ATLANTIC HEALTH SYSTEM
COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

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

MAY 2022

Atlantic Health System

ACKNOWLEDGEMENTS & COMPLIANCE

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

Atlantic Health System acknowledges the hard work and dedication of the individuals and the organizations they represent who contributed to the development of the 2022 Community Health Improvement Plan. The ongoing work of AHS employees and our community partners to achieve meaningful improvement of the health status of the communities we serve is paramount in the System's drive to provide high quality and affordable health care.

This 2022 Community Health Improvement Plan was developed in conjunction with hospital and community stakeholders and approved by hospital leadership. Data informing the Community Health Needs Assessment and Community Health Improvement Plan were compiled by AHS Planning & System Development. AHS' ongoing work with community and government agencies across Atlantic Health's service area is critical to ensuring that clinical staff, government agencies and community organizations achieve recognizable improvements in a wide range of population health issues.

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

Atlantic Health System
Planning & System Development
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COMMUNITY HEALTH NEEDS ASSESSMENT PRIORITIES

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

The table below reflects AHS' hospital defined priority areas for the 2022 CHIP.

MMC	OMC	CMC	NMC	HMC
Behavioral Health (Including Substance Use Disorders)	Mental Health & Substance Misuse	Behavioral Health (Including Substance Use as it pertains to Mental Health)	Mental Health & Substance Misuse	Mental Health & Substance Misuse
Diabetes & Obesity	Diabetes & Obesity / Unhealthy Weight / Food Insecurity	Diabetes	Diabetes & Obesity	Diabetes & Overweight/Obesity
Cancer	Cancer	Cancer	Cancer	Cancer
Heart Disease	Heart Disease	Heart Disease	Heart Disease	Heart Disease
	Stroke	Stroke	Stroke	
Geriatrics & Healthy Aging	End of Life Care	Pulmonary Disease		
COMMUNITY HEALTH NEEDS ASSESSMENT PUBLICATION YEAR				
Dec 2019	***Dec 2019***	***Dec 2019***	***Dec 2021***	***Dec 2021***

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

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

Virtual Platforms and Community Health

The impact of Covid-19 on Atlantic Health System and the communities we serve was profound. As our co-workers continued to battle the pandemic daily, our focus on community health was challenged to create safe and effective opportunities for communities to connect about their ongoing health needs. Many of the most effective methods for maintaining contact with those in need were virtual; community groups, support groups for high-risk patients, caregiver outreach, diabetes, oncology, and cardiovascular all became reliant on virtual tools to maintain needed contact with our community. In many cases the effort to connect virtually during a time of crisis led to increased levels interaction and a broader reach for programs. This positive response to virtual offerings and interaction has become a common rallying point for AHS and its communities; this level of connection has become another successful tool that AHS will build upon in 2022 as it seeks to broaden its reach to at-risk populations.

Care Coordination and Social Determinants of Health

At Atlantic Health System, we focus on connecting clinical, behavioral, and social care across the health care continuum to produce great health outcomes, improve patient experience, and lower the total cost of care. The care coordination department of nurses, social workers, community health workers, and behavioral health clinicians ensures that each patient's clinical, behavioral, and social needs are met to manage safe transitions of care and support people with complex chronic conditions.

Diversity and Inclusion

AHS strives for an inclusive health care environment where patients, visitors and team members are welcomed and afforded equitable treatment regardless of sexual orientation, gender, gender identity and expression, race, ethnicity, immigration status, socioeconomic background, disability and/or age.

We not only value diversity but are also committed to inclusivity; the practice of engaging our diversity in decision making that affects the health and wellbeing of our communities. Atlantic Health System meets with diverse workgroups of community representatives at each hospital location to develop and implement programs that address the specific health care needs of our surrounding populations.

Supporting Funding of Community Partners and Community Health Needs

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

AHS provides additional support to community partners through the New Jersey Healthy Communities Network (NJHCN). The NJHCN supports local policy, systems, and environmental changes to enhance physical activity, nutrition, and address social determinants of health. Through its hospital community health advisory boards and foundations AHS provides funding and technical assistance for community organizations in the hospitals' service areas.

Community Health Education and Wellness

Community Health offers a wide variety of system-wide health and wellness programs to meet the needs of the community. These programs promote healthy lifestyles and reduces the community's modifiable risk factors for chronic disease though expanded health education programming in alignment with the AHS community health improvement plan. One of the program's goals is to offer system-wide programs on the following topics: cardiac, stroke, cancer, pulmonary, diabetes, behavioral health, and coronavirus.

Other Collaborative Support

In addition to actions within a specific strategy, Atlantic Health System is contributing a great deal of resources to support the CHNA/Implementation process via in-kind support for the North Jersey Health Collaborative (NJHC). Our resource and financial investments in the collaborative reflect our belief that bringing groups together, across sectors, is itself a significant community health intervention. The collaborative structure allows us to address our identified health needs and builds capacity in individual local organizations and our hospitals. It also serves to coordinate health and social service agencies in a way that supports collaborative investment in best-practices.

Atlantic's contributions to the collaborative include:

- AHS staff provide technical assistance and evaluation support for NJHC on an as needed basis.
- AHS service and participation in NJHC boards, workgroups, and other periodic meetings.
- Financial support for the North Jersey Health Collaborative underwriting of www.njhealthmatters.com, and analysis of underlying secondary data sources

Evaluation Plan & Needs Not Addressed

Atlantic Health System's hospitals will track measurable progress for all activities. Where opportunities exist to demonstrate the impact of an activity, AHS' hospitals can request analytic support from the planning office. Data collection is tailored to each individual action, and therefore, will include a variety of methodologies. Formatting the evaluation in this way will allow us to provide feedback to employees leading these actions so that they can adjust to ensure maximum positive impact on the health of the community.

Atlantic Health System's hospitals will address their individually prioritized community health needs identified in their current Community Health Needs Assessment. Working with partners in the community, AHS' hospitals will leverage existing resources across sectors to maximize positive impact on the health of our communities.

Atlantic Health System
Morristown Medical Center

MORRISTOWN MEDICAL CENTER – COMMUNITY OVERVIEW

Morristown Medical Center (MMC) is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. To that end, beginning in June 2019, MMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, which encompasses portions of Essex, Hunterdon, Morris, Passaic, Somerset, Sussex, Union, and Warren counties in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing residents of MMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

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

The complete MMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This community health improvement plan (CHIP) delineates how MMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2019-2021 Community Health Needs Assessment process identified five priority need areas. The 2022 CHIP incorporates these five priorities (below) as well as barriers to care identified among key populations by the MMC Cancer Committee and the MMC Healthy Aging Task Force.

- Behavioral Health (Including Substance Use Disorders)
- Diabetes & Obesity
- Geriatrics & Healthy Aging
- Cancer
- Heart Disease

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

MORRISTOWN MEDICAL CENTER – IMPLEMENTATION PLAN

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

PRIORTY AREA: BEHAVIORAL HEALTH (INCLUDING SUBSTANCE USE DISORDERS)

- Provide the necessary level of community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and opioid and alcohol misuse.

