RWJF Grant ID # 32010

Grantee Organization: The Gateway Family YMCA

Organization Address: 144 Madison Avenue, Elizabeth NJ 07201

Project Title: Healthy Connected Community

Date Submitted: May 13, 2016

Project Director: Alane McCahey

Taste Tasting Nutrition Education City Hall Employees
Healthy Connected Community

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ELIZABETH - A HEALTHY CONNECTED COMMUNITY

Shaping Elizabeth (SE) (CHI) is a team composed of likeminded community leaders committed to improving the health and well-being of the residents of the City of Elizabeth by creating sustainable change to policies and the environment through strategies that support improved health, nutrition and physical activity for all.

Since its inception in 2013 the Shaping Elizabeth Team has been working to improve the health and well-being of the residents of Elizabeth, NJ. Our first community forum asked the question “Why should your zip code determine your health”? Since asking that question health equity has been our focus.

Experiencing both the Boundary Spanning Creative Leadership Training and coaching from County Health Ranking and Roadmaps Coach we have expanded our scope from improving healthy eating and increasing physical activity & broadened to Health Outcomes including Health Behaviors, Clinical Care, Social & Economic Factors and Physical Environment, including land and housing conditions. We will focus on evidence based systems and strategies which impact health equity to reduce the prevalence of obesity and chronic disease.

SE focuses on 3 local communities with strategies for healthy families and children in Elizabeth – Bayway, Elizabethport and Midtown. SE has strong committed partners from many sectors of the community including health education, education, public health, hospital, clinical care, non-profits, policy makers and local community leaders. We understand that we need to broaden our team to include some key partners including local business, faith based and private health practitioners. In addition we work within local, county and state coalitions to be able to influence change on all levels. We are collecting baseline city data as well as county data to create Bold Actions to impact the health factors that contribute to healthy individuals living longer lives.

We will collect the following data for measurement:

Preliminary Base Line Data:

Collect data from residents of Mrvalag Manor and Hope 6 using survey and data collection tools at Health Fairs, Mobile Market, and Community Meetings.
Trinitas Hospital Community Needs Assessment and Emergency Department and hospital admissions.
Union County Rankings Data

Mrvalag Manor – 1000 residents
Hope 6 - 560 residents
Proceed – Serves XX
YMCA – Serves all of Elizabeth

1. Obesity – Reduce by % # of adults with BMI >30
2. Healthy Eating – Increase % of residents that consume >3 servings of fresh fruits and vegetables per day (Through surveys of housing residents baseline
3. Increase by % of residents who get a minimum of 90 minutes of physical activity per week -
4. Increase % of adults with insurance
5. Increase % of residents with a primary care physician
6. Reduce % of population that is a smoker
7. Reduce the % of adults with High Blood Pressure
8. Reduce the % of adults diagnosed with Diabetes

Once data is collected we will indicate % of change in year 1, year 2, year 3.

Jewish Family Services of Central New Jersey is also conducting a survey of Elizabeth residents over 55 years of age to get their opinions on their perception of their quality of life in Elizabeth and improvements that they recommend to improve the quality of services. Many of the issues addressed in the survey have a direct impact on the health of the City’s aging population. This effort is part of the Lifelong Elizabeth initiative being supported by the Grotta Fund and Taub Foundation. The results of these surveys should be available by June of 2016 and will be helpful to the Shaping Elizabeth planning effort.

In the past year we have impacted the community in the following ways:

- Monthly Mobile Market began March 2016 in 2 months served over 600 residents of M rvalag Manor, a low income housing facility. Over 40,000 pounds of food was delivered and distributed with partners from Community Food Bank NJ, HACE, YMCA, City of Elizabeth, Trinitas RMC, Bayway Family Success Center.
- Nutrition Education – In September 2015 a nutritionist was hired through a grant. 152 people have received nutrition education through partner organizations. Through pre and post surveys people have reported changes in the way they purchase prepare and consume nutrition. Over 30 community organizations have been contacted for future education.
- 2015 3 playstreets serving 450 people to increase physical activity. Partners included City of Elizabeth, YMCA, Council People, WellCare and several others.
- In 2015 8 Work Group Meetings with 18-25 people each planned and implemented projects in the community. In 2016 3 work group meetings were held and Charts of Work Developed and implementation beginning.
- 2015-16 over 18 Executive Committee Meetings were held to plan direction and alignment of team.
- 2015-2016 NJHI Teams attended 4 days of training and conducted many conversations, meetings and a retreat to help define direction, alignment and commitment.
- January 2016 1 Executive Committee Retreat with 11 of 13 partners in attendance to define boundaries and discuss alignment, commitment and direction. 2 task force teams were developed to define organization and identify possible additions to the team.
- April 2016 added one new member of EC – a pediatrician with a practice in Midtown Elizabeth with a focus on childhood obesity.
- Two health fairs at M rvalag Manor offering screenings, education and resources to over 100 people at each event.
- YMCA’s Diabetes Prevention Program through YUSA grant can serve Medicaid recipients at no cost. We have been building relationships with Federally Qualified Health Center and other agencies to identify and serve this population.
- March 2016 the City of Elizabeth partnered with the YMCA, Rutgers Cooperative Extension and Trinitas, RMC to offer a Women’s Wellness Day. Approximately 75 women participated and received free breast cancer, blood pressure and glucose screenings as
well as a day filled with fun active, educational experiences. The Health & Wealth program, designed and delivered by Dr. Karen Ensle, Rutgers Cooperative, received high reviews and indicates this may be a need for the community.

- Developed Shaping Elizabeth Facebook page to enhance community communication. Currently we have grown to 148 likes and have reached thousands of people.

