.

Charlotte Hungerford Hospital
Community Health
Improvement Plan

2018-2021

Introduction

"For he who has health has hope; and he who has hope, has everything." Owen Arthur

Health assessments help us examine changes to the health of our community, provide insights as to how residents can lead healthy and happy lives, and identify key health issues facing the community. The definition of health now includes the quality of the community in which we live, work, and play – not just the lifestyle habits of individuals. A comprehensive assessment process must provide a framework that helps communities prioritize public health issues; identify resources for addressing them; and effectively develop and implement community health improvement plans.

The 2018 Community Health Needs Assessment ("CHNA") for Charlotte Hungerford Hospital ("CHH" or the "Hospital"), part of Hartford HealthCare's (HHC) Northwest Region, leveraged numerous sources of local, regional, state and national data along with input from community-based organizations and individuals to provide insight into the current health status, health-related behaviors and community health needs for the Hospital service area.

In addition to assessing traditional health status indicators, the 2018 CHNA took a close look at social determinants of health (SDH) such as poverty, housing, transportation, education, fresh food availability, and neighborhood safety. SDH have become a national priority for identifying and addressing health disparities, and HHC is committed to addressing these disparities through this Community Health Improvement Plan (CHIP).

In addition to the above assessment and analysis, this CHIP is based on:

- Discussion of top needs to focus on from the late February Northwest Region Board Meeting

- Integration of elements from the recently updated 2016-2019 CHH CHIP, building upon those successes and maintaining or enhancing initiatives underway
- Community outreach, including prioritizing needs to address (completed at a community forum held in May, including discussion of best ways to partner on improvement initiatives)
- Leadership from regional community directors, who work closely with engaging community partners
- Input from discussions with regional leadership and planners, the regional president, and regional Executive Leadership Team (ELT)

The intent of this plan is to be responsive to community needs and expectations and create a plan that can be effectively executed to leverage the best of the system resources, regional hospital and network resources, and community partners. The CHIP supports HHC's mission "to improve the health and healing of the people and communities we serve" and is part of HHC's vision to be "most trusted for personalized coordinated care." More specifically, this CHIP is collectively aimed at:

• Improving the health status of the community;

• Identifying opportunities for better preventive care and wellness initiatives;

• Addressing social determinants of health and health disparities within the service area;

• Continuously improving access to and quality of health care and community education that will enable community members to improve their overall well-being.

While a CHIP is designed to address these multiple needs, narrowing the focus to key areas of need and impact with associated key strategies best positions a health system for success. A CHIP is a dynamic rather than a static plan and should be modified and adjusted as external environmental factors change, including market conditions, availability of community resources, and engagement from community providers. Furthermore, a CHIP should build on and leverage success while simultaneously adjusting strategies and actions as obstacles are encountered.

The Region has narrowed its work to four focus areas that are intended to address root causes of community health issues while recognizing where the Northwest Region in partnership with the community can be most effective in impacting change. The plan for each of these areas is outlined on the following pages. The driving rationale for each of these can be summarized as follows:

Promote Healthy Behaviors and Lifestyles – Research has repeatedly shown that good eating and exercise choices are critical to averting lost or unproductive time at school or work, growing and maintaining cognitive and physical functioning, promoting mental health, and preventing and managing many chronic diseases such as heart disease, cancer, stroke, diabetes, and osteoporosis

