supports and fosters healthy behaviors and preventive care services across Middlesex and Somerset*counties.

Priority Area 4: **Disease Specific Issues with a focus on Obesity, Diabetes, and Mental Health**
Goal 4: To achieve physically and mentally healthy communities by addressing obesity, diabetes, and mental health in Middlesex and Somerset*counties.

Health improvement plans were then developed for each of these areas by the community.

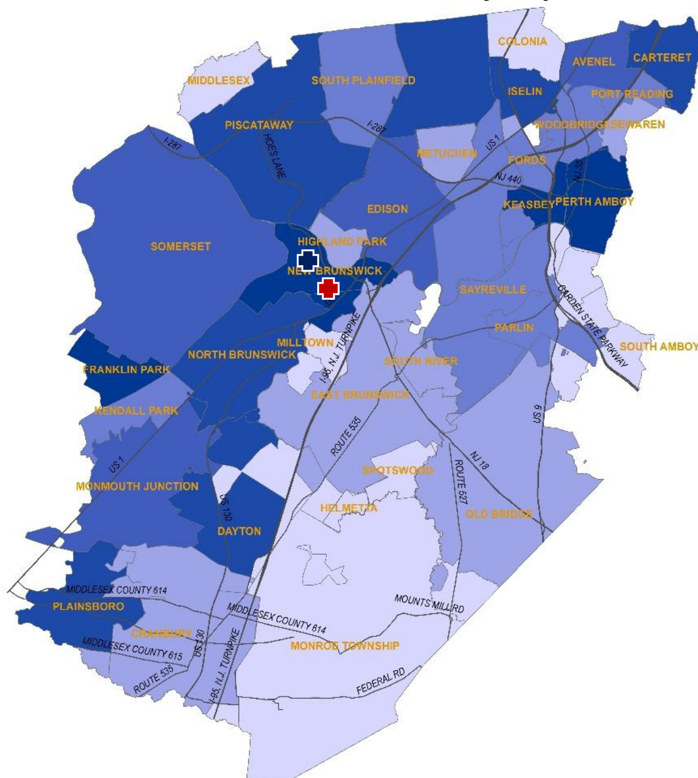
2013 Community Health Needs Assessment/Improvement Planning Area

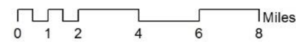
CHIP Focus Area



**Southeast Section*

CHIP Focus Area: 2013 % Minority Population***





Saint Peter's University Hospital

Robert Wood Johnson University Hospital

Percent Minority Population:

- 14.6% - 32.5%
- 32.6% - 37.7%
- 37.8% - 55.7%
- 55.8% - 63.3%
- 63.4% - 71.4%
- 71.5% - 88%

***Source: Claritas 2013 Estimates; Minority population includes Hispanic ethnicity and non-white race*

Middlesex and Somerset*Community Health Improvement Plan

I. BACKGROUND

Understanding the current health status of the community is important in order to identify priorities for future planning and funding, the existing strengths and assets on which to build upon, and areas for further collaboration and coordination across organizations, institutions, and community groups. To this end, Saint Peter's University Hospital and Robert Wood Johnson University Hospital are leading a comprehensive health planning effort comprised of two phases:

- Community Health Needs Assessment (CHNA) – identifies the health-related needs and community strengths in Middlesex and Somerset* counties
- Community Health Improvement Plan (CHIP) – determines the key health priorities, overarching goals, and specific strategies to implement across the service area that will improve health

In addition to guiding future services, programs, and policies for these agencies and the area overall, the CHNA and CHIP are also required prerequisites for a hospital to submit to the IRS as proof of their community benefit and a health department to earn accreditation, which indicates that the agency is meeting national standards.

The 2013 Middlesex and Somerset* CHIP was developed over the period of April 2013 – August 2013, using the key findings from the CHNA, which included qualitative data from focus groups and key informant interviews that were conducted locally, as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas.

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Middlesex and Somerset*assessment and planning process engaged community members and Local Public Health System (LPHS) Partners through different avenues:

a. the Steering Committee was responsible for overseeing the community health assessment, identifying the health priorities, and overseeing the development of the community health improvement plan, and
b. the CHIP Workgroups, which represented broad and diverse sectors of the community, were formed around each health priority area to develop the goals, objectives, strategies, and potential partners for the CHIP.

In April 2012, Saint Peter's University Hospital and Robert Wood Johnson University Hospital hired 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 and develop the report deliverables. Prior to beginning the CHIP work, a comprehensive CHNA was developed by Rutgers University Center for State Health Policy (CSHP) and the University of Medicine & Dentistry of New Jersey-Robert Wood Johnson Medical School (UMDNJ-RWJMS) Department of Family Medicine and Community Health, Research Division.

The results of this research were reviewed by the Steering Committee and the following four key priority areas were selected for action planning at a county level:

- Coordination and Communication
- Access to Care and Health Information
- Promoting Healthy Behaviors
- Disease Specific Issues with a focus on Obesity, Diabetes, and Mental Health

*Refers to southeast section of Somerset County

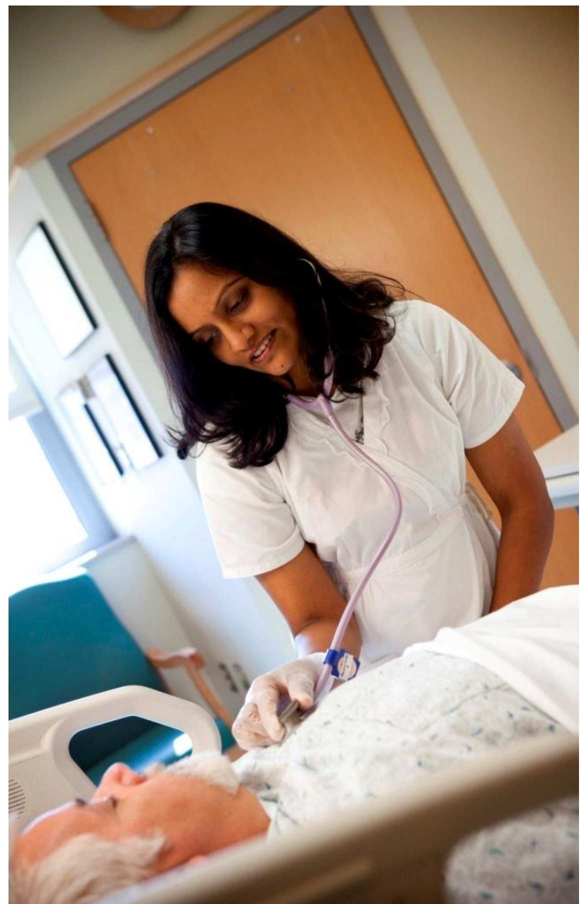
II. OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PROCESS

A. What is a Community Health Improvement Plan?

A Community Health Improvement Plan, or CHIP, is an action-oriented strategic plan that outlines the strategic priority 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.

B. How to use a 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, 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.



