

Community Health Needs Assessment Report 2016



EXECUTIVE SUMMARY AND KEY FINDINGS

The start of this Community Health Needs Assessment (CHNA) would likely be defined as the first meeting we had as a team back in March of 2015. But really it began as soon as the last CHNA was published in 2013. The lessons learned from that experience informed our approach and led us to the Centers for Disease Control and Prevention’s Health Investment Model, which provides a framework for understanding the volumes of available data. We also had the benefit of the DataHaven Community Health and Well-being Survey, which provides significant input from community members. And, a “Community Conversation” held in the fall with leaders and residents to help clarify priorities.

Priority areas of focus and key findings:

- Survey respondents report being impacted by:
 - ~ Obesity (69%)
 - ~ Diabetes (68%)
 - ~ Heart Disease (51%)
 - ~ Substance Abuse (39%)
- 54% of Hartford residents said it was not safe to walk in their neighborhood.
- Housing stability is a critical concern with only 26% of residents owning homes.
- Mental Health is one of the top 5 reasons for hospitalization.
- Substance Abuse is a problem in urban and rural settings and accounts for 13% of hospital admissions.
- Youth and Adult Tobacco Use is similar at 16% of the population.
- Above all, poverty is seen as the main reason people suffer with poor health.

What became clear as we listened to the community and looked further into the data is that improvements in health will only take place when solutions are designed to be sustainable; when the varied priorities of communities are valued; and when the systems that need improvement are changed. We look forward to finding those solutions and impacting the health and well-being of those who live in our community.

Approved and adopted by the Saint Francis Board of Directors June 22, 2016.

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I. Acknowledgements

Creating a comprehensive, useful and engaging Community Health Needs Assessment is a difficult task. Including the voices of the community, analyzing the data available and focusing the findings in a meaningful way requires input from many sources. This document would not have been possible without the generous support from the following groups and individuals, who took the time to share their knowledge, tell their stories and engage in discussion about potential solutions.

The CHNA team:

- Hartford Foundation for Public Giving – Scott Gaul, Yvette Bello
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- Trinity Health - New England – Marcus McKinney
- Saint Francis Hospital and Medical Center – Rebecca Crowell
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- University of Connecticut Medical School – Deborah Pacik
- Community Solutions – Gina Federico-Muslim
- DataHaven – Mark Abraham

We also benefited from frank discussions with Key Informants (community leaders and leaders of partner agencies) and significant input from community members without whom we would not have a context for understanding this data. Although these sources remain anonymous, their stories and observations provided critical insight for understanding what we found.

A thank-you as well is owed to our three very helpful (and wonderfully responsive) consultants: analyst Bernie Bernstein, writer Karen Berman and designer John Johnson.



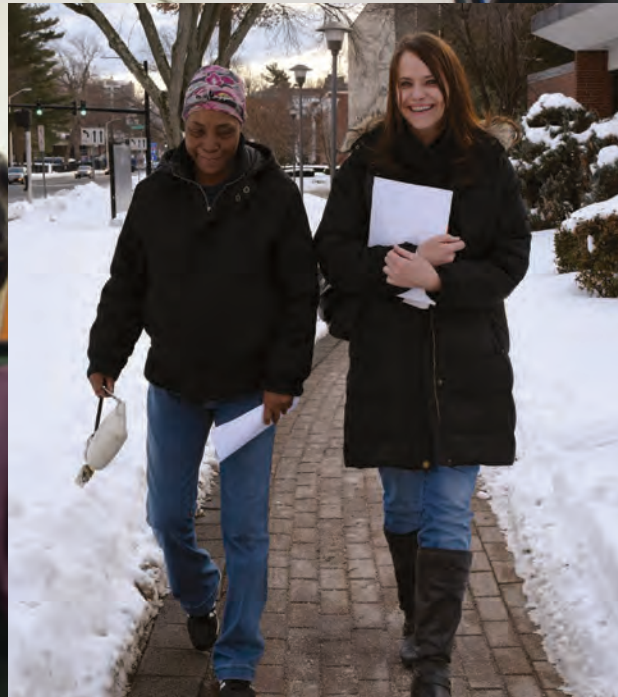
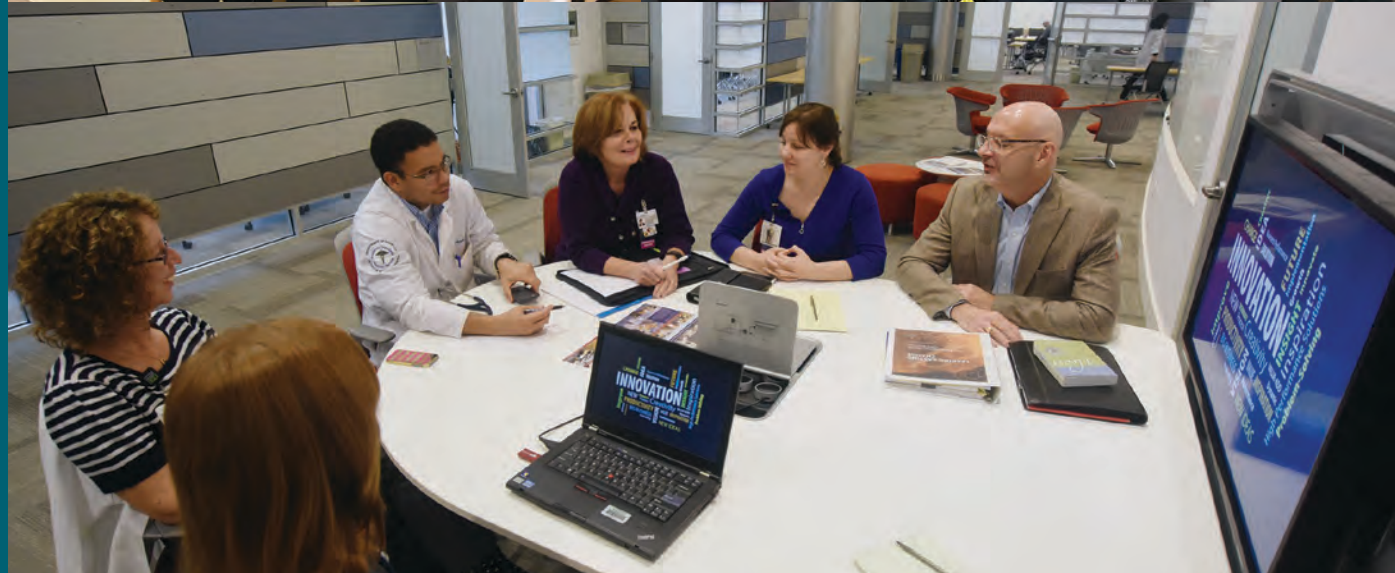
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III. Introduction

In recent years, the world of health care has undergone tremendous upheaval; old norms have imploded and new expectations have taken hold. Yet, more than a century after its birth, Saint Francis Hospital and Medical Center remains steadfast in its Mission: *to serve in the spirit of the Gospel as a compassionate and transforming healing presence within the community.* Saint Francis is committed to improving and enriching the lives of individuals and families in the region; combining compassionate care, superior technology and prevention-oriented education in centers of clinical excellence; and fulfilling its founders' vision of a hospital as a spiritual and healing environment.

This Community Health Needs Assessment (CHNA) is the first step in a process designed to better understand community needs by engaging community members, community leaders and health care providers in a conversation about how to improve health and well-being.

We are excited to share what we have learned and to find ways to collaborate on solutions. The exchanges that took place during the implementation of the CHNA demonstrate a readiness for collaboration across disciplines, in ways that respect community input. New ideas about how hospitals and health care systems can support community development are beginning to take hold, and Saint Francis Hospital and Medical Center is ready to embrace a leading role in Hartford.

Our collaboration with Trinity Health has brought to the table significant expertise in this area. We look forward to the next steps in the process of developing a strategic plan for Community Health and Well-being designed to address the needs identified within this document.

*A note about the format:
This CHNA is organized with a "story narrative" at the start of each chapter. These narratives relate the lives of composite characters developed from the many conversations and interviews held with community members and community leaders. They do not represent specific individuals and are fully fictional. However, the settings, challenges and comments reflect the realities of those who live and work in our community.*

IV. A Mission with Staying Power

The 161 bus rounds the corner at Sigourney Street and Asylum Avenue. As it passes the middle school and a series of community buildings, the Saint Francis Hospital and Medical Center campus rises into view. At the corner of Asylum and Woodland Street, the hospital looms on the right; to the left, the white spire of Grace Lutheran Church gleams in the distance.

At the bus stop, a handful of passengers disembark. The first to step off is a woman cradling her baby in one arm and guiding her six-year-old son with the other. “Cuidado,” she says to him. “Watch out.” A senior citizen follows, clutching the handrail firmly until he is safely on the terra firma of the sidewalk. A threesome of twenty-somethings come next, one of them maneuvering a wayward get-well balloon through the narrow doorway of the bus.

They join the steady parade of people who arrive by car—or in emergencies, by ambulance. Young and old, alone or in clusters, they form a never-ending procession, ebbing and flowing through the day and into the night, people from every corner of the city of Hartford and more than 50 surrounding communities. All come seeking care for a seemingly infinite number of health needs spanning the first moments of life to the last.

Altogether, this parade of souls added up to more than 83,000 emergency department visits and 32,000 inpatient discharges in 2015 alone. Clinic visits for ongoing care add to these numbers, as do services provided at the many access centers affiliated with Saint Francis across the greater Hartford region.

It’s a far cry from the hospital’s opening day in 1897, when the Sisters of Saint Joseph of Chambéry—four near-penniless nuns—overcame almost impossible odds to welcome Hartford’s Asylum Hill neighborhood to their two-room hospital.

From the very first moment its doors opened, the new hospital offered a refuge for immigrants who wanted to know that their faith and traditions would be understood and appreciated if they ever needed inpatient care.

Saint Francis Hospital and Medical Center serves people from all walks of life, but has always reserved a special place in its efforts for those who most need its help—the poor and the most vulnerable of society. The dignity of every person, the importance of serving the common good and the sustainability of Earth are at the foundation of the hospital’s daily practice.

OUR MISSION

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

OUR CORE VALUES

Reverence

We honor the sacredness and dignity of every person.

Commitment to those who are poor

We stand with and serve those who are poor, especially those most vulnerable.

Justice

We foster right relationships to promote the common good, including sustainability of Earth.

