Community Health Needs Assessment 2019

Coming together to make a difference

Yale NewHaven Health
L+M Healthcare

Health Improvement Collaborative
Southeastern Connecticut

Acknowledgments

PRIMARY CONTRIBUTORS

Mark Abraham, DataHaven
Megan Brown, Thames Valley Council for Community Action
David Burnside, Southern CT State University
Stephanye Clarke, New London NAACP and Community Foundation of Eastern Connecticut
Judelysse Gomez, Connecticut College
Laurel Holmes, L+M Hospital
Russell Melmed, Ledge Light Health District
Fawatih Mohamed-Abouh, L+M Hospital
Jennifer Muggeo, Ledge Light Health District

HEALTH IMPROVEMENT COLLABORATIVE OF SOUTHEASTERN CT

Jennifer Baldwin, Office of Chief Public Defender
Karen Barber, CT Behavioral Health Associates
Kerry Bilda, United Community and Family Services
Elizabeth Billingsley, resident
Paige Bogda, Beacon Health
Emily Boushee, Office of U.S. Senator Chris Murphy
Sharon Bousquet, New London Recreation
Yolanda Bowes, United Community and Family Services
Lee Carenza, Thames Valley Council for Community Action
Brianna Chaput, United Community and Family Services
Tom Curcio, New London Police Department
Joe Cypriano, resident
Gino Demaio, Sound Community Services
Michelle Devine, SE Regional Action Council
Dana Dixon, New London Homeless Hospitality Center
Karen Ethier-Waring, Child and Family Agency
Ron Flores, Connecticut College
Matt Galante, New London Police Department
Peter Greenwald, resident
Stephenie Guess, Southeastern Mental Health Authority
Jim Haslam, CT Legal Services
Beth Hogan, The Connection
Chelsea Humphrey, The Connection
Jessica Johnson, Planned Parenthood of Southern New England
Carol Jones, Alliance for Living
Mary Beth Jordan, Southeastern Mental Health Authority
Mary Ellen Jukoski, Three Rivers Community College
Lexa Juhre, Fiddleheads Food Co-op
Margaret Lancaster, New London Community Campus Coalition
Jerry Lokken, Groton Parks and Recreation
Frank Maletz, HEALTHSPITAL Foundation
Stephen Mansfield, Ledge Light Health District
Bud McAllister, Partners for Healthy Communities
Alicia McAvay, FRESH New London
Alejandro Melendez-Cooper, Hispanic Alliance
Jeanne Milstein, City of New London
Justin Mink, Natchaug Hospital
Patrick Murphy, Community Health Center
Jennifer O'Brien, Community Foundation of Eastern Connecticut
Geanine Peck, Yale New Haven Health System
Ocean Pellett, United Action
Jon Persson, resident
Kate Rattan, Southeastern CT Council of Governments
Jonathan Reiner, Groton Town Planning
Jessica Resto, L+M Hospital
Daniel Rissi, resident
Gloria Rodriguez, New London Public Schools
Michele Scott, Eastern Area Health Education Center
Jesus Silva, Eastern Region Service Center
Scott Sjoquist, Director of Health, Mohegan Tribal Health Department
Stephen Smith, Community Health Center
Anas Tarrabolsi, CT Behavioral Health Associates
Sybil Tetteh, New London Planning
Kelly Thompson, Alliance for Living
Diane Verrochi, resident
Victor Villagra, UCONN Health Disparities Institute
Melinda Wilson, Southeastern CT Enterprise Region
Catherine Zall, New London Homeless Hospitality Center

KEY INFORMANT SURVEY

Yale School of Public Health Students

COMMUNITY ENGAGEMENT CONSULTANTS

Tekisha Everette, Health Equity Solutions
Eve Berry, Eve Berry & Partners, LLC

CONTACTS

L+M Hospital Department of Community Partnerships + Population Health (860) 271-4698 or laurel.holmes@lmhosp.org

Ledge Light Health District (860) 448-4882 ext. 1300 or jmuggeo@llhd.org

FUNDING SUPPORT

Funding for this project was generously provided by the Community Foundation of Eastern Connecticut

DATA SOURCES

The graphs and information included on the following pages reflect data from several sources:

- The 2018 DataHaven Wellbeing Survey (2018 Wellbeing Survey)
- The 2015 DataHaven Wellbeing Survey (2015 Wellbeing Survey)
- The American Community Survey (ACS), US Census
- Centers for Disease Control and Prevention (CDC)
- Connecticut Department of Public Health (CT DPH)
- Connecticut Department of Mental Health and Addiction Services (CT DMHAS)
- Connecticut Office of Chief Medical Examiner (CT OCME)
- Connecticut State Department of Education (CSDE)
- Connecticut Department of Transportation (DOT)
- Connecticut Hospital Association (CHA) – Chime Data
- Environmental Protection Agency (EPA)
- FBI Uniform Crime Reporting (UCR)
- Lawrence + Memorial Hospital (L+M)
- Ledge Light Health District (LLHD)
- Locally Conducted Focus Groups – Community Conversations by Health Equity Solutions
- Southeastern Regional Action Council (SERAC)
- The SEOW Prevention Data Portal by Center for Prevention and Evaluation Statistics (CPES)
- TVCCA
- National Survey on Drug Use and Health (NSDUH), from Substance Abuse and Mental Health Service Administration (SAMHSA)

Executive Summary

Guided by the Southeastern CT Health Improvement Collaborative, a partnership of health care providers, local public health, federally qualified health centers, higher education, and numerous social service and other non-profit organizations serving the region, data from primary and secondary sources were considered in order to identify and elucidate the leading health indicators for the region included in this report.

The data in this assessment provide a rich array of information and move the process toward a more holistic understanding of health status, perceptions, barriers, and strategies for improvement. Community member input reveal consistent themes around both the many assets in our region and the many challenges that residents face in achieving health and wellbeing. Particular attention has been paid to the intersection between social, economic, and environmental conditions and health as well as to health disparities in recognition of the significant contribution of social determinants to overall health and wellness.

The data further reiterate that where one lives has a very powerful impact on life expectancy. A determinant strongly tied to neighborhood, economic security, or the ability to regularly and comfortably pay for one's basic needs such as food, housing, transportation, and other goods and services, is closely associated with health outcomes. Residents in lower income categories report lower wellbeing, less access to basic resources including high quality fruits and vegetables, lower rates of feeling safe and trusting their neighbors, and more incidences of discrimination. Food insecurity among the working poor ($30K to $75K annual income) exceeds that of the lower income category. Further, rates of poverty in the Black and LatinX populations of the region are disproportionate to their overall population.

Those unemployed and wanting to work are more represented among the low income, young adults, and those with less education. Poverty and less education lead to poor health, which makes the ability to work more difficult, further exacerbating poverty. Additionally, the Wellbeing Survey highlighted several indicators related to the experience of discrimination including in employment, in relationship with the police, and in healthcare. This discrimination was perceived to be most often associated with race. These measures are of critical importance in formulating the Community Health Improvement Plan as the micro-aggressions and toxic stress associated with racism is linked to poor health outcomes.

Housing stock in the region is older in general and more likely to harbor health hazards such as defective lead paint, failing plumbing, and asbestos insulation underscoring poorer health among lower income residents who are more likely to live in poor quality housing. Although housing cost burden, defined as spending 30% or more on housing costs, has declined slightly in recent years, there is a continued challenge for many families to find affordable housing in the region. Transportation has continued to be a key concern impacting health; focus group, web survey participants, and community partners repeatedly cited the need for more and better public and specialty transportation.

As it relates to chronic disease, there are repeated associations between poor health and social determinants in the assessment data. When sedentary lifestyle is examined by income, those with incomes less than $75,000 are more likely to be sedentary than the state and greater New London overall. Vaping, diabetes, asthma, and heart disease also have higher prevalence among those within lower income categories and those with lower levels of education. Lower income and education is also correlated with higher emergency department use, the delaying of healthcare, not getting necessary care, less dental care, a lack of primary care provider, and not getting necessary medications due to cost.

Mental and emotional wellbeing is an area of concern, with disparities by race and also by income. People of color report anxiety and depression at significantly higher rates than Whites in the region. Drug overdoses and overall substance use remain an area of grave concern.

Racial and ethnic health disparities were evident on several indicators including asthma (higher among people of color), oral health (less preventive care among people of color), obesity (higher among African Americans) and hypertension (higher among African Americans). People of color are more likely to use the hospital emergency department (ED) three or more times per year, considered a proxy for access to care in the community.

Understanding the connections between wide ranging factors and their relative contributions to overall health is one goal of the community health assessment process. Only through this understanding can the community effectively impact policies, systems and practices toward a healthier community.

Table of contents

Introduction

Collective impact momentum that began in 2016 with the formation of the Community Health Improvement Collaborative of Southeastern Connecticut (Collaborative), a coalition of L+M Hospital, other health care providers, local public health, federally qualified health centers, tribal representatives, higher education, and numerous non-profit organizations serving the region, was again leveraged in 2018 – 2019 for the updated community health assessment (CHA) presented in this report. Collaborative partners considered data from primary and secondary sources to identify and elucidate the leading health indicators for the region. Particular attention was paid to inequities in health and social determinants, the interplay of factors or intersectionality, and to uncovering what might be some unexpected correlations in the data.

In the intervening years since the last CHA report, it has become generally understood and accepted that social determinants, such as poverty, educational attainment, food security, housing, and transportation, contribute to overall wellbeing and health more than clinical care. As frequently stated, zip code is more important that genetic code as a contributor to health. Developing the best strategies to improve health requires an understanding of how socialdeterminants influence health. It is especially important when considering health inequities; the fact that some groups within our communities bear disproportionate rates of disease and/or experience disparate quality of care is related to many intersecting factors. Achieving a "healthy community" where everyone has the same opportunities to make healthy choices and access quality, culturally and linguistically sensitive, timely and affordable health care requires us to examine inequities in socioeconomic conditions and the policies and practices that create them.

Accompanying this assessment is an updated Community Health Improvement Plan (CHIP) to address the findings. Through the prioritization and planning process, the Collaborative has recommitted to ongoing strategies and/or identify new initiatives to implement in order to achieve improved health outcomes. The member organizations of the Collaborative intend for the reports to serve as guides for planning future programs and for policy agendas for agencies, municipalities, and the State of Connecticut.

	WINTER 2018	SPRING 2018	SUMMER 2018	FALL 2018	WINTER 2019	SPRING 2019	SUMMER 2019
Key Informant Survey (YSPH Consulting Group)							
CT Well-Being Survey Conducted (DataHaven)							
Secondary Data Collection							
Community Engagement (Health Equity Solutions)							
Primary & Secondary Data Findings Presented							
Prioritization Meeting							
CHIP Updated							
Community Meetings							
Hospital Board Presentation							

Process

On May 26, 2015, L+M and LLHD organized the first meeting of what would become the Southeastern CT Health Improvement Collaborative (Collaborative). From that time forward, the Collaborative has met regularly to engage in planning and implementation of strategies to address the findings of the 2015–2016 community health needs assessment (CHNA).

The 2016 CHNA and related Community Health Improvement Plan (CHIP) were posted to the L+M Hospital and Ledge Light Health District websites. Printed copies were made available upon request and comments were solicited publicly with a dedicated email address established to receive public comment. Progress on the CHIP has been reported at public meetings in New London on 7/6/17, 12/4/17, 7/10/18, 12/4/18 at which times community members had the opportunity to ask questions and offer feedback.

In order to respond to the identified needs, four focused action teams were formed. Action teams also hold regular meetings and engage in additional data collection, strategies and tactics. A coordinating team consisting of leadership from the four priority area action teams as well as Ledge Light Health District and L+M Hospital ensures the forward movement of the efforts, identifies opportunities to cross-pollinate ideas and activities between the Action Teams, reviews potential funding sources, and develops agendas for the full Collaborative. The Collaborative distribution group includes representation from over 100 community agencies.

Quantitative and qualitative data for the CHNA were collected and reviewed throughout 2018 and early 2019. This assessment includes review and analysis of data from primary and secondary data sources. Secondary data sources included, but were not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, state public health departments, Connecticut Health Information Management Exchange (CHIME), as well as local organizations and agencies. Types of data included vital statistics based on birth and death records.

For primary data, the Collaborative partnered with DataHaven on the 2018 DataHaven Community Wellbeing Survey (CWS), the statewide Wellbeing Survey of adults conducted by DataHaven in the fall of 2018. A telephone survey of area residents with oversampling conducted in select communities, the survey included nearly 1,000 residents from Greater New London. The survey was delivered in English and Spanish and included both landline and cell phones. The sampling methodology and survey tool are available upon request.

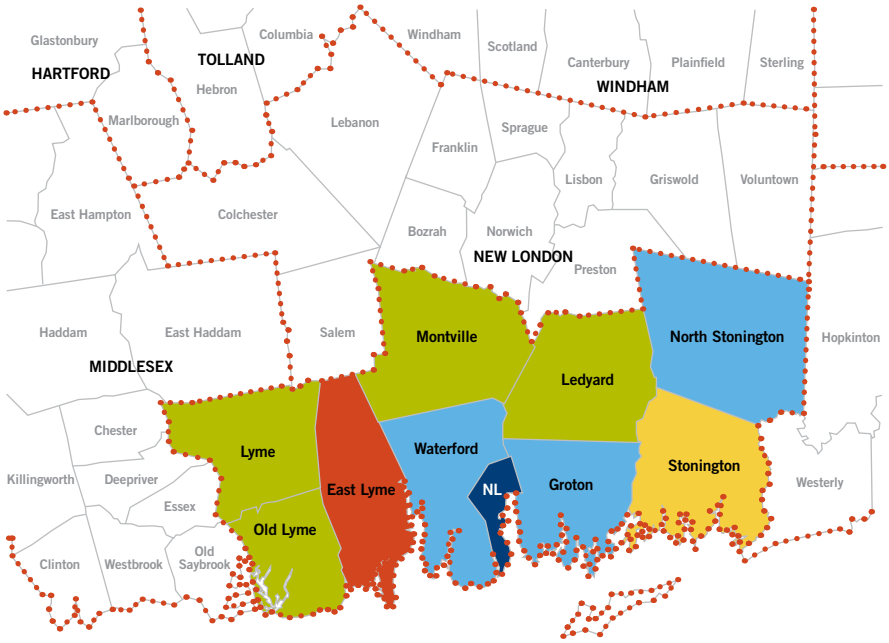
A key informant survey was another source of primary data and students from the Yale School of Public Health Student Consulting Groups conducted and analyzed that survey in the Spring of 2018. Based on community leaders identified by the Collaborative, there were 112 electronic surveys distributed with a 37% response rate. A summary of the results is included in this report in Appendix D.

Additionally, the Collaborative engaged Health Equity Solutions to conduct community conversations in the Greater New London Region in order to gather qualitative data. Seven resident groups representing vulnerable populations were identified for the conversations with the goal of gathering a deeper understanding of identified community issues from their perspectives. These conversations took place in the Winter/Spring of 2019; a summary is included in this report in Appendix E.

In order to consider all of the data collected, the Collaborative facilitated prioritization meetings in May and June of 2019 and developed the Community Health Improvement Plan (CHIP). Once the CHNA and CHIP documents are approved, they will be available on the L+M Hospital and Ledge Light Health District websites. Community meetings to present data will be held in the summer and fall of 2019.

Geographic Scope

The geography included in the 2019 Community Health Assessment consists of the primary service area of L+M Hospital. These municipalities are a mix of urban and suburban communities and include two federally-recognized Tribal Nations. Upon defining the geographic area and population serviced in Greater New London, the Collaborative was diligent to ensure that no groups, especially minority, low-income or medically under-served, were excluded.



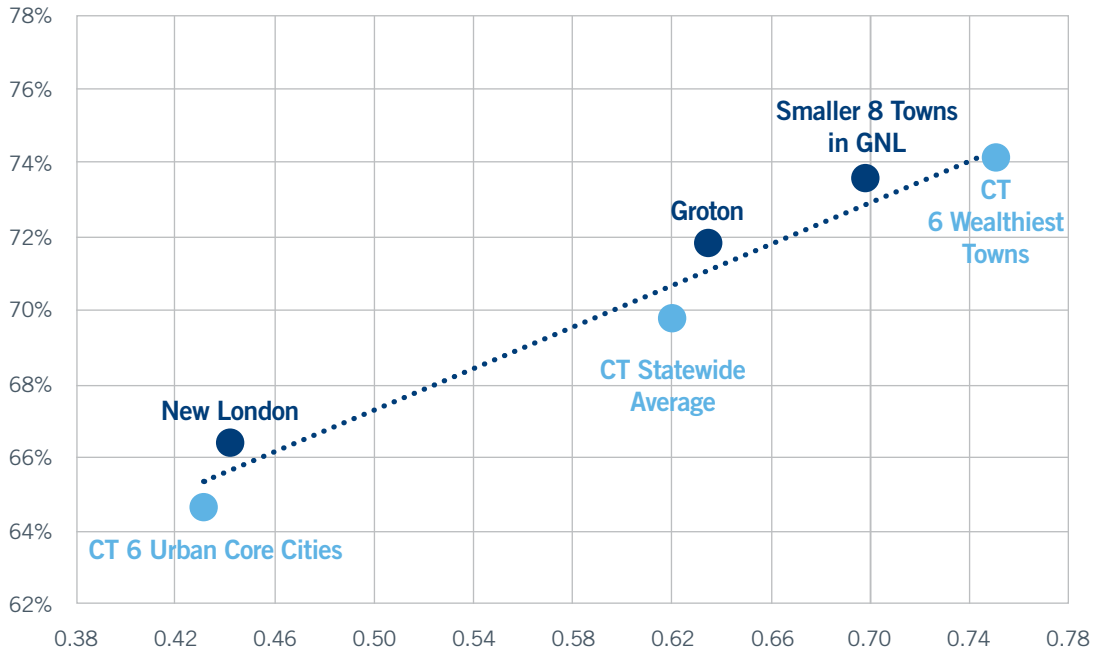
Greater New London (GNL) area includes:

- Ledge Light Health District Towns
- East Lyme
- Lyme
- Old Lyme
- Waterford
- New London
- Groton
- Ledyard
- Stonington
- North Stonington
- Uncas Health District Town
- Montville

Wellbeing Index

Throughout the Greater New London Region, personal wellbeing is strongly associated with the Community Index.

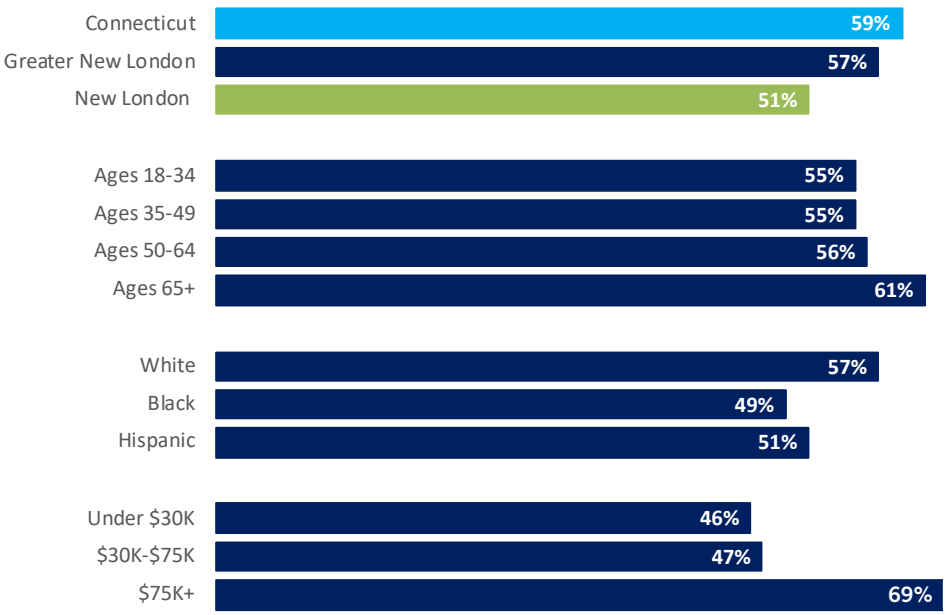
Personal wellbeing score based on self-reported happiness, health, anxiety, and life satisfaction.



Community Index score based on employment, education, income, poverty, life expectancy, and other community-level factors.

Source: DataHaven analysis of 2018 DataHaven Community Wellbeing Survey live, in-depth interviews with 16,043 randomly selected adults throughout CT, and DataHaven analysis of U.S. Census 2013-2017 5-year American Community Survey and other local data.

Self-Reported Wellbeing



Adults rating their overall health as excellent or very good, GNL, Wellbeing Survey 2018.

Self-rated health status is a measure used internationally and a strong predictor of health outcomes and hospitalizations. There are significant disparities by income, race/ethnicity, and geography.

Demographics

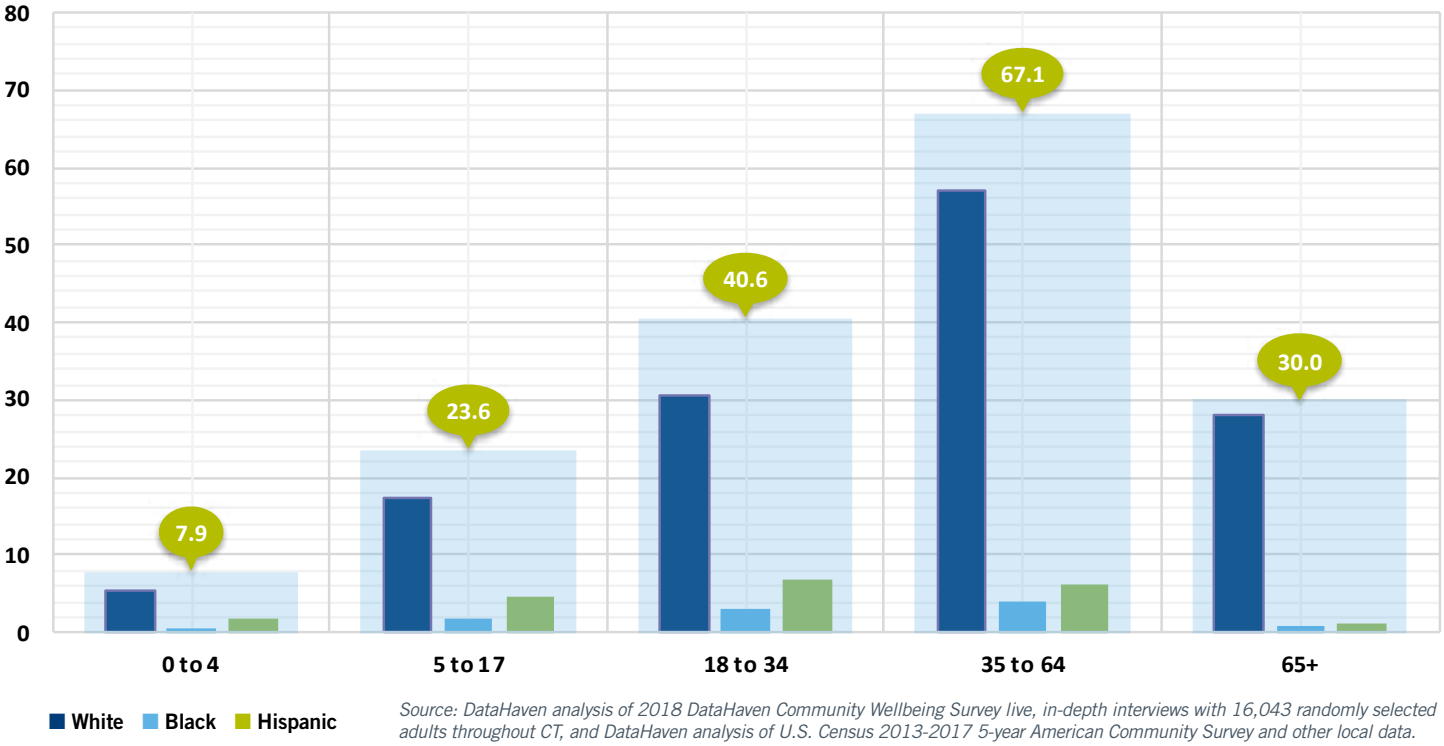
Population

2015-2017 GNL population by race and ethnicity ACS 2013-2017:

The region's population is becoming more diverse. In the urban centers of Groton and New London, the population trends younger. The school enrollment population is more racially and ethnically diverse than the overall population.

Race/Ethnicity	Number (%) 2015	Number (%) 2017
Hispanic or Latino	10.4%	11.7%
White	76.0%	74.5%
Black	5.5%	5.3%
Asian	4.1%	4.0%
Other	0.1%	0.2%)
American Indian	0.5%	0.5%
Two or more Races	3.4%	3.8%

GNL population in thousands by age group:

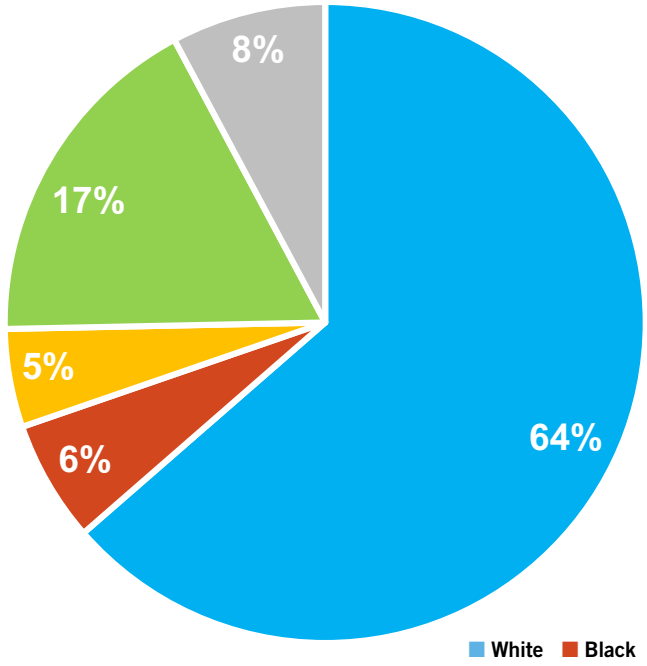


Source: DataHaven analysis of 2018 DataHaven Community Wellbeing Survey live, in-depth interviews with 16,043 randomly selected adults throughout CT, and DataHaven analysis of U.S. Census 2013-2017 5-year American Community Survey and other local data.

