Community Health Improvement Plan

Hartford HealthCare

St. Vincent's Medical Center

2022 - 2025

INTRODUCTION

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

Background

Health assessments help us to:

- 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 St. Vincent's Medical Center (St. Vincent's), part of Hartford HealthCare's (HHC) Fairfield 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 (HSA). The HSA for the CHIP will be referred to as the Greater Bridgeport Region (GBR), which includes the following seven towns: Bridgeport, Easton, Fairfield, Milford, Monroe, Stratford and Trumbull.

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. 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 St. Vincent's Medical Center are committed to addressing these disparities and inequities through its Community Health Improvement Plan (CHIP).

Our CHIP intends to:

- Be responsive to community needs and expectations.
- Create a plan that effectively leverages the best of HHC system resources, regional hospital and network resources, and community partners.
- Support HHC's mission "to improve the health and healing of the people and communities we serve."
- Help realize HHC's vision to be "most trusted for personalized coordinated care."
- Intentionally embed our shared value of Equity into this work, which reminds us all to do the just thing.

While a CHIP addresses multiple needs, health systems and hospitals must narrow the focus to the key areas they are best positioned to address. A CHIP is a dynamic plan that requires modification and adjustment in response to external environmental factors, including market conditions, availability of community resources, public health emergencies, and engagement from community partners. Furthermore, a CHIP should build on and leverage prior success while simultaneously adjusting strategies and actions in response to obstacles.

Focus Areas

This CHIP is organized across four focus areas that are intended to address root causes of community health issues, while recognizing where the Fairfield Region - in partnership with the community – can most effectively effect change. The plan for each of these areas is outlined on the following pages, while the rationales for action are summarized below. Please note that data is for GBR unless otherwise noted.

1. Reduce the Burden of Chronic Disease, and Promote Healthy Behaviors and Lifestyles

Proven interventions can prevent and reduce the effects of chronic and infectious diseases and are aimed at the most common health conditions revealed by the CHNA – high blood pressure, asthma, diabetes – and these conditions can be countered by proven specific interventions as highlighted by the CDC. Empowering patients to learn how to control and prevent chronic disease also decreases the burden of paying for expensive treatment for advanced disease, which can affect their overall financial stability.

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
➢ **20%** of people have been told by a doctor or health professional that they have asthma
➢ **31%** have been told by a doctor or a health professional that they have high blood pressure or hypertension
➢ **10%** have been told by a doctor or a health professional that they have diabetes
➢ **32%** are experiencing obesity (44% in Bridgeport)

Rationale for Action
➢ **19%** never exercise (26% in Bridgeport)
➢ **17%** received food from emergency services during the pandemic
➢ **29%** cited low availability of high-quality fruits and vegetables
➢ **11.5%** live below the poverty level (22% in Bridgeport)
➢ **32%** experiencing financial difficulties or are just getting by (48% in Bridgeport)
➢ **15%** still in debt if sold everything to pay off debts

2. Improve 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
➢ **19%** of people do not have one person or place they think of as their personal doctor or health care provider
➢ **13%** report that when seeking health care, they have been treated with less respect or received services that were not as good as what other people get
➢ **30%** reported the last time they were seen by a dentist was never or more than 1 year
➢ **33%** report that they have stayed home from a doctor's appointment or a visit to a health care provider because of no access to reliable transportation
➢ **29%** of adults put off or postponed getting medical care they needed in the past 12 months
➢ **11.5%** live below the poverty level (22% in Bridgeport)
➢ **32%** experiencing financial difficulties or are just getting by (48% in Bridgeport)
➢ **15%** still in debt if sold everything to pay off debts

3. Enhance 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 screening that is more accessible, improved, and timelier referrals, expanded programming and public awareness and empowerment.

Rationale for Action
➢ **10.4%** of visits to St. Vincent's and Bridgeport Hospital were for anxiety disorders and 7.2% for depressive disorders
➢ **34%** of people in the Greater Bridgeport Area report that they have experienced feeling down, depressed, or hopeless in the past two weeks
➢ Only **62%** of people in the Greater Bridgeport Area said that they "always" or "usually" get the social and emotional support they need
➢ Roughly **33%** of adults across all demographic groups personally know someone struggling with opiate addiction
➢ Mental health and addiction services is one of the top most requested services through the 211 Referral System.
➢ Community members prioritized mental health and drug/alcohol use as priorities in their neighborhoods.

