

Backus Hospital

2015 Community Health Needs Assessment and Implementation Plan

In the Fall of 2014, Hartford Health Care embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community. Backus Hospital is a partner in the Hartford HealthCare System, affiliating in August of 2013.

It is Backus Hospital's mission "to deliver and coordinate a continuum of high quality health care that is sensitive to the needs of individuals in eastern Connecticut. Backus is committed to being responsive and accountable to those for whose benefit it exists, and to improving the health of its communities."

Community health at Backus Hospital is founded on the principles of population health management. Backus Hospital bases its Community Health Improvement Plan on four pillars, which, with a patient centered focus, support Hartford HealthCare's five year strategies, mission, vision, and core values. These four pillars are:

- 1) **Data:** Listening to the voices of the community and understanding objective health outcomes
- 2) **Partnership:** Engaging with community resources, both medical and social
- 3) **Access:** Creating multiple connections to communicate with, and care for, our community, regardless of payor type or socioeconomic status
- 4) **Coordination:** Providing management across the entire spectrum of health to optimize the distribution of health outcomes, regardless of payor source or socioeconomic status

About Backus Hospital, a Hartford HealthCare Partner

Backus Hospital is a not-for-profit, 213-bed, 20-bassinet hospital with approximately 1,800 employees, accredited by The Joint Commission, primarily serving the New London County and Windham County.

Backus Hospital is located in Norwich, Connecticut, and provides high quality inpatient and outpatient care, including comprehensive emergency care, including LIFESTAR, the only air ambulance stationed in Eastern Connecticut, a level III Trauma Center, and a 24/7 satellite emergency department in Plainfield, Connecticut, Labor and Delivery services, a comprehensive Cancer Center, Cardiology services, and behavioral health services that span the continuum of care. Backus has numerous off-site locations, including 5 Family Health Centers, providing primary and urgent care. The Backus Emergency Care Center in Plainfield offers emergency services 24 hours per day, 7 days per week, as well as diagnostic imaging and lab services. The Backus Outpatient Care Center offers a weight loss center, diabetes center, arthritis center, physical therapy, radiology, lab services, and more.

Backus Hospital maintains a department, resourced with appropriate funding, dedicated to addressing its outreach objective to serve the entire community, not only those who come through its doors. The hospital also recognizes that health outcomes are driven by much more than traditional medical care. Working alongside other well-established community partners, the Backus Hospital provides resources to understand and improve the health outcomes of our population. This strategy allows Backus to understand the needs of the high risk, rising risk and healthy sectors of its community and to provide each sector with appropriate access.

Backus' goal is to improve the community's health status by partnering with its members to make healthy life choices, while providing smarter, better, and cost-effective care to Eastern Connecticut.

Pillar 1: Data

Goal

Listening to the voices of the community and understanding objective health outcomes

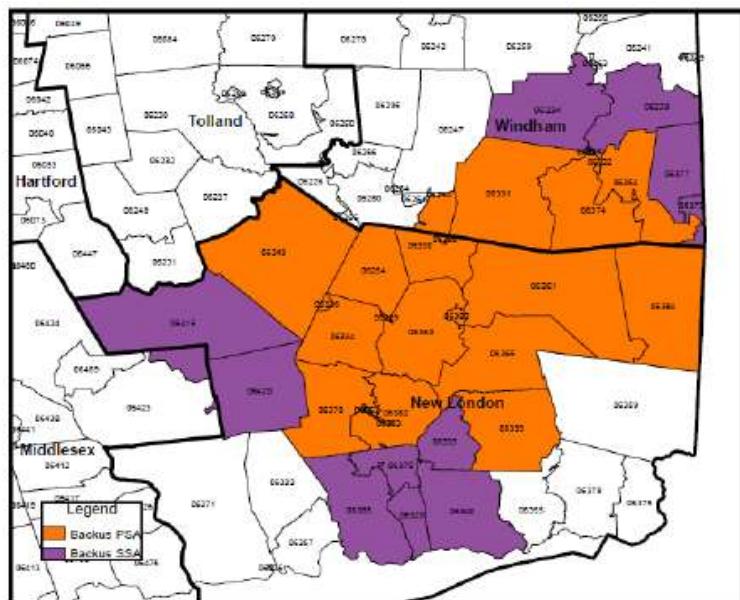
Timeframe FY 2016-2019

Strategies & Scope

Definition of the Community Served

[IRS Form 990, Schedule H, Part V, Section B, 1a, 2, 2013]

