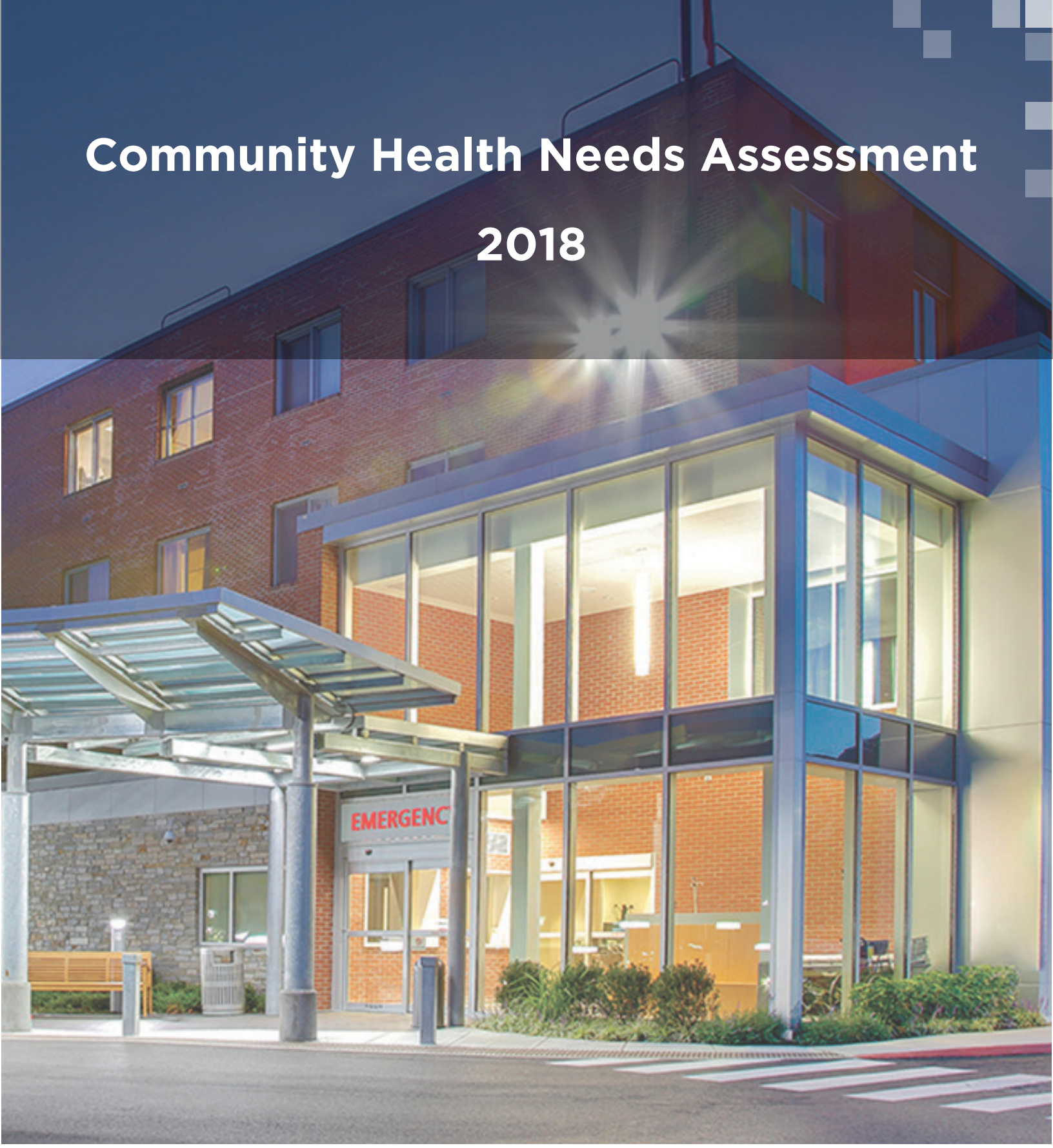
Community Health Needs Assessment

2018



DKH DAY KIMBALL HEALTHCARE

Day Kimball Healthcare

Anne Diamond

LETTER FROM THE PRESIDENT

"Day Kimball Healthcare...Improving the health of our community…every day…every way"

In 2018, Day Kimball Healthcare completed a community health needs assessment (CHNA) for Windham County and our extended service area as required of nonprofit hospitals by the Affordable Care Act of 2010. The hospital completed a previous needs assessment in 2015.

The community health needs assessment is a systematic process for determining and addressing the health needs of our community, or "gaps" between current health conditions and desired health conditions. This gap between the current condition and wanted condition must be measured to appropriately identify the need. The need can be a desire to improve current performance or to correct a deficiency or gap in service.

Over the past eight months extensive interviews and surveys were completed to capture the thoughts and ideas of a broad spectrum of stakeholders in our community. This effort revealed six gaps to be explored further. These gaps include:

1. Lack of adequate transportation within the community. This gap presents a barrier for some patients to access healthcare, get their prescriptions filled, or engage in wellness activities such as regular visits to a gym.

2. The opioid crisis looms large in our community mirroring the state and national challenges. Each month, approximately 30 patients visit the emergency department with a suspected drug overdose. Education and alternative therapies to opioids is our goal to address this regional and national challenge.

3. Diabetes is the 7th leading cause of death in Connecticut. At DKH we follow 3,500 patients with either Type 1 or Type 2 diabetes. Our future goal is to address a gap in pre-diabetic education.

4. As a Certified Advanced Primary Stroke Center, DKH provides excellent care in emergent patient care presenting with symptoms of stroke. However, we have a lack of neurologists in our community to help in both pre-stroke and post-stroke care. This is a problem nationally as there is a shortage of practicing neurologists in our country. To fill this gap we are exploring a telemedicine solution.

5. In cancer care, DKH has seen an increase in both cancer visits and chemotherapy in the 20% range from 2017 to 2018. Northeast Connecticut has some of the highest rates of cancer both in the state and country for breast, lung, skin, colorectal, prostate and leukemia. Our service line strategy is to provide more specialty cancer care at DKH, this means adding more medical and surgical oncologists to meet the increase in the number of cancer diagnoses in our region. We also need to create a larger space; the environment that we care for our patients is not only the patient experience but necessary to ensure the most effective infection prevention and spread of disease. In addition, a new skin cancer institute is under development to begin addressing the undiagnosed melanoma and other skin cancers in northeast Connecticut.

6. Behavioral Health remains a challenge in our community. Here at DKH, we have been successful in recruiting new providers to increase our access to both inpatient and outpatient behavioral health services thus closing in the access gap in our community. Our next recruitment will be an adolescent psychiatrist to further close our gaps in that growing patient population.

On behalf of DKH, thank you to our Board of Directors, our employees and the many community stakeholders who took the time to be interviewed or respond to a survey about our communities' health needs. We have identified needs within our community that as the community hospital we are committed to addressing.

Sincerely,

Anne Diamond

Anne Diamond
President and CEO

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INTRODUCTION & OVERVIEW

Day Kimball Healthcare (DKH) is an independent, non-profit, community hospital and integrated healthcare system serving Northeast Connecticut and nearby Massachusetts and Rhode Island, for close to 125 years.

In coordination with our affiliated healthcare centers, Day Kimball Hospital, a 122-bed acute care community hospital in Putnam, Connecticut: offers acute and general medical/surgical care, a 24-hour emergency department, a birthing center, obstetrics and gynecology, pediatrics, hematology and oncology, cardiopulmonary, mental health programs, leading-edge technology, sophisticated diagnostics, and much more. Our highly-skilled physicians offer comprehensive services that integrate primary care medicine with specialties such as emergency medicine, cardiology, neurology, women's health, cancer treatment, general surgery and more. Approximately 1,000 personnel including more than 200 highly skilled physicians, surgeons and specialists, are employed by Day Kimball Healthcare.

Advanced and highly specialized healthcare services are provided to patients through Day Kimball Healthcare's clinical partnerships with Yale New Haven Health, Connecticut Children's Medical Center, and the University of Massachusetts Memorial Medical Center in Worcester, Massachusetts, and other tertiary care centers in Connecticut. Day Kimball Healthcare became a Community Partner with Yale New Haven Health in May 2017, a relationship that enhances clinical care at Day Kimball Hospital and expands access to care providers in Northeast Connecticut.

On average each year, some 42,000 seek primary and specialty care through our Medical group practices, with 123,000 office visits each year, while approximately another 107,100 take advantage of DKH's inpatient, outpatient (ambulatory care), diagnostic and emergency services. Approximately 50% of the primary care physicians in Windham County are employed by Day Kimball Medical Group.

Day Kimball Healthcare provides numerous programs to promote health and wellness, a variety of support groups, services and programs throughout the community to enhance the quality and accessibility of healthcare services. Our organization is also proud and thankful to have a long history of community support through fun and engaging events that also serve to bring our community together.

