

Healthier Middlesex Community Health Improvement Plan

2026

PREPARED BY
HEALTH RESOURCES IN ACTION

Acknowledgements

Healthier Middlesex is a consortium of individuals, groups, and organizations who are committed to building a healthier community for people in Middlesex and Somerset counties. Our diverse group of partners provide the Consortium with a spectrum of experiences. See below a full listing of our partners. We welcome anyone who has a passion for health and wellness to join in our collective efforts and create a healthy community.

Healthier Middlesex recognizes the following organizations and community partners for their participation in the community health improvement process:

| Healthier Middlesex Member Organizations | |
|--|--|
| AARP- New Jersey | National Alliance on Mental Illness (NAMI) New Jersey |
| Aetna- New Jersey | New Americans of New Jersey |
| Affinity Credit Union | New Brunswick Tomorrow |
| All About You Healthcare Advocates | New Jersey Citizen Action Group |
| Brady United Against Gun Violence | New Jersey Department of Health |
| Central Jersey Family Health Consortium | New Jersey Department of Labor |
| Chase Bank | New Jersey Institute for Disabilities (NJID) |
| Community Affairs & Resource Center (CARCNJ) | New Jersey Prevention Network |
| Community Food Bank Center of New Jersey | Puerto Rican Action Board |
| Coordinated Family Care | Raritan Bay YMCA |
| Culturizing Access | Raritan Valley YMCA |
| Diocese of Metuchen | REPLINSH |
| East Brunswick- Mayor's Wellness Campaign | Robert Wood Johnson (RWJ) Hospital |
| East Brunswick Public Library | Robert Wood Johnson University Hospital Somerset |
| Empower Somerset | Rutgers Cancer Institute of New Jersey |
| Eric B. Chandler Health Center | Rutgers Cooperative Extension |
| Girls on The Run of Central Jersey | Rutgers Gardens |
| Greenway Family Success Center | Rutgers RWJ Medical School |
| Hackensack Meridian Health | Rutgers University Behavioral Health Care (UBHC) |
| Harmony Family Success Center | Rutgers University School of Public Health |
| Highland Park Borough | RWJBH- Hospital Violence Intervention Program |
| Horizon Blue Cross Blue Shield of New Jersey | RWJBH- Injury Prevention |
| Johnson and Johnson | Saint Peters University Hospital |
| Keep Middlesex Moving | Somerset County Department of Health |
| Middlesex College | The College of New Jersey |
| Middlesex County Municipal Alliance | Township of Edison |
| Middlesex County Office of Aging | WellCare of New Jersey |
| Middlesex County Office of Health Services | Wellspring Center for Prevention |
| Middlesex County Office of Human Services | Woodbridge Township- Mayor's Wellness Campaign |
| Middlesex County Office of Planning | YMCA of Metuchen, Edison, Woodbridge, South Amboy and Piscataway |
| Mobile Family Success Center | |

Technical Advisers:

Health Resources in Action, Community Health Needs Assessment and Planning Consultant

Table of Contents

| | |
|--|-----------|
| Executive Summary | 3 |
| Introduction | 4 |
| Background | 4 |
| Purpose of a Community Health Improvement Plan | 4 |
| Community Engagement | 5 |
| Community Engagement Approach | 5 |
| Prioritization Process and Priorities Selected for Planning | 6 |
| Criteria for Prioritization..... | 6 |
| Prioritization Process | 7 |
| Priorities Selected for Planning | 8 |
| Development of the CHIP Strategic Components | 8 |
| Goals, Objectives, Indicators, and Strategies | 8 |
| CHIP Framework | 9 |
| Healthier Middlesex CHIP Snapshot | 10 |
| Healthier Middlesex CHIP | 11 |
| Priority Area 1: Mental Health/Behavioral Health | 11 |
| Priority Area 2: Healthy Eating/Food Security | 15 |
| Priority Area 3: Access to Healthcare..... | 19 |
| Priority Area 4: Access to Social Services | 24 |
| Next Steps and Sustainability | 27 |
| Appendices | 28 |
| Appendix A: Participants in the CHIP Process..... | 28 |
| Appendix B: Acronyms | 29 |
| Appendix C: Planning Definitions | 30 |
| Appendix D: RWJUH Strategic Implementation Plan (SIP) Focus Areas | 31 |

Executive Summary

Where and how we live, learn, work, and play affects our health. Understanding how these factors influence health is critical for developing the best strategies to address them. To accomplish these goals, the Robert Wood Johnson University Hospital New Brunswick, part of RWJBarnabas Health, in collaboration with Saint Peter's University Hospital and the Healthier Middlesex Consortium, led a comprehensive community health improvement effort to measurably improve the health of Middlesex County, New Jersey residents. This effort included two major phases:

- A community health needs assessment (CHNA) to identify the health-related needs and strengths of Middlesex County
- 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 County

In addition to guiding future services, programs, and policies for community agencies and organizations, the CHNA and CHIP are also required for the health departments to earn accreditation by the Public Health Accreditation Board (PHAB), a distinction which indicates that the agency is meeting national standards for public health system performance.

The *2026-2029 Middlesex County Community Health Improvement Plan* was developed over the period of January 2025 to June 2025 using key findings from the CHNA, which included qualitative data from key informant interviews and focus groups, feedback from community survey respondents, and quantitative data from local, state, and national indicators on health, social, and economic data.

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Middlesex County assessment and planning process engaged community members and local public health partners through different avenues:

- Healthier Middlesex: The Healthier Middlesex Consortium members provided vital input on the CHNA and CHIP development including guiding outreach, giving feedback on the planning mission and vision, and participating in the planning process.
- Middlesex County Community: Middlesex County residents were engaged in data collection during the CHNA process and provided input on priorities through the Middlesex CHNA Community Health Survey. Healthier Middlesex members conducted outreach to community members to encourage participation in the planning process.
- RWJBarnabas Health System: The RWJBarnabas Health Systemwide CHNA Steering Committee developed criteria that were used to guide prioritization discussions and voting processes.

Healthier Middlesex Consortium members and community members used common criteria and a multi-voting process to identify the following priority health issues to address in the CHIP, with equity as a cross-cutting theme:

| Priority Area |
|--|
| Priority 1: Mental Health/Behavioral Health |
| Priority 2: Healthy Eating/Food Security |
| Priority 3: Access to Healthcare |
| Priority 4: Access to Social Services |

Introduction

Background

A community health improvement plan, or CHIP, is an 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. **Robert Wood Johnson University Hospital New Brunswick (RWJUH-NB)**, part of **RWJBarnabas Health**, in partnership with **Saint Peter's University Hospital** and the **Healthier Middlesex Consortium**, led its fifth comprehensive community health improvement process to measurably enhance the health of the communities it serves in Middlesex and Southeastern Somerset Counties, New Jersey (NJ).

The Healthier Middlesex Consortium was created in 2012 to convene a broad cross-section of organizations to improve the health and well-being of those who live and work in Middlesex and Southeastern Somerset County, NJ. The Consortium facilitates the collaboration and partnership of over 32 organizations including representatives from businesses, local government, non-profit organizations, and social service agencies, that serve approximately 900,000 members across the community.

In January of 2025, RWJUH New Brunswick contracted with Health Resources in Action (HRiA), a non-profit public health consultancy located in Boston, Massachusetts, to provide support and help facilitate its community health improvement process. HRiA worked closely with RWJUH New Brunswick and the Healthier Middlesex Consortium to develop the Middlesex County CHIP. This effort included two major phases:

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

Purpose of a Community Health Improvement Plan

CHIPs are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.¹

The CHNA and CHIP are essential frameworks for guiding future services, programs, and policies for healthcare and public health-serving agencies in the area. For nonprofit hospitals like RWJUH New Brunswick and Saint Peters University Hospital, the CHNA and the hospital-based strategic implementation plan (SIP) are required to maintain nonprofit status with the Internal Revenue Service (IRS), form 990, and deliver community-based programming that is well aligned with and informed by community needs. The CHNA and CHIP are also required for Middlesex County health departments to earn or renew accreditation by the Public Health Accreditation Board (PHAB), a distinction which indicates that these agencies are meeting national standards for public health system performance.

This CHIP is designed to:

- Identify priority issues for action to improve community health

¹ As defined by the Health Resources in Action, Strategic Planning Department, 2013

- Outline an implementation and improvement plan with performance measures for monitoring and evaluation
- Guide 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, learn, work, and play in Middlesex County. People, communities, and organizations should review the CHIP’s priorities and goals, reflect on the suggested strategies, and consider how to participate in this effort, in whole or in part.

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 health of Middlesex County. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP planning process identified potential partners and resources wherever possible for inclusion in this CHIP.

Community Engagement

To develop a shared, sustainable plan for improved community health, RWJUH New Brunswick, Saint Peter’s University Hospital, and the Healthier Middlesex Consortium led the assessment and planning process by engaging community members and local public health partners through different avenues.

Community Engagement Approach

The 2025 Middlesex County CHNA’s data collection approach focused on the social and economic upstream issues that affect a community’s health, recognizing that health is not only affected by people’s genes and lifestyle behaviors but also by upstream factors such as employment status, quality of housing, and economic policies. The CHNA also utilized a health equity lens and presents health patterns for the Middlesex County population overall, as well as areas of need for specific subpopulations.

