2022-2024 Somerset County Community Health Improvement Plan

PREPARED BY
HEALTH RESOURCES IN ACTION

Robert Wood Johnson University Hospital Somerset | RWJBarnabas HEALTH

Healthier SOMERSET

Acknowledgements

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

Healthier Somerset Member Organizations	
AARP NJ	Franklin Township MacAfee School
Adult Day Center of Somerset County	Franklin Township Parks & Rec
Affinity Credit Union	Greater Somerset County YMCA - Hillsborough
Allied Wealth Partners	Greater Somerset County YMCA - Somerset Hills
Allstate	Greater Somerset County YMCA - Somerville
Alternatives, Inc.	Greater Somerset County YMCA Association
American Heart Association	Greater Somerset Public Health Partnership
American Lung Association	Green Brook Township Public Schools
Bernards High School	Green Brook Township
Bernards Township	Healthier Middlesex
Bernards Township Health Department	High Focus Centers Branchburg
Bonnie Brae	Hillsborough Ag Adv.
Bound Brook	Hillsborough BOE
Branchburg Health Department	Hillsborough Township
Brandywine Living at Middlebrook Crossing	Hillsborough Township Public Schools
Bridgewater Raritan Regional School District	Hope Street
Bridgewater Township	Horizon Blue Cross Blue Shield of New Jersey
Bridgeway	Horizon Blue Cross Blue Shield
Bridgeway Rehab	Horizon NJ Health
Brother International	Housing and Community Development Network of New Jersey
Building Bridges to Better Health	IHN
CrossRoads4Hope	IMH Stigma Free N Plainfield
Center For Neuro Muscular Therapy	Jewish Family Services
Centerpath Wellness	Johnson & Johnson
Central Jersey Family Health Consortium	LifeCamp
Comfort Keepers	Literacy Volunteers of Somerset County
Community in Crisis	Manville School District
Community Visiting Nurse Assocation	March of Dimes
Courier News	Marriott
Duke Farms	Matheny
EmPoWER Somerset	Mental Health Directs
EOS Partners	MHANJ
Epiphany Community Services	Middle Earth
Feeding Hands	Middle-Brook Regional Health Commission
Final Touch Plantscaping	Middlebush Reformed Church & Church Based Mental Health Services
Franklin Township Clarement Elementary School Nurse	NAMI Somerset
Franklin Township Elizabeth Avenue School	Natural Medicine & Rehabilitation

Healthier Somerset Member Organizations	
New Jersey Health Initiatives	Somerset County Department of Health
Nicotine Anonymous	Somerset County Department of Human Services
NJ Center for Tourette Syndrome & Associated Disorders	Somerset County Freeholders
North Plainfield	Somerset County Library System of New Jersey
Norz Hill Farm	Somerset County Office on Aging & Disability Services
OFS Fitel	Somerset County Park Commission
Ortho Clinical Diagnostics	Somerset County Planning Board
Peapack-Gladstone Bank	Somerset County Department of Public Works
Perkins Partnership	Somerset County Prosecutor's Office
Prestige Medical Solutions	Somerset County Public Health and Safety /Emergency Management
Profile Plan	Somerset County Public Information
Raritan Valley Habitat for Humanity	Somerset County Richard Hall
RideWise, Inc.	Somerset County School Nurses Association
Right At Home Home Care	Somerset County Youth Services
Rock Steady Boxing	Somerset IFSS
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Somerset County Health Officers Association	
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Bernards Township Health Department	Middle-Brook Regional Health Commission
Branchburg Health Department	Montgomery Health Department

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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 Somerset, part of RWJBarnabas Health, in collaboration with Healthier Somerset led a comprehensive community health improvement effort to measurably improve the health of Somerset 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 Somerset 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 Somerset 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 *2022-2024 Somerset County Community Health Improvement Plan* was developed over the period of March to October 2021, 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. Of note, all engagement for the CHNA and CHIP was done virtually due to the novel coronavirus-COVID-19 pandemic.

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

- Healthier Somerset: The Healthier Somerset Coalition members, including key members of the Data and Planning Subcommittees, 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.

- Somerset County Community: Somerset County residents were engaged in data collection during the CHNA process and provided input on priorities through the Somerset CHNA Community Survey. Healthier Somerset 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 Somerset coalition members and community members used common criteria and a multi-voting process to identify the following priority health issues to address in the CHIP:

- Priority Area 1: **Behavioral Health (Mental Health & Substance Use)**
  Goal 1: Prioritize mental health and substance use programing that is equitable and available without fear or judgment throughout Somerset County.

- Priority Area 2: **Chronic Disease with a Focus on Healthy Eating & Active Living (HEAL)**
  Goal 2: Ensure all residents have equitable access to education and resources to promote healthy eating and active living and to prevent and manage chronic disease.

- Priority Area 3: **Economic Wellbeing**
  Goal 3: Address the root causes of economic disparities in Somerset County so all have equitable access to economic opportunities and sustainable financial security.

- Priority Area 4: **Access to Services**
  Goal 4: Ensure residents have access to affordable, equitable, and high quality services where they are treated with dignity and respect in order to improve health and thrive in the communities they call home.

Initially, addressing systemic racism, racial injustice, and discrimination was identified as a priority area, but planning participants elected to integrate this priority as a cross-cutting theme in the CHIP. These issues have been identified as key focal points for integration across all the priority areas in the plan and are incorporated into each priority through related strategies.

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 (RWJUH) Somerset**, part of **RWJBarnabas Health**, in partnership with the **Healthier Somerset Coalition**, led its fourth comprehensive community health improvement process to measurably enhance the health of the communities it serves in Somerset County, New Jersey (NJ).

The Healthier Somerset Coalition was created in 2010 to convene a broad cross-section of organizations to improve the health and well-being of those who live and work in Somerset County, NJ. The Coalition facilitates the collaboration and partnership of over 60 organizations including representatives from businesses, local government, non-profit organizations, and social service agencies.

In early 2021, RWJUH Somerset contracted with Health Resources in Action (HRiA), a non-profit public health consultancy located in Boston, MA, to provide support and help facilitate its Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) processes. HRiA worked closely with RWJUH Somerset and the Healthier Somerset Coalition to develop the Somerset County CHIP. This effort included two major phases:

1. A community health needs assessment (CHNA) to identify the health-related needs and strengths of Somerset County through comprehensive data collection and analysis.
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 Somerset 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 Somerset, the CHNA and the hospital-based strategic implementation plan (SIP) are required to maintain nonprofit status with the Internal Revenue Service (IRS), form 990, and deliver community-based programming that is well aligned with and informed by community needs. The CHNA and CHIP are also required for Somerset County health departments to earn 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
- Outline an implementation and improvement plan with performance measures for monitoring and evaluation
- Guide future community decision-making related to community health improvement

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

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 Somerset 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. See Appendix D for RWJUH Somerset's specific role in implementing this CHIP.

