Hartford Hospital

2015 Community Health Needs Assessment and Implementation Plan

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

It is Hartford Hospital's mission "to improve the health and healing of the people and communities we serve".

Hartford Hospital's implementation of Community health is founded on the principles of population health management. Our Community Health Improvement Plan (CHIP) is based 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 Hartford Hospital, a Hartford HealthCare Partner

Hartford Hospital was born in the wake of an industrial disaster – the 1854 explosion at a Hartford railroad car factory that killed 19 and injured 23 workers. There was no central place to care for the injured. In response, civic leaders came together to found Hartford Hospital. The community created our hospital, and we have cared for that community ever since.

Hartford Hospital, based in Hartford, Connecticut, is a not-for-profit, 867-bed hospital serving the Greater Hartford Region. With over 7,000 employees, Hartford Hospital provides services primarily to residents of the Hartford County, but also serves those in neighboring cities and towns.

It is Hartford Hospital's mission to improve the health and healing of the people and communities it serves.

Founded in 1854, Hartford Hospital is one of the largest teaching hospitals and tertiary care centers in New England and has a robust clinical research program. The 867-bed hospital occupies a 65-acre campus in downtown Hartford and operates satellite facilities in Avon, Enfield, Glastonbury, Newington, West Hartford, Wethersfield, and Windsor. Hartford Hospital has New England's second-busiest surgical practice, after Massachusetts General. It is ranked among the top 10 centers in the country for experience in robotic surgery and performs more minimally invasive surgery than any hospital in the region.

The hospital owns and operates LIFE STAR, the state's longest running and one of two critical-care air transport system, and is Hartford's only Level 1 Trauma Center. Hartford Hospital has been training physicians for more than 130 years, primarily in collaboration with the University Of Connecticut School Of Medicine, and is a major teaching site for nurses and allied health professionals. The hospital's new Center for Education, Simulation and Innovation is taking education to a new level by training health care professionals in simulated, life-like environments.

Hartford Hospital includes the Institute of Living, a 114-bed mental health facility with a national reputation for excellence, and Jefferson House, a 104-bed long-term-care facility. The hospital's active medical staff includes more than 1,000 physicians and dentists in 17 departments. In 2011, the hospital had 40,674 discharges, saw 95,567 Emergency Department Visits, and delivered 3,760 babies.

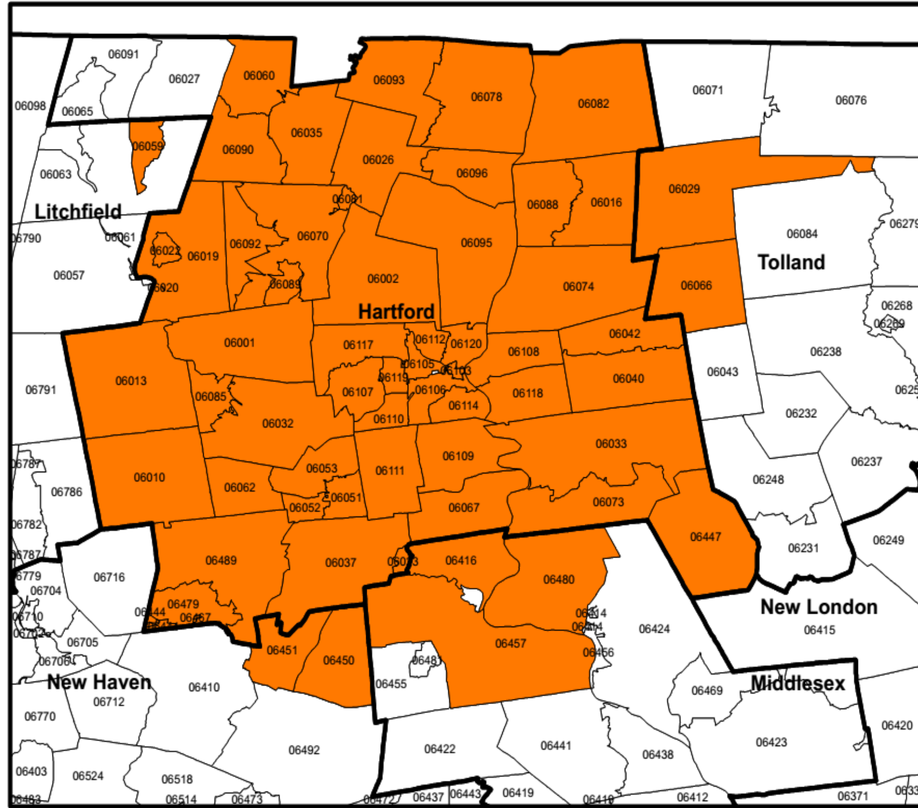
Hospitals today are faced with an array of challenges as they attempt to move from volume-to-value based services. We know that most of the drivers of poor health are outside the health care delivery system and so it is essential that we build partnerships with diverse stakeholders in order to affect changed behaviors across communities and ultimately impact the health outcomes we are trying to achieve as part of our population health strategies. Hartford Hospital maintains a department dedicated to addressing and coordinating its outreach objectives of serving the entire community, not only those who come through its doors. Building on a long tradition of service, the Government & Community Relations Department utilizes hospital strengths alongside those of other well-established community partners. This strategy allows Hartford Hospital to better understand and reach a broad segment of individuals in our service area and most importantly, 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