C. Methods

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

- Identify priority issues for action to improve community health
- Develop a health improvement plan
- Guide future community decision-making related to community health improvement

In addition to guiding future services, programs, and policies for participating agencies and the area overall, the community health improvement plan fulfills the prerequisites for a hospital to submit to the IRS as proof of their community benefit and a health department to earn accreditation, which indicates that the agency is meeting national standards.

III. PRIORITIZATION OF HEALTH ISSUES

A. Community Engagement

Saint Peter's University Hospital and Robert Wood Johnson University Hospital led the planning process for Middlesex and Somerset*counties and oversaw all aspects of the CHIP development, including the establishment of CHIP Workgroups, to develop the details for identified health priorities. The Steering Committee continued from the Assessment Phase to the Planning Phase, guiding all aspects of the planning phase and offering expert input on plan components.

CHIP Workgroup members were comprised of individuals with expertise and interest in identified priority areas who volunteered to participate and who represented broad and diverse sectors of the community. See Appendix A for workgroup participants and affiliations.

B. Strategic Components of the CHIP

Workgroup members provided initial input for the CHIP vision and core values through an online survey. During the CHIP retreat participants were presented with the core values and were asked to vote on the final language for the vision statement. The following vision and core values were developed for the 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.

C. Selection of Priority Areas

On January 17, 2013, a summary of the CHNA findings was presented to the Steering Committee and other key partners. Following the presentation, meeting participants identified three health priorities from the list, utilizing a computerized group meeting voting system that allowed for health organization representatives to democratically come to a consensus around key healthcare needs. The system allowed for each attendee to cast a vote that was automatically tabulated and projected for the group to view.

Of the list of issues, the following priorities areas received the highest number of votes:

- Access to Care and Health Information
- Promoting Healthy Behaviors
- Disease Specific Issues with a focus on Obesity, Diabetes, and Mental Health

A fourth priority area that focused on **communication and coordination among community health partners** was identified as the CHIP report was being written.

D. Development of the CHIP Strategic Components

Saint Peter's University Hospital and Robert Wood Johnson University Hospital convened a day-long planning session in June of 2013. Key community partners were invited to participate in work groups based on interest and expertise in the three identified priority areas. These facilitated work groups resulted in the development of goals, objectives, strategies, and potential partner organizations. The facilitators provided sample evidence-based strategies from a variety of resources including *The Community Guide to Preventive Health Services, The Clinical Guide to Preventive Health Services,* and the

CDC and Healthy People 2020 for the strategy setting session. As policy is inherently tied to sustainability and effectiveness, work groups were encouraged to identify strategies that would result in a policy change.

A core team from both hospitals and the HRiA consultants and workgroup members reviewed the draft output from the planning sessions and edited material for clarity, consistency, and evidence base. This feedback was incorporated into the version of the CHIP contained in this report.

IV. The Middlesex and Somerset* Community Health Improvement Plan

Goals, Objectives, Strategies, Key Partners, and Outcome Indicators

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of where you would like to be, and a clear evaluation of whether your efforts are making a difference. The following pages outline the goals, objectives, strategies, action steps, and performance measures for the four priority areas outlined in the Community Health Improvement Plan. This plan is meant to be reviewed annually and adjusted to accommodate revisions that merit attention.

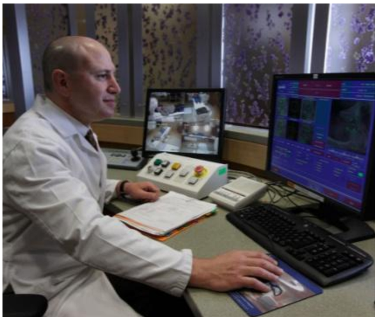
A. PRIORITY AREA 1: Coordination and Communication among Community Health Partners

Goal 1: **To ensure that community health partners have clear methods for connecting, collaborating, coordinating, and communicating with each other.**		
Objective 1.1 By December 2016, a sustainable structure for local health system partner collaboration, coordination, and communication will be fully implemented.		
Strategy 1.1.1 Establish a sustainable structure for community health partners to convene and collaborate on community health issues and implement the Community Health Improvement Plan (CHIP). ***Source/Evidence Base:*** *National Public Health Performance Standards, Local Public Health System Performance Instrument, Version 2.0, Essential Public Health Service #4: Mobilizing Community Health Partnerships to Identify and Solve Health Problems*		
Performance Indicator(s) By December 2014, 30% of the CHIP strategies will have been implemented. By December 2015, 40% of the CHIP strategies will have been implemented. By December 2016, the remaining 30% of the CHIP strategies will have been implemented.		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Adopt a group charter and mission.	February 2014	Executive Leadership
Implement a letter of commitment or memorandum of agreement with all partners.	March 2014	Executive Leadership
Develop standard agenda template to be used for meetings that will ensure implementation and monitoring of the CHIP as well as sustainability and maintenance of the committee.	March 2014	Executive Leadership
Expand membership by inviting a broad range of local public health system partners, making sure to include underrepresented groups, groups with an inequitable burden of poor health, and groups representing social determinants of health (housing, employment, education).	April 2014	Executive Leadership & Steering Committee
Brainstorm and select a name for the committee.	April 2014	Steering Committee
Determine the leadership structure for the committee and workgroups.	May 2014	Steering Committee
Draft and adopt bylaws.	May 2014	Executive Leadership & Steering Committee
Begin discussions about how the partners can assist with increasing involvement and participation of health system partners, including partners addressing social determinants of health and health inequities, in the community.	August 2014	Executive Leadership & Steering Committee
Promote awareness of the committee through a variety of methods (media, social media, word of mouth, etc.).	August 2014	Executive Leadership & Steering Committee
Regularly evaluate and maintain structure of local public health system partner collaboration.	Ongoing	Executive Leadership
Identify funding to maintain and update current resources to support and sustain the community health partnership.	Ongoing	Executive Leadership

Goal 1: **To ensure that community health partners have clear methods for connecting, collaborating, coordinating, and communicating with each other.**		
Objective 1.1 By December 2016, a sustainable structure for local health system partner collaboration, coordination, and communication will be fully implemented.		
Strategy 1.1.2 Develop clearinghouse, database, or guide of local community resources and organizations which support health, in an effort to increase communication and connections to local community health partners. ***Source/Evidence Base:****http://www.guideline.gov/*		
Performance Indicator(s) A clearing house, database or guide of local community resources and organizations has been created and promoted throughout the community.		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Research how other communities have compiled, distributed, and promoted resource guides/clearinghouses.	June 2014	Executive Leadership
Explore possibilities of student and university involvement and resources for project.	December 2014	Executive Leadership
Identify categories of resources to include (local public health system partners, community resources, free resources, health services, events, etc.).	June 2015	Executive Leadership & Steering Committee
Identify information needed for each resource (contact info, website, Facebook, description of services, etc.)	December 2015	Executive Leadership & Steering Committee
Delegate the gathering of resource data and information for each category among committee members and workgroups.	June 2016	Steering Committee
Activity	**Long-term Target Date**	**Lead Organization**
Create a "Hub" – work with local health departments as centralized disseminators of a web-based system to cross-share health information and services (e.g., blogs, website, mass mail).	Year 4	Data Collection & Evaluation Workgroup
Input data into a spreadsheet or database.	Year 4	Data Collection & Evaluation Workgroup
Determine formats for distribution of information (electronic, print, etc.). Make list of potential methods of communication, distribution, and promotion (email, social media, physical copies, etc.).	Year 4	Data Collection & Evaluation Workgroup
Create plan for communication, distribution, and promotion to local health partners and community who may have barriers to accessing resources.	Year 4	Executive Leadership & Steering Committee
Create policy/plan for the maintenance and sustainability of the resource (making sure it is updated, etc.).	Year 4	Executive Leadership & Steering Committee
Put the guide in the formats chosen.	Year 4	Executive Leadership & Steering Committee
Implement plan for communication, distribution, and promotion.	Year 4	Executive Leadership & Steering Committee