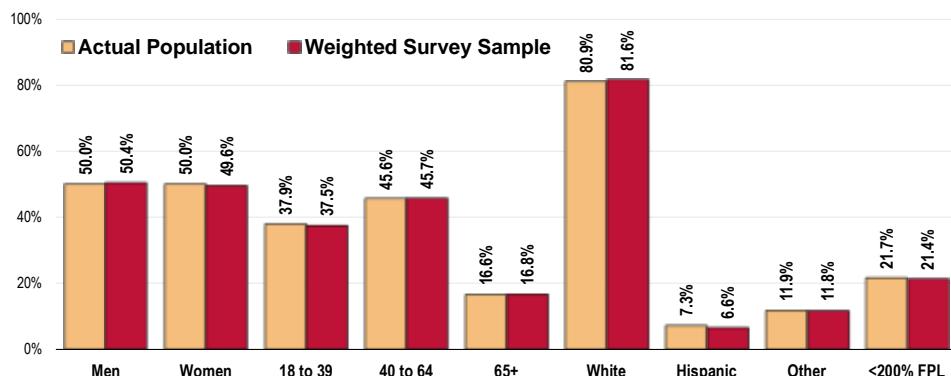
The study area for the survey effort (referred to as the "Backus Hospital Service Area" in this report, or "BHSA") is defined by 29 residential ZIP Codes in Connecticut. This area definition is illustrated in the following map.



The following chart outlines the characteristics of the Backus Hospital Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]



Population & Survey Sample Characteristics (Backus Hospital Service Area, 2015)



Sources: • Census 2010, Summary File 3 (SF 3). US Census Bureau.
 • 2015 PRC Community Health Survey, Professional Research Consultants, Inc.

How CHNA Data Were Obtained

CHNA Goals & Objectives

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2013, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of Backus Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

The Community Health Needs Assessment provides the information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. The 2015 PRC Community Health Needs Assessment serves as a tool toward reaching three basic goals:

- **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various

diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.

- **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

CHNA Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels.

Community Health Survey

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by PRC, with input from Backus Hospital and the other community sponsors.

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 614 individuals age 18 and older in the Backus Hospital Service Area. Because this study is part of a larger effort involving multiple regions and hospital service areas, the surveys were distributed among various strata. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Backus Hospital Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

For statistical purposes, the maximum rate of error associated with a sample size of 614 respondents is $\pm 4.0\%$ at the 95 percent level of confidence.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Backus Hospital Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- Connecticut Department of Public Health
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Assessment of Empirical Data

The Community Health Needs Assessment (which can be found on the Backus website at <https://backushospital.org/about-us/community-outreach/health-needs-assessment/>) provides the detailed results of the community health survey and secondary data review conducted in 2014/2015. These data points, in conjunction with input from community partners, helped the Hospital to determine its key priority areas, and the most pressing health needs of the region.

Community Stakeholder Input

[IRS Form 990, Schedule H, Part V, Section B, 1h & 3, 2013]

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Hartford HealthCare; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 25 community stakeholders took part in the Online Key Informant Survey. Their participation is outlined below:

Online Key Informant Survey Participation

Key Informant Type	Number Invited	Number Participating
Community/Business Leader	23	4
Health Provider	23	9
Public Health Expert	4	2
Social Services Representative	22	10

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such, and how these might be better addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Vulnerable Populations

[IRS Form 990, Schedule H, Part V, Section B, 1f. 2013]

Through this process, input was gathered from several individuals whose organizations work with low-income, minority populations, or other medically underserved populations.

