MidState Medical Center

2015 Community Health Needs Assessment and Implementation Plan

In the Spring of 2014, MidState Medical Center [MMC] embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community. MidState Medical Center is a partner in the Hartford HealthCare System.

It is MidState Medical Center's mission "to deliver and coordinate a continuum of high quality health care that is sensitive to the needs of individuals in Central Connecticut. MidState Medical Center 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 MidState Medical Center is founded on the principles of population health management. MidState Medical Center 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 payer source or socioeconomic status

About MidState Medical Center, a Hartford HealthCare Partner

MidState Medical Center (MSMC), based in Meriden, Connecticut, is a not-for-profit, 156-bed acute-care hospital serving the communities of central Connecticut since 1998. It is the only hospital in Connecticut to offer all private rooms. It has a long-standing reputation for high quality care and high patient satisfaction. MSMC is accredited by The Joint Commission.

MidState offers a complete range of services including general and minimally invasive surgery, emergency medicine and urgent care, including LIFE STAR, the only air ambulance stationed in Hartford HealthCare's Central region, weight management, and state-of-the-art care dedicated to oncology, wound care and hyperbaric medicine, family birthing and maternal fetal medicine, sleep care, digestive health, pain management, neurosciences and cardiac care. Its satellite offices located in Meriden, Cheshire, and Wallingford help bring more accessible outpatient care to those it serves. MidState Medical Center is proud to boast over 1,200 employees and 350 affiliate physicians and is a member of the Hartford HealthCare system.

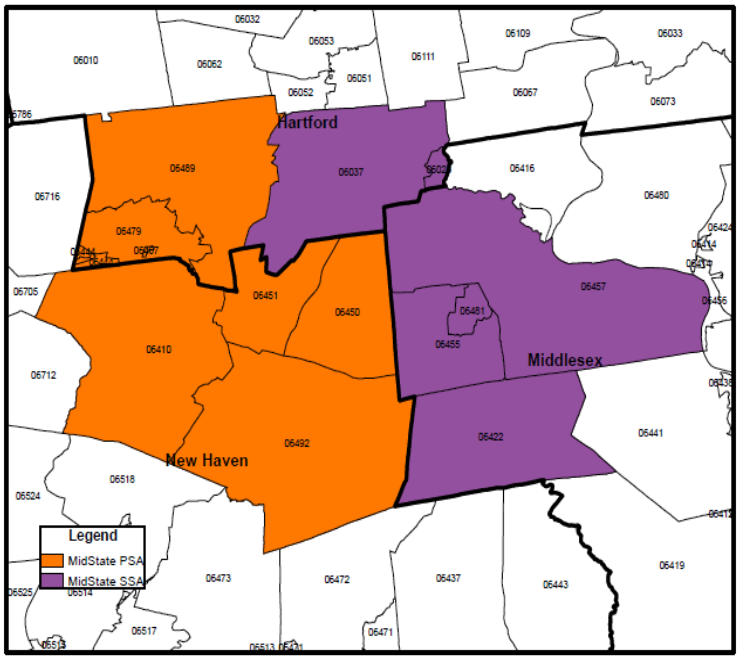
MidState Medical Center maintains a department dedicated to addressing its outreach objectives of serving the entire community, not only those who come through its doors. Building on a long tradition of service, the Community Relations Department utilizes hospital strengths alongside those of other well-established community partners. This strategy allows MSMC 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.

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]