Goal 1:
To ensure that community health partners have clear methods for connecting, collaborating, coordinating, and communicating with each other.
Objective 1.2
By December 2016, engage local community health partner involvement and participation in the development of three policies, programs or activities that support local health and wellness initiatives.
Strategy 1.2.1
Work in collaboration with local community health partners to implement policies, programs or activities that support local health and wellness initiatives.
Source/Evidence Base: *CDC, The Community Guide*
Performance Indicator(s)
Three policies, programs or initiatives have been successfully implemented.
ACTION PLAN

Activity	Target Date	Lead Organization
Research evidence based practices for community health and wellness policies, programs, and activities.	March 2014	Executive Leadership & Steering Committee
Start compiling ideas, examples, and resources of community health and wellness policies, programs, and activities.	March 2014	Executive Leadership & Steering Committee
Start compiling data on local health, wellness, and stress reduction resources and/or ideas.	March 2014	Workgroup
Explore funding opportunities for community wellness support.	March 2014	Workgroup
Brainstorm potential community organizations to work with, including those who work with lower-income populations who have less capacity and access to health, wellness, and stress reduction resources.	June 2014	Workgroup
Create plan to implement policies, programs, and/or activities in community.	December 2014	Workgroup
Implement plan for policies, programs, and/or activities in community.	June 2015	Workgroup
Monitor sustainability of community activities.	June 2015	Executive Leadership & Steering Committee
Identify satellite networks consisting of inter-related community organizations (e.g., senior centers, community centers).	December 2015	Workgroup
Create a mechanism to share evidence-based programs between providers.	Ongoing	Workgroup

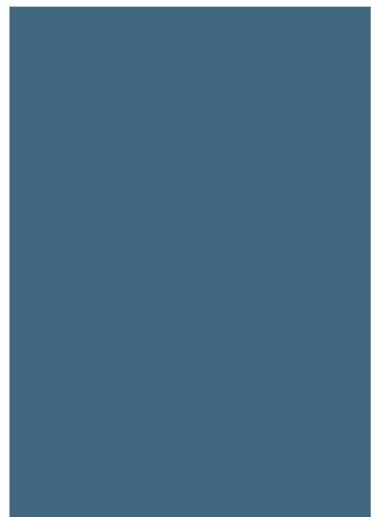


B. PRIORITY AREA 2: Access to Care and Health Information

Increase access and improve the quality of health and wellness services and ensure that they meet the culture and language needs of our communities.

Goal 2: To ensure that every person has access to health and wellness services that meet the culture and language needs of Middlesex and Somerset*counties.		
Objective 2.1: **By December 2016, increase the adoption of patient centered strategies within the healthcare system.**		
Strategy 2.1.1: Increase the number of healthcare providers and members of the public health community at each partner agency who are culturally and linguistically trained in the following areas: domestic violence, developmental disabilities, mental health issues, substance abuse and addiction). ***Source/Evidence Base:*** *U.S. Department of Health and Human Services, Office of Minority Health. 2000. Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda. http://www.ormhrc.gov/clas/finalpo.htm*		
Performance Indicator(s) Increase number of providers trained in evidence-based cultural and linguistic competence.		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Research and develop a list of evidence-based culturally competent care trainings.	March 2014	Workgroup
Research and develop a list of evidence-based language service resources and trainings.	March 2014	Workgroup
Identify what cultural and linguistic competence resources may already be available in the community.	June 2014	Workgroup
Advocate for inclusion of cultural and linguistic competence trainings as a requirement/policy for all healthcare providers and staff.	September 2014	Executive Leadership
Identify organizations and individuals that could incorporate cultural and linguistic competence training activities into current services and activities.	December 2014	Workgroup
Coordinate ongoing culturally competent care training, awareness, and education to healthcare providers and staff at community health organizations and hospitals.	June 2015	Workgroup
Coordinate and host a health summit addressing cultural and linguistic competence among health care providers.	September 2015	Executive Leadership & Steering Committee
Centralize interpretation and translation services and increase the number of professional, healthcare interpreters for patients with limited English proficiencies with a goal of improving the quality of communication between providers and patients.	September 2015	Executive Leadership & Steering Committee
Ensure sustainability of activities to improve cultural and linguistic competence among healthcare providers and staff.	Ongoing	Executive Leadership
Survey trained providers to determine if they are referring patients to appropriate care.	June 2016	Workgroup

Goal 2: **To ensure that every person has access to health and wellness services that meet the culture and language needs of Middlesex and Somerset*counties.**		
Objective 2.1: **By December 2016, increase the adoption of patient centered strategies within the healthcare system.**		
Strategy 2.1.2: Expand the number of providers who have locations, hours and appointment availability that meet the needs of the community. ***Source/Evidence Base:*** *Scholls SH, Torda P, Peikes D, Han E, Genevro J. Patient-Centered Care: Engaging Patients and Families in the Medical Home. (Prepared by Mathematica Policy Research). Agency for Healthcare Research and Quality.*		
Performance Indicator(s) Patients report increased access to healthcare providers and services due to expanded hours, locations or appointments within a reasonable timeframe.		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Conduct a survey to ascertain current list of providers that offer expanded hours, are located in underserved areas of the community and who have available appointments.	March 2014	Workgroup
Assess and estimate the number of people in the intervention area that do not have access to health care due to location, hours or appointment availability.	April 2014	Workgroup
Determine barriers to establishing new locations, expanding hours and increasing appointments.	June 2014	Workgroup
Brainstorm and research solutions to those barriers.	December 2014	Workgroup
Work with key community health partners to explore addressing identified barriers.	March 2015	Executive Leadership Steering Committee & Workgroup
Create a plan to address barriers and implement changes.	September 2015	Steering Committee & Workgroup
Ensure sustainability of interventions to reduce barriers to connect people to healthcare services.	Ongoing	Workgroup
Maintain and distribute a master list of healthcare providers accepting new patients, and/or who have expanded hours, and/or are located in underserved communities.	Ongoing	Workgroup



