

2006 New London
Community Health Needs Assessment
Findings and Recommendations

April 5, 2007

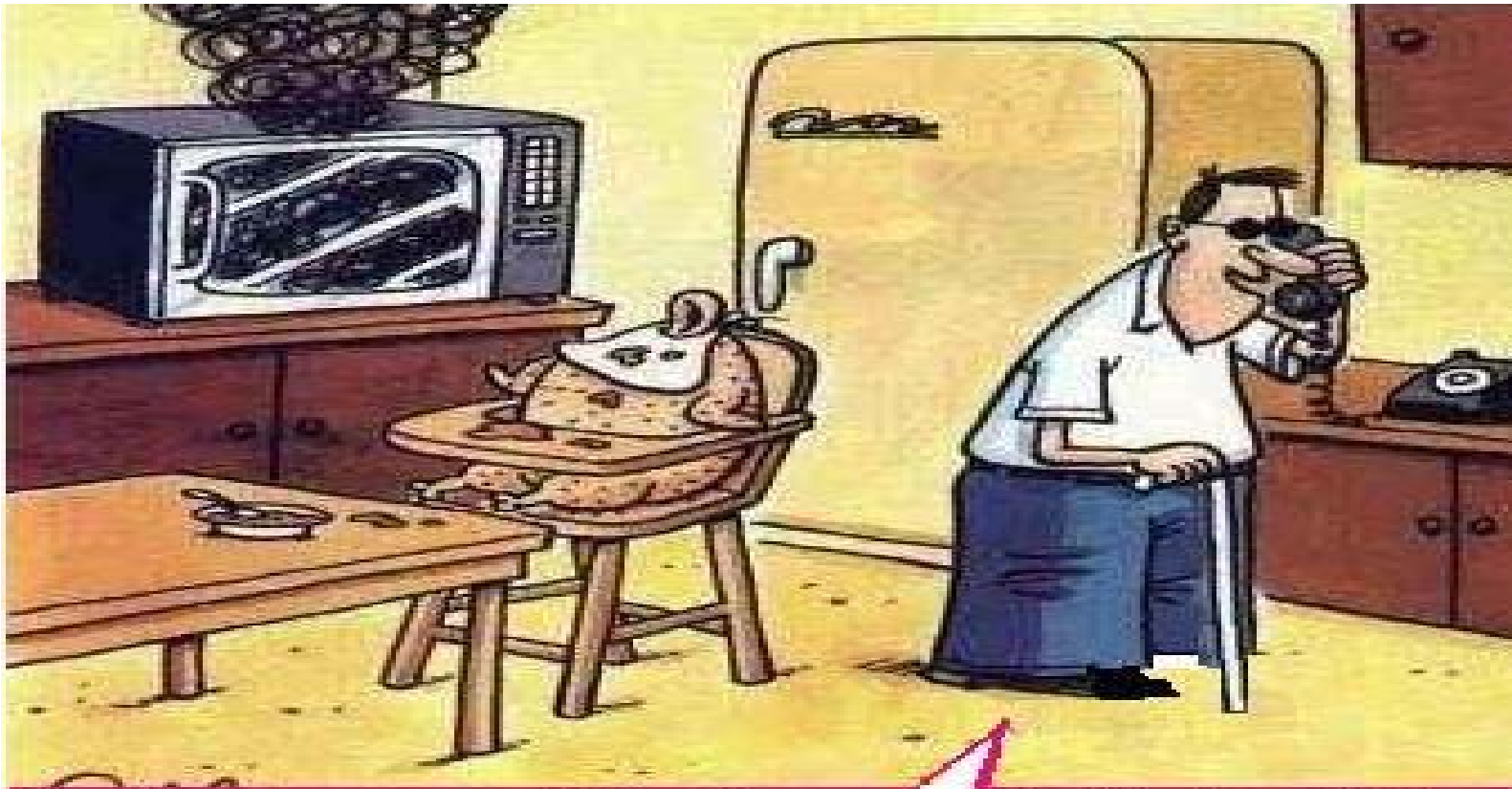
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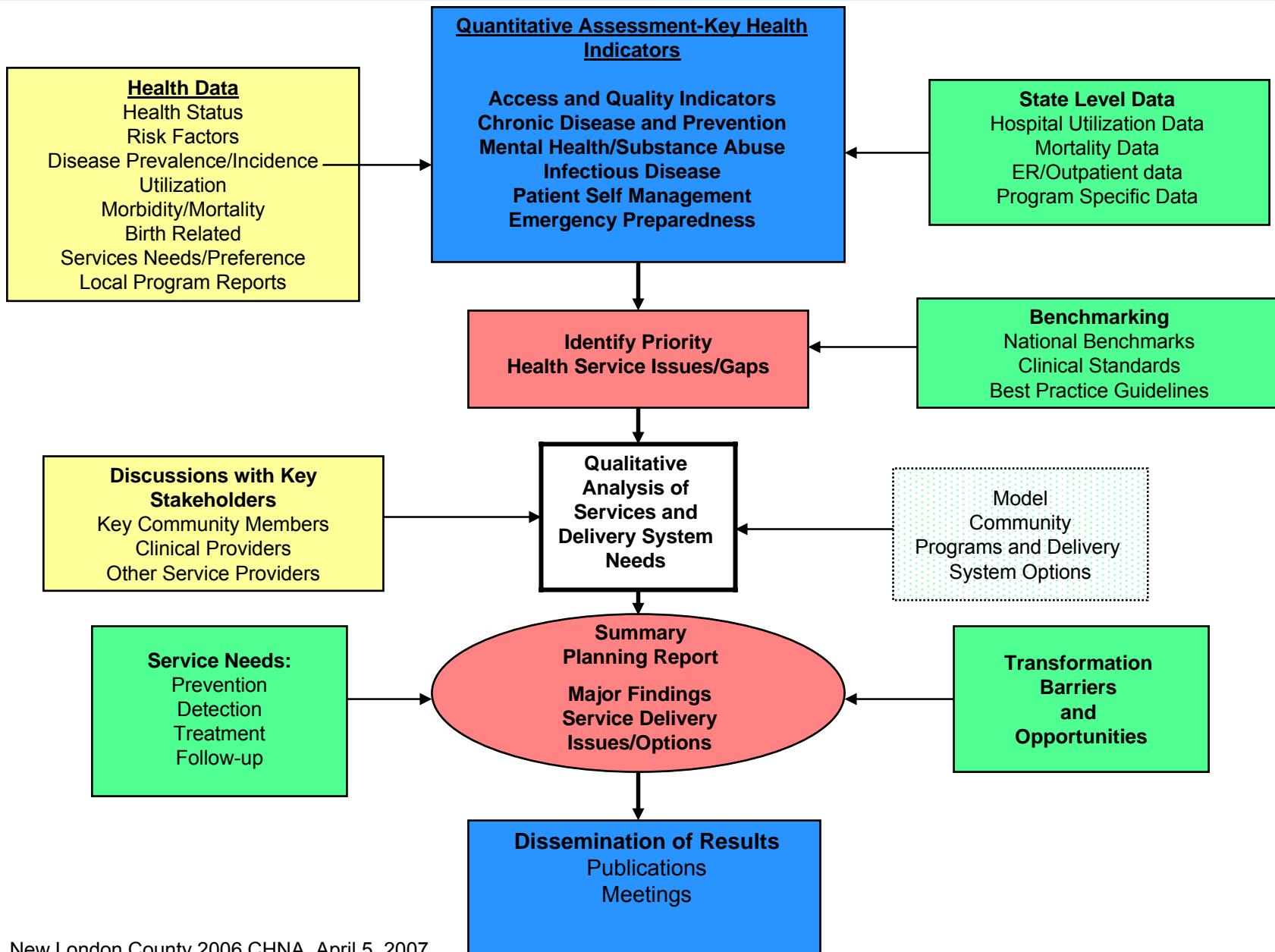
Presentation Objectives

- Present Overview of the Study
 - Content and Methods
- Present Priority Health Issues based on findings of the Community Health Needs Assessment
- Present Recommendations for each Health Issue
- Lay the foundation for the Breakout Sessions
 - Recommendations
 - Are they feasible?
 - What resources already exist?
 - How should be expanded?
 - What would it take to implement?
 - » Resources, leadership, other barriers to overcome
 - Who should be involved?
 - How will you define success?

What we want to find out?



Dont worry , everything is great , the Turkey in the microwave , and i am feeding the baby ...



Methods: Community and Institutional Assessment Process (CIAP)

I. Data Acquisition

- Community Household Survey
- Public Data (e.g. birth and mortality records)
- Private Data (e.g. detailed reports)

II. Identify Priority Health Issues through analysis of health status, care management and outcome indicators

- Access to Care
- Prevention and Public Health
- Chronic and Infectious Disease
- Behavioral Health

Methods: Community and Institutional Assessment Process (CIAP)

(cont.)