The Elizabeth Community is a strong, historic community in Union County. Union County is ranked 11th in the County Health Rankings. Elizabeth is a diverse low economic community, with lower % then county rankings for Children in poverty, Median Household Income, Uninsured adults and Unemployment and higher % in obesity, diabetes and children eligible for free and reduced lunch. In order to combat health equity concerns SE is determined to work across lines and established patterns to provide resources and changes that will help people adapt and change within their own environment to make the healthy choice not only the easy choice but the preferred choice.

Our Roadmap for Action reflects the work of our SE Executive Team and Work Groups as well as the actions of organizations in their areas of expertise. Our focus will begin with small communities within each target area – City of Elizabeth (HACE); Low Income Housing Communities connected to Family Success Centers as well as community based organizations which serve many residents. Imperative for success is the development of a Community Advisory Team, Marketing Program and Financial Sustainability Plan.

We will build trust and relationships with residents by providing monthly healthy food distributions in partnership with Community Food Bank, NJ as well as health fairs, playstreets, workshops and social media information. We will determine additional needs, through surveys and focus groups with residents which will allow us to focus on areas of concern in health behaviors, clinical care, social & economic and the physical environment utilizing the strengths of our current partners such as Trinitas, RMC, the YMCA, Proceed, Inc., Rutgers Cooperative Extension, City of Elizabeth, United Way and the new partners we will identify as steps in our plan. Each housing area will become the “hub” from which we will extend our reach into the community in small concentric circles from the housing and FSC’s. In addition, we will pinpoint: Schools, corner stores, food pantries, farmers markets, clinics, medical support, WIC/Snap Stores, parks etc. in order to impact the overall health & wellness of the entire community.

Our plan also outlines how we will continue our efforts to increase physical activity, improve access to clinical care, reduce BMI, reduce Diabetes, Reduce Aids and impact school wellness. Each section of our Roadmap will be coordinated by one of our NJHI team members as well as members of our Executive Team. Our strong organizational structure supports collective impact through a common agenda, shared measurement, shared leadership and resources. Strong project management from The Gateway Family YMCA will continue to be the “backbone” organization providing leadership, administrative and fiduciary support for the team.

Tools for data collection with collective input will be developed for measuring impact based on the roadmap. Goggle Drive will be used in order to facilitate team members recording data in a timely basis.

SE is committed to impacting the Elizabeth Community for improved health outcomes leading to longer and healthier lives. This roadmap will provide us with a starting point which will be
accessed annually and redefined as we develop a better understanding of the needs of the residents of Elizabeth.

**Shaping Elizabeth Partners**

Executive Committee (EC)
The Gateway Family YMCA
Trinitas Regional Medical Center
City of Elizabeth
Groundwork Elizabeth
Rutgers Cooperative Extension
United Way
Proceed, Inc.
Housing Authority of Elizabeth
Community Food Bank of NJ
Meija Pediatrics (new partner)

**Work Group (In addition to EC)**

Elizabeth Public Schools
Shaping Elizabeth Nutritionist
Bayway Family Success Center
Prevention Links
Wellcare Health Plans
EatWell, Inc.
YWCA of Union County
Jewish Family Services
Elizabeth Health Center
Planned Parenthood
Community Coordinated Child Care

**Additional Collaborative Efforts Include:**

- North Jersey Health Collaborative Participant and Chair of Obesity Task Force – Focus Early Childhood Obesity reduction to impact High Pre-School Obesity Rates.
- Jewish Family Services - “Lifelong Elizabeth” impacting 55 and older for healthy living.
- City of Elizabeth – Green Team – Sustainable NJ
- NJ YMCA Alliance – Healthy Communities Network
HEALTH OUTCOMES - Improve Health Equity for the residents of Elizabeth by reducing obesity and chronic disease leading to longer lives with improved quality of life. (Over Arching Strategy).

We will focus on Hispanic & African American low income adults and children residing in 3 target areas of Elizabeth: Midtown, Elizabethport and Bayway. Our priorities will include increasing consumption of healthy foods, increasing physical activity, improving clinical care through shifting focus on intervention (already sick) to prevention. We will support families to improve economic environment in Elizabeth and provide educational experiences with a focus on health related issues. Will support an environment to assist in healthy changes within the individual’s current environment.

OVERALL GOAL: To intentionally engage community stakeholders in order to have a positive impact on Health Outcomes in all areas: Health Behaviors, Clinical Care, Social & economic & physical environment

<table>
<thead>
<tr>
<th>Bold Steps (Objectives)</th>
<th>Development of Community Advisory Team, Expansion of Executive Team to improve health outcomes through understanding needs and adapting to current realities which will support our ability to improve Health Outcomes in Elizabeth.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage the community, local press and stakeholders with our NJHI Roadmap for improving health equity in order to improve awareness of SE’s mission, vision, goals &amp; objective in order to improve health equity in Elizabeth</td>
<td>Develop a community recruitment plan to engage stakeholders within the community. Develop onboarding of new member's format &amp; create pathway for new organizations to join. Align with Shaping Elizabeth Mission, Vision, Norms and Structure.</td>
</tr>
<tr>
<td>Community Advisory Team will be developed with community stakeholders. SE Exec. Team will focus on areas not currently engaged to improve Social &amp; Economic Factors &amp; Physical Environment</td>
<td>Develop Benchmarks to determine measurements for success for Roadmap. Collect data. Develop tools to share data with team members and the community (Communication Plan).</td>
</tr>
<tr>
<td>Be seen in the community as a premier organization which promotes health equity through collaborations</td>
<td>Discuss and develop a plan for financial sustainability plan and budget.</td>
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Indicators of Success by 2019