The CHNA process engaged the Healthier Middlesex Consortium and was guided by an Advisory Committee comprised of volunteers from the full Consortium. Community engagement strategies were tailored to reach traditionally medically underserved populations. The CHNA utilized several different methods for data collection including:

- Reviewing existing social, economic, and health data in Middlesex and Middlesex County.
- Conducting a community health survey designed and administered by HRiA with 2,514 Middlesex County respondents. The survey was disseminated both online and as hard copies in 8 languages (English, Spanish, Portuguese, Arabic, Chinese, Haitian Creole, Yiddish, and Hindi).
- Facilitating 4 virtual focus groups with participants from populations of interest: newly arrived immigrants who are Spanish-speaking, people experiencing food insecurity who are Spanish-speaking, those working with seniors, and LGBTQIA+ community members.
- Conducting 9 key informant interviews with representatives from food assistance/food insecurity, mental health providers, social work, faith community leaders, local public health officials, school

systems, transportation and organizations that work with specific populations (e.g., undocumented residents, and people living with disabilities)

Healthier Middlesex Engagement

The 2025 CHNA-CHIP Advisory Committee of the Healthier Middlesex Consortium met twice virtually in April and May 2025 to provide input on the planning process, including affirming guiding principles and vision, guiding outreach and engagement of community members, and utilizing CHNA data to inform and determine community health priorities.

Middlesex Community Engagement

The community was engaged in the data collection process through focus groups, interviews, and a community survey. Members of the Consortium also reached out to community members to participate in the CHIP planning session.

RWJBarnabas Health System Engagement

The RWJBarnabas Health Systemwide CHNA Steering Committee includes medical and public health experts across RWJBarnabas Health as well as representatives from each of the system's 13 hospitals. The CHNA Steering Committee met twice in June 2021 and developed the criteria outlined in the next section that were used to guide prioritization discussions and voting processes.

Prioritization Process and Priorities Selected for Planning

Prioritization allows hospitals, organizations, and coalitions to target and align resources, leverage efforts, and focus on achievable goals and strategies for addressing key needs. The prioritization process was multifaceted and aimed to be inclusive, participatory, and data informed. Priorities for this process were identified by examining data and themes from the CHNA findings utilizing a systematic, engaged, and multi-pronged approach. This section describes the approach and outcomes of the prioritization process.

Criteria for Prioritization

A set of criteria were used to determine which issues from the CHNA could be potential priorities for collective action. The RWJBH Systemwide CHNA Steering Committee put forth the following criteria to guide prioritization processes across the RWJBH system; these criteria were used to guide prioritization discussions and voting processes with Healthier Middlesex Consortium members.

- **Burden:** How much does this issue affect health in the community?
- **Equity:** Will addressing this issue substantially benefit those most in need?
- **Impact:** Can working on this issue achieve both short-term and long-term changes? Is there an opportunity to enhance access/accessibility?
- **Systems Change:** Is there an opportunity to focus on/implement strategies that address policy, systems, environmental change?
- **Feasibility:** Is it possible to take steps to address this issue given current infrastructure, capacity, and political will?
- **Collaboration/Critical Mass:** Are there existing groups across sectors already working on or willing to work on this issue together?
- **Significance to Community:** Was this issue identified as a top need by a significant number of community members?

Prioritization Process

The prioritization process was multifaceted and aimed to be inclusive, participatory, and data informed.

Step 1: Input from Community Members and Stakeholders via Primary Data Collection

During each step of the primary data collection phase of the CHNA, assessment participants were asked for input. Key informant interviewees and focus group participants were asked about the most pressing concerns in their communities and the three highest priority issues for future action and investment. Community survey respondents were also asked to select the top three issues or concerns in their communities overall, noted in the Community Health Issues section of the CHNA Report.

Based on responses gathered from key informant interviews, focus group participants, and community survey respondents, as well as social, economic, and health data from surveillance systems, nine major initial issue areas were identified for Middlesex County (listed below in no particular order):

- Financial Security
- Affordable Housing
- Transportation
- Food Insecurity & Healthy Eating
- Systemic Racism & Discrimination
- Mental Health & Behavioral Health
- Chronic Disease Prevention/Management
- Healthcare Access
- Access to Social Services & Other Essential Services

Step 2: Data-Informed Voting via a Consortium Advisory Committee Prioritization Meeting

On May 1, 2025, a virtual Preliminary CHNA Findings and Prioritization meeting was facilitated for the Healthier Middlesex Consortium CHNA-CHIP Advisory Committee so members could discuss and vote on preliminary community priorities. During the prioritization meeting, attendees heard a brief data presentation on the key findings for the Middlesex County CHNA. Participants were asked to reflect on how the findings reflected what they see in the community, what was surprising or missing from the key themes, and what they saw as top issues for future collaborative efforts and investment in the community. Additionally, participants also reviewed the Prioritization Criteria so that they could consider how to rank the nine health issues in relation to the prioritization criteria (Burden, Equity, Impact, Systems Change, Feasibility, Collaboration/Critical Mass, Significance to Community).

At the end of the meeting, using Mentimeter's online polling tool, meeting participants were asked to vote for up to four of the nine priorities identified from the data and based on the specific prioritization criteria. A total of sixteen Advisory Committee members voted during this Prioritization Meeting.

Voting identified that several issues ranked closely together:

- Mental Health & Behavioral Health: 88% (14/16)
- Chronic Disease Prevention/Management: 75% (12/16)
- Food Insecurity & Healthy Eating: 69% (11/16)
- Healthcare Access: 38% (6/16)
- Access to Social Services & Other Essential Services: 38% (6/16)
- Affordable Housing: 38% (6/16)

Priorities Selected for Planning

The Healthier Middlesex Consortium finalized the following four priorities to focus on for planning sessions, with Systemic Racism and Discrimination/Health and Racial Equity as a cross-cutting theme:

| Priority Areas | |
|-----------------|---|
| Priority Area 1 | Mental Health/Behavioral Health |
| Priority Area 2 | Healthy Eating/Food Security |
| Priority Area 3 | Access to Healthcare (including sub-focus on Chronic Disease Prevention and Management) |
| Priority Area 4 | Access to Social Services |

Development of the CHIP Strategic Components

Development of this CHIP utilized a participatory, community-driven approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.²

Planning for the CHIP took place during a one-day in-person planning session on June 6, 2025 at the Rutgers Robert Wood Johnson Medical School in New Brunswick, New Jersey. Healthier Middlesex Consortium members and community members participated in the sessions, working in four Priority Area Working Groups to develop plan components (goals, objectives, potential outcome indicators, strategies, and potential community partners) (See Appendix A for list of planning participants). The session was facilitated by consultants from HRiA and included opportunity for cross-priority feedback and refinement of each of the core elements of the CHIP.

Following the planning session, subject matter experts, external partners, and HRiA consultants reviewed the draft output from the planning workgroups and edited material for clarity, consistency, and evidence base. This feedback has been incorporated into the final version of the CHIP contained in this report.

The Healthier Middlesex Consortium will finalize outcome indicators, including identification of baselines, targets and data sources, as part of the Year 1 Action Planning process for implementation of the CHIP.

Goals, Objectives, Indicators, and Strategies

The following pages outline the goals, objectives, indicators, and strategies for the four priority areas outlined in the CHIP. See **Appendix B** for a list of acronyms used in the CHIP. See **Appendix C** for definitions of the planning terminology used in this process. See **Appendix D** for a glossary of terms used in the plan.

² MAPP, a comprehensive, planning process for improving health, is a strategic framework that local public health departments across the country have utilized to help direct their strategic planning efforts. 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: <https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp>

CHIP Framework

The CHIP Framework provides the foundational elements of the CHIP. Together, they describe the desired future the Healthier Middlesex Consortium hopes to create by fulfilling its mission and goals; the central purpose for the Healthier Middlesex Consortium; and the principles that guide all aspects of Healthier Middlesex's work with partners in community.

Our Consortium is committed to working collaboratively by sharing information, creating alliances and increasing efforts for the health and wellness of all who live and work in Middlesex County.

Healthier Middlesex Vision: To become one of the healthiest counties in New Jersey.

Healthier Middlesex Mission: To improve the health and well-being of all who live and work in Middlesex County.