III. Assess Specific Local Healthcare Services

- Focus on Priority Health Issues

Recommendations and Implementation Strategies

IV. Health Service Needs and Planning Report

- Recommendations on priority health issues
- Baseline data for planning and implementing health care delivery changes

Data/Information Sources

- **Adult Household Survey, 2006 (N = 1300 households)**
- **Hospital inpatient data, 2004-2005**
- **Emergency visit data, 2004-2005**
- **Birth data, 2002-2004**
- **Mortality data, 2002-2004**
- **Cancer incidence and staging data, 2001-2003**
- **Infectious Disease 2000-2005**
- **Connecticut BRFSS data, 2005**
- **Key Informant Interviews**
- **Existing reports**
- **Population, 2000 and 2005 estimates**

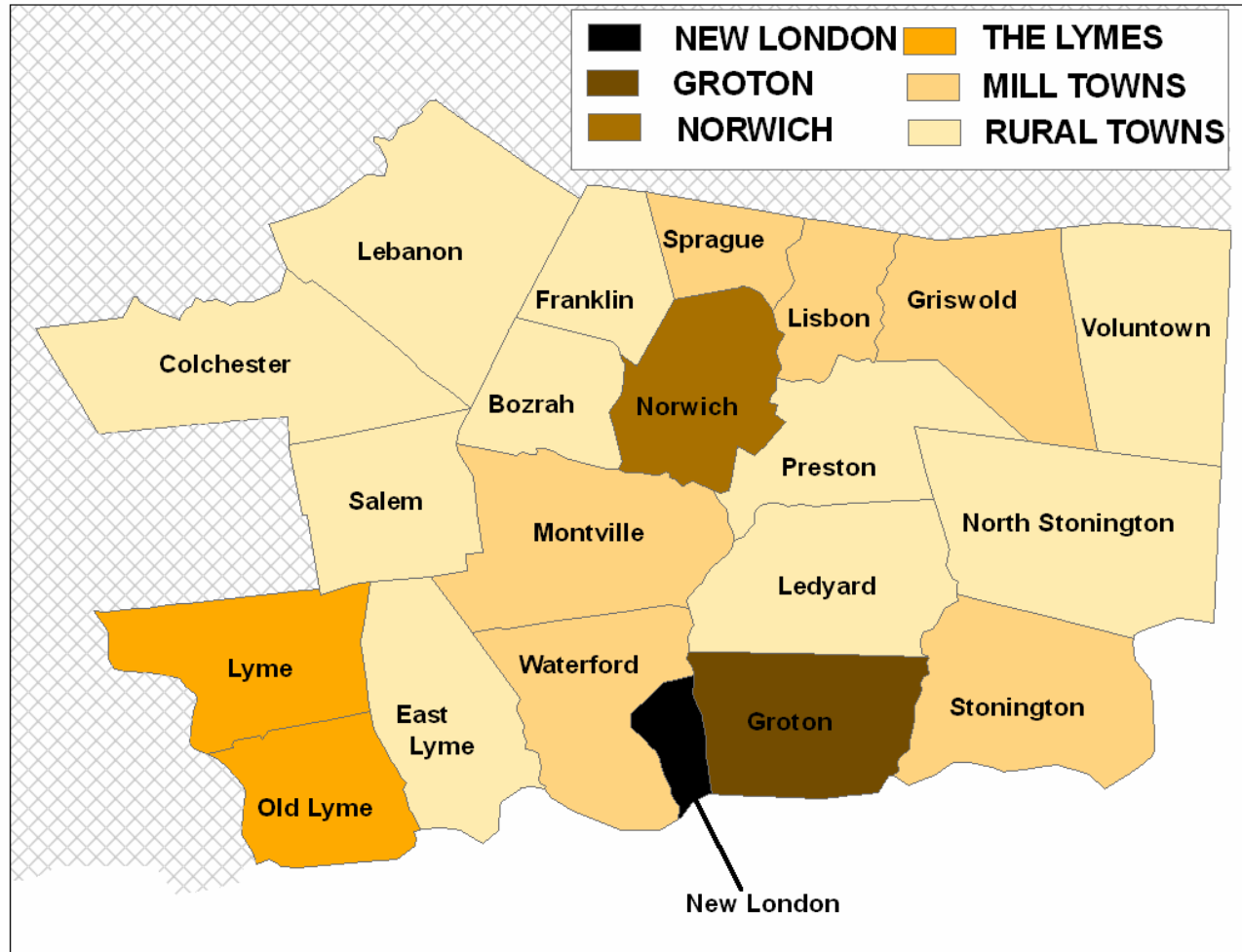
Methods: How does the assessment process identify service needs?

- Prioritize service issues/disparities (prevention, access, detection, treatment, care management,)
- Determine where follow-up is needed and with whom
- Conduct interviews/focus groups to identify service access, capacity, organizational and related issues
- Develop specific health services recommendations

Methods: Health Indicator Analysis

- County and sub-county analysis
 - Use of Health Reference Groups
- Pattern Analysis (risk factor, disease prevalence, care management, outcome measures)
- Comparisons to Health External Standards, Benchmarks
 - State, National, Healthy People 2010
- Drill down by age, gender, race, pay source, provider type, etc.
- Clinical vs. Statistical Significance