Stewardship

We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.

Integrity

We are faithful to who we say we are.

Healing the Community

Saint Francis strives to fulfill its Mission in many ways. Hospitals will always be a place people go when they are sick, but in recent years, their role has expanded to that of community resource for the promotion of good health. Saint Francis is no exception; the hospital devotes significant resources to engaging and educating the community in the pursuit of healthful living. In 2015, Saint Francis Hospital and Medical Center contributed over \$104 million in benefits to the community.

The Curtis D. Robinson Center for Health Equity is the prime example of Saint Francis’ commitment to both its historic Mission and the newer concept of hospital as champion and promoter of the health of its community. The center is a resource for both the community and the health care system to improve health equity through community engagement, education and training; health advocacy and health care systems change. This innovative model of a dedicated Health Equity team within a hospital system highlights the commitment of Saint Francis to help those most affected by health disparities. The center collaborates with neighborhood organizations, caregivers, health professionals, researchers, foundations, state agencies and others to eliminate health disparities in communities served by Saint Francis Hospital and Medical Center.

This Mission will help ensure health, well-being and improve outcomes by providing better access to less complicated services and eliminating barriers to quality care. This is our version of implementing the Triple Aim of Health Care, a set of widely accepted public health goals that emphasize improved outcomes, increased satisfaction and lower cost.



More Than a Century of Caring

From the beginning, Saint Francis Hospital served on the front lines against outbreaks of then-deadly infectious diseases, from typhoid fever to influenza, and later, polio in a facility that housed 32 patients in a ward. Much has changed since then. Today, Saint Francis Hospital and Medical Center fights newer but no less serious threats to health: cardiovascular disease, cancer, lung disease, diabetes, to name just a few. And it has grown to be New England’s largest Catholic hospital, with 617 licensed inpatient beds, 65 bassinets and five centers of excellence that embrace patients at every stage of life (see Appendix 1).

An Eye to the Future

While Saint Francis strives to honor the legacy of the Sisters of Saint Joseph through its Mission of compassionate care, the hospital is hardly focused on the past. Saint Francis is continually looking ahead to anticipate better ways to deliver that care in a rapidly changing environment. The result is a patient-centered model of care designed to produce a patient experience of the highest measurable quality.

In 2015, Saint Francis Care and its affiliates were acquired by Trinity Health, one of the largest health care systems in the nation, and more importantly, an organization whose Mission and values are an ideal match for the hospital. The resources and benefits available to Saint Francis as a result of the acquisition have positioned the hospital and its affiliates to respond nimbly to the changes in health care that the future will inevitably bring.

The CHNA: A Metric and a Mission

The federal Patient Protection and Affordable Care Act, passed into law in 2010, requires hospitals to conduct a Community Health Needs Assessment (CHNA)—a periodic evaluation of the health needs of the community they serve. The CHNA may be a modern-day metric, but it fits easily into Saint Francis’ ongoing efforts to be a center of healing for its local and regional communities.

Saint Francis published its first federally mandated Community Health Needs Assessment in 2013 in partnership with the City of Hartford Department of Health and Human Services and the other Hartford-based hospitals. For this 2016 Community Health Needs Assessment the partners agreed to use the Centers for Disease Control and Prevention’s Health Investment Model. This approach affords an opportunity for ongoing assessment of the community’s needs; focuses on community transformation and paves the way for the development of strong partnerships.

V. Progress Since the 2013 Community Health Needs Assessment: Some Good News, In Increments

He never had any trouble breathing until he moved north a few years ago. Maybe it was the climate—so different from what he had known back home. Or maybe it was that old furnace in his uncle’s apartment building. One day he felt his chest getting tight—and then it was hard to breathe. His uncle had gotten him to the hospital and they had given him a breathing treatment. And, then he could breathe again.

They gave him inhalers and a prescription for more, but sometimes he forgot them when he went out.

When he had another attack, this time at work, he had gone to the hospital again. The doctors there knew exactly how to ease his symptoms, and anyway, he didn’t know where else to go. The Emergency Room seemed like a safe place—a good place—and as his attacks became more frequent, he would go there more often.

Then one time, they told him there was a better way to deal with his asthma. He was assigned a caseworker who helped him find a private doctor and sign up for health insurance to pay for his inhalers and other costs. She walked him through how to deal with the whole thing. And she checked in with him regularly to be sure he was remembering his inhalers and taking his asthma meds, so he wouldn’t have to go to the Emergency Room. He was good with that.

The Affordable Care Act’s CHNA mandate does not stop with assessment. It also requires hospitals to follow up with a strategic plan to address the needs identified.

In 2013, four goals were identified as priorities for the Saint Francis Hospital Implementation Strategy for Community Benefits. Three years later, here is a progress report:

GOAL 1: Improve Communication Between Health Care Providers and Patients

The Relationship-Based Care program continues to provide high-quality training and support to Saint Francis staff with a focus on cultural change that emphasizes respect. In addition, the Diversity Collaborative Team continues to offer free, rigorous cultural competency training and has embarked on a project to modify the hospital environment to signal inclusion for all patients who come through the door.

The Language Services Program (3+1) is now in effect throughout the entire hospital and its offsite locations. During FY2015, over 15,000 patients and their caregivers took advantage of the improved communication offered by this resource. The hospital now spends over \$300,000 annually to support this program, which includes a new initiative to train bilingual staff who can assist with interpretation. Thus far, 25 staff members have been trained to serve as qualified interpreters.

GOAL 2: Address Structural Barriers

Initiatives to support patients with complex health needs and to assist with transitions of care are underway. Navigators (professionals whose job is to help patients coordinate their health care) are now working with Saint Francis HealthCare Partners, the Curtis D. Robinson Center for Health Equity, the Department of Surgery and the Cancer Center. These navigators support, advocate and coordinate patient needs. Two initiatives have shown particular success:

- The Emergency Department (ED) developed a partnership with Community Solutions, an international non-profit active in Hartford. The department analyzed ED visits and identified patients who used its services most frequently for conditions that had the potential to be managed more economically in other settings. Community Solutions assigned a case manager to a subgroup of the frequent ED users, assisting them with navigating the various barriers to care outside the ED on an ongoing basis, resulting in a 50 percent reduction in ED visits by this group of patients during the first year of implementation. The case manager served as go-between in communications with medical providers, helped with transportation and worked with clients to adhere to prescribed treatments.

- Saint Francis Hospital and Medical Center played a role in the expansion of health insurance enrollment in Connecticut. Thanks to a partnership between the hospital and Access Health CT (the state insurance exchange, which was established as a result of the Affordable Care Act), financial assistance counselors from Saint Francis educated over 800 people about health insurance enrollment during the most recent open enrollment period. According to Access Health CT, the percentage of uninsured residents in Connecticut was cut in half from 8 percent to 4 percent in the past three years.

GOAL 3: Focus on Specific Clinical Areas of Need

Saint Francis clinical services include programs that are designed to address diseases known to have a significant impact on the health of those living in its service area. For many of these illnesses, preventive services and support for behavior change can affect the incidence of these diseases. Some highlights in this area include:

- Development of a comprehensive protocol for smoking cessation in the Behavioral Health Unit, which helps patients quit smoking during hospital stays.
- An increase in the types of prevention screening provided in the community, including: cholesterol, diabetes, prostate cancer, lung cancer, high blood pressure and early childhood development. More than 3,500 people have been served by these programs in the past year.

GOAL 4: Target Social Determinants of Health

Saint Francis addresses the social determinants of health largely through partnerships with community organizations that have experience and knowledge about how to engage residents and influence systems for positive change. Partnerships include the Asylum Hill Neighborhood Association (in an effort to increase affordable housing), the Blue Hills Civic Association and the Urban League (to address issues related to employment for youth), Community Solutions in connection with Harriott Home Health Services (to address cultural and logistical barriers to health care access) and Malta House of Care (to provide care to those who do not qualify for health insurance assistance).

Although progress has been made, the needs of the community served by Saint Francis continue to be significant. The CHNA 2016 is intended to identify these needs and develop priority areas of focus.

VI. A Broad and Diverse Service Area

He was born at Saint Francis, and he had lived all of his eighty-four years in the city of Hartford, except, of course, for the time he spent in the service. It was his city, and he had never given a thought to living anywhere else. It had changed a lot since his youth, as people became established and moved up and newcomers moved in. A lot of his neighbors had moved to the suburbs long ago, but he was a city boy. He liked the mix of people, all going their different ways. When he struck up a conversation, he liked hearing about where they came from. He liked overhearing bits of foreign languages in the streets. He even liked the bustle of traffic.

He thought of Saint Francis as “his” hospital. All three of his kids had been born there. They lived in the suburbs now, but when it was time for the grandkids to come into the world, they had made their debuts at Saint Francis. These days he visited Saint Francis for a different reason—his diabetes. His kids drove him when they could, and when they couldn’t, he took the bus. It took a while to get there by bus, but he thought of it as another opportunity to enjoy the sights and sounds of his city.

Saint Francis Hospital and Medical Center’s service area comprises urban, suburban and rural communities that together form a rich and complex mixture of highly diverse populations—a rainbow spectrum of races and ethnicities, and a huge range of socioeconomic categories.

Its primary service area includes 25 towns and corresponds largely with the greater Hartford region. This area includes towns north of Hartford, including Enfield, where our affiliated care partner and fellow Trinity Health – New England member Johnson Memorial Hospital is located (see Figure 1, Map of Service Area). A separate CHNA has been completed by Johnson Memorial Hospital, and is available on their website. <http://www.jmmc.com/jmmc/about/communityhealthneeds/>. Seven of these communities have at least 1,000 annual patient discharges (see Figure 2). Further information can be found in Appendix 4.

The hospital’s secondary service area includes 28 towns largely to the west and south of the primary service area. These towns are more rural, and their needs are very different than those of the city of Hartford, which has more than three times as many patients discharged from Saint Francis than any other municipality.

A comparison of population density, household income and median age reveal that these communities are anything but uniform, and the resources for addressing concerns and needs of their residents differ as well. Yet, many of the health issues they face are similar; obesity, diabetes, heart disease and behavioral health were all mentioned by the leaders of health districts who serve these towns.

It is also clear from this comparison that Hartford is much poorer, younger and more densely populated than the surrounding towns. Not surprisingly, the highest numbers of

patients seen at Saint Francis are from Hartford, in part due to the location of the hospital, its long history of providing services and the needs of Hartford residents. Given this inequity and the percentage of Saint Francis patients who are from the city, this CHNA has a significant focus on Hartford data and the critical health needs facing its residents.

