2016 Greater Danbury Region

Community Health Improvement Plan and Implementation Strategy

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Norwalk Health Department

United Way
United Way of Western Connecticut

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Regional YMCA of Western Connecticut

hvlcasa
housatonic valley coalition against substance abuse

Campus of Danbury Hospital
New Milford Hospital
Western Connecticut Health Network

Danbury Hospital
Western Connecticut Health Network

Community Health Improvement Plan

The **2016 Greater Danbury Community Health Improvement Plan** (CHIP) was developed over the period of September 2016 through January 2017, using the key findings and identified priorities from the **Community Health Needs Assessment** (CHNA). The Greater Danbury CHNA included data from the 2015 Community Wellbeing Survey (CWS), the key informant survey (KIS), community agencies and services, as well as quantitative data from local, state, and national sources to inform discussions and determine priority health areas. The CHIP will be a dynamic document that outlines strategies and tactics to improve the health of the Greater Danbury Region and will serve as a roadmap for implementation.

Danbury Hospital, in collaboration with the Community Action Planning Steering Committee (CAPSC), led the development of the CHIP, with participation from local health departments and other community partners. Membership of the CAPSC and health departments can be found in Appendix A. Lorentson Consulting, a company with extensive community program development, was engaged to conduct community conversations and facilitate the workgroups convened for each priority identified in the CHNA. The workgroups developed goals, objectives, strategies, actions steps and metrics to measure success for their respective health priorities. Workgroup participants are listed in Appendix B.

Overview of the Community Health Improvement Process

A CHIP is an action-oriented strategic plan that outlines how the defined priority health issues for a community will be addressed, including strategies and indicators to measure improvement in the health of the community. CHIPs are created through a community-wide, collaborative process that engages community members and organizations to develop, support and implement the plan. The CHIP serves as a vision for the health of the community and a framework for organizations to use in leveraging and coordinating resources, engaging partners and sharing best practices across sectors and the region.

As a broad, strategic framework, the CHIP is designed to be modified and adjusted as conditions, resources and external environmental factors change. It has been developed to provide guidance to the hospital, health departments and community partners, so that all community groups and sectors — private and nonprofit organizations, government and social service agencies, community and faith-based organizations — can participate in the effort to improve the health and quality of life for all people who live, work and play in the Greater Danbury Region.

Methods

Building on the work underway and based on the key findings and priorities identified in the **Community Health Needs Assessment** (CHNA), the goals of the CHIP are to:

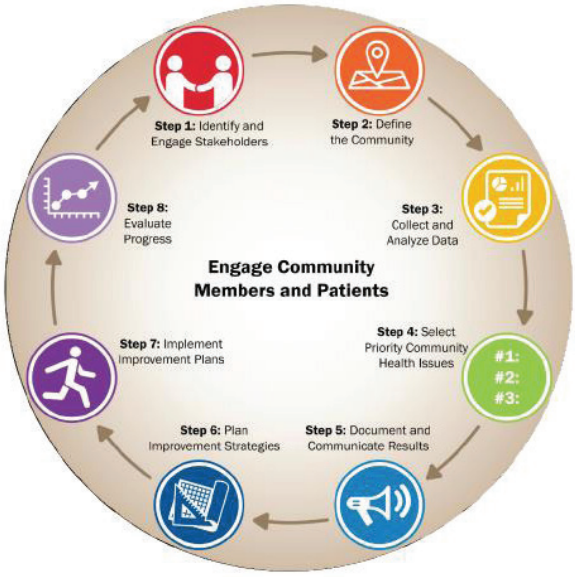
- Develop a strategic framework to address the priority health issues identified in the CHNA
- Identify resources and partners to develop and implement an improvement plan with performance measure for evaluation of impact
- Guide future community decision-making related to community health improvement

In addition to guiding future services and programs for the Greater Danbury Region, the CHIP fulfills the prerequisites for a hospital to submit to the IRS as proof of its community benefit and for a health department to earn voluntary accreditation, which indicates the agency is meeting national standards.

To develop the CHIP, Danbury Hospital was the convening organization that brought together community agencies, represented by the CAPSC, region Health Departments, community members, and additional community representatives.