ACTIVITY	APPROACH
Develop Programming Aimed at Reducing Stigma Related to Mental Health	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. **No More Whispers** ○ Suicide Prevention in Teens & Adults ○ Culturally Competent Suicide Prevention ○ Suicide Prevention - with Trusted Adults, Clergy, Schools, Parents ○ Autism Spectrum Disorder Awareness ○ Alcohol Awareness ○ Hope & Mental Wellness ○ Post-Traumatic Stress Disorder ○ Sleep Hygiene ○ Stress & Resilience ○ General Mental Health Wellness ○ Substance Use Disorder ○ Social Isolation ○ Covid-19 – Stress and Anxiety ○ “Return-to-School” Preparation for Parents • Develop a shared resource for use among AHS community health departments and the behavioral health service line in response to identified needs within the community, with a focus on development of virtual resources easily accessible by the communities served by AHS. • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.

PRIORTY AREA: DIABETES & OBESITY

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

ACTIVITY	APPROACH
Identification of at-risk populations and creation of linkages to care	• Build on success of the Diabetes Health Partnership, which identifies patients, including AHS team members, with A1C greater than 9 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in diabetes self-management education and medical nutrition therapy with a certified diabetes care and education specialist. The partnership is being expanded to Atlantic Medical Group (AMG) primary care offices through AHS. • Initiate annual status report of AHS Diabetes Education Centers to AMG primary, nephrology, and endocrinology offices to provide summary of care rendered throughout calendar year and future updates to show impact on patient outcomes and increase referral volumes for linkage to care. • Body mass index (BMI) screening/nutritional education for overweight population and referral to Metabolic Center, as appropriate. • Collaboration with all AHS inpatient and outpatient diabetes education services to ensure consistency and resource sharing across sites. • In-person and virtual community education sessions at community centers, libraries, and schools. • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction. • Collaboration with Morristown Medical Center Retail Pharmacy for financial assistance programs for diabetes medication and supplies. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes and obesity medicine. • Offer virtual informational seminars on bariatric surgical options. • Conduct telehealth visits, as allowable, for increased access to care.
Continued partnership With Community Organizations that Address Food Insecurities	• Expand relationships with organizations such as Interfaith Food Pantry and Soup Kitchen that provide food rescue programs. • Expand access to healthier foods and groceries to the community served by MMC.

ACTIVITY	APPROACH
Promotion of Atlantic Health System Health and Wellness Apps	• Support and promote the adoption in MMC's community of technology driven solutions to improve health and wellness. • Partnership with AHS Employee Wellness for risk assessment and reduction/mitigation for team members with diabetes mellitus.
Reduction in Diabetes-related 30-day Readmissions	• Develop and implement diabetes discharge order set for comprehensive guidance on at-home needs, including referrals for follow up care at AHS associated Diabetes Education Centers and Endocrinology practices. • Update and increase usage of inpatient subcutaneous hyperglycemia order set for care planning and initiation of education and resource evaluation in the inpatient setting. • Continue monthly meetings of 30-day Readmissions Committee, to review readmission cases and create proactive systemic plans for improvement.

PRIORTY AREA: CANCER

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

ACTIVITY	APPROACH
Health and Wellness	• **Preventative screenings**: Continued coordinatization of outreach, education, and cancer screening opportunities with NJCEED (New Jersey Cancer Education and Early Detection) and Community Health departments, local health departments and the Regional Chronic Disease Coalitions. Outreach, educational, and screening programs will focus on colorectal, breast, skin, cervical, and prostate cancer. In addition, expand education and screening services related to lung, oral, and head and neck cancer screenings and management for patients with high risk of developing breast cancer. Expand smoking cessation programs that are offered at the Carol. G Simon Cancer Center. Maintain the working relationship with American Cancer Society, the Morris/Somerset County Chronic Disease Coalition, AHS Community Health Department, local health departments, and community organizations to provide cancer prevention education, chronic disease management, and access to cancer screenings and support services. Expanded follow up of high-risk breast screenings for medical evaluation and surveillance. Initiate a high-risk pancreatic screening program. • **SCREEN NJ grants**: Continue collaboration with Rutgers Cancer Institute of New Jersey for outreach, education, and screening to underserved populations around colon and lung cancer screening and smoking cessation services. • **Wellness:** Cancer center to provide information and education on tips for self-care along the cancer care continuum (surgery, chemotherapy, radiation) and into survivorship. Topics include nutrition, supportive

ACTIVITY	APPROACH
	programs, integrative medicine, and general issues on coping with cancer and will be provided to both patients and caregivers through formal lectures, printed materials, and virtually. Offer other programs to the community to encourage early detection and reduce risk of cancer through smoking cessation, exercise, and good nutrition. Enhance survivorship educational programs to promote healthy lifestyle practices through nutrition, exercise, and psychosocial support.
Practical/Financial Needs	• Each oncology patient is assessed for financial, practical, and psychosocial needs. As barriers are identified social workers collaborate with the nurse navigator and other staff to address the patient's practical and financial needs. Patients are also referred to our network of community partners for assistance. The System works with the community-based agencies to provide wigs, food, transportation, and solutions for other financial/practical matters. A new process has been designed to streamline referrals for financial evaluation. Improved processes have been developed for more timely Advanced Care Planning and Palliative Care services. • Continue to identify grant and other funding opportunities to meet this unmet need.
Mental Health	• The cancer center social worker assesses patients referred to them (by a practitioner or identified through the distress screening process or depression scale). Referrals are provided to our behavioral health services or to community resources for counseling and psychiatric services. Behavioral health services are offered on-site in the cancer center through a psychiatrist. • Continue to identify internal resources and opportunities with community partners to provide greater access to this vital service both on-site and in the community. • Enhance services that are embedded in cancer center, including a nurse practitioner supporting referrals between the center and MMC, OMC and CMC. • Continue to seek ways to expand or improve this referral network.
Transportation	• Transportation remains a major barrier for many patients, especially those in urban or rural communities. The RN Navigator, Resource Navigator, and social worker work with community partners and other organizations to coordinate transportation. • Explore funding opportunities for commercial ride-share service gift cards. • Collaborate with community resources to expand and enhance access to transportation services.
Insurance Issues	• The Cancer Center staff identify patients who do not have health insurance who are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. • Social Workers meet with and counsel each patient in need, directing and referring to the appropriate resources. • Oncology RN Navigators, nursing staff, registered dietitians, and social workers continually reassess a patient's barriers to care at each encounter.

ACTIVITY	APPROACH
Access	• Employ virtual resources and programs to provide our community with access to support groups, educational programs and supplemental services related to cancer treatment, care, and management. • Use virtual platforms to supplement for the lack of face-to-face support services resulting from COVID-19. • Review and update the AHS Cancer Center website to improve access to virtual services, programs, and resources. • Evaluate and supplement resources available to the African American and Hispanic/Latino population to provide culturally sensitive care. • Improve care considerations and reduce healthcare disparities for the LGBTQ population

PRIORTY AREA: HEART DISEASE

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

ACTIVITY	APPROACH
Hypertension Management Program (HMP)	• Across AHS' service area, the combined inpatient and emergency room utilization rate per 1,000 population for hypertension has increased over the last 5 years. Data also reflect disparities in rates/1,000 population that are geographic and payer specific among the broader community served by Atlantic Health System. A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. • Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs). • AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve. • Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.
Women's Health Initiatives	• Heart disease is the leading killer of men and women in the United States. Despite the disease's unbiased impact on gender, there are documented gender disparities in the community when it comes to treatment for heart disease among women. • Designate a women's cardiovascular disease champion tasked with developing a clinical protocol to improve identification and treatment of cardiovascular disease and comorbidities among women served by the AHS. • Develop an awareness program speaking to the different presentation of heart disease in women than in men focused on minority and underserved residents
Access	• Enhance access to care and awareness of cardiovascular programs and services available across AHS, as well as advancements and improvements in treatment options (STEMI, etc.).