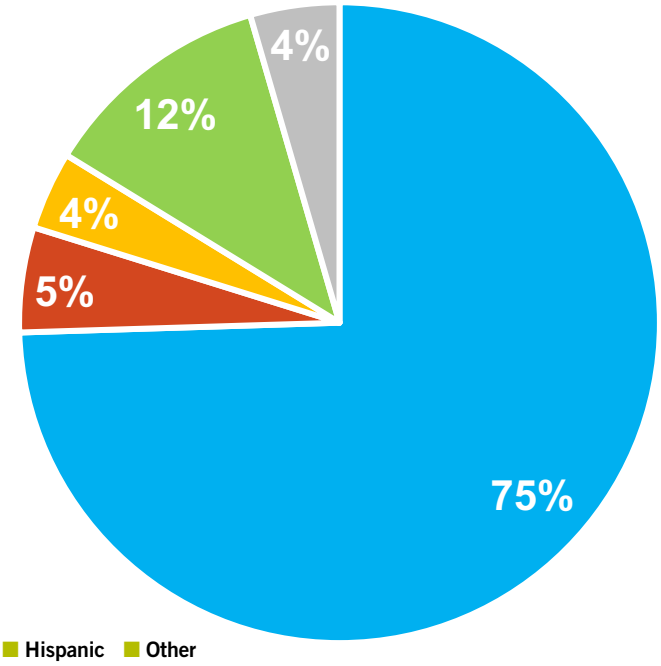
Population

GNL school enrollment VS. population by race/ethnicity:

Public school students by race/ethnicity, GNL, 2017-2018

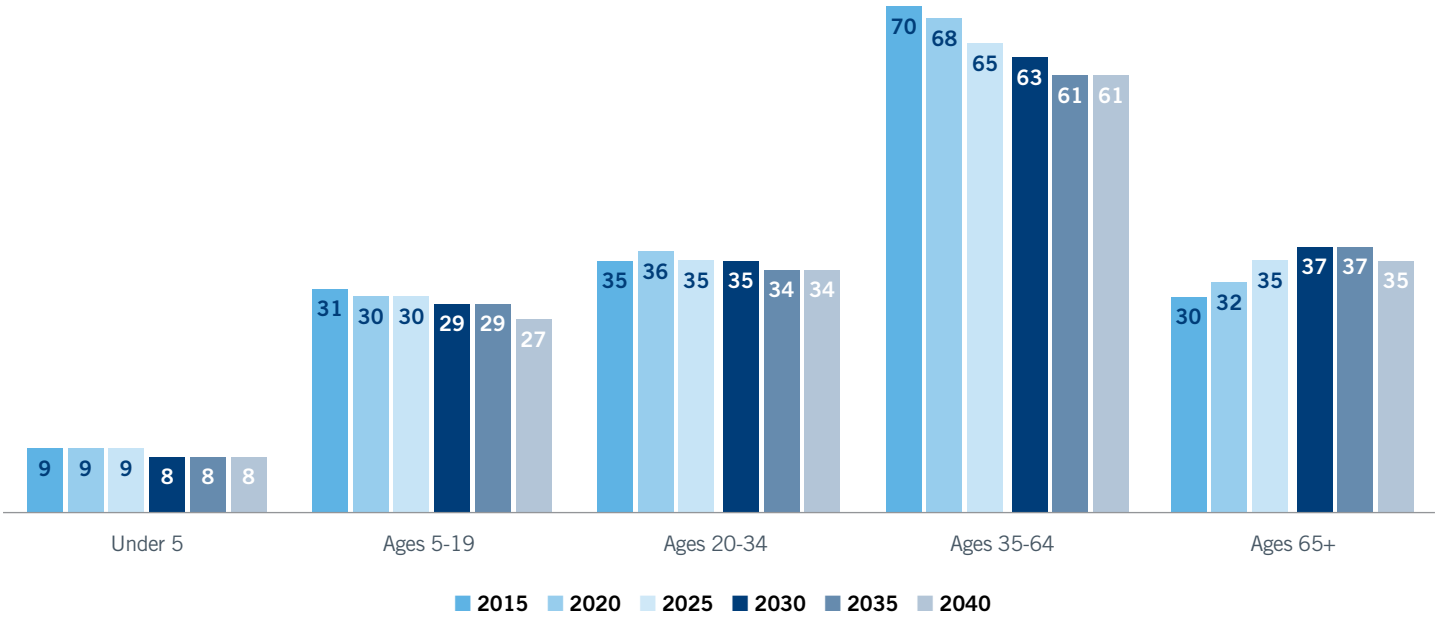


GNL 2017 population by race/ethnicity:



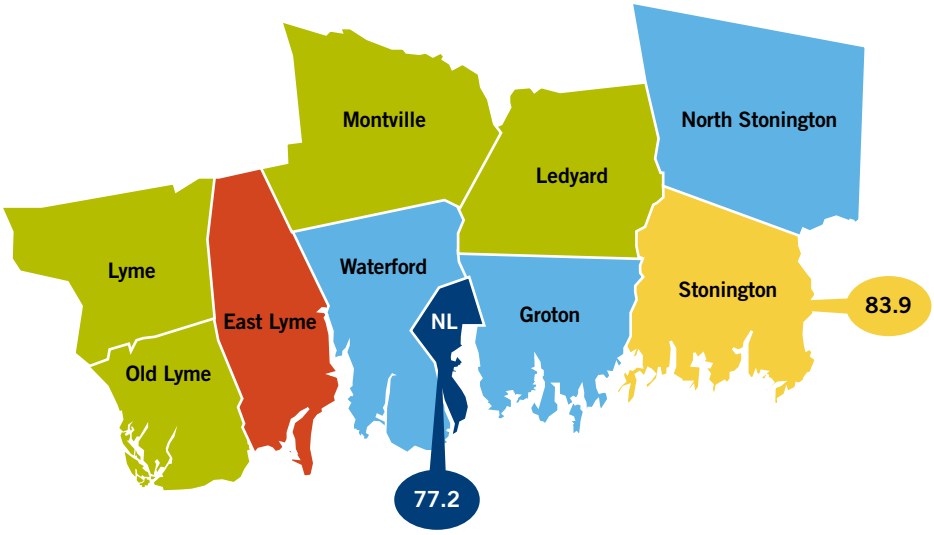
White Black Asian Hispanic Other

GNL projected population in 1000s by age group, ACS 2015-2040:



Life Expectancy

Life expectancy at birth, Greater New London by town, CDC 2018:



Where you live matters in terms of life expectancy. In southeastern Connecticut there is a 5+ year disparity between the town with the highest life expectancy and that with the lowest. An examination to the census tract level reveals even greater disparities.

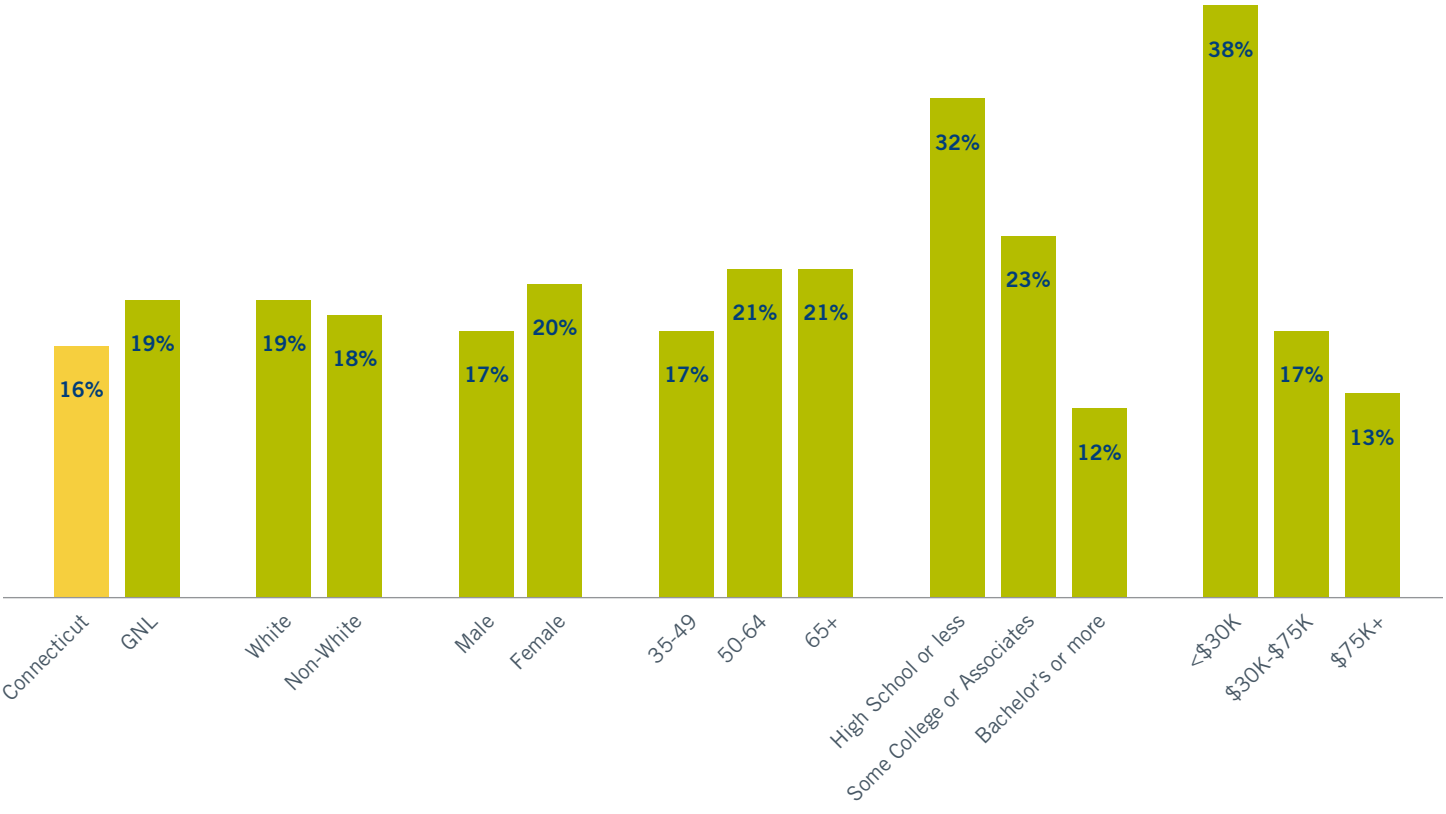
GNL: 80.89

Connecticut: 80.30

US: 78.70

- 0.01 - 77.20
- 77.21 - 79.90
- 79.91 - 81.00
- 81.01 - 82.30
- 82.31 - 83.90

Does any disability, handicap, or chronic disease keep you from participating fully in work, school, housework, or other activities? Wellbeing Survey 2018:

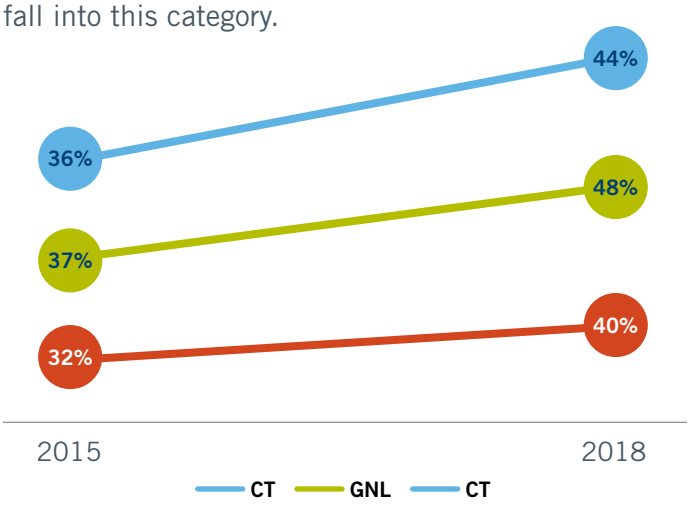


Social and Economic Factors

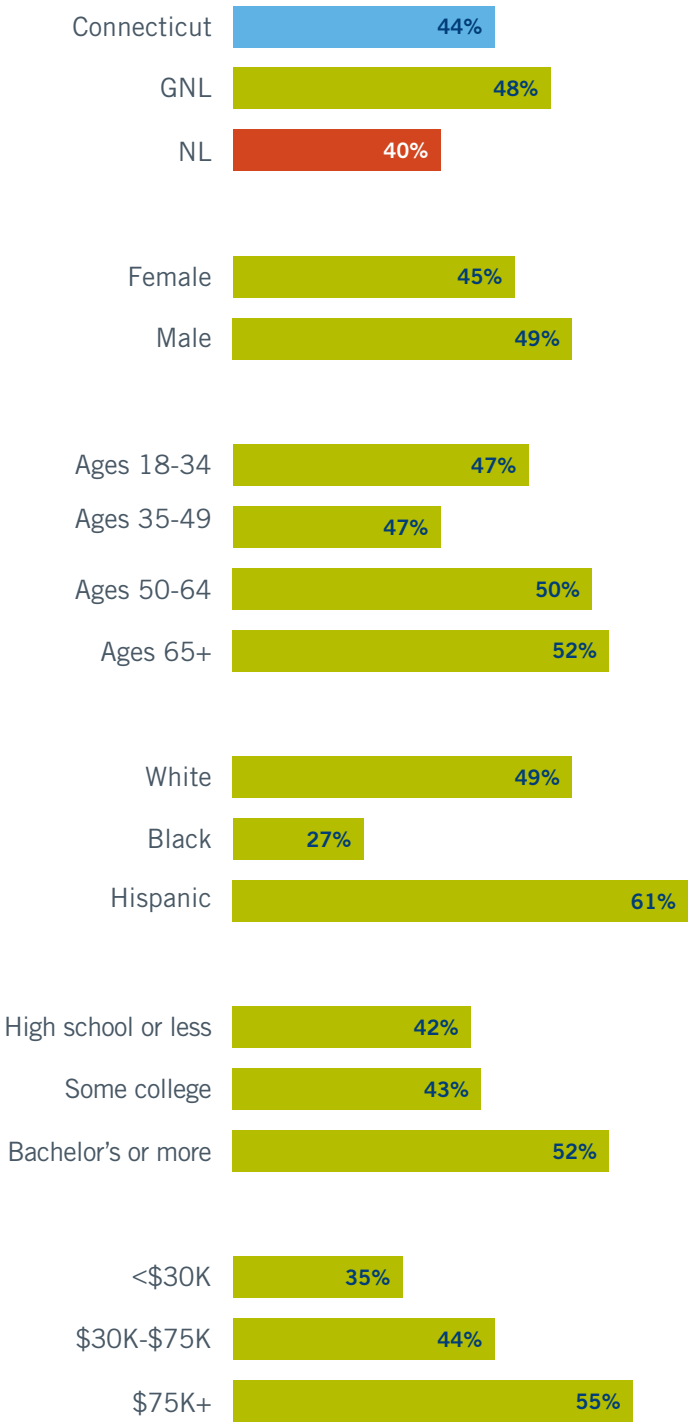
Economic Security

Perception that there is good availability of job opportunities, Wellbeing Survey 2015-2018:

Economic Security, or the ability to regularly and comfortably pay for one's basic needs such as food, housing, transportation, and other goods and services, is closely associated with health outcomes. Perceptions about job opportunities vary widely based on age, race/ethnicity, education level, and income. "Real unemployment" references the portion of the population who are unemployed but would like to be working. Significantly higher percentages of those who are younger, less educated and earning lower incomes fall into this category.

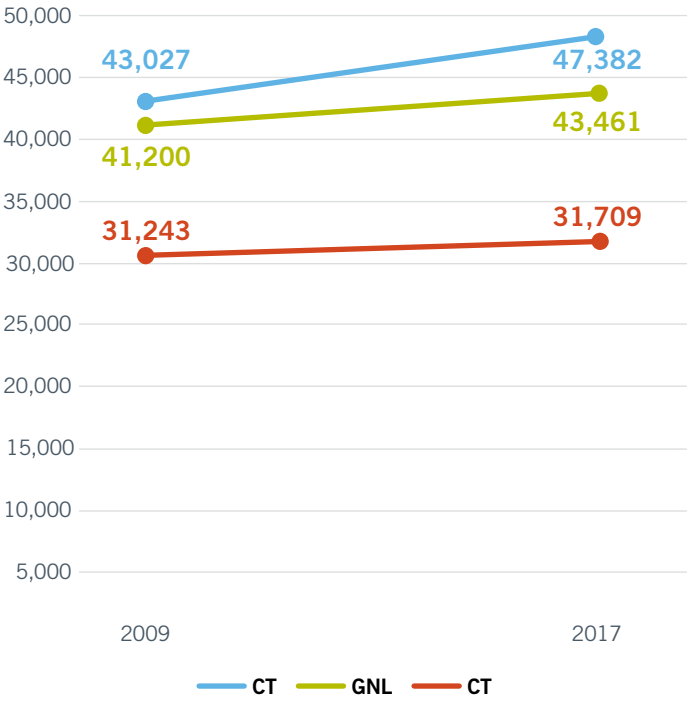


Perception that there is good availability of job opportunities, GNL, Wellbeing Survey 2018:

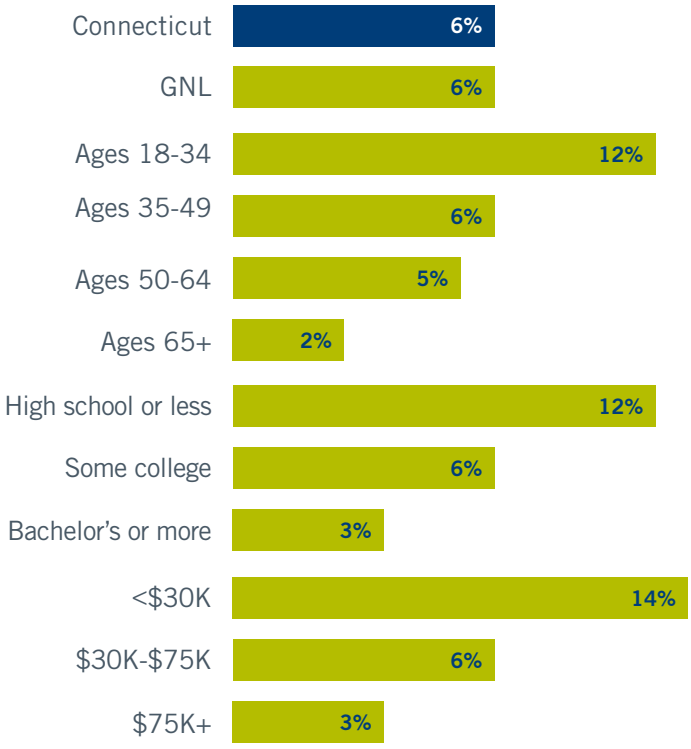


Economic Security

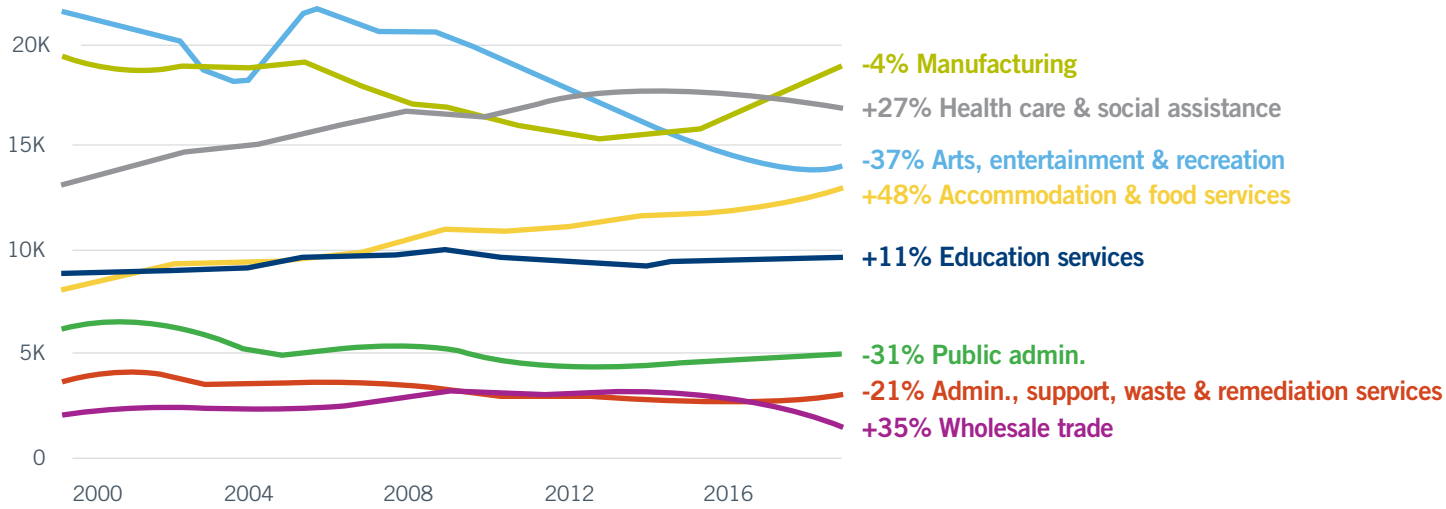
Median earnings for 25 years and older (inflation-adjusted dollars), ACS 2009-2017:



Adults unemployed and want to work, GNL, Wellbeing Survey 2018:

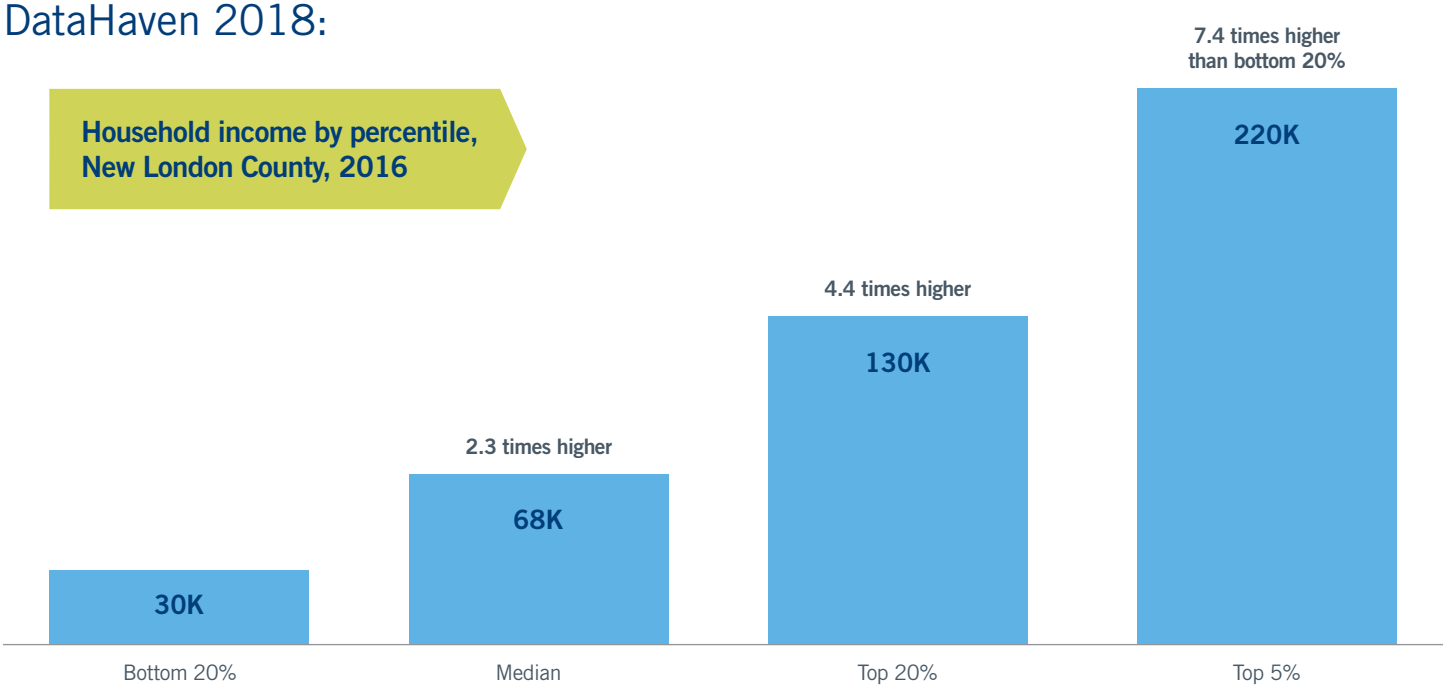


As entertainment jobs have declined, health care and accommodations industries are on the rise, DataHaven 2018:



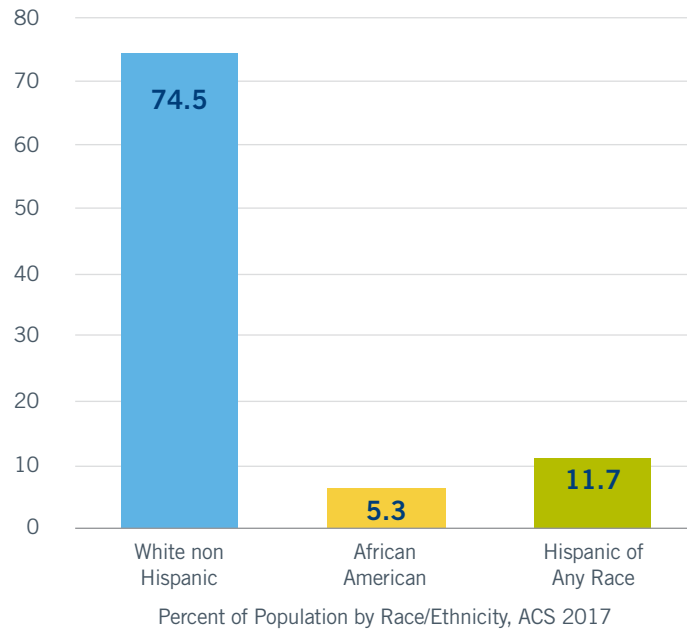
Economic Security

New London County's richest 5% earn seven times more than the lowest 20%, DataHaven 2018:

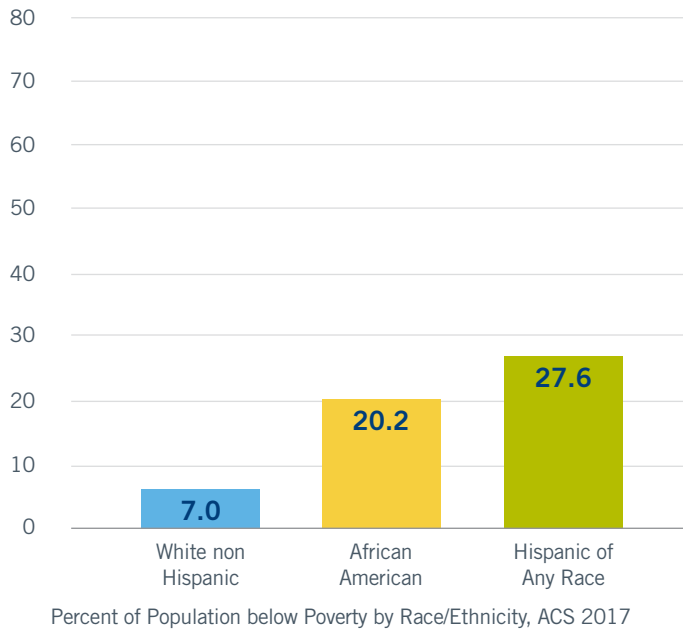


GNL Population by race/ethnicity and population in poverty by race/ethnicity:

Poverty rates among Black and LatinX people is disproportionate to the overall population. Certain groups are experiencing a continued upward trend in poverty.