CHIP Guiding Principles:

- Collaboration
- Effectiveness
- Equity
- Evaluation
- Innovation
- Integrity

Healthier Middlesex CHIP Snapshot

| Priority Area | Goal Statements | Objectives |
|---|---|---|
| Priority 1: Mental Health/ Behavioral Health | Goal 1: Middlesex County prioritizes behavioral health and well-being in an equitable and culturally responsive manner. | 1.1: Increase access dissemination points for behavioral health information and resources for youth, immigrants, older adults, and providers. |
| | | 1.2: Expand mental health prevention and evidence-based educational programming for non-clinical community-based care providers (e.g., clergy, school personnel, social service providers). |
| | | 1.3: Offer mental and behavioral health-related trainings and education sessions to Middlesex County community members. |
| | | 1.4: Increase the number of culturally appropriate peer support resources in Middlesex County. |
| | | 1.5: Track and increase the number of community groups, organizations, and/or agencies with which the hospitals (RWJUH and SPUH) collaborate to implement strategies related to mental/behavioral health. |
| Priority 2: Healthy Eating/ Food Security | Goal 2: Everyone in Middlesex County has reliable and convenient access to healthy and culturally appropriate food and resources to feed themselves and their families. | 2.1: Increase opportunities for people to enhance their knowledge and confidence about making healthy food choices. |
| | | 2.2: Increase the number of food pantries that develop and implement sustainability plans (see also 2.5). |
| | | 2.3: Support food assistance services and expand Access to these services whenever possible. |
| | | 2.4: Reduce food waste by increasing the number of meals recovered by 10% annually through health care partners. |
| | | 2.5: Increase the number of people screened for food insecurity and referred to services. |
| | | 2.6: Increase the capacity of food pantries (see also 2.2). |
| | | 2.7: Track and increase the number of community groups, organizations, and/or agencies with which the hospitals (RWJUH and SPUH) collaborate to implement strategies related to healthy eating/food insecurity. |
| Priority 3: Access to Healthcare | Goal 3: Everyone in Middlesex County can access quality care strengthened by equitable and inclusive healthcare policies, sustainable systems, and environments. | 3.1: Increase interest in and opportunities for diverse community members to become employed in healthcare careers (primary and frontline care) through targeted education and recruitment. |
| | | 3.2: Increase the cultural competency education and language capacity at hospital facilities. |
| | | 3.3: Increase collaborative relationships among healthcare systems in Middlesex County to maximize resources and share best practices and policies for quality care. |
| | | 3.4: Increase the percentage over baseline of the number of chronic disease identification screenings and referrals to prevention and treatment, targeting those who are most at risk. |
| | | 3.5: Increase awareness of healthcare and primary care services for the underserved population. |
| | | 3.6: Provide chronic disease and other health-related education to community members. |
| Priority 4: | | 4.1: Increase the knowledge of currently available transportation resources for vulnerable populations. |

| | | |
|----------------------------------|---|--|
| Access to Social Services | Goal 4: Everyone in Middlesex County has equitable access to the culturally and linguistically comprehensive social services that fulfill their best quality of life. | 4.2: Enhance connections and collaboration among providers in the social service system to provide equitable and seamless access to services. |
| | | 4.3: Increase the number of educational opportunities and types provided for community members that promote awareness of social service resources. |

Healthier Middlesex CHIP

Priority Area 1: Mental Health/Behavioral Health

Mental health issues were ranked the top community health concern for children and youth and among the top five health concerns for the community overall on the Community Health Survey. Assessment participants shared mental health concerns for specific populations including seniors (e.g. isolation), youth, and immigrant populations and concerns about access to providers. They noted substance use and alcoholism were common and led to increased safety concerns for community members. The percentage of substance use treatment admissions for alcohol is higher in Middlesex County (37.9%) compared to New Jersey (35.1%).

Goal 1: Middlesex County prioritizes behavioral health and well-being in an equitable and culturally responsive manner.

Outcome Measures

- Decrease in deaths from overdose
- Decrease in suicides
- Decrease in wait times for accessing behavioral health care
- Decrease in rate of ED and inpatient visits due to mental health
- Increase the accessibility and availability of substance use treatment admissions for alcohol and other drugs

Objective 1.1: Increase access dissemination points for behavioral health information and resources for youth, immigrants, older adults, and providers.

Indicators

- Number of website/social media hits
- Number of non-traditional spaces engaged (e.g., faith-based, libraries, community centers, senior centers)
- Number of people engaged by partners in non-traditional spaces

Draft Strategies

- 1.1.1 Work with collaborative partners to organize existing resources into a standard list inclusive of key populations that catalog clinical services as well as community and peer supports.
- 1.1.2 Identify and outreach to venues in non-traditional spaces (e.g. libraries, faith-based, fairs, town events, provider offices, schools, food pantries) to discuss options for providing information on behavioral health resources.
- 1.1.3 Disseminate resources digitally and via hard printed copies.

- 1.1.4 Develop informational materials on behavioral health at appropriate literacy level that can be shared in plain and multiple languages and modalities (e.g., video clips, brochures, infographics).

Potential Partners

- Princeton House
- Saint Peter’s Family Health Center- FOR KEEPS
- Caritas Counseling Services, Sacred Heart Catholic Church

Objective 1.2: Expand mental health prevention and evidence-based educational programming for non-clinical, community-based care providers (e.g., clergy, school personnel, social service providers).

Indicators

- Pre and post tests
- Number of educational sessions
- Number of attendees at educational sessions
- Program Evaluation

Draft Strategies

- 1.2.1 Survey, identify and prioritize top 3 topical areas for skill-building on behavioral health.
- 1.2.2 Identify current and potential partners and champions and promote the programs they provide related to the identified topical areas (e.g., Rutgers School of Social Work trauma-informed training, school-based programs).
- 1.2.3 Explore Train-the-Trainer to train champions.
- 1.2.4 Provide trainings to community-based partners on evidence-based approaches to mental and behavioral health (e.g., coping skills, Mental Health First Aid, QPR, Narcan training).
- 1.2.5 Support ongoing recruitment, promotion, and follow-up for trainings including curriculum enhancement.

Potential Partners

- PRAB HVIP Counseling Services
- NAMI
- NAMI- NJ
- Rutgers
- UBHC
- Wellspring Center for Prevention

Objective 1.3: Offer mental and behavioral health-related trainings and education sessions to Middlesex County community members.

Indicators

- Number of trainings/education sessions offered
 - Among these, # of class sessions or workshops that are part of multi-module / multi-session program
 - Among these, # of stand-alone class sessions or workshops (i.e., one-time sessions)
- Number of people in attendance at training/education sessions

Draft Strategies

- 1.3.1 Utilizing the CHNA and other resources, identify mental/behavioral health topics affecting Middlesex County community members.
- 1.3.2 Identify mental health specialists who can offer trainings about such topics for the community.
- 1.3.3 Offer at least three trainings free and open to anyone in the community who is interested.
- 1.3.4 Work with local partners such as NAMI/NAMI en Español to offer additional workshops to community members.
- 1.3.5 Saint Peter's Community Health Services will provide at minimum one in person/virtual adolescent behavioral health education program per year.
- 1.3.6 RWJUH Community Health Education will offer at least one health talk per year in partnership with Rutgers Family Medicine about mental/behavioral health-related topics.
- 1.3.7 RWJUH Hospital Violence Intervention Program staff will offer support to traumatically injured victims of violence as well as education and workshops about violence prevention to partners/community members.
- 1.3.8 Track support groups and counseling services offered at community partners such as Puerto Rican Action Board (PRAB).

Potential Partners

- PRAB
- Rutgers Medical School
- UBHC
- Middlesex County Behavioral Health
- NAMI- NJ
- NAMI Espanol
- MHFA
- Wellspring Center for Prevention

Objective 1.4: Increase the number of culturally appropriate peer support resources in Middlesex County.

Indicators

- Number of community and hospital support groups, peer recovery groups, youth groups
- Resources in various languages

Draft Strategies

- 1.4.1 Develop/create inventory of existing programs specific to constituent groups.
 - Languages, faith-based, LGBTQ+, Immigrant
- 1.4.2 Identify key stakeholders from within constituent groups that can provide peer support.
- 1.4.3 Identify resources required for new partners to provide support (e.g., space, training).
- 1.4.4 Provide support to partners and promote peer support resources.

Potential Partners

- MHFA
- Middlesex County Behavioral Health
- Rutgers Medical School

- NAMI NJ
- NAMI Espanol
- RWJUH Pride Center
- UBHC
- Wellspring Center for Prevention
- Hospitals
- Alcoholics Anonymous en Español

Objective 1.5: Track and increase the number of community groups, organizations, and/or agencies with which the hospitals (RWJUH and SPUH) collaborate to implement strategies related to mental/behavioral health/wellness.

Indicators

- Number of community groups, organizations, and/or agencies with which the hospitals (RWJUH and SPUH) collaborate

Draft Strategies

- 1.4.1 Track and record the number of community groups, organizations, and/or agencies with which the hospitals (RWJUH and SPUH) collaborate on strategies related to mental/behavioral health/wellness.
- 1.4.2 Increase the number or organizations they collaborate with in New Brunswick or greater Middlesex County by at least one per year.

Potential Partners

- Rutgers Medical School
- UBHC
- Middlesex County Behavioral Health
- NAMI- NJ
- NAMI Espanol
- MHFA
- Wellspring Center for Prevention
- Hospitals
- RWJUH Pride Center
- Alcoholics Anonymous en Español

Priority Area 2: Healthy Eating/Food Security

Assessment participants named food insecurity as a pressing and rising need. On the Community Health Survey, about one in three (32.3%) of all respondents and more than half (58.9%) of Hispanic/Latino respondents indicated it was “often or sometimes true” in response to the prompt “We worried whether our food would run out before we get money to buy more.” While 41.1% of Middlesex County survey respondents indicated that “Nothing keeps me from eating healthy foods,” 35.9% indicated that cost was a barrier to healthy eating and 28.0% indicated lack of time to buy or prepare healthy meals was a barrier.