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

PRIORTY AREA: GERIATRICS & HEALTHY AGING

- Provide high quality and compassionate primary care, behavioral health, consultative, and emergency services to seniors in Morris County.
- Offer a robust spectrum of training, support, and counseling services for seniors and family caregivers designed to improve care coordination and caregiver competence.
- Continue offering memory screening to seniors in the community through our relationship with the Alzheimer's Foundation of America as a National Memory screening site.

ACTIVITY	APPROACH

Clinical Services for Seniors	• The Geriatric Assessment Center is a state-of-the-art outpatient practice that offers high quality compassionate primary care and consultative services to area seniors. Its highly skilled team of geriatricians, advanced practice nurses and social workers uses a multidisciplinary approach to provide person centered care to our frailest seniors.
	  ○ Employ telemedicine services for seniors who are unable to visit in-person.
	  ○ The Geriatric Assessment Center will begin offering counseling services to patients and caregivers.
	• The Emergency Department at Morristown Medical Center is a Level 1 accredited Geriatric Emergency Department utilizing geriatric specific evidence-based protocols, multidisciplinary care teams and post-discharge support to provide a continuum of care for all patients >70 years of age who enter our ED.
	• Provide referrals to palliative care as identified by the Emergency Department.

Patient and Caregiver Support and Training	• Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA). It aims to improve the care of older adults in clinical settings by addressing their mobility, mentation, medications and aligning care to 'what matters' to the older adult and their family caregivers. MMC and the Geriatric Assessment Center continue to be recognized by AFHS as an Age-Friendly Health System committed to care excellence. • AHS's Healthy Aging Program helps older adults and their caregivers find the health care services and community resources that they need to live longer, healthier, and more active lives. This hotline assists seniors and their caregivers with obtaining information regarding private home care and visiting nurse

ACTIVITY	APPROACH
	services, rehabilitation facilities, housing organizations, adult day care centers, and hospice care providers. Telephone and virtual consults are made available for caregivers. • The Art of Caregiving course is a 5-part interactive course offered quarterly, using a virtual platform, to caregivers to help them navigate the nuances of the eldercare maze. This program provides personalized guidance on how best to care for their aging loved one while ensuring their own health does not suffer. • The Caregiver Training Lab is a model home environment for older adults and is located at the Geriatric Assessment Center. It provides hands on training and education to seniors and their caregivers. • Offer support and counseling services for patients and caregivers as they age and navigate the elder care journey.
Memory Screening	• A memory screening is a simple and safe evaluation tool that checks memory and other thinking skills. It can indicate whether an additional check up by a qualified healthcare professional is needed. The Geriatric Assessment Center at MMC is approved as a National Memory Screening site through the Alzheimer's Foundation of America. • The Geriatric Assessment Center offers annual memory screening for all patients at the center. • Memory screening events are open to community seniors and aid in early detection and proper treatment of Seniors who may have Alzheimer's disease. These events are currently web-based but are intended to move to in-person as Covid-19 restrictions are lifted.
Injury Prevention	• Morristown Medical Center's Injury Prevention Program offers seniors and caregivers a variety of home, pedestrian, and motor vehicle safety programs throughout the year. The programs are typically run in a group setting but are offered as needed to individual patients and their families. • As a direct response to the impacts of Covid-19 and to ensure continued community access to the service, the program will continue offering virtual programming for these groups through 2022.

Atlantic Health System
Overlook Medical Center

OVERLOOK MEDICAL CENTER – COMMUNITY OVERVIEW

Overlook Medical Center (OMC) is committed to the people it serves and the communities where they 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 2019, OMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, which encompasses portions of Union, Essex, Morris, Somerset, Hudson, and Middlesex counties in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing residents of OMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

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

The complete OMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This community health improvement plan (CHIP) delineates how OMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2019-2021 Community Health Needs Assessment process identified six priority health needs that have been included in the 2022 CHIP.

- Mental Health & Substance Misuse
- Obesity / Unhealthy Weight / Food Insecurity
- Cancer
- Heart Disease & Diabetes
- End of Life Care
- Stroke

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

OVERLOOK MEDICAL CENTER – IMPLEMENTATION PLAN

The Community Health Implementation Plan (CHIP) addresses the way OMC will approach prioritized needs and the expected outcome and timeframe for the evaluation of its efforts.

PRIORTY AREA: END OF LIFE CARE

- Develop innovative and effective methods to educate and inform the community and providers about the importance of addressing end of life care and related issues.

ACTIVITY	APPROACH
Palliative Care Advisory Board	• The Palliative Care Advisory Board is charged with identifying appropriate ways to promote palliative care and hospice, including promoting advance care planning. OMC will continue to develop its approach to end of life care options including building on its relationships with academic institutions, community stakeholders, faith leaders, and internal stakeholders including Atlantic Visiting Nurse. • The board has been expanded to include community members, including the public guardian for intellectually/developmentally disabled (IDD) populations, the director of medical humanities program at Drew University, and the former executive director of Sage Eldercare. • Continue to build upon representation of the Latinx and African American communities served by OMC.
Partner to Educate	• Through a partnership with Sage Eldercare's program "Your Decisions Matter" identify innovative and effective methods to educate the public and providers about end-of-life issues across all age groups. • Three-year grant funded program (2019 – 2022) is aimed at engaging public in conversations about end-of-life care decision making through the Conversation Starter Kit. • Shifted to virtual programming due to COVID – which had the positive side effect of increasing presence and participation. Going forward programming will adopt a hybrid virtual/in-person model. • Training for care coordination and community health workers (approx. 60 across AHS) as part of effort to normalize content for the community. This will aid in maintaining a continuity of conversation as patients return to the community. • Initiating embedded long-term care "your Decisions Matter" programming which partners with facilities to survey clients/patients on their attitudes towards advance care planning and featuring a series of programs to address the need.
Provider Education	• OMC will implement provider education for end-of-life care at all Atlantic Health System acute care sites. Education includes end of life communication skills, POLST completion, and appropriate sourcing for palliative care, hospice, and other collaborative interdisciplinary services.

ACTIVITY	APPROACH
	• Integrated new workflow into inpatient environment. Palliative care screening tool to encourage identification of patients who would benefit from palliative care, encourage earlier orders/referrals, and provide education to the entire healthcare team about palliative care.
AHS Palliative Care Steering Committee	• Work with other AHS departments, sites, and stakeholders to develop system-wide approach to delivery of palliative care and support for advance care planning. • Expanded to include accountable care organization (ACO) providers and integrated care. • Integrated palliative care screening criteria into EPIC (AHS' electronic health record) for admitted patients (previously implemented for the emergency department). This enables earlier referrals to palliative care, aids in the building of an effective care pathway, and lowers cost. This places the program ahead of a legislative mandate that focuses only on emergency departments.
Expanded Bereavement Program	• Further develop resources, experience of those who are grieving including patients, family, and staff, through support, resources, and professional development. • AHS-wide grief and bereavement committee. • AHS consumer focused webpage for consumer resources.
Collaborate with Post-Acute Facilities	• The OMC Post-Acute Care Task Force collaborates with facilities on mutual issues related to transitions of care. Its mission is to support the continuum of Advance Care Planning for residents and families of those facilities through planned educational endeavors. The task force assists with interventions for Advance Care Planning for facility residents admitted to the hospital whenever possible and to strive to enhance effective care planning across the continuum. • The Community Palliative Care Learning Collaborative includes 17 long-term care (LTC) facilities and is a one-year project to utilize palliative and integrated care experts working with LTC staff on screening, order sets, conversations, and data collection. The collaborative will help to build a best practice model for the New Jersey.
Outpatient Palliative Care Program	• Ambulatory practice launched in Q3 2020, designed to support patients with serious illnesses in the community, which includes helping to facilitate appropriate end of life decision making. Most visits have been virtual with an employed AHS physician located in a pulmonary practice. The provider meets with patients across many diagnoses and will be part of a collaborative to provide support primary care and specialty clinicians. AHS expects to add a nurse practitioner and/or a social worker based on the success and growth of the program.
Consumer Facing Material	• Produced six (6) microlearning videos for consumer/public to educate and support decision making for end-of-life care. Open access. Advance Care Planning-Palliative Care - YouTube • Developed consumer facing website to provide education and support to public and healthcare professionals about the benefits of palliative care. www.pallcarenj.org

