Healthier Middlesex Community Health Improvement Plan

2023

PREPARED BY
HEALTH RESOURCES IN ACTION

Robert Wood Johnson University Hospital | RWJBarnabas HEALTH

Healthier Middlesex
Working Together

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

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 coalition 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:

Apex Physical Therapy and Sports Rehabilitation
Community Affairs and Resource Center
Community Food Bank of New Jersey
County Health Rankings and Roadmaps
Catholic Charities Dioceses of Metuchen
East Brunswick Public Library
Township of Edison
Girls on the Run
Johnson & Johnson
Keep Middlesex Moving
Hackensack Meridian Health
Horizon Blue Cross Blue Shield of New Jersey
Middlesex County Office of Health Services
National Institutes of Health: National Network of Libraries of Medicine, Middle Atlantic Region
National Alliance on Mental Illness (N Brunswick, NJ)
New Americans Program
New Brunswick Area NAACP
New Brunswick Public Schools
New Brunswick Tomorrow
New Jersey Prevention Network
New Jersey Institute for Diabetes
Puerto Rican Action Board (PRAB)
Raritan Bay YMCA
Regional Chronic Disease Coalition of Middlesex and Union Counties
Replenish (Middlesex County, NJ)
Robert Wood Johnson University Hospital (RWJ Barnabas Health)
Rutgers Robert Wood Johnson Medical School
Rutgers New Jersey Agricultural Experiment Station, Rutgers Cooperative Extension
Saint Peter's University Hospital (Saint Peter's HealthCare System)
Somerset County Department of Health
Woodbridge Mayor's Wellness Campaign
WellCare of New Jersey
Wellspring Center for Prevention

Technical Advisers:
Health Resources in Action, Community Health Needs Assessment and Community Health Improvement Planning Consultant

Table of Contents

Executive Summary

Where and how we live, learn, work, and play affects our health. Understanding the key factors in our community that influence health is critical for identifying and implementing the best strategies to address them. To accomplish this aim, Robert Wood Johnson University Hospital, part of RWJ Barnabas Health, in collaboration with Saint Peter's University Hospital and the Healthier Middlesex Coalition, led a comprehensive community health improvement effort to measurably improve the health of Middlesex and southeastern 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 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 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 *2023-2025 Middlesex County Community Health Improvement Plan* was developed over the period of June to November 2022, 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 initial engagement for the CHNA and CHIP was done virtually due to the novel coronavirus-COVID-19 pandemic; the CHIP planning session was facilitated on-site in New Brunswick on September 13, 2022, with 35 Coalition members participating.

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 Advisory Board and Coalition members provided vital input on the CHNA and CHIP development including guiding outreach, giving feedback on the planning priorities, 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 Survey.
- RWJ Barnabas Health System: The RWJ Barnabas Health Systemwide CHNA Steering Committee developed criteria that were used to guide prioritization discussions and voting processes.

Healthier Middlesex coalition members used common criteria and a multi-voting process to identify the following priority health issues to address in the CHIP:

Priority Areas
Priority Area 1: **Mental Health and Substance Use**
Priority Area 2: **Financial Well-being and Housing Stability**
Priority Area 3: **Access to Healthcare (including Chronic Disease and Technology)**
Priority Area 4: **Supplemental Food Assistance**

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)**, part of **RWJ Barnabas Health**, in partnership with Saint Peter's University Hospital and the **Healthier Middlesex Coalition**, led its fourth 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 Coalition 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 Coalition 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 early 2022, RWJUH 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 and the Healthier Middlesex Coalition 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.
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, 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
- Outline an implementation and improvement plan with performance measures for monitoring and evaluating progress
- 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 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. See Appendix D for RWJUH Hospital's specific role and Appendix E for SPUH'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 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.

Context for the Community Health Improvement Plan

The CHNA and CHIP were conducted during an unprecedented time due to the ongoing novel coronavirus (COVID-19) pandemic and the national movement for racial justice. The COVID-19 pandemic coincided with the activities of the CHNA and impacted both the CHNA data collection process, as well as topics and concerns that residents raised in focus groups and key informant interviews. A wave of national protests for racial equity in 2020 highlighted how racism is embedded in systems across the US. The national movement informed the content of this report including the data collection processes, design of data collection instruments, and the input that was shared during focus groups, key informant interviews, and through survey responses. Fortunately, the CHIP planning process was facilitated in-person during a day-long planning session on September 13, 2022, with strong representation by Healthier Middlesex Coalition members, due to the timing of COVID-19 boosters and on-site prevention protocols.

Community Engagement

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

Community Engagement Approach

The CHNA identified health needs and strengths in Middlesex County by utilizing a variety of data collection methods including:

- Reviewing existing data on social, economic, and health indicators in Middlesex County.
- Conducting a community survey with 526 residents designed and administered by the survey firm Bruno & Ridgway.
- Facilitating four virtual focus groups with 24 participants from specific populations of interest [e.g., newly arrived residents of South Asian descent, African American men between the ages of 18-35, economically vulnerable residents (one group of English-speaking residents and one group of Spanish-speaking residents), and one group of youth and young adults].
- Conducting eleven key informant interviews or group discussions with 13 stakeholders in the community from a range of sectors.

Prioritization Process and Priorities Selected for Planning

Prioritization allows organizations, partnerships, and consortia to target and align resources, leverage efforts, and focus on achievable goals and strategies for addressing priority needs. Priorities for the community health improvement plan (CHIP) were identified by examining data and themes from the CHNA findings utilizing a systematic, engaged approach.

Criteria for Prioritization

Planning participants used set prioritization criteria to help determine what community health issues should be prioritized for the CHIP. The RWJ Barnabas Health's Systemwide CHNA Steering Committee selected the following seven criteria for prioritization; they were used to guide discussions and voting processes with Healthier Middlesex Consortium members. Please see Appendix B for the RWJ Barnabas Health System prioritization tool. These criteria included:

- **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, as well as the priority issues for future action and investment. Survey respondents also were asked to select up to five of the most important issues for future action in their communities, 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, ten major priorities were identified for Middlesex County:

- Systemic Racism, Racial Injustice & Discrimination
- Financial Insecurity
- Food Insecurity
- Housing Instability
- Technology Use and Access
- Access to care
- Mental Health
- Substance Use
- Violence
- Chronic Disease

Step 2: Data-Informed Voting via a Consortium Prioritization Meeting
On June 27, 2022, a one-and-a-half-hour virtual community meeting was held for the Healthier Middlesex Advisory Board members to discuss and vote on preliminary community priorities. During the prioritization meeting, attendees heard a data presentation on the key findings for the Healthier Middlesex CHNA. Participants were asked to reflect on the data shared, including whether any key topics were missing, and to share thoughts via the Chat feature in Zoom. Next, meeting participants were divided into small groups to discuss the data and offer their own perspectives and expertise on the various priorities. Meeting participants then shared information from their discussions with the full group. Additionally, participants were also given a prioritization matrix tool so that they could rate the ten health issues on how they meet the prioritization criteria. 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. After the discussions, using Mentimeter's online polling tool, meeting participants were asked to vote for up to four of the ten priorities identified from the data and based on the specific prioritization criteria. A total of fifteen Consortium advisory board members voted during the Community Prioritization Meeting. Voting resulted in issues identified in the CHNA ranked by priority as follows:

- Mental Health 80% (12/15)
- Access to Healthcare 60% (9/15)
- Systemic Racism, Racial Injustice, and Discrimination 53% (8/15)
- Food Insecurity 47% (7/15)
- Financial Insecurity and Unemployment 40% (6/15)
- Chronic Disease 40% (6/15)
- Housing Instability 33% (5/15)
- Technology Use and Access 20% (3/15)
- Substance Use 13% (2/15)
- Violence 13% (2/15)

Step 3: Prioritization Refinement via a Consortium Prioritization & Planning Meeting
All members of the Healthier Middlesex Consortium were invited to participate in an additional planning session on July 19, 2022, to further refine the top priorities. As part of this second meeting, all Consortium members met virtually to review and discuss a brief presentation on the CHNA findings and to review the outcome of the previous prioritization meeting that was held on June 27, 2022 with the smaller Advisory Board. The goal of this meeting was to further refine and narrow priorities into four priority areas. In the meeting, participants were asked to reflect on whether the findings were consistent with their experience and understanding of the community and specifically to discuss the following prioritization options:

- Should Mental Health and Substance Use be combined under one priority or kept separate?
- Should Systemic Racism be its own priority area, or should it be integrated across ALL priorities of the plan?
- Should Chronic Disease and Food Insecurity be combined under one priority or kept separate?
- Should Financial Insecurity and Housing be combined under one priority or kept separate?
- Should Access to Health Care and Technology Use and Access be combined under one priority or kept separate?

Participants were then asked to vote using Mentimeter's online polling tool to indicate which choices they were in favor of combining or keeping separate. A total of 21 individuals responded to the prioritization question. Participants elected to:

- Integrate addressing Systemic Racism across all categories - 57% (12/21)
- Combine Financial Insecurity and Housing Instability under a single priority - 67% (14/21)
- Combine Mental Health and Substance Use under a behavioral health priority - 62% (13/21)
- Keep Chronic Disease and Food Insecurity as separate priorities - 57% (12/21)

- Combine Access to Health Care and Technology into one category - 52% (11/21)

After planning participants voted on the above items, the priority areas were adjusted to reflect these new additions. Planning participants were then asked via a Mentimeter poll to identify their top four priorities based on the condensed categories for voting results. Following the voting and subsequent discussions, the Healthier Middlesex Consortium decided on the following four priorities for CHIP planning with **Addressing Systemic Racism** as an overarching theme across all priority areas:

1. Financial Insecurity and Housing Instability
2. Mental Health and Substance Use
3. Access to Health Care with Chronic Disease and Technology as sub-categories
4. Food Insecurity

These four priority areas were the focus of the in-person planning session conducted in September 2022 to identify goals, measurable objectives, and strategies to address these issues.

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 in New Brunswick on September 13, 2022. The Advisory Board of the Healthier Middlesex Coalition was instrumental in recruiting participants to engage in this full-day, rapid planning process. All planning participants were invited to participate in a Pre-Planning Session conducted by HRiA to ensure they were well prepared for the planning sessions, understood the evolution and context for the CHIP, and were clear about expectations for engagement.

The session was 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 the 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.