Hartford Hospital completed its last Community Health Needs Assessment in 2012.

The study area for the survey effort (referred to as the "Hartford Region" in this report) is defined by 62 residential ZIP Codes in Central Connecticut. This area definition is illustrated in the following map.

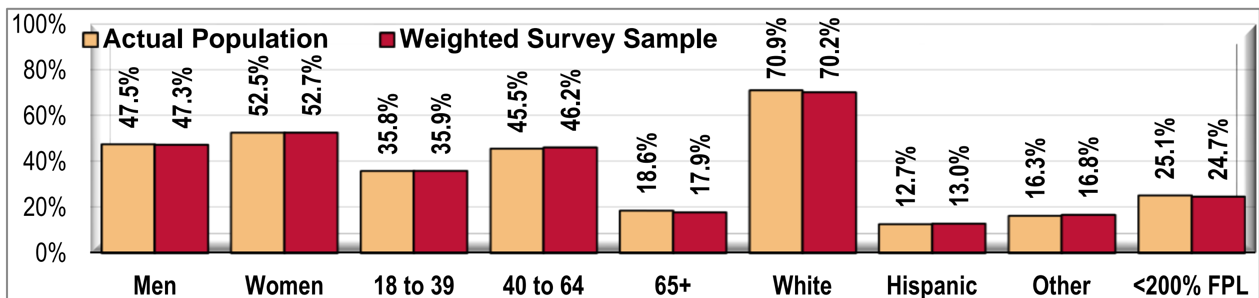


Demographics of the Community

The population of the hospital's service area is estimated at 893,504 people. It is predominantly non-Hispanic White (73.3%), but also has substantial African American (13.1%) and Hispanic (15.4%) populations.

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

Population and Survey Sample Characteristics
Hartford Region (2015)



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

Please also note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2014 guidelines place the poverty threshold for a family of four at $23,850 annual household income or lower). In sample segmentation: "very low income" refers to community members living in a household with defined poverty status; "low income" refers to households with incomes just above the poverty level, earning up to twice the poverty threshold; and "mid/high income" refers to those households living on incomes which are twice or more the federal poverty level.

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

How CHNA Data Were Obtained

CHNA Goals & Objectives

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Hartford Region of Hartford HealthCare's service area. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A 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. This Community Health Needs Assessment will serve 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 on behalf of Hartford HealthCare 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 an Online Key Informant Survey of various community stakeholders.

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 Hartford HealthCare and PRC.

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

The sample design used for this effort consisted of a random sample of 1,446 individuals age 18 and older in the Hartford Region. 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 Hartford Region as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

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 Hartford Region 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

Note that town-specific secondary data were sought and included where available; the remainder of secondary data indicators reflects county-level data for Hartford County.

Assessment of Empirical Data

The Community Health Needs Assessment (which can be found on the Hartford Hospital website at http://www.harthosp.org/AboutUs/Community/CHNA/default.aspx 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, 47 community stakeholders in the Hartford Region took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation

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

Key informants were asked to rate the degrees to which various health issues are a problem in the Hartford Region. Follow-up questions asked them to describe why they identified areas as such, and how these might be better addressed. Results of their ratings, as well as their verbatim comments, are included throughout the assessment report as they relate to the various other data presented.

Note: these findings represent qualitative data meant to augment the quantitative analysis. The Online Key Informant survey was designed to gather input regarding their opinions and perceptions of the health of the residents in the hospital's service region based on their knowledge and experience.