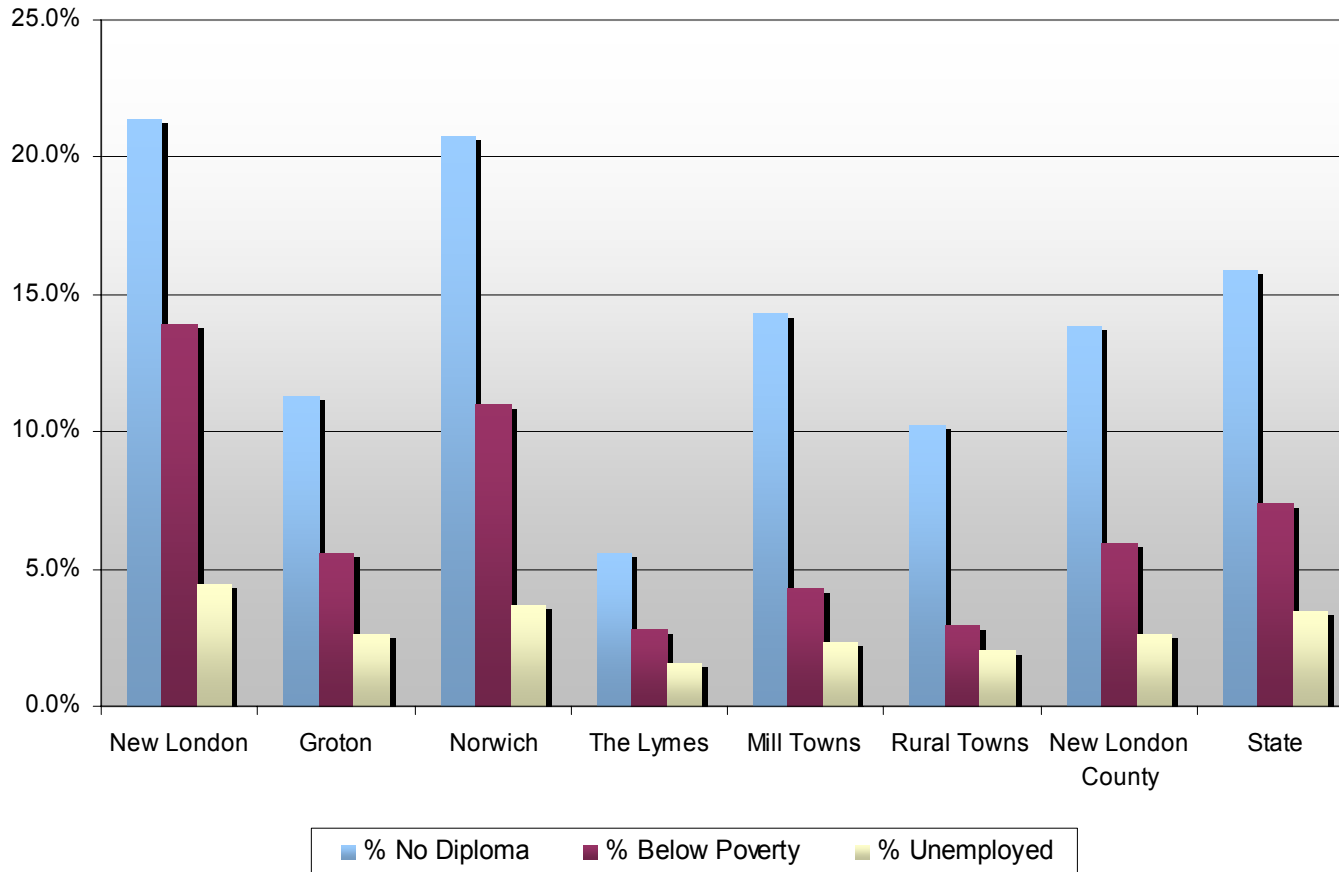
Study Regions



Demographics

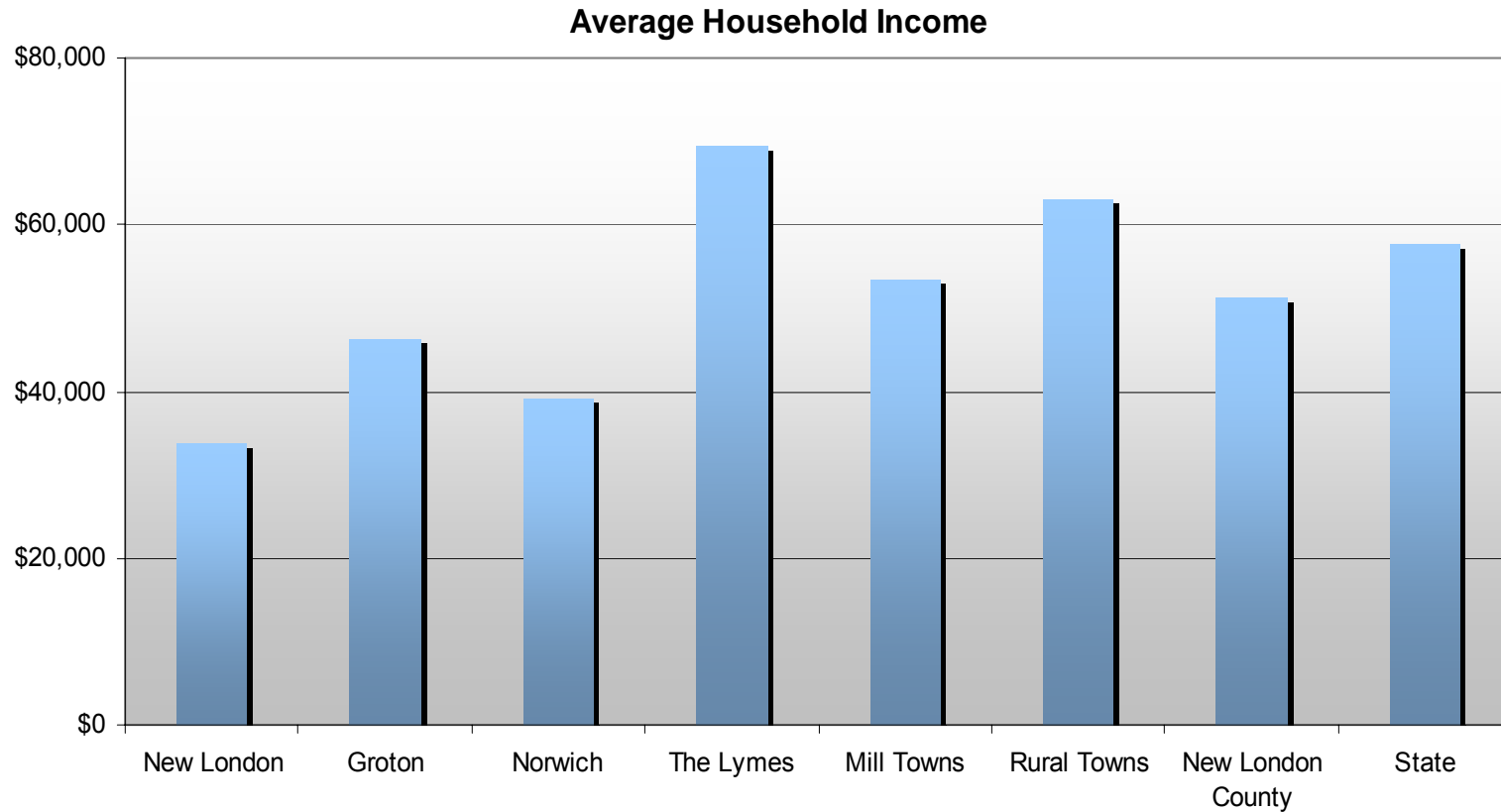
- In general, NLC compares favorably with the State with respect to many socioeconomic measures.
- The Lymes and the Rural Towns were the most socio-economically prosperous regions of NLC.
- New London and Norwich are lagging behind other regions of NLC socio-economically.

Demographic Indicators



Source: 2000 and 2005 Estimates US Census

Demographic Indicators



Source: 2000 US Census

Priority Health Issues

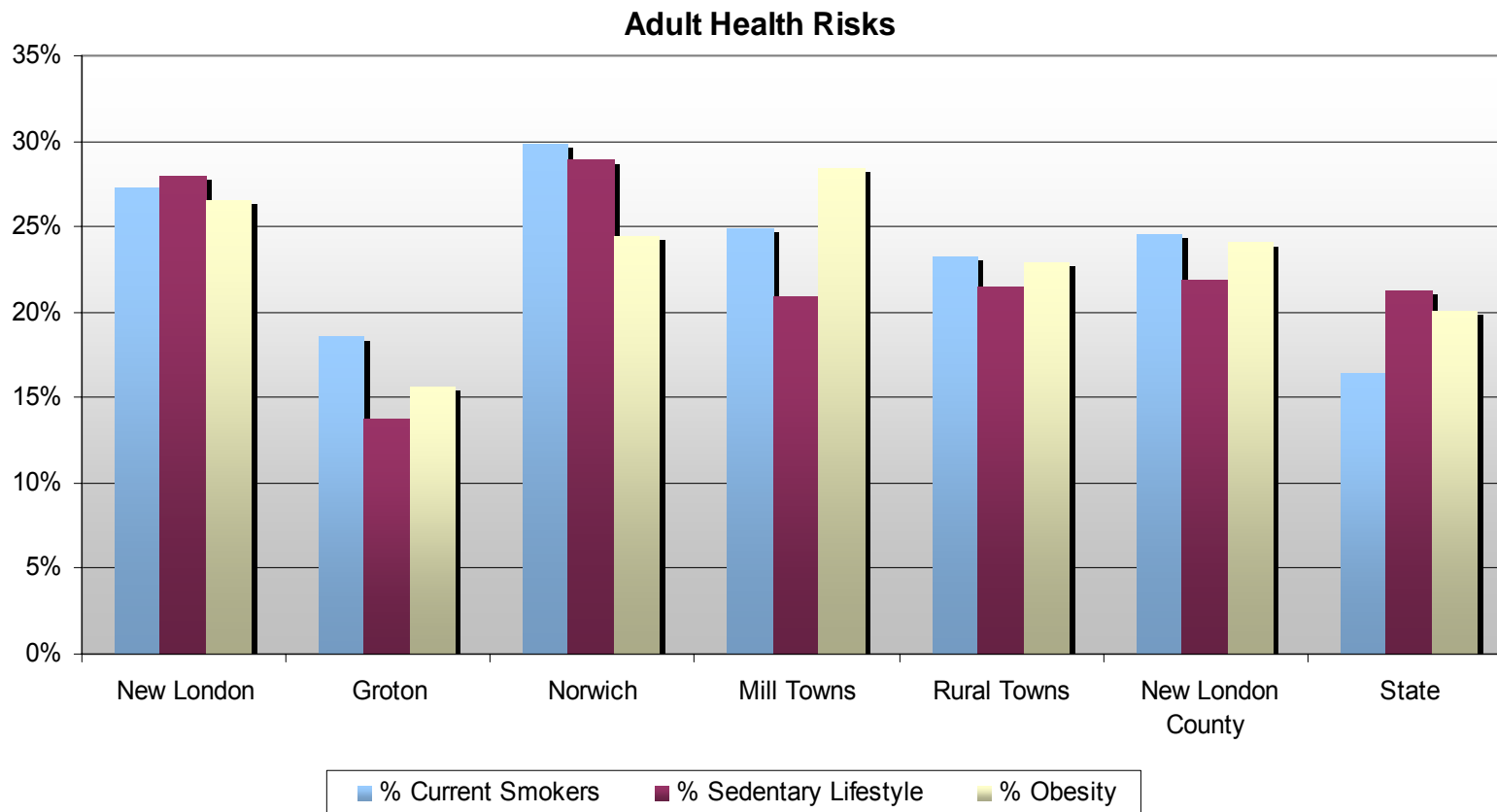
- **Primary Prevention**
- **Access to Care**
- **Care for Chronic Conditions**
- **Mental Health/ Substance Abuse**
- **Reproductive Health**

Priority Health Issue I: Primary Prevention

- **Risk Factor Prevalence:**
 - High levels of smoking and obesity in all regions except Groton.
 - High rates of chronic drinking in all regions.

