Community Health Improvement Plan

LAWRENCE + MEMORIAL HOSPITAL

LLHD Ledge Light Health District

Collective Action to Create a Healthier Community

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Table of Contents

Introduction

Over the course of one year, L+M Hospital (L+M) and Ledge Light Health District (LLHD) worked with the community partners on the SECT Health Improvement Collaborative (Collaborative) to collect and analyze the local health data presented in the Community Health Assessment (CHA) which accompanies this Community Health Improvement Plan (CHIP). The CHA examined leading health indicators in eight domains: social determinants of health; health systems and access to care, chronic disease, infectious disease, maternal and infant health, mental health and substance abuse, injury and violence, and environmental risk factors and health. The indicators explored were limited to those for which there were local data available. As a result of very limited local population health data on children, the CHA is predominately focused on the health status of adults in the community. The CHA brought to light certain areas of concern, where statistical analysis documented a disparate burden of disease, illness, injury, social or economic condition or limitation in healthcare access. While the work to produce the CHA and understand health and well-being and their contributing factors was crucial, addressing the question of how to impact identified issues is equally, if not more, important. This document identifies the health issues selected by the Collaborative for immediate action and objectives and strategies for each.

It is important to note that this Community Health Improvement plan is a dynamic "living document". In the absence of unlimited funding, people resources and influence in social and economic systems, it was necessary to "start some where" and the prioritization process identified in this document helped the Collaborative identify the starting point. Future work will focus on continuing to untangle the complex interactions among the socioeconomic status, physical environment, individual health behaviors and clinical care factors that impact health and well-being as we seek to better understand the priority issues. The CHIP will continue to evolve and reflect that changing understanding as well as new partners and strategies that join the effort.

For questions about this plan or to find out more about the Southeastern Connecticut Health Improvement Collaborative, please contact the leadership team:

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Process

Following the completion of the CHA, the Collaborative engaged in a process to prioritize issues and develop strategies to improve health and well-being in the region. The prioritization process included several rounds of review, discussion and group prioritization exercises:

- As the CHA was being edited and finalized, the leadership team from L+M and LLHD identified 31 indicators from the eight domains on which the region or a group within the region was an outlier. Efforts were taken to define the indicators as specifically as possible and to identify where certain groups were experiencing disparate health outcomes in the community. The 31 indicators are listed as Appendix A.

- In May 2016, 35 community partners (listed in Appendix B) participated in a data review and prioritization process using an objective scoring tool (attached as Appendix C), focused on these 31 indicators. The tool provided a frame for each participant to independently score each indicator on relevance ("how important is the issue?"), impact ("what do we get out of addressing it?"), and feasibility ("can we do it?"). The indicators were ranked according to their overall score—both within their domains and within the complete list.

- The leadership team then took effort to group the eight domains into four categories: social determinants/health systems; chronic disease; maternal-child health/infectious disease/environmental risk; and mental health/substance abuse/injuries and violence. At the June meeting of the Collaborative, members voted by selecting their top three indicators in each category. Following the meeting, members were given another opportunity to vote for their top twelve indicators, this time not categorized.

In addition to these group exercises by the Collaborative, input was solicited from the residents who had participated in the CHA focus groups, the community at large through the LLHD website, the Directors of Health for LLHD and Uncas Health District, and the ACHIEVE New London Collaborative (a group focused on chronic disease prevention). All told, over 65 individuals, presenting a broad range of perspectives, participated in the prioritization work.

Throughout all these prioritization exercises and discussions, five indicators consistently rose to the top of the list. The leadership team grouped them under three areas of focus and presented them to the Collaborative for input and approval:

- Improve the conditions that support mental wellbeing and reduce substance use. Indicators:
  - ⇒ opioid use
  - ⇒ anxiety/depression among minorities
- Support and nurture healthy lifestyles. Indicator:
  - ⇒ contributing factors to diabetes
- Ensure access to care. Indicators:
  - ⇒ prenatal care and related birth outcomes
  - ⇒ access to care for the low-income population

Subsequent meetings of the Collaborative included analysis of strengths, weaknesses, opportunities and threats in the region for each area of focus followed by the definition of goals and objectives, the creation of strategies, and the development of other plan elements. The resulting CHIP is a dynamic document that serves as a roadmap for interventions going forward.

