Community Health Improvement Plan

2022 - 2025

Hartford HealthCare
Backus Hospital

INTRODUCTION

"The greatness of a community is most accurately measured by the compassionate actions of its members." – Coretta Scott King

Health assessments help us examine changes to the health of our community, provide insights as to how residents can lead healthy and happy lives, and identify key health issues facing the community. The definition of health now includes the quality of the community in which we live, work, and play – not just the lifestyle habits of individuals. A comprehensive assessment process must provide a framework that helps communities prioritize public health issues; identify resources for addressing them; and effectively develop and implement community health improvement plans.

The 2021 Community Health Needs Assessment ("CHNA") for Backus Hospital, part of Hartford HealthCare's (HHC) East Region, leveraged numerous sources of local, regional, state and national data along with input from community-based organizations and individuals to provide insight into the current health status, health-related behaviors and community health needs for the Hospital service area.

In addition to assessing traditional health status indicators, the 2022 CHNA took a close look at social determinants of health (SDH) such as poverty, housing, transportation, education, fresh food availability, and neighborhood safety and contains an Equity Profile. These two enhancements are in response to the lessons of COVID and in recognition of an emerging national priority to identify and address health disparities and inequities. HHC and Backus Hospital are committed to addressing these disparities and inequities through its Community Health Improvement Plan (CHIP).

The intent of our CHIP is to be responsive to community needs and expectations and create a plan that can be effectively executed to leverage the best of the system resources, regional hospital and network resources, and community partners. The CHIP supports HHC's mission "to improve the health and healing of the people and communities we serve" and is part of HHC's vision to be "most trusted for personalized coordinated care." More specifically, this CHIP is collectively aimed at living our Value of Equity which reminds us all to do the just thing.

While a CHIP is designed to address these multiple needs, narrowing the focus to key areas of need and impact with associated key strategies best positions a health system for success. A CHIP is a dynamic rather than a static plan and should be modified and adjusted as external environmental factors change, including market conditions, availability of community resources, and engagement from community partners. Furthermore, a CHIP should build on and leverage prior success while simultaneously adjusting strategies and actions as obstacles are encountered.

This CHIP is organized across four focus areas that are intended to address root causes of community health issues while recognizing where the East Region in partnership with the community can be most effective in impacting change. The plan for each of these areas is outlined on the following pages. The driving rationale for each of these can be summarized as follows:

1. Promote Healthy Behaviors and Lifestyles

Research has repeatedly shown that good eating and exercise choices are critical to averting lost or unproductive time at school or work, growing and maintaining cognitive and physical functioning, promoting mental health, and preventing and managing many chronic diseases such as heart disease, cancer, stroke, diabetes, and osteoporosis

Rationale for Action

- New London County experienced the largest increase in child food insecurity from 11.7% in 2019 to 14.8% in 2021. From 2015 – 2021, 20% of adults in Norwich reported food insecurity as compared to 14% for the State of CT. (Backus CHNA 2022)

- 30% of the Backus Hospital, Hospital Services Areas (HSA) households are cost-burdened, meaning they spend at least 30% of their total income on housing costs. (Backus CHNA 2022)

- 53% of adults in the Backus Hospital HSA say they are in excellent or very good health as compared to 59% State of CT (Backus CHNA 2022)

- In 2020, 65 people in the Backus Hospital HSA died of drug overdoses. (Backus CHNA 2022)

2. Reduce the Burden of Chronic Disease

Proven interventions can prevent and reduce the effects of chronic and infectious diseases and are aimed at the **six** most common and costly health conditions – tobacco use, high blood pressure, healthcare-associated infections, asthma, unintended pregnancies, and diabetes – these conditions can be countered by proven specific interventions as highlighted by the CDC.