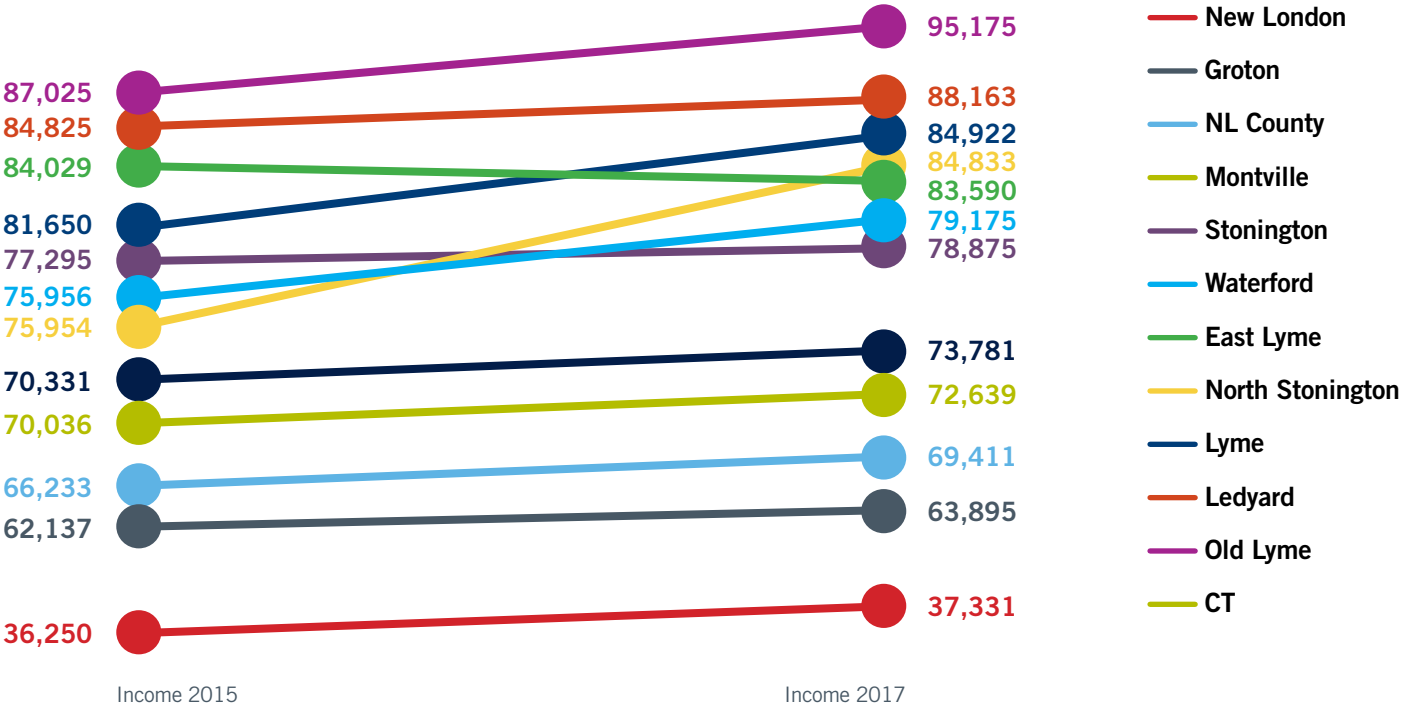
Percent of Population by Race/Ethnicity, ACS 2017



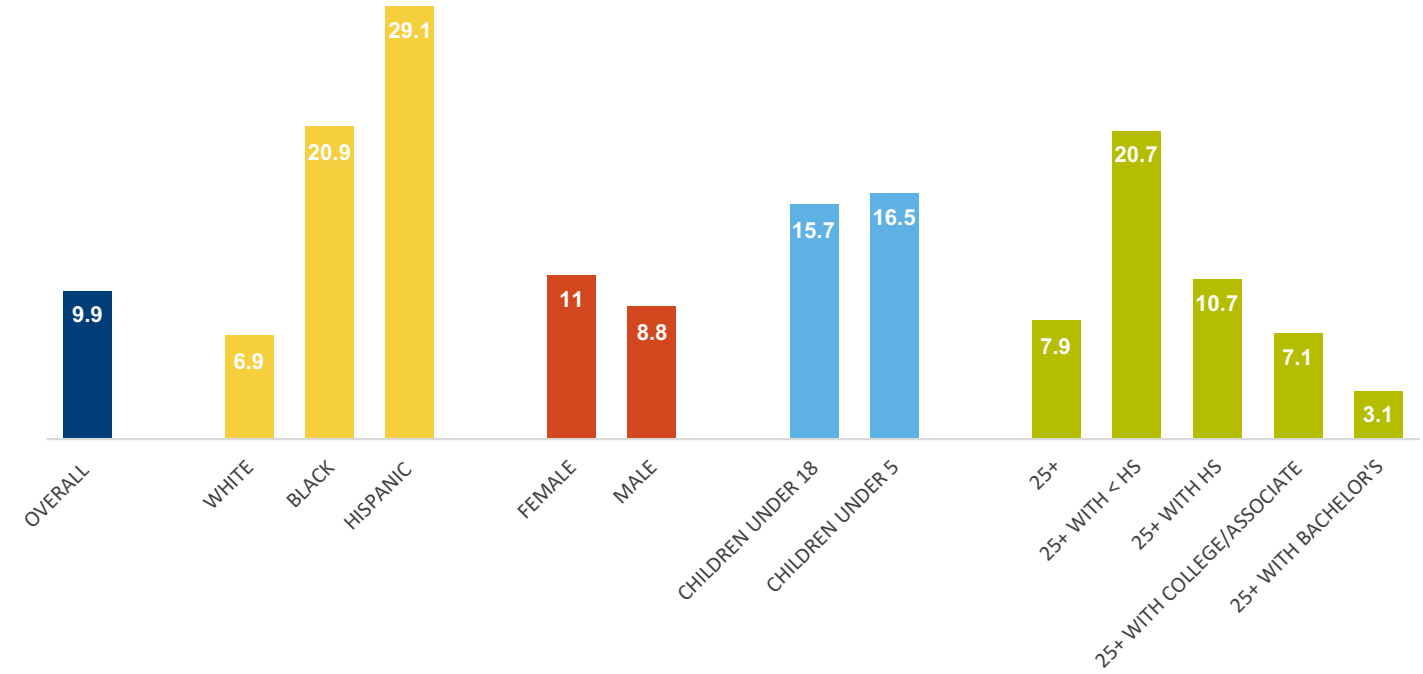
Percent of Population below Poverty by Race/Ethnicity, ACS 2017

Economic Security

GNL median household income by town, ACS 2015-2017:

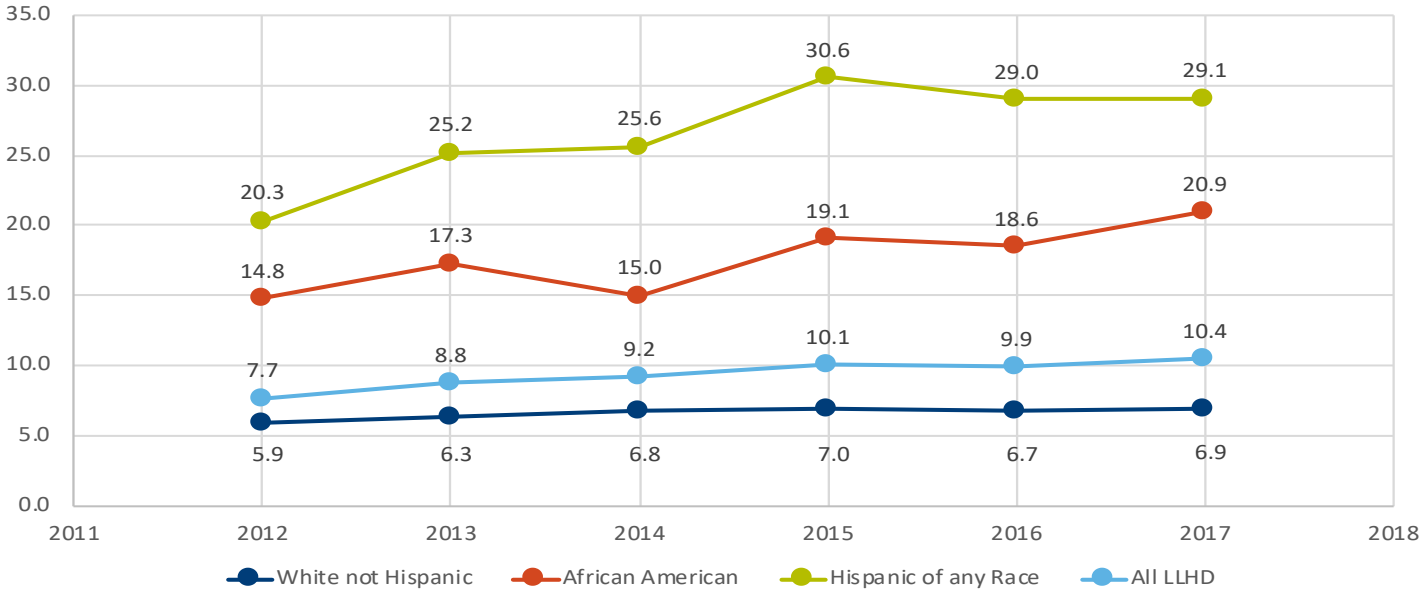


Percent of population below poverty in NL County, ACS 2017:



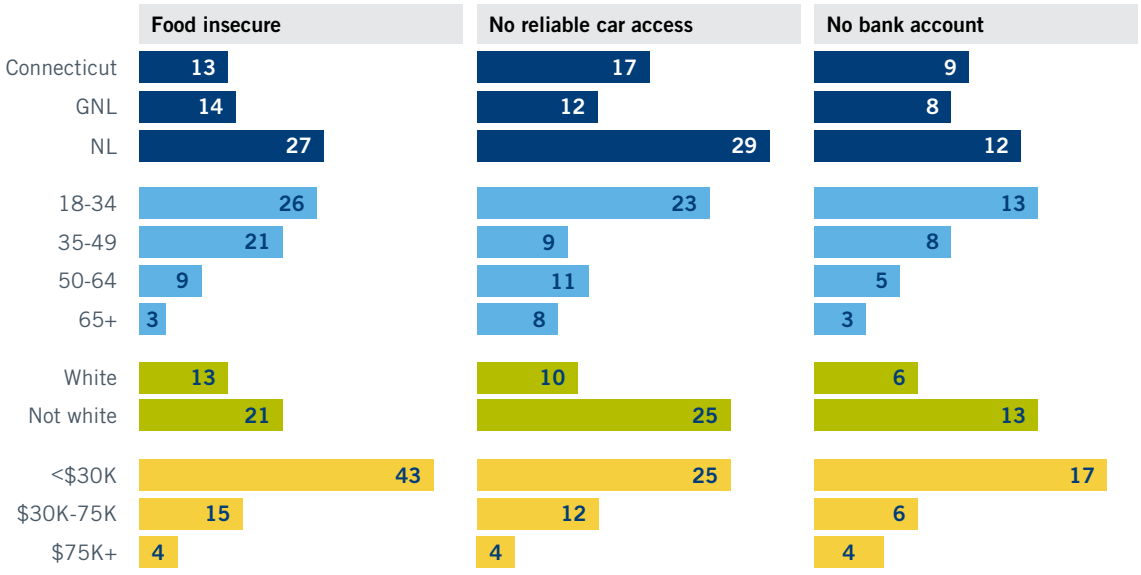
Economic Security

Change in percent in poverty rate by race/ethnicity and for all LLHD, ACS 2012-2017:



Household Resources

Younger adults, lower-income adults, and adults of color have less access to basic resources, Wellbeing Survey 2018:

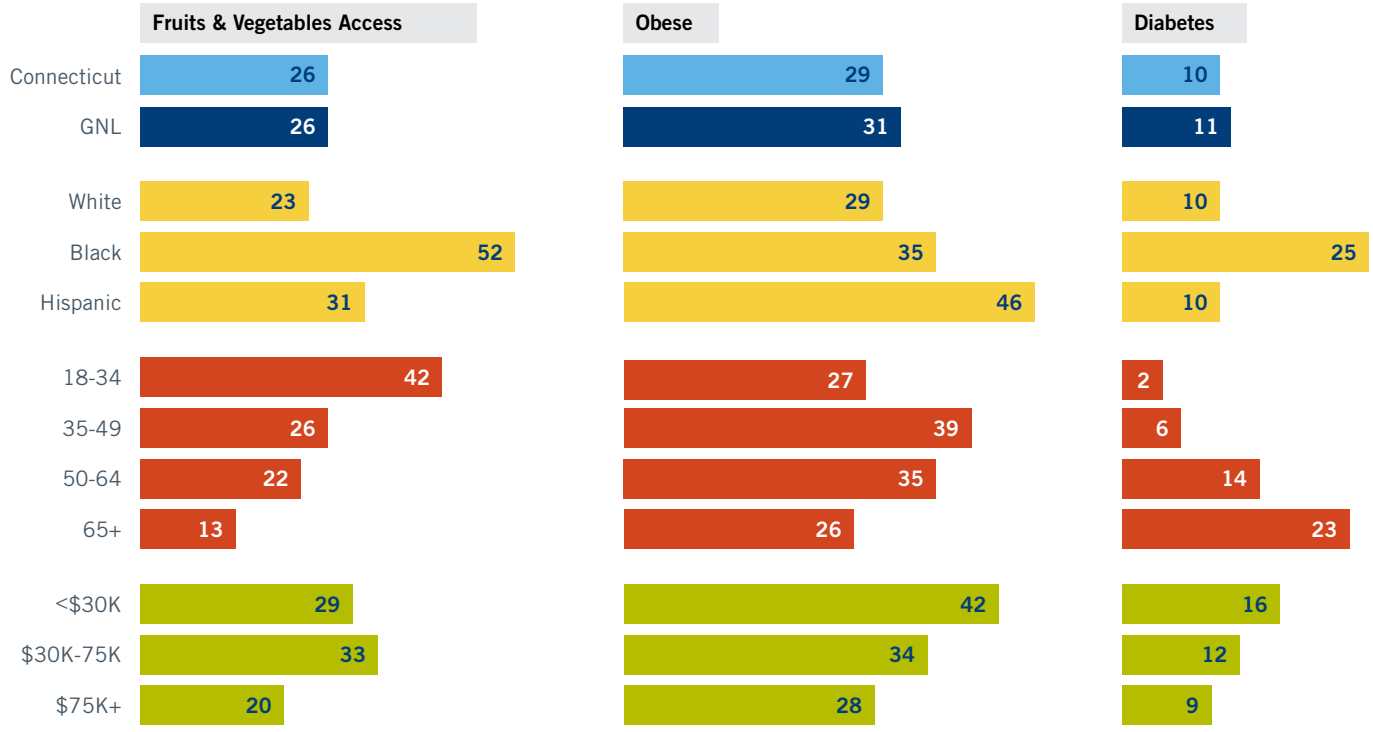


Percent of adults facing measures of financial insecurity by age, race, and income Greater New London, 2018

Food Security

Affordability of high-quality fruits and vegetables, obesity, and diabetes, GNL, Wellbeing Survey 2018:

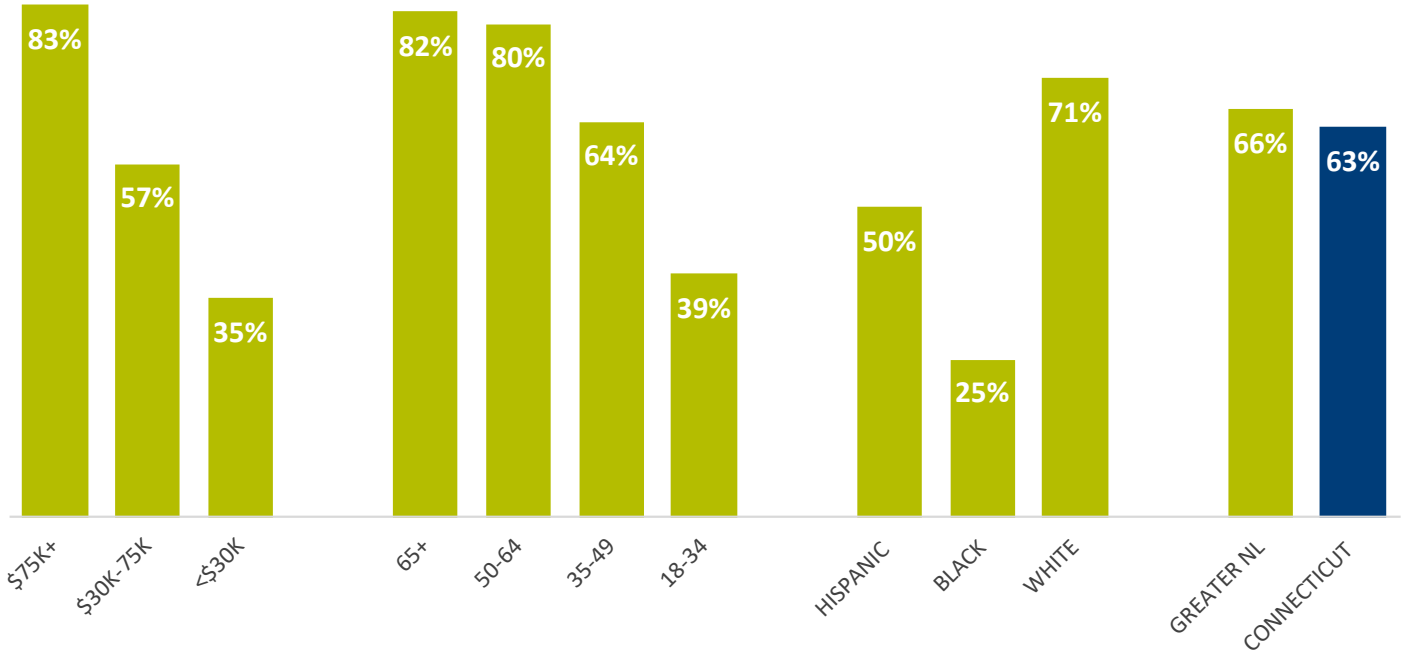
One of the direst consequences of poverty is the inability to buy food. Food insecurity in the region continues to be a significant challenge, particularly for middle-income earners and working poor. There is also an association between food insecurity and obesity.



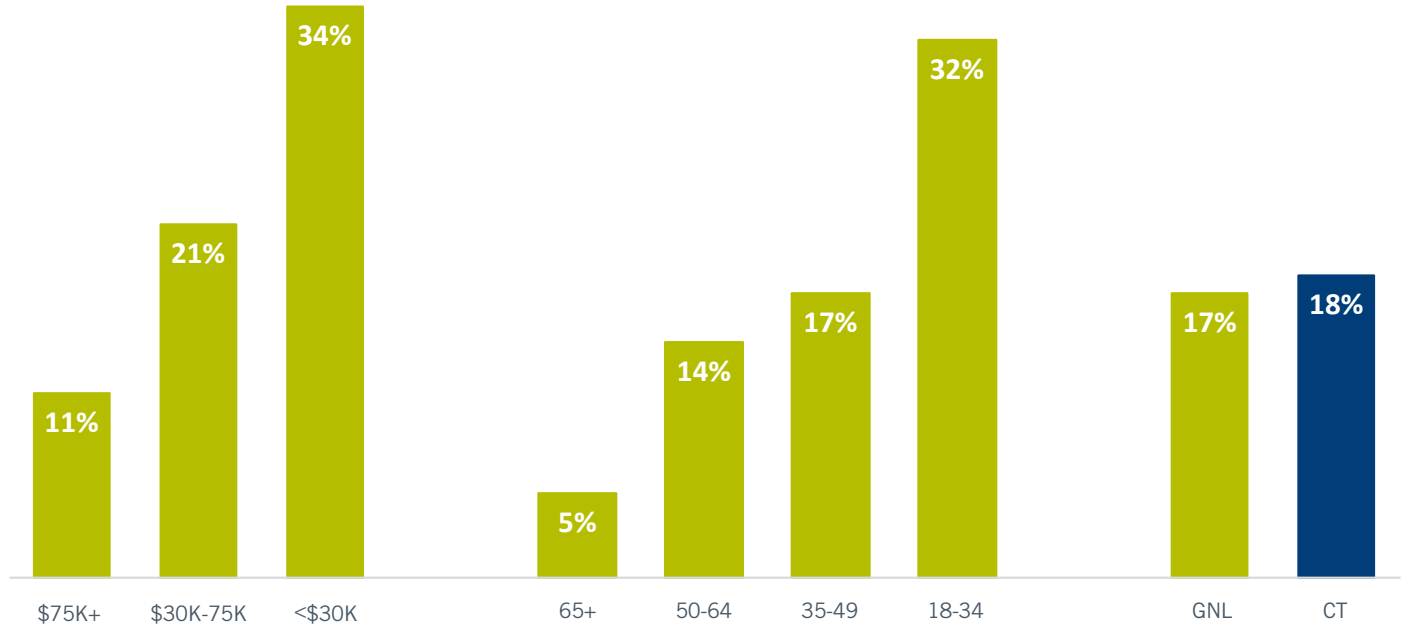
Housing Security

Home ownership, GNL, Wellbeing Survey 2018:

Good health depends on having safe, clean, affordable housing. Housing stability contributes to healthy neighborhoods and a sense of community. Poor quality and inadequate housing contribute to health problems such as infectious and chronic diseases, injuries and poor childhood development.



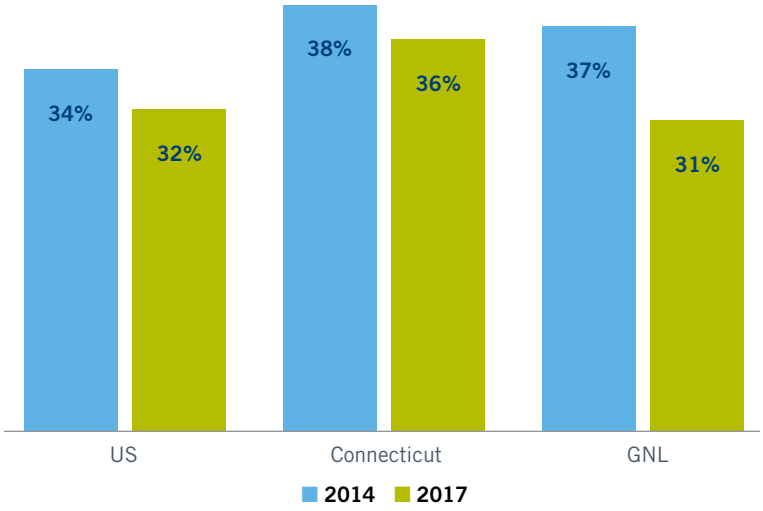
Lived at the same address for less than three years, GNL, Wellbeing Survey 2018:



Housing Cost Burden

Percentage of occupied housing units paying over 30% of income towards housing costs:

When residents spend over 30% of their income on housing alone, some struggle to pay for other necessities such as food, transportation, healthcare, and child care.

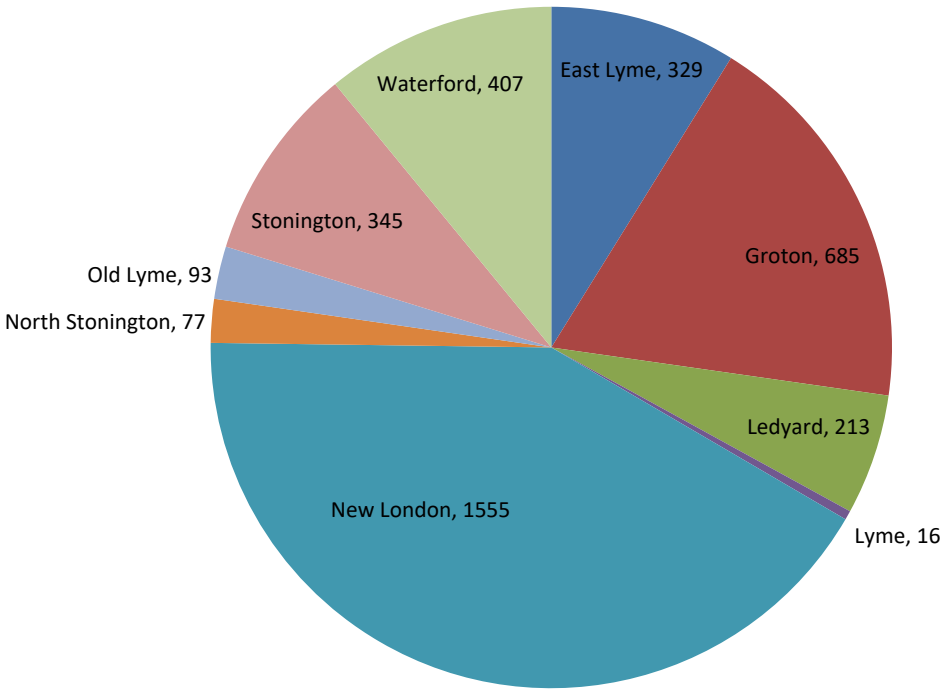


Source: American Community Survey (ACS) 2018.

Energy Assistance

TVCCA energy assistance by town, LLHD:

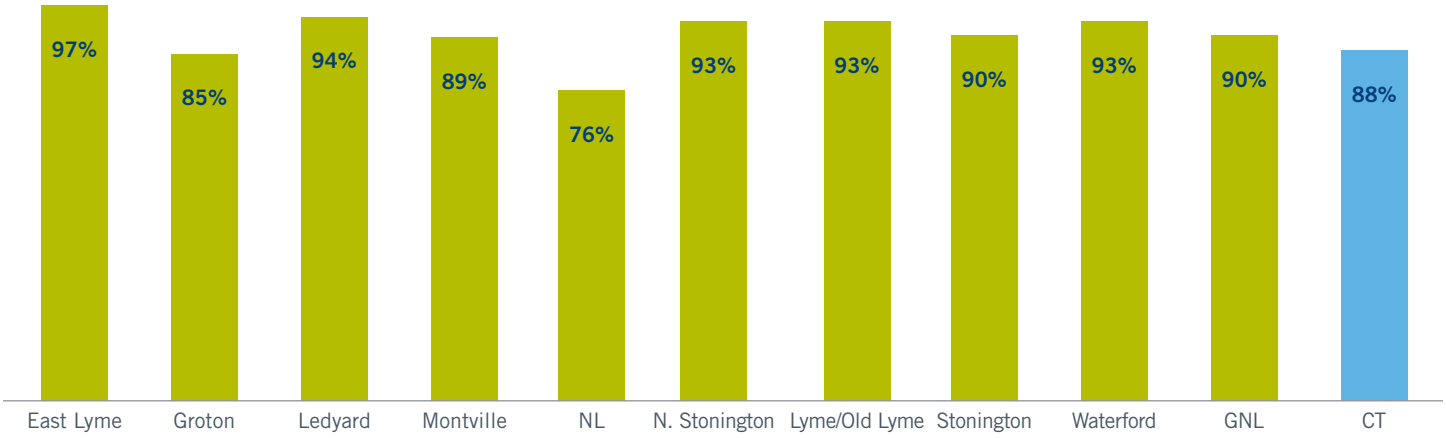
Residents of the urban centers of the region represent the greater numbers in energy assistance requests however difficulty in paying for household energy expenses impacts all area communities.