The Healthier Middlesex 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 and Substance Use	**Goal 1:** Establish a system to enhance equitable, local access to, and availability and utilization of, affordable, culturally aware mental health and substance use resources for all in Middlesex County.	1.1: By December 2025, increase equitable access and availability of mental health and substance use prevention and wellness programs in Middlesex County by updating and aligning the Behavioral Health Resource and Referral Guide (BHRRG) and the Middlesex County Service Locator.
		1.2: By December 2025, increase utilization of mental health, substance use, and wellness services by 10% from baseline.
		1.3: By December 2025, expand the RWJUH- Hospital Violence Intervention Program (HVIP), serving traumatically injured adult victims of community violence, to improve patient outcomes, reduce patient re-injury, and reduce retaliatory violence.
		1.4: By December 2025, enhance and support collaborations with internal and external partners to improve outcomes for HVIP participants.
Priority Area 2: Financial Well-being and Housing Stability	**Goal 2:** Everyone has equitable access to secure the financial resources to meet their basic needs, save for the future, and maintain safe, quality, and stable housing.	2.1 By December 2025, increase the number of people who participate in financial literacy programs within Middlesex County, with a focus on engaging traditionally underserved communities/populations.
		2.2: By December 2025, partner with community-based organizations in Middlesex County to hold 5 employment fairs within the community for county residents.
		2.3: By December 2025, engage participants enrolled in financial literacy programs to increase the number of people (by 15%) who can meet their basic needs and save 10% of their income.
		2.4: By December 2025, hold 3 workshops per year to increase the education and awareness of safe, affordable housing options.
Priority 3: Access to Healthcare	**Goal 3:** Ensure all community members have awareness of and equitable access to affordable, comprehensive, and culturally appropriate health education/ information and quality care.	3.1: By December 2025, create a dynamic access point/hub for culturally appropriate social determinants of health provider information and service resources.
		3.2: By December 2025, develop a standard for the collection, analysis, and sharing of health service use data by individual, community, and county.
		3.3: By December 2025, coordinate and align data collected from the community, health systems, and stakeholders to consistently measure social determinants of health (SDOH) (e.g., housing) and identify linguistically/culturally appropriate solutions.
		3.4: By December 2025, increase (by 10%) the number of people in Middlesex County that participate in education programs to improve their health literacy, with a focus on engaging traditionally underserved communities/populations within the county.
		3.5: By December 2025, increase annually by 10%, the number of residents that can access health and social services within their community with a focus on engaging medically underserved populations within the county in their preferred language.
		4.1: By December 2025, establish and increase the number of organizations addressing food insecurity that educate their staff and utilize mapping

Priority 4: Supplemental Food Assistance	**Goal 4:** Ensure access to and utilization of local, healthy, culturally appropriate, and sustainable food choices without stigma or barriers.	technology to promote their services and connect the community to resources.
		4.2: By December 2025, increase annually by 10% from baseline, the number of health and social service providers who are educated on food resources and barriers to access.
		4.3: By December 2025, to create and expand volunteer base (healthcare and other social service providers) by 50% from baseline to assist Middlesex County's food insecurity programs.
		4.4: By December 2025, increase community members' awareness and skills related to healthy eating, food safety, and available resources by 70%.
		4.5: By December 2025, increase access to supplemental food resources within the healthcare setting.

CHIP Strategic Framework

The Strategic Framework provides the foundational elements of the Community Health Improvement Plan. Together, they described the desired future the Healthier Middlesex Coalition hopes to create as a result of fulfilling its mission and goals; the central purpose for the Healthier Middlesex Coalition; and the principles that guide all aspects of Healthier Middlesex's work with partners in community.

Healthier Middlesex Vision:
All who live, learn, work, and play in Greater Middlesex County ensure a healthy community.

Healthier Middlesex Mission:
Healthier Middlesex collectively improves the health and well-being of our diverse communities through partnerships with individuals, groups, and organizations.

Healthier Middlesex Core Values:

- Collaboration
- Commitment
- Communication
- Compassion
- Cultural competence
- Equality
- Equity
- Empowerment
- Integrity
- Passion
- Professionalism
- Respect
- Teamwork
- Transparency
- Trust
- Understanding
- Unity

Priority Area 1: Mental Health and Substance Use

Behavioral health is the connection between the body and mind's health and well-being. In the field, mental health and substance use are typically discussed under the larger behavioral health framework. Additionally, results from the 2019 Middlesex County Needs Assessment reported that focus groups held with residents identified the need for additional treatment programs – in particular, those jointly focused on addressing mental health and substance abuse.

Job loss and financial insecurity, virtual schooling, social isolation, loss of friends and family members, disruptions in access to care, and the general uncertainty associated with the COVID-19 pandemic were all cited as contributors to increased stress, depression, anxiety, and trauma among Middlesex County's residents.

Substance use was mentioned as a concern by some focus group and interview participants. Participants noted that they felt the pandemic was creating difficult personal situations and increased isolation, which could lead to people turning to substance use. Current surveillance data are not available on this topic for Middlesex County.

Goal 1: Establish a system to enhance equitable, local access to, and availability and utilization of, affordable, culturally aware mental health and substance use resources for all in Middlesex County.

Objective 1.1: By December 2025, increase equitable access to and availability of mental health and substance use prevention and wellness programs in Middlesex County by updating and aligning the Behavioral Health Resource and Referral Guide (BHRRG) and the Middlesex County Service Locator.

Outcome Indicator	Baseline	Target	Data Source
Number of prevention and wellness programs			
Number of people accessing programs (increase over baseline)			
Prevention and wellness programs' quality and outcomes			
Number of trainings conducted (MHFA and others) (increase over baseline)			
Number of people trained across all trainings			
Number of future providers trained across all trainings			

Strategies

1.1.1 Cross reference the list of services in the Behavioral Health Resource and Referral Guide (BHRRG) to those in the Middlesex County Service Locator to incorporate services missing from each guide/database and identify gaps in prevention and wellness programs in Middlesex County.

1.1.2 Collaborate with all Healthier Middlesex organizations and mental health and substance use providers in a process to address gaps.

1.1.3 Continue to provide free mental health and substance use wellness trainings for Healthier Middlesex Partners and Healthcare providers.

Responsible Party(ies)

- Healthier Middlesex Coalition Partners
- Mental Health and Substance Use Providers
- RWJMS-HIPHOP

Objective 1.2: By December 2025, increase utilization of mental health, substance use, and wellness services by 10% from baseline.

Outcome Indicator	Baseline	Target	Data Source
Anti-stigma communication campaign launched.			
Increased use of the BHRRG.			
Number of calls to state hotlines segmented by county (e.g., 988).			

Strategies

1.2.1 Align and partner with the County Stigma Campaign to promote the awareness of Mental Health and Substance Use service providers.
1.2.2 Align and partner with community based mental health organizations and partners to promote culturally aware education programs.
1.2.3 Recruit and train trusted messengers for educational programs.
1.2.4 Promote tools to empower families and caregivers.
1.2.5 Identify gaps in service utilization, population, and types of service.
1.2.6 Promote the use of the BHRRG to connect residents to existing mental health services.
1.2.7 Explore the intake process for the 988 line, identify gaps/barriers, and promote the use of the 988 line.

Responsible Party(ies)

- The County Stigma Campaign
- Traumatic Loss Coalition
- NJ Department of Health (DOH)
- Community-based mental health and substance use providers
- Community leaders
- Governor's Council on Mental Health Stigma
- National Alliance on Mental Illness (NAMI-NJ)
- Garden State Equality (GSE)

Objective 1.3: By December 2025, expand the RWJUH- Hospital Violence Intervention Program (HVIP), serving traumatically injured adult victims of community violence, to improve patient outcomes, reduce patient re-injury, and reduce retaliatory violence.

Outcome Indicator	Baseline	Target	Data Source
Number of crime victim patients enrolled in HVIP and provided case management over 15-month period		75 new	*RWJUH-HVIP Staff*
Number of patients enrolled in the HVIP who come from the ED		50%	*RWJUH-HVIP Staff*
Documented receipt of consent, intake, and case plan		100%	*RWJUH-HVIP Staff*
Documented receipt of program brochure		100%	*RWJUH-HVIP Staff*
Reduced traumatic symptoms among patients who accept mental health counseling		50% > baseline	*RWJUH-HVIP Staff*
Percent of patients who report a positive experience with the HVIP		50% +	*RWJUH-HVIP Staff*
Percent of HVIP program participants' goals achieved thru a trauma-informed, collaborative case management approach		50%	*RWJUH-HVIP Staff*

Strategies

1.3.1 Actively recruit, engage, and enroll a minimum of 75 additional traumatically injured victims of community violence admitted to the Trauma Service.
- Actively recruit to ensure that at least 50% of traumatically injured victims of community violence admitted to the Trauma Service come from the ED.
- Obtain patient consent, conduct intake, and create the initial case plan including a safety plan.

1.3.2 Ensure that all eligible patients introduced to the HVIP receive a program brochure and support to meet their current needs.

1.3.3 Provide ongoing advocacy and case management for 6-12 months.

1.3.4 Implement Patient Experience Surveys at 6 months and at program end.

1.3.5 Utilize participant benchmark reports to assess individual progress.

1.3.6 Utilize Penelope software to document, track, and identify trends.

Responsible Party(ies)

- RWJUH-HVIP Staff, Violence Intervention Specialists (VIS) Team

Objective 1.4: By December 2025, enhance and support collaborations with internal and external partners to improve outcomes for HVIP participants.

Outcome Indicator	Baseline	Target	Data Source
Percent of patients who report a positive experience with the HVIP		50%+	*HVIP Team at RWJUH and PRAB*
Consortium members' understanding of root causes of community violence and the impact of systemic racism			*RWJUH-HVIP Staff*
Number of member organizations who use a trauma-informed approach and engage patients and their families in decision-making			*RWJUH-HVIP Staff*
Number of families impacted by violence and poverty that participate in Safe Spaces community gatherings during the HVIP grant period (reduced isolation and increased awareness of resources)		>25	*RWJUH-HVIP Staff*
Annual March and Rally Against Domestic Violence conducted • Number of CBOs attending • Number of attendees • Number of flyers on violence resources distributed		 6+ 200+ 500	*RWJUH-HVIP Staff*
Number of at-risk New Brunswick students who learn tools to increase resiliency and how to express themselves using art as an alternative to violence		40	*RWJUH-HVIP Staff*

Strategies

1.4.1 Conduct bimonthly WAVE Consortium meetings to identify trends in service gaps for program participants and enhance a safety net that is accessible to a diverse community.