PRIORTY AREA: STROKE

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

ACTIVITY	APPROACH
EMS and Caregiver Support	• Virtual and in-person education sessions for EMS and caregivers on stroke signs and symptoms for rapid identification and transport to a stroke center. • Printed material is distributed to EMS agencies in service area to increase awareness of state designated comprehensive stroke center. • Education to AHS and volunteer agencies on the statewide rollout of validated pre-hospital Large Vessel Occlusion recognition tool (RACE Scale).
Community Education	• Educate the community on stroke signs and symptoms for rapid identification and transport to a stroke center. • Educate the community on risk factors and comorbidities associated with stroke and availability of tools to identify risk factors for stroke. • Provide tools for stroke survivors and care givers to cope with disability and education to prevent future stroke, support post-stroke follow-up related to symptom education and nutritional counseling. • Educate health care professionals and members of the communities we serve regarding advances in stroke treatment and availability of stroke related services and resources. • Documentation of at least two educational programs focused on stroke prevention/care provided for the public. • Collaborative work with community health team for comorbidity focused educational sessions to address major risk factors for stroke. • BEFAST Fridays to increase awareness of stroke signs and symptoms to patients seeking care in the emergency department for a variety of medical needs.
Stoke Follow-Up Clinic	• New follow up clinic for stroke/TIA discharges planned for Q4 2022 • Expansion on transition of care to ensure best practice strategies for patients as they are discharged back to community following an event.

PRIORITY AREA: HEART DISEASE

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

ACTIVITY	APPROACH
Hypertension Management Program (HMP)	• Across AHS' service area, the combined inpatient and emergency room utilization rate per 1,000 population for hypertension has increased over the last 5 years. Data also reflect disparities in rates/1,000 population that are geographic and payer specific among the broader community served by Atlantic Health System. A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. • Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs). • AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve. • Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.
Access	• Enhance access to care and awareness of cardiovascular programs and services available across AHS, as well as advancements and improvements in treatment options (STEMI, etc.). • Educate the community on availability and appropriate use of emergency transportation services, i.e., when and how to seek help and the importance of acting quickly when emergency care is necessary. • Educate the community on the importance of seeking preventative care with their cardiologist, understanding warning signs for cardiovascular events, and what to do when a warning sign presents itself. • Identify structural barriers to health equity in our communities as they pertain to heart disease and capitalize on AHS' existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: OBESITY / UNHEALTHY WEIGHT / FOOD INSECURITY / DIABETES

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

ACTIVITY	APPROACH
Identification of at-risk populations and creation of linkages to care	• Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 9 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. • The partnership uses an interdisciplinary model to identify hospitalized patients with diabetes who are at risk and refers them to the program to aid in the reduction of readmissions. • The program is being expanded to Atlantic Medical Group primary care offices through Atlantic Health System.
Reduce Disparity in the Community	• Engage pregnant and new mothers with the medical community as the "trusted" partner to provide information and education in those locations with strategies that have been tested and are determined to reduce disparities. • Diabetes and Cardiovascular Disease – Linking Clinic to Community is a program for community providers that reviews ADA standards and identifies relevant community resources.
Reduce Level of Food Insecurity in the Community	• Develop Overlook Medical Center's partnerships with local food banks to link at-risk patients to food sources that will improve the patients' overall wellness. • Continue to build on Overlook Medical Center's relationship with GRACES's Refrigerator, which offers nutrient dense produce, dairy, and prepared meals to food insecure families in the community served by Overlook. • Continue to support Overlook Medical Center's Community Garden initiative and promote employee and patient wellness through serving and promoting in the hospital cafeteria the fresh produce grown in the garden. Additionally, the community garden will continue to serve surrounding elementary students by hosting hospital-sponsored chefs healthy eating and nutrition education.

PRIORTY AREA: MENTAL HEALTH AND SUBSTANCE MISUSE

- Provide the necessary level of community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and opioid and alcohol misuse.

ACTIVITY	APPROACH
Develop Programming Aimed at Reducing Stigma Related to Mental Health	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. **No More Whispers** ○ Suicide Prevention in Teens & Adults ○ Culturally Competent Suicide Prevention ○ Suicide Prevention - with Trusted Adults, Clergy, Schools, Parents

ACTIVITY	APPROACH
	○ Autism Spectrum Disorder Awareness ○ Alcohol Awareness ○ Hope & Mental Wellness ○ Post-Traumatic Stress Disorder ○ Sleep Hygiene ○ Stress & Resilience ○ General Mental Health Wellness ○ Substance Use Disorder ○ Social Isolation ○ Covid-19 – Stress and Anxiety ○ "Return-to-School" Preparation for Parents • Develop a shared resource for use among AHS community health departments and the behavioral health service line in response to identified needs within the community, with a focus on development of virtual resources easily accessible by the communities served by AHS. • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.

PRIORTY AREA: CANCER

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

ACTIVITY	APPROACH
Health and Wellness	• **Preventative screenings**: Continued coordinatization of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments and the Regional Chronic Disease Coalition. Educational and screening programs will focus on colorectal, breast, skin, cervical, and prostate cancer. In addition, continue to increase screening services to include lung cancer screenings and management for high-risk breast cancer. Resume smoking cessation programs that are offered at the Carol. G Simon Cancer Center. Maintain the working relationship with American Cancer Society, the Union County Chronic Disease Coalition, AHS Community Health Department, local health departments and community organizations to provide cancer prevention education, chronic disease management and access to cancer screenings and support services. Expand follow up of high-risk breast screenings for medical evaluation and surveillance. Initiating development of a high-risk pancreatic screening program. • **Wellness**: Cancer center to provide information and education on tips for self-care while in treatment (surgery, chemotherapy, radiation) and into survivorship. The information will be provided to both patients and caregivers through formal lectures, printed materials and virtually. Offer other programs to the

ACTIVITY	APPROACH
	community to encourage early detection and reduce risk of cancer through smoking cessation, exercise, and good nutrition. Enhance survivorship educational series to include exercise, nutrition, and other tips for maintaining a healthy lifestyle after cancer treatment.
Practical/Financial Needs	• Each oncology patient is assessed for financial, practical, and psychosocial needs. As barriers are identified the social worker collaborates with the nurse navigator and other staff to address the patient's practical and financial needs. As barriers or needs are identified, patients are referred to our network of community partners for assistance. The System works with the community-based agencies to provide wigs, food, transportation, and other financial/practical matters. A new process has been designed to streamline referrals for financial evaluation in a timely manner. Similarly, improved processes have been developed for more timely Advanced Care Planning and Palliative Care services Continue to identify grant and other funding opportunities to meet this unmet need.
Mental Health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). Referrals are provided to our Behavioral Health Services or to community resources for counseling and psychiatric services. Behavioral Health Services are offered on site in the cancer center through a nurse practitioner. • AHS continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service.
Transportation	• Transportation remains a major barrier for many patients, especially those in urban or rural communities. The RN Navigator and social worker work with community partners and other organizations to coordinate transportation as available. • Explore funding opportunities for commercial ride-share service gift cards. • Collaborate with community resources to expand and enhance access to transportation services.
Insurance Issues	• The Cancer Center staff identify patients who do not have health insurance and are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. • Social Workers meet with and counsel each patient in need, directing and referring to the appropriate resources. • Oncology navigators, nursing staff, registered dietitians and social workers continually reassess a patient's barriers to care at each encounter.
Access	• Employ virtual resources and programs to provide community with access to support groups, educational programs and supplemental services related to cancer treatment, care, and management. • Use virtual platforms to supplement for the lack of face-to-face support services resulting from COVID-19. • Review and update the AHS Cancer Center website to improve access to virtual services, programs, and resources.

