

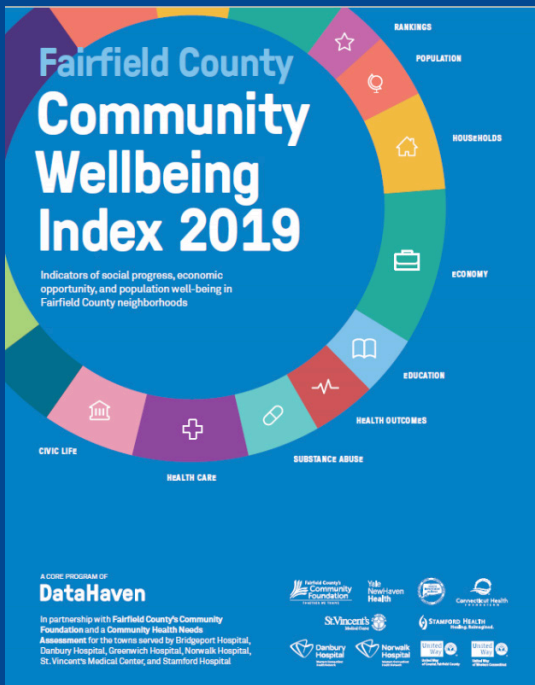


Public Health
Prevent. Promote. Protect.

Norwalk Health Department



**2019 Greater
Norwalk Region
Community
Health Needs
Assessment and
Community Health
Improvement Plan**



This report serves as the **Community Health Needs Assessment and Improvement Plan for Greater Norwalk** 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 Norwalk Hospital.



About this report

This **Community Health Needs Assessment (CHNA)** provides local level health related data about Norwalk and the surrounding towns of New Canaan, Weston, Westport and Wilton. (These towns will be abbreviated NCWWW throughout the remainder of this report though in the Fairfield County Community Wellbeing Index they are included in the grouping described as “Wealthy Towns” which, in addition to these four towns, captures Darien and Ridgefield). 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 Norwalk Hospital, now part of Nuvance Health, and local partners [listed on page 6] serving the Greater Norwalk 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 and qualitative data specific to the individual towns within the Greater Norwalk region. It also documents the process that Norwalk 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, Norwalk Hospital or any of the town health departments.

This **Community Health Needs Assessment**, including priority areas to inform the Community Health Improvement Plan, was approved by the Norwalk Hospital Board of Trustees on November 26, 2019.

The **Community Health Improvement Plan** was approved on January 28, 2020.



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Community Health Needs Assessment

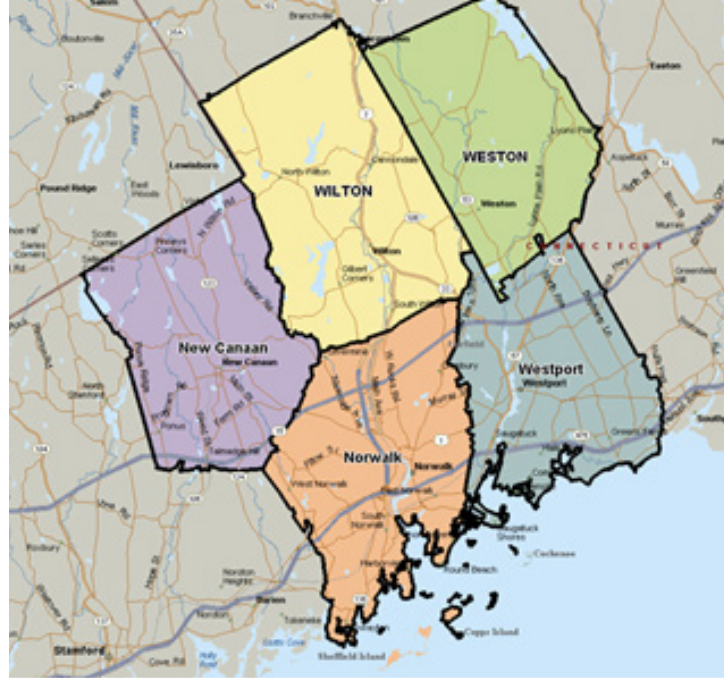


Figure 1: Map of Greater Norwalk Region

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.

Norwalk Hospital, under the guidance of the Community Health Committee, Norwalk Health Department and Greater Norwalk community partners, participated in this effort to assess the

health and social needs of the Greater Norwalk community.

Community partners:

- AmeriCare Free Clinics
- Community Health Centers, Inc.
- Darien Health Department
- New Canaan Health Department
- NAACP
- Norwalk ACTS
- Norwalk Community Health Center
- Norwalk Health Department

- Positive Directions
- Regional Behavioral Health Action Organization
- Riverbrook Regional YMCA
- Town of Ridgefield
- Westport/Weston Health District

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. Norwalk Hospital collected quantitative and qualitative data from the Greater Norwalk Region, which includes Norwalk and the towns of New Canaan, Weston, Westport and Wilton. This five-town service area reflects the regional approach taken in this assessment. Towns included in other hospital CHNAs were not included in this assessment of the Greater Norwalk region.

The assessment was conducted under the guidance of the Norwalk 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 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.

Social determinants framework

It is important to recognize that multiple factors affect health, and there is a

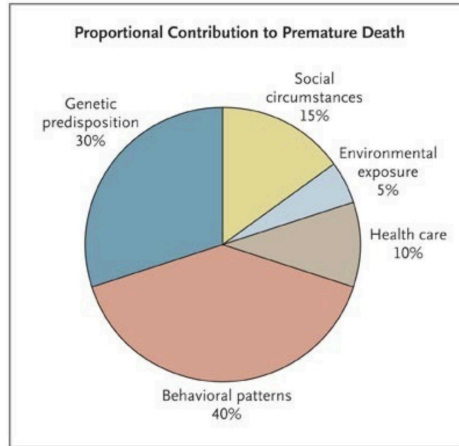


Figure 2: Determinants of health and their contribution to premature death¹

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.

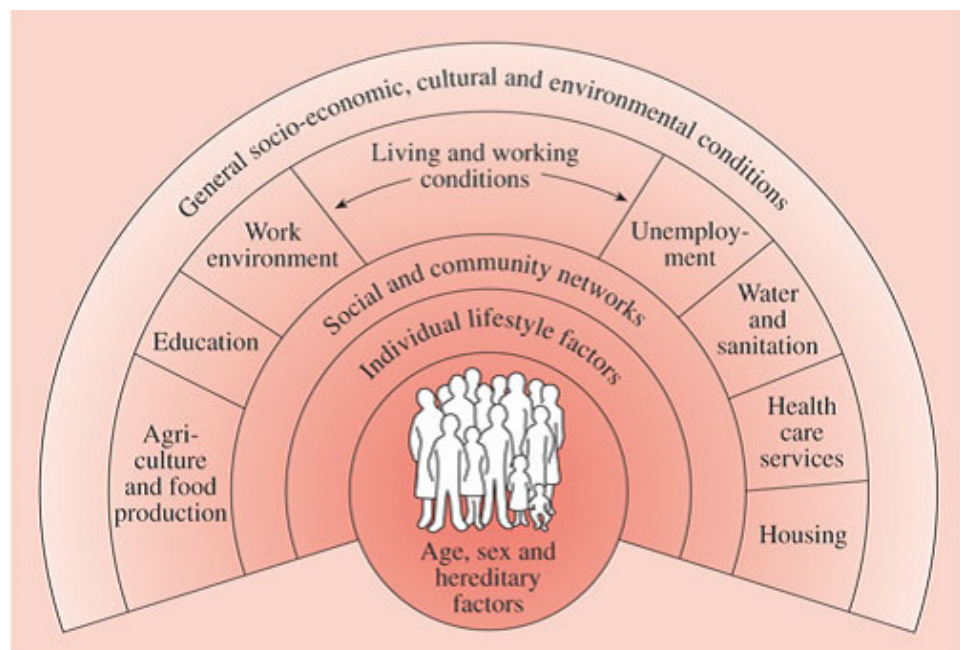


Figure 3: World Health Organization Commission on the Social Determinants of Health, 2005

Quantitative data: Selected findings

Demographics and social determinants of health

Overall population (Table 1): Population peaked in the Greater Norwalk Region in 2015 at 159,250. By 2025, that number is forecasted to decline to 151,103. Through 2035, Norwalk is the only town projected to see continued growth. That year, the town of Norwalk is expected to comprise 60% of the Greater Norwalk Region, up from 54% in 2015.

Age distribution (Table 2): The age distribution for the region is similar to that of the state of Connecticut. Across the region, 77% of the population is adults, and 46% of the population is aged 45 years and older. Norwalk has the youngest population, with over 57% below the age of 45. The most significant growth rates are seen in the 65 and over age group (Claritas, 2019).

