Newton Medical Center
Community Health Needs Assessment

2024-2026

Atlantic Health System

Newton Medical Center

ACKNOWLEDGEMENTS & CHNA COMPLIANCE

Atlantic Health System – Newton Medical Center (NMC) acknowledges the hard work and dedication of the individuals and the organizations they represent who contributed to NMC's Community Health Needs Assessment.

The 2024-2026 Newton Medical Center Community Health Needs Assessment (CHNA) was approved by NMC's Community Advisory Board in December 2024. Questions regarding the Community Health Needs Assessment should be directed to:

Atlantic Health System
Newton Medical Center
Planning & System Development
973-660-3522

A copy of this document has been made available to the public via Atlantic Health System's website at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. The public may also view a hard copy of this document by making a request directly to the office of the President, Newton Medical Center.

COMPLIANCE CHECKLIST: IRS FORM 990, SCHEDULE H	REPORT PAGE(S)
Part V Section B Line 1a A definition of the community served by the hospital facility	4
Part V Section B Line 1b Demographics of the community	7
Part V Section B Line 1c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	Appendix E
Part V Section B Line 1d How data was obtained	Addressed Throughout
Part V Section B Line 1f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 1g The process of identifying and prioritizing community health needs and services to meet the community health need	6, 23
Part V Section B Line 1h The process for consulting with persons representing the community's interests	6, 14
Part V Section B Line 1i Information gaps that limit the hospital facility's ability to assess the community's health needs	None Identified

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EXECUTIVE SUMMARY

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 2024, 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 that encompasses portions of Sussex and Warren counties in New Jersey as well as portions of Pike County in Pennsylvania. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing residents of NMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

The completion of the CHNA provided NMC with a health-centric view of the population it serves, enabling NMC to prioritize relevant health issues and inform the development of future community health implementation plan(s) focused on meeting community needs. This CHNA Final Summary Report serves as a compilation of the overall findings of the CHNA process. This document is not a compendium of all data and resources examined in the development of the CHNA and the identification of health priorities for NMC's service area, but rather an overview that highlights statistics relevant to NMC's health priorities for the CHNA/ CHIP planning and implementation period.

CHNA Components

- Secondary Data Research
- Key Informant Survey
- Prioritization Session
- Implementation Plan
- Key Community Health Issues

Key Community Health Issues

Newton Medical Center, in conjunction with community partners, examined secondary data and community stakeholder input to select key community health Issues. The following issues were identified and adopted as the key health priorities for NMC's 2024-2026 CHNA:

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

Based on feedback from community partners, health care providers, public health experts, health and human service agencies, and other community representatives, Newton Medical Center plans to focus on multiple key community health improvement efforts and will create an implementation strategy of their defined efforts, to be shared with the public on an annual basis through its community health improvement plan (CHIP).

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Organization Overview

Newton Medical Center is home to over 1,200 employees and over 580 physicians. As part of its community benefit programs, NMC provides screenings, health education programs, classes, support groups, vaccinations, and health professions education.

Since 1932, Newton Medical Center has been providing care to the people of Sussex and Warren counties in New Jersey, Pike County in Pennsylvania, and southern Orange County in New York. NMC is home to the Center for Breast Health, the only one of its kind in Sussex County, addressing all women's breast health needs with state-of-the-art technology, resources, education, support and follow-up care. Newton Medical Center achieved the American Nurses Credentialing Center's Pathway to Excellence designation and is one of a select few health care facilities in New Jersey accredited by the Inter-societal Accreditation Commission (IAC) in all three echocardiography procedures: adult transthoracic, adult transesophageal and adult stress.

Newton Medical Center provides emergency care that is close to home for many in northern New Jersey with access to high-tech specialty services available through Atlantic Health System, when needed. Atlantic Health System provides access to renowned specialists, clinical trials, innovative technology and medical treatments, and compassionate support services right here in NJ. Our network of hospitals and providers spans 11 counties, so patients can enter our all-encompassing community of care no matter where they live or work.

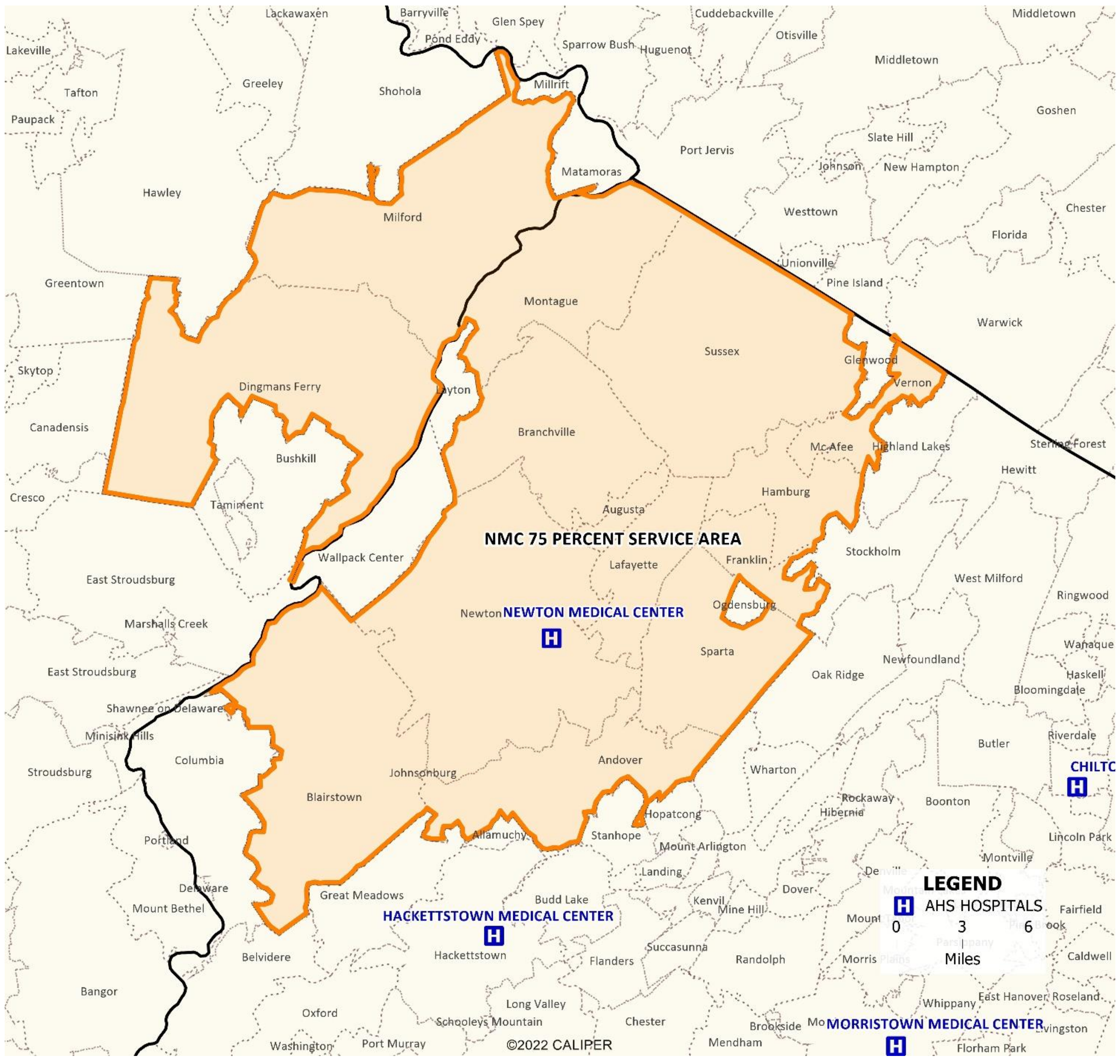
Community Overview

NMC defines the area it serves as the geographic reach from which it receives 75% of its inpatient admissions. For NMC, this represents 11 ZIP Codes, encompassing portions of Warren and Sussex counties in New Jersey and Pike County in Pennsylvania.[1] There is broad racial, ethnic, and socioeconomic diversity across the geographic area served by NMC, from more populated suburban settings to rural-suburban areas of the state. Throughout the service area, NMC always works to identify the health needs of the community it serves. Following are the towns and cities served by NMC.

NMC 75% Inpatient Service Area					
ZIP Code	City	County	ZIP Code	City	County
07416	Franklin	Sussex	07419	Hamburg	Sussex
07461	Sussex	Sussex	07821	Andover	Sussex
07826	Branchville	Sussex	07827	Montague	Sussex
07848	Lafayette	Sussex	07860	Newton	Sussex
07871	Sparta	Sussex	07825	Blairstown	Warren
18337	Milford	Pike			

[1] Source: NJDOH Discharge Data Collection System – UB-04 Inpatient Discharges

Geographic Area Served by Newton Medical Center



Methodology

NMC's CHNA comprised quantitative and qualitative research components. A brief synopsis of the components is included below with further details provided throughout the document:

- A secondary data profile depicting population and household statistics, education and economic measures, morbidity and mortality rates, incidence rates, and other health statistics related to the service area was compiled with findings presented to advisory committees for review and deliberation of priority health issues in the community.

- A key stakeholder survey was conducted with community leaders and partners. Stakeholders represented a variety of sectors, including public health and medical services, non-profit and social organizations, public schools, and the business community.

- An analysis of hospital-utilization data was conducted which allowed us to identify clinical areas of concern based on high utilization and whether there were identified disparities among the following socioeconomic demographic cohorts: insurance type, gender, race/ethnicity, and age cohort.

Analytic Support

Atlantic Health System's corporate Planning & System Development staff provided NMC with administrative and analytic support throughout the CHNA process. Staff collected and interpreted data from secondary data sources, collected and analyzed data from key informant surveys, provided key market insights and prepared all reports.

Community Representation

Community engagement and feedback were an integral part of the CHNA process. NMC's Community Health Department played a critical role in obtaining community input through surveys of community leaders and partners and included community leaders in the prioritization process. Public health and health care professionals shared knowledge about health issues, and leaders and representatives of non-profit and community-based organizations provided insight on the community, including the medically underserved, low income, and minority populations.

Research Limitations

Timelines and other restrictions impacted the ability to survey all potential community stakeholders. NMC sought to mitigate these limitations by including in the assessment process a diverse cohort of representatives or and/or advocates for underserved population in the service area.

Prioritization of Needs

Following the completion of the CHNA research, NMC's Community Health Advisory Sub-Committee prioritized community health issues, which are documented herein. NMC will utilize these priorities in its ongoing development of a Community Health Improvement Plan (CHIP) which will be shared publicly on an annual basis.

SECONDARY DATA PROFILE

One of the undertakings of the CHNA was to evaluate a secondary data profile compiled by the Atlantic Health System Planning & System Development department. This county and service area-based profile is comprised of multiple data sources. Secondary data is comprised of data obtained from external and internal resources (see Appendix) and includes demographic and household statistics, education and income measures, morbidity and mortality rates, health outcomes, health factors, social determinants of health, and other data points. County-level secondary data were augmented, where possible, by aggregated ZIP Code level health care utilization data.

Secondary data was integrated into a graphical report to inform key stakeholders and NMC Community Advisory Board's Community Health Subcommittee of the current health and socio-economic status of residents in NMC's service area. Following is a summary of key details and findings from the secondary data review.

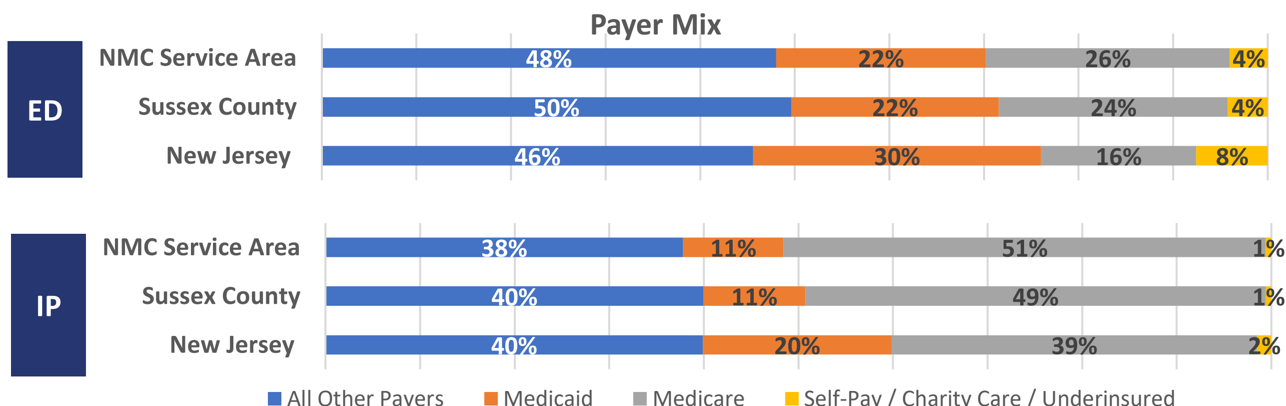
Demographic Overview[2]

NMC's Service Area's projected population change is -1.7% through. At approximately 274.97 residents per square mile, the area is the 2nd least densely populated area in New Jersey; NJ's 21 counties range from a low of 183.02 population/sq. mile (Salem County) to a high of 14,864.40 population/sq. mile (Hudson County). NMC's service area is predominately White (Non-Hispanic). The New Jersey average for White (Non-Hispanic) is approximately 54%, NMC's service area is 85%. About 87% of the population speak only English only at home. About 7% speak Spanish at home. In 2021, 64% of households had an income greater than $75,000, a figure expected to remain constant through 2026. About 35% of the population have a college degree or greater and 30% of the population have some college or an associate degree.

Health Insurance Coverage / Payer Mix[3]

Health insurance coverage can have a significant influence on health outcomes. Among ED visits, NMC's Service Area is approximately 22% Medicaid with another 4% of Self Pay/Charity Care. The area is approximately 48% Commercial and 22% Medicare. From a payer mix perspective, the ED payer distribution in the Service Area is largely similar to Sussex County overall and is more favorably distributed than the statewide figures.

Among inpatients, NMC's Service Area is approximately 11% Medicaid with another 1.0% of Self Pay/Charity Care. The area is approximately 38% Commercial and 51% Medicare. From a payer mix perspective, the inpatient payer distribution in the Service Area is largely similar to Sussex County overall and is slightly more favorably distributed than the statewide figures.



Localized Data

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 needs of the population served by Newton Medical Center, 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[4]. This aids in determining if there are/were disparities among the population we serve directly.

