

The Hospital of Central Connecticut

2015 Community Health Needs Assessment and Implementation Plan

In the Spring of 2014, The Hospital of Central Connecticut (THOCC) embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community. The Hospital of Central Connecticut is a partner in the Hartford HealthCare System.

It is The Hospital of Central Connecticut's mission "to deliver and coordinate a continuum of high quality health care that is sensitive to the needs of individuals in Central Connecticut. The Hospital of Central Connecticut 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 The Hospital of Central Connecticut is founded on the principles of population health management. The Hospital of Central Connecticut 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

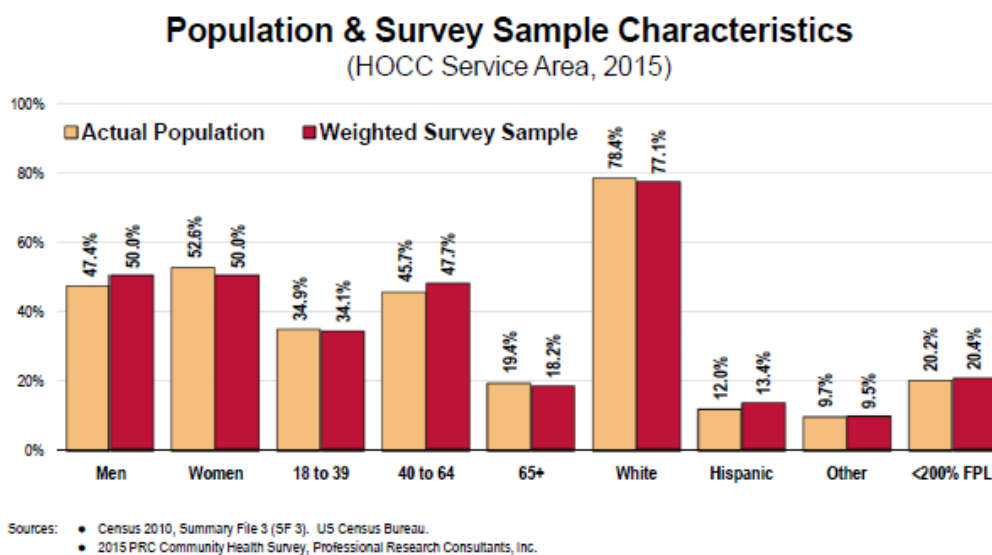
About The Hospital of Central Connecticut, a Hartford HealthCare Partner

The Hospital of Central Connecticut, based in New Britain, Connecticut, is a not-for-profit, 414-bed, 32-bassinets, acute-care community teaching hospital with campuses in New Britain and Southington. The hospital was created with the 2006 merger of the former New Britain General and Bradley Memorial hospitals. With 2,385 employees, THOCC serves the communities of New Britain, Plainville, Southington, Berlin and Bristol. It is accredited by The Joint Commission.

The Hospital of Central Connecticut provides comprehensive inpatient and outpatient services in general medicine and surgery and a wide variety of specialties. Specialty centers include the Endocrine and Bone Health Center, Cancer Services, Cardiology, Clinical Research, Sauer Family BirthPlace, Diabetes Center, Joint and Spine Center, Psychiatry and Behavioral Health, Sleep Disorders Center, Vascular Center, Weigh Your Options Weight Loss Center, Wolfson Palliative Care Consult Services, and Wound Care Center.

The Hospital of Central Connecticut maintains a department dedicated to addressing its outreach objective of serving the entire community, not only those who come through its doors. Building on a long tradition of service, the Community Outreach Department utilizes hospital strengths alongside those of other well-established community partners. This strategy allows THOCC to better understand and reach the most vulnerable sectors of the community, while meeting pressing healthcare needs. The goal is to improve the community's health status by empowering citizens to make healthy life choices.

The following chart outlines the characteristics of the Hospital of Central Connecticut 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.]



How CHNA Data Were Obtained

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

CHNA Goals & Objectives

[IRS Form 990, Schedule H, Part V, Section B, 4, 2013]

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2012, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area for The Hospital of Central Connecticut. 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 2014 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.