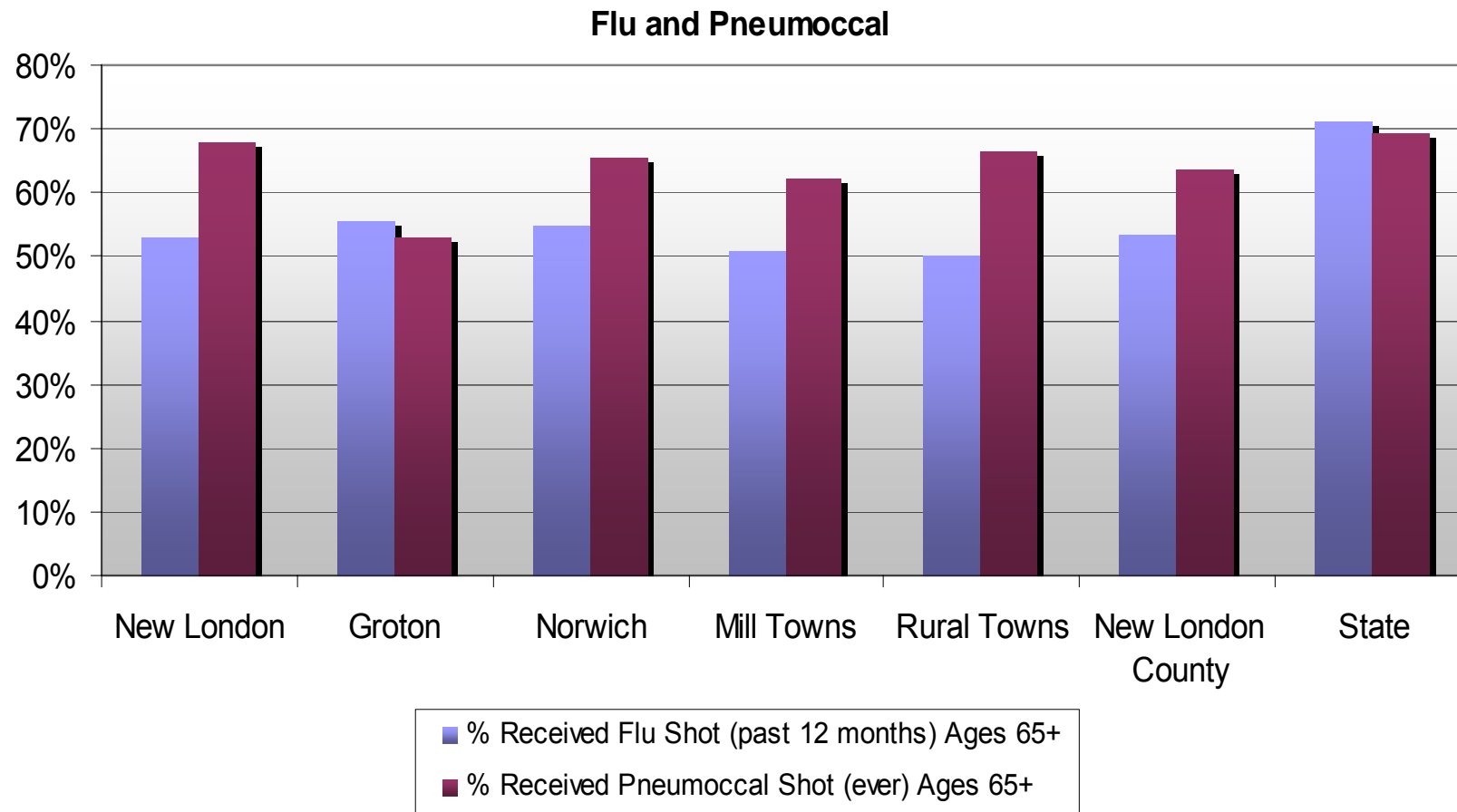
- **Access and Availability of Primary Prevention Services for:**
 - At Risk Populations, esp. low income and uninsured.
 - Adults with Chronic Health Conditions.

Primary Prevention: Supporting Findings



Source: CHPPR Adult Household Survey

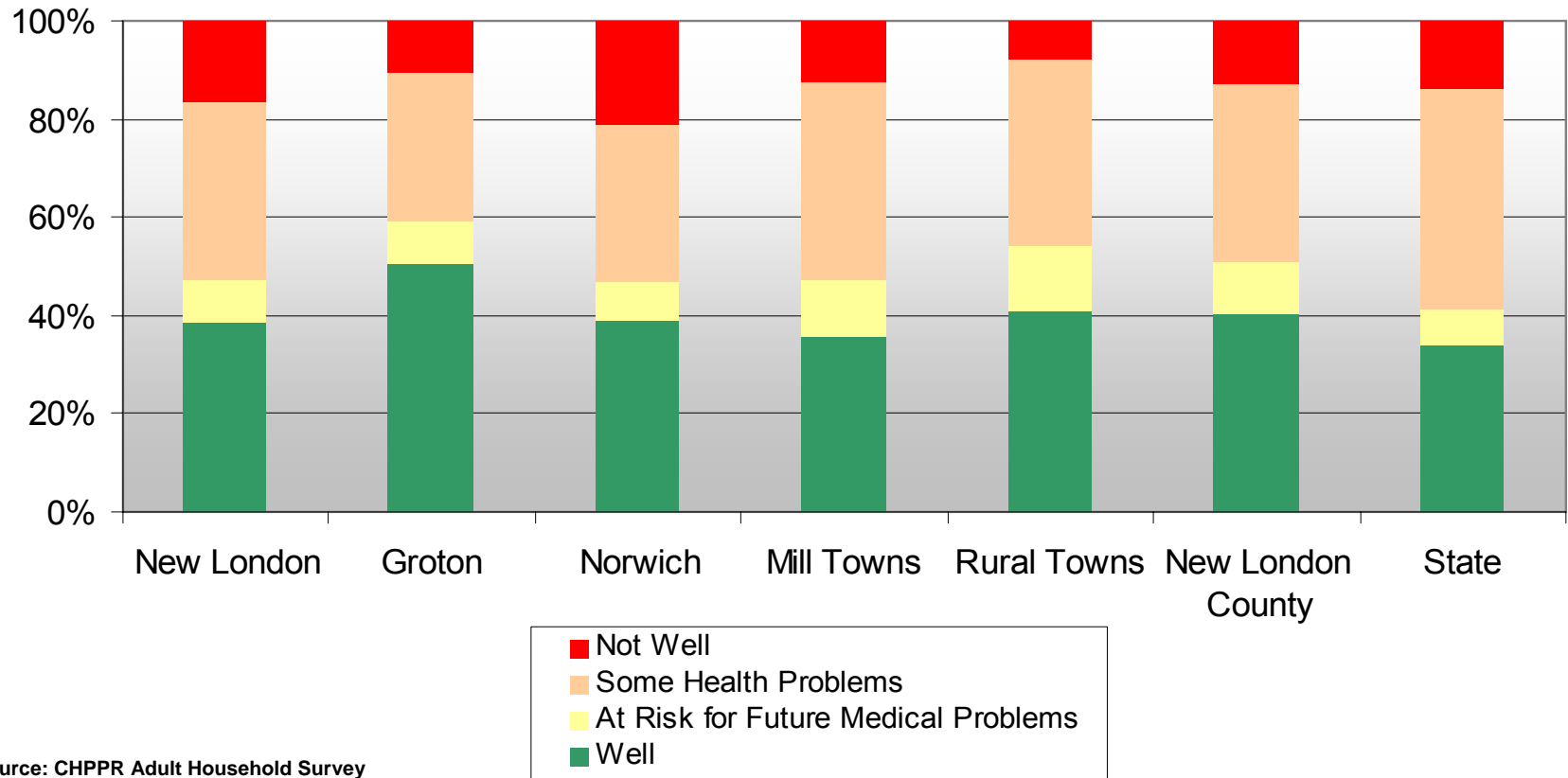
Primary Prevention: Supporting Findings



Source: CHPPR Adult Household Survey

Primary Prevention: Supporting Findings

Wellness



Source: CHPPR Adult Household Survey

Primary Prevention: Supporting Findings

Interviewees Cited:

- Prevention activities in County being driven by grant funding opportunities and not by need
- Lack of coordination between groups and collaboratives providing prevention programs— no overall plan for prevention activities in the County
- Lack of awareness of existing prevention programs by providers resulting in poor participation in programs
- No central resource for the communication on prevention and treatment programs available to residents.
- Limited number of employee wellness programs available in County – mostly in large employers

Primary Prevention: Recommendations

Objectives:

- Decrease tobacco use and reduce levels of obesity in the population
- Improve provider education and counseling to patients
- Improve PCP linkages to local health related resources for their patients

Primary Prevention: Recommendations

Recommendations:

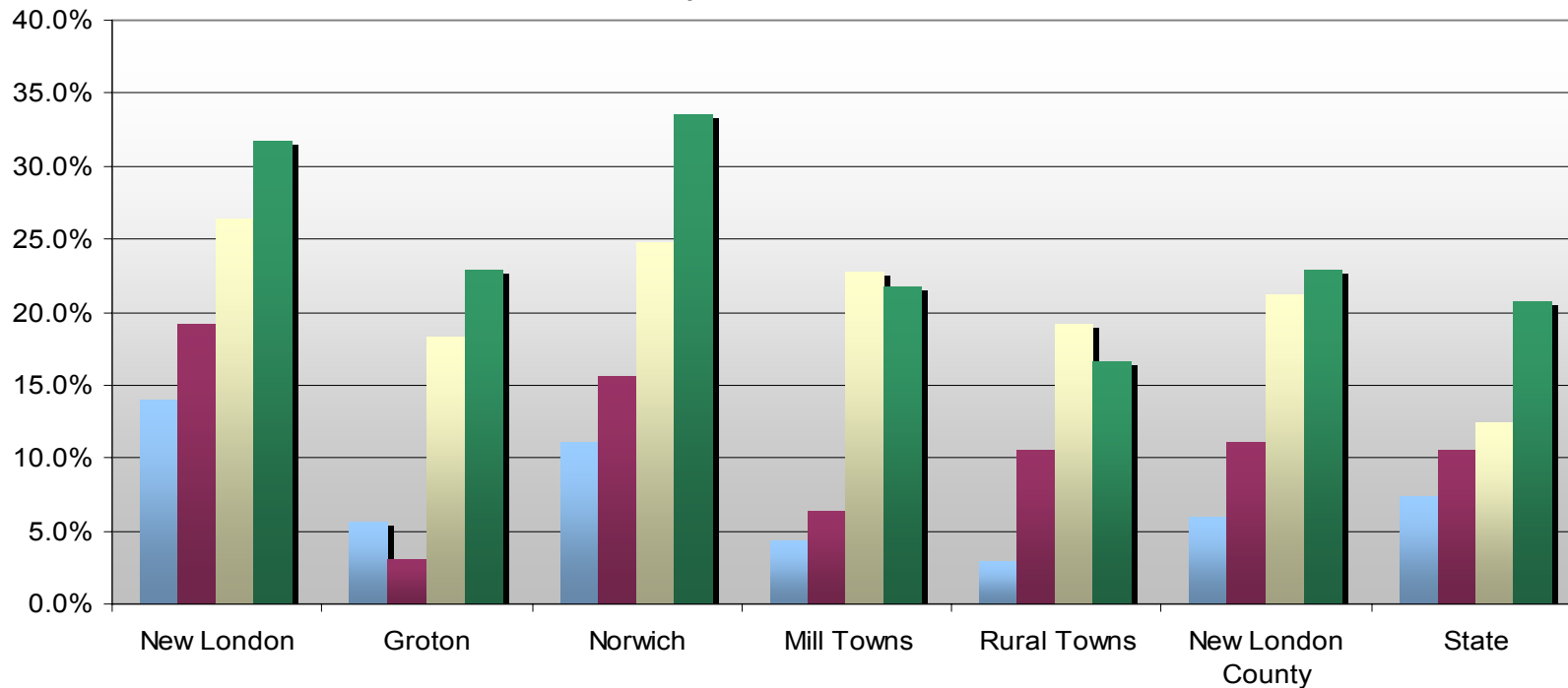
1. Implement evidence based prevention programs that
 - Prevent/Reduce tobacco use
(achieve Healthy People 2010 goal)
 - Reduce obesity and overweight
(exercise and nutrition education and programs)
2. Assist primary care providers (PCPs) in linking patients to local prevention resources
3. Assist local businesses in the development of evidence based employee wellness programs

