Hunterdon Health

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HUNTERDON COUNTY NEW JERSEY

COMMUNITY HEALTH IMPROVEMENT PLAN

SUPPORTING THE COMMUNITIES OF HUNTERDON COUNTY AND THE HUNTERDON HEALTH SERVICE AREA

2026-2028

Hunterdon Health

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COMMUNITY HEALTH IMPROVEMENT PLAN

2026-2028

Hunterdon Health, Hunterdon County Health Department, and the member organizations of the Hunterdon Partnership for Health (PFH) are excited to share and begin implementation of the 2026-2028 Community Health Improvement Plan (CHIP). Over the next three years, these organizations will drive efforts to address three primary priority health needs, while also strengthening partnership infrastructure and addressing the cross-cutting issue of social isolation in the Service Area.

Mental Health

Goal 1: PFH will address mental health needs in the Hunterdon Service Area by:

- *Increasing access to mental healthcare for residents experiencing barriers.*
- *Increasing access and reducing barriers to programs, services, and community resources that support mental wellness.*

Healthy Lifestyle

Goal 1: PFH will address healthy lifestyles in the Hunterdon Service Area by:

- *Increasing prevention, early detection, and/or management of chronic disease.*
- *Increasing access and reducing barriers to programs, services, and community resources that support healthy lifestyle choices and habits.*

Substance Use

Goal 1: PFH will address substance use in the Hunterdon Service Area by:

- *Increasing access and reducing barriers to prevention, intervention, and treatment for substance use disorders.*
- *Changing community attitudes, social normalization, and perceived health risks associated with alcohol use, marijuana/THC use, and vaping nicotine/THC.*

Social Isolation

Goal 1: PFH will address social isolation in the Hunterdon Service Area by:

- *Improving community connectedness and sense of belonging for all residents.*

Strengthening and Sustaining PFH Infrastructure

Goal 1: PFH will enhance and sustain the Partnership's Infrastructure by:

- *Forming a Data Advisory Committee/Group*
- *Forming a Senior Advisory Committee/Group*

Goal 2: PFH will improve community awareness of CHNA and CHIP-related activities by:

- *Communicating findings and activities resulting from the CHNA and CHIP to key leaders, partners, and community members*

The 2026-2028 Hunterdon CHIP provides a collaborative roadmap for addressing mental health, healthy lifestyle, and substance use needs, along with cross-cutting initiatives addressing social isolation and PFH infrastructure improvements over the next three years. Through regular monitoring of performance metrics and ongoing collaboration, this plan will guide efforts to improve health outcomes for all residents, particularly those at risk for poorest health outcomes. The Hunterdon Partnership for Health remains committed to building a healthier community through evidence-informed and inclusive approaches that respond to emerging needs while focusing on our shared goals.

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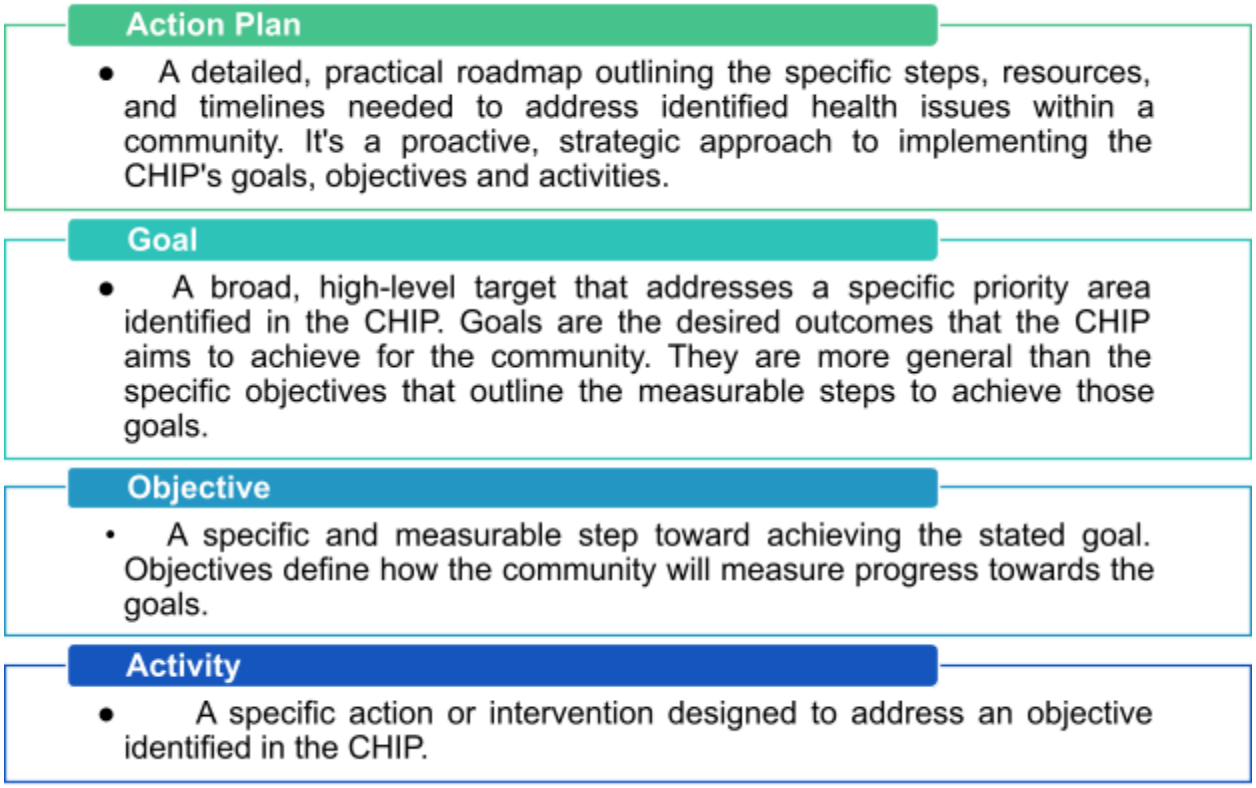
Table of Contents

Key Terms and Acronyms

To ensure shared understanding of the key components of this Community Health Improvement Plan (CHIP), this section of the report lists and defines key acronyms that are used throughout the report and describes the meaning behind each of the key CHIP report elements, as described in the figure below.

Key Terms:



Acronyms:

Acronym	Meaning
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
DFTF	Drug Free Task Force
HCHD	Hunterdon County Health Department
MAPP	Mobilizing for Action through Planning and Partnerships
PFH	Partnership for Health

Record of Changes

Hunterdon Health, in collaboration with Hunterdon County Health Department (HCHD) and the Partnership for Health (PFH), reviews progress and updates this CHIP annually by Steering Committee. Any major changes to the contents of this document, including but not limited to goals, objectives, and/or activities outlined in the Appendices will be noted in this section of the report to support version control.

Original Date of Publication: October 2025

Reviewed and Approved by Hunterdon Health Board: December 2025

Anticipated Dates of Implementation: January 2026 to December 2028

Anticipated Timeline for Steering Committee Reviews: February of each year

Date of Update(s)	Brief Description of CHIP Update	Responsible Party
1/7/2026	Added baseline measurements for EHR metrics	A. Drake

Introduction

The 2026-2028 Hunterdon CHIP represents a collaborative effort between Hunterdon Health, the HCHD, and community partners through the Partnership for Health (PFH) to address the most pressing health needs identified in the 2025 Hunterdon CHNA. This plan outlines goals, objectives, and activities designed to improve health outcomes for the Service Area's approximately 410,000 residents over the next three years.

Steering Committee & the PFH

The Steering Committee, consisting of seven members, served as the core governance body for the 2025 Hunterdon CHNA and provided strategic oversight throughout the assessment process. This Committee was responsible for serving as a "sounding board" for process inputs and findings, facilitating community-wide participation in primary data collection, identifying key leaders for engagement, offering feedback on CHNA and CHIP process steps, providing access to relevant data sources, and participating in the prioritization process. The Steering Committee was comprised of staff and leaders representing Hunterdon Health and Hunterdon County Health Department. A list of members can be found in the Acknowledgements section of this report.

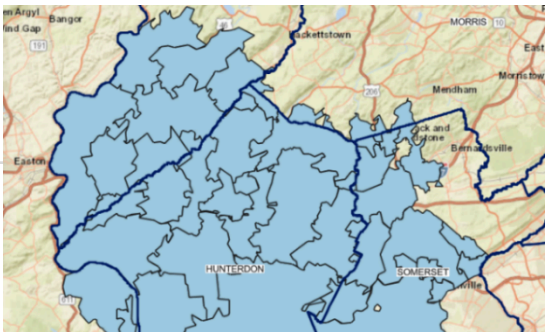
The PFH represents a broader coalition united by a shared vision that:

"...every individual of Hunterdon County has a state of optimal physical, mental, spiritual, and social well-being which allows the individual to pursue the most fulfilling life possible, and not merely a life absent of disease or infirmity."