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

While this Community Health Needs Assessment is quite comprehensive, Hartford Hospital recognizes 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.

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 Community Health Needs Assessment report, which can be viewed online at:

http://harthosp.org/AboutUs/Community/CHNA/default.aspx

Public Dissemination:

This Community Health Needs Assessment is available to the public using the following URL:
http://harthosp.org/AboutUs/Community/CHNA/default.aspx

Hartford 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. Hartford 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]

Prioritized Health Needs

After reviewing the Community Health Needs Assessment findings, the CHNA Steering Committee met on June 10, 2015 to determine the health needs to be prioritized for action. During 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.

Organizations Present:

- Capital Workforce Partners
- Community Health Services
- Community Renewal Team
- CT Association of Human Services
- East Hartford Health Department
- Hartford Food System
- Hartford Health Department
- Hartford Public Library
- Hispanic Health Council
- Hockanum Valley Community Council
- Manchester Health Department
- Metro Hartford Alliance
- United Way of Central & Northeastern CT
- Urban League of Greater Hartford
- Windsor Health Department
- Windsor Social Services Department
- United Way of CT
- Hartford Hospital

- Farmington Valley Health District
- Southside Institutions Neighborhood Alliance (SINA)
- Hartford Foundation for Public Giving
- Greater Hartford Legal Aid
- Saint Francis Hospital & Medical Center
- Billings Forge Community Works
- Connecticut Children's Medical Center
- Hartford Gay & Lesbian Collective
- Intercommunity, Inc.
- CT Association of Directors of Health
- Reach Coalition
- Central Connecticut Health District
- Capital Region Education Council
- Charter Oak Health Center
- Faithcare, Inc.
- Legal Assistance Resource Center of CT
- Jewish Federation
- The Village for Families & Children
- Connecticut Health Foundation
- North Central Health Regional Mental Health Board
- North Hartford Promise Zone
- Hartford Public Schools
- Department of Public Health, West Hartford/Bloomfield
- Department of Public Health, Glastonbury

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

Prioritization of Significant Health Needs		
1	Mental Health	• Access, Lack of Services • Stigma • Residential Homes • Co-Occurrence with Substance Abuse
2	Nutrition, Physical Activity & Weight Status	• Prevalence of Obesity • Access to Healthful Foods • Health Education • Access to Recreating/Fitness Facilities • Meeting Physical Activity Guidelines o Moderate Physical Activity o Vigorous Physical Activity
3	Diabetes	• Disease Management • At-Risk Groups (Communities of Color; Lower-Income) • Education and Prevention
4	Substance Abuse	• Access to Resources • Stigma • Prevalence • Culturally-Appropriate Programs • Alcohol use • Cirrhosis/ Liver Disease Deaths
5	Cancer	• Cancer Deaths o Including Prostate Cancer, Colorectal Cancer Deaths o Cancer is the 32 Leading Cause of Death • Cancer Incidence o Including Prostate Cancer, Female Breast Cancer
6	Heart Disease and Stroke	• Heart Disease is the #1 Leading Cause of Death; Stroke is the #3 Leading Cause • High Blood Pressure Prevalence

Additional needs identified as "Areas of Opportunity" were not deemed as significant needs and did not rank highly enough to earn a prioritized ranking. However in some areas such as Injury and Prevention and Dementia, major initiatives underway at Hartford Hospital, will respond to this identified need as will be noted in later in this report.

Other Identified Health Needs
Chronic Kidney Disease
Dementia, Including Alzheimer's Disease
HIV/AIDS
Infant Health and Family Planning
Injury and Violence
Sexually Transmitted Diseases

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 Hartford Hospital's hope and intention that this will foster greater desire to embark on a community-wide community health improvement planning process. Hartford Hospital 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

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.