Hartford Contrasts

Saint Francis Hospital and Medical Center campus is located in the city of Hartford, which is also the largest municipality in its coverage area. The city is best known as both the capital of Connecticut and as a center of the insurance industry (some call it the Insurance Capital of the World).

Located on the Connecticut River, the city became a center of trade, and goods were carried by ship in and out of the port from all around the world. Risky ocean transport gave rise to its famed insurance industry, a major presence in the city to this day. Homegrown industries thrived in Hartford as well. But many other elements have gone into the making of the city.

Hartford is a city of culture, home to the Wadsworth Atheneum, the nation’s oldest public art museum; Bushnell Park, the nation’s oldest public park and several other artistic and cultural organizations. Opera, symphony, theater and sports all contribute to the city’s cultural life. In addition, Hartford is dotted with churches and faith-based organizations of varied denominations and sizes.

A Multi-faceted City

Today, the major employers in the greater Hartford region include United Technologies, Hartford Financial Group, Chase Enterprises, Travelers Insurance, Hartford Hospital, Aetna, Bank

FIGURE 1

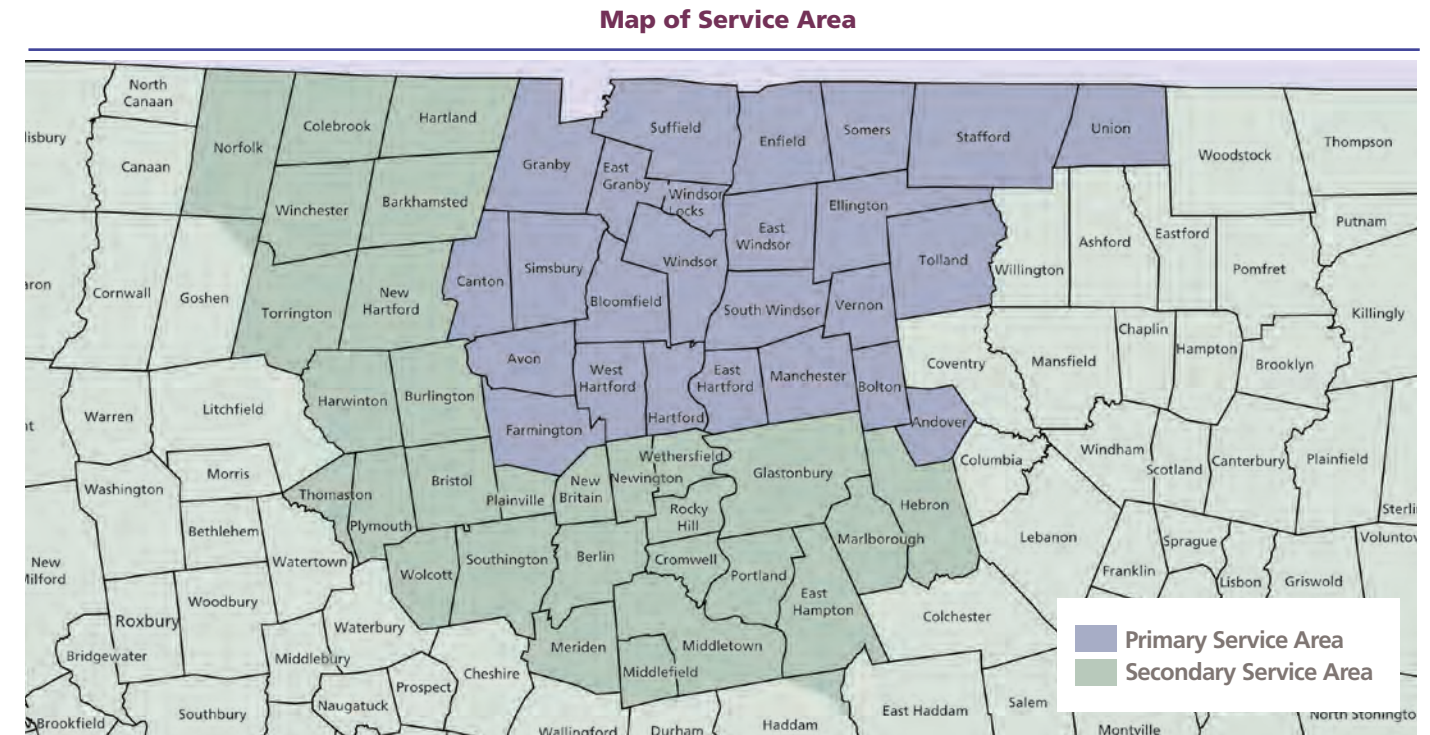


FIGURE 2

Comparison of Communities with at Least 1,000 Annual Hospital Discharges

TOWN	ANNUAL DISCHARGES	POPULATION DENSITY	MEDIAN AGE	MEDIAN HOUSEHOLD INCOME
Hartford	6,912	7,204	30	\$29,313
East Hartford	2,236	2,845	38	\$50,355
West Hartford	2,112	2,902	42	\$84,092
Enfield	1,522	1,343	41	\$68,168
Bloomfield	1,463	790	48	\$73,519
Manchester	1,424	2,126	35	\$63,198
Windsor	1,350	987	43	\$79,244

of America and Saint Francis Hospital. Most of those who work as professionals for these corporations do not live in the city; they reside in more affluent surrounding communities that make up Saint Francis Hospital’s secondary service area.

Hartford’s population of 125,000 is composed of all races and myriad ethnicities. Some 44 percent of its citizens are Hispanic/Latino and 35 percent Black/African American, with subgroups that include refugees and immigrants from Africa, Eastern Europe, the Middle East, Asia, South America and the West Indies. Additionally, 22 percent of the total population in Hartford is foreign-born, bringing a tremendous diversity to the city.

The city is proportionately younger than the rest of the state as well as the country; over 25 percent of its residents are under age 17, and only 9 percent are over age 65, as compared to 22 percent and 15 percent for the state as a whole. This affects age-

related health issues such as some forms of cancer, violence and accidental injury.

Hartford is a city of vibrant neighborhoods—17 distinct neighborhoods, to be exact—with a variety of housing stock ranging from high-rise downtown luxury apartments and condos to historic houses to single-family homes and a variety of rental options. The city’s many neighborhoods are supported by a roster of community organizations that focus on issues such as economic development, housing, assimilation of new immigrants, education and historic preservation.

The city’s 18 square miles are dotted with green space—more than 20 parks of all sizes, which provide a respite from the commotion of the urban environment.

FIGURE 3

Priority Health Issues

Town/Health District	Top Health Priorities
East Hartford	Diet • Exercise • Diabetes • Mental health • Heart disease • Substance abuse
Northeast Health District	Behavioral health • Substance abuse • Obesity • Access to health care
Windham	Crime • Safety • Sexually transmitted diseases
Enfield	Substance abuse
Bloomfield/West Hartford	Social isolation of Asian population • Diabetes • Exercise • Obesity • Heart disease

VII. The CHNA Process: A Review of Existing Data and Measurement of Community Perspective

The telephone chirps its insistent ring. The four-year-old sees her mother busy with the baby and runs to answer it.

“Hello?” she says. And then, in a louder voice, calls “Mom,” drawing out the word to make it more than one syllable.

“A lady wants to talk to you about your health.”

“My health?” The mother tucks the baby into his crib and picks up the phone.

“Hello?”

The voice on the other end of the line laughs softly.

“Was that your daughter? She’s so cute! We are calling residents in Connecticut towns to ask them questions about the health of their community. The survey takes about 20 minutes; is this a time that would work for you?”

Saint Francis’ 2016 CHNA is based on an iterative community engagement and data collection strategy that began in July of 2015 and continued for the next nine months (see Figure 4). The process commenced with the identification of a team representing health care, community development, government and local groups and community foundation agencies. Work officially began with an agreement among these groups to review existing data sets; to engage DataHaven (a nonprofit data-collection organization specializing in public health) to complete telephone interviews of community residents; to involve program participants and conduct interviews and discuss priorities with “Key Informants” (community leaders and leaders of partner agencies, see Appendix 2).

All aspects of the information-gathering process were designed to reach beyond the walls of the hospital to get answers to the questions: *Who? What? Where? How?* Throughout, the emphasis was on significant community input—in the form of telephone interviews with community members, surveys of program participants, informal discussions with community leaders and interviews with Key Informants to gain a better understanding of what is affecting the health of the Hartford

All aspects of the information-gathering process were designed to reach beyond the walls of the hospital to get answers to the questions: Who? What? Where? How?

region. The team collected data at the local level to facilitate and identify *where* the greatest needs are concentrated and gathered information from collaborative partners through Key Informant interviews to maximize who should be included for collective impact. The resulting assessment will serve as a starting point to develop data-driven goals and strategies on how to address the needs that have been identified.

