2016 Greater Norwalk Region

Community Health Improvement Plan and Implementation Strategy

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Norwalk Health Department

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Norwalk Hospital
Western Connecticut Health Network

Community Health Improvement Plan

The **2016 Greater Norwalk Community Health Improvement Plan** (CHIP) was developed over the period of September 2016 through January 2017, using the key findings and identified priorities from the **Community Health Needs Assessment** (CHNA). The Greater Norwalk CHNA included data from the 2015 Community Wellbeing Survey (CWS), the key informant survey (KIS), community agencies and services, as well as quantitative data from local, state, and national sources to inform discussions and determine priority health areas. The CHIP will be a dynamic document that outlines strategies and tactics to improve the health of the Greater Norwalk Region and will serve as a roadmap for implementation.

Norwalk Hospital, in collaboration with the Norwalk Health Department, led the development of the CHIP, with participation from community partners. The Community Health Committee (CHC) of the Norwalk Hospital Board provided oversight of the process. Membership of the Norwalk Hospital CHC, and the Norwalk Hospital and Health Department team members can be found in Appendix A. Lorentson Consulting, a company with extensive community program development, was engaged to conduct community conversations and facilitate the workgroups convened for each priority identified in the CHNA. The workgroups developed goals, objectives, strategies, actions steps and metrics to measure success for their respective health priorities. Workgroup participants are listed in Appendix B.

Overview of the Community Health Improvement Process

A CHIP is an action-oriented strategic plan that outlines how the defined priority health issues for a community will be addressed, including strategies and indicators to measure improvement in the health of the community. CHIPs are created through a community-wide, collaborative process that engages community members and organizations to develop, support and implement the plan. The CHIP serves as a vision for the health of the community and a framework for organizations to use in leveraging and coordinating resources, engaging partners and sharing best practices across sectors and the region.

As a broad, strategic framework, the CHIP is designed to be modified and adjusted as conditions, resources and external environmental factors change. It has been developed to provide guidance to the hospital, health departments and community partners, so that all community groups and sectors — private and nonprofit organizations, government and social service agencies, community and faith-based organizations — can participate in the effort to improve the health and quality of life for all people who live, work and play in the Greater Norwalk Region.

Methods

Building on the work underway and based on the key findings and priorities identified in the **Community Health Needs Assessment** (CHNA), the goals of the CHIP are to:

- Develop a strategic framework to address the priority health issues identified in the CHNA
- Identify resources and partners to develop and implement an improvement plan with performance measure for evaluation of impact
- Guide future community decision-making related to community health improvement

In addition to guiding future services and programs for the Greater Norwalk Region, the CHIP fulfills the prerequisites for a hospital to submit to the IRS as proof of its community benefit and for a health department to earn voluntary public health accreditation, which indicates the agency is meeting national standards.

To develop the CHIP, Norwalk Hospital and Norwalk Health Department were the convening organizations that brought together community agencies, region Health Departments, community members, and additional community representatives.

The approach to the CHNA and CHIP was guided by the Association for Community Health Improvement (ACHI)/ Health Research & Educational Trust (HRET) framework (Figure 1). The CHIP process

FIGURE 1: Community Health Assessment and Implementation Pathway

SOURCE: HRET, 2016

was designed to integrate and enhance the current community health activities of many organizations in order to leverage existing resources for greater efficiency and impact.

The next phase of the community health improvement process will involve implementation of the strategies and action steps developed from the CHIP and monitoring and evaluation of the CHIP's outcomes and impact.

Development of 2016 CHIP Strategic Components

The key findings and health priorities identified in the CHNA (i.e. chronic disease/obesity, mental health/substance abuse, and access to health care) were presented to community partners and various community organizations from September 2016 to November 2016. Then workgroups were convened and facilitated by Lorentson Consulting over several days in November and December 2016 to draft goals, objectives, strategies, short-term action steps, long-term action steps and outcome measures for each of the four priority areas. See Appendix B for workgroup participants.