This larger partnership, committed to harnessing collective power from multiple sectors, became actively involved in the process once the 2025 CHNA data was collected and analyzed, voting on selection of health priorities and participating in Action Team meetings during the CHIP development phase. Moving forward, PFH will serve as the implementation body focused on sustainable, systems-level solutions, carrying out activities to put optimal health within everyone's reach by addressing gaps that disproportionately affect the Service Area's population while continuously monitoring and sharing progress toward achieving the 2026-2028 CHIP goals and objectives.

Hunterdon Health Service Area

Hunterdon Health serves a unique Service Area comprised of 53 zip codes that encompasses Hunterdon County, New Jersey, and extends into



bordering Mercer, Somerset, and Warren counties. This Service Area represents the geographic region where Hunterdon Health provides primary and specialty healthcare services to residents. This distinctive location provides residents with access to both rural landscapes and urban employment opportunities, creating a unique demographic and economic profile that influences community health needs and intervention strategies.

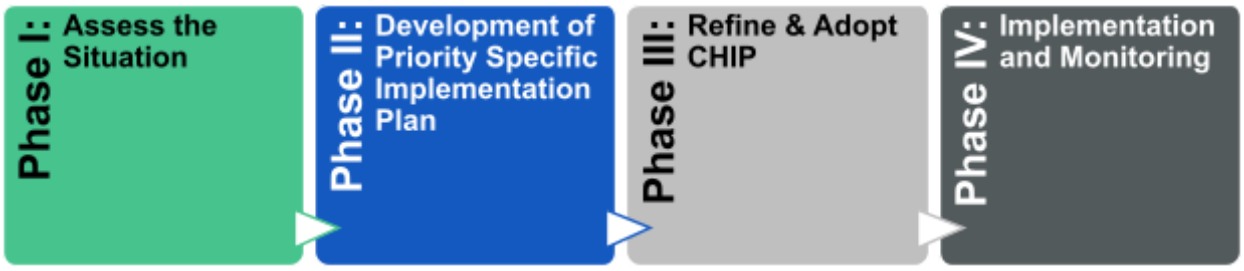
Hunterdon County Health Department Service Area

The Hunterdon County Health Department (HCHD) is the sole public health authority serving approximately 130,000 residents across 26 municipalities, operating under the governance of the Board of County Commissioners. With a staff of 45 across six divisions — Environmental Health, Mosquito and Vector Control, Solid Waste and Recycling, Weights and Measures, Public Health Nursing, and Public Health Preparedness—HCHD provides comprehensive services ranging from disease prevention and health promotion to environmental protection and emergency preparedness. The department works in close partnership with state agencies including the New Jersey Department of Health, Department of Environmental Protection, and Department of Community Affairs, which provide guidance, technical assistance, and regulatory oversight. HCHD uniquely maintains a hybrid model with the Hunterdon County Office of Emergency Management, strengthening cross-discipline collaboration in communicable disease control, hazardous materials response, and emergency planning. As the enforcement agency for New Jersey Administrative Code related to public health, HCHD delivers both regulatory oversight and grant-funded programs that address the county's identified health priorities.

CHIP Development Process Overview

The CHIP development process brought together public health professionals, community organizations, and healthcare providers through the established PFH network to ensure the plan reflects both technical expertise and diverse community perspectives. It involved a MAPP[1]-informed, four-phased process demonstrated in Figure I.1 below.

Figure I.1: The Four CHIP Phases



[1] MAPP 2.0 Handbook, NACCHO

Phase I: Assess the Situation

This phase involved conducting a comprehensive CHNA that analyzed extensive secondary data on health indicators including length of life, quality of life, clinical care, health behaviors, physical environment, and social/economic factors. The assessment also gathered input from over 570 community members and key leaders through community health opinion surveys, key leader surveys, focus groups, and key leader interviews. Through this comprehensive data collection and analysis, three priority health needs were identified: *mental health, healthy lifestyles, and substance use*. Data also indicated a need for special consideration of three cross-cutting themes - *transportation barriers, health equity concerns, and social isolation* - during the CHIP's development.

Phase II: Development of Priority-Specific Action Plans

During this phase, three pre-established Action Teams within the PFH structure were engaged to develop establish issue profiles and issue statements, discuss possible goals, and brainstorm and prioritize corresponding objectives and activities for each of the three selected priority health needs. The Steering Committee worked collaboratively with PFH stakeholders and a consulting firm to ensure goals, objectives, strategies and their corresponding action plans reflected community priorities, considered existing local community assets and resources, and noted opportunities for new and innovative approaches to addressing priority health needs.

Phase III: Refine & Adopt CHIP

This phase involved refining and finalizing issue profiles, goals, objectives, and activities with the Steering Committee. During this phase, the Steering Committee identified a need for formally including PFH strengthening goals and objectives alongside the priority health need specific goals and objectives in the CHIP to ensure PFH's sustainability and impact in the Service Area. Action plans were established and further refined by the Steering Committee during August 2025.

The final CHIP draft was shared with the Hunterdon Health Board of Directors in December 2025 for review and approval.

Phase IV: Implementation & Monitoring

The last phase focuses on implementing CHIP action plans while monitoring progress toward achievement of CHIP goals and objectives. This phase includes regular review and reporting mechanisms to ensure accountability and continuous improvement throughout the implementation period, building on the successful collaborative approach demonstrated in previous Hunterdon CHIP cycles.

This CHIP builds upon the strong foundation of community collaboration that exists in Hunterdon County and the broader Service Area, leveraging the established PFH network and the unique strengths, assets and resources available in the Service Area. The CHIP is designed to create meaningful, measurable improvements in the health and well-being of all Service Area residents and should serve as the roadmap for coordinated community health improvement efforts led by Hunterdon Health, HCHD, and partner organizations participating as members of the PFH collaborative structure.

Over the next several pages, each of the CHIP Phases, information and data reviewed, findings considered, and decisions made by the Steering Committee and PFH are described in greater detail.

Phase I: Assess the Situation

Community Health Needs Assessment Overview

The CHNA and CHIP processes were led by a Steering Committee comprised of Hunterdon Health and HCHD, with input from partners serving as members of PFH and technical support from consulting partners at Ascendient Healthcare Advisors. The Steering Committee was responsible for overseeing all aspects of the assessment process including data collection methodologies, analysis of findings, and facilitation of community engagement activities. The Steering Committee, with input from the broader membership of PFH, were responsible for identification and prioritization of community health needs in the 2025 CHNA and 2026-2028 CHIP cycle.

The process used to produce this CHNA was informed by the MAPP 2.0[1] framework, a community-based planning process used to assess health issues and align resources across sectors to address health priorities. Key objectives of the Hunterdon CHNA process were to assess health needs and contributing factors affecting residents in the Service Area, gather input from community members and leaders representing diverse perspectives, identify priority health needs that should be addressed collaboratively, and meet regulatory and accreditation requirements for CHNAs.

Primary Data: The Service Area's comprehensive CHNA employed a robust, multi-method approach to identify and prioritize health needs across the 53-zip-code Service Area encompassing all of Hunterdon County, New Jersey and certain zip codes in surrounding Mercer, Somerset, and Warren counties. The Steering Committee helped facilitate data collection from over 570 community members and key leaders through four primary data collection strategies:

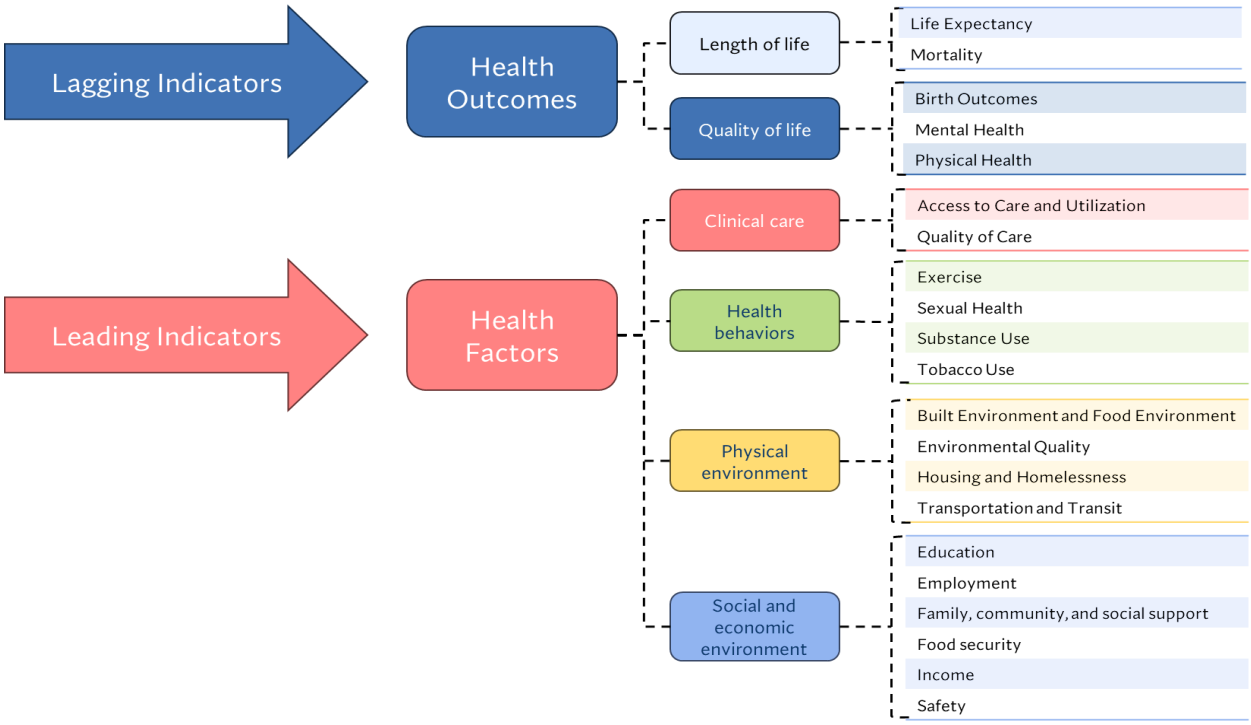
Table 1.1: Primary Data Inputs for 2025 CHNA Process

Data Collection Strategy	Total Number of Participants
Community Health (Resident) Survey	414
Key Leader Survey	63
Community Focus Groups	87 participants across 8 focus groups
Key Leader Interviews	7

Secondary Data: Primary data were complemented by extensive secondary data analysis using the Robert Wood Johnson Foundation County Health Rankings[2] methodology, which examined indicators across categories like length of life, quality of life, clinical care, health behaviors, physical environment, and social/economic factors.