The approach to the CHNA and CHIP was guided by the Association for Community Health Improvement (ACHI)/Health Research & Educational Trust (HRET) framework (Figure 1). The CHIP process was designed to integrate and enhance the current community health activities of many organizations in order to leverage existing resources for greater efficiency and impact.

FIGURE 1: Community Health Assessment and Implementation Pathway



SOURCE: HRET, 2016

The next phase of the community health improvement process will involve implementation of the strategies and action steps developed from the CHIP and monitoring and evaluation of the CHIP's outcomes and impact.

Development of 2016 CHIP Strategic Components

The key findings and health priorities identified in the CHNA were presented to community partners and various community organizations from September 2016 to November 2016. Then workgroups were convened and facilitated by Lorentson Consulting over several days in November and December 2016 to draft goals, objectives, strategies, short term action steps, long term action steps and outcome measures for each of the four priority areas. See Appendix B for workgroup participants.

On September 14, 2016 the CHNA findings were presented to the members of the Housatonic Valley Region Health Directors (which includes Brookfield, Bethel, Bridgewater, Danbury, Redding Ridgefield, New Fairfield, New Milford, Newtown and Sherman).

The Community Action Planning Steering Committee (CAPSC) met on September 29, 2016. The CHNA was reviewed and the plan for sharing the CHNA and the CHIP workgroup process was developed.

Two community conversations were held in the Greater Danbury Region to present the key findings and identified priorities of the CHNA. One was held at Danbury Hospital on November 1, 2016 and one was held at New Milford Hospital on November 2, 2016. Over 200 community members were invited to validate the health concerns and priorities in our communities and give their perspective on how best to work toward addressing them. Over 30 people participated in the discussions.

The workgroups for three of the four priority areas began to meet in November, 2016. The Access to Care priority did not have an identified work group, and was addressed by the CAPSC as a whole. Data profiles and copies of the existing action plan and strategies were distributed to workgroup members to ensure that plan components were data driven, and considered work already underway.

The Chronic Disease/Obesity Prevention workgroup was expanded with additional community members and health care providers and met on November 8, 2016. Through facilitated discussion, brainstorming and working in small groups, proposed goals, objectives and strategies were developed. Drafts of the plans were circulated to workgroup members via email, and edited through two subsequent meetings on December 13, 2016 and January 17, 2017.

The Mental Health and Substance Abuse goals and strategies were developed via phone and email contact during November and December 2015 with leaders of the key initiatives currently underway. Drafts of the plan were circulated and edited through email.

The Healthy Aging workgroup met on December 8, 2016, and a draft plan was developed, which was then circulated to members via email, and revised as needed.

The CAPSC convened on December 20, 2016. The drafts plans for the Chronic Disease, Mental Health and Substance Abuse, and Healthy Aging priorities were reviewed, and suggestions for revisions were made. The Access to Care priority was reviewed by the group as a whole, via a facilitated discussion, and a preliminary action plan was drafted.

Revised action plans and strategies were developed and circulated to workgroup members via email at the end of December, 2016. The Chronic Disease workgroup reviewed the revised plan and strategies at the January 17, 2017 meeting, and additional modifications were made. These plans were presented to and endorsed by the Western Connecticut Health Network Community Health Committee (WCHN CHC) on January 23, 2017.