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 RHMC and the other community sponsors.

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for The Hospital of Central Connecticut 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

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 1,000 individuals age 18 and older in the Primary Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Primary Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree 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. These secondary data were available at the county level; to best match the Primary Service Area, data from Hartford and New Haven Counties was used. These were obtained from a variety of sources (specific citations are included in the CHNA report), such as:

- Centers for Disease Control & Prevention
- National Center for Health Statistics, State Department of Public Health
- State Department of Health and Human Services
- State Uniform Crime Report
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

Assessment of Empirical Data

The Community Health Needs Assessment (which can be found on The Hospital of Central Connecticut's website at <http://thocc.org/about/community-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]

As part of the Community Health Needs Assessment, Key Informants were invited to participate in an online survey to allow for input from persons with special knowledge of or expertise in public health, as well as others who represent the broad interests of the community served by The Hospital of Central Connecticut. Participants included key informants in the region, including physicians, other health professionals, social service providers, business leaders and 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. Participants included a representative of public health, as well as several individuals who work with low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions. Specific names/titles of those participating are available upon request.

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, 47 community stakeholders in the HOCC Service Area took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation

Key Informant Type	Number Invited	Number Participating
Community/Business Leader	41	11
Other Health (non-physician)	19	16
Physician	10	3
Public Health Expert	9	5
Social Services Representative	27	12

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]

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary quantitative (survey) research is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease

needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

For additional statistics about uninsured, low-income, and minority health needs please refer to the complete PRC Community Health Needs Assessment report, which can be viewed online at <http://thocc.org/>

Information Gaps

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

While this Community Health Needs Assessment is quite comprehensive, THOCC 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.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

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://thocc.org/about/community-health-needs-assessment> This site:

- Informs readers that the CHNA Report is available and provides instructions for downloading it;
- Offers the CHNA Report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

A link to the needs assessment is also made available at THOCC's hospital website at: <http://thocc.org/>

THOCC will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. THOCC 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

After reviewing the Community Health Needs Assessment findings, the CHNA Stakeholders met on June 10, 2015, to determine the health needs to be prioritized for action. During the detailed presentation of the CHNA findings, consultants from PRC used audience response system (ARS) technologies to lead members through a process of understanding key local data findings (Areas of Opportunity) and ranking identified health issues against the following established, uniform criteria:

- **Magnitude.** The number of persons affected, also taking into account variance from benchmark data and Healthy People targets.

- **Impact/Seriousness.** The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- **Feasibility.** The ability to reasonably impact the issue, given available resources.
- **Consequences of Inaction.** The risk of not addressing the problem at the earliest opportunity.

From this exercise, the Areas of Opportunity were prioritized as follows by the committee:

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. Nutrition, Physical Activity & Weight
2. Mental Health/Substance Abuse
3. Heart Disease & Stroke
4. Diabetes
5. Cancer
6. Respiratory Diseases
7. Infant Health & Family Planning
8. Dementias, Including Alzheimer's Disease
9. Injury & Violence
10. Sexually Transmitted Diseases
11. Chronic Kidney Disease
12. HIV/AIDS
13. Potentially Disabling Conditions

Community-Wide

Community Benefit Planning

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

As individual organizations begin to parse out the information from the 2014 Community Health Needs Assessment, it is THOCC's hope and intention that this will foster greater desire to embark on a community-wide community health improvement planning process. THOCC has expressed this intention to partnering organizations and is committed to being a productive member in this process as it evolves. The goal is to achieve "collective impact" by collaborating with other organizations and developing focused initiatives.