ACTIVITY	APPROACH
	• Evaluate and supplement resources available to the African American and Hispanic/Latino population to provide culturally sensitive care. • Improving Care Considerations and reducing healthcare disparities for the LGBTQ population.

Atlantic Health System
Chilton Medical Center

COMMUNITY OVERVIEW – CHILTON MEDICAL CENTER

Community Served by Chilton Medical Center

Chilton Medical Center (CMC) is committed to the people it serves and the communities where they reside. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life. To that end, beginning in June 2019, CMC, a member of Atlantic Health System (AHS), undertook a comprehensive community health needs assessment (CHNA) to evaluate the health needs of individuals living in the hospital service area, which encompasses portions of Morris and Passaic counties in New Jersey. The purpose of the assessment was to gather current statistics and qualitative feedback on the key health issues facing residents of CMC's service area. The assessment examined a variety of health indicators including chronic health conditions, access to health care, and social determinants of health.

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

The complete CMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This community health improvement plan (CHIP) delineates how CMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2019-2021 Community Health Needs Assessment process identified six priority health needs that have been included in the 2022 CHIP.

- Behavioral Health (including Substance Use as it pertains to Mental Health)
- Diabetes
- Cancer
- Heart Disease
- Stroke
- Pulmonary Disease

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

CHILTON MEDICAL CENTER – IMPLEMENTATION PLAN

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

PRIORTY AREA: BEHAVIORAL HEALTH (INCLUDING SUBSTANCE USE AS IT PERTAINS TO MENTAL HEALTH)

- Provide the necessary level of community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and opioid and alcohol misuse.

ACTIVITY	APPROACH
Develop Programming Aimed at Reducing Stigma Related to Mental Health	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. **No More Whispers** ○ Suicide Prevention in Teens & Adults ○ Culturally Competent Suicide Prevention ○ Suicide Prevention - with Trusted Adults, Clergy, Schools, Parents ○ Autism Spectrum Disorder Awareness ○ Alcohol Awareness ○ Hope & Mental Wellness ○ Post-Traumatic Stress Disorder ○ Sleep Hygiene ○ Stress & Resilience ○ General Mental Health Wellness ○ Substance Use Disorder ○ Social Isolation ○ Covid-19 – Stress and Anxiety ○ "Return-to-School" Preparation for Parents • Develop a shared resource for use among AHS community health departments and the behavioral health service line in response to identified needs within the community, with a focus on development of virtual resources easily accessible by the communities served by AHS. • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.
Access to Care	• Chilton Medical Center has increased its capacity to meet the needs of behavioral health and substance abuse crisis patients by constructing a specially outfitted pod of patient rooms in the emergency department. The medical center intends to recruit a peer recovery representative who will work in the emergency department an on inpatient units, supporting patients who are emerging from acute crises.

PRIORITY AREA: CANCER

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

ACTIVITY	APPROACH
Health and Wellness	• **Preventative screenings**: Continued coordinatization of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments and the Regional Chronic Disease Coalition. Educational and screening programs will focus on colorectal, breast, skin, cervical, and prostate cancer. In addition, continue to increase screening services to include lung cancer screenings and management for high-risk breast cancer. Continuation of smoking cessation programs offered at Chilton Medical Center. Maintain the working relationship with American Cancer Society, the Regional Chronic Disease Coalition, AHS Community Health Department, local health departments and community organizations to provider cancer prevention education, chronic disease management and access to cancer screenings and support services. Expand follow up of high-risk breast screenings for medical evaluation and surveillance. Initiating development of a high-risk pancreatic screening program. • Chilton Medical Center has partnered with Screen NJ, a state-funded program part of Rutgers Health that offsets the costs of colorectal and lung cancer screenings for uninsured and underinsured patients who qualify. • **Wellness**: Cancer center to provide information and education on tips for self-care while in treatment (surgery, chemotherapy, radiation) and into survivorship. The information will be provided to both patients and caregivers through formal lectures, printed materials and virtually. Offer other programs to the community to encourage early detection and reduce risk of cancer through smoking cessation, exercise, and good nutrition. Survivorship series provided on nutrition for healthy lifestyle.
Practical/Financial Needs	• Each oncology patient is assessed for financial, practical, and psychosocial needs. As barriers are identified the social worker collaborates with the nurse navigator and other staff to address the patient's practical and financial needs. As barriers or needs are identified, patients are referred to our network of community partners for assistance. AHS works with the community-based agencies to provide wigs, food, transportation, and other financial/practical matters. A new process has been designed to streamline referrals for financial evaluation in a timely manner. Similarly, improved processes have been developed for more timely Advanced Care Planning and Palliative Care services. Continue to identify grant and other funding opportunities to meet this unmet need. • The Chilton Medical Center Foundation has led effort to help cancer patients overcome financial barriers to care by establishing an Oncology Patient Assistance Fund. Administered by the Oncology Social Worker, these monies are used to offset expenses associated with transportation to and from treatments, stave off

ACTIVITY	APPROACH
	food, medication, and housing insecurity, provide for specialty garments, at-home medical equipment relevant to care, and more.
Mental Health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). Referrals are provided to our behavioral health services or to community resources for counseling and psychiatric services. Behavioral health services are offered on a referral through a nurse practitioner and in the community • AHS continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service.
Transportation	• Transportation remains a major barrier for many patients, especially those in urban or rural communities. The RN Navigator, and social worker work with community partners and other organizations to coordinate transportation as available. • Explore funding opportunities for commercial ride-share service gift cards. • Collaborate with community resources to expand and enhance access to transportation services. • The Oncology Patient Assistance Fund, operated by the Chilton Medical Center Foundation, works to reduce patient dependence on volunteer and community-based transportation services.
Insurance Issues	• The Cancer Center staff identify patients who do not have health insurance and are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. Social Workers meet with and counsel each patient in need, directing and referring to the appropriate resources. • Oncology navigators, nursing staff, and social workers continually reassess a patient's barriers to care at each encounter.
Access	• Employ virtual resources and programs to provide community with access to support groups, educational programs and supplemental services related to cancer treatment, care, and management. • Use virtual platform to supplement for the lack of face-to-face support services resulting from COVID-19. • Review and update the AHS Cancer Center website to improve access to virtual services, programs, and resources. • Evaluate and supplement resources available to the African American and Hispanic/Latino population to provide culturally sensitive care. • Improving Care Considerations and reducing healthcare disparities for the LGBTQ population

PRIORITY AREA: DIABETES

- Refer community residents with diabetes or significant risk factors to existing diabetes management and prevention programs, and to clinical services, as needed.
- CMC will seek to improve awareness of diabetes risk factors, with an emphasis on residents of underserved areas.