Rationale for Action

- Based on FIGURE 7: SELECTED HEALTH RISK FACTORS, SHARE OF ADULTS, 2015-2021*(Backus CHNA 2022, Data Haven Health Equity Profile 2022)*
    - Obesity Rates New London County – Black 38%, Latino 42%, Native American 50% as compared to State of CT 29%

- Based on FIGURE 24: SELECTED HEALTH INDICATORS BY AGE AND RACE/ETHNICITY, SHARE OF ADULTS, NEW LONDON COUNTY, 2015– 2021 *(Backus CHNA 2022, Data Haven Health Equity Profile 2022)*
    - Diabetes prevalence by race ages 50-64: white 11%, Black 32%, Latino 22%
    - Asthma prevalence by race ages 18-34: White 16%, Black 29%, Latino 23%
    - Hypertension Prevalence by race ages 65 and older: white 59%, Black 59%, Latino 42%

3. Improve Health Equity, Social Determinants of Health, and Access to and Coordination of Care and Services

Coordination of care is consistently identified as a key obstacle to achieving better access to care and services, as awareness of available resources, depth of patient and provider knowledge of community services, and tracking and follow-up of patients as they move from and between different provider organizations or points of care are challenged.

Rationale for Action

- The Backus HSA has a poverty rate of 9% and Norwich has a poverty rate of 13% *(Backus CHNA 2022)*

- As of 2019, 5,783 Backus Hospital HSA residents, or 5% of the population age 5 and older, were linguistically isolated. Latinos and Asian Americans are more likely to be linguistically isolated than other racial/ethnic groups. *(Backus CHNA 2022)*

- Individuals living below the poverty level (2019) - Backus Hospital HSA 15% and Norwich 25% as compared with 10% State of CT *(Backus CHNA 2022)*

4. Enhance Community-Based Behavioral Health Services

Mental health and substance abuse were also consistently identified as a top issue by the community and a root cause impacting all aspects of health. These services and interventions include more accessible screening, improved and timelier referrals, expanded programming and public awareness and empowerment.

Rationale for Action

- Overall, 12% of Backus Hospital HSA adults report experiencing anxiety regularly and 9% report being bothered by depression. *(Backus CHNA 2022)*

- Compared to the Connecticut rates, the encounter data HSA analysis for Backus Hospital suggests Mental Health, especially Depressive Disorder encounters are also significantly elevated: Mental Disorder (Any) per 10,000 residents: CT State 800 as compared to 1,500 Backus HSA. *(Backus CHNA 2022, CHIME data 2022)*

- Youth have positive role models: 58% Norwich as compared to 72% New London County and 77% State of CT *(Data Haven Equity Profile 2022)*

- Good Place to raise kids: 59% Norwich as compared to 71% New London County and 75% State of CT *(Data Haven Equity Profile 2022)*

The Call to Action

As community health leaders, this CHIP is essentially our call to action over the next three years to do our part to assure those we serve live long and healthy lives. Community partnerships will be a key ingredient to achieving success. This plan aims to further develop and pursue active engagement with the community. The good news is that we do not do this work alone. And, even though this work can be overwhelming at times, with important partnerships throughout the communities we serve, success is made possible.

Backus Hospital relies on the input, partnerships and opportunities presented by community partner organizations. Working in tandem to address needs and disparities outlined in the community health needs assessment is tantamount in order to improve the health of the Backus community. There limitless possibilities in how we can work together to address the difficult health care, social, and civil needs that are apparent in our communities.

We will continue to invigorate and expand programs and initiatives that have had positive effects throughout the years like our Rx for Health program (funded by Backus Hospital) which has remained a fixture in the Norwich community for the past 11 years. Moving forward we will continue to utilize our FQHC partners (Generations, United Children and Families Services), as well as our local pediatricians to identify families and children who would benefit from nutritional support and vegetable and fruit vouchers. However, our Community Health Needs Assessment (CHNA) has shown us that expanding upon the voucher program by incorporating primary care, faith based organizations and other local non-profits to include larger swaths of the Norwich population will increase the effectiveness, reach and utilization of the program. It is imperative to continue to build and expand our grocery infrastructure so we have added Shop Rite Grocery Store and the A&S Asian Market as partners alongside the Norwich Farmers Market as partners in the program. We continue to expand relationships with the south eastern CT area nutritional network partners (Gemma Moran Food Pantry, CT Food Bank, United Way, St. Vincent De Paul Pantry, Pawcatuck Neighborhood center, other Local food pantries, etc.). We will explore these new pipelines and partnership for food donation through our Compass One Waste Not 2.0 program. This strategy donates unused food from hospital kitchens to qualifying distribution partners within the community. These types of programs are not only positive for the community but help to reduce our environmental footprint as a hospital system.

