April 20, 2023

Dr. Deidre Gifford, MD, MPH
Executive Director
Department of Public Health
Office of Health Strategy
P.O. Box 340308
450 Capital Avenue, MS# 51OHS
Hartford, CT 06134

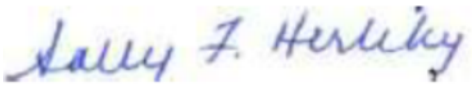
Docket Number: 18-32238-CON
Project Title: Transfer of Ownership of Western Connecticut Health Network, Inc. with Health Quest Systems, Inc. to a New Not-for-Profit Parent Corporation

Dear Deidre,

As stipulated in the Agreed Settlement executed on April 1, 2019 ("Closing Date") regarding approval for the transfer of ownership of the two organizations - Western Connecticut Health Network, Inc. ("WCHN") and Health Quest Systems, Inc. ("HQ") – condition sixteen (16) requires yearly updates. Updates for condition one (1), two (2), seven (7) and twenty-one (21) are also included at this time.

If you should have any questions, please feel free to give me a call directly at 203-739-4903 or e-mail me at sally.herlihy@nuvancehealth.org.

Sincerely,



Sally F. Herlihy, FACHE
Vice President, Planning

Annual Updates

April 20, 2023

Condition #1 and #2

Condition one (1) and two (2) request notification of the appointment of new board members for Danbury, Norwalk and Sharon Hospitals.

Response:

Descriptions below of the Board member updates for the CT hospitals:

Danbury Hospital: Four new board members for 2023.

1) Maria Garcia

Ms. Garcia is currently the Vice President and District Manager of 16 Kohl's location in the state of CT. She has a passion for Diversity, Equity, Inclusion and Belonging and is an active participant in Kohl's Diversity and Inclusion task force. Ms. Garcia is also the group leader for the Hispanic y Latino Business Resource Group within Kohl's.

Ms. Garcia graduated from Fordham University with a Bachelor of Arts in Spanish language and literature. She resides in Ridgefield, CT.

2) Michelle James, MBA

Ms. James is the Executive Director of The Community Action Agency of Western CT - an anti-poverty agency providing programs and services to low-income individuals and families to help them become self-sufficient. In her role, she is responsible for the overall strategic and operational activities of the organization. Ms. James is also the President of MHJ Consulting Services, a consulting firm focused on improving efficiencies and effectiveness of nonprofit organizations. Ms. James spent many years working in the community for the AmeriCares Foundation, Stamford Achieves, the Apollo Theater Foundation, the United Way of Western CT, Union Savings Bank, Ethan Allen and The Charles Ives Center for the Arts.

Ms. James received her MBA in Management from University of New Haven and her Bachelor of Science in Marketing from Rutgers University. She also has a Diversity and Inclusion Certificate from Cornell University and a Direct and Interactive Marketing Certificate from Western CT State

University. She is Certified Financial Marketing Professional and has completed both the Leadership Danbury and the Leadership Fairfield County programs.
Ms. James also serves on the board of the National Community Action Partnership and the Greater Danbury Chamber of Commerce. She is the treasurer of the New England Community Action Partnership and 2nd Vice President of the Connecticut Association for Community Action. She also sits on the Governor's Workforce Council. Ms. James resides in Danbury, CT.

3) Kimberly Morgan

Ms. Morgan is an experiences Chief Executive Officer with over 30 years of experience working in non-profit organizational management. She is currently the CEO if Prosperity Digital Marketplace, where she launched a technology start-up as a non-profit subsidiary to build a digital marketplace for households living paycheck to paycheck. They connect resources to the need. Ms. Morgan has also been the CEO of the United Way of Western CT since 2012, where she also served as COO from 2005-2012.

Ms. Morgan graduated Summa Cum Laude from Manhattanville College with her M.S. in Management Communications and received her B.A. in Psychology from Eastern University. Ms. Morgan sits on the board of United Way of CT, Newtown-Sandy Hook Community Foundation, Christian Community Outreach Services, New Fairfield Community Foundation, and the National ALICE Advisory Council. She volunteers at Hillside Food Outreach and the CCOM Breakfast Program. Ms. Morgan is a licensed foster parent in the community.

4) Rob Parker

Mr. Parker has more than 30 years of healthcare corporate banking experience. He has been the Managing Director of Healthcare Corporate Banking at BofA Securities since 2003, where he coordinates and delivers BofA's corporate banking suite to large companies across the health care continuum. Mr. Parker has led BofA's Stern MBA recruiting and remains an active recruiter. He is also a leader of BofA's LGBTQ+ affinity group and currently mentors several LGBTQ+ colleagues. Prior to that, he serviced as Managing Director, Healthcare Group at both Leerink Swann and JPMorgan Chase.

Mr. Parker graduated from NYU School of Business with a B.S. in Computer Applications and Accounting. He also completed a Japanese Management Study at the Sonno Institute of Management in Tokyo, Japan. Mr. Parker currently serves as treasurer of ASAP!, which provides arts education and engagement to kids of all economic backgrounds in northwestern CT. He resides in Washington, CT with his husband.

Norwalk Hospital: No new board members for 2023.

Sharon Hospital: No new board members for 2023.

There are no new community board members for 2023, however, Christina McCulloch, Sharon Hospital President, replaced Dr. Mark Hirko, former Sharon Hospital President, on the board in late 2022.

Condition #7

Complete a CHNA and Implementation Strategy; submit to OHS and publish on Hospital's website.

Response:

See attached CHNA and Implementation Plans completed in February 2023. As required by the IRS, all documents are posted on the Nuvance Health website: www.nuvancehealth.org/community.

Condition #16

a. A **written report describing the achievement of the Strategic Plan components** to retain and enhance healthcare services in the Danbury, Norwalk and Sharon Hospital communities, including with respect to physician recruitment and resource commitments for clinical service programming.

Response:

Condition #16

b. A **written report describing the achievement of the Strategic Plan components** to retain and enhance healthcare services in the Danbury, Norwalk and Sharon Hospital communities, including with respect to physician recruitment and resource commitments for clinical service programming.

Response:

As submitted on 3/9/20 in response to Condition #14, the Nuvance Health Strategic Plan 2025 focuses on six key imperatives, and progress reports submitted on 4/30/21 and 4/29/22 provided highlights for FY 2020 and FY 2021 respectively. Noted below is an updated status report for FY 2022:

- *Person-Centered Care* - Cultivate a personalized lifetime relationship between Nuvance Health and the people we serve
    - The Find Care platform on the Nuvance Health website enables individuals to search for providers and directly self-schedule with many of the medical group practices, ensuring access to clinical providers in our communities and system.
    - Medical group efforts coupled provider performance metrics with relationship-centered care, clinician shadowing and interaction skills in the simulation laboratory to drive enhanced patient experience.
    - Introduction of human-centered design to the Nuvance Health primary care and breast care teams resulted in mapping of patient journeys and undertaking of multiple small tests of change that highlighted the value of listening to patient and team member voices.
    - A 48-hour discharge phone call program was implemented to help discharged patients navigate care transitions.

- *Primary Care* - Use the Nuvance Health primary care network to establish relationships with customers throughout the service area
    - Solidified an onboarding orientation process and checklist to support new clinical staff joining our Medical Practices.
    - Activated the residency programs as a primary care feeder and recruited three Family Practice residents and two Internal Medicine residents.
    - Supported a new Health Equity, Diversity & Inclusion Initiative (HEDI) with a quality focus on Hemoglobin A1C and Hypertension.
- *Ambulatory Care* - Expand the ambulatory network and customer-facing services as a gateway into the Nuvance Health system
    - Standardized patient experience training with a focus on ensuring quality, access and relationship-centered care completed in breast imaging centers and urgent care centers.
- *Digital Health* - Develop and deploy digital health solutions that support and transform the Nuvance Health system of care to serve its community
    - Continued to add physicians, advanced practice providers, and services (including mammography) available to our communities through online self-scheduling, with over 14,000 appointments booked through our online DirectBook capabilities.
    - Deployed online pre-registration forms across all Nuvance Health Medical Practices to allow patients to complete their registration documents in advance of their appointment.
    - Data management analytics operations enhanced across the enterprise with a public cloud analytics platform, leveraging industry-leading tools to bring artificial intelligence, machine learning, and real-time visualizations to the enterprise.
    - Formalized collaboration between the HEDI committee and technology to remove numerous racially/ethnically coded algorithms from systems, medical records, and biomedical tools.
- *Value-Based Care* - Position Nuvance Health to be the strategic partner of choice through payer and community partnerships
    - Continued focus on our Medicare Shared Savings Programs, emphasis on annual wellness visits to identify all conditions and services needed for the patient.
    - Implemented Programs focusing on vulnerable populations to address dual diagnosis mental health, substance use disorder and chronic disease while addressing social drivers of health. Since the inception of the program, housed over 300 individuals with connection to services.
    - Entered a downside risk arrangement with the state of CT for the Statewide Partnership Plan to provide high quality, equitable and affordable care.
- *Network Optimization* - Identify specific strategic opportunities to optimize the network and advance enterprise strategy in each Nuvance Health community
    - Despite the financial pressures and workforce shortages experienced in each market, continued focused efforts on evaluating and strengthening operational and financial performance of each network hospital.

- Clinical Institutes interacted regularly and effectively with hospital operations and the ambulatory practices across the continuum in each market.
- Operational efficiencies in practices focused on daily management systems and huddle boards has enhanced both staff engagement and reduced first-year voluntary turnover across the 75 Nuvance Health Medical Practice ambulatory sites.

c. A **written report on its activities directed at meeting condition 4,** regarding efforts toward making culturally and linguistically appropriate service available and integrated throughout the Hospital's operations.

Response:

The Nuvance Health hospitals continue to be guided by The Joint Commission (TJC) Hospital Standards and Elements of Performance. The National CLAS Standards can be directly cross-walked to the standards and elements of performance that TJC accredited hospitals to follow. This cross-walk, published by TJC, is available online here.

In 2020, Nuvance Health launched a HEDI Initiative – Health Equity, Diversity, and Inclusion –to deliver on our commitment to health equity, cultural humility, and anti-racism; and to provide an environment where every member of the Nuvance Health community – including those at the forefront – patients and colleagues – have equitable opportunities, feel welcomed, valued, respected, supported, and accepted. Health Equity, Diversity & Inclusion strategy has been implemented throughout the organization to ensure that equitable, culturally competent care is provided to the diverse populations Nuvance Health serves.

The AVP Health Equity, Diversity & Inclusion was appointed in FY22 and is responsible overall for the development, implementation, and evaluation of the health equity, diversity and inclusion strategies and processes for the organization. The AVP of HEDI Partners with the Medical Director of Health Equity, who assists in developing and evaluating strategies that support health-equity related clinical outcomes, such as 30-day inpatient readmission and hypertension control. The HEDI Operations team discusses priorities and processes for the organization, and the HEDI Advisory Committee provides feedback/guidance on rollout and evaluation of the HEDI strategy. Executive Leadership supports and promotes the overall HEDI strategy.

Additionally, both CMS and The Joint Commission have new requirements around health equity. The CMS Office of Minority Health (OMH) recently released its CMS Framework for Health Equity. The framework is meant to challenge hospitals to incorporate health equity and efforts to address health disparities as a foundational element across all of its work. CMS finalized three new health equity-related measures in the Inpatient Quality Reporting (IQR) program which will have mandatory reporting requirements and payment impacts in the upcoming years. Similarly, The Joint Commission issued a new standard that includes six new elements of performance around reducing health care disparities, taking effect on January 1, 2023.

The AVP of HEDI and Chief Human Resources Officer are responsible for managing the overall strategy, distribution, and communications of the HEDI Workforce standards and goals. Starting with onboarding new employees and through Mandatory Annual Training, education is rolled out on all levels to provide continuous education on cultural and linguistic congruency in all care provided to patients, their families, and the diverse workforce. Creating equitable opportunities for all is a shared goal of the organization where all populations can achieve the highest level of health possible and can function to his or her full potential.

Since the Office of Health Equity, Diversity & Inclusion has been established, much work has been done to form meaningful equity- focused partnerships with Institutes, Services Lines, and additional Departments of Impact throughout the organization, such as Pharmacy and Research. Utilizing these strong partnerships, system – level leaders have the opportunity to identify existing gaps in quality of care and utilize stratified demographic patient data to focus on the population that is most impacted by the disparity. Once stratified data is analyzed, leaders can identify and implement processes to effectively reduce or eliminate such gaps, positively impacting the quality of life of those, who are otherwise often marginalized and left behind.

It is well known that health disparities, such as cardiovascular disease, maternal mortality, breast feeding, cancer -related outcomes, just to name a few, impact especially those, who are culturally diverse, and often speak languages other than English. To address a few of the major disparities, the office of HEDI established system-wide task forces, such as the Hypertension Task Force and the ERACED Task Force. Where the Hypertension Task Force set targets to improve hypertension control for especially people of color, the ERACED Task Force aims to eliminate the utilization of racially- based algorithms from clinical decision making, improving the chance of providing equitable care to all.

Another area where Nuvance Health gained great momentum is addressing the many disparities that the LGBTQIA population faces. Utilizing existing frameworks, such as the Healthcare Equality Index, Nuvance Health had embarked on major work to implement policies and processes that will increase equity for patients, their families, and the work force. The organization will apply for the Top Performer Index this summer and anticipated to receive the designation by the fall. This designation will be the first step in not only creating equity, but also sharing with the community Nuvance Health's values and reason for being.

As noted in the 2022 reporting, establishing Employee Resource Groups (ERG) to create a fully inclusive culture and foster a sense of belonging in the employee community was a key HEDI goal for FY22. The goal was to establish three ERGs in FY22, however due to success of the first groups established, Nuvance Health currently has 11 active ERGs:

- Asian American/Pacific Islander ERG
- Black/African American ERG
- Coexist, Interfaith ERG
- Disabilities and Allies ERG
- Environmental Social Governance ERG

- Hispanic/Latinx ERG
- LGBTQIA+ and Allies ERG
- Thrive and Allies ERG
- Veterans ERG
- Women's ERG
- Working Parents ERG

Language Assistance

Federal, New York State and Connecticut laws require all patients receive the language assistance they need for meaningful access to medical care. At Nuvance Health, we provide many ways to overcome the barriers that language differences and physical disabilities can create. Language assistance is provided free of charge, and all services are confidential. We offer services:

For non-English speakers

Interpretation services are available for patients or family members who speak a language other than English.

For the hearing impaired

American Sign Language interpreters, sound-amplifying devices and TTY devices are available.

For the visually impaired

Audible and large-print discharge instructions are available upon request.

More information can be found: Language Services | Nuvance Health

There have been no changes to the insurance navigation services. Danbury Hospital and Norwalk Hospital have bilingual financial counselors. Sharon Hospital continues to use Quality Billing Services (QBS) for their insurance navigation services. QBS has bilingual financial counselors on staff. All hospitals utilize interpretation services when needed. All materials regarding applying for financial assistance are now available in seven languages - English, Spanish, Portuguese, Mandarin, Haitian Creole, Arabic and Albanian.

d. An updated plan demonstrating how health care services are currently provided and will be provided by Danbury, Norwalk and Sharon Hospital for the first five (5) years following the Closing, **including any consolidation, reduction or elimination of existing services/group practices or introduction of new services/ group practices** (the "Services Plan").

Response:

HOSPITAL SERVICE PLAN
(Please note some services may have been temporarily adjusted due to COVID-19[1])

Service Category	# of Available Inpatient Beds	Address of Service	Hours of Operation	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
Inpatient (list existing & planned)								
DANBURY HOSPITAL								
Danbury/New Milford Adult/Peds Med/Surg	317	24 Hospital Avenue, Danbury, CT and 21 Elm Street, New Milford CT 06776	24/7					
Danbury ICU/Progressive Care	49							
Danbury Maternity	29							
Danbury NICU	19							
Danbury Psych	22						X[2]	
Danbury Rehab	14							
NORWALK HOSPITAL								
Norwalk Adult/Peds Med/Surg	179	34 Maple Street, Norwalk, CT	24/7					
Norwalk ICU/CCU/Telemetry	48							
Norwalk Maternity	27							
Norwalk NICU	18							
Norwalk Psych	21					X[3]		
SHARON HOSPITAL								
Sharon Med/Surg	28	50 Hospital Hill Rd, Sharon, CT	24/7					
Sharon ICU	9			X[4]				
Sharon Maternity	8					X[5]		
Sharon Psych	17							

[1] See response to 18-32238-CON OHS Inquiry filed on 11/22/21, pages 4-7.
[2] Expansion plans announced 2023
[3] Pending OHS approval, pursuant to Docket No. 22-32513-CON.
[4] Pending OHS approval, pursuant to Docket No. 22-32504-CON.
[5] Pending OHS approval, pursuant to Docket No. 22-32511-CON.

Service Category	Address of Service	Hours of Operation	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
Outpatient (list existing & planned)							
DANBURY HOSPITAL							
Danbury/New Milford Therapies & Diagnostics (e.g. Lab, Nutrition, Chemo, Infusion, etc.)	24 Hospital Avenue Danbury, CT	Varies by program					
	21 Elm Street New Milford, CT	Varies by program					
Danbury Hospital Medical Arts Center (e.g. Cardiovascular and Gastroenterology, etc.)	111 Osborne Street Danbury, CT	Varies by specialty					
Lab Service Center	120 Park Lane Road New Milford, CT	M-Sat variable					
	79 Sand Pit Road Danbury CT	M-Sat variable					
	60 Old New Milford Road Brookfield, CT	M-F 7:30am-4pm					
	10 South Street Ridgefield, CT	M-F 7:30am-4pm					
	22 Old Waterbury Road Southbury, CT	M-F 7:30am-4pm					
Diagnostic Imaging	20 Germantown Road Danbury, CT	Varies by modality					
	901 Ethan Allen Highway Ridgefield, CT	Varies by modality					
Cardiac Rehab	24 Hospital Avenue Danbury, CT	M-F 6:30am-7:15pm					
	21 Elm Street New Milford, CT	M-Sat variable					
Rehab and Physical Therapy	235 Main Street Danbury, CT	M-F variable					
	22 Old Waterbury Road Southbury, CT	M-F variable					
	79 Sand Pit Road Danbury CT	M-F variable					
Sleep Center	21 Lake Avenue Extension Danbury CT	M-F variable					
	21 Elm Street New Milford, CT	M-F variable					
Ambulatory Surgery	24 Hospital Avenue Danbury, CT	M-F					
Wound Care	24 Hospital Avenue Danbury, CT	M-F 8am-5pm					
	21 Elm Street New Milford, CT	Tue 1-5pm					

Service Category	Address of Service	Hours of Operation	Consolidating	Reducing	Eliminating	Expanding	Adding New Service
NORWALK HOSPITAL							
Norwalk Therapies & Diagnostics (e.g. Lab, Nutrition, Chemo, Infusion, etc.)	34 Maple Street Norwalk, CT	Varies by program					
Norwalk Cardiovascular Center	34 Maple Street Norwalk, CT	9:15am-2:45pm					
Lab Service Center	40 Cross Street Norwalk, CT	M-F 7:30am-4pm					
	333 Post Road West Westport, CT	M-F 8:30am-4:45pm					
Norwalk Radiology	761 Main Ave[6] Norwalk, CT	Varies by specialty					
Norwalk Rehab and Physical Therapy	520 West Avenue Norwalk, CT	M-F, Varies					
Norwalk Sleep Center	520 West Avenue Norwalk, CT	M-F 9am-5pm					
Norwalk Wound Care	34 Maple Street Norwalk, CT	8am-4:30pm					
Sharon Hospital							
Sharon Therapies (e.g. Lab, Rehab, Nutrition, Respiratory, etc.)	50 Hospital Hill Rd Sharon, CT	Varies by program					
Sharon Radiology	50 Hospital Hill Rd Sharon, CT	MRI M-F, Varies Diagnostic and CT 24/7					
Sharon Wound Care	50 Hospital Hill Rd Sharon, CT	M-Th, Varied					

[6] Relocation per Docket No. 21-32450-DTR

Condition #21

Status of any outstanding initiatives submitted in a written report every six (6) months following the initial annual report until all items are addressed.

Response:

The only remaining item from the report submitted in November 2021, is the consolidation to one electronic medical record ("EMR") and enterprise resource planning (ERP)system. Phase 2 is the unification of the two Cerner EMR systems maintained by Nuvance Health, and this remains on track to be achieved over incremental phases across multiple sites with an expected completion date of 6/1/2023.

Nuvance Health

April 17, 2023

I am writing on behalf of Nuvance Health and its subsidiaries Vassar Health Connecticut, Inc. d/b/a Sharon Hospital, The Danbury Hospital, and The Norwalk Hospital Association, to make attestations as required in Condition 16(d) of the Agreed Settlement dated April 1, 2019 with the Department of Public Health Office of Health Care Access, regarding the transfer of Western Connecticut Health Network, Inc. and Health Quest Systems, Inc. to a New Not-for-Profit Parent Corporation (Nuvance Health), under docket number 18-32238-CON.

As agent/representative of Nuvance Health, I affirm the following regarding Condition number16(d) to the Agreed Settlement:

i. Nuvance Health is meeting the obligations of Conditions 1-2.
ii. No Danbury, Norwalk or Sharon Hospital physician office has been converted to hospital-based status.
iii. All Danbury, Norwalk and Sharon Hospital commercial health plan contracts in place as of the Date of Closing are/were maintained through the remainder of their terms, and that any new contracts are consistent with the commitments of Condition 13, to the extent such commitments remain in effect under the terms of the Agreed Settlement.
iv. Danbury, Norwalk and Sharon Hospital have each continued to maintain separate emergency room services, inpatient general medicine services, cardiology services, inpatient obstetrics/gynecology services, inpatient behavioral health services, critical care unit services and oncology services, such services shall assure patient affordability and adhere to standards of care, quality, and accessibility and reflect local community need. It should be noted that Nuvance Health has three pending CONs filed with the State of Connecticut (as outlined in the Services Plan) that could impact the provision of services outlined in this condition.
v. There has been no change in the service provision plan submitted on pages 66-69 of "Repaginated Exhibit A 18-32238-CON WCHN HQ Affiliation."

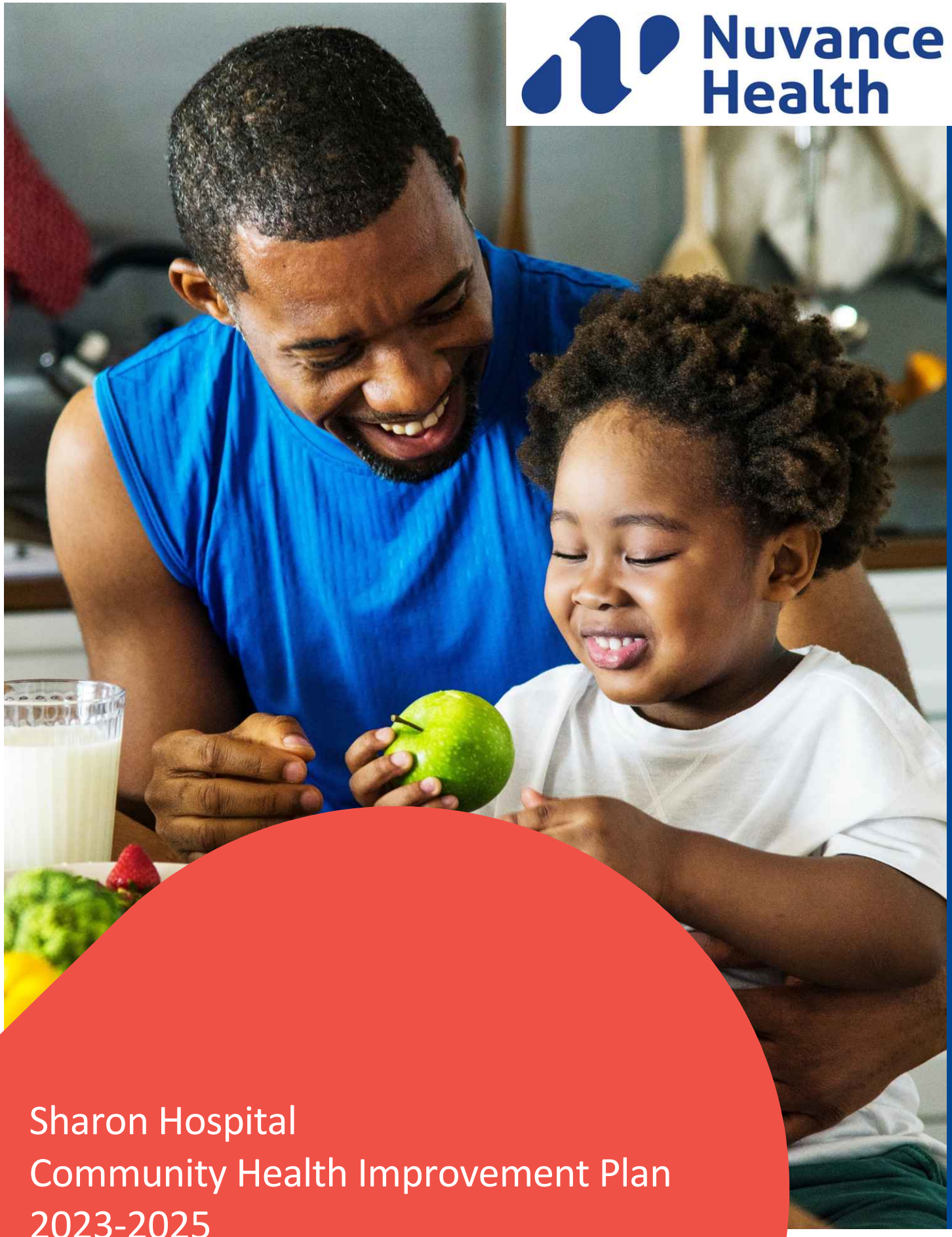
Dated: 4/18/23

Signed: Michelle R Sut
Name: Michelle Robertson
Title: Chief Operating Officer

Sworn to before me this 18th day of April, 2023
Name: Virginia Marie DeLillo
Notary Public

Virginia Marie DeLillo
Notary Public - Connecticut
My Commission Expires
September 30, 2027

Nuvance Health



Sharon Hospital
Community Health Improvement Plan
2023-2025

What is a Community Health Improvement Plan (CHIP)

A CHIP helps organizations move from data to action to address health priorities identified in the CHNA. The CHIP serves as a guide for strategic planning and a tool by which to measure impact by detailing goals, objectives, strategies, and action steps over the three-year reporting timeframe. Anchoring initiatives and community benefit activities to measurable objectives, the CHIP creates a framework for measuring the impact of collective action towards community health.

Community Input

Like the CHNA, the CHIP reflects input from diverse stakeholders and helps to foster collaboration among community-based organizations. Experts and community members provided input to define and recommend solutions to health challenges in our community. This input provided diverse perspectives on health trends and helped us better understand lived experiences of populations that experience barriers to care. Each Nuvance Health hospital has a Community Health Committee (CHC) with representatives from the board, the executive team, hospital staff, community members, local health departments, and community agencies. Nuvance Health employees participate in an array of community boards and task forces to foster collaboration with community partners.

Determining Priority Health Needs

To work toward health equity and improve health disparities, it is imperative to prioritize resources and activities for meaningful community impact. Through the CHNA research and ongoing engagement of community representatives, Nuvance Health collected input to determine the most pressing health needs affecting residents in the Sharon Hospital service. Priority health needs were determined through discussions with the hospital's Community Health Committee and input from community stakeholders including public health experts, health and human service providers, representatives of underserved populations, and community members. Nuvance Health reviewed recommendations for priority areas in consideration with existing resources and gaps in services to determine which community health priorities Sharon Hospital could best impact over the next three years. Based on this determination, Sharon Hospital's 2023-2025 CHIP will focus community benefit activities on **Preventing Chronic Diseases** and **Addressing Behavioral Health needs**.

Some health needs that were identified in the CHNA will not be directly addressed in Sharon Hospital's CHIP, however these needs will continue to be met through clinical care services and support of our community partners that focus on these issues. Examples of other community health needs that we identified in the 2022 CHNA that are not directly reflected in Sharon Hospital's CHIP include housing and access to oral health care.

Alignment with State Health Improvement Plans

Serving residents in Connecticut and New York, Sharon Hospital collaborates with health and human service agencies and community partners in both states and seeks to align with state initiatives to advance the health and well-being of all people. The Sharon Hospital CHIP is aligned with the Connecticut Department of Health State Health Improvement Plan (SHIP) as well as the New York State Prevention Agenda.

Alignment with State and Federal Requirements

The Sharon Hospital 2022 CHNA and CHIP process and timeline are in line with IRS Tax Code 501(r) requirements to conduct a CHNA every three years and Connecticut state requirements for hospital community benefit reporting.

Advancing Health Equity

The CHNA documented disparities in poverty, education, and socioeconomic measures; access to health care and social services; disease rates and outcomes; and quality and length of life. These health disparities are most often driven by social determinants of health and reflect longstanding inequities. To work toward health equity, we need to redefine how we deliver health care, increase our knowledge and understanding, and confront policies that perpetuate disparities. At Nuvance Health we have outlined specific objectives and strategies to guide our efforts in creating more welcoming care settings that honor the diversity of our communities, and promote diverse and inclusive environments for our patients, staff, and providers.

Nuvance Health Commitment to Health Equity, Diversity, and Inclusion

Strategy: Increase cultural awareness and humility among staff and providers.

Initiatives:

- Use Patient Family Advisory Councils to provide feedback on care quality and patient experience.
- Recruit diverse representatives from community-based organizations to serve on Health Equity, Diversity, and Inclusion Advisory Committees, Community Health Committees, and Community Care Teams.
- Provide implicit bias and cross-cultural care education to all employees.

Strategy: Reduce disparities in outcomes among vulnerable patient populations.

Initiatives:

- Accurately collect patient demographic data and socioeconomic needs within medical records.
- Stratify clinical data to identify health disparities; implement strategies to reduce or eliminate these disparities.
- Evaluate clinical documents and educational materials to reflect preferred patient languages in each hospital service area.

Strategy: Increase diversity of staff and providers.

Initiatives:

- Cultivate awareness of healthcare careers within underserved communities.
- Modify recruitment and hiring processes to attract and support diverse staff and cultivate advancement opportunities.
- Grow scholarships, mentorship, and new workforce pipelines.

Strategy: Support a sustainable and equitable community.

Initiatives:

- Evaluate hiring, supply chain, and opportunities for local economic investment.
- Purchase goods from local and diverse vendors.
- Make contributions of dollars, time, and expertise to advance community initiatives.

Strategy: Increase, improve, strengthen, and evaluate partnerships with community-based organizations.

Initiatives:

- Foster collaboration with organizations that serve diverse or underserved populations.
- Invite input from diverse stakeholders to define and address community health needs.
- Support and cultivate opportunities for community-wide cross-cultural engagement.

Priority Area One: Prevent Chronic Diseases

Goals:

- Reduce health disparities in chronic disease prevention and disease.
- Reduce the impact of social drivers of health on patient outcomes.

Strategies:

- Increase early detection of cardiovascular disease, diabetes, prediabetes, and obesity.
- Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity.
- In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity.
- Increase access to care for populations that experience disparities in chronic disease burden and care.
- Improve cultural competency of providers and adopt inclusive healthcare environments
- Partner with community agencies to connect people to resources for housing, food security, transportation, and related socioeconomic needs.
- Track data across populations to identify and address health disparities.

Sharon Hospital Initiatives:

- Initiate cultural competency training in all patient care areas to support an inclusive healthcare environment.
- In partnership with the American Heart Association, implement a Public Library Hypertension Program to provide education and home management of hypertension.
- Expand telehealth for primary and specialty care and increase digital equity; provide telehealth kiosk at Sharon Hospital to aid in accessing specialty care.
- Support LION Food Program to provide education on healthy eating to school-aged children.
- Foster and strengthen partnerships with faith-based organizations to bring chronic disease prevention education to priority populations.
- Implement Senior Care Team to support older adults seeking care at the emergency department.
- Support North East Community Center, LION food program, and other food security programs; increase networking with available food pantries and share resources with patients and community members.
- Implement Senior Care Team to address social drivers of health among older adults seeking care in the emergency department.

Priority Area Two: Promote Well-Being and Prevent Mental and Substance Use Disorders

Goals:

- Strengthen opportunities to build well-being and resilience across the lifespan.
- Improve access to behavioral health services within the community.
- Prevent opioid overdose death.

Strategies:

- Integrate mental health screenings and services within primary care practices.
- Increase the traditional and alternative (community and technology based) places people can access health care.
- Strengthen community partnerships in underserved communities.
- Increase understanding of the impact of trauma.
- Provide expertise and support to reduce misuse of alcohol and drugs.
- Reduce opioid prescriptions in primary and specialty care settings.
- Provide expertise and support for community-based services for substance use disorders.

Sharon Hospital Initiatives:

- Provide Mental Health First Aid; expand offerings to include Spanish language classes.
- Provide competency training for healthcare and social services providers on Screening, Brief Intervention, and Referral to Treatment (SBIRT).
- Increase access to behavioral health services in primary care practices.
- Recruit behavioral health providers including Psychiatrists and Licensed Clinical Social Workers to increase capacity of services.
- Provide education to increase provider expertise in opioid prescribing, chronic pain management, and Medically Assisted Treatment (MAT).
- Support and participate in community mental health awareness and training efforts.

Collaborate with community partners

Nuvance Health hospitals consistently collaborates with a wide range of community partners that serve diverse populations across the communities we serve. Additional information can be found on our website nuvancehealth.org under Community Outreach and Sponsorship or by following this link: Community Outreach and Sponsorships | Nuvance Health.

Resources Allocated to the 2023-2025 Community Health Improvement Plan

At Nuvance Health, we are not only caregivers — we are also friends, family, and neighbors. Through our CHIP initiatives, we aim to increase well-being for everyone. The hospital initiatives and community benefit activities outlined in the Sharon Hospital 2023-2025 CHIP reflect Nuvance Health's dedication to investing in community partnerships and programs to promote wellness and health equity. The CHIP reflects a workplan that outlines specific resources and oversight for our initiatives. The Sharon Hospital Community Health Committee exists to support this work and is tasked with the review and oversight of the CHIP, including the following responsibilities.

- Monitor implementation of the CHIP to address identified priority areas.
- 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.

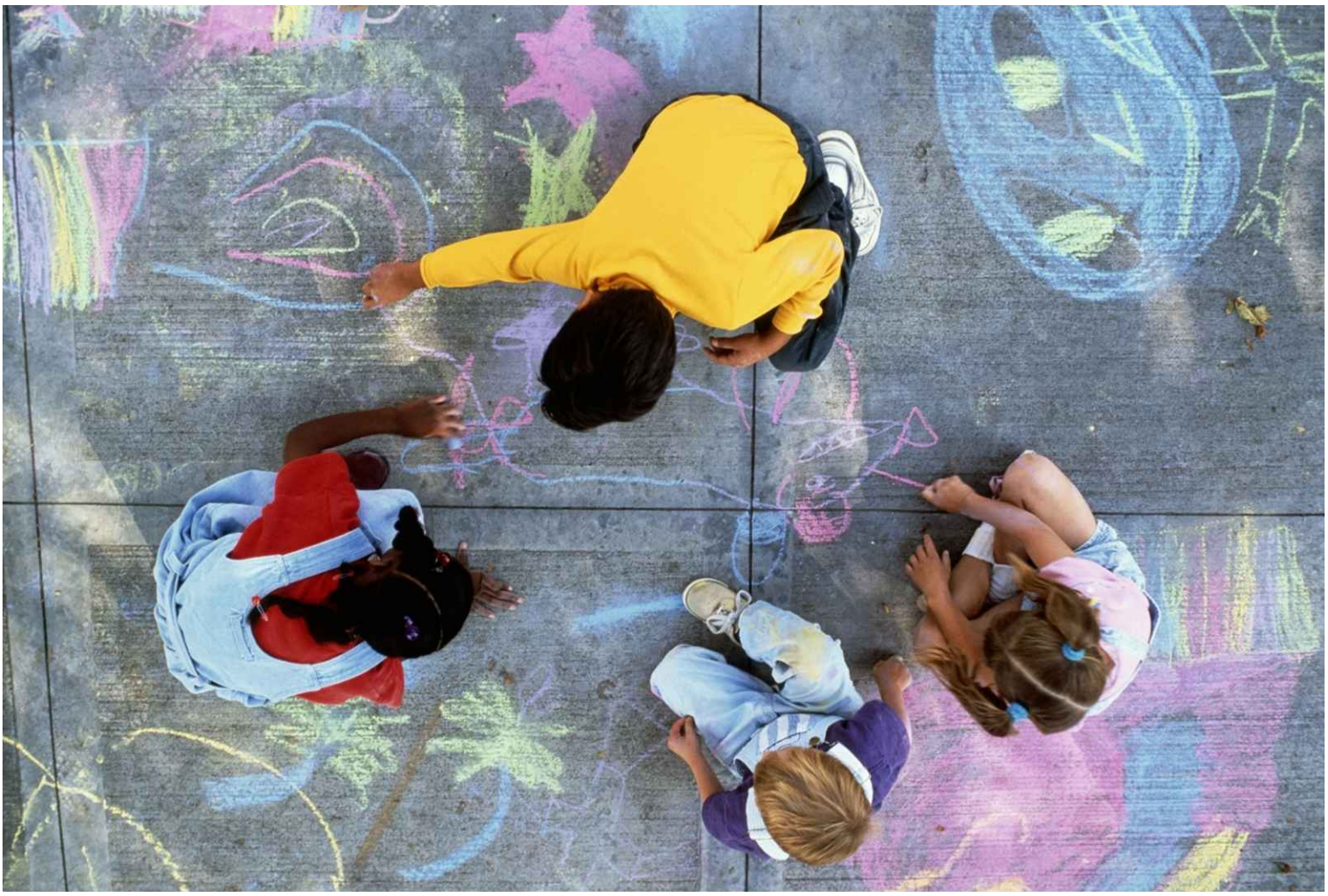
Maintaining Engagement and Tracking Progress

The Sharon Hospital CHC oversees the development and updating of the CHNA and monitors community health activities and progress. The CHC meets quarterly to review progress toward the goals stated in the Community Health Improvement Plan and to determine whether any changes in objectives or strategies are required.

Dissemination to the Public

The 2022 Community Health Needs Assessment and 2023-2025 Community Health Improvement Plan are available on the Nuvance Health website under Community Benefit. Printed copies of these documents will be made available to the public (free of charge) in the administrative offices at Sharon Hospital.

Sharon Hospital
2022 Community Health Needs Assessment Report



Nuvance Health

A letter from Nuvance Health

Communication. Collaboration. Commitment.

These are essential elements for improving population health in our communities.

Nuvance Health is pleased to present our 2022 CHNA findings. This report includes a review and analysis of health and socio-economic data that impact the health of people across our service area. The purpose of this assessment is to identify the area's health needs so we may better align with stakeholders, such as public health and healthcare providers, about opportunities for improving the health of our region. These results allow Nuvance Health, state and county public health departments, our community partners, and other providers to set priorities, develop interventions, and commit the appropriate resources to our region more strategically.

Our workforce of more than 1 5,000 compassionate caregivers provides high-quality care through our six nonprofit hospitals on seven campuses, multiple outpatient care sites, numerous primary care and specialty provider locations, and increasing set of virtual healthcare services. Across the system, we offer state-of- the-art facilities, technology and a breadth of clinical services.

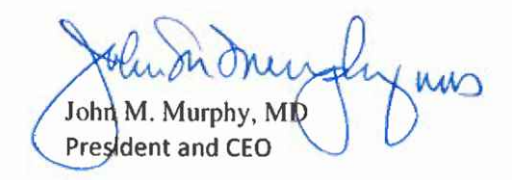
The staff of Nuvance Health are dedicated to the health and well-being of everyone in our region, regardless of race, ethnicity, age, gender, religion, sexual orientation, gender identity, gender expression, disability, economic status and other diverse backgrounds. This is our promise to the more than 1.5 million children and adults we serve in western Connecticut and the Hudson Valley of New York.

To ensure our services are aligned with the healthcare needs of our community, we complete a Community Health Needs Assessment (CHNA) every three years for each hospital community, and it was conducted January to September 2022. This helps us better serve our community by measuring the health status of residents, gathering community input on health concerns, and identifying opportunities to collaborate. With the help of many state, county and community partners, we had strong participation in our surveys, and we value this feedback and recognize all community stakeholders who play an integral part in advancing the health of our region.

And this is only the beginning. We continually assess how we serve our region so we can provide outstanding care, as well as education and outreach activities that meet priority needs. In doing so, we will continue to collaborate with our partners, educate our policy makers, and engage community residents to promote health for all residents of our region.

We look forward to our continued work together and thank you for putting your trust in us. At Nuvance Health, we are not only your caregivers—we are also your friends, family and neighbors. Through our community benefit initiatives, we aim to increase well-being for everyone.

With gratitude,



John M. Murphy, MD
President and CEO

Table of Contents

Our Commitment to Community Health

Where some see impossible, we see what's possible. At Nuvance Health, we continually strive for progress and push past the status quo in all aspects of what we do. We are Nuvance Health!

Nuvance Health is an integrated health system offering convenient, accessible, and affordable care to community members. We're here for you–whenever and wherever you need us. Our talented team of more than 15,000 compassionate caregivers provides high-quality care through:

- Community hospitals
- Primary care and specialty practice locations
- Outpatient settings
- Home care services
- A skilled nursing and rehabilitation facility
- Telehealth visits

Our network also includes a well-known research institute, which brings breakthroughs from the lab directly to the bedside. We take research to heart and focus on treatments and cures that will benefit our community.

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. Sharon Hospital, under the auspices of the Community Health Committee, partnered with community stakeholders and public health professionals to conduct a Community Health Needs Assessment (CHNA) to assess the health and social needs of the Sharon Hospital community.

This report provides an overview of key findings from the CHNA and the priority elements that will be used to develop the three-year Community Health Improvement Plan to guide our community benefit and community health improvement efforts.

2022 CHNA Executive Summary

CHNA Leadership

The 2022 CHNA was overseen by the Community Health Committee of the Board of Directors of Nuvance Health. The Committee includes representations of the hospital communities, including hospital Board leadership, administrative leadership from the Nuvance Health network, local health department directors, community stakeholders, and other key hospital stakeholders.

Sharon Hospital Community Health Committee

- **Katie Palmer-House – Chair – Board Member**
- John Charde, MD – Board Member
- Hugh Hill – Board Member
- Nancy Heaton – Community (CEO, Foundation for Community Health)
- Aisha M. Phillips – Community (Senior Public Health Education Coordinator, Dutchess Co. Dept. of Behavioral and Community Health)
- Stefanie Hubert – Community (Executive Director, Putnam Co. Cornell Cooperative Extension)
- Christine Sergent – Community (Executive Director, Northeast Community Center, Certified Dietician Nutritionist)
- Mimi Tannen – Board Member (Chair, Foundation for Community Health)

Professional Staff

- Marina Ballantine – SH Associate, Public and Community Affairs
- Rowena Bergmans – Nuvance VP Strategic Payer and Community Partnerships
- Sally Herlihy – VP Strategic Planning & Bus Development Planning
- Melissa Braislin – Director of Rehabilitation Services and Cardiac Rehab
- Jim Hutchinson – SH Clinical Navigator
- Christina McCulloch – Nuvance President Sharon Hospital
- Trista Parker – Nuvance Manager Strategic Business/Planning
- Ildiko Rabinowitz – Nuvance AVP of Health Equity, Diversity & Inclusion

Our Research Partners

Nuvance Health contracted with Community Research Consulting to compile the CHNA reporting and guide the development of the Community Health Improvement Plan. CRC is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. Their interdisciplinary team of researchers and planners have worked with hundreds of health and human service providers and their partners to reimagine policies and achieve measurable impact. Learn more about our work at buildcommunity.com.

DataHaven conducted the DataHaven Community Wellbeing Survey (DCWS), a statistical household survey to gather information on wellbeing and quality of life for Connecticut's neighborhoods. The DCWS is a nationally recognized program that provides critical, highly reliable local information not available from any other public data source. A

501(c)3 nonprofit organization and registered as a Public Charity with the State of Connecticut, DataHaven is a partner of the National Neighborhood Indicators Partnership, a learning network, coordinated by the Urban Institute, of independent organizations in 30 cities that share a mission to ensure all communities have access to data and the skills to use information to advance equity and wellbeing across neighborhoods.

Siena College Research Institute conducted a random-digit dial Regional Community Health Survey. The survey was designed to supplement the Regional CHNA and to gauge residents' perception of the health and resources in their communities. Founded in 1980 at Siena College in New York's Capital District, the Siena College Research Institute (SCRI) conducts regional, statewide, and national surveys on business, economic, political, voter, social, academic, and historical issues. The surveys include both expert and public opinion polls.

The Greater New York Hospital Association (GNYHA) conducted the 2022 GNYHA CHNA Survey of adults aged 18 or older who live in a zip code or county served by the hospital. The survey was intended to garner resident input on community health priorities based on perceived importance and satisfaction. The survey used a non-probability convenience sample. A web-based survey tool and a paper-based tools were used to collect the survey data. Surveys were available in a variety of languages. The GNYHA CHNA questionnaire was translated from English into Spanish, Chinese, Russian, Yiddish, Bengali, Korean, Haitian Creole, Italian, Arabic, and Polish.

Methodology and Community Engagement

The 2022 CHNA included quantitative research methods and community conversations to determine health trends and disparities affecting the Sharon Hospital community. Community engagement was an integral part of the 2022 CHNA. In assessing community health needs, input was solicited and received from persons who represent the broad interests of the community, as well as underserved, low-income, and minority populations. These individuals provided wide perspectives on health trends, expertise about existing community resources available to meet those needs, and insights into service delivery gaps that contribute to health disparities and inequities.

The following research methods were used to determine community health needs:

- **Analysis of Health and Socioeconomic Data:** Public health statistics, demographic and social measures, and healthcare utilization data were collected and analyzed to develop a comprehensive community profile that illuminated health disparities and underlying inequities.
- **Community Surveys of Lived Experiences:** As part of the DataHaven Community Wellbeing Survey across Connecticut and Siena College Regional Community Health Survey within New York, statistical telephone surveys were conducted with households in the Sharon Hospital community to gather information on wellbeing and quality of life.

- **Community Perception Surveys:** As part of the Greater New York Hospital Association CHNA Survey, a web- and paper-based convenience survey was conducted with nearly 200 households in the Sharon Hospital community to garner perceptions on health priorities.
- **Input from Experts and Key Stakeholders:** Health and social service providers, public health experts, and representatives from a wide range of community-based organizations participated in the CHNA to guide the process and provide insights on community health needs.

Community Health Priorities

To work toward health equity, Nuvance Health commits to ensuring hospital resources and activities build upon existing priorities and collaborative activities, while ensuring responsiveness to emergent needs. Determination of priorities made by leadership of Nuvance Health included review of existing commitments, new research findings, and community feedback.

Nuvance Health will focus efforts on the following community health priorities as part of its 2022-2025 Community Health Implementation Plan (CHIP):

- Prevent Chronic Diseases
- Promote Well-Being and Prevent Mental and Substance Use Disorders

Nuvance Health is committed to continuing its collaboration with the Community Health Committee and other stakeholders to further refine focus areas within the identified health priorities. Together with these partners and stakeholders, Nuvance Health will create a CHIP that reflects collective health impact strategy and the many strengths and assets of our community partners to address these needs.

Board Approval

The 2022 CHNA was conducted in a timeline to comply with IRS Tax Code 501(r) requirements to conduct a CHNA every three years as set forth by the Affordable Care Act (ACA). The 2022 CHNA report was presented to the Nuvance Health Board of Directors and approved in September 2022.

Following the Board's approval, the CHNA report was made available to the public via the Nuvance Health website at Nuvance Health.

Sharon Hospital Service Area

Sharon Hospital is located in Sharon, Connecticut in Litchfield County, along the Columbia County and Dutchess County, New York borders. The hospital serves residents of all three counties, although most patients reside in Litchfield or Dutchess. For purposes of the CHNA and partnering with state-based initiatives, Sharon Hospital focused on its Litchfield and Dutchess County service areas and conducted research for these communities separately.

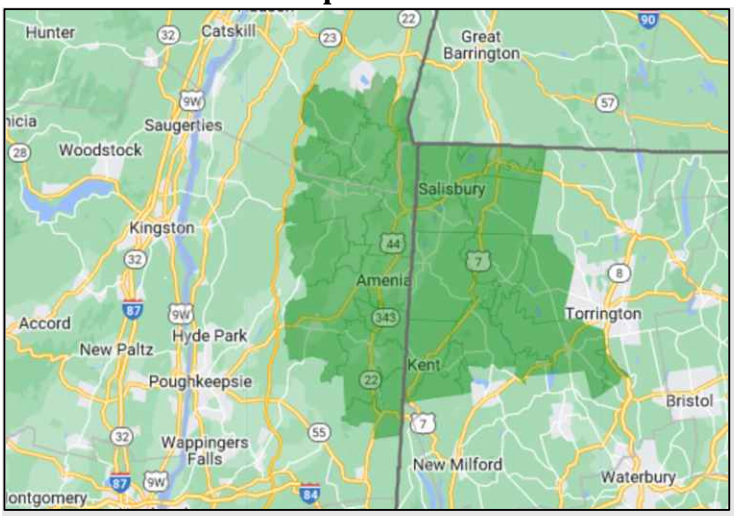
Sharon Hospital's CT and NY service areas, as depicted below, are referred to as the Connecticut Hospital Service Area (HSA) and New York HSA throughout the report. The CHNA data may also be presented for Dutchess and/or Litchfield counties, based on availability.

Connecticut HSA data includes DataHaven Community Wellbeing Survey results. Survey results are presented for the HSA with comparisons to Connecticut overall. Due to data limitations, results by respondent demographics, including race, ethnicity, and income, are only shown for Connecticut. New York HSA data includes Siena College Regional Community Health Survey results. Due to data limitations, survey results are presented for the aggregate service area only. The GNYHA CHNA Survey garnered feedback from residents across the Connecticut and New York HSAs.

Health and socioeconomic data for the New York HSA were collected as part of the Mid-Hudson Region CHNA, unless otherwise noted. The regional CHNA was led by seven health departments and area health systems serving Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties. Data are most robust at the county-level and generally compare Dutchess County to the region, New York State (NYS), and/or New York State excluding New York City (NYS excl NYC).

Note: Connecticut HSA data is presented by town, including Sharon and the surrounding communities of Canaan, Cornwall, Goshen, Kent, North Canaan, Salisbury, and Warren. New York HSA data is presented by zip code for the communities of Amenia, Dover Plains, Millbrook, Millerton, Pine Plains, Stanfordville, Wassaic, and Wingdale. This difference in service area definition reflects community partner data collection and reporting practices.

Sharon Hospital Service Area



Understanding changes in population demographics is critical to plan for changes in healthcare, housing, economic opportunity, education, social services, transportation, and other essential infrastructure elements.

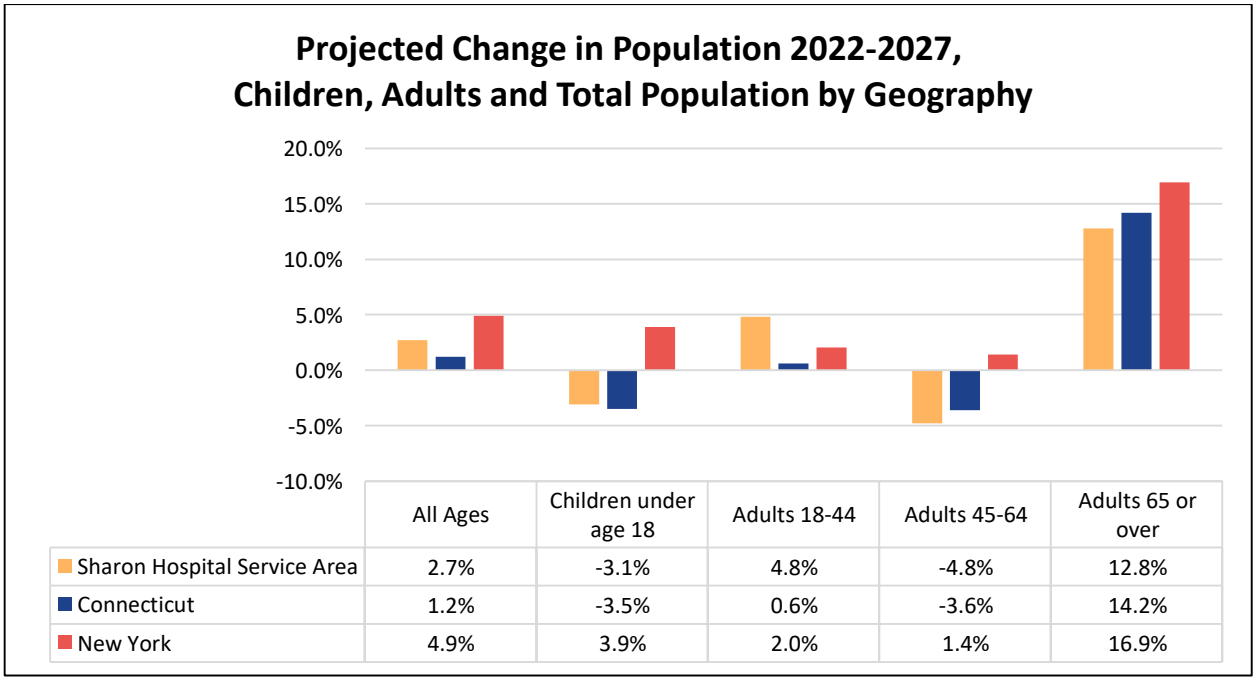
Connecticut and New York overall are aging states. Between 2022 and 2027, the population aged 65 or older is projected to increase 14.2% and 16.9%, respectively, the largest increase of any reported age group. The total population for Connecticut and New York is projected to increase 1.2% and 4.9%, respectively.

The Sharon Hospital Service Area population is projected to increase +1,549 people or 2.7% from 2022 to 2027, although consistent with an aging demographic, this growth will occur exclusively among adult populations. The population aged 65 or older will increase by +1,904 people or 12.8% from 2022 to 2027, while the child population under age 18 will decline by -297 people or -3.1%.

Total Population and Population Change by Age Group

	2022 Population	2027 Population Projection	Projected Change
Sharon Hospital Service Area			
All Ages	57,968	59,517	+1,549
Children under age 18	9,624	9,327	-297
Adults 18-44	16,109	16,877	+768
Adults 45-64	17,361	16,535	-826
Adults 65 or over	14,874	16,778	+1,904

Source: Claritas



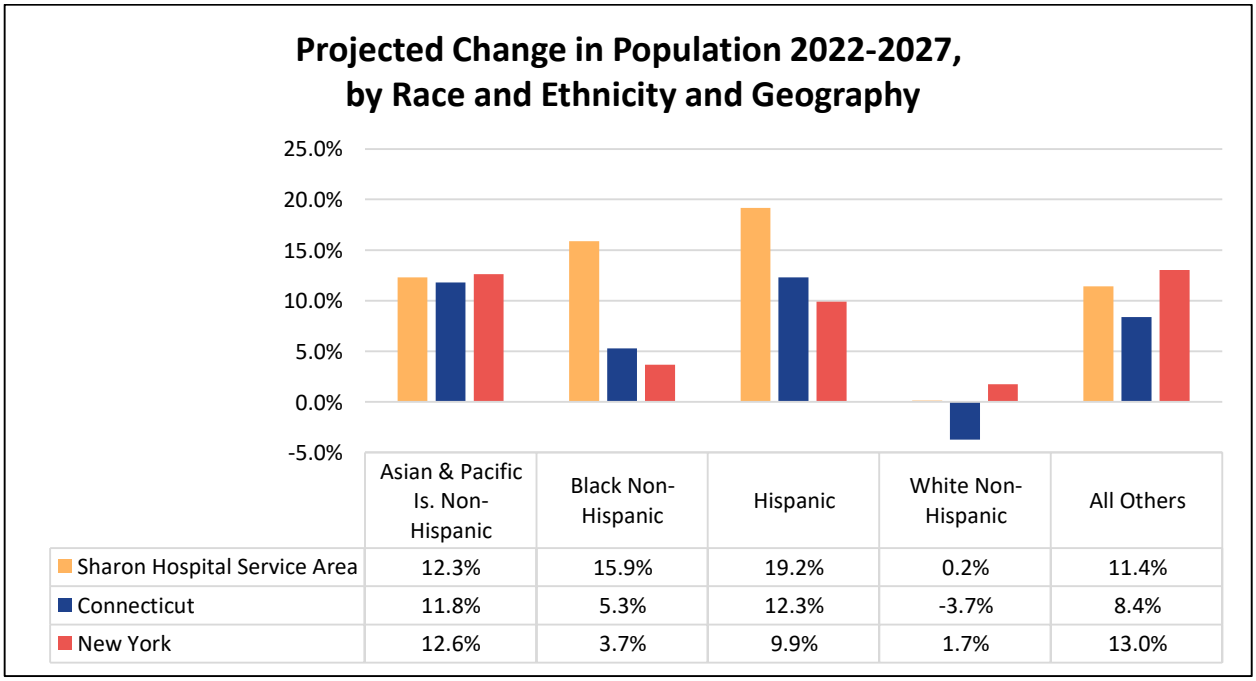
Source: Claritas

The Sharon Hospital Service Area is less racially and ethnically diverse than Connecticut and New York overall, although consistent with statewide trends, people of color are the fastest growing populations within the service area. Between 2022 and 2027, the white population within the Sharon Hospital Service Area is projected to grow 0.2%, while all other racial and ethnic groups are projected to grow 11% or more.

2021 Total Population by Race and Ethnicity

	2022 Population		Projected Change 2022-2027
	Count	Share of Population	
Sharon Hospital Service Area			
Asian & Pacific Islander Non-Hispanic	838	1.5%	+103
Black Non-Hispanic	1,513	2.6%	+240
Hispanic	5,220	9.0%	+1,001
White Non-Hispanic	49,259	85.0%	+75
All Others	1,138	2.0%	+130

Source: Claritas

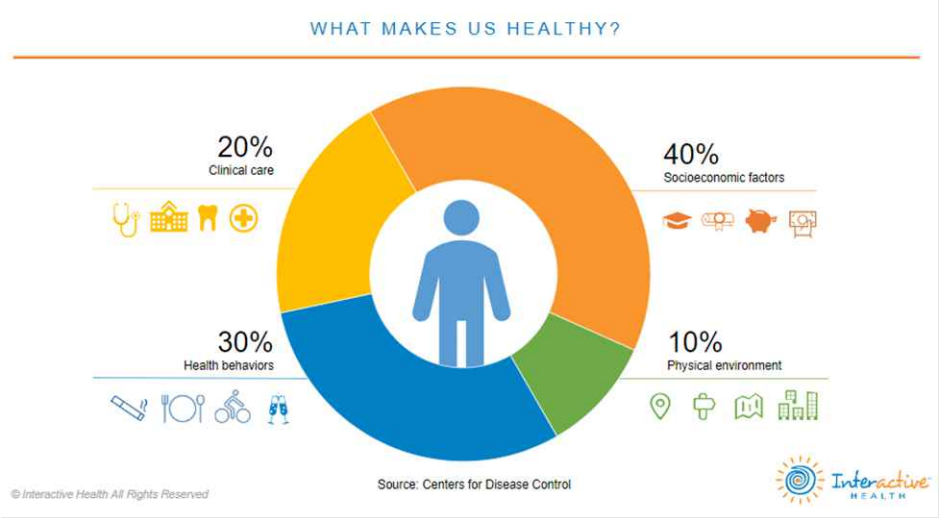


Source: Claritas

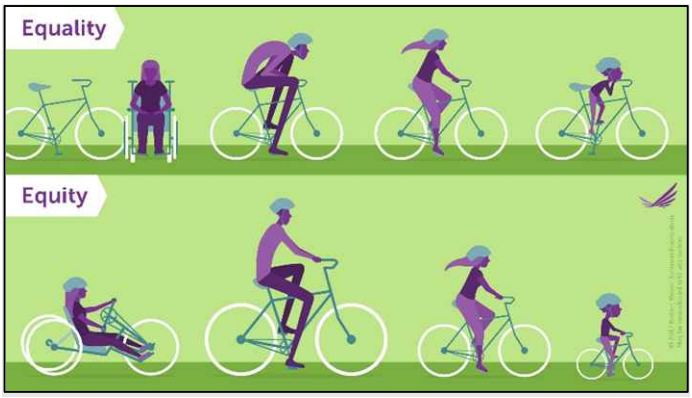
Social Determinants of Health and Health Equity: A closer look at factors that influence well-being

Social determinants of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes. Healthy People 2030, the CDC's national benchmark for health, outlines five key areas of SDoH: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

While health improvement efforts have historically targeted health behaviors and clinical care, public health agencies, including the US Centers for Disease Control and Prevention (CDC), widely hold that at least **50% of a person's health profile is determined by SDoH.**



Addressing SDoH is a primary approach to achieving *health equity*. **Health equity can be simply defined as "a fair and just opportunity for every person to be as healthy as possible."** To achieve health equity, we need to look beyond the healthcare system to dismantle systematic inequities born through racism and discrimination like power and wealth distribution, education attainment, job opportunities, housing, and safe environments, to build a healthier community for all people now and in the future.



Social Determinants of Health within the Sharon Hospital Service Area

Economic Stability

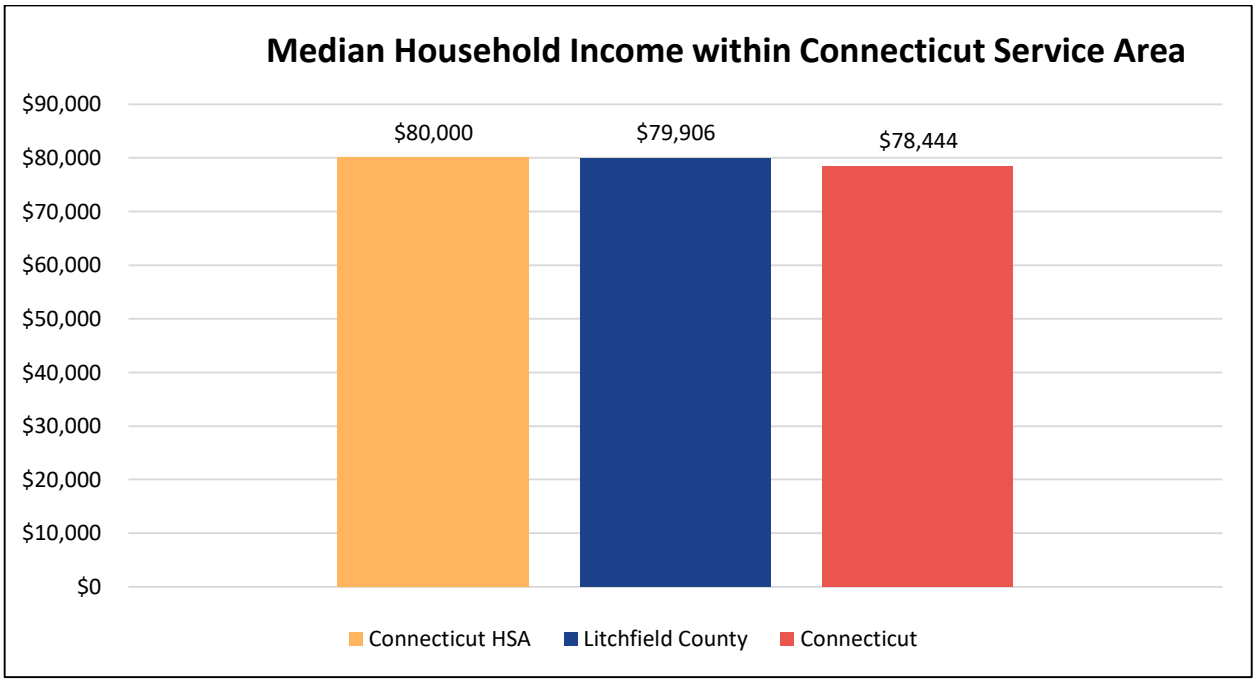
Income and work impact health outcomes. For example, many Americans access health insurance through their job, although not all types of work provide access to health insurance. Beyond health insurance, making healthy choices, such as purchasing lean meats and fresh produce or joining a gym, all cost money. Securing employment that allows individuals to provide a safe and decent home, nutritious food, transportation, child and elder care services, leisure activities, exercise, and medical needs depends on many factors. These factors can include education, age, access to employment opportunities, racism, language, and literacy, among others.

The median household income in the Connecticut HSA is $80,000, compared to $77,696 statewide, and fewer residents live in poverty compared to the state overall. However, this positive experience is not shared by all residents. Within the HSA, median household incomes by town range from $62,432 in North Canaan to $109,886 in Goshen. North Canaan also has higher poverty levels, affecting approximately 14% of all residents.

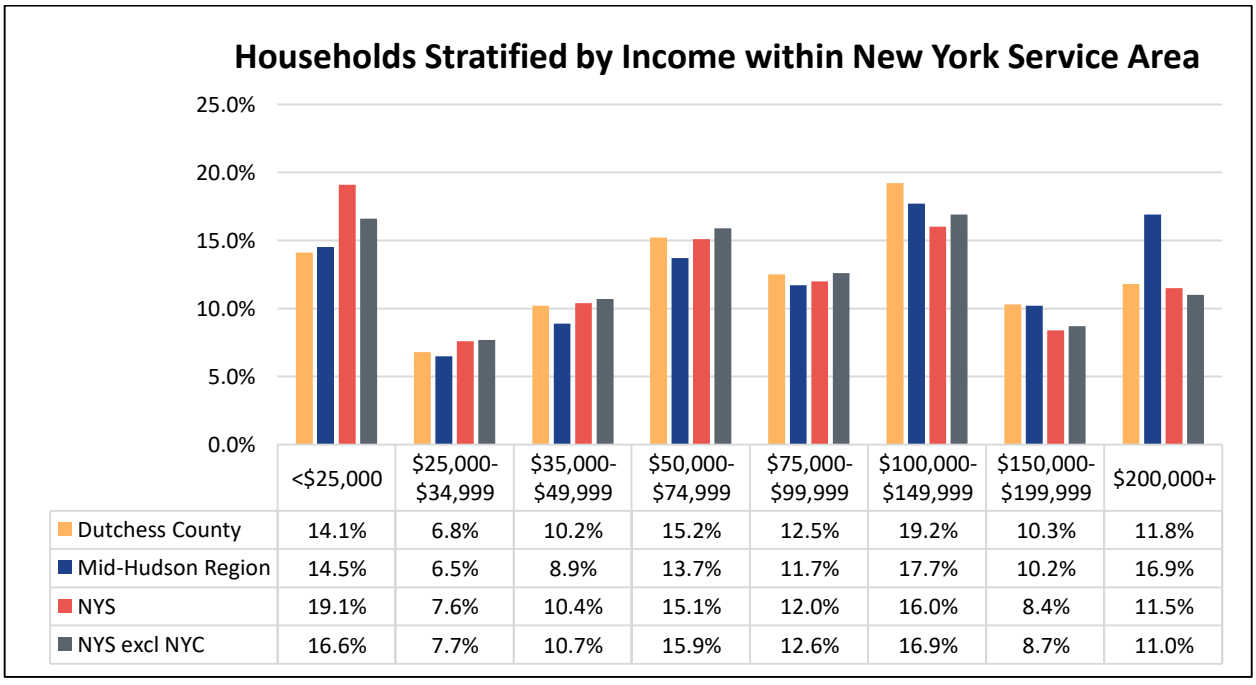
Residents of neighboring Dutchess County also have historically higher household incomes and lower poverty compared to New York overall. However, it is worth noting that across the county, more than 1 in 10 (14.1%) households have an annual income of less than $25,000.

Siena College Community Health Survey results indicate potentially higher socioeconomic need within Sharon Hospital's New York HSA relative to Dutchess County overall. Among survey respondents, 52% said it was "not very true" or "not at all true" that there are enough jobs that pay a living wage in their community. Approximately 18% of respondents had a time in the past 12 months when they or a member of their household were unable to get food when they needed it, and 8% had a time when they were unable to get utilities, including heat and electricity.

