ATLANTIC HEALTH SYSTEM
COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

- Morristown Medical Center
- Overlook Medical Center
- Chilton Medical Center
- Newton Medical Center
- Hackettstown Medical Center

MAY 2023

Atlantic Health System

ACKNOWLEDGEMENTS & COMPLIANCE

Atlantic Health System is steadfast in its commitment to building healthier communities by improving access to care and addressing inequities that drive health disparities.

Atlantic Health System acknowledges the hard work and dedication of the individuals and the organizations they represent who contributed to the development of the 2023 Community Health Improvement Plan. The ongoing work of AHS employees and our community partners to achieve meaningful improvement of the health status of the communities we serve is paramount in the System's drive to provide high quality and affordable health care.

This 2023 Community Health Improvement Plan was developed in conjunction with hospital and community stakeholders and approved by hospital leadership. Data informing the Community Health Needs Assessment and Community Health Improvement Plan were compiled by AHS Planning & System Development. AHS' ongoing work with community and government agencies across Atlantic Health's service area is critical to ensuring that clinical staff, government agencies and community organizations achieve recognizable improvements in a wide range of population health issues.

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

Atlantic Health System
Planning & System Development
(973) 660-3522

or

Atlantic Health System
Community Health
(844) 472-8499

CONTENTS **PAGE**

ATLANTIC HEALTH SYSTEM COMMUNITY HEALTH NEEDS ASSESSMENT PRIORITIES 4

ATLANTIC HEALTH SYSTEM COMPREHENSIVE APPROACH TO ADDRESSING COMMUNITY HEALTH NEED AND IMPROVEMENT

- CARE COORDINATION AND SOCIAL DETERMINANTS OF HEALTH 5
- COMMUNITY HEALTH WORKERS 5
- SOCIAL DETERMINANTS OF HEALTH INTIATIVE 5
- DIVERSITY AND INCLUSION 6
- SUPPORTING FUNDING OF COMMUNITY PARTNERS AND COMMUNITY HEALTH NEEDS 6
- COMMUNITY HEALTH EDUCATION AND WELLNESS 6
- OTHER COLLABORATIVE SUPPORT 7
- EVALUATION PLAN & NEEDS NOT ADRESSED 7

ATLANTIC HEALTH SYSTEM ACUTE CARE COMMUNITY HEALTH IMPROVEMENT PLANS

- MORRISTOWN MEDICAL CENTER 8
- OVERLOOK MEDICAL CENTER 22
- CHILTON MEDICAL CENTER 34
- NEWTON MEDICAL CENTER 45
- HACKETTSTOWN MEDICAL CENTER 56

COMMUNITY HEALTH NEEDS ASSESSMENT PRIORITIES

The CHIP initiatives and activities described in this document reflect the collective input of individual hospitals and community representatives based on their understanding and knowledge of the communities they serve. These initiatives and strategies align with those mentioned in Healthy People 2030. AHS hospitals' individual prioritization lends itself to areas where coordinated resources from AHS' corporate office can facilitate inter-hospital strategies that result in broad geographic strategies to address commonalities across the communities served by AHS.

Shown below are the individual hospital health priorities adopted by the hospital Community Advisory Boards at the conclusion of the most recent hospital CHNA development process. There is broad continuity of focus across the AHS hospitals on behavioral health, diabetes/healthy weight/obesity, cancer, and heart disease and stroke with some individual site level priorities (geriatrics & healthy aging, maternal infant health, and respiratory disease) called out by the CABs during the CHNA process. The selection of the health priorities by the CABs follows a deep dive into data and community stakeholder survey data. These health priorities drive the annual development of the Community Health Improvement Plan (CHIP).

ATLANTIC HEALTH SYSTEM COMMUNITY HEALTH NEEDS ASSESSMENT PRIORITIES				
MMC	OMC	CMC	NMC	HMC
Behavioral Health	Mental Health and Substance Use Disorder	Mental Health / Substance Abuse	Mental Health and Substance Misuse	Mental Health Substance Misuse
Diabetes / Obesity / Unhealthy Weight	Diabetes	Diabetes	Diabetes Obesity	Diabetes and Overweight/Obesity
Cancer	Cancer	Cancer	Cancer	Cancer
Heart Disease Stroke	Heart Disease (including as it relates to Stroke)	Heart Disease	Heart Disease Stroke	Heart Disease
Geriatrics & Healthy Aging	Maternal / Infant Health	Respiratory Disease		
COMMUNITY HEALTH NEEDS ASSESSMENT PUBLICATION YEAR				
Dec 2022	***Dec 2022***	***Dec 2022***	***Dec 2021***	***Dec 2021***

In the development of the CHNAs, two common themes (access and quality) arose, serving as the lens through with we should view the health priorities and our attempts to address health disparities among clinical populations. This lens also has the added benefit of driving our conversations to align with the AHS Enterprise Strategic Objective of continuing to demonstrate clinical excellence at the highest level nationally and to lead in improving patient access, experience, and affordability.

ATLANTIC HEALTH SYSTEM COMPREHENSIVE APPROACH TO ADDRESSING COMMUNITY HEALTH NEED AND IMPROVEMENT

Each year, Atlantic Health System approaches its community health improvement plan (CHIP) with the intent to standardize, to the extent possible, proven, and effective methods for addressing community health needs across the enterprise. Where necessary or appropriate, individual activities specific to distinct populations served by hospitals are documented. Efforts addressed from a system perspective for all AHS hospitals include virtual care and community involvement, community coordination and social determinants of health, diversity and inclusion, supportive funding for community partners or collaboratives that are focused on common areas of concern related to community health needs, and health and wellness for older adults and at-risk populations.

Care Coordination and Social Determinants of Health

AHS Care Coordination Social Workers have insight into how social determinants of health – social, functional, environmental, cultural, and psychological factors – are linked to health outcomes for our patients. The interdisciplinary team, including our Social Workers, comprehensively identify and address various social needs that influence health behaviors to promote successful outcomes. They work in partnership with department 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 for 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

Community Health Workers provide patients with 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. Care Coordination has a team of Community Health Workers embedded in our medical center footprints who, in partnership with our social work team, assist in 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.

