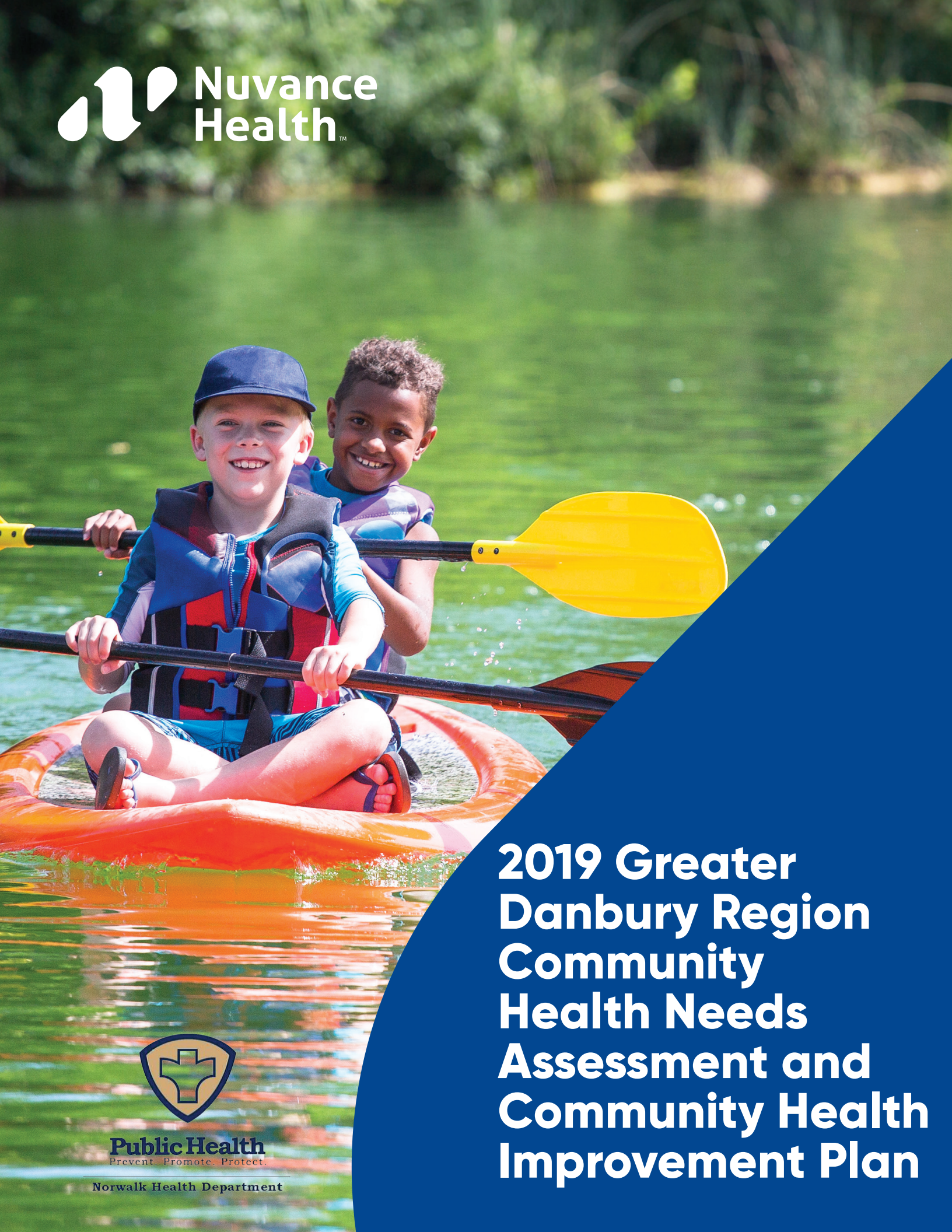


Nuvance Health™

2019 Greater Danbury Region Community Health Needs Assessment and Community Health Improvement Plan

Public Health
Prevent. Promote. Protect.
Norwalk Health Department

This report serves as the **Community Health Needs Assessment and Improvement Plan for Greater Danbury** and complements the 2019 ***Fairfield County Community Wellbeing Index: Indicators of social progress, economic opportunity, and well-being in Fairfield County neighborhoods***; a core program of DataHaven, in partnership with Fairfield County's Community Foundation and a Community Health Needs Assessment for the towns served by all Fairfield County hospitals, including Danbury Hospital.

Partnerships → Collaboration → Education → Healthy communities

About this report

This **Community Health Needs Assessment (CHNA)** provides local level health related data about Danbury and New Milford, and the surrounding towns of Bethel, Bridgewater, Brookfield, New Fairfield, Newtown, Redding, Ridgefield, Roxbury, Sherman, Southbury, Washington and Woodbury. (This region will be referred to as Greater Danbury throughout the remainder of this report.) This report complements the 2019 ***Fairfield County Community Wellbeing Index***, a comprehensive report about Fairfield County and the towns within it. The ***Community Wellbeing Index*** was produced by DataHaven in partnership with Fairfield County's Community Foundation and many other regional partners, including Danbury Hospital, now part of Nuvance Health, and local partners [listed on page 6] serving the Greater Danbury Region. Topics covered in the ***Index*** include: overall community well-being, demographic changes, housing, transportation, early childhood education, K-12 education, economic opportunity, leading public health indicators (such as premature mortality, chronic disease prevalence, health behaviors, health care access, and the social determinants of health) and civic life.

This report provides additional local detail of relevance to the region, including quantitative an d qualitative data specific to the individual towns within the Greater Danbury region. It also documents the process that Danbury Hospital and partners used to conduct the regional health assessment and health improvement activities. You will find a link to the full ***Index*** in the appendix of this report and posted on the websites for DataHaven, Fairfield County's Community Foundation, Danbury Hospital or many of the town health departments.

This **Community Health Needs Assessment**, including priority areas to inform the Community Health Improvement Plan, was approved by the Danbury Hospital Board of Trustees on November 14, 2019.

The **Community Health Improvement Plan** was approved on March 5, 2020.

Table of contents

Community Health Needs Assessment

Community Health Improvement Plan

Community Health Needs Assessment

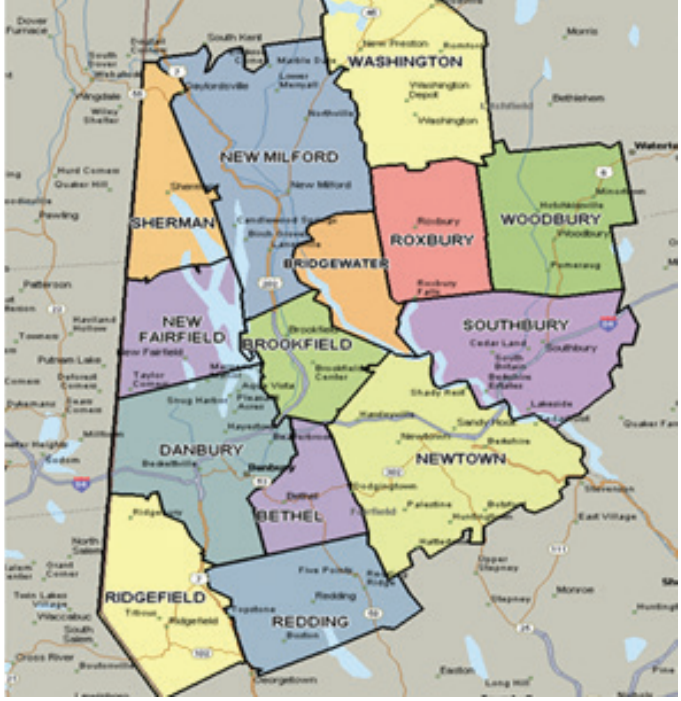


Figure 1: Map of Greater Danbury Region

Introduction

Improving the health of the community is essential to enhancing its residents' quality of life and supporting its future economic and social wellbeing. To effectively improve health, communities must address social, environmental and behavioral factors in addition to ensuring access to medical services.

Danbury Hospital, under the auspices of the Community Health Committee, and Greater Danbury community partners participated in this effort to assess the health and social needs of the Greater Danbury community.

Community partners:

- Community Action Agency of Western Connecticut
- Connecticut Counseling Centers
- Connecticut Community Care
- Connecticut Institute for Communities
- Danbury Youth Services
- Jericho Partners
- Reach, Newtown
- Regional YMCA of Western Connecticut
- United Way of Western Connecticut
- Western Connecticut Coalition for Mental Health and Substance Abuse

In addition to the Danbury and New Milford health departments, the Pomperaug Health District and the health departments of Bethel, Brookfield, New Fairfield, Newtown and Ridgefield were active participants in this assessment.

This report provides an overview of key findings from the community health needs assessment and the priority elements that will be used to develop the **Community Health Improvement Plan (CHIP)**.

Methods and procedures

The **Community Health Needs Assessment (CHNA)** was guided by a participatory approach that examined health and the social and environmental factors that affect health. Danbury Hospital and New Milford Hospital collected quantitative and qualitative data from the Greater Danbury Region, which includes Danbury, New Milford and the surrounding towns of Bethel, Bridgewater, Brookfield, New Fairfield, Newtown, Redding, Ridgefield, Roxbury, Sherman, Southbury, Washington and Woodbury. This 14-town service area expands beyond Fairfield County, reflecting the regional approach taken in this assessment. Towns included in other hospital CHNAs were not included in this assessment of the Greater Danbury region.

The assessment was conducted under the guidance of the Danbury Hospital Community Health Committee (CHC). The CHC provided oversight of the 2019 CHNA in alignment with the goals of community partnership and advancement of population health.

This report contains both quantitative and qualitative data. Quantitative data was collected, analyzed and reported by DataHaven in the Fairfield County Community Wellbeing Survey (CWS), which can be accessed through a link in the Appendix of this report. The qualitative data collection was conducted by The Strategy Group LLC and consisted of key informant surveys (KIS) including focus groups, individual interviews and an online survey. Secondary data sources included, but were not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, State of Connecticut Department of Public Health, Connecticut Health Information Management Exchange (CHIME), County Health Rankings as well as local organizations and agencies. Types of data included vital statistics based on birth and death records.

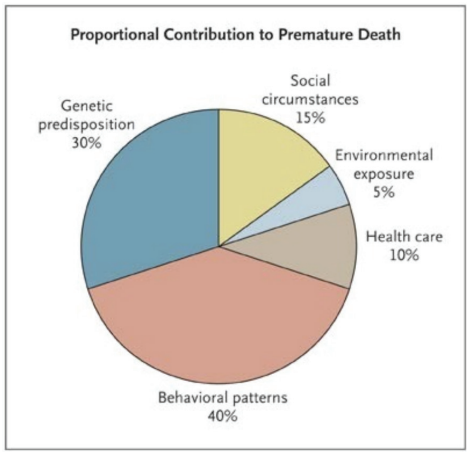


Figure 2: Determinants of health and their contribution to premature death[1]

Social determinants framework

It is important to recognize that multiple factors affect health, and there is a dynamic relationship between people and their environments. Where and how we live, work, play and learn are interconnected factors that are critical to consider when assessing a community's health. That is, not only do people's genes and lifestyle behaviors affect their health, but health is also influenced by factors such as employment status and quality of housing. This "social determinants of health" framework addresses the distribution of wellness and illness among a population—its patterns, origins and implications. While the data to which we have access is often a snapshot of a population in time, the people represented by that data have lived their lives in ways that are enabled and constrained by economic circumstances, social context and government policies. Building on this framework, this assessment utilizes data to assess which populations are healthiest and least healthy in the community as well as to examine the larger social and economic factors associated with good and poor health.

Limitations must be noted for both the quantitative and qualitative data collection methods. Sample size in some of the smaller towns may misrepresent results for these areas, particularly when pertaining to health conditions with low prevalence.

The qualitative survey results are entirely dependent on the focus group and interview participants and while adding to the flavor of the results, they cannot necessarily be more broadly interpreted as representative.

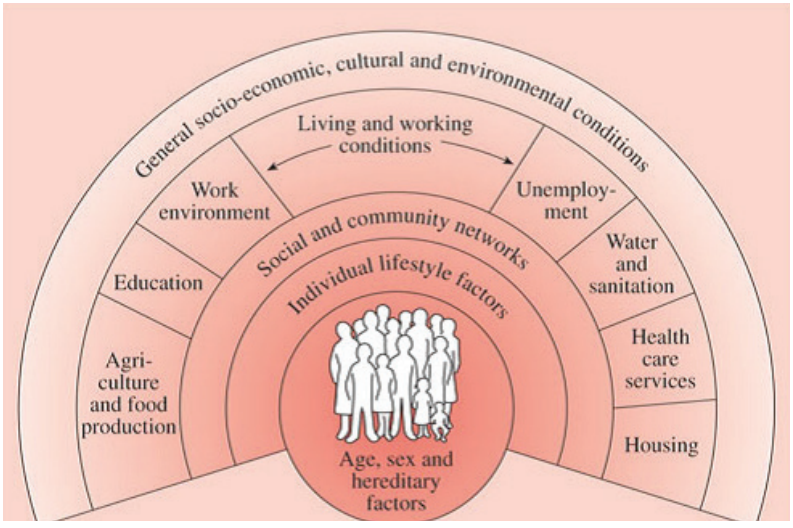


Figure 3: World Health Organization Commission on the Social Determinants of Health, 2005

Quantitative data: Selected findings

Demographics and social determinants of health

Overall population (Figure 4, Table 1): In 2019, the total population of the Greater Danbury Region was 254,912, with a projected increase to 258,560 in 2024 (Claritas, 2019). The towns within the region vary in size, growth patterns, wealth, age and diversity of residents. Danbury is the most populous town in the area, comprising 33.8% of the region's population.

