Hospital *for* Special Care

We Rebuild Lives.

Community Health Needs Assessment (CHNA) 2019

March 2019

Community members and key informants (representatives of organizations that serve or support Hospital for Special Care's community) were surveyed regarding health status, services needed, and barriers to care. Results of surveys and research on state and national data are presented here, with identified health needs prioritized. Following approval of this report by the Hospital for Special Care (HSC) Board of Directors, an implementation strategy will be developed toward impacting those needs in the next three years.

As a requirement of the Affordable Care Act (ACA), not-for-profit hospitals in the United States complete a Community Health Needs Assessment (CHNA) every three years. Once needs are identified, the hospitals create an implementation strategy to outline programs to meet those needs and to track the outcomes of the programs. This process was created to assure that, as tax-exempt organizations, hospitals are working with their communities to meet the health needs of residents. HSC performed an assessment in 2016 and has been working to impact the stated needs for the last three years. Program progress is included in this report. Details of ACA requirements are in Attachment 1.

The main focus of this report is the results of our 2019 CHNA. The data collected will impact HSC's decisions on programs and services for 2019 – 2021. Acute care hospitals usually consider their "community" to be a geographic area surrounding their facilities. At HSC, we define our community as individuals living with chronic conditions or physical disabilities, statewide. This definition impacts the population we survey, the comparative data we collect, and the services we offer.

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INTRODUCTION

Hospital for Special Care

Hospital for Special Care (HSC) is the 4th largest, free-standing long-term acute care hospital (LTACH) in the United States and one of the nation's two LTACHs serving adults and children. Established in 1941 as The New Britain Memorial Hospital, it was a municipal hospital for "the medical and surgical treatment of all persons suffering from chronic or other diseases." Today Hospital for Special Care provides a comprehensive continuum of care for complex rehabilitation and chronic disease for both children and adults, including 228 inpatient beds and a broad range of highly specialized outpatient services.

HSC is recognized for advanced care and rehabilitation in:

- Pulmonary, including COPD and ventilator weaning and management
- Brain injury, including stroke
- Medically-complex pediatrics
- Neuromuscular disorders
- Spinal cord injury
- Cardiac, including congestive heart failure(CHF) and left ventricular assist device (LVAD)
- Autism spectrum disorders

HSC is an independent, not-for-profit organization serving Connecticut, the New England region and beyond at facilities located in Hartford, New Britain and Middletown. HSC collaborates with key stakeholders, including patients, advocates, physicians, hospital systems, state and federal agencies, payers, human service organizations and our community to address the most challenging health care issues.

The hospital's main campus features walking paths and flower gardens designed to enhance the patient experience. Therapeutic horseback riding, adaptive sports, a comprehensive aquatics and fitness center and extensive arts programs enhance quality of life for both patients and community members. At Hospital for Special Care we believe that people living with disabilities should have every opportunity to pursue their dreams.

Mission Statement

- We will ensure exemplary care within our continuum, with the active involvement of those we serve, so that they can achieve enduring improvements in their quality of life.
- We will anticipate and be responsive to changing needs of our communities and a changing healthcare environment by creating an innovative, fiscally sound, cost effective system of care.
- We will support the practice of rehabilitation and continuing medical care through research and education.
- We will create a work environment and climate where employees are supported to provide excellent care, and find opportunities for personal and professional growth.
- We will be, in all of the above, responsive and accountable to our communities, for whose benefit we exist.

Demographics of HSC's Community and Connecticut

HSC defines our community as individuals living with chronic conditions or physical disabilities, statewide.

Catastrophic illnesses and accidents occur regardless of personal demographics, income levels, insurance coverage, or ability to pay for care. HSC's clinical expertise in advanced care, commitment to patient-centered, multi-disciplinary approaches and state of the art technology provide critical resources for patients throughout the state and region.

In the past two years our clinicians and medical staff cared for:

- patients from 162 of Connecticut's 169 towns
- children with autism spectrum disorder (ASD) from 66% of CT towns
- inpatients admitted from 74% of CT towns
- patients from 14 other states

Our patient population and community participants in ancillary programs and services represent a cross-section of state residents. Connecticut demographics are detailed in Attachment 2.

HSC provides care to the highest percentage of patients eligible for Medicaid of any hospital in Connecticut. Approximately 75 percent of HSC patients receive Medicaid benefits, as the nature of their disease process or critical injury has exhausted their family's financial resources. While many of our newly admitted inpatients have healthcare coverage, many become Medicaid-eligible during their stay. Our social workers and case managers support patient and family efforts through the Title XIX application process. All of our healthcare programs accept patients with Medicaid coverage. Community-based programs have free services or sliding scale services and depend on philanthropic support.

Previous Community Health Needs Assessments

HSC partnered with The Hospital of Central Connecticut (HOCC), a neighboring not-for-profit acute care hospital, to complete health needs assessments for residents of the greater New Britain area in 2007 and 2013.

HSC conducted a 2016 CHNA independently, gathering data to help refine our implementation strategies. We created an online survey, using typical questions posed on past health needs surveys, with added questions specific to our targeted population. Telephone surveys and paper surveys were offered as alternatives to the on-line survey. Translation was offered for those who would prefer to complete the survey in a language other than English.

2016 CHNA
RESULTS OF THE IMPLEMENTATION PLAN

The 2016 CHNA report and Implementation Plan were made available on the HSC website (https://hfsc.org/about/) and in our Health Services Library. Opportunities for public comment on the CHNA were provided however no written comments were received. A summary of the progress on the 2016 implementation strategies is provided as Attachment 3.

HSC co-hosted a meeting of key informants to discuss potential efforts to meet community health needs with The Hospital of Central Connecticut following the completion of each organization's 2016 CHNA. That meeting evolved into the Greater New Britain Community Providers Network, a network comprised of more than two dozen health and human service providers, and continues to meet regularly to address the health needs and well-being of our communities.

2019 CHNA METHODOLOGY

Data included in this assessment was obtained through surveys of community members and key informants, and statistics from related government and healthcare organizations. Most data was collected from November 2018 - January 2019. We solicited and obtained input from individuals across the state and a variety of organizations. HSC appreciates the time and information shared by everyone who completed a survey.

Collection processes

We used a community member survey to identify the significant health needs. This survey offered insight directly from individuals within HSC's community. A key informant survey targeted organizations that work with individuals within our statewide community.

Additional data sources were utilized to ensure comprehensive analysis of the unique challenges faced by individuals living with chronic conditions or physical disabilities. Primary sources of data included:

- United States Census Bureau
- State of Connecticut Department of Public Health
- DataHaven (New Haven, CT)
- American Lung Association
- CDC - Disability and Health Data System (DHDS)
- CDC - National Center for Health Statistics (NCHS)
- AARP Public Policy Institute
- American Community Survey (ACS) Indicators 2016
- Health and Behavioral Risk Factor Surveillance System (BRFSS) Indicators (Source: https://www.udsmapper.org/benchmarks.cfm)

Community member survey

An important component of the CHNA is the data provided by community members. For the 2019 assessment, we used the 2016 online survey, adding clarifying questions and timely topics. Telephone surveys and paper surveys were again offered as alternatives to the on-line survey. Translation was available for those who preferred to complete the survey in a language other than English.

The survey was distributed widely throughout the state using a variety of methods:

- Mailings, both email and postal mail, to 3,000 participants in HSC programs including aquatic fitness center members, therapeutic horseback riding participants, adaptive sports and inclusive recreation attendees, and HSC volunteers
- Paper surveys and the link to the online survey were distributed to outpatients in our physicians clinic, therapy services, and Autism Center
- Paper surveys and the link to the online survey were distributed at several HSC support groups
- Survey availability was promoted on multiple HSC social media channels with more than 3,000 followers resulting in a minimum of 1,500 exposures, as well as multiple shares from collaborating organizations and individuals familiar with HSC
- Requests were sent to collaborative organizations (Spinal Cord Injury Association-CT, Brain Injury Alliance-CT, Muscular Dystrophy Association-CT, ALS Association-CT) asking them to use email, social media, and newsletters to promote the HSC survey to their members

Multi-channel and media distribution strategies reached a diverse group of Connecticut residents, including medically underserved, low-income and minority populations.

Key informant survey

The CHNA process also collected data from organizations across the state representing our community members and populations historically impacted by disparities in access to care and health outcomes. HSC regularly works with facilities, organizations and associations that support our community. An online key informant survey was created and distributed to individuals representing 57 organizations, asking each to explain the priority health needs of HSC community members served by their organization. Attachment 4 lists the organizations.

SUMMARY OF NEEDS ASSESSMENT SURVEYS WITH COMPARISON DATA

Community Member Survey

Online and paper surveys were completed by nearly 260 Connecticut residents between December 2018 and February 2019. Common health issues reported reflect statewide and national trends.

Data on each topic is discussed in this section. The complete survey results are in Attachment 5. Available state and/or national statistics are included in the tables as comparison data.

Comparison sources:

- The 2018 DataHaven Community Wellbeing Survey conducted by the Siena College Research Institute collected information from 16,043 randomly-selected adults in Connecticut from March 6 to November 29, 2018. Data is available in statewide and regional documents: http://www.ctdatahaven.org/reports/datahaven-community-wellbeing-survey.

- Disability and Health Data System ("DHDS") offers a great deal of 2016 data on individuals living with disabilities in Connecticut and the United States: https://www.cdc.gov/ncbddd/disabilityandhealth/dhds/index.html

- National Center for Health Statistics ("NCHS") offers data on the United States and the northeast region from 2017: https://www.cdc.gov/nchs/about/index.htm.

General Health Status

HSC community members rate their overall health as lower than state and national data, yet most report relatively few days of poor/fair health. 59% report their weight is higher than desired, a considerable decrease from the 2016 survey response of 70%.

Chronic Illnesses and Conditions

HSC offers a wide range of inpatient and outpatient services and community programs for individuals with chronic conditions. When asked "Has a doctor, nurse, or other health professional ever told you that you have a chronic illness or condition?" 70% of people surveyed by HSC responded in the affirmative. Questions posed in the survey provide details on the challenges these individuals experience within their community. Items of concern include the number of individuals reporting asthma, heart disease, pulmonary disease, and depression or mental health issues.

Q9. Which chronic illnesses or conditions do you have?	HSC Survey	DataHaven	DHDS
Addiction disorder	3%		
Asthma	17%	15%	
ASD (autism spectrum disorder), Asperger syndrome	2%		
Cardiac: coronary heart disease, congestive heart failure (CHF), angina	20%	6%	9%
Pulmonary disease: COPD, emphysema, chronic bronchitis, pulmonary fibrosis	40%		13%
Depressive disorder, dysthymia, major depressive disorder	10%		
Diabetes	16%	10%	16%
Mental health issues	10%		
Memory loss, dementia, Alzheimer's disease	1%		
Neuromuscular disease: ALS, Muscular Dystrophy, Parkinson's Disease	6%		
Stroke or CVA	1%		6%
Other (wide variety of issues, most incorporated above)	58%		

Most HSC respondents are receiving follow-up treatment and monitoring and take prescribed medications for the condition on a regular basis. Those that responded negatively say they are not currently in need of treatment or medication. Only 5% have not seen a health professional in the past year.