Goal 2: Everyone in Middlesex County has reliable and convenient access to healthy and culturally appropriate food and resources to feed themselves and their families.

Objective 2.1: Increase opportunities for people to enhance their knowledge and confidence about making healthy food choices.

Indicators

- Pre and post education event survey
- Number of workshops and presentations per year
- Number of participants
- Number of surveys
- Number of identified sites to host education

Draft Strategies

- 2.1.1 Identify the areas most vulnerable for chronic health conditions (i.e., high diabetes rates, high obesity rates) and offer healthy eating educational programs to community residents either before or after food distribution hours as much as possible.
- 2.1.2 Expand hospital pantry partnerships to address time/accessibility barriers.
- 2.1.3 Host a minimum of five culturally appropriate workshops focused on:
 - Food storage/preparation
 - Food demonstrations
 - Food label education
 - Food/vegetables/fruits people are not accustomed to eating/buying
 - Modification of dishes (swapping ingredients)
 - Present at senior centers, community organizations, and/or summer programs
 - Consider food literacy and reading level
- 2.1.4 Record workshops and make information available online through Healthier Middlesex platforms.
- 2.1.5 Educate HM consortium partners about all nutrition programs and workshops to assist in promotion to community members.
- 2.1.6 Promote awareness of existing Middlesex County Health Education programs (e.g. diabetes prevention, healthy habits, cancer, food is medicine).
 - Include on resource hub

Objective 2.2: Increase the number of food pantries that develop and implement sustainability plans (see also 2.5).

Indicators

- Number of sustainability plans developed
- Number of sustainability plans being implemented

Draft Strategies

- 2.2.1 Partner with Replenish to implement strategies for this objective.
- 2.2.2 Identify best practices for training and education, succession planning, operating procedures, and collective volunteer recruitment and retention impact.
- 2.2.3 Create training using best practices.
- 2.2.4 Provide training to pantries.
- 2.2.5 Conduct pre/post surveys to evaluate effectiveness of training.
- 2.2.6 Solicit feedback from pantries on implemented plans and expanded networks.
- 2.2.7 Provide templates for sustainability plans.
- 2.2.8 Share relevant portions of the plan with partners who support food pantries.

Potential Partners

- REPLENISH
- Hospitals
- Pantries

Objective 2.3: Support food assistance services and expand access to these services whenever possible.

Indicators

- Number of individuals and families served at hospitals' pantries
- Pounds of food distributed at hospitals
- Number of Common Market/fresh produce boxes distributed by RWJUH
- Number of meals recovered by RWJUH – data source: Share My Meals, RWJUH Partnership

Draft Strategies

- 2.3.1 Track the number of individuals and families served at hospitals' pantries, and increase this number if resources allow.
- 2.3.2 Track and report on the number of pounds of food distributed total each month at the hospitals' pantries, and increase this number if resources allow.
- 2.3.1 Track and report the number of how many people served feminine hygiene/baby products distributed by each hospitals' pantries and increase this number if resources allow.
- 2.3.3 Track and report on the total number of Common Market/fresh produce boxes distributed annually.
- 2.3.4 Track and report on any other supplemental food distributed and to whom it is going.

Potential Partners

- REPLENISH
- Hospitals
- Pantries
- Share My Meals

Objective 2.4: Reduce food waste by increasing the number of meals recovered by 10% annually through health care partners.

Indicators

- Number of meals recovered – data source: Share My Meals, RWJUH Partnership
- Number of collaborations between food recovery partners and those distributing food

Draft Strategies

- 2.4.1 Create a buddy system to share excess/non-preferred food.
- 2.4.2 Educate food pantries on streams of re-purposing “unwanted” food via compost, farm animals, other pantries.
- 2.4.3 Collaborate with Share My Meals on Meal Recovery to connect with Middlesex County partners.
- 2.4.4 Track and report on total number of meals recovered and distributed with Share My Meals partnership.
- 2.4.5 Promote Too Good to Go app.
- 2.4.6 Identify at least 2 more organizations who will collaborate with Share My Meals to distribute excess meals in Middlesex County.

Potential Partners

- Replenish
- Share My Meals
- Hospitals

Objective 2.5: Increase the number of people screened for food insecurity and referred to services.

Indicators

- Number of people screened in partner medical settings
- Number of people screened in partner community settings
- Number of Applications to SNAP – Hospital SNAP Navigator Program
- Number of Approved Applications to SNAP – Hospital Navigator Program
- Number of referrals in partner medical settings
- Number of referrals in partner community settings
- Number of providers educated/informed about Healthy Food Access Map
- Number of community partners educated/informed about Healthy Food Access Map
- Number of people referencing the Healthy Food Access Map (e.g., number of site hits)

Draft Strategies

- 2.5.1 Create survey for use in screening for food security in partner community settings.
- 2.5.2 Identify potential programs and settings for community screening with a focus on in-need zip codes (e.g., social service agencies, churches, schools/senior centers/libraries, Housing Authority, affordable housing, transition housing, shelters, and special countywide events such as fairs, National Night Out).
- 2.5.3 Promote the importance of food security screening to community organizations working in the community.
- 2.5.4 Develop and distribute survey to partners for use in identified community programs and settings.
- 2.5.5 Educate partners about the Healthy Food Access Map (provide link/handouts/etc.) and how to use it for referrals.
- 2.5.6 Post screening information and resources on Healthier Middlesex website.
- 2.5.7 Engage SNAP Navigators to assist with community screening and referrals.
- 2.5.8 Collect data on screenings done and referrals provided.

Potential Partners

- Hospitals – CHW’s/ Navigators/ Social Workers
- All About You Healthcare Advocates
- Middlesex County- Libraries
- Middlesex County Office of Health Services
- Pantries

- REPLENISH

Objective 2.6: Increase the capacity of food pantries (see also 2.2).

Indicators

- Food Capacity Assessment (Replenish)

Draft Strategies

- 2.6.1 Leverage data in the Middlesex County Food Insecurity Index to identify:
 - Areas of highest need
 - Gaps in services
 - Overlapping services (hours of operation, locations)
- 2.6.2 Support adoption of modified or full choice pantry model.
- 2.6.3 Facilitate networking and mentorships to support pantries in best practices.
- 2.6.4 Provide templates and support to pantries in obtaining neighbor feedback on pantry services through surveys, focus groups, and/or interviews.
- 2.6.5 Support pantries in providing a welcoming culture, including signage.
- 2.6.6 Support pantries in making connections to community resources (utilize Capacity Assessment Data to measure).
- 2.6.7 Support pantries in improving processes to be more time efficient.
- 2.6.8 Explore models for mobile food delivery and share findings with partners.
- 2.6.9 Conduct culturally appropriate training for food pantries on key topics such as: cultural sensitivity, trauma informed care, de-escalation, and customer service.

Potential Partners

- Healthier Middlesex
- REPLENISH

Objective 2.7: Track and increase the number of community groups, organizations, and/or agencies with which the hospitals (RWJUH and SPUH) collaborate to implement strategies related to healthy eating/food insecurity.

Indicators

- Number of community groups, organizations, and/or agencies with which the hospitals (RWJUH and SPUH) collaborate.
- Number of Feeding New Brunswick meetings attended per year

Draft Strategies

- 2.7.1 Track and record the number of community groups, organizations, and/or agencies with which the hospitals (RWJUH and SPUH) collaborate on strategies related to healthy eating/food insecurity.
- 2.7.2 Increase the number of organizations we collaborate with in New Brunswick or greater Middlesex County by at least one per year.
- 2.7.3 RWJUH CHPP/Healthier Middlesex staff will attend at least 10 Feeding New Brunswick meetings per year.

Potential Partners

- REPLENISH
- Healthier Middlesex
- Feeding New Brunswick Network
- Feeding Middlesex
- CFBNJ

- Elijah’s Promise
- RWJBH Corporate
- Suydam Street Reformed Church
- Share My Meals
- La Cocina 367

Additional Potential Partners for Priority 2 (will need to be distributed across appropriate objectives)

- Central Jersey Family Health Consortium
- CFBNJ- nutrition education, child nutrition, community nutrition, community connections
- Churches
- CINJ
- Family Success Centers
- Health Department (Diabetes)
- Hospitals
- Local non- profits and for-profits
- MEAL (Metuchen and Edison Assistance League)
- Meals on Wheels
- Middlesex County food pantries
- National School Lunch program
- RCDC
- Replenish
- Rutgers University Cooperative Extension
- Schools/afterschool programs
- SEED
- Senior Farmers Market
- Share My Meal
- SNAP
- WIC

Priority Area 3: Access to Healthcare

Chronic disease prevention and management was incorporated into this priority area, with chronic health conditions (diabetes, cancer, and heart disease) being named as the top community health concerns by respondents in the Community Health Survey. Those respondents also indicated that the top barriers to accessing medical care were (with Hispanic/Latino respondents reporting more barriers):

- Hard to schedule an appointment at a convenient time of day/evening/weekend (37.8%)
- Long wait times at doctor’s office or clinic (33.6%) and
- Doctors not accepting new patients (26.5%)

Goal 3: Everyone in Middlesex County can access quality care strengthened by equitable and inclusive healthcare policies, sustainable systems, and environments.