Education

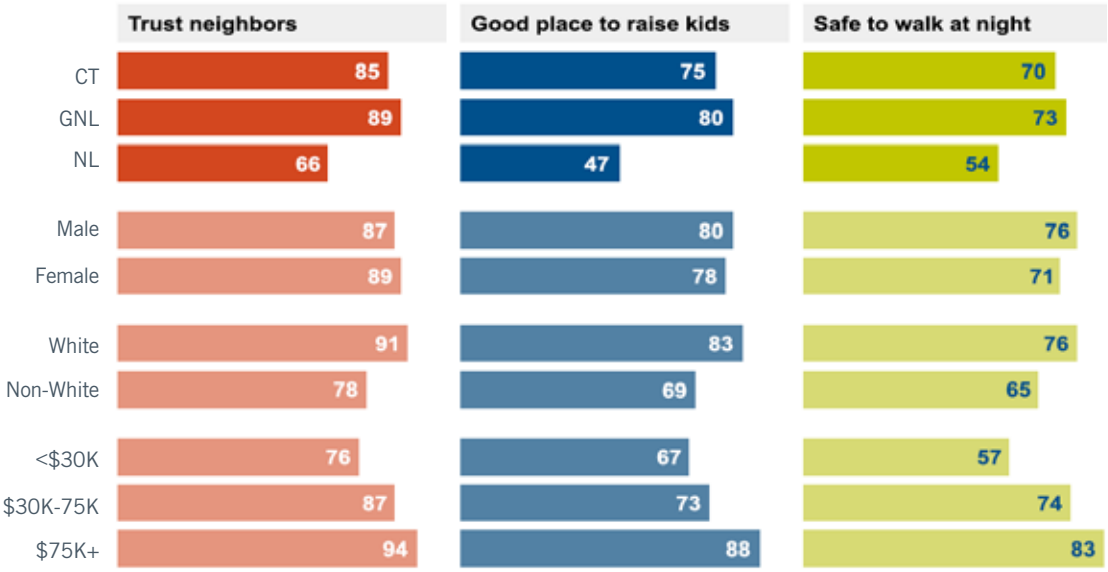
GNL 4-Year Cohort High School graduation rate, 2016-2017:

Educational attainment is strongly associated with health and wellbeing. People with higher levels of education tend to live longer, healthier lives than those with lower levels of education. Existing research has documented that this association is not due to differences in health literacy or behavior alone, but also influenced by differences in income, housing, social support and childhood poverty and trauma.



Social and Community Context

NL trails behind surrounding towns on community cohesion:

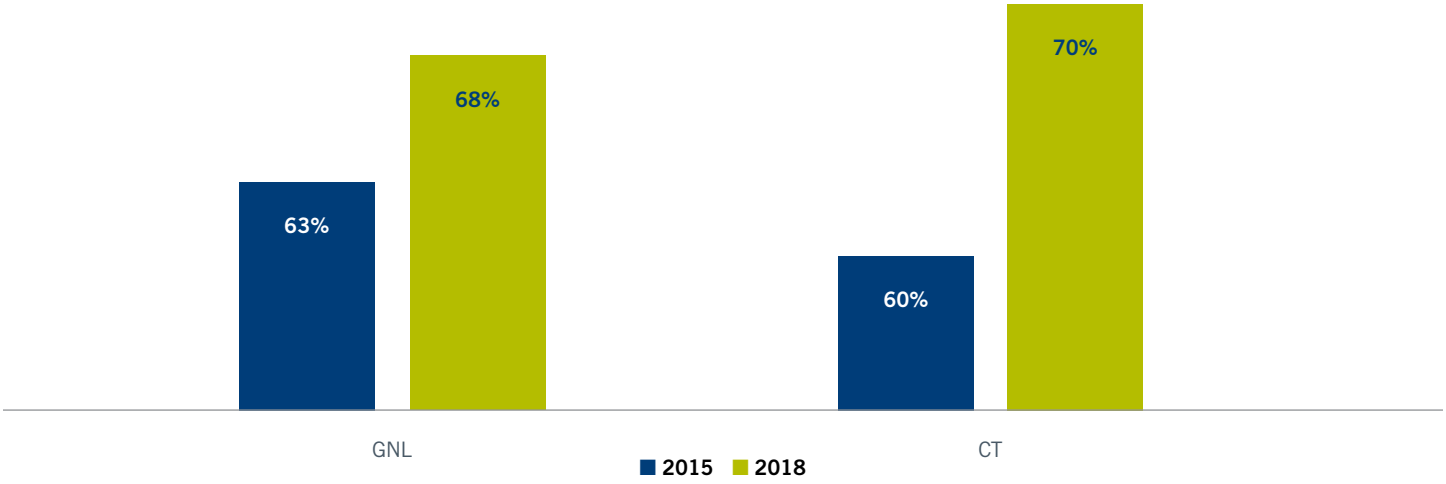


Having a strong social support system and feeling connected to a community can be a protective factor for both physical and mental health. Lower income residents are impacted substantially by factors of community cohesion.

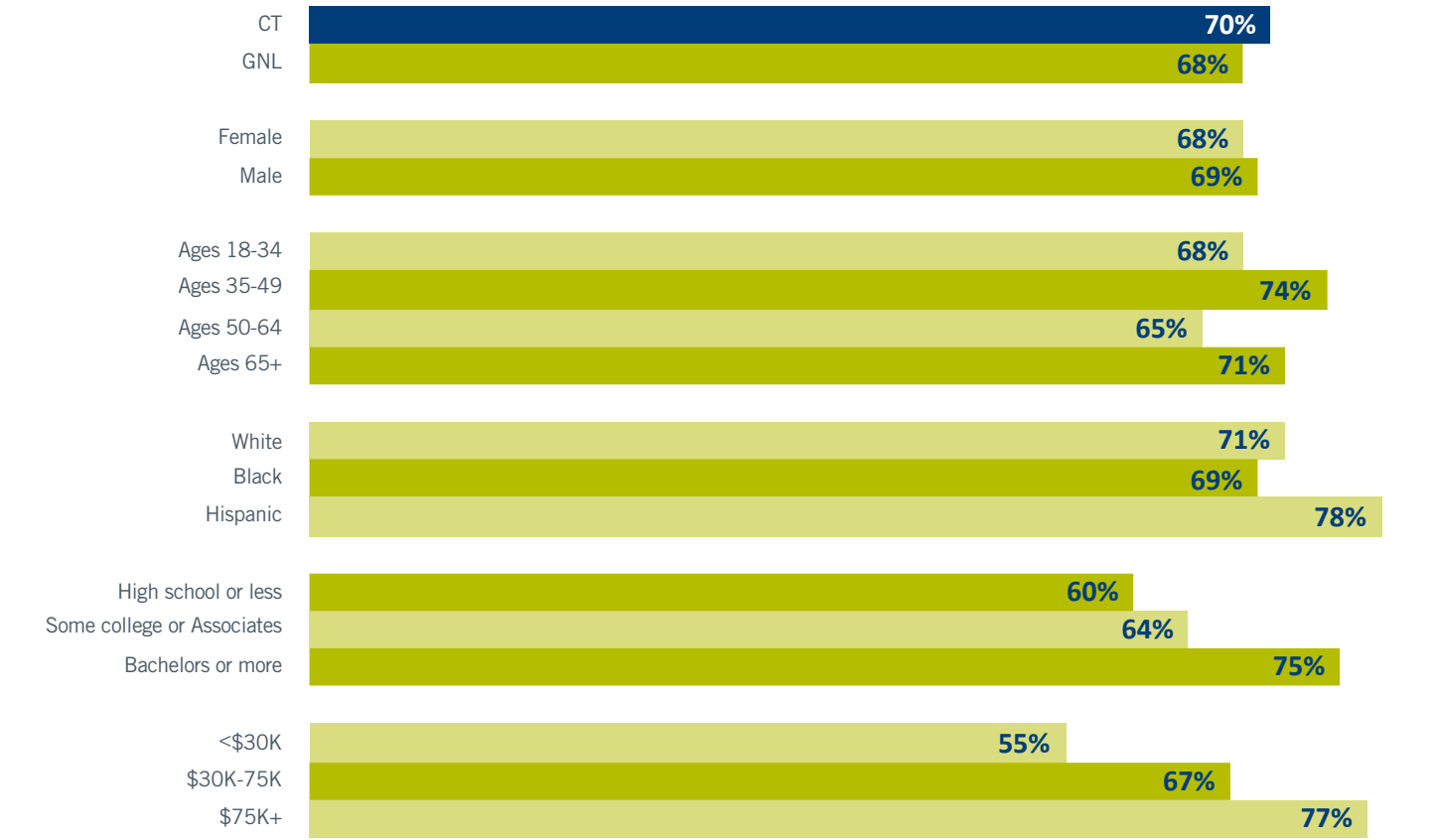
Source: DataHaven Analysis of 2018 Wellbeing Survey.

Social and Community Context

Confidence in ability to influence local government in CT and GNL, Wellbeing Survey 2015-2018:



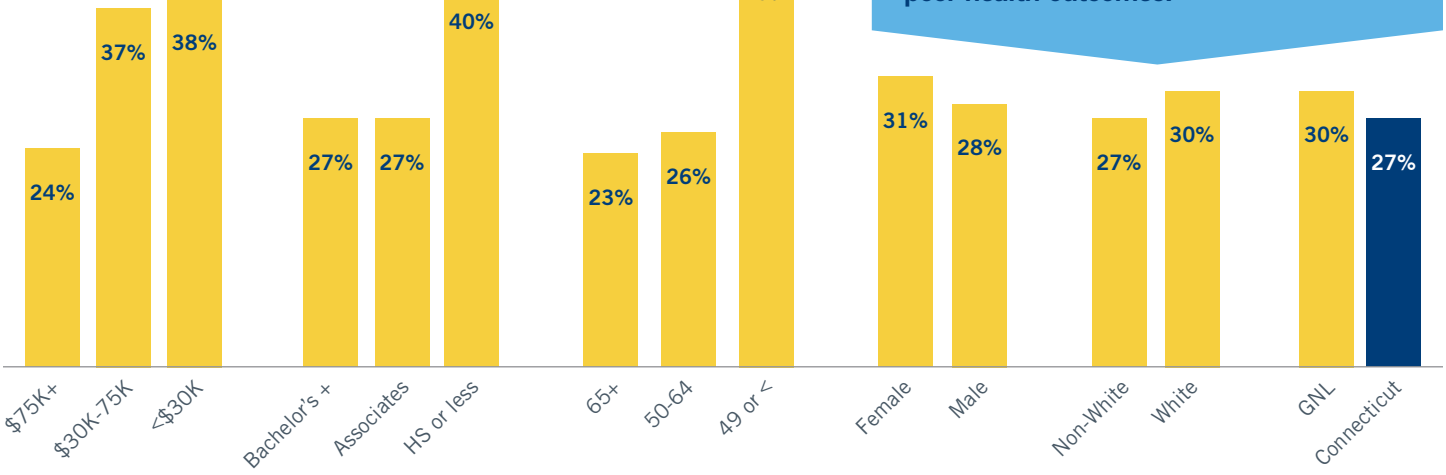
Confidence in ability to influence local government, GNL, Wellbeing Survey 2018:



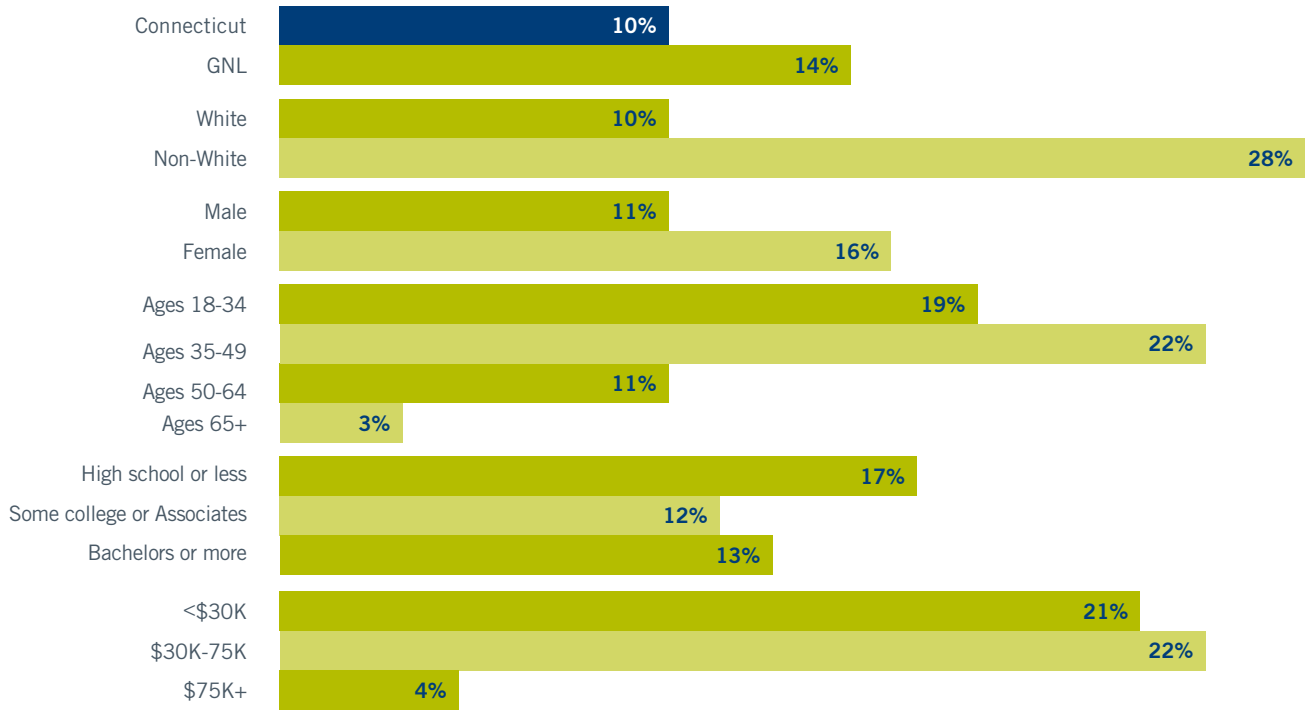
Social and Community Context

Unfairly fired, unfairly denied a promotion or raise, or not hired for a job for unfair reasons, GNL, Wellbeing Survey 2018:

Those with lower incomes, males, and people of color report higher incidences of discrimination, largely based on race, physical appearance, and age. The toxic stress associated with racism is linked to poor health outcomes.

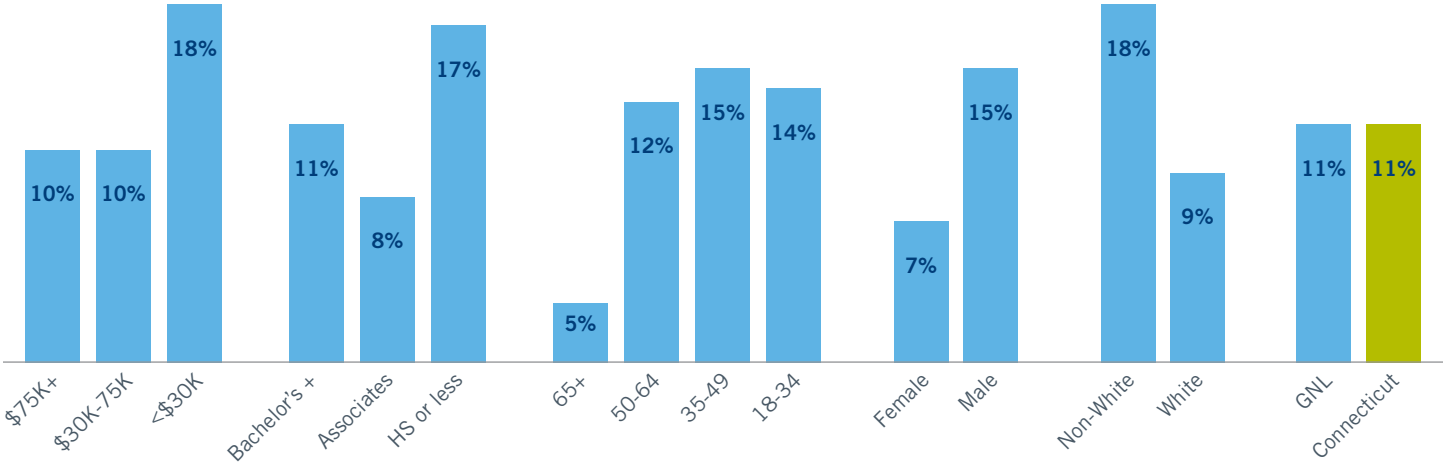


Reported unfairly treated when seeking healthcare, Wellbeing Survey, 2018:

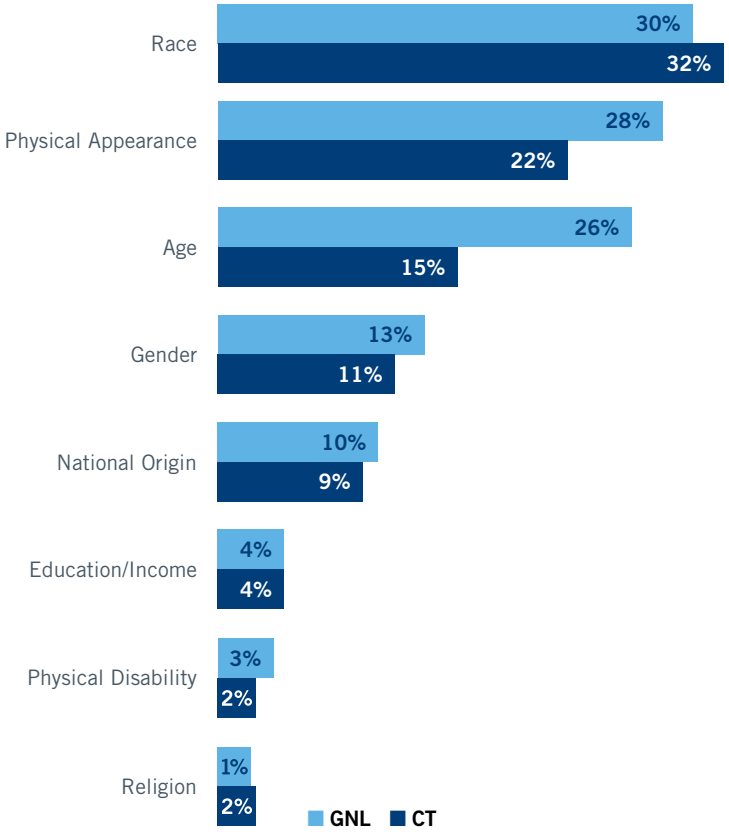


Social and Community Context

Unfairly stopped, searched, questioned, physically threatened, or abused by the police, GNL, Wellbeing Survey 2018:



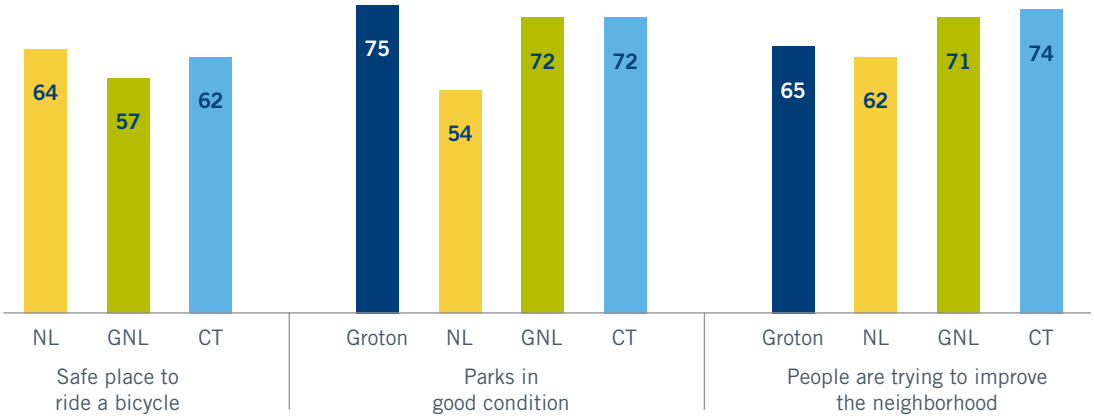
Main perceived reason for being unfairly treated by the police, GNL, Wellbeing Survey 2018:



Neighborhood and Environment

Percentages of people with good perceptions about their neighborhood and environment:

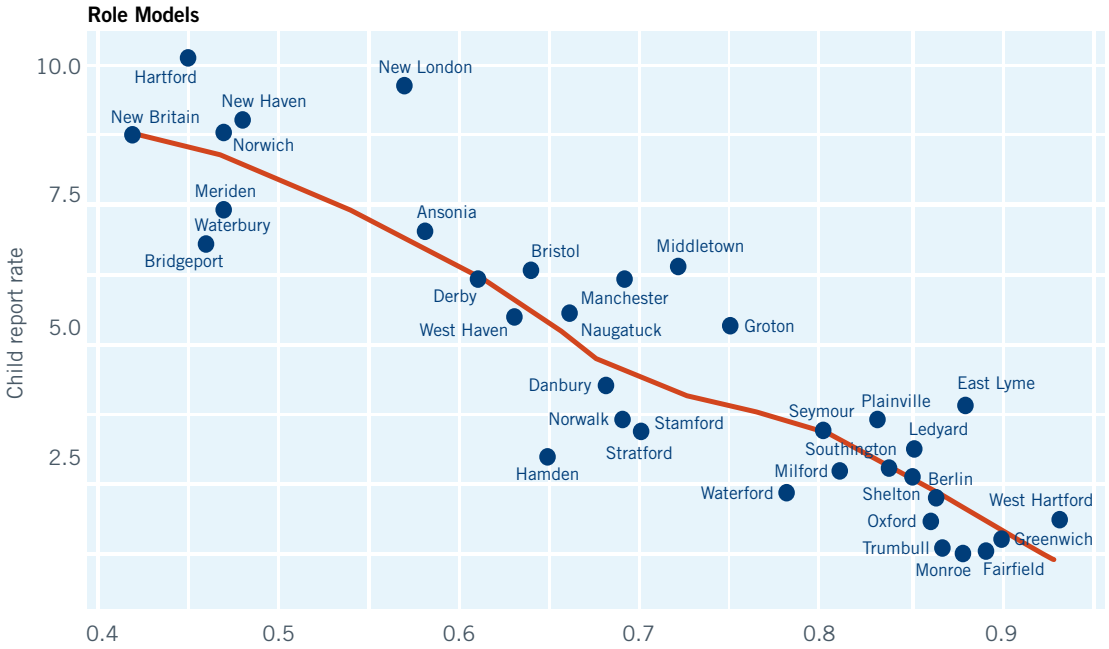
Sedentary behavior is strongly correlated with chronic disease and impacts longevity. Residents who lack access to safe and available spaces for recreation or whose economic situations limit their ability to be physically active are at greater risk.



Source: DataHaven Analysis of 2018 Wellbeing Survey.

Adverse Childhood Experiences

In communities, there is an inverse correlation between perception of positive role models for children and reports for abuse and neglect to DCF, DataHaven 2019:

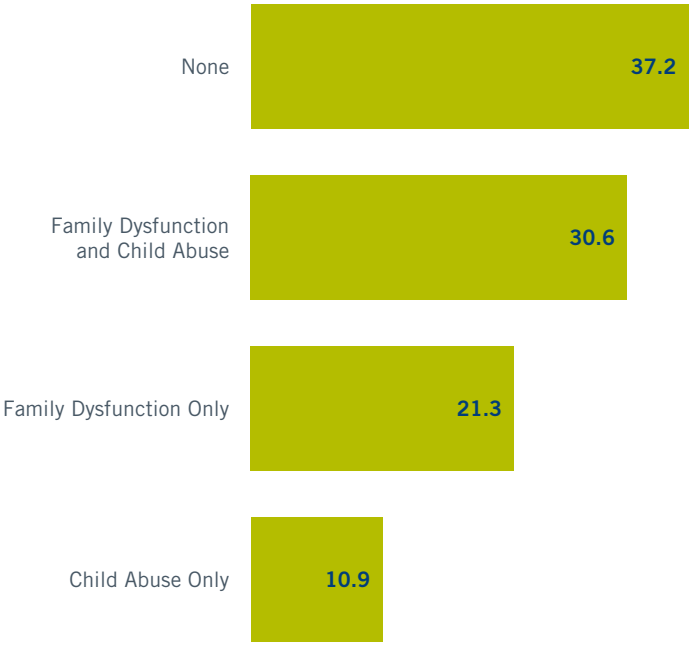


Strongly/Somewhat Agree: Children and youth generally have the positive role models they need around here.
Source: DataHaven Analysis of 2018 Wellbeing Survey.

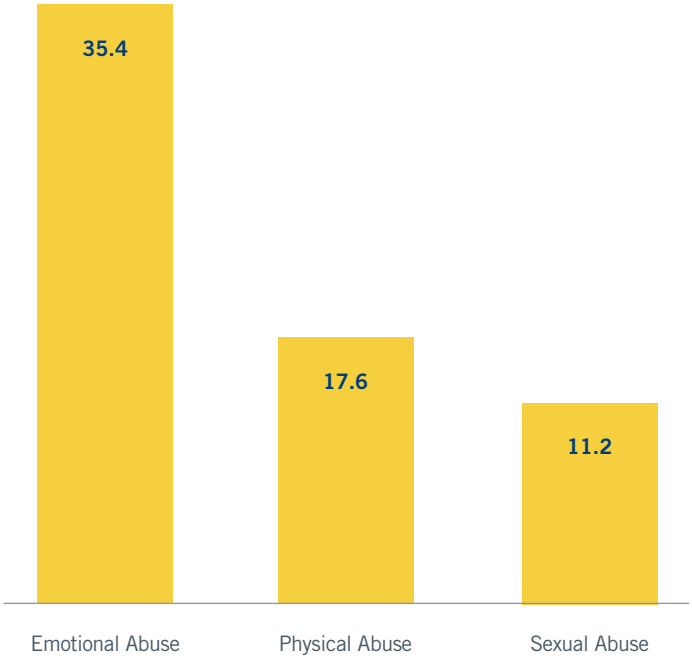
Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violent or growing up with family members who have substance use disorders. Much research has demonstrated that ACEs have lifelong impact in terms of both physical and mental health.

