GCHIP

GREENWICH COMMUNITY HEALTH IMPROVEMENT PARTNERSHIP

2022 CHNA Overview
February 8, 2022

Community Research Consulting LLC

YaleNewHavenHealth Greenwich Hospital

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The 2022 CHNA Project Team

Community Research Consulting LLC

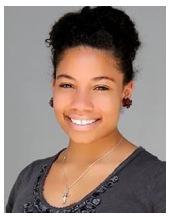

Colleen Milligan, MBA


Danielle Walters, MPH


Catherine Birdsey, MPH


Grace Gorenflo, RN, MPH


Priyanka Dhamane, MPH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2022 CHNA Objectives

- Demonstrate impact of Social Drivers of Health, advance health equity
- Bridge local community health initiatives with systemwide process and reporting and Anchor Strategy
- Deepen emphasis on upstream drivers of health inequities, including racism as a public health crisis
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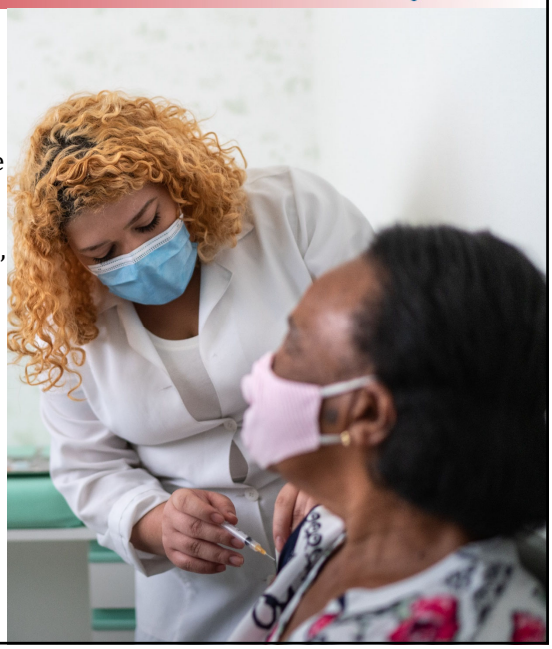

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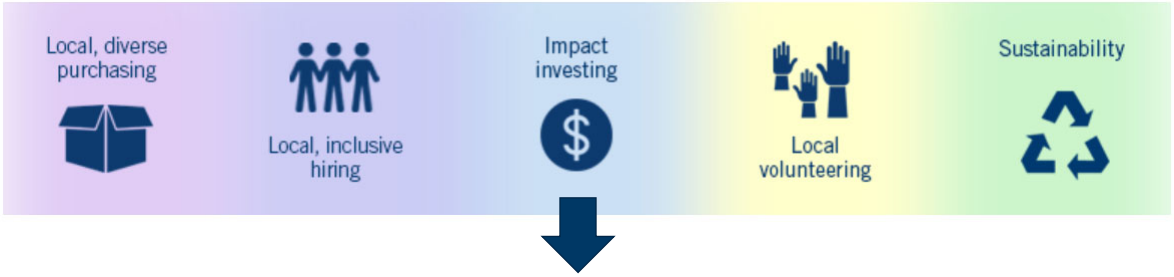
YaleNewHavenHealth

Anchor Mission



health, education and youth, housing, food and economic vitality

4

2022 CHNA Methodology

Secondary Data
-Demographics, socioeconomic, health statistics
-Focus on disparities, SDoH, COVID-19 trends

Planning and Strategy
-Systemwide approach, reflect local partners and initiatives
-Focus on root causes, transparent framework, measurable strategies

Data Haven Community Survey
-Document lived experiences
-Impact of COVID, health behaviors

Data Analysis
-Compare health indicators across communities and populations
-Demonstrate disparities, inequities, root causes

Community Conversations
-Define challenges, develop solutions
-Develop communication channels for meaningful dialogue

Final Reporting
-Balance readability and value as data resource
-Highlight initiatives and opportunities

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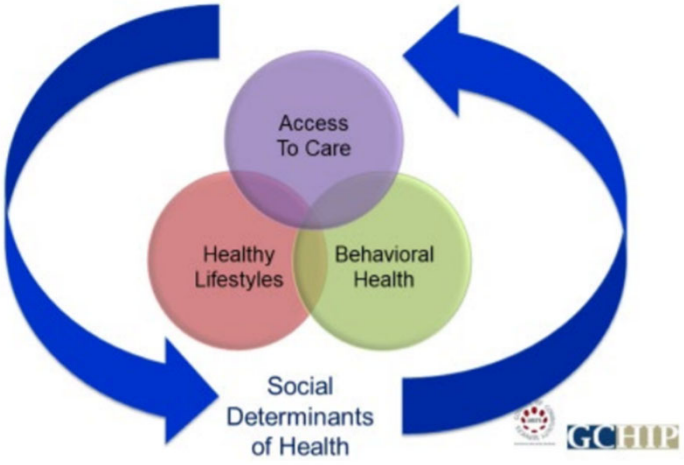
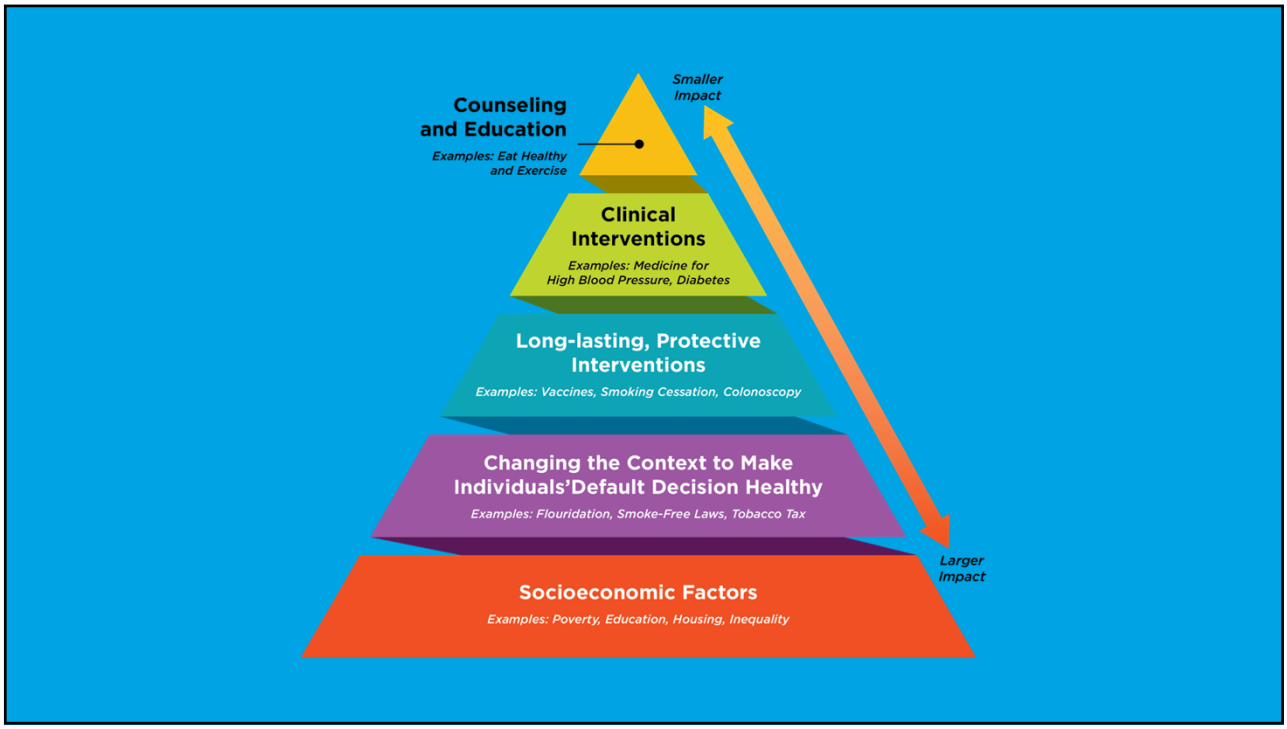
2019 GCHIP and CCS Priorities



- Access to Care & Provider Availability
- Transportation
- Neighborhood and Built Environment
- Food
- Safety
- Social and Community Context
- Mental Health
- Substance Use Disorder

6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Counseling and Education
Examples: Eat Healthy and Exercise
Clinical Interventions
Examples: Medicine for High Blood Pressure, Diabetes
Long-lasting, Protective Interventions
Examples: Vaccines, Smoking Cessation, Colonoscopy
Changing the Context to Make Individuals' Default Decision Healthy
Examples: Flouridation, Smoke-Free Laws, Tobacco Tax
Socioeconomic Factors
Examples: Poverty, Education, Housing, Inequality
Larger Impact

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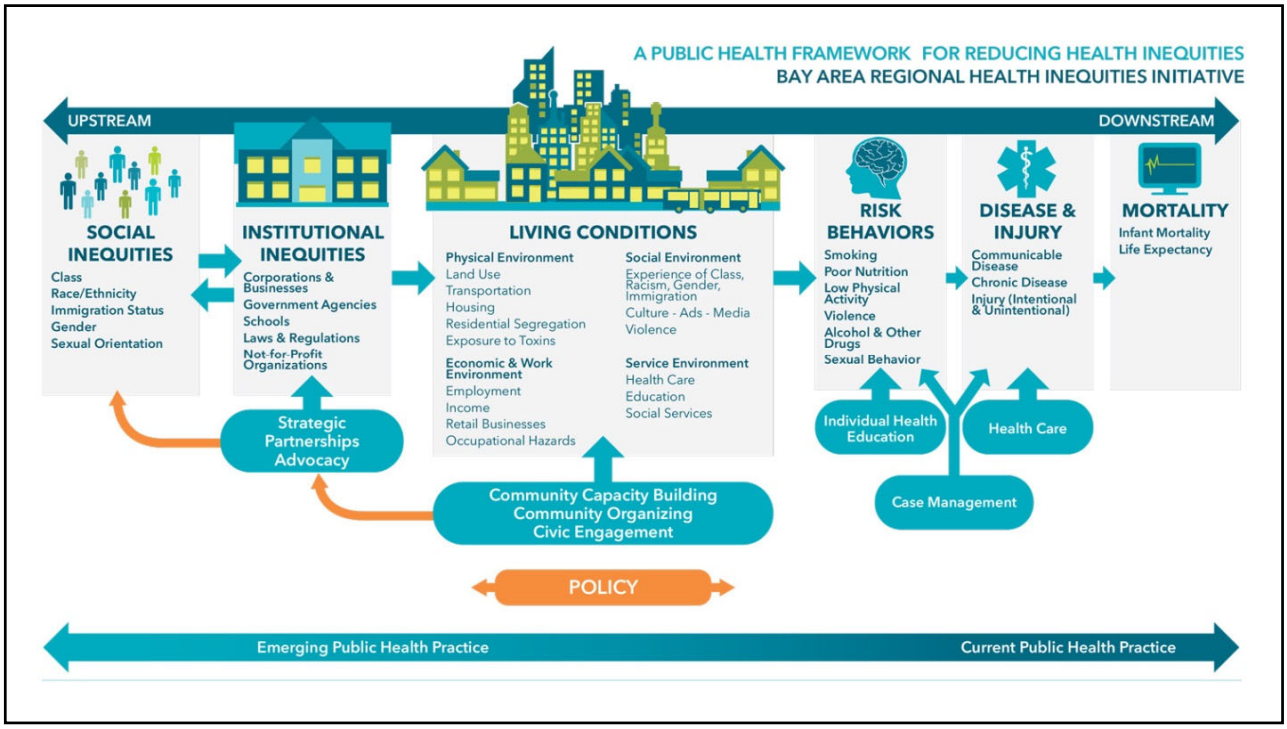
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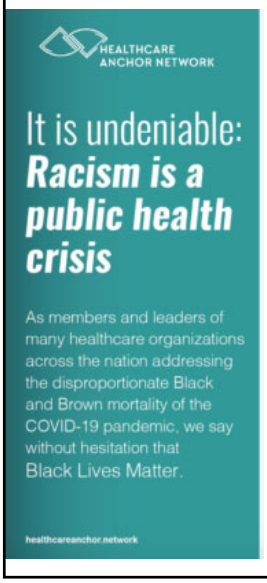
COVID-19: Leveraging Lessons Learned to Address Inequity and Gaps



Data Opportunities

- Morbidity/mortality statistics: cases, deaths, hospitalizations stratified by age, race, ethnicity (as available) and geography
- Vaccination data
- SDoH impact: community vulnerability
- Understand residents' perceptions
  - Fears and misconceptions
  - Impact of disproportionate burden of death and disease
  - Access to care and services
  - Needed information and trusted communication channels
  - Recommendations for improved processes

9

- Demographic and socioeconomic profiles for each community
- Household survey and community conversations with residents
- Demonstrate impact of SDOH and underlying inequities
- Understand impact of COVID on health and socioeconomic needs
- Leverage assets, strengths, opportunities; identify gaps
- Create data driven strategies and measurable outcomes

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Community Conversations:

What do we want to learn from our community stakeholders?

