# MIDDLESEX HEALTH

# Middlesex Hospital Community Health Needs Assessment Implementation Strategy

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Middlesex Health
Middlesex Hospital

## ACKNOWLEDGEMENTS

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***Many thanks to the following contributors for their input and participation in the community health needs assessment implementation strategy planning team and community conversation event:***

- Reverend Robyn Anderson, Director, Ministerial Health Fellowship
- Amber Kapoor, MPH, Health Education and Grants Coordinator, Cancer Center, Middlesex Health
- Russell S. Melmed, MPH, Director of Health, Chatham Health District

Additional thanks to those who gave their time and expertise to participate in the community conversation.

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## EXECUTIVE SUMMARY

A community health needs assessment (CHNA) implementation strategy is a written plan that describes how a hospital intends to address the significant health and health-related needs identified in its community health needs assessment. Middlesex Health completed its CHNA in 2019, and this implementation strategy report outlines the process by which Middlesex Health has identified the most pressing health and health-related needs of the communities we serve, and, the priority areas Middlesex Health plans to address through goals, strategies and partnership. Conducting a CHNA and executing an implementation strategy allows not-for-profit hospitals to use a data-driven and collaborative practice approach for improving community health, quality of life and advancing health equity.

The work of improving community health and well-being and reducing health disparities is most successful and impactful through community engagement and collaboration. Middlesex Health remains grateful to its community partners and the community members who continue to work alongside us on initiatives that promote health and address the drivers that influence health status. The strength of these targeted interventions is through our partnerships.

As in the past, Middlesex Health continues to use its CHNA and implementation strategy to highlight social determinants of health and health equity. Health equity is the state where everyone has the opportunity to attain full health potential and no one is prevented from achieving this potential due to social position or socially defined circumstances. Addressing social determinants of health – the conditions that affect health, functioning and quality of life outcomes – is critical for reducing health disparities and ensuring that people have what they need to thrive and be successful. It is through this lens that Middlesex Health views health equity and social determinants of health as foundational to its CHNA implementation strategy initiatives.

To assist Middlesex Health in prioritizing the significant health and health-related needs identified in its most recently completed CHNA, a facilitated community conversation was held. Multi-sector representatives participated in a ranking exercise and a discussion of potential strategies and solutions. The results of the community conversation served as a guide for Middlesex Health's selection of priority areas for its CHNA implementation strategy. Through this process, Middlesex Health will focus on the following four areas: 1) **Healthy Weight / Obesity / Diabetes Prevention**; 2) **Mental Health – Adverse Childhood Experiences**; 3) **Substance Use Disorder – Opioids**; and 4) **Cancer**, with social determinants of health and health equity as essential components for each health area. Middlesex Health looks forward to continuing and expanding its community health partnerships in these key areas, where together, we can continue to meaningfully improve the health, well-being and quality of life for all community members.

## BACKGROUND

### ABOUT MIDDLESEX HEALTH AND MIDDLESEX HOSPITAL

Middlesex Hospital proper, founded in 1904, is an independent, not-for-profit, acute-care community hospital located in Middletown, CT. An organizational rebranding from Middlesex Hospital to Middlesex Health occurred in December 2018 in order to represent the system's comprehensive network of services provided in conjunction with hospital services. The hospital is licensed for 275 beds and 22 bassinets, and Middlesex Health serves a total population of over 250,000 persons. Services provided include inpatient and emergency services, teaching services, extensive outpatient care, including diagnostic, physical medicine and rehabilitation (5 locations), behavioral health, disease management, radiology, laboratory, cancer care (2 locations), homecare, assisted living, wound and ostomy care, surgical services, medical specialists, urgent care (3 locations), and a network of primary care offices (15 sites). In addition to its emergency department located in Middletown, Middlesex Health operates two satellite medical centers in Westbrook and Marlborough that have fully accredited, stand-alone emergency departments.

Middlesex Health is a member of the Mayo Clinic Care Network (effective October 2015) a relationship that provides the system with access to information, knowledge and expertise from Mayo Clinic's expert specialists.

### MEASURING COMMUNITY HEALTH

The purpose of the community health needs assessment is to measure the health and health-related status of a defined geographic area through a systematic and comprehensive data collection process with input from persons representing the broad interests of the community. The goal of the CHNA is to use primary, secondary, quantitative and qualitative data sources of key health and well-being indicators to document the unique characteristics and needs of the community served. Middlesex Health's most recently conducted CHNA can be accessed at https://middlesexhealth.org/middlesex-and-the-community/serving-our-community/community-health-needs-assessment.

### COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY

Using the results of the community health needs assessment, an implementation strategy is developed as a road map for meeting identified needs. Priority setting informs the formation of a CHNA implementation strategy where comprehensive action plans are developed to address identified community health and health-related needs. Using the results of a CHNA to develop an implementation strategy that addresses both the symptoms and underlying causes of persistent health problems is critical for improving community health, well-being and advancing health equity.

## COMMUNITY CONVERSATION

A facilitated community conversation was held to review, prioritize, and discuss strategies and solutions for the significant health and health-related needs identified in Middlesex Health's 2019 community health needs assessment, thereby informing Middlesex Health's CHNA implementation strategy. The invitation to the event was widely disseminated to an array of contacts in Middletown, Middlesex County and the periphery towns of Middlesex Health's primary service area to ensure participation by community leaders, stakeholders and community members with diverse backgrounds, perspectives and first-hand knowledge about their communities.

The community conversation format was selected as it provides a practical, purposeful and interactive approach for 1) exploring the causes and underlying issues behind specific health problems; 2) addressing concerns; 3) discussing desired future state; 4) designing strategies based on data and individual knowledge, perspective and experience; and, 5) serving as a foundation to encourage sustained engagement and to create opportunities for cooperative action.

The community conversation was held at Cross Street AME Zion Church in Middletown, Connecticut. A total of 44 people participated, representing various sectors including advocacy groups, alliances/ coalitions, educational institutions, community based organizations, community residents, elected officials, faith-based organizations, health care organizations (including medical and behavioral), local health departments, municipal agencies, public safety organizations (police, emergency management), social services, state agencies and youth and family services.

Using a layout of round tables in the meeting space to foster group discussion, facilitators with expertise in community conversations led the participants through prioritization and strategy/solution exercises. To launch the meeting, an overview of Middlesex Health's 2019 CHNA was given, including background on the process; key demographic data; data limitations; definitions of health equity, health disparities and social determinants of health; social and health disparity data, when available; and an overview of the top ten health needs previously validated and refined by the planning committee through review of the significant health and health-related needs identified in Middlesex Health's 2019 CHNA. Cancer data from Middlesex Health's Cancer Center community health needs assessment was also presented, specifically noting health disparities (the full report can be accessed at https://middlesexhealth.org/cancer-center/about-our-cancer-center/cancer-center-community-health-needs-assessment).

Reverend Robyn Anderson, Director, Ministerial Health Fellowship and Russell Melmed, MPH, Director of Health, Chatham Health District, facilitated the prioritization, discussion and strategy development phases of the community conversation.

## PRIORITIZATION

An individual exercise where participants were given a list of the top ten significant health needs **(Table 1)**, not in rank order, was led by Russell Melmed, MPH, Director of Health, Chatham Health District. Attendees were asked to utilize a framework consisting of four elements – 1) magnitude of the problem; 2) seriousness of the problem; 3) feasibility of interventions; and 4) presence of significant inequities – to guide the prioritization process. Participants were given factors to consider (i.e., probing questions that would assist in assigning a numerical value to each element for each health indicator) and were asked to consider the impacts of social determinants of health and health disparities when reviewing each health issue. On a worksheet, participants used the numerical scale of 1 = low/least; 3 = moderate; 5 = high/most for each element relative to each indicator, and concluded the first step of the prioritization exercise with totaling the score for each health indicator.

**Table 1**

| Top Ten Health Issues |
|---|
| Cancer |
| Cardiovascular Disease |
| Diabetes |
| Healthy Aging (including dementia, falls, social isolation) |
| Healthy Weight / Obesity |
| Hypertension |
| Maternal Child Health |
| Mental Health – all ages (including depressive disorder, anxiety, adverse childhood experiences) |
| Respiratory Diseases (including asthma, chronic obstructive pulmonary disease) |
| Substance Use Disorder (specifically alcohol, opioids, tobacco) |
| *With a focus on social determinants of health and health disparities* |

Based on the worksheet results, participants were then asked to identify their top five priority areas through the dot voting technique where each participant was given five same-colored dot stickers and instructed to affix them to the corresponding health issues noted on easel pad paper posted on the meeting space walls. Once this process was completed, the results were tallied and five priority areas were determined **(Table 2)**. As there was a tie for substance use disorder and cancer for the 4$^{th}$ highest priority area, they have been coded as 4a and 4b respectively in **Table 2**.

