Health Improvement Collaborative
Southeastern Connecticut

Colectivo Para Mejorar La Salud
Sureste de Connecticut

Fiscal Years (FY) 2019-22
Community Health Needs Assessment
Community Health Improvement Plan

July 11, 2019

Approved _____

FY 2019-22 Access to Care
Community Health Improvement Plan
A2C Action Team

Health Improvement Collaborative
Southeastern Connecticut

Colectivo Para Mejorar La Salud
Sureste de Connecticut

In the Southeastern CT region (source DataHaven Wellbeing Survey):

Indicator: Percentage earning less than $30K that did not receive the medical care they needed (27% in 2015, 21% in 2018)

Indicator: Percentage of adults without 1 person/place considered primary care provider (31% earning <$30K, 40% of Blacks, 33% of LatinX 2018)

Indicator: Percentage earning less $30K per year who could not receive Rx medications due to cost (15.5% in 2015, 15% in 2018)

Indicator: Percentage earning less than $30K per year who delay necessary healthcare (32% in 2015, 40% in 2018)

Indicator: Percentage earning less than $30K per year who used the ED for any condition 3 or more times per year (11.5% in 2015, 15% in 2018)

Indicator: Percentage earning less than $30K per year who have not seen a dentist in more than 2 years (33% in 2015, 27% in 2018)

Vision: Respectful care that I want, understand, and can afford. Care that I can easily get.

Goal: Increase Access to equitable and quality healthcare for low income residents

Strategy	Action Steps	Outcomes
Improve health education and community resource awareness	• Continue partnership with the United Way Mobile Food pantry and other pantries as an outreach and education opportunity	Activity at minimally 5 sites reaching at least 500 people
Promote connection to primary care providers and the expansion of specialty care services in the region	• Continue outreach efforts to support primary care access • Survey area providers on their experience in referring to specialty care and identify gaps • Develop strategies to address primary and specialty care gaps	Improvement in people reporting having a primary care provider (PCP)
Support efforts to strengthen the regional transportation system	• Participate in the regional transportation action group • Advocate on behalf of consumers with Veyo services • Advocate for medical providers to consider bus access in siting decisions	Improve transportation options for the most vulnerable populations
Pursue opportunities to expand integrated care teams/specialty care	• Advocate with CT Dept. of Social Services for Medicaid billing of community health worker (CHW) services	CHWs integrated into at least 25% of area primary care provider practices

FY 2019-22 Access to Care
Community Health Improvement Plan
A2C Action Team

Strategy	Action Steps	Outcomes
Improve cultural humility among providers	• Collaborate with Yale New Haven Health System (YNHHS) Chief Diversity Officer and local committee • Add cultural humility component to continuing education • Include persons with lived experience as co-speakers	Increase number of Culturally and Linguistically Appropriate Services (CLAS) standards met by providers Increase number of providers meeting any standard
Partners Thames Valley Council for Community Action, United Community and Family Services, L+M Hospital, Community Health Center, United Action, residents, United Way, CT Legal Services, Southeastern CT Enterprise Region, Southeastern CT Council of Governments, YNHHS, Eastern Area Health Education Center		

FY 2019-22 Access to Care
Health Disparities
Community Health Improvement Plan
Black Health Collective

Health Improvement Collaborative
Southeastern Connecticut

Colectivo Para Mejorar La Salud
Sureste de Connecticut

In Southeastern CT Region (DataHaven Wellbeing Survey):

Indicator: Percentage reporting having Diabetes (African Americans – 13% in 2015, 25% in 2018)

Indicator: Percentage reporting having hypertension (African Americans – 40% in 2015, 37.5% in 2018)

Indicator: Percentage of low income residents reporting never exercising in an average week (21% in 2015, 28% in 2018)

Indicator: Percentage reporting they are overweight or obese (African Americans – 74% in 2015, 60% in 2018)

Indicator: Percentage reporting fair or poor access to affordable, high quality fruits and vegetables (29% of people earning <$30K per year, 33% of people earning $30K - $75K per year in 2018)

Indicator: Percentage of Black people statewide reporting depression (32% vs. 26% Whites in CT 2018)

Goal: To improve the overall health and wellbeing of the region's Black residents by

Goal: By March 2021, increase physical activity and health food consumption to reduce the incidence of diabetes and hypertension

Goal: By January 2020, develop a plan and implement activities to raise awareness of healthy lifestyles

Goal: By January 2020, create a more welcoming culture for Health Improvement Collaborative and Action Team meetings in order to engage residents in HIC work that is focused on community strategies to improve health.