1.4.2 Work with community partners to expand monthly Safe Spaces community gatherings initiative within neighborhoods heavily impacted by community violence and poverty.

1.4.3 Collaborate with the New Brunswick Domestic Violence Awareness Coalition to expand community awareness of domestic violence prevention and resources by:
- Co-sponsoring Annual March & Rally Against Domestic Violence
- Recruiting more community-based organizations to participate
- Engaging attendees
- Distributing flyers with community, domestic, and sexual violence hotlines/resources

1.4.4 Provide two anti-violence workshops and a public art mural in partnership with the Artists Mentoring Against Racism, Drugs, and Violence: Healing Through the Arts (AMARD&V) summer program for at-risk youth in New Brunswick.

Responsible Party(ies)

- HVIP Team at RWJUH and PRAB
- Other RWJUH staff
- WAVE Consortium members
- Refugio City Church
- Community partners
- Crime survivors and their families

Priority Area 2: Financial Well-being and Housing Stability

Income is a powerful social determinant of health that influences where people live and their ability to access resources, affecting health and well-being. Like the rest of the nation, Middlesex County experienced economic challenges due to the COVID-19 pandemic. The loss of employment and income exacerbated the financial vulnerability of individuals and communities. Financial insecurity was a primary concern voiced in both focus groups and interviews, with several participants considering the loss of a job as detrimental and leading to the loss of a home, transportation, and increasing isolation, stress, and anxiety.

The COVID-19 pandemic exacerbated people's concerns about housing affordability and housing stability as well. With some residents' financial situations being more uncertain or diminishing during the pandemic, there was more concern that residents might lose their housing, even with the multiple housing eviction moratoriums in place. When asked about the impact of COVID-19, about 6% of Middlesex County community survey respondents reported that they or an immediate family member had lost their housing due to the COVID-19 pandemic; Black and Hispanic/Latino respondents were more likely to report that they or an immediate family member had lost their housing due to COVID-19. Overcrowding in housing was another issue during some discussions, primarily when community residents discussed living in multi-generational houses and extended family, which is considered more common among immigrant communities. Several Middlesex County communities have housing units deemed crowded, with the most prevalent being in New Brunswick, Perth Amboy, Edison, Carteret, and North Brunswick.

Goal 2: Everyone has equitable access to secure the financial resources to meet their basic needs, save for the future, and maintain safe, quality, and stable housing.

Objective 2.1: By December 2025, increase the number of people who participate in financial literacy programs within Middlesex County, with a focus on engaging traditionally underserved communities/populations.

Outcome Indicator	Baseline	Target	Data Source
List of organizations in Middlesex County that offer financial literacy classes			
Number of financial literacy classes offered in Middlesex County			
Number of participants that attend/complete financial literacy classes offered in Middlesex County			
Pre-and post-test for financial literacy			*Baseline: 2022 data from Family Success Centers and Family Leadership Academy programs*
Number of participants that attend/complete employer-based financial literacy classes.			
Number of schools with financial literacy in the curriculum.			
Number of traditional/non-traditional partners that offer financial literacy classes.			
Number of employer-based financial literacy classes offered.			

Strategies

2.1.1 Identify, provide, and promote organizations (within and outside of Healthier Middlesex) that offer financial literacy education classes (with and without participation incentives) to share learnings and increase participation.

2.1.2 Work with traditional and non-traditional partners (small business employers, CBOs) to identify, provide, and promote incentives for people to participate in financial literacy classes (e.g., first-time home buyers, 401k savings).

2.1.3 Promote employer-based financial literacy training for employers and employees (staff) and develop best practices for employers to offer trainings.

2.1.4 Utilize multi-media approaches for education and promotion of financial literacy.

2.1.5 Inventory financial literacy education in schools within Middlesex County (as mandated in NJ) and advocate for inclusion where applicable, especially in New Brunswick and Perth Amboy schools' curricula; Assess against minimum requirement for schools per legislation.

Responsible Party(ies)

- Employers
- Financial institutions
- Middlesex College
- Schools
- Middlesex County organizations
- PRAB's Family Leadership Academy
- Family Success Centers
- Adult Learning Centers

Objective 2.2: By December 2025, partner with community-based organizations in Middlesex County to hold 5 employment fairs within the community for county residents.

Outcome Indicator	Baseline	Target	Data Source
TBD			

Strategies

2.2.1 Share information about educational opportunities and job training (e.g., evening vocational/technical training, AmeriCorps, Skill Up NJ).

2.2.2 Partner with the Workforce Development Board and the Human Services Advisory Council (HSAC) to identify opportunities for collaboration, networking, and leveraging resources.

2.2.3 Invite employers to be part of the discussion and solutions for increasing the number of opportunities available.

2.2.4 Host hiring events with major employers in Middlesex County (SPUH, RWJUH, Rutgers, MCC, etc.) to increase the number of people who have local, gainful employment (e.g., partner with current hiring local initiatives inclusive of but not limited to job fairs).

2.2.5 Invite employers to community events (other than job fairs) to advertise open positions that promote stable and secure job opportunities that have the possibility for advancement.

Responsible Party(ies)

- Employers
- Middlesex County Workforce Development Board
- One Stop Center – Middlesex County

Objective 2.3: By December 2025, engage participants enrolled in financial literacy programs to increase the number of people (by 15%) who can meet their basic needs and save 10% of their income.

Outcome Indicator	Baseline	Target	Data Source
10% of income saved			
Specific target percentages for specific populations			
Debt to income ratio credit score			
Amount of savings			

Strategies

2.3.1 Research way(s) to gather and report on population savings data for Middlesex County.

2.3.2 Gather information about savings programs/incentives that are being offered in Middlesex County and in other areas.

2.3.3 Develop relationships with financial institutions and work with them to lower barriers to allow savings (e.g., no checking/savings account minimum balance required, make it easier to establish an account, lower/eliminate account fees); promote their services in the community.

2.3.4 Encourage residents to enroll in new and existing savings programs.

2.3.5 Research best practices and work with savings institutions to increase the number of people with savings accounts.

2.3.6 Create spaces for holding conversations around savings within Healthier Middlesex (e.g., convene meetings, set agendas, secure time and bandwidth, establish subcommittee).

2.3.7 Explore options for working with partners to provide incentives for savings.

2.3.8 Explore options for establishing employer-sponsored savings plans.

Responsible Party(ies)

- Financial institutions
- Healthier Middlesex
- Schools and after-school programs
- PRAB, Inc.

Objective 2.4: By December 2025, hold 3 workshops per year to increase the education on and awareness of safe, affordable housing options.

Outcome Indicator	Baseline	Target	Data Source
Number/percent of housing units available in communities of greatest need			
Broad and diverse coalition of stakeholders convened to address affordable housing and the housing crisis in Middlesex County			
Number of Healthy homes social media posts			
Number of innovative, replicable projects/pilots for expanding affordable housing identified and shared			

Strategies

2.4.1 Determine the number of organizations working with residents on affordable housing within Middlesex County.

2.4.2 Convene a broad and diverse coalition of stakeholders to participate in and support housing education in Middlesex County.

2.4.3 Conduct an inventory of available resources for housing education.

2.4.4 Utilize the available resource inventory tools (e.g., lessons learned from BUILD, Healthy Home Roadmap) to expand on housing resources.

2.4.5 Source and share innovative, replicable projects/pilots for expanding safe, affordable housing.

Responsible Party(ies)

- Consumer advocacy groups
- Division of Housing (HOME program)
- Housing advocacy groups
- Housing developers
- Legislators
- Town leadership
- Community members
- Middlesex County Housing Continuum of Care Committee

Priority Area 3: Access to Healthcare

Access to healthcare services is important for promoting and maintaining health, preventing and managing disease, and reducing the chance of premature death. Delayed care during the COVID-19 pandemic, particularly routine preventive services, occurred because of concerns around health and safety related to COVID, barriers around costs and insurance, and/or a lack of awareness regarding available services that different groups could qualify for. The community survey fielded in spring/summer 2021 asked respondents about their participation in various healthcare screenings, including preventive services. On average, respondents identifying as Hispanic/Latino reported the lowest utilization rates for annual physical exams and flu shots, while residents identifying as Asian reported the lowest utilization rates for dental and vision screenings.

Goal 3: Ensure all community members have awareness of and equitable access to affordable, comprehensive, culturally appropriate health education/information and quality care.

Objective 3.1: By December 2025, create a dynamic access point/hub for culturally appropriate social determinants of health provider information and service resources.

Outcome Indicator	Baseline	Target	Data Source
A Hub is created (current information systems are streamlined and integrated)			
Lead organization identified/ established to manage the Hub			
Increased awareness/understanding/ satisfaction levels of consumers as measured by surveys			
Social media impressions			
SDOH Guide with LIVE Well/HM (websites)			
Four resource events days convened			
Professional development training provided to school support staff			

Strategies

3.1.1 Define the purpose, function, and parameters of an improved "Hub."

3.1.2 Work with lead organization (MC Human Services) to streamline new programs to be included.
- Identify or provide point person for monthly updates.
- Tap into Rutgers for public health and other interns.

3.1.3 Promote the Middlesex County Services Locator. Create a marketing campaign including events, an app with resources, and a media campaign.
- Recruit video influencers to deliver.
- Develop a QR code to access resource directories.

3.1.4 Deliver professional development training to school support staff and additional CBOs.

Responsible Party(ies)

- Rutgers (faculty, staff and interns)
- School support staff
- United Way/NJ 211
- Middlesex County

Objective 3.2: By December 2025, develop a standard for the collection, analysis, and sharing of health service use data by individuals, community, and county.

Outcome Indicator	Baseline	Target	Data Source
Increase in number of data sources			
Improved, timely analysis and sharing of findings across data sources			
Number of data requests			

Strategies

3.2.1 Convene and recharge Healthier Middlesex Data Committee.

3.2.2 Identify current and potential data sources.

3.2.3 Develop standard metrics to collect and measure best practices and utilization rates across data sources (e.g., Medicare metric).

- Understand the feasibility of developing standard metrics for data collection.