Goal 2: **To ensure that every person has access to health and wellness services that meet the culture and language needs of Middlesex and Somerset*counties.**		
Objective 2.1: **By December 2016, increase the adoption of patient centered strategies within the healthcare system.**		
Strategy 2.1.3: Implement activities to increase the health literacy of patients and improve communication between patients and healthcare providers. ***Source/Evidence Base:*** *Health Literacy: A Prescription to End Confusion. Lynn Nielson-Bohlman, Allison M. Panzer, David A. Kindig, Editors, Institute of Medicine, Committee on Health Literacy.*		
Performance Indicator(s) Increase in health literacy resources.		
Action Steps/Activity	**Target Date**	**Lead Organization**
Invite the Library to participate in the workgroup.	January2014	Executive Leadership & Steering Committee
Research health literacy and healthcare communication interventions.	March 2014	Workgroup
Identify what health literacy resources may already be available through the Library and in the community.	June 2014	Workgroup
Identify organizations and individuals that could incorporate health literacy activities into current services and activities.	October 2014	Workgroup
Identify local populations at higher risk for low health literacy.	January 2015	Workgroup
Work with local providers (i.e., adult learning centers) to implement activities to improve health literacy among patients and communication between healthcare providers and patients.	March 2015	Workgroup
Promote use of library programs (e.g., “Just for the Health of It” website).	Ongoing	Workgroup
Leverage the accessibility, infrastructure and social networks of public libraries to cross-share health information and resources.	Ongoing	Workgroup
Ensure sustainability of activities to improve health literacy among patients and communication between healthcare providers and patients.	Ongoing	Executive Leadership, Steering Committee & Workgroup

*Refers to southeast section of Somerset County

Goal 2: **To ensure that every person has access to health and wellness services that meet the culture and language needs of Middlesex and Somerset*counties.**		
Objective 2.2 **By December 2016, increase promotional and educational efforts of key support services necessary to access health care.**		
Strategy 2.2.1: Implement educational and promotional activities about existing health and wellness services in our diverse communities and develop mechanisms to link individuals with these services. ***Source/Evidence Base:*** *National Public Health Standards, LPHS Performance Instrument, Version 2.10, Essential Public Health Service #7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable.*		
Performance Indicator(s) Increase in number of programs offered and resources to educate people about accessing existing healthcare services.		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Invite representatives from education and wellness services to participate on the workgroup.	January 2014	Workgroup
Research best practices for conducting effective promotion and education of healthcare resources and services.	March 2014	Workgroup
Brainstorm a list of key educational resources for accessing health care (2-1-1 resource line, etc.)	June 2014	Workgroup
Make sure community resources are correct for 2-1-1 and other resources.	June 2014	Workgroup
Create a plan to distribute information about accessing health and wellness services at health fairs, resource fairs, health literacy workshops, libraries, schools, community centers, etc.	December 2014	Workgroup
Collaborate with NJ 2-1-1 and promote NJ 2-1-1 among clients.	Ongoing	Executive Leadership & Steering Committee
Start discussions of current promotion being done and how the workgroup can expand upon local promotional efforts.	Januayr 2015	Workgroup
Develop and implement social media tools/forums/mediums that promote health and wellness services.	June 2015	Executive Leadership & Steering Committee
Develop a list of culturally sensitive health education materials and identify gaps in available materials.	June 2015	Workgroup
Encourage and advocate for health provider to translate and distribute health education information/materials in major languages.	Ongoing	Workgroup
Outreach to faith-based and ethnic organizations.	Ongoing	Workgroup
Identify best practices for social marketing within the community.	December 2013	Workgroup
Identify multiple tools to address solutions to link individuals with health and wellness services.	December 2015	Workgroup
Identify funding to maintain and update current resources.	Ongoing	Executive Leadership & Steering Committee
Sustain ongoing activities which increase promotion of these resources.	Ongoing	Executive Leadership & Steering Committee

Goal 2: **To ensure that every person has access to health and wellness services that meet the culture and language needs of Middlesex and Somerset*counties.**		
Objective 2.2 **By December 2016, increase promotional and educational efforts of key support services necessary to access health care.**		
Strategy 2.2.2: Implement activities to connect patients with medical homes (and the supportive services that they need). ***Source/Evidence Base:*** *Peiks D, Genevro J, Scholler SH, primary care settings and patients. Publication No. 11-0029. Rockville, MD: Agency for Healthcare Research and Quality. February 2011.*		
Performance Indicator(s) Increase in number of patients who report having a medical home. (Will need to conduct local provider survey.)		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Ensure that representatives from the FQHCs, hospitals, and other providers are represented on the workgroup.	January 2014	Executive Leadership & Steering Committee
Understand and report on how healthcare reform and the affordable care act will affect medical homes.	March 2014	Executive Leadership
Work with newly formed organizations to assist people in enrolling in plans based on healthcare reform guidelines.	Ongoing	Outreach Workgroup
Research medical home interventions (connecting people with medical homes).	March 2014	Executive Leadership
Assess and estimate the number of people in Middlesex and Somerset*counties who do not have a medical home.	September 2014	Executive Leadership & Steering Committee
Determine current capacity of local medical providers to accept new patients who don't currently have a medical home.	September 2014	Executive Leadership & Steering Committee
Determine local barriers to establishing a medical home and populations most affected by lack of a medical home.	September 2014	Workgroup
Brainstorm and research solutions to those barriers.	January 2015	Workgroup
Work with the clinics on strategies to reduce barriers to connecting patients with a medical home.	June 2015	Workgroup
Work with FQHCs to explore reducing barriers to accessing the federally qualified health center.	December 2015	Workgroup
Create a plan for reducing barriers to medical homes and implementing strategies to connect people with medical homes who aren't already established.	March 2016	Workgroup
Implement the plan for reducing barriers to medical homes and implementing strategies to connect people with medical homes.	June 2016	Workgroup
Re-examine the allocation of funding for current mental health consumer resources such as PACT/ICMS.	December 2016	Workgroup
Reassess current exclusionary criteria for mental health, consumer access to treatment and case management/support services (group home, PACT services)	December 2016	Workgroup
Ensure sustainability of interventions to reduce barriers and connect people to medical homes.	Ongoing	Workgroup
Maintain and distribute master list of healthcare providers accepting new patients.	Ongoing	Executive Leadership

C. PRIORITY AREA 3: Healthy Behaviors

Support healthy behaviors and increase utilization of and access to preventive care.

Goal 3:
To build a community that promotes, supports, and fosters healthy behaviors and preventive care services across Middlesex and Somerset*counties.

Objective 3.1:
By December 2016, increase the number of adults and children who meet or exceed physical activity guidelines for health by 5%.

