

CONNECTICUT HOSPITAL ASSOCIATION

2016: Community Benefit Report





Connecticut Hospitals

Serving their Communities

Hospitals are always there when we need them — caring for all regardless of ability to pay. Their contributions to community health extend far beyond the hospital walls.

Connecticut hospitals are continually identifying and utilizing new and more effective ways to improve community health. They are collaborators, innovators, caregivers, and deliverers of services that people in their communities need and want.

Not only do Connecticut hospitals provide outreach and support services for cancer, diabetes, asthma, and other chronic conditions, their doctors, nurses, and staff also provide

community-based care to inner-city patients, lead support groups for young fathers, help educate the next generation of healthcare professionals, run summer camps for kids, and sit down to dinner with patients. And this is just a small sampling of their efforts.

In 2014, Connecticut hospitals provided more than 13.2 million services to individuals and families at a cost to them of \$1.5 billion — that's 14 percent of total hospital revenue. While the dollars and cents of Connecticut hospitals' community benefit are impressive, in the pages that follow, you'll learn the human impact of these programs and services.

Community Benefit by the Numbers

In 2014, Connecticut's hospitals benefitted their communities in many ways.

\$710.5 million	Unpaid government-sponsored healthcare - Medicaid
\$471.6 million	Unpaid government-sponsored healthcare - Medicare
\$247.6 million	Uncompensated care: Charity care/bad debt to provide services for those who cannot pay
\$39.6 million	Community services to improve the health of the community
\$18.9 million	Research and other programs to advance healthcare for patients and the community
\$9.2 million	Donations to help support community organizations
\$8.0 million	Community building to create stronger, healthier communities
\$4.4 million	Subsidized health services* to provide care needed by the community

*Most subsidized health services funds are reflected in the "unpaid costs of government programs" numbers

\$1.5 billion Total community benefit provided by Connecticut Hospitals in 2014

The William W. Backus Hospital



Rx for Health Finishes Record Fifth Season

The Rx for Health program helped a record 53 families gain access to a healthy diet of fresh fruits and vegetables over the course of its fifth and most successful season, which recently wrapped up after making great strides in the fight against childhood obesity.

“It’s been so heartening to see the impact that this program is having on some of our most vulnerable families,” said the William W. Backus Hospital Community Health Nurse Alice Facente, RN, MSN, who helps coordinate the program with Community Dietitian Jennifer Fetterley, RD, of Backus, and Thames Valley Council for Community Action.

Maira DeJesus, the mother of an 11-year-old boy, said the program has helped her son lose more than 100 pounds since they began participating five years ago.

“It has benefited us money-wise, health-wise, and my son just loves it,” she said.

The program has helped hundreds of families improve their diets by providing them access to local farmers markets, where they receive vouchers to purchase fresh fruits, vegetables, farm fresh eggs, or whole grain bread. Families are referred to the program by participating providers who identify children in their care who may be at risk of being overweight due to lack of access to healthy fruits and vegetables.

This year, for the first time, several local pediatricians were invited to participate

in the program, joining pediatricians from United Community & Family Services (UCFS) and Generations, both Federally Qualified Health Centers.

“Our collaboration with all of the area pediatricians has allowed us to reach a greater number of families in need,” Ms. Facente said. She said surveys that were filled out by many participating families showed how much of a difference the program is making.

“We have a lot of statistics supporting the value of what we are doing, but when you read the comments from the families themselves, it really hits home,” she said.

Under the program, providers write prescriptions to families for fresh fruits and vegetables, which can be redeemed at the Norwich and Voluntown farmers markets, which run for 17 weeks over the summer and fall. At the markets, families bring the scripts to the Backus CareVan, where a registered dietitian or a trained healthy eating advocate are present to share healthy recipes and, most importantly, provide nutritional counseling to both children and their parents. Then they receive \$20 worth of vouchers that they can spend at the market. A family can visit the market up to five times, receiving \$20 worth of vouchers each visit. The program is funded by Backus Hospital donors.

Ms. Facente praised the collaborative effort of the community partners who make this outreach so impactful and meaningful.

Esté Listo/Be Prepared: Breast Health for Teens

Educating young women about breast cancer is extremely important in communities in Fairfield County, where there is a high rate of breast cancer, late-stage diagnosis, and early death from breast cancer.

Bridgeport has been especially hard hit. The city has a minority population of more than 60 percent. Research has shown that in the Hispanic community, many women under the age of 40 develop breast cancer, yet most are unaware of their increased risk, especially at a younger age. This lack of awareness extends over many generations, making outreach to this community extremely important.

Research has shown that minority women are also less likely to begin routine mammograms until they notice a problem with their health and their cancer is at an advanced stage. It has also shown African-American women tend to develop a more aggressive form of breast cancer and have higher death rates than any other group.

Norma Pfriem Breast Center’s Esté Listo/Be Prepared outreach program is designed to reach these high-risk groups early and empower young women to become better caretakers of their health. Through Esté Listo/Be Prepared: Breast Health for Teens, the hospital is educating the next generation of women and instilling risk awareness early.

The program recognizes that girls are also the pipeline to their parents. Students are asked to become healthcare ambassadors to the adult women in their families and are sent home with instructions on breast self-exams. Family members are a trusted source of information in the Hispanic and African-American communities. By reaching out to women through family, the program hopes to build family support for breast health.

During the past year, Norma Pfriem Breast Center’s Esté Listo/Be Prepared: Breast Health for Teens served a record 3,447 students.

Following are some examples of how the program is educating teens who, in

turn, are raising awareness among adult women in their families.

One of the eighth graders in the breast health education class used the information she received to examine her breast and found a lump. She and her mother came to Norma Pfriem Breast Center to have the lump examined. The daughter had a cyst, which is normal for her age, but she did exactly what teens are asked to do – advocate for themselves. Her mother also made an appointment for a breast examination and mammogram.

After a presentation to a ninth grade class, a student shared what she learned with her mother. The mother called the breast center the next day to say she wanted to discuss this topic with her daughter but didn’t know the proper time. When her daughter initiated the discussion, the mother felt comfortable opening up to her and disclosed that not only was she herself a breast cancer survivor, but that her mother and grandmother were as well. The program teaches that family history and genetics are two very important pieces of the breast cancer puzzle, and knowing this information is important. The mother and daughter decided to bring self-exam cards to a family gathering to share with their female relatives.

After attending a breast health class, a student found a lump in her breast and told her mother. She remembered from class that breast cancer in teens is uncommon and knew it might only be a cyst. She told her mother and they scheduled her for an ultrasound. Her mother, who was very relieved and grateful to have the program in her school, scheduled her first mammogram after talking about it with her daughter.

About Norma Pfriem Breast Center
Bridgeport Hospital’s Norma Pfriem Breast Center was the first freestanding community breast center in Connecticut to offer one-stop coordination of care, patient navigation and rapid diagnosis, without regard for a women’s ability to pay. Since 1999, the center has served more than 30,000 women and each year provides nearly 1,000 uninsured and underinsured women with financial assistance for patient care services.

Bridgeport Hospital

3,447

The number of students served by the Norma Pfriem Breast Center’s Esté Listo/Be Prepared: Breast Health for Teens during the past year.

Caring Closet

The average cost of diapers is \$80/month or \$960/year. Babies need an average of 6-10 diapers/day, and many toddlers stay in diapers until age 3.



Addressing “Diaper Need” in Low-income Families

Since 2000, Bristol Hospital Parent and Child Center has operated a diaper and clothing bank for low-income families with young children. The Caring Closet’s chief objective is to address childhood poverty by providing low-income families with basic need supplies, such as diapers, baby wipes, baby food, clothing and other supplies, free-of-charge, for their young children. The program operates on a first-come, first-served basis.

All items are supplied by community donations. The number of families needing support has grown tremendously in the last few years. In FY 2013, 365 families signed up for the Caring Closet. Only 246 actually accessed services, however, which meant 119 registered families were never served. Adding dedicated staff hours in 2014 and 2015 enabled the program to better serve low-income families. Program utilization has skyrocketed the last few years, from 246 families in FY 2013, to 321 families in FY 2014 and 422 families in FY 2015.

The 2013 Pediatrics article, *Defining Diaper Need and Its Impact on Maternal and Child Health*, reported that 34 percent of surveyed families

cut back on child care, food, or utilities to afford diapers. This study suggests that an adequate supply of diapers can reduce parental stress, a critical factor influencing child health and development. According to the National Diaper Bank Network (NDBN), the average cost of diapers is \$80/month or \$960/year. Babies need an average of 6-10 diapers/day, and many toddlers stay in diapers until age 3.