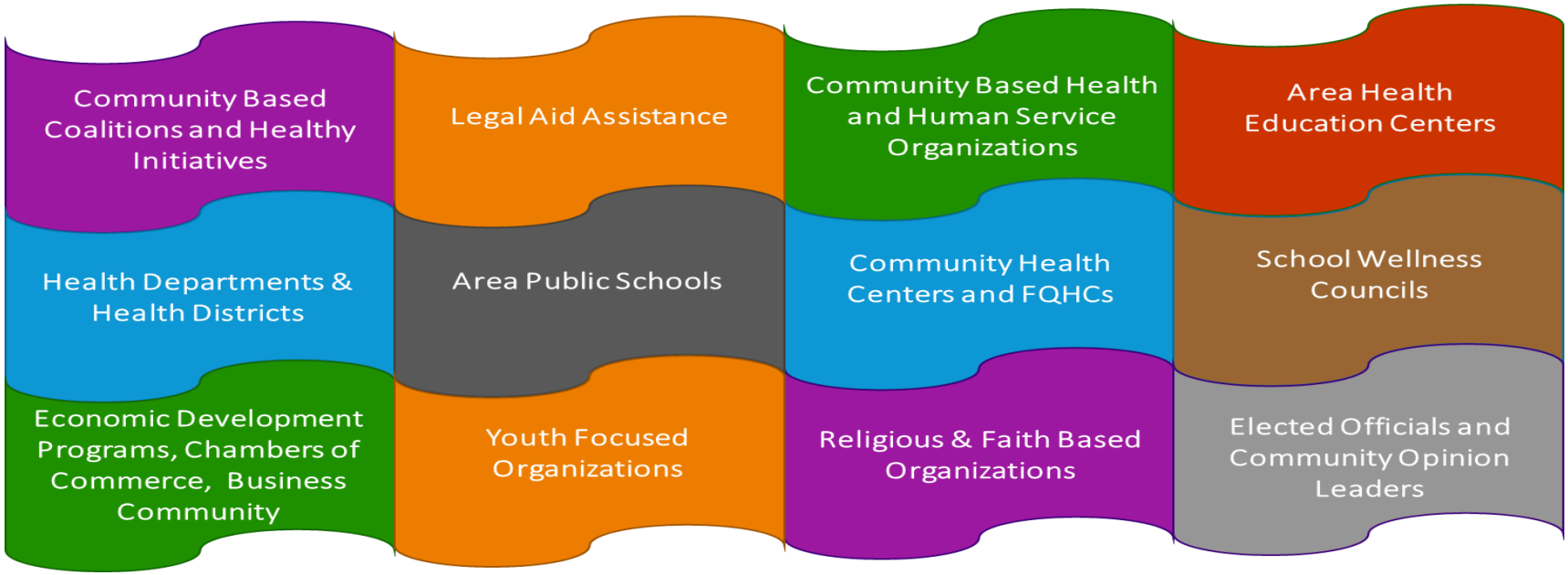
Reduce the Burden of Chronic Disease – Proven interventions can prevent and reduce the effects of chronic and infectious diseases and are aimed at the **six** most common and costly health conditions – tobacco use, high blood pressure, healthcare-associated infections, asthma, unintended pregnancies, and diabetes – these conditions can be countered by proven specific interventions as highlighted by the CDC.

Improve Coordination of Services and Access to Care – Coordination of care is consistently identified as a key obstacle to achieving better access to care and services, as awareness of available resources, depth of patient and provider knowledge of community services, and tracking and follow-up of patients as they move from and between different provider organizations or points of care are challenged.

Enhance Community-based Behavioral Health Services– Mental health and substance abuse were also consistently identified as a top issue by the community and a root cause impacting all aspects of health. These services and interventions include more accessible screening, improved and timelier referrals, expanded programming and public awareness and empowerment.

As community health leaders, this CHIP is essentially our call to action over the next three years to do our part to assure those we serve live long and healthy lives. Community partnerships will be a key

ingredient to achieving success. This plan aims to further develop and pursue active engagement with the community. The diagram below represents some of the key categories of community stakeholders.



The good news is that we do not do this work alone. And, even though this work that can be overwhelming at times, with important partnerships throughout the communities we serve, success is made possible. What's more, we have formalized these partnerships around these population health goals in recent years, and three of these important and relevant collaborations loom above all others, including:

1) **Fit Together -** A community collaborative of health and social service providers and public officials, formed in 2011, with the purpose of identifying and implementing environmental and social improvements in the Greater Torrington and Winsted areas that help make healthy choices for

individuals, easy choices. With objectives to increase physical activity and promote healthy lifestyles, Fit Together serves as the main vehicle for implementing many of the CHIP strategies that relate to its purpose and receives $100,000 per year for the next five years from HHC.

2) **Building Healthier Communities Advisory Board –** As part of the Affiliation Agreement between The Charlotte Hungerford Hospital (CHH) and Hartford Health Care Corporation (HHC), a distribution of $2,500,000 has been made to the Northwest Connecticut Community Foundation, Inc. (Foundation) for the express purpose of enhancing the economic and community well-being of the Greater Torrington and Winsted areas. Funds are to be used for the formulation of a regional economic and social development plan to improve the Social Determinants of Health (SDH). The four areas pre-selected by the Board for their initial focus on SDH impact include: Education, Health and Healthcare, Neighborhood and Environment, and Economic Stability.

