ATLANTIC HEALTH SYSTEM
COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

- Morristown Medical Center
- Overlook Medical Center
- Chilton Medical Center
- Newton Medical Center
- Hackettstown Medical Center
- CentraState Healthcare System

MAY 2025

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 2025 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 2025 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 our community and not-for-profit and government agencies across Atlantic Health's service area is critical to ensuring that clinical staff, 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
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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 (CAB) 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. Some individual site level priorities (geriatrics & healthy aging, maternal infant health, and respiratory disease) were 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 & PUBLICATION YEAR					
Morristown Medical Center (Dec 2022)	**Overlook Medical Center (Dec 2022)**	**Chilton Medical Center (Dec 2022)**	**Newton Medical Center (Dec 2024)**	**Hackettstown Medical Center (Dec 2024)**	**CentraState Healthcare System (Dec 2022)**
Behavioral Health	Mental Health and Substance Use Disorder	Mental Health / Substance Abuse	Mental Health / Substance Misuse	Mental Health / Substance Misuse	Behavioral Health
Diabetes / Obesity / Unhealthy Weight	Diabetes	Diabetes	Diabetes	Diabetes / Obesity	Nutrition, Physical Activity, and Weight (Diabetes)
Cancer	Cancer	Cancer	Cancer	Cancer	Cancer
Heart Disease Stroke	Heart Disease (including as it relates to Stroke)	Heart Disease	Heart Disease	Heart Disease	Heart Disease
Geriatrics & Healthy Aging	Maternal / Infant Health	Respiratory Disease			

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 focused on common areas of concern related to community health needs, and health and wellness for older adults and at-risk populations.

Community Benefit

Atlantic Health System is committed to improving the health status of the communities it serves and provides community benefit as part of a measured approach to meeting identified health needs in the community. Community benefit includes charity care, subsidized health services, community health services, and financial contributions to community-based health organizations. For the most recent year of data available (2023), Atlantic Health System provided $458,430,813 in total community benefit across the following areas:

- Subsidized Health Services: *$233,992,805*
- Cash and In-Kind Contributions: *$1,266,526*
- Financial Assistance: *$32,129,959*
- Medicaid Assistance Shortfall: *$115,268,246*
- Health Professional Education: *$52,172,471*
- Health Research Advancement: *$2,499,827*
- Community Health Improvement Services: *$21,100,979*

Supporting Funding of Community Partners and Community Health Needs

The Community Advisory Boards (CAB) at Morristown, Overlook, Chilton, Newton, and Hackettstown Medical Centers and the Board of CentraState Healthcare System 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. In 2024, funds allocated to community partners through the AHS Community Advisory Boards totaled $599,108.

Identifying Potential Health Disparities

Health disparities are preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities. The main determinants of health disparities are poverty, unequal access to health care, lack of education, stigma, and race or ethnicity. As part of AHS' CHNA and CHIP development process, we evaluate community demographics, mortality rates, county and ZIP Code based disease incidence rates, other secondary source information for broad community health outcomes and factors, and community stakeholder input.

The ability to gain actionable perspective on the health needs of the population served can be limited in secondary data by geographic or clinical aggregation and to a degree the use of estimates to extrapolate findings. To gain deeper perspective on the health needs of the population served by AHS' hospitals, the hospital analyzed deidentified claims that allow for application of a disparity ratio methodology published by the Minnesota Department of Health Center for Health Statistics, Division of Health Policy. This application aids in determining if there are/were disparities among the population served by the hospital. Four separate analyses (race/ethnicity, age, gender, and insurance cohort) were performed on the data using clinical cohorts defined by The Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Clinical Classification Software – Refined (CCSR). The CCSR aggregates International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) codes into clinically meaningful categories. These analyses, not published here, allowed for stakeholders to gain deeper understanding of potential disparities in the patient population served by AHS and creates a roadmap for identifying where resources could best be deployed to address disparities among specific patient cohorts. This information was used in conjunction with secondary data analysis and stakeholder input to prioritize health topics of most concern throughout the AHS service area.

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

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

In early 2020, AHS launched a pilot program among 11 primary care practices to screen adult patients for SDOH. Screenings were broadened to all Atlantic Medical Group and Primary Care Partner primary care practices in August 2020, taking place once a year at adult patients' physical examinations. In October 2021, an inpatient SDOH screening pilot was launched on a Morristown Medical Center unit and transitioned in March 2023 to a targeted screening initiative for adult inpatients with high-risk medical needs enrolled in the Transitions of Care program at all five medical centers. In October 2024, a systemwide SDOH screening process was launched to screen all adult patients admitted to our hospitals for 5 key SDOH domains. In December 2024, this structured screening process was implemented to enhance SDOH screening for pregnant patients in our Women's Health practices.

A Social Drivers of Health (SDOH) Navigator table 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 care team. The SDOH Navigator table displays fourteen domains, each representing a factor that can influence health: financial resource strain, housing instability, utility needs, transportation needs, alcohol use, depression, intimate partner violence, social connections, physical activity, tobacco use, stress, health literacy, postpartum depression, and food insecurity. Based on patient answers to questions in each of the domains, the icons turn green to indicate low risk, yellow for moderate risk, or red for high risk. Referrals can be sent to Social Workers and Community Health Workers for additional support and to connect the patient to key community resources.

A system Psychosocial Collaborative has been formed to align the roles, infrastructure, support, and design of how we care for patients' psychosocial needs across the care continuum and foster health equity. An early focus of the Psychosocial Collaborative has been expanding and enhancing workflows for SDOH screening and intervention to proactively identify and address barriers to care, improve health outcomes, enhance patient satisfaction, and reduce ED utilization and readmissions. Additionally, AHS has contracted with Unite Us, a social needs digital referral platform that integrates with our electronic health record to facilitate patients experiencing social needs receive individualized SDOH resources tailored to their needs

and health goals. Patients with complex social needs or who would benefit from individualized intensive support in addressing health-related social needs may be connected to our social workers and community health workers.

Social Workers have insight into how social determinants of health – social, functional, environmental, cultural, and psychological factors – may be linked to our patients' health outcomes. Social workers work in partnership with Community Health Workers and assist with more complex patient needs and barriers, such as interpersonal violence, crisis, difficulty coping with illness or stress, behavioral health or substance misuse linkage, abuse/neglect, or long-term care planning. Social Workers assess 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 are uniquely positioned to provide peer level structured support to help reduce barriers to care, infuse access to community resources for ongoing support, and assist patients to set and achieve their individualized health goals. Our Community Health Workers are embedded in our medical center footprints who, in partnership with our social work team, assist patients in identifying SDOH needs and barriers to care. Community Health Workers partner with patients to help them overcome these barriers and achieve their health goals by providing at-the-elbow support, creating sustainable connections with key community partners and social service organizations, and empowerment and self-management skills to navigate the health and social service systems.