**Table 2**

| Priority Areas in Rank Order | |
|---|---|
| **1** | **Diabetes** |
| **2** | **Mental Health all ages (including depressive disorder, anxiety, adverse childhood experiences)** |
| **3** | **Healthy Weight / Obesity** |
| **4a** | **Substance Use Disorder (specifically alcohol, opioids, tobacco)** |
| **4b** | **Cancer** |
| **5** | Maternal Child Health |
| **6** | Cardiovascular Disease |
| **7** | Healthy Aging (including dementia, falls, social isolation) |
| **8** | Hypertension |
| **9** | Respiratory Diseases (including asthma, chronic obstructive pulmonary disease) |
| | *With a focus on social determinants of health and health disparities* |

## STRATEGY DEVELOPMENT

With the top five priority areas selected, Reverend Robyn Anderson, Director, Ministerial Health Fellowship, facilitated a strategy development group exercise where participants were asked to select a table captain and scribe and discuss three questions in relation to each priority area. In an order to align with existing collaborative and cross-sector efforts to improve community health, the questions were drawn from the Greater Middletown Health Enhancement Community (HEC), a community-based initiative through the State of Connecticut Office of Health Strategy and Department of Public Health.

1) *How can our community and its resources (in place or not yet developed) provide and support prevention of and care for this priority area?*
2) *What obstacles might get in the way of that?*
3) *How can we do this in a way that equitably benefits all members of our community?*

At the conclusion of the timed exercise, the table captains were asked to report their group's responses while a note-taker scribed themes, actions, solutions, strategies, impacts, resources and partners on easel pad paper. The compilation of the robust notes from the individual tables and the synthesized report-out notes will serve as a reference document for the planning of the community health improvement CHNA implementation strategy goals.

## IMPLEMENTATION STRATEGY PRIORITIES & GOALS

The results of the community conversation were integral for informing Middlesex Health's CHNA implementation strategy. From this process, Middlesex Health has selected the below four priority areas. In addition to these priority areas, Middlesex Health will continue to broadly focus on initiatives relative to social determinants of health and improving data collection methodologies, as the lack of availability of data stratification by race and ethnicity and other vulnerable populations for Middlesex County was identified in Middlesex Heath's recently completed CHNA as insufficient and causing data limitations.

### HEALTHY WEIGHT / OBESITY / DIABETES PREVENTION

| Priority #1 | Healthy Weight / Obesity / Diabetes Prevention |
|---|---|
| **Goal** | Promote healthy weight and reduce burden of obesity-related chronic disease. |
| **Actions** | • Work with community partners to develop evidence-based intervention, prevention and risk reduction initiatives for healthy weight and obesity-related chronic diseases.<br>• Focus on social determinants of health barriers that prevent optimal and equitable achievement of healthy weight.<br>• Focus on at-risk populations to reduce health disparities. |
| **Anticipated Impact** | • Improved healthy weight.<br>• Chronic disease prevention. |
| **Community Partners** | Community Health Center, Inc.; Food pantries; Faith-based organizations; Greater Middletown Health Enhancement Community; Health Departments in primary service area; Middlesex County Chamber of Commerce; Middlesex Coalition for Children; Middlesex County NAACP Branch Health Committee; Middlesex Health Center for Chronic Care Management; Middletown Ministerial Alliance; Middletown Youth Services Bureau; Middlesex United Way; Middlesex YMCA; Ministerial Health Fellowship; Opportunity Knocks; Primary care physicians; Public school systems in primary service area; Soup kitchens; St. Vincent de Paul, Middletown; Valley Shore YMCA; Youth & Family Services; Other municipal and community based organizations. |

## MENTAL HEALTH – ADVERSE CHILDHOOD EXPERIENCES

| Priority #2 | Mental Health – Adverse Childhood Experiences |
|---|---|
| **Goal** | Improve well-being by addressing Adverse Childhood Experiences (ACEs) for children, and adults who experienced ACEs in their youth. |
| **Actions** | • Work with community partners to develop evidence-based intervention, prevention and risk reduction initiatives for ACEs.<br>• Focus on social determinants of health barriers that may contribute to ACEs prevention and treatment.<br>• Focus on at-risk populations to reduce health disparities. |
| **Anticipated Impact** | • Prevention of ACEs.<br>• Improved mental well-being through connection to services and reduction in toxic stress caused by ACEs. |
| **Community Partners** | Behavioral health providers; Community Health Center, Inc.; Faith-based organizations; Greater Middletown Health Enhancement Community; Health Departments in primary service area; Mental health providers; Middletown Youth Services Bureau; Middletown Ministerial Alliance; Middletown Racial Justice Coalition; Middlesex Coalition for Children; Middlesex County Chamber of Commerce; Middlesex County NAACP Branch Health Committee; Middlesex Health Center for Behavioral Health; Middlesex Health Family Advocacy; Middlesex United Way; Middlesex YMCA; Ministerial Health Fellowship; Opportunity Knocks; Primary care physicians; Public school systems in primary service area; Social work providers; Youth & Family Services; Valley Shore YMCA; Other municipal and community based organizations. |