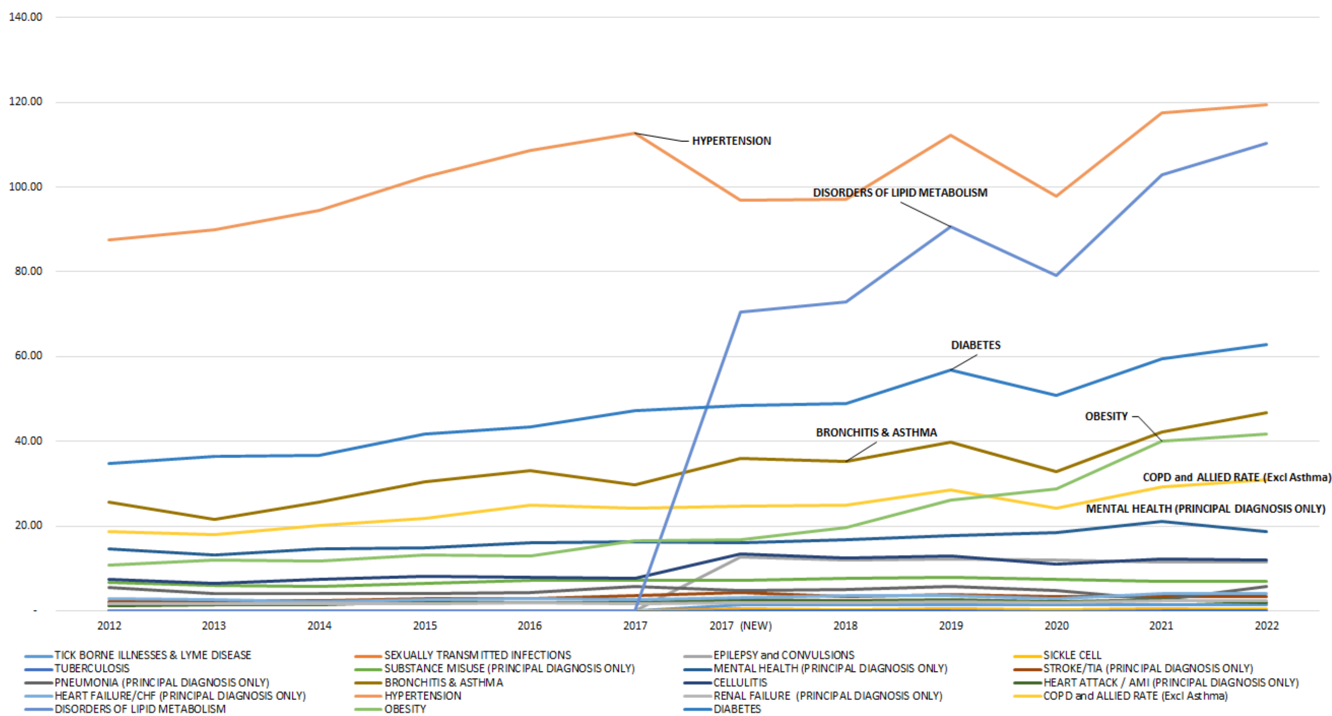
Three separate analyses (race/ethnicity, age, and insurance cohort) were performed on the data using clinical cohorts defined by The Agency For Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Clinical Classification Software – Refined (CCSR). The CCSR aggregates 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, allow for stakeholders to gain deeper understanding of the disparities in the patient population served by NMC and creates, in effect, a roadmap for identifying where resources can best be deployed to address specific clinical and demographic patient cohorts. The findings of the analyses will be tracked over time and will serve as key data elements to inform NMC's community health improvement plan. Summary data by select disease cohorts (shown below) reflect the overall hospital-based utilization among the population served by NMC.

HOSPITAL BASED UTILIZATION BY DISEASE COHORT
Inpatient/Hosptial-Based Outpatietn/Emergency Department
Source: NJ UB Data/AHS Planning & System Development

NMC 75% Service Area

SERVICE AREA: HOSPITAL UTILZATION RATE/1,000 POPULATION - SELECT DISEASE COHORTS



[4] Minnesota Department of Health. Health Disparities by Racial/Ethnic Populations in Minnesota. Available online: http://www.health.state.mn.us/data/mchs/pubs/raceethn/rankingbyratio20032007.pdf (accessed on 11 November 2021).

Health Status Indicators – Sussex County[5]

A health status indicator describes an aspect of the population used to measure health or quality of life. Health indicators may include measurements of illness or disease, as well as behaviors and actions related to health. Quality of life indicators include measurements related to economy, education, built environment, social environment, and transportation. We know, from literature, that quality of life indicators may be drivers of health status - which is why both categories of data (approximately 206 indicators) are included in this analysis.

For each indicator, a county is assigned a score based on its comparison to four things: other NJ counties, whether state and national health targets have been met, and the directional trend of the indicator value over time. These four comparison scores range from 0-3, where 0 indicates the best performance and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities, and changes in methodology over time. Where comparison data is not available, a neutral score is substituted. For ease of interpretation and analysis, indicator comparison scores of concern are visually highlighted in red, showing how the county is faring in each category of comparison.

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results. Indicator values are compared against the trend and against other local New Jersey counties, for the purposes of prioritizing interventions, which is why these two comparisons are the most heavily weighted.

Sussex county-based scoring of specific health indictors are organized by major indicator topic and the specific indicators within that grouping and pertinent data points based on available secondary data sources. An indicator can be compared against all US or NJ counties, US or Statewide values, and the trend of an indicator value. A score greater than 2 represents an indicator where the county performs at lower than preferred targets. Where a population segment disparity can be identified that population segment is noted.

Mortality Rates[6]

Age-adjusted mortality rates can provide a general sense of a community's health in comparison to other communities. The leading causes of death in the United States are heart disease, cancer, accidents (unintentional injuries), chronic lower respiratory disease, cerebrovascular disease (stroke), and Alzheimer’s disease. In Sussex County the top 5 leading causes of death are heart disease, cancer, unintentional injuries, chronic lower respiratory disease (CLRD) and Alzheimer’s disease.

Over the last 23 years, heart disease and cancer have been the number 1 and 2 causes of death in the county. For heart disease, there is a 102 point decrease over the last 23 years. Cancer figures declined 92 points over the same period while Unintentional injuries increased increase of 17.4 points. CLRD shows a drop at the 13 points over period. Alzheimer’s Disease showed a 3.1 point decrease from 2000 to 2023.

[5] Healthy Communities Institute/Conduent.

[6] Source: Center for Health Statistics, New Jersey Department of Health. Deaths with unintentional injury as the underlying cause of death. ICD-10 codes: V01-X59, Y85-Y86 Unintentional injuries are commonly referred to as accidents and include poisonings (drugs, alcohol, fumes, pesticides, etc.), motor vehicle crashes, falls, fire, drowning, suffocation, and any other external cause of death. Data suppressed for, Enterocolitis due to Clostridium difficile, Nutritional deficiencies, Atherosclerosis, Aortic aneurysm and dissection, Certain conditions originating in the perinatal period, Congenital malformations, deformations, and chromosomal abnormalities (birth defects), Viral hepatitis, Homicide (assault), HIV (human immunodeficiency virus) disease. Aggregating years improves the reliability of the estimates.

Age-adjusted Rates (Deaths Per 100,000 Standard Population)	Year 1	Year 2	Year 1 – Year 2 Change	Trend Period
Diseases of heart	289.9	187.9	-102.00	2000-2023
Cancer (malignant neoplasms)	237.1	145.1	-92.00	2000-2023
Unintentional injuries	20.9	38.3	17.40	2000-2023
Chronic lower respiratory diseases	44.2	31.2	-13.00	2000-2023
Alzheimer's disease	26.6	23.5	-3.10	2000-2023
Stroke (cerebrovascular diseases)	43.2	21.2	-22.00	2000-2023
Septicemia	15.6	13.2	-2.40	2005-2023
Diabetes mellitus	27.8	12.1	-15.70	2000-2023
Parkinson's disease	11.7	11.7	0.00	2022-2023
Pneumonitis due to solids and liquids	12.1	11.3	-0.80	2018-2023
Nephritis, nephrotic syndrome, and nephrosis (kidney disease)	18.1	10.8	-7.30	2002-2023
Chronic liver disease and cirrhosis	12.4	12.8	0.40	2017-2022
COVID-19	116.4	47.4	-69.00	2020-2022
Suicide (intentional self-harm)	13.9	15.5	1.60	2006-2022
Influenza and pneumonia	36.8	11.3	-25.50	2000-2020

Health Equity Index[7]

Community health improvement efforts must determine what sub-populations are most in need to focus services and interventions. Social and economic factors are well known to be strong determinants of health outcomes – those with a low socioeconomic status are more likely to suffer from chronic conditions such as diabetes, obesity, and cancer.

The Health Equity Index is a tool developed by Conduent Healthy Communities Institute and part of the SocioNeeds Index® Suite. It was formerly titled the SocioNeeds Index. It is a measure of socioeconomic need that is correlated with poor health outcomes. All zip codes, census tracts, counties, and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need). To help you identify the areas of highest need in your community, the selected locations are ranked from 1 (low need) to 5 (high need) based on their index value.

The Health Equity Index and other indices in SNI Suite can help:

- Justify and validate investments for prevention and early intervention
- Clearly communicate areas for shared action by healthcare, public health, social services, community organizations, business, and others
- Inform policies and interventions at the regional level.

Outcome indicators of poor health were selected based on their broad applicability and geographic granularity. A regression analysis was performed to measure the strength of the component indicators with each outcome indicator. Component indicators were standardized into Z-scores, in which they were transformed into a z-distribution with a mean value of zero and a standard deviation of one. The final index score was calculated as a weighted average of the component indicator Z-scores. The optimal weighting for each component indicator was determined by examining the Pearson correlation coefficient between the aggregated z-score of component

[7] Conduent Healthy Communities Institute. Health Equity Index.

indicators and each outcome indicator. Weights were adjusted until the optimal coefficients were observed for the association between the index and the outcome indicators.

In NMC's community, Sussex, Franklin, and Blairstown have the highest index scores (indicating greater need). Compared to 2014, index scores have improved in 7 areas served by NMC.

City	2014	2024	Change
Andover	33.7	17.0	Improved
Blairstown	38.3	43.4	
Branchville	39.4	21.5	Improved
Franklin	45.7	50.3	
Hamburg	40	29.6	Improved
Lafayette	35.9	20.1	Improved
Montague	51.5	38.3	Improved
Newton	40.4	23.9	Improved
Sparta	29.8	4.7	Improved
Sussex	40.5	44.1	

Food Insecurity Index[8]

The Food Insecurity Index, created by Conduent Healthy Communities Institute, is a measure of food access that is correlated with economic and household hardship. All zip codes, census tracts, counties, and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need).

The U.S. Department of Agriculture (USDA) defines food insecurity as a lack of consistent access to enough food for an active, healthy life. It is important to know that though hunger and food insecurity are closely related, they are distinct concepts. Hunger refers to a personal, physical sensation of discomfort, while food insecurity refers to a lack of available financial resources for food at the household level.

Extensive research reveals food insecurity is a complex problem. Many people do not have the resources to meet their basic needs, challenges which increase a family's risk of food insecurity. Though food insecurity is closely related to poverty, not all people living below the poverty line experience food insecurity and people living above the poverty line can experience food insecurity.

Food insecurity does not exist in isolation, as low-income families are affected by multiple, overlapping issues like lack of affordable housing, social isolation, chronic or acute health problems, high medical costs, and low wages. Taken together, these issues are important social determinants of health, defined as the "conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks." To that end-AHS will aim to align its social determinants of health efforts to the Healthy people 2030 objectives to guide evidence-based programs, and other actions to improve health and well-being of the community.

[8] Conduent Healthy Communities Institute. Food Insecurity Index.

Effective responses to food insecurity must address the overlapping challenges posed by the social determinants of health. In NMC's community, Newton, Sussex, Franklin, and Lafayette have the highest index scores (indicating greater need). Compared to 2020, index scores have improved in 6 areas served by NMC.

City	2020	2024	Change
Andover	7.1	6.8	Improved
Blairstown	7.4	7.3	Improved
Branchville	11.3	6.4	Improved
Franklin	44.2	16.8	Improved
Hamburg	15.5	15.2	Improved
Lafayette	9.4	16.5	
Montague	25.2	8.9	Improved
Newton	19.1	28.0	
Sparta	4.6	9.7	
Sussex	16.9	24.1	

Mental Health Index[9]

The Mental Health Index is a tool developed by Conduent Healthy Communities Institute and part of the SocioNeeds Index® Suite. It is a measure of social determinants and health factors correlated with self-reported poor mental health. All zip codes, census tracts, counties, and county equivalents in the United States are given an index value from 0 (low need) to 100 (high need). To help you identify the areas of highest need in your community, the selected locations are ranked from 1 (low need) to 5 (high need) based on their index value.

The Mental Health Index and other indices in SNI Suite can help:

- Justify and validate investments for prevention and early intervention
- Clearly communicate areas for shared action by healthcare, public health, social services, community organizations, business, and others
- Inform policies and interventions at the regional level.

Conduent HCI reviewed its current library of indicators for component indicators to include in the Mental Health Index. Indicators were considered if available at the county, zip code, and census tract level, and updated at least annually. Index components were then scored based on the strength of their Pearson correlation coefficient with selected health outcomes.

Outcome indicators of poor mental health were selected based on their broad applicability and geographic granularity (see Outcome Indicators in table below). A regression analysis was performed to measure the strength of the component indicators with each outcome indicator. Component indicators were standardized into Z-scores, in which they were transformed into a z-distribution with a mean value of zero and a standard deviation of one. The final index score was calculated as a weighted average of the component indicator Z-scores. The optimal weighting for each component indicator was determined by examining the Pearson correlation coefficient between the aggregated z-score of component indicators and each outcome indicator. Weights were adjusted until the optimal coefficients were observed for the association between the index and the outcome indicators.

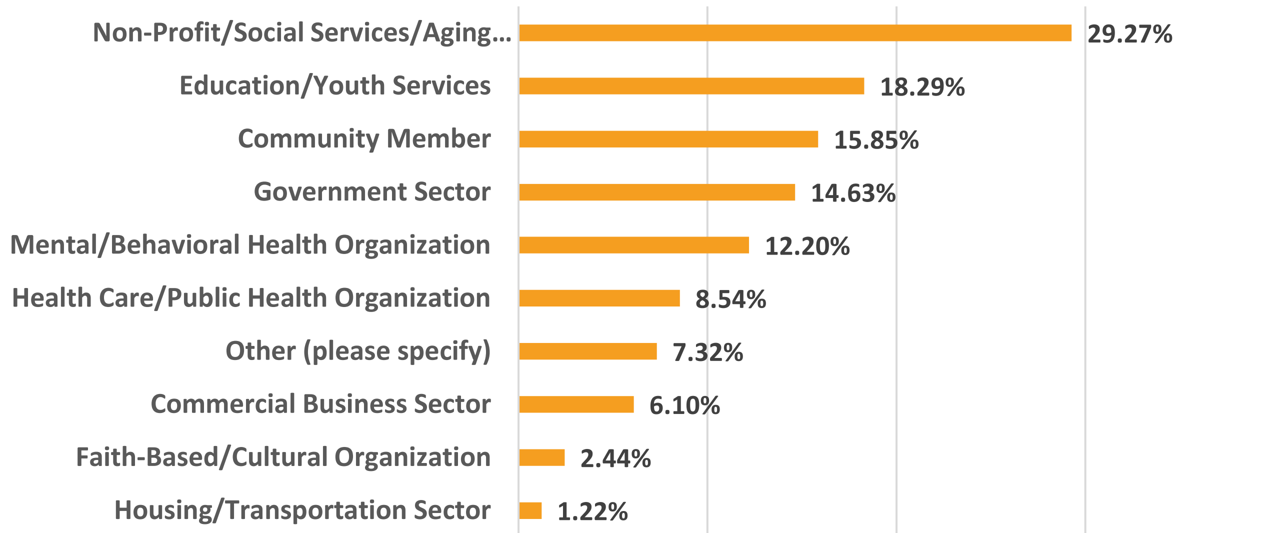
[9] Conduent Healthy Communities Institute. Mental Health Index.