Diversity and Inclusion

AHS strives for an inclusive health care environment where patients, visitors and team members are welcomed and afforded equitable treatment regardless of race, ethnicity, gender, sexual orientation, gender identity or expression, religion, age, disability, military status, language, immigration status, marital or parental status, occupation, education, or socioeconomic background. We 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 organizes diverse workgroups of community representatives at each hospital location to develop and implement programs that address the specific health care needs of our surrounding populations. Some programs and policies implemented within our hospitals, include:

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

Food Is Medicine

Atlantic Health System partners with GRACE Food Pantry to offer our Food Is Medicine program (currently implemented at Overlook Medical Center), giving residents of our community access to fresh, healthy food and resources. Residents are given referrals to the program where they receive nutritional coaching and community referrals to help them on their nutritional journey. GRACE Food Pantry staff assist residents with choosing healthy foods that match their Food Is Medicine prescription.

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

Atlantic Center for Research

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

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

In addition to advancing medical research, ACR actively engages with the local community through educational programs, health screenings, and awareness campaigns. These initiatives help individuals make informed health decisions, address social determinants of health, and promote preventive care strategies. By prioritizing research on prevalent conditions within the community—such as diabetes, cardiovascular disease, and mental health disorders—ACR ensures that its efforts align with the specific health needs of the population it serves. At the end of 2024, ACR had 444 trials across 16 therapeutic areas, and served over 14,000 patients on them. The portfolio comprises of several groundbreaking trials; first in human, first in US, and first for AHS.

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

ACR’s clinical research advancement highlights include the first personalized treatment to fight against systemic lupus erythematosus (SLE), the first non-surgical treatment for bladder cancer (NMIBC), the first treatment trial for pediatric hypertrophic cardiomyopathy (HCM) patients, and a landmark publication in the New England Journal of Medicine (NEJM) redefining structural heart intervention strategies for transcatheter aortic valve replacement (TAVR) is slated for publication.

Other Collaborative Support

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

Evaluation Plan & Needs Not Addressed

Efforts to address community health needs requires a complex interplay of internal resources, relationships with community partners, identification of co-morbidities across priority areas and, most importantly, the ability to course-correct when strategies or approaches to a priority can be better served through yet unknown pathways. Atlantic Health System's Community Health team facilitates quarterly check-ins with hospital leadership and clinical service line teams to document activities and progress related to Community Health Improvement objectives. 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.

AHS' Community Health team delivers programs and events that are aimed at addressing all health priorities to prevent disease, reduce health disparities, promote healthy behaviors, and make good health and well-being accessible to everyone. Broad programming includes:

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

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 2025 CHIP.

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

MORRISTOWN MEDICAL CENTER – IMPLEMENTATION PLAN

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

PRIORITY AREA: BEHAVIORAL HEALTH

Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and substance abuse and addiction disorders.		
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: • Anxiety and fear-related disorders • Neurodevelopmental disorder • Depressive disorders • Alcohol-related disorders • Opioid misuse • Schizophrenia spectrum and other psychotic 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. • Atlantic Behavioral Health is motivated to get people talking openly about a condition that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. **<u>Atlantic Behavioral Health Programming</u>** ○ 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.
	Clinical programming related to addressing the growing	• Continue to build clinical programs and services that meet patients in their community, which includes efforts to improve access and treatment options for

Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and substance abuse and addiction disorders.		
Clinical Utilization Overview	**Focus**	**Objectives**
	behavioral health needs of the community	adult and pediatric behavioral health patients in inpatient, emergency room, and outpatient settings. • Expansion of peer recovery services. • Continue expansion of medication for addiction treatment (MAT) services. • Continued expansion of outpatient addiction services at all levels of care. • Continued expansion of adolescent outpatient mental health services. • Develop geriatric psychiatry outpatient services. • Expansion of MMC Behavioral Health Assessment Center that improves access through decreasing time to first appointment and ability to provide bridge appts up to 30 days.

PRIORITY AREA: DIABETES / OBESITY / UNHEALTHY WEIGHT

Goal 1: Improve access to and awareness of services.		
Goal 2: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.		
Goal 3: MMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.		
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: • Diabetes mellitus without complication • Diabetes mellitus with complication • Nutritional deficiencies • Disorders of lipid metabolism • Thyroid disorders	**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, *Navigating Supermarkets and Nutrition Labels, Understanding Eating Disorders, Foot Care, etc.* • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes. • Partner with Diabetes Foundation to enhance educational opportunities in the community.
	Clinical care & identification of at-risk populations and creation of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Continue to track and monitor data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the program to aid in the reduction of readmissions. The program continues to be used throughout Atlantic Medical Group primary care offices through Atlantic Health System. • Collaboration with Morristown Medical Center Retail Pharmacy for financial assistance programs for diabetes medication and supplies.

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Clinical Utilization Overview	**Focus**	**Objectives**
		• Body mass index (BMI) screening/nutritional education and referral to Metabolic Center, as appropriate. ○ Continue to offer sleep screening, as appropriate. • Continue to screen patients for needs related to SDOH. • Use evidenced based diabetes and obesity care management strategies for use of GLP-1 agonists and incorporate risks and benefits of this class of drugs into patient education.
	Promotion of Employee Health	• Partnership with AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus. • Collaborate with BRGs to provide educational presentations on diabetes management.
	Reduce the level of food insecurity in the community	• Expand relationships with organizations such as Interfaith Food Pantry and Soup Kitchen that provide food rescue programs. • Partnership with Food Is Medicine • 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: • Prostate cancer • Breast cancer- all types • Skin cancers- melanoma • Respiratory cancers • Colorectal cancer	**Community-based screening**	• Coordinate education and cancer screening program with NJCEED and Community Health departments, local health departments, Morris/Somerset Chronic Disease Coalition, and other community agencies. • Identify patients at risk for developing breast cancer, educate and promote high-risk breast services. • Promote smoking cessation, lung cancer screening and navigation. • Launch high risk pancreatic cancer screening program • Maintain and expand access to screening for colorectal, breast, and lung cancer conducted at AMG and ACO practices.
	Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction (Reduce risk of cancer through Healthy Lifestyles including nutrition and physical activity, smoking cessation, Importance of early detection through screening for Breast, Lung, Colorectal, Prostate, Skin, and Lung cancer)
	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. • Provide resources and materials to help patients navigate financial resources, community food insecurity, nutritional education, resources, pharmaceutical assistance, and other barriers to care. • Work with community-based agencies to provide wigs, food, transportation, and other financial/practical matters, Medicaid eligibility and charity care. • Promote and educate providers and community on Advanced Care Planning and Palliative Care services.
	Mental Health	• The cancer center social worker conducts assessments on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). • Refer patients/caregiver to Behavioral Health Services and/or to community resources for counseling and psychiatric services.

