



## **Saint Francis Hospital & Medical Center CHNA Implementation Strategy Fiscal Years 2019-2021**

Saint Francis Hospital and Medical completed a comprehensive Community Health Needs Assessment (CHNA) that was approved on 9-26-19 in adherence with applicable federal requirements for not-for-profit hospitals set forth in the Affordable Care Act (ACA) and by the Internal Revenue Service (IRS). The assessment took into account a comprehensive review of secondary data analysis of patient outcomes, community health status, and social determinants of health, as well as primary data collection including input from representatives of the community, community members, and various community organizations.

The complete CHNA report is available electronically at:

<http://www.stfranciscare.org/documents/NewEngland/2019-Saint%20Francis-CHNA.pdf>

Printed copies are available from:

Department of Community Health and Well Being at Trinity Health Of New England  
140 Woodland St.  
Hartford, CT 06105.  
860-714-5770

### **Hospital Information**

Francis Hospital and Medical Center has been an anchor institution in Connecticut since 1897. Saint Francis is a member of Trinity Health Of New England and Trinity Health, one of the largest multi-institutional Catholic health care delivery systems in the nation. Saint Francis Hospital, a Level 1 Trauma Center, is a 617 bed hospital and a major teaching hospital. Other Saint Francis entities include the Comprehensive Women's Health Center, the Connecticut Joint Replacement Institute, and the Curtis D. Robinson Center for Health Equity, the Hoffman Heart and Vascular Institute of Connecticut, the Smilow Cancer Hospital Yale-New Haven at Saint Francis, Trinity Health Of New England Medical Group, and two outpatient substance abuse treatment centers.

The service area for Saint Francis Hospital is the Greater Hartford region comprised of 38 cities and towns—the urban hubs of Hartford and New Britain, an inner ring of 13 towns surrounding the urban core, and an outer ring of 23 suburbs. Area residents are growing both older and more diverse. Diversity is increasingly concentrated in urban areas— including the region's Inner Ring towns—and is highest amongst residents under 35. Since 1990, the number of households in Greater Hartford increased by 10 percent. While there was a significant decrease in the number of married-couple households with children during this time, this was offset by larger increases in the number of single-person and non-family households. In 2017, most

housing units in Greater Hartford were single-family, although housing construction permits have shifted toward multi-family buildings in recent years.

Greater Hartford's median household income is similar to Connecticut as a whole, but the region is home to significant income inequality. In 2017, the City of Hartford had the lowest median household income in the state, while the median household income is nearly three times as high in the Outer Ring towns. In addition to the geographic concentration of wealth, multiple significant wage gaps can be seen when looking at gender, race, and education level. Likely related, at least in part, to this income inequality, Greater Hartford's neighborhoods are growing more segregated as middle-class neighborhoods shrink and neighborhoods at both income extremes grow. Further compounding these economic challenges, inflation-adjusted median household incomes grew modestly between 1990 and 2017 in Outer Ring towns, while decreasing in the Inner Ring and urban core.

### **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.

The CHNA conducted in 2019 identified the significant health needs within the Saint Francis Hospital & Medical Center community. Those needs were then prioritized based on the magnitude and severity of impact of the identified need, the populations impacted, and the rates of those needs compared to referent (generally the state) statistics. The significant health needs identified, in order of priority include:

## SIGNIFICANT HEALTH NEEDS

Health Issues	Asthma Obesity and Diabetes Mental Health Substance Abuse
Social Influencers of Health Issues	Access to Healthy Foods Stable Housing Neighborhood Safety

### Hospital Implementation Strategy

Saint Francis Hospital resources and overall alignment with the hospital’s mission, goals and strategic priorities were taken into consideration in light of the significant health needs identified through the most recent CHNA process.

### Significant health needs to be addressed

Saint Francis Hospital and Medical Center will focus on developing and/or supporting initiatives and measure their effectiveness, to improve the following health needs:

- **Mental Health** – page 5 and 6
- **Access to Healthy Foods** – page 7 and 8
- **Obesity** – pages 9 and 10

### Significant health needs that will not be addressed

Saint Francis Hospital and Medical Center acknowledges the wide range of priority health issues that emerged from the CHNA process, and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. Saint Francis Hospital and Medical Center will collaborate with local, state and national partners to take action on the following health needs:

- **Stable Housing and Neighborhood Safety** – Saint Francis Hospital and Medical Center does not plan to directly address this particular need because, although playing its role in this collective effort, we do not have the expertise to fully address these issues in the community. Saint Francis Hospital and Medical Center is a founding partner of the North Hartford Triple Aim Collaborative (NHTAC) which includes a wide array of anchor institutions including the city of Hartford. The NHTAC has developed a portfolio of work that includes working on access to housing and improving safety for residents in the neighborhoods most impacted by these critical needs.

