Greater Mercer Public Health Partnership Community Health Improvement Plan

July 2025

PREPARED BY
HEALTH RESOURCES IN ACTION

GMPHP Greater Mercer Public Health Partnership

capitalhealth

RWJBarnabas HEALTH | Robert Wood Johnson University Hospital Hamilton

Dear Partners,

On behalf of the Greater Mercer Public Health Partnership (GMPHP), we want to extend our sincere gratitude for your invaluable support in developing this Community Health Improvement Plan (CHIP). Your active participation in planning sessions, thoughtful contributions, and commitment to identifying actionable strategies have been instrumental in shaping a plan that truly reflects the needs of our community.

The insights and expertise you shared have helped ensure that the CHIP is both meaningful and actionable. Your willingness to collaborate and contribute to the plan underscores the strength of our collective efforts in driving positive change.

We deeply appreciate your time, dedication, and ongoing commitment to this work. We look forward to continuing our collaboration as we move forward in implementing the plan and making a lasting impact in our community.

With appreciation,
The GMPHP Board of Directors

Acknowledgments

The *Greater Mercer Public Health Partnership (GMPHP) Community Health Improvement Plan* was developed with the guidance of numerous partners who provided oversight and input throughout the planning process.

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Questions

Questions regarding the GMPHP Community Health Improvement Plan should be directed to the GMPHP Executive Director, at ExecutiveDirector@gmphp.org. More information about the GMPHP can be found online at www.gmphp.org.

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For questions regarding Robert Wood Johnson University Hospital Hamilton or RWJBarnabas Health, please email BHPlanning@RWJBH.org.

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Executive Summary

Founded in 2012, the Greater Mercer Public Health Partnership (GMPHP) is a collaboration of hospitals, health departments, the Mercer County Department of Human Services, and other not-for-profit organizations whose mission is to improve in measurable terms the health of residents of the Greater Mercer County community. GMPHP consists of over 15 core organizations and more than 80 collaborating entities, including community non-profits, schools, businesses, social service agencies, and governmental organizations. Two major hospitals in the area are part of the GMPHP: Capital Health and RWJUH Hamilton.

GMPHP assesses the community's health every three years and brings together a broad cross-section of organizations to develop a collaborative plan to improve the health and well-being of those who live and work in Mercer County, New Jersey (NJ). To this end, in 2024 GMPHP and Robert Wood Johnson (RWJ) Barnabas Health System engaged Health Resources in Action (HRiA), a non-profit public health organization in Boston, MA, to conduct a Community Health Needs Assessment (CHNA) and develop a Community Health Improvement Plan (CHIP).

The CHNA-CHIP process aims to identify the health-related needs and strengths of the community, prioritize residents' health needs through a data-driven, community-led approach, and utilize these findings to inform health improvement planning efforts. The CHIP sets major health priorities based in the key findings from the *2024 Greater Mercer Public Health Partnership Community Health Needs Assessment*, and includes overarching goals, objectives, indicators, and strategies to be implemented in a coordinated way to improve the health of residents of Mercer County.

Priority Area
Priority 1: **Mental & Behavioral Health**
Priority 2: **Access to Wellness**
Priority 3: **Housing & Built Environment**
Priority 4: **Maternal & Infant Health**

Health and Racial Equity, and ***Systemic Racism and Discrimination*** are cross-cutting themes which have been integrated across all priority areas, with specific objectives, indicators, and strategies to ensure equitable outcomes.

The CHIP is intended to focus and guide a continuous health improvement process that will monitor and evaluate health priorities and system changes. It is not intended to be a static report. Instead, it provides an approach that is structured and specific enough to guide decisions, but flexible enough to respond to new health challenges and environmental changes. Implementation of this CHIP is intended to be a collaborative effort involving GMPHP member organizations and community members.

Introduction

Background

A community health improvement plan, or CHIP, is an action-oriented strategic plan that outlines the priority health concerns for a defined community. It indicates how these concerns will be addressed, including strategies and measures, to ultimately improve the health of the community. The COVID-19 pandemic shed light on the disparities many of our residents routinely face in mental and behavioral health, access to wellness, housing and built environment, and maternal and infant health. Gaps also came to light related to the partnerships and collaborations needed to address these disparities.

In early 2024, GMPHP and Robert Wood Johnson (RWJ) Barnabas Health System engaged Health Resources in Action (HRiA), a non-profit public health organization in Boston, MA to conduct a Community Health Needs Assessment (CHNA) and develop a Community Health Improvement Plan (CHIP). HRiA has extensive experience developing health assessments and health improvement plans locally, regionally, and nationally, including state-level plans in Massachusetts, Maine, and Connecticut.

The CHIP utilized a participatory, collaborative approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.[1] MAPP, a comprehensive, community-driven planning process for improving health, is a strategic framework that local public health departments across the country have employed to help direct their planning efforts. MAPP is comprised of distinct assessments that are the foundation of the planning process and includes the identification and prioritization of strategic issues and goal or strategy formulation as prerequisites for action. Since the health needs and environment of a community constantly change and evolve, the cyclical nature of the MAPP process allows for the periodic identification of new priorities and the realignment of activities and resources to address them.

The CHIP was developed from September 2024 through February 2025, using the key findings from the *2024 Greater Mercer Public Health Partnership Community Health Needs Assessment.* The CHNA data collection approach focused on the social and economic upstream issues that affect a community's health. Data collection was conducted using a social determinants of health framework and a health equity lens. The CHNA process utilized a mixed-methods participatory approach that engaged agencies, organizations, and community residents through different approaches. Community engagement strategies were tailored to reach traditionally medically underserved populations and included conducting a community survey, focus groups, and key informant interviews.

The *2024 Greater Mercer Public Health Partnership Community Health Needs Assessment* is available online on the GMPHP website.

Community Health Improvement Plan Purpose

A Community Health Improvement Plan (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.

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

- Identify priority areas for action to improve community health
- Outline an implementation and improvement plan with performance measures for evaluation
- Guide future community decision-making related to community health improvement

The CHNA and CHIP provide essential frameworks for guiding future services, programs, and policies for healthcare and public health-serving agencies in the area.

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 community members – can unite to improve the health and quality of life for all people who live, work, learn, and play in Mercer County. We encourage you to review the priorities and goals, reflect on the suggested strategies, and consider how you can participate in this effort, in whole or in part.

Relationship Between the CHIP and Other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the health of 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 for further collaboration.

Community Engagement

To develop a plan for improved community health and help sustain implementation efforts, the GMPHP assessment and planning process engaged diverse, multi-sector community organizations, community members, community hospitals and key partners through different avenues:

1. The **Greater Mercer Public Health Partnership** (GMPHP) was the decision-making leadership body for the CHNA-CHIP. The Partnership is comprised of over 200 individuals from over 80 organizations 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. See **Appendix B** for a list of GMPHP member organizations.

2. The **GMPHP Community Advisory Board** (CAB) guided and offered feedback on the CHNA and CHIP processes. The CAB is comprised of over 20 individuals who are representative of the overall GMPMP membership.
3. The **CHIP Priority Area Work Groups**, representing broad and diverse sectors of the community and organized around each health priority area, developed and refined the goals, objectives, and strategies for the CHIP.

GMPHP, in collaboration with community partners, led the planning process and oversaw all aspects of the CHIP development, including the identification of CHIP priorities, establishment of CHIP workgroups, coordination of planning and feedback efforts, and refinement of all aspects of the CHIP.

Identifying Priority Areas

Prioritization allows hospitals, organizations, and coalitions to target and align resources, leverage efforts, and focus on achievable objectives and strategies for addressing priority needs. Priorities for this process were identified by examining data and themes from the CHNA findings utilizing a systematic, engaged approach.

In September 2024, a summary of the CHNA key findings was presented to GMPHP members and partners. Participants reviewed the issues and themes from which priority health issues were identified and subcategories were developed. While many areas were considered significant, it was emphasized that identifying 3-4 priority areas would enable greater focus and collaboration for impacting the community.

Criteria for Prioritization

A set of criteria were used to determine which issues were a priority for action in the GMPHP service area. A high-level set of criteria were used for the large-scale GMPHP meeting for ease of the initial process. These criteria include:

- Relevance – How important is it?
- Appropriateness – Should we do it?
- Impact – What will we get out of it?
- Feasibility – Can we do it?

A more detailed set of prioritization criteria were then used to guide additional conversations with the GMPHP Advisory Board to refine the priorities:

- **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, and environmental change?
- **Feasibility**: Can we take steps to address this issue given the current infrastructure, capacity, and political will?
- **Collaboration/Critical Mass**: Are 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 driven.

Step 1: Input from Community Members and Stakeholders via Primary Data Collection
During each step of the primary data collection phase of the CHNA, assessment participants were asked for input. Key informant interviewees and focus group participants were asked about the most pressing concerns in their communities and the three top priority issues for future action and investment. Community survey respondents were also asked to select up to four of the most important issues for future action in their communities, noted in the Community Health Issues section of this 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, eleven major initial issue areas were identified for the GMPHP service area (listed below in no particular order):

- Affordable Housing
- Chronic Disease Prevention & Management
- Employment & Financial Security
- Food Security & Healthy Eating
- Health and Racial Equity
- Health Care Access
- Infectious & Communicable Diseases
- Maternal & Infant Health
- Mental & Behavioral Health, including ACEs
- Systemic Racism & Discrimination
- Transportation & Walkability

Step 2: Data-Informed Voting via a Prioritization Meeting
A virtual Key Findings Presentation & Prioritization meeting was held in September with GMPHP members and partners to present and discuss the preliminary findings and conduct a poll on the preliminary priorities for action.

During the prioritization meeting, attendees heard a brief data presentation on the preliminary key findings from the assessment. Next, meeting participants discussed the data as a group and offered their perspectives and feedback on the various issues. At this time, a participant suggested adding Safety & Violence as an additional potential priority area for consideration. In addition, participants uplifted **Health and Racial Equity** and **Systemic Racism & Discrimination** as cross-cutting themes. Then, using the polling platform Mentimeter, meeting participants were asked to vote for up to four of the twelve priorities identified from the data and based on the high-level prioritization criteria. Preliminary polling results identified the following issues: Mental & Behavioral Health; Food Security & Healthy Eating; Health Care Access; and Chronic Disease Prevention & Management.

Step 3: GMPHP Health Officers and Advisory Board Review & Recommendation
GMPHP Health Officers met to review the polling results and discuss priorities for the CHIP. Discussions resulted in combining Food Insecurity and Healthy Eating with Chronic Disease, adding Housing, and including Maternal and Child Health to support the strong coalition work in

this area. The resulting recommendations for priority areas were shared with members of the GMPHP Board for approval. HRiA met with GMPHP's Project Director to refine priority area titles and the topics to be included under each priority based on assessment data.

Priorities Selected for Planning
Based on the assessment findings as well as existing initiatives, expertise, capacity, and experience, the GMPHP selected the following priorities to focus on when developing their CHIP: Mental & Behavioral Health; Access to Wellness; Housing and Built Environment; and Maternal and Infant Health. GMPHP will address these priority areas as part of ongoing community engagement efforts, with an overarching emphasis on addressing **systemic racism and discrimination** and promoting **health and racial equity**.

CHIP Framework

In October 2024, two planning events were held to develop the planning components of the CHIP. All planning participants were invited to a virtual Preplanning Session as an orientation for the upcoming planning session: to learn about the final priority areas identified for the CHIP, understand the CHIP's context, define relevant planning terms, and clarify engagement expectations. This was followed by a one-day interactive and collaborative planning session at the RWJ Fitness and Wellness Center in Hamilton, NJ. The planning session was attended by over 70 community members representing diverse sectors of the community with expertise and interest in the identified CHIP priority areas. See **Appendix A** for a list of CHIP planning participants.

The all-day session was designed and facilitated by consultants from HRiA using a process that emphasized cross-priority feedback and refinement of each of the core elements of the CHIP. It was structured in both large and small group formats to develop the draft CHIP components (goals, objectives, indicators, strategies, and potential partners and resources) "live" during the planning session, with time built in for feedback and refinement.

Following the all-day planning session, the HRiA team reviewed the draft output from the work groups and revised the plan components for clarity and consistency. The draft plan components were then shared electronically with planning participants for additional feedback. GMPHP leadership met with various subject matter experts, community-based organizations, and key partners to review the refined output from the work groups, with particular focus on the indicators. These efforts ensured inclusion of diverse voices from community members with lived experiences and those working with them. This feedback has been incorporated into the final version of the CHIP in this report.

Goals, Objectives, and Strategies

The following pages outline the goals, objectives, and strategies for the four priority areas outlined in the CHIP. See **Appendix C** for a list of acronyms used in the CHIP. See **Appendix D** for definitions of the planning terminology used in this process. See **Appendix E** for a glossary of terms used in the plan. See **Appendix F** for the 2025 GMPHP Action Plan for implementation.

GMPHP CHIP Snapshot

Priority Area	Goal Statements	Objectives
Priority 1: Mental & Behavioral Health	Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community.	1.1: Increase awareness of and connection to available mental health services across the lifespan by 2027.
		1.2: Increase mental health education and skills building for non-mental health professionals by 2027.
		1.3: Increase community knowledge on mental health stigma, prevention, and harm reduction by 2027.
Priority 2: Access to Wellness	Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.	2.1: Increase referrals and enrollment to assistance programs to support the cost of healthcare services and reduce the uninsured rate by 2027.
		2.2: Improve access to nutritious food and nutrition education to align with individual, cultural, and financial needs by 2027.
		2.3: Increase convenient, affordable, and accessible transportation options to key wellness destinations in Mercer County by 2027.
		2.4: Increase the number of linguistically and culturally competent resources and personnel along the healthcare continuum by 2027.
		2.5: Reduce the impact of chronic disease for minority groups most at risk by 2027.
Priority 3: Housing & Built Environment	Goal 3: Everyone in Mercer County has a place to feel safe and call home in a thriving community.	3.1: Develop infrastructure to collect and share data on home affordability and insights across agencies to more effectively demonstrate need, reality, and demand by 2027.
		3.2: Connect partners to coordinate data collection and testing to improve unsafe housing conditions by 2027.
		3.3: Increase the number of Vision Zero activities implemented by Mercer County municipalities by 10% by 2027.
		3.4: Increase the number of open spaces available for outdoor activity in communities in need by 2027.
		3.5: Increase awareness of the resources that exist to obtain and maintain stable housing by 2027.
Priority 4: Maternal & Infant Health	Goal 4: All birthing people and infants in Mercer County have equitable access to quality care and resources across the birthing continuum to improve health outcomes.	4.1: Increase access to prenatal care services to reduce the risk factors for maternal and infant morbidity and mortality to more closely align with NJ rate (3.5 per 1,000 births) by 2027.
		4.2: Increase the number of partnerships among community-based organizations to streamline resources and build supportive networks for families by 2027.
		4.3: Increase health education opportunities to promote health and well-being of all birthing people, infants, and families in Mercer County by 2027.
		4.4: Increase and diversify the number of professionals working in the community to bridge the gap in access to maternal and infant health care by 2027.