Disability

A much higher percentage of HSC Survey participants report physical disabilities (43%) than other state data sources (DHDS 16%).This is not surprising since many respondents were somehow connected the hospital or its community programs. Only 2% are limited in activities due to mental or emotional problems. DHDS and AARP data breaks out disability types nationally and in Connecticut respectively:

Percent of adults with disabilities: DHDS data, adults age 18+	
Mobility disability	10%
Cognitive disability	9%
Independent living disability	5%
Self-care disability	3%
Have no disability	79%

AARP Public Policy Institute Disability Rates, 2016				
	Connecticut	Percent	Rank	US
People ages 65+ with disabilities				
Self-care difficulty	45,000	8%	22	8%
Cognitive difficulty	45,000	8%	30	9%
Any disability	176,000	32%	44	35%
People ages 18-64 with disabilities				
Self-care difficulty	28,000	1%	47	2%
Cognitive difficulty	87,000	4%	42	5%
Any disability	192,000	9%	47	11%

Exercise / Activities

Most HSC Survey respondents did not report frequent falls or falls that necessitated a visit to their physician. About 22% of respondents use a cane or walker and 13% use some type of oxygen equipment. Despite 33% of HSC community members relying on a variety of DME (durable medical equipment) for ambulation or daily care, they are more likely than other state residents to exercise one to four days each week and nearly the same number exercise five to six days per week.

Tobacco, Alcohol and Drug Use

The number of HSC respondents who smoke every day or some days is only 10%, compared with the general public rate of 25% and the statewide rate of individuals living with disabilities of 27%. As an LTACH, many of HSC inpatients and outpatients have pulmonary diseases, making smoking cessation an essential component of our programs. All of the individuals who currently smoke have tried to quit during the last year. Most were successful.

The HSC Survey did not include a question on e-cigarettes or vaping. DataHaven's question shows 36% of people age 18-34 have tried vaping. A CT State Department of Public Health study found many reasons teens choose e-cigarettes including their availability in flavors and because they believe e-cigarettes are less harmful than other forms of tobacco.[1]

Ten percent of HSC Survey respondents say they have felt the need to decrease use of alcohol or drugs. Of those who said "Yes" to the need to decrease consumption, only two were not successful.

Emotional Health

HSC respondents report more days of "feeling down" (44%) than the state average (30%). Given that 10% of people reporting chronic conditions/illnesses include depression and 10% include mental health issues, this topic will be further explored. HSC provides psychiatric care, medication management, psychological counseling, marriage and family therapy and applied behavioral analysis within the scope of current inpatient and outpatient rehabilitation and chronic care programs. These services are provided for children and youth diagnosed with Autism Spectrum Disorder and as secondary to a patient's medical diagnoses.

Access to Healthcare

The data surveys reported show more than 90% of Connecticut residents have health care coverage, have one or more healthcare providers, have had a routine check-up in the last year, and usually seek care at a doctor's office or walk-in/urgent care center.

[1] https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/hems/tobacco/PDF/2017-CT-Youth-Tobacco-Survey-Results.pdf?la=en

Q22. Do you have any kind of health care coverage?		
	No	Yes
HSC Survey	1%	91%
DataHaven	5%	94%
DHDS: 92% of persons age 18+ living with disabilities have healthcare coverage		

Q22. What type of coverage?	HSC Survey	DataHaven
Insurance obtained through a current or former employer or union	54%	57%
Insurance purchased directly from an insurance company	12%	11%
Medicare	47%	23%
Medicaid, Medical Assistance, HUSKY, or any kind of government-assistance plan	16%	7%
Medicare supplement	5%	
From family member	4%	
Other (HSC added into above categories)		5%

Over 90% of people in both HSC and DataHaven surveys said they had no problem obtaining needed prescription medicines and they were able to obtain needed medical care. However, 6% to 9% of respondents could not afford their medications and took them less frequently. These are small, but concerning, percentages and will be explored for opportunities to improve.

The individuals reporting challenges in receiving medical care offered similar reasons. Difficulty obtaining transportation to medical appointments was reported in the 2016 CHNA. Some improvement has been accomplished, but it remains a reason for missed care. The cost of care and their health plans not paying for treatment are the reason for 60% of missed care by HSC respondents. 79% of those surveyed said care by specialist physicians was postponed or not received; they did not have difficultly seeing their regular physicians.

Demographics of Those Surveyed

Individuals from 51 zip codes responded to the HSC Survey. Despite the wide distribution of surveys and online links, the demographics of individuals who completed surveys do not reflect the diverse populations statewide and served by HSC. Those individuals most acutely impacted by disparities in access to health care, including individuals living in poverty or who are asset-limited, income constrained, individuals with low English proficiency, lacking legal residency or impacted by mental illness or addiction may not be fully reflected in the data collected. The experience of these populations, which may include distrust of healthcare institutions and the difficulties they may experience in navigating health care systems, may be underrepresented.

Rapidly expanding access to health care information, from apps to teladoc systems may be beginning to bridge some gaps in access to information, but have limited utility for assisting patients with more complex episodes of care.

Caregivers (HSC Survey questions)

A number of HSC respondents (29%) serve as caregivers to family or friends While tasks performed are varied, providing transportation and maintaining the home are the top two tasks. Caregivers report a number of serious difficulties as a result of their responsibilities, including stress and the impact on time for themselves, family, and work.

When asked what support would help the most with caregiving responsibilities, the top response involved coordination of care and providing care (availability, affordability, reliability).

Persons Receiving Care

Children and adult children comprised the largest group receiving care.

Q46. What is the person's relationship to you? (Top four responses)	
Child: biologic, step, adoptive, foster	27%
Parent	23%
Non-relative	22%
Spouse, partner	11%

HSC Survey respondents who said they are providing care to someone with health needs were asked the same questions about the individuals receiving care.

Overall Health of Persons Receiving Care

Although the ratings of overall health vary quite a bit, they are generally lower than that of the survey respondents. 46% were reported to be overweight.

Chronic Illnesses and Conditions of Persons Receiving Care

Eighty percent of individuals receiving care have been told by a doctor, nurse, or other health professional that they have a chronic illness or condition. Memory loss and pulmonary disease are the most reported conditions. Persons receiving care are more likely to have seen a health professional multiple times in a year.

Although underrepresented in the survey responses, the most recent report from the Centers for Disease Control and Prevention notes that approximately 1 in 59 children in the United States have an autism spectrum disorder (ASD). The complex needs of this population, in Connecticut and across the country, overwhelm the capacity of families, acute care facilities, schools and traditional human service providers. A recent Kaiser Health News article, *Nowhere to Go: Young People With Severe Autism Languish in Hospitals*, documents a national crisis that has become all too familiar in Connecticut.[2]

[2] https://khn.org/news/for-thousands-of-autistic-teens-hospital-ers-serve-as-home/ September 26, 2017.

Q58. Which chronic illnesses or conditions does the person have?	
Memory loss, dementia, Alzheimer's disease	35%
Pulmonary disease: COPD, emphysema, chronic bronchitis, pulmonary fibrosis	29%
Cardiac: coronary heart disease, congestive heart failure (CHF), angina	20%
Depressive disorder, dysthymia, major depressive disorder	20%
Diabetes	18%
Neuromuscular disease: ALS, Muscular Dystrophy, Parkinson's Disease	18%
Mental health issues	16%
Stroke or CVA	11%
Asthma	9%
Brain Injury, TBI, ABI, other	9%
ASD (autism spectrum disorder), Asperger syndrome	5%
Addiction disorder	2%
Other (wide variety of issues, most incorporated above)	50%

Disabilities of Persons Receiving Care

Nearly 70% of people receiving care are described as being limited in activities due to physical problems. Common challenges are walking, balance, breathing, personal care, and driving. Brain injuries and pulmonary diseases are the most common causes of the limitations.

Despite living with disabilities, two-thirds of individuals are described as exercising regularly and not having emotional problems. Nearly three-quarters of individuals use equipment such as walkers and wheelchairs to assist with mobility.

Tobacco, Alcohol and Drug Use by Persons Receiving Care

Like the HSC survey respondents, persons receiving care have a much lower rate of smoking than other Connecticut residents. The rate of persons receiving care needing to cut down on drinking or drug use is half that of community respondents.

Access to care

The reported experience of these individuals' access to health professionals is similar to caregivers. 78% of the individuals have health coverage. 60% have Medicare coverage, 31% have government assistance plans, and 31% have insurance through a current or former employer. Only 4% do not have one person or place serving as their personal doctor or healthcare professional. 89% of the individuals usually receive care at a doctor's office and nearly all have had a routine checkup within 12 months.

Most respondents report no problem with access to prescription medications. 11% of individuals postponed or could not get needed medical care. The top reasons were lack of transportation and not getting an appointment soon enough. Unlike survey respondents who had difficulty accessing specialists, the persons receiving care had more trouble seeing a primary care physician (67%).

Key Informant Survey

Online surveys were completed by 27 key informants, allowing us to obtain input on the health needs of the group(s) they represent. In addition to individuals living in poverty, medically-underserved communities and communities of color, data on individuals with chronic conditions or physical disabilities was provided by organizations representing these specific groups.

The demographic data collected reflects a wide variety of respondent organizations representing:

Community Affiliation	
Non-profit organization	52%
Community member	48%
Social services organization	24%
Education services	24%
Youth services	19%
Faith-based organization	19%
Business sector	14%
Transportation services	14%
Healthcare organization/association	10%
Government	10%
Housing services	10%
Aging services	10%
Mental or behavioral health services	10%
Hospital or other healthcare facility	14%
Healthcare provider	5%
Cultural organization	5%
Clothing and food services	5%
Homeless services	5%

Top health issues

Key informants (KI) ranked most of HSC's specialties as middle or lower priorities. Although the conditions treated by HSC are often devastating, debilitating, and life-long, these patient populations are often marginalized by traditional providers lacking resources to meet their complex needs. This situation reinforces the need for our medical home (MH) services, specialty care centers of excellence and primary care specialty practices (PCSP) that offer individuals living with autism, brain injuries, neuromuscular diseases, pulmonary disease, strokes and spinal cord injuries a full range of services.

Access to care

Regarding access to care, KI believe most people can now access primary care providers and that some of the providers accept Medicaid and other state assistance programs. However, accessing specialists remains a challenge for some of the patients/clients with whom they work, as is obtaining mental and behavioral healthcare, and finding providers fluent in their preferred

language. Even when people can obtain healthcare appointments, if they do not drive, transportation may not be available to get them to the appointments.

Choice of service location

KI believe people with healthcare coverage generally go to a doctor's office (57%) when they need care, with some using health clinics and walk-in/urgent care centers (5% and 19%). Lack of convenient office hours and long wait times may influence their choice for walk-in centers. It is the opinion of KI that 90% of individuals who are uninsured or underinsured choose and emergency department for care because they can go at any time of day and cannot be turned away.

Underserved populations

The expected populations mentioned by KI as underserved by existing healthcare systems are immigrants or refugees, and those who are uninsured, low-income, or homeless. Again, groups typically served by HSC are not at the top of the list, but they are seen as having difficulty obtaining care. The experiences of individuals representing multiple under-served groups, including individuals of color living in economically challenged communities who experience chronic or catastrophic disease or injury, are difficult to capture through available data sources or key informant interviews.

Barriers to care

Significant barriers to care perceived by KI include individuals' healthcare plans not paying for a treatment, cost of healthcare coverage (premiums, deductibles, co-pays, prescriptions, etc.), being uninsured, the inability to navigate the healthcare system, basic needs of the individual/family not being met, and lack of transportation to appointments.

As an LTACH, nearly all of HSC's patients are admitted following a stay in an acute care hospital. HSC works with many patients and their families to apply for eligible coverage not only for their stay at HSC, but for future healthcare treatments.