Social Determinants of Health Initiative

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. A Social Determinants of Health (SDOH) Wheel in Epic makes key information about the social factors that can influence a patient's health and health outcomes easier to see amongst the interdisciplinary team. The SDOH Wheel shows ten domains, each representing a factor that can influence health: financial resource strain, transportation needs, alcohol use, depression, intimate partner violence, social connections, physical activity, tobacco use, stress, and food insecurity. Based on patient answers to questions in each of

the domains, the panels turn green to indicate low risk, yellow for moderate risk or red to signal the need for intervention. Referrals can be sent to Care Coordination Social Workers and Community Health Workers for additional support and to connect the patient to key community resources.

In the first quarter of 2020, AHS launched a pilot program among 11 PCP practices to screen patients for SDOH. Screenings were broadened to all AMG/PCP practices in August 2020, taking place once a year at patients' annual physical examinations. In October 2021, an inpatient SDOH screening pilot was launched on a Morristown Medical Center unit and in March 2023 a second inpatient pilot was launched to screen patients with high-risk medical needs enrolled in the Transitions of Care program at all five medical centers. Both ambulatory and inpatient SDOH Steering Committees have formed to continue to hone, expand, and enhance SDOH screening and intervention to proactively identify and address barriers to care, improve health outcomes, enhance patient satisfaction, and reduce ED utilization and readmissions. AHS providers and Care Coordination continue to collaborate to ensure patients are connected to social support resources to ensure positive health outcomes.

Diversity and Inclusion

AHS strives for an inclusive health care environment where patients, visitors and team members are welcomed and afforded equitable treatment regardless of sexual orientation, gender, gender identity and expression, race, ethnicity, immigration status, socioeconomic background, disability and/or age. We not only value diversity but are also committed to inclusivity; the practice of engaging our diversity in decision making that affects the health and wellbeing of our communities. Atlantic Health System meets with 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.

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 likely to enhance resources available in the community and address elements of health priorities identified in the individual hospital's community health needs assessment. Grants are funded through a competitive review process, which includes a requirement that approved funding be linked to community health need as identified by the medical centers.

Community Health Education and Wellness

Community Health 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 determinants of health is a key component of our programs, helping to address all of the factors that influence chronic disease and heathier living. Delivering programs in-person as well as virtually, we align our programs to the AHS Community Health Improvement Plan. By working with our community stakeholders and partners, we are able to deliver programs that meet the needs of specific populations with a focus on the priority health issues of heart disease, stroke, cancer, diabetes and obesity, mental health and substance misuse, geriatrics and healthy aging, respiratory diseases and maternal and infant health.

Other Collaborative Support

In addition to actions within a specific strategy, Atlantic Health System is contributing a great deal of resources to support the CHNA/Implementation process via in-kind support for the North Jersey Health Collaborative (NJHC). Our resource and financial investments in the collaborative reflect our belief that bringing groups together, across sectors, is itself a significant community health intervention. To this end, we also participate in many community-based collaboratives that focus on health and social issues. The collaborative structure allows us to address our identified health needs and builds 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

Atlantic Health System's hospitals will track measurable progress for all activities. Where opportunities exist to demonstrate the impact of an activity, AHS' hospitals can request analytic support from the planning office. Data collection is tailored to each individual action, and therefore, will include a variety of methodologies.

Atlantic Health System
Morristown Medical Center

MORRISTOWN MEDICAL CENTER – COMMUNITY OVERVIEW

Morristown Medical Center (MMC) is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. To that end, beginning in June 2022, MMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, which encompasses portions of Essex, Hunterdon, Morris, Passaic, Somerset, Sussex, Union, and Warren counties in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing residents of MMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

The completion of the CHNA provided MMC with a health-centric view of the population it serves, enabling MMC to prioritize relevant health issues and inform the development of future community health implementation plan(s) focused on meeting community health need.

The complete MMC 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 MMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2022-2024 Community Health Needs Assessment process identified six priority health needs that have been included in the 2023 CHIP.

- Behavioral Health
- Diabetes / Obesity / Unhealthy Weight
- Cancer
- Heart Disease
- Stroke
- Geriatrics & Healthy Aging

While each priority area is addressed separately on the following pages, MMC's effort to address community health needs requires a complex interplay of internal resources, relationships with community partners, identification of co-morbidities across priority areas and, perhaps most importantly, the ability to course-correct when strategies or approaches to a priority can be better served through yet unknown pathways.

MORRISTOWN MEDICAL CENTER – IMPLEMENTATION PLAN

The Community Health Implementation Plan (CHIP) addresses the way MMC will approach health priorities and the expected timeframe for efforts.

PRIORITY AREA: BEHAVIORAL HEALTH

<table>
<tr><th colspan="3">Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and opioid and alcohol misuse.</th></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td>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 System in the Morristown Medical Center service area:

• Anxiety and fear-related disorders
• Neurodevelopmental disorder
• Depressive disorders
• Alcohol-related disorders
• Opioid misuse
• Schizophrenia spectrum and other psychotic disorders</td><td>Community-based education programming</td><td>• 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.

• No More Whispers 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, No More Whispers will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care.

<u>No More Whispers Programming</u>
○ Mental Health in the New Year
○ Programs to support those dealing with grief
○ Programs to support those dealing with trauma
○ Children’s and Adolescent Mental Health
○ Recognizing and Addressing Abuse
○ Geriatric Mental Health
○ Mental Health and Other Support for Caregivers
○ Education on Sleep
○ Alcohol, marijuana, tobacco, and vaping awareness
○ Substance Misuse and Addiction
○ Food and Impact on Mood
○ LGBTQ+ and Mental Health in Vulnerable Populations

• Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.</td></tr>
</table>

		• 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. • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	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. • Establish a pediatric behavioral health crisis intervention pathway. • Expansion of peer recovery services. • Develop a medication-assisted treatment (MAT) program. • Continued expansion of outpatient addiction services. • Continued expansion of adolescent outpatient mental health services.

