



## COMMUNITY HEALTH NEEDS ASSESSMENT

### IMPLEMENTATION STRATEGY

#### BACKGROUND

The Backus Health System led a comprehensive **Community Health Needs Assessment (CHNA)** to evaluate the health needs of its service area defined as New London and Windham Counties, Connecticut.

The purpose of the CHNA was to gather information about local health needs and behaviors to ensure Backus community health improvement initiatives and community benefit activities are aligned with community need. The assessment examined a variety of community, household and health statistics to portray a full picture of the health and social determinants of health in the Backus Health System service area.

#### *The primary goals of the CHNA were to:*

- **Provide a baseline measure** of key health indicators
- **Guide health policy** and health strategies
- **Offer a platform** for collaboration among community groups
- **Identify** community health needs
- **Establish benchmarks** and monitor health trends
- **Assist** with community benefit requirements

The study included research conducted in 2009-10 and 2012-13.

#### *Research components included:*

- **Statistical Secondary Data Profile** of New London/Windham Counties
- **A household telephone survey** with 461 community residents focused on the Ancillary Service Area, to augment study of 1,109 households focused on the Primary and Secondary Service Areas in 2010
- **Key Informant Interviews** with 49 community stakeholders
- **Focus group discussions** with 24 healthcare consumers

Backus engaged Holleran Consulting, a research and consulting firm based in Lancaster, Pennsylvania, as its research partner.

Since the Backus Health System extends beyond the walls of the hospital, and serves communities throughout New London and Windham Counties, Backus initiated a CHNA in 2013 to enhance existing data that was gathered as part of a 2010 study.

The datasets are used in tandem, and provide a full, comprehensive picture of the Eastern Connecticut region. Further, data is now easily comparable to gold standard studies and national benchmarks, such as the Robert Wood Johnson Foundation County Health Ranking, and Healthy People 2020. All study components will be made available to the public; the new, enhanced data will be useful to a wider audience, including agencies throughout the region.

The complete study will be used as a baseline to measure the impact of programs and services offered.

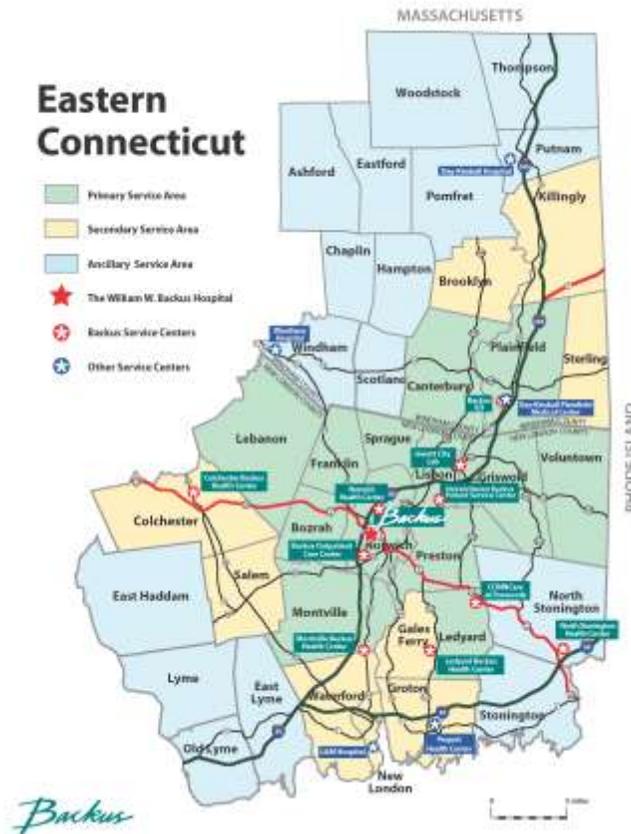
The CHNA research was reviewed by Backus and its Advisory Task Force, which included Backus leadership, Public Health experts, and agencies representing medically underserved and vulnerable communities. A review of the research findings and a facilitated Prioritization Session was held with community partners to identify priority needs within the community. Backus reviewed feedback from the Prioritization Session, along with its current services and programs, resources and areas of expertise, and other existing community assets, to determine what identified needs it would address, and those it would play a support role in addressing.

## **BACKUS HEALTH SYSTEM SERVICE AREA**

The Backus Health System defines the communities it serves as Primary, Secondary and Ancillary Service Areas.