ACTIVITY	APPROACH
Identification of at-risk populations and creation of linkages to care	• Build on success of the Diabetes Health Partnership, which identifies patients with A1C greater than 9 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes educator. • The partnership is being expanded to Atlantic Medical Group primary care offices through Atlantic Health System.

PRIORTY AREA: HEART DISEASE

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

ACTIVITY	APPROACH
Hypertension Management Program (HMP)	• Across AHS' service area, the combined inpatient and emergency room utilization rate per 1,000 population for hypertension has increased over the last 5 years. Data also reflect disparities in rates/1,000 population that are geographic and payer specific among the broader community served by Atlantic Health System. A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. • Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs). • AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve. • Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.
Access	• Enhance access to care and awareness of cardiovascular programs and services available across AHS, as well as advancements and improvements in treatment options (STEMI, etc.). • Educate the community on availability and appropriate use of emergency transportation services, i.e., when and how to seek help and the importance of acting quickly when emergency care is necessary.

ACTIVITY	APPROACH
	• Educate the community on the importance of seeking preventative care with their cardiologist, understanding warning signs for cardiovascular events, and what to do when a warning sign presents itself. • Identify structural barriers to health equity in our communities as they pertain to heart disease and capitalize on AHS' existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORTY AREA: STROKE

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

ACTIVITY	APPROACH
EMS and Caregiver Support	• Virtual and in-person education sessions for EMS and caregivers on stroke signs and symptoms for rapid identification and transport to a stroke center. • Printed material distributed to EMS agencies in service area to increase awareness of state designated comprehensive stroke center • Education to AHS and volunteer agencies on the statewide rollout of validated pre-hospital Large Vessel Occlusion recognition tool (RACE Scale).
Community Education	• Educate the community on stroke signs and symptoms for rapid identification and transport to a stroke center. • Educate the community on risk factors and comorbidities associated with stroke and availability of tools to identify risk factors for stroke. • Provide tools for stroke survivors and care givers to cope with disability and education to prevent future stroke, support post-stroke follow-up related to symptom education and nutritional counseling. • Educate health care professionals and members of the communities we serve regarding advances in stroke treatment and availability of stroke related services and resources. • Documentation of at least two educational programs focused on stroke prevention/care provided for the public. • Collaborative work with community health team for comorbidity focused educational sessions to address major risk factors for stroke. • BEFAST Fridays to increase awareness of stroke signs and symptoms to patients seeking care in the emergency department for a variety of medical needs.

PRIORITY AREA: PULMONARY DISEASE

- Increase education of the community served by CMC related to the dangers of nicotine.
- Identify opportunities to improve community health through continued reduction of 30-day readmissions for COPD.
- Increase the awareness of the AHS Lung Cancer Screening Program in the community served by CMC.

ACTIVITY	APPROACH
Nicotine Cessation, Prevention & Education	• **Nicotine Cessation (Smoking & Vaping)**: Educate patients, community residents, and AMG providers about the CMC Quit Smoking Support Group. CMC will distribute the CMC Quit Smoking flyer and will collect metrics annually on enrolled/graduated participants in smoking cessation programs. • As needed/appropriate, employ virtual and/or in person outreach and programming that provides an in-depth on-line educational approach to nicotine cessation. • All Atlantic Health locations will have access to Spanish speaking smoking cessation classes with a respiratory therapist. • **Nicotine Prevention:** Employ virtual and/or in-person education and programming to educate the community on nicotine prevention for both youth and adults.
Decrease 30-Day Readmissions Rates Within COPD Population	• **COPD Population:** 1) Increase use of EPIC COPD Order Set; 2) Increase the use of the AHM COPD Disease Management Program EPIC order; 3) Daily patient COPD education by respiratory therapist COPD Educator; 4) 7-day or less pulmonary/PCP appointments arranged prior to discharge; 5) Continued education at CMC on the *2021 GOLD Guidelines* at yearly training days for RNs, RTs, and hospitalists. • Remote patient monitoring as ordered by providers for cases among the patients served by CMC. • Pulmonary rehabilitation services will be made available at CMC in calendar year 2022, further aiding in the reduction of readmissions.
AHS Lung Cancer Screening	• CMC will increase awareness of AHS' lung cancer screening program (LCS) in the community and among providers through focused outreach and education programs. • Providers working on AHS' electronic medical record will be encouraged to utilize "Best Practice Alerts" for lung cancer screening. • CMC will work to increase awareness of LCS criteria in the broader population: people between the ages of 55 to 77 who are current smokers (or have quit in the last 15 years), have a 30 pack per year tobacco history and have no history of lung cancer. • CMC will monitor relevant metrics related to LCS, including how many patients had an LCS from CMC, how many patients had a RADs (Reporting and Data System) 3 or 4 nodule and of these how many had a resection or chemotherapy. • Chilton Medical Center's partnership with Screen NJ is providing funds for low-dose CT scans and other pulmonary screening modalities for at-risk financially vulnerable patients.

Atlantic Health System
Newton Medical Center

NEWTON MEDICAL CENTER – COMMUNITY OVERVIEW

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

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

The complete NMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This community health improvement plan (CHIP) delineates how NMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2021-2023 Community Health Needs Assessment process identified six priority health needs that have been included in the 2022 CHIP.

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

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

IMPLEMENTATION PLAN – NEWTON MEDICAL CENTER

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

PRIORTY AREA: MENTAL HEALTH & SUBSTANCE MISUSE

- Provide the necessary level of community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and opioid and alcohol misuse.

ACTIVITY	APPROACH
Develop Programming Aimed at Reducing Stigma Related to Mental Health	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. **No More Whispers** ○ Suicide Prevention in Teens & Adults ○ Culturally Competent Suicide Prevention ○ Suicide Prevention – with Trusted Adults, Clergy, Schools, Parents ○ Autism Spectrum Disorder Awareness ○ Alcohol Awareness ○ Hope & Mental Wellness ○ Post-Traumatic Stress Disorder ○ Sleep Hygiene ○ Stress & Resilience ○ General Mental Health Wellness ○ Substance Use Disorder ○ Social Isolation ○ Covid-19 – Stress and Anxiety ○ "Return-to-School" Preparation for Parents • Develop a shared resource for use among AHS community health departments and the behavioral health service line in response to identified needs within the community, with a focus on development of virtual resources easily accessible by the communities served by AHS. • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.

PRIORTY AREA: CANCER

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

ACTIVITY	APPROACH
Health and Wellness	• **Preventative screenings**: Continued coordinatization of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments and the Regional Chronic Disease Coalition. Educational and screening programs will focus on colorectal, breast, skin, cervical, and prostate cancer. In addition, continue to increase screening services to include lung cancer screenings and management for high-risk breast cancer. Continuation of smoking cessation programs offered at Newton Medical Center. Maintain the working relationship with American Cancer Society, the Regional Chronic Disease Coalitions, AHS Community Health Department, local health departments and community organizations to provider cancer prevention education, chronic disease management and access to cancer screenings and support services. Expand follow up of high-risk breast screenings for medical evaluation and surveillance. Initiating development of a high-risk pancreatic screening program. • **Wellness**: Cancer center to provide information and education on tips for self-care while in treatment (surgery, chemotherapy, radiation) and into survivorship. The information will be provided to both patients and caregivers through formal lectures, printed materials and virtually. Offer other programs to the community to encourage early detection and reduce risk of cancer through smoking cessation, exercise, and good nutrition. Survivorship series provided on nutrition, exercise, and other tips to maintain a healthy lifestyle after cancer treatment.
Practical/Financial Needs	• Each oncology patient is assessed for financial, practical, and psychosocial needs. As barriers are identified the social worker works together with the nurse navigator and other staff to address the patient's practical and financial needs. As barriers or needs are identified, patients are referred to our network of community partners for assistance. AHS works with the community-based agencies to provide wigs, food, transportation, and other financial/practical matters. A new process has been designed to streamline referrals for financial evaluation in a timely manner. Similarly, improved processes have been developed for more timely Advanced Care Planning and Palliative Care services.
Mental Health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). Referrals are provided to our behavioral health services or to community resources for counseling and psychiatric services. • AHS continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service.