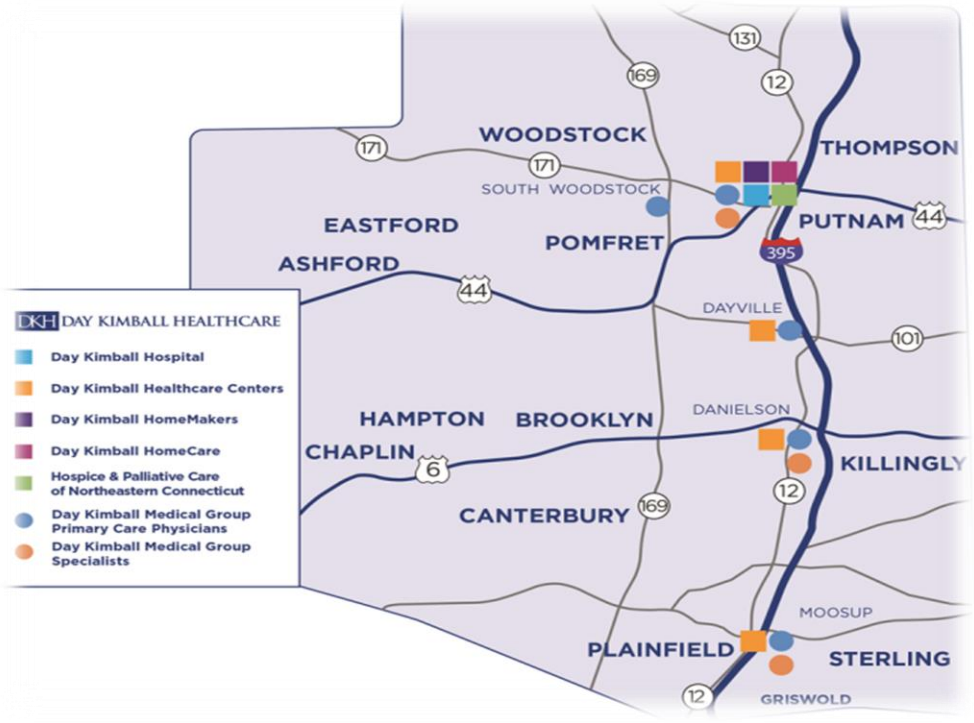
HISTORICAL BACKGROUND & TIMELINE

Day Kimball Hospital of Windham County

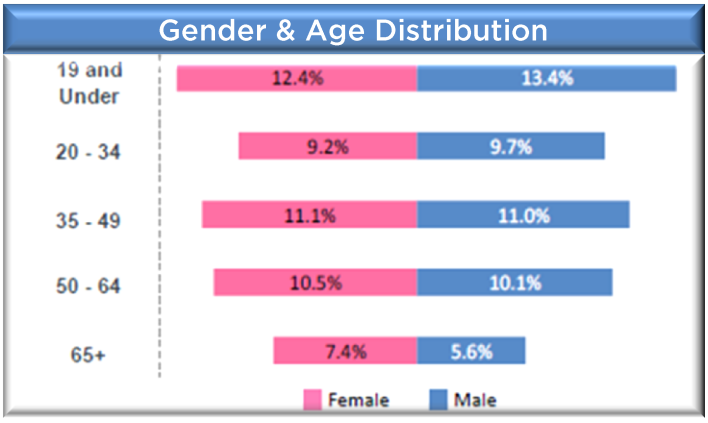
Day Kimball Hospital opened on September 1, 1894. It was the inspiration of two sisters, Miss Elizabeth and Gertrude Vinton, who had a vision for the "Windham County Infirmary." Mrs. M. Day Kimball donated $5,000 for the construction of the infirmary building in memory of her recently deceased son, Moses Day Kimball, with the condition that the institution be named after him. Other Kimball family members pledged an additional $4,000, and community members contributed another $1,000. With the $10,000 total donations, Day Kimball Hospital was born.

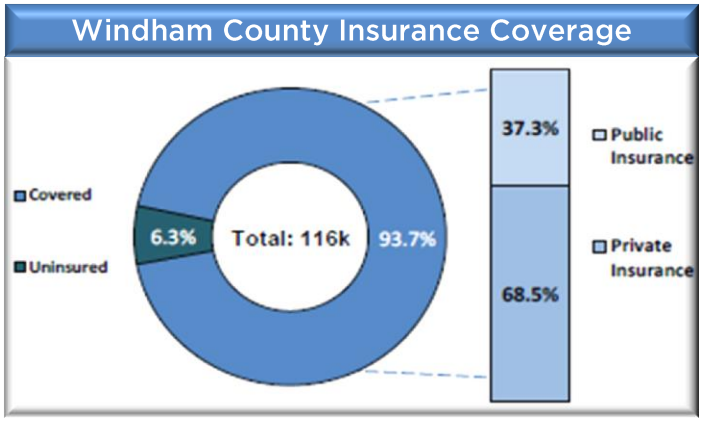
DESCRIPTION OF COMMUNITY SERVED

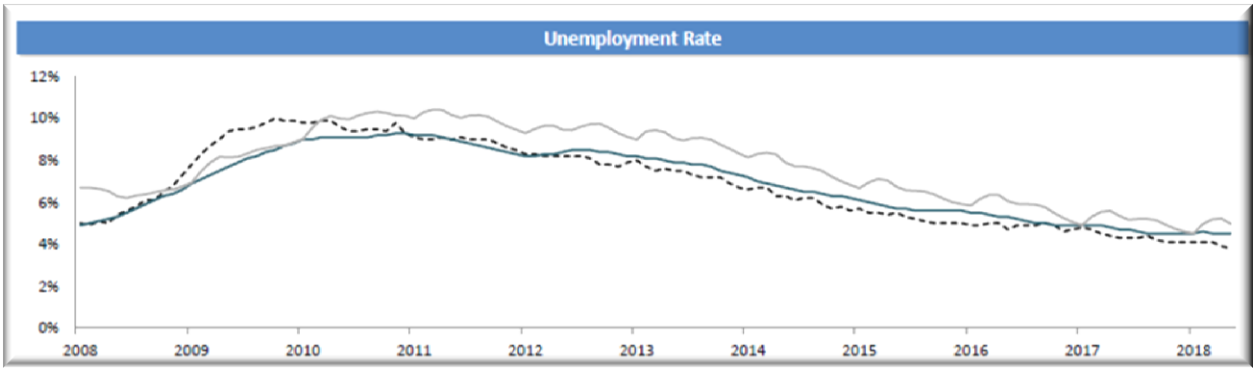
Day Kimball Healthcare is a premier provider of integrated healthcare services in Northeast Connecticut and nearby Massachusetts and Rhode Island. In Connecticut, the service area includes 450 square miles, spanning 13 towns across Northeast Connecticut. We serve 70,000 of the approximated 100,000 residents of those communities through our high-quality, comprehensive medical services delivered by skilled medical professionals, close to home. Approximately 80% of our employees live in the communities where we provide care. Day Kimball Healthcare is the market share leader for Windham County residents based on inpatient admissions and observation cases (1).

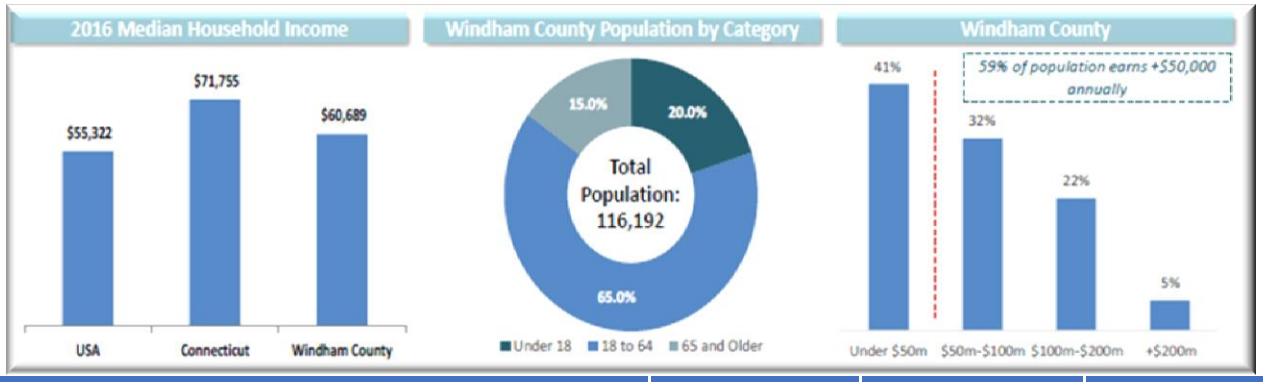


Community Served: Statistics (2)









Metric	2017	2022	% Growth
Population: Total	127,500	127,800	0.2%
Females: Child bearing (15-44 yrs.)	22,800	22,400	-1.7%
Population: 55 – 64 yrs.	19,600	20,600	5.0%
Population: 65+ years	21,100	24,700	17.1%
Total Households	49,200	49,400	0.4%
Average Household Income	$82,400	$87,000	5.6%

Data Collection Method & Process

Windham County ranks lowest in the state for health outcomes and health factors (3). As an organization, Day Kimball Healthcare (DKH) has a responsibility to meet the needs of the community we serve; addressing those challenges to improve the quality of health in our community. The 2018 Day Kimball Healthcare community health needs assessment (CHNA) takes a broad look at the needs of individuals in our primary service area.