3.2.4 Work with Healthier Middlesex Data Committee to analyze data and identify gaps in service provision.

3.2.5 Communicate findings with partners and stakeholders to support advocacy efforts at state and federal levels.

Responsible Party(ies)

- Healthier Middlesex Data Committee
- Agencies/partners who collect relevant data
- PolicyMap full access
- County, Human Services, and Health Department data

Objective 3.3: By December 2025, coordinate and align data collected from the community, health systems, and stakeholders to consistently measure social determinants of health (SDOH) (e.g., housing) and identify linguistically/culturally appropriate solutions.

Outcome Indicator	Baseline	Target	Data Source
Stakeholders (health providers, community organizations, and community members) engaged to identify needs, develop solutions, and provide feedback to enhance access to care			
Access to current transportation/housing/financial services and resources		Increase over baseline	
Establishment of standards for assessing SDOH data			
Improved patient experience scores			

Strategies

3.3.1 Convene and engage stakeholders (health providers, community organizations, and community members) to identify needs, develop solutions, and provide feedback to enhance access to care.

3.3.2 Work with content experts to promote and increase access to current SDOH (e.g., transportation/housing/financial) services and resources.

- Expand rideshare agreements among providers.

3.3.3 Collaborate with existing chronic disease/condition prevention and management programs to prioritize, implement, and promote disease-specific initiatives to target populations.
   - Develop a working group to explore and identify options/ideas, such as creating a fund and/or identifying grants to cover gaps in insurance coverage (copays, etc.).

Potential Partners and Resources

- Churches
- Community ambassadors
- Developers
- Financial Institutions
- Fraternal organizations
- Health ministries
- Health Networks: Healthier Middlesex, Healthier Perth Amboy
- Landlords
- Regional Chronic Disease Coalition
- Transportation providers
- Unite Us (system to help find resources)
- YMCA

Objective 3.4: By December 2025, increase by 10% the number of people in Middlesex County that participate in education programs to improve their health literacy, with a focus on engaging traditionally underserved communities/populations within the county.

Outcome Indicator	Baseline	Target	Data Source
Number of education sessions offered			
Number of people who attend health literacy education sessions		Increase over baseline	
Pre and post-test for health literacy			
Number of schools with health literacy in the curriculum			
Number of health literacy classes offered in the County			
Number of libraries with health literacy centers			
Number of providers who are providing health literacy education in community settings			
Number of health navigators in insurance companies			
Number of health navigators in hospitals			
Patient satisfaction survey scores with respect to care transitions			*Patient satisfaction surveys at hospitals*
Number of Conversation Tree trainings held with CHWs and RWJ Nurses			*RWJUH Staff*

Outcome Indicator	Baseline	Target	Data Source
Tools identified to increase accessibility to patient-centered health information and linked to Healthier Middlesex website			*Healthier Middlesex staff*
CHWs and patient navigators integrated into health literacy efforts			

Strategies

3.4.1 Engage more libraries in Middlesex County to participate in health screenings, disseminate information about other stakeholder health programs, and to offer technology trainings, including telehealth.

3.4.2 Provide online training for front-line health staff and other stakeholders focused on community health literacy and appropriate reading levels.

3.4.3 Develop inclusive and culturally appropriate content for health promotion and health literacy to be disseminated uniformly across the county.

- Flyers
- Social media
- Emergency Room vs Primary Care (when to utilize each)
- SMOG readability formula (resource/tool)

3.4.4 Explore available tools that increase accessibility to patient-centered health information (e.g., CDC tool that provides "translation" of medical terms into plain language, and hospital systems that convert diagnostic information into the relevant language for the patient); link to Healthier Middlesex website.

3.4.5 Enhance and integrate CHWs (who have knowledge of local resources and connection to community members) and patient navigators (who provide continuity of care) in health literacy efforts.

3.4.6 Promote incentives to increase attendance at health literacy sessions.

Responsible Party(ies)

- Community Based Organizations (CBOs)
- CDC
- Churches
- Community Health Workers (CHWs)
- Faith-based organizations
- Food banks
- Health service providers
- Hospitals (RWJUH, SPUH, and Hackensack Meridian Health)
- Libraries
- Schools

Objective 3.5: By December 2025, increase annually by 10% the number of residents that can access health and social services within their community, with a focus on engaging medically underserved populations within the county in their preferred language.

Outcome Indicator	Baseline	Target	Data Source
Patient/provider ratios in Middlesex County by municipality			
Amount of time it takes to get an appointment by provider type			
Number of health providers at all community events			
Evidence-based programs for expanding access via non-traditional access points identified			
Comprehensive resource developed to document and share information on current and alternative/nontraditional healthcare access points			
Increased awareness of access points			
Number of health screenings held in target communities		Increase over baseline	

Strategies

3.5.1 Conduct an inventory of available traditional and non-traditional access points for health information and health services.

3.5.2 Partner with non-traditional access points to continue services (e.g., retail food establishments are already mapped/documented to aid in the provision of healthy food distribution, so use these sites as non-traditional access points for health services).

3.5.3 Research evidence-based programs for expanding access via non-traditional access points (e.g., educational workshops and pop-up locations for provision of health services where people feel most comfortable).

3.5.4 Develop a comprehensive resource to document and share information on current and alternative/non-traditional healthcare access points.
- Initial focus on early screenings
- Utilize telehealth, social media, and CHWs to distribute

3.5.5 Raise awareness of available access points by educating community members through "community ambassadors" (e.g., hair salons, barber shops, local businesses, community organizations).

3.5.6 Partner with Health Department(s)/hospitals to schedule regular health screenings and vaccinations in target communities, utilizing nurses, nursing students, nursing organizations, etc.

Responsible Party(ies)

- Barber shops
- CBOs
- Faith-based organizations
- Hair salons
- Health Departments
- Hospitals

- Libraries
- Local businesses
- Retail food establishments
- Pharmacies
- Municipalities
- Parks/open spaces
- Schools

Priority Area 4: Supplemental Food Assistance

Not having reliable access to affordable, nutritious food is directly related to health and is impacted by financial insecurity. Rising food costs and availability; supporting the nutritional needs of children when Supplemental Nutrition Assistance Program (SNAP) benefits do not provide full coverage for those needs; and the stigma of asking for help and utilizing food pantries present significant challenges to addressing this issue.

Goal 4: Ensure access to and utilization of local, healthy, culturally appropriate, and sustainable food choices without stigma or barriers.

Objective 4.1: By December 2025, establish and increase the number of organizations addressing food insecurity that educate their staff and utilize mapping technology to promote their services and connect the community to resources.

Outcome Indicator	Baseline	Target	Data Source
Number of new people enrolled in SNAP			
Number of new people enrolled in WIC			
Number of providers offering SNAP/WIC enrollment on site			
Number of outreach events			
Number of people who access the Accessing Healthy Foods Map (AHFM)			
Inventory of food pantries providing Client Choice Model (CCM)			
Number of education sessions on best practices			
List of transportation/delivery options			

Strategies

4.1.1 Work with food insecurity resource providers to offer SNAP/WIC enrollment on site.

4.1.2 Promote guidelines and benefits for enrolling in the Accessing Healthy Foods Map (AHFM).

4.1.3 Work with food banks and pantries to support them in converting to the Client Choice Model (CCM), allowing people seeking food assistance to choose for themselves what products they receive; identify potential forums to educate food pantries on CCM.

4.1.4 Work with partners to engage/hire outreach staff to lead campaign about resources that address food insecurity.

4.1.5 Identify and work with partners to provide alternative transportation/delivery options for those who identify transportation as a barrier to accessing healthy foods.

Responsible Party(ies)

- Board of Social Services
- City/Township Health Departments
- Consumer advocacy groups
- Elijah's Promise (mobile food truck)
- Faith-based organizations
- Food banks
- Food pantries
- Lyft/Uber
- Meals on Wheels and other mobile food providers
- Middlesex County REPLENISH

- Community Food Bank of NJ (CFBNJ)
- Soup kitchens
- YMCAs

Objective 4.2: By December 2025, increase annually by 10% over baseline the number of health and social service providers who are educated on food resources and barriers to access.

Outcome Indicator	Baseline	Target	Data Source
Baseline established (Number of pantry staff)			
Number of workshops/trainings; resources located			
Number of health and social service providers who participated in workshops/trainings			
Number of community partners trained to implement the curriculum			

Strategies

4.2.1 Develop a curriculum to educate supplemental food assistance providers, health and social service providers, and other stakeholders on topics such as: using the Accessing Healthy Foods Map (AHFM) and the food bank directory; resources available; cultural barriers and stigma; the impact of the pandemic on food insecurity; dispelling misconceptions about food pantries; and food safety (Best by, Sell by, Use by dates).

4.2.2 Use the curriculum to train community partners and educate health and social service providers and other stakeholders.

4.2.3 Identify and secure resources required to deliver workshops/trainings for health and social service providers, law enforcement, case workers, and community health workers.

4.2.4 Conduct train the trainer sessions for community-based food insecurity resources (e.g., churches, pantries) and health and social service providers.

Responsible Party(ies)

- AHFM
- Board of Social Services
- Case workers
- Community Health Workers
- County Health Department
- County Office of Emergency Management
- Food banks
- Health and social service providers
- Law enforcement
- Middlesex County REPLENISH
- Middlesex County Office of Information Technology

Objective 4.3: By December 2025, create and expand the volunteer base of healthcare and other service providers by 50% from baseline to assist Middlesex County's food insecurity programs.

Outcome Indicator	Baseline	Target	Data Source
Number of corporate collaborations and volunteers at distribution sites		50% Increase over baseline	

Strategies

4.3.1 Promote opportunities for corporate collaborations (i.e., corporations provide coupons for products) and regular and consistent volunteering at distribution sites.

4.3.2 Expand support for Feeding Middlesex County through their social media campaigns.

4.3.3 Support capacity-building in food pantries (e.g., succession planning, leadership development, operational guidance, ensuring operational sustainability).

Responsible Party(ies)

- Soup Kitchen 411
- Corporations
- Feeding Middlesex County
- Middlesex County REPLENISH
- Government officials
- Hospitality industry
- Hospitals
- Restaurants
- Rutgers and Princeton Universities

Objective 4.4: By December 2025, increase community members' awareness and skills related to healthy eating, food safety, and available resources by 70%

Outcome Indicator	Baseline	Target	Data Source
Pre and post community surveys			
Number of community members actively engaged in healthy eating and food safety-related initiatives (trends year to year)			
Culturally relevant recipes using typical food pantry items compiled and posted on REPLENISH website			
Number of home gardening classes held			

Strategies

4.4.1 Assess availability of and participation in current workshops and conduct outreach to increase utilization.

4.4.2 Identify organizations to host and educators to lead additional community workshops related to healthy eating and food safety (e.g., senior groups/centers, schools and youth centers, social media/virtual settings, faith-based organizations, YMCAs, FSCs).