Age distribution (Figure 5): The age distribution for the region is similar to that of Connecticut. Across the region, 80% of the population is adults, and 48% of the population is adults ages 45 and older. Danbury has the youngest population, with over 60% below the age of 44, with Bethel a distant second at 52%. Although the younger age groups comprise about half of the population, they show declining growth rates in all towns. The most significant growth rate is seen in the 65+ age group in every town in the region (Claritas, 2019).

Racial and ethnic diversity (Figure 6): Danbury is the most diverse town, in the region, with 52% identifying as minority (CT Data, 2017) and the largest minority group identifying as Hispanic (30%). In the Greater Danbury region, 74% identify as white, with smaller populations of Hispanic (14%) and black (3%).

Income and employment (Figure 7): The Greater Danbury Region is characterized by substantial variation in income, with both very wealthy and less affluent households across the region and within municipalities. A majority of the towns in the region have a median household income greater th an $100,000

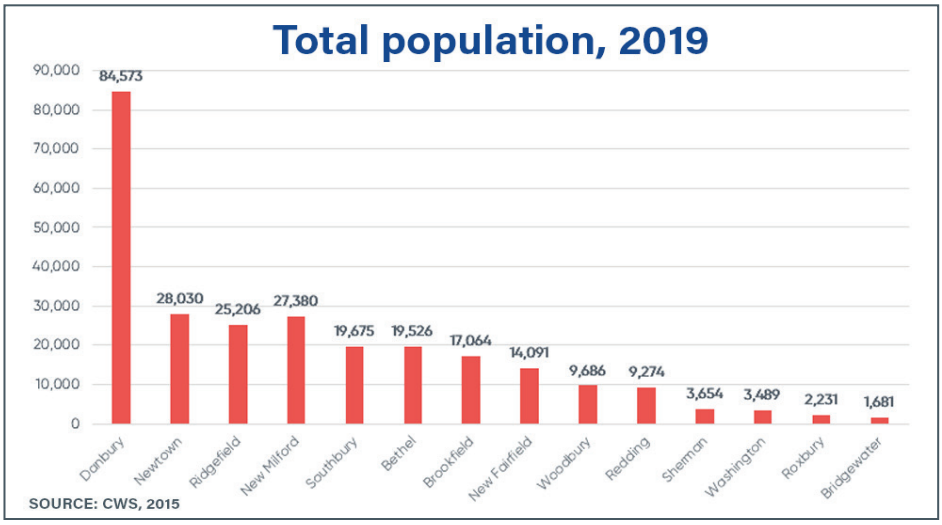


Figure 4: Population in Greater Danbury Region towns, 2019 CERC Town Profiles

	Population 2019	Population 2024	Population change
Danbury	86,158	87,877	1,719
Ridgefield	25,629	26,062	433
New Milford	25,729	25,289	-440
Southbury	20,549	20,849	300
Bethel	19,561	20,022	461
Brookfield	17,993	18,497	504
Newtown	17,000	17,399	399
New Fairfield	14,553	14,882	329
Redding	9,629	9,838	209
Woodbury	9,494	9,309	-185
Sherman	3,814	3,835	21
Roxbury	2,120	2,085	-35
Bridgewater	1,597	1,550	-47
Washington	1,086	1,066	-20
Grand total	**254,912**	**258,560**	**3,648**

Table 1: Population change in Greater Danbury and towns, 2019 and 2024

(CT Data, 2017). Danbury has the lowest median household income in the region ($68,068). The unemployment rate in the state of Connecticut in September 2019 was 3.4%, higher than every town in the Greater Danbury Region, where the unemployment rates ranged from 1.8% (Washington) to 3.2% (Bridgewater) (Connecticut Department of Labor).

Poverty (Figure 8): Poverty rates vary throughout the Greater Danbury Region, ranging from 1.6% in New Fairfield to 13.7% in the 06810 zip code in Danbury (CT Data, 2017).

Education attainment (Figure 9): According to the US Census Bureau, 82% of Danbury residents over the age of 25 have graduated from high school and 31% have a bachelor's degree or higher. The rates in New Milford are higher, with 92% of residents completing high school and 40% attaining a bachelor's degree or higher.

Housing (Figure 10): Danbury has an owner-occupied housing rate of 60% and median housing value of $289,700, as compared with the median cost in Connecticut of $270,000 and in the U.S. of $193,000. According to the CWS, 7% of Danbury residents, or about 6,000 people, reported not having enough money during the past year to adequately house themselves or their families. Key informants surveyed noted that affordable housing is inaccessible to many low- and moderate-income residents and, as a result, they have to settle for overcrowded conditions, neighborhood crime and unscrupulous landlords.

Environmental quality: A majority of the population, 83% in both Danbury and New Milford, reported feeling satisfied with their city or town. Of those in Danbury, 78% felt that as a place to live, the area was improving or at least staying the same. In New Milford, the rate was higher, at 80%. While 81% of those in New Milford reported the condition of the parks was good or excellent, only 22% agreed there were safe sidewalks and crosswalks in most neighborhoods. Of Danbury residents, 65% thought the condition of the parks was good or excellent and 43% reported there were enough sidewalks and crosswalks.

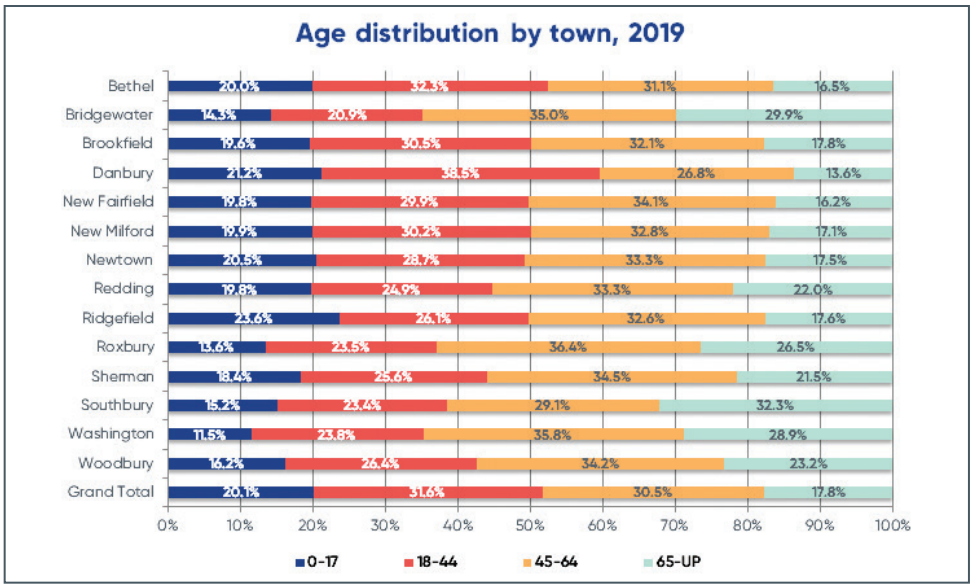


Figure 5: Age distribution in Connecticut, Greater Danbury, and towns in the region, 2019

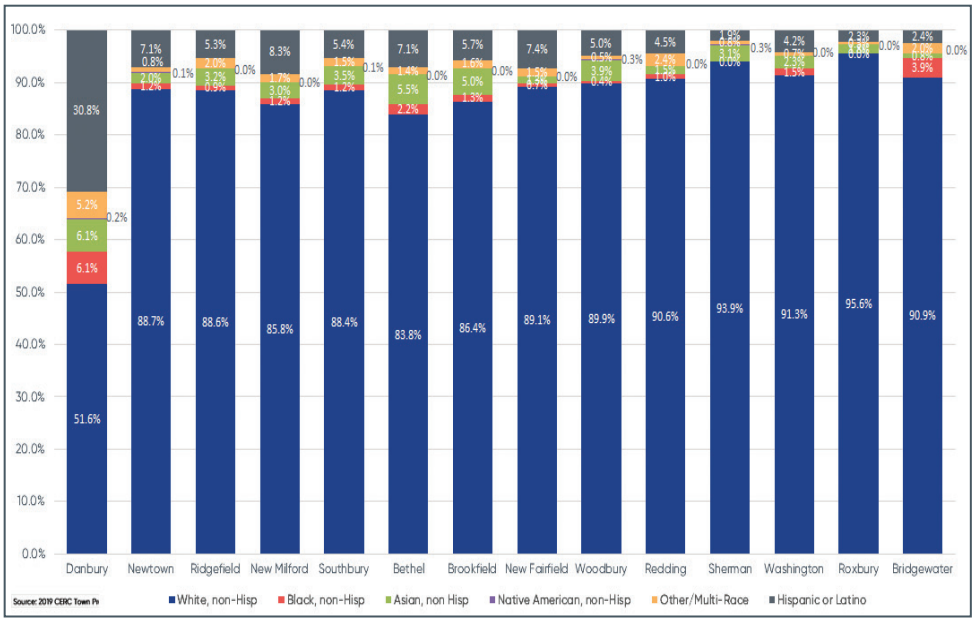


Figure 6: Population by race and ethnicity, 2019 CERC Town Profiles

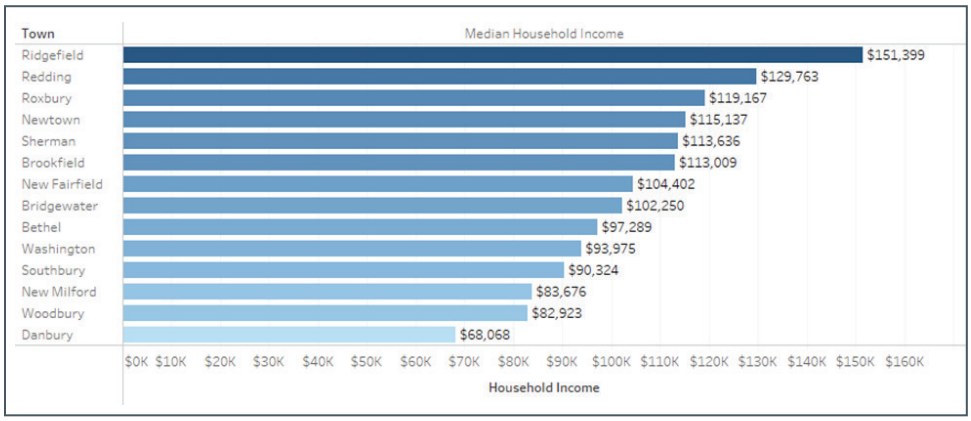


Figure 7: Median household income by town, 2017 (CT Data, 2017)

Transportation: According to the CWS, 8% of Danbury residents struggle with unreliable transportation, while that number is 10% in New Milford and 12% in Connecticut as a whole. Key informants surveyed noted that those with low income and seniors are particularly impacted by unreliable transportation.

Crime and violence: The majority of area residents feel safe in their homes and neighborhoods although 5% of Danbury and New Milford residents reported that in the past 12 months, someone had tried to steal from them or vandalize their property. Most Danbury and New Milford area residents feel the police are doing a good or excellent job keeping them safe, with rates of 79% for Danbury and 81% for New Milford. However, 30% of Danbury residents and 24% of New Milford residents report that they do not feel safe walking in their neighborhood at night. When asked about the local governments, 59% of Danbury residents and 45% of New Milford residents feel that they are responsive to their residents' needs.

Health behaviors

Healthy eating, physical activity and overweight/obesity (Figures 11, 12, 13): Healthy eating, physical activity and weight are key drivers of health status and remain areas of significant concern. Obesity rates in Danbury have risen five percentage points since 2015, to 27%. These rates are lower than Connecticut as a whole, where the rate was 26% in 2015 and 28% in 2018. For those earning less than $35,000 per year, the obesity rate in Danbury was 37%. New Milford has shown an alarming increase in the obesity rate, from 26% to 35% of residents surveyed. Almost half of those surveyed in New Milford report they exercise less than three times per week, compared with 37% of those in Danbury exercising two or fewer days.

KIS input indicate difficulty, particularly for the lower income groups, accessing healthy food. This was attributed to lack of time due to job and extracurricular activities and difficulty finding reliable transportation.

