COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

Atlantic Health **Morristown** Medical Center
Atlantic Health **Overlook** Medical Center
Atlantic Health **Chilton** Medical Center
Atlantic Health **Newton** Medical Center
Atlantic Health **Hackettstown** Medical Center
Atlantic Health **CentraState** Medical Center

PUBLISHED: MAY 15, 2026

Atlantic Health

ACKNOWLEDGEMENTS & COMPLIANCE

Atlantic Health is committed to improving community health by enhancing access to care and addressing inequities that contribute to health disparities across the populations it serves.

Atlantic Health acknowledges and expresses its appreciation for the individuals and organizations whose expertise, collaboration, and commitment contributed to the development of the 2026 Community Health Improvement Plan. The continued engagement of Atlantic Health team members and community partners is integral to advancing measurable improvements in community health status and to supporting the delivery of high-quality, accessible, and cost-effective care.

The 2026 Community Health Improvement Plan was developed in accordance with applicable federal requirements, including those set forth under Internal Revenue Service Schedule H, in collaboration with hospital leadership and community stakeholders. The data and analyses informing both the Community Health Needs Assessment and the Community Health Improvement Plan were compiled by Atlantic Health's Strategy and Business Planning function. Ongoing collaboration with community-based organizations, governmental entities, and other stakeholders across the Atlantic Health service area is essential to addressing identified community health needs and achieving sustainable improvements in population health outcomes.

Questions regarding this Community Health Improvement Plan may be directed to:

Atlantic Health
Strategy and Business Planning
(973) 660-3522

or

Atlantic Health
Community Health
(844) 472-8499

CONTENTS **PAGE**

COMMUNITY HEALTH NEEDS ASSESSMENT PRIORITIES

The Community Health Improvement Plan (CHIP) initiatives and activities described herein reflect the collective input of individual Atlantic Health hospitals and community representatives, informed by their knowledge of and engagement with the communities they serve.

Hospital-specific prioritization of community health needs enables both localized and system-level approaches. This structure allows Atlantic Health to leverage coordinated resources at the corporate level to support inter-hospital strategies, facilitating broader, geographically aligned efforts to address common health needs across its service area.

Presented below are the community health priorities identified and formally adopted by each hospital's Community Advisory Board (CAB) following the most recent Community Health Needs Assessment (CHNA) process. Across Atlantic Health hospitals, there is strong alignment in priority focus areas, including behavioral health, endocrine and metabolic disease, diabetes and nutrition, cancer, and heart disease (including stroke). In addition, certain site-specific priorities—such as geriatrics and healthy aging, and maternal and infant health—were identified by individual CABs based on localized community needs.

During the development of the Community Health Needs Assessments (CHNAs), two overarching themes—access and quality—emerged as foundational lenses through which identified health priorities and strategies to address health disparities should be evaluated.

The selection of these priorities was informed by a comprehensive review of quantitative data and qualitative input, including community stakeholder engagement and survey findings. These identified health priorities serve as the foundation for the development and annual implementation of each hospital's Community Health Improvement Plan.

ATLANTIC HEALTH COMMUNITY HEALTH NEEDS ASSESSMENT PRIORITIES						
PUBLICATION YEAR	AHMMC 2025-2027	AHOMC 2025-2027	AHCMC 2025-2027	AHNMC 2024-2026	AHHMC 2024-2026	AHCSMC 2025-2027
Access to Care	●	●	●			●
Cancer	●	●	●	●	●	●
Endocrine and Metabolic Disease, Diabetes, and Nutrition	●	●	●	●	●	●
Geriatrics and Healthy Aging	●	●	●			
Heart Disease	●	●	●	●	●	●
Maternal / Infant Health		●				
Mental Health & Substance Use Disorders	●	●	●	●	●	●
Neurological Disease	●					

Applying this framework supports a consistent, system-wide approach to advancing equitable health outcomes while aligning with Atlantic Health's enterprise strategic objectives, including the continued pursuit of nationally recognized clinical excellence and leadership in improving patient access, experience, and affordability.

ATLANTIC HEALTH'S COMPREHENSIVE APPROACH TO ADDRESSING COMMUNITY HEALTH

Atlantic Health develops its Community Health Improvement Plan on an annual basis with the objective of standardizing, to the extent practicable, evidence-based and effective approaches to addressing identified community health needs across the enterprise. Where appropriate, hospital-specific initiatives are incorporated to address the unique needs of distinct populations served within individual communities.

System-wide efforts applicable across all Atlantic Health hospitals include initiatives focused on expanding access through virtual care and community engagement; strengthening community coordination and addressing social drivers of health; advancing diversity, equity, and inclusion; providing financial and operational support to community partners and collaborative initiatives; and promoting health and wellness among older adults and other at-risk populations.

Community Benefit

Atlantic Health is committed to improving the health status of the communities it serves and provides community benefit programs and activities as part of a measured approach to meeting identified health needs in the community. Community benefits include charity care, subsidized health services, community health services, and financial contributions to community-based health organizations.

For the most recent year of data available, Atlantic Health provided $508,664,662 in total community benefit across the following areas:

- Subsidized Health Services: $263,586,072
- Cash and In-Kind Contributions: $1,186,383
- Financial Assistance: $41,980,920
- Medicaid Assistance Shortfall: $112,284,266
- Health Professional Education: $66,277,822
- Health Research Advancement: $1,284,211
- Community Health Improvement Services: $22,064,988

Supporting Funding of Community Partners and Community Health Needs

The Community Advisory Boards (CAB) at Morristown, Overlook, Chilton, Newton, and Hackettstown Medical Centers all provide annual funding opportunities for community partners in the form of grants to enhance resources available in the community. Grants are funded through a competitive review process, which includes a requirement that approved funding be linked to a community health need as identified by the medical centers in their CHNA. In 2025, funds allocated to community partners through the AH Community Advisory Boards totaled $722,752.98

Identifying Potential Health Disparities

As a leading health care provider, our mission is to build healthier communities. Health can be different for each person and for different groups of people. At Atlantic Health, we believe everyone should have an equal chance to be as healthy as possible. This is what we call health equity. Health disparities are differences in health that affect certain groups of people more than others. These groups often face more challenges with good health, including factors historically linked to discrimination or exclusion.

As part of AH's CHNA and CHIP development process, we evaluate community demographics, mortality rates, county and ZIP Code based disease incidence rates, other secondary source information for broad community health outcomes and factors, and community stakeholder input.

The ability to gain actionable perspective on the health needs of the population served can be limited in secondary data by geographic or clinical aggregation and to a degree the use of estimates to extrapolate findings. To gain deeper perspective on the health needs of the population served by AH's hospitals, the hospital analyzed deidentified claims that allow for application of a disparity ratio methodology published by the Minnesota Department of Health Center for Health Statistics, Division of Health Policy. This application aids in determining if there are/were disparities among the population served by the hospital. Four separate analyses (race/ethnicity, age, gender, and insurance cohort) were performed on the data using clinical cohorts defined by The Agency for Healthcare Research and Quality (AHRQ)

Healthcare Cost and Utilization Project (HCUP) Clinical Classification Software – Refined (CCSR). The CCSR aggregates International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes into clinically meaningful categories. These analyses, not published here, allowed stakeholders to gain deeper understanding of potential disparities in the patient population served by AH, and creates a roadmap for identifying where resources could best be deployed to address disparities among specific patient cohorts. This information was used in conjunction with secondary data analysis and stakeholder input to prioritize health topics of most concern throughout the AH service area.

Social Drivers of Health (SDOH) Initiative: A Proactive Approach to Identifying and Addressing Barriers to Health

An integrated patient-centered approach that includes identifying social needs and providing structured support to help reduce barriers to care, access community resources for ongoing support, and setting and achieving short-term goals toward long-term health are strategies key to coordinated, cost-effective, high-quality care. Because we want the best health for our patients and communities, Atlantic Health is helping patients address the non-medical, social needs impacting their health through proactive SDOH screening and connections to community resources.

In early 2020, Atlantic Health developed an initiative to proactively screen adult patients for SDOH across select primary care practices before expanding annual SDOH screenings for adult patients to all primary care practices mid-year. In 2021, an inpatient SDOH screening pilot was launched and then expanded to a targeted screening initiative for adult inpatients with high-risk medical needs enrolled in the Transitions of Care program. In 2024, a systemwide SDOH screening process was launched to screen all adult patients admitted to our hospitals for 5 key SDOH domains. In 2025, this structured proactive SDOH screening process was implemented to enhance SDOH screening in Pulmonary practices and for pregnant patients in our Women's Health practices.

The SDOH Navigator table in Epic (AH's electronic health record) makes key information about the social factors that can influence a patient's health and health outcomes easier to see amongst the interdisciplinary care team. The SDOH Navigator table displays fourteen domains, each representing a factor that can influence health: financial resource strain, housing instability, utility needs, transportation needs, alcohol use, depression, intimate partner violence, social connections, physical activity, tobacco use, stress, health literacy, postpartum depression, and food insecurity. Based on patient answers to questions in each of the domains, the icons turn green to indicate low risk, yellow for moderate risk, or red for high risk. Referrals can be sent to Social Workers and Community Health Workers for additional support and to connect the patient to key community resources. A Community resource directory on the Atlantic Health website allows patients to autonomously search for local social programs and community resources to help with their psychosocial barriers. This Community Resource Directory and a list of key community resources are included in adult After Visit Summaries.

A system Psychosocial Collaborative has formed to align the roles, infrastructure, support, and design of how we care for patients' psychosocial needs across the care continuum and foster health equity. An early focus of the Psychosocial Collaborative has been expanding and enhancing workflows for SDOH screening and intervention to proactively identify and address barriers to care, improve health outcomes, enhance patient satisfaction, and reduce ED utilization and readmissions. Additionally, AH has contracted with Unite Us, a social needs digital referral platform that integrates with our electronic health record to facilitate patients experiencing social needs receive individualized SDOH resources tailored to their needs and health goals. Patients with complex social needs or who would benefit from individualized intensive support in addressing health-related social needs may be connected to our social workers and community health workers who have insight into how social drivers of health – social, functional, environmental, cultural, and psychological factors – may be linked to our patients' health outcomes.

Social workers work in partnership with Community Health Workers and assist with more complex patient needs and barriers, such as interpersonal violence, crisis, difficulty coping with illness or stress, behavioral health or substance misuse linkage, abuse/neglect, or long-term care planning. Social Workers assess patient strengths and social needs and coordinate linkage to a wide range of community resources, providing supportive handoffs and follow-through for successful and sustainable engagement with resources, brief behavioral interventions and referral to treatment, and emotional support.

Community Health Workers are uniquely positioned to provide peer-level structured support to help reduce barriers to care, infuse access to community resources for ongoing support, and assist patients to set and achieve their individualized health goals. Our Community Health Workers are embedded in our medical center footprints and, in

partnership with our social work team, assist patients in identifying SDOH needs and barriers to care. Community Health Workers partner with patients to help them overcome these barriers and achieve their health goals by providing at-the-elbow support, creating sustainable connections with key community partners and social service organizations, and empowerment and self-management skills to navigate the health and social service systems.

Diversity, Equity, and Inclusion

Atlantic Health strives for an inclusive health care environment where patients, visitors and team members are welcomed and afforded equitable treatment regardless of race, ethnicity, gender, sexual orientation, gender identity or expression, religion, age, disability, military status, language, immigration status, marital or parental status, occupation, education, or socioeconomic background. We are committed to including a broad cross-section of perspectives for decision making that affects the health and wellbeing of our communities. We are also committed to achieving the highest standard of health equity for all within our communities while providing culturally responsive care. Atlantic Health organizes diverse workgroups of community representatives at each hospital location to develop and implement programs that address the specific health care needs of our surrounding populations. Some programs and policies implemented within our hospitals include:

- Establishing support groups and educational classes for vulnerable populations – such as people living with HIV and AIDS, and non-English speaking families who are expecting children
- Revising patient visitation policies to allow for more inclusion and respect for all families and visitors
- Expanding pastoral and spiritual care for patients of all faith communities
- Translating “Patient Rights," patient forms and medical records into Spanish and other languages
- Enhancing interpretation of languages other than English through innovative technologies
- Improving meal services to accommodate diverse dietary and nutritional preferences

Food Is Medicine, Food Rx Program

Promoting preventive care, nutrition education, and chronic disease management programs, and partnering with local organizations to expand access to nutritious food are core strategies to address diabetes, healthy weight, and obesity. In 2024, Atlantic Health Equity Institute launched the Food is Medicine Pilot Program in collaboration with its Community Health Department, The Community Food Bank of New Jersey, and a local Food Pantry near Atlantic Health Overlook Medical Center. This innovative pilot program was designed to bridge the gap between clinical care and community wellness by recognizing the critical role nutrition plays in overall health. In 2025, Atlantic Health began expanding this pilot for Atlantic Health Morristown Medical Center (AHMMC) with plans to launch the AHMMC program in 2026 in partnership with the Community Food Bank of New Jersey, as well as local food pantry, Nourish NJ, and three clinical departments which include the AHMMC’s Women’s Health Center, the Family Medicine Department and the Diabetes Education & Nutrition Center.

Through a food Rx prescription provided by a patient's clinical care team, eligible residents were enrolled in the program and gained access to monthly distributions of nutrient-rich groceries tailored to support chronic disease management (i.e., Diabetes, Anemia, and Hypertension) and general wellness. Participants also received one-on-one nutrition coaching with trained health educators and registered dietitians to build sustainable, personalized eating habits and referrals to local services to address broader social drivers of health. By integrating food access into the health care continuum, the Food is Medicine Pilot Program empowered participants to take control of their health and serves as a model for future programs aimed at reducing health disparities. This intervention supports those needs identified in the community health needs assessment and is in the process of being implemented across all Atlantic Health hospitals.

Community Health Education and Wellness

Atlantic Health’s Community Health department offers a wide variety of health and wellness programs to meet the needs of the community. These programs aim to provide the knowledge and skills people need to live healthier lives and to connect them to supportive resources. Education about the social drivers of health is a key component of our programs, helping to address all the factors that influence chronic disease and heathier living. Delivering programs in-person as well as virtually, we align our programs to the AH Community Health Improvement Plan. By collaborating with our community stakeholders and partners we can deliver programs that meet the needs of specific populations with a focus on the priority health issues of access to care, heart disease, stroke, cancer, diabetes and obesity, mental health and substance misuse, geriatrics and healthy aging, and maternal and infant health.

Atlantic Center for Research

Atlantic Health is building healthier communities through groundbreaking research. The driving force behind the award-winning network of care is the Atlantic Center for Research (ACR) which is the hub for innovative, clinical research that has the potential to directly impact patient outcomes and shape the future of personalized care.

ACR plays a vital role in enhancing community health by adopting a population health approach that focuses on prevention, early detection, and innovative treatment solutions. Through clinical trials and research initiatives, ACR helps bring innovative medical advancements to the community, improving access to new treatments that may not yet be widely available. By partnering with healthcare providers, academic institutions, and pharmaceutical companies, ACR contributes to the development of therapies for chronic and emerging diseases, improving patient outcomes on a larger scale. Our research findings are regularly published in prestigious, peer-reviewed journals and presented at esteemed conferences, showcasing our commitment to sharing innovative discoveries and advancing the scientific community's knowledge of healthcare and medicine.