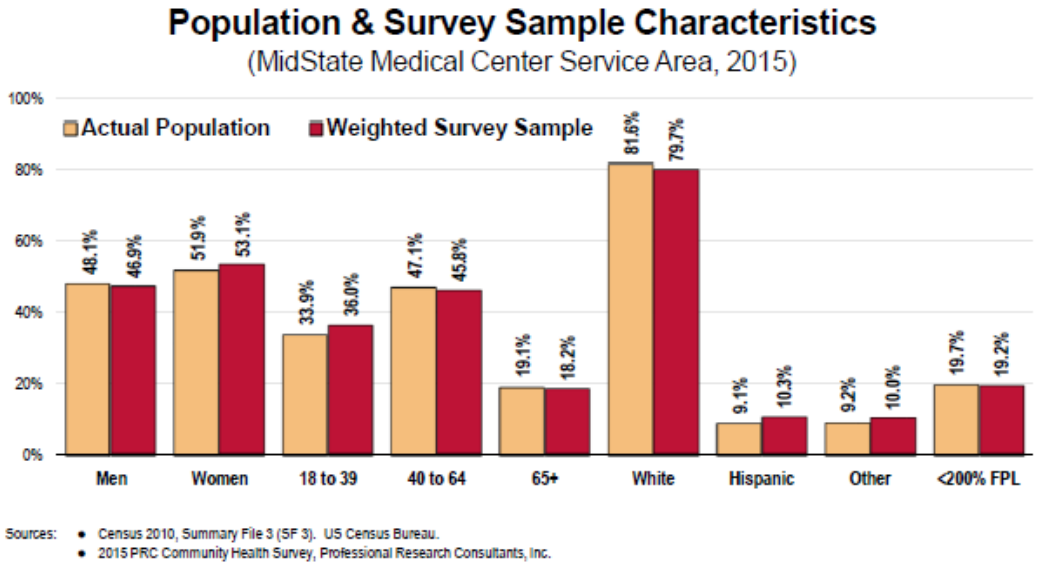
The study area for the survey effort (referred to as the "MidState Medical Center Service Area" in this report) is defined by 13 residential ZIP Codes in Connecticut. This area definition is illustrated in the following map. MidState Medical Center completed its last Community Health Needs Assessment in 2014.



Demographics of the Community

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

The following chart outlines the characteristics of the MidState Medical Center 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 of MidState Medical Center. 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 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.

Qualitative data input includes primary research gathered through a series of Key Informant online surveys.

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 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 603 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 New Haven County 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 MidState Medical Center website at https://www.midstatemedical.org/pdf/2015-PRC-CHNA-Report.pdf) 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 MidState Medical Center. 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. Their participation is outlined below:

Online Key Informant Survey Participation

Key Informant Type	Number Invited	Number Participating
Community/Business Leader	53	18
Health Provider	8	5
Public Health Expert	3	1
Social Services Representative	21	8

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 https://www.midstatemedical.org/pdf/2015-PRC-CHNA-Report.pdf

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

While this Community Health Needs Assessment is quite comprehensive, MSMC 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: https://www.midstatemedical.org/pdf/2015-PRC-CHNA-Report.pdf designed to share CHNA data with community partners and the public at large.

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.

Links to CHNA are also made available at MSMC's hospital website at: http://midstatemedical.org/

MSMC will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. MSMC 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 10, 2015, MidState Medical Center hosted a meeting of both internal stakeholders and representatives of community organizations to evaluate, discuss and prioritize health issues for the community, based on findings of the 2015 PRC Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research.

During the a detailed presentation of the CHNA findings, consultants from PRC used audience response system (ARS) technologies to lead steering committee 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.

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. Diabetes
4. Heart Disease & Stroke
5. Cancer
6. Infant Health & Family Planning
7. Injury & Violence
8. Potentially Disabling Conditions
9. Sexually Transmitted Diseases
10. HIV/AIDS
11. Chronic Kidney Disease

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 MSMC's hope and intention that this will foster greater desire to embark on a community-wide community health improvement planning process. MSMC has expressed this intention to partnering organizations and is committed to being a productive member in this process as it evolves.

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 Healthcare Services
2-1-1 Hotline
Access Health CT
Community Health Center
Hartford Health Care
Insurance Policies
Master's Manna
Meriden Dept. of Health and Human Services
MidState Medical Center
New Opportunities
Urgent Care
Women, Infants and Children

Hearing & Vision
Area Senior Centers
Audiologists
BESB
Center for Healthy Aging
Insurance
Lions Club
School Nurses

Heart Disease & Stroke
American Heart Association
Cardiac Units
Community Health Centers
Emergency Medical Dispatch
Institute for Living
Klingberg Family Services
Meriden Health Department and Youth Services Department
Rushford Center
Social Workers
Southington Community Services Department
Southington Youth Service Department
UConn Health Center
Wheeler Clinic

Cancer
American Cancer Society
Community Health Center
Meriden Health and Human Services
MidState Medical Center
Primary Care Providers
Private Oncologists
Public Health
Quitline—State of CT
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
Alzheimer's Association
Center for Healthy Aging in Southington
CT Center for Healthy Aging
Long-Term Care/Nursing Home
Masonicare - Hearth at Pond Ridge Assisted Living
Memory Lane Adult Day Program
Mental Health Providers
Mulberry Gardens
North Central Area Agency on Aging
Primary Care Providers
Senior Citizen Services
Social Services
Visiting Nurses Associations