3) **The Litchfield County Opiate Task Force – A Task Force** formed in December 2013 to assure collaboration of area agencies, officials and community members who meet monthly to share information and develop interventions that will reduce the harm of opioid addiction. The Task Force organizes its work around four essential goals of improving access to care, enhancing collaboration and data sharing between and among service providers, reducing opioid use and misuse in the community, and sharing helpful information about addiction, prevention, safety and treatment.

Contents

Community Health Improvement Plan

STRATEGIC AREA #1: Promote Healthy Behaviors and Lifestyles

Rationale for Action

21% current tobacco users in Torrington/Winsted much higher than state average of 15%
Area residents more frequently reported heavy drinking and current smoking vs. state residents
E-cigarette use among youths at 5.3% in CT vs. 2.2% nationally. The percentage of students in local school districts passing all four components of state physical fitness tests was 34% in Torrington and 22% in Winsted with a statewide average of 51%.
One in five CT children in the TAHD services area was obese according to Body Mass Index (BMI) for age standards. For children living in households with incomes below $35,000, this increased to one in every three children
34.8% Torrington and Winsted adults are at a healthy weight vs 38.6% in state overall
9.5% Litchfield county residents are food insecure, 14.1% Litchfield county children are food insecure
37% US Adults have Pre-Diabetes

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
Reduce tobacco use: **Increase participation in evidence-based tobacco cessation treatments**	Offer “Freedom From Smoking” in conjunction with the American Lung Association to the public and our workforce 3 times per year	Free Smoking Cessation class offered January 2018 with 7 of 13 participants April, 2018 with 9 of 15 participants, October, 2018 Torrington with 12 of 12 participants and October 2018 Winsted with 2 of 5 participants from the community becoming tobacco free Six month follow up with October 2018 participants planned.

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
Remove barriers that impede access to covered cessation treatments	Offer "Freedom From Smoking" program free of charge for each community and CHH staff participant by subsidizing the $75 fee	All programs for staff and community are provided at no cost for classes and materials.
Measure the reach and contact points for community based education and public awareness activities effectively communicating the harmful effects of all forms of tobacco	Collaborate with McCall Center for Behavioral Health, Northwestern CT Community College, Torrington Area Health District and EdAdvance to promote tobacco prevention activities community wide and in area high schools	Design and implement Tobacco Free display presentation to be used for CHH anti-tobacco community outreach. Tobacco free messaging and activities targeting local youth and adolescents offered at a booth at Main Street Marketplace in downtown Torrington in Summer of 2017 and 2018
	Provide tobacco free policies and signage at no cost to area businesses, organizations and public parks that plan to go tobacco free.	Assist Northwest CT Community College in becoming a smoke free campus by 2019 with worksite signage and facilitators for smoking cessation programs starting in Oct. 2018. Spring 2019 program being planned for NCCC Winsted location. City of Torrington Parks &Recreation Dept. adopted a Tobacco/Smoke and Vape-Free Parks Policy October 3, 2018

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
Decrease Type Two Diabetes rates **Increase participation in diabetes prevention programs** **Increase the number of individuals receiving glucose screening**	Expand access to a diabetes prevention program promoting lifestyle change to prevent Type 2 diabetes by implementing a CDC-approved curriculum diabetes prevention program with local YMCA for adults.	CHH supports the "Measurable Progress Unlimited Support" Diabetes Prevention Program at the Northwest CT YMCA. Total number of participants since 2016 is 17, nine of whom have hit their weight loss goals. Group A started 9/2016 with 5 participants. Three of these 5 lost >7% of their body weight. Group B started 3/2017 with 5 participants. Three of these 5 lost >7% of their body weight. Group C started 11/2017 with 7 participants. Three of the four still-active participants have lost >7% of their body weight. in the program
	Promote screening for abnormal blood glucose in those who are overweight or obese as part of a cardiovascular risk assessment	CHH staff provides free blood glucose screenings to community and local business-based wellness fairs throughout the year CHH Be Well Program provides opportunity for ConnectiCare covered staff members to received annual free biometric screenings, including blood glucose. Screenings held in Oct/Nov., 2018.

