



MIDDLESEX HOSPITAL Community Health Needs Assessment Implementation Strategy

Middletown, Connecticut
February 2017

EXECUTIVE SUMMARY

Middlesex Hospital remains committed to improving the health and well-being of our community members. In order to continue to achieve this core function, we have measured and evaluated the health status of our community for the past eight years and, in response, have developed programs and services that meet identified needs. We are ever grateful to the community partners who have participated in our community health needs assessments over the years and to the community organizations that have collaborated in developing evidence-based interventions and innovative practices resulting from assessment findings - work that has resulted in meaningful and sustained health and quality of life improvements for those living in our shared communities.

In addition to health indicators, Middlesex Hospital is using the platform of its 2016 community health needs assessment to examine how determinants of health and health disparities impact health outcomes, and to raise awareness regarding these critical influences on health, well-being and quality of life. Achieving health equity – the attainment of the highest level of health for all people – starts with examining how determinants of health disproportionately affect certain groups of people, followed by developing and strengthening partnerships to address the conditions that prevent the realization of good health for these vulnerable groups.

In this implementation strategy, Middlesex Hospital provides the priority areas and the goals, actions and anticipated impacts that we hope to achieve in addressing the needs identified in our 2016 community health needs assessment. Based on analysis of the assessment data and the results of our community forum, the Hospital has selected four broad priority areas: 1) **Mental Health**; 2) **Substance Abuse**; 3) **Aging Population**; and 4) **Asthma**. Embedded in our priority areas is a focus on social determinants of health and health equity.

Middlesex Hospital continues its dedication to providing high quality services that help our community members live healthy lives, and joining partners in the goal of transforming the health of our community. We enthusiastically embark on the implementation phase of our community health needs assessment strategy to further our purpose of improving the health and well-being of the communities we serve.



Vincent G. Capece, Jr.
President/CEO
Middlesex Hospital

BACKGROUND

About Middlesex Hospital

Middlesex Hospital, founded in 1904, is a not-for-profit, acute-care community hospital located in Middletown, CT. It is the only acute-care hospital in its service area, which includes Middlesex County and the lower Connecticut River Valley region. The Hospital is licensed for 275 beds and serves a total population of over 250,000 persons. Middlesex Hospital functions within the Middlesex Health System which offers comprehensive community-based inpatient and emergency services, teaching services, and extensive outpatient care including diagnostic, rehabilitation, behavioral health, disease management, radiology, laboratory, cancer care, homecare, wound and ostomy care, surgical services, urgent care, and a network of primary care offices. In October 2015, Middlesex Hospital joined the Mayo Clinic Care Network, giving its physicians a direct link to Mayo Clinic's expert specialists.

Measuring Community Health

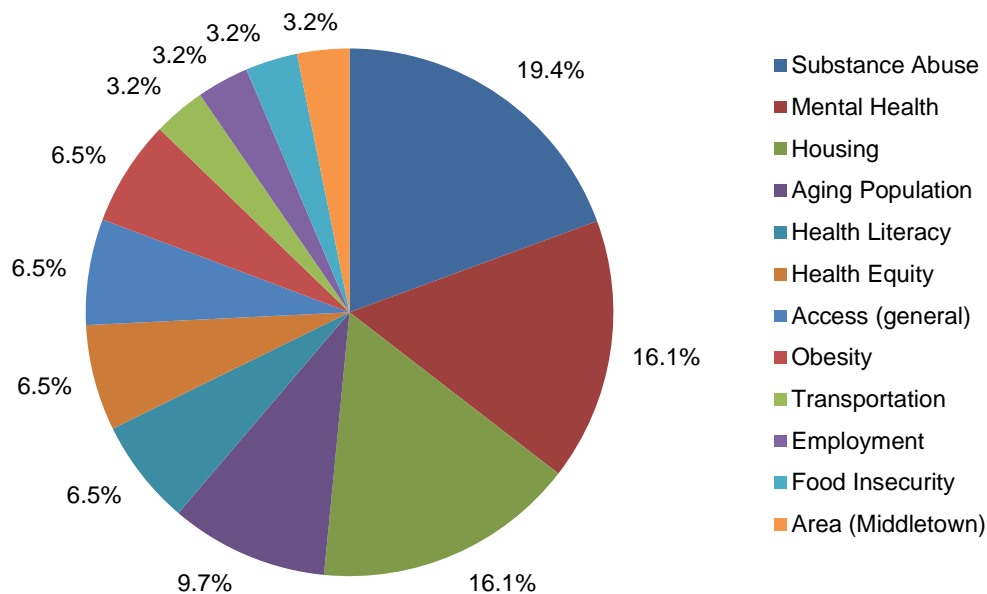
The Patient Protection and Affordable Care Act (the Affordable Care Act, or ACA) was enacted on March 23, 2010 as a means of enhancing the quality of health care delivery and outcomes in the United States. Internal Revenue Code 501(r), as set forth by the ACA, requires not-for-profit hospitals to conduct a community health needs assessment (CHNA) every three taxable years with input from persons representing the broad interests of the community. CHNAs identify the health needs of a defined geographic area through a systematic and comprehensive data collection process. The goal is a community health improvement process that documents the unique characteristics and needs of the community served and responds to those needs through development and implementation of purposeful and effective initiatives.