- 50% of Elizabeth residents will be aware of SE
- 40% of residents in pilots will report that their overall health and well-being has improved
- Data will indicate improvement in health behaviors categories.
- SE Facebook Page will exceed 1500 likes from 149
- Media coverage for improved health outcomes will appear monthly in Elizabeth Social media and press coverage
- Identify missing partners in line with County Health Rankings and Roadmaps. Effective tools will be developed for recruitment outlining mission, goals, and achievements:
  - Power points
  - Media documents
  - Onboarding questionnaire
  - Process in place for invitation to team
- An Executive Community Advisory Team with 10-12 people representing with 3 representatives and 3 at-large members meet quarterly to review SE direction and give recommendations to SE Exec Team. Each target community will have teams of stakeholder meeting to discuss concerns for health & wellbeing. Focus groups formed as needed. Executive team will have representation from all areas as defined by roadmaps wheel.
- Develop yearly objective measurable with indicators for success. Goals will be measured annually against plan.
- Measurement will be shared through “google” docs for easy access by team members. Annual results will be shared with community through social media and public documents
- Organizations will contact collaborative for partnering and support and to join.
- Annual budgets will be developed to support plan and funding will be secured for implementation.
Program: TGFYMCA/Shaping Elizabeth/RWJF/NJHI ID #32010 Logic Model

Situation: High Incidence of Obesity and Chronic Disease (Diabetes, Heart Disease) in Elizabeth Target Areas Midtown, Bayway, Elizabethport

Solution: Achieve large scale change through Collective Impact Model with a focus on target areas through pilot programs and community input reduce BMI, incidence of diabetes, high blood pressure, smokers and increase access to fresh fruits and vegetables, primary care physicians, physical activity in order to lower obesity and chronic disease.

We will focus on Hispanic & African American low income adults and children residing in target areas by intentionally engaging stakeholders in order to have a positive impact on Health Outcomes with a focus on reducing obesity and chronic disease by impacting, health behaviors, and clinical care, social & economic & physical environment.

Inputs

Activities

- Engage the community, local press, and stakeholders.
- Develop community recruitment plan for Community Advisory Team and Executive Committee
- Plan for financial sustainability

Outputs

Participation

- Residents
  - YMCA
  - FQHC
  - Trinitas
  - EPIN
  - Proceed
  - Rutgers
  - Cooperative
  - Extension
  - Groundwork
  - Elizabeth
  - Elizabeth Public Schools
  - SE Work Group Teams

Planned for financial sustainability

Short Year 1&2

- Media Event Introducing SE “Roadmap” to Community
- Develop plan for engaging community members for Community Advisory Teams

Outcomes

Medium Year 3&4

- Recruitment plan developed identifying stakeholders missing from team and support stakeholders
- Community Advisory Team developed with representation from target communities
- Discuss and develop strategy for financial sustainability with SE Exec team
- Data Collection and impact measurements developed

Long Year 5

- Annual media event sharing results and next phase of impact. Results shared with funders and the community
- Community Advisory Team will meet quarterly to review SE, Exec. Team strategy and give input.
- SE Exec. Team will have representation from business, school, and medical community
- Onboarding plan instituted for Work Group members and Exec. Team.
- Yearly SE budget developed by team and strategy for funding developed and implemented. All members of team track results in centralized shared documents

Media Event Introducing SE “Roadmap” to Community

Resident

YMCA

FQHC

Trinitas

EPHN

Proceed

Rutgers

Cooperative

Extension

Groundwork

Elizabeth

Elizabeth Public Schools

SE Work Group Teams

Survey developed using measurements for change
Survey distributed at mobile market, health fairs, within community organizations in 7-16-6/17 for baseline data.

Collection local data on: BMI Consumption of fruits and vegetables, minutes of PA.

% insurance and PMCP, % smoker, & high blood pressure, % diabetes

SE Nutritionist

HACE

Proceed

YMCA

Trinitas

FQHC

EPHN

Can document changes to BMI, healthy eating, diabetes, high blood pressure, increased PA, smoking cessation in pilot groups.

Inputs

Activities

Participation

Outputs

Outcomes

Short Year 1&2

Medium Year 3&4

Long Year 5
Assumptions
Residents of Elizabeth are not eating healthy diets, not physically active, have high incidence of chronic disease.
Due to socio economic, education, access and awareness
Data – Union County Rankings, Trinitas, RMC Health Assessment, Anecdotal Data and Hospital ED data,

External Factors
Cost and Access of Health Foods
Time
Knowledge
Single Parent Homes
High Stress
High Drug and Alcohol Use
Page 2 ID#32010 Health Outcome - Improve Health Equity for the residents of Elizabeth by reducing obesity and chronic disease leading to longer lives with improved quality of life.

Clinical Care (Access to Care, Quality of Care) 2016 Trinitas, RMC Health Assessment indicates that 30.7% of adults in Elizabeth are uninsured, emergency room visits 45% are uninsured or on Medicaid. Patients present with diabetes, heart disease and metabolic disorders and complications.

We will focus on adults and children residing in 3 target areas of Elizabeth: Midtown, Elizabethport and Bayway. Our priorities will include, improving clinical care, access to the healthcare system, and increased screenings.

OVERALL GOAL: OVERALL GOAL: To improve access and clinical care to the residents of Elizabeth

Bold Steps (Objectives): Use of the Trinitas Community Advisory Council to understand the needs of the community and target interventions in pilot communities.

Complete share and analyze community needs assessment (CAN) by the Advisory team.

Identify and engage partner organizations to assist in the Trinitas Community Advisory Council implementation plan.

