Community Health Improvement Plan

2022 - 2025

Hartford HealthCare
Windham Hospital

INTRODUCTION

"The greatness of a community is most accurately measured by the compassionate actions of its members." – Coretta Scott King

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 2021 Community Health Needs Assessment ("CHNA") for Windham Hospital, part of Hartford HealthCare's (HHC) East 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 2022 CHNA took a close look at social determinants of health (SDH) such as poverty, housing, transportation, education, fresh food availability, and neighborhood safety and contains an Equity Profile. These two enhancements are in response to the lessons of COVID and in recognition of an emerging national priority to identify and address health disparities and inequities. HHC and Windham Hospital are committed to addressing these disparities and inequities through its Community Health Improvement Plan (CHIP).

The intent of our CHIP 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 living our Value of Equity which reminds us all to do the just thing.

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 partners. Furthermore, a CHIP should build on and leverage prior success while simultaneously adjusting strategies and actions as obstacles are encountered.

This CHIP is organized across four focus areas that are intended to address root causes of community health issues while recognizing where the East 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:

1. 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

Rationale for Action

- Food insecure population Windham County 2019 12.6% compared to 2022 14.9% *(Windham CHNA 2022)*
- Food insecure children Windham County 2019 15.3% compared to 2022 19.4% *(Windham CHNA 2022)*
- Food insecurity for 2015 – 2021: State of CT 14% compared to Windham Hospital, Hospital Service Area (HSA) White 11% and Latino 29% *(Windham CHNA 2022)*

- "Access to affordable, nutritious food is a financial (and mental health) challenge to many families, though there is a somewhat lower perceived stigma about using a food bank (or similar resource)." *(Community Conversations, Windham CHNA 2022)*

2. 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.

Rationale for Action

- Throughout the state, people of color face greater rates and earlier onset of many chronic diseases and risk factors, particularly those that are linked to socioeconomic status and access to resources. For example, diabetes is much more common among older adults than younger ones, yet middle-aged Black adults in Connecticut have higher diabetes rates than White adults aged 65 and older. *(Windham CHNA 2022)*

- Based upon CHRONIC DISEASE PREVALENCE, SHARE OF ADULTS BY CENSUS TRACT, WINDHAM HOSPITAL HSA 2019 – *(Windham CHNA 2022, Data Haven Health Equity Profile 2022)*
    - Percentage of Adults with Coronary Heart Disease Towns of Mansfield, Chaplin, Hampton and Windham: 4.5% - 7.0%
    - Percentage of Adults with Current Asthma City of Willimantic: 12.5% to 14.0%
    - Percentage of Adults with Diabetes Town of Windham: 9.5% to 11%
    - Percentage of Adults with High Blood Pressure Towns of Windham, Mansfield and Hampton 30.5% to 34.0%

3. Improve Health Equity, Social Determinants of Health, and Access to and Coordination of Care and Services

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.

Rationale for Action

- The Windham HSA has a poverty rate of 15% and Town of Windham has a poverty rate of 25% *(Windham CHNA 2022)*

- Median Household Income by Race for Windham HSA: White $70,843, Black $27,344, Asian $53,258, Latino $40,998 *(Windham CHNA 2022)*

- "Members of underrepresented communities or ones in which English is not the primary language are challenged to find providers who can grasp the health-related nuances of their culture or lifestyle."*(Community Conversations, Windham CHNA 2022)*

4. 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.

Rationale for Action

- Overall, 15% of Windham Hospital HSA adults report experiencing anxiety regularly and 9% report being bothered by depression. Town of Windham shows 23% of adults report experiencing anxiety and 16% report being bothered by depression. *(Windham CHNA 2022)*

- In 2015 and 2016, 36% of the drug overdose deaths in the Windham Hospital HSA involved fentanyl; in 2019 and 2020, this share was 88%. *(Windham CHNA 2022)*

- Age-adjusted semi-annual rates of drug overdose deaths per 100,000 residents by race/ethnicity, 2015–2020: Town of Windham >50 as compared to State of CT <25 *(Windham CHNA 2022)*

The Call to Action

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 good news is that we do not do this work alone. And, even though this work can be overwhelming at times, with important partnerships throughout the communities we serve, success is made possible.