PRIORITY AREA: DIABETES / OBESITY / UNHEALTHY WEIGHT

<table>
<tr><td colspan="3">Goal 1: Improve access to and awareness of services.</td></tr>
<tr><td colspan="3">Goal 2: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.</td></tr>
<tr><td colspan="3">Goal 3: MMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.</td></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="2">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 System in the Morristown Medical Center service area:

• Diabetes mellitus without complication
• Diabetes mellitus with complication
• Nutritional deficiencies
• Disorders of lipid metabolism
• Thyroid disorders</td><td>Community-based education programming</td><td>• Referral, as appropriate, to AHS 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.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices.
• Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
• 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.</td></tr>
<tr><td>Clinical care & identification of at-risk populations and creation of linkages to care</td><td>• 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 9 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</td></tr>
</table>

		used throughout Atlantic Medical Group primary care offices through Atlantic Health System. • Collaboration with Morristown Medical Center Retail Pharmacy for financial assistance programs for diabetes medication and supplies. • Body mass index (BMI) screening/nutritional education for overweight population and referral to Metabolic Center, as appropriate.
	Promotion of Employee Health	• Partnership with AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus.
	Reduce the level of food insecurity in the community	• Expand relationships with organizations such as Interfaith Food Pantry and Soup Kitchen that provide food rescue programs. • Expand access to healthier foods and groceries to the community served by MMC.

PRIORITY AREA: CANCER

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.		
Clinical Utilization Overview	**Focus**	**Objectives**
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 System in the Morristown Medical Center service area: • Male reproductive system cancers- prostate • Breast Cancer- all types • Neoplasms of unspecified nature or uncertain behavior • Skin cancers- melanoma • Secondary malignancies	**Community-based screening**	• Continued coordination of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments, Morris/Somerset Chronic Disease Coalition, and other community agencies. • Expand follow up of high-risk breast and lung screenings for medical evaluation and surveillance. • Maintain and expand access to screening for colorectal, breast, and lung cancer conducted at AMG practices.
	Community-based education programming	• 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 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,* etc. • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	Practical / financial needs	• Providers assess each patient for financial, practical, and psychosocial needs—including food insecurity, 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 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 our Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site in the cancer center through a nurse practitioner. • AHS 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 are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. • 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.
	Access	• Employ virtual resources and programs to provide community with access to support groups, educational programs and supplemental services related to cancer treatment, care, and management. • Continue to use and expand virtual platforms to supplement for the lack of face-to-face support services resulting from COVID-19. • Review and update the AHS 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. • Improving Care Considerations and reducing healthcare disparities for the LGBTQ population.

PRIORITY AREA: HEART DISEASE

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 System, specifically among populations disproportionally impacted by cardiovascular disease.

Clinical Utilization Overview	Focus	Objectives
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 System in the Morristown Medical Center service area: • Essential hypertension • Nonrheumatic and unspecified valve disorders • Heart failure • Nonspecific chest pain	**Community-based education programming**	• 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 topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Sports Cardiology/BLS Importance, Women with Cardiac Disease* etc. • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	Hypertension Management Program (HMP)	• A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. • Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs). • AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve. • Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.
	Women's Health Initiatives	• Designate 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 AHS.

		• 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 the difference of heart attack symptoms in men and women; and then place this education in AMG practices to reach a wide audience.
	Access	• Enhance access to care and awareness of cardiovascular programs and services available across AHS, 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 AHS' existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: STROKE

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.

Clinical Utilization Overview	Focus	Objectives
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 System in the Morristown Medical Center service area: • Cerebral Infarction • Acute hemorrhagic cerebrovascular disease • Sequela of hemorrhagic cerebrovascular disease • Sequela of cerebral infarction and other cerebrovascular disease	**EMS and Caregiver Support**	• Continued virtual and in-person education sessions for EMS and caregivers on stroke signs and symptoms for rapid identification and transport to a stroke Center. • Education for AHS and volunteer agencies on the statewide rollout of validated pre-hospital Large Vessel Occlusion recognition tool (RACE Scale). • Support group for caregivers and survivors that is currently offered virtually, with ongoing efforts to switch to a quarterly hybrid format.
	Community-based education programming	• Educate the community 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. • Educate health care professionals and members of the communities we serve regarding advances in stroke treatment and availability of stroke related services and resources. • 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. • Improved website by continuously making sure the resources available remain up to date and are accessible to the community. • World Stroke Day presentation scheduled for October • 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. • Offer virtual and in person exercise classes to support healthy lifestyle choices.

		• Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	Staff Education	• Educational Stroke Symposium, conducted annually, provides an outlet for education and discussion for healthcare providers on various topics pertaining to stroke, such as ongoing clinical research, nursing care options, and post rehabilitation. • As a system, stroke education was included within AHS' PRIDE essentials, an annual training for team members.
	Stroke Governmental Advocacy	• Support local, regional, state, and national stroke communities through advocacy and peer forums which drive stroke care. • Promote, identify, and design the statewide system of stroke care through appointment to the New Jersey Department of Health, Stroke Care Advisory Panel (SCAP).

PRIORITY AREA: GERIATRICS & HEALTHY AGING

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.

Clinical Utilization Overview	Focus	Objectives
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 System in the Morristown Medical Center service area: • Musculoskeletal pain, not low back pain • Sleep wake disorders • Spondylopathies /spondyloarthropathy • Osteoarthritis • Urinary tract infections • Nutritional anemia • Aplastic anemia • Osteoporosis • Conduction disorders • Chronic kidney disease • Parkinson's disease • Neurocognitive disorders	**Community-based education programming**	• 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 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.* • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.

	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.
		• 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.

	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. MMC and the Geriatric Assessment Center continue to be recognized by AFHS as an Age-Friendly Health System committed to care excellence. • AHS' 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 hotline assists seniors and their caregivers with obtaining information regarding private home care and visiting nurse services, rehabilitation facilities, housing organizations, adult day care centers, and hospice care providers. Telephone and virtual consults are made available for caregivers. • The Art of Caregiving course is a 5-part interactive course offered quarterly, using a virtual platform, to caregivers to help them navigate the nuances of the eldercare maze. This program provides personalized guidance on how best to care for their aging loved one while ensuring their own health does not suffer. • The Caregiver Training Lab is a model home environment for older adults and is located at the Geriatric Assessment Center. It provides hands on training and education to seniors and their caregivers. • Offer support and counseling services for patients and caregivers as they age and navigate the elder care journey.
	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 MMC 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 Alzheimer's disease.