In addition to advancing medical research, ACR actively engages with the local community through educational programs, health screenings, and awareness campaigns. These initiatives help individuals make informed health decisions, address social determinants of health, and promote preventive care strategies. By prioritizing research on prevalent conditions within the community—such as diabetes, cardiovascular disease, and mental health disorders—ACR ensures that its efforts align with the specific health needs of the population it serves. At the end of 2025, ACR had 469 trials across 16 therapeutic areas, and served over 15,000 patients on them. The portfolio comprises of several groundbreaking trials; first in human, first in U.S., and first for AH.

ACR's commitment to data-driven decision-making supports healthcare policies and interventions that enhance overall public health. By collecting and analyzing population health data, ACR identifies trends, risk factors, and disparities that affect community well-being. This evidence-based approach allows for targeted strategies that improve healthcare accessibility, reduce health inequities, and enhance the quality of life for diverse populations. Through its research and outreach, ACR plays a crucial role in shaping healthier communities and advancing the field of population health.

ACR's clinical research advancement highlights include the first and only FDA approved non-surgical treatment for recurrent bladder cancer using the medication ZUSDURI; FDA approval for preemptive treatment for aortic stenosis, driving a change in national guidelines; and the first-of-its-kind Hypertrophic Cardiomyopathy (HCM) registry that advances understanding of the most common genetic heart disorder.

Other Collaborative Support

In addition to actions within a specific strategy, Atlantic Health continues to contribute resources and expertise to support area CHNA/CHIP processes, community-based health coalitions, and collaboratives that focus on health and social issues. Our resources and investments in key community partnerships reflect our belief that bringing groups together, across sectors, is itself a significant community health intervention. Nurturing these collaborative efforts and shared health improvement goals with governmental, municipal, and community benefit organizations allows us to address identified health needs and build capacity in individual local organizations and our hospitals. It also serves to coordinate health and social service agencies in a way that supports collaborative investment in best practices.

Evaluation Plan & Needs Not Addressed

Efforts to address community health needs require a complex interplay of internal resources, relationships with community partners, identification of co-morbidities across priority areas and, most importantly, the ability to course-correct when strategies or approaches to a priority can be better served through yet unknown pathways. Atlantic Health's Community Health team facilitates regular check-ins with hospital leadership and clinical service line teams to document activities and progress related to Community Health Improvement Plan objectives. Atlantic Health's hospitals track measurable progress for all activities. Data collection is tailored to each individual action, and therefore, will include a variety of methodologies.

ATLANTIC HEALTH MORRISTOWN MEDICAL CENTER – COMMUNITY OVERVIEW

Atlantic Health Morristown Medical Center (AHMMC) is committed to advancing the health and well-being of the individuals and communities it serves. Recognizing that healthier communities are associated with improved quality of life, stronger partnerships, and more sustainable health care delivery, AHMMC undertook a comprehensive Community Health Needs Assessment (CHNA) beginning in June 2025. As a member of Atlantic Health (AH), AHMMC conducted this assessment to evaluate the health needs of residents within its service area, which includes portions of Essex, Hunterdon, Morris, Passaic, Somerset, Sussex, Union, and Warren counties in New Jersey.

The CHNA was designed to collect and analyze current quantitative data and qualitative input to identify the most significant health issues affecting the community. The assessment incorporated a broad range of indicators, including the prevalence of chronic conditions, access to health care services, and the impact of social determinants of health, to inform the identification of priority health needs and guide subsequent community health improvement efforts.

Atlantic Health's Community Health department supports these efforts by delivering virtual and in-person health education programs, as well as resources and services that promote prevention and wellness. In collaboration with community partners, these initiatives are intended to expand access to care, reduce barriers, and address the needs of diverse and underserved populations. Key programs include community-based tobacco cessation services offered both virtually and in person, virtual exercise classes that encourage healthy lifestyles, and the provision of education and resources through community events, presentations, and health fairs.

Completion of the CHNA provides AHMMC with a comprehensive understanding of the health needs of its service area, enabling the prioritization of key issues and informing the development of implementation strategies. The full AHMMC Community Health Needs Assessment is available at www.atlantichealth.org/chna. This Community Health Improvement Plan (CHIP) outlines how AHMMC will address the priority health needs identified through the CHNA.

Prioritized Health Needs

The 2025-2027 Community Health Needs Assessment process identified seven priority health needs that have been included in the 2026 CHIP.

- Mental Health & Substance Use Disorders
- Endocrine and Metabolic Disease, Diabetes, and Nutrition
- Cancer
- Heart Disease
- Neurological Disease
- Geriatrics & Healthy Aging
- Access to Care

ATLANTIC HEALTH MORRISTOWN MEDICAL CENTER– IMPLEMENTATION PLAN

The Community Health Improvement Plan (CHIP) serves as AHMMC's implementation strategy to address the significant health needs identified in the Community Health Needs Assessment (CHNA). It outlines the hospital's approach, including targeted strategies, initiatives, and anticipated timeframes for each priority area, along with measurable objectives and methods for evaluating progress. Implementation occurs over a multi-year period with ongoing monitoring and annual updates to ensure continued alignment with community needs, resource availability, and program effectiveness, while supporting broader Atlantic Health priorities and evidence-based practices.

PRIORITY AREA: MENTAL HEALTH & SUBSTANCE USE DISORDERS

MMC is making steady progress toward expanding community-based behavioral health services, with a strong emphasis on education, access, and program growth.

For the goal, community education and outreach efforts are actively reducing stigma and increasing awareness of mental health, suicide prevention, substance use, and support services. Multiple virtual and in-person programs, along with community events and targeted campaigns, are engaging diverse populations and promoting open dialogue.

Clinically, MMC continues to expand behavioral health services across the continuum of care, including peer recovery, medication-assisted treatment, outpatient addiction services, and specialized programs for adolescents and older adults. Efforts to improve access—such as enhancing assessment services and reducing wait times—are ongoing, with most initiatives designed for sustained long-term impact.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHMMC service area:

- Anxiety and fear-related disorders
- Neurodevelopmental disorder
- Depressive disorders
- Alcohol-related disorders
- Opioid misuse
- Schizophrenia and other psychotic disorders

Goals and objectives to address these health disparities include:

Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and substance abuse and addiction disorders.

Focus	Objectives
Community-based education programming	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. • Atlantic Behavioral Health is motivated to get people talking openly about a condition that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. **<u>Atlantic Behavioral Health Programming</u>** ○ Programs to support those dealing with grief ○ Children's and Adolescent Mental Health ○ Geriatric Mental Health ○ Mental Health and Other Support for Caregivers ○ Alcohol, marijuana, tobacco, and vaping awareness

	○ Food and Impact on Mood • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.
Clinical programming related to addressing the growing behavioral health needs of the community	• Continue to build clinical programs and services that meet patients in their community, which includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, and outpatient settings. • Expansion of peer recovery services • Continuing expansion of medication for addiction treatment (MAT) services. • Continued expansion of outpatient addiction services at all levels of care. • Continued expansion of adolescent outpatient mental health services. • Develop geriatric psychiatry outpatient services. • Expansion of AHMMC Behavioral Health Assessment Center that improves access through decreasing time to first appointment and ability to provide bridge appts up to 30 days. • Expand True North to support more veterans and their families through therapy, case management, and connections to resources. • Expansion of geriatric psychiatry through collaborative care and outpatient services.

PRIORITY AREA: ENDOCRINE AND METABOLIC DISEASE, DIABETES, AND NUTRITION

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHMMC service area:

- Diabetes mellitus without complication
- Diabetes mellitus with complication
- Nutritional deficiencies
- Disorders of lipid metabolism
- Thyroid disorders

Goals and objectives to address these health disparities include:

Goal 1: Improve access to and awareness of services.
Goal 2: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.
Goal 3: AHMMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.

Focus	Objectives
Community-based education programming	• Referral, as appropriate, to AH Quit Smoking Program for smoking cessation. Increase access to tobacco cessation support through offering virtual and in-person, community-based tobacco cessation groups, with a focus on diverse populations and underserved communities. • Provide information and educational programs on the importance of screening and healthy lifestyle choices, *Navigating Supermarkets and Nutrition Labels, Understanding Eating Disorders, Foot Care, etc.* • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes. • Offer monthly bariatric virtual support groups • Partner with Diabetes Foundation to enhance educational opportunities in the community.

Clinical care & identification of at-risk populations and creation of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Continue to track and monitor data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the program to aid in the reduction of readmissions. The program continues to be used throughout Atlantic Medical Group primary care offices through Atlantic Health. • Collaboration with Morristown Medical Center Retail Pharmacy for financial assistance programs for diabetes medication and supplies. • Body mass index (BMI) screening/nutritional education and referral to Metabolic Center, as appropriate. ○ Continue to offer sleep screening, as appropriate. • Continue to screen patients for needs related to SDOH. • Integration, awareness, and education of GLP-1 medications into MMC's Diabetes and Bariatric programs promoting preventive care, supporting sustained behavior change, and improving long-term health outcomes, particularly in populations with high rates of obesity and diabetes. • Offering a New Outpatient Endoscopic Sleeve Gastroplasty (ESG). Minimally invasive, lower-risk option, non-surgical weight-loss procedure.
Promotion of Employee Health	• Partnership with AH Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus. • Collaborate with Business Resource Groups (BRGs) to provide educational presentations on diabetes management.
Reduce the level of food insecurity in the community	• Expand relationships with organizations such as Interfaith Food Pantry and nourish.nj that provide free food pantries and meal service to those in need. • Partnership with Food Is Medicine • Expand access to healthier foods and groceries to the community served by AHMMC. • Partnership with Share my Meals, donating extra food from our cafeterias to food recovery and distribution program Local recipient organizations serve our community members.

PRIORITY AREA: CANCER

Atlantic Health Morristown Medical Center (AHMMC) has demonstrated strong progress in advancing comprehensive cancer-related initiatives, with many elements completed and others ongoing to enhance access, education, and supportive care. Efforts to expand community-based screening and early detection are well established through strategic partnerships and targeted programs, including high-risk cancer screenings and increased access to lung cancer screening and smoking cessation services. Barriers to care are actively addressed through robust support services, including financial assistance, care navigation, insurance support, and psychosocial resources. In parallel, community education and wellness initiatives are actively engaging individuals through virtual programming focused on prevention and healthy lifestyles. Supportive services—such as mental health, peer support, and integrative care—are embedded across the care continuum, with continued enhancements to digital resources and a sustained emphasis on culturally responsive care to improve access and patient experience.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Morristown Medical Center service area:

- Prostate cancer

- Breast cancer- all types
- Skin cancers- melanoma
- Secondary Malignancies
- Respiratory cancer
- Colorectal cancer
- Pancreatic cancer

Goals and objectives to address these health disparities include:

Goal 1: Address barriers to cancer care through direct services and program development that focus on clinical areas of higher utilization and various health disparities that may exist within the community served.

Goal 2: Promote health and wellness among the patient's continuum of care: diagnosis, treatment, and survivorship.

Focus	Objectives
Community-based screening	• Coordinate education and cancer screening opportunities with NJCEED and Community Health departments, local health departments, and the Regional Chronic Disease Coalition. • Expand access of high-risk breast, pancreatic and lung screenings services for medical evaluation and surveillance. • Maintain and expand the screening for colorectal, breast, gyn, prostate, and lung cancer conducted at AMG practices.
Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction (e.g., *Nutrition and Healthy Lifestyle for Cancer Prevention, Debunking the Myths About Skin Cancer and Sun Protection, Breast Cancer: Are You at Risk,* and *Lung and Colorectal Cancer Awareness* etc.).
Practical / financial needs	• Providers assess patients for financial, practical, and psychosocial needs, including food insecurity, financial needs and referring to the cancer center social worker for further assessment. Work with community-based agencies to provide wigs, food, transportation, and other financial/practical matters. • Continue to develop more timely Advanced Care Planning and Palliative Care services and continue to identify grant and other funding opportunities to meet this unmet need.
Mental Health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). • Referrals are provided to Integrative Program Services as appropriate. • Referrals are provided to Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site through a nurse practitioner. • Referrals to community resources for Peer-to-Peer support and other supportive services. • AH continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service.
Insurance Issues	• Identify patients who do not have health insurance and refer to the NJCEED Program, the preauthorization team, or to AH's patient financial services (PFS) and Charity Care for evaluation and support. Referrals to McKesson for drug copay assistance. • Social Workers meet with and counsel patients in need, directing and referring to the appropriate resources. • Oncology navigators, nursing staff, registered dietitians, and social workers continually reassess patients' barriers to care at each encounter.
Access	• Employ virtual resources and programs to provide the community with access to support groups, educational programs and supplemental services related to

	cancer treatment, care, management, nutritional support, fertility and family planning, cardio-oncology, palliative care, and survivorship. • Continue to use and expand virtual and hybrid educational programs. • Review and update the AH Cancer Center website to improve access to virtual services, programs, and resources. • Evaluate and supplement resources available to the African American and Hispanic/Latino population to provide culturally sensitive care. • Improve care coordination and reduce healthcare disparities among underserved populations through community partnerships.

PRIORITY AREA: HEART DISEASE

The Atlantic Health cardiovascular initiative focuses on reducing disparities in heart disease and improving access to prevention, education, and specialized care, particularly for underserved and minority populations. Community-based education and screening efforts are actively expanding, including programs on heart disease awareness, cholesterol and blood pressure management, and women's cardiovascular health, supported by both virtual and in-person outreach.

Women's cardiovascular health is a key priority, with ongoing development of clinical protocols, expanded awareness initiatives, and establishment of a cardio-obstetrics program to support high-risk patients. Several of these efforts are completed or well underway, reflecting strong progress in addressing gender-specific cardiovascular risk.

Access to care has been strengthened through expanded cardiology capacity, improved diagnostic services, and enhanced emergency and preventive care education, though some equity-focused initiatives are still being further defined. Clinical programming continues to evolve through partnerships such as heart failure and transplant coordination with NYU and specialized hypertrophic cardiomyopathy services, ensuring continuity of advanced care. Overall, the program shows meaningful advancement in education, clinical expansion, and access, with continued work needed to fully address structural health disparities.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHMMC service area:

- Essential hypertension
- Nonrheumatic and unspecified valve disorders
- Heart failure
- Nonspecific chest pain

Goals and objectives to address these health disparities include:

Goal 1: Take proactive steps to reduce cardiovascular health disparities in underserved and minority populations.
Goal 2: Employ broad measures to increase access to care and educational resources in the communities served by Atlantic Health, specifically among populations disproportionally impacted by cardiovascular disease.