Strategy 3.1.1: Increase access and enhance quality of existing programs that promote physical activity among youth.
Source/Evidence Base: *Centers for Disease Control and Prevention Guide to Strategies for Increasing Physical Activity in the Community. Studies demonstrate that a broad range of effective physical activity promotion strategies appropriate for public health agencies and their partners that include: Community wide campaigns, Increased access, enhanced playgrounds and playground amenities are positively related to increasing physical activity among children and adolescents. (Sallis et al., Ridgers et al., 2007; Stratton & Mullan, 2005). Active Living Research: Promoting physical activity through shared use of school and community recreational resources. www.rwjf.org*

Performance Indicator(s)
Increase in number of youth who engage in physical activity for at least 60 minutes/day on 5 or more days/week. (YRBS)
Decrease in number of overweight and obese elementary and middle school children as reported by the school nurses.
Decrease in number of overweight and obese high school children. (school nurses/YRBS)

ACTION PLAN

Action Steps	Target Date	Lead Organization
Invite representatives from schools to participate on the workgroup.	January 2014	Executive Leadership & Steering Committee
Assess school base physical activity policies and programs and develop a plan for improvement as needed.	March 2014	Workgroup
Strengthen physical activity policies (implement policies that require schools to require a minimum of 150 minutes per week of PE in public elementary schools and a minimum of 225 minutes per week of PE in public middle and high schools throughout the school year).	September 2014	Workgroup
Address physical activity through a Coordinated School Health Program (CSHP) that includes (health education, physical education, health services, nutrition services, counseling, and psychological services, health promotion for staff, and parent involvement).	September 2014	Workgroup
Support schools in implementing quality evidence-based physical activity programs that assist students in achieving the national standards for K-12 physical education.	September 2014	Workgroup
Support schools in implementing or expanding Safe Routes to Schools.	September 2015	Workgroup
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership, Steering Committee & Workgroup

Goal 3: **To build a community that promotes, supports, and fosters healthy behaviors and preventive care services across Middlesex and Somerset*counties.**		
Objective 3.1: **By December 2016, increase the number of adults and children who meet or exceed physical activity guidelines for health by 5%.**		
Strategy 3.1.2: Enhance the built environment in multiple settings (including worksites, places of worship, schools, parks, neighborhoods) to create opportunities for physical activity. ***Source/Evidence Base:*** *Centers for Disease Control and Prevention Guide to Strategies for Increasing Physical Activity in the Community.*		
Performance Indicator(s) Increase in number of youth who engage in physical activity for at least 60 minutes/day on 5 or more days/week. (YRBS) Increase in number of adults that engage in aerobic physical activity for 30 minutes/week most of the week. (BRFSS) Decrease in number of overweight and obese adults. (BRFSS)		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Invite representatives from city government (Planning, Public Works, Parks and Recreation), transportation, land use, and community design to participate on the workgroup.	January 2014	Executive Leadership & Steering Committee
Evaluate the possibilities for enhancing current infrastructure supporting bicycling by creating bike lanes, shared-use paths, and routes on existing or new roads; providing bike racks in vicinity of commercial and other public space.	March 2014	Workgroups
Work with partners to implement improved bicycling infrastructure.	December 2014	Workgroups
Evaluate the possibilities of enhancing infrastructure that supports walking that include sidewalks, footpaths, walking trails, and pedestrian crossings including the implementation of Complete Streets policy.	December 2014	Workgroups
Work with partners to implement improved pedestrian infrastructure.	December 2015	Workgroups
Work with schools and local city and county partners to implement joint use agreements that allow the use of athletic facilities and outdoor recreational facilities by the public on a regular basis (school gyms, parks and green space, outdoor sports fields and facilities, walking and biking trails, public pools, and community playgrounds).	June 2016	Workgroups
Support existing Shaping NJ Obesity Prevention Strategies and Mayor's Wellness Campaign and Municipal Alliance. • Provide safe/convenient opportunities for daily physical activity in all neighborhoods.	Ongoing	Workgroups
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership, Steering Committee & Workgroup

*Refers to southeast section of Somerset County

Goal 3: **To build a community that promotes, supports and fosters healthy behaviors and preventive care services across Middlesex and Somerset*counties.**		
Objective 3.2: **By December 2016, increase the number of adults and children who consume five or more servings of fruits and vegetables per day by 5%.**		
Strategy 3.2.1: Implement a wide variety of strategies that increase access to fruits and vegetables among children in the school setting. ***Source/Evidence Base:*** *CDC Team Nutrition Program.*		
Performance Indicator(s) Increase in the number of adults and children who consume five or more servings of fruits and vegetables per day. (YRBS and BRFSS) Increase in the number of childcare centers that have implemented nutrition policies. Increase in number of new community gardens or farmers' markets implemented in the region. (local survey)		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Invite representatives from schools to participate on the workgroup.	March 2014	Executive Leadership & Steering Committee
Work with schools to assess school nutrition policies and programs and develop a plan for improvement.	March 2014	Workgroups
Work with schools and childcare centers to strengthen fruit and vegetable policies.	June 2014	Workgroups
Work with schools to implement a policy that requires all school districts to serve at least one serving of fresh fruits and vegetables at each meal served in the school cafeteria.	September 2014	Workgroups
Work with schools to implement high quality health promotion program for staff that focuses on nutrition and weight management (worksite wellness initiative).	September 2015	Workgroups
Provide healthy cooking curriculum in senior centers.	September 2015	Workgroups
Implement nutrition lectures through worksite wellness programs.	September 2015	Workgroups
Establish community gardens and or farmers markets in food deserts.	December 2015	Workgroups
Support existing Shaping NJ Obesity Prevention Strategies and Mayor's Wellness Campaign, Municipal Alliance, Food Banks. • Shaping NJ: Put fruits/vegetables and other healthy foods/beverages within easy reach for all residents in all neighborhoods.	Ongoing	Workgroups
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership, Steering Committee & Workgroup

Goal 3:
To build a community that promotes, supports and fosters healthy behaviors and preventive care services across Middlesex and Somerset*counties.

Objective 3.3:
By December 2016, increase by 5% the number of people screened each year using age and gender appropriate preventive health screenings in high risk communities to identify those at risk for a wide range of preventable health conditions.

Strategy 3.3.1: Organize and conduct health screening events that are well publicized and geographically widespread to ensure easy accessibility to community members.
Source/Evidence Base: *http://www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm*

Performance Indicator(s)
Increase number of individuals getting preventive health screenings at community health fairs. (Glucose, BMI, depression, BP, PSA, Breast Exam, Colon Exam, etc.). (BRFSS/local survey)

ACTION PLAN

Action Steps	Target Date	Lead Organization
Organize quarterly screening calendar with events sponsored by this partnership.	December 2014	Workgroup
Distribute screening calendar at health fairs and other health-related community events.	December 2014	Workgroup
Develop a referral sheet with the following: 1. Identifies concrete options for follow up care 2. Interprets each individual participant’s screening results 3. Guides participant to appropriate printed information 4. Provides a postage-paid response card/stub to provide feedback on follow-up actions taken	July 2015	Workgroup
Advertise events and calendar via all communication channels.	Ongoing	Workgroup