[2] University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025 https://www.countyhealthrankings.org/

Figure 1.1: Population Health Framework



Data Integration: A major strength of the 2025 CHNA was intentional integration of primary and secondary data, creating a comprehensive understanding that reflects both statistical realities and lived community experiences. This approach allowed the Steering Committee and the PFH to identify disparities, triangulate findings across multiple sources, and ensure the priorities identified truly represent the most pressing health challenges facing Service Area residents.

Priority Health Needs Identified: Through this assessment process, three priority health needs were identified: *Mental Health, Healthy Lifestyles, and Substance Use*. Data also indicated a need for special consideration of three cross-cutting themes - *transportation barriers, health equity concerns, and social isolation* - during the CHIP's development.

Figure 1.2: 2025 CHNA Priorities

Access to the Full 2025 CHNA Report

The complete 2025 Hunterdon CHNA report provides detailed methodology, comprehensive data analysis, and a full report of findings used to inform priority health need selection and to inform the development of the 2026-2028 CHIP. The full report is available online through Hunterdon Health and the HCHD.

Phase II: Development of Action Plans

Phase II leveraged pre-established PFH Action Teams, which each focused on one of the three priority health needs identified through the 2025 CHNA. These Action Teams were operating as ongoing workgroups within the PFH, providing a strong foundation for CHIP development and an opportunity for continuity of existing community health improvement efforts.

Each Action Team participated in one of three facilitated 90-minute virtual meetings in July 2025. During these meetings, they reviewed 2025 CHNA findings and progress on previous CHIP implementation, discussed and refined issue profiles and issue statements, discussed possible CHIP goals, and engaged in brainstorming and prioritization of possible CHIP objectives and activities. Action Team members provided ongoing input on perceived impact and feasibility of various potential CHIP activities through a follow-up survey that was deployed following each meeting to Action Team participants. Each of these CHIP-development actions are described in further detail in the following sections.

Review of 2025 CHNA Findings & Previous CHIP Accomplishments

Mental Health Action Team: The Mental Health Action Team met on July 22, 2025, to review CHNA findings that highlighted mental health as a critical community priority. The team reviewed data showing that mental health emerged as the most frequently cited health concern across multiple data sources, with community health opinion survey respondents and key leaders consistently identifying depression, anxiety, and stress management as major challenges.

Key 2025 CHNA Data Points Reviewed:

- Elevated suicide rates in Hunterdon County compared to state averages.
- Residents reporting multiple poor mental health days per month.
- Significant barriers to mental health care access, including provider shortages and stigma.
- Social isolation as a critical driver, particularly affecting seniors and post-pandemic recovery.
- Need for increased screening and early intervention, especially for adolescents and seniors.

The Action Team also reviewed successful outcomes from the previous CHIP cycle, including an increase in depression screenings for adolescent patients with a treatment plan and an increase in social isolation screening for patients 65 years of age or older on Medicare.

Healthy Lifestyles Action Team: The Healthy Lifestyles Action Team met on July 29, 2025, to review CHNA data that revealed healthy lifestyle as an interconnected challenge requiring comprehensive approaches to address both individual behaviors and community-level environmental factors.

Key 2025 CHNA Data Points Reviewed:

- Infrastructure barriers requiring community solutions, including low walkability scores and (physical) safety concerns.
- Food access challenges despite generally favorable food security indicators, with specific geographic areas functioning as food deserts.

- Economic constraints affecting healthy lifestyle choices for some residents.
- Strong community awareness and existing recreational assets providing foundation for prevention-focused interventions.

The Action Team also reviewed successful outcomes from the previous CHIP cycle, including exceeding the established target for increasing in physical activity levels of patients aged 40-60 and increasing food insecurity screening for patients 65 years of age and older.

Substance Use Action Team: The Substance Use Action Team (also referred to as the PFH Drug Free Task Force) met on July 31, 2025, to review and discuss CHNA findings that showed substance use as a multifaceted priority area where individual health challenges intersect with community culture, family dynamics, and systemic barriers.

Key 2025 CHNA Data Points Reviewed:

- Consistency across community voices and professional perspectives in identifying substance use as a significant health priority.
- Complex substance use landscape with lower drug overdose deaths compared to state averages, but excessive drinking rates exceeding benchmarks.
- Concerning vaping nicotine/THC rates among teens and emerging challenges from marijuana legalization.
- Young adult perceptions showing decreased risk perception associated with substance use.
- Need for better prevention education and treatment access across age groups.

The Action Team also reviewed successful outcomes from the previous CHIP cycle, including an increase in vaping nicotine/THC screening achievements, implementation of controlled substance agreements, and alcohol screening improvements.

Establishing Issue Profiles & Issue Statements

Figure 2.1: Key Components of Issue Profiles

Using primary and secondary data, each Action Team created an Issue Profile for their respective priority health need. Per the MAPP 2.0 handbook[1] issue profiles are crucial for developing the CHIP as they help community partners create concise, data-driven descriptions that summarize key findings for priority health issues.

During Action Team meetings, participants reviewed available data to draft issue statements that concisely describe each priority health issue in the 2025 CHNA and 2026-2028 CHIP. These statements were refined with team input before adoption for inclusion in the CHIP. The **approved issue statements for each the three 2026-2028 CHIP priority health needs** are presented below.

Mental Health Issue Statement

Hunterdon County is New Jersey's healthiest county with many resources for promoting and supporting mental wellbeing. However, mental health is a substantial health problem in the Hunterdon area, with 65% of community members and 81% of key leaders surveyed saying it's their top concern, especially for teens, older adults, and Hispanic/Latino residents who have trouble getting help. Mental health, at all ages, was strongly affected by the COVID-19 pandemic, leaving many people feeling alone and seeking mental health services. High suicide rates, barriers like cost, transportation, stigma, and language barriers prevent people from getting the help they need. A lack of adequate mental health providers compounds these challenges. The community would benefit from increasing access to providers and services, technologies, and community programming. The Service Area needs more providers, better linkage to services in regular doctor offices, better technology access, and community programs that work for all cultures and languages.

Healthy Lifestyle Issue Statement

Hunterdon County is New Jersey's healthiest county with many resources for promoting and supporting healthy lifestyles and preventing chronic disease, like parks, recreational facilities, food assistance programs, and strong community partnerships. However, maintaining healthy weight and lifestyle habits – key factors in chronic disease prevention - remains challenging, with 37% of community members and 43% of key leaders surveyed identifying this as a top concern, particularly for children, Hispanic/Latino adults, and older adults. While resources exist, access barriers prevent full utilization: rural geography limits walkable infrastructure, transportation challenges restrict access to facilities and healthy food, and economic, literacy and cultural barriers limit participation in wellness opportunities. There is a need to improve accessible pathways to existing resources, address transportation and economic barriers, expand culturally responsive programming, and enhance health literacy education to ensure all residents can maintain healthy lifestyles and reduce their risk of chronic disease.

Substance Use Issue Statement

Hunterdon County is New Jersey's healthiest county with lower substance use rates than other areas. However, alcohol and drug problems are health concerns in the Hunterdon area. About 33% of community residents and key leaders surveyed said this is a top 3 health issue, especially for teens who vape nicotine and THC and adults who drink too much alcohol. While deadly overdoses are going down because of naloxone efforts, keeping healthy community attitudes and habits is still hard. Hunterdon County has the highest binge drinking rates in New Jersey (18.0% vs 17.4% statewide), and alcohol use is very normalized in the community. Deaths from suicide and drug/alcohol poisoning are much higher than the state average (58.5 vs 38.7 per 100,000 people). Prevention programs and treatment services can be challenging to

implement or access because of rural location, long wait times, mental health problems that lead to substance use, community attitudes and lack of perceived risks, economic and cultural barriers. There is a need to improve easy access to existing resources, fix treatment and prevention barriers, and expand programs that work for all cultures so all residents can stay healthy and reduce substance use risks.