Adverse Childhood Experiences

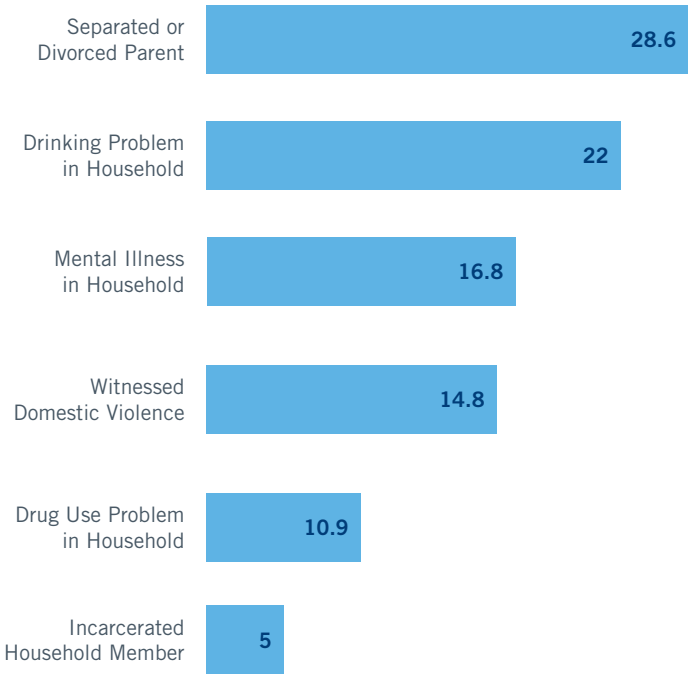
Type of ACE prevalence, NL County, 2017, Chime Data:



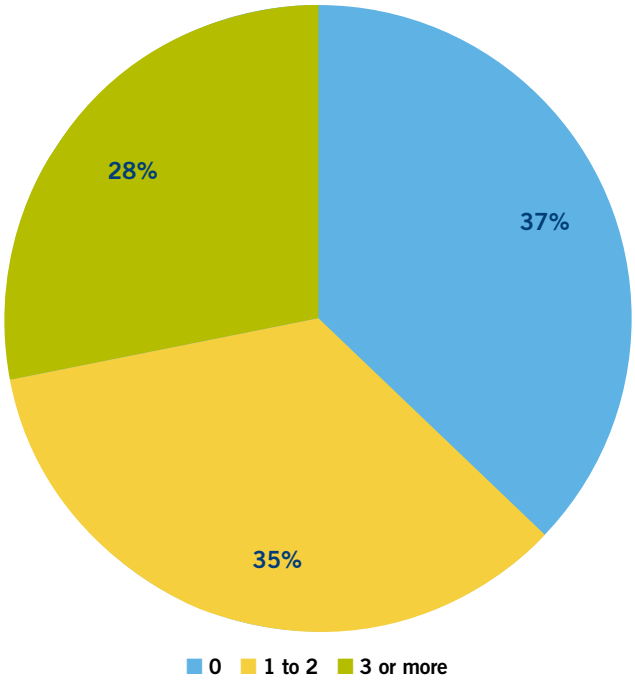
Child abuse prevalence, NL County, 2017, Chime Data:



NL County, 2017, Chime Data:



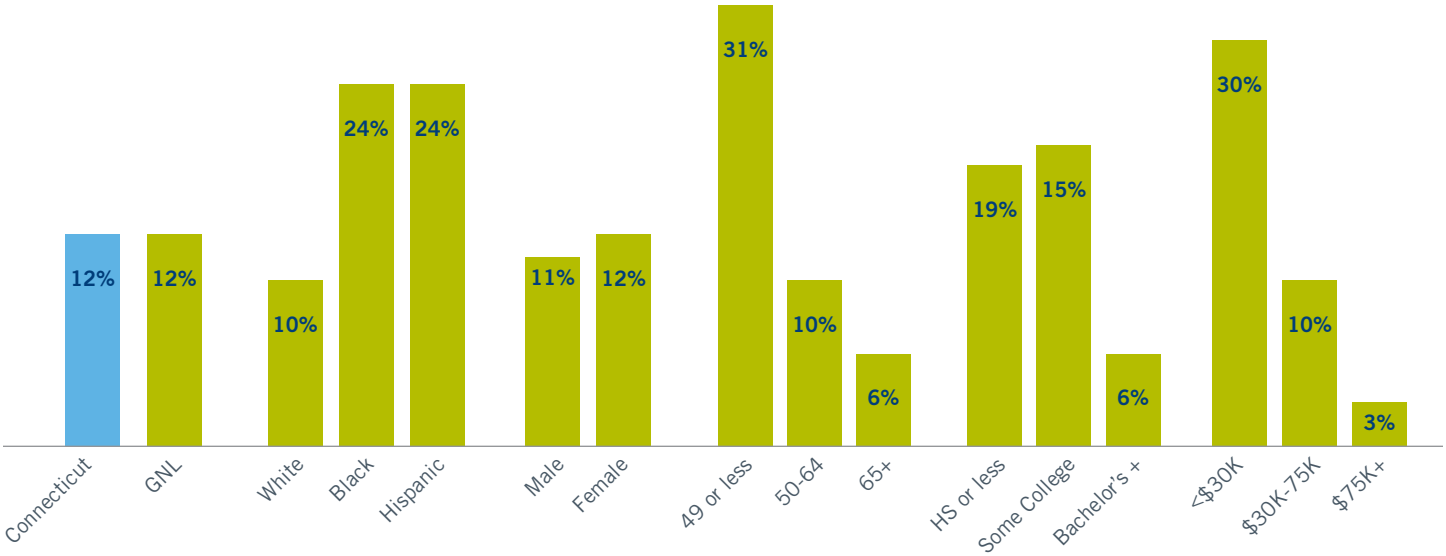
Chime Data, 2017:



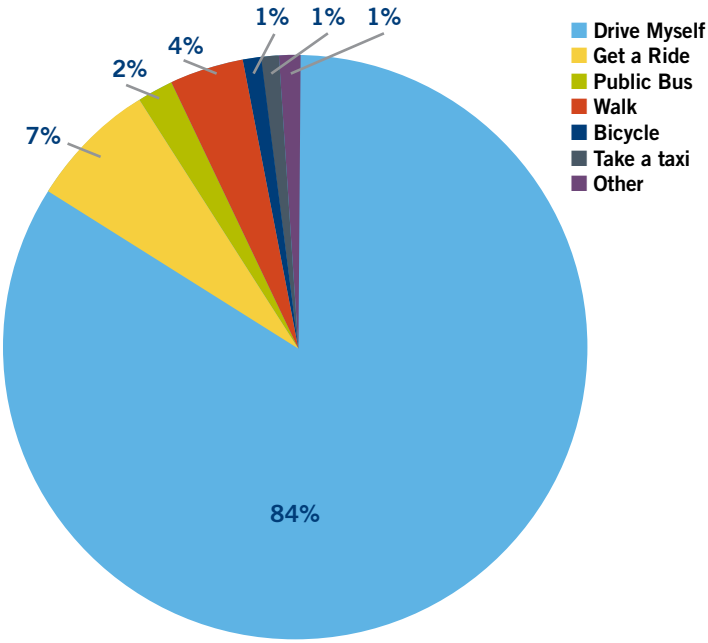
Transportation

Stayed home when needed to go somewhere due to no access to reliable transportation in the past 12 months, Wellbeing Survey 2018:

The majority of residents drive themselves as their primary means of transportation however lower income residents, young adults, those with less education, and people of color report at significantly higher percentages that they stayed home when they needed to go somewhere due to lack of reliable transportation. Health and social service providers report that transportation barriers are a perennial challenge for area residents.



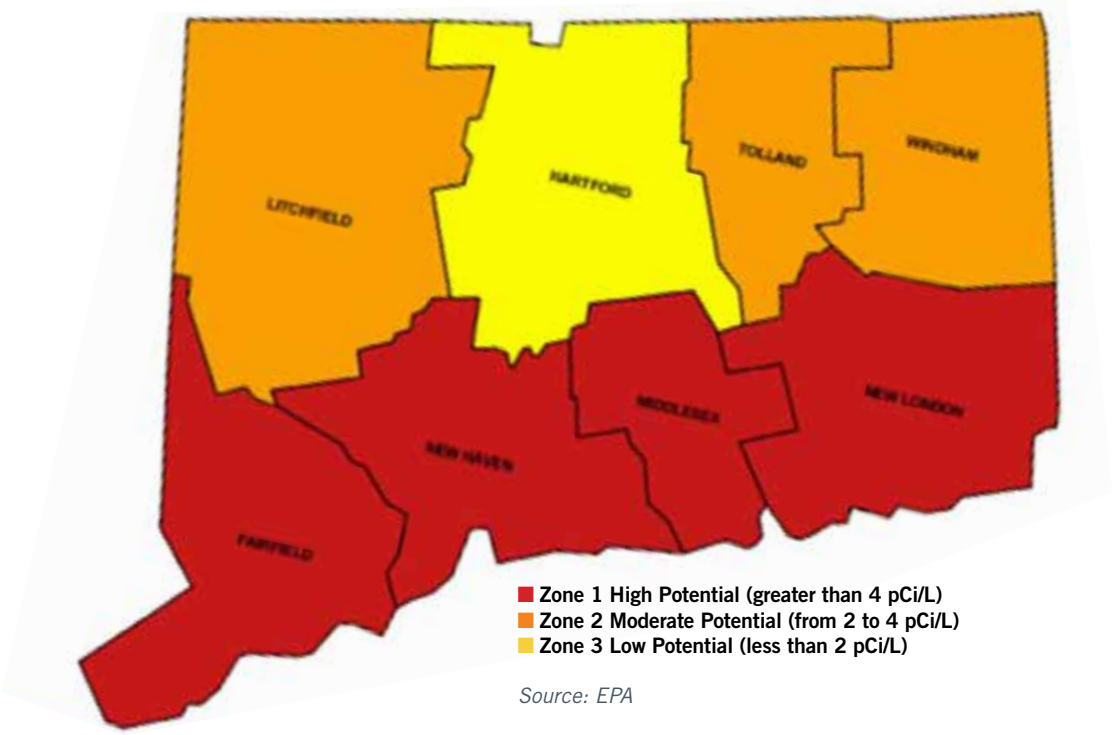
Primary means of transportation, GNL, Wellbeing Survey 2018:



Environment

CT Radon Zones, EPA:

Radon, a gas formed with the breakdown of radioactive elements in rock, occurs naturally in some areas more than others. Radon is the second leading cause of lung cancer after cigarette smoking according to the Centers for Disease Control. The high potential for exposure in our region may be contributing to the locally high rates of lung cancer.



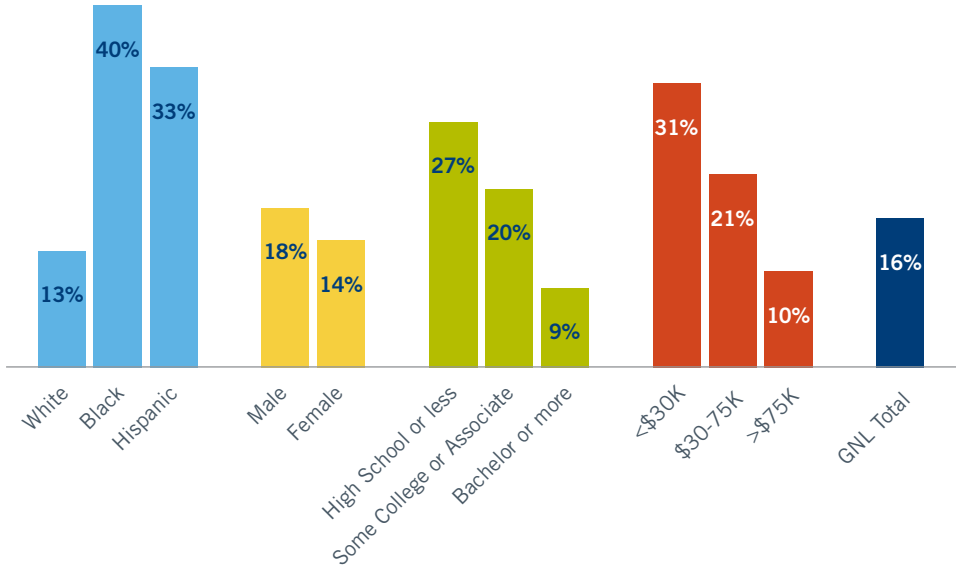
Source: EPA

Healthcare Utilization

Access to Care

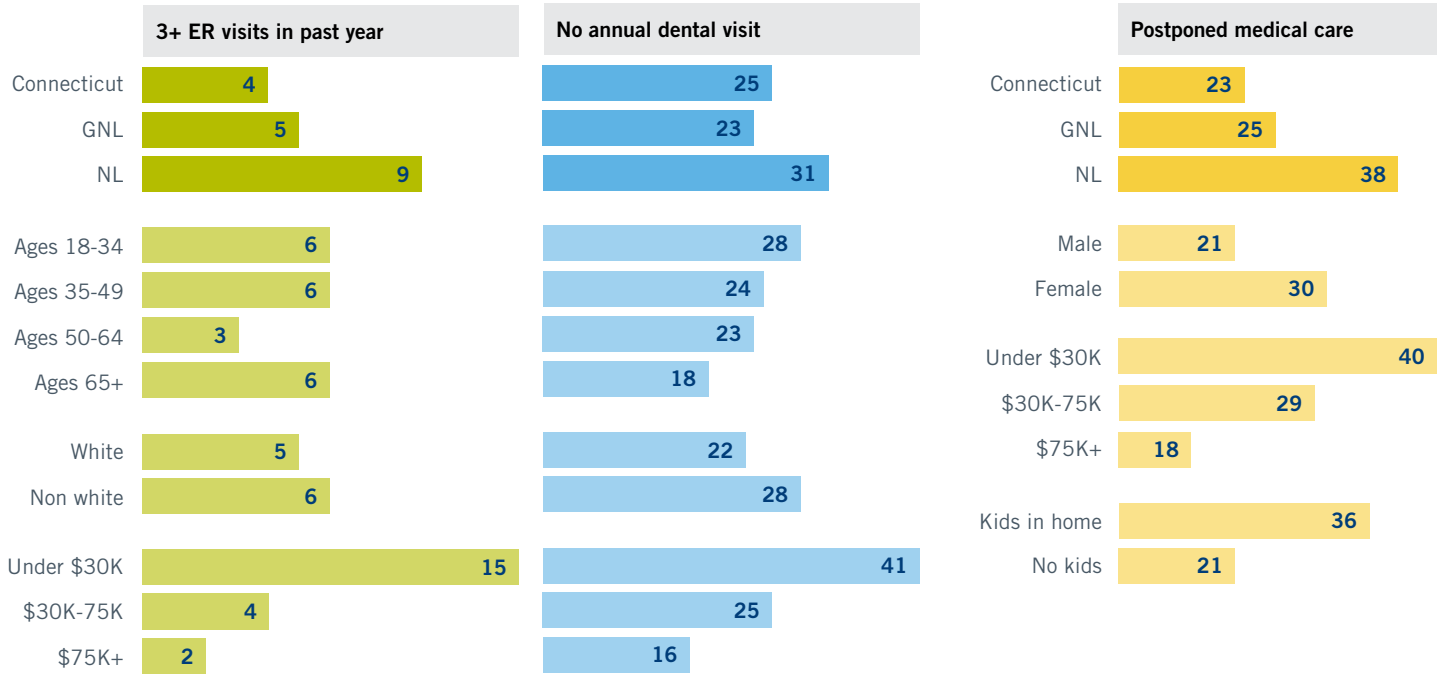
Percent of adults reported they have no one person or place to think of as their primary care practitioner. DataHaven Community Wellbeing Survey, GNL, 2018:

Access to primary care continues to be challenging in Greater New London overall, and more dramatically impacts low-income persons in the region. One indication of inadequate access to primary care is the use of the emergency department for primary care conditions; three or more visits to the emergency department is an indicator of primary care inadequacy. Frequent emergency department visitors are significantly more likely to report health-related social needs.



Wellbeing Survey 2018:

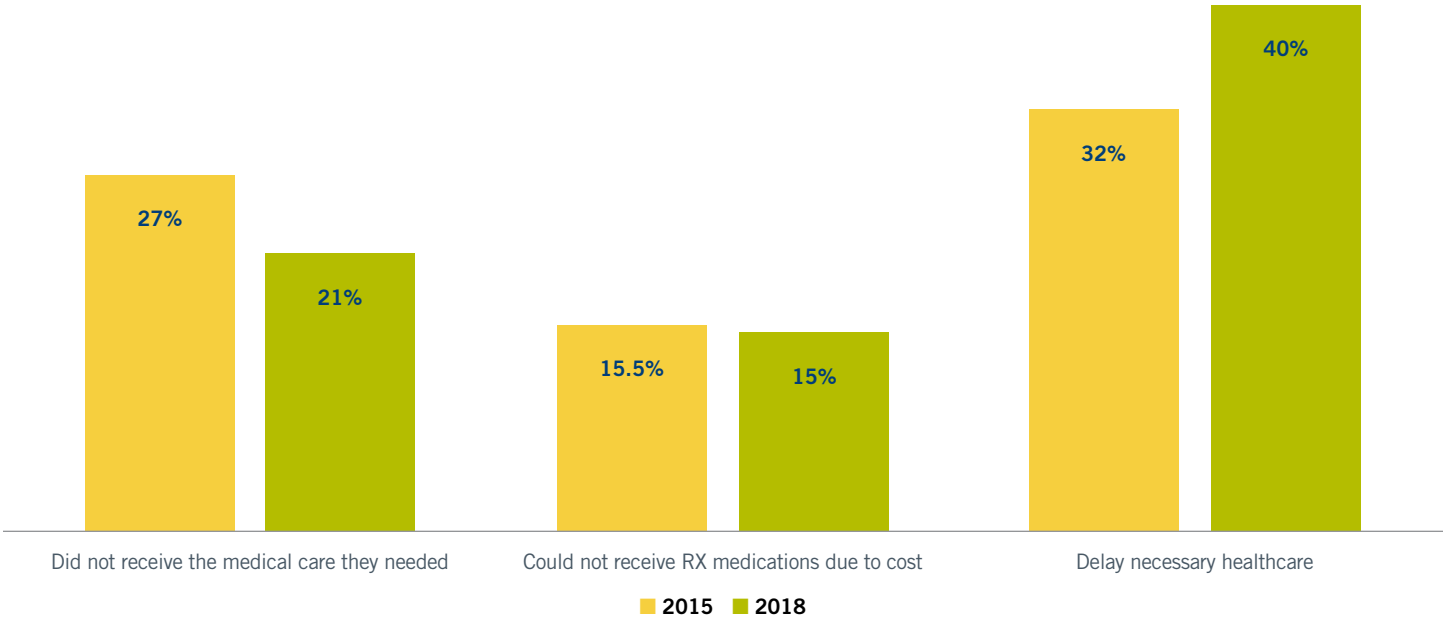
Almost half of low-income area residents report no dental visits in the last year. Urban, younger, and people of color are more at risk for inadequate oral healthcare.



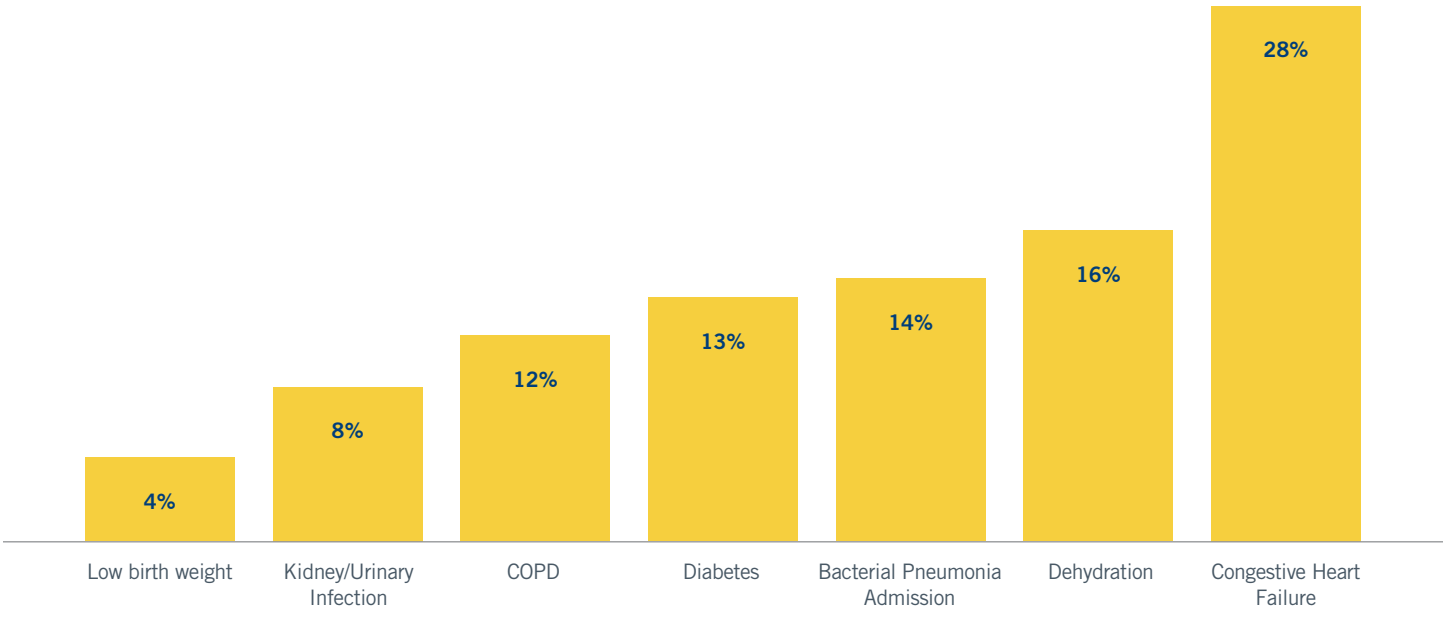
Access to Care

Access to care for those earning <$30K per year:

One indication of inadequate access to primary care is the use of the emergency department for primary care conditions. Three or more visits to the emergency department is another indicator of primary care inadequacy. Frequent emergency department visitors are significantly more likely to report health related social needs.

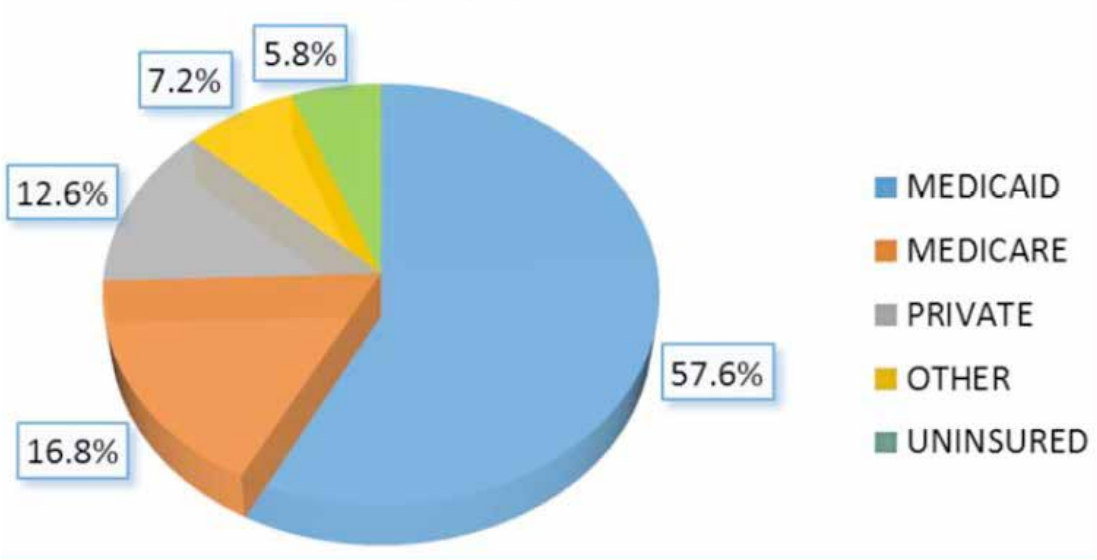


Percentage of all L+M ED visits for top seven ambulatory care sensitive conditions, Chime Data, FY 2018:



Access to Care

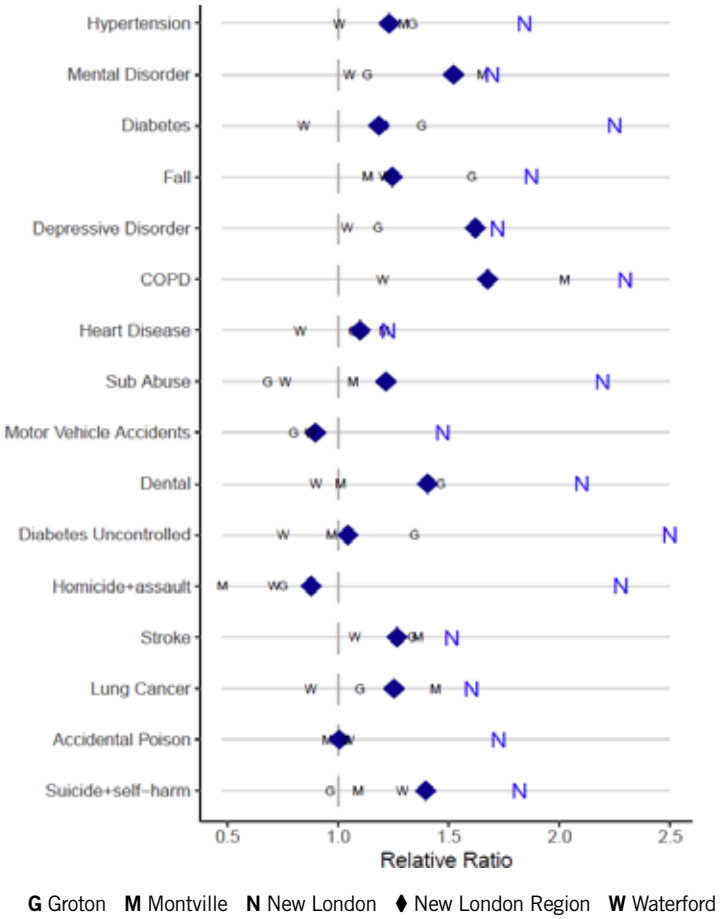
Distribution of payer for ambulatory care sensitive ED visits, GNL, 2014-2015:



CHIME data on all hospital encounters, CT Hospital Association 2018:

Annual encounters per 10,000 residents, age-adjusted and in a ratio relative to state, 2015-2017 (in order of most to least common, for selected diagnosis areas.)

A higher risk of hospital encounters is observed in New London for many diagnoses, especially hypertension, diabetes, COPD, falls, motor vehicle-related injuries, substance abuse, preventable dental conditions, injury due to homicide/assault.