Resources Available to

Address the Significant Health Needs

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

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:

Access to Health Care

2-1-1 Hotline
Access Health CT
AIDS CT
Chronic Disease
Management Programs
Chrysalis Center
Community Health
Center
Community Health
Services

HIV/AIDS

AIDS CT
Faith communities
Community Health
Centers
CTARC
DPH
Government Sponsored
HIV Programs
Hartford Gay and
Lesbian Health

Food Share

Hartford HealthCare
Behavioral Health
Hispanic Nurses
Association
Parks and Recreation
Department
Planning and Zoning
Departments
Public Health
School-Based Health

CT Transadvocacy
Coalition
Culturally Competent
Nutritionists
Diabetes Prevention
Program
Federally Funded
Clinics
Federally Qualified
Health Centers
Hartford Gay and
Lesbian Health
Collective
Health Department
Hispanic Health
Intercommunity, Inc.
Latino Community
Services
Mobile Clinic
Planned Parenthood
Private Providers
Ryan White Medical
Transportation Program
Social Services

**Arthritis, Osteoporosis
& Chronic Back
Conditions**

Arthritis Foundation
Hospital programs

Cancer

American Cancer
Society
Clinics
Community Health
Centers
Community Health
Services
Educators
The Hospital of Central
Connecticut
Hispanic Health Council
Local Health
Department
Local Support Groups
Medicaid Breast and
Cervical Cancer
Program
Planned Parenthood
Primary Care Providers
Public Health
Quitline—State of CT

Collective
Health Educators
Hispanic Health Council
HIV CT
HIV/AIDS Support
Groups
Infectious Disease
Clinics
Latino Community
Services
National Institute of
Health
Needle Exchange
Planned Parenthood
Ryan White

**Immunization &
Infectious Diseases**

Community Health
Centers
Department of Public
Health
Local Health
Department
Mobile Clinic

Infant & Child Health

Clinical Programs
Specializing in Autism
Community Health
Center
Connecticut Children's
Medical Center
CT DSS
Easy Breathing
Programs
First Choice
Healthy Start
Help Me Grow
Home Visiting
Hospital for Special
Care autism program
Local Health
Department
Local Parks and
Recreation Department
School-Based Health
Centers
WIC

Injury & Violence

2-1-1 Hotline

Centers
Schools
SNAP
Summer Food
Weight Management
and Lifestyle Programs

Oral Health

Community Health
Center
Community Health
Services
CT Children's Medical
Center
Free Dental Cleaning
Fairs
Mobile Dental Clinics
Private Dentists

Respiratory Diseases

American Lung
Association
Classes at Local
Hospitals
Community Health
Centers
Easy Breathing Program
Hospital for Special
Care
HUD Projects
Local Health
Department
Mobile Clinics
Public Health
School-Based Health
Centers
State Department of
Public Health Smoking
Cessation
Support Groups
Visiting Nurses Assn.

**Sexually Transmitted
Diseases**

STD Clinics
Community Health
Center--FQHC
Hartford Gay and
Lesbian Health
Collective
Latino Community
Services/STI Testing
Clinic

School Health
Programs
YMCA Live Strong
Program

**Chronic Kidney
Disease**

Hospital Clinics
KEEP Health Screening
National Kidney
Foundation
Private Providers
Sub-Specialists

**Dementias, Including
Alzheimer's Disease**

Adult Day Programs
Alzheimer's Association
Community Caregiver
Support Groups
Elder Services
Family Support Groups
Private Assisted Living
Facilities
Rehab Facilities/Skilled
Nursing Care
Senior Center
Visiting Nurse
Association

Diabetes

American Diabetes
Association
Community Health
Centers
Community Health
Workers/Health
Educators
Community Support
Groups
Foot Clinics
FQHC
The Hospital of Central
Connecticut
Health Department
Local Church Programs
Mobile Clinic
Nutritional Educators
Primary Care Providers
Public Health
YMCA

Family Planning

Community Health

Boys and Girls Club
Churches and Youth
Groups
Community Mental
Health Providers
Conflict Resolution
Programs
Connecticut Behavioral
Health Partnership
Domestic Violence
Shelters
DPH Injury Prevention
Hartford HealthCare
Health Educators
Injury Prevention
Center
Intercommunity, Inc.
Local Health
Department
Neighborhood Violence
Prevention Programs
Safe Kids Connecticut
School Social Workers
School-Based Health
Centers
Strengthening Families
Framework
Suicide Prevention
Advisory Board
Teen Driver Laws
Village for Families and
Children
Wheeler Clinic
YMCA