Access to Healthcare Services

- *Access Health CT*
- *Access to Quality, Affordable Health Food*
- *AIDS CT*
- *Asylum Hill Family Services*
- *Brownstone Clinic*
- *Charter Oak Health Center*
- *Chronic Disease Management Programs*
- *Chrysalis Center*
- *Community Health Foundation*

- *Community Health Services*
- *Connecticut State Medical Society*
- *CT Transadvocacy Coalition*
- *Culturally Competent Nutritionists*
- *Curtis D. Robinson Center for Health Equity*
- *Diabetes Prevention Program*
- *FaithCare*
- *Federally Funded Clinics*
- *Federally Qualified Health Centers*
- *Hartford Gay and Lesbian Health Collective*
- *Hartford Health Care*
- *Health Department*
- *Hispanic Health*
- *Hospital Clinics*
- *Hospitals*
- *Intercommunity, Inc.*
- *Latino Community Services*
- *Malta*
- *Malta House of Care Mobile Clinic*
- *Nothing*
- *Planned Parenthood*
- *Private Providers*
- *Project STEP*
- *Revitalize*
- *Ryan White Medical Transportation Program*
- *Social Services*
- *Urban League of Greater Hartford*
- *Visiting Nurse Association*
- *Weight Loss Management Program*

Arthritis, Osteoporosis & Chronic Back Conditions

- *Charter Oak Health Center*
- *Community Health Services*
- *Connecticut Orthopedic Society*
- *Connecticut State Medical Society*
- *Health Centers*
- *HHC Brownstone Clinic*
- *Hospital Clinics*

Cancer

- *American Cancer Society*
- *Clinics*
- *Community Health Centers*
- *Community Health Services*
- *Community Health Workers/Health Educators*
- *Community/Senior Centers*
- *Curtis D. Robinson Center for Health Equity*
- *Eastern CT Health Network*
- *Hartford Hospital*
- *Helen and Harry Gray Cancer Center*
- *Hispanic Health Council*
- *Jefferson Radiology*
- *Local Health Department s*
- *Local Support Groups*
- *Medicaid Breast and Cervical Cancer Program s*
- *Planned Parenthood*
- *Primary Care Providers*
- *Public Health*
- *CT Quitline*

Hartford Hospital

FY2014-FY2016 Implementation Strategy

For more than 160 years, Hartford Hospital has demonstrated its commitment to meeting the health needs of the Greater Hartford Region.

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

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

Improvement in the health outcomes of these areas will be achieved by employing goals and strategies focused on Partnerships, Access, and Coordination with consistent assessment through secondary data sources (i.e. Robert wood Johnson Foundation), internally collected statistics and analytics, and primary research.

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

Beginning in 2016, Hartford Hospital includes a Community Benefit section within its operational plan.

Priority Health Issues That Will Not Be Addressed & Why [IRS Form 990, Schedule H, Part V, Section B, 7, 2013]

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

Health Priorities Not Chosen for Action	*Reason*
Chronic Kidney Disease	*Hartford Hospital through its various departments and specialty designation as a Level 1 trauma Center and acute care hospital treats many individuals with chronic kidney disease. We are one of two regional hospitals serving as a major transplant provider. We believe we are already responding to the identified need appropriately.*
HIV/Aids	*Hartford Hospital already responds to the needs of the community for those infected with HIV/Aids. We are responding to the needs of the underserved in the community and providing services through our Brownstone Clinic.*
Dementia/Alzheimer's Disease	*Hartford Hospital does address this area of need through our identified gerontology services. Various strategies noted in our plan address cognitive wellness and are being addressed through our primary care efforts, including the underserved population. We believe that this approach is responding to the identified need.*
Infant Health & Family Planning	*Family Planning is addressed through our Women's Health Center with particular focus on the underserved. Harford Hospital does not provide pediatric services. The Connecticut Children's Medical Center is on our campus and is solely dedicated to pediatric care.*
Respiratory Disease	*Respiratory disease is already being addressed through major initiatives in COPD and Asthma. We are partnering with the state Hospital association regarding asthma initiatives and provide services within our Clinics. Given lower priority designation we did not target for additional specialized activities.*

Implementation Strategies & Action Plans

[IRS Form 990, Schedule H, Part V, Section B, 6f-6h, 2013]

The following displays outline Hartford Hospital's plans to address those priority health issues chosen for action in the FY2016-FY2019 period.

