2016 MERCER COUNTY, NJ

YEAR 1 CHIP ACTION PLAN

ADDENDUM TO THE 2012 COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

SUBMITTED TO:
GREATER MERCER PUBLIC HEALTH PARTNERSHIP
MARCH 17, 2016

Table of Contents

This report was written by a mobilized group of geographically broad
Mercer County constituents, facilitated, compiled and prepared by:

Health Resources in Action
Advancing Public Health and Medical Research

in cooperation with
the Greater Mercer Public Health Partnership and Community Advisory Board

ACTION PLAN EXECUTIVE SUMMARY

Improving the health of a community is critical for not only enhancing residents' quality of life but also supporting their future prosperity. To this end, the Greater Mercer Public Health Partnership (GMPHP)—a collaborative of 14 area non-profit organizations, including four hospitals (St. Frances Hospital of Trenton, Capital Health Medical Center- Hopewell, Robert Wood Johnson University Hospital-Hamilton, St. Lawrence Rehabilitation Center), the Mercer County Department of Human Services, and eight local health departments (Ewing, Hamilton, Lawrence, Hopewell, Montgomery, Princeton, Trenton, and West Windsor) —is leading a comprehensive effort to measurably improve the health of greater Mercer County, NJ residents.

Overview of the CHA, CHIP, and Annual Action Plan

The Community Health Improvement Planning process includes two major components:

1. A community health assessment (CHA) to identify the health-related needs and strengths of greater Mercer County, and
2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across the County.
3. An Annual Action Plan to define the activities, persons responsible, and timelines for implementing and reporting on selected CHIP objectives and strategies.

The 2012 CHIP report was developed using the key findings from the CHA to inform discussions and select data driven priority health issues, goals, and objectives. The CHA was updated in 2015 using a streamlined data gathering process; the results from this update were used to confirm and refine the 2012 priority areas, goals, and objectives, as outlined in the tables below.

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

Moving from Assessment to Planning to Action

Similar to the process for the Community Health Assessment (CHA), the original and refined CHIP utilized a participatory, community-driven approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.[1,2] See Figure 1.

Figure 1: Mobilizing for Action Planning and Partnership (MAPP)

In 2011, The Greater Mercer Public Health Partnership (GMPHP) was formed as the decision-making leadership body for the CHIP. In January 2012, the GMPHP hired Health Resources in Action (HRiA), a non-profit public health organization located in Boston, MA, as a research partner to provide strategic guidance and facilitation of the CHA-CHIP process, to collect and analyze data, and to develop the report deliverables.

The Community Advisory Board (CAB) was established in January 2012 to guide and offer feedback on the CHA and CHIP processes. The CAB is comprised of approximately 60 individuals who represent the local community in all its diverse aspects: business, education, communications, transportation, health and wellness, faith-based groups, civic and government, vulnerable populations (disabled, seniors, etc.), and other organizations and specialized areas.

In 2014, the **GMPHP and CAB** were reconstituted with new partners and a new organizational structure (see Appendix A). The GMPHP Steering Committee determined that the focus of the current structure and planning year would be to revitalize the CAB, strengthen the CHIP implementation plan, improve performance measurement, and increase accountability for implementation of selected strategies. The new CAB is comprised of 75 community leaders and organizations, representing broad and diverse sectors of the community.

In early September, 2015, a summary of the updated CHA findings was presented to the Community Advisory Board for review and refinement, serving as the official launching point of the 2015-2016 CHIP year one action planning process. The results of the CHA and stakeholder feedback confirmed that the Priority Areas identified in the earlier 2012-2015 CHIP remain valid and continue to resonate with the community.

[1] www.uwgmc.org/CHA)

[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: http://www.naccho.org/topics/infrastructure/mapp/

CAB members participated in an introductory meeting on September 15, 2015 facilitated by HRiA to discuss what has happened since the original 2012 CHIP (key successes, key challenges, what current members are working on that align with 2012 CHIP priorities); new structures and systems for sustainability (GMPHP and CAB); and a new charge for the CAB.