On September 7, 2016 the CHNA findings were presented to the members of the Norwalk Chapter of the NAACP. A focus group was held on September 29, 2016 with students from Brien McMahon High School in Norwalk. Both these community forums utilized facilitated discussion to elicit feedback on the community perception about the health strengths and needs and to explore how these concerns can best be addressed in the future.

The workgroups for the three priority areas met over two days in November 2016. Data profiles and copies of the existing action plan and strategies were distributed to workgroup members to ensure that plan components were data driven and considered work already underway. The Chronic Disease/Obesity Prevention workgroup was expanded with additional community members and health care providers.

The workgroups to address Chronic Disease/Obesity Prevention and Mental Health/Substance Abuse met on November 29, 2016, and the Access to Care workgroup convened on November 30, 2016. Through facilitated discussion, brainstorming and working in small groups, the workgroups developed proposed goals, objectives and strategies for their specific priority area.

In December 2016, draft plans for Chronic Disease/Obesity, Mental Health/Substance Abuse, and Access to Care were circulated to workgroup members, refined via email and phone communication, and edited as needed.

Updates on the progress of the CHIP development were provided to the Norwalk CHC at meetings held on December 9, 2016 and again on January 27, 2017.

The proposed action plans and strategies were developed and circulated to the newly formed Western Connecticut Health Network (WCHN) Community Health Committee (CHC). These plans were presented to and endorsed by the WCHN CHC on January 23, 2017.

Overview of the Implementation Plan

Priority	Goal	Objective(s)	Collaborating Community Partners
Chronic Disease/ Obesity	Reduce and prevent obesity and chronic disease in our community by promoting healthy lifestyles	• Increase the number of children and adults who meet physical activity guidelines • Increase community knowledge of and access to healthy and affordable foods	Norwalk Hospital, Norwalk HD, Riverbrook YMCA, Healthy for Life Project, Norwalk Public Schools, Norwalk Grows
	Prevent the onset of chronic disease, and increase chronic disease self-management skills in our community	• Expand screening and risk assessment programs (e.g. Know Your Numbers – KNY) • Increase number of chronic disease self-management programs in the community	Healthy for Life Project, Norwalk Hospital, Norwalk HD, Riverbrook YMCA, American Heart Association, American Cancer Society
Mental Health & Substance Abuse	Improve access to appropriate behavioral health care for adults and children	• Identify lower risk and needs populations and provide short-term treatment • Identify highly vulnerable populations and connect to care • Develop/ensure complete continuum of levels of care	Regional Prevention Councils, Southwest Regional Mental Health Council, Norwalk Community Care Team (CCT), WCMG Primary Care Providers (PCPs)
	Provide education on Mental Health and Substance Abuse to increase awareness and promote prevention	• Provide access to information and resources that reduce stigma, enhance awareness and encourage early identification of behavioral health issues • Increase awareness of available resources among PCPs and pediatricians • Increase the number of prevention and intervention activities related to opioids	Regional Prevention Council, Local Prevention Councils, Norwalk Hospital Emergency Department (ED) & Emergency Medical Services (EMS), Norwalk Hospital Pharmacy
Access to Care	Increase access to health providers and services for uninsured, underinsured, and undocumented populations	• Increase access to primary care and improve health literacy • Increase access to oral care services • Improve access to culturally sensitive programs and providers • Increase access to specialty care/services • Increase access to medications	Federally Qualified Health Centers, e.g. Norwalk Community Health Center (NCHC), and Day Street Community Health Center, AmeriCares, Primary Care Providers

Planning for Action and Monitoring Progress

The Norwalk (CHC) was created during the community health planning process in the Greater Norwalk Region in 2012. The Charter for the Committee was defined:

Mission: The CHC is a committee of the Board of Trustees at Norwalk Hospital and exists to assess, guide, participate, and deliver community based clinical and non-clinical prevention programs.

Purpose: The Board of Trustees for Norwalk Hospital is responsible for the implementation of projects and programs aimed at improving the health of citizens in lower Fairfield County. To fulfill this responsibility the committee and its partners will assess population health status and social determinants that impact health, identify priority issues for action to improve community health, develop and implement improvement plans, and help guide future policies and programs that address health and wellness strategies. To accomplish this, we are committed to ensuring that our actions support community health programs that are accountable and continuously measured to improve health outcomes and reduce inefficiencies in delivery of programs and services.