4. Strengthen Communities and Families (Child Wellbeing)

The wellbeing of a community's children reflects the viability of that community. By providing supports for families that strengthen parenting skills, making resources more accessible, and providing neonatal and post-partum care for parents and infants, children and families will become more resilient.

Rationale for Action
➢ The City of Bridgeport has lower rates of early prenatal care and higher infant mortality rates than the rest of GBR and the state of CT.
➢ The City of Bridgeport has a **76%** high school graduation rate.
➢ Only **27.2%** of infants and toddlers in GBR are enrolled in high quality early care and education.

The Call to Action

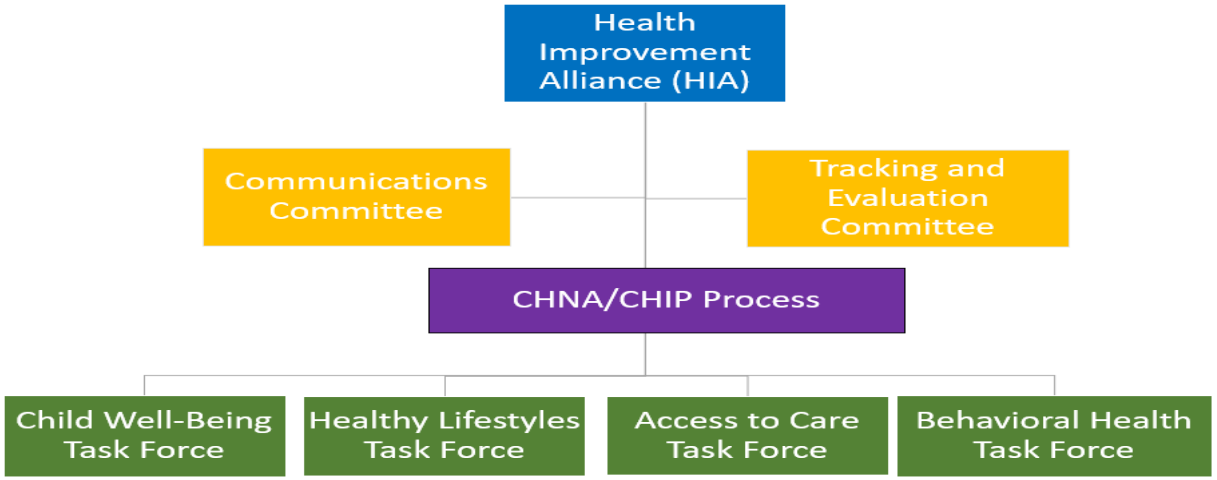
As community health leaders, this CHIP is our call to action over the next three years to do our part to assure those we serve live long and healthy lives. Community partnerships will continue to be key to achieving success. This plan aims to further develop our active engagement with the community. 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. St. Vincent's Medical Center co-leads one of the most successful health-focused coalitions in the State of Connecticut.

The Health Improvement Alliance of Greater Bridgeport (HIA)

HIA is a coalition led by St. Vincent's Medical Center and Bridgeport Hospital, along with the seven departments of public health, two federally qualified health centers, and about 50 community and non-profit organizations all serving the Greater Bridgeport Region. The core group meets monthly and consists of:

- Co-chairs from St. Vincent's and Bridgeport Hospital;
- The team leaders from each task force;
- Other leaders from both St. Vincent's and Bridgeport Hospital;
- Health directors and staff from the departments of health of Bridgeport, Fairfield, Milford, Monroe, Trumbull, Stratford, and Aspetuck (Easton);
- Leaders from Optimus Healthcare, Southwest Community Health Center, AmeriCares Free Clinic of Bridgeport, LLC; and
- Decision makers from other partner agencies.

HIA also oversees four task forces that work to address the health priorities identified through the Community Health Needs Assessment (CHNA). These task forces consist of representatives from partner organizations, as well as others interested in improving the health of the community through collaboration. Each task force also meets monthly, working to ensure their specific Community Health Improvement Plan (CHIP) goals are met and progress is tracked.