Minority populations represented:

African-Americans, American Indians, Asians, Cape Verdeans, Chinese residents, disabled elderly, French Creole residents, Haitian residents, Hispanics, persons with HIV/AIDS, the homeless, lesbian/gay/bisexual/transgender

individuals, low-income residents, middle easterners, migrant farm workers, mixed race individuals, northern Europeans, unemployed residents, victims of crime.

Medically underserved populations represented:

Persons with behavioral health issues, children, diabetics, the disabled, the elderly, the homeless, lesbian/gays/bisexual/transgender individuals, low-income residents, Medicaid/Medicare recipients, those who are mentally ill, non-English speaking persons, persons with substance abuse issues, undocumented immigrants, uninsured/underinsured residents, veterans, women and children, young adults.

Information Gaps

[IRS Form 990, Schedule H, Part V, Section B, 1i, 2013]

While this Community Health Needs Assessment is quite comprehensive, Backus Hospital and PRC recognize that it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Public Dissemination

[IRS Form 990, Schedule H, Part V, Section B, 5-5c, 2013]

This Community Health Needs Assessment is available to the public using the following URL: <http://BackusHospital.org>

Backus Hospital will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. Backus Hospital will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.

Health Needs of the Community

[IRS Form 990, Schedule H, Part V, Section B, 1e, 2013]

SELECTION OF THE COMMUNITY HEALTH PRIORITIES

On June 11, 2015, Backus Hospital held a Prioritization Session with hospital and community representatives to review the research findings and prioritize the key issues for adoption and inclusion in the Backus Hospital Implementation Plan.

The objectives of the half-day strategic planning session were to:

- Provide an overview of recently compiled community health data and highlight key research findings
- Initiate discussions around key health issues and prioritize based on select criteria
- Brainstorm goals and objectives to guide Backus Hospital's Implementation Plan
- Examine Backus Hospital's role in addressing community health priorities
- A total of 43 individuals attended the strategic planning session, including experts in public health, representatives of underserved populations, health and social services agencies, and other community stakeholders. A full list of attendees is included below.

Name	Agency
Angela Arnold	Diocese of Norwich
Nancy Cowser	United Community & Family Services
Shirley Terry	Department of Children and Families
Lee-Ann Gomes	Norwich Human Services
Karen Sears	Connecticut Legal Services
Yolanda Bowes	United Community & Family Services
Jim Haslam	Connecticut Legal Services

Carrie Dyer	Reliance House, Inc.
Paris Silvestri	Reliance House, Inc.
Greg Allard	American Ambulance
Patrick McCormack	Uncas Health District
Anitha Nair	Uncas Health District
Sgt. Peter Camp	Norwich Police Department
Deberey Hinchey	Mayor, City of Norwich
Christine Miskell	South Eastern Regional Action Council
Deb Monahan	Thames Valley Council for Community Action
Mary Lou Underwood	Thames Valley Council for Community Action
Megan Brown	Thames Valley Council for Community Action
Scott Sjoquist	Mohegan Tribal Health Director
Patrick Turek	Backus Emergency Management Coordinator
Nancy Almeida Crocker	Safe Futures
Katherine Verano	Safe Futures
Bob Mills	Norwich Community Development Corporation
Shawn Mawhiney	Hartford HealthCare
Alice Facente	Backus Hospital
Jim Maffuid	Catholic Charities
Janette Edwards	Hartford HealthCare
Kim Brown	Backus Hospital
Judi Gaudet	Generations Family Health Center
Kathleen Pounch	Norwich Adult Education
Cheryl Egan	Norwich Adult Education
Victoria Samolis	CONNCare
Carol Mahier	Center for Hospice Care
Kelcey Johnson	Backus Family Health Centers
Sheila Lake	Reliance House
Brenda Keefe	Sprague Community Center
Edie Ouellet	Three Rivers Community College Nursing Program
Carrie Pichie	Natchaug Hospital
Jill Bourbeau	Natchaug Hospital
Sue Greeno	Senior Resources AAA
Tony Sheridan	Chamber of Commerce E. Connecticut
Cathy Osten	State Senator
Claire Silva	Bethsaida Community