Priority Health Issue II: Access to Care

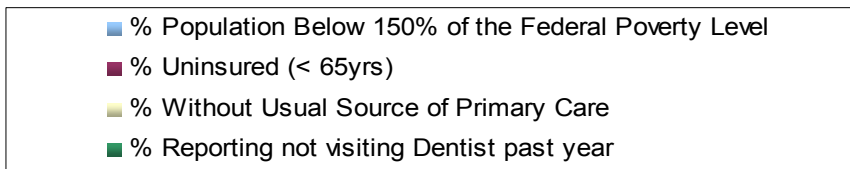
- **Access and Availability to Primary Health Care for:**
 - Low Income Individuals (150%-300% <FPL)
 - Uninsured and Underinsured
 - New London and Norwich have a high proportion of people who are uninsured and without a usual source of Primary Care.
 - High utilization of Emergency Room for ambulatory care sensitive (ACS) conditions in New London and Groton.

Access to Care: Supporting Findings

Key Access Indicators

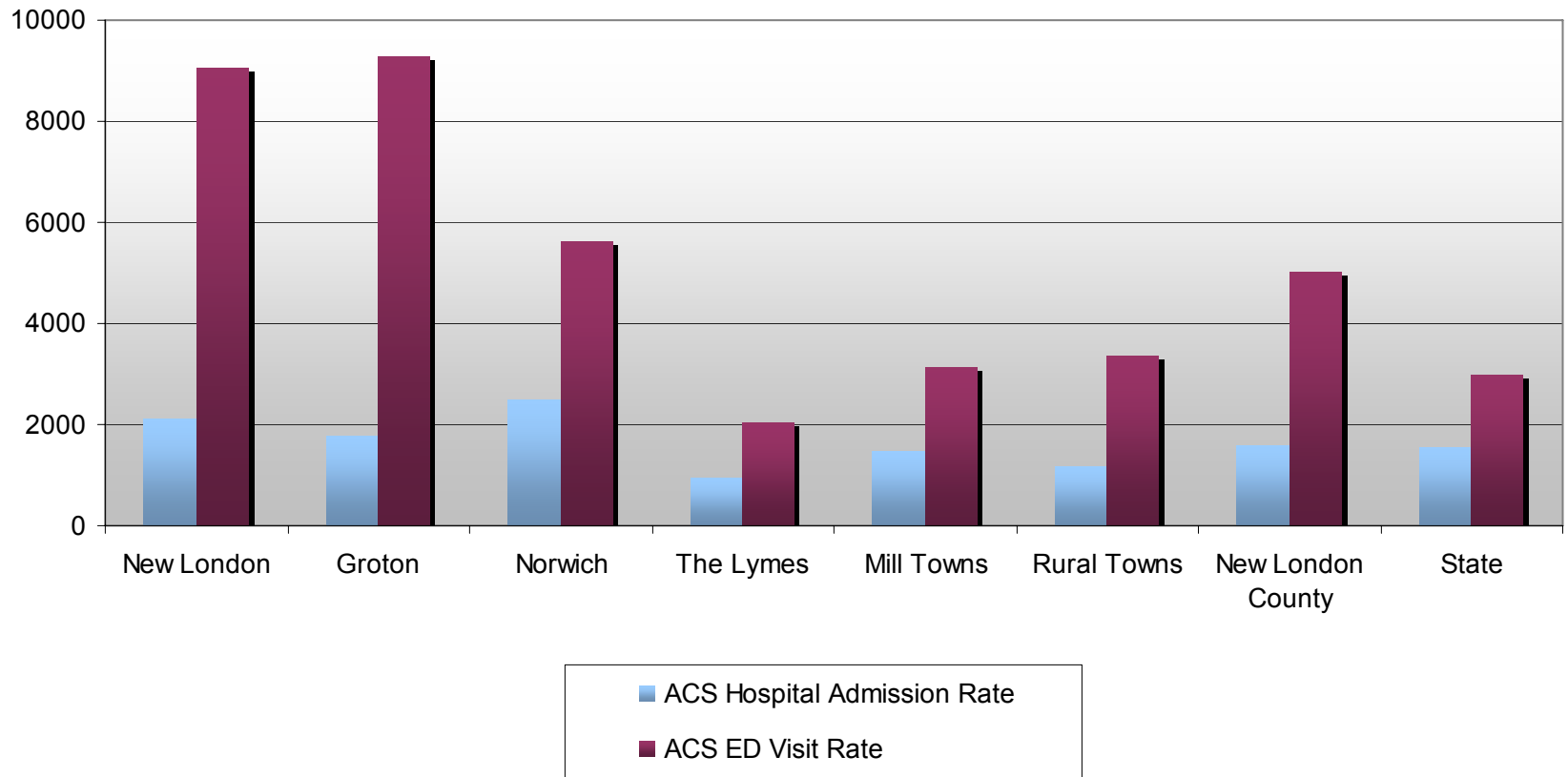


Source: 2000 US Census
CHPPR Household Survey
2005 BRFSS



Access to Care: Supporting Findings

Hospital and ED Utilization Rates for ACS Conditions



Access to Care: Supporting Findings

Interviewees Cited:

- Poor payment structures under Medicaid and SAGA:
 - Limited private provider participation in Medicaid and SAGA programs
 - Lack of incentives to care for uninsured/underinsured
- Lack of access/office hours to primary care providers
 - Particularly for adults throughout the County
 - No night or weekend hours at community health center (New London and Groton)
 - High ED utilization among Public Insurance/CHAMPUS recipients for ACS Conditions
 - Lack of knowledge of community health centers and sliding fee options
- Difficult to recruit physicians to area
 - Reimbursement rates for physicians low
- Limited communication between primary care providers and emergency departments:
 - No current electronic connectivity between ED and primary care providers
 - No formal protocols on management of frequent ED users with established PCPS