Continue to develop community paramedic program (CPP) to act as a bridge and resource to get appropriate care to residents in pilot communities.

Engage funders that are interested in expanding services to different sectors of the community.

Indicators of Success by 2019

Community Needs Assessment action plan developed with priority areas and partner support.

Partners are identified to provide services or interventions as outlined in plan. Engage with 2-3 new partners.

CPP will extend its reach to the families in HACE in Bayway and Elizabethport focusing on individuals using ED or admissions.

3 health fairs serving 100 people in pilot areas providing screenings and education with partners.

2-3 funders identified to support specific needs from CAN.
Access to Clinical Care, Quality of Care Program: Shaping Elizabeth/RWJF/NJHI ID#32010 Logic Model

Situation: The 2016 Trinitas, RMC Health Assessment has reported that 30.7% of adults in Elizabeth are uninsured. Of emergency department (ED) visits 45% are uninsured or on Medicaid. Patients present with diabetes, heart disease and metabolic disorders to ED.

Solution:

The Trinitas Community Advisory Council (CAC) will work to understand the needs of the community and develop targeted intervention to pilot groups in Bayway, Midtown and Elizabethport.

Complete, share and analyze Community Needs Assessment.

Identify and engage with partner organization develop intervention plan.
Create partnerships with other health organizations to extend reach of services.

Continue to develop community paramedic program (CPP) to act as a bridge and resource to get appropriate care to residents.
Have 3 health fairs per year one in each geographic area.

Engage funders that are interested in expanding services to targeted sectors of the community.

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Outputs</th>
<th>Participation</th>
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<tbody>
<tr>
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<td>Activities</td>
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<th>Short 1&amp;2</th>
<th>Medium 3&amp;4</th>
<th>Long 5</th>
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<tbody>
<tr>
<td>Community Needs Assessment Action Plan developed with priority areas.</td>
<td>Partners are identified to provide interventions as outlined in plan. New partner are identified and approached. 2-3 new partners will be engaged.</td>
<td>TBD</td>
</tr>
<tr>
<td>CPP will extend its reach to the families in HACE in Bayway and Elizabethport providing services to residents who use ED or admitted for follow up. 3 health fairs serving 100 people in pilot areas. Providing as needed screenings and information’s</td>
<td>10% more residents will have health care with lowered incidence of ED visits for diabetes and heart related concerns</td>
<td>TBD</td>
</tr>
<tr>
<td>2-3 funders identified to support specific needs from CAN.</td>
<td>TBD</td>
<td>TBD</td>
</tr>
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Assumptions
Residents of are using ED as primary care and intervention when sick. Lack of primary care physicians leads to less preventative care. Diabetes and Heart Disease can be reduced through increased access to preventative care.

External Factors
Low % of insured residents
Low access to primary care
ED is seen as the primary clinical care option.
**Page 3 ID# 32010 Health Outcome - Improve Health Equity for the residents of Elizabeth by reducing obesity and chronic disease leading to longer lives with improved quality of life.**

Health Behavior (Diet & Exercise) Reduce obesity through increased **physical activity** for residents in target areas with a focus on residents living in HACE areas and surrounding community and residents receiving series from community based organization such as the YMCA, Proceed, Inc. etc.

**Bold Steps (Objectives) to provide families/individuals with tools, access, monitoring and support in order to increase physical activity**

**OVERALL GOAL:** Engage residents in programming designed to increase physical activity to decrease incidences of obesity and chronic health conditions by providing access to tools for monitoring, access to fitness and encouraging walking.

<table>
<thead>
<tr>
<th>Educate and engage individuals in fitness plans including free access to fitness programs and facilities</th>
<th>Provide individual support in order to track fitness and knowledge of levels of activity with a focus on increased walking.</th>
<th>Health care providers will “prescribe” walking to reduce obesity and improve overall health.</th>
<th>Engage school board and public schools to add 30-60 minutes of activity daily to wellness plan and develop a plan implement through recess, PE, to and from school and classroom activates.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better understand barriers to activity in pilot areas through data collection.</td>
<td>With community advisory team develop solutions to barriers.</td>
<td>Engage City Planners to consider “health” and walking safety in planning efforts.</td>
<td>Facilitate events focused on physical activity in Schools and community.</td>
</tr>
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**Indicators of Success by 2019 –** Increased participation in physical activity to reduce obesity and related chronic disease diagnosis. Residents will know and understand benefits of fun physical activity. Public facilities will have increased usage and residents will be healthier with increased

<table>
<thead>
<tr>
<th>Increase % of individuals with access to fitness programs and facilities where people live.</th>
<th>City and County parks will have safe walking paths with positive signage. # of residents using parks will increase.</th>
<th>“Health” will be a priority in city planning and used as a measure when improvements or changes are initiated for residents.</th>
<th>A representative from Superintendents Office will be a member of executive team by 2017.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide programming and education in target areas housing facilities.</td>
<td>Elizabeth Fitness facilities will offer families incentives for increased physical activity for joining.</td>
<td>Develop a coalition of health care providers and partners to advise on health practices.</td>
<td>School Wellness policies will reflect 60 minutes of activity including directed recess, activity breaks and physical education.</td>
</tr>
<tr>
<td>Work with Housing Authority in target areas and surrounding community to provide safe routes to schools and encouraging walking to school. 3-5 schools will adopt Walk to school days.</td>
<td>“Health” will be a priority in city planning and used as a measure when improvements or changes are initiated for residents.</td>
<td>Local City Council will support Shaping Elizabeth Mission.</td>
<td>Monthly walk to school days will be planned.</td>
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<tr>
<td>Encourage use of extended city river walk – Monthly activities planned to engage community in walking.</td>
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</tr>
</tbody>
</table>
Situation: High Incidence of Obesity and Chronic Disease (Diabetes, Heart Disease) in Elizabeth Target Areas Midtown, Bayway, Elizabethport

Solution: Reduce Obesity through increased physical activity for residents in target areas with a focus on residents living in Housing Authority Areas and surrounding community and residents receiving services from community based organizations such as the YMCA, Proceed, Inc. etc.