For the past year, we have collected data through multiple resources and stakeholders. Data collection included:

- Anonymous paper and electronic surveys to employees and DKH corporators focusing on access, quality, and services needed.
- Interviews with more than 50 community leaders.
- Day Kimball Healthcare Board of Directors.
- Data review from multiple publicly reported resources.

This assessment not only focuses on the health of patients within the walls of DKH; it focuses on social determinants of health in our community. Day Kimball strives to impact on this more than ever. Overall, the assessment shows the continued need for DKH to deepen existing partnerships and develop new partnerships to achieve our mission: To improve the health and wellbeing of our community by providing the best medical care.

This assessment is broken down into several sections of identified needs including:

- Social Determinants of Health
- Employee Wellness
- Day Kimball Healthcare at Home
- Cancer Services
- Opioid Epidemic
- Diabetes
- Stroke
- Mental Health

SOCIAL DETERMINANTS OF HEALTH

TRANSPORTATION

Over 3 million people annually in the United States cannot obtain medical care due to transportation. In our assessment, we found that Day Kimball Healthcare's primary service area, like many other rural health systems, have barriers to adequate transportation, thus affecting the health of our community. Transportation issues result in missed or delayed appointments and ability to fill medication prescriptions, leading to overall poorer health outcomes (4). By the year 2022, the 65 and older age group will increase by 17% in Day Kimball's primary service area. This escalates the need for DKH to assist with a solution for transporting people to and from non-emergency medical appointments. Patients are less likely to fill prescriptions if they experience transportation issues. According to one study, 65 percent of patients said transportation assistance would help with prescriptions fills after discharge (5).

Northeast Connecticut Transit District

Submitted by: Hoween Flexer, Director of Regional Services, Northeastern Connecticut Council of Governments

The Northeastern Connecticut Transit District is the public transportation provider for northeastern Connecticut, available for all residents and visitors to the region, serving the towns of Brooklyn, Canterbury, Killingly, Putnam, Thompson, Eastford, Plainfield, Pomfret, Woodstock, and Union. The Northeastern Connecticut Transit District provides two types of service:

Deviated Fixed Route Service:

- The deviated fixed route service operates Monday - Sunday with various scheduled stops located throughout the service area.
- The Northeastern Connecticut Transit District offers Deviated Fixed Route service on its entire regular routes.
- A deviated-fixed route service is a hybrid of fixed-route and demand response services.
- With this type of service, a bus stops at fixed points and keeps to a timetable but can deviate its course between two stops to go to a specific location for a pre-scheduled request. After deviating from the route, buses return to the same point to continue their run.
- Deviated Fixed Route service requires 24-hour advance reservations.

Elderly and Disabled (Door to Door) Service:

- Elderly and Disabled service, which provides door-to-door service, is also available seven days per week by reservation with NECTD. The deviated fixed route services currently the towns of Thompson, Putnam, Killingly and Brooklyn.
- The Northeastern Connecticut Transit District provides elderly disabled service, funded with a special grant (Municipal Grant Program) from the State of Connecticut, NECTD provides door-to-door service for pre-qualified elderly and disabled persons. This service requires a simple application and 48-hour advanced reservation Monday-Friday and no later than Thursday before Monday service.

SOCIAL DETERMINANTS OF HEALTH

We are funded through local, state and federal funding and adhere to all state and federal transportation regulations. The Northeastern Connecticut Transit District issues surveys to riders about the NECTD services and routes. The district re-evaluates customer feedback and evaluates their feedback. A recent survey gained insight from 198 respondents. Surveys were issued during August 2018 and were available for completion at the following locations: All NECTD transit buses, The Town Halls and Libraries of Killingly, Putnam and Thompson, United Services, TEEG, Daily Bread, Friends of Assisi and Northeast Community Kitchens.

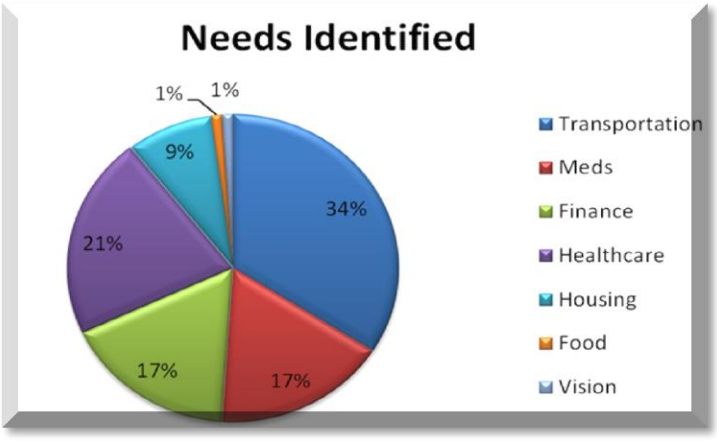
The survey results revealed that 60% of customers use the NECTD bus for transportation dealing with medical needs and 22% use the NECTD for social services. DKH is working to create partnerships and models in order to keep patients closer to home, when clinically appropriate, in an effort to cut down on travel distance for patients and families.

NECTD are currently are working on an expansion of the deviated fixed route to Plainfield and revising our current deviated fixed services in Brooklyn, Killingly, Putnam and Thompson. We also received funding from the State of CT Department of Transportation to provide medical transportation for veterans.
NECTD works collaboratively with Day Kimball Hospital and other medical providers to assist transporting residents to and from their appointments. The partnership has been successful and we look forward to continuing this partnership and improving access to residents of Northeastern Connecticut.

Connecticut Social Health Initiative Pilot

In the winter of 2018, Day Kimball Hospital participated in the Connecticut Social Health Initiative pilot program. The program was led by the Connecticut Hospital Association with support from the Connecticut Health Foundation. The initiative focuses on identifying and addressing social determinants of health which may influence the health of individuals within the community. Data was gathered during the participant screens within the participating hospitals. The data identified social determinants of health with potential for creating barriers to optimal health. By addressing social determinants of health within the communities, improved health equity and health outcomes may be realized.

Day Kimball Hospital was one of four hospitals in Connecticut to participate in the pilot program. Through the pilot, patients were interviewed by medical social workers using a standardized 10 question screening tool developed by the Connecticut Social Health Initiative Advisory Group. The screening tool was used to collect data on social determinants of health which could impact the health of the members within the Day Kimball community.



During the pilot program, 69 individuals were screened at Day Kimball Hospital. Several social determinants with potential to create barriers to health were noted. The most frequently reported barrier was lack of reliable or affordable transportation, followed by access to health care, financial insecurities, and obtaining medications (see graph). In addition to identifying social determinants of health, the medical social workers also provided interventions through referrals of available community resources. Through the pilot, several positive interventions occurred, where patients were successfully referred to community resources thus, reduced the health disparities the patient faced.

SOCIAL DETERMINANTS OF HEALTH

Keeping Our Patients Close to Home

During the fall of 2017, DKH recognized a community need to keep more of its patients in the local Northeast CT area, which meant keeping them at Day Kimball Hospital. An analysis of the data regarding ED transfers showed there were patients who had health conditions which could be managed at DKH.

There have been approximately 55 patients identified with the diagnosis of both acute and chronic renal failure who have been transferred from the ED of Day Kimball Hospital since 12/6/2017. These statistics show a need for hemodialysis in NE CT. This need includes both inpatient and outpatient hemodialysis services. Currently, the closest hemodialysis center to NE CT is over the state line in Webster, MA. There are hemodialysis centers in Norwich, CT and Willimantic, CT as well. The distance to reach these facilities from Putnam, CT is approximately 45 minutes. DKH has identified this as an additional reason for placing hemodialysis services in NE CT.

Through philanthropy, we are working to have hemodialysis available in this community. Travel for these treatments can add undue stress and strain for the patient and their family and/or friends. With the combined need for hemodialysis in NE CT coupled with a philanthropist, DKH has also started discussions with a nephrology physician group who are interested in providing these services. With these actions, DKH has plans to bring hemodialysis services to fruition in NE CT. This would include both acute hemodialysis at DKH and a hemodialysis outpatient center.

Telemedicine Intensive Care Unit

Working towards achieving this goal, in September of 2017, DKH and Yale New Haven Healthcare (YNHH) began a clinical partnership to implement a "Tele-ICU" service line at DKH. As part of reaching this goal, 13 physicians and 2 Advanced Practice Providers from YNHH have been credentialed, and are teaming up with DKH Hospitalists to form a clinical partnership that has allowed this service line to come to fruition at DKH. This clinical partnership began in DKH's ICU on December 6, 2017.

An analysis of ED transfer data over a nine-month period revealed a decrease from 3.1 patients per day in CY2017 to as low as 2.0 patients per day during CY2018. During this same time period, we have monitored our CMI (Case Mix Index) which has risen from a low of 1.04 in 2017 to as high as 1.29 in 2018.