Racial and ethnic diversity (Figure 4): Norwalk is the most diverse town in the region, with 48% identifying as minority (CT Data, 2017). The largest minority group identifies as Hispanic (27%) and 12% of residents say that English is not the primary language spoken at home, double the rate in Connecticut as a whole. This represents a marked difference from the adjacent four towns where between 85% (Westport and Wilton) and 88% (New Canaan) identify as white.

Income and employment (Table 3): The Greater Norwalk Region is characterized by substantial variation in income, with both very wealthy and less affluent households across the region and within municipalities. Median household income in the four towns surrounding Norwalk ranges from \$174,677 in New Canaan to \$219,868 in Weston (CT Data, 2017). Norwalk, at \$81,546, has

	Population by year				
	1990	2000	2015	2025	2035
New Canaan	17,864	19,395	19,742	17,687	17,651
Norwalk	78,331	82,951	85,928	87,129	89,242
Weston	8,648	10,037	9,658	8,122	7,310
Westport	24,410	25,749	26,197	22,822	21,297
Wilton	15,989	17,633	17,725	15,343	14,224
Grand total	145,242	155,765	159,250	151,103	149,724

Table 1: Population change in Greater Norwalk and towns since 1990 (CT State Data Center, 1990–2035)

	2015					
	Ages 0–4	Ages 5–17	Ages 18–34	Ages 35–64	Ages 65–79	Ages 80+
New Canaan	1,021	4,904	2,637	8,352	1,953	875
Norwalk	5,522	13,325	19,859	35,887	8,153	3,182
Weston	408	2,478	1,053	4,512	936	271
Westport	1,229	6,204	3,000	11,435	3,016	1,313
Wilton	826	4,383	2,140	7,746	1,802	828
Grand total	9,006	31,294	28,689	67,932	15,860	6,469

Table 2: Age distribution in Connecticut, Greater Norwalk, and towns, 2015

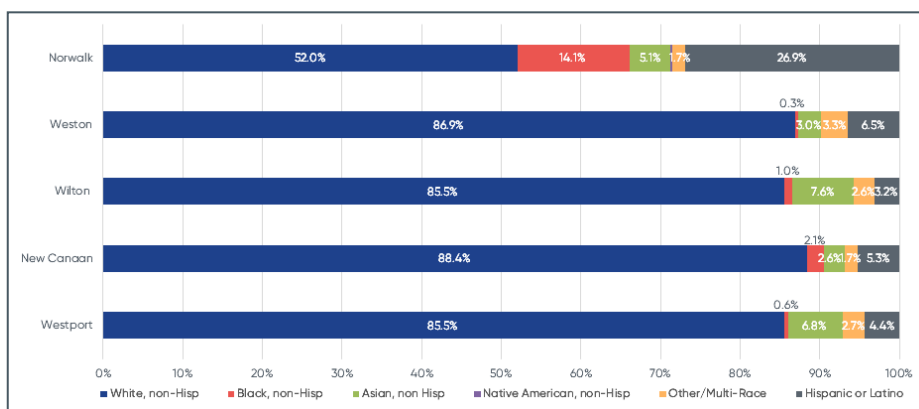


Figure 4: Population by race and ethnicity, CERC Town Profiles

less than half the median household income of New Canaan. Despite an unemployment rate below 3% across the Greater Norwalk Region (Connecticut Department of Labor), almost one-third of Norwalk residents report they are struggling financially, and only 48% rated the opportunity to obtain suitable employment as positive.

Poverty (Table 4): Poverty rates in 2017 varied throughout the Greater Norwalk Region, ranging from 2.7% in Weston to 9.2% in Norwalk, where 12.5% of children reside in households below the FPL (CT Data, 2017).

	2000	2017
Connecticut	7.9%	10.1%
Greater Norwalk	5.0%	6.6%
New Canaan	2.5%	3.7%
Norwalk	7.2%	9.2%
Weston	1.9%	2.6%
Westport	2.6%	4.3%
Wilton	2.9%	3.5%

Table 4: Poverty rates by town (Sg2/Claritas, 2017)

Education attainment (Table 5):

According to the US Census Bureau, 41% of Norwalk adults have a bachelor's degree or higher. The rates are higher in the surrounding towns, ranging from 76% in Westport to 83% in Weston.

Housing (Table 6): Home values in Lower Fairfield County are very high, contributing to the high rates of housing related financial stress. The median home value in Norwalk is \$421,900, significantly higher than the statewide average of \$270,000. Home values in the surrounding towns are at least double that of Norwalk, ranging from \$815,000 in Wilton to \$1.44 million in New Canaan. According to the CWS, 7% of Norwalk residents, or more than 6,200 people, reported not having enough money during the past year to adequately house themselves or their families. Survey respondents 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: The majority of the population in Norwalk, 83%, reported

	Median household income 1990	Median household income 2017	Change
Connecticut	\$76,106	\$73,781	\$(2,325)
Greater Norwalk	\$120,682	\$126,849	\$6,167
New Canaan	\$167,733	\$174,677	\$6,944
Norwalk	\$87,871	\$81,546	\$(6,325)
Weston	\$190,591	\$219,868	\$29,277
Westport	\$149,502	\$181,360	\$31,858
Wilton	\$159,953	\$180,313	\$20,360

Table 3: Median household income by town, 2017 (CT Data, 2017)

	No HS diploma	HS diploma only	Some college or community college	Bachelor's degree	Master's degree or higher
Connecticut	242,500	673,582	611,016	532,055	421,144
Greater Norwalk	8,851	18,148	20,918	34,731	29,665
New Canaan	377	945	1,676	5,446	4,663
Norwalk	7,881	14,051	14,719	15,141	10,435
Weston	56	440	618	2,652	2,877
Westport	279	1,948	2,128	6,799	7,284
Wilton	258	764	1,777	4,693	4,406

Table 5: Educational attainment in Greater Norwalk (CT Data, 2017)

	Owner cost burden share	Owner severe cost burden share	Renter cost burden share	Renter severe cost burden share
Connecticut	29%	12%	49%	25%
Greater Norwalk	34%	16%	49%	27%
New Canaan	32%	14%	47%	24%
Norwalk	37%	17%	52%	28%
Weston	35%	15%	42%	10%
Westport	28%	15%	40%	23%
Wilton	32%	15%	35%	23%

Table 6: Housing cost burden by town (CT Data, 2017)

feeling satisfied with their city or town, 79% felt that as a place to live the area was improving or at least staying the same. As a place to raise children, 68% described it as good or excellent. Of Norwalk residents, 74% thought the condition of the parks was good or excellent and 75% reported that there are enough sidewalks and crosswalks. However, only 65% thought there are enough safe places to bicycle.

Transportation: According to the CWS, 9% of Norwalk residents struggle with unreliable transportation, which is slightly less than the statewide rate of 12% and Fairfield County rate of 10%. Survey respondents noted that those with low income and seniors are particularly impacted by unreliable transportation.

Crime and violence: Most Norwalk residents feel safe in their homes and neighborhoods. Eight percent reported that in the past 12 months someone had tried to steal from them or vandalize their property. However, almost one-third of residents report that they do not feel safe walking in their neighborhood at night, despite the fact that 76% felt the police are doing a good job keeping them safe. Only 42% think the government is doing a good or excellent in responding to the needs of its residents.

Health behaviors

Healthy eating, physical activity, and overweight/obesity (Figures 5, 6 and 7):

Healthy eating, physical activity and weight are key drivers of health status and remain areas of significant concern. Obesity rates in Norwalk have risen from 22% to 24% since 2015, which is less striking than the increase in Fairfield County (from 22% to 27%) and statewide (from 26% to 29%). For those earning less than \$35,000 per year, the obesity rate in Norwalk jumps to 42%. Almost half of those surveyed in Norwalk report they exercise less than three times per week, and 20% say they don't exercise at all. A full 24% report it is difficult to access affordable fruits and vegetables.

KIS input indicates difficulty, particularly for the lower income groups, accessing healthy food. Access challenges were attributed to lack of time due to job and extracurricular activities, as well as difficulty finding reliable transportation.

