Windham 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. Windham Hospital is a partner in the Hartford HealthCare System, affiliating in June of 2008.

It is Windham Hospital's mission "to offer comprehensive services in an environment where innovation and teaching are integral to care; where we are proud to serve patients and one another; where meeting the challenge of complex medical needs is viewed as a defining competency; and where quality and safety of care are a constant."

Community health at Windham Hospital is founded on the principles of population health management. Windham 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 Windham Hospital, a Hartford HealthCare Partner

Windham Hospital is a not-for-profit, 130-bed hospital with approximately 544 employees, accredited by The Joint Commission, primarily serving 19 towns in Windham and Tolland Counties.

Windham Hospital is located in Willimantic, Connecticut, and provides high quality inpatient and outpatient care, including comprehensive emergency care, Labor and Delivery services, two Physical Therapy and Rehabilitation Clinics, Cancer services, Cardiology services, and Behavioral Health services embedded in the ED. Windham Hospital also has numerous on-campus support services, including family centered care, providing primary and urgent care, as well as diagnostic imaging and lab services. Windham Hospital offers a Cardiac Rehabilitation Center and Lipid Clinic, Pulmonary & Respiratory services, orthopedic services, Diabetes Center, Pain Management, Physical Therapy, Imaging & Radiology, lab services, and more.

Windham Hospital recognizes that health outcomes are driven by much more than traditional medical care. Working alongside other well-established community partners, the Windham Hospital provides resources to understand and improve the health outcomes of our population. This strategy allows Windham to understand the needs of the high risk, rising risk and healthy sectors of its community and to provide each sector with appropriate access.

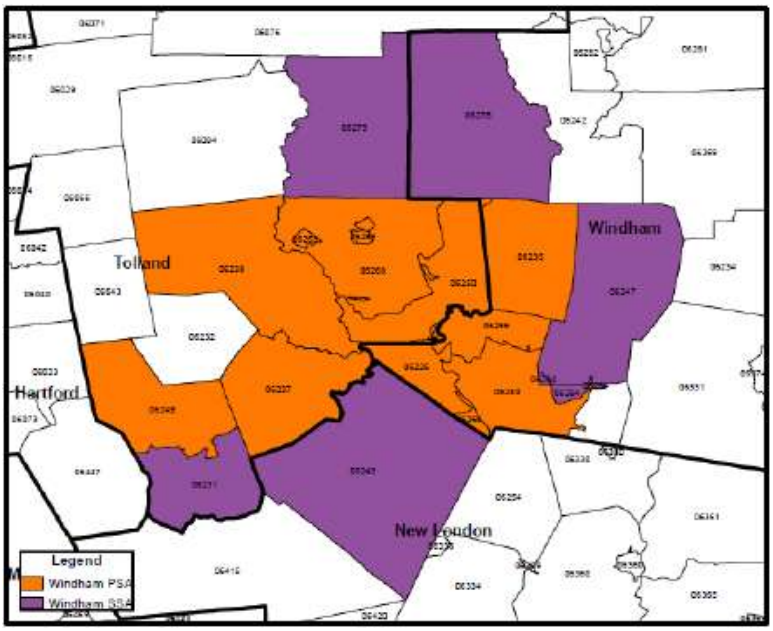
Windham Hospital's goal is to improve the community's health status by partnering with its members to make healthy life choices, while providing smarter, better, and cost-effective care to Northeastern Connecticut.

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

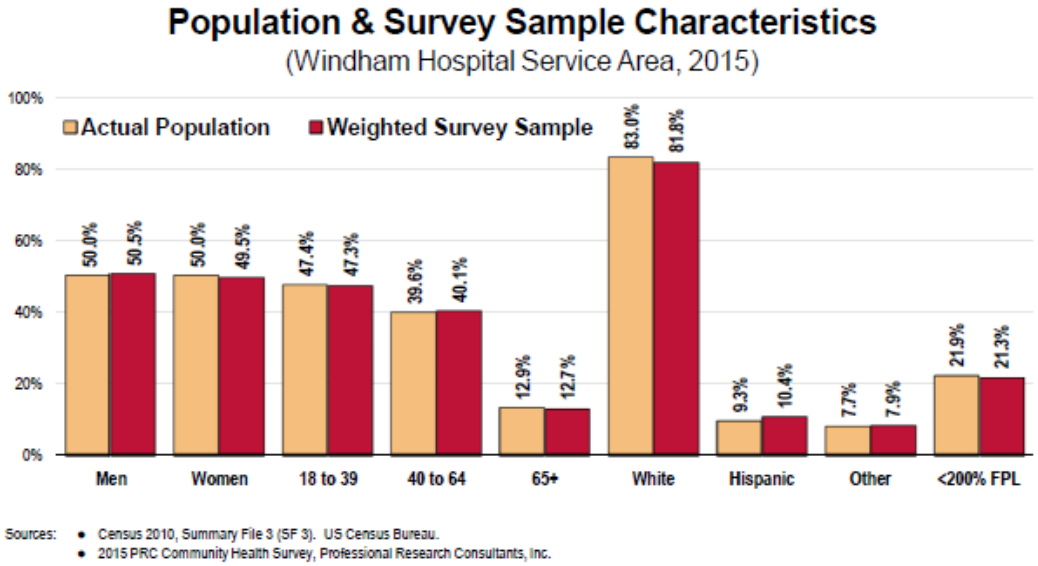
[IRS Form 990, Schedule H, Part V, Section B, 1a, 2, 2013]

The study area for the survey effort (referred to as the "Windham Hospital Service Area" in this report, or "WHSA") is defined by 16 residential ZIP Codes in Connecticut. This area definition is illustrated in the following map.