HIA Success Factors

Several factors have contributed to the success of this long-running coalition:

- **Regularly scheduled monthly meetings with decision makers of our partner organizations at the table.** This regular interaction, around a shared mission, ensure the work of the four task forces are a top priority for each organization involved and keep all of our partners engaged in the work.
- **Sharing resources and connections.** At a time when many organizations are facing budget constraints, the sharing of resources is now more important than ever.
- **CHNA and CHIP.** Our collective mission ties directly to the CHNA/CHIP process that hospitals, health departments and federally qualified health centers are required to complete. All partners have a stake in the work, which encourages engagement.
- **Backbone organizations of St. Vincent's Medical Center and Bridgeport Hospital.** Senior leaders from both lead organizations co-chair HIA and convene the monthly meetings. Both hospitals dedicate staff time to the work of HIA, the task forces and the CHNA process. In addition, both hospitals provide a facilitator and a back-up to support meetings, projects and track progress against CHIP goals.

Priority Area #1: Reduce the Burden of Chronic Disease, and Promote Healthy Behaviors and Lifestyles *(Healthy Lifestyles)*			
Goal: Work towards equitable life expectancy by providing access to resources which help residents learn and develop healthy habits.			
Healthy CT 2025 SHIP Goal: Achieve equitable life expectancy by ensuring Greater Bridgeport residents have access to the health supporting resources they need.			
OBJECTIVE	**STRATEGIES**	**LEAD**	**METRICS/MILESTONES – STATUS**
Continue leading and providing support for the Health Improvement Alliance (HIA)	• Provide leadership and in-kind support to HIA and HIA Healthy Lifestyles Task Force • Staff person/RN serves as co-chair of Healthy Lifestyles Task Force • Collaborate with HIA partners to deliver Healthy Lifestyle events and activities throughout the region	•Bill Hoey •Marilyn Faber •Edna Borchetta - Mission Services - Parish Nurse - Community Impact	• # of staff hours committed to preparation of and participation in meetings • HIA CHIP Progress
Improve health outcomes across the region, focusing on at-risk and vulnerable populations with high rates of chronic disease	• Explore options for expanding preventative screening services for the community • Provide education and increase awareness of disease prevention and available resources • Educate community on blood pressure and diabetes control, particularly in priority zip codes • Identify and address social determinants of health (SDOH) • Leverage existing and foster new partnerships in underserved communities • Continue funding and supporting Medical Mission at Home	•Mission Services/Community Impact/Parish Nurse/CHWs •Cross-functional and multi-disciplinary	• # of new screening services offered and # persons served • # of new partnerships • # of SDOH screenings conducted by CHWs and # of SDOH addressed • # of provider hours • Pre- and post-assessments • DataHaven survey – diabetes, CVD, hypertension, obesity, SDOH
Know Your Numbers (KYN) program and related screenings in the Greater Bridgeport region Threshold = 10 Target = 25	• Expand KYN screenings where feasible, leveraging community-based organizations • Partner with Community Health Workers (CHW) to link KYN participants to follow-up care • Continue A1C and blood pressure screenings and distribution of free blood pressure cuffs for those with hypertension • Leverage existing education programs from reliable sources to share with community members	•Mission Services/Community Impact/Parish Nurse/CHWs •Neighborhood Health	• # persons served • # referrals to PCPs/specialists • # cuffs distributed • # of events • # of referrals to follow-up care • Pre- and post-assessments • DataHaven survey – diabetes, CVD, hypertension, obesity, SDOH
Increase access to healthy food through programming and awareness-building	• Support and expand partnership with Bridgeport Farmer's Market collaborative • Continue to fund and distribute Bridgeport Bucks coupons • Partner with the CT Foodshare Mobile Pantry • Leverage CHW pilot program to provide food resources to those in need for the duration of program • Seek to expand existing and coordinate new programs that address access to healthy food (e.g., HHC Waste Not program) • Leverage existing programs and communication vehicles/channels to provide nutrition education • Increase awareness of access points where community members can obtain affordable, healthy, and nutritious food	•Mission Services/Community Impact/Parish Nurse/CHWs	• BFMC market growth • $ of coupons funded • # of persons served via food pantry • # of persons connected to food resources • # of nutrition education events; social media engagement metrics • # of referrals to food sources • DataHaven survey
Pursue funding opportunities to support programming and initiatives	• Grow the St. Vincent's Mission Fund in partnership with the philanthropy team • Pursue grants to support work	•Mission Services •Philanthropy Team	• # and $ Private donations • # of grants awarded • $ grants