	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.

OVERLOOK MEDICAL CENTER – COMMUNITY OVERVIEW

Overlook Medical Center (OMC) is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. To that end, beginning in June 2022, OMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, which encompasses portions of Union, Essex, Morris, Somerset, Hudson, and Middlesex counties in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing residents of OMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

The completion of the CHNA provided OMC with a health-centric view of the population it serves, enabling OMC to prioritize relevant health issues and inform the development of future community health implementation plan(s) focused on meeting community needs.

The complete OMC 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 OMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2022-2024 Community Health Needs Assessment process identified five priority health needs that have been included in the 2023 CHIP.

- Mental Health and Substance Use Disorder
- Cancer
- Heart Disease (including as it relates to Stroke)
- Diabetes
- Maternal / Infant Health

While each priority area is addressed separately on the following pages, OMC's effort to address community health needs requires a complex interplay of internal resources, relationships with community partners, identification of co-morbidities across priority areas and, perhaps most importantly, the ability to course-correct when strategies or approaches to a priority can be better served through yet unknown pathways.

OVERLOOK MEDICAL CENTER – IMPLEMENTATION PLAN

The Community Health Implementation Plan (CHIP) addresses the way OMC will approach health priorities and the expected timeframe for efforts.

PRIORITY AREA: MENTAL HEALTH AND SUBSTANCE USE DISORDER

Goal 1: Provide community-based behavioral health services with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and substance use disorder.		
Clinical Utilization Overview	**Focus**	**Objectives**
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 System in the Overlook Medical Center service area: • Anxiety and fear-related disorders • Neurodevelopmental disorder • Depressive disorders • Feeding and eating disorders • Cannabis-related disorders	**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. • *No More Whispers* 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, *No More Whispers* will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. ***No More Whispers* Programming** ○ Mental Health in the New Year ○ Programs to support those dealing with grief ○ Programs to support those dealing with trauma ○ Children's and Adolescent Mental Health Issues ○ Recognizing and Addressing Abuse ○ Geriatric Mental Health ○ Mental Health and Other Support for Caregivers ○ Education on Sleep ○ Alcohol, marijuana, tobacco, and vaping awareness ○ Substance Misuse and Addiction ○ Food and Impact on Mood ○ LGBTQ+ and Mental Health Mental Health Issues in Vulnerable Populations

		• Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community. • 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. • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	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. • Establish a pediatric behavioral health crisis intervention pathway. • Develop a medication-assisted treatment (MAT) program. • Continued expansion of outpatient addiction services. • Continued expansion of adolescent outpatient mental health services.

PRIORITY AREA: CANCER

<table>
<tr><th colspan="3">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.</th></tr>
<tr><th colspan="3">Goal 2: Promote health and wellness among the patient's continuum of care: diagnosis, treatment, and survivorship.</th></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="3">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 System in the Overlook Medical Center service area:

• Male reproductive system cancers- prostate
• Breast Cancer- all types
• Conditions due to neoplasm or the treatment of neoplasm
• Gastrointestinal cancers- esophagus
• Secondary malignancies</td><td>Community-based screening</td><td>• Continued coordination of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments and the Regional Chronic Disease Coalition.
• Expand follow up of high-risk breast and lung screenings for medical evaluation and surveillance.
• Maintain and expand the screening for colorectal, breast, and lung cancer conducted at AMG practices.</td></tr>
<tr><td>Community-based education programming</td><td>• 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 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, etc.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices. Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.</td></tr>
<tr><td>Practical / financial needs</td><td>• Providers assess each patient for financial, practical, and psychosocial needs—including food insecurity, 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 Continue to identify grant and other funding opportunities to meet this unmet need.</td></tr>
</table>

	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 our Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site in the cancer center through a nurse practitioner. • AHS 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.
	Insurance issues	• Identify patients who do not have health insurance and are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. • 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.
	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, and management. • Continue to use and expand virtual platforms to supplement the lack of face-to-face support services resulting from COVID-19. • Review and update the AHS 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. • Improving Care Considerations and reducing healthcare disparities for the LGBTQ population.

PRIORITY AREA: HEART DISEASE

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 System, specifically among populations disproportionally impacted by cardiovascular disease.

Clinical Utilization Overview	Focus	Objectives
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 System in the Overlook Medical Center service area: • Essential Hypertension • Nonspecific chest pain • Coronary atherosclerosis and other heart disease • Cardiac dysrhythmias • Nonrheumatic and unspecified valve disorders • Heart Failure	**Community-based education programming**	• 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 topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Sports Cardiology/BLS Importance, Women with Cardiac Disease* etc. • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	Hypertension Management Program (HMP)	• A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs). • AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve. • Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.
	Access	• Increased access to care and awareness of cardiovascular programs and services available across AHS, 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 AHS' existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: STROKE

<table>
<tr><td colspan="3">Goal 1: Educate the community and first responders on stroke signs and symptoms for rapid identification and transport to a stroke center.</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="3">Goal 3: Educate health care professionals and members of the communities we serve regarding advances in stroke treatment.</td></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="2">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 System in the Overlook Medical Center service area:

• Cerebral Infarction
• Acute hemorrhagic cerebrovascular disease
• Sequela of hemorrhagic cerebrovascular disease
• Sequela of cerebral infarction and other cerebrovascular disease</td><td>EMS and Caregiver Support</td><td>• Continued virtual and in-person education sessions for EMS and caregivers on stroke signs and symptoms for rapid identification and transport to a stroke center.
• Education for AHS and volunteer agencies on the statewide rollout of validated pre-hospital Large Vessel Occlusion recognition tool (RACE Scale).
• Support group for caregivers and survivors that is currently offered virtually, with ongoing efforts to switch to a quarterly hybrid format.</td></tr>
<tr><td>Community-based education programming</td><td>• Educate the community 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.
• Educate health care professionals and members of the communities we serve regarding advances in stroke treatment and availability of stroke related services and resources.
• 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.
• Improved website by continuously making sure the resources available remain up to date and are accessible to the community.
• B.E. F.A.S.T. Fridays: Increase awareness of stroke signs and symptoms to patients seeking care in the emergency department for a variety of medical needs.
• World Stroke Day presentation scheduled for October.
• 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.</td></tr>
</table>

		• Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	Staff Education	• Educational Stroke Symposium, conducted annually, provides an outlet for education and discussion for healthcare providers on various topics pertaining to stroke, such as ongoing clinical research, nursing care options, and post rehabilitation. • As a system, stroke education was included within AHS' PRIDE Essentials, an annual training for team members.