CAB members next participated in two facilitated planning sessions that followed on October 27 & 28, 2015 to develop the year one action plan, incorporating the feedback from both the revised CHA and the September 15 meeting. CAB members self-selected to participation in Priority Area Working Groups based on their interest and expertise. The Working Groups were guided by 2-person teams comprised of Community Advisory Board members, and the planning sessions were facilitated by consultants from HRiA. Groups prioritized year one objectives, identified local "winnable battles" (strategies) to align with the overarching goals and objectives of the 2012 CHIP, and assigned tasks, timelines, and partners/resources to assure accountability for implementation. HRiA provided sample evidence based strategies that were identified from the *Community Guide to Preventive Services*, *County Health Rankings*, and the *National Prevention Strategy* prior to the strategy setting session.

The GMPHP, CAB and HRiA consultants reviewed the draft output from the planning sessions. Priority groups reconvened in February/March 2016 and edited material for clarity, consistency, and inclusion of evidence base. Their feedback was incorporated into the final versions of the CHIP Action Plan contained in this report.

Using the Year One CHIP Action Plan

The Mercer County Year One CHIP Action Plan provides an approach that is structured and specific enough to guide decisions, but flexible enough to respond to new health challenges. Its inclusive process represents a framework for all stakeholders to use as they develop and implement their organizational priorities and plans.

PRIORITY AREA 1: MENTAL HEALTH & SUBSTANCE ABUSE	
Goal 1:	**Improve access to quality mental health and substance abuse prevention, treatment and recovery services for all persons while reducing the associated stigma.**
Objective 1.2:	Increase awareness and utilization of existing mental health and substance base services among adolescents, young adults, and seniors by 25%.
Objective 1.4:	Increase the number of evidence-based educational programs in Mercer County that address mental health disorders and substance abuse among adolescents, young adults, and seniors.
PRIORITY AREA 2: HEALTHY EATING & ACTIVE LIVING	
Goal 2:	**Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices.**
Objective 2.1:	By 2018, increase the number of children in daycare settings, schools (K-12), and after-school programs who meet the Healthy New Jersey physical activity guidelines.
Objective 2.3:	By 2017, provide guidelines for, and educate the community on, all aspects of healthy eating and active living (specifically in areas of economic hardship).
Objective 2.5:	By 2020, increase the percent of Mercer County employers that have implemented evidence-based worksite wellness initiatives.

PRIORITY AREA 3: CHRONIC DISEASE	
Goal 3:	**Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).**
Objective 3.1:	By 2017, increase the number of venues that provide access to information about the continuum of chronic disease services (i.e., prevention, treatment, maintenance) especially for those in areas of greatest disparity.
Objective 3.3:	By 2018, increase by 5% the number of chronic disease patients educated on and adherent to their medication plans.
PRIORITY AREA 4: TRANSPORTATION	
Goal 4:	**Increase the overall health and wellbeing of Mercer County residents by enhancing safe, affordable, accessible options for people to move easily and freely within and between communities in Mercer County.**
Objective 4.2:	Research organizations currently addressing community development master plan transportation issues and develop strategies for improvement.

Accountability and Sustainability

Each Priority Area Leader will be responsible for submitting quarterly progress reports to the GMPHP Steering Committee using the Action Plan Template as a guide. Priority groups are expected to meet twice yearly to evaluate progress and make modifications to assure continued progress toward implementation of the identified strategies. Data collected will be posted on the GMPHP website quarterly, and shared with the CAB. An Annual progress report will be shared at the CAB Annual Meeting, with invitations extended to local media.

Priority 1: MHSA Year 1 Action Plan

Year 1 Action Plan			
PRIORITY AREA 1: Mental Health and Substance Abuse			
Goal 1: Improve access to quality mental health and substance abuse prevention, treatment and recovery services for all persons while reducing the associated stigma.			
Objective 1.2: Increase awareness and utilization of existing mental health and substance base services among adolescents, young adults, and seniors by 25%.			
Selected Outcome Indicators	**Baseline**	**2020 Target**	**Data Source**
• Increase in number of clients accessing mental health and substance abuse services			
• Increase in number of community members who are aware of mental health and substance abuse services			
• Increased awareness in community about available resources			
Partners for this Objective			
•			
•			
Resources Required (human, partnerships, financial, infrastructure or other)			
• Local churches			
• MECHA-ESL departments in schools			
• State police community or recruiting department			
• Asian, Russian, and Polish organizations			
Monitoring/Evaluation Approaches			
• Keep list of presentations given in Mental Health - canvass Mental Health CAB quarterly to capture their data too.			
• Track mental health media campaign			
• Track High School drug prevention programs			
• Track educational material on Mental Health going to Senior Centers.			