Values and Vision

This work follows a collective impact model, one which is effective when addressing entrenched social and community issues. Collective impact begins with the idea that large-scale social change requires broad cross-sector coordination and occurs when organizations from different sectors agree to solve a specific social problem. The key elements of collective impact include creating and following a common agenda, aligning and coordinating efforts to ensure that they are mutually reinforcing, using common measures of success, maintaining excellent communication among partners, and facilitating through a "backbone organization." The Collaborative shares the responsibility to ensure that the strategies identified are implemented and that impact is measured. It can work to build capacity of existing efforts on a particular issue or take leadership on issues not being addressed. A tracking tool will be developed in order to enable the Collaborative to monitor progress on prioritized issues. The Collaborative leadership team will maintain transparency in all activities, communicate regularly with the Collaborative, and facilitate the ongoing efforts of the group.

Throughout the work of the Collaborative to date and going forward, the group has operated within values that include:

- Intentional creation of a culture of trust
- Authenticity in seeking community involvement
- Inclusiveness
- Respectfulness of cultural considerations and differences
- Social justice

At the June meeting of the Collaborative, members began discussing a vision statement that would reflect these values as well as some of the common themes that emerged from the CHA when residents were asked about their visions of a healthy community. As the work continues, the resulting draft vision statement will be refined and have an accompanying mission statement:

Southeastern Connecticut is a community healthy in body and mind that promotes access, healthy equity, social justice, inclusiveness and opportunities for all!

Priority Area: Mental Well-being and Substance Abuse

Mental Wellbeing and Substance Abuse

Priority Area and Indicators	
Improve the conditions that support mental wellbeing and reduce substance use. **Indicators: Opioid Use and Anxiety/Depression among Minorities**	
Goals	**Objectives**
Ensure systems are in place to support mental and emotional wellbeing in our community	By January 2018, better understand the characteristics of people living with opioid addiction in order to inform prevention activities.
	By January 2018 identify and understand local disparities related to anxiety and depression and take concrete action to improve local mental health systems of care.

Objective 1

By January 2018, better understand the characteristics of people living with opioid addiction in order to inform prevention activities.

Community Needs	Populations at Risk/ Disparities	Root Causes
In 2015, alcohol and substance abuse was the 5th most prevalent condition among hospitalization (inpatient and ED) among area residents.	All residents	trauma, frontal lobe development, experimentation, family stressors, mental health issues, ready access to Rx opioids, vulnerable subpopulations (to be identified)
ED encounters at L+M for opioid abuse more than doubled between 2009 and 2014.		

Existing Community Assets	People to Bring to the Table
various community coalitions including community prevention coalitions, first responders, municipal leaders, social service agencies, healthcare/treatment providers, SERAC, LLHD	entities coordinating the various community efforts, MPH students to contribute to research, first line providers for research collaboration

Mental Wellbeing and Substance Abuse

Objective 2

By January 2018 identify and understand local disparities related to anxiety and depression and take concrete action to improve local mental health systems of care.

Community Needs	Populations at Risk/ Disparities	Root Causes
Substantially fewer people earning less than $30K report trusting people in their neighborhood	Low income residents	poverty, lack of culturally sensitive services, transportation, social isolation, immigration/newcomer issues, emotional stressors, stigma, trauma
Hispanics were much more likely than Whites or Blacks to report depression, hopelessness, and/or anxiety	Hispanics	
Medicaid participants are disproportionately represented-at twice the rate-among residents with ED Non-Admissions for suicides and self-inflicted injuries	Medicaid beneficiaries	

Existing Community Assets	People to Bring to the Table
FQHCs, private providers, L+M/LMMG, Southeastern Mental Health Authority, Sound Community Services	Hispanic provider group through Hispanic Alliance

Mental Wellbeing and Substance Abuse

Priority Area: Healthy Lifestyles

Healthy Lifestyles

Priority Area and Indicators

Support and nurture healthy lifestyles

Indicators: Contributing factors to diabetes

Goals	Objectives
Increase healthy food consumption and physical activity—both contributing factors to diabetes, to reduce incidence, particularly among minority populations	By January 2018, identify policy/systems change opportunities and take concrete action in support of healthy food consumption and increased physical activity.
	By January 2018, develop a plan and implement a campaign to raise awareness of healthy lifestyles.
	By January 2018, identify gaps in the system of care for people with pre-diabetes and create strategies to address those gaps.

Healthy Lifestyles

Objective 1

By January 2018, identify policy/systems change opportunities and take concrete action in support of healthy food consumption and increased physical activity.