Professional Research Consultants facilitated an open group discussion for attendees to share what they perceived to be the needs and areas of opportunity in the region. This included a discussion of overlapping issues, root causes of health, and the ability for regional health and human services providers to effectively address the various needs. After some consolidation and a considerable amount of dialogue, the following list was developed by the attendees. The following list was considered the "Master List" of needs to be evaluated as potential priority areas for community health improvement activities. The list is presented in alphabetical order.

- Access to care (physician ratio/insurance, cultural competency, other barriers, hospitalizations)

- Cancer
- Dementia, Including Alzheimer's Disease
- Diabetes
- Heart Disease and Stroke
- Infant Health and Family Planning
- Injury & Violence
- Mental Health
- Nutrition, Physical Activity & Weight
- Oral Health
- Potentially Disabling Conditions
- Respiratory Diseases
- Substance Abuse
- Tobacco Use

Prioritization of Community Issues

To further identify the most urgent priority areas, participants were asked to rank the master list. The participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures. Participants were asked to rate each need based on two criteria: seriousness of the issue and the ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 10 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. Each attendee received a keypad to register their vote. The following tables reveal the results of the voting exercise.

<u>Scope & Severity Ranking</u>		<u>Ability to Impact Ranking</u>	
9.25	Mental Health	7.47	Mental Health
8.80	Substance Abuse	7.32	Nutrition, Physical Activity & Weight
8.24	Nutrition, Physical Activity & Weight	7.00	Diabetes
7.95	Heart Disease & Stroke	6.95	Access to Healthcare Services
7.74	Diabetes	6.63	Heart Disease & Stroke
7.63	Cancer	6.55	Substance Abuse
7.33	Tobacco Use	6.47	Respiratory Disease
6.94	Access to Healthcare Services	6.37	Infant Health & Family Planning
6.80	Oral Health	6.25	Oral Health
6.76	Respiratory Diseases	6.20	Injury & Violence
6.61	Dementias, Including Alzheimer's Disease	6.05	Tobacco Use
6.50	Potentially Disabling Conditions	5.05	Potentially Disabling Conditions
6.24	Injury & Violence	4.95	Cancer
5.62	Infant Health & Family Planning	4.43	Dementias, Including Alzheimer's Disease

Community-Wide

Community Benefit Planning

[IRS Form 990, Schedule H, Part V, Section B, 6c-6d, 2013]

It has been Backus Hospital's hope and intention that this Community Health Implementation Plan (CHIP) development process fosters a movement to embark on a community-wide effort to improve the health of the community. One of the HHC affiliated hospitals developed a questionnaire intended to elicit support, in writing, from community organizations in addressing specific health needs, as appropriate for each individual organization. During the June 11 Prioritization meeting, Backus Hospital asked the assembled community leaders to fill out the questionnaire. The responses were extremely helpful in detailing specific programs or resources that could be offered in the process of planning a collaborative community benefit plan. For one example, the local ambulance service director expressed keen interest in collaborating on a substance abuse coalition, and the newly-established falls prevention coalition.