Strategy 1.2.1: Improve point-of-entry that includes easily accessible information and resources for all human services provided in Mercer County.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Mercer County will make at least one public presentation per month to improve issues of access and educate community members and organizations on prevention, treatment and recovery services.	Mercer County Dept. of Human Services staff		X	X	X	X

Year 1 Action Plan						
PRIORITY AREA 1: Mental Health and Substance Abuse						
Goal 1: Improve access to quality mental health and substance abuse prevention, treatment and recovery services for all persons while reducing the associated stigma.						
b. Public presentations to the community on the prevention, treatment, and recovery of mental health and substance abuse, through 2 events. The second event will distribute free Naxolone kits for attendees.	Robert Wood Johnson University Hospital – Hamilton	RWJ to provide # of attendees and # who receive a Naxolone kit.		X		
c. Host 3 Mental Health first aid courses for youth.	Attitudes in Reverse	Increased awareness of mental health signs and symptoms and reduced stigma surrounding those diagnosed with mental health disorders. Anticipated attendees: 15 per course.	X		X	X
Strategy 1.2.2: Develop and implement a culturally and linguistically appropriate media campaign that addresses stigma, is directed at the community, that drives people to the website and that also increases their awareness and use of available metal health and substance abuse services.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Mercer County will screen existing media campaigns for adults and seniors, hold focus groups to get community feedback on the campaigns, and distribute the information to the community.	Mercer County Dept. of Human Services staff				X	X
Strategy 1.2.4: Develop and distribute targeted educational materials for seniors for dissemination throughout senior centers.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Mercer County will present and disseminate educational materials for senior groups (6 times per year).	Mercer County Dept. of Human Services staff				X	X
Objective 1.4: Increase the number of evidence-based educational programs in Mercer County that address mental health disorders and substance abuse among adolescents, young adults, and seniors.						

Selected Outcome Indicators	**Baseline**	**2020 Target**	**Data Source**
• Increase in the number of community members with knowledge about mental health and substance abuse prevention and early intervention programs			
• Increase the number of community members participating in prevention programs			

Year 1 Action Plan						
PRIORITY AREA 1: Mental Health and Substance Abuse						
Goal 1: Improve access to quality mental health and substance abuse prevention, treatment and recovery services for all persons while reducing the associated stigma.						
Partners						
•						
•						
Resources Required (human, partnerships, financial, infrastructure or other)						
•						
•						
Monitoring/Evaluation Approaches						
•						
•						
Strategy 1.4.2: Identify and disseminate information about local programs to school, colleges, primary care physicians, senior center, health clinics, law enforcements, first responders, clergy, educators, adult care facilities, and non-profits.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Identify evidence based and best practices that are not necessarily certified as evidence based and create a list.	Mercer County Dept. of Human Serv. staff				X	X
b. Make available and distribute this list to the community.						
c. Provide educational information for mental health and substance abuse treatment to people of all ages in Mercer County.	Phoenix Behavioral Health	Street Teams will spread awareness and resources to those in need, educating 100 people per quarter through their outreach efforts.		X	X	X
d. Increase awareness of mental health and addiction services by hosting a community picnic. “STYGMA”, a band committed to this cause, will perform.	Phoenix Behavioral Health	The event is expected to welcome over 100 people.			X	