Overview of the Implementation Plan

Priority	Goal	Objective(s)	Collaborating Community Partners
Chronic Disease Prevention	All people are supported in practicing positive habits that include physical activity and healthy eating	• Promote and strengthen universal healthy lifestyle message (e.g. 5,3,2,1,0) across sectors in community • Support community gardening programs and farmers markets • Advocate for proven physical activity initiatives	Regional YMCA of Western CT, United Way of Western CT, City of Danbury, Danbury Promise for Children, WCHN
	People of all ages and economic backgrounds are supported in obtaining health screenings and participating in disease prevention/health maintenance programs	• Develop continuum of services for target populations • Increase provider awareness of/referrals to community programs • Implement screening and awareness campaigns for chronic disease	Local Health Departments, Regional YMCA of Western CT, WCHN
	Develop or enhance access to places and programs to promote physical activity opportunities for all	• Develop inventory of free trails, parks, and recreational opportunities in the Greater Danbury Region • Promote participation in national physical activity events (e.g. Walk to School Day) • Advocate for and support development of infrastructure improvements that encourage walking and/or biking	Local Health Departments, municipalities, United Way of Western CT, Coalition for Healthy Kids (CHK), Schools
Mental Health & Substance Abuse	Reduce substance use across the lifespan in our region	• Create community level change and ensure a continuum of care by utilizing the Strategic Prevention Framework and evidence-based initiatives	Regional Prevention Councils, Drug-free Schools Committee, HVCASA, Midwest CT Council on Alcoholism
	Promote behavioral health and wellness across the lifespan in our region	• Provide access to information and resources that reduce stigma, enhance awareness and encourage early identification of behavioral health issues • Embed behavioral health into Primary Care	WCHN Community Care Team (CCT), Greater Danbury CHC, WCMG Primary Care
	Reduce the number of opiate addiction disorders, overdoses and related deaths in our region	• Increase the number of prevention and intervention activities related to opioids • Promote SBIRT, MAT, and Narcan training	Regional Opioid Prevention Workgroup, EMTs, Pharmacies, LPCs, WCHN ED, Danbury/NM Police

Priority	Goal	Objective(s)	Collaborating Community Partners
Healthy Aging	Support those planning for healthy aging and those managing immediate needs for services and supports	• Increase pathways to a comprehensive resource for individuals who are planning for healthy aging • Increase pathways to a comprehensive resource for seniors and caregivers who are managing an immediate need for services and supports	Aging in Place Council, CT Department of Social Services, WCHN- WCHC, VNAs, Senior Housing Sites, Health Departments
	Enhance education, advocacy, access and communication to support ability of seniors to age in place	• Increase awareness of services and supports that enable seniors to age in the place of their choice • Implement targeted outreach to decision makers at the local, regional and state level to inform and shape public policies	
Access to Care	Identify key needs within our community related to access to care, which are not addressed by other priority areas	• Engage community partners to assess barriers to care and identify at-risk populations • Conduct additional surveys/focus groups among at risk populations	FQHCs, Americares, WCHN ED and CCT, CT Mission of Mercy
	Develop a comprehensive action plan to address identified needs/ barriers	• Implement targeted outreach and strategies to improve access and/or reduce barriers to care	

Planning for Action and Monitoring Progress

The CAPSC was created during the community health planning process in the Greater Danbury Region in 2012. The Vision and Mission for the CAPSC participants were defined:

Vision: Healthy People Living in Health Communities

A community of diverse individuals who, through a commitment to creativity and innovation, collaborative leadership, cultural responsiveness, and the development of evidence-based solutions for priority health issues, strives to create a community of the healthiest people in Connecticut.

Mission: Promote optimal overall Physical, Social, Emotional and Mental Health

Through collaborative and sustained action and a commitment to excellence, we strive to promote and maintain the health of our community residents through prevention, education, evidence-based interventions, and the assurance of access to quality health care.

Progress on the 2016 CHIP and implementation strategies will continue to be monitored at routine workgroup meetings, and will be reported quarterly to the CAPSC. The CAPSC will report to the WCHN CHC, made of community members and representatives from community health organizations on a quarterly basis (see Appendix C for reporting structure and WCHN CHC membership), and annually to the Danbury Hospital Board and the network Strategic Planning Committee, as a delegate of the WCHN Board of Directors.