In conclusion, Northeast CT has received multiple benefits from this initiative. Our patients remain closer to home for appropriate care of their acute illnesses. This also is a benefit to the family and friends of these patients. In the NE CT area, travel time to tertiary care centers can range from 40 minutes to UMass Medical Center, an hour to Hartford Hospital and 1-1/2 hrs to YNHH. Travel to these distant locations is a significant barrier for residents of this area. Another derived benefit is an increase in reimbursement to DKH for these acutely ill patients which will contribute to stabilize the finances of our community hospital.

SOCIAL DETERMINANTS OF HEALTH

FOOD & NUTRITION

Windham County has a food insecurity rate of 12% and rates lower than state average for having access to healthy foods (6). DKH case managers have identified that while there are multiple community resources for addressing food insecurities, there are limited food options on Sundays. In addition, Windham County has 44% of children who are eligible for free or reduced price lunch, which is higher than state average (6). Access to healthy foods and maintaining a nutritional diet is essential to wellness for all ages.

Quinebaug Valley Community College (QVCC): Food Insecurity Initiative

QVCC is located in DKH's primary service area and is one of 17 state colleges and universities in Connecticut, governed by the Connecticut Board of Regents for Higher Education. QVCC identified that its student population faces food insecurity. It is estimated that 25% of students utilize the interventions described below to prevent hunger.

In spring 2017, QVCC began a pilot Meal Ticket Program with the cafeteria that provides students with vouchers for breakfast ($3 value for a fruit, muffin, yogurt, and milk or water) or lunch ($4.50 for pizza and salad or soup and salad, milk or water). This pilot received funding from private donations.

In fall 2017, the President's Office budgeted to extend the program through the spring and fall 2018 semesters. In addition, the College formed a Student Food Insecurity Taskforce that raised money from faculty, staff, and community organizations to fund "Help Yourself" boxes. The boxes contain healthy grab-and-go items such as oatmeal cups, granola bars, soup, and crackers. The Taskforce strategically placed these boxes in the Library, Learning Center, Student Success Center, Reading Room, and the 10 most heavily used classrooms. Student volunteers from the Student Government Association, Phi Theta Kappa Honor Society, and Early Childhood Education Club refill the boxes daily. With generous donations from local sponsors, the Taskforce set up a "Pop-Up Pantry" with pasta and sauce, peanut butter and jelly, cereal, and the like for students to take home to their families. The Taskforce meets monthly to monitor the Meal Ticket and "Help Yourself" Programs and to plan for future initiatives and sustainability. Students also receive referrals to the local soup kitchens and food pantries. Although we do not have hard statistics (as this program does not want to invade students' privacy) some student comments include:

"Since you've put these food boxes out, I've eaten every day"! (Student in the Library)

"I was wondering what I was going to feed my kids tonight. I don't have a lot right now. This is awesome". (Student at Pop-Up Pantry)

FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

September 24, 2018

After over 10 long years of assessments, determining location, fundraising, building and staffing, the Hale YMCA Youth and Family Center opened its doors to the community on February 27, 2016. Though the immediate impact was anticipated, it was not anticipated how quickly the Y would grow and how significantly it would impact the broader community. On paper, the Hale YMCA serves seven local towns, however the members of the Y are actually coming from over 20 towns located in three different states with the largest member populations coming from the most proximal towns; Putnam, Killingly and Woodstock. While the number of members fluctuates depending on the time of year, on average there are between 7,500 and 8,500 individual members with between 500 to 1,000 visits on a daily basis.

As a national organization, the Y's focus is on Youth Development, Healthy Living and Social Responsibility with a goal of Strengthening Communities. We are able to meet those goals locally by implementing programs that tackle chronic disease, teach safety around water and partnering with community based organizations to work together to overcome identified community issues. Our longer term strategy and mission attainment occurs by building partnerships and collaborating to help meet the unmet needs in the communities for all ages. In the short two and a half years that the Hale YMCA has been open, we have implemented several programs tackling chronic disease and strengthening community.

LIVESTRONG at the YMCA is a program designed for cancer survivors to regain their strength after going through treatment. The program is evidence based and was developed originally in partnership with LIVESTRONG Foundation. The LIVESTRONG at the YMCA program offers cancer survivors the opportunity to build cardiovascular endurance, core muscular strength and endurance, core flexibility, and balance, which may help improve functional ability, reduce the severity of therapy side effects, prevent unwanted weight changes, and improve energy levels and self-esteem. The Mission of LIVESTRONG at the YMCA is to empower adult cancer survivors to improve functional capacity and to increase their quality of life through an organized program of fitness and strength. The Hale YMCA launched the program in June of 2016. Since that time the program has grown to six classes a year and we are projected to serve over 150 individuals by the end of 2018.

In 2017, the YMCA of the USA launched its first ever Safety Around Water campaign coinciding with a restructure of youth swim lessons. According to the CDC, every day three children die as a result of drowning. In fact, drowning is the second-leading cause of death for children between the ages of 1 and 14. The structure of the new swim lessons focuses on drowning prevention and teaching children basic skills like asking permission before going in the water, rolling from a front float to a back float, and turning around to kick back towards the side. With our two swimming pools, swim lessons have been one of the most successful programs to date at the Hale YMCA. In 2017 we served 251 individual children in swim lessons or swim team. We are on track to exceed that number in 2018.

The Moving for Better Balance program was launched in the summer of 2017 in partnership with the Northeast District Department of Health and the HealthQuest Coalition. As part of the Falls Prevention Grant that the NDDH receives, money was allocated to the YMCA to certify an instructor in the program. According to the CDC, 1 in 4 older adults (65+) falls each year and costs over $50 billion annually. Moving For Better Balance is a 12-week evidence-based group exercise program developed by researchers at the Oregon Research Institute. The program, based on the principles of Tai Chi, is led by a qualified Instructor and teaches eight movements modified especially for falls prevention. The program works to improve balance, muscle strength, flexibility, and mobility to enhance overall physical health, which leads to better functioning in daily activities. Participation in the program may also result in better mental health, reduced stress, improved memory and cognition, and increased self-esteem. The program's safe and supportive group setting also provides an opportunity for participants to enjoy learning with like-minded adults and find relief from the isolation that can sometimes come from living with limited mobility.

The YMCA's Diabetes Prevention Program helps overweight adults at risk for type 2 Diabetes reduce their risk for developing the disease by taking steps that will improve their overall health and well-being. The program provides a supportive environment where participants work together to achieve the program goals of reducing individual weight by 7% and building up to 150 minutes of moderate (the equivalent of brisk walking) physical activity per week for the purpose of reducing their risk for developing diabetes. The program is delivered over a 12-month period in a classroom setting and can be offered in any community location to participants who meet qualification criteria putting them at risk for developing type 2 diabetes. The YMCA Diabetes Prevention Program can reduce the number of new cases of type 2 diabetes by 58%, and 71% in adults over the age of 60 according to the CDC. Though in its inception at the Hale YMCA (launched on Aug 21, 2018), we currently have 8 participants enrolled and are starting to see data in line with the national statistics. Attendance rate has been 100% including make-up class completion for of 25 completed sessions. Five (5) of the eight (8) (63%) participants are already more than halfway to the 7% weight loss goal in the first 5 weeks.

Though a new organization to the local community, the impact of the Hale YMCA Youth and Family Center is clear based on the individuals served and the programs and partnerships that have begun. Through expanding our mission to the broader community and developing strong and strategic community partnerships, the Y will meet its overall mission of Strengthening Communities by focusing on Healthy Living, Youth Development and Social Responsibility. We look forward to what the future holds both for our local YMCA and our local community hospital Day Kimball as we begin to partner to impact the health of the community.

Respectfully,

Amanda Kelly
Executive Director
Hale YMCA Youth and Family Center

Hale YMCA Youth and Family Center
9 Technology Park Drive, Putnam, CT 06260
P 860 315 9622
www.haleYMCA.org

*Kelly, A. (Sept 24, 2018). Hale YMCA Community Letter. Putnam, CT.

TAKING CARE OF OUR OWN: EMPLOYEE WELLNESS

The top chronic conditions found among the Day Kimball employees and family members covered under our health insurance plan show some clear patterns over the three most recently completed years 2015, 2016 and 2017. Over that period the following five chronic conditions were most prevalent among our covered population: Hypertension, Hyperlipidemia, Depression and other mental health disorders, Diabetes, and Asthma. The prevalence of Hypertension, Depression, and Asthma among our group is higher than benchmark data.

We're making DKH a healthier place to work, learn, and play!

DKH WELLNESS CHAMPIONS

NDDH

HealthQuest Northeast Connecticut
Achieving Healthier Communities Together

The Day Kimball Healthcare Wellness Committee is proud to support this garden bed, which is part of a healthy community initiative by the Northeast District Department of Health, Tourtellotte Memorial High School Technical Education students, and HealthQuest, a coalition of health and wellness partners working to make northeast Connecticut a healthier place to live, work, learn, and play.