Engage residents in programming designed to increase physical activity, decreasing incidences of obesity and chronic health conditions by providing access to healthcare, tools for monitoring fitness level, and access to fitness facilities.

Educate and engage individual in fitness plans including free trial memberships to fitness facilities.

Provide individual support in order to track fitness activity with a focus on increased walking introducing tools for monitoring.

Understand barriers to PA. Community Advisory team develops solutions with SE.

Health care providers "prescribe" walking to for walking activity to reduce obesity.

Engage school board to review Wellness Policy on PA add 30-60 minutes daily. Implement plan to enforce 30-60 minutes.

Facilitate events focused on physical activity in Schools and community.

School Board
Elizabeth Public Schools
Ward leadership
YMCA
COE

School Board
Elizabeth Public Schools
Ward leadership
YMCA
COE

Resident
HACE
Trinitas
FQHC
EPHN
YMCA
Doctors/clinicians

Assumptions
Elizabeth Residents have a low % of active minutes on a daily basis.
Time and access are barriers to PA.
Schools are not offering enough opportunity for PA each day.
To be healthy and reduce obesity and diabetes more people need to be active

External Factors
Residents cannot afford local fitness prices
Single family homes difficult find activity due to work and environment

Inputs
Activities
Outputs
Participation

Short Year 1&2
Increase availability of memberships to fitness facilities and /or access to "fitness" programming where residents live

Medium Year 3&4
YMCA and Elizabeth Fitness facilities will offer Financial Assistance to residents
YMCA and Fitness will offer onsite programs and encourage walking encourage tracking

Long Year 5
Increase % of residents reporting "activity" as part of their lives in pilot groups
Reduction in Obesity

Outcomes

Medical professionals will prescribe physical activity to improve health outcomes on a regular basis.

All Elizabeth Schools will have 30 – 60 minutes of activity every day through PE, recess, classroom

Schools will become hubs for family activity
Community will support active living

Increase number of "Playstreets" from 3-6 each year,
Increase school “activity” day events

Development of a coalition consisting of medical, education, and governmental partners who will 'prescribe PA and walking as a way to recued obesity

A representative from Elizabeth Public Schools on SE Exec Team. Elizabeth Public schools will review wellness policy and develop plans to increase PA during PE, Recess and to and from school.

Increase tracked of PA by residents in pilot groups encouraging 150 minutes of PA each week.

Increase % of residents reporting "activity" as part of their lives in pilot groups
Reduction in Obesity
Health Outcome - Improve Health Equity for the residents of Elizabeth by reducing obesity and chronic disease leading to longer lives with improved quality of life.

Health Behaviors (Diet & Exercise) – Improve Healthy Eating and Access to Healthy Foods
According to data Elizabeth Residents in Bayway, Midtown and Elizabethport have limited access and resources to purchase healthy foods especially fresh fruits and vegetables. In addition, we believe that knowledge of healthy eating may be limited. Residents have access to Corner Stores/Bodegas and Fast Food which are the main source of nutrition for adults and children due to cost, access and time. Many youth are unaware of the process of growing food as well.

OVERALL GOAL: Increase access and knowledge of healthy eating of residents in target areas to reduce BMI.

Bold Steps (Objectives) Healthy Food Option will be the “Easy and Preferred” Choice for Elizabeth Residents in target areas and

- Implement and Expand Mobile Market bringing healthy and fresh food to residents in low income housing units and surrounding community.
- Actively engage stakeholders in discussion on barriers to healthy eating. Implement changes based on feedback.
- Expand Healthy Corner Store Initiative & healthy food pantries in all 3 target areas of Elizabeth to increase access to healthy foods.
- Implement restaurant Healthy Food Options, with calorie counts labeled on all restaurant and take out menus
- SE Nutritionist Implement robust and visible campaign around healthy eating and food quality in Elizabeth.
- Implement changes based on feedback.
- Public Schools will serve fresh fruits and vegetables at lunch and offer only healthy options for snacks and group occasions.
- % of High School students receiving fee breakfast will increase from 50% to 75%.
- Develop relationships with school nurses - Collect BMI data beginning June 2017.

Indicators of Success by 2019

- Monthly mobile markets expanded adding 2 new HACE communities.
- X% of residents will report increased consumption of fresh fruits and vegetables daily.
- Community Advisory Team will be developed with representation from all 3 target areas which will advise and educate Shaping Elizabeth Executive Team on needs and priorities for healthy eating.
- Expand Health Corner Stores to 2-3 stores in each target area and increase purchasing of healthy foods through supportive programs together with stores:
  - Food Tastings, Recipes, labeling.
- 25% of restaurants and 25% of takeout menus will include actual healthy options with calorie count and food labeling identified with Shaping Elizabeth Logo
- There will be an active media campaign focused on healthy eating and food quality that to support work in other priority areas including social media, marketing and PR campaigns throughout all organizations engaged with Shaping Elizabeth. Monthly messages will be developed
- Every public school will have fresh fruit and vegetables available to students at every lunch.
- School signage will encourage healthy choices.
- All HS students will have access to in class breakfast with encouragement to participate.
- BMI data comparison June 2017 – 2018 for Healthy U Schools.
**Logic Model**

**Situation:** High Incidence of Obesity and Chronic Disease (Diabetes, Heart Disease) in Elizabeth Target Areas Midtown, Bayway, Elizabethport

**Solution:** Reduce Obesity – lower BMI through increased access and knowledge of healthy eating of residents in target areas with a focus on residents living in Housing Authority Areas and surrounding community and residents receiving services from community based organizations such as the YMCA, Proceed, Inc. etc.