The work of the various task forces, workgroups, and committees follows a collective impact model,

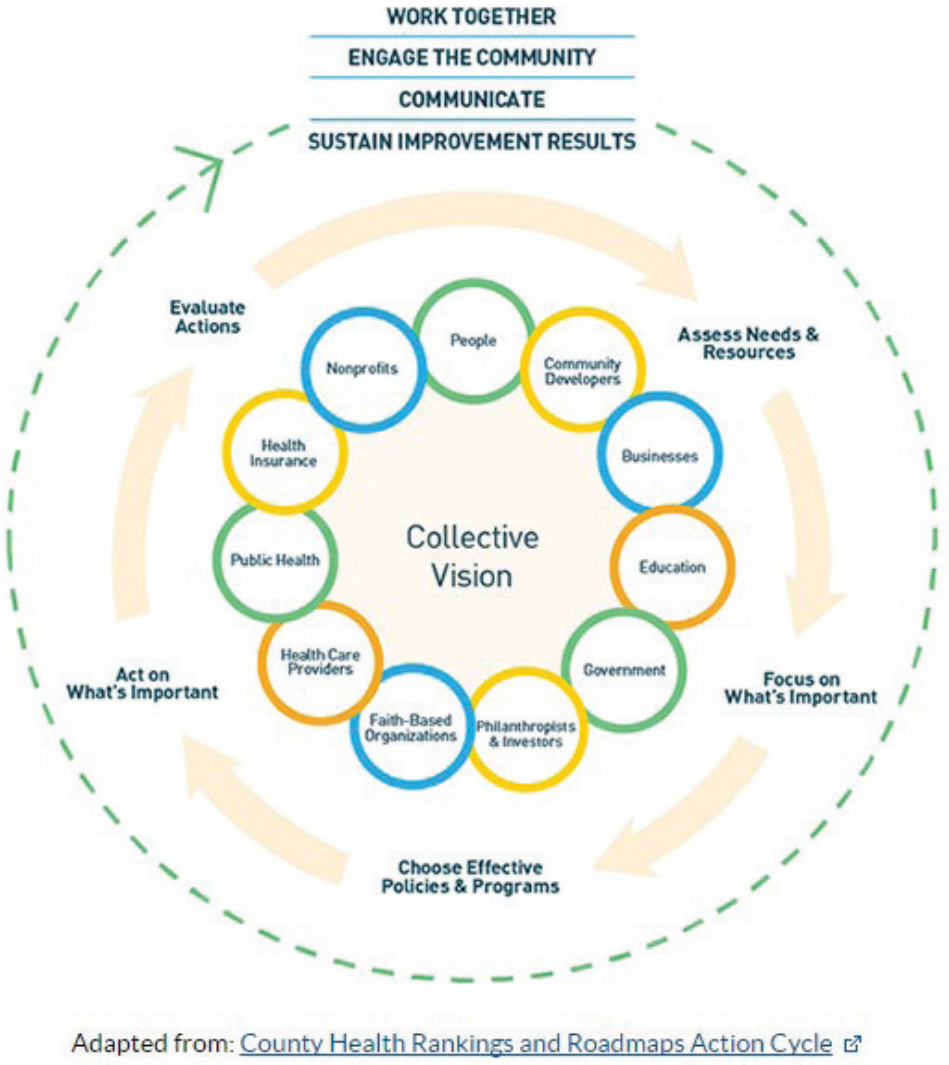


FIGURE 2: Community Health Assessment and Implementation Pathway

which has proven to be an effective approach when addressing entrenched social and community issues. Collective impact begins with the idea that large-scale social change requires broad cross-sector coordination, and occurs when organizations from different sectors agree to solve a specific social problem. The key elements of collective impact include:

- Creating and following a common agenda
- Aligning and coordinating efforts to ensure that they are mutually reinforcing
- Using common measures of success
- Maintaining excellent communication among partners
- Facilitating through "backbone" support organizations

Appendices

Community Health Improvement Plan

Real lasting community change and improvement stems from the comprehensive assessment of current needs, an aspirational framework of goals and objectives to bring about change, and a rigorous evaluation of whether our collaborative efforts are making an impact. The following pages (Appendix D) outline the goals, objectives, strategies, action steps and indicators of success for the health priority areas identified in the community health needs assessment.