4.4.3 Deliver workshops where needed on topics such as nutritious meal preparation, healthy eating, accessing available community resources, food safety guidelines, food waste, and community gardens.
  - Content could include: Cooking classes, where to access ingredients, culturally appropriate ingredient substitutions, food safety, etc.

4.4.4 Lead an education campaign on using the AFHM online and offline.

4.4.5 Provide information on other available resources that address food insecurity at food distribution sites (e.g., resource table with culturally appropriate flyers/handouts in multiple languages).

4.4.6 Compile culturally relevant recipes using items typically found in food pantries to be shared on REPLENISH website.

4.4.7 Align with the appropriate partners to hold educational programs in schools, at food pantries, and other community sites to teach about home gardening.

Responsible Party(ies)

- Area Offices on Aging
- Chefs and food educators
- County Health Department
- Faith-based organizations
- Family Success Centers (FSCs)
- Libraries
- Master Gardeners
- Middlesex County REPLENISH
- Rows for the Hungry
- School nurses
- Schools and youth centers
- Senior groups/centers
- SNAP Ed.
- Social media/virtual sites
- WIC office
- YMCAs

Objective 4.5: By December 2025, increase access to supplemental food resources within the healthcare setting.

Outcome Indicator	Baseline	Target	Data Source
Food pantry in healthcare setting established			

Strategies

4.5.1 Establish a food pantry within a healthcare setting to increase access to supplemental food assistance.

Responsible Party(ies)

- CFBNJ
- REPLENISH
- RWJBH
- RWJUH
- SPUH

Next Steps and Sustainability

The components included in this report represent the strategic framework for a data-informed community health improvement plan (CHIP). Healthier Middlesex, along with its 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 during Plan implementation. RWJUH will continue to hold meetings and provide quarterly updates to the Healthier Middlesex Coalition to monitor progress and address any challenges for CHIP implementation.

Appendices

Appendix A: Participants in the CHIP Process
Appendix B: RWJB Hospital System Prioritization Tool
Appendix C: Acronyms
Appendix D: RWJUH Strategic Implementation Plan (SIP) Focus Areas
Appendix E: SPUH Strategic Implementation Plan (SIP) Focus Areas

Appendix A: Participants in the CHIP Planning Process

Priority Area 1: Mental Health and Substance Use	***Priority Area 2: Financial Well-being and Housing Stability***
Lynn Sherman- Girls on the Run *Mara Carlin- Wellspring Center for Prevention* *ShaRonda Amon- Wellspring Center for Prevention* *Charoulla Georgiou- Middlesex County Municipal Alliance* *Lisa Powell- NAMI, NJ* *Viviana De Los Angeles- Middlesex County Office of Health Services* *Marge Drozd- Saint Peter's University Hospital* *Meghan Bissett- Rutgers School of Public Health* *Jennifer Sevilla- Saint Peter's University Hospital/ New Brunswick Board of Education* *Diana Starace- Robert Wood Johnson University Hospital*	*Camilla Comer-Carruthers- Robert Wood Johnson University Hospital* *Gina Stravic- Raritan Valley YMCA* *Robert LaForgia- Healthier Middlesex* *Gregg Ficarra- Woodbridge Mayor's Wellness Council* *Deborah Morgan- New Brunswick NAACP* *Mary Ann Allard- New Brunswick NAACP* *Jose Montes- PRAB* *Christine Newman- AARP*
Priority Area 3: Access to Healthcare	***Priority Area 4: Supplemental Food Assistance***
John Dowd- Middlesex County Office of Health Services *Angella Reid- Saint Peter's University Hospital* *Manuel Castaneda- New Brunswick Tomorrow* *Melissa Hernandez- Robert Wood Johnson University Hospital* *Karen Parry- East Brunswick Public Library* *Shailja Mathur- Rutgers Cooperative Extension* *Mariam Merced- Robert Wood Johnson University Hospital* *Agny Valle- Rutgers HIPHOP* *Susan Girodano- Rutgers HIPHOP*	*Jennifer Apostol- REPLENISH* *Marianella Flores- Middlesex County* *Brenda Crespo- Raritan Bay Area YMCA* *Julie Marte- AARP* *Mohamed Ayad- Healthier Middlesex* *Rosela Roman- Mobile Family Success Center* *Syeda Jaffry- Mobile Family Success Center*

HRiA Facilitators
Donna Burke
Eliza Campbell
Heather Sumba
Rose Purrelli Swensen

Healthier Middlesex Reviewers
Jennifer Apostol
Mara Carlin
Camilla Comer-Carruthers
Michael Davidson
Robert LaForgia
Deborah Morgan
Christine Newman
Maria Pellerano

Appendix B: RWJ Barnabas Health System Prioritization Rating Tool

We are asking you to provide input in rating the key issues identified in the Middlesex 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 **CHNA Key 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

Appendix C: Acronyms

AHFM	Accessing Healthy Foods Map
CBO	Community Based Organizations
CCM	Client Choice Model
CDC	Centers for Disease Control and Prevention
CFBNJ	Community Food Bank of NJ
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CHW	Community Health Worker
COVID-19	Coronavirus Disease 2019
DOE	Department of Education
DOH	Department of Health
HSAC	Human Services Advisory Council
IRS	Internal Revenue Service
MA	Massachusetts
MAPP	Mobilization for Action through Planning and Partnership
NAMI	National Alliance on Mental Illness
NIH	National Institute of Health
NJ	New Jersey
PHAB	Public Health Accreditation Board
RWJ	Robert Wood Johnson
RWJBH	Robert Wood Johnson Barnabas Healthcare
RWJUH	Robert Wood Johnson University Hospital
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SIP	Strategic Implementation Plan
SMOG	Simple Measure of Gobbledygook
SNAP	Supplemental Nutrition Assistance Program
SPUH	Saint Peter's University Hospital
US	United States
WIC	Women, Infants, and Children's Program
YMCA	Young Men's Christian Association

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

The CHNA report provides a more in-depth discussion of the communities served and the methods, participants, and findings leading to the selected priorities (https://www.healthiermiddlesex.com/assessments-plans).

While there were other significant needs that were identified in the CHNA, the hospital has limited resources and therefore must focus on prioritized needs to be most successful in its improvement efforts for the SIP. The SIP does not include all activities that are or may be undertaken by the hospital, but those developed to achieve specific objectives within the mission of Community Benefit.

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

Robert Wood Johnson University Hospital (RWJUH) Strategic Implementation Plan (SIP) Focus Areas
Priority 1: Mental Health and Substance Use
Goal 1: Establish a system to enhance equitable, local access to, and availability and utilization of, affordable, culturally aware mental health and substance use resources for all in Middlesex County.
Objective 1.1: By December 2025, increase equitable access to and availability of mental health and substance use prevention and wellness programs in Middlesex County by updating and aligning the Behavioral Health Resource and Referral Guide (BHRRG) and the Middlesex County Service Locator.
Outcome Indicators
• Number of prevention and wellness programs • Number of people accessing programs (increase over baseline) • Prevention and wellness programs' quality and outcomes • Number of trainings conducted (MHFA and others) (increase over baseline) • Number of people trained across all trainings • Number of future providers trained across all trainings
Strategies
1.1.1 Cross reference the list of services in the Behavioral Health Resource and Referral Guide (BHRRG) to those in the Middlesex County Service Locator to incorporate services missing from each guide/database and identify gaps in prevention and wellness programs in Middlesex County. 1.1.2 Collaborate with all Healthier Middlesex organizations and mental health and substance use providers in a process to address gaps. 1.1.3 Continue to provide free mental health and substance use wellness trainings for Healthier Middlesex Partners and Healthcare providers.
Objective 1.2: By December 2025, increase utilization of mental health, substance use, and wellness services by 10% from baseline.
Outcome Indicators
• Anti-stigma communication campaign launched. • Increased use of the BHRRG. • Number of calls to state hotlines segmented by county (e.g., 988).
Strategies
1.2.1 Align and partner with the County Stigma Campaign to promote the awareness of Mental Health and Substance Use service providers. 1.2.2 Align and partner with community based mental health organizations and partners to promote culturally aware education programs. 1.2.3 Recruit and train trusted messengers for educational programs. 1.2.4 Promote tools to empower families and caregivers. 1.2.5 Identify gaps in service utilization, population, and types of service.

1.2.6 Promote the use of the BHRRG to connect residents to existing mental health services.
1.2.7 Explore the intake process for the 988 line, identify gaps/barriers, and promote the use of the 988 line.

Objective 1.3: By December 2025, expand the RWJUH- Hospital Violence Intervention Program (HVIP), serving traumatically injured adult victims of community violence, to improve patient outcomes, reduce patient re-injury, and reduce retaliatory violence.

Outcome Indicators

- Number of crime victim patients enrolled in HVIP and provided case management over 15-month period
- Number of patients enrolled in the HVIP who come from the ED
- Documented receipt of consent, intake, and case plan
- Documented receipt of program brochure
- Reduced traumatic symptoms among patients who accept mental health counseling
- Percent of patients who report a positive experience with the HVIP
- Percent of HVIP program participants' goals achieved thru a trauma-informed, collaborative case management approach

Strategies

1.3.1 Actively recruit, engage, and enroll a minimum of 75 additional traumatically injured victims of community violence admitted to the Trauma Service.
  - Actively recruit to ensure that at least 50% of traumatically injured victims of community violence admitted to the Trauma Service come from the ED.
  - Obtain patient consent, conduct intake, and create the initial case plan including a safety plan.

1.3.2 Ensure that all eligible patients introduced to the HVIP receive a program brochure and support to meet their current needs.
1.3.3 Provide ongoing advocacy and case management for 6-12 months.
1.3.4 Implement Patient Experience Surveys at 6 months and at program end.
1.3.5 Utilize participant benchmark reports to assess individual progress.
1.3.6 Utilize Penelope software to document, track, and identify trends.

Objective 1.4: By December 2025, enhance and support collaborations with internal and external partners to improve outcomes for HVIP participants.