Windham Hospital relies on the input, partnerships and opportunities presented by community partner organizations. Working in tandem to address needs and disparities outlined in the community health needs assessment is tantamount in order to improve the health of the Windham community. There limitless possibilities in how we can work together to address the difficult health care, social, and civil needs that are apparent in our communities.

We will continue to invigorate and expand programs and initiatives that have had positive effects throughout the years like our Rx for Health program (funded by Windham Hospital) which celebrated its first year in Windham in 2021. Moving forward we will continue to utilize our FQHC partner Generations to identify families and children who would benefit from nutritional support and vegetable and fruit vouchers. However, our Community Health Needs Assessment (CHNA) has shown us that expanding upon the voucher program by incorporating primary care, faith based organizations and other local non-profits to

include larger swaths of the Windham population will increase the effectiveness, reach and utilization of the program. It will be imperative to continue to build upon relationships both within our grocery infrastructure (Windham Farmers Market, Windham Food Coop, Windham Hospital Farm Stand) but also with the Windham area nutritional network partners (Grow Windham, CLICK Kitchen, Food Share, Covenant Soup Kitchen, etc.). We will explore these new pipelines and partnership for food donation through our Compass One Waste Not 2.0 program. This strategy donates unused food from hospital kitchens to qualifying distribution partners within the community. These types of programs are not only positive for the community but help to reduce our environmental footprint as a hospital system.

A large portion of our community health improvement strategies for the 2023-2025 Community Health Improvement Plan (CHIP) fall under the focus area of improving health equity, coordination of services, and access to care. Covid-19 has had a lasting impact on our health care system and community and has taught us valuable lessons about how to better collaborate with heath care organizations and health and human services agencies. The pandemic has also shone a bright light onto the disparities that exist within our communities of color and our underserved populations. We have learned that trust, education, access to care and coordination of services are key components to addressing disparities and supporting these areas of our population. It is important to recognize that this work is not done in silos and it is only when community agencies and health care organizations work together that we can maximize the benefits of our resources and outreach. Strategies such as Neighborhood Health/ Mobile health hub, Community Care Team meetings, and our Coordinated Clinical Services Team are examples of how we can work together in supportive, non-prescriptive roles while doing our part to address community needs and access to care.

Our state funded Diaper Connection program offers a unique opportunity afforded to hospitals. This initiave allows us to take resources and share them with community benefit agencies who in turn support the individuals of our community. We aspire to continue to develop a pipeline for resources, data, expertise to further demonstrate how hospitals can be anchor institutions. Our Healthy Beginnings program, that provide resources to new mothers and families, is also a partnership with the Eastern Area Health Education Center (HEC). Through this collaboration we provide work based learning opportunities for aspiring Community Health Workers (CHWs) and paid opportunities for CHWs who have become certified.

Health equity is the cornerstone of the work we are trying to promote within the community health space and a recurring theme that runs through every aspect of this CHIP. Our multi-lingual initiative aims at not only advocating for and lifting up our native language speaker colleagues but ultimately provides essential communication resources for the individuals in our community from diverse cultures. It is important that the education we are providing within our CHIP goals is culturally relevant and not only reflects appropriate language and customs but takes into account how individuals navigate their preferences, struggles and celebrations throughout their everyday lives. We rely on our partnerships with the NAACP, Windham Human Services and our ever-growing list of community ambassadors who are subject matter experts in this arena. It is through their partnership and collaboration that we can continue to improve the way we offer services and care.

The most important principles in the execution of this CHIP are communication and inclusion. It is our responsibility to keep the lines of communication open by sharing progress, seeking feedback and welcoming contributions for the work we are trying to accomplish. Our CHIP strategies are only as successful as the partnerships that help to inform, promote and celebrate the work being done.

Focus Area #1: Promote Healthy Behaviors and Lifestyles

OBJECTIVE 1	Decrease the amount of food waste and increase food donations to the community by providing individuals with free healthy excess food from the hospital kitchens.		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES – STATUS**
Access to Healthy, Affordable Food	**Hospital/Community Based -** Compass One's **Waste Not 2.0** program is utilized in other Hospitals in the HHC HealthCare system to determine unused food that could be donated to people in need. Food Share has partnered to onboard and identify local agencies who would meet the requirements and have the capacity to accept unused food from Hospital Kitchens. The hospitals track their donations and work together with local agencies to enact the program. The goal would be to raise the level of donation to meals that can be consumed by our underserve members of the community. Food and nutrition staff would utilize Covenant Soup Kitchen to be the point of contact and source of distribution for meals donated to the community.	George Zern *Executive Chef* Whitney Bundy *Senior Director Guest Services* Frederick Goodman *Manager of Retail Donations and Partnerships Food Share* Kim Clark *Covenant Soup Kitchen* Patrice Sulik North Central Health District	**Targets:** #lbs or food shared # of individuals served/ meals shared Monthly updates about progress shared with community **Actual**