Appendix A

Community Action Planning Steering Committee (CAPSC) Members

Organization	Member Name
United Way of Western CT	Lisa Alexander
Western CT Home Care	Judy Becker
CT Institute for Communities (CIFC)	Melanie Bonjour
Western CT Health Network (WCHN)	Amber Butler
Greater Danbury Community Health Center	Deb Channing
New Milford Health Department	Michael Crespan
Regional YMCA of Western CT	Maureen Farrell
HVCASA	Allison Fulton
United Way of Western CT	Frank Kelly
WCHN	Sally Herlihy
Danbury Health & Human Services	Scott LeRoy
Pomperaug District Department of Health	Neal Lustig
WCHN	Kevin McVeigh
Regional YMCA of Western CT	Marie Miszewski
United Way of Western CT	Kim Morgan
Danbury Health & Human Services	Lisa Morrissey
Connecticut Community Care, Inc.	Sherry Ostrout
Peter & Carmen Lucia Buck Foundation	June Renzulli
WCHN WCHN	Andrea Rynn Jeryl Topalian
Connecticut Community Care, Inc.	Janice Wiggins

Area Health Department Directors

Area Health Department Directors	Member Name
Bethel	Lauren Vasile
Brookfield	Raymond Sullivan, MD
Newtown Health District	Donna Culbert
Ridgefield	Edward Briggs
New Fairfield	Timothy Simpkins

Ad Hoc Members

Area Health Department Directors	Member Name
United Way of Western CT	Megan Chrysler
WCHN	Amy Bethge
CT Counseling, Inc	Alan Nolan
Americares	Karen Gottlieb
WCHN	Rowena Bergmans
WCHN	K. Tait Michael, MD

Appendix B: Workgroup Participants

Chronic Disease & Obesity – Lead: Maureen Farrell, Regional YMCA of Western Connecticut

Organization	Member Name
WCHN – CT BCCEDP/ Wise Woman	Alba Wong
United Way of Western CT	Frank Kelly
Regional YMCA of Western CT	Marie Miszewski
Newtown Health District	Donna Culbert
Bethel VNA	Joan Santucci
New Milford Health Department	Mike Crespan
Pomperaug Health District	Neal Lustig
Brookfield Health Department	Raymond Sullivan MD
WCHN - WCMG	Cornelius Ferreira MD
WCHN - WCMG	Laurel Halloran APRN
WCHN	Ellen Ryan, RN
New Milford VNA	Gerri Rodda
WCHN	Jeryl Topalian
WCHN	Lynn Crager
WCHN	Michele Smallidge
New Milford VNA	Heidi Bettcher

Mental Health & Substance Abuse – Lead: Allison Fulton, HVCASA

Organization	Member Name
WCHN	K. Tait Michael MD
United Way of Western CT	Megan Chrystal
Prevention Council	
WCHN	Kevin McVeigh
WCHN	Andrea Rynn

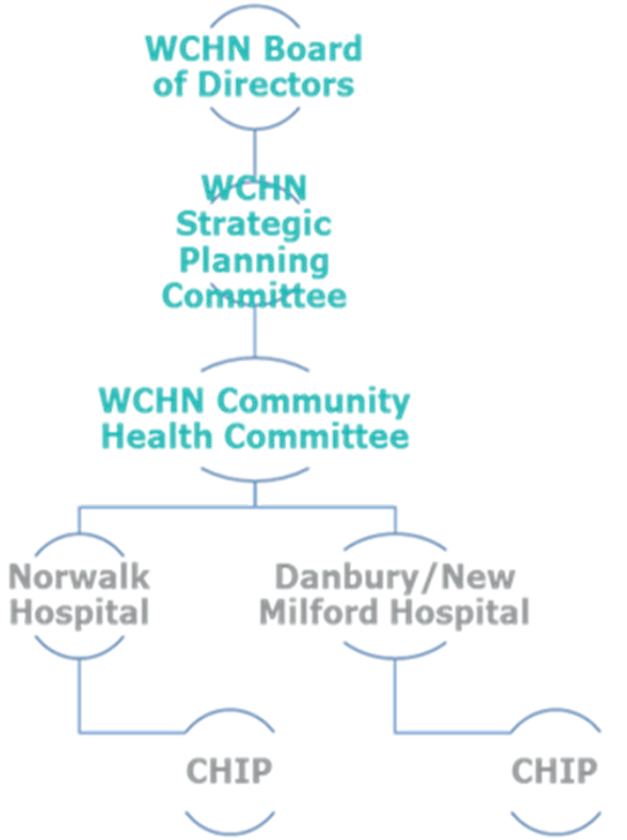
Healthy Aging – Leads: Janice Wiggins, CT Community Cares | June Renzulli, Buck Foundation