The Primary and Secondary Service Areas are defined utilizing percentage of hospital inpatient discharges.

Backus leaders included an “Ancillary” service area encompassing all remaining towns in New London and Windham Counties to get a true picture of health for the region. Pieces of the Health System, including outpatient health centers, and a full service 24/7 satellite emergency department, touch patients residing in all towns in Eastern Connecticut.



## SELECTION OF THE COMMUNITY HEALTH PRIORITIES

On January 23, 2013, Backus hosted a Prioritization Session with hospital and community representatives to review the research findings and prioritize the key issues for adoption and inclusion in the Backus Implementation Plan.

***The objectives of the half-day strategic planning session were to:***

- **Provide an overview** of recently compiled community health data and highlight key research findings
- **Initiate discussions** around key health issues and prioritize based on select criteria
- **Brainstorm goals** and objectives to guide the Backus Implementation Plan
- **Examine the Backus Health System's role** in addressing community health priorities

A total of 25 individuals attended the strategic planning session, including experts in public health, representatives of underserved populations, health and social services agencies, and other community stakeholders. A full list of attendees is included below.

<b>Name</b>	<b>Agency</b>
Thomas Reynolds	United Way
Nancy Cowser	United Community & Family Services
Jillian Corbin	St. Vincent DePaul Soup Kitchen
Lee-Ann Gomes	Norwich Human Services
Kelcey Johnson	United Community & Family Services
Yolanda Bowes	United Community & Family Services
John Wong	Chinese American Cultural Association
Beverly Goulet	Norwich Human Services
Gregory Allard	American Ambulance
Patrick McCormack	Uncas Health District
Cindy Arpin	Uncas Health District
Bethany Duval	Plainfield School Nurse Coordinator
Kathy Sinnett	APRN, Norwich Public Schools
Michele Devine	South Eastern Regional Action Council
Deborah Monahan	Thames Valley Council for Community Action
David Yovaisis	Thames Valley Council for Community Action
Scott Sjoquist	Mohegan Sun Tribal Health Director
Dee Boisclair	Backus Home Health Care
Sue Starkey	Northeast District Department of Health
Robert Mills	Norwich Community Development Corporation
Shawn Mawhiney	Backus Hospital
Alice Facente	Backus Hospital
Lisa Cook	Backus Hospital
Janette Edwards	Backus Hospital

Holleran facilitated an open group discussion for attendees to share what they perceived to be the needs and areas of opportunity in the region. This included a discussion of overlapping issues, root

causes of health, and the ability for regional health and human services providers to effectively address the various needs. After some consolidation and a considerable amount of dialogue, a list was developed by the attendees. The list was considered a “master list” of needs to be evaluated as potential priority areas for community health improvement activities. The list is presented in alphabetical order:

- Access to Care (physician ratio/insurance, cultural competency, other barriers, hospitalizations)
- Built Environment
- Infectious Disease
- Mental Health: Depression and Anxiety
- Obesity and Related Chronic Conditions (diabetes management)
- Preventative Health (mammograms, pneumonia vaccinations, oral health, seatbelts)
- Respiratory Disease: Asthma/Lung Cancer (smoking)
- Substance Abuse

### Prioritization of Community Issues

To further identify the most urgent priority areas, participants were asked to rank the master list. The participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures.