A large portion of our community health improvement strategies for the 2023-2025 Community Health Improvement Plan (CHIP) fall under the focus area of improving health equity, coordination of services, and access to care. Covid-19 has had a lasting impact on our health care system and community and has taught us valuable lessons about how to better collaborate with heath care organizations and health and human services agencies. The pandemic has also shone a bright light onto the disparities that exist within our communities of color and our underserved populations. We have learned that trust, education, access to care and coordination of services are key components to addressing disparities and supporting these areas of our population. It is important to recognize that this work is not done in silos and it is only when community agencies and health care organizations work together that we can maximize the benefits of our resources and outreach. Strategies such as Neighborhood Health/ Mobile health hub, Community Care Team meetings, and our Coordinated Clinical Services Team are examples of how we can work together in supportive, non-prescriptive roles while doing our part to address community needs and access to care.

Our recent support and active involvement for the building and revitalization of Jubilee Park allows us to take resources and share them in the form of community building activities. We aspire to continue to develop a pipeline for resources, data, expertise to further demonstrate how hospitals can be anchor institutions. Many of our leaders from Backus hospital hold board or committee seats on various organizations (ARC of Eastern CT, Prevention council, Safe Futures, Senior Resources, etc.) throughout the Backus Hospital service area. These types of partnerships not only allow for greater connections and communications but affords us the opportunity to give back and serve the community where we work and live.

Health equity is the cornerstone of the work we are trying to promote within the community health space and a recurring theme that runs through every aspect of this CHIP. Our multi-lingual initiative aims at not only advocating for and lifting up our native language speaker colleagues but ultimately provides essential communication resources for the individuals in our community from diverse cultures. It is important that the education we are providing within our CHIP goals is culturally relevant and not only reflects appropriate language and customs but takes into account how individuals navigate their preferences, struggles and celebrations throughout their everyday lives. We rely on our partnerships with the NAACP, Norwich Racial Equity Committee, and our ever-growing list of community ambassadors who are subject matter experts in this arena. It is through their partnership and collaboration that we can continue to improve the way we offer services and care.

The most important principles in the execution of this CHIP are communication and inclusion. It is our responsibility to keep the lines of communication open by sharing progress, seeking feedback and welcoming contributions for the work we are trying to accomplish. Our CHIP strategies are only as successful as the partnerships that help to inform, promote and celebrate the work being done.

Focus Area #1: Promote Healthy Behaviors and Lifestyles			
Objective 1	**Decrease the amount of food waste and increase food donations to the community by providing individuals with free healthy excess food from the hospital kitchens.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/Partner**	**METRICS/MILESTONES – STATUS**
Access to Healthy, Affordable Food **Enhanced Collaboration with Community Partners**	**Hospital/Community Based -** Compass One's **Waste Not 2.0** program is utilized in Hospitals in the HHC HealthCare system to determine unused food that could be donated to people in need. Food Share has partnered to onboard and identify local agencies who would meet the requirements and have the capacity to accept unused food from Hospital Kitchens. The hospitals track their donations and work together with local agencies to enact the program. Currently Backus hospital utilizes a version of the waste not program to donate food scraps to local farmers to be used in the raising and cultivation of livestock. The goal would be to raise the level of donation to meals that can be consumed by our underserve members of the community. Food and nutrition staff would utilize St. Vincent de Paul Soup Kitchen to be the point of contact and source of distribution for meals donated to the community.	Lisa Gibney *CWR Compass Manager* Scott Mickelson *Executive Chef Backus* Whitney Bundy *Senior Director Guest Services* Frederick Goodman *Manager of Retail Donations and Partnerships Food Share* Jill Corbin *St. Vincent de Paul Soup Kitchen* Patrick McCormack *Uncas Health District*	**Targets:** #lbs of food shared/monthly # of individuals served/ meals shared/monthly Monthly updates about progress shared with community **Actual**

