Hartford HealthCare
Natchaug Hospital

Community Health Improvement Plan
2022 - 2025

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INTRODUCTION

"For he who has health has hope; and he who has hope, has everything." Owen Arthur

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 **Natchaug** (or the "Hospital"), part of Hartford HealthCare's (HHC) **Behavioral Health Network**, 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 2021 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 **Natchaug** 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 **Behavioral Health Network** 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 (reference CHNA)

- Enhanced Collaboration with Community Partners
- Substance Use Disorder…early intervention
- Substance Use Disorder education

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 (reference CHNA)

- Suicide Prevention
- Mental Health Services for Adolescents and Their Families
- Access to care
- Recruit and Retain Medical and Mental Health Care Staff with DEI Awareness

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3. Improve the Coordination of Services and Access to Care

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 (reference CHNA)
- Substance Use Disorder…treatment services
- Multilingual Medical and Mental Health Services
- Broad-based, integrated services – Medical, Mental Health, Substance Use Disorder, SDoH – for People and Families Experiencing Homelessness

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 (reference CHNA)
- Counseling and other behavioral health services
- Services for people with disabilities
- Substance Use Disorder Crisis Care and Treatment

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 diagram below represents some of the key categories of community stakeholders.

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. **Natchaug works with multiple community partners including ECSU, UConn, Access Agency, Perception Programs, local first responders, Generations, Community Health Center, the Windham Senior Center, Three Rivers Community College, the local chambers of commerce, CHR, United Services, and many others.**

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Strategy #1: Promote Healthy Behaviors and Lifestyles

CHNA IDENTIFIED OBJECTIVE	STRATEGIES/TIMELINE	LEAD	PARTNERS	METRICS/MILESTONES
Increase access to steady, healthy food supply	• Ensure clients in need of food are able to access pantry resources • Ensure community members are aware of the availability of food resources at the pantry • Provide basic nutritional guidance to those in need of information	Kate	BH Clinical SUD Clinical Operations Council	**Target** • Move 12,000 pounds of food annually • Provide fliers in the community encouraging persons in need to visit the pantry on open days or by appointment
Increase knowledge around the importance of proper use and disposal of prescription medications and the dangers of using illegal substances	• Provide information to clients and the community on the risks of misusing prescriptions and substances • Act as a source of information and assist with referrals to care as needed	Sherry	SUD Clinical Community Partners	**Target** • Provide four information sessions, virtually or in person, to the community on prevention of substance use/abuse • Provide mechanism for proper disposal of medications in tandem with an interested community partner
Increase knowledge around the dangers of alcohol abuse	• Provide information to the community on the risks of excessive alcohol consumption • Provide online self-assessment tool for community members to detect alcohol misuse • Act as a source of information and assist with referrals to care as needed	Kate	SUD Clinical Medical Director Community Partners	**Target** • Provide two information sessions, virtually or in person, to the community on excessive alcohol use • Provide online self-assessment tool and track number of users per year • Provide presentations targeting high school students – invite community partners to participate

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Strategy #2: Improve Health Equity, Coordination of Services, and Access to Care

CHNA IDENTIFIED OBJECTIVE	STRATEGIES/TIMELINE	LEAD	PARTNERS	METRICS/MILESTONES
Provide Narcan™ kits and training on how to dispense the drug	• Provide Narcan™ kits and training opportunities to first responders in the Natchaug CSA • Provide Narcan™ kits to clients and client families/friends as appropriate • Provide online resources to learn how to dispense Narcan™ and identify an opioid related overdose	Kate	**Pharmacy SUD Clinical Medical Director**	**Target** • Provide 200 Narcan™ kits to the community annually • Create educational video on how to dispense the product and offer it online • Provide Narcan™ kit to each interested clients and to interested friends/family • Provide information to clients and their friends/family regarding how to dispense the product
Develop materials related to treatment and/or services options in multiple languages	• Provide materials for use in the community and internally with patients in multiple languages • Ensure Google Translate™ is available on the Natchaug website • Ensure staff are knowledgeable about translation services and able to access materials in multiple languages for clients	Sherry	**Medical Director Marketing iTi** *(Translation Provider)*	**Target** • Work with marketing to identify appropriate materials for printing in multiple languages • Work with website vendor to install Google Translate™ on the Natchaug homepage • Regularly remind staff of the availability of translated materials (minimally twice annually)
Offer closed caption translation of presentations available online	• Provide closed captioning in multiple languages • Work with staff and community to identify which languages to include	Kate	**Medical Director Natchaug Clinical iTi**	**Target** • Have a minimum of two videos available with closed captioning in at least one language • Work with staff to prioritize translation calendar

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Strategy #3: Reduce the Burden of Chronic Disease				
CHNA IDENTIFIED OBJECTIVE	**STRATEGIES/TIMELINE**	**LEAD**	**PARTNERS**	**METRICS/MILESTONES**
Provide information on suicide prevention strategies	• Perform caring connection calls for patients leaving the inpatient milieu • Create and deploy materials to communities related to suicide prevention • Provide support to individuals seeking assistance with suicidal ideation	Sherry	Zero Suicide Committee BH Clinical Marketing	**Target** • Attend community health events or visit public schools to deploy information regarding suicide prevention • Provide recorded, continually available online presentations offering information on suicide prevention and how to access services
Provide resources in the community to help identify behavioral health issues and provide support accessing services at the appropriate level of care	• Ensure staff are aware of resources • Provide information to the community on what depression is and how to access services • Act as a referral source for treatment and/or services for depression	Kate	Natchaug Clinical	**Target** • Target wider population (college campuses/young adults) • Provide continually available online presentations on behavioral health care topics • Develop anti-stigma materials or presentations for community groups to participate in

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Strategy #4: Enhance Community-Based Behavioral Health Services

CHNA IDENTIFIED OBJECTIVE	STRATEGIES/ACTION STEPS	LEAD	PARTNERS	METRICS/MILESTONES
Ensure clients and the community are able to connect as peers	• Offer information on support groups and provide space for groups to meet	Kate	Natchaug Development Council SUD Clinical	**Target** • Provide physical space for behavioral health support groups to meet • Assist in coordination of space for groups • Assist in marketing the availability of groups • Identify behavioral health support groups in need of space and coordinate with Backus Hospital to refer groups and pinpoint ideal locales for meetings
Provide mental health screenings and resources through the mobile health hub initiative through the Eastern CT Health Collaborative	• Offer depression screenings to interested persons • Ensure community awareness of around in-person resources at Natchaug outpatient sites	Sherry	Natchaug Clinical Dr. Vargas	**Target** • Attend four Neighborhood Health events with the "CareVans" to provide depression screenings and other behavioral screenings as possible • Provide access to Narcan™ kits at events as possible • Develop a referral process for persons with needs outside Natchaug's scope

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