Responsibilities and Scope of Activities

The committee shall provide recommendations to the chair for approval to the following scope activities:

- **Direction (goals and strategy)**
  - Development and implementation of a community benefit report and plan
  - Development and implementation of a Community Health Improvement Plan which identifies distinct improvement targets
  - Ensure that clear expectations for community health are established, transparent and developed collaboratively with community stakeholders
  - Solicit Board of Trustee approval for direction and scope of committee work
- **Monitoring and Accountability**
  - Approve and monitor key performance indicators tied to committee goals
  - Provide a structure/process to measure, report and improve the programs delivered
  - Ensure that adequate resources are allocated for assessing, improving, and sustaining programs
  - Oversee compliance with regulatory reporting
  - Report in summary fashion to the Board of Trustees on a biannual basis
- Population Health Improvement
  - Improving the health status for defined populations; which includes, but is not limited to, access to care, equity and quality of services delivered, responsiveness of services to priority community need
  - Assure stakeholder engagement by defining a process for responding to issues that arise from the community and incorporating the consumer perspective of quality of care into the work of the committee
- **Membership**
  - **a.** Norwalk Hospital Chief Medical Officer
  - **b.** Executive Administrative Leadership from Hospital
  - **c.** Local Health Department Directors
  - **d.** Community Health Care Leaders
  - **e.** Social Services Leaders
  - **f.** Private Business leaders
  - **g.** Board Leadership
  - **h.** Key Hospital Stakeholders (e.g., Dept. Chair of Psychiatry)

Subsequent minor revisions to the committee scope and membership have been made as Norwalk Hospital became a member of WCHN.

Progress on the 2016 CHIP and implementation strategies will continue to be monitored at routine workgroup meetings, and will be reported regularly to the Norwalk CHC. The Norwalk CHC will report to the WCHN CHC, made of community members and representatives from community health organizations on a quarterly basis, and annually to the Norwalk Hospital Board and the network Strategic Planning Committee, as a delegate of the WCHN Board of Directors (see Appendix C for reporting structure and CHC membership).

The work of the various task forces, workgroups, and committees follows a collective impact model, which has proven to be an effective approach when addressing entrenched social and community issues. Collective impact begins with the idea that

FIGURE 2: Community Health Assessment and Implementation Pathway

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
- Facilitating through "backbone" support organizations

Appendices

Community Health Improvement Plan

Real lasting community change and improvement stems from the comprehensive assessment of current needs, an aspirational framework of goals and objectives to bring about change, and a rigorous evaluation of whether our collaborative efforts are making an impact. The following pages (Appendix D) outline the goals, objectives, strategies, action steps and indicators of success for the health priority areas identified in the community health needs assessment.

Appendix A

Norwalk Community Health Committee (CHC) Members

Organization	Member Name
Western Connecticut Health Network (WCHN)	Rowena Bergmans
Town of Westport, Human Services	Barbara Butler
Americares	Karen Gottlieb
Norwalk Department of Health	Tim Callahan
Norwalk Hospital Volunteers	Fred Lione
Education Growth Partners	Peter Campbell
Norwalk Community Health Center	Craig Glover
Norwalk Chapter of the NAACP	Yolanda Skinner
WCHN, Department of Psychiatry	K. Tait Michael, MD
Town of New Canaan, Director of Health	David Reed
Greenwich Education Group	Robyn Whittingham
Norwalk Hospital Chaplain Service	Carol Bauer
Darien Department of Health	David Knauf
Soundview Medical Associates	Eileen Smith
Sunrise Brighton Gardens	Dwain King
WCHN, Community Relations	Maura Romaine
Town of Ridgefield, Director of Health	Edward Briggs
Town of Westport, Department of Health	Mark Cooper
Guests:	
Riverbrook YMCA	Mary Ann Genuario
Norwalk Department of Health	Theresa Argondezzi
WCHN	Joyce Bretherton