Strategy	Action Steps	Outcomes
Strengthen community capacity through meaningful engagement to amplify resident voice with a focus that is neighborhood and place based	• Secure and monitor progress of a cohort of interested people from the target population • Determine baseline data regarding health factors • Secure resources for incentives	Cohort participants report improvements on biometrics from baseline measures
Provide/support implementation of evidence-based, culturally-respectful and responsive, high-quality health programs/activities	• Implement "pop-up" prototypes of healthy lifestyle events • Engage with residents to take an active role in neighborhood improvement efforts • Partner with anchor institutions in neighborhoods with lower incomes and greater social determinant and health burden	At least 2 pop up events implemented Increased participation from at-risk populations

FY 2019-22 Access to Care
Health Disparities
Community Health Improvement Plan
Black Health Collective

Strategy	Action Steps	Outcomes
Strive to improve systems, policies and practices that influence participation, social conditions, and health outcomes	• Utilize virtual public engagement tools • Engage civic, ecumenical, and neighborhood groups in order to have the people impacted involved in design of the efforts • Ensure that the community and its residents are defining what matters to them and determining course of action • Adjust collaborative and action team meeting times to be more accessible to resident participation • Secure resources in order to offer food and childcare as appropriate	• Increase resident involvement
Focus on outreach, education, prevention and advocacy to raise awareness around health issues in the Black community	• Develop strategic, targeted messaging to increase awareness of health issues that impact Black residents in the region. • Combat the narrative that healthy eating is unaffordable • Identify community and healthcare champions • Connect interested residents to resources to assist them with organizing and participating • Employ electronic and digital communications, utilizing best practices in social media • Increase opportunities for community partners to share information.	• Increase awareness and knowledge among those impacted by the activities • At least 5 community champions engaged • Multi-modal communications used consistently
Partners: SECT Ministerial Alliance, New London Branch NAACP Health Committee, Community Alliance for Health Equity, Community Health Center (Groton and NL), Parks and Recreation (Groton and NL), OIC of New London, FRESH New London, Ledge Light Health District, L+M Hospital		

FY 2019-22 Behavioral Health
LatinX Mental Health
Community Health Improvement Plan
Hispanic Alliance Mental Health Network

Health Improvement Collaborative Southeastern Connecticut

Colectivo Para Mejorar La Salud Sureste de Connecticut

In the Southeastern CT region (DataHaven Wellbeing Survey):

Indicator: Percentage of overall population reporting depression/hopelessness several days or more in the last 2 weeks (30% in 2018)

Indicator: Percentage of LatinX reporting depression/hopelessness several days or more in the last 2 weeks (42.5% in 2018 vs. 28% Whites)

Indicator: Percentage of overall population feeling mostly or completely anxious yesterday (12% in 2018)

Indicator: Percentage of LatinX feeling mostly or completely anxious yesterday (20.8% in 2018)

Goal: Ensure systems are in place to support mental health and emotional wellbeing in our community

Goal: Improve access to quality culturally responsive mental health services for the LatinX population

Strategy	Action Steps	Outcomes
Increase bicultural and bilingual mental health providers in the region	• Partner with Chris Soto from the Governor's office and legislative delegation on opportunities for policy change	Advocacy opportunities identified
Create an online resource for area providers	• Create a website platform, section of Hispanic Alliance website, for the resource list	Website platform created to host resource list
Focus on outreach, education, prevention and advocacy to raise awareness/reduce stigma around BeH issues in the LatinX community	• Focus groups among providers not currently part of group, agency directors, and consumers Summer 2019	Three focus groups with at least 10 providers and 10 agency directors and 25 consumers held
Improve cultural humility among providers	• Collaborate with Yale New Haven Health System (YNHHS) Chief Diversity Officer and local committee • Add cultural humility component to continuing education • Include persons with lived experience as co-speakers	Increase number of Culturally and Linguistically Appropriate Services (CLAS) standards met by providers Increase number of providers meeting any standard