Objective 3.1: Increase interest in and opportunities for diverse community members to become employed in healthcare careers (primary and frontline care) through targeted education and recruitment.

Indicators

- Number of diverse community members participating in education/recruitment opportunities (i.e: Healthcare Hospitality)
- Number of education and recruitment opportunities

Draft Strategies

- 3.1.1 Conduct landscape analysis and compile inventory of healthcare pipeline programs that are available.
- 3.1.2 Develop communication strategy to inform key communities about available pipeline programs.
- 3.1.3 For pipeline programs, increase the breadth of healthcare areas that students are exposed to (recommendation- summer program).
- 3.1.4 Nurture and enhance relationships and collaboration with key institutions that offer pipeline programs to ensure sustainability.
- 3.1.5 Promote best practices for mentorship to increase learner retention.

Potential Partners

- Magnet school/tech school (all schools)
- Medical school/nursing schools
- Middlesex County College
- Hospital HR department recruiters
- Funders

Objective 3.2: Increase the cultural competency education and language capacity at hospital facilities.

Indicators

- Number of cultural competency trainings offered among RWJUH and SPUH/Healthier Middlesex
- Number of participants in cultural competency trainings
- Utilization rates of interpreters (MARTTI for RWJUH, and MARTII and Cyacom for SPUH)

Draft Strategies

- 3.2.1 Encourage/promote cultural competency best practices among ambulatory, outpatient, and EMT providers.
- 3.2.2 Encourage new signage in multiple languages when possible.
- 3.2.3 Develop materials for the community promoting the translation and interpretation services offered by the hospitals (i.e.: Cryacom, MARTII)
- 3.2.4 Increase the utilization rates of the translation and interpretation services available at both hospitals.
- 3.2.4 Increase skill-based recruitment and retention of diverse staff, including pastoral care, with an emphasis on native language proficiency and/or multilingual capacity.
- 3.2.5 Promote positions available in the hospitals to diverse local community members
- 3.2.6 Provide cultural competency trainings to staff members at SPUH and RWJUH, and track the numbers of people who have completed the training.

Potential Partners

- Funders
- Hospitals

Objective 3.3: Increase collaborative relationships among healthcare systems in Middlesex County to maximize resources and share best practices and policies for quality care.

Indicators

- Healthier Middlesex committee convened
- Best practices and policies identified

Draft Strategies

- 3.3.1 Conduct a stakeholder/resource analysis and build on provider strength/capacity to facilitate bringing CBOs/FBOs/partners together.
- 3.3.2 Convene a Healthier Middlesex committee to:
 - Identify common agendas/themes for collaboration and provide and elevate community voices in decision making.
 - Identify best practices for quality care to address the priority area.
 - Support data sharing to improve care coordination (policies).
 - Develop a shared document with statistics on best practices, resources, policies, etc.
- 3.3.3 Track and record the number of community groups, organizations, and/or agencies with which the hospitals (RWJUH and SPUH) collaborate on strategies related to access to care.
- 3.3.4 Increase the number or organizations we collaborate with in New Brunswick or greater Middlesex County by at least one per year.

Potential Partners

- Healthier Middlesex

Objective 3.4: Increase the percentage over baseline of the number of chronic disease identification screenings and referrals to prevention and treatment targeting those who are most at risk.

Indicators

- Number of screenings provided by Healthier Middlesex healthcare providers
- Number of abnormal biometrics
- Number of participants at Healthier Middlesex health education offerings
- Number of participants in self-management (chronic disease programs)

Draft Strategies

- 3.4.1 Collect baseline data among Healthier Middlesex providers.
- 3.4.2 Promote and provide community screenings in underserved areas by Healthier Middlesex providers.
- 3.4.3 Survey participants in chronic disease prevention and treatment programs to assess awareness of and barriers to participation in chronic disease prevention and treatment programs.
- 3.4.4 Customize promotional materials and develop strategies to address barriers to accessing chronic disease prevention and treatment resources from 3.4.3 survey.

Potential Partners

- Healthier Middlesex
- Middlesex County Office of Health Services

Objective 3.5: Increase awareness of healthcare and primary care services for the underserved population.

Indicators

- Number of community healthcare clinics
- Number of co-located services by facility
- Enrollment rates by navigators for care payment options (i.e., Medicaid, Charity Care, 340B, NJ CEED)
- Number of people successfully navigated into care payment options
- Utilization rate of Service Locator tool

Draft Strategies

- 3.5.1 Explore and share to Healthier Middlesex partners locations where multiple healthcare services are in one location (e.g., specialty care/ phlebotomy/ pharmacy 340B program).
- 3.5.2 Train navigators to educate patients about available resources and tools (e.g., Medicaid enrollment, Charity Care, 340B, NJ CEED).
- 3.5.3 Identify and provide care in safe spaces for immigrant communities.
- 3.5.4 Explore role and engagement of CHW's among Healthier Middlesex partner facilities.
- 3.5.5 Promote utilization of Service Locator tool.
- 3.5.6 Gap Analysis: Identify programs and services no longer available due to change in federal policy in the County.
- 3.5.7 Identify resources/grants or potential funding sources to fill program/service gaps identified.

Potential Partners

- FQHC- Eric B., JRF
- Middlesex County Office of Health Services
- Resource Management – Hospitals
- RWJUH – Community Health Workers

Objective 3.6: Provide chronic disease and other health-related education to community members.

Indicators

- Number of educational sessions offered
- Number of people in attendance at educational sessions
- Post-program or post-event feedback survey completed

Draft Strategies

- 3.6.1 Provide educational classes at Senior Centers and other locations around Middlesex County.
- 3.6.2 Provide educational sessions to the public about various chronic disease/health-related topics, offered by residents and other healthcare professionals.
- 3.6.3 Provide disease-specific educational sessions to underserved members of the community.
- 3.6.4 Provide and track health education curriculum provided to local schools.

Potential Partners

- Latino Diabetes Support Group
- RWJUH Community Health Education

- Rutgers Family Medicine
- RWJUH Family Planning Clinic
- Middlesex County Senior Centers
- Franklin Food Bank
- New Brunswick Schools (can name which ones)
- PRAB

Priority Area 4: Access to Social Services

While Middlesex County has many resources and collaborations, interview and focus group participants reported that barriers to accessing existing social services included: Language barriers, lack of awareness of available services to community, transportation challenges, long wait times, structural racism and community trust, fear, and a need for more navigation and connections across services.

Goal 4: Everyone in Middlesex County has equitable access to the culturally and linguistically comprehensive social services that fulfill their best quality of life.

Objective 4.1: Increase the accessibility and knowledge of currently available transportation resources for vulnerable populations.

Indicators

- Percentage of survey respondents who named transportation as a barrier.
- Percentage of need based on SDOH at hospitals
- Number of RIDE destinations at healthcare facilities, food pantries, social service offices (RIDE – Middlesex County)
- Percentage of rides from low-income communities (RIDE – Middlesex County)

Draft Strategies

- 4.1.1 Identify and catalog transportation resources currently available.
- 4.1.2 Promote the importance of providing transportation service information in diverse languages.
- 4.1.3 Recruit Middlesex DOT representation at Healthier Middlesex for regular meetings and updates.
- 4.1.4 Distribute transportation information via multiple media, including publishing on Consortium website and passing out hard copies at community sites.
- 4.1.5 Have contact information for transportation resources available at locations where population is congregated (e.g., faith communities, community centers, schools).
- 4.1.6 Address transportation barriers by implementing mobile clinics, Uber Health/ride share (NJ transit for busing to healthcare locations); offering home visits/telehealth services

Potential Partners

- CHWs
- KMM
- Middlesex County community organizations active in disaster (MC-COAD)
- Middlesex RIDE/ DOT

Objective 4.2: Enhance connections and collaboration among providers in the social service system to provide equitable and seamless access to services.

Indicators

- Metrics for improved service coordination including: frequency of inter-organizational meetings, amount of data sharing, amount of shared/pooled funding
- Number of Trainings for providers on SLT, My Chart*
- Number of providers trained

Draft Strategies

- 4.2.1 Develop content and key talking points for education campaign(s) for healthcare and social service providers, CBOs, frontline staff, etc. on what services are available and how to refer patients and users.
 - Potential action step: Coordinate with REPLENISH to attend their quarterly virtual meetings where they showcase various social services.
- 4.2.2 Provide training to organizations, healthcare and social service providers, CBOs, etc. on the Services Locator tool (e.g., My Chart* trainings, how to use it, how to send and receive referrals, how to find needed services) (see also 4.3.2).
- 4.2.3 Explore options and resources that can provide affordable existing translation and interpreting services and share with CBOs or other service providers within Healthier Middlesex (i.e., Rutgers Student translation services).
- 4.2.4 Provide/produce a member directory for Healthier Middlesex, including a description of services.
- 4.2.5 Encourage more collaboration among healthcare, housing/homeless and other basic needs providers by attending and participating in different communities' task forces.