Process for Initial Goal Development

Following the data review and issue statement development, each Action Team engaged in discussion pertaining to CHIP goal development. The teams identified focus areas that leveraged existing community assets while addressing the most pressing gaps in services and support systems for their respective priority areas. The goal development process considered multiple factors, including:

- Implementation **feasibility**, including existing resources, workforce capacity, and organizational readiness
- Potential community **impact**, assessing reach, effectiveness, and alignment with identified needs
- **Alignment** with successful strategies from the previous CHIP cycle
- **Integration** opportunities with cross-cutting themes (transportation, health equity, social isolation)

Each Action Team considered multiple draft goals for their respective priority health need and participated in a ranking exercise to determine which of those presented were perceived to be most important to address via the 2026-2028 CHIP.

Brainstorming & Prioritizing Initial CHIP Activities

In addition to goal development, each Action Team engaged in brainstorming and prioritization of possible activities that could be included in the CHIP to address the draft goals. Due to limited synchronous time with Action Team members, this process utilized a multi-modal approach to gathering PFH input.

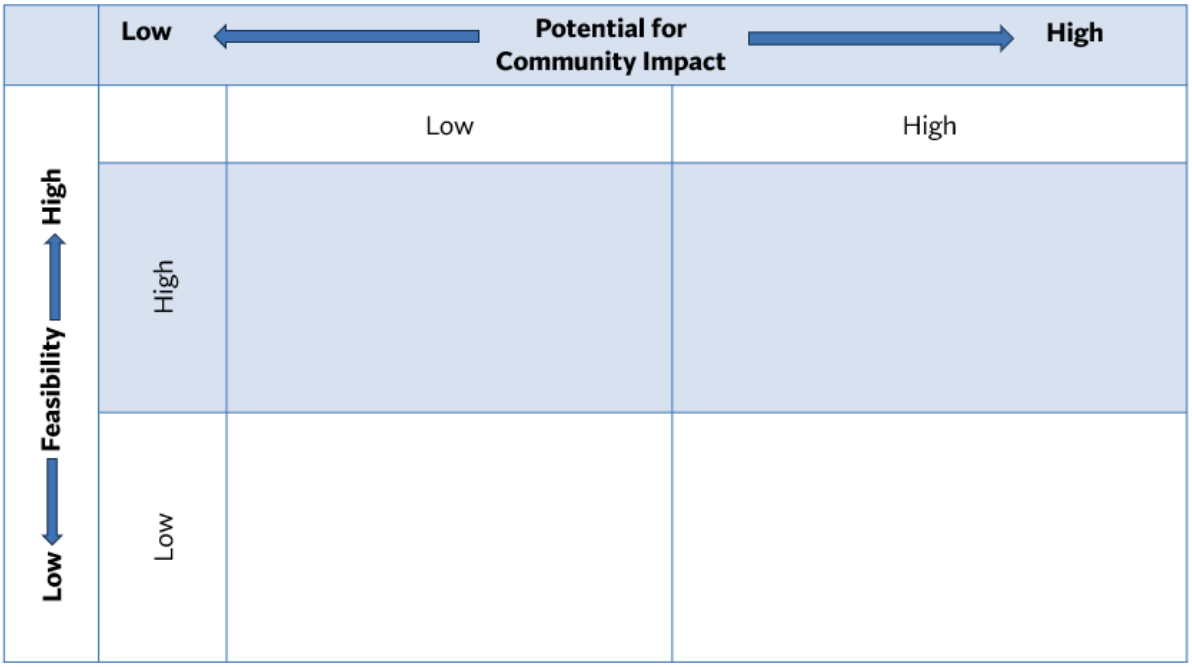
Strategy Grid for Prioritization Discussion: During the Action Team meetings in July 2025, each Action Team engaged in Strategy Grid prioritization activities to establish draft activities for addressing their draft goals. This process was facilitated using a virtual whiteboard with a 2x2 grid like that depicted in Figure 2.2. It allowed Action Team members to discuss and evaluate various possible CHIP activities on two key criteria and narrow the focus of planning to activities based on perceptions about the greatest ability to realistically make progress over the next three years. Potential activities were plotted on the grid based on:

- **Implementation Feasibility (Y-axis):** Considering available resources, organizational capacity, partnership readiness, and regulatory/policy environment
- **Potential Community Impact (X-axis):** Assessing population reach, evidence base for effectiveness, alignment with community priorities, and potential for measurable outcomes

Online Prioritization Survey: Following Action Team meetings, additional input was sought and gathered from the Action Team via an online survey. The survey asked Action Team members to provide input on feasibility and potential for impact for various additional activities that were not discussed during the meetings due to time constraints. This process resulted in composite scores for each possible activity that were plotted on the Strategy Grid and allowed Action Team members to include additional ideas for strategies to be considered in the CHIP's development.

Combined Findings: Data gathered during Action Team meetings and input submitted through the online survey tool were compiled into a Strategy Grid for Prioritization for each priority health need.

Figure 2.2: Strategy Grid for Prioritization



This prioritization methodology ensured draft activities discussed and considered for inclusion in the draft CHIP Action Plan represented a balance between what could realistically be accomplished and what would have the greatest positive impact on community health outcomes.

Phase III: Refine & Adopt CHIP

Phase III involved a reconvening of the Steering Committee to review synthesized input from the Action Team meetings, surveys, existing PFH logic models, and draft 2026-2028 Hunterdon Health community benefit metrics. During this discussion, the Steering Committee had an extensive discussion about finding balance between addressing community needs, leveraging existing resources to do so, and finding ways to identify and fill gaps in programs, services, and initiatives when appropriate and feasible. Inputs documented throughout the CHNA and CHIP

processes to date were then used to further define health priorities and to establish a framework with guiding goals, objectives, and measures of success for inclusion in the CHIP.

This CHIP represents a strategic roadmap for community health improvement initiatives in the Service Area over the next three years. While it provides direction, the Steering Committee and PFH recognizes achieving meaningful improvements in community health requires flexibility, ongoing assessment, and adaptation as new challenges and opportunities emerge.

Goals and Objectives: The tables that follow list the goals and objectives for each of the three priority health needs – *mental health, healthy lifestyle, and substance use* - as well as two additional focus areas. The additional focus areas – *strengthening and sustaining PFH infrastructure and addressing social isolation* – were added to the CHIP after the August 2025 Steering Committee meeting. Since social isolation impacts all three priority health needs and can be addressed more effectively as a cross-cutting approach, it was added as a standalone goal area. Additionally, the infrastructure of PFH is critical for the successful implementation of CHIP's activities. Action plans for each of the five priority areas are included in Appendices 1-5 of this document.

The 2025 CHNA also identified *health equity and transportation* as two major and consistently referenced themes in the data. While not included in the CHIP explicitly as standalone priorities, both will be addressed less explicitly via the planned strategies (e.g., reducing barriers to accessing services) and priority populations that will benefit from the implementation of those strategies.

Priority populations: Priority populations for the 2025 CHIP were identified through the CHNA, as well, and include:

Approach to CHIP Strategies: For each of the objectives listed in the CHIP for the priority health needs – mental health, healthy lifestyle, and substance use - the Steering Committee desired to have three standard approaches to addressing them:

- Improving, expanding, and/or enhancing screening services, if appropriate
- Promoting, expanding, and/or removing barriers to existing community resources
- Developing and implementing new programs, services, and/or initiatives when possible.

Please note that throughout this section and thereafter, the PFH refers to the community collaboration that led the CHNA/CHIP process which includes Hunterdon Health, the HCHD, and PFH member agencies. A full list of PFH partners can be found by visiting the PFH website.

Hunterdon CHIP Goals and Objectives

This section lists the 2026-2028 Hunterdon CHIP goals and objectives by priority area. Additional detail for each priority area, including activities, timelines for implementation,

measures of success, assets and resources, and more are included in Appendices 1-5 of this document.

Strengthening & Sustaining PFH Infrastructure Goals & Objectives

Table 3.1: Strengthening and Sustaining Partnership for Health Infrastructure Goals and Objectives
Goal 1: PFH will enhance and sustain the Partnership's infrastructure by:
Objective 1.1: Forming a Data Advisory Committee/Group.
Objective 1.2: Forming a Senior Advisory Committee/Group.
Goal 2: PFH will improve community awareness of CHNA and CHIP-related activities by:
Objective 2.1: Communicating findings and activities resulting from the CHNA and CHIP to key leaders, partners, and community members.

Social Isolation Goal & Objective

Table 3.2: Social Isolation Goal and Objective
Goal 1: PFH will address social isolation in the Hunterdon Service Area by:
Objective 1.1: Improving community connectedness and sense of belonging for all residents.

Mental Health Goals & Objectives

Table 3.3: Mental Health Priority Area Goal and Objectives
Goal 1: PFH will address mental health needs in the Hunterdon Service Area by:
Objective 1.1: Increasing access to mental healthcare for residents experiencing barriers.
Objective 1.2: Increasing access and reducing barriers to programs, services, and community resources that support mental wellness.