Pillar 2: Partnership		
Community Partners/ Planned Collaboration Legacy Foundation, Hispanic Health Council, Hartford Food System, Hispanic Nurses Association, Southside Institutions Neighborhood Association, Malta House of Care, Partnership for Strong Communities, Village for Families and Children, REACH Coalition, Central CT Health District, Hartford Department of Health & Human Services, community shelters for the Homeless, Journey Home, United Way, Salvation Army, Charter Oak Health Center, Community Renewal Team, Hartford Hospital Brownstone Clinics, American Heart Association, Jewish Federation, Spanish American Merchants Association, Local Health Departments, Catholic Charities, domestic violence shelters, mental health and substance abuse providers, Memorial Sloan Kettering, Hartford Hospital clinics and outpatient departments, Rushford, Hartford HealthCare Medical Group, Hartford HealthCare Senior Resources, Physician Services, Hartford Public Schools, other social service agencies, schools, super markets, Urban Alliance, FaithCare, and other faith-based organizations, foundations and community-based providers.		
Goal Engage with a diverse group of community resources, both medical and social, to improve the health of our community		
Timeframe	FY2016 - FY2019	
Community Health Needs Impacted	• Nutrition, Physical Activity & Weight (Obesity), • Diabetes • Mental Health & Substance Use • Heart Disease & Stroke • Cancer	• Injury and Violence • Respiratory Diseases
Strategies & Scope		
Initiative #1: Identify and collaborate with community stakeholders in addressing identified needs. Utilize collective impact strategies to impact population health outcomes by adopting innovative evidence based program models that can impact health status of the broader population. • Tactic 1a: Community Health Needs Assessment prioritization session o *See pages 9-13* Initiative #2: Development of a robust, data driven, primary prevention model to keep the community healthy and reduce future disease burden		

- Tactic 2a: NUTRITION, PHYSCAL ACTIVITY, & WEIGHT
    - Increase availability and access to healthy foods, particularly in urban environments, with emphasis on fresh fruits and vegetables working with community partners.
    - Establish Food Prescription program within the Brownstone clinic with *Mobile Farm Market* partners.
    - Develop and implement *Just Ask* partnership, with area supermarkets to promote healthy eating and nutrition education
    - Support community efforts to increase community gardens.
    - Provide education, including community partners, to increase knowledge of healthy food purchase, preparation and consumption as part of our Bone & Joint Center for Musculoskeletal Health
    - Link to and work with the HHC Medical Weight Loss Centers

- Tactic 2a (2): Center for Musculoskeletal Health
    - Community Education/Seminars as part of Sports and Human Performance Program, Motion Analysis Lab, and Injury Prevention
    - Development of assessment tools for Population Health Management for Arthritis and Osteoporosis
    - Support reduction, management of Arthritis and Osteoporosis (Falls Prevention, Fragility Fracture)
    - Support development of collateral for educational materials in support of Arthritis, Osteoporosis, Injury Prevention and Back & Neck Pain Management
    - Support the establishment of a Bone Health assessment outpatient specialty center
    - Partner with community agencies to provide education on the health benefits of physical activity and nutrition, and address issues of weight and obesity.
    - Work with Community businesses, local agencies to promote active living opportunities,(biking lanes, walking trails, pedestrian walk ways)

- Tactic 2a (3): Partner with one of the local health departments, Central CT Health District, to support the surgeon General's "Step it Up!" program in 3 towns within the HH service area
    - Sponsor community education program through public awareness campaign promotion of "STEP it Up!" with community nonprofit agencies.

- Tactic 2b: Chronic Disease-Diabetes, Heart Disease & Stroke
    - Improve chronic disease management through education and community partnerships to meet growing needs of targeted populations, especially those at-risk and underserved.
    - Increase education sessions to individuals in the community about the prevalence and prevention of chronic conditions specifically targeting cancer, heart disease and stroke, diabetes, including promoting appropriate screening and early detection
    - Partner with community social service provider (Community Renewal Team) to address continuity of care for a cohort of diabetic patients who are at high risk for readmission
    - Establish consolidated Diabetes Life Center and Endocrine clinic within Hartford Hospital's Brownstone Clinics, a community based health clinic serving the under and uninsured in over 50 specialty areas including primary care, in order to enhance service to low-income and underserved populations.
    - Implement a Food Prescription Program pilot for patients with diabetes within the Brownstone Clinic with two community agencies; the Hispanic Health council and Hartford Food System.
    - Provide comprehensive follow-up care and promotion of chronic disease management through ongoing education and support programs
    - Support regular community health screenings and education within public libraries, churches, barber shops, nonprofit agencies with partners from the Legacy Foundation, Southside Institutions Neighborhood Alliance (SINA), and Hispanic Nurses Association.