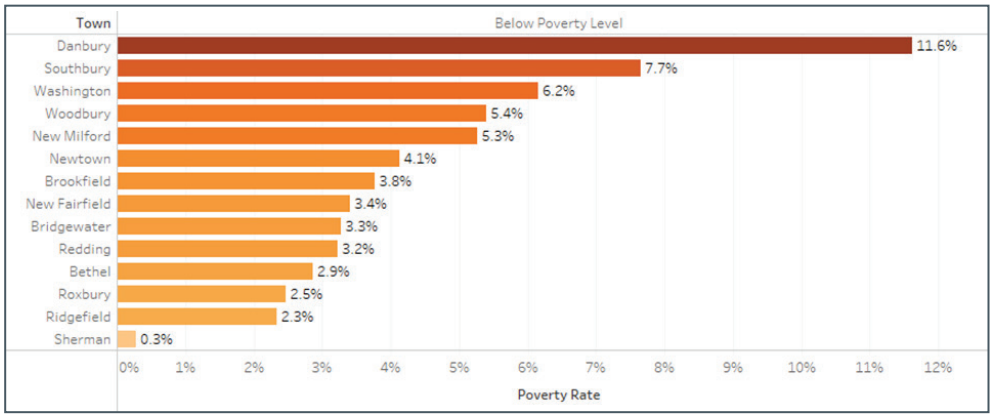


Figure 8: Poverty rates by town (CT Data, 2017)

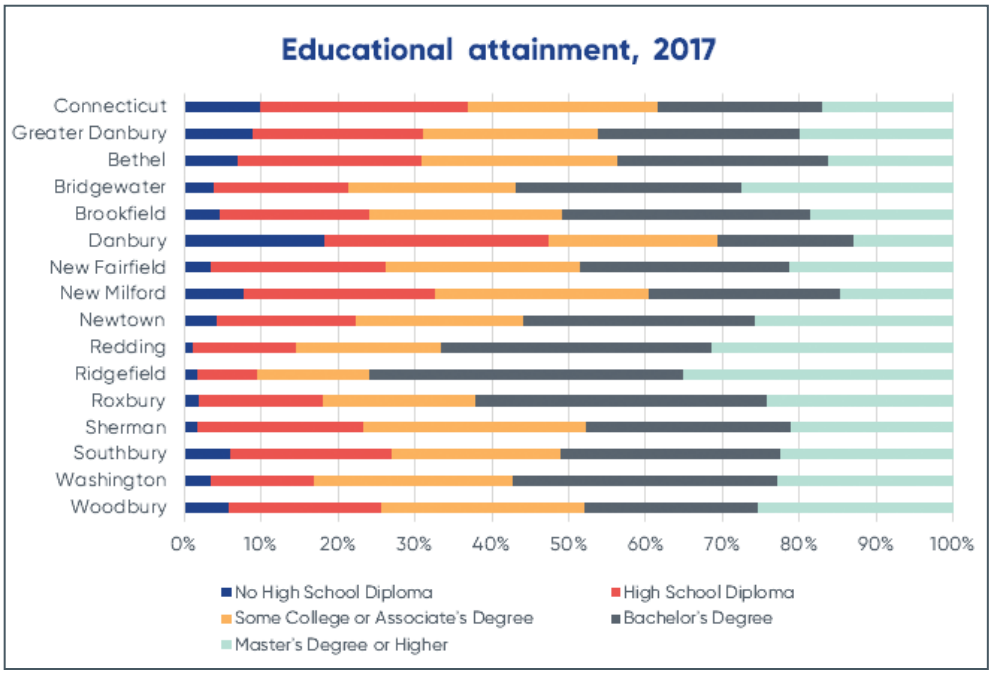


Figure 9: Educational attainment (CT Data, 2017)

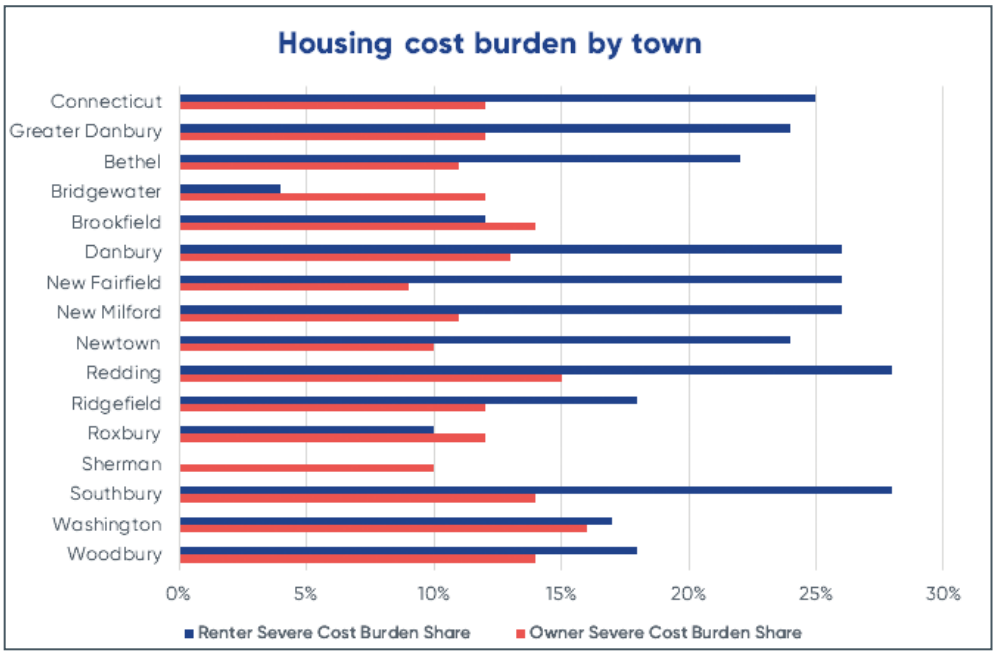


Figure 10: Housing cost burden by town (CT Data, 2017)

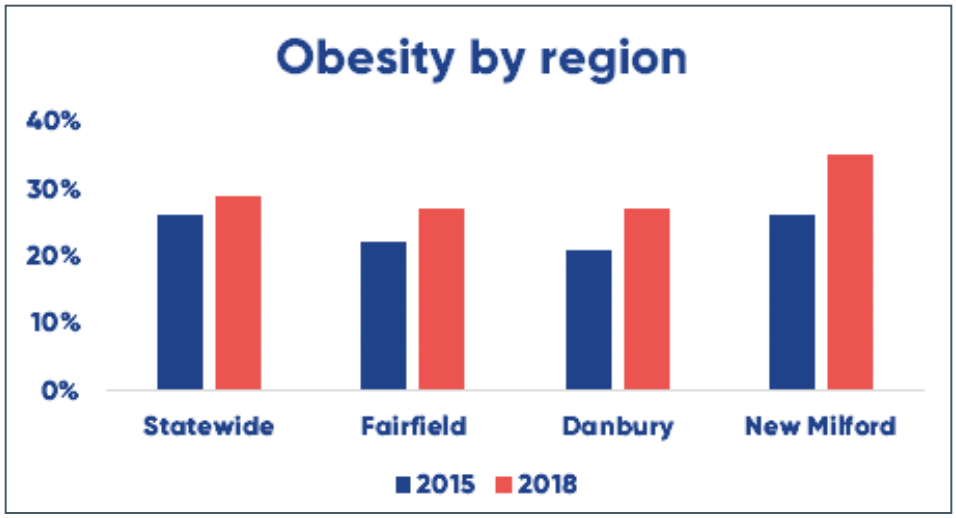


Figure 11: Obesity rates by region from 2015 to 2018 (CWS, 2018)

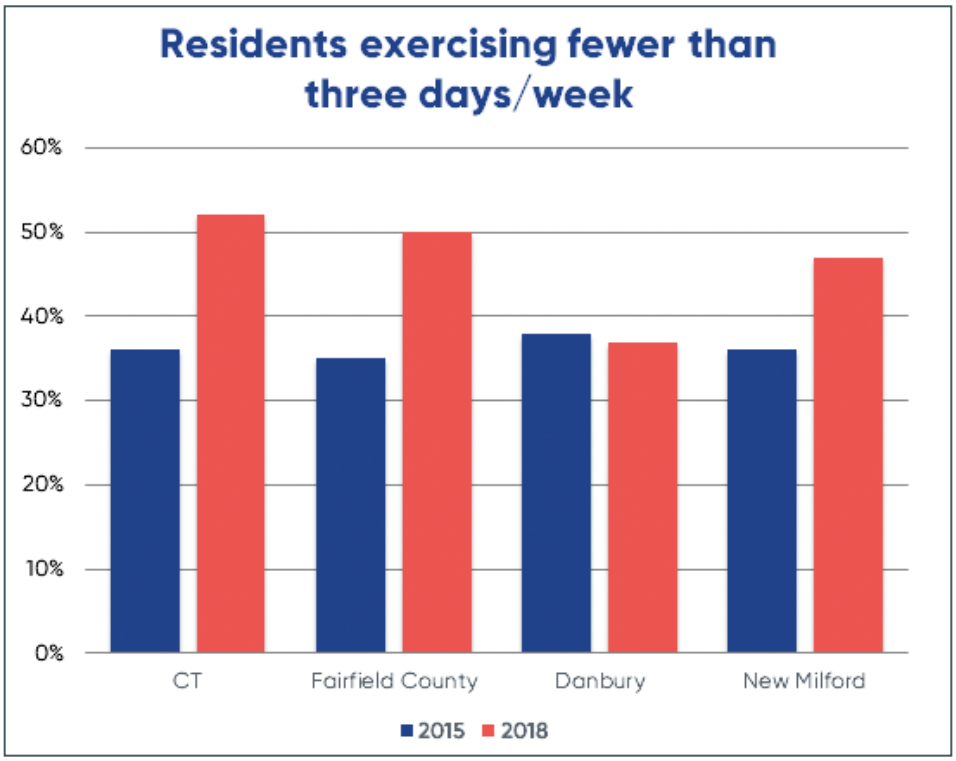


Figure 12: Exercise rates by region from 2015 to 2018 (CWS, 2018)

Mental health and substance abuse (Figures 14, 15 and Table 2): Mental health and substance abuse were the top health concerns reported in the KIS and were felt to impact persons of every socio-economic level. These findings align with the previous health assessment completed in 2016 and with the CWS data from the current survey. Ten percent of Danbury residents surveyed reported they rarely or never get the emotional support they need and seven percent reported feeling depressed more than half the days or nearly every day. Of the Danbury population, 29% report at least one episode of binge drinking in the past month and 22% of the population knows at least one person who has died of an opioid overdose. When asked about the likelihood that young people will abuse drugs or alcohol, 21% of Danbury residents and 28% of New Milford residents reported this was "likely or very likely."

Smoking: Rates of smoking have remained fairly consistent with 15% in Danbury, 14% in Connecticut and 11% in New Milford reporting they are active smokers. Rates are higher in those earning less than $75,000 with 19% reporting that they smoke. Rates of vaping have increased dramatically with 44% of Greater Danbury residents between the ages of 18 and 34 reporting they have tried or are active users of vaping devices.

Figures and tables continue on pages 12 and 13.

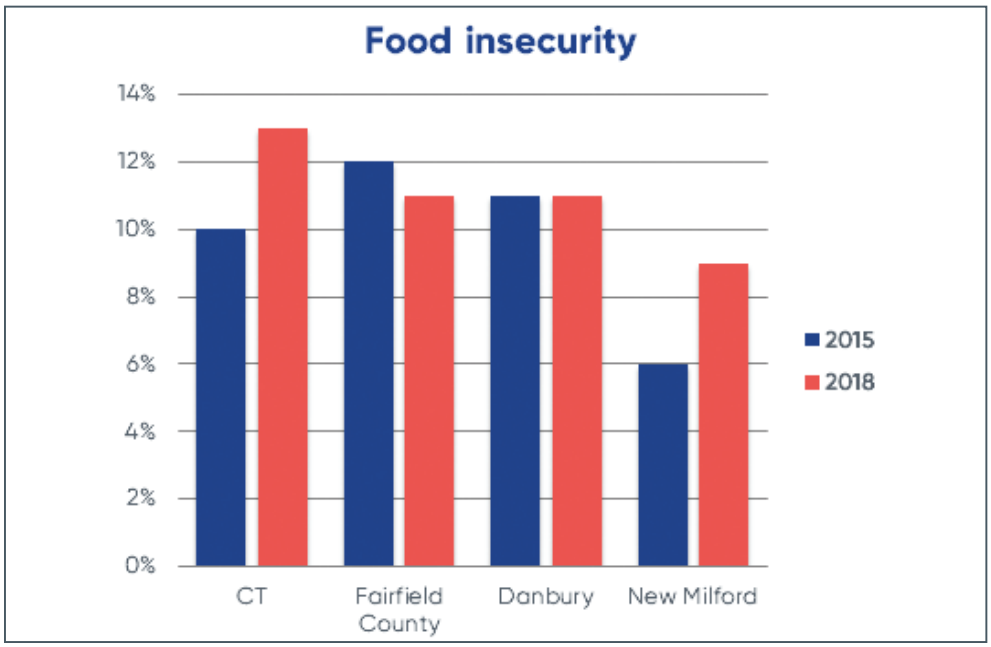


Figure 13: Rate of food insecurity by region (CWS, 2018)

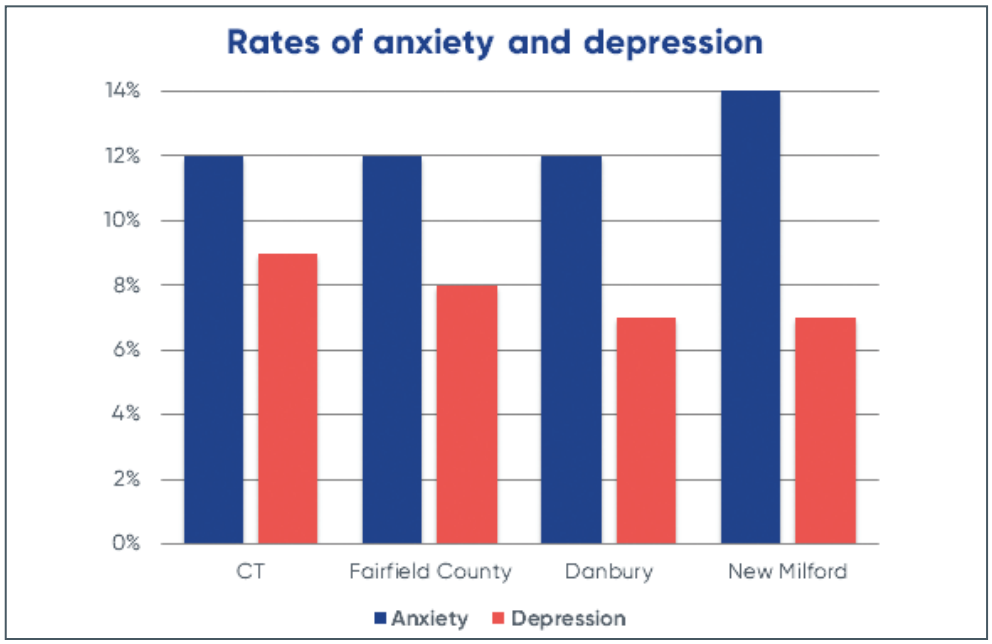


Figure 14: Rates of anxiety and depression by region (CWS, 2018)