**Inputs**
- Engage residents in programming designed to decrease incidences of obesity and chronic health conditions by providing nutrition education, access to healthy foods in target areas to target populations in HACE and Community based organizations.
- Increase access to healthy foods with healthy corner stores and food pantries.
- SE nutritionist will work with housing and community organizations to provide nutrition education and individual support.

**Activities**
- Implement a Monthly “mobile food Market” in partnership with Housing Authority and NJ Community Food bank.
- Encourage medical community to provide “nutrition prescription” to certified nutritionists. Develop list of nutritionist for referrals.
- Residents, YMCA, Proceed, Rutgers Cooperative Extension, Groundwork Elizabeth, Community Food Pantry, HACE, FGHC, EPHN, Trinitas, Bayway Family Success Center, Elizabethport FSC, Physicians, Nutritionist.

**Outputs**
- Residents, YMCA, Proceed, Rutgers Cooperative Extension, Groundwork Elizabeth, Community Food Pantry, HACE, FGHC, EPHN, Trinitas, Bayway Family Success Center, Elizabethport FSC, Physicians, Nutritionist.

**Inputs**
- Monthly Mobile markets at Mrvalag serving 300 -350 people. Possible second locations Elizabethport. X% of residents surveyed and report increased consumption to fresh fruits and vegetables.
- Development of a model for service coalition with medical, education, and governmental partners. 5 doctors in Elizabeth will use Nutrition prescriptions.
- SE nutritionist will work with housing and community organizations to provide nutrition education and individual support.

**Outcomes/Impact**
- 50% of people reached with mobile market will report lifestyle changes and incorporating healthy recipes into daily diets.
- Residents will have the ability for a cohesive plan for medical and educational support which will result in healthier weights and reduction of BMI for target group.
- Development of a model for service coalition with medical, education, and governmental partners. 5 doctors in Elizabeth will use Nutrition prescriptions.

**Activities**
- 2 Healthy corner stores in each target area to increase access to fresh foods. Stores report residents are purchasing healthy items.
- 20% of residents in pilot will report increased knowledge of portion sizes, healthy options and the ability to include in daily food preparation and consumption.

**Participation**
- Residents in pilot will report increased knowledge of portion sizes and healthy meal preparation. 10% of participants will show reduction in BMI.
Assumptions:
- Residents lack the nutritional knowledge to plan healthy meals.
- Residents do not have easy access to healthy affordable foods.
- Residents do not have access to fresh fruits and vegetables.

External Factors:
- Residents have had limited exposure to correlation of healthy eating and weight.
- Residents may not connect obesity to development of chronic diseases.

Public Schools will serve fruits and vegetables at lunch offer healthy snacks for celebrations, meetings and events as outlined in wellness policy.

100% of HS students will have access to breakfast.

Develop relationship with school nurses and collect baseline BMI data of all students in September 2017.

Rutgers Cooperative Extension, SNAP Groundwork FSC YMCA Shaping Elizabeth Nutritionists. Board of Education and Elizabeth Public School administration and families School nurses

Elizabeth public schools will rewrite wellness policy to include fresh fruit and vegetables and healthy celebrations.

All Elizabeth HS will offer “Breakfast in the classroom” for all students.

BMI data collected in Sept 2017 and June 2018 compare results in Healthy U schools.
OVERALL GOAL: Residents in the targeted areas (and later in entire city of Elizabeth) will have access to the education and services they need to maintain their sexual health, promoting healthy behaviors to remain HIV-negative.

Bold Steps (Objectives): Implement a robust on-site and mobile counseling testing and referral service across the targeted areas of the city of Elizabeth.

**Promote HIV prevention social marketing across the targeted areas; participate in 3-4 health fairs in the targeted areas**

**Using culturally appropriate evidence-based HIV prevention intervention for the high risk HIV negative population**

**Helping navigate services for high-risk HIV-negative persons to healthcare and other human and social services**

**Availability of sexually transmitted infection screening services for high risk residents in targeted areas**

**Distribution of condom kits via all HIV prevention activities; providing community awareness events, and hosting SISTA groups within the community settings in targeted areas**

**Provide linkage and re-engagement of HIV positive individuals in medical care and other support services; create partnerships with other health care agencies to reach the targeted population**

**Indicators of Success by 2019**

- **Proceed, Inc. will provide monthly screenings to residents in targeted areas serving 150 people annually in each target area.**
- **Through FB and Twitter provide educational information on importance of testing and healthy behaviors monthly.**
- **The targeted population across the HIV risk categories will have access to individual, group-level and community level interventions through support provided by Proceed, Inc. for 10 people per month.**
- **100 people will be screened per year.**
- **Annually distribute 100-150 kits at health fairs and community events.**
- **Partnerships developed and deepened with Trinitas, FQHC and clinics to engage at risk populations.**
Prevention of AIDS (COPA)

Program: TGYMCA/Shaping Elizabeth/RWJF/NJHI IF # 32010 Logic Model

Situation: High Incidence of HIV risk Elizabeth ranks 5th among the 10 NJ cities most impacted by HIV/AIDS

Solution: Residents in target areas will have access to education and services to maintain their sexual health and remain HIV negative.