- Participate with other community-based collaborative efforts to promote chronic disease prevention and management
- Partner with American Heart Association to provide education and screenings at grocery stores, malls, senior centers, and churches on heart health.
- Participate in establishing and expanding Heart Disease management and opportunities for multidisciplinary outpatient support team to improve access to care across the HHC healthcare system.
- Increase participation in, and access to, clinics, and community practitioners as we evolve the cardiology service line.
- Support and participate in initiatives with our community partners for health promotion, preventive care initiatives, and overall access to community health initiatives.
- Provide programs and initiatives specifically for underserved and at-risk populations

- Tactic 2c: MENTAL HEALTH & SUBSTANCE ABUSE
- Educate the community on mental health and substance use disorders and how best to respond, improving awareness of problems and access to services. Support community-based strategies to address prevention and intervention.
- Strengthen partnerships between the hospital, the Institute of Living through the Behavioral Health Network (BHN) , and community-based services
  - Increase mental health literacy within faith and shelter communities providing mental health training (Mental Health First Aid), throughout the region.
  - Provide educational materials at less or no cost to community agencies
- Offer Regional National Dialogues on Mental Health Forum to raise awareness of behavioral health issues
  - Provide regional community events regarding mental health/substance abuse for the Greater Hartford Region.
- Expand support group offering in response to community need in areas such as Teen LGBTQ, Medically complex, or Trauma Support.
- Naloxone (Narcan) training for all EMS providers through Emergency Department physicians and Pharmacists.
- Collaborate with community providers to address psycho-social needs of frequent utilizers of the ED, a majority of which suffer from behavioral health issues, through our established community Care Team.
- Continue Smoking Cessation initiative with the state Department of Public Health
- Continue outpatient services at Duncaster Home for seniors addressing dementia and cognitive impairment
- Continue efforts to prevent delirium pre and post-surgery through the Hospital's ADAPT program

- Tactic 2d: CANCER
- Reduction of cancer through early detection strategies across Hartford HealthCare region
  - Support initiatives that influence prevention and early detection by supporting implementation of community based prevention services and outreach
  - Provide cancer screenings throughout various community based settings.
  - Provide community education presentations to discuss risk factors of breast, prostate, lung, and colorectal cancers including multi-cultural and culturally competent sessions, as well as Integrative Medicine services
  - Launch added Lymphedema education presentations
  - Maximize Memorial Sloan Kettering and Hartford HealthCare Cancer Institute alliance to meet community health needs utilizing print media and other community forums to promote public

awareness and education.
Collaborate with state and local agencies to implement CT state policy on tobacco-free living and support cessation efforts
  - Increase American Lung Association "Freedom from Smoking" classes

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 among community partners around identified priority needs
- Enhanced strategies to address mental health access, chronic disease management, physical activity

Plan to Evaluate Impact

- Assessment of Programs offered
- Evaluate levels of services consistent with identified need
- Set benchmarks for patients/clients and monitor outcomes within specific initiatives
- Set priorities based on community impact and empirical health outcomes data
- Community benefit dollars invested

Results-TBD

Pillar 3: Access		
Community Partners/ Planned Collaboration Integrated Care Partners (ICP), Hartford HealthCare Medical Group, Hartford HealthCare at Home, Hartford HealthCare Senior Resources, Charter Oak Health Center, Community Renewal Team, Brownstone Clinics, Hispanic Health council, Hispanic Nurses Association, Legacy Foundation, community-based health and mental health providers, social service agencies, HHC Behavioral Health Network; Hartford Hospital Institute of Living, State Department of Mental Health and Addiction Services, local health departments.		
Goal Create multiple connections to communicate with, and care for, our community regardless of socioeconomic status and for all payor types.		
Timeframe	FY2016 - FY2019	
Community Health Needs Impacted	• Nutrition, Physical Activity & Weight (Obesity), • Diabetes • Mental Health & Substance Use • Heart Disease & Stroke • Cancer	• Injury and Violence • Respiratory Diseases
Strategies & Scope		

Initiative #1: Ambulatory Expansion and Growth

- Tactic 1a: NUTRITION, PHYSICAL ACTIVITY& WEIGHT
- *Bone & Joint Institute-Center for Musculoskeletal Health*- Develop Sports & Human Performance Programs incorporating Rehab, Motion Analysis, Injury Prevention
- Tactic 1b: Musculoskeletal Health & Fitness Program
- Osteoporosis Prevention through community osteoporosis screening
- Fragility Fracture re-fracture prevention
- Osteoarthritis Prevention
  Weight management
  Conditioning & Fitness
  Family Life Education childhood obesity program
  Nutritional counseling & instruction ("Connect to Healthier" demo kitchen)
- Population Health Management
  Musculoskeletal (MSK) Data and Analytics will be used to assess and determine population health strategies and implementation
  Primary Care Support (algorithms & tools) will serve to inform physical health
  Culturally-based decision-making support will ensure culturally sensitive treatment modalities.
- Exercise & Weight Management
  Promotion of lifestyle changes and gentle exercise for those hoping to address weight management and prevent or slow osteoarthritis,
  Support efforts of providers and community agencies to address Pediatric obesity in Hartford.

