VII. COMMUNITY HEALTH IMPROVEMENT PLAN

In addition to guiding future services, programs and policies for the Primary Care Action Group members and the overall area, the Community Health Needs Assessment and Community Health Improvement Plan are also prerequisites for health departments to earn voluntary accreditation, and for hospitals to maintain their tax-exempt status.

The 2016 Community Health Improvement Plan was developed over the period of January through May 2016, using the key findings from the Community Health Needs Assessment, which included qualitative or primary data from the 2015 Community Wellbeing Survey, focus groups, and key informant surveys that were conducted locally, as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas.

As was the case in 2013, the Primary Care Action Group was responsible for overseeing the Community Health Needs Assessment, identifying the health priorities, and overseeing the development of the Community Health Improvement Plan. A core coordinating committee was responsible for the overall management of the process, and Community Health Improvement Plan Workgroups, which represented broad and diverse sectors of the community, were continued in each health priority area. The CHIP Workgroups developed goals, objectives, strategies, and action steps for their respective components of the Health Improvement Plan.

Primary Care Action Group members outlined a compelling and inspirational vision and mission to support the planning process and the CHIP.

Vision: To work together as a coalition to identify, prioritize, and measurably improve the health of our community, through healthcare prevention, education, and services

Mission: To improve the health of the community

OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PROCESS

- **What is a Community Health Improvement Plan?**
  A Community Health Improvement Plan or CHIP is an action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed, including strategies and indicators for measurement, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.

- **How to use a CHIP**
  A CHIP is designed to be a broad strategic framework for community health and should be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives so that all community groups and sectors – private and nonprofit organizations, government agencies, academic institutions, community – and faith-based organizations can participate in the effort and unite to improve the health and quality of life for all people who live, work, and play in the Greater Bridgeport Region.

- **Methods**

Building upon the key findings identified in the Community Health Needs Assessment, the CHIP aims to:

- Identify priority issues for action to improve community health
- Develop and implement an improvement plan with performance measures for evaluation
- Guide future community decision-making related to community health improvement

In addition to guiding future services, programs, and policies for participating agencies and the area overall, the Community Health Improvement Plan 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 accreditation, which indicates that the agency is meeting national standards.

To develop the Community Health Needs Assessment and the Community Health Improvement Plan, the Primary Care Action Group (which includes representatives from local public health entities) was the convening organization that brought together community residents and the area's influential leaders in healthcare, community organizations, and other key sectors, including mental health, local government, and social services. Using the guidelines of the Association for Community Health Improvement (ACHI) the six-step health assessment and improvement process was designed to incorporate the following steps:

1) Identification of a team and resources,
2) Clearly defining the purpose and scope of the project,
3) Collecting and analyzing data,
4) Selecting priorities and developing a health improvement plan,
5) Documenting and communicating results, and
6) Planning for action and monitoring progress.

Development of the 2016 CHIP Strategic Components

The four PCAG task force groups (Access to Care, Cardiac and Diabetes, Obesity [Healthy Lifestyles], and Mental Health and Substance Abuse) convened regularly from March to May 2016 and actively used the CHNA findings to review goals, objectives, and strategies to pursue for the next three-year cycle. From these meetings, groups developed a 2016 Community Health Improvement Plan document that is organized by the four priority areas and includes specific goals, measurable indicators (short and long-term), strategies, action steps, and partners. Information from the State of CT Health CT 2020 action agendas was also included to ensure continuity of efforts between state and local conditions. These meetings were facilitated by Chanana Consulting, Yale New Haven Health's Community Benefits Manager, a PCAG co-chair, and the Community Health Improvement Coordinator.

Planning for Action and Monitoring Progress

Progress will be monitored at routine monthly task force meetings and monthly PCAG meetings using a monitoring tool developed to track the specific goals, objectives, and strategies identified in each area. If gaps in resources are identified, PCAG will extend collaborative efforts to other organizations and programs that are currently providing those services as a means to foster relationships and efficiently meet the needs of the community members.

