Bergen County
Community Health Implementation Strategy
2020 - 2022

Hospital Partners

- Bergen New Bridge Medical Center
- Christian Health Care Center – Ramapo Ridge Psychiatric Hospital
- Englewood Health
- Hackensack Meridian *Health* Hackensack University Medical Center
- Hackensack Meridian *Health* Pascack Valley Medical Center
- Holy Name Medical Center
- The Valley Hospital

Local Health Department Partners

- Bergen County Department of Health Services – Hansel Asmar, Director/Health Officer
- City of Hackensack Health Department – Susan McVeigh, Health Officer
- Englewood Health Department – James Fedorko, Health Officer
- Fair Lawn – Carol Wagner, Health Officer
- Fort Lee Health Department – Stephen Wielkocz, Health Officer
- Mid-Bergen Regional Health Commission – Sam Yanovich, Health Officer
- NW Bergen Regional Health Commission – Angela Musella, Health Officer
- Palisades Park/Ridgefield Health Department – Branka Lulic, Health Officer
- Paramus Board of Health – Judy Migliaccio, Health Officer
- Teaneck Health Department – Ken Katter, Health Officer
- Village of Ridgewood – Dawn Cetrulo, Health Officer

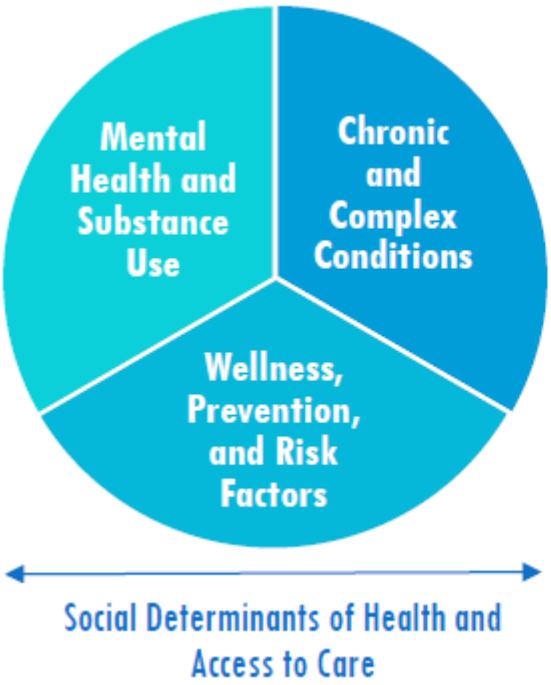
CHIP

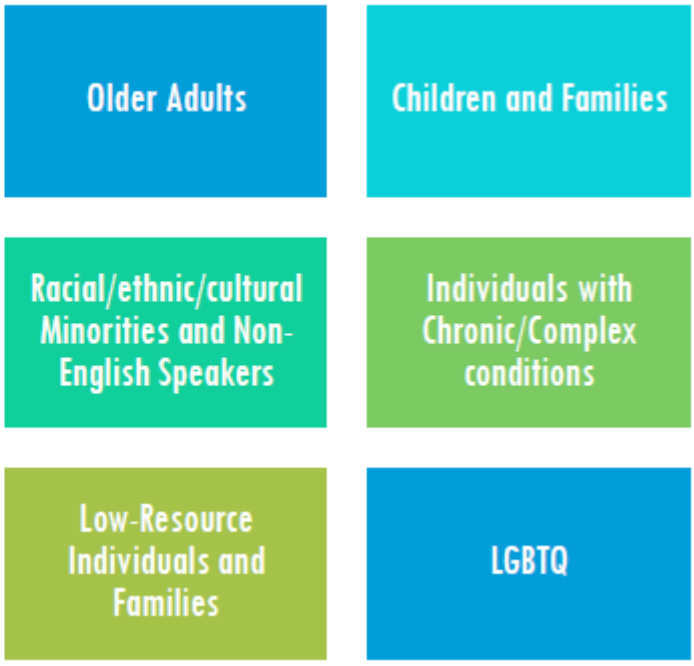
Community Health *Improvement* Partnership
OF BERGEN COUNTY
www.healthybergen.org