Norwalk Health Department/ Norwalk Hospital Team

Organization	Member Name
Norwalk Department of Health	Theresa Argondezzi
Norwalk Department of Health	Deanna D'Amore
Norwalk Department of Health	Tim Callahan
Western Connecticut Health Network (WCHN)	Jeryl Topalian
WCHN	Kara Jose
WCHN	Jessie Joseph

Appendix B: Workgroup Participants

Chronic Disease & Obesity – Lead: Theresa Argondezzi, Norwalk Health Department

Organization	Member Name
Riverbrook YMCA	Mary Ann Genuario
Americares	Barbara McCabe
Norwalk Health Department	Megan DiMeglio
Norwalk Health Department	Kaitlin Latham
Norwalk Health Department	Jordan Siegel
Norwalk Health Department	Theresa Argondezzi
American Cancer Society	John Brannelly
American Heart Association	Lisa Neff
American Heart Association	Judy Campisi
Norwalk Housing Authority	Candace Mayer
City of Norwalk, Early Childhood Council	Mary Oster
Cooking Matters	Terry Young
Norwalk Hospital	Caitlin Rohrmann
Norwalk Hospital	Amanda Loveless
CHC, Inc.	Stefanie Lynn
WCHN	Jeryl Topalian
Norwalk Grows	Lisa Lenskold
WCHN NCHC	Ellen Ryan Tiffany Sanders MD
WCHN	Maura Romaine
Norwalk Public Schools	Jo Ann Malinowski
Westport/Weston Family YMCA	Shelly Goldman

Mental Health & Substance Abuse – Lead: K. Tait Michael, MD, WCHN

Organization	Member Name
WCHN	K. Tait Michael MD
Human Services Council	Giovanna Pisani
Community Health Center	Erin Forler
Silver Hill Hospital	Ellen Brezovsky
NHA	Particia Marsden-Kish
Norwalk CHC	Kirsten Coveny Clarke
WCHN	Staci Peete
WCHN	Susan Arnold
WCHN	Maura Romaine
WCHN	Rowena Bergmans
Norwalk Hospital CCT	Eileen Kordos
SWRMHB	Margaret Watt

Access to Care – Lead(s): TBD

Organization	Member Name
Norwalk Community Health Center (NCHC)	Craig Glover
NCHC	Maria Escalera
CHC – Day Street	Adele Gordon
Americares	Karen Gottlieb
Soundview Medical Associates	Eileen Smith
Community Health Network of CT	Tressa Spears

Appendix C: WCHN Community Health Structure

Committee Member	Organization	WCHN Staff
Barbara Butler	Norwalk Hospital Board	Rowena Bergmans, VP Population Health
Tim Callahan	Norwalk Health Department	Bob Carr, MD VP Clin. Transformation
Debra Channing	Greater Danbury CHC	Sally Herlihy, VP Planning
Cornelius Ferreira, MD	Western CT Medical Group	K. Tait Michael, MD
Mary Ann Genuario	Riverbrook YMCA	
Craig Glover	Norwalk CHC	
Karen Gottlieb	Americares	
Marie Miszewski	Regional YMCA of Western CT	
Others TBD		

The Norwalk Hospital CHIP will be overseen by the Norwalk CHC. This committee will provide ongoing reports to the WCHN CHC, which, in turn, will report to the WCHN Strategic Planning Committee.