Services and resources missing in the community

KI cited multilingual services and health education/information/outreach as the most needed resources they see as missing in the community. Also highly ranked were prescription assistance, substance abuse treatment, transportation to medical services and low-cost care.

Challenges to maintaining a healthy lifestyle

While healthy foods, habits, and activities are well established as factors, there are many challenges and barriers to adopting and maintaining a healthy lifestyle. KI cite a number of common challenges (family and work responsibilities, finding time for exercise) as well as challenges specific to the described community. These include the inability to afford healthy foods and their unavailability, chronic conditions or physical disabilities that make exercise difficult, depression, and for some, the absence of a location to exercise.

Being done well

KI see some helpful trends and services that can improve health and the quality of life. Community health centers and federally qualified health centers (FQHC) make care available to more people without healthcare coverage. Urgent care centers offer more flexible schedules. There are some free or low-cost programs providing transportation to medical appointments but they are struggling to meet the demand for their services.

Continuing improvements

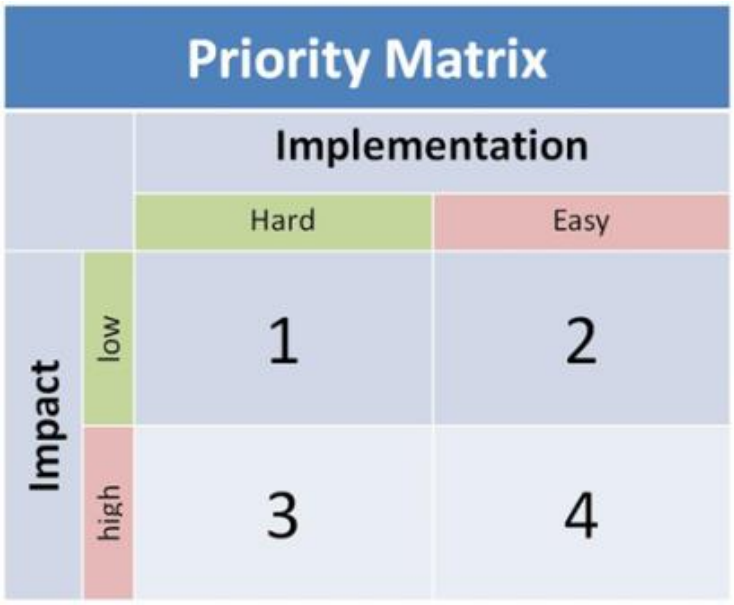
Many KI agree that continued and expanded education on health topics is key to helping community members to achieve healthy lifestyles. One suggests education about prevention of illness and chronic diseases beginning early in life and in popular media such as television. Other KI see potential in outreach programs for educating and reinforcing healthy choices and assisting in navigating the healthcare system.

PRIORITIZED COMMUNITY HEALTH NEEDS

The health needs stated or implied by the community member survey—targeted groups like those served by HSC—differ from the priorities measured by the key informant group. Most key informants serve a much broader range of the general population than our LTACH facility, which impacts their priorities. Our hospital does not provide all of the types of services requested, but we do have the ability to impact several important needs. When comparing our community member survey to state and national statistics, differences are noticeable. Many of those currently served by HSC's programs demonstrate good choices (healthcare coverage and access, not smoking, regular medical checkups and treatment of chronic conditions). There are identified needs for assistance in special areas.

Needs documented in the 2016 CHNA have been addressed by new or expanded HSC programs and we will continue to strive to meet these needs for additional community members. The data collected in the 2019 assessment provides updated information on our community, supporting our choices in future programming. We will continue to explore needs, strategies, and resources available to meet the needs of our identified community.

The HSC community health needs team and clinical operations leadership examine the data, select needs, and prioritize those needs. As in 2016, we use a simple but effective tool employed regularly by our Lean process teams to rank projects by the level of impact (high or low) and the ability of HSC to implement the project (hard or easy). Using this method, HSC identified and prioritized four healthcare needs.



Prioritization Matrix Source: CONNSTEP a CBIA affiliate Hartford, CT www.connstep.org

Access to Care

Rated as *high impact, hard to implement*

To ensure access to coordinated, patient-centered specialty care and care management services, HSC will provide care to existing and new patients in our medical home programs and advocate on systems issues. Issues include reimbursement for care coordination and nurse navigators, and educating patients and families on navigating healthcare systems. Methods will include:

- Partnering with patient advocacy orgs such as ALSA-CT and MDA to connect patients to transportation resources
- Promoting the work our partners are doing to enhance ancillary services
- Offering multidisciplinary clinics so outpatients can see all clinicians in one visit
- Hosting partners on-site to help patients navigate resources
- Providing evidence of the success of HSC's models of care

Autism Services

Rated as *high impact, hard to implement*

HSC will continue to add patients to our medical home program for autism. A new building is planned for our inpatient unit, expanding the program to twelve private beds. Expansion of offered services will include an ABA (applied behavioral analysis) clinic and a new PHP (partial hospitalization program). These services help to divert children and adolescents on the spectrum from Emergency Departments.

Increasing Physical Activity Levels

Health issues include: obesity, diabetes, stroke prevention, asthma, and pulmonary and cardiac disease

Rated as *high impact, easy to implement*

HSC fitness programs offer opportunities to reduce obesity, encourage heart-healthy lifestyles, and introduce individuals to adaptive sports and inclusive recreation programs. Our adaptive sports program and member support to our Aquatic and Fitness Center are constrained by our ability to raise philanthropic dollars. Some examples of programs:

- Team Special Care: Employees and families, former patients and families, community members are encouraged to participate in Hartford Marathon Foundation races and walks (the Marathon, MahoneySabol 5K) and the ALS Association, Muscular Dystrophy Association, and other organizations' statewide walks
- Adaptive Yoga is demonstrated in the community and at HSC support groups, with participation in HSC programs invited

Dementia, Memory Loss

Rated as *high impact, easy to implement*

Aging demographics in state demonstrate the need to expand access to diagnostic and multidisciplinary care for Alzheimer's disease, dementia and memory loss and to secure resources to expand community education and support for family caregivers. HSC's Center for Cognitive Health is developing these services.

Existing Community Resources

Connecticut has many acute care hospitals that work to meet the healthcare needs of their community members. HSC is part of the continuum of care for these hospitals statewide. In addition, HSC works with a variety of health centers, state offices, and advocacy organizations as we coordinate care and services for our community members. Lists of these groups can be found as Attachments 7 - 10.

HSC also maintains working relationships with a number of additional advocacy and professional organizations via the involvement of our employees in the community. Examples of these organizations:

- The ASD Advisory Council: https://portal.ct.gov/DSS/Health-And-Home-Care/Autism-Spectrum-Disorder---ASD/Autism-Spectrum-Disorder-Advisory-Council
- Medical Assistance Program Oversight Council (MAPOC): https://www.cga.ct.gov/med/
- Connecticut Society for Respiratory Care: https://www.ctsrc.org/

Community Health Needs Not Specifically Addressed by HSC

Using our core competencies in specialized areas, HSC will continue to focus on the needs of individuals living with chronic conditions or physical disabilities. HSC has a history of working with groups throughout the state to develop programs rather than to duplicate care. We look forward to continued partnerships to address needs beyond HSC's scope of care. We routinely promote the work our partners are doing to enhance a range of ancillary services, including:

- Transportation to medical appointments: HSC works with patient advocacy organizations to connect patients to transportation resources and will continue to participate in CHA efforts to improve DSS vendor transportation to medical appointments
- Tobacco and e-cigarettes: HSC will continue to support our partner the American Lung Association in their tobacco cessation programs
- Availability of fresh foods: HSC is beginning a partnership with a community gardening group

NEXT STEPS

Approval of CHNA Report by the Governing Body

The Hospital for Special Care Board of Directors met on March 28, 2019 to review the findings of the CHNA. The report was approved.

Public Access to the 2019 CHNA

This report can be found on the HSC website at: https://hfsc.org/about/. A paper copy is available in the HSC Health Sciences Library.

Approval of Implementation Strategy by the Governing Body

An Implementation Strategy of the prioritized needs will be created with participation of the HSC program managers. The Strategy will be submitted to the Hospital for Special Care Board of Directors for their approval prior to August 15, 2019. [NOTE: approved July 25, 2019]

Implementation Strategy

Upon receiving Board approval:

- The Implementation Strategy will be added to the HSC website and will be available in the HSC Health Sciences Library.
- Program managers will work on strategies through 2021.
- Meetings with key informants and service providers will discuss the implementation strategy and potential collaborative efforts.
- Data collection will be ongoing throughout the three-year cycle of this CHNA.

ATTACHMENTS

Attachment 1
ACA Requirements for CHNA - IRS Form 990, Schedule H, Section B

Line	Requirement	Page
3	Conduct a CHNA in the current tax year: CHNA conducted during fiscal year 2018 for Board approval in March, 2019	5
3a	Define the community served: Connecticut residents living with chronic conditions or physical disabilities	4
3c	Resources potentially available to address the needs identified: List of CT healthcare facilities and organizations, Attachments 7- 10	56
3d	Process and methods to conduct the CHNA: 2019 CHNA Methodology	5
3e	A prioritized description of the needs of the community, identified through the CHNA: Prioritization section	17
3g	Process and criteria used to (1) identify health needs as significant (2)prioritizing those needs: Prioritization section	17
3h	Solicited input from persons who represent the broad interests of the community: Key Informant survey	14
3i	Evaluation of the impact of actions taken since the 2016 CHNA: 2016 CHNA Summary of Implementation, Attachment 3	27
5	2019 CHNA input from: Persons representing interests of the community (state/local government with information on health needs; organizations representing the interests): Key Informant Organizations list, Attachment 4 Medically underserved, low-income, and minority populations: Key Informant and Community survey results, Attachments 4 - 6 Written comment received on the 2016 CHNA and implementation strategy: None Process: time period; how input provided, by whom; medically underserved, low-income, or minority populations represented by organizations; if input not obtained, describe efforts: 2019 CHNA Methodology	 32 32 --- 5
6a/b	CHNA conducted with another hospital or organization: No	---
7a/c 10a 7b	After Board of Directors' approval the 2019 CHNA report and implementation strategy will be available (a) HSC's website and (c) on paper. The report is not available on another website.	20
8	HSC will develop and approve an implementation strategy to meet the health needs identified in the 2019 CHNA prior to August 15, 2019	20
11	HSC is addressing the significant needs identified in the 2016 CHNA; any needs that aren't being addressed are explained: See Line 3i above	---
12a	HSC liable during the tax year for the excise tax for failure to conduct a CHNA?: No	---