Across Dutchess County, the percentage of all food insecure residents was unchanged from 2017 to 2020, while the percentage of food insecure children declined. This finding may indicate increasing food insecurity among other vulnerable populations, such as older adults, communities of color, and/or individuals with low-income.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates



	<$25,000	$25,000-$34,999	$35,000-$49,999	$50,000-$74,999	$75,000-$99,999	$100,000-$149,999	$150,000-$199,999	$200,000+
Dutchess County	14.1%	6.8%	10.2%	15.2%	12.5%	19.2%	10.3%	11.8%
Mid-Hudson Region	14.5%	6.5%	8.9%	13.7%	11.7%	17.7%	10.2%	16.9%
NYS	19.1%	7.6%	10.4%	15.1%	12.0%	16.0%	8.4%	11.5%
NYS excl NYC	16.6%	7.7%	10.7%	15.9%	12.6%	16.9%	8.7%	11.0%

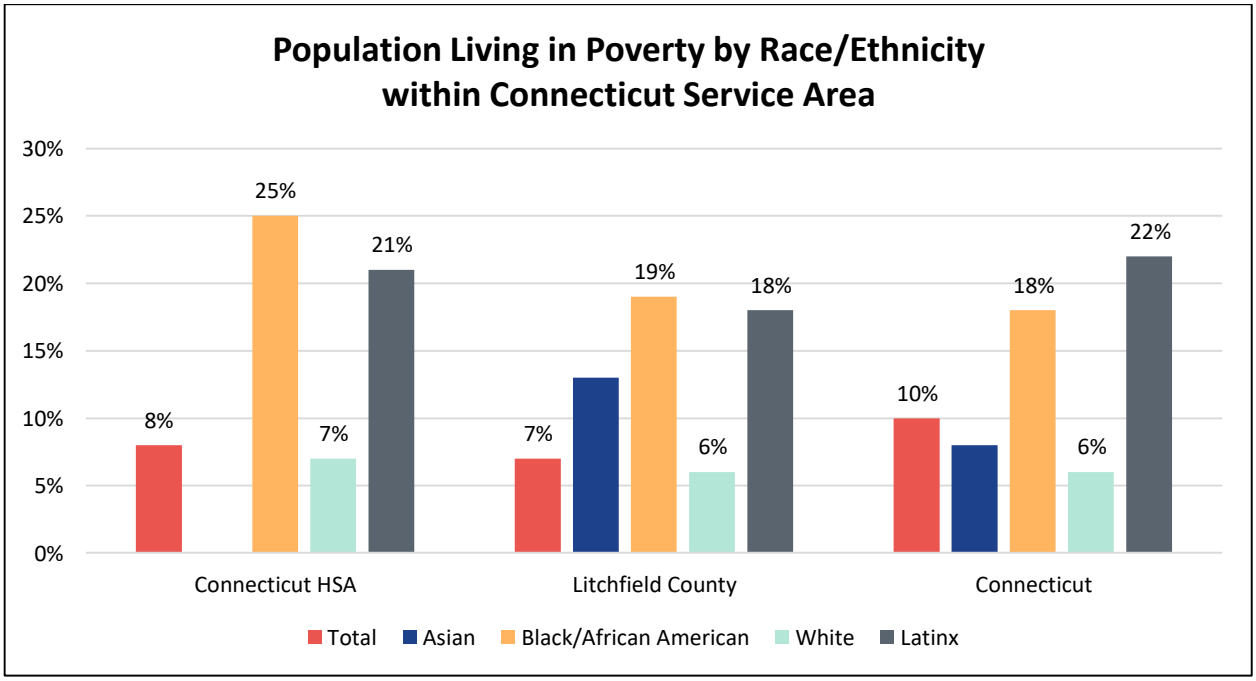
Source: Mid-Hudson Region CHNA, US Census Bureau American Community Survey 2020 5-year estimates

Food Insecurity within New York Service Area

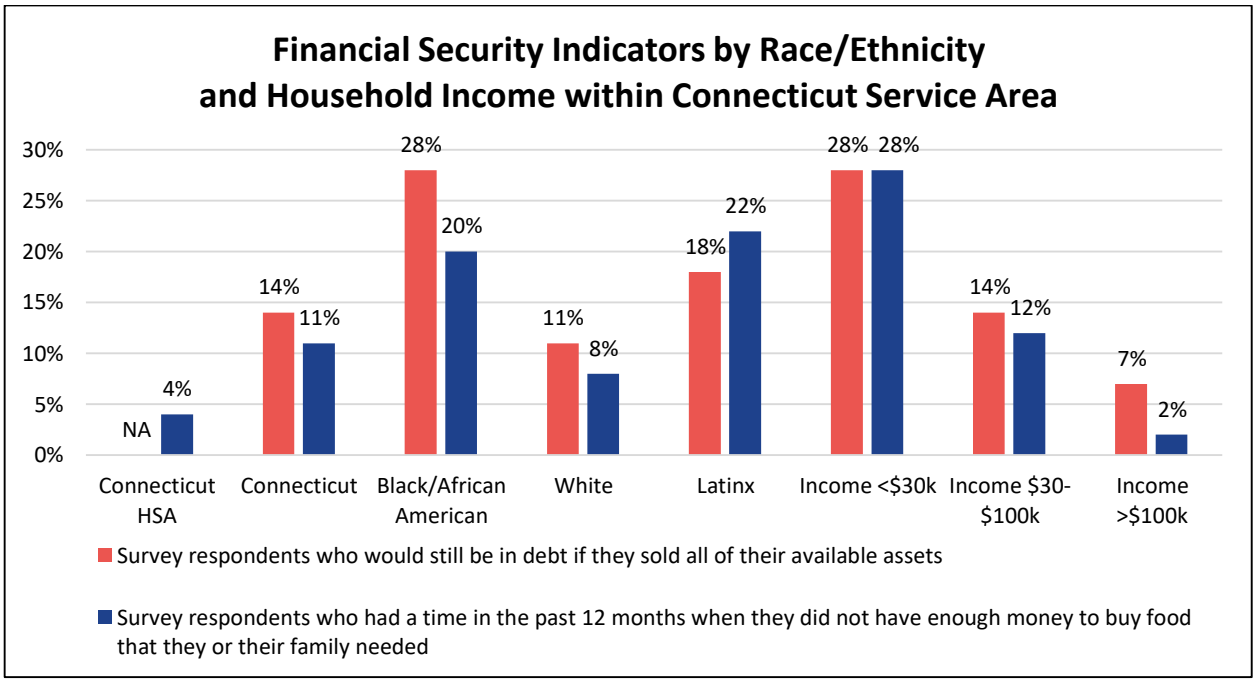
	All Residents		Children	
	Dutchess County	New York	Dutchess County	New York
2017	8.6%	11.4%	14.5%	17.6%
2018	8.7%	11.1%	14.1%	16.9%
2019	8.5%	10.7%	12.5%	15.7%
2020	8.7%	9.6%	12.0%	14.6%

Source: Mid-Hudson Region CHNA, Feeding America, 2022

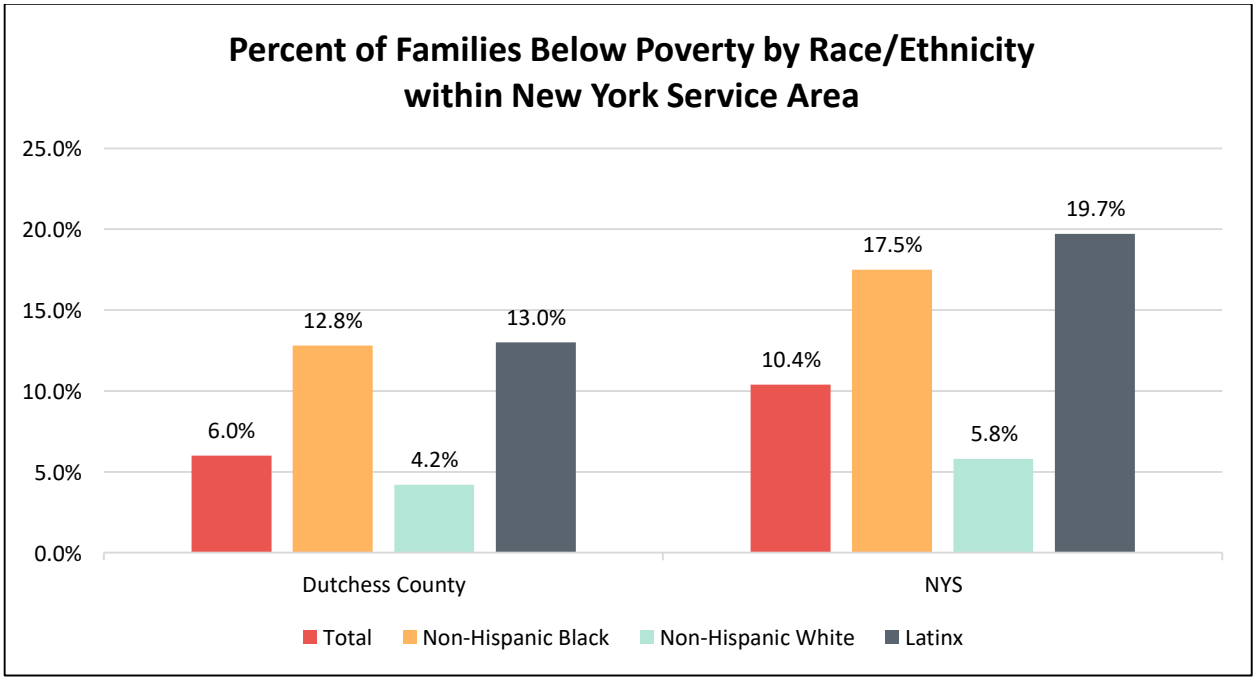
Historical barriers based on race, gender, ethnicity, and other factors continue to impact financial security and income for people today. For example, across the Connecticut and New York service areas, Black/African American and Latinx residents are more than twice as likely to live in poverty as white residents. Among Connecticut HSA Community Wellbeing Survey respondents, 28% of Black/African American respondents said they would still be in debt if they sold all of their assets, compared to 11% of white respondents. This disparity in economic resources impacts the ability of people with lower incomes to engage in health promoting activities, creating differences in the choices available to people to live their healthiest lives.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates



Source: 2021 DataHaven Community Wellbeing Survey



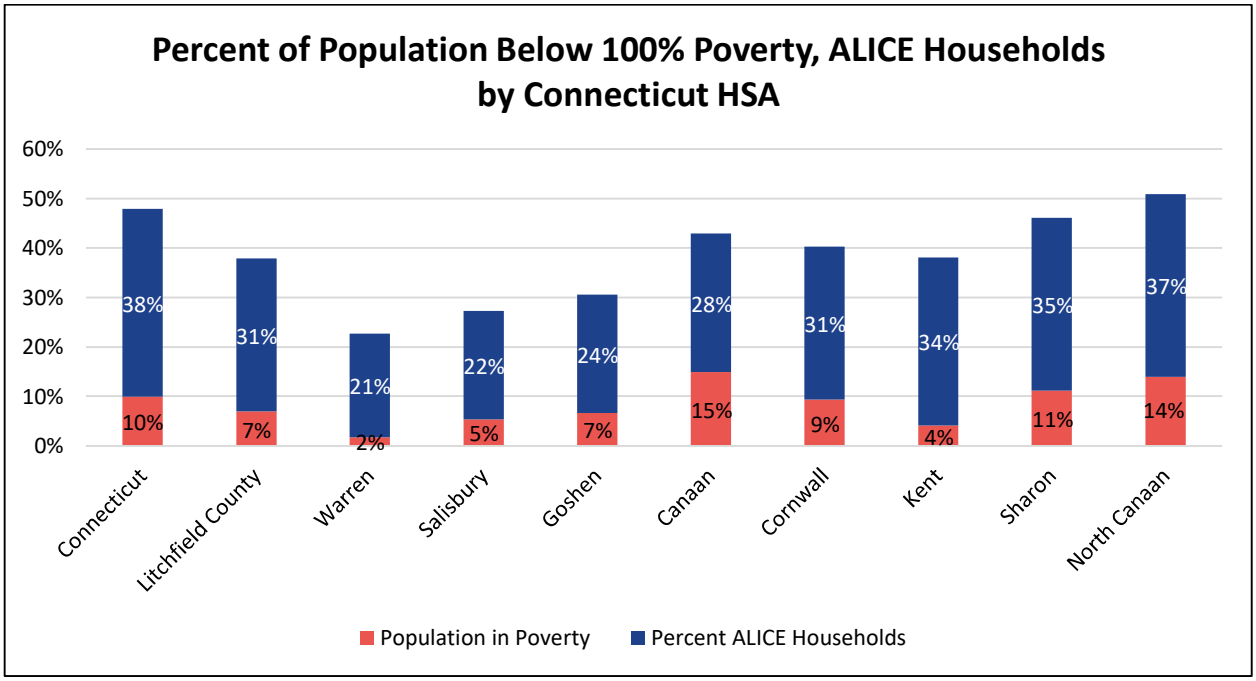
Source: Mid-Hudson Region CHNA, NYS Department of Health County Health Indicators, 2017-2019

Asset Limited, Income Constrained, Employed (ALICE) The ALICE threshold is an index that captures the percent of households whose income is above the federal poverty level, but below the threshold necessary to meet all basic needs based on localized cost of living and local average

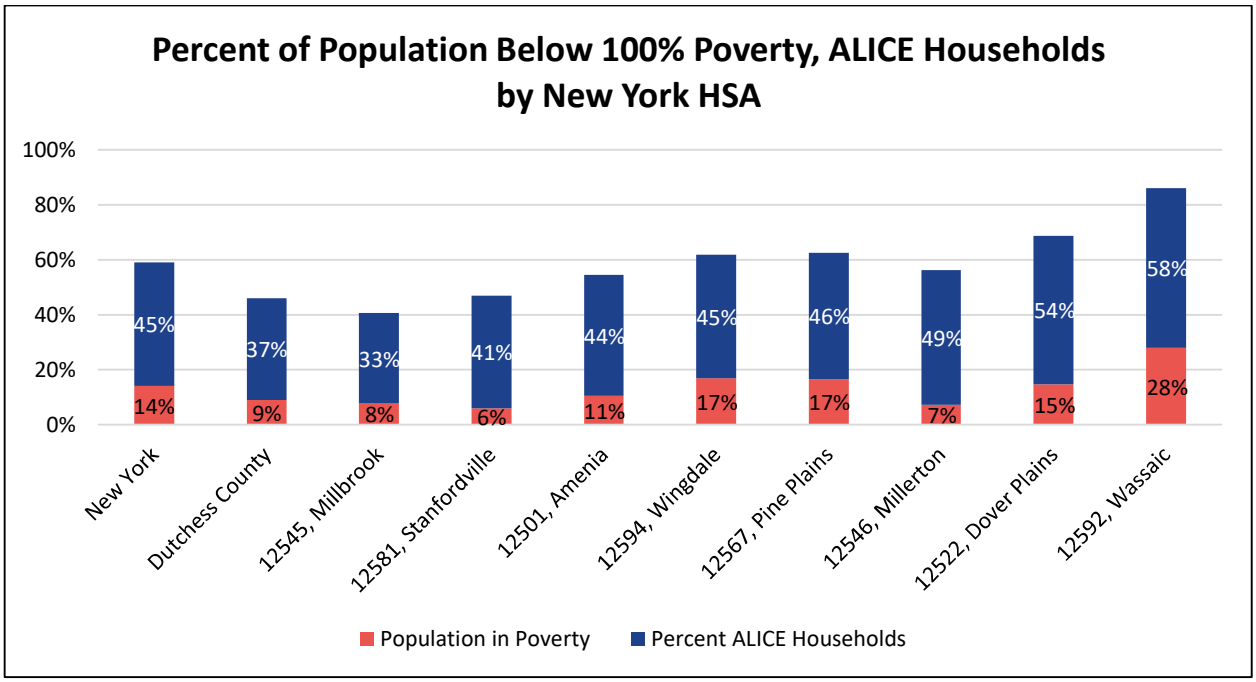
household sizes. ALICE measures the proportion of working poor and households who struggle to meet basic needs and are a paycheck or two away from acute financial strife.

While the proportion of people living in poverty is relatively low across the Connecticut HSA, more than 1 in 10 and up to 37% of all households throughout the area met the ALICE threshold. Within the New York HSA, Wassaic zip code 12592 is a pocket of economic disparity with 28% of residents living in poverty and 58% of households below ALICE. In comparison to the Connecticut HSA, New York HSA households overall are more likely to meet the ALICE threshold.

It is worth noting that ***ALICE findings reflect pre-COVID-19 pandemic data***. While the data regarding these measures during the pandemic are not yet available, anecdotal information suggests that the proportion of struggling households has increased during more recent years.



Source: United for ALICE and US Census Bureau American Community Survey 2019 5-year estimates



Source: United for ALICE and US Census Bureau American Community Survey 2019 5-year estimates

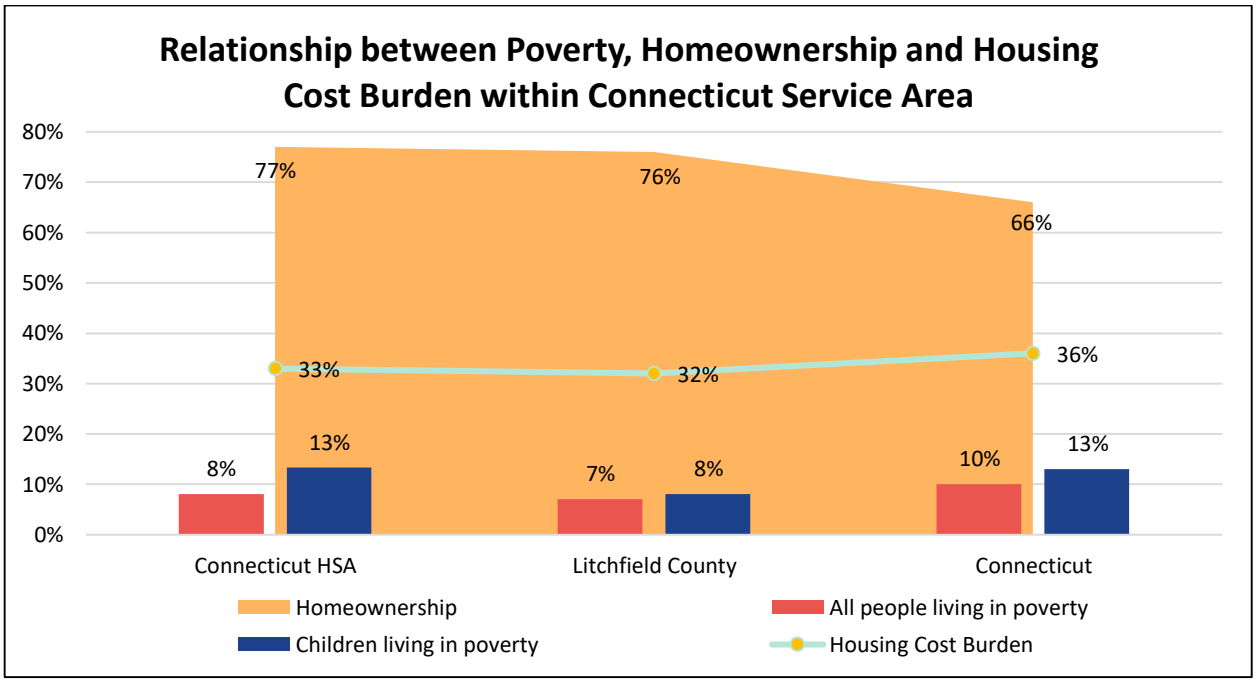
Where you live impacts the choices available to you. These choices impact your income, wellness, and ultimately how long you live. These place-based choices, as well as lived experiences like discrimination and racism, also inform perception of opportunities.

For neighborhoods, a higher proportion of homeownership means greater neighborhood stability. Greater neighborhood stability means greater opportunities for investment in infrastructure, such as schools, roads, public transportation, and green spaces, key elements for healthy living.

Owning a home is an investment. For many families, their home is their largest asset. However, historically, structures have been in place that prevent people of color and others from purchasing a home. Today, this historic structural inequity manifests in the financial assets that certain populations have been able to pass on to future generations. The security of knowing one has a home can also reduce chronic stress, a significant factor in developing chronic disease.

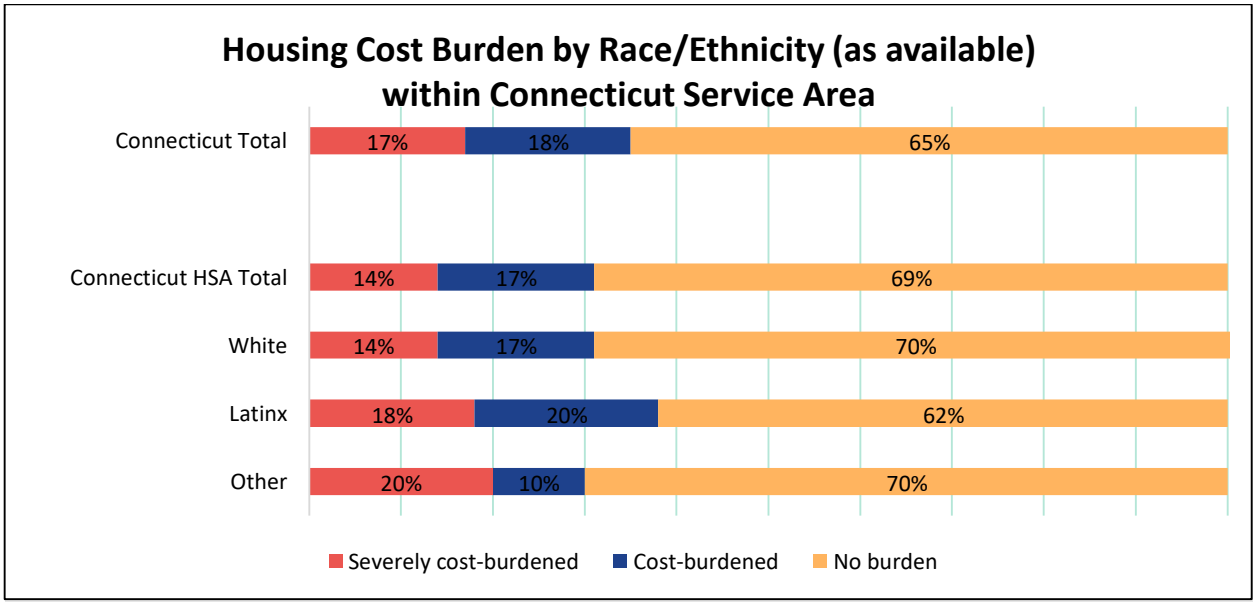
Housing is often the largest single monthly expense for households and should represent no more than 30% of a household's monthly income. When households spend more than 30% of their income on housing, they are considered housing cost-burdened. When housing costs consume more than 30% of a household budget, fewer resources are available for other necessities like food, transportation, and childcare.

The graph below demonstrates that across Connecticut, communities with greater proportions of homeowners are associated with fewer residents living in poverty and fewer cost burdened households. However, it is worth noting that within the Connecticut HSA, 1 in 3 households are considered housing cost burdened.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Among renter households in the Connecticut HSA, 52% are cost-burdened compared to 25% of owner households. Among Latinx householders (owner or renter), approximately 38% are cost-burdened compared to 30% of white householders.

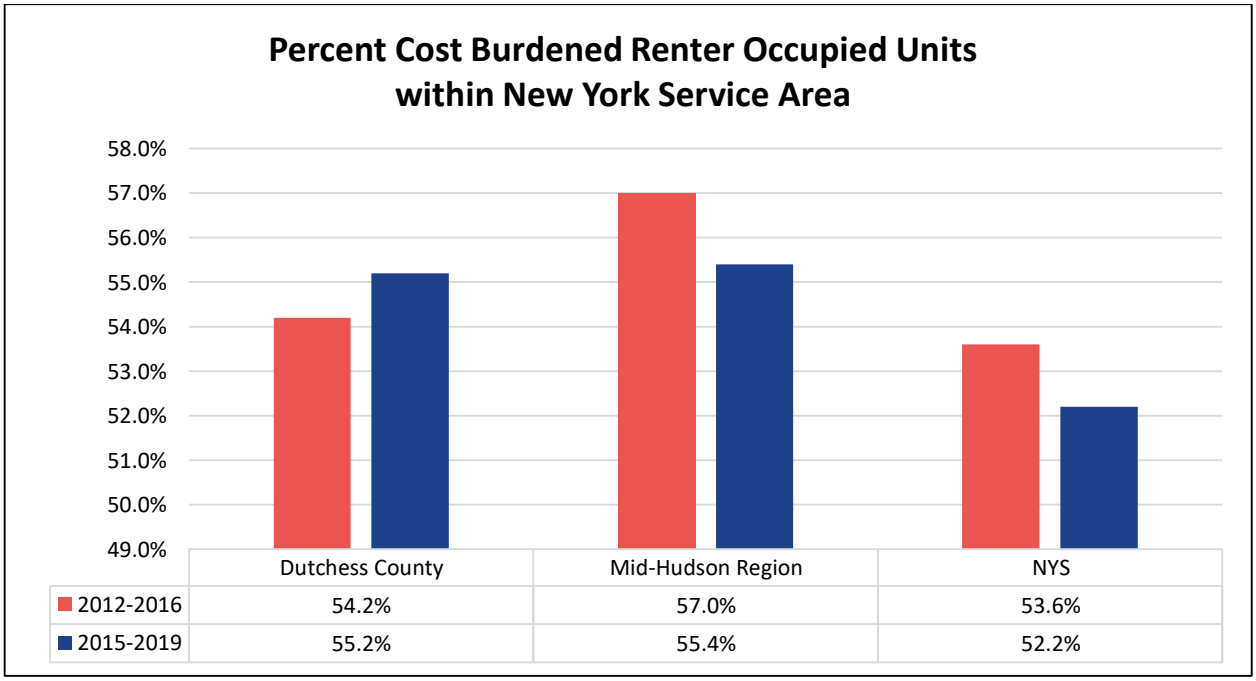


Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Among renter households in Dutchess County, 55.2% are cost burdened, and contrary to Mid-Hudson Region and New York statewide trends, the percentage increased from prior years. Among

all households (renter or owner) in Dutchess County from 2016-2020, 16% were considered severely cost burdened compared to 19% statewide. Severely cost burdened is defined as spending more than 50% of household income on housing.

Housing affordability was a concern for New York HSA Community Health Survey respondents. Approximately 88% said it was "completely true" or "somewhat true" that people may have a hard time finding a quality place to live due to high costs. Approximately 12% had a time in the past 12 months when they or a member of their household were unable to get housing when they needed it.



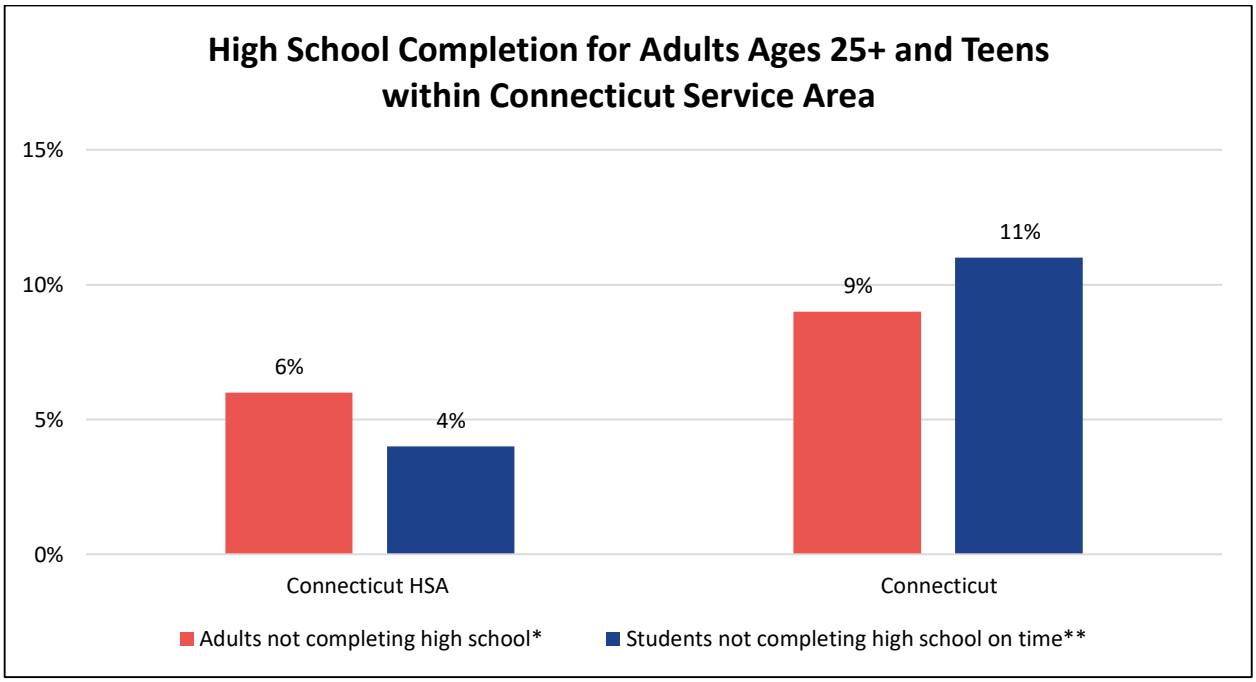
	Dutchess County	Mid-Hudson Region	NYS
2012-2016	54.2%	57.0%	53.6%
2015-2019	55.2%	55.4%	52.2%

Source: Mid-Hudson Region CHNA, NYS Department of Health County Health Indicators, 2021

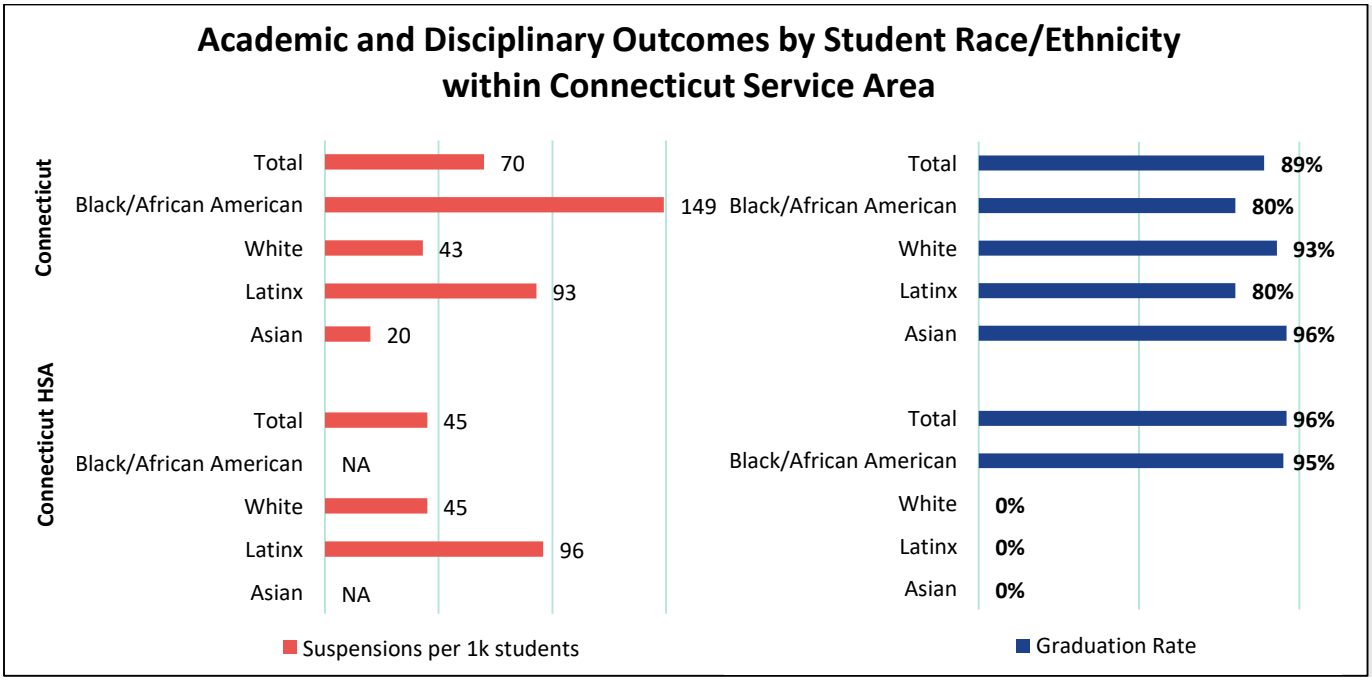
Education Access and Quality

Education is one of the best predictors of good health and long lives. Availability of accessible, well-funded, and well-resourced public education opportunities and exposure to diverse employment pathways, such as in the healthcare and social services fields, build a strong foundation for young people and increase the opportunity for upward mobility, economic security, and better health.

Overall, people living in the Connecticut HSA are well educated. Nearly all adults complete high school and nearly all teens graduate from high school on time, exceeding statewide averages. However, statewide trends point to underlying inequities among students of color. Statewide, Black/African American and Latinx students are more likely to experience unfairly harsh discipline and are less likely to graduate high school due to these and other structural barriers.



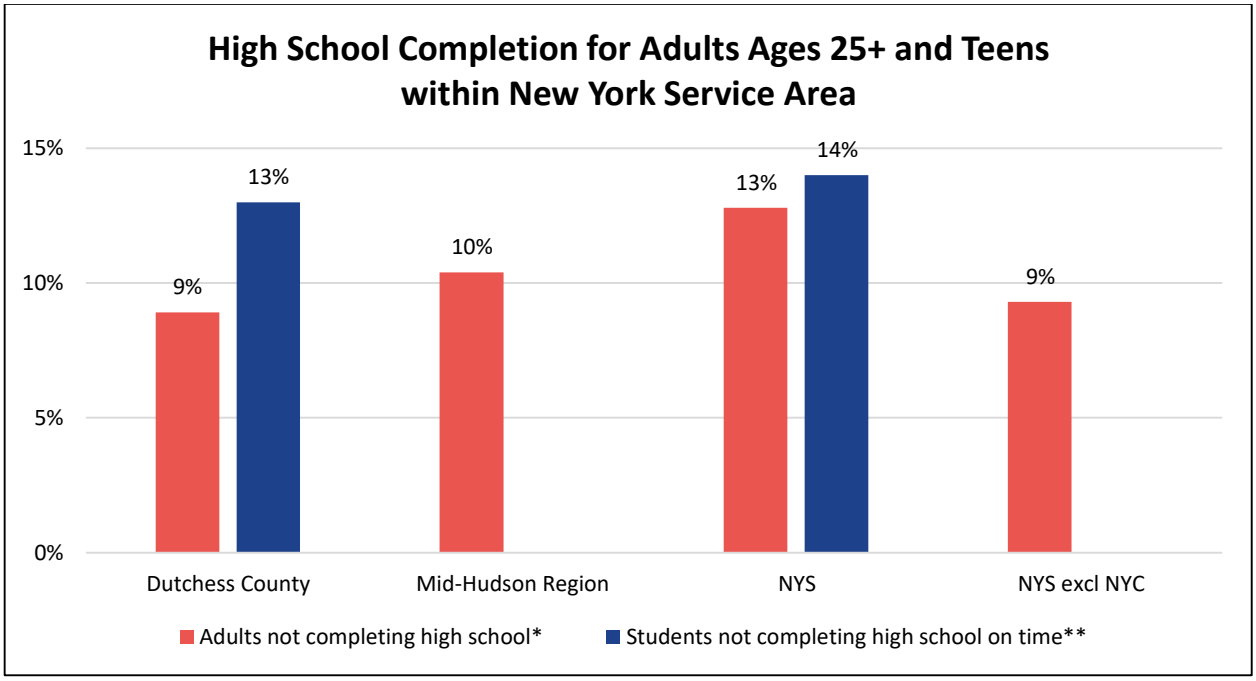
Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates* and Connecticut State Department of Education, 2018-2019**



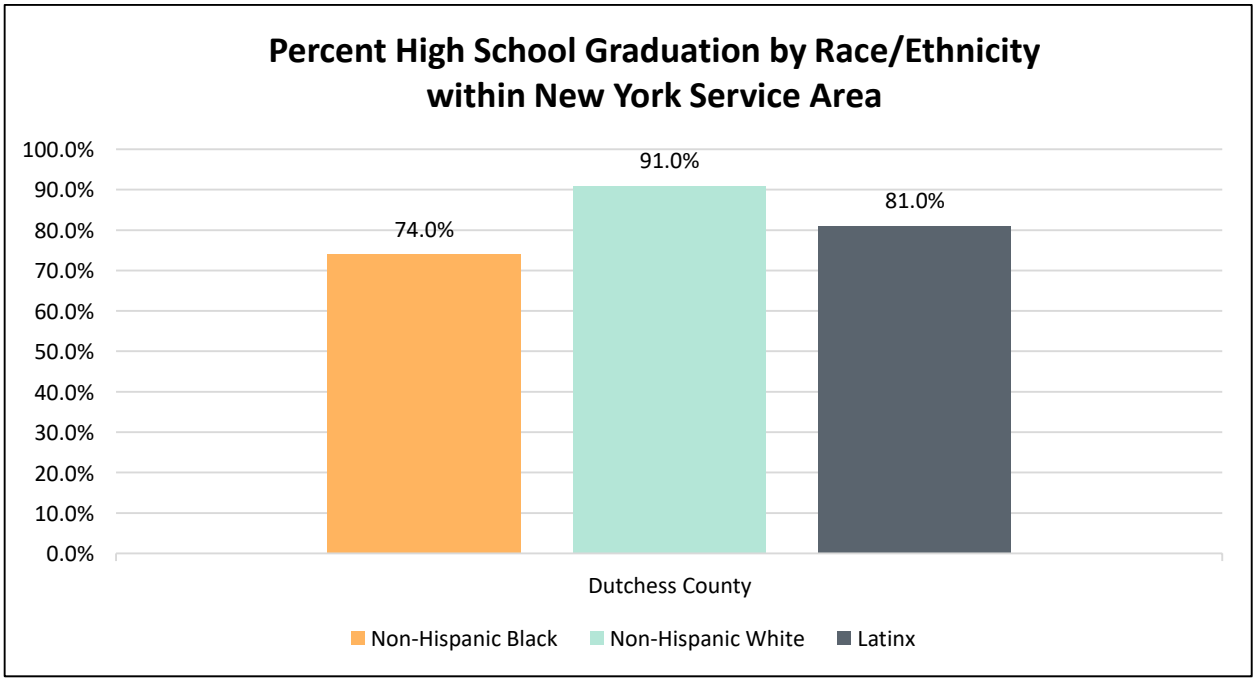
Source: Connecticut State Department of Education, 2018-2019 School Year

Residents of neighboring Dutchess County also benefit from higher educational attainment overall, although in comparison to Connecticut, residents are slightly less likely to complete high school and/or graduate on time. Additionally, educational inequities among students of color are more

evident in Dutchess County. Within the seven-county Mid-Hudson Region, Dutchess County has the largest disparity in graduation rates between non-Hispanic white (91%) and non-Hispanic black (74%) students.



Source: Mid-Hudson Region CHNA, US Census Bureau American Community Survey 2020 5-year estimates* and NYS Department of Education, 2021**

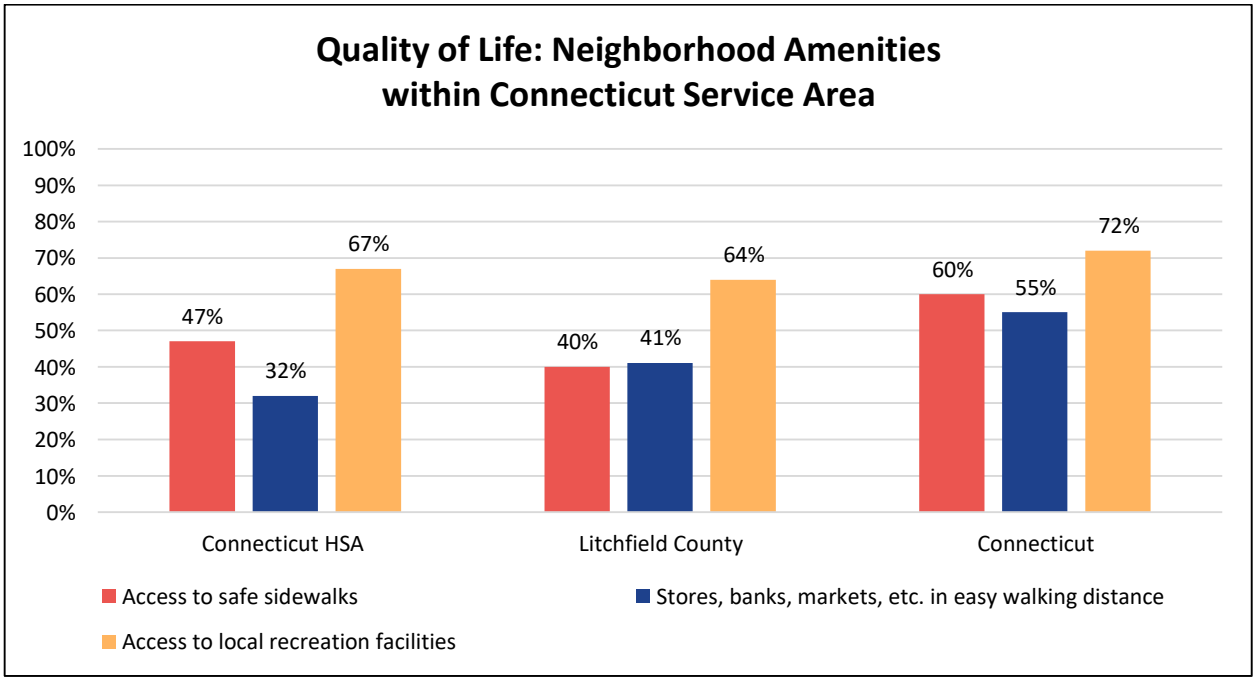


Source: Mid-Hudson Region CHNA, NYS Department of Education, 2022

Neighborhood and Built Environment

In addition to the resources available in communities, the physical environment and infrastructure of neighborhoods impacts health. The availability of well-maintained roads and safe sidewalks, and access to recreation, stores, banks, and other amenities are important components for healthy living.

Access to safe sidewalks, recreation, and shopping is less available in the Connecticut HSA than the state as a whole. While residents are more likely to have a vehicle at home to access services not within walking distance, lack of transportation is a barrier for many people, particularly those with lower incomes. Among statewide Community Wellbeing Survey respondents, 32% of respondents in the low-income range stated that they stayed home when they needed or wanted to go someplace, because they did not have reliable transportation, compared to 12% of respondents in the mid-income range and 3% of respondents in the high-income range. Similar disparities affect Black/African American and Latinx respondents relative to their white counterparts.



Source: DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey

No Vehicle at Home within Connecticut Service Area

Connecticut HSA	Connecticut
5%	9%

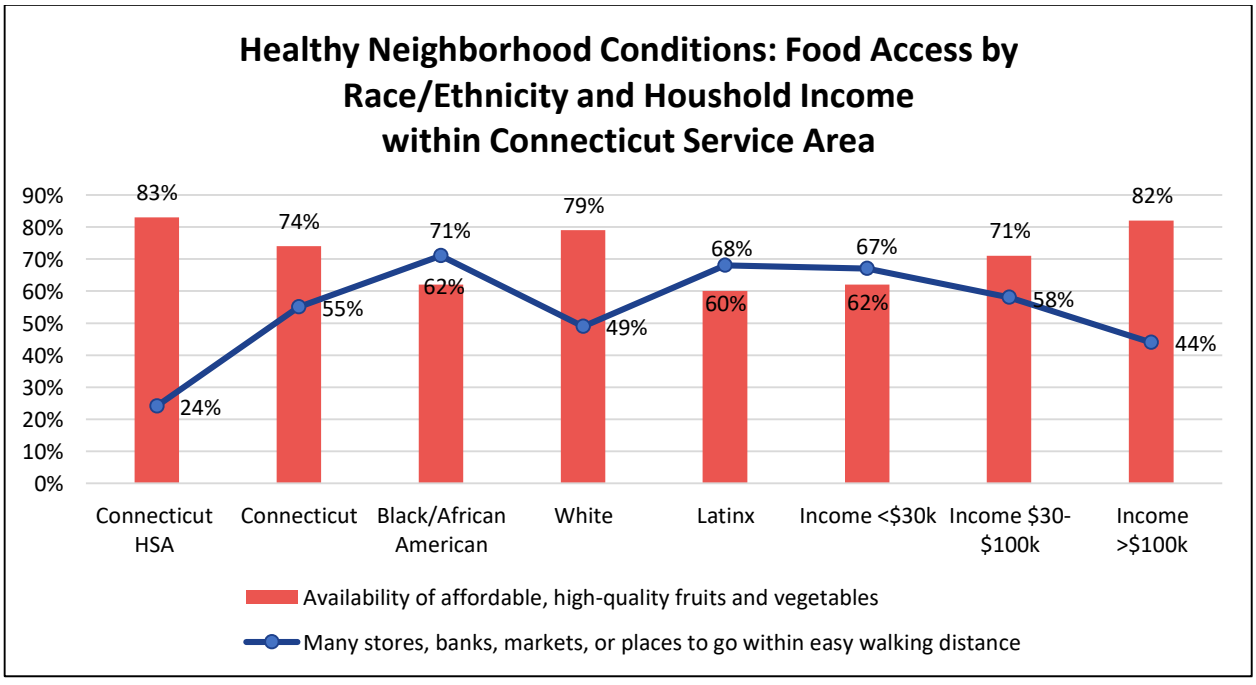
Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Connecticut HSA: Community Wellbeing Survey Respondents Who Stayed Home When Needed or Wanted to Go Someplace Because They Did Not Have Reliable Transportation

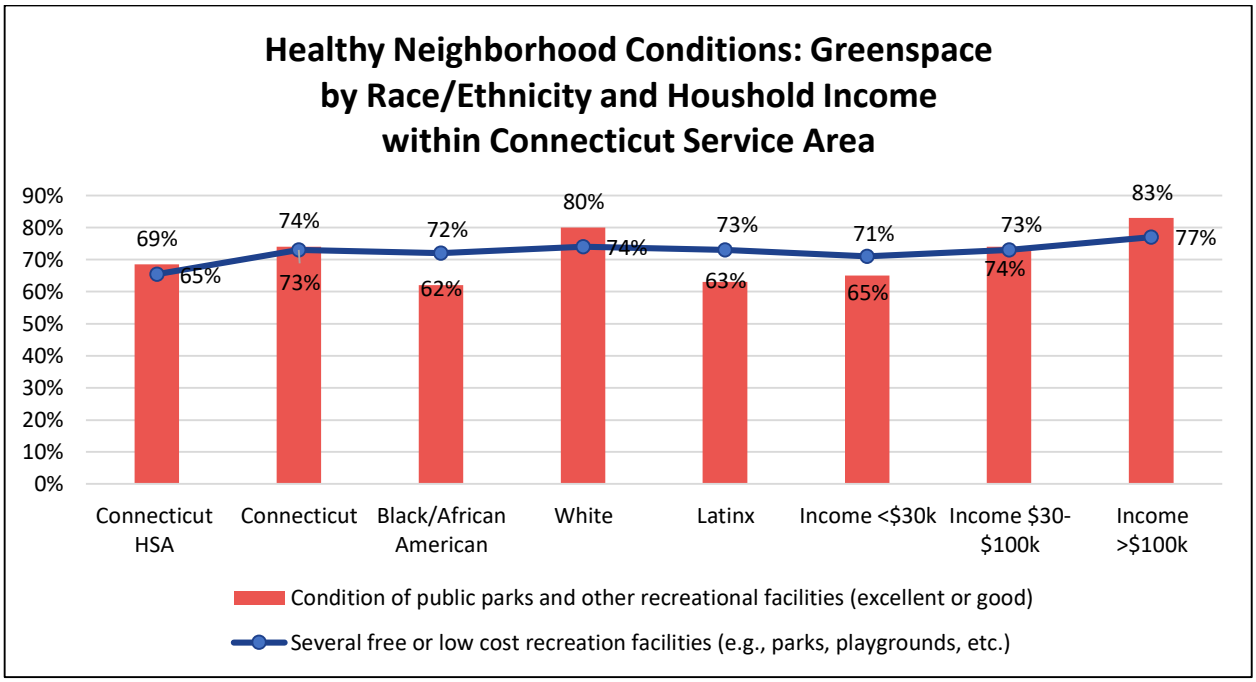
	Percent
Connecticut HSA (All Adults)	4%
Connecticut (All Adults)	13%
Black/African American	21%
White	9%
Latinx	22%
Household income <$30k	32%
Household income $30-$100k	12%
Household income >$100k	3%

Source: 2021 DataHaven Community Wellbeing Survey

Across Connecticut, there is wide variability in perceptions of the quality of available amenities within communities. Disparities are most evident among individuals with lower income and/or identifying as Black/African American or Latinx. Of note, statewide, 62% of individuals with lower income perceived having access to affordable and high-quality fruits and vegetables compared to 82% of individuals with higher income. Similarly, 62-63% of Black/African American and Latinx residents perceived having access to quality parks or other recreational facilities compared to 80% of white residents.



Source: 2021 DataHaven Community Wellbeing Survey



Source: 2021 DataHaven Community Wellbeing Survey

Across Dutchess County in 2019, approximately 6% of residents were estimated to have limited access to healthy foods compared to 2% of residents statewide. This estimate remained unchanged from 2015 data findings. Limited access to healthy foods measures the percentage of the population that is low-income and does not live close to a grocery store. Among New York HSA Community Health Survey respondents, 46% said it was "not very true" or "not at all true" that most people are able to access affordable food that is healthy and nutritious.

Fewer Dutchess County households do not have access to a personal vehicle compared to the state overall, and the percentage of households without a vehicle has declined. However, lack of public transportation is a concern, particularly for Sharon Hospital New York HSA residents. Among Community Health Survey respondents, 64% said it was "not very true" or "not at all true" that people can get to where they need using public transportation. Additionally, 19% of respondents had a time in the past 12 months when they or a member of their household were unable to get transportation when they needed it.

No Vehicle at Home within New York Service Area

	Dutchess County	New York
2014-2019	8.2%	29.1%
2015-2019	7.8%	29.1%
2016-2020	7.5%	29.0%

Source: Mid-Hudson Region CHNA, US Census Bureau American Community Survey 5-year estimates

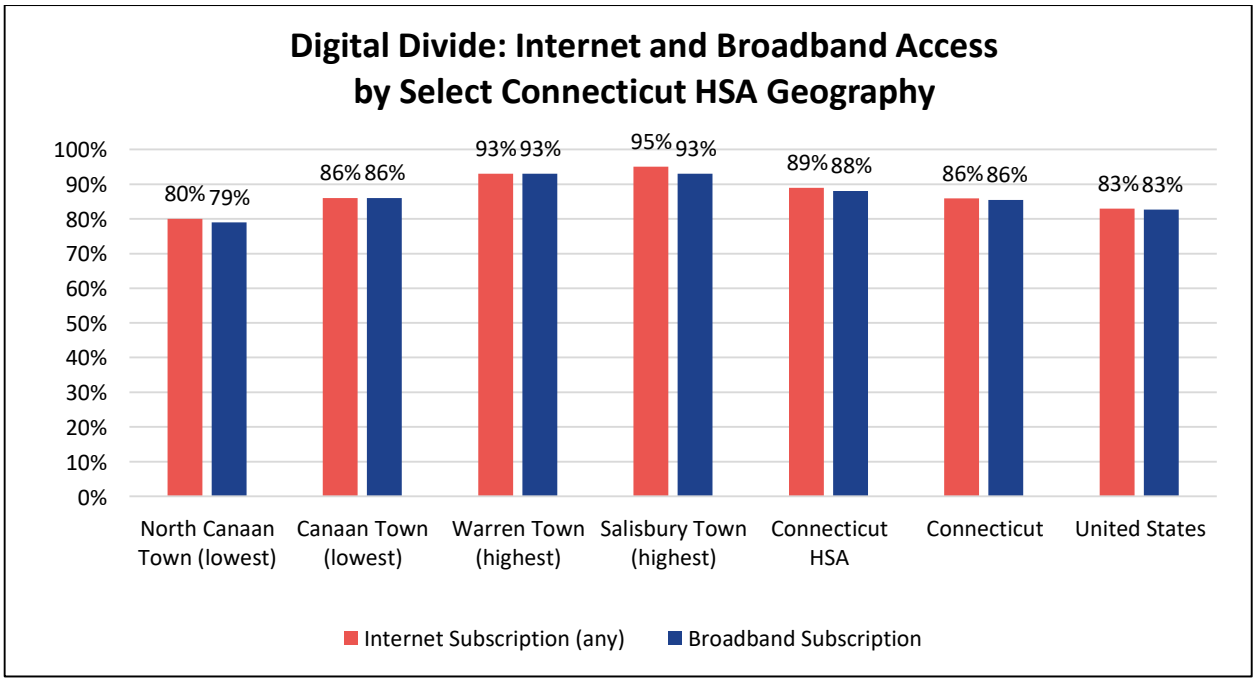
Approximately 17% of New York HSA Community Health Survey respondents had a time in the past 12 months when they or a member of their household were unable to get childcare when they needed it. Access to affordable, quality childcare is a primary barrier, with 65% of residents indicating it was "completely true" or "somewhat true" that parents struggle to find these services.

New York HSA (All Adults): Community Health Survey Respondents Perceptions of Available Services

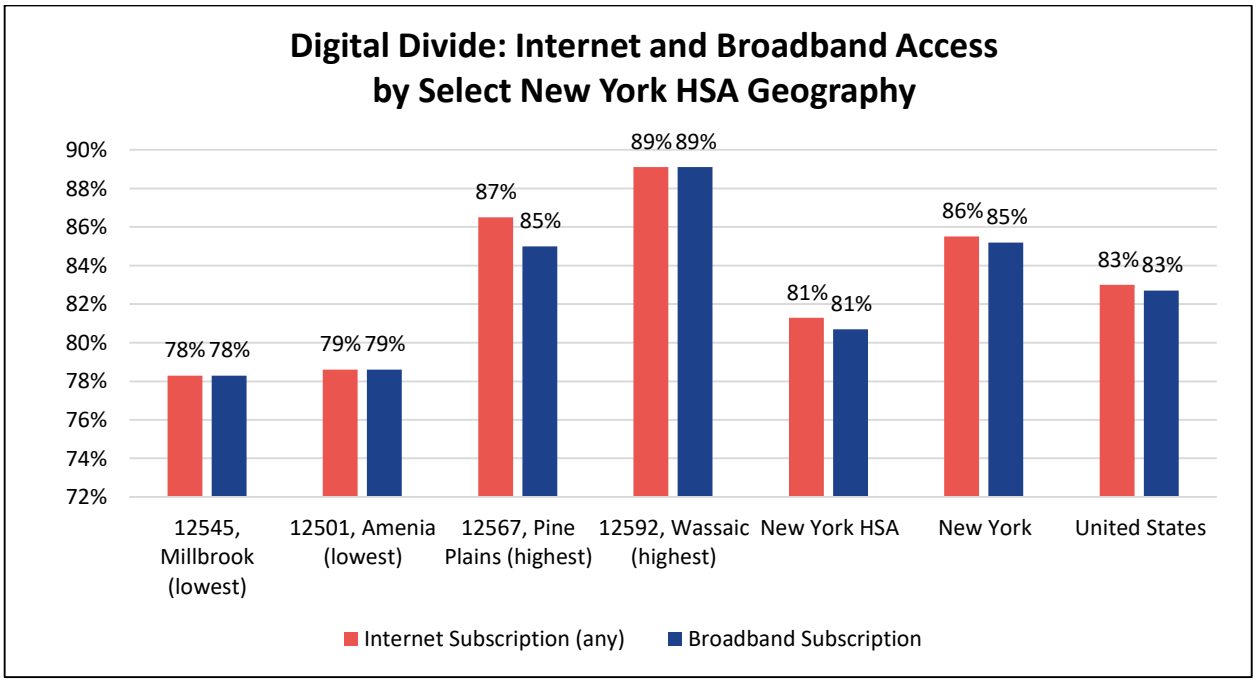
	Most people are able to access affordable food that is healthy and nutritious.	People can get where they need using public transportation.	Parents struggle to find affordable, quality childcare.
Completely true	10%	9%	36%
Somewhat true	43%	18%	29%
Not very true	30%	26%	6%
Not at all true	16%	38%	2%
Don't know	1%	9%	27%

Source: 2022 Siena College Regional Community Health Survey

During COVID we were able to use technology to bring services to people in their homes, but we need to bridge the wide digital divide within our communities to effectively reach all residents. Within the Connecticut HSA, there is a more than 10-point difference in access to internet and broadband between residents of North Canaan and residents of Warren or Salisbury. Within the New York HSA, there is a more than 20-point difference between residents of Millbrook or Amenia and Pine Plains or Wassaic. Millbrook and Amenia are home to an older population overall, which likely impacts findings.



Source: US Census Bureau American Community Survey 2019 5-year estimates



Source: US Census Bureau American Community Survey 2019 5-year estimates

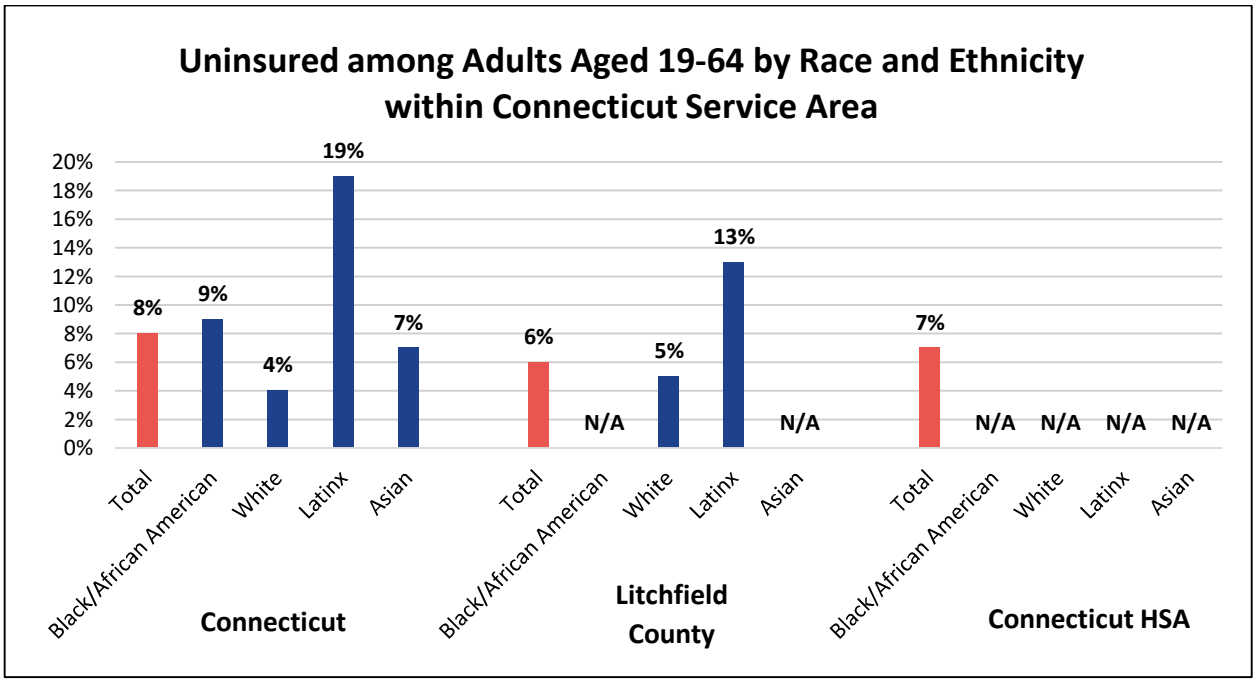
Healthcare Access and Quality

Lack of health insurance is a barrier to accessing healthcare. Without health insurance, residents face high costs for care when they need it, and they are less likely to receive preventive care. Preventive care, such as well visits and screenings, can detect small problems that can be treated more easily and effectively than if treatment is delayed. More residents across the Connecticut and New York service areas have health insurance when compared to statewide benchmarks. However, Connecticut trends point to potential disparities among Latinx residents who are more than four times as likely to be uninsured as white residents.

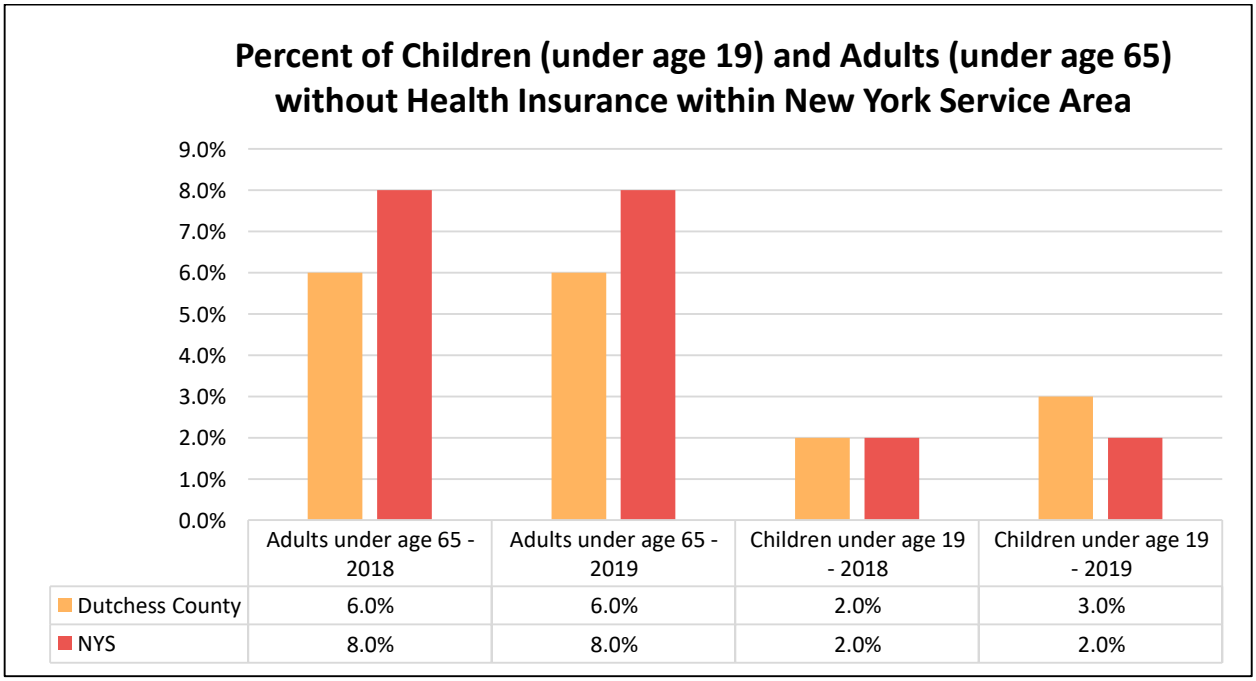
Having health insurance does not ensure access to healthcare when it is needed. Many other factors—like affordability, transportation, language, provider availability, and trust—keep people from receiving the care they need.

Litchfield County has lower provider availability than Connecticut and/or the nation, and all of the county is a Health Professional Shortage Area (HPSA) for mental healthcare. When viewed at the census tract-level, residents of North Canaan in Litchfield County are less likely to receive regular physical or dental checkups when compared to neighboring communities. This finding is consistent with existing economic barriers for North Canaan residents, including a lower median income and more households living below the ALICE threshold.

Dutchess County also has lower provider availability when compared to state benchmarks, and lower primary care provider availability when compared to the nation. While none of the county is a HPSA, migrant and seasonal farm workers are a Medically Underserved Population (MUP) within the eastern portion of the county, including the communities of Amenia, Wassaic, and Dover Plains. MUP designations identify geographic populations with a lack of access to primary care services.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates



	Adults under age 65 - 2018	Adults under age 65 - 2019	Children under age 19 - 2018	Children under age 19 - 2019
Dutchess County	6.0%	6.0%	2.0%	3.0%
NYS	8.0%	8.0%	2.0%	2.0%

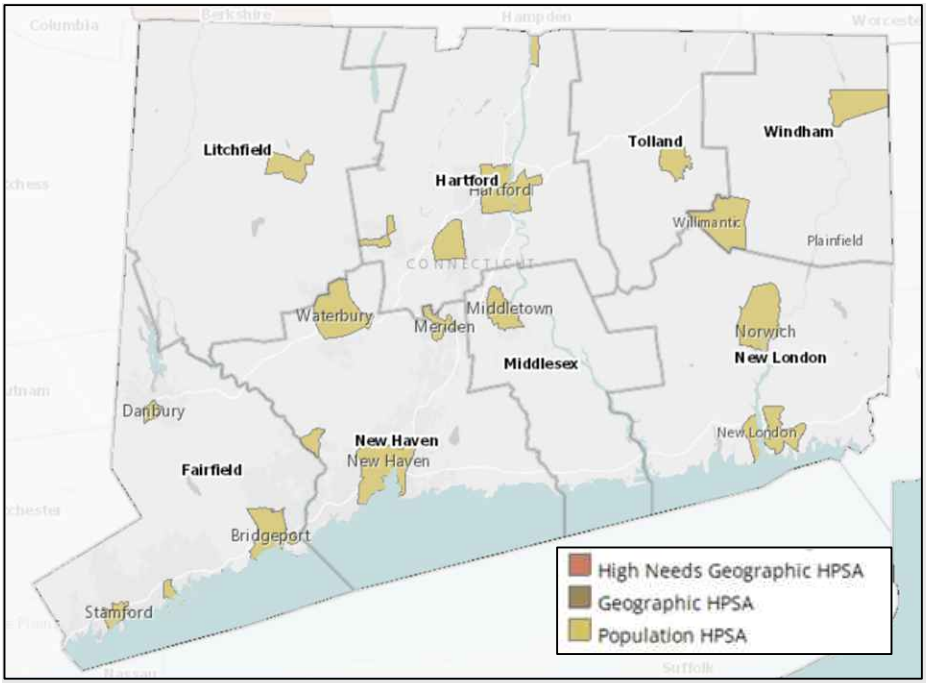
Source: Mid-Hudson Region CHNA, US Census Bureau American Community Survey 2020 5-year estimates

Healthcare Provider Availability: Provider Rates per 100,000 Residents

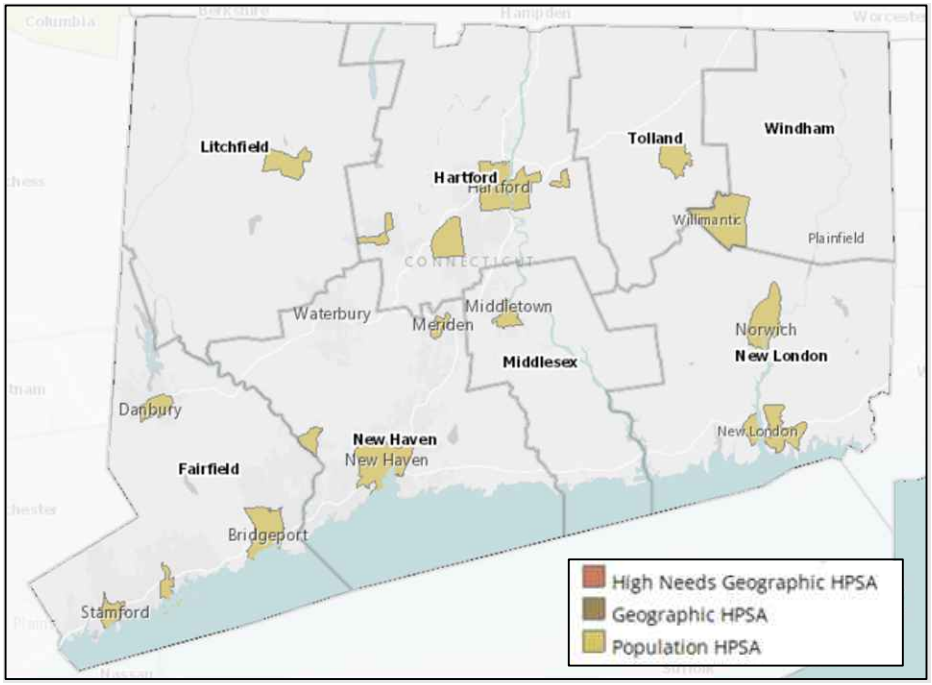
	2019 Primary Care Physicians	2020 Dentists	2021 Mental Health Providers
Litchfield County	58.2	66.3	287.8
Connecticut	85.2	87.1	439.2
Dutchess County	66.6	72.6	310.3
New York	84.7	83.9	325.2
United States	76.3	71.4	285.7

Source: Health Resources and Services Administration and Centers for Medicare and Medicaid Services

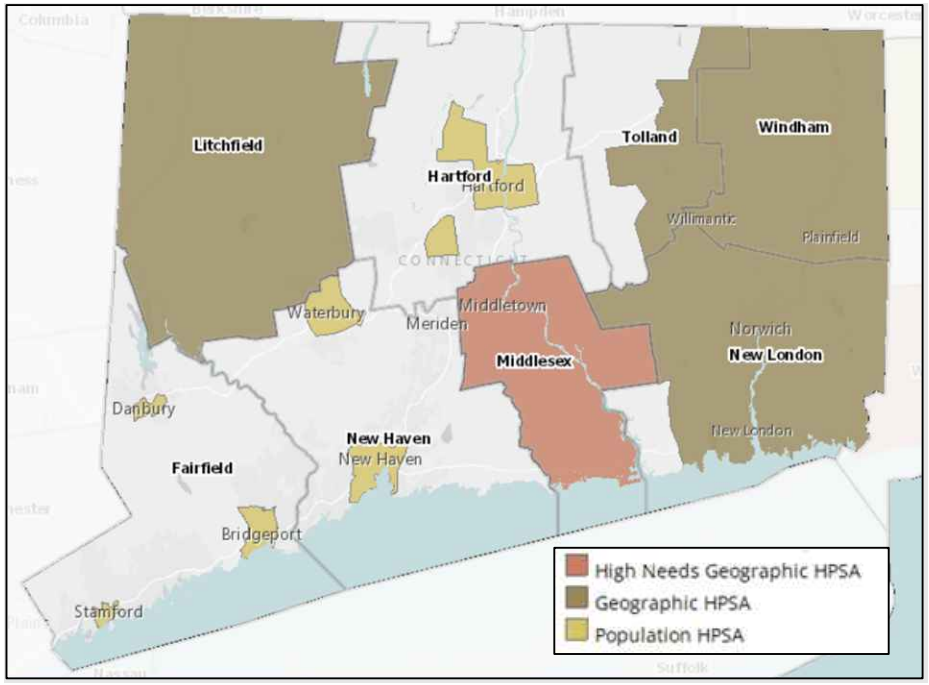
Connecticut: Primary Care Health Professional Shortage Areas



Connecticut: Dental Health Professional Shortage Areas

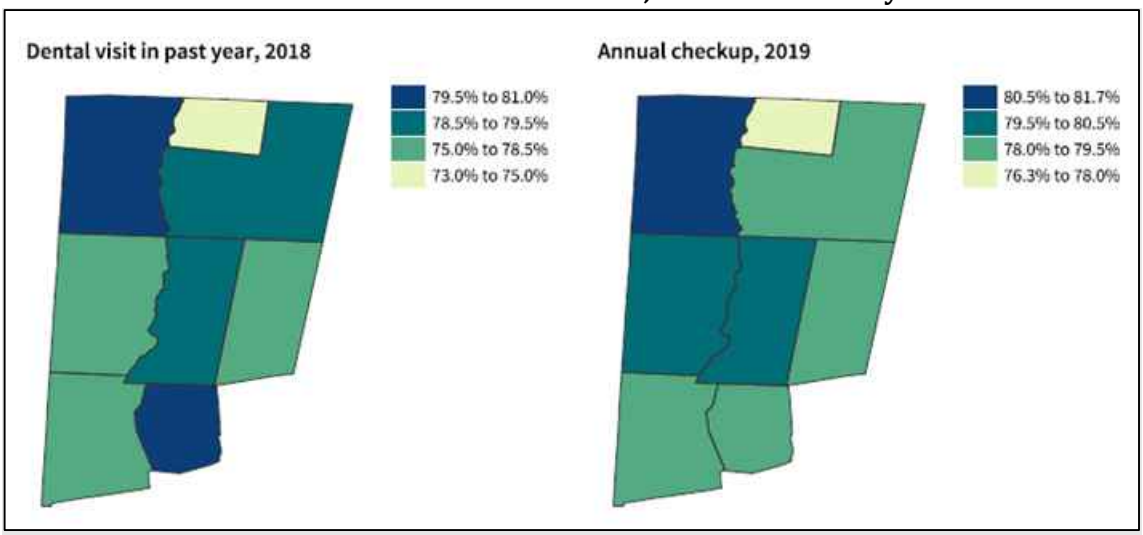


Connecticut: Mental Healthcare Health Professional Shortage Areas



Dutchess County: Medically Underserved Populations

Connecticut HSA Preventive Care Measures, Share of Adults by Census Tract



Source: PLACES Project. Centers for Disease Control and Prevention

Additional disparities in accessing healthcare are evidenced by resident survey results. Among Connecticut statewide Community Wellbeing Survey respondents, 21% of Latinx respondents reported not have a personal doctor or healthcare provider and 37% reported putting off or postponing needed medical care in the past 12 months. Among respondents with lower incomes, 36% reported putting off or postponing needed medical care in the past 12 months and 23% reported not visiting a dentist within the past two years.