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**
		• Refer to Integrative Program Services as appropriate. • AHS continues to identify resources and opportunities through community partnerships to provide greater on-site access to this vital service. • Promote Peer to Peer services as additional resources to support patients and care givers.
	Insurance Issues	• Identify patients who do not have health insurance and refer them to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation, referrals, and support. • Provide resources and materials to help patients navigate financial resources. • 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	• Oncology Nurse Navigators support patients and families through the cancer care continuum. • 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, and survivorship. • Review and update the AHS Cancer Center website to improve access to virtual services, programs, and resources. • In partnership with community agencies, evaluate resources available to the underserved community with a focus on African American and Hispanic/Latino population to provide culturally sensitive care.

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**	• 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.
	Hypertension Management Educational Program	• A hypertension educational program can aid in improving the health of our community and address identified disparities. • AHS will implement an enterprise-wide hypertension patient/community educational program aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve.
	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 gender related difference of heart attack symptoms and place this education in AMG practices to reach a wide audience. • Develop a cardio-OB program that cares for high-risk obstetrical patients.
	Access	• Enhance access to care and awareness of cardiovascular programs 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.

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Clinical Utilization Overview	**Focus**	**Objectives**
	Clinical programming	• The Heart Success program has partnered with the heart transplant program at NYU, this partnership will provide a more seamless transition of patients from AHS to NYU for heart transplant services. Pre- and post-transplant care will be provided at the Morristown Medical Center. • Dr. Matt Martinez leads the Hypertrophic Cardiology program at AHS which is based in Morristown. The program offers outpatient diagnostic testing and surgical interventions offered by Dr. Benjamin Van Boxtel.

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: • Stroke • Long term consequences or effects of stroke • Epilepsy	**EMS and Caregiver Support**	• Continued education sessions for EMS on stroke signs and symptoms for rapid identification and transport to a stroke Center. • Education for AHS and volunteer agencies on the statewide pre-hospital Large Vessel Occlusion recognition tool (RACE Scale). • Increased EMS education offerings with contact hours for stroke and epilepsy. • Stroke support groups for caregivers and survivors on monthly basis. • Provide tools for stroke survivors and care givers to cope with disability and education to prevent future stroke, support post-stroke follow-up related to symptom education and nutritional counseling.
	Community-based education programming	• Educate the community and cooperate partners on stroke signs and symptoms for rapid identification and transport to a stroke center, including at tabling events. • Educate the community on risk factors and comorbidities associated with stroke and availability of tools to identify risk factors for stroke. • Update the deliverables for the community and patients to include Hypertension as the major modifiable risk factor for all strokes. • Expanded Hemorrhagic stroke specific education in English and Spanish. • Educate health care professionals and members of the communities we serve regarding advances in stroke treatment and availability of stroke related services and resources. • Improved website by continuously making sure the resources available remain up to date and are accessible to the community. BE FAST sign and symptom video updated to include T “Terrible Headache” in English and Spanish. • Website Stroke signs and symptoms are linked to the A.D.A.M. library. • May Stroke awareness and World Stroke Day is celebrated internally and externally. • Partnership with local school for Stroke awareness and symptom education.

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**
	Staff Education	• Educational Stroke Symposium, conducted annually, provides an outlet for education and discussion for healthcare providers on diverse topics pertaining to stroke, such as ongoing clinical research, nursing care options, and post rehabilitation. • Provider onboarding stroke specific education • As a system, stroke education was included within AHS' PRIDE essentials, an annual training for all team members. • Roll out a hemorrhagic stroke awareness initiative, including a new 'BE-FAST'. 'T' includes terrible headache, to focus on hemorrhage. • Workforce development programs through nursing education, residencies and ancillary staff.
	Stroke Governmental Advocacy	• Support local, regional, state, and national stroke communities through advocacy and peer forums which drive stroke care and leadership positions on NJSCC—New Jersey Stroke Coordinator Consortium. • Promote, identify, and design the statewide system of stroke care.

PRIORITY AREA: GERIATRICS & HEALTHY AGING

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 65 and older populations served by Atlantic Health System in the Morristown Medical Center service area: • Neurocognitive disorders • Musculoskeletal pain, not low back pain • Sleep wake disorders Prioritized clinical areas for continued improvement: • ED utilization • Readmissions	**Community-based education programming**	• Provide information and educational programs on topics related to healthy aging e.g., *Alzheimer's, Dementia and Memory Loss, Strength and Balance, Caregiver support, etc.* • Offer virtual and in-person exercise classes with topics relevant to seniors, e.g., *Exercise for Arthritis, Chair Yoga, etc.*

	Clinical Services for Seniors	• The Geriatric Assessment Center is a state-of-the-art outpatient practice that offers high quality compassionate primary care and consultative services to area seniors. Its highly skilled team of geriatricians, advanced practice nurses and social workers uses a multidisciplinary approach to provide person centered care to our frailest seniors.
		  ○ Employ telemedicine services for seniors when appropriate.
		  ○ The Geriatric Assessment Center offers counseling services to patients.
		  ○ Continue to offer discussions regarding advance directives and goals of care.
		• The Emergency Department at Morristown Medical Center is a Level 1 accredited Geriatric Emergency Department utilizing geriatric specific evidence-based protocols, multidisciplinary care teams and post-discharge support to provide a continuum of care for all patients >70 years of age who enter our ED.
		• Provide referrals to palliative care as identified by the Emergency Department.
		• The Primary Care at Home program includes nurse practitioners who make house calls to homebound patients 65 or older, who live in the Morris County area.

	Patient and Caregiver Support and Training	• Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA). It aims to improve the care of older adults in clinical settings by addressing their mobility, mentation, medications and aligning care

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**
		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. • The Art of Caregiving course is a 5-part interactive course offered quarterly to caregivers to help them navigate the nuances of the eldercare maze. This course provides personalized guidance on how best to care for an aging loved one while finding balance as a family caregiver. • The Caregiver Training Lab is a model home environment for older adults and is located at the Geriatric Assessment Center. It provides direct training and education to seniors and their caregivers. It also offers recommendations for community organizations that can assist with home safety assessments and home modifications. • Offer support and counseling services for patients and caregivers as they age and navigate the elder care journey. • 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 weekday hotline provides guidance on navigating the eldercare maze and connection to home health services, senior housing options, adult day services, transportation, insurance and financial options, and other services available to older adults and their caregivers. Telephone and virtual consultations are made available for caregivers.
	Memory Screening	• A memory screening is a simple and safe evaluation tool that checks memory and other thinking skills. It can indicate whether an additional check up by a qualified healthcare professional is needed. The Geriatric Assessment Center at 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.