In NMC's community, Newton, Franklin, Hamburg, and Sussex have the highest index scores (indicating greater need). Compared to 2021, index scores have improved in 2 areas served by NMC.

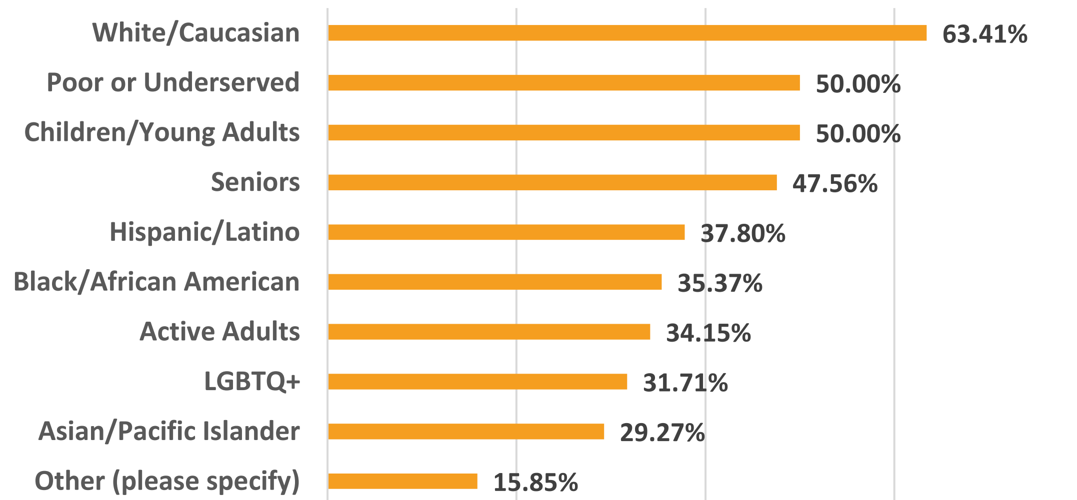
City	2021	2024	Change
Andover	45.4	46.1	
Blairstown	63.2	53.0	Improved
Branchville	38.8	43.1	
Franklin	55.3	70.2	
Hamburg	39.6	68.0	
Lafayette	60.5	42.1	Improved
Montague	32.6	37.8	
Newton	72.7	76.6	
Sparta	35.5	44.7	
Sussex	60.2	60.7	

STAKEHOLDER SURVEY - FINDINGS

NMC received 92 responses to its community-based key-stakeholder survey, which was administered online. Below we show the breakdown of the respondents' organizational and community affiliations and alignment with community populations.

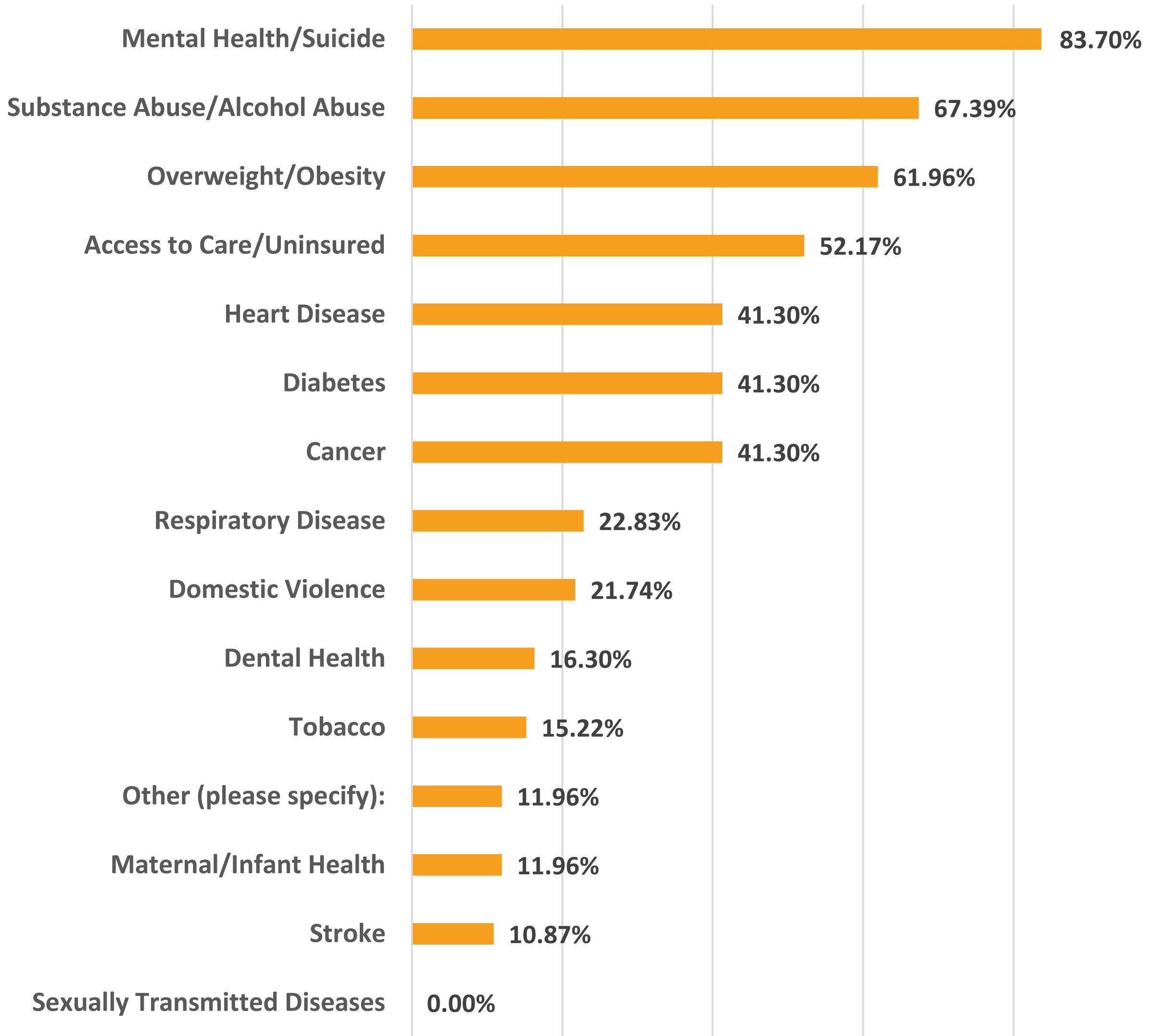


Respondents represented a diverse cross section of the residents in the area served by Newton Medical Center.



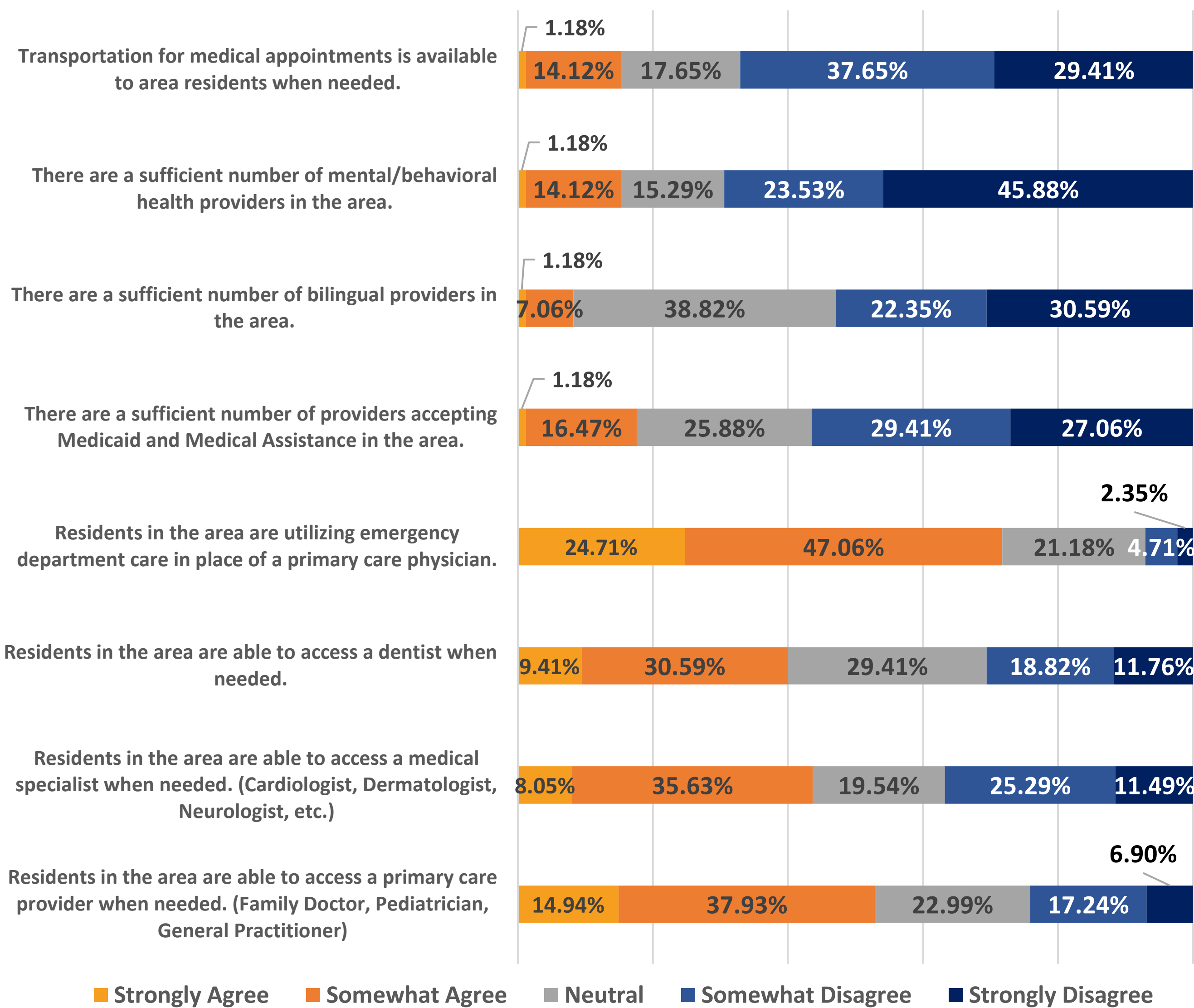
Below we show the breakdown of the percent of respondents who selected each health issue in the 2024 survey. Issues are ranked on the number of participants who selected the issue. Each respondent chose 5. This year, the top 4 ranked issues were mental health/suicide, substance abuse/alcohol abuse, overweight/obesity, access to care/uninsured. Heart disease, diabetes, and cancer were tied for the 5th top health issue in the community.

What are the top 5 health issues you see in your community? (CHOOSE 5)

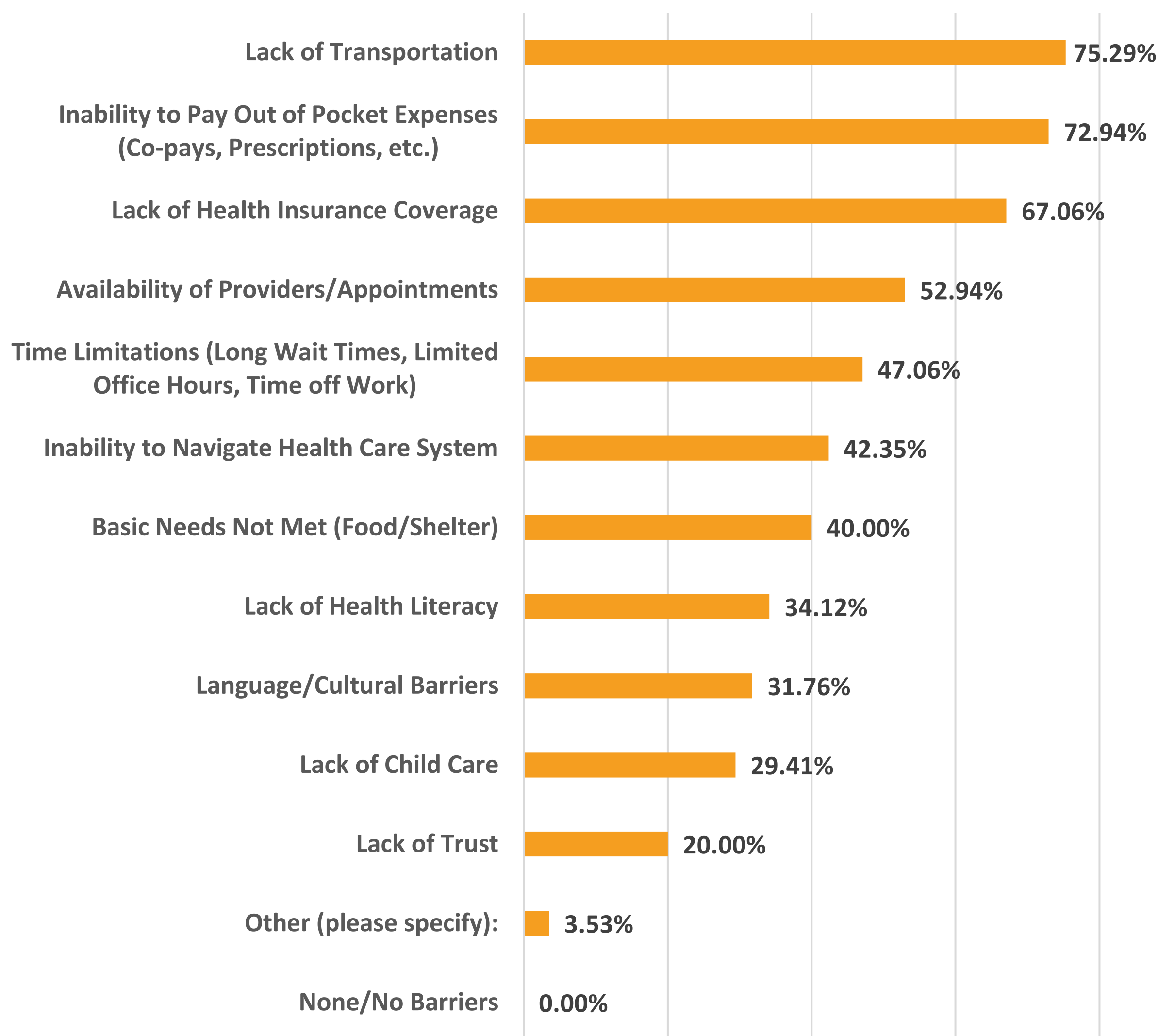


Respondents were asked about the ability of residents to access health care services such as primary care providers, medical specialists, dentists, transportation, Medicaid providers, and bi-lingual providers. Respondents were provided with statements such as: “Residents in the area are able to access a primary care provider when needed.” They were then asked to rate their agreement with these statements on a scale of 1 (Strongly Disagree) through 5 (Strongly Agree).