Among New York HSA Community Health Survey respondents, 51% said it was "not very true" or "not at all true" that there are sufficient, quality mental health providers. Approximately 17% of respondents said there was a time in the past 12 months when they or a member of their household were unable to get medication when they needed it, and 16% said there was a time when they couldn't get healthcare, including dental or vision.

Approximately 78% of New York HSA Community Health Survey respondents received a routine physical or checkup within the past year, and 69% received a routine dental checkup or cleaning. It is worth noting that the top reason for not receiving a routine dental checkup was cost (33%), followed closely by inability to get an appointment (25%) and lack of insurance (24%).

Connecticut HSA: Community Wellbeing Survey Respondents Healthcare Access

	No personal doctor or healthcare provider	Put off or postponed needed medical care in past 12 months	Saw a dentist more than two years ago
Connecticut HSA (All Adults)	14%	25%	9%
Connecticut (All Adults)	15%	30%	13%
Black/African American	14%	27%	14%
White	14%	28%	13%
Latinx	21%	37%	14%
Household Income <$30k	18%	36%	23%
Household Income $30-$100k	16%	31%	15%
Household Income >$100k	14%	27%	7%

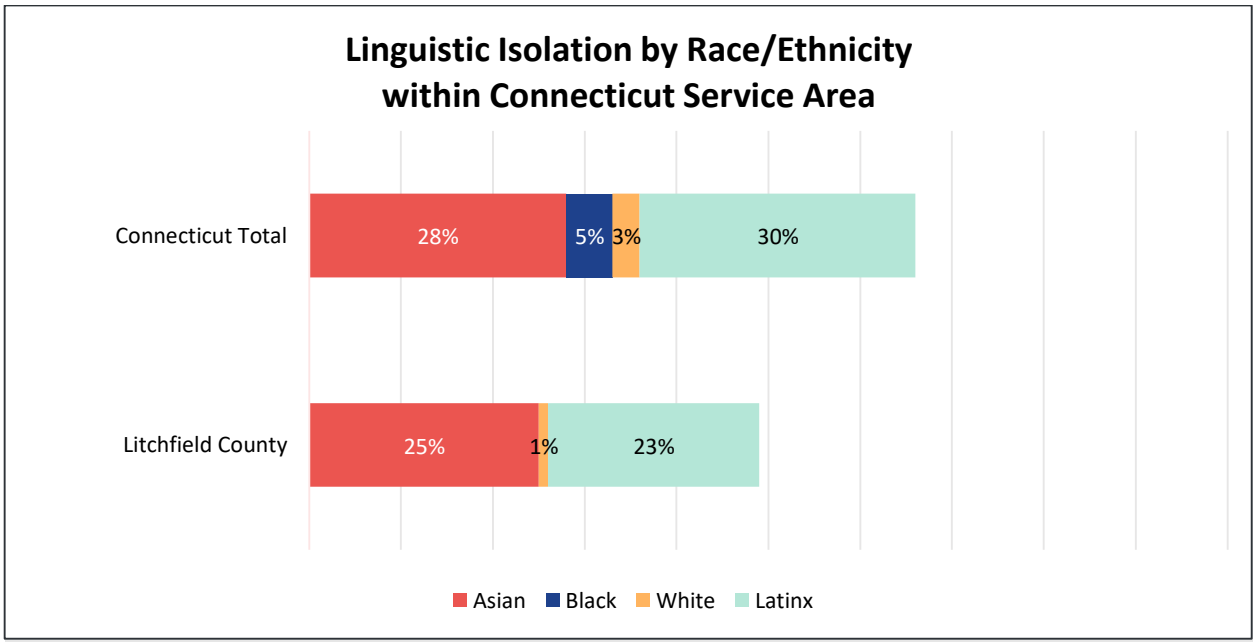
Source: 2021 DataHaven Community Wellbeing Survey

New York HSA (All Adults): Community Health Survey Respondents
Top Reasons for Not Receiving Routine Physical or Dental Checkup in Past 12 Months

	No personal doctor or healthcare provider	Put off or postponed needed medical care in past 12 months
I chose not to go for another reason	45%	9%
I did not have enough money	26%	33%
I did not have time	20%	17%
I did not have insurance	19%	24%
Other	11%	11%
I chose not to go due to concerns over COVID	6%	19%
I couldn't get an appointment	3%	25%
I did not have transportation	0%	0%

Source: 2022 Siena College Regional Community Health Survey

Healthcare access disparities among residents may be exacerbated by language barriers and lack of bilingual providers or interpreter services. Approximately 25% of Litchfield County Asian residents and 23% of Latinx residents are considered linguistically isolated, characterized as speaking English less than "very well." Across Dutchess County, approximately 4.7% of all residents are considered linguistically isolated compared to 13.1% across New York.



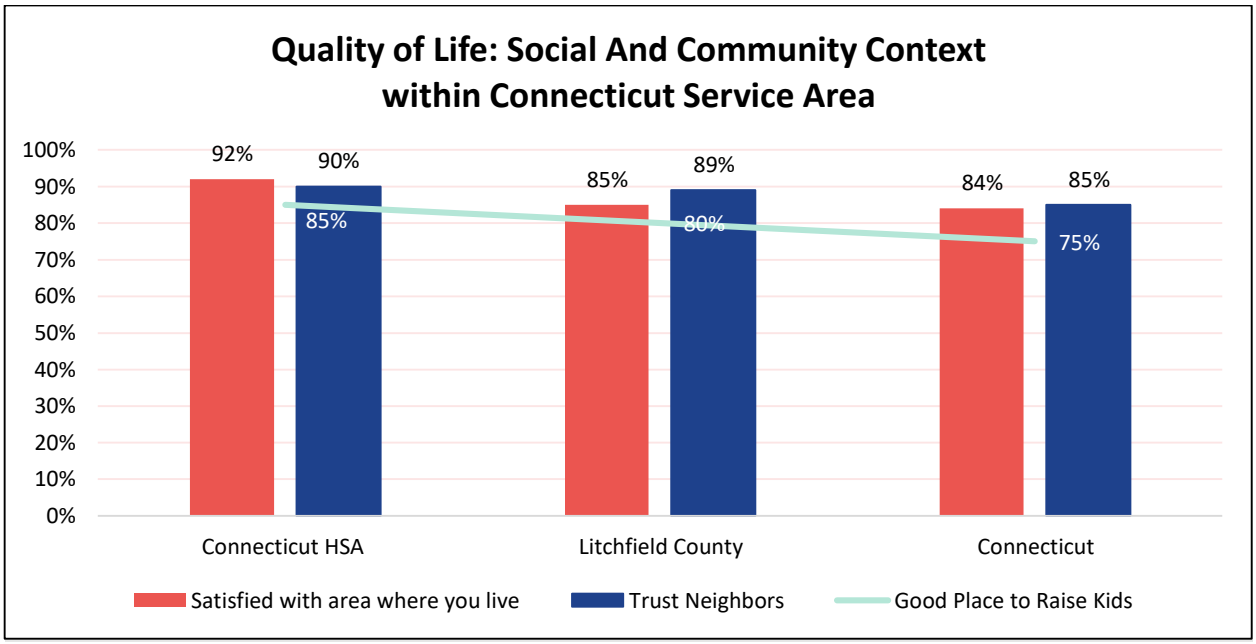
Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Social and Community Context

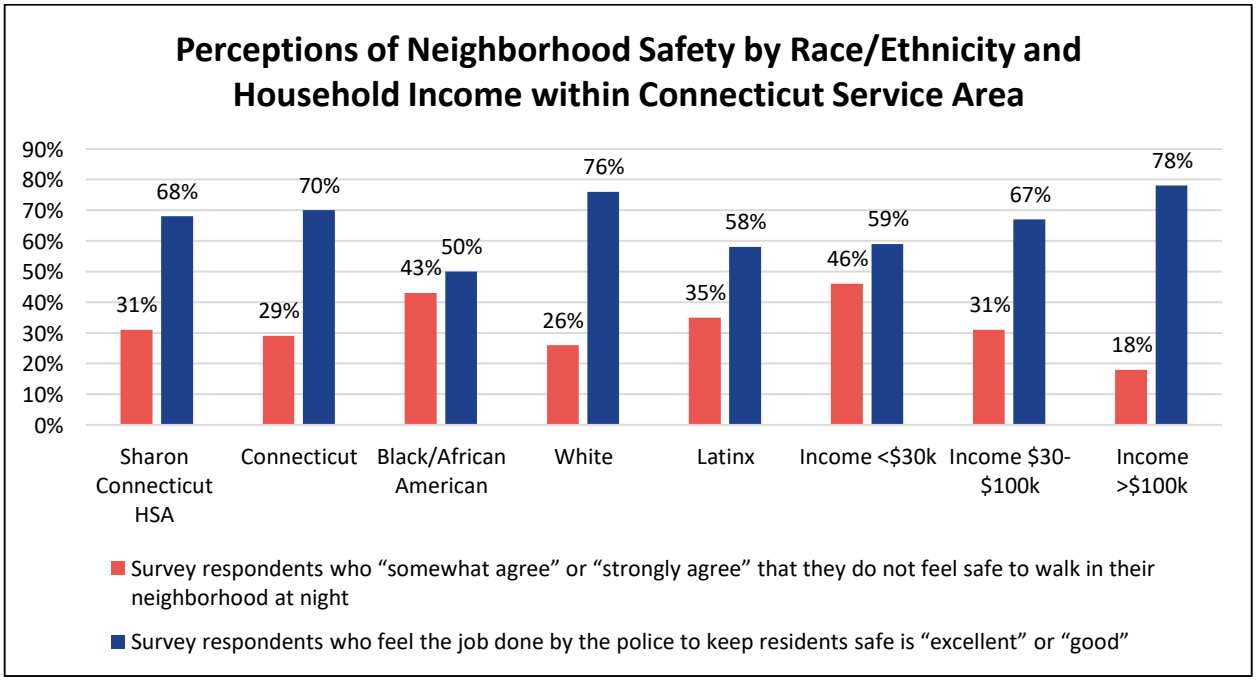
As much as communities are shaped by those who live there, people are impacted by the social context of the places where they live. Social context includes family, neighborhoods, school or work environments, political or religious systems, and other interpersonal infrastructures within a community. People's lived experiences within their social context play a significant role in good health and wellbeing.

Feeling like you belong, are appreciated, and are valued in your community reinforces protective health factors that help people and communities overcome adversity. Experiences of poverty, violence, poor housing, racism, and discrimination create Adverse Community Environments and chronic stress that perpetuate trauma and increase Adverse Childhood Events (ACEs) that have a lasting impact on people and their communities.

Residents of the Connecticut HSA have overall high perceived satisfaction in where they live, as well as positive perceptions of neighborhood safety, relative to the state. For example, approximately 85% of HSA residents feel it is a good place to raise kids compared to 75% of residents statewide. However, statewide trends illustrate that these experiences are not shared by all residents. Black/African American residents are less likely to feel safe walking in their neighborhood at night and/or that police are doing a "good" or "excellent" job of keeping residents safe. Disparities in safety along race lines indicate an opportunity to examine policies and procedures that can be amended to create greater equity of access and inclusion.



Source: DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey



Source: 2021 DataHaven Community Wellbeing Survey

As stated in the Mid-Hudson Region CHNA, "Disconnected youth are teenagers and young adults between the ages of 16 and 19 who are neither working nor attending school. This vulnerable population is cut off from resources, people, and experiences that help them gain knowledge, skills, capital, and a sense of purpose. " From 2016 to 2020, approximately 5% of Dutchess County youth

were considered disconnected compared to 6% statewide. The percentage has been generally stable in recent years.

Percent Disconnected Youth (Ages 16-19) within New York Service Area

	Dutchess County	New York
2014-2018	4.0%	6.0%
2015-2019	5.0%	6.0%
2016-2020	5.0%	6.0%

Source: Mid-Hudson Region CHNA, University of Wisconsin Population Health Initiative County Health Rankings & Roadmaps 2022

Discrimination is also a measure of social and community context and can be measured by everyday or major discriminatory events. The Mid-Hudson Region CHNA states, "Residential segregation is an example of major discrimination, as it stems from structural racism. Causes vary and include being refused to be rented to or being unfairly denied a bank loan. The implications of residential segregation are extensive, impacting quality of education, access to healthy food options and physical activities, safety, and transportation, and contribute to disparities in health status across groups. In the US, residential segregation between non-Hispanic Black and non-Hispanic white populations is a key determinant of health disparity, leading to poor health outcomes including mortality, reproductive, and chronic diseases."

The residential segregation index measures the distribution of non-Hispanic Black and non-Hispanic white residents across census tracts, with an index of 0 representing complete integration and an index of 100 complete segregation. Dutchess County saw a small decline in its residential segregation index and has a lower index than New York overall.

Index Score of Residential Segregation within New York Service Area

	Dutchess County	New York
2013-2017	52	74
2016-2020	50	74

Source: Mid-Hudson Region CHNA, University of Wisconsin Population Health Initiative County Health Rankings & Roadmaps 2022

Life Expectancy

Life expectancy is an overall measure of health and social equity within a community. Structural factors, including housing quality and affordability, environmental conditions, employment, education, transportation, food security, and experience of racism, all play a role in impacting the quality and length of lives.

The Community Need Index (CNI) is a zip code-based index of community socioeconomic need. The CNI is strongly linked to variations in community healthcare needs, and as such, represents a useful planning tool for prioritization of geographic interventions. The CNI scores zip codes on a scale of 1.0 to 5.0, with 1.0 indicating a zip code with the least need and 5.0 indicating a zip code with the

most need compared to the US national average of 3.0. The CNI weights, indexes, and scores zip codes by socioeconomic barriers, including income, culture, education, insurance, and housing.

Consistent with having overall positive social determinants of health factors, no zip code within the Connecticut HSA has a high CNI score. North Canaan zip code 06018 has the highest CNI score of 2.6. This finding is consistent with existing socioeconomic barriers within this community and lower average life expectancy of 74.4 years.

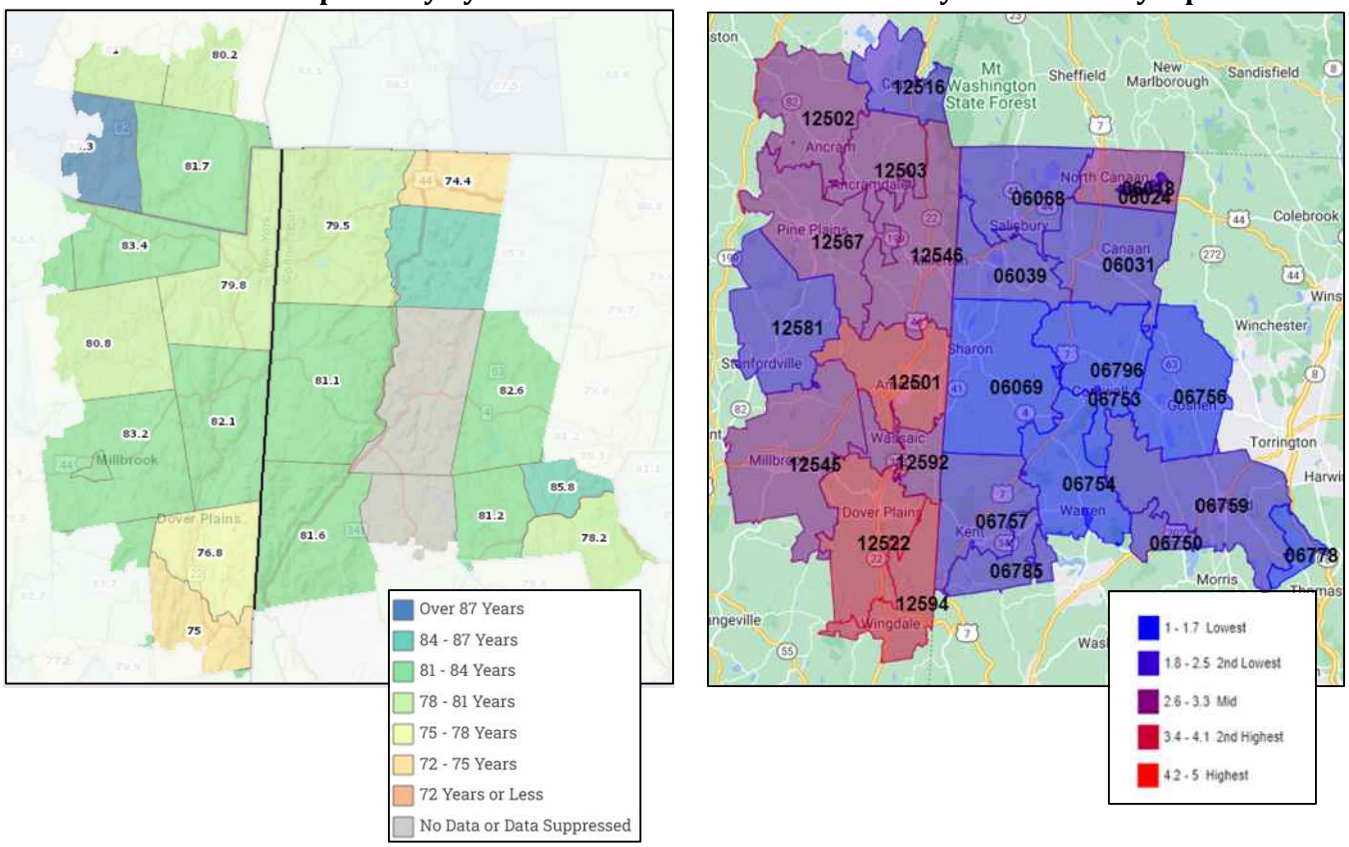
Within the New York HSA, the communities of Amenia, Dover Plains, and Wingdale have higher CNI scores of 3.4. In Dover Plains and Wingdale, these findings are consistent with lower average life expectancy. In comparison to neighboring Kent in Connecticut, there is a nearly 7-year difference in life expectancy for portions of Dover Plains and Wingdale.

Average Life Expectancy (years)

Dutchess County	Litchfield County	Connecticut	New York
80.1	79.2	**80.1**	**80.3**

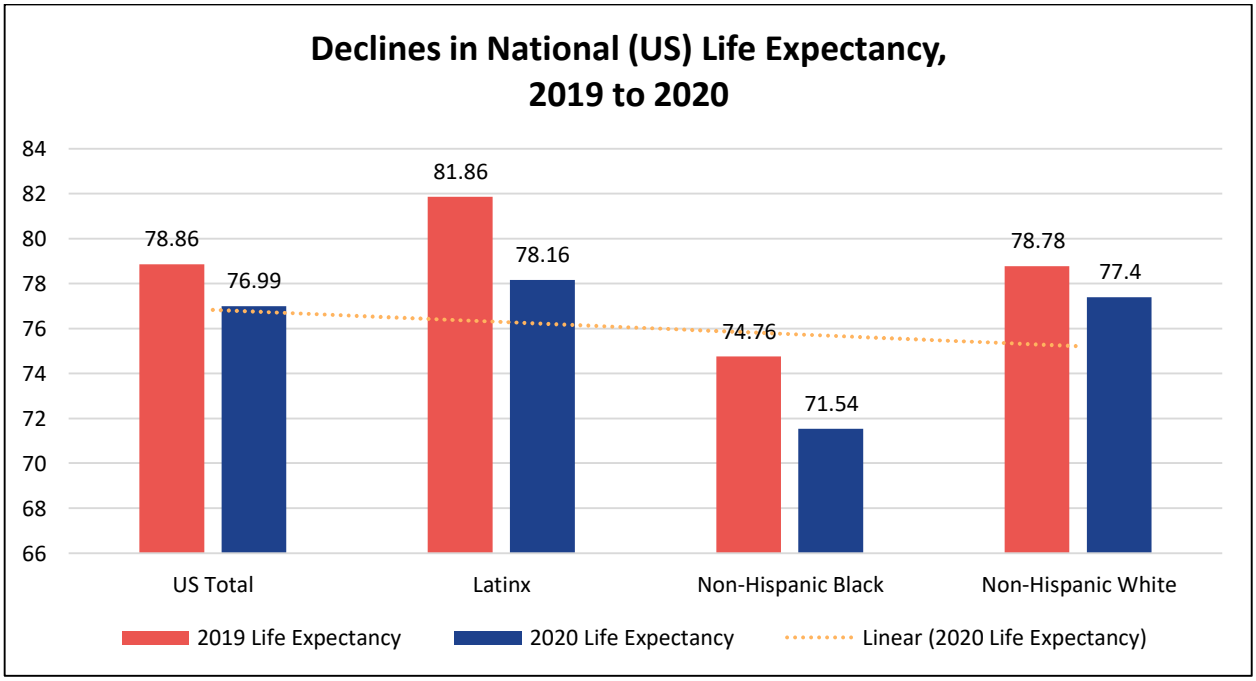
Source: National Center for Health Statistics, 2018-2020

2010-2015 Life Expectancy by Census Tract and 2021 Community Need Index by Zip Code

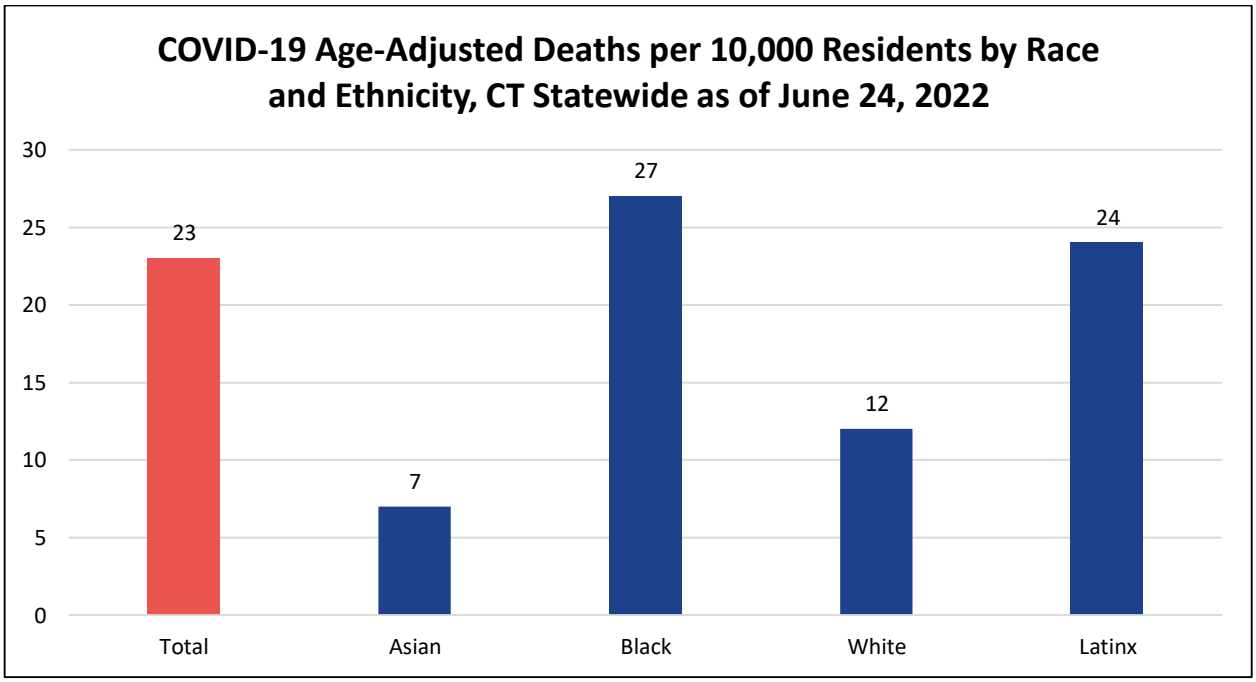


The COVID-19 pandemic both highlighted and deepened socioeconomic and health inequities and exposed disparities within the health and social services systems. COVID-19 has not impacted all people equally. Rather, certain structural issues—population density, low income, crowded workplaces, etc.—contribute to higher levels of spread and worse outcomes from COVID-19, and potentially other infectious diseases.

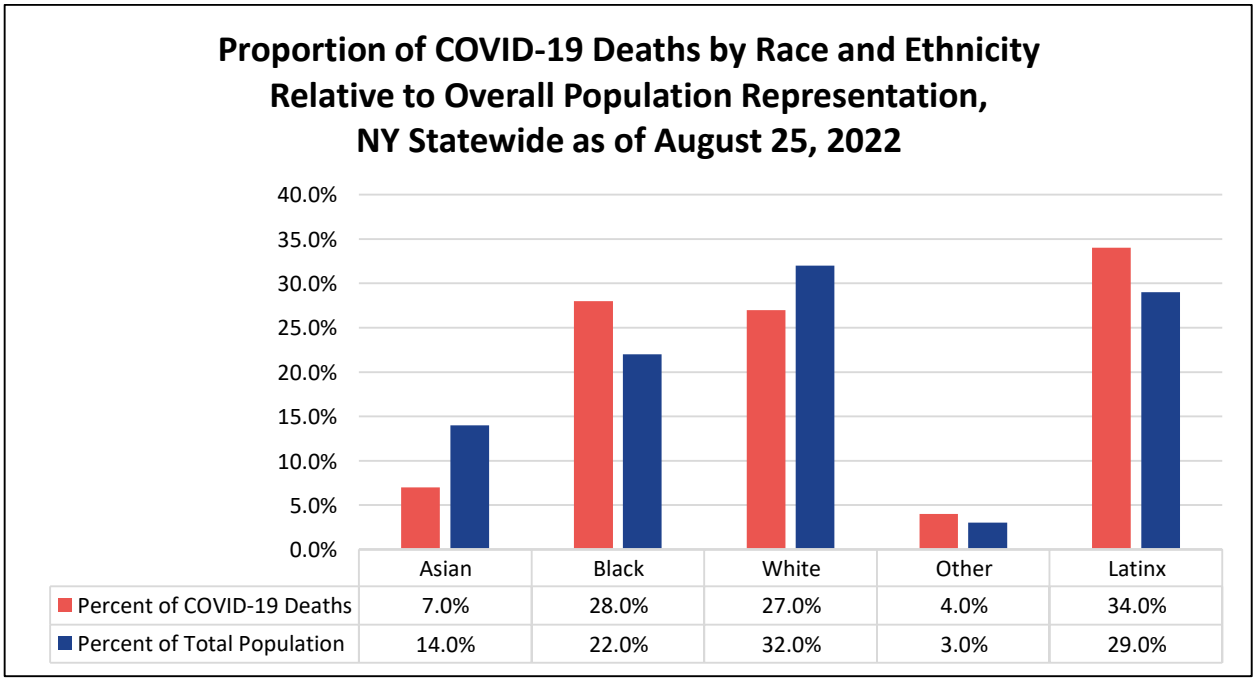
The graph below shows that while overall life expectancy decreased nationally from 2019 to 2020, it decreased by more than 3 years for Black/African American and Latinx residents compared to 1.4 years for white residents. This finding is also reflected in disproportionately higher deaths due to COVID-19 among people of color, as depicted by Connecticut and New York statewide findings.



Source: Centers for Disease Control and Prevention



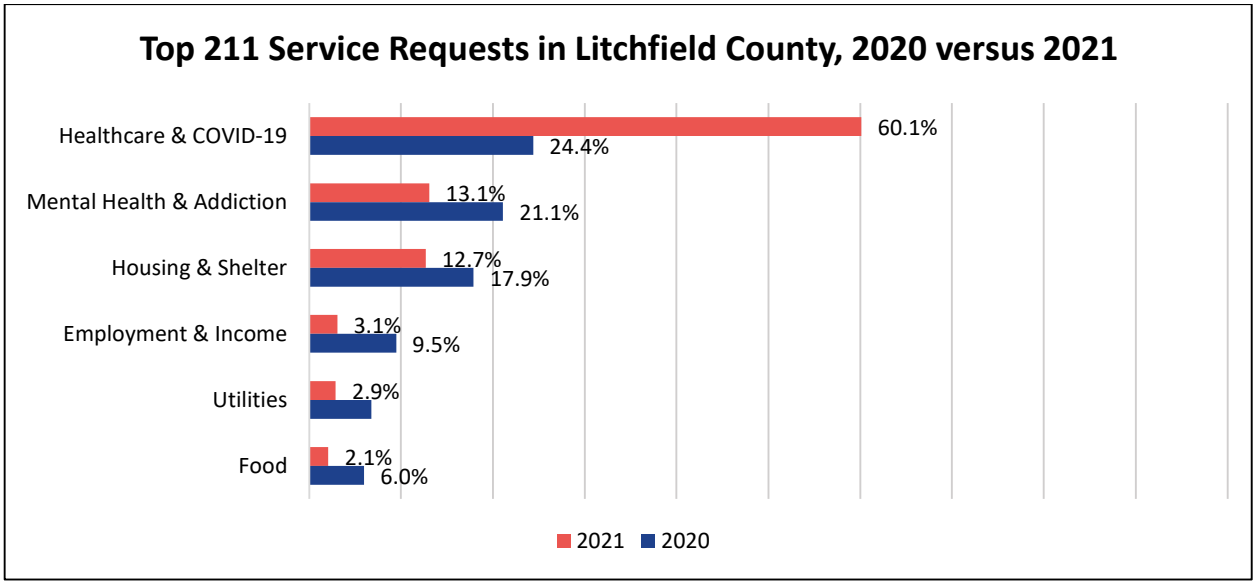
Source: Connecticut Department of Public Health



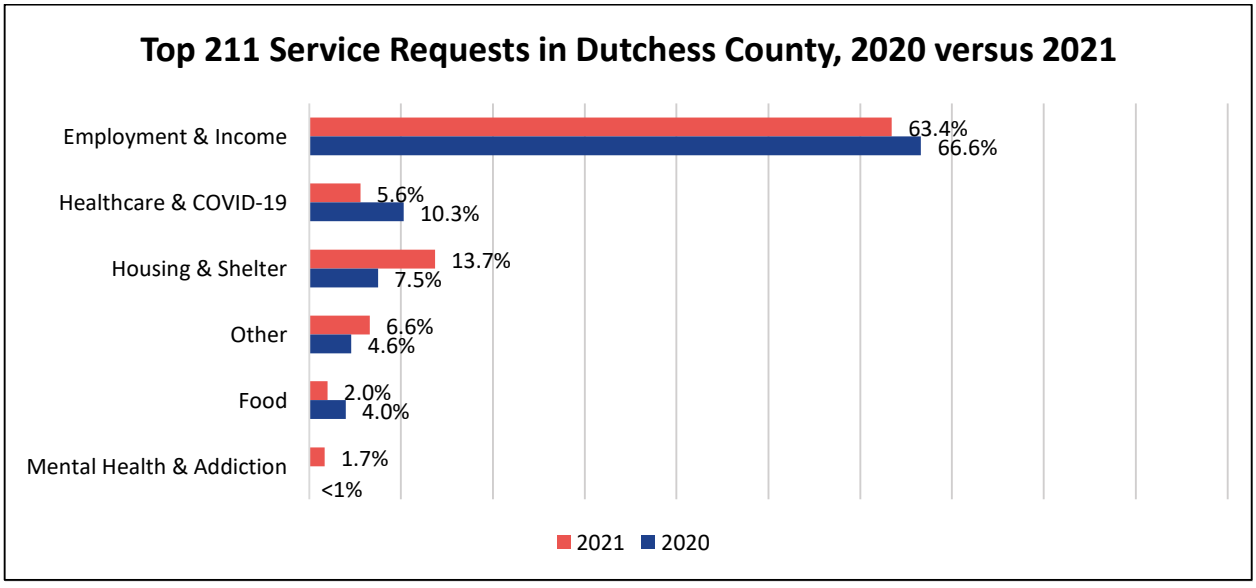
Source: New York State Department of Public Health

United Way 211 is a 24/7 go-to resource that helps people across the nation find local resources they need. 211 is the most comprehensive source of information about local resources and services in the country. The following graphs depict the top 211 service requests by Litchfield and Dutchess County residents during the COVID-19 pandemic.

The COVID-19 pandemic had deep economic and mental health impacts. Among Litchfield County residents, the top 211 service requests, after healthcare and COVID-19, were mental health and addiction and housing and shelter. Among Dutchess County residents, the top 211 service request in both 2020 and 2021 was employment and income. Housing and shelter requests nearly doubled from 2020 to 2021 for Dutchess County residents.



Source: United Way 211

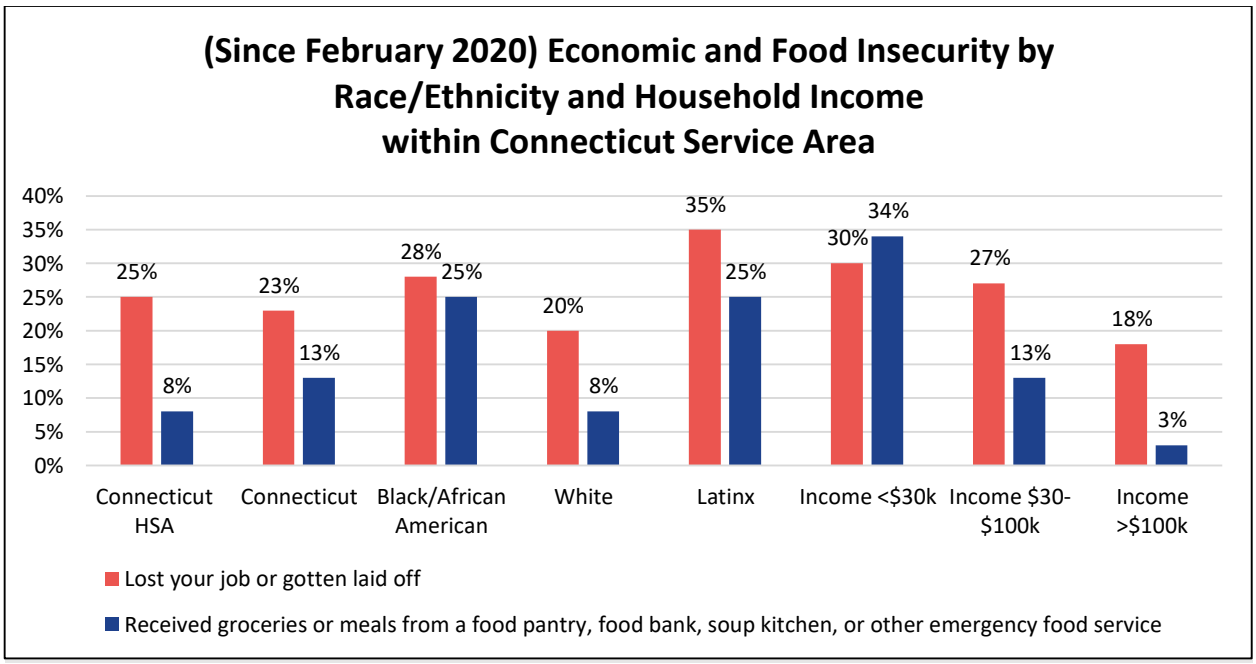


Source: United Way 211

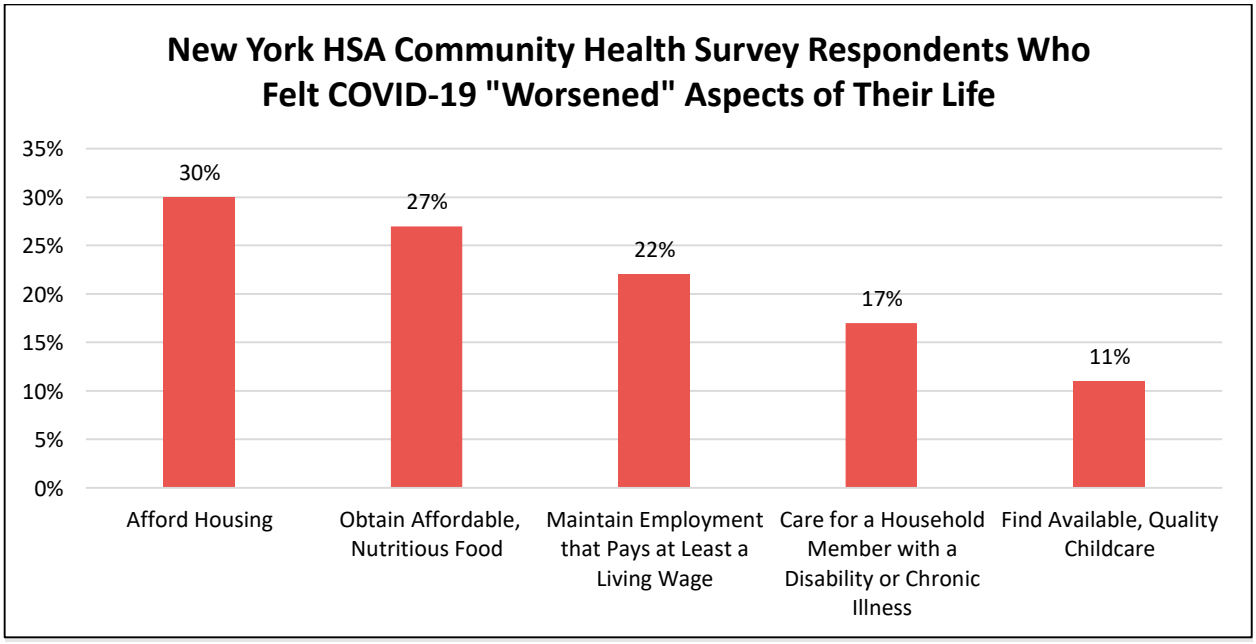
Community survey results demonstrated the economic impacts of the pandemic, including the disproportionate impact among low-income households and communities of color. Among Connecticut statewide Community Wellbeing Survey respondents, 35% of Latinx respondents and

28% of Black/African American respondents reported being laid off or losing their job compared to 20% of white respondents. Approximately 30% of low-income households received food assistance compared to 18% of high-income households.

Similar negative economic impacts were felt by New York HSA Community Health Survey respondents, with the most negative impacts on ability to afford housing and nutritious food.



Source: 2021 DataHaven Community Wellbeing Survey



Source: 2022 Siena College Regional Community Health Survey

Community Health Needs

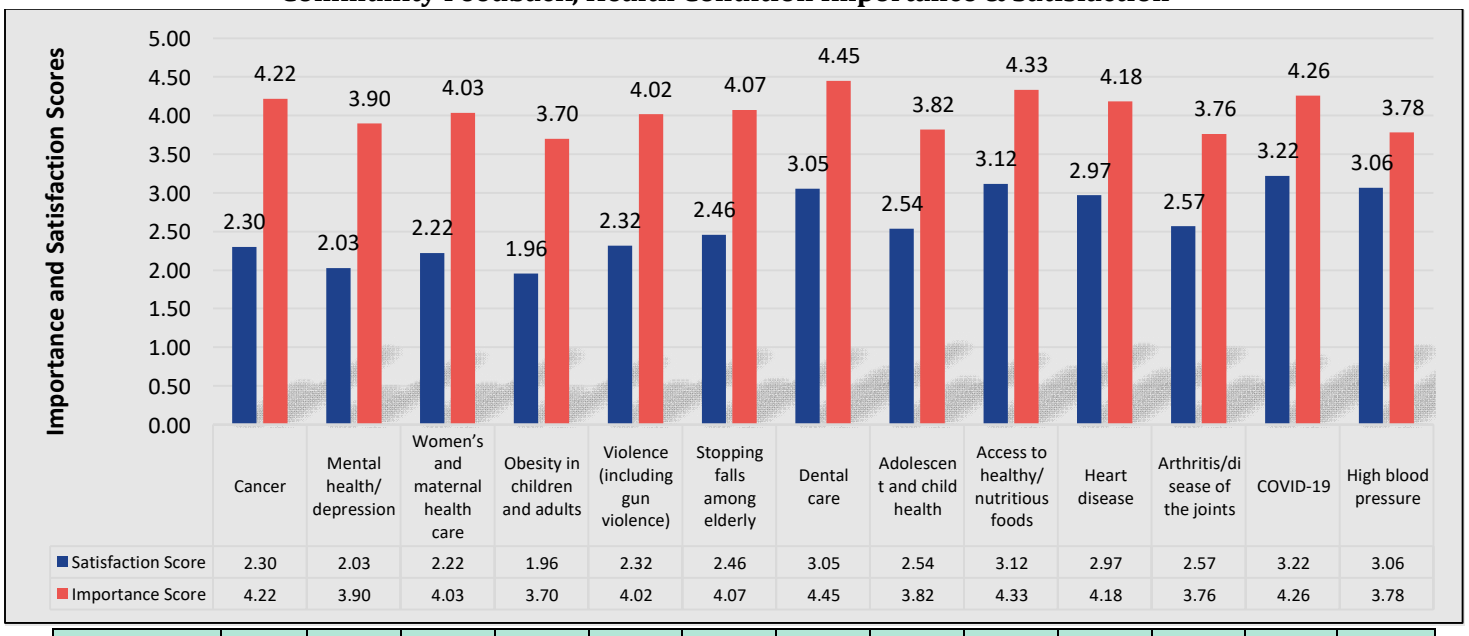
To determine community health priorities, we must consider what the data are telling us, and more importantly, what our community sees as the most pressing health concerns.

Community engagement was a central part of the CHNA. We invited wide participation from community stakeholders and organizations, including experts in health, social service representatives, advocates, community champions, policy makers, and lay community residents. These stakeholders were asked to weigh in on data findings, share their perspectives on challenges facing our community, and provide input on collaborative solutions.

The following graph depicts community feedback for the entire Sharon Hospital Service Area, as garnered from the GNYHA 2022 Community Health Survey. Feedback included perceived importance of community health conditions and satisfaction with current neighborhood services to address these conditions. Results are presented as aggregate scores on a scale of 1 (not at all) to 5 (extremely). The "Gap" represents the difference between importance and satisfaction scores.

The results demonstrated high perceived importance for issues like dental care, access to healthy/nutritious foods, COVID-19, cancer, and heart disease, but, with the exception of cancer, higher satisfaction in available services to address these needs. In contrast, there was a notable gap in perceived satisfaction in available services for issues like obesity, mental health, women's and maternal healthcare, violence, and stopping falls among elderly. These findings may help inform the prioritization of community interventions.

What you told us: Sharon Hospital Service Area
Community Feedback, Health Condition Importance & Satisfaction



	Cancer	Mental health/ depression	Women's and maternal health care	Obesity in children and adults	Violence (including gun violence)	Stopping falls among elderly	Dental care	Adolescent and child health	Access to healthy/ nutritious foods	Heart disease	Arthritis/disease of the joints	COVID-19	High blood pressure
Satisfaction Score	2.30	2.03	2.22	1.96	2.32	2.46	3.05	2.54	3.12	2.97	2.57	3.22	3.06
Importance Score	4.22	3.90	4.03	3.70	4.02	4.07	4.45	3.82	4.33	4.18	3.76	4.26	3.78
Gap*	1.92	1.87	1.81	1.74	1.70	1.61	1.39	1.28	1.21	1.21	1.19	1.04	0.72

Source: Greater New York Hospital Association CHNA Survey, 2022
*Difference between Importance Score and Satisfaction Score

The following report sections further highlight data relative to specific health areas like behavioral health, health risk factors and chronic disease, and maternal and child health.

Behavioral Health

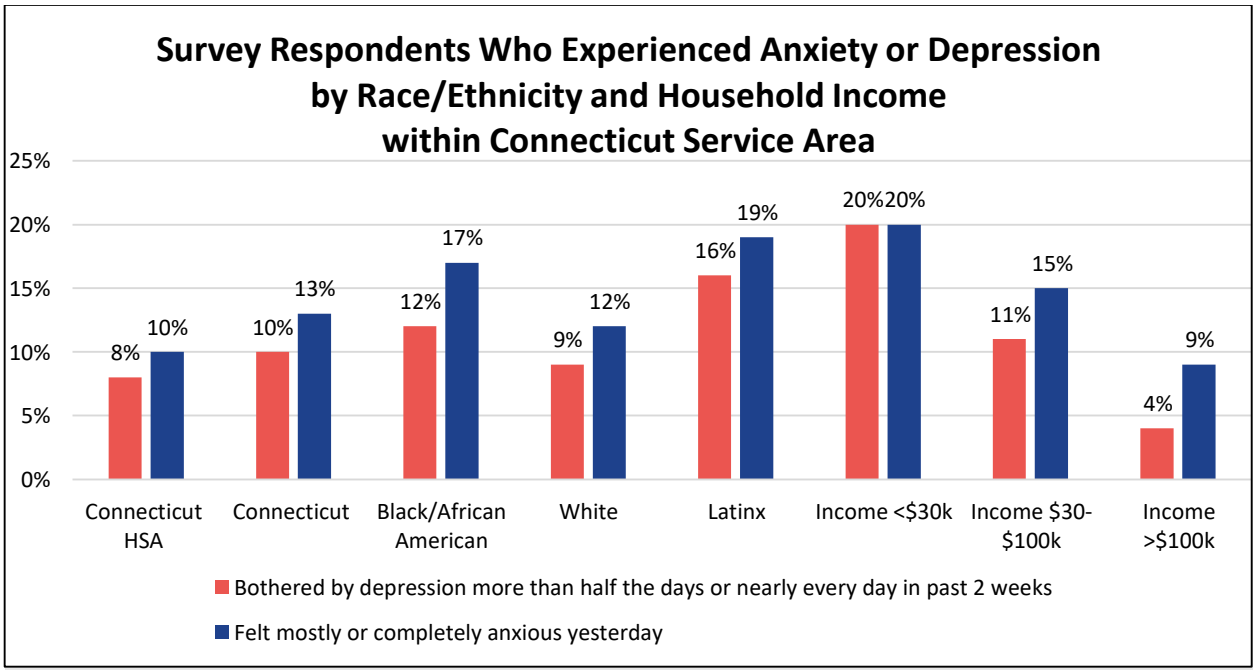
Mental health concerns like depression and anxiety can be linked to social determinants like income, employment, and environment, and can pose risks of physical health problems, including by complicating an individual's ability to keep up other aspects of their healthcare.

Overall, 10% of Connecticut HSA adults report experiencing anxiety regularly and 8% report being bothered by depression. Statewide, these experiences are more prevalent among Black/African Americans, Latinx, and individuals with lower income, a finding that is consistent with being more likely to experience chronic stress related to health and social inequities and/or racism and discrimination, among other factors.

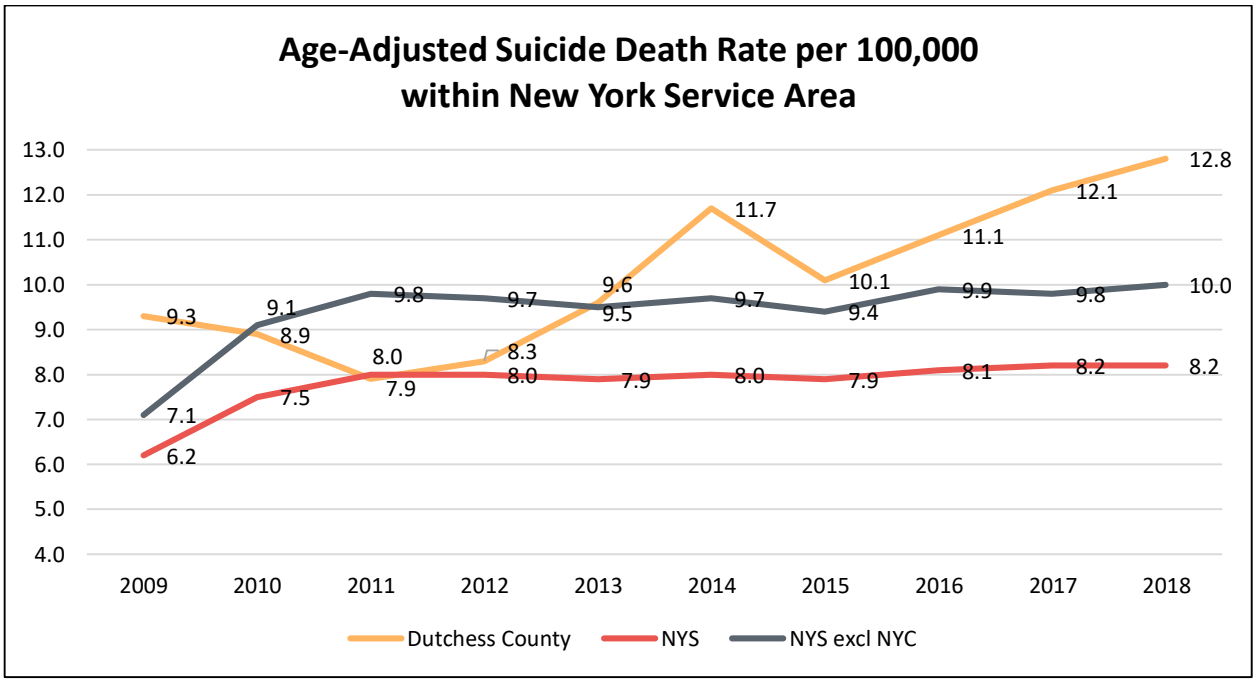
Across Dutchess County in 2018, 16.8% of adults reported having a depressive disorder, an increase from 12.9% in 2016 and higher than the statewide average of 15.3%. Within the seven-county Mid-Hudson Region, Dutchess County had the second highest proportion of adults with a depressive disorder, behind Sullivan County at 23.5%.

Depression is a risk factor for poor mental health and suicide. Among New York HSA Community Health Survey respondents, 27% rated their overall mental health as "fair" or "poor" and 63% said they were "somewhat stressed" or "very stressed" on an average day.

While Dutchess County met the Healthy People 2030 goal for suicide-related deaths as of 2018, it had a higher rate of death than the state overall and the second highest rate of death in the Mid-Hudson Region behind Ulster County (13.2). The death rate increased in recent years.



Source: 2021 DataHaven Community Wellbeing Survey



Source: Mid-Hudson Region CHNA, NYS Department of Health Vital Statistics, 2022
*Dutchess County data represent three-year averages; NYS data reflect single-year trends (2018.

The COVID-19 pandemic exacerbated many behavioral health concerns, particularly for youth, due to stress, isolation, and lost learning, among other factors. Before the pandemic, approximately 31% of Connecticut youth and 35% of New York youth reported feeling sad or depressed and 7-8.5% had attempted suicide. About one-fifth to one-quarter of youth used one or more substances like tobacco, alcohol, or marijuana. These findings should continue to be monitored in light of the pandemic.

2019 Youth Measures of Mental Health and Substance Use

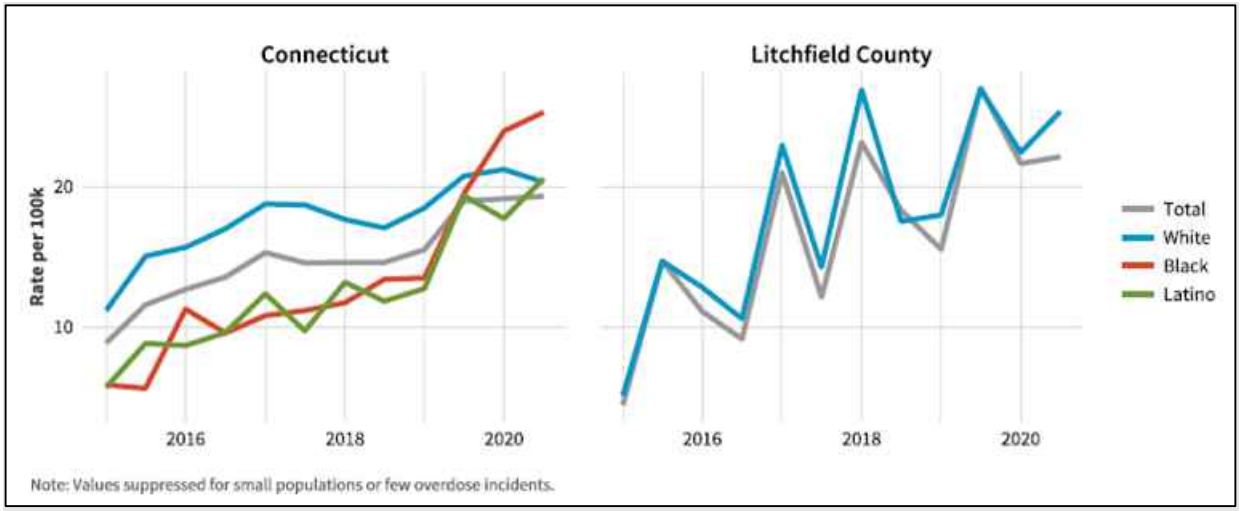
	Feel Consistently Sad or Depressed	Attempted Suicide	E-cigarette Use (last 30 days)	Alcohol Use (last 30 days)	Marijuana Use (last 30 days)
Connecticut	30.6%	6.7%	27.0%	25.9%	21.7%
New York	35.1%	8.5%	22.4%	26.4%	19.1%
US	36.7%	8.9%	32.7%	29.1%	21.7%

Source: CDC Youth Risk Behavior Survey

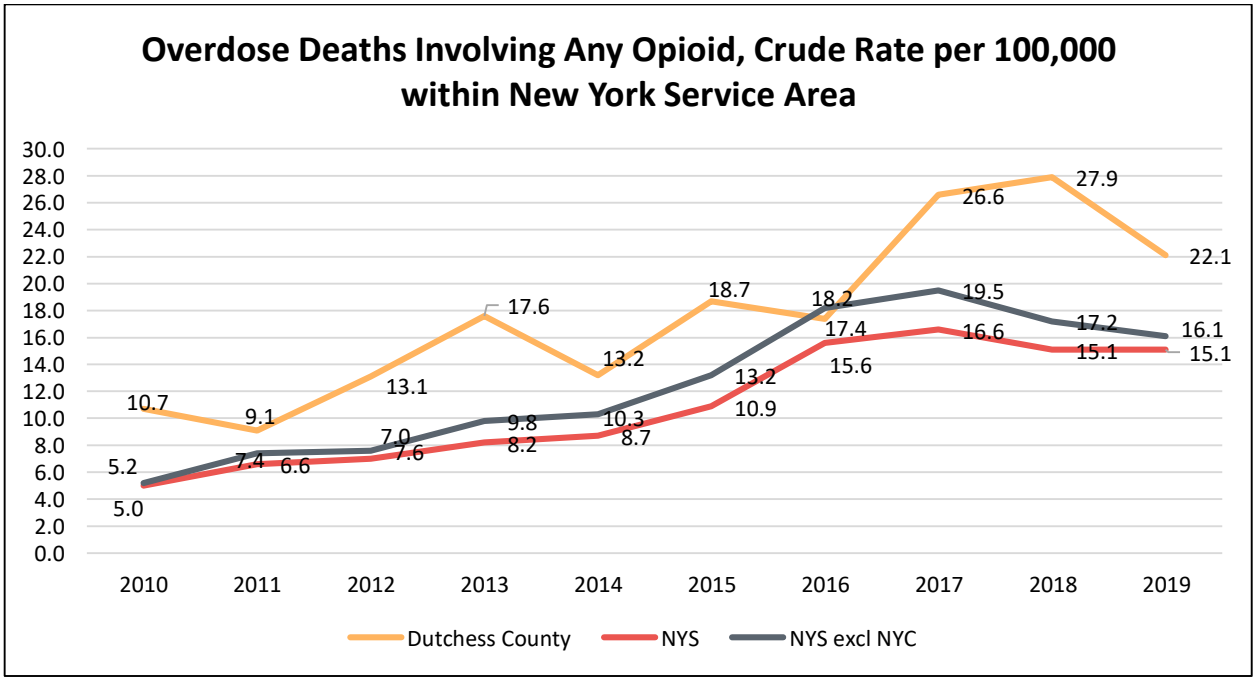
Like other states, Connecticut and New York have seen a rise in drug overdose deaths in the last several years. In 2020, Connecticut saw an average of 113 overdose deaths per month, up from 60 in 2015. Litchfield County overall has trended higher than the state for drug overdose deaths in recent years. Statewide, white residents long comprised the bulk of drug overdose deaths, but as overall death rates have increased, an increasing share of those deaths have been people of color.

Across New York, the rate of overdose death involving any opioid tripled from 2010 to 2019. Dutchess County has historically had a higher rate of overdose death than the state, and the death rate doubled from 2010 to 2019. Within the Mid-Hudson Region, Dutchess County has the second highest rate of opioid-related overdose death behind Sullivan County (39.8). Dutchess County has the highest rate of emergency department (ED) visits involving any opioid overdose in the region.

Age-Adjusted Semi-Annual Rates of Accidental Overdose Death per 100,000 Residents By Race and Ethnicity within Connecticut Service Area



Source: DataHaven analysis (2021)



Source: Mid-Hudson Region CHNA, NYS Department of Health Vital Statistics, 2022

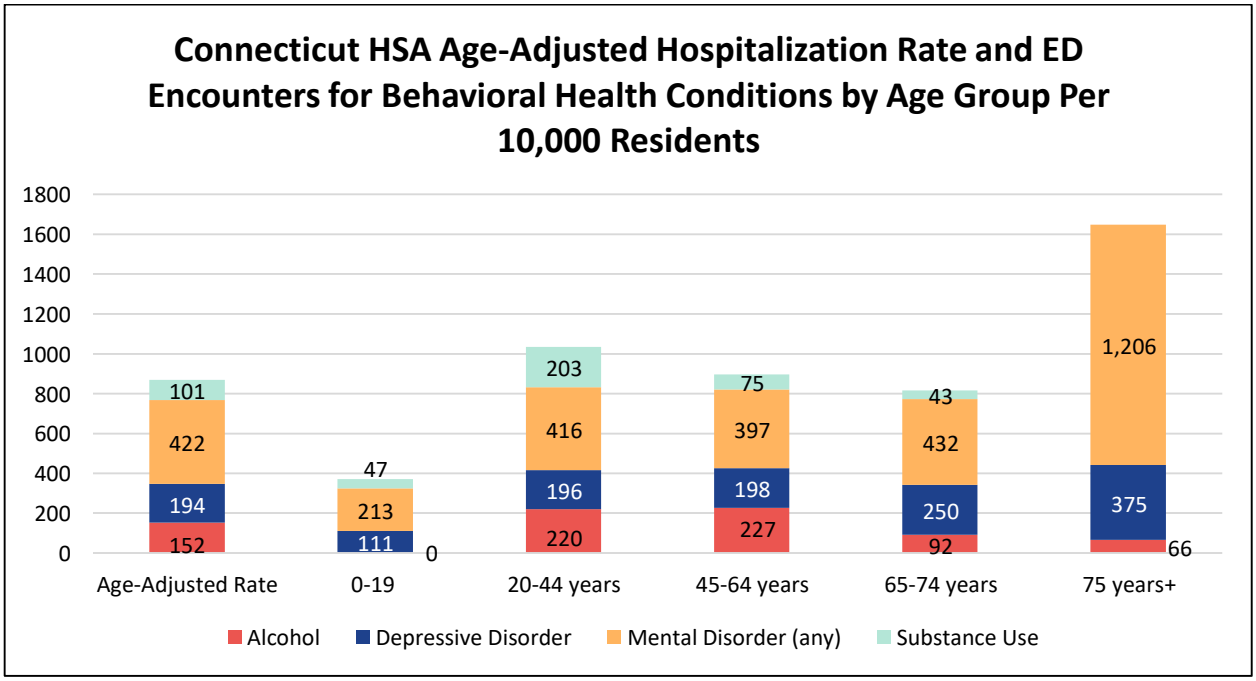
Age-Adjusted Rate of ED Visits (including outpatients and admitted patients) Involving any Opioid Overdose per 100,000 within New York Service Area

Dutchess County	New York State	New York State excl New York City
97.2	53.1	**66.1**

Source: Mid-Hudson Region CHNA, NYS Department of Health Statewide Planning and Research Cooperative System, 2019

Behavioral health conditions are considered ambulatory care sensitive (ACS) conditions, which if effectively managed in an outpatient setting, should not be the primary reason for a hospital visit. The following graph depicts hospital and emergency department (ED) encounters by residents of the Connecticut HSA for select behavioral health conditions, as provided by the Connecticut Hospital Association and analyzed by DataHaven.

Behavioral health encounter data include any encounter by any resident of any town in Connecticut to Sharon Hospital. Across all age groups, mental disorders are the most prevalent behavioral health conditions that patients seek help for at the hospital, and the rate of visits is approximately three times as high for older adults aged 75 or over compared to younger adult populations. It is worth noting that substance use disorder-related visits, including alcohol and drugs, follow an opposite trend, with increasing rates among younger adult populations.



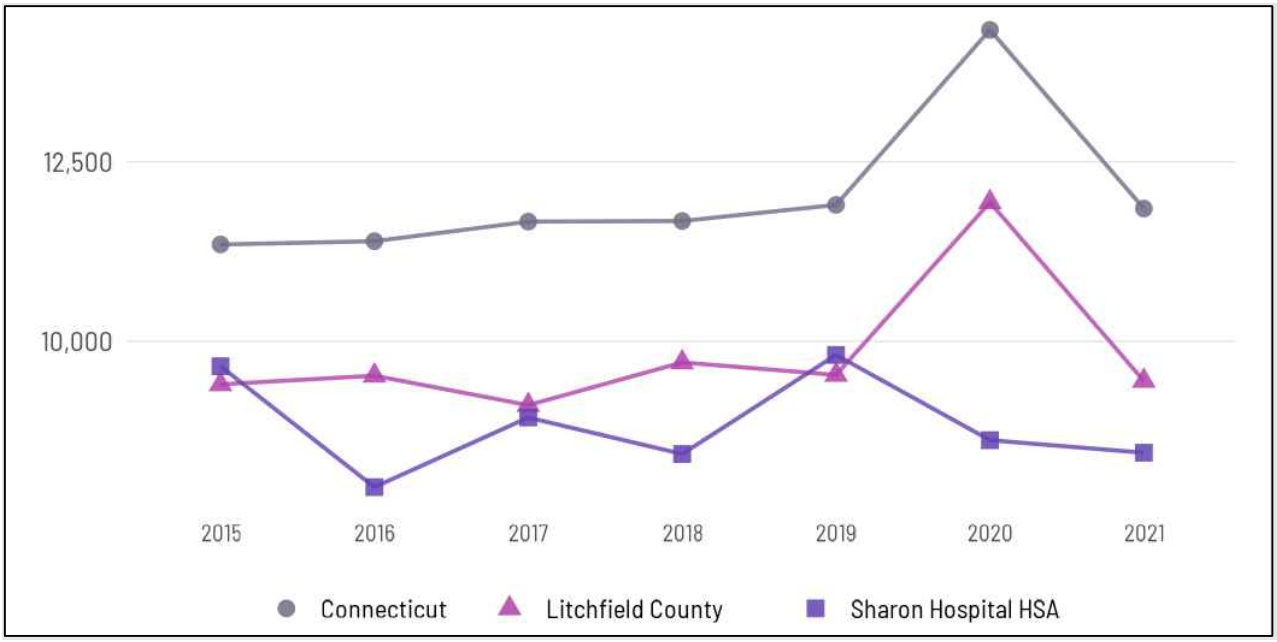
Source: DataHaven analysis (2021) of 2018-2021 Connecticut Hospital Association CHIME

Health Risk Factors and Chronic Disease

All-cause mortality spiked in 2020 due to the COVID-19 pandemic. This trend is illustrated in the graph below for Connecticut and Litchfield County. Across Litchfield County in 2020, COVID-19

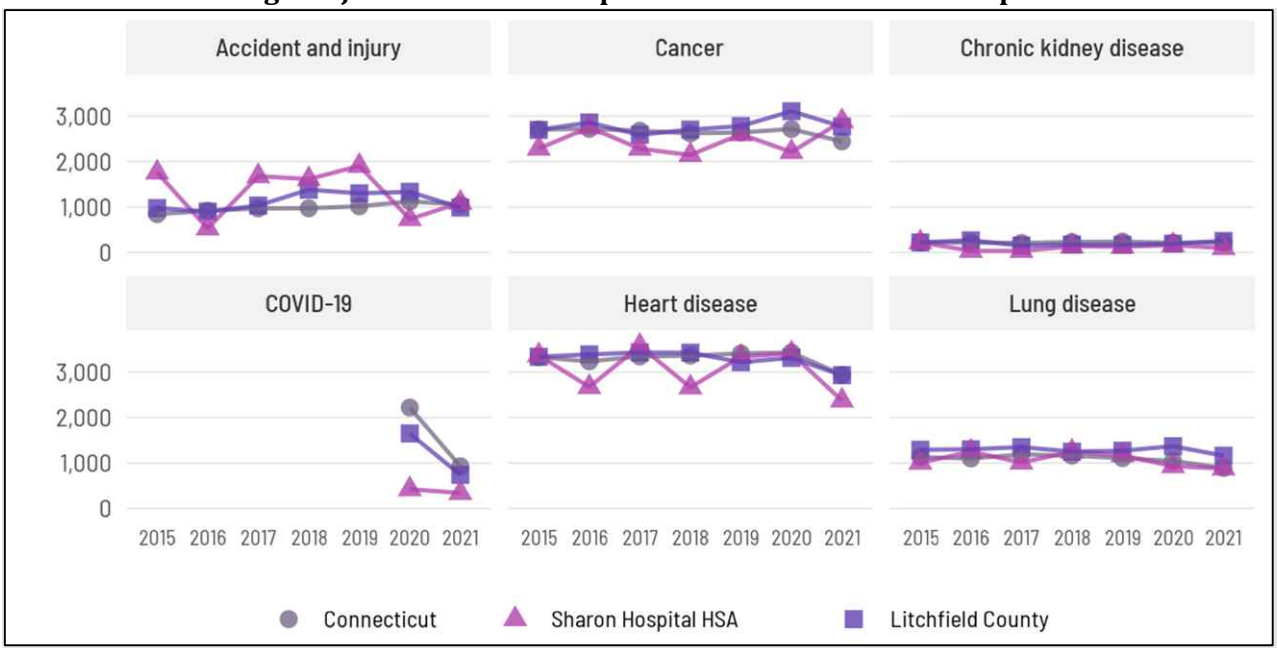
mortality rates were similar to mortality rates from heart disease and cancer. The Connecticut HSA differed from county and statewide findings with a declining rate of death in 2020, although residents of the HSA suffer a higher overall premature death rate per 100,000 (6,600) than the state (6,100). Within the Connecticut HSA, cancer, heart disease, and poisonings (including overdose) were the leading causes of premature death from 2015 to 2021.