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**
		• Memory screening events are open to community seniors and aid in early detection and proper treatment of seniors who may have cognitive changes.
	Injury Prevention	• Morristown Medical Center's Injury Prevention Program offers seniors and caregivers a variety of home, pedestrian, and motor vehicle safety programs throughout the year, including the Car Fit for Mature Drivers at all Car Seat Inspection Stations. The programs are typically run in a group setting but are offered as needed to individual patients and their families.
	Care Coordination	• Guide Program offered through The Geriatric Assessment Center. The Guiding an Improved Dementia Experience (GUIDE) Model is a voluntary nationwide model test that aims to support people with dementia and their unpaid caregivers. The GUIDE Model focuses on comprehensive, coordinated dementia care and aims to improve quality of life for people with dementia, reduce strain on their unpaid caregivers, and enable people with dementia to remain in their homes and communities. It will achieve these goals through Medicare payments for a comprehensive package of care coordination and care management, caregiver education and support, and respite services.

Atlantic Health System
Overlook Medical Center

OVERLOOK MEDICAL CENTER – COMMUNITY OVERVIEW

Overlook Medical Center (OMC) is committed to the people it serves and the communities where they live. 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.

AHS' Community Health team delivers programs and events that are aimed at addressing all health priorities to prevent disease, reduce health disparities, promote healthy behaviors, and make good health and well-being accessible to everyone. Broad programming includes:

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

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 2025 CHIP.

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

OVERLOOK MEDICAL CENTER – IMPLEMENTATION PLAN

The Community Health Implementation Plan (CHIP) addresses the way OMC will approach health priorities and the expected time frame 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, child and adolescent behavioral health, aging and mental health, and substance abuse and addiction disorders.		
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 • Addiction 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. • Atlantic Behavioral Health is motivated to get people talking openly about a disease that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. **<u>Atlantic Behavioral Health Programming</u>** ○ 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.

Goal 1: Provide community-based behavioral health services with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and substance abuse and addiction disorders.		
Clinical Utilization Overview	**Focus**	**Objectives**
	Clinical programming related to addressing the growing behavioral health needs of the community	• Continue to build clinical programs and services that meet patients in their community, which includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, behavioral health observation unit, and outpatient settings. • Continued expansion of medication for addiction treatment (MAT) services. • Continued expansion of addiction services at all levels of care. • Continued expansion of adolescent outpatient mental health services. • Continued expansion of geriatric services to include cognitive disorders, such as dementia. • Development of child & adolescent behavioral health outpatient services including a pediatric behavioral health assessment center; intensive outpatient program • Continued enhancement of the EmPATH unit for adults who come to the ED with behavioral health needs.

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 Overlook Medical Center service area: • Breast Cancer- all types • Colorectal and esophageal cancers • Prostate cancer • Lung cancer	**Community-based screening**	• Continued coordination of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments and the Union County Chronic Disease Coalition and other community agencies. • Continue to identify patients at risk for developing breast cancer, educate and promote high risk breast services. • Continue promotion of smoking cessation and lung cancer screening and navigation. • Develop high risk pancreatic cancer screening program. • Maintain and expand the screening for colorectal, breast, prostate and lung cancer conducted at AMG and ACO practices.
	Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction, (Reduce risk of cancer through Healthy Lifestyles including nutrition and physical activity, smoking cessation, importance of early detection through screening for Breast, Lung, Colorectal, Prostate, Skin and Lung cancer).
	Practical / financial needs	• Providers assess each patient for financial, practical, and psychosocial needs—including food insecurity, financial needs and referring to the cancer center social worker for further assessment. Provide resources and materials to help patients navigate financial resources, food insecurity, nutritional education, pharmaceutical assistance and other barriers to care. Work with community-based agencies to provide wigs, food, transportation, and other financial/practical matters, Medicaid eligibility and charity care. • Continue to promote, educate more timely Advanced Care Planning and Palliative Care services and continue to identify grant and other funding opportunities to meet this unmet need.
	Mental health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). • Referrals are provided to Integrative Program Services as appropriate.

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**
		• 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. Obtain gift cards/Uber cards to support transportation 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) and Charity Care 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, management, and survivorship. • Continue to use and expand virtual and hybrid programming to expand access. • 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 among underserved populations through community partners and established coalitions.

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**	• 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.
	Hypertension Management Program (HMP)	• A hypertension educational program can aid in improving the health of our community and address identified disparities. • AHS will implement an enterprise-wide hypertension patient/community educational program aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve.
	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. • Continued development of Atlantic's Heart Success program (Heart Failure Program) at Overlook Medical Center, including inpatient care provided by a board-certified heart failure cardiologist.

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 Overlook Medical Center service area: • Stroke • Long term consequences or effects of stroke	**EMS and Caregiver Support**	• Provide in-person education sessions for EMS personnel on stroke signs and symptoms for rapid identification and transport to a stroke center. Continued education for AHS and volunteer agencies on the statewide rollout of validated pre-hospital Large Vessel Occlusion recognition tool (RACE Scale). • Provide in-person and virtual education sessions for community members on stroke signs and symptoms for rapid recognition and initiation of emergency medical services. • Continue to offer support groups for caregivers and survivors in a hybrid format (virtual and in-person).
	Community-based education programming	• Educate the community at senior centers, health fairs, YMCAs, churches, etc. on stroke signs and symptoms for rapid identification and transport to a stroke center. • 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. • Improve external website by continuously making sure the resources available and recent data remain up to date and are accessible to the community.
	Staff Education	• Educational Stroke Symposium, conducted annually, provides an outlet for education and discussion for healthcare providers on diverse topics pertaining to stroke, such as ongoing clinical research, nursing care options, and post rehabilitation. • As a system, stroke education was included within AHS' PRIDE Essentials, an annual training for team members.

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**
		• Roll out a hemorrhagic stroke awareness initiative, including a new 'BE-FAST'. 'T' includes terrible headache, to focus on hemorrhagic stroke identification. • Continuously improving internal website by ensuring resources available remain up to date and are accessible to team members.
	Technology	• Continue to advance the technology used to acutely treat stroke and manage deficits • Deployment of technology such as the vivistim system.
	Stroke Governmental Advocacy	• Support local, regional, state, and national stroke communities through advocacy and peer forums which drive stroke care and leadership positions on NJSCC—New Jersey Stroke Coordinator Consortium.