Mental Health

2-1-1 Crisis
Intervention
Behavioral Health
Partnership
Catholic Charities
Center for Healthy
Aging
Child Guidance Clinic
Chrysalis
Community Health
Resources
Community Mental
Health Providers
Connecticut Behavioral
Health Partnership
Connecticut Psychiatric
Society

Local Health
Department
Planned Parenthood
Ryan White
School-Based Health
Centers
Schools
The Health Collective
Various Clinic and
Hospital Services
Walk-in Clinics

Substance Abuse

Alcohol and Drug
Rehabilitation
Alcoholics Anonymous
Catholic Charities
Community Health
Center
Community Mental
Health Affiliates
Community-Based
MH/SA Providers
Department of Mental
Health and Addiction
Services
Hartford HealthCare
Behavioral Health
Institute for Hispanic
Families
Institute of Living
Intercommunity, Inc.
Local prevention
councils
LCS/Project STEP
Linkage to Care
Medicaid
Narcotics Anonymous
Rushford Center
Social Workers
Village for Families and
Children
Wheeler Clinic
Youth Challenge

Tobacco Use

Community Health
Center
Community Health
Providers
Hospital for Special
Care
Local Health

Centers
Family Centers
Healthy Start
Hispanic Health Council
Nurturing Families
Planned Parenthood
School-Based Health
Teen Pregnancy
Prevention

Hearing & Vision

Audiology
CT Eye and ENT Society
Ophthalmology
Consults

Heart Disease & Stroke

After School Programs
American Heart
Association
Church Programs
Community Health
Centers
Emergency Room
Employee Health and
Wellness Programs
Farmers' Markets
The Hospital of Central
Connecticut
The Hospital of Central
Connecticut Heart
Center
Health Educators
Local Hospitals and
Community Centers
Mobile Clinics
Primary Care Physicians
Public Health

DMHAS
Employee Assistance
Programs
Hartford Behavioral
Health
Institute for Living
Intercommunity, Inc.
Klingberg Center
LCS/Hartford
Behavioral Health
Local Health
Department
Private Providers
Rushford Center
School-Based Health
Centers
Social Workers
The Village
Wheeler Clinic

**Nutrition, Physical
Activity & Weight**

Bariatric Program and
Comprehensive
Evaluations
Black Nurses
Association
CHCs and Clinics
Church and Town
Pantries
Early Childhood
Programs
Faith communities
Farmers' Markets
Weight Watchers
WIC
YMCA
Yoga
YWCA

Department
Local Pharmacy
Medicaid
Public Health
Quit Line
School-Based Health
Center
Smoking Cessation
State Smoking
Cessation Program
Quit Line

Throughout its history of healthcare provision, The Hospital of Central Connecticut has demonstrated its commitment to meeting the health needs of the central Connecticut area.

This summary outlines The Hospital of Central CT's plan (Implementation Strategy) to address our 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 The Hospital of Central CT would focus on developing and/or supporting strategies and initiatives to improve:

- Nutrition, Physical Activity & Weight Status
- Mental Health & Substance Abuse
- Heart Disease/Stroke
- Diabetes
- Cancer

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

Beginning in 2014, The Hospital of Central Connecticut 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, The Hospital of Central Connecticut 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
Chronic Kidney Disease	<i>THOCC believes that efforts outlined herein to improve and increase awareness of healthy lifestyles will have a positive impact on the detection of kidney disease and that we do not have the available resources to create a separate set of kidney-specific initiatives.</i>
Dementia, including Alzheimer's Disease	<i>THOCC believes that this priority area falls more within the purview of local organizations, such as the area Alzheimer's Resource Center. THOCC will support communication of these services</i>
Potentially Disabling Conductions	<i>Those voting felt that more pressing health needs existed. Limited resources and lower priority excluded this as an area chosen for action</i>
Respiratory Diseases	<i>THOCC participates in a statewide asthma collaborative established by the CT Department of Public Health and The CT Hospital Association. THOCC will support the established initiatives from this collaborative. THOCC also collaborates with the Hospital for Special Care's asthma program.</i>
Sexually Transmitted Diseases	<i>THOCC believes that this priority area falls more within the purview of the community/district health departments and other community organizations. Limited resources and lower priority excluded this as an area chosen for action.</i>
HIV/AIDS	<i>THOCC believes that this priority area falls more within the purview of the community/district health departments and other community organizations. Limited resources and lower priority excluded this as an area chosen for action.</i>
Infant Health & Family Planning	<i>THOCC has limited resources, services, and expertise to address these issues. Other community organizations have infrastructure and programs in place to better address these needs. Limited resources excluded this as an area chosen for action.</i>
Injury & Violence Prevention	<i>THOCC believes that this priority area falls more within the purview of the community/district health departments and other community organizations. Limited resources and lower priority excluded this as an area chosen for action.</i>

