Health Improvement Alliance
2022-2025 Community Health Implementation Plan

Priority Area: Access to Care		
Goal: Identify barriers and change processes to ensure equitable access to health care and community-based services.		
Healthy CT 2025 Goal: Ensure all Connecticut residents have knowledge of, and suitable access to, affordable, comprehensive, appropriate, quality health care.		
Objectives	**Strategies**	**Action Steps**
Improve health outcomes across the region, focusing on at risk and vulnerable populations with high rates of chronic disease	▪ Increase enrollment in safety net programs that provide access to medical and dental services for those insured and uninsured ▪ Increase number of community members that receive services when they need them. ▪ Increase participation in preventive screening services ▪ Provide simple, consistent health messaging in multiple languages using technology and other communication strategies ▪ Empower the community to prioritize health and wellness by fostering existing and creating new partnerships	▪ Work with community members to develop and disseminate clear health messages ▪ Screen community members in different settings to assess social drivers of health needs and provide appropriate referrals ▪ Develop, maintain, and distribute a resource guide of local medical, dental, and community programs ▪ Develop initiatives to assist community members with access to HUSKY, prescription assistance services, and other income-based health and social services
Increase the percent of community members who report having a primary care provider Expand access to specialty care services to ensure people can receive care when they need it.	▪ Examine processes and policies that may be limiting access to services ▪ Reduce no show rates for medical appointments. ▪ Increase access to telehealth, mobile, school-based and community services ▪ Increase health care worker support to increase staff satisfaction and retention ▪ Examine processes and policies that may be limiting access to services ▪ Improve coordination of primary and specialty care	▪ Assess capacity and administrative barriers of current services within agencies ▪ Screen community members in different settings to assess for primary care needs and provide appropriate referrals ▪ Partner with new and existing organizations to identify and address barriers to accessing services ▪ Identify and share best practices to address staff burnout ▪ Identify trainings available for trauma informed care
Reduce the percentage of people who report being treated with less respect or received services that were not as good as others in the community	▪ Increase utilization of Culturally and Linguistically Appropriate Services (CLAS) standards in healthcare and other settings ▪ Create welcoming health care and community services settings that honor diversity and reflect the community served	▪ Offer trainings on best practices for Culturally and Linguistically Appropriate Services (CLAS) standards and Diversity, Equity and Inclusion (DEI) practices for HIA partner organizations ▪ Increase availability and utilization of community health workers (CHWs) / community messengers whose lived experience reflects the communities they serve.

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Priority Area: Behavioral Health		
Goal: Every resident in Greater Bridgeport has equitable access to behavioral health services and resources available to build resiliency. **Healthy CT 2025 Goal:** Ensure community strength, safety, and resiliency by providing equitable and sustainable access to community resources to address the unique physical, social, and behavioral health needs of all Connecticut residents.		
Objectives	**Strategies**	**Action Steps**
Increase the percentage of adults and youth who report feeling satisfied with life and their community	▪ Increase the number of ways to connect residents to their community ▪ Normalize the discussion of behavioral health in clinical and social settings ▪ Ensure residents can benefit from existing services	▪ Boost awareness of resources using social media, events, website ▪ Leverage messaging around healthy body/healthy mind while acknowledging that healthy bodies can look different ▪ Leverage The HUB and other community resources ▪ Increase community Mental Health First Aid Training ▪ Collaborate across child wellbeing, healthy lifestyles, access to care task ▪ Embed Behavioral Health and wellbeing moments across existing community meetings/group settings ▪ Coordinated HIA presence at local events ▪ Implement Behavioral Health screening at point of care/services and provide a direct referral to services
Expand the use of additional sites for behavioral health care, including community, schools, home health, and telehealth	▪ Link clinical and non-clinical settings and services ▪ Identify ways to reduce barriers to seeking care ▪ Increase access to telehealth, mobile, and community-based services; ensure cultural competency and health literacy ▪ Identify interim solutions for those who are waitlisted/waiting for services	▪ Identify funding opportunities to support this work ▪ Create waiting list “toolkit” for families that includes peer support, phone numbers and contacts, encourage signing up for groups ▪ Identify and prioritize barriers to address across multiple organizations ▪ Develop/promote an inventory/list of BeH resources for those uninsured/undocumented ▪ NARCAN initiatives

Increase behavioral health workforce and development	▪ Increase availability and utilization of community health workers and peer support specialists whose lived experience reflects the communities they serve ▪ Retain and recruit staff that reflect the communities we serve	▪ Diversity, Equity & Inclusion staff training ▪ Increase internship opportunities ▪ Provide SMEs to participate in existing after-school programs ▪ Expand Career Pathways / Behavioral Health Workforce Development ▪ Create pipelines to channel new job seekers toward behavioral health careers ▪ Share best practices on staff recruitment and retention ▪ Encourage diverse placement among the community of the developing workforce
Increase the number of people who receive behavioral health care in the appropriate setting	▪ Continue to improve the coordination of care for frequent use of ED for behavioral health ▪ Involve/educate community police (presenting symptoms, best methods of interventions, etc.) ▪ Create a welcoming service delivery setting that honors diversity and reflects the community we serve ▪ Identify new partners within underserved communities and populations to assist as liaisons for services and care	▪ Refine Community Care Team and patient navigators ▪ Recruit new partners including school administrators, school-based health centers, area agency on aging, etc. ▪ Ongoing implementation of Diversity, Equity and Inclusion and cultural competency initiatives ▪ Implement BH screening at point of care/services and provide a direct referral to services