Women who struggle to afford diapers tend to have greater stress and depression levels and decreased coping skills. The NDBN reports that diaper need leads parents to leave their child in soiled diapers longer than recommended, leading to frequent diaper rashes. It can also cause staph and urinary tract infections. The Caring Closet helps to reduce parental stress and physical neglect by improving a family’s ability to access basic need items for their young children. During a family’s visit to the program, staff may learn more about a family’s situation and offer referrals to other helpful programs. In light of increasing regional child poverty rates, the Caring Closet helps decrease parental stress and positively impact the health of area children.

Family Enrichment Center Offers Support to Young Fathers

Sometimes parents need a little help being parents. The Hospital of Central Connecticut’s Family Enrichment Center helps New Britain-area moms and dads do just that with three programs that focus on family support, child development, and even playtime.

Located in a welcoming former house that sits on the hospital’s New Britain General campus, the center staff of 16 employees helps families adjust to having a child and being a family.

M.O.M.S. (Mothers Offering Mothers Support) is a weekly support program for mothers 21 years old and under. Nurturing Families Network is for first-time pregnant or parenting families and provides information, guidance, and assistance through home visiting services, phone calls, and monthly social groups. The Parents as Teachers Program provides support and education to increase parenting skills and includes the DADS program, which offers support and helpful parenting information for dads and couples.

Depending on the service, clients visit the center or receive in-home visits. At its hospital campus, the center averages 30 clients each day, Monday through Friday. It also offers M.O.M.S. and DADS groups at New Britain High School. Program funding is through state and federal grants.

Leading the DADS program are family support workers Troy Ellison and Roberto Marquez. About 20 fathers, ages 15 to 25, receive a weekly, 90-minute home visit from either Mr. Ellison or Mr. Marquez during which they teach developmental milestones of children and help coach the dad, or both mom and dad, to be a better parent.

Jennifer Hernandez, Ed.D., Family Enrichment Center program manager,



says that while meeting one-on-one with dads is unique, research suggests a male helping another male provides “more opportunity to have a successful outcome.”

Mr. Ellison says establishing trust between himself and his clients is very important since he may work with a family for up to five years, “giving them those basic tools to navigate through life,” including making them aware of community resources like food and clothing banks. The DADS program also offers social events, like a recent trip to the Naismith Memorial Basketball Hall of Fame in Massachusetts.

Mr. Ellison says he is familiar with the struggles his clients face as he, too, was a father at a young age. He notes it’s important for the fathers to set goals. “It was a road that I traveled,” he said. “It is important as a father to keep setting goals for yourself and making sure you’re hitting those marks.”

He sees his role as a farmer planting seeds for the young fathers to become successful, adding that it takes time and patience. “You might not see it prosper right away; however, with continued time and patience, they will prosper.”

20

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Connecticut Children's Medical Center



Connecticut Children's Office for Community Child Health and The Village for Families & Children hosted a two-day training to prepare agencies to administer the Mid-Level Developmental Assessment. Participants included three Connecticut-based agencies and Help Me Grow® affiliates from Vermont and California.

A New Model to Meet the Needs of Children At-Risk for Developmental Delay

Developmental screening tools identify increasing numbers of children at risk for developmental delays. However, many children with mild to moderate delays do not qualify for publicly-funded, formal early intervention services. The Office for Community Child Health at Connecticut Children's Medical Center recognized that many young children for whom developmental concerns have not yet evolved into moderate to severe delays could receive a less extensive, more efficient evaluation and begin helpful community-based programs and services in a timelier manner.

To fill the existing gap in assessment options for at-risk children, Connecticut Children's Office for Community Child Health partnered with The Village for Families & Children and the United Way of Connecticut to expand the availability of Mid-Level Developmental Assessment (MLDA), a cost-efficient and timely alternative for children with mild to moderate concerns.

How MLDA Works

The family and others involved in the child's care collaborate with early childhood professionals during the MLDA evaluation, which comprises parent interviews, a play-based assessment of the child, and an individualized family recommendation plan. Since 2009, Village staff has assessed more than 350 children using

MLDA. Eighty percent of the children have been able to benefit immediately from community-based developmental and behavioral programs and services, while 20% have required more extensive evaluation following MLDA to determine their eligibility for state-funded early intervention.

Children are referred to MLDA by parents and service providers concerned about how a child is learning, developing, or behaving through the Child Development Infoline (CDI), a specialized call line of United Way of Connecticut's 211. Once the MLDA evaluation is complete, CDI refers children with mild concerns to Help Me Grow®, a program of Connecticut's Office of Early Childhood, to facilitate linkage to community services. Children with more severe concerns are connected to Birth to Three or preschool education programs for eligibility determination.

Replication of MLDA Statewide and Beyond

With funding from the LEGO Community Fund U.S. and the W.K. Kellogg Foundation, Connecticut Children's Office for Community Child Health is replicating MLDA throughout the state and nationally.

For more information on MLDA, visit <http://mlda.connecticutchildrens.org>.

Helping Patients Manage Diabetes

Danbury Hospital's Diabetes Self-Management Education Program (DSME) was established in 2011 with a goal to create optimal health outcomes for patients. The mission of the DSME program of Danbury Hospital is to educate and empower people with diabetes so they have optimized health-related outcomes. The program believes that providing quality education and fostering the relationship with the person who has diabetes (and his/her family) are essential elements of a successful partnership.



Diabetes is the seventh leading cause of death in the United States and Connecticut, where an estimated 9.3% of Connecticut adults (about 257,000 people) have Type 1 and Type 2 diabetes. The disease complications come at a great cost, including approximately \$164 million billed in Connecticut for hospitalizations due to diabetes.

Connecticut's Department of Public Health (DPH) has issued best practice recommendations for prevention and maintenance of diabetes that include education and patient engagement for weight management and good nutritional habits, as well as controlling blood glucose, blood pressure, and cholesterol. Additionally, routine eye and foot care, as well as other primary care and prevention measures, are key to managing this disease.

Danbury Hospital's DSME has Certified Diabetes Educators and Registered Dietitians who offer individual and group sessions to patients referred by their physicians. Program goals support the needs of patients and the referring physician, providing the education and support necessary to:

- Help patients manage their diabetes
- Improve self-care skills
- Encourage a positive outlook
- Improve the quality of patient lives

The American Diabetes Association-accredited program is beneficial to anyone with Type 1 or Type 2 diabetes – newly diagnosed or long-standing. Monthly curriculum includes:

- Personalized goal-setting.
- Preventive care.
- Daily self-care.
- Choosing an insulin pump.
- Blood glucose monitoring.
- Low/high blood sugar management.
- Self-awareness of sick days.
- Diet and nutritional counseling.
- Exercise recommendations.
- Medication education.

Day and evening group education consists of four interactive classes with a specific area of focus to minimize complications and maximize quality of life. Data show a 65% completion rate. The program instructors are registered dietitians and nurses who are also certified diabetes counselors who have served 288 patients. Program costs are based on patient income and insurance, with an annual community benefit investment supporting any patient needing help.

Danbury Hospital

9.3%

An estimated 9.3% of Connecticut adults (about 257,000 people) have type 1 and type 2 diabetes.



Day Kimball Healthcare

600

Nearly 600 Day Kimball employees, interns, volunteers, and partner providers have been taught how to prevent and recognize child sexual abuse.

Day Kimball Healthcare's Mission to Stop Child Sexual Abuse in the Northeast



According to statistics compiled by Connecticut's Child Advocacy Centers, Windham County has, by far, the highest incidence of child sexual abuse per capita in the state. The statistics show that children who live, learn, grow and play in Windham County are at a higher risk for being sexually abused before they reach adulthood than children in other areas of the state. In fact, more than 3,000 reports are placed annually to the state Department of Children and Families.

In 2013, Day Kimball Healthcare responded to this significant threat to children's health by embarking on an ambitious and dedicated mission to train all 1,300+ of its employees (currently about 1,100), as well as interested community members, in the *Darkness to Light: Stewards of Children* child abuse prevention program. The program teaches participants how to prevent and recognize child sexual abuse and empowers them to react responsibly when abuse is suspected. (Learn more at www.d2l.org.)

In just the last two years, nearly 600 Day Kimball employees, interns, volunteers, and partner providers have been trained in the program, which puts the healthcare system right on

track to achieve its goal of 100 percent employee participation by the end of 2017. More than 300 community members have also been trained in the program. Pomfret Community School (PCS), for example, hosted two sessions in 2014 and trained more than 100 teachers, staff members, and bus drivers. The program was also selected as one of eight finalists in DSW Designer Shoe Warehouse's 2015 Leave Your Mark Program, a national contest that awards a large donation annually to one deserving not-for-profit program nominated by DSW employees.