Mental health and substance abuse

(Figures 8 and 9, Table 7): 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. Twelve percent of Norwalk residents surveyed reported they rarely or never get the emotional support they need, and seven percent reported feeling depressed more than half the time or nearly every day. Of the Norwalk population, 30% report at last one episode of binge drinking in the past month, and 18% of the population

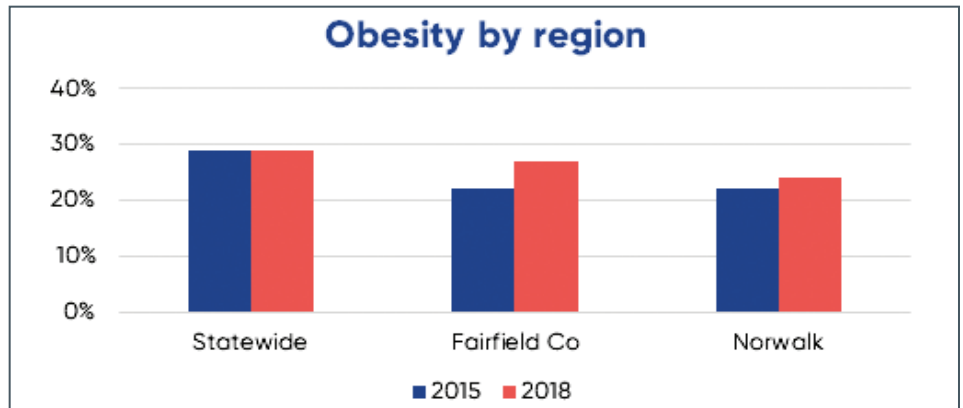


Figure 5: Obesity rates by region from 2015 to 2018 (CWS, 2018)

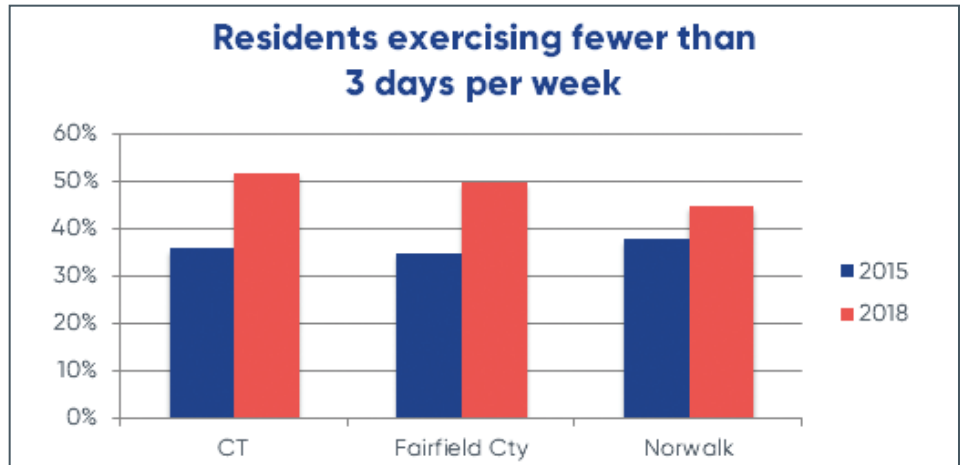


Figure 6: Exercise rates by region from 2015 to 2018 (CWS, 2018)

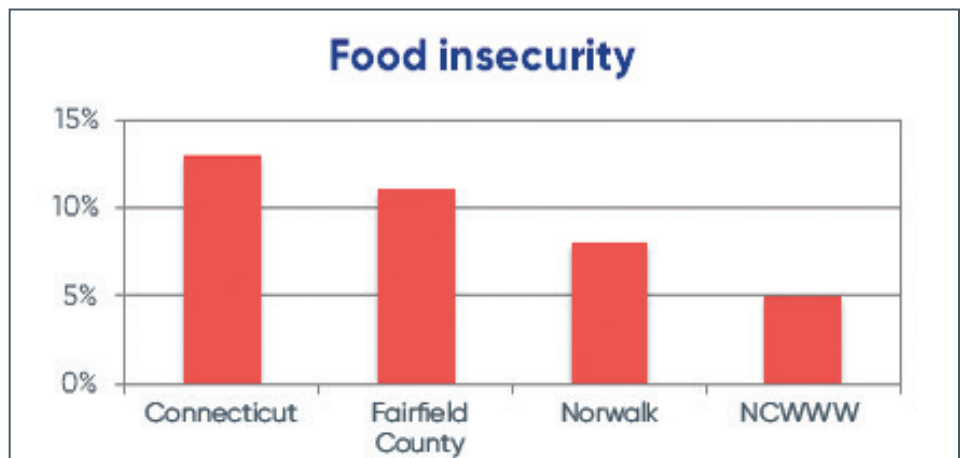


Figure 7: Rates of food insecurity by region (CWS 2018)

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, 20% of Norwalk residents reported this was "very likely or almost certain."

Smoking: Rates of smoking have improved significantly in Norwalk from 13% in 2015 to 9% in 2018. Rates of vaping, however, have increased. KIS participants report great concern by parents and schools about

the increase in vaping and the difficulty in monitoring this behavior. CWS results indicate 17% of Norwalk residents say they have tried or are regular users of vape devices. The current survey does not break this rate down by age group, but as noted in other communities and at the state level, rates of vaping are dramatically higher in the 18 to 34 age group.

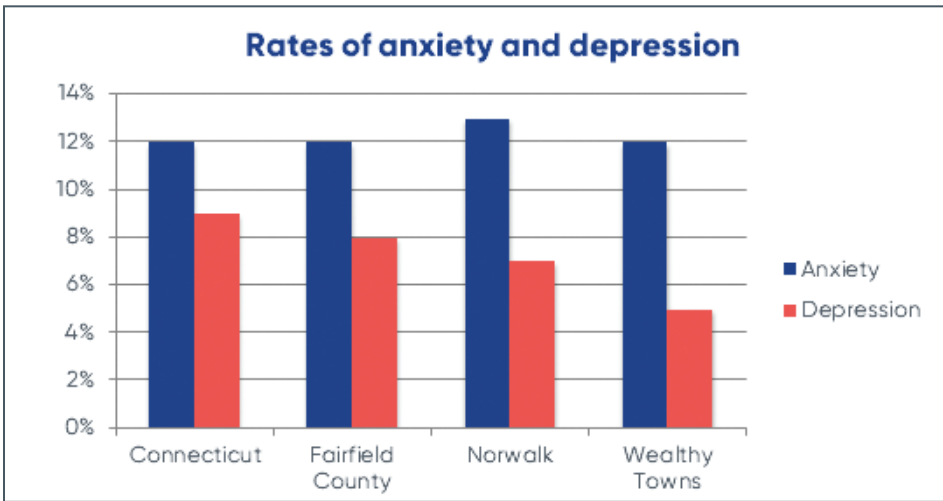


Figure 8: Rates of anxiety and depression by region (CWS, 2018)

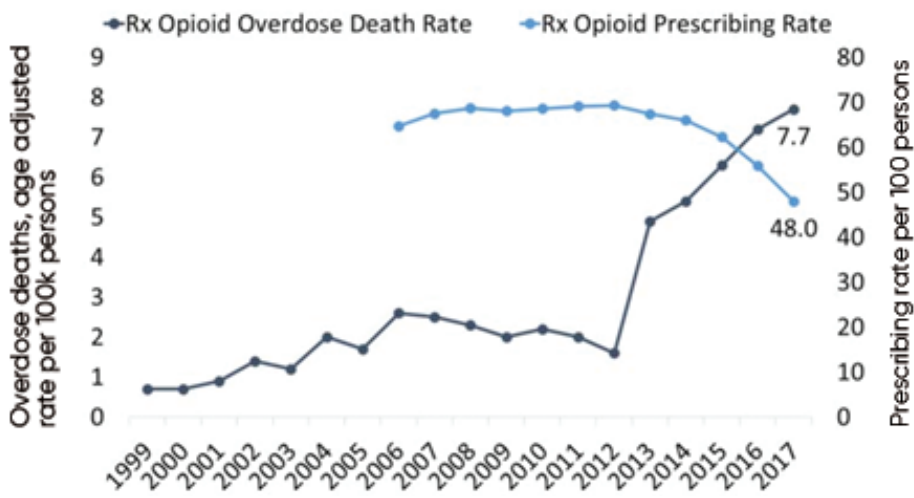


Figure 9: Connecticut rate of overdose deaths involving prescription opioids

	Deaths in 2017	Deaths in 2018
Norwalk	14	8
New Canaan	1	1
Weston	0	1
Westport	2	2
Wilton	0	2
Grand total	17	14

Source: Office of the Chief Medical Examiner

Table 7: Accidental drug intoxication deaths in Greater Norwalk, 2017–2018

Health status of the community

Perceived health status (Figure 10): In the CWS, 62% of those in Norwalk report their health is very good or excellent. This is similar to the 63% in Fairfield County but significantly lower than the 76% of residents in the NCWWW towns. Norwalk, while higher than the rating for the state as a whole, shows a decline from 2015. Of the KIS, only 47% assessed their health as “very good” or “excellent.”

Overall leading causes of death and hospitalization (Table 8): In Norwalk, high blood pressure is the most common reason for a hospital encounter when looking at age-adjusted rates. Diabetes and heart failure are the second and third most common reasons. Next most common were anxiety disorders and depressive disorders. High blood pressure, accidents/falls, and diabetes comprise the top three conditions for emergency room visits that did not result in admission.

Chronic disease (Figure 11): Chronic diseases impact life satisfaction and cause significant economic burden in the form of opportunity cost and healthcare expenditure. According to the CWS, hypertension rates in Norwalk have increased since 2015, from 21% to 26%. This compares slightly favorably to Fairfield County and the State, with rates of 28% and 30%, respectively. Diabetes rates in Norwalk and the rest of Fairfield County have increased from 7% to 9%. Asthma rates in Norwalk have improved from 13% to 11%. KIS participants cited chronic diseases and obesity as priority concerns, along with mental health and substance abuse.