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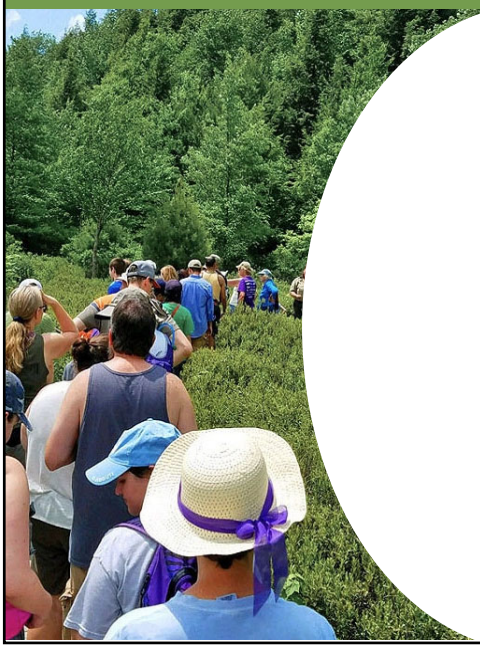
Timeline



Month	Key Milestones and Activities
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Aug 2022	• Finalize and deliver CHIPs/Implementation Plans
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Next Steps

- Analyze data sets: secondary data, Data Haven Community Survey, Hospital utilization data
- Develop questions for Community Conversations
- Share findings with local coalitions: GCHIP, CCS
- Relate data findings to local community initiatives and refine goals, strategies, partners
- Develop Greenwich Hospital Final Report and CHIP

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March 8, 2022

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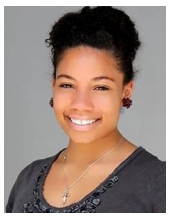
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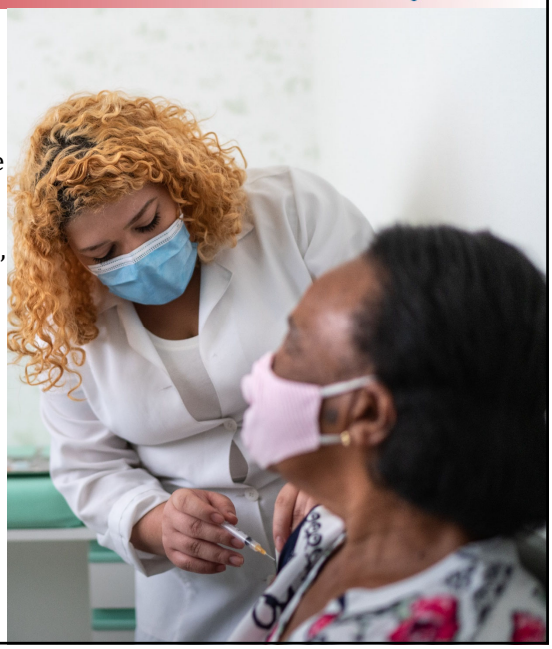

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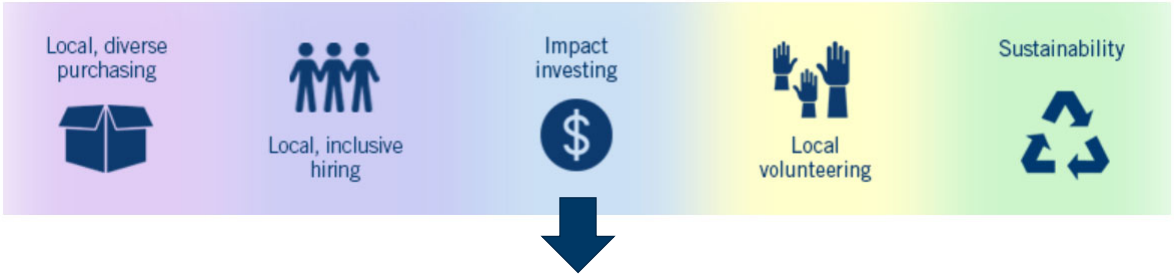

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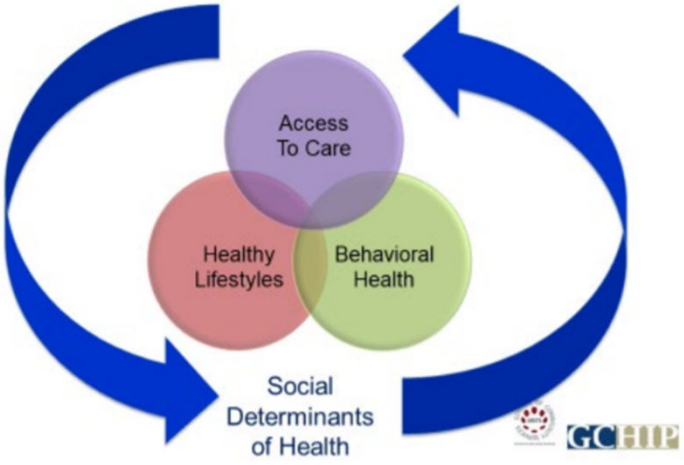

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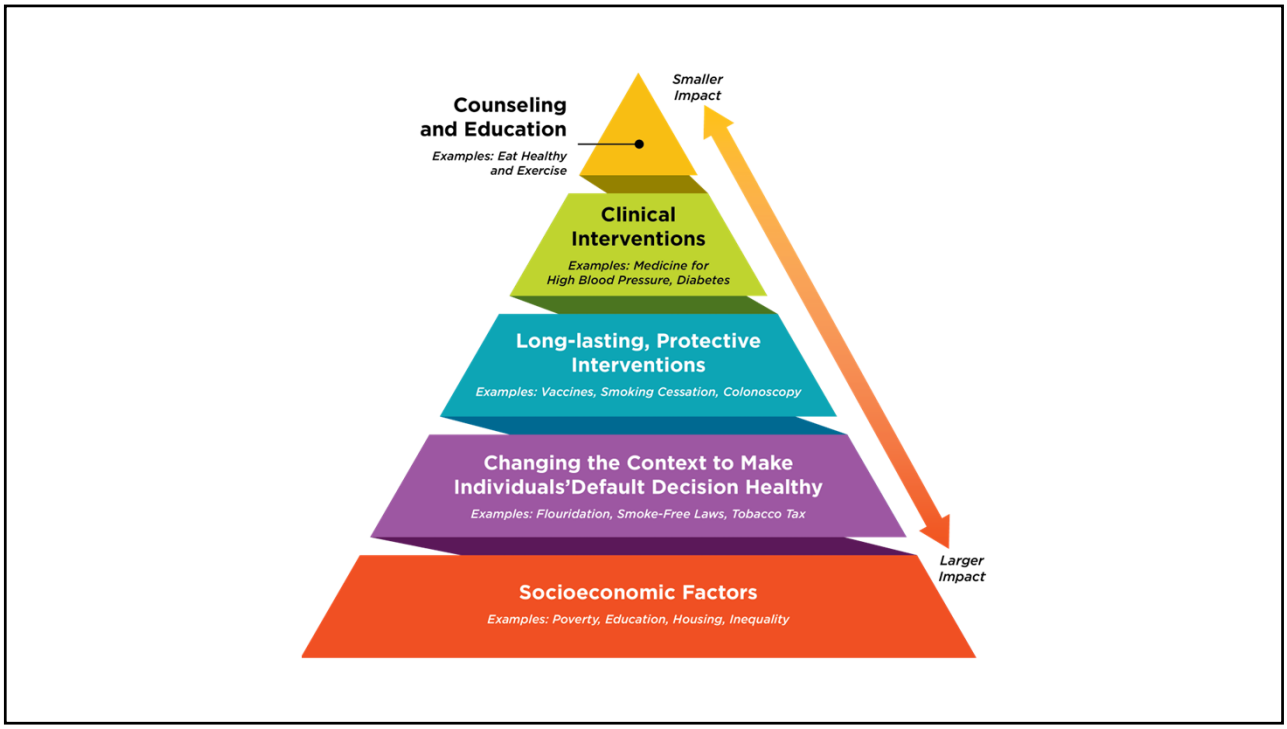
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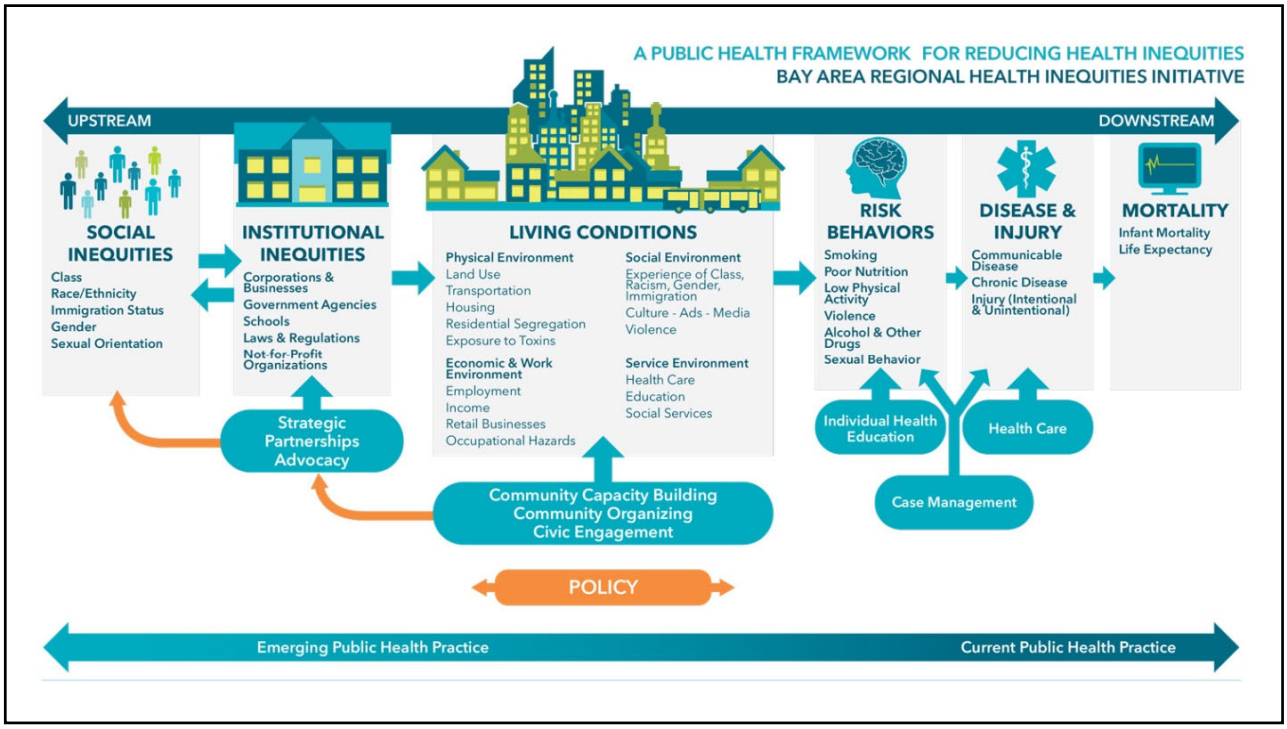
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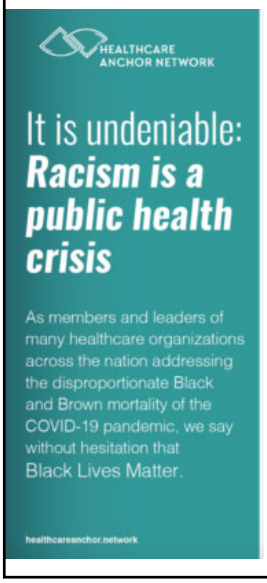