Priority 1: Mental & Behavioral Health

Mental health was identified as a community concern in almost every interview and focus group. Youth mental health was of particular concern to interviewees and focus group participants, particularly following the COVID-19 pandemic. Poor mental health has a negative impact on overall well-being: those with mental health conditions have difficulty managing other health conditions and accessing services such as healthcare, housing, and food resources. [2]

Populations Most Impacted

Youth

Older Adults

LGBTQ

Immigrants

Quantitative data confirm participants' perceptions that mental health is a pressing community issue. As described earlier, community survey respondents identified mental health issues as the top health concern in their communities. Among Mercer County survey community respondents, 13.8% reported experiencing 10-19 days of poor mental health, and 10.1% reported 20-30 days of poor mental health in the last 30 days.[3]

Difficulty accessing mental health services was a theme in focus group and interview conversations. Mercer County community survey respondents were asked about their experiences seeking help for mental health problems for themselves or a family member over the past two years. Overall, 14.8% of Mercer County respondents who reported seeking mental health services and/or treatment indicated that they could not access them. A higher proportion of Latino respondents (22.1%) reported not being able to access needed help. In Mercer County, 22.8% of respondents sought mental health services and/or treatment and accessed them in the past two years. White respondents (26.7%) were the most likely to access needed mental health help.[4]

The Mental and Behavioral Health Priority Area of the CHIP outlines objectives and strategies intended to promote a healthier community by nourishing the mental health and wellness of everyone. Implementation efforts will seek to increase awareness of and connections to mental health and behavioral health services that are available in Mercer County, provide mental health education and skills building for non-metal health professionals, and increase community members knowledge on mental health stigma, prevention and harm reduction.

Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community

Objective 1.1: Increase awareness of and connection to available mental health services across the lifespan by 2027.

Strategies

1.1.1 Explore and promote existing NAMI Mercer, HELP Line Plus, Mercer County human services directory and other navigation services.

1.1.2 Foster connections and collaborations between organizations that provide mental & behavioral health services.

1.1.3 Explore integrating mental health data in the Trenton Health Information Exchange (THIE) to facilitate referrals and coordinate services.

1.1.4 Identify and partner with organizations and agencies that work with older adults to provide education and connection to resources.
1.1.5 Partner with schools and youth serving organizations to share age-appropriate mental health resources and information with youth.
1.1.6 Advocate for funding in state departments and agency budgets to support partners and resources in achieving these goals and objectives.
1.1.7 Update and promote the county Prevention Hub Resource.
1.1.8 Collaborate with Capital Healthy Living to provide education and connection to community resources including mental health.
1.1.9 Advocate for sharing outcome data, opportunities for improvement, and additional funding related to the state-funded ARRIVE program.

Objective 1.2: Increase mental health education and skills building for health professionals by 2027.

Strategies

1.2.1 Identify the mental health training topics of interest our partner organizations would appreciate for their staff.
1.2.2 Expand professional development training on various topics for health professionals, including community health workers.
1.2.3 Explore providing and/or expanding continuing education units (CEUs) for training.
1.2.4 Provide and promote mental health training, including mental health first aid and harm reduction strategies, for community service providers.
1.2.5 Advocate with community colleges and universities (especially with health programs) for the importance of mental health training, including mental health first aid and ACEs training.

Objective 1.3: Increase community knowledge of mental health stigma, prevention, and harm reduction by 2027.

Strategies

1.3.1 Identify and promote existing programs and resources, particularly for high-risk populations.
1.3.2 Partner with organizations to provide free training and resources.
1.3.3 Increase awareness and utilization of substance use prevention, treatment and recovery services, and harm reduction in connection to mental health.

Priority 2: Access to Wellness

The Access to Wellness Priority Area of the CHIP outlines objectives and strategies to work towards having equitable access to the physical, social, and economic resources needed to achieve optimal health and wellness for all in Mercer County. Implementation efforts will seek to increase enrollment and referrals to assistance programs to support the cost of healthcare services; improve access to nutritious food and other supplemental resources to meet/align with individual cultural and financial needs; increase convenient, affordable, accessible transportation options to key destinations for food/ healthcare in Mercer County; increase the number of linguistically and culturally competent resources and personnel along the healthcare continuum; and reduce the impact of chronic disease for individuals most at risk, particularly Black, LGBTQ+, Asian, and Hispanic peoples.

Populations Most Impacted

Latino residents
Black residents
Housing unstable population
Low-income people, the working poor
Immigrants
Older adults
Young people

Cost of Services, Linguistically and Culturally Competent Resources and Personnel

Interviewees and focus group participants shared that Mercer County residents in the GMPHP service area faced barriers to accessing healthcare. Challenges such as cost, lack of providers, lack of insurance, language and transportation barriers, lack of culturally competent care, and stigma or bias were among the barriers mentioned.[5] Community survey respondents were asked to identify the issues that made it harder for them or a family member to get medical care or treatment when needed. The top issues survey respondents identified overall were inability to schedule an appointment at a convenient time (33.1%), long wait times (26.3%), doctors not accepting new patients (24.8%), insurance problems (22.4%), and cost of care (20.5%).[6]

Food Insecurity

Several participants discussed how food insecurity has seemed to increase due to inflation and the rising cost of living. Unhoused populations, many of them families with children and older adults, were particularly food insecure. The food insecure population in Mercer County increased from 7.4% to 9.7% from 2020 to 2022. Almost one third of Mercer County community survey respondents (29.3%) reported that it was sometimes or often true that they worried their food would run out before they had more money to buy more. The situation was more dire for Black (51.6%) and Latino (63.1%) residents.[7]

Transportation

Participants shared differing perspectives on transportation and walkability in Mercer County. Focus group and interview participants indicated that in some areas, such as neighborhoods in Trenton and Princeton, there was public transportation, but that in other areas, such as Hightstown Borough, transportation was absent. Additionally, participants noted the lack of sidewalks and the cost of transportation as barriers to accessing basic needs for those lacking transportation. Overall, less than one quarter (24.4%) of Mercer County community survey respondents agreed or strongly agreed with the statement “it would be easy for me to take public transportation to where I needed to go day-today.” Despite this, interview and focus group participants mentioned several promising programs and initiatives to improve

transportation and walkability, such as Complete Streets and Vision Zero initiatives and a federal grant to improve bus use, among others. [8]

Chronic Disease
Chronic disease prevention and management continued to be a top priority. Data showed racial/ethnic disparities in chronic disease burden across Mercer County. Black residents experienced nearly double the rate of cardiovascular disease inpatient hospitalizations (144.1/10,000) than the Mercer County average (77.4/10,000). Diabetes was a top concern for survey respondents and data indicated that it was disproportionately prevalent among Latino (17.3%) and Black (13.6%) Mercer County residents. The cancer mortality rate in Mercer County was highest among Black (164.1/100,000), followed by White (135.0/100,000) residents.[9]

Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.

Objective 2.1: Increase referrals and enrollment to assistance programs to support the cost of clinical healthcare services and reduce the uninsured rate by 2027.

Strategies

2.1.1 Utilize Social Determinants of Health (SDOH) screening tools at points of care to identify needs and connect patients to assistance programs.
2.1.2 Expand outreach at community events with a focus on underserved areas, to increase awareness and enrollment in insurance and cost assistance programs.
2.1.3 Increase organizational knowledge of NJ Family Care and other cost-saving benefit programs across coalition partners.

Objective 2.2: Improve access to nutritious food and nutrition education to align with individual, cultural, and financial needs by 2027.

Strategies

2.2.1 Leverage the Mercer County Food Stakeholders group to promote existing food resources and increase knowledge around free food resources in Mercer County.
2.2.2 Expand food resources targeting areas and populations in need, to reduce racial & ethnic disparities in rates of food insecurity.
2.2.3 Strengthen partnerships with schools to enhance nutritious food access for children.
2.2.4 Expand the type and amount of culturally and dietarily appropriate foods offered among free food providers.
2.2.5 Provide nutrition education in community with particular focus on reaching marginalized populations.

Objective 2.3: Increase convenient, affordable and accessible transportation options to key wellness destinations in Mercer County by 2027.

Strategies

2.3.1 Engage transportation organizations to address transportation gaps and barriers for key destinations.
2.3.2 Enhance communication efforts to encourage knowledge of and use of public transportation to essential services.
2.3.3 Identify, advocate for, and promote awareness of transportation subsidies, and non-public transportation programs to increase awareness and participation for populations of greatest need.

Objective 2.4: Increase the number of linguistically and culturally competent resources and personnel along the healthcare continuum by 2027.

Strategies

2.4.1 Identify resources currently available and gaps in meeting patients' cultural and language needs.
2.4.2 Conduct & promote cultural competency trainings for healthcare and Community Based Organizations (CBO) staff.
2.4.3 Promote effective recruitment and retention strategies and best practices for expanding the cultural and linguistic diversity of healthcare staff.
2.4.4 Explore ways to use technology to aid in translation.

Objective 2.5: Reduce the impact of chronic disease for minority groups most at risk by 2027.

Strategies

2.5.1 Deliver education for chronic disease prevention and management across the lifespan.
2.5.2 Deliver screenings for cancer and cardiovascular disease for key at-risk populations.
2.5.3 Promote utilization of healthcare navigators for chronic disease follow up and management.
2.5.4 Strengthen collaborations between organizations that provide chronic disease services and supports.

Priority 3: Housing & Built Environment

Safe and affordable housing is integral to life, health, and well-being. Housing was described as a substantial community challenge in focus groups and interviews. As is true across the nation, affordable housing in Mercer County is scarce. Participants reported that the housing issues cut across race and age. Participants noted that an increase in the unhoused population was driven by rising housing costs coupled with the end of the eviction moratoriums enacted during COVID-19.[10]

Populations Most Impacted

Latino residents
Black residents
Housing unstable population
Low-income people, the working poor
Immigrants
Older adults
People with substance use disorders and mental health conditions

Overall, only one-third (34.5%) of survey respondents in Mercer County agreed that there was sufficient affordable and safe housing in their community. This proportion was higher for Asian respondents (46.8%) and much lower for Black (23.4%) and Latino (26.1%) respondents.[11] 16.6% of survey respondents were concerned about their housing stability in the next two months. This concern was highest among Latino respondents (38.6%), followed by Black respondents (31.9%). In contrast, only 8.5% of Asian respondents and 8.2% of White respondents shared this concern.[12]

Neighborhood characteristics, including the availability of green space and the quality of the built environment, influence the public's health, particularly in relation to chronic diseases. Physical space can also influence lifestyles. Playgrounds, green spaces, and trails, as well as bike lanes, and safe sidewalks and crosswalks, all encourage physical activity and social interaction, which can positively affect physical and mental health.[13]

Focus group and interview participants valued the recreational child-friendly areas in their neighborhoods and, according to the RWJF County Rankings, most Mercer County residents (99.0%) had adequate access to a location for physical activity.11 Additionally, 78.7% of Mercer County community health survey respondents indicated that they agreed or completely agreed with the statement "my community has safe outdoor places to walk and play." However, there were disparities by race/ethnicity, with White (86.0%) and Asian (86.1%) survey respondents being more likely to agree with the statement than Latino (65.9%) and Black (55.5%) survey respondents.[14]

The Housing & Built Environment Priority Area of the CHIP outlines objectives and strategies to work towards everyone in Mercer County having a place to feel safe and call home in a thriving community. Implementation efforts will seek to increase community-based support for home affordability, decrease unsafe housing units/conditions, increase the number of Vision Zero activities implemented by Mercer County municipalities, increase the number of open spaces available for outdoor activity in communities in need, and increase awareness of the resources that exist to obtain and maintain stable housing.

Goal 3: Everyone in Mercer County has a place to feel safe and call home in a thriving community.

Objective 3.1: Develop infrastructure to collect and share data on home affordability and insights across agencies to more effectively demonstrate need, reality, and demand by 2027.

Strategies

3.1.1 Collect and share data on home affordability and insights across agencies to more effectively demonstrate need, reality, and demand.
3.1.2 Identify housing stakeholders, prioritize county-wide housing needs, and coordinate services among stakeholders at both the county and municipal level.
3.1.3 Support outreach and education campaigns to educate the public and policy makers about the need for and importance of affordable housing options.

Objective 3.2: Connect partners to coordinate data collection and testing to improve unsafe housing conditions by 2027.

Strategies

3.2.1 Promote education on available programs, including financial assistance for inspections, remediation & clean up, treatment proper disposal of contaminants and water pollution.
3.2.2 Expand education about Healthy Homes programs and practices to home-visitors and partner organizations.
3.2.3 Advocate for state agency budgets to include requests for funding for testing, inspection, remediation, and treatment.
3.2.4 Support testing and inspection services: health, housing, code.
3.2.5 Promote remediation and treatment.
3.2.6 Advocate for resources and support materials to be available in multiple languages.

Objective 3.3: Increase the number of Vision Zero activities implemented by Mercer County municipalities by 10% by 2027.

Strategies

3.3.1 Educate municipal officials on how to implement Vision Zero activities as part of the “Health in All Policies” framework.
3.3.2 Identify which municipalities have adopted a Vision Zero resolution, and identify activities that can be implemented by municipalities.
3.3.3 Share info on Vision Zero and the resulting changes and successes.

Objective 3.4: Increase the number of open spaces available for outdoor activity in communities in need by 2027.

Strategies

3.4.1 Conduct an inventory of open spaces, recreational locations, and municipal and county-owned land.
3.4.2 Develop recommendations to improve existing and create additional open spaces focused on communities in need.
3.4.3 Support projects that create safe routes to walk/bike to public spaces.
3.4.4 Advocate for municipalities to plant more trees in urban areas and explore ways to utilize open spaces to mitigate climate change.

