

2019 Healthier Greater New Haven Partnership Community Health Improvement Plan Implementation Strategies

Priority Area: Access to Care		
Indicator: Percentage of people reporting t 2018-17%]	hey do not have one person or place you think of as your personal	doctor or health care provider [2015-13%,
Indicator: Percentage of people reporting the second secon	ney experienced discrimination at the doctor's office [2015- N/A ;2	2018-52%]
Indicator: Percentage of people in Greater N *Source – CT DataHaven Wellbeing Survey 2015 and 2	Iew Haven that indicate they do not have a medical home [2015- N 018	N/A;2018-12%]
Goal: By February 2022, the rate of adults without a medical home will reduce by 2%.		
Strategy	Action Steps	Outcomes
Promote available primary and specialty medical services in the Greater New Haven region to impact the number of individuals who have a medical home	 Continue to work with the Primary Care Consortium Identify gaps in specialty care access for Medicaid and uninsured patients and investigate ways to increase availability and access Collaborate with specialty care providers to increase the number of providers who accept Medicaid and uninsured patients Promote the importance of having a regular source of care (medical home) Leverage Patient Centered Medical Home (PCMH) and Person Centered Medical Home + (PCMH+), CMMI Accountable Health Communities (AHC) and CDC Racial and Ethnic Approaches to Community Health (REACH) grants to improve referrals and patient navigation between partner organizations and providers (primary and specialty, including mental health) Leverage CARE Health Leaders program Improve / evaluate access to Community Health Workers (CHWs) 	 # of gaps identified # of collaborations with specialty care providers accepting uninsured and Medicaid patients # of communications regarding medical homes # of referrals



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Priority Area 1: Access to Care, continued		
Strategy	Action Steps	Outcomes
Increase implementation of culturally and linguistically appropriate services (CLAS) standards throughout the greater new haven region as a way to address discrimination in the health care setting	 Complete a CLAS assessment with local partner organizations to determine current gaps and implement CLAS strategies as needed Collect CLAS implementation tools and disseminate (ensure awareness of race, ethnicity, gender and LGBTQ issues) Engage patients, public health departments, hospital association and other groups to conduct events promoting and/or training on CLAS (New England Public Health Training Center (NEPHTC), Connecticut Public Health Association (CPHA), Health & Equity, LLC, others) 	# of organization assessments completed# of events promoting CLAS
Strategy	Action Steps	Outcomes
Address access issues such as clinic times and appointment availability	 Asset mapping and gap analysis focused on hours of operation for clinical and community based care options, to include urgent care, Federally Qualified Health Centers (FQHCs), FQHC look-alike, and other community health centers Create a report of the findings and share broadly with the provider community and the community 	Completion of mapping and analysis Completion of report # of educational sessions using the report # of providers using the report to drive change
Support efforts to increase economic security of individuals living in the region (for those organizations who can)	 Identify areas of focus each legislative session. 2019 examples include paid family medical leave, affordable housing, and living wage) 	# of letters of support # of issues supported



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Partner Organizations

Community Alliance for Research and Engagement (CARE), Cornell Scott Hill Health Center, East Shore District Health Department, Fair Haven Community Health Care, Milford Health Department, Project Access-New Haven, Quinnipiak Valley Health District, Yale New Haven Health, Yale New Haven Hospital, Yale School of Medicine Primary Care Residency Program