Organization	Member Name
CT Community Cares	Sherry Ostrout
Council on Aging	
WCHN	Judy Becker
Health Departments	

Access to Care – Lead(s): TBD

Organization	Member Name
Greater Danbury CHC	Deb Channing
CHC	Adele Gordon
Americares	Karen Gottlieb

Appendix C: WCHN Community Health Structure



Committee Member	Organization	WCHN Staff
Barbara Butler	Norwalk Hospital Board	Rowena Bergmans, VP Population Health
Tim Callahan	Norwalk Health Department	Bob Carr, MD VP Clin. Transformation
Debra Channing	Greater Danbury CHC	Sally Herlihy, VP Planning
Cornelius Ferreira, MD	Western CT Medical Group	Katherine Michael, MD
Mary Ann Genuario	Riverbrook YMCA	
Craig Glover	Norwalk CHC	
Karen Gottlieb	Americares	
Marie Miszewski	Regional YMCA of Western CT	
Others TBD		

The Danbury Hospital CHIP will be overseen by the local community health committee, formerly the Community Action Planning Steering Committee, now re-named the Community Health Improvement Committee (CHIC). This committee will provide on-going report to the WCHN CHC, which in turn, will report to the WCHN Strategic Planning Committee.

Appendix D: WCHN Community Health Structure

Priority Area 1: Chronic Disease Prevention			
Goal 1: All people are supported in practicing positive habits that include physical activity and healthy eating			
Indicator: % of overweight and obese adults in the community (Baseline 2015 CWS)			
Indicator: % of children in kindergarten, 6th and 9th grades with BMI > 85 percentile (Danbury Public Schools)			
Indicator: # of towns with access to mobile food pantries, community gardens, farmers markets			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Promote and strengthen universal healthy lifestyle message (e.g. 5,3,2,1,0) across sectors in community	• Build on the Go! 5,2,1,0 message across sectors in the community (schools, worksites, CBOS, FBOs, Healthcare and Health Departments • Identify/employ indicators to measure family adoption and reinforcement of the Go! 5,2,1,0 message	• Enlist municipal leaders and providers including pediatricians, PC providers, school and preschool leaders • Coordinate with the city of Danbury to involve 24 sites via United Way grant • Refine survey used by YMCA-SCRAM program to measure parent behaviors in the home	• 5 new sites by October 2017 (Total 20 sites) • 5 new policies adopted by organizations w/ MOU status by 2017 • 5 new sites by October 2018 (Total 25 sites) • 50% of parents surveyed will report improvement in reinforcing health behaviors at home
• Support community gardening programs and farmers markets	• Collaborate with United Way strategic plan(SP) for Mobile Food Pantry to address food access issues • Support and expand current community efforts for garden programs, farmers markets, and food pantries	• Identify number of gardens, farmers markets and people served in low income communities • Support initiatives for organizations seeking grant funding to improve food access	• Increase # of low-income areas with access to food pantry, community garden, or farmers market
• Advocate for proven physical activity initiatives	• Support the work of the Coalition for Healthy Kids on reducing barriers to physical activity and healthy food among low income families	• Support initiatives for organizations seeking grant funding to improve physical activity access	• The # of environmental changes for health made by 2017