Relationship Between the CHIP and Other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the health of Somerset County. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP planning process identified potential partners and resources wherever possible for inclusion in this CHIP.

Context for the Community Health Improvement Plan

COVID-19 Pandemic

The novel coronavirus (COVID-19) pandemic coincided with the activities of the 2021 Somerset County CHNA and CHIP. In March 2021, at the beginning of this CHNA process, the COVID-19 pandemic had already been in effect for over a year. Logistically, the pandemic impacted the feasibility of convening in-person groups for the CHNA and CHIP (e.g., subcommittees, focus groups, etc.) and the availability of key stakeholders and community members to participate in CHIP activities, given their focus on addressing immediate needs. Consequently, all data collection and engagement occurred in a virtual setting (e.g., telephone or video focus groups, interviews, planning sessions), and therefore engagement of residents and stakeholders was challenging.

National Movement for Racial Justice

Over the past year, sparked by the national protests for racial equity amidst the killings of George Floyd, Ahmaud Arbery, Breonna Taylor, Tony McDade, and many others, national attention focused on how racism is embedded in every system and structure of our country, including housing, education, employment, and healthcare. This context impacted the content of the CHNA and CHIP, including the design of data collection instruments and the input that was shared during interviews and focus groups. While racism and oppression have persisted in this country for over 400 years, it is important to acknowledge the recent focus on these issues in 2021 in the form of increased dialogue, locally and nationally, as context for this assessment and plan.

Community Engagement

To develop a shared, sustainable plan for improved community health, RWJUH Somerset and the Healthier Somerset Coalition led the assessment and planning process by engaging community members and local public health partners through different avenues.

Community Engagement Approach

The CHNA identified health needs and strengths in Somerset County by utilizing a variety of data collection methods including qualitative interviews and focus groups with residents, a community survey, and reviewing existing data on social, economic, and health indicators in Somerset County. Similar to the process for the CHNA, the CHIP utilized a participatory, collaborative approach. The CHIP process was guided by the Healthier Somerset Coalition and its two subcommittees (Data and Planning Subcommittees), the RWJBH Systemwide CHNA Steering Committee, and the Somerset County community overall.

Healthier Somerset Engagement

The Planning Subcommittee of the Healthier Somerset Coalition met four times virtually during May to September 2021 to provide input on the planning process including affirming guiding principles, mission, and vision, guiding outreach and engagement of community members, and utilizing CHNA data to inform and determine community health priorities. Members of both the Data and Planning subcommittees also provided outreach support for HRiA to connect with stakeholders and specific population groups. Additionally, members of both subcommittees participated in community prioritization.

Somerset Community Engagement

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

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 below that were used to guide prioritization discussions and voting processes.

Prioritization Criteria

- **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?

Development of Data-Informed, Community-Identified Health Priorities

Priorities for the community health improvement plan (CHIP) were identified by examining data and themes from the CHNA findings using a systematic, engaged approach.

Issues and Themes Identified in the Community Health Needs Assessment

On September 9, 2021, The CHNA-CHIP Data and Planning Subcommittees of the Healthier Somerset Coalition reviewed preliminary findings of the 2021 Somerset County CHNA. 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 priorities emerged for Somerset County including:

- Coronavirus/COVID-19 (specifically related to testing, transmission, disease mitigation, etc.)
- Financial Insecurity/Unemployment
- Housing
- Transportation
- Systemic Racism, Racial Injustice & Discrimination
- Mental Health
- Alcohol & Substance Use
- Chronic Disease
- Access to Services

Process to Set CHIP Health Priorities

Facilitators used a multi-voting process to identify the most important public health issues for Somerset County from the list of major themes identified from the CHNA. During the joint meeting of the CHNA-CHIP Data and Planning Subcommittees, participants were divided into small groups to discuss the data and their own perspectives on the health priorities facing their communities. Additionally, participants were given a prioritization matrix tool so that they could rate the nine health issues on how they met the prioritization criteria (Burden, Equity, Impact, Systems Change, Feasibility, Collaboration/Critical Mass, Significance to Community). The tool allowed users to rate each of the issues as 1=low, 2=medium, 3=high, or 4=very high for each of the criteria and tally the total to help participants rank issues against one another. See Appendix B for the prioritization tool. See Appendix A for a list of planning participants.

At the end of the meeting, using an 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 twenty coalition subcommittee members voted during the Community Prioritization Meeting. Voting identified that seven of the nine issues ranked closely together:

Health Issue	Voting Results	
Systemic Racism, Racial Injustice, and Discrimination	60%	12/20
Financial Insecurity/Unemployment	60%	12/20
Transportation	55%	11/20
Mental Health	50%	10/20
Access to Services	50%	10/20
Chronic Disease	45%	9/20
Housing	45%	9/20

Refining Health Priorities

As part of the pre-planning orientation meeting on October 5, 2021, planning participants, made up of Healthier Somerset Coalition members and community members, met virtually to discuss CHNA findings and the outcome of the previous prioritization meeting that was held for the Data & Planning Subcommittees. The goal of this meeting was to refine and narrow priorities into four priority areas in order to create a manageable scope for the CHIP.

After a brief data presentation that reviewed CHNA key findings and results of the previous meeting, participants were divided into small groups to discuss if the findings were consistent with their experiences in Somerset County, and consider the following four questions to help further refine priorities:

A. Should Systemic Racism, Racial Injustice, and Discrimination be its own priority area, or should it be integrated across ALL priorities of the plan?
B. Would you be in favor of combining Access to Health Care and Transportation under one priority?
C. Would you be in favor of combining Mental Health and Substance Use under one priority?
D. Would you like to keep Chronic Disease broadly focused as a priority, or focus specifically on Healthy Eating and Active Living (HEAL)?