The 2016 Fairfield County Community Index, hospital data and other resources identified in the CHIP provide common measurement indicators to monitor and evaluate progress on the implementation strategies.

Community Health Improvement Plan

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of where the Primary Care Action Group would like to be, and clear evaluation of whether the collaborative efforts are making a difference. The following pages outline the goals, strategies, action steps, and indicators for the four health priority areas outlined in the Community Health Improvement Plan.

Priority Area 1: Cardiovascular Disease and Diabetes			
Goal: Reduce the incidence, progression and burden of cardiovascular disease (CVD) and diabetes (DM) in the Greater Bridgeport Region			
Indicator: Rate of ED visits for which CVD or DM was the primary diagnosis. [2015 baseline SVMC and BH Combined ED Treat and Release – CHF: 108#, Diabetes: 688#] Indicator: % of adults who have been told by a doctor or health professional they have CVD or DM [2015 Baseline DCWS: 9% diabetes, 5% heart disease] Indicator: # of Greater Bridgeport CVD and DM Health and Social Service Organizations who have adopted CLAS Standards. [2016 baseline data to be collected.]			
Strategy	Action Steps	Partners	Short term indicator
Decrease the number of repeat emergency room visits with complications from diabetes or cardiovascular disease.	a. Develop a pilot with Optimus Healthcare to reduce ED visits within client population with CVD or DM as a primary diagnosis I. Review current ED utilization with Optimus Healthcare clients with CVD or DM as a primary diagnosis II. Identify and obtain baseline metrics including ED utilization III. Develop pilot to reduce visits within this population using Optimus Community Health Workers IV. Obtain IRB approval from Bridgeport Hospital and St. Vincent's Medical Center V. Evaluate pilot at 3 and 6 month intervals VI. Expand to other pilot sites based on success measures b. Collaborate to increase number of medical providers and organizations on Heart360 database c. Continue to educate the community about risk reduction strategies and the signs and symptoms of stroke (Act F.A.S.T.) d. Share data/information in order to assist clients of food pantries and meal programs and address any food/nutrition issues that are creating barriers to making healthy choices	Optimus Healthcare, Bridgeport Hospital, St. Vincent's Medical Center, Sacred Heart University College of Nursing, Fairfield University School of Nursing, St. Vincent's College, Southwestern Area Health Education Center (CHW Advisory Committee), Council of Churches of Greater Bridgeport, American Heart Association	# of ED visits for Optimus Healthcare clients with CVD and DM

Priority Area 1: Cardiovascular Disease and Diabetes, Continued			
Strategy	Action Steps	Partners	Short term indicator
Improve access to healthy food at local food pantries and meal programs	a. Continue to work with food pantries and meal programs to increase availability of healthy options b. Distribute information about healthy food donations c. Work with food pantry managers to implement stop light shelving system	Council of Churches of Greater Bridgeport, Hunger Outreach Network, Bridgeport Hospital, St. Vincent's Medical Center, Get Healthy CT, Sacred Heart University, Fairfield University, University of Bridgeport, Housatonic Community College, St. Vincent's Parish Nurse program, St. Vincent's College, American Heart Association (Heart360)	# of sites implementing stop light shelving
Increase the number of new and repeat people screened / year in high risk communities to identify those at risk for CVD and DM and provide linkages to services	a. Analyze prior KYN screening locations and identify pilot location(s) for repeat screenings to high risk populations b. Improve enrollment in AHA's Heart360 to enable easier tracking c. Develop and implement pilot protocol for screening follow-up, expand as feasible d. Explore feasibility of expanding network of individuals able to provide blood pressure screenings at community locations I. Pilot the project at 1 local food pantry II. Educate and train food pantry staff on blood pressure screenings and provide automated blood pressure cuffs to pilot site e. Provide disease management education (AHA's Life's Simple 7)	Council of Churches of Greater Bridgeport, Hunger Outreach Network, Bridgeport Hospital, St. Vincent's Medical Center, Get Healthy CT, Sacred Heart University, Fairfield University, University of Bridgeport, Housatonic Community College, St. Vincent's Parish Nurse program, St. Vincent's College, American Heart Association (Heart360)	# of adults screened 1 or more times # of blood pressure screenings