METHODOLOGY

The Community Health Improvement Partnership of Bergen County (CHIP) offers its Community Health Needs Assessment (CHNA) Implementation Strategy for 2020-2022. The Implementation Strategy is the result of Bergen County's Community Health Needs Assessment, conducted in 2019. Through the assessment, the CHIP identified multiple community health priority areas. These areas were identified after consideration of various criteria, including secondary data (comparison of Bergen County data to New Jersey and national data); qualitative findings from surveys, focus groups, community listening sessions, and key informant interviews; and The CHIP's ability to have impact on a priority area. Complete details are available within the 2019 Bergen County CHNA, available at http://www.healthybergen.org/.

CHIP COMMUNITY HEALTH PRIORITY AREAS AND PRIORITY POPULATIONS, 2020-2022





CHIP IMPLEMENTATION STRATEGY

The Community Health Improvement Partnership's (CHIP) Vision is that "All people in Bergen County will have access to resources that enable them to reach optimum health……Community stakeholders will collaborate to create and leverage resources to build a healthier Bergen County." The Partnership is committed to working with partners to implement the goals and strategies listed below. Partners will address wellness, prevention, and risk factors; chronic and complex conditions; mental health and substance use; and the crosscutting priorities of social determinants of health and access to care. The Implementation Strategy may include outreach to individuals most at-risk, including older adults, children and families, racial/ethnic/cultural minorities and non-English speakers, individuals with chronic/complex conditions, low-resource individuals and families, and the LGTBQ population.

PRIORITY AREA: WELLNESS, PREVENTION, AND RISK FACTORS	
Goal 1: Promote regular physical activity	**Process/Outcome Measurements**
A. Sponsor and/or support local, community-based, free and low cost exercise opportunities (e.g., CHIP Wellness/Weight Loss Challenge) B. Continue to offer programs that provide opportunity for free exercise in community-based settings (e.g., CHIP Get Fit Bergen Program)	• # of towns and community partners participating • # of participants in exercise/physical activity programs • Results of pre- and post- tests and/or evaluations
Goal 2: Promote healthy eating	**Process/Outcome Measurements**
A. Offer educational programs, cooking demonstrations, and weekly weigh-in opportunities through the CHIP Wellness/Weight Loss Challenge B. Offer educational programs and trainings for professionals and community members	• # of towns and community partners participating • # of participants • Results of pre- and post- tests and/or evaluations • % change in biometrics (e.g., lab work, blood pressure), if available
Goal 3: Promote health and wellness screenings and resources	**Process/Outcome Measurements**
A. Publicize and assist with planning programs, services and screenings available to community members to increase awareness and engagement B. Promote free and low-cost immunizations, vaccinations, education and outreach to community members	• # of collaborative programs • # of participants • # of screenings reported by community partners • # of people viewing webpages and social/media messages • # of education/outreach programs

CHIP IMPLEMENTATION STRATEGY

PRIORITY AREA: CHRONIC AND COMPLEX CONDITIONS	
Goal 1: Promote chronic disease management and behavior change	**Process/Outcomes Measurements**
A. Plan, co-sponsor, and publicize chronic disease-related educational conferences and trainings for professionals and education workshops, classes, and literature for community members B. Collaborate with hospital and community partners to promote county-wide programs and resources to prevent and/or manage chronic conditions.	• # of participants in classes, workshop and trainings • Results of pre- and post- tests and/or evaluations • # of individuals who enroll in chronic disease management programs (e.g., Stanford CDSM and CTS programs) • Names and # of the collaborating partners
Goal 2: Increase awareness of end-of-life and palliative care programs	**Process/Outcomes Measurements**
A. Provide outreach and education regarding palliative care and end-of-life planning/care in community-based settings B. Collaborate with community partners and local health care providers to increase access to caregiver support programs	• # of individuals reached • Results of pre- and post- tests and/or evaluations • Lists of caregiver support programs