Focus	Objectives
Community-based education programming	• Provide information and educational programs on topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Women with Cardiac Disease and cardio-obstetrics*
Women's Health Initiatives	• Support a women's cardiovascular disease champion tasked with developing a clinical protocol to improve identification and treatment of cardiovascular disease and comorbidities among women served by the AH. • Develop an awareness program speaking to the different presentation of heart disease in women than in men focused on minority and underserved residents.

	• Continue to deliver education on gender related differences of heart attack symptoms and place this education in AMG practices to reach a wide audience. • Develop a cardio-OB program that cares for high-risk obstetrical patients.
Access	• Enhance access to care and awareness of cardiovascular programs, cardiology practices, and services available across AH, as well as advancements and improvements in treatment options. • Educate the community on availability and appropriate use of emergency transportation services, i.e., how, and when to seek help and the importance of acting quickly when emergency care is necessary. • Educate the community on the importance of seeking preventative care with their cardiologist, understanding warning signs for cardiovascular events, and what to do when a warning sign presents itself. • Identify structural barriers to health equity in our communities as they pertain to heart disease and capitalize on AH's existing community partnerships as a path to reducing and/or eliminating these barriers.
Clinical programming	• The Heart Success program has partnered with the heart transplant program at NYU; this partnership will provide a more seamless transition of patients from AH to NYU for heart transplant services. Pre- and post-transplant care will be provided at AHMMC. • Planning on launching a lipid apheresis program at AHMMC. • Dr. Amy Ahnert is leading the Women's Heart program focusing on cardiovascular disease in women and developing a cardio-obstetric program.

PRIORITY AREA: NEUROLOGICAL DISEASE

The Atlantic Health Morristown Medical Center (AHMMC) Community Health Improvement Plan (CHIP) outlines a coordinated set of stroke-related initiatives spanning EMS engagement, community education, staff training, and advocacy. Implementation is well underway, with several foundational elements completed and most initiatives actively in progress.

Efforts related to EMS and caregiver support focus on enhancing stroke identification and transport through ongoing EMS education, implementation of large vessel occlusion recognition tools, and increasing appropriate EMS activation. In parallel, AHMMC continues to expand stroke support resources, including support groups and educational tools for survivors and caregivers to support recovery and secondary prevention. Several training components and recognition tools have been implemented, with additional enhancements ongoing.

Community-based education initiatives are aimed at improving public awareness of stroke signs, symptoms, and key risk factors, particularly hypertension. These efforts include the development and dissemination of multilingual educational materials, expanded outreach through community events and partnerships, and enhanced access to digital resources. Core educational content and awareness materials have been completed, while broader outreach and engagement efforts continue to expand.

Staff education remains a priority, with ongoing efforts to maintain current clinical knowledge through regular training, integration of stroke education into annual competencies, and the delivery of symposiums and collaborative learning opportunities. Key curriculum updates and new training elements have been implemented, with continued refinement in progress.

Advocacy efforts include active participation in state and national stroke initiatives, contributions to public awareness campaigns, and engagement in the development of a coordinated system of stroke care. These activities are ongoing and reflect sustained institutional commitment.

Overall, AHMMC has demonstrated steady progress across all focus areas, with a strong pipeline of initiatives in progress and critical foundational components in place, supporting continued improvement in stroke recognition, treatment, and long-term outcomes.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHMMC service area:

- Stroke
- Long term consequences or effects of stroke
- Epilepsy

Goals and objectives to address these health disparities include:

Goal 1: Educate the community and first responders on stroke signs and symptoms for rapid identification and transport to a stroke center.
Goal 2: Provide tools for stroke survivors and care givers to cope with disability and education to prevent future stroke, particularly among high-risk and post-stroke groups.
Goal 3: Educate health care professionals and members of the communities we serve regarding advances in stroke treatment.

Focus	Objectives
EMS and Caregiver Support	• Continued education sessions for EMS on stroke signs and symptoms for rapid identification and transport to a stroke Center. • Education for AH and volunteer agencies on the statewide pre-hospital Large Vessel Occlusion recognition tool (RACE Scale). • Increased EMS education offerings with contact hours for stroke and epilepsy. • Stroke support groups for caregivers and survivors on monthly basis. • Provide tools for stroke survivors and care givers to cope with disability and education to prevent future stroke, support post-stroke follow-up related to symptom education and nutritional counseling.
Community-based education programming	• Educate the community and cooperate partners on stroke signs and symptoms for rapid identification and transport to a stroke center, including at tabling events. • Educate the community on risk factors and comorbidities associated with stroke and availability of tools to identify risk factors for stroke. • Update the deliverables for the community and patients to include Hypertension as the major modifiable risk factor for all strokes. • Expanded Hemorrhagic stroke specific education in English and Spanish. • Educate health care professionals and members of the communities we serve regarding advances in stroke treatment and availability of stroke related services and resources. • Improved website by continuously making sure the resources available remain up to date and are accessible to the community. BE FAST sign and symptom video updated to include T “Terrible Headache” in English and Spanish. • Website Stroke signs and symptoms are linked to the A.D.A.M. library. • May Stroke Awareness and World Stroke Day are celebrated internally and externally. • Partnership with local school for Stroke awareness and symptom education.
Staff Education	• Educational Stroke Symposium, conducted annually, provides an outlet for education and discussion for healthcare providers on diverse topics pertaining to stroke, such as ongoing clinical research, nursing care options, and post rehabilitation. • Provider onboarding stroke specific education • As a system, stroke education was included within AH’s PRIDE essentials, an annual training for all team members. • Roll out a hemorrhagic stroke awareness initiative, including a new ‘BE-FAST’. ○ ‘T’ includes terrible headache, to focus on hemorrhage. • Workforce development programs through nursing education, residencies, and ancillary staff.

Stroke Governmental Advocacy	• Support local, regional, state, and national stroke communities through advocacy and peer forums which drive stroke care and leadership positions on NJSCC—New Jersey Stroke Coordinator Consortium. • Promote, identify, and design the statewide system of stroke care.

PRIORITY AREA: GERIATRICS & HEALTHY AGING

The Morristown Medical Center (MMC) senior care program is focused on delivering comprehensive, compassionate, and coordinated care for older adults while strengthening support for caregivers and improving access to community resources. Community-based education and wellness programming are actively expanding, including initiatives on healthy aging, caregiver support, exercise, and memory care, with strong participation in both virtual and in-person formats.

Clinical and supportive services for seniors remain robust and continue to grow, particularly through the Geriatric Assessment Center, emergency department geriatric care, home-based primary care, behavioral health services, and telemedicine. These services are complemented by ongoing attention to advance care planning, palliative care integration, and age-friendly care standards.

Caregiver and patient support programs are well established, including caregiver training, counseling, care navigation through the Healthy Aging Program, and structured education initiatives. Memory screening remains a key focus, supported through national program participation and clinical assessments, though some community screening events were temporarily paused due to staffing constraints.

Additional efforts in injury prevention and dementia care coordination continue to expand, including participation in the GUIDE dementia model and safety programs for seniors. Overall, the program demonstrates strong ongoing growth in clinical services, caregiver support, and care coordination, with continued emphasis on access, quality, and aging-in-place support.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among 65 and older populations served by Atlantic Health in the Morristown Medical Center service area:

- Neurocognitive disorders
- Musculoskeletal pain, not low back pain
- Sleep wake disorders
- Prioritized clinical areas for continued improvement:
    - ED utilization
    - Readmissions

Goals and objectives to address these health disparities include:

Goal 1: Provide high quality and compassionate primary care, behavioral health, consultative, and emergency services to seniors in the area served by Morristown Medical Center.
Goal 2: Offer a robust spectrum of training, support, and counseling services for seniors and family caregivers designed to improve care coordination and caregiver competence.
Goal 3: Continue offering memory screening to seniors in the community through our relationship with the Alzheimer's Foundation of America as a National Memory screening site.

Focus	Objectives
Community-based education programming	• Provide information and educational programs on topics related to healthy aging e.g., *Alzheimer's, Dementia and Memory Loss, Strength and Balance, Caregiver support, etc.* • Offer virtual and in-person exercise classes with topics relevant to seniors, e.g., *Exercise for Arthritis, Chair Yoga, etc.*
Clinical Services for Seniors	• The Geriatric Assessment Center is a state-of-the-art outpatient practice that offers high quality compassionate primary care and consultative services to area

	seniors. Its highly skilled team of geriatricians, advanced practice nurses and social workers uses a multidisciplinary approach to provide person centered care to our frailest seniors. ○ Employ telemedicine services for seniors when appropriate. ○ The Geriatric Assessment Center offers counseling services to patients. ○ Continue to offer discussions regarding advance directives and goals of care. • The Emergency Department at Morristown Medical Center is a Level 1 accredited Geriatric Emergency Department utilizing geriatric specific evidence-based protocols, multidisciplinary care teams, and post-discharge support to provide a continuum of care for all patients >70 years of age who enter our ED. • Provide referrals to palliative care as identified by the Emergency Department. • The Primary Care at Home program includes nurse practitioners who make house calls to homebound patients 65 or older, who live in the Morris County area.
Patient and Caregiver Support and Training	• Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA). It aims to improve the care of older adults in clinical settings by addressing their mobility, mentation, medications and aligning care to 'what matters' to the older adult and their family caregivers. AHMMC and the Geriatric Assessment Center continue to be recognized by AFHS as an Age-Friendly Health System committed to care excellence. • The Art of Caregiving course is a 5-part interactive course offered quarterly to caregivers to help them navigate the nuances of the eldercare maze. This course provides personalized guidance on how best to care for an aging loved one while finding balance as a family caregiver. • The Caregiver Training Lab is a model home environment for older adults and is located at the Geriatric Assessment Center. It provides direct training and education to seniors and their caregivers. It also offers recommendations for community organizations that can assist with home safety assessments and home modifications. • Offer support and counseling services for patients and caregivers as they age and navigate the elder care journey. • AH's Healthy Aging Program helps older adults, and their caregivers, find the health care services and community resources that they need to live longer, healthier, and more active lives. This weekday hotline provides guidance on navigating the eldercare maze and connection to home health services, senior housing options, adult day services, transportation, insurance and financial options, and other services available to older adults and their caregivers.
Memory Screening	• A memory screening is a simple and safe evaluation tool that checks memory and other thinking skills. It can indicate whether an additional check-up by a qualified healthcare professional is needed. The Geriatric Assessment Center at AHMMC is approved as a National Memory Screening site through the Alzheimer's Foundation of America. • The Geriatric Assessment Center offers annual memory screening for all patients at the center. • Memory screening events are open to community seniors and aid in early detection and proper treatment of seniors who may have cognitive changes.
Injury Prevention	• Morristown Medical Center's Injury Prevention Program offers seniors and caregivers a variety of home, pedestrian, and motor vehicle safety programs throughout the year, including the Car Fit for Mature Drivers at all Car Seat Inspection Stations. The programs are typically run in a group setting but are offered as needed to individual patients and their families.
Care Coordination	• Guide Program offered through The Geriatric Assessment Center. The Guiding an Improved Dementia Experience (GUIDE) Model is a voluntary nationwide model

	test that aims to support people with dementia and their unpaid caregivers. The GUIDE Model focuses on comprehensive, coordinated dementia care and aims to improve quality of life for people with dementia, reduce strain on their unpaid caregivers, and enable people with dementia to remain in their homes and communities. It will achieve these goals through Medicare payments for a comprehensive package of care coordination and care management, caregiver education and support, and respite services.
Memory Screening	• A memory screening is a simple and safe evaluation tool that checks memory and other thinking skills. It can indicate whether an additional check-up by a qualified healthcare professional is needed. The Geriatric Assessment Center at AHMMC is approved as a National Memory Screening site through the Alzheimer's Foundation of America. • The Geriatric Assessment Center offers annual memory screening for all patients at the center. • Memory screening events are open to community seniors and aid in early detection and proper treatment of seniors who may have cognitive changes.
Injury Prevention	• Morristown Medical Center's Injury Prevention Program offers seniors and caregivers a variety of home, pedestrian, and motor vehicle safety programs throughout the year, including the Car Fit for Mature Drivers at all Car Seat Inspection Stations. The programs are typically run in a group setting but are offered as needed to individual patients and their families.

PRIORITY AREA: ACCESS TO CARE

Access to care challenges affect patients across the communities we serve and may arise from a range of factors, including insurance coverage limitations, transportation barriers, scheduling availability, language and cultural differences, and other social determinants of health. These barriers can impact the ability of individuals to obtain timely primary, preventive, and specialty services, regardless of demographic group. Addressing access to care in a comprehensive and equitable manner supports earlier intervention, improves care continuity, and contributes to better overall health outcomes for all patients.

Goals and objectives to address these health disparities include:

Goal 1: Increase timely access to primary, preventative, and behavioral health services
Goal 2: Address structural and non-clinical barriers that prevent individuals from obtaining care and advancing health equity by targeting disparities in access and utilization.

Focus	Objectives
Scheduling and Appointment Availability	• Improve transparency of scheduling times • Expand the available times slots open to patients • Implement centralized access / call center optimization • Expand evening/weekend hours in high-demand service lines • Leverage digital self-scheduling and waitlist functionality • Standardize "third next available appointment" tracking across sites
Clinical Workforce Capacity	• Recruit and retain physicians and advanced practice providers to meet community demand • Target recruitment in high-need specialties (e.g., primary care, behavioral health) • Expand use of APPs and team-based care models • Explore academic/community partnerships to build workforce pipelines • Deploy flexible staffing models in high-growth geographies
Care Navigation & Coordination	• Improve patient ability to access, understand, and navigate the healthcare system • Expand patient navigation and care coordination programs • Enhance discharge follow-up and referral completion rates • Utilize community health workers (CHWs) for high-risk populations

Affordability & Financial Barriers	• Improve access to care regardless of ability to pay • Enhance financial counseling and charity care awareness • Streamline Medicaid enrollment and eligibility support

ATLANTIC HEALTH OVERLOOK MEDICAL CENTER– COMMUNITY OVERVIEW

Atlantic Health Overlook Medical Center (AHOMC) is committed to advancing the health and well-being of the individuals and communities it serves. Recognizing that healthier communities are associated with improved quality of life, stronger partnerships, and more sustainable health care delivery, AHOMC undertook a comprehensive Community Health Needs Assessment (CHNA) beginning in June 2025. As a member of Atlantic Health (AH), AHOMC conducted this assessment to evaluate the health needs of residents within its service area, which includes portions of Essex, Morris, Somerset, and Union counties in New Jersey.

The CHNA was designed to collect and analyze current quantitative data and qualitative input to identify the most significant health issues affecting the community. The assessment incorporated a broad range of indicators, including the prevalence of chronic conditions, access to health care services, and the impact of social determinants of health, to inform the identification of priority health needs and guide subsequent community health improvement efforts.

Atlantic Health's Community Health department supports these efforts by delivering virtual and in-person health education programs, as well as resources and services that promote prevention and wellness. In collaboration with community partners, these initiatives are intended to expand access to care, reduce barriers, and address the needs of diverse and underserved populations. Key programs include community-based tobacco cessation services offered both virtually and in person, virtual exercise classes that encourage healthy lifestyles, and the provision of education and resources through community events, presentations, and health fairs.