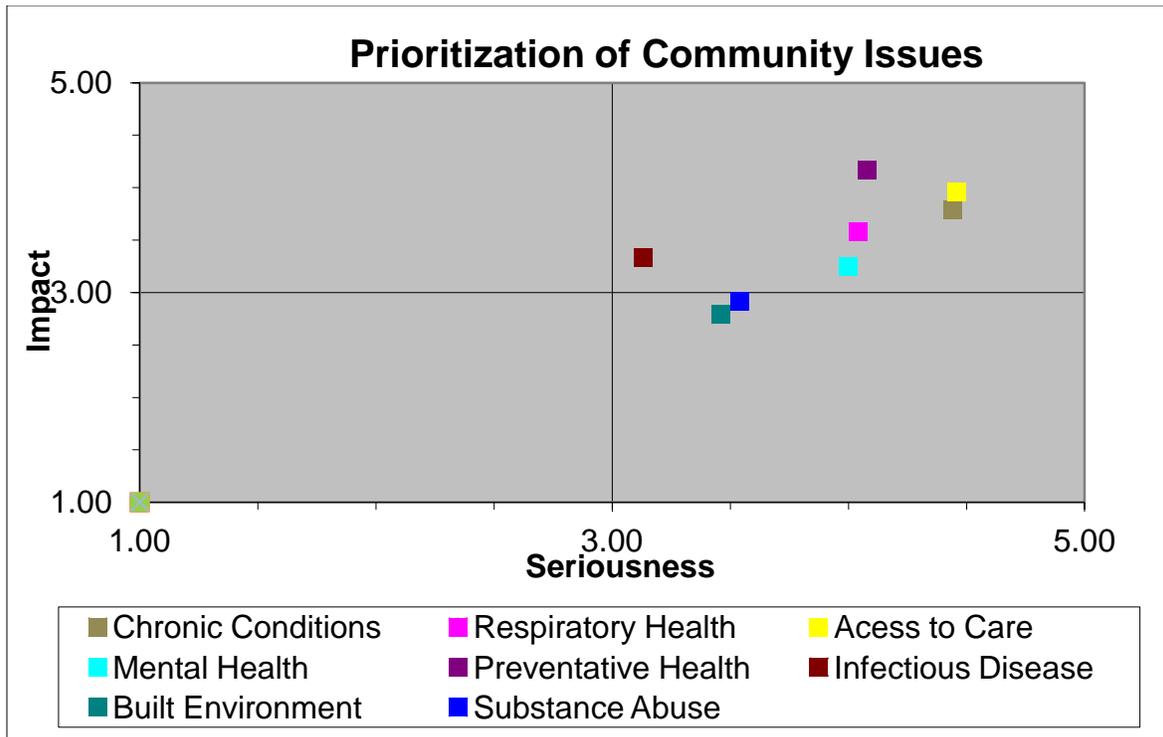
Participants were asked to rate each need based on two criteria: seriousness of the issue and the ability to impact the issue. Respondents were asked to rate each issue on a 1 (not at all serious; no ability to impact) through 5 (very serious; great ability to impact) scale. The ratings were gathered instantly and anonymously through a wireless audience response system. The following tables reveal the results of the voting exercise.

Master List	Seriousness Rating (average)	Impact Rating (average)
Access to Care	4.46	3.96
Preventative Health	4.08	4.17
Chronic Conditions	4.44	3.79
Respiratory Health	4.04	3.58
Mental Health	4.00	3.25
Infectious Disease	3.13	3.33
Substance Abuse	3.54	2.92
Built Environment	3.46	2.79

The priority area that was perceived as the most serious was Access to Care (4.46 average rating), followed by Chronic Conditions (4.44 average rating). The ability to impact Preventative

Health was rated the highest at 4.17, followed by Access to Care with an impact rating of 3.96. The matrix below outlines the intersection of the seriousness and impact ratings. The scores are graphed below in Figure A1. The needs in the upper right quadrant are rated the most serious and with the greatest ability to impact.

**Figure A1: Results of Seriousness and Impact Voting**



### NEEDS THAT THE BACKUS HEALTH SYSTEM WILL ADDRESS

Backus reviewed feedback from the Prioritization Session, along with its current services and programs, resources and areas of expertise, and other existing community assets, to determine which identified needs it would address.

*The following needs were identified by Backus as its priority areas for the following three-year cycle:*

- **Access to Care**
- **Preventative Health** (including chronic and infectious disease, respiratory health, and obesity)
- **Mental Health** (including substance abuse)

## STRATEGIES TO ADDRESS COMMUNITY HEALTH NEEDS

In support of the 2013 Community Health Needs Assessment, and ongoing community benefit initiatives, Backus plans to implement the following strategies to impact and measure community health improvement.

### Access to Quality Health Care

Backus supports the Institute for Healthcare Improvement's "Triple Aim" assertion that providing access to the right care, in the right setting, at the right time improves health status and outcomes.

By utilizing the quantitative and qualitative data gathered as part of the 2012-2013 Community Health Needs Assessment, Backus plans to enhance and increase access to care for vulnerable populations in Eastern Connecticut. Backus expects that by providing access to primary care in community-based settings, a reduction in Emergency Department utilization among affected populations will occur. Backus plans to leverage existing Access to Care programs and initiatives to meet this goal.

