Hartford Region Update on Community Health Improvement Plan

June 25, 2018
Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
The Three Pillars of Addressing Root Cause

- **Enhance Coordination of Services**
- **Promote Healthy Behaviors and Lifestyle**
- **Improve Community Behavioral Health**

Strategic priority interests that drive our response to addressing root cause.
**Enhance Coordination of Services**

**Baseline Indicators**

- **Parts of Hartford Designated as Medically Underserved**
- **73% Hartford City Report Good Health (86% in CT)**
- **Health Disease Mortality 151.4 (101.6 in CT)**

**Key Plan Initiative Tactics to Implement**

- Evaluate and use information exchange portal resources, linking healthcare providers with community-based organizations.
- Improve IT resources to enable community focus and better measurement of outcomes.
- Develop a playbook for infrastructure, dashboard of health, governance, and community workflows.
- Enable dynamic and up-to-date asset mapping.

- Develop innovation network for learning, research, co-creation, and rapid knowledge dissemination (bi-directional communication platform).
- Implement new or increased use of Community Health Workers (CHW).
- Evaluate and use adaptive technology (e.g., geofencing, GIS mapping, artificial intelligence, biometric risk assessment, Epic tie-ins).
Promote Healthy Behaviors and Lifestyle

**Key Plan Initiative Tactics to Implement**

- Screen for healthy food need identification in community population and provide assessment at points of care
- Enhance Promotion and Marketing, including adopting 5-2-1-0 initiative, at schools, workplaces, public spaces, faith communities, and healthcare events
- Provide voucher/prescription programs for fruits and vegetables
- Promote and improve healthy food donation

**Baseline Indicators**

- 11.6% of the population in poverty (10.4% in CT)
- 42% of food insecure county residents have income too high to qualify for assistance
- 33% Hartford city at healthy weight (39% CT)

- Further partnerships with food pantries/banks and food providers and suppliers
- Create more access points for healthy foods
- Develop urban gardens, community gardens, hospital campus gardens, farmer’s markets (fresh food)
- Evaluate and use mobile food programs
- Create and support food policy councils
Improve Community Behavioral Health

Key Plan Initiative Tactics to Implement

- Embed behavioral health services in primary care (ongoing)
- Recruit more mental health providers, with focus on community outpatient services (e.g., family therapists)
- Implement Recovery Coach program in ED
- Provide more depression screening – growth and at more points of care with referrals (including at public schools) and integrate into Epic

Baseline Indicators

19.0% ADULT DEPRESSION (17.2 % IN CT)
15% AREA (24% IN CITY) CIGARETTE SMOKING (12% IN US)
77% HARTFORD CITY REPORT GOOD MENTAL HEALTH (84% CT)

Further Mental Health First Aid training and grow community behavioral health training at the local level
Enhance services in virtual mental health, including tele-psychiatry