Connecticut HSA Age-Adjusted, All-Cause Mortality per 1 Million Residents 2015-2021



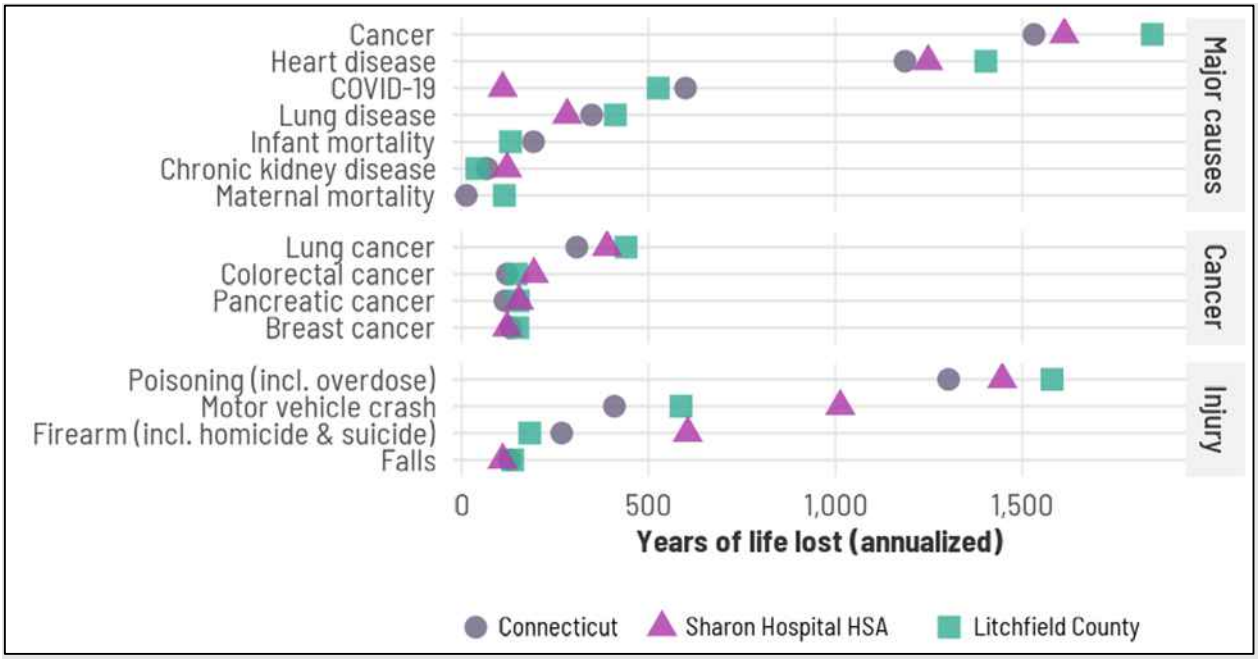
Source: DataHaven analysis (2021)

Connecticut HSA Age-Adjusted Death Rates per 1 Million Residents for Top Causes of Death



Source: DataHaven analysis (2021)

Connecticut HSA Years of Potential Life Lost Before Age 75 per 100,000 Residents by Cause of Death 2015-2021



Source: DataHaven analysis (2021)

Connecticut HSA residents generally report a lower burden of chronic disease relative to surrounding communities, as evidenced by hospital and ED encounters data. The following table compares age-adjusted encounter rates for leading causes of morbidity and mortality for the Connecticut HSA and neighboring Danbury and Norwalk regions.

Age-Adjusted Hospitalization and ED Encounters for Leading Causes of Morbidity and Mortality

	Sharon Hospital HSA	Greater Danbury	Greater Norwalk
Hypertension	668	905	733
Type 2 Diabetes	290	561	375
Heart Disease	143	203	201
Asthma	137	222	167
COPD	142	191	113
Uncontrolled Diabetes	25	64	54

Source: DataHaven analysis (2021) of 2018-2021 Connecticut Hospital Association CHIME

Prior to COVID-19, the top leading causes of death for US residents were chronic diseases. Within the New York Mid-Hudson Region, the leading cause of death for nearly all counties, including Dutchess, was heart disease. Other top causes of death included cancer, chronic lower respiratory disease (CLRD), and stroke.

The following table depicts deaths and death rates from the top five leading causes of death in Dutchess County and the state overall. Dutchess County has historically had similar or lower death rates than the state, except for accidents which trends higher. This finding is consistent with more positive health behaviors, like physical activity and nutrition, among Dutchess County residents. However, it is worth noting that more than one-quarter of Dutchess County adults had obesity in 2016, an increase from 2013-2014 findings (24%) and higher than the statewide average.

Top Five Leading Causes of Death within the New York Service Area

	#1 Cause of Death	#2 Cause of Death	#3 Cause of Death	#4 Cause of Death	#5 Cause of Death
Dutchess County	Heart Disease	Cancer	CLRD	Accidents	Stroke
	No.: 665	No.: 533	No.: 134	No.: 133	No.: 95
	Rate: 161.4	Rate: 130.1	Rate: 32.3	Rate: 42.1	Rate: 24.0
New York State	Heart Disease	Cancer	Accidents	CLRD	Stroke
	Rate: 167.1	Rate: 133.6	Rate: 33.8	Rate: 27.7	Rate: 23.9
New York State excl New York City	Heart Disease	Cancer	CLRD	Accidents	Stroke
	Rate: 161.3	Rate: 143.1	Rate: 33.7	Rate: 39.6	Rate: 27.0

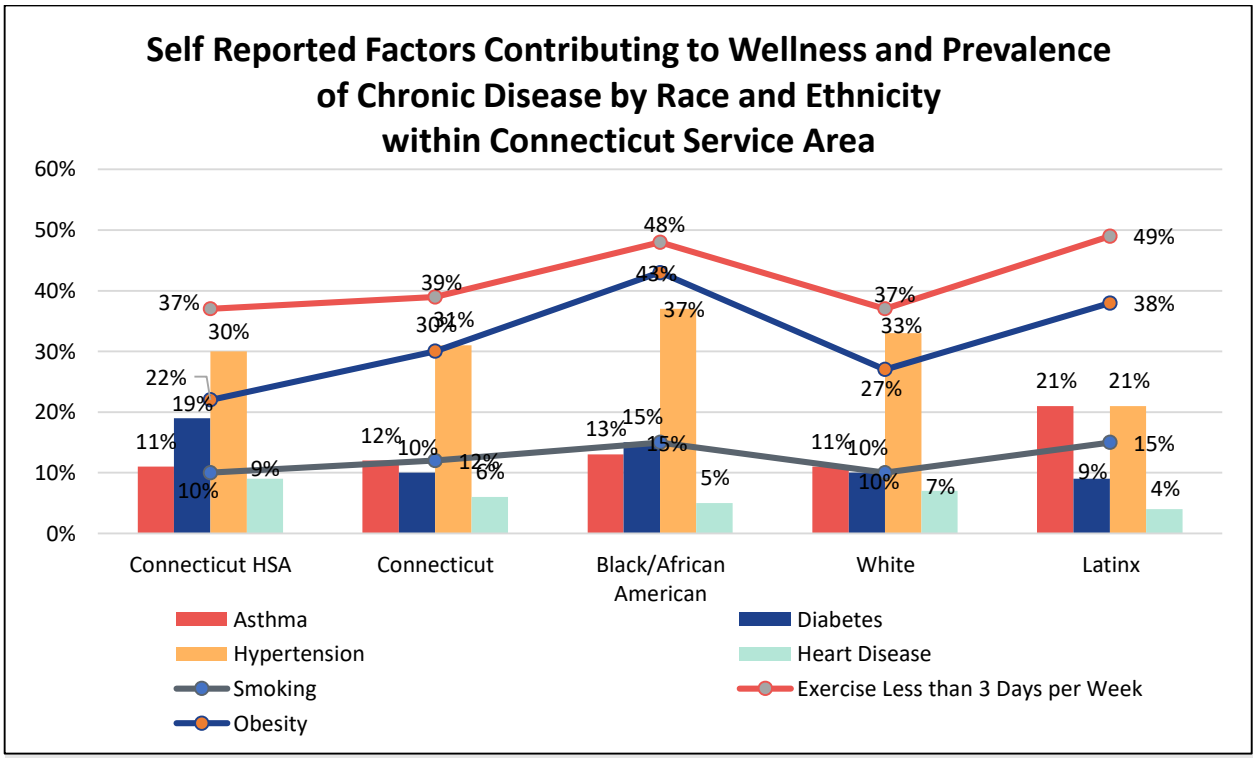
Source: Mid-Hudson Region CHNA, NYS Department of Health Vital Statistics, 2019

Adult Health Risk Factor Indicators within the New York Service Area

	Dutchess County	Mid-Hudson Region	New York State	New York State excl New York City
Participation in leisure time physical activity (2018)	80.2%	78.1%	76.4%	78.3%
Consume less than one fruit and less than one vegetable daily (2018)	25.4%	25.8%	28.1%	26.1%
Consume one or more sugary beverages daily (2018)	23.5%	22.3%	24.7%	25.5%
Adults who have obesity (2016)	26.2%	22.9%	25.5%	27.4%

Source: Mid-Hudson Region CHNA, NYS Department of Health Expanded Behavioral Risk Factor Surveillance system, 2016, 2018

Across the Connecticut and New York service areas, it is clear that social determinants of health directly impact health risk factors and ultimately chronic disease, resulting in inequities in life expectancy by race and neighborhood. This connection is demonstrated in the following graph which looks at prevalence of self-reported factors like obesity and physical inactivity and prevalence of chronic conditions like hypertension and diabetes within the Connecticut service area.



Source: 2021 DataHaven Community Wellbeing Survey

Maternal and Child Health

Having a healthy pregnancy is the best way to have a healthy birth and a healthy start to life. The data show that most people in the Connecticut and New York service areas are able to access early prenatal care, which is the best way to promote a healthy pregnancy and delivery. However, this positive experience is not shared equally across communities or population groups. Trends to note include a slightly higher proportion of people within the Connecticut HSA receiving late or no prenatal care compared to the state overall, and wide disparities in access among pregnant people of color in both Connecticut and New York service areas. These disparities contribute to more negative birth outcomes like low birth weight and preterm birth among people of color.

Infant mortality measures the rate of death under one year of age per 1,000 live births. Maternal mortality measures the rate of death during pregnancy or within one year of the end of pregnancy. Both measures are internationally utilized as key community health indicators because they are particularly sensitive to structural factors including social and economic factors and quality of life conditions, such as housing insecurity, educational attainment of the mother, and ACEs.

Disparities in infant and maternal mortality are measures of structural inequities that are at play well before a mother gets pregnant or gives birth. Therefore, upstream strategies that address the root causes of inequities can have far reaching impact on these indicators. Statewide data show that infant mortality impacts Black babies at two to three times the rate as white babies and approximately twice the rate of Latinx babies. Maternal mortality impacts Black pregnant people at more than three times the rate of white pregnant people in Connecticut, and more than four times the rate of white pregnant people in New York.

2016-2018 Selected Birth Outcomes by Race and Ethnicity of Parent Giving Birth within Connecticut Service Area

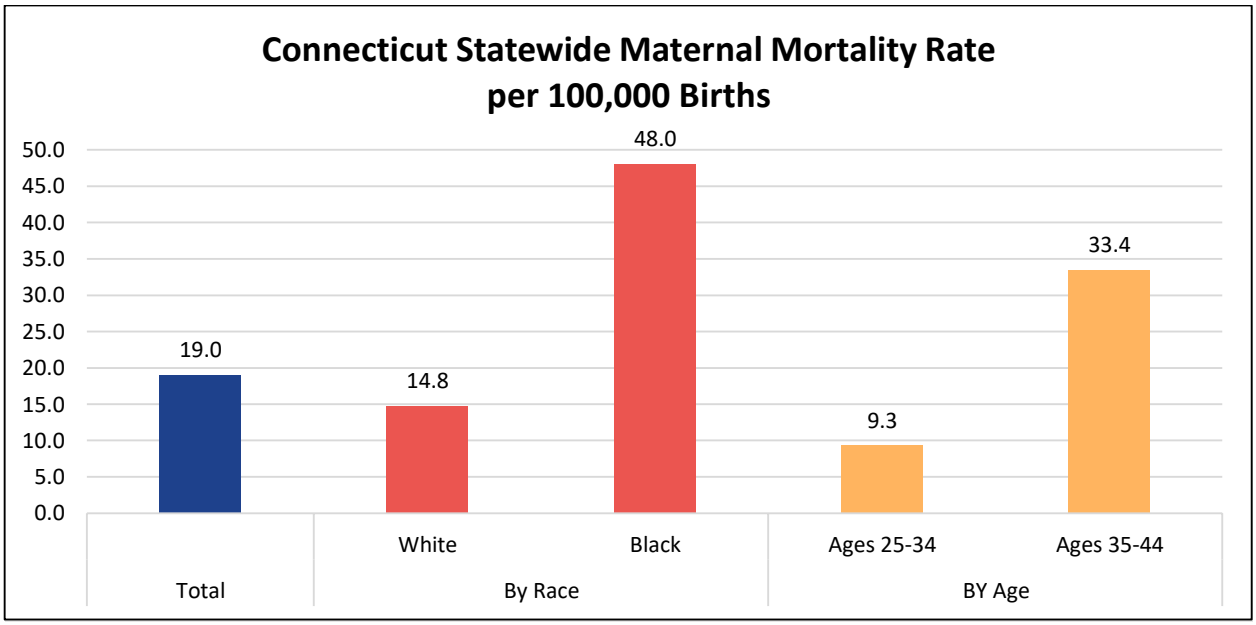
	Total	Asian	Black	White	Latina		
					Latina (overall)	Puerto Rican	Other Latina
Late or no prenatal care							
Connecticut HSA	5.2%	NA	NA	4.2%	NA	NA	NA
Litchfield County	3.2%	NA	5.4%	2.8%	5.4%	4.7%	5.6%
Connecticut	3.4%	3.5%	5.7%	2.5%	4.0%	2.9%	5.1%
Low Birth Weight							
Connecticut HSA	0.0%	NA	NA	NA	NA	NA	NA
Litchfield County	6.4%	8.4%	8.7%	6.5%	4.9%	6.8%	4.2%
Connecticut	7.8%	8.7%	12.1%	6.4%	8.3%	10.2%	6.6%
Infant Mortality (per 1,000 live births)							
Connecticut HSA	NA	NA	NA	NA	0.0	NA	NA
Litchfield County	2.9	NA	0.0	1.7	NA	NA	NA
Connecticut	4.6	NA	9.5	3.1	5.0	NA	NA

Source: DataHaven analysis (2021) of data from the Connecticut Department of Public Health Vital Statistics.

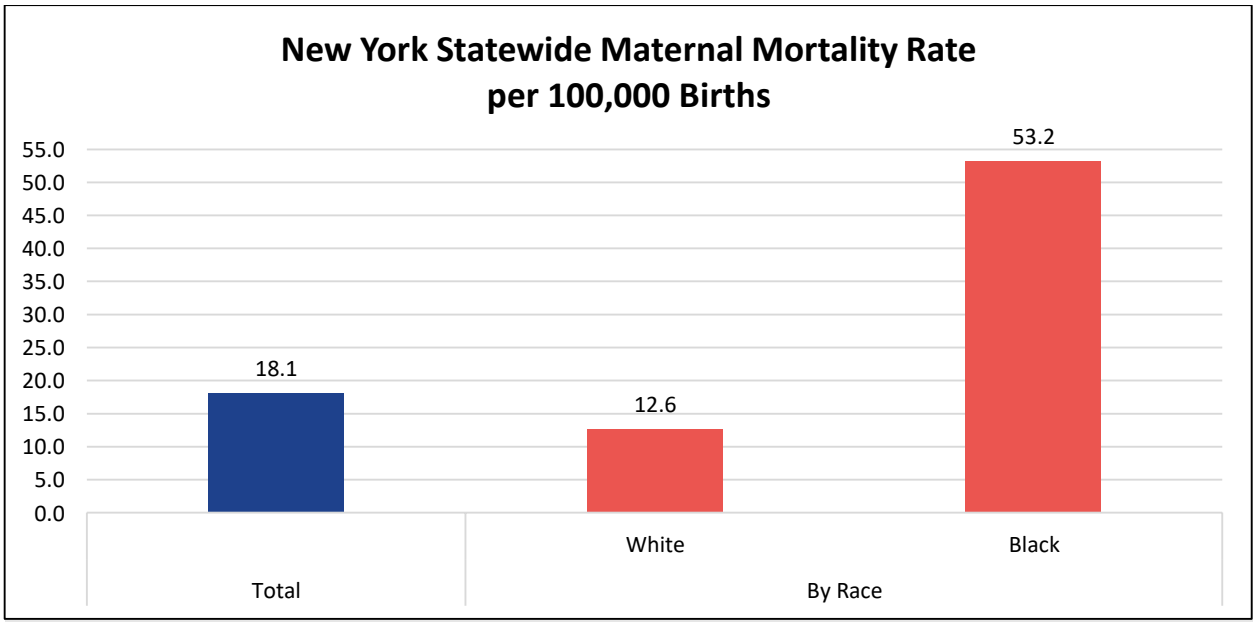
2017-2019 Selected Birth Outcomes by Race and Ethnicity of Parent Giving Birth within New York Service Area

	Total	Non-Hispanic Black	Non-Hispanic White	Latinx
Early (1st trimester) Prenatal Care				
Dutchess County	84.4%	77.8%	88.0%	79.7%
Mid-Hudson Region	77.8%	NA	NA	NA
New York State	73.6%	69.2%	81.8%	73.2%
Teen Pregnancy Rate per 1,000 Females Under Age 18				
Dutchess County	NA	8.1	2.0	5.9
Mid-Hudson Region	NA	NA	NA	NA
New York State	NA	8.2	1.8	7.0
Preterm (before 37 weeks) Births				
Dutchess County	9.2%	NA	NA	NA
Mid-Hudson Region	8.3%	NA	NA	NA
New York State	9.0%	12.9%	7.6%	9.8%
Low Birth Weight				
Dutchess County	7.5%	12.4%	6.5%	8.1%
Mid-Hudson Region	7.1%	NA	NA	NA
New York State	8.1%	12.9%	6.3%	8.3%
Infant Mortality (per 1,000 live births)				
Dutchess County	4.3	NA	NA	NA
Mid-Hudson Region	3.6	NA	NA	NA
New York State	4.3	8.8	3.3	3.9

Source: Mid-Hudson Region CHNA, NYS Department of Health Community Health Indicator Reports, 2021



Source: America's Health Rankings analysis of CDC WONDER Online Database, Mortality files, 2013-2017



Source: NYS Department of Health, 2016-2018

The CHNA data findings were analyzed to inform health priorities for the Sharon Hospital Service Area. The data included in this report are valuable for tracking and benchmarking community health status indicators, as well as for identifying emerging community needs. In addition to the research collected as part of the 2022 CHNA, community conversations were held to solicit feedback on health priorities and opportunities for community health improvement.

Evaluation of Impact from 2019-2022 Community Health Improvement Plan

Each Nuvance Health hospital has a Community Health Committee (CHC) with representatives from the board, the executive team, hospital staff, community members and local health departments and community agencies. The CHC at Sharon Hospital convened workgroups to review the findings of the Regional Community Health Needs Assessment and review the local health department priority areas to determine the hospitals' community health improvement priorities for the 2019-2021 period.

Sharon Hospital identified the following two priorities:

- Prevent chronic diseases.
- Promote well-being and prevent mental and substance use disorders.

The workgroups developed goals, objectives, strategies, action steps, and metrics to measure success for these priority areas.

Due to the COVID-19 pandemic, many of the planned community health programming and activities related to the prevention agenda priorities and implementation plan outlined in the 2019-2021 plan were put on-hold or scaled back due to social distancing and hospital visitation policies. The Let's Improve our Nutrition School Pilot Program, kicked off during the 2018/2019 school year, was paused during the pandemic when schools moved to virtual learning. Where possible programs, like Mental Health First Aid and support groups, were moved to an online platform like Zoom.

As a result of the pandemic Sharon Hospital pivoted their community programming to focus on COVID-19 education, testing, and vaccinations. In 2020, the hospital set up drive-through COVID-19 testing for the community and partnered with the local private, residential schools to set up N95 fit test clinics for their staff. The Nuvance Health hospitals helped staff a community hotline for information and questions in the early pandemic. Additionally, from 2020 to 2022, there was a regular cadence of Facebook Live Q&A and informational sessions in English and Spanish, with over 35,000 views. Many of the Sharon Hospital staff became local resources on COVID and the impact of the pandemic on the community. They provided hours of radio and Zoom interviews for various local radio shows, newspapers, senior programs and local community groups.

Where CHIP efforts did continue to address chronic disease prevalence in the region, at the same time, the emerging mental health disparity brought on by the pandemic did make it necessary to prioritize the implementation of interventions that address the increased prevalence of anxiety and depression in the community. In addition to addressing urgent mental health needs throughout the greater Sharon Hospital Service Area, the pandemic also brought into focus the importance of connecting community members with services that address food insecurity, housing, transportation, and utilities.

Next Steps

The Sharon Hospital Community Health Committee (CHC) is tasked with the review and oversight of the CHNA and CHIP in support of the organization's mission and population health initiatives.

Responsibilities and scope of activities

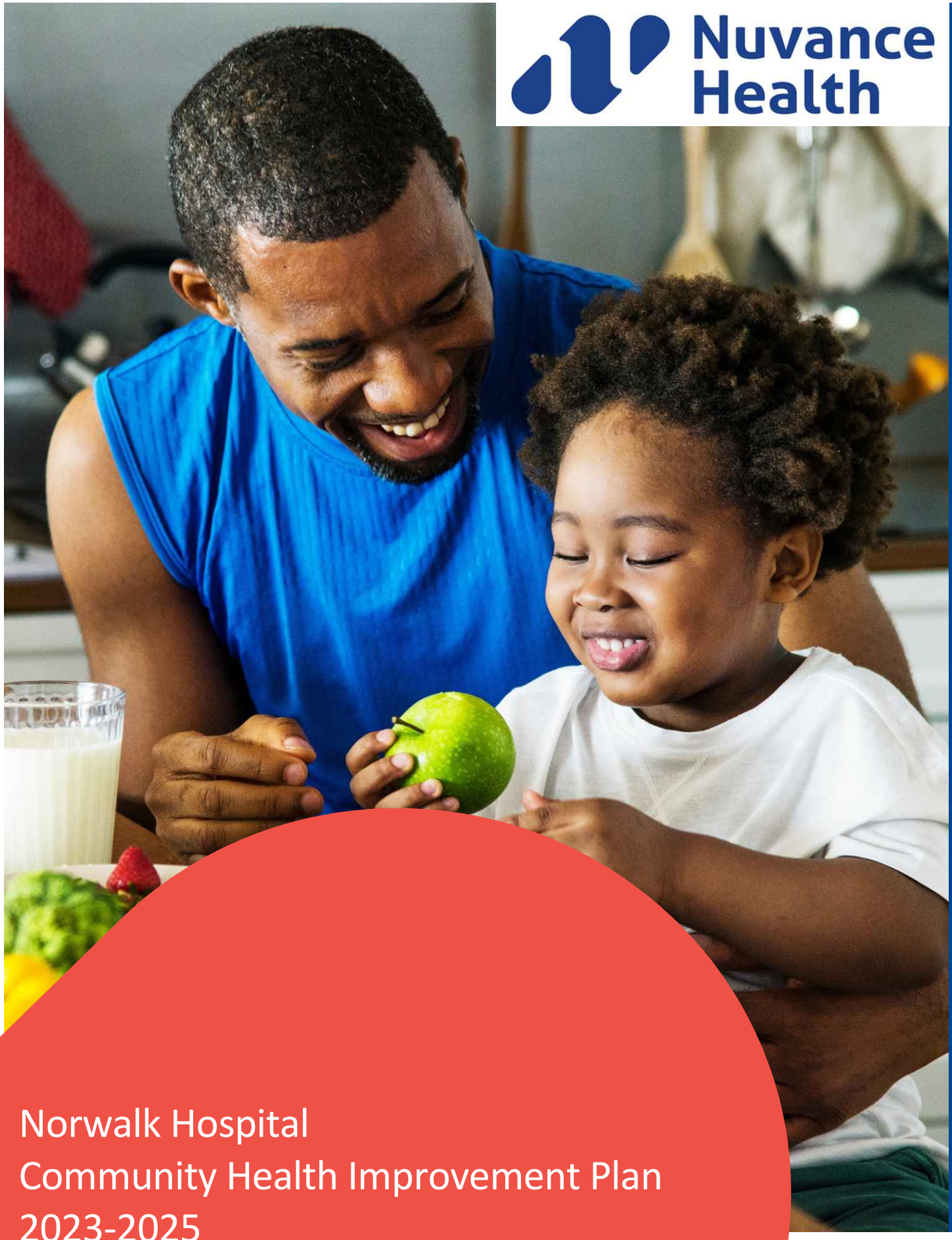
- Monitor assessments of population health status and social determinants that impact health
- Guide priority issues for action to improve community health
- Monitor implementation of approved work plans to address identified priority issues
- Help inform, guide, share and link successful programs and 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 2022 CHIP and implementation strategies will continue to be monitored at routine workgroup meetings and will be reported regularly to the Sharon Hospital CHC. The Sharon Hospital 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 Sharon Hospital board and the network Strategic Planning Committee.

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.

Nuvance Health



Norwalk Hospital
Community Health Improvement Plan
2023-2025

What is a Community Health Improvement Plan (CHIP)

A CHIP helps organizations move from data to action to address health priorities identified in the CHNA. The CHIP serves as a guide for strategic planning and a tool by which to measure impact by detailing goals, objectives, strategies, and action steps over the three-year reporting timeframe. Anchoring initiatives and community benefit activities to measurable objectives, the CHIP creates a framework for measuring the impact of collective action towards community health.

Community Input

Like the CHNA, the CHIP reflects input from diverse stakeholders and helps to foster collaboration among community-based organizations. Experts and community members provided input to define and recommend solutions to health challenges in our community. This input provided diverse perspectives on health trends and helped us better understand lived experiences of populations that experience barriers to care. Each Nuvance Health hospital has a Community Health Committee (CHC) with representatives from the board, the executive team, hospital staff, community members, local health departments, and community agencies. Nuvance Health employees participate in an array of community boards and task forces to foster collaboration with community partners.

Determining Priority Health Needs

To work toward health equity and improve health disparities, it is imperative to prioritize resources and activities for meaningful community impact. Through the CHNA research and ongoing engagement of community representatives, Nuvance Health collected input to determine the most pressing health needs affecting residents in the Norwalk Hospital service area. Priority health needs were determined through discussions with the hospital's Community Health Committee and input from community stakeholders including public health experts, health and human service providers, representatives of underserved populations, and community members. Nuvance Health reviewed recommendations for priority areas in consideration with existing resources and gaps in services to determine which community health priorities Norwalk Hospital could best impact over the next three years. Based on this determination, Norwalk Hospital's 2023-2025 CHIP will focus community benefit activities on **Preventing Chronic Diseases** and **Addressing Behavioral Health needs**.

Some health needs that were identified in the CHNA will not be directly addressed in Norwalk Hospital's CHIP, however these needs will continue to be met through clinical care services and support of community partners that focus on these issues. Examples of other community health needs that we identified in the 2022 CHNA that are not directly reflected in Norwalk Hospital's CHIP include housing and access to oral health care.

Alignment with Healthy Connecticut 2025

The Norwalk Hospital CHIP is aligned with the Healthy Connecticut 2025 State Health Improvement Plan (SHIP), a five-year strategic plan for improving the health of CT residents. This coordination serves to advance statewide and local efforts to improve the health and wellbeing of all people.

Alignment with State and Federal Requirements

The Norwalk Hospital 2022 CHNA and CHIP process and timeline are in line with IRS Tax Code 501(r) requirements to conduct a CHNA every three years and Connecticut state requirements for hospital community benefit reporting.

Advancing Health Equity

The CHNA documented disparities in poverty, education, and socioeconomic measures; access to health care and social services; disease rates and outcomes; and quality and length of life. These health disparities are most often driven by social determinants of health and reflect longstanding inequities. To work toward health equity, we need to redefine how we deliver health care, increase our knowledge and understanding, and confront policies that perpetuate disparities. At Nuvance Health we have outlined specific objectives and strategies to guide our efforts in creating more welcoming care settings that honor the diversity of our communities, and promote diverse and inclusive environments for our patients, staff, and providers.

Nuvance Health Commitment to Health Equity, Diversity, and Inclusion

Strategy: Increase cultural awareness and humility among staff and providers.

Initiatives:

- Use Patient Family Advisory Councils to provide feedback on care quality and patient experience.
- Recruit diverse representatives from community-based organizations to serve on Health Equity, Diversity, and Inclusion Advisory Committees, Community Health Committees, and Community Care Teams.
- Provide implicit bias and cross-cultural care education to all employees.

Strategy: Reduce disparities in outcomes among vulnerable patient populations.

Initiatives:

- Accurately collect patient demographic data and socioeconomic needs within medical records.
- Stratify clinical data to identify health disparities; implement strategies to reduce or eliminate these disparities.
- Evaluate clinical documents and educational materials to reflect preferred patient languages in each hospital service area.

Strategy: Increase diversity of staff and providers.

Initiatives:

- Cultivate awareness of healthcare careers within underserved communities.
- Modify recruitment and hiring processes to attract and support diverse staff and cultivate advancement opportunities.
- Grow scholarships, mentorship, and new workforce pipelines.

Strategy: Support a sustainable and equitable community.

Initiatives:

- Evaluate hiring, supply chain, and opportunities for local economic investment.
- Purchase goods from local and diverse vendors.
- Make contributions of dollars, time, and expertise to advance community initiatives.

Strategy: Increase, improve, strengthen, and evaluate partnerships with community-based organizations.

Initiatives:

- Foster collaboration with organizations that serve diverse or underserved populations.
- Invite input from diverse stakeholders to define and address community health needs.
- Support and cultivate opportunities for community-wide cross-cultural engagement.

Priority Area One: Prevent Chronic Diseases

Goals:

- Reduce health disparities in chronic disease prevention and disease.
- Reduce the impact of social drivers of health on patient outcomes.

Strategies:

- Increase early detection of cardiovascular disease, diabetes, prediabetes, and obesity.
- Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity.
- In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity.
- Increase access to care for populations that experience disparities in chronic disease burden and care.
- Improve cultural competency of providers and adopt inclusive healthcare environments.
- Partner with community agencies to connect people to resources for housing, food security, transportation, and related socioeconomic needs.
- Track data across populations to identify and address health disparities.

Norwalk Hospital Initiatives:

- Increase Social Drivers of Health screenings and referrals to community resources.
- Leverage Norwalk Hospital Diabetes Center to provide education and services.
- Increase Community Care Team (CCT) partnerships to increase services relating to SDOH to community members (Promote UW 211 with high-risk navigators to provide SDOH services to community)
- Increase referrals to Riverbrook Regional YMCA Diabetes Prevention Program.
- Partner and participate with the Norwalk Health Department on Healthy for Life Project community-based initiatives (e.g., Know Your Numbers, NorWalker, Growing Gardens Program, Food Access Initiative).
- In partnership with the American Heart Association, implement a Public Library Hypertension Program to provide education and home management of hypertension.
- Foster and strengthen partnerships with faith-based organizations to bring chronic disease prevention education to priority populations.
- Offer smoking cessation programs to community members; partner with YMCA smoking cessation programs.
- In partnership with United Way of Western Connecticut, promote Prosperi-Key program to assist ALICE populations.
- Implement primary care collaboration with the Connecticut Dental Health Partnership Program to connect community members to dental services.
- Expand telehealth for primary and specialty care and increase digital equity.
- Partner with the Norwalk Health Department, FQHCs, Americares Free Clinic, and others to promote awareness of CT HUSKY health insurance and help people apply.

Priority Area Two: Promote Well-Being and Prevent Mental and Substance Use Disorders

Goals:

- Strengthen opportunities to build well-being and resilience across the lifespan.
- Improve access to behavioral health services within the community.
- Prevent opioid overdose death.

Strategies:

- Integrate mental health screenings and services within primary care practices.
- Increase the traditional and alternative (community and technology based) places people can access health care.
- Strengthen community partnerships in underserved communities.
- Increase understanding of the impact of trauma.
- Provide expertise and support to reduce misuse of alcohol and drugs.
- Reduce opioid prescriptions in primary and specialty care settings.
- Provide expertise and support for community-based services for substance use disorders.

Norwalk Hospital Initiatives:

- Partner and participate with the Norwalk Health Department on statewide Suicide Prevention Program.
- Partner with The HUB for referral and education for behavioral health care.
- Refer patients to established Mental Health First Aid training sessions.
- Leverage expertise and resources of Norwalk Hospital Behavioral Health department.
- Implement Adolescent Intensive Outpatient program at Norwalk Hospital.
- Provide competency training for healthcare and social services providers on Screening, Brief Intervention, and Referral to Treatment (SBIRT).
- Recruit behavioral health providers including Psychiatrists and Licensed Clinical Social Workers to increase capacity of services.
- Increase access to behavioral health services in primary care practices.
- Expand behavioral health telehealth options and increase patient knowledge and ability to access to these services.
- Partner with Mid Fairfield Aids Project (MFAP) to provide harm reduction needle exchange and fentanyl test strips.

Collaborate with Community Partners

Nuvance Health hospitals consistently collaborates with a wide range of community partners that serve diverse populations across the communities we serve. Additional information can be found on our website nuvancehealth.org under Community Outreach and Sponsorship or by following this link: Community Outreach and Sponsorships | Nuvance Health.

Resources Allocated to the 2023-2025 Community Health Improvement Plan

At Nuvance Health, we are not only caregivers — we are also friends, family, and neighbors. Through our CHIP initiatives, we aim to increase well-being for everyone. The hospital initiatives and community benefit activities outlined in the 2023-2025 CHIP reflect Nuvance Health's dedication to investing in community partnerships and programs to promote wellness and health equity. The CHIP reflects a workplan that outlines specific resources and oversight for our initiatives. The Norwalk Hospital Community Health Committee exists to support this work and is tasked with the review and oversight of the CHIP, including the following responsibilities.

- Monitor implementation of the CHIP to address identified priority areas.
- 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.

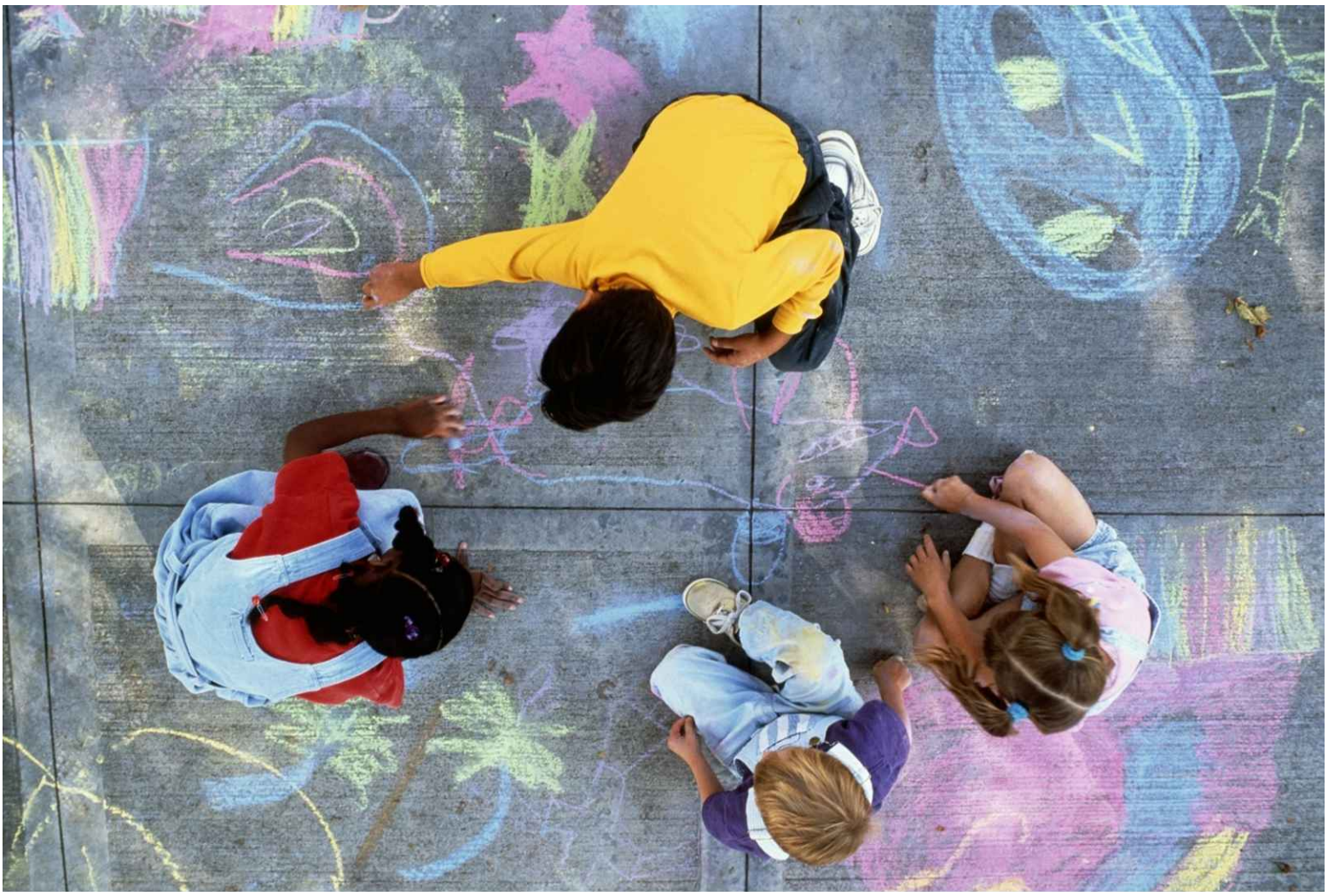
Maintaining Engagement and Tracking Progress

The Norwalk Hospital CHC oversees the development and updating of the CHNA and monitors community health activities and progress. The CHC meets quarterly to review progress toward the goals stated in the Community Health Improvement Plan and to determine whether any changes in objectives or strategies are required.

Dissemination to the Public

The 2022 Community Health Needs Assessment and 2023-2025 Community Health Improvement Plan are available on the Nuvance Health website under Community Benefit. Printed copies of these documents will be made available to the public (free of charge) in the administrative offices at Norwalk Hospital.

Norwalk Hospital
2022 Community Health Needs Assessment Report



Nuvance Health

A letter from Nuvance Health

Communication. Collaboration. Commitment.

These are essential elements for improving population health in our communities.

Nuvance Health is pleased to present our 2022 CHNA findings. This report includes a review and analysis of health and socio-economic data that impact the health of people across our service area. The purpose of this assessment is to identify the area's health needs so we may better align with stakeholders, such as public health and healthcare providers, about opportunities for improving the health of our region. These results allow Nuvance Health, local health departments, our community partners, and other providers to set priorities, develop interventions, and commit the appropriate resources to our region more strategically.

Our workforce of more than 15,000 compassionate caregivers provides high-quality care through our six nonprofit hospitals on seven campuses, multiple outpatient care sites, numerous primary care, and specialty provider locations, and increasing set of virtual healthcare services. Across the system, we offer state-of- the-art facilities, technology, and a breadth of clinical services.

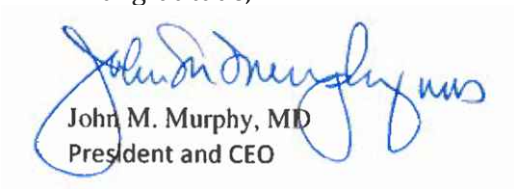
The staff of Nuvance Health are dedicated to the health and well-being of everyone in our region, regardless of race, ethnicity, age, gender, religion, sexual orientation, gender identity, gender expression, disability, economic status, and other diverse backgrounds. This is our promise to the more than 1.5 million children and adults we serve in western Connecticut and the Hudson Valley of New York.

To ensure our services are aligned with the healthcare needs of our community, we complete a Community Health Needs Assessment (CHNA) every three years for each hospital community, and it was conducted January to September 2022. This helps us better serve our community by measuring the health status of residents, gathering community input on health concerns, and identifying opportunities to collaborate. With the help of many state, county, and community partners, we had strong participation in our surveys, and we value this feedback and recognize all community stakeholders who play an integral part in advancing the health of our region.

And this is only the beginning. We continually assess how we serve our region so we can provide outstanding care, as well as education and outreach activities that meet priority needs. In doing so, we will continue to collaborate with our partners, educate our policy makers, and engage community residents to promote health for all residents of our region.

We look forward to our continued work together and thank you for putting your trust in us. At Nuvance Health, we are not only your caregivers—we are also your friends, family, and neighbors. Through our community benefit initiatives, we aim to increase well-being for everyone.

With gratitude,



John M. Murphy, MD
President and CEO

Table of Contents

Our Commitment to Community Health

Where some see impossible, we see what's possible. At Nuvance Health, we continually strive for progress and push past the status quo in all aspects of what we do. We are Nuvance Health!

Nuvance Health is an integrated health system offering convenient, accessible, and affordable care to community members. We're here for you–whenever and wherever you need us. Our talented team of more than 15,000 compassionate caregivers provides high-quality care through:

- Community hospitals
- Primary care and specialty practice locations
- Outpatient settings
- Home care services
- A skilled nursing and rehabilitation facility
- Telehealth visits

Our network also includes a well-known research institute, which brings breakthroughs from the lab directly to the bedside. We take research to heart and focus on treatments and cures that will benefit our community.

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 and Greater Norwalk community partners participated in a Community Health Needs Assessment (CHNA) to assess the health and social needs of the Greater Norwalk community.

Community partners:

- Americares 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 CHNA and the priority elements that will be used to develop the three-year Community Health Improvement Plan to guide our community benefit and community health improvement efforts.

2022 CHNA Executive Summary

CHNA Leadership

The 2022 CHNA was overseen by the Community Health Committee of the Board of Directors of Nuvance Health. The Committee includes representations of the hospital communities, including hospital Board leadership, administrative leadership from the Nuvance Health network, local health department directors, community stakeholders, and other key hospital stakeholders.

Norwalk Hospital Community Health Committee

- **Susan Beyman - Chair – Board Member**
- Trisha Bam– Board Member
- Peter Campbell – Board Member
- Pablo Colon – Board Member
- Thomas Dubin – Board Member
- Carol Bauer – Community (former NH Board Member)
- Janice Anderson – Community (The Hub)
- Theresa Argondezzi – Community (Norwalk Health Dept.)
- Daniella Arias – Community (Regional Youth Adult Social Action Partnership)
- Edward Briggs – Community (Ridgefield Health Dept.)
- Kelsey Ciarleglio – Community (High Focus Centers)
- Mark Cooper – Community (Aspetauk Health Dept.)
- Deanna D'Amore – Community (Norwalk Health Dept.)
- Lamond Daniels – Community (City of Norwalk)
- Jen Eielson – Community (New Canaan Health Dept.)
- MaryAnn Gennuario – Community (Riverbrook YMCA)
- Karen Gottlieb – Community (Americares)
- David Knauf – Community (Darien Health Dept.)
- Fred Lione– Community (former NH Board Member)
- Giovanna Mozzo – Community (The Hub)
- Jackie Romaniuk – Community – (CT Dental Health Partnership)
- Veronica Sullivan – Community (Americares)
- Amy Taylor – Community (Community Health Center of Norwalk)
- Margaret Watt – Community (Positive Directions-Center for Prevention & Counseling)
- Denique Weidema-Lewis – Community (Norwalk ACTS)
- Michael Witherspoon - Community

Professional Staff

- Rowena Bergmans – Nuvance VP Strategic Payer and Community Partnerships
- Sally Herlihy – Nuvance VP Strategic Planning & Bus Development
- Staci Peete – NH Community Care Team Manager
- Ildiko Rabinowitz – Nuvance AVP Health Equity Diversity & Inclusion
- Ellen Ryan – Nuvance Clinician
- Curtis Stewart – Nuvance Volunteer Services

Our Research Partners

Nuvance Health contracted with Community Research Consulting to compile the CHNA reporting and guide the development of the Community Health Improvement Plan. CRC is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. Their interdisciplinary team of researchers and planners have worked with hundreds of health and human service providers and their partners to reimagine policies and achieve measurable impact. Learn more about our work at buildcommunity.com.

DataHaven conducted the DataHaven Community Wellbeing Survey (DCWS), a statistical household survey to gather information on wellbeing and quality of life for Connecticut's neighborhoods. The DCWS is a nationally recognized program that provides critical, highly reliable local information not available from any other public data source. A 501(c)3 nonprofit organization and registered as a Public Charity with the State of Connecticut, DataHaven is a partner of the National Neighborhood Indicators Partnership, a learning network, coordinated by the Urban Institute, of independent organizations in 30 cities that share a mission to ensure all communities have access to data and the skills to use information to advance equity and wellbeing across neighborhoods.

The Greater New York Hospital Association (GNYHA) conducted the 2022 GNYHA CHNA Survey of adults aged 18 or older who live in a zip code or county served by the hospital. The survey was intended to garner resident input on community health priorities based on perceived importance and satisfaction. The survey used a non-probability convenience sample. A web-based survey tool and a paper-based tools were used to collect the survey data. Surveys were available in a variety of languages. The GNYHA CHNA questionnaire was translated from English into Spanish, Chinese, Russian, Yiddish, Bengali, Korean, Haitian Creole, Italian, Arabic, and Polish.

Methodology and Community Engagement

The 2022 CHNA included quantitative research methods and community conversations to determine health trends and disparities affecting Greater Norwalk. Community engagement was an integral part of the 2022 CHNA. In assessing community health needs, input was solicited and received from persons who represent the broad interests of the community, as well as underserved, low-income, and minority populations. These individuals provided wide perspectives on health trends, expertise about existing community resources available to meet those needs, and insights into service delivery gaps that contribute to health disparities and inequities.

The following research methods were used to determine community health needs:

- **Analysis of Health and Socioeconomic Data:** Public health statistics, demographic and social measures, and healthcare utilization data were collected and analyzed to develop a comprehensive community profile that illuminated health disparities and underlying inequities.
- **Community Surveys of Lived Experiences:** As part of the DataHaven Community Wellbeing Survey across Connecticut, a statistical telephone survey was conducted with nearly 400 households in the Greater Norwalk community to gather information on wellbeing and quality of life.
- **Community Perception Surveys:** As part of the GNYHA CHNA Survey, a web- and paper-based convenience survey was conducted with more than 471 households in the Norwalk Hospital service area to garner perceptions on community health priorities.
- **Input from Experts and Key Stakeholders:** Health and social service providers, public health experts, and representatives from a wide range of community-based organizations participated in the CHNA to guide the process and provide insights on community health needs.

Community Health Priorities

To work toward health equity, Nuvance Health commits to ensuring hospital resources and activities build upon existing priorities and collaborative activities, while ensuring responsiveness to emergent needs. Determination of priorities made by leadership of Nuvance Health included review of existing commitments, new research findings, and community feedback.

Nuvance Health will focus efforts on the following community health priorities as part of its 2022-2025 Community Health Implementation Plan (CHIP):

- Address Chronic Diseases
- Promote Well-Being and Address Mental and Substance Use Disorders

Nuvance Health is committed to continuing its collaboration with the Community Health Committee and other stakeholders to further refine focus areas within the identified health priorities. Together with these partners and stakeholders, Nuvance Health will create a CHIP that reflects collective health impact strategy and the many strengths and assets of our community partners to address these needs.

Board Approval

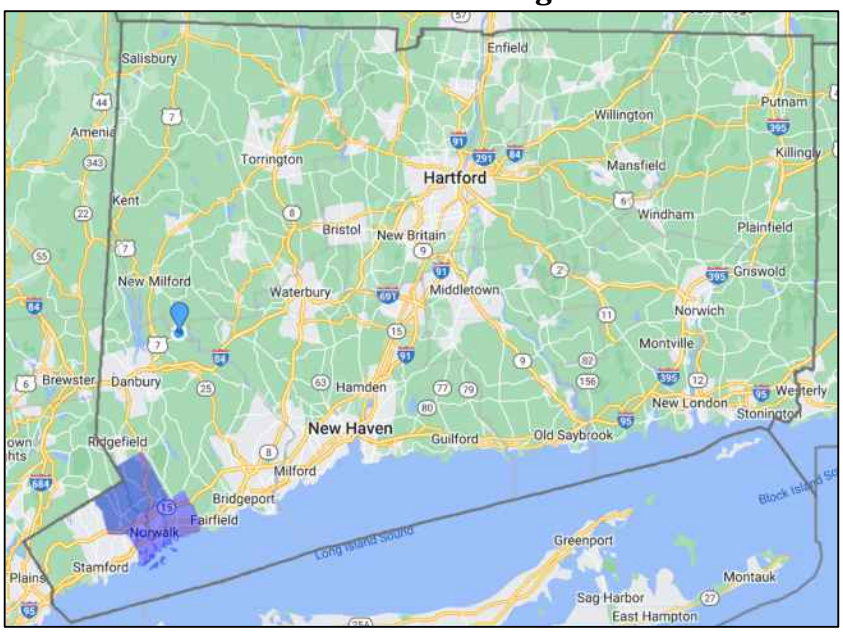
The 2022 CHNA was conducted in a timeline to comply with IRS Tax Code 501(r) requirements to conduct a CHNA every three years as set forth by the Affordable Care Act (ACA). The 2022 CHNA report was presented to the Nuvance Health Board of Directors and approved in September 2022.

Following the Board's approval, the CHNA report was made available to the public via the Nuvance Health website at Nuvance Health.

Norwalk Hospital Service Area

The 2022 CHNA provides local level health-related data about Norwalk, and the surrounding towns of New Canaan, Weston, Westport, and Wilton. This region is referred to as Greater Norwalk throughout the remainder of the report. The CHNA data may also be presented for all of Fairfield County, the home county of Norwalk, based on data availability.

Greater Norwalk Region



Greater Norwalk Region and 2020 Populations by Town
• New Canaan (20,622) • Norwalk (91,184) • Weston (10,354) • Westport (27,141) • Wilton (18,503)

Understanding changes in population demographics is critical to plan for changes in healthcare, housing, economic opportunity, education, social services, transportation, and other essential infrastructure elements.

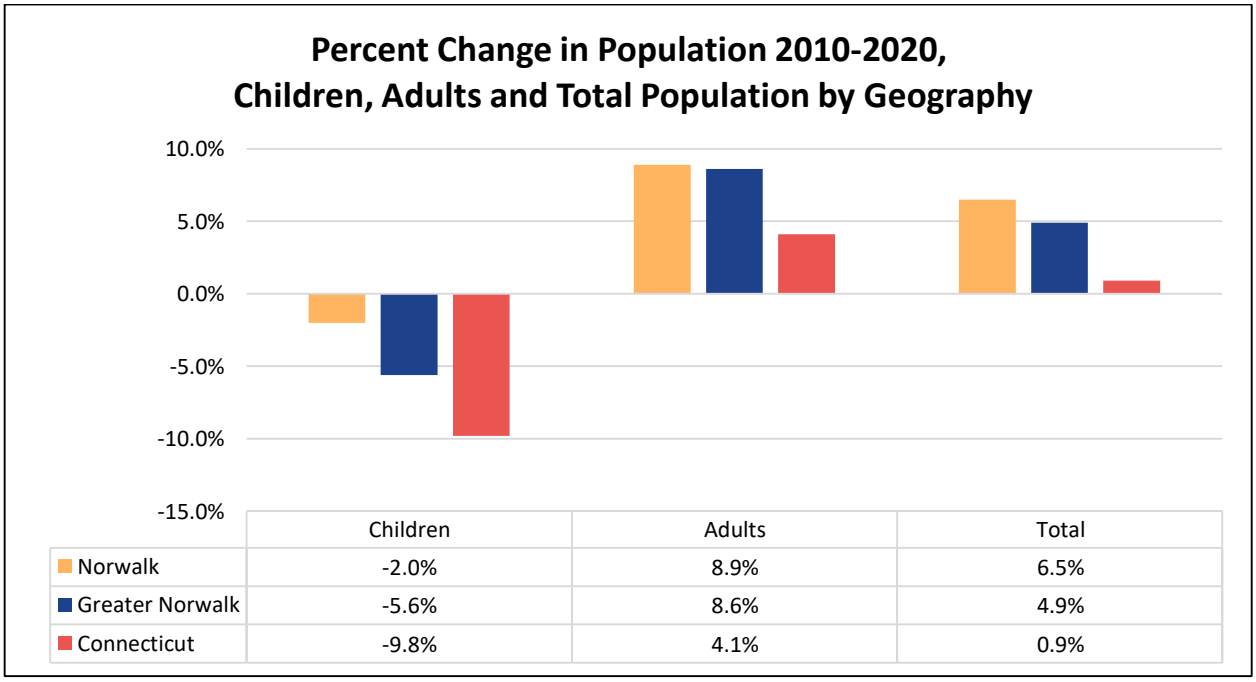
Connecticut overall is an aging state. Between 2010 and 2020, the state's population remained similar in total number, but increased in the proportion of adults and decreased in the proportion of children. During the same period, Greater Norwalk experienced a 5% increase in overall population, although this growth occurred largely within Norwalk, and the region overall is also

aging. Between 2010 and 2020, Greater Norwalk saw adult population growth of +10,198 individuals and child population loss of -2,367 individuals.

Total Population and Population Change by Age Group

	2010 Population	2020 Population	Change
Norwalk			
All Ages	85,603	91,184	+5,581
Children under age 18	18,874	18,502	-372
Adults 18 or over	66,729	72,682	+5,953
Greater Norwalk			
All Ages	159,973	167,804	+7,831
Children under age 18	42,062	39,695	-2,367
Adults 18 or over	117,911	128,109	+10,198
Connecticut			
All Ages	3,574,097	3,605,944	+31,847
Children under age 18	817,015	736,717	-80,298
Adults 18 or over	2,757,082	2,869,227	+112,145

Source: US Census Bureau 2020 Decennial Census P.L. 94-171 Redistricting Data



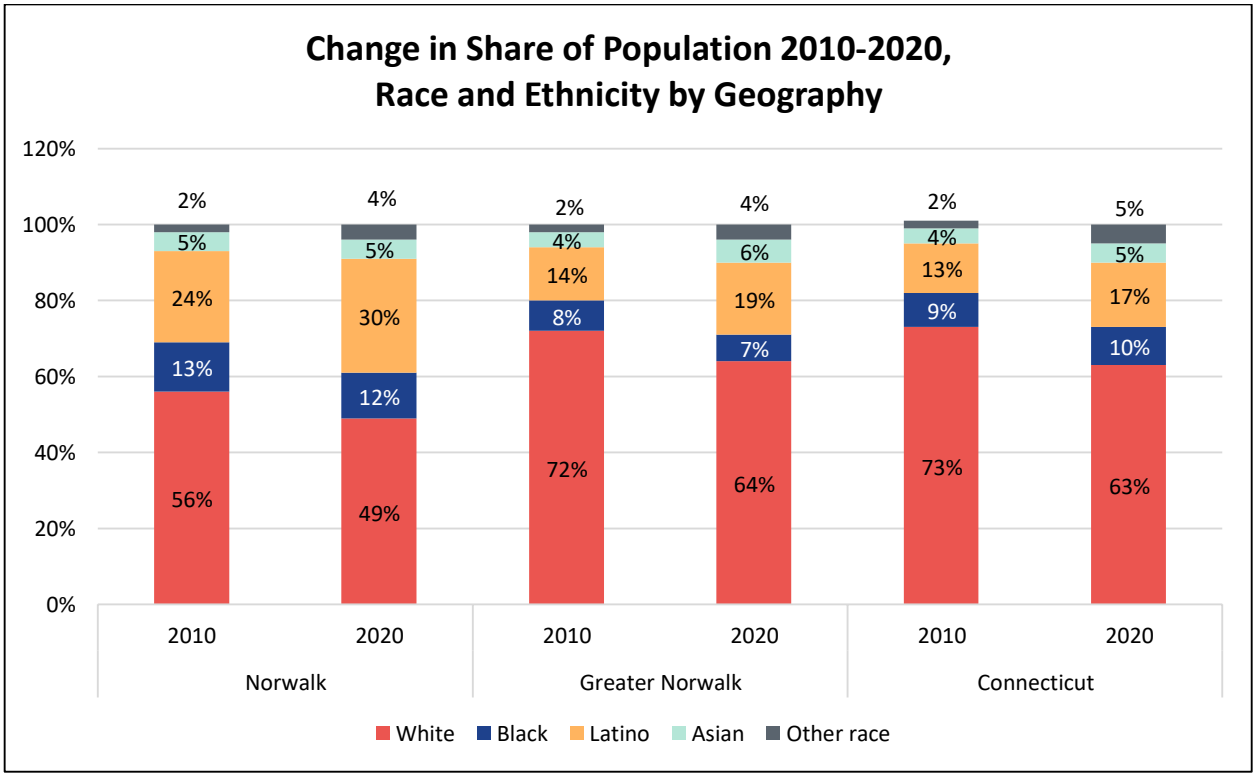
Source: US Census Bureau 2020 Decennial Census P.L. 94-171 Redistricting Data

The City of Norwalk is a majority-minority city, with a racial and ethnic diversity of residents unmatched in the surrounding areas. Regionally, Greater Norwalk has a similar racial and ethnic makeup as Connecticut overall, and consistent with statewide trends, the region is becoming more diverse.

Total Population by Race and Ethnicity

	White	Black	Latino	Asian	Native American	Other race/ethnicity
Norwalk						
Count	44,314	11,074	27,629	4,772	102	3,293
Share	49%	12%	30%	5%	<1%	4%
Greater Norwalk						
Count	106,971	12,037	31,889	9,821	129	6,957
Share	64%	7%	19%	6%	<1%	4%
Connecticut						
Share	63%	10%	17%	5%	<1%	5%

Source: US Census Bureau 2020 Decennial Census P.L. 94-171 Redistricting Data

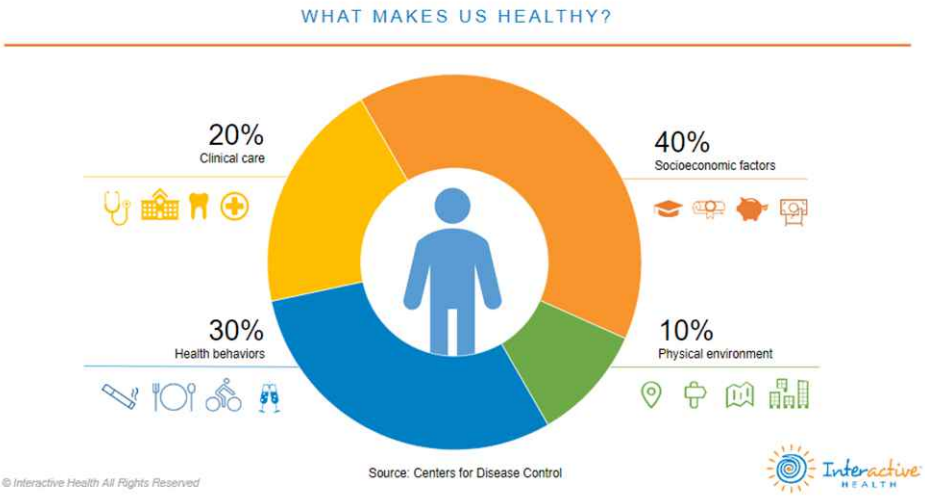


Source: US Census Bureau 2020 Decennial Census P.L. 94-171 Redistricting Data

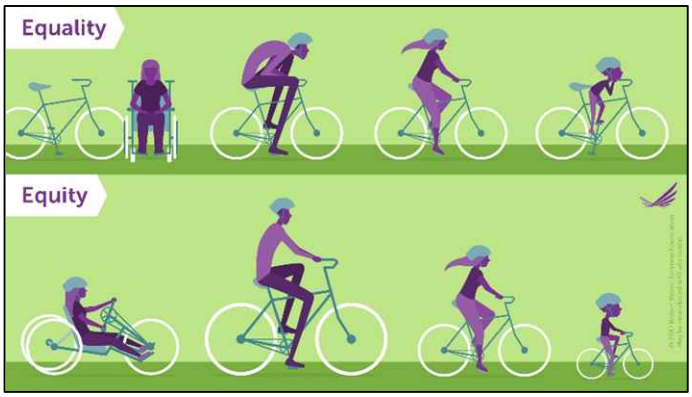
Social Determinants of Health and Health Equity: A closer look at factors that influence well-being

Social determinants of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes. Healthy People 2030, the CDC's national benchmark for health, outlines five key areas of SDoH: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

While health improvement efforts have historically targeted health behaviors and clinical care, public health agencies, including the US Centers for Disease Control and Prevention (CDC), widely hold that at least **50% of a person's health profile is determined by SDoH.**



Addressing SDoH is a primary approach to achieving *health equity*. **Health equity can be simply defined as "a fair and just opportunity for every person to be as healthy as possible."** To achieve health equity, we need to look beyond the healthcare system to dismantle systematic inequities born through racism and discrimination like power and wealth distribution, education attainment, job opportunities, housing, and safe environments, to build a healthier community for all people now and in the future.

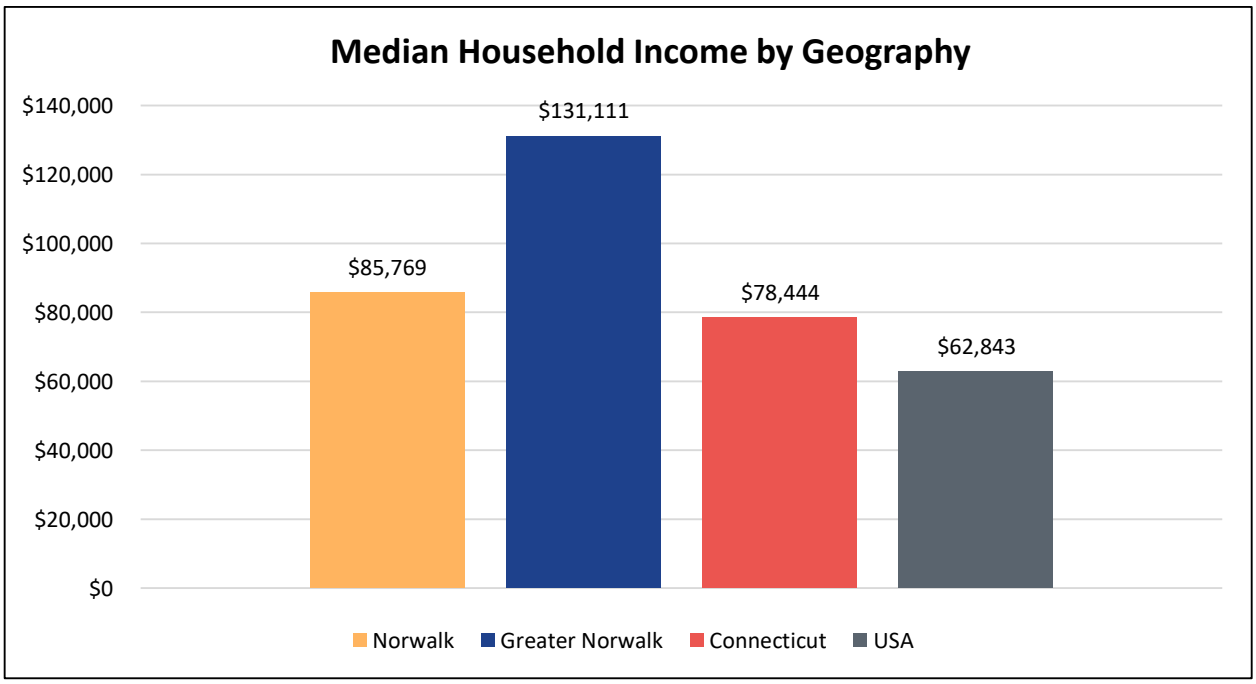


Social Determinants of Health within Greater Norwalk

Economic Stability

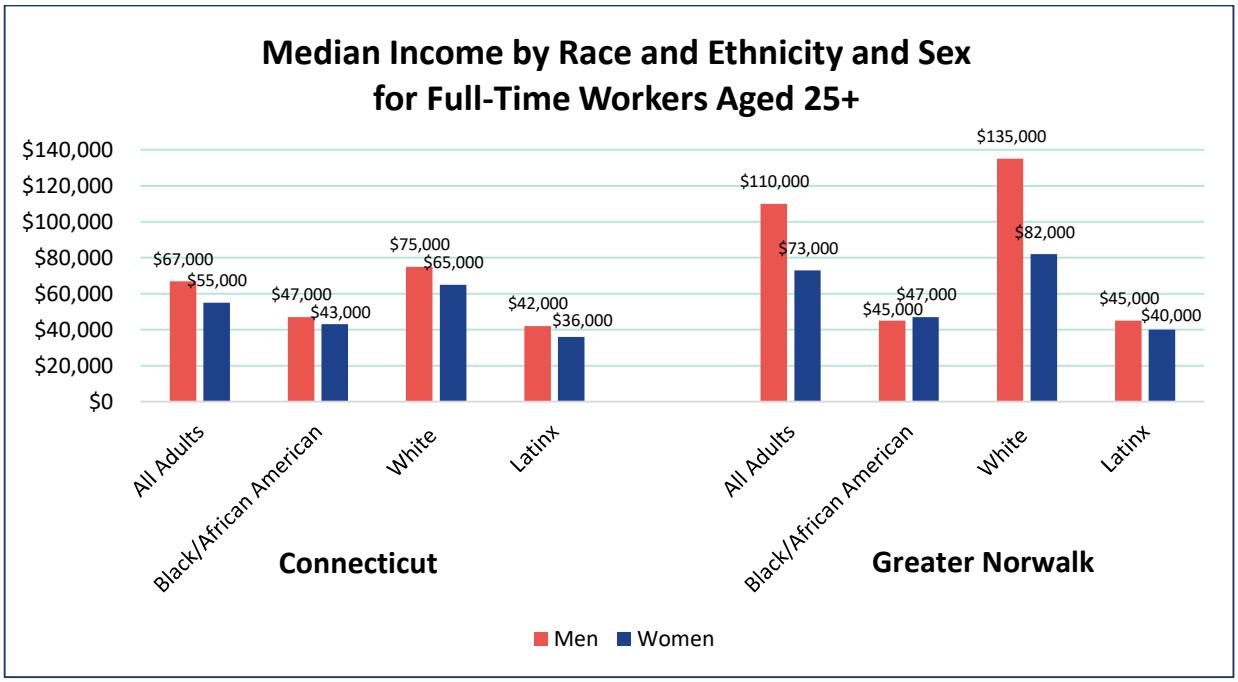
Income and work impact health outcomes. For example, many Americans access health insurance through their job, although not all types of work provide access to health insurance. Beyond health insurance, making healthy choices, such as purchasing lean meats and fresh produce or joining a gym, all cost money. Securing employment that allows individuals to provide a safe and decent home, nutritious food, transportation, child and elder care services, leisure activities, exercise, and medical needs depends on many factors. These factors can include education, age, access to employment opportunities, racism, language, and literacy, among others.

The median household income in Greater Norwalk is $131,111, compared to $77,696 statewide, and fewer residents or children in Greater Norwalk live in poverty compared to the state overall. However, this positive experience is not shared by all residents. Within the region, median household incomes by town range from $85,769 in Norwalk to $222,535 in Weston. Norwalk also has higher poverty levels, affecting 10% of all residents and 14% of children.