**GOAL: Increase access to quality health care for Eastern Connecticut residents, through the Backus Health System Access to Care program (a partnership with United Community & Family Services), and the My Health Direct system.**

#### OBJECTIVES:

- Increase the number of residents who have access to primary care providers
- Increase utilization of free and low cost health care services

#### KEY INDICATORS:

- #/% of adults who are connected to a medical home via My Health Direct
- #/% of adults who attend scheduled appointments through My Health Direct
- #/% of adults who have health coverage, after participating in the Access to Care program
- #/% of Emergency Department visits for non-emergency care, in those patients who participated in Access to Care or received a My Health Direct appointment
- #/% of hospital admissions or readmissions in those patients who participated in Access to Care or received a My Health Direct appointment

**BACKUS HEALTH SYSTEM STRATEGIES:**

- ***Identify and enroll uninsured individuals in health coverage programs***
- ***Assist individuals with no primary care provider with establishing a primary medical home.***
  - **Access to Care**, A partnership with the United Community and Family Services, which provides on-site screenings, during first and second shifts, at the Emergency Department, the Plainfield Backus Emergency Care Center, and the Backus Health Centers for Medicaid programs, the Supplemental Nutrition Assistance Program, Prescription Assistance Program, and other health and human services. The Access to Care program also provides education to patients regarding the importance of establishing a primary care medical home, and can create appointments for patients with a primary care physician.
  - **My Health Direct**, An online tool the Hospital subscribes to that allows hospital staff to create follow up appointments with community providers for patients post discharge from the Emergency Department, an inpatient unit, or an outpatient program. My Health Direct is used throughout the Backus Health System, including in the Emergency Departments, Care Management, Behavioral Health, the Cardiac Unit, the Mobile Health Resource Center Van, and the Backus CareVan.
- ***Provide free or reduced cost primary care services.***
  - **Partnerships with Generations Family Health Centers**, A fully-funded 501(c)3 Federally Qualified Health Center with locations throughout Eastern Connecticut.
  - **Partnerships with United Community & Family Services**, A 501(c)3 Federally Qualified Health Center look-alike, with locations throughout New London and Windham Counties.

**EXISTING COMMUNITY ASSETS AND RESOURCES:**

- Backus CareVan
- Backus Mobile Health Resource Center (MHRC)
- United Community & Family Services (UCFS)
- Generations Family Health Centers
- Thames Valley Council for Community Action (TVCCA)
- St. Vincent de Paul Place
- Uncas Health District (UHD)
- Northeast District Department of Health

## Preventative Health, including Chronic & Infectious Disease, Respiratory Health, and Obesity

Backus plays a leadership role in preventative health in Eastern Connecticut. Acknowledging chronic disease conditions that were identified in the CHNA, (Diabetes, Cardiovascular Disease, Lung Cancer, Asthma, Hepatitis C, and HIV/AIDS) and their relationship to diet, exercise, smoking, and other preventable risk factors, Backus will seek to reduce chronic conditions by focusing on education and awareness programs. A reduction in disease rates will likely not be seen in the initial three-year cycle, however, Backus expects that success in reducing the prevalence of residents who are at risk for chronic conditions and better managing current chronic conditions will positively impact chronic disease in the future.

**GOAL: Reduce risk factors that contribute to disease, and management for patients with a diagnosis of chronic disease.**

### OBJECTIVES:

- Reduce overweight and obesity rates in patients enrolled in a Backus Health System weight loss initiative
- Reduce prevalence of smoking among adults enrolled in a Backus Health System smoking cessation or prevention initiative
- Reduce Emergency Department visits for unmanaged chronic conditions including Asthma, Heart Failure, and Diabetes among individuals enrolled in a Backus Health System chronic disease management initiative

### KEY INDICATORS:

- #/% of patients who attend Backus Health System health improvement programs
- #/% ED/hospital admissions/readmissions for chronic conditions, among individuals enrolled in a Backus Health System Chronic Disease Management program
- #/% of individuals participating in free or reduced cost health screenings sponsored by the Backus Health System

### BACKUS HEALTH SYSTEM STRATEGIES:

- ***Provide education and opportunities to improve diet and increase physical activity***
  - **Healthy Community Initiative** — focusing on identifying uninsured individuals and families, providing health screenings, and mobile health care to improve access to care and the overall health of the community residents. Backus will partner with organizations like the United Way, the Mobile Food Pantry, and schools to build upon existing assets to reach residents through established resources and channels of communication.
  - **Backus StrongKids** — a pilot program in the local schools focusing on education on healthy eating and exercise.