Findings from the CHNA will be used to develop a balanced portfolio of interventions in the areas of:

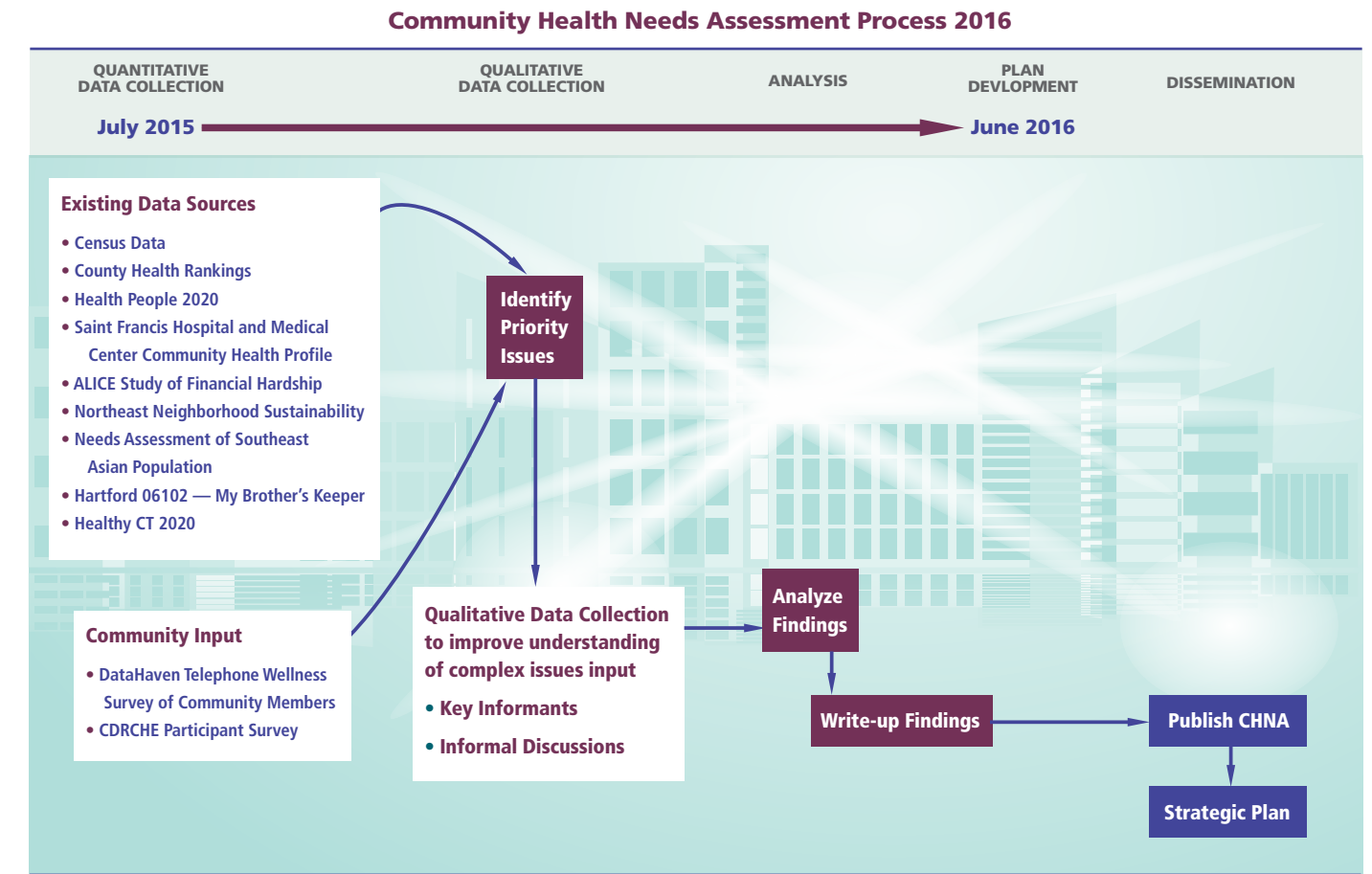
- Socioeconomic factors and the physical environment
- Health behaviors
- Clinical care

Analysis of Existing Data Sets

The CHNA research team consulted existing data sets from a variety of sources, including (See Appendix 3 for list of website addresses):

The ALICE Study of Financial Hardship Report was based on 2012 data and commissioned by Connecticut’s United Way organizations. The study, carried out by the Rutgers University-Newark School of Public Affairs and Administration (SPAA), utilizes

FIGURE 4



substantial community social and economic data to calculate indicators of financial viability and marginality, such as the “ALICE Threshold.” ALICE is an acronym for Asset Limited, Income Constrained, Employed; the ALICE Threshold is “the actual cost of basic household necessities on a per county basis,” i.e., the adequate survival level above the federal poverty guidelines. This metric provides a more realistic assessment of the “working poor.” Data are provided for the state, by county and major municipal areas, including Hartford.

The Northeast Neighborhood Sustainability Plan – Health Impact Assessment (2014) is the result of a remarkable initiative comprising community organizing, assessment and plan development, led by community residents and stakeholders in Hartford’s impoverished North End. This plan was drafted under the direction of Community Solutions, an international non-profit active in Hartford. It identified community concerns and local resources and mobilized stakeholders to collectively address social determinants known to affect health problems characteristic of the area, such as street safety, deteriorating public and private infrastructure and green spaces, a lack of recreational opportunities and high unemployment.

Needs Assessment on the Southeast Asian Population in Connecticut (2014) was conducted by the Asian Pacific American Affairs Commission. The report presents data from a cross-sectional, face-to-face survey with 300 Asian Pacific

residents of Connecticut (100 of Laotian origin, 100 Vietnamese and 100 Cambodian). Extensive data on demographics, health issues, and health access were collected.

Hartford 06120 (2015) is a report generated by the My Brother’s Keeper/Violence Free Zone Coalition. The report details the community assessment, program development and preliminary outcomes of the coalition’s efforts to support education, foster employment opportunities and reduce violence among Hartford’s North End youth. Data presented include a demographic profile and data on employment, educational attendance and graduation and violent injury data. The report concludes with recommendations for sustaining and enhancing the programs developed by the coalition.

Healthy Connecticut 2020: State Health Assessment report (2014) was developed by the Connecticut Department of Public Health with the assistance of the Connecticut Health Improvement Planning Coalition’s Advisory Council. Data was compiled from an abundance of sources from the past year and decade, including 2010 census data, statewide hospital data and numerous other state reports. Seven focus areas were described: maternal, infant and child health; chronic diseases and their risk factors; infectious disease; mental health, alcohol and substance use; injuries and violence, environmental risk factors and health system data.



The Saint Francis Hospital and Medical Center Community Health Profile (2015) was provided by the Connecticut Hospital Association. This document summarizes hospital admissions and related data for the Saint Francis service area, with statewide comparisons extracted from data annually reported to the CHA by most hospitals in the state. The report features a demographic and social profile, summaries and key insights concerning 13 “leading health indicators.”

Community Input Sources

The CHNA research team used multiple techniques to engage community member input, including a comprehensive randomized telephone survey, a written participant survey, interviews and informal discussions with “Key Informants” (community leaders and leaders of partner agencies).

The 2015 DataHaven Community Health and Well-being Survey was conducted by DataHaven, a nonprofit public service organization, and was supported by over 100 state and local government, health care, academic and community partners. DataHaven’s Mission is “to improve quality of life by collecting, interpreting and sharing public data for effective decision-making.” The organization designed and conducted a telephone survey that collected information from a sampling of 16,820 residents of Connecticut and several zip codes in Westchester County, New York state. The sample was drawn with a random-digit dialing methodology and included subjects from all 169 Connecticut towns. Questions derived from a variety of standard surveys yielded data on residents’ perceptions of their well-being, quality of life, neighborhood, employment and public health. The

raw data and weighted data aggregated by various demographic variables are available online. This study represents an enormous resource for health care and social service agencies throughout Connecticut.

The Curtis D. Robinson Center for Health Equity Participant Survey (2015) generated data by conducting voluntary written participant surveys at public, typically faith-based, health screening events conducted by the center’s staff. Demographic data, checklists of health concerns and access issues were collected in an effort to determine priorities for health education and engagement activities.

“Key Informant” interviews and informal discussions with community leaders were also used to gain insight into issues affecting the health of the community. The CHNA research team conducted qualitative telephone interviews of community leaders. The Key Informants consulted for this study have lived and/or worked in Hartford for decades. Some grew up in Hartford and have worked there all their lives. Others have worked in Hartford for decades. Most have been working in the public health field for 10 to 20 years. Participants were from community-based organizations, such as the Hispanic Health Council, Food Share and the YMCA, while others were from public health agencies, such as the Department of Health and Human Services.

The CHNA research team also engaged with leaders of partner organizations about priority health issues and how to have a positive impact on those they serve.



VIII. CHNA Findings: A Model For Understanding Health Needs

They had gotten together over lunch for one of their periodic catch-up sessions. It was easy to feel burned out in this kind of work and sometimes it was just good to talk to someone who understood the challenges. The pair had known each other since their school years, and both had gone into social services. She worked with a public health agency and he was from a youth services program. The modest conference room at her office wasn't being used, so they opened their bag lunches on the table and dug in.

"I have one case that's just so hard," she said. "The father has been out of work for two years. He's hypertensive and he just had a heart attack. No wonder he's also depressed. The mother works part-time and does all of the housework. When I've been to see the father on home visits, the kids are acting out, showing signs of stress."

"That's so typical," he said. "Kids might not be able to express it in words, but their behavior will always tell you when there's stress at home. Were they there when he had the attack? Having a sick parent is hard for a kid."

I don't know where he was," she said. "But even if they weren't with him, it's devastating." Now he's supposed to be on his diet, but it's hard for him to stick to it, because their SNAP benefits typically run out a few days before the end of the month, and anyway, the only place that sells food in their neighborhood is a convenience store. That's a minefield for a hypertensive cardiac patient! The supermarket is across town. At the beginning of the month she pays for bus fare or a taxi to get home after she stocks up on groceries. She's got it down to a science, but she still winds up at the pantry at the end of the month—and whatever's there is there—salty canned foods, like canned ham and mac 'n' cheese.

"It all comes down to money," he replied. "Everything—what you eat, where you live, the quality of the school your kids go to. And any little hiccup—things that middle class people in the 'burbs wouldn't think twice about—can be a crisis. I had a kid whose brother threw one of his sneakers down the sewer. So he didn't go to school for two weeks because he didn't have shoes. The family had just enough money for rent and food. They're fairly new in town and the parents don't speak English well, so they didn't know where to go for help. When I found out about it, I got the kid a pair of sneakers—and some boots for the snow. But by then he had already missed two weeks of school. Oh, and they don't have a working phone, so when the school tried calling, they couldn't get through. Money again."

"It's really heartbreaking," she replied.

Barriers to good health have a disproportionate effect on those who live in poverty, and those barriers fall into several broad categories. The federal Centers for Disease Control and Prevention (CDC) created a framework that defines the elements of good health and published this framework as an infographic titled "Invest in Your Community: 4 Considerations to Improve Health and Well-Being for All" (see Figure 5).

Data collected and reviewed by the CHNA team was analyzed using a modified version of the CDC's framework. This model is organized to focus the findings into categories that impact health.

- Socioeconomic Factors and Physical Environment, which account for 50 percent of the health "pie"
- Health Behaviors, which account for 30 percent
- Clinical Care, which accounts for 20 percent.