Appendix D: Health Priority Implementation Strategies & Metrics

Priority Area 1: Chronic Disease and Obesity Prevention			
Goal 1: Reduce and prevent obesity and chronic disease in our community by promoting healthy lifestyles			
Indicator: % of overweight and obese adults in the community (Baseline 2015 CWS)			
Indicator: % of children in 6th grade with healthy BMI (Norwalk Public Schools)			
Indicator: # of adults exercising 3–4 times/week (Baseline 2015 CWS)			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Increase the number of children who meet physical activity guidelines	• Incorporate physical activity into classrooms • Incorporate more physical activity into afterschool programs • Incorporate strategies from the Move More Toolkit into early childhood education settings	• Survey school staff on needs/assets • Review Board of Ed policies related to physical activity • Pilot approaches to incorporate more physical activity into the school day (Move More Toolkit, Fit Kids) • Distribute toolkit to licensed daycare centers	• # of teachers incorporating physical activity into classrooms • # of afterschool programs with Fit Kids • # of toolkits distributed to ECEs • Increase # of school/ afterschool/EC activity opportunities by 10%
• Increase the number of adults who meet physical activity guidelines	• Promote the NorWALKer Program • Identify barriers to physical activity for adults • Implement or expand one strategy for physical activity in seniors	• Translate at least 3 maps into Spanish • Create and implement promotion/distribution plan for all maps • Develop and implement PA survey for adults • Inventory existing senior activity programs, identify gaps	• # of people accessing maps on line • # of printed maps distributed • # of surveys completed • Inventory completed
• Increase community knowledge of and access to healthy and affordable foods	• Increase awareness of and access to nutrition education resources • Implement environ-mental, policy or systems change to improve access to healthy foods	• Establish nutrition education workgroup to assess available resources/programs and create guide • Conduct a community food system assessment • Continue restaurant initiative • Continue work on increasing access to farmers markets	• # of guides distributed • # of participants in nutrition education programs • # of policy, system of environmental changes to improve access

Priority Area 1: Chronic Disease and Obesity Prevention			
Goal 2: Prevent the onset of chronic disease; increase chronic disease self-management skills in our community			
Indicator: Admissions to Emergency Department (ED) and Inpatient (IP) related to chronic disease			
Indicator: Self-reported rates of Diabetes, Heart Disease, Smoking (Baseline 2015 CWS)			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Increase health risk screenings available to the public	• Expand screening and risk assessment programs (e.g. KYN) in the community	• Create inventory of existing programs and resources • Create campaigns to boost participation	• # of screening programs offered • # participants in screening programs
• Increase number of chronic disease self-management programs in the community	• Expand Live Well program and/or other chronic disease self-management program • Increase access to smoking cessation programs	• Create inventory of existing programs • Develop strategy to increase PCP awareness of/re ferrals to programs • Identify barriers to enrollment in smoking cessation programs	• Increased # of PCP's making referrals • Increased # of locations offering programs • Increased # of participants in programs

Priority Area 2: Mental Health & Substance Abuse			
Goal 1: Improve access to appropriate care for adults and children			
Indicator: Increased enrollment in behavioral health prevention and intervention activities			
Indicator: Self-reported rates of anxiety, depression (Baseline 2015 CWS)			
Indicator: #ED and IP Admissions related to Behavioral Health			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Identify lower risk and needs populations and provide short-term treatment	• Increase the integration of behavioral health into primary care (PC) • Increase screening by and referrals from PC practices • Promote use of on-line cognitive behavioral therapy (CBT)	• Provide SBIRT training to primary care providers • Embed LCSWs and peers in primary care practices • Pilot Cobalt (CBT) in select WCMG PC offices • Complete a gap analysis and prioritization of need/ barriers	• # of referrals from PCP's currently referring • Increase # of PCP's making referrals • # of PCP offices with LCSW's/peer counsel
• Identify highly vulnerable populations and connect to care	• Expand the Community Care Team (CCT) model • Design "hotspot" program for ED • Design and develop flexible outreach program for mental health and substance abuse	• Implement hotspotter program – hire staff • Develop cultural and linguistic standards • Develop messaging in appropriate languages	• # of people identified through hot-spotter program • # of people assisted via CCT • # of people reached through outreach program
• Develop/ensure complete continuum of care levels	• Identify resources and gaps in the community e.g. transitional residence program (TRP), sobering centers • Expand case management, community support programs (CSP) and Assertive Community Treatment (ACT)	• Complete gap analysis • Outreach to members of the recovery community and BH sectors • Explore DPH funded care coordination activities	• Plan developed