## SUBSTANCE USE DISORDER - OPIOIDS

| Priority #3 | Substance Use Disorder – Opioids |
|---|---|
| **Goal** | Improve support services for individuals struggling with opioid use disorder and increase opioid use disorder prevention efforts. |
| **Actions** | • Work with community partners to expand support services for individuals struggling with opioid use disorder and for family/friends of those struggling with opioid use disorder.<br>• Focus on social determinants of health barriers that may contribute to opioid use disorder prevention and treatment.<br>• Focus on at-risk populations to reduce health disparities. |
| **Anticipated Impact** | • Increase in access to support services for individuals struggling with opioid use disorder and for family/friends of those struggling with opioid use disorder.<br>• Increase in community awareness regarding the harms of opioid use disorder. |
| **Community Partners** | Behavioral health providers; Columbus House; Community Health Center, Inc.; Connecticut Community for Addiction Recovery (CCAR); Community based recovery coaches; Faith-based organizations; Health Departments in primary service area; Middlesex County Chamber of Commerce; Middlesex County NAACP Branch Health Committee; Middlesex Health Center for Behavioral Health; Middlesex Health Paramedics; Middlesex YMCA; Middletown Youth Services Bureau; Ministerial Health Fellowship; Middletown Ministerial Alliance; Middletown Substance Abuse Prevention Council; Primary care physicians; Public Safety organizations (police departments, fire departments, emergency management); Public school systems in primary service area; St. Vincent de Paul, Middletown; Youth & Family Services; Valley Shore YMCA; Other municipal and community based organizations. |

## CANCER

| Priority #4 | Cancer |
|---|---|
| **Goal** | Reduce burden of cancer through prevention and early detection efforts and by supporting individuals through cancer treatment and survivorship care. |
| **Actions** | • Engage with community partners to develop and implement evidence-based outreach activities which promote cancer prevention and facilitate early detection of cancer.<br>• Focus on social determinants of health barriers that prevent optimal and equitable cancer prevention, early detection, treatment, and/or survivorship care.<br>• Focus on at-risk populations to reduce health disparities. |
| **Anticipated Impact** | • Decreased cancer incidence and/or rate of late-stage cancer diagnoses.<br>• Improved cancer mortality rates.<br>• Improved rates of receipt of guideline-concordant cancer-related care for at-risk populations. |
| **Community Partners** | Community Health Center, Inc.; Connecticut Oncology Group; Health Departments in Middlesex Health service area; Middlesex County NAACP Branch Health Committee; Middlesex Health Cancer Center; Middlesex Health Radiology; Middlesex Health Surgical Alliance; Ministerial Health Fellowship; Middletown Ministerial Alliance; Middlesex YMCA; Primary care physicians; Public school systems in primary service area; St. Vincent de Paul, Middletown; Valley Shore YMCA; Other municipal and community based organizations. |

## CONCLUSION

### NEXT STEPS

When developing action plans for the selected priority areas, each goal will have defined metrics where post-implementation data will be compared to baseline data in order to measure impact. An evaluation plan to assess the effectiveness of the initiatives will also be developed during the program planning phase.

In addition, to sustain the collaborative momentum from the community health needs assessment process and the community conversation, Middlesex Health will work with community partners to develop and/or expand a county-wide multi-stakeholder coalition designed to improve community health and well-being and advance health equity through targeted goals and strategies in alignment with the findings of the CHNA. During the community conversation, sign-up sheets were provided for participants interested in continued involvement. Critical to developing and/or expanding a community health improvement collaborative will be ensuring that those who are disproportionately impacted by health disparities have sufficient representation and voice in developing community health improvement strategies that are guided by and in alignment with their articulated needs and preferences.

### ADOPTION OF THE IMPLEMENTATION STRATEGY

The Middlesex Health Board of Directors approved and adopted the Hospital's community health needs assessment implementation strategy on February 7, 2020, which is within Internal Revenue Code 501(r)(3) requirements for a hospital facility's authorized body to adopt the implementation strategy on or before the 15th day of the fifth month after the end of the taxable year in which the hospital facility finished conducting the community health needs assessment.

### COMMUITY HEALTH NEEDS NOT ADDRESSED

Middlesex Health recognizes that it cannot focus on every health and social need identified in its 2019 community health needs assessment and is therefore committed to allocating resources and in-kind time to the highest areas of identified need and/or areas with greatest potential for impact and feasibility (the selected priority areas). Resource constraints prevent the Hospital from addressing every need, and in many cases, other local community based organizations may be better suited to take a leadership role in improving certain health outcomes. As with our previous community health needs assessments, the Hospital will continue to be a willing partner, when able, for initiatives not related to its selected CHNA implementation strategy priority areas.

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