Diabetes
Community Health Centers
Faith Communities
Health Department
LaPlanche Clinic
Meriden Health and Human Services Department
Meriden/Wallingford NAACP Health Fair
MidState Medical Center
Emergency Medical Services
Faith Communities
Heart-Healthy Communities
MidState Medical Center
Private Practice Physicians
Public Health Department
Schools
WIC
YMCA

HIV/AIDS
AIDS CT
Faith communities
Community Health Centers
DPH
Government Sponsored HIV Programs
Hartford Gay and Lesbian Health 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
Meriden Health Department
MidState Medical Center
Primary Care Providers
Protein Sciences
Walk-In Facilities

Infant & Child Health
Birth to Three
Chrysalis
Community Health Center
MidState Medical Center
Pediatric Care
Private Providers
Public Health Department
WIC-- Women, Infants and Children

Nutrition, Physical Activity & Weight
Beat the Street
Board of Education for Cheshire School
Boys and Girls Clubs
Boys Club of Wallingford
Chamber of Commerce wellness councils
Chesprocott (Cheshire, Prospect, and Wolcott) Health District
Libraries
My City Kitchen
Private Nutritionists
Public Health
Spanish Community of Wallingford for Zumba
TOPS—Take Off Pounds Sensibly
Weight Watchers
YMCA
Youth Recreation Programs
Youth Services

Oral Health
CHC Dental Clinic
Community Health Center
Dental Lifeline Network
Free Dental Cleaning Fairs
Head Start
Master's Manna
Meriden Public Schools
Private Dentists
UCONN School of Dentistry

Substance Abuse
Alcoholics Anonymous
Boys and Girls Club
Bristol Hospital
Community Health Center
Coalition for a Better Wallingford
Community Agencies for Outpatient Treatment Programs
Community Health Services
Local prevention councils
MidState Medical Center
Needle Programs
Police Department
Private Physicians
Public Health Department
Rushford Center
Schools
South Central CT Substance Abuse Council

Primary Care Providers
Private Pediatricians
Public Clinics
Public Health
School Nursing Personnel
SCOW—Spanish Community of Wallingford
Support Groups at MidState
Wallingford Senior Center
Yale New Haven Hospital
YMCA

Family Planning
Community Health Centers
Meriden Health Department
Planned Parenthood
Women and Families Center
Youth Services, Department of Health and Human Services
YMCA Teen Centers
Women and Families Center

Injury & Violence
2-1-1 Hotline
Board of Education
Chrysalis
Faith communities
Juvenile Diversion Program
Local Police Department
Master's Manna
Meriden Wallingford Chrysalis
Meriden Youth Services
Outpatient Mental Health Facilities
Primary Care Providers
Senior Ombudsman Area Agency on Aging
Women and Families Center

Mental Health
2-1-1 Crisis Intervention
Behavioral Health Partnership
Catholic Charities
Center for Healthy Aging
Child Guidance Clinic
Chrysalis
Community Health Center
Community Services
Emergency Room
Hospital of Central CT Bradley Campus
Hospital of Central CT inpatient unit
STEPS Program
Wheeler Clinic

Tobacco Use
Beat the Street
Boys and Girls Club
Public Health cessation
State Smoking Cessation Program Quit Line
School System

FY2015-FY2018 Implementation Strategy

Throughout its history of healthcare provision, MidState Medical Center has demonstrated its commitment to meeting the health needs of the Meriden, Wallingford, and Cheshire region.

This summary outlines MidState Medical Center'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 Regional Hospital Medical Center 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, MidState Medical Center 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, Regional Hospital Medical Center 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	*MMC 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.*
Dementia, including Alzheimer's Disease	*MMC believes that this priority area falls more within the purview of local organizations, such as the area Alzheimer's Resource Center. MMC will support communication of these services*
Potentially Disabling Conductions	*Those voting felt that more pressing health needs existed. Limited resources and lower priority excluded this as an area chosen for action*
Respiratory Diseases	*MMC participates in a statewide asthma collaborative established by the CT Department of Public Health and The CT Hospital Association. MMC will support the established initiatives from this collaborative*
Sexually Transmitted Diseases	*MMC 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.*
HIV/AIDS	*MMC 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.*
Infant Health & Family Planning	*MMC 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.*
Injury & Violence Prevention	*MMC 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.*