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

The following displays outline The Hospital of Central Connecticut plans to address those priority health issues chosen for action in the FY2016-FY2018 period.

Pillar 2: Partnership

Community Partners/ Planned Collaboration

The Community Health Center (FQHC), The Friendship Center, YWCA, early childhood collaboratives, Hospital for Special Care, faith communities, clergy associations, soup kitchens, MSK, and outpatient departments, Hartford HealthCare Medical Group, Hartford HealthCare Senior Resources, 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,
- Respiratory Diseases,
- Tobacco Use
- Access to Care
- Oral health,
- Dementias, Alzheimer's Disease, and Geriatric Psycho-Social Issues
- Mental Health
- Substance Use

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 7-8

Initiative #2: Develop 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 address identified community health needs
 - Scheduled head and neck cancer screenings
 - Annual skin screening
 - Ongoing breast cancer screening promotion
 - Special focus in community education on the importance of colorectal cancer screening, including regular colonoscopies.
 - Sustain support of LIVESTRONG physical activity program for breast cancer survivors in collaboration with area YMCAs
- Tactic 2b: ACCESS TO CARE
 - Expand community outreach for health education and health screenings
 - Increase mobile mammography van use in more communities
 - In collaboration with senior health services and other area providers sustain support for Healthy Family FunFest, an annual event held in central Connecticut

- Tactic 2c: OBESITY, PHYSICAL ACTIVITY, AND NUTRITION AND RELATED COMORBIDITIES (I.E. HEART DISEASE/STROKE, DIABETES)
 - *Support nutrition education by community-based dietitians in schools, community centers, senior centers, senior housing.*
 - *Establish the "Just Ask" initiative in restaurants and Shop Rite grocery stores*
 - *Link to and work with the Medical Weight Loss Center to increase community education*
 - *Expand and work with the hospital Heart Failure program & support group*
 - *Continue to provide diabetes self-management program and education classes*
 - *Provide glucose and cholesterol screenings in community settings*
 - *Continue monthly community BP clinics in collaboration with senior health services*
 - *Support community efforts to increase access to healthy foods: including collaborating with community initiatives to support farmers' markets and establishment of community gardens*
 - *Establish "Step It Up" walking programs for all communities.*
 - *Develop, publish, and promote trail maps for walking routes.*
 - *Work with communities, businesses, and local/state agencies to create and promote active living options (e.g. bike lanes, bike paths, pedestrian paths).*
 - *Explore feasibility of best practice programs, such as "5-2-1-0" program in collaboration with Boards of Education, United Way, youth recreational providers.*
 - *Promote the "myplate.gov" guidelines.*
 - *Hospital diabetes program will conduct quarterly education sessions to at risk populations on pre-diabetes.*

- Tactic 2d: MENTAL HEALTH, SUBSTANCE USE, INCLUDING TOBACCO
 - *Participate in the Statewide Asthma Coalition through Connecticut Hospital Association and State of CT Department of Public Health collaboration.*
 - *Collaborate with area health departments to promote smoking cessation.*
 - *Collaborate with chambers of commerce wellness programming to promote smoking cessation.*
 - *Partner with key community stakeholders to evaluate the effectiveness of existing efforts and initiatives to address substance abuse.*
 - *Support community-based programs that address substance abuse.*
 - *Participate in community-based collaborative efforts to improve access to behavioral health services.*
 - *Coordinate training and education of professionals and the community on substance use disorder, especially heroin addiction:*
 - *Promote Community and Congregational Assistance Program with regional substance abuse councils.*
 - *Engage more faith communities in training to recognize signs and symptoms and to understand how to make referrals for appropriate programs.*
 - *Expand the number of Behavioral Health Network Mental Community Health Forums*
 - *Promote Mental Health First Aid training*