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Community Conversations:

Update on Community Wisdom Survey

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Using Data to Drive Equity Strategy

Data Collection:

- Demographic and socioeconomic community profiles
- Data Haven household survey
- Community Wisdom conversations with residents
- CHIME data for hospital utilization 2020-2021

Objectives:

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Timeline

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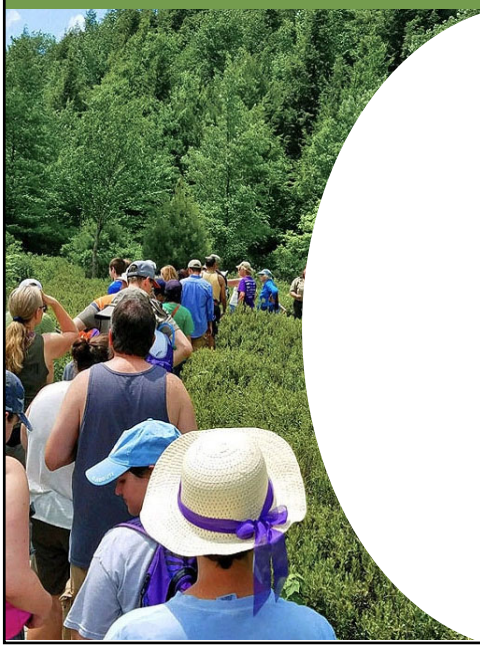

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2022 CHNA Data Presentation
April 12, 2022

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-CHA, state, federal, asset mapping

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-Key Informant, Community Wisdom Surveys
-Define challenges, develop solutions
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DataHaven Wellbeing Survey

- Telephone survey in-depth interviews with nearly 9,150 Connecticut residents, one of the largest well-being surveys in the United States
- Topics include physical and mental health, economic opportunity, housing, transportation, and civic engagement
- Surveys conducted in English and Spanish

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2022 CHNA & CHIP Timeline

	Spring 2021	Summer 2021	Fall 2021	Winter 2022	Spring 2022	Summer 2022
Key Informant Survey						
Asset Mapping						
CT Well-Being Survey Conducted						
Ct Well-Being Survey Results Analyzed						
Quantitative Data Collected and Analyzed						
Community Engagement Plan Developed						
Community Engagement Conducted						
Prioritization & CHIP Development						
Community Presentations						
CHNA Report Development						
CHNA Internal and External Presentations						
Hospital Board Presentations						

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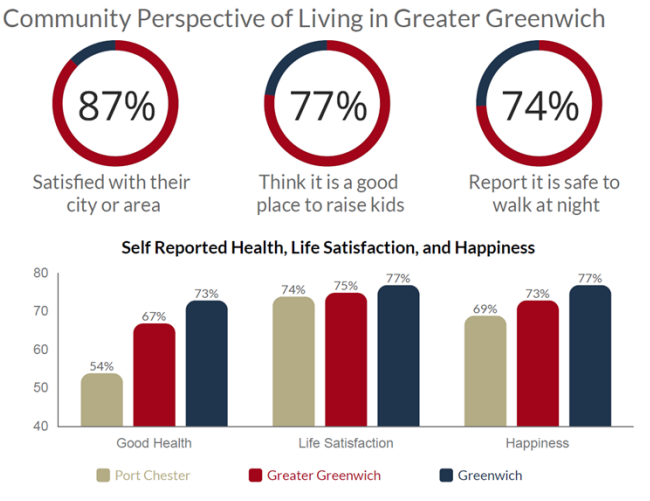
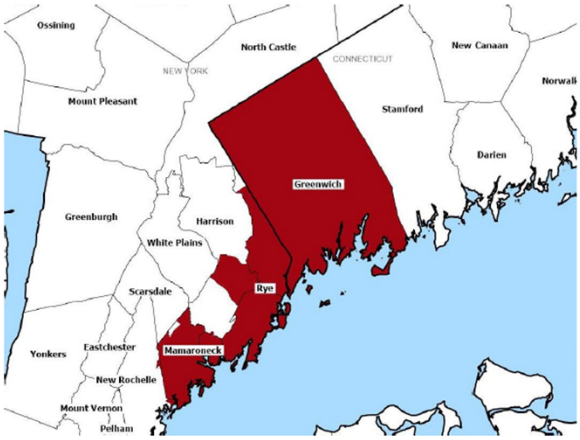
The Greater Greenwich community at a glance…





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Social Drivers: Data to Drive Equity

	Median Household Income	Population in Poverty	ALICE	White Population	Black Population	Latinx Population
Greater Greenwich	N/A	6.1%	N/A	66.1%	2.8%	23.4%
Greenwich Town, CT	$152,577	6.0%	21.0%	72.9%	3.3%	13.8%
Mamaroneck Town, NY	$137,135	4.6%	21.0%	74.6%	1.6%	17.1%
Rye City, NY	$192,688	4.0%	18.0%	82.9%	1%	6.7%
Rye Town, NY	$91,415	8.1%	31.0%	46%	3.4%	46%
Port Chester Village, NY	$74,920	11.0%	37.0%	30.6%	3%	63.9%
Rye Brook Village, NY	$141,652	3.5%	13.0%	74.6%	1.5%	15.7%
Fairfield County	$95,645	8.9%	29.0%	61.7%	10.6%	19.7%
Connecticut	$78,444	9.9%	26.0%	66.9%	9.9%	16.1%
Westchester County, NY	$96,610	8.8%	27.0%	53.5%	13.4%	24.7%
New York	$68,486	14.1%	30.0%	55.6%	14.3%	19.0%
US	$62,843	13.4%	N/A	60.7%	12.3%	18.0%

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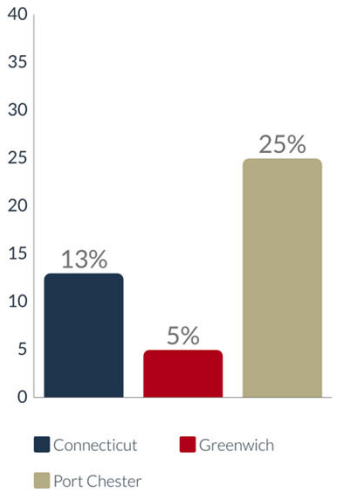
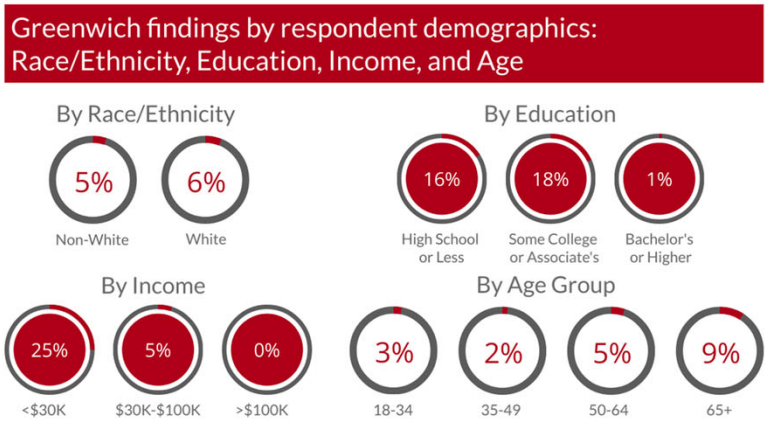
How COVID Highlighted Inequities

Since February 2020, have you or any other adult in your household: Received groceries or meals from a food pantry, food bank, soup kitchen, or other emergency food service? (Data Haven)





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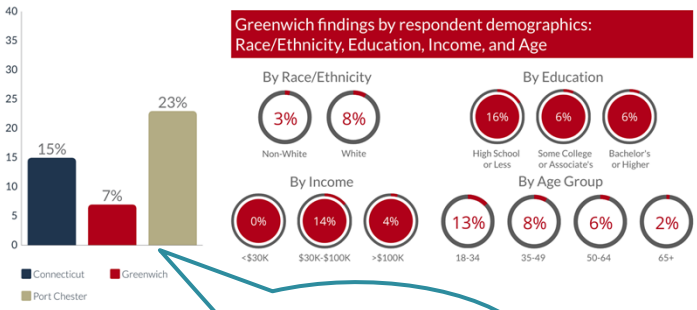
Access to Care

	% Uninsured	% First Trimester Prenatal Care
Greater Greenwich	5.9%	NA
Port Chester Village, NY	14.4%	NA
Rye Town, NY	10.4%	NA
Greenwich Town, CT	4.7%	84.6%
Rye Brook Village, NY	3.9%	NA
Mamaroneck Town, NY	3.8%	NA
Rye City (CDP), NY	1.2%	NA
Fairfield County	8.4%	81.5%
Connecticut	5.3%	84.7%
Westchester County, NY	5.8%	82.0%
New York	5.8%	77.5%
US	8.8%	77.6%

Adults who reported they <u>don't have one person or place</u> they think of as their primary care practitioner (DataHaven)



2019 CHNA Findings:
CT – 16%
Greenwich – 15%
Port Chester – 20%

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Access to Care

Adults who reported the last time they were seen by a dentist was <u>never or more than one year</u> (Data Haven)

	Total	Non-white	Hispanic	White	Low-Income ($30k or less)
Greenwich	26%	24%	34%	26%	22%

Total by City/Town	Total
Greater Greenwich	N/A
Port Chester Village, Rye, NY	34%
Greenwich Town, CT	26%
Mamaroneck Town, NY	N/A
Rye City (CDP), NY	N/A
Rye Town, NY	N/A
Rye Brook Village, Rye, NY	N/A
Fairfield County	28%
Connecticut	28%
Westchester County, NY	N/A
New York	N/A