Priority Area 2: Mental Health & Substance Abuse			
Goal 2: Provide education on Mental Health and Substance Abuse to increase awareness ad promote prevention			
Indicator: # of opoid related deaths reduced in our region (Baseline xx in 2015, Source Office of CME)			
Indicator: # of legislative and policy changes around opoid adminstration			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Provide access to information and resources that reduce stigma, enhance awareness and encourage early identification of behavioral health issues	• Increase community awareness of MH/SA services and resources available • Hold/participate in community workshops or awareness events • Incorporate 211 into regional partnerships	• Develop annual plan and schedule of events • Contact United Way to request involvement with team activities • Work with United to increase number of providers involved in updating 211 • Provide outreach to community on 211	• # of community workshops/year • # of participants at community events/ workshops 211 utilization
• Increase awareness of PCPs and pediatricians of available resources and programs	• Distribute information to PC and Pediatric offices in the region • Utilize WCHN physician liaisons, SBIRT trainers, Early Childhood Council (ECC), Norwalk Health Department (NHD) and other community partners	• Provide SBIRT training to PCPs and pediatricians • Provide outreach to providers on 211 • Distribute materials/ resources to physician offices	• # of PC offices reached • # of pediatric offices reached 211 utilization
• Increase the number of prevention and intervention activities related to opioids	• Promote safe storage and disposal of medi-cations • Provide education re-lated to use of opioids • Encourage wider avail-ability of naxolone	• Initiative to decrease the use and prescribing of opiates in the NH ED • Work with PCPs, Pain Management specialists to make info available • Promote SBIRT, MAT, and Narcan training	• # of safe drug disposal locations • # of providers or responders trained to administer Narcan

Priority Area 3: Access to Care			
Goal 1: Increase access to health providers and services for uninsured, underinsured, and undocumented populations			
Indicator: Reduction in ED visits for ambulatory-sensitive care (Baseline Top 5 Conditions for ED Non-admissions)			
Indicator: Reduction in Missed/Postponed Care and Reasons for Missed/Postponed Care (Baseline CWS 2015)			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Increase access to primary care and improve health literacy	• Assess primary care resources and identify gaps • Increase patient awareness & education on PCMH • Develop more efficient referral process/sources to improve access to existing providers	• Complete inventory of current services • Develop PCMH tools to use with patients in ED, then SBHCs, CHCs • Identify roadblocks/ barriers in existing referral process	• Inventory completed • PCMH tool(s) developed • PCMH tools distributed • Referral process streamlined
• Increase access to oral care services	• Assess oral health resources and identify gaps • Integrate oral health into primary care • Develop/obtain education materials/ tools and donated toothbrushes	• Complete inventory of current services • Create list of services • Embed oral health education in PC offices and schools • Distribute materials at PC offices/schools	• Inventory completed • Resource list developed • # of material/supplies distributed
• Increase access to specialty care and services	• Assess adult and pediatric specialists and identify gaps • Create more efficient referral sources to improve access to existing providers • Examine models of how other communities promote access for key populations	• Complete inventory of current services • Create list of existing resources/tools • Review other health care models such as e-consults, funding specialists, bringing high need specialists to community	• Inventory completed • Referral process streamlined • Increased # referrals • Increase access for uninsured and underinsured by 5%

Objective	Strategy	Action Steps	Short-term Indicators
• Improve access to culturally and linguistically-sensitive programs and providers	• Bring programs closer to patients/community • Promote patient/client comfort level through cultural competency • Collaborate with organizations that work with undocumented population to build trust • Improve cultural competency by developing tool kit that meets CLAS standards	• Promote awareness of existing programs & services via multiple channels • Identify transportation/ timing issues • Identify existing cultures in the region – specially new/emerging cultures • Complete inventory and identify programs and practitioners who are culturally competent	• Additional communication channels identified and utilized • Increased # of patients/clients attend programs • Inventory and tool kit completed
• Increase access to medication	• Educate providers and patients on prescribing and obtaining lower cost medications • Identify programs that allow access to medication at low cost	• Identify most commonly prescribed medications by specialty • Complete inventory of potential sources of lower cost medications	• Inventory completed • Tool developed • # physicians educated • Increased # of patients filling Rx