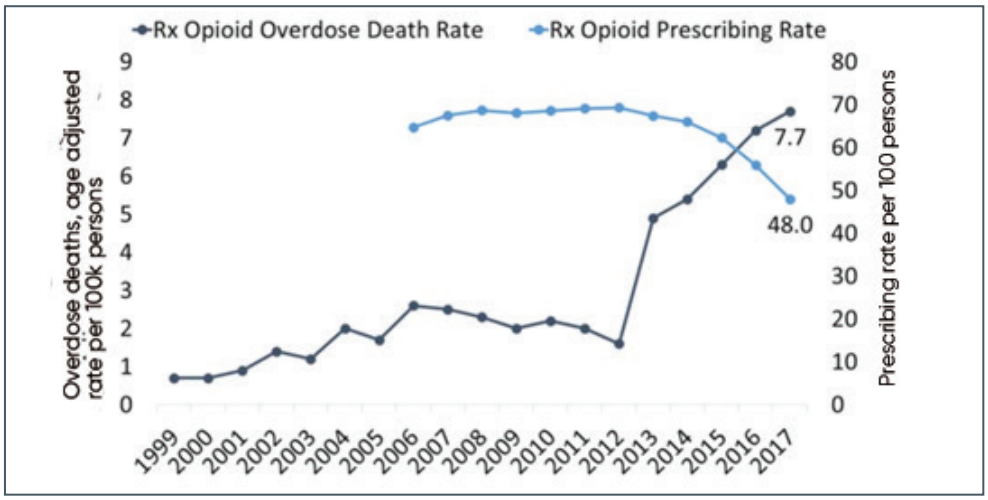
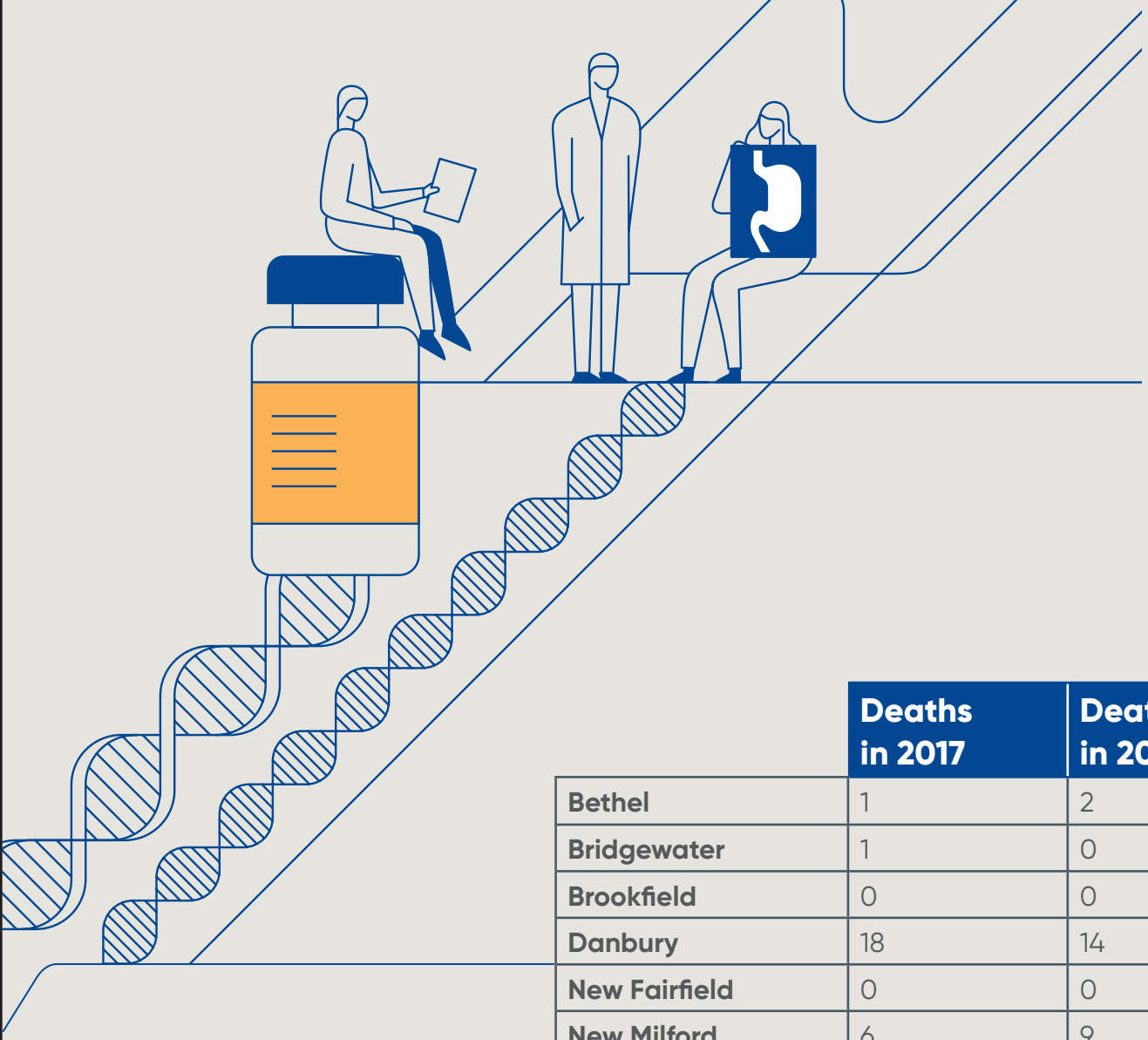


Figure 15: Connecticut rate of overdose deaths involving prescription opioids



	Deaths in 2017	Deaths in 2018
Bethel	1	2
Bridgewater	1	0
Brookfield	0	0
Danbury	18	14
New Fairfield	0	0
New Milford	6	9
Newtown	1	5
Redding	1	2
Ridgefield	1	1
Roxbury	0	0
Sherman	0	0
Southbury	1	7
Washington	0	0
Woodbury	0	0
Grand total	**30**	**40**

Table 2: Accidental drug intoxication deaths in Greater Danbury, 2017–2018 (Office of the Chief Medical Examiner)

Health status of the community

Overall leading causes of death and hospitalization (Figure 16, Table 3): High blood pressure was the most prevalent condition found in inpatient hospitalizations and in emergency department visits that did not result in admission. Type II diabetes was the second most common condition associated with inpatient hospitalizations and falls were the second most common reason for an ED visit. The third most common reason for inpatient admission was heart failure, while anxiety was the fourth most common reason in both categories. Alcohol and/or substance abuse was the fifth most common reason for an ED visit that did not result in admission.

Chronic disease (Figure 17): Chronic diseases impact life satisfaction and cause significant economic burden in the form of opportunity cost and healthcare expenditure. Diabetes rates in Danbury have improved from 9% to 7% while they have increased in New Milford, Fairfield County and in Connecticut as a whole to 8%, 9% and 10% respectively. Asthma rates in Danbury have also improved from 11% to 8% while they have been steady in New Milford at 9%. KIS participants cited chronic diseases and obesity as priority concerns along with mental health and substance abuse.

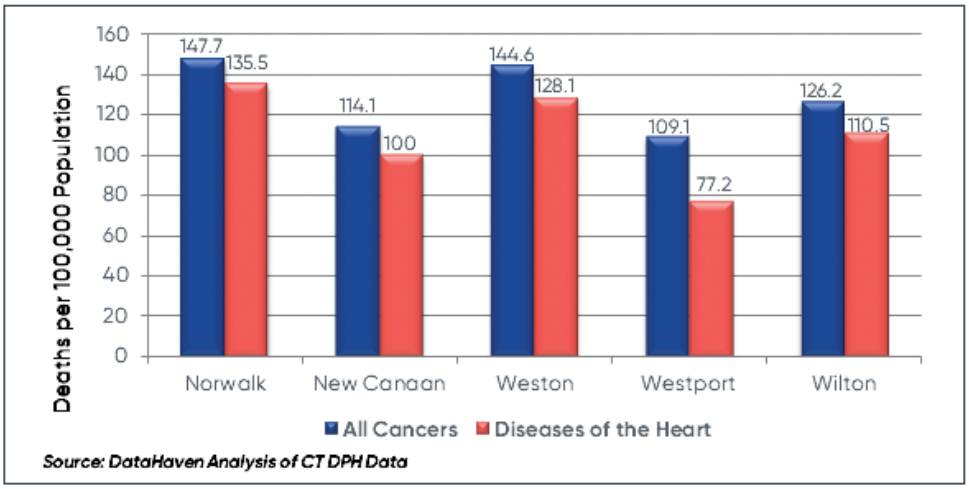


Figure 16: Age-adjusted leading causes of death, 2008-2012

Top five conditions for inpatient hospitalizations	Top five conditions for emergency department non-admissions
1. High blood pressure	1. High blood pressure
2. Diabetes – Type II	2. Accidents – falls
3. Heart failure	3. Diabetes – Type II
4. Anxiety disorders	4. Anxiety disorders
5. Chronic obstructive pulmonary disorder	5. Alcohol–related disorders

Table 3: Top five conditions for hospital utilization, FY 2019 (CHA, Danbury Hospital)

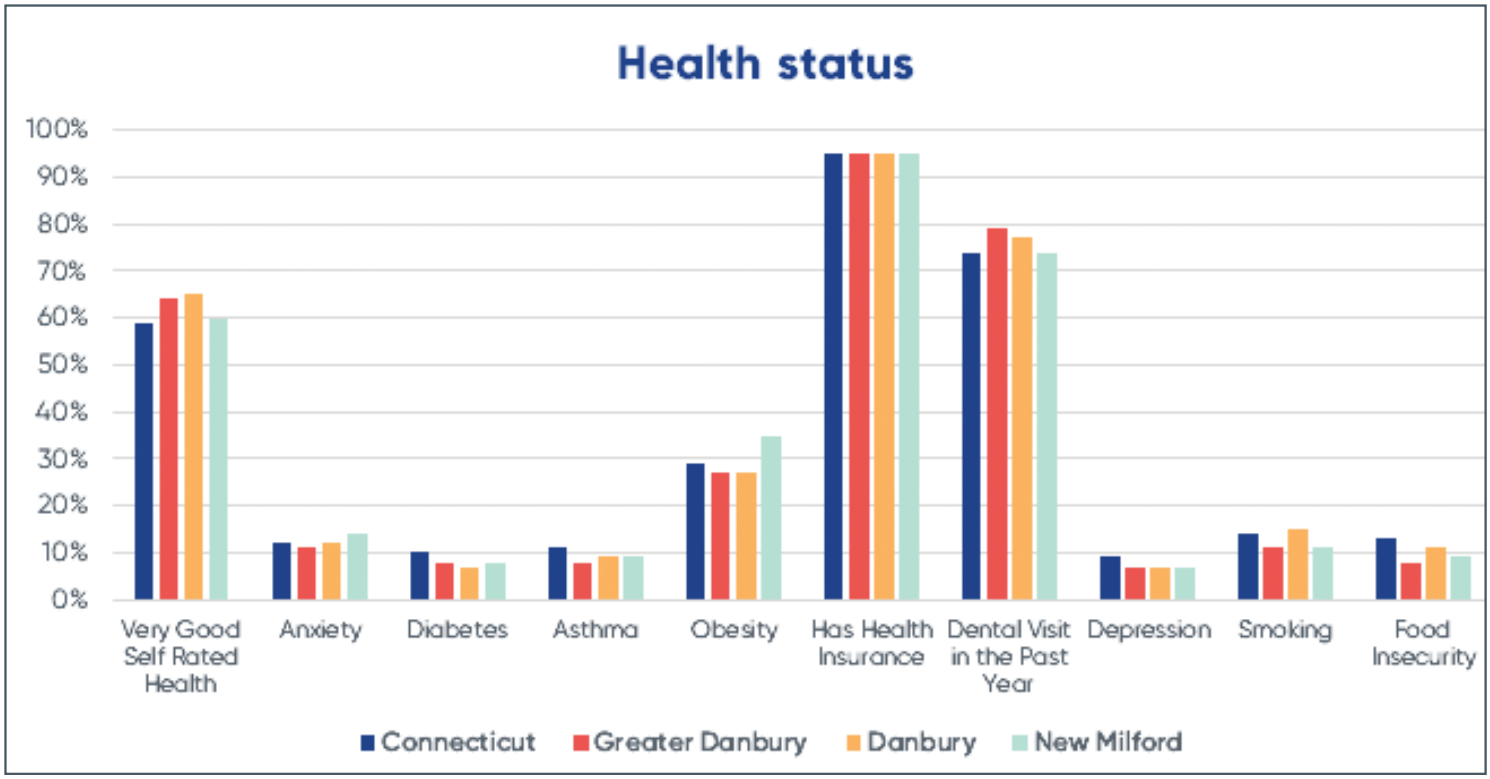


Figure 17: Prevalence of chronic diseases by region

Health access and utilization

Resources and use of health care services: The Greater Danbury Region is seen as having substantial health resources, including two hospitals, community health centers, health clinics and various healthcare organizations. In addition, the Regional YMCA, senior centers and school-based programs throughout the region play an important role in advancing public health.

Of the key informants surveyed, 70% of those in Greater Danbury believe access to quality health care has improved or remained the same over the last three years—with increased access to services, better quality health care and improved awareness and communication. They also note that significant strides have been made in developing community partnerships working together to advance wellness.

