Northwest Region Update on Community Health Improvement Plan

June 27, 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 Four Pillars of Addressing Root Cause

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

**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)

**Baseline Indicators**

- **TORRINGTON DESIGNATED AS UNDERSERVED (MUA/HPSA)**
- **NW HEALTH DISEASE MORTALITY 168.2 (101.6 IN CT)**
- **1 PCP PER 1,569 NW (1 PCP PER 1,180 CT & 1,030 US)**
**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 continuing the 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
- 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

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**Baseline Indicators**

- **SCHOOL BREAKFAST PARTICIPATION 20% OR LESS IN MOST NW TOWNS**
- **ONLY 39% OF RESIDENTS AT HEALTHY WEIGHT (SAME AS CT)**
- **LOWER RATE OF COLLEGE AND GRADUATE DEGREE (31.7% NW, 38.1% CT)**
### Improve Community Behavioral Health

**Key Plan Initiative Tactics to Implement**

- Embed behavioral health services in primary care
- 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
- 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
- Build on tobacco prevention and cessation programs
- Continue development of Opioid Task Force

### Baseline Indicators

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<tr>
<th>Indicator</th>
<th>Value</th>
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<tr>
<td>Torrington &amp; NW Depression</td>
<td>25.9% &amp; 18.4% (17.2% in CT)</td>
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<td>Torrington &amp; Plymouth Cigarette Smoking</td>
<td>Over 21%</td>
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<td>Mental Health Provider</td>
<td>1 per 461 NW (1 per 290 CT)</td>
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### Key Plan Initiative Tactics to Implement

- Congestive Heart Failure discharge programs and CHF clinic
- Growth in diabetes programs, including Diabetes Center at CHH with specialists and prevention program at YMCA (Measurable Progress Unlimited Support Diabetes Prevention Program)
- Leverage CHW dietician (see Coordination of Services initiative)
- Case management, self-management (including access to self-measure devices or monitors), at-home programs, and support groups

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<tr>
<td>68.2% OF DEATHS IN NW RELATED TO CHRONIC DISEASE (61.2% CT)</td>
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<td>PROSTATE CANCER</td>
<td>125.4 PER 1,000 (118.8 CT, 114.8 US)</td>
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<td>6.9% COPD, 33.6 MORTALITY RATE (5.5% AND 15.9 RESPECTIVELY CT)</td>
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- Coordination at primary care access points (communication, connecting to resources)
- Coordination of care: enhance feedback loop and follow-up care with improved information portal
- Promote screening (e.g., abnormal blood glucose for obese patients) and team based approaches to care
- Incorporate elements of 6/18 initiative (which includes specific focus on high blood pressure, asthma, and diabetes) – e.g., expand access to the National Diabetes Prevention Program