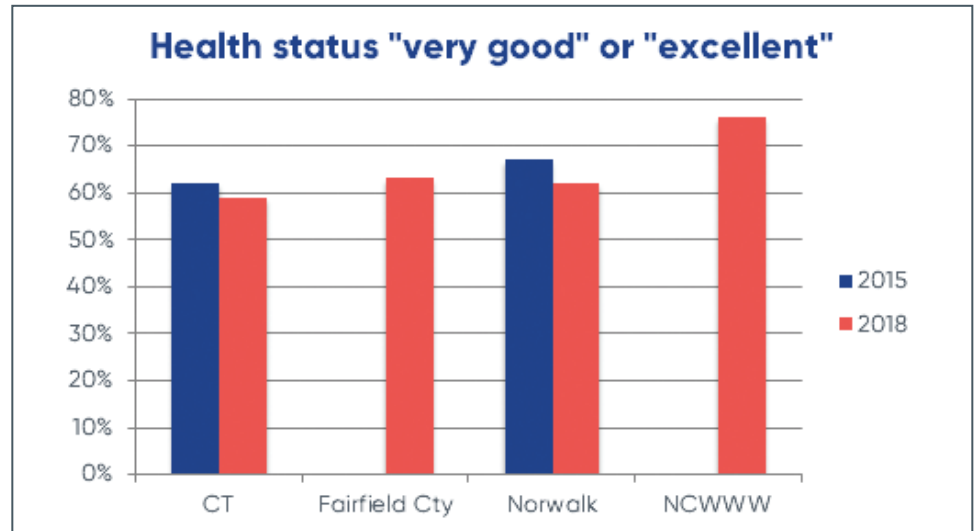


Figure 10: Self-rated health status as very good or excellent (CWS, 2015, 2018)

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. Alcohol-related disorders
5. Depressive disorders	5. Accidents – motor vehicles

Table 8: Top five conditions for hospital utilization, FY19 (CHA, Norwalk community profile)

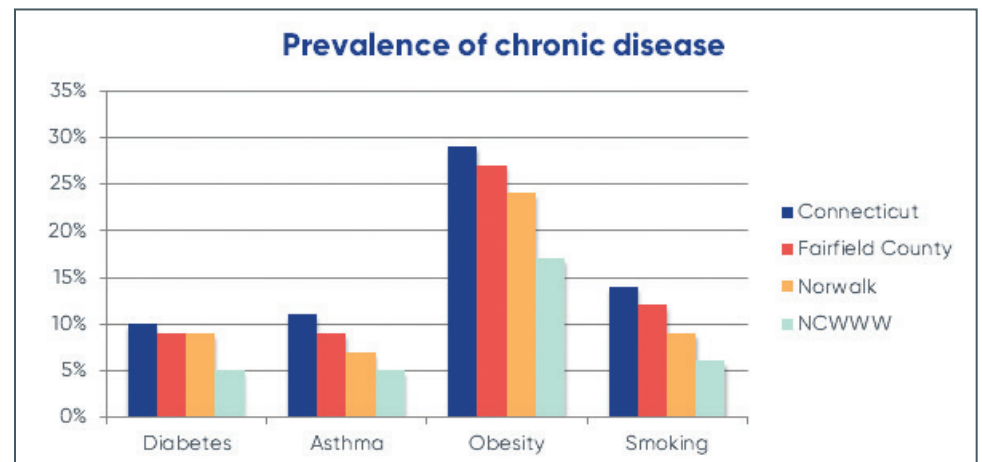


Figure 11: Prevalence of chronic diseases by region (CWS, 2018)

Health access and utilization

Resources and use of health care services:

The Greater Norwalk Region is seen as having substantial health resources, including the hospital, community health centers, health clinics, and various healthcare organizations. In addition, the Riverbrook YMCA, senior centers, and school based programs throughout the region play an important role in advancing public health.

Of the key informants surveyed, 82% believe access to quality health care has improved or at least remained the same over the last three years. They also note that significant strides have been made

in developing community partnerships working together to advance wellness.

Challenges in accessing health care services:

The majority of area residents, 95% in Norwalk and 94% Fairfield County as a whole, have health insurance. Despite the high rates of insurance coverage, 16% of Norwalk residents say they do not have a medical home. This compares unfavorably with Fairfield County and the rest of the state, with rates of 13% and 11%, respectively. Of those earning less than \$75,000 per year, a full 30% say they do not have an identified primary care physician. Postponing medical care

often magnifies the progression of chronic disease and adds to overall cost burden. This trend has remained steady, with 20% reporting in 2018 that they postpone care, compared with 19% in 2015.

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 out-patient and preventive care. The system is worst for recent immigrants, who lack insurance and often have language barriers.



Qualitative data: Key informant surveys

Introduction and methods

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 American Free Clinics in Norwalk. 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.

In Greater Norwalk, the majority of the responses were received from New Canaan as a result of very effective outreach by the New Canaan Health Department. While The Strategy Group found the outcomes with and without the New Canaan responses to be similar, this should be considered a limitation to the wider applicability of the online survey.

Interviews and focus groups	Online survey (955 responses)
<ul style="list-style-type: none"> • 12 individuals interviewed (119 people) • 6 focus groups (67 people) • Special meeting: New Canaan Community Foundation (40 attendees) 	<ul style="list-style-type: none"> • New Canaan: 834 • Norwalk: 77 • Ridgefield: 12 • Westport: 4 • Weston: 22 • Wilton: 6



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 Norwalk 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. Connecticut is the seventh oldest state in the country and the rising cost of housing impedes many senior residents who want to stay in their homes. There are limited affordable, independent housing options that are appropriate for aging in place and the social service agencies for seniors are overstretched. 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. 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 and suicidal thoughts.

Residents in all communities continue to struggle with substance abuse, most notably alcohol, heroin, prescription opioids, 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 though 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 are more reports of hoarding. Several health directors reported spending their time addressing the urgent issues of hoarding, blight, suicide and sexually transmitted disease such that chronic disease prevention is pushed aside. Health departments expressed interest in partnering with Norwalk Hospital to increase 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. Norwalk Community Health Center, AmeriCare Free Clinics and the Community Health Centers Inc. striving to provide quality health care to low-income, uninsured patients on a daily basis but as one participant noted, *"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)	56.2%	31.8%	6.7%	1.0%	4.3%
Dental care	73.3%	19.6%	3.4%	1.6%	2.1%
Mental and behavioral health services	26.8%	28.2%	14.0%	3.9%	27.2%
Substance abuse services	20.5%	22.6%	10.9%	1.7%	44.4%

Table 9: Specialty care

Online survey findings

The majority of the respondents were women (67%), Caucasian (85%) and over 55 years of age (61%). 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. Almost half (47%) of the Greater Norwalk respondents described their overall health as excellent and only 1% described their health as poor. Greater Norwalk area respondents were generally positive about their ability to access specialty care.

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

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

Respondents ranked the barriers to good health:

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

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. However, they were more likely to cite cancer as the top concern.

Summary of the qualitative data

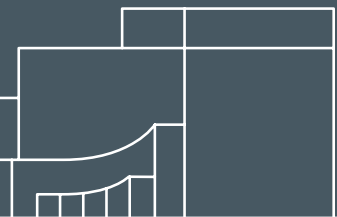
In 2016 the key findings and health priorities identified in the Greater Norwalk area **Community Health Needs Assessment** were chronic disease/obesity, mental health/substance abuse and access to health care. Three years later, while there have been improvements in community partnerships, attention 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 socio-economic 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 (now NuVance Health) 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. NuVance Health 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.



18 Discussion

Progress from the 2016 Community Health Improvement Plan

Chronic disease and obesity prevention: Healthy for Life Project

The **Healthy for Life Project (H4LP)** was established in 2012 as part of the Greater Norwalk Community Health Improvement Plan. It has grown in scale and currently involves 41 individuals and 28 organizations with the mission to reduce and prevent obesity and chronic disease by promoting healthy lifestyles.

The H4LP has made significant progress since its inception and particularly since the most recent Community Health Improvement Plan in 2016. The four primary projects include: 1.) The Eat Well Healthy Restaurant Program, 2.) The NorWalker program, 3.) The Move More in Schools project and 4) The Food Access program.

The **Eat Well Healthy Restaurant Program** is now in 25 locations including 13 in Norwalk, five in Westport and nine in Fairfield. Successes include positive feedback from establishment owners and diners in the participating restaurants and particularly from parents when there are child-friendly options available. Wider adoption by restaurants has been challenging due to the initial time required for the recipes to be vetted. It has also been challenging to find healthy children's options since kids' menus often involve fried food.