Access to Care: Recommendations

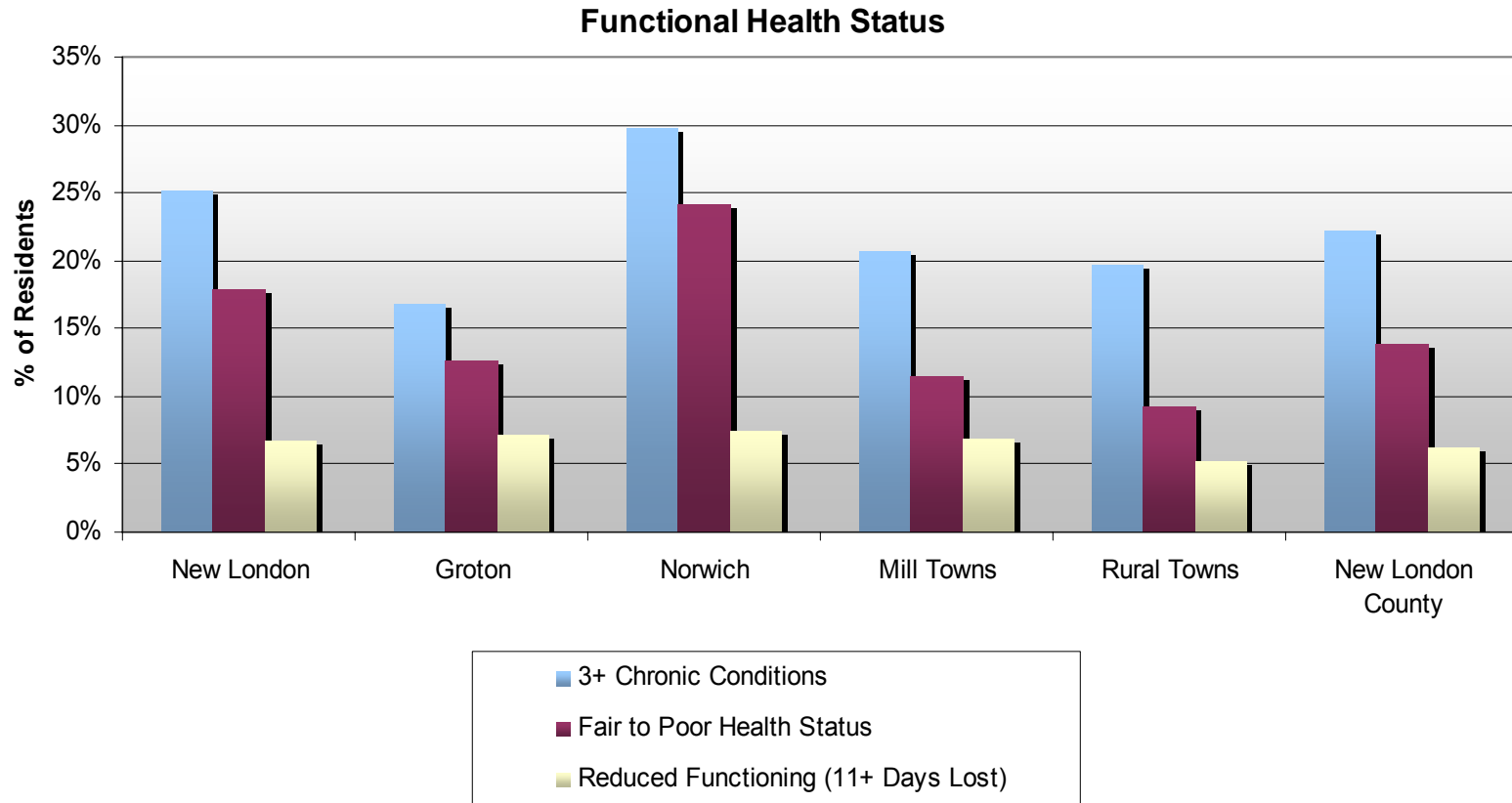
Recommendations:

1. Expand availability and increase awareness of safety net services for dental, primary care, behavioral health, and prescription drug coverage.
2. Develop/promote standards of care to guide PCP referral practices for an ED visit.
3. Develop/implement alternatives to ED use for patients needing immediate but non-emergent care [examples: fast track/convenient care, walk-in centers, expanded hours at CHCs].
4. Develop/implement a county-wide education campaign on appropriate utilization of the ED.

Priority Health Issue III: Care for Chronic Conditions

- **Risk Factors and Chronic Disease**
 - High prevalence of Chronic Conditions in New London and Norwich
 - Risk factor prevalence among those with diagnosed chronic conditions
- **Care Management of persons with Chronic Health Conditions:**
 - ED use for ACS conditions

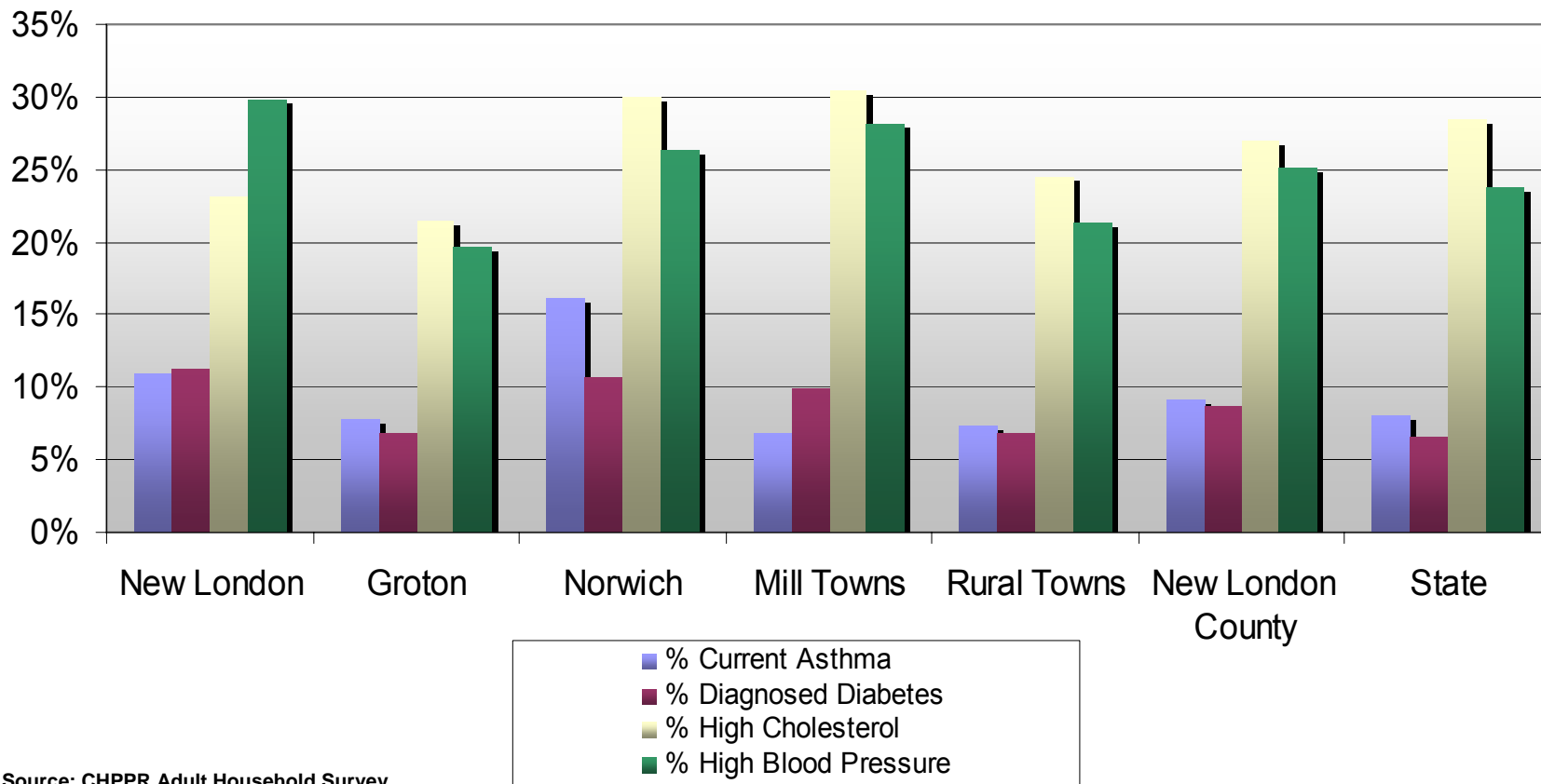
Care for Chronic Conditions: Supporting Findings



Source: CHPPR Household Survey
2005 BRFSS

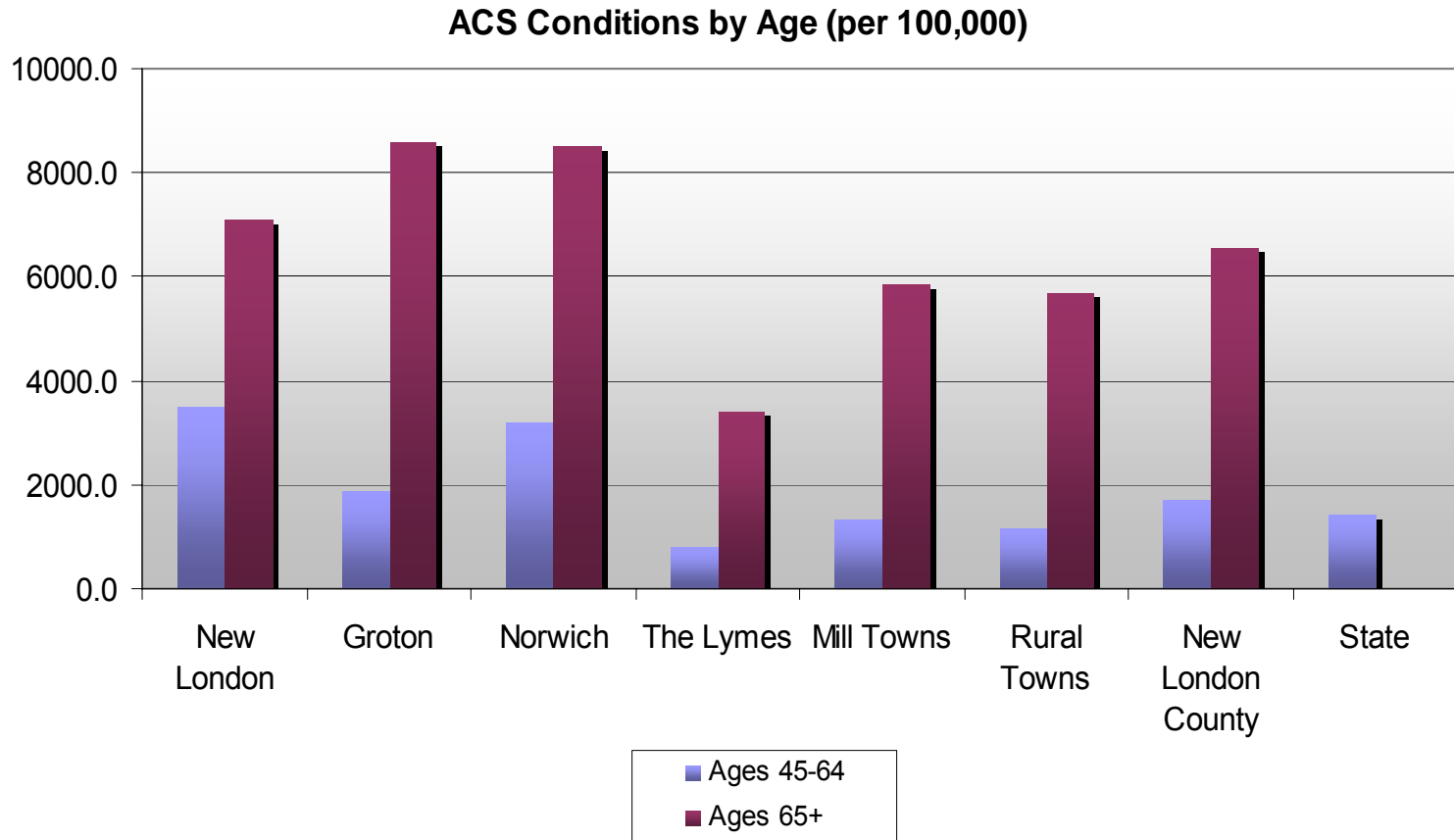
Care for Chronic Conditions: Supporting Findings

