Community Health Implementation Plan (CHIP) 2022-2024

Based on the 2022-2024 Community Health Needs Assessment, AtlantiCare has proposed partnering with external organizations and community entities to achieve the following goals and strategies addressing these six identified community needs:

A. **Provide timely access to care** through work to decrease wait times for existing and new patients; improve access and ease for making appointments; and increase capabilities in specialty areas such as cardiology, oncology and orthopedics.

B. **Increase affordability of care** by gaining understanding of patients' social needs, connecting them to related resources and benefits; implementing interventions to prevent future needs such as financial coaching; and ensuring that our community is well educated on low cost care settings.

C. **Reduce transportation barriers** which impede one's ability to access medical care and social services by expanding the use of ride share and medical transport services; working to enhance internet access so that telehealth appointments are an option; working to advocate for additional transportation infrastructure; and creating mobile or in-community services.

D. **Expand mental health services** ensuring that every community member has access to services in a timely manner through expansion of community-based programs as well as virtual services; the establishment of a Psychiatric Residence Clinic within our Federally Qualified Health Center, and expanded School-Based services within the county.

E. **Reduce the fatal consequences of substance use** in Atlantic County by expanding inpatient and outpatient treatment options; continuing to provide harm reduction resources; establish and expand community support for those in recovery for substance use disorders.

F. **Improve food security** by screening patients to identify those with limited resources and ensure that they are connected to healthy emergency food provisions and when appropriate connected to benefits to prevent future needs.

G. **Ensure that all in our community have a place to call home** by screening patients for housing insecurity; establishing housing partnerships with area agencies; supporting affordable housing projects; and sponsoring down payment assistance programs.

Addressing each priority: The tables below outlines specific strategies to ensure that we meet each priority identified via the 2022 Community Health Needs Assessment. The metrics to monitor our success and enabling supports are also listed.

Health Need (Priority) #1: Connections to Care			
Goal	**Strategies**	**Metrics (What is AtlantiCare measuring?)**	**External Needs /Enabling Supports**
Provide timely access to care	Make easier the way in which to secure an appointment. Decrease wait time for new and existing patients. Continue to invest in and expand specialty services.	Time to Available Appointment (3-7 days Primary Care; 10 days Specialist; 30 days behavioral health) Digital Technology Usage Telehealth Utilization	Community partnerships needed to support training of individuals to use technology tools which could complement their care.
Affordability of Care	Screen and Connect Patients to available resources and benefits to ensure that all healthcare & related social needs are met. Implement upstream interventions to mitigate future social determinant needs.	Average number of SDOH needs per patient. Number of patients enrolled in financial coaching.	Referral agencies to support patient's social needs. SDOH technologies to ensure efficiency in addressing patient needs.

Activities/Initiatives

Access:

1. Expand digital technologies to support to enable access to care (self-scheduling, chat bot, etc.)
2. Provide services during non-traditional appointment hours
3. Expand the use of telehealth where appropriate as a timely option for accessing care.
4. Invest in new capabilities and services to continue to care for individuals locally.

Affordability:

1. Implement a social needs and referral directory technology to ensure patients get connected to both internal and external supports for their health and social needs.
2. Establish formal partnerships with community agencies to refer clients when appropriate.
3. Capture data and follow trends to better understand the needs of community and evaluate successful interventions.
4. Extend SDOH interventions to include financial coaching to prevent future needs.

Health Need (Priority) #2: Transportation			
Goal	**Strategies**	**Metrics (What is AtlantiCare measuring?)**	**External Needs / Enabling Supports**
Reduce transportation barriers which impedes one's ability to access medical care and social services.	Expand the use of Medical transport and ride share services as a more efficient mode of transport for patients. Advocate for greater public transportation resources & infrastructure to exist within South Jersey. Address the digital divide enabling telehealth to be a viable option for those with transportation barriers. Create more in-community/ mobile services to reduce the need for transportation.	Number of patients indicating transportation insecurity Number of rides and number of services offering ride share program Number of patient transported via medical transport Missed appointment rates Community digital access rates Number of telehealth appointments in digital deserts Number of services which provide in-community access points.	Ride Share programs State/ Local Transportation Offices Internet Providers

Activities/Initiatives

1. Expand Rideshare services to limited mobility patients and other prioritized populations with elevated social and medical needs.
2. Advocate for increased public transportation services throughout South Jersey.
3. Formalize partnerships with current medical transportation organizations to expand services.
4. Support the expansion of digital access to communities with limited resources.
5. Provide education on the digital tools that could complement a patient's treatment/ connections to care.
6. When appropriate, expand in-home, mobile, and in-community services to reduce the need for transportation.