- **Asthma** – Saint Francis Hospital is not going to address asthma as an issue for a couple of reasons. There is a children’s hospital across town that has been partnering with the city and the state to address this issue for many years and has the best opportunity to impact this issues. They work collaboratively with HUD to remediate homes as well as provide care for those suffering with asthma. Saint Francis makes referrals to this program but is not directly involved in the implementation.
- **Diabetes** – Patients with Diabetes are being served in Hartford by a number of programs provided by community based organizations, the hospitals and health clinics. Saint Francis will not directly work on the issue of diabetes. However the work we are doing to address obesity is expected to overlap with those impacted by diabetes.
- **Substance Abuse** – Saint Francis Hospital is not going to directly address the issue of substance abuse; however, addressing the needs of patients with mental health disorders who frequent the Emergency Department is expected to overlap with those being impacted by substance abuse. Additionally, community partners have developed programs that reach those with Substance Abuse disorders and have worked closely with our staff for years.

This implementation strategy specifies community health needs that the hospital has determined to address in whole or in part and that are consistent with its mission. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During these three years, other organizations in the community may decide to address certain needs, indicating that the hospital then should refocus its limited resources to best serve the community.

**CHNA IMPLEMENTATION STRATEGY  
FISCAL YEARS 2019-2021**

<b>Hospital Facility:</b>	Saint Francis Hospital and Medical Center		
<b>CHNA Significant Health Need:</b>	Mental Health		
<b>CHNA Reference Page:</b>	5 and 6	<b>Prioritization #:</b>	3

**Brief description of need:**

Rates of hospitalizations and Emergency Department (ED) visit for Hartford residents are higher than surrounding towns and diagnosis of high blood pressure, mental health and anxiety are some of the reason most commonly cited for ED visits.

**Goal:** Decrease ED visits for patients presenting with mental health disorders and improve care coordination.

**SMART Objective:**

Decrease the use of the ED by 25% over a 6 months period after being assigned a community health worker.

**Actions the hospital facility intends to take to address the health need:**

Strategies	Timeline			Committed Resources		Potential Partners
	Y1	Y2	Y3	Hospital	Other Sources	
Support the Community and Clinical Integration Program by hiring a Community Health Worker to be assigned to patients. Continue Community Care Team to support frequent ED users.	x	x	x	Hospital staff, Community Health budget and administrative support	In-kind staff time, resources and services from community partners	Public Health department staff, private providers, homeless providers, Catholic Charities, other community base organizations.
Develop database for collection of variables needed to measure outcomes.	x	x	x			
Complete analysis and share results.		x	x			

**Anticipated impact of these actions:**

CHNA Impact Measures	CHNA Baseline	Target
Decrease in ED visits due to mental health disorders.	575 persons per 10,000 used ED or where hospitalized for depressive disorders in Hartford	Decrease this measure by 10%.
Decrease in hospitalization due to mental health disorders.	700 persons per 10,000 used ED or were hospitalized for Substance Abuse in Hartford	Decrease this measure by 10%

**Plan to evaluate the impact:**

CHNA Measures have been completed by partner agency – Data Haven. Results will be monitored with patients enrolled in program during the 3 year period. Analysis for overall resident levels will be repeated by Datahaven in 2021.

## CHNA IMPLEMENTATION STRATEGY

FISCAL YEARS 2019-2021

<b>Hospital Facility:</b>	Saint Francis Hospital and Medical Center		
<b>CHNA Significant Health Need:</b>	Access to Healthy Foods		
<b>CHNA Reference Page:</b>	7 and 8	<b>Prioritization #:</b>	1

**Brief description of need:**

Food insecurity is a widespread problem in Hartford with over 23% of residents reporting that their household is food insecure. Addressing food insecurity has been shown to increase overall life satisfaction as measured by the Well Being Index.

**Goal:** Improve community member health by offering food related resources such as Cooking Matters Classes, Farmers Markets, Nutrition Education resources and access to healthy foods at the Joan C. Dauber Food Pantry.

**SMART Objective:**

Increase nutrition knowledge by 15% and consumption of healthy foods by 15% for 400 residents per year as measured by data collection at program enrollment and discharge.