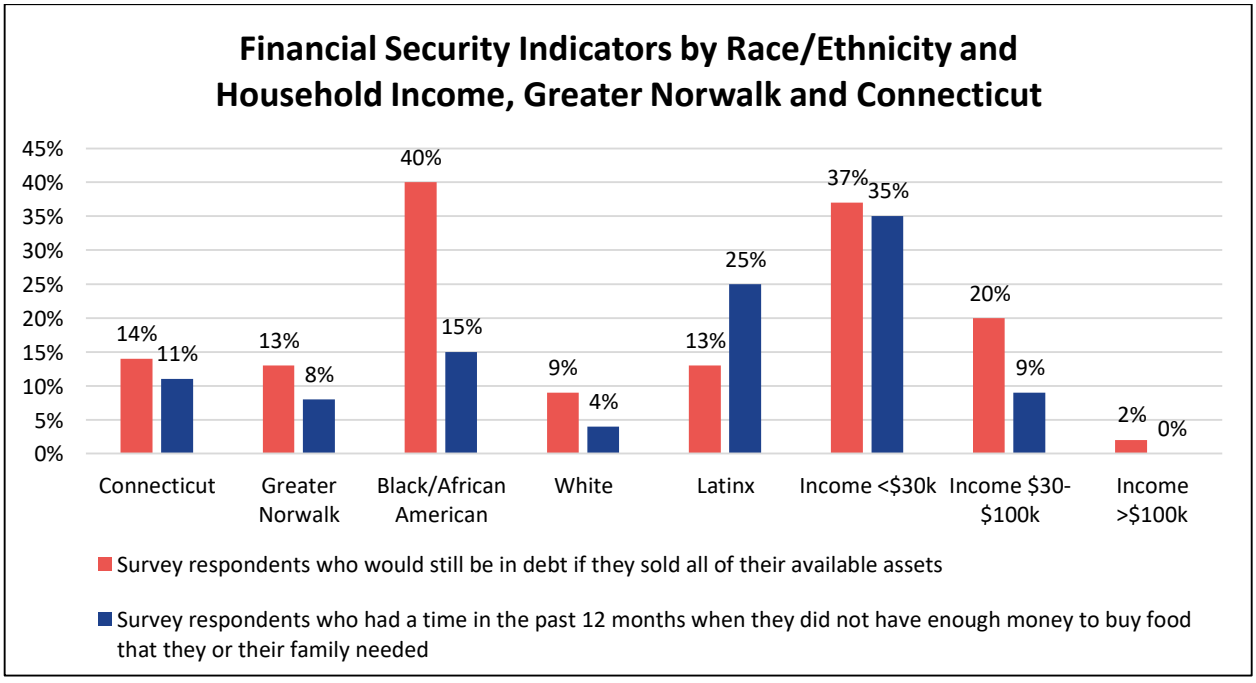


Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Historical barriers based on race, gender, ethnicity, and other factors continue to impact financial security and income for people today. For example, within Greater Norwalk, median income for male Black/African American workers is approximately one-third less than for male white workers. Among Black/African American Community Wellbeing Survey respondents in Greater Norwalk, 40% said they would still be in debt if they sold all of their assets compared to 9% of white respondents. This disparity in economic resources impacts the ability of people with lower incomes to engage in health promoting activities, creating differences in the choices available to people in Greater Norwalk to live their healthiest lives.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

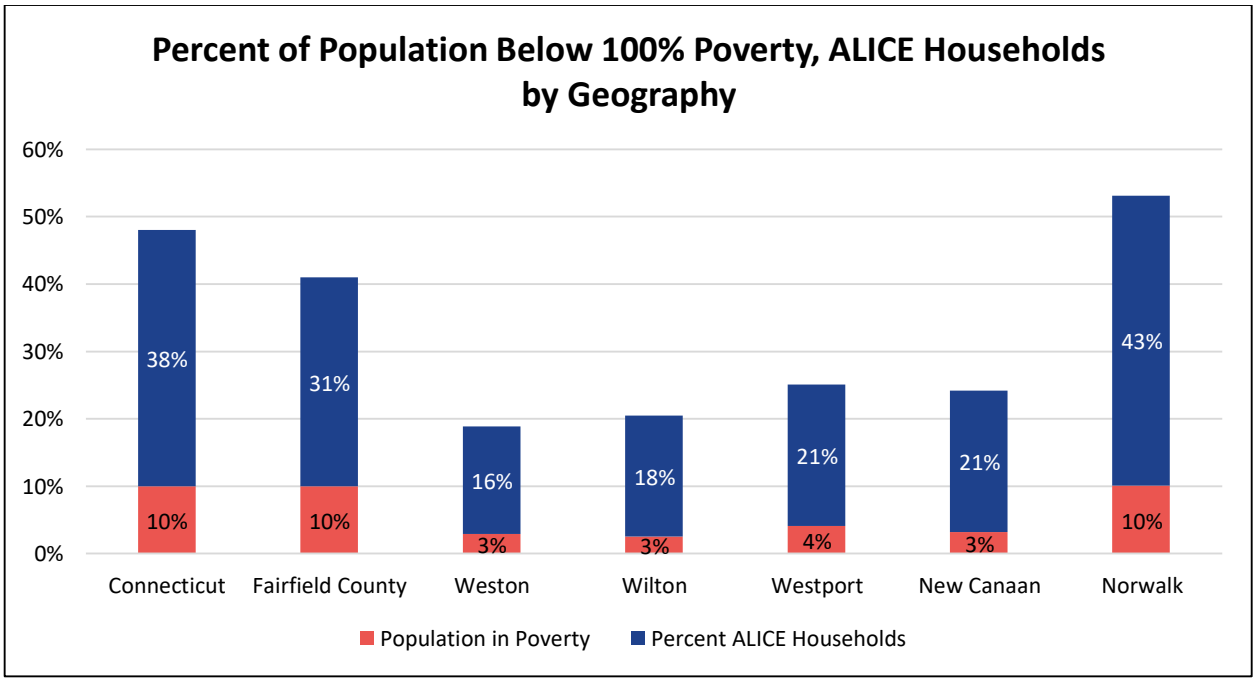


Source: 2021 DataHaven Community Wellbeing Survey

Asset Limited, Income Constrained, Employed (ALICE) The ALICE threshold is an index that captures the percent of households whose income is above the federal poverty level, but below the threshold necessary to meet all basic needs based on localized cost of living and local average

household sizes. ALICE measures the proportion of working poor and households who struggle to meet basic needs and are a paycheck or two away from acute financial strife.

While the proportion of people living below the poverty level is relatively low across the Greater Norwalk Area, more than 1 in 10 and up to 43% of all households throughout the area met the ALICE threshold ***before the start of the COVID-19 pandemic***. While the data regarding these measures during the pandemic are not yet available, anecdotal information suggests that the proportion of struggling households has increased during more recent years.



Source: United for ALICE and US Census Bureau American Community Survey 2019 5-year estimates

Where you live impacts the choices available to you. These choices impact your income, wellness, and ultimately how long you live. These place-based choices, as well as lived experiences like discrimination and racism, also inform perception of opportunities.

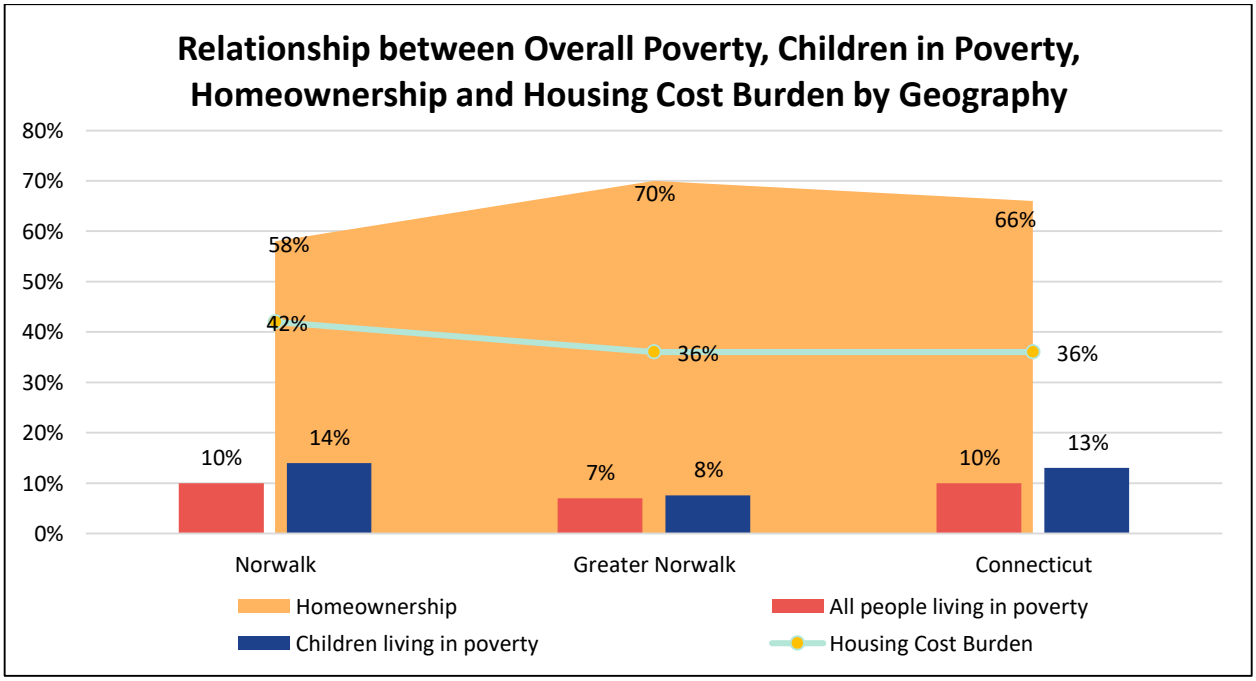
For neighborhoods, a higher proportion of homeownership means greater neighborhood stability. Greater neighborhood stability means greater opportunities for investment in infrastructure, such as schools, roads, public transportation, and green spaces, key elements for healthy living.

Owning a home is an investment. For many families, their home is their largest asset. However, historically, structures have been in place that prevent people of color and others from purchasing a home. Today, this historic structural inequity manifests in the financial assets that certain populations have been able to pass on to future generations. The security of knowing one has a home can also reduce chronic stress, a significant factor in developing chronic disease.

Housing is often the largest single monthly expense for households and should represent no more than 30% of a household's monthly income. When households spend more than 30% of their

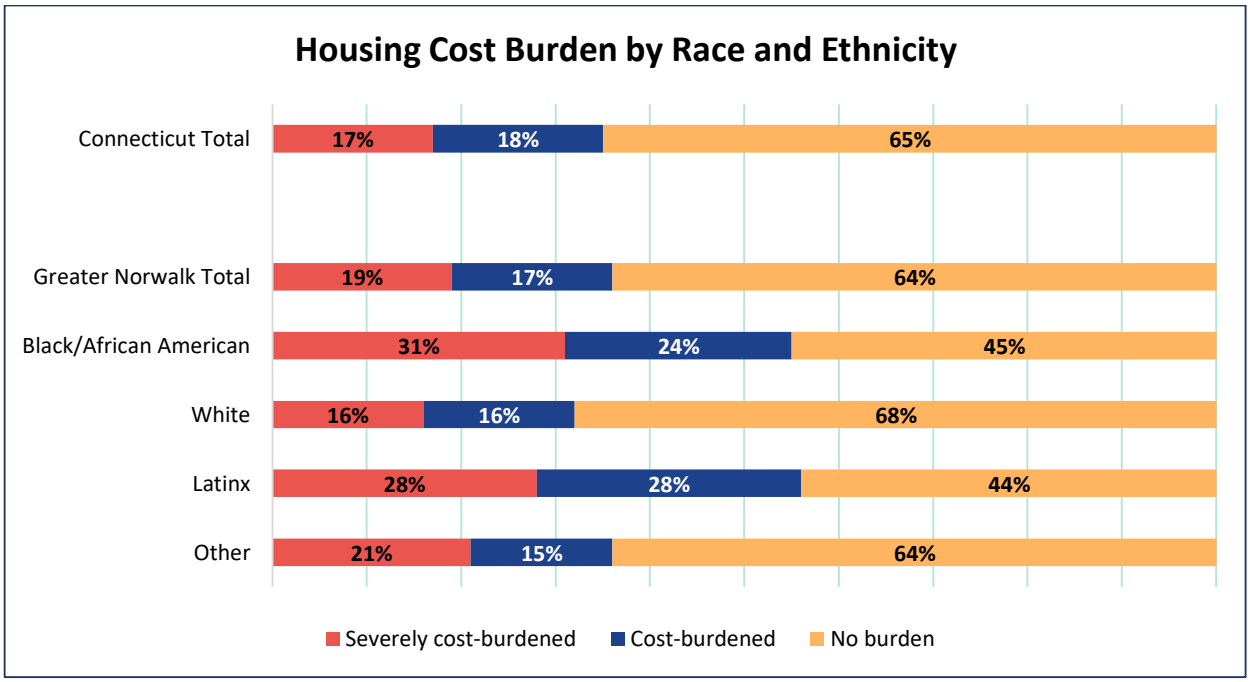
income on housing, they are considered housing cost burdened. When housing costs consume more than 30% of a household budget, fewer resources are available for other necessities like food, transportation, and childcare.

The graph below demonstrates that communities with greater proportions of homeowners are associated with fewer children living in poverty and fewer cost burdened households. However, it is worth noting that more than 1 in 3 households are considered housing cost burdened throughout the area.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Among renter households in Greater Norwalk, 46% are cost-burdened compared to 34% of owner households. Among Black/African American and Latinx householders (owner or renter), approximately 55% are cost-burdened compared to 32% of white householders.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Education Access and Quality

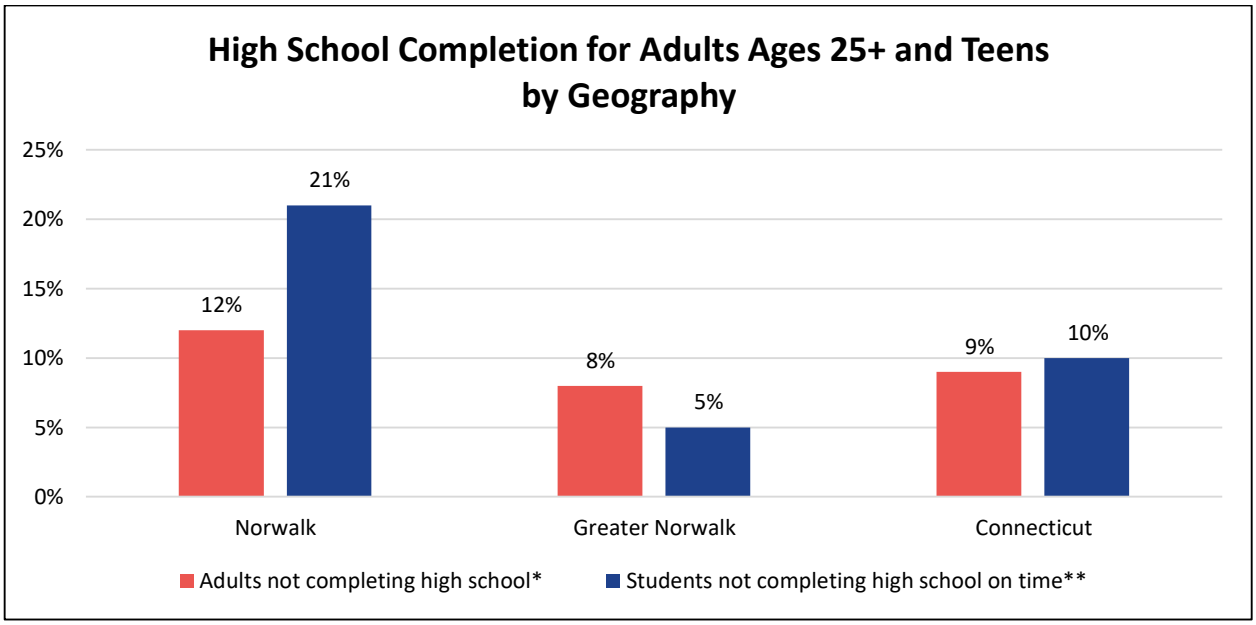
Education is one of the best predictors of good health and long lives. Availability of accessible, well-funded, and well-resourced public education opportunities and exposure to diverse employment pathways, such as in the healthcare and social services fields, build a strong foundation for young people and increase the opportunity for upward mobility, economic security, and better health.

Overall, people living in Greater Norwalk are well educated and residents perceive high likeliness for school success and job opportunities post-graduation. However, disparities in the city of Norwalk include 21% of high school students not graduating on time and 12% of adults not completing high school. These disparities likely reflect, in part, inequities among students of color, who make up a higher proportion of the Norwalk population, are more likely to experience unfairly harsh discipline, and are less likely to graduate high school due to other structural barriers. Disparities may also reflect fewer community resources and investments in public education, a factor that is common in communities with more rental households.

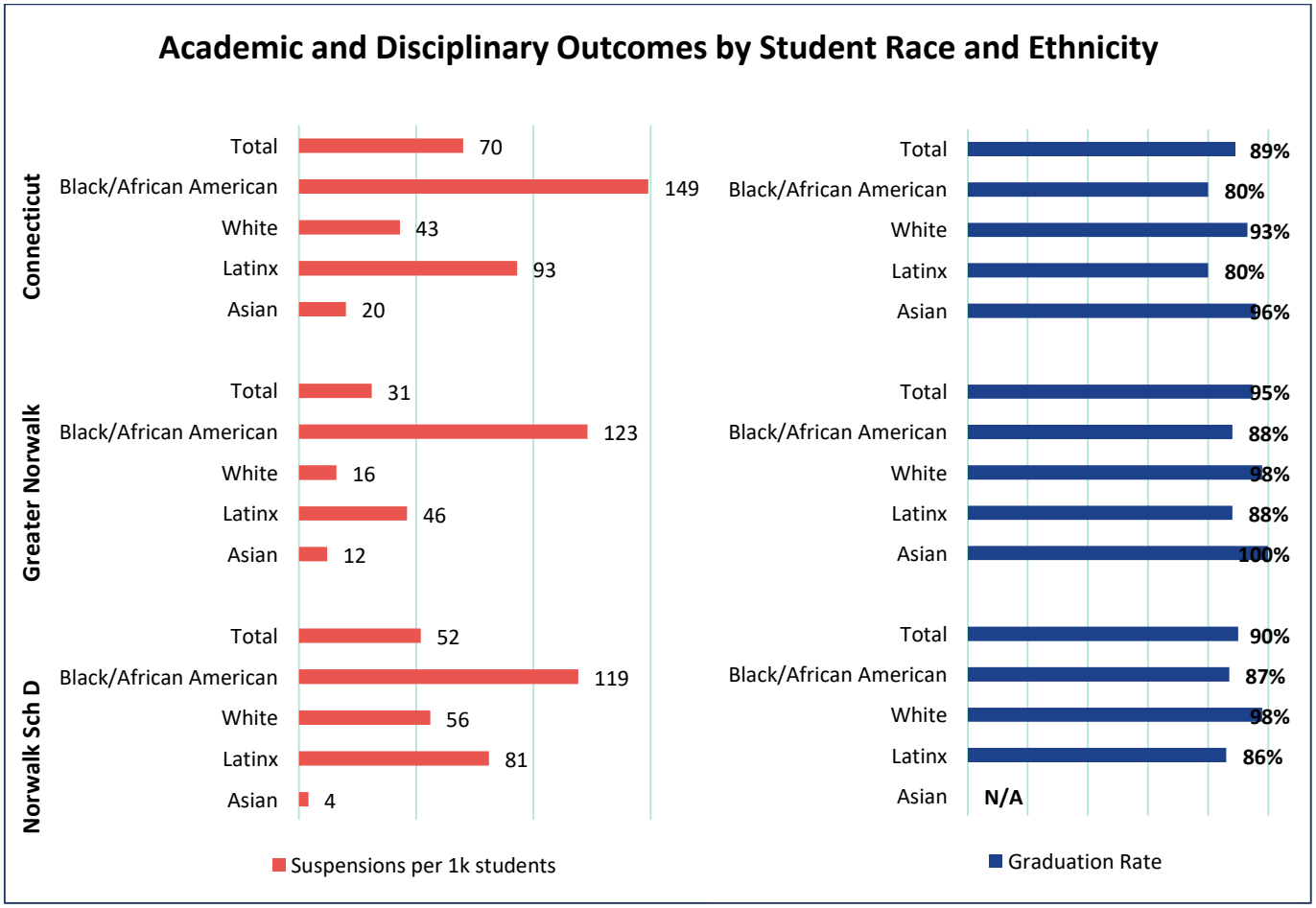
Community Wellbeing Survey Respondents Who Thought It Was "Almost Certain" or "Very Likely" That Young People in Their Neighborhood Could:

	Greater Norwalk	Connecticut
Graduate from high school	90%	91%
Get a job with opportunities for advancement	79%	61%

Source: 2021 DataHaven Community Wellbeing Survey



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates* and Connecticut State Department of Education, 2018-2019**



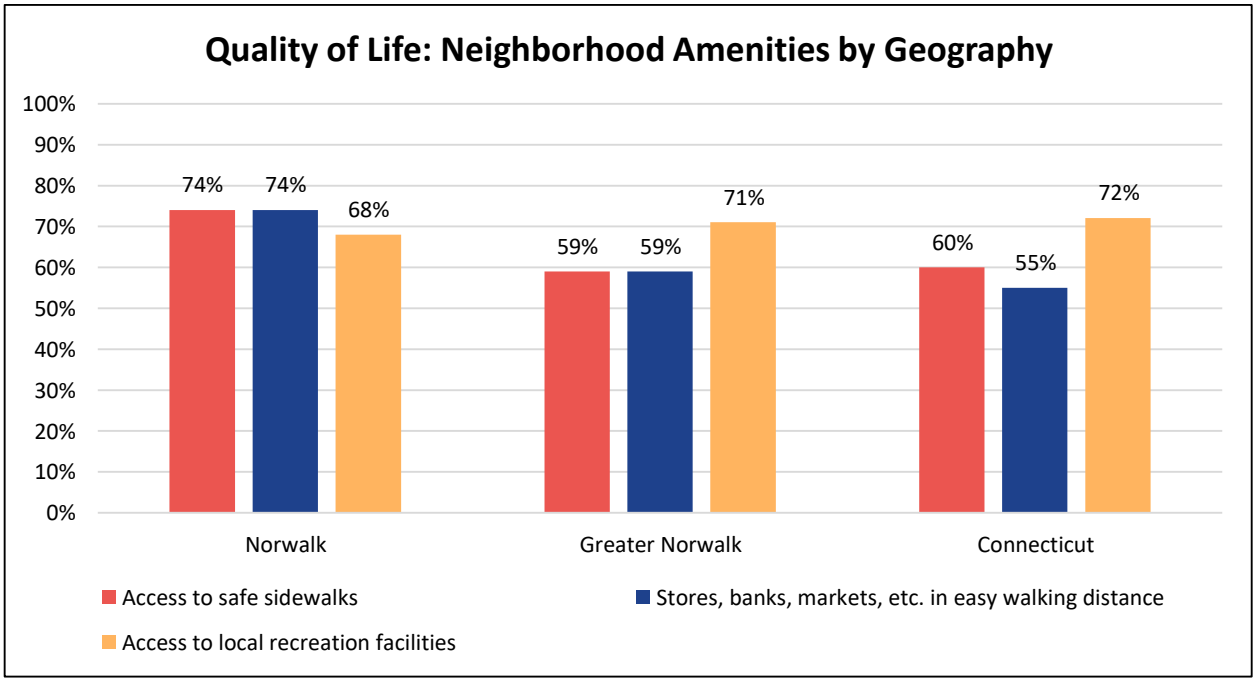
Source: Connecticut State Department of Education, 2018-2019 School Year

Neighborhood and Built Environment

In addition to the resources available in communities, the physical environment and infrastructure of neighborhoods impacts health. The availability of well-maintained roads and safe sidewalks, and access to recreation, stores, banks, and other amenities are important components for healthy living.

Greater Norwalk, including Norwalk, has comparable or better access to safe sidewalks, recreation, and shopping as Connecticut as a whole. Greater Norwalk residents are also more likely to have a vehicle at home to access services not within walking distance.

Despite these positive findings, transportation is still an access barrier for many residents, largely along income lines. Among Community Wellbeing Survey respondents, 32% of individuals in the low-income range stated that they stayed home when they needed or wanted to go someplace, because they did not have reliable transportation. In comparison, 1% of respondents in the high-income range experienced the same barrier.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

No Vehicle at Home

Norwalk	Greater Norwalk	Connecticut
7%	4%	9%

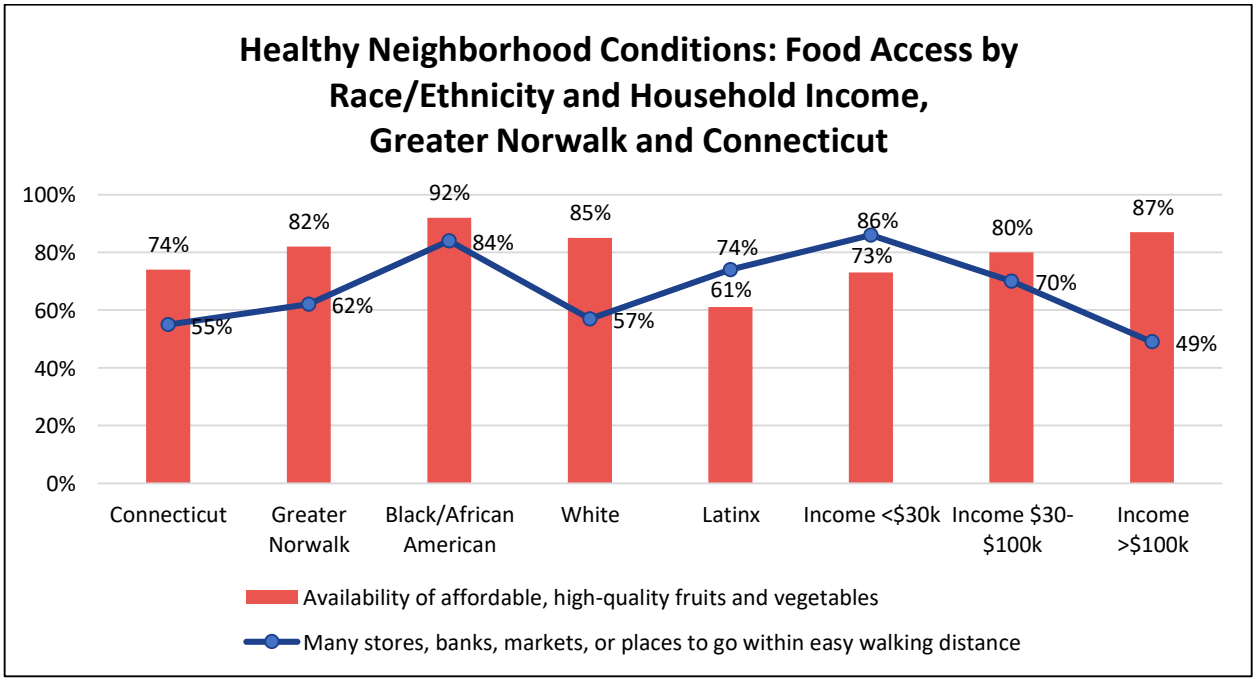
Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Community Wellbeing Survey Respondents Who Stayed Home When They Needed or Wanted to Go Someplace Because They Did Not Have Reliable Transportation

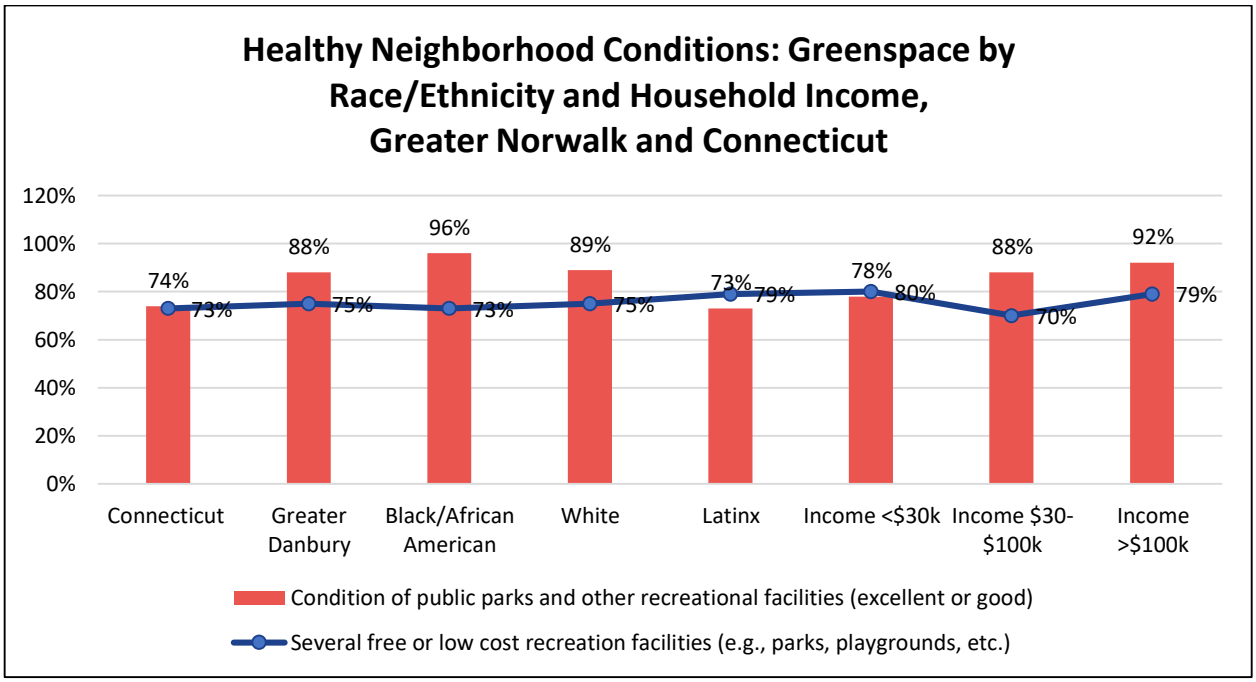
	Percent
Connecticut (All Adults)	13%
Greater Norwalk (All Adults)	9%
Black/African American	2%
White	7%
Latinx	21%
Household income <$30k	32%
Household income $30-$100k	11%
Household income >$100k	1%

Source: 2021 DataHaven Community Wellbeing Survey

While community services are generally perceived as more accessible in the Greater Norwalk area, there are wide differences in perceptions of the quality of these services. Disparities are most evident among individuals with lower income and/or identifying as Latinx. Of note, 73% of individuals with lower income perceived having access to affordable and high-quality fruits and vegetables compared to 87% of individuals with higher income.

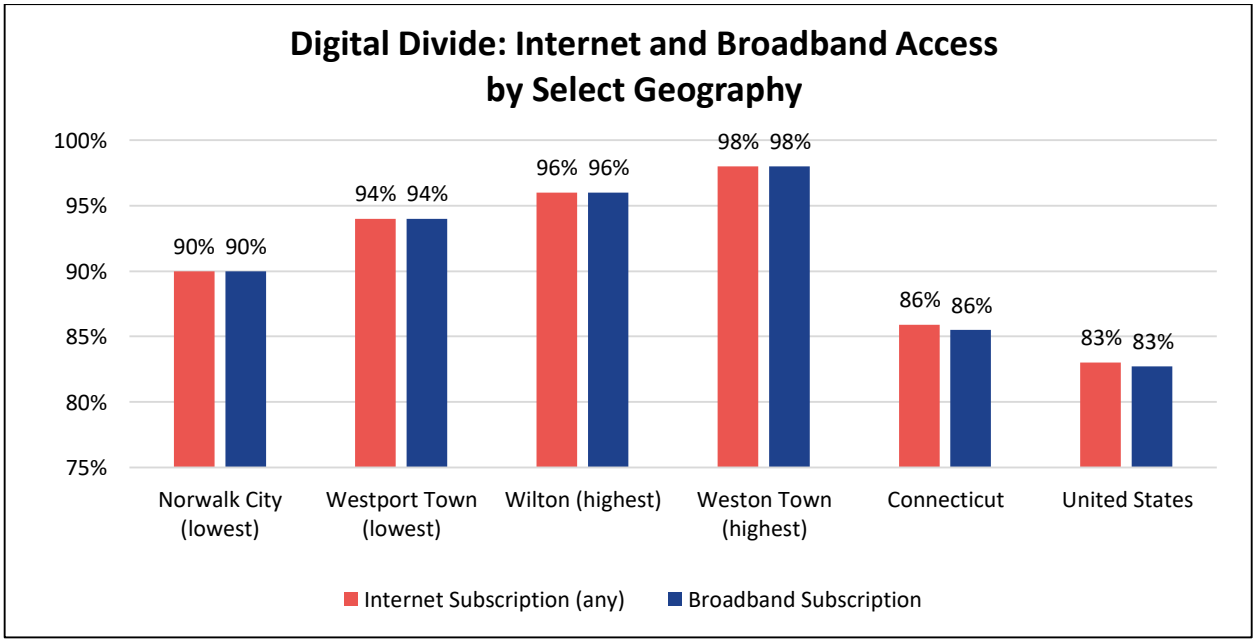


Source: 2021 DataHaven Community Wellbeing Survey



Source: 2021 DataHaven Community Wellbeing Survey

During COVID we were able to use technology to bring services to people in their homes, but we need to bridge the wide digital divide within our communities to effectively reach all residents. Within Greater Norwalk, there is a more than 5-point difference in access to internet and broadband between residents of Norwalk and residents of Wilton or Weston.



Source: US Census Bureau American Community Survey 2019 5-year estimates

Healthcare Access and Quality

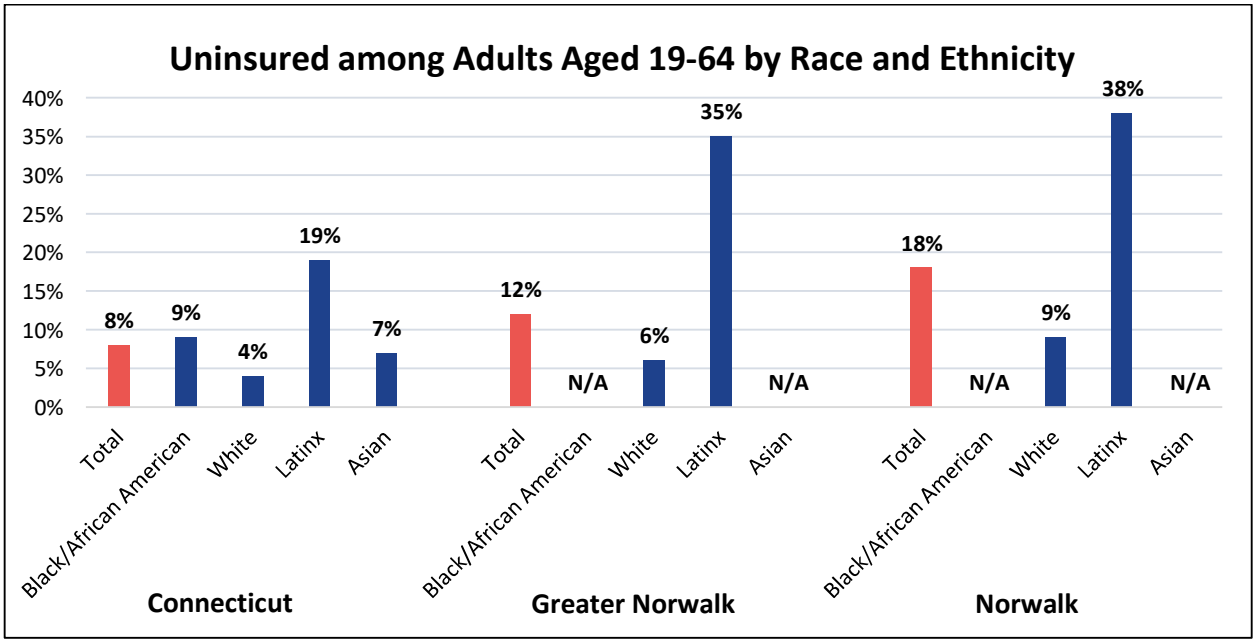
Lack of health insurance is a barrier to accessing healthcare. Without health insurance, residents face high costs for care when they need it, and they are less likely to receive preventive care. Preventive care, such as well visits and screenings, can detect small problems that can be treated more easily and effectively than if treatment is delayed. While many Greater Norwalk residents have health insurance, 1 in 3 individuals identifying as Latinx are lacking health insurance.

Having health insurance does not ensure access to healthcare when it is needed. Many other factors—like affordability, transportation, language, provider availability, and trust—keep people from receiving the care they need.

While Fairfield County overall is generally well served by healthcare providers, much of the south-central portion of Norwalk is a Health Professional Shortage Area (HPSA) for primary and dental care services. When viewed at the census tract-level, Norwalk residents are less likely to have received an annual checkup or to have visited a dentist within the past year when compared to neighboring communities.

Additional disparities in accessing healthcare are evidenced by Community Wellbeing Survey results. Across Greater Norwalk, 50% of Latinx respondents and 55% of individuals with lower household income put off or postponed needed medical care in the past 12 months. Contrary to expected data outcomes, survey respondents with higher incomes were the least likely to report having a personal doctor or healthcare provider, a finding that may be explored further.

Access disparities among Latinx residents may be exacerbated by language barriers and lack of bilingual providers or interpreter services. Approximately 42% of Greater Norwalk Latinx residents are considered linguistically isolated, characterized as speaking English less than "very well." Approximately 19% of Asian residents are also considered linguistically isolated.



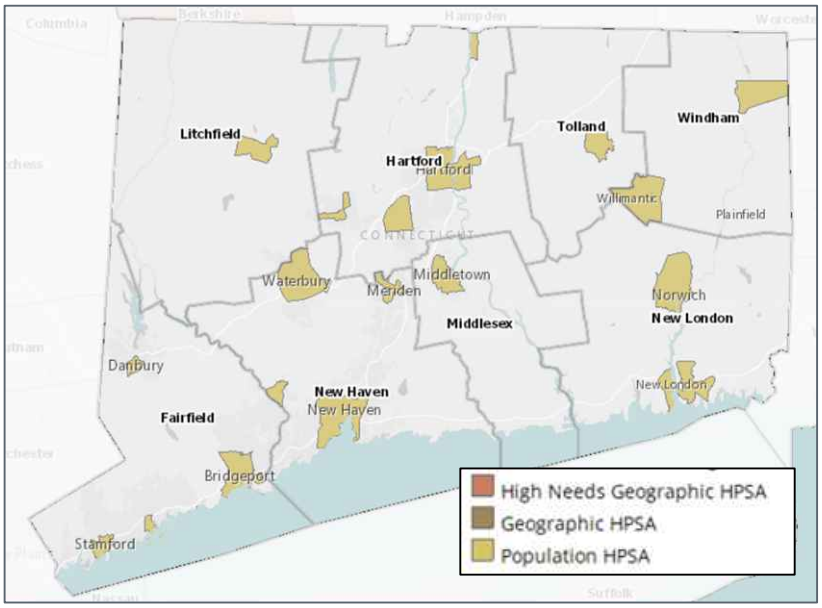
Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Healthcare Provider Availability: Provider Rates per 100,000 Residents

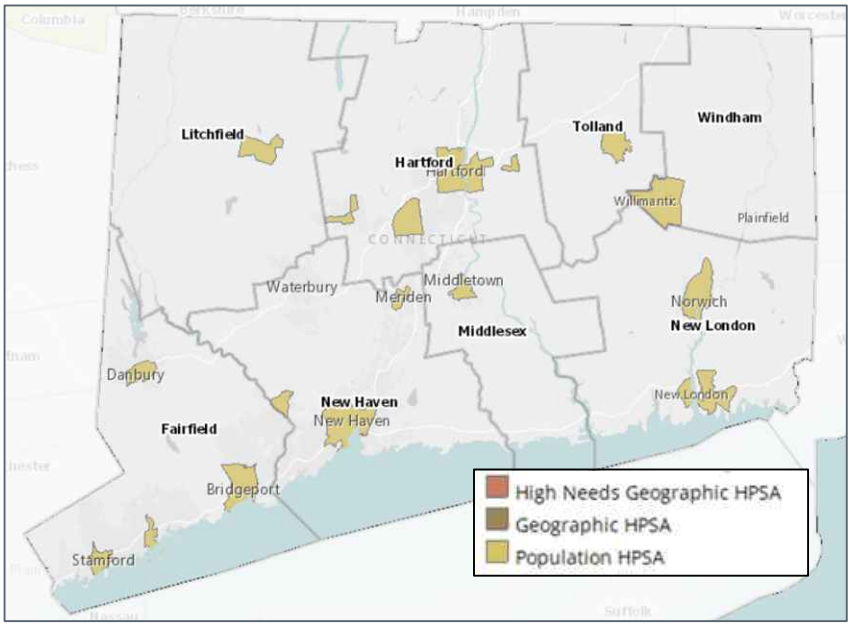
	2019 Primary Care Physicians	2020 Dentists	2021 Mental Health Providers
Fairfield County	94.3	94.0	338.4
Connecticut	85.2	87.1	439.2
United States	76.3	71.4	285.7

Source: Health Resources and Services Administration and Centers for Medicare and Medicaid Services

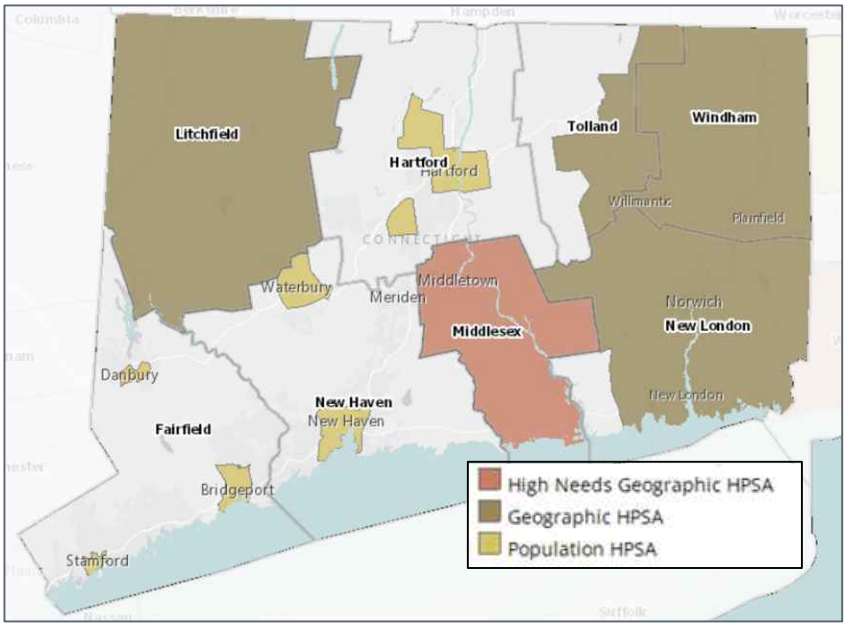
Connecticut: Primary Care Health Professional Shortage Areas



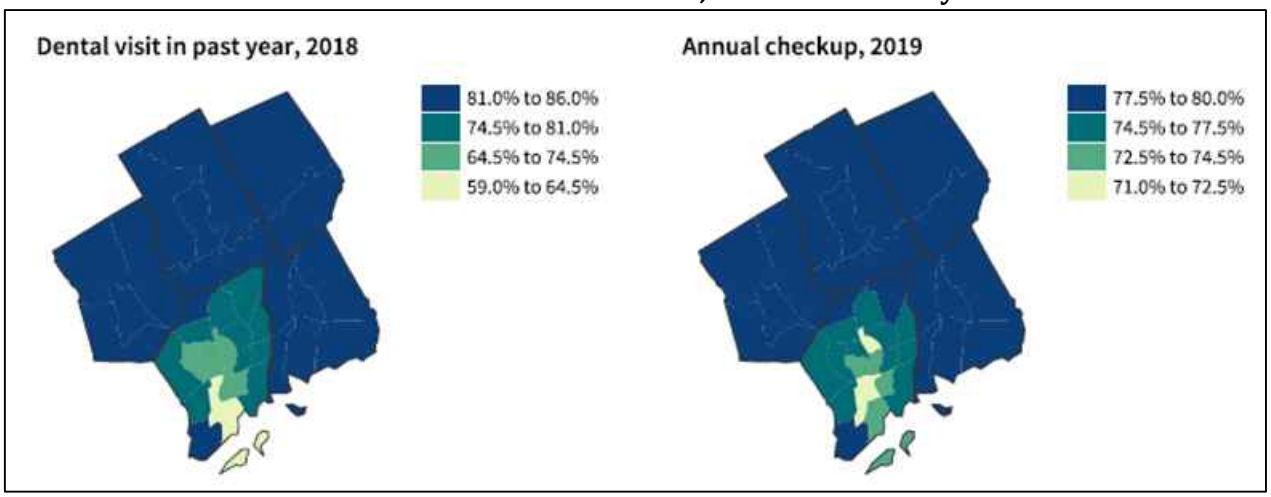
Connecticut: Dental Health Professional Shortage Areas



Connecticut: Mental Healthcare Health Professional Shortage Areas



Greater Norwalk Preventive Care Measures, Share of Adults by Census Tract

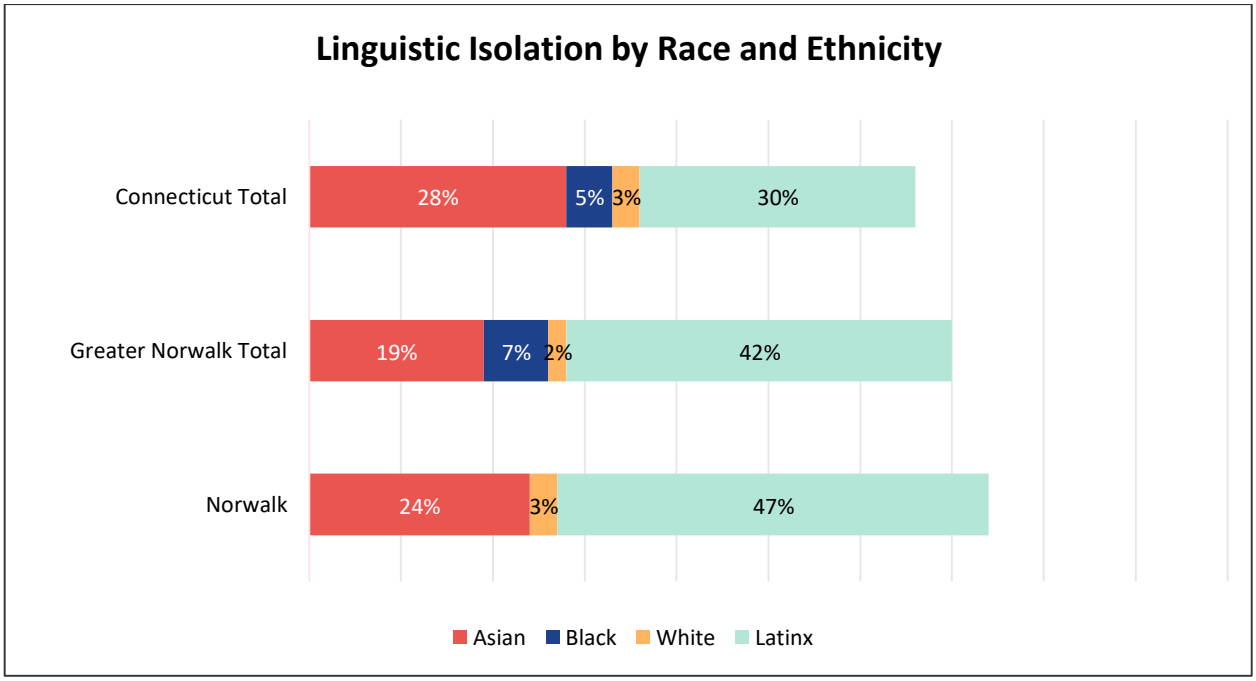


Source: PLACES Project. Centers for Disease Control and Prevention

Healthcare Access among Adults in Greater Norwalk

	No personal doctor or healthcare provider	Put off or postponed needed medical care in past 12 months	Saw a dentist more than two years ago
Connecticut (All Adults)	11%	30%	13%
Greater Norwalk (All Adults)	19%	33%	9%
Black/African American	11%	22%	13%
White	23%	32%	9%
Latinx	12%	50%	8%
Household income <$30k	7%	55%	9%
Household income $30-$100k	13%	28%	13%
Household income >$100k	30%	32%	7%

Source: 2021 DataHaven Community Wellbeing Survey



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Social and Community Context

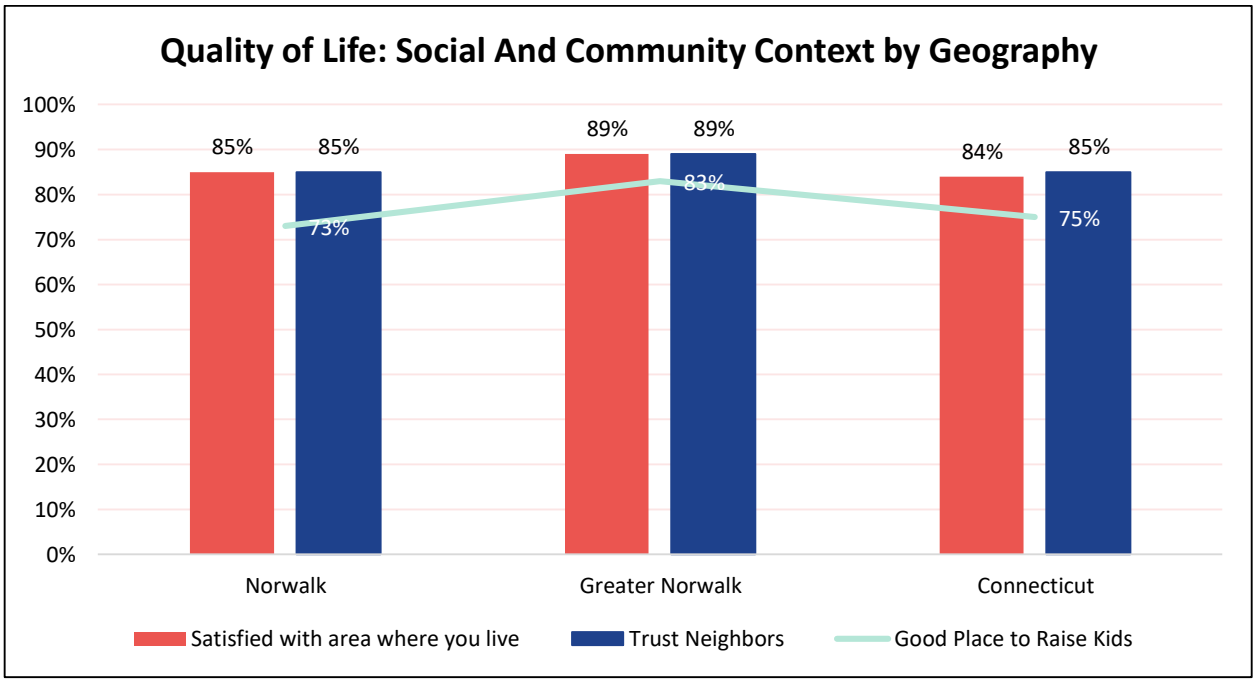
As much as communities are shaped by those who live there, people are impacted by the social context of the places where they live. Social context includes family, neighborhoods, school, or work environments, political or religious systems, and other interpersonal infrastructures within a community. People's lived experiences within their social context play a significant role in good health and wellbeing.

Feeling like you belong, are appreciated, and are valued in your community reinforces protective health factors that help people and communities overcome adversity. Experiences of poverty, violence, poor housing, racism, and discrimination create Adverse Community Environments and

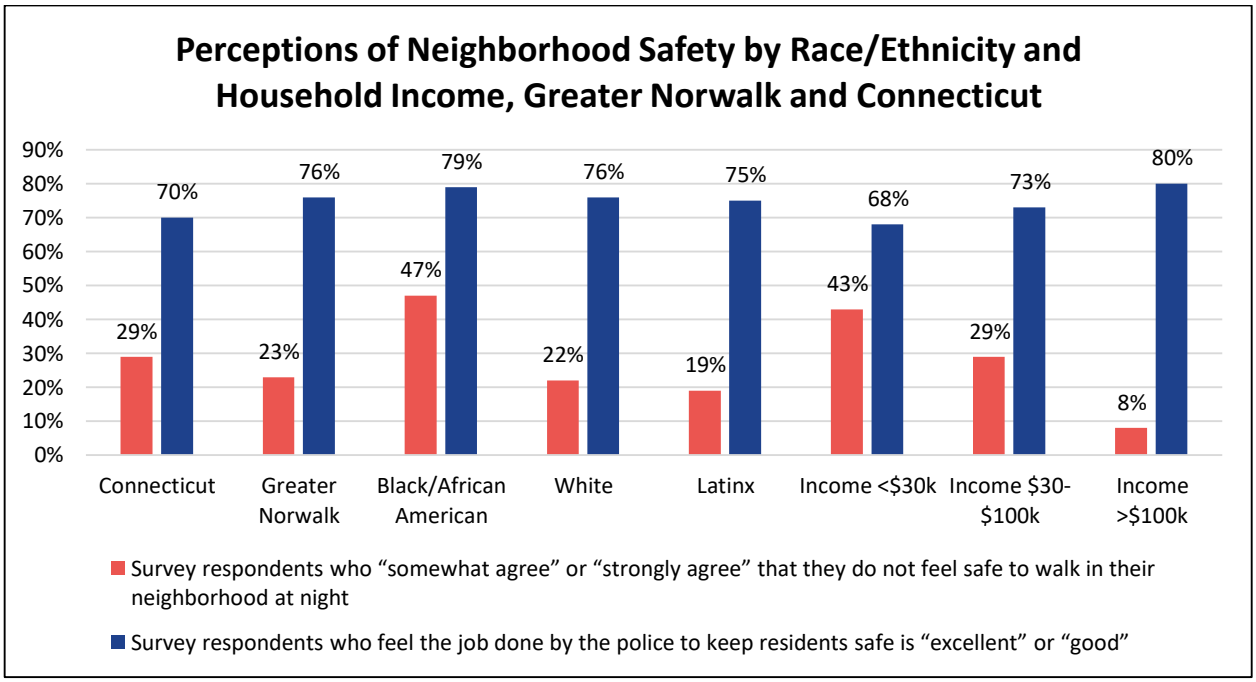
chronic stress that perpetuate trauma and increase Adverse Childhood Events (ACEs) that have a lasting impact on people and their communities.

Residents of Greater Norwalk, including Norwalk, have overall high perceived satisfaction in where they live, as well as overall positive perceptions of neighborhood safety, relative to the state. However, these experiences are not shared by all residents. Black/African American residents and individuals with lower income are less likely to feel safe walking in their neighborhood at night and/or that police are doing a "good" or "excellent" job of keeping residents safe.

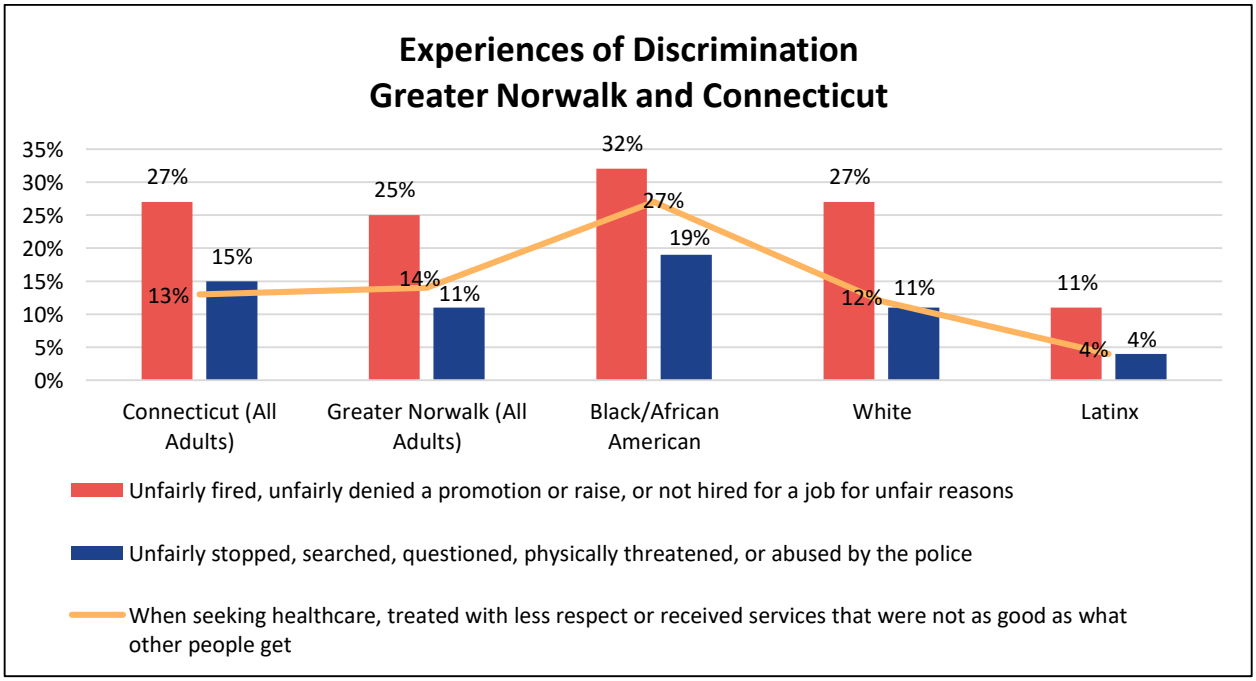
Black/African American residents of Greater Norwalk are also more likely to perceive experiences of discrimination in their workplace, in interactions with police, and in the healthcare setting. Disparities in safety and discrimination along race lines indicate an opportunity to examine policies and procedures that can be amended to create greater equity of access and inclusion.



Source: DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey



Source: 2021 DataHaven Community Wellbeing Survey



Source: 2021 DataHaven Community Wellbeing Survey

Life Expectancy

Life expectancy is an overall measure of health and social equity within a community. Structural factors, including housing quality and affordability, environmental conditions, employment, education, transportation, food security, and experience of racism, all play a role in impacting the

quality and length of lives. The average life expectancy in Greater Norwalk is 83.6 years, compared to 82.6 years in Norwalk and 80.3 years statewide.

The Community Need Index (CNI) is a zip code-based index of community socioeconomic need. The CNI is strongly linked to variations in community healthcare needs, and as such, represents a useful planning tool for prioritization of geographic interventions. The CNI scores zip codes on a scale of 1.0 to 5.0, with 1.0 indicating a zip code with the least need and 5.0 indicating a zip code with the most need compared to the US national average of 3.0. The CNI weights, indexes, and scores zip codes by socioeconomic barriers, including income, culture, education, insurance, and housing.

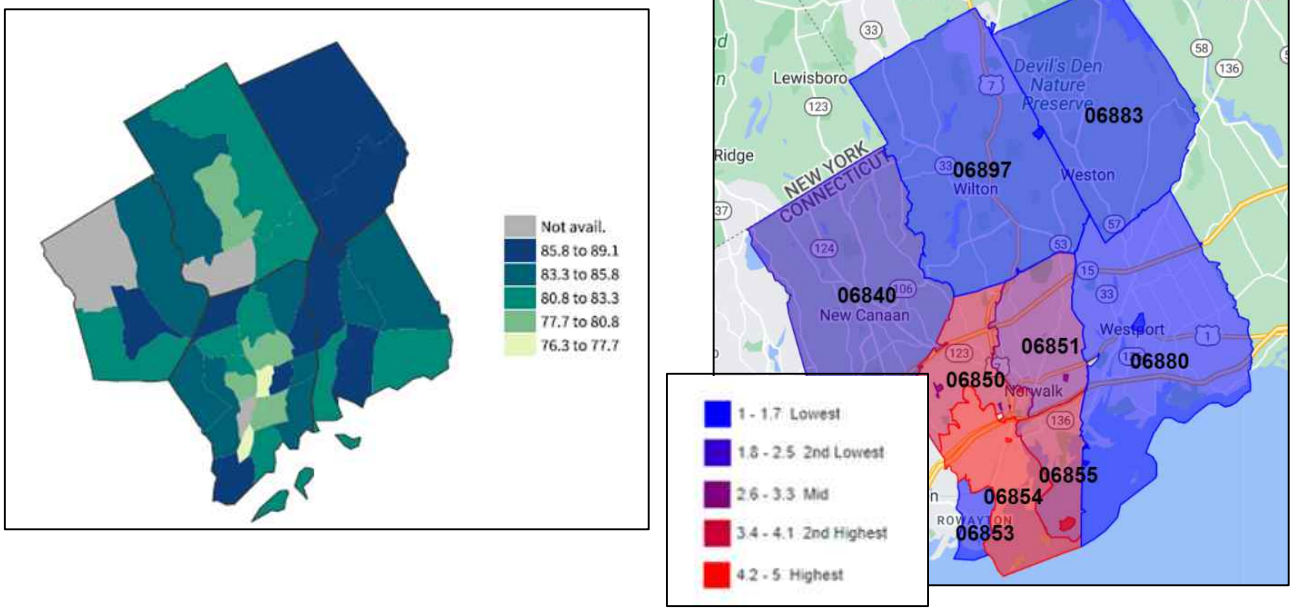
Within Greater Norwalk, Norwalk zip code 06854 has the highest CNI score of 4.2. The next highest CNI score within the region is in Norwalk zip codes 06850 and 06855 at 3.4. The CNI score, reflective of community socioeconomic barriers, correlates with wide differences in life expectancy in Norwalk relative to other neighboring communities.

Average Life Expectancy (years)

Norwalk	Greater Norwalk	Connecticut
82.6	83.6	80.3

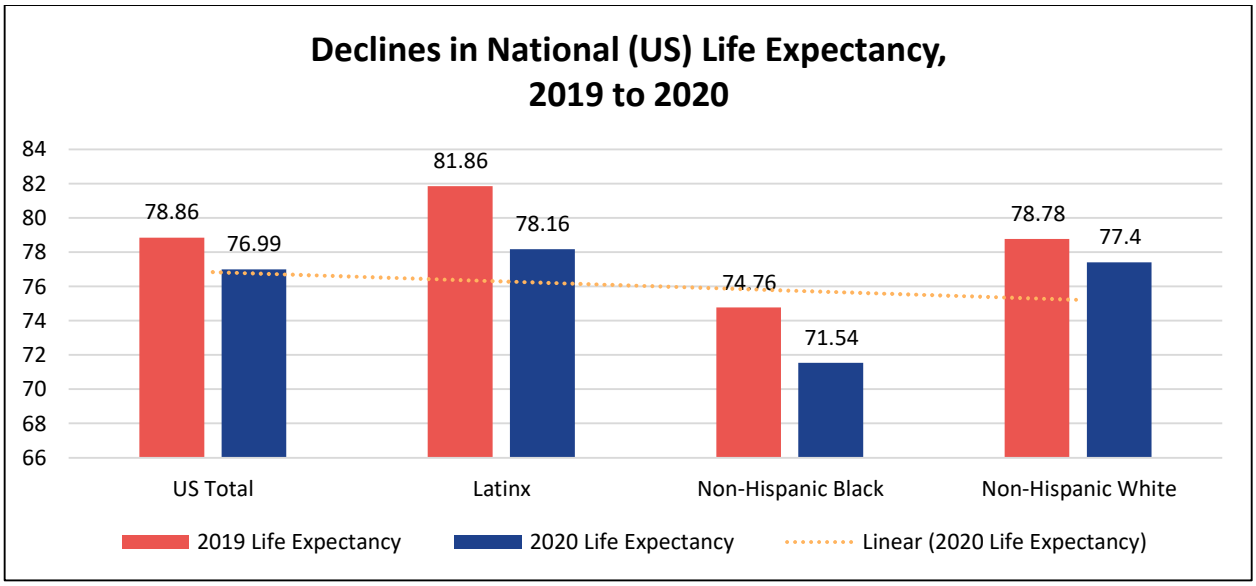
Source: Small-Area Life Expectancy Estimates Project: Life Expectancy Estimates Files, 2010–2015

2015 Life Expectancy by Census Tract and 2021 Community Need Index by Zip Code

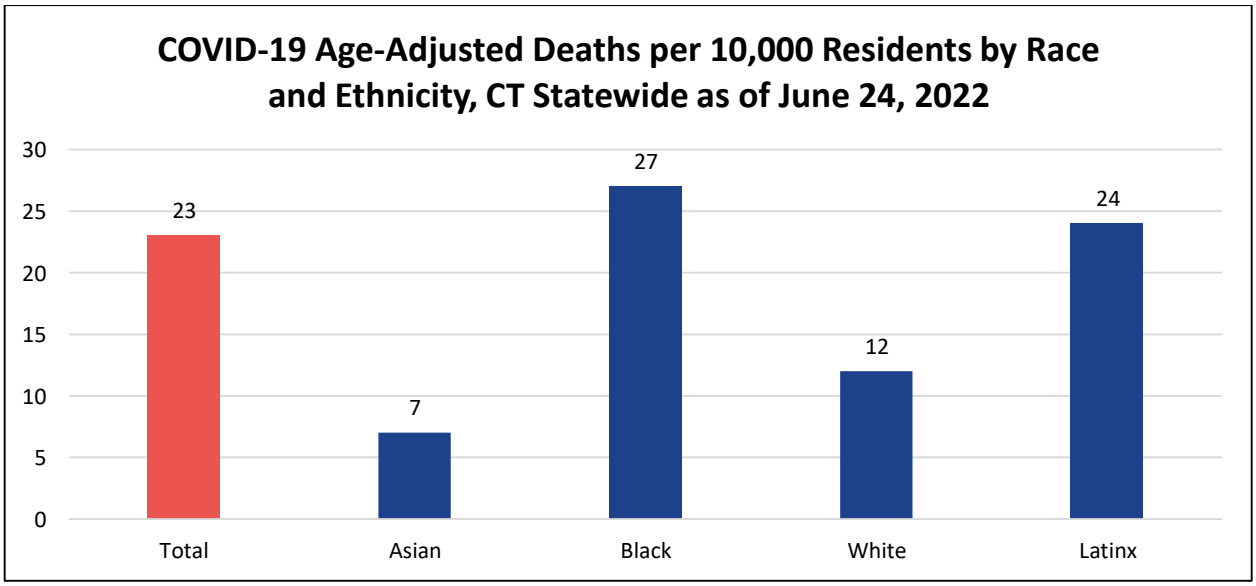


The COVID-19 pandemic both highlighted and deepened socioeconomic and health inequities and exposed disparities within the health and social services systems. COVID-19 has not impacted all people equally. Rather, certain structural issues—population density, low income, crowded workplaces, etc.—contribute to higher levels of spread and worse outcomes from COVID-19, and potentially other infectious diseases.

The graph below shows that while overall life expectancy decreased nationally from 2019 to 2020, it decreased by more than 3 years for Black/African American and Latinx residents compared to 1.4 years for white residents. This finding is also reflected in disproportionately higher death rates due to COVID-19 among people of color.



Source: Centers for Disease Control and Prevention

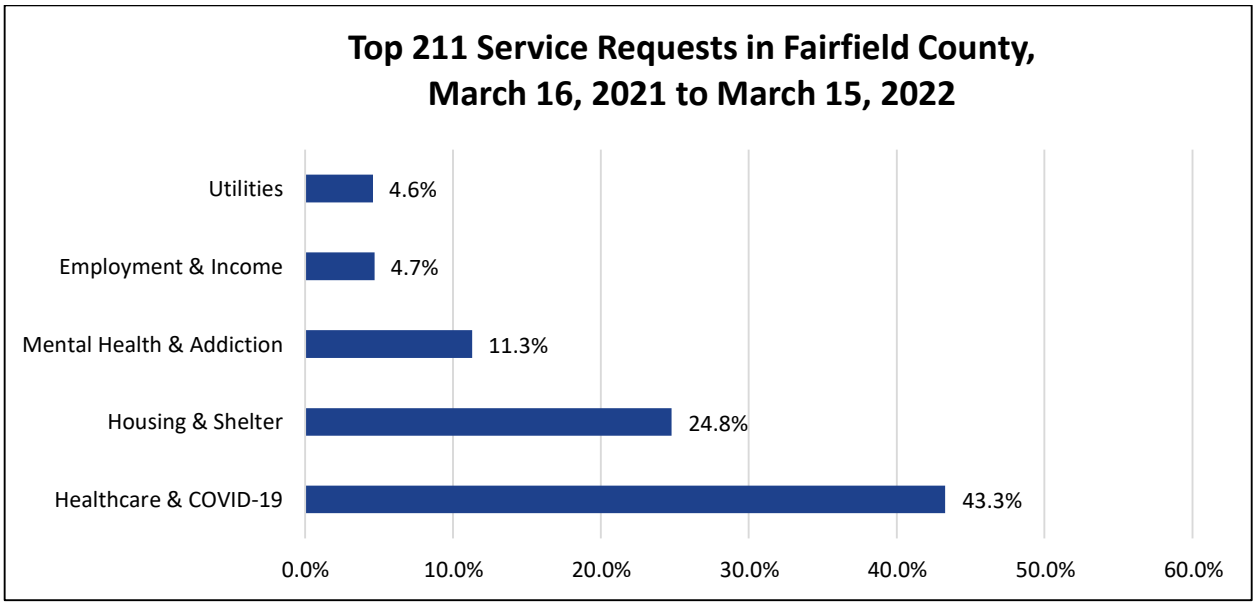


Source: Connecticut Department of Public Health

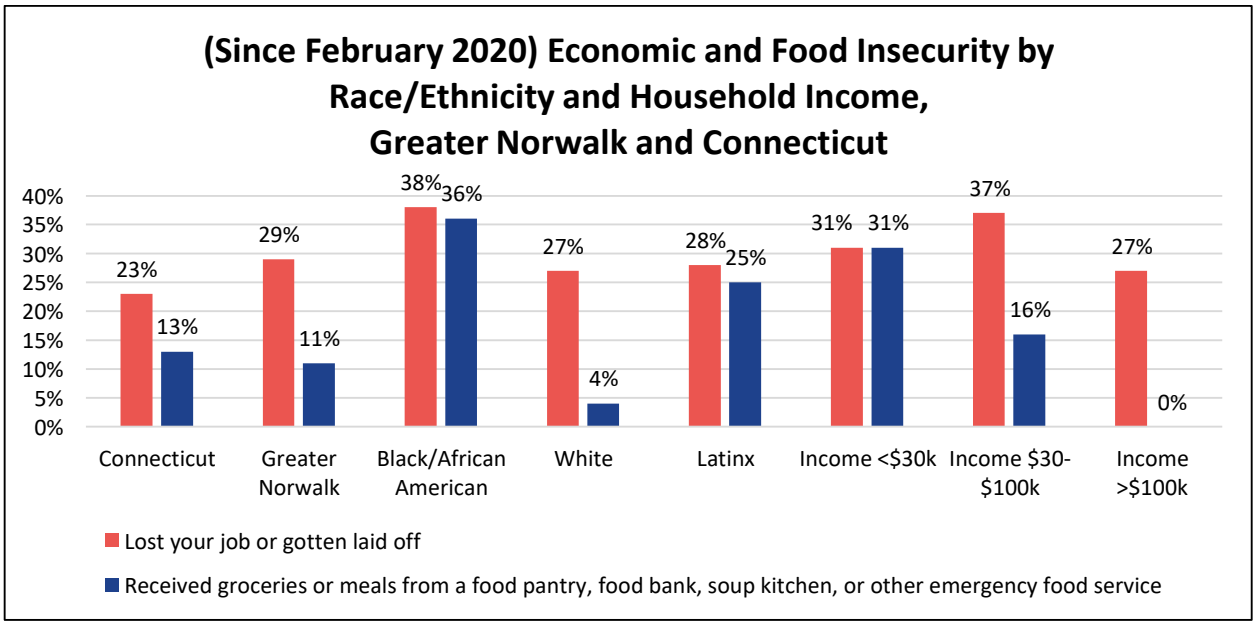
United Way 211 is a 24/7 go-to resource that helps people across the nation find local resources they need. 211 is the most comprehensive source of information about local resources and services in the country. The following graph depicts the top 211 service requests by Fairfield County residents during the COVID-19 pandemic, from March 16, 2021 to March 15, 2022.