Attachment 2
Connecticut Demographics and Data
Page 1 of 4

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

Subject	Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE				
Total population	3,594,478	*****	3,594,478	(X)
Male	1,754,046	+/-337	48.8%	+/-0.1
Female	1,840,432	+/-337	51.2%	+/-0.1
Sex ratio (males per 100 females)	95.3	+/-0.1	(X)	(X)
Under 5 years	186,188	+/-217	5.2%	+/-0.1
5 to 9 years	206,536	+/-2,378	5.7%	+/-0.1
10 to 14 years	225,831	+/-2,341	6.3%	+/-0.1
15 to 19 years	249,777	+/-525	6.9%	+/-0.1
20 to 24 years	245,849	+/-542	6.8%	+/-0.1
25 to 34 years	439,239	+/-548	12.2%	+/-0.1
35 to 44 years	433,401	+/-426	12.1%	+/-0.1
45 to 54 years	535,611	+/-388	14.9%	+/-0.1
55 to 59 years	266,501	+/-2,370	7.4%	+/-0.1
60 to 64 years	229,788	+/-2,363	6.4%	+/-0.1
65 to 74 years	318,515	+/-298	8.9%	+/-0.1
75 to 84 years	167,133	+/-1,719	4.6%	+/-0.1
85 years and over	90,109	+/-1,720	2.5%	+/-0.1
Median age (years)	40.8	+/-0.1	(X)	(X)
Under 18 years	762,732	+/-181	21.2%	+/-0.1
16 years and over	2,928,091	+/-1,176	81.5%	+/-0.1
18 years and over	2,831,746	+/-181	78.8%	+/-0.1
21 years and over	2,674,688	+/-1,625	74.4%	+/-0.1
62 years and over	706,528	+/-2,075	19.7%	+/-0.1
65 years and over	575,757	+/-239	16.0%	+/-0.1
18 years and over	2,831,746	+/-181	2,831,746	(X)
Male	1,363,518	+/-214	48.2%	+/-0.1
Female	1,468,228	+/-157	51.8%	+/-0.1
Sex ratio (males per 100 females)	92.9	+/-0.1	(X)	(X)
65 years and over	575,757	+/-239	575,757	(X)
Male	248,048	+/-174	43.1%	+/-0.1
Female	327,709	+/-143	56.9%	+/-0.1
Sex ratio (males per 100 females)	75.7	+/-0.1	(X)	(X)

Connecticut Demographics and Data
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Subject	Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
RACE				
Total population	3,594,478	*****	3,594,478	(X)
One race	3,483,824	+/-3,017	96.9%	+/-0.1
Two or more races	110,654	+/-3,017	3.1%	+/-0.1
One race	3,483,824	+/-3,017	96.9%	+/-0.1
White	2,757,064	+/-5,474	76.7%	+/-0.2
Black or African American	376,240	+/-2,518	10.5%	+/-0.1
American Indian and Alaska Native	9,385	+/-867	0.3%	+/-0.1
Cherokee tribal grouping	710	+/-284	0.0%	+/-0.1
Chippewa tribal grouping	155	+/-82	0.0%	+/-0.1
Navajo tribal grouping	46	+/-45	0.0%	+/-0.1
Sioux tribal grouping	40	+/-36	0.0%	+/-0.1
Asian	156,450	+/-1,587	4.4%	+/-0.1
Asian Indian	57,571	+/-2,647	1.6%	+/-0.1
Chinese	37,834	+/-2,111	1.1%	+/-0.1
Filipino	12,930	+/-1,337	0.4%	+/-0.1
Japanese	3,820	+/-562	0.1%	+/-0.1
Korean	10,284	+/-1,050	0.3%	+/-0.1
Vietnamese	9,523	+/-1,068	0.3%	+/-0.1
Other Asian	24,488	+/-1,716	0.7%	+/-0.1
Native Hawaiian and Other Pacific Islander	931	+/-212	0.0%	+/-0.1
Native Hawaiian	246	+/-136	0.0%	+/-0.1
Guamanian or Chamorro	160	+/-83	0.0%	+/-0.1
Samoan	180	+/-121	0.0%	+/-0.1
Other Pacific Islander	345	+/-155	0.0%	+/-0.1
Some other race	183,754	+/-5,315	5.1%	+/-0.1
Two or more races	110,654	+/-3,017	3.1%	+/-0.1
White and Black or African American	31,768	+/-1,809	0.9%	+/-0.1
White and American Indian and Alaska Native	12,494	+/-669	0.3%	+/-0.1
White and Asian	20,176	+/-1,194	0.6%	+/-0.1
Black or African American and American Indian and Alaska Native	5,191	+/-861	0.1%	+/-0.1
Race alone or in combination with one or more other races				
Total population	3,594,478	*****	3,594,478	(X)
White	2,846,570	+/-5,500	79.2%	+/-0.2
Black or African American	432,616	+/-2,326	12.0%	+/-0.1
American Indian and Alaska Native	36,335	+/-1,610	1.0%	+/-0.1
Asian	184,858	+/-908	5.1%	+/-0.1
Native Hawaiian and Other Pacific Islander	4,755	+/-540	0.1%	+/-0.1
Some other race	211,484	+/-5,871	5.9%	+/-0.2
HISPANIC OR LATINO AND RACE				
Total population	3,594,478	*****	3,594,478	(X)
Hispanic or Latino (of any race)	551,916	*****	15.4%	*****
Mexican	57,969	+/-3,357	1.6%	+/-0.1
Puerto Rican	286,751	+/-4,468	8.0%	+/-0.1
Cuban	12,271	+/-1,292	0.3%	+/-0.1
Other Hispanic or Latino	194,925	+/-4,517	5.4%	+/-0.1
Not Hispanic or Latino	3,042,562	*****	84.6%	*****
White alone	2,446,049	+/-1,131	68.1%	+/-0.1
Black or African American alone	350,820	+/-1,829	9.8%	+/-0.1
American Indian and Alaska Native alone	5,201	+/-446	0.1%	+/-0.1
Asian alone	154,910	+/-1,516	4.3%	+/-0.1
Native Hawaiian and Other Pacific Islander alone	665	+/-185	0.0%	+/-0.1
Some other race alone	11,615	+/-1,268	0.3%	+/-0.1
Two or more races	73,302	+/-2,470	2.0%	+/-0.1
Two races including Some other race	4,809	+/-825	0.1%	+/-0.1
Two races excluding Some other race, and Three or more races	68,493	+/-2,381	1.9%	+/-0.1
Total housing units	1,507,711	+/-283	(X)	(X)

Connecticut Demographics and Data
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Subject	Connecticut			
	Estimate	Margin of Error	Percent	Percent Margin of Error
CITIZEN, VOTING AGE POPULATION				
Citizen, 18 and over population	2,599,794	+/-4,066	2,599,794	(X)
Male	1,242,583	+/-2,884	47.8%	+/-0.1
Female	1,357,211	+/-2,154	52.2%	+/-0.1

https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

Although the American Community Survey (ACS) produces population, demographic and housing unit estimates, it is the Census Bureau's Population Estimates Program that produces and disseminates the official estimates of the population for the nation, states, counties, cities, and towns and estimates of housing units for states and counties.

Explanation of Symbols:

1. An '**' entry in the margin of error column indicates that either no sample observations or too few sample observations were available to compute a standard error and thus the margin of error. A statistical test is not appropriate.
2. An '-' entry in the estimate column indicates that either no sample observations or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest interval or upper interval of an open-ended distribution.
3. An '-' following a median estimate means the median falls in the lowest interval of an open-ended distribution.
4. An '+' following a median estimate means the median falls in the upper interval of an open-ended distribution.
5. An '***' entry in the margin of error column indicates that the median falls in the lowest interval or upper interval of an open-ended distribution. A statistical test is not appropriate.
6. An '*****' entry in the margin of error column indicates that the estimate is controlled. A statistical test for sampling variability is not appropriate.
7. An 'N' entry in the estimate and margin of error columns indicates that data for this geographic area cannot be displayed because the number of sample cases is too small.
8. An '(X)' means that the estimate is not applicable or not available.

Connecticut Demographics and Data
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American Community Survey (ACS) Indicators 2016						
New England	CT	ME	MA	NH	RI	VT
% Poverty	11%	14%	12%	9%	14%	12%
% Low-Income	24%	34%	25%	22%	30%	29%
% Not Employed	33%	36%	33%	32%	34%	33%
% Limited English Proficiency	5%	1%	6%	1%	5%	1%
% Less than High School Education	10%	8%	10%	8%	14%	8%
% Uninsured	8%	10%	4%	9%	9%	6%
Source: https://www.udsmapper.org/benchmarks.cfm						

Health and Behavioral Risk Factor Surveillance System (BRFSS) Indicators, 2015						
New England	CT	ME	MA	NH	RI	VT
% Low Birth Weight[1]	8%	7%	8%	7%	8%	7%
% Diabetes	9%	10%	9%	8%	9%	8%
% High Blood Pressure	30%	34%	30%	29%	32%	29%
% Obese	25%	30%	24%	26%	26%	25%
% No Dental Visit	25%	36%	25%	31%	28%	28%
% Delayed Care Due to Cost	11%	9%	9%	9%	10%	8%
% No Usual Source of Care	15%	12%	11%	12%	12%	12%
Source: Health and BRFSS Indicators, 2015 [1]CDC National Center for Health Statistics, Low Birth Weight Rates per 100 live births - https://www.cdc.gov/nchs/pressroom/sosmap/lbw_births/lbw.htm, 2015						

Attachment 3
Community Health Needs Assessment 2016 Implementation Plan and Metrics

Health Need / Strategy	Key Indicator / Metric (reported annually 2016-2018)
Health Need 1: Reduce obesity and overweight by increasing physical activity levels	
Increase enrollment and utilization of the Aquatic Rehabilitation and Fitness Center	While the number of new and renewing members decreased slightly, Silver Sneakers members have increased. The number of visits increased by more than 10,000.
Increase enrollment and utilization of the Adaptive Sports programs	The number of programs offered (basketball, soccer, power soccer, track & field, inclusive recreation) has varied little. The unduplicated count of participants shows a 25% increase and we continue to have inactive participants return. The number of attendees at sessions/events/activities increased by 12%.
Increased activity by Outpatient Therapy patients	Functional improvement is measured before and after therapy
Expand services of Special Care Equipment Exchange (EE)	51% increase in the number of items given away. EE now coordinates requests and donations with six similar programs throughout CT if it cannot meet needs or accept offered items.
Health Need 2A: Enhancing the ability of like groups to communicate and share aspects of their conditions	
Attendance at HSC-based support group meetings	Wide variance depending on the group. The pulmonary group averages 70 people each month, while some groups are quite small by design or as expected due to condition. Participant satisfaction is gauged by the number of individuals that continue to participate.
Measure interest/participation in online support groups	No interest reported by facilitators of the groups. HSC has evaluated available technology as inadequate to assure confidentiality.
Explore options to expand support groups beyond current geographic area, coordinating with local groups	HSC coordinates with organizations such as the ALS Association and Muscular Dystrophy Association who offer meetings throughout the state.
HSC representatives at outside groups	While we have not tracked HSC speakers at other programs, our staff support other organizations as requested.
Explore emerging subjects for new support groups to meet the interests of our target populations	HSC clinical staff has suggested groups which have been started, restarted, or are being explored.
Track number of monthly media hits/listings	Print and online media only sporadically announce meetings; we no longer rely on them. Local papers do not understand readers will travel distances for support groups not offered by local hospitals. Support group meetings are listed on the HSC website calendar every month and are regularly promoted on HSC social media.
Health Need 2B: Support caregivers of our community members	
Establish Caregiver Support Group	Established in October 2016, a small group that reported satisfaction with meetings. Also, caregivers regularly attend all support groups with their family member. The group was put on hold and re-started as a Stroke & Caregivers group.