"Child abuse is an uncomfortable topic to address. I applaud those who are willing to come forward, look at what's happening in our community, and then feel empowered and inspired to make a difference," said Erica Kesselman, MD, a gynecologist with Day Kimball Medical Group who is one of Day Kimball's certified Darkness to Light program facilitators. Dr. Kesselman also serves as a member of the CT State Advisory Council on Children and Families and as Forensic Medical Examiner at Day Kimball Hospital, where she works with children, families, community members, and other judiciary and state services to identify risk factors and evidence for suspected cases of child sexual abuse.

Kids Cooking in the Kitchen Tackles Childhood Obesity

Kids Cooking in the Kitchen is a wellness program that brought together Greenwich Hospital and the Boys & Girls Club of Greenwich to tackle obesity and its associated health risks by educating and empowering youth to make healthy food and lifestyle choices.

Ten children ages 10 to 12 years old attended three weekly, 90-minute after school sessions of *Kids Cooking in the Kitchen* at the Boys & Girls Club of Greenwich.

The goal was to engage children in a safe, supervised culinary environment that provided nutrition education and healthy cooking that would ultimately benefit the entire family as participants shared what they learned with their parents and siblings in their own language and culture at home.

Each week, a Greenwich Hospital chef, registered dietitian, and registered nurses conducted health promotion and nutrition lessons followed by culinary demonstrations. The children donned aprons, gloves, and chef hats, and prepared easy, fun, low-fat meals such as turkey, cheese and fruit kabobs, fresh vegetables and dip, Mexican chicken salad with homemade dressing, and fruit and yogurt parfaits.

Encouraged to be "food detectives," the children learned to read and interpret food labels to reduce fat, salt, and sugar content in their diet. They took part in interactive hands-on activities such as food models and word searches to learn about healthy choices. Classes highlighted the benefits of good nutrition and exercise to reduce chronic diseases associated with obesity. They also learned about kitchen and sharp safety, proper hand-washing, and food-handling techniques to prevent food-borne illness.



Greenwich Hospital chef Barbara Kanner helps youngsters create turkey, cheese, and fruit kabobs during a session of the hospital's *Kids Cooking In the Kitchen* program at the Boys & Girls Club of Greenwich.

Using "Choose My Plate," the children learned how to use the food groups to plan a healthy diet that is lower in fat and calories, with an emphasis on eating more fruits and vegetables.

At the final class, each child received a "Kids Fun and Healthy Cookbook," a pair of safety silicon cooking mitts, an apron, and a "Choose My Plate" reusable plate to reinforce the nutrition lessons.

Evidence that the children benefitted from the program was found on their happy faces as they tasted their own meal creations and in their cognitive knowledge.

Greenwich Hospital's *Kids Cooking in the Kitchen* shows how engaging children in an upbeat environment that provides nutrition education and healthy eating can lead to positive emotional, physical, and behavioral changes that enhance self-esteem while reducing the harmful effects of obesity.

Greenwich Hospital

Kid Kitchen

Using "Choose My Plate," the children learned how to use the food groups to plan a healthy diet that is lower in fat and calories with an emphasis on eating more fruits and vegetables.

500

Since the program's inception, more than 500 free scans have been performed, with nine of the seven lung cancers detected through the program between Stage 1 and 2, when the cancer is most treatable.

Bending the Curve in Lung Cancer Diagnosis and Treatment

Despite advances in treatment, the facts surrounding lung cancer mortality, primarily due to late stage diagnosis, remain quite grim. More than 70% of lung tumors are Stage 3 or 4 at time of diagnosis, with little to no chance of cure. Meanwhile, cure rates for Stage 1 (a tumor less than 2 cm) are better than 90%.

Faced with this data, Griffin Hospital came to the obvious conclusion: *we need to find lung cancers earlier.*

The hospital's response to this challenge was to launch its *Low-Dose CT*

Lung Cancer Screening Program in October 2013. This comprehensive, multidisciplinary effort was intended to bend the curve in lung cancer early diagnosis and, subsequently, survival rates. Studies have shown that use of low-dose CT lung cancer screening gives patients a 20% greater chance of lung cancer survival than screening with traditional chest X-ray.

Griffin's program was based on guidelines established by the National Lung Cancer Screening Trial (NLST), which established patient eligibility/enrollment criteria for the program as follows: Age 55-77, with at least a 30 pack-per-year history of smoking and/or a lung cancer survivor; or age 50-79, with at least a 20 pack-per-year history of smoking and one or more added risk factors for lung cancer.

Until recently, low-dose CT lung cancer screening was not covered by Medicare/Medicaid or most insurance companies, and the hospital recognized that the roughly \$300 being charged by similar programs often created a barrier to patients receiving this potentially life-saving intervention. This prompted Griffin to offer the initial screening free of charge to patients.

Utilizing Griffin Hospital's state-of-the-art, 128-slice CT scanner, screening exams were performed at ultra low-dose radiation levels yet still yielding excellent imaging results. In cases in which a suspicious finding was identified, the hospital's physicians utilized PET scanning or Griffin's navigational bronchoscopy technology to perform a non-invasive procedure to determine pathology that often spared patients unnecessary surgery.

"Today there are people in our community looking forward to a future with their families that, without this program, would have been taken away by lung cancer," said Dr. Salzano. "This is why I became a doctor."

Since the program's inception, more than 500 free scans have been performed, with nine of the seven lung cancers detected through the program between Stage 1 and 2, when the cancer is most treatable. This percentage of early stage diagnosis is inversely proportionate to the stage of lung cancer diagnosis for patients not enrolled in the program. What's more, all of the nine cancers detected would have likely gone undetected until a much later state, when the hope for a cure diminishes considerably.

"This program is a unique blend of technology, community health, and shared commitment to patient care, enabling us to find and successfully treat lung cancers at a much earlier stage than ever before," said cardiothoracic surgeon Richard Salzano, MD, one of the founders of the program along with pulmonologist Marya Chaisson, MD.

"Today there are people in our community looking forward to a future with their families that, without this program, would have been taken away by lung cancer," said Dr. Salzano. "This is why I became a doctor."

Hartford Hospital Sponsors Food as Medicine

Every day, Hartford Hospital provides some of the region's most sophisticated medical treatment, but a new initiative aims to fight disease with a much simpler prescription: eat healthier food.

In 2014, Hartford Hospital partnered with two community agencies to launch the Hartford Mobile Market, which brings fresh fruit and vegetables year-round to the city's low-income neighborhoods.

The Mobile Market is a collaboration between Hartford Food System, which operates the fruit and veggie van, and the Hispanic Health Council, which is evaluating the program to learn if providing fresh food can make a dent in high rates of chronic diseases, such as diabetes, that are associated with unhealthy diets.

Hartford Hospital provided a grant to initiate the program, as did the Harvard Pilgrim Health Care Foundation.

During the summer of 2015, the Mobile Market, a retrofitted 39-foot bus, stopped at about a dozen locations across the city, bringing fresh produce into areas with the greatest need. In the fall and winter, it continues to make the rounds, delivering favorites, such as mangos, to appreciative customers.

"Research in low-income communities shows that access to affordable and culturally appropriate fruits and vegetables is essential for addressing food insecurity, and Hartford's population is the most at risk of food insecurity in the state," said Martha Page, Executive Director of Hartford Food System. "We believe that the Mobile Market is one way to address this challenge and create better access to healthy food."

The Mobile Market accepts most food vouchers and coupons, including WIC (for pregnant women and mothers of infants), SNAP (previously known as



food stamps), farmer's market coupons, and any other voucher intended for the purchase of healthy food.

The Mobile Market also offers cooking demonstrations and nutrition lessons that are sponsored by the Hispanic Health Council and Hartford Hospital.

This year, Hartford Hospital asked its partners to participate in a pilot program dubbed "food as medicine," through which doctors who treat low-income patients at its Brownstone Clinic will prescribe a diet higher in fruits and vegetables and provide coupons to use at the Mobile Market. The van will park at the clinic once a week for even easier access. Researchers from the Hispanic Health Council will evaluate patients before and after the healthy food prescription to see if better access to fresh food is indeed a recipe for better health.