Goal 3: **To build a community that promotes, supports and fosters healthy behaviors and preventive care services across Middlesex and Somerset*counties.**		
Objective 3.3: **By December 2016, increase by 5% the number of people screened each year using age and gender appropriate preventive health screenings in high risk communities to identify those at risk for a wide range of preventable health conditions.**		
Strategy 3.3.2: Train/equip screeners with information/resources to refer upon diagnosis and to provide immediate/appropriate follow up. ***Source/Evidence Base:*** *http://www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm*		
Performance Indicator(s) Increase in number of adequately trained screeners.		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Establish standard protocol for each screening and recommendations for referral and next steps.	January 2014	Workgroup
Coordinate the set of established protocols amongst community.	June 2014	Workgroup
Identify and standardize the list of written resources.	June 2014	Workgroup
Make the information linguistically/culturally appropriate.	September 2014	Workgroup
Insure that all materials are utilizing health literacy principles.	September 2014	Workgroup
Create a network of clinical partners available as referral sources.	December 2014	Workgroup
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership, Steering Committee & Workgroup

Goal 3:		
To build a community that promotes, supports and fosters healthy behaviors and preventive care services across Middlesex and Somerset*counties.		
Objective 3.4:		
By December 2016, decrease prescription drug use among youths and adults by 5%.		
Strategy 3.4.1: Enhance or establish a community-wide comprehensive prescription drug abuse prevention program to decrease inappropriate use of prescription drugs. ***Source/Evidence Base:*** *http://www.cadca.org/resources/detail/rx-abuse-prevention-toolkit*		
Performance Indicator(s) Decrease in the number of admissions for prescription drug overdose. (hospital discharge data)		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Invite representatives from key stakeholder groups (e.g., parents, law enforcement, pharmacies, and schools) groups to participate on the Workgroup to ensure coordination.	March2014	Workgroup
Partner with the National Council on Alcohol and Drug Dependence (NCADD) to increase the number of Medicine Drug Boxes in catchment area by 100%.	December 2014	Workgroup
Partner with NCADD to increase community awareness of the availability of drop box locations through distribution of educational material at outreach events (safe, anonymous, etc.), press releases, and social media.	December 2014	Workgroup
Provide prescription drug education regarding prescribing practices for physicians, dentist, and other healthcare providers.	December 2014	Workgroup
Provide community education about safe medicine disposal and storage.	December 2014	Workgroup
Provide training for parents/caregivers about the dangers of prescription medicine abuse.	December 2014	Workgroup
Advocate for policy change to increase use of Prescription Monitoring Program.	December 2015	Workgroup
Implement evidence-based prevention education programs in schools and outside of schools that teach critical personal and social skills that promote health and wellbeing among youths and help them avoid substance abuse (including prescription drug abuse).	March 2015	Workgroup
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership, Steering Committee & Workgroup

Goal 3: To build a community that promotes, supports and fosters healthy behaviors and preventive care services across Middlesex and Somerset*counties.		
Objective 3.5 By December 2016, identify and implement two policy changes that have a positive impact on the community by encouraging/promoting healthy behaviors.		
Strategy 3.5.1: Implement a comprehensive smoke-free park policy resulting in an increased number of smoke-free municipal parks in Middlesex and Somerset*counties. ***Source/Evidence Base:*** *http://www.tobaccofreeparks.org/materials.html*		
Performance Indicator(s) Increase the number of towns with smoke-free policies covering buildings and grounds (parks) in Middlesex and Somerset*counties.		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Invite representatives from parks department and city government to participate in the workgroup.	January 2014	Executive Leadership
Learn about current policies and laws related to smoking outdoors.	January 2014	Workgroup
Review model policies.	March 2014	Workgroup
Assess potential barriers/challenges to implementing policy.	March 2014	Workgroup
Develop educational material to inform public and gain community support.	June 2014	Workgroup
Conduct survey to assess number of parks that will be impacted.	September 2014	Workgroup
Develop presentation to go before decision makers.	September 2014	Workgroup
Present policy request to decision makers.	January 2015	Executive Leadership
Celebrate successful implementation of smoke-free park policy.	To be determined	All

D. PRIORITY AREA 4: Disease Specific Issues with a Focus on Obesity, Diabetes and Mental Health

Goal 4:		
To achieve physically and mentally healthy communities by addressing obesity, diabetes, and mental health in Middlesex and Somerset*counties. (Obesity prevention is addressed under Goal 3)		
Objective 4.1 (Diabetes) **By December 2016, increase awareness of current diabetes guidelines (standards of care and evidence-based practices) to improve management of diabetes and associated complications.**		
Strategy 4.1.1: Implement education and training programs for healthcare providers, healthcare professionals (Certified Diabetes Educators) and persons with diabetes. ***Source/Evidence Base:*** *http://patienteducation.stanford.edu/programs/diabeteseng.html*		
Performance Indicator(s) Delineation of educational needs of healthcare providers and professionals regarding diabetes management. Increase in the number of evidence-based programs held and number and types of participants. Improved diabetes self-care management among persons with diabetes.		
ACTION PLAN		
Action Steps	**Target Date**	**Lead Organization**
Identify the educational needs of healthcare providers, health care professionals and ancillary personnel.	January 2014	Executive Leadership
Implement health education and diabetes self-management programs for persons with diabetes to assure access to quality care.	June 2014	Workgroup
Identify, develop, implement, and promote evidence-based diabetes education programs.	June 2014	Workgroup
Identify best practices for increasing awareness for critical care issues related to diabetes.	September 2014	Workgroup
Increase referrals to diabetes self-management education.	January 2015	Workgroup
Promote disease management programs for diabetes control in multiple languages.	Ongoing	Workgroup
Work to increase utilization of self-management programs in community settings.	Ongoing	Workgroup
Strategy 4.1.2: Increase coordination of care resources for persons with diabetes. ***Source/Evidence Base:*** *http://patienteducation.stanford.edu/programs/diabeteseng.html*		
Performance Indicator(s) Increased resources available in the community on coordination of care for persons with diabetes.		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Create a "Hub" – work with local health departments as centralized disseminators of a web-based system to cross-share health information and services (e.g., blogs, website, mass mail)	January 2014	Workgroup
Leverage the accessibility, infrastructure and social networks of public libraries to cross-share health information and resources.	March 2014	Workgroup
Identify satellite hubs consisting of inter-related community entities as sites for diabetes self-management.	June 2014	Workgroup
Create a tool for sharing evidence-based programs between providers.	September 2014	Workgroup
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership

Goal 4: **To achieve physically and mentally healthy communities by addressing obesity, diabetes, and mental health in Middlesex and Somerset*counties. (Obesity prevention is addressed under Goal 3)**		
Objective 4.2 (Obesity) **By December 2016, increase awareness of current obesity guidelines (standards of care and evidence-based practices) to improve management of obesity and associated complications.**		
Strategy 4.2.1: Implement education and training programs for healthcare providers, healthcare professionals and persons who are obese. ***Source/Evidence Base:*** *IOM Obesity Prevention, CDC Community Strategies*		
Performance Indicator(s) Delineation of educational needs of healthcare providers and professionals regarding obesity management. Increase in the number of evidence-based programs held and number and types of participants.		
ACTION PLAN		
Action Steps	**Target Date**	**Lead Organization**
Identify the educational needs of healthcare providers, healthcare professionals and ancillary personnel.	January 2014	Executive Leadership
Implement health education and weight reduction programs for persons who are obese to assure access to quality care.	June 2014	Workgroup
Identify, develop, implement, and promote evidence-based weight loss education programs.	June 2014	Workgroup
Identify best practices for increasing awareness for critical care issues related to overweight and obesity.	June 2014	Workgroup
Increase referrals to weight loss programs.	January 2015	Workgroup
Promote weight loss programs in multiple languages.	March 2015	Workgroup
Develop training for allied health professionals on obesity screening, prevention, and referrals.	June 2015	Workgroup
Work to increase utilization of evidence-based weight loss programs in community settings.	Ongoing	Workgroup
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership, Steering Committee & Workgroup

*Refers to southeast section of Somerset County

Goal 4:
To achieve physically and mentally healthy communities by addressing obesity, diabetes, and mental health in Middlesex and Somerset*counties. (Obesity prevention is addressed under Goal 3)

Objective 4.3 (Obesity)
By December 2016, increase by 10% the number of worksites that offer a comprehensive worksite wellness program that offer obesity treatment.

Strategy 4.2.1: Increase the number of employers who offer benefits, coverage and/or incentives for obesity treatment.
Source/Evidence Base: *IOM Obesity Prevention, CDC Community Strategies from Community Guide*

Performance Indicator(s)
Increase in the number of employers who offer benefits for obesity treatment.

ACTION PLAN

Action Steps	Target Date	Lead Organization
Invite representatives from local businesses to participate in the workgroup.	January 2014	Executive Leadership
Learn about evidence-based worksite wellness programs that include obesity treatment.	March 2014	Workgroup
Identify employers who are willing to offer benefits, coverage and/or incentives for obesity prevention and obesity treatment.	June 2014	Workgroup
Engage employers to promote/make visible and value obesity reduction.	September 2014	Workgroup
Increase employer-based referrals to weight loss programs.	January 2015	Workgroup
Promote weight loss programs in worksites (i.e., Weight Watchers).	January 2015	Workgroup
Work with employers to support utilization of evidence-based weight loss programs in community settings.	Ongoing	Workgroup
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership, Steering Committee & Workgroup

*Refers to southeast section of Somerset County

Goal 4:
To achieve physically and mentally healthy communities by addressing obesity, diabetes, and mental health in Middlesex and Somerset*counties. (Obesity prevention is addressed under goal 3)

Objective 4.4 (Mental Health)
By December 2016, incorporate mental health services and education into primary care settings.

Strategy 4.4.1: Identify primary healthcare settings that are willing to develop their team with required skills and competencies to identify mental disorders; provide basic medication and psychosocial interventions; undertake crisis interventions; refer to specialists when appropriate; and provide education and support to patients and families.
Source/Evidence Base: *http://www.integration.samhsa.gov/integrated-care-models*

Performance Indicator(s)
Increase in the number of primary care providers aware of available mental health services.
Increase in the number of primary care providers that provide mental health screening and treatment services.
Increase in mental health screenings by primary care providers.

ACTION PLAN

Activity	Target Date	Lead Organization
Assess primary care providers and gather statistics on the current availability of mental health information and education.	January 2014	Workgroup
Provide education to primary care providers/medical homes on an ongoing basis to ensure that they are equipped to incorporate mental health services and screening into primary care setting.	June 2014	Workgroup
Help to develop for primary care providers/medical home referral processes for specialists to ensure continuity of care for the patient with mental health issues.	October 2014	Workgroup
Develop and provide educational materials for families needing support.	December 2014	Workgroup
Provide primary care providers/mental homes with current mental health resource information.	Ongoing	Workgroup
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership, Steering Committee & Workgroup

Goal 4: **To achieve physically and mentally healthy communities by addressing obesity, diabetes and mental health in Middlesex and Somerset*counties. (Obesity prevention is addressed under goal 3)**		
Objective 4.5 (Mental Health) **By December 2016, increase the number of evidence-based educational programs in Middlesex and Somerset*counties that address prevention of mental illness and substance abuse along with treatment and recovery services.**		
Strategy 4.5.1: Identify and disseminate existing evidence-based programs on mental health and substance abuse issues such as anxiety, substance abuse, addiction, depression, social isolation. ***Source/Evidence Base:*** *http://www.samhsa.gov/ebpwebguide/*		
Performance Indicator(s) Increase in evidence-based educational programs in Middlesex and Somerset*counties that address prevention of mental illness and substance abuse. Increase the number of community members participating in prevention programs.		
ACTION PLAN		
Activity	**Target Date**	**Lead Organization**
Research evidence-based mental health educational programs.	January 2014	Workgroup
Conduct an assessment to determine the current number of evidence-based educational programs in the region.	March 2014	Workgroup
Disseminate information about existing evidence-based programs to schools, primary care physicians, senior centers, health clinics, adult care facilities, and nonprofit organizations.	December 2014	Workgroup
Partner with schools, community-based organizations, employers, and faith-based organizations to implement new programs.	June 2015	Workgroup
Work with the media to promote those evidence-based programs that are available in the region.	December 2015	Workgroup
Ensure sustainability of intervention efforts.	Ongoing	Executive Leadership, Steering Committee & Workgroup

V. Next Steps

This report represents the strategic framework for a data-driven, community-enhanced Community Health Improvement Plan. 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 Middlesex and Somerset*counties.

VI. SUSTAINABILITY PLAN

The Saint Peter's University Hospital and Robert Wood Johnson University Hospital CHIP team, including the core agencies, CHIP workgroups, partners, stakeholders, and community residents, will continue finalizing the CHIP by refining the specific 3-year action steps, assign lead responsible parties, and identify resources for each priority area. An annual CHIP progress report will illustrate performance and will guide subsequent 3-year implementation planning.

The Executive Committee, consisting of representatives from each Community Health Partner, will provide executive oversight for the improvement plan, progress, and process. The Steering Committee continues to be a vital part of the partnership and will expand agency membership to match the scope of the CHIP's four priority areas. Additional workgroup meetings and participants will be identified once the 3-year action plan is finalized. 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.