Health Need / Strategy	Key Indicator / Metric (reported annually 2016-2018)
Provide increased resources for caregivers on HSC website	2016-2018: HSC librarian maintained links on website resources page. Measures of website use were unavailable with the old website. In November 2018, a new website offers a link to Medline Plus; our librarian is available in person or via telephone or email to assist with requests for resources.
Explore opportunities/interest/ participation in utilization of technology to help caregivers communicate as a support group	The hospital has evaluated available technology as inadequate to assure confidentiality.
Health Need 3 Offer education on prevention of slips, trips and falls to individuals who report falls and challenges with ambulation	
Develop education webpage	Page not created (see next strategy)
Develop community education session	2016-2018: Not pursued as other topics became priorities. January 2019: planning began for a 2019 seminar Growth of Dizziness/Balance support group: Small but steady increase in members; the facilitator reports members are more engaged in the group. On-line option: The hospital has evaluated available technology as inadequate to assure confidentiality.
Health Need 4 Improve access to primary care by establishing medical homes, coordinating care for specific groups, providing education on navigating the healthcare system	
Research and implement HSC programs for groups in need: Medical Home [MH] Patient-Centered Specialty Practice [PCSP] Disease Management [DM])	HSC studied the needs of our outpatients, and conducted state and national research. HSC created or expanded six programs serving as MH for patients whose complicated diagnoses may impact routine medical care. Importantly, HSC programs accept Medicaid payment, while many others do not. Details: *Autism Center outpatient care* 2015: NCQA certified as Level 1 PCSP (only one in USA) 2018: certification renewed and increased to Level 3 (highest) Nearly all families consider the Center their MH *Autism Center inpatient care* Jan. 2016 (12/28/15): opened the only autism-specific inpatient unit in CT (8 beds); accepting patients from CT and other states FY 17: 48 patients, FY 18: 112 patients Dec. 2018: based on need (waiting list), expanded to 10 beds Spring 2019 (planning began July 2018): will construct a 12-bed building *Autism Center partial hospitalization program (PHP)* Spring 2019 (planning began July 2018): the new building will include a PHP level of care, serving as either a transition from inpatient to home/school or to prevent the need for inpatient admission when challenges in home/school become too great for the child.

Health Need / Strategy	Key Indicator / Metric (reported annually 2016-2018)
Survey patient interest, utilization, and satisfaction related to HSC services and medical home model	*COPD Disease Management Program* 2017: established the Gawlicki COPD DM program 2018: became our second NCQA certified PCSP *Parkinson's Disease and Movement Disorders Center* 2018: functioned as PCSP; added a nurse care coordinator April 2019: will apply for NCQA certification *Neuromuscular Center* The center has served as a medical home for persons with ALS, MD, Parkinson's, and other neuromuscular diseases throughout this report period and earlier. All programs continue to grow as patients to choose HSC as their medical home. The number of repeat patients and patient surveys demonstrate satisfaction with the programs.
Coordinating care for healthcare needs beyond HSC services and educating patients/family members to navigate healthcare systems	Report of HSC work with inpatients & outpatients: Each patient has different needs and may live in any part of the state; community information and patient care education is prepared on an individual basis. *Autism Center (inpatient and outpatient)* Clinicians work with families, the child's school, and other local support services to develop a behavior plan so expectations will be consistent throughout the child's day. Most families continue to use HSC outpatient services, but if they live too far away, our clinicians help the family to arrange for services in their area. *Adult inpatient units* Each patient's discharge plan includes patient and family education on care and arranging future services. Clinicians work with each family to coordinate homecare and equipment services post discharge. *Adult outpatient services* All of our outpatient nurses are care coordinators, providing patients with resources and teaching them to navigate the healthcare system. The Greater New Britain Community Providers Network formed based on the CHNA implementation plans by HSC (2016) and the Hospital of Central CT (2015), meets every other month. Members or guest speakers present programs relevant to the health and lifestyle of area residents. At HSC, information from the meeting is shared with patient care coordinators.

Health Need / Strategy	Key Indicator / Metric (reported annually 2016-2018)
Health Need 5: Advocate for improved transportation to medical services via public transportation and private transport companies	
Study the impact of transportation issues on outpatients	A number of respondents to the CHNA survey in Nov. 2015 were experiencing problems with transportation to medical appointments. A survey in Dec. 2016 showed a significant decrease in issues. In 2017 and 2018 reports of problems increased (reports were documented and monitored) See next strategy. Some patients drive themselves to medical appointments at HSC but cannot comfortably walk from the car to the entrance. These patients can now request an HSC Security escort.
Participate in CT Hospital Association's (CHA) project with facilities state-wide to improve coordination of medical transportation	April 2016: CHA project worked with state of CT DSS and vendor Logisticare. Some improvement was seen. 2017: When that trend reversed, DSS changed vendor to Veyo but problems persisted. 2018: HSC continues to attend these CHA meetings.
Explore HSC opportunities with Rideshare	Early 2017: HSC met with Rideshare, but did not have a need at the time. The availability of wheelchair accessible vehicles is very limited, so not pursued.
Create & maintain website resources for transportation	No good resources have been located.
Health Need 6 Provide education and support to encourage people to make healthy lifestyle choices	
Provide smoking cessation program	The HSC stand-alone program was discontinued due to low enrollment, despite promotional efforts. Smoking cessation is offered on an individual basis as part of outpatient pulmonary rehabilitation services.
Study offering AA (Alcoholics Anonymous) group at HSC	Strategy was not pursued due to patient privacy and security concerns.
Promote oral health care for adults and children	Special Care Dental Services Clinic (for children) was closed 2017 due to decreased numbers of patients, despite promotional efforts. Other providers now accept Medicaid and offer emergency services and oral surgery. The planned oral health promotion for adults was discontinued with the closing of the children's clinic.
Increase health literacy through access to healthcare information / resources	Attempts to collect data were unsuccessful. There is no accurate count of the number of users of the Health Science Library / Resource Center when librarian is out of the office. The count of clicks on links to the Health Library Database became inaccurate due to pass-through use of the link. The new website (2018) links users to NIH MedlinePlus.
Promote healthy food choices by example (employee habits influence patients & families and employees' families)	Working with the Employee Wellness Committee, HSC Food Services improved the menu for employees & visitors. In 2016 "Meatless Mondays" offered vegetarian entrees and low-calorie desserts were sold on Fridays. In 2017 this changed to a daily

Health Need / Strategy	Key Indicator / Metric (reported annually 2016-2018)
	"healthy options" menu item. Summer farmers markets were offered in 2016 and 2017. Weight Watchers meetings for employees are held on-site (2016-2018).
Health Need 7: Explore collaborative promotion of mental health services, substance abuse treatment, and weight loss and healthy food choice programs	
Referring inpatients & outpatients to community services	*Department of Psychology 2017-present*: outpatients and inpatients are now treated by HSC practitioners, with a minimal number referred out. *Autism Center 2017-present*: the increased number of practitioners at Autism Center allows patients to be treated at HSC, with a minimal number referred out. *Available community services:* Planner shares new provider information with HSC case managers, managers, social workers as presented at Community Forum meetings.

Attachment 4
Key Informant Organizations Contacted

ACT (Advocate Counsel Teach) Services LLC	LISA, Inc. (Living In Safe Alternatives, Inc.)
Adora Homecare	Literacy Volunteers of Central Connecticut
ALS Association of Connecticut	Main Street Foundation
Amberwoods of Farmington	MidState Hospital Medical Center
American Savings Foundation	Muscular Dystrophy Association-Connecticut
Ana Grace Project	NAACP (National Association for the Advancement of Colored People)
Boys & Girls Club of New Britain	Neighborhood Housing Services, NB
Brain Injury Alliance of CT (BIAC)	New Britain EMS (Emergency Medical Services)
Catholic Charities, Archdiocese of Hartford	New Britain Roots (gardens, farmers markets)
Central CT Health District	New Britain Salvation Army
Central CT State University	Okay Industries
City of New Britain	Opportunities Industrialization Center of New Britain
Coalition for New Britain's Youth	Patient Advocate 4 You
Community Foundation Greater New Britain	Prudence Crandall Center (services for victims of domestic violence)
Community Health Centers (Middletown, New Britain, New London, other locations)	SEET Consultants, LLC (cultural competency)
Community Mental Health Affiliates, Inc. (CMHA), central and northwest Connecticut	Senior Transportation Services
Consolidated School District of New Britain	Southington Public Schools
Corporation for Independent Living	Spinal Cord Injury Association-Connecticut
Connecticut Junior Republic	The Friendship Center, NB
Early Childhood Collaborative of Southington	The Hospital of Central Connecticut
Farrell Treatment Center	The Salvation Army (Hartford)
FoodShare	Town of Berlin
Friendship Service Center	Town of Plainville
Hartford Healthcare	Tunxis Foundation
Human Resources Agency of New Britain	United Way
Jerome Home	Wheeler Clinic
Journey Found	YMCA, New Britain
Klingberg Family Centers	YWCA, New Britain
League of Women Voters	

Attachment 5
Community Survey Questions and Results
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Community Members

Q1. How would you rate your overall health?					
	Poor	Fair	Good	Very good	Excellent
HSC Survey	6%	17%	39%	29%	9%
DataHaven-CT	3%	11%	26%	36%	23%
NCHS-US	12%		26%	62%	
NCHS-Northeast	11%		25%	64%	

Q2. During the past 30 days, did you experience poor or fair physical health?					
	0 days	1-2 days	3-5 days	6-9 days	10 or more days
HSC Survey	43%	14%	18%	9%	16%
DHDS	40% of persons age 18+ living with disabilities report physically unhealthy days				

Q3. During the past 30 days, have you been bothered by feeling down, depressed, or hopeless?						
HSC Survey	0 days	1-2 days	3-5 days	6-9 days	10 or more days	
	55%	27%	6%	4%	7%	
DataHaven	0 days	Several days			More than half the days	Nearly every day
	68%	21%			5%	4%

Q4. How often do you get the social and emotional support you need?					
	Never	Rarely	Sometimes	Usually	Always
HSC Survey	4%	8%	19%	40%	30%
DataHaven	5%	6%	18%	31%	39%

Q5. In the past 12 months, have you felt unsafe or physically threatened in your home?		
HSC Survey	No: 97%	Yes: 3% (8 respondents)

Q6. In an average week, how many days do you exercise? (Examples: running, walking, golf, gardening)					
	0 days	1-2 days	3-4 days	5-6 days	Every day
HSC Survey	17%	23%	37%	14%	9%
DataHaven	20%	22%	30%	15%	13%

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Q7. How would you describe your weight?				
HSC Survey	Underweight	At your desired weight	10-25 pounds over your desired weight	More than 25 pounds over your desired weight
	4%	38%	36%	21%
DataHaven	Underweight	At your desired weight	Overweight	Obese
	2%	33%	36%	29%
NCHS[1]	Underweight	Healthy weight	Overweight	Obese
US	2%	34%	34%	30%
Northeast	2%	37%	35%	26%

[1]Calculated from information that respondents supplied in response to survey questions regarding height and weight. For both men and women, underweight is indicated by body mass index (BMI) under 18.5; healthy weight is indicated by BMI of 18.5 up to 25.0; overweight is indicated by BMI of 25.0 up to 30.0; and obesity is indicated by BMI of 30.0 or higher. Note that self-reported height and weight may differ from actual measurements. The weighted percentage of unknown with respect to BMI among adults aged 18 and over was 3.2%.