Objective 2

By January 2018, develop a plan and implement a campaign to raise awareness of healthy lifestyles.

Objective 3

By January 2018, identify gaps in the system of care for people with pre-diabetes and create strategies to address those gaps.

Community Needs	Populations at Risk/Disparities
59% of residents with incomes below $30K report being food insecure	Low income residents
Higher rates of obesity among lower income populations	
42% of residents with incomes below $30K report never exercising	
34% of residents with incomes below $30K report having diabetes	
Higher rates of obesity among Black/African American population	Black/African Americans
13% of residents with a high school education or less report having diabetes	Residents with less than HS education

Healthy Lifestyles

Objective 1

By January 2018, identify policy/systems change opportunities and take concrete action in support of healthy food consumption and increased physical activity.

Objective 2

By January 2018, develop a plan and implement a campaign to raise awareness of healthy lifestyles.

Objective 3

By January 2018, identify gaps in the system of care for people with pre-diabetes and create strategies to address those gaps.

Root Causes	Existing Community Assets	People to Bring to the Table
Food insecurity, inadequate nutrition education, access to safe spaces to recreate, built environment deficits, food deserts, excessive screen time	Mobile market, community gardens, farm to school programs, school food programs, summer feeding program, produce at food banks, parks and rec programs/scholarships, organized sports, public parks, NLC Food Policy Council, Gemma Moran Food Center, WIC program, Youth centers, Diabetes Prevention Programs, Joslin Diabetes Center, LLHD, L+M Hospital/LMMG, SECT Health Improvement Collaborative,	schools

Priority Area: Access to Care

Access to Care

Priority Area and Indicators	
Ensure Access to Care **Indicators: Prenatal Care and Access to Care for Low-Income Populations**	
Goals	**Objectives**
Increase access to equitable and quality health care for low income residents.	By January 2018, increase understanding of community needs and misalignments between local systems of care, transportation systems and other factors impacting access, and take concrete action to increase access to equitable and quality health care.
Ensure systems are in place to support healthy pregnancies and positive birth outcomes for all SECT residents.	By January 2018, identify and understand local disparities with regard to prenatal care, low birthweight, neonatal abstinence syndrome and infant mortality, and take concrete action to improve local systems that improve these birth outcomes.

Objective 1

By January 2018, increase understanding of community needs and misalignments between local systems of care, transportation systems and other factors impacting access, and take concrete action to increase access to equitable and quality health care.

Community Needs	Populations at Risk/Disparities	Root Causes
31.5% of all ED visits by residents of Greater New London were for Ambulatory Care Sensitive Conditions	Medicaid beneficiaries/Blacks	Insurance status, cost, hours of available appointments, transportation, cultural and linguistic competence of providers
At-risk groups are more than twice as likely to receive care in the ED 3 or more times in the past 12 months compared to the overall population	HS or less education/<$30k income group/Black/Hispanic	
1 in 5 residents of Greater New London delayed getting needed medical care in the past 12 months.	Low income residents	

Existing Community Assets	People to Bring to the Table
FQHCs, private providers, SECT Health Improvement Collaborative, SEAT and other transportation providers, SECOG, SECTER, SMHA	SEAT, SECOG

Access to Care

Objective 2

By January 2018, identify and understand local disparities with regard to prenatal care, low birthweight, neonatal abstinence syndrome and infant mortality, and take concrete action to improve local systems that improve these birth outcomes.

Community Needs	Populations at Risk/ Disparities	Root Causes
Infant mortality rate in LLHD was 7.2 per 1,000 live births in 2013.	State data suggest Blacks and Hispanics	Insurance status, lack of awareness of importance of prenatal care, lack of transportation, maternal mental health, tobacco use, nutrition, food insecurity, maternal chronic illness, pattern of avoidance of Ob/Gyn care, hiding pregnancy, chronic maternal stress
16.1% of births in LLHD did not receive adequate prenatal care in 2013.		
7.7% of births in LLHD resulted in infants of low birth weight in 2013		
There was an increase of 60% in the number of babies born at L+M Hospital with neonatal abstinence syndrome.	State data suggest Whites and Medicaid	Overprescribing/availability/affordability of opiates, limited access to alternative pain management

Existing Community Assets	People to Bring to the Table
L+M, SCADD, Sound Community Services, Private providers, FQHCs	SCADD, Private providers

Appendices