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Organizations include:

- American Ambulance Service, Inc.
- American Red Cross Blood Services
- Catholic Charities
- City of Norwich, Human Services
- Generations Family Health Center, Inc
- Hartford HealthCare at Home
- Ledge Light Health District
- Mohegan Tribal Health
- New London County Food Policy Council
- Norwich Adult Education
- Norwich Police Department
- Reliance House, Inc
- Rose City Senior Center
- Safe Futures
- St. Vincent DePaul Place Soup Kitchen
- Southeastern Regional Action Council (SERAC)
- Sprague Community Center
- Three Rivers Community College Nursing and Allied Sciences Program
- Town of Windham
- TVCCA
- Uncas Health District
- United Community and Family Services (UCFS)
- Windham Region No-Freeze Project
- United Way
- Windham Hospital

Backus Hospital

[FY2015-FY2017 Implementation Strategy](#)

For more than 122 years, Backus Hospital has demonstrated its commitment to meeting the health needs of the Eastern Connecticut region.

This summary outlines Backus Hospital's plan (Implementation Strategy) to address its community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations and within the public itself.

Hospital-Level Community Benefit Planning

Priority Health Issues To Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that Backus Hospital would focus on developing and/or supporting strategies and initiatives to improve:

1. Mental Health (including Dementia & Alzheimer's Disease)
2. Substance Use
3. Nutrition, Physical Activity & Weight (Obesity)

4. Heart Disease & Stroke
5. Diabetes
6. Access to Health Care Services (including oral health)
7. Cancer
8. Respiratory Diseases

Priorities were set by the community through the prioritization process; cancer was added to the list due to the significant cancer incidence in Eastern Connecticut, and the strong focus Hartford HealthCare has on improving cancer care in Connecticut through its affiliation with Memorial Sloan Kettering (MSK).

Respiratory diseases were also included due to the high rate of smoking that is prevalent in Eastern Connecticut.

Improvement of these health outcomes will be achieved through partnership, Access, and Coordination strategies, with consistent assessment through secondary data sources (i.e. the Robert Wood Johnson Foundation), internally collected statistics, and primary research.

Integration With Operational Planning [IRS Form 990, Schedule H, Part V, Section B, 6e, 2013]

Beginning in 2014, Backus Hospital includes a Community Benefit section within its operational plan.

Priority Health Issues That

Will Not Be Addressed & Why

[IRS Form 990, Schedule H, Part V, Section B, 7, 2013]

In acknowledging the wide range of priority health issues that emerged from the CHNA process, Backus Hospital determined that it could only effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence.

Health Priorities Not Chosen for Action	Reason
Infant Health and Family Planning	<i>Backus Hospital has limited resources, services and expertise available to address family planning and infant health. Other community partners such as UCFS and Madonna Place have infrastructure and programs in place to better meet this need.</i>
Violence & Injury	<i>Backus Hospital believes that this priority area falls more within the purview of Safe Futures, the former Women's Shelter. Backus is a community partner and has arranged for Safe Futures to open an office in the Medical Office Building, adjoining the hospital.</i>
Potentially Disabling Conditions	<i>Backus Hospital offers a pain management program, and will partner with stakeholders and private physicians to manage these conditions.</i>

All community leaders attending the June 11, 2015 prioritization meeting filled out a questionnaire detailing their interest and commitment to the different issues revealed in the community health needs assessment. The compiled commitments support the plan to share the burden of addressing all of the issues as a community.

Implementation Strategies & Action Plans [IRS Form 990, Schedule H, Part V, Section B, 6f-6h, 2013]

The following displays outline Backus Hospital's plans to address those priority health issues chosen for action in the FY2016-FY2018 period.

Pillar 2: Partnership

Community Partners/ Planned Collaboration

United Community & Family Services (UCFS), Generations Family Health Center, soup kitchens, TVCCA, MSK, Backus clinics and outpatient departments, Hartford HealthCare Medical Group, Hartford HealthCare Senior Resources, CONNCare, Backus Physician Services, local health departments, municipalities, Catholic Charities, other social service agencies, community-based providers

Goal

Engage with community resources, both medical and social, to improve the health of our community

Timeframe FY2016 - FY2018

Community Health Needs Impacted	Nutrition, Physical Activity & Weight (Obesity), Cancer, Diabetes, Heart disease & Stroke, Tobacco Use	Access to Care Dementias, Alzheimer's Disease, Mental Health, Substance Use, Respiratory Diseases
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Strategies & Scope