**Inputs**

- Engage residents in target areas in a robust on-site and mobile testing and referral service with a focus on Hispanic and African American Woman,

**Activities**

- Promote HIV prevention through social marketing across target areas.
- Using culturally appropriate evidence based HIV prevention intervention for the his risk HIV negative pollution Make available screenings for high risk residents
- Help residents navigate services for high risk HIV negative person to healthcare and other human services
- Distribute condom kits at all HIV prevention Events
- Provide linkage and reengagement of HIV positive individuals in medical care and other support services

**Outputs**

- Proceed, Inc. Residents HACE Trinitas FQHC EPHN YMCA Doctors/clinicians BFSC EPFSC

**Participation**

- All HACE in pilot will receive prevention information. Shaping Elizabeth Facebook page will have weekly messaging.
- Provide HIV screenings at all healthy fairs and community events. Screen 25 people per month at these events or community organizations,
- Proceed will provide information and education about HIV services using computer labs at Family Success Center and Proceed on quarterly basis targeting 10-15 people.
- Condom kits will be distributed at all health fairs. Distribute 25 kits at each event.
- Any reporting they are HIV positive will receive follow up intervention for support.

**External Factors**

- Language
- Subject Sensitivity

**Assumptions**

- Sexual Behaviors are impacting Elizabeth residents for high % of HIV Aids
- Education & materials will decrease % of residents diagnosed with Aids
Health Outcomes – Improve Health Equity for the residents in Elizabeth by reducing obesity to impact Diabetes Reduction

Health Behavior (Diet & Exercise) **Reduce incidence of Diabetes** of residents in target areas with a focus on HACE residents in pilot areas and surrounding community through healthy eating, DPP program, and increased physical activity.

**OVERALL GOAL: Reduce Incidence of Diabetes**

**Bold Steps (Objectives) Engage residents in programs designed to reduce diabetes encourage and support healthy eating and**

- Provide informational workshops to learn about causes, symptoms and prevention of diabetes
- Provide health screenings with follow up prescriptions for YMCA DPP program, Healthy Eating & increased physical activity.
- Shaping Elizabeth Nutritionist will conduct nutrition workshops at community locations
- Facilitate support for residents with Diabetes to live healthier lives with healthy control education assistance.

**Indicators of Success by 2019**

- Provide education to residents identified with BMI greater than 25 on diabetes prevention with Diabetes educators from Trinitas and nutritionist. Residents will be identified through registration of Mobile Market and Health Fair BMI measurement.
- Increased attendance at YMCA Diabetes prevention workshops from 3-4 people per class to 8-10 at 3 cycles per year. At 3-4 health fairs screen for blood glucose levels for 100 – 150 people per year where they live with follow up “prescription”
- Eat Healthy, Be Active Workshops scheduled 6 times per year at 3 locations with enrollment of 180 people per year. Classes offered in Spanish & English.
- Development of a coalition consisting of medical, education, and governmental partners to provide more complete service.

Identify people with Diabetes and find what support is needed to live healthier with Diabetes to reduce related chronic
Situation: High Incidence of Obesity and Chronic Disease (Diabetes, Heart Disease) in Elizabeth Target Areas Midtown, Bayway, Elizabethport

Solution: Reduce Obesity – Reduce incidence of Diabetes of residents in target areas with a focus on residents living in Housing Authority Areas and surrounding community and residents receiving services from community based organizations such as the YMCA, Proceed, Inc. etc.

**Inputs**
- Engage residents In programming designed to reduce the # adults diagnosed with diabetes by decreasing incidences of obesity and providing tools for monitoring and tracking health conditions. Together with plans to improve healthy eating and increased physical activity.
- Provide informational workshops to learn about causes, symptoms and prevention of diabetes
- Provide health screenings with follow up prescriptions for YMCA DPP program, PA, HE
- Shaping Elizabeth Nutritionist will conduct nutrition workshops at community locations
- Facilitate support for residents with Diabetes to live healthier lives

**Outputs**
- Residents
- YMCA
- FQHC
- Trinitas
- EPHN
- HACE
- Proceed
- Rutgers
- Cooperative Extension
- SE Nutritionist

**Activities**
- Increased attendance at YMCA Diabetes prevention workshops from 3-4 people per class to 8-10
- At 3-4 health fairs screen for blood glucose levels for 100 – 150 people per year where they live with follow up “prescription”
- Development of a coalition consisting of medical, education, and governmental partners to provide more complete service.
- Identify people with Diabetes and find what support is needed to live healthier with Diabetes to reduce related chronic disease outcomes

**Participants**
- Medical professionals will prescribe participation in nutrition workshops and diabetes prevention workshops to improve health outcomes
- Decrease in BMI to 25 and below
- Increase in complete circle of care for residents in target groups.
- 10% of people identified with diabetes will receive support for control and healthy lifestyles

**External Factors**
- PreDiabetes is not diagnosed by medical community
- Individuals do not understand the risk of prediabetes leading to diabetes and that lifestyle changes can make a difference in not developing diabetes,

**Assumptions**
- Workshops/information will need to be offered in more than one language because of diversity of the City of Elizabeth
- Events will need to be heavily promoted and possibly incentives offered because participation has been minimal
**Health Outcomes**

**Length of Life**
- Premature Deaths: 5,000

**Quality of Life**
- Poor or fair health: 15%
- Poor Physical health days: 3.1
- Poor Mental Health Days: 3.2
- Low Birthweight: 8%

**Additional Health Outcomes**
- Pre Mature Age-adjusted mortality: 260
- Child Mortality: 40
- Infant Mortality: 5
- Frequent Physical distress: 10%
- Frequent Mental Distress: 10%
- Diabetes Prevalence: 10%