The **NorWalker Project** has been an effort to educate residents about the benefits of exercise and to

encourage increased physical activity by offering vetted city walking paths with maps. Successes include redesign of 16 maps, the addition of one new map in English and five maps translated into Spanish. This program was awarded the Best Place to Live-Work-Play Car-Free award by the Business Council of Fairfield County, received recognition from the US Department of Transportation Mayor's Challenge for Safer People and Safer Streets, and was invited to present at the America Walks National Walking Summit. The NorWalker program actively supports the Bike/Walk Commission advocating for safer biking and walking routes throughout Norwalk. Sustaining the organized community walks has been challenging despite the active participation by Norwalk Mayor Rilling who often leads walks on the weekend.

The **Move More in Schools Toolkit** is a polished and user-friendly guide for teachers to incorporate short bursts of physical activity into the school day. This is especially useful as recess and gym time continue to shrink. One challenge has been to broaden adoption by the teachers who have many different competing initiatives and limited time. Additional challenges have been keeping the toolkit up to date and finding the resources to dedicate to expansion of this program.

The **Food Access initiative** began in the spring of 2019. The program has made significant strides in a short period of time starting with convening community partners and the organization of five planning meetings. Goals included analyzing the emergency food system in Norwalk,

identifying priorities for improvement and implementing programs such as Supporting Wellness at Pantries (SWAP) and increasing enrollment in SNAP. The committee developed a four language Food Access Guide directing residents to food pantries and available meal services. A Community Food Access Report is almost complete and will help identify food insecurity in vulnerable populations. The primary challenge with the Food Access initiative is sustainability.

Mental health and substance abuse subcommittee

The Mental Health and Substance Abuse Subcommittee of the Community Health Committee was organized in 2012 following the CHNA of that year. It has guided the development of several community health programs, which 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. The program also addresses 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) into 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 Norwalk Community Care Team (NCCT) was started in 2012 as a collaborative between Norwalk Hospital and Norwalk Housing First. 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 Norwalk. The CCT has served more than 350 people providing connection to needed primary care, mental health, addiction and social services. Efforts of the CCT 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, Norwalk Hospital added a Peer Recovery Specialist to the Greater Norwalk 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.

Strengths

Norwalk 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, Norwalk Hospital as part of WCHN 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. Building on the Behavioral Health Integration Program, screening and brief intervention will be available in all primary care practices in the WCHN region including four offices in the Greater Norwalk area. 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 in is the 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. Norwalk Hospital was fortunate to be included in this successful and innovative program beginning in the fall of 2019.

To better meet the needs of patients at risk for opioid use disorders, Norwalk Hospital as part of WCHN, 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.

Norwalk Hospital participates in the Accountable Health Communities program. In 2017, the Centers for Medicare and Medicaid Innovation (CMMI) awarded Danbury Hospital of WCHN the Accountable Health Communities Grant. This five-year, \$4.5 million grant, screens Medicare and Medicaid beneficiaries for access to transportation, food, housing, utilities and treatment for domestic violence. Those who screen positive for these social determinants of health receive resources or are connected to a Navigator. There is growing evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs.

Nuvance Health including Norwalk Hospital has several innovative programs to meet the needs of area seniors. WCHN employees—care managers and Emergency Management Services (EMS)—saw a need and an opportunity to improve the clinical management of falls. They developed the Lift Assist program, which provides previously unavailable EMS data to the patient's primary care provider to address causes of the fall. The team is partnering with local agencies to create a Network community team that will discuss identified individuals who frequently request emergency service assistance after a fall at home as well as other patients identified by community partners. The team meets weekly to discuss patients and develops appropriate action plans.

The Senior Care Team began in 2018 to address the needs of vulnerable elderly patients in Greater Norwalk. This team was modeled after the CCT with the goals of identifying vulnerable residents, assessing needs and working with community agencies to provide services. This team meets weekly in the Norwalk Community and brings together community agencies with expertise to meet the need of seniors.

Norwalk Hospital is involved in two additional programs addressing the social determinants of health. RoundTrip offers those with limited access to transportation the ability to get to medical appointments. The program is

accessible through a phone application or a phone call and rides are easily monitored and available promptly. Early results show significant decrease in appointment no-show rates.

The Healthy Savings Program was initiated by United Way to assist low income residents who do not qualify for SNAP benefits. Norwalk Hospital participates in this program that 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 Norwalk 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.^{2,3}

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.

Norwalk Hospital is dependent on partnership with these agencies to support prevention, chronic disease management and behavioral health intervention services.

Access to specialty care services for those who are under-insured 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.

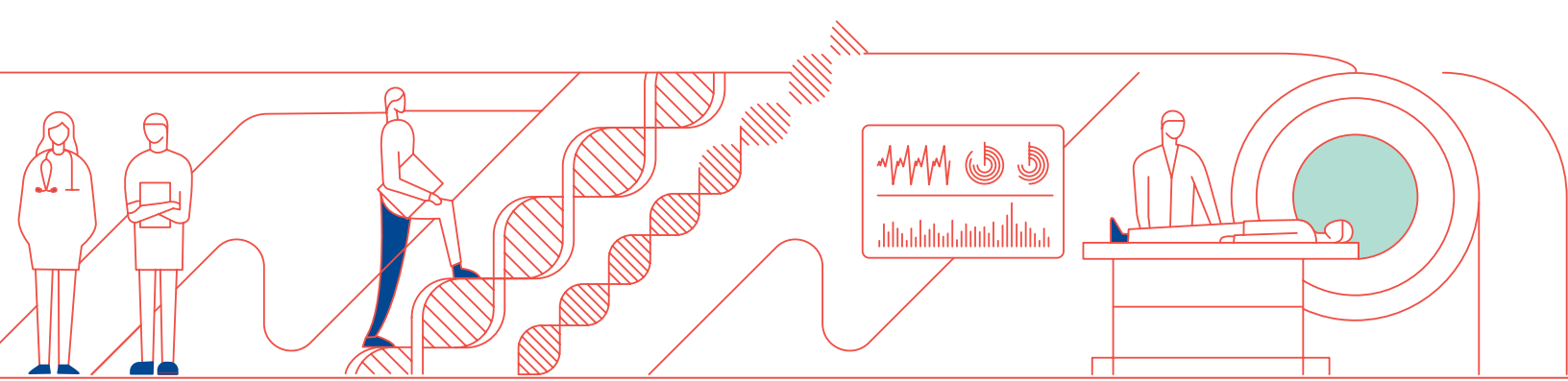
Norwalk Hospital through the Greater Norwalk CHNA is invested in alignment with the CDC 6/18 Initiative (Attachment). This program focuses on six common health conditions using 18 interventions: 1.) Reduce tobacco use; 2.) Control high blood pressure; 3.) Improve antibiotic use; 4.) Control asthma; 5.)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

Summary and conclusions

Norwalk 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 rate of food insecurity in Norwalk, many measures have continued to worsen. Obesity diabetes and hypertension continue to increase and the number of residents in Norwalk without an identified medical home is higher than in Fairfield County and the state. Falls remain a major cause of infirmity, loss of quality of life and healthcare expense. Opioid overdose rates continue to climb and access to addiction treatment remains challenging.

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 under-insured; 3.) align with state and national initiatives where the potential for synergy exists.

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Community Health Improvement Plan

The 2019 Greater Norwalk **Community Health Improvement Plan (CHIP)** was developed over the period of September 2019 through January 2020, using the key findings and identified priorities from the **Community Health Needs Assessment (CHNA)**. The Greater Norwalk 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 Norwalk Region and will serve as a roadmap for implementation.

Norwalk Hospital, in collaboration with the Norwalk Health Department, led the development of the CHIP, with participation from community partners.

The Community Health Committee (CHC) of the Norwalk Hospital Board provided oversight of the process. Members of the Norwalk Hospital CHC can be found in Appendix B. Workgroups were convened for each of three priority areas 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 C.

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 Norwalk 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 12: 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 Norwalk 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, Norwalk Hospital and Norwalk Health Department were the convening organizations that brought together community agencies, 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 12). 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 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 C for workgroup participants.

Workgroups for the three 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.

The workgroup to address Access to Care met on January 7, the Mental Health and Substance Use group met on January 10 and the Chronic Disease/Obesity

Prevention Workgroup met on January 14. The workgroups developed proposed goals, objectives and strategies for their specific priority area, which they then forwarded to the larger Community Health Committee for review and comment. These plans were presented to and endorsed by the WCHN CHC on February 7, 2020.