Outcome Indicators

- Percent of patients who report a positive experience with the HVIP
- Consortium members' understanding of root causes of community violence and the impact of systemic racism
- Number of member organizations who use a trauma-informed approach and engage patients and their families in decision-making
- Number of families impacted by violence and poverty that participate in Safe Spaces community gatherings during the HVIP grant period (reduced isolation and increased awareness of resources)
- Annual March and Rally Against Domestic Violence conducted
  - Number of CBOs attending
  - Number of attendees
  - Number of flyers on violence resources distributed
- Number of at-risk New Brunswick students who learn tools to increase resiliency and how to express themselves using art as an alternative to violence

Strategies

1.4.1 Conduct bimonthly WAVE Consortium meetings to identify trends in service gaps for program participants and enhance a safety net that is accessible to a diverse community.
1.4.2 Work with community partners to expand monthly Safe Spaces community gatherings initiative within neighborhoods heavily impacted by community violence and poverty.
1.4.3 Collaborate with the New Brunswick Domestic Violence Awareness Coalition to expand community awareness of domestic violence prevention and resources by:
  - Co-sponsoring Annual March & Rally Against Domestic Violence
  - Recruiting more community-based organizations to participate
  - Engaging attendees
  - Distributing flyers with community, domestic, and sexual violence hotlines/resources

1.4.4	Provide two anti-violence workshops and a public art mural in partnership with the Artists Mentoring Against Racism, Drugs, and Violence: Healing Through the Arts (AMARD&V) summer program for at-risk youth in New Brunswick.

Robert Wood Johnson University Hospital (RWJUH)
Strategic Implementation Plan (SIP) Focus Areas

Priority 2: Financial Well-being and Housing Stability

Goal 2: Everyone has equitable access to secure the financial resources to meet their basic needs, save for the future, and maintain safe, quality, and stable housing.

Objective 2.1: By December 2025, increase the number of people who participate in financial literacy programs within Middlesex County, with a focus on engaging traditionally underserved communities/populations.

Outcome Indicators

- List of organizations in Middlesex County that offer financial literacy classes
- Number of financial literacy classes offered in Middlesex County
- Number of participants that attend/complete financial literacy classes offered in Middlesex County
- Pre-and post-test for financial literacy
- Number of participants that attend/complete employer-based financial literacy classes.
- Number of schools with financial literacy in the curriculum.
- Number of traditional/non-traditional partners that offer financial literacy classes.
- Number of employer-based financial literacy classes offered.

Strategies

2.1.1 Identify, provide, and promote organizations (within and outside of Healthier Middlesex) that offer financial literacy education classes (with and without participation incentives) to share learnings and increase participation.

2.1.2 Work with traditional and non-traditional partners (small business employers, CBOs) to identify, provide, and promote incentives for people to participate in financial literacy classes (e.g., first-time home buyers, 401k savings).

2.1.3 Promote employer-based financial literacy training for employers and employees (staff) and develop best practices for employers to offer trainings.

2.1.4 Utilize multi-media approaches for education and promotion of financial literacy.

2.1.5 Inventory financial literacy education in schools within Middlesex County (as mandated in NJ) and advocate for inclusion where applicable, especially in New Brunswick and Perth Amboy schools' curricula; Assess against minimum requirement for schools per legislation.

Objective 2.2: By December 2025, partner with community-based organizations in Middlesex County to hold 5 employment fairs within the community for county residents.

Outcome Indicators

- Number of residents participating in employment fairs
- Number of posts on social media
- Social media engagement
- Number of employers participating in employment fairs
- Number of cities targeted for the employment fairs

Strategies

2.2.1 Share information about educational opportunities and job training (e.g., evening vocational/technical training, AmeriCorps, Skill Up NJ).

2.2.2 Partner with the Workforce Development Board and the Human Services Advisory Council (HSAC) to identify opportunities for collaboration, networking, and leveraging resources.

2.2.3 Invite employers to be part of the discussion and solutions for increasing the number of opportunities available.

2.2.4 Host hiring events with major employers in Middlesex County (SPUH, RWJUH, Rutgers, MCC, etc.) to increase the number of people who have local, gainful employment (e.g., partner with current hiring local initiatives inclusive of but not limited to job fairs).

2.2.5 Invite employers to community events (other than job fairs) to advertise open positions that promote stable and secure job opportunities that have the possibility for advancement.

Objective 2.4: By December 2025, hold 3 workshops per year to increase the education on and awareness of safe, affordable housing options.

Outcome Indicators	
• Number/percent of housing units available in communities of greatest need • Broad and diverse coalition of stakeholders convened to address affordable housing and the housing crisis in Middlesex County • Number of Healthy homes social media posts • Number of innovative, replicable projects/pilots for expanding affordable housing identified and shared	
Strategies	
2.4.1	Determine the number of organizations working with residents on affordable housing within Middlesex County.
2.4.2	Convene a broad and diverse coalition of stakeholders to participate in and support housing education in Middlesex County.
2.4.3	Conduct an inventory of available resources for housing education.
2.4.4	Utilize the available resource inventory tools (e.g., lessons learned from BUILD, Healthy Home Roadmap) to expand on housing resources.
2.4.5	Source and share innovative, replicable projects/pilots for expanding safe, affordable housing.

Robert Wood Johnson University Hospital (RWJUH)
Strategic Implementation Plan (SIP) Focus Areas

Priority 3: Access to Healthcare

Goal 3: Ensure all community members have awareness of and equitable access to affordable, comprehensive, culturally appropriate health education/information and quality care.

Objective 3.2: By December 2025, develop a standard for the collection, analysis, and sharing of health service use data by individuals, community, and county.

Outcome Indicators

- Increase in number of data sources
- Improved, timely analysis and sharing of findings across data sources
- Number of data requests

Strategies

3.2.1 Convene and recharge Healthier Middlesex Data Committee.
3.2.2 Identify current and potential data sources.
3.2.3 Develop standard metrics to collect and measure best practices and utilization rates across data sources (e.g., Medicare metric).
  - Understand the feasibility of developing standard metrics for data collection.
3.2.4 Work with Healthier Middlesex Data Committee to analyze data and identify gaps in service provision.
3.2.5 Communicate findings with partners and stakeholders to support advocacy efforts at state and federal levels.

Objective 3.3: By December 2025, coordinate and align data collected from the community, health systems, and stakeholders to consistently measure social determinants of health (SDOH) (e.g., housing) and identify linguistically/culturally appropriate solutions.

Outcome Indicators

- Stakeholders (health providers, community organizations, and community members) engaged to identify needs, develop solutions, and provide feedback to enhance access to care
- Access to current transportation/housing/financial services and resources
- Establishment of standards for assessing SDOH data
- Improved patient experience scores

Strategies

3.3.1 Convene and engage stakeholders (health providers, community organizations, and community members) to identify needs, develop solutions, and provide feedback to enhance access to care.
3.3.2 Work with content experts to promote and increase access to current SDOH (e.g., transportation/housing/financial) services and resources.
  - Expand rideshare agreements among providers.
3.3.3 Collaborate with existing chronic disease/condition prevention and management programs to prioritize, implement, and promote disease-specific initiatives to target populations.
  - Develop a working group to explore and identify options/ideas, such as creating a fund and/or identifying grants to cover gaps in insurance coverage (copays, etc.).

Objective 3.4: By December 2025, increase by 10% the number of people in Middlesex County that participate in education programs to improve their health literacy, with a focus on engaging traditionally underserved communities/populations within the county.

Outcome Indicators

- Number of education sessions offered
- Number of people who attend health literacy education sessions
- Pre and post-test for health literacy
- Number of health literacy classes offered in the County
- Number of libraries with health literacy centers
- Number of providers who are providing health literacy education in community settings
- Number of health navigators in hospitals
- Patient satisfaction survey scores with respect to care transitions
- Number of Conversation Tree trainings held with CHWs and RWJ Nurses

- Tools identified to increase accessibility to patient-centered health information and linked to Healthier Middlesex website
- CHWs and patient navigators integrated into health literacy efforts

Strategies

3.4.1 Engage more libraries in Middlesex County to participate in health screenings, disseminate information about other stakeholder health programs, and to offer technology trainings, including telehealth.

3.4.2 Provide online training for front-line health staff and other stakeholders focused on community health literacy and appropriate reading levels.

3.4.3 Develop inclusive and culturally appropriate content for health promotion and health literacy to be disseminated uniformly across the county.
- Flyers
- Social media
- Emergency Room vs Primary Care (when to utilize each)
- SMOG readability formula (resource/tool)

3.4.4 Explore available tools that increase accessibility to patient-centered health information (e.g., CDC tool that provides "translation" of medical terms into plain language, and hospital systems that convert diagnostic information into the relevant language for the patient); link to Healthier Middlesex website.

3.4.5 Enhance and integrate CHWs (who have knowledge of local resources and connection to community members) and patient navigators (who provide continuity of care) in health literacy efforts.

3.4.6 Promote incentives to increase attendance at health literacy sessions.

Objective 3.5: By December 2025, increase annually by 10% the number of residents that can access health and social services within their community, with a focus on engaging medically underserved populations within the county in their preferred language.

Outcome Indicators

- Number of health providers at all community events
- Evidence-based programs for expanding access via non-traditional access points identified
- Comprehensive resource developed to document and share information on current and alternative/nontraditional healthcare access points
- Increased awareness of access points
- Number of health screenings held in target communities

Strategies

3.5.1 Conduct an inventory of available traditional and non-traditional access points for health information and health services.

3.5.2 Partner with non-traditional access points to continue services (e.g., retail food establishments are already mapped/documented to aid in the provision of healthy food distribution, so use these sites as non-traditional access points for health services).

3.5.3 Research evidence-based programs for expanding access via non-traditional access points (e.g., educational workshops and pop-up locations for provision of health services where people feel most comfortable).

3.5.4 Develop a comprehensive resource to document and share information on current and alternative/non-traditional healthcare access points.
- Initial focus on early screenings
- Utilize telehealth, social media, and CHWs to distribute

3.5.5 Raise awareness of available access points by educating community members through "community ambassadors" (e.g., hair salons, barber shops, local businesses, community organizations).

3.5.6 Partner with Health Department(s)/hospitals to schedule regular health screenings and vaccinations in target communities, utilizing nurses, nursing students, nursing organizations, etc.