"Unequal access to healthy food is a major contributor to health disparities," said Yvette Meléndez, Vice President of Government and Community Alliances for Hartford Hospital. "Hartford Hospital is proud to partner with the Hispanic Health Council and Hartford Food System in helping to provide access to healthy foods in Hartford's poorest neighborhoods and to be a part of this innovative solution that will help contribute toward healthy outcomes for our neediest residents."

VEGGIE VAN

During the summer of 2015, the retrofitted 39-foot bus stopped at about a dozen locations across the city, bringing fresh produce into areas with the greatest need.

The Charlotte Hungerford Hospital

5210
 “We teach kids and educators to use the numbers 5210 to help them easily remember behaviors and activities to help them live healthy. The numbers stand for 5 or more fruit and vegetables, 2 hours or less of recreational screen time, 1 hour or more of physical activity, and zero sugary drinks and more water.”



The Charlotte Hungerford Hospital Fit Together 5210 – A Health and Fitness Initiative

The Charlotte Hungerford Hospital (CHH) collaborates with the Northwest YMCA and other area not-for-profit child and family advocacy groups to develop and promote community wide “Fit Together” health initiatives. The mission of Fit Together is to build the healthiest kids, families, and communities through sustainable strategies that foster healthy eating and active living. Childhood obesity has tripled in the past 30 years, and diseases that were once seen only in adults, such as type 2 diabetes and heart disease, are now appearing in children.



Charlotte Hungerford’s registered dietitian nutritionist, Carla Angevine, MS, RD, CDN, helps develop and conduct many public and educational programs and training sessions to promote Fit Together’s healthy lifestyles for kids and adults. Ms. Angevine, an ACE Certified Health Coach and chair of the 5210 Subcommittee, is licensed by the State

of Connecticut and registered by the Academy of Nutrition and Dietetics.

“We teach kids and educators to use the numbers 5210 to help them easily remember behaviors and activities to help them live healthy. The numbers stand for 5 or more fruit and vegetables, 2 hours or less of recreational screen time, 1 hour or more of physical activity, and zero sugary drinks and more water,” said Ms. Angevine.

The Fit Together group recently created a Fit Together 5210 coordinator position who could take the lead. Morgan Osborn, a recent graduate of Hamilton College, was selected and is busy at work with new ideas. Ms. Osborn has partnered with several early child care centers and pediatricians’ offices by using evidence-based strategies that have the greatest impact on healthy eating and active living activities within the early childcare settings.

For more information about Fit Together 5210 visit www.fittogethernwct.org

Johnson Memorial Hospital



Pictured L-R: Jeffrey Thompsen, M.D., President, JMMC Medical Staff and the 2015 Medical Staff Scholarship Recipients.

Medical Staff Scholarship Program Has Provided \$100,000 to Area Students

One of the many benefits of being a community hospital like Johnson Memorial is the ability to meet community needs on a large scale with a personalized feel. Whether through high quality care in the hospital, preventive care and education outside its walls, or through acts of kindness to help people with their day-to-day lives, Johnson Memorial Hospital’s mission for more than 100 years has been, and continues to be, to improve the health and well-being of the communities it serves. One of the many ways the hospital impacts the well-being of the community is through the Johnson Memorial Hospital Medical Staff Scholarship Program.

The medical staff’s work in this area is evidence that its members are as passionate about grooming the next generation of health professionals as they are about educating and serving the community in which they work and live.

The Medical Staff Scholarship Program, which began in 2003, provides awards to local high school students from five

area towns – Ellington, Enfield, Somers, Stafford, and Tolland.

Since that time, the Medical Staff Scholarship Program has expanded to include not only graduating seniors from those five area towns, but students

The medical staff’s work in this area is evidence that its members are as passionate about grooming the next generation of health professionals as they are about educating and serving the community in which they work and live.

from parochial and vocational/technical schools outside the local community, previous recipients, children of JMMC staff members, and JMMC employees and volunteers who are pursuing higher or continuing education.

The scholarships provide financial support to students pursuing studies in Health or Human Services related fields and are funded by the Medical Staff and its fundraising events. Since 2003, the Medical Staff Scholarship program has provided nearly \$100,000 to students in the community.

\$100K

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Lawrence + Memorial Hospital

Free of Charge

The primary objective of the program is to increase significantly the number of women who receive breast and cervical cancer screening, as well as diagnostic and treatment referral services.

Connecticut Breast and Cervical Cancer Early Detection Program

Maria Rodriguez was scared. Her doctor at the Community Health Center of New London had sent her for a routine mammogram in 2014 because she was 45 years old and a baseline exam was recommended. But the test turned out to be routine in name only when she was told she needed to have a follow-up because of what looked like an abnormality in her left breast.

The 45-year-old East Haddam resident makes a living cleaning houses. She has no health insurance. She gets her medical care from the Community Health Center of New London.

“They said I needed to have a second test, an ultrasound. They said don’t be scared. But I was all shaky and in tears,” Ms. Rodriguez remembers.

The ultrasound did not show the same abnormality as the mammogram, but doctors who read both tests wanted to schedule an MRI just to be safe. Back at the Community Health Center, Ms. Rodriguez’s doctor ordered the test, which would be done at Lawrence + Memorial Hospital at a cost of \$5,000.

In phone conversations with the hospital’s finance office, payment plans were discussed and options were weighed. But for Ms. Rodriguez and her sister, with whom she lives, the bottom line was clear: They did not have \$5,000.

“So I decided not to get it done,” Ms. Rodriguez says, wiping tears from her cheeks as she told the story. “I did not have the money no matter how we figured it.”

Her doctor at Community Health Center would not give up, though, and referred her to a breast specialist at L+M. That doctor said that based on the discrepancies between the mammogram and the ultrasound, and her own examination of Ms. Rodriguez, an MRI was the best course of action. She connected her to the hospital’s Breast and Cervical Cancer Early Detection Program.

The Connecticut Breast and Cervical Cancer Early Detection Program is a comprehensive screening program for medically underserved women. The primary objective of the program is to increase significantly the number of women who receive breast and cervical cancer screening, as well as diagnostic and treatment referral services. All services are offered free of charge through the Connecticut Department of Public Health’s contracted healthcare providers, located statewide.

L+M is the only hospital in southeastern Connecticut, and one of only three in all of eastern Connecticut, that offer the program.

“The Breast and Cervical Cancer Early Detection Program at L+M is an example of our commitment to provide access to care for all, particularly the most vulnerable among us,” said Guadalupe Cuellar, the Site Coordinator of the program. “In addition to the hospital’s doors being open 24/7, L+M supports critical services such as cancer screening that otherwise might not be available for everyone.”

It was through this program that the cost of the MRI for Ms. Rodriguez was covered 100 percent.

“When they called me (to say the cost was covered), I started crying, I started laughing,” she says. “My sister was crying. It was out of this world.”

The MRI also came back negative, and so Ms. Rodriguez was put on a monitoring program, and must do a monthly self-exam. She is grateful for all the help.

“You feel so alone in all this,” she says. “It was a year, but it felt like forever. And the early detection, they don’t leave you. They make you feel like you are important. They never ask why you don’t have the money, they just try to help.”



Manchester Memorial Hospital Work Source Employment Program

For the past 30 years, the Work Source program of Manchester Memorial Hospital has helped people who are battling mental health or substance abuse issues achieve vocational success and social and economic independence.

Supported by a grant from the Department of Mental Health and Addiction Services (DMHAS), the Work Source program is contracted by Community Health Resources (CHR) of Manchester to provide employment services to CHR patients. The program is also open to patients involved in the hospital’s outpatient adult behavioral health program. Overhead costs are supplemented by Eastern Connecticut Health Network, of which Manchester Memorial Hospital is an affiliate.

Employment coordinators work with clients to determine strengths and weaknesses, interests, identify short- and long-term vocational

goals and barriers to employment. Services provided include job searching techniques, assistance with applications, computer skills, letter and resume writing, eliminating poor work behaviors, and improving the client’s overall presentation.

Once a person does secure employment, ongoing support is extended and includes brief on-the-job training, visits to the job site, communicating with employers/supervisors, and help continuing to reduce and ultimately eliminate any barriers to employment.

In FY 2015, four full-time employment coordinators assisted 830 individuals in securing and maintaining competitive employment opportunities in a variety of fields including retail, warehouse, restaurant, office, human service, education, and healthcare.

Manchester Memorial Hospital

830

In 2015, four full-time employment coordinators assisted 830 individuals in securing and maintaining competitive employment opportunities in a variety of fields including retail, warehouse, restaurant, office, human service, education and healthcare.

NOW
HIRING

Middlesex Hospital

Got Care!

The goal is to improve the health outcomes for those receiving the service through improved assessment, continuity of care, linkages to appropriate services and follow-up.