Priority Area 1: Cardiovascular Disease and Diabetes, Continued			
Strategy	Action Steps	Partners	Short term indicator
Communicate awareness and benefits of CLAS to CVD and DM health and social service agencies	a. Work in collaboration with PCAG Access to Care Task Force to determine number of CVD and DM health and social service agencies who have adopted or taken steps to implement CLAS b. Identify best resource and develop "in-service" for CLAS c. Determine local lead for effort d. Develop and implement communication plan	Bridgeport Hospital, St. Vincent's Medical Center, Optimus Healthcare, Southwest Community Health Center, United Way of Coastal Fairfield County, American Heart Association, American Diabetes Association, Get Healthy CT, Sacred Heart University College of Nursing, Fairfield University School of Nursing, Departments of Public Health	# of CVD and DM health and social service organizations with representation at in-services # of CVD and DM health and social service organizations with representation at in-services

Priority Area 2: Healthy Lifestyles			
Goal: Reduce and prevent obesity and chronic disease by creating environments that promote healthy eating and active living in Greater Bridgeport			
Indicator: % of overweight adults in the community. [2015 Baseline DCWS, 36%] Indicator: % of overweight children 5-12 years of age and students in grades 9-12 [Baseline-to be determined] Indicator: Smoking prevalence [2015 Baseline DCWS, 15%]			
Strategy	Action Steps	Partners	Short term indicator
Increase access to and availability of affordable healthy food and beverage choices in the community	a. Identify existing programs and resources to support healthy eating and update regional online directory of resources on Get Healthy CT website b. Educate the community about healthy eating using existing programs/materials (Eat Smart, MyPlate) c. Create and distribute healthy eating materials (healthy cooking, limiting sugar sweetened beverages, drink more water) d. Institute smaller portion size options in public service venues e. Utilize Get Healthy CT website, newsletter and Facebook page to disseminate information and share events f. Evaluate other Fruit and Veggie (F&V) Prescription programs to identify best practices and explore implementing a program in Bridgeport g. Continue to promote and support farmers' markets h. Implement evidence-based comprehensive worksite wellness programs throughout the region i. Encourage healthier food pantry donations j. Develop and implement a healthy restaurant initiative to label healthier options on restaurant menus and distribute restaurant nutrition information	Bridgeport Hospital, St. Vincent's Medical Center, Bridgeport Health Department, Stratford Health Department, Trumbull Health Department, Fairfield Health Department, Monroe Health Department, American Heart Association, Hispanic Health Council, Parish Nurses, American Diabetes Association, Central Connecticut Coast YMCA, Bridgeport Regional Business Council, local businesses, Bridgeport Food Policy Council, Bridgeport Farmer's Market Manager, Council of Churches, local feeding programs, Green Village Initiative	# of visits to Healthy Eating section on Get Healthy CT website # of people who receive Get Healthy CT newsletter # of Get Healthy CT Monthly Health Features that focus on sugar-sweetened beverages and portion size # of farmers' market schedules distributed # of Get Healthy CT website visits to Workplace Wellness Feature # of new organizations implementing healthy food donation campaign # of Get Healthy CT website visits to restaurant nutrition information link