Objective 2	Provide fresh fruits and vegetables to low-income individuals and families.		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/Partner**	**METRICS/MILESTONES – STATUS**
Access to Healthy, Affordable Food **Enhanced Collaboration with Community Partners**	**Community Based -** **RX for Health Program** provides vouchers for fresh produce to individuals who are in need of nutritional support. Funded by Backus Hospital, vouchers are distributed in various settings such as pediatrician offices, soup kitchens, primary care offices, farmers markets, etc. Backus Hospital collaborates with local community partners to identify families and individuals who would benefit. Vouchers are currently exchanged at the Norwich Farmers' Market, A&S Asian Market, Shop Rite Grocery Store and Backus hospital's farm stands. Backus Hospital dietician provides ongoing nutritional support to families.	Shannon Haynes *Dietician* Michele Brezniak *Community Health RN*	**Targets:** $ vouchers - $9,450 # individuals served - 700 # vouchers distributed – 4,725 Increase the percentage of vouchers redeemed to 75% **Actual**

Focus Area #2: Improve Health Equity, Coordination of Services, and Access to Care			
Objective 1	**To provide, promote, and coordinate resources to train hospital staff to be interpreters. By increasing the number of trained hospital staff interpreters, we will provide linguistically responsive and culturally relevant information to community members accessing health care related services.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/ Partners**	**METRICS/MILESTONES – STATUS**
Multilingual Medical and Mental Health Services **Recruit And Retain Medical and Mental Health Care Staff With DEI Awareness**	**Hospital Based** Gather current HHC system resources surrounding translation services. Recruit HHC staff to be part of a committee to complete this objective, responsibilities will include: Promote current HHC system resources for staff interested in becoming interpreters. Planning for training time, how to fill current hospital job roles when individuals are spending time interpreting. Recruiting and training HHC hospital staff to be interpreters.	Mary Brown *East Region Interpreter Services Manager* Whitney Bundy *Senior Director, Guest Services* HHC DEIB Regional Council Interpreters and Translators Inc. William Gerjes *Regional Director Environmental Services*	**Targets:** Increase number of interpreters *(baseline 3 interpreters 4 languages)* # hours spent interpreting **Milestones:** Accurate inventory of needs and opportunities Committee formation to work on linguistic opportunities **Actual**

Objective 2	**Provide at least 4 free or low cost health clinics a month to individuals in the community in conjunction with community partners from the Eastern CT Health Collaborative to provide wrap around services for individuals in need. This will help to coordinate care between agencies and increase access for individuals while addressing chronic and preventable health conditions.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/ Partners**	**METRICS/MILESTONES – STATUS**
Care Coordination and Support to Help Manage Care for Patients with Complex Health Conditions **Broad-based, integrated services for People and Families Experiencing Homelessness** **Enhanced Collaboration with Community Partners**	**Community Based -** Neighborhood Health Our mobile "CareVans" visit and operate daytime health clinics several times a month at specifically chosen locations. They offer a variety of health services including screenings, mental health counseling, medical referrals, education and support. Neighborhood Health was developed in collaboration with trusted community partners throughout the state. These groups and individuals help determine the health needs and priorities for their residents and communities. These innovative health clinics are adaptable, flexible, and open to feedback to ensure access to needed services and programs. Currently Neighborhood Health functions under the Mobile health Hub model from the Eastern Connecticut Health Collaborative. Within this model "Anchor Agencies" host mobile services and invite collaborative partners to attend thus providing wrap around services (food and nutrition resources, energy assistance, primary care, insurance, legal assistance, etc.) for individuals in the community.	East Region Community Health Dept. HHC Neighborhood Health Eastern CT Health Collaborative Patrick McCormack *Uncas Health District*	**Suggested Targets** **HHC**:/Monthly Volume #56 Medical visits # BH/CH # Immunizations # Infectious Disease tests #8 Days **Suggested Targets** **ECHC**:/Monthly # Individuals served # Events # Services offered # Referrals services connected to geographic reach (zip codes)