Overview of the implementation plan

Priority	Goal	Objective(s)	Collaborating community partners
Chronic disease/obesity	Reduce and prevent obesity and chronic disease in our community by promoting healthy lifestyles	<ul style="list-style-type: none"> Increase the number of children and adults who meet physical activity guidelines Increase community knowledge of and access to healthy and affordable foods 	Healthy for Life Project, Norwalk Hospital, Norwalk Health Department, Riverbook YMCA, Norwalk Public Schools, Norwalk ACTS, others
	Prevent the onset of chronic disease, and increase chronic disease self-management skills in our community	<ul style="list-style-type: none"> Expand screening and risk assessment programs (e.g., Know Your Numbers–KNY) Increase number of chronic disease self-management programs in the community 	Healthy for Life Project, Norwalk Hospital, Norwalk Health Department, Riverbrook YMCA, American Heart Association, others
Mental health and substance use	Improve access to appropriate behavioral healthcare for adults and children	<ul style="list-style-type: none"> Identify lower risk and needs populations and provide short-term treatment Identify highly vulnerable populations and connect to care 	Regional Behavioral Health Action Organization (The Hub), Norwalk Community Care Team (CCT), WCMG primary care providers, Positive Directions, Norwalk ACTS
	Provide education on mental health and substance use to increase awareness and promote prevention	<ul style="list-style-type: none"> Provide access to information and resources that reduce stigma, enhance awareness and encourage early identification of behavioral health issues Educate providers about the treatment of SUDs and increase provider awareness of available resources and programs for mental health and addiction treatment 	Regional Prevention Council, Norwalk Hospital Emergency Department (ED) and Emergency Medical Services (EMS, Norwalk Hospital Pharmacy, Norwalk Health department
Access to care	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	<ul style="list-style-type: none"> Screen for and address gaps in social determinants of health such as food insecurity, transportation difficulties and unstable housing Increase access to specialists for uninsured and Medicaid beneficiaries Increase available resources for pediatric population specially immigrant children who require primary care, school physicals and BH services 	Federally qualified health centers, e.g., Norwalk Community Health Center (NCHC) and Day Street Community Health Center, Americares Free Clinics, primary care providers, Norwalk Health Department

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 and obesity prevention

Goal 1: Reduce and prevent obesity and chronic disease in our community by promoting healthy lifestyles

Indicator: Percentage of overweight and obese adults in the community (Baseline 2015, 2018 CWS)

Indicator: Percentage of children in sixth grade with healthy BMI (Norwalk Student BMI Report)

Indicator: Percentage of adults exercising three to four times per week (Baseline 2015, 2018 CWS)

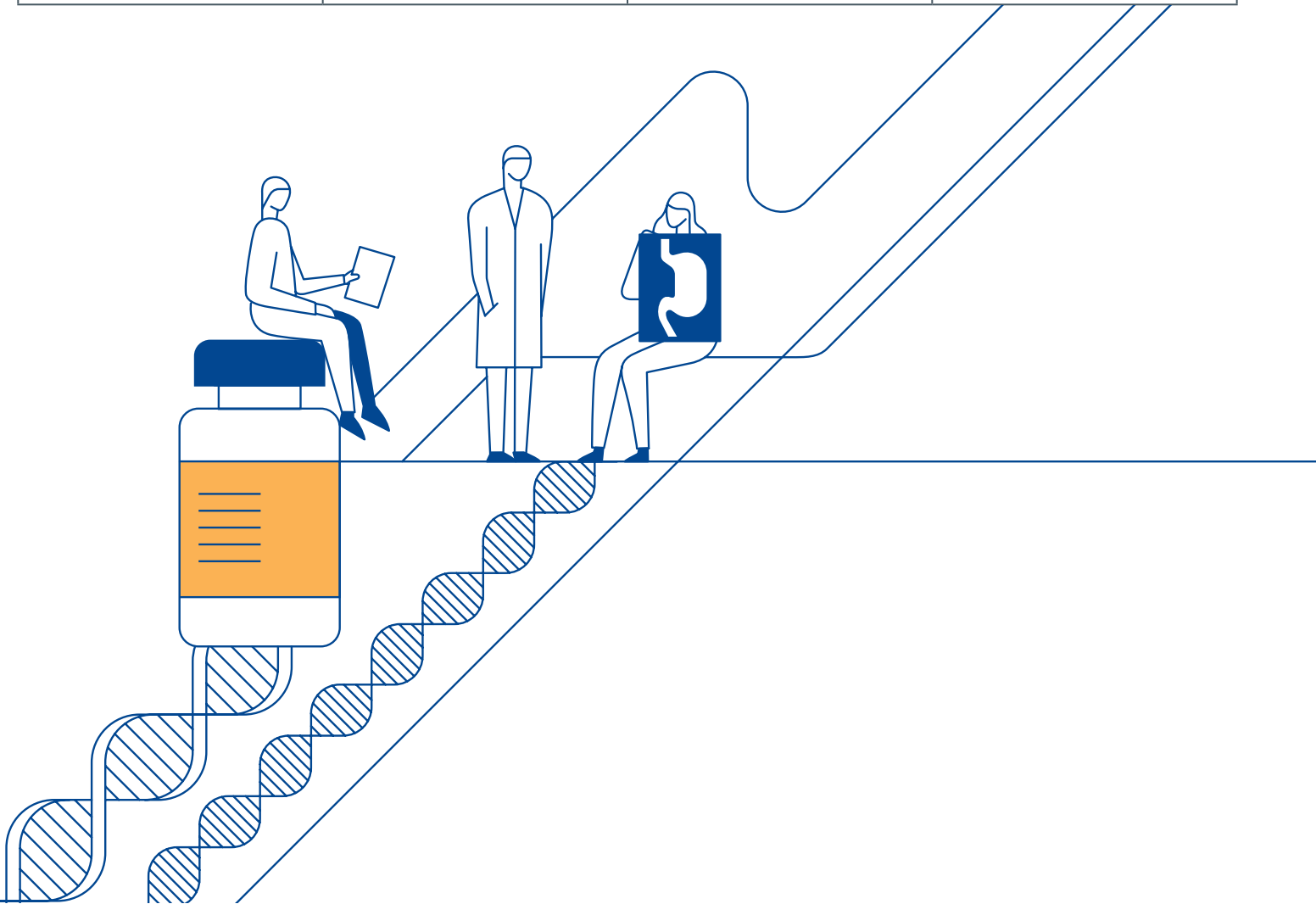
Objective	Strategy	Action steps	Short-term indicators
Increase the number of children who meet physical activity guidelines	<ul style="list-style-type: none"> Explore physical activity opportunities for young children Support Norwalk Public Schools District Wellness Committee efforts to promote physical activity Incorporate more physical activity opportunities for children outside of the school setting 	<ul style="list-style-type: none"> Compile and distribute early childhood physical activity recommendations to providers Review Board of Ed policies related to physical activity Promote physical activity in the school day and with out-of-school time providers 	<ul style="list-style-type: none"> Number of educators receiving recommendations and resources Increase number of physical activity opportunities in school, out-of-school time, and in early childhood education Updated Norwalk Public Schools physical activity policy
Increase the number of adults who meet physical activity guidelines	<ul style="list-style-type: none"> Promote and expand the NorWALKer program, utilizing potential technology solutions Implement or expand strategies for physical activity in seniors Continue to support Norwalk Bike/Walk Advisory Commission to promote pedestrian infrastructure Create new and strengthen existing partnerships with Norwalk Department of Recreation and Parks 	<ul style="list-style-type: none"> Translate five additional maps into Spanish Explore and implement technology solutions to help increase NorWALKer map utilization Facilitate community-led walking groups Provide subject matter expertise and support to Norwalk Bike/Walk Advisory Commission to promote increased pedestrian infrastructure and active transportation 	<ul style="list-style-type: none"> Number of people accessing maps online Number of printed maps distributed Number of community walks held Number of community members participating Number of pedestrian safety improvements implemented
Increase community knowledge of access to healthy and affordable foods	<ul style="list-style-type: none"> Increase awareness of access to nutrition education programs and resources Implement environmental, policy or systems changes to improve access to healthy foods 	<ul style="list-style-type: none"> Expand Eat Well Healthy Restaurant initiative Complete and distribute a community food system assessment Conduct community outreach campaign to increase awareness of and enrollment in SNAP Pilot nutrition education program in food access agencies 	<ul style="list-style-type: none"> Number of new restaurants enrolled in Eat Well Healthy Restaurant Program SNAP enrollment among eligible residents Number of food agencies piloting nutrition education programs Healthy options at food pantries and other charitable food agencies

Goal 2: Prevent the onset of chronic disease, increase chronic disease self-management skills in our community

Indicator: Admissions to Emergency Department (ED) and inpatient (IP) related to chronic disease

Indicator: Self-reported rates of diabetes, hypertension, heart disease (Baseline 2015, 2018 CWS)