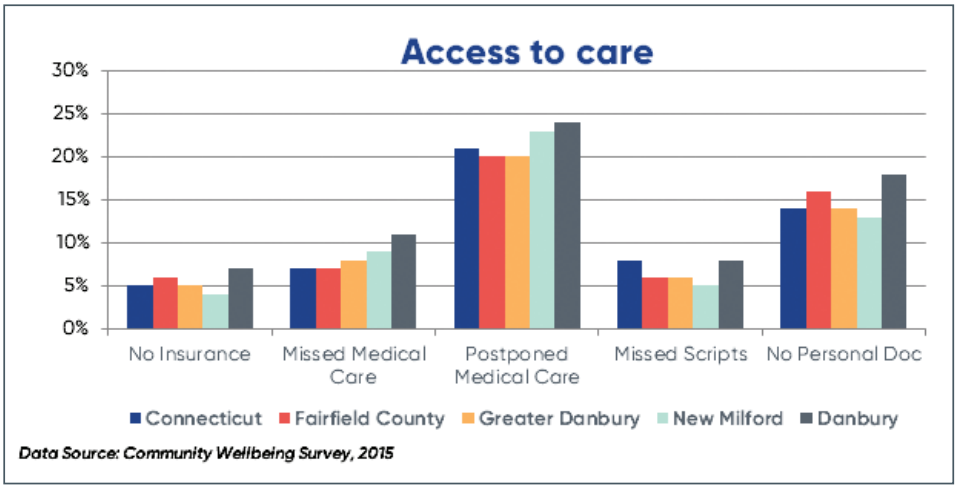


Figure 18: Access to care barriers

Challenges in accessing health care services (Figure 18): The majority of area residents, 94% in Danbury and in Fairfield County as a whole, have health insurance. Despite the high rates of insurance coverage, Danbury residents reporting connection to a PCP have decreased from 84% to 79%, with 72% of those earning less than $75,000 per year identifying a primary care physician. This compares unfavorably to Fairfield County and Connecticut where 82% and 83% respectively report they are connected to a PCP. New Milford residents are doing much better in this regard, where 88% surveyed report having a PCP. Postponing medical care often magnifies progression of chronic disease and adds to overall cost burden. This is of particular concern in Danbury where, of those earning less than $75,000 per year, 64% say they postpone medical care and 28% say they do not fill prescriptions due to cost.

KIS also noted that health access disparities exist along socio-economic lines. Residents who lack health insurance and have limited resources struggle to access the full continuum of care, particularly outpatient and preventive care. The system is the worst for recent immigrants who lack insurance and often have language barriers.

16

Qualitative data: Key informant surveys

Introduction

This section of the report is an overview of the qualitative findings from the **Community Health Needs Assessment** conducted on behalf of the Western Connecticut Health Network (now part of Nuvance Health). The Strategy Group (TSG) consultants spoke with community leaders, service providers, clergy members, medical professionals and residents (Appendix A). All participants in the focus groups and interviews were asked standardized, open-ended questions concentrated primarily on health concerns including access challenges and gaps in services.

Below are synopses of the primary questions:

1. What are the most pressing health concerns in the community? Why? How do these health issues affect your community? Who is most vulnerable or at risk for these issues?
2. What are the residents' greatest challenges to addressing these health issues? How could these challenges be addressed?
3. Where are the health care gaps? What programs/services are not available but should be?
4. What would you like to tell Western Connecticut Health Network (WCHN)?

In addition, a 21-question online survey was sent out via multiple channels including email blast, Facebook, Instagram, newspapers, text messaging and in paper form in Spanish at the Americares clinics. The survey covered a broad range of issues including community health concerns, barriers to good health, access to services and opinions on the future outlook for health.

Interviews and focus groups (101 people)	Online survey (527 responses)
• 13 individuals interviewed • 7 focus groups (68 people) • Special meeting: YMCA parent meeting (20 attendees)	• Bethel: 38 • Bridgewater: 5 • Brookfield: 106 • Danbury: 193 • New Fairfield: 82 • New Milford: 64 • Newtown: 22 • Redding: 4 • Ridgefield: 12 • Roxbury: 0 • Sherman: 2 • Southbury: 6 • Washington: 4 • Woodbury: 1

Summary of focus group and interview findings

Strengths

Fairfield County is known for its green spaces and strong parks and recreation departments. More sidewalks and walking paths are needed in some areas but in general, there is plenty of space for people to bike, exercise and walk their dogs. With the exception of certain low-income neighborhoods where there remains concern about crime, the majority of participants felt that their towns are safe, their relationships with police departments are strong and the speed of emergency fire and EMS care is exceptional. Many cited racial and ethnic diversity as a strength setting Danbury apart from other towns due to the richness in people of different cultures, religions and backgrounds.

Many pointed to the hospital system as a strength, citing the high quality doctors and nurses and the interest in working together with community providers. According to one interviewee, "*There is an explicit effort to promote community connections to bring people together in a healthy way*." Another noted, "*Although some doctors are less available, the local hospitals seem to have filled the gap by expanding their services/networks*."

Barriers

Nutrition, housing, transportation and wellbeing of seniors were the most commonly cited barriers to optimal health. Access to healthy meals is a struggle for many families. Parents are juggling multiple jobs, kids are overscheduled and the family mealtime has fallen away. These concerns are even more prominent in low-income areas where affordable healthy food choices are scarce and fast food is a cheaper, more filling alternative. Participants reported that many towns have good supermarkets, but no bus or train lines to get there. One interviewee said, "*If you want to move the dial, you need to make access to healthy food at a price point similar to potato chips—this is going to be hard to do, but that's the reality*."

High costs in this region make affordable quality housing inaccessible to many low- and moderate-income residents. Lower income residents felt they have settled for overcrowded conditions, neighborhood crime and landlord disputes. Additional barriers for low-income residents are lack of reliable public transportation and affordable childcare.

The area's seniors experience multiple social and access barriers. The rising cost of housing in Connecticut—the seventh oldest state—affects many senior residents who want to stay in their homes rather than move to assisted living or transitional care communities. There are limited affordable, independent housing options that are appropriate for aging in place and the social service agencies for seniors are overstretched. Additionally, there are not enough geriatric practitioners to manage the prevalence of dementia, chronic lung disease, diabetes, slips and falls, and problems with medication management. Seniors also struggle with isolation and limited transportation, impairing the ability to get to senior centers, supermarkets and doctors' appointments.

Health concerns: Mental health, substance abuse and chronic conditions

Mental health and substance abuse were the top health concerns reported in the interviews and focus groups and were felt to impact persons of every socio-economic level. These findings echo the previous health assessment completed in 2016.

Mental health services are present but limited and often strained. There are long waiting lists, especially for those with no health insurance and for those with Medicaid seeking outpatient services. Even those with commercial insurance often have difficulty finding outpatient care. Immigrants have additional challenges accessing care due to the lack of bilingual practitioners in the area. "*It is difficult to find mental health and substance abuse treatment—not enough providers—high costs and many don't take insurance. The system is complicated—many phone calls required to sort out billing—it is time consuming and confusing.*"

Many mentioned the high prevalence of stress and depression and cited contributing factors, such as the high cost of living, the influence of technology and the struggle to care for aging parents and children, all of whom are experiencing anxiety and stress themselves. Some reported these stresses starting as early as preschool, evidenced by disruptive behaviors in and out of the classroom. The rising rates of suicide were also cited as a strong concern. Many schools are surveying their youth about their involvement with risky behaviors to gauge perceptions and trends around substance use, suicidal thoughts and mental status.

Residents in all communities continue to struggle with substance abuse, most notably heroin, opioids, alcohol, marijuana and now vaping. Health directors and school personnel expressed the need for increased prevention and intervention for residents of all ages.

Chronic conditions such as hypertension, diabetes and obesity remain concerns for all ages and socio-economic groups. People with higher education and income levels have more access to specialty care, and are more likely to receive treatment for these chronic issues. *"Access to quality health care is very available to those with money, education and transportation."*

Health department directors reported two issues of growing concern. The rates of chlamydia and gonorrhea amongst teens and young adults are increasing, and there is a notable increase in reports of hoarding. Several health directors reported spending their time addressing the urgent issues of hoarding, blight, suicide and sexually transmitted disease such that prevention is pushed to the back burner. Health departments expressed interest in partnering with Danbury Hospital to provide more community education, outreach and program development.

Access to care

Access to specialty care is an acute issue regionally, especially for those with little or no health insurance. The Greater Danbury Community Health Center, Americares Free Clinics, and the Community Health Centers Inc. are striving to provide quality health care to low-income, uninsured patients on a daily basis but "*can only treat the surface problems, not the serious deeper problems, as there are not enough orthopedists, urologists, cardiologists and dental care specialists who will take referrals.*"

Many we spoke to acknowledged the disparity of care—there are quality practitioners and specialists in the area, and access to continuum of care if you have the financial resources to pay for it. As one focus group respondent said, *"Those that have money have health care, those that are low income don't. Those of us living paycheck to paycheck sometimes feel we might be better off quitting our jobs and being truly poor, then we'd qualify for free lunch, reduced health care or welfare to get by."* People also spoke about the challenge of having to pay high deductibles under private pay plans.

Finally, several professionals expressed potential concern that health system expansion and mergers may result in "reduction of services" and are hopeful for more collaboration between the hospital and community partners. As one interviewee said, *"There are forces that have pushed these smaller hospitals together out of necessity—likely for economies of scale, but what is going to happen on the community level?"*

Can residents access . . .	Almost always	Most of the time	Some-times	Rarely	Don't know
Specialty care (such as orthopedists and cardiologists)	42.6%	42.6%	10.6%	1.7%	2.6%
Dental care	58.1%	32.0%	6.5%	1.5%	1.9%
Mental and behavioral health services	18.1%	31.6%	25.5%	6.8%	17.4%
Substance abuse services	14.7%	28.5%	26.0%	4.1%	34.7%

Table 4: Specialty care

Online survey findings

The majority of the respondents were women (70%), Caucasian (75%) and over 45 years of age (75%). Most (82%) believe access to quality health care has improved or remained the same over the last three years with increased access to services, better quality health care and improved awareness and communication. The majority (85%) of Greater Danbury respondents described their overall health as either good or excellent and only one percent described their health as poor. The ability to access specialty care was mixed. Greater Danbury area respondents were generally positive about their ability to access specialty medical services but found it more difficult to access mental health and substance abuse services.

Respondents ranked the five top issues though to impact their community, family, friends and neighbors:

1. Obesity
2. Mental health
3. High blood pressure/hypertension
4. Cancer
5. Heart disease/high cholesterol/stroke

Respondents ranked the barriers to good health:

1. Access to medical insurance
2. Access to transportation
3. Access to education regarding healthy behaviors
4. Access to healthy foods

The online survey represents a segment of the Connecticut population that is generally insured, is able to access and navigate the health care system and can access food and transportation, but is struggling with the rising costs of health care and cost of living in this area. Like the focus group and interview respondents, those who completed the online survey had concerns about mental health, substance abuse and chronic disease. They included cancer as a top concern.

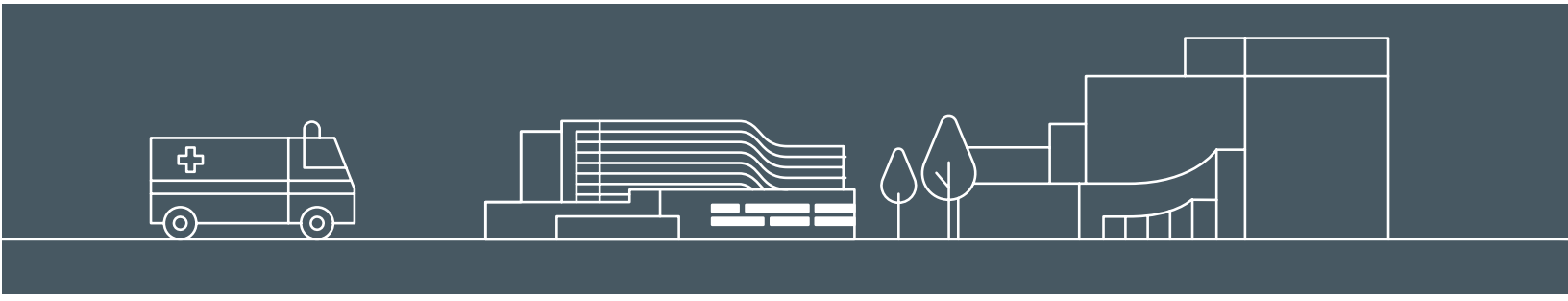
Summary of the qualitative data

In 2016 the key findings and health priorities identified in the Greater Danbury area **Community Health Needs Assessment** were chronic disease/obesity, mental health/substance abuse, access to health care and healthy aging. Three years later, while there have been improvements in community partnerships, attention to mental health and screening for social determinants data suggests that the 2016 indicators remain priority concerns. According to those surveyed, mental health needs remain high and there is a critical need for bilingual practitioners. Vaping, along with opioid and alcohol use, are problems voiced by members of all communities surveyed.

Disparity in access to healthcare persists and depends on socioeconomic status and the presence of health insurance. Finally, access to public transportation and healthy food continue to be challenges for those in many of the communities surveyed.

Health access disparities exist among socio-economic lines. Residents who have resources and adequate health insurance have access to quality care. Those who lack health insurance and have limited resources struggle to access the full continuum of care, particularly outpatient and preventive care. The system is worst for recent immigrants who lack insurance and have language barriers.

Western Connecticut Health Network has made significant progress in developing community partnerships to assess gaps and develop programs addressing access to care and the social needs of its area residents. Despite this advancement, gaps persist. WCHN has the opportunity to continue to be a leader in addressing mental health, substance abuse, chronic disease management, access to healthy food and advocacy for area senior and immigrant residents.



20 Discussion

Progress from the 2016 Community Health Improvement Plan

Chronic disease and obesity prevention

The Chronic Disease Subcommittee (CDS) consisting of representatives from the Regional YMCA of Western Connecticut, Danbury Hospital, Visiting Nurses Association of Bethel and the health districts of Bethel, Brookfield, Danbury, New Fairfield, New Milford, Newtown and Southbury, has been meeting since 2012. Prominent among the initiatives have been programs for children and youth. The **Go! 5,2,1,0** program has demonstrated success in increasing activity and has been adopted by local pediatricians, and nine public schools and 43 sector sites. Parents surveyed report maintaining healthy behaviors at home with reduction in sugary beverages, decreased screen time and increase in consumption of healthy food. The CDS has actively supported community gardening programs for children of low-income families.