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

The following displays outline MidState Medical Center's 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, United Way of Meriden and Wallingford, soup kitchens, South Central CT Substance Abuse Council,, 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 meet community health needs*
    - *Scheduled head and neck cancer screening*
    - *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*
    - *Review needs of the elderly in collaboration with area senior health services and establish a focus on health and wellness with senior centers.*

- 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*
    - *Continue to provide diabetes self-management program and education classes*
    - *Provide glucose and cholesterol screenings and education in community settings with focus on faith communities*
    - *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.*
    - *In collaboration with health and parks departments, create inner city walking route maps.*
    - *Develop and publish park 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).*
    - *Collaborate with local shopping mall to expand its availability of walking program times before regular business hours.*
    - *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 for healthy eating in collaboration with boards of education and youth services providers.*
    - *Hospital diabetes program will conduct quarterly education sessions to at risk populations on pre-diabetes.*

- Tactic 2d: MENTAL HEALTH AND SUBSTANCE USE, INCLUDING TOBACCO
    - *Participate in the Statewide Asthma Coalition through CHA*
    - *Collaborate with area health departments 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 mental 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 and location Behavioral Health Network Mental Community Health Forums*
        - *Promote greater community participation in 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*
    - *In collaboration with chambers of commerce wellness councils, incorporate a prevention talk within community walks.*

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 participating in programs

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 payor types and regardless of socioeconomic status

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: 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 acquisition 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*
  - *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 the feasibility of acquiring a mobile health resource van to provide services within communities.*
  - *Explore potential for primary care provided by FQHC clinicians on mobile health resource van at local soup kitchens*

- *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 consumer experience throughout the network to ensure that patients receive high quality, competent, and empathic care regardless of socio-economic status*

- Tactic 1e: Establish new Single and/or Multi-Specialty Surgical Centers to create lower cost options for minor same-day procedures for Central Connecticut residents
  - *Build a Gastrointestinal Joint Venture surgi-center at a non-hospital based location with easy throughway access*
  - *Review the feasibility of market potential for building multi-specialty surgical Joint Venture*

- Tactic 1f: Increase access to emergency services in community settings
  - *Create a Southern CT base for LIFE STAR to improve emergency response times for those on Hartford HealthCare's Southern region*
  - *Enhance relationships with EMS to review MidState Medical Center capabilities*

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
  - *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 of 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 MidState's Emergency Department*

- *HHC "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

- Reduction in the number of uninsured individuals
- Increase in call center utilization
- Increase in primary and urgent care visits
-

Plan to Evaluate Impact

- Number of uninsured
- 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

- 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: 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 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 Centers*
  - *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*

        - *Establish an Emergency Services-Community Public Safety Collaborative*
        - *Expand the Center for Healthy Aging for the Geriatric populations in central Connecticut*
        - *Sustain community care teams embedded in the MidState Medical Center Emergency Department*

- Tactic 2c: ACCESS TO CARE
    - Establish new programs and opportunities to improve care coordination to support community members and community-based providers
        - *Establishment of the Geriatric Fracture Program*
        - *Develop a comprehensive urgent care strategy that is aligned with primary care providers*
        - *Partner more fully with retail access points, such as CVS Minute Clinics to provide more cost effective medical care where patients frequent*
    - Improve accessibility and provide assistance for health insurance options and referrals
        - *Utilize call center to facilitate referrals to primary care and community programs*
    - 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 within the retail low cost environment

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
- Tactic 3b: Implement Epic electronic health record

Anticipated Impact

- Reduction in avoidable admissions, avoidable ED visits, and readmissions
- Increase in utilization of call center
- Improvement in appropriate quality and safety scores

Plan to Evaluate Impact

- Initiative engagement with the Advisory Board to analyze and critique population health strategies at THOCC
- Inventory current resources and best practice approaches to data analytics in population health
- Avoidable admissions,
- ED visits,
- Readmissions
- Call Center
- Quality & Safety Scores as appropriate

Results

MidState Medical Center 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 MidState Medical Center 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 MidState Medical Center Board Approval & Adoption:

_____

By Name & Title

_____

Date