Priority 2: Healthy Eating and Active Living Year 1 Action Plan

Year 1 Action Plan			
PRIORITY AREA 2: Health Eating and Active Living			
Goal 2: Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices.			
Objective 2.1: By 2018, increase the number of children in daycare settings, schools (K-12), and after-school programs who meet the Healthy New Jersey physical activity guidelines.			
Selected Outcome Indicators	**Baseline**	**2020 Target**	**Data Source**
• Increase in the number of preschool, elementary, middle and high schools that have policies that require the recommended amount of physical activity during the school day (K-12)			
• Decrease the % of youth that report a BMI >= to 30			
• Increase the # of youth who say they were physically active during the school day			
• Increase in physical activity in after school programs			
Partners for this Objective			
• Districts •			
Resources Required (human, partnerships, financial, infrastructure or other)			
• NJ AHPERD • CDC School Funding • SNAP ED Rutgers			
Monitoring/Evaluation Approaches			
• Spreadsheet and key concept sheet - complete • Communication to school leaders - complete • Contact/presentation of information to parents – complete • Spreadsheet of nurses/PE teachers - complete • Three (3) evidence-based physical activity strategies identified • Survey developed and implemented			

Strategy 2.1.1: Clearly define the issue of childhood obesity, and present it to parents, school administrators and key stakeholders to ensure support for increasing physical activity during the school day.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Identify the point of contact and decision makers to connect and receive approval for programs.	Michelle Brill	Spreadsheet of contents completed One page sheet of key concepts		x		
b. Identify key concepts and desired objectives for presentation.						

Year 1 Action Plan						
PRIORITY AREA 2: Health Eating and Active Living						
Goal 2: Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices.						
c. Present issue (implications and concerns) of childhood obesity to school district leadership and desired outcomes of childhood obesity initiative/awareness campaign.	Sakeenah Boyd	Time/avenue of communication decided Key school leaders received communication (one page sheet)		x	x	
d. Identify parents be champions and advocates of the initiative and supply them with resources/materials.	Sakeenah Boyd	Present to at least one PTA/PTO per district and champions identified (oral or virtual) Reach out to at least 1 guidance counselor or nurse per district			x	
e. Identify all school nurse and physical education teachers' seminars.	Bonniwell CMI	Compile spreadsheet (NJ AHPERD) School Nurses Association Seminars presented at annual conference				2017
f. Select best/most strategic seminars at which to present.						
g. Apply to be on program(s).						

Strategy 2.1.2 (rewritten): Identify three evidence-based strategies to increasing activity among school-aged children. Work with school districts to identify one approach (to implement in year 2.)						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Research successful strategies. EBS kids self-reporting test.	Frances Perrin (L,M,I)	List of evidence-based strategies and references	x			

Year 1 Action Plan						
PRIORITY AREA 2: Health Eating and Active Living						
Goal 2: Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices.						
b. Identify three (3) schools, choose one (1) strategy for all three (3) schools, to pilot program.	Frances Perrin (L,M,I)	3 strategies identified, 1 chosen by group		x		
Strategy 2.1.3 (NEW): Investigate baseline (survey).						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Collect existing data on programs out there.	L- Christine L.	Identify existing evidence-based surveys or survey methods used in current programs		x		
b. Develop 5-question parent survey on activity.	L- Christine L.	Survey developed			x	x
c. Implement survey at various community events or functions.	I- Christine L.	Collect and organize results of survey				Y2

Objective 2.3: By 2017, provide guidelines for, and educate the community on, all aspects of healthy eating and active living (specifically in areas of economic hardship).

Selected Outcome Indicators	**Baseline**	**2020 Target**	**Data Source**
• Increase # of county residents with easy access to bike/walking paths or other recreational facilities			
• Increase in # of county residents that participate in county wide healthy eating and active living events			
• Increase in general well-being and quality of life of county residents			
• Database of volunteers			

Partners for this Objective

- Community groups/businesses
- Faith-based organizations
-

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

- Mercer County Directory
- List of organizations
- GMP
-

Monitoring/Evaluation Approaches

- Track community events/programs

Year 1 Action Plan

PRIORITY AREA 2: Health Eating and Active Living

Goal 2: Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices.

Strategy 2.3.1: Establish partnerships with key community groups especially those with resources/focus on healthy eating and active living (e.g., area businesses, faith-based organizations, childcare centers, and assisted living centers, and other agencies) in an effort to work more collaboratively to implement healthy eating and active living community events.