OBJECTIVE 2	Provide fresh fruits and vegetables to low-income individuals and families.		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES – STATUS**
Access to Healthy, Affordable Food	**Community Based -** **RX for Health** Program provides vouchers for fresh produce to individuals who are in need of nutritional support. Funded by Windham Hospital, vouchers are distributed in various settings such as pediatrician offices, soup kitchens, women's health centers, Head Start Programs, etc. Windham Hospital collaborates with local community partners to identify families and individuals who would benefit. Vouchers are currently exchanged at the Willimantic Farmers' Market, Willimantic Food Co-op and Windham hospital's farm stand. HHC dietitian provides ongoing nutritional support to families.	Shannon Haynes *Dietician* Michele Brezniak *Community Health RN*	**Targets:** $ vouchers - $2,496 # individuals served - 200 # vouchers distributed/redeemed – 1,248 Increase the percentage of vouchers redeemed to 75% **Actual**

Focus Area #2: Improve Health Equity, Coordination of Services, and Access to Care			
OBJECTIVE 1	**To provide, promote, and coordinate resources to train hospital staff to be interpreters. By increasing the number of trained hospital staff interpreters, we will provide linguistically responsive and culturally relevant information to community members accessing health care related services.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/ PARTNERS**	**METRICS/MILESTONES – STATUS**
Multilingual Medical and Mental Health Services **Recruit And Retain Medical and Mental Health Care Staff With DEI Awareness**	**Hospital Based** Gather current HHC system resources surrounding translation services Recruit HHC staff to be part of a committee to complete this objective, responsibilities will include: Promote current HHC system resources for staff interested in becoming interpreters. Planning for training time, how to fill roles when individual are spending time interpreting. Recruiting and training HHC hospital staff to be interpreters.	Mary Brown *East Region Interpreter Services Manager* Whitney Bundy *Senior Director, Guest Services* HHC DEIB Regional Council Interpreters and Translators Inc. William Gerjes *Regional Director Environmental Services*	**Targets:** Increase number of interpreters (baseline 1 interpreters 1 languages) # hours spent interpreting **Milestones:** Accurate inventory of needs and opportunities Committee formation to work on linguistic opportunities **Actual**

OBJECTIVE 2	**Provide at least 4 free or low cost health clinics a month to individuals in the community in conjunction with community partners from the Eastern CT Health Collaborate to provide wrap around services for individuals in need. This will help to coordinate care between agencies and increase access for individuals while addressing chronic and preventable health conditions.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/ PARTNERS**	**METRICS/MILESTONES – STATUS**
Coordinated Efforts Between Larger Health Systems And Community-Based Health Services To Care For People With More Complicated Medical Needs **Additional Programs To Enhance Access to Care For Lower-income Families** **Broad-based, integrated services for People and Families Experiencing Homelessness**	**Community Based -** Neighborhood Health Our mobile "CareVans" visit and operate daytime health clinics several times a month at specifically chosen locations. They offer a variety of health services including screenings, mental health counseling, medical referrals, education and support. Neighborhood Health was developed in collaboration with trusted community partners throughout the state. These groups and individuals help determine the health needs and priorities for their residents and communities. These innovative health clinics are adaptable, flexible, and open to feedback to ensure access to needed services and programs. Currently Neighborhood Health functions under the Mobile health Hub model from the Eastern Connecticut Health Collaborative. Within this model "Anchor Agencies" host mobile services and invite collaborative partners to attend thus providing wrap around services (food and nutrition resources, energy assistance, primary care, insurance, legal assistance, etc.) for individuals in the community.	East Region Community Health Dept. HHC Neighborhood Health Eastern CT Health Collaborative	**Targets HHC**:/Monthly Volume #56 Medical visits # BH/CH # Immunizations # Infectious Disease tests #8 Days **Suggested Targets ECHC**:/Monthly # Individuals served # Events # Services offered # Referrals services connected to geographic reach (zip codes) **Milestones:**