Participants were asked to submit individual responses to the questions above based on their discussion, personal viewpoint, and the prioritization criteria using an online polling tool. A total of 36 individuals responded to prioritization question A and 38 individuals responded to questions B, C, and D. Participants elected to:

Question	Voting Results	
A. Integrate addressing systemic racism, racial injustice, and discrimination across all categories.	66%	24/36
B. Keep access to health care and transportation separate priorities.	51%	19/37
C. Combine mental health and substance use under a behavioral health priority.	92%	34/37
D. Focus the chronic disease priority on healthy eating and active living (HEAL).	58%	21/36

After planning participants voted on the above items, the priority areas were adjusted to reflect these new additions. Planning participants were then asked via an online poll to identify their top three CHIP priorities based on the seven condensed categories for voting results. The following four areas were identified as priorities from this activity:

Priority Areas		Voting Results	
Priority Area 1	**Behavioral Health (Mental Health & Substance Use)**	77%	27/35
Priority Area 2	**Chronic Disease** with a focus on Healthy Eating/Active Living (HEAL)	51%	18/35
Priority Area 3	**Financial Insecurity/Unemployment** *Note, planning participants later elected to rename this priority as "Economic Wellbeing"*	51%	18/35
Priority Area 4	**Access to Services**	46%	16/35

These four priority areas were the focus of virtual planning sessions conducted in late Fall 2021 to identify goals, measurable objectives, and strategies to address these issues. Systemic racism, racial injustice, and discrimination were highlighted as a cross-cutting theme across all priority area. overarching priority areas for the CHIP, and they have been incorporated as key themes across the CHIP's priority areas.

Development of the CHIP Strategic Components

Planning Model

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 virtually via Zoom due to the COVID-19 pandemic. The Planning and Data Subcommittees of Healthier Somerset were instrumental in recruiting participants to engage in a series of virtual planning sessions over two weeks. Healthier Somerset Coalition members and community members also participated in the sessions. All planning participants were invited to participate in a Pre-Planning Session conducted by HRiA to ensure planning participants were well prepared for the planning sessions, understood the evolution and context for the CHIP, and were clear about expectations for engagement.

Following the Pre-Planning Session, four planning sessions were held in October 2021. The sessions ranged in length from 2 to 3 hours and were structured in both small and large group formats to develop plan components (goals, objectives, potential outcome indicators, strategies, and potential community partners). Sessions were 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 sessions, subject matter experts, external partners, and HRiA consultants reviewed the draft output from the planning workgroups and edited material for clarity, consistency, and evidenced base. Healthier Somerset also posted draft CHIP components on its web site for community feedback. This feedback has been incorporated into the final version of the CHIP contained in this report.

The Healthier Somerset Coalition 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.

[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. MAPP is comprised of four distinct assessments that are the foundation of the planning process and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP planning/implementation/ evaluation/correction process allows for the periodic identification of new priorities and the realignment of activities and resources to address them. 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 Snapshot

Priorities	Goals	Objectives
Priority 1: Mental Health/Substance Use	Goal 1: Prioritize mental health and substance use programing that is equitable and available without fear or judgment throughout Somerset County.	1.1: By December 2024, increase access to culturally appropriate mental health programming across the life span (youth, adults, and seniors) with an emphasis on traditionally underserved populations.
		1.2: By December 2024, increase access to culturally appropriate substance use programming across the life span (youth, adults, and seniors) with an emphasis on traditionally underserved populations.
		1.3: By December 2024, reduce stigma around mental health issues and substance use disorders.
Priority Area 2: Chronic Disease with a focus on HEAL	Goal 2: Ensure all residents have equitable access to education and resources to promote healthy eating and active living and to prevent and manage chronic disease.	2.1: By December 2024, increase the number of people who are diagnosed with a chronic disease who can effectively manage their chronic health condition.
		2.2: By December 2024, increase fruit and vegetable consumption in Somerset County.
		2.3: By December 2024, increase the percentage of residents who meet current federal physical activity guidelines.
Priority 3: Economic Well-Being	Goal 3: Address the root causes of economic disparities in Somerset County so all have equitable access to economic opportunities and sustainable financial security.	3.1: By December 2024, increase the number of safe, energy efficient, and accessible housing options at all levels of affordability.
		3.2: By December 2024, increase participation in current/existing financial literacy programs/services that are targeted across the lifespan and have an equity focus.
		3.3: By December 2024, increase the percent of people who can meet their living expenses and contribute to savings.
		3.4: By December 2024, increase the percent of people who rise above the ALICE (Asset, Limited, Income Constrained, Employed) poverty guidelines in Somerset County.
Priority 4: Access to Services	Goal 4: Ensure residents have access to affordable, equitable, and high quality services where they are treated with dignity and respect in order to improve health and thrive in the communities they call home.	4.1: By December 2024, increase the number of patients who use medical navigation services.
		4.2: By December 2024, improve the county-wide resource, navigation, and referral system for the full range of social services available in the county, especially for non-English speakers and seniors.
		4.3: By December 2024, decrease the number of residents experiencing transportation challenges when accessing health and social services.
		4.4: By December 2024, increase the number of residents who can access health and social services within their community.

CHIP Framework

CHIP Guiding Principles

- Integrity, Equity, Effectiveness, Evaluation, Collaboration, Innovation
- Our coalition 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 Somerset County.

Healthier Somerset Mission

- To improve the health and well-being of all who live and work in Somerset County.

Healthier Somerset Vision

- To become one of the healthiest counties in New Jersey.

Priority Area 1: Behavioral Health (Mental Health & Substance Use)

Among Somerset CHNA Community Survey respondents, mental health was identified as the top community health concern, high stress lifestyle was the third, and substance use, abuse, and overdose was the fourth. Interviewees and focus group members noted that while mental health has been a longstanding health concern, the COVID-19 pandemic has made the issues of stress, isolation, and boredom more pressing. While mental health issues affected people of all ages, races, and genders, mental health concerns for seniors, parents and youth, LGBTQ persons, Latino residents, and low-income adults were highlighted in qualitative discussions. Additionally, focus group participants and interviewees highlighted several barriers to accessing mental health services including cost, wait times, and lack of bilingual providers.

Similarly, several qualitative participants reported that substance use, particularly alcohol use, has increased over the past eighteen months, a consequence of the boredom, isolation, and anxiety caused by the pandemic. Alcohol, opioid, and marijuana use were highlighted as concerns for substance use; several interviewees described an increase in substance use among youth. Among substance use treatment admissions in Somerset County in 2019, 52.0% of admissions were for alcohol, 26.0% for heroin, 10.0% for marijuana, and under 10% each for other opiates, cocaine, and other drugs.[3] Qualitative participants also noted barriers to receiving substance use treatment including of cost, wait times, and lack of bilingual providers, similar to mental health.