Healthy Lifestyle Goals & Objectives

Table 3.4: Healthy Lifestyle Priority Area Goals and Objectives
Goal 1: PFH will address healthy lifestyle in the Hunterdon Service Area by:
Objective 1.1: Increasing prevention, early detection, and/or management of chronic disease.
Objective 1.2: Increasing access and reducing barriers to programs, services, and community resources that support healthy lifestyle choices and habits.

Substance Use Goals & Objectives

Table 3.5: Substance Use Priority Area Goal and Objective

Goal 1: PFH will address substance use in the Hunterdon Service Area by:
Objective 1.1: Increasing access and reducing barriers to prevention, intervention, and treatment for substance use disorders.
Objective 1.2: Changing community attitudes, social normalization, and perceived health risks associated with alcohol use, marijuana/THC use, and vaping nicotine/THC.

Phase IV: Implementation and Monitoring

Process for Monitoring Implementation Progress

The implementation of the CHIP will be monitored quarterly via Action Team report-outs provided by representatives of PFH member organizations. This monitoring will involve Action Team report-outs with progress updates for all established goals, objectives, and activities across three priority health needs of mental health, healthy lifestyles, and substance use and the two cross-cutting priorities relating to social isolation and PFH infrastructure strengthening and sustainability. Quarterly reporting on all CHIP activities will occur during regularly scheduled PFH meetings.

During each CHIP review session, participating organizations will report on specific metrics and activities tied to each objective, documenting both quantitative data (such as number of screenings completed, referrals made, or participants enrolled in programs) and qualitative outcomes (such as narrative descriptions), as appropriate. Partner organizations will evaluate whether activities are proceeding according to planned timelines and address any implementation barriers. Modifications to the CHIP may be made during these reviews and will be recorded in the record of changes section of this report. Changes to the CHIP should be communicated to partners and stakeholders impacted by the changes.

CHIP Performance Metrics

Performance metrics have been established for each goal and objective to enable tracking of progress on CHIP implementation. These metrics include both process indicators (measuring implementation activities) and outcome indicators (measuring health impact) that align with the PFH's existing data collection and reporting capabilities.

Regular monitoring will ensure accountability and enable continuous improvement throughout the implementation period, building on the successful collaborative approach demonstrated in the 2023-2025 CHIP cycle and the established PFH governance structure.

CHIP Process Measures

Table 4.1: CHIP Process Measures

Priority	Metric	Data Source	Frequency	Baseline Establishment	Target
Infrastructure	Data Advisory Committee Existence	PFH Charter	Once	Formal committee structure established	1 committee established
	Senior Advisory Committee	PFH Charter	Once	Formal committee structure established	1 committee established

Table 4.1: CHIP Process Measures					
Priority	Metric	Data Source	Frequency	Baseline Establishment	Target
	PFH Communications Strategy	PFH program tracking	Bi-Annually	Communications strategy established and reviewed annually; Action Team leaders meet twice per year	2 Action Team meetings per year
	Number of PFH member organizations actively participating in CHIP activities	PFH membership records	Quarterly	2025 baseline established from current membership based on quarterly meeting logs	Ongoing
Social Isolation	Percentage of patients aged 65+ screened for social isolation	NextGen EHR	Annually	Baseline: 92.79% (Dec 2025)	
	Community awareness of existing community connectedness programs	PFH program tracking	Annually	Establish baseline: 0 (new strategy)	Baseline of existing programs established in YR1 Increased communication about existing programs in YR2 and YR3
Mental Health	Percentage of patients aged 65+ screened for depression with treatment plan	NextGen EHR	Annually	Baseline: 72.93% (Dec 2025)	
	Percentage of adolescent patients aged 12-19 screened for depression with treatment plan	NextGen EHR	Annually	Baseline: 63.63% (Dec 2025)	
	Community awareness of mental health education programs	PFH program tracking	Annually	Establish baseline: 0 (new strategy)	Baseline of existing programs established in YR1 Increased communication about existing

Table 4.1: CHIP Process Measures					
Priority	Metric	Data Source	Frequency	Baseline Establishment	Target
					programs in YR2 and YR3
Healthy Lifestyle	Percentage of LGBTQ+ patients (aged 40-74) receiving breast cancer screening	NextGen EHR	Annually	Baseline: 60.87% (Dec 2025)	
	Percentage of Hispanic/Latina patients aged 40-74 receiving breast cancer screening	NextGen EHR	Annually	Baseline: 64.64% (Dec 2025)	
	Percentage of patients aged 30-64 screened for food insecurity	NextGen EHR	Annually	Baseline: 55.58% (Dec 2025)	
	Percentage of patients aged 65+ screened for food insecurity	NextGen EHR	Annually	Baseline: 46.23% (Dec 2025)	
	Community awareness of healthy lifestyle programs/ services	PFH program tracking	Annually	Establish baseline: 0 (new strategy)	Baseline of existing programs established in YR1 Increased communication about existing programs in YR2 and YR3
Substance Use	Percentage of patients aged 13+ screened for vaping nicotine/THC	NextGen EHR	Annually	Baseline: 79.53% (Dec 2025)	
	Total number of substance use treatment admissions for all substances	NJ DHS, DMHAS[3]	Annually	Baseline: 691 (2023)	Monitor for trends
	Total number and percent of substance use treatment	NJ DHS DMHAS[3]	Annually	Baseline: 322, 47% (2023)	Monitory for trends

[3] New Jersey Drug and Alcohol Use Treatment, Substance Use Overview, 2023, Hunterdon

Table 4.1: CHIP Process Measures					
Priority	Metric	Data Source	Frequency	Baseline Establishment	Target
	admissions for alcohol as primary drug				
	Community awareness of substance use prevention programs, or community education campaigns about alcohol/ substance use risks initiatives	PFH program tracking	Annually	Establish baseline:	Baseline of existing programs established in YR1 Increased communication about existing programs in YR2 and YR3

CHIP Outcome Measures

Table 4.2: CHIP Outcome Measures					
Priority	Metric	Data Source	Frequency	Baseline Establishment	Target
Infrastructure	Percentage increase in community awareness and membership of PFH activities	PFH program tracking	Annually	Establish baseline:	
Social Isolation	Age-adjusted percentage of adults aged 18+ feeling socially isolated	BRFSS, CHNA data	Annually	Baseline: 30.6% (2022)	
Mental Health	Suicide rate (per 100,000)	NJ Vital Statistics, CHNA data	Annually	Baseline: 13.1 (2019-2023)	
	Percentage of residents with improved access to mental health services	CHNA Survey	Triennially	Establish baseline:	
	Age adjusted percentage of adults 18+ reporting poor mental health 14 or more days in the past 30 days	BRFSS, CHNA data	Annually	Baseline: 14.2% (2022)	
	Average poor mental health days per month	BRFSS, CHNA data	Annually	Baseline: 4.7 days (2022)	

Table 4.2: CHIP Outcome Measures					
Priority	Metric	Data Source	Frequency	Baseline Establishment	Target
Healthy Lifestyle	Percentage of birth sex male patients aged 20-40 seeking preventive care	NextGen EHR	Annually	Baseline: 58.15% (Dec 2025)	
	Percentage of Hispanic/Latino patients aged 40-64 seeking preventive care	NextGen EHR	Annually	Baseline: 68.04% (Dec 2025)	
	Percentage of patients aged 2-19 moving from no physical activity to higher levels	NextGen EHR	Annually	Baseline: 47.85% (Dec 2025)	
	Percentage of patients aged 2-19 with BMI in healthy weight range	NextGen EHR	Annually	Baseline: 69.36% (Dec 2025)	
	Age-adjusted adults aged 18+ with obesity	BRFSS, CHNA data	Annually	Baseline: 26.5% (2022)	
	Adult food insecurity rates	BRFSS, CHNA data	Annually	Baseline: 6.8% (2022)	
	Child food insecurity rates	NCES, CHNA data	Annually	Baseline: 3.0% (2022-2023)	
Substance Use	Percent of adult population reporting excessive drinking in past 30 days	BRFSS, CHNA data	Annually	Baseline: 21.4% (2022)	
	Youth vaping nicotine/THC rates (*past year*)	NJ YRBS[4], CHNA data	Annually	Baseline: 4.1% (2021)	
	Deaths of despair[5] per 100,000 population	CDC Wonder Statistics, CHNA data	Annually	Baseline: 36.6 (2019-2023)	
	Community perceptions of substance use risks	CHNA Survey	Triennially	Establish baseline:	

[4] NJ Middle School Risk and Protective Factors Survey: 2021 Hunterdon County Summary
[5] Suicide and drug/alcohol poisoning

Acknowledgements

The development of this CHIP represents the collective efforts of numerous community partners, organizations, and individuals who are dedicated to improving the health and wellbeing of Hunterdon County and the Service Area residents. This collaborative process was made possible through the strong foundation of the Steering Committee and the commitment of PFH and other stakeholders across healthcare, public health, education, social services, and community organizations.

We extend our sincere gratitude to all who participated in the CHNA data collection process, including the more than 570 community members and leaders who shared their insights through surveys, focus groups, and interviews. Their voices and perspectives were essential in identifying priority health needs and shaping the goals and strategies outlined in this plan.