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
Increase physical activity and healthy eating habits: **Reduce rates of obesity to below state averages** **Increase percentage of adults and children meeting recommended exercise requirements**	Utilizing the Fit Together collaboration, focus on long-term policy changes including the following activities (See Fit Together Strategic Plan): Families Fit Together- Nutrition and Movement - CHH and local YMCA piloting project at Brooker Memorial, working with local pediatricians to refer overweight/obese children who are given access to a Registered Dietitian Nutritionist, Y Personal Trainer, Psychiatric Clinician, cooking classes, etc.	Families Fit Together, nutrition and movement program: Six 8-week sessions were held from August 2016- April 2018. 17 families and 34 children completed the program. Pre and post tests revealed increase awareness of nutrition and physical activity guidelines. Merging Program with evidence based YMCA prevention program Healthy Weight and Your Child. Launch date March 2019
	Assist in creating a linear fitness park along the existing Sue Grossman Greenway	Funding approved. In process.
	Recruit sponsors for distribution of 20 bike racks in Torrington and Winsted by 2019	13 bike rack secured Spring 2019 installation
	Support and promote Northwest CT Food Hub to increase availability of fresh local produce via collaboration with Building Healthier Communities Advisory Board	In planning phases – targeting Spring 2019

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
	Sponsor and coordinate StrongWomen, a Tufts University training program specifically for age 55+ women	Program provides muscle mass and strength training, improved bone density and reduced risk for diabetes, heart disease, depression and obesity. One ongoing program is for community population and one is for CHH employees. As of Oct. 31, 2018, 44 individuals have participated in this program on an ongoing basis.
	CHH provides outreach and financial sponsorship to promote local events that encourage healthy activities and lifestyles	One such sponsored event is Torrington Kids Marathon final mile which has been held annually at Torrington High School since 2016. Over 300 area children participated in the 12 week wellness event each year in the past 3 years
	CHH clinicians and CCD staff participate in annual workplace wellness fairs for LARC, the City of Torrington, Town of Winsted, and Torrington Savings Bank to promote 5210 healthy lifestyles, healthy nutrition and portion control information	Will be repeating these wellness fairs and are targeting 6 more
Improve access to healthy foods for school-aged children **Increase FIT Together 5210 School participation rates by 25%** **Increase the number of culinary training classes for school food service workers**	Promote Fit Together 5210 Let's Go! In early childhood education and schools by adopting healthy eating standards, wellness policies and facility/program reviews for optimal health environments	We are currently using outdoor advertising to give Fit Together constant exposure in a high impact, high frequency setting. Eight area preschools, 4 area elementary schools, 2 middle school and 2 high school have signed on the Fit Together's 5210 initiative.

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
		Culinary Classes for school food services workers planned for 2018-2019
	Support Northwest CT Food Hub via collaboration with Building Healthier Communities to provide locally sourced produce to area schools	In planning phases –targeting Spring 2019

STRATEGIC AREA #2: Reduce the Burden of Chronic Disease

Rationale for Action

68.2% of deaths in NW related to chronic disease vs. 61.2% in CT
6.9% COPD in NW with mortality rate of 33.6% vs. 5.5% and 15.9% respectively in state overall
The most prevalent medical diagnosis for persons hospitalized in the CHH service area was Hypertension (high blood pressure), followed by Type II Diabetes.
ED visit rates for selected diagnoses show rates for heart disease and stroke were higher in Litchfield County vs. state overall

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
Improve management of chronic diseases **Increase number of referrals to CHF clinic** **Increase access to CVD medications and devices**	Promote strategies that improve access and adherence to anti-hypertensive and lipid-lowering medications	Expand access to Patient Support Fund to CHH Multi-Specialty Group Cardiology Office to assist patients with cost of new medications. We have recently committed to a 6 month pilot program with two local pharmacies to begin Jan. 2019.