Q8. Has a doctor, nurse, or other health professional ever told you that you have a chronic illness or condition?		
HSC Survey	No: 30%	Yes: 70%

Q9. Which chronic illnesses or conditions do you have?	HSC Survey	DataHaven	DHDS
Addiction disorder	3%		
Asthma	17%	15%	
ASD (autism spectrum disorder), Asperger syndrome	2%		
Cardiac: coronary heart disease, congestive heart failure (CHF), angina	20%	6%	9%
Pulmonary disease: COPD, emphysema, chronic bronchitis, pulmonary fibrosis	40%		13%
Depressive disorder, dysthymia, major depressive disorder	10%		
Diabetes	16%	10%	16%
Mental health issues	10%		
Memory loss, dementia, Alzheimer's disease	1%		
Neuromuscular disease: ALS, Muscular Dystrophy, Parkinson's Disease	6%		
Stroke or CVA	1%		6%
Other (wide variety of issues, most incorporated above)	58%		

Q10. Regarding the condition(s), which actions are you taking?	HSC Survey
Seeing a primary care/family doctor for follow up treatment and monitoring	61%
Seeing a specialist for follow up treatment and monitoring	78%
Taking any prescribed medications to treat the condition	77%
Not receiving any follow up treatment or monitoring	2%
Reasons for not being treated: "in the past", "not needed", "Don't need any right now"	

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Q11. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for the chronic condition(s)?					
	None	1-2 times	3-5 times	6-9 times	10 or more times
HSC Survey	5%	25%	27%	19%	24%
Q12. In the past 3 months, have you fallen? How many times?					
HSC Survey	79%	16%	1%	2%	2%
Q13. How many of these falls caused an injury that made you limit your activities for at least a day or to go see a doctor?					
HSC Survey	74%	22%	2%	0%	2%

Q14. Are you limited in any way in any activities because of physical problems?		
	No	Yes
HSC Survey	57%	43%
DHDS	83%	16%

Q15. Does a physical disability prevent you from visiting a health care provider?		
HSC Survey	No: 97%	Yes: 3%

Percent of adults with disabilities: DHDS data, adults age 18+	
Mobility disability	10%
Cognitive disability	9%
Independent living disability	5%
Self-care disability	3%
Have no disability	79%

Q16. Do you have any health problems that require you to use special equipment?		
	No	Yes
HSC Survey	67%	33%
Equipment		**Users**
Oxygen (including BiPap)		13%
Cane		12%
Walker		10%
Wheelchair		6%
Leg brace		4%
Special bed		2%
Other: wide variety of items listed		

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Q17. Are you limited in any way in any activities because of mental or emotional problems?		
HSC survey	No: 92%	Yes: 8%

AARP Public Policy Institute Disability Rates, 2016				
People ages 65+ with disabilities				
	Connecticut	Percent	Rank	United States
Self-care difficulty	45,000	8%	22	8%
Cognitive difficulty	45,000	8%	30	9%
Any disability	176,000	32%	44	35%
People ages 18-64 with disabilities				
Self-care difficulty	28,000	1%	47	2%
Cognitive difficulty	87,000	4%	42	5%
Any disability	192,000	9%	47	11%

Q18. Have you smoked at least 100 cigarettes in your entire life? (100 cigarettes = about 5 packs)			
	No		Yes
HSC Survey	52%		48%
DataHaven	61%		39%
Q19. Do you now smoke cigarettes every day, some days, or not at all?			
	Every day	Some days	Not at all
HSC Survey	4%	6%	90%
DataHaven	25%	10%	64%
DHDS	27% individuals living with disabilities are current smokers		
Q20. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?			
	No		Yes
HSC Survey	0%		100%
DHDS			57%
HSC Survey: If "Yes", were you successful?			
Number	6		4
DataHaven: Have you ever tried using vapor or vape pens, electronic cigarettes or E-cigarettes (such as blu, Vuse), even just one time in your entire life?			
	No		Yes
Total	81%		19%
18-34 yr	64%		36%
DHDS: 8% of those with disabilities have tried E-cigarettes			

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Q21. During the past 12 months, have you ever felt the need to cut down on your drinking or drug use?		
HSC Survey	No: 90%	Yes: 10%
DHDS: 18% of those living with disabilities age18+ report binge drinking in past 30 days (19% no disability)		

Q22. Do you have any kind of health care coverage?		
	No	Yes
HSC Survey	1%	91%
DataHaven	5%	94%
DHDS: 92% of persons age 18+ living with disabilities have healthcare coverage		

What type of coverage?	HSC Survey	DataHaven
Insurance obtained through a current or former employer or union	54%	57%
Insurance purchased directly from an insurance company	12%	11%
Medicare	47%	23%
Medicaid, Medical Assistance, HUSKY, or any kind of government-assistance plan	16%	7%
Medicare supplement	5%	
From family member	4%	
Other (HSC added into above categories)		5%

Q23. Do you have one person or place you think of as your personal doctor or health care provider?			
	No	Yes, only one	More than one
HSC Survey	5%	40%	55%
DataHaven	16%	83%	26%
DHDS: 72% of persons age 18+ living with disabilities have a personal doctor or health care provider (79% of persons without a disability)			

Q24. About how long has it been since you visited a doctor for a routine checkup?					
HSC Survey	0-12 months	1-2 years	2-5 years	5 years or more	Never
	92%	6%	1%	1%	0%

Q25. In general, where do you go when you are in need of medical care?				
HSC Survey	Doctor's Office	Emergency Department	Health Clinic	Walk-in / Urgent Care Center
	90%	2%	1%	8%

Q26. In the past 12 months, did you receive care in an emergency room?				
	None	1-2 times	3 or more	Don't know
HSC Survey	76%	20%	4%	2%
DataHaven	73%	22%	4%	0%

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Q27. Was there a time in the past 12 months when you needed prescription medicines but did not get them because you could not afford them?		
	No	Yes
HSC Survey	93%	7%
DataHaven	91%	9%
Q28. Was there a time in the past 12 months when you altered the way you take your prescription medicines (such as taking them less frequently than prescribed) because you could not afford to get more?		
HSC Survey	95%	6%
DataHaven	93%	7%
Q29. Was there a time in the past 12 months when you could not get, or postponed, medical care you needed?		
HSC Survey	90%	10%
DataHaven	90%	9%

Q30. What was the reason you could not get, or postponed, medical care you needed?	HSC Survey	Data Haven
Could not get an appointment soon enough	35%	30%
Lack of transportation	20%	38%
Did not have healthcare coverage	16%	
Cost	40%	50%
Health plan would not pay for the treatment	20%	29%
Doctor/hospital would not accept your insurance	8%	18%
Could not get there when the office or facility was open due to work, caregiving, or other obligations	24%	*
Other (variety of reasons)	20%	
*when the office was open: 25%; work: 53%; caregiving: 22%		

Q31. What type of doctor?		
Primary care physician: 16%	Specialist: 79%	Other: 4% (counseling)

Q32. What is your zip code? Respondents reported 51 Connecticut zip codes		
Q33. What is your age?	HSC Survey	DataHaven
under 18	1%	--
18-34	12%	27%
35-49	10%	23%
50-64	29%	24%
65 and older	48%	22%
Q34. What is your gender?	HSC Survey	DataHaven
Male	32%	48%
Female	68%	52%

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Q35. In which language are you most fluent?	HSC Survey	DataHaven
English	93%	94%
Arabic	2%	2%
Spanish	1%	41%
Polish, Ukrainian, Russian	1%	5%

Q36. Have you ever served on active duty in the United States Armed Forces, National Guard or a military reserve unit?	HSC Survey	DataHaven
No	90%	90%
Yes (DataHaven: 1 refused to answer)	10%	9%

Q38. What is your marital status?	HSC Survey	DataHaven
Never married	20%	30%
Married	54%	48%
A member of an unmarried couple	1%	5%
Separated	2%	1%
Divorced	14%	8%
Widowed	8%	7%

Q39. Which of these groups would you say best represents your race? Please check all that apply.	HSC Survey	DataHaven
Asian	1%	5%
Native American, Alaskan Native	1%	1%
Black or African American	4%	11%
Native Hawaiian or Other Pacific Islander	0%	
White	93%	76%
Hispanic	1%	7%
Other (HSC *mixed race)	<1%*	5%

Q40. What is your highest grade/year of school completed?	HSC Survey	DataHaven
Less than high school	6%	3%
High school or GED	13%	20%
Some college	20%	28%
Associate's Degree	8%	
Bachelor's Degree	21%	25%
Post Graduate Degree	33%	23%

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Q41. What is your employment status?	HSC Survey	DataHaven
Employed for wages	33%	61%
Self-employed	3%	
Student	6.%	3%
Homemaker	4%	4%
Retired	43%	19%
Unable to work	11%	5%
Out of work for less than one year	0.5%	51%
Out of work for more than one year	4%	41%

Q42. What is the annual household income from all sources?	HSC Survey	DataHaven
Less than $15,000	10%	8%
$15,000-$30,000	12%	11%
$30,000-$50,000	16%	12%
$50,000-$75,000	19%	15%
$75,000-$100,000	13%	13%
$100,000-$200,000	24%	20%
$200,000 or more	7%	7%
DHDS 19% persons age 18+ living with a disability have an income <$15,000. 5% of persons without a disability		

Q43. What are your regular means of transportation?	HSC Survey	DataHaven
Walk	8%	3%
Public bus system	6%	5%
Bicycle	2%	1%
Get a ride with family or friends	11%	7%
Taxi, Uber, Lyft	3%	0%
Paratransit (wheelchair-accessible van)	2%	0%
Drive myself	86%	81%
Other *Other plus Rail	3%	2%*

Number of Households with vehicles available U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates	
Occupied housing units	1,361,755
No vehicles available	122,253
1 vehicle available	442,460
2 vehicles available	512,498
3 or more vehicles available	284,544

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Q44. Which of these devices do you use regularly?	HSC Survey	DataHaven
Computer or tablet with internet access	85%	82%
Smartphone	78%	79%
Cell phone with text and calling (no internet)	24%	22%
None of these	0%	5%

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Caregivers (HSC Survey questions)

Q45. During the past 30 days, did you provide regular care or assistance to a friend or family member?		
No: 71%	Yes: 29%	Number responding: 229

Q82. In which of the following areas does the person you care for need your help?	
Transportation outside of the home	71%
Maintaining the household	61%
Taking medications	47%
Personal care	37%
Relieving/decreasing anxiety or depression	35%
Learning or remembering	33%
Supervision (for children or adults)	29%
Communicating with others	27%
Wound care, injections, or other medical treatments	24%
Moving around within the home	22%
Seeing or hearing	20%
Completing schoolwork	6%
Other tasks: • Managing schedules • Decision making, legal (healthcare agent, POA) • Scheduling & training staff • Cooking • Shopping • Attending doctor visits (ER/hospital/care facilities • Socialization	22%

Q83. Please indicate which of the following difficulties you face as a caregiver.	
Creates stress	63%
No difficulty	33%
Doesn't leave enough time for yourself	31%
Affects family relationships	27%
Creates or aggravates your health problems	25%
Interferes with your work	24%
Doesn't leave enough time for your family	20%
Creates a financial burden	16%
Other difficulties: • lack of patience • being disabled and neglecting my own healthcare	10%

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Q84. What type of support would help you the most with your caregiving responsibilities?	54 responses
Home health aide/PCA (available, affordable or free, reliable), service coordination	15%
Transportation	6%
Funding	6%
Care coordination / case management	6%
More family support	4%
More time	4%
Respite care	4%
Relieve stress	4%
Support group	4%
Dementia services	2%
More patience	2%

AARP Public Policy Institute Family Caregivers	CT	Per 1,000 People	Rank	U.S.
Number of family caregivers, 2013	459,000	128	22	127
Economic value of family caregiving, 2013 (millions)	$5,930	$1.65	7	$1.49
Economic value per hour, 2013	$13.87		10	$12.51
Ratio of economic value to Medicaid HCBS spending, 2013	4.2		42	6.2
Caregiver Support Ration (age 45.64 per age 80+), 2015	6.4		40	7.0
Caregiver Support Ration, 2050 (projected)	2.8		28	2.9

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Questions Regarding Persons Receiving Care

Data in this section is from the HSC Survey unless otherwise noted.