The COVID-19 pandemic had deep economic and mental health impacts. Among Fairfield County residents, the top 211 service requests, after healthcare and COVID-19, were housing and shelter and mental health and addiction.

Community Wellbeing Survey results demonstrated that the economic impacts of the pandemic were disproportionately felt by low-income households and communities of color. Within Greater Norwalk, 38% of Black/African American respondents reported being laid off or losing their job compared to 27% of white respondents. Approximately 31% of low-income households received food assistance compared to 16% of mid-income and 0% of high-income households.



Source: United Way 211



Source: 2021 DataHaven Community Wellbeing Survey

Community Health Needs

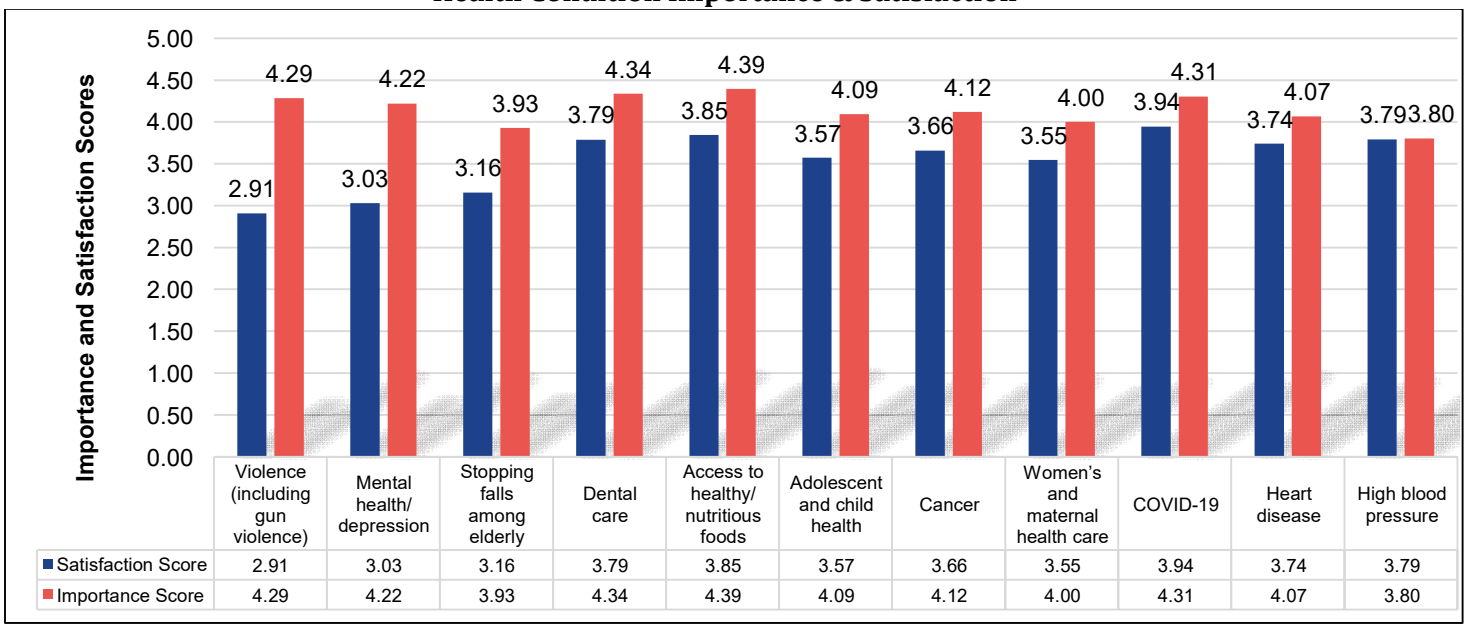
To determine community health priorities, we must consider what the data are telling us, and more importantly, what our community sees as the most pressing health concerns.

Community engagement was a central part of the CHNA. We invited wide participation from community stakeholders and organizations, including experts in health, social service representatives, advocates, community champions, policy makers, and lay community residents. These stakeholders were asked to weigh in on data findings, share their perspectives on challenges facing our community, and provide input on collaborative solutions.

The following graph depicts community feedback garnered from the GNYHA 2022 Community Health Survey, including perceived importance of community health conditions and satisfaction with current neighborhood services to address these conditions. Results are presented as aggregate importance and satisfaction scores on a scale of 1 (not at all) to 5 (extremely). The "Gap" represents the difference between importance and satisfaction scores.

The results demonstrated high perceived importance for issues like violence, mental health, and falls among elderly. Violence and mental health were further prioritized based on lower perceived satisfaction in available services to address these needs. This finding was generally supported by other CHNA research, which found that mental health concerns were largely exacerbated by the pandemic, and that residents have varying perceptions of community safety, with evident disparities among lower-income and communities of color.

What you told us: Norwalk Hospital Service Area Community Feedback, Health Condition Importance & Satisfaction



	Violence (including gun violence)	Mental health/ depression	Stopping falls among elderly	Dental care	Access to healthy/ nutritious foods	Adolescent and child health	Cancer	Women's and maternal health care	COVID-19	Heart disease	High blood pressure
Satisfaction Score	2.91	3.03	3.16	3.79	3.85	3.57	3.66	3.55	3.94	3.74	3.79
Importance Score	4.29	4.22	3.93	4.34	4.39	4.09	4.12	4.00	4.31	4.07	3.80
Gap*	**1.38**	**1.19**	0.77	0.55	0.55	0.52	0.46	0.45	0.36	0.33	0.01

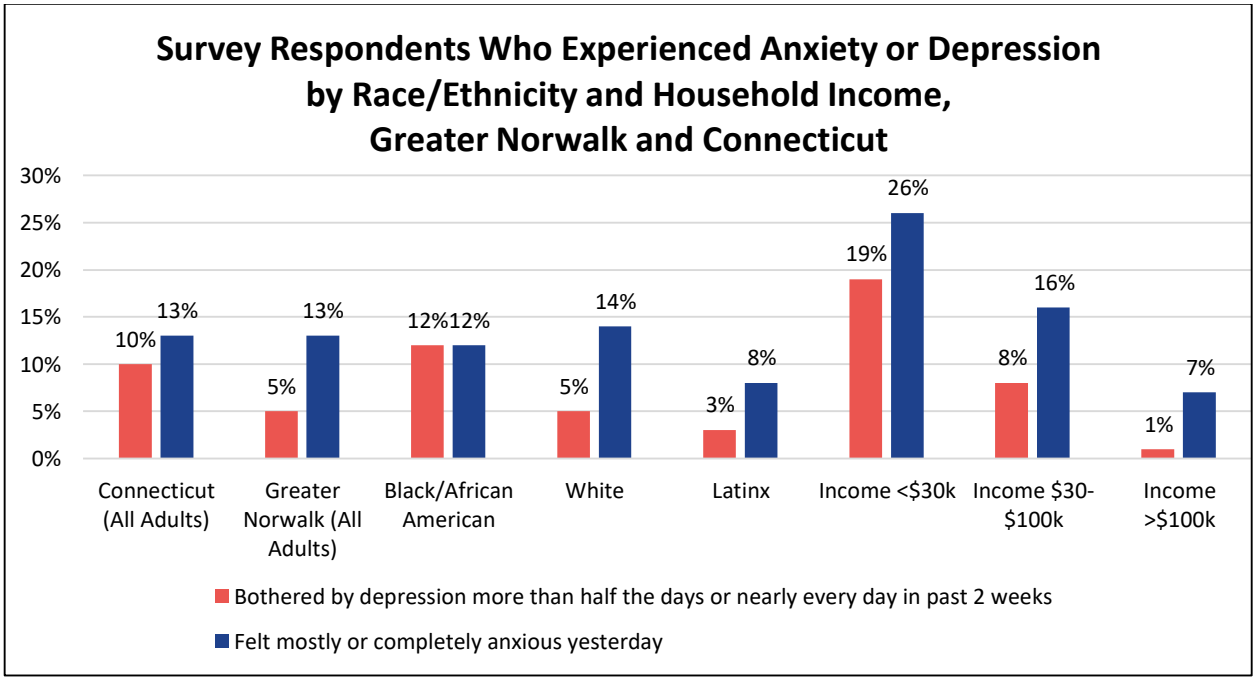
Source: Greater New York Hospital Association CHNA Survey, 2022
*Difference between Importance Score and Satisfaction Score

The following report sections further highlight data relative to specific health areas like behavioral health, health risk factors and chronic disease, and maternal and child health.

Behavioral Health

Mental health concerns like depression and anxiety can be linked to social determinants like income, employment, and environment, and can pose risks of physical health problems, including by complicating an individual's ability to keep up other aspects of their healthcare. Overall, 13% of Greater Norwalk adults report experiencing anxiety regularly and 5% report being bothered by depression. Adults with lower income are more likely to report these experiences.

The COVID-19 pandemic exacerbated many behavioral health concerns, particularly for youth, due to stress, isolation, and lost learning, among other factors. Before the pandemic, approximately 31% of Connecticut youth reported feeling sad or depressed and 7% had attempted suicide. About one-quarter of youth used one or more substances like tobacco, alcohol, or marijuana.



Source: 2021 DataHaven Community Wellbeing Survey

2019 Youth Measures of Mental Health and Substance Use

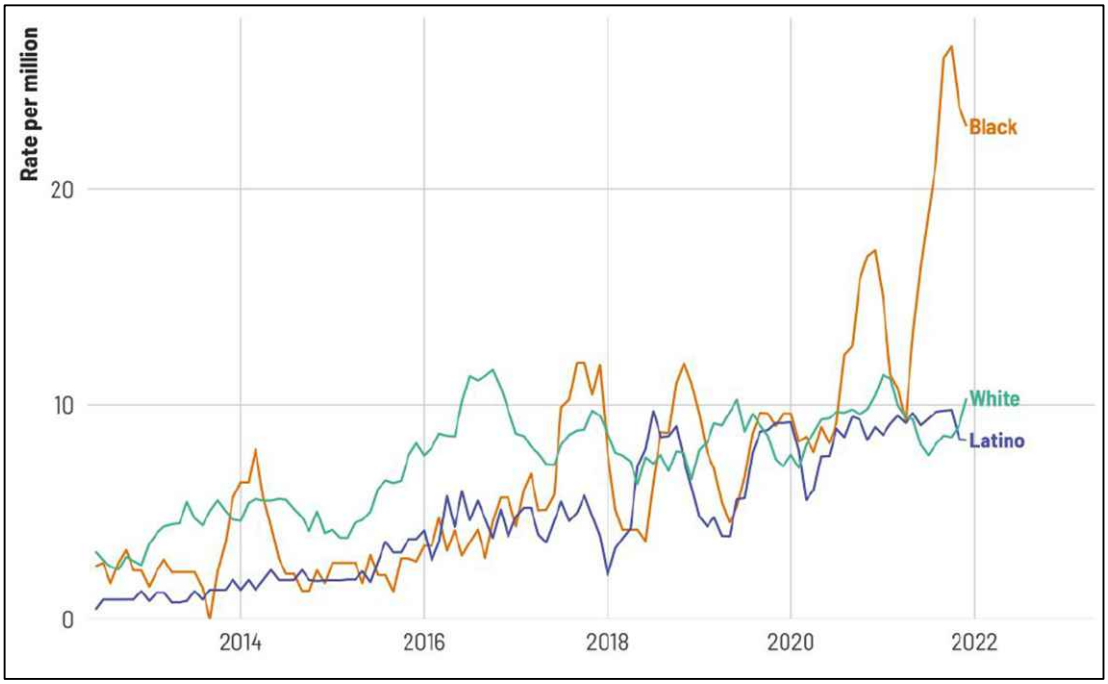
	Feel Consistently Sad or Depressed	Attempted Suicide	E-cigarette Use (last 30 days)	Alcohol Use (last 30 days)	Marijuana Use (last 30 days)
Connecticut	30.6%	6.7%	27.0%	25.9%	21.7%
US	36.7%	8.9%	32.7%	29.1%	21.7%

Source: CDC Youth Risk Behavior Survey

Like other states, Connecticut has seen a rise in drug overdose deaths in the last several years. In 2020, Connecticut saw an average of 113 overdose deaths per month, up from 60 in 2015. In the Greater Norwalk area, the overdose death rate more than doubled from 2012-2016 to 2017-2021, but overall is still much lower than most other areas: Greater Norwalk (15), Greater Danbury (38), Greater Bridgeport (81), Greater Waterbury (96), and Hartford (139).

Across Connecticut, white residents long comprised the bulk of overdose deaths, but as overall overdose death rates have increased, an increasing share of those deaths have been people of color.

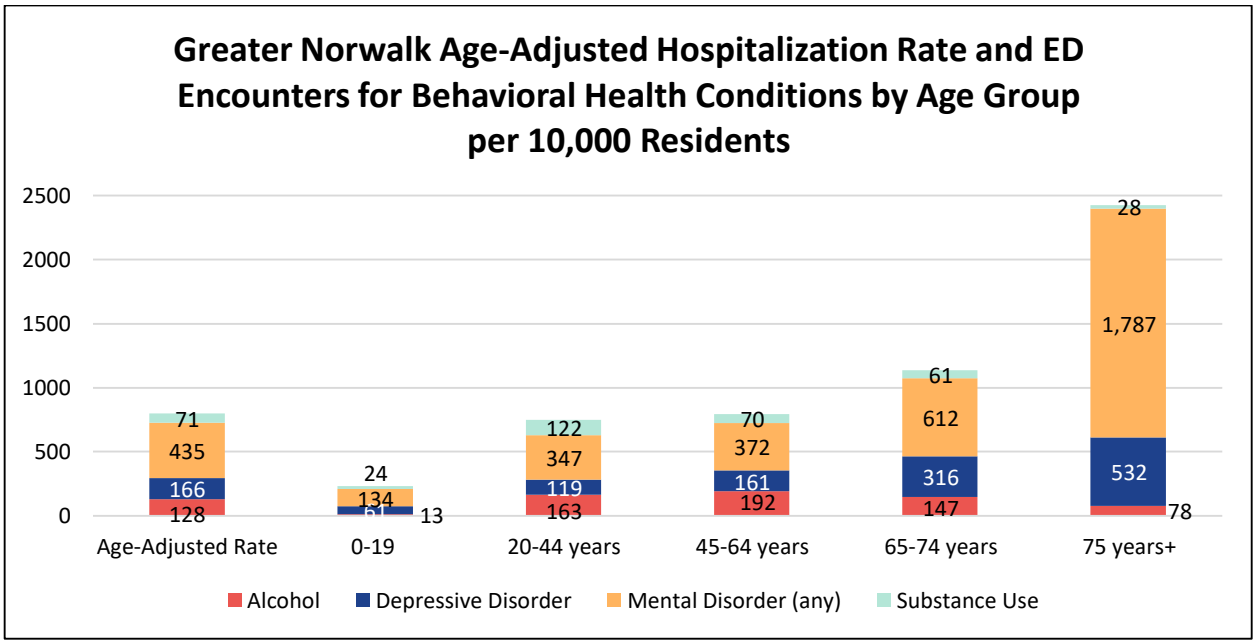
Age-adjusted Accidental Overdose Death per 1 Million Residents by Race and Ethnicity as Available, Fairfield County 2012-2021 6-Month Rolling Mean



Source: DataHaven analysis (2021)

Behavioral health conditions are considered ambulatory care sensitive (ACS) conditions, which if effectively managed in an outpatient setting, should not be the primary reason for a hospital visit. The following graph depicts hospital and emergency department (ED) encounters for select behavioral health conditions, as provided by the Connecticut Hospital Association and analyzed by DataHaven.

Across all age groups, mental disorders are the most prevalent behavioral health conditions that patients seek help for at the hospital, and the rate of visits is more than four times as high for older adults aged 75 or over compared to younger adult populations. It is worth noting that substance use disorder-related visits, including alcohol and drugs, follow an opposite trend, with increasing rates among younger adult populations.

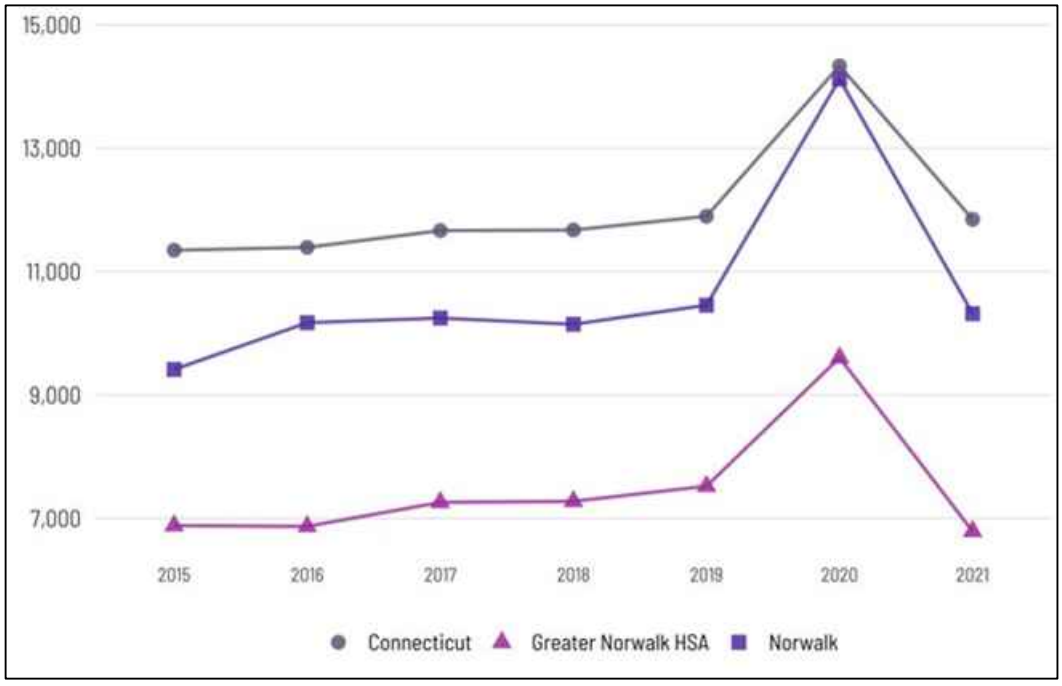


Source: DataHaven analysis (2021) of 2018-2021 Connecticut Hospital Association CHIME

Health Risk Factors and Chronic Disease

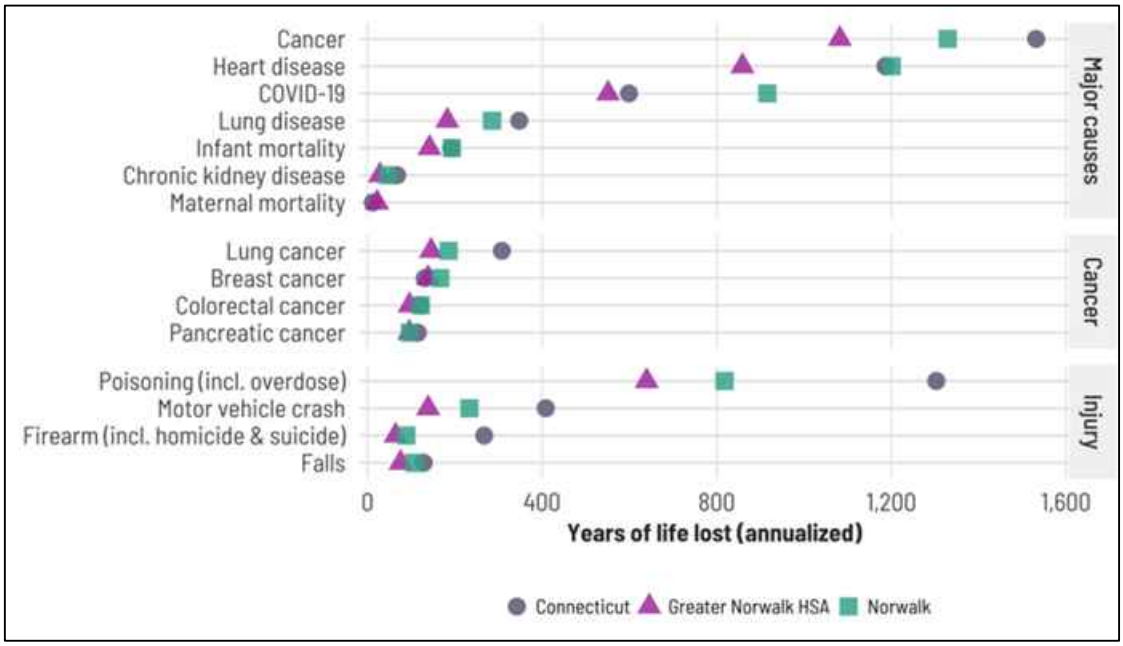
All-cause mortality spiked in 2020 due to the COVID-19 pandemic. Across Fairfield County in 2020, COVID-19 mortality rates were similar to mortality rates from heart disease and cancer. Excluding COVID-19, cancer, heart disease, and poisonings (including overdose) were the leading causes of premature death in the region from 2015 to 2021.

Age-Adjusted, All-Cause Mortality per 1 Million Residents 2015-2021



Source: DataHaven analysis (2021)

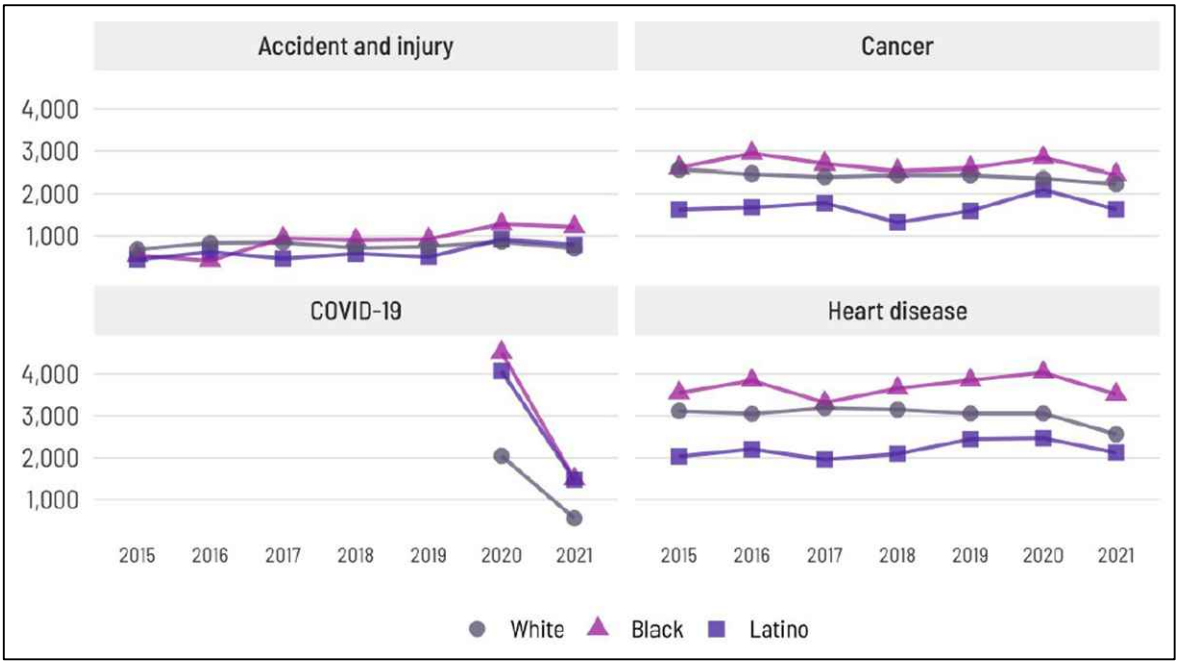
Years of Potential Life Lost Before Age 75 per 100,000 Residents by Cause of Death 2015-2021



Source: DataHaven analysis (2021)

Relative to the top causes of death in the region, residents of color experience higher mortality rates. This disparity is clearly demonstrated by heart disease death rates.

Age-Adjusted Rates of Death per 1 Million Residents for Top Causes of Death by Race and Ethnicity, Fairfield County



Source: DataHaven analysis (2021)

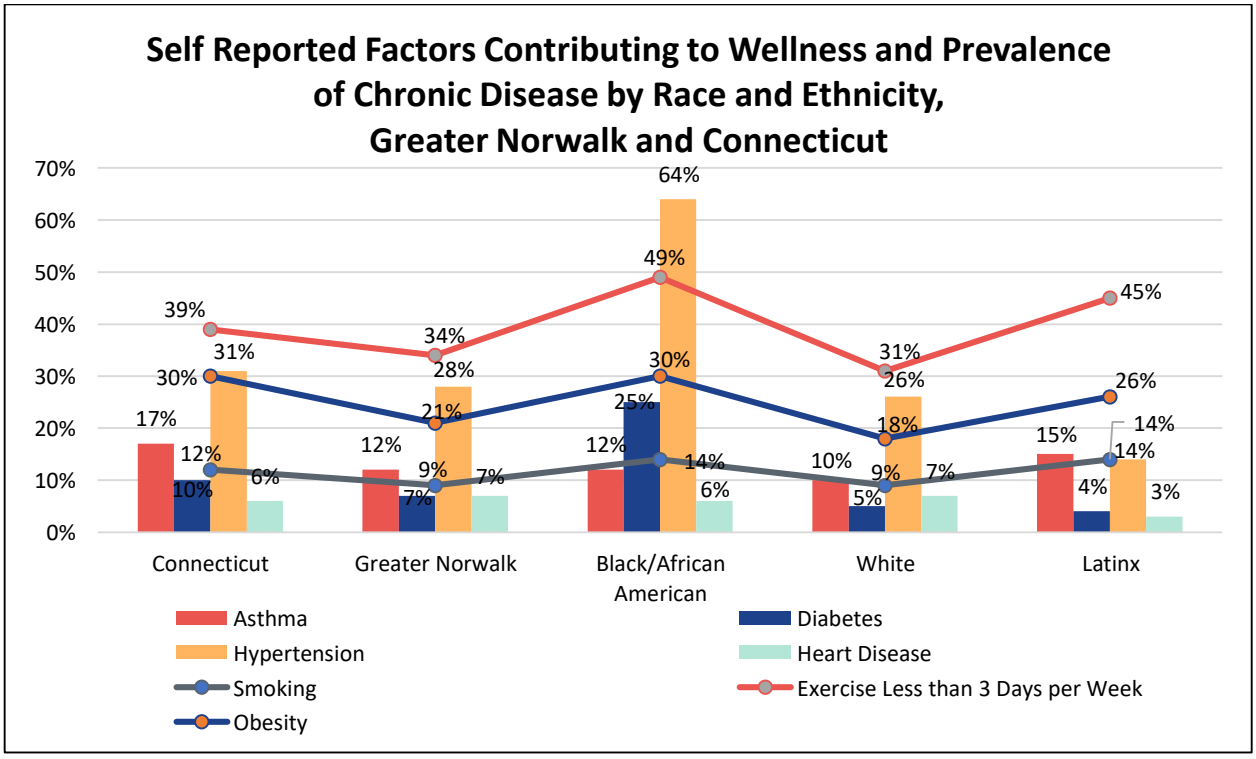
Norwalk residents generally report a lower burden of chronic disease relative to surrounding communities, as evidenced by hospital and ED encounters data. The following table compares age-adjusted encounter rates for leading causes of morbidity and mortality for Norwalk and neighboring Danbury.

Age-Adjusted Hospitalization and ED Encounters for Leading Causes of Morbidity and Mortality

	Norwalk	Danbury
Hypertension	733	905
Type 2 Diabetes	375	561
Heart Disease	201	203
Asthma	167	222
COPD	113	191
Uncontrolled Diabetes	54	64

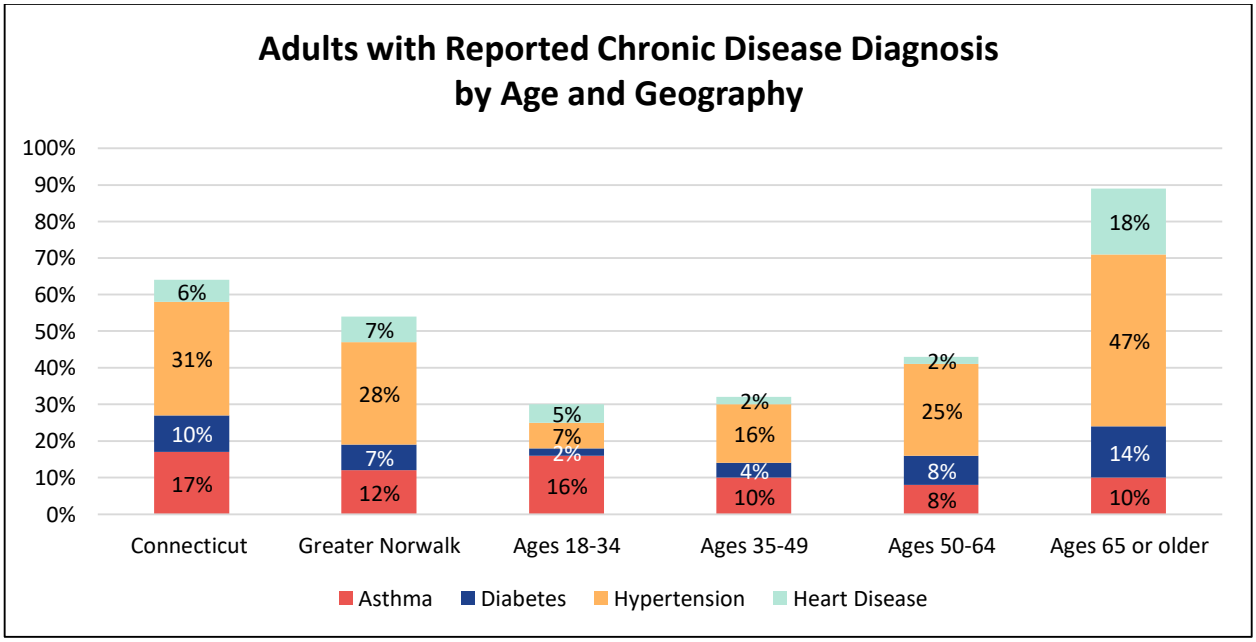
Source: DataHaven analysis (2021) of 2018-2021 Connecticut Hospital Association CHIME

Prior to COVID-19, the top leading causes of death for US residents were chronic diseases. Across Greater Norwalk, it is clear that social determinants of health directly impact health risk factors and ultimately chronic disease, resulting in inequities in life expectancy by race and neighborhood. This connection is demonstrated in the following graph which looks at prevalence of self-reported factors like obesity and physical inactivity and prevalence of chronic conditions like hypertension and diabetes.



Source: 2021 DataHaven Community Wellbeing Survey

Greater Norwalk is an aging community and older adults are more vulnerable to chronic disease. The following graph depicts self-reported chronic disease by age group. Of note, 47% of Greater Norwalk adults aged 65 or over report having hypertension and 18% report having heart disease.



Source: 2021 DataHaven Community Wellbeing Survey

Maternal and Child Health

Having a healthy pregnancy is the best way to have a healthy birth and a healthy start to life. The data show that most people in Greater Norwalk are able to access early prenatal care, which is the best way to promote a healthy pregnancy and delivery. However, the proportion of people receiving late, or no prenatal care slightly exceeds the statewide average, and across the state and region, pregnant people of color are at least twice as likely as their white counterparts to receive late or no prenatal care and to experience related negative birth outcomes like low birth weight.

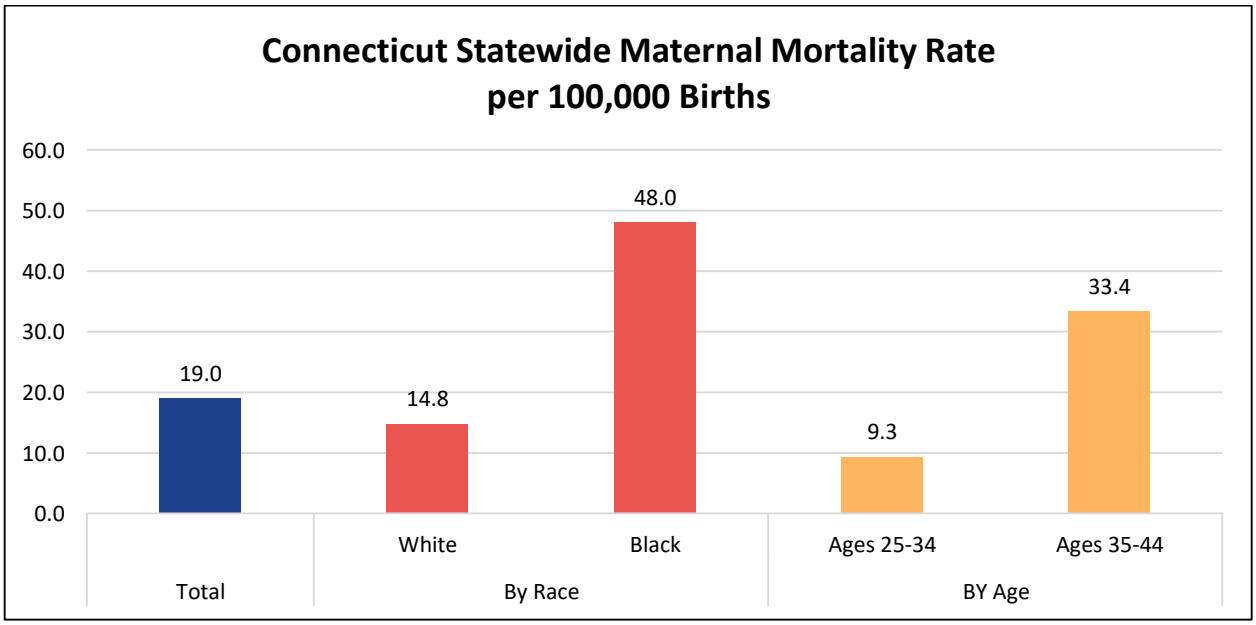
Infant mortality measures the rate of death among people under one year of age per 1,000 live births. Maternal mortality measures the rate of death during pregnancy or within one year of the end of pregnancy. Both measures are internationally utilized as key community health indicators because they are particularly sensitive to structural factors including social and economic factors and quality of life conditions, such as housing insecurity, educational attainment of the mother, and ACEs.

Disparities in infant and maternal mortality are measures of structural inequities that are at play well before a mother gets pregnant or gives birth. Therefore, upstream strategies that address the root causes of inequities can have far reaching impact on these indicators. The data show that infant mortality impacts Black babies at three times the rate as white babies and nearly twice the rate of Latinx babies. Maternal mortality impacts Black pregnant people at more than three times the rate of white pregnant people.

2016-2018 Selected Birth Outcomes by Race and Ethnicity of Parent Giving Birth

	Total	Asian	Black	White	Latina		
					Latina (overall)	Puerto Rican	Other Latina
Late or no prenatal care							
Connecticut	3.4%	3.5%	5.7%	2.5%	4.0%	2.9%	5.1%
Greater Norwalk	4.9%	4.6%	8.9%	3.5%	6.6%	7.9%	6.4%
Norwalk	5.3%	5.5%	8.3%	3.8%	6.2%	7.2%	6.1%
Low Birth Weight							
Connecticut	7.8%	8.7%	12.1%	6.4%	8.3%	10.2%	6.6%
Greater Norwalk	7.1%	NA	13.7%	6.6%	6.6%	NA	6.4%
Norwalk	7.5%	NA	13.7%	7.0%	6.6%	NA	6.4%
Infant Mortality (per 1,000 live births)							
Connecticut	4.6	NA	9.5	3.1	5.0	NA	NA
Greater Norwalk	3.1	NA	NA	1.9	5.9	NA	NA
Norwalk	3.6	NA	NA	NA	5.6	NA	NA

Source: DataHaven analysis (2021) of data from the Connecticut Department of Public Health Vital Statistics.



Source: America's Health Rankings analysis of CDC WONDER Online Database, Mortality files, 2013-2017

The CHNA data findings were analyzed to inform health priorities for Greater Norwalk. The data included in this report are valuable for tracking and benchmarking community health status indicators, as well as for identifying emerging community needs. In addition to the research collected as part of the 2022 CHNA, community conversations were held to solicit feedback on health priorities and opportunities for community health improvement.

Evaluation of Impact from 2019-2022 Community Health Improvement Plan

The Norwalk Community Health Committee (CHC) has representatives from the board, the executive team, hospital staff, community members, local health departments and community agencies. The CHC at Norwalk Hospital convened to review the findings of the Regional Community Health Needs Assessment (CHNA), also review the local health department priority areas to determine the hospitals' prevention agenda priorities for the 2019-2022 period.

Based on the 2019 Greater Norwalk Region CHNA, The Norwalk Hospital CHC identified the following priorities that also aligned with local health department priorities:

- CHRONIC DISEASE/OBESITY
- MENTAL HEALTH/SUBSTANCE ABUSE
- ACCESS TO HEALTHCARE

Workgroups were developed for each of these 3 areas, and goals, objectives, strategies, action steps and metrics were implemented to measure success for these priority areas. Where we have seen improvements in some of these priorities during the last couple of years, COVID has exacerbated the community needs, also barriers that were tied to these health conditions.

During the COVID-19 pandemic, Norwalk Hospital paused some of their planned community health programs and activities related to the prevention agenda priorities and implementation plan and pivoted its community programs to focus on COVID-19 education, testing and vaccinations. The hospital partnered with the Norwalk Health Department to quickly stand-up drive-up testing and vaccination sites for the local community. Where CHIP efforts did continue to address access to health care and chronic disease and obesity prevalence in the region, the emerging mental health disparity brought on by the pandemic made it necessary to prioritize the implementation of interventions that addressed the increased prevalence of anxiety and depression in the community. In addition to addressing urgent mental health needs throughout the greater Norwalk region, the pandemic also brought into focus the immediate need to conduct screening for social determinants of health factors, such as food security, adequate housing, resources to cover utilities, and domestic safety.

While maintaining efforts to address chronic disease prevalence, address gaps in access and increase efforts to meet the mental health needs of the community, the Norwalk Hospital Community Care Teams (CCTs) were highly utilized to meet the needs of vulnerable populations. The CCTs continued to partner with key community stakeholders to address homelessness, in addition, coordinated resources for residents who frequented the emergency rooms. To maintain adequate communication with community members and create opportunities for community members to stay in touch with their community-based service agencies, the hospital and CCTs leveraged technology, such as IPads for communication, which proved to be a great success, impacting the quality of lives of so many.

To address the three priority areas described in the CHIP, Nuvance Health implemented the following interventions:

1. CHRONIC DISEASE/OBESITY

- Hospital staff and affiliated physicians participated in health fairs, community education lectures, support groups and screenings, while closely partnering with community-based organizations. When the pandemic prompted the cancellation of in-person events, lectures were held via Zoom, talk shows were aired on Optimal Chanel 88, a television program organized by the Public Relations department. Topics of discussions included heart health, exercise, nutrition, pulmonary medicine, anxiety, handwashing at head start preschools, just to name a few.
- Norwalk Hospital, partnering with Americares, held multiple nutritional counseling and healthy weight classes, serving 92 individuals from the community.
- Addressing heart health, 85 individuals attended the lectures of the Riverbrook YMCA and Timex Corporation.
- Food drives for local communities were held at the hospital area facilities in the spring of 2020 to benefit local food pantries.
- In 2020, Norwalk hospital provided education on COVID-19 testing, vaccines, infection prevention, and coping tips, and translated the education materials in Spanish and Portuguese to eliminate language barriers for the most vulnerable. To ensure adequate levels of communication, the hospital created a community hotline, providing an additional avenue for the community to receive updated information on COVID-19 subject areas, which was well received by the community.

2. MENTAL HEALTH/SUBSTANCE ABUSE

- Norwalk Hospital was able to utilize a DHMAS grant for the state of Connecticut to support much needed outpatient psychiatric care for the community. This grant made it possible to provide mental health services to those who were uninsured and underinsured in the region.
- Discussions held on Optimal Chanel 88 proved to be an effective way of discussing emerging mental health needs, such as the increased prevalence of anxiety across all populations, all ages.
- Norwalk Hospital CCTs collaborated closely with local mental/ behavioral health providers to address the mental health, alcohol and substance use challenges that the community faced at significantly higher levels than prior to the pandemic.

3. ACCESS TO HEALTH CARE

- Norwalk Hospital provided information on all patient statements on ways to access assistance with hospital bills. Counselors were available to provide further assistance if needed.
- All uninsured patients were interviewed by financial councilors and assessed for eligibility for assistance programs.
- Schedulers referred uninsured patients to financial counseling prior to their test or procedure taking place.
- The collection department referred patients to financial counseling when patients indicated that they could not afford their balances.

Next Steps

The Norwalk Community Health Committee (CHC) was created during the community health planning process in the Greater Norwalk Region in 2012. The Committee is tasked with the review and oversight of the CHNA and CHIP in support of the organization's mission and population health initiatives.

Responsibilities and scope of activities

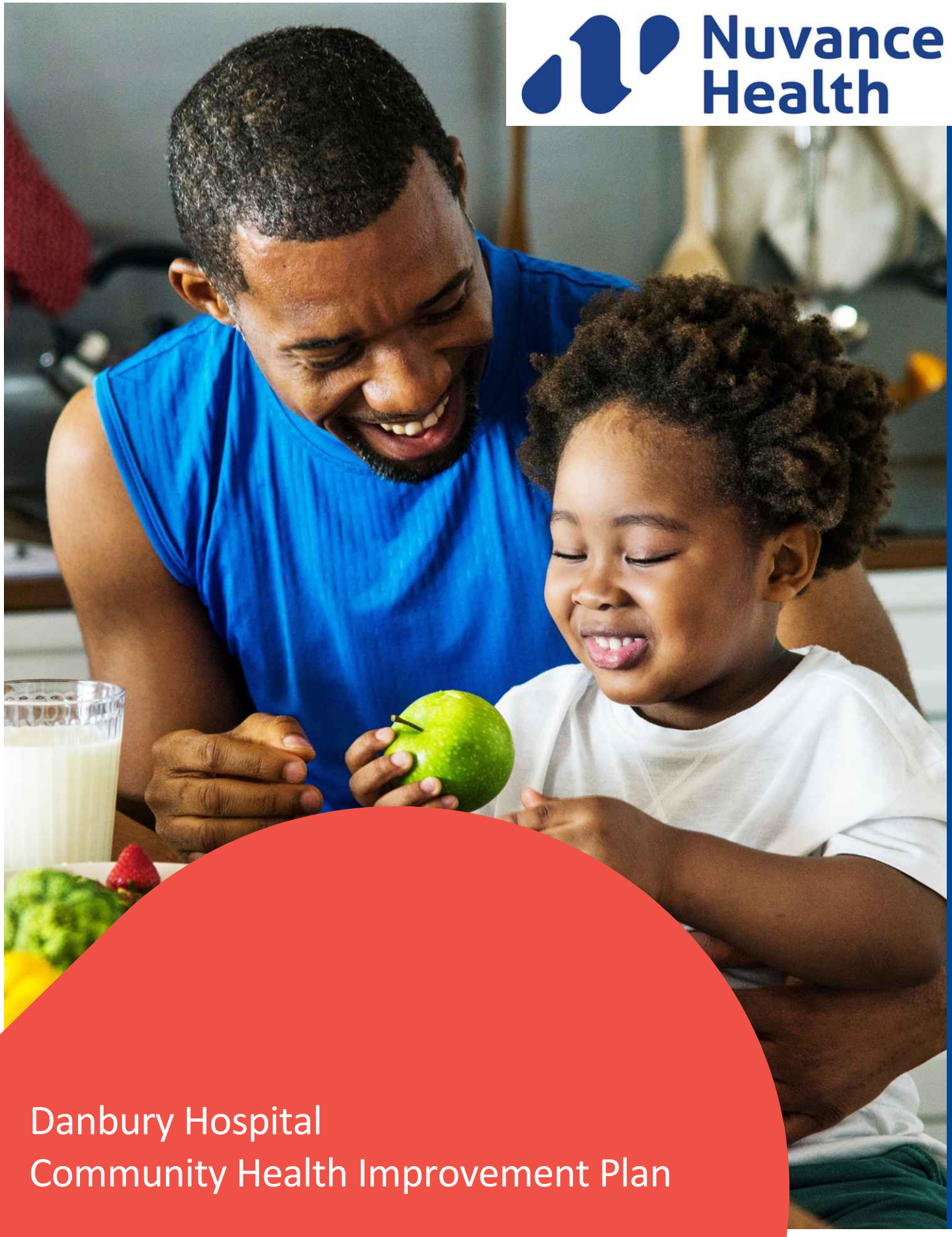
- Monitor assessments of population health status and social determinants that impact health
- Guide priority issues for action to improve community health
- Monitor implementation of approved work plans to address identified priority issues
- Help inform, guide, share and link successful programs and 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 2022 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 up 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.

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

Nuvance Health



Danbury Hospital
Community Health Improvement Plan

What is a Community Health Improvement Plan (CHIP)

A CHIP helps organizations move from data to action to address health priorities identified in the CHNA. The CHIP serves as a guide for strategic planning and a tool by which to measure impact by detailing goals, objectives, strategies, and action steps over the three-year reporting timeframe. Anchoring initiatives and community benefit activities to measurable objectives, the CHIP creates a framework for measuring the impact of collective action towards community health.

Community Input

Like the CHNA, the CHIP reflects input from diverse stakeholders and helps to foster collaboration among community-based organizations. Experts and community members provided input to define and recommend solutions to health challenges in our community. This input provided diverse perspectives on health trends and helped us better understand lived experiences of populations that experience barriers to care. Each Nuvance Health hospital has a Community Health Committee (CHC) with representatives from the board, the executive team, hospital staff, community members, local health departments, and community agencies. Nuvance Health employees participate in an array of community boards and task forces to foster collaboration with community partners.

Determining Priority Health Needs

To work toward health equity and improve health disparities, it is imperative to prioritize resources and activities for meaningful community impact. Through the CHNA research and ongoing engagement of community representatives, Nuvance Health collected input to determine the most pressing health needs affecting residents in the Danbury Hospital service area. Priority health needs were determined through discussions with the hospital's Community Health Committee and input from community stakeholders including public health experts, health and human service providers, representatives of underserved populations, and community members. Nuvance Health reviewed recommendations for priority areas in consideration with existing resources and gaps in services to determine which community health priorities Danbury Hospital could best impact over the next three years. Based on this determination, Danbury Hospital's 2023-2025 CHIP will focus community benefit activities on **Preventing Chronic Diseases** and **Addressing Behavioral Health needs**.

Some health needs that were identified in the CHNA will not be directly addressed in Danbury Hospital's CHIP, however these needs will continue to be met through clinical care services and support of community partners that focus on these issues. Examples of other community health needs that we identified in the 2022 CHNA that are not directly reflected in Danbury Hospital's CHIP include housing and access to oral health care.

Alignment with Healthy Connecticut 2025

The Danbury Hospital CHIP is aligned with the Healthy Connecticut 2025 State Health Improvement Plan (SHIP), a five-year strategic plan for improving the health of CT residents. This coordination serves to advance statewide and local efforts to improve the health and wellbeing of all people.

Alignment with State and Federal Requirements

The Danbury Hospital 2022 CHNA and CHIP process and timeline are in line with IRS Tax Code 501(r) requirements to conduct a CHNA every three years and Connecticut state requirements for hospital community benefit reporting.

Advancing Health Equity

The CHNA documented disparities in poverty, education, and socioeconomic measures; access to health care and social services; disease rates and outcomes; and quality and length of life. These health disparities are most often driven by social determinants of health and reflect longstanding inequities. To work toward health equity, we need to redefine how we deliver health care, increase our knowledge and understanding, and confront policies that perpetuate disparities. At Nuvance Health we have outlined specific objectives and strategies to guide our efforts in creating more welcoming care settings that honor the diversity of our communities, and promote diverse and inclusive environments for our patients, staff, and providers.

Nuvance Health Commitment to Health Equity, Diversity, and Inclusion

Strategy: Increase cultural awareness and humility among staff and providers.

Initiatives:

- Use Patient Family Advisory Councils to provide feedback on care quality and patient experience.
- Recruit diverse representatives from community-based organizations to serve on Health Equity, Diversity, and Inclusion Advisory Committees, Community Health Committees, and Community Care Teams.
- Provide implicit bias and cross-cultural care education to all employees.

Strategy: Reduce disparities in outcomes among vulnerable patient populations.

Initiatives:

- Accurately collect patient demographic data and socioeconomic needs within medical records.
- Stratify clinical data to identify health disparities; implement strategies to reduce or eliminate these disparities.
- Evaluate clinical documents and educational materials to reflect preferred patient languages in each hospital service area.

Strategy: Increase diversity of staff and providers.

Initiatives:

- Cultivate awareness of healthcare careers within underserved communities.
- Modify recruitment and hiring processes to attract and support diverse staff and cultivate advancement opportunities.
- Grow scholarships, mentorship, and new workforce pipelines.

Strategy: Support a sustainable and equitable community.

Initiatives:

- Evaluate hiring, supply chain, and opportunities for local economic investment.
- Purchase goods from local and diverse vendors.
- Make contributions of dollars, time, and expertise to advance community initiatives.

Strategy: Increase, improve, strengthen, and evaluate partnerships with community-based organizations.

Initiatives:

- Foster collaboration with organizations that serve diverse or underserved populations.
- Invite input from diverse stakeholders to define and address community health needs.
- Support and cultivate opportunities for community-wide cross-cultural engagement.

Priority Area One: Prevent Chronic Diseases

Goals:

- Reduce health disparities in chronic disease prevention and disease.
- Reduce the impact of social drivers of health on patient outcomes.

Strategies:

- Increase early detection of cardiovascular disease, diabetes, prediabetes, and obesity.
- Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity.
- In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity.
- Increase access to care for populations that experience disparities in chronic disease burden and care.
- Improve cultural competency of providers and adopt inclusive healthcare environments.
- Partner with community agencies to connect people to resources for housing, food security, transportation, and related socioeconomic needs.
- Track data across populations to identify and address health disparities.

Danbury Hospital Initiatives:

- Initiate cultural competency training in all patient care areas to support an inclusive healthcare environment.
- Expand telehealth for primary and specialty care and increase digital equity.
- Implement a Food as Medicine Program in partnership with the United Way.
- Increase referrals from primary care practices to the YMCA Diabetes Prevention Program, Blood pressure self-management, and Fall Prevention Tai Chi Quang.
- Partner with United Way of Western Connecticut Prosperi-Key program, the Healthy Savings program, food pantries, and other sources for food security to assist people in accessing healthy fresh foods.
- Partner with Faith Community Nurse Program to provide education on chronic disease prevention.
- Refer patients to Connecticut Healthy Living Connective for chronic disease, pain management, and services for people with disabilities.
- In partnership with the American Heart Association, implement a Public Library Hypertension Program to provide education and home management of hypertension.
- Foster and strengthen partnerships with faith-based organizations to bring chronic disease prevention education to priority populations.
- Conduct Annual Mission Health Day to provide health screenings, vaccinations, education, and referrals for care to underserved populations.
- Offer smoking cessation programs to community members.
- Explore partnership with the CT Department of Aging and Disability Services to educate ED staff on equitable care and available community resources to meet patients' socioeconomic needs.
- Provide support groups, resources, and educational programs through the Danbury Hospital Caregiver Center.

Priority Area Two: Promote Well-Being and Prevent Mental and Substance Use Disorders

Goals:

- Strengthen opportunities to build well-being and resilience across the lifespan.
- Improve access to behavioral health services within the community.
- Prevent opioid overdose death.

Strategies:

- Integrate mental health screenings and services within primary care practices.
- Increase the traditional and alternative (community and technology based) places people can access health care.
- Strengthen community partnerships in underserved communities.
- Increase understanding of the impact of trauma.
- Provide expertise and support to reduce misuse of alcohol and drugs.
- Reduce opioid prescriptions in primary and specialty care settings.
- Provide expertise and support for community-based services for substance use disorders.

Danbury Hospital Initiatives:

- Provide Mental Health First Aid; expand offerings to include Spanish language classes.
- Provide competency training for healthcare and social services providers on Screening, Brief Intervention, and Referral to Treatment (SBIRT).
- Increase access to behavioral health services in primary care practices.
- Leverage expertise and resources of Danbury Hospital Behavioral Health department; recruit behavioral health providers including Psychiatrists and Licensed Clinical Social Workers to increase capacity of services.
- Partner with Connecticut Institute for Communities (CIFC) health psychiatry residency program.
- Expand behavioral health telehealth options and increase patient knowledge and ability to access these services.
- Partner with the Alzheimer's Association to provide education for providers to on early recognition of dementia and available community services.
- Continue partnership with Connecticut Community for Addition Recovery (CCAR) Recovery Coaching Program to provide addiction support services in the ED.
- Provide education to increase provider expertise in opioid prescribing, chronic pain management, and Medically Assisted Treatment (MAT); Expand MAT options in partnership with Midwestern Connecticut Council of Alcoholism (MCCA), Connecticut Counseling Centers, Connecticut Institute for Communities (CIFC).
- Partner with Age Well Community Council of Danbury, the United Way, Senior Centers, and other agencies that serve older adults to address community isolation, depression, and chronic health needs.
- Implement Harm Reduction Training for NARCAN administers, including CPR Training, in partnership with AHA
- Partner with Western CT Coalition to bring increase access to substance use support groups, NARCAN initiatives, and Suicide Prevention to community members.

Collaborate with community partners

Nuvance Health hospitals consistently collaborates with a wide range of community partners that serve diverse populations across the communities we serve. Additional information can be found on our website nuvancehealth.org under Community Outreach and Sponsorship or by following this link: Community Outreach and Sponsorships | Nuvance Health.

Resources Allocated to the 2023-2025 Community Health Improvement Plan

At Nuvance Health, we are not only caregivers — we are also friends, family, and neighbors. Through our CHIP initiatives, we aim to increase well-being for everyone. The Danbury Hospital initiatives and community benefit activities outlined in the Danbury Hospital 2023-2025 CHIP reflect Nuvance Health's dedication to investing in community partnerships and programs to promote wellness and health equity. The CHIP reflects a workplan that outlines specific resources and oversight for our initiatives. The Danbury Hospital Community Health Committee exists to support this work and is tasked with the review and oversight of the CHIP, including the following responsibilities.

- Monitor implementation of the CHIP to address identified priority areas.
- 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.

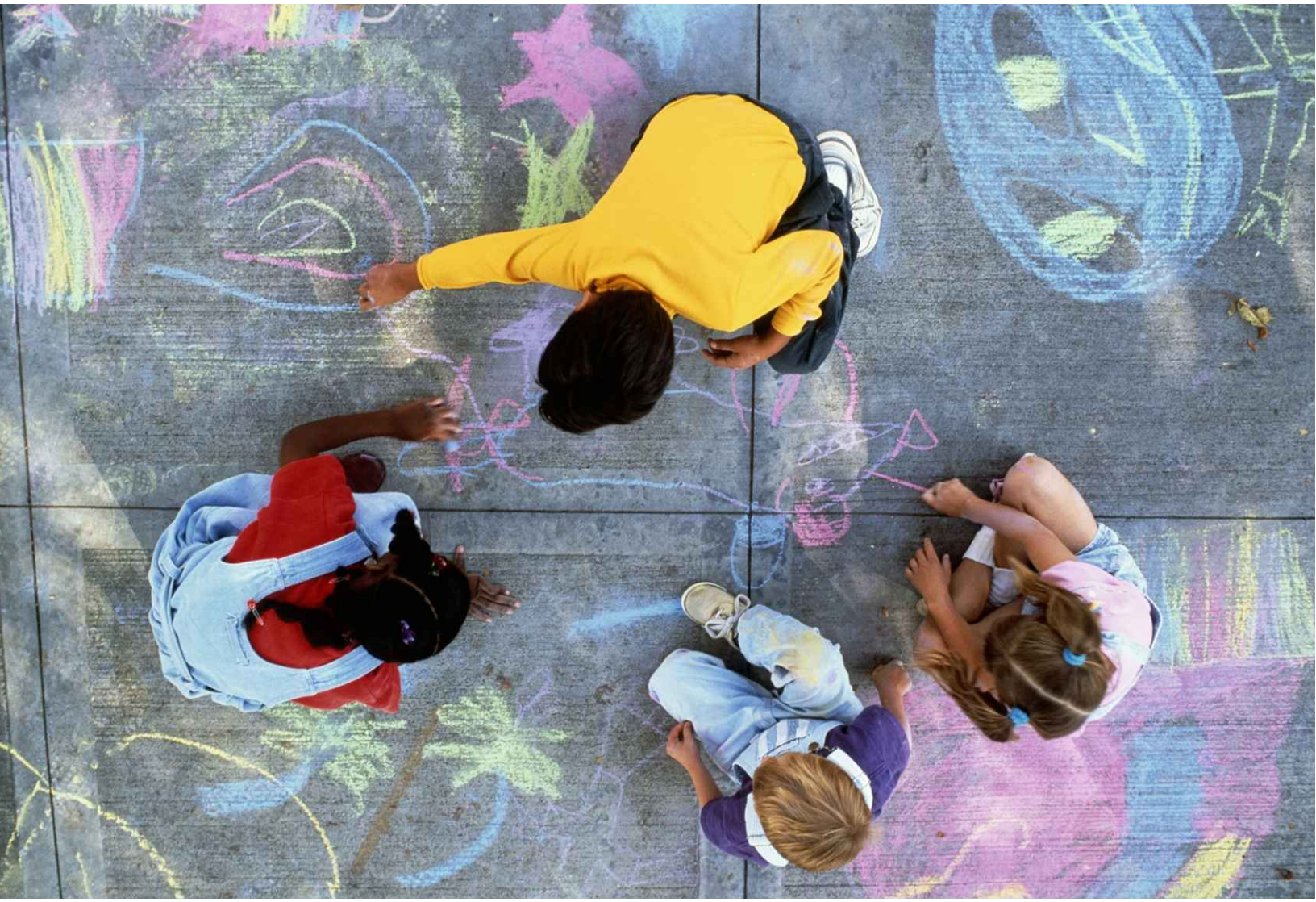
Maintaining Engagement and Tracking Progress

The Danbury Hospital CHC oversees the development and updating of the CHNA and monitors community health activities and progress. The CHC meets quarterly to review progress toward the goals stated in the Community Health Improvement Plan and to determine whether any changes in objectives or strategies are required.

Dissemination to the Public

The 2022 Community Health Needs Assessment and 2023-2025 Community Health Improvement Plan are available on the Nuvance Health website under Community Benefit. Printed copies of these documents will be made available to the public (free of charge) in the administrative offices at Danbury Hospital.

Danbury Hospital & New Milford Hospital 2022 Community Health Needs Assessment Report



Nuvance Health

A letter from Nuvance Health

Communication. Collaboration. Commitment.

These are essential elements for improving population health in our communities.

Nuvance Health is pleased to present our 2022 CHNA findings. This report includes a review and analysis of health and socio-economic data that impact the health of people across our service area. The purpose of this assessment is to identify the area's health needs so we may better align with stakeholders, such as public health and healthcare providers, about opportunities for improving the health of our region. These results allow Nuvance Health, state and county public health departments, our community partners, and other providers to set priorities, develop interventions, and commit the appropriate resources to our region more strategically.

Our workforce of more than 15,000 compassionate caregivers provides high-quality care through our six nonprofit hospitals on seven campuses, multiple outpatient care sites, numerous primary care, and specialty provider locations, and increasing set of virtual healthcare services. Across the system, we offer state-of- the-art facilities, technology, and a breadth of clinical services.

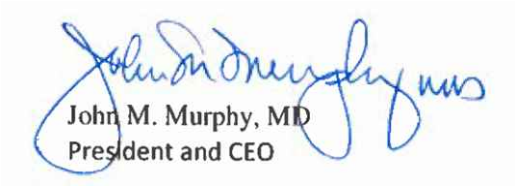
The staff of Nuvance Health are dedicated to the health and well-being of everyone in our region, regardless of race, ethnicity, age, gender, religion, sexual orientation, gender identity, gender expression, disability, economic status, and other diverse backgrounds. This is our promise to the more than 1.5 million children and adults we serve in western Connecticut and the Hudson Valley of New York.

To ensure our services are aligned with the healthcare needs of our community, we complete a Community Health Needs Assessment (CHNA) every three years for each hospital community, and it was conducted January to September 2022. This helps us better serve our community by measuring the health status of residents, gathering community input on health concerns, and identifying opportunities to collaborate. With the help of many state, county, and community partners, we had strong participation in our surveys, and we value this feedback and recognize all community stakeholders who play an integral part in advancing the health of our region.

And this is only the beginning. We continually assess how we serve our region so we can provide outstanding care, as well as education and outreach activities that meet priority needs. In doing so, we will continue to collaborate with our partners, educate our policy makers, and engage community residents to promote health for all residents of our region.

We look forward to our continued work together and thank you for putting your trust in us. At Nuvance Health, we are not only your caregivers—we are also your friends, family, and neighbors. Through our community benefit initiatives, we aim to increase well-being for everyone.

With gratitude,



John M. Murphy, MD
President and CEO

Table of Contents

Our Commitment to Community Health

Where some see impossible, we see what's possible. At Nuvance Health, we continually strive for progress and push past the status quo in all aspects of what we do. We are Nuvance Health!

Nuvance Health is an integrated health system offering convenient, accessible, and affordable care to community members. We're here for you–whenever and wherever you need us. Our talented team of more than 15,000 compassionate caregivers provides high-quality care through:

- Community hospitals
- Primary care and specialty practice locations
- Outpatient settings
- Home care services
- A skilled nursing and rehabilitation facility
- Telehealth visits

Our network also includes a well-known research institute, which brings breakthroughs from the lab directly to the bedside. We take research to heart and focus on treatments and cures that will benefit our community.

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 and New Milford Hospital (part of the Danbury Hospital campus), under the auspices of the Community Health Committee, and Greater Danbury community partners participated in a Community Health Needs Assessment (CHNA) 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 CHNA and the priority elements that will be used to develop the three-year Community Health Improvement Plan to guide our community benefit and community health improvement efforts.

2022 CHNA Executive Summary

CHNA Leadership

The 2022 CHNA was overseen by the Community Health Committee of the Board of Directors of Nuvance Health. The Committee includes representations of the hospital communities, including hospital Board leadership, administrative leadership from the Nuvance Health network, local health department directors, community stakeholders, and other key hospital stakeholders.

Danbury Hospital Community Health Committee

- **Carrie Amos- Chair – Jericho Partnerships**
- Thomas Dubin – Board Member
- Lisa Alexander– Community (United Way of Western CT)
- Isabel Almeida– Community (United Way of Western CT)
- Stacy Benson– Community (CT Counseling)
- John S. Bocuzzi – Community - Friends of Newtown Seniors
- Melanie Bonjour– Community (CT Institute for Communities)
- Edward Briggs – Community (Ridgefield Health Dept.)
- Adam Carley– Community (Reach Newtown)
- Elizabeth Cotter – Community (Danbury Youth Services)
- Donna Culbert– Community (Newtown Health Dept.)
- Diane Doling– Community (Danbury Youth Services)
- Alison Fulton– Community (Western CT Coalition)
- Michelle James– Community (Community Action Agency)
- Joan Laucius – Community (Reach Western CT)
- Marie Miszewski – Community (Regional YMCA)
- Lisa Morrisey – Community (Housatonic Valley Health District)
- Lisa O'Connor – Community (Regional YMCA)
- Sherry Ostrout – Community (Age Well Community Council)
- Kara Prunty – Community (Danbury Health Dept.)
- Timothy Simpkins – Community (New Fairfield Health Dept.)
- Jackie Romaniuk – Community – (CT Dental Health Partnership)
- Ray Sullivan – Community (Brookfield Health Dept.)
- Laura Vasile – Community (Bethel Health Dept.)
- Janice Wiggins – Community (CT Community Care

Professional Staff

- Rowena Bergmans – Nuvance VP Strategic Payer and Community Partnerships
- Robert Carr, MD – Nuvance
- Billie-Jo Frazier – DH Program Manager Account Health Committee
- Sally Herlihy – Nuvance VP Strategic Planning & Bus Development
- Kevin McVeigh – DH Community Care Team Manager
- Akshara Patel – DH Clinical Research Coordinator
- Ildiko Rabinowitz – Nuvance AVP Health Equity Diversity & Inclusion
- Ellen Ryan – Nuvance Clinician
- Andrea Rynn – Nuvance AVP Community Govt and Public Relations
- Alison Zaloski– DH Nursing Manager

Our Research Partners

Nuvance Health contracted with Community Research Consulting to compile the CHNA reporting and guide the development of the Community Health Improvement Plan. CRC is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. Their interdisciplinary team of researchers and planners have worked with hundreds of health and human service providers and their partners to reimagine policies and achieve measurable impact. Learn more about our work at buildcommunity.com.

DataHaven conducted the DataHaven Community Wellbeing Survey (DCWS), a statistical household survey to gather information on wellbeing and quality of life for Connecticut's neighborhoods. The DCWS is a nationally recognized program that provides critical, highly reliable local information not available from any other public data source. A 501(c)3 nonprofit organization and registered as a Public Charity with the State of Connecticut, DataHaven is a partner of the National Neighborhood Indicators Partnership, a learning network, coordinated by the Urban Institute, of independent organizations in 30 cities that share a mission to ensure all communities have access to data and the skills to use information to advance equity and wellbeing across neighborhoods.

The Greater New York Hospital Association (GNYHA) conducted the 2022 GNYHA CHNA Survey of adults aged 18 or older who live in a zip code or county served by the hospital. The survey was intended to garner resident input on community health priorities based on perceived importance and satisfaction. The survey used a non-probability convenience sample. A web-based survey tool and a paper-based tools were used to collect the survey data. Surveys were available in a variety of languages. The GNYHA CHNA questionnaire was translated from English into Spanish, Chinese, Russian, Yiddish, Bengali, Korean, Haitian Creole, Italian, Arabic, and Polish.

Methodology and Community Engagement

The 2022 CHNA included quantitative research methods and community conversations to determine health trends and disparities affecting Greater Danbury. Community engagement was an integral part of the 2022 CHNA. In assessing community health needs, input was solicited and received from persons who represent the broad interests of the community, as well as underserved, low-income, and minority populations. These individuals provided wide perspectives on health trends, expertise about existing community resources available to meet those needs, and insights into service delivery gaps that contribute to health disparities and inequities.

The following research methods were used to determine community health needs:

- **Analysis of Health and Socioeconomic Data:** Public health statistics, demographic and social measures, and healthcare utilization data were collected and analyzed to develop a comprehensive community profile that illuminated health disparities and underlying inequities.