Special recognition goes to the Action Team members who volunteered their time and expertise during the Phase II development process, and to all PFH members who provided ongoing input and feedback throughout the CHNA/CHIP development cycle.

Steering Committee

Name	Title	Organization
Kim Blanda	Director, Community Relations	Hunterdon Health
Karen DeMarco	Health Officer, Department Head	Hunterdon County Health Department
Andrea Drake	Manager, Population Health and Ambulatory Data Analytics	Hunterdon HealthCare Partners
Shu-Chen Chiang	Director of Nursing	Hunterdon County Health Department
Michele Menditto	Emergency Response Specialist/Health Education Risk Communicator	Hunterdon County Health Department
Gail Callahan	COVID-19 Social Service Coordinator	Hunterdon County Health Department
Christine Schwarz	COVID-19 Epidemiologist	Hunterdon County Health Department
Meredith Olson	COVID-19 Coordinator	Hunterdon County Health Department

Action Team Members

Mental Health Action Team

Name	Organization
Kristy Alfano	Hunterdon Health, COO
Cindy Barter	Hunterdon Health, Family Medicine Physician
Kim Blanda	Hunterdon Health
Kristin Bonham	Hunterdon County Health Department
John Celi	Center for Family Services
Jaclyn Connell	Family Promise
Mary Ann Desapio	Angel Essence Qi Gong LLC
Jan Downs	Hunterdon Health
Carol Dvoor	Safe Harbor
Rick Falkenstein	Kingwood Township School District
Angela Fields	Family Promise
Justin Francis	Lyons VA Medical Center
Stephen Goldman	Hunterdon County Superintendent's Office
Tanya Hart	Family Promise
Jennifer Harrison	Center for Family Services
Mary Hegyi	Hunterdon HealthCare Partners
Kristin Heimall	YMCA
Marlin Hernandez	Tri-County Care Management Organization (CMO)
Gregory Hobaugh	High Bridge Schools
Christine Huang	Hunterdon County Health Department
Tanya Kero	VA New Jersey Health Care System
Amanda Kovacs	Prevention Resources
Julianne Lucco	Hunterdon Health, Family Medicine Physician
Nicole Maniez	Jersey Community Acupuncture
Kari McGann	Flemington-Raritan School District
Kevin McPeek	Alexandria Township Schools

Name	Organization
Jordan Mealey	Ellie Mental Health of Central New Jersey
Shawna Mehall	Hunterdon HealthCare Partners
Monica Meyer-Schapiro	Hunterdon Health, Family Medicine Physician
Della Porzl	Hunterdon Behavioral Health
Roia Rafieyan	Flemington DIY, NAACP
Brooke Renkens	Catholic Charities
Elizabeth Roithmayr	American Foundation for Suicide Prevention
Nancy Russo	Tri-County Care Management Organization (CMO)
Robin Schneider	Hunterdon Health and Wellness Center
Wendy Sidebottom	Prevention Resources, Inc.
Corinne Steinmetz	Hunterdon Educational Services Commission
Alicia Stevenson	Community Member
Jessica Taaj	Hunterdon HealthCare Partners
Amy Torres-Valverde	One Voice
Penni Trionfo	Prevention Resources, Inc.
Nancy Tucker	One Voice
Natalia Vallejos	Center for Family Services
Karl Vonderheyde	Prevention Resources, Inc.
Bryan Welsh	American Foundation for Suicide Prevention
Barry Wolfson	Hypnosis Counseling Center
Andrew Zima	United Way of Hunterdon County
Gail Callahan	Hunterdon County Health Department

Healthy Lifestyle Action Team

Name	Organization
Janet Acosta-Hobschaidt	Hunterdon Health
Shauna Alvarez	America's Grow A Row
Philippe Beekman	Hunterdon Health
Kim Blanda	Hunterdon Health
Shu-Chen Chiang	Hunterdon County Health Department
Jeannie Colalillo	Shoprite of Hunterdon County
Andrea Drake	Hunterdon HealthCare Partners
Amanda Gerko	Prevention Resources, Inc.
Jeannine Gorman	Flemington Area Food Pantry
Kristen Heimall	YMCA
Jane Selitto	Zufall Health
Ricardo Kairjos	New Jersey Agricultural Experiment Station – Rutgers University
Kirsten McKee	Hunterdon Health
Meredith Olson	Hunterdon County Health Department
Bonnie Petrauskas	Hunterdon Health
Lisa Pitz	Center for Food Action New Jersey
Krithicka Raghunathan	Hand in Hand Healthcare Solutions
Beth Schwartz	Hunterdon County Health Department
Kim Seppelt	Zufall Health
Laura Tarlowski	Hunterdon County Health Department
Penni Trionfo	Prevention Resources, Inc.

Substance Use Action Team (PFH Drug Free Task Force)

Name	Organization
Lori Albanese	St. Mary's Abbey/Girl Scouts
Kim Blanda	Hunterdon Health
Todd Bonsall	Hunterdon County Polytech
Ed Brandt	Hunterdon Central Regional High School
Rich Broan	North Hunterdon-Voorhees High School District
Joseph Cavalchire	First Bank/Hunterdon Bears Hockey
Sarah Chittenden	Holland Township Schools, Student Assistant Counselor
Jean Ciullo	Prevention Resources, Inc.
Linda Cohen	OORP
Erin Cohen	Prevention Resources, Inc.
Jerri Collevechio	Safe Communities Coalition
Joy Costigan	Prevention Resources, Inc.
Dr. Greg Cottrell	North Hunterdon High School, Principal
Frank Crisologo	Hunterdon County Prosecutor's Office
James Crouse	Highpoint Partial Care
Jim Curry	Readington Police Department
Karen DeMarco	Hunterdon County Health Department, Health Officer
Kristen Deniz	Holland Township Schools, Student Assistant Counselor
Renata Denlinger	Prevention Resources, Inc.
Peggy Dowd	One Voice
Jose Figueroa	Prevention Resources, Inc.
Lynne French	North Hunterdon High School, Project Graduation Coordinator
Lesley Gabel	One Voice
Matteo Giles	Recovery Center Advocate

Name	Organization
Michael Golembiewski	Hunterdon Bears/Flemington Ice Owner
Brandon Griffiths	Readington Police Department
Danche Haralampieva	Prevention Resources, Inc.
Kristin Heimall	YMCA
Amy Hicks	Recovery Center Advocate
Christine Huang	Hunterdon County Health Department
Samantha Iraca	Hunterdon County Prosecutor's Office
Susan Jelvani	Hunterdon Health
Michael Kays	Delaware Valley High School, Principal
Tanya Kero	Department of Veterans Affairs
Amanda Kovacs	Prevention Resources, Inc.
Jennifer Leap	Holland Township Schools, Student Assistant Counselor
Laurie Livesey	Prevention Resources, Inc.
Nick Marcantuono	Safe Communities Coalition
Tyler Marcantuono	Prevention Resources, Inc.
Daniel Meara	Council on Compulsive Gambling
Meghan Moore	Harvest Success Center
Mary Noone-Kozakiewicz	Hunterdon County Library - North Branch
Cynthia Orsi-Kuhl	Flemington Elks
Norm Penney	One Voice
Kyle Perloff	Clinton Town Council
Christopher Phelan	Hunterdon County Chamber of Commerce
Richard Phelan	Town of Clinton
Sarah Pike	Hunterdon County Library, Teen Librarian
Kathy Powick	Prevention Resources, Inc.
Roia Rafieyan	Hunterdon DIY, NAACP
Maryjean Riou	Hunterdon County Library, Teen Librarian

Name	Organization
Allison Roberts	AMR Law/CRC
Justina Ryan	Media, Prevention Resources, Inc.
Joan Sabo	Hunterdon County Library, Public Relations and Outreach
Flor Sanchez	Latino Outreach Specialist
Christine Schwarz	Hunterdon County Health Department
Wendy Sidebottom	PFH Drug Free Task Force
Jennifer Slotterback	Flemington Area Food Pantry
Sandra Sparatta	Nurse, Hunterdon County Resident
Jeanne Swain	Council on Compulsive Gambling
Laura Talty	PFH Drug Free Task Force
Penni Trionfo	Harvest Success Center
Nancy Tucker	Mental Health Action Team
Karl Vonderheyde	Prevention Resources Inc., Community Wellness Center
Bryan Welsh	American Foundation for Suicide Prevention, Hunterdon Health
Emily Witkowski	Hunterdon County Library, Teen Librarian
DJ Wright	Wright & Ford Funeral Home, Max Challenge

Plan Consultants

The Steering Committee engaged a consulting partner, Ascendient Healthcare Advisors (Ascendient) for the creation of the 2026-2028 CHIP. Ascendient team members involved in the Hunterdon CHIP process included: Brian Ackerman, MHA, Partner; Chelsey Saari, DrPH, MPH, Manager; and Kristen Lewis, MPH, Consultant. To learn more about Ascendient Healthcare Advisors, please visit their website at www.ascendient.com.