Demographics of the Community [IRS Form 990, Schedule H, Part V, Section B, 1b 2013]

The following chart outlines the characteristics of the Windham 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.]



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 Windham 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 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 lifespans, 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 Windham 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 579 individuals age 18 and older in the Windham 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 Windham Hospital Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 579 respondents is ±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 Windham 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 Windham website at http://www.windhamhospital.org/about-us/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]

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, Windham 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 on the Windham website at http://www.windhamhospital.org/about-us/community-health-needs-assessment

Windham 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. Windham 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, Windham 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 Windham 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 Windham Hospital's Implementation Plan
- Examine Windham Hospital's role in addressing community health priorities
- A total of 25 individuals were invited to attend the strategic planning session, including experts in public health, representatives of underserved populations, health and social services agencies, and other community stakeholders.

PRC 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
- 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.

Scope & Severity Ranking		Ability to Impact Ranking	
9.22	Mental Health	7.89	Diabetes
8.60	Heart Disease & Stroke	7.71	Access to Healthcare Services
8.42	Nutrition, Physical Activity & Weight	7.42	Mental Health
8.34	Substance Abuse	7.36	Heart Disease & Stroke
8.07	Cancer	6.79	Nutrition, Physical Activity & Weight
7.97	Diabetes	6.31	Respiratory Disease
7.72	Respiratory Diseases	6.23	Cancer
7.20	Tobacco Use	6.18	Substance Abuse
6.71	Access to Healthcare Services	5.86	Tobacco Use
6.28	Dementias, Including Alzheimer's Disease	5.17	Potentially Disabling Conditions
6.14	Potentially Disabling Conditions	4.72	Oral Health
5.97	Oral Health	4.69	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 Windham 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 Hartford HealthCare 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, Windham 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.

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 CHNA.

Organizations include:

- Access Agency
- American Cancer Society
- Backus Hospital
- American Red Cross
- Cancer Navigation Program
- CT Breast & Cervical Cancer Screening Program
- Dept of Children & Families (DCF)
- Diabetes Education Dept.
- Generations Family Health Center, Inc.
- Hartford HealthCare at Home
- Holy Family Home and Shelter
- Meals to the Home Program
- Northeastern CT Health District
- Prenatal Clinic
- Pulmonary Rehab program
- State Representative
- State Senator
- Three Rivers Community College Nursing Program
- Town of Windham
- Thames Valley Council for Community Action(TVCCA)
- UCONN School of Nursing
- United Way
- Windham Region No Freeze Project
- Windham Regional Community Council
- Windham School Based Health Clinics
- Wise Women Program

Windham Hospital

FY2015-FY2017 Implementation Strategy

For more than 80 years, Windham Hospital has demonstrated its commitment to meeting the health needs of the Eastern Connecticut region.

This summary outlines Windham 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 Windham Hospital would focus on developing and/or supporting strategies and initiatives to improve:

1. Mental Health (including Dementia & Alzheimer's Disease)
2. Substance Use (including tobacco 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]

Windham Hospital includes a Community Benefit section within its operational planning process.

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, Windham Hospital determined that it could address all of the issues identified in the CHNA using a community-wide collaborative approach.

Health Priorities Not Chosen for Action	*Reason*
Potentially Disabling Conditions	*Windham Hospital will work with its System partners to develop a strategy to address Potentially Disabling Conditions.*

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

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

Pillar 2: Partnership

Community Partners/ Planned Collaboration

Access Agency, United Community & Family Services (UCFS), Generations Family Health Center, soup kitchens, Thames Valley Council for Community Action (TVCCA), Memorial Sloan Kettering (MSK), Northeastern CT Health District, Windham School Based Health Clinics, Hartford HealthCare at Home, Hartford HealthCare Medical Group, Hartford HealthCare Senior Resources, University of Connecticut School of Nursing, Three Rivers Community College Nursing Program, 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
- Access to Care
- Oral health,
- Dementias, Alzheimer's Disease,
- Mental Health
- Substance Use
- Tobacco 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 7-10*

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 community health requirements*
    - *Annual head and neck cancer screening*
- Tactic 2b: ACCESS TO CARE
  - Expand community outreach for health education and health screenings
    - *CareVan – provide more screenings in more communities*
- Tactic 2c: OBESITY, PHYSICAL ACTIVITY, AND NUTRITION AND RELATED COMORBIDITIES (I. E. HEART DISEASE/STROKE, DIABETES)
  - *Embed 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 partnership with TVCCA for elderly nutrition in Willimantic housing centers.*
  - *Hispanic Diabetes Weight Loss Class @ Windham Hospital*
  - *Expansion of Rx for Health program for low-income youth at risk for obesity*