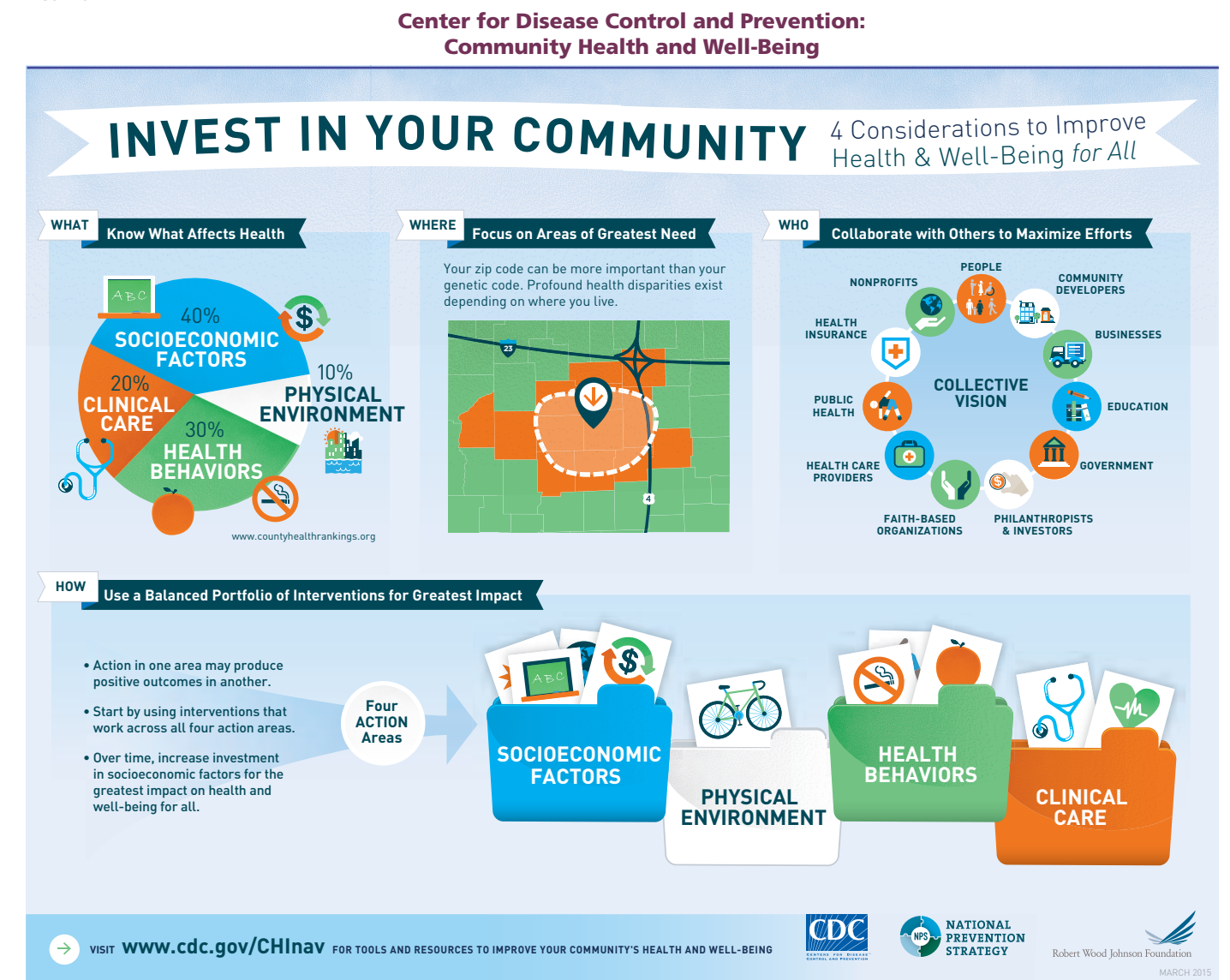
(Note that the CDC model considers socioeconomic factors and the physical environment as two separate elements of good

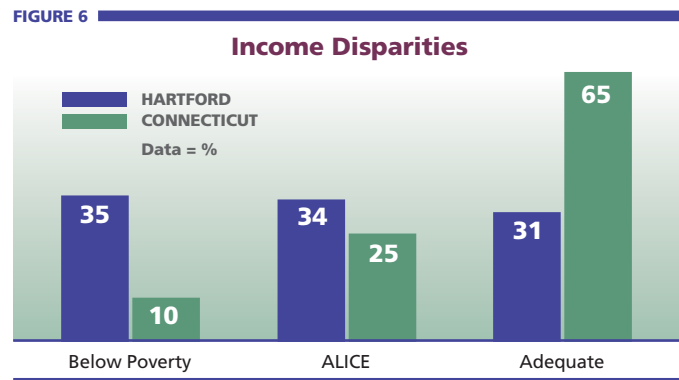
health; however, the Saint Francis CHNA team chose to consider them together, as they are often interdependent.)

Socioeconomic Factors and Physical Environment

Good health owes to a combination of factors: genetics, lifestyle, environment, medical care, education and, most importantly, place. Where you live is the greatest predictor of what how healthy you will be. People are born with their genetic makeup, but the other factors that contribute to health depend on resources like a good education, a safe neighborhood, employment opportunities, affordable housing, appropriate medical care, community support and an environment that allows for good lifestyle choices, these factors are known as the "social determinants" of health. The Key Informants consulted for CHNA 2016 had much to say about the socioeconomic factors impacting health, as did the quantitative demographic and public health sources analyzed.

FIGURE 5





Source: ALICE Survey

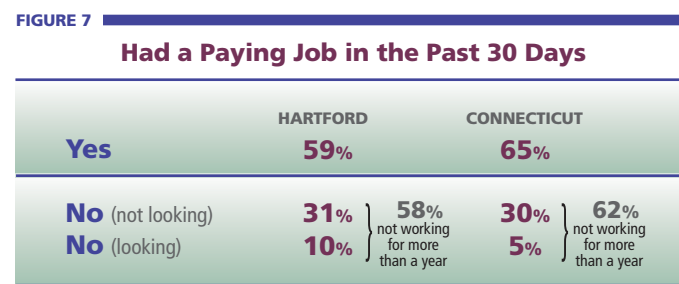
Income, Employment and Poverty

The data about poverty in Hartford is dramatic. When combined, the numbers of households living below the federally defined poverty level and those living at the ALICE Threshold (Asset Limited, Income Constrained, Employed) reveal that only 31 percent of Hartford households had adequate income, compared to statewide figures of 65 percent of households with adequate income (see Figure 6). The DataHaven survey found that the median household income for Hartford is \$29,313; less than half that of the state average of \$69,899.

Many interviewees said that access to the resources needed for good health is based on economics—specifically, on an individual or household’s income. Good lifestyle choices are easier to make when there is enough income available to follow through on them; healthful environments are likewise more easily accessible when an individual or household has the income to afford them. Time and again, the Key Informants consulted for this CHNA cited poverty and/or low income as a significant barrier to a healthy community. **“When it comes to poverty, you have very, very limited opportunities and options and that absolutely, directly impacts who you are, how you are and your overall well-being,”** said one.

Nor does Hartford’s overall employment rate fare well when compared to that of the state as a whole. Some 59 percent of Hartford residents held jobs during the 30 days prior to the survey, as compared to 65 percent statewide. And twice as many Hartford residents were actively seeking employment as residents of the state as a whole (see Figure 7).

Some of the Key Informants for this CHNA maintained that poverty is the underlying factor to all the other barriers to health, and said that it impacts all aspects of life and makes it difficult



Source: DataHaven Community Health and Well-being Survey, 2015

for individuals to meet their basic needs. As one person said, **“It affects everything.”** Another Key Informant summed up the issue of poverty and its global impact on the quality of life by saying, **“The barriers that have been identified [education, employment, and safety]. . . are really about opportunity and resources. . . . It’s a lot more challenging and difficult for individuals to be able to secure employment that is actually able to sustain a quality of life for them and their families.”**

Education

Clearly, the level of educational attainment is correlated with employment and poverty, which determines where children live and, in turn, which schools they attend. One Key Informant put it like this: **“In a larger sense, it’s a city that is so poor, it has less of a tax base and that impacts city services, so then it impacts the education system. So it creates, in a sense—I hate to say a cycle of poverty ‘cause I hate the way that usually is used—but in this sense, poverty impacts the city’s ability to turn the situation around unless larger systems are changed in a much more fundamental way.”**

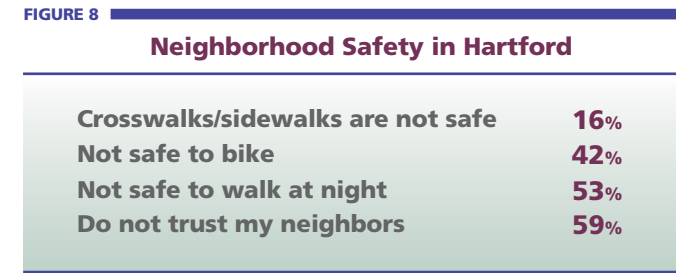
Only 70 percent of Hartford residents over age 25 have a high school diploma, as compared to 90 percent of state residents. Additionally, just 5 percent of city residents complete college, compared to 37 percent of residents throughout the state. Data from *Hartford 06120* by the My Brother’s Keeper/Violence Free Zone Coalition highlights the issue of chronic absenteeism, which affects the rate of graduation. In the Northeast neighborhood, between 30 and 65 percent of students are absent from school each day. If this were due to illness, it would be seen as an epidemic.

Unsafe Neighborhoods

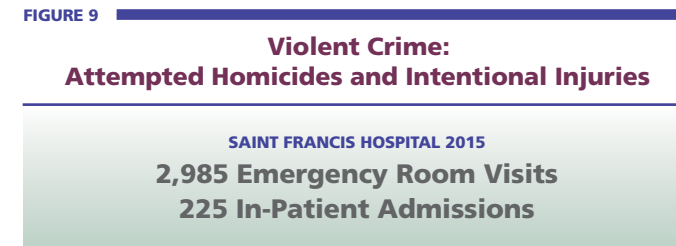
Violence and neighborhood safety have a direct impact on health in areas of Hartford. Some of the residents surveyed noted that they feel unsafe in crosswalks and walking on sidewalks, while others bemoaned the lack of bike lanes. Even more reported feeling threatened walking the streets in their own neighborhoods (see Figure 8). Indeed, homicides and physical violence are a frightening reality in some areas. In 2015, Saint Francis had 2,985 Emergency Department visits and 225 inpatient admissions resulting from attempted homicides and intentional injuries. *Hartford 06120*, the report by My Brother’s Keeper/Violence Free Zone, noted that the city’s homicide rate increased from 15 murders in 2014 to 31 homicides in 2015. A survey by the Curtis D. Robinson Center for Health Equity found that 46 percent of Hispanic respondents had been “impacted by violence”. This finding is supported by data from the National Center for Children in Poverty, which found between 25 and 90 percent of children and youth experience events that leave them traumatized.