Action Steps	Organizations(s) Responsible L=Lead, M=Manage, I=Implement	Outcome (Products) or Results	Year 1 Time Line			
			Q1	Q2	Q3	Q4
a. Develop a community events list.	L-Mary Capital and Jean I-Jean and Andrea I-Pam Ford THT	2-3 events held	x	x	x	x
b. Identify and decide which community groups/events to collaborate with.	L-Kathy Korwin I-Lu Ann I-Megan K., United Way Alison, American Cancer Society	2-3 events held		x		
c. Plan and conduct joint community-based program(s).						

Strategy 2.3.2: Update and publicize a website for volunteers, mission, partners, events, and basic information on nutrition, fitness, and overall health and wellbeing that is appropriate for a variety of cultures, languages, and literacy levels.

Action Steps	Organizations(s) Responsible L=Lead, M=Manage, I=Implement	Outcome (Products) or Results	Year 1 Time Line			
			Q1	Q2	Q3	Q4
a. Update website	L-Arshe Ahmed		x	x	x	x
b. Update brochures in English and Spanish, include website URL.	L-Arshe Ahmed		x	x	x	x
c. Connect partner/collaborator websites to main GMPHP website.						
d. Publicize the website utilizing print media and social media	L-Arshe Ahmed I-Whitney Hendrickson (?/✓) I-MJ Fuhrer (?/✓)			x		

Year 1 Action Plan

PRIORITY AREA 2: Health Eating and Active Living

Goal 2: Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices.

Objective 2.5: By 2020, increase the percent of Mercer County employers that have implemented evidence-based worksite wellness initiatives.

Selected Outcome Indicators	Baseline	2020 Target	Data Source
• Increase % of employers who participate in a worksite wellness program			
• Increase % of employees who participate in a workplace program that is offered			

Partners for this Objective

- Chambers of Commerce
- Mercer County
- NJBIA

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

- Mercer County
- Chambers of Commerce
- Benchmark Healthy Somerset Coalition
-

Monitoring/Evaluation Approaches

- Track how many employers exposed to worksite health kit idea
- Track the number of new worksite wellness programs are started.

Strategy 2.5.1: Assess and compile current workplace health and wellness programs to establish a resource of existing initiatives and examples.

Action Steps	Organizations(s) Responsible L=Lead, M=Manage, I=Implement	Outcome (Products) or Results	Year 1 Time Line			
			Q1	Q2	Q3	Q4
a. Compile list of Mercer County employers.	L-jane Millner L-Mary Jo I-Mercer County Employers from Anthony Carabelli I-Chambers of Commerce	Get list.	x			
b. Review list and choose targets for survey (range of large to small employers, for profit and not for profit organizations, minority businesses, etc.).					x	
c. Research and develop survey tools.		Identify and speak with businesses. Meeting with Chambers. Create survey.				x
d. Compile, analyze, and disseminate survey data via GMPHP on best practices among local employers.						

Year 1 Action Plan						
PRIORITY AREA 2: Health Eating and Active Living						
Goal 2: Improve the health and well-being of the community by advocating for sustainable healthy lifestyle choices.						
Strategy 2.5.2: Design and implement a plan to raise awareness and educate employers on the benefits of employee worksite wellness initiatives.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Plan summit meeting.	Andrea	Form committee. Summit logistics.				x
b. Inventory different levels of programs for varied size businesses.	Summit Committee	Identify panels and agenda.				x
c. Hold summit year 2	Amazon sponsorship of wellness programs	Host survey. Post summit survey.		x		