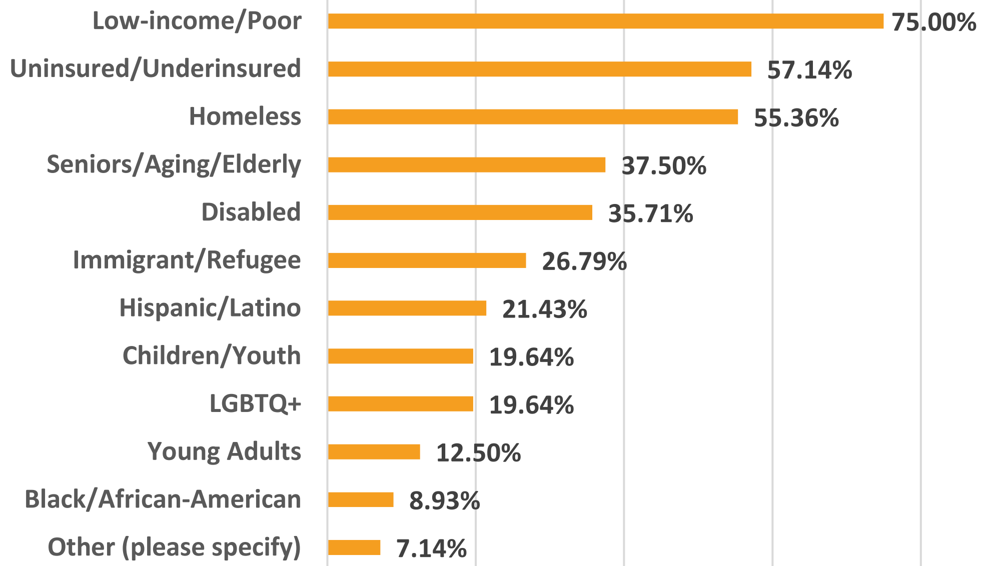
More than 50% of respondents felt that transportation to medical appointments, a lack of mental health providers in the area, a lack of bilingual providers in the area, and Medicaid access were all issues in the community.



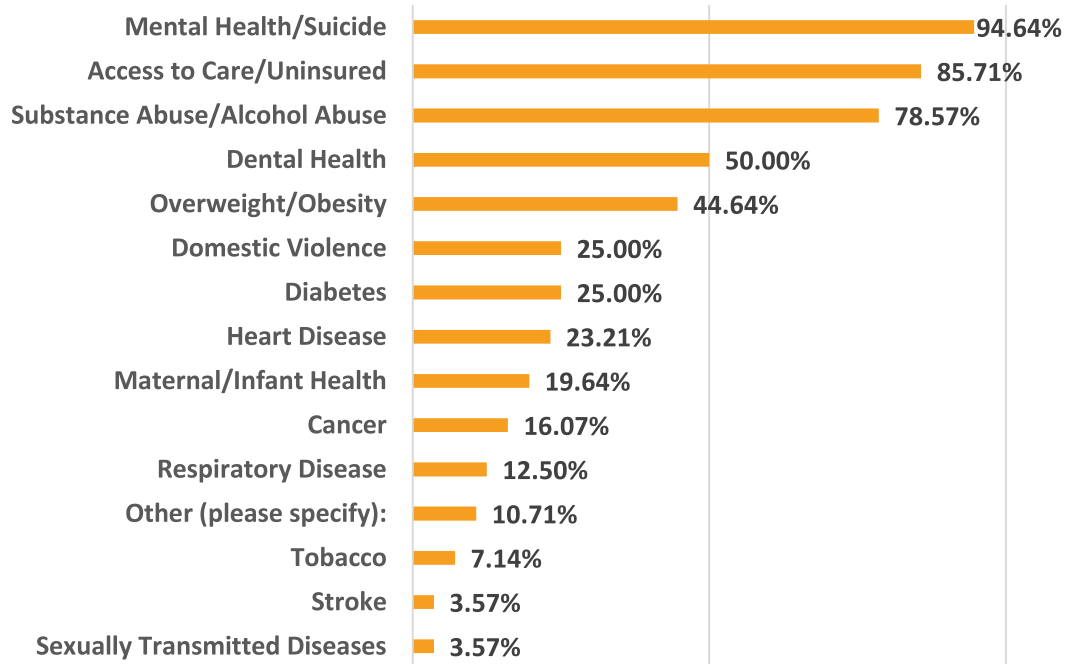
After rating availability of health care services, respondents were asked about the most significant barriers that keep people in their community from accessing healthcare when they need it. The barriers that were most frequently selected are summarized below. Of the barriers listed, the inability to pay out of pocket expenses and the availability of providers were viewed as the most significant barriers to care.



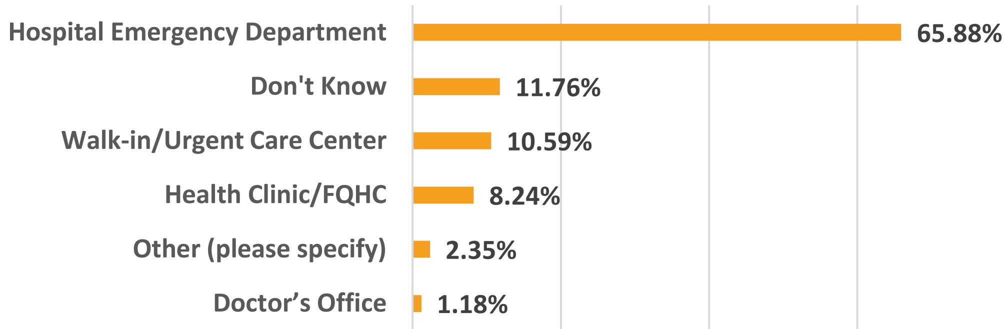
66% of respondents felt that there were specific populations in this community not being adequately served by local health services. The top three population groups identified by key informants as being underserved when compared to the general population in this current survey were, low-income/poor, uninsured/underinsured, and homeless. These were followed by seniors/aging/elderly, disabled, and immigrant/refugee populations.



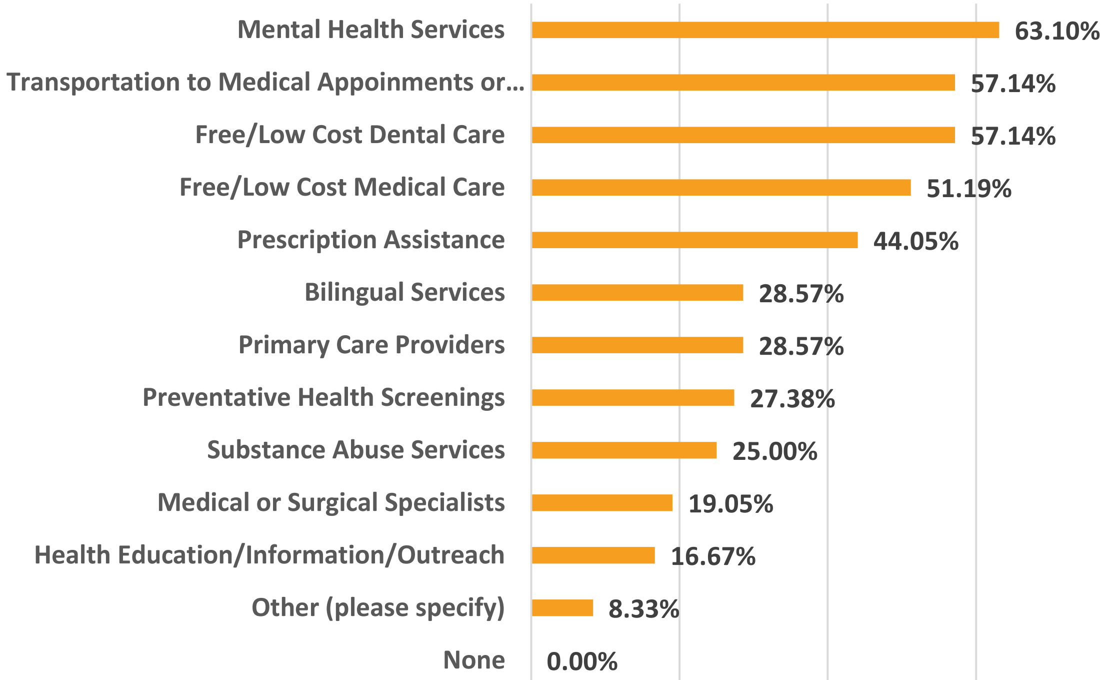
Below we show the breakdown of the health issues that respondents felt most impacted underserved populations Issues are ranked on the number of participants who selected the issue. Each respondent chose 5. This year, the top 5 ranked issues were mental health/suicide, access to care/uninsured, substance abuse/alcohol abuse, dental health, and overweight/obesity.



66% of key informants indicated hospital emergency departments as the primary place where uninsured/ underinsured individuals go when they are in need of medical care, this was down from 71% prior surveys. Walk-in/Urgent Care Center and Health Clinic/FQHC were also mentioned as preferred places to obtain medical care. 1% of respondents selected the Doctor's Office as the primary place where uninsured/underinsured individuals go when in need of care.



Respondents were asked if there were resources affecting quality of life missing in the community. The top three responses were mental health services, transportation to medical appointments, and free/low-cost care.



AHS' APPROACH TO ADDRESSING COMMUNITY HEALTH IMPROVEMENT AND ACCESS TO CARE

Atlantic Health System approaches community health improvement with proven and effective methods for addressing access to care. 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 diversity and inclusion, virtual care, and community involvement, supportive funding for community partners or collaboratives that are focused on common areas of concern related to community health needs, and health and wellness for older adults and at-risk populations.

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 Workers

AHS 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. The interdisciplinary team, including our Social Workers, comprehensively identify and address various social needs that influence health behaviors to promote successful outcomes. They work in partnership with department Community Health Workers and assist with more complex patient needs and barriers, such as interpersonal violence, crisis, difficulty coping with illness or stress, behavioral health or substance misuse linkage, abuse/neglect, or long-term care planning. Social Workers assess for patient strengths and social needs and coordinate linkage to a wide range of community resources, providing supportive handoffs and follow-through for successful and sustainable engagement with resources, brief behavioral interventions and referral to treatment, and emotional support.

Community Health Workers

Community Health Workers provide patients with structured support to help reduce barriers to care, infuse access to community resources for ongoing support, and assist patients to set and achieve their individualized health goals. Care Coordination has a team of Community Health Workers embedded in our medical center footprints

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

Social Determinants of Health Initiative

An integrated patient-centered approach that includes identifying social needs and providing structured support to help reduce barriers to care, access community resources for ongoing support, and setting and achieving short-term goals toward long-term health are strategies key to coordinated, cost-effective, high-quality care. A Social Determinants of Health (SDOH) 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 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 to signal the need for intervention. Referrals can be sent to Social Workers and Community Health Workers for additional support and to connect the patient to key community resources.

In the first quarter of 2020, AHS launched a pilot program among 11 PCP practices to screen patients age 18+ for SDOH. Screenings were broadened to all AMG/PCP primary care practices in August 2020, taking place once a year at patients' annual physical examinations. In October 2021, an inpatient SDOH screening pilot was launched on a Morristown Medical Center unit and transitioned in March 2023 to a targeted screening initiative for inpatients age 18+ with high-risk medical needs enrolled in the Transitions of Care program at all five medical centers. In October 2024, a systemwide SDOH inpatient screening initiative was deployed with a goal to screen all inpatients 18+ for 5 key SDOH domains during their admission and offer 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, including 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 Epic to facilitate patients experiencing social needs receive patient specific SDOH resources at the point of care. AHS embedded a Community Resource Directory in our public website, providing access to a comprehensive directory of local community resources and social programs, searchable by zip code, social need category or keyword.

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

Supporting Funding of Community Partners and Community Health Needs

The Community Advisory Boards (CAB) at Morristown, Overlook, Chilton, Newton, and Hackettstown Medical Centers all provide annual funding opportunities for community partners in the form of grants likely to enhance resources available in the community and address elements of health priorities identified in the individual hospital's community health needs assessment. Grants are funded through a competitive review process, which includes a requirement that approved funding be linked to community health need as identified by the medical centers. In 2023, funds allocated to community partners through the AHS Community Advisory Boards totaled $606,125.

Community Health Education and Wellness

Community Health offers a wide variety of health and wellness programs to meet the needs of the community. These programs aim to provide the knowledge and skills people need to live healthier lives and to connect them to supportive resources. Education about the social determinants of health is a key component of our programs, helping to address all 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.

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. In the most recent available reporting (2022), Atlantic Health System provided $290,938,760 in total community benefit across the following areas:

- Subsidized Health Services $59,448,289
- Cash and In-Kind Contributions $1,138,942
- Financial Assistance $24,793,174
- Medicaid Assistance Shortfall $135,159,638
- Health Professional Education $50,402,584
- Health Research Advancement $1,276,616
- Community Health Improvement Services $18,719,517

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 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.

IDENTIFICATION OF COMMUNITY HEALTH NEEDS

Prioritization

Following a review of secondary data and key informant findings, a select group of providers, community health agency representatives and other community stakeholders were asked to participate in a health issue prioritization survey. The prioritization survey included 15 health issues or concerns, which were identified during the primary and secondary analysis phases of the community health needs assessment. For each of the 15 health issues included in the survey, participants in this prioritization process were asked to respond to six statements related to the extent to which the health-related disparity or concern impacts the community served by Newton Medical Center or can be positively impacted by community health improvement efforts directed by Newton Medical Center. In completing their responses, prioritization survey participants were asked to provide their perspective based on a scale from 1 (Strongly Disagree) to 5 (Strongly Agree) for six criteria for each of the 15 identified health issues. The six prioritization criteria used to evaluate each issue were:

- Number of people impacted
- The risk of morbidity and mortality associated with the problem
- Impact of the problem on vulnerable populations
- Availability of resources to address the problem
- Relationship of issue to other community issues
- Is within the organization's capability/competency to impact over the next three years

The 15 issues identified for prioritization in the area served by NMC were:

- Diabetes
- Mental Health
- Heart Disease
- Substance Misuse
- Access to Providers
- Access to Care for Underserved / Insurance Coverage
- Preventative Health Screenings
- Obesity / Unhealthy Weight
- Barriers to Transportation Access
- Neurological Disease (Including Stroke)
- Prescription Assistance
- Maternal and Child Health
- Injuries / Poisonings
- Cancer
- COVID-19

Weighted averages for each impact on an issue were calculated. For each of the six potential impacts on an issue, the weighted averages were combined to create an overall weighted average for each issue (the overall ranking). The most impactful factor for each issue had the highest weighted average of the six impacts for that issue, the least impactful factor had the lowest weighted average for that issue. These results were presented to the Newton Medical Center Community Health Committee, who, in partnership with hospital administration, recommended the adoption of the following priority areas for inclusion in the 2024-2026 CHNA for NMC.