Completion of the CHNA provides AHOMC with a comprehensive understanding of the health needs of its service area, enabling the prioritization of key issues and informing the development of implementation strategies. The full AHOMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This Community Health Improvement Plan (CHIP) outlines how AHOMC will address the priority health needs identified through the CHNA.

Prioritized Health Needs

The 2025-2027 Community Health Needs Assessment process identified seven priority health needs that have been included in the 2026 CHIP.

- Mental Health and Substance Use Disorders
- Cancer
- Heart Disease
- Geriatrics and Healthy Aging
- Endocrine and Metabolic Disease, Diabetes, and Nutrition
- Maternal / Infant Health
- Access to Care

ATLANTIC HEALTH OVERLOOK MEDICAL CENTER– IMPLEMENTATION PLAN

The Community Health Improvement Plan (CHIP) serves as AHOMC's implementation strategy to address the significant health needs identified in the Community Health Needs Assessment (CHNA). It outlines the hospital's approach, including targeted strategies, initiatives, and anticipated timeframes for each priority area, along with measurable objectives and methods for evaluating progress. Implementation occurs over a multi-year period with ongoing monitoring and annual updates to ensure continued alignment with community needs, resource availability, and program effectiveness, while supporting broader Atlantic Health priorities and evidence-based practices.

PRIORITY AREA: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

AHOMC's progress toward behavioral health goals is ongoing, with strong emphasis on expanding community-based behavioral health education and clinical services.

Community outreach efforts are actively reducing stigma and increasing awareness through virtual programs, campaigns like Mental Health Month, and broad educational topics spanning mental health, substance use, and support for vulnerable populations. Partnerships continue to strengthen access to local resources.

Clinically, services are being continuously expanded across the continuum of care, including addiction treatment (MAT), adolescent and geriatric mental health, and new pediatric-focused programs. Enhancements to access points, such as outpatient services and the EmPATH unit, support timely, community-based care. All initiatives are in progress and designed for sustained, long-term impact.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHOMC service area:

- Anxiety and fear-related disorders
- Neurodevelopmental disorder
- Depressive disorders
- Feeding and eating disorders
- Addiction disorders

Goals and objectives to address these health disparities include:

Goal 1: Provide community-based behavioral health services with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and substance abuse and addiction disorders.

Focus	Objectives
Community-based education programming	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. • Atlantic Behavioral Health is motivated to get people talking openly about a disease that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. **<u>Atlantic Behavioral Health Programming</u>** ○ Programs to support those dealing with grief ○ Children's and Adolescent Mental Health Issues ○ Geriatric Mental Health ○ Mental Health and Other Support for Caregivers

	○ Alcohol, marijuana, tobacco, and vaping awareness ○ Food and Impact on Mood • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.
Clinical programming related to addressing the growing behavioral health needs of the community	• Continue to build clinical programs and services that meet patients in their community, which includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, behavioral health observation unit, and outpatient settings. • Continued expansion of medication for addiction treatment (MAT) services. • Continued expansion of addiction services at all levels of care. • Development and Expansion of child & adolescent behavioral health outpatient services including a pediatric behavioral health assessment center; outpatient; intensive outpatient program. • Continued enhancement of the EmPATH unit for adults who come to the ED with behavioral health needs.

PRIORITY AREA: CANCER

The OMC Cancer Program is advancing efforts to reduce barriers to care and promote wellness across the cancer continuum through a combination of completed and ongoing initiatives. Community-based screening and education programs are well established, with strong partnerships supporting prevention, early detection, and outreach, while additional screening capacity—particularly for high-risk and multiple cancer types—continues to expand.

Supportive services addressing financial, practical, and psychosocial needs are actively being strengthened through care coordination, social work involvement, and community partnerships. Mental health and supportive care services remain a key focus, with ongoing integration of behavioral health, distress screening, and referral pathways.

Efforts to improve access include transportation support, insurance navigation, and expanded virtual and hybrid programming, alongside initiatives to enhance culturally responsive care for underserved populations. Overall, while many foundational elements are complete, most initiatives are in progress with continued growth and refinement planned through 2026 to further reduce disparities and improve access to comprehensive cancer care.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Overlook Medical Center service area:

- Breast Cancer- all types
- Colorectal and esophageal cancers
- Prostate cancer
- Lung cancer

Goals and objectives to address these health disparities include:

Goal 1: Address barriers to cancer care through direct services and program development that focus on clinical areas of higher utilization and various health disparities that may exist within the community served.

Goal 2: Promote health and wellness among the patient's continuum of care: diagnosis, treatment, and survivorship.

Focus	Objectives
Community-based screening	• Coordinate education and cancer screening opportunities with NJCEED and Community Health departments, local health departments, and the Regional Chronic Disease Coalition. • Expand access to high-risk breast, pancreatic and lung screenings services for medical evaluation and surveillance.

	• Maintain and expand the screening for colorectal, breast, prostate and lung cancer conducted at AMG practices.
Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction (e.g., *Nutrition and Healthy Lifestyle for Cancer Prevention, Debunking the Myths About Skin Cancer and Sun Protection, Breast Cancer: Are You at Risk,* and *Lung and Colorectal Cancer Awareness* etc.).
Practical / financial needs	• Providers assess patients for financial, practical, and psychosocial needs, including food insecurity, financial needs and referring to the cancer center social worker for further assessment. Collaborate with community-based agencies to provide wigs, food, transportation, and other financial/practical matters. • Continue to develop more timely Advanced Care Planning and Palliative Care services and continue to identify grant and other funding opportunities to meet this unmet need.
Mental health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). • Referrals are provided to Integrative Program Services as appropriate. • Referrals are provided to Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site through a nurse practitioner. • Referrals to community resources for Peer-to-Peer support and other supportive services. • AH continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service.
Transportation	• Collaborate with community resources to expand and enhance access to transportation services. Obtain gift cards/Uber cards and other resources to support transportation needs.
Insurance issues	• Identify patients who do not have health insurance and refer to the NJCEED Program, the preauthorization team, or to AH's patient financial services (PFS) and Charity Care for evaluation and support. Referrals to McKesson for drug copay assistance. • Social Workers meet with and counsel patients in need, directing and referring to the appropriate resources. • Oncology navigators, nursing staff, registered dietitians, and social workers continually reassess patients' barriers to care at each encounter.
Access	• Employ virtual resources and programs to provide the community with access to support groups, educational programs and supplemental services related to cancer treatment, care, management, nutritional support, fertility and family planning, cardio-oncology, palliative care, and survivorship. • Continue to use and expand virtual and hybrid educational programs. • Review and update the AH Cancer Center website to improve access to virtual services, programs, and resources. • Evaluate and supplement resources available to the African American and Hispanic/Latino population to provide culturally sensitive care. • Improve care coordination and reduce healthcare disparities among underserved populations through community partnerships.

PRIORITY AREA: HEART DISEASE (INCLUDING STROKE)

The Atlantic Health cardiovascular initiative is focused on reducing health disparities and improving access to cardiovascular care and education, particularly for underserved and high-risk populations. Community-based education efforts are actively underway, addressing key topics such as heart disease management, prevention, and women's cardiovascular health through virtual and in-person programming.

Efforts to improve hypertension management are still evolving, with prior system-wide programming unable to be fully scaled. Access to cardiovascular care has been strengthened through expanded cardiology staffing, improved diagnostic capacity, and broader service availability across the network, representing a major complete advancement in care access.

Ongoing work continues to focus on preventive education, emergency response awareness, and identification of structural barriers to health equity, though some initiatives remain in development. Clinical expansion efforts, including growth of the Heart Success program at Overlook Medical Center, are underway but limited by staffing constraints. Overall, the program reflects meaningful progress in expanding access and education, with continued work needed to fully address disparities and system-wide hypertension management goals.

The stroke program is actively advancing education, support, and system improvement, with most initiatives in progress and key staff education milestones completed.

Efforts are focused on strengthening stroke recognition, response, and recovery through a comprehensive, coordinated approach. Initiatives include expanding EMS training, community education, and outreach to promote rapid identification and transport, supported by in-person and virtual programming and continued collaboration with EMS councils and community organizations. Support for stroke survivors and caregivers is being enhanced through hybrid support groups, improved care coordination, and education on prevention and risk factors, complemented by updated public-facing resources and digital content. In parallel, staff and professional education remain robust through system-wide training and symposiums, while clinical care continues to advance through the adoption of innovative technologies and emerging therapies to improve outcomes and continuity of care.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Overlook Medical Center service area:

- Essential Hypertension
- Nonspecific chest pain
- Coronary atherosclerosis and other heart disease
- Cardiac dysrhythmia
- Nonrheumatic and unspecified valve disorders
- Heart Failure

Goals and objectives to address these health disparities include:

Goal 1: Take proactive steps to reduce cardiovascular health disparities in underserved and minority populations.

Goal 2: Employ broad measures to increase access to care and educational resources in the communities served by Atlantic Health, specifically among populations disproportionally impacted by cardiovascular disease.

Focus	Objectives
Community-based education programming	• Provide information and educational programs on topics related to understanding heart disease, e.g., Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Women with Cardiac Disease
Access	• Increased access to care and awareness of cardiovascular programs, cardiology practices, and services available across AH, as well as advancements and improvements in treatment options (STEMI, etc.). • Educate the community on availability and appropriate use of emergency transportation services, i.e., how, and when to seek help and the importance of acting quickly when emergency care is necessary. • Educate the community on the importance of seeking preventative care with their cardiologist, understanding warning signs for cardiovascular events, and what to do when a warning sign presents itself.

- Identify structural barriers to health equity in our communities as they pertain to heart disease and continue to capitalize on AH's existing community partnerships as a path to reducing and/or eliminating these barriers.
- Atlantic's Heart Success program (Heart Failure Program) will be expanded to Overlook Medical Center. Expansion will include inpatient care provided by a board-certified heart failure cardiologist.

PRIORITY AREA: GERIATRICS AND HEALTHY AGING

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among 65 and older populations served by Atlantic Health in the AHOMC service area:

- Neurocognitive disorders
- Musculoskeletal pain, not low back pain
- Sleep wake disorders
- Prioritized clinical areas for continued improvement:
  - ED utilization
  - Readmissions

Goals and objectives to address these health disparities include:

Goal 1: Provide high quality and compassionate primary care, consultative, and emergency services to seniors in the area served by Overlook Medical Center.
Goal 2: Offer a robust spectrum of support and counseling services for seniors and family caregivers designed to improve care coordination and caregiver competence.
Goal 3: Continue offering memory screening and cognitive assessments in the home, office, assisted and independent living setting.

Focus	Objectives
Community-based education programming	• Deliver educational programs and resources on healthy aging—including Alzheimer's disease, dementia, memory loss, and caregiver support—across local assisted living communities and ambulatory care settings. • Provide family caregivers with dedicated support and resources through the Thomas Glasser Caregivers Center at Overlook Medical Center, helping them navigate the healthcare system during complex and challenging times. Services include individual and family counseling by a licensed clinical social worker (LCSW), end-of-life and bereavement support, referrals, and connections to community-based resources.
Clinical Services for Seniors	• The Geriatric Program delivers comprehensive, person-centered care through a multidisciplinary team of geriatricians, advanced practice nurses, and social workers. Focused on serving the most medically complex and vulnerable seniors, the program provides high-quality, compassionate outpatient primary care and consultative services across office, assisted living, independent living, and home settings. Care is guided by the "4Ms" framework—Mind, Mobility, Medications, and What Matters Most—ensuring it is personalized, safe, and aligned with each patient's goals. o Leverages telemedicine, when appropriate, to enhance access and continuity of care for older adults. o Proactively engages patients and families in advance care planning and goals-of-care discussions to support quality of life. • The Home Visit Program at AHOMC includes nurse practitioners who provide in-home care for homebound patients aged 65 and older residing in Union County, improving access for those unable to travel to clinical settings.

	• Collaborates closely with the Atlantic Neuroscience Institute, including cognitive neurologists and neuropsychiatrists, to facilitate timely referrals for comprehensive neurocognitive evaluation. • Partners with Geriatric Psychiatry to support the evaluation and management of depression, anxiety, and behavioral changes in older adults, including those with neurocognitive disorders.
Patient and Caregiver Support and Training	• Age-Friendly Health is a national initiative led by the John A. Hartford Foundation and the Institute for Healthcare Improvement, in partnership with the American Hospital Association and the Catholic Health Association of the United States. It is designed to enhance care for older adults by focusing on the "4Ms" framework—Mobility, Mentation, Medications, and What Matters—ensuring care is safe, effective, and aligned with patient goals and caregiver needs. AHOMC continues to be recognized by Age-Friendly Health Systems for its commitment to delivering high-quality, age-friendly care.
Memory Screening	• A memory screening is a simple, safe evaluation that assesses memory and other cognitive functions, helping identify potential concerns and determine whether follow-up evaluation by a qualified healthcare professional is recommended. • The Geriatric Program at AHOMC provides annual memory screenings for all enrolled patients, delivered conveniently in the home, community, or office setting.
Care Coordination	• AHOMC coordinates referrals to a licensed clinical social worker (LCSW) to support care coordination and address unmet clinical and social needs, ensuring a comprehensive, patient-centered approach to care. Our team also facilitates referrals to the GUIDE Program through the Geriatric Assessment Center in Morristown. The Guiding an Improved Dementia Experience (GUIDE) Model is a voluntary, nationwide initiative designed to support individuals living with dementia and their caregivers. It emphasizes comprehensive, coordinated care; caregiver education and support; and access to respite services—improving quality of life, reducing caregiver burden, and enabling individuals to remain safely in their homes and communities.

PRIORITY AREA: ENDOCRINE AND METABOLIC DISEASE, DIABETES, AND NUTRITION

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHOMC service area:

- Disorders of lipid metabolism
- Thyroid disorders
- Obesity
- Fluid and electrolyte disorders
- Diabetes mellitus without complications

Goals and objectives to address these health disparities include:

Goal 1: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.
Goal 2: AHOMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.
Goal 3: Improve access to and awareness of services in the AHOMC service area.

Focus	Objectives
Community-based education programming	• Referral, as appropriate, to AH Quit Smoking Program for smoking cessation. Increase access to tobacco cessation support through offering virtual and in-person, community-based tobacco cessation groups, with a focus on diverse populations and underserved communities.