- **Life Happens** — a collaborative program in a local technical high school with monthly presentations on physical and mental health topics, based on student survey results.
  - **Rx For Health** — a program that allows participating physicians to “prescribe” farmers’ market fare for children who are obese or at risk to be obese.
  - **Enjoy LIFE (Lifelong investment in Fitness & Exercise)** — a collaboration between Backus Hospital and Plainfield Recreation Department to promote healthy lifestyle changes for the people of Windham County.
  - **Medical Weight Loss Center and Wellness Program** — a 17-week comprehensive, multi-disciplinary approach to weight loss for those individuals seeking significant weight loss and lifestyle changes to improve long-term health and overall wellness. The program includes education and support from registered dietitians, physical therapists and behavioral health specialists. Participants receive one-on-one consults as well as 16, one-hour education classes.
- ***Provide education and opportunities to prevent and manage chronic disease***
- **Backus Hospital Heart Failure and Wellness Program** — designed to meet special needs of adult patients and families suffering from heart failure. The goal of the program is to prolong life and improve patient’s quality of life.
  - **Smoking Cessation** — a seven-week, eight-session course, ALA “Freedom from Smoking” cessation classes, offered six times per year.
  - **Asthma Initiative** — a program designed to teach participants management skills to keep their asthma under control, have fewer symptoms and gain a better quality of life.
  - **Outpatient Diabetes Self Management Program** — provides comprehensive care through a collaboration between a multi-disciplinary team and primary care provider. The goal is for the person with diabetes to be involved in the establishment of a management program based on the individual’s needs.
- ***Support preventative care programming through “hot-spotting” to determine health care conditions and utilization by geography***
- **Connecticut Hospital Association ChimeMaps**, Interactive GIS-mapping software used to evaluate hospital, health, and population data for the purposes of strategic planning and business development, community analysis and population health assessment. The *ChimeMaps* tool is used to provide targeted outreach in neighborhoods and communities, by analyzing hospital utilization for specific diagnoses. The tool gives Backus Health System the ability to address health needs proactively, providing preventative care to reduce the need for residents to seek care in an acute setting.

**EXISTING COMMUNITY ASSETS AND RESOURCES:**

- Backus CareVan
- Connecticut Hospital Association (CHA)
- Backus Mobile Health Resource Center (MHRC)
- Uncas Health District (UHD)
- United Community & Family Services (UCFS)
- Generations Family Health Centers
- Thames Valley Council for Community Action (TVCCA)
- St. Vincent de Paul Soup Kitchen
- New London County Food Policy Council
- Children First (Norwich, Griswold, Colchester)
- Parks and Recreation departments (Norwich, Griswold, Colchester, Plainfield, Sprague)
- Public School Systems (Norwich, Griswold, Colchester, Plainfield, Sprague)
- Northeast District Department of Health

## Mental Health and Substance Abuse

**GOAL: Improve the access to, and coordination of, mental health services and substance abuse treatment for residents of Eastern Connecticut.**

### OBJECTIVES:

- Improve collaboration between community agencies providing residential and outpatient substance abuse treatment programs
- Increase awareness and utilization of Access to Care and Prescription Assistance Programs among Emergency Department psychiatric clinicians
- Increase community outreach and education efforts focusing on mental health and substance abuse

### KEY INDICATORS:

- #/% of Emergency Department psychiatric patients who are referred to the Access to Care program by an Emergency Department psychiatric clinician prior to discharge
- #/% of psychiatric patients who are referred and accepted into regional substance abuse programs
- # of community education and outreach programs focused on mental health and substance abuse

### BACKUS HEALTH SYSTEM STRATEGIES:

- ***Increase collaboration between community agencies that offer residential and outpatient substance abuse treatment programs***
  - **Center for Mental Health** — an outpatient component of the full continuum of care in the Department of Psychiatric Services. Provides individual and group assessments and therapy sessions, as well as medication evaluation and treatment visits.
  - **Partial Hospitalization Program** — provides intensive psychiatric treatment to patients who are experiencing acute symptoms that require a highly structured environment in which to receive treatment. Partial hospitalization — which is offered for five hours a day, for up to five days per week — can follow a course of inpatient treatment, or to avoid inpatient treatment altogether.
  - **Inpatient Psychiatric Services** — an 18-bed unit that provides high quality inpatient services to individuals with any psychiatric disorder including major depression, schizophrenia, bipolar disorder, anxiety disorders, postpartum psychosis, as well as those with dual diagnosis of substance abuse and psychiatric illness.