**Actions the hospital facility intends to take to address the health need:**

Strategies	Timeline			Committed Resources		Potential Partners
	Y1	Y2	Y3	Hospital	Other Sources	
Ensure that that community is able to access community based resource by partnering with CBOs and engaging in contract to provide services including: Cooking Matters Farmers Markets Nutrition Education at the Food Pantry	x	x	x	Hospital staff and budget	In-kind staff time, resources and services from community partners	Hartford Food System  City of Hartford Health and Human Services  Data Haven  Joan C. Dauber Food Pantry
Outreach Activities to increase volume of participants reached.	x	x	x			
Development of tools to measure outcomes.	x	x	x			

**Anticipated impact of these actions:**

CHNA Impact Measures	CHNA Baseline	Target
Personal Well Being Index	Fours items included in measure: 40% baseline for Hartford	Cohort at least 20 points better than baseline
Food Insecurity	Household measure by Data Haven: Baseline 23%	Cohort at least 5% better than CHNA baseline
Availability of Affordable High Quality Vegetables	Baseline – 51% said Excellent or Good – Hartford Residents	Cohort at least 5% better than CHNA baseline

**Plan to evaluate the impact:**

Quantitative data collection about the program impact will be recorded collected during at time of program completion for participants and compared to overall CHNA measures for similar metrics.



## CHNA IMPLEMENTATION STRATEGY

### FISCAL YEARS 2019-2021

<b>Hospital Facility:</b>	Saint Francis Hospital and Medical Center		
<b>CHNA Significant Health Need:</b>	Obesity		
<b>CHNA Reference Page:</b>	9 and 10	<b>Prioritization #:</b>	2

**Brief description of need:**

Chronic health conditions continue to remain an area of prioritized health need for Hartford residents. Residents continue to experience high rates of chronic health conditions and associated morbidity, particularly for obesity, diabetes, cardiovascular disease. A chronic health condition is one that persists over time and typically can be controlled but not cured. According to the CDC, chronic disease is the leading cause of death and disability in the U.S. By 2020 it is estimated that 81 million Americans will have multiple chronic conditions. A healthy diet and physical activity play an important role in preventing and managing obesity.

**Goal:** Improve community member health through the Step Up, Eat Up, & Drink Up Health Challenge: Increase daily steps and physical activity; Increase daily servings of fruit & vegetables; Increase daily water intake. And reduce the prevalence of obesity among Hartford residents.

**SMART Objective:**

Increase the physical activity level and consumption of fruit & vegetables among community participants by 15% while reducing their soda consumption by 15% during each of the three challenge periods up to January 2021.

**Actions the hospital facility intends to take to address the health need:**

Strategies	Timeline			Committed Resources		Potential Partners
	Y1	Y2	Y3	Hospital	Other Sources	
Ensure that that community is able to access community based services by offering a fully integrated program website that includes health information, capability to answer program questions and the opportunity to sign up for numerous health classes and events	x	x	x	Hospital staff, New England 61 Day Challenge budget and administrative support	In-kind staff time, resources and services from community partners	New agencies for promotion – local Fox Affiliate  Other Hartford based hospitals.  Big Y grocery  City of Hartford  UCONN
Comprehensive Daily and Weekly Health tips email and social media campaign along with video presentations for the community partners and the local news media	x	x	x			

Expand the availability of community based services by offering nutrition education, stress management, diabetes awareness, and cooking and wellness outreach activities.	x	x	x			
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**Anticipated impact of these actions:**

CHNA Impact Measures	Baseline ( Red Cap Survey)	Target Measure
How often engaged in Physical Activity at least 3 times a week	Baseline to be determined at start of challenge	Upon program completion measure will be 10% better than baseline.
Number of servings of Fruits per Vegetables per week	Baseline to be determined at start of challenge	Upon program completion measure will be 10% better than baseline.
Number of Sugary Drinks in past 7 days	Baseline to be determined at start of challenge	Upon program completion measure will be 10% better than baseline.

**Plan to evaluate the impact:**

Research team at the University Of Connecticut to analyze the quantitative statistics of each challenge period with full assessment planned by June 2021. Qualitative data about the program impact collected during each challenge and full review by June 2021. Plan to examine the ability to track access, referrals and enrollment of the cohort group during period to health resources offered by the hospital system and community partners.

Adoption of Implementation Strategy

On January 31, 2020, the 2019-2021 Implementation Strategy for addressing the community health needs identified in the 2019 Community Health Needs Assessment was approved by the authorized body of Trinity Health of New England.

  
Carlos Brown (Feb 3, 2020)

Carlos Brown  
Regional Vice President, Community Health and Well Being

Feb 3, 2020

Date