			Milestones: Expand the geographic footprint of mobile health (include # of towns) Increase the amount of partners participating in mobile health Continue to explore, expand and evaluate metrics within HHC and ECHCH **Actual**
Objective 3	**To coordinate care between community benefit organizations, Federally Qualified Health Centers and Backus hospital by facilitating, planning, and participating in monthly meetings throughout the year to discuss new services/programs, opportunities for partnership, and barriers to care. By improving interagency communication, we will eliminate roadblocks to health care access and increase utilization of services for individuals in the community.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/ Partners**	**METRICS/MILESTONES – STATUS**
Enhanced Collaboration with Community Partners **Care Coordination and Support to Help Manage Care for Patients with Complex**	**Community Based:** **Activity 1** Become an active partner (Co Chair and members) in the Community Care Team meeting. "Community Care Teams are made up of local hospital staff and community service providers, including mental health and substance abuse treatment providers, community health centers, city social services, faith-based organizations, shelters, and housing agencies, among others. These providers develop a care plan to address the healthcare and social service needs of CCT clients. Hospital	Joseph Zuzel *Regional Director Community Health* Dr. David Wheeler *Regional Manager Psychiatric Emergency Services*	**Activity 1** **Targets:** Build into ED work flow referral mechanism for CCT # of Community Resources connected to ED visit frequency **Milestones:** Enter MOU/BAA with participating Agencies

Health Conditions	EDs can help identify these "frequent visitors." Referrals to CCTs are also made by other community providers. An individual must sign a Release of Information (discussed below) before s/he is presented to a CCT meeting. When someone is presented to the CCT, the CCT team then assesses the person's health and social needs and sets up a plan to connect the individual with community care, housing and support services." *211/tb (June 2022). Community Care Teams (CCT's) and Related Care Coordination for Connecticut's Vulnerable Populations* https://uwc.211ct.org/community-care-teams-ccts-and-related-care-coordination-for-connecticuts-vulnerable-populations/ **Activity 2** Coordinated Clinical Services meeting: Backus Hospital will organize, facilitate and host a monthly meeting between United Children and Family Services, Generations Family health Center and Hartford HealthCare to explore health care access, new services/ programs, and barriers/opportunities for partnership and care coordination.	**HHC** **Rebecca Durham** *Senior Director of Clinical and Operational Integration* **Jonathan Watts** *Regional Director Beh. Health* **Generations** **Judith Gaudet** *Systems Of Care Director* **Sandy Fairbarn** *Director Beh. Health* **Michael Steinmetz** *CMO* **Melissa Meyers** *COO* **UCFS** **Cara Westcott**, *COO* **Ramindra Walia, MD,** CMO **Deberey Hinchey** *VP of Behavioral Health Services* **Norma Glover** *Supervisor of Community Outreach*	Establish Patient Standard – 10 or more ED visits in a 6 month period or 5 or more Ambulance rides to ED in 30 days- Develop standard report- Set targets and evaluate program **Activity 2** **Targets:** # of meetings/yearly and attendance (orgs present) **Milestones:** Create and form clinical services team and set regular monthly meeting cadence Active list of opportunities/coordinated efforts identified **Actual**