Priority 3: Chronic Disease Year 1 Action Plan

Year 1 Action Plan			
PRIORITY AREA 3: Chronic Disease			
Goal 3: Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).			
Objective 3.1: By 2017, increase the number of venues that provide access to information about the continuum of chronic disease services (i.e., prevention, treatment, maintenance) especially for those in areas of greatest disparity.			
Selected Outcome Indicators	**Baseline**	**2020 Target**	**Data Source**
• Increase in # of people served from underserved population groups	#		Population/Economic Data, 2015
• Decrease in % existing vulnerable groups in ER use	#		ER Claims Data, 2015
• Increase in # of organizations/venues providing services in areas of need	#		CAB connection, 2015
• Decrease in % of existing vulnerable groups' hospital re-admission rate	#		2015
Partners for this Objective			
• Acute Care hospitals • Trenton Health Team • Web Design Consultant			
Resources Required (human, partnerships, financial, infrastructure or other)			
• Financial support for website infrastructure and mobile app development • Vendor/human resources •			
Monitoring/Evaluation Approaches			
• Utilization rate for existing programs and services. • Number of community organizations connected to website. • Number of townships connected to the website (added healthymercer.org link to their website). • Website hit rates for community organizations.			
Strategy 3.1.1: Work with community organizations to disseminate information about chronic disease through access to our website.			

Action Steps	Organizations(s) Responsible L=Lead, M=Manage, I=Implement	Outcome (Products) or Results	Year 1 Time Line			
			Q1	Q2	Q3	Q4
a. Publicize process for posting information on screenings, access, treatment, social services, financial services/support, patient education	GMPH Steering Darlene Chronic Diagnosis Group	Traffic on website		a	c	
b. Link website						b. Y2, Q4
c. Identify CAB members with a desire to post on the website.		Inventory of CAB members				

Year 1 Action Plan PRIORITY AREA 3: Chronic Disease						
Goal 3: Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).						
d. Provide link to GMPHP website on existing CAB member sites and community organizations.					x	
e. Convene organizational groups to communicate this strategy					x	
f. Add link to website on senior page on Township website.	L-Carol I-Health Officers				x	
g. Develop and implement a web and print-based community calendar.		Website calendar				x
h. Create brochures for distribution with website information for people not connected.		update website postcard				Y2 Q1
i. Make sure information is available in Spanish.		Seek translation in print.				Y2 Q2
j. Publicize information at health fairs, PSA's (radio).		Develop marketing messaging materials.				Y2 Q3
Strategy 3.1.2: Research or use existing evidence-based programs with local healthcare professionals and agencies to offer programs for specific underserved target populations/audiences.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Identify priority communities through the CHA.	Chronic Disease Work Group Amanda HJ Austin	Inventory on website			x	Year 2
b. Work with community leaders of high-priority populations to garner support for initiatives.	Chronic Disease Work Group Amanda HJ Austin				x	
c. Develop an approach and areas of focus to create a logic model that can be used for different chronic diseases. Outcome for the logic model will be a presentable logic model template.						
Strategy 3.1.3: Identify and engage partner organizations that provide community screening and preventative services.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Inventory existing resources. Identify access points: where, when who goes?	Chronic Disease Work Group Jill	Number of facilities identified			x	

Year 1 Action Plan						
PRIORITY AREA 3: Chronic Disease						
Goal 3: Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).						
b. Identify source or contact person.		Number of new CAB recruits.			x	
c. Invite organizations to join CAB.		Number of organizations actively participating in CAB				x
d. Identify agencies collecting data		Lead agencies				Y2Q4

Year 1 Action Plan
PRIORITY AREA 3: Chronic Disease

Goal 3: Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).

Objective 3.3: By 2018, increase by 5% the number of chronic disease patients educated on and adherent to their medication plans.

Selected Outcome Indicators	Baseline	2020 Target	Data Source
• Track re-admissions for congestive heart failure and COPD within 30 days of hospitalization.	2015		ER Claims Data
• Track number of patients seen in ED/Urgent Care office with the primary diagnosis of diabetes.	2015		ER Claims Data
• Track number of patients who have had a visit to an ED/Urgent Care office for asthma in the past six months	2015		ER Claims Data

Partners for this Objective

- Acute care hospitals
- Chronic Disease Team

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

- Data extraction from ER claims data.

Monitoring/Evaluation Approaches

- Internal hospital monitoring processes.

Strategy 3.3.1: Identify, select, and utilize evidence-based community education tools to promote medication adherence.