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.* • 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. • Collaborate with BRGs to provide educational presentations on diabetes management. • Continue to share diabetes educational information to team members and externally.
	Clinical care & identification of at-risk populations and creation of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Continue to track and monitor data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the

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**
		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. • Continue to partner with Cardiometabolic Alliance and provide diabetes education to referred patients as support.
	Reduce disparity in the community	• Engage pregnant and new mothers with the medical community as the "trusted" partner to provide information and education in those locations with strategies that have been determined to reduce disparities. • Through this engagement, if health disparities such as food insecurity, are identified, proper linkage to resources or care is made. • Diabetes and Cardiovascular Disease – Linking Clinic to Community is a program for community providers that reviews ADA standards and identifies relevant community resources.
	Reduce the level of food insecurity in the community	• Develop Overlook Medical Center's partnerships with local food banks to link at-risk patients to food sources that will improve the patients' overall wellness. • Overlook Medical Center & Atlantic Health System partner with GRACE Food Pantry to offer our Food Is Medicine program, giving residents of our community access to fresh health food and resources. Residents are given referrals to the program where they receive nutritional coaching and community referrals to help them on their nutritional journey. GRACE Food Pantry staff assist residents with choosing healthy foods that match their Food Is Medicine prescription. • Continue to support Overlook Medical Center's Community Garden initiative and promote employee and patient wellness through serving and promoting in the hospital cafeteria the fresh produce grown in the garden. • Continue to serve surrounding elementary students by hosting hospital-sponsored chefs healthy eating and nutrition education.

PRIORITY AREA: MATERNAL / INFANT HEALTH

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.		
Goal 2: Continue to develop community-based education that meets the needs of the communities served by OMC.		
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: • 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	**Community-based education programming**	• Provide information and educational programs on diverse topics such as the importance of prenatal and postpartum care, lifestyle and other modifiable risk factors, chronic condition management, etc. • Offer prenatal classes in Spanish.
	Expand access to care	• Support improved access to care for OB/Gyn services through increased provider presence and breadth/availability of subspecialist services available at 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. • Continue to grow midwifery access for patients. • Continue to meet the growing needs for the diabetes in pregnancy program at OMC.
	Awards & Recognitions	• US News health analysis team has identified nine hospitals that are High Performing in Maternity Care and are achieving excellent outcomes for cesarean section and unexpected newborn complications among Black patients and Overlook Medical Center was one of those nine identified.

Atlantic Health System
Chilton Medical Center

COMMUNITY OVERVIEW – 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. As CMC continues to address the needs of the community served, an emphasis will be placed on survivorship and caregiver support related to all the priority areas mentioned below.

AHS' Community Health team delivers programs and events that are aimed at addressing all health priorities to prevent disease, reduce health disparities, promote healthy behaviors, and make good health and well-being accessible to everyone. Broad programming includes:

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

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 2025 CHIP.

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

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 time frame 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, child and adolescent behavioral health, aging and mental health, and addiction disorders.		
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. • Atlantic Behavioral Health is motivated to get people talking openly about a condition that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. **Atlantic Behavioral Health 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 ○ 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.

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

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 Chilton Medical Center service area: • Essential hypertension • Cardiac dysrhythmias • Coronary atherosclerosis • Heart Failure • Nonrheumatic and unspecified valve disorders	**Community-based education programming**	• Provide information and educational programs on topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Sports Cardiology/BLS Importance, Women with Cardiac Disease* etc.
	Hypertension Management Program (HMP)	• A hypertension educational program can aid in improving the health of our community and address identified disparities. • AHS will implement an enterprise-wide hypertension patient/community educational program aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve.
	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. • Continue to evaluate programmatic needs of the community, particularly for vascular services. Atlantic's Heart Success program (Heart Failure Program) will be expanded to Chilton Medical Center. Expansion will include inpatient care provided by a board-certified heart failure cardiologist.

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 and melanoma • Prostate cancer • Lung cancer • Colorectal cancer	**Community-based screening**	• Coordinate education and cancer screening programs with NJCEED and Community Health departments, local health departments and the Regional Chronic Disease Coalition. • Identify patients at risk for developing breast cancer, educate and promote high-risk breast services. • Promote smoking cessation and lung cancer screening and navigation. • Maintain and expand the screening for colorectal, breast, and lung cancer conducted at AMG practices.
	Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction (reduce risk of cancer through Healthy Lifestyles including nutrition and physical activity, smoking cessation, importance of early detection through screening for Breast, Lung, Colorectal, Prostate, Skin and Lung cancer).
	Practical / financial needs	• Providers assess each patient for financial, practical, and psychosocial needs—including food insecurity, financial needs and referring to the cancer center social worker for further assessment. • Provide resources and materials to help patients navigate financial resources, community food insecurity, nutritional education, pharmaceutical assistance and other barriers to care. • Work with community-based agencies to provide wigs, food, transportation, and other financial/practical matters, Medicaid eligibility and charity care. • Promote and educate the provider and the community on Advanced Care Planning and Palliative Care services.
	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 through a nurse practitioner.

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**
		• AHS continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service. • Promote Peer to Peer services to offer additional support to patients and care givers.
	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. • Provide resources and materials to help patients navigate financial resources. • 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	• Oncology Nurse Navigators support patients and families through the cancer care continuum. • 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, and survivorship. • Review and update the AHS Cancer Center website to improve access to virtual services, programs, and resources. • In partnership with community agencies, evaluate resources available to the underserved community with a focus on African American and Hispanic/Latino population to provide culturally sensitive care.

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: CMC 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 CMC 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 Chilton Medical Center service area: • Disorders of lipid metabolism • Fluid and electrolyte disorders • Thyroid disorders • Obesity • Diabetes mellitus with complication	**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.* • Provide educational programming for schools, public libraries, senior centers, school nurses (patients and caregivers). • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Offer one AHS-wide virtual support group for patients with type 1 diabetes and type 2 diabetes. • Offer monthly in-person support group meetings and promote service to the community.
	Promotion of Employee Health	• Partnership with AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus. • Collaborate with BRGs to provide educational presentations on diabetes management.
	Clinical care & identification of at-risk populations and creations of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Continue to track and monitor data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify

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: CMC 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 CMC service area.		
Clinical Utilization Overview	**Focus**	**Objectives**
		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. • Continue to increase access to diabetes care.

PRIORITY AREA: RESPIRATORY DISEASE

Goal 1: Increase education of the community served by CMC to the dangers of nicotine.		
Goal 2: Identify opportunities to improve community health through continued reduction of 30-day readmissions for COPD.		
Goal 3: Increase the awareness of the AHS Lung Cancer Screening Program in the community served by CMC.		
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: • Pneumonia (except that caused by tuberculosis) • Chronic obstructive pulmonary disease and bronchiectasis • Asthma • Other specified upper respiratory infections	**Community-based prevention and education**	• 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 smoking cessation classes in Spanish. • 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. • The respiratory therapy department partners with AHS Community Health to participate in community events, providing a table with resources and a respiratory therapist to provide information and education.
	Decrease 30-day Readmissions Rates Within COPD Population	• 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* yearly for RNs, RTs, hospitalists, and SNF's via online learning modules. • Remote patient monitoring as ordered by providers for cases among the patients served by CMC. • AHS patients now have access (with an order from their Pulmonologist) to virtual Pulmonary Rehab via "Home Rehab Network."