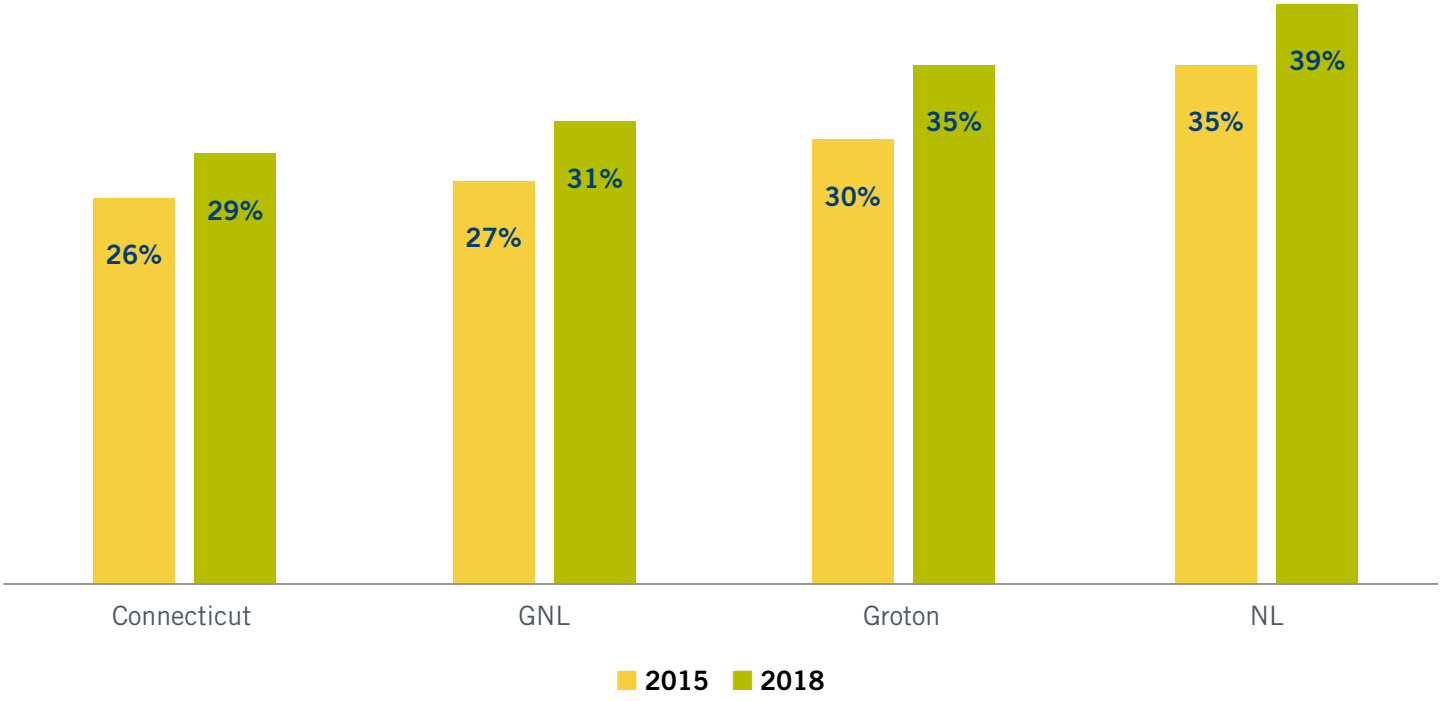


Health Risk Factors

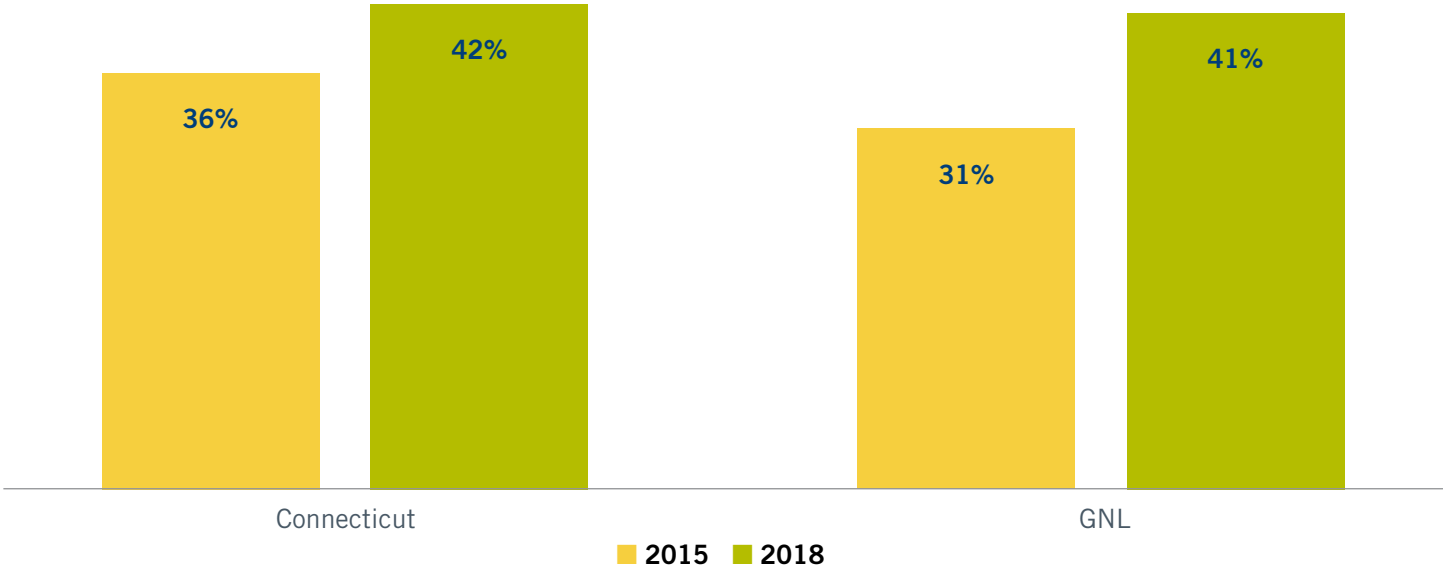
BMI, Exercise, Obesity

Obesity rate (BMI), Wellbeing Survey 2018:

Obesity impacts health outcomes from cardiovascular disease and diabetes to mental health. It carries a heavy economic strain through direct costs related to increased use of the healthcare system to indirect costs like lower productivity in the workplace.

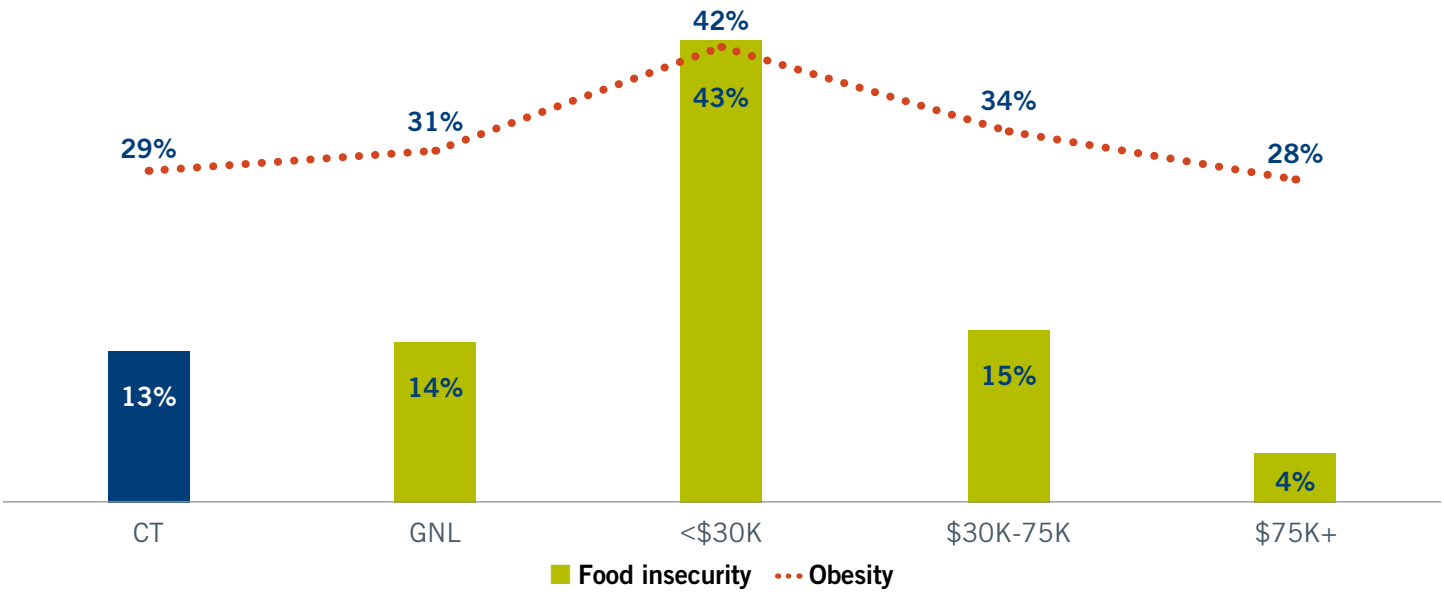


Exercise (adults not getting three days of exercise), Wellbeing Survey 2018:



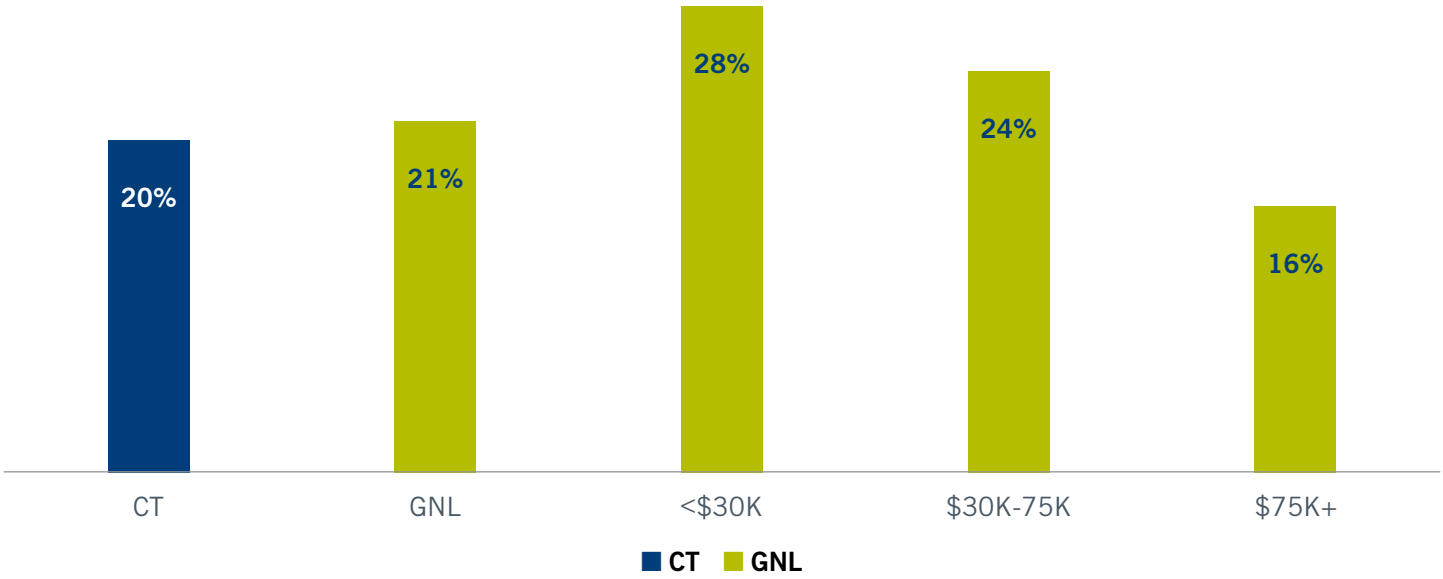
BMI, Exercise, Obesity

Food insecure at any time in the past 12 months and obesity, GNL, Wellbeing Survey 2018:



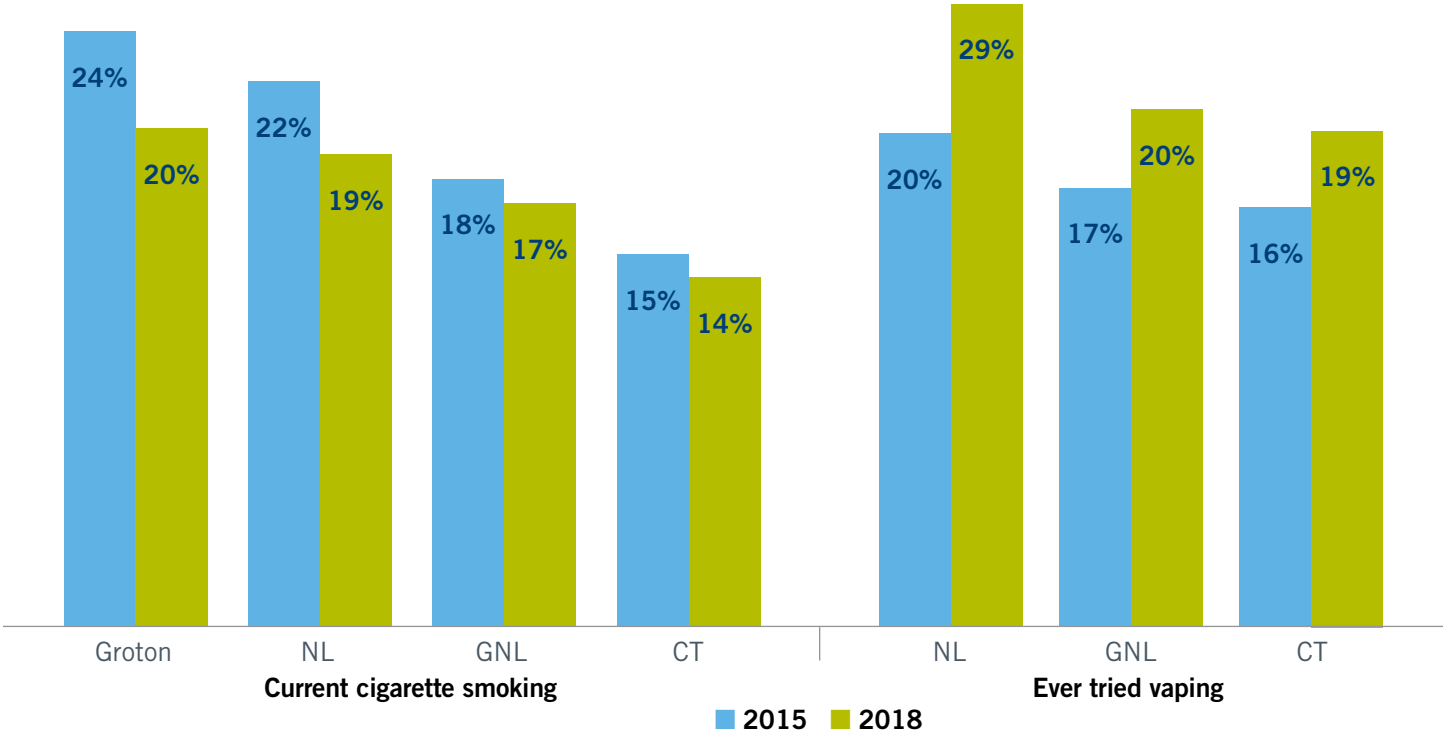
Health Risk Factors

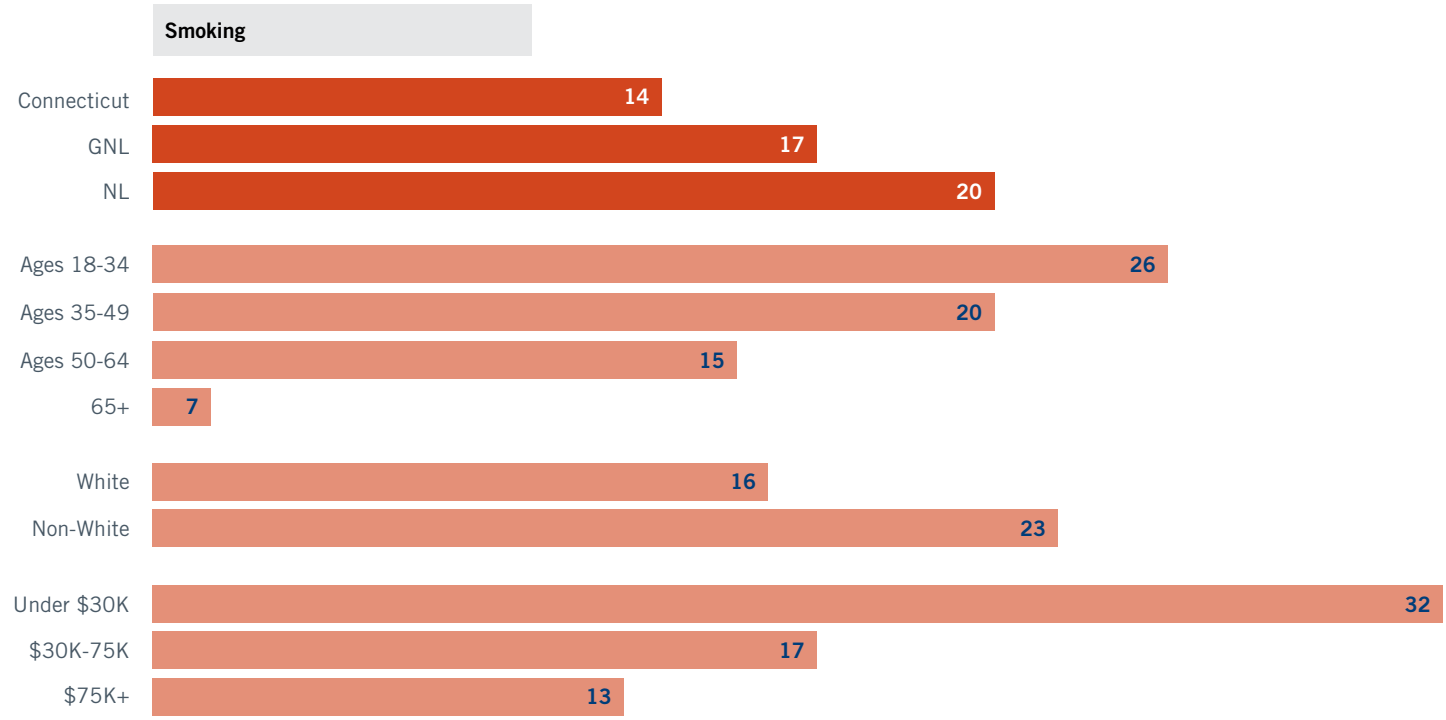
Never exercising by income, GNL, Wellbeing Survey 2018:



Cigarette Smoking and Vaping

Trend: cigarette smoking and vaping, Wellbeing Survey 2015-2018:

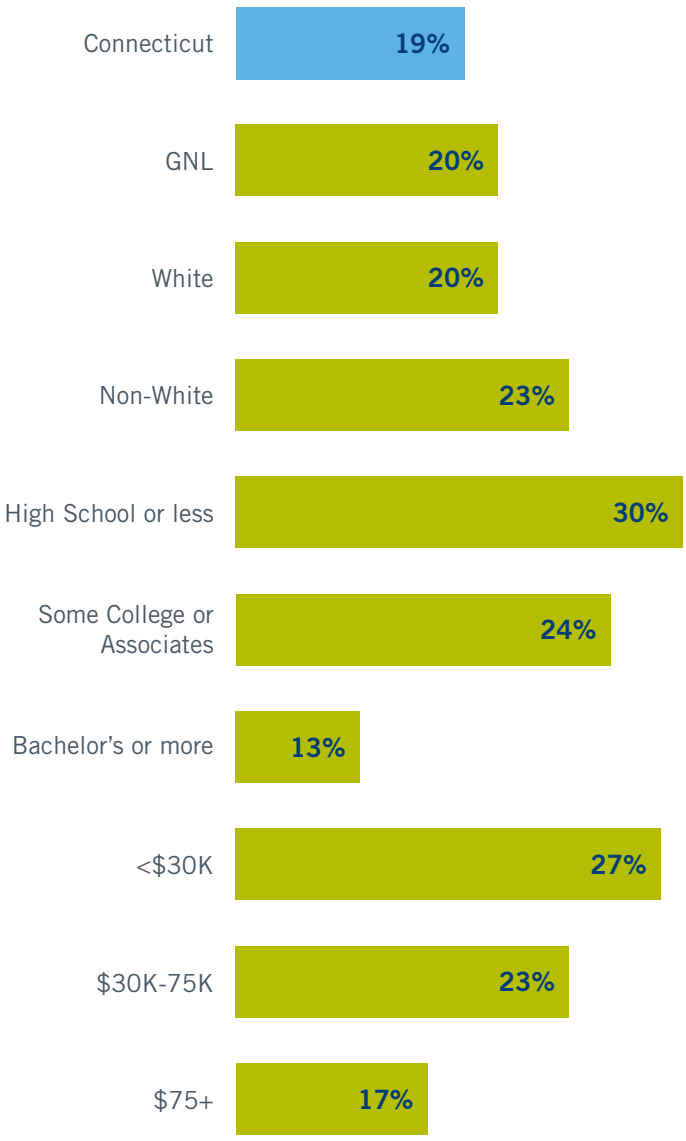




Cigarette Smoking and Vaping

Ever Tried Vaping 2018:

Although the rates of smoking in the region have continued a downward trend, there are still higher smoking rates among young adults, lower income residents, and people of color. Vaping has escalated dramatically, particularly among younger residents and those with lower incomes and educational levels.

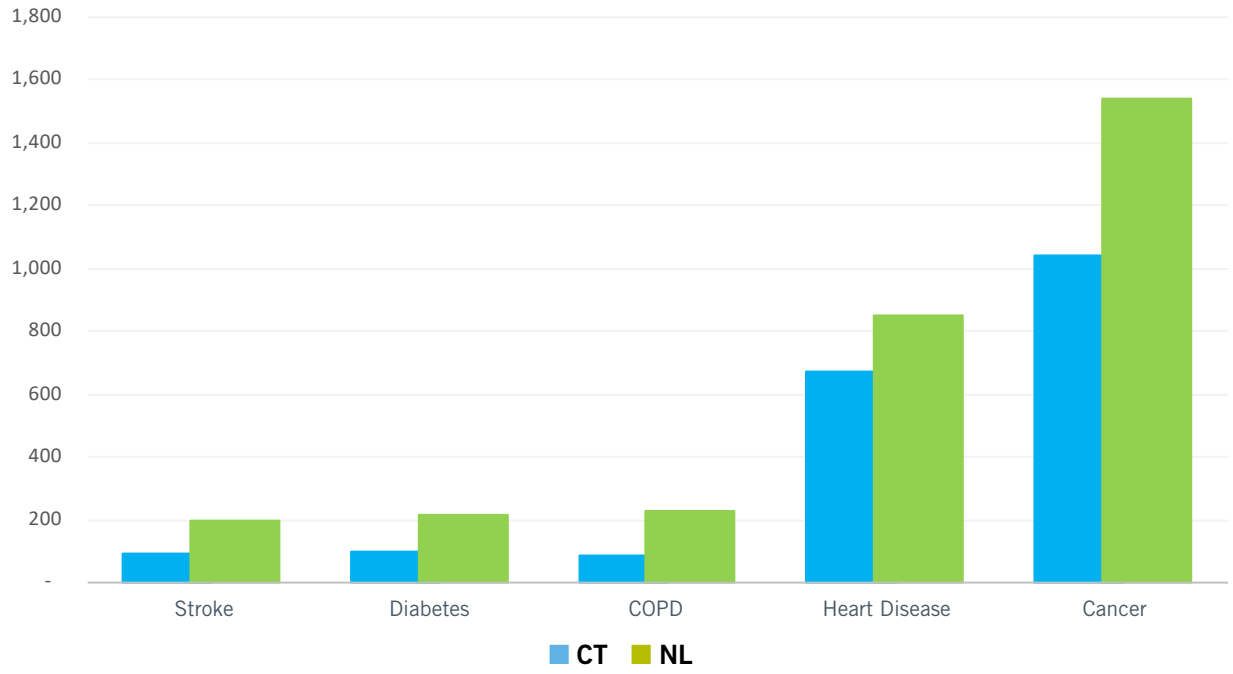


Source: DataHaven Analysis of 2018 Wellbeing Survey.

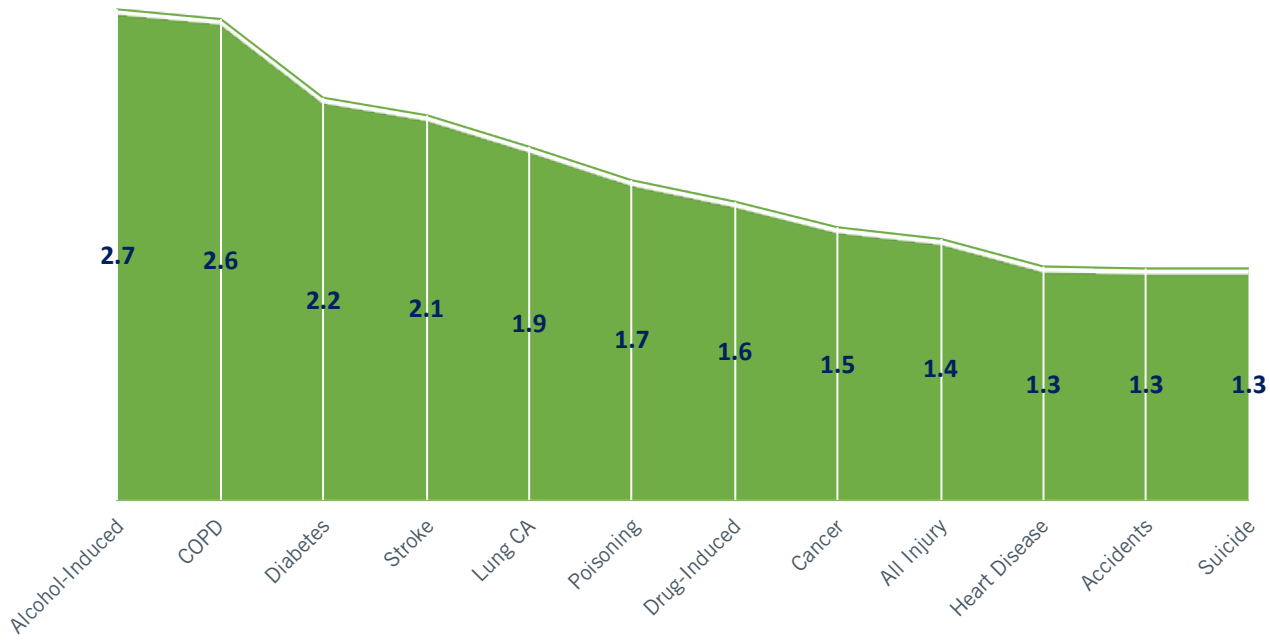
Health Outcomes

Healthy Outcomes

Age-adjusted years of potential life lost under 75 (AAYPLL<75) due to chronic conditions, CT DPH, 2010-2014:



Relative Risk of premature death in New London compared to Connecticut, CT DPH, 2010-2014:

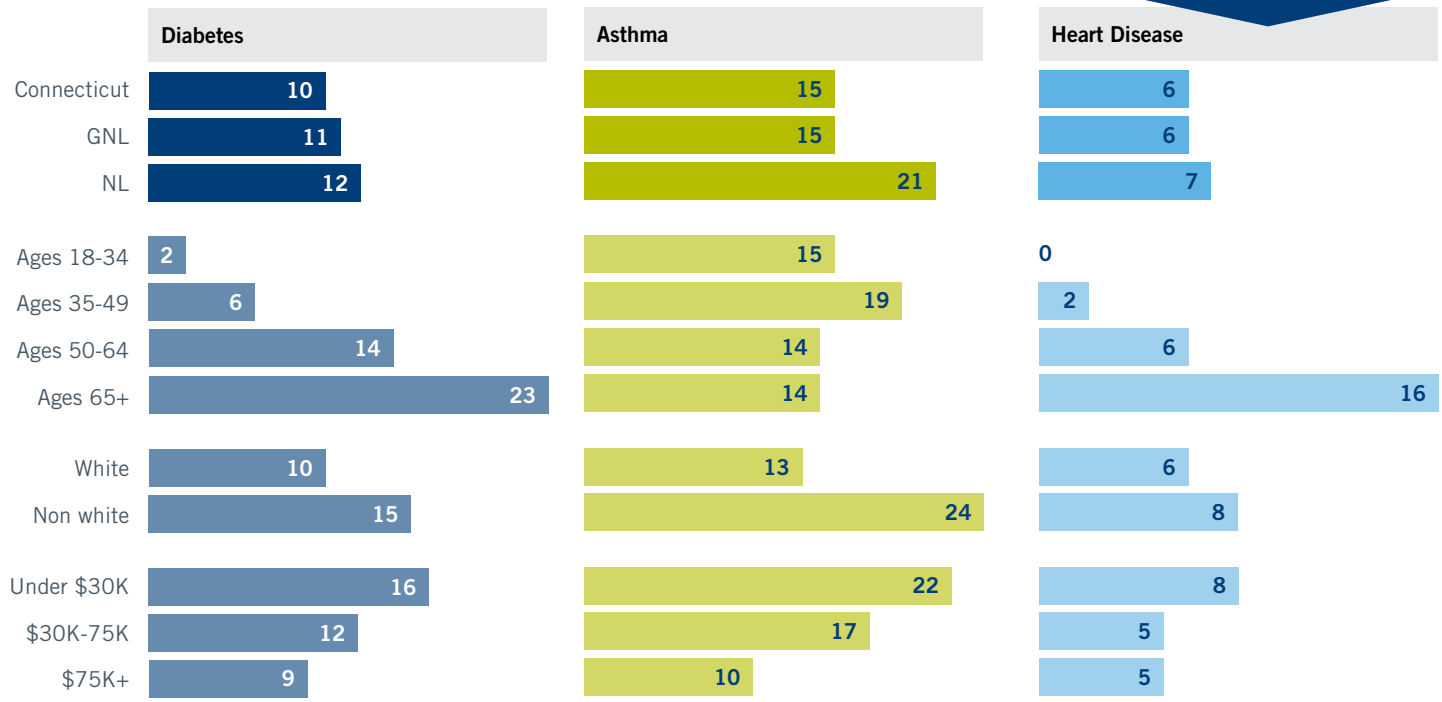


Chronic Disease

Diabetes, asthma, and heart disease are more prevalent among urban, people of color, and lower income area residents. Lower income residents are less likely to exercise and have a higher prevalence of diabetes.