The CDS has supported the expansion of the Connecticut multi-use trail system including the Still River Greenway, the second most used trail in the state. A survey of over one thousand users shows 63% use the trails for recreation, 49% for exercise/weight management, 45% for relaxation and 40% for exercise/prevention.

Mental health and substance abuse subcommittee

The Mental Health and Substance Abuse Subcommittee (MHSA) is led by the Western Connecticut Coalition Regional Behavioral Health Action Organization—Region 5. Region 5 conducted an assessment of the behavioral health needs in 2019. Results of the data collection and focus group, reported in the Regional Priority Report (Appendix), shows widespread concern about the prevalence of mental health issues. These concerns include rates of anxiety and depression in young people, lack of appropriate services for nonacute mental health and substance use disorders and treatment providers reaching for medications before considering alternative therapies. There were discussions about the risks of addiction compounding behavioral health problems.

Prescription drug misuse is seen as an ongoing challenge. In Region 5, recent treatment data supported key informant assertions that benzodiazepines and amphetamines are accessible and misused by youth and adults alike. During 2018, 33% of all Western Connecticut overdose fatalities were related to one form or another of these prescription medications. The consequences of alcohol, and underage drinking, were also ranked in the top three. This is likely because it remains the most widely used of all substances.

The Mental Health and Substance Abuse Subcommittee of the Community Health Committee has guided the development of several community health programs. These have been expanded and scaled since 2016 with the goals of improving access to appropriate care for children and adults and providing education to increase awareness and promote prevention.

The Behavioral Health Integration Program was implemented in 2015 to improve access for patients with behavioral health issues. These issues may range from depression and anxiety to sleep disturbance and grief reactions to substance misuse. There is also the opportunity to address health behaviors, such as smoking, lack of exercise, obesity and substance use, which are the main causes of poor health outcomes in our country.

This Behavioral Health Integration model incorporates Behavioral Health Consultants (BHCs) to our primary care teams. BHCs are experienced behavioral health social workers who serve as members of the care team that includes the physician, nurse, medical assistant, care manager and office staff. Using this model, the primary care team is better able to meet the medical and emotional health needs of their patients in a coordinated, patient centered and convenient manner.

For the more vulnerable residents in our community, the Greater Danbury Community Care Team (DCCT) was started in 2014. Since then it has expanded to include more than 30 organizations that meet weekly to organize patient-centered outreach and navigation for vulnerable and high-need residents of Greater Danbury. The DCCT has served more than 200 people providing connection to needed primary care, mental health, addiction and social services. Efforts of the DCCT have resulted in decreased emergency department utilization, indicating an increase in medical and social stability for the residents served.

Recognizing the unique needs of patients with substance use disorders, Danbury Hospital added a peer recovery specialist to the Greater Danbury CCT. Peer recovery specialists are motivated, energetic individuals with lived experience and specialized training to better engage patients who have substance use disorders. The peers provide direct outreach and assistance in connecting patients to appropriate care.

The Interprofessional Community Academic Navigation (iCAN) program was started in 2016 as a collaborative effort between Western Connecticut Health Network and Sacred Heart University. This program expands the reach of the CCT while offering an innovative teaching opportunity for undergraduate social work and graduate level nursing students. Under the guidance of a faculty clinical advisor, the iCAN team provides direct in-person and telephone outreach services to patients who need connection to medical, mental health, social or substance services. This program not only has immediate impact on the patients we serve, it also provides impactful training for future caregivers working with our most vulnerable community members.

Healthy aging subcomittee

The Healthy Aging Subcommittee was convened in 2016 following the **Community Health Needs Assessment** of that year. Among other programs, Healthy Aging has focused on fall prevention.

Strengths

Danbury Hospital as part of WCHN has developed successful partnerships with many local and regional agencies. This forms the infrastructure on which to continue building programs to address prevention and management of chronic disease, mental illness and addiction. Because of these successful partnerships, Danbury Hospital has been awarded several grants that advance the community health objectives of the region.

The Screening, Brief Intervention and Referral to Treatment (SBIRT) Implementation Grant was awarded in 2018 and has provided the opportunity to expand services addressing substance use disorders. Leveraging the Behavioral Health Integration Program, screening and brief intervention is being rolled out to all primary care practices in the WCHN region, including seven offices in the Greater Danbury region. The goal of the SBIRT program is to identify risky use of substances and provide education and intervention to avoid downstream health problems and negative social consequences. The SBIRT program is inthe early phases of implementation with the goal of being fully rolled out by summer of 2020.

Connecticut Community for Addiction Recovery (CCAR) has a grant funded outreach program providing services to hospital emergency departments in Connecticut. Danbury Hospital was included in this successful and innovative program beginning in the fall of 2017.

To better meet the needs of patients at risk for opioid use disorders, Danbury Hospital hired an opioid navigator. The goals of this role include monitoring patients using risky doses of prescribed opioids, reaching out to patients who have received opioid reversal treatment in the community and educating providers and staff about available opioid treatment programs.

In 2017, the Centers for Medicare and Medicaid Innovation (CMMI) awarded Danbury Hospital the Accountable Health Communities Grant. This five-year, $4.5 million grant, screens Medicare and Medicaid beneficiaries for housing instability, food insecurity, utility needs, interpersonal violence and transportation challenges. Those with identified needs are evaluated for high-risk status and either provided resources or

offered a navigator to assist them in connecting with services. Danbury Hospital was one of only 20 national awardees.

Danbury Hospital has several innovative programs to meet the needs of area seniors. Enterprising employees including care managers and Emergency Management Services (EMS) saw a need to address falls in seniors and developed the Lift Assist program. Oftentimes when EMS is called after a fall and the decision is made not to transport to the hospital, this information does not get passed along to the primary care provider. The Lift Assist Program uses this EMS data to connect the patient to their primary care provider to address the cause of the fall. The hospital team is partnering with local community agencies to form a community network to review identified individuals and develop appropriate action plans.

Danbury Hospital is participating in the Healthy Savings Program initiated by United Way to assist low-income residents who do not qualify for SNAP benefits. This program provides a 50% discount on fresh produce and healthy staples.

These community partnerships, in addition to addressing the needs of individuals, have provided further benefit in the form of investment in the community, collaboration with the local government and identification of Danbury Hospital as a primary leader, employer and driver of the local economy.

Challenges

Connecticut as a state is aging and, along with that, can expect increase in chronic disease and related healthcare costs. While immigration adds to diversity and mitigates the average age of the population, culturally sensitive programming is required to maintain health and address prevention, ultimately enhancing the social and economic vitality of the region.

Fairfield County has significant income inequality. This has negative repercussions for the entire population, not just for those left out of the wage and asset expansion. Income inequality depresses economic growth, breeds unrest and ultimately risks undermining capitalism-based democracy.[1,2]

The prevalence of chronic disease, with the exception of asthma, continues to climb. Obesity and hypertension are leading indicators of chronic disease burden and associated costs. While generating revenue for those in the healthcare sector, these costs will eventually depress the economy as a whole through lost opportunity and increased burden on taxpayers.

Not-for-profit community agencies are experiencing reduction in grants and government funding and are relying increasingly on philanthropic support. Danbury Hospital is dependent on these agencies to provide the programming to support prevention, chronic disease management and behavioral health intervention services.

Access to specialty care services for those who are underinsured remains a problem including, but not limited to, orthopedics, urology, dermatology and child psychiatry.

National and state initiatives

Alignment with regional and statewide initiatives will enhance the success of local efforts. The Connecticut State Health Assessment, though not yet finalized, will likely focus on eight areas: 1) Maternal infant and child health; 2) Environmental health; 3) Drinking water; 4) Chronic disease; 5) Infectious disease; 6) Behavioral health, injury and trauma; 7) Health systems; 8) Climate and health.

Danbury Hospital through the Greater Danbury CHNA is invested in alignment with the CDC 6/18 Initiative.[3] This program focuses on six common health conditions using 18 interventions: 1) Reduce tobacco use; 2) Control high blood pressure; 3) Improve antibiotic use; 4) Control asthma; 5) Prevent unintended pregnancy; 6) Prevent Type II diabetes.

Summary and conclusions

Danbury Hospital and WCHN have effectively enhanced community partnerships and worked to develop the infrastructure needed to improve community wellness. While some indicators have improved, such as emergency department utilization, access to integrated care, asthma rates in all communities and the rate of diabetes in Danbury, many measures have continued to worsen. Obesity and hypertension continue to increase at an alarming rate and the number of residents without a medical home has increased. Opioid overdose rates continue to climb and access to addiction treatment remains challenging. More are struggling financially and increased numbers are postponing healthcare due to cost.

The **Community Health Improvement Plan** developed from this assessment will seek to: 1) maintain and enhance community partnerships and service delivery infrastructure; 2) expand availability of partnerships and programs addressing chronic disease, mental health, addiction and specialty services for the underinsured; 3) align with state and national initiatives where the potential for synergy exists.

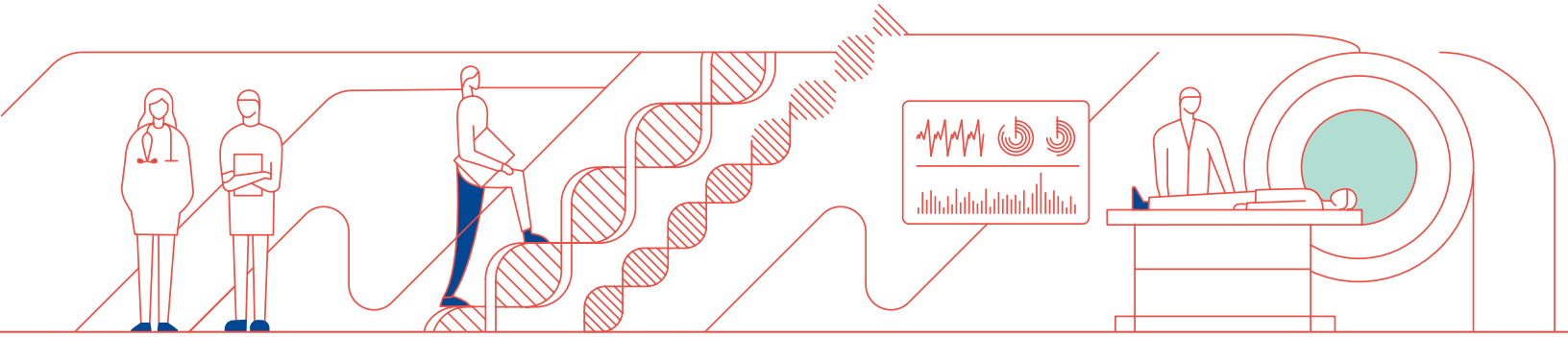
Priority areas

I. Chronic disease and obesity prevention

II. Mental health and substance abuse

III. Healthy aging

IV. Access



Community Health Improvement Plan

Introduction

The 2019 Greater Danbury **Community Health Improvement Plan (CHIP)** was developed over the period of September 2019 through February 2020, using the key findings and identified priorities from the **Community Health Needs Assessment (CHNA)**. The Greater Danbury CHNA included data from the 2018 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 and New Milford Hospitals, in collaboration with the Regional YMCA of Western Connecticut, the Western Connecticut Coalition and Connecticut Community Care, Inc., led the development of the CHIP, with participation from community partners. The Community Health Committee (CHC) of the Danbury Hospital Board provided oversight of the process. Members of the Danbury Hospital CHC can be found in Appendix A. Workgroups were convened for each of four priority areas identified in the CHNA. The workgroups developed goals, objectives, strategies, action 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:

Figure 20: Community Health Assessment and Implementation Pathway.
Source: HRET, 2016

- 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 public health 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 22). 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.

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 2019 CHIP strategic components

The key findings and health priorities identified in the CHNA (e.g., chronic disease/obesity, mental health/substance use, and healthy aging access to health care) were presented to community partners and various community organizations from October 2019 to December 2019. Then workgroups were convened and facilitated in January 2020

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.

Workgroups for the four priority areas met during the month of January 2020. 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 aligned with work already underway. These plans were presented, reviewed and endorsed by the WCHN CHC on February 12, 2020.