- Nutrition Counseling
  - Provide program support for patient population at high risk for surgical intervention due to excessive BMI
- Injury Prevention
  - Provide educational support for athletic teams around proper sport kinematics
- Fragility Fracture Prevention
- Establish fall prevention program to include core strengthening and gait and balance components
- Launch mobile Musculoskeletal Health community van to conduct screenings for area employers and other community members.

- Tactic 1c: Establish new ambulatory care centers and Family Health Centers to create additional primary care and urgent care access points for Hartford Region residents
  - Access points will meet identified community needs and fill documented physician shortages, in key specialty areas as well as in primary care
  - Creation of Neurosciences Institute which will better coordinate care for Stroke care and address Stroke prevention as one of several neurological services.
  - Creation of Cardiology Institute
  - Recruit and retain primary care providers to fill identified shortages and to supplement new shortages arising due to pending retirements

Initiative #2: Establishment of clinical programs & services which align with Hartford Region strategy and which meets identified community health needs, and satisfy community benefit requirements

- Tactic 2a: Chronic Disease-Diabetes, Health Disease & Stroke
  - Launch case management project within Brownstone Clinic with an identified cohort of Diabetic patients in partnership with a community agency, the Community Renewal Team.
  - Heart disease provide education to community based EMS services to facilitate implementation of life saving heard disease strategies, such as pre-hospital ECG, STEMI (St-Elevation Myo-Cardial Infarction)
  - Continue air ambulance system to allow advanced placement and quick transport of heart attack victims
  - Support and expand partnerships with Federally Qualified Health Center (FQHC's) providers
  - Increase access to cardiac care in community settings.
  - Evaluate the development of comprehensive cardio-vascular services that are multidisciplinary and co-locator practitioners.
  - Establish and expand Heart Disease management programs and initiatives.
  - Include community health services as part of the Cardiovascular strategic plan.

- Tactic 2b: CANCER
  - Support the Memorial Sloan Kettering Alliance through requirements set by MSK in its "Community Health" pillar. Please see Cancer Institute's Community Health Improvement Plan
  - Increase utilization of clinical and community preventive service through implementation of community based services
  - Enhance linkages with primary care
  - Engage Federally Qualified Health Centers in making referrals to cancer screenings
  - Target community populations that have higher mortality rates
  - Provide community outreach by attending community health fairs, town and employee health fairs, senior centers, high schools, libraries, community agencies, food pantries and shelters, and sponsored events.

- Provide educational presentations on cancer risk factors
- Partner with stakeholders to ensure multi-cultural approach to education and to provide culturally competent information
- Provide low to no-cost screenings to include; mammograms and ultrasounds, lung, mobile mammography, skin, head and neck screenings, bone marrow drives, colorectal screening, prostate screening
- Provide Integrative therapy services to cancer patients to improve wellbeing. Services to include yoga, reiki, art therapy, acupressure and cranial sacral therapy, among others
- Facilitate support groups for cancer patients and care givers

Initiative #3. ACCESS TO MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

- Tactic 3a: Mental health and substance abuse
  - Increase access to mental health care for underserved through Institute of Living case management pilot in the Brownstone clinic
  - Offer weekly peer support group in Brownstone Clinic
  - Work with Hartford HealthCare Rehabilitation Services to place Behavioral Health Clinician in specialty office for pain/headache
  - Work with Behavioral Health Network Primary Care Behavioral Health Group to increase embedded clinicians in Primary Care Office
  - Sustain community Care Teams embedded in the Hartford Hospital Emergency Department
  - Actively participate through education and community forums in addressing mental health awareness through the HHC Stop the Stigma campaign.
  - Develop Suboxone training to Brownstone providers and provide to patients
  - Establish partnership with Rushford and support Fellow in Addiction Services at Brownstone
  - Dementia assessment in geriatric patients as part of Duncaster and Brownstone/HH partnership
  - Smoking cessation program offering for patients at Brownstone clinic