- Tactic 2e: 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 area 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

- Programs offered
- Number of persons attending

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, community-based providers & social service agencies, HHC Behavioral Health Network; Dept. of Mental Health and Addiction Services (DMHAS)

Goal

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

Timeframe FY2016 - FY2018

Community Health Needs Impacted	<ul style="list-style-type: none"> • Nutrition, Physical Activity & Weight (Obesity), • Cancer, • Diabetes, • Heart disease & Stroke, • Respiratory Diseases, • Tobacco Use 	<ul style="list-style-type: none"> • Access to Care • Oral health, • Dementias, Alzheimer's Disease, and Geriatric Psycho-Social Issues • Mental Health • Substance Use
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Strategies & Scope

Initiative #1: Ambulatory Expansion and Growth

- Tactic 1a: Establish new Family Health Centers to create additional primary, specialty and urgent care access points for Central Connecticut residents
 - Access points will meet identified community needs and fill documented physician shortages, including primary care and specialists.
 - Work with Hartford HealthCare Medical Group and independent urgent care partner to offer quick, efficient walk-in care with ease of transfer for patients requiring more comprehensive care.
 - Develop a primary care strategy to ensure that maximum care coordination is achieved along with providing a medical home for individuals whose physicians are close to retirement
- Tactic 1b: Support and expand partnerships with Federally Qualified Health Center (FQHC) providers
 - Support FQHC expansion opportunities throughout the central Connecticut area to expand access to services.
 - Work with outpatient partners and HHC partners to provide flu clinics in the region.
- Tactic 1c: Support the primary and specialty care physician network in central 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
 - Identify specialty deficits where a mix of recruitment and partnerships with independent specialty physicians need to be established in order to increase access for community members seeking care for identified community need, e.g. cancer, heart disease, etc..
- Tactic 1d: Increase access to care in community settings
 - Explore feasibility of acquiring a mobile health resource van to provide services within the communities.
 - Explore primary care provided by FQHC clinicians on mobile health resource van at local

soup kitchens as well as other locations where the indigent receive other services.

- *Collaborate with community providers to establish a dental clinic on mobile health resource van for community screenings.*
- *Explore the feasibility of providing multiple technological options for patients needing to access care, including: mobile health resource van, telemedicine, online appointment bookings, and partnership with CVS's Minute Clinic.*
- *Improve the experience throughout the network to ensure that consumers receive high quality, competent, and empathic care regardless of socio-economic status.*

- Tactic 1d: Increase access to emergency services in community settings
 - *Enhance relationships with EMS to review THOCC capabilities and address community need*

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

- Tactic 2a: Cardiovascular services for the community
 - *Explore expanding elective angioplasty services*
 - *Establish and expand Heart Disease management with a focus on women's health*
 - *Expansion and enhancement of management of cardiac rhythm patients in cooperation with private physicians*
- Tactic 2b: Orthopedic Services
 - *Establish a geriatric fracture program, focused on osteoporosis prevention, early identification, and management protocols*
 - *Develop a comprehensive sports medicine program to ensure healthy habits and care are established early*
 - *Collaborate with community physicians for implementation of new technologies to improve quality for joint replacements, reduce length of stay and improve outcomes.*
- Tactic 2c: Cancer Services
 - *Support the Memorial Sloan Kettering alliance through its "Community Health" pillar, with focus on community health education and screening*