GOT Care! Middlesex Hospital – UConn School of Nursing Collaborative

Middlesex Hospital identified a higher-than-average, rapidly growing older adult population in Middlesex County (when compared to benchmarks) and high emergency department utilization by older adults for health conditions that should ideally be addressed in the outpatient setting. Based on this data, Community Benefit goals were developed to address access and care coordination among Middlesex County's older adult population. Through analysis of utilization data, meetings with community partners specializing in older adult services, and gap analysis, a need for an in-home comprehensive geriatric assessment was identified.

To meet this goal, Middlesex Hospital's Community Benefit department started to collaborate with the UConn School of Nursing on ways to test an in-home geriatric assessment, as well as support workforce development in the specialty of geriatrics. UConn's grant application to Health Resources and Services Administration (HRSA) under the U.S. Department of Health and Human Services, with Middlesex Hospital as a sub-recipient, was accepted and funded (\$1.4M over three years), and launched in January 2015.

Geriatric Outreach and Training with Care (GOT Care!) is an interprofessional collaborative practice model designed to: improve care for Middlesex Hospital's vulnerable older adult population by conducting in-home comprehensive geriatric assessments and linking patients to needed services; provide nursing leadership in the development and execution of an interprofessional team; and increase workforce expertise in geriatrics by providing a learning experience for UConn students in the fields of nursing, physical therapy, social work, pharmacy, and dental medicine, as

well as Middlesex Hospital's Family Medicine residents.

Middlesex Hospital is a key clinical partner in the GOT Care! initiative and is providing support from hospital Homecare, Family Medicine Residency and Community Benefit departments. For the three-year grant cycle, each semester, students will accompany their respective UConn faculty members, a Middlesex Hospital Homecare nurse navigator, and a Middlesex Hospital Family Medicine Residency faculty member into the homes of patients who agree to the service. Each discipline will conduct a comprehensive assessment, which is then compiled and reviewed in an interprofessional, team-based meeting. A care plan is then developed and the nurse navigator helps to execute the plan along with the Family Medicine Residency faculty member, who works closely with the patient's primary care physician. The goal is to improve the health outcomes for those receiving the service through improved assessment, continuity of care, linkages to appropriate services and follow-up.

According to Millicent Malcolm, DNP, GNP-BC, APRN, from Middlesex Hospital Primary Care, who is also an Assistant Clinical Professor for the UConn School of Nursing and the project's principal investigator, the program will lead to a more skilled workforce that specializes in the care of older patients.

"The expert, interprofessional faculty for this GOT Care! project are very excited to have the opportunity to better prepare our emerging healthcare workforce with special knowledge and skills for the care of the rapidly growing population of older persons," said Ms. Malcolm. "Students will learn from and practice with these interprofessional leaders in geriatric care, setting the stage for improved health outcomes for older persons, now and well into the future."



Jenny Gaity, RN, clinical resource leader for MidState's emergency department, consults with a patient and uses a six-question assessment to gauge the patient's resources at home.

Improving Care Coordination for Seniors in the Emergency Department

When most people think of an emergency room visit, they envision episodic care – patients coming in for treatment for an acute need and then being admitted or discharged based on the findings. With the need for better care coordination becoming paramount, MidState Medical Center is changing the way care is delivered to seniors in its emergency department. In June 2013, the hospital launched an innovative initiative – called the Senior Emergency Care Services initiative – designed to improve care coordination among seniors and keep them healthy and well.

Under the Senior Emergency Care Services initiative, when a patient 65 or older has an emergency department visit, they are not just treated for the ailment that brought them to the hospital. The MidState healthcare team instead goes a step further, with staff administering a unique six-question assessment that gauges a senior's potential needs at home, any medication issues they may have, what their fall risk is or if conditions like dementia and depression might be present. The goals are to identify a need for follow-up care before a condition begins or worsens and ensure a smoother transition to home when leaving the hospital.

The specially trained senior-ED team is multidisciplinary and includes physicians, nurses, technicians, pharmacists, a social worker, and case manager who all play a vital role in the process.

The program has had a significant impact on community health since its inception. The biggest win has been identifying medication interactions among seniors. After a patient's initial assessment, a pharmacist reviews the patient's medication list. As of November 2015, pharmacists made 690 pharmacy referrals, noting approximately 678 medication interactions. Additionally, 75 seniors without primary care providers were referred to a local physician for follow-up care.

"Twenty percent of our patients are over the age of 65. We've made an ongoing commitment to connect with this population and provide them with the resources they need to ensure the best possible outcomes and the best quality of life for our patients," said Alan Weiner, MD, Associate Director, emergency department, MidState Medical Center.

MidState was among the first hospitals in Connecticut to offer this unique program.

MidState Medical Center

Over 65

When a patient 65 or older has an Emergency Department visit, the MidState healthcare team administers a unique six-question assessment that gauges a senior's potential medical needs.



Offering a Delicious and Informative “Dinner with the Doctor”

Key health indicators identified in Milford Hospital’s 2013 Community Health Needs Assessment and subsequent Community Health Improvement Plan led to the hospital’s expansion of free community health and wellness programming. Of particular concern were Milford’s rapidly aging population and its disproportionate mortality rates for heart disease, cancer, and chronic health conditions.

Recognizing that knowledge and education are vital “ingredients” in preventing and managing health risk factors, Milford Hospital engaged the support of its affiliated providers and launched a new educational forum, the “Dinner with the Doctor” program. As a result, in 2015, nearly 500 community members had their health-related questions and concerns addressed by a Milford Hospital physician specialist.

The “Dinner with the Doctor” series featured nine different topics. As a mechanism to promote interest regarding preventive health, several in the series were scheduled to coincide with designated health promotion weeks or months. The “Dinner with the Doctor” program topics included heart health, colorectal cancer prevention and treatment, women’s health, diabetes, vascular conditions, orthopedics, sleep disturbances, and more.

Each session provided participants the opportunity to obtain current information and engage in interactive discussions with on-staff physicians, while enjoying a free, healthy dinner. In many cases, the meals were planned to exemplify easy, balanced and nutritious menu options related to the subject matter.

Since its inception, feedback on the program has been overwhelmingly positive. Nearly every participant expressed “thanks” for the opportunity to attend a “Dinner with the Doctor.” One participant in the



“Heart Smart” session wrote, “The doctor took questions as he spoke, which was so helpful. He was very clear in his explanations. I felt like he was only speaking to me. This was a very effective program.”

A participant in the orthopedic session commented, “I was very impressed with the format of this program. I got more information than I expected and it was very well presented. The doctor anticipated and answered many questions that I had. I am convinced that this is the doctor and hospital for me. I am not afraid to make an appointment.”

The “Dinner with the Doctor” programs were designed and developed collaboratively between the community education department and the hospital medical staff with a two-fold purpose of addressing the specific needs of our community while offering Milford Hospital and its team of physician specialists as a healthcare resource to the community. The new “Dinner with the Doctor” series is just one component in a robust schedule of health screenings and wellness programming that Milford Hospital offers in-house, in work-sites, and in the community.

Free CT Lung Cancer Screening Program For At-Risk Populations



Lung cancer is the leading cause of cancer death in men and women. According to the American Cancer Society (ACS), each year more people die of lung cancer than of colon, breast, and prostate cancers combined. Removing cost as a barrier to readily access the screenings is critical to early detection and survivorship. Those at highest risk are current or former heavy smokers between the ages of 55 and 79 years.

Studies have shown that treatment for lung cancer is more effective and the likelihood of death decreases significantly if it is detected early through screening. However, until recently, there has not been an effective tool for diagnosing early-stage lung cancer. The National Lung Screening Trial (NLST), a multi-year research study of more than 53,000 people conducted at 33 trial sites nationwide, showed a 20 percent reduction in lung cancer deaths among those who were screened by CT versus those who had standard chest X-rays.

In early 2012, Norwalk Hospital became the first hospital in Connecticut to launch a low-dose CT (computed tomography) lung cancer-screening program to identify lung cancer in its earliest stages. The program was based upon the findings of the NLST sponsored by

the National Cancer Institute.

Since then, more than 1,845 patients have been screened through the Norwalk Hospital program and 25 seemingly-healthy people without symptoms were diagnosed with lung cancer and at an earlier stage than would have been detected without the screening. These cancers would not have been detected through a standard chest X-ray. The hospital has eliminated cost as a barrier and given all people access to these screenings.