Priority Area 1: Chronic Disease Prevention			
Goal 2: People of all ages and economic backgrounds are supported in obtaining health screenings and participating in disease prevention/health maintenance programs			
Indicator: Admissions to Emergency Department (ED) and Inpatient (IP) related to chronic disease			
Indicator: Self-reported rates of diabetes, heart disease, smoking (Baseline 2015 CWS)			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Develop continuum of services for target populations	• Identify POC providers and prevention programs • Differentiate target populations: those that can self-manage and those requiring more intensive community-based resources	• Develop resource list of providers • Identify fall risk assessment tool for use by community partners • Increase the number of culturally relevant programs in community; address language barrier	• Increased # of community based programs • # enrolled in bi-lingual diabetes prevention program • # of people screened for fall risk increases by 50%
• Increase provider awareness of/referrals to community programs	• Establish processes for provider referral to community programs for improvement in health outcomes and for follow up/loop closure	• Develop strategy to increase PCP awareness of/referrals to programs (Create WCHN/ community task force) • Develop referral mechanism for use by POC providers • Develop and implement mechanism to ensure screened populations (e.g. KYN, Fall Prevention) receive follow-up services/care	• # of referrals from PCP's currently referring • Increase # of PCP's making referrals • Increase number of locations making referrals
• Implement screening and awareness campaigns for chronic disease	• Increase population at risk entering into culturally relevant primary prevention and health maintenance programs offered in the community	• Measure 2016 participation in primary prevention/health maintenance programs to establish baseline • Partner with WCHN Speakers Bureau for town/community forums • Partner with American Heart Association on blood pressure self-management program	• # of people enrolled in programs for primary prevention increases by 50% • # of people enrolled in disease management programs increases by 50% • # of towns providing programs increases

Priority Area 1: Chronic Disease Prevention			
Goal 3: Develop/enhance access to places and programs to promote physical activity opportunities for all			
Indicator: % of people reporting exercising 3-4 times/week (Baseline CWS 2015)			
Indicator: # of new/improved walking and biking trails increases			
Indicator: # of people utilizing free walking/recreational programs increases			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Develop inventory of free trails, parks, and recreational opportunities in the Greater Danbury Region	• Explore opportunities to develop an app to promote share and use the inventory of services, trails and facilities	• Identify student or intern to inventory resources in all 14 towns • Identify barriers to use of free activities (time, physical or season)	• # of resource inventory shared • App developed or other digital media implemented
• Promote participation in national physical activity events (e.g. Walk to School Day)	• Promote awareness through towns and schools	• Develop communica-tion materials • Promote through website links/emails	• # of towns/people participating in events that promote physical activity
• Advocate for and support development of infrastructure improvements that encourage walking and/or biking	• Promote and support use of existing resources available in all 14 towns • Partner with United Way initiative on scholarship funding for ALICE families	• Increase access by facility sharing between towns • Develop and create signs &encouragement programs	• # of towns taking steps to improve walking and biking in their communities

Priority Area 2: Mental Health & Substance Abuse			
Goal 1: Reduce substance use across the lifespan in our region			
Indicator: % of people reporting need to cut down on alcohol use (Baseline 2015 CWS)			
Indicator: # of participants in IN and OP treatment programs			
Indicator: #ED admissions related to alcohol/substance abuse			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Create community level change and ensure a continuum of care	• Utilize the Strategic Prevention Framework and evidence-based initiatives • Conduct capacity building activities • Coordinate w/Community Care Team (CCT) • Identify new funding sources	• Perform needs assessment (survey, focus groups) • Outreach to new partners and general population • Provide information to Local Prevention Coalitions (LPC) and general population • Identify evidence based metrics	• # of surveys, focus groups • # of events/venues where information is distributed • # of new partners • # of participants at events/venues
Goal 2: Promote behavioral health and wellness across the lifespan in our region			
Indicator: Admissions to Emergency Department (ED) and Inpatient (IP) related to behavioral health			
Indicator: Increased enrollment in behavioral prevention and intervention activities			
Indicator: Self-reported rates of anxiety, depression (Baseline 2015 CWS)			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Provide access to information and resources that reduce stigma enhance awareness and encourage early identification of behavioral health issues	• Include mental health promotion information in newsletters and other publications that are distributed across the region • Hold/participate in community workshops or awareness events	• Identify newsletters or other publications to partner with • Provide skill building opportunities at community workshops • Outreach to members of the recovery community and BH sectors	• # of newsletters/ publications that include mental health promotion • # of parent awareness or other workshops/ year
• Improve the integration of behavioral health into Primary Care	• Increase screening by and referrals from PC practices • Promote use of on-line cognitive behavioral therapy (CBT) • Increase collaboration and communication among BH and PC providers	• Provide SBIRT training to primary care providers • Embed LCSWs in primary care practices • Pilot Cobalt (CBT) in select WCMG primary care offices • Enhance & support CCT	• # of referrals from PCP's currently referring • Increase # of PCP's making referrals • # of PCP offices with LCSWs