Goal 1: Prioritize mental health and substance use programing that is equitable and available without fear or judgment throughout Somerset County.

1.1: By December 2024, increase access to culturally appropriate mental health programming across the life span (youth, adults, and seniors) with an emphasis on traditionally underserved populations.

Potential Outcome Indicators

- Number of people accessing mental health programs by age, race/ethnicity
- Number of services/outreaches developed in conjunction with demographic stakeholders

Strategies

1.1.1 Promote awareness of mental health education and services to traditional and non-traditional settings to meet people where they are (e.g., churches, bodegas, pharmacies, social services).

1.1.2 Research and advocate for effective ways to increase bilingual counseling services and counselors for schools (e.g., create resource page of bilingual counseling services/providers).

1.1.3 Promote and increase family support programming to help parents support their children's mental health as they grow from childhood to adolescence.

1.1.4 Research and implement evidence-based approaches for combatting senior isolation (including intergenerational programming).

1.1.5 Advocate for county-wide policy for later school start time to improve behavioral health of students.

Potential Partners:

- Bodegas

[3] New Jersey Department of Human Services, Division of Mental Health and Addiction Services, New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview, 2019

- Counseling Services/Providers
- Faith-Based Organizations
- Family Support Providers
- Pharmacies
- RWJUH Somerset
- Schools
- Senior Centers
- Social Services

1.2: By December 2024, increase access to culturally appropriate substance use programming across the life span (youth, adults, and seniors) with an emphasis on traditionally underserved populations.

Potential Outcome Indicators

- Number of people accessing substance use programs by age, race/ethnicity

Strategies

1.2.1 Promote awareness of substance use education and services to traditional and non-traditional settings to meet people where they are (e.g., churches, bodegas, pharmacies, social services).

1.2.2 Increase visibility of community-based organizations, such as National Alliance on Mental Illness (NAMI), to highlight services for Spanish-speaking residents, including access to bilingual counselors and peer recovery specialists.

1.2.3 Promote alternative approaches to pain management for seniors.

1.2.4 Educate providers about harm reduction and advocate for providers to implement harm reduction policies, programs, and practices as part of their services.

Potential Partners:

- Bodegas
- Counseling Services/Providers
- Faith-Based Organizations
- Family Support Providers
- NAMI
- Peer Recovery Specialists
- Pharmacies
- RWJUH Somerset
- Schools
- Senior Centers
- Social Services

1.3: By December 2024, reduce stigma around mental health issues and substance use disorders.

Potential Outcome Indicators

- Evidence-based, health-related stigma scales (TBD)

Strategies

1.3.1 Implement educational programs including Mental Health First Aid (MHFA) (education on stigma and awareness) and Suicide prevention.

1.3.2 Offer training, education, and other resources for the school community (including staff, parents, students, and volunteers) around mental health.

1.3.3 Advocate for medical and social service providers, school staff, and police departments to learn about and adopt trauma-informed approaches.

1.3.4 Translate existing resources in multiple languages and modify existing resources for varying cultural backgrounds and socio-economic statuses.

1.3.5 Partner with municipalities, churches, and businesses to take the Stigma Free pledge.

Potential Partners:

- Businesses/Employers
- Clinical Service Providers
- Faith-Based Organizations
- Law Enforcement
- Municipalities
- Schools
- Social Service Providers
- Somerset County Business Partnership/Chamber of Commerce

Priority Area 2: Chronic Disease, with a Focus on Healthy Eating/Active Living (HEAL)

Heart disease and cancer have remained the leading causes of death in Somerset County (except possibly for the anomaly of 2020 during the COVID-19 pandemic).[4] Incidence and mortality data indicate that residents of color have disproportionately higher rates of most chronic conditions such as diabetes and heart disease, despite high screening rates among residents. For example, 13.4% of Black, Non-Hispanic adult residents reported diabetes, followed by 12.1% of Asian, Non-Hispanic residents, 12% of Hispanic/Latino residents, and 6.7% of White, Non-Hispanic residents in 2014-2018.[5]

Black and Latino focus group participants expressed concerns with the social and economic factors contributing to diabetes and other chronic diseases—such as affordable healthy living opportunities and access to good healthcare—more than the conditions themselves. For example, focus group participants spoke about the high cost of healthy food and the convenience of fast food. Food insecurity- not having reliable access to enough affordable, nutritious food- rose from 3.3% in 2018 to 8.5% in 2020 among Somerset County residents.[6]

Goal 2: Ensure all residents have equitable access to education and resources to promote healthy eating and active living, and to prevent and manage chronic disease.

2.1: By December 2024, increase the number of people who can effectively manage their chronic health condition.

Potential Outcome Indicators

- Number of people who are managing their condition by condition (TBD), and by age, race/ethnicity
- Attendance as tracked by hosts of chronic disease management events/activities, including SNAP-Ed
- Responses to behavior change evaluation questions on exit surveys at chronic disease management events/activities
- Attendance at education sessions, with regular attendance at chronic disease support group, regular attendance at walking or other exercise group
- % of people who are overweight
- % of people who are obese
- Number of people screened for chronic disease

[4] Death Certificate Database, Office of Vital Statistics and Registry, New Jersey Department of Health as reported New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2019

[5] New Jersey Behavioral Risk Factor Survey (NJBRFS), New Jersey Department of Health, Center for Health Statistics, New Jersey State Health Assessment Data (NJSHAD), 2014-2018

[6] Feeding America, Map the Meal Gap, 2018 and 2020

Strategies

2.1.1 Identify and collect population-specific baseline data for the diseases defined in the Outcome Indicators.

2.1.2 Update, manage, and promote a comprehensive directory of existing chronic disease management resources) (e.g., Community-based organizations (CBO's), hospitals, health care plans, local health departments). See also Objective 4.2.

2.1.3 Identify the best entities to connect people with resources (e.g., health champions, community leaders, faith-based organizations).

2.1.4 Promote participation in chronic disease management programs.

2.1.5 Encourage chronic disease management programs to also offer screenings.

Potential Partners:

- Community Leaders
- Community-Based Organizations (CBO's)
- Faith-Based Organizations
- Health Care Plans
- Hospitals
- Local Health Departments
- RWJUH Somerset

2.2: By December 2024, increase fruit and vegetable consumption in Somerset County.