Objective 3.5: Increase awareness of the resources that exist to obtain and maintain stable housing by 2027.

Strategies

3.5.1 Develop and conduct in-person programs and events in areas with underserved populations that focus on basic housing information and financial literacy.

3.5.2 Connect with schools to promote and implement community education sessions to bridge gaps in knowledge for households and families.

3.5.3 Assess existing resource guides and explore creating a comprehensive database of county-wide resources for housing stability.

3.5.4 Advocate for state agency budgets to include requests for funding needs for housing stability.

3.5.5 Promote resources to assist individuals in securing economically viable employment.

Priority 4: Maternal & Infant Health

The health and well-being of mothers, infants, and children are important indicators of community health. Maternal and infant health were issues of concern in the last CHIP and were discussed by several participants in the current assessment.[15]

Populations Most Impacted

Black women/birthing parents and families
Latina women/birthing parents and families

Quantitative data evidence that maternal and infant health were issues of concern in Mercer County. Teen mothers face higher risks of pregnancy complications, such as eclampsia and systemic infections, than women in their twenties. Teen pregnancy is more prevalent in Mercer County than in the state overall. Teen pregnancy is more prevalent in Mercer County than in the state overall. According to the Hospital Discharge Data Collection System, in 2022, there were 8.4 births per 1,000 females ages 15-17, higher than 3.4 births per 1,000 females ages 15-17 in New Jersey (Figure 123 in the appendix). Infant mortality per 1,000 births was also high in Mercer County at 6.4 per 1,000 births compared to a New Jersey rate of 3.5 per 1,000 births in 2021.[16]

Grave racial and ethnic disparities exist in maternal and infant health outcomes. Birth data from the NJ Birth Certificate Database showed that Mercer County (8.0%) had a slightly higher percentage of low-birth-weight babies born from 2018-2022 than the state (7.8%). Data across racial/ethnic groups shows that a higher percentage of Black newborns were of low birth weight compared to other races/ethnicities in Mercer County and the state, with White women having the lowest percentage of low-birth-weight births in the county. These findings were consistent with findings from the 2021-CHNA-CHIP where maternal and infant health were identified as priority areas. A similar pattern occurred for very low birth weight outcomes and preterm births.[17]

Prenatal care is a critical evidence-based strategy to prevent and manage pregnancy complications and reduce poor birth outcomes. The percentage of pregnant women receiving prenatal care in the first trimester was lower in Mercer County (64.2%) than in New Jersey overall (74.1%). There were stark differences by race/ethnicity, with 48.7% of Latino women in Mercer County receiving prenatal care in the first trimester compared to 83.5% of White women in Mercer County.[18]

The Maternal & Infant Health Priority Area of the CHIP outlines objectives and strategies intended to achieve equitable access to quality care and resources across the continuum to improve health outcomes for all birthing people and infants in Mercer County. Implementation efforts will seek to increase access to prenatal care services to reduce the risk factors for maternal and infant mortality, increase the number of partnerships among community-based organizations to streamline resources and build supportive networks for families, increase health education opportunities to promote health and well-being of all birthing people, infants, and families, and increase and diversify the number of professionals working in the community to bridge the gap in access to maternal and infant health care.

Goal 4: All birthing people and infants in Mercer County have equitable access to quality care and resources across the birthing continuum to improve health outcomes.

Objective 4.1: Increase access to prenatal care services to reduce the risk factors for maternal and infant morbidity and mortality to more closely align with NJ rate (3.5 per 1,000 births) by 2027.

Strategies

4.1.1 Identify gaps in telehealth services to better understand disparities.
4.1.2 Expand services to high-risk and underserved neighborhoods that could benefit from mobile health clinics.
4.1.3 Explore opportunities to integrate/co-locate health services.
4.1.4 Promote community-based service providers to support care navigation and planning.
4.1.5 Partner with urgent care and Emergency Departments to provide support to pregnant individuals to enroll in prenatal care.
4.1.6 Identify and promote transportation options to allow individuals to reach care.
4.1.7 Promote existing digital tools, and development of new methods, to enable individuals to identify social support resources needed based on preferences indicated.
4.1.8 Promote family leave insurance and other State legislation regarding FMLA/TDI/Earned Sick time.
4.1.9 Increase organizational knowledge of NJ Family Care (Medicaid) enrollment process.
4.1.10 Continue working on developing the Maternal & Infant Health Innovation Center in the city of Trenton.
4.1.11 Implement TeamBirth by the end of 2025.
4.1.12 Implement Centering Pregnancy by the end of 2026.

Objective 4.2: Increase the number of partnerships among the community-based organizations to streamline resources and build supportive networks for families by 2027.

Strategies

4.2.1 Identify the number of Community Based Organizations (CBOs) providing services for maternal and infant health, the services they are providing, and the CBOs they are currently collaborating with.
4.2.2 Identify high need communities lacking services and facilitate strategic partnerships.
4.2.3 Continue monthly Maternal Health Stakeholders Meetings and conduct outreach to increase membership.

Objective 4.3: Increase health education opportunities to promote health and well-being of all birthing people, infants, and families in Mercer County by 2027.

Strategies

4.3.1 Diversify representation in health education materials and public health campaigns, including incorporating fathers and partners into materials, to be more culturally and linguistically sensitive.
4.3.2 Share diverse health education materials on social media, radio, TV.
4.3.3 Provide affordable and/or free classes and workshops in community locations.
4.3.4 Strengthen school-based support for reproductive and sexual health education and resources, including healthy pregnancies, to reduce risk of teen pregnancy to meet State level.

4.3.5 Incorporate cultural competence into trainings for providers of maternal and infant health services.
4.3.6 Develop a resource toolkit for prenatal care providers on culturally sensitive care specific to Mercer County.

Objective 4.4: Increase and diversify the number of professionals working in the community to bridge the gap in access to maternal and infant health care by 2027.

Strategies

4.4.1 Establish a baseline by identifying the number of community-based professionals from underserved backgrounds.
4.4.2 Develop and provide informational sessions on community-based professions to attract and recruit diverse providers, including promoting existing community-based training and loan forgiveness options (e.g., Community Health Worker Institute).
4.4.3 Establish partnerships with schools and community colleges/higher education institutions to promote volunteer, internship, and career options for students from culturally and linguistically diverse backgrounds.
4.4.4 Offer training programs in partnership with public health departments, targeting cultural competency, anti-bias, and trauma informed practices.

Next Steps

The components included in this report represent the strategic framework for a data-driven, community-enhanced Community Health Improvement Plan. GMPHP members, the Community Advisory Board, key partners, and community members will continue to revise and refine the suggested activities and timelines drafted by workgroup members to develop annual action plans for the CHIP (See **Appendix F**). As part of the implementation process, partners and resources will be solidified to ensure successful CHIP implementation and coordination of activities and resources among key partners in Mercer County.

Appendices

Appendix A: CHIP Process Participants

Priority 1: Mental Health

Alex Aikens	HiTOPS
Malissa Arnold	Prevention Coalition of Mercer County/ Mercer Council
April Brown	Capital Health
Nicole Cowan	Millhill Child and Family Development
Heather DeLorenzo	Mercer County Office on Addiction
Christina Desalvo	Capital Health
Janet Haag	NAMI Mercer NJ
Fatema Haque	West Windsor Health Department
Dawn Hutchinson	RWJUH Hamilton
Chris Kirk	Trenton Health Team
Tammy Leigh	RWJUH Hamilton
Keith Levine	Lawrence Health Dept
Connie Moceri	RWJUH Hamilton
Charlene Phelps	Mercer Council on Alcoholism and Drug Addiction
Kami Scully	RWJUH Hamilton
Laura Taylor	Central Jersey Family Health Consortium, Inc.
Ted Taylor	RWJUH Hamilton
Dr Dara Whalen	TCNJ

Priority 2: Access to Wellness

Johanna Agila	RISE
Jessica Alleman	RWJUH Hamilton
Matthew Broad	Trenton Health Team
Joyce Cantalice	RWJUH Hamilton
Jeremye Cohen	Capital Health
Sasha Desai	RWJUH Hamilton
Beth Englezos	Meals on Wheels of Mercer County
Mamai-ee Freeman	Hamilton Township Division of Health
Yonatan Gershon	Mercer County Division of Public Health
Diane Grillo	RWJUH Hamilton
Giovanna Guarraggi	Hamilton Township Division of Health
Sandy Haas	RWJUH Hamilton
Joan Healy	Rutgers Cooperative Extension - SNAP-Ed
Ricardo Kairios	Rutgers Cooperative Extension of Mercer County
Sarah King	RWJUH Hamilton
Ann Mancuso	RWJUH Hamilton
Ana Montero	Mercer County
Bonnie Petrauskas	Hunterdon-Mercer Chronic Disease Coalition
Rebecca Reynolds	RWJUH Hamilton
Seth Rosenbaum	RWJUH Hamilton
Melissa White McMahon	YWCA Princeton's Breast Cancer Resource Center

Priority 3: Housing and Built Environment

Micaella Acevedo	RWJUH Hamilton
David Bosted	GMPHP Board
Lisa Breza	RWJUH Hamilton
Carol Chamberlain	Community Rep/West Windsor HD
Marinela Constantino	NAMI Mercer (Intern)
Jackie Cornell	Mercer County, Dept of Human Services
Ruth DelPino	ISLES
Gary Dorsi	Hopewell Township Health Department
Alix Fellman	Trenton Health Team
Glenda Grant Roberts	East Windsor
Chris Hellwig	Hamilton Division of Health
Allen Lee	Ewing Twp. Health Dept.
Kam Maghazehe	Capital Health
Dana Nelson-Barnes	HomeFront
Michael Nordquist	HomeFront
Kristin Reed	Mercer County Health Department
Corinne Shields	NAMI Mercer (intern)
Sarah Steward	HomeFront

Priority 4: Maternal & Infant Health

Kristen Cere	Community Action Service Center dba Rise
Jocelyn Claudio	Central Jersey Family Health Consortium
Emily DeHaan	Mercer County Division of Public Health
William DiStanislao	RWJUH Hamilton
Dynell Kellyman	Children's Futures
Alexandra Nelson	Capital Health
Stephen Papenberg	GPHP/Pennington Board of Health
Amy Pellicane	RWJUH Hamilton
Eriny Saad	CHS Of Mercer WIC Program
Jodie Sessoms	TruDoulas of New Jersey
Hiral Shukla	Aetna-CVS Health
Brielle Spadola	Hamilton Township Division of Health
Cheryl Towns	Trenton Health Team
Nye Veale	KinderSmile Perinatal Health and Wellness Program

Appendix B: GMPHP Member Organizations

Acenda
Aetna - CVS Health
American Heart Association
Advocates for Mom and Dad
Attitudes in Reverse
Avalon Rehabilitation
Arm in Arm
Brain Injury Association
Boys and Girls Club
Campfire
Capital City Farm
Capitol County Children's Collaborative
Catholic Charities Diocese of Trenton
Central Jersey Family Health Consortium
Children's Futures
Children's Home Society of NJ
Crossroads4Hope
East Windsor Health Department
Eat for Your Health
Empower Somerset
Encouraging Kids
Ewing Health Department
Greater Mercer Transportation Mgmt. Assn.
Grounds for Sculpture
Hamilton Health Department
Hamilton YMCA
Hand in Hand
Helping Arms
Henry J Austin
HiTOPS
HomeFront
Hopewell Health Department
Hunterdon Mercer Chronic Disease Coalition
Interfaith Caregivers of Mercer County
Isles
Jewish Family and Children's Services
KinderSmile
Latin American Legal and Ed. Defense Fund
Lawrence Health Department
Lawrence Hopewell Trail
Lawrence Rehabilitation Hospital
Meals on Wheels
Mercer Council on Alcohol and Drug Abuse
Mercer County Health Officer Association
Mercer County Hispanic Association
Mercer County Human Services
Mercer County Office of Economic Development
Mercer County Office on Aging and Disability
Mercer Street Friends
Mount Carmel Guild
NAMI Mercer
NJ Cancer Institute
NJCEED
NJ Futures
NJ Health Care Quality Institute
NJDOH - Office of Minority and Multicultural Health
NJ Hospital Association
Oaks Integrated Care
Office of Early Childhood
Phoenix Behavioral Health
Presbyterian Church of Lawrenceville
Princeton Breast Cancer Resource Center
Princeton Health Department
Princeton House
Princeton Housing Authority
Rainbow Nursery Medical Day Care
Rolling Harvest
Rider University – Health Care Management
RISE
Rutgers Cooperative Extension - SNAP Ed
Rutgers Cooperative Extension of MC
RWJB Hamilton Hospital
Share My Meals
SNAP-Ed
TCNJ School of Nursing and Public Health
Terhune Orchard
The Community Well
The Watershed
Thomas Edison State University
Trenton Free Public Library
Trenton Health Department
Trenton Health Team
Tri-State Transportation Circuit
Trinity Cathedral
TruDoulas of NJ
United Way of Greater Mercer County
Well Beyond Partners
West Windsor Health Department
Woman Space
YWCA Princeton Breast Cancer Resource Center

Appendix C: Acronyms

ACEs	Adverse Childhood Experiences
ANCHOR	Affordable New Jersey Communities for Homeowners and Renters
ATW	Access to Wellness Workgroup
BCBS	Blue Cross Blue Shield
CAB	Community Advisory Board
CARE	Cultivating Access, Rights and Equity Grant Program
CBO	Community Based Organizations
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CHS of NJ	The Children's Home Society of New Jersey
CHW	Community Health Worker
CJFHC	Central Jersey Family Health Consortium
CoC	Trenton/Mercer Continuum of Care
COVID-19	Coronavirus Disease
CUNA	Pregnancy Help and Services for the Latino Community in Trenton and surrounding areas
ED	Emergency Department
ETC	East Trenton Collaborative
FCHS	Family and Community Health Sciences
FMLA	Family and Medical Leave Act
GHHI	Green & Healthy Homes Initiative
GMPHP	Greater Mercer Public Health Partnership
GMTMA	Greater Mercer Transportation Management Association
HBE	Housing & Built Environment Workgroup
HM	Hunterdon-Mercer Chronic Disease Coalition
HSAC	Mercer County Health Services Action Committee
JCFS	Jewish Family & Children's Service
LALDEF	The Latin American Legal Defense and Education Fund, Inc
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, and Queer
LT STAC	Lawrence Township Shade Tree Advisory Committee
MA	Massachusetts
MAPP	Mobilization for Action through Planning and Partnerships
MBH	Mental & Behavioral Health
MC	Morris County
MCADA	Mercer Council on Alcoholism and Drug Addiction
MCCCT	Mercer County Coalition for Coordinated Transportation
MCFS	Mercer County Food Stakeholders
MH/BH	Mental Health/Behavioral Health
MHSG	Maternal Health Stakeholder Group
MSF	Mercer Street Friends
NAMI	National Alliance on Mental Illness
NCLAS	National Standards for Culturally and Linguistically Appropriate Services
NJ	New Jersey
NJMIHIA	New Jersey Maternal and Infant Health Innovation Authority
NJPRSN	NJ Postpartum Resource and Support Network Program
OB	Obstetrics