Norwalk Hospital’s free lung screening program has a three-part benefit. In addition to the “low-dose” non-contrast CT — which produces a three-dimensional image of the lungs for early detection of lung cancer — a coronary calcium score is calculated from the information available from this study. This supplemental testing can improve risk assessment for heart disease when added to traditional risk factors. A smoking cessation program is also offered by Norwalk Hospital to active smokers who enroll in this screening program.

Patients and referring physicians are notified of the test results and a lung health navigator assists patients who have positive findings with any follow-up that is needed.

1,845

More than 1,845 patients have been screened through the Norwalk Hospital program and 25 seemingly-healthy people without symptoms were diagnosed with lung cancer and at an earlier stage than would have been detected without the screening.

500

Nearly 500 community members attended the “Dinner with the Doctor” program. Topics included heart health, colorectal cancer prevention and treatment, women’s health, diabetes, vascular conditions, orthopedics, sleep disturbances, and more.

Prenatal Care

The program strives to not only promote maternal and fetal well-being but improve self-image, self-care, and parenting skills for the uninsured and underinsured women served by the Center.



Family Circles Prenatal Care Program Empowers Women

In the spring of 2014, the Maternity Care Center at Rockville General Hospital began offering the Family Circles Prenatal Care Program, an alternative to one-on-one prenatal care that combines routine health assessments with childbirth education and support in a group environment. The program strives to not only promote maternal and fetal well-being but improve self-image, self-care, and parenting skills for the uninsured and underinsured women served by the Center.

The Family Circles groups comprise three to six pregnant women who are all due to deliver their babies within two months, a healthcare provider, and a facilitator.

Women are empowered to participate in self-care activities and self-assessment, such as taking their own blood pressure and weight, and are seen privately by the healthcare

provider for a wellness visit. Guided by the facilitator, group discussions cover topics such as nutrition, exercise, infant care and feeding, and postpartum issues, and foster a dynamic atmosphere for learning and sharing that may be impossible to create in a one-on-one encounter. Hearing other women share concerns that mirror their own helps women to normalize the experience of pregnancy. Groups also empower women to provide support to one another and increase individual motivation to learn and make positive changes.

Thanks to a grant provided by Sovereign Bank, incentives are provided to those enrolled in the program including an educational workbook, snacks, and a small gift at the end of each meeting.

In FY 2015, 11 women benefitted from the Family Circles program.

Removing Barriers to Healthcare

Management of a chronic illness can be a difficult task, but it is even more challenging when one is faced with limited resources and insufficient health insurance coverage. Saint Francis Hospital and Medical Center has partnered with a national organization called Community Solutions, which is engaged locally in community development designed to improve the quality of life for the residents in the North End of Hartford. One focus of this partnership has been to help residents find the services they need to manage chronic illness rather than using the high-cost services of the emergency room for their healthcare. In the first nine months of a pilot project, participants experienced a 57 percent decrease in their Emergency Room use. A social worker from Community Solutions, Nadia Lugo, says her client Deborah Knowles' story shows how the new approach works.

Deborah is a North End resident by way of South Carolina. She lives in a very clean and homey apartment, and she has an amazing smile – a smile that becomes even more amazing when you learn she is living with chronic back pain, cirrhosis of the liver, diabetes, and hypertension. It's clear when you sit in her kitchen that she loves to cook. She has a large bag of onions and potatoes on the shelf in the corner along with big bags of both rice and beans. She even has a set of measuring cups adorning the walls.

"When I was a kid, we moved to South Carolina and we didn't have any furniture in our new house. My mom said she could buy the furniture if we all agreed to eat beans for a full month. So we did – and we got that furniture. And you know – I still love to cook beans."

When she met Nadia, Deborah was using the emergency room to deal with her health issues. She did not have transportation and, because of acute back pain, she was unable to walk to the bus stop. Sometimes her medical cabs did not show up, so she would call the ambulance to get



Heather Applewhite, MD, a first-year Family Medicine resident, consults with Deborah Knowles about her medical history.

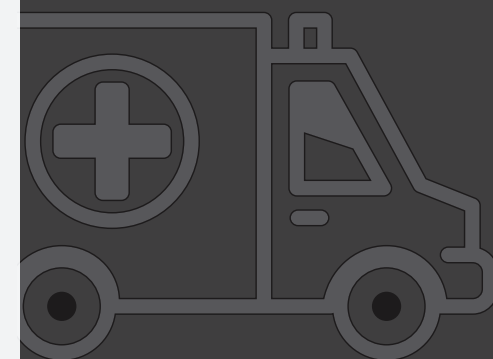
to the emergency room and receive the treatment she needed. This use of the emergency room was logical, but it was also expensive and time-consuming for Deborah. Nadia helped her develop a better strategy for managing her chronic conditions.

Since she met Nadia, Deborah has seen her quality of life, and her health, improve significantly. She now has a plan set up with her landlord to address back rent, and a walker and stability bars to get around her apartment more easily. Her prescriptions are now delivered to her home, and she has gained control of her diabetes thanks to a primary care doctor and a visiting nurse, who help with her insulin shots. Deborah no longer spends the day in bed depressed and in chronic pain. Instead, she says she wants to get outside more and visit her friends and family.

Community-based care coordination has helped Deborah spend less time in the hospital and more time doing what she loves. She is forever grateful to Nadia for helping her get her life back.

57%

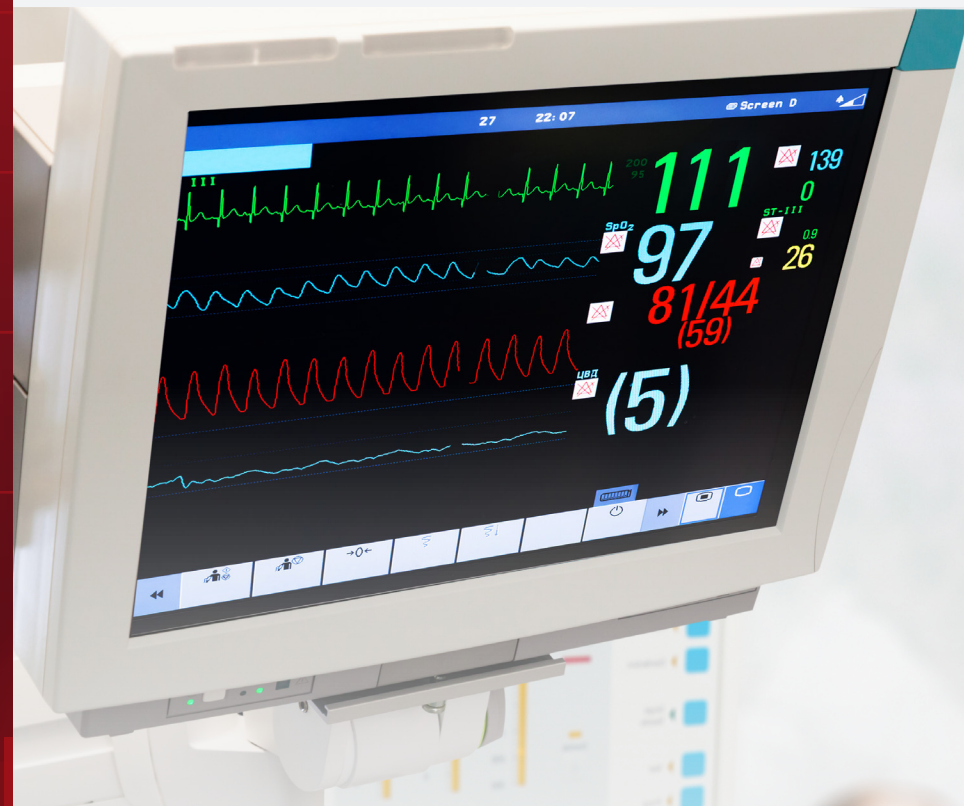
In the first nine months of a pilot project, participants experienced a 57 percent decrease in their emergency room use.



Saint Mary's Hospital

Pump Club

The Pump Club currently has about 50 members, and providers have noted those who are participating have required fewer ER visits and fewer readmissions since the program was introduced.



Eliminating Barriers to Heart Failure Care

As one of the first hospitals in the country participating in the American College of Cardiology's Patient Navigator Program, Saint Mary's Hospital was tasked with identifying innovative solutions to reduce readmission rates for heart failure patients. One of the hospital's responses was to establish a clinic known as the "Pump Club" to enhance access to care for heart failure patients who face barriers to care, as well as a greater risk of readmission.