Initiative #3: Access to Mental Health Services

- Tactic 3a: Increase access to coordinated mental health services in the community
 - *Build and enhance inpatient psychiatry services within the central region by joining MidState's and THOCC's program and building a new and expanded unit*
 - *Expand upon and refine the primary care behavioral health integration within primary care for immediate mental health care coordination and referral, in partnership with Hartford HealthCare Medical Group*
 - *Expand and promote the Center for Healthy Aging services for the geriatric populations in central Connecticut*
 - *Sustain Community Care Teams embedded in the THOCC Emergency Departments*
 - *Promote a "Stop the Stigma" campaign to increase awareness of behavioral health issues and to reduce the "stigmas" that may be associated.*
 - *Support education programs in schools focusing on stress, anxiety, depression, suicide prevention*

Anticipated Impact <ul style="list-style-type: none"> • Reduction in the number of uninsured individuals • Increase in call center utilization • Increase in primary and urgent care visits
Plan to Evaluate Impact <ul style="list-style-type: none"> • Number of uninsured seen • Primary and urgent care visits volume • Call Center utilization •
Results

Pillar 4: Coordination

Community Partners/ Planned Collaboration

Integrated Care Partners (ICP), 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">• Nutrition, Physical Activity & Weight (Obesity),• Cancer,• Diabetes,• Heart disease & Stroke,• Respiratory Diseases,• Tobacco Use | <ul style="list-style-type: none">• Access to Care• Oral health,• Dementias, Alzheimer's Disease, and Geriatric Psycho-Social Issues• Mental Health• Substance Use |
|--|--|

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.
 - 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 payer 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 community-based providers.
 - Further the development of embedded health coaches as a member of the care team in family health
 - Expand health coach model to community-based providers
- Tactic 2b: MENTAL HEALTH
 - Increase access to coordinated mental health services in the community
 - Expand upon and refine the primary care behavioral health integration within primary care for immediate mental health care coordination and referral in partnership with Hartford HealthCare Medical Group
 - Support the HHC/DCF partnership spearheaded by Regional Director of Emergency Care Services

<ul style="list-style-type: none"> ▪ <i>Establish an Emergency Services-Community Public Safety Collaborative</i> ▪ <i>Expand the Center for Healthy Aging for the geriatric populations in central Connecticut</i> ▪ <i>Sustain community care teams embedded in The Hospital of Central CT Emergency Departments</i> <ul style="list-style-type: none"> • Tactic 2c: ACCESS TO CARE <ul style="list-style-type: none"> ○ Establish new programs and opportunities to improve care coordination to support community members and community-based providers <ul style="list-style-type: none"> ▪ <i>Establishment of the Geriatric Fracture Program</i> ▪ <i>Develop a comprehensive urgent care strategy that is aligned with primary care providers</i> ▪ <i>Partner more fully with retail access points, such as CVS Minute Clinics to provide more cost effective medical care where patients frequent</i> ○ Improve accessibility and provide assistance for health insurance options and referrals <ul style="list-style-type: none"> ▪ <i>Utilize call center to facilitate referrals and expand access to primary care and community programs</i> ▪ Provide multiple technological options for patients needing to access care; they include but are not limited to mobile health resource van, telemedicine, online appointment bookings, and partnership with CVS's Minute Clinic.
<p>Initiative #3: Build an IT Infrastructure to provide risk stratification, aggregation, and analysis of population health data</p> <ul style="list-style-type: none"> • Tactic 3a: Develop risk stratification competencies and processes • Tactic 3b: Implement Epic electronic health record
<p>Anticipated Impact</p> <ul style="list-style-type: none"> • Reduction in avoidable admissions, avoidable ED visits, and readmissions • Increase in utilization of call center Improvement in appropriate quality and safety scores
<p>Plan to Evaluate Impact</p> <ul style="list-style-type: none"> • Initiative engagement with the Advisory Board to analyze and critique population health strategies at THOCC • Determine appropriate IT requirements to support inpatient and outpatient care coordination activities: <i>Inventory current resources and best practice approaches to data analytics in population health</i> • Avoidable admissions, • ED visits, • Readmissions • Call Center • Quality & Safety Scores as appropriate
<p>Results</p>

The Hospital of Central Connecticut 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 The Hospital of Central CT, 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 The Hospital of Central Connecticut Board Approval & Adoption:

By Name & Title

Date