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
Increase participation in chronic disease management programs	Promote access to devices for self-measured blood pressure monitoring for home use.	Case Management working with HHC to update standardized pathways
	Promote a team-based approach to hypertension control through the implementation of a Congestive Heart Failure transition programs and CHF clinic	CHH Case Managers refer CHF patients at discharge to Cardiovascular Medicine's CHF Clinic. APRN at the office coordinates the care and services. Patients receive treatment once a week for 2-5 weeks CHF Primary diagnosis- 103 admissions in FY17 and 106 admissions in FY18
	Diabetes center with endocrinologist, PA, diabetes nurse educator and registered dietitian/certified diabetes educator provide treatment and education: insulin pump training, carbohydrate counting classes, blood glucose awareness training, continuous glucose monitoring and support for patients with gestational diabetes.	CHH Multi-Specialty Group Diabetes and Endocrinology Office provided annual "What's New in Diabetes" talk on Nov. 14, 2018. This free community education program included dinner and a presentation by Egils Bogdanovics, MD for 79 attendees. CHH offers Diabetes Boot Camp, an annual intensive, programmed, 3-day weekend retreat for Type 1 and 2 diabetes patients. It features lectures, equipment demonstrations, group education sessions, nutrition and exercise instruction and glucose monitoring. Boot camp held September 7-9, 2018 with 13 participants.

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
	Expand Medical Nutrition Therapy and Intensive Behavioral Therapy for Obesity Services by Registered Dietitian Nutritionist	In 2017 a registered dietitian nutritionist began providing medical nutrition therapy and intensive behavioral therapy for obesity for Thomaston primary care patients. 105 patient visits for MNT and IBT for the 2017-2018 fiscal year
	CHH Case Management provides a Lung Talk education program for inpatients with a COPD diagnosis prior to discharge	Case Management working with HHC to update standardized pathways Primary COPD Diagnosis: 195 admissions in FY17 and 106 admissions in FY18
	Co-sponsor LIVE-WELL six-week chronic disease self-management program focusing on easy exercises, improving nutrition and appropriate uses of medications and supplements	Periodically launched and free to area residents- January 2019 planned at Keystone Place collaboration with Torrington Area Health District.
	Provide CHH Educational Doc Talks to the public throughout the year addressing various topics including chronic diseases	2018 Fall Doc Talks: Sept.19-Urology Oct. 2,17,30-Ortho Series Nov. 6-Memory Nov. 14-Diabetes 2019 Spring Education: Walk with a Doc – health topic discussion for community members
	Sponsor a series of presentations on Women and Heart Disease annually to provide education and expertise and direct communication to community members.	Heart, Body and Soul, a health and wellness series focused on women is planned for Spring 2019

Strategic Area #3: Improve Coordination of Services and Access to Care

Rationale for Action

Litchfield County has one primary care physician per 1,569 residents, well below the national benchmark of one per 1,030 and the state average of one per 1,180 residents.
Torrington is designated as underserved (MUA/HPSA)

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
Improve access to Primary and Preventive Care **Improve Per Capita Ratio of Providers** **Number of screening and encounters with Center for Healthy Aging**	Recruit additional primary care providers and assure adequate distribution throughout our service area	Additional providers 2018: June, full-time physician at Thomaston Primary Care Office July, a full-time APRN at Primary Care Office in Canaan August, two additional full time physician have been contracted for one year each for Thomaston and Winsted Primary Care offices. Contract signed in Nov. 2018 for new Primary Care physician in Litchfield. Entered contract for July, 2019 for Primary Care physician in Winsted.
	Provide BP, cholesterol and blood glucose screenings to community members free of charge at health fairs and local business employee wellness fairs. Provide access to specialized services for seniors through education and navigation	CHH and many of its Multi-Specialty Group practices provide secure online tools to give patients free access to their medical information and health resources. System upgraded May, 2018. The HHC Center for Healthy Aging, opened in August, 2018, is a new resource and assessment center that provides seniors and their care givers access to a navigator who works to arrange for services and offer information in order to improve their quality of life.

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
Improve access to Primary and preventive care for CHH employees **Number of Screenings** **Number of HRA completed**	Employee Wellness platform, BE Well, provides ConnectiCare covered employees: Annual biometric prevention screenings Annual health assessment Incentives for preventative exams Health coaching services	In 2017, Biometric Screenings were performed for 183 employees and 183 employees completed the Annual Health Assessment
Improve access and resources addressing Social Determinates of Health **Number primary care patients screened for SDH** **Number of positive assessments** **Number of referrals made**	Adopt a system wide HHC web based portal for the exchange of healthcare and social services	In planning phases on a centralized basis
	Enhance the services at the Gathering Place and assure consistent availability of services	Fund a full time staff person to provide coverage at the resource center for homeless individuals where providers assist them in obtaining and maintaining housing CHH continues to fund a grant for $5,000 over 5 years in support of the Gathering Place operations CHH purchased a defibrillator and extra battery and provided training for staff and volunteers.