Initiative #1: Engage community partners in an ongoing community health discussion, including prioritization of needs

- Tactic 1a: Community Health Needs Assessment prioritization session
 - See pages 7-11

Initiative #2: Development of a robust, data driven, primary prevention model to keep the community healthy and reduce future disease burden

- Tactic 2a: CANCER
 - Provide cancer screenings and community outreach
 - *Collaborate and partner with the Hartford HealthCare Cancer Institute, and affiliation with Memorial Sloan Kettering, to meet MSK's community health requirements*
 - *Hold annual head and neck cancer screening*
- Tactic 2b: ACCESS TO CARE
 - Expand community outreach for health education and health screenings
 - *CareVan – provide more preventive and diagnostic screenings in more communities*
 - Partner with HHC Senior Services to provide access to post acute, Dementia, and Alzheimer's care
- Tactic 2b: OBESITY, PHYSICAL ACTIVITY, AND NUTRITION AND RELATED COMORBIDITIES (I.E. HEART DISEASE/STROKE, DIABETES)
 - Imbed and support nutrition education by dedicated community dietitian in schools, community centers, senior centers, senior housing.
 - Establish and expand the "Just Ask" initiative in restaurants and Shop Rite grocery stores
 - Continue the Healthy Eating Advocate Training (HEAT) program for health education sustainability.
 - Link to and work with the Backus Medical Weight Loss Center

- Expand and work with the Backus Heart Failure program & support group
- Expansion of Rx for Health program for low-income youth at-risk for obesity
- Support the Backus "Healthy Community" initiatives – pilot program at Sprague Community Center
- Support and partner with the UCFS H.E.L.P.S. program
- Continue to provide diabetes self-management program and education classes
- Provide glucose and cholesterol screenings in community settings
- Continue monthly community BP clinics
- Tactic 2d: SUBSTANCE USE, INCLUDING TOBACCO & RESPIRATORY DISEASES
 - Sponsor the Better Breathers Club
 - Expand "Freedom from Smoking" cessation classes through UHD grant
 - Participate in the Statewide Asthma Coalition through CHA
 - Continue the "Be Aware" Program for high school students
- Tactic 2f: MENTAL HEALTH AND SUBSTANCE USE
 - Backus Hospital supports and collaborates with Natchaug Hospital, and the entire Behavioral Health Network, to ensure adequate access to mental health services are available to residents of the Backus Hospital region.
 - Coordinate training and education of professionals and the community on substance use disorder, especially heroin addiction:
 - *Naloxone (Narcan) training for all EMS providers spearheaded by Backus ED Physician*
 - *Southeastern Naloxone Taskforce*
 - *Behavioral Health Network Mental Community Health Forums*
 - *"Current Drug Trends" educational program by SERAC*
 - *Mental Health First Aid training*
- Tactic 2c: Continue to provide community education opportunities about health and wellness
 - Provide Community Education series; examples include:
 - *"Let's Talk About Your Health"*
 - *Arthritis Center education series*
 - Publish health columns in The Day and, Norwich Bulletin newspapers

Anticipated Impact

- Increase in the number of programs offered that meet identified community needs
- Increase in the number of collaborative strategies and programs offered to the community
- Increase in the number of "persons served" through community health improvement activities
- Ongoing and sustained conversations with community partners around identified priority needs

Plan to Evaluate Impact

- Number of programs offered
- Number of persons served
- Evaluate community impact by using empirical health outcomes data
- Amount of community benefit dollars invested

Results

Pillar 3: Access to Care & Services

Community Partners/ Planned Collaboration

Integrated Care Partners (ICP), Hartford HealthCare Medical Group, Hartford HealthCare at Home, Hartford HealthCare Senior Resources, ConnCare, Backus Physician Services, United Community & Family Services, community-based providers & social service agencies, HHC Behavioral Health Network; Southeastern Mental Health Authority (SMHA); Reliance House; Dept of Mental Health and Addiction Services (DMHAS), South Eastern Regional Action Council (SERAC)