ACTIVITY	APPROACH
Transportation	• Transportation remains a major barrier for many patients, especially those in urban or rural communities. The RN Navigator and social worker work with community partnerships and other organizations to coordinate transportation as available. • Explore funding opportunities for commercial ride-share service gift cards.
Insurance Issues	• The Cancer Center staff identify patients who do not have health insurance and are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. A central number has been developed for expedited referral to PFS. • Social Workers meet with and counsel each patient in need, directing and referring to the appropriate resources. • Oncology navigators, nursing staff, and social workers continually reassess a patient's barriers to care at each encounter.
Access	• Employ virtual resources and programs to provide community with access to support groups, educational programs and supplemental services related to cancer treatment, care, and management. • Use virtual platforms to supplement for the lack of face-to-face support services resulting from COVID-19. • AHS' website updates continue to improve patient access to virtual services, programs, and resources. • Enhance resources for Hispanic/Latino population to provide culturally sensitive care.

PRIORTY AREA: HEART DISEASE

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

ACTIVITY	APPROACH
Hypertension Management Program (HMP)	• Across AHS' service area, the combined inpatient and emergency room utilization rate per 1,000 population for hypertension has increased over the last 5 years. Data also reflect disparities in rates/1,000 population that are geographic and payer specific among the broader community served by Atlantic Health System. A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. • Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs). • AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve. • Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.

ACTIVITY	APPROACH
Access	• Enhance access to care and awareness of cardiovascular programs and services available across AHS, as well as advancements and improvements in treatment options (STEMI, etc.). • Educate the community on availability and appropriate use of emergency transportation services, i.e., when and how to seek help and the importance of acting quickly when emergency care is necessary. • Educate the community on the importance of seeking preventative care with their cardiologist, understanding warning signs for cardiovascular events, and what to do when a warning sign presents itself. • Identify structural barriers to health equity in our communities as they pertain to heart disease and capitalize on AHS' existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: DIABETES & OBESITY

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

ACTIVITY	APPROACH
Identify Successful Programs for Broader AHS Implementation	• Work with other AHS hospitals to identify opportunities for collaborative and innovative approaches to diabetes management and prevention. • Best practice alerts are active at NMC with plan to expand to all AHS hospitals.
Identification of at-risk populations and creation of linkages to care	• Build on success of the Diabetes Health Partnership, which identifies patients, including Atlantic Health System team members, with A1C greater than 9 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes care and education specialist. The partnership is being expanded to Atlantic Medical Group (AMG) primary care offices through Atlantic Health System. • Initiate annual status report of Atlantic Health System Diabetes Education Centers to AMG primary, nephrology, and endocrinology offices to provide summary of care rendered throughout calendar year and future updates to show impact on patient outcomes and increase referral volumes for linkage to care. • Body mass index (BMI) screening / nutritional education for overweight population and referral to Metabolic providers, as appropriate. • Collaboration with all Atlantic Health Center inpatient and outpatient diabetes education services to ensure consistency and resource sharing across sites. • Live in-person and virtual community education sessions at community centers, libraries, and schools, Zoom sessions for Atlantic Health System, as needed.

ACTIVITY	APPROACH
	• Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Referral, as appropriate, to Atlantic Health System Quit Smoking Program for smoking cessation and risk reduction. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes. • Conduct telehealth visits if federal regulations allow for increased access to care.
Reduction in Diabetes-related 30-day Readmissions	• Develop and implement diabetes discharge order set for comprehensive guidance on at-home needs to consider, including, but not limited to referrals to follow up care at associated Diabetes Education Centers and Endocrinology practices. • Update and increase usage of inpatient subcutaneous hyperglycemia order set for care planning and initiation of education and resource evaluation in the inpatient setting. • Determine plan for site specific review of readmission cases and create proactive systemic plans for improvement.

PRIORITY AREA: STROKE

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

ACTIVITY	APPROACH
EMS and Caregiver Support	• Virtual and in-person education sessions for EMS and caregivers on stroke signs and symptoms for rapid identification and transport to a stroke center. • Printed material distributed to EMS agencies in service area to increase awareness of state designated comprehensive stroke center. • Education to AHS and volunteer agencies on the statewide rollout of validated pre-hospital Large Vessel Occlusion recognition tool (RACE Scale).
Community Education	• Educate the community on stroke signs and symptoms for rapid identification and transport to a stroke center. • Educate the community on risk factors and comorbidities associated with stroke and availability of tools to identify risk factors for stroke. • Provide tools for stroke survivors and care givers to cope with disability and education to prevent future stroke, support post-stroke follow-up related to symptom education and nutritional counseling.

ACTIVITY	APPROACH
	• Educate health care professionals and members of the communities we serve regarding advances in stroke treatment and availability of stroke related services and resources. • Documentation of at least two educational programs focused on stroke prevention/care provided for the public. • Collaborative work with community health team for comorbidity focused educational sessions to address major risk factors for stroke. • BEFAST Fridays to increase awareness of stroke signs and symptoms to patients seeking care in the emergency department for a variety of medical needs.

Atlantic Health System
Hackettstown Medical Center

HACKETTSTOWN MEDICAL CENTER – COMMUNITY OVERVIEW

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

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

The complete HMC Community Health Needs Assessment is available at https://www.atlantichealth.org/patients-visitors/education-support/community-resources-programs/community-health-needs-assessment.html. This community health improvement plan (CHIP) delineates how HMC will address the health priorities identified in the CHNA.

Prioritized Health Needs

The 2021-2023 Community Health Needs Assessment process identified five priority health needs that have been included in the 2022 CHIP.

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

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

HACKETTSTOWN MEDICAL CENTER – IMPLEMENTATION PLAN

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

PRIORTY AREA: HEART DISEASE

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

ACTIVITY	APPROACH
Hypertension Management Program (HMP)	• Across AHS' service area, the combined inpatient and emergency room utilization rate per 1,000 population for hypertension has increased over the last 5 years. Data also reflect disparities in rates/1,000 population that are geographic and payer specific among the broader community served by Atlantic Health System. A hypertension management program (HMP) can aid in improving the health of our community and address identified disparities. • Studies published by the CDC spanning a 10-year time horizon show that an HMP is a cost-effective method for controlling hypertension among patients who received hypertension management visits (HMVs). • AHS will implement an enterprise wide HMP aimed at improving the management of hypertension with the goal of decreasing the prevalence of uncontrolled hypertension in the community we serve. • Referral, as appropriate, to AHS Quit Smoking Program for smoking cessation and risk reduction.
Access	• Enhance access to care and awareness of cardiovascular programs and services available across AHS, as well as advancements and improvements in treatment options (STEMI, etc.). • Educate the community on availability and appropriate use of emergency transportation services, i.e., when and how to seek help and the importance of acting quickly when emergency care is necessary. • Educate the community on the importance of seeking preventative care with their cardiologist, understanding warning signs for cardiovascular events, and what to do when a warning sign presents itself. • Identify structural barriers to health equity in our communities as they pertain to heart disease and capitalize on AHS' existing community partnerships as a path to reducing and/or eliminating these barriers.