Objective	Strategy	Action steps	Short-term indicators
Increase awareness of chronic disease risk factors and prevention strategies among community members	<ul style="list-style-type: none"> Expand screening and risk assessment programs in the community Strengthen partnerships with health care providers to ensure appropriate education, counseling and referral systems at community-based screenings 	<ul style="list-style-type: none"> Establish workgroup/team to develop comprehensive chronic disease prevention/management strategies Create inventory of existing programs and resources Create communications campaigns to boost participation 	<ul style="list-style-type: none"> Number of screening programs offered Number of participants in screening programs
Increase access to evidence-based chronic disease prevention and self-management programs in the community	<ul style="list-style-type: none"> Expand and promote Live Well program and/or other chronic disease self-management programs 	<ul style="list-style-type: none"> Create inventory of existing programs and resources Develop strategy to increase PCP awareness of/referrals to programs 	<ul style="list-style-type: none"> Increased number of PCPs making referrals Increased number of locations offering programs Increased number of participants in programs



PRIORITY AREA 2: Mental health and substance use

Goal 1: Improve access to appropriate care for adults and children

Indicator: Increased enrollment in behavioral health prevention and intervention activities

Indicator: Self-reported rates of anxiety, depression (Baseline 2015, 2018 CWS)

Indicator: Number of ED visits and IP admissions related to behavioral health

Objective	Strategy	Action steps	Short-term indicators
Identify lower risk/lower needs populations and provide or connect to appropriate short-term treatment	<ul style="list-style-type: none"> Expand use of Screening and Brief Intervention Leverage technology solutions Utilize the brief group therapy model to address mental health and addiction issues Support community level non-clinical interventions Approach treatment of SUDs using chronic disease model 	<ul style="list-style-type: none"> Implement SBIRT into Nuvance Primary Care Practices in Connecticut Implement UniteUs referral platform Partner with community agencies to organize and implement short-term skills groups and Smart Recovery Groups with focus on special populations (teens, parents, seniors) using culturally sensitive strategies Partner with community agencies to support longer term community-based programs promoting mental health and addiction recovery Implement pilot SUD bundled payment program 	<ul style="list-style-type: none"> Number of practices incorporating SBIRT Number of community providers using UniteUs Assessment of community groups and draft plan for alignment of goals Implementation plan for SUD bundle
Identify highly vulnerable populations and connect to care	<ul style="list-style-type: none"> Enhance and scale CCT model Leverage and expand Recovery Coach model Expand substance and Dual Diagnosis treatment programs Identify needs and support vulnerable immigrant residents Support and assist peer respite for mental health and addiction issues 	<ul style="list-style-type: none"> Implement web-based tool to assist with linkage to services and to communicate with CCT members and agencies Continue to expand use of ED-based recovery coaching and develop plan for sustainability of CCAR model at Norwalk Hospital; explore funding for peer-based mental health coaching Implement Dual Diagnosis IOP Partnering with the Norwalk Health Department and community agencies, develop plan to address needs of immigrant children and families 	<ul style="list-style-type: none"> Implement either UniteUs or similar communication tool Number of people referred from ED to SUD treatment program Dual Diagnosis IOP implemented by summer 2020 Review Norwalk ACTS and MFCG goals and align priorities

Goal 2: Provide education on mental health and substance use to increase awareness and promote prevention

Indicator: Number of area practices providing screening and brief interventions

Indicator: Number of area providers offering MAT

Indicator: Rate of opioid related deaths reduced in our region (2015, 2018 Source Office of CME)

Objective	Strategy	Action steps	Short-term indicators
<p>Provide access to information and resources to enhance awareness and encourage early identification of behavioral health issues</p>	<ul style="list-style-type: none"> • Increase community awareness of MH/SA services and resources available • Hold/participate in community workshops or awareness events • Enhance partnership with area health departments and health districts 	<ul style="list-style-type: none"> • Develop annual plan and schedule of events and identify hospital representative to update community accessible calendar; allot time in CHC meetings to review community wide events • With community partners, develop and participate or host educational forums: SUDs, mental illness, trauma, immigrant needs • Review membership of the Community Health Committee for adequate representation of Greater Norwalk towns and local prevention councils 	<ul style="list-style-type: none"> • Identify hospital representative by April 2020 • Host at least one educational training program annually • Update CHC membership list annually
<p>Educate providers about the treatment of SUDs and increase provider awareness of available resources and programs for mental health and addiction treatment and programs</p>	<ul style="list-style-type: none"> • Educate providers about benefits of screening and brief intervention • Encourage providers to become certified for MAT • Distribute information to PC and pediatric offices in the region • Promote safe storage and disposal of medications 	<ul style="list-style-type: none"> • Provide SBIRT training to PCPs and pediatricians • Offer and financially support providers to attend MAT simulation training programs • Develop standardized, updated information to providers • Offer information about the Detera drug deactivation system 	<ul style="list-style-type: none"> • Obtain option for providers to receive CME for SBIRT training • Develop sustainability plan for high-risk opioid navigation • Distribute MAT and SBIRT information to local providers • Disseminate information about drug take-back opportunities

PRIORITY AREA 3: Access to care

Goal 1: 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: Maintain or reduce rate of uninsured (Baseline 2015, 2018 CWS)

Indicator: Increase percentage of residents who identify a medical home (Baseline 2015, 2018 CWS)

Indicator: Reduce appointment wait times and no-show rates for specialty care for Medicaid beneficiaries

Objective	Strategy	Action steps	Short-term indicators
Screen for and address gaps in social determinants of health such as food insecurity, transportation difficulties and unstable housing	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Implement UniteUs Expand Healthy Savings Program for ALICE population Expand RoundTrip 	<ul style="list-style-type: none"> Number of community programs using UniteUs Number of participants using Healthy Savings Program Number of sites served by RoundTrip Program
Increase access to specialists for uninsured and Medicaid beneficiaries	<ul style="list-style-type: none"> Implement e-consult capabilities for specialty referral Further develop tele-psychiatry services with local Federally Qualified Health Centers (FQHC) 	<ul style="list-style-type: none"> Explore reimbursement opportunities Address tele-health strategies through BH service line 	<ul style="list-style-type: none"> Determine number of payers reimbursing for e-consults Advocate with CHA for Medicaid reimbursement for e-consults Number of NH psychiatrists participating in tele-psych program
Increase available resources for pediatric population, specifically immigrant children who require primary care, school physicals and BH services	<ul style="list-style-type: none"> Explore options for increasing access to school physicals Increase BH partnerships through the FQHCs 	<ul style="list-style-type: none"> Collaborate with health department and school system to provide school physicals Support Red Card training, know your rights Explore expanded relationship with Child Guidance Center of Southern CT 	<ul style="list-style-type: none"> Investigate option of including school physicals in Norwalk Mission Health Day Ensure that FQHCs are represented in the CHC Include immigrant access to care as discussion item at CHC meetings

Planning for action and monitoring progress

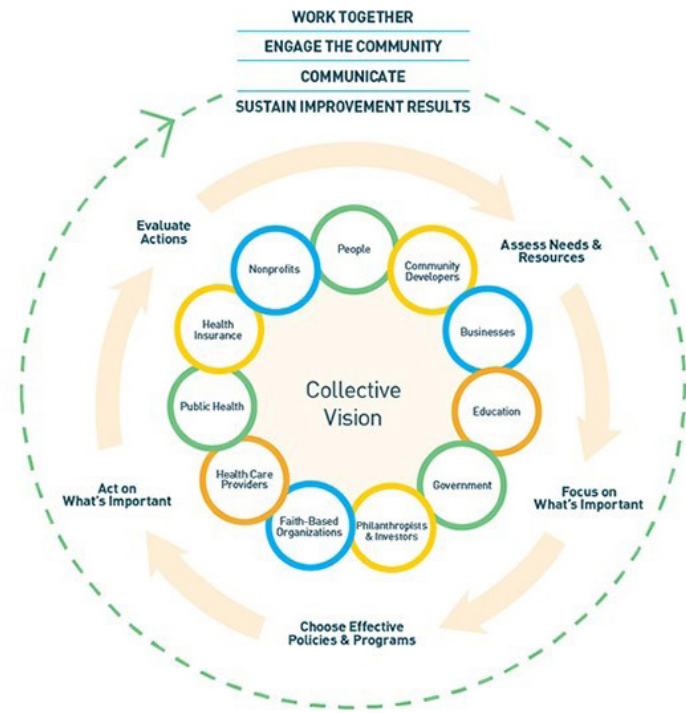


Figure 13: Collective vision. *Source:* County Health Rankings and Roadmaps Action Cycle

The Norwalk (CHC) was created during the community health planning process in the Greater Norwalk 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

Progress on the 2019 CHIP and implementation strategies will continue to be monitored at routine workgroup meetings, and will be reported regularly to the Norwalk CHC. The Norwalk CHC, made of community members and representatives from community health organizations, will meet on a quarterly basis, and report at least annually to the Norwalk 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 Norwalk, New Canaan, Weston, Westport, Wilton**
- **Norwalk Early Childhood Community Maps**
- **CT Trail Census**
- **Healthy Restaurant Program Video Campaign**
- **CDC 6/18 Initiative: Accelerating Evidence into Action; October 2018; (cdc.gov/sixteen/index.html)**