Objective 4	**Partner with high schools within the Backus Hospital HSA to provide opportunities for high school students to explore careers and promote interest in the health care industry.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/ Partners**	**METRICS/MILESTONES – STATUS**
Recruit And Retain Medical and Mental Health Care Staff With DEI Awareness	**Community Based:** In order to continue to promote careers in the health care sector and to address the pipeline issue that many students from diverse and underserved backgrounds face when it comes to education and training we will conduct a series health care career events and opportunities within local high schools. -Schools with established certification programs i.e. CNA, EMT, etc. will be given specific focus as partnerships with high schools can lead students to open positions at Backus hospital resolving department staffing needs -Students will have exposure to different career pathways through interactions with department representatives to educate them about specific job roles and responsibilities within a given department. We will approach these interactions through a diversity and equity lens and whenever possible have staff members that can relate culturally to the students with whom they are interacting. -Career path exploration events will occur semiannually. -Periodic engagement opportunities will be conducted throughout the academic year via students participating in job shadow/internship	**Jonathan Chew** *Project Coordinator East Region* Community Health Department DEIB Regional Council Michael Bontempo *VP Human Resources*	**Targets:** # students who take part in internship/job shadow opportunities # Semiannual events for the purpose of health care career exploration and job offers for graduating students # of individuals attending events **Milestones:** -Identify and partner with local area schools solidify stake holders in the community - Explore the opportunity for paid internships - Explore Connecticut Technical Education and Career System's Work Based learning program and how the Hospital could participate. -Advanced planning of events and opportunities and regular communication with schools to increase promotion to students. The goal to have as many

	programs at Backus Hospital and through guest speaking events by department representatives		students as possible take advantage of events and opportunities.

Focus Area #3: Reduce the Burden of Chronic Disease			
Objective 1	**Provide screenings and resources to assist individuals who remain undiagnosed due to lack of regular medical care in places like soup kitchens, housing complexes, mobile health fairs, homeless shelters, and food pantries.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/Partner**	**METRICS/MILESTONES - STATUS**
Additional Programs To Enhance Access to Care For Lower-income Families **Focused Initiatives Addressing Chronic Health Conditions**	**Community Based** **HHC Regional Screenings** is a program designed to meet the underserved members of our community where they are. Multiple hospital departments provide free chronic disease screenings in a variety of environments and locations. During testing, participants will be given education regarding the disease that they have been screened for and how to achieve a "normal" range. Participants will be given information about Primary Care Physicians (PCPs) as well as Urgent Care if needed. Every participant is given a brief health history questionnaire that includes questions such as: current medications, family history of chronic disease, and information about any recent Emergency Room visits.	Joseph Zuzel *Regional Director Community Health* Michele Brezniak *Community Health RN* Frederick Bailey *Regional Director Oncology* Tiffany Rindell *Regional Director Rehab* Nicole Porter *Regional director HVI* Colin McMillan *Regional Director Neuroscience*	Mobilize Hospital departments to identify Type of screening provided, appropriate staffing/training, and frequency through interdepartmental meetings and planning/coordinating sessions. Review licensing protocols for departments to provide screenings within the community Increase in targets would be directly related to staffing and resources by other HHC departments and community benefit organizations **Suggested Target Screenings** A1C/Blood Pressure – see below Melanoma – 1 per year Depression Screenings – in development Limb Preservation – 1 per year

		Jonathan Watts *Regional Director Beh. Health* Sarah Bouchard *Regional Director Women's health* Patrick McCormack *Uncas Health District*	Bone Density - in development COPD/Lung Cancer – 2 per year Stroke Education – 2 per year Breast Screenings – in development **Target: A1C/Blood Pressure** #BP Cuffs distributed 70 # ind. served 80 # no hx with elevated result 48 # Clinics/Events 11 # elevated results 60
Objective 2	**PMT is a tertiary prevention program to identify at risk patients, implement interventions, and establish triple aim goals for experience of care, cost, and population health.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/Partner**	**METRICS/MILESTONES - STATUS**
Care Coordination and Support to Help Manage Care for Patients with Complex Health Conditions **Focused Initiatives Addressing Chronic Health Conditions**	**Hospital- Based** Preventive Medicine Team – • Identify at-risk patients and enroll in Preventive Medicine registry • Personal interview and in-depth clinical and psychosocial assessment ➢ Identify and address social determinants of health (SDOH) ➢ Complete depression screening (PHQ-2/PHQ-9) ➢ Assess self management abilities ➢ Solicit patient, family, and caregiver engagement and understanding of current health status and goals of care ➢ Review and/or educate on Advance Directives	Barbara Sinko *Social Worker Preventive Medicine* Lisa DeCarlo *APRN Preventative Medicine*	**Target:** # Number of PHQ2 completed # Number PHQ9 completed based on Positive PHQ2 screens # Number of Community Referrals made # Number of Behavioral Health Referrals made # Number of patients identified with cognitive impairment (subsequently set up with appropriate services) # Number of home visits