- *Continue to provide diabetes self-management program and education classes*
- *Provide glucose and cholesterol screenings in community settings*
- *Flu clinics in soup kitchens*

- Tactic 2d: SUBSTANCE USE, INCLUDING TOBACCO
  - *Expand "Freedom from Smoking" cessation classes*
  - *Better Breathers Club*
  - *Participate in Statewide Asthma Coalition through the Connecticut Hospital Association (CHA)*

- Tactic 2e: MENTAL HEALTH AND SUBSTANCE USE
  - Windham Hospital supports and collaborates with Natchaug Hospital, and the entire Behavioral Health Network, to ensure adequate access to mental health services is available to residents of the Windham 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*
    - *Southeastern Naloxone Taskforce*
    - *Behavioral Health Network Mental Community Health Forums*
    - *"Current Drug Trends" educational program by Northeast Communities Against Substance Abuse (NECASA)*
    - *Mental Health First Aid training*

- Tactic 2f: Continue to provide community education opportunities about health and wellness
  - Provide Community Education series including:
    - *"Let's Talk About Your Health"*
  - *Annual Diabetes Health Fair*
  - *Annual Hispanic Diabetes Health Fair*
  - *Publish health columns in The Willimantic Chronicle, Norwich Bulletin*

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
- Lives touched
- Set priorities based on community impact and empirical health outcomes data
- Community benefit dollars invested

Results

Pillar 3: Access to Care & Services

Community Partners/ Planned Collaboration

Access Agency; Integrated Care Partners (ICP); Hartford HealthCare Medical Group; Hartford HealthCare at Home; Hartford HealthCare Senior Resources; Northeastern CT Health District; Generations Family Health Center; United Community & Family Services; community-based providers & social service agencies; Hartford HealthCare Behavioral Health Network; Windham School Based Health Clinics; Southeastern Mental Health Authority (SMHA); Dept of Mental Health and Addiction Services (DMHAS); Northeast Communities Against Substance Abuse (NECASA)

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,
- Respiratory Diseases,
- Tobacco Use
- Oral Health
- 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*

- 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 in community settings
  - *Primary Care provided by preferred FQHC clinicians on Mobile Health Resource Van at local Soup Kitchens*
  - *Primary Care provided at the Willimantic No-Freeze Shelter*

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
  - *Expand Heart Disease management and infusion program*
  - *Expansion of the "Just Ask" campaign to Willimantic region*

- Tactic 2b: Surgical Services
  - *Establishment of the Peri-Operative Surgical Home model in multiple locations throughout the Region*

- Tactic 2c: Orthopedic Services
  - *Establishment of a regional geriatric fracture program, focused on osteoporosis prevention, early identification, and management protocols*

- Tactic 2d: Cancer Services
  - *Support the Memorial Sloan Kettering alliance through 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 and refine the Primary Care Behavioral Health Project in the Colchester and Norwichtown Family Health Centers for immediate mental health care coordination and referral to the Willimantic region*
  - *Support the Hartford HealthCare/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*
  - *Participate in the Hartford HealthCare "Stop the Stigma" campaign*
  - *Education programs in schools focusing on stress, anxiety, depression, suicide prevention*
  - *Sustain Community Care Teams embedded in the Windham Emergency Department*

Anticipated Impact

- Reduction in the number of uninsured individuals
- Increase in primary care panel sizes
- Increase in primary and urgent care visits
- Reduction in ED visits

Plan to Evaluate Impact

- Number of uninsured
- Primary care panel growth
- Primary and Urgent Care visits volume

Results

Pillar 4: Coordination

Community Partners/ Planned Collaboration

Integrated Care Partners (ICP), Windham Diabetes Management Center, Center for Hospice Care, United Community & Family Services (UCFS), Thames Valley Council for Community Action (TVCCA), Generations Family Health Centers, Hartford HealthCare 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

- Cancer,
- Diabetes,
- Heart disease & Stroke,
- Respiratory Diseases,
- Potentially Disabling Conditions
- Dementias, Alzheimer's Disease,
- Mental Health
- Substance Use
- Access to Care

Strategies & Scope

Initiative #1: 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 embedded 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 and refine the Primary Care Behavioral Health Project in the Colchester and Norwichtown Family Health Centers for immediate mental health care coordination and referral to the Willimantic region*
    - *Support the HHC/DCF partnership spearheaded by the 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 Windham Emergency Department*

- 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*
    - *Establishment of the Geriatric Fracture Program*
    - *Participate in the 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*
  - *Partner with the Northeastern CT Health District and UCFS, two AccessHealthCT agencies for referral*
  - *Maintain and improve upon the partnership with Access Agency*

Anticipated Impact

- Reduction in avoidable admissions, avoidable ED visits, and Readmissions
- Increase in the in-network rate
- Improvement in appropriate quality and safety scores

Plan to Evaluate Impact

- Rate of avoidable admissions
- Number of ED visits
- Readmission rate
- In-Network Rate to determine care coordination opportunities
- Quality & Safety Scores as appropriate

Results

Windham 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