			Expand the geographic footprint of mobile health (include # of towns) Increase the amount of partners participating in mobile health Continue to explore, expand and evaluate metrics within HHC and ECHC **Actual**
OBJECTIVE 3	**To coordinate care between community benefit organizations, Federally Qualified Health Centers and Windham Hospital by facilitating, planning, and participating in monthly meetings throughout the year to discuss new services/programs, opportunities for partnership, and barriers to care. By improving interagency communication, we will eliminate roadblocks to health care access and increase utilization of services for individuals in the community.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/ PARTNERS**	**METRICS/MILESTONES – STATUS**
Coordinated Efforts Between Larger Health Systems And Community-Based Health Services To Care For People With More Complicated Medical Needs	**Community Based:** **Activity 1** Become an active partner (Co chair and members) in the Community care Team meeting. "Community Care Teams are made up of local hospital staff and community service providers, including mental health and substance abuse treatment providers, community health centers, city social services, faith-based organizations, shelters, and housing agencies, among others. These providers develop a care plan to address the healthcare and social service needs of CCT	Joseph Zuzel *Regional Director Community Health* Meghan Hilliard *Director of Emergency Services* Angela Fournier	**Activity 1** **Targets:** Build into ED work flow referral mechanism for CCT # of Community Resources connected to ED visit frequency **Milestones:** Enter MOU/BAA with participating Agencies

	clients. Hospital EDs can help identify these "frequent visitors." Referrals to CCTs are also made by other community providers. An individual must sign a Release of Information (discussed below) before s/he is presented to a CCT meeting. When someone is presented to the CCT, the CCT team then assesses the person's health and social needs and sets up a plan to connect the individual with community care, housing and support services." *211/tb (June 2022). Community Care Teams (CCT's) and Related Care Coordination for Connecticut's Vulnerable Populations* *https://uwc.211ct.org/community-care-teams-ccts-and-related-care-coordination-for-connecticuts-vulnerable-populations/* **Activity 2** Coordinated Clinical Services meeting: Windham Hospital will organize, facilitate and host a monthly meeting between United Children and Family Services, Generations Family Health Center and Hartford HealthCare to explore health care access, new services/ programs, and barriers/opportunities for partnership and care coordination.	Windham Dept. Human Services Rebecca Durham *Senior Director of Clinical and Operational Integration* Jonathan Watts *Regional Director Beh. Health* **Generations** **Judith Gaudet** *Systems Of Care Director* **Sandy Fairbarn** *Director Beh. Health* **Michael Steinmetz** *CMO* **Melissa Meyers** *COO* **UCFS** **Cara Westcott**, *COO*	Establish Patient Standard – 10 or more ED visits in a 6 month period or 5 or more Ambulance rides to ED in 30 days- Develop standard report- Set targets and evaluate program **Activity 2** **Targets:** # of meetings/yearly and attendance (orgs present) **Milestones:** Create and form clinical services team and set regular monthly meeting cadence Active list of opportunities/coordinated efforts identified **Actual**

		Ramindra Walia, MD, CMO **Deberey Hinchey** *VP of Behavioral Health Services* **Norma Glover** *Supervisor of Community Outreach*	
OBJECTIVE 4	**Promote healthy recovery for new moms and healthy growth for infants by providing information and access to community services the new family may need.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/ PARTNERS**	**METRICS/MILESTONES – STATUS**
Additional Programs To Enhance Access to Care For Lower-income Families	**Community Based** **Activity 1** **Healthy Beginnings program** serves new mothers and their babies who use the Windham Women's Health Center for pre and post-natal care. Two appointments are offered. First visit is a prenatal appointment and the second appointment occurs after birth, beginning around one week after delivery, to discuss programs	Joseph Zuzel *Regional Director Community Health* Michelle Brezniak *Community Health RN*	**Activity 1** **Target**: # Resource Connected 180yr # Resources 300yr #1st assessments 60yr #2nd assessments 30yr # CHW Hrs. 45yr # Translator Hrs. 30yr # HHC SW referrals 24yr

	that are available to both mom, baby, and support system and to discuss any concerns or challenges they may be facing in taking care of their new infant. Services offered may include information on Husky insurance, SNAP/EBT benefits, fuel assistance, Care4Kids, diaper bank locations, and how to apply for these programs. Information about the local lactation consultant and healthy growth and development for infants will also be provided. **Activity 2** **Diaper Connections** The Connecticut Hospital Association (CHA) is partnering with the Diaper Bank of Connecticut to address diaper insecurity and diaper need through a new statewide program called Diaper Connections. The partners will work together to develop and implement diaper distribution models that leverage existing local community assets and partnerships. Models can include partnering with community organizations to organize distribution channels, and distributing diapers in hospital settings such as labor and delivery units, maternity and pediatric clinics, emergency departments and primary care sites.	Sarah Bouchard *Regional Director Women's health* Adrianne Devivo *Will I Volunteer*	**Activity 2** **Target:** 95 families served 2000 diapers distributed