Priority Area 2: Mental Health & Substance Abuse			
Goal 3: Reduce the number of opiate addiction disorders, overdoses and related deaths in our region			
Indicator: # of opioid related deaths reduced in our region (Baseline 35 in 2015 Source Office of CME)			
Indicator: # of legislative and policy changes around opioid administration			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Increase the number of prevention and intervention activities related to opioids	• Advocate for legislative and policy changes • Promote safe storage and disposal of medications • Provide education related to use of opioids • Encourage wider availability of naxolone	• Help local police departments acquire permanent boxes • Work with PCPs, Pain Management specialists to make info available • Promote SBIRT, MAT, and Narcan training	• # of safe drug disposal locations • # of local officials, legislators reached • # of providers or responders trained to administer Narcan

Priority Area 3: Healthy Aging			
Goal 1: Support those planning for healthy aging and those managing immediate needs for services and supports			
Indicator: Western Connecticut Seniors website utilization trends			
Indicator: # of successful referrals increases			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Increase pathways to a comprehensive resource for individuals who are planning for healthy aging and for seniors and caregivers who are managing an immediate need for services and supports	• Assess the expectations and experiences of Danbury seniors and caregivers in accessing relevant/appropriate information, services and supports • Establish an advisory group of participating towns to guide development of a website for western CT seniors • Identify opportunities to improve access to information, services and supports	• Conduct community conversations • Identify gaps between expectations and experiences • Identify barriers and challenges in areas where experiences fall short of expectations • Implement the Western CT Seniors website • Link to 211 • Implement the No Wrong Door planning grant • Identify and sign MOUs with 60 Connectors & 10 Navigators to form a network of information access points and pathways	• # community conversations held • Report completed • Website launched • Utilization of website • # of Connectors and Navigators hired
Goal 2: Enhance education, advocacy, access and communication to support the ability of seniors to age in place			
Indicator: % of seniors successfully able to remain at home			
Indicator: Seniors use of home care vs. nursing home (DSS data)			
Indicator: UCONN Center on Aging evaluation data			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Increase awareness of services and supports that enable seniors to age in the place of their choice	• Conduct and/or sponsor public information sessions • Create and implement marketing and outreach initiatives; create and disseminate related materials	• Working with DDS, create marketing and outreach materials for reaching Danbury seniors and caregivers • Conduct 1-4 information sessions	• # materials created/ disseminated • # of individuals reached at information sessions
• Increase advocacy initiatives to enable seniors to age in the place of their choice	• Implement targeted outreach to decision makers at the local, regional and state level to inform and shape public policies	• Create standard engagement tools to guide outreach to and discussions with decision makers	• Tools created • # of decision makers/ discussion

Priority Area 4: Access to Care			
Goal 1: Identify key needs within our community related to access to care, which are not adddressed by other priority areas			
Indicator: Reduction in ED visits for ambulatory-sensitive care (Baseline Top 5 Conditions for ED Non-Admission)			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Engage community partners to assess barriers to care and identify at-risk populations	• Identify community groups that work with at-risk populations • Identify resources available to at-risk populations	• Review United Way's ALICE survey • Engage student/intern to review ED data	• Groups identified • Resource inventory completed
• Conduct additional surveys/focus groups among at risk populations	• Utilize existing community group	• Identify group to survey • Develop survey tool	• Completed surveys and/or focus groups
Goal 2: Develop a comprehensive action plan to address identified needs/barriers			
Indicator: Reduction in missed/postponed care and reasons for missed/postponed care (Baseline CWS 2015)			
Objective	**Strategy**	**Action Steps**	**Short-term Indicators**
• Implement targeted outreach and strategies to improve access and/or reduce barriers to care	• Based on identified barriers among at-risk populations, develop pilot program and or tools to improve access	• Review models in other communities that have improved access	