PCMC	Prevention Coalition of Monmouth County
PRSA	Public Relations Society of America
QPR	Question, Persuade, Refer
RCE	Rapid cycle evaluation
RWJ	Robert Wood Johnson
RWJF	Robert Wood Johnson Foundation
RWJUH	Robert Wood Johnson University Hospital
SDOH	Social Determinants of Health
SNAP	Supplemental Nutrition Assistance Program
TCNJ	The College of New Jersey
TDI	Temporary Disability Insurance
THIE	Trenton Health Information Exchange
THT	Trenton Health Team
VA	Veterans Association
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
WOW	WIC on Wheels
YWCA	Young Women's Christian Association

Appendix D: Planning Definitions

	Planning Definitions	Probing Questions
GOAL	• **A goal is a broadly stated, non-measurable change in a priority.** • It describes in broad terms a desired outcome of the planning initiative. • **Characteristics of Goals** – Global in nature; provide general direction – Non-specific – Non-measurable; cannot be quantified – Long-term – Can be lofty and idealistic, as it is not necessary that a goal be reached during a specific time frame	a. What is the desired state or outcome for this priority area? b. What do we need to do in this priority area to significantly change the current state and move toward a desired state?
OBJECTIVES	• Objectives state how much of what you hope to accomplish and by when; usually start with INCREASE, DECREASE, ENHANCE, IMPROVE… • Are **SMART/SMARTIE**: **S**pecific: Does it clearly state what will be achieved? **M**easurable: Is it measurable? How will I know when it is accomplished? **A**chievable: Is it action-oriented and attainable? **R**ealistic: Is it realistic with the resources you have? **T**ime-bound: When will it be achieved? **I**nclusive: Brings traditionally marginalized people—particularly those most impacted—into processes, activities, and decision/policymaking in a way that shares power **Eq**uitable: Seeks to address systemic injustice, inequity, or oppression GOALS and OBJECTIVES describe the "**WHAT**" of your plan. GOALS are broad and OBJECTIVES lend specificity and precision to the goal.	a. What do we mean by this goal area? How would we break it down into its three most important parts? Or what are the three biggest ideas that feed into this goal statement? b. It can help to literally break the goal statement out into clauses and ask: What do we mean by this clause? What are we trying to achieve here?
INDICATORS	Measure(s) of progress or completion of an objective. They describe the baseline and target values for each objective based on data that are relevant and available.	
STRATEGIES	• Strategies are: – Specific ways to meet each of the objectives – An approach to getting things done – a statement of **HOW** an objective will be achieved – Something that identifies the general direction of the specific action steps • Strategies begin with words such as "identify," "advocate for," "support," "develop," "train" and "educate."	a. What do we need to do to achieve this objective? b. Will these strategies, when combined, fulfill our objective and goal?

Appendix E: Glossary of CHIP Terms

Discrimination -The impact of discrimination occurs at both structural and individual levels. Structural discrimination refers to macro-level conditions (e.g., residential segregation) that limit "opportunities, resources, and well-being" of less privileged groups. Individual discrimination refers to negative interactions between individuals in their institutional roles (e.g., health care provider and patient) or as public or private individuals (e.g., salesperson and customer) based on individual characteristics (e.g., race, gender, etc.). Individual and structural discrimination can cause either intentional or unintentional harm, whether or not it is perceived by the individual.[19]

Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[20]

Housing Affordability - The U.S. Department of Housing and Urban Development defines "affordable housing" as housing on which the occupant is paying no more than 30 percent of gross income for housing costs, including utilities. Keeping housing costs below 30 percent of income is intended to ensure that households have enough money to pay for other nondiscretionary costs; therefore, policymakers consider households who spend more than 30 percent of income on housing costs to be housing cost burdened. In reality, the definition of affordable housing is nebulous, with different programs and stakeholders often adopting their own slightly different definitions of what is considered "affordable housing."[21]

Racial Equity is the condition that would be achieved if one's racial identity no longer predicted life outcomes. This includes elimination of policies, practices, attitudes, and cultural messages that reinforce differential outcomes by race or fail to eliminate them.[22]

Social Determinants of Health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[23]

Systemic Racism is the oppression of a racial group to the advantage of another as perpetuated by inequity within interconnected systems (such as political, economic, and social systems). [24]

Systemic Racism & Discrimination - from the Community Health Needs Assessment
Perceptions related to discrimination and racism varied throughout qualitative discussions [during CHNA data gathering]. These discussions took place in a national context of polarization and backlash against efforts to redress systemic racism and discrimination and promote diversity, equity, and inclusion for all regardless of gender and racial identity, among other identity categories. Several interviewees and focus group participants recognized discrimination and hatred as a systemic, public health issue. Interviewees described instances of discrimination and stereotyping against the unhoused population and the LGBTQ+ community, including in schools and healthcare centers.[25]

Survey respondents who identified as people of color mentioned incidences of being discriminated against due to their race or nationality. Data from the 2024 community survey provide additional insight into experiences of discrimination when receiving healthcare. More

than one-third of Black (38.0%) and Latino (40.3%) respondents reported experiencing discrimination due to their race/ethnicity when receiving medical care compared to 16.9% of respondents overall. Additionally, Latino (18.0%), Black (19.2%), and Asian (20.9%) survey respondents also reported feeling discriminated against when receiving medical care based on their culture and religious background. Nearly 2 in 5 Latino respondents (38.1%) and 1 in 5 Asian respondents (18.8%) also reported feeling discriminated against due to their language/speech. Other forms of discrimination while receiving medical care also emerged from the survey. In Mercer County, 18.6% of survey respondents felt discriminated against due to their age, 15.8% due to their body size, 8.0% due to their gender or gender identity, and 5.6% due to their sexual orientation. However, 32.4% of LGBTQ+ respondents experienced discrimination due to their sexual orientation.[26]

Vision Zero is a fundamental shift in how road safety is addressed. It is a strategy that aims to achieve zero traffic fatalities and serious injuries while increasing safe, healthy, and equitable mobility for all. Vision Zero addresses safety as a shared responsibility by system designers and roadway users.[27]

Appendix F: 2025 GMPHP CHIP Action Plan

Priority 1: Mental & Behavioral Health

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community
Objective 1.1: Increase awareness of and connection to available mental health services across the lifespan by 2027
Objective 1.2: Increase mental health education and skills building for non-mental health professionals by 2027
Objective 1.3: Increase community knowledge of mental health stigma, prevention, and harm reduction by 2027

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.1: Increase awareness of and connection to available mental health services across the lifespan by 2027					
CHNA Indicators = 29.5% of survey respondents identified mental health as top health concern (CHNA p. 50)					
41.2% of respondents identified mental health as top health issue impacting children and youth (CHNA p. 52)					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
1.1.1 Explore and promote existing NAMI Mercer, HELP Line Plus, Mercer County mental health directory and other navigation services in Mercer County.	NAMI GMPHP HiTOPS TCNJ Mercer County Mental Health & Addiction Services (MCMHAS) Mental & Behavioral Health (MBH) Workgroup RWJUHH	Creation of flyer.	Create a resource flyer that nonprofits and GMPHP can help to promote.	NAMI	
		Collection of all LGBTQ+ contacts for directory.	Collect LGBTQ+ contacts to create Mercer County mental health directory.	HiTOPS	
		Creation of directory.	Work with a student to help create mental health directory for Mercer County.	TCNJ	
			Promote and distribute guide and MC Dept. of Human Services Resource Directory that is updated annually. Will keep all resources updated on GMPHP website.	GMPHP & Workgroup	
1.1.2 Foster connections and collaborations between organizations that provide mental & behavioral health services.	TCNJ GMPHP MCMHAS Mental & behavioral health (MBH)	Increase in collaborative activities between workgroup members.	Workgroup will allocate time in meetings for networking, expanding membership opportunities, and sharing resources. Priority workgroup will meet 2-4 times a year to network and share resources.	GMPHP MBH workgroup	

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.1: Increase awareness of and connection to available mental health services across the lifespan by 2027					
CHNA Indicators = 29.5% of survey respondents identified mental health as top health concern (CHNA p. 50)					
41.2% of respondents identified mental health as top health issue impacting children and youth (CHNA p. 52)					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
	workgroup Health Departments Capital Health RWJUHH	Increase in attendance and organizations represented at quarterly workgroup meetings. # new members/organizations added annually	Conduct outreach to expand workgroup membership and representation.	GMPHP	*18 attendees at 10/8/24 planning session from 13 organizations, 9 attendees from 8 orgs. present at workgroup mtg. 1/24/25. 48 addresses in email list-serv in Feb. 2025)*
		# of meetings attended and participants attended for both sessions.	Hire a mental health educator to ensure continuous representation at workgroup meetings.	Capital Health	
1.1.3 Explore integrating mental health data in the Trenton Health Information Exchange (THIE) to facilitate referrals and coordinate services.			Not currently data that THIE has access to. Reassess in 2026 if this is something the group has capacity to take on.		
1.1.4 Identify and partner with organizations and agencies that work with older adults to provide education and connection to resources.	Mercer Council on Alcoholism and Drug Addiction (MCADA) MCMHAS TCNJ NAMI Mercer Millhill Health Departments Capital Health RWJUHH	5% annual increase in number of older adults reached among coalition partners. Total # of programs annually.	Conduct Healthy Outlooks for older Adults Workshop and Wellness Initiative for Senior Education.	Mercer Council on Alcoholism and Drug Addiction (MCADA)	*156 adults reached in 2023.*
		# of community groups, organizations, or agencies collaborating in MH/BH strategies	RWJUHH will conduct Better Health for 65+ to provide education and connection to resources.	RWJUHH (3.m.)	
1.1.5 Partner with schools and youth serving organizations to share age-appropriate mental health resources and information with youth.	TCNJ NAMI Mercer Millhill Capital Health Health Departments	# of attendees at trainings. Qualitative survey results.	Will do 5 nursery school teacher trainings on ACEs & create a survey specific to school age mental health. Dara will ask Michel Madiou if she can present to the County Superintendents.	TCNJ	*4 nursery school trainings in 2024.*

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.1: Increase awareness of and connection to available mental health services across the lifespan by 2027					
CHNA Indicators = 29.5% of survey respondents identified mental health as top health concern (CHNA p. 50)					
41.2% of respondents identified mental health as top health issue impacting children and youth (CHNA p. 52)					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
	MCADA RWJUHH	# of presentations in schools, attendance at presentations. # of toolkits sent to schools	Conduct educational presentations in schools and send out toolkits to school staff on different mental health topics	NAMI Mercer	
		# of education sessions, attendance at trainings.	Will do quarterly peer mental health education in schools.	Millhill	
		Presenting youth/# of referrals to DCF established programs	1) Sign an MOU w/ DCF, 2) Establish set meetings with DCF, 3) Data reporting to DCF.	Capital Health	
		# trainings, # attendees	Conduct Teen Mental Health First Aid trainings in schools and community locations.	MCADA	
		# of classes, workshops, events, campaigns, or trainings provided. # of people (residents and providers/organizational stakeholders) reached through classes, workshops, events, campaigns, or trainings. # of community groups, organizations, or agencies	Partner with schools and youth serving organizations to share age-appropriate mental health resources and information with youth, including how mental health can be supported by integrating healthy eating/nutritional education. Develop and host parent and teenager programs targeting community needs relative to stigmas.	RWJUHH (3.n. + 3.e.)	
1.1.6 Advocate for funding in state departments and agency budgets to support partners and resources in achieving these goals and objectives.	HiTOPS MCMHAS	# of advocacy efforts, details of efforts.	Advocate for funding for mental health support programs in schools.	HiTOPS MCMHAS	
1.1.7 Update and promote the county Prevention Hub Resource.			Workgroup will discuss at next meeting how to do this and who has capacity for this.		

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.1: Increase awareness of and connection to available mental health services across the lifespan by 2027					
CHNA Indicators = 29.5% of survey respondents identified mental health as top health concern (CHNA p. 50)					
41.2% of respondents identified mental health as top health issue impacting children and youth (CHNA p. 52)					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
1.1.8 Collaborate with Capital Healthy Living to provide education and connection to community resources including mental health.	Capital Health	Total # of educational workshops offered by the Capital Healthy Living program (goal=12).	Continue providing educational workshops for members.	Capital Health	
1.1.9 Advocate for sharing outcome data, opportunities for improvement, and additional funding related to the state-funded ARRIVE program.	Capital Health	# of monthly ARRIVE together calls CH responds to, # of police calls Barricade program, all outreach calls excluding ARRIVE and Barricade programs.	Educate law enforcement and the AG office on the outcomes and opportunities of the ARRIVE program.	Capital Health	

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.2: Increase mental health education and skills building for health professionals by 2027					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
1.2.1 Identify the mental health training topics of interest our partner organizations would appreciate for their staff.	TCNJ	Qualitative survey results.	Create a survey to distribute to partners and present results at quarterly workgroup meeting.	TCNJ	
1.2.2 Expand professional development training on various topics for health professionals, including community health workers.	TCNJ GMPHP MBH Workgroup MCMHAS Capital Health RWJUHH	# of attendees	Hold this action for now until survey results are available in order to understand what partners are interested in. Consider ACEs training, QPR, Columbia scale for suicide prevention.		*4 Mental Health First Aid trainings, 3 QPR trainings were completed in 2023.*
		# of attendees	Host a psychiatric conference for all healthcare professionals within our Community in October.	Capital Health	
		# of classes, workshops, events, campaigns, or trainings provided. # of people (residents and providers/organizational stakeholders) reached through classes, workshops, events, campaigns, or trainings. # of community groups, organizations, or agencies	Offer outreach and education to providers and healthcare workers on trauma informed care, ACEs, Mental Health First Aid, cultural/sensitivity comforts, understanding how to recognize MH/BH concerns during screening assessments, and what appropriate actions to take.	RWJUHH (3.f.)	