PRIORITY AREA: DIABETES

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: OMC 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 OMC service area.		
Clinical Utilization Overview	**Focus**	**Objectives**
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 System in the Overlook Medical Center service area: • Disorders of lipid metabolism • Thyroid disorders • Obesity • Fluid and electrolyte disorders • Diabetes mellitus without complications	**Community-based education programming**	• Referral, as appropriate, to AHS 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.* • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations. • 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 AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus.
	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 9 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 System.
	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 tested and are 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. • Continue to build on Overlook Medical Center's relationship with Grace Refrigerator, which offers nutrient dense produce, dairy, and prepared meals to food insecure families in the community served by Overlook. • 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

<table>
<tr><td colspan="3">Goal 1: Improve access to care throughout the OMC community by focusing on areas where health disparities may exist and where resources are in greater demand.</td></tr>
<tr><td colspan="3">Goal 2: Continue to develop community-based education that meets the needs of the communities served by OMC.</td></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="2">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 System in the Overlook Medical Center 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</td><td>Community-based education programming</td><td>• 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 various topics such as the importance of prenatal and postpartum care, lifestyle and other modifiable risk factors, chronic condition management, etc.
• Develop an outreach plan to promote access to maternal/infant education and information topics among high-risk populations.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices. Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.</td></tr>
<tr><td>Expand access to care</td><td>• Support improved access to care for OB/Gyn services through increased provider presence and breadth/availability of subspecialist services available at OMC'S HealthStart Clinic.
• Address screening and treatment of anemia and hypertension through education across AMG practices and at the OMC HealthStart Clinic.
• Develop and continue to grow a doula program offered throughout AHS, including expansion of services to postpartum care.</td></tr>
</table>

Atlantic Health System
Chilton Medical Center

COMMUNITY OVERVIEW – CHILTON MEDICAL CENTER

Community Served by Chilton Medical Center

Chilton Medical Center (CMC) is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. To that end, beginning in June 2022, CMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, which encompasses portions of Morris and Passaic counties in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing residents of CMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

The completion of the CHNA provided CMC with a health-centric view of the population it serves, enabling CMC to prioritize relevant health issues and inform the development of future community health implementation plan(s) focused on meeting community needs.

The complete CMC 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 CMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2022-2024 Community Health Needs Assessment process identified five priority health needs that have been included in the 2023 CHIP.

- Mental Health / Substance Abuse
- Heart Disease
- Cancer
- Diabetes
- Respiratory Disease

While each priority area is addressed separately on the following pages, CMC's effort to address community health needs requires a complex interplay of internal resources, relationships with community partners, identification of co-morbidities across priority areas and, perhaps most importantly, the ability to course-correct when strategies or approaches to a priority can be better served through yet unknown pathways.

CHILTON MEDICAL CENTER – IMPLEMENTATION PLAN

The Community Health Implementation Plan (CHIP) addresses the way CMC will approach each priority need and the expected outcome and timeframe for the evaluation of its efforts.

PRIORITY AREA: MENTAL HEALTH / SUBSTANCE ABUSE

Goal 1: Provide community-based behavioral health services with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and substance use disorder.		
Clinical Utilization Overview	**Focus**	**Objectives**
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 System in the Chilton Medical Center service area: • Anxiety and fear-related disorders • Neurodevelopmental disorder • Depressive disorders • Trauma-and-stressor related disorders • Alcohol related disorders	**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. • *No More Whispers* 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, *No More Whispers* will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. ***No More Whispers*** **Programming** o Mental Health in the New Year o Programs to support those dealing with grief o Programs to support those dealing with trauma o Children's and Adolescent Mental Health o Recognizing and Addressing Abuse o Geriatric Mental Health o Mental Health and Other Support for Caregivers o Education on Sleep o Alcohol, marijuana, tobacco, and vaping awareness o Substance Misuse and Addiction o Food and Impact on Mood o LGBTQ+ and Mental Health in Vulnerable Populations

		• Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community. • 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. • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	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, with includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, and outpatient settings. • Establish a pediatric behavioral health crisis intervention pathway. • Continued expansion of outpatient addiction services.

PRIORITY AREA: HEART DISEASE

<table>
<tr><td colspan="3">Goal 1: Take proactive steps to reduce cardiovascular health disparities in underserved and minority populations.</td></tr>
<tr><td colspan="3">Goal 2: Employ broad measures to increase access to care and educational resources in the communities served by Atlantic Health System, specifically among populations disproportionally impacted by cardiovascular disease.</td></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="3">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 System in the Chilton Medical Center service area:

• Essential hypertension
• Cardiac dysrhythmias
• Coronary atherosclerosis
• Heart Failure
• Nonrheumatic and unspecified valve disorders</td><td>Community-based education programming</td><td>• 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 topics related to understanding heart disease, e.g., Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Sports Cardiology/BLS Importance, Women with Cardiac Disease etc.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices.
• Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.</td></tr>
<tr><td>Hypertension Management Program (HMP)</td><td>• A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs).
• AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve.
• Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.</td></tr>
<tr><td>Access</td><td>• Enhance access to care and awareness of cardiovascular programs and services available across AHS, 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.</td></tr>
</table>