PRIORITY AREA: MENTAL HEALTH AND SUBSTANCE USE (BEHAVIORAL HEALTH)	
Goal 1: Reduce stigma related to behavioral health	**Process/Outcomes Measurements**
A. Provide education and outreach in the community B. Collaborate with community partners and local health care providers to help reduce the stigma related to behavioral health issues	• # of Stigma Free programs • # of collaborating organizations/providers • # of education/outreach programs completed • Results of pre- and post- tests and/or evaluations
Goal 2: Increase and improve collaboration with partners to help reduce depression, isolation, anxiety and stress	**Process/Outcomes Measurements**
A. Plan, co-sponsor and publicize education, outreach, and screenings (i.e. depression) in community-based settings B. Collaborate with community partners and local health care providers to address these issues C. Assist with collecting, vetting and publicizing resources including mental health centers and providers, community programs, self-help groups, health care providers, etc.	• # of outreach/education events • # of collaborating organizations • Annual reports from partner agencies/providers • # of individuals reached at education and outreach events • URL link to lists of resources • Websites and media/social messages • Results of pre- and post- tests and/or evaluations

CHIP IMPLEMENTATION STRATEGY

PRIORITY AREA: MENTAL HEALTH AND SUBSTANCE USE (continued)	
Goal 3: Reduce the use of tobacco and e-cigarette/vaping products	**Process/Outcomes Measurements**
A. Increase awareness of community resources, prevention programs, care/treatment options, and supportive services through community outreach, education, and media/social messages B. Collaborate with community partners, hospitals, schools, and local health care providers to reduce the use of tobacco and e-cigarette/vaping products	• # of outreach/educational events offered • # of individuals reached • # of collaborative efforts with community partners • List of community partners • Results of pre- and post- tests and/or evaluations
Goal 4: Reduce risky alcohol use	**Process/Outcomes Measurements**
A. Increase awareness of community resources, prevention, care/treatment options, and supportive services through community outreach and education B. Collaborate with community partners and local health care providers to reduce risky alcohol use	• # of outreach/educational events offered • # of individuals reached • # of collaborative efforts with community partners • List of community partners • Results of pre- and post- tests and/or evaluations
Goal 5: Reduce prescription drug abuse and illegal drug use	**Process/Outcomes Measurements**
A. Increase awareness of community resources, prevention programs, care/treatment options, and supportive services through community outreach and education B. Collaborate with community partners and local health care providers to reduce prescription drug abuse	• # of outreach/educational events offered • # of individuals reached • # of collaborative efforts with community partners • List of community partners • Results of pre- and post- tests and/or evaluations

CHIP IMPLEMENTATION STRATEGY

PRIORITY AREA: SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO CARE	
Goal 1: Improve access to affordable and safe housing and transportation	**Process/Outcomes Measurements**
A. Promote programs and services that aim to increase access to affordable and safe housing and transportation B. Work with governmental and community partners to discuss collaborative solutions to housing and transportation issues and prepare and update resource lists	• # collaborative meetings • # of collaborating partners and names of organizations represented • URL for the lists of resources
Goal 2: Promote access to and engagement in primary care	**Process/Outcomes Measurements**
A. Collaborate with community partners and local health care providers to promote primary care resources B. Continue to include primary care partners from Federally Qualified Health Centers, hospitals, and other medical practices on the CHIP Core Steering Committee and task forces	• # of collaborative programs • # attending meetings, programs, and donating time and funds to CHIP related activities to enhance access to primary care services • Lists of collaborating partners
Goal 3: Promote access to and engagement in behavioral health care	**Process/Outcomes Measurements**
A. Increase awareness of community resources, prevention, care/treatment options, and programs through community outreach and education B. Collaborate with community partners and local health care providers to promote access to and engagement in behavioral health care	• # of outreach/educational events offered • # of individuals reached • # of collaborative efforts with community partners • URL and lists of behavioral health resources