- ***Reduce identified barriers to accessing mental health and substance abuse services for those patients being discharged from the Emergency Department***
  - **Access to Care** — a partnership with the United Community & Family Services, which provides on-site screenings, during first and second shifts, at the Backus Emergency Department, the Plainfield Backus Emergency Care Center, and the Backus Health Centers for Medicaid programs, the Supplemental Nutrition Assistance Program, Prescription Assistance Program, and other health and human services. The Access to Care program also provides education to patients regarding the importance of establishing a primary care medical home, and can create appointments for patients with a primary care physician.
  - **Prescription Assistance** — a service offered by United Community and Family Services through the Access to Care program, in addition to Generations Family Health Center, that assists low-income and uninsured patients enroll in prescription assistance programs to receive pharmaceuticals at no or low cost.
  - **Connecticut Hospital Association *ChimeMaps*** — interactive GIS-mapping software used to evaluate hospital, health, and population data for the purposes of strategic planning and business development, community analysis and population health assessment. The *ChimeMaps* tool is used to provide targeted outreach in neighborhoods and communities, by analyzing hospital utilization for specific diagnoses. The tool gives Backus the ability to address health needs proactively, providing preventative care to reduce the need for residents to seek care in an acute setting.
  - **Mental Health First Aid** — a 12-hour internationally recognized, interactive training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. Mental Health First Aiders learn to apply a 5-step action plan to:
    - help someone through a panic attack
    - engage with someone who may be suicidal
    - support a person experiencing psychosis
    - help an individual who has overdosed
  
- ***Educate the community and reduce stigma associated with mental health and substance abuse through community outreach efforts***
  - **Life Happens** — a collaborative program in regional technical high school with monthly presentations on physical and mental health topics, based on student survey results.
  - **Tics and Tourette's in Teens and Children** — an educational program for parents focusing on recognition and treatment in youth.
  - **Thrive4Life** — a collaborative initiative with Norwich Public Schools to discuss mental health issues identified by a youth survey.

- **Evening Educational Seminars and Program** — various educational opportunities open to the public and free of charge focusing on anxiety, depression, and bullying.
  - **Autism Awareness in Public School Nurses and Staff** — workshops on identifying and managing Autism in school age children.
  - **Emergency Management of the Autistic Patient** — a workshop designed for Emergency Department clinical staff to become familiar with techniques to better manage autistic patients.
  - **Partnership with University of Connecticut Study** — coordination of local pediatric practices in Eastern Connecticut participating in an Autism Early Detection Study to evaluate the use of a new screening tool.
- ***Improve the discharge process and care coordination for homeless psychiatric patients by utilizing existing models within the region***
- **Primary Care at St. Vincent de Paul Place** — free primary care is offered at the St. Vincent de Paul Place Soup Kitchen every Monday in partnership with Generations Family Health Center.

#### **EXISTING COMMUNITY ASSETS AND RESOURCES:**

- Natchaug Hospital, including the Care Plus Program
- Stonington Institute
- SouthEastern Council on Alcohol and Drug Dependence (SCADD)
- Lebanon Pines
- SouthEastern Regional Action Council (SERAC)
- Norwich Hospitality Center
- SouthEastern Mental Health Authority (SMHA)
- Danielson Shelter
- St. James' Place, New London
- Reliance House

## **RATIONALE FOR COMMUNITY HEALTH NEEDS NOT ADDRESSED**

By focusing efforts the cross-cutting issues of **Access to Care, Preventative Health (including chronic and infectious disease, respiratory health, and obesity), and Mental Health (including substance abuse)**, the Backus Health System will take a comprehensive approach to addressing eight of the nine most urgent needs in the communities it serves. As with all Backus Health System programs, it will continue to monitor community needs and adjust programming and services accordingly.

Backus recognizes that there are a numerous partners in the community that can help to improve the identified health needs. In some cases, partners are better suited to lead the initiative to impact certain health needs. Such is the case with the built environment. Backus Health System will support ongoing and new efforts to improve the community's physical environment and infrastructure to improve safety, the transportation system, and create more opportunities for physical activity, but sees its primary role as allocating resources to address direct health needs for the community.

To secure commitment of support from community partner agencies, Backus will seek formal letters of support from community agencies that participated in the study. These letters of support verify that community partners are willing to work together to address the priority areas identified through the Needs Assessment, and acknowledge that Backus cannot address all concerns alone.