	➢ Complete intensive medication reconciliation and thorough review of medical history • Develop personalized Transitional Care Guide • Update problem list/medical history in EMR • Educate on chronic disease states • Coordinate transitions with community medical providers and partners • Follow up with patient after discharge (phone calls and home visits as needed)		# Number of telehealth visits # Number of Medication Bridging Completed #Collaborate with Community Agencies for Community Health Worker #Advocate for expansion of program through HHC system #Increase collaboration with FQHCs by identifying single point of contact for high risk patients to enhance coordination of care

Focus Area #4: Enhance Community-Based Behavioral Health Services			
Objective 2	**Provide mental health screenings, resources and access to care at all neighborhood health events. These events are presented to the community through the mobile health hub initiative through the Eastern CT Health Collaborative which helps to coordinate care between agencies and increase access for individuals while addressing chronic and preventable health conditions.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES - STATUS**
Coordinated Efforts Between Larger Health Systems And Community-Based Health Services To Care For People With More Complicated Medical Needs **Enhanced Collaboration with Community Partners** **Outpatient Mental Health**	**Community Based -** Neighborhood Health Our mobile "CareVans" visit and operate daytime health clinics several times a month at specifically chosen locations. They offer a variety of health services including screenings, mental health counseling, medical referrals, education and support. Neighborhood Health was developed in collaboration with trusted community partners throughout the state. These groups and individuals helped determine the health needs and priorities for their residents and communities. These innovative health clinics will be adaptable, flexible, and open to feedback to ensure access to needed services and programs. Currently Neighborhood Health functions under the Mobile health Hub model from the Eastern Connecticut Health Collaborative. Within this model Anchor agencies host mobile services and invite collaborative partners to attend thus providing wrap around services (food and nutrition resources, energy assistance, primary care, insurance, legal assistance, etc.) for individuals in the community. Mental Health staff and resources is a service that is needed but not always available through these events. By	Community Health Dept. HHC Neighborhood Health Katherine McNulty *Regional Director of Development* Sherry Smardon *Manager of Philanthropy and Community Benefits* Eastern CT Health Collaborative	**Targets:** # of screenings for depression and anxiety # of individuals served # of events # of referrals for access to care **Milestones** Develop a referral process for behavioral health supports at all East Region Neighborhood health events

Services Capacity for Adults, Adolescents, and Children – Including in-home and caregiver support	partnering with Natchaug Hospital we will be able to have a behavioral health clinical professional present and able to connect to services for the community.		
Objective 3	**Utilize hospital resources to provide support and resources for community based mental health and substance use focused support groups.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES - STATUS**
Outpatient Mental Health Services Capacity for Adults, Adolescents, and Children – Including in-home and caregiver support **Enhanced Collaboration with Community Partners**	**Hospital- Based** Collaborate and partner with local community agencies to offer support groups for the community at Backus Hospital and other Backus hospital sites. Natchaug Hospital will identify active mental health and substance use support groups in the community looking for resources and a brick and mortar location. The Community Health department will utilize physical spaces and assist in coordinating and advertising, resources, contacts, and availability in order to bring support to the community.	Community Health Dept. Katherine McNulty *Regional Director of Development* Sherry Smardon *Manager of Philanthropy and Community Benefits*	**Target -** 2 active support groups, meeting consistently at Backus Hospital or a Backus hospital supported location # individuals served **Milestones:** Develop a referral process for behavioral health supports to be utilized by support group facilitators and community agencies.