Appendix 1: Strengthening & Sustaining PFH Infrastructure Action Plan

Throughout this Appendix, in the Measures of Success column there are symbols and color-coding used to indicate the origination of the stated metric. The following key has been provided to help readers easily identify the metric source(s). Some metrics have more than one source which are indicated through the symbols depicted below.

- *Hunterdon Health Community Benefit Metric (2026-2028)
- **CHNA Report Metric/Indicator
- ^PFH program or member agency-level metrics

Table A1.1: Strengthening and Sustaining Partnership for Health Infrastructure Action Plan			
Goal 1: PFH will enhance and sustain the Partnership's infrastructure by:			
Obj 1.1	**Forming a Data Advisory Committee/Group**		
	This will be accomplished by:		
	Activities	**Target Timeline**	**We will know we've been successful if: (Measure(s) of Success)**
	1. Developing an organizational structure, defining its purpose, and drafting a Committee Charter	By Dec 31, 2028	• A Draft Charter has been completed for Data Advisory Committee
	To do this, PFH can leverage and rely on:		
	Resources:	• PFH members' time	
	Organizations:	• PFH membership organizations, led by PFH Executive Committee	
Obj 1.2	**Forming a Senior Advisory Committee/Group**		
	This will be accomplished by:		
	Activities	**Target Timeline**	**We will know we've been successful if: (Measure(s) of Success)**

	1. Developing an organizational structure, defining its purpose, and drafting a Committee Charter	By Dec 31, 2028	• A Draft Charter has been completed for Senior Advisory Committee
	To do this, PFH can leverage and rely on:		
	Resources:	• PFH members' time	
	Organizations:	• PFH membership organizations, led by PFH Executive Committee	
Goal 2: PFH will improve community awareness of CHNA and CHIP-related activities by:			
Obj 2.1	**Communicating findings and activities resulting from the CHNA and CHIP to key leaders, partners, and community members.**		
	This will be accomplished by:		
	Activities	**Target Timeline**	**We will know we've been successful if: (Measure(s) of Success)**
	1. Establishing a communication strategy for PFH members to use when sharing information about CHNA and CHIP with different audiences	By Dec 31, 2027	• Communication strategy has been established for PFH
	To do this, PFH can leverage and rely on:		
	Resources:	• PFH members' time	
	Organizations:	• PFH membership organizations, led by PFH Executive Committee	
	2. Implementing PFH communication strategy	By Dec 31, 2027	• At least 1 communication activity from the communication strategy has been implemented by PFH members

			● There is increased awareness among key leaders, partners, and community members about the work of PFH, especially related to the CHNA/CHIP
	To do this, PFH can leverage and rely on:		
	Resources:	● PFH members' time, networks, and funding identification and obtention	
	Organizations:	● PFH membership organizations, led by PFH Executive Committee	

Appendix 2: Social Isolation Action Plan

Throughout this Appendix, in the Measures of Success column there are symbols and color-coding used to indicate the origination of the stated metric. The following key has been provided to help readers easily identify the metric source(s). Some metrics have more than one source which are indicated through the symbols depicted below.

- *Hunterdon Health Community Benefit Metric (2026-2028)
- **CHNA Report Metric/Indicator
- ^PFH program or member agency-level metrics

Table A2.1: Social Isolation Action Plan

Goal 1: PFH will address social isolation in the Hunterdon Service Area by:			
Obj 1.1	**Improving community connectedness and sense of belonging for all residents.**		
	This will be accomplished by:		
	Activities	**Target Timeline**	**We will know we've been successful if: (Measure(s) of Success)**
	1. Improving social isolation screening for **priority populations**	By Dec 31, 2028	• Increased percentage of **patients age 65 and above** with a NextGen electronic health record in the primary care setting who are screened for social isolation*
	To do this, PFH can leverage and rely on:		
	Resources:	• NextGen electronic health records • Hunterdon Health staff time and commitment to implementing screening	
	Organizations:	• Hunterdon Health	
	2. Promoting, expanding, and/or removing barriers to existing community resources	By Dec 31, 2028	• Increased community awareness and utilization of existing resources focused on connecting people to other people • Expanded access to community resources focused on connecting people to other people • Reduced barriers to existing community resources focused on connecting people to other people • Reduced social isolation**

	To do this, PFH can leverage and rely on:		
	Resources:	● PFH members' time, networks, and funding identification and obtention	
	Organizations:	● PFH membership organizations, led by PFH Executive Committee	
	3. Developing and implementing new programs, services, and/or initiatives when possible	By Dec 31, 2028	● Identified gaps in programs, services, and/or initiatives for facilitating community connectedness and belonging ● New programs, services, or initiatives implemented to improve community connectedness and belonging ● Reduced social isolation**
	To do this, PFH can leverage and rely on:		
	Resources:	● PFH members' time, networks, and funding identification and obtention	
	Organizations:	● PFH membership organizations, led by PFH Executive Committee	

Appendix 3: Mental Health Action Plan

Throughout this Appendix, in the Measures of Success column there are symbols and color-coding used to indicate the origination of the stated metric. The following key has been provided to help readers easily identify the metric source(s). Some metrics have more than one source which are indicated through the symbols depicted below.

- *Hunterdon Health Community Benefit Metric (2026-2028)
- **CHNA Report Metric/Indicator
- ^PFH program or member agency-level metrics

Table A3.1: Youth Mental Health Services Action Plan			
Goal 1: PFH will address mental health needs in the Hunterdon Service Area by:			
Obj 1.1	**Increasing access to mental healthcare for residents experiencing barriers.**		
	This will be accomplished by:		
	Activities	**Target Timeline**	**We will know we've been successful if: (Measure(s) of Success)**
	1. Improved depression screening for **priority populations**	By Dec 31, 2028	• Increased percentage of patients **age 65 and above** in the primary care setting who have been screened for depression and if positive have a plan to address depression within the last 12 months* • Increased percentage of **adolescent patients age 12 through 19** in the primary care setting who have been screened for depression and if positive have a plan to address depression within the last 12 months*
	To do this, PFH can leverage and rely on:		
	Resources:	• NextGen electronic health records • Hunterdon Health staff time and commitment to implementing screening	
	Organizations:	• Hunterdon Health	
	2. Promoting, expanding, and/or removing barriers to	By Dec 31, 2028	• Increased percentage of patients **age 65 and above** in the primary care setting who have been screened for depression and if positive have a plan to address depression within the last 12 months*

	existing community resources		• Increased percentage of **adolescent patients age 12 through 19** in the primary care setting who have been screened for depression and if positive have a plan to address depression within the last 12 months* • Increased access to and utilization of existing mental health services** • Improved mental health outcomes metrics**
	To do this, PFH can leverage and rely on:		
	Resources:	• NextGen electronic health records • Hunterdon Health staff time and commitment to establishing plan • PFH members' time, networks, and funding identification and obtention	
	Organizations:	• Hunterdon Health • PFH membership organizations led by the Mental Health Workgroup	
	3. Developing and implementing new programs, services, and/or initiatives when possible.	By Dec 31, 2028	• Identified gaps in programs, services, and/or initiatives for addressing mental health concerns • New mental health-related programs, services, and/or initiatives implemented to improve access and improve outcomes • Improved mental health outcomes metrics**
	To do this, PFH can leverage and rely on:		
	Resources:	• PFH members' time, networks, and funding identification and obtention	
	Organizations:	• PFH membership organizations, led by the PFH Mental Health Workgroup	
Obj 1.2			
	Increasing access and reducing barriers to programs, services, and community resources that support mental wellness.		
	This will be accomplished by:		
	Activities	**Target Timeline**	**We will know we've been successful if: (Measure(s) of Success)**
	1. Promoting, expanding, and/or	By Dec 31, 2028	• Increased access to and utilization of existing mental health services**

	removing barriers to existing community resources		● Improved mental health outcomes metrics**
	To do this, PFH can leverage and rely on:		
	Resources:	● PFH members' time, networks, and funding identification and obtention	
	Organizations:	● PFH membership organizations, led by the PFH Mental Health Workgroup	
	2. Developing and implementing new programs, services, and/or initiatives when possible.	By Dec 31, 2028	● Identified gaps in programs, services, and/or initiatives for addressing mental health concerns ● New mental health-related programs, services, and/or initiatives implemented to improve access and improve outcomes ● Improved mental health outcomes metrics**
	To do this, PFH can leverage and rely on:		
	Resources:	● PFH members' time, networks, and funding identification and obtention	
	Organizations:	● PFH membership organizations, led by the PFH Mental Health Workgroup	

Appendix 4: Healthy Lifestyle Action Plan

Throughout this Appendix, in the Measures of Success column there are symbols and color-coding used to indicate the origination of the stated metric. The following key has been provided to help readers easily identify the metric source(s). Some metrics have more than one source which are indicated through the symbols depicted below.