Robert Wood Johnson University Hospital (RWJUH) Strategic Implementation Plan (SIP) Focus Areas
Priority 4: Supplemental Food Assistance
Goal 4: Ensure access to and utilization of local, healthy, culturally appropriate, and sustainable food choices without stigma or barriers.
Objective 4.1: By December 2025, establish and increase the number of organizations addressing food insecurity that educate their staff and utilize mapping technology to promote their services and connect the community to resources.
Outcome Indicators
• Number of new people enrolled in SNAP • Number of new people enrolled in WIC • Number of providers offering SNAP/WIC enrollment on site • Number of outreach events • Number of people who access the Accessing Healthy Foods Map (AHFM) • Inventory of food pantries providing Client Choice Model (CCM) • Number of education sessions on best practices • List of transportation/delivery options
Strategies
4.1.1 Work with food insecurity resource providers to offer SNAP/WIC enrollment on site. 4.1.2 Promote guidelines and benefits for enrolling in the Accessing Healthy Foods Map (AHFM). 4.1.3 Work with food banks and pantries to support them in converting to the Client Choice Model (CCM), allowing people seeking food assistance to choose for themselves what products they receive; identify potential forums to educate food pantries on CCM. 4.1.4 Work with partners to engage/hire outreach staff to lead campaign about resources that address food insecurity. 4.1.5 Identify and work with partners to provide alternative transportation/delivery options for those who identify transportation as a barrier to accessing healthy foods.
Objective 4.2: By December 2025, increase annually by 10% over baseline the number of health and social service providers who are educated on food resources and barriers to access.
Outcome Indicators
• Baseline established (Number of pantry staff) • Number of workshops/trainings; resources located • Number of health and social service providers who participated in workshops/trainings • Number of community partners trained to implement the curriculum
Strategies
4.2.1 Develop a curriculum to educate supplemental food assistance providers, health and social service providers, and other stakeholders on topics such as: using the Accessing Healthy Foods Map (AHFM) and the food bank directory; resources available; cultural barriers and stigma; the impact of the pandemic on food insecurity; dispelling misconceptions about food pantries; and food safety (Best by, Sell by, Use by dates). 4.2.2 Use the curriculum to train community partners and educate health and social service providers and other stakeholders. 4.2.3 Identify and secure resources required to deliver workshops/trainings for health and social service providers, law enforcement, case workers, and community health workers. 4.2.4 Conduct train the trainer sessions for community-based food insecurity resources (e.g., churches, pantries) and health and social service providers.
Objective 4.3: By December 2025, create and expand the volunteer base of healthcare and other service providers by 50% from baseline to assist Middlesex County's food insecurity programs.
Outcome Indicators
• Number of corporate collaborations and volunteers at distribution sites
Strategies

4.3.1	Promote opportunities for corporate collaborations (i.e., corporations provide coupons for products) and regular and consistent volunteering at distribution sites.
4.3.2	Expand support for Feeding Middlesex County through their social media campaigns.
4.3.3	Support capacity-building in food pantries (e.g., succession planning, leadership development, operational guidance, ensuring operational sustainability).

Objective 4.4: By December 2025, increase community members' awareness and skills related to healthy eating, food safety, and available resources by 70%

Outcome Indicators

- Pre and post community surveys
- Number of community members actively engaged in healthy eating and food safety-related initiatives (trends year to year)
- Culturally relevant recipes using typical food pantry items compiled and posted on REPLENISH website
- Number of home gardening classes held

Strategies

4.4.1	Assess availability of and participation in current workshops and conduct outreach to increase utilization.
4.4.2	Identify organizations to host and educators to lead additional community workshops related to healthy eating and food safety (e.g., senior groups/centers, schools and youth centers, social media/virtual settings, faith-based organizations, YMCAs, FSCs).
4.4.3	Deliver workshops where needed on topics such as nutritious meal preparation, healthy eating, accessing available community resources, food safety guidelines, food waste, and community gardens. – Content could include: Cooking classes, where to access ingredients, culturally appropriate ingredient substitutions, food safety, etc.
4.4.4	Lead an education campaign on using the AFHM online and offline.
4.4.5	Provide information on other available resources that address food insecurity at food distribution sites (e.g., resource table with culturally appropriate flyers/handouts in multiple languages).
4.4.6	Compile culturally relevant recipes using items typically found in food pantries to be shared on REPLENISH website.
4.4.7	Align with the appropriate partners to hold educational programs in schools, at food pantries, and other community sites to teach about home gardening.

Objective 4.5: By December 2025, increase access to supplemental food resources within the healthcare setting.

Outcome Indicators

- Food pantry in healthcare setting established
- Farm Box Subscription Program established at RWJUH for employees

Strategies

4.5.1	Establish a food pantry within a healthcare setting to increase access to supplemental food assistance.
4.5.2	Work with the RWJBH – Social Impact and Community Investment team to promote the online Farm Box Subscription Program amongst RWJUH employees to increase access to fresh, locally sourced food.

Appendix E: SPUH Strategic Implementation Plan (SIP) Focus Areas

The CHNA report provides a more in-depth discussion of the communities served and the methods, participants, and findings leading to the selected priorities (https://www.healthiermiddlesex.com/assessments-plans).

While there were other significant needs that were identified in the CHNA, the hospital has limited resources and therefore must focus on prioritized needs to be most successful in its improvement efforts for the SIP. The SIP does not include all activities that are or may be undertaken by the hospital, but those developed to achieve specific objectives within the mission of Community Benefit.

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

Saint Peter's University Hospital **Strategic Implementation Plan (SIP) Focus Areas**
Priority 1: Mental Health and Substance Use
Goal 1: Establish a system to enhance equitable, local access to, and availability and utilization of, affordable, culturally aware mental health and substance use resources for all in Middlesex County.
Objective 1.1: By December 2025, increase equitable access to and availability of mental health and substance use prevention and wellness programs in Middlesex County by updating and aligning the Behavioral Health Resource and Referral Guide (BHRRG) and the Middlesex County Service Locator.
Outcome Indicators
• Number of prevention and wellness programs • Number of people accessing programs (increase over baseline) • Prevention and wellness programs' quality and outcomes • Number of trainings conducted (MHFA and others) (increase over baseline) • Number of people trained across all trainings • Number of future providers trained across all trainings
Strategies
1.1.1 Cross reference the list of services in the BHRRG to those in the Middlesex County Service Locator to incorporate services missing from each guide/database and identify gaps in prevention and wellness programs in Middlesex County. 1.1.2 Collaborate with all Healthier Middlesex organizations and mental health and substance use providers in a process to address gaps.
Objective 1.2: By December 2025, increase utilization of mental health, substance use, and wellness services by 10% from baseline.
Outcome Indicators
• Anti-stigma communication campaign launched. • Increased use of the BHRRG. • Number of calls to state hotlines segmented by county (e.g., 988).
Strategies
1.2.2 Align and partner with community based mental health organizations and partners to promote culturally aware education programs. 1.2.3 Recruit and train trusted messengers for educational programs. 1.2.4 Promote tools to empower families and caregivers. 1.2.5 Identify gaps in service utilization, population, and types of service. 1.2.6 Promote the use of the resource guide to connect residents to existing mental health services.

1.2.7	Offer support groups related to depression/anxiety and other important, relevant topics for our patients based on continuous information gathering and aggregation

Saint Peter's University Hospital Strategic Implementation Plan (SIP) Focus Areas
Priority 2: Financial Well-being and Housing Stability
Goal 2: Everyone has equitable access to secure the financial resources to meet their basic needs, save for the future, and maintain safe, quality, and stable housing.
Objective 2.1: By December 2025, increase the number of people who participate in financial literacy programs within Middlesex County, with a focus on engaging traditionally underserved communities/populations.
Outcome Indicators
• List of organizations in Middlesex County that offer financial literacy classes • Number of financial literacy classes offered in Middlesex County • Number of participants that attend/complete financial literacy classes offered in Middlesex County • Pre-and post-test for financial literacy • Number of participants that attend/complete employer-based financial literacy classes. • Number of schools with financial literacy in the curriculum. • Number of traditional/non-traditional partners that offer financial literacy classes. • Number of employer-based financial literacy classes offered.
Strategies
2.1.1 Identify, provide, and promote organizations (within and outside of Healthier Middlesex) that offer financial literacy education classes (with and without participation incentives) to share learnings and increase participation. 2.1.2 Work with traditional and non-traditional partners (small business employers, CBOs) to identify, provide, and promote incentives for people to participate in financial literacy classes (e.g., first-time home buyers, 401k savings). 2.1.3 Promote employer-based financial literacy training for employers and employees (staff) and develop best practices for employers to offer trainings. 2.1.4 Utilize multi-media approaches for education and promotion of financial literacy. 2.1.5 Inventory financial literacy education in schools within Middlesex County (as mandated in NJ) and advocate for inclusion where applicable, especially in New Brunswick and Perth Amboy schools' curricula; Assess against minimum requirement for schools per legislation.
Objective 2.2: By December 2025, partner with community-based organizations in Middlesex County to hold 5 employment fairs within the community for county residents.
Outcome Indicators
• Number of residents participating in employment fairs • Number of posts on social media • Social media engagement • Number of employers participating in employment fairs • Number of cities targeted for the employment fairs
Strategies
2.2.1 Share information about educational opportunities and job training (e.g., evening vocational/technical training, AmeriCorps, Skill Up NJ). 2.2.2 Partner with the Workforce Development Board and the Human Services Advisory Council (HSAC) to identify opportunities for collaboration, networking, and leveraging resources. 2.2.3 Invite employers to be part of the discussion and solutions for increasing the number of opportunities available. 2.2.4 Host hiring events with major employers in Middlesex County (SPUH, RWJUH, Rutgers, MCC, etc.) to increase the number of people who have local, gainful employment (e.g., partner with current hiring local initiatives inclusive of but not limited to job fairs). 2.2.5 Invite employers to community events (other than job fairs) to advertise open positions that promote stable and secure job opportunities that have the possibility for advancement.
Objective 2.4: By December 2025, hold 3 workshops per year to increase the education on and awareness of safe, affordable housing options.

