Community Health Improvement Plan

Hartford HealthCare
MidState Medical Center

Hartford HealthCare
The Hospital of Central Connecticut

2022 - 2025

Introduction

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 2022 Community Health Needs Assessment ("CHNA") for **MidState Medical Center and The Hospital of Central CT**, part of Hartford HealthCare's (HHC) **Central 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 (SDoH) such as poverty, housing, transportation, education, fresh food availability, and neighborhood safety and contains an "Equity Profile."

As community health leaders, Central Region hospitals consider this Community Health Improvement Plan (CHIP) 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 achieve success. These inter-sectoral relationships will assure effective and productive initiatives.

The Central Region maintains robust relationships with community-based organizations, as well as the business community, government, faith communities, key groups and individuals, as well as collaborative networks and is always seeking ways to build additional relationships.

The Central Region hospitals are committed to addressing these disparities and inequities through its **Community Health Improvement Plan (CHIP).**

The intent of our CHIP:

- 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.

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."

> **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.

Impact Areas

This CHIP is organized across **three** focus areas to address root causes of community health issues recognizing where the Central 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.

- **Addressing behavioral health and substance abuse**
- **Healthy lifestyle development and chronic disease management**
- **Improve health equity/Access to care/Social Determinants of Health**

Enhance Community 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. We propose to implement services and interventions to include more accessible screening, improved and timelier referrals, expanded programming and public awareness and empowerment.

Rationale for Action

- Substance abuse
- Identified behavioral health needs

Initiatives Proposed:

- Increase community care team participation with community-based organizations meeting together under central region leadership to identify other needs of those who have frequent visits to the emergency department and to link them to additional services. This initiative will focus on increasing the consistent participation of community-based organizations.

- With Rushford (pending funding), increase youth and family outreach and education and expand exposure of the training opportunities for use of Narcan. (MidState)

  - Rushford continue outreach and education documents for distribution through e-blasts and other community distribution

- Continue integration of recovery support specialists

- Continue expanded low barrier access for medical assisted treatment in the community with Rushford and New Britain Recovers

- Expand collaboration with New Britain Police Department/New Britain Recovers for outpatient services

- Promote new 9-8-8 hotline in conjunction with the Meriden Health Department (pamphlets, magnets, social media blasts)

- Expanding mobile crisis availability for ages 18 & over (Meriden/Wallingford)

- Increase access of medical detox and residential treatment beds. New program "The Ridge" will double current capacity.

Promote Healthy Lifestyles and Behaviors/Address Chronic Disease

Research shows 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, and diabetes.

Rationale for Action

- Rates of obesity
- Managing chronic disease: diabetes, heart disease, cancer

Initiatives proposed:

- **Cancer: mammography/screenings/education—for targeted (BIPOC, men, women) communities**
  - Increase Number of screening mammograms completed in the community.
  - Increase number of screening breast ultrasounds completed in the community
  - Increase number of patients screened for hereditary cancer risk through radiology
- **Education programs/screenings with community groups, such as YMCAs and health departments, addressing diabetes, heart health, and cancer, including colo-rectal and prostate cancers**
  - Support and promotion of these programs

- **Promote 5-2-1-0 in conjunction with YMCAs, early childhood organizations, school systems for youth/families**
  - Target roll-out pilot in Southington in conjunction with Early Childhood Collaborative. Identify other possible partners.
- **Promote greater collaborative projects with Community Health Centers**
- **Promote use of healthy food donation list to the business community and faith communities to increase donations of healthy foods to food banks**
  - Distribution and suggested ways to highlight donations of healthy food to pantries by increasing the involvement/support of Chambers of Commerce and faith communities in all towns.
- **Update/create food pantry distribution calendars for each community in region**
  - Inventory existing community calendars: New Britain, Meriden, others
  - Identify how to organize in other communities
- **Promote use of community trails, parks, facilities for exercise**
- **Increase number of physician education presentations as well as community participation rates**
- **Maintain bi-weekly e-blasts to community partners on identified health topics and education**
- **Collaborate with HHC neighborhood health initiative to address health education, screenings, referrals**
  - When the initiative is ready for roll out in central region, sync our action plan with HHC plan for targeting neighborhoods
  - Initial focus at Spanish Community of Wallingford/Meriden (MidState)
  - Initial focus at Friendship Service Center (New Britain) (THOCC)