Appendix A: Work Group Participants

Xenia Acquaye	Community Mission Manager, Eastern Division American Cancer Society, Inc.
Lexy Anderson	Senior Program Director, Wellness/Aquatics, YMCA of Woodbridge Community Center
Migdaliz Auciello	Outreach Specialist, WellCare Health Plans, Inc.
Harriet Black	Nurse Diabetes Educator, RWJUH Outpatient Diabetes Education Program
Ana Bonilla Martinez	Community Liaison, Sacred Heart Church
Janet Bowen	Director, Ambulatory Services, Saint Peter's Healthcare System
Heather Brown	Health Educator, Edison Township
Linda Brown	Health Educator
Donna Burke	Facilitator, Health Resources in Action
Bill Campbell	Director, Pastoral Care and Counseling, First Baptist Church of Lincoln Gardens
Debbie Charette	Director of Nursing, East Mountain Hospital
Carl Chase	Program Development Analyst, Department of Public Affairs, University of Medicine & Dentistry of New Jersey
Tabiri Chukunta	Executive Director, Community Outreach, Saint Peter’s Healthcare System
Stan Cohen	Grant Writer, Saint Peter’s Foundation
María Victoria Coll	Regional Director, Health Equity & Multicultural Initiatives, American Heart/Stroke Association, Founders Affiliate
Camilla Comer-Carruthers	Manager, Community Education, Robert Wood Johnson University Hospital
Carlos Cordero	Director, Social Services, RWJ Medical School/Eric B. Chandler Health Center
Cynthia Cox	Social Worker
Margaret Drozd	Director, Community Mobile Health Services, Saint Peter's University Hospital
Kiameesha Evans	Program Director, The Cancer Institute of New Jersey
Marcia Feldheim	Anshe Emeth Community Development Corporation
Siriade Filipe	St. John’s Health & Family Service Center, Catholic Charities, Diocese of Metuchen
Stephanie Fitzsimmons	Nursing Manager, Adult Communities in Monroe Township, Saint Peter's University Hospital
Adrienne Garber	Nurse, Lead Program, Middlesex County Office of Human Services
Debee Gash	Nurse Director, Middlesex County Office of Public Health
Keisha Griffin	Community Connections Coordinator, YMCA Diabetes Prevention Program, YMCA of Metuchen, Edison, Woodbridge, and South Amboy
Tara Gunthner	Supervisor, Community Mobile Health Services, Saint Peter's University Hospital
Sana Hashim	YDPP-Lifestyle Coach, YMCA of Metuchen, Edison, Woodbridge, and South Amboy
Jennifer Herriott	Facilitator, Health Resources in Action
Elaine Hewins	Coordinator, Domestic Violence Prevention Program, RWJUH CHPP
Kathleen Iannuzzo	Staff Nurse, Community Mobile Health Services, Saint Peter's University Hospital
Eric Jahn, MD	Senior Associate Dean for Community Health – Rutgers Robert Wood Johnson Medical School
Jay Jimenez	Vice President, Government Affairs, Saint Peter's Healthcare System
Nisha Joshi	Office of Minority Health, New Jersey Department of Health
Bridget Kennedy	Director, Middlesex County Office of Human Services
Matthew Kielczewski	Student Intern, Community Mobile Health Services, Saint Peter's University Hospital
Mary Anne Kokidis	Amerigroup
Jennifer Kurdyla	Health Educator, County of Middlesex Office of Health Services
Yoojin Lee	Facilitator, Health Resources in Action
Karen Lin	Program Director, RWJMS - Family Medicine Residency
Nancy MacKay	Public Health Nurse Administrator, South Brunswick Health Department
Jacqueline McDonald	Community Member

Mariam Merced	Director, RWJUH Community Health Promotion Program
Nicole Michel	YDPP-Lifestyle Coach, YMCA of Metuchen, Edison, Woodbridge, and South Amboy
Yvette Molina	Social Worker, Elijah's Promise
Cimaris Moronta	Student Intern, Community Mobile Health Services, Saint Peter's University Hospital
Stephen Papenberg	Health Officer, South Brunswick Township
Karen Parry	Manager of Information Services, East Brunswick Public Library
Devangi Patel	New Jersey Outreach Representative, New Jersey Paternity Opportunity Program
Radha Patel	Student Intern at RWJUH, BTG Internship Program
Maria Pellerano	Instructor, Family Medicine and Community Health – Rutgers Robert Wood Johnson Medical School
Bonnie Petrauskas	Johnson and Johnson
Tyesha Pichardo	Horizon NJ Health
Preethi Raghava	Student Intern at RWJUH, BTG Internship Program
Daniel Reilley	Health Specialist, Community Mobile Health Services, Saint Peter's University Hospital
Sarah Reilly	Director, St. John's Health & Family Service Center, Catholic Charities, Diocese of Metuchen
Samira Ruiz	Clerk/Administrative Assistant, Community Mobile Health Services, Saint Peter's University Hospital
Michéle Samarya-Timm	Health Educator/Registered Environmental Health Specialist, Somerset County Department of Health
Sudha Sharma	Program Management Officer, Office of Commissioner
Diana Starace	Coordinator, RWJ Injury Prevention Program
Heather Steel	Public Relations Manager, Carrier Clinic
Linda Surks	Coordinator, Coalition for Healthy Communities, NCADD
Margo Tarasov	Director of Clinical Social Services, Carrier Clinic
Anna Trautwein	Practice Administrator, Women's Ambulatory Care Services, Saint Peter's University Hospital
Jag Vasudev	New Americans/United Way
Emilia Volyand	YDPP-Lifestyle Coach, YMCA of Metuchen, Edison, Woodbridge, and South Amboy
Patricia Zito	YDPP-Lifestyle Coach, YMCA of Metuchen, Edison, Woodbridge, and South Amboy

Appendix B: Community Partners and Resources

- American Heart/Stroke Association, Founders Affiliate
- Amerigroup
- Anshe Emeth Community Development Corporation
- BTG Internship Program - RWJUH
- Carrier Clinic
- Catholic Charities, Diocese of Metuchen
- Center for Great Expectations
- Center for State Health Policy, Rutgers University
- Central Jersey Community Development Corporation
- County of Middlesex Office of Health Services
- East Brunswick Public Library
- East Mountain Hospital
- Eastern Division | American Cancer Society, Inc.
- Edison Township Health Department
- Elijah's Promise
- Horizon New Jersey Health
- Johnson and Johnson
- Middlesex County Health Department
- Middlesex County Office of Human Services
- NCADD
- New Americans/United Way
- New Brunswick Tomorrow
- New Jersey Paternity Opportunity Program
- New Jersey Department of Health
- Office of the Commissioner
- Puerto Rican Action Board
- Robert Wood Johnson Injury Prevention Program
- Robert Wood Johnson Medical School-Eric B. Chandler Health Center
- Robert Wood Johnson University Hospital
- Robert Wood Johnson University Hospital Community Health Promotion Program
- Robert Wood Johnson University Hospital Outpatient Diabetes Education Program
- Sacred Heart Church
- Saint Peter's Foundation
- Saint Peter's Healthcare System
- Saint Peter’s University Hospital
- Saint Peter's University Hospital Community Mobile Health Services
- Saint Peter’s Community Outreach Department
- Somerset County Department of Health
- South Brunswick Health Department
- South Brunswick Township
- The Cancer Institute of New Jersey
- University of Medicine & Dentistry of New Jersey
- WellCare Health Plans, Inc.
- YMCA at Woodbridge Community Center
- YMCA DPP / Edison Health Department
- YMCA of Metuchen, Edison, Woodbridge, and South Amboy