- **Community Surveys of Lived Experiences:** As part of the DataHaven Community Wellbeing Survey across Connecticut, a statistical telephone survey was conducted with more than 700 households in the Greater Danbury community to gather information on wellbeing and quality of life.
- **Community Perception Surveys:** As part of the GNYHA CHNA Survey, a web- and paper-based convenience survey was conducted with nearly 750 households in the Danbury Hospital and New Milford Hospital service area to garner perceptions on community health priorities.
- **Input from Experts and Key Stakeholders:** Health and social service providers, public health experts, and representatives from a wide range of community-based organizations participated in the CHNA to guide the process and provide insights on community health needs.

Community Health Priorities

To work toward health equity, Nuvance Health commits to ensuring hospital resources and activities build upon existing priorities and collaborative activities, while ensuring responsiveness to emergent needs. Determination of priorities made by leadership of Nuvance Health included review of existing commitments, new research findings, and community feedback.

Nuvance Health will focus efforts on the following community health priorities as part of its 2022-2025 Community Health Implementation Plan (CHIP):

- Address Chronic Diseases
- Promote Well-Being and Address Mental and Substance Use Disorders

Nuvance Health is committed to continuing its collaboration with the Community Health Committee and other stakeholders to further refine focus areas within the identified health priorities. Together with these partners and stakeholders, Nuvance Health will create a CHIP that reflects collective health impact strategy and the many strengths and assets of our community partners to address these needs.

Board Approval

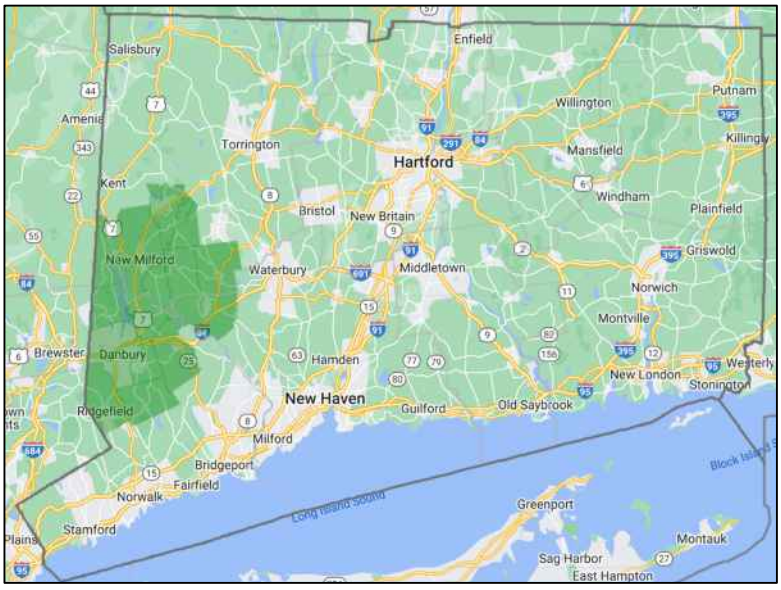
The 2022 CHNA was conducted in a timeline to comply with IRS Tax Code 501(r) requirements to conduct a CHNA every three years as set forth by the Affordable Care Act (ACA). The 2022 CHNA report was presented to the Nuvance Health Board of Directors and approved in September 2022.

Following the Board's approval, the CHNA report was made available to the public via the Nuvance Health website at Nuvance Health.

Danbury Hospital & New Milford Hospital Service Area

The 2022 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 is referred to as Greater Danbury throughout the remainder of the report. The CHNA data may also be presented for all of Fairfield and Litchfield counties, the home counties of Danbury and New Milford, based on data availability.

Greater Danbury Region



Greater Danbury Region and 2020 Populations by Town	
• Bethel (20,358)	• Redding (8,765)
• Bridgewater (1,662)	• Ridgefield (25,033)
• Brookfield (17,528)	• Roxbury (2,260)
• Danbury (86,518)	• Sherman (3,527)
• New Fairfield (13,579)	• Southbury (19,879)
• New Milford (28,115)	• Washington (3,646)
• Newtown (27,173)	• Woodbury (9,723)

Understanding changes in population demographics is critical to plan for changes in healthcare, housing, economic opportunity, education, social services, transportation, and other essential infrastructure elements.

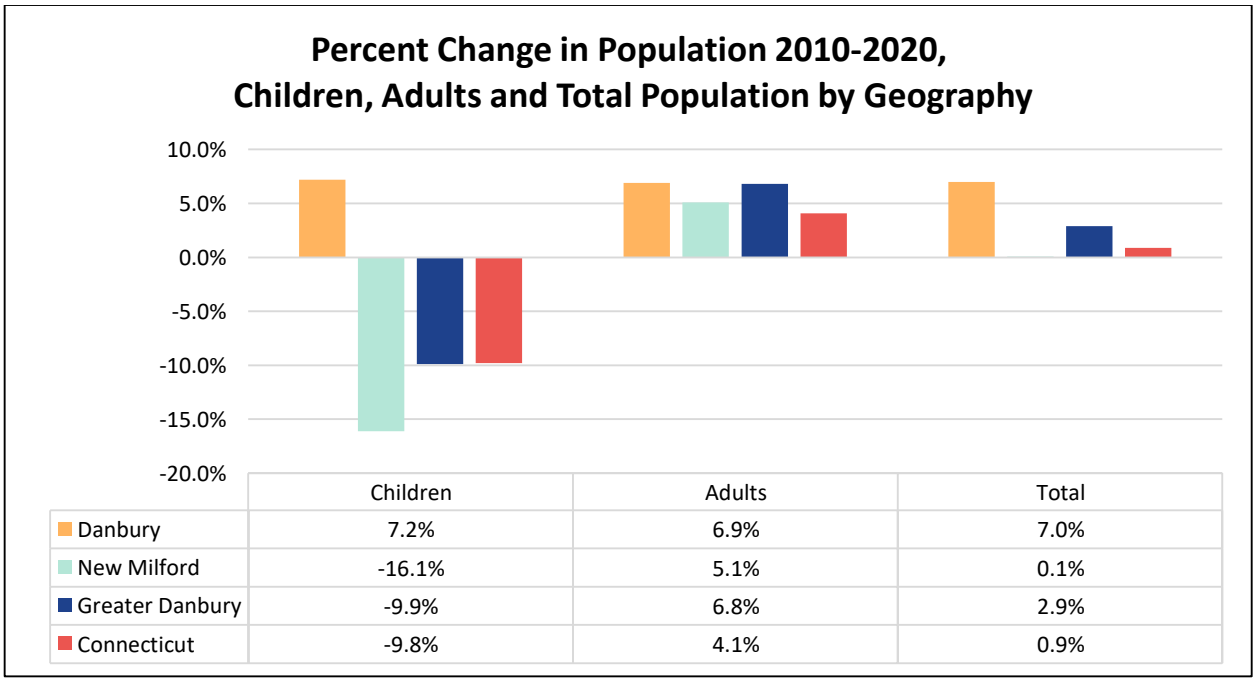
Connecticut overall is an aging state. Between 2010 and 2020, the state's population remained similar in total number, but increased in the proportion of adults and decreased in the proportion

of children. During the same period, Greater Danbury experienced a 3% increase in overall population, although the region is also aging. Between 2010 and 2020, Greater Danbury saw adult population growth of +13,537 individuals and child population loss of -6,106 individuals. The City of Danbury is unique within the region, experiencing growth in both adult and child populations.

Total Population and Population Change by Age Group

	2010 Population	2020 Population	Change
Danbury			
All Ages	80,893	86,518	+5,625
Children under age 18	17,042	18,270	+1,228
Adults 18 or over	63,851	68,248	+4,397
New Milford			
All Ages	28,241	28,115	-27
Children under age 18	6,839	5,735	-1,104
Adults 18 or over	21,303	22,380	+1,077
Greater Danbury			
All Ages	260,335	267,766	+7,431
Children under age 18	61,891	55,785	-6,106
Adults 18 or over	198,444	211,981	+13,537
Connecticut			
All Ages	3,574,097	3,605,944	+31,847
Children under age 18	817,015	736,717	-80,298
Adults 18 or over	2,757,082	2,869,227	+112,145

Source: US Census Bureau 2020 Decennial Census P.L. 94-171 Redistricting Data



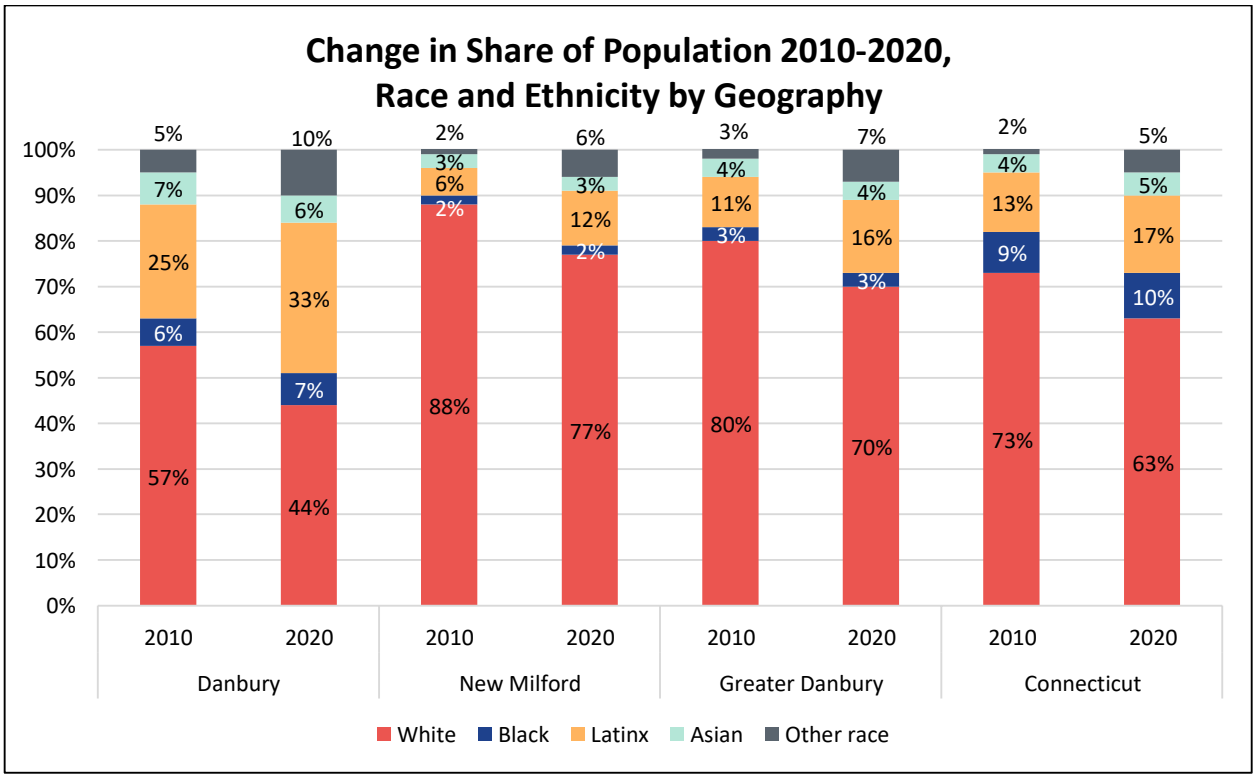
Source: US Census Bureau 2010 & 2020 Decennial Census P.L. 94-171 Redistricting Data

The City of Danbury is a majority-minority city, with a racial and ethnic diversity of residents unmatched in the surrounding areas. Regionally, Greater Danbury is less diverse than Connecticut, although consistent with statewide trends, the region is becoming more diverse.

Total Population by Race and Ethnicity

	White	Black	Latinx	Asian	Native American	Other race/ethnicity
Danbury						
Count	37,963	5,630	28,690	5,339	70	8,826
Share	44%	7%	33%	6%	<1%	10%
New Milford						
Count	21,515	639	3,241	958	<50	1,730
Share	77%	2%	12%	3%	NA	6%
Greater Danbury						
Count	186,769	8,547	42,725	11,760	221	17,744
Share	70%	3%	16%	4%	<1%	7%
Connecticut						
Share	63%	10%	17%	5%	<1%	5%

Source: US Census Bureau 2020 Decennial Census P.L. 94-171 Redistricting Data

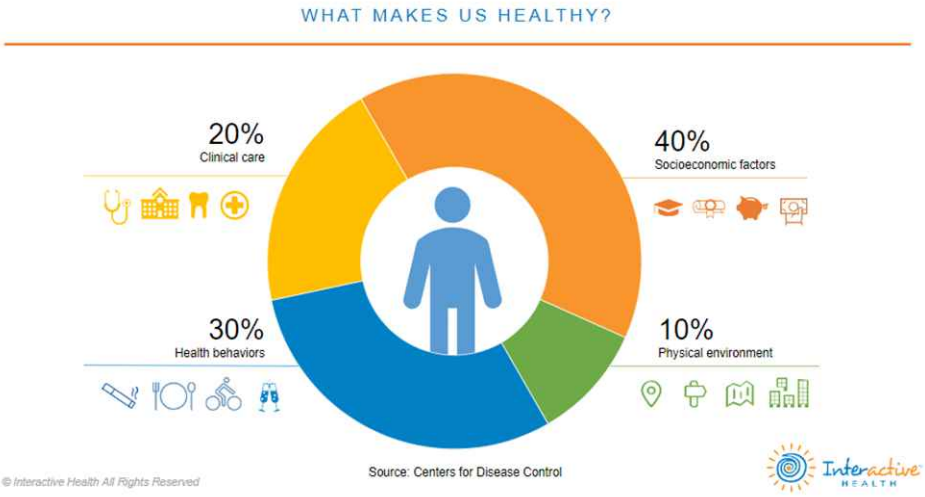


Source: US Census Bureau 2010 & 2020 Decennial Census P.L. 94-171 Redistricting Data

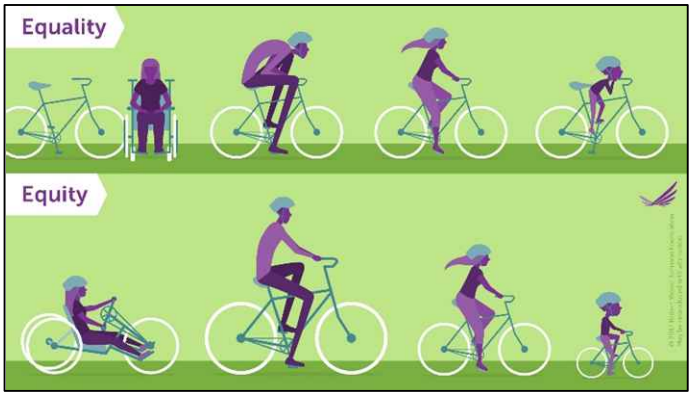
Social Determinants of Health and Health Equity: A closer look at factors that influence well-being

Social determinants of health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health risks and outcomes. Healthy People 2030, the CDC's national benchmark for health, outlines five key areas of SDoH: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

While health improvement efforts have historically targeted health behaviors and clinical care, public health agencies, including the US Centers for Disease Control and Prevention (CDC), widely hold that at least **50% of a person's health profile is determined by SDoH.**



Addressing SDoH is a primary approach to achieving *health equity*. **Health equity can be simply defined as "a fair and just opportunity for every person to be as healthy as possible."** To achieve health equity, we need to look beyond the healthcare system to dismantle systematic inequities born through racism and discrimination like power and wealth distribution, education attainment, job opportunities, housing, and safe environments, to build a healthier community for all people now and in the future.

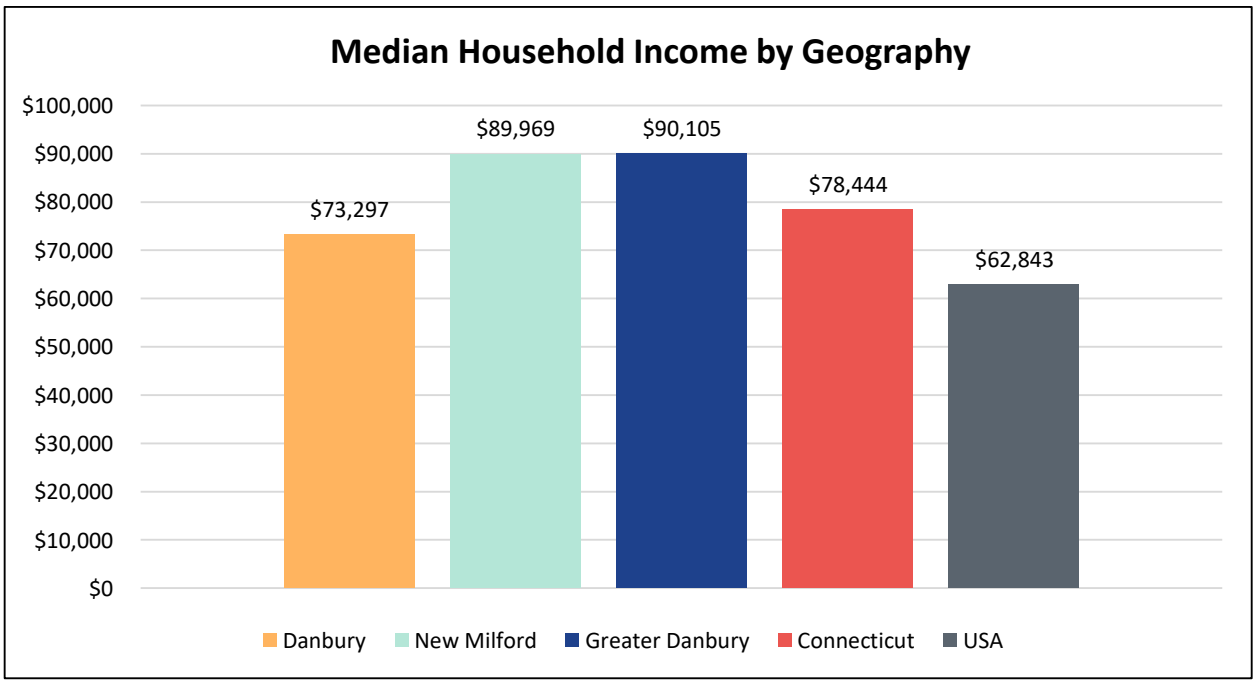


Social Determinants of Health within Greater Danbury

Economic Stability

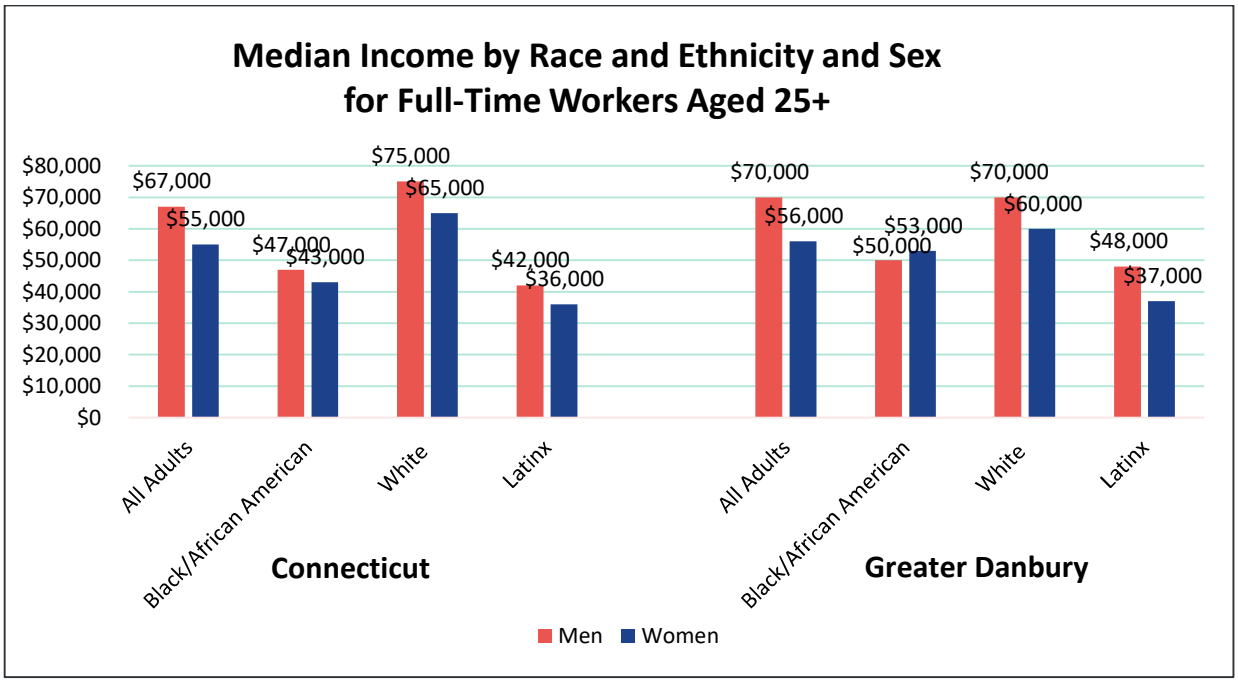
Income and work impact health outcomes. For example, many Americans access health insurance through their job, although not all types of work provide access to health insurance. Beyond health insurance, making healthy choices, such as purchasing lean meats and fresh produce or joining a gym, all cost money. Securing employment that allows individuals to provide a safe and decent home, nutritious food, transportation, child and elder care services, leisure activities, exercise, and medical needs depends on many factors. These factors can include education, age, access to employment opportunities, racism, language, and literacy, among others.

The median household income in Greater Danbury is $90,105, compared to $77,696 statewide, and fewer residents or children in Greater Danbury live in poverty compared to the state overall. However, this positive experience is not shared by all residents. Within the region, median household incomes by town range from $73,297 in Danbury to $163,945 in Ridgefield. Danbury also has higher poverty levels, affecting 12% of all residents and 17% of children.

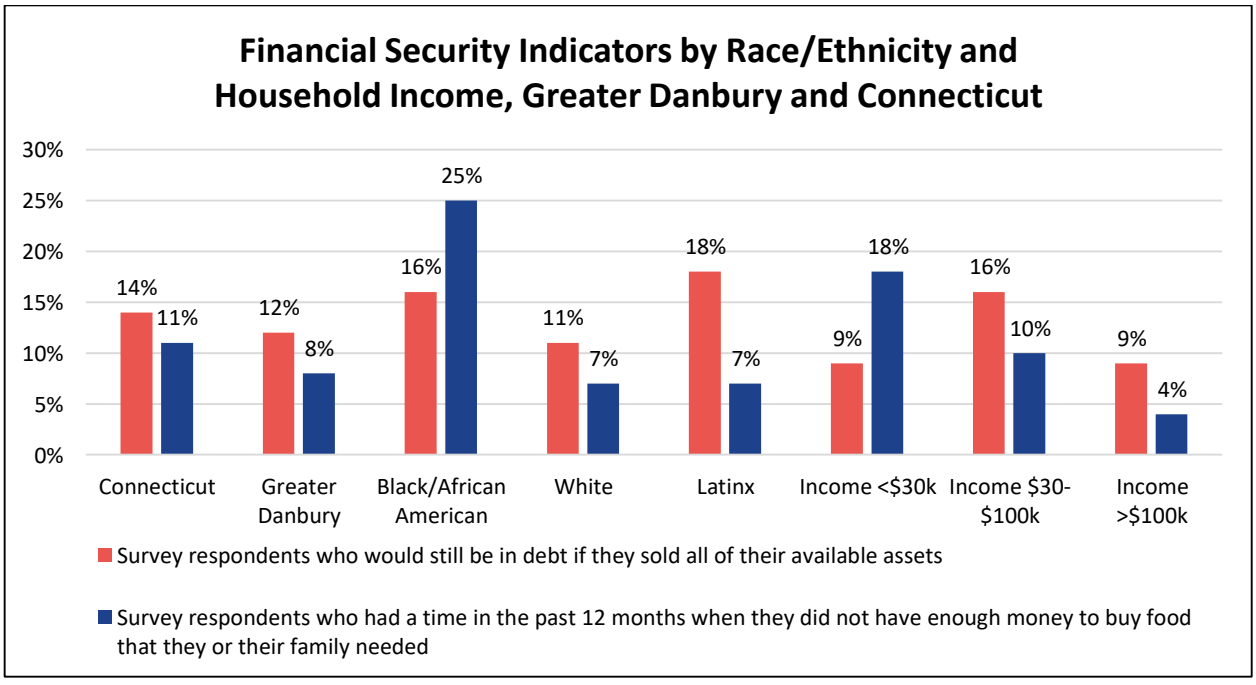


Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Historical barriers based on race, gender, ethnicity, and other factors continue to impact financial security and income for people today. For example, within Greater Danbury, median income for male Black/African American and Latino workers is approximately $20,000 less than for male white workers. A similar disparity is seen for female Latina workers compared to female white workers. This disparity in economic resources impacts the ability of people with lower incomes to engage in health promoting activities, creating differences in the choices available to people in Greater Danbury to live their healthiest lives.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

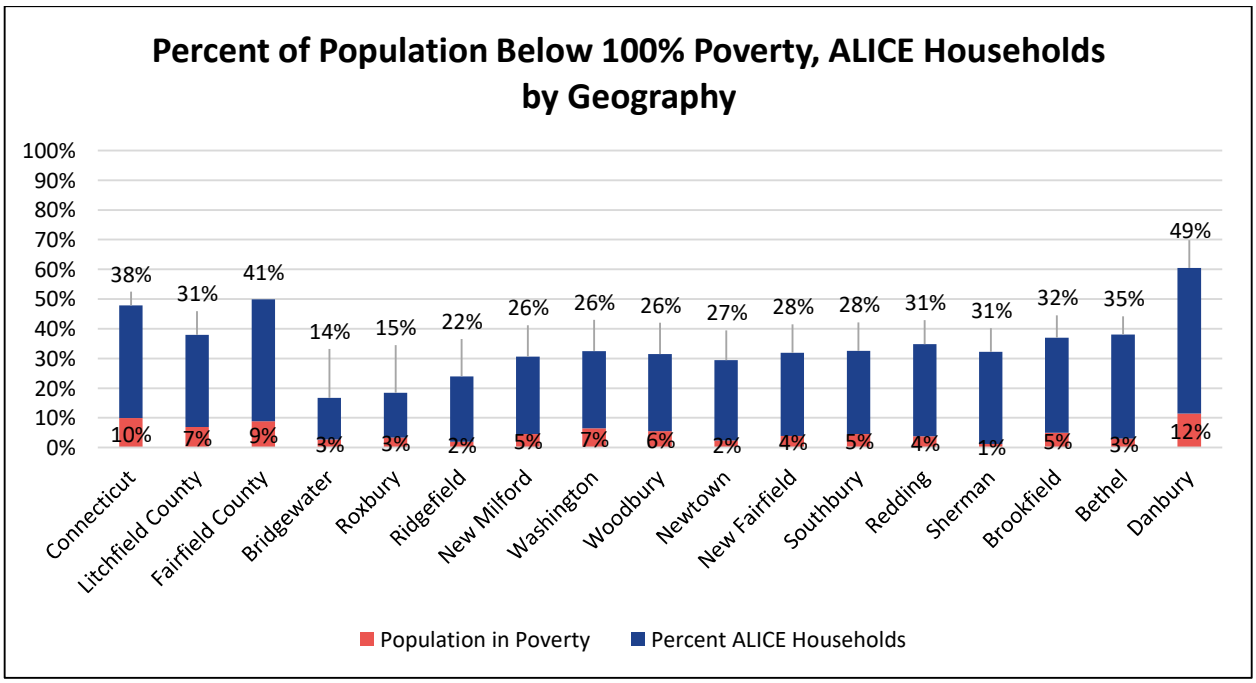


Source: 2021 DataHaven Community Wellbeing Survey

Asset Limited, Income Constrained, Employed (ALICE) The ALICE threshold is an index that captures the percent of households whose income is above the federal poverty level, but below the threshold necessary to meet all basic needs based on localized cost of living and local average

household sizes. ALICE measures the proportion of working poor and households who struggle to meet basic needs and are a paycheck or two away from acute financial strife.

While the proportion of people living below the poverty level is relatively low across the Greater Danbury Area, more than 1 in 10 and up to 49% of all households throughout the area met the ALICE threshold ***before the start of the COVID-19 pandemic***. While the data regarding these measures during the pandemic are not yet available, anecdotal information suggests that the proportion of struggling households has increased during more recent years.



Source: United for ALICE and US Census Bureau American Community Survey 2019 5-year estimates

Where you live impacts the choices available to you. These choices impact your income, wellness, and ultimately how long you live. These place-based choices, as well as lived experiences like discrimination and racism, also inform perception of opportunities.

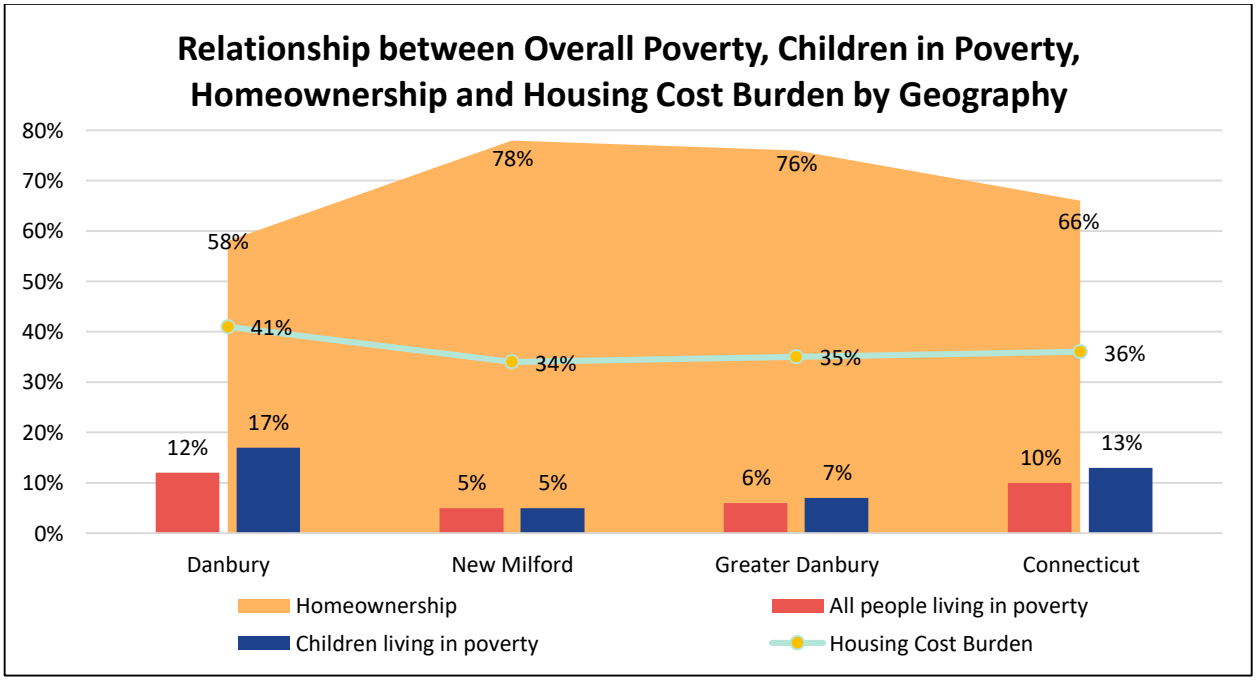
For neighborhoods, a higher proportion of homeownership means greater neighborhood stability. Greater neighborhood stability means greater opportunities for investment in infrastructure, such as schools, roads, public transportation, and green spaces, key elements for healthy living.

Owning a home is an investment. For many families, their home is their largest asset. However, historically, structures have been in place that prevent people of color and others from purchasing a home. Today, this historic structural inequity manifests in the financial assets that certain populations have been able to pass on to future generations. The security of knowing one has a home can also reduce chronic stress, a significant factor in developing chronic disease.

Housing is often the largest single monthly expense for households and should represent no more than 30% of a household's monthly income. When households spend more than 30% of their

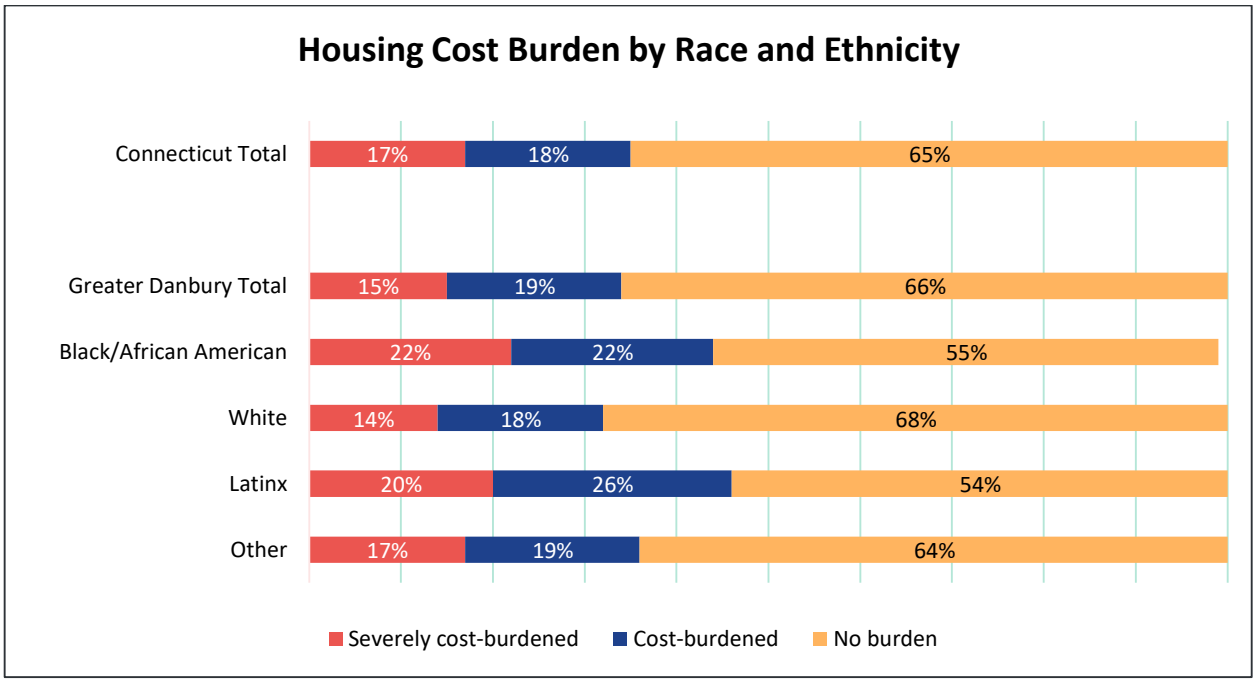
income on housing, they are considered housing cost-burdened. When housing costs consume more than 30% of a household budget, fewer resources are available for other necessities like food, transportation, and childcare.

The graph below demonstrates that communities with greater proportions of homeowners are associated with fewer children living in poverty and fewer cost burdened households. However, it is worth noting that more than 1 in 3 households are considered housing cost burdened throughout the area.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Among renter households in Greater Danbury, 49% are cost-burdened compared to 30% of owner households. Among Black/African American and Latinx householders (owner or renter), approximately 45% are cost-burdened compared to 32% of white householders.



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Education Access and Quality

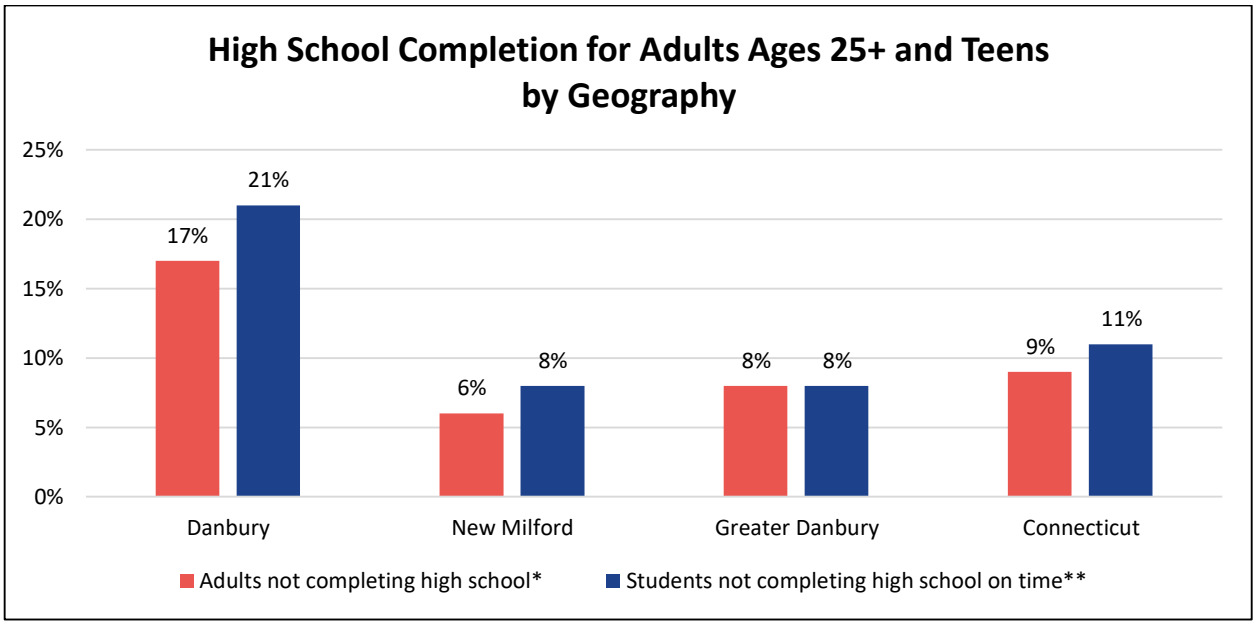
Education is one of the best predictors of good health and long lives. Availability of accessible, well-funded, and well-resourced public education opportunities and exposure to diverse employment pathways, such as in the healthcare and social services fields, build a strong foundation for young people and increase the opportunity for upward mobility, economic security, and better health.

Overall, people living in Greater Danbury are well educated and residents perceive high likeliness for school success and job opportunities post-graduation. However, disparities in the City of Danbury include 21% of high school students not graduating on time and 17% of adults not completing high school. These disparities likely reflect, in part, inequities among students of color, who make up a higher proportion of the Danbury population, are more likely to experience unfairly harsh discipline, and are less likely to graduate high school due to other structural barriers. Disparities may also reflect fewer community resources and investments in public education, a factor that is common in communities with more rental households.

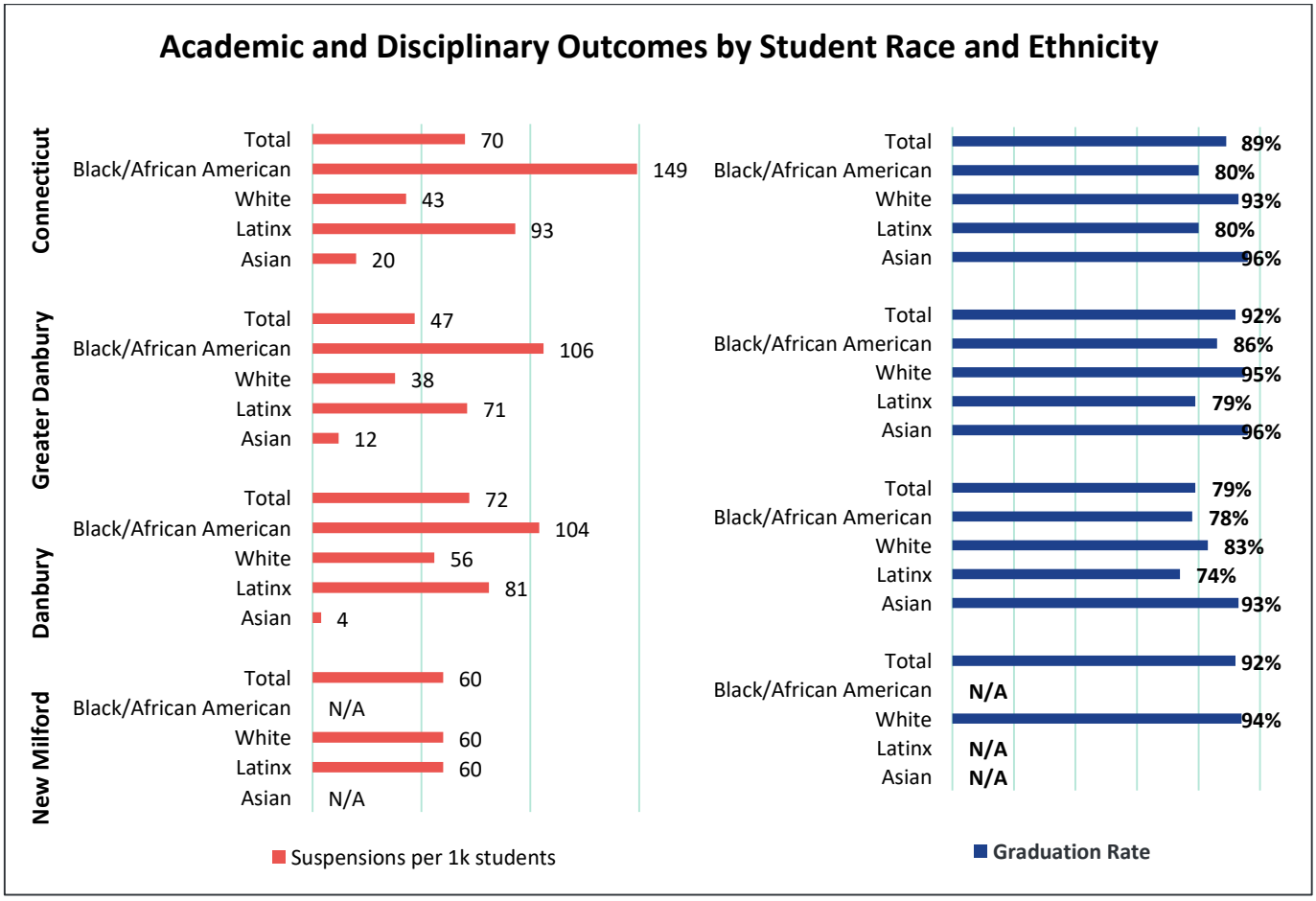
Community Wellbeing Survey Respondents Who Thought It Was "Almost Certain" or "Very Likely" That Young People in Their Neighborhood Could:

	Greater Danbury	Connecticut
Graduate from high school	100%	91%
Get a job with opportunities for advancement	72%	61%

Source: 2021 DataHaven Community Wellbeing Survey



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates* and Connecticut State Department of Education, 2018-2019**



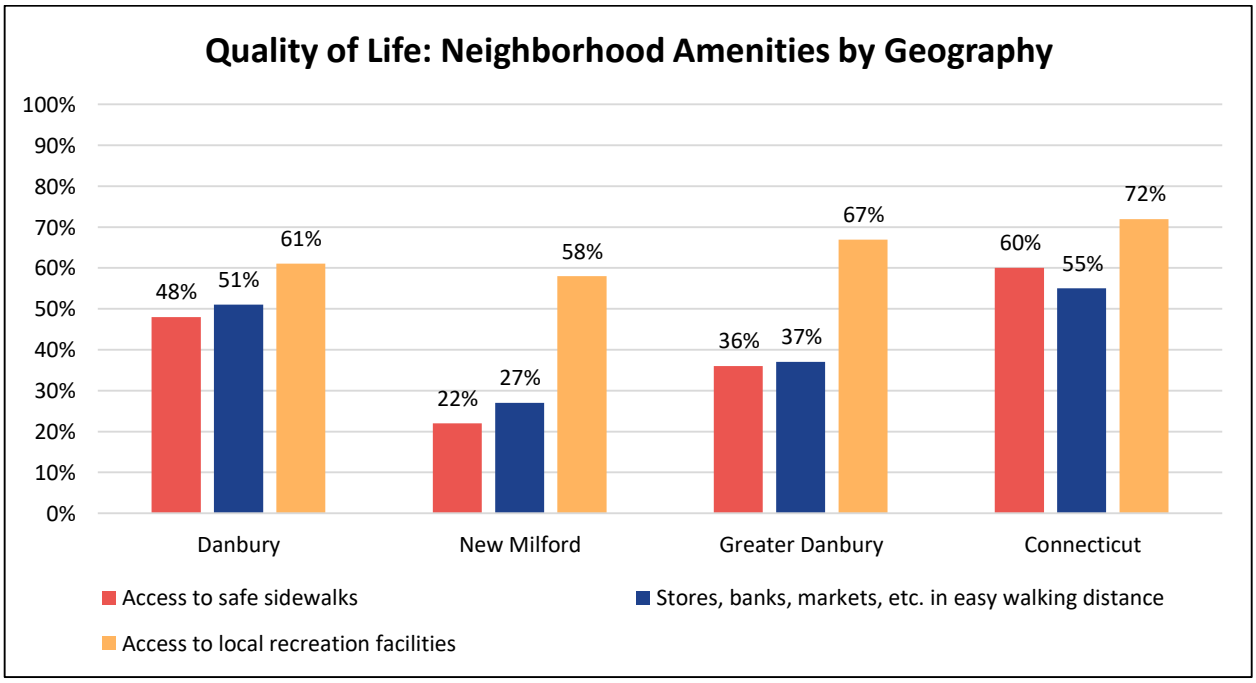
Source: Connecticut State Department of Education, 2018-2019 School Year

Neighborhood and Built Environment

In addition to the resources available in communities, the physical environment and infrastructure of neighborhoods impacts health. The availability of well-maintained roads and safe sidewalks, and access to recreation, stores, banks, and other amenities are important components for healthy living.

Access to safe sidewalks, recreation, and shopping is less available in the Greater Danbury area than Connecticut as a whole. Within the Greater Danbury area, the City of Danbury has better access to these amenities than New Milford, although fewer households in Danbury have a vehicle at home to access services not within walking distance.

Lack of transportation is an access barrier for many residents, largely along income lines. Among Community Wellbeing Survey respondents, nearly 20% of individuals in the low-income range and nearly 10% in the middle-income range stated that they stayed home when they needed or wanted to go someplace, because they did not have reliable transportation.



Source: DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey

No Vehicle at Home

Danbury	New Milford	Greater Danbury	Connecticut
9%	3%	5%	9%

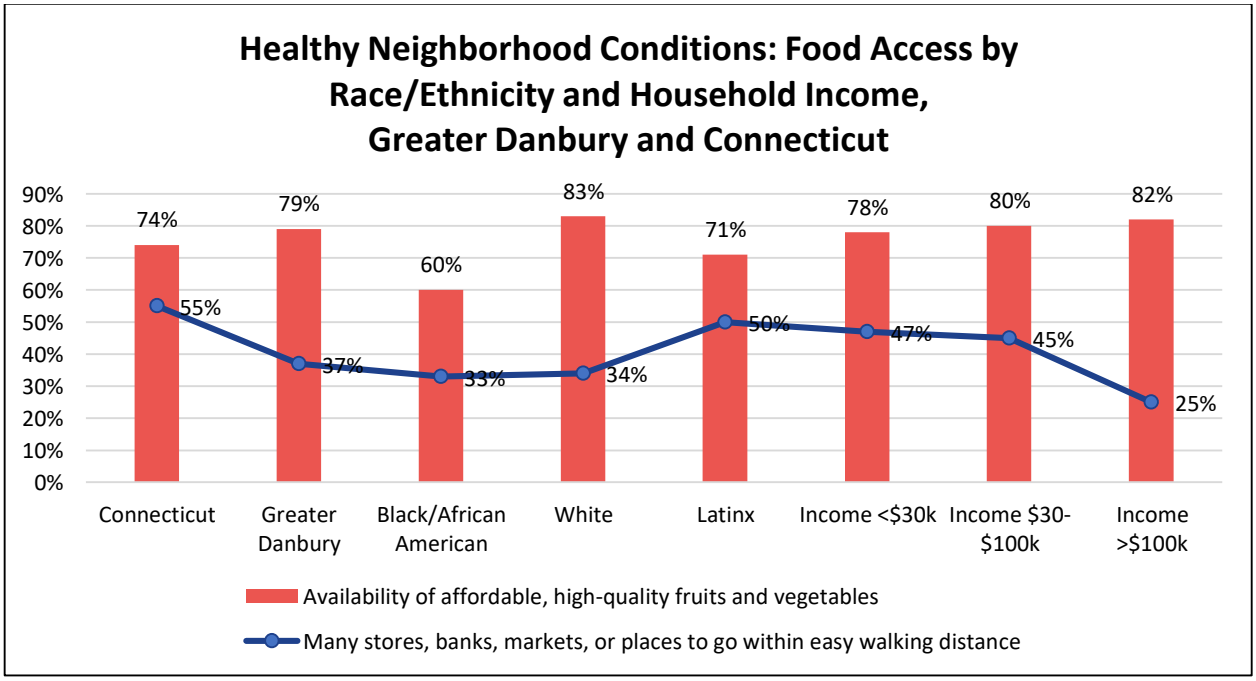
Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Community Wellbeing Survey Respondents Who Stayed Home When They Needed or Wanted to Go Someplace Because They Did Not Have Reliable Transportation

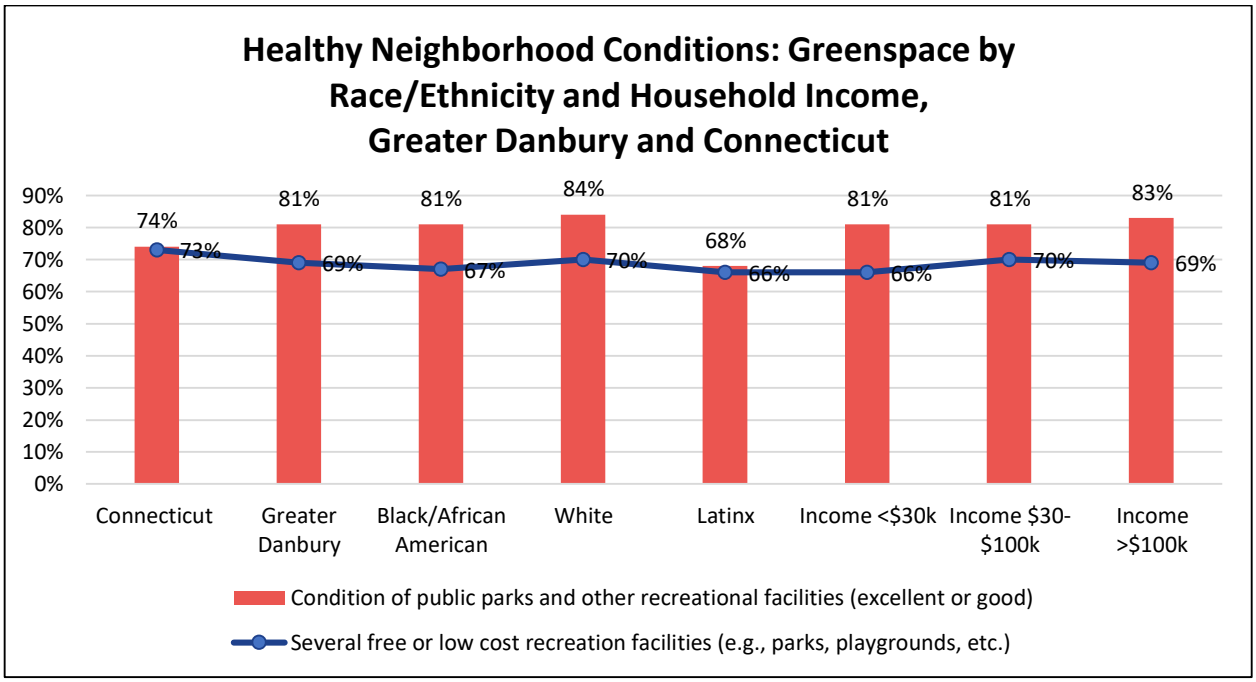
	Percent
Connecticut (All Adults)	13%
Greater Danbury (All Adults)	6%
Black/African American	15%
White	6%
Latinx	8%
Household income <$30k	19%
Household income $30-$100k	8%
Household income >$100k	2%

Source: 2021 DataHaven Community Wellbeing Survey

In addition to reporting lower access to community amenities, residents of Greater Danbury have wide variability in their perceptions of the quality of available amenities. Disparities are most evident among individuals with lower income and/or identifying as Black/African American or Latinx. Of note, 60% of Black/African American and 71% of Latinx residents perceived having access to affordable and high-quality fruits and vegetables compared to 83% of white residents. Latinx residents also perceived lower access to quality parks and other recreational facilities.

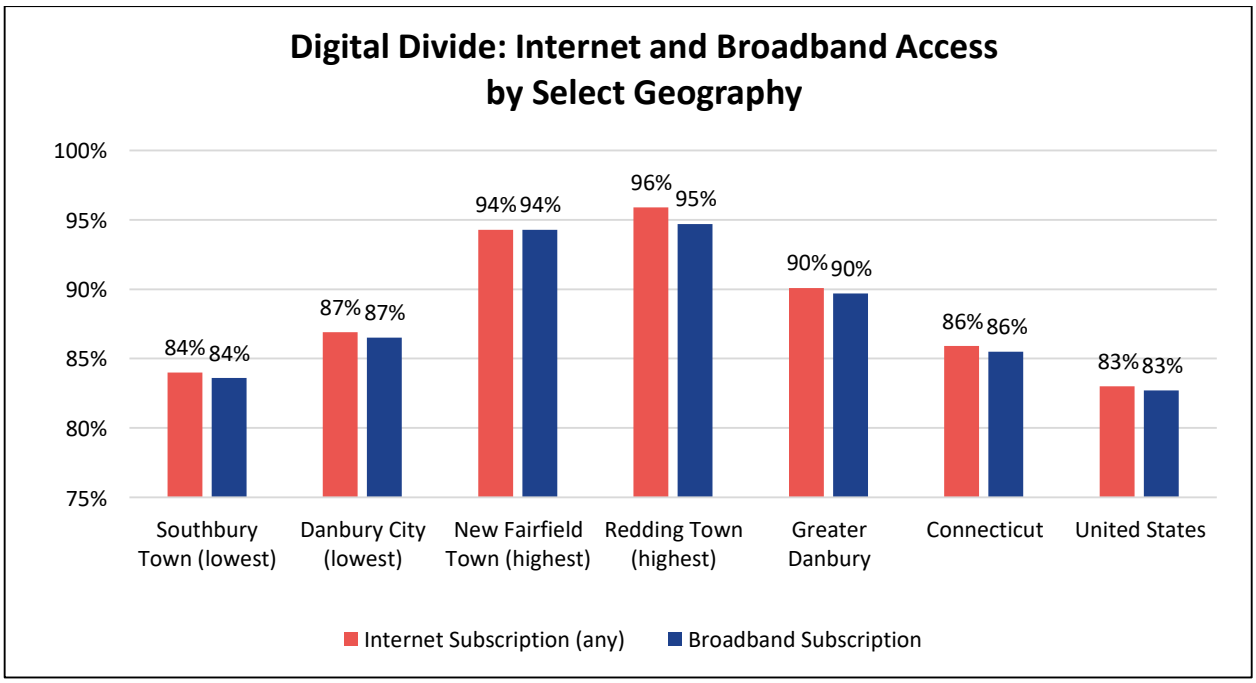


Source: 2021 DataHaven Community Wellbeing Survey



Source: 2021 DataHaven Community Wellbeing Survey

During COVID we were able to use technology to bring services to people in their homes, but we need to bridge the wide digital divide within our communities to effectively reach all residents. Within Greater Danbury, there is approximately a 10-point difference in access to internet and broadband between residents of Southbury or Danbury and residents of New Fairfield or Redding.



Source: US Census Bureau American Community Survey 2019 5-year estimates

Healthcare Access and Quality

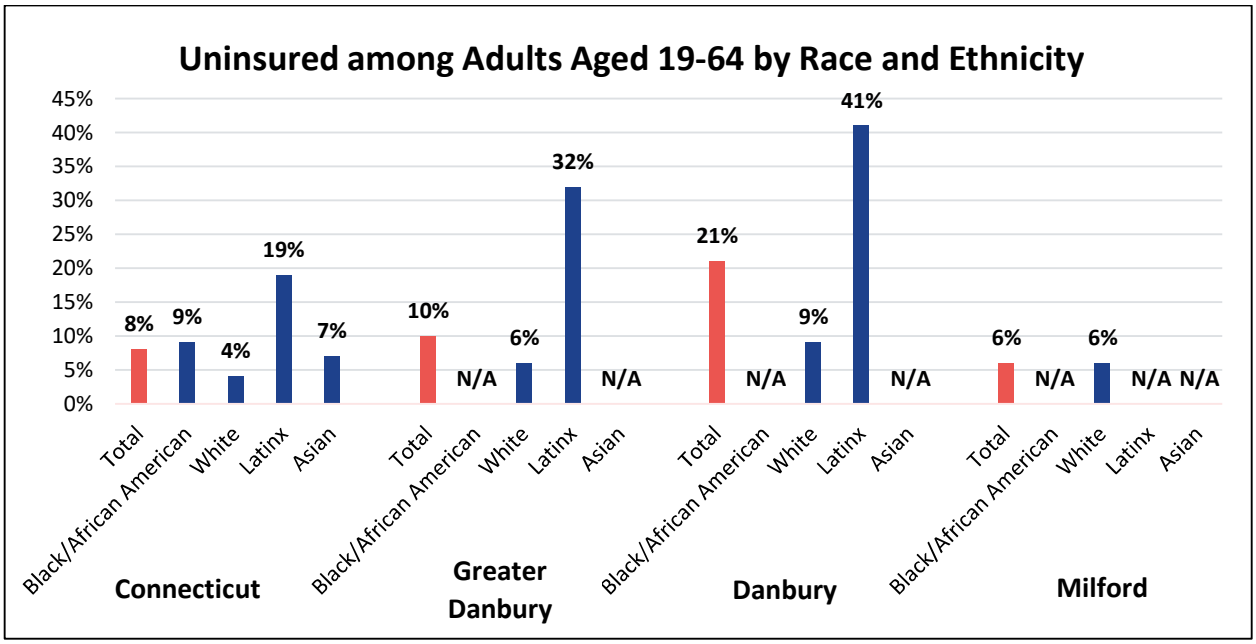
Lack of health insurance is a barrier to accessing healthcare. Without health insurance, residents face high costs for care when they need it, and they are less likely to receive preventive care. Preventive care, such as well visits and screenings, can detect small problems that can be treated more easily and effectively than if treatment is delayed. While many Greater Danbury residents have health insurance, 1 in 3 residents identifying as Latinx are lacking health insurance.

Having health insurance does not ensure access to healthcare when it is needed. Many other factors—like affordability, transportation, language, provider availability, and trust—keep people from receiving the care they need.

While Fairfield County overall is generally well served by healthcare providers, Danbury is a Health Professional Shortage Area (HPSA) for primary, dental, and mental health services. Neighboring Litchfield County has lower provider availability than the state and/or nation and is also a HPSA for mental healthcare. When viewed at the census tract-level, Danbury residents are less likely to receive regular physical or dental checkups when compared to neighboring communities.

Additional disparities in accessing healthcare are evidenced by Community Wellbeing Survey results. Across Greater Danbury, 12% of Latinx respondents reported not have a personal doctor or healthcare provider and 24% reported not visiting a dentist within the past two years. Access disparities among Latinx residents may be exacerbated by language barriers and lack of bilingual providers or interpreter services. Approximately 37% of Greater Danbury Latinx residents are considered linguistically isolated, characterized as speaking English less than "very well." Approximately 27% of Asian residents are also considered linguistically isolated.

While only 4% of Black/African American respondents reported not having a personal doctor or healthcare provider, 37% reported putting off or postponing needed medical in the past 12 months. This finding may reflect a multitude of factors, including experiences of discrimination. Twenty-six percent of Black/African American respondents stated that when seeking healthcare, they were treated with less respect or received services that were not as good as what other people get.



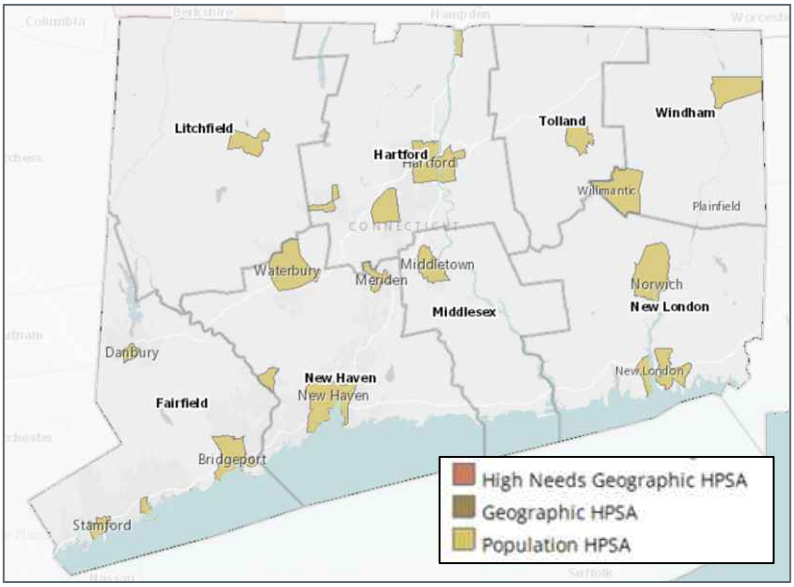
Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

Healthcare Provider Availability: Provider Rates per 100,000 Residents

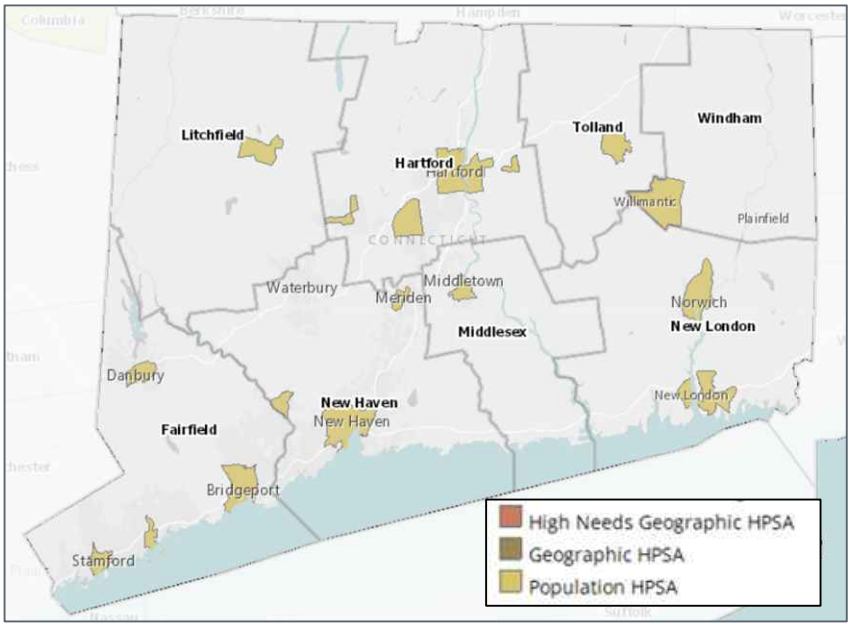
	2019 Primary Care Physicians	2020 Dentists	2021 Mental Health Providers
Fairfield County	94.3	94.0	338.4
Litchfield County	58.2	66.3	287.8
Connecticut	85.2	87.1	439.2
United States	76.3	71.4	285.7

Source: Health Resources and Services Administration and Centers for Medicare and Medicaid Services

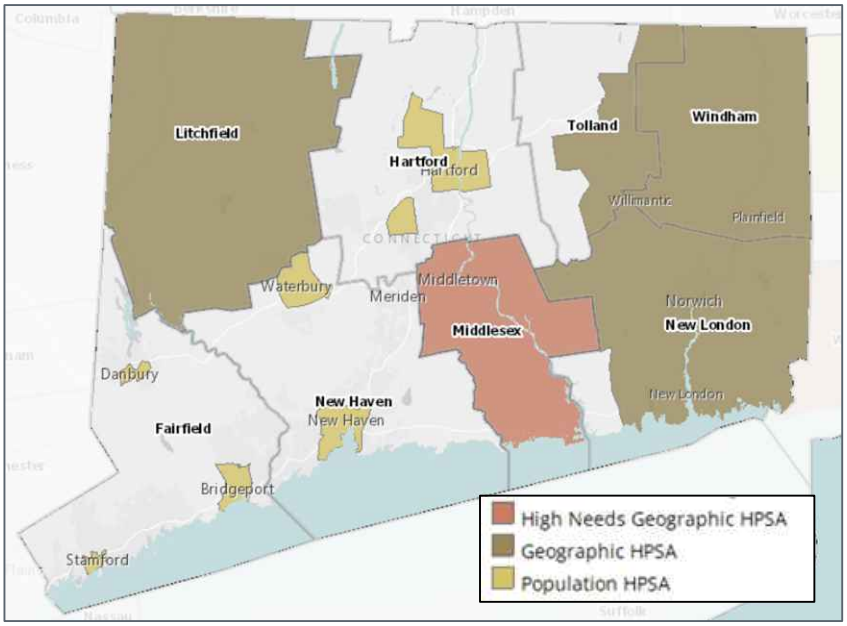
Connecticut: Primary Care Health Professional Shortage Areas



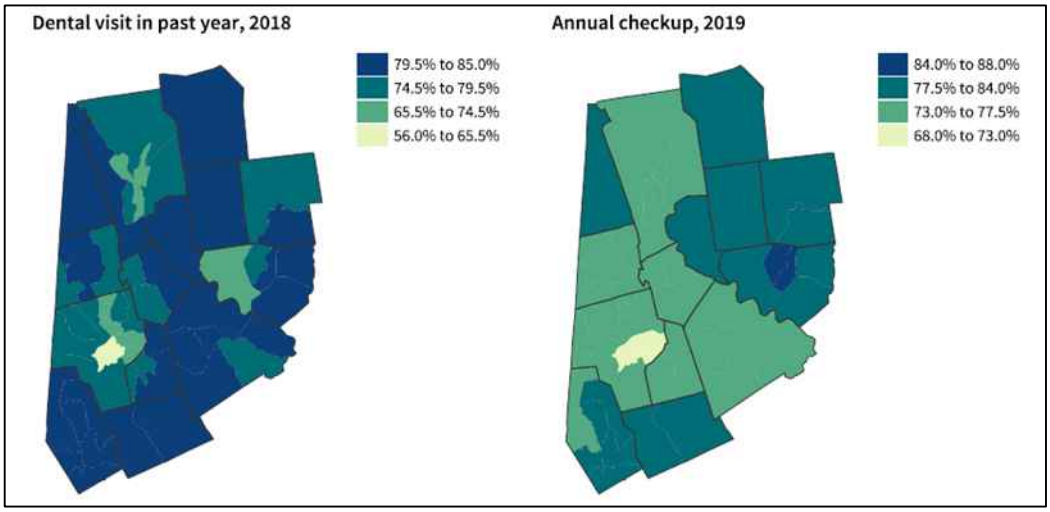
Connecticut: Dental Health Professional Shortage Areas



Connecticut: Mental Healthcare Health Professional Shortage Areas



Greater Danbury Preventive Care Measures, Share of Adults by Census Tract

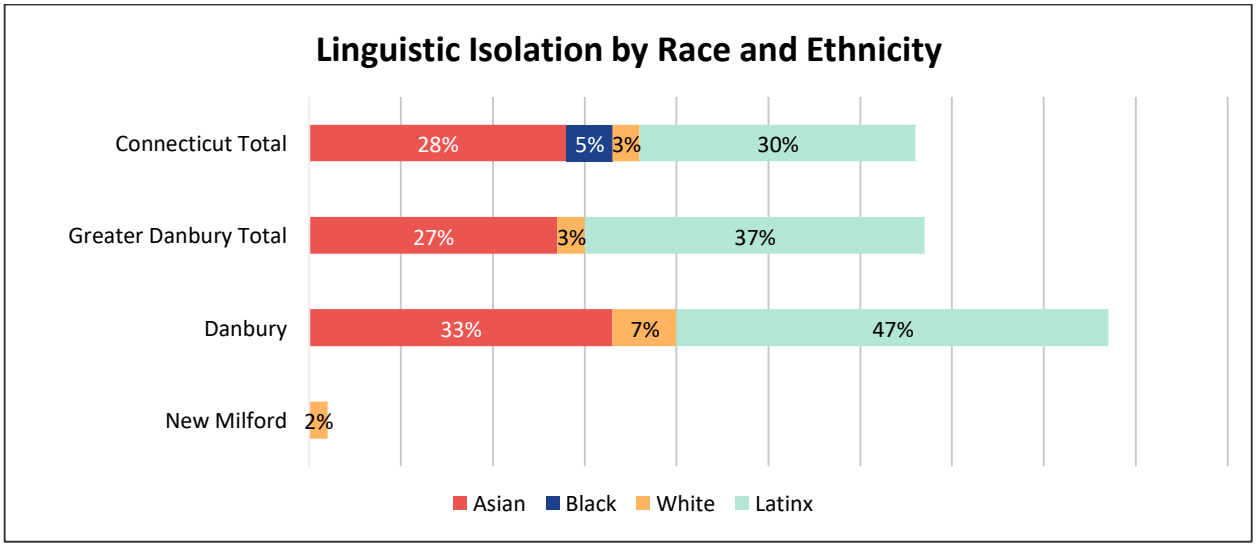


Source: PLACES Project. Centers for Disease Control and Prevention

Healthcare Access among Adults in Greater Danbury

	No personal doctor or healthcare provider	Put off or postponed needed medical care in past 12 months	Saw a dentist more than two years ago
Connecticut (All Adults)	11%	30%	13%
Greater Danbury (All Adults)	9%	31%	13%
Black/African American	4%	37%	7%
White	9%	31%	11%
Latinx	12%	32%	24%
Household income <$30k	2%	31%	29%
Household income $30-$100k	16%	31%	14%
Household income >$100k	6%	34%	8%

Source: 2021 DataHaven Community Wellbeing Survey



Source: DataHaven analysis (2021) of US Census Bureau American Community Survey 2019 5-year estimates

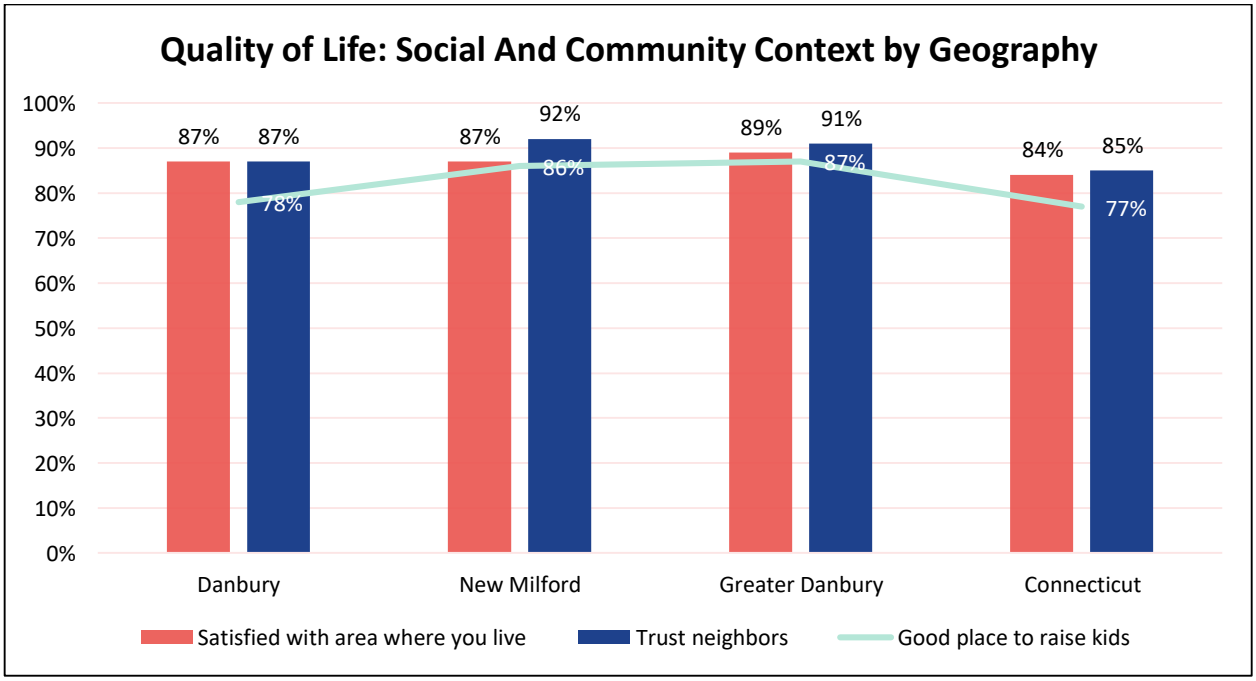
Social and Community Context

As much as communities are shaped by those who live there, people are impacted by the social context of the places where they live. Social context includes family, neighborhoods, school, or work environments, political or religious systems, and other interpersonal infrastructures within a community. People's lived experiences within their social context play a significant role in good health and wellbeing.

