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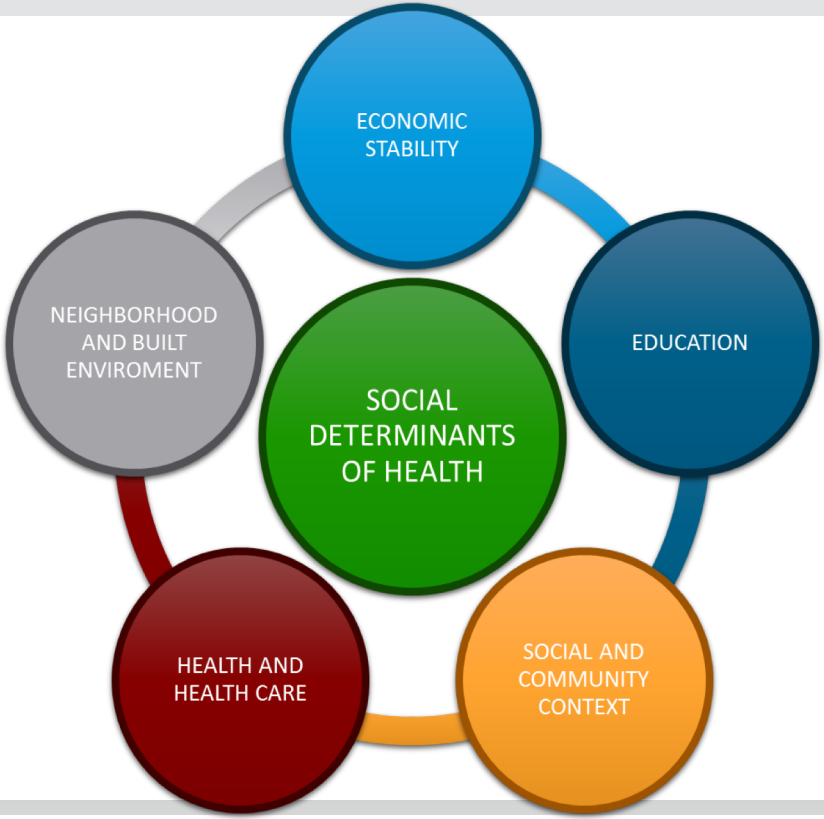
Northwest Region Update on Community Health Improvement Plan

June 27, 2018

A Focus on Root Cause: Social Determinants of Health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.



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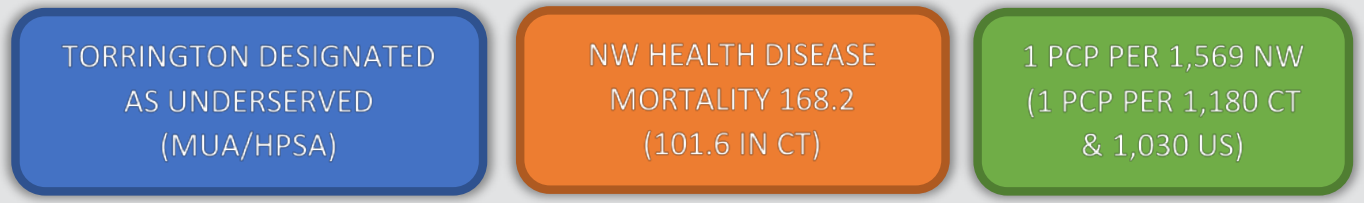
The Four Pillars of Addressing Root Cause

Strategic priority interests that drive our response to addressing root cause

Enhance Coordination of Services

Baseline Indicators



Key Plan Initiative Tactics to Implement

- **Evaluate and use information exchange portal resources, linking healthcare providers with community-based organizations**
- **Improve IT resources to enable community focus and better measurement of outcomes**
- **Develop a playbook for infrastructure, dashboard of health, governance, and community workflows**
- **Enable dynamic and up-to-date asset mapping**
- **Develop innovation network for learning, research, co-creation, and rapid knowledge dissemination (bi-directional communication platform)**
- **Implement new or increased use of Community Health Workers (CHW)**
- **Evaluate and use adaptive technology (e.g., geo-fencing, GIS mapping, artificial intelligence, biometric risk assessment, Epic tie-ins)**

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Promote Healthy Behaviors and Lifestyle