**HIV Prevalence**: 64%

**First trimester prenatal care**: 80%

**% low Birth Weight Infants**: 8%

**% Pre term Births**: 9.80%

**Health Factors**

**Health Behaviors**
- Adult smoking: 15%
- Adult Obesity: 25%
- Food Environment Index: 8.4
- Physical Activity: 25%
- Access to exercise opportunities: 100%
- Excessive drinking: 17%
- Alcohol Impaired driving deaths: 31%
- Sexually Transmitted infections: 335

**Additional Health Behaviors**
<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Percentage A</th>
<th>Percentage B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food insecurity</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Limited access to healthy foods</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>Drug Overdose Deaths</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Motor Vehicle Crashes</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Insufficient Sleep</td>
<td>39%</td>
<td>37%</td>
</tr>
</tbody>
</table>

**Clinical Care**

- **Uninsured**: 19% (A) vs. 15% (B)
- **Primary Care Physicians**: 1,450:1 (A) vs. 1,170:1 (B)
- **Dentists**: 1,220:1 (A) vs. 1,220:1 (B)
- **Mental Health Providers**: 590:1 (A) vs. 570:1 (B)
- **Diabetic Monitoring**: 84% (A) vs. 84% (B)
- **Preventable Hospital stays**: 45 (A) vs. 55 (B)
- **Mammography screening**: 59% (A) vs. 61% (B)

**Additional Clinical Care**

- **Uninsured adults**: 23% (A) vs. 30.70% (B)
- **Uninsured children**: 6% (A) vs. 6% (B)
- **Health care costs**: $9,162 (A) vs. $10,037 (B)

**Social Economic Factors**

- **High School graduation**: 86% (A) vs. 66.60% (B) vs. 88% (C)
- **Some College**: 61% (A) vs. 66% (B)
- **Unemployment**: 6.80% (A) vs. 9.60% (B) vs. 10.10% (C) vs. 10.50% (D)
- **Children in poverty**: 16% (A) vs. 16% (B)
- **Families in poverty**: 18.60% (A) vs. 23.60% (B) vs. 18.10% (C) vs. 17.80% (D) vs. 14.30% (E)
- **Income inequity**: 5.1 (A) vs. 5.1 (B)
- **Children in single parent homes**: 33% (A) vs. 30% (B)
- **Violent Crimes**: 418 (A) vs. 302 (B)

**Additional Factors**

- **Median Household Income**: $68,200 (A) vs. $41,312 (B) vs. $72,000 (C)
- **Children Eligible for free lunch**: 40% (A) vs. 88% (B) vs. 31% (D)
- **Homicides**: 6 (A) vs. 5 (B) vs. 23% (D)

**Physical Environment**

- **Air Pollution**: 11.1 (A) vs. 11.3 (B)
- **Drinking water violations**: Yes (A) vs. Yes (B)
- **Severe housing problems**: 30% (A) vs. 23% (B)

**Elizabeth Data**
Elizabeth is the largest city in Union County, New Jersey and is the county seat. As of the 2010 United States Census, Elizabeth is New Jersey’s fourth largest city, with a population of 124,969. The demographics of Elizabeth are as follows:

<table>
<thead>
<tr>
<th></th>
<th>7206</th>
<th>7202</th>
<th>7201</th>
<th>7208</th>
</tr>
</thead>
<tbody>
<tr>
<td>55% (68,292) White</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22% (26,343) Black or African American</td>
<td>24.30%</td>
<td>14.90%</td>
<td>26.80%</td>
<td>22.40%</td>
</tr>
<tr>
<td>0.83% (1,036) Native American</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.08% (2,604) Asian</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>0.04% (52) Pacific Islander</td>
<td></td>
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</tr>
<tr>
<td>16.72% (20,901) from other races</td>
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</tr>
<tr>
<td>3.33% (5,741) from two or more races.</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>59% (73,731) Hispanic or Latino of any race</td>
<td>68.70%</td>
<td>68.70%</td>
<td>57.80%</td>
<td>54.80%</td>
</tr>
</tbody>
</table>

As of 2009, the estimated median household income of Elizabeth residents was $41,312 compared to the New Jersey average of $68,342.

Males had a median income of $32,268 versus $27,228 for females.

Approximately 15% of families and 17% of the population were below the poverty line,

The number of individuals in Elizabeth below the poverty line was 11.1% higher than of all Union County.

88% of the Elizabeth school children qualified for free or reduced lunch in 2016.

Data from a recent 2012 Community Needs Assessment for the Hospitals of Union County which reported and confirmed that the incidence of diabetes and obesity will continue to increase within both the Hispanic/Latino and African populations of Union County.

Since the year 2000, both the Hispanic/Latino and African American populations have lead NJ in diabetes related deaths.

Data 2016 Trinitas Community Health Assessment

Leading Cause of death in UC Heart Disease and Cancer
30.0% UC High Blood Pressure
38.5% UC High Cholesterol

Heart Disease Death Rate is highest UC Blacks/African American Female Breast Cancer & Prostate Cancer % highest in UC Diabetes Prevalance increase UC Whites, Non-Hisp and Blacks/African American Health Behavior ED visits increased by 5.5% since 2010 highest increase 55 and over Medicaid and Uninsured account for 45% of ED visits Heroin treatment accounts for 39% of drug treatment in Elizabeth 27% for alcohol

### 2016 Priority Areas

<table>
<thead>
<tr>
<th>TRMC</th>
<th>NJHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Disparities - Access To Care</td>
<td>Health Literacy</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Abuse Cancer</td>
<td>Mental Health Diabetes Heart Disease</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Obesity</td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
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<tr>
<td>Obesity</td>
<td></td>
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</table>