	• Provide information and educational programs on the importance of screening and healthy lifestyle choices, e.g., *Navigating Supermarkets and Nutrition Labels, Understanding Eating Disorders, Foot Care, etc*. • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes.
Promotion of Employee Health	• Partnership with AH Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus. • Collaborate with BRGs to provide educational presentations on diabetes management. • Continue to share diabetes educational information to team members and externally.
Clinical care & identification of at-risk populations and creation of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Continue to track and monitor data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the program to aid in the reduction of readmissions. The program continues to be used throughout Atlantic Medical Group primary care offices through Atlantic Health. • Continue to partner with Cardiometabolic Alliance and provide diabetes education to referred patients as support.
Reduce disparity in the community	• Engage pregnant and new mothers with the medical community as the "trusted" partner to provide information and education in those locations with strategies that have been determined to reduce disparities. • Through this engagement, if health disparities such as food insecurity are identified, proper linkage to resources or care is made. • Diabetes and Cardiovascular Disease – Linking Clinic to Community is a program for community providers that reviews ADA standards and identifies relevant community resources.
Reduce the level of food insecurity in the community	• Develop Overlook Medical Center's partnerships with local food banks to link at-risk patients to food sources that will improve the patients' overall wellness. • Overlook Medical Center & Atlantic Health partner with GRACE Food Pantry to offer our Food Is Medicine program, giving residents of our community access to fresh health food and resources. Residents are given referrals to the program where they receive nutritional coaching and community referrals to help them on their nutritional journey. GRACE Food Pantry staff assist residents with choosing healthy foods that match their Food Is Medicine prescription. • Continue to support Overlook Medical Center's Community Garden initiative and promote employee and patient wellness through serving and promoting in the hospital cafeteria the fresh produce grown in the garden. • Continue to serve surrounding elementary students by hosting hospital-sponsored chefs healthy eating and nutrition education.

PRIORITY AREA: MATERNAL / INFANT HEALTH

Atlantic Health Overlook Medical Center (AHOMC) is advancing a comprehensive set of maternal and infant health initiatives focused on improving access to care and expanding community-based education to address health disparities and meet local needs.

Community education efforts are well established, including virtual programming and in-person outreach on prenatal care, chronic disease management, and modifiable risk factors, complemented by Spanish-language prenatal education through HealthStart. Access to care has been strengthened through expanded OB/GYN and subspecialty services, growth in midwifery staffing, and implementation of targeted programs such as complex family planning and Food is Medicine, with continued expansion underway.

Additional initiatives are in progress to enhance screening and management of anemia and hypertension, expand doula services, and support diabetes care in pregnancy. These efforts are reinforced by national recognition for high-quality maternity care outcomes, including strong performance in advancing equitable outcomes for Black patients. Overall, AHOMC demonstrates meaningful progress in expanding access, strengthening maternal health services, and improving health equity, with several initiatives continuing to advance into 2026.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHOMC service area:

- Supervision of high-risk pregnancy
- Other specified complications in pregnancy
- Early, first, or unspecified trimester hemorrhage
- Spontaneous abortion and complications of spontaneous abortion
- Complications specified during childbirth

Goals and objectives to address these health disparities include:

Goal 1: Improve access to care throughout the AHOMC community by focusing on areas where health disparities may exist and where resources are in greater demand.

Goal 2: Continue to develop community-based education that meets the needs of the communities served by AHOMC.

Focus	Objectives
Community-based education programming	• Provide information and educational programs on diverse topics such as the importance of prenatal and postpartum care, lifestyle and other modifiable risk factors, chronic condition management, etc. • Offer prenatal classes in Spanish.
Expand access to care	• Support improved access to care for OB/Gyn services through increased provider presence and breadth/availability of subspecialist services available at AHOMC'S HealthStart Clinic. • Growing food is medicine program to 50 patients in 2026. • Address screening and treatment of anemia and hypertension through education across AMG practices and at the AHOMC HealthStart Clinic. • Team Birth – patient centered communication initiative across labor & delivery and mother/baby • Develop and continue to grow a doula program offered throughout AH, including expansion of services to postpartum care. • Continuing to grow midwifery access for patients (also includes work around clinical leadership expectations within the midwifery department.) • Continue to meet the growing needs for the 'diabetes in pregnancy' program at AHOMC. • Provide outpatient lactation services at AHOMC. • Team member bereavement training. • Collaboration with Women's & Cardiac service line for the Women's Heart Program
Awards & Recognitions	• US News health analysis team has identified nine hospitals that are High Performing in Maternity Care and are achieving excellent outcomes for cesarean section and unexpected newborn complications among Black patients and Overlook Medical Center was one of those nine identified.

PRIORITY AREA: ACCESS TO CARE

Access to care challenges affect patients across the communities we serve and may arise from a range of factors, including insurance coverage limitations, transportation barriers, scheduling availability, language and cultural differences, and other social determinants of health. These barriers can impact the ability of individuals to obtain timely primary, preventive, and specialty services, regardless of demographic group. Addressing access to care in a comprehensive and equitable manner supports earlier intervention, improves care continuity, and contributes to better overall health outcomes for all patients.

Goals and objectives to address these health disparities include:

Goal 1: Increase timely access to primary, preventative, and behavioral health services
Goal 2: Address structural and non-clinical barriers that prevent individuals from obtaining care and advancing health equity by targeting disparities in access and utilization.

Focus	Objectives
Scheduling and Appointment Availability	• Improve transparency of scheduling times • Expand the available times slots open to patients • Implement centralized access / call center optimization • Expand evening/weekend hours in high-demand service lines • Leverage digital self-scheduling and waitlist functionality • Standardize “third next available appointment” tracking across sites
Clinical Workforce Capacity	• Recruit and retain physicians and advanced practice providers to meet community demand • Target recruitment in high-need specialties (e.g., primary care, behavioral health) • Expand use of APPs and team-based care models • Explore academic/community partnerships to build workforce pipelines • Deploy flexible staffing models in high-growth geographies
Care Navigation & Coordination	• Improve patient ability to access, understand, and navigate the healthcare system • Expand patient navigation and care coordination programs • Enhance discharge follow-up and referral completion rates • Utilize community health workers (CHWs) for high-risk populations
Affordability & Financial Barriers	• Improve access to care regardless of ability to pay • Enhance financial counseling and charity care awareness • Streamline Medicaid enrollment and eligibility support

COMMUNITY OVERVIEW – CHILTON MEDICAL CENTER

Atlantic Health Chilton Medical Center (AHCMC) is committed to the health and well-being of the individuals and communities it serves. Recognizing that healthier communities contribute to improved quality of life, stronger community partnerships, and more sustainable health care delivery, AHCMC undertook a comprehensive Community Health Needs Assessment (CHNA) beginning in June 2025. AHCMC, a member of Atlantic Health (AH), conducted this assessment to evaluate the health needs of residents within its service area, which includes portions of Morris, Passaic, and Sussex counties in New Jersey.

The purpose of the CHNA was to collect and analyze current quantitative data and qualitative input to identify the most significant health issues affecting the community. The assessment incorporated a broad range of health indicators, including the prevalence of chronic conditions, access to health care services, and the impact of social determinants of health, to inform the identification of priority health needs and guide subsequent community health improvement efforts.

Atlantic Health's Community Health department helps people live healthier lives by providing virtual and in-person health education programs along with resources and services that support prevention and wellness. By collaborating closely with community partners, these efforts aim to make health services more accessible, reduce barriers to care, and meet the needs of diverse and underserved populations. Key initiatives include community-based tobacco cessation groups offered both virtually and in person; virtual exercise classes that promote healthy lifestyles; and the delivery of education and resources at community events, presentations, and health fairs in partnership with local organizations.

The completion of the CHNA provided AHCMC with a health-centric view of the population it serves, enabling AHCMC to prioritize relevant health issues and inform the development of future community health implementation plan(s) focused on meeting community needs. The complete AHCMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This community health improvement plan (CHIP) delineates how AHCMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2025-2027 Community Health Needs Assessment process identified six priority health needs that have been included in the 2026 CHIP.

- Mental Health and Substance Use Disorders
- Heart Disease
- Cancer
- Endocrine and Metabolic Disease, Diabetes, and Nutrition
- Geriatrics and Healthy Aging
- Access to Care

CHILTON MEDICAL CENTER – IMPLEMENTATION PLAN

The Community Health Improvement Plan (CHIP) serves as AHCMC's implementation strategy to address the significant health needs identified in the Community Health Needs Assessment (CHNA). It outlines the hospital's approach, including targeted strategies, initiatives, and anticipated timeframes for each priority area, along with measurable objectives and methods for evaluating progress. Implementation occurs over a multi-year period with ongoing monitoring and annual updates to ensure continued alignment with community needs, resource availability, and program effectiveness, while supporting broader Atlantic Health priorities and evidence-based practices.

PRIORITY AREA: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

AHCMC's progress toward behavioral health goals is ongoing, with a strong focus on community education and expanding access to behavioral health services. Community-based efforts are actively increasing awareness and reducing stigma through virtual programs, outreach events, and broad educational topics, supported by partnerships to strengthen local resources.

On the clinical side, efforts aim to expand access across care settings; however, current limitations restrict services primarily to crisis care in the emergency department, highlighting a gap in outpatient behavioral health resources.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Chilton Medical Center service area:

- Anxiety and fear-related disorders
- Neurodevelopmental disorder
- Depressive disorders
- Trauma-and-stressor related disorders
- Alcohol related disorders

Goals and objectives to address these health disparities include:

Goal 1: Provide community-based behavioral health services with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and addiction disorders.

Focus	Objectives
Community-based education programing	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. • Atlantic Behavioral Health is motivated to get people talking openly about a condition that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. **<u>Atlantic Behavioral Health Programming</u>** o Programs to support those dealing with grief o Children's and Adolescent Mental Health o Geriatric Mental Health o Mental Health and Other Support for Caregivers o Alcohol, marijuana, tobacco, and vaping awareness o Food and Impact on Mood • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.

Clinical programming related to addressing the growing behavioral health needs of the community	• Build clinical programs and services that meet patients in their community, with includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, and outpatient settings.

PRIORITY AREA: HEART DISEASE

The Atlantic Health cardiovascular initiative is focused on reducing disparities in heart disease and improving access to care and education for underserved and high-risk populations. Community-based education efforts are ongoing, providing information on key cardiovascular topics such as cholesterol management, heart failure, arrhythmia, and women's heart health through both virtual and in-person programming.

Hypertension management education remains in development, while a prior system-wide program was discontinued due to scalability challenges. Access to cardiovascular services has been strengthened, with completed expansion of cardiology services and ongoing monitoring of diagnostic capacity within the AHCMC market.

Additional efforts continue to promote preventive care awareness, emergency response education, and identification of structural barriers to health equity, though several initiatives remain in progress. Clinical expansion, including the Heart Success program at Chilton Medical Center and enhanced vascular services, is underway with added staffing and navigator support planned. Overall, the initiative reflects steady progress in expanding access and education, with continued work needed to fully advance hypertension management and equity-focused goals.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Chilton Medical Center service area:

- Essential hypertension
- Cardiac dysrhythmia
- Coronary atherosclerosis
- Heart Failure
- Nonrheumatic and unspecified valve disorders

Goals and objectives to address these health disparities include:

Goal 1: Take proactive steps to reduce cardiovascular health disparities in underserved and minority populations.

Goal 2: Employ broad measures to increase access to care and educational resources in the communities served by Atlantic Health, specifically among populations disproportionally impacted by cardiovascular disease.

Focus	Objectives
Community-based education programming	• Provide information and educational programs on topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Women with Cardiac Disease*
Access	• Enhance access to care and awareness of cardiovascular programs, cardiology practices, and services available across AH, as well as advancements and improvements in treatment options (STEMI, etc.). • Educate the community on availability and appropriate use of emergency transportation services, i.e., how, and when to seek help and the importance of acting quickly when emergency care is necessary. • Educate the community on the importance of seeking preventative care with their cardiologist, understanding warning signs for cardiovascular events, and what to do when a warning sign presents itself. • Identify structural barriers to health equity in our communities as they pertain to heart disease and capitalize on AH's existing community partnerships as a path to reducing and/or eliminating these barriers.

- Continue to evaluate programmatic needs of the community, particularly for vascular services.

PRIORITY AREA: CANCER

The CMC Cancer Program is advancing its goals of reducing barriers to care and promoting wellness across the cancer continuum through a mix of complete and ongoing initiatives. Community-based screening and education efforts are well established, with strong partnerships supporting early detection, prevention, and outreach, while screening programs for breast, colorectal, and lung cancers continue to expand.

Supportive services addressing financial, practical, and psychosocial needs are actively being strengthened through provider assessments, social work support, and collaboration with community agencies to connect patients with essential resources. Mental health services remain a priority, with ongoing distress screening, behavioral health integration, and peer support initiatives.

Efforts to improve access include insurance navigation, oncology nurse navigation, and expanded virtual programming, along with continued evaluation of resources for underserved populations to ensure culturally responsive care. Overall, while many foundational components are complete, most initiatives remain in progress with continued development and expansion planned through 2026.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Chilton Medical Center service area:

- Breast cancer
- Skin cancer- basal cell carcinoma and melanoma
- Prostate cancer
- Lung cancer
- Colorectal cancer

Goals and objectives to address these health disparities include:

Goal 1: Address barriers to cancer care through direct services and program development.
Goal 2: Promote health and wellness among the patient's continuum of care: diagnosis, treatment, and survivorship.

Focus	Objectives
Community-based screening	• Coordinate education and cancer screening opportunities with NJCEED and Community Health departments, local health departments, and the Regional Chronic Disease Coalition. • Expand access to high-risk breast, pancreatic and lung screenings services for medical evaluation and surveillance. • Maintain and expand the screening for colorectal, breast, prostate and lung cancer conducted at AMG practices.
Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction (e.g., *Nutrition and Healthy Lifestyle for Cancer Prevention, Debunking the Myths About Skin Cancer and Sun Protection, Breast Cancer: Are You at Risk,* and *Lung and Colorectal Cancer Awareness* etc.).
Practical / financial needs	• Providers assess patients for financial, practical, and psychosocial needs, including food insecurity, financial needs referring to the cancer center social worker for further assessment. Collaborate with community-based agencies to provide wigs, food, transportation, and other financial/practical matters. • Continue to develop more timely Advanced Care Planning and Palliative Care services and continue to identify grant and other funding opportunities to meet this unmet need.

	• ACS transportation grant to provide Uber/Lyft rides and QuickChek gas cards.
Mental health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). • Referrals are provided to Integrative Program Services as appropriate. • Referrals are provided to Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site through a nurse practitioner. • Referrals to community resources for Peer-to-Peer support and other supportive services. • AH continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service.
Transportation	• Collaborate with community resources to expand and enhance access to transportation services. • The Cancer Program at CMC provides financial support to reduce barriers to care. The funds can cover transportation, food assistance, and other practical needs. • ACS transportation grant to provide Uber/Lyft rides and QuickChek gas cards.
Insurance Issues	• Identify patients who do not have health insurance and are then referred to the NJCEED Program, the preauthorization team, or to AH patient financial services (PFS) and Charity care for evaluation and support. • Referrals to McKesson for drug copay assistance. • Social Workers meet with and counsel each patient in need, directing and referring to the appropriate resources. • Oncology navigators, nursing staff, registered dietitians, and social workers continually reassess a patient's barriers to care at each encounter.

PRIORITY AREA: ENDOCRINE AND METABOLIC DISEASE, DIABETES, AND NUTRITION

The CMC Diabetes Initiative is focused on improving awareness, prevention, and access to care for individuals with diabetes and those at high risk, particularly in underserved communities. Community-based education and outreach efforts are actively underway, including smoking cessation support, nutrition and lifestyle education, school and community presentations, and monthly support groups, with both in-person and virtual options expanding access.