Potential Outcome Indicators

- Number of servings of fruit consumed per day by age, race and ethnicity (Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS))
- Number of servings of vegetables consumed per day by age, race and ethnicity (BRFSS and YRBSS)
- SNAP dollars spent on fruit and vegetables

Strategies

2.2.1 Identify how to measure outcomes and identify baselines and targets.

2.2.2 Form **food policy council** specific to Somerset County or specific towns to bring together businesses, farmers, schools, economic development, food trucks, etc.

2.2.3 Identify areas with the least access/highest need and partner with famers markets and grocery stores to create opportunities for pop-up farmers markets and Grocery Store Rescue (free) (e.g., senior centers, churches).

2.2.4 Enroll food pantries in the Healthy Pantries Initiative and partner with food pantries and pop-up markets to include culturally diverse/appropriate recipes using healthy foods.

2.2.5 Promote available resources that define healthy beverages and foods and provide healthy eating guidelines and educate residents on how to prepare healthy meals through live classes, videos, etc. (e.g., partner with farmer's markets, www.americasgrowarow.org, Veggie Rx program, work sites).

Potential Partners:

- Businesses/Employers
- Economic Development Commission
- Economic Development Council
- Faith-Based Organizations

- Farmers/Farmers' Markets
- Food Trucks
- Grocery Stores/Nutritionists
- RWJUH Somerset
- Schools
- Senior Centers
- Somerset County Business Partnership/Chamber of Commerce

2.3: By December 2024, increase the percentage of residents who meet current federal physical activity guidelines.

Potential Outcome Indicators

- % of residents meeting federal physical activity guidelines for youth
- % of residents meeting federal physical activity guidelines for adults

Strategies

2.3.1 Continue to promote the Walk-Bike-Hike Initiative started under the previous CHIP.

2.3.2 Explore the expansion of Safe Routes to School program.

2.3.3 Expand providers and others who talk with patients about their level of physical activity (Physical Activity Vital Signs questionnaire) and who prescribe Parks Rx (database with up-to-date listing where parks are and what they offer, paved walking trails, restrooms, playgrounds).

2.3.4 Provide policy recommendations to municipalities to evaluate and address the walkability and bikeability of their communities

2.3.5 Provide education/information to encourage residents to be physically active at home and on ways to facilitate walking groups and other rec programs within neighborhoods.

2.3.6 Develop partnership(s) with existing regional/national campaigns to increase diversity in free/low-cost spaces for active lifestyle activities.

2.3.7 Promote programs to close down streets for physical activity "Open Streets" (explore pairing with farmer's markets).

2.3.8 Encourage installation & use of Fitness Court® (https://nationalfitnesscampaign.com/), fitness trails (with strength stations) & similar in parks & pocket parks.

2.3.9 Partner with employers to adopt policies that encourage taking breaks for physical activity during the work day (there are lots of things employers can do for free to encourage physical activity).

2.3.10 Work with schools to make policy, systems & environmental changes to encourage active recess, and include physical activity in after school programming.

Potential Partners:

- Businesses/Employers
- Community/Neighborhood Leaders
- Farmers' Markets
- Municipalities & Municipal Leaders
- Providers
- Schools
- Somerset County Business Partnership/Chamber of Commerce

Priority Area 3: Economic Wellbeing

Financial insecurity was reported as a priority concern in the majority of focus groups and interviews, with participants indicating that COVID-19 has exacerbated long-standing issues of inequity. There was notable income inequality among certain racial/ethnic groups in Somerset County; Asian ($162,035) and White ($119,046) households reported incomes that were 43% and 5% higher than the median household income in Somerset County ($113,611) respectively, while Black ($80,549) and Hispanic/Latino ($75,324) households earned 29% and 34% below the county median in 2015-2019.[7] During the COVID-19 pandemic, the unemployment rate peaked at 12.8% for Somerset County in June 2020.[8] Focus group and interview participants described the challenges of the COVID-19 pandemic on essential front-line workers, lower wage workers, and Latino residents, and how many lost their jobs, either temporarily or permanently.

Goal 3: Address the root causes of economic disparities in Somerset County so all have equitable access to economic opportunities and sustainable financial security.

3.1: By December 2024, increase the number of safe, energy efficient, and accessible housing options at all levels of affordability.

Potential Outcome Indicators

- Number of housing options at each level of affordability as measured key points in time
- % people who spend more than 30% of income on housing
- % of households with 1 occupant per room (overcrowding); baseline is 98.5%

Strategies

3.1.1 Work with partners to advocate for equitable and anti-exclusionary housing policies and models at the local, state, and Federal level to ensure all people have access to safe, healthy, and affordable housing.

3.1.2 Partner with Central Jersey Housing Resource Center to assess gaps in affordable housing and provide additional educational programming.

3.1.3 Explore feasibility of expanding RWJUH Somerset's Healing Homes program and identify how partners can support expansion.

3.1.4 Educate on and promote utility-based programs for energy assistance (e.g., Low Income Home Energy Assistance Program (LIHEAP), Public Service Enterprise Group Inc. (PSE&G), Jersey Central Power & Light (JCP&L)).

3.1.5 Promote available housing resources to identified communities that are impacted by environmental injustice to address systemic health disparities.

Potential Partners:

- Central Jersey Housing Resource Center
- Jersey Central Power & Light (JCP&L)
- Low Income Home Energy Assistance Program (LIHEAP)
- Public Service Enterprise Group Inc. (PSE&G)
- RWJUH Somerset

[7] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

[8] Bureau of Labor Statistics, Local Area Unemployment Statistics, 2020-2021

3.2: By December 2024, increase participation in current/existing financial literacy programs/services that are targeted across the lifespan and have an equity focus.

Potential Outcome Indicators

- Number of programs and services available for each demographic (students, young families, college age, seniors)
- Number of participants in each program
- # of benefits counseling services to maximize income for those receiving Federal benefits

Strategies

3.2.1 Identify and engage with existing programs/services that have an equity focus and promote to key constituencies (e.g., high school students, college age, seniors, low-income) to create culturally and linguistically appropriate educational material, campaigns, etc.

3.2.2 Educate health and social service providers on resources and benefits available, how to refer residents to receive assistance in applying for them, and on the importance of providing services in culturally and linguistically competent ways (e.g., translation services, literacy levels, technology access).

3.2.3 Advocate for funding for new programs/services to meet identified gaps (e.g., content areas and demographics).

3.2.4 Promote existing home-buyer workshops/programs.

3.2.5 Work with the Economic Development Group to encourage employers to provide education and support for retirement planning/savings.