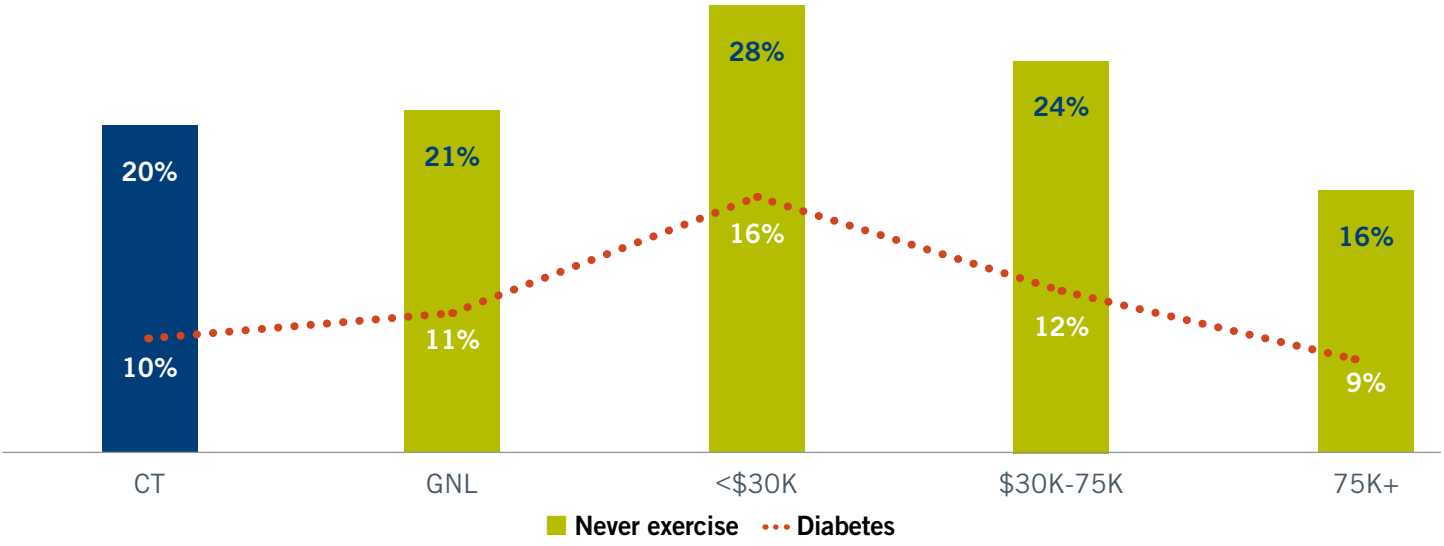
Chronic Disease Prevalence, Wellbeing Survey 2018:

Percent of adults reporting chronic diseases by age, race, and income, GNL, 2018



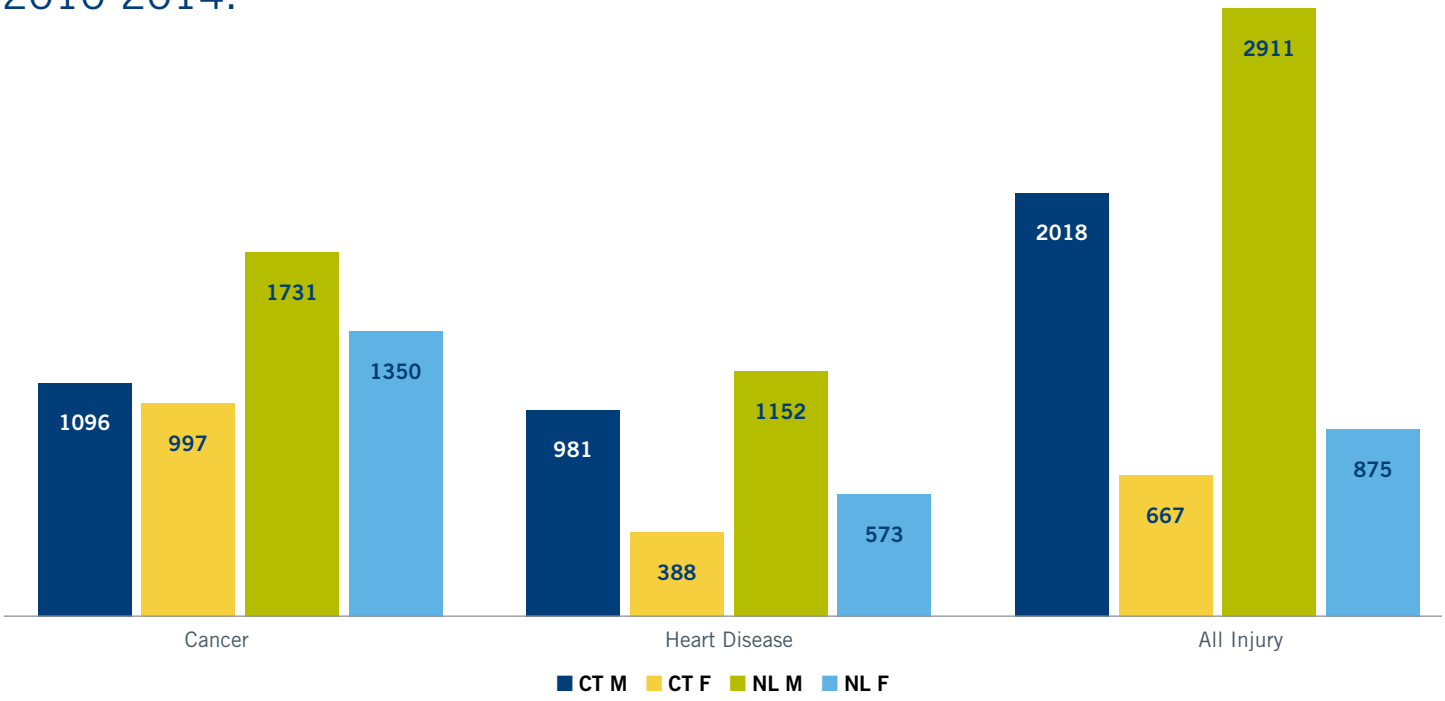
Never exercising and prevalence of diabetes, GNL, Wellbeing Survey 2018:

NL males have higher risk of dying from injuries, cancer, and heart disease than CT males and all females.

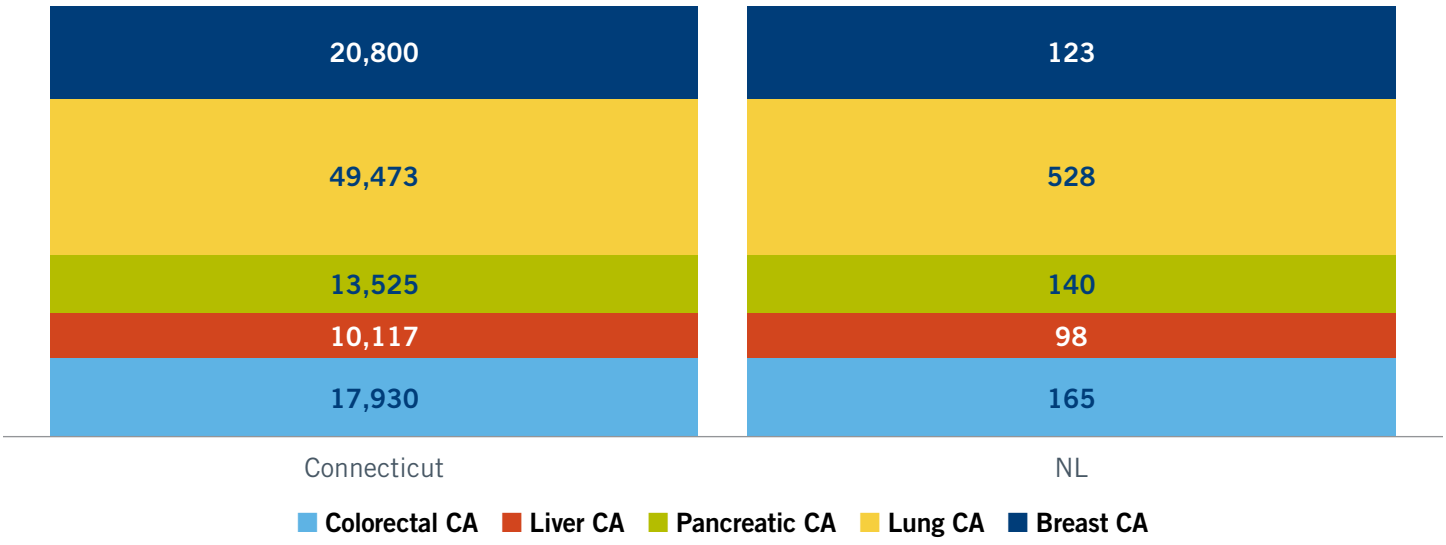


Chronic Disease

New London vs. Connecticut age adjusted years of potential life lost (YPLL) <75 due to cancer, heart diseases, and injuries by gender, Connecticut DPH 2010-2014:



Cancer

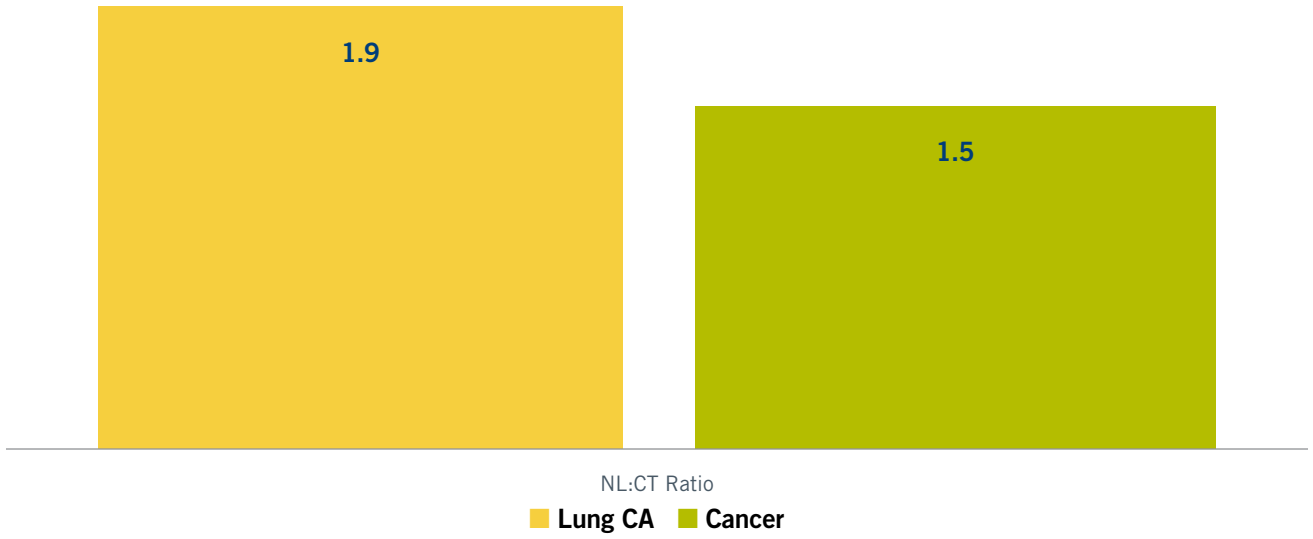


Years of potential life lost (YPLL) <75 due to cancer by cancer type, Connecticut DPH 2010-2014

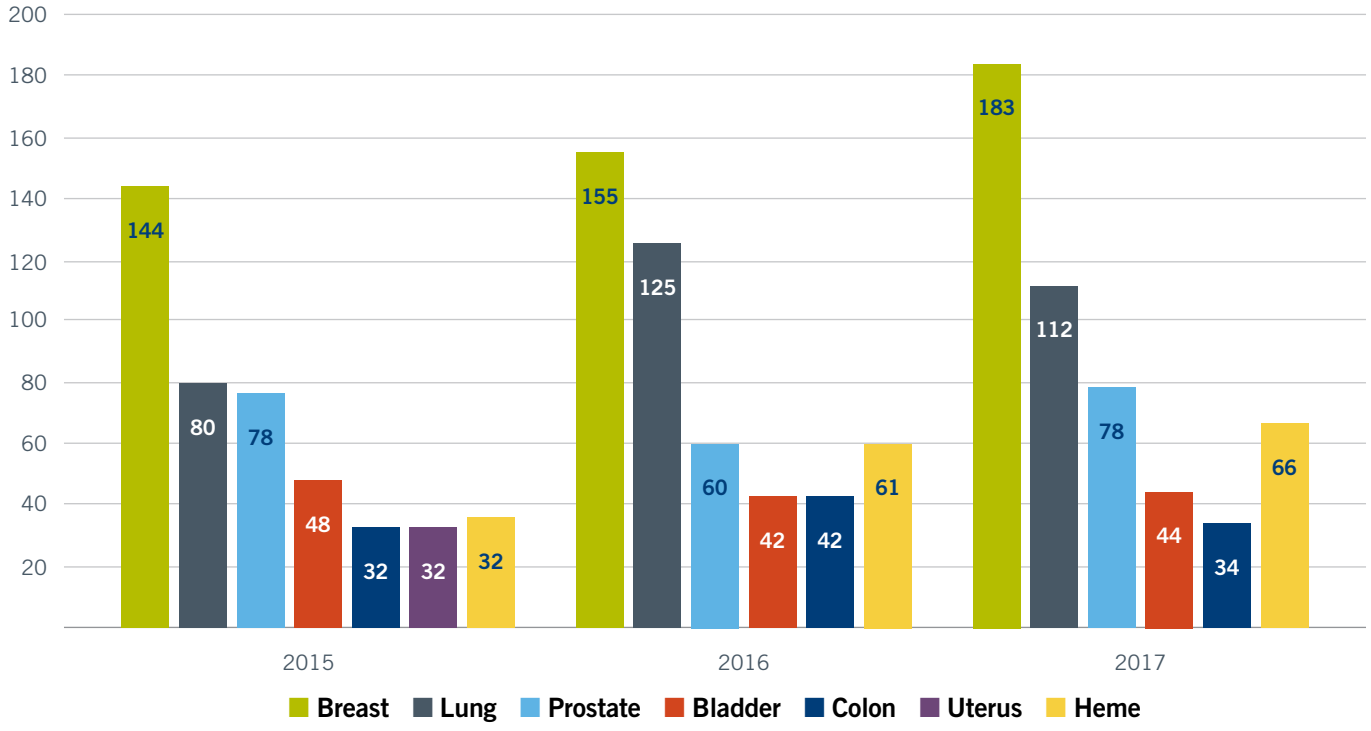
Cancer

Ratio of NL to Connecticut in AAYPLL <75 due to lung cancer and all cancers, CT DPH 2010-2014

Age adjusted YPLL <75 due to lung cancer in NL is almost two times (1.9) in Connecticut.



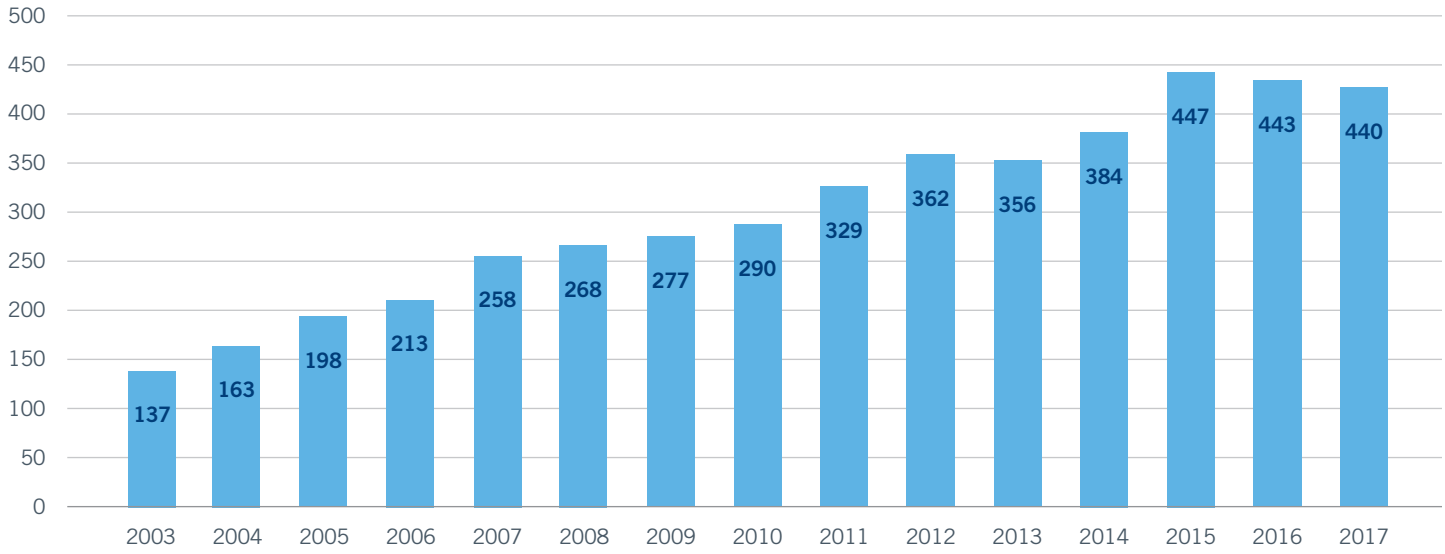
L+M solid tumor sites, 2015-2017



Maternal Child Health

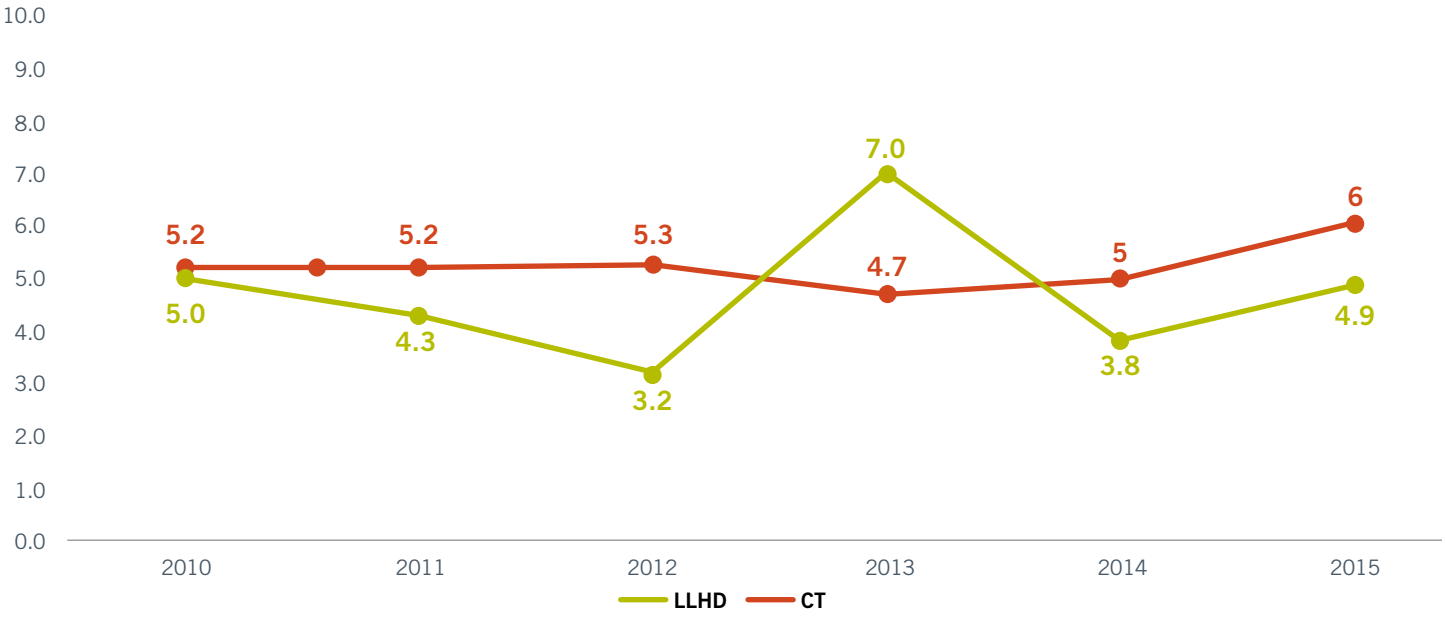
Number of hospital discharges for babies born with Neonatal Abstinence Syndrome in CT, 2003-2017

Neonatal abstinence syndrome (NAS) is diagnosed when there has been in utero exposer to opioids. Overall in CT, NAS has trended upwards over the last 14 years however there has been a slight decrease among local infants. The incidence of NAS births is spread throughout greater New London and has been historically more concentrated in the White, non-Hispanic population.



Note: FFY, federal fiscal year, defined to be October 1-September 30 of each year. Data source is the CHIME Hospital Discharge data.

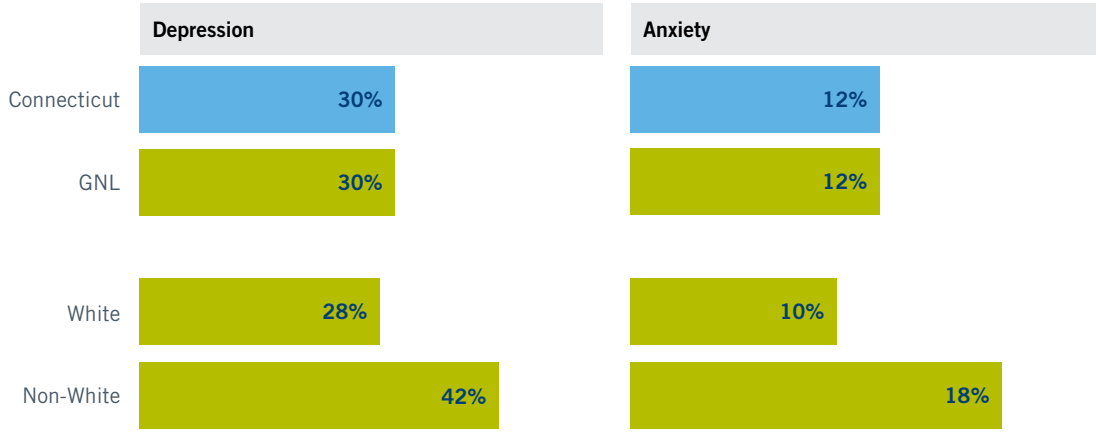
Infant death rate per 1,000 live birth, LLHD vs. CT, DPH 2010-2015



Mental Health

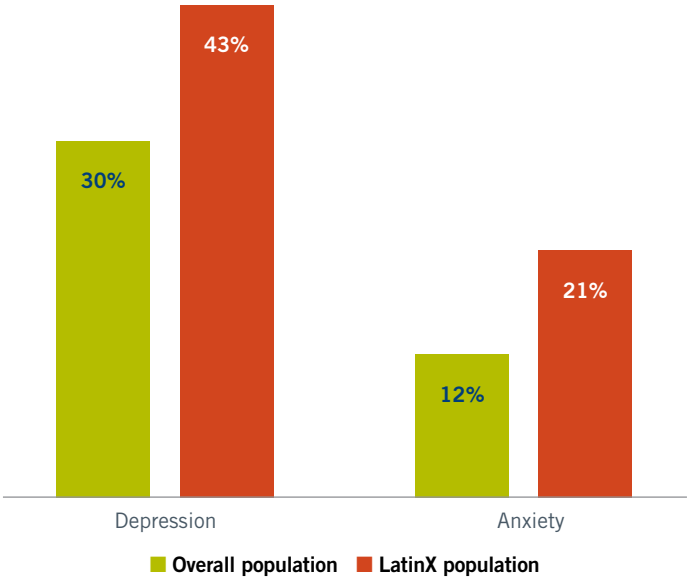
Percentage of overall population reporting depression and anxiety, Wellbeing Survey 2018:

Depression and anxiety disproportionately impact people of color in the region and there are not adequate culturally appropriate services to accommodate the need.