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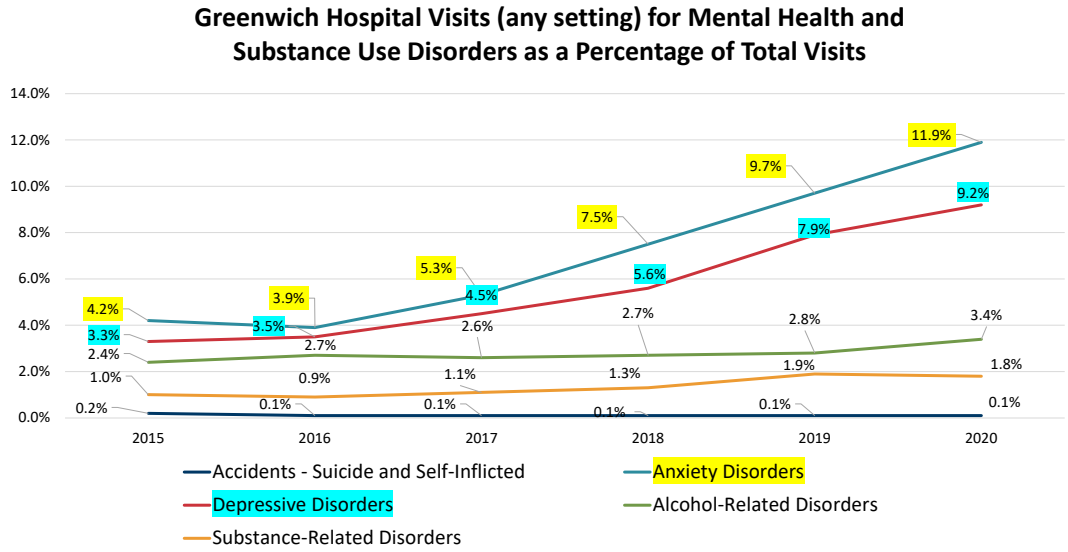
Behavioral Health



11

Behavioral Health

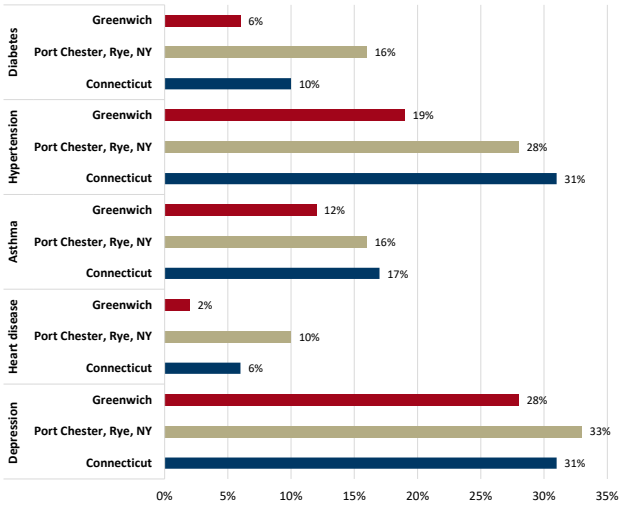
Over the past 2 weeks, how often have you been bothered by any of the following problems? Feeling down, depressed, or hopeless (DataHaven)

	Overdose Death per 100,000 (2020)
Greater Greenwich	**N/A**
Greenwich Town, CT	12.8
Mamaroneck Town, NY	N/A
Rye City (CDP), NY	N/A
Rye Town, NY	N/A
Port Chester Village, NY	N/A
Rye Brook Village, NY	N/A
Fairfield County	23.9
Connecticut	35.2
Westchester County, NY	N/A
New York	N/A

12

Healthy Lifestyles

Survey Respondents (adults) who have been told by a health professional that they have... (Data Haven)



Youth (high school) Health Indicators, 2019 YRBS

	Connecticut	United States
Obesity	14.4%	15.5%
E-Cigarette Use	27.0%	32.7%
Alcohol Use	25.9%	29.1%
Marijuana Use	21.7%	21.7%

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Further Exploring Social Drivers & Inequities

	% Uninsured		
	White	Black	Latinx
Greater Greenwich	4.7%	6.3%	15.5%
Greenwich Town, CT	4.1%	9%	12.5%
Mamaroneck Town, NY	3.5%	1.7%	9.4%
Rye City (CDP), NY	1.2%	0%	1.6%
Rye Town, NY	8%	4.9%	18.8%
Port Chester Village, NY	11.8%	7.7%	19.7%
Rye Brook Village, NY	3.8%	0%	11.7%
Fairfield County	6.6%	9.7%	21.4%
Connecticut	4.2%	6.8%	13.3%
Westchester County, NY	3.6	6.4	13.1
New York	4.2	6.4	11.3
US	7.9%	10.1%	18.2%

Adults who ever stay home from a doctor's appointment or a visit to a health care provider because of no access to reliable transportation (DataHaven)

	Percent of Adults
Greater Greenwich	N/A
Greenwich residents	22%
Port Chester	67%
Connecticut	35%

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Further Exploring Social Drivers & Inequities

Adults who had times in the past 12 months when they put off or postponed getting medical care they needed (Data Haven)

	Percent of Adults
Greenwich residents	25%
Port Chester Residents	36%
White	30%
Non-White	37%
Hispanic	37%
Low-income ($30k or less)	50%
Fairfield County	31%
Connecticut	30%
Westchester County, NY	N/A
New York	N/A

Adults who had times in the past 12 months when they didn´t get the medical care they needed (Data Haven)

	Percent of Adults
Greenwich residents	8%
Port Chester Residents	22%
White	15%
Non-White	24%
Hispanic	24%
Low-income ($30k or less)	38%
Fairfield County	12%
Connecticut	11%
Westchester County, NY	N/A
New York	N/A

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Further Exploring Social Drivers & Inequities

	Homeownership			Cost-Burdened Renters
	White	Black	Latinx	
Greater Greenwich	69.7%	30.3%	32.7%	46.3%
Greenwich Town, CT	68.2%	27.8%	33.9%	44.0%
Mamaroneck Town, NY	74.9%	NA	41.0%	40.4%
Rye City (CDP), NY	75.0%	35.4%	53.2%	39.7%
Rye Town, NY	65.7%	31.8%	28.7%	52.8%
Port Chester Village, NY	56.2%	24.1%	24.8%	53.3%
Rye Brook Village, NY	81.6%	100.0%	63.9%	52.5%
Fairfield County	74.0%	40.5%	38.7%	54.1%
Connecticut	72.5%	39.4%	34.3%	51.6%
Westchester County, NY	72.2%	35.8%	33.5%	54.5%
New York	63.6%	31.3%	25.7%	52.2%
US	69.5%	41.8%	47.3%	49.6%

Have you ever been told by a doctor you have Asthma? (DataHaven)

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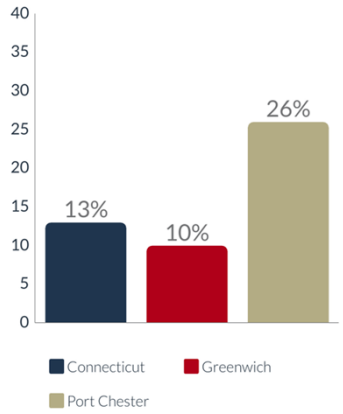
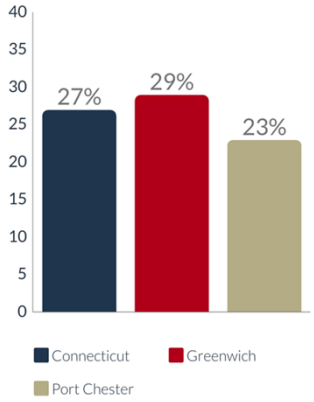
PD0

Discrimination – Survey Respondents who perceived…

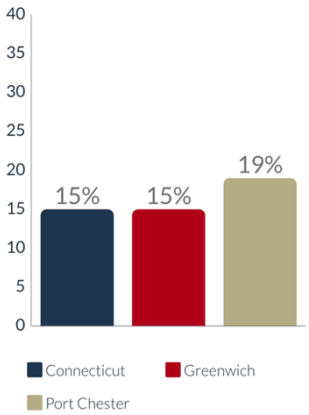
That, when seeking health care, they have been treated with less respect or received services that were not as good as what other people get.



That, at any time in their life, they have been unfairly denied a promotion or raise, or not hired for a job for unfair reasons.



That, they have been unfairly stopped, searched, questioned, physically threatened, or abused by the police.



17

Moving from Data to Action…Creating the 2022-25 CHIP

1. What are some key milestones to work toward now?
2. What will new success look like?
3. What should we measure to demonstrate our impact.

2022 Greenwich Priorities:

- Healthy minds
- Healthy living
- Healthy bodies

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GCHIP

GREENWICH COMMUNITY
HEALTH IMPROVEMENT PARTNERSHIP

2022 CHNA and CHIP
May 10, 2022

Community Research Consulting LLC

1

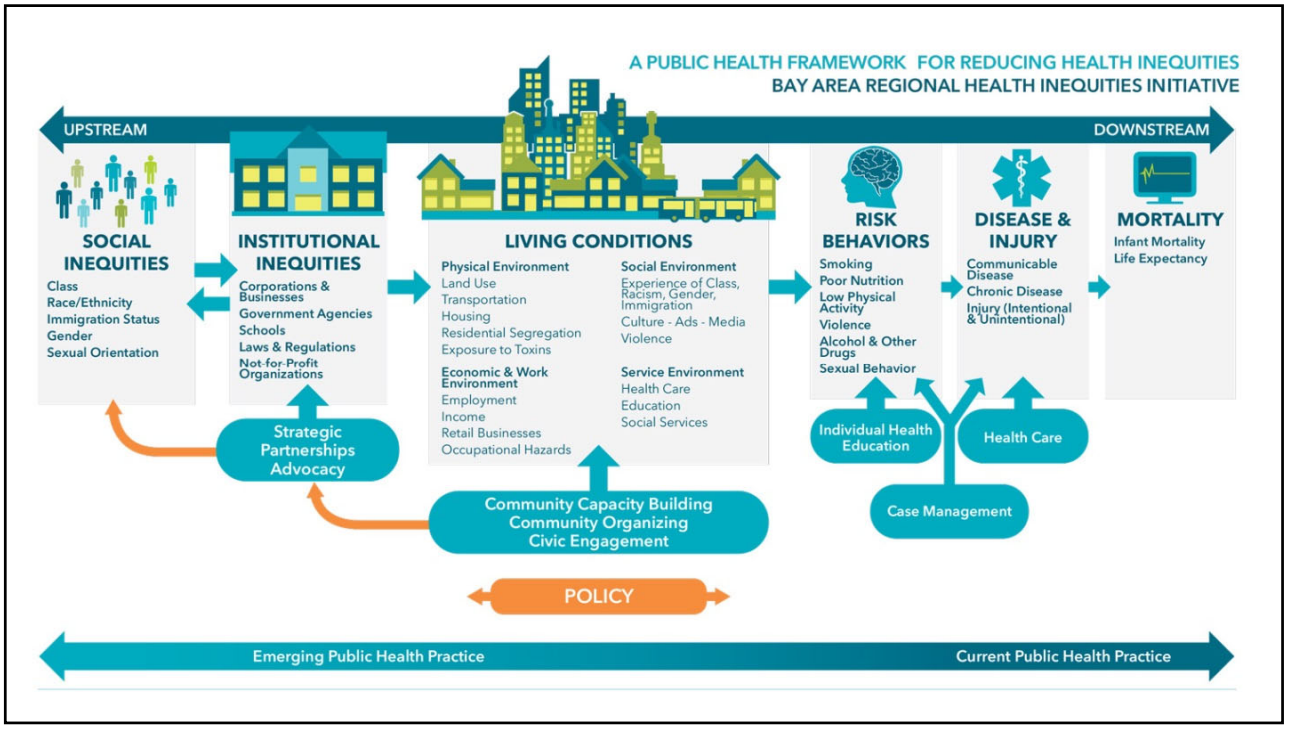
2022 CHNA & CHIP Timeline

	Spring 2021	Summer 2021	Fall 2021	Winter 2022	Spring 2022	Summer 2022
Key Informant Survey						
Asset Mapping						
CT Well-Being Survey Conducted						
Ct Well-Being Survey Results Analyzed						
Quantitative Data Collected and Analyzed						
Community Engagement Plan Developed						
Community Engagement Conducted						
Prioritization & CHIP Development						
Community Presentations						
CHNA Report Development						
CHNA Internal and External Presentations						
Hospital Board Presentations						