Potential Partners

- County CBO's
- County HSAC
- Healthier Middlesex
- Mexican Consulate
- REPLENISH
- Rutgers

Objective 4.3: Increase the number of educational opportunities and types provided for community members that promote awareness of social service resources.

Indicators

- Number of education sessions
- Number of types of education/outreach (webinars, community lectures)
- Number of people attending
- Number of unique organizations tabling during hospitals food distribution days

Draft Strategies

- 4.3.1 Promote collection of data by service providers to capture how people learn about their services.
- 4.3.2 Work with schools and houses of worship to promote resources and provide information on how to access social services (see also: 4.2.2).
- 4.3.3 Track and record the number of unique organizations who table social service information during the SPUH Family Health Center Market distribution days and seek to bring new organizations who meet the needs of the population accessing the market.
- 4.3.4 Identify and engage trusted community agencies or individuals to host sessions for community education on key topics within the social determinants of health, such as tenants' issues and tenants' rights.
- 4.3.5 Distribute social services information via multiple media, including publishing on HM Consortium website and passing out at community sites.

Potential Partners

- 988

- Board of Social Services
- Catholic Charities
- Coming Home
- iRise/RCHP
- JRF
- KMM LCNJ
- LCCNJ
- Local Alliance
- Local Government
- MCCollege
- Middlesex Department- Office of Human Services
- NJ Citizen Action Committee
- Office of Aging
- Replenish
- RIDE/MC DOT
- RWJMS
- RWJUH (CHW/Your Health Kiosk), SPUH
- Schools
- Senior Centers
- Unity Square/ Catholic charities
- YMCA

Next Steps and Sustainability

The components included in this plan represent the strategic framework for a data-informed community health improvement plan (CHIP). Healthier Middlesex, including community partners, stakeholders, and community residents, will begin implementation of the CHIP by finalizing outcome indicators' baselines, targets, and data sources; prioritizing strategies; developing specific Year-1 action steps; assigning lead responsible parties; and identifying and securing resources for each priority area.

As this is a “living” document, Healthier Middlesex expects that information-gathering and sharing will be an ongoing process that will be facilitated by RWJUH New Brunswick and Saint Peter’s University Hospital during Plan implementation.

RWJUH New Brunswick and Saint Peter’s University Hospital will continue to hold meetings and provide quarterly updates to the Healthier Middlesex Consortium to monitor progress and address any challenges for CHIP implementation.

Appendices

Appendix A: Participants in the CHIP Process

| <i>Priority Area 1: Mental Health/Behavioral Health</i> | <i>Priority Area 2: Food Insecurity and Healthy Eating</i> |
|--|---|
| <i>Maria Pellerano Lisa Powell Charoulla Georgiou Mara Carlin Samantha Orefice Carolyn Timmons Karen Parry Elizabeth Caruso Maggie Luo Diana Starace Mohamed Ayad</i> | <i>Jennifer Apostol Nicole Correa John Dowd Allison Young Cecilia Gomez Jen Shukaitis Heather Kizner-Kagedan Tomiko Hackett Rosela Roman Lella Smith Manuel Castaneda Laila Cane Ishani Ved</i> |
| <i>Priority Area 3: Chronic Disease Prevention/Management</i> | <i>Priority Area 4: Access to Services</i> |
| <i>Mariam Merced Jaime Rivello Lisa DiGiovanni Jharline Iglesias Camilla Comer-Carruthers Loretta Kelly Vanita Tulski Eric Jahn Brittany Wooden Tamesha Owens Lisa Cheng Hiral Shukla Robin Krippa</i> | <i>Michael Davidson Jeanne Swain Christopher Gonda Melissa Bellamy Susan Giordano Deborah Morgan Nuris Rodriguez-Pabon</i> |

HRiA Facilitators

*Donna Burke
 Eliza Campbell*

*Rose Swensen
 Julia Taylor*

Appendix B: Acronyms

| | |
|-----------|--|
| CBO | Community Based Organizations |
| CFBNJ | Community Food Bank of New Jersey |
| CINJ | Cancer Institute of New Jersey |
| CHIP | Community Health Improvement Plan |
| CHW | Community Health Worker |
| CHNA | Community Health Needs Assessment |
| NJ DOT | New Jersey Department of Transportation |
| ED | Emergency department |
| EMT | Emergency Medical Technicians |
| FQHC | Federally Qualified Health Center |
| HR | Human Resources |
| HSAC | Human Services Advisory Councils |
| HVIP | Hospital-Based Violence Intervention Program |
| IRS | Internal Revenue Service |
| JRF | Jewish Renaissance Foundation Community Health |
| KMM | Keep Middlesex Moving |
| LSCNJ | Legal Services of Central New Jersey |
| LGBTQ/IA+ | Lesbian, gay, bisexual, transgender, transsexual, queer, intersex, asexual, and others |
| MAPP | Mobilization for Action through Planning and Partnerships |
| MC-COAD | Middlesex County Community Organizations Active in Disaster |
| MEAL | Metuchen and Edison Assistance League |
| MHFA | Mental Health First Aid |
| NAMI | National Alliance on Mental Illness |
| NJ | New Jersey |
| NJ CEED | New Jersey Cancer Early Education and Early Detection |
| PAAR | Pittsburgh Action Against Rape |
| PHAB | Public Health Accreditation Board |
| QPR | Question, Persuade, Refer |
| RCDC | Regional Chronic Disease Coalition |
| RCHP | Reformed Church of Highland Park (Affordable Housing Corporation) |
| RWJMS | Robert Wood Johnson Medical School |
| RWJUH | Robert Wood Johnson University Hospital |
| SIP | Strategic Implementation Plan |
| SLT | Middlesex County Service Locator Tool |
| SM | Social Media |
| SNAP | Supplemental Nutrition Assistance Program |
| SPUH | Saint Peter's University Hospital |
| UBHC | Rutgers University Behavioral Health Care |
| WIC | Special Supplemental Nutrition Program for Women, Infants, and Children |

Appendix C: Planning Definitions

| | Planning Definitions | Probing Questions |
|-------------------|--|--|
| GOAL | <ul style="list-style-type: none"> • A goal is a broadly stated, non-measurable change in a priority. • It describes in broad terms a desired outcome of the planning initiative. • Characteristics of Goals <ul style="list-style-type: none"> – Global in nature; provide general direction – Non-specific – Non-measurable; cannot be quantified – Long-term – Can be lofty and idealistic, as it is not necessary that a goal be reached during a specific time frame | <p>a. What is the desired state or outcome for this priority area?</p> |
| OBJECTIVES | <ul style="list-style-type: none"> • Objectives state how much of what you hope to accomplish and by when; usually start with INCREASE, DECREASE, ENHANCE, IMPROVE... • Are SMART/SMARTIE: <ul style="list-style-type: none"> <u>Specific</u>: Does it clearly state what will be achieved? <u>Measurable</u>: Is it measurable? How will I know when it is accomplished? <u>Achievable</u>: Is it action-oriented and attainable? <u>Realistic</u>: Is it realistic with the resources you have? <u>Time-bound</u>: When will it be achieved? <u>Inclusive</u>: Brings traditionally marginalized people—particularly those most impacted—into processes, activities, and decision/policy-making in a way that shares power <u>Equitable</u>: Seeks to address systemic injustice, inequity, or oppression <p>GOALS and OBJECTIVES describe the “WHAT” of your plan. GOALS are broad and OBJECTIVES lend specificity and precision to the goal.</p> | <p>a. What do we mean by this goal area? How would we break it down into its three most important parts? Or what are the three biggest ideas that feed into this goal statement?</p> <p>b. It can help to literally break the goal statement out into clauses and ask: What do we mean by this clause? What are we trying to achieve here?</p> |
| INDICATORS | Measure(s) of progress or completion of an objective. They describe the baseline and target values for each objective based on data that are relevant and available. | |
| STRATEGIES | <ul style="list-style-type: none"> • Strategies are: <ul style="list-style-type: none"> – Specific ways to meet each of the objectives – An approach to getting things done – a statement of HOW an objective will be achieved – Something that identifies the general direction of the specific action steps • Strategies begin with words such as “identify,” “advocate for,” “support,” “develop,” “train” and “educate.” | <p>a. What do we need to do to achieve this objective?</p> <p>b. Will these strategies, when combined, fulfill our objective and goal?</p> |