- **Direct sponsorships of events with healthy lifestyle development-focus**

Improve Health Equity/Social Determinants of Health/Access to and Coordination of Care and Services

There are many factors that shape health outcomes, including obstacles related to accessing care and services, awareness of available resources, and tracking patients as they move to and from points of care. More systemically, racial and economic inequities and other unfavorable environmental conditions provide powerful influencers in limiting individuals and communities from reaching their health potential. A focus on racial equity is an over-arching tenet to all of our community work.

Rationale for Action

- Community feedback that noted systemic racism and lack of trust in the healthcare system among minority populations
- Language barriers for Latinos and Asians
- Increasing Arabic-speaking populations in New Britain
- Racial and ethnic health and economic disparities, associated with systemic racism and language barriers.

Improve health equity/Access to care/Social Determinants of Health

Expand collaborative relationships and foster more opportunity for cross referrals and relationship-building

- **Expand faith community participation in health events**
- **Promote availability of "Connections that Matter" to faith communities**
    - Identify HHC plans for the program
- **Expand "Connections that Matter": encourage community-based organizations (CBOs) to continually update resource listings and hardwire process for use by HHC providers**

    - Develop outreach plan for CBOs to present opportunity for client use of the platform + reminders for the CBOs to update their program information
- **New Britain YWCA and THOCC Family Enrichment Center**: outreach/home visitation program for Arabic-speaking families referring for identified needs.
- With **THOCC Family Enrichment Center**, support DPH-funded "Specialized Supports for Teens" to work on efforts to prevent teen pregnancy and intervene with supports for healthy birth outcomes. The Center also has Office of Early Childhood funding to engage families (all ages) with priority on teens in home-based education.
- **Expand racial justice initiatives to address systemic racism with focus on social determinants of health (SDoH)**
    - Meriden, New Britain, Wallingford, Plainville
    - Identify other communities and status of initiatives
- **Expand collaborative relationships with United Ways and school systems to focus on workforce development**
    - Meriden—collaborative project workforce development
    - New Britain—Healthcare Academy with New Britain H.S.

Community Partnerships

- Health Ministry Partnership with faith communities
- Community Provider Networks in Meriden, Wallingford, Southington, Cheshire, Bristol, New Britain/Berlin, Plainville
- Chambers of Commerce: Meriden, New Britain, Central CT, Quinnipiac/Greater New Haven, Waterbury, Southington, Middletown, Cheshire, Prospect
- United Ways: Meriden/Wallingford, Southington, UW of Central and NE CT, UW of Western CT

- Community Health Centers: Meriden and New Britain
- Neighborhood associations/revitalization zones (Meriden and New Britain)
- Community Actions programs: HRA in New Britain/Bristol; New Opportunities of Greater Meriden
- Health Departments and Health Districts: Meriden, Southington/Plainville, Bristol, New Britain, Cheshire, Wallingford, Berlin/Newington
- YMCAs: Meriden/Berlin/New Britain; Southington/Cheshire; Wallingford; Plainville
- Other community-based organizations: New Britain YWCA, libraries, senior centers

Measuring success

The evaluation of progress can be done in a variety of ways, including participation and what participants have learned. But, in the scheme of things, the impact of community health improvement plans may take more of a longitudinal approach. While lifestyles and habits may change at the present time, the effect and impact of these changes may not be seen for many years. However, in the interest of measuring specific initiatives, the following dashboards have been created for each hospital.