2

Moving from Data to Action

3

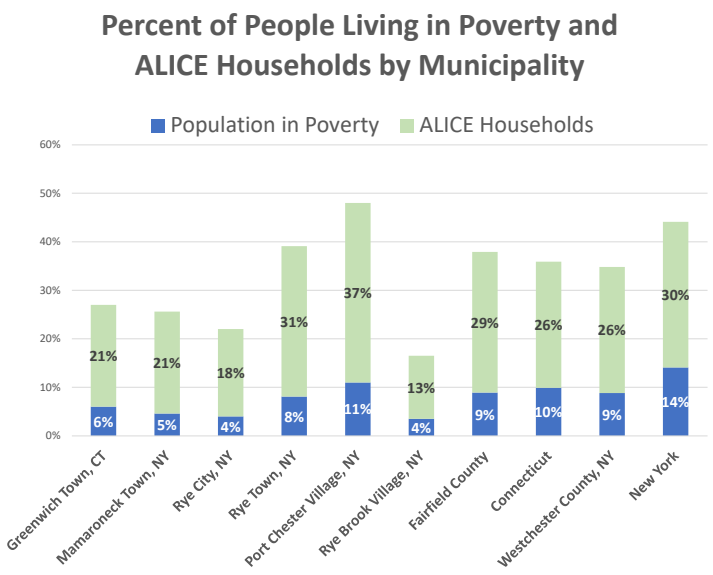


4

Where you live impacts choices for good health

ALICE households are ***working households*** *who do not earn enough to meet* ***basic needs*** *based on the* ***local cost of living.***

Roughly ***1 in 3*** *area households were ALICE households* ***before the COVID-19 pandemic.***



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Our CHIP definitions:

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Goals: The long-term outcome that you hope to achieve.

Objectives: Measurable targets toward achieving your goal.
Concise, time-driven, statements that describe how you will achieve your goal.

Strategies: The actions you will undertake to achieve your objectives.
Should reflect your populations, partners, and community resources. Different organizations will have different strategies toward meeting collective objectives.

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2022-25 Priority heath needs
Advancing health equity

Equity Approach:
1. Achieve equitable outcomes for all residents by challenging structural and institutional inequities
2. Leverage collaboration to counteract social drivers of health
3. Change processes and policies to reimagine equitable distribution of services

2022 Priority Areas

Access to Care:
Goal: Achieve equitable access to services for all people.

Healthy Living:
Goal: Achieve equitable life expectancy for all people.

Behavioral Health:
Goal: Reduce and prevent the impact of trauma on health outcomes.

8

Moving from Data to Action…Creating the 2022-25 CHIP

1. What are some key milestones to work toward now?

2022 Greenwich Priorities:
- Behavior Health: Healthy minds
- Healthy Living: Healthy bodies
- Access to Care & Services

2. What will new success look like?

3. What should we measure to demonstrate our impact.

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Priority Area: ACCESS TO CARE

Root Issues	Goal: A vision for the future or desired state	Objectives: Key success factors you can achieve in 3 years	Strategies: Actions or interventions that support your objectives	Outputs and Outcomes: The activities and *change* you can measure
Inequities & Racism Economic Security Education Opportunities Built Environment Health & Healthcare Social Context	Achieve equitable access to services for all people.			Disparities Medical Home Cultural Competencies Utilization Wait times Staffing/Capacity Affordability Health literacy Referrals to/from CBO Health insurance

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Priority Area: Healthy Bodies		
Goal: Achieving equitable life expectancy for all people		
Objective: (Food Security)		
Identified Community Needs	**Disparities and Inequities**	**Priority Populations**
Affordability of medication, food security	Disproportionate prevalence of chronic dx in Port Chester	Port Chester/Rye NY
Medical home, access to care	Disparity in prevalence by race	
Community Assets	**Community Partners**	**New Partners**
Asset Map from 2021	GCHIP Group	

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By February 2022, there will be a 2% reduction in CVD risk factors among adults in the Greater Greenwich region
Implement initiatives to improve the cardiovascular health of the community and promote a culture of healthy living
Implement initiatives to increase awareness of diabetes and to promote self-management for people living with diabetes
Promote exercise and physical activity in the community
Address food insecurity issues in the Greater Greenwich region
By February 2022, increase adults who have a regular source of care in the Greenwich & Port Chester area by 2%.
Implement initiatives to improve access to coordinated primary and specialty health care
Identify and mobilize individuals and/or trusted organizations that can assist in navigating and connecting uninsured and underinsured residents to healthcare resources
Improve access to/awareness of about medication/prescription availability
Collaborate with partners to improve access to and community awareness about reliable medical transportation
Promote diversity & Inclusion to reduce discrimination and improve access
By February 2022, there will be a 2% increase in adults in the Greater Greenwich region indicating they receive the social-emotional support they need.
Implement initiatives to reduce stress and promote behavioral health & wellness in the community
Implement initiatives to address depression and anxiety

13

Priority Area: Healthy Lifestyles

Indicator: Percentage of people in Greater Greenwich region who indicate that they have been told by a doctor or health professional that they have hypertension. [2015-Greenwich 24% Port Chester 26%, 2018-23%; 27%]

Indicator: Percentage of people in Greater Greenwich region who indicate that they work out 1 or more days per week [2015-Greenwich 86% Port Chester 77%, 2018-77%; 74%]

Indicator: Percentage of people who did not have enough money to buy food that you or your family needed [2015-Greenwich 6% Port Chester 14%, 2018-7%; 11%]

Goal: By February 2022, there will be a 2% reduction in CVD risk factors among adults in the Greater Greenwich region

Strategy	Action Steps	Outcomes
Implement initiatives to improve the cardiovascular health of the community and promote a culture of healthy living	• Implement collaboration among organizations to focus on decreasing hypertension rates in the community • Implement collaboration among organizations to focus on decreasing cardiovascular disease rates in the community • Collaborate with community partners to conduct & promote cardiovascular health and wellness programs and screening events • Provide education & promote awareness of healthy CVD lifestyles • Work with food pantries to have increased implementation of the SWAP • Provide education & awareness on the benefits of consumption of fresh fruits /vegetables/plant-based diets	# of initiatives for promoting awareness of hypertension # of initiatives for promoting cardiovascular health & wellness programs to reduce CVD disease # of health/wellness screening events # of initiatives to promote heart healthy lifestyles 25% increase in food pantries adopting SWAP Evaluation data on satisfaction and utility of events and initiatives

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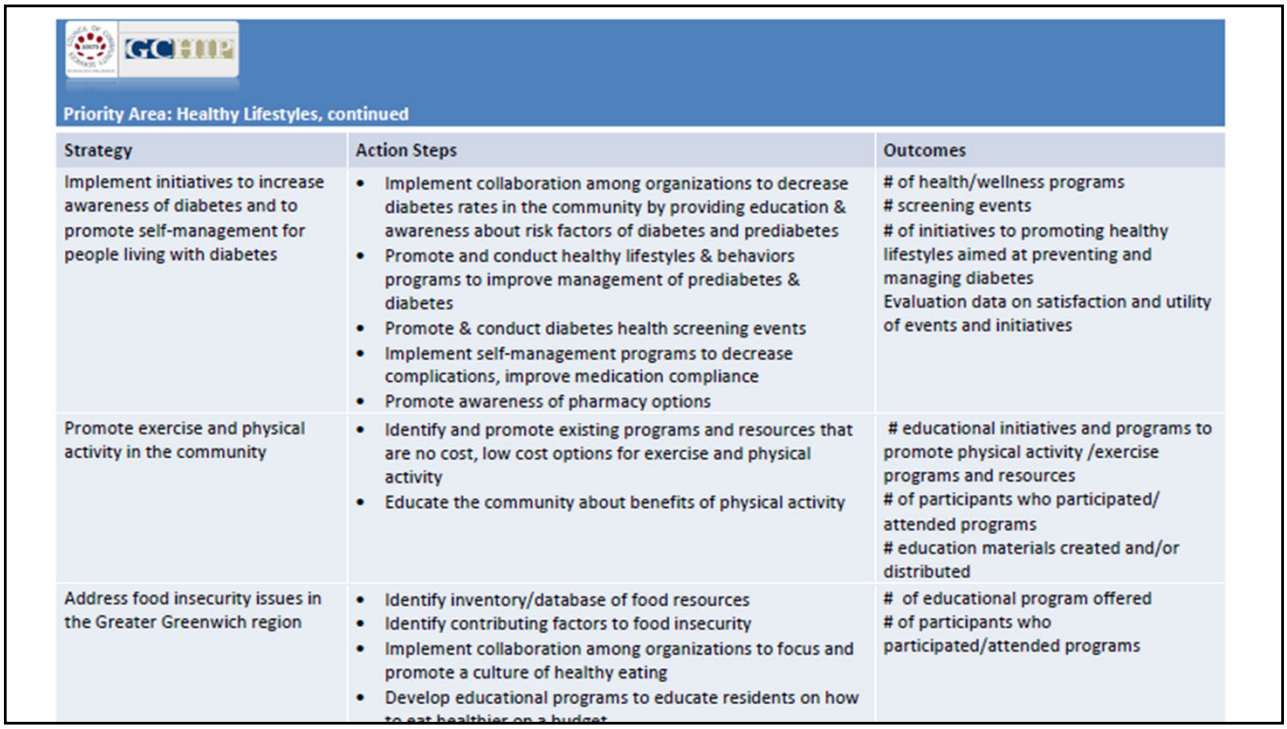

Priority Area: Healthy Lifestyles, continued

Strategy	Action Steps	Outcomes
Implement initiatives to increase awareness of diabetes and to promote self-management for people living with diabetes	• Implement collaboration among organizations to decrease diabetes rates in the community by providing education & awareness about risk factors of diabetes and prediabetes • Promote and conduct healthy lifestyles & behaviors programs to improve management of prediabetes & diabetes • Promote & conduct diabetes health screening events • Implement self-management programs to decrease complications, improve medication compliance • Promote awareness of pharmacy options	# of health/wellness programs # screening events # of initiatives to promoting healthy lifestyles aimed at preventing and managing diabetes Evaluation data on satisfaction and utility of events and initiatives
Promote exercise and physical activity in the community	• Identify and promote existing programs and resources that are no cost, low cost options for exercise and physical activity • Educate the community about benefits of physical activity	# educational initiatives and programs to promote physical activity /exercise programs and resources # of participants who participated/ attended programs # education materials created and/or distributed
Address food insecurity issues in the Greater Greenwich region	• Identify inventory/database of food resources • Identify contributing factors to food insecurity • Implement collaboration among organizations to focus and promote a culture of healthy eating • Develop educational programs to educate residents on how to eat healthier on a budget	# of educational program offered # of participants who participated/attended programs