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

Following is a broad overview of each of the health priorities. NMC will develop a Community Health Improvement Plan (CHIP) to address these health priorities in 2025 and annually thereafter.

IDENTIFIED HEALTH PRIORITIES

DIABETES[10,11]

NMC is committed to its continued work with community partners to ensure that the many years of funding committed by NMC for projects that work to stem the spread of chronic diseases linked to diabetes and obesity continue to drive successful improvements in overall health of the community.

Diabetes mellitus (DM) occurs when the body cannot produce enough insulin or cannot respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications.

Many forms of diabetes exist. The 3 common types of DM are:

- Type 2 diabetes, which results from a combination of resistance to the action of insulin and insufficient insulin production
- Type 1 diabetes, which results when the body loses its ability to produce insulin
- Gestational diabetes, a common complication of pregnancy. Gestational diabetes can lead to perinatal complications in mother and child and increases the likelihood of cesarean section. Gestational diabetes is also a risk factor for the mother and, later in life, the child's subsequent development of type 2 diabetes after the affected pregnancy.

Effective therapy can prevent or delay diabetic complications. However, about 28 percent of Americans with DM are undiagnosed, and another 86 million American adults have blood glucose levels that increase their risk of developing type 2 DM in the next several years. Diabetes complications tend to be more common and more severe among people whose diabetes is poorly controlled, which makes DM an immense and complex public health challenge. Preventive care practices are essential to better health outcomes for people with diabetes.

DM affects an estimated 29.1 million people in the United States and is the 7th leading cause of death. Diagnosed DM:

- Increases the all-cause mortality rate 1.8 times compared to persons without diagnosed diabetes
- Increases the risk of heart attack by 1.8 times
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness
- In addition to these human costs, the estimated total financial cost of DM in the United States in 2012 was $245 billion, which includes the costs of medical care, disability, and premature death.
- The number of DM cases continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with DM, and possibly earlier onset of type 2 DM, there is growing concern about:
    - The possibility of substantial increases in prevalence of diabetes-related complications in part due to the rise in rates of obesity
    - The possibility that the increase in the number of persons with DM and the complexity of their care might overwhelm existing health care systems

[10] https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes
[11] https://stateofobesity.org/wp-content/uploads/2018/09/stateofobesity2018.pdf

- The need to take advantage of recent discoveries on the individual and societal benefits of improved diabetes management and prevention by bringing life-saving discoveries into wider practice
- The clear need to complement improved diabetes management strategies with efforts in primary prevention among those at risk for developing type 2 DM

Four "transition points" in the natural history of diabetes health care provide opportunities to reduce the health and economic burden of DM:

- Primary prevention: Movement from no diabetes to diabetes
- Testing and early diagnosis: Movement from unrecognized to recognized diabetes
- Access to care for all persons with diabetes: Movement from no diabetes care to access to appropriate diabetes care
- Improved quality of care: Movement from inadequate to adequate care
  Disparities in diabetes risk:
- People from minority populations are more likely to be affected by type 2 diabetes. Minority groups constitute 25 percent of all adult patients with diabetes in the United States and represent most children and adolescents with type 2 diabetes.
- African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians and other Pacific Islanders are at particularly high risk for the development of type 2 diabetes.
- Diabetes prevalence rates among American Indians are 2 to 5 times those of whites. On average, African American adults are 1.7 times as likely and Mexican Americans and Puerto Ricans are twice as likely to have the disease as non-Hispanic whites of similar age.
  Barriers to progress in diabetes care include:
- Systems problems (challenges due to the design of health care systems)
- The troubling increase in the number of people with diabetes, which may result in a decrease in the attention and resources available per person to treat DM

Evidence is emerging that diabetes is associated with additional comorbidities including:

- Cognitive impairment
- Incontinence
- Fracture risk
- Cancer risk and prognosis

The importance of both diabetes and these comorbidities will continue to increase as the population ages. Therapies that have proven to reduce microvascular and macrovascular complications will need to be assessed considering the newly identified comorbidities.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals. Based on this, new public health approaches are emerging that may deserve monitoring at the national level. For example, the Diabetes Prevention Program research trial demonstrated that lifestyle intervention had its greatest impact in older adults and was effective in all racial and ethnic groups. Translational studies of this work have also shown that delivery of the lifestyle intervention in group settings at the community level are also effective at reducing type 2 diabetes risk. The National Diabetes Prevention Program has now been established to implement the lifestyle intervention nationwide.

Another emerging issue is the effect on public health of new laboratory-based criteria, such as introducing the use of A1c for diagnosis of type 2 diabetes or for recognizing high risk for type 2 diabetes. These changes may impact the number of individuals with undiagnosed diabetes and facilitate the introduction of type 2 diabetes prevention at a public health level.

Several studies have suggested that process indicators such as foot exams, eye exams, and measurement of A1c may not be sensitive enough to capture all aspects of quality of care that ultimately result in reduced morbidity. New diabetes quality-of-care indicators are currently under development and may help determine whether appropriate, timely, evidence-based care is linked to risk factor reduction. In addition, the scientific evidence that type 2 diabetes can be prevented or delayed has stimulated new research into the best markers and approaches for identifying and referring high-risk individuals to prevention programs in community settings.

Finally, it may be possible to achieve additional reduction in the risk of type 2 diabetes or its complications by influencing various behavioral risk factors, such as specific dietary choices, which have not been tested in large randomized controlled trials.

OBESITY

Each year, the *State of Obesity: Better Policies for a Healthier America* report, issued by the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF), highlights the latest obesity trends as well as strategies, policies, programs, and practices that can reverse the epidemic. State of Obesity also demonstrates the level of commitment necessary to effectively fight obesity on a large scale and includes key recommendations for specific action.

New studies documenting national obesity rates and trends from the past year reinforce what we already know: obesity rates are alarmingly high; sustained, meaningful reductions have not yet been achieved nationally except possibly among our youngest children in low-income families; many populations continue to see steady increases in obesity; and racial, ethnic, and geographic disparities are persistent. Therefore, addressing the obesity epidemic remains imperative for ensuring the health of the nation.

According to the most recent National Health and Nutrition Examination Survey (NHANES), 18.5 percent of children and 39.6 percent of adults had obesity in 2015–2016. These are the highest rates ever documented by NHANES. There were no statistically significant changes in youth or adult rates compared with the 2013–2014 survey, but rates have increased significantly since 1999–2000, when 13.9 percent of children and 30.5 percent of adults had obesity.

The severity of racial, ethnic, and geographic disparities remains striking. Black and Latino children and adults continue to have higher obesity rates than Whites and Asians. The Youth Risk Behavior Survey, which is based on self-reported data, found that 14.8 percent of U.S. high school students had obesity in 2017. That survey also reported persistent inequities–18.2 percent of Black and Latino high schoolers had obesity compared to 12.5 percent of their White peers. Two other studies found that adults and children who live in rural areas have higher rates of severe obesity.

Accelerating progress to address obesity will require collaboration, sufficient resources, and sustained efforts, including by federal, state, and local agencies and the private sector. For decades, experts at CDC, National Institutes of Health (NIH), U.S. Department of Agriculture (USDA), U.S. Department of Education, the Administration for Children and Families, and the Food and Drug Administration (FDA) have been researching and developing strategies to prevent and address obesity. Over the past 15 years, policymakers have taken significant

steps to implement new approaches through the WIC program, the Supplemental Nutrition Assistance Program, the National School Lunch and Breakfast Programs, updated menu labeling rules, and an updated Nutrition Facts label. Some of these efforts were delayed or weakened, preventing full implementation, and thus denying researchers the ability to effectively study which efforts best help people maintain a healthy weight.

For instance, a USDA rule published in November 2017 scaled back key nutrition standards for school breakfast and lunch programs that went into effect in 2012. The question is whether schools will continue the healthy changes that they already implemented. In 23 states, 100 percent of school food agencies were compliant as of September 2016 and at least 90 percent of agencies were compliant in every state. FDA requirements for food retailers and restaurants to post calorie information on menus and elsewhere went into effect in May 2018, more than eight years after becoming law and after several unnecessary delays. Recent federal budget proposals include deep cuts to key health programs such as the CDC's National Center for Chronic Disease Prevention and Health Promotion. This cut would eliminate dedicated funding for addressing nutrition, physical activity, and obesity.

Limiting policies and funding for obesity prevention efforts at a moment when the enormity and intractability of this public health problem is so pressing will have adverse consequences for the country and its residents. After all, Americans' health is directly tied to national security and the U.S. economy.

In response to ongoing high levels of obesity, the United States must be bold enough to find and test new strategies, and resolute enough to intensify evidence-based solutions that are already making a difference. This means communities, governments, and other institutions need to work across sectors and levels to support policies, practices, and programs that work. Over time, these investments can pay off—in lives saved and in reduced healthcare costs.

The annual State of Obesity reports have documented how, over the past 15 years, a series of evidenced-based policies and programs have helped Americans eat healthier and provided more opportunities for physical activity in their homes, schools, and communities. These initiatives have taken root at the local, state, and federal levels, with participation from the private sector.

A renewed commitment to obesity prevention policies and programs, and continued innovation at the state and local levels is critical to achieving success among more children and adults in our country. Effective obesity prevention efforts also require substantial investment to support multifaceted, multi-sector collaborations; merging multiple sources of public and private funding can best ensure that these efforts are sustainable as a long-term enterprise. This is particularly important for populations that have elevated risk.

TFAH and RWJF recommend three guiding principles regarding obesity prevention:

1) Promote policies and scale programs that take a multi-sector approach. Multi-sector aligned initiatives—collaborations that involve, for example, health departments, schools, transportation departments, local businesses, and other agencies—are more likely to achieve results.
2) Adopt and implement policies that help make healthy choices easy. Federal, state, and local governments can create conditions in schools, communities, and workplaces that make healthy eating and active living accessible, affordable, and convenient.
3) Invest in programs that level the playing field for all individuals and families. While obesity affects all populations, some have significantly higher levels than others—often due to social and economic factors largely beyond their control, such as racism, poverty, and lack of access to healthcare. Carefully designed initiatives are informed by community input and address these challenges are critically important.

Investing in these programs requires not only adequate funding, but also staffing, public promotion, and other community resources.

TFAH and RWJF offer the following specific recommendations to Healthcare System and Providers:

- Hospitals should no longer sell or serve sugary drinks on their campuses; they should also improve the nutritional quality of meals and promote breastfeeding.
- Nonprofit hospitals should prioritize childhood obesity prevention programs as they work to meet their community benefit requirements.
- All public and private health plans should cover the full range of obesity-prevention, treatment, and management services, including nutritional counseling, medications, and behavioral health consultation.
- Medicare should encourage eligible beneficiaries to enroll in obesity counseling as a covered benefit and evaluate its use and effectiveness. Health plans, medical schools, continuing medical education, and public health departments should raise awareness about the need and availability of these services.
- The healthcare system should extend programs that are effective in terms of costs and performance, such as the Diabetes Prevention Program (DPP) and the community health worker–clinical coordination models. Providers and payers should allocate resources to educating and referring patients to DPP and other covered benefits as appropriate.
- Public and private payers should cover value-based purchasing models that incorporate health outcome measures that incentivize clinicians to prioritize healthy weight.

MENTAL HEALTH

Need for Mental Health Providers[12]

Most counties in the United States face shortages of mental health professionals. In 96 percent of the counties in the nation, there is a shortage of psychiatrists who prescribe medications for people with serious mental illness (SMI). From 2003 to 2013, the number of practicing psychiatrists decreased by 10 percent when adjusted for population size. Many psychiatrists are shifting to private practice, accepting only cash for reimbursement. In part, this may reflect low reimbursement for psychiatric services from state Medicaid programs and Medicaid-contracted managed care payers, cuts to federal and state funding for public sector programs, and inadequate rate setting for psychiatric services. The greatest shortages are in poorer and more rural counties. The need for child psychiatrists is even greater than the shortage of psychiatrists for adults with SMI. The lack of access to psychiatric services creates several issues, such as long wait times for scheduled appointments, often leading to emergency department visits and hospitalizations.

Expanding the workforce by allowing advanced practice registered nurses to practice to the full extent of their training, broadening the scope of practice of psychologists to prescribe some medications, and educating more advanced practice registered nurses and psychiatric-mental health physician assistants, are examples of strategies to address the shortage. Tele-mental health is widely accepted as a mechanism that can address shortages in some geographic areas. One in five counties also has a shortage of non-prescriber mental health professionals, defined as psychologists, advanced practice psychiatric nurses, social workers, licensed professional counselors, and marriage and family therapists. Also, there are categories of mental health service providers, including licensed professional counselors and marriage and family therapists, whose services are not eligible for reimbursement by Medicare. Peer support can play an important role in a functioning mental health system and should be included as a part of a full continuum of services, whenever possible. Peer support services have been

[12] https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

demonstrated to promote recovery and resiliency through the generation of hope, engagement in treatment services, and activation for improved health outcomes. Youth and family peer support services have also generated notable outcomes in this area.

Most states report insufficient psychiatric crisis response capacity as well as insufficient numbers of inpatient psychiatric hospital beds. It is critical that every state have adequate bed capacity to respond to the needs of people experiencing both psychiatric crises and those who need longer periods of inpatient care, such as people in forensic care (care that is provided because of involvement in the criminal or juvenile justice systems). In many areas, bed shortages have led to long delays in gaining access to treatment and an increase in individuals waiting for competency restoration services needed to restore competency to participate in legal proceedings. A report by the National Association of State Mental Health Program Directors Research Institute found that most states (35 of the 46 who responded) have shortages of psychiatric hospital beds. The configuration of available beds and the number of beds per 100,000 population varies across states, but few states report they have adequate numbers of inpatient beds to meet needs. Use of a variety of strategies, such as building psychiatric respite bed capacity, may help to address these capacity issues.

- The workforce is too few, aging into retirement, inadequately reimbursed, inadequately supported and trained and facing significant changes affecting practice, credentialing, funding, and ability to keep up with changes in practice models driven by changing science, technologies, and systems.
- Shortages of qualified workers, recruitment and retention of staff and an aging workforce have long been cited as problems.
- Lack of workers in rural/frontier areas and the need for a workforce more reflective of the racial and ethnic composition of the U.S. population create additional barriers to accessing care for many.
- Recruitment and retention efforts are hampered by inadequate compensation, which discourages many from entering or remaining in the field.
- The misperceptions and prejudice surrounding mental and substance use disorders and those who experience them are imputed to those who work in the field.
- Pre-service education and continuing education and training of the workforce have been found wanting, as evidenced by the long delays in adoption of evidence-based practices, underutilization of technology, and lack of skills in critical thinking. These education and training deficiencies are even more problematic with the increasing integration of primary care and mental or substance use disorder treatment, and the focus on improving quality of care and outcomes.
- Of additional concern, the current workforce is unprepared to meet the mental and substance use disorder treatment needs of the rapidly growing population of older adults.