Goal

Create multiple connections to communicate with, and care for, our community, for all payor types and regardless of socioeconomic status

Timeframe FY2016 - FY2018

Community Health Needs Impacted

- Cancer,
- Diabetes,
- Heart disease & Stroke,
- Tobacco Use
- Access to Care
- Dementias, Alzheimer's Disease,
- Mental Health
- Substance Use

Strategies & Scope

Initiative #1: Ambulatory Expansion and Growth

- Tactic 1a: Establish new Family Health Centers to create additional primary care and urgent care access points for Eastern Connecticut residents
 - Access points will meet identified community needs and fill documented physician shortages, including primary care and specialists
- Tactic 1b: Support and expand partnerships with preferred Federally Qualified Health Center (FQHC) providers
 - Support preferred FQHC expansion opportunities throughout Eastern Connecticut
 - Provide flu clinics at Soup Kitchens in the region
- Tactic 1c: Support the independent primary care physician network in Eastern Connecticut
 - Recruit and retain primary care providers to fill identified shortages and to supplement new shortages arising due to pending retirements
 - Link to the Medical Staff Development Plan to ensure community needs are met
- Tactic 1d: Increase access to care (including oral health) in community settings
 - Primary Care provided by preferred FQHC clinicians on Mobile Health Resource Van at local Soup Kitchens
 - Dental Clinic on Mobile Health Resource Van for community screenings

Initiative #2: Establishment of clinical programs and services identified in the East Region strategic plan which meet identified community health needs, and satisfy community benefit requirements

- Tactic 2a: Cardiovascular services (HEART DISEASE & STROKE)
 - Establish Angioplasty services
 - Establish and expand Heart Disease management and infusion program
 - Expansion of the "Just Ask" campaign
- Tactic 2b: Cancer Services
 - Support the Memorial Sloan Kettering alliance through requirements set by MSK in its "Community Health" pillar. Please see the Cancer Institute Community Health Improvement Plan for action items.

Initiative #3: Access to Mental Health Services

- Tactic 3a: Increase access to coordinated mental health services in the community
 - Expand upon and refine the Primary Care Behavioral Health Project in the Colchester and Norwichtown Family Health Centers for immediate mental health care coordination and referral
 - Support the HHC/DCF partnership spearheaded by Regional Director of Emergency Care Services
 - Establish an Emergency Services-Community Public Safety Collaborative
 - Create a Center for Healthy Aging for the Geriatric populations in Eastern Connecticut
 - Sustain Community Care Teams embedded in the East Region Emergency Departments
 - HHC "Stop the Stigma" campaign
 - Education programs in schools focusing on stress, anxiety, depression, suicide prevention

Anticipated Impact

- Reduction in the number of uninsured individuals
- Increase in primary care panel sizes
- Increase in My Health Direct and ZocDoc utilization
- Increase in primary and urgent care visits

Plan to Evaluate Impact

- Number of uninsured
- Primary care panel growth
- Primary and Urgent Care visits volume
- My Health Direct utilization
- ZocDoc utilization

Results

Pillar 4: Coordination

Community Partners/ Planned Collaboration

Integrated Care Partners (ICP), Backus Diabetes Outpatient Management Center, Backus Arthritis Center, Center for Hospice Care, United Community & Family Services (UCFS), TVCCA, and Generations Family Health Centers, HHC Behavioral Health Network; Hartford HealthCare Medical Group, Hartford HealthCare at Home, regional skilled nursing facilities, regional social service agencies and independent community-based healthcare providers

Goal

Provide management across the entire spectrum of health to optimize the distribution of health outcomes, regardless of payor source or socioeconomic status

Timeframe FY 2016-2019, with defined key milestones throughout the three year timeline