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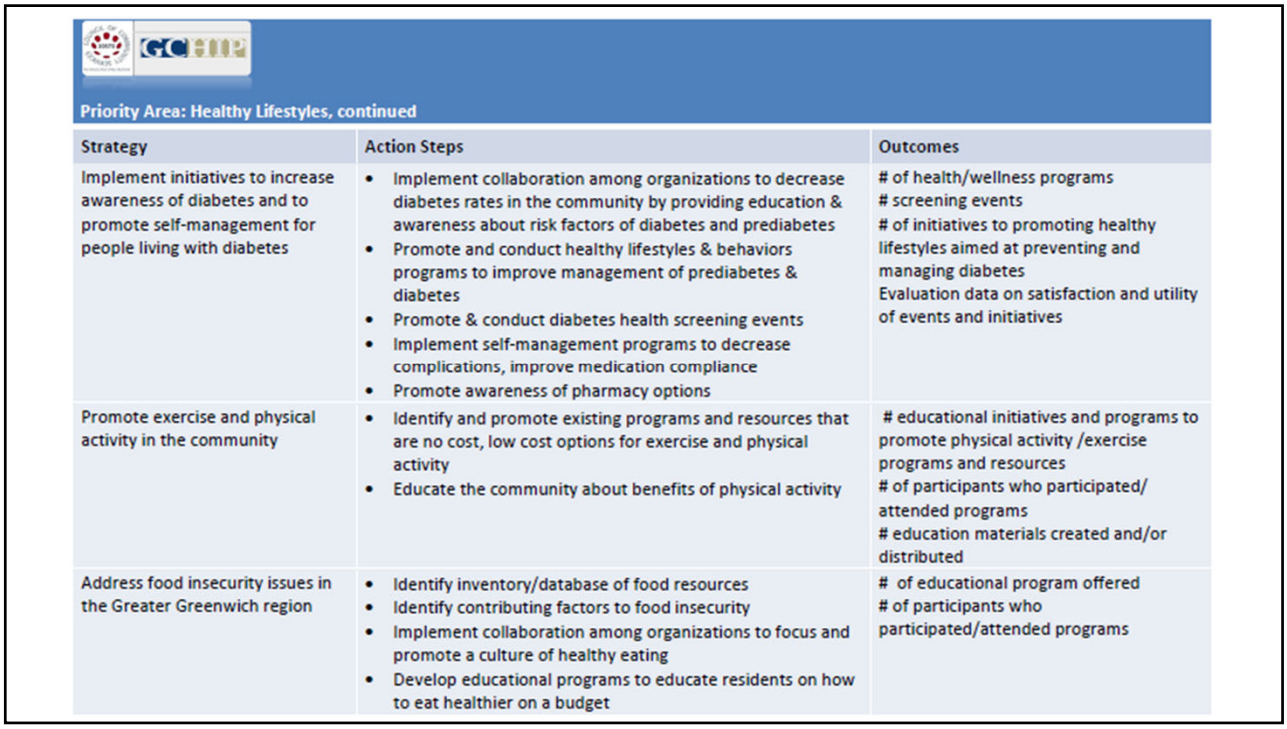

Priority Area: Healthy Lifestyles, continued

Strategy	Action Steps	Outcomes
Implement initiatives to increase awareness of diabetes and to promote self-management for people living with diabetes	• Implement collaboration among organizations to decrease diabetes rates in the community by providing education & awareness about risk factors of diabetes and prediabetes • Promote and conduct healthy lifestyles & behaviors programs to improve management of prediabetes & diabetes • Promote & conduct diabetes health screening events • Implement self-management programs to decrease complications, improve medication compliance • Promote awareness of pharmacy options	# of health/wellness programs # screening events # of initiatives to promoting healthy lifestyles aimed at preventing and managing diabetes Evaluation data on satisfaction and utility of events and initiatives
Promote exercise and physical activity in the community	• Identify and promote existing programs and resources that are no cost, low cost options for exercise and physical activity • Educate the community about benefits of physical activity	# educational initiatives and programs to promote physical activity /exercise programs and resources # of participants who participated/ attended programs # education materials created and/or distributed
Address food insecurity issues in the Greater Greenwich region	• Identify inventory/database of food resources • Identify contributing factors to food insecurity • Implement collaboration among organizations to focus and promote a culture of healthy eating • Develop educational programs to educate residents on how to eat healthier on a budget	# of educational program offered # of participants who participated/attended programs

16

Priority Area: Access to Care

Indicator: Percentage of people in the Greenwich region that indicate that they have put off or postponed getting medical care that they thought they needed. [2015- Greenwich 13%, Port Chester 22% 2018-Greenwich 19% Port Chester 20%]

Indicator: Percentage of people in the Greenwich region who report having one person or place as their personal doctor or health care provider. [2015- Greenwich 87%, Port Chester 79% 2018-Greenwich 84%% Port Chester 79%]

Indicator: Percentage of people in the Greenwich region who report missing a doctor's appointment or a visit to a health care provider because they did not have reliable transportation [2015- Greenwich 4% Port Chester 14%-2018-Greenwich 9% Port Chester 11%]

Indicator: Percent of people in Greater Greenwich reporting discrimination in a medical setting (2015-N/A, 2018-Fairfield County: 37% Doctor's office, 30% Hospital/ER, 14% Dentist]

Goal: By February 2022, increase adults who have a regular source of care in the Greenwich & Port Chester area by 2%.

Strategy	Action Steps	Outcomes
Implement initiatives to improve access to coordinated primary and specialty health care	• Determine barriers to accessing primary and specialty care health care providers and develop collaborative strategies to address (hours of operation the number and availability of providers located in Greenwich (Port Chester area) etc. • Promote awareness of primary care and specialty care options and how to access • Implement initiatives to facilitate coordination of primary care and specialty care • Promote awareness of specialty care options and how to access • Develop initiatives to address specialty care transportation issues	# initiatives to determine barriers # efforts to increase the community's awareness of available resources # initiatives to facilitate coordination # providers who accept a broader range of insurance assignment # providers who provide sliding scale payment schedule for uninsured # providers with more expanded operations (e.g. hours, days)

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Priority Area: Access to Care, continued

Strategy	Action Steps	Outcomes
Identify and mobilize individuals and/or trusted organizations that can assist in navigating and connecting uninsured and underinsured residents to healthcare resources	• Collaborate with partners to identify trusted individuals and/or organizations with connections to uninsured and underinsured residents • Increase connection and promote awareness to available resources for uninsured and underinsured residents	# additional outreach workers and organizations engaged # of uninsured and underinsured residents engaged in outreach efforts.
Improve access to/awareness of about medication/prescription availability	• Determine barriers to care for medication/prescription availability • Promote awareness of medication/pharmacy options	# initiatives to increase awareness about resources # Medicare Savings Program (MSP) applications filed # Residents who registered with a new Rx plan
Collaborate with partners to improve access to and community awareness about reliable medical transportation	• Determine accessibility issues related to medical transportation options, including public transportation and medical ride programs • Continue conversation(s) with transportation organizations in understanding resident concerns about medical transportation • Partner with aging-in-place organizations to assist with medical transportation improvements • Promote community awareness of transportation options etc.	# medical transportation resources available # affordable transportation options # Changes in policies and procedures by transportation providers that influence access (Ex: extended hours of operation) # initiatives to increase community awareness about transportation resources
Promote diversity & Inclusion to reduce discrimination and improve access	• Promote CLAS tools in medical community • Initiate discussions with healthcare providers to increase awareness of implicit bias • Share written information about CLAS and ways to incorporate in medical setting	# of CLAS initiatives # attendees % increase in providers implementing CLAS # of providers who self-report use of CLAS in practice

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Priority Area : Behavioral Health

Indicator: Percentage of people in Greenwich region who indicate that they felt down, depressed or hopeless in the past two weeks. [2015-N/A; 2018-Greenwich-several or more days: 25% Port Chester 27%]

Indicator: Percentage of people in the Greater Greenwich region who indicate that they receive the emotional and social support they need. [2015-N/A; 2018-Greenwich- 75% Port Chester 70%]

Indicator: Percentage of people in the Greater Greenwich region who indicate that they were somewhat/mostly/completely anxious yesterday. [2015-23% Greenwich 31% Port Chester; 2018-Greenwich- 27% Port Chester 36%]

Community partners collaboratively addressing substance misuse issues:

Indicator: Percentage of people in the Greater Greenwich region who indicate that they know anyone who has struggled with misuse or addiction to heroin or other opiates such as prescription painkillers at any point during the last three years. [2015-N/A; 2018-Greenwich-one or more people: 22% Port Chester 19%]

Indicator: Percentage of people in the Greater Greenwich region who indicate that they have tried using vapor or vape pens, electronic cigarettes or E-cigarettes [2015-Greenwich 11% Port Chester 21%, 2018-16%; 14%]

Goal: By February 2022, there will be a 2% increase in adults in the Greater Greenwich region indicating they receive the social-emotional support they need.

Strategy	Action Steps	Outcomes
Implement initiatives to reduce stress and promote behavioral health & wellness in the community	• Promote and increase resident awareness and knowledge of community emotional health/wellness resources and social support systems available (mindful meditation, healthy diets, Yoga, spirituality/faith communities) • Identify unified messages and materials for dissemination by targeted providers • Develop & disseminate strategies to reduce stress by providing education and resources on utilizing coping skills and resiliency techniques	% targeted providers disseminating emotional and wellness resources to patients

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Priority Area : Behavioral Health, continued

Strategy	Action Steps	Outcomes
Implement initiatives to reduce stress and promote behavioral health & wellness in the community (continued)	• Identify subgroups most impacted by the lack of social-emotional support and target outreach and support strategies tailored to the group • Identify and address myths surrounding mental illness and addiction	% of targeted vulnerable groups reached using identified strategies Change in perception related to myths supporting stigma
Implement initiatives to address depression & anxiety	• Promote awareness and knowledge of services for mental health in the community and how to access (hours of operation, in town availability, etc.) • Increase screening & early intervention throughout the community • Collaborate to promote and launch 1 or more peer support options for identified vulnerable population(s) • Promote awareness and use/implementation of e-consults / teletherapy • Determine strategies for selected populations in need (young adults, older adults, racial/ethnicity/language, etc.)	% targeted providers conducting screenings during patient visits & community events % peer support participants indicating satisfaction with peer support option
Support substance use education and prevention efforts in the community	• Leverage existing collaborative to promote awareness of health impacts of vaping and marijuana • Focus action steps on supporting the efforts that are underway by other partners responsible for this area • Develop collaborative strategies to educate residents and providers on prescription opiates misuse, heroin and fentanyl. Promote education and awareness of available treatment services, including harm reduction and use of Narcan, and how to access • Determine strategies for selected populations in need (young adult, ethnicity, etc)	• Decrease in vaping incidents at Greenwich schools as measured by Greenwich Together • Increase community participation in take-back days as measured by pounds of medication turned in • Increase in attendance at community events as a result of GCHIP / CCS promotional/supportive efforts • Increase in number of GCHIP partners who display safe medication disposal cards

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GCHIP

GREENWICH COMMUNITY
HEALTH IMPROVEMENT PARTNERSHIP

2022 CHNA and CHIP
June 14, 2022

Community Research Consulting LLC

1

	Spring 2021	Summer 2021	Fall 2021	Winter 2022	Spring 2022	Summer 2022	Fall 2022
Key Informant Survey							
Asset Mapping							
CT Well-Being Survey Conducted							
Ct Well-Being Survey Results Analyzed							
Quantitative Data Collected and Analyzed							
Community Engagement Plan Developed							
Community Engagement Conducted							
Prioritization & CHIP Development							
Community Presentations							
CHNA Report Development							
CHNA Internal and External Presentations							
Hospital Board Presentations							