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
	Implement CHA State Wide Social Determinants of Health (SDH) Screening tool in CHH primary care offices – Torrington, Thomaston, Winsted and Canaan.	All offices have signed off on the questions and program. Offices will institute in Jan. 2019.
	Employ a CHH Community Wellness Coordinator position who develops new and evaluates existing systems/programs to promote and support goals and wellness initiatives as defined by CHH and Fit Together. Communicates and responds to wellness needs requested by CHH and the community.	February 2018 position filled.
Support Staff Medical Interpreter Training **Train up to 4 staff to serve as medically certified interpreters**	Using the AHEC Eastern CT Medical Interpreter training program, train 4 employees through a fully subsidized training program. In exchange, employees agree to be available for interpretation at a pre-approved rate under a secondary job code.	Class in Fall 2018. Three staff members have signed up for the class. We have been invoiced and using Patient Program Fund to cover the cost of the training for our employees.
Continuation of Support Groups **Maintain current**	CHH currently underwrites, promotes and supports many Support Groups.	Alzheimer's Support Group Better Breathers Support Group Cancer Patient Support Group Cancer Caregiver Support Group Partners in Healing Support Group Diabetes Support Group Northwest Breast Cancer Support Group Ostomy Support Group Pulmonary Fibrosis Support Group Torrington Area Parkinson's Support Group

STRATEGIC AREA #4: Enhance Community-Based Behavioral Health Services

Rationale for Action

3.4% opioid use rate among CT youth versus 2.2% nationally

Accidental drug intoxication deaths in CT (pure ethanol intoxications were excluded) increased from 729 to 1,038 from 2015 to 2017

The county has a ratio of 1 mental health provider to every 461 residents, considerably below the state average of 1 provider to every 290 residents, and national benchmark of 1 provider to every 330 residents.

Heroin-related deaths are projected to more than double over the next 10 years

Depression is indicated by 25.9% of the population in the Torrington and 18.4% in NW vs. 17.2% of the state overall

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
Decrease accidental drug intoxication deaths and heroin-related deaths year over year. **CCAR Referrals**	Secure Technical Support Coordinator and Task Force Coordinator	Hired individual for both positions as of Sept. 2018.
	Study capacity of MAT providers in NWCT to receive referrals from the Emergency Department of individuals started on Suboxone.	Litchfield County Opiate Task Force outlined an approach and sought funding for expansion of treatment. Provider feedback has shown that there is adequate existing knowledge of protocol for Suboxone and further education for that is not required. The primary goal of the grant will be to increase medical provider, clinician and community competency regarding best practices for MAT and recovery from opiates in NWCT.

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
		Two primary objectives to meet this goal will be: Sponsor a NWCT continuing education event with a keynote speaker and panel regarding best practices in CT and nationwide. Provide continuing education dollars to local providers/clinicians to underwrite the cost to attend trainings focused upon recovery from opiate addiction so that providers new to treating those in recovery from opiate addiction can open their doors, and advanced practitioners can further their skills and bring state-of-the-art approaches back to NWCT.
	Embed behavioral health services in CHH primary care offices Continue support of Litchfield County Opioid Task Force	Targeting late Fall 2018 for one practice and expansion to a second in Winter 2019. Currently providing resources and expertise in marketing, planning and grant-writing.

OBJECTIVES/MEASUREMENTS	STRATEGIES	STATUS
	Implement Recovery Coach Program in CHH Emergency Department. Coach will serve to reach out to ED patients and their families with hope, care and the concept that recovery is possible and provide assistance when a desire for recovery is indicated (1 ED Recovery Coach)	Service put in place in June 2018 with over 50 individuals referred to our Coach with 7 referred due to OD as of 8/15/18
Increase per capita ratio of mental health providers	Completed Provider Needs Assessment and have developed recruitment targets for BH	Secured one Psychiatrist for July 2019 Targeting one more for 2019 and for session space in Canaan, CT
	Continue to expand use of telepsych and non-physician providers (i.e., psychologists, social workers, counselors, etc.) to address need	Ongoing
Develop niche service plans for pain management, eating disorders and LGBT medical and behavioral healthcare.	Recruitment of physiatrist 2021 Clinician specially trained in eating disorders to establish group therapy. Support LGBTQ training for existing CHH Behavioral Health staff.	