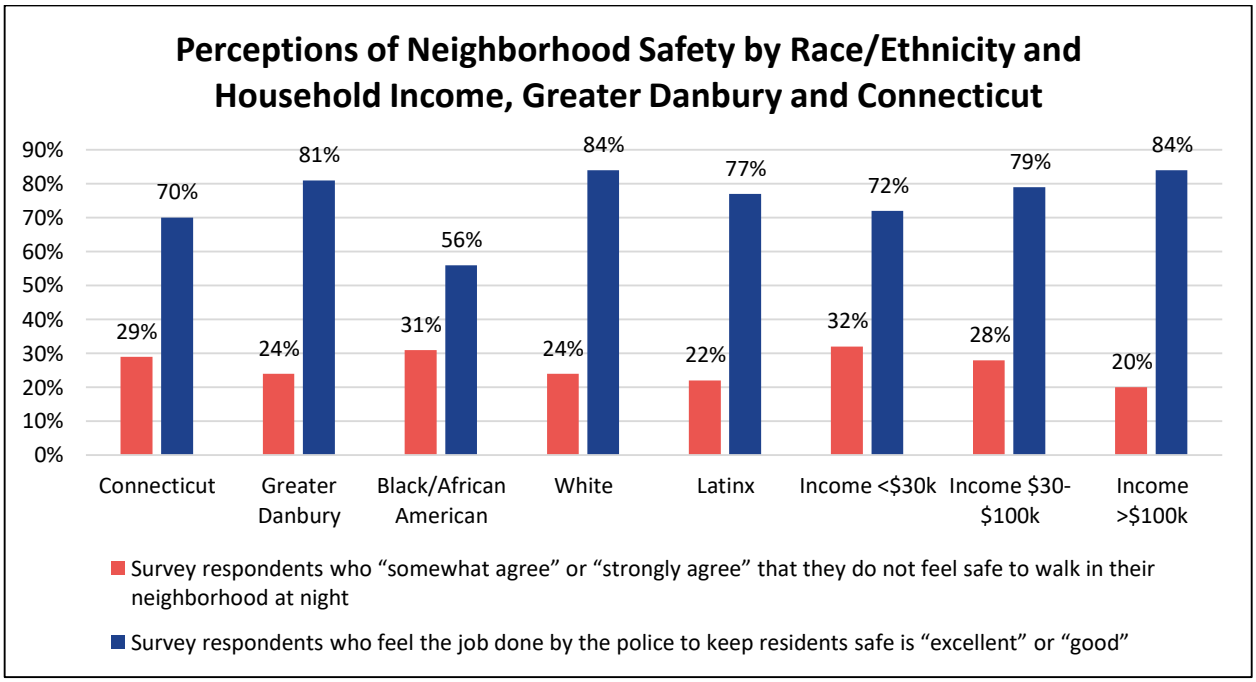
Feeling like you belong, are appreciated, and are valued in your community reinforces protective health factors that help people and communities overcome adversity. Experiences of poverty, violence, poor housing, racism, and discrimination create Adverse Community Environments and chronic stress that perpetuate trauma and increase Adverse Childhood Events (ACEs) that have a lasting impact on people and their communities.

Residents of Greater Danbury, including Danbury and New Milford, have overall high perceived satisfaction in where they live, as well as overall positive perceptions of neighborhood safety, relative to the state. However, these experiences are not shared by all residents. Black/African American residents are less likely to feel safe walking in their neighborhood at night and/or that police are doing a "good" or "excellent" job of keeping residents safe. These findings are consistent with experiences of discrimination among Black/African American residents in interacting with police, as well as in other environments like the workplace or healthcare setting.

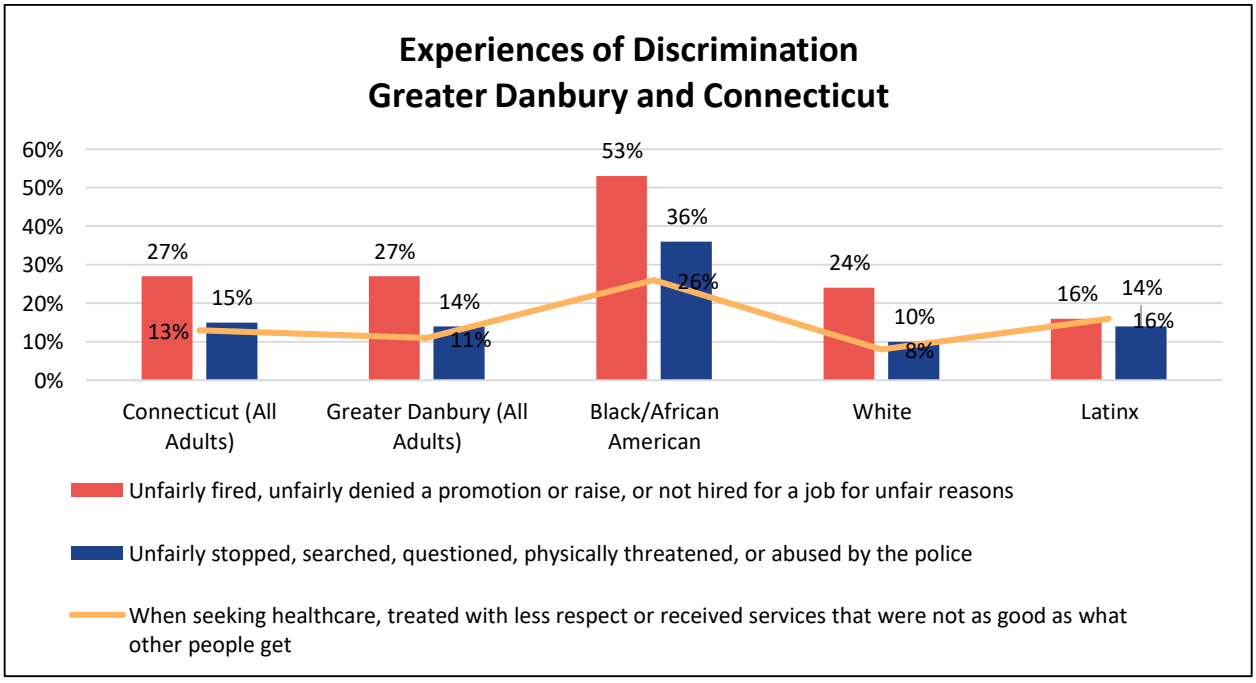
Disparities in safety and discrimination along race lines indicate an opportunity to examine policies and procedures that can be amended to create greater equity of access and inclusion.



Source: DataHaven analysis (2021) of 2015, 2018, and 2021 DataHaven Community Wellbeing Survey



Source: 2021 DataHaven Community Wellbeing Survey



Source: 2021 DataHaven Community Wellbeing Survey

Life Expectancy

Life expectancy is an overall measure of health and social equity within a community. Structural factors, including housing quality and affordability, environmental conditions, employment, education, transportation, food security, and experience of racism, all play a role in impacting the

quality and length of lives. The average life expectancy in Greater Danbury is 82 years, compared to 81.4 years in Danbury, 81 years in New Milford, and 80.3 years statewide.

The Community Need Index (CNI) is a zip code-based index of community socioeconomic need. The CNI is strongly linked to variations in community healthcare needs, and as such, represents a useful planning tool for prioritization of geographic interventions. The CNI scores zip codes on a scale of 1.0 to 5.0, with 1.0 indicating a zip code with the least need and 5.0 indicating a zip code with the most need compared to the US national average of 3.0. The CNI weights, indexes, and scores zip codes by socioeconomic barriers, including income, culture, education, insurance, and housing.

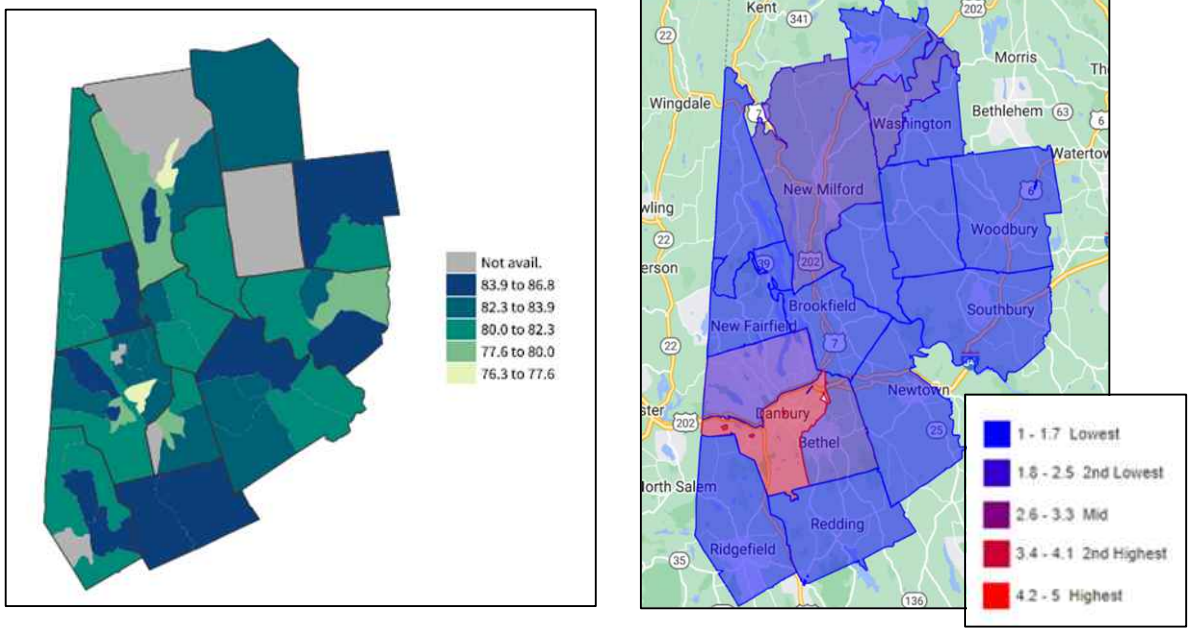
Within Greater Danbury, Danbury zip code 06810 has the highest CNI score of 4.0. The next highest CNI score within the region is in Danbury zip code 06811 at 2.4. The CNI score, reflective of community socioeconomic barriers, correlates with wide differences in life expectancy in Danbury relative to other neighboring communities.

Average Life Expectancy (years)

Danbury	New Milford	Greater Danbury	Connecticut
81.4	81.0	82.0	80.3

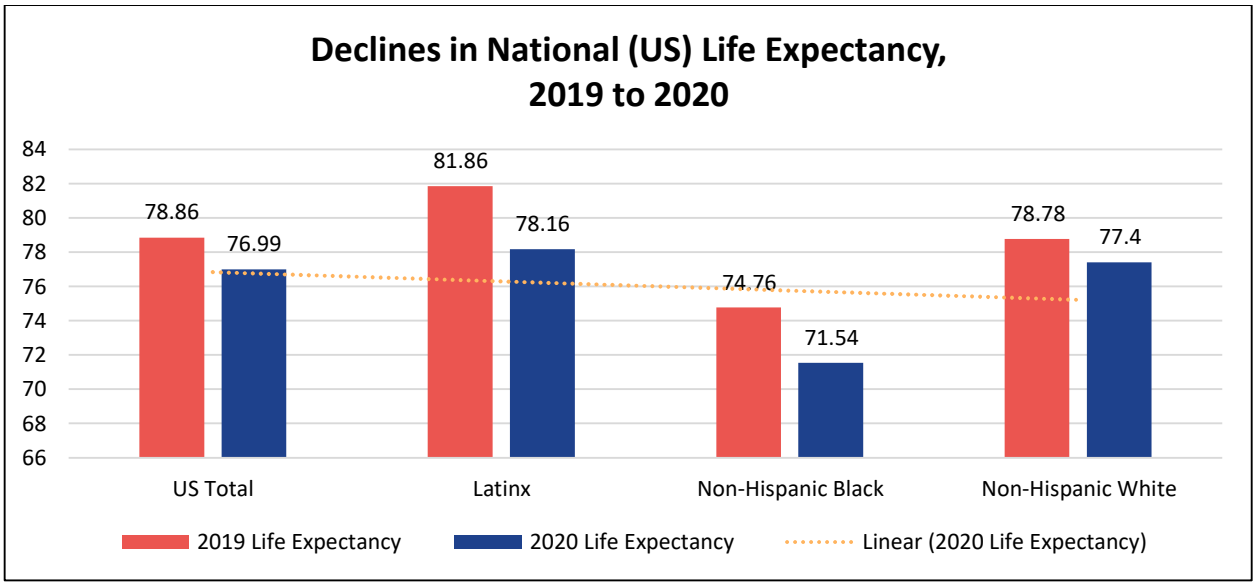
Source: Small-Area Life Expectancy Estimates Project: Life Expectancy Estimates Files, 2010–2015

2015 Life Expectancy by Census Tract and 2021 Community Need Index by Zip Code

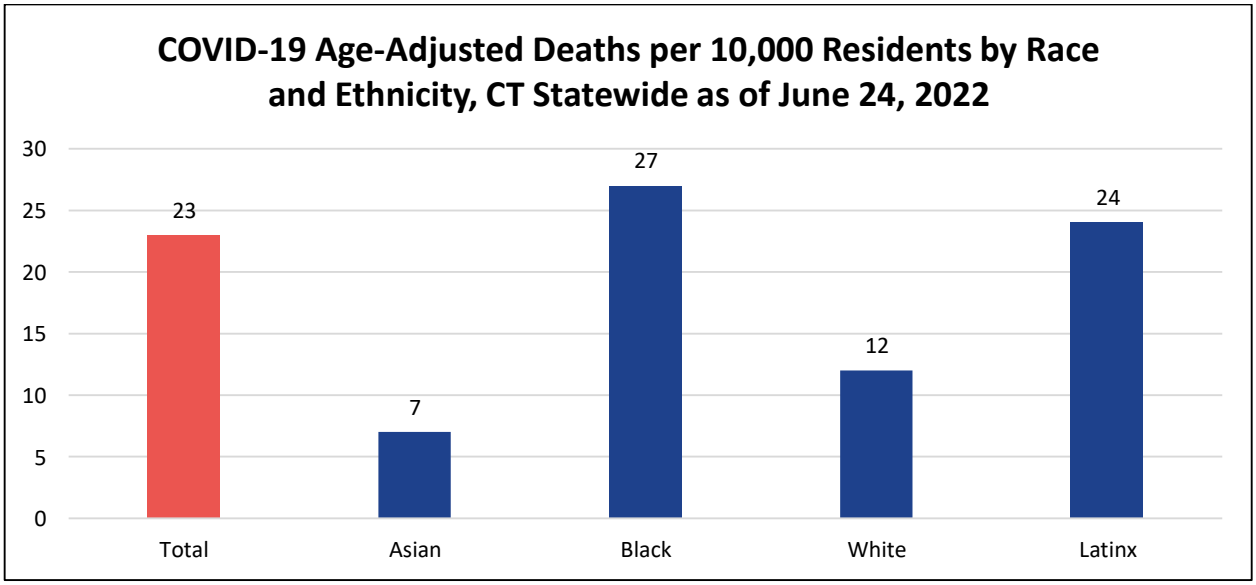


The COVID-19 pandemic both highlighted and deepened socioeconomic and health inequities and exposed disparities within the health and social services systems. COVID-19 has not impacted all people equally. Rather, certain structural issues—population density, low income, crowded workplaces, etc.—contribute to higher levels of spread and worse outcomes from COVID-19, and potentially other infectious diseases.

The graph below shows that while overall life expectancy decreased nationally from 2019 to 2020, it decreased by more than 3 years for Black/African American and Latinx residents compared to 1.4 years for white residents. This finding is also reflected in disproportionately higher death rates due to COVID-19 among people of color.



Source: Centers for Disease Control and Prevention

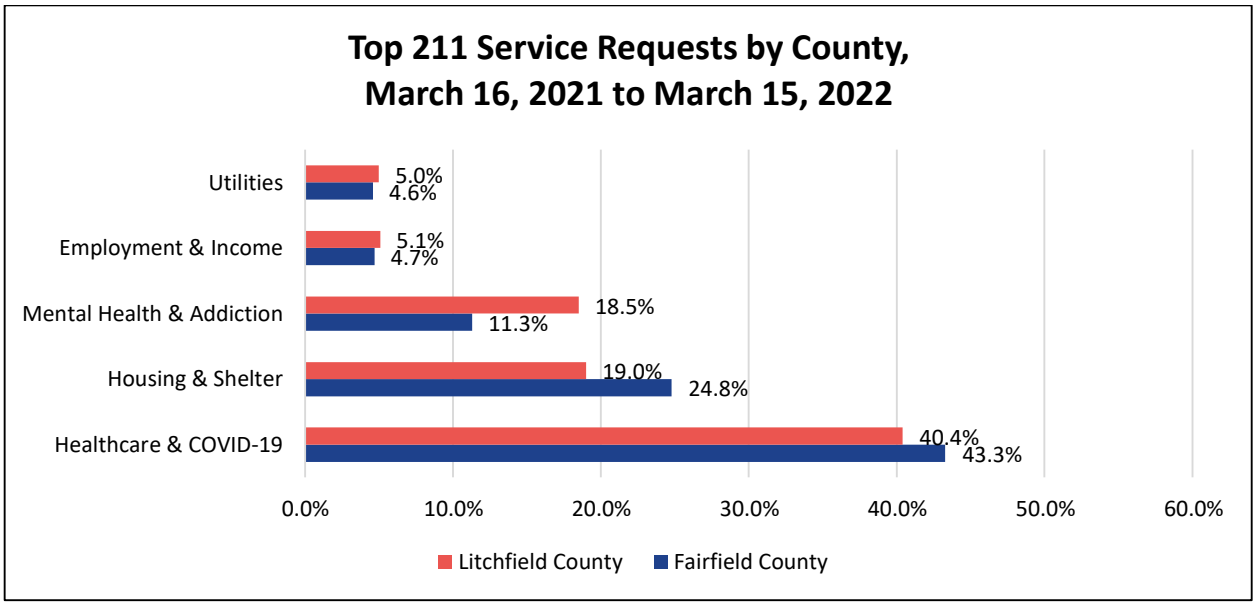


Source: Connecticut Department of Public Health

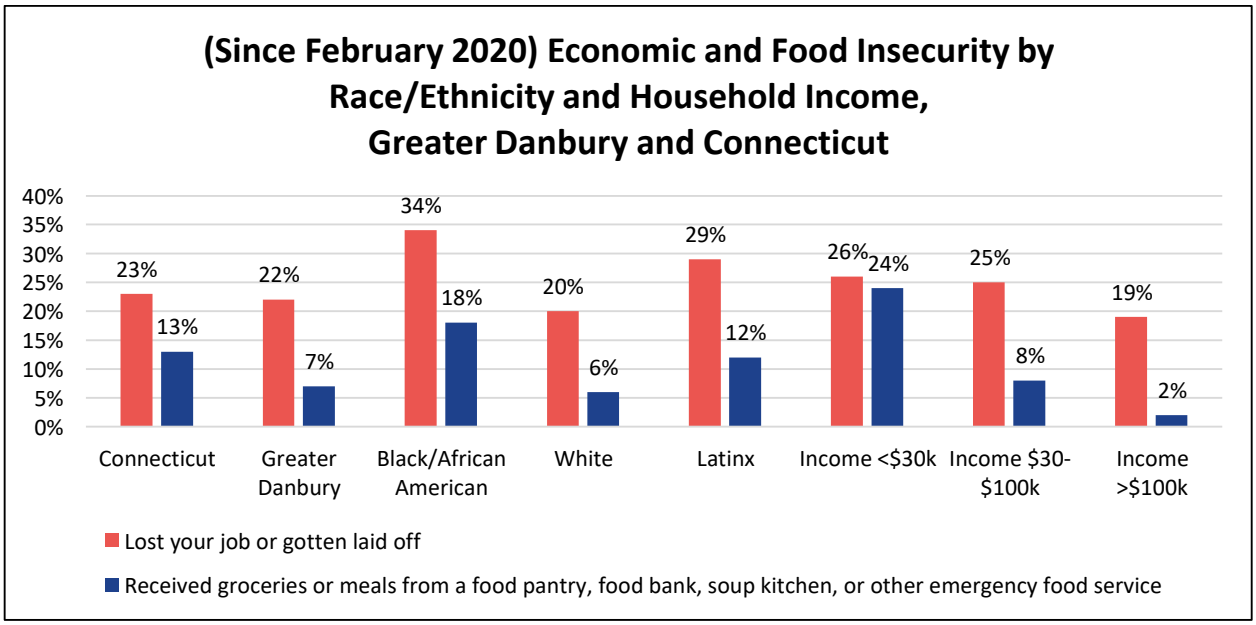
United Way 211 is a 24/7 go-to resource that helps people across the nation find local resources they need. 211 is the most comprehensive source of information about local resources and services in the country. The following graph depicts the top 211 service requests by Fairfield and Litchfield County residents during the COVID-19 pandemic, from March 16, 2021, to March 15, 2022.

The COVID-19 pandemic had deep economic and mental health impacts. Among Fairfield and Litchfield County residents, the top 211 service requests, after healthcare and COVID-19, were housing and shelter and mental health and addiction.

Community Wellbeing Survey results demonstrated that the economic impacts of the pandemic were disproportionately felt by low-income households and communities of color. Within Greater Danbury, 34% of Black/African American respondents reported being laid off or losing their job compared to 20% of white respondents. Approximately 24% of low-income households received food assistance compared to 8% of mid-income and 2% of high-income households.



Source: United Way 211



Source: 2021 DataHaven Community Wellbeing Survey

Community Health Needs

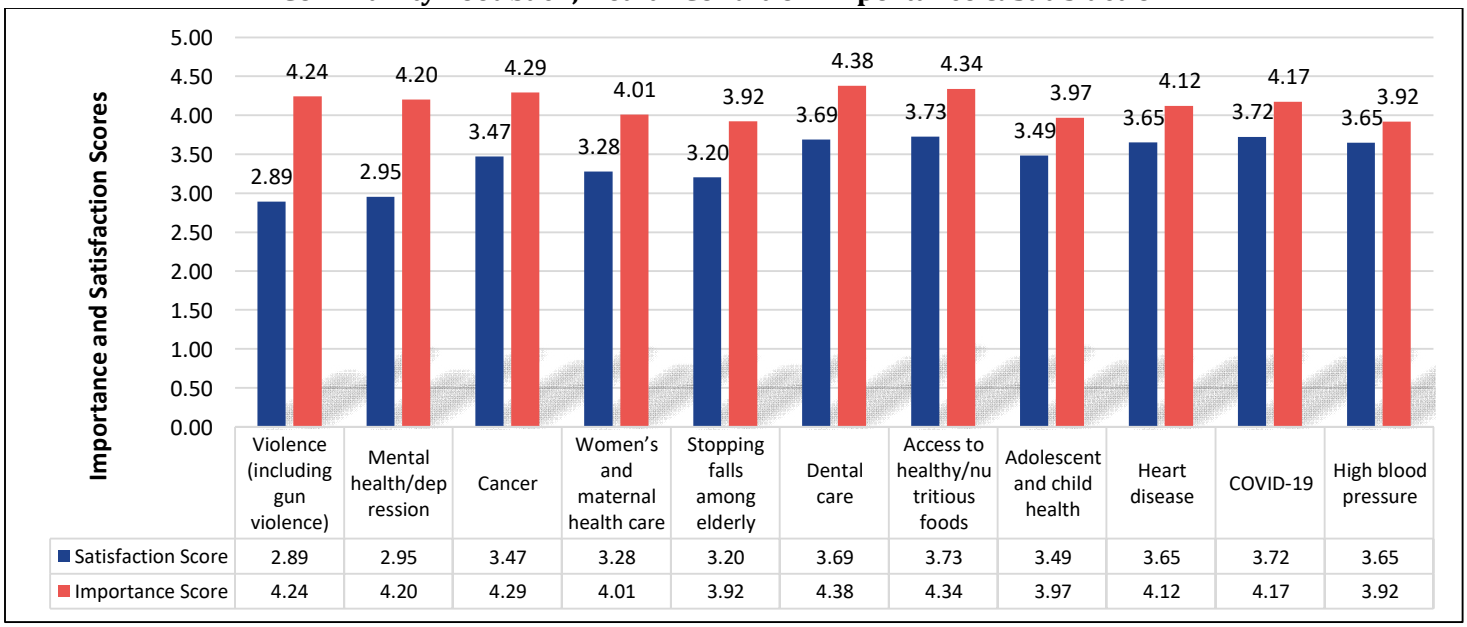
To determine community health priorities, we must consider what the data are telling us, and more importantly, what our community sees as the most pressing health concerns.

Community engagement was a central part of the CHNA. We invited wide participation from community stakeholders and organizations, including experts in health, social service representatives, advocates, community champions, policy makers, and lay community residents. These stakeholders were asked to weigh in on data findings, share their perspectives on challenges facing our community, and provide input on collaborative solutions.

The following graph depicts community feedback garnered from the GNYHA 2022 Community Health Survey, including perceived importance of community health conditions and satisfaction with current neighborhood services to address these conditions. Results are presented as aggregate importance and satisfaction scores on a scale of 1 (not at all) to 5 (extremely). The "Gap" represents the difference between importance and satisfaction scores.

The results demonstrated high perceived importance for issues like violence, mental health, women's, and maternal healthcare, and falls among elderly. Violence and mental health were further prioritized based on lower perceived satisfaction in available services to address these needs. This finding was generally supported by other CHNA research, which found that mental health concerns were largely exacerbated by the pandemic, and that residents have varying perceptions of community safety, with evident disparities among lower-income and communities of color.

What you told us: Danbury Hospital & New Milford Hospital Service Area
Community Feedback, Health Condition Importance & Satisfaction



	Violence (including gun violence)	Mental health/depression	Cancer	Women's and maternal health care	Stopping falls among elderly	Dental care	Access to healthy/nutritious foods	Adolescent and child health	Heart disease	COVID-19	High blood pressure
Satisfaction Score	2.89	2.95	3.47	3.28	3.20	3.69	3.73	3.49	3.65	3.72	3.65
Importance Score	4.24	4.20	4.29	4.01	3.92	4.38	4.34	3.97	4.12	4.17	3.92
Gap*	1.35	1.25	0.82	0.73	0.72	0.69	0.61	0.48	0.47	0.45	0.27

Source: Greater New York Hospital Association CHNA Survey, 2022

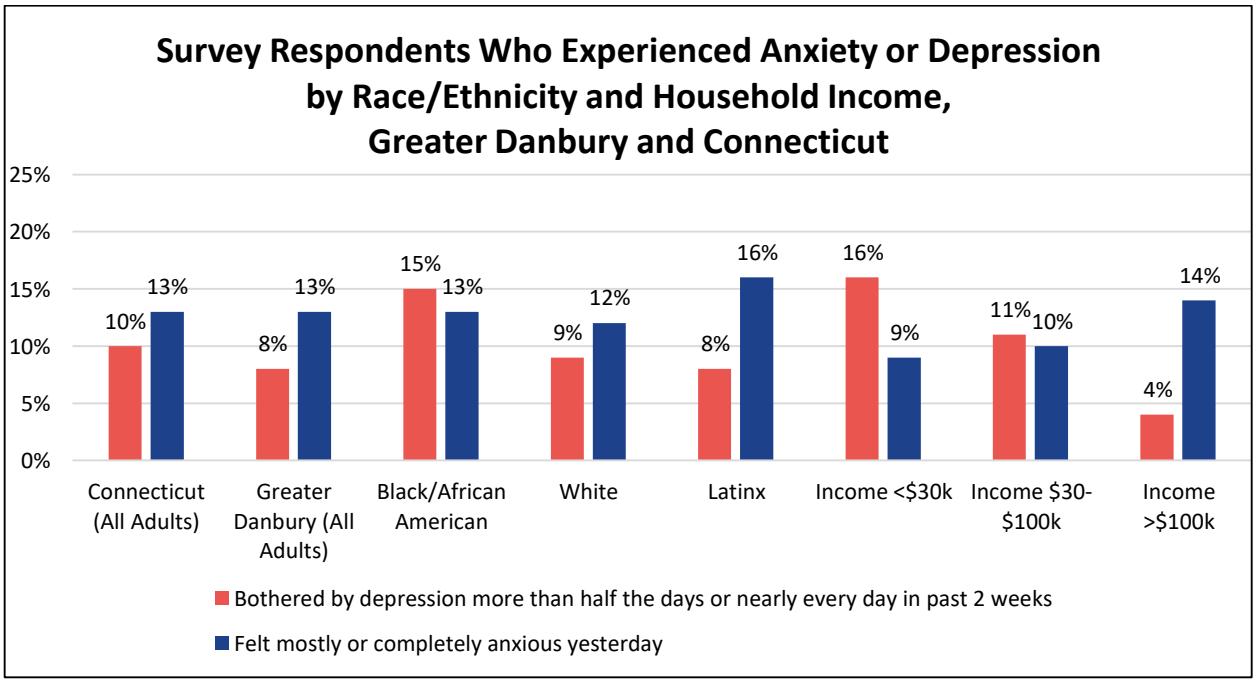
*Difference between Importance Score and Satisfaction Score

The following report sections further highlight data relative to specific health areas like behavioral health, health risk factors and chronic disease, and maternal and child health.

Behavioral Health

Mental health concerns like depression and anxiety can be linked to social determinants like income, employment, and environment, and can pose risks of physical health problems, including by complicating an individual's ability to keep up other aspects of their healthcare. Overall, 13% of Greater Danbury adults report experiencing anxiety regularly and 8% report being bothered by depression. Consistent with having a higher likelihood of experiencing chronic stress related to health and social inequities and/or experiences of racism and discrimination, feelings of anxiety and depression are higher among Black/African Americans and individuals with lower income.

The COVID-19 pandemic exacerbated many behavioral health concerns, particularly for youth, due to stress, isolation, and lost learning, among other factors. Before the pandemic, approximately 31% of Connecticut youth reported feeling sad or depressed and 7% had attempted suicide. About one-quarter of youth used one or more substances like tobacco, alcohol, or marijuana.



Source: 2021 DataHaven Community Wellbeing Survey

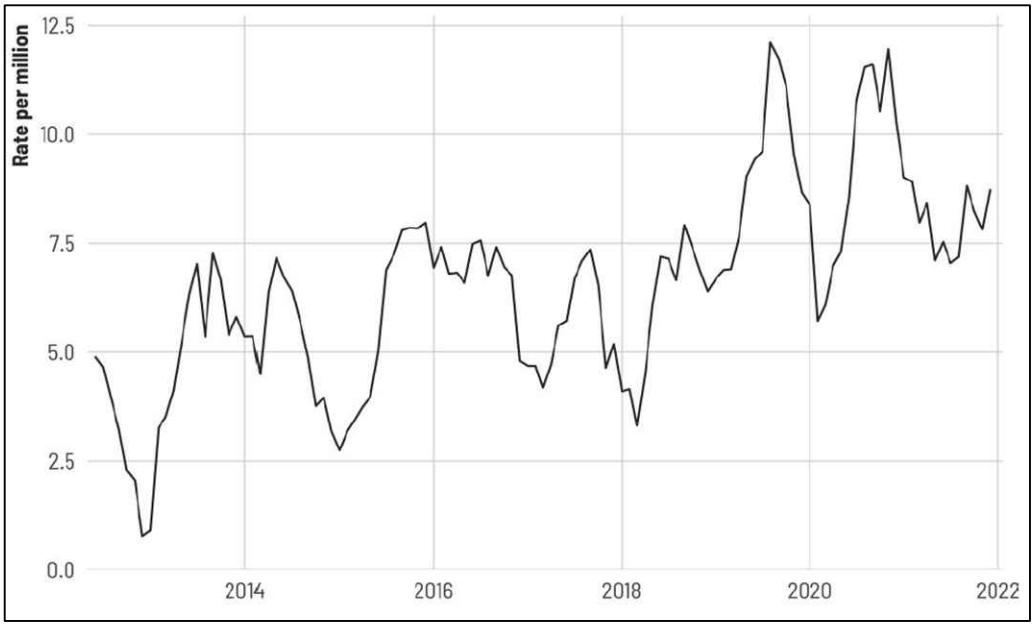
2019 Youth Measures of Mental Health and Substance Use

	Feel Consistently Sad or Depressed	Attempted Suicide	E-cigarette Use (last 30 days)	Alcohol Use (last 30 days)	Marijuana Use (last 30 days)
Connecticut	30.6%	6.7%	27.0%	25.9%	21.7%
US	36.7%	8.9%	32.7%	29.1%	21.7%

Source: CDC Youth Risk Behavior Survey

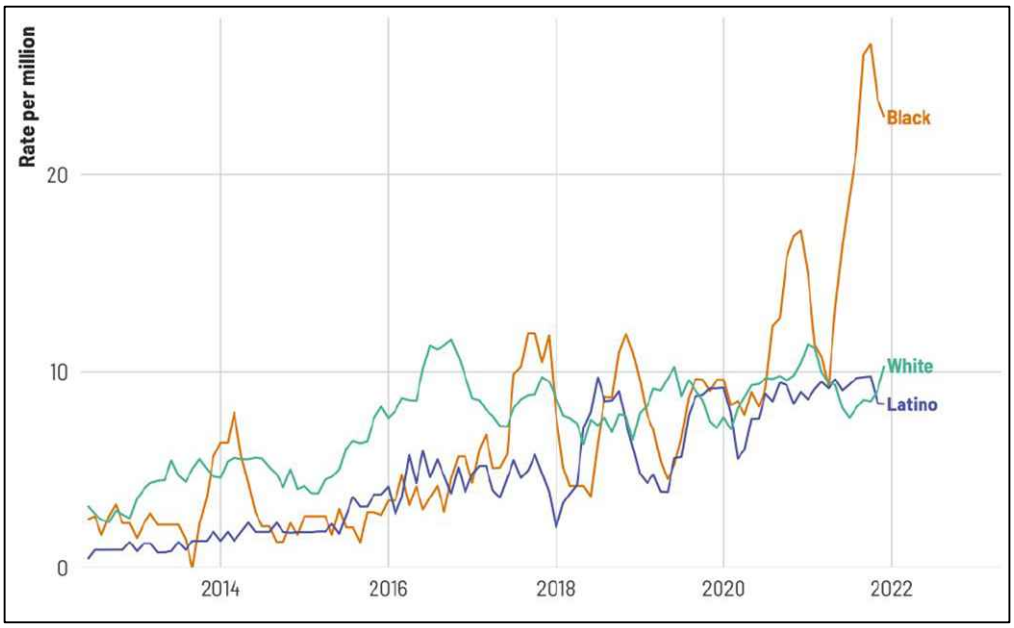
Like other states, Connecticut has seen a rise in drug overdose deaths in the last several years. In 2020, Connecticut saw an average of 113 overdose deaths per month, up from 60 in 2015. White residents long comprised the bulk of these deaths, but as overall overdose death rates have increased, an increasing share of those deaths have been people of color.

Age-Adjusted Accidental Overdose Death per 1 Million Residents, Greater Danbury Hospital Service Area 2012-2021 6-Month Rolling Mean



Source: DataHaven analysis (2021)

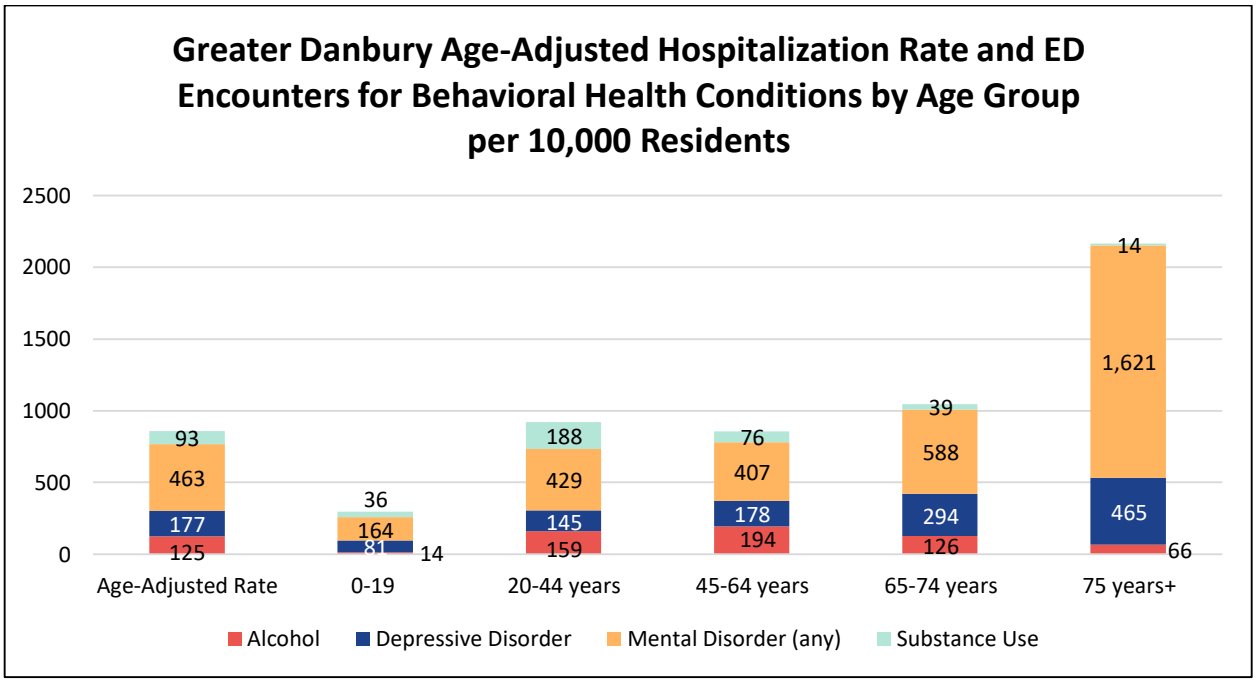
Age-adjusted Accidental Overdose Death per 1 Million Residents by Race and Ethnicity as Available, Fairfield County 2012-2021 6-Month Rolling Mean



Source: DataHaven analysis (2021)

Behavioral health conditions are considered ambulatory care sensitive (ACS) conditions, which if effectively managed in an outpatient setting, should not be the primary reason for a hospital visit. The following graph depicts hospital and emergency department (ED) encounters for select behavioral health conditions, as provided by the Connecticut Hospital Association, and analyzed by DataHaven.

Across all age groups, mental disorders are the most prevalent behavioral health conditions that patients seek help for at the hospital, and the rate of visits is more than three times as high for older adults aged 75 or over compared to younger adult populations. It is worth noting that substance use disorder-related visits, including alcohol and drugs, follow an opposite trend, with increasing rates among younger adult populations.

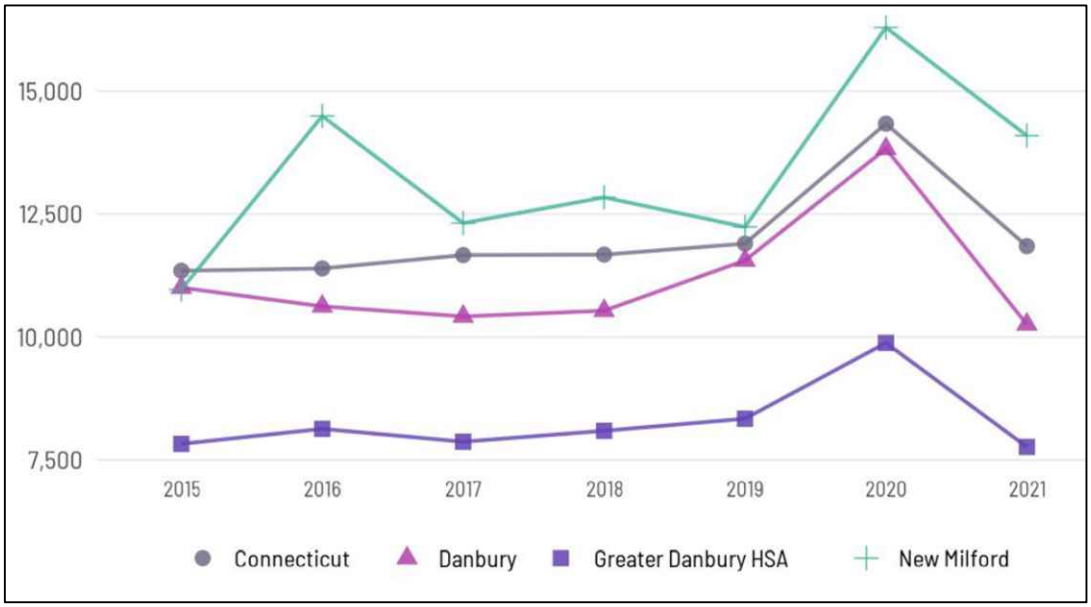


Source: DataHaven analysis (2021) of 2018-2021 Connecticut Hospital Association CHIME

Health Risk Factors and Chronic Disease

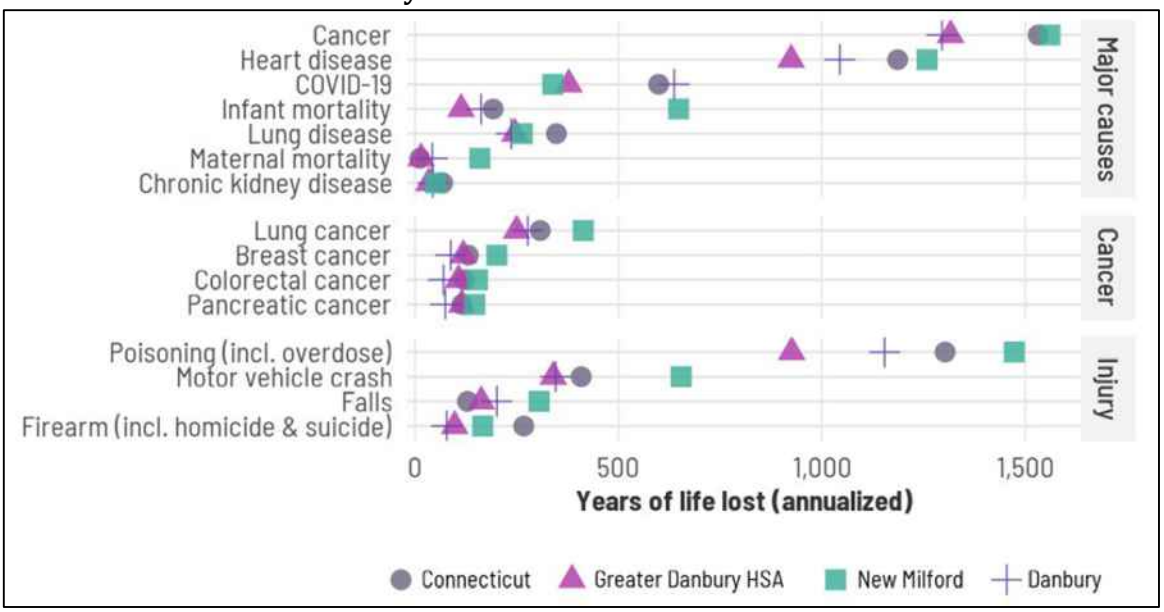
All-cause mortality spiked in 2020 due to the COVID-19 pandemic. In Danbury, nearly all of the increase in mortality in 2020 is attributable to COVID-19 deaths. In 2020 in Danbury, COVID-19 mortality rates were similar to mortality rates from heart disease and cancer, at about 2-3 times the rate of the surrounding region. Excluding COVID-19, cancer, heart disease, and poisonings (including overdose) were the leading causes of premature death in the region from 2015 to 2021.

Age-Adjusted, All-Cause Mortality per 1 Million Residents 2015-2021



Source: DataHaven analysis (2021)

Years of Potential Life Lost Before Age 75 per 100,000 Residents by Cause of Death 2015-2021

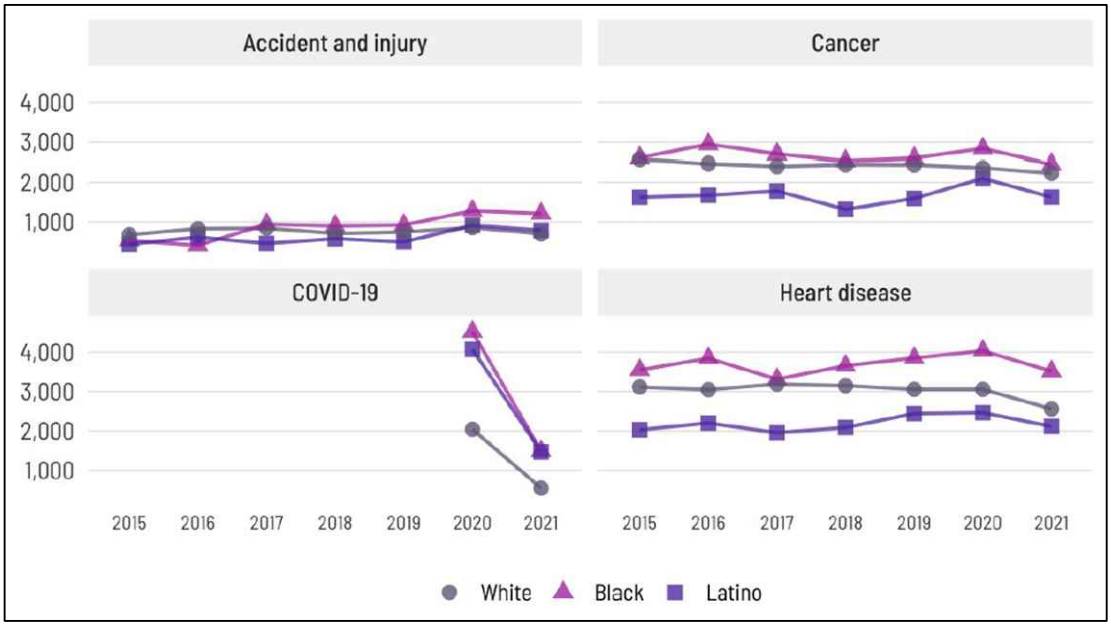


Source: DataHaven analysis (2021)

Relative to the top causes of death in the region, residents of color experience higher mortality rates. This disparity is most evidenced by heart disease death rates. Danbury overall also reports a disproportionately high burden of chronic disease relative to surrounding communities, as evidenced by hospital and ED encounters data. A risk ratio assessment, a measure of the risk of an event happening to one group compared to the risk of the same event happening to another group,

found that Danbury patients were about twice as likely to seek hospital services for uncontrolled diabetes or type 2 diabetes relative to surrounding communities.

Age-Adjusted Rates of Death per 1 Million Residents for Top Causes of Death by Race and Ethnicity, Fairfield County



Source: DataHaven analysis (2021)

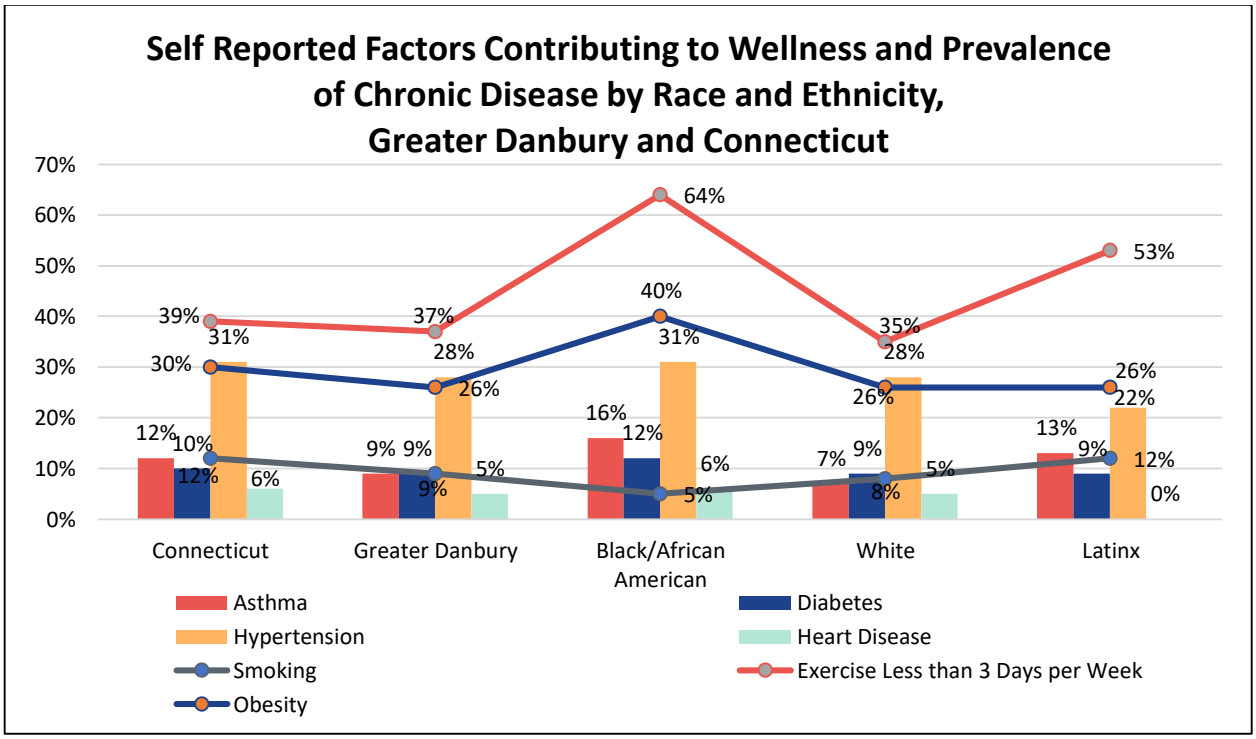
Danbury Age-Adjusted Hospitalization and ED Encounters and Risk Ratios for Leading Causes of Morbidity and Mortality

	Age-Adjusted Encounter Rate	Risk Ratio Compared to Surrounding Towns	Number of Fewer Encounters per 10,000 Residents (age-adjusted) if Rate was Same as Surrounding Towns
COVID-19	139	2.2	75
Uncontrolled Diabetes	64	2.1	34
Type 2 Diabetes	561	1.9	269
Asthma	222	1.5	72
COPD	191	1.4	53
Hypertension	905	1.3	204
Heart Disease	203	1.3	50

Source: DataHaven analysis (2021) of 2018-2021 Connecticut Hospital Association CHIME

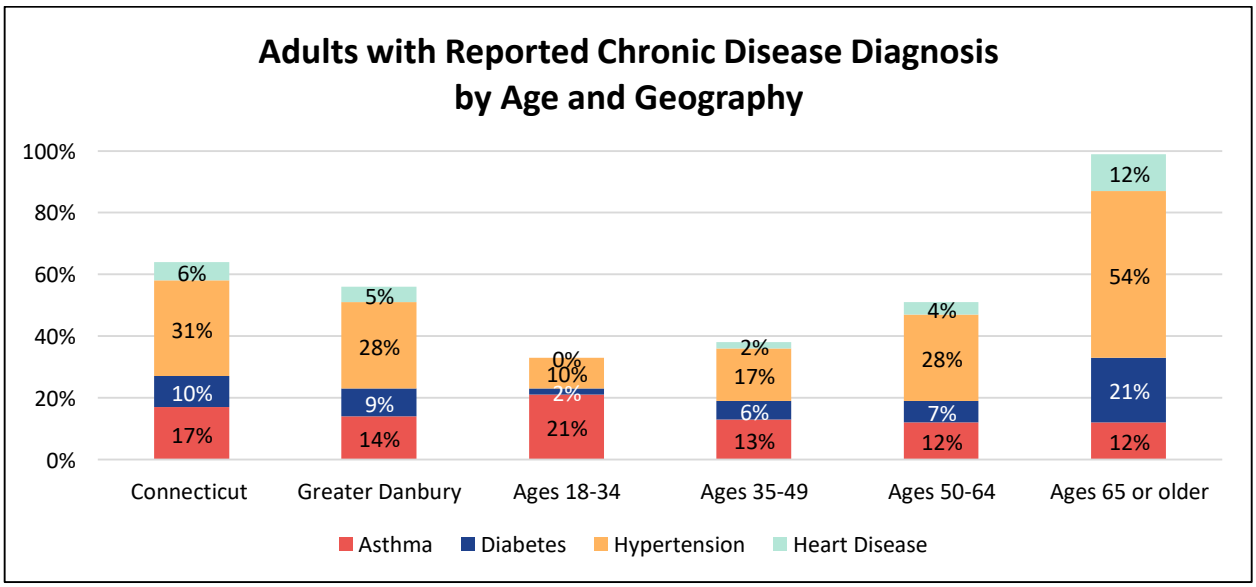
Prior to COVID-19, the top leading causes of death for US residents were chronic diseases. Across Greater Danbury, it is clear that social determinants of health directly impact health risk factors and ultimately chronic disease, resulting in inequities in life expectancy by race and neighborhood. This connection is demonstrated in the following graph which looks at prevalence of self-reported

factors like obesity and physical inactivity and prevalence of chronic conditions like hypertension and diabetes.



Source: 2021 DataHaven Community Wellbeing Survey

Greater Danbury is an aging community and older adults are more vulnerable to chronic disease. The following graph depicts self-reported chronic disease by age group. Of note, 54% of Greater Danbury adults aged 65 or over report having hypertension and 21% report having diabetes.



Source: 2021 DataHaven Community Wellbeing Survey

Maternal and Child Health

Having a healthy pregnancy is the best way to have a healthy birth and a healthy start to life. The data show that most people in Greater Danbury are able to access early prenatal care, which is the best way to promote a healthy pregnancy and delivery. However, across the state and region, pregnant people of color are as much as twice as likely as their white counterparts to receive late or no prenatal care and to experience related negative birth outcomes like low birth weight.

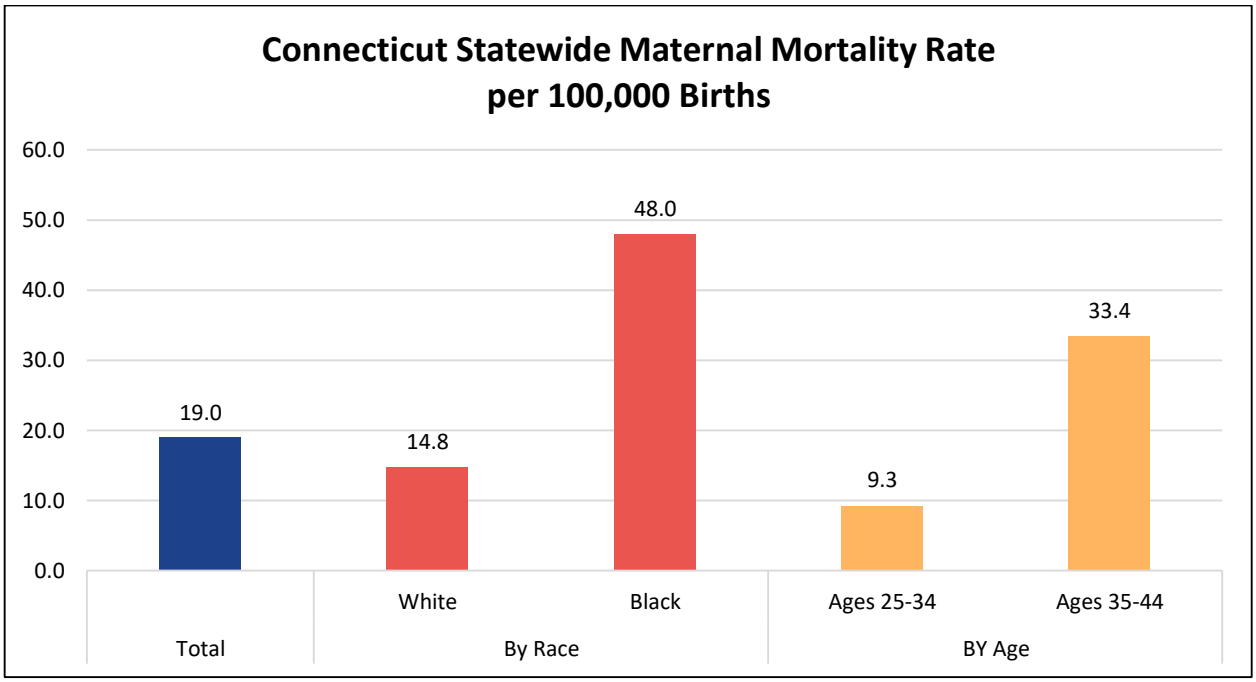
Infant mortality measures the rate of death among people under one year of age per 1,000 live births. Maternal mortality measures the rate of death during pregnancy or within one year of the end of pregnancy. Both measures are internationally utilized as key community health indicators because they are particularly sensitive to structural factors including social and economic factors and quality of life conditions, such as housing insecurity, educational attainment of the mother, and ACEs.

Disparities in infant and maternal mortality are measures of structural inequities that are at play well before a mother gets pregnant or gives birth. Therefore, upstream strategies that address the root causes of inequities can have far reaching impact on these indicators. The data show that infant mortality impacts Black babies at three times the rate as white babies and nearly twice the rate of Latinx babies. Maternal mortality impacts Black pregnant people at more than three times the rate of white pregnant people.

2016-2018 Selected Birth Outcomes by Race and Ethnicity of Parent Giving Birth

	Total	Asian	Black	White	Latina		
					Latina (overall)	Puerto Rican	Other Latina
Late or no prenatal care							
Connecticut	3.4%	3.5%	5.7%	2.5%	4.0%	2.9%	5.1%
Greater Danbury	2.9%	2.5%	5.2%	2.2%	4.1%	NA	4.3%
Danbury	3.6%	NA	3.4%	2.3%	4.6%	NA	4.8%
New Milford	2.4%	0.0%	NA	2.1%	NA	0.0%	NA
Low Birth Weight							
Connecticut	7.8%	8.7%	12.1%	6.4%	8.3%	10.2%	6.6%
Greater Danbury	6.7%	NA	NA	6.7%	5.7%	NA	5.9%
Danbury	7.0%	NA	NA	7.3%	5.7%	NA	5.9%
New Milford	7.5%	NA	NA	8.2%	NA	NA	NA
Infant Mortality (per 1,000 live births)							
Connecticut	4.6	NA	9.5	3.1	5.0	NA	NA
Greater Danbury	2.8	NA	0.0	2.4	3.6	NA	NA
Danbury	3.4	NA	0.0	NA	4.5	NA	NA
New Milford	NA	NA	0.0	0.0	0.0	NA	NA

Source: DataHaven analysis (2021) of data from the Connecticut Department of Public Health Vital Statistics.



Source: America's Health Rankings analysis of CDC WONDER Online Database, Mortality files, 2013-2017

The CHNA data findings were analyzed to inform health priorities for Greater Danbury. The data included in this report are valuable for tracking and benchmarking community health status indicators, as well as for identifying emerging community needs. In addition to the research collected as part of the 2022 CHNA, community conversations were held to solicit feedback on health priorities and opportunities for community health improvement.

Evaluation of Impact from 2019-2022 Community Health Improvement Plan

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 2019-2022 CHIP, with participation from community partners. The Community Health Committee (CHC) of the Danbury Hospital Board provided oversight of the process, and work groups were convened for each of four priority areas identified. The workgroups developed goals, objectives, strategies, short-term and long-term action steps, and metrics to measure success for their respective health priorities.

During the COVID-19 pandemic, Danbury Hospital and partnering community-based organizations paused some of their planned community health programs and activities related to the prevention agenda priorities and implementation plan and pivoted their community programs to focus on COVID-19 education, testing and vaccinations. The hospital partnered with the surrounding health departments to quickly stand-up drive-up testing and vaccination sites for the local community. Where CHIP efforts did continue to address the four focus areas that were identified by the CHNA, the emerging mental health disparity brought on by the pandemic made it necessary to prioritize the implementation of interventions that addressed the increased prevalence of anxiety and depression in the community. In addition to addressing urgent mental health needs throughout the greater Danbury region, the pandemic also brought into focus the immediate need to conduct screening for social determinants of health factors, such as food security, adequate housing, resources to cover utilities, and domestic safety.

While maintaining efforts to address chronic disease prevalence, address gaps in access and increase efforts to meet the mental health needs of the community, the Danbury Hospital Community Care Team (CCT) was highly utilized to meet the needs of vulnerable populations. The CCT continued to partner with key community stakeholders to address gaps in access to healthcare, healthy food resources, homelessness, in addition, coordinated resources for residents who frequented the emergency rooms for medical or mental health needs.

The four focus areas that were considered for the joint Danbury Hospital and New Milford Hospital CHIP were:

- Chronic disease prevention/Obesity
- Mental health/Substance use
- Healthy aging
- Access to healthcare

<u>The goal of the CHIP was to:</u>

- 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 measures for evaluation of impact
- Guide future community decision- making related to community health improvement.

Chronic Disease Prevention/Obesity

Goals:

- All people to be supported in practicing positive habits that include physical activity and healthy eating
- People of all ages and economic backgrounds need to be supported in obtaining health screenings and participating in disease prevention and health maintenance programs

Interventions:

- Chamber of Commerce meetings and events were held to promote economic development in the Danbury Hospital service area, state and local elected officials and agency heads were lobbied in support of maintaining patient access to essential services for the uninsured and underinsured
- Through the Health Fairs held in towns of Bethel, Candlewood Valley, and the Mission Health Day event in Danbury, 805 residents were included to address chronic disease prevention, healthy food choices, physical activity, and exercise
- The Women's Club of Danbury provided Diabetes-focused education to 74 community members during an in-person event
- Cardiovascular disease-focused education was completed in partnership with the Danbury Library, Newtown Community Center, and Bethel Health Care
- 49 chronic disease- specific lectures were held via Health Talks, aired on Comcast, serving over quarter million residents in partnership with the Danbury Man's Club, Heritage Village, Cartus Corporation, and the Community Forum
- Over 300 residents attended the "Let's Get Cooking" nutrition and wellness-focused lecture, in partnership with the new Milford Food Pantry
- The Go! 5,2,1,0 program demonstrated great success in increasing physical activity in children. This program has been adopted by local pediatricians, nine public schools and 43 sector sites. Parents reported their children maintaining healthy behaviors at home, reducing sugary beverages, decreased screen time and increased consumption of health foods.

Mental Health/Substance Use

Goals:

- Educate and increase awareness of preventive infections that have chronic implications focusing on influenza and sexually transmitted diseases
- Reduce substance use across the lifespan in our region
- Promote behavioral health and wellness across the lifespan in the Greater Danbury region
- Reduce the number of opiate addition disorders, overdoses, and related deaths in the region.

Interventions:

- To address the increased prevalence of anxiety and depression, which was further exacerbated by the COVID pandemic, large-scale support group meetings were held in the

region to provide coping support, grief and recovery assistance in the form Zoom discussions, in partnership with the COVID-Loss Support Group

- Opioid and Substance Use Disorder work group meetings were held to support the prevention of opioid and substance use in the community, also promoting treatment options

- A Behavioral Health Integration Model was applied to primary care areas, allowing behavioral health consultants to be added to the interdisciplinary teams. Together with the primary care providers, these consultants (experienced behavioral health social workers) were able to meet the medical and emotional health needs of their patients in a coordinated, patient centered manner

- Assisting the most vulnerable populations, the Danbury Community Care Team assisted hundreds of residents with medical, mental, addiction, detox, residential rehabilitation, and outpatient treatment needs, resulting in reduced ED utilization, and improved medical, behavioral health and social outcomes. Peer Recovery Specialist were integrated into the CCT team to better serve the residents who needed detox and recovery service support. In addition, we worked with the City of Danbury and community/state agencies to convert hotel space into temporary housing for homeless individuals.

Healthy Aging

Goals:

- Identify needs and support services to achieve healthy aging
- Enhance education, advocacy, access, and communication to support the ability of seniors to age in place
- Address prevention of falls

Interventions:

- In order to increase services and supports to allow seniors to age in the place of their choice, Danbury Hospital partnered with numerous community-based agencies, such as the Age Well Community Council, Connecticut Community Care, United Way of Western Connecticut, Nuvance Health Primary Care, and the Danbury EMS.

- While the pandemic prompted the cancellation of many in-person events, lectures held via Zoom and holding Health Talks aired on Comcast reached nearly a quarter million residents, with a large presence from the aging population. These events were available through Nuvance Health's websites, social media sites and through links in Vital Signs. Topics during these discussions included chronic disease prevention, heart and cardiac wellness, depression & anxiety, and cancer, to name a few.

Access to Healthcare

Goals:

- Identify needs and address deficiencies in access to programs that prevent chronic diseases
- Improve behavioral health and social determinants of health factors by enhancing partnerships with community services, school-based services and specialty care clinics and others.

Interventions:

- It is the policy of Danbury Hospital to provide necessary treatment to all without discrimination on the grounds of many dimensions, including race, ethnicity, national origin, age, and sexual orientation. Once the patient was classified as a charity care based on ability to pay for healthcare related services, the hospital did not anticipate a payment for such services provided. In assessing the patient's ability to pay, the hospital utilized the generally recognized federal poverty income guidelines, but also included certain cases when incurred charges were significant compared to the patient's income and countable assets, limiting the financial burden on the patient

Next Steps

The Danbury Community Health Committee (CHC) was created during the community health planning process in the Greater Danbury Region in 2012. The Committee is tasked with the review and oversight of the CHNA and CHIP in support of the organization's 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 2022 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.

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