Employee wellness initiatives and partnerships are in progress to support diabetes risk reduction and self-management among staff. Clinically, efforts are centered on strengthening care coordination and expanding access through telehealth and interdisciplinary programs such as the Diabetes Health Partnership, which identifies high-risk patients, addresses social determinants of health, and connects individuals to education and support services.

While most initiatives are progressing, some areas—such as clinical staffing growth, outpatient data tracking, and development of a Diabetes Prevention Program curriculum—remain limited or have been discontinued. Overall, the program continues to build capacity and improve access to comprehensive diabetes prevention and management services.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Chilton Medical Center service area:

- Disorders of lipid metabolism
- Fluid and electrolyte disorders
- Thyroid disorders
- Obesity
- Diabetes mellitus with complication

Goals and objectives to address these health disparities include:

Goal 1: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.
Goal 2: AHCMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.
Goal 3: Improve access and awareness of services in the AHCMC service area.

Focus	Objectives
Community-based education programming	• Referral, as appropriate, to AH Quit Smoking Program for smoking cessation. Increase access to tobacco cessation support through offering virtual and in-person, community-based tobacco cessation groups, with a focus on diverse populations and underserved communities. • Provide a series of group diabetes education classes on managing diabetes and making healthy lifestyle changes • *Partner with Cardiac Rehab to provide Heart Healthy Eating classes monthly to participants of cardiac rehab program* • Provide educational programming for community centers, senior centers, at community outreach events, health fairs, and worksites • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Offer one AH-wide virtual support group for patients with type 1 diabetes and type 2 diabetes. • Offer monthly in-person support group meetings and promote service to the community. • Refer patients to Diabetes Foundation for assistance in obtaining diabetes supplies and medication/insulin • Partner with community-based organizations such as local food pantries to link at risk patients to food sources • Offer a Diabetes Education Program in November
Promotion of Employee Health	• Partnership with AH Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus. • Collaborate with BRGs to provide educational presentations on diabetes management as requested • Offer A1C screening at AHCMC in Fall (in observance of Diabetes Month)
Clinical care & identification of at-risk populations and creations of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Continue to track and monitor data on a quarterly basis reduction in A1C and weight for participants of diabetes education • Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the program to aid in the reduction of readmissions. The program continues to be used throughout Atlantic Medical Group primary care offices through Atlantic Health. • Continue to increase access to diabetes care via in person and telehealth visits

PRIORITY AREA: GERIATRICS AND HEALTHY AGING

Atlantic Health Chilton Medical Center (AHCMC) is actively advancing its Healthy Aging and geriatrics-focused priorities, with initiatives centered on prevention, education, and enhanced care coordination for older adults. Efforts emphasize promoting healthy aging through community education, outreach programs, and expanded access to resources, including culturally and linguistically appropriate offerings. Clinical strategies focus on improving management of chronic conditions common among seniors by standardizing care practices, strengthening patient and caregiver education, ensuring timely follow-up, and expanding supportive services such as remote monitoring

and virtual care models. In parallel, AHCMC is increasing awareness and utilization of age-appropriate preventive services through community engagement and provider alignment, supported by clinical decision tools and streamlined care pathways. Collectively, these efforts aim to improve health outcomes, reduce avoidable utilization, and support older adults in maintaining independence and quality of life.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among 65 and older populations served by Atlantic Health in the AHCMC service area:

- Neurocognitive disorders
- Musculoskeletal pain, not low back pain
- Sleep wake disorders
- Prioritized clinical areas for continued improvement:
    - ED utilization
    - Readmissions

Goals and objectives to address these health disparities include:

Goal 1: Refer community residents in need of multispecialty hospital-based medical services to the multispecialty hospital-based practices located in senior living facilities.
Goal 2: AHCMC will seek to improve awareness of our multispecialty hospital-based practice at senior living facilities
Goal 3: Improve access and awareness of services in the AHCMC service area.

Focus	Objectives
Community-based prevention and education	• Deploy targeted virtual and in-person outreach, as appropriate, to deliver in-depth education on specialty services and care offerings. • Strengthen awareness and growth of the multispecialty practice through regularly scheduled engagement with senior living facility leadership, with a focus on expanding presence and partnerships. • Offer educational programming on healthy aging within senior living communities, including advanced directives and proactive healthcare planning. • Ensure equitable access by providing language services and real-time translation support through virtual interpreter services.

PRIORITY AREA: ACCESS TO CARE

Access to care challenges affect patients across the communities we serve and may arise from a range of factors, including insurance coverage limitations, transportation barriers, scheduling availability, language and cultural differences, and other social determinants of health. These barriers can impact the ability of individuals to obtain timely primary, preventive, and specialty services, regardless of demographic group. Addressing access to care in a comprehensive and equitable manner supports earlier intervention, improves care continuity, and contributes to better overall health outcomes for all patients.

Goals and objectives to address these health disparities include:

Goal 1: Increase timely access to primary, preventative, and behavioral health services
Goal 2: Address structural and non-clinical barriers that prevent individuals from obtaining care and advancing health equity by targeting disparities in access and utilization.

Focus	Objectives
Scheduling and Appointment Availability	• Improve transparency of scheduling times • Expand the available times slots open to patients • Implement centralized access / call center optimization • Expand evening/weekend hours in high-demand service lines • Leverage digital self-scheduling and waitlist functionality

	• Standardize “third next available appointment” tracking across sites
Clinical Workforce Capacity	• Recruit and retain physicians and advanced practice providers to meet community demand • Target recruitment in high-need specialties (e.g., primary care, behavioral health) • Expand use of APPs and team-based care models • Explore academic/community partnerships to build workforce pipelines • Deploy flexible staffing models in high-growth geographies
Care Navigation & Coordination	• Improve patient ability to access, understand, and navigate the healthcare system • Expand patient navigation and care coordination programs • Enhance discharge follow-up and referral completion rates • Utilize community health workers (CHWs) for high-risk populations
Affordability & Financial Barriers	• Improve access to care regardless of ability to pay • Enhance financial counseling and charity care awareness • Streamline Medicaid enrollment and eligibility support

ATLANTIC HEALTH NEWTON MEDICAL CENTER– COMMUNITY OVERVIEW

Atlantic Health Newton Medical Center (AHNMC) is committed to the health and well-being of the individuals and communities it serves. Recognizing that healthier communities contribute to improved quality of life, stronger community partnerships, and more sustainable health care delivery, AHNMC undertook a comprehensive Community Health Needs Assessment (CHNA) beginning in June 2024. AHNMC, a member of Atlantic Health (AH), conducted this assessment to evaluate the health needs of residents within its service area, which includes portions of Sussex and Warren counties in New Jersey.

The purpose of the CHNA was to collect and analyze current quantitative data and qualitative input to identify the most significant health issues affecting the community. The assessment incorporated a broad range of health indicators, including the prevalence of chronic conditions, access to health care services, and the impact of social determinants of health, to inform the identification of priority health needs and guide subsequent community health improvement efforts.

Atlantic Health's Community Health department helps people live healthier lives by providing virtual and in-person health education programs along with resources and services that support prevention and wellness. By collaborating closely with community partners, these efforts aim to make health services more accessible, reduce barriers to care, and meet the needs of diverse and underserved populations. Key initiatives include community-based tobacco cessation groups offered both virtually and in person; virtual exercise classes that promote healthy lifestyles; and the delivery of education and resources at community events, presentations, and health fairs in partnership with local organizations.

The completion of the CHNA provided AHNMC with a health-centric view of the population it serves, enabling AHNMC to prioritize relevant health issues and inform the development of future community health implementation plan(s) focused on meeting community needs. The complete AHNMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This community health improvement plan (CHIP) delineates how AHNMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2024-2026 Community Health Needs Assessment process identified four priority health needs that have been included in the 2026 CHIP.

- Diabetes
- Mental Health / Substance Misuse
- Heart Disease
- Cancer

IMPLEMENTATION PLAN – NEWTON MEDICAL CENTER

The Community Health Improvement Plan (CHIP) serves as AHNMC's implementation strategy to address the significant health needs identified in the Community Health Needs Assessment (CHNA). It outlines the hospital's approach, including targeted strategies, initiatives, and anticipated timeframes for each priority area, along with measurable objectives and methods for evaluating progress. Implementation occurs over a multi-year period with ongoing monitoring and annual updates to ensure continued alignment with community needs, resource availability, and program effectiveness, while supporting broader Atlantic Health priorities and evidence-based practices.

PRIORITY AREA: DIABETES

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHNMC service area:

- Fluid and electrolyte disorders
- Disorders of lipid metabolism
- Obesity
- Diabetes mellitus with complication
- Thyroid disease

Goals and objectives to address these health disparities include:

Goal 1: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.
Goal 2: AHNMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.
Goal 3: Improve access to and awareness of services in the AHNMC service area.

Focus	Objectives
Community-based education programming	• Referral, as appropriate, to AH Quit Smoking Program for smoking cessation. Increase access to tobacco cessation support through offering virtual and in-person, community-based tobacco cessation groups, with a focus on diverse populations and underserved communities. • Provide information and educational programs on the importance of screening and healthy lifestyle choices, e.g., *Navigating Supermarkets and Nutrition Labels, Understanding Eating Disorders, Foot Care, etc.* • Provide educational programming for schools, public libraries, senior centers, school nurses (patients and caregivers). • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes. • Monthly bariatric virtual support group • Monthly Nutrition Lectures at YMCA Sussex County • Quarterly Diabetes & Nutrition Education in Long Term Care facilities in Warren & Sussex County
Promotion of Employee Health	• Partnership with AH Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus. • Collaborate with BRGs to provide educational presentations on diabetes management.
Clinical care & identification of at-risk populations and creations of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • New Endocrinolgy opened in Sparta (89 Sparta Ave) in response to patient needs, two providers and adding a third.

	• Continue to track and monitor data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Rural Health transformation funding for telemedicine, continuous glucose monitors, fitness trackers, increase the amount of expensive produce to provide to participants, produce boxes to feed participants entire family, and monthly virtual support group. • Partnership with Food Is Medicine program. • Partnership with Share My Meals program. • Nourish and Connect Class Series sponsored by the HMC CAB Grant • Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the program to aid in the reduction of readmissions. The program continues to be used throughout Atlantic Medical Group primary care offices through Atlantic Health. • Optimize the use of telemedicine to increase access to care for diabetes care and endocrinology.

PRIORITY AREA: MENTAL HEALTH / SUBSTANCE MISUSE

AHNMC's progress toward behavioral health goals is ongoing, with strong emphasis on community education and gradual expansion of behavioral health services. Community-based efforts are actively reducing stigma and increasing awareness through multiple virtual and in-person programs, outreach events, and broad educational topics, supported by partnerships to strengthen local resources.

Clinically, services continue to expand across addiction treatment and outpatient mental health care, though growth is incremental and ongoing. While most initiatives are advancing, expansion of peer recovery services has been paused, reflecting current resource or strategic limitations.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Newton Medical Center service area:

- Anxiety and fear-related disorders
- Depressive disorders
- Bipolar and related disorders
- Alcohol-related disorders
- Trauma- and stressor-related disorders

Goals and objectives to address these health disparities include:

Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and addiction disorders.

Focus	Objectives
Community-based education programing	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. • Atlantic Behavioral Health is motivated to get people talking openly about a condition that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance

	awareness and engage influencers throughout New Jersey about the importance of access to mental health care. **<u>Atlantic Behavioral Health Programming</u>** ○ Programs to support those dealing with grief ○ Children's and Adolescent Mental Health ○ Geriatric Mental Health Issues ○ Mental Health and Other Support for Caregivers ○ Alcohol, marijuana, tobacco, and vaping awareness ○ Food and Impact on Mood • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.
Clinical programming related to addressing the growing behavioral health needs of the community	• Continue to build clinical programs and services that meet patients in their community, which includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, and outpatient settings. • Continuing expansion of medication for addiction treatment (MAT) services. • Continued expansion of addiction services at all levels of care. • Expansion of outpatient mental health services. • Develop collaborative care in partnership with Premier Health • Expansion of addiction and co-occurring (substance misuse/mental health) treatment at all levels of care • Continue to support individuals we serve with case management services to support their SDOH needs

PRIORITY AREA: HEART DISEASE

The Atlantic Health cardiovascular initiative is focused on reducing disparities in heart disease and improving access to care and education in underserved populations. Community-based education efforts are underway, providing information on key cardiovascular topics such as lipid management, heart failure, arrhythmias, and women's heart health through virtual programming.

Hypertension management education remains in development, while a prior enterprise-wide program was discontinued due to scalability limitations. Access to cardiovascular services has been strengthened through expanded cardiology staffing, adequate diagnostic and interventional capacity, and improved system-wide service availability, representing a completed area of progress.

Ongoing efforts continue to promote preventive care awareness and emergency response education, though some equity-focused and structural barrier initiatives remain in progress. Overall, the program reflects meaningful advancement in access and education, with continued work needed to fully address hypertension management and health equity goals.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Newton Medical Center service area:

- Essential hypertension
- Cardiac dysrhythmia
- Coronary atherosclerosis and other heart disease
- Heart Failure
- Acute myocardial infarction

Goals and objectives to address these health disparities include:

Goal 1: Take proactive steps to reduce cardiovascular health disparities in underserved and minority populations.

Goal 2: Employ broad measures to increase access to care and educational resources in the communities served by Atlantic Health, specifically among populations disproportionally impacted by cardiovascular disease.

Focus	Objectives
Community-based education programming	• Provide information and educational programs on topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Women with Cardiac Disease*
Access	• Enhance access to care and awareness of cardiovascular programs, cardiology practices, and services available across AH, as well as advancements and improvements in treatment options (STEMI, etc.). • Educate the community on availability and appropriate use of emergency transportation services, i.e., how, and when to seek help and the importance of acting quickly when emergency care is necessary. • Educate the community on the importance of seeking preventative care with their cardiologist, understanding warning signs for cardiovascular events, and what to do when a warning sign presents itself. • Identify structural barriers to health equity in our communities as they pertain to heart disease and capitalize on AH's existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: CANCER

The NMC Cancer Program is making steady progress toward reducing barriers to care and promoting wellness across the continuum of cancer. Community-based screening and education efforts are well established, with strong partnerships supporting prevention, early detection, and outreach, while screening access for colorectal, breast, and lung cancers continues to expand.

Supportive services addressing financial, practical, and psychosocial needs are actively being enhanced through provider assessments, social work collaboration, and community partnerships that connect patients to essential resources such as food, transportation, and financial assistance. Mental health services remain a key focus, with ongoing distress screening, behavioral health referrals, integrative services, and peer support initiatives.