PRIORITY AREA: DIABETES / OVERWEIGHT / OBESITY

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

ACTIVITY	APPROACH
Identify Successful Programs for Broader AHS Implementation	• Work with other AHS hospitals to identify opportunities for collaborative and innovative approaches to diabetes management and prevention. • Western region diabetes education platform united across two sites and a virtual platform was added specific to AHS hospitals in Warren and Sussex counties.
Identification of at-risk populations and creation of linkages to care	• Build on success of the Diabetes Health Partnership, which identifies patients, including Atlantic Health System team members, with A1C greater than 9 and provides screenings for social determinants of health, creates linkages to care for social and community health workers, and engages patients in a diabetes self-management education with a certified diabetes care and education specialist. The partnership is being expanded to Atlantic Medical Group (AMG) primary care offices through Atlantic Health System. • Initiate annual status report of Atlantic Health System Diabetes Education Centers to AMG primary, nephrology, and endocrinology offices to provide summary of care rendered throughout calendar year and future updates to show impact on patient outcomes and increase referral volumes for linkage to care. • Body mass index (BMI) screening / nutritional education for overweight population and referral to Metabolic providers, as appropriate. • Collaboration with all Atlantic Health Center inpatient and outpatient diabetes education services to ensure consistency and resource sharing across sites. • Live in-person and virtual community education sessions at community centers, libraries, and schools, Zoom sessions for Atlantic Health System, as needed. • Referral, as appropriate, to Atlantic Behavioral Health for emotional support and coping with chronic disease. • Referral, as appropriate, to Atlantic Health System Quit Smoking Program for smoking cessation and risk reduction. • Offer virtual support groups for patients with type 1 diabetes and type 2 diabetes. • Conduct telehealth visits if federal regulations allow for increased access to care. •

ACTIVITY	APPROACH
Reduction in Diabetes-related 30-day Readmissions	• Develop and implement diabetes discharge order set for comprehensive guidance on at-home needs to consider, including, but not limited to referrals to follow up care at associated Diabetes Education Centers and Endocrinology practices • Update and increase usage of inpatient subcutaneous hyperglycemia order set for care planning and initiation of education and resource evaluation in the inpatient setting. • Determine plan for site specific review of readmission cases and create proactive systemic plans for improvement.

PRIORTY AREA: MENTAL HEALTH & SUBSTANCE MISUSE

- Provide the necessary level of community-based behavioral health services, with a focus on suicide prevention, survivorship, patient and family support groups, disparities among minority populations, adolescent behavioral health, aging and mental health, and opioid and alcohol misuse.

ACTIVITY	APPROACH
Develop Programming Aimed at Reducing Stigma Related to Mental Health	• Raise awareness of mental health issues in the community to ensure that access and utilization of services is unencumbered by stigma through education, outreach, development of clinical and social partnerships. **No More Whispers** ○ Suicide Prevention in Teens & Adults ○ Culturally Competent Suicide Prevention ○ Suicide Prevention - with Trusted Adults, Clergy, Schools, Parents ○ Autism Spectrum Disorder Awareness ○ Alcohol Awareness ○ Hope & Mental Wellness ○ Post-Traumatic Stress Disorder ○ Sleep Hygiene ○ Stress & Resilience ○ General Mental Health Wellness ○ Substance Use Disorder ○ Social Isolation ○ Covid-19 – Stress and Anxiety ○ “Return-to-School” Preparation for Parents • Develop a shared resource for use among AHS community health departments and the behavioral health service line in response to identified needs within the community, with a focus on development of virtual resources easily accessible by the communities served by AHS. • Utilize internal and community partnerships to establish a sustainable level of locally based behavioral health resources in the community.

PRIORITY AREA: CANCER

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

ACTIVITY	APPROACH
Health and Wellness	• **Preventative screenings**: Continued coordinatization of education and cancer screening opportunities with NJCEED and Community Health departments, local health departments and the Regional Chronic Disease Coalition. Educational and screening programs will focus on colorectal, breast, skin, cervical, and prostate cancer. In addition, continue to increase screening services to include lung cancer screenings and management for high-risk breast cancer. Continuation of smoking cessation programs offered at Newton Medical Center. Maintain the working relationship with American Cancer Society, the Regional Chronic Disease Coalitions, AHS Community Health Department, local health departments and community organizations to provider cancer prevention education, chronic disease management and access to cancer screenings and support services. Expand follow up of high-risk breast screenings for medical evaluation and surveillance. Initiating development of a high-risk pancreatic screening program. • **Wellness**: Cancer center to provide information and education on tips for self-care while in treatment (surgery, chemotherapy, radiation) and into survivorship. The information will be provided to both patients and caregivers through formal lectures, printed materials and virtually. Offer other programs to the community to encourage early detection and reduce risk of cancer through smoking cessation, exercise, and good nutrition. Survivorship series provided on nutrition, exercise, and other tips to maintain a healthy lifestyle after cancer treatment.
Practical/Financial Needs	• Each oncology patient is assessed for financial, practical, and psychosocial needs. As barriers are identified the social worker works together with the nurse navigator and other staff to address the patient's practical and financial needs. As barriers or needs are identified, patients are referred to our network of community partners for assistance. AHS works with the community-based agencies to provide wigs, food, transportation, and other financial/practical matters. A new process has been designed to streamline referrals for financial evaluation in a timely manner. Similarly, improved processes have been developed for more timely Advanced Care Planning and Palliative Care services
Mental Health	• The cancer center social worker conducts an assessment on patients referred to them (by a practitioner or identified through the distress screening process or depression scale). Referrals are provided to our behavioral health services or to community resources for counseling and psychiatric services. • AHS continues to identify internal resources and opportunities and community partnerships to provide greater on-site access to this vital service.

ACTIVITY	APPROACH
Transportation	• Transportation remains a major barrier for many patients, especially those in urban or rural communities. The RN Navigator, and social worker work with community partnerships and other organizations to coordinate transportation as available. • Explore funding opportunities for commercial ride-share service gift cards.
Insurance Issues	• The Cancer Center staff identify patients who do not have health insurance and are then referred to the NJCEED Program, the preauthorization team, or to AHS' patient financial services (PFS) for evaluation and support. A central number has been developed for expedited referral to PFS. • Social Workers meet with and counsel each patient in need, directing and referring to the appropriate resources. • Oncology navigators, nursing staff, and social workers continually reassess a patient's barriers to care at each encounter.
Access	• Employ virtual resources and programs to provide community with access to support groups, educational programs and supplemental services related to cancer treatment, care, and management. • Use virtual platforms to supplement for the lack of face-to-face support services resulting from COVID-19. • AHS' website updates continue to improve patient access to virtual services, programs, and resources. • Enhance resources for Hispanic/Latino population to provide culturally sensitive care.

PREPARED FOR

MORRISTOWN MEDICAL CENTER

OVERLOOK MEDICAL CENTER

CHILTON MEDICAL CENTER

NEWTON MEDICAL CENTER

HACKETTSTOWN MEDICAL CENTER

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