Anticipated Impact

- Reduction in the number of uninsured and underinsured individuals without access to specialty care
- Increase access to healthy food
- Increase in community efforts supporting physical activity and nutrition information
- Increase in My Health Direct and ZocDoc utilization
- Increase in primary care access and coordination

Plan to Evaluate Impact

- Number of under and uninsured accessing care
- Primary care panel growth
- Primary and Urgent Care visits volume
- Decrease in dropped appointments to clinics
- ZocDoc utilization

Results-TBD

Pillar 4: Coordination

Community Partners/ Planned Collaboration

Integrated Care Partners (ICP), Hartford Hospital Brownstone Clinics, Hartford Hospital Diabetes Life Care, Bone & Joint Institute, Hartford HealthCare Neurosciences Institute, Hartford HealthCare Rehabilitation Network, HHC Senior Services, HHC Cancer Institute, Charter Oak Health Services, Community Health Services, Hispanic Health Council, Hartford Hospital Institute of Living, 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), • Diabetes • Mental Health & Substance Use • Heart Disease & Stroke • Cancer	• Injury & Prevention • Respiratory Diseases

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: Nutrition, Physical Activity& Weight

  Musculoskeletal Health & Fitness Program - Advance musculoskeletal care through injury risk assessment, through Integrated Care Partners (ICP), and HHC Rehabilitation Network

- Tactic 1b: Initiate a care coordination team, to work alongside the Hospitalist team, to provide coordination and management to identified at-risk patients
  - Hire a Community Health Worker within the Department of Medicine and Brownstone clinic
  - Team will be mobilized to address social needs that impeded care coordination and good outcomes
  - 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

- Tactic 1c: Chronic Disease-Diabetes, Health Disease & Stroke
  - Develop and sustain strong partnership with Integrated Care Partners (ICP)
  - Further the development of imbedded health coaches as a member of the care team in Family Health Centers in collaboration with ICP
  - Expand health coach model to private providers within the ICP network
  - Establish new programs and opportunities to improve care coordination to support patients and community based providers.

- Provide assistance and improve access to health insurance options and referrals.
- Enhance care coordination for stroke patients including comprehensive post stroke follow up and rehabilitation
- Established model for improved care coordination of stroke victims presenting in Hartford HealthCare Emergency Departments.
- Expansion of Movement Disorder program

- Tactic 1d: Mental Health & Substance Abuse
  - Increase access to coordinated mental health services in the community
  - Expand the Primary Care Behavioral Health Project in selected Family Health Centers in the region for immediate mental health care coordination and referral
  - Sustain Community Care Teams embedded in the Hartford Hospital Emergency Departments

- Tactic 1e: CANCER
  - Team will coordinate with disease-specific clinics whenever appropriate to manage patients on an outpatient and ongoing basis.
  - Team will develop Outreach Pillar that will serve to facilitate care coordination

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

- Tactic 2a: Build the capacity of local health care clinics to provide coordinated health delivery with a focus on population health management services
  - Develop and sustain strong partnership with Integrated Care Partners (ICP)
  - Further the development of imbedded health coaches as a member of the care team in Family Health Centers in collaboration with ICP
  - Expand health coach model to private providers who are ICP members

- Tactic 2b:- Enhance care coordination and integration of spine services across the system, medical and surgical spine care, rehabilitation and pain management

- Tactic 2c:: Expansion of general neurology services

- Tactic 2d: Improve accessibility and provide assistance for health insurance options and referrals

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

- Tactic 3a: Develop risk stratification competencies and processes

- Tactic 3b: Implement Epic electronic health record

Anticipated Impact

- Reduction in avoidable admissions, avoidable ED visits, and Readmissions
- Increase in utilization of ZocDoc
- Increase in the in-network rate allowing for better care coordination
- Improvement in patient quality and safety

Plan to Evaluate Impact • Avoidable admissions and readmissions, • Decrease in ED visits, • Decrease in readmissions • ZocDoc utilization • Better Patient care through enhanced Quality & Safety Scores as appropriate
Results: TBD

Hartford Hospital 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 December 21, 2015, the Board of Hartford Hospital 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, Hartford Hospital Board Approval & Adoption:

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By Name & Title

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Date