Health Need (Priority) #3: Mental Health/ Behavioral Health			
Goal	**Strategies**	**Metrics (What is AtlantiCare measuring?)**	**External Needs/ Enabling Supports**
Ensure that all in our community are able to obtain the mental health services they need in a timely manner	Expand community based programs. Expand virtual services as timely option. Ensure a comprehensive continuum of services for both adult and pediatric services populations.	Wait Time to Appointment Readmission/ Recidivism Increased Virtual Visit utilization Continuum Expansion & Service Portfolio for all populations	Transportation Referral Networks Embedded Services School/ Community Partnerships
Invest in greater behavioral health capabilities and services	Review opportunities for growth and expansion to meet community needs.	Provider: Population Count Patient Experience	

Activities/Initiatives

1. Introduce new services to the region to broaden the availability of services to treat mental health conditions and reduce care gaps.
2. Expand operational hours of existing services to better meet demand.
3. Provide virtual visits as an option to patients looks for mental health services, when appropriate.
4. Establish a Psychiatry Residence Clinic at the HealthPlex, a Federally Qualified Health Center, to better meet demand in Atlantic City for mental health services.
5. Expansion of School Based services to provide both preventative and therapeutic offerings for youth and families in need.
6. Host community and staff educational and awareness opportunities to reduce stigma around services.

Health Need (Priority) #4: Substance Use			
Goal	**Strategies**	**Metrics (What is AtlantiCare measuring?)**	**External Needs/ Enabling Supports**
Reduce the fatal consequences of substance use in our community.	Expand inpatient and outpatient treatment options to meet community demand. Further train clinical teams to identify and treat substance use disorder across the enterprise and in the community. Continue to provide harm reduction resources to patients and the community. Address stigma around substance use. Establish and expand on community supports for recovery.	Number of Overdose Deaths AMA Rates Continuum of Services/ Treatment Providers	County & City Overdose Fatality Review Teams Treatment Providers Prevention-Based Community Organizations Trained Providers Peer Recovery Specialists

Activities/Initiatives

1. Expand substance use services via acquisition of John Brooks Recovery Center.
2. Expand Bridge Clinic operations to be seven days a week.
3. Train internal and community providers to identify and treat substance use disorders.
4. Expand the use of Peer Recovery Specialists.
5. Continue efforts to be a recovery-friendly employer.
6. Establish community supports for individuals in recovery.

Health Need (Priority)# 5: Access to Food			
Goal	**Strategies**	**Metrics (What is AtlantiCare measuring?)**	**External Needs/ Enabling Supports**
Improve food security thorough the provision of healthy food.	Screen patients for food insecurity. Provide internal and external interventions to solve for food insecurity.	Number of food insecure patients Number of patients/ clients served by AtlantiCare pantries Number of patients connected to SNAP/ WIC when appropriate.	The Community Food Bank of New Jersey, Southern Division Local Food Pantries SNAP/ WIC offices

Activities/Initiatives

1. Provide food resources to address immediate hunger at point of service.
2. Shift pantry focus to a choice pantry to ensure we are meeting patient needs/ preferences.
3. Implement food bank technology to better understand needs and trends of pantry utilizers.
4. Ensure pantry utilizers are connected to SNAP and/or WIC resources when appropriate.
5. Operate two food pantries at AtlantiCare service sites.
6. Establish an employee program to support colleagues who are struggling with food insecurity.

Health Need (Priority) #6: Housing			
Goal	**Strategies**	**Metrics (What is AtlantiCare measuring?)**	**External Needs/ Enabling Supports**
Ensure that all in our community have a place to call home.	Screen patients for housing insecurity. Enable safe, adequate, and affordable housing.	Number of patients experiencing housing insecurity Number of patients referred to housing agencies/ supports. Housing programs established	State, County & City Based Officials Housing Agencies Developers

Activities/Initiatives

1. Establish housing partners for patient referrals.
2. Invest in affordable/ workforce housing projects within the community.
3. Continue to expand programming which improves quality of housing stock, promotes home ownership, and builds wealth via the Midtown Neighborhood Revitalization Project.
4. Expand our down payment assistance program for employees.