Potential Partners:

- Colleges & Universities
- Economic Development Group/Somerset County Business Partnership
- Health and Social Service Providers
- Low Income Home Energy Assistance Program (LIHEAP)
- Schools
- Senior Centers

3.3: By December 2024, increase the percent of people who can meet their living expenses and contribute to savings.

Potential Outcome Indicators

- % people in the workforce and/or unemployment rate by race/ethnicity
- % people in the workforce who spend no more than 30% of income on housing
- % of people in the workforce who can contribute 10% of income toward savings
- % of people who earn more than minimum wage
- % of people graduating from high school/GED

Strategies

3.3.1 Advocate for better benefits and wages across employment sectors.

3.3.2 Partner with exemplary employers and the Somerset County Business Partnership to promote best practices and to share the fiscal benefits of providing livable wages/benefits to employees.

3.3.3 Promote grant- or employer-sponsored savings match programs (e.g., Central Jersey Housing Resource Center).

3.3.4 Encourage community nonprofits who work with individuals and families to incorporate the importance of financial management and savings in all programming.
3.3.5 Promote workforce development programs across Somerset County (e.g., community settings, community colleges).
3.3.6 Connect residents of Somerset County to education and workforce training programs that focus on sustainable career pathways (e.g., STEM-based careers, environmental science and clean energy careers). See also 3.4.3.

Potential Partners:

- Businesses/Employers
- Central Jersey Housing Resource Center
- Community Colleges
- Community-Based Non-Profits
- Economic Development Group/Somerset County Business Partnership

3.4: By December 2024, increase the percent of people who rise above the ALICE (Asset- Limited, Income- Constrained, Employed) poverty guidelines in Somerset County.

Potential Outcome Indicators

- ALICE Baseline 24% in Somerset County 2018
- % of people below Federal poverty guideline (baseline 5.1%)
- % of people who receive SNAP benefits (2.6% baseline for Somerset County, 2015-2019)

Strategies

3.4.1 Advocate for increased income limits for safety net programming (e.g., to support childcare costs, caregiving costs).
3.4.2 Promote and advocate for maintaining pandemic-related changes made to guidelines/eligibility requirements.
3.4.3 Connect residents of Somerset County to education and workforce programs that focus on sustainable career pathways. See also 3.3.6.

Potential Partners:

- Municipal Leaders
- State Legislators
- Advocacy Groups

Priority Area 4: Access to Services

While many focus group members and interviewees reported that Somerset County has high quality and extensive healthcare and social services, accessing these services can be challenging for some residents. When survey respondents were asked about barriers to receiving medical care, they selected convenient timing of appointments (28.1%), insurance problems (19.3%), and cost of care (18.0%) as the top three concerns. Health insurance and the cost of medical care were highlighted in focus group discussions, especially among Latino residents. In 2015-2019, 15.9% of people under age 19 were uninsured in Somerset County, higher than New Jersey overall (11.5%).[9] Qualitative discussions also highlighted transportation, language, lack of racial and ethnic diversity among providers, and discrimination as barriers to receiving medical care. Black focus group participants and an interviewee who works with LGBTQ residents spoke about the need for greater cultural humility and sensitivity among providers.

Several focus group participants discussed the lack of information around social services in their communities as well as difficulty understanding how social sector programs work—including eligibility requirements and how to apply. Qualitative participants mentioned how it would be helpful to have a more coordinated referral system.

For this priority, Access to Services is defined as a broad range of services, including but not limited to: preventive health and wellness, medical, housing assistance, food assistance, employment assistance, and other social services.

Goal 4: Ensure residents have access to affordable, equitable, and high-quality services where they are treated with dignity and respect in order to improve their health and enable them to thrive in the communities they call home.

4.1: By December 2024, increase the number of patients by who use medical navigation services.

Potential Outcome Indicators

- Number of people who utilize navigation services (by age, race, geography & ethnicity)

Strategies

4.1.1 Conduct tailored marketing/outreach to all sectors in the community (e.g., residents, organizations, businesses) to increase awareness of current navigation services.

4.1.2 Work with hospital departments (e.g., the emergency department (ED)) to increase awareness among staff about current medical navigation services so they are more likely to refer patients in need.

4.1.3 Develop a broad, outcomes-based educational campaign to increase the use of medical navigation services.

Potential Partners:

- RWJUH Somerset

[9] U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

4.2: By December 2024, improve the county-wide resource, navigation, and referral systems for the full range of health and social services available in the county, especially for non-English speakers and seniors.

Potential Outcome Indicators

- Number of people who utilize county-wide resources by age, race, ethnicity
- Number of people who utilize navigation systems by age, race, ethnicity
- Number of people who utilize referral systems or number of referrals made by age, race, ethnicity
- Caseload # reporting from current coalition members (applicable services)

Strategies

4.2.1 Inventory current resource guides and referral services that are available and identify gaps.

4.2.2 Identify best practices of successful resource/referral programs and navigation services that could be implemented in in Somerset County; explore triage models from other systems.

4.2.3 Develop and implement trainings for health and social services professionals to enable cross-referrals of residents to needed services.

4.2.4 Develop a marketing and dissemination plan tailored to specific populations that highlights available services (e.g., local media, place-based settings such as bodegas and barber shops, disability & literacy service providers).

See also Strategy 2.1.2.

Potential Partners:

- Barber Shops
- Bodegas
- Disability & Literacy Service Providers
- Local Media

4.3: By December 2024, decrease the number of residents experiencing transportation challenges when accessing health and social services.

Potential Outcome Indicators

- Number of residents reporting transportation challenges - pre- and post-survey (by age, race, geography & ethnicity)

Strategies

4.3.1 Increase signage in multiple languages about transportation routes and options.

4.3.2 Increase communication channels (e.g., building mobile apps or mobile texting) in multiple languages about transportation routes and options.

4.3.3 Develop a coalition-supported, outcomes-based campaign to educate the community on transportation options and availability.

4.3.4 Increase awareness of health and social service staff on the importance of sharing information about the best ways for clients to access their services, including transportation options and routes.

Potential Partners:

- Health and Social Service Providers & Staff
- Healthier Somerset Coalition
- Transportation Providers

4.4: By December 2024, increase the number of residents who can access health and social services within their community.

Potential Outcome Indicators

- Number of residents reporting access barriers - pre- and post-survey (by age, race, geography & ethnicity)
- % insured (by age, race, geography & ethnicity)

Strategies

4.4.1 Pool public health resources to acquire and implement a mobile van that works across municipalities to provide child wellness check-ups, vaccines, and prenatal care within municipalities.