The Pump Club goes beyond the scope of existing, hospital-based heart failure clinics by delving deeper into the socioeconomic needs of patients and helping them to overcome obstacles that prevent them from accessing care. Many of these patients begin each day in crisis. Do they have transportation to their appointments? What are their living conditions like? Do they have heat, access to food? Are they or their family members struggling with substance abuse issues? For these patients, a diagnosis of heart failure can be overwhelming.

Club "members" are able to bypass the traditional patient registration process and proceed directly to an outpatient therapy clinic on the hospital's fifth floor. There, skilled cardiac nurses provide patient education, check vitals, manage medications and, if necessary, provide treatment that might otherwise require a trip to the emergency room. It's a place where patients can get a cup of coffee and a sandwich and "check in" with providers who are there to ensure the patient's needs are being met. Often, it is simply a matter of connecting the dots and identifying available resources.

The Pump Club currently has about 50 members, and providers have noted those who are participating have required fewer ER visits and fewer readmissions since the program was introduced in January 2015. One patient who was hospitalized at least six times in 2014 avoided readmission in 2015. As with any heart failure patient, the goal is to keep these patients as healthy and stable as possible. And so far, they are succeeding.

St. Vincent's Medical Center

Medical Mission Demonstrates Healthcare That Leaves No One Behind

St. Vincent's Health Services has proudly served the Greater Bridgeport community for more than 112 years, and serves all who need care, regardless of their ability to pay. In 2015, St. Vincent's embarked on its first "Medical Mission at Home" at Cesar Batalla School in Bridgeport's West End.

"Medical missions" typically involve volunteer caregivers traveling to other countries to provide medical services. The St. Vincent's Medical Mission at Home, presented by St. Vincent's Medical Center Foundation and staffed entirely by volunteers, was designed to deliver healthcare, as well as social and support services to neighbors in need in the local community. The Medical Mission at Home was an even deeper demonstration of St. Vincent's commitment to a mission that calls for delivering "healthcare that leaves no one behind," by concentrating on serving individuals who are homeless and under or uninsured.

Thanks to the support of 155 clinical and 193 non-clinical volunteers, St. Vincent's Health Services' inaugural Medical Mission at Home was an impactful day of service to the Bridgeport community. With temperatures suddenly dropping from the 70s to the 40s, more than 330 of Bridgeport's most vulnerable residents were able to come in from the cold for an experience they won't soon forget.

While the doors were not scheduled to open until 9:30 a.m., community members arrived as early as 8:00 a.m. As medical staff, employees, medical and nursing students, and other volunteers gathered to receive a Blessing of the Hands, the mood was expectant and

the energy was high. Everyone was looking forward to a day that was sure to be filled with meaningful connection and humbling service.

Residents of all ages received medical care, foot washing and podiatry services, nutrition counseling, behavioral health services, physical therapy, smoking cessation, spiritual care, and social services. In addition, community members were provided with a healthy lunch and child care services during their visit.

A total of 325 vaccinations and flu shots were provided and 94 prescriptions were filled at the Medical Mission. In addition to point-of-care services and testing, significant effort went into connecting patients with a permanent medical home. To that end, 14.5 percent of those treated made follow-up appointments with primary care providers.

Thanks to community partnerships, each person was invited to take home reader eyeglasses, a warm coat, new shoes, and socks. Volunteers also worked with attendees to refer anyone without insurance to Access Health CT. Other community partners on site included Greater Bridgeport Transit, 2-1-1, Hope Dispensary of Greater Bridgeport, Southwest Community Health Center, Project Homeless Connect, and the Bridgeport Health Department.

St. Vincent's Medical Mission at Home was truly the demonstration of St. Vincent's mission and core values in action and serving "the least of our brothers." Each person served had a story to share, reminding everyone involved of our shared humanity.

330

More than 330 residents received medical care, nutrition counseling, behavioral health services, physical therapy, smoking cessation, spiritual care, and social services.



Stamford Hospital

1,000

During the first two years of operation, the clinic has served more than 1,000 patients with over 3,500 visits – with an estimated value exceeding \$2.5 million for these services.

Partnering with AmeriCares to Provide Free Clinical Care



In an example of just what can be accomplished when a community comes together, the AmeriCares Free Clinic (AFC) of Stamford provides quality healthcare to low-income, uninsured residents of the community. A key component of this program comes from resources provided by Stamford Health, which includes Stamford Hospital as well as outpatient and ambulatory care locations in the region. Through this relationship, patients of AFC of Stamford are provided ready access to diagnostic testing, emergency medical services, and other procedures at no cost.

The program operates from a 40-foot mobile medical clinic, and attracts outstanding volunteers – physicians, nurses, interpreters, and administrative volunteers – all of whom come together to keep this vulnerable population healthy and able to take care of themselves and their families. By providing these services, lives are saved, emergency room visits

and hospitalizations are decreased, and complications of chronic disease are better controlled through early diagnosis, treatment, and patient education and empowerment.

Specialized care is also available primarily through Stamford Health's network of clinics. Medications are a vital part of the program, and laboratory services are available through Quest Diagnostics at no charge. AFC of Stamford is an active member of the Vita Health & Wellness Community Collaborative and is working closely to implement the hospital's health improvement plan.

During the first two years of operation, the clinic has served more than 1,000 patients with over 3,500 visits. With the ever-increasing number of new patients and overall patient visits, AFC is now seeking permanent space for the clinic in Stamford and anticipates expanding its relationship with Stamford Health as well as other community partners.

Community Breast Navigator Helps High-Risk Population

A grant from Connecticut's Susan G. Komen Foundation enables a new UConn John Dempsey Hospital educator to go into the local community and raise awareness about breast cancer and the importance of early detection among African American and Latina women.

Rashea Banks, a Community Breast Navigator with Community Health Services, provides one-on-one counseling about breast cancer early detection with the women who visit Community Health Services. She has already met with more than 224 women, and scheduled 83 mammogram screenings.

When patients are scheduled for mammograms, Ms. Banks tracks their experience. Should mammogram results detect any abnormalities, she then connects the patient with the Breast Nurse Navigator Molly Tshipouras at UConn John Dempsey Hospital in Farmington, who assists in their needed work-up and treatment. Ms. Banks also distributes mammogram magnets to serve as a reminder to remember to be screened annually.

"As a fellow African American woman who was raised in an inner-city community, I think it is so important to raise awareness of breast cancer directly in the community," says Ms. Banks, who is currently pursuing her Master of Public Health at UConn Health.

"Risk factors for breast cancer can be genetics, or family history, along with lifestyle. A lot of people are not aware that they may be at high risk," she says. "Breast cancer in African American and Latina women tends to be more aggressive, such as triple-negative breast cancer, and can be more difficult to treat."

Ms. Banks recalls guiding her first Latina woman at Community Health Services to a mammogram screening. The woman expressed that she didn't know where to get a mammogram but wanted one because several members of her family had died of breast cancer.

"This woman's experience and [the experience of] others are fueling my determination, ambition, and passion to reach as many women as possible and navigate them through early detection in order to prevent diagnosis at a later stage of breast cancer," Ms. Banks said.

Outreach by Ms. Banks is taking place at other community events, expos, and local churches, and is currently being planned for hair salons, nail salons, local school administrative offices, and local small businesses within the Hartford area.

The Carole and Ray Neag Comprehensive Cancer Center at UConn Health recommends these tips for breast health:

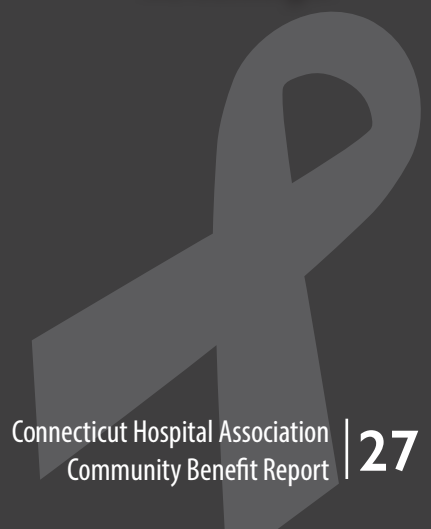
- Keep breast health awareness top of mind all year round, not just in October.
- Mark your calendar to perform a monthly self-breast exam, ideally 10 days after the start of your menstrual cycle.
- Make sure you receive a yearly clinical breast exam during your annual physical or gynecology appointment.
- Maintain a healthy diet that is low in fat.
- Exercise at least 30-minutes a day. Brisk walking counts.
- Limit alcohol consumption.
- Don't forget to schedule a mammogram screening.
- If you're 40, talk to your doctor about annual mammogram screening.
- If you're high-risk due to family history, talk to your doctor about mammogram screenings at age 35 or younger.