Priority Area 2: Healthy Lifestyles, Continued			
Strategy	Action Steps	Partners	Short term indicator
Increase access to and availability of affordable healthy food and beverage choices in the community, continued	k. Continue to support the work of the Bridgeport Food Policy Council and partners as appropriate (healthy initiatives)	Same as Action Steps A - J	# of new healthy corner stores in Bridgeport
	l. Support school gardens by working with the Green Village Initiative		# of new community and school gardens
Increase access to and availability of affordable physical activity in the community	a. Identify, expand and distribute current inventory of children and adult physical activity opportunities b. Partner with local university students and local businesses to support the creation of physical activity opportunities c. Continue to host yearly National Dance Day event d. Work with local daycare programs to increase physical activity opportunities available e. Identify existing programs and resources to support physical activity and update regional online directory of resources on Get Healthy CT website f. Utilize Get Healthy CT website, newsletter and Facebook page to disseminate information and share events g. Work with local gyms to distribute Get Healthy CT information and promote their services h. Support enhancements to infrastructure supporting safe bicycling and walking i. Partner with towns and cities to publish or create walking maps j. Promote the health benefits of reduced screen time	Parks and Recreation departments in Bridgeport, Monroe, Trumbull, Fairfield, Stratford, Lighthouse Program in Bridgeport, local businesses, local daycare programs, local schools, Bridgeport Health Department, Stratford Health Department, Trumbull Health Department, Fairfield Health Department, Monroe Health Department, Central Connecticut Coast YMCA, American Heart Association, American Diabetes Association	# of visits to Get Healthy CT physical activity inventory # of daycare programs increasing physical activity opportunities # of Get Healthy CT Monthly Health Features that focus on reduced screen time # of walking maps distributed # of new programs supporting safe biking and walking # of updates to online physical activity directory for the region

Priority Area 2: Healthy Lifestyles, Continued			
Strategy	Action Steps	Partners	Short term indicator
Enhance wellness in the school environment	a. Support the development of the Bridgeport Schools Wellness Council b. Explore engaging local School Wellness Councils in a networking group to share best practices c. Support limiting advertisements of less healthy foods and beverages in schools d. Link Get Healthy CT website to school/district websites and newsletters to parents	Bridgeport, Monroe, Trumbull, Stratford and Fairfield Public Schools, Bridgeport Health Department, Stratford Health Department, Trumbull Health Department, Fairfield Health Department, Monroe Health Department, Bridgeport School Wellness Council, American Heart Association, PTO/PTA organizations	Get Healthy CT representation at Wellness Council meetings # of local schools represented on the networking group # of schools limiting advertisements of less healthy foods # of schools/districts sharing link to Get Healthy CT website on their websites and materials
Support tobacco cessation in the community	a. Develop and implement an online campaign to educate adults and children about the dangers of smoking and e-cigs b. Advocate for legislation, policies, and ordinances that support tobacco-free spaces c. Promote smoking cessation programs	Bridgeport Hospital, St. Vincent's Medical Center, Optimus, Southwest, AmeriCares, American Cancer Society, American Lung Association, American Diabetes Association, American Heart Association, City of Bridgeport, Town of Stratford, Town of Fairfield, Town of Monroe, Town of Trumbull	# of visits to tobacco cessation pages on Get Healthy CT website # of local businesses that become tobacco-free # of advocacy activities # of municipalities with tobacco-free ordinances # of visits to inventory on Get Healthy CT website

Priority Area 3: Mental Health and Substance Abuse			
Goal: Increase understanding of mental health and substance abuse as public health issues in order to achieve equal access to prevention and treatment in the Greater Bridgeport Region			
Indicators: Decrease in total days (ED/Inpatient) after engagement [2016 Baseline CCT Data] # of alternative opportunities available [Baseline data to be collected]			
Strategy	Action Steps	Partners	Short term indicator
Increase access to mental health and substance abuse resources in the community through health education initiatives	Continue to strengthen and expand Mental Health Wellness awareness and education campaign Refine message a. Research existing messages b. Hardwire the work being done- continue to expand reach into the communities (senior centers, colleges, universities) c. Ensure messages are culturally and linguistically relevant messages	Bridgeport Hospital, Child First, Child and Family Guidance Center, Liberation Programs, Optimus Health Care, RYASAP, Southwest Community Health Center, Southwest CT Mental Health System, Southwest Regional Mental Health Board, Southwestern AHEC, Southwestern CT Area Agency on Aging, St. Vincent's Medical Center, Town of Monroe Community & Social Services, Town of Stratford Community Services, Recovery Network of Programs, Value Options, Pivot Ministries, Child and Family Guidance Center, Supportive Housing Works, The Connection, Inc., Bridgeport Department of Health, DMHAS, CT Renaissance	# of visitors engaged at community events # of screenings at live events
Integrate mental health and substance abuse screenings into urgent care settings	a. Develop pilot protocol b. Select site and implement pilot c. Collect data d. Expand pilot locations as feasible		# of adults screened