Oversight of Middlesex Hospital's 2016 CHNA implementation strategy will reside under its Community Benefit department, where Hospital staff will collaborate with community agencies whenever possible to build evidence-based programs that improve health outcomes, including a focus on social determinants of health and health equity.

Prioritization Process

There are many data elements and considerations involved in a community health needs assessment prioritization process given the depth and breadth of the study's conclusions. Middlesex Hospital has selected a total of four priority areas based on internal review of the assessment findings and the results of the informative CHNA community forum prioritization discussion. This joint approach was utilized in order to include broad-based community perspectives (i.e., those represented at the community forum and those represented in the CHNA) in conjunction with data analysis.

The Hospital hosted a community forum to review the summary findings and themes of the assessment and to facilitate a prioritization dialogue. Participants included representatives from key community sectors and hospital departmental leadership; a total of 47 stakeholders attended. Presentation of the findings included primary and secondary data based on the following categories: demographic data; social determinants of health; health equity; health indicators; behavioral health indicators; key informant survey results; United Way 2-1-1 Connecticut system utilization; and a selection of DataHaven 2016 Wellbeing Survey results. During the prioritization exercise, participants formed six groups and were asked to identify five top priorities based on the assessment data, not in rank order. The percentage of times that broad themes were selected is outlined below:



Opioid use was identified as a sub-category under substance abuse; access and lack of providers and services were identified as a sub-category under mental health; homelessness, supportive housing and affordable housing were identified under the housing broad category; and aging population with chronic care conditions was identified under the aging population broad category. When combining housing, health literacy, healthcare access, transportation, employment and food insecurity into a “social determinants of health” category, the result is 38.7% of the top priority areas.

PRIORITIES – MENTAL HEALTH

Priority #1.1	
Goal	Improve access to mental health services through interprofessional collaborative practice.
Actions	Implement an evidence-based integrated model for mental health treatment within the primary care setting, including a focus on social determinants of health and health equity.
Anticipated Impact of Actions	<ul style="list-style-type: none"> • Increased access and utilization of mental health services • Improved overall functioning, quality of life and health outcomes
Plan to Evaluate Actions	<ul style="list-style-type: none"> • Assessment of mental health treatment progress through psychometric testing • Evaluation of health outcomes for primary care cohort referred to behavioral health specialists
Community Partners	Primary care providers; community resources for social determinants of health needs.

Priority #1.2	
Goal	Provide specialized mental health treatment for high risk populations.
Actions	Plan, develop, and implement an early treatment intervention program for young adults with emerging mental illness and/or substance use disorders, including a focus on social determinants of health and health equity.
Anticipated Impact of Actions	<ul style="list-style-type: none"> • Preservation of functioning • Reduction and/or prevention of negative health outcomes
Plan to Evaluate Actions	<ul style="list-style-type: none"> • Assessment of young adults enrolled in program who are able to regain and sustain functioning, remain safe and healthy
Community Partners	Community partners involved with young adult populations; educational facilities; health clinics.

PRIORITIES – SUBSTANCE ABUSE

Priority #2.1	
Goal	Develop a treatment program for high-risk patients experiencing severe alcohol use disorders.
Actions	Plan, develop, and implement targeted treatments to support patients gaining and sustaining sobriety utilizing evidence-based interventions, including a focus on social determinants of health and health equity.
Anticipated Impact of Actions	<ul style="list-style-type: none"> • Reduction in avoidable emergency department visits • Reduction in avoidable hospitalizations • Improved health and quality of life outcomes
Plan to Evaluate Actions	<ul style="list-style-type: none"> • Pre- and post-data analysis on a variety of indicators, including utilization • Monitor health outcomes post-intervention
Community Partners	Primary care providers; community resources for social determinants of health needs.