OBJECTIVE 5	**Partner with high schools within the Windham Hospital HSA to provide opportunities for high school students to explore careers and promote interest in the health care industry.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD/ PARTNERS**	**METRICS/MILESTONES – STATUS**
Recruit And Retain Medical and Mental Health Care Staff With DEI Awareness	In order to continue to promote careers in the health care sector and to address the pipeline issue that many students from diverse and underserved backgrounds face when it comes to education and training we will conduct a series health care career events and opportunities within local high schools. -Schools with established certification programs i.e. CNA, EMT, etc. will be given specific focus as partnerships with high schools can lead students to open positions at Windham hospital resolving department staffing needs -Students will have exposure to different career pathways through interactions with department representatives to educate them about specific job roles and responsibilities within a given department. We will approach these interactions through a diversity and equity lens and whenever possible have staff members that can relate culturally to the students with whom they are interacting. -Career path exploration events will occur semiannually.	Jonathan Chew *Project Coordinator East Region* Community Health Department DEIB Regional Council Michael Bontempo *VP Human Resources*	**Targets:** -# students who take part in internship/job shadow opportunities # Semiannual events for the purpose of health care career exploration and job offers for graduating students # of individuals attending events **Milestones:** -Identify and partner with local area schools solidify stake holders in the community - Explore the opportunity for paid internships - Explore Connecticut Technical Education and Career System's Work Based learning program and how the Hospital could participate. -Advanced planning of events and opportunities and regular communication with schools to increase promotion to students. The goal to have as many students as possible take advantage of events and opportunities.

	-Periodic engagement opportunities will be conducted throughout the academic year via students participating in job shadow/internship programs at Windham Hospital and through guest speaking events by department representatives		

Focus Area #3: Reduce the Burden of Chronic Disease			
OBJECTIVE 1	**Provide screenings and resources to assist individuals who remain undiagnosed due to lack of regular medical care in places like soup kitchens, housing complexes, mobile health fairs, homeless shelters, and food pantries.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES - STATUS**
Additional Programs To Enhance Access to Care For Lower-income Families **Focused Initiatives Addressing Chronic Health Conditions**	**Community Based** **HHC Regional Screenings** is a program designed to meet the underserved members of our community where they are. Multiple hospital departments provide free chronic disease screenings in a variety of environments and locations. During testing, participants will be given education regarding the disease that they have been screened for and how to achieve a "normal" range. Participants will be given information about Primary Care Physicians (PCPs) as well as Urgent Care if needed. Every participant is given a brief health history questionnaire that includes questions such as: current medications, family history of chronic disease, and	Joseph Zuzel *Regional Director Community Health* Michele Brezniak *Community Health RN* Frederick Bailey *Regional Director Oncology*	Mobilize Hospital departments to identify Type of screening provided, appropriate staffing/training, and frequency through interdepartmental meetings and planning/coordinating sessions. Review licensing protocols for departments to provide screenings within the community Increase in targets would be directly related to staffing and resources by other HHC departments and community benefit organizations **Suggested Target Screenings** A1C/Blood Pressure – see below

	information about any recent Emergency Room visits.	Tiffany Rindell *Regional Director Rehab* Nicole Porter *Regional director HVI* Colin McMillan *Regional Director Neuroscience* Jonathan Watts *Regional Director Beh. Health* Sarah Bouchard *Regional Director Women's health*	Melanoma – 1 per year Depression Screenings – in development Limb Preservation – 1 per year Bone Density - in development COPD/Lung Cancer – 2 per year Stroke Education – 2 per year Breast Screenings – in development Target: A1C/Blood Pressure # ind. served 60 # no hx with elevated result 36 # Clinics/Events 10 # elevated results 45
OBJECTIVE 2	**Increase referrals to the Preventive Medicine Team. PMT is a tertiary prevention program to identify at risk patients, implement interventions, and establish triple aim goals for experience of care, cost, and population health**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES - STATUS**
Care Coordination and Support to Help Manage Care for Patients with	**Hospital- Based** Preventive Medicine Team – • Identify at-risk patients and enroll in Preventive Medicine registry	Barbara Sinko *Social Worker Preventive Medicine*	**Target** -Increase number of Windham Referrals (ED and Inpatient) by establishing PMT