Priority Area #2: Improve Access to Care *(Access to Care)*			
Goal: Identify barriers and change processes to ensure equitable access to health care and community-based services.			
Healthy CT 2025 SHIP Goal: Ensure all Connecticut residents have knowledge of, and suitable access to, affordable, comprehensive, appropriate, quality health care.			
OBJECTIVE	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES – STATUS**
Continue leading and providing support for the Health Improvement Alliance (HIA)	• Provide leadership and in-kind support to HIA and HIA Access to Care Task Force • Continue membership with Access to Care Task Force • Collaborate with HIA partners to implement and promote programs for historically underserved communities	• Bill Hoey • Edna Borchetta - Mission Services - Community Impact	• # of staff hours committed to preparation of and participation in meetings • HIA CHIP Progress • # of events
Build capacity by developing the medical workforce along the educational continuum	• Continue funding the Graduate Medical Education Program • Resume education/tour/mentor programs for High School students and develop new relationships to expand school-to-work pipeline • Host medical education sessions in-person and via zoom (e.g., Stop the Bleed) • Continue and seek to expand Nurse Residency Program	• Graduate Medical Education Nursing Education • Mission Services • EMS/Trauma Coordinators	• # of partner high schools • # of partner colleges/univ. • # of students who complete programs • Pre- and post- assessments • Student and partner feedback • # of new nurses hired and retention rates over time
Increase the percentage of community members who report having a primary care provider/medical home	• Increase referrals to primary care providers including Federally Qualified Health Centers (e.g., Southwest, Optimus Healthcare, etc.) and free clinics (e.g., Americares, etc.) • Educate the community about the importance of having a medical home and the importance of dental care, particularly in the young adult population • Produce and distribute resources promoting available medical and dental services in the region	• CHW Pilot Program • ED	• # of referrals • # of persons served • # of resources, places shared and engagement metrics (downloads, likes, copies distributed, etc.) • # of ED visits avoided • DataHaven metrics
Continue to promote continuity of care for patients	• Continue with primary care clinics in collaboration with Southwest Community Health Center, staffed by internal medicine residents • Leverage CHWs through our program and HIA • Continue funding and supporting Medical Mission at home	• Graduate Medical Education • Mission Services • Philanthropy	• # of patients served • Funds raised for Medical Mission • Medical Mission dashboard metrics
Increase access to care providers in multiple settings	• Identify gaps in specialty care access for Medicaid and collaborate with specialty care providers to increase the number of providers who accept Medicaid and uninsured patients • Continue specialty care clinics • Continue to fund and operate the Hope Charitable Pharmacy of Greater Bridgeport • Continue leading the St. Vincent's Parish Nurse Program serving Fairfield County • Leverage Neighborhood Health Initiative to bring care to communities in need	• HHCMG • Mission Services • Pharmacy • Parish Nurse	• % increase in Medicaid providers • % or # increase in access points • # of persons served • # of prescriptions dispensed • Retail value of prescriptions • Parish Nurse program metrics • NHI – 4 clinics/month, target 28 people per clinic; 2 health education events or health fairs

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OBJECTIVE	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES – STATUS**
Address Social Determinants of Health to improve health equity	• Continue the CHW Pilot Program and consider operationalizing upon completion of grant funding • Increase utilization and implementation of Culturally and Linguistically Appropriate Services (CLAS) standards • Create a welcoming service delivery setting that honors diversity and reflects the community we serve • Continue to work with partners to improve access to reliable medical transportation • Continue providing food resources to those in need • Connect patients with community resources	• Mission Services • CHW Pilot Program	• CLAS Assessments – target assessing five standards per year • # of SDOH screenings, identified needs vs. addressed • PX metrics • DataHaven metrics • # referrals to outside service providers
Pursue funding opportunities to support programming and initiatives	• Grow the St. Vincent's Mission Fund in partnership with the philanthropy team • Pursue grants to support work	• Mission Services • Philanthropy Team	• # and $ Private donations • # of grants awarded • $ grants