		• 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 AHS' existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: CANCER

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.		
Clinical Utilization Overview	**Focus**	**Objectives**
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 System in the Chilton Medical Center service area: • Breast Cancer • Skin cancers- basal cell carcinoma • Urinary system cancers- bladder • Skin cancers- melanoma • Male reproductive system cancers- prostate	**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 follow up of high-risk breast and lung screenings for medical evaluation and surveillance. • Maintain and expand the screening for colorectal, breast, and lung cancer conducted at AMG practices.
	Community-based education programming	• 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 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,* etc. • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	Practical / financial needs	• Providers assess each patient for financial, practical, and psychosocial needs—including food insecurity, 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 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 our Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site in the cancer center through a nurse practitioner. • AHS 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.
	Insurance Issues	• Identify patients who do not have health insurance and are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. • 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.
	Access	• Employ virtual resources and programs to provide community with access to support groups, educational programs and supplemental services related to cancer treatment, care, and management. • Review and update the AHS 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. • Improving Care Considerations and reducing healthcare disparities for the LGBTQ population.

PRIORITY AREA: DIABETES

<table>
<tr><td colspan="3">Goal 1: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.</td></tr>
<tr><td colspan="3">Goal 2: CMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.</td></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="3">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 System in the Chilton Medical Center service area:

• Disorders of lipid metabolism
• Fluid and electrolyte disorders
• Thyroid disorders
• Obesity
• Diabetes mellitus with complication</td><td>Community-based education programming</td><td>• Referral, as appropriate, to AHS 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.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices
• Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations
• 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.</td></tr>
<tr><td>Promotion of Employee Health</td><td>• Partnership with AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus.</td></tr>
<tr><td>Clinical care & identification of at-risk populations and creations of linkages to care</td><td>• 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 9 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</td></tr>
</table>

		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 System. • Develop Diabetes Prevention Program (DPP) Curriculum.

PRIORITY AREA: RESPIRATORY DISEASE

<table>
<tr><td colspan="3">Goal 1: Increase education of the community served by CMC to the dangers of nicotine.</td></tr>
<tr><td colspan="3">Goal 2: Identify opportunities to improve community health through continued reduction of 30-day readmissions for COPD.</td></tr>
<tr><td colspan="3">Goal 3: Increase the awareness of the AHS Lung Cancer Screening Program in the community served by CMC.</td></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="2">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 System in the Chilton Medical Center service area:

• Pneumonia (except that caused by tuberculosis)
• Other specified upper respiratory infections
• Chronic obstructive pulmonary disease and bronchiectasis
• Asthma
• Respiratory failure; insufficiency; arrest</td><td>Community-based prevention and education</td><td>• Nicotine Cessation (Smoking & Vaping): Educate patients, community residents, and AMG providers about the CMC Quit Smoking Support Group. CMC will distribute the CMC Quit Smoking flyer and will collect metrics annually on enrolled/graduated participants in smoking cessation programs.
• As needed/appropriate, employ virtual and/or in-person outreach and programming that provides an in-depth on-line educational approach to nicotine cessation.
• All Atlantic Health locations will have access to Spanish speaking smoking cessation classes with a respiratory therapist.
• Nicotine Prevention: Employ virtual and/or in-person education and programming to educate the community on nicotine prevention for both youth and adults.
• Provide information and educational programs on the importance of screening and healthy lifestyle choices e.g. Vaping and E-Cigarettes, Treating Viral Conditions, etc.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices.
• Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.</td></tr>
<tr><td>Decrease 30-day Readmissions Rates Within COPD Population</td><td>• COPD Population: 1) Increase the use of EPIC COPD Order Set; 2) Increase the use of the AHM COPD Disease Management Program EPIC order; 3) Daily patient COPD education by respiratory therapist and/or COPD Educator; 4) 7-day or less pulmonary/PCP appointments arranged prior to discharge; 5) Continued education at CMC on the 2021 GOLD Guidelines at yearly training days for RNs, RTs, and hospitalists.
• Remote patient monitoring as ordered by providers for cases among the patients served by CMC.
• Pulmonary rehabilitation services will be made available at CMC.</td></tr>
</table>

	AHS Lung Cancer Screening	• CMC will increase awareness of AHS' lung cancer screening program (LCS) in the community and among providers through focused outreach and education programs. • Providers working on AHS' electronic medical record will be encouraged to utilize "Best Practice Alerts" for lung cancer screening. • CMC will work to increase awareness of LCS criteria in the broader population. • CMC will monitor relevant metrics related to LCS, including how many patients had an LCS from CMC, how many patients had a RADs (Reporting and Data System) 3 or 4 nodule and of these how many had a resection or chemotherapy. • Chilton Medical Center's partnership with Screen NJ is providing funds for low-dose CT scans and other pulmonary screening modalities for at-risk financially vulnerable patients.

NEWTON MEDICAL CENTER – COMMUNITY OVERVIEW

Newton Medical Center (NMC) is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. To that end, beginning in June 2021, NMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, which encompasses portions of Sussex and Warren counties in New Jersey, as well as portions of Pike County in Pennsylvania. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing residents of NMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

The completion of the CHNA provided NMC with a health-centric view of the population it serves, enabling NMC to prioritize relevant health issues and inform the development of future community health implementation plan(s) focused on meeting community needs.

The complete NMC 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 NMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2021-2023 Community Health Needs Assessment process identified six priority health needs that have been included in the 2023 CHIP.

- Mental Health and Substance Misuse
- Cancer
- Heart Disease
- Diabetes
- Obesity
- Stroke

While each priority area is addressed separately on the following pages, NMC's effort to address community health needs requires a complex interplay of internal resources, relationships with community partners, identification of co-morbidities across priority areas and, perhaps most importantly, the ability to course-correct when strategies or approaches to a priority can be better served through yet unknown pathways.

IMPLEMENTATION PLAN – NEWTON MEDICAL CENTER

The Community Health Implementation Plan (CHIP) addresses the way NMC will approach each priority need and the expected outcome and timeframe for the evaluation of its efforts.