The Community Breast Navigator position was made possible by the Komen CT grant awarded to UConn Health's Dr. Christina Stevenson.

UConn John Dempsey Hospital

224

Community Health Services provided one-on-one counseling about breast cancer early detection for 224 women and scheduled 83 mammogram screenings.



Waterbury Hospital



Helping HIV Patients Lead Healthier Lives

HIV-positive patients receiving effective antiviral therapy are living longer lives and are increasingly affected by non-HIV-related chronic diseases such as liver disease, cancer, and cardiovascular disease. Considering this trend, the Food for Life Program was created to provide an opportunity for low income, HIV-infected patients with cardiac risk factors to improve their health.

Started in 2014, the Food for Life Program is part of services offered at the Waterbury Hospital Infectious Disease Clinic, which is a Ryan White grant-funded, multidisciplinary program. The Clinic provides comprehensive HIV care services to approximately 500 patients.

Fifty-four multicultural HIV-infected patients were enrolled in the Food for Life Program over the course of 12 months. Health providers referred patients into the program who are HIV-infected, at or below 250% poverty level with at least one of the following elevated clinical indicators: Hemoglobin A1c, Glucose, Body Mass Index (BMI), cholesterol and/or blood pressure.

Participants were provided access to healthy foods through food gift cards to the Waterbury ShopRite Supermarket, gym memberships to the Greater Waterbury YMCA, along with mandatory counseling sessions with a registered dietitian, as well as support from a medical case manager.

As the program evolved, nutrition, health, and wellness support groups were created. The program provides on-site exercise classes every month including yoga and strength



training. Waterbury Hospital's Head Chef provides quarterly cooking demonstrations with recipes. Patients participated in the Waterbury 2015 Walk Against Hunger and the St. Vincent DePaul Walk in Their Footsteps 5k Run and Walk.

The Food for Life Program has continued to evolve and grow. It has enabled low income, HIV-infected patients with other chronic medical conditions an opportunity to improve their overall health and lifestyle. This resulted in a decrease in their weight and reduced serum lipids.



Spanish Health Fair Bridges Cultural Barrier

More than 50 people attended a health fair for Spanish-speaking community members hosted by Windham Hospital on May 28, 2015 in the hospital's education center.

The event provided free health screenings including blood pressure, glucose, cholesterol and head and neck cancer screening.

Providers and translators were on-site to interpret results and provide education. Healthy snacks and information about healthy eating were also available.

The event was organized by Karen Barbone, RN, CDE; Lynne McPhee, RD; and Angela Frankland, RD, from the Windham Hospital Diabetes Education

Department, which offers outpatient diabetes support for education through the use of a translator paid for through donor funds.

"This was a tremendous turnout for what is really an important event. Thank you to all of our providers and translators who helped make this possible," said Ms. McPhee.

"It's so important for us to let our Spanish-speaking community members know that Windham Hospital is the place where they can come to get information and screenings that will lead to a healthier life," she added. "And, with an event like this, maybe even have a little fun in the process."

Windham Hospital

Building Bridges

The hospital provided free health screenings including blood pressure, glucose, cholesterol and head and neck cancer screening. Providers and translators were on-site to interpret results and provide education.

Food For Life

Participants were provided access to healthy foods through food gift cards to the Waterbury ShopRite Supermarket, provided gym memberships to the Greater Waterbury YMCA, counseling sessions with a registered dietitian, and support from a medical case manager.

250

This partnership seeks to provide more than 250 children ages 8 to 13 years old with a well-rounded exploration of health in a fun and supportive environment.

Camp New Haven Injects Healthy Dose of Fun Into Summer



Children in New Haven often lack access to affordable summer programming that is engaging, active, and educational. To provide more summer opportunities for kids, the Yale-New Haven Hospital (YNHH) teamed up with the New Haven Department of Police Service's Police Athletic League (PAL). The result is Camp New Haven, which serves more than 250 children ages 8 to 13 each summer.

This partnership seeks to provide all of the campers with a well-rounded exploration of health in a fun and supportive environment. For example, YNHH set up a "day in the life" at the hospital by creating a hypothetical scenario about a car crash resulting from a teenager who was texting while driving. To teach the kids about the dangers of distracted driving, the youth are lead through a series of vignettes, including a staged automobile crash, complete with paramedics and truck from the fire department, an ambulance and crew, and a transport helicopter, all of which were interactive.

Campers were then brought through the different departments of the hospital, set up at the camp, so they could experience all of the different areas a patient would go through, as well as meet the people who

save lives and help people heal on a daily basis. More than 60 staff were involved, including emergency department nurses, radiology technicians, operating room staff, casting specialists, and many others, who provided the kids with hands-on learning experiences.

To illustrate to the campers the well-rounded approach to healing, YNHH included staff from the chaplaincy, food and nutrition, and even the staff clowns from the Children's Hospital, showcasing the many ways in which YNHH takes great care of its patients.

More staff from Yale-New Haven Hospital came out on another day to get active with campers. The YNHH basketball team taught fundamentals and set up friendly half-court games. Other staff led games of kickball, touch football, and soccer. Groups of campers rotated through all of the stations to experience each of the different activities.

This is only one example of Yale-New Haven's partnerships with youth in the hospital's community. YNHH also conducts the annual Health Sciences Career Expo, which reaches 1,200 students statewide each year. There is also an annual mock trial with local fifth graders, school supply drive, and read aloud days.

- 4 **The William W. Backus Hospital** – Rx for Health Finishes Record Fifth Season
- 5 **Bridgeport Hospital** – Esté Listo/Be Prepared: Breast Health for Teens
- 6 **Bristol Hospital** – Addressing "Diaper Need" in Low-income Families
- 7 **The Hospital of Central Connecticut** – Family Enrichment Center Offers Support to Young Fathers
- 8 **Connecticut Children's Medical Center** – A New Model to Meet the Needs of Children At-Risk for Developmental Delay
- 9 **Danbury Hospital** – Helping Patients Manage Diabetes
- 10 **Day Kimball Healthcare** – Day Kimball Healthcare's Mission to Stop Child Sexual Abuse in the Northeast Connecticut
- 11 **Greenwich Hospital** – Kids Cooking in the Kitchen Tackles Childhood Obesity
- 12 **Griffin Hospital** – Bending the Curve in Lung Cancer Diagnosis and Treatment
- 13 **Hartford Hospital** – Food as Medicine: Hartford Hospital Sponsors Mobile Market
- 14 **The Charlotte Hungerford Hospital** – The Charlotte Hungerford Hospital Fit Together 5210 - A Health and Fitness Initiative
- 15 **Johnson Memorial Hospital** – Medical Staff Scholarship Program Has Provided \$100,000 to Area Students
- 16 **Lawrence + Memorial Hospital** – Connecticut Breast and Cervical Cancer Early Detection Program
- 17 **Manchester Memorial Hospital** – Manchester Memorial Hospital Work Source Employment Program
- 18 **Middlesex Hospital** – GOT Care! Middlesex Hospital – UConn School of Nursing Collaborative
- 19 **MidState Medical Center** – Improving Care Coordination for Seniors in the Emergency Department
- 20 **Milford Hospital** – Offering a Delicious and Informative "Dinner with the Doctor"
- 21 **Norwalk Hospital** – Free CT Lung Cancer Screening Program For At-Risk Populations
- 22 **Rockville General Hospital** – Family Circles Prenatal Care Program Empowers Women
- 23 **Saint Francis Hospital and Medical Center** – Removing Barriers to Healthcare
- 24 **Saint Mary's Hospital** – Eliminating Barriers to Heart Failure Care
- 25 **St. Vincent's Medical Center** – Medical Mission Demonstrates Healthcare That Leaves No One Behind
- 26 **Stamford Hospital** – Partnering with AmeriCares to Provide Free Clinical Care
- 27 **UConn Health John Dempsey Hospital** – Community Breast Navigator Helps High-Risk Population
- 28 **Waterbury Hospital** – Helping HIV Patients Lead Healthier Lives
- 29 **Windham Hospital** – Spanish Health Fair Bridges Cultural Barrier
- 30 **Yale-New Haven Hospital** – Camp New Haven Injects Healthy Dose of Fun Into Summer

About the Connecticut Hospital Association

The Connecticut Hospital Association has been dedicated to serving Connecticut's hospitals since 1919. Through state and federal advocacy, CHA represents the interests of Connecticut's hospitals on key healthcare issues in the areas of quality and patient safety, access and coverage, workforce, community health, health equity, and hospital reimbursement.

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