Efforts to improve access include robust insurance navigation, oncology nurse navigation, and widespread use of virtual programming, most of which are fully implemented and ongoing. Additional work continues to expand transportation support, update digital resources, and strengthen culturally responsive care for underserved populations. Overall, many core components are complete and sustained, with targeted areas still in progress to further enhance access and reduce disparities through 2026.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Newton Medical Center service area:

- Breast cancer
- Lung cancer
- Prostate cancer
- Colorectal cancer

Goals and objectives to address these health disparities include:

Goal 1: Address barriers to cancer care through direct services and program development.
Goal 2: Promote health and wellness among the patient's continuum of care: diagnosis, treatment, and survivorship.

Focus	Objectives
Community-based screening	• Continued coordination of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments, and the Regional Chronic Disease Coalition.

	• Expand access to high-risk breast, pancreatic and lung screenings services for medical evaluation and surveillance. • Maintain and expand the screening for colorectal, breast, and lung cancer conducted at AMG practices.
Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction (e.g., *Nutrition and Healthy Lifestyle for Cancer Prevention, Debunking the Myths About Skin Cancer and Sun Protection, Breast Cancer: Are You at Risk,* and *Lung and Colorectal Cancer Awareness* etc.).
Practical / financial needs	• Providers assess patients for financial, practical, and psychosocial needs, including food insecurity, financial needs and referring to the cancer center social worker for further assessment. Collaborate with community-based agencies to provide wigs, food, transportation, and other financial/practical matters. • Continue to develop more timely Advanced Care Planning and Palliative Care services and continue to identify grant and other funding opportunities to meet this unmet need.
Mental health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). • Referrals are provided to Integrative Program Services as appropriate. • Referrals are provided to Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site through a nurse practitioner. • Referrals to community resources for Peer-to-Peer support and other supportive services. • AH continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service.
Transportation	• Collaborate with community resources to expand and enhance access to transportation services. • NMC Foundation with Patient Assistance Fund available to provide transportation assistance to patients to and from their oncology focused appointments such as radiation, physician appointments, chemotherapy, etc. Obtain gift cards/Uber cards and other resources to support transportation needs.
Insurance Issues	• Identify patients who do not have health insurance and refer to the NJCEED Program, the preauthorization team, or to AH's patient financial services (PFS) and Charity Care for evaluation and support. Referrals to McKesson for drug copay assistance. • Social Workers meet with and counsel patients in need, directing and referring to the appropriate resources. • Oncology navigators, nursing staff, registered dietitians, and social workers continually reassess patients' barriers to care at each encounter.
Access	• Employ virtual resources and programs to provide the community with access to support groups, educational programs and supplemental services related to cancer treatment, care, management, nutritional support, fertility and family planning, cardio-oncology, palliative care, and survivorship. • Continue to use and expand virtual and hybrid educational programs. • Review and update the AH Cancer Center website to improve access to virtual services, programs, and resources. • Evaluate and supplement resources available to the African American and Hispanic/Latino population to provide culturally sensitive care. • Improve care coordination and reduce healthcare disparities among underserved populations through community partnerships.

ATLANTIC HEALTH HACKETTSTOWN MEDICAL CENTER– COMMUNITY OVERVIEW

Atlantic Health Hackettstown Medical Center (AHHMC) is committed to the health and well-being of the individuals and communities it serves. Recognizing that healthier communities contribute to improved quality of life, stronger community partnerships, and more sustainable health care delivery, AHHMC undertook a comprehensive Community Health Needs Assessment (CHNA) beginning in June 2024. AHHMC, a member of Atlantic Health (AH), conducted this assessment to evaluate the health needs of residents within its service area, which includes portions of Warren, Morris, Hunterdon, and Sussex counties in New Jersey.

The purpose of the CHNA was to collect and analyze current quantitative data and qualitative input to identify the most significant health issues affecting the community. The assessment incorporated a broad range of health indicators, including the prevalence of chronic conditions, access to health care services, and the impact of social determinants of health, to inform the identification of priority health needs and guide subsequent community health improvement efforts.

Atlantic Health's Community Health department helps people live healthier lives by providing virtual and in-person health education programs along with resources and services that support prevention and wellness. By collaborating closely with community partners, these efforts aim to make health services more accessible, reduce barriers to care, and meet the needs of diverse and underserved populations. Key initiatives include community-based tobacco cessation groups offered both virtually and in person; virtual exercise classes that promote healthy lifestyles; and the delivery of education and resources at community events, presentations, and health fairs in partnership with local organizations.

The completion of the CHNA provided AHHMC with a health-centric view of the population it serves, enabling AHHMC to prioritize relevant health issues and develop a community health implementation plan focused on meeting community needs. The complete AHHMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This community health improvement plan (CHIP) delineates how AHHMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2024-2026 Community Health Needs Assessment process identified four priority health needs that have been included in the 2026 CHIP.

- Mental Health / Substance Misuse
- Heart Disease
- Cancer
- Diabetes/Obesity

ATLANTIC HEALTH HACKETTSTOWN MEDICAL CENTER– IMPLEMENTATION PLAN

The Community Health Improvement Plan (CHIP) serves as AHHMC's implementation strategy to address the significant health needs identified in the Community Health Needs Assessment (CHNA). It outlines the hospital's approach, including targeted strategies, initiatives, and anticipated timeframes for each priority area, along with measurable objectives and methods for evaluating progress. Implementation occurs over a multi-year period with ongoing monitoring and annual updates to ensure continued alignment with community needs, resource availability, and program effectiveness, while supporting broader Atlantic Health priorities and evidence-based practices.

PRIORITY AREA: MENTAL HEALTH & SUBSTANCE MISUSE

AHHMC's progress toward behavioral health goals is ongoing, with a strong focus on community education and expanding access to behavioral health services. Community-based efforts are actively reducing stigma and increasing awareness through virtual programming, outreach events, and diverse educational topics, supported by partnerships to strengthen local resources.

Clinically, services continue to expand across the continuum of care, including medication-assisted treatment, addiction services, and outpatient mental health care. All initiatives are in progress and designed for sustained, long-term impact.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHHMC service area:

- Alcohol-related disorders
- Anxiety and fear-related disorders
- Neurodevelopmental disorders
- Cannabis-related disorders
- Schizophrenia and other psychotic disorders
- Depressive disorders

Goals and objectives to address these health disparities include:

Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and addiction disorders.

Focus	Objectives
Community-based education programming	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. • Atlantic Behavioral Health is motivated to get people talking openly about a condition that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. **<u>Atlantic Behavioral Health Programming</u>** ○ Programs to support those dealing with grief ○ Children's and Adolescent Mental Health ○ Geriatric Mental Health Issues ○ Mental Health and Other Support for Caregivers ○ Alcohol, marijuana, tobacco, and vaping awareness ○ Food and Impact on Mood

	• Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.
Clinical programming related to addressing the growing behavioral health needs of the community	• Continue to build clinical programs and services that meet patients in their community, which includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, and outpatient settings. • Continued expansion of Medication for addiction treatment (MAT) services. • Continued expansion of addiction services at all levels of care. • Expansion of outpatient mental health services. • Develop collaborative care in partnership with Premier Health. • Expansion of addiction and co-occurring (substance misuse/mental health) treatment at all levels of care. • Continue to support individuals we serve with case management services to support their SDOH needs.

PRIORITY AREA: HEART DISEASE

The Atlantic Health cardiovascular initiative is focused on reducing disparities in heart disease and improving access to care and education for underserved and high-risk populations. Community-based education efforts are ongoing, with virtual programming addressing key cardiovascular topics such as cholesterol management, heart failure, arrhythmia, and women's heart health.

Hypertension education remains an area in development, while a prior system-wide program was discontinued due to scalability challenges. Access to cardiovascular care has been strengthened through expanded cardiology staffing and adequate diagnostic capacity, reflecting a complete area of improvement.

Additional efforts continue to promote preventive care awareness and emergency response education, though work remains to further define strategies addressing structural barriers to health equity. Overall, the initiative shows steady progress in education and access, with continued focus needed on hypertension management and equity-driven interventions.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHHMC service area:

- Essential hypertension
- Cardiac dysrhythmia
- Coronary atherosclerosis and other heart disease
- Heart failure
- Nonrheumatic and unspecified valve disorders

Goals and objectives to address these health disparities include:

Goal 1: Take proactive steps to reduce cardiovascular health disparities in underserved and minority populations.

Goal 2: Employ broad measures to increase access to care and educational resources in the communities served by Atlantic Health, specifically among populations disproportionally impacted by cardiovascular disease.

Focus	Objectives
Community-based education programming	• Provide information and educational programs on topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Women with Cardiac Disease*
Access	• Enhance access to care and awareness of cardiovascular programs and services available across AH, as well as advancements and improvements in treatment options (STEMI, etc.).

	• Educate the community on availability and appropriate use of emergency transportation services, i.e., how, and when to seek help and the importance of acting quickly when emergency care is necessary. • Educate the community on the importance of seeking preventative care with their cardiologist, understanding warning signs for cardiovascular events, and what to do when a warning sign presents itself. • Identify structural barriers to health equity in our communities as they pertain to heart disease and capitalize on AH's existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: DIABETES / OBESITY

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHHMC service area:

- Diabetes mellitus with complication
- Obesity
- Fluid and electrolyte disorders
- Disorders of lipid metabolism
- Thyroid disorders

Goals and objectives to address these health disparities include:

Goal 1: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.
Goal 2: AHHMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.
Goal 3: Improve access to and awareness of services in the AHHMC service area.

Focus	Objectives
Community-based education programming	• Referral, as appropriate, to AH Quit Smoking Program for smoking cessation. Increase access to tobacco cessation support through offering virtual and in-person, community-based tobacco cessation groups, with a focus on diverse populations and underserved communities. • Provide information and educational programs on the importance of screening and healthy lifestyle choices, e.g., *Navigating Supermarkets and Nutrition Labels, Understanding Eating Disorders, Foot Care, etc.* • Provide educational programming for schools, public libraries, senior centers, school nurses (patients and caregivers). • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes. • Offer monthly bariatric virtual support group
Promotion of Employee Health	• Partnership with AH Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus. • Collaborate with BRGs to provide educational presentations on diabetes management.
Clinical care & identification of at-risk populations and creation of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Expansion of medical office suite/space, to support volume and growth. Space enables access to endocrine services. • Continue to track and monitor data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages

	patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the program to aid in the reduction of readmissions. The program is used throughout AH's Atlantic Medical Group primary care offices. • Optimize the use of telemedicine to increase access to care for diabetes care and endocrinology. • Partnership with Food Is Medicine program. • Partnership with Share My Meals program.

PRIORITY AREA: CANCER

The HMC Cancer Program is progressing toward reducing barriers to care and promoting wellness across the cancer continuum through a combination of established and developing initiatives. Community-based screening efforts and partnerships are well established, supporting prevention and early detection, while expansion of screening services across key cancer types remains ongoing. Community education programming is also actively being implemented to promote risk reduction and early detection.

Supportive services addressing financial, practical, and psychosocial needs are in progress, with strong collaboration between providers and social work to connect patients with essential resources. Mental health services continue to be developed through assessments, referrals, and integration of behavioral health, integrative care, and peer support.

Efforts to improve access include completed insurance navigation and oncology navigation services, along with established virtual programming. Ongoing work focuses on enhancing transportation support, updating digital resources, and expanding culturally responsive care for underserved populations. Overall, core access and navigation services are in place, while several supportive care and outreach initiatives continue to advance through 2026.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the Hackettstown Medical Center service area:

- Breast cancer
- Lung cancer
- Colorectal cancer
- Prostate cancer
- Non-Hodgkin lymphoma

Goals and objectives to address these health disparities include:

Goal 1: Address barriers to cancer care through direct services and program development.
Goal 2: Promote health and wellness among the patient's continuum of care: diagnosis, treatment, and survivorship.

Focus	Objectives
Community-based screening	• Continued coordination of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments, and the Regional Chronic Disease Coalition. • Expand access to high-risk breast, pancreatic and lung screenings services for medical evaluation and surveillance. • Maintain and expand the screening for colorectal, breast, and lung cancer conducted at AMG practices.

Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction (e.g., *Nutrition and Healthy Lifestyle for Cancer Prevention, Debunking the Myths About Skin Cancer and Sun Protection, Breast Cancer: Are You at Risk,* and *Lung and Colorectal Cancer Awareness* etc.).
Practical / financial needs	• Providers assess patients for financial, practical, and psychosocial needs, including food insecurity, financial needs and referring to the cancer center social worker for further assessment. Collaborate with community-based agencies to provide wigs, food, transportation, and other financial/practical matters. • Continue to develop more timely Advanced Care Planning and Palliative Care services and continue to identify grant and other funding opportunities to meet this unmet need.
Mental health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). • Referrals are provided to Integrative Program Services as appropriate. • Referrals are provided to Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site through a nurse practitioner. • Referrals to community resources for Peer-to-Peer support and other supportive services. • AH continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service.
Transportation	• Collaborate with community resources to expand and enhance access to transportation services. • HMC Foundation with Patient Assistance Fund is available to provide transportation assistance to patients to and from their oncology focused appointments such as radiation, physician appointments, chemotherapy, etc. Obtain gift cards/Uber cards and other resources to support transportation needs.
Insurance issues	• Identify patients who do not have health insurance and refer to the NJCEED Program, the preauthorization team, or to AH's patient financial services (PFS) and Charity Care for evaluation and support. Referrals to McKesson for drug copay assistance. • Social Workers meet with and counsel patients in need, directing and referring to the appropriate resources. • Oncology navigators, nursing staff, registered dietitians, and social workers continually reassess patients' barriers to care at each encounter.
Access	• Employ virtual resources and programs to provide the community with access to support groups, educational programs and supplemental services related to cancer treatment, care, management, nutritional support, fertility and family planning, cardio-oncology, palliative care, and survivorship. • Continue to use and expand virtual and hybrid educational programs. • Review and update the AH Cancer Center website to improve access to virtual services, programs, and resources. • Evaluate and supplement resources available to the African American and Hispanic/Latino population to provide culturally sensitive care. • Improve care coordination and reduce healthcare disparities among underserved populations through community partnerships.

CentraState Healthcare System®
ATLANTIC HEALTH SYSTEM PARTNER

ATLANTIC HEALTH CENTRASTATE MEDICAL CENTER – COMMUNITY OVERVIEW

Atlantic Health CentraState Medical Center (AHCSMC) is committed to the health and well-being of the individuals and communities it serves. Recognizing that healthier communities contribute to improved quality of life, stronger community partnerships, and more sustainable health care delivery, AHCSMC undertook a comprehensive Community Health Needs Assessment (CHNA) beginning in June 2025. AHCSMC, a partner of Atlantic Health (AH), conducted this assessment to evaluate the health needs of residents within its service area, which includes portions of Monmouth, Middlesex, Mercer, and Ocean counties in New Jersey.

The purpose of the CHNA was to collect and analyze current quantitative data and qualitative input to identify the most significant health issues affecting the community. The assessment incorporated a broad range of health indicators, including the prevalence of chronic conditions, access to health care services, and the impact of social determinants of health, to inform the identification of priority health needs and guide subsequent community health improvement efforts.