Chronic Disease Prevalence (Adults 18+)



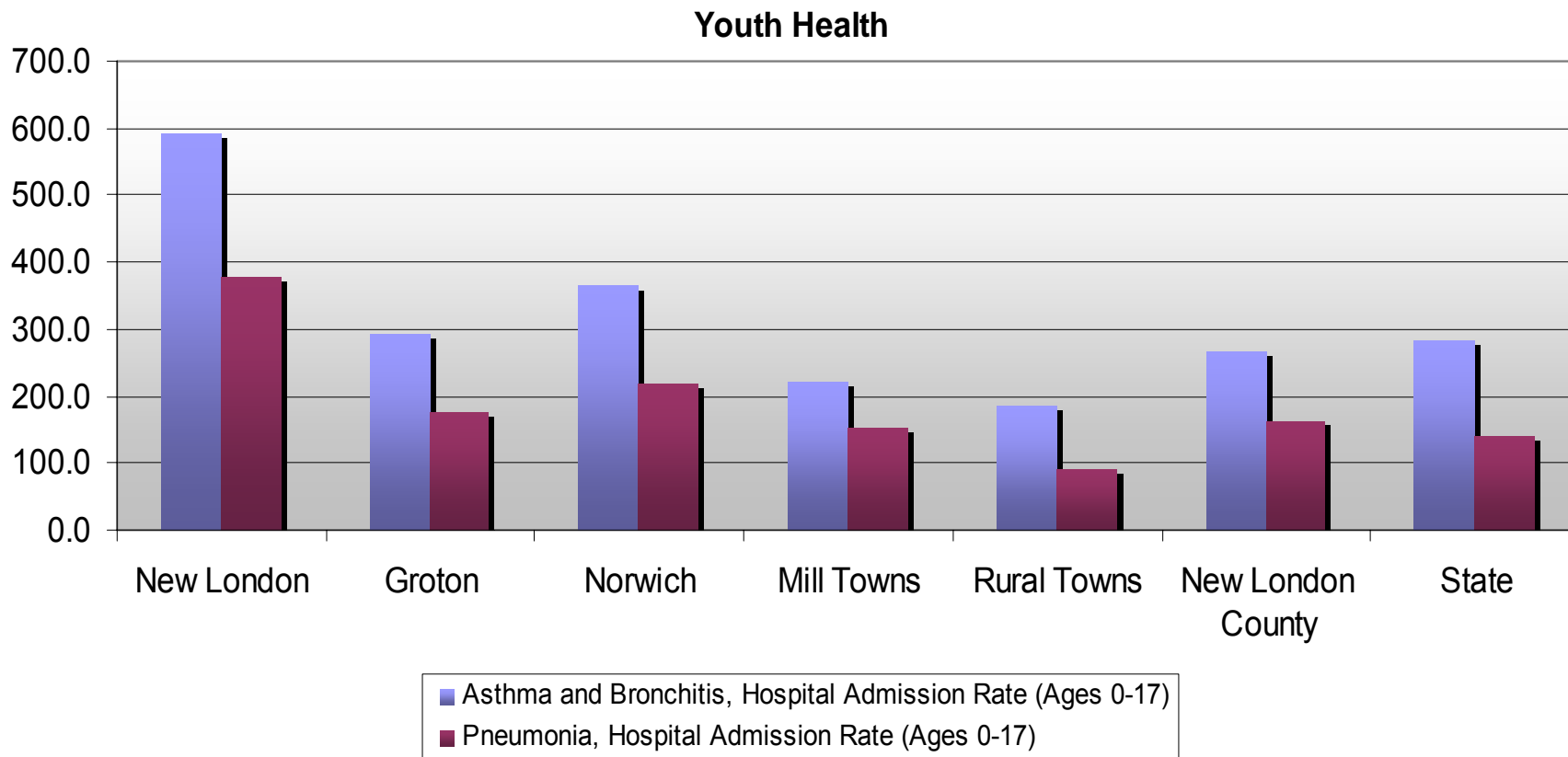
Source: CHPPR Adult Household Survey

Care for Chronic Conditions: Supporting Findings



Source: CHIME Inpatient 2004-2005

Care for Chronic Conditions: Supporting Findings



Source: CHIME Inpatient 2004-2005

Care for Chronic Conditions: Supporting Findings

- **Interviewees Cited:**
- **Very little quality improvement efforts in chronic disease management**
- **Shortage of primary care providers in region**
- **Lack of referral sources for specialty care especially orthopedics and cardiology for underserved populations**
- **Access Issues**
 - Low patient turnout to secondary prevention programs
 - Transportation issues for underserved populations

Care for Chronic Conditions: Recommendations

Objectives:

- Improve the care and health of persons with chronic health conditions
- Reduce the use of the hospital to treat non-emergent chronic disease conditions

Care for Chronic Conditions: Recommendations

Recommendations:

1. Establish primary care medical home system, especially for persons with one or more chronic conditions
2. Establish referral mechanisms for consults with specialty care providers, especially for uninsured/underinsured persons with multiple chronic medical conditions
3. Develop/expand evidence based quality improvement programs at primary care practice sites:
 - Quality improvement teams
 - Clinical information systems and use of registries
 - Patient self-management programs
 - Linkages to public health and community providers

Priority Health Issue IV: Mental Health/Substance Abuse

- **Substance Abuse Prevention and Treatment**
 - High utilization of ED for alcohol and drug-related mental disorders (Norwich and New London)

- **Mental Health Services**
 - Access to Mental Health Services in New London

- **Risk Factors**
 - High prevalence of depression and psychiatric disorders (Norwich)

Mental Health/Substance Abuse: Supporting Findings

Substance Abuse Indicators

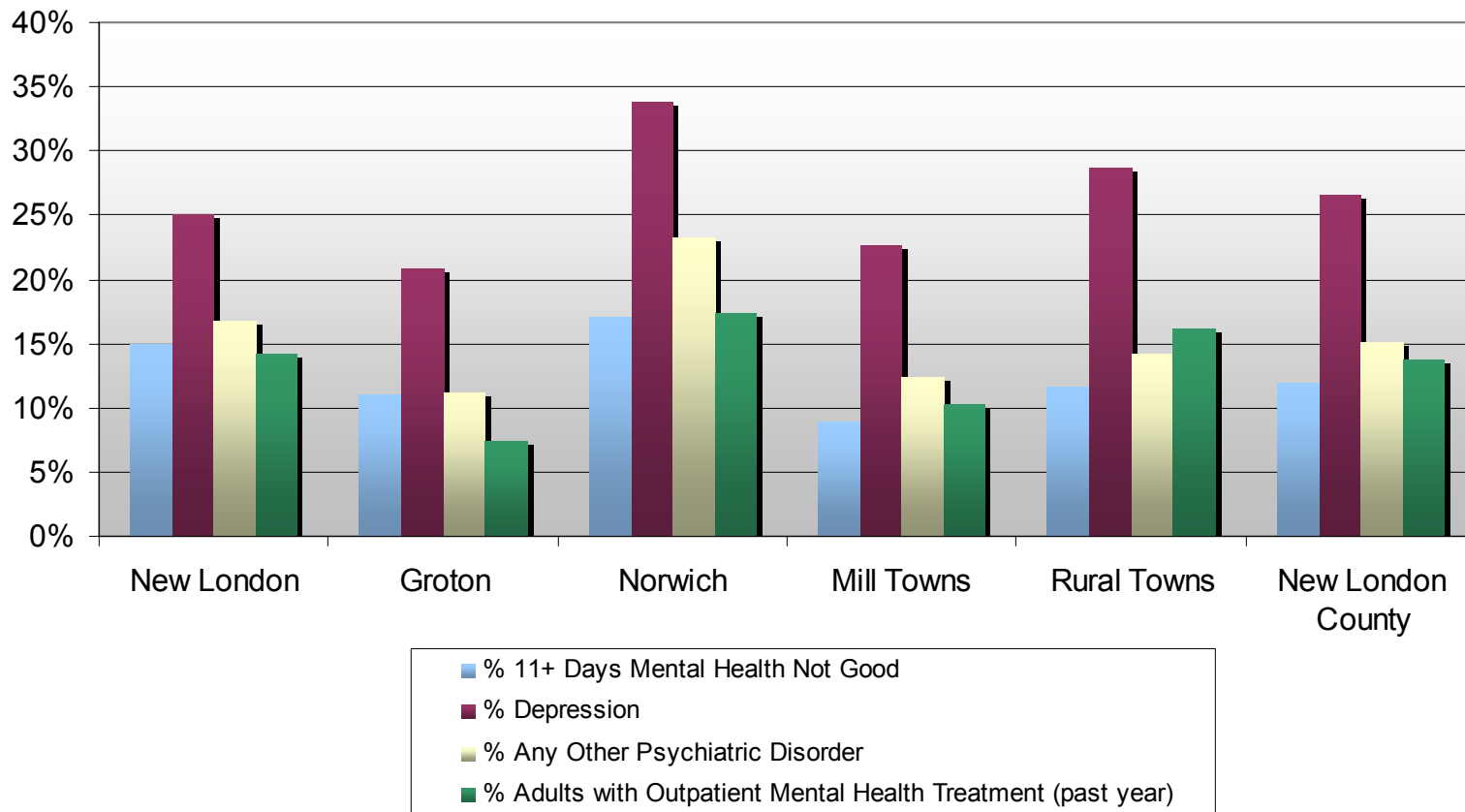
	New London	Groton	Norwich	The Lymes	Mill Towns	Rural Towns	New London County	State
% Chronic Heavy Drinking (Past Month)	3.0	6.8	5.1	NA	6.5	6.8	5.8	3.5
Acute Alcohol-Related Mental Disorders, ED Visit Rate*	1432.3	403.6	1453.7	341.2	327.5	281.9	591.0	534.9
Acute Drug-Related Mental Disorders, ED Visit Rate*	114.9	55.4	167.7	45.8	67.3	59.0	80.9	116.2
Alcohol-Related Mortality Rate*	24.3	7.4	10.8	17.0	14.1	8.6	12.1	9.9