Priority Area #3: Enhance Behavioral Health Services *(Behavioral Health)*			
Goal: Every resident in Greater Bridgeport has equitable access to behavioral health services and resources available to build resiliency.			
Healthy CT 2025 SHIP GOAL: Ensure community strength, safety, and resiliency by providing equitable and sustainable access to community resources to address the unique physical, social, and behavioral health needs of all Connecticut residents.			
OBJECTIVE	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES - STATUS**
Continue leading and providing support for the Health Improvement Alliance (HIA)	• Provide leadership and in-kind support to HIA and HIA Behavioral Health Task Force • Continue membership with Behavioral Health Task Force • Collaborate with HIA partners to implement and promote programming for historically underserved communities	• Bill Hoey, Tonisha Cohen-King, Joyce Platz, Edna Borchetta	• # of staff hours committed to preparation of and participation in meetings • HIA CHIP Progress • # of events
Expand the use of additional sites for behavioral health care, including community, schools, home, health, and telehealth	• Link clinical and non-clinical settings and services • Identify and implement ways to reduce barriers to seeking care • Increase access to telehealth, mobile, and community-based services • Identify interim solutions for those who are waitlisted/waiting for services • Seek to expand beds by actively pursuing appropriate grants • Increase support groups, self-help resources, and leverage those offered by community-based organizations through HIA	• BHN • Mission Services • CHW Pilot Program	• % increase YOY of sites or # increase • Size of waitlist, time waiting, patient experience scores/anecdotal feedback
Build community capacity by increasing awareness and education around behavioral health	• Increase availability and utilization of CHWs and peer support specialists whose lived experience reflects the communities they serve • Provide information/education sessions on current behavioral health concerns • Leverage reliable resources to deliver training to the community (e.g., Narcan Training)	• CHW Pilot Program/Mission Services/HIA partners • Behavioral Health • Others TBD	• CHW referrals • # of trainings and attendance • Pre- and post-assessments
Increase the number of people who receive behavioral health care in the appropriate setting	• Continue to improve the coordination of care for frequent use of the ED for behavioral health • Continue and explore expansion of the Emergency Department Recovery Coach program to support individuals affected by substance use • Continue Community Residential Services, offering permanent supportive housing and case management for adults with behavioral health needs who might otherwise be homeless • Identify new partners within underserved communities and populations to assist as liaisons for services and care	• HIA CCT • BHN • Others TBD	• CCT metrics • EDRC metrics • CRS metrics • # of new partners and referrals to those partners
Pursue funding opportunities to support programming and initiatives	• Grow the St. Vincent's Mission Fund in partnership with the philanthropy team • Pursue grants and donations to support work	• Westport, BHU, 9E • Mission Services • Philanthropy Team	• # and $ Private donations • # of grants awarded • $ grants

Priority Area: Strengthen Communities and Families *(Child Wellbeing)*			
Goal: Achieve equitable health and development outcomes for children by strengthening communities and families and promoting child wellbeing and resiliency.			
Healthy CT 2025 SHIP Goal: Ensure community strength, safety, and resiliency by providing equitable and sustainable community resources to address the unique physical, social, and behavioral health needs of all Connecticut residents.			
OBJECTIVE	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES - STATUS**
Continue leading and providing support for the Health Improvement Alliance (HIA)	• Provide leadership and in-kind support to HIA and HIA Child Wellbeing Task Force • Continue membership with Child Wellbeing Task Force • Collaborate with HIA partners to implement and promote programming for historically underserved communities	• Mission Services • Edna Borchetta • Bill Hoey	• # of staff hours committed to preparation of and participation in meetings • HIA CHIP Progress
Increase community engagement in programming for parenting and childhood development	• Leverage reliable education sources to deliver programming to community members • Explore funding and partnership opportunities to expand maternal and post-partum support to families (e.g., Diaper Connections, Universal Nurse Home Visiting Grant)	• CHW Pilot program • Philanthropy • Birthing Center	• # of programs offered • Feedback from community • # of persons served
Increase screenings of children at all access points	• Explore the use of developmental and Adverse Childhood Experience (ACE) screenings through CHWs, the Emergency Department, and HHCMG pediatric and family practice providers • Expand Medical Mission at Home to include pediatrics	• Mission Services • Philanthropy • Pharmacy • TBD – EPIC team/HHCMG	• Baseline - #of screenings, ACES scores • # of children served • # of referrals
Engage youth in health education and learning opportunities at the Medical Center	• Resume education/tour/mentor programs for High School students and develop new programs and relationships to expand school-to-work pipeline • Provide subject matter experts to youth education programs in the community	• Community Impact; Nursing Education • Multi-disciplinary • Others TBD	• # of school engaged • # of students engaged • % increase YOY
Pursue funding opportunities to support programming and initiatives	• Grow the St. Vincent's Mission Fund in partnership with the philanthropy team • Pursue grants to support work	• Mission Services • Philanthropy Team	• Funds raised • # of Grants awarded • $ grants