Outcome Indicators	
• Number/percent of housing units available in communities of greatest need • Broad and diverse coalition of stakeholders convened to address affordable housing and the housing crisis in Middlesex County • Number of Healthy homes social media posts • Number of innovative, replicable projects/pilots for expanding affordable housing identified and shared	
Strategies	
2.4.1	Determine the number of organizations working with residents on affordable housing within Middlesex County.
2.4.2	Convene a broad and diverse coalition of stakeholders to participate in and support housing education in Middlesex County.
2.4.3	Conduct an inventory of available resources for housing education.
2.4.4	Utilize the available resource inventory tools (e.g., lessons learned from BUILD, Healthy Home Roadmap) to expand on housing resources.
2.4.5	Source and share innovative, replicable projects/pilots for expanding safe, affordable housing.

Saint Peter's University Hospital
Strategic Implementation Plan (SIP) Focus Areas

Priority 3: Access to Healthcare

Goal 3: Ensure all community members have awareness of and equitable access to affordable, comprehensive, culturally appropriate health education/information and quality care.

Objective 3.2: By December 2025, develop a standard for the collection, analysis, and sharing of health service use data by individuals, community, and county.

Outcome Indicators

- Increase in number of data sources
- Improved, timely analysis and sharing of findings across data sources
- Number of data requests

Strategies

3.2.1 Convene and recharge Healthier Middlesex Data Committee.
3.2.2 Identify current and potential data sources.
3.2.3 Develop standard metrics to collect and measure best practices and utilization rates across data sources (e.g., Medicare metric).
  - Understand the feasibility of developing standard metrics for data collection.
3.2.4 Work with Healthier Middlesex Data Committee to analyze data and identify gaps in service provision.
3.2.5 Communicate findings with partners and stakeholders to support advocacy efforts at state and federal levels.

Objective 3.3: By December 2025, coordinate and align data collected from the community, health systems, and stakeholders to consistently measure social determinants of health (SDOH) (e.g., housing) and identify linguistically/culturally appropriate solutions.

Outcome Indicators

- Stakeholders (health providers, community organizations, and community members) engaged to identify needs, develop solutions, and provide feedback to enhance access to care
- Access to current transportation/housing/financial services and resources
- Establishment of standards for assessing SDOH data
- Improved patient experience scores

Strategies

3.3.1 Convene and engage stakeholders (health providers, community organizations, and community members) to identify needs, develop solutions, and provide feedback to enhance access to care.
3.3.2 Work with content experts to promote and increase access to current SDOH (e.g., transportation/housing/financial) services and resources.
  - Expand rideshare agreements among providers.
3.3.3 Collaborate with existing chronic disease/condition prevention and management programs to prioritize, implement, and promote disease-specific initiatives to target populations.
  - Develop a working group to explore and identify options/ideas, such as creating a fund and/or identifying grants to cover gaps in insurance coverage (copays, etc.).

Objective 3.4: By December 2025, increase by 10% the number of people in Middlesex County that participate in education programs to improve their health literacy, with a focus on engaging traditionally underserved communities/populations within the county.

Outcome Indicators

- Number of education sessions offered
- Number of people who attend health literacy education sessions
- Pre and post-test for health literacy
- Number of health literacy classes offered in the County
- Number of libraries with health literacy centers
- Number of providers who are providing health literacy education in community settings
- Number of health navigators in hospitals
- Patient satisfaction survey scores with respect to care transitions
- Number of Conversation Tree trainings held with CHWs and RWJ Nurses

- Tools identified to increase accessibility to patient-centered health information and linked to Healthier Middlesex website
- SDOH Coordinators and patient navigators integrated into health literacy efforts

Strategies

3.4.1 Engage more libraries in Middlesex County to participate in health screenings, disseminate information about other stakeholder health programs, and to offer technology trainings, including telehealth.

3.4.2 Provide online training for front-line health staff and other stakeholders focused on community health literacy and appropriate reading levels.

3.4.3 Develop inclusive and culturally appropriate content for health promotion and health literacy to be disseminated uniformly across the county.
- Flyers
- Social media
- Emergency Room vs Primary Care (when to utilize each)
- SMOG readability formula (resource/tool)

3.4.4 Explore available tools that increase accessibility to patient-centered health information (e.g., CDC tool that provides "translation" of medical terms into plain language, and hospital systems that convert diagnostic information into the relevant language for the patient); link to Healthier Middlesex website.

3.4.5 Enhance and integrate CHWs (who have knowledge of local resources and connection to community members) and patient navigators (who provide continuity of care) in health literacy efforts.

3.4.6 Promote incentives to increase attendance at health literacy sessions.

Objective 3.5: By December 2025, increase annually by 10% the number of residents that can access health and social services within their community, with a focus on engaging medically underserved populations within the county in their preferred language.

Outcome Indicators

- Number of health providers at all community events
- Evidence-based programs for expanding access via non-traditional access points identified
- Comprehensive resource developed to document and share information on current and alternative/nontraditional healthcare access points
- Increased awareness of access points
- Number of health screenings held in target communities

Strategies

3.5.1 Conduct an inventory of available traditional and non-traditional access points for health information and health services.

3.5.2 Partner with non-traditional access points to continue services (e.g., retail food establishments are already mapped/documented to aid in the provision of healthy food distribution, so use these sites as non-traditional access points for health services).

3.5.3 Research evidence-based programs for expanding access via non-traditional access points (e.g., educational workshops and pop-up locations for provision of health services where people feel most comfortable).

3.5.4 Develop a comprehensive resource to document and share information on current and alternative/non-traditional healthcare access points.
- Initial focus on early screenings
- Utilize telehealth, social media, and CHWs to distribute

3.5.5 Raise awareness of available access points by educating community members through "community ambassadors" (e.g., hair salons, barber shops, local businesses, community organizations).

3.5.6 Partner with Health Department(s)/hospitals to schedule regular health screenings and vaccinations in target communities, utilizing nurses, nursing students, nursing organizations, etc.

Saint Peter's University Hospital Strategic Implementation Plan (SIP) Focus Areas	
Priority 4: Supplemental Food Assistance	
Goal 4: Ensure access to and utilization of local, healthy, culturally appropriate, and sustainable food choices without stigma or barriers.	
Objective 4.1: By December 2025, establish and increase the number of organizations addressing food insecurity that educate their staff and utilize mapping technology to promote their services and connect the community to resources.	
Outcome Indicators	
• Number of new people enrolled in SNAP • Number of new people enrolled in WIC • Number of providers offering SNAP/WIC enrollment on site • Number of outreach events • Number of people who access the Accessing Healthy Foods Map (AHFM) • Inventory of food pantries providing Client Choice Model (CCM) • Number of education sessions on best practices • List of transportation/delivery options	
Strategies	
4.1.1	Work with food insecurity resource providers to offer SNAP/WIC enrollment on site.
4.1.2	Promote guidelines and benefits for enrolling in the Accessing Healthy Foods Map (AHFM).
4.1.3	Work with food banks and pantries to support them in converting to the Client Choice Model (CCM), allowing people seeking food assistance to choose for themselves what products they receive; identify potential forums to educate food pantries on CCM.
4.1.4	Work with partners to engage/hire outreach staff to lead campaign about resources that address food insecurity.
4.1.5	Identify and work with partners to provide alternative transportation/delivery options for those who identify transportation as a barrier to accessing healthy foods.
Objective 4.2: By December 2025, increase annually by 10% over baseline the number of health and social service providers who are educated on food resources and barriers to access.	
Outcome Indicators	
• Baseline established (Number of pantry staff) • Number of workshops/trainings; resources located • Number of health and social service providers who participated in workshops/trainings • Number of community partners trained to implement the curriculum	
Strategies	
4.2.1	Develop a curriculum to educate supplemental food assistance providers, health and social service providers, and other stakeholders on topics such as: using the Accessing Healthy Foods Map (AHFM) and the food bank directory; resources available; cultural barriers and stigma; the impact of the pandemic on food insecurity; dispelling misconceptions about food pantries; and food safety (Best by, Sell by, Use by dates).
4.2.2	Use the curriculum to train community partners and educate health and social service providers and other stakeholders.
4.2.3	Identify and secure resources required to deliver workshops/trainings for health and social service providers, law enforcement, case workers, and community health workers.
4.2.4	Conduct train the trainer sessions for community-based food insecurity resources (e.g., churches, pantries) and health and social service providers.
Objective 4.3: By December 2025, create and expand the volunteer base of healthcare and other service providers by 50% from baseline to assist Middlesex County's food insecurity programs.	
Outcome Indicators	
• Number of corporate collaborations and volunteers at distribution sites	
Strategies	

4.3.1	Promote opportunities for corporate collaborations (i.e., corporations provide coupons for products) and regular and consistent volunteering at distribution sites.
4.3.2	Expand support for Feeding Middlesex County through their social media campaigns.
4.3.3	Support capacity-building in food pantries (e.g., succession planning, leadership development, operational guidance, ensuring operational sustainability).

Objective 4.4: By December 2025, increase community members' awareness and skills related to healthy eating, food safety, and available resources by 70%

Outcome Indicators

- Pre and post community surveys
- Number of community members actively engaged in healthy eating and food safety-related initiatives (trends year to year)
- Culturally relevant recipes using typical food pantry items compiled and posted on REPLENISH website
- Number of home gardening classes held

Strategies

4.4.1	Assess availability of and participation in current workshops and conduct outreach to increase utilization.
4.4.2	Identify organizations to host and educators to lead additional community workshops related to healthy eating and food safety (e.g., senior groups/centers, schools and youth centers, social media/virtual settings, faith-based organizations, YMCAs, FSCs).
4.4.3	Deliver workshops where needed on topics such as nutritious meal preparation, healthy eating, accessing available community resources, food safety guidelines, food waste, and community gardens. – Content could include: Cooking classes, where to access ingredients, culturally appropriate ingredient substitutions, food safety, etc.
4.4.4	Lead an education campaign on using the AFHM online and offline.
4.4.5	Provide information on other available resources that address food insecurity at food distribution sites (e.g., resource table with culturally appropriate flyers/handouts in multiple languages).
4.4.6	Compile culturally relevant recipes using items typically found in food pantries to be shared on REPLENISH website.
4.4.7	Align with the appropriate partners to hold educational programs in schools, at food pantries, and other community sites to teach about home gardening.

Objective 4.5: By December 2025, increase access to supplemental food resources within the healthcare setting.

Outcome Indicators

- Food pantry in healthcare setting established

Strategies

4.5.1	Establish a food pantry within a healthcare setting to increase access to supplemental food assistance and integrate with the clinical and nutrition team to offer food choices that are best for certain disease states.