Attachment A. Interview and focus group participants

Individual interviews

1. Anthony Allison, Chief Initiatives Officer, Norwalk ACTS
2. Adam Bovilsky, Executive Director, Norwalk Housing Authority
3. Mendi Blue-Paca, VP, Community Impact, Fairfield County's Community Foundation
4. Mark Cooper, Director of Health, Weston and Westport
5. Deanna D'Amore, Director of Health, Norwalk
6. Dr. Howard Eisen, Volunteer with AmeriCares Free Clinics
7. Rev. Mark Lingle, St. Francis Episcopal, President of Interfaith Council of Southwestern CT
8. Dr. Ari Perkins, Volunteer with AmeriCares Free Clinics
9. Nour Qinawi, Islamic Culture Center of NY, Stamford
10. Veronica Sullivan, RN, Director, AmeriCares Free Clinics (Norwalk)
11. Jeff Wieser, Executive Director, Homes with Hope
12. Lisa Roger, Choice Neighborhood Partnership Director, Norwalk Housing Authority

Focus groups

AmeriCares Free Clinic focus group (Spanish speaking parents)
9 parents

Gini's House
9 women

New Canaan community representatives

1. Jenn Eielson, Director of Health, Town of New Canaan
2. Bill Flynn, Director, New Canaan Nature Center
3. Carol McDonald, Director of Human Services, Town of New Canaan
4. Kevin Moynihan, First Selectman, Town of New Canaan
5. Tucker Murphy, Director, Chamber of Commerce
6. Lynn Aspinwall, Program Manager, Lapham Community Center-Elderly Services
7. Bethany Zaro, Assistant Director of Human Services, Town of New Canaan

Norwalk Community Care team

1. Dawn Berger, Community Health Center, Day St.
2. Pat Bonenfant, CT Counseling Center
3. Juan Cintrón, Mid-Fairfield AIDS Project
4. Suzanne Curto, Norwalk Community Health Center
5. Sofia Gulino, Norwalk Police Department
6. Nicole Hampton, Norwalk CCT
7. Emily Hartwell, Norwalk Health Department
8. Janice Hylton, Adult Probation
9. Dr. Tait Michael, Western Connecticut Health Network
10. Mayra Munoz, Adult Probation
11. Nicole Murray-King, Keystone House
12. Staci Peete, Western Connecticut Health Network
13. Alison Salem, Western Connecticut Health Network
14. Eve St. Sturin, Community Action Agency of Western CT
15. Jennifer Vasquez, Ability Beyond
16. Margaret Watt, The Hub, RBHAO for Southwestern CT
17. Shalonta Williams, Liberation Programs

Norwalk Senior Community Care team

1. Katie Agis, RN, Assistant Director of Nursing, Norwalk Community Health Center
2. Katy Ayuso, Director of Admissions, Cassena Care
3. Chris Curran, Care Transition Coordinator, Constellation Health
4. Susan Doyle, Owner, Oasis Senior Advisors
5. Adonis Filpo, Director of Business Development, LCB Senior Living

6. Eileen Kardus, High Risk Navigator, Norwalk Hospital
7. Tania Khammouch, Social Work Supervisor, Department of Social Services/Protective Services for the Elderly
8. Alan Libset, Owner, Always Best Care
9. Anna Liik, RN, Western Connecticut Health Network
10. Elanit Linder, Clinical and Community Liaison, Wilton Meadows
11. Karen Page, LCSW, Community Care Team, Western Connecticut Health Network
12. Linda Pritchard, RN, Community Care Team, Western Connecticut Health Network
13. Jeanie Ricci, Community Relations Director, Bridges Memory Care Assisted Living
14. Sue Root, Social Worker, Western Connecticut Health Network
15. Diala Samawi, Admissions, Cassena Care
16. Debi Selvage, Insurance Coordinator and Case Management, Soundview Medical
17. Craig Shoop, Resident Services Coordinator, Kingsway Senior Apartments
18. Carol Wolfen, RN

Wilton Community Representatives

1. Barry Bogle, Town of Wilton, Director of Health
2. Mary Ann Genaurio, Wilton/Riverbrook YMCA Wellness Director
3. Don Hay, Senior Pastor of Hope Church, Wilton
4. John Lynch, Chief Wilton Police Department
5. Bob McDowell, Wilton/Riverbrook YMCA CEO
6. Dr. Kevin Smith, Wilton Public Schools Superintendent
7. Lynne Vanderslice, First Selectwoman, Town of Wilton

Attachment B. Norwalk Community Health Committee (CHC) members

Organization

Norwalk ACTS
 Norwalk Department of Health
 Norwalk Hospital Chaplain Service
 Nuvance Health, Population Health
 Norwalk Hospital
 Town of Ridgefield, Director of Health
 Town of Westport
 Education Growth Partners
 Westport/Weston Health District
 Norwalk Dept. of Health, Director
 City of Norwalk, Chief of Community Services
 Town of New Canaan, Director of Health
 Riverbrook YMCA
 AmeriCare Free Clinics
 Nuvance Health, Planning

Member Name

Anthony Alison
 Theresa Argondezzi
 Carol Bauer
 Rowena Bergmans
 Joyce Bretherton
 Edward Briggs
 Barbara Butler
 Peter Campbell
 Mark Cooper
 Deanna D'Amore
 Lamond Daniels

 Jennifer Eielson

 Mary Ann Genuario
 Karen Gottlieb
 Sally Herlihy

Organization

Darien Department of Health, Director
 Norwalk Hospital Volunteers
 Norwalk Community Health Center
 Nuvance Health, Psychiatry and Community Health
 Town of New Canaan Health Department, Medical Director
 Norwalk Hospital
 Nuvance Health, Homecare
 AmeriCare Free Clinics
 Community Health Centers, Inc.
 Regional Behavioral Health Action Organization (The Hub)
 Positive Directions
 Greenwich Education Group
 Norwalk Hospital, Community Relations

Member Name

David Knauf
 Fred Lione
 Maria Escalera
 K. Tait Michael, MD

 David Reed, MD

 Maura Romaine
 Ellen Ryan
 Veronica Sullivan
 Amy Taylor
 Margaret Watt

 Denique Weidema-Lewis
 Robyn Whittingham
 Maura Romaine

Attachment C. Workshop participants

Chronic Disease & Obesity – Lead: Theresa Argondezzi, Norwalk Health Department

Organization

American Heart Association
 Norwalk Health Department
 City of Norwalk, Early Childhood Council
 Norwalk Health Department
 Cooking Matters
 Norwalk Public Schools
 Norwalk ACTS
 Norwalk Public Schools
 Norwalk Bike/Walk Advisory Commission

Member Name

Kaitlin Latham
 Deanna D'Amore
 Mary Oster

 Patricia DiPietro
 Laurie Stiles
 Jo Ann Malinowski
 Anthony Allison
 Grace Vetter
 Barbara McCabe

Organization

Norwalk Public Schools
 Norwalk Health Department
 Nuvance Health
 Norwalk Health Department
 Nuvance Health
 Norwalk Health Department
 Riverbrook YMCA
 Norwalk Health Department
 Sacred Heart University

Member Name

Lisa Lenskold
 Pamela Silva
 Katherine Michael, MD
 Carly Smolick
 Ellen Ryan
 Jahliah Green
 Mary Ann Genuario
 Theresa Argondezzi
 Wendy Bjerke

Mental Health & Substance Use – Lead: K. Tait Michael, MD, Nuvance Health

Organization

Norwalk ACTS
 Norwalk Health Department
 Nuvance Health
 Education Growth Partners
 Norwalk Health Department

Member Name

Anthony Alison
 Theresa Argondezzi
 Rowena Bergmans
 Peter Campbell
 Deanna D'Amore

Organization

New Canaan Health Department
 Nuvance Health
 The Hub
 Positive Directions

Member Name

Jennifer Eielson
 Tait Michael
 Margaret Watt
 Denique Weidema-Lewis

Access to Care – Lead: Rowena Bergmans, Nuvance Health

Organization

Norwalk Health Department
 Nuvance Health
 Norwalk Health Department
 Norwalk Health Department
 Norwalk Community Health
 Center (NCHC)

Member Name

Theresa Argondezzi
 Rowena Bergmans
 Deanna D'Amore
 Lamond Daniels
 Maria Escalera

Organization

Americares Free Clinics
 Nuvance Health
 Nuvance Health
 Community Health Centers, Inc.

Member Name

Karen Gottlieb
 Sally Herlihy
 Tait Michael
 Amy Taylor

Attachment D. WCHN community health structure



References

¹ Schroeder, S. A. (2007). We can do better—improving the health of the American people. *New England Journal of Medicine*, 357(12), 1221–1228.

² Lahart, J. (September 10, 2019). Inequality is Holding Back the US Economy. *Wall Street Journal*.

³ Ingraham, C. (February 6, 2018). How rising Inequality Hurts Everyone, Even the Rich. *The Washington Post*.



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