Q46. What is the person's relationship to you?	
Child: biologic, step, adoptive, foster	27%
Parent	23%
Non-relative	22%
Spouse, partner	11%
Parent-in-law	5%
Sibling: biologic, step, adoptive, foster	5%
Other relative	5%
Grandparent	2%
Grandchild	2%
Q47 What is the person's age?	
0-9	5%
10-19	7%
20-29	5%
30-39	8%
40-49	7%
50-59	7%
60-69	14%
70-79	15%
80-89	15%
90-99	15%
Q48. What is the person's gender? Respondents could choose multiple categories	
Male	47%
Female	60%
Other	0%
Q49. In which language is the person most fluent?	
English	92%
Polish	3%
Arabic	2%
Italian	2%
Sign language	2%
Ukrainian, Russian	2%
Q50. Would you like healthcare providers to use this language?	
No: 2%	Yes: 98%

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Q51. Which of these groups would you say best represents the person's race?	
Asian	0%
Native American, Alaskan Native	2%
Black or African American	5%
Native Hawaiian or Other Pacific Islander	0%
White	97%
Hispanic	0%
Other	0%

Q52. What is the annual household income from all sources?	
Included in household	15%
Less than $15,000	21%
$15,000-$30,000	15%
$30,000-$50,000	19%
$50,000-$75,000	15%
$75,000-$100,000	8%
$100,000-$200,000	8%
$200,000 or more	0%

Q53. How would you rate the person's overall health?				
Poor	Fair	Good	Very good	Excellent
14%	41%	31%	12%	3%
Q54. During the past 30 days, did the person experience poor or fair physical health?				
0 days	1-2 days	3-5 days	6-9 days	10 or more days
27%	21%	11%	13%	29%
Q55. During the past 30 days, has the person been bothered by feeling down, depressed, or hopeless?				
0 days	1-2 days	3-5 days	6-9 days	10 or more days
39%	29%	6%	6%	20%
Q56. In an average week, how many days does the person exercise?				
0 days	1-2 days	3-4 days	5-6 days	every day
31%	31%	17%	9%	11%

Q57. How would you describe the person's weight?			
Underweight	At a desired weight	10-25 pounds over a desired weight	More than 25 pounds over a desired weight
13%	41%	30%	16%

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Q58. Has a doctor, nurse, or other health professional ever told the person that he or she has a chronic illness or condition?	
No: 21%	Yes: 79%

Q59. Which chronic illnesses or conditions does the person have?	
Memory loss, dementia, Alzheimer's disease	35%
Pulmonary disease: COPD, emphysema, chronic bronchitis, pulmonary fibrosis	29%
Cardiac: coronary heart disease, congestive heart failure (CHF), angina	20%
Depressive disorder, dysthymia, major depressive disorder	20%
Diabetes	18%
Neuromuscular disease: ALS, Muscular Dystrophy, Parkinson's Disease	18%
Mental health issues	16%
Stroke or CVA	11%
Asthma	9%
Brain Injury, TBI, ABI, other	9%
ASD (autism spectrum disorder), Asperger syndrome	5%
Addiction disorder	2%
Other (wide variety of issues, most incorporated above)	50%

Q60. Regarding the condition(s), which actions is the person taking?	
Seeing a primary care/family doctor for follow up treatment and monitoring	73%
Seeing a specialist for follow up treatment and monitoring	76%
Taking any prescribed medications to treat the condition	69%
Not receiving any follow up treatment or monitoring	4%
Not being treated: "healthcare agency discharged home services"; "resident of facility"	

Q61. About how many times in the past 12 months have the person seen a doctor, nurse, or other health professional for the chronic condition(s)?				
None	1-2 times	3-5 times	6-9 times	10 or more times
0%	23%	28%	12%	37%
Q62. In the past 3 months, has the person fallen? How many times?				
None	1-2 times	3-5 times	6-9 times	10 or more times
50%	32%	9%	9%	0%
Q63. How many of these falls caused an injury that made the person limit his or her regular activities for at least a day, or to go see a doctor?				
50%	43%	7%	0%	0%

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Q64. Is the person limited in any way in any activities because of physical problems?		
No	Yes	Common challenges: walking, balance, breathing, ADLs, driving
31%	69%	Common causes: brain injury, pulmonary disease

Q65. Does a physical disability prevent the person from visiting a health care provider??		
No	Yes	Please explain: Hard to get in and out of home; Does not drive;
94%	6%	Now unable to drive self

Q66. Does the person have any health problems that require the use special equipment?	
No: 42%	Yes: 55%
Special Equipment	Users
Oxygen (including BiPap)	13%
Cane	9%
Walker	38%
Wheelchair	20%
Leg brace	4%
Special bed	5%
Special telephone	4%
Other: wide variety of items listed	

Q67. Is the person limited in any way in any activities because of mental or emotional problems?	
No: 67%	Yes: 33%

Q68. Has the person smoked at least 100 cigarettes in his or her entire life? (100 cigarettes = about 5 packs)		
No: 67%	Yes: 33%	
Q69. Does the person now smoke cigarettes every day, some days, or not at all?		
Every day	Some days	Not at all
5%	16%	79%
Q70. During the past 12 months, has the person stopped smoking for one day or longer because he or she was trying to quit smoking?		
No: 40%	Yes: 60%	
Individuals who tried to quit were not successful.		
Q71. During the past 12 months, has the person ever felt the need to cut down on drinking or drug use?		
No: 95%	Yes: 5%	
One response: successful many years ago		

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Q72. Does the person have any kind of health care coverage?	
No: 4%	Yes: 78%
What type of coverage?	
Insurance obtained through a current or former employer or union	31%
Insurance purchased directly from an insurance company	9%
Medicare	60%
Medicaid, Medical Assistance, HUSKY, or any kind of government-assistance plan	31%
Covered by a family member's insurance	11%
Other Please specify:	24%

Q73. Does the person have one person or place he or she thinks of as their personal doctor or health care provider?		
No	Yes, only one	More than one
4%	44%	53%

Q74. About how long has it been since the person visited a doctor for a routine checkup?				
0-12 months	1-2 years	2-5 years	5 years or more	Never
91%	2%	4%	4%	0%

Q75. In general, where does the person go when he or she is in need of medical care?			
Doctor's Office	Emergency Department	Health Clinic	Walk-in / Urgent Care Center
89%	4%	2%	6%

Q76. In the past 12 months, did the person receive care in an emergency room?			
No	Yes: 1-2 times	Yes: 3 or more	Don't know how many times
67%	67%	25%	8%

Q77. Was there a time in the past 12 months when the person needed prescription medicines but did not get them because he or she could not afford them?	
No: 93%	Yes: 7%
Q78. Was there a time in the past 12 months when the person altered the way he or she takes prescription medicines (such as taking them less frequently than prescribed) because they could not afford to get more?	
No: 93%	Yes: 7%

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Q79. Was there a time in the past 12 months when the person could not get, or postponed, medical care he or she needed?	
No: 89%	Yes: 11%
Q80. What was the reason the person could not get, or postponed, medical care he or she needed?	
Could not get an appointment soon enough	33%
Lack of transportation	33%
Did not have healthcare coverage	17%
Cost	17%
Health plan would not pay for the treatment	0%
Doctor/hospital would not accept your insurance	17%
Could not get there when the office or facility was open due to work, caregiving, or other obligations	0%
Other (fear)	17%
Q81. What type of doctor?	
Primary care physician	Specialist
67%	33%

Attachment 6
Key Informant Survey Questions and Results
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Q1. What are the top health issues you see in your community? *(Conditions treated at Hospital for Special Care are italicized for comparison with KI ranking)*	
Mental health	67%
Addiction disorder	59%
Diabetes	56%
Obesity/Overweight	56%
Heart disease: CHD (coronary heart disease), atherosclerosis, CHF (Congestive Heart Failure), angina	44%
Asthma	26%
Depressive disorder, dysthymia, major depressive disorder	26%
Memory loss, dementia, Alzheimer's disease	*26%*
Autism, ASD (Autism Spectrum Disorder), Asperger syndrome	*22%*
Pulmonary disease: COPD, emphysema, chronic bronchitis, pulmonary fibrosis	*15%*
Brain injury, concussion	*11%*
Arthritis	4%
Neuromuscular disease: ALS / Lou Gehrig's disease, muscular dystrophy, Parkinson's disease, CMT (Charcot-Marie-Tooth disease)	*4%*
Stroke / CVA	*4%*
Vision abnormalities in children	4%
Spinal cord injury	*0%*

Strongly disagree	Disagree	Agree	Strongly Agree
Q2. Community members are able to access a primary care provider when needed			
0%	28%	72%	0%
Q3. Community members are able to access a medical specialist when needed			
13%	33%	54%	0%
Q4. Community members are able to find providers accepting Medicaid, Medical Assistance, HUSKY, or any other government-assistance plan in Connecticut.			
13%	25%	58%	4%
Q5. Community members are able to receive care from providers who are fluent in their preferred language or make translation services available.			
9%	50%	41%	0%
Q6. Community members are able to obtain transportation to medical appointments.			
17%	30%	52%	0%
Q7. Community members are able to obtain mental or behavioral health care.			
21%	42%	38%	0%

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Q8. In general, where do you think most individuals with healthcare coverage go when they are in need of medical care?			
Doctor's office	Health clinic	Emergency department	Walk-in / urgent care center
57%	5%	19%	19%

Q9. Why do you think they go there? What would make the best choices more accessible?
Because they get the same doctor who knows them.
Because most insurance requires a primary doctor to be identified. I think this is the best choice for coordinated care.
Dr. has your records.
First line of defense
Because they have an established relationship
Insurance limitations and long wait times at other clinics.
Difficulty getting an appointment or transportation to regular doctor
I see a lot of homelessness and many clients use their illness just to get a bed for the night.
Most accessible and no appointment needed.
doctor's office
Because it is convenient and requires very little follow-up. The goal is to get medicine to "cure" the immediate problem without looking into historical factors. I think more education in prevention.
I think private insurance goes to their doctor, but Medicaid uses the ED more often because the hours are more convenient.
Because their type of insurance is accepted by the doctor.

Q10. In general, where do you think most uninsured and underinsured individuals go when they are in need of medical care?				
Doctor's office	Health clinic	Emergency department	Walk-in / urgent care center	Don't know
0%	0%	90%	5%	5%

Q11. Why do you think they go there? What would make the best choices more accessible?
Because they have to take them
It's free and always open. Have urgent care co-located at ER with 24-7-365 hours.
Because they do not know how to navigate "the system" at the other places and their top priority is: help my child who is ill, or my mother, or themselves....
Universal coverage, like the rest of the civilized world.
Because they don't have to pay out of pocket mentally ill
Have to be seen there.
They will be told they have a huge bill to pay without ins. or they will not be seen at specialists if no insurance.
Ease of access
Cost
Clients feel they cannot be refused care at an emergency room .
Same reasons as above.