Complex Health Conditions **Focused Initiatives Addressing Chronic Health Conditions**	• Personal interview and in-depth clinical and psychosocial assessment ➢ Identify and address social determinants of health (SDOH) ➢ Complete depression screening (PHQ-2/PHQ-9) ➢ Assess self management abilities ➢ Solicit patient, family, and caregiver engagement and understanding of current health status and goals of care ➢ Review and/or educate on Advance Directives ➢ Complete intensive medication reconciliation and thorough review of medical history • Develop personalized Transitional Care Guide • Update problem list/medical history in EMR • Educate on chronic disease states • Coordinate transitions with community medical providers and partners • Follow up with patient after discharge (phone calls and home visits as needed)	Lisa DeCarlo *APRN Preventative Medicine*	program at Windham Hospital (beginning 9/1/22) -Join Windham CCT **Actual**

Focus Area #4: Enhance Community-Based Behavioral Health Services			
OBJECTIVE 2	**Provide mental health screenings, resources and access to care at all neighborhood health events. These events are presented to the community through the mobile health hub initiative through the Eastern CT Health Collaborative which helps to coordinate care between agencies and increase access for individuals while addressing chronic and preventable health conditions.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES - STATUS**
Coordinated Efforts Between Larger Health Systems And Community-Based Health Services To Care For People With More Complicated Medical Needs **Outpatient Mental Health Services Capacity for Adults, Adolescents, and Children – Including in-home and caregiver support**	**Community Based -** Neighborhood Health Our mobile "CareVans" visit and operate daytime health clinics several times a month at specifically chosen locations. They offer a variety of health services including screenings, mental health counseling, medical referrals, education and support. Neighborhood Health was developed in collaboration with trusted community partners throughout the state. These groups and individuals helped determine the health needs and priorities for their residents and communities. These innovative health clinics will be adaptable, flexible, and open to feedback to ensure access to needed services and programs. Currently Neighborhood Health functions under the Mobile health Hub model from the Eastern Connecticut Health Collaborative. Within this model Anchor agencies host mobile services and invite collaborative partners to attend thus providing wrap around services (food and nutrition resources, energy assistance,	Community Health Dept. HHC Neighborhood Health Katherine McNulty *Regional Director of Development* Sherry Smardon *Manager of Philanthropy and Community Benefits* Eastern CT Health Collaborative	**Targets:** # of screenings for depression and anxiety # of individuals served # of events # of referrals for access to care **Milestones** Develop a referral process for behavioral health supports at all East Region Neighborhood health events

	primary care, insurance, legal assistance, etc.) for individuals in the community. Mental Health staff and resources is a service that is needed but not always available through these events. By partnering with Natchaug Hospital we will be able to have a behavioral health clinical professional present and able to connect to services for the community.		
OBJECTIVE 3	**Utilize hospital resources to provide support and resources for community based mental health and substance use focused support groups.**		
CHNA Need	**STRATEGIES/TIMELINE**	**LEAD**	**METRICS/MILESTONES - STATUS**
Outpatient Mental Health Services Capacity for Adults, Adolescents, and Children – Including in-home and caregiver support	**Hospital- Based** Collaborate and partner with local community agencies to offer support groups for the community at Windham Hospital and other Windham hospital sites. Natchaug Hospital will identify active mental health and substance use support groups in the community looking for resources and a brick and mortar location. The Community Health department will utilize physical spaces and assist in coordinating and advertising, resources, contacts, and availability in order to bring support to the community.	Community Health Dept. Katherine McNulty *Regional Director of Development* Sherry Smardon *Manager of Philanthropy and Community Benefits*	**Target -** • 2 active support groups, meeting consistently at Windham Hospital or a Windham hospital supported location • # individuals served **Milestones:** Develop a referral process for behavioral health supports to be utilized by support group facilitators and community agencies.