*Rates are calculated per 100,000 population.

Source: Connecticut Dept of Public Health Office of Vital Records, ChimeData-Connecticut Hospital Association, CHPPR Adult Household Survey

Mental Health/Substance Abuse: Supporting Findings

Prevalence of Mental Health Conditions



Source: CHPPR Adult Household Survey

Mental Health/Substance Abuse: Supporting Findings

Interviewees Cited:

- **Disproportionate usage of services by small # of individuals**
- **Supply of behavioral health services in New London not enough to meet demand**
- **Lack of coordination between primary care providers and behavioral health providers**
- **Residual base of mental health clients in community from closing of Norwich Hospital**

Mental Health/Substance Abuse: Recommendations

Objectives:

- Improve care coordination between mental health and medical providers
- Improve PCP skills in providing mental health services (diagnosis, use of medications, treatment alternatives)
- Improve access to mental health services for patients of primary care practices

Mental Health/Substance Abuse: Recommendations

Recommendations:

1. Assess the adequacy of behavioral health services in New London especially for those insured under Medicaid and for the uninsured
2. Increase affordable supportive housing in NLC
3. Expand Community Care Initiative teams
 - Provide coordinated care management to persons who frequently use EDs
4. Implement evidence based sustainable models of behavioral health co-location services at primary medical sites
5. Promote education of PCPs on diagnosis and treatment alternatives for patients with mental health and substance abuse problems

Priority Health Issue V: Reproductive Health

- **Risk Factor Prevalence**
 - Teens in New London have high rates of pregnancy and are more likely to give birth prematurely
 - The Mill Towns and Rural Towns have relatively high rates of low birth weight babies among teen pregnancies
 - Care adequacy for teens in Norwich who are pregnant

Reproductive Health: Supporting Findings

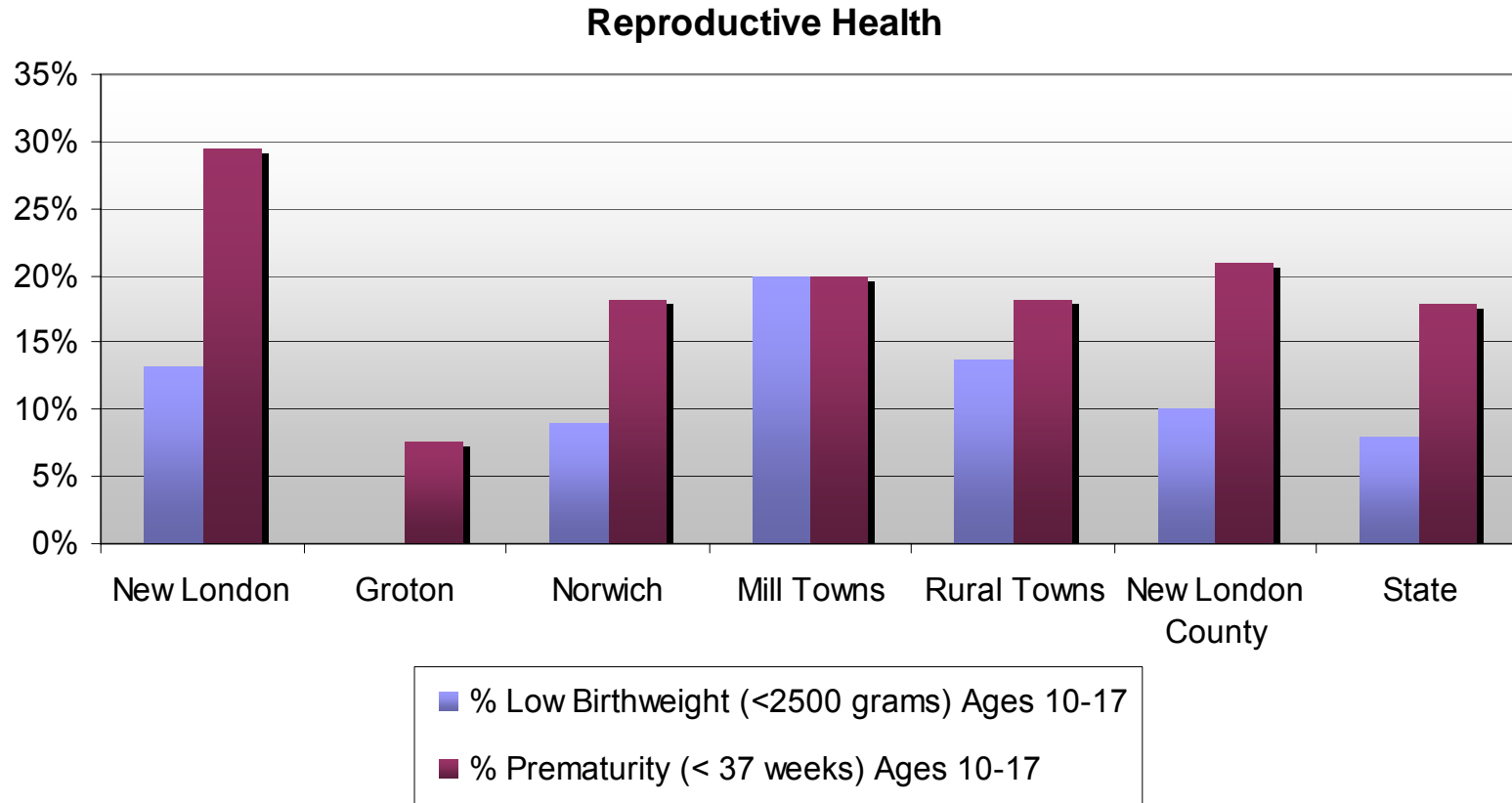
Measures of Reproductive Health

	New London	Groton	Norwich	The Lymes	Mill Towns	Rural Towns	New London County	State
Teen Birth Rate (10-17 yrs) Per 1,000 Females	16.4	4.7	5.5	*	0.8	1.6	3.6	5.1
% Adequate Prenatal Care Age 10-17	62.3	88.5	39.3	*	50.0	59.1	60.8	59.2
High Risk, Hospital Admission Rate Age 10-17	201.8	27.3	100.9	*	12.7	10.9	42.7	77.9

* Rates based on too few number of cases to report

Source: Connecticut Dept of Public Health Office of Vital Records, ChimeData – Connecticut Hospital Association, CHPPR Adult Household Survey

Reproductive Health: Supporting Findings



Source: Birth 2002-2004 CT Vital Records

Reproductive Health: Supporting Findings

Interviewees Cited:

Reproductive Health: Recommendations

Recommendations:

1. Continue/expand teen pregnancy prevention programs in New London
2. Improve care to pregnant teens in Norwich with evidence based programs—coordinate with New London programs
3. Promote standardized teacher training and curriculum for sexuality education at schools in the region

Break-Out Sessions—Issues to Cover

Recommendations

- Are they feasible?
- What resources already exist?
- How should be expanded?
- What would it take to implement?
 - Resources, leadership, other barriers to overcome
- Who should be involved?
- How will you define success?

Next Steps

- Complete Qualitative Data Collection and Analysis
- Gain additional comments on priority issues, objectives and recommendations
- Finalize Report