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Q11. continued
Not sure
The ED will not turn anyone away because of finances, so it is the easiest option. Plus, many folks go to get care when they have transportation, which may not coincide with clinic hours
Because the ER is the only place that cannot refuse treatment. Accessibility is 100% tied to having insurance. National health care is the best answer.

Q12. Are any of these populations under-served by existing healthcare systems? *(Populations treated at Hospital for Special Care are italicized for comparison with KI ranking)*	
Immigrant / refugee	71%
Uninsured or underinsured	62%
Low-income, poor, ALICE (Asset Limited, Income Constrained, Employed)	62%
Black/African-American, Hispanic/Latino, other racial or cultural groups	38%
Adults living with developmental disabilities or behavioral challenges	*33%*
Children / youth living with developmental disabilities or behavioral challenges	*29%*
Adults living with physical disabilities	*24%*
Children / youth living with physical disabilities	*19%*
Children / youth	14%
Adults	14%
Seniors / elderly	33%
Homeless	62%
Other: “middle class, self-employed”; “our society is broken”; “mentally ill”	14%

Q13. Why do you think that is? Can you give examples of how they are not being served?
Many can't afford insurance; many have partial insurance that doesn't cover all expenses.
ALICE households may work at multiple PT jobs that do not offer paid sick leave (especially for dr appointments). So they get very sick before they seek care. Refugees may avoid any contact with any institutions for fear of being kicked out of the country or separated from their family.
The answer is: greed has been allowed to 'take over' and run rampant throughout our society
Shortage of practitioners and facilities
They don't have the access or $ to stay on top of their health.
Lack of documentation.
Housing and jobs
Community emphasis on our most needy populations and the lack of education.
Difficulty in language, transportation, or providers accepting new patients with complex needs.
As I said above, getting good health case (psychical, mental health, substance abuse) is 100% tied to having adequate or better health insurance. National Health Care!

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Q14. If community members are unable to access health care when they need it, what are the significant barriers?	
Healthcare plan would not pay for the treatment	71%
Cost of healthcare: coverage premiums, deductibles, co-pays, prescriptions, etc.	67%
Inability to navigate the healthcare system	62%
Basic needs not met (food/shelter)	62%
Uninsured	57%
Lack of transportation	48%
Time limitations (long wait for an available appointment, limited office hours, unable to take time off work, etc.)	43%
Provider would not accept their healthcare plan	43%
Language or cultural barriers	43%
Availability of providers or appointments	38%
Lack of child care	14%
Q15. Why do you think that is? What are some ways to minimize those barriers?	
Cut costs by capping drug prices and limiting doctor kickbacks for recommending procedures, surgery or certain drugs. Focus more on prevention.	
Employers of PT employees may NOT offer paid leave.	
Replace greed/apathy with Compassion, walk a mile in their shoes,	
Universal coverage	
Universal Health Care	
Universal healthcare system	
Good health care is 100% tied to good insurance	

Q16. Related to the health and quality of life for individuals living with chronic conditions or physical disabilities, what services or resources do you think are missing in the community?	
Multilingual services	48%
Health education / information / outreach	48%
Transportation to medical services	43%
Substance abuse services	43%
Prescription assistance	43%
Low cost medical care	43%
Mental health services	38%
No cost medical care	29%
Rehabilitation services (physical, occupational, speech therapy)	24%
Primary care providers	19%
Medical specialists	14%
Health screenings	10%
Other: Access to affordable healthy food (as medicine) Let's rise into the 21st c, where all the other nations are already..... More accessible places in the community in general	14%

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Q17. What challenges do community members face in trying to maintain healthy lifestyles?	
Affordability of healthy foods	71%
Family responsibilities (child care, caring for ailing family member, etc.)	67%
Work responsibilities (number of hours worked, time of day working, unable to take time off, etc.)	62%
Chronic health conditions make exercising difficult	57%
Depression, mental or emotional problems	57%
Physical disabilities make exercising difficult	48%
Lack of time for exercise	43%
Availability of healthy foods (market in the neighborhood)	33%
Need help to stop using alcohol or drugs	33%
Lack of location to exercise (nearby park, gym, walking trail, etc.)	24%
Need help with smoking cessation	19%
Other: We need an American culture that embraces Wholesome Living Loneliness Transportation to a facility	14%

Q18. In your opinion, what is being done well in terms of health and quality of life?
I see more of a move toward prevention. Need more. We need more public health, wellness and prevention advertisements instead of so many drug advertisements.
High quality care is available at various hospital settings.
With so many hospital readmissions, I am not convinced that things are being done.
Are you aware of FQHC (federally qualified health centers)? This is a first step to treating All unconditionally: you don't feel well, you need help with your anxiety, you have a sore tooth? Come...and be treated with respect. Period.
Providers in the area
Medicare is a big help.
Sports 120 opened, rails to trails
More education being introduced.
community health initiatives Coalition for New Britain Youth
There are more community health centers in New Britain than there were in the past years. The centers can support the health and quality.
There are a lot of services available for free or low cost transportation to medical appointments.
Intervention into schools including screenings and health education.
efforts nationwide to view health care as a right not a privilege
There is more awareness
Children under 18 still being able to qualify for free health insurance.
Gathering data to make better decisions. Increased awareness of disparities related to race and culture.
Urgent Care Services Health Clinics
There seems to be more mental health option available for family.

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Q18. continued
Awareness of social determinants and starting to address them.
There are many services available in all areas of health care but the problem is the inability to pay for good services.

Q19. What recommendations or suggestions do you have to improve health and quality of life for persons living with chronic conditions and physical disabilities?
Start preventive education about chronic disease early in life, on TV.
Provide ongoing education about the importance of eating healthy food based on one's health conditions, and ensure that those foods are affordable and accessible.
More education and access to appointments as well as a more diverse and educated home health care professionals
?
LOVE.
Outreach and education
Blank.
Get out and do things
Ombudsmen to help them navigate
Nutritional support and meal prep to help them have more energy and stamina to deal with their disabilities.
Continued coordination and communication among service providers
Ensure there are enough social engagements for these people to feel welcome in and engage with.
More one-on-one regular interaction between care givers and patients is needed.
Better access to health care; access to long term rehabilitation and support services
To improve medical insurance cost
More places where clients can go to get information as to where they can get the help they need and what type of documentation and qualifications they might need. (community outreach in the health place)
Allow for more reimbursable home health delivery.
More providers
The quality of services must be more holistic/comprehensive.
Universal healthcare
Push for national health care. In the meantime, work with appropriate providers to get them to provide some low cost/free services for those living in poverty.

Attachment 7
Connecticut Acute Care Hospitals

The William W. Backus Hospital, Norwich
Bridgeport Hospital, Bridgeport
Bristol Hospital, Bristol
The Hospital of Central Connecticut, New Britain
Connecticut Children's Medical Center, Hartford
Danbury Hospital, Danbury
Day Kimball Hospital, Putnam
Greenwich Hospital, Greenwich
Griffin Hospital, Derby
Hartford Hospital, Hartford
The Charlotte Hungerford Hospital, Torrington
Johnson Memorial Hospital, Stafford Springs
Lawrence + Memorial Hospital, New London
Manchester Memorial Hospital, Manchester
Middlesex Hospital, Middletown
MidState Medical Center, Meriden
Milford Hospital, Milford
New Milford Hospital, New Milford
Norwalk Hospital, Norwalk
Rockville General Hospital, Vernon
Saint Francis Hospital and Medical Center, Hartford
Saint Mary's Hospital, Waterbury
St. Vincent's Medical Center, Bridgeport
Stamford Hospital, Stamford
UConn John Dempsey Hospital, Farmington
Waterbury Hospital, Waterbury
Windham Hospital, Willimantic
Yale-New Haven Hospital, New Haven

Attachment 8
Connecticut Community Health Centers

Charter Oak Health Center
- Hartford (Medical, Behavioral Health & Dental Services)

Community Health & Wellness Center of Greater Torrington
- Torrington (Medical Services)
- Winsted (Medical Services)

Community Health Center, Inc.
- Clinton (Medical & Behavioral Health Services)
- Enfield (Medical Services)
- Groton (Medical Services)
- Meriden (Medical, Behavioral Health & Dental Services)
- Middletown (Medical, Behavioral Health & Dental Services)
- New Britain (Medical, Behavioral Health & Dental Services)
- New London (Medical, Behavioral Health & Dental Services)
- Norwalk (Dental Services)
- Old Saybrook (Dental Services)
- Stamford (Dental Services)

Community Health Services, Inc.
- Hartford (Medical, Behavioral Health & Dental Services)

East Hartford Community HealthCare, Inc.
- East Hartford (Medical & Dental Services)
- Manchester (Medical & Dental Services)
- Vernon (Medical & Dental Services)

Fair Haven Community Health Center
- New Haven (Medical Services)

Generations Family Health Center
- Killingly (Medical Services)
- Norwich (Medical Services)
- Willimantic (Medical, Behavioral Health & Dental Services)

Cornell Scott-Hill Health Center
- Ansonia (Medical & Behavioral Health Services)
- Derby (Dental Services)
- New Haven (Medical, Behavioral Health & Dental Services)
- West Haven (Medical & Behavioral Health Services)

Intercommunity Health Care
- East Hartford (Primary Care, Mental Health Services)
- Hartford (Primary Care, Mental Health Services, Addiction Recovery Services)

Norwalk Community Health Center
- Norwalk (Medical & Behavioral Health Services)

Connecticut Community Health Centers, continued

Optimus Health Care: Formerly known as Bridgeport Community Health Center
- Bridgeport (Medical, Behavioral Health & Dental Services)
- Stamford (Medical & Behavioral Health Services)
- Stratford (Medical, Behavioral Health & Dental Services)

Southwest Community Health Center
- Bridgeport (Medical, Behavioral Health & Dental Services)

StayWell Health Care, Inc.
- Waterbury (Medical, Behavioral Health & Dental Services)

United Community & Family Services
- Colchester (Behavioral Health)
- Groton (Dental Services)
- New London (Behavioral Health)
- Noank (Medical Services)
- Norwich (Medical, Behavioral Health & Dental Services)
- Quaker Hill (Medical & Dental Services)
- Waterford (Medical & Dental Services)

Wheeler Clinic
- Bristol (Behavioral Health, Addiction, Mental Health & Primary Care)
- Hartford (Behavioral Health, Addiction, Mental Health & Primary Care)
- New Britain (Behavioral Health, Addiction, Mental Health & Primary Care)

Source: https://portal.ct.gov/DPH/Family-Health/Community-Health-Centers/Find-A-Community-Health-Center-In-Connecticut

Attachment 9
Connecticut State Departments and Offices

Department of Public Health
Department of Mental Health and Addiction Services
Department of Children and Families
Department of Developmental Services
Department of Housing
Department of Rehabilitation Services
Department of Social Services, Money Follows the Person
Department on Aging
Council on Developmental Disabilities
Office of Early Childhood
Office of the Healthcare Advocate
Office of Policy and Management
Office of Protection and Advocacy for Persons with Disabilities

Attachment 10
Not-for-Profit Advocacy Organizations

ALS Association – CT (Amyotrophic lateral sclerosis)
American Heart Association, CT Affiliate
American Lung Association in CT
Autism Families CONNECTicut
Autism Services and Resources Connecticut
Brain Injury Alliance – CT
Food Share (CT)
Lighthouse Psychoeducational Services, Avon & New London
Muscular Dystrophy Association, CT office
National Stroke Association
Spinal Cord Injury Association – CT