May we all grow healthy, happy, and strong.

Day Kimball Healthcare has a very active Employee Wellness Committee whose goal is to establish and maintain a culture of wellness by providing educational, environmental, and social opportunities for employees and their families to optimize their health and well-being. This year the committee concentrated efforts in areas that might help people with the diagnoses listed above. They did this by offering programs which would help with weight loss and/or maintenance and exercise, as well as by providing socialization opportunities and a pleasant working environment. Following is a listing of many but not all of the wide variety of activities coordinated by the committee over the last year:

- "A Walk Across the World" campaign which saw 133 employees walk a total of over 34,000 miles during the summer.
- Sponsoring "wall art" in employee and some patient areas designed to provide a soothing and pleasant environment
- Spa Day for employees with 183 employees enjoying treatments from various local therapists
- A "What I am Thankful For" campaign over Thanksgiving period
- A "Maintain Don't Gain" campaign over the holiday season with 65 participants
- A "Be Fit Be Strong" weight loss campaign in January and February
- Wellness classes at low or no cost including Zumba, Pound, & Yoga
- A series of Lunch and Learn programs featuring subjects such as Harmony in the Workplace, Pressure Ulcers and Prevention, Diabetes and Exercise, Preventing Colon Cancer, Preventing Exposure to Hazardous Drugs, Esophageal Cancer, and Day Kimball's Memory Café
- Arranging for discounts for Day Kimball employees at area health and wellness related businesses
- Providing several information booths at 2 area high school Wellness Fairs
- Establishing a Wellness Tree in one of the hospital Lobbies and maintaining it with different wellness related decorations
- Established a Wellness Box Garden on site

TAKING CARE OF OUR OWN: EMPLOYEE WELLNESS

For the coming year we plan to work closely with our health insurance provider and benefits advisors, accessing more of their expertise and experience to help devise programs that will have the most impact in helping our employees and their families maintain health or manage their chronic conditions to maximize their well-being. We also will focus on measuring the impact of our interventions and on changing the way we count our success from how many activities we sponsor to how much we have actually impacted the health of our population.

DAY KIMBALL HEALTHCARE AT HOME

Day Kimball Healthcare at Home consists of three in-home programs serving both the medical and non-medical needs of the residents of sixteen towns in northeastern Connecticut including Brooklyn, Canterbury, Eastford, Killingly, Plainfield, Pomfret, Putnam, Sterling, Thompson, Union, Woodstock, Ashford, Chaplin, Hampton, Griswold and Voluntown. Our in-home programs include Day Kimball Homecare, Hospice & Palliative Care of Northeastern CT, and Day Kimball Homemakers.

Day Kimball Homecare, a Medicare-certified and Joint Commission accredited home health agency, provides skilled services for individuals recovering from an acute illness, transitioning home from an inpatient hospital or skilled nursing facility stay, or experiencing difficulty managing a chronic health condition. Available services include nursing, physical therapy, occupational therapy, speech therapy, medical social work, and home health aides for assistance with personal care. Using a team-based approach, services are delivered under the direction of a primary care or specialty physician, with the goal of ensuring the highest possible quality care to help our patients achieve optimal health outcomes. In 2017, Day Kimball Homecare provided a total of 26,447 home visits, with the top five diagnoses for the home health population served including orthopedic aftercare, cardiovascular disorders, fractures, respiratory disorders, and vascular disorders. For both quality and patient satisfaction, Day Kimball Homecare consistently scores at or above both state and national averages for preventing re-hospitalizations and overall patient satisfaction with care. (www.medicare.gov/homehealthcompare).

In addition to providing skilled visits in the home, Day Kimball Homecare offers community programs such as local flu clinics and educational programs for seniors at our local community college. A primary focus of our community education is Fall Prevention, with ongoing collaboration between our Homecare team, the Northeast District Department of Health, and the Yale Fall Prevention Coalition, guiding the content and location of the education, fall risk screenings, and exercise classes we provide for area seniors free of charge.

Hospice and Palliative Care of Northeastern Connecticut

Hospice and Palliative Care of Northeastern Connecticut, a program of Day Kimball Homecare, provides skilled and compassionate care for individuals and families facing life-limiting and terminal illness. Our team of nurses, therapists, medical social workers, clergy and volunteers, work together under the direction of our Medical Director to provide care that meets not only the physical, but also psychological, spiritual,

DAY KIMBALL HEALTHCARE AT HOME

and emotional needs of the population we serve. Hospice services are provided not only to individuals living in their own homes, but also for the residents of several local skilled nursing facilities we contract with. In 2017, we provided a total of 7,685 hospice and palliative care visits, with the top five most common diagnoses including neoplasms, cardiovascular disorders, respiratory disorders, dementias, and neuromuscular disorders. In addition to providing skilled hospice care in the home or skilled nursing facility, our Hospice program includes bereavement support for family members for up to thirteen months after the death of a loved one, as well as, community grief support groups and annual memorial celebrations including our annual Tree of Life Ceremony, now in its 29th year, held each December in eleven towns throughout Northeast Connecticut.

Day Kimball Homemakers

Day Kimball Homemakers is a non-medical homecare agency providing homemaking services, personal care assistance, and live-in care, primarily for seniors residing in their own homes or in the home of a family member. Services are available on an hourly basis for up to twenty four hours per day. Working closely with our Homecare and Hospice programs, our Homemakers team provides additional services when an individual's needs exceed those covered by insurance, and most importantly, the ongoing services and support needed for seniors to remain safe at home when skilled services have ended. In addition to serving private pay clients, Day Kimball Homemakers provides services for at risk seniors through the Connecticut Homecare Program for Elders, and for individuals eligible for grant funding we received from Senior Resources Agency on Aging. In 2017, Day Kimball Homemakers provided over 94,000 hours of Homemaking and Personal Care Assistance to those populations as follows:

Grant funded clients – 12,437 hours
Private pay clients – 40,240 hours
State funded clients – 41,475 hours

In addition to providing services in the home, Day Kimball Homemakers also operates Memory Lane Café, an activity program for individuals living with Alzheimer's and Dementia. This program, open 4 days per week from 1-4pm, is designed to help provide stimulation and socialization for participants, as well as, respite time for their caregivers. Special guests including artists and musicians are included in each month's calendar of activities. In 2017, 638 memory care sessions were attended by our community members.

Community Outreach

Community outreach, in the form of both educational programs and community events for seniors, is a strong focus for our Day Kimball Healthcare at Home team. In addition to the support groups and bereavement programs provided by our Hospice program, we also sponsor the Alzheimer's and Dementia Family Training Seminar, a series of four free classes offered twice per year. Our Senior Dances, a popular event attended by more than 100 seniors each month from April through October, are staffed by Day Kimball Healthcare at Home employee volunteers and are offered to the public free of charge.

CANCER SERVICES

Addressing the Needs of Our Community: the Future of Cancer Care at DKH

Over the years, Day Kimball Hospital (DKH) has been able to build a formidable cancer treatment practice. Following the National Comprehensive Cancer Network (NCCN) standards of cancer care, and as a result of this unwavering commitment to detail, our program is accredited by the American College of Surgeons Commission on Cancer. Our physicians are board certified in the hematology and oncology specialties, while our nurses are certified chemotherapy/biotherapy providers and Oncology Certified Nurses (OCN) by the Oncology Nursing Society (ONS). DKH oncology nurse navigators (ONN) are on track to become certified by the Academy of Oncology Nurse and Patient Navigators. The DKH cancer care team uses the latest evidence-based practices and innovations in the care we provide, including groundbreaking clinical trials, genetic counseling and fertility preservation.

Being able to provide this high-quality level of specialized care here in Putnam is a critical benefit to the community. DKH is using state-of-the-art chemotherapy and immunotherapy treatments in accordance with the latest national standards of care. We collaborate and coordinate with specialty centers to offer radiation oncology services, highly advanced surgical procedures and bone marrow transplantation to keep as much local care as possible. Equally important, our nurses have intimate knowledge of each patient and our teams case manage every patient from screening through survivorship, attending to financial, emotional and/or physical needs. Based upon our ongoing analysis, there is a growing need and interest in DKH's cancer care services.

Looking at a three-year average, annual doctor visits stand at 4,962 while treatments are trending at 7,327. Approximately 13,000 visits occur at DKH's cancer center each year. Through February of fiscal 2018, new patient referrals had increased 19.6% over the previous year during the same time period; fiscal 2017 saw a 23.3% increase over 2016; and 2016 was up 5.7% over 2015. At DKH, the rates specifically for lymphoma, bladder, pancreatic, lung cancer and melanoma are particularly high in comparison to both state and national averages. In Windham County alone, there are approximately 630 new cancer patients annually. In 2017, approximately 31% of these patients were diagnosed at DKH. While this percentage is consistent with DKH's Windham County annual estimated medical and surgical market share, there is clearly an opportunity to improve both.