Goal 1: Increase education of the community served by CMC to the dangers of nicotine.		
Goal 2: Identify opportunities to improve community health through continued reduction of 30-day readmissions for COPD.		
Goal 3: Increase the awareness of the AHS Lung Cancer Screening Program in the community served by CMC.		
Clinical Utilization Overview	**Focus**	**Objectives**
	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.

Atlantic Health System
Newton Medical Center

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.

AHS' Community Health team delivers programs and events that are aimed at addressing all health priorities to prevent disease, reduce health disparities, promote healthy behaviors, and make good health and well-being accessible to everyone. Broad programming includes:

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

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 2024-2026 Community Health Needs Assessment process identified six priority health needs that have been included in the 202 CHIP.

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

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 time frame for the evaluation of its efforts.

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: NMC 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 NMC 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 Newton Medical Center service area: • Fluid and electrolyte disorders • Disorders of lipid metabolism • Obesity • Diabetes mellitus with complication • Thyroid disease	**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.* • Provide educational programming for schools, public libraries, senior centers, school nurses (patients and caregivers). • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes.
	Promotion of Employee Health	• Partnership with AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus. • Collaborate with BRGs to provide educational presentations on diabetes management.
	Clinical care & identification of at-risk populations and creations of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Continue to track and monitor data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Partnership with Food Is Medicine program. • Partnership with Share My Meals program.

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: NMC 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 NMC service area.		
Clinical Utilization Overview	**Focus**	**Objectives**
		• Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the program to aid in the reduction of readmissions. The program continues to be used throughout Atlantic Medical Group primary care offices through Atlantic Health System. • Optimize the use of telemedicine to increase access to care for diabetes care and endocrinology.

PRIORITY AREA: MENTAL HEALTH / SUBSTANCE MISUSE

<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, child and adolescent behavioral health, aging and mental health, and addiction disorders.</th></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 Newton Medical Center service area:

• Anxiety and fear-related disorders
• Depressive disorders
• Bipolar and related disorders
• Alcohol-related disorders
• Trauma- and stressor-related disorders</td><td>Community-based education programing</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.
• Atlantic Behavioral Health is motivated to get people talking openly about a condition that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care.

<u>Atlantic Behavioral Health Programming</u>
○ 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 Issues
○ 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>
<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, which includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, and outpatient settings.
• Expansion of peer recovery services.
• Continue expansion of medication for addiction treatment (MAT) services.</td></tr>
</table>

Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and addiction disorders.		
Clinical Utilization Overview	**Focus**	**Objectives**
		• Continued expansion of addiction services at all levels of care. • Expansion of 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 Newton Medical Center service area: • Essential hypertension • Cardiac dysrhythmias • Coronary atherosclerosis and other heart disease • Heart Failure • Acute myocardial infarction	**Community-based education programming**	• Provide information and educational programs on topics related to understanding heart disease, e.g., *Lipid/Cholesterol Management, Heart Failure Management, Management of Atrial Fibrillation, Sports Cardiology/BLS Importance, Women with Cardiac Disease* etc.
	Hypertension Management Program (HMP)	• A hypertension educational program can aid in improving the health of our community and address identified disparities. • AHS will implement an enterprise-wide hypertension patient/community educational program aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve.
	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: 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 Newton Medical Center service area: • Breast cancer • Lung cancer • Prostate cancer • Colorectal cancer	**Community-based screening**	ion and cancer screening program with NJCEED and Community Health health departments, and other Sussex County community agencies. risk for developing breast cancer, educate and promote high-risk breast services. cessation, lung cancer screening and navigation. nd access to screening for colorectal, breast, and lung cancer conducted at AMG and
	Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction (Reduce risk of cancer through Healthy Lifestyles including nutrition and physical activity, smoking cessation, Importance of early detection through screening for Breast, Lung, Colorectal, Prostate, Skin, and Lung cancer)
	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. • Provide resources and materials to help patients navigate financial resources, community food insecurity, nutritional education, resources, pharmaceutical assistance, and other barriers to care. • Work with community-based agencies to provide wigs, food, transportation, and other financial/practical matters, Medicaid eligibility and charity care. • Promote and educate providers and community on Advanced Care Planning and Palliative Care services.
	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). • Refer patients/caregiver to Behavioral Health Services and/or to community resources for counseling and psychiatric services. • Refer to Integrative Program Services as appropriate. • AHS continues to identify resources and opportunities through community partnerships to provide greater on-site access to this vital service.

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**
		• Promote Peer to Peer services as additional resources to support patients and care givers.
	Transportation	• Collaborate with community resources to expand and enhance access to transportation services. Obtain gift cards/Uber cards to support transportation needs.
	Insurance Issues	• Identify patients who do not have health insurance and refer them to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. • Provide resources and materials to help patients navigate financial resources. • 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	• Oncology Nurse Navigators support patients and families through the cancer care continuum. • 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, and survivorship. • Review and update the AHS Cancer Center website to improve access to virtual services, programs, and resources. • In partnership with community agencies, evaluate resources available to the underserved community with a focus on African American and Hispanic/Latino population to provide culturally sensitive care.

Atlantic Health System
Hackettstown Medical Center

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.

AHS' Community Health team delivers programs and events that are aimed at addressing all health priorities to prevent disease, reduce health disparities, promote healthy behaviors, and make good health and well-being accessible to everyone. Broad programming includes:

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

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 2024-2026 Community Health Needs Assessment process identified five priority health needs that have been included in the 2025 CHIP.

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

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 time frame 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, child and adolescent behavioral health, aging and mental health, and addiction disorders.		
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. • Atlantic Behavioral Health is motivated to get people talking openly about a condition that affects one in six U.S. adult lives, according to the National Institute of Mental Health. Through digital and printed materials, presentations, and community outreach efforts, the behavioral health service line will enhance awareness and engage influencers throughout New Jersey about the importance of access to mental health care. **<u>Atlantic Behavioral Health Programming</u>** ○ 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 Issues ○ 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.

Goal 1: Provide community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, child and adolescent behavioral health, aging and mental health, and addiction disorders.		
Clinical Utilization Overview	**Focus**	**Objectives**
	Clinical programming related to addressing the growing behavioral health needs of the community	• Continue to build clinical programs and services that meet patients in their community, which includes efforts to improve access and treatment options for adult and pediatric behavioral health patients in inpatient, emergency room, and outpatient settings. • Continued expansion of Medication for addiction treatment (MAT) services. • Continued expansion of addiction services at all levels of care. • Expansion of outpatient mental health services.