PRIORITY AREA: MENTAL HEALTH AND SUBSTANCE MISUSE

Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and opioid and alcohol misuse.		
Clinical Utilization Overview	**Focus**	**Objectives**
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 System 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	**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. • *No More Whispers* 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, *No More Whispers* will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. ***No More Whispers* Programming** o Mental Health in the New Year o Programs to support those dealing with grief o Programs to support those dealing with trauma o Children's and Adolescent Mental Health o Recognizing and Addressing Abuse o Geriatric Mental Health Issues o Mental Health and Other Support for Caregivers o Education on Sleep o Alcohol, marijuana, tobacco, and vaping awareness o Substance Misuse and Addiction o Food and Impact on Mood o LGBTQ+ and Mental Health in Vulnerable Populations • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.

<table>
<tr>
<td rowspan="2"></td>
<td></td>
<td>

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
Offer virtual and in-person exercise classes to support healthy lifestyle choices.
Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.

</td>
</tr>
<tr>
<td>Clinical programming related to addressing the growing behavioral health needs of the community</td>
<td>

Continue to 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.
Establish a pediatric behavioral health crisis intervention pathway.
Expansion of peer recovery services.
Develop a medication-assisted treatment (MAT) program.
Continued expansion of outpatient addiction services.
Continued expansion of adolescent outpatient mental health services.

</td>
</tr>
</table>

PRIORITY AREA: CANCER

<table>
<tr><th colspan="3">Goal 1: Address barriers to cancer care through direct services and program development.</th></tr>
<tr><th colspan="3">Goal 2: Promote health and wellness among the patient’s continuum of care: diagnosis, treatment, and survivorship.</th></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="3">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 System in the Newton Medical Center service area:

• Breast cancer- all other types
• Secondary malignancies
• Respiratory cancers
• Neoplasm of unspecified nature or uncertain nature
• Male reproductive system cancers- prostate</td><td>Community-based screening</td><td>• Continued coordination of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments and the Regional Chronic Disease Coalition.
• Expand follow up of high-risk breast and lung screenings for medical evaluation and surveillance.
• Maintain and expand the screening for colorectal, breast, and lung cancer conducted at AMG practices.</td></tr>
<tr><td>Community-based education programming</td><td>• 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 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, etc.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices.
• Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.</td></tr>
<tr><td>Practical / financial needs</td><td>• Providers assess each patient for financial, practical, and psychosocial needs—including food insecurity, 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 Continue to identify grant and other funding opportunities to meet this unmet need.</td></tr>
</table>

	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 our Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site in the cancer center through a nurse practitioner. • AHS 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.
	Insurance Issues	• Identify patients who do not have health insurance and are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. • 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.
	Access	• Employ virtual resources and programs to provide community with access to support groups, educational programs and supplemental services related to cancer treatment, care, and management. • Review and update the AHS 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. • Improving Care Considerations and reducing healthcare disparities for the LGBTQ population.

PRIORITY AREA: HEART DISEASE

<table>
<tr><td colspan="3">Goal 1: Take proactive steps to reduce cardiovascular health disparities in underserved and minority populations.</td></tr>
<tr><td colspan="3">Goal 2: Employ broad measures to increase access to care and educational resources in the communities served by Atlantic Health System, specifically among populations disproportionally impacted by cardiovascular disease.</td></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="3">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 System in the Newton Medical Center service area:

• Essential hypertension
• Cardiac dysrhythmias
• Coronary atherosclerosis and other heart disease
• Heart Failure
• Acute myocardial infarction</td><td>Community-based education programming</td><td>• 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 topics related to understanding heart disease, e.g., Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Sports Cardiology/BLS Importance, Women with Cardiac Disease etc.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices.
• Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.</td></tr>
<tr><td>Hypertension Management Program (HMP)</td><td>• A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs).
• AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve.
• Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.</td></tr>
<tr><td>Access</td><td>• Enhance access to care and awareness of cardiovascular programs and services available across AHS, 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.</td></tr>
</table>

		• 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 AHS' existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: DIABETES & OBESITY

<table>
<tr><th colspan="3">Goal 1: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.</th></tr>
<tr><th colspan="3">Goal 2: NMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.</th></tr>
<tr><th colspan="3">Goal 3: Improve access to and awareness of services in the NMC service area.</th></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="3">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 System in the Newton Medical Center service area:

• Fluid and electrolyte disorders
• Disorders of lipid metabolism
• Obesity
• Diabetes mellitus with complication
• Thyroid disease</td><td>Community-based education programming</td><td>• Referral, as appropriate, to AHS 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.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices.
• Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
• 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.</td></tr>
<tr><td>Promotion of Employee Health</td><td>• Partnership with AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus.</td></tr>
<tr><td>Clinical care & identification of at-risk populations and creations of linkages to care</td><td>• 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 9 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and</td></tr>
</table>

		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 System.

PRIORITY AREA: STROKE

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 stoke treatment.

Clinical Utilization Overview	Focus	Objectives
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 System in the Newton Medical Center service area: • Cerebral infraction • Sequela of cerebral infarction and other cerebrovascular disease • Acute hemorrhagic cerebrovascular disease • Sequela of hemorrhagic cerebrovascular disease	**EMS and Caregiver Support**	• Continued virtual and in-person education sessions for EMS and caregivers on stroke signs and symptoms for rapid identification and transport to a stroke center. • Education for AHS and volunteer agencies on the statewide rollout of validated pre-hospital Large Vessel Occlusion recognition tool (RACE Scale). • Support group for caregivers and survivors that is currently offered virtually, with ongoing efforts to switch to a quarterly hybrid format.
	Community-based education programming	• Educate the community 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. • Educate health care professionals and members of the communities we serve regarding advances in stroke treatment and availability of stroke related services and resources. • 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. • Improved website by continuously making sure the resources available remain up to date and are accessible to the community. • B.E. F.A.S.T. Fridays: Increase awareness of stroke signs and symptoms to patients seeking care in the emergency department for a variety of medical needs. • World Stroke Day presentation scheduled for October. • 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.