The need and interest in cancer care at DKH is clear, as is the community's confidence in our abilities. However, with everything that we do in health care, we are committed to evolve our cancer care practice as we strive to provide high quality and comprehensive cancer care "close to home." It is a well-known fact that DKH is a leading cancer provider in the region as it relates to awareness, screening, diagnosis, and survivorship. But in terms of ensuring the complete care of our patients – their treatments, therapies, and the comprehensive cancer care that they need and deserve, we've limited the breadth and depth of what we've been able to provide by the confines of our physical plant. Knowing what we know about the prevalence of cancer in our region and the hundreds of patients and families who are affected year after year, DKH can wait no longer.

CANCER SERVICES

Now is the time for DKH to lead the way in comprehensive cancer care and research for the residents of northeastern Connecticut.

Simply stated, DKH is "space challenged". There are limits on the number of patients that can be seen daily, limits on the amount of clinical staff that can be on site at one time, and limits on our ability to add doctors to staff. We need to make room for debilitated patients and those receiving intraperitoneal chemotherapy. We are multi-tasking in the operating room to accommodate special procedures and there is no space to offer integrated therapies on site. And though 50% of our patients request counseling, social service, financial assistance, and nutritional help and counseling, the lack of available space educed the time that we can provide these important services. As such, DKH is ready to launch a capital campaign to address and alleviate these limitations and enable DKH to provide the complete, integrated care that our patients need and want access to in their community hospital.

A recently formulated Steering Committee has begun the hard work of planning and implementing a two-year, $3 million campaign to begin in 2019 and which also marks the 125th anniversary of the incorporation of Day Kimball Hospital. This campaign will revolve around the building of a physical infrastructure that accommodates the volume and diversity of patient procedures and services; that respects patient privacy and confidentiality; and complements the work of our dedicated clinical and administrative staff. Working hand in hand with enhancement of cancer services, and woven into every facet of care, DKH will also look to provide a new generation of technological and diagnostic sophistication, ensuring that we have an infrastructure that supports the professionals on the front line of care with technology that is cutting edge. These are the tools that are necessary to continue providing the best possible care in a rapidly evolving and advancing field.

Accepting the status quo is not an option at DKH. Our commitment to be better, fueled by the investment and commitment of our community is what keeps Day Kimball moving forward. We take great pride in the fact that our community has fostered the evolution of this unique and historic institution and look forward to engaging the community in support of this campaign for the enhancement and expansion of cancer services, and the next evolution of care at DKH.

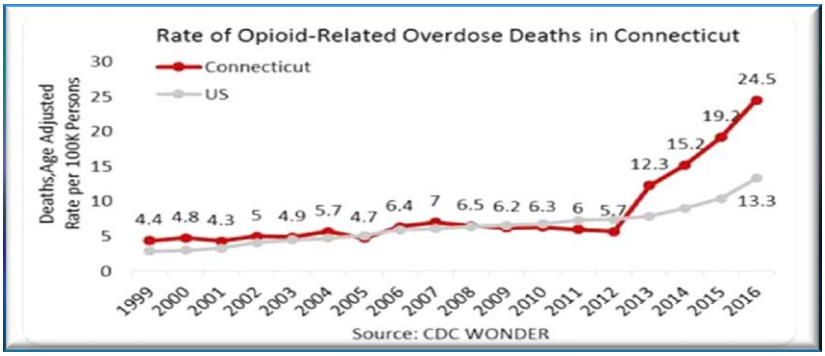
ADDRESSING THE OPIOID CRISIS

A study conducted in 2016 by the Health and Human Services (HHS), estimated that 11.5 million people in the US misuse prescription opioids, with 116 people dying a day in the US from opioid use. In 2017 HHS declared a public health emergency and developed strategies to combat the opioid crisis.

Opioid-Related Overdose Deaths

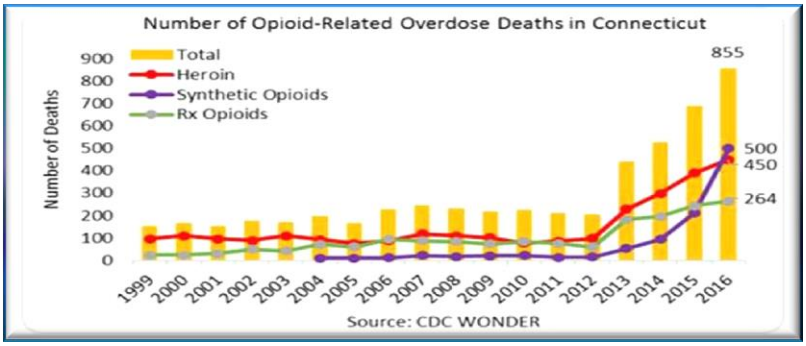
Connecticut is among the top ten states with the highest rates of opioid-related overdose deaths. From 1999 through 2012, the death rate in Connecticut hovered near the national average. Through 2016, a more than fourfold increase was seen—from 5.7 deaths per 100,000 persons to 24.5 deaths per 100,000 persons. The national average in 2016 was 13.3 deaths per 100,000 persons.

In 2016, the number of heroin-related deaths increased to 450 deaths compared to 98 deaths reported in 2012. In the same period, prescription opioid-related deaths increased from 95 to 264 and deaths related to synthetic opioids (mainly fentanyl) increased from 15 to 500 deaths (CDC WONDER).



Opioid Pain Reliever Prescriptions

In 2015, Connecticut prescribers wrote 2.3 million prescriptions for opioid pain relievers, or 64.0 prescriptions for every 100 persons. This was a 9.3 percent decline since 2013, and less than the national rate of 71 prescriptions per 100 persons (IMS Health).

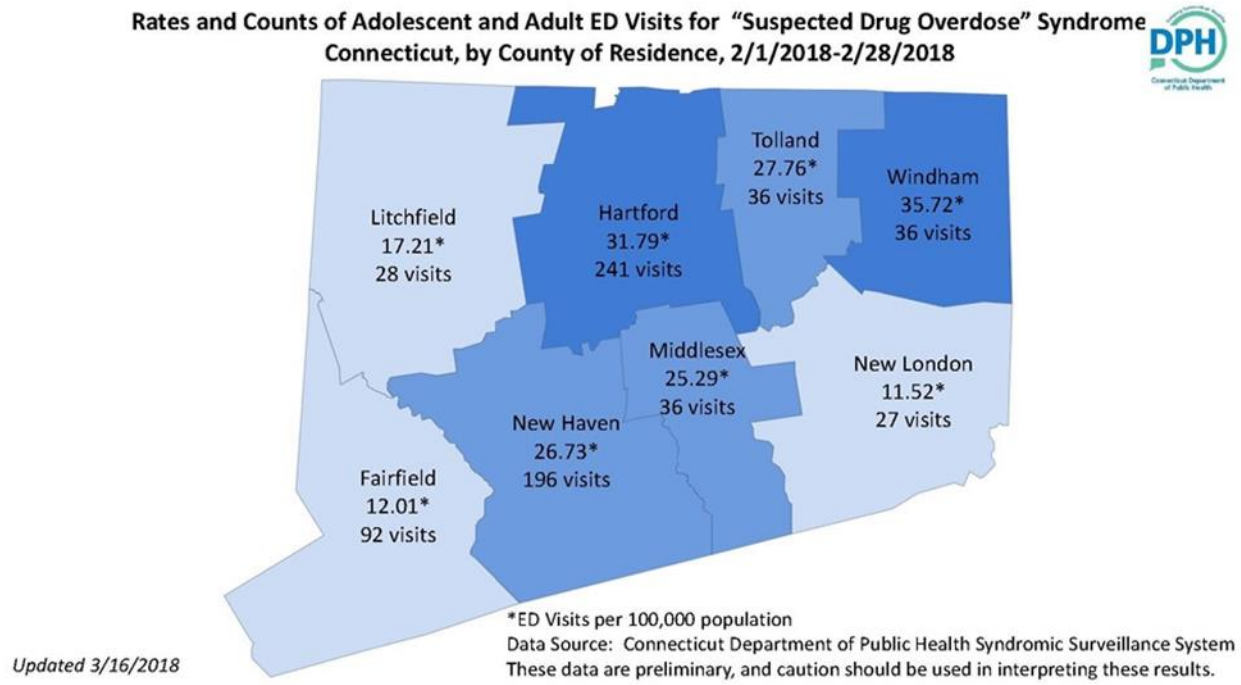


ADDRESSING THE OPIOID CRISIS

Connecticut implemented "The Connecticut Opioid Response Initiative" on October 5, 2016.The genesis of this strategic plan was initiated by Governor Dannel P. Malloy's charge to the Alcohol and Drug Policy Council (ADPC), a statewide stakeholder group, to comprehensively address Connecticut's opioid crisis. Governor Malloy engaged the Connecticut Opioid Response (CORE) team to supplement and support the work of the ADPC by creating a focused set of tactics and methods for immediate deployment in order to have a rapid impact on the number of opioid overdose deaths in Connecticut. He asked the CORE team to focus on evidence-based strategies with measurable and achievable outcomes. Finally, the Governor requested that the CORE team's strategic plan be cognizant of Connecticut's new economic reality while not shying away from proven strategies that may not be funded currently.