Priority Area 3: Mental Health and Substance Abuse, Continued			
Strategy	Action Steps	Partners	Short term indicator
Increase access to services by improving the coordination of care for frequent users of ED in local hospitals	Refine Bridgeport Care Coordination Team (CCT) process a. Staff with a dedicated staff person b. Broaden partnerships c. Establish and/or build relationships (Federally Qualified Health Centers, DMHAS Regional Action Councils, substance abuse providers, Community health centers) d. Identify ways to engage hard to reach populations (e.g. substance abuse client population) e. Collect data (re-utilization and access) f. Align with statewide initiatives g. Evaluate	Optimus Health Care, Southwest Community Health Center, DMHAS Regional Action Councils Care Coordination Team members: Bridgeport Hospital, St. Vincent's Medical Center, DMHAS, Housing Agencies, Substance Abuse Treatment Agencies, Residential Providers, Shelters and Homeless Outreach Teams, Beacon, Guardian Ad Litem Services	# of CCT clients
Increase access to mental health providers	a. Monitor and evaluate non-traditional approaches (e.g. current telemedicine model in the community) b. Research best practices for co-location of providers with primary care physicians or medical homes c. Research additional best-practice programs - Speakers - Site-visits d. Support legislative efforts	State Representatives, Southwest Regional Mental Health Board, PCAG, Mental Health and Substance Abuse Task Force, St. Vincent's Medical Center, Weissman Institute	# of guest speakers, site visits and models evaluated.

Priority Area 4: Access to Care			
Goal: Improve access to quality health care for all individuals living in Greater Bridgeport			
Indicator: % of adults who have a person or place they use for personal doctor or health care provider [2015 Baseline DCWS, 82%] Indicator: % of adults who have been told by a doctor or health professional that they have asthma and in the last 30 days have used a prescription asthma inhaler more than twice a week to stop an asthma attack [2015 Baseline DCWS, 24%] Indicator: % of adults who report getting dental care in the past year [2015 Baseline DCWS, 74%]			
Strategy	Action Steps	Partners	Short term indicator
Increase the number of people accessing care from the appropriate delivery site (clinic, hospital, ED, etc.)	a. Educate and raise awareness about the use of appropriate care b. Develop information sheet and disseminate it at multiple sites and provider settings I. Include information at time of ED discharge II. Include / incorporate into general information and education sessions throughout the community	Bridgeport Hospital, St. Vincent's Medical Center, Optimus Healthcare, Southwest Community Health Center	# of information sheets distributed (A) # of ED visits for primary care (aim to reduce) (P) # of avoidable hospital admissions (aim to reduce) (P)
Increase % of Greater Bridgeport population accessing specialists (Developmental)	a. Collect data to support identified need among clinic patients for access to specialty care I. Develop survey tool II. Collect internal data (BH and SVMC) regarding referrals to specialists, limitations, and challenges b. Analyze and summarize survey findings c. Communicate findings to PCAG and senior hospital and community clinic leadership	Bridgeport Hospital Primary Care Center and St. Vincent's Medical Center Family Health Center, Optimus, Southwest, AmeriCares Free Clinic	Data presented and action plan developed (A) # of specialty clinics and available slots increase from 2016 to 2017 [2016 baseline data to be collected] (P)