		• Offer virtual and in person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	Staff Education	• Educational Stroke Symposium, conducted annually, provides an outlet for education and discussion for healthcare providers on various topics pertaining to stroke, such as ongoing clinical research, nursing care options, and post rehabilitation. • As a system, stroke education was included within AHS' PRIDE Essentials, an annual training for team members.

HACKETTSTOWN MEDICAL CENTER – COMMUNITY OVERVIEW

Hackettstown Medical Center (HMC) is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. To that end, beginning in June 2021, HMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, which encompasses portions of Warren, Morris, and Sussex counties in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing resident of HMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

The completion of the CHNA provided HMC with a health-centric view of the population it serves, enabling HMC to prioritize relevant health issues and develop a community health implementation plan focused on meeting community needs.

The complete HMC 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 HMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2021-2023 Community Health Needs Assessment process identified five priority health needs that have been included in the 2023 CHIP.

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

While each priority area is addressed separately on the following pages, HMC's effort to address community health needs requires a complex interplay of internal resources, relationships with community partners, identification of co-morbidities across priority areas and, perhaps most importantly, the ability to course-correct when strategies or approaches to a priority can be better served through yet unknown pathways.

HACKETTSTOWN MEDICAL CENTER – IMPLEMENTATION PLAN

The Community Health Implementation Plan (CHIP) addresses the way HMC will approach each priority need and the expected outcome and timeframe for the evaluation of its efforts.

PRIORITY AREA: MENTAL HEALTH & SUBSTANCE MISUSE

Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and opioid and alcohol misuse.		
Clinical Utilization Overview	**Focus**	**Objectives**
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 System in the Hackettstown Medical Center service area: • Alcohol-related disorders • Anxiety and fear-related disorders • Neurodevelopmental disorders • Cannabis-related disorders • Schizophrenia spectrum and other psychotic disorders • Depressive disorders	**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. • *No More Whispers* 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, *No More Whispers* will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. ***No More Whispers* Programming** o Mental Health in the New Year o Programs to support those dealing with grief o Programs to support those dealing with trauma o Children's and Adolescent Mental Health o Recognizing and Addressing Abuse o Geriatric Mental Health Issues o Mental Health and Other Support for Caregivers o Education on Sleep o Alcohol, marijuana, tobacco, and vaping awareness o Substance Misuse and Addiction o Food and Impact on Mood o LGBTQ+ and Mental Health in Vulnerable Populations

		• Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community. • 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 • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	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, with includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, and outpatient settings. • Establish a pediatric behavioral health crisis intervention pathway. • Develop a medication-assisted treatment (MAT) program. • Continued expansion of outpatient addiction services. • Continued expansion of adolescent outpatient mental health services.

PRIORITY AREA: HEART DISEASE

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 System, specifically among populations disproportionally impacted by cardiovascular disease.		
Clinical Utilization Overview	**Focus**	**Objectives**
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 System in the Hackettstown Medical Center service area: • Essential hypertension • Cardiac dysrhythmias • Coronary atherosclerosis and other heart disease • Heart failure • Nonrheumatic and unspecified valve disorders	**Community-based education programming**	• 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 topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Sports Cardiology/BLS Importance, Women with Cardiac Disease* etc. • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	Hypertension Management Program (HMP)	• A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs). • AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve. • Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.
	Access	• Enhance access to care and awareness of cardiovascular programs and services available across AHS, 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 AHS' existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: DIABETES AND OVERWEIGHT / OBESITY

<table>
<tr><td colspan="3">Goal 1: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.</td></tr>
<tr><td colspan="3">Goal 2: HMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.</td></tr>
<tr><td colspan="3">Goal 3: Improve access to and awareness of services in the HMC service area.</td></tr>
<tr><th>Clinical Utilization Overview</th><th>Focus</th><th>Objectives</th></tr>
<tr><td rowspan="3">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 System in the Hackettstown Medical Center service area:

• Diabetes mellitus with complication
• Obesity
• Fluid and electrolyte disorders
• Disorders of lipid metabolism
• Thyroid disorders</td><td>Community-based education programming</td><td>• Referral, as appropriate, to AHS 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.
• Offer virtual and in-person exercise classes to support healthy lifestyle choices.
• Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
• 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.</td></tr>
<tr><td>Promotion of Employee Health</td><td>• Partnership with AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus.</td></tr>
<tr><td>Clinical care & identification of at-risk populations and creation of linkages to care</td><td>• 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 9 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and</td></tr>
</table>

		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 System.

PRIORITY AREA: CANCER

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.		
Clinical Utilization Overview	**Focus**	**Objectives**
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 System in the Hackettstown Medical Center service area: • Breast cancer - all other types • Respiratory cancers • Neoplasms of unspecified nature or uncertain behavior • Gastrointestinal cancers – colorectal • Secondary malignancies • Male reproductive system cancers- prostate	**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 follow up of high-risk breast and lung screenings for medical evaluation and surveillance. • Maintain and expand the screening for colorectal, breast, and lung cancer conducted at AMG practices.
	Community-based education programming	• 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 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, etc*. • Offer virtual and in-person exercise classes to support healthy lifestyle choices. • Provide education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.
	Practical / financial needs	• Providers assess each patient for financial, practical, and psychosocial needs—including food insecurity, 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 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 our Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site in the cancer center through a nurse practitioner. • AHS 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.
	Insurance issues	• Identify patients who do not have health insurance and are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. • 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.
	Access	• Employ virtual resources and programs to provide community with access to support groups, educational programs and supplemental services related to cancer treatment, care, and management. • Continue to use and expand virtual platforms to supplement for the lack of face-to-face support services resulting from COVID-19. • Review and update the AHS 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. • Improving Care Considerations and reducing healthcare disparities for the LGBTQ population.

PREPARED FOR

MORRISTOWN MEDICAL CENTER

OVERLOOK MEDICAL CENTER

CHILTON MEDICAL CENTER

NEWTON MEDICAL CENTER

HACKETTSTOWN MEDICAL CENTER

BY

ATLANTIC HEALTH SYSTEM
PLANNING & SYSTEM DEVELOPMENT

Atlantic Health System