Trauma has a disproportionate effect on members of minority groups. Using statistics from the Saint Francis Hospital and Medical Center Trauma Registry, *Hartford 06120* reported that in 2015, 75 percent of its trauma patients were black/African American; 18.5 percent were Hispanic and 7.3 percent were white or “other.”

For some Hartford residents, violence seems to be something they know and live with every day. One Key Informant put it this way: **“We get a lot of the gunshot victims. So after the**



Source: DataHaven Community Health and Well-being Survey, 2015.



Source: SFHMC Community Health Profile 2015.

gunshot, they’re going home paralyzed, same home, same neighborhood, same idea that violence may be the answer. The nurse goes in and makes a home visit and it is in this environment where they’re plotting and planning that you’re not even certain if you’re safe.”

Housing

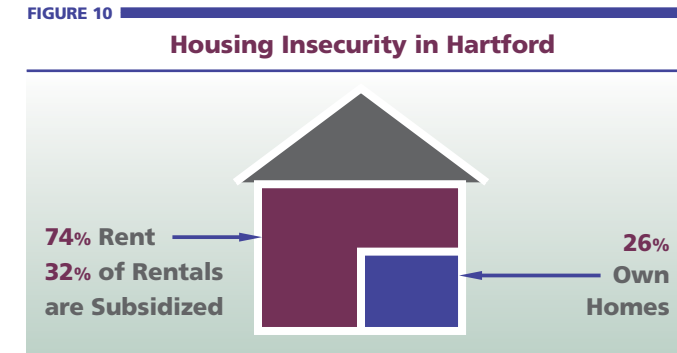
Housing is a basic human need, and one that contributes to health in innumerable ways, both directly and indirectly. As one of our Key Informants noted, **“You may have the most wonderful hospital in the world, but if people are going home to houses that are not properly heated, or going to poison them because of lead, or in neighborhoods where you worry if you send your children outside, then it’s not a healthy community.”**

Some 20,000 housing units in Hartford were constructed prior to 1960, according to *Healthy Connecticut 2020*. Older housing brings with it an assortment of threats to health that range from deteriorated conditions to insufficient heat to high levels of lead. In Hartford, over 3 percent of children less than age 6 have blood lead levels over 5 µg/dl 2 which puts them in the 97th percentile as compared to national lead levels.

One Key Informant commented that for some city residents, being able to afford any housing at all remains a challenge.

Lacking enough income and/or consistent income, **“they jump from**

“You may have the most wonderful hospital in the world, but if people are going home to houses that are not properly heated, or going to poison them because of lead, or in neighborhoods where you worry if you send your children outside, then it’s not a healthy community.”



Source: DataHaven Community Health and Well-being Survey 2015

one housing place to another,” resulting in a lack of stability and continuity in other areas of life, including their health care, the informant said. Home ownership in Hartford is very low, at 26 percent, compared to a state average of 67 percent.

DataHaven developed a “Housing Insecurity Rate” which is made up of a set of questions that measure the cost of housing compared to income; rate of home ownership; satisfaction with current housing; length of residency and plans for continued residency. The rate of housing insecurity in Hartford is 12 percent, twice that of the state overall. This lack of housing stability impacts both physical and emotional health and is inextricably linked to poverty.

As one Key Informant said, **“Poverty impacts housing; if folks don’t have a sustainable job and a sustainable income, they jump from one housing place to another and especially for the young children, it doesn’t create the kind of stability that is needed.”**

Food Insecurity

Food insecurity—the lack of regular access to a high-quality, varied and healthful diet, or worse, the lack of regular access to any food at all—is common in Hartford. More than one-third of residents surveyed reported lacking enough money to feed themselves or their families at some point in the 12

months prior to the survey, and of those, 25 percent said this happened repeatedly (see Figure 11). **“People who are below poverty [level] tend to need food assistance all the time,”** said one Key Informant. Those who are working but still, as the Key Informant said, **“near poor,”** are not necessarily eligible for any government assistance, but they’re not making enough money to pay all their bills. **“That makes them food-insecure.”**

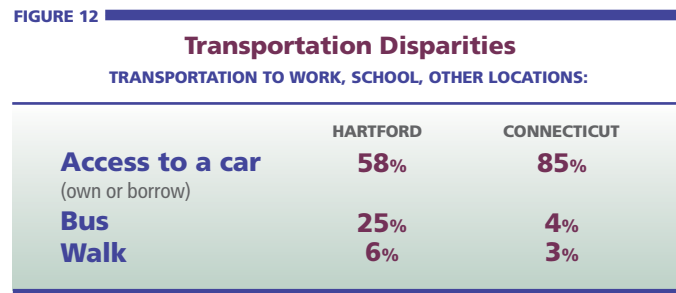
Even for those who can buy food, the availability of *healthful* food is yet another challenge, especially for people who must rely on mass transportation and



Source: DataHaven Community Health and Well-being Survey, 2015

live in neighborhoods without supermarkets where fresh produce and other healthful choices are available. “You have the mom-and-pop stores and the bodegas, but when we talk about access to healthy foods and vegetables, you don’t see that in Hartford.”

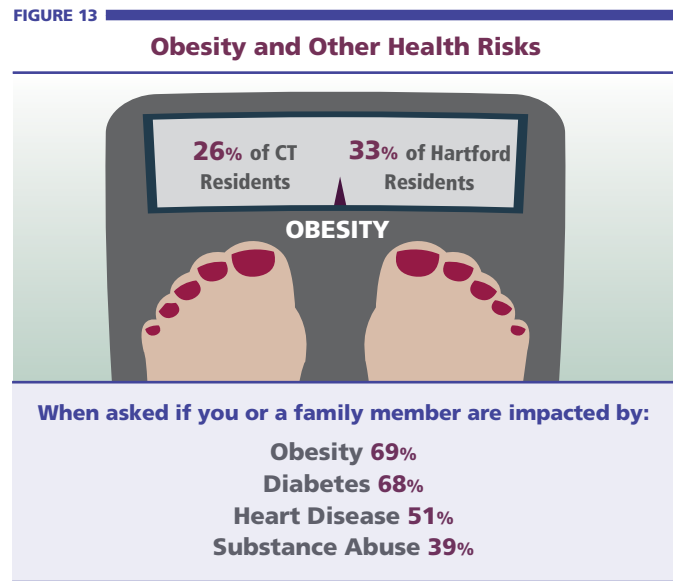
In Hartford, over one-third of residents surveyed report not having enough money to feed themselves and their families. Of the people who don’t have enough money for food on a regular basis, 25 percent don’t have enough food almost every month. Children were living in over 30 percent of the homes that reported inadequate money for food. Compare this to Connecticut as a whole, where just over 10 percent of residents reported insufficient funds to pay for food on a regular basis.



Source: DataHaven Community Health and Well-being Survey, 2015

Transportation

Of those who live in Hartford, only 58 percent indicated they had regular access to a car, as compared to 85 percent in Connecticut as a whole. Access to reliable transportation is correlated with income; low-income residents indicated they had access 33 percent of the time, while upper-income residents had access 92 percent of the time. In Hartford, 25 percent of residents indicated that public transportation is their primary means of getting from place to place. Transportation barriers are also cited as a reason for not going to health care appointments.



Source: Connecticut Department of Public Health, *Healthy Connecticut 2020*; and Curtis D. Robinson Center for Health Equity Participant Survey, 2015.

Health Behaviors

In the CDC’s model for community health and well-being, health behaviors account for 30 percent of the health equation. Health behaviors refer to choices that individuals make with regard to their lifestyle or habits that are known to influence their health. Data about diet and exercise, obesity and substance abuse are included in this section.

Several Key Informants commented that people who face multiple significant challenges—starting with poverty and continuing with the struggles in housing, education, child care, safety and others that result—simply don’t have the bandwidth left over to make health and/or healthy lifestyle choices a priority.

Diet, Exercise and Obesity

The problem of obesity has gained renewed attention in recent years, especially thanks to First Lady Michelle Obama’s efforts to promote healthful eating and exercise. The health risks of obesity have become well known; it has been linked to diabetes, heart disease and high blood pressure.

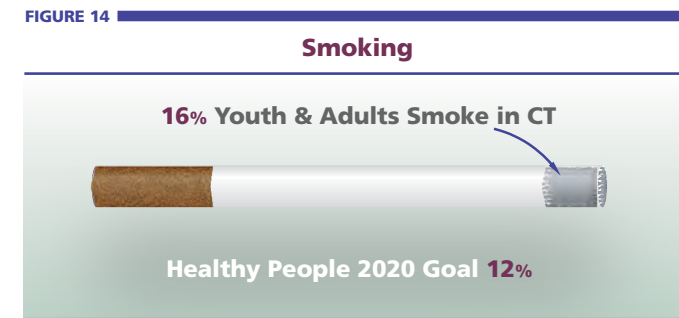
But despite the widespread publicity about the benefits of a healthy diet and maintaining a healthy weight, making behavioral choices to fight obesity is more of a challenge in some neighborhoods than others. It’s easier to eat fresh produce on a regular basis when it is available in a nearby supermarket that you can get to in a private car and you have sufficient income. For those who rely on mass transportation, have no local markets that carry fresh foods and can’t afford higher-priced selections, eating for health—a key health behavior—is no easy matter.

As one Key Informant said, “A lot of the general public does not understand the connection between food insecurity—let’s just call it simply someone who’s been hungry—and obesity. They may be eating food because it’s donated food and that’s all they’re being offered. . . .

Someone with high blood pressure is eating too much salt because that is what’s donated—a whole lot of canned food. And they’re eating canned food two and three times a day, if that’s what they’re being offered.” Another Key Informant pointed out: “Someone who is working two or three jobs in order to feed their family . . . [has] very little time left in their day to do basic things: go to the food store, prepare a meal, shop, or meal planning. And so they end up needing to do things in the shortest amount of time, which generally means less healthy options.”

The rate of obesity in Hartford is 33 percent, comparable to that of the state of Alabama—which means that the prevalence of obesity among Hartford residents is equivalent to that of the top five states with the highest rates of obesity nationwide. In contrast, the state of Connecticut is ranked 43rd for overall obesity rates.