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.2: Increase mental health education and skills building for health professionals by 2027					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
1.2.3 Explore providing and/or expanding continuing education units (CEUs) for training	RWJUHH	# of classes, workshops, events, campaigns, or trainings provided. # of people (residents and providers/organizational stakeholders) reached through classes, workshops, events, campaigns, or trainings. # of community groups, organizations, or agencies	RWJUHH hosted a 2 day workshop on trauma-informed-care with CEUs; Day 1: 5 PDAs NCCAOM & 5 ASWB Ces; Day 2: 6 PDAs NCCAOM. Additional workshops are being planned.	RWJUHH (3.f.)	
1.2.4 Provide and promote mental health training, including mental health first aid and harm reduction strategies, for community service providers.	TCNJ RWJUHH MCMHAS	# of classes, workshops, events, campaigns, or trainings provided. # of people (residents and providers/organizational stakeholders) reached through classes, workshops, events, campaigns, or trainings. # of community groups, organizations, or agencies	RWJUHH will provide training for community youth service providers and community faith-based leaders on skills to recognize BH(MH&SUD) issues and awareness of services to refer resources appropriately.	RWJUHH (3.g. + 3.h.)	

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.2: Increase mental health education and skills building for health professionals by 2027					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
1.2.5 Advocate with community colleges and universities (especially with health programs) for the importance of mental health training, including mental health first aid and ACEs training.	CJFHC JFCS MCMHAS RWJUHH	Increase in # reached annually through classes, workshops, events, campaigns.	Track the number of people reached through classes, workshops, events, campaigns or trainings related MH/BH, using data through NJ postpartum resource and support network (NJPRSN) program. Work to formalize connections with local colleges that offer relevant training/education/programs/internships/ and alumni with job postings in Mercer County.	CJFHC	

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.3: Increase community knowledge of mental health stigma, prevention, and harm reduction by 2027					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
1.3.1 Identify and promote existing programs and resources, particularly for high-risk populations	GMPHP Mercer County MBH workgroup Health Departments MCADA MCMHAS RWJUHH	Attendance and organization representation at Resilience Series screening & panel discussion.	Workgroup will promote "Resilient Mercer" and continue efforts to expand the program to continue to enhance diversity and representation. Explore programs related to substance use harm reduction, LGBTQ+ support.	MBH Workgroup	
		# of classes, workshops, events, campaigns, or trainings provided. # of people (residents and providers/organizational stakeholders) reached through classes, workshops, events, campaigns, or trainings. # of community groups, organizations, or agencies	Identify and promote existing and new MH/BH programs/resources particularly for populations identified in the CHNA. Identify and partner with trusted community-based organizations that work with underserved (priority) populations to share information in culturally and linguistically appropriate ways.	RWJUHH (3.b. & 3.l.)	

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.3: Increase community knowledge of mental health stigma, prevention, and harm reduction by 2027					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
1.3.2 Partner with organizations to provide free training and resources.	GMPHP MCADA CJFHC Dept. of Veteran Affairs Health Departments MCMHAS RWJUHH	# trainings, resources distributed & distribution efforts. VA: # of gun locks distributed.	Explore incorporating stigma education/prevention into municipal camp programs for youth and adults. GMPHP will promote to partners and community.	GMPHP MCADA	
		# of support groups & # of attendees # of calls for 1:1 support	Track programs and resources through NJ Postpartum Resource and Support Network tracking system. The NJPRSN program provides education, training, and resources on perinatal mental health through outreach programs to providers and community members.	CJFHC	
		# of trainings and tabling events. At least 200 gun locks distributed in Mercer County	VA will conduct suicide prevention trainings and tabling events: Operation SAVE, WHOLE HEALTH, and other trainings related to specific veteran populations (i.e. LGBTQ+, Women, etc.). Suicide Prevention Dept. will provide at least 200 gun locks to Mercer County and other prevention resources and educational materials.	Dept. of Veteran Affairs	*186 gun locks distributed in 2023, 105 in 2024.*
		# trainings, resources distributed	Conduct various mental health trainings for vulnerable populations throughout the County. Distribute Deterra bags to senior centers.	MCMHAS	*Conducted 4 Mental Health First Aid trainings, 3 QPR trainings in 2023.* *2 QPR trainings, 2 LGBTQ Mental Health trainings in 2024.*

MENTAL & BEHAVIORAL HEALTH/ACEs CHIP					
Goal 1: Mercer County nourishes the mental health and wellness of all, promoting a healthier community					
Objective 1.3: Increase community knowledge of mental health stigma, prevention, and harm reduction by 2027					
STRATEGY	**PARNTER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
		# of classes, workshops, events, campaigns, or trainings provided. # of people (residents and providers/organizational stakeholders) reached through classes, workshops, events, campaigns, or trainings. # of community groups, organizations, or agencies	Offer Mental Health First Aid training and programs for youth, teens, adults and other high-risk populations.	RWJUHH (3.c.)	
1.3.3 Increase awareness and utilization of substance use prevention, treatment and recovery services, and harm reduction in connection to mental health.	Trenton Health Team (THT) PCMC RWJUHH	Launch of updated live map tool.	Update Harm Reduction, Substance Use and Mental Health Resources in Mercer County map and make public.	THT	
		Promotion of drop-box locations Distribution of Deterra bags.	PCMC Prescription drugs and opioids action team will promote project medicine drop-box locations and work to get Deterra bags distributed to area Senior Centers.	PCMC GMPHP	
		# of classes, workshops, events, campaigns, or trainings provided. # of people (residents and providers/organizational stakeholders) reached through classes, workshops, events, campaigns, or trainings. # of community groups, organizations, or agencies	Launch Awareness Campaign to share information on MH/BH in public places to raise awareness, address stigmas/population bias/cultural sensitivities, including access to assessments and resources. Partner with the Institute for Prevention and Recovery to expand awareness of existing support services for populations identified in the CHNA to provide opportunities for equitable outcomes for all.	RWJUHH (3.d. & 3.k.)	

Priority 2: Access to Wellness

ACCESS TO WELLNESS CHIP 2025-2027
Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.
Objective 2.1: Increase referrals and enrollment to assistance programs to support the cost of clinical healthcare services by 2027.
Objective 2.2: Improve access to nutritious food and nutrition education to align with individual, cultural, and financial needs by 2027.
Objective 2.3: Increase convenient, affordable and accessible transportation options to key wellness destinations in Mercer County by 2027.
Objective 2.4: Increase the number of linguistically and culturally competent resources and personnel along the healthcare continuum by 2027.
Objective 2.5: Reduce the impact of chronic disease for minority groups most at risk by 2027.

ACCESS TO WELLNESS CHIP 2025-2027					
Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.					
Objective 2.1: Increase referrals and enrollment to assistance programs to support the cost of clinical healthcare services by 2027.					
CHNA Indicators = 1) 5.7% overall, 30.3% of Latino respondents had no health insurance (CHNA p. 99)					
2) 22.4% of survey respondents identified insurance problems, and 20.5% indicated cost of care as barriers to getting medical care.					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
2.1.1 Utilize Social Determinants of Health (SDoH) screening tools at points of care to identify needs and connect patients to assistance programs.	Horizon BCBS Access to Wellness (ATW) Workgroup Capital Health RWJUHH	10% increase in # of SDOH screenings conducted annually among coalition partners.	Workgroup will identify and map existing SDoH screening efforts among partner organizations. Discuss current screening methods and referral processes across workgroup partners.	Horizon BCBS Access to Wellness (ATW) Workgroup.	
		# of classes, workshops, events, campaigns # of people tested/screened in community for chronic disease-related conditions and referred to services based on screening	Continue to capture SDOH information and analyze the EPIC data to determine the implications of chronic disease as it relates to SDOH positive screenings.	RWJUHH (2.i.)	
		Screening Utilization Rate: (# of patients screened for 5 HRSN/ Total number of patients seen minus exclusions) x 100, *goal = 100% of patients screened for 5 HRSN during inpatient stays and RD encounters.*	Go live with Renal Dialysis and Inpatient psychiatry screening by the end of 2025.	Capital Health	

ACCESS TO WELLNESS CHIP 2025-2027					
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STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
2.1.2 Expand outreach at community events with a focus on underserved areas, to increase awareness and enrollment in insurance and cost assistance programs.	GMPHP Aetna Better Health NJ Horizon NJ Health Rise United Way of Greater Mercer County RWJUHH	# of enrollment events # assisted with applying for healthcare	Conduct outreach events to enroll participants.	Rise	*630 families referred or assisted with applying for healthcare services in 2024.*
		# enrollment events # enrolled at events	Hold outreach and enrollment events	Aetna Better Health	
		# enrollment events # enrolled at events	Hold outreach and enrollment events	Horizon NJ Health	
		# of enrollment events # enrolled in each cost assistance program	Bilingual Resource Specialists will be available at Catholic Charities, TASK, MCCC, Princeton Library, Center for Modern Aging Princeton, Princeton Human Services, and Mercer County Hispanic Association to connect families to benefits.	United Way of Greater Mercer County	
		# of classes, workshops, events, campaigns # of people reached through classes, workshops, events, campaigns # of people tested/screened in community for chronic disease-related conditions and referred to services based on screening	Continue to conduct and expand screenings at Senior Centers and in multiple other community locations: farmers markets, town fairs, Fitness & Wellness Center, and beyond. Identify and include assistance program representatives at appropriate community events to educate and enroll qualified individuals.	RWJUHH (2.j. & 2.m.)	
2.1.3 Increase organizational knowledge of NJ Family Care and other cost-saving benefit programs across coalition partners.	Horizon NJ Health	# of professional development workshops # of attendees at workshops	Work with partners to provide Medicaid professional development workshops and enrollment trainings.	Horizon NJ Health	

ACCESS TO WELLNESS CHIP 2025-2027					
Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.					
Objective 2.2: Improve access to nutritious food and nutrition education to meet and align with individual, cultural, and financial needs by 2027.					
CHNA Indicators = 1) Food insecure population in Mercer County increased from 7.4% to 9.7% from 2020-2022.					
2) 29.3% of survey respondents reported that it was sometimes or often true that they worried their food would run out before they had money to buy more. 51.6% of Black and 63.1% of Latino residents.					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
2.2.1 Leverage the Mercer County Food Stakeholders group to promote existing food, nutrition, and assistance resources and increase knowledge around free food resources in Mercer County.	Trenton Health Team Mercer County Food Stakeholders Group (MCFS) JFCS GMPHP Capital Health RWJUHH	**THT:** Increase in app utilization via app analytics. **RCE:** Increase food utilization, measured through qualitative feedback from pantries.	Promote the Mercer County Free Food Finder. They will create a dedicated communications plan to promote and share the food finder with target populations across Mercer County.	Trenton Health Team (THT) Mercer County Food Stakeholders (MCFS) Rutgers CoOp. SNAP Ed. (RCE)	*4,170 users in 2024, averaging ~350 a month.*
		# reached at events	Present on the Free Food Finder and Mercer County Food Stakeholders group at GMPHP and Mercer County Health Services Action Committee (HSAC) meetings.	Mercer County Food Stakeholders (MCFS)	
		# attendees & # of organizations represented at CAB meeting.	Have food insecurity panel at spring CAB meeting with organizations promoting their work, including MCFS group. Will add Mercer County Free Food Finder information to website and provide information to partners.	GMPHP	
		# partner activities	Incorporate more in pantry service and trying to address with partnerships, such as with Rutgers SNAP Ed reps, to disseminate information about eligibility to our clients. Will utilize ATW workgroup to promote information.	JFCS	
			Spotlight Arm in Arm mobile food pantry and Share My Meals programs at various CAB meetings.	Capital Health	

ACCESS TO WELLNESS CHIP 2025-2027					
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STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
2.2.2 Expand food resources targeting areas and populations in need, to reduce racial & ethnic disparities in food insecurity.	Rise Meals on Wheels JFCS Mercer County Office of Food Security Capital Health RWJUHH	# of deliveries Increased serving #s with extended pantry hours.	Secure a larger, accessible location for the food pantry within the next three years. Extend pantry hours to accommodate a broader range of community schedules. Introduce delivery services for individuals unable to visit the pantry, particularly for the elderly, homeless, and those with mobility challenges. Make the new pantry fully handicap accessible to meet the needs of individuals with disabilities. Enhance inventory and client tracking through implementation of an efficient inventory management system to monitor stock levels and prevent waste. They will develop a system to track the number of clients served, improving service efficiency and resource allocation.	Rise	*845 registered families, 194,244 food boxes in 2024.*
		# of meals provided & participant demographics (age, township, ethnicity).	Expand meal deliveries to those who experience challenges in accessing nutritious food.	Meals on Wheels	*Delivered to 300 shut-in people weekly in 2023.*
		Increased serving #s # of outreaches events.	Expand the mobile food pantry and number of outreaches over the next three years to areas without food resources to create awareness of services.	JFCS	*19,032 bags of groceries, 4,795 meals through Kosher Café, delivered 7,696 meals to homebound seniors in 2024.*

ACCESS TO WELLNESS CHIP 2025-2027					
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Objective 2.2: Improve access to nutritious food and nutrition education to meet and align with individual, cultural, and financial needs by 2027.					
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STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
		Funds awarded & actions of funding.	Leveraging ARPA funds for 3 NOFOs - 1. Fresh perishable food items, 2. Innovative pilots to expand or launch new endeavors in tackling food insecurity, and 3. Funding to support a Food Hub in Trenton's West Ward that will serve as both a choice pantry but also offer a cadre of wrap around social services. Funds could also be used to address needs identified in 2.2.4.	MC Office of Food Security	
		Serve at least 15,260 meals with TASK and Arm in Arm	Continue the current food distribution locations at 433 and CHET 4x a month.	Capital Health	
		# of classes, workshops, events, campaigns # of people reached through classes, workshops, events, or campaigns # of people tested/screened in community for chronic disease-related conditions and referred to services based on screening	RWJUHH will sustain and expand 'Farm to Family' programming and community gardens; Sustain 'Mobile Meals of Hamilton' services; Launched 'Share My Meals'; Hosting food drives; Making referrals to SNAP Coordinator and continue to promote local food assistance resources for those identified as food insecure.	RWJUHH (1.c.-e. & 1.h.)	
2.2.3 Strengthen partnerships with schools to enhance nutritious food access for children.			Reassess who has capacity for this in 2026.		