Action Steps	Organizations(s) Responsible L=Lead, M=Manage, I=Implement	Outcome (Products) or Results	Year 1 Time Line			
			Q1	Q2	Q3	Q4
a. Survey CAB organizations as to the standard educational tools they utilize.	Hospitals Community Health Organizations Agencies Chronic Health Team				x	
b. Invite organizations to share their evidence-based education tools for medication adherence.	Hospitals				x	
c. Evaluate all tools and identify best practices.	Community Health Organizations Chronic Health Team	Tools standardized and disseminated among providers			x	
d. Create a health education literacy committee to evaluate, translate, and ensure materials are at a fifth grade level.	Hospitals Community Health Organizations Agencies Chronic Health Tools					X
e. Post the tools on the website.	GMPHP					

Year 1 Action Plan						
PRIORITY AREA 3: Chronic Disease						
Goal 3: Prevent and reduce chronic disease incidence and morbidity (e.g., cancer, diabetes, heart disease, asthma).						
Strategy 3.3.6: Establish an effective Mercer County Chronic Disease Work Group.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Develop a process to establish priority areas of focus for chronic disease	Community leaders	The health Literacy Committee is formalized as a global, strategic committee for the GMPHP and defines and monitors approaches across all priority areas.				
b. Use the logic model developed in 3.1.2 to develop model template for programs to address priority areas of focus. (See where other chronic diseases fit in. In order to replicate the program for other chronic disease.)	Community leaders					Y2 Q4

Priority 4: Transportation Year 1 Action Plan

Year 1 Action Plan			
PRIORITY AREA 4: Transportation			
Goal 4: Increase the overall health and wellbeing of Mercer County residents by enhancing safe, affordable, accessible options for people to move easily and freely within and between communities in Mercer County.			
Objective 4.2: Research organizations currently addressing community development master plan transportation issues and develop strategies for improvement.			
Selected Outcome Indicators	**Baseline**	**2020 Target**	**Data Source**
• # of community development master plans reviewed			
• # of strategies developed			
• Implementation of awareness campaign			
• List of transportation-related agencies and key stakeholders			
Partners for this Objective			
• Transportation Management Association (TMA) • Trail Groups • Trenton Health Team			
Resources Required (human, partnerships, financial, infrastructure or other)			
• •			
Monitoring/Evaluation Approaches			
• Track number of programs and campaigns they organize •			

Strategy 4.2.2: Contact transportation-related agencies that may have relevant data, research, and resources available to identify needs (e.g., Transportation Management Association (TMA), Trail Groups).						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Identify transportation-related agencies.	Carol C – L Dan	List of transportation agencies	x	x		
b. Determine what data is desired.	Cheryl – I TCNJ DON Mercer Co HD	Data needs analysis	x	x		
c. Conduct/disseminate transportation survey to agencies and general public via social media (NJ DOT, NJ Transit, Police, Faith-based Community, Planning Dept, DVRPC, Trenton, and Community Coalitions).	Courtney Tilton – I Trenton Health Team 609-658-5804 ctilton!trentonhealthteam.org	Survey administered	x	x		

Year 1 Action Plan						
PRIORITY AREA 4: Transportation						
Goal 4: Increase the overall health and wellbeing of Mercer County residents by enhancing safe, affordable, accessible options for people to move easily and freely within and between communities in Mercer County.						
d. Review data, summarize, and disseminate report.	Transportation Group	Data analysis report developed and disseminated			x	
e. Develop strategies/recommendations to ensure that all residents from Trenton and new socio-economic groups have access to transportation (to various health agencies and employment opportunities and food).	Transportation Group					
f. Identify needs and gaps based on relevant data	Transportation Group	Transportation needs identified			x	
Strategy 4.2.5: Develop an awareness campaign to promote all modes of transportation available.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Conduct 2 “train the trainer” sessions in 2016, for case managers, social workers, transition counselors, etc.					X	X
b. Share mobility guide and spread campaign throughout Mercer County (GMPHP, hospitals, social services agencies)			X	X		
c. Consider mobile app (look at HopStop model, etc.)						X
d. Explain “Complete Streets” to community groups, in order to obtain input, locations, etc.					X	X
e. Brainstorm awareness campaign and develop a few concepts.					X	X
Strategy 4.2.6: (FORMERLY 4.4.1) Partner with area and regional hospitals to verify and address the need for a shuttle service for communities where there is limited transportation (i.e., access to healthcare facilities, three hospitals, and health clinics (Henry J. Austin)).						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Identify facilities to review for transportation resources. The hospitals and health centers for review would be identified and after interviewing or surveying an inventory of their transportation resources and gaps would be developed.					X	X