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Priority Area: Child Wellbeing		
Goal: Achieve equitable health and development outcomes for children by strengthening communities and families and promoting child wellbeing and resiliency. **Healthy CT 2025 Goal:** Ensure community strength, safety, and resiliency by providing equitable and sustainable access to community resources to address the unique physical, social, and behavioral health needs of all Connecticut residents.		
Objectives	**Strategies**	**Action Steps**
Increase positive childhood experiences through youth engagement in social athletic, civic, cultural, recreational, and educational activities	▪ Increase participation in extracurricular programming by addressing awareness, safety, affordability and access/transportation ▪ Increase participation in STEM programming ▪ Promote the benefits of youth-driven community programming to improve positive youth development and outcomes	▪ Increase awareness of programs offered in the community through a detailed communication plan involving CHWs, BPT4ME, and leveraging schools ▪ Safe school environment (No Bullying) ▪ Identify program leaders and recruit for participation in this task force ▪ Pursue funding through grants, etc. ▪ Identify transportation partners, such as school bus routes ▪ Partner to create school to work pipelines ▪ STEM workforce development leveraging the Greater Bridgeport STEM ecosystem ▪ Leverage technology and social media to deliver campaigns for youth ▪ Promote peer support groups through The Hub ▪ Leverage subject matter experts from HIA to deliver in- and after-school programming co-designed and co-developed by youth
Build Community capacity by increasing awareness and prevention of Adverse Childhood Experiences (ACES)	▪ Increase knowledge of parenting and childhood development ▪ Increase the use of developmental and ACES screenings across multiple settings	▪ MOMs Partnership maternal mental health supports ▪ Bridgeport Basics parental education ▪ Advocate to embed ACES screenings into Electronic Medical Record (EMR) ▪ Conduct ACES screenings through CHWs ▪ Increase use of Sparkler app
Increase access to services offered by community-based organizations	▪ Create and continue partnerships to increase access to services for prenatal, neonatal, and postpartum care through doula care, education and access, and home visiting programs ▪ Increase engagement of community health workers and community messengers, whose lived experiences reflect the communities they serve, across multiple settings	▪ Collaborate under the Universal Nurse Home Visiting-CHW Grant ▪ Provide education to at-risk pregnant persons ▪ Partner with doulas, including seeking new members for this task force ▪ Partner with emme coalition to empower women and girls ▪ Create CHWs/messengers work group across HIA partners to encourage collaboration ▪ Collaborate across behavioral health, healthy lifestyles, access to care task forces

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Priority Area: Healthy Lifestyles		
Goal: Achieve equitable life expectancy by ensuring Greater Bridgeport residents have access to the health supporting resources they need.		
Healthy CT 2025 Goals: Ensure all Connecticut residents have knowledge of, and suitable access to, affordable, comprehensive, appropriate, quality health care; Ensure that all Connecticut residents have equitable access to safe and affordable nutritious and culturally appropriate food.		
Objectives	**Strategies**	**Action Steps**
Improve health outcomes across the region, focusing on at risk and vulnerable populations with high rates of chronic disease	▪ Reduce disparities in chronic disease and life expectancy by addressing social drivers of health (SDOH). ▪ Empower the community to prioritize health and wellness. ▪ Increase number of residents who receive services when they need them. ▪ Increase availability and use of free community-based recreation for all ages. ▪ Increase participation in preventive screening services. ▪ Leverage existing and foster new partnerships in underserved communities. ▪ Provide consistent health messaging in plain language using technology and social media.	▪ Develop resources on how to access health care providers, healthy food, and other resources that address SDOH ▪ Develop community-based initiatives to increase community connections through physical activity (Walk 'n Talks, etc.) ▪ Continue to offer free community health screenings and education programs (Know Your Numbers, blood pressure screenings, etc.) ▪ Work with community members to develop and disseminate clear health messages
Increase the percent of community members who report having a primary care provider	▪ Increase awareness of available medical services and community resources. ▪ Expand use of non-traditional sites for care including community, schools, home health, and telehealth. ▪ Promote and support utilization of community health workers (CHWs)/community messengers whose lived experience reflects the communities they serve.	▪ Disseminate resources on where and how to access health care providers for those insured and uninsured ▪ Continue to offer Know Your Numbers screenings that include and connect to follow-up care ▪ Increase availability of community health workers (CHWs)/community messengers

Increase the utilization of available food programs by eligible residents	▪ Increase the awareness of access points where community members can obtain affordable, healthy, and nutritious food. ▪ Evaluate and seek to coordinate new and existing programs that address access to healthy food. ▪ Enhance awareness and provision of nutrition assistance services and nutrition education.	▪ Develop, disseminate and maintain an inventory of local food resources ▪ Seek funding opportunities to expand regional access to healthy food ▪Provide access to new and existing health education programs (Diabetes self-management, Live Well, nutrition education, etc.)
Reduce the percentage of people who report being treated with less respect or received services that were not as good as others in the community	▪ Increase utilization of Culturally and Linguistically Appropriate Services (CLAS) standards in healthcare and other settings ▪ Strengthen community trust in health care providers. ▪ Increase community connections. ▪ Create welcoming health care and community services settings that honor diversity and reflect the community served	▪ Offer trainings on best practices for Culturally and Linguistically Appropriate Services (CLAS) standards and Diversity, Equity and Inclusion (DEI) practices for HIA partner organizations ▪ Identify and collaborate with new community partners (CHWs, faith-based organizations, employers, etc.)