Atlantic Health's Community Health department helps people live healthier lives by providing virtual and in-person health education programs along with resources and services that support prevention and wellness. By collaborating closely with community partners, these efforts aim to make health services more accessible, reduce barriers to care, and meet the needs of diverse and underserved populations. Key initiatives include community-based tobacco cessation groups offered both virtually and in person; virtual exercise classes that promote healthy lifestyles; and the delivery of education and resources at community events, presentations, and health fairs in partnership with local organizations.

The completion of the CHNA provided AHCSMC with a health-centric view of the population it serves, enabling AHCSMC to prioritize relevant health issues and develop a community health implementation plan focused on meeting community needs. The complete AHCSMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This community health improvement plan (CHIP) delineates how AHCSMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2025-2027 Community Health Needs Assessment process identified five priority health needs that have been included in the 2026 CHIP.

- Cancer
- Heart Disease
- Mental Health and Substance Use Disorders
- Endocrine and Metabolic Disease, Diabetes, and Nutrition
- Access to Care

CENTRASTATE MEDICAL CENTER – IMPLEMENTATION PLAN

The Community Health Improvement Plan (CHIP) serves as Atlantic Health CentraState Medical Center's implementation strategy to address the significant health needs identified in the Community Health Needs Assessment (CHNA). It outlines the hospital's approach, including targeted strategies, initiatives, and anticipated timeframes for each priority area, along with measurable objectives and methods for evaluating progress. Implementation occurs over a multi-year period with ongoing monitoring and annual updates to ensure continued alignment with community needs, resource availability, and program effectiveness, while supporting broader Atlantic Health priorities and evidence-based practices.

PRIORITY AREA: HEART DISEASE

The Atlantic Health cardiovascular initiative is focused on reducing disparities in heart disease and improving access to care and education for underserved and high-risk populations. Community-based education efforts are ongoing, addressing key cardiovascular topics such as cholesterol management, heart failure, arrhythmias, and women's heart health.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHCSMC service area:

- Coronary atherosclerosis and other heart disease
- Acute myocardial infarction
- Heart failure
- Cardiac dysrhythmia
- Postthrombotic syndrome and venous insufficiency/hypertension
- Acute pulmonary embolism
- Cerebral infarction
- Peripheral and visceral vascular disease
- Hypotension

Goals and objectives to address these health disparities include:

Goal 1: Offer supportive services designed to reduce cardiovascular risk factors which put a person at increased risk for cardiovascular disease.

Focus	Objectives

Community-based education programming	• Offer programs and services that help modify behaviors such as cigarette smoking/vaping, physical inactivity, and overweight/obesity.
	• Offer programs/screenings that stress the importance of adhering to treatment for high blood pressure and cholesterol, both critical for preventing and controlling cardiovascular disease.
	• Provide education on chronic conditions including related heart disease such as heart failure, hypertension, and diabetes.
	  ○ Offer digital scales, blood pressure monitors, or glucometers/test strips to medically referred patients in need.
	• Train people to identify the signs and symptoms of a heart attack and how to provide Early Heart Attack Care (EHAC)
	• Provide information and educational programs on topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Importance, Women with Cardiac Disease*
	• Assist patients and community members in obtaining and understanding information about heart health
	  ○ MyChart electronic health record promotion and utilization
	  ○ Work with PCPs and RN Health Coaches to lower patients' cardiovascular risk scores
	  ○ Early Heart Attack Care training, hands only CPR, and BLS training

- Provide and promote screenings onsite and in community settings for cardiovascular disease
  - Lipid profile, blood pressure, and/or A1C
- Partner with community organizations to support initiatives related to nutrition education and access to healthy food
  - Neighborhood Connections to Health, Freehold Family Health Center, Fulfill Food Bank
- Provide and promote physical activity
  - Live Life Well programs
  - Fitness Center disease specific programs including cardiac rehab step down program
- Offer diabetes prevention program to reduce risk factors

PRIORITY AREA: ENDOCRINE AND METABOLIC DISEASE, DIABETES, AND NUTRITION

The CentraState Diabetes Initiative demonstrates strong progress in achieving its goals of improving prevention, early identification, and management of diabetes, particularly among high-risk and underserved populations. Community-based screening and education efforts were fully implemented, exceeding targets with over 400 pre-diabetes screenings, expanded referrals to Diabetes Prevention and Self-Management Education programs, and broad community outreach through employers, farmers markets, and wellness programs.

Significant efforts were also made to address social determinants of health, including food insecurity through an on-site food pantry and mobile pantry services, as well as expanded access to nutrition, fitness, and preventive health programming. Employee wellness initiatives and screenings further support early detection and risk reduction within the workforce.

Clinically, the program strengthened care coordination through inpatient consultations, diabetes education referrals, glucose monitoring, and SDOH screening with navigation support via population health social work. While clinical team expansion remains in progress, overall, the initiative shows strong completion of core activities with ongoing efforts focused on capacity building and sustained access to comprehensive diabetes care.

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the AHCSMC service area:

- Thyroid disorders
- Diabetes mellitus with complication
- Disorders of lipid metabolism
- Other specified and unspecified nutritional and metabolic disorders
- Diabetes mellitus without complication
- Nutritional deficiencies
- Obesity
- Fluid and electrolyte disorders

Goals and objectives to address these health disparities include:

Goal 1: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.
Goal 2: CentraState will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.
Goal 3: Improve access to and awareness of services in the CentraState service area.

Focus	Objectives
Community-based education programming	• Screen 300+ people for pre-diabetes – specifically targeting those community members at increased risk for severe complications of diabetes.

	• Refer people with diabetes to the CDC-recognized Diabetes Prevention Program at CentraState or elsewhere for management and monitoring of nutrition and physical activity.
	• Refer individuals with diabetes to Diabetes Self-Management Education (DSME) programs led by certified diabetes educators to support effective self-care and disease management.
	• Increase awareness annual Medicare education benefit for 2 hours of DSME education.
	• Collaborate with employers to offer a range of preventive health programs.
	• Expand access to healthy food options through community-based initiatives:
	  ○ Support mobile food pantry programs in partnership with local food banks
	  ○ Participate in farmers' markets and nutrition voucher programs to improve affordability and availability of fresh foods
	• Provide community-based weight management programs to support healthy lifestyles and chronic disease prevention.
	• Offer accessible exercise and fitness classes to promote physical activity and overall wellness.
	• Conduct community screenings for head, neck, and thyroid conditions to support early detection and timely intervention.

Promotion of Employee Health	• Provide A1C screenings to employees and refer them to appropriate resources depending on the findings.

Clinical care & identification of at-risk populations and creation of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care.
	• Nursing tracks and monitors data on a quarterly basis on severe hyperglycemia and severe hypoglycemia.
	• Submit an Inpatient Consult to Certified Diabetes Educator for:
	  ○ Newly diagnosed patients and for continued support and education if non-adherence found.
	  ○ As needed for problem solving (unexplained hypo or hyperglycemia, decline in control, changes in physical or emotional health, change in living situations, cognitive or physical and self-care ability)
	  ○ CDE review of report for inpatients with A1c>8 and, if appropriate, recommend a consultation.
	  ○ PCP/ Hospitalist recommendation/Best practice advisory for outpatient DSME referral if A1c>8.
	  ○ Issue glucometer and test strips to patients in need.
	• Screen patients 18+ for social determinants of health. Refer patients to community-based resources via Unite Us as needed. Hand off to Population Health Social Worker to help patient navigate community-based resources post discharge.

PRIORITY AREA: CANCER

The following represent clinical populations with the greatest rate of utilization and/or are areas where potential health utilization disparities may exist among populations served by Atlantic Health in the CentraState Medical Center service area:

- Breast Cancer – All Types
- Prostate Cancer
- Thyroid and Pancreatic Cancers
- Esophageal Cancer

Goals and objectives to address these health disparities include:

Goal 1: Address barriers to cancer care through direct services and program development that focus on clinical areas of higher utilization and various health disparities that may exist within the community served.

Goal 2: Promote health and wellness among the patient's continuum of care: diagnosis, treatment, and survivorship.

Focus	Objectives
Community-based education programming and screening	• Provide tailored information and educational programs on topics related to early detection and cancer risk reduction for the general, older-adult, and high-risk populations. • Reduce risk of cancer through healthy lifestyles including nutrition and physical activity • Smoking cessation • Importance of early detection through screenings for breast, prostate, pancreatic, thyroid, and esophageal cancers. • Provide multilingual educational materials and screening reminders to promote participation in preventive and screening services
Practical / financial needs	• Clinicians assess and appropriately refer each patient to internal resources (social workers, nurse navigators, and dieticians) based on their financial, practical, and psychosocial needs. • Internal resources will collaborate with community health clinics to create streamlined referral pathways for patients with financial barriers. • Provide resources and materials to help patients navigate financial resources (Medicaid eligibility and charity care), community food insecurity, nutritional education, resources, pharmaceutical assistance, and other barriers to care. • Increase clinician and community awareness on advanced care planning and palliative care services. • Establish partnerships with foundations and grant programs to subsidize diagnostic and treatment costs for uninsured or underinsured individuals. • Include financial wellness education in survivorship programs to support long-term recovery and reduce post-treatment economic stress.
Mental health	• The social workers, nurse navigators, and/or oncology nursing professionals conduct distress screening on patients and refer them to applicable resources. • Referrals are provided to Integrative Program Services as appropriate. • Referrals are provided to our behavioral health services or other community resources for counseling and psychiatric services. • AHCSMC continues to identify resources and opportunities through community partnerships to provide access to mental health service(s). • Referrals to community resources for Peer-to-Peer support and other supportive services. • Include mental health navigation in survivorship planning.
Insurance Issues	• Identify patients who have health insurance barriers and refer them to the preauthorization team, CSMC patient financial services (PFS), Charity Care, and/or NJCEED program. • Referrals to McKesson for drug copay assistance. • Social workers meet with and counsel each patient in need, directing and referring to the appropriate resources. • Cancer navigators, nursing staff, registered dietitians, and social workers continually reassess a patient's barriers to care at each encounter. • Educate clinical staff to identify and refer uninsured and underinsured patients to the appropriate care team. • Provide resources and materials to help patients navigate financial resources.
Access	• Cancer navigators support patients and families through the cancer care continuum.

	• Utilize virtual and/or in-person resources and programs to provide the community with access to support groups, educational programs, and supplemental services related to cancer treatment, care management, and survivorship. • Incorporated additional cancer specialists. • Expand telehealth offerings for oncology consultations and follow-ups to reach patients with transportation or mobility challenges. • Increase the presence of surgical oncology specialists at CSMC satellite locations based on patient residential proximity. • Increase access to clinical trials. • Partner with local transportation providers, volunteer driver programs, and ride-sharing services to offer low-cost or no-cost rides for cancer appointments and incorporate transportation planning into the patient intake process. • Offer multilingual scheduling and navigation services to help non-English-speaking patients access care confidently and comfortably. • Review and update the AH and CSMC cancer center websites to improve access to virtual services, programs, and resources. • Partner with local faith-based and cultural organizations to improve trust and awareness of available oncology services within diverse communities.

PRIORITY AREA: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Progress toward Goal is primarily focused on acute care and referral-based support, with limited direct involvement in broader community and outpatient initiatives.

Behavioral health efforts center on clinical practices within the Emergency Department, including suicide screening, referral to appropriate treatment, and coordination with community partners for follow-up care, particularly given the absence of onsite outpatient behavioral health services. Partnerships support connections to external resources such as substance use treatment and peer-support programs.

Many planned community education, prevention, and outreach activities—such as awareness campaigns, school collaborations, and cessation programs—have not been actively implemented, reflecting gaps in current behavioral health engagement beyond the hospital setting.

Goals and objectives to address these health disparities include:

Goal 1: Offer a range of education, prevention and treatment options for behavioral health issues and substance use disorders.

Focus	Objectives
Promote the launch of the new 988 suicide hotline as well as the CentraState hotline. **Create linkages between the hospital and outpatient community-based services to assess and treat mental health conditions.** **Increase the number of individuals who receive treatment for mental**	• Provide suicide screenings for Emergency Department patients and refer to treatment as needed • Expand primary care practitioners in the service area who can identify at-risk individuals • Generate outpatient referrals to community partners and encourage treatment within 30 days of hospital/ED discharge • Promote awareness of CentraState's crisis line and behavioral health resources • Increase community awareness and understanding about mental health issues through community education events. • Collaborate with schools to improve life skills and decision-making regarding drugs and alcohol. • Provide self-assessments to identify potential binge-drinking patterns. • Offer support for smoking/vaping cessation. • Partner with collaborating agencies to identify and assist ED and inpatients, including Maternal/Child patients, with Substance Use Disorders for outpatient treatment.

health services in the appropriate setting.	• Refer patients to 12-step and other peer-programs as needed. • Evaluate the scope and development of outpatient services

PRIORITY AREA: ACCESS TO CARE

Access to care challenges affect patients across the communities we serve and may arise from a range of factors, including insurance coverage limitations, transportation barriers, scheduling availability, language and cultural differences, and other social determinants of health. These barriers can impact the ability of individuals to obtain timely primary, preventive, and specialty services, regardless of demographic group. Addressing access to care in a comprehensive and equitable manner supports earlier intervention, improves care continuity, and contributes to better overall health outcomes for all patients.

Goals and objectives to address these health disparities include:

Goal 1: Increase timely access to primary, preventative, and behavioral health services
Goal 2: Address structural and non-clinical barriers that prevent individuals from obtaining care and advancing health equity by targeting disparities in access and utilization.

Focus	Objectives
Scheduling and Appointment Availability	• Improve transparency of scheduling times • Expand the available times slots open to patients • Implement centralized access / call center optimization • Expand evening/weekend hours in high-demand service lines • Leverage digital self-scheduling and waitlist functionality • Standardize “third next available appointment” tracking across sites
Clinical Workforce Capacity	• Recruit and retain physicians and advanced practice providers to meet community demand • Target recruitment in high-need specialties (e.g., primary care, behavioral health) • Expand use of APPs and team-based care models • Explore academic/community partnerships to build workforce pipelines • Deploy flexible staffing models in high-growth geographies
Care Navigation & Coordination	• Improve patient ability to access, understand, and navigate the healthcare system • Expand patient navigation and care coordination programs • Enhance discharge follow-up and referral completion rates • Utilize community health workers (CHWs) for high-risk populations
Affordability & Financial Barriers	• Improve access to care regardless of ability to pay • Enhance financial counseling and charity care awareness • Streamline Medicaid enrollment and eligibility support

PREPARED FOR

ATLANTIC HEALTH MORRISTOWN MEDICAL CENTER

ATLANTIC HEALTH OVERLOOK MEDICAL CENTER

ATLANTIC HEALTH CHILTON MEDICAL CENTER

ATLANTIC HEALTH NEWTON MEDICAL CENTER

ATLANTIC HEALTH HACKETTSTOWN MEDICAL CENTER

ATLANTIC HEALTH CENTRASTATE MEDICAL CENTER

BY

ATLANTIC HEALTH
STRATEGY AND BUSINESS PLANNING

Atlantic Health