Priority Area 4: Access to Care, Continued			
Strategy	Action Steps	Partners	Short term indicator
Increase the effective control of asthma in the community	a. Encourage partnerships among health professionals for effective asthma treatment and education programs b. Ensure that every clinic patient with asthma has an Asthma Action Plan c. Ensure handoff communication to School-Based Health Centers and other health professionals as needed d. Educate patients regarding asthma triggers and irritants including poor air quality days and tobacco cessation as appropriate e. Identify community-based resources to help mitigate triggers and irritants f. Support CHA ED specific goals as appropriate g. Define data to track	Bridgeport Hospital Primary Care Center, St. Vincent's Medical Center Family Health Center, emergency departments, Fairfield Health Department, City of Bridgeport Health Department, Monroe Health Department, Stratford Health Department, Trumbull Health Department	% of clinic patients with Asthma Action Plans (A) Develop data tracking system (A) Track improvements for patients participating in Putting on Airs (A) # ED visits for asthma care (aim to reduce) (P) # hospital admissions for asthma (aim to reduce) (P) # deaths due to asthma (target = 0) (P)
Increase the % Greater Bridgeport population accessing dental care	a. Meet with ORBIT collaborative to identify ways to support efforts to enhance insurance coverage and increase providers for oral health b. Develop and implement a plan c. Define data to track	ORBIT	TBD pending ORBIT meeting

Priority Area 4: Access to Care, Continued			
Strategy	Action Steps	Partners	Short term indicator
Develop a network of health and social service agencies who have adopted or taken documented steps to implement National Culturally and Linguistically Appropriate Services (CLAS Standards) to reduce health inequality among at risk and minority populations	e. Communicate awareness and benefits of CLAS to health and social service agencies f. Identify best resource and develop "in-service" for CLAS g. Determine local lead for effort h. Develop and implement communication plan i. Collaborative effort with Cardiac & Diabetes Task Force for related providers j. Determine # of health and social service agencies who have adopted or taken steps to implement CLAS (collect baseline data)	Bridgeport Hospital, St. Vincent's Medical Center, Optimus Healthcare, Southwest Community Health Center, United Way of Coastal Fairfield County, Sacred Heart University College of Nursing, Fairfield University School of Nursing, Department of Public Health	# of health and social service organizations with representation at in-services (A) # of Healthcare and Social Service Agencies who have adopted or taken documented steps to implement CLAS Standards [2016 baseline data to be collected] (P)

VIII. APPENDIX A: PRIMARY CARE ACTION GROUP MEMBERS

Providers

Bridgeport Hospital/YNHHS
St. Vincent's Medical Center
Optimus Healthcare
Southwest Community Health Center
AmeriCares Free Clinic of Bridgeport, LLC
Greater Bridgeport Medical Association
Northeast Medical Group
Pediatric Healthcare Associates
Visiting Nurse Services of CT

Health Departments

City of Bridgeport Department of Health and Social Services
Fairfield Health Department
Monroe Health Department
Trumbull Health Department
Stratford Health Department
Easton Health Department

Faith Based

Greater Bridgeport Council of Churches
Catholic Charities

Schools

Bridgeport Public School System
Bridgeport Hospital School of Nursing
Fairfield University School of Nursing
Sacred Heart University School of Nursing
St. Vincent's College Nursing Program
Southern CT State University
Housatonic Community College
University of Bridgeport

Government

City of Bridgeport/City Council
Town of Stratford/City Council
Town of Fairfield
Town of Trumbull
Town of Monroe
Local and national legislators

Advocacy Groups

American Diabetes Association
American Heart & Stroke Association
Bridgeport Alliance for Young Children Bridgeport Child Advocacy Coalition
Bridgeport Food Policy Council
Southwestern Area Health Education Center
DataHaven
Hispanic Health Council

State Agencies

Connecticut Department of Mental Health and Addiction Services/Greater Bridgeport Mental Health Services
CT Department of Public Health
CT Department of Social Services
Southwest CT Mental Health Board

Businesses

Bridgeport Regional Business Council

Housing

Supportive Housing Works

Social Service Agencies

Bridgeport Rescue Mission
Council of Churches Food Pantries
United Way of Coastal Fairfield County
Wholesome Wave
Central CT Coast YMCA
YMCA Kolbe Daycare Center
Cooking Matters
Green Village Initiative

Mental Health Providers

Recovery Network of Programs
The Connection
Continuum of Care
Liberation Programs

Payers

Community Health Network
Access Health CT
Value Options