Several themes emerged as common factors that are influencing workforce trends across the country.[13]

- The Affordable Care Act and Medicaid expansion: The Patient Protection and Affordable Care Act (ACA) and accompanying reforms expanded access to SUD treatment to millions of Americans. Treatment agencies need more staff to treat more clients. Many existing SUD staff need to complete additional coursework or pursue master's level degrees.
- Clinical supervision: In many states, clinical supervision is also required when implementing evidence-based practices. Organizations that invest in their staff by providing good clinical supervision may have greater success with workforce recruitment and retention.

[13] SAMHSA. (2017, September). ATTC: Network Coordinating Office. National Workforce Report 2017. From http://attcnetwork.org/documents/ATTC_Network_Natl_Report2017_single.pdf (

- Healthcare integration: The movement to integrate mental health and SUD treatment with primary care has had an impact on the workforce. SUD professionals are under increasing pressure to acquire skills that allow them to work in integrated healthcare settings, and primary care physicians, nurses, and other medical professionals are beginning to play larger roles in SUD treatment and recovery services.
- The opioid epidemic: No state in the country has been spared from the devastation of the opioid epidemic. Building the capacity of the SUD workforce to provide effective evidence-based treatment for opioid use disorders has been a top priority.

What are some strategies to increase the size of the workforce to better provide evidence-based mental health services and supports?[14]

- HRSA has taken several steps to address these workforce challenges as part of its mission to prepare a diverse workforce and improve the workforce distribution to increase access for underserved communities. Among its many programs, HRSA awards health professional and graduate medical education training grants and operates scholarship and loan repayment programs.
- Of note is the National Health Service Corps, where, as of September 2015, roughly 30 percent of its field strength of 9,683 was composed of behavioral health providers, meeting service obligations by providing care in areas of high need.
- HRSA is also putting increased emphasis on expanding the delivery of medication-assisted treatment, increasing SBI, and coordinating RSS. The development of the workforce qualified to deliver these services and services to address co-occurring medical and mental disorders will have significant implications for the national workforce's ability to reach the full potential of integration.

What are SAMHSA and other Federal agencies doing to address the workforce crisis and enhance recovery supports as an integral part of the solution?[15]

- SAMHSA will support active strategies to strengthen and expand the behavioral health workforce and improve the behavioral health knowledge and skills of those health care workers not considered behavioral health specialists. Through technical assistance, training, partnerships, and traditional and social media outreach, SAMHSA will promote an integrated, aligned, and competent workforce.
- This workforce will enhance the availability of prevention and treatment for substance abuse and mental illness, strengthen the capabilities of behavioral health professionals, and promote health system infrastructure that can deliver competent, organized behavioral health services.
- SAMHSA will monitor and assess the needs of youth, young adult and adult peers, communities, and health professionals in meeting behavioral health needs within America's transforming health promotion and health care delivery systems.
- SAMHSA also recognizes the growing understanding and value of peer providers to assist with engagement, support, and peer services. Increasing the peer and paraprofessional workforce and increasing the evidence base for the best uses of peer and paraprofessional behavioral health services and supports, will require additional commitment, and will help to expand the reach of limited professional treatment and support professionals.

What is the best way to ensure the behavioral health workforce has access to the information they need to remain current in advancing technologies in prevention, treatment, and recovery support? [16]

[14] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.
[15] SAMHSA. Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018
[16] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.

- Strong health IT systems improve the organization and usability of clinical data, thereby helping patients, health care professionals, and health system leaders coordinate care, promote shared decision-making, and engage in quality improvement efforts. These systems have the capacity to easily provide information in multiple languages and to put patients in touch with culturally appropriate providers through telehealth.

What kinds of training programs or strategies might BH managers adopt to enhance staff retention?[17]

- Members of the behavioral health workforce benefit from continued training and clinical supervision to maintain high-quality services. In addition, these practices and other organizational factors may prevent staff from experiencing burnout and may assist in overcoming challenges in retention of qualified workers.
- For example, clinical supervision has been shown to serve as a protective factor in substance abuse treatment counselors' turnover, emotional exhaustion, and job satisfaction. In the substance abuse treatment field, staff turnover has been found to be as high as 50 percent in some contexts, with average annual estimates around 32 percent for counselors. Substance abuse treatment facilities can play a key role in supporting their workforce through training and supervision practices.

What are initiatives that increase access to providers in underserved areas and integrate behavioral health and primary care?

- The National Network to Eliminate Disparities (NNED) in Behavioral Health is dedicated to promoting equality in behavioral health services for individuals, families, and communities. NNED, with help from SAMHSA and the National Alliance for Multi-Ethnic Behavioral Health Associations, builds coalitions of racial, ethnic, cultural, and sexual minority communities and groups dedicated to removing disparities in behavioral health care.[18]
- The Minority Fellowship Programs (MFP) increase the knowledge of issues related to mental health conditions and addictions among minorities, and to improve the quality of mental health services and substance abuse prevention and treatment delivered to ethnic minority populations. SAMHSA provides grants to encourage and facilitate the doctoral and post-doctoral development of nurses, psychiatrists, social workers, psychologists, marriage and family therapists, and professional counselors by providing funding to organizations which oversee the fellowship opportunities.
- Graduate Psychology Education (GPE) Program: HRSA grants in the GPE program support interdisciplinary training for health service psychologists to provide mental and behavioral health care services to underserved populations, such as those in rural areas, older adults, children, chronically ill or disabled persons, and victims of abuse or trauma, including returning military personnel.
- HRSA's National Health Service Corps are health professionals who provide primary health care services in underserved communities in exchange for either loan repayment assistance or scholarships to help pay the costs of their medical education.
- SAMHSA's cooperative agreement with Historically Black Colleges and Universities supports a Center for Excellence in Substance Abuse and Mental Health which provides student internships at minority serving institutions.[19]

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[17] Sherman, Laura, Lynch, Sean, et. al. Behavioral Health Workforce: Quality Assurance Practices in Substance Abuse Treatment Facilities. The CBHSQ Report. SAMHSA.
[18] SAMHSA. (n.d.). Serving the Needs of Diverse Populations.
[19] SAMHSA. (2013, January 24). Report to Congress on Nation's Substance Abuse and Mental Health Workforce Issues.

- CMS is providing technical and program support to states to introduce policy, program, and payment reforms to identify individuals with substance use disorders, expand coverage for effective treatment, expand access to services, and develop data collection, measurement, and payment mechanisms that promote better outcomes.
- Medicaid is also encouraging the trend to integration in other ways, including supporting new models for delivering primary care, expanding the role of existing community-based care delivery systems, enacting mental health and substance use disorder parity for Medicaid and Children's Health Insurance Program (CHIP) as included in the final rule that CMS finalized in March 2016.[20]

SUBSTANCE MISUSE[21]

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Following are overviews of the most common substance use disorders in the United States.

Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea, constipation, and, depending upon the amount of drug taken, can depress respiration. Illegal opioid drugs, such as heroin and legally available pain relievers such as oxycodone and hydrocodone can cause serious health effects in those who misuse them. Some people experience a euphoric response to opioid medications, and it is common that people misusing opioids try to intensify their experience by snorting or injecting them. These methods increase their risk for serious medical complications, including overdose. Other users have switched from prescription opiates to heroin because of availability and lower price. Because of variable purity and other chemicals and drugs mixed with heroin on the illegal market, this also increases risk of overdose. Overdoses with opioid pharmaceuticals led to almost 17,000 deaths in 2011. Since 1999, opiate overdose deaths have increased 265% among men and 400% among women.

In 2014, an estimated 1.9 million people had an opioid use disorder related to prescription pain relievers and an estimated 586,000 had an opioid use disorder related to heroin use.

Symptoms of opioid use disorders include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.

Stimulants increase alertness, attention, and energy, as well as elevate blood pressure, heart rate, and respiration. They include a wide range of drugs that have historically been used to treat conditions, such as obesity, attention deficit hyperactivity disorder and, occasionally, depression. Like other prescription medications, stimulants can be diverted for illegal use. The most abused stimulants are amphetamines, methamphetamine, and cocaine.

[20] U.S. Department of Health & Human Services. (2016, Nov.). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health.
[21] https://www.samhsa.gov/disorders/substance-use

Stimulants can be synthetic (such as amphetamines) or can be plant-derived (such as cocaine). They are usually taken orally, snorted, or intravenously.

In 2014, an estimated 913,000 people ages 12 and older had a stimulant use disorder because of cocaine use, and an estimated 476,000 people had a stimulant use disorder because of using other stimulants besides methamphetamines. In 2014, almost 569,000 people in the United States ages 12 and up reported using methamphetamines in the past month.

Symptoms of stimulant use disorders include craving for stimulants, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use stimulants, and withdrawal symptoms that occur after stopping or reducing use, including fatigue, vivid and unpleasant dreams, sleep problems, increased appetite, or irregular problems in controlling movement.

Marijuana is the most-used drug after alcohol and tobacco in the United States. According to SAMHSA data:

- In 2014, about 22.2 million people ages 12 and up reported using marijuana during the past month.
- Also, in 2014, there were 2.6 million people in that age range who had used marijuana for the first time within the past 12 months. People between the ages of 12 and 49 report first using the drug at an average age of 18.5.

In the past year, 4.2 million people ages 12 and up met criteria for a substance use disorder based on marijuana use.

Marijuana's immediate effects include distorted perception, difficulty with thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory infection, impaired memory, and exposure to cancer-causing compounds. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Some symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use.

According to the CDC, more than 480,000 deaths each year are caused by cigarette smoking. Tobacco use and smoking do damage to nearly every organ in the human body, often leading to lung cancer, respiratory disorders, heart disease, stroke, and other illnesses.

In 2014, an estimated 66.9 million Americans aged 12 or older were current users of a tobacco product (25.2%). Young adults aged 18 to 25 had the highest rate of current use of a tobacco product (35%), followed by adults aged 26 or older (25.8%), and by youths aged 12 to 17 (7%).

In 2014, the prevalence of current use of a tobacco product was 37.8% for American Indians or Alaska Natives, 27.6% for Whites, 26.6% for Black people, 30.6% for Native Hawaiians or other Pacific Islanders, 18.8% for Hispanics, and 10.2% for Asians.

Excessive alcohol use can increase a person's risk of developing serious health problems in addition to those issues associated with intoxication behaviors and alcohol withdrawal symptoms. According to the Centers for Disease Control and Prevention (CDC), excessive alcohol use causes 88,000 deaths a year.

Data from the National Survey on Drug Use and Health (NSDUH) show that in 2014, slightly more than half (52.7%) of Americans ages 12 and up reported being current drinkers of alcohol. Most people drink alcohol in moderation. However, of those 176.6 million alcohol users, an estimated 17 million have an AUD. Many Americans begin drinking at an early age. In 2012, about 24% of eighth graders and 64% of twelfth graders used alcohol in the past year.

The definitions for the different levels of drinking include the following:
- Moderate Drinking—According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.
- Binge Drinking—SAMHSA defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 drinks for women and 5 drinks for men over a 2-hour period.
- Heavy Drinking—SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Excessive drinking can put you at risk of developing an alcohol use disorder in addition to other health and safety problems. Genetics have also been shown to be a risk factor for the development of an AUD.

To be diagnosed with an AUD, individuals must meet certain diagnostic criteria. Some of these criteria include problems controlling intake of alcohol, continued use of alcohol despite problems resulting from drinking, development of a tolerance, drinking that leads to risky situations, or the development of withdrawal symptoms. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

Hallucinogens can be chemically synthesized (as with lysergic acid diethylamide or LSD) or may occur naturally (as with psilocybin mushrooms, peyote). These drugs can produce visual and auditory hallucinations, feelings of detachment from one's environment and oneself, and distortions in time and perception.

In 2014, approximately 246,000 Americans had a hallucinogen use disorder. Symptoms of hallucinogen use disorder include craving for hallucinogens, failure to control use when attempted, continued use despite interference with major obligations or social functioning, use of larger amounts over time, use in risky situations like driving, development of tolerance, and spending a great deal of time to obtain and use hallucinogens.

HEART DISEASE[22]

In the area served by Hackettstown Medical Center, there are identified health concerns or disparities among the population that are related to heart disease.

Heart disease currently stands as the leading cause of death in the United States, with more than 600,000 Americans dying of heart disease and related conditions each year.[23] This amounts to one in every four deaths in the United States annually. Several health conditions, your lifestyle, and your age and family history can increase your risk for heart disease. About half of all Americans (47%) have at least one of the three key risk factors for heart disease: high blood pressure, high cholesterol, and smoking. Some of the risk factors for heart disease cannot be controlled, such as your age or family history. But you can take steps to lower your risk by changing the factors you can control.

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[22] https://www.cdc.gov/heartdisease/about.htm
[23] www.cdc.gov/nchs/ data/nvsr/nvsr60/nvsr60_03.pdf

The term "heart disease" refers to several types of heart conditions.

Coronary artery disease (CAD) is the most common type of heart disease in the United States. For some people, the first sign of CAD is a heart attack. CAD is caused by plaque buildup in the walls of the arteries that supply blood to the heart (called coronary arteries) and other parts of the body. Plaque is made up of deposits of cholesterol and other substances in the artery. Plaque buildup causes the inside of the arteries to narrow over time, which could partially or totally block the blood flow. This process is called atherosclerosis.

Too much plaque buildup and narrowed artery walls can make it harder for blood to flow through your body. When your heart muscle doesn't get enough blood, you may have chest pain or discomfort, called angina. Angina is the most common symptom of CAD. Over time, CAD can weaken the heart muscle. This may lead to heart failure, a serious condition where the heart can't pump blood the way that it should. An irregular heartbeat, or arrhythmia, also can develop. Being overweight, physical inactivity, unhealthy eating, and smoking tobacco are risk factors for CAD. A family history of heart disease also increases your risk for CAD.

Heart Attack, also called a myocardial infarction, occurs when a part of the heart muscle doesn't receive enough blood flow. The more time that passes without treatment to restore blood flow, the greater the damage to the heart muscle. Learn more about the signs and symptoms of a heart attack.

Every year, about 790,000 Americans have a heart attack. Of these cases, 580,000 are a first heart attack and 210,000 happen to people who have already had a first heart attack. One of 5 heart attacks is silent—the damage is done, but the person is not aware of it. Coronary artery disease (CAD) is the main cause of heart attack. Less common causes are severe spasm, or sudden contraction, of a coronary artery that can stop blood flow to the heart muscle.