Priority #2.2	
Goal	<ul style="list-style-type: none"> • A) Develop and launch an opioid awareness campaign • B) Increase access of naloxone to patients at high risk for opioid overdose
Actions	<ul style="list-style-type: none"> • A) Provide education to key community stakeholders • B) Provide patients brought to the emergency department following opioid overdose with naloxone
Anticipated Impact of Actions	<ul style="list-style-type: none"> • A) Increased awareness regarding the dangers of opioid use • B) Reduction in deaths associated with opioid overdose
Plan to Evaluate Actions	<ul style="list-style-type: none"> • A) Assessment of dissemination efforts • B) Monitor dispensing of naloxone to patients in the emergency department
Community Partners	Community organizations with expertise in substance abuse; providers; police departments.

PRIORITIES – AGING POPULATION

Priority #3	
Goal	Design and implement interventions to promote healthy aging in place and improve outcomes for the aging population.
Actions	Develop an in-home comprehensive geriatric assessment and management service line using the HRSA funded GOT Care! (Geriatrics Outreach and Training with Care) program as a template. Coordinate care through an integrated and collaborative approach including a focus on social determinants of health and health equity.
Anticipated Impact of Actions	<ul style="list-style-type: none"> • Reduction in avoidable emergency department utilization • Reduction in avoidable hospital readmissions • Enhanced provider communication for improved care coordination • Appropriate referral to community-based services
Plan to Evaluate Actions	<ul style="list-style-type: none"> • Use of the Institute for Healthcare Improvement Triple Aim framework for outcome evaluation: <ol style="list-style-type: none"> 1. Improved patient experience of care (quality and satisfaction) 2. Improved health of target population 3. Reduced healthcare costs • Provider satisfaction
Community Partners	Community partners specializing in aging populations, such as (but not limited to): St. Luke's Community Services; Alzheimer's Association, Connecticut Chapter; senior centers; Community Health Center, Middletown; Community Renewal Team Meals on Wheels; Senior Resources Agency on Aging; homecare agencies; behavioral health programs for older adults; primary care physician offices; specialists.

PRIORITIES – ASTHMA

Priority #4	Asthma
Goal	Improve asthma outcomes by meeting the Connecticut Asthma Initiative goals.
Actions	<ul style="list-style-type: none"> • Improve access and appropriate asthma care by partnering with the community • Enhance patient education techniques for asthma management • Advance progress toward health equity for asthma care and outcomes by focusing on social determinants of health • Develop a pediatric asthma pathway • Increase utilization of asthma action plans and enhance asthma action plan handoffs
Anticipated Impact of Actions	<ul style="list-style-type: none"> • Reduction in avoidable asthma emergency department visits • Reduction in avoidable asthma hospitalizations • Strengthening of community partnerships relative to asthma care • Improved transitions of care across the continuum for asthma population
Plan to Evaluate Actions	<ul style="list-style-type: none"> • Pre- and post-data analysis on a variety of indicators, including utilization • Assess if actions have been met in desired time-frame
Community Partners	School system; City of Middletown Health Department; Community Health Center, Middletown; primary care physicians; pediatricians; pulmonologists; Middlesex County Asthma Coalition partners; Connecticut Hospital Association and CT Asthma Initiative partners.

CONCLUSION

Adoption of the Implementation Strategy

The Middlesex Hospital Board of Directors approved and adopted the Hospital's community health needs assessment implementation strategy on February 3, 2017 (which is within 501(r) requirements for a hospital facility's authorized body to adopt the implementation strategy on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility finished conducting the community health needs assessment).

Community Health Needs Not Addressed

Middlesex Hospital recognizes that it cannot focus on every health and social need identified in its 2016 community health needs assessment and is therefore committed to allocating resources and in-kind time to the highest areas of identified need and/or areas with greatest potential for impact and feasibility (the four selected priority areas). Resource constraints prevent the Hospital from addressing every need, and in many cases, other local community based organizations may be better suited to take a leadership role in improving certain health outcomes. As with our previous community health needs assessments, the Hospital will continue to be a willing partner, when able, for initiatives not related to its selected CHNA priority areas.

Please contact Catherine Rees, MPH, Director, Community Benefit, with any questions (860) 358-3034, catherine.rees@midhosp.org.