ACCESS TO WELLNESS CHIP 2025-2027					
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2) 29.3% of survey respondents reported that it was sometimes or often true that they worried their food would run out before they had money to buy more. 51.6% of Black and 63.1% of Latino residents.					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
2.2.4 Expand the type and amount of culturally and dietarily appropriate food offerings among free food providers.	Mercer Street Friends (MSF) MCFS Rise RWJUHH	Survey results analyzed and action taken to address clients' cultural food needs.	Conduct culturally-appropriate food survey for food pantries to distribute to their clients, to assess foods offered to member agencies. They will ensure a steady stock of food items to avoid shortages and meet client demand consistently.	MSF MCFS	*Survey & focus group results - available mid 2025.*
		Enhanced offerings through client-choice style pantry.	Expansion of food pantry which will enable families to select food items based on their preferences and needs through a shopping-style experience.	Rise	
		RD assessments of culturally and nutritionally appropriate food.	Support 'Mercer Street Friends' and other agencies to expand the type and amount of culturally appropriate foods offered to member agencies.	RWJUHH (1.j.)	
2.2.5 Provide nutrition education in community, focusing on reaching marginalized populations.	Rise RCE Snap-ED RWJUHH Capital Health	# of cooking classes # of participants	Offer cooking classes and workshops to teach clients how to prepare meals with pantry items. They will develop and share a community recipe collection to help families use pantry items more effectively and creatively.	Rise	
		Collaborators report on # of nutrition classes and # of participants served.	Co-lead Nutrition & Cooking Education Workgroup with MSF to expand nutrition education to marginalized populations. Rutgers Cooperative Extension (RCE) - SNAP Ed will promote SNAP-Ed resources at food pantries. They will conduct food tastings at the pantries and provide recipes for commonly supplied foods to help clients utilize the foods they are provided.	RCE SNAP-Ed	

ACCESS TO WELLNESS CHIP 2025-2027					
Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.					
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2) 29.3% of survey respondents reported that it was sometimes or often true that they worried their food would run out before they had money to buy more. 51.6% of Black and 63.1% of Latino residents.					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
		# of classes, workshops, events, campaigns # of people reached through classes, workshops, events, or campaigns	RWJUHH will provide programming on nutrition education and health lifestyle habits in conjunction with its relationship to dual-diagnosis education needs.	RWJUHH (2.d.)	
		Finalized and approved job description completed. Establish a project charter for development of a nutrition guide.	1. Develop, finalize and secure approval for a comprehensive job description for a postgraduate volunteer position to support the CH Clinics' patient education initiatives by August 21, 2025. 2) Create a project charter that outlines the objectives, scope, roles, and timeline for developing nutrition guides focused on diabetes and hypertension by December 21, 2025.	Capital Health	

ACCESS TO WELLNESS CHIP 2025-2027					
Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.					
Objective 2.3: Increase convenient, affordable and accessible transportation options to key wellness destinations in Mercer County by 2027.					
CHNA Indicators = 1) 24.4% of survey respondents agree or strongly agree with the statement "it would be easy for me to take public transportation to where I need to go day to day" (CHNA p. 44)					
2) 25.4% of owner-occupied households and 3.5% of renter-occupied households did not have access to a personal vehicle (CHNA p. 44)					
3) 9.6% of respondents noted transportation problems as a barrier to accessing health care					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
2.3.1 Engage transportation organizations to address transportation gaps and barriers in accessing key destinations.	GMTMA Mercer County Coalition for Coordinated Transportation (MCCCT)	MCCCT meetings	MCCCT members meet and discuss community needs and goals. Advocate for the extension of NJ transit service to underserved areas.	GMTMA MCCCT	
2.3.2 Enhance communication efforts to encourage knowledge of and use of public transportation to essential services.	GMTMA MCCCT	# education sessions # of participants	Publish annual Mercer County Mobility Guide, with information on how to access and utilize all public transportation options in Mercer County. Conduct transportation trainings	GMTMA	
		# of community outreach and education events	Conduct outreach with Community and Local Officials. Increase Hospital/Health Providers participation in Coordination. Educate case manager and mobility managers.	MCCCT	
2.3.3 Identify, advocate for, and promote awareness of transportation subsidies, and non-public transportation programs to increase participation for populations of greatest need.	GMTMA MCCCT	Increased enrollment in transportation subsidies	Promotion of Mobility Guide & Community Transportation Options Guide that include information on reduced fare programs. Promotion of programs such as GoTrenton and Mercer Moves among workgroup partners.	GMTMA/MCCCT	

ACCESS TO WELLNESS CHIP 2025-2027					
Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.					
Objective 2.4: Increase the number of linguistically and culturally competent resources and personnel along the healthcare continuum by 2027.					
CHNA Indicators = 1) 38% of Black, 40.3% of Latino, and 32.4% of LGBTQ+ respondents reported experiencing discrimination when receiving medical care compared to 16.9% of survey respondents overall (CHNA p. 48)					
2) 24.4% of Latino respondents identified language problems as a barrier to accessing medical care (CHNA p. 104)					
3) 38.1% of Latino respondents reported feeling discriminated against due to their language/speech (CHNA p. 48)					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
2.4.1 Identify resources currently available and gaps in meeting patients' cultural and language needs.			Reassess who has capacity for this in 2026. Consider convening a taskforce within the workgroup to accomplish this.		
2.4.2 Conduct and promote cultural competency trainings for healthcare and Community Based Organization (CBO) staff.	GMPHP Rutgers FCHS Capital Health	# of participants # of organizations represented at training	Organize at least 1 cultural competency training for community partners. Consider training topic on the use of technology for translation.	GMPHP Rutgers FCHS	
		Pending	Identify training structure and resources for education in collaboration with HR.	Capital Health	
2.4.3 Promote effective recruitment and retention strategies and best practices for expanding the cultural and linguistic diversity of healthcare staff.	Capital Health	Pending	Reorganization in HR for 2025 will allow for discussion around this initiative.	Capital Health	
2.4.4 Explore ways to use technology to aid in translation	Capital Health	Pending	Seek approval for project funding, get IT approvals, and submit Pos for the Pockettalk.	Capital Health	

ACCESS TO WELLNESS CHIP 2025-2027					
Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.					
Objective 2.5: Reduce the impact of chronic disease for minority groups most at risk by 2027.					
CHNA Indicators = Cancer baseline = 130.4/100k residents overall, 164.1/100k Black residents.					
Cardiovascular disease baseline = 77.4/10k (higher than state), Black residents hospitalized 2x county rate, 144.1/10k inpatient hospitalizations.					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
2.5.1 Deliver education for chronic disease prevention and management across the lifespan.	HM Chronic Disease Coalition Crossroads4hope Lead Free NJ YWCA Horizon BCBS Health Departments RWJUHH	# of programs # of attendees	Deliver education on ways to prevent chronic disease including healthy eating guidelines at community events, workshops, training sessions.	Mercer County Health Departments	
		# classes, events # reached at events	Hold health education workshops and events.	Hunterdon-Mercer Chronic Disease Coalition	
		# of classes, workshops, events, campaigns # of people reached through classes, workshops, events, or campaigns	Work with partners to deliver education for chronic disease prevention and management across the lifespan, including healthy eating guidelines/options (cancer, cardiovascular disease).	RWJUHH (2.n.)	*RWJ Better Health Program offered 1,213 educational programs to 16,958 people in 2024.*
2.5.2 Deliver screenings for cancer and cardiovascular disease for key at-risk populations.	Trenton Health Team Hunterdon-Mercer Chronic Disease Coalition Health Departments RWJUHH	# of screening events # screened	Provide cancer screenings including breast, cervical, colorectal and prostate, in partnership with NJCEED program.	HM Chronic Disease Coalition	
		# of screening events # screened	Provide health screenings at key community locations to check blood pressure, BMI diabetes risk, and provide referrals for cancer screenings.	Trenton Health Team	
		# of classes, workshops, events, campaigns # of people reached through classes, workshops, events, or campaigns	Expand and promote opportunities for key populations to obtain screenings for cancer and cardiovascular disease (via widespread promotion, mobile clinics).	RWJUHH (2.h.)	
2.5.3 Promote utilization of healthcare navigators for chronic disease follow up and management	Rise Capital Health RWJUHH	Increase in # of referrals annually	Introduction of new software in January 2025 to track healthcare appointments and referrals, ensuring individuals are connected with necessary services. Create communication initiatives that promote evidence-based interventions, local resources and health behaviors.	Rise	

ACCESS TO WELLNESS CHIP 2025-2027					
Goal 2: All in Mercer County have equitable access to physical, social, and economic resources to achieve their own optimal health and wellness.					
Objective 2.5: Reduce the impact of chronic disease for minority groups most at risk by 2027.					
CHNA Indicators = Cancer baseline = 130.4/100k residents overall, 164.1/100k Black residents.					
Cardiovascular disease baseline = 77.4/10k (higher than state), Black residents hospitalized 2x county rate, 144.1/10k inpatient hospitalizations.					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION 2025**	**RESPONSIBLE PARTY**	***BASELINE***
		60% of inpatients diagnosed with acute heart failure will have an outpatient appointment scheduled within 7 days of discharge.	Starting in March 2025, an Advanced Practice Nurse (APN) will identify discharged acute heart failure (AHF) patients and notify the appropriate office to coordinate and schedule an outpatient appointment within 7 days of discharge.	Capital Health	
		# of classes, workshops, events, campaigns # of people reached through classes, workshops, events, or campaigns	RWJUHH will promote and deliver self-management skill programs, such as Stanford Chronic Disease Program.	RWJUHH 2.c.	
2.5.4 Strengthen collaborations between organizations that provide chronic disease services and supports.	GMPHP Access to Wellness Workgroup HM Chronic Disease Coalition Rutgers CoOp Ext. FHCS	10% increase in ATW group members. Collaboration activities between workgroup members	GMPHP will work to increase workgroup membership and representation. Will allocate meeting time to network and share updates.	GMPHP Access to Wellness Workgroup	*19 attended 10/8/24 planning meeting from 12 organizations, 11 attended 2/4/5 mtg. from 11 organizations. 58 on email list serv. in Jan 2025.*
		4 wellness articles in 2025.	Write Wellness article for GMPHP quarterly newsletter to update partners on current wellness activities at Rutgers Cooperative Extension.	Rutgers CoOp Ext. FHCS	

Priority 3: Housing & Built Environment

HOUSING AND BUILT ENVIRONMENT CHIP 2025-2027
Goal 3: Everyone in Mercer County has a place to feel safe and call home in a thriving community
Objective 3.1: Develop infrastructure to collect and share data on home affordability and insights across agencies to more effectively demonstrate need, reality, and demand by 2027.
Objective 3.2: Connect partners to coordinate data collection and testing to improve unsafe housing conditions by 2027.
Objective 3.3: Increase the number of Vision Zero activities implemented by Mercer County municipalities by 10% by 2027.
Objective 3.4: Increase the number of open spaces available for outdoor activity in communities in need by 2027.
Objective 3.5: Increase awareness of the resources that exist to obtain and maintain stable housing by 2027.

HOUSING AND BUILT ENVIRONMENT CHIP 2025-2027					
Goal 3: Everyone in Mercer County has a place to feel safe and call home in a thriving community					
Objective 3.1: Develop infrastructure to collect and share data on home affordability and insights across agencies to more effectively demonstrate need, reality, and demand by 2027.					
CHNA Indicator = 1) 34.5% of survey respondents agreed that there was sufficient affordable and safe housing in their community, 23.4% Black and 26.1% Latino respondents (CHNA p. 35)					
2) 24.8% of survey respondents identified 'housing people can afford' as top health concern (CHNA p. vi)					
STRATEGY	**PARTNER(S)**	**INDICATOR**	**ACTION 2025**	**RESPONSIBLE PARTY**	**BASELINE**
3.1.1 Collect and share data on home affordability and insights across agencies to more effectively demonstrate need, reality, and demand.	Trenton/Mercer Continuum of Care (CoC) Housing & Built Environment (HBE) Workgroup	Quarterly housing report including # of new affordable units and number of rent burdened families	CoC quarterly meetings with coalition and workgroup members. Allocate time in HBE workgroup meetings to update and discuss.	Trenton/Mercer Continuum of Care (CoC) Housing & Built Environment (HBE) Workgroup	
3.1.2 Identify housing stakeholders, prioritize county-wide housing needs, and coordinate services among stakeholders at both the county and municipal level.	HBE Workgroup GMPHP	# of taskforce meetings # of participating organizations	Determine which agency should administart a Housing Affordability taskforce, convene the taskforce and set meeting schedule and priorities.	HBE workgroup GMPHP	
3.1.3 Support outreach and education campaigns to educate the public and policy makers about the need for and importance of affordable housing options.	HBE workgroup housing affordability taskforce	Number of advocacy efforts for home affordability, number of policy recommendations submitted	HBE Workgroup to assess outreach and education campaigns. Consider including a variety of recommendations for addressing housing affordability (e.g., policy change, support programs, implementation of local models based on the State ANCHOR Benefit, development/land bank,)	Housing Affordability Taskforce	