Appendix D: RWJUH Strategic Implementation Plan (SIP) Focus Areas

| Priority Area 1: Mental Health & Behavioral Health | | | |
|--|-----------------|---------------|----------------------------|
| Goal 1: Middlesex County prioritizes behavioral health and well-being in an equitable and culturally responsive manner. | | | |
| Indicators | Baseline | Target | Reporting Mechanism |
| Number of classes, workshops, events, campaigns, or trainings provided related to MH/BH | TBD | | |
| Number of people (residents and providers / organizational stakeholders) reached through classes, workshops, events, campaigns, or trainings related to MH/BH | TBD | | |
| Number of Healthier Middlesex website/Su Salud social media hits | TBD | | |
| Number of non-traditional spaces engaged (e.g., faith-based, libraries, community centers, senior centers) | TBD | | |
| Number of hospital-supported peer support groups offered and promoted (i.e., LGBTQ support groups in English and Spanish, NA groups offered at F&W, AA en Español invited to health fairs) | TBD | | |
| Number of community groups, organizations, or agencies collaborating in MH/BH strategies | TBD | | |

| Priority Area 1: Mental Health & Behavioral Health | | | | | |
|--|--|------------------------------|-------------------------------|------------------------|-----------------------------|
| Goal 1: Middlesex County prioritizes behavioral health and well-being in an equitable and culturally responsive manner. | | | | | |
| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
| Objective 1.1: Increase access dissemination points for behavioral health information and resources for youth, immigrants, older adults, and providers. | | | | | |
| Work with collaborative partners to organize existing resources into a standard list inclusive of key populations that catalog clinical services as well as community and peer supports. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time | | |
| Identify and outreach to venues in non-traditional spaces (e.g. libraries, faith-based, fairs, town events, provider offices, schools, food pantries) to discuss options for providing information on behavioral health resources. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion | | |

Priority Area 1: Mental Health & Behavioral Health

Goal 1: Middlesex County prioritizes behavioral health and well-being in an equitable and culturally responsive manner.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|--|--|------------------------------|---|------------------------|-----------------------------|
| Develop informational materials on behavioral health at appropriate literacy level that can be shared in plain and multiple languages and modalities (e.g., video clips, brochures, infographics). | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Disseminate resources digitally and via hard printed copies. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Objective 1.2: Expand mental health prevention and evidence-based educational programming for non-clinical, community-based care providers (e.g., clergy, school personnel, social service providers). | | | | | |
| Survey, identify and prioritize top 3 topical areas for skill-building on behavioral health. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Materials | | |
| Identify current and potential partners and champions and promote the programs they provide related to the identified topical areas (e.g., Rutgers School of Social Work trauma-informed training, school-based programs). | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion | | |
| Provide trainings to community-based partners on evidence-based approaches to mental and behavioral health (e.g., coping skills, Mental Health First Aid, QPR, Narcan training). | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Materials | | |

Priority Area 1: Mental Health & Behavioral Health

Goal 1: Middlesex County prioritizes behavioral health and well-being in an equitable and culturally responsive manner.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|--|--|------------------------------|---|------------------------|-----------------------------|
| Support ongoing recruitment, promotion, and follow-up for trainings. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Materials | | |
| Objective 1.3: Offer mental and behavioral health-related trainings and education sessions to Middlesex County community members. | | | | | |
| Utilizing the CHNA and other resources, identify mental/behavioral health topics affecting Middlesex County community members. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Materials | | |
| Identify mental health specialists who can offer trainings about such topics for the community. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time -Promotion | | |
| Offer at least three trainings free and open to anyone in the community who is interested. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Work with local partners such as NAMI/NAMI en Español to offer additional workshops to community members. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| RWJUH Community Health Education will offer at least one health talk per year in partnership with Rutgers Family Medicine about mental/behavioral health-related topics. | -Community Health (Mahwish Chishti) -Rutgers Family Medicine | Y1-Y3 | -Staff time -Promotion -Educational materials | | |

Priority Area 1: Mental Health & Behavioral Health

Goal 1: Middlesex County prioritizes behavioral health and well-being in an equitable and culturally responsive manner.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|--|--|-----------------------|---|-----------------|----------------------|
| RWJUH Hospital Violence Intervention Program staff will offer support to traumatically injured victims of violence as well as education and workshops about violence prevention to partners/community members. | -Community Health (Elaine Hewins) -PRAB -Trauma Dept | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Objective 1.4: Track and increase the number of community groups, organizations, and/or agencies with which the hospital collaborates to implement strategies related to mental/behavioral health/wellness. | | | | | |
| Track and record the number of community groups, organizations, and/or agencies with which the hospital collaborates on strategies related to mental/behavioral health/wellness. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time | | |
| Increase the number or organizations they collaborate with in New Brunswick or greater Middlesex County by at least one per year. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time -Promotion | | |

Priority Area 1: Mental Health & Behavioral Health
Goal 1: Middlesex County prioritizes behavioral health and well-being in an equitable and culturally responsive manner.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|--|-----------------------|-----------------------|------------------------|-----------------|-------------------------|
| Current and Potential Partners | | | | | Partners Engaged |
| <ul style="list-style-type: none"> • PRAB HVIP Counseling Services • NAMI • NAMI- NJ • Rutgers University • Rutgers Medical School • UBHC • Wellspring Center for Prevention • Hospitals (SPUH, Hackensack Meridian) • Caritas Counseling Services, Sacred Heart Catholic Church • Princeton House • Middlesex County Behavioral Health • RWJBH Institute for Prevention and Recovery • RWJUH Pride Center • Alcoholics Anonymous en Español • MHFA | | | | | |

Priority Area 2: Healthy Eating/Food Security
Goal 2: Everyone in Middlesex County has reliable and convenient access to healthy and culturally appropriate food and resources to feed themselves and their families.

| Indicators | Baseline | Target | Reporting Mechanism |
|---|-----------------|---------------|----------------------------|
| Number of people screened for food insecurity in hospital and community settings & referred to related services | TBD | | |
| Amount of food distributed to those in need at RWJUH facility (Maternal Wellness Pantry, Common Market boxes, Share My Meals, etc.) | TBD | | |
| Number of healthy eating-related classes, workshops, events, or campaigns provided | TBD | | |
| Number of people reached through healthy eating-related classes, workshops, events, or campaigns | TBD | | |
| Number of community groups, organizations, or agencies collaborating in food-related strategies | TBD | | |

Priority Area 2: Healthy Eating/Food Security
Goal 2: Everyone in Middlesex County has reliable and convenient access to healthy and culturally appropriate food and resources to feed themselves and their families.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|---|--|------------------------------|---|------------------------|-----------------------------|
| Objective 2.1: Increase opportunities for people to enhance their knowledge and confidence about making healthy food choices. | | | | | |
| Identify the areas most vulnerable for chronic health conditions (i.e., high diabetes rates, high obesity rates) and offer healthy eating educational programs to community residents. | -Community Health -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Host a minimum of five culturally appropriate workshops focused on topics such as: -Food storage/preparation -Food demonstrations -Food label education -Food/vegetables/fruits people are not accustomed to eating/buying -Modification of dishes (swapping ingredients) Keep in mind food literacy and reading level. | -Community Health -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Objective 2.2: Support food assistance services and expand access to these services whenever possible. | | | | | |
| Track the number of individuals and families served at hospital's pantry, and increase this number if resources allow. | -Community Health -Corporate | Y1-Y3 | -Staff time -Materials | | |

Priority Area 2: Healthy Eating/Food Security

Goal 2: Everyone in Middlesex County has reliable and convenient access to healthy and culturally appropriate food and resources to feed themselves and their families.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|---|--|-----------------------|---|-----------------|----------------------|
| Track and report on the number of pounds of food distributed total each month at the hospital's pantry, and increase this number if resources allow. | -Community Health -Corporate | Y1-Y3 | -Staff time -Materials | | |
| Track and report the number of how many people served feminine hygiene/baby products distributed by each hospitals' pantries and increase this number if resources allow. | -Community Health -Corporate | Y1-Y3 | -Staff time -Materials | | |
| Track and report on the total number of Common Market/fresh produce boxes distributed annually. | -Community Health -Corporate | Y1-Y3 | -Staff time -Materials | | |
| Track and report on any other supplemental food distributed and to whom it is going. | -Community Health -Community Partners | Y1-Y3 | -Staff time -Materials | | |
| Objective 2.3: Reduce food waste by increasing the number of meals recovered by 5% annually through Share My Meals. | | | | | |
| Track and report on total number of meals recovered and distributed with Share My Meals partnership. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time | | |
| Objective 2.4: Increase the number of people screened for food insecurity and referred to services. | | | | | |
| Create survey for use in screening for food security in partner community settings. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Identify potential programs and settings for community screening with a focus on in-need zip codes. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion | | |

Priority Area 2: Healthy Eating/Food Security
Goal 2: Everyone in Middlesex County has reliable and convenient access to healthy and culturally appropriate food and resources to feed themselves and their families.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|---|--|-----------------------|---|-----------------|----------------------|
| Promote the importance of food security screening to community organizations working in the community. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Develop and distribute survey to partners for use in identified community programs and settings. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Engage SNAP Navigators to assist with community screening and referrals. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion | | |
| Collect data on hospital and community screenings done and referrals provided. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion | | |
| Objective 2.5: Track and increase the number of community groups, organizations, and/or agencies with which the hospital collaborates to implement strategies related to healthy eating/food insecurity. | | | | | |
| Track and record the number of community groups, organizations, and/or agencies with which the hospital collaborates on strategies related to healthy eating/food insecurity. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time | | |
| Increase the number or organizations we collaborate with in New Brunswick or greater Middlesex County by at least one per year. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time | | |