Accordingly, the CORE team's strategic plan lays out a series of actions designed to rapidly reduce opioid-related overdose deaths in Connecticut. As a strategic, tactical document, it does not represent a broader strategy to address many of the complex factors that have produced the opioid crisis. The CORE team will continue to work with the ADPC as they lead the state's comprehensive response to the opioid crisis and collaborate on future challenges as they develop. (CT DPH Website)

Connecticut is not immune to this opioid crisis and based on data from the Connecticut Department of Health, Windham County has one of the highest opioid misuse and suspected overdose in the state. Sadly, more than 2 million people may transition to persistent opioid use following elective, ambulatory surgery each year. Patients who are discharged after surgery with opioids and choose to not take them as directed lead to billions of unused pills, with an opportunity for others to steal, sell or take the medication.



ADDRESSING THE OPIOID CRISIS

The misuse of prescription medication and opioid based drugs has increased significantly over the years to become a public health concern in Connecticut. This misuse or abuse includes taking these medications in higher doses than prescribed, for a purpose other than that for which it was prescribed, or taking a medication that was prescribed for another person or obtained off the streets. Opioid overdose is often characterized by a decrease in breathing rate which if not quickly addressed leads to death.

In Connecticut, residents are more likely to die from unintentional drug overdose than a motor vehicle accident. Majority of these deaths are linked to overdose of prescription opioid painkillers. According to 2013 CDC report, the Connecticut age-adjusted rate for drug induced mortality is 16.4 per 100,000 population compared to the national rate of 14.6. These data are being made available through DPH syndromic surveillance system, EpiCenter, which provides near real-time estimates of emergency department (ED) utilization of suspected drug overdoses in order to quickly detect and respond to changes in patterns of both fatal and non-fatal opioid overdoses.

Rates and Counts of Adolescent and Adult ED Visits for "Suspected Drug Overdose" Syndrome Connecticut, Windham County:

1/1/2018 – 1/31/2018	2/1/2018 – 2/28/2018	3/1/2018 – 3/31/2018	4/1/2018 – 4/30/2018
30.95*	38. 94*	17.97*	24.96*
31 Visits	39 Visits	18 Visits	25 Visits

*ED visits per 100,000 population
Data Source: Connecticut Department of Public Health Syndromic Surveillance System
(These data are preliminary and caution should be used in interpreting these results)

There were 54 patients treated in DKH Emergency Department in the last 12 months for suspected opioid overdose based on internal data. A recently released report from Cigna for the period of 4/1/17 – 3/31/18 shows a 42.3% reduction in opioid patients, multiple prescribers decreased by 33.3% and acute fills greater than 7 days are down 23.1%.

DKH has already put into place several interventions to address this issue. For example, DKH has offered weekly Narcotics Anonymous meetings. NA members have an average of 11.07 years clean. In addition, DKH began offering Enhanced Recovery After Surgery to prevent opioid abuse and addition.

Implementation of an Enhanced Recovery After Surgery (ERAS) at Day Kimball Hospital

Why is Enhanced Recovery After Surgery an Identified need for the community?

DKH has chosen to be a part of preventing new cases of opioid addiction and abuse through the Enhanced Recovery After Surgery program. The Enhanced Recovery After Surgery program was implemented at DKH in 2018. Initially the focus was on statewide initiatives focused on Abdominal Hysterectomy, Colon Resection cases, Total Joints, and Spine Surgery; but has now been rolled out to include all surgical cases.

ADDRESSING THE OPIOID CRISIS

Enhanced Recovery After Surgery (ERAS) is a pain management strategy used to decrease opioid use during and after surgery. Day Kimball has had tremendous success so far with ERAS and continues to grow the program. ERAS involves non-pharmacologic approaches, peripheral nerve blocks, and other methods to reduce opioid use while focusing on patient communication with the entire care team.

Goals of ERAS

ERAS is a program that is evidence-based and has proven, when implemented, to improve quality outcomes, decrease opioid use, and improve patient satisfaction. Evidence shows that ERAS reduces patient length of stay by 3-4 days on average, reduces 30 day patient readmission rates and costs, helps patients return to normal activities more quickly and reduces surgical site infections. **The DKH ERAS program has focused on:**

1. Significantly decreasing opioid use through the use of alternative pain modalities such as:
    - Patient teaching related to expectations of pain and alternative pain modalities
    - Use of non-narcotic pain medications pre and post operatively
    - Use of regional blocks; i.e., Transverse Abdominis Pain Blocks
2. Decreasing length of stay
3. Decreasing re-admission and healthcare costs
4. Improving patient outcomes by providing coordinated care starting in the physician offices through the patient recovery after surgery
5. Decreasing surgical site infection
6. Surgical Site Infections (SSI) are the most common and costly of all hospital-acquired infections, accounting for 20 percent of all hospital-acquired infections. SSIs impact quality of patient care with increased length of stay, re-admission, and even death.

The following evidence-based steps were implemented through our ERAS program to decrease SSIs.

1. Multidisciplinary approach to implementing best evidence–based practices through Service Line Committees for each surgical specialty
2. Education of surgeons, staff, and physician offices of expectations related to ERAS to ensure that patients are optimized prior to their surgical care
3. Patient teaching which is started in the physician offices and reinforced through the patient pre-admission testing, and again on the day of surgery
4. Pre-warming of all surgical patients with the use of specific warming gowns starting 30 minutes prior to surgery and continued through recovery to maintain hypothermia
5. Carbohydrate loading the night prior to surgery and two hours before admission for all surgical patients (except Type 1 IDDM)

ADDRESSING THE OPIOID CRISIS

6. Pre A1C testing and tight monitoring of blood glucose levels throughout the surgical care

7. Use of alternative modalities for management of pain; minimize narcotic usage

Results

Since implementing ERAS at DKH earlier this year, we have realized as an organization the following results:

- Decrease in Surgical Site Infection
- Minimal use of narcotics in recovery phase of surgery
- Minimal or no use of narcotics 24 hours post-surgery
- Decrease length of stay
- Improved patient experience for the surgical patient based on patient feedback received
- We continue to look to evidence-based practices to improve quality outcomes and the patient experience while being aware of how the greater good of the community can be impacted once our patients leave our facility.

Putnam PRIDE (Partnership to Reduce the Influence of Drugs for Everyone) is a coalition of local agencies, business owners, town officials, law enforcement, school administrators, parents and youth, which was formed to address substance abuse in our community.

Their mission is "to unite the citizens of Putnam in a partnership to create and foster a safe, drug-free environment for the entire community."

"As a representative of Day Kimball, I have been a member of the PRIDE Committee since November 2016. The committee discusses planned community events as well as the future of the program. As a member, I have provided numbers of patients that have been treated for substance-related issues in our catchment area".

John O'Keefe
Chief Nursing Officer

This program is well-intended and serves as a good, positive purpose for our community.

DIABETES

Day Kimball Medical Group is proud to offer diabetes management as part of an enhanced coordinated care program through our 16 Primary Care Practitioners. These patients are seen in one of our five primary care practices located in Woodstock, Putnam, Dayville, Danielson and Plainfield.

Diabetes is the 7th leading cause of death in Connecticut (2012 mortality files). Additionally, in CT an estimated 8.9% of the adult population or approximately 250,000 adults age 18 years and older have been diagnosed with diabetes (2012-14 data). An additional 83,000 CT adults have undiagnosed diabetes. The associated cost is an estimated 2.92 billion (direct and indirect costs) in 2012 for CT. In 2014, approximately $197.8 million was billed for hospitalizations due to diabetes as principal diagnosis and $79.8 million for diabetes with lower extremity amputation.

Currently we follow approximately 3,500 adolescents and adults living with Type I or Type II diabetes, pre-diabetes, or gestational diabetes to manage their condition and maintain their health.

Specialized care plans are developed by providers with goals mutually developed with patient input. Within each of the practices the Nurse Care Coordinator works with the patients on an individualized basis to ensure the patient has the care needed.

Patients are provided with education and instruction about how to perform diabetic self-care, including the importance of home blood glucose-testing, how nutrition and exercise impacts diabetes, strategies for lifestyle modifications; as well as, modalities based on the needs of individuals.

As stated earlier, transportation issues have a negative impact on patients. Within our community, transportation is an issue for several of our diabetic patients. We do not have a public transport system; therefore, one of the issues that the nurse coordinator has to address regularly is to discuss options with patients regarding transportation to appointments and the ability to obtain prescriptions. Some of the options we have used are local transportation offered through patient's neighbors, church or senior center. Additionally, some insurance payers have resources through the payer's case management program for transportation, medication assistance, counseling, etc. Some of the pharmacies in our area do deliver medications to patients. We have found that the care plan needs to be tailored to the individual, since the barriers are different on a patient-by-patient basis; as well as, changes periodically as a patient's condition improves or worsens.