Baseline Indicators

SCHOOL BREAKFAST PARTICIPATION 20% OR LESS IN MOST NW TOWNS

ONLY 39% OF RESIDENTS AT HEALTHY WEIGHT (SAME AS CT)

LOWER RATE OF COLLEGE AND GRADUATE DEGREE (31.7% NW, 38.1% CT)

Key Plan Initiative Tactics to Implement

- **Screen for healthy food need identification in community population and provide assessment at points of care**
- **Enhance Promotion and Marketing, including continuing the 5-2-1-0 initiative, at schools, workplaces, public spaces, faith communities, and healthcare events**
- **Provide voucher/prescription programs for fruits and vegetables**
- **Promote and improve healthy food donation**
- **Further partnerships with food pantries/banks and food providers and suppliers**
- **Create more access points for healthy foods**
- **Develop urban gardens, community gardens, hospital campus gardens, farmer's markets (fresh food)**
- **Evaluate and use mobile food programs**
- **Create and support food policy councils**

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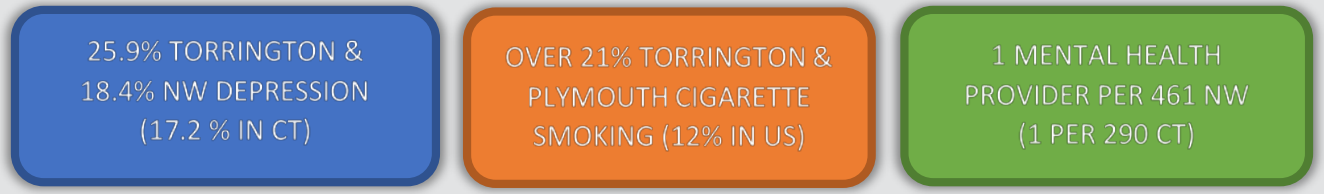
Improve Community Behavioral Health

Baseline Indicators



Key Plan Initiative Tactics to Implement

- **Embed behavioral health services in primary care**
- **Recruit more mental health providers, with focus on community outpatient services (e.g., family therapists)**
- **Implement Recovery Coach program in ED**
- **Provide more depression screening – growth and at more points of care with referrals (including at public schools) and integrate into Epic**
- **Further Mental Health First Aid training and grow community behavioral health training at the local level**
- **Enhance services in virtual mental health, including tele-psychiatry**
- **Build on tobacco prevention and cessation programs**
- **Continue development of Opioid Task Force**

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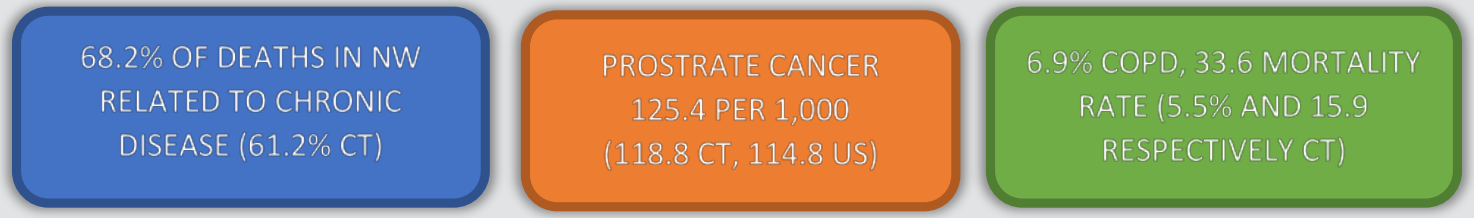
Reduce the Burden of Chronic Disease

Baseline Indicators



Key Plan Initiative Tactics to Implement

- **Congestive Heart Failure discharge programs and CHF clinic**
- **Growth in diabetes programs, including Diabetes Center at CHH with specialists and prevention program at YMCA (Measurable Progress Unlimited Support Diabetes Prevention Program)**
- **Leverage CHW dietician (see Coordination of Services initiative)**
- **Case management, self-management (including access to self-measure devices or monitors), at-home programs, and support groups**
- **Coordination at primary care access points (communication, connecting to resources)**
- **Coordination of care: enhance feedback loop and follow-up care with improved information portal**
- **Promote screening (e.g., abnormal blood glucose for obese patients) and team based approaches to care**
- **Incorporate elements of 6/18 initiative (which includes specific focus on high blood pressure, asthma, and diabetes) – e.g., expand access to the National Diabetes Prevention Program**

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