HOUSING AND BUILT ENVIRONMENT CHIP 2025-2027					
Goal 3: Everyone in Mercer County has a place to feel safe and call home in a thriving community					
Objective 3.2: Connect partners to coordinate data collection and testing to improve unsafe housing conditions by 2027.					
CHNA Indicator = 1) 55.8% of houses built prior to 1979 in Mercer County (CHNA p. 90)					
2) % of children aged 1-5 with elevated blood lead levels was higher in Mercer County (3.4%) than in NJ overall (1.9%) (CHNA p. 90)					
STRATEGY	**PARTNER(S)**	**INDICATOR**	**ACTION 2025**	**RESPONSIBLE PARTY**	**BASELINE**
3.2.1 Promote education on available programs, including financial assistance for inspections, remediation & clean up, treatment proper disposal of contaminants and water pollution.	Isles Lead-Free NJ (LFNJ) Trenton Health Team (THT) East Trenton Collaborative (ETC) Green & Healthy Homes Initiative (GHHI)	Increase in # of education events and # referred to programs annually.	Promotion of existing education programs through workgroup members and outreach efforts. GMPHP will post information on their website and share with partners.	Isles Lead-Free NJ (LFNJ) Trenton Health Team (THT) East Trenton Collaborative (ETC) GHHI	
3.2.2 Expand education about Healthy Homes programs and practices to home-visitors and partner organizations.	Isles GHHI THT Capital Health Isles	# of trainings for CHWs and other home visitors.	Identify and promote best practices to engender trust in the community for people to let someone into their home. THT will be launching a pilot program for home visits conducted by CHWs who are going to be making referrals for healthy homes.	Isles GHHI THT	
		# of resident education and home assessment visits, focused on asthma mitigation (goal =35)	GHHI will provide asthma self-management education and environmental health services assessments to Trenton families that have high asthma hospitalizations.	GHHI	
		# of healthy home assessments (*goal =50*)	Partner with Isles to support healthy home assessments.	Capital Health Isles	
3.2.3 Advocate for state agency budgets to include requests for funding for testing, inspection, remediation, and treatment.	Isles LFNJ THT ETC GHHI	Number of advocacy efforts LFNJ	Lead-Free NJ will create and circulate Budget prep questions that can be used to support budget testimony. They also will develop information for Gubernatorial race to ensure that lead poisoning, education, testing and funding remain a top priority. LFNJ is also spearheading a campaign for sustaining funding of LRAP past the expiration of ARPA dollars.	Isles LFNJ THT ETC GHHI	

HOUSING AND BUILT ENVIRONMENT CHIP 2025-2027					
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STRATEGY	**PARTNER(S)**	**INDICATOR**	**ACTION 2025**	**RESPONSIBLE PARTY**	**BASELINE**
3.2.4 Support testing and inspection services: health, housing, code.	Isles LFNJ THT ETC GHHI GMPHP	Number of tests Number of inspections	Advocate for increased inspections of homes in areas with vulnerable populations. Increase water testing. Advocate for compliance with lead testing regulations, including in rental dwellings. Subsidize lead paint inspectors in non-rental dwellings. Target lead inspections to likely lead-impacted homes using public health and property data, focusing outreach to communities, municipalities, and healthcare providers. GMPHP connects healthcare providers and Lead-Free NJ Trenton Hub to coordinate data collection and lead testing. Support capacity building among municipalities in GMC to achieve operating rental inspection programs throughout the area.	Isles LFNJ THT ETC GHHI GMPHP	*Lead found in inspected properties=2372 (96.19%) positive, 94 (3.81%) negative. Certificate issues to properties w/ lead = 90 (95.74%) No, 4 (4.26%) Yes. Presence of children in properties w/ lead = 93 (98.94%) data not collected, 1 (1.06%) yes.* Lead Paint Inspection Law Dashboard
3.2.5 Promote remediation and treatment.	Isles LFNJ THT ETC GHHI	Increase in number of remediations and water line replacements annually.	Remove contaminated soils from properties. Subsidize treatment. Increase lead-based home remediation. Test and fund remediation for safe drinking water-potable wells. Advocate for leaded water line replacement. Explore opportunities in the new Medicaid 1115 Waiver CHW Pilot, and use HBE table to build referral/collaboration networks.	Isles LFNJ THT ETC GHHI	Isles - 68 lead remediations in 2023

HOUSING AND BUILT ENVIRONMENT CHIP 2025-2027					
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STRATEGY	**PARTNER(S)**	**INDICATOR**	**ACTION 2025**	**RESPONSIBLE PARTY**	**BASELINE**
3.2.6 Advocate for resources and support materials to be available in multiple languages	Isles LFNJ THT ETC GHHI	Increase in number of materials in multiple languages and number of languages represented.	Workgroup will assess current needs of material and resources needing to be translated and into what languages. Will collaborate and work with other organizations to have necessary materials translated. Confirm requirements on state agencies to make materials available in multiple languages and make coordinated requests.	Isles LFNJ THT ETC GHHI	

HOUSING AND BUILT ENVIRONMENT CHIP 2025-2027					
Goal 3: Everyone in Mercer County has a place to feel safe and call home in a thriving community					
Objective 3.3: Increase the number of Vision Zero activities implemented by Mercer County municipalities by 20% by 2027.					
STRATEGY	**PARTNER(S)**	**INDICATOR**	**ACTION 2025**	**RESPONSIBLE PARTY**	**BASELINE**
3.3.1 Educate municipal officials on how to implement Vision Zero activities as part of the "Health in All Policies" framework.	GMTMA Mercer County Planning	Number of safety campaigns implemented and conducted	Provide education to municipal officials. Ensure that local health organizations are connected to conversations about transportation and Vision Zero. Completion of a Mercer County Vision Zero Safety Action Plan. Measure number of safety trainings completed including Street Smart, PRSA, school travel plans, etc.)	GMTMA Mercer County Planning	
3.3.2 Identify which municipalities in the County have adopted a Vision Zero resolution, and identify activities that can be implemented by municipalities.	GMTMA Mercer County Planning	Adoption of Municipal & County Vision Zero Resolutions. Number of safety campaigns GMTMA survey Number of Complete Streets/safety projects implemented or in progress. Number of municipalities receiving grants to work on safety/Vision Zero related projects.	Establish a steering committee for Vision Zero Safety Action Plan. Record which municipalities have adopted resolutions. Share among HBE workgroup municipalities that have adopted Vision Zero resolution and collaborate to connect with others. Survey will be sent related to Vision Zero to get community feedback. GMPHP will send survey to all partners.	GMTMA Mercer County Planning	*4 municipalities with Vision Zero initiatives (Princeton, Lawrence, Pennington, and Hopewell Borough)*
3.3.3 Share info on Vision Zero and the resulting changes and successes.	GMTMA GMPHP Mercer County Planning	All municipalities participating in Vision Zero by 2027.		GMTMA GMPHP Mercer County Planning	

HOUSING AND BUILT ENVIRONMENT CHIP 2025-2027					
Goal 3: Everyone in Mercer County has a place to feel safe and call home in a thriving community					
Objective 3.4: Increase the number of open spaces available for outdoor activity in communities in need by 2027					
CHNA Indicator = 78.7 % of survey respondents agreed or completely agreed with the statement "My community has safe outdoor places to walk and play", 55.5% for Black and 65.9% for Latino respondents (CHNA p. 40)					
STRATEGY	**PARTNER(S)**	**INDICATOR**	**ACTION 2025**	**RESPONSIBLE PARTY**	**BASELINE**
3.4.1 Conduct an inventory of open spaces, recreational locations, and municipal and county-owned land.	Mercer County	County inventory results	County will be conducting an assessment of all open spaces that fall under county domain.	Mercer County	
3.4.2 Develop recommendations to improve existing and create additional open spaces focused on communities in need.	HBE Workgroup GMPHP Municipalities community gardens	Improved outdoor spaces # community gardens # open spaces project implemented	Workgroup will assess needs in marginalized communities and brainstorm ideas to engage partners in discussions around improving spaces. Create list of existing community gardens and engage municipalities to create community gardens with plots available to residents. Improve conditions of existing greenways (i.e. D&R Canal).	HBE Workgroup GMPHP Municipalities community gardens	
3.4.3 Support projects that create safe routes to walk/bike to public spaces.	GMTMA	Number of safe routes reports completed	GMTMA conducts safe routes reports for any community that request them. Workgroup will promote the availability of this service.	GMTMA	
3.4.4 Advocate for municipalities to plant more trees in urban areas and explore ways to utilize open spaces to mitigate climate change.	Lawrence Township Shade Tree Advisory Committee (LT STAC) Mercer County Shade Tree Commission Municipalities shade tree commissions	Number of trees planted per municipality. County shade tree convenings.	**LT STAC** will work to get more trees planted. They aim to ID and replant one large parking lot per town. Work with County Executive to convene a county-wide meeting of Shade Tree appointees and municipal officials to coordinate the identification and replanting of tree islands on large parking lots.	Lawrence Township Shade Tree Advisory Committee (LT STAC) Mercer County Shade Tree Commission Municipalities shade tree commissions	

HOUSING AND BUILT ENVIRONMENT CHIP 2025-2027					
Goal 3: Everyone in Mercer County has a place to feel safe and call home in a thriving community					
Objective 3.5: Increase awareness of the resources that exist to obtain and maintain stable housing by 2027					
CHNA Indicator = 16.6% of respondents were concerned about their housing stability in the next two months, 38.6% for Latino and 31.9% for Black respondents (CHNA p. 36)					
STRATEGY	**PARTNER(S)**	**INDICATOR**	**ACTION 2025**	**RESPONSIBLE PARTY**	**BASELINE**
3.5.1 Develop and conduct in-person programs and events in areas with underserved populations that focus on basic housing information and financial literacy.	Trenton Health Team United Way of Greater Mercer County Capital Health Isles	# of education events # participants at events.	Recruit local ambassadors to share stories and successes of people in the community. Use local ambassadors to demonstrate real examples of housing issues and their solutions.	THT	
		# of workshops, education sessions # of participants receiving home buying education certificate	Hold first time homebuyers workshops educating on the key elements of buying a home. Offer one-on-one counseling on homeownership.	Isles	*83 earned housing certificates in 2023* *26 purchased a first home in 2023* *65 received individual pre-purchase counseling in 2023*
		# of financial coaching sessions # of participants	Conduct financial coaching - 8-week financial coaching program designed to help individuals get financial life organized and create financial goals.	United Way of Greater Mercer County	
		# of families that completed the financial literacy training program through TNI (*goal = 20)* # of families who received downpayment assistance (*goal =10*)	Improve financial literacy and increase homeownership for Trenton residents through continuing to enroll families into the TNI financial literacy program.	Capital Health	*127 families have received homeownership /financial counseling to date*
3.5.2 Connect with schools to promote and implement community education sessions to bridge gaps in knowledge for households and families.	Boys and Girls Club LALDEF Mercer County Hispanic Association Mercer Street Friends Isles? MC extension service?	# of workshops, education sessions, events, # participants reached through education events	Housing counseling program at Isles. Conduct community education events on topics including resources for stable housing, how to do taxes, home economics, financial literacy, home maintenance, eviction policies, awareness of 211.	Boys and Girls Club LALDEF Mercer County Hispanic Association Mercer Street Friends	

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STRATEGY	**PARTNER(S)**	**INDICATOR**	**ACTION 2025**	**RESPONSIBLE PARTY**	**BASELINE**
3.5.3 Assess existing resource guides and explore creating a comprehensive database of county-wide resources for housing stability.	Mercer County Office of Aging		Promote existing housing resource guides - Housing & community development network guide, Affordable housing directory, Office of Aging resources for seniors. Reassess at a later workgroup meeting what the further need is and who has capacity to assess further resources and develop taskforce to create guide.	Mercer County Office of Aging	
3.5.4 Advocate for state agency budgets to include requests for funding needs for housing stability.	Isles Trenton/Mercer CoC			Isles	
3.5.5 Promote resources to assist individuals in securing economically viable employment.	MC Economic Development HBE Workgroup GMTMA Isles Capital Health	# of programs # of students # job fairs	GMTMA promotes transportation to employment information at job fairs, case worker trainings. Explore skills-based trainings for individuals who are looking for new lines or fork and vocational technical pathways to middle school and high school students. Explore partnership with Mercer County Community College programs. Share information on job trainings/job fairs within workgroup partners.	MC Economic Development HBE Workgroup GMTMA	
		# individuals who received coaching	Employment coaching to support participants in securing or advancing jobs or careers.	Isles	
		# of scholarships awarded at MCCC (*goal = 20*) # of EMT intern graduates (*goal = 20*)	Through the TNI program, continue to provide scholarships and support for the EMT academy.	Capital Health	

Priority 4: Maternal & Infant Health

Priority 4: Maternal & Infant Health
Goal 4: All birthing people and infants in Mercer County have equitable access to quality care and resources across the birthing continuum to improve health outcomes.
Objective 4.1: Increase access to prenatal care services to reduce the risk factors for maternal and infant morbidity and mortality to more closely align with NJ rate (3.5 per 1,000 births) by 2027.
Objective 4.2: Increase the number of partnerships among community-based organizations to streamline resources and build supportive networks for families by 2027.
Objective 4.3: Increase health education opportunities to promote health and well-being of all birthing people, infants, and families in Mercer County by 2027.
Objective 4.4: Increase and diversify the number of professionals working in the community to bridge the gap in access to maternal and infant health care by 2027.