Year 1 Action Plan						
PRIORITY AREA 4: Transportation						
Goal 4: Increase the overall health and wellbeing of Mercer County residents by enhancing safe, affordable, accessible options for people to move easily and freely within and between communities in Mercer County.						
b. Document transportation available and disseminate via web and print media.	Hopewell Twp Bob E. – I	Transportation options identified and list developed			x	
c. Identify gaps in services.	Ilsa – Homefront – I	Transportation resource gaps identified and begin to address gaps			x	
d. Explore midday delivery of health services at senior centers.		Partners in community identified to provide transportation services.			x	
e. Identify and partner with faith-based organizations to provide transportation services in areas where there are gaps.						
Strategy 4.2.7: (FORMERLY 4.3.2) Identify one successful community model for Mercer County and use as the basis for developing a plan (examine policies, with help of TCNJ).						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Contact TCNJ.	TCNJ Dave Vandergrift	TCNJ contact identified and contacted	x	x		
b. Meet with TCNJ to identify the needs of urban cities in Mercer County.	Mercer Public Health – Sharon GMTMA Courtney – Trenton Health	GMPHP representatives meet with TCNJ representatives	x	x		
c. Review models with TCNJ students and GMPHP.	Group (Trenton representatives must be included)	Transportation group meets with TCNJ representatives to review Model Plans			x	

Year 1 Action Plan						
PRIORITY AREA 4: Transportation						
Goal 4: Increase the overall health and wellbeing of Mercer County residents by enhancing safe, affordable, accessible options for people to move easily and freely within and between communities in Mercer County.						
d. Revise and modify the selected model to reflect urban needs gathered in step b.	Group	Transportation group identifies a model which reflects Mercer County as a whole (all communities – urban, suburban, rural)			x	
e. Implement the model for Mercer County	Group	Model selected				x
Strategy 4.2.8: (NEW) Develop Complete Street policy (tracking), implementation.						
Action Steps	**Organizations(s) Responsible** L=Lead, M=Manage, I=Implement	**Outcome (Products) or Results**	**Year 1 Time Line**			
			Q1	**Q2**	**Q3**	**Q4**
a. Identify project under discussion.	NJ DOT – traffic deaths GMTMA DVRPC Twp Planning/Zoning Boards Biking and Trails organizations	Post "complete streets" onto every MCD website	x			
b. Identify locations.						
c. Contact planning, zoning, depts. in municipalities to determine status of policy implementation. Look at Canada/Europe as models.						
d. Conduct Street Audits.	TMA Community Partners Dave Bosted 883-6116 davidbosted@gmail.com	Presentations PowerPoint Posters				
e. Look for community interest for street audits (i.e., AmeriCorps, TCNJ/Bonner group, NJP/HK (Healthy Kids, local health officers).						
f. Explain "complete streets" to community groups, etc. in order to obtain input, locations, etc.	Conduct community presentations and programs	Programs at: Rider TCNJ MCCC			x	x
g. Hold focus groups at senior centers, faith-based organizations, etc., to determine needs, etc.						

Global Strategies

A global strategy is one that is implemented collaboratively and consistently across those priority area working groups that have identified this topic in their annual action plan.

Strategy A: Expand and promote the website to become the premier site for health and wellness information in the county.

Action Steps:
Double number of resources on www.HealthyMercer.org by Year 1, Q4.
Double number of events on the site by Year 1, Q4.
Double number of monthly visitors to the site by Year 1, Q4.
Assess the needs of Spanish-speaking site visitors and incorporate materials (resources, events) in Spanish if needed by Year 1, Q4.
Promote the site on GMPHP members' and CAB members' agencies' sites to help residents access information more readily.
Utilize the site to distribute information as noted in above priority areas.

Strategy B: Secure a data system to track outcomes.

Strategy C: Host or partner with existing agency on the Employer Health Summit.

Appendix A: Action Planning Partners and Participants