Other related conditions include:

- Acute coronary syndrome: a term that includes heart attack and unstable angina.
- Angina: a symptom of coronary artery disease, is chest pain or discomfort that occurs when the heart muscle is not getting enough blood. Angina may feel like pressure or a squeezing pain in the chest. The pain also may occur in the shoulders, arms, neck, jaw, or back. It may feel like indigestion.
- Stable angina: happens during physical activity or under mental or emotional stress.
- Unstable angina: chest pain that occurs even while at rest, without apparent reason. This type of angina is a medical emergency.
- Aortic aneurysm and dissection: conditions that can affect the aorta, the major artery that carries blood from the heart to the body. An aneurysm is an enlargement in the aorta that can rupture or burst. A dissection is a tear in the aorta. Both conditions are medical emergencies.
- Arrhythmias: irregular or unusually fast or slow heartbeats. Arrhythmias can be serious. One example is called ventricular fibrillation. This type of arrhythmia causes an abnormal heart rhythm that leads to death unless treated right away with an electrical shock to the heart (called defibrillation). Other arrhythmias are less severe but can develop into more serious conditions, such as atrial fibrillation, which can cause a stroke.
- Atherosclerosis: occurs when plaque builds up in the arteries that supply blood to the heart (called coronary arteries). Plaque is made up of cholesterol deposits. Plaque buildup causes arteries to narrow over time.
- Atrial fibrillation: a type of arrhythmia that can cause rapid, irregular beating of the heart's upper chambers. Blood may pool and clot inside the heart, increasing the risk for heart attack and stroke.

- Cardiomyopathy: occurs when the heart muscle becomes enlarged or stiff. This can lead to inadequate heart pumping (or weak heart pump) or other problems. Cardiomyopathy has many causes, including family history of the disease, prior heart attacks, uncontrolled high blood pressure, and viral or bacterial infections.
- Congenital heart defects: problems with the heart that are present at birth. They are the most common type of major birth defect. Examples include abnormal heart valves or holes in the heart's walls that divide the heart's chambers. Congenital heart defects range from minor to severe.
- Heart failure: often called congestive heart failure (CHF) because of fluid buildup in the lungs, liver, gastrointestinal tract, and the arms and legs. Heart failure is a serious condition that occurs when the heart can't pump enough blood to meet the body's needs. It does not mean that the heart has stopped but that muscle is too weak to pump enough blood. Most heart failure cases are chronic, or long-term heart failures. The only cure for heart failure is a heart transplant. However, heart failure can be managed with medications or medical procedures.
- Peripheral arterial disease (PAD): occurs when the arteries that supply blood to the arms and legs (the periphery) become narrow or stiff. PAD usually results from atherosclerosis, the buildup of plaque and narrowing of the arteries. With this condition, blood flow and oxygen to the arm and leg muscles are low or even fully blocked. Signs and symptoms include leg pain, numbness, and swelling in the ankles and feet.
- Rheumatic heart disease is damage to the heart valves caused by a bacterial (streptococcal) infection called rheumatic fever.

CANCER

Like heart disease, cancer is another chronic disease that immensely impacts the HMC community. Stakeholders answered that there is a high risk of morbidity and mortality associated with cancer and that it impacts a lot of people in the area served by Hackettstown Medical Center. Within this area there are identified health concerns or disparities among the population that are related to cancer, including:

- The incidence rate of melanoma
- The incidence of prostate cancer
- The incidence rate of oral cavity and pharynx cancer
- The incidence of colorectal cancer
- The age-adjusted death rate due to cancer
- The age-adjusted death rate due to prostate cancer

The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Cancer also has a high disease burden on the community served by HMC. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health.[24]
Many cancers are preventable by reducing risk factors such as:

- Use of tobacco products
- Physical inactivity and poor nutrition
- Obesity
- Ultraviolet light exposure

[24] https://health.gov/healthypeople/objectives-and-data/browse-objectives/cancer

Other cancers can be prevented by getting vaccinated against human papillomavirus (HPV) and hepatitis B virus. In addition to prevention, screening is effective in identifying some types of cancers in early, often highly treatable stages including:

- Breast cancer (using mammography)
- Cervical cancer (using Pap test alone or combined Pap test and HPV test)
- Colorectal cancer (using stool-based testing, sigmoidoscopy, or colonoscopy)
- Lung Cancer (using low dose computed tomography)

For cancers with evidence-based screening tools, early detection must address the continuum of care from screening to appropriate follow-up of abnormal test results and referral to cancer treatment.[25]

When talking about cancer, equity is when everyone has an equal opportunity to prevent cancer, find it early, and get proper treatment and follow-up after treatment is completed. Unfortunately, many Americans can't make healthy choices because of factors like where they live, their race or ethnicity, their education, their physical or mental abilities, or their income. As a result, they have more health problems than others. These differences in health among groups of people that are linked to social, economic, geographic, or environmental disadvantage are known as health disparities.[26]

Cancer affects all population groups in the United States, but due to social, environmental, and economic disadvantages, certain groups bear a disproportionate burden of cancer compared with other groups. Cancer disparities reflect the interplay among many factors, including social determinants of health, behavior, biology, and genetics—all of which can have profound effects on health, including cancer risk and outcomes.

Certain groups in the United States experience cancer disparities because they are more likely to encounter obstacles in getting health care. For example, people with low incomes, low health literacy, long travel distances to screening sites, or who lack health insurance, transportation to a medical facility, or paid medical leave are less likely to have recommended cancer screening tests and to be treated according to guidelines than those who don't encounter these obstacles.

People who do not have reliable access to health care are also more likely to be diagnosed with late-stage cancer that might have been treated more effectively if diagnosed at an earlier stage.[27]

Screening and Diagnosis

Cancer detection and diagnosis involves identifying the presence of cancer in the body and assessing the extent of disease—whether it is the initial diagnosis of a cancer or the detection of a recurrence. For some cancers, this definition can be expanded to include identifying precancerous lesions that are likely to become cancer, providing an opportunity for early intervention and preventing cancer altogether.

Screening tests for cancer can help find cancer at an early stage before typical symptoms might appear. When this is done early, it is often easier to treat. Some screening tests include: a physical exam, laboratory test, imaging procedure, or a genetic test.[28]

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[25] Zapka, J. G., et al. (2003). A framework for improving the quality of cancer care: the case of breast and cervical cancer screening. Cancer Epidemiology and Prevention Biomarkers, 12(1), 4-13.
[26] https://www.cdc.gov/cancer/health-equity/equity.htm
[27] https://www.cancer.gov/about-cancer/understanding/disparities#contributing-factors
[28] https://www.cancer.gov/about-cancer/screening/patient-screening-overview-pdq

Overall, stakeholders acknowledge the immense impact that cancer has on the HMC community. A way to improve health outcomes is to screen and diagnose cancer early on. This can be achieved by addressing access to care issues. When access is improved, community members can seek primary care treatment and be screened regularly. This can help to lower the risk of morbidity and mortality due to cancer.

APPENDIX A: SECONDARY DATA SOURCES

The following table represents data sources for health-related indicators that were reviewed as part of NMC's CHNA secondary data analysis.

SOURCE
American Community Survey
Annie E. Casey Foundation
CDC - PLACES
Centers for Disease Control and Prevention
Centers for Medicare & Medicaid Services
Conduent Healthy Communities Institute
County Health Rankings
Emergency Department Data
Feeding America
Healthy Communities Institute
National Cancer Institute
National Center for Education Statistics
National Environmental Public Health Tracking Network
New Jersey Association of Child Care Resource and Referral Agencies
NJ State Health Assessment Data & US Census
State of New Jersey Department of Health
State of New Jersey Department of Human Services, Division of Mental Health, and Addiction Services
State of New Jersey Department of State
U.S. Bureau of Labor Statistics
U.S. Census - County Business Patterns
U.S. Census Bureau - Small Area Health Insurance Estimates
U.S. Department of Agriculture - Food Environment Atlas
U.S. Environmental Protection Agency
United For ALICE

APPENDIX B: HEALTH INDICATORS

The following table represents health-related indicators that were reviewed as part of NMC's CHNA secondary data analysis. The data are compiled and maintained by the Conduent Healthy Communities Institute.

Primary Topic	Indicator
Alcohol & Drug Use	Adults who Binge Drink
	Adults who Drink Excessively
	Adults who Use Alcohol: Past 30 Days
	Age-Adjusted Alcohol-Related Emergency Department Visit Rate
	Age-Adjusted Rate of Substance Use Emergency Department Visits
	Death Rate due to Drug Poisoning
	Opioid Treatment Admission Rate
Cancer	Adults with Cancer
	Age-Adjusted Death Rate due to Breast Cancer
	Age-Adjusted Death Rate due to Cancer
	Age-Adjusted Death Rate due to Colorectal Cancer
	Age-Adjusted Death Rate due to Lung Cancer
	Age-Adjusted Death Rate due to Pancreatic Cancer
	Age-Adjusted Death Rate due to Prostate Cancer
	All Cancer Incidence Rate
	Breast Cancer Incidence Rate
	Cancer: Medicare Population
	Cervical Cancer Incidence Rate
	Cervical Cancer Screening: 21-65
	Colon Cancer Screening
	Colorectal Cancer Incidence Rate
	Liver and Bile Duct Cancer Incidence Rate
	Lung and Bronchus Cancer Incidence Rate
	Mammogram in Past 2 Years: 50-74
	Melanoma Incidence Rate
	Non-Hodgkin Lymphoma Incidence Rate
	Oral Cavity and Pharynx Cancer Incidence Rate
	Pancreatic Cancer Incidence Rate
	Pap Test in Past 3 Years: 21-65
	Prostate Cancer Incidence Rate
Community	Age-Adjusted Death Rate due to Motor Vehicle Collisions
	Alcohol-Impaired Driving Deaths
	Households with an Internet Subscription
	Households with One or More Types of Computing Devices
	Linguistic Isolation
	Mean Travel Time to Work
	People 65+ Living Alone

Primary Topic	Indicator
	Persons with an Internet Subscription
	Single-Parent Households
	Social Associations
	Solo Drivers with a Long Commute
	Substantiated Child Abuse Rate
	Violent Crime Rate
	Voter Turnout: Presidential Election
	Within County Disparity in Life Expectancy at Birth
	Workers Commuting by Public Transportation
	Workers who Drive Alone to Work
County Health Rankings	Clinical Care Ranking
	Health Behaviors Ranking
	Morbidity Ranking
	Mortality Ranking
	Physical Environment Ranking
	Social and Economic Factors Ranking
Diabetes	Adults 20+ with Diabetes
	Adults with Prediabetes
	Age-Adjusted Death Rate due to Diabetes
	Diabetes: Medicare Population
Disabilities	Persons with Disability Living in Poverty
	Persons with Disability Living in Poverty (5-year)
Economy	Child Food Insecurity Rate
	Children Living Below Poverty Level
	Cost of Family Child Care as a Percentage of Income
	Cost of Licensed Child Care as a Percentage of Income
	Families Living Below Poverty Level
	Female Population 16+ in Civilian Labor Force
	Food Insecure Children Likely Ineligible for Assistance
	Food Insecurity Rate
	Homeownership
	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold
	Households that are Asset Limited, Income Constrained, Employed (ALICE)
	Households that are Below the Federal Poverty Level
	Households with Cash Public Assistance Income
	Income Inequality
	Median Household Gross Rent
	Median Household Income
	Median Housing Unit Value
	Median Monthly Owner Costs for Households without a Mortgage

Primary Topic	Indicator
	Mortgaged Owners Median Monthly Household Costs
	Mortgaged Owners Spending 30% or More of Household Income on Housing
	Overcrowded Households
	People 65+ Living Below Poverty Level
	People Living 200% Above Poverty Level
	People Living Below Poverty Level
	Per Capita Income
	Population 16+ in Civilian Labor Force
	Projected Child Food Insecurity Rate
	Projected Food Insecurity Rate
	Renters Spending 30% or More of Household Income on Rent
	Severe Housing Problems
	Size of Labor Force
	Students Eligible for the Free Lunch Program
	Total Employment Change
	Unemployed Workers in Civilian Labor Force
	Young Children Living Below Poverty Level
Education	People 25+ with a bachelor's degree or Higher
	People 25+ with a High School Degree or Higher
	Student-to-Teacher Ratio
Environmental Health	Access to Exercise Opportunities
	Blood Lead Levels in Children (>=5 micrograms per deciliter)
	Children with Low Access to a Grocery Store
	Farmers Market Density
	Fast Food Restaurant Density
	Food Environment Index
	Grocery Store Density
	Households with No Car and Low Access to a Grocery Store
	Liquor Store Density
	Low-Income and Low Access to a Grocery Store
	Number of Extreme Heat Events
	Number of Extreme Precipitation Days
	PBT Released
	People 65+ with Low Access to a Grocery Store
	People with Low Access to a Grocery Store
	Recognized Carcinogens Released into Air
	Recreation and Fitness Facilities
	SNAP Certified Stores
	Weeks of Moderate Drought or Worse
	WIC Certified Stores
Health	Age-Adjusted Years of Potential Life Lost

Primary Topic	Indicator
Health Care Access & Quality	Adults Unable to Afford to See a Doctor
	Adults who have had a Routine Checkup
	Adults with Health Insurance
	Adults without Health Insurance
	Children with Health Insurance
	Non-Physician Primary Care Provider Rate
	Persons with Health Insurance
	Primary Care Provider Rate
Heart Disease & Stroke	Adults who Experienced a Heart Attack
	Adults who Experienced a Stroke
	Adults who Experienced Coronary Heart Disease
	Adults who Have Taken Medications for High Blood Pressure
	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)
	Age-Adjusted Death Rate due to Heart Attack
	Age-Adjusted Death Rate due to Heart Disease
	Age-Adjusted Death Rate due to Hypertensive Heart Disease
	Age-Adjusted Hospitalization Rate due to Heart Attack
	Age-Adjusted Rate of Adult ED Visits for Acute Myocardial Infarction
	Atrial Fibrillation: Medicare Population
	Cholesterol Test History
	Heart Failure: Medicare Population
	High Blood Pressure Prevalence
	High Cholesterol Prevalence: Adults 18+
	Hyperlipidemia: Medicare Population
	Hypertension: Medicare Population
	Ischemic Heart Disease: Medicare Population
	Stroke: Medicare Population
Immunizations & Infectious Diseases	Adults 50+ with Influenza Vaccination
	Adults with Pneumonia Vaccination
	Age-Adjusted Death Rate due to Influenza and Pneumonia
	Age-Adjusted Rate of ED Visits Due to Influenza
	COVID-19 Daily Average Case-Fatality Rate
	COVID-19 Daily Average Incidence Rate
	Kindergartners with Required Immunizations
	Lyme Disease Cases
	Persons Fully Vaccinated Against COVID-19
	Tuberculosis Incidence Rate
Maternal, Fetal & Infant Health	Babies with Low Birth Weight
	Babies with Very Low Birth Weight

Primary Topic	Indicator
	Infant Mortality Rate
	Mothers who Received Early Prenatal Care
	Mothers who Received No Prenatal Care
	Preterm Births
	Very Preterm Births
Mental Health & Mental Disorders	Adults Ever Diagnosed with Depression
	Age-Adjusted Death Rate due to Suicide
	Age-Adjusted Rate of Emergency Department Visits due to Mood Disorder
	Depression: Medicare Population
	Frequent Mental Distress
	Mental Health Provider Rate
	Poor Mental Health: 14+ Days
	Poor Mental Health: Average Number of Days
Mortality Data	Age-Adjusted Death Rate
	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
Older Adults	Adults 65+ who Received Recommended Preventive Services: Females
	Adults 65+ who Received Recommended Preventive Services: Males
	Adults who were Injured in a Fall: 45+
	Adults with Arthritis
	Age-Adjusted Death Rate due to Alzheimer's Disease
	Alzheimer's Disease or Dementia: Medicare Population
Oral Health	Adults 65+ with Total Tooth Loss
	Adults who Visited a Dentist
	Dentist Rate
Other Conditions	Adults with Kidney Disease
	Chronic Kidney Disease: Medicare Population
	Osteoporosis: Medicare Population
	Rheumatoid Arthritis or Osteoarthritis: Medicare Population
Physical Activity	Adults 20+ who are Sedentary
	Adults Engaging in Regular Physical Activity
Prevention & Safety	Age-Adjusted Death Rate due to Unintentional Injuries
	Age-Adjusted Death Rate due to Unintentional Poisonings
Respiratory Diseases	Adults with COPD
	Adults with Current Asthma
	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases
	Age-Adjusted Rate of Adult ED Visits for COPD
	Asthma: Medicare Population
	COPD: Medicare Population
Sexually Transmitted Infections	Chlamydia Cases

Primary Topic	Indicator
	Gonorrhea Cases
Tobacco Use	Adults who Currently Use Smokeless Tobacco
	Adults who Smoke
Weight Status	Adults 20+ who are Obese
Wellness & Lifestyle	Frequent Physical Distress
	Insufficient Sleep
	Life Expectancy
	Poor Physical Health: 14+ Days
	Poor Physical Health: Average Number of Days
	Self-Reported General Health Assessment: Poor or Fair

APPENDIX C: STAKEHOLDER SURVEY INSTRUMENT

The Affordable Care Act added new a requirement that every 501(c)(3) hospital organization is required to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy at least once every three years effective for tax years beginning after March 23, 2012.