Priority Area 2: Healthy Eating/Food Security

Goal 2: Everyone in Middlesex County has reliable and convenient access to healthy and culturally appropriate food and resources to feed themselves and their families.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|--|---|-----------------------|------------------------|-----------------|-------------------------|
| RWJUH CHPP/Healthier Middlesex staff will attend at least 10 Feeding New Brunswick meetings per year. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time | | |
| Current and Potential Partners | | | | | Partners Engaged |
| <ul style="list-style-type: none"> • REPLENISH • Healthier Middlesex • Feeding New Brunswick Network • Feeding Middlesex • CFBNJ • Elijah's Promise • RWJBH Corporate • Suydam Street Reformed Church • Share My Meals • Central Jersey Family Health Consortium • CFBNJ- nutrition education, child nutrition, community nutrition, community connections • Churches • CINJ • Family Success Centers • Health Department (Diabetes) • Hospitals (SPUH, Hackensack Meridian) • Local non- profits and for-profits • MEAL (Metuchen and Edison Assistance League) • Meals on Wheels • Middlesex County food pantries • National School Lunch program • RCDC • Rutgers University Cooperative Extension • Schools/afterschool programs • SEED • Senior Farmers Market • SNAP • WIC | | | | | |

Priority Area 3: Healthcare Access/Chronic Disease Prevention & Management, and Access to Social Services
Goal 3: Everyone in Middlesex County can access quality care strengthened by equitable and inclusive healthcare policies, sustainable systems, and environments.

| Indicators | Baseline | Target | Reporting Mechanism |
|--|----------|--------|---------------------|
| Number of classes, workshops, events, or campaigns provided related to chronic disease and their risk factors | TBD | | |
| Number of people reached through classes, workshops, events, or campaigns related to chronic disease and their risk factors | TBD | | |
| Number of people tested or screened in the community for chronic disease-related conditions and referred to healthcare services based on screening | TBD | | |
| Number of education and recruitment opportunities and number of diverse community members participating in education/recruitment opportunities (i.e: Healthcare Hospitality) | TBD | | |
| Number of community groups, organizations, or agencies collaborating in addressing health care access, social service access, & chronic disease-related strategies, including the social determinants of health driving these issues | TBD | | |
| Number of people screened as needing transportation. | TBD | | |
| Number of rides provided by RWJUH using Uber Health. | TBD | | |

Priority Area 3: Healthcare Access/Chronic Disease Prevention & Management, and Access to Social Services
Goal 3: Everyone in Middlesex County can access quality care strengthened by equitable and inclusive healthcare policies, sustainable systems, and environments.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|---|---|-----------------------|------------------------|-----------------|----------------------|
| Objective 3.1: Increase interest in and opportunities for diverse community members to become employed in healthcare careers (primary and frontline care) through targeted education and recruitment. | | | | | |
| Conduct landscape analysis and compile inventory of healthcare pipeline programs that are available. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time | | |
| Develop communication strategy to inform key communities about available pipeline programs. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time | | |

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| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|---|--|-----------------------|---|-----------------|----------------------|
| For pipeline programs, increase by one per year the breadth of healthcare areas that students are exposed to (recommendation-summer program). | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion | | |
| Nurture and enhance relationships and collaboration with key institutions that offer pipeline programs to ensure sustainability. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion | | |
| Promote best practices for mentorship to increase learner retention. | -Community Health -Community partners | Y1-Y3 | -Staff time -Promotion | | |
| Objective 3.2: Increase the cultural competency education and language capacity at hospital facilities. | | | | | |
| Encourage/promote cultural competency best practices among ambulatory, outpatient, and EMT providers. | -Community Health -Other RWJUH Departments | Y1-Y3 | -Staff time -Promotion | | |
| Encourage new signage in multiple languages when possible. | -Community Health -Other RWJUH Departments | Y1-Y3 | -Staff time -Promotion -Materials | | |
| Develop materials for the community promoting the translation and interpretation services offered by the hospitals (i.e. MARTII) | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Increase the utilization rates of the translation and interpretation services available RWJUH. | -Community Health -Other RWJUH Departments | Y1-Y3 | -Staff time -Promotion | | |

Priority Area 3: Healthcare Access/Chronic Disease Prevention & Management, and Access to Social Services
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| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|--|--|------------------------------|---|------------------------|-----------------------------|
| Whenever possible, increase skill-based recruitment and retention of diverse staff, including pastoral care, with an emphasis on native language proficiency and/or multilingual capacity. | -Community Health -Other RWJUH Departments | Y1-Y3 | -Staff time | | |
| Promote positions available in the hospitals to diverse local community members. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time -Promotion | | |
| Provide cultural competency trainings to staff members RWJUH and track the numbers of people who have completed the training. | -Community Health -Human Resources | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Objective 3.3: Increase the percentage over baseline of the number of chronic disease identification screenings and referrals to prevention and treatment targeting those who are most at risk. | | | | | |
| Promote and provide community screenings in underserved areas. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Materials | | |
| Survey/talk to participants in chronic disease prevention and treatment programs to assess awareness of and barriers to participation in chronic disease prevention and treatment programs. | -Community Health | Y1-Y3 | -Staff time -Promotion | | |
| Develop strategies to address those barriers to accessing chronic disease prevention and treatment resources. | -Community Health -Community partners | Y1-Y3 | -Staff time -Promotion | | |
| Promote the use of MyChart for RWJUH patients and community members. | -Community Health -Community partners | Y1-Y3 | -Staff time -Promotion | | |
| Objective 3.4: Increase awareness of healthcare and primary care services for the underserved population. | | | | | |

Priority Area 3: Healthcare Access/Chronic Disease Prevention & Management, and Access to Social Services
Goal 3: Everyone in Middlesex County can access quality care strengthened by equitable and inclusive healthcare policies, sustainable systems, and environments.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|--|--|------------------------------|---|------------------------|-----------------------------|
| Train navigators to educate patients about available resources and tools (e.g., Medicaid enrollment, Charity Care, 340B, NJ CEED). | -Community Health -Community Health Worker Initiative -Health Navigators | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Identify and provide care in safe spaces for immigrant communities. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Materials | | |
| Gap Analysis: Identify programs and services no longer available due to change in federal policy in the County. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time | | |
| Identify resources/grants or potential funding sources to fill program/service gaps identified. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time | | |
| Objective 3.5: Provide chronic disease and other health-related education to community members. | | | | | |
| Provide educational classes at Senior Centers and other locations around Middlesex County. | -Community Health -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Provide educational sessions to the public about various chronic disease/health-related topics, offered by residents and other healthcare professionals. | -Community Health -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Provide disease-specific educational sessions to underserved members of the community. | -Community Health -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |

Priority Area 3: Healthcare Access/Chronic Disease Prevention & Management, and Access to Social Services
Goal 3: Everyone in Middlesex County can access quality care strengthened by equitable and inclusive healthcare policies, sustainable systems, and environments.

| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|--|---|------------------------------|---|------------------------|-----------------------------|
| Provide and track sex education curriculum with local schools. | -Community Health -Family Planning Clinic -Community partners (local schools) | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Objective 3.6: Increase the accessibility and knowledge of currently available transportation resources for vulnerable populations. | | | | | |
| Identify and catalog transportation resources currently available. | -Community Health -Healthier Middlesex staff | Y1-Y3 | -Staff time | | |
| Distribute transportation information via multiple media, including publishing on Consortium website and Su Salud Facebook page, and passing out hard copies at community sites. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Educational materials | | |
| Have contact information for transportation resources available at locations where population is congregated (e.g., faith communities, community centers, schools). | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Materials | | |
| Objective 3.7: Promote programs available through social service agencies that can enhance quality of life for RWJUH patients and community members. | | | | | |
| Work with schools and houses of worship to promote resources and provide information on how to access social services. | -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | -Staff time -Promotion -Materials | | |

Priority Area 3: Healthcare Access/Chronic Disease Prevention & Management, and Access to Social Services
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| Strategies/Initiatives | Person(s) Responsible | Timeline (Y1, Y2, Y3) | Hospital Contribution* | Other Resources | Successes/Challenges |
|---|--|------------------------------|---|------------------------|-----------------------------|
| Distribute social services information via multiple media, including publishing on Su Salud website, and passing out at community sites/events. | <ul style="list-style-type: none"> -Community Health -Healthier Middlesex staff -Community partners | Y1-Y3 | <ul style="list-style-type: none"> -Staff time -Promotion -Educational materials | | |

| Current and Potential Partners | Partners Engaged |
|---|------------------|
| <ul style="list-style-type: none"> • Magnet school/tech school (all schools) • Middlesex County College • Hospital HR Department • Funders • Middlesex County Office of Health Services • FQHC- Eric B. Chandler, JRF • Middlesex County Office of Health Services • Resource Management – Hospitals • RWJUH – Community Health Workers • Latino Diabetes Support Group • RWJUH Community Health Education • Rutgers Family Medicine • RWJUH Family Planning Clinic • Middlesex County Senior Centers • Franklin Food Bank • New Brunswick Schools • PRAB • 988 • Board of Social Services • Unity Square / Catholic Charities • Coming Home • iRise/RCHP • JRF • KMM LCNJ • LCCNJ • YMCA • Local Government • Middlesex County College • Middlesex Department- Office of Human Services • NJ Citizen Action Committee • Office of Aging • REPLENISH • RIDE/MC DOT • RWJMS • Nursing Schools • Senior Centers | |