4.4.2 Develop medical hubs that provide expanded services within underserved communities.

4.4.3 Expand evening and weekend hours for medical and social services in the community.

4.4.4 Increase telehealth access via education/device availability.

4.4.5 Expand the capacity of medical and social services to provide culturally and linguistically appropriate care (e.g., utilizing community navigators).

4.4.6 Expand promotion of Get Covered New Jersey, CHIP, and Medicaid to help people acquire health insurance coverage.

Potential Partners:

- Community Navigators
- Local Public Health Departments
- Medical and Social Service Providers

Next Steps and Sustainability

The components included in this report represent the strategic framework for a data-informed community health improvement plan (CHIP). Healthier Somerset, including RWJUH Somerset, the Data and Planning Subcommittees, 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 Somerset expects that information-gathering and sharing will be an ongoing process that will be facilitated by RWJUH Somerset during Plan implementation. RWJUH Somerset will continue to hold meetings and provide quarterly updates to the Healthier Somerset Coalition to monitor progress and address any challenges for CHIP implementation.

Appendices

Appendix A: Participants in the CHIP Process
Appendix B: Prioritization Tool
Appendix C: Acronyms
Appendix D: RWJUH Somerset's Strategic Implementation Plan (SIP) Focus Areas

Appendix A: Participants in the CHIP Process

Priority Area 1: Behavioral Health (Mental Health and Substance Use)	*Priority Area 2: Chronic Disease, with a Focus on Health Eating/Active Living*
Susan Bruder *Michael Chenkin* *Luisa Gutierrez* *Amy Mahoney Harris* *Meg Isbitski* *Megan James* *Aarti Patel* *Kim Petro-Orlik* *Kristen Schiro* *Katelyn Sheridan* *Maria Strada*	*Cristina Anastasio* *Rashida Boima* *Rosemarie Bonk* *Chris Corvino* *Maryann Couch* *Dina Fornataro-Healey* *Karolina Georgens* *Sean Harrison* *Lea Kimmelman* *Robert LaForgia* *Daryl Minch* *Gina-Marie Miraglia* *Jen Salt* *Sigrid Solis* *Eze Udensi*
Priority Area 3: Economic Wellbeing	***Priority Area 4: Access to Services***
Zachary Berliner *Heather Bielefeldt* *Adam Bradford* *Patricia Cregg* *Chris Edwards* *Marilyn Feliciano* *Melissa Feltmann* *John Gorman* *Paul Grzella* *Walter Lane* *Saleena Marria* *Vonetta McDonald* *Tiffany Neal* *Mary Pudlowski* *James Ruggieri* *Kevin Sumner*	*Joan Chan* *Serena Collado* *Hilary Kurchowy* *Mike McCarty* *Manuel Nolasco Munoz* *Christine Newman* *James Norgalis* *Shisha Patel* *Linda Rapacki* *Siobhan Spano* *Nicole Wiggs*

HRiA Facilitators

Donna Burke
Kevin Myers
Dana Rosenberg
Rose Swensen
Lisa Wolff

Appendix B: Prioritization Rating Tool

We are asking you to provide input in rating the key issues identified in the Somerset CHNA as priorities for the CHIP. Please rate the following issues below on how they meet seven main criteria: **burden, equity, impact, systems change, feasibility, collaboration/critical mass, and significance to the community.**

Based on your own knowledge, experience and the findings from the CHNA, please rate each of the issues below on whether they are 1=low, 2=medium, 3=high, or 4=very high when answering each of these questions.

Selection Criteria	***Burden***	***Equity***	***Impact***	***Systems Change***	***Feasibility***	***Collaboration/ Critical Mass***	***Significance to Community***	**Total Rating**
Definition	The magnitude of hardship or distress caused by an issue	Recognizing each person/ group has different circumstance and allocating resources & opportunities needed to reach an equal outcome	Having a strong effect on someone or something	Addressing the root causes & structures of social problems, which are often deeply embedded in networks of cause and effect	Describing how easy or difficult it is to do something; capability of being accomplished	Size, number, or amount of support or collaborative partnerships large enough to produce a desired result	Identified as significant by community	
Key Questions **Issues**	***How much does this issue affect health in the community?***	***Will addressing this issue substantially benefit those most in need?***	***Can working on this issue achieve both short-term and long-term changes?*** ***Is there an opportunity to enhance access/ accessibility?***	***Is there an opportunity to focus on/ implement strategies that address policy, systems, environmental change?***	***Is it possible to take steps to address this issue given infrastructure, capacity, and political will?***	***Are there existing groups across sectors willing to work together on this issue?***	***Was this issue identified as a top need by a significant number of community members?***	**Step 2:** Add the seven ratings to determine the total rating
Coronavirus/COVID-10 (transmission, vaccination, etc.)								
Financial Insecurity/Unemployment								
Housing								
Transportation								
Systemic Racism, Racial Injustice, and Discrimination								
Mental Health								
Alcohol/Substance Use								
Chronic Disease								
Access to Services								

Appendix C: Acronyms

ALICE	Asset, Limited, Income Constrained, Employed
BRFSS	Behavioral Risk Factor Surveillance System
CBO	Community Based Organizations
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
COVID-19	Coronavirus Disease 2019
CSA	Community Supported Agriculture
ED	Emergency department
FCHS	Family and Community Health Sciences
GED	General Educational Development
HEAL	Healthy Eating and Active Living
IRS	Internal Revenue Service
JCP&L	Jersey Central Power & Light
LGBTQ	Lesbian, gay, bisexual, transgender, transsexual, queer
LIHEAP	Low Income Home Energy Assistance Program
MHFA	Mental Health First Aid
NAMI	National Alliance on Mental Illness
NJ	New Jersey
PHAB	Public Health Accreditation Board
PSE&G	Public Service Enterprise Group Inc.
QPR	Question, Persuade, Refer
RWJUH	Robert Wood Johnson University Hospital
SIP	Strategic Implementation Plan
SNAP	Supplemental Nutrition Assistance Program
STEM	Science, technology, engineering and math
TA	Technical Assistance
TBD	To be determined
YRBSS	Youth Risk Behavior Surveillance System

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

Specific responsibilities, timelines and baselines will be determined during action planning for CHIP Year 1 Implementation.