Data from the Curtis D. Robinson Center for Health Equity Participant Survey showed that diseases linked to health-related behaviors impact Hartford residents at alarming rates.



Source: Connecticut Department of Public Health, *Healthy Connecticut 2020*

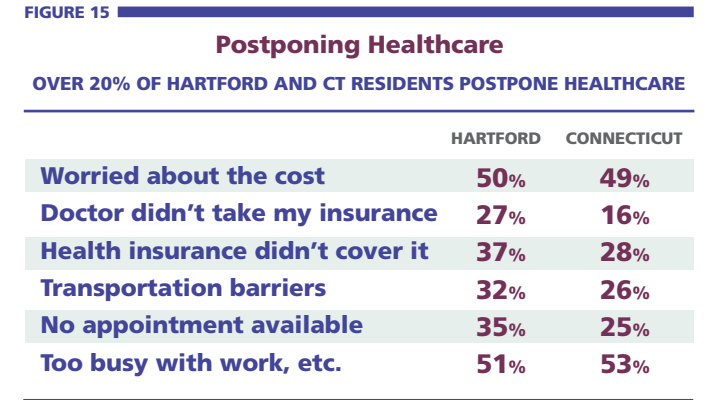
Smoking

Smoking, another individual health choice, causes a spectrum of serious and life-threatening illnesses; it can lead to a host of lung diseases including cancer, as well as cardiovascular disease. Although changes in smoking regulations over the past decade have affected overall smoking rates, the current rates of smoking among youth and adults is similar, highlighting the challenge to further impact this behavior. This is important in part because becoming addicted at a young age makes it harder to quit smoking in adulthood (see Figure 14).

Substance Abuse

The impact of substance abuse on Hartford residents is significant. As noted in Figure 13, more than one-third of survey respondents indicated that substance abuse is a problem that impacts themselves or their family. For Hispanic respondents, this percentage increased to 46 percent.

Opioid use and abuse of prescription drugs at the national level has increased, and the Hartford region is no different. As noted in Figure 17, Alcohol and Substance Abuse is one of the top 5 reasons for Emergency Department non-admissions at Saint Francis. The issue of opioid use was also mentioned by health leaders in surrounding towns served by Saint Francis.



Source: DataHaven Community Health and Well-being Survey, 2015

Clinical Care

The CDC’s model of community health and well-being identifies one other factor: clinical care. Clinical care encompasses all the many kinds of health care that modern society relies on, from preventive care to treatment, from everyday illnesses to serious, chronic conditions, from mental health care to dental care and more.

Access to providers and necessary preventive treatment is the foundation of clinical care. Yet, the data collected for this CHNA showed that, as with the other aspects of the CDC model, socioeconomic barriers can and do interfere with access to care.

Socioeconomic Barriers to Care

The Affordable Care Act has done much to ensure that citizens can enroll in a health insurance plan, but it is only part of the equation. As with food insecurity, lack of money and reliance on public transportation can limit access to care, and so can the parameters that are set by health insurance plans: copays, referral policies and specific “in-network” providers.

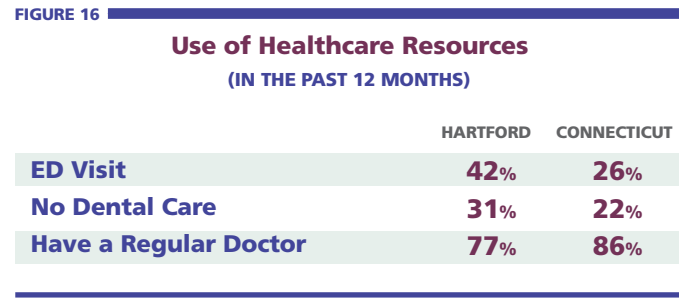
Finally, providers’ business hours might not match clients’ needs (see Figure 15). All of these socioeconomic realities can result in people postponing needed clinical care.

Access to care continues to be a problem in both Hartford and the entire state of Connecticut. Over 20 percent of residents report delaying care in the past year, primarily due to finances and insurance problems. Remarkably, in a city with a relatively high density of health care facilities, 35 percent of residents could not get an appointment in a timely fashion and 32 percent couldn’t get to the facility when it was open.

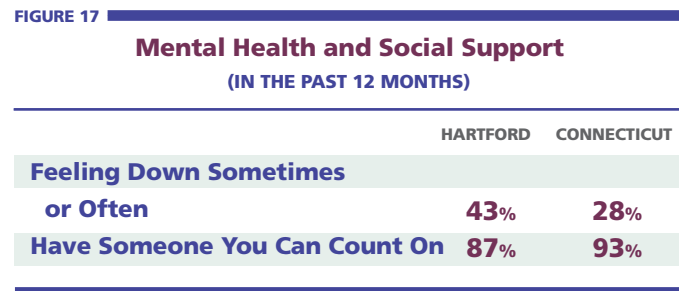
Cultural Barriers to Care

Hartford is diverse, and many of the people interviewed said that health care practitioners do not know enough about the population they serve to provide quality care. Something as seemingly simple as providers speaking the same language as their clients can make all the difference; if a patient doesn’t understand follow-up instructions, there’s a good chance the clinical visit will not have the intended outcome.

“I still think that there are pockets of population that—I believe—are completely disconnected from the concept



Source: 2015 DataHaven Community Well-being Survey



Source: 2015 DataHaven Community Well-being Survey

of health,” said one Key Informant. “Thinking about the population we serve, it was a linguistic barrier, and economic barriers that prevented optimal health. I also think when they did access health services, more often than not they perceived—or they experienced—racial bias.”

In the same way that that providers’ lack of cultural knowledge of their patients gives rise to cultural barriers to care, so too, can their clients’ misunderstandings and mistrust of the health care system.

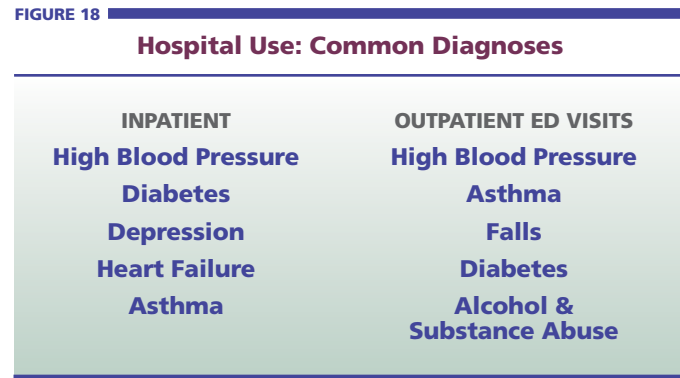
This point was brought out in interviews with Key Informants. “What it boils down to,” said one Key Informant, “[is that] it’s really about communities not having accessibility for the qualified care that they deserve, and that would include being considerate of their culture and language.”

Leading Health Conditions

This CHNA also explored the specific health problems of Hartford’s residents—many of them problems that are exacerbated by both poverty and the barriers to community health detailed earlier.

For example, diabetes is a disease whose control is dependent on at least two of the major barriers to community health (food insecurity and access to clinical care). It was among the top five reasons for both in-patient admissions and Emergency Department non-admissions at Saint Francis. Hospital data also counted high blood pressure, depression, asthma, heart failure, alcohol and substance abuse (see Fig. 18).

In the same way that that providers’ lack of cultural knowledge of their patients gives rise to cultural barriers to care, so too, can their clients’ misunderstandings and mistrust of the health care system.



Source: 2015 DataHaven Community Well-being Survey

Community Health Profiles, developed by the Connecticut Hospital Association for the Saint Francis Service Area and for Hartford, reveal significant racial and ethnic differences in the population of these two regions and in the care they receive. The diversity of Hartford is reflected in the profile of patients seen in the ED as noted above.

Cardiovascular Disease

Connecticut is experiencing over 27,000 years of potential life lost due to premature death as a result of heart disease, according to *Healthy Connecticut 2020*. The rates of both high blood pressure and heart disease in Connecticut are approximately 30 percent. Blacks and Hispanics have significantly poorer outcomes than whites.

Cardiac issues can cause a ripple effect that touches every area of life, which is especially hard for those who live in poverty or near-poverty. This, in turn, affects their well-being dramatically. As one of the Key Informants explained, “Any kind of cardiac issue that results in mobility problems impact your ability to get to your doctors, move around your house, even bathe yourself. It may mean you need help from someone every day.”

Asthma

In Connecticut, 10 percent of adults and 12 percent of children overall suffer from asthma. It is clear when looking at the data more carefully that there are significant disparities in the incidence of asthma in Hartford and the state as a whole, and among different racial and ethnic groups.

Diabetes

In Connecticut, over 8 percent of adults are diagnosed with diabetes; in Hartford that rate is 12 percent of adults. This represents a significant increase in the past 10 years. Diabetes is often the result of other issues including obesity, limited access to healthful food and lack of physical activity. Differences are also seen when looking at the data by race. As with



obesity, behavior change related to diabetes is a long process and requires that patients remain motivated to make lasting change.

Mental Health

Mental health issues can have a profound effect on quality of life. Depression was among the top-five reasons for admissions at Saint Francis in 2015. The data review and the Key Informant interviews highlight the importance of mental health. Several Key Informants maintained that it is both a disease that requires care and a barrier to care—and to the challenges of living in poverty. As one Key Informant said, “Integration and collaboration between mental and physical health is critical. People cannot get well if their mental health and their substance abuse issues aren’t addressed.”

Depression and trauma cut across class, race and geography; however, youth and families of color disproportionately experience trauma. This, according to *Hartford 06120*, the report by My Brother’s Keeper/Violence Free Zone, can lead to other behaviors that impact the trajectory of a child’s life. For example:

- Truancy, poor academic performance and dropping out of school.
- Frequent encounters with law enforcement and involvement in the juvenile justice system.
- Anxiety and depressive disorders and thoughts of suicide and/or hurting others.
- Difficulty forming trusting and meaningful relationships at home and school, and among peers, with significant others and other positive role models.
- Early initiation of drug use.

As one Key Informant commented, “Mental health is a huge barrier. We have a lot of communities that are suffering with mental health issues. . . . We don’t do enough to be able to engage in outreach to these specific communities and tailor it to their cultural and linguistic needs.”