- *Hunterdon Health Community Benefit Metric (2026-2028)
- **CHNA Report Metric/Indicator
- ^PFH program or member agency-level metrics

Table A4.1: Healthy Lifestyle Action Plan

Goal 1: PFH will address healthy lifestyle in the Hunterdon Service Area by:

Obj 1.1 — **Increasing prevention, early detection, and/or management of chronic disease.**

This will be accomplished by:

Activities	Target Timeline	We will know we've been successful if: (Measure(s) of Success)
1. Provision of culturally competent chronic disease screening for **priority populations**	By Dec 31, 2028	• Increased percentage of **LGBTQ+ patients age 40 - 74** in the primary care setting who have had a breast cancer screening in the last 24 months* • Increased percentage of **Hispanic/Latina patients age 40 - 74** in the primary care setting who have had a breast cancer screening in the last 24 months* • Improved screening for other chronic disease conditions impacting the Service Area

To do this, PFH can leverage and rely on:

Resources:	• NextGen electronic health records • Hunterdon Health staff time and commitment to implementing screening • Chronic disease screening tools, programs, and services available in the Service Area
Organizations:	• Hunterdon Health • PFH membership organizations led by the Healthy Lifestyles Workgroup

	2. Promoting, expanding, and/or removing barriers to existing community resources	By Dec 31, 2028	• Increased percentage of **LGBTQ+ patients age 40 - 74** in the primary care setting who have had a breast cancer screening in the last 24 months* • Increased percentage of **Hispanic/Latina patients age 40 - 74** in the primary care setting who have had a breast cancer screening in the last 24 months* • Improved screening for other chronic disease conditions impacting the Service Area • Improved chronic disease health outcomes metrics**
	To do this, PFH can leverage and rely on:		
	Resources:	• NextGen electronic health records • Hunterdon Health staff time and commitment to implementing screening • Chronic disease screening tools, programs, and services available in the Service Area • Evidence-based practices and funding to expand existing screening programs and services	
	Organizations:	• Hunterdon Health • PFH membership organizations led by the Healthy Lifestyle Workgroup	
	3. Developing and implementing new programs, services, and/or initiatives when possible.	By Dec 31, 2028	• Increased percentage of **LGBTQ+ patients age 40 - 74** in the primary care setting who have had a breast cancer screening in the last 24 months* • Increased percentage of **Hispanic/Latina patients age 40 - 74** in the primary care setting who have had a breast cancer screening in the last 24 months* • Identified gaps in chronic disease screening programs, services, and/or initiatives • New chronic disease screening programs, services, and/or initiatives implemented to improve access and improve outcomes • Improved chronic disease health outcomes metrics**
	To do this, PFH can leverage and rely on:		

	Resources:	• NextGen electronic health records • Hunterdon Health staff time and commitment to implementing screening • Evidence-based practices for new chronic disease screening tools, programs, and services in the Service Area	
	Organizations:	• Hunterdon Health • PFH membership organizations led by the Healthy Lifestyle Workgroup	
Obj 1.2	**Increasing access and reducing barriers to programs, services, and community resources that support healthy lifestyle choices and habits.**		
	This will be accomplished by:		
	Activities	**Target Timeline**	**We will know we've been successful if: (Measure(s) of Success)**
	1. Provision of culturally competent SDOH screening for **priority populations**	By Dec 31, 2028	• Increased awareness and screening for "food insecurity" documented at least once in the past 12 months, in the electronic health record (NextGen), in the primary care setting, for **patients age 30–64*** • Increased awareness and screening for "food insecurity" documented at least once in the past 12 months, in the electronic health record (NextGen), in the primary care setting, for **patients age 65 and above***
	To do this, PFH can leverage and rely on:		
	Resources:	• NextGen electronic health records • Hunterdon Health staff time and commitment to implementing screening	
	Organizations:	• Hunterdon Health	
	2. Promoting, expanding, and/or removing barriers to existing community resources	By Dec 31, 2028	• Increased percentage **of birth sex male patients age 20-40** in the primary care setting who seek preventive care within the last 12 months* • Increased percentage of **Hispanic/Latino patients, age 40-64** in the primary care setting who seek preventive care within the last 12 months*

			• Increased awareness of, access to and utilization of existing recreation spaces**^ • Increased percentage of **patients age 2-19 in our primary care practices** who move from no physical activity to a higher level of activity documented in their electronic medical record in NextGen as medium or high* • Increased percentage of **patients age 2-19 in primary care practices** with records in NextGen, with a BMI in the healthy weight range within the past 12 months* • Increased awareness of, access to, and utilization of existing food pantries and like entities **^ • Expanded capacity for existing healthy lifestyle programs, services, and initiatives tailored to meet the needs of priority populations, as appropriate^ • Improved healthy lifestyle/behavior metrics**
	To do this, PFH can leverage and rely on:		
	Resources:	• PFH members' time, networks, and funding identification and obtention	
	Organizations:	• PFH membership organizations led by the Healthy Lifestyle Workgroup	
	3. Developing and implementing new programs, services, and/or initiatives when possible.	By Dec 31, 2028	• Identified gaps in healthy lifestyle programs, services, and/or initiatives • Newly implemented healthy lifestyle programs, services, and initiatives tailored to meet the needs of priority populations • Improved healthy lifestyle/behavior metrics**
	To do this, PFH can leverage and rely on:		
	Resources:	• PFH members' time, networks, and funding identification and obtention	
	Organizations:	• PFH membership organizations led by the Healthy Lifestyle Workgroup	

Appendix 5: Substance Use Action Plan

Throughout this Appendix, in the Measures of Success column there are symbols and color-coding used to indicate the origination of the stated metric. The following key has been provided to help readers easily identify the metric source(s). Some metrics have more than one source which are indicated through the symbols depicted below.

- *Hunterdon Health Community Benefit Metric (2026-2028)
- **CHNA Report Metric/Indicator
- ^PFH program or member agency-level metrics

Table A5.1: Substance Use Action Plan

Goal 1: PFH will address substance use in the Hunterdon Service Area by:			
Obj 1.1	**Increasing access and reducing barriers to prevention, intervention, and treatment for substance use disorders.**		
	This will be accomplished by:		
	Activities	**Target Timeline**	**We will know we've been successful if: (Measure(s) of Success)**
	1. Improved substance use screening for **priority populations**	By Dec 31, 2028	• Maintained percentage of **patients age 13 and above** being screened for vaping nicotine/THC in the past 24 months in our electronic health record (NextGen)*
	To do this, PFH can leverage and rely on:		
	Resources:	• NextGen electronic health records	

			• Hunterdon Health staff time and commitment to implementing screening • Other substance use screening tools, programs, and services in the Service Area • Evidence-based practices for new substance use screening tools, programs, and services in the Service Area
	Organizations:		• Hunterdon Health • PFH membership organizations led by the Healthy Lifestyle Workgroup
	2. Promoting, expanding, and/or removing barriers to existing community resources	By Dec 31, 2028	• Increased awareness of, access to, and utilization of existing or expanded substance use early intervention programs and treatment services • Implemented substance use prevention programs, services, and initiatives tailored to meet the needs of priority population groups in the Service Area • Improved substance use health outcomes metrics**
	To do this, PFH can leverage and rely on:		
	Resources:		• PFH members' time, networks, and funding identification and obtention
	Organizations:		• PFH membership organizations led by the Substance Use Workgroup (DFTF)
	3. Developing and implementing new programs, services, and/or initiatives when possible.	By Dec 31, 2028	• Implemented new substance use prevention programs, services, and initiatives tailored to meet the needs of priority population groups in the Service Area • Improved substance use health outcomes metrics**
	To do this, PFH can leverage and rely on:		
	Resources:		• PFH members' time, networks, and funding identification and obtention
	Organizations:		• PFH membership organizations led by the Substance Use Workgroup (DFTF)
Obj 1.2	**Changing community attitudes, social normalization, and perceived health risks associated with alcohol use, marijuana/THC use, and vaping nicotine/THC**		

This will be accomplished by:		
Activities	**Target Timeline**	**We will know we've been successful if: (Measure(s) of Success)**
1. Screening of community attitudes toward alcohol, marijuana/THC, and vaping nicotine/THC	By Dec 31, 2028	• Data about community attitudes, normalization, and perceived health risks gathered
To do this, PFH can leverage and rely on:		
Resources:	• PFH members' time, networks • Evidence-based data collection tools, processes, approaches	
Organizations:	• PFH membership organizations led by the Substance Use Workgroup (DFTF)	
2. Promoting, expanding, and/or removing barriers to existing community resources	By Dec 31, 2028	• Increased community knowledge about the link between alcohol use and cancer and disease risk through community programs and campaigns* • Shifted community attitudes and perceptions regarding health risks and normalization of alcohol, marijuana, and vaping nicotine/THC
To do this, PFH can leverage and rely on:		
Resources:	• PFH members' time, networks, and funding identification and obtention	
Organizations:	• PFH membership organizations led by the Substance Use Workgroup (DFTF)	
3. Developing and implementing new programs, services, and/or initiatives when possible.	By Dec 31, 2028	• Increased community knowledge about the link between alcohol use and cancer and disease risk through community programs and campaigns* • Shifted community attitudes and perceptions regarding health risks and normalization of alcohol, marijuana, and vaping nicotine/THC
To do this, PFH can leverage and rely on:		

	Resources:	● PFH members' time, networks, and funding identification and obtention
	Organizations:	● PFH membership organizations led by the Substance Use Workgroup (DFTF)