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 including opportunities in schools	Regional YMCA of Western Connecticut, United Way of Western Connecticut, 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 and 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 Connecticut, 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 Connecticut, Coalition for Healthy Kids (CHK), schools
Mental health and substance use	Educate and increase awareness of preventive infections that have chronic implications focusing on influenza and sexually transmitted diseases	• Increase public awareness and education about seasonal flu vaccinations • Increase school, parental and public awareness of rise in STD infections	Local health departments, municipalities, Coalition for Health Kids (CHK), schools
	Reduce substance use across the lifespan in our region	• Create community level change and ensure a continuum of care	Regional prevention councils, Drug-free Schools Committee, Western Connecticut Coalition, Midwest Connecticut Council on Alcoholism

Priority	Goal	Objective(s)	Collaborating community partners
Mental health and substance use	Promote behavioral health and wellness across the lifespan in our region	• Provide access to information and resources that enhance awareness and encourage early identification of behavioral health issues • Improve the integration of behavioral health into primary care to enhance prevention and optimize use of psychiatry specialists	Danbury Community Care Team (CCT), Greater Danbury CHC, WCMG Primary Care
	Reduce the number of opiate addition disorders, overdoses and related deaths in our region	• Increase the number of prevention and intervention activities related to opioids	Regional Opioid Prevention Workgroup, EMTs, pharmacies, LPCs, WCHN ED, Danbury/NM police
	Reduce the negative consequences of electronic nicotine delivery systems (ENDS) in our region	• Enhance prevention efforts around ENDS use and increase cessation opportunities	Regional Prevention Councils, Drug-free Schools Committee, Western Connecticut Coalition
Healthy aging	Identify needs and support services to achieve healthy aging	• Support local partnerships to enhance availability of resources of healthy aging • Enhance resources for seniors and caregivers with needs for services and supports	Age Well Community Council, Connecticut Community Care, United Way of Western Connecticut, Nuvance Health Primary Care, Danbury EMS
	Enhance education, advocacy, access and communication to support the ability of seniors to age in place	• Increase awareness of services and supports enabling seniors to age in the place of their choice • Enhance bidirectional communication between medical providers and community supports • Increase advocacy initiatives to enable seniors to age in the place of their choice	Age Well Community Council, Connecticut Community Care, United Way of Western Connecticut, Nuvance Health Primary Care, Danbury EMS
Access to health promotion information and services	Identify needs and address access to programs for chronic disease, behavioral health and social determinants of health by enhancing partnerships with community services, school-based services and specialty care clinics and others	• Engage community partners to assess barriers to care and identify at-risk populations • Implement targeted outreach and strategies to improve access and/or reduce barriers to care • Increase available resources for pediatric population specifically immigrant children who require primary care, school physicals and BH services	Untied Way, local health departments, Nuvance Health medical groups, Nuvance Health Integrated Care Program

Community Health Improvement Plan priority areas

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 outline the goals, objectives, strategies, action steps and indicators of success for the health priority areas identified in the **Community Health Needs Assessment**.

Health priority implementation strategies & metrics

PRIORITY AREA 1: Chronic disease prevention 2020

Goal 1: All people are supported in practicing positive habits that include physical activity and healthy eating

Indicator: Percentage of overweight and obese adults in the community (Baseline 2018 CWS)
Indicator: Percentage of children in kindergarten, sixth and ninth grade with BMI > 85 percentile (Danbury Public Schools)
Indicator: Percentage 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 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 and employ indicators to measure family adoption and reinforcement of the Go! 5,2,1,0 message	• Continue resource and policy support with 43 current MOU sites/Danbury serving 45,922 residents • Identify new funding source for full time coordinator position to promote expansion of initiative to towns in Greater Danbury • With funding, upgrade Survey Monkey tool to collect surveys in multiple languages using APP and QR code	• New Go! 5,2,1,0 funding by June 2020 • Identify champions message adoption two towns per year • Five new sector sites per year • 65% improvement in health behaviors at home
• Support community gardening programs and farmers markets and food programs	• Support and expand current community efforts for garden programs, farmers markets and food pantries in Greater Danbury	• Update Community Resource Guide: 1. SNAP4CT.org mobile app—lists all farmers markets accepting SNAP, WIC 2. Current website for updated information on local food pantries 3. UCONN office in Danbury for SNAP applications 4. UWWCT Healthy Savings Program • Share Community Resource Guide with 155 community stakeholders and 211CT • Support initiatives for organizations seeking grant funding to improve food access	• Increase number of low-income areas with access to food pantry, community garden or farmers' market • Improvement in CWS metrics: Self-reported food insecurity and parent health behavior survey

Objective	Strategy	Action steps	Short-term indicators
• Advocate for proven physical activity initiatives including opportunities in schools	• Support the work of the Coalition for Healthy Kids on reducing barriers to physical activity and healthy food among low-income families living in Danbury	• Support organizations seeking grant funding to improve physical activity access with low-income youth and adults • Update Community Resource Guide with: 1. UWWCT ALICE Enrichment fund 2. Tai Ji Quan: MBB • Expand evidenced-based fall prevention programs to target 65-75 age group • Enhance fitness, Tai Ji Quan: MBB; Matter of Balance	• Percentage of adults and children self-reporting being physically active three or more times per week

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 (2018 CHIME data #1 Falls, #2 HTN, #3 Diabetes)
Indicator: Self-reported rates of diabetes, heart disease, smoking (Baseline 2018 CWS)

Objective	Strategy	Action steps	Short-term indicators
• Develop continuum of services for target populations including bi-directional feedback to referring healthcare clinicians • Strengthen healthcare engagement and awareness of/referrals to community programs • Implement screening and awareness campaigns for chronic disease • Increase awareness and engage older adults in fall prevention efforts at home and in community	• Update current list point of care providers and prevention programs • Triage target populations for those to self-manage and those requiring more intensive community-based resources • Target age group for health intervention 45-65 years • Establish workflows and EMR referrals to community programs • Increase participation of at-risk in culturally relevant primary prevention and health maintenance programs offered in the community • Collaborate with AgeWellCT to promote fall prevention programs targeting 55+ adults	• Update Community Health Resource Guide to include new programs and distribute to stakeholders; update 211ct.org • Increase the number of culturally relevant programs in community; address language barrier • Develop strategy to increase PCP awareness of referrals to programs • Continue HRSA partnership with Nuvance • Educate PCPs on referral workflow processes for HTN, YDPP, DSMP and fall prevention • Track "Know Your Numbers" (VNA) and fall prevention screens (HRSA)	• Percent enrollment into community based programs; average age • Number enrolled in bilingual programs • Percentage screened for fall risk • Number of referrals from PCPs • Percentage change from 2019 • Number of healthcare partner locations making referrals • Percentage increase in enrollment over 2019 • Number of towns providing programs • Number of adults in NCOA AMP

Goal 3: Develop/enhance access to places and programs to promote physical activity opportunities for all

Indicator: Percent of people reporting exercising three to four times/week (Baseline CWS 2018= 37%) SRG=44% > 3x week; Children Go! 5,2,1,0 74%-3x week; Safe sidewalks and crosswalks 43%; safe places to bike 47%

Indicator: Number of new/improved walking and biking trails and physical activity locations (i.e., basketball, pickle ball)

Indicator: Number of people utilizing free walking/recreational programs increases

Objective	Strategy	Action steps	Short-term indicators
• Advocate use of Connecticut Trail Census Maps to find trails in Greater Danbury towns	• Explore opportunities to partner with Connecticut Trail Census	• Add mobile app to Community Resource Guide	• Number of stakeholders sharing app with constituents
• Promote participation in national physical activity events (e.g., Walk to School Day)	• Promote awareness through towns and schools	• Develop communication materials • Promote through website links/emails	• Number of towns/people participating in events that promote physical activity
• Advocate for and support development of infrastructure improvements that encourage walking and/or biking	• Identify one trail per town to survey resident use • Collaborate with HART Transit and Brookfield Zoning to place bus stop sign at SRG in Brookfield	• Replicate Survey Monkey tool used on SRG in 2019 • Partner with Connecticut Trail Census—Counters • Survey bus users on SRG awareness • Communicate results to stakeholders	• Number of towns taking steps to improve walking and biking in their communities • Number of bus riders who use SRG

Goal 4: Educate and increase awareness of preventive infections that have chronic implications focusing on influenza and sexually transmitted diseases

Indicator: Number of people vaccinated for flu in Greater Danbury; obtain baseline from HRSA data collection (Nuvance)

Indicator: Number and type of STD's reported to local health directors; baseline TBD

Objective	Strategy	Action steps	Short-term indicators
• Increase public awareness and education about seasonal flu vaccinations	• Develop social marketing strategies	• Add VNA and local health department flu vaccination and contact information to Community Health Resource Guide • Develop messaging about flu to share on social media	• Number vaccinated for flu • Number of non-pharmacy locations offering flu vaccine
• Increase school, parental and public awareness of rise in STD infections	• Determine baseline indicators • Analyze data for insight into root causes and types of STD's reported by town • Develop social marketing strategy that targets 18 to 30 age group	• Centrally collect local health department data • Meet with local school districts and health education specialists to gain insight into implications of commonly reported STD infections • Identify available PSA's from the CDC that can be used as marketing tool	• Evidence from baseline measures that STD's are declining

PRIORITY AREA 2: Mental health and substance use

Goal 1: Reduce substance use across the lifespan in our region

Indicator: Percentage of people reporting need to cut down on alcohol use (Baseline 2015, 2018 CWS)
Indicator: Percentage of youth reporting past month use of alcohol, marijuana, tobacco and prescription drugs
Indicator: Number of emergency department (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 with Community Care Team (CCT) • Expand Screening and Brief Intervention • Explore Bundled Payment program for SUDs	• Perform needs assessment • Outreach to new partners and general population • Provide information to Local Prevention Coalitions (LPC) and general population • Identify evidence based metrics • Implement SBIRT in Nuvance primary care practices • Pilot Bundled Payment program	• Number of events/venues where information is distributed • Number of new partners • Number of participants at events/venues • Number of Nuvance practices incorporating SBIRT • Number of patients entering Bundled Payment program

Goal 2: Promote behavior 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) update CWS

Objective	Strategy	Action steps	Short-term indicators
• Provide access to information and resources that enhance awareness and encourage early identification of behavioral health issues	• Include mental health promotion information in newsletters and other publications distributed across the region • Hold and/or participate in community workshops or awareness events	• Identify newsletters or other publications with whom to partner • Provide skills building opportunities at community workshops • Outreach to members of the recovery community and BH sectors	• Number of newsletters/ publications that include mental health promotion • Number of parent awareness or other workshops/year
• Improve the integration of behavioral health into primary care to enhance prevention and optimize use of psychiatry specialists	• Increase screening by and referrals from primary care practices • Increase collaboration and communication among behavioral health and primary care providers	• Increase number of integrated LCSWs in primary care practices • Enhance and support community care teams • Participate in Catchment Area Council 21 • Review and report on school-based integrated care model	• Number of referrals from PCP's to integrated BHC • Increase number of PCP's making referrals • Number of PCP offices with LCSW's

Goal 3: Reduce the number of opioid use disorders, overdoses and related deaths in our region

Indicator: Number of opioid related deaths reduced in our region (Baseline 35, 2015 Source Office of CME)
Indicator: Number 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 Naloxone • Improve access to MAT	• Work with PCPs, pain management specialists to make information available • Promote SBIRT, MAT and Narcan training • Develop spike response plan with area partners	• Number of local officials, legislators reached • Number of providers or responders trained to administer MAT • Narcan kits distributed • Sustainability plan for Nuvance opioid navigator

Goal 4: Reduce the negative consequences of electronic nicotine delivery systems (ENDS) in our region

Indicator: Percentage of people reporting use of JUUL and other vaping products
Indicator: Percentage of youth reporting past 30-day use of vaping products
Indicator: Number of legislative and policy changes regarding ENDS

Objective	Strategy	Action steps	Short-term indicators
• Enhance prevention efforts around ENDS use and increase cessation opportunities	• Utilize the Strategic Prevention Framework and evidence-based initiatives such as Community Messenger model and/or Parent Guide • Enhance education and awareness • Assist with policy development through media, local and state governments	• Perform needs assessment • Reach out to new partners and general population • Provide information to Local Prevention Coalitions (LPC) and general population • Encourage the use of restorative consequences at schools including education and cessation support	• Analyze baseline data • Number of events/venues where information is distributed • Number of new partners • Number of participants at events/venues • Number of cessation options • Messaging campaigns

PRIORITY AREA 3: Healthy aging

Goal 1: Identify needs and support services to achieve healthy aging

Indicator: Percentage over 50 rating overall health as "excellent" or "very good" (CWS 2015, 2018)
Indicator: Percentage over 50 reporting they "usually or always" get needed social and emotional support (CWS 2015, 2018)
Indicator: Trend in utilization of websites

Objective	Strategy	Action steps	Short-term indicators
• Support local partnerships to enhance availability of resources for healthy aging • Enhance resources for seniors and caregivers with needs for services and support	• Support and align with local agencies advancing initiatives to develop resources and enhance services: Age Well Community Council; Agency on Aging • Support efforts to disseminate information including through websites: AgeWellCT.org and DanburySeniors.org • Identify other opportunities to improve access to information, services and supports	• Continue community conversations • Identify service and resource gaps • Maintain link to 211 and other area resources • Continue and seek new grants to support the Healthy Aging mission	• Number of community conversations held • Updated report identifying service and resource gaps • Resources updated • Utilization of website • Number of funding sources identified

Goal 2: Enhance education, advocacy, access and communication to support the ability of seniors to age in place

Indicator: Percentage of 55 and over who consider their homes a suitable place to grow older (CWS 2015, 2018)
Indicator: Seniors' use of home care compared with nursing home (DSS data)