Newton Medical Center (NMC) is undertaking a comprehensive community health needs assessment (CHNA) to re-evaluate the health needs of individuals living in the hospital service area. The purpose of the assessment is to gather current statistics and qualitative feedback on the key health issues facing service area residents. The completion of the CHNA will enable NMC to take an in-depth look at its community and the findings will be utilized to prioritize public health issues and develop a community health implementation plan focused on meeting community needs.

1. What are the top 5 health issues you see in your community? (CHOOSE 5)

- ☐ Access to Care/Uninsured
- ☐ Cancer
- ☐ Dental Health
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Maternal/Infant Health
- ☐ Mental Health/Suicide
- ☐ Overweight/Obesity
- ☐ Sexually Transmitted Diseases
- ☐ Stroke
- ☐ Substance Abuse/Alcohol Abuse
- ☐ Tobacco
- ☐ Domestic Violence
- ☐ Other (specify):

2. Of those health issues selected, which 1 is the most significant? (CHOOSE 1)

- ☐ Access to Care/Uninsured
- ☐ Cancer
- ☐ Dental Health
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Maternal/Infant Health
- ☐ Mental Health/Suicide
- ☐ Overweight/Obesity
- ☐ Sexually Transmitted Diseases
- ☐ Stroke
- ☐ Substance Abuse/Alcohol Abuse
- ☐ Tobacco
- ☐ Domestic Violence
- ☐ Other (specify):

3. Please share any additional information regarding these health issues and your reasons for ranking them this way in the box below:

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____
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4. On a scale of 1 (Strongly Disagree) through 5 (Strongly Agree), please rate each of the following statements about Health Care Access in the area.

	(1) Strongly Disagree	(2) Somewhat Disagree	(3) Neutral	(4) Somewhat Agree	(5) Strongly Agree
Residents in the area are able to access a primary care provider when needed. (Family Doctor, Pediatrician, General Practitioner)					
Residents in the area are able to access a medical specialist when needed. (Cardiologist, Dermatologist, Neurologist, etc.)					
Residents in the area are able to access a dentist when needed.					
Residents in the area are utilizing emergency department care in place of a primary care physician.					
There are a sufficient number of providers accepting Medicaid and Medical Assistance in the area.					
There are a sufficient number of bilingual providers in the area.					
There are a sufficient number of mental/behavioral health providers in the area.					
Transportation for medical appointments is available to area residents when needed.					

5. What are the most significant barriers that keep people in the community from accessing health care when they need it? (Select all that apply)

- ☐ Availability of Providers/Appointments
- ☐ Basic Needs Not Met (Food/Shelter)
- ☐ Inability to Navigate Health Care System
- ☐ Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
- ☐ Lack of Child Care
- ☐ Lack of Health Insurance Coverage
- ☐ Lack of Transportation
- ☐ Lack of Trust
- ☐ Language/Cultural Barriers
- ☐ Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
- ☐ Lack of Health Literacy
- ☐ None/No Barriers
- ☐ Other (please specify)

6. Of those barriers mentioned in question 5, which 1 is the most significant? (CHOOSE 1)

- ☐ Availability of Providers/Appointments
- ☐ Basic Needs Not Met (Food/Shelter)
- ☐ Inability to Navigate Health Care System
- ☐ Inability to Pay Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
- ☐ Lack of Child Care
- ☐ Lack of Health Insurance Coverage
- ☐ Lack of Transportation
- ☐ Lack of Trust
- ☐ Language/Cultural Barriers
- ☐ Time Limitations (Long Wait Times, Limited Office Hours, Time off Work)
- ☐ Lack of Health Literacy
- ☐ None/No Barriers
- ☐ Other (please specify)

7. Please share any additional information regarding barriers to health care in the box below:

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8. Are there specific populations in this community that you think are not being adequately served by local health services?

- YES, (*proceed to Question 9*)
- NO, (*proceed to Question 11*)

9. If #8 YES, which populations are underserved? (Select all that apply)

- ☐ Uninsured/Underinsured
- ☐ Low-income/Poor
- ☐ Hispanic/Latino
- ☐ Black/African American
- ☐ Immigrant/Refugee
- ☐ Disabled
- ☐ Children/Youth
- ☐ Young Adults
- ☐ Seniors/Aging/Elderly
- ☐ Homeless
- ☐ LGBTQ+
- ☐ Other (please specify)

10. What are the top 5 health issues you see affecting the underserved population(s) you selected? (CHOOSE 5)

- ☐ Access to Care/Uninsured
- ☐ Cancer
- ☐ Dental Health
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Maternal/Infant Health
- ☐ Mental Health/Suicide
- ☐ Overweight/Obesity
- ☐ Sexually Transmitted Diseases
- ☐ Stroke
- ☐ Substance Abuse/Alcohol Abuse
- ☐ Tobacco
- ☐ Domestic Violence
- ☐ Other (specify):

11. In general, where do you think MOST uninsured and underinsured individuals living in the area go when they are in need of medical care? (CHOOSE 1)

- ☐ Doctor's Office
- ☐ Health Clinic/FQHC
- ☐ Hospital Emergency Department
- ☐ Walk-in/Urgent Care Center
- ☐ Don't Know
- ☐ Other (please specify)

12. Please share any additional information regarding Uninsured/Underinsured Individuals & Underserved Populations in the box below:

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13. Related to health and quality of life, what resources or services do you think are missing in the community? (Select all that apply)

- ☐ Free/Low-Cost Medical Care
- ☐ Free/Low-Cost Dental Care
- ☐ Primary Care Providers
- ☐ Medical or Surgical Specialists
- ☐ Mental Health Services
- ☐ Substance Abuse Services
- ☐ Bilingual Services
- ☐ Transportation
- ☐ Prescription Assistance
- ☐ Health Education/Information/Outreach
- ☐ Health Screenings
- ☐ None
- ☐ Other (please specify):

14. What challenges do people in the community face in trying to maintain healthy lifestyles, like exercising and eating healthy and/or trying to manage chronic conditions, like diabetes or heart disease?

____
____
____
____

15. In your opinion, what is being done well in the community in terms of health and quality of life? (Community Assets/Strengths/Successes)

____
____
____
____

16. What recommendations or suggestions do you have to improve health services that impact the health needs of the community?

____
____
____
____

17. Name & Contact Information: (Note: Your name and email address are required to track survey participation. *Your identity WILL NOT be associated with your responses.)*

- Name (*Required*) ____
- Organization ____
- Address ____
- Address 2 ____
- City/Town ____
- State/Province ____
- ZIP/Postal Code ____
- Email (*Required*) ____

18. Which one of these categories would you say BEST represents your organization's community affiliation? (CHOOSE 1)

- ☐ Health Care/Public Health Organization
- ☐ Mental/Behavioral Health Organization
- ☐ Non-Profit/Social Services/Aging Services
- ☐ Faith-Based/Cultural Organization
- ☐ Education/Youth Services
- ☐ Government/Housing/Transportation Sector
- ☐ Business Sector
- ☐ Community Member
- ☐ Other (please specify)

19. Which of the following represents the community(s) your organization serves? (Select all that apply)

- ☐ White/Caucasian
- ☐ Black/African American
- ☐ Asian/Pacific Islander
- ☐ Seniors
- ☐ Active Adults
- ☐ Poor or Underserved
- ☐ LGBTQ+
- ☐ Hispanic/Latino
- ☐ Other (please specify)

20. Newton Medical Center will use the information gathered through this survey in guiding their community health improvement activities. Please share any other feedback you may have for them below:

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____
____
____

APPENDIX D: STAKEHOLDER SURVEY PARTICIPANTS

Newton Medical Center solicited input in the stakeholder survey process from a wide-ranging group of organizations serving the needs of residents who are served by the hospital and health system. Following are the organizations from which NMC solicited responses to a stakeholder survey. Newton Medical Center solicited input in the prioritization phase of the CHNA process from a sub-set of respondents who participated in the stakeholder survey and serve the needs of residents served by the hospital and health system.

Organizational Affiliation(s)	Organizational Affiliation(s)
Advance Housing	NORWESCAP
AHS Diabetes and Nutrition Center at NMC	Nosivoccia LLP
Alzheimer's Association Greater NJ Chapter	Organization
Alzheimer's New Jersey	Our Lady Queen of Peace Church
American Cancer Society, Eastern Division	Overcoat Owner
Andover School	Pass It Along
Atlantic Health System - Newton Medical Center Leadership	Pathways to Prosperity
Atlantic Health System Social Work	Patient Experience
Atlantic Home Care & Hospice	Peace by Piece
Behavioral Health	Perona Farms
Birth Haven	Pike County Area Agency on Aging
Bridgeway Sussex	Planned Parenthood of New Jersey
Bristol Glen	Project Help
Cancer Institute of New Jersey	Project SEARCH
Cardiology and ICU (NMC)	Project Self-Sufficiency
Catholic Family and Community Services	RoNetco Supermarkets
Center for Evaluation and Counseling (CEC)	Rutgers Cooperative Extension
Chabad of Northwest New Jersey	Samaritan Inn
Christian Faith Fellowship Church	SART
Community Health	SCARC
Community Health & Care Coordination Social Services	Selective Insurance
DAWN Center for Independent Living, Inc.	Smoking Cessation
Division of Youth and Family Services	SNAP-Ed
Domestic Abuse & Sexual Assault Intervention Services	Sparta Community Food Pantry
Family Intervention Services	Sparta Evangelical Free Church
Family Promise of Sussex County	Sparta Presbyterian Church
First Hope Bank	Special Child Health Services
Forward Franklin Alliance	Spiritual Care
Franklin Borough School	Sussex County ADRC
Franklin Mutual Insurance	Sussex County Chamber of Commerce
Garden State Equality	Sussex County Community College

Organizational Affiliation(s)	Organizational Affiliation(s)
Ginnie's House Child Advocacy Center	Sussex County Department of Health & Human Services
JCP&L	Sussex County Department of Human Services
Karen Ann Quinlan Hospice	Sussex County Division of Child Protection and Permanency
Laddey, Clark & Ryan	Sussex County Division of Community and Youth Services
Lakeland Bank	Sussex County Division of Health
LocalShare	Sussex County Division of Senior Services
Macaroni Kid	Sussex County Library
Manna House	Sussex County Office of Public Health Nursing / NJ CEED
Mount Calvary Baptist Church	Sussex County Office of Transit
NAMI Sussex	Sussex County School Nurses Association
NewBridge	Sussex County Senior Services
Newton - Mayor	Sussex County Technical School
Newton Medical Center Auxiliary	Sussex County YMCA
Newton Police Department	Sussex County Youth Services
Newton Schools	Sussex PASP
Newton Town Manager	The Center for Prevention and Counseling
NJ VA	Tobacco-Free for a Healthy NJ
NJ211	TransOptions
NMC Community Advisory Board	United Way of Northern New Jersey
NMC Emergency Department	Visiting Angels
NMC Foundation	Willow Glen Academy
NMC Medical Imaging/Radiology	Zufall Health

APPENDIX E: NJ DEPT OF HEALTH LICENSED HEALTHCARE FACILITIES – SUSSEX COUNTY

FACILITY TYPE / NAME	ADDRESS	CITY
AMBULATORY CARE FACILITY		
Newton Imaging	222 High Street	Newton
Newton Imaging	376 Lafayette Road	Sparta
Newton Imaging	89 Sparta Avenue	Sparta
Sussex Radiation Oncology Associates	89 Sparta Avenue	Sparta
Planned Parenthood Of NCSNJ	8 Moran Street	Newton
Eye Physicians Of Sussex County	183 High Street	Newton
Premier Health Associates	532 Lafayette Road Suite 200	Sparta
Skylands Surgery Center	16 Us Route 206, Suite A	Stanhope
Specialty Surgical Center	380 Lafayette Road, Suite 110	Sparta
ASSISTED LIVING RESIDENCE		
Sparta Senior Living	513 Lafayette Road	Sparta
Evermay At Branchville	3 Phillips Road	Branchville
Bristol Glen	200 Bristol Glen Drive	Newton
Grace Eldercare	25 Main Street	Franklin
COMPREHENSIVE PERSONAL CARE HOME		
Grace Eldercare	25 Main Street	Franklin
END STAGE RENAL DIALYSIS		
Renal Center Of Newton	7 East Clinton Street	Newton
GENERAL ACUTE CARE HOSPITAL		
Newton Medical Center	175 High St	Newton
HOSPICE CARE		
Karen Ann Quinlan Hospice	28 Fairview Hill Road	Newton
Karen Ann Quinlan Memorial Foundation	99 Sparta Avenue	Newton
LONG TERM CARE FACILITY		
Bristol Glen	200 Bristol Glen Drive	Newton
Complete Care At Barn Hill	249 High Street	Newton
Homestead Rehabilitation & Health Care Center	129 Morris Turnpike	Newton
Bemet	1 O'Brien Lane	Lafayette
Valley View Rehabilitation And Healthcare Ctr	1 Summit Avenue	Newton
SURGICAL PRACTICE		
North Jersey Center For Surgery	39 Newton Sparta Road	Newton

PREPARED FOR

NEWTON MEDICAL CENTER

BY

ATLANTIC HEALTH SYSTEM
PLANNING & SYSTEM DEVELOPMENT

Atlantic Health System

Newton Medical Center