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**	• 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.
	Hypertension Management Program (HMP)	• A hypertension educational program can aid in improving the health of our community and address identified disparities. • AHS will implement an enterprise-wide hypertension patient/community educational program aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve.
	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 / OBESITY

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: HMC 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 HMC 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 Hackettstown Medical Center service area: • Diabetes mellitus with complication • Obesity • Fluid and electrolyte disorders • Disorders of lipid metabolism • Thyroid disorders	**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.* • Provide educational programming for schools, public libraries, senior centers, school nurses (patients and caregivers). • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes.
	Promotion of Employee Health	• Partnership with AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus. • Collaborate with BRGs to provide educational presentations on diabetes management.
	Clinical care & identification of at-risk populations and creation of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Continue to track and monitor data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 8 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the

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: HMC 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 HMC service area.		
Clinical Utilization Overview	**Focus**	**Objectives**
		program to aid in the reduction of readmissions. The program is used throughout AHS' Atlantic Medical Group primary care offices. • Optimize the use of telemedicine to increase access to care for diabetes care and endocrinology. • Partnership with Food Is Medicine program. • Partnership with Share My Meals program.

PRIORITY AREA: CANCER

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 • Lung cancer • Colorectal cancer • Prostate cancer • Non-Hodgkin lymphoma	**Community-based screening**	• Coordinate education and cancer screening program with NJCEED and Community Health departments, local health departments, and other Warren County community agencies. • Identify patients at risk for developing breast cancer, educate and promote high-risk breast services. • Promote smoking cessation, lung cancer screening and navigation. • Maintain and expand access to screening for colorectal, breast, and lung cancer conducted at AMG and ACO practices.
	Community-based education programming	• Provide information and educational programs on topics related to early detection and cancer risk reduction (Reduce risk of cancer through Healthy Lifestyles including nutrition and physical activity, smoking cessation, Importance of early detection through screening for Breast, Lung, Colorectal, Prostate, Skin, and Lung cancer)
	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. • Provide resources and materials to help patients navigate financial resources, community food insecurity, nutritional education, resources, pharmaceutical assistance, and other barriers to care. • Work with community-based agencies to provide wigs, food, transportation, and other financial/practical matters, Medicaid eligibility and charity care. • Promote and educate providers and community on Advanced Care Planning and Palliative Care services.
	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). • Refer patients/caregiver to Behavioral Health Services and/or to community resources for counseling and psychiatric services. • Refer to Integrative Program Services as appropriate.

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**
		• AHS continues to identify resources and opportunities through community partnerships to provide greater on-site access to this vital service. • Promote Peer to Peer services as additional resources to support patients and care givers.
	Transportation	• Collaborate with community resources to expand and enhance access to transportation services. Obtain gift cards/Uber cards to support transportation needs.
	Insurance issues	• Identify patients who do not have health insurance and refer them to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. • Provide resources and materials to help patients navigate financial resources. • 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	• Oncology Nurse Navigators support patients and families through the cancer care continuum. • 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, and survivorship. • Review and update the AHS Cancer Center website to improve access to virtual services, programs, and resources. • In partnership with community agencies, evaluate resources available to the African American and Hispanic/Latino population to provide culturally sensitive care.

CentraState Healthcare System®
ATLANTIC HEALTH SYSTEM PARTNER

CENTRASTATE HEALTHCARE SYSTEM – COMMUNITY OVERVIEW

CentraState Healthcare System (CSHS) 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. CSHS 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 Monmouth, Middlesex, and Ocean 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 CSHS's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

CSHS's Community Health team delivers programs and events that are aimed at addressing all health priorities to prevent disease, reduce health disparities, promote healthy behaviors, and make good health and well-being accessible to everyone. Broad programming includes:

- Access to tobacco cessation support through offering virtual and telephonic community-based tobacco cessation coaching, with a focus on diverse populations and underserved communities.
- Virtual and in-person exercise classes to support healthy lifestyle choices.
- Education and resources to diverse populations and underserved communities at community events and health fairs in partnership with community organizations.

The completion of the CHNA provided CSHS with a health-centric view of the population it serves, enabling CSHS to prioritize relevant health issues and develop a community health implementation plan focused on meeting community needs. The complete CSHS 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 CSHS will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2023-2025 Community Health Needs Assessment process identified four priority health needs that have been included in the 2025 CHIP.

- Cancer
- Heart Disease
- Behavioral Health
- Nutrition, Physical Activity, and Weight (Diabetes)

CENTRASTATE HEALTHCARE SYSTEM – IMPLEMENTATION PLAN

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

PRIORITY AREA: HEART DISEASE

Goal 1: Offer supportive services designed to reduce cardiovascular risk factors which put a person at increased risk for 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 CentraState Healthcare System service area:
 	
• Coronary atherosclerosis and other heart disease
• Acute myocardial infarction
• Heart failure
• Cardiac dysrhythmias
• Postthrombotic syndrome and venous insufficiency/hypertension
• Acute pulmonary embolism
• Cerebral infarction
• Peripheral and visceral vascular disease
• Hypotension
	Community-based education programming	• Offer programs and services that help modify behaviors such as cigarette smoking/vaping, physical inactivity, and overweight/obesity.
		• Offer programs/screenings that stress the importance of adhering to treatment for high blood pressure and cholesterol, both critical for preventing and controlling cardiovascular disease.
		• Provide education on chronic conditions including related to heart disease such as heart failure, hypertension, and diabetes.
		  ○ Offer digital scales, blood pressure monitors, or glucometers/test strips to medically referred patients in need.
		• Train people to identify the signs and symptoms of a heart attack and how to provide Early Heart Attack Care (EHAC)
		• Assist patients and community members in obtaining and understanding information about heart health
		  ○ MyChart electronic health record promotion and utilization
		  ○ Work with PCPs and RN Health Coaches to lower patients' cardiovascular risk scores
		  ○ Early Heart Attack Care training, hands only CPR, and BLS training
		• Provide and promote screenings onsite and in community settings for cardiovascular disease
		  ○ Lipid profile, blood pressure, and/or A1C
		• Partner with community organizations to support initiatives related to nutrition education and access to healthy food
		  ○ Neighborhood Connections to Health, Freehold Family Health Center, Fulfill Food Bank
		• Provide and promote physical activity
		  ○ Live Life Well programs

Goal 1: Offer supportive services designed to reduce cardiovascular risk factors which put a person at increased risk for cardiovascular disease.		
Clinical Utilization Overview	**Focus**	**Objectives**
		○ Fitness Center disease specific programs including cardiac rehab step down program • Offer diabetes prevention program to reduce risk factors

PRIORITY AREA: NUTRITION, PHYSICAL ACTIVITY, AND WEIGHT (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: CentraState will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.		
Goal 3: Improve access to and awareness of services in the CentraState service area.		
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 CentraState Healthcare System service area:
 	
• Thyroid disorders
• Diabetes mellitus with complication
• Disorders of lipid metabolism
• Other specified and unspecified nutritional and metabolic disorders
• Diabetes mellitus without complication
• Nutritional deficiencies
• Obesity
• Fluid and electrolyte disorders
	Community-based education programming	• Screen 300+ people for pre-diabetes – specifically targeting those community members at increased risk for severe complications of diabetes.
		• Refer persons with diabetes to the CDC-recognized Diabetes Prevention Program at CentraState or elsewhere for management and monitoring of nutrition and physical activity.
		• Refer persons with diabetes to Diabetes Self-Management Education (DSME) with a certified diabetes educator.
		• Increase awareness annual Medicare education benefit for 2 hours of DSME education.
		• Collaborate with employers to offer a range of preventive health programs
		• Increase access to healthy food options.
		  ○ Food bank mobile food pantry
		  ○ Participate in Farmers' markets and Voucher Programs
		• Offer weight management programs to the community.
		• Offer exercise and fitness classes.
		• Offer head, neck, and thyroid screenings to the community.