RWJUH Somerset Strategic Implementation Plan (SIP) Focus Areas	
Priority Area 1: Behavioral Health (Mental Health & Substance Use)	
Goal 1:	**Prioritize mental health and substance use programing that is equitable and available without fear or judgment throughout Somerset County.**
Objective 1.1: By December 2024, increase access to culturally appropriate mental health programming across the life span (youth, adults, and seniors) with an emphasis on traditionally underserved populations.	
Outcome Indicators	
• Number of people accessing mental health programs by age, race/ethnicity • Number of services/outreaches developed in conjunction with demographic stakeholders	
Strategies	
1.1.1	Promote awareness of mental health education and services to traditional and non-traditional settings to meet people where they are (e.g., churches, bodegas, pharmacies, social services).
1.1.2	Research and advocate for effective ways to increase bilingual counseling services and counselors for schools (e.g., create resource page of bilingual counseling services/providers).
1.1.3	Promote and increase family support programming to help parents support their children's mental health as they grow from childhood to adolescence.
1.1.4	Research and implement evidence-based approaches for combatting senior isolation (including intergenerational programming).
1.1.5	Advocate for county-wide policy for later school start time to improve behavioral health of students.
Objective 1.2: By December 2024, increase access to culturally appropriate substance use programming across the life span (youth, adults, and seniors) with an emphasis on traditionally underserved populations.	
Outcome Indicators	
• Number of people accessing substance use programs by age, race/ethnicity	
Strategies	
1.2.1	Promote awareness of substance use education and services to traditional and non-traditional settings to meet people where they are (e.g., churches, bodegas, pharmacies, social services).
1.2.2	Increase visibility of community-based organizations, such as National Alliance on Mental Illness (NAMI), to highlight services for Spanish-speaking residents, including access to bilingual counselors and peer recovery specialists.
1.2.3	Promote alternative approaches to pain management for seniors.
1.2.4	Educate providers about harm reduction and advocate for providers to implement harm reduction policies, programs, and practices as part of their services.

RWJUH Somerset Strategic Implementation Plan (SIP) Focus Areas
Priority Area 2: Chronic Disease, With a Focus on Healthy Eating/Active Living (HEAL)
Goal 2: Ensure all residents have equitable access to education and resources to promote healthy eating and active living and to prevent and manage chronic disease.
Objective 2.1: By December 2024, increase the number of people who can effectively manage their chronic health condition.
Outcome Indicators
• Number of people who are managing their condition by condition (TBD), and by age, race/ethnicity • Attendance as tracked by hosts of chronic disease management events/activities, including SNAP-Ed • Responses to behavior change evaluation questions on exit surveys at chronic disease management events/activities • Attendance at education sessions, with regular attendance at chronic disease support group, regular attendance at walking or other exercise group • % of people who are overweight • % of people who are obese • Number of people screened for chronic disease
Strategies
2.1.1 Identify and collect population-specific baseline data for the diseases defined in the Outcome Indicators. 2.1.2 Update, manage, and promote a comprehensive directory of existing chronic disease management resources) (e.g., Community-based organizations (CBO's), hospitals, health care plans, local health departments). See also Objective 4.2. 2.1.3 Identify the best entities to connect people with resources (e.g., health champions, community leaders, faith-based organizations). 2.1.4 Promote participation in chronic disease management programs. 2.1.5 Encourage chronic disease management programs to also offer screenings.
Objective 2.2: By December 2024, increase fruit and vegetable consumption in Somerset County.
Outcome Indicators
• Number of servings of fruit consumed per day by age, race and ethnicity (Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveillance System (YRBSS)) • Number of servings of vegetables consumed per day by age, race and ethnicity (BRFSS and YRBSS) • SNAP dollars spent on fruit and vegetables
Strategies
2.2.1 Identify how to measure outcomes and identify baselines and targets. 2.2.2 Form food policy council specific to Somerset County or specific towns to bring together businesses, farmers, schools, economic development, food trucks, etc. 2.2.3 Identify areas with the least access/highest need and partner with famers markets and grocery stores to create opportunities for pop-up farmers markets and Grocery Store Rescue (free) (e.g., senior centers, churches). 2.2.4 Enroll food pantries in the Healthy Pantries Initiative and partner with food pantries and pop-up markets to include culturally diverse/appropriate recipes using healthy foods. 2.2.5 Promote available resources that define healthy beverages and foods and provide healthy eating guidelines and educate residents on how to prepare healthy meals through live classes, videos, etc. (e.g., partner with farmer's markets, www.americasgrowarow.org, Veggie Rx program, work sites).

RWJUH Somerset Strategic Implementation Plan (SIP) Focus Areas	
Priority Area 3: Economic Wellbeing	
Goal 3:	**Address the root causes of economic disparities in Somerset County so all have equitable access to economic opportunities and sustainable financial security.**
Objective 3.1: By December 2024, increase the number of safe, energy efficient, and accessible housing options at all levels of affordability.	
Outcome Indicators	
• Number of housing options at each level of affordability as measured key points in time • % people who spend more than 30% of income on housing • % of households with 1 occupant per room (overcrowding); baseline is 98.5%	
Strategies	
3.1.1	Work with partners to advocate for equitable and anti-exclusionary housing policies and models at the local, state, and Federal level to ensure all people have access to safe, healthy, and affordable housing.
3.1.2	Partner with Central Jersey Housing Resource Center to assess gaps in affordable housing and provide additional educational programming.
3.1.3	Explore feasibility of expanding RWJUH Somerset's Healing Homes program and identify how partners can support expansion.
3.1.4	Educate on and promote utility-based programs for energy assistance (e.g., LIHEAP, PSE&G, JCP&L).
3.1.5	Promote available housing resources to identified communities that are impacted by environmental injustice to address systemic health disparities.
Priority Area 4: Access to Services	
Goal 4:	**Ensure residents have access to affordable, equitable, and high-quality services where they are treated with dignity and respect in order to improve their health and enable them to thrive in the communities they call home.**
Objective 4.1: By December 2024, increase the number of patients who use medical navigation services.	
Outcome Indicators	
• Number of people who utilize navigation services	
Strategies	
4.1.1	Conduct tailored marketing/outreach to all sectors in the community (e.g., residents, organizations, businesses) to increase awareness of current navigation services.
4.1.2	Work with hospital departments (e.g., the emergency department (ED)) to increase awareness among staff about current medical navigation services so they are more likely to refer patients in need.
4.1.3	Develop a broad, outcomes-based educational campaign to increase the use of medical navigation services.