Ranking of Priorities

On September 13th, 2016 a Community Conversation was held with leaders and community members to discuss the findings of the Community Health Needs Assessment and identify the priorities to be included in the Strategic Implementation Plan. The evening meeting was held in an accessible location and over 35 people participated representing a wide array of community organizations from those addressing violence prevention and homelessness to clinical care providers, faith leaders, and community members. The discussion included an overview of the findings and a participatory exercise designed to get input from everyone. The County Health Rankings Model was used to outline the broad topics for ranking priorities.

The following items were identified:

1. Community Safety and Violence
2. Housing Insecurity and Transportation Needs
3. Family and Social Support
 - a. Behavioral Health
 - b. Neighborhood Support and Resources
4. Employment and Poverty
5. Access to Care

The next step in our process will be to organize work groups and outline our approach to addressing the priority issues noted above.

IX. Going Forward: Making Hartford A Healthier Place to Live and Work

The warm, sunny day had brought everyone out to the park. The farmer's market was in full swing, the music of a salsa band filled the air, and a gaggle of children danced in front of their makeshift stage.

At the other side of the market, a chef was demonstrating a recipe for a spicy slaw. "It's full of nutrition," she said, handing out samples in tiny paper cups. "And best of all, it's delicious and easy."

Throughout the market, young and old wandered through the farmers' stalls, eyeing the bright greens, vivid reds, and brilliant oranges and yellows of the produce that had been picked that very morning. At one stall, the farmer was selling watermelon. Elsewhere juicy peaches were on offer, along with peppers, carrots, onions, herbs, assorted greens, and even honey. A baker was selling several kinds of fragrant, yeasty breads.

Some of the shoppers paid with cash, but others paid with their vouchers or SNAP cards—and got double the value because they were shopping at the farmer's market. On this day, a health information booth occupied a spot in the market. Nurses were taking people's blood pressure and talking about follow-up care.

Salsa music echoed through the market, putting everyone in a good mood. One couple began to dance. Then another, and then a group of teens joined in. A woman with her arms full of grocery bags had been just about to leave, but she too found herself dancing, still holding her packages. "I can't resist," she said to no one in particular.

A bus rounded the corner and stopped at the bus stop. A half dozen people got off and made their way to the park, headed for the market. A mother and her six-year-old daughter got on. "Cuidado," said the mother, who was carrying bags loaded with fresh fruit, vegetables and bread. "Watch your step."

The six-year old climbed onto the bus; the steps were almost too big for her short legs. Once seated next to her mother, she retrieved a handful of sugar snap peas from the pocket of her jacket and munched on them contentedly. "Mama," she said, "I never knew vegetables tasted so good!"

Visions of A Healthy Community

Many of the Key Informants consulted during the preparation of this CHNA had strong opinions about the ingredients of a healthy community. These typically focused directly on the socioeconomic factors that affect health outcomes. The socioeconomic factors mentioned most often by the Key Informants were:

- Healthy food options and information about nutrition
- Adequate employment that pays enough for people to support their families without the need to work two or three jobs
- Safe and affordable housing
- Good-quality education for both for children and adults
- Culturally sensitive support systems

Another common theme was the need for communication and dissemination of information between the various organizations and agencies in Hartford and from these organizations and agencies to the residents.

Hartford's Assets

The Key Informants who participated in this CHNA noted that despite the numerous problems the city faces, it has many assets as well. They enumerated the city's physical assets, including its neighborhoods, hospitals, and parks. While they acknowledged the city's tangible assets, they also emphasized intangibles. Almost every Key Informant said that diversity enriches the city of Hartford and makes it a more interesting place to live and work.

They also cited the number and quality of its community-based organizations, some of them with national reputations. The leaders and staff of these organizations are passionate, intelligent and have a deep understanding of Hartford, the residents, politics and ecosystem as a whole.

Next Steps/Conclusion

Clearly, there is much work ahead for public health organizations, of which Saint Francis Hospital and Medical Center is just one. Setting up a health care infrastructure that is able and equipped to take on the barriers to community health will require:

- Strong leadership and a committed set of coalition partners.
- Maintaining an iterative ongoing community engagement process.
- A broad focus on community health and well-being.
- An understanding that the climate for community transformation work has changed.

This information will be used to develop a Strategic Plan for Community Transformation. The groundwork has already begun with the development of the Transforming Communities initiative. This group will play a critical role in reviewing the findings here and working to develop a plan for change. Having affiliated with Trinity Health, Saint Francis Hospital and Medical Center is poised to meet the challenges that will come.



X. Appendices

Appendix 1: Centers of Excellence – Saint Francis Hospital and Medical Center

Saint Francis Hospital and Medical Center offers five centers of excellence—easily accessible treatment centers focused on particular conditions—plus a host of other services.

- **The Mount Sinai Rehabilitation Hospital** occupies the former Mount Sinai Hospital campus in the city's North End. In 1990, Saint Francis affiliated with Mount Sinai Hospital, a Jewish-sponsored institution that opened in 1923. Mount Sinai was born of a vision similar to the one that led to the founding of Saint Francis decades earlier. The collaboration marked the first recorded instance of a Catholic and Jewish hospital affiliation in United States history. The arrangement was formalized as a corporate merger in 1995. Today, the 60-bed facility is Connecticut's only freestanding acute care rehabilitation hospital.
- **Smilow Cancer Center Yale-New Haven at Saint Francis** is one of New England's leading outpatient cancer treatment centers, providing the latest technology and the most comprehensive range of treatment options in the region. More than 1,500 cancer patients and their families depend on the center every year. The team approach that distinguishes the center streamlines the diagnosis and consultation process, and individualized care plans can include a combination of conventional and investigational therapies.
- **The Hoffman Heart and Vascular Institute of Connecticut** is the largest open-heart surgery center in Connecticut. In emergencies, Saint Francis delivers the fastest response to heart attack in the area and routinely performs more cardiac catheterizations than any other heart center in the state—numbers that directly correlate with saving lives. With state-of-the-art technology, Saint Francis cardiologists can correct heart rhythm disorders and manage patients with advanced congestive heart failure. Because heart disease is also the leading cause of death in women and frequently overlooked, the **Women's Heart Program at Saint Francis** is a risk-reduction and education program for women designed to prevent both heart attack and stroke.
- **The Connecticut Joint Replacement Institute**, is recognized as one of the major arthritis and joint replacement centers on the East Coast. Since it opened in 2007, it has become the largest joint replacement center in Connecticut. Led by fellowship-trained orthopedic surgeons, this "hospital within a hospital," is distinguished by dedicated operating rooms and staff for hip and knee replacement and multidisciplinary teams working together to provide expert care for patients needing joint replacement procedures. The staff is also involved in research in materials used in joint replacement surgery and in post-operative pain control.
- **Women and Children's Health:** Caring for women and children begins before conception and extends beyond retirement. Labor and delivery, gynecological care and comprehensive breast health are flagship programs of Saint Francis' Women and Infants Health program. The **New Beginnings Family Birth Care** model provides a unique birthing experience for each mother and her family. It offers enhanced privacy features, attractive and comfortable surroundings and the latest medical technology, including a Level III neonatal intensive care unit (NICU) and a state-of-the-art antepartum diagnostic center. Delivery by a nurse midwife is among the options available. When gynecological problems arise, expert surgeons and minimally invasive technologies, including robotic surgery, offer quicker recovery with better outcomes. At the **Comprehensive Women's Health Center**, women with breast health concerns, both routine and complex, benefit from a streamlined approach to breast cancer prevention, diagnosis, treatment and recovery.

In addition to its centers of excellence, Saint Francis offers a full range of expert medical and dental care with respected programs in:

- Stroke care
- Surgery
- Surgical weight loss
- Diabetes management
- Orthopedic and sports medicine
- Pain management
- Integrative medicine

Appendix 2: Key Informant Agencies

Community Health Needs Assessment

Organization	Topic Area	Geographic Area
Faith Care	Faith/Health	Hartford
Harriott Home Health Services	Home Health	Hartford
YMCA	Physical Health	Hartford
Hispanic Health Council	Hispanic Health and Well-Being	Hartford
Hartford Food System	Food Insecurity	Hartford
Food Share	Food Insecurity	Hartford
Hartford Health and Human Services	Public Health	Hartford
CT Asian Pacific American Affairs Commission	Asian American Well-Being	Connecticut
Hartford Foundation For Public Giving	Community Investment	Connecticut
Asylum Hill Neighborhood Association	Community Development	Hartford

Appendix 3: 2106 CHNA Data Resource Website Addresses

- The ALICE Study of Financial Hardship Report: http://alice.ctunitedway.org/files/2014/11/14UW-ALICE-Report_CT.pdf
- The Northeast Neighborhood Sustainability Plan – Health Impact Assessment: https://cmtysolutions.org/sites/default/files/wysiwyg/nh_healthimpactassessment.pdf
- Needs Assessment on the Southeast Asian Population in Connecticut (2014): <http://ctapaac.com/wp-content/uploads/2014/12/APAAC-NEEDS-ASSESSMENT30JUNE2014-REPORT.pdf>
- Hartford 06120 (2015): <http://www.mbkhartford.org/>
- Healthy Connecticut 2020: State Health Assessment report (2014): http://www.ct.gov/dph/lib/dph/state_health_planning/shaship/hct2020/hct2020_state_hlth_assmt_032514.pdf
- The 2015 DataHaven Community Health and Well-being Survey: <http://www.ctdatahaven.org>

Appendix 4: Priority Health and Well-being Issues for Surrounding Towns

Priority Health Issues — Community members from towns surrounding Hartford have some of the same health needs and others that differ due to their suburban environment. Discussions with the health leaders from surrounding towns revealed the following information:

Town/Health District	Top Health Priorities
East Hartford	Nutrition/Diet/Exercise; Diabetes; Mental health; Heart Disease; Substance abuse

Average Chronic Absenteeism of Students by School District — Information about school delinquency indicates a significant amount of instability in households in these towns.

School District	Percent
Hartford School District	26%
Manchester School District	16%
East Hartford School District	14%
Somers School District	13%
Enfield School District	12%
East Windsor School District	11%
Windsor Locks School District	11%

ALICE households by town — The ALICE Index is a measure of income stability which identifies families who have limited resources but do not meet the federal poverty guidelines. Data about surrounding towns reveal significant pockets of low income residents.

Town	Total (ALICE + poverty households)
Hartford	69%
East Hartford	47%
Vernon	39%
Manchester	35%
Windsor Locks	35%

ENDNOTE

1. *Why We Can't Wait for Tomorrow: Saint Francis Hospital and Medical Center 2015 Annual Report*, page 16.





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