Community Health Needs Impacted	<ul style="list-style-type: none">• Cancer,• Diabetes,• Heart disease & Stroke,• Dementias, Alzheimer's Disease,• Mental Health• Substance Use• Access to Care
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Strategies & Scope

Initiative #1: Development of a care coordination model for identified at-risk inpatients, regardless of patient's payor source or socioeconomic status

- Tactic 1a: Initiate a high-risk care coordination team, to work alongside the Hospitalist team, to provide coordination and management to identified at-risk patients
 - Hire an APRN and LCSW team
 - Team will ensure care plans are in place and utilized
 - Team will ensure "warm hand offs" to community physicians and partners in care
 - Team will be mobilized to provide home visits when necessary, at no charge to the patient or healthcare system
 - Team will coordinate with the Heart Failure program as well as disease-specific clinics whenever appropriate to manage patients on an outpatient and ongoing basis

Initiative #2: Development of an interdisciplinary rising-risk care coordination model focused on the community and outpatient settings, regardless of patient's payor source or socioeconomic status

- Tactic 2a: Build the capacity of local health care clinics to provide population health management services
 - Develop and sustain strong partnership with Integrated Care Partners (ICP)
 - Further the development of imbedded health coaches as a member of the care team in Family Health Centers in collaboration with ICP
 - Expand health coach model to private providers who are ICP members
- Tactic 2b: MENTAL HEALTH
 - Increase access to coordinated mental health services in the community
 - Expand upon and refine the Primary Care Behavioral Health Project in the Colchester and Norwichtown Family Health Centers for immediate mental health care coordination and referral
 - Support the HHC/DCF partnership spearheaded by Regional Director of Emergency Care Services
 - Establish an Emergency Services-Community Public Safety Collaborative

- Create a Center for Healthy Aging for the Geriatric populations in Eastern Connecticut
- Sustain Community Care Teams embedded in the Backus Emergency Departments
- Tactic 2c: ACCESS TO CARE
 - Establish new programs and opportunities to improve care coordination to support patients and community-based providers
 - *Establishment of a peri-operative surgical home in multiple access points throughout the Region to reduce cost and duplicative testing*
 - *Establishment of the Geriatric Fracture Program*
 - *LLHD Falls Prevention Coalition*
 - Improve accessibility and provide assistance for health insurance options and referrals
 - *Utilize My Health Direct and ZocDoc to facilitate referrals to primary care and community programs*
 - *Uncas Health District and UCFS – AccessHealthCT agents for referral*
 - *Maintain and improve upon the Access to Care partnership with UCFS*

Initiative #3: Build an IT Infrastructure to provide risk stratification, aggregation, and analysis of population health data

- Tactic 3a: Determine appropriate IT requirements to support inpatient and outpatient care coordination activities
 - Inventory current resources and best practice approaches to data analytics in population health
- Tactic 3b: Develop risk stratification competencies and processes

Anticipated Impact

- Reduction in avoidable admissions, avoidable ED visits, and Readmissions
- Increase in utilization of My Health Direct and ZocDoc
- Increase in the in-network rate
- Improvement in appropriate quality and safety scores

Plan to Evaluate Impact

- Engagement with the Advisory Board to analyze and critique population health strategies at Backus Hospital
- Avoidable admissions,
- ED visits,
- readmissions
- My Health Direct utilization
- ZocDoc utilization
- In-Network Rate
- Quality & Safety Scores as appropriate

Results

Backus is committed to investing in the health of the community through a continuous process of assessment, partnership, access and coordination to achieve its goal of providing high value care for all.

Implementation Strategy [IRS Form 990, Schedule H, Part V, Section B, 6a-6b, 2013]

On _____, the Board of Hartford HealthCare met to discuss this plan for addressing the community health priorities identified through our Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget items to undertake these measures to meet the health needs of the community.

Hartford HealthCare Board Approval & Adoption:

By Name & Title

Date