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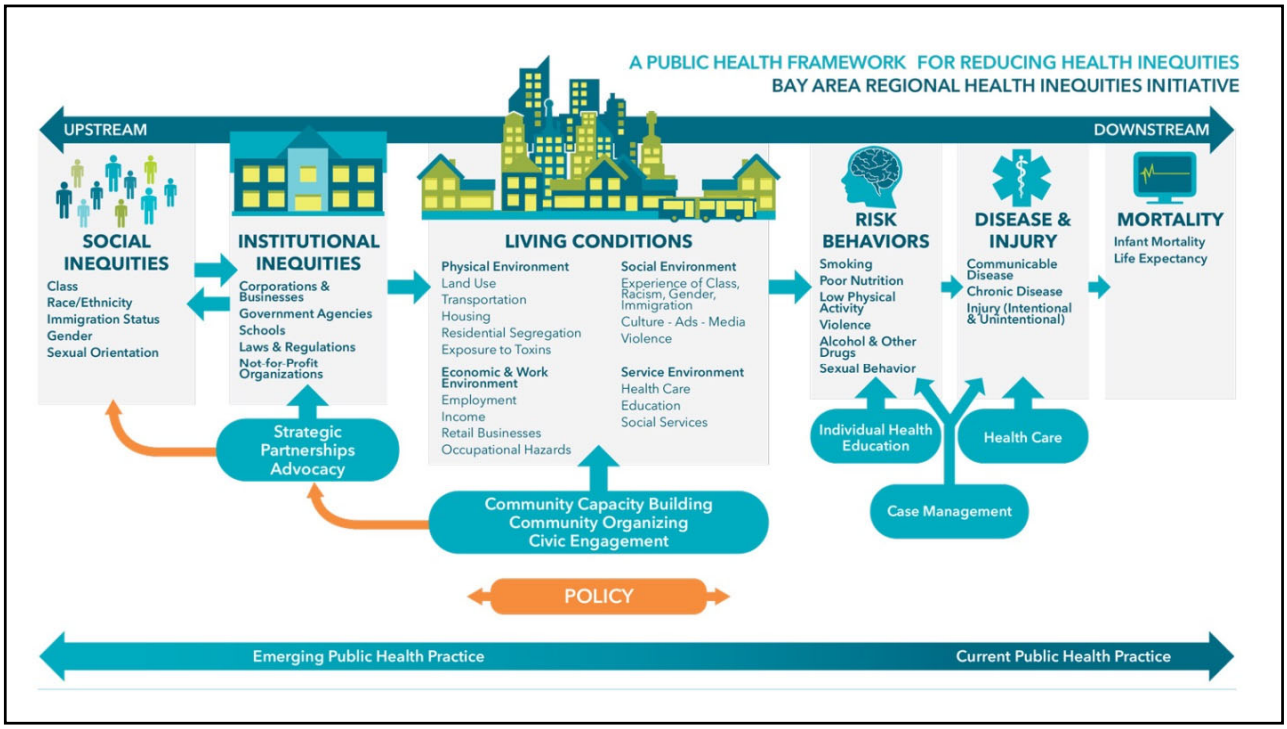

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Feedback from Community Partners

- COVID Impacts
- Successes to build upon
- Strategies and resources needed now

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4

Persistent and Emerging Needs

Impact of COVID: What will take our communities longest to recover?

Access to Care
- Postponed care
- Backlog of patients, higher acuity, longer wait times
- Reduced staff in health and human services
- Lost trust in healthcare and providers
- Re-establish relationships

Behavioral Health
- Isolation
- Access to care for adults and children
- Substance use unchecked; lack of community/family interventions
- Trauma: loss of life; SUD overdose deaths in addition to pandemic realities

Socioeconomic needs
- COVID loss of jobs
- Loss of life, loss of breadwinners
- Affordable housing; affordability gap widened
- Food security
- Increased inflation
- Services for those not eligible for gov assistance

Loss of learning, developmental delays
- Students all ages affected; impact next years of learning
- Lost year for students without virtual access to school
- Re-establish connections with peers, re-socialize
- Increased behavioral health needs among students
- Widespread staff shortages, particularly in cc/early ed
- Don't have resources to meet increased needs

5

What are successes that we can build upon?

- Collective impact: Increased collaboration and partnerships, sustained collaboration
- Nimble/adaptive in an emergent situation
- Robust community resources and getting people the help they needed during COVID
- Able to transform programs/training of staff and clients. Example: adapted programs to virtual for in-home and on-demand delivery of services
- Found new ways to meet people's needs: tele-everything; taught people how to use technology
- Continue to add new initiatives in response to needs
- Better using data to anticipate, respond to, and manage people's needs

6

Where do we need to (re)focus our efforts now?

- Create a welcoming and safe space – "If clients don't trust us, they won't come or tell others about us; they won't trust us with their children."
- Continuing to create opportunities for social interactions; create new connections; rebuild trust
- Improve communications among CBOs and bi-directional communication with the community; invite input
- Increase awareness of what services are available, and how to receive them; remove barriers to accessing them
- Identify additional partners to join the work and make a seat at the table for them
- Invest in staff retention and recruitment, with focus on career awareness in HHS among BIPOC communities
- Foster forums for developing creative solutions to address the needs
- Reduce competition between orgs for funding; reduce bureaucracy
- Go beyond addressing the immediate need; provide financial literacy, career training; need to invest in training to help people think differently, change behavior

7

Feedback from Residents

- What they see as top concerns
- Accessing community resources
- Needed services

8

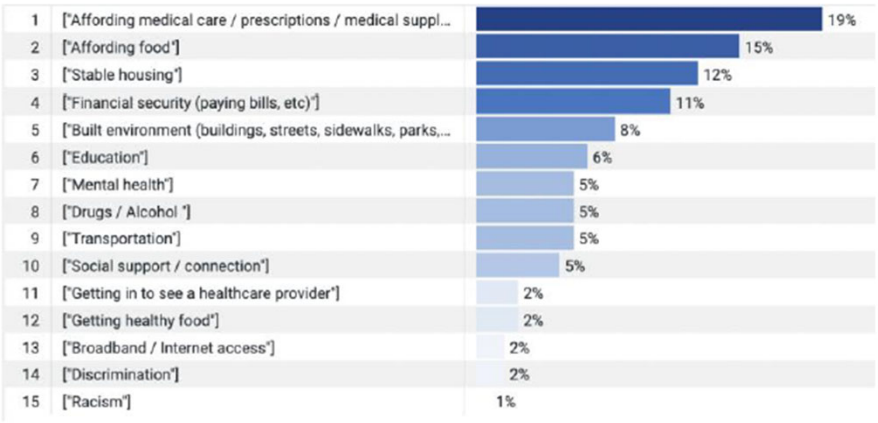
Executive Summary

- The Community Wisdom survey launched on March 24, 2022. The goal was to reach 125 individuals.
- The survey link for Greenwich was clicked 168 times.
  - 137 (82%) surveys had more than half of the questions answered.
- Demographic distribution:
  - Age ranges from 18 or younger to 85 or older, with most users being between 35-44 years old.
  - Gender is mostly female (71%).
  - 72% of users prefer to speak in English, 22% in Spanish, and less than 6% in Italian, Portuguese, Haitian Creole or other.
- More than 50% of respondents reported that their community was affected by *fear and worry about the health of loved ones and concern about money and finances.*
- When asked about the most important concern in the community, respondents highlighted six issues:
  - Affording medical care / prescriptions / medical supplies
  - Affording food
  - Stable housing
  - Financial security
  - Drugs / Alcohol
  - Mental health
- 'People are NOT aware' and 'Cost is NOT affordable' are the primary reasons for not using available resources or support services.

9

Community Conversations

The #1 most important concern in your community



*People could only choose one option

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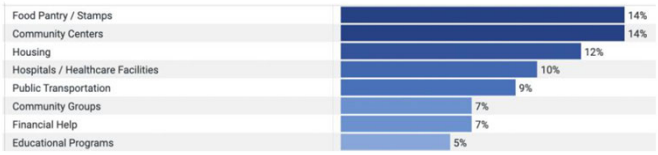
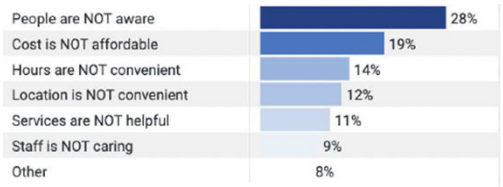
Community Conversations

What resources or support services are available to help



What stops people from using these resources or services



What other resources or support services are needed?

nrc HEALTH

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Top 10 211 Counts Request Categories by Need in Greenwich in 2021

Need Ranking	Need Category	Count	Percent
1	Mental Health & Addictions	465	38.4%
2	Housing & Shelter	414	34.2%
3	Employment & Income	93	7.7%
4	Government & Legal	70	5.8%
5	Food	67	5.5%
6	Utilities	62	5.1%
7	Disaster	13	1.1%
8	Transportation Assistance	12	1.0%
9	Clothing & Household Goods	8	0.7%
10	Child Care & Parenting	7	0.6%

The "Healthcare & Covid-19" and "Other" categories were omitted from the analysis to better understand what other medical and social drivers of health information persons requested assistance with during the pandemic. There were 1,212 total requests in Greenwich used in this analysis.

Yale NewHaven Health

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Moving from Data to Action

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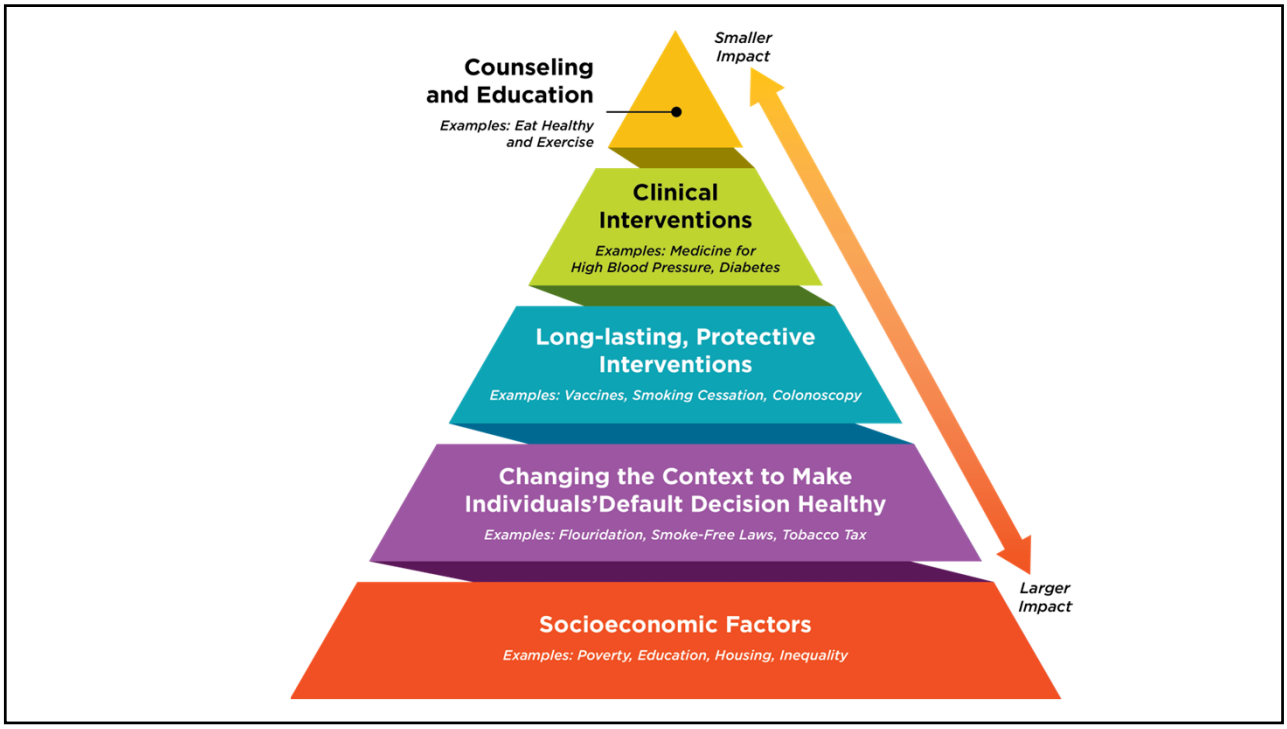