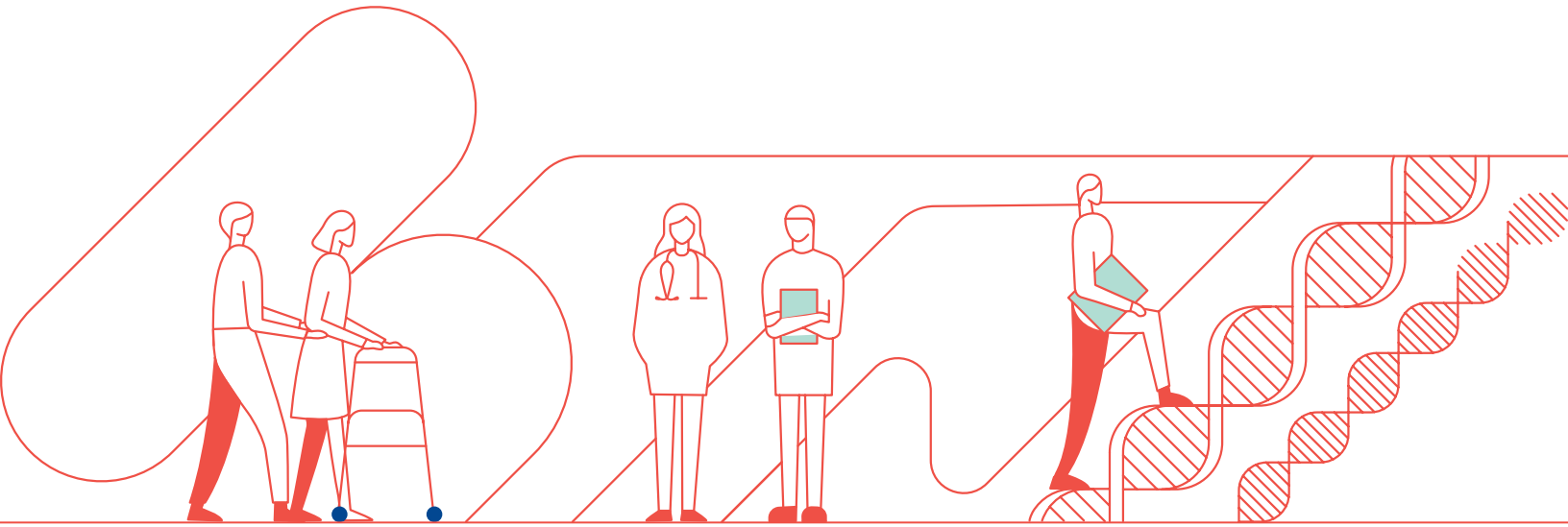
Objective	Strategy	Action steps	Short-term indicators
• Increase awareness of services and supports enabling seniors to age in the place of their choice • Enhance bidirectional communication between medical providers and community supports	• Organize and implement programs outlining availability of programs addressing food and transportation insecurity; fall prevention • Enhance access to primary care resources and community services	• Create and disseminate informational material • Create marketing and outreach materials for reaching Danbury seniors and caregivers • Conduct information sessions • Review AHC data to inform future programs • Maintain the Lift Assist Program	• Number of materials created and disseminated • Number of individuals reached at information sessions • Number of individuals reached through Lift Assist
• Increase advocacy initiatives to enable seniors to age in the place of their choice	• Provide targeted outreach and support for key senior agencies and decision makers at the local, regional and state levels to inform and shape public policies	• Create standard engagement tools to guide outreach to and discussions with decision makers	• Tools created • Number of decision makers/discussion

PRIORITY AREA 4: Access to health promotion information and services

Goal 1: Identify needs and address access to programs for chronic disease, behavioral health and social determinants of health by enhancing partnerships with community services, school-based services and specialty care clinics and others

Indicator: Rate of uninsured (Baseline 2015, 2018 CWS)
Indicator: Rate and reasons for missed or postponed care (Baseline 2015, 2018 CWS)
Indicator: Emergency department 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	• Develop plan to implement Kids Care Team in Danbury • Review trends in United Way's 2018 ALICE data • Engage resources to assist with data analysis	• Care team implementation plan • Increase number of ALICE residents accessing Healthy Food program • Update resource inventory
• Implement targeted outreach and strategies to improve access and/or reduce barriers to care	• Screen Medicare and Medicaid beneficiaries for SDOH in primary care setting and connect to services • Screen Medicare and Medicaid beneficiaries for SDOH in hospital facilities (labor and delivery, emergency department) and connect to services	• Care navigators to connect individuals to services and 211 • Visitors in ED receive information on 211 and other services • Implement UniteUs • Expand Healthy Savings program for ALICE population	• Number of community programs using UniteUs • Number of participants using Healthy Savings program • Number of sites served by RoundTrip program
• Increase available resources for pediatric population, specifically immigrant children who require primary care, school physicals and BH services	• Explore options for increasing access to school physicals • Increase BH partnerships through the FQHC's	• Collaborate with health department and school system to provide school physicals • Support Red Card training, "know your rights"	• Consider including school physicals in Mission Health Day • Ensure that FQHC's are represented in the CHC • Include immigrant access to care as discussion item at CHC meetings



Planning for action and monitoring progress

Figure 21: Collective vision. ***Source***: County Health Rankings and Roadmaps Action Cycle

The Danbury (CHC) was created during the community health planning process in the Greater Danbury Region in 2012. The Charter for the Committee was defined:

Mission: Review and provide oversight to the organization's community health needs assessments and community health improvement plans in support of its mission and population health initiatives

Responsibilities and scope of activities

- Monitor assessments of population health status and social determinants that impact health
- Guide priority issues for action to improve community health
- Monitor implementation of approved work plans to address identified priority issues
- Help inform, guide, share and link successful programs and strategies that address health and wellness throughout the network's service areas
- Support community health programs that are accountable and continuously measured to improve health outcomes and reduce inefficiencies in delivery of programs and services

Responsibilities and scope of activities

- Monitor assessments of population health status and social determinants that impact health
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- Support community health programs that are accountable and continuously measured to improve health outcomes and reduce inefficiencies in delivery of programs and services

Progress on the 2019 CHIP and implementation strategies will continue to be monitored at routine workgroup meetings, and will be reported regularly to the Danbury CHC. The Danbury CHC, made up of community members and representatives from community health organizations, will meet on a quarterly basis, and report at least annually to the Danbury Hospital board and the network Strategic Planning Committee (see Appendix D for reporting structure and CHC membership).

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

Attachments and appendices

- FC Community Wellbeing Index
- Chime Reports for Danbury and surrounding towns
- Western Connecticut Coalition 2019 Regional Priority Report
- Connecticut Trail Census – www.cttrailcensus.uconn.edu
- Better Together: Clinic to Community Benefits, Regional YMCA of Western Connecticut, June 18, 2019
- Health Priorities of Danbury Parents: Focus Group Data and Health Priority Themes, May 22, 2019
- Community Health Resource Guide

Appendix A. Qualitative survey interview and focus group participants

Individual interviews

1. Megan Chrysler, Director of Early Childhood, United Way of Western Connecticut
2. Cara Donovan, Food Policy Manager, United Way of Western Connecticut
3. Michael Gold, President/Owner, GeronNursing Respite Care, Inc.
4. Natalie Jackson, Director of Human Services, Newtown
5. Michelle James, Executive Director, Community Action Agency
6. Mona LiBissoniere, Health Educator, Pomperaug Health District
7. Neal Lustig, Director of Health, Pomperaug Health District
8. Hon. Jim Maloney, President & CEO, Connecticut Institute for Communities
9. Lisa Michelle Morrissey, Director, Danbury Health & Human Services
10. Sherry Ostrout, Director, Government Initiatives, Connecticut Community Care
11. Liz Quinonez, Community Engagement Coordinator, United Way of Western Connecticut
12. Beth Trott, Director of Human Services, Sherman
13. Dina Valenti, RN, Director, Americares Clinic (Danbury)

Focus groups

Americares focus group (Spanish speaking parents)
12 parents attended

Bethel community representatives

1. Mary Rose Beauvais, Bethel Visiting Nurse Association
2. Beth Cavagna, Planning & Zoning Director, Bethel Housing Authority
3. Lisa Plumb, Bethel Senior Center/Municipal Agent
4. Joan Santucci, Bethel Visiting Nurses Association
5. Laura L. Vasile, Bethel Health Department
6. Theresa Yonsky, Bethel Director of Finance, Bethel Board of Education

Brookfield community representatives

1. Blair Balmforth, WCHN Injury Prevention Coordinator
2. Stephen Dunn, Brookfield First Selectman
3. Maureen Farrell, Regional YMCA of Western Connecticut, Director of Community Wellness
4. Ron Jaffe, Brookfield Cares
5. Deacon Peter Kuhn, Saint Joseph's Church
6. Ellen Melville, Town of Brookfield, Director of Social/Senior Services
7. Rob Montgomery, Brookfield Cares
8. Dr. Kenneth Pellegrino, Geriatric/Family Practice Doctor in Brookfield; Danbury Hospital
9. Kerry Reilly, WCMG – Brookfield Office, Behavioral Health
10. Lieutenant Eric Sullender, Brookfield EMS
11. Jennifer Whipple, Congregational Church of Brookfield

Danbury ALICE parents

6 parents attended

Greater Danbury area health directors

1. Ed Briggs, Ridgefield Health Department
2. Fernanda Carvalho, Danbury Health Department
3. Michael Crespan, New Milford Health Department
4. Donna Culbert, Newtown Health District (Newtown, Bridgewater, Roxbury)
5. Doug Hartline, Redding Health Department
6. Cooper Mead, Danbury PHEP Coordinator
7. Tim Simpkins, New Fairfield/Sherman Health Department

New Milford community representatives

1. Shelby Baumer, Community Engagement and Outreach Director, New Milford Visiting Nurses Association
2. Ivana Butera, Director of Social Services
3. Michael Crespan, Director, New Milford Health Department
4. Carolyn Haglund, Director, New Milford Senior Center
5. Jill Hart, Community Health Nurse, New Milford Visiting Nurses Association
6. Laura Olson, Director of Pupil Personnel and Special Services, New Milford Public Schools
7. Geri Rodda, Public Health Nurse

School-based health centers

1. Christopher Bestany, Western Connecticut Southern University Student Intern
2. Melanie Bonjour, Program Manager, SBHC/CIFC/GDCHC
3. Clare Gelissen, Clinician, SBHC, Henry Abbott Tech
4. Christy Georgouus, Dental Coordinator, CIFC 1st Floor Hygienist
5. Jolene Henion, APRN, SBHC, Rogers Park Middle School
6. Clare Nespolie, APRN, SBHC, Broadview Middle School

Appendix B. Danbury Community Health Committee (CHC) members

Organization	Member Name
United Way of Western Connecticut	Lisa Alexander
Jericho Partnership	Carrie Amos
Nuvance Health, Accountable Health Communities	Kelly Bastura
Connecticut Counseling Centers, Inc. – Danbury	Stacy Benson
Nuvance Health, Population Health	Rowena Bergmans
Connecticut Institute for Communities, Inc.	Melanie Bonjour
Ridgefield Health Department	Edward Briggs
Reach, Newtown	Adam Carley
Nuvance Health, Healthcare Integration	Robert Carr, MD
United Way of Western Connecticut	Megan Chrysler
Nuvance Health, Accountable Health Communities	Lauren Cople
New Milford Health Department	Mike Crespan
Newtown Health District	Donna Culbert
Danbury Youth Services	Diane Doling
Regional YMCA of Western Connecticut	Maureen Farrell
Western Connecticut Coalition for Mental Health and Substance Use	Allison Fulton
United Way of Western Connecticut	Elizabeth Goehring
Nuvance Health, Planning	Sally Herlihy
Community Action Agency	Michelle James
Reach, Newtown	Joan Laucius

Organization	Member Name
Pomperaug Health District	Neal Lustig
Nuvance Health, Danbury Community Care Team	Kevin McVeigh
Nuvance Health, Psychiatry and Community Health	K. Tait Michael, MD
Regional YMCA of Western Connecticut	Marie Miszewski
United Way of Western Connecticut	Kim Morgan
Danbury Health Department	Lisa Morrissey
Connecticut Community Care	Sherry Ostrout
Nuvance Health, Research	Akshara Patel
Nuvance Health, Research and Innovation	Joann Petrini
The Peter and Carmen Lucia Buck Foundation	June Renzulli
Nuvance Health, Accountable Health Communities	Health Repko
Nuvance Health, Accountable Health Communities	Edmar Rocha
Nuvance Health, Homecare	Ellen Ryan
Nuvance Health, Government and Community Relations	Andrea Rynn
Danbury Youth Services	Julie Schmitter
New Fairfield Health Department	Timothy Simpkins
Brookfield Health Department	Raymond Sullivan, MD
Bethel Health Department	Laura Vasile
Connecticut Community Care	Janice Wiggins

Appendix C. Workshop participants

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

Member Name	Organization
Cornelius Ferreira, MD	Primary Care, Nuvance Health
Sandra Gianvito	Ambulatory Care, Nuvance Health
Blair Balmforth	Injury Prevention, Nuvance Health
Laurel Halloran	Western Connecticut Medical Group
Alba Wong	Early Detection & Prevention, Danbury Hospital
Lisa Morrissey	Danbury Health Department
Ellen Ryan	Riverbrook Regional YMCA, Nuvance Health
Mike Crespan	Director, New Milford Health Department
Veasna Roeun	Danbury Health Department
Donna Culbert	Newtown Health District
Neal Lustig	Pomperaug Health District
Joan Santucci	Bethel Visiting Nurses Association
Raymond Sullivan, MD	Brookfield Health Department
Kaitlin Latham	American Heart Association, Connecticut
Tim Simpkin's	New Fairfield Health Department

Mental Health & Substance Use – Lead: Alison Fulton, Western Connecticut Coalition

Member Name	**Organization**
K. Tait Michael, MD	Nuvance Health
Kim Morgan	United Way of Western Connecticut
Stacy Benson	Connecticut Counseling Centers
Kevin McVeigh	Nuvance Health

Healthy Aging – Lead: Sherry Ostrout, Connecticut Community Care

Member Name	**Organization**
Lisa Morrissey	Danbury Health Department
Rowena Bergmans	Nuvance Health
Robert Carr, MD	Nuvance Health
Ellen Ryanb	Nuvance Health

Access to Care – Lead: Kim Morgan, United Way of Western Connecticut

Member Name	**Organization**
Lisa Morrissey	Danbury Health Department
Rowena Bergmans	Nuvance Health
Melanie Bonjour	Connecticut Institute for Communities
K. Tait Michael, MD	Nuvance Health

Attachment D. WCHN community health structure

References

1 Lahart, J. (September 10, 2019). Inequality is Holding Back the US Economy. Wall Street Journal.

2 Ingraham, C. (February 6, 2018). How Rising Inequality Hurts Everyone, Even the Rich. The Washington Post.

3 CDC 6/18 Initiative: Accelerating Evidence into Action; October 2018; cdc.gov/sixeighteen/index.html

Nuvance Health

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