	Promotion of Employee Health	• Provide A1C screenings to employees and refer them to appropriate resources depending on the findings.
	Clinical care & identification of at-risk populations and creation of linkages to care	• Continue to grow the clinical team to meet the demands of the community seeking care. • Nursing tracks and monitors data on a quarterly basis on severe hyperglycemia and severe hypoglycemia. • Submit an Inpatient Consult to Certified Diabetes Educator for: ○ Newly diagnosed patients and for continued support and education if non-adherence found.

Goal 1: Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.		
Goal 2: CentraState will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.		
Goal 3: Improve access to and awareness of services in the CentraState service area.		
Clinical Utilization Overview	**Focus**	**Objectives**
		○ As needed for problem solving (unexplained hypo or hyperglycemia, decline in control, changes in physical or emotional health, change in living situations, cognitive or physical and self-care ability) ○ CDE review of report for inpatients with A1c>8 and, if appropriate, recommend a consult. ○ PCP/ Hospitalist recommendation/Best practice advisory for outpatient DSME referral if A1c>8. ○ Issue glucometer and test strips to patients in need. • Screen patients 18+ for social determinants of health. Refer patients to community-based resources via Unite Us as needed. Hand off to Population Health Social Worker to help patient navigate community-based resources post discharge.

PRIORITY AREA: CANCER

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 CentraState Medical Center service area: • Urinary system cancers – kidney • Endocrine system cancers – thyroid • Head and neck cancers - lip and oral cavity • Prostate cancer • Skin cancers - basal cell carcinoma	**Community-based education programming**	• Provide tailored information and educational programs on topics related to early detection and cancer risk reduction for the general, older-adult, and high-risk populations. • Reduce risk of cancer through healthy lifestyles including nutrition and physical activity • Smoking cessation • Importance of early detection through screenings for breast, lung, colorectal, prostate, and skin cancers • Provide multilingual educational materials and screening reminders to promote participation in preventive and screening services
	Practical / financial needs	• Clinicians assess and appropriately refer each patient to internal resources (social workers, nurse navigators, and dieticians) based on their financial, practical, and psychosocial needs. • Internal resources will collaborate with community health clinics to create streamlined referral pathways for patients with financial barriers. • Provide resources and materials to help patients navigate financial resources (Medicaid eligibility and charity care), community food insecurity, nutritional education, resources, pharmaceutical assistance, and other barriers to care. • Increase clinician and community awareness on advanced care planning and palliative care services. • Establish partnerships with foundations and grant programs to subsidize diagnostic and treatment costs for uninsured or underinsured individuals. • Include financial wellness education in survivorship programs to support long-term recovery and reduce post-treatment economic stress.
	Mental health	• The social workers, nurse navigators, and/or oncology nursing professionals conduct a distress screening on patients and refer them to applicable resources. • Referrals are provided to our behavioral health services or other community resources for counseling and psychiatric services.

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**
		• CSMC continues to identify resources and opportunities through community partnerships to provide access to mental health service(s). • Include mental health navigation in survivorship planning.
	Insurance Issues	• Identify patients who have health insurance barriers and refer them to the preauthorization team, CSMC patient financial services (PFS), and/or NJCEED program. • Social workers meet with and counsel each patient in need, directing and referring to the appropriate resources. • Cancer navigators, nursing staff, registered dietitians, and social workers continually reassess a patient's barriers to care at each encounter. • Educate clinical staff to identify and refer uninsured and underinsured patients to the appropriate care team. • Notify research nurses of appropriate patients for study, COSTCOM EAQ222CD, to assist with ongoing treatment/care plan. • Provide resources and materials to help patients navigate financial resources.
	Access	• Cancer navigators support patients and families through the cancer care continuum. • Utilize virtual and/or in-person resources and programs to provide the community with access to support groups, educational programs, and supplemental services related to cancer treatment, care management, and survivorship. • Incorporated additional cancer specialists. • Expand telehealth offerings for oncology consultations and follow-ups to reach patients with transportation or mobility challenges. • Increase the presence of surgical oncology specialists at CSMC satellite locations based on patient residential proximity. • Increase access to clinical trials. • Partner with local transportation providers, volunteer driver programs, and ride-sharing services to offer low-cost or no-cost rides for cancer appointments and incorporate transportation planning into the patient intake process.

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**
		• Offer multilingual scheduling and navigation services to help non-English-speaking patients access care confidently and comfortably. • Review and update the CSMC cancer center website to improve access to virtual services, programs, and resources. • Partner with local faith-based and cultural organizations to improve trust and awareness of available oncology services within diverse communities.

PRIORITY AREA: BEHAVIORAL HEALTH

Goal 1: Offer a range of education, prevention and treatment options for behavioral health issues and substance use disorders.		
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 CentraState Healthcare System service area: • Bipolar and related disorders • Trauma- and stressor-related disorders • Anxiety and fear-related disorders • Depressive disorders	**Promote the launch of the new 988 suicide hotline as well as the CentraState hotline.** **Create linkages between the hospital and outpatient community-based services to assess and treat mental health conditions.** **Increase the number of individuals who receive treatment for mental health services in the appropriate setting.**	• Provide suicide screenings to Emergency Department patients and refer to treatment as needed • Expand primary care practitioners in the service area who can identify at-risk individuals • Generate outpatient referrals to community partners and encourage treatment within 30 days of hospital/ED discharge • Promote awareness of CentraState's crisis line and behavioral health resources • Increase community awareness and understanding about mental health issues through community education events. • Collaborate with schools to improve life skills and decision-making regarding drugs and alcohol. • Provide self-assessments to identify potential binge-drinking patterns. • Offer support for smoking/vaping cessation. • Partner with collaborating agencies to identify and assist ED and inpatients, including Maternal/Child patients, with Substance Use Disorders for outpatient treatment. • Refer patients to 12-step and other peer-programs as needed.

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CENTRASTATE HEALTHCARE SYSTEM

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