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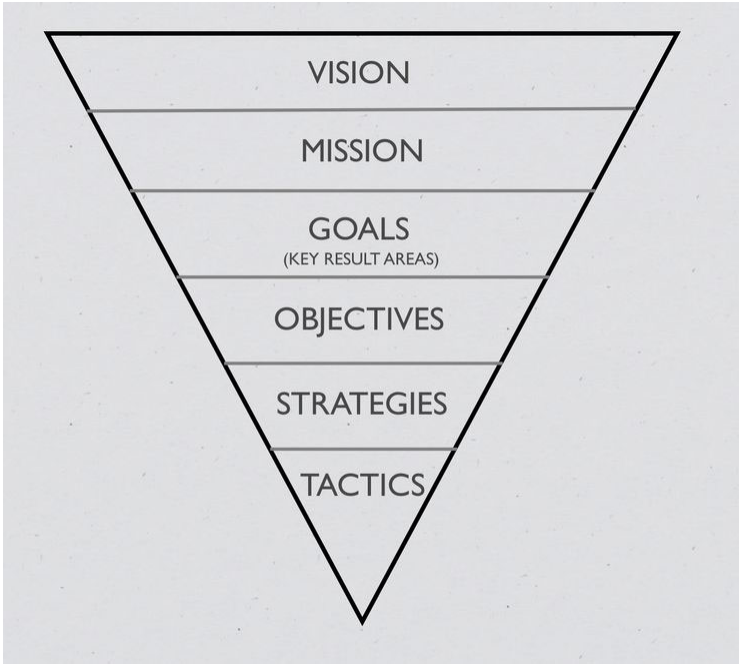

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Our CHIP definitions:

Community Research Consulting LLC

Goals: The long-term outcome that you hope to achieve.

Objectives: Measurable targets toward achieving your goal.
Concise, time-driven, statements that describe how you will achieve your goal.

Strategies: The actions you will undertake to achieve your objectives.
Should reflect your populations, partners, and community resources. Different organizations will have different strategies toward meeting collective objectives.

	WHAT	HOW
High Level	GOALS	STRATEGY
Detail Level	OBJECTIVES	TACTICS

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Advancing health equity

Equity Approach:
1. Reduce health and socioeconomic disparities
2. Achieve equitable outcomes for all residents by challenging structural and institutional inequities
3. Leverage collaboration to counteract social drivers of health
4. Change processes and policies to reimagine equitable distribution of services

2022-25 Priority Areas

Access to Care and Services
Goal: Ensure all residents have knowledge of, and equitable access to, affordable, comprehensive, appropriate, quality health care.)

Healthy Living: Healthy Bodies
Goal: Achieve equitable life expectancy for all people by ensuring all residents have the resources they need to maintain their health.

Behavioral Health: Healthy Minds
Goal: Provide equitable and sustainable access to community resources to address the unique physical, social, and behavioral health needs of all residents.

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Alignment with State Health Improvement Plans (CT and NY)

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Healthy Connecticut 2025

STATE HEALTH IMPROVEMENT PLAN

LINK↓

https://portal.ct.gov/-/media/DPH/State-Health-Planning/CT_DPH_SHIP_Report_r1-10-6-2021.pdf

FOCUS: ROOT CAUSE OF HEALTH INEQUITIES (Structural racism and inherent bias)				
	PRIORITY AREAS: SOCIAL DRIVERS OF HEALTH			
Framework for HCT2025: The Connecticut State Health Improvement Plan	**A. Access to Health Care** Primary care, health/ mental health care	**B. Economic Stabiity** Poverty, unemployment	**C. Healthy Food and Housing** Housing quality/ accessibility, healthy food access	**D. Community Strength and Resilience** Cohesion, safety, emergency respose & preparedness
	GOALS & OBJECTIVES	GOALS & OBJECTIVES	GOALS & OBJECTIVES	GOALS & OBJECTIVES
KEY IMPACT/ SURVEILLANCE MEASURE • Obesity • Suicide • Drug Overdose • Sexual Violence • Domestic Violence • Percent Insured • ER Visits	Strategies (PSE & PP)	Strategies (PSE & PP)	Strategies (PSE & PP)	Strategies (PSE & PP)
	Considered PSE & PP (Policy, Systems, Environment, and Primary Prevention) Strategies			

CROSS-CUTTING THEMES ADDRESSED BY PSE & PP STRATEGIES

- Structural Racism/Inherent Bias
- Transportation
- Education

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NEW YORK STATE Prevention Agenda

LINK↓

https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/overview.pdf

Prevent Chronic Diseases Action Plan

Focus Area 1 - **Healthy Eating and Food Security**
Focus Area 2 - **Physical Activity**
Focus Area 3 - **Tobacco Prevention**
Focus Area 4 - **Chronic Disease Preventive Care and Management**

Promote a Healthy and Safe Environment Action Plan

Focus Area 1 - **Injuries, Violence and Occupational Health**
Focus Area 2 - **Outdoor Air Quality**
Focus Area 3 - **Built and Indoor Environments**
Focus Area 4 - **Water Quality**
Focus Area 5 - **Food and Consumer Products**

Promote Healthy Women, Infants and Children Action Plan

Focus Area 1 - **Maternal and Women's Health**
Focus Area 2 - **Perinatal and Infant Health**
Focus Area 3 - **Child and Adolescent Health**
Focus Area 4 - **Cross Cutting Healthy Women, Infants, and Children**

Promote Well-Being and Prevent Mental and Substance Use Disorders Action Plan

Focus Area 1 - **Well-Being**
Focus Area 2 - **Mental and Substance Use Disorders Prevention**

Prevent Communicable Diseases Action Plan

Focus Area 1 - **Vaccine Preventable Diseases**
Focus Area 2 - **Human Immunodeficiency Virus (HIV)**
Focus Area 3 - **Sexually Transmitted Infections (STIs)**
Focus Area 4 - **Hepatitis C Virus (HCV)**
Focus Area 5 - **Antibiotic Resistance and Healthcare-Associated Infections**

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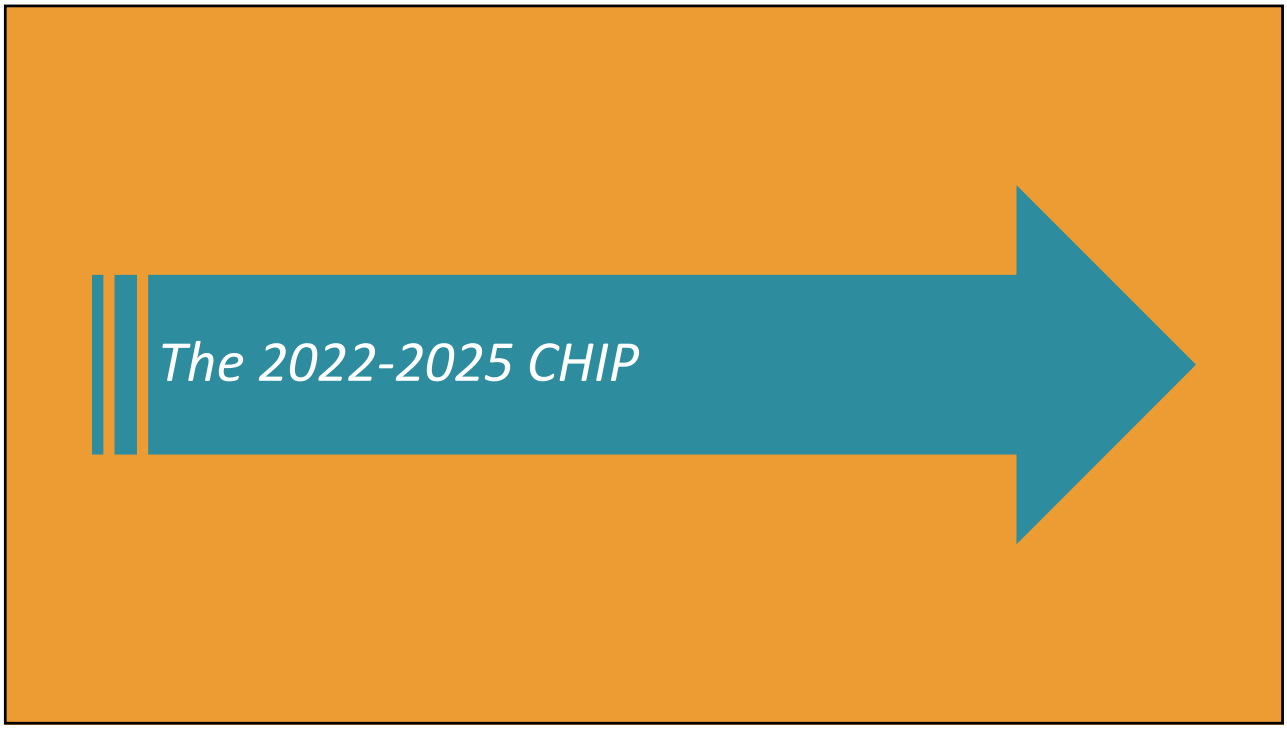

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GCHIP

Priority Area: Access to Care & Services			
Goal: Ensure all residents have knowledge of, and equitable access to, affordable, comprehensive, appropriate, quality health care.			
Our Approach →	**Achievable and Measurable**	**Promote Equity**	**Leverage Assets**
Key areas to address: ↓	**Objectives** *(What we must do to achieve this goal)*	**Strategies** *(How we will meet our objectives; reflect goal)*	**Action Steps/Tactics/Initiatives** *Specific activities or initiatives)*
Prevention and Awareness			
Build Capacity			
Effective Intervention			

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GCHIP

Priority Area: Healthy Bodies (Heathy Living)			
Goal: Achieve equitable life expectancy for all people by ensuring all residents have the resources they need to maintain their health.			
Our Approach →	**Achievable and Measurable**	**Promote Equity**	**Leverage Assets**
Key areas to address: ↓	**Objectives** *(What we must do to achieve this goal)*	**Strategies** *(How we will meet our objectives; reflect goal)*	**Action Steps/Tactics/Initiatives** *Specific activities or initiatives)*
Prevention and Awareness			
Build Capacity			
Effective Intervention			

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GCHIP

Priority Area: Heathy Minds (Behavioral Health)			
Goal: Provide equitable and sustainable access to community resources to address the unique physical, social, and behavioral health needs of all residents.			
Our Approach →	**Achievable and Measurable**	**Promote Equity**	**Leverage Assets**
Key areas to address: ↓	**Objectives** *(What we must do to achieve this goal)*	**Strategies** *(How we will meet our objectives; reflect goal)*	**Action Steps/Tactics/Initiatives** *Specific activities or initiatives)*
Prevention and Awareness			
Build Capacity			
Effective Intervention			

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