In our practices, each of our patient's quality measures is collected through the electronic medical record. For diabetic patients, these measures include: BP screening and control, completion of annual foot exam and eye exam, glucose screening and whether result is < 7; as well as, kidney function and cholesterol screening. Currently 57% of our diabetics have a HA1c <8. Our baseline measurement was 23% in 2012. We recognize that although we are making improvements we still have more to do in the future.

One of the interventions we would like to pursue over the next 2-3 years is a more defined educational program for the pre-diabetic patient. Representatives from our organization have completed the CDC pre-diabetic training program in the past. This program's premise is if we are able to avoid a patient being diagnosed with diabetes, then we could also avoid the associated sequelae.

STROKE

Stroke is the 5th leading cause of death in Connecticut, with heart disease and stroke accounting for about 27 percent of deaths. The number of fatal strokes increases with age, with almost 90 percent of stroke deaths occurring among people 65 years and older. Stroke disproportionately affects African Americans in the state and while stroke incidents do not vary significantly among men and women, a majority, or 61 percent, of stroke deaths in the state from 2011 to 2015 were among women, who live longer than men.

Day Kimball Hospital is a designated Certified Advanced Primary Stroke Center by the Joint Commission since 2014. This designation was achieved by providing comprehensive care for all patients presenting with stroke symptoms including a complete administrative infrastructure supporting and guiding the process of stroke patients. Evidence-based
clinical practice guidelines are in place that provide an interdisciplinary approach to care. Stroke education to staff, patients, families, physicians, EMS and the community is integral to the program. Specific quality improvement initiatives are implemented to assist us in ongoing assessment and evaluation of our performance in caring for stroke.

Services provided in the Emergency Department of Day Kimball Hospital include:

- 24 hour/7 day a week care for all patients presenting with stroke symptoms
- A team of professionals educated in stroke care
- Diagnostic Imaging (CT, CTA, MRI imaging)
- Laboratory services to support goals for "door-to-lab resulted times"
- Expert consultation with a comprehensive stroke center, including telemedicine services
- Immediate availability of intravenous thrombolytic therapy
- Acute stabilizing management of intracerebral hemorrhage
- Access to advanced treatment interventions such as intra-arterial thrombolytic therapy, thrombectomy, neurosurgery and neurosurgical interventions for
- hemorrhagic stroke, and potential for inclusion into clinical trials

Services provided in the Inpatient Setting of Day Kimball Hospital include:

- A team of professionals educated in stroke care
- Diagnostic Imaging (CT, CTA, MRI imaging)
- Laboratory services to support goals for "door to lab resulted times"
- Expert consultation with a comprehensive stroke center, including telemedicine services
- Face-to-Face Neurology Consultation
- Inpatient monitoring
- Speech screening and evaluations, with therapy as needed
- Physical therapy evaluations, with treatment as needed
- Occupational therapy evaluations, with treatment as needed
- Case management services for patient centered plan of care and discharge planning
- Referrals to Day Kimball Home Care / Visiting Nurse Agencies
- Referrals to Skilled Nursing Facilities
- Referrals to Day Kimball Rehabilitative Outpatient Services

STROKE

On average, Day Kimball Hospital treats approximately 200 stroke and stroke-related illnesses annually. The volume has increased over the past two years. According to the National Institute of Neurological Disorders and Stroke, the treatable risk factors for stroke include: high blood pressure, cigarette smoking, heart disease, diabetes, warning signs or history of stroke, cholesterol imbalance, physical inactivity and obesity. As noted in other sections of this document, Day Kimball is taking actions to work on reducing these treatable risk factors and will continue to do so in the future.

*American Heart Association. (2018)

BEHAVIORAL HEALTH

Overview: Day Kimball Healthcare offers outpatient, inpatient and emergency behavioral health services. The outpatient program is located in the Community Services Building (CSB) on the main hospital campus and consists of a physician and nurse practitioner, who provide medication evaluations and ongoing medication management. The program also includes a licensed clinical psychologist, licensed clinical social workers (LCSW), and licensed professional counselors (LPC), who provide comprehensive assessments for children and adults throughout the lifespan, as well as ongoing individual, group, and family therapy. All providers serve a range of conditions, including depression, anxiety, psychotic disorders, and post-traumatic stress (PTSD). The program offers an adjusted rate for uninsured patients. Over 500 patients and 6,500 visits are serviced annually.

The psychiatric inpatient program (PIP) consists of a 15-bed hospital unit, including the services of a psychiatrist, licensed clinical social worker (LCSW), registered nurses (RN), and support staff, who provide 24/7 care for individuals who are at high risk due to their condition. The program accepts patients who are evaluated in the DKH emergency department by the emergency mental health (EMH) team, as well as referrals from other hospitals throughout the state of Connecticut, and neighboring Rhode Island and Massachusetts. The program uses a comprehensive approach, evaluating and managing medication needs, social and environmental concerns, and using therapeutic interventions for individuals, groups, and family support. The program serves approximately 500 patients annually, including over 3,000 patient care units provided. The staff is also able to provide detoxification services for individuals with alcohol and opioid use disorders, who are admitted with a primary psychiatric diagnosis.

The emergency mental health (EMH) team consists of psychologists, licensed clinical social workers (LCSW), and licensed professional counselors (LPC) who evaluate patients in the DKH emergency center, provide recommendations for care and therapeutic interventions, and help patients reach a disposition for their ongoing psychiatric needs. The team evaluates over 1,500 patients annually, working with several local community providers to assure follow-up care, referrals for new patients, and transfers to higher level of services when necessary.

The Community We Serve

Although DKH offers routine psychiatric services in the outpatient program, there are occasions when medication and therapy alone are insufficient to resolve patients' symptoms. In some cases, patients who are unable to provide adequate relief for their psychiatric symptoms may turn to drugs and/or alcohol to relieve their discomfort. This often creates further difficulties, resulting in co-occurring disorders (COD), which require comprehensive evaluation and care. Patients who do not receive sufficient treatment for COD often suffer economically, emotionally, socially, and physically. CODs often result in job loss (or underperforming in work), family and relationship discord, legal problems, worsening health, and increased psychiatric symptoms. In addition to more specialized and comprehensive treatment for COD, patients with psychiatric conditions often benefit from assertive case management to help navigate economic difficulties, which often result in difficulty attaining basic needs, such as food, housing, and transportation, as well as lack of access to sufficient health care. Assertive case management and care coordination is associated with superior outcomes for individuals with major psychiatric disorders and COD1.

BEHAVIORAL HEALTH

In cases where outcomes are insufficient, case managers and care coordinators work with community resources and providers to access appropriate services to address the needs of the individual. Often times, patients may be referred to providers specializing in their particular condition, or to more intensive programming, such as an intensive outpatient program (IOP), partial hospital program, detoxification services, or residential treatment centers (RTC). In other cases, therapies such as electroconvulsive therapy (ECT) or transcranial magnetic stimulation (TMS) are beneficial.

TMS is a non-invasive procedure using magnetic fields to stimulate nerves in the brain cell, and is typically used for patients experiencing depression, when other treatments have not been successful. The procedure is performed by a certified technician in an outpatient setting under the care of a psychiatrist, and consists of the application of an electromagnetic coil to the patient's head. Patients remain awake and alert through the procedure, which is typically safe and well-tolerated. Treatments last less than one hour, with a common pattern of repeating the treatment multiple times per week, if not daily, until benefits can be achieved.

Identified Needs

While there are other organizations that provide services for co-occurring disorders, DKH is uniquely positioned to provide this service in a comprehensive, holistic fashion. Patients who receive medication management and/or ongoing psychotherapy may also benefit from case management, physical therapy, pain management, nutritional consultation, and a strong connection to a primary care provider (PCP). At this time, however, several community needs must be addressed for DKH to emerge as a leader in the application of these services.

Inpatient detoxification services – While DKH has the capability to provide detoxification services to patients admitted to the PIP or medical floors, patients whose primary need is detoxification must be admitted elsewhere due to limitations on the contractual agreement between DKH and third-party reimbursement companies, as well as regulatory bodies, including the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), Department of Public Health (DPH), and Department of Mental Health and addiction services (DMHAS). Currently, there are no other inpatient detoxification services within 30 miles of Putnam, CT, and no facility within 40 miles that accepts in-state, low-income Medicaid insurance.

Comprehensive care coordination for patients with co-occurring disorders (COD)

Transcranial magnetic stimulation (TMS)

Increased medication management for elderly patients

Assertive clinical case management for individuals with severe, chronic, or complicated psychiatric illness

CONCLUSION

Over the next year, DKH will continue to develop their implementation plan to meet the needs identified in this assessment. We take pride in taking care of the community. Our service area is rich with organizations who can partner with DKH to better meet the needs of our community members. The medical needs will be addressed in addition to looking at social and economic forces and how they impact diseases.

We want to thank all of the DKH staff, leaders, board members, and local organizations for participating in our assessment process. We are looking forward to working collaboratively to make Windham County a healthier community.

*Cargill Falls, Putnam, CT (2018)

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