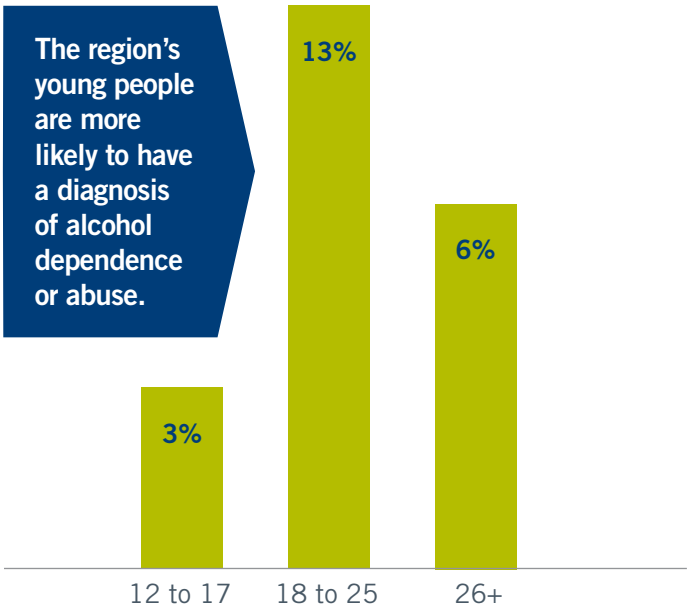
LatinX Mental Health

Percentage with depression/hopelessness several days or more in the last two weeks, and percentage feeling mostly or completely anxious yesterday, Wellbeing Survey 2018:

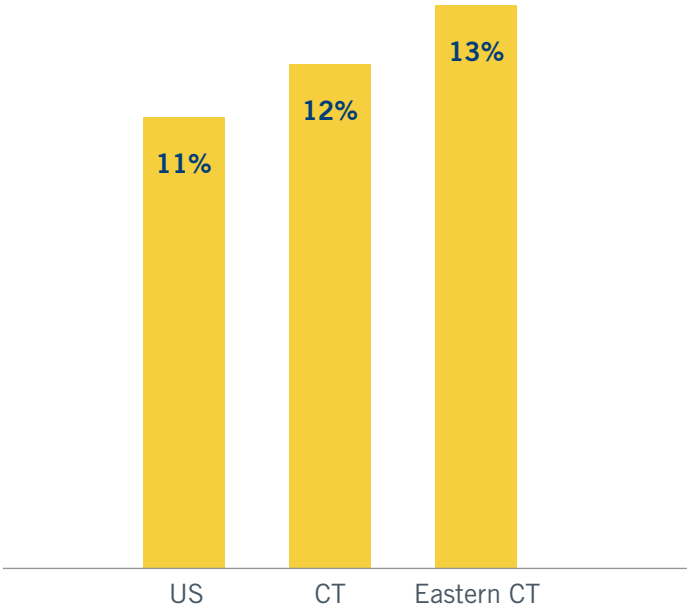


Alcohol Dependence or Abuse

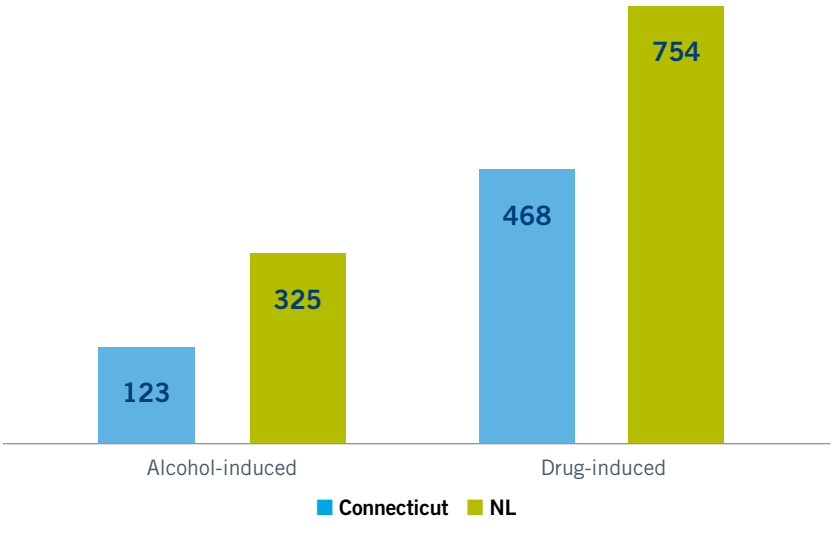
Alcohol Dependence or Abuse in Eastern CT in the Past Year, NSDUH 2014-2016:



Alcohol Dependence or Abuse in the Past Year for ages 18 to 25 Years, NSDUH 2014-2016:



Substance Use

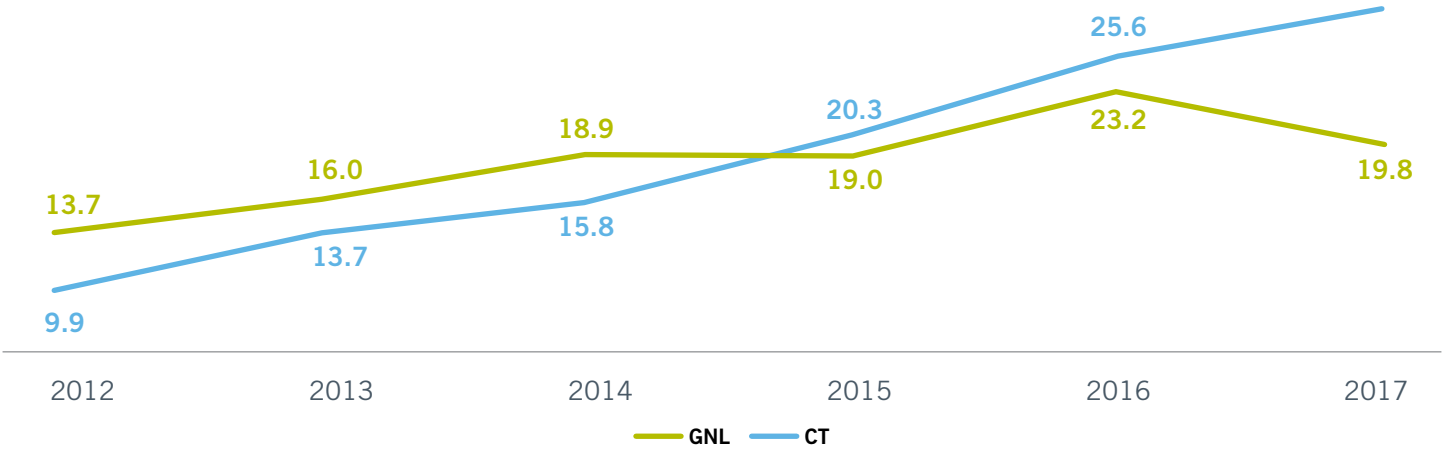


Age-adjusted years of potential life lost under 75 (AAYPLL<75) due to substance abuse, CT DPH, 2010-2014.

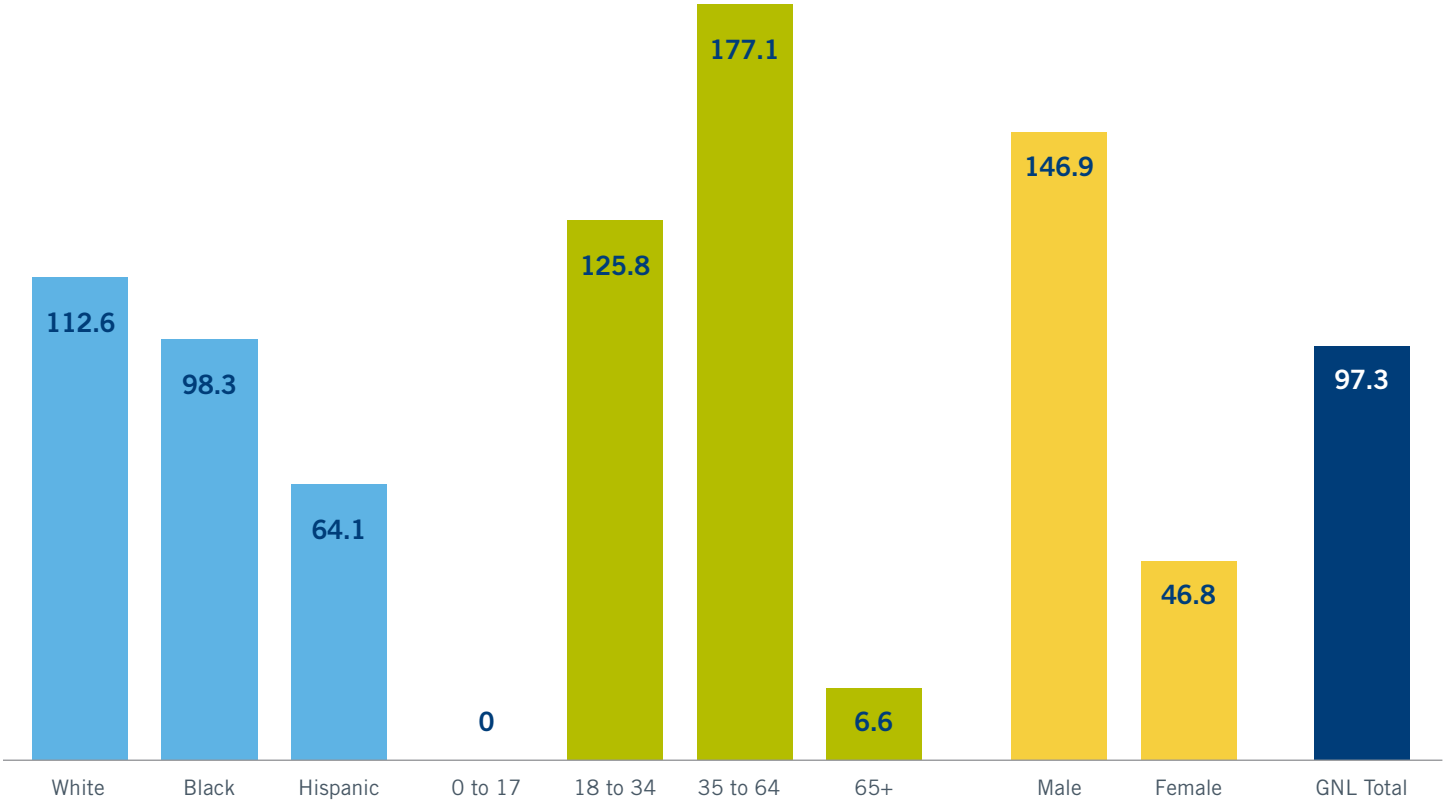
The region's young people are more likely to report being diagnosed with an alcohol use disorder. Years of potential life lost related to both alcohol and drug-induced deaths are higher in New London than in CT. As in the state, local rates of fatal overdoses have increased dramatically since 2013. Rates of overdose death are highest among white males and in the 35 to 64 age group. In the vast majority of overdose deaths, the person had more than one substance in their system at the time of death, and most had at least one opioid on board. Between 2015 and 2017 there was a sharp decrease in deaths related to prescription opioids and a sharp increase in deaths related to fentanyl.

Substance Use

Drug Overdose Deaths: Drug overdose death rate per 100,000 population in GNL vs. CT, OCME 2012-2017:

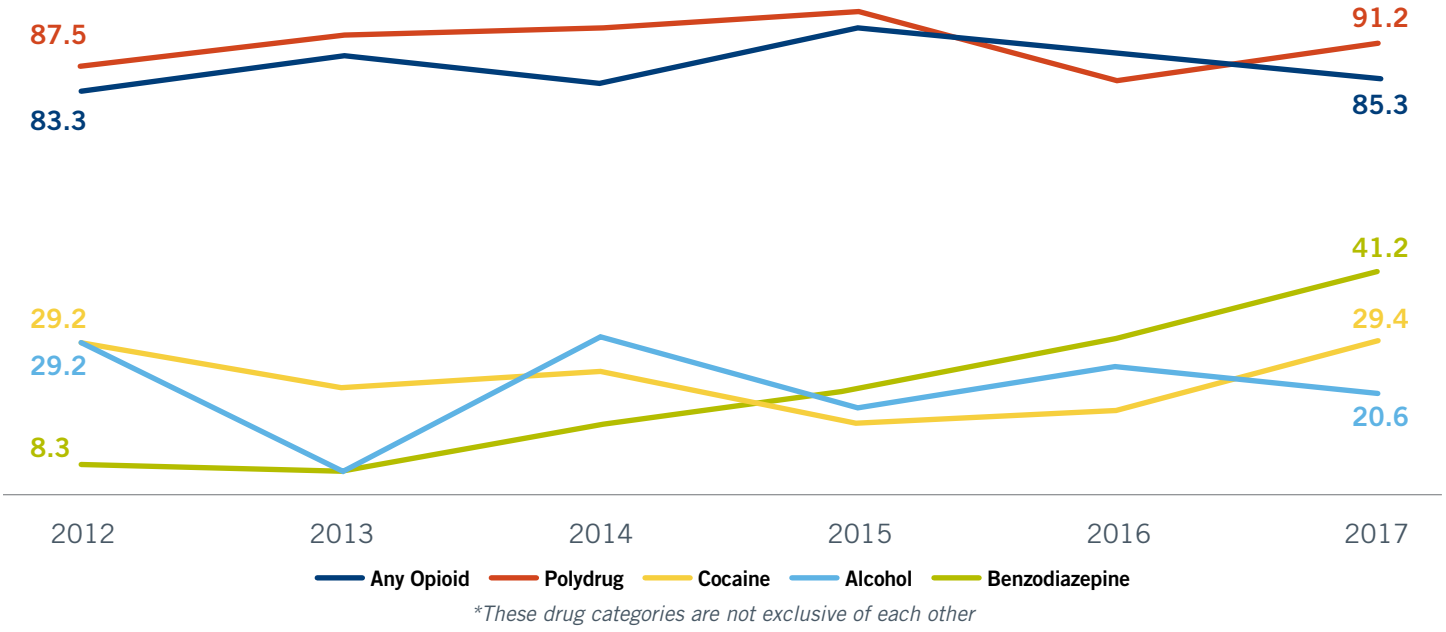


Drug Overdose Deaths: Five-year drug overdose death rate per 100,000 population in GNL, CT OCME 2013-2017:



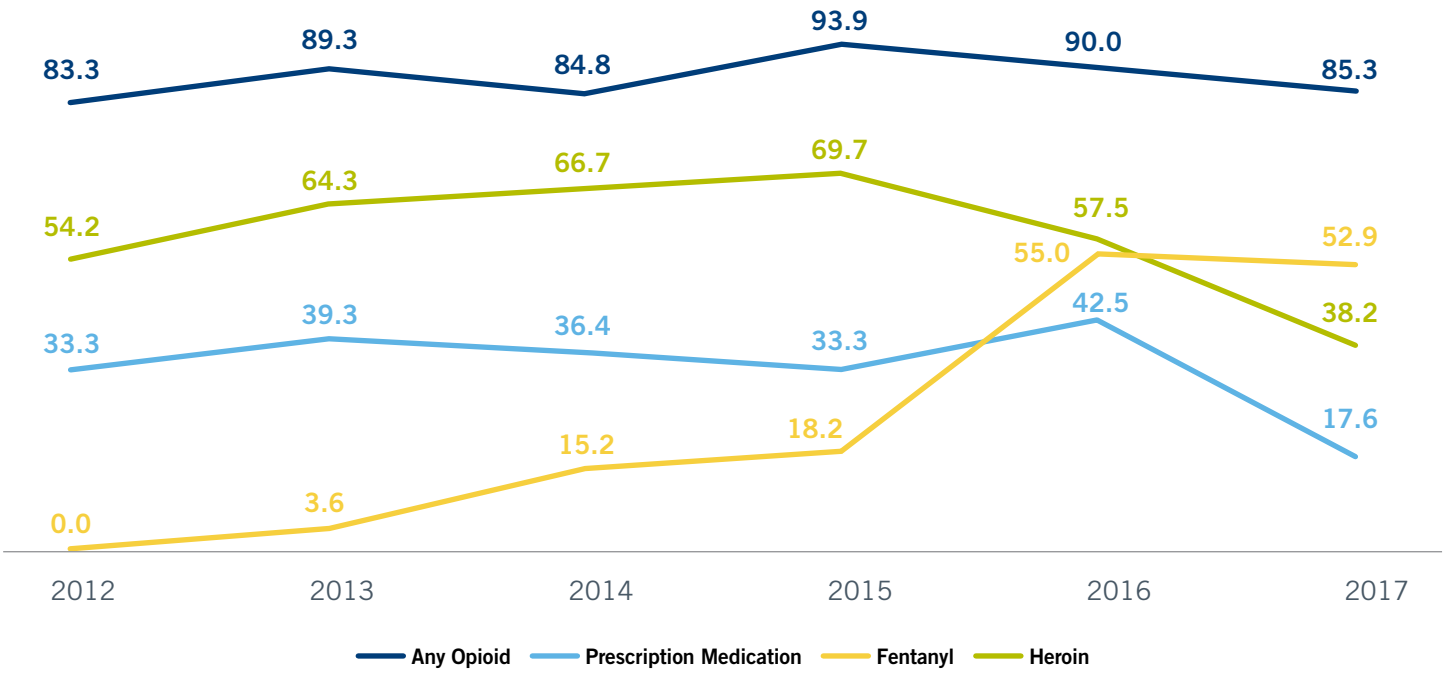
Substance Use

Drug Overdose Deaths: Percentage of substances involved in drug overdose death in GNL by drug type*, CT OCME 2012-2017:



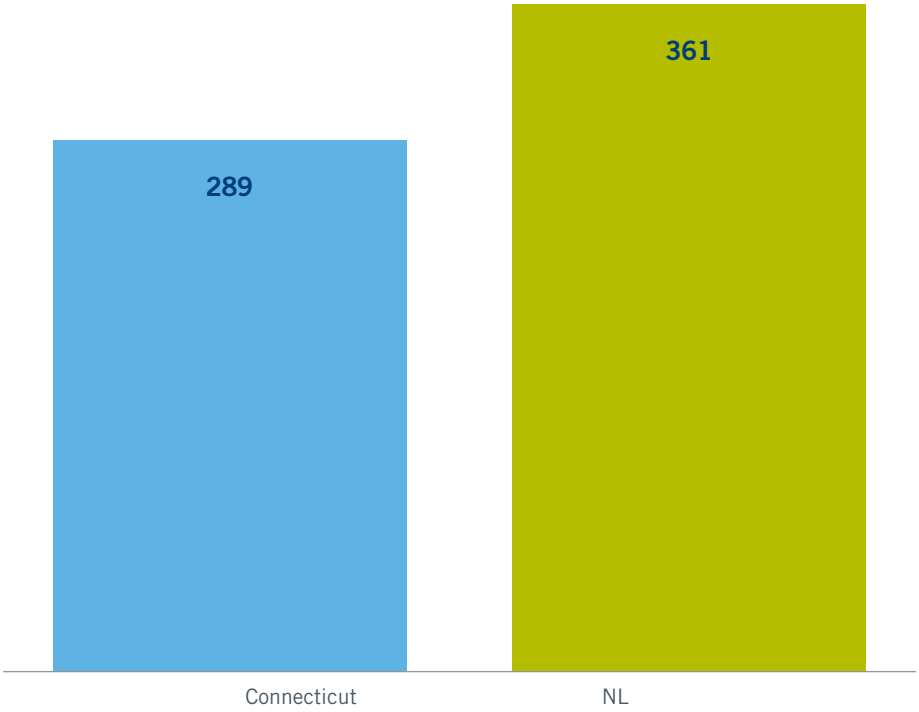
These drug categories are not exclusive of each other

Opioids: Percentage of opioids involved in drug overdose death in GNL, CT OCME 2012-2017:



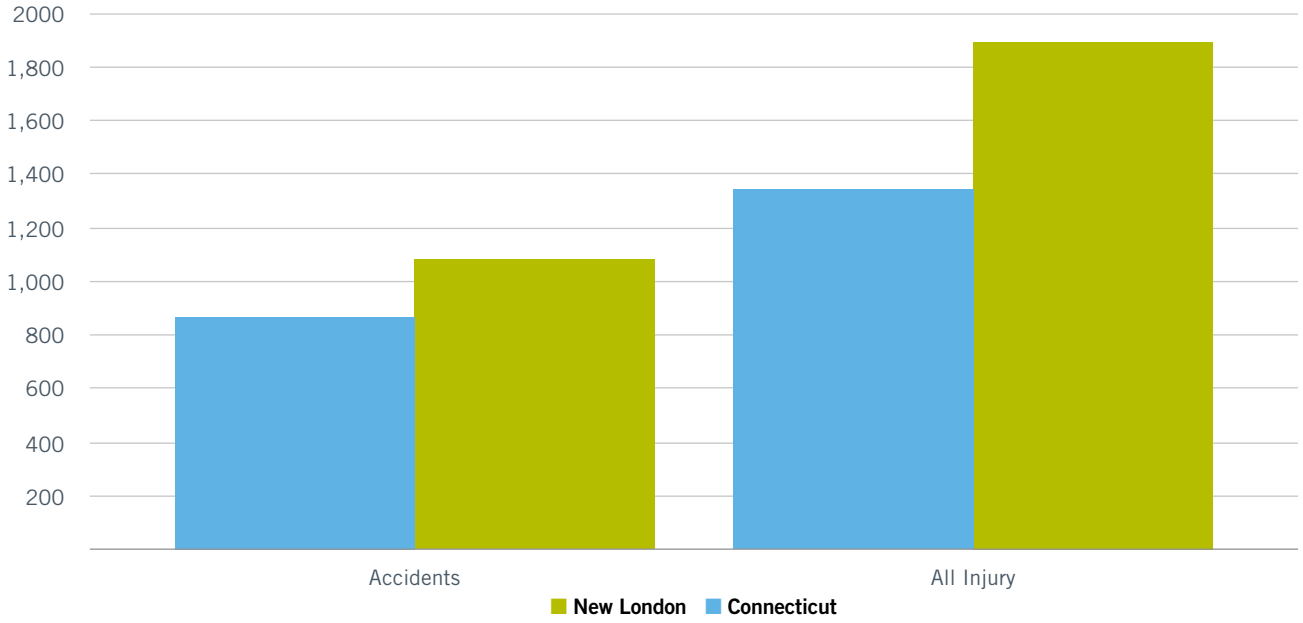
Suicide

Age-adjusted years of potential life lost under 75 (AA YPLL<75) due to Suicide, Connecticut vs. New London, CT DPH, 2010-2014

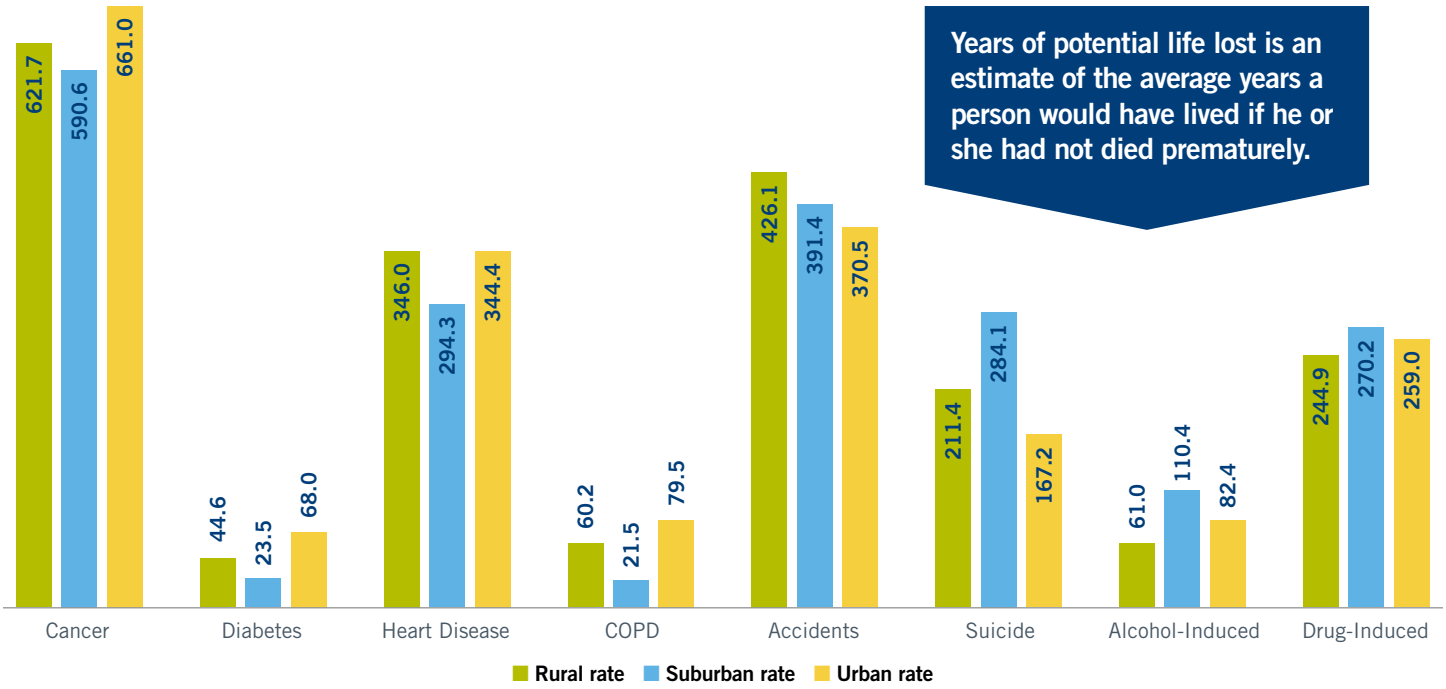


Unintentional Injury

Age-adjusted years of potential life lost under 75 (AAYPLL<75) due to injuries, CT DPH, 2010-2014:



Burden of accidents and chronic conditions: Rate of YPLL <75 per 10,000 population in GNL, 2010-2014, by community type, DPH 2010-2014:



Years of potential life lost is an estimate of the average years a person would have lived if he or she had not died prematurely.

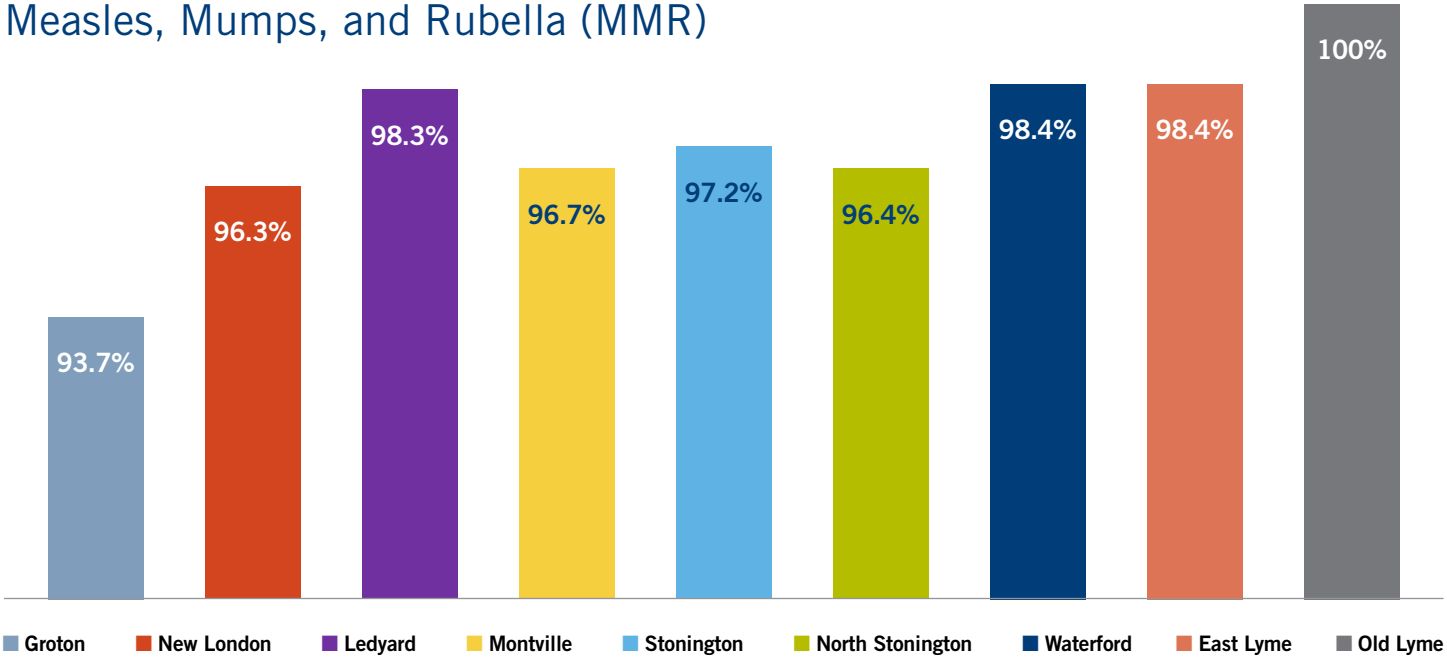
Infectious Disease

Immunizations