Partners: Hispanic Alliance, Connecticut College, L+M Hospital, community behavioral health providers, African American Health Council, United Community and Family Services, Child and Family Agency, New London Public Schools, Community Health Center, Sound Community Services, Church of the City, Eastern Area Health Education Center

FY 2019-22 Behavioral Health
Opioids
Community Health Improvement Plan
Opioid Action Team

Health Improvement Collaborative Southeastern Connecticut

Colectivo Para Mejorar La Salud Sureste de Connecticut

In the Southeastern CT region (CT Department of Public Health):

Indicator: Percentage of opioids involved in drug overdose deaths (85% in 2017)

Indicator: Percentage of Fentanyl-related drug overdose deaths (53% in 2017)

Goal: Ensure systems are in place to support mental health and emotional wellbeing in our community

Goal: Expand harm-reduction services and improve access to equitable and quality services for people living with substance use disorder.

Strategy	Action Steps	Outcomes
Reduce Stigma	• Promote "language matters" • Continue community conversations and education about SUD	Features in local and state media outlets reducing the use of dehumanizing and stigmatizing language Offer at least 2 session per year on biology of Substance Use Disorder for various audiences
Increase Naloxone saturation in the community	• Promote awareness of availability of naloxone at pharmacy • Distribute naloxone kits to individuals for whom there is a barrier to access at the pharmacy	At least 100 kits to be distributed
Coordinate access to evidence-based treatment and remission support services	• Continue and enhance recovery navigator program • Continue and expand community-based clinical services for people living with SUD including mobile access program • Recruit, train and support new Suboxone prescribers	Current level of service maintained and expanded with available funding
Advocate for public policy change	• Continue to advocate for public policy to be rooted in harm reduction, equity and an understanding of SUD as a chronic disease	Expand low threshold access to evidence-based treatment for SUD

Partners: Alliance for Living, Ledge Light Health District, Community Health Center, Sound Community Services, CT Department of Mental Health and Addiction Services, Southeast Mental Health Authority, L+M Hospital, people with lived experience, City of New London, local substance use disorder treatment providers

FY 2019-22 Community Health Improvement Plan
Racism as a Public Health Issue
Health Improvement Collaborative

Health Improvement Collaborative Southeastern Connecticut

Colectivo Para Mejorar La Salud Sureste de Connecticut

In Southeastern CT Region (DataHaven Wellbeing Survey):

Indicator: Percentage reporting being unfairly stopped, searched, questioned, physically threatened, or abused by police (18% of people of color vs. 9% of Whites, 2018)

Indicator: Percentage reporting that their neighborhood Is safe to walk at night (65% people of color vs. 78% Whites, 2018)

Indicator: Percentage of survey respondents reporting that race is their main perceived reason for being unfairly treated by police (30%, 2018)

Indicator: Percentage of survey respondents reporting being unfairly treated when seeking healthcare (28% people of color vs. 10% Whites, 2018)

Indicator: Percentage of survey respondents reporting being unemployed and wanting to work (9% people of color vs. 5% Whites, 2018)

Goal: A reduction in racial and ethnic health disparities resulting from the community addressing:

-Institutional racism that drives systemic inequities in the social determinants of health, and

-Implicit bias, discrimination, and micro-aggressions to reduce racism related chronic stress and resulting health outcomes for people of color

Strategy	Action Steps	Outcomes
Create opportunities for learning about/intervention on implicit bias, discrimination & micro-aggressions & their impact on health and on historical/current systems & policies that perpetrate structural racism and how to disrupt those structures	• Consider locally available assets to guide conversations with organizations and residents • Build capacity at the HIC level, in particular increasing knowledge	Demonstrate awareness, knowledge, and skills that lead to personal, institutional/structural and cultural change.
Support local organizations in assessing internal policies & on working to create inclusive organizations with specific activities to increase diversity	• Engage partner organizations in creating a process for assessment • Research best practices to increase diversity	Assessment complete in at least 3 organizations Compendium of best practices developed
Advocate for policies that improve health in communities of color	• Partner with advocacy organizations to join their efforts	At least one new public policy enacted
Partners: Full membership of the Health Improvement Collaborative, municipalities, employers, healthcare providers		