Hospital of Central CT Objective	Metric	FY 22 Baseline	FY 23 Target/Milestone	YTD Actual	YTD Target Status	
Initiative #1: Enhance Community Behavioral Health Services						
Increase community care team participation	# of participating community partners	5	8			
Increase referrals to recovery coaches	Increase referrals by 10%	400	440			
Expand collaboration with New Britain Police Department/ New Britain Recovers for outpatient services	# of diverted referrals from ED to OP Services by NB Recovers	No data	10 Diversions			
Collaborate with CCSU for Behavioral Health screenings	TBD	FY23 Initiative	No Data			

Outreach & Education	Promote new 9-8-8 hotline in conjunction with the Health Departments & other community based organizations (pamphlets, magnets, social media blasts)	No Data	Phase 1: targeted dissemination to the following audiences: • Consumers and the general public • Healthcare Professionals • Other stakeholders (e.g. local government authorities, industry bodies, policymakers, businesses, non-profits)			
Initiative #2: Promote Healthy Lifestyles and Behaviors/Address Chronic Disease						
Increase number of screening mammograms completed in the community	Mammo Volume	18,445	18,814			
Increase number of screening breast ultrasounds completed in the community	Breast Ultrasound Volume	5,793	5,909			

Increase number of patients screened for hereditary cancer risk through radiology	# of patients actually screened	400	408			
Support Community education programs/screenings	Increase community education health talks per month (taking into consideration institute input, schedules, etc.)	6 talks/ screenings	9 talks/screenings			
Collaborate with HHC neighborhood health initiative to address health education, screenings, referrals	Initial focus at Friendship Service Center (New Britain) (THOCC)	TBD	#8 Clinics per month #56 Medical visits per month #4 Education events			
Gain Level III Trauma Status	Injury Prevention Education	FY23 Initiative	No Data			

Initiative # 3: • Improve health equity/Access to care/SDoH						
Expand faith community participation in health events	Align with Neighborhood Health initiatives	0	5			
Expand racial justice initiatives	Identify current initiatives and expand community conversations with partners	2	4			
With New Britain YWCA and THOCC Family Enrichment Center: Outreach/home visitation program for Arabic-speaking families referring for identified needs	Increase Enrollment of prenatal moms by 5%	15	18			
With THOCC Family Enrichment Center - Support DPH-funded "Specialized Supports for Teens" to work on efforts to prevent teen	Increase School enrollment by 5%	51% not enrolled	56% Enrolled			

pregnancy and intervene with supports for healthy birth outcomes. The Center also has Office of Early Childhood funding to engage families (all ages) with priority on teens in home-based education						

MidState Medical Center Objective	Metric	FY 22 Baseline	FY 23 Target Milestone	YTD Actual	YTD Target Status	
Initiative #1: Enhance Community Behavioral Health Services						
Increase community care team participation	# of participating community partners	5	7			
Increase referrals to recovery coaches	Increase referrals by 10%	281	310			
Continue youth and family outreach and education.	Promote new 9-8-8 hotline in conjunction with the Health Departments & other community based organizations (pamphlets, magnets, social media blasts)	No Data	Phase 1: targeted dissemination to the following audiences: • Consumers and the general public • Healthcare Professionals • Other stakeholders			

			(e.g. local government authorities, industry bodies, policymakers, businesses, non-profits)			
With Rushford:	Increase access of medical detox and residential treatment beds. New program "The Ridge" will double current capacity)	2,219	FY 23 Initiative			
With Rushford:	Expand mobile crisis availability for ages 18 & over (Meriden/Wallingford)	40 hrs/week	24-hour coverage			
Initiative #2: Promote Healthy Lifestyles and Behaviors/Address Chronic Disease						
Increase number of screening mammograms completed in the community	Mammo Volume	15,139	15,442			

Increase number of screening breast ultrasounds completed in the community	Breast Ultrasound Volume	5,085	5,187			
Increase number of patients screened for hereditary cancer risk through radiology	# of patients actually screened	629	642			
Support community education/screening	Increase community education health talks per month (taking into consideration institute input, schedules, etc.)	6 talks/ screenings	9 talks/ screenings			
Collaborate with HHC neighborhood health initiative to address health education, screenings, referrals	Initial focus at Spanish Community of Wallingford/Meriden (MidState)	TBD	#8 Clinics per month #56 Medical visits per month #4 Education events			
Initiative # 3: Improve health equity/Access to care/SDoH						

Expand faith community participation in health events	Align with Neighborhood Health initiatives	1	5			
Expand racial justice initiatives	Identify current initiatives and expand community conversations with partners	2	3			