Priority 4: Maternal & Infant Health					
Goal 4: All birthing people and infants in Mercer County have equitable access to quality care and resources across the birthing continuum to improve health outcomes.					
Objective 4.1: Increase access to prenatal care services by to reduce the risk factors for maternal and infant morbidity and mortality by 2027					
CHNA Indicator = 1) Infant mortality was higher in County (6.4 per 1,000 births) than State (3.5 per 1,000 births) (CHNA p. 95) *2) 2018-2022 64.2% overall, and 48.7% of Latinas received prenatal care in Mercer County (NJSHAD, CHNA p. 95)* *3) County had higher % of low and very low birth weight babies (8% and 1.4%), than the State (7.8% and 1.2%) (CHNA p.viii)*					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
4.1.1 Identify gaps in telehealth services to better understand disparities.	Central Jersey Family Health Consortium (CJFHC)		Put on hold for this year. Will think about in the future. Discuss possibility of looking at claims THT has through HIE data.	CJFHC	
4.1.2 Expand services to high-risk or underserved neighborhoods that could benefit from mobile health clinics.	Children's Home Society of NJ (CHSofNJ) CJFHC	# of WIC mobile unit events/days and locations. Increased # of new participants enrolled in services during WOW Clinics	CHSofNJ will conduct outreach with the WIC mobile unit. CHSofNJ/WIC Mercer County Program will share monthly calendar of events & coordinate on-site WOW activities	CHSofNJ	
		Targeting neighborhoods with no or delayed prenatal care of 10% or higher.	CJFHC will look at map of no prenatal care overlayed on clinic locations.	CJFHC	
4.1.3 Explore opportunities to integrate/co-locate health services.	CHSofNJ Kindersmile	Increased number of educational workshops annually.	CHSofNJ will conduct educational workshops integrated as part of their CUNA Prenatal Health Education Programs.	CHSofNJ	

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STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
		# partnerships with non-dental orgs, # maternal health workers trained on perinatal oral health.	Kindersmile to partner with non-dental maternal health organizations to extend resources and train maternal health workers on perinatal oral health.	Kindersmile	
4.1.4 Promote community-based service providers to support care navigation and planning.	Aetna Better Health NJ Children's Futures CHSofNJ: AMAR and NEST Community Based Doulas Trenton Health Team CHWs TruDoulas of New Jersey Trenton Maternal Health Stakeholders Group (MHSG) Capital Health	# of doulas trained	Train and equip doulas	TruDoulas of NJ	*12 trained in 2024*
		# referred to GEMS program # of community baby showers # of enrollment events.	Continue to refer expecting mothers to the Mother's Getting Early Maternity Service (GEMS) programs and hold in person enrollment events.	Horizon NJ Health	
		# enrollment events # community baby showers	Hold community baby showers and other healthcare enrollment events for expecting persons.	Aetna Better Health NJ	
		# of Trainers and Community-Based Doula Trainees trained, certified and/or hired in the county under HealthConnect One Curriculum	CHS of NJ will train staff as CHWs under the CWH Institute to increase professional development and capacity building as part of the Perinatal Community Integration Model. CHS of NJ will provide HC1 training to hire more community-based doulas.	CHS of NJ	
		Increase in # enrolled in Family Connects annually.	Promote Family Connects program among workgroup members and partners. Provide updates on program at several monthly meetings.	MHSG Family Connects	*Family Connects nurses completed 729 home visits in 2024.*
		# of doulas trained	Train doulas through the Trenton Community Doula Program.	Children's Futures	*22 doulas trained in 2023*

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STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
		Increase referrals to family connects by 3%. Increase in utilization of birthing plans.	Continue providing referrals to the Family Connects program and educating providers. 1) Promote the idea of birthing plans at CHMG visits, 2) Add a birthing plan template to the Capital Health Website.	Capital Health	*1950 referrals to Family connects in 2024.*
4.1.5 Partner with urgent care and ED's to provide support to pregnant individuals to enroll in prenatal care.	TruDoulas CHSofNJ, Safer Childbirth Cities	Increased access to doula services.	Work to increase access to doula services and prenatal care within ED settings.	TruDoulas of NJ & CHSofNJ, Safer Childbirth Cities	
		# of pregnant individuals referred to CHSofNJ CUNA and Body and Soul Prenatal Health Groups	Safer Childbirth Cities Health Liaison will complete referrals to Prenatal Health Groups.	CHSofNJ, Safer ChildbirthCities	
4.1.6 Identify and promote transportation options to allow individuals to reach care.	Greater Mercer Transportation Management Association (GMTMA) CHSofNJ Isles Rise MHSG NJMIHIA CJFHC	Distribution and sharing of Mercer County Mobility Guide and Access Link program information.	Mercer County Mobility Guide is updated annually which includes information on medical transportation. This guide will be promoted by workgroup members.	GMTMA	
		# of GoTrenton Kiosks installed at CHSofNJ sites across the City of Trenton.	Collaborate to install a FREE GoTrenton Kiost to facilitate participants' pick-up and drop-off at healthcare facilities, appointments, and education workshops for prenatal and postpartum care.	CHS of NJ Isles	
			Partner with Mercer County and healthcare resources to promote transportation options to healthcare services.	Rise	
		Promote resource among workgroup members.	Promote Access Link program offering transportation assistance for those with high-risk pregnancies.	MHSG	
		Analysis of distance information.	Explore providing distance information for workgroup to address cost of transportation.	CJFHC	

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STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
4.1.7 Promote existing digital tools, and development of new methods, to enable individuals to identify social support resources needed based on preferences indicated.	Horizon NJ Health CJFHC MHSG	Increase in website traffic to community resource finder and Mercer Resource websites.	Promote Horizon NJ Health community resource finder and MercerResource website through sharing with partner organizations and adding to website. Look at developing new tools after baseline data has been gathered for strategy 4.2.1	GMPHP MHSG	
		Completion of a resource map and data gathered from dashboard	Build a resource map that has a data dashboard.	CJFHC	
4.1.8 Promote family leave insurance and other State legislation regarding FMLA/TDI/Earned Sick time.	Rise	# of outreach events, # reached through outreach events	Through CARE grant, will conduct outreach and education around worker benefits and protections, including NJ Paid Family and Medical Leave, Sick Leave, and unemployment.	Rise	
4.1.9 Increase organizational knowledge of NJ Family Care (Medicaid) enrollment process.	Horizon NJ Health NJ Hospital Association	# of professional development workshops, # attendees at workshops.	Work with partners to provide Medicaid professional development workshops and enrollment trainings.	Horizon NJ Health	
		# of trainings, # trained in Mercer County	Provide Medicaid enrollment trainings to healthcare leaders and professionals.	NJ Hospital Association	
4.1.10 Continue working on developing the Maternal & Infant Health Innovation Center in the city of Trenton	Capital Health	Completion of the patient journey paths and floor plans.	Completion of flowcharts depicting the patient journey paths and completion of the innovation center floor plans.	Capital Health	
4.1.11 Implement TeamBirth by the end of 2025.	Capital Health	Implementation of TeamBirth.	Pending	Capital Health	
4.1.12 Implement Centering Pregnancy by the end of 2026.	Capital Health	Enroll a cohort into the program.	Pending	Capital Health	

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Objective 4.2: Increase the number of partnerships among community-based organizations to streamline resources and build supportive networks for families by 2027					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
4.2.1 Identify the number of Community Based Organizations (CBOs) providing services for maternal and infant health, the services they are providing, and the CBOs they are currently collaborating with.	Maternal Health Stakeholder Group (MHSG)	Creation of a comprehensive list of all organizations.	Group will form a sub-committee to develop a plan to accomplish this.	MHSG	
4.2.2 Identify high need communities lacking services and facilitate strategic partnerships.	MHSG Rise	Increase in group members and member organizations.	Promotion of the MHSG & CHIP priority workgroup in community to increase awareness and participation to build partnerships.	MHSG Rise	
4.2.3 Continue monthly Maternal Health Stakeholders Meetings and conduct outreach to increase membership.	MHSG/THT	# of meetings Increase in # of participants at meetings # new organizations participating in meetings	Continue to organize monthly MHSG meetings and promote CJFHC Convening meetings. Organize at least one in person MHSG convening.	MHSG	

Priority 4: Maternal & Infant Health					
Goal 4: All birthing people and infants in Mercer County have equitable access to quality care and resources across the birthing continuum to improve health outcomes.					
Objective 4.3: Increase health education opportunities to promote health and well-being of all birthing people, infants, and families in Mercer County by 2027.					
CHNA Indicators = County has higher rates of teen pregnancy (8.4 per 1,000 births) than state (3.4 per 1,000 births)					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
4.3.1 Diversify representation in health education materials and public health campaigns, including incorporating fathers and partners into materials, to be more culturally and linguistically sensitive.	TruDoulas of NJ CHSofNJ WIC Mercer NJ Breastfeeding Coalition Capital Health	Implementation of changes determined by survey results.	Diversify and expand culturally inclusive childbirth & lactation education. Conduct a client survey asking client's opinions on diversity of education materials.	TruDoulas of NJ	
		Incorporation of NCLAS in health education materials distributed by CHSofNJ.	Purchase of interpretation equipment to support language access for limited English-speaking clients in the county.	CHSofNJ and WIC Mercer Program	
		# of languages materials translated into	Expand translation of materials.	NJ Breastfeeding Coalition	*English & Spanish only in 2024.*
		# of birthing parent enrollments in the "Yo Mingo" application. Translated e-books available on Capital Health website	1) Establish "Yo Mingo" app and begin tracking utilization. 2) Translate "baby 360 e-books" to Spanish and Creole.	Capital Health	
		Class established, # of participants	Partner with community partners to help establish a birthing class for expecting fathers.	Capital Health	
4.3.2 Share diverse health education materials on social media, radio, TV.	Children's Futures Rise MIH Workgroup/MHSG GMPHP		Discuss with TCNJ Pubic Health student participation as a Capstone Project.	Children's Futures	
		Promotion activities, # of shares	Cross-promote the Mercer County Library's maternal/child health programs to clients.	Rise	
			Workgroup will promote diverse health education materials from numerous member agencies across partners.	MHSG GMPHP	
4.3.3 Provide affordable and/or free classes and workshops in community locations.	Rise TruDoulas of NJ CHSofNJ Capital Health	# of classes and workshops.	Provide affordable/free classes and workshops at their uRise campus locations. Classes will include parenting classes that meet the cultural and linguistic needs of the community in an easily accessible location.	Rise	

Priority 4: Maternal & Infant Health					
Goal 4: All birthing people and infants in Mercer County have equitable access to quality care and resources across the birthing continuum to improve health outcomes.					
Objective 4.3: Increase health education opportunities to promote health and well-being of all birthing people, infants, and families in Mercer County by 2027.					
CHNA Indicators = County has higher rates of teen pregnancy (8.4 per 1,000 births) than state (3.4 per 1,000 births)					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
		# of classes and workshops, # attendees	Provide free/affordable childbirth education and lactation classes and workshops.	TruDoulas	*42 families attended childbirth education classes, 8 lactation consultations in 2024.*
		# of FREE CUNA and Body and Soul prenatal and postnatal education group workshops/cohorts	Provide a minimum of four groups of 9-12 sessions, each focusing on prenatal health education that is culturally and linguistically appropriate.	CHSofNJ	
		Increase in # of community-based educational events by 5%.	Continue and increase number of educational classes offered by Capital Health within the community.	Capital Health	*535 events in 2024*
4.3.4 Strengthen school-based support for reproductive and sexual health education and resources, including healthy pregnancies, to reduce risk of teen pregnancy to meet State level.	Horizon NJ Health HiTOPS	# of school education events.	Work with schools to conduct education and outreach. Provide health education workshops to students and professional development for teachers and parents. Including topics like reproductive health, family planning, pregnancy/postpartum, menstrual health. Share resources with school-based partners on upcoming events and educational resources.	Horizon NJ Health	
		# of school education events.	Conduct education in schools.	HiTOPS	
4.3.5 Incorporate cultural competence into trainings for providers of maternal and infant health services.	CHSofNJ	# of cultural sensitivity classes.	Uzo will track how many cultural sensitivity classes she holds for staff at Capital Health OB clinic.	CHSofNJ	
4.3.6 Develop a resource toolkit for prenatal care providers on culturally sensitive care specific to Mercer County			Reassess who has the capacity to do this and how to best go about this next year. Consider convening a taskforce within workgroup.		

Priority 4: Maternal & Infant Health					
Goal 4: All birthing people and infants in Mercer County have equitable access to quality care and resources across the birthing continuum to improve health outcomes.					
Objective 4.4: Increase and diversify the number of professionals working in the community to bridge the gap in access to maternal and infant health care by 2027					
STRATEGY	**PARTNER(S)**	**INDICATOR(S)**	**ACTION(S) 2025**	**RESPONSIBLE PARTY**	**BASELINE**
4.4.1 Establish a baseline by identifying the number of community-based professionals from underserved backgrounds.	MIH Workgroup	# of determined community-based professionals.	Put on hold for now and reassess in 2026. Group discussed difficulty of tracking this. Consider tracking one community based professional i.e. doulas.	MIH Workgroup	
4.4.2 Develop and provide informational sessions on community-based professions to attract and recruit diverse providers, including promoting existing community-based training and loan forgiveness options (e.g., Community Health Worker Institute).	MIH Workgroup		Put on hold, discuss at next workgroup meeting. First assess what materials exist and what is needed.	MIH Workgroup	
4.4.3 Establish partnerships with high schools and community colleges/higher education institutions to promote volunteer, internship, and career options for students from culturally and linguistically diverse backgrounds.	GMPHP MIH Workgroup	Established partnership with MCCC, and other higher education institutions.	Conduct outreach to Mercer County Community College to establish partnerships and invite to attend workgroup meetings. Work with County Workforce Development office Consider working with Dept. of Education Office of Career Readiness Promote job/career fairs to partners to increase awareness of available positions.	GMPHP MIH Workgroup	
4.4.4 Offer training programs in partnership with public health departments, targeting cultural competency, anti-bias, and trauma informed practices.	GMPHP MIH Workgroup	Attendance and organizations represented at training.	GMPHP will organize a cultural competency training and invite members of all priority workgroups. Will promote any other trainings within workgroup.	GMPHP MIH Workgroup	

References

[1] 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/

[2] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 74.

[3] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 74-75.

[4] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 79.

[5] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 101.

[6] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 102.

[7] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, iv.

[8] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, v.

[9] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, vii.

[10] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 35.

[11] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 35.

[12] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 36.

[13] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 39.

[14] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, iv.

[15] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 94.

[16] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 95.
[17] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 95.
[18] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 95.
[19] ODPHP, Healthy People 2030, Discrimination, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/discrimination#cit10
[20] Robert Wood Johnson Foundation, What is Health Equity?, https://www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html
[21] National League of Cities, What is Affordable Housing?, https://www.nlc.org/article/2024/01/08/what-is-affordable-housing/#:~:text=The%20U.S.%20Department%20of%20Housing,2.2%20million%20low%2Dincome%20households.
[22] UCSF Multicultural Resource Center, Racial Equity & Anti-Black Racism, https://mrc.ucsf.edu/racial-equity-anti-black-racism#:~:text=Racial%20Equity%20is%20the%20condition,that%20fail%20to%20eliminate%20them
[23] ODPHP, Healthy People 2030, Social Determinants of Health, https://health.gov/healthypeople/objectives-and-data/social-determinants-health
[24] Merriam-Webster Dictionary, https://www.merriam-webster.com/dictionary/systemic%20racism
[25] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 48.
[26] Greater Mercer Public Health Partnership Community Health Needs Assessment 2024, https://gmphp.org/wp-content/uploads/2025/01/2024-GMPHP-Community-Health-Needs-Assessment.pdf, 48.
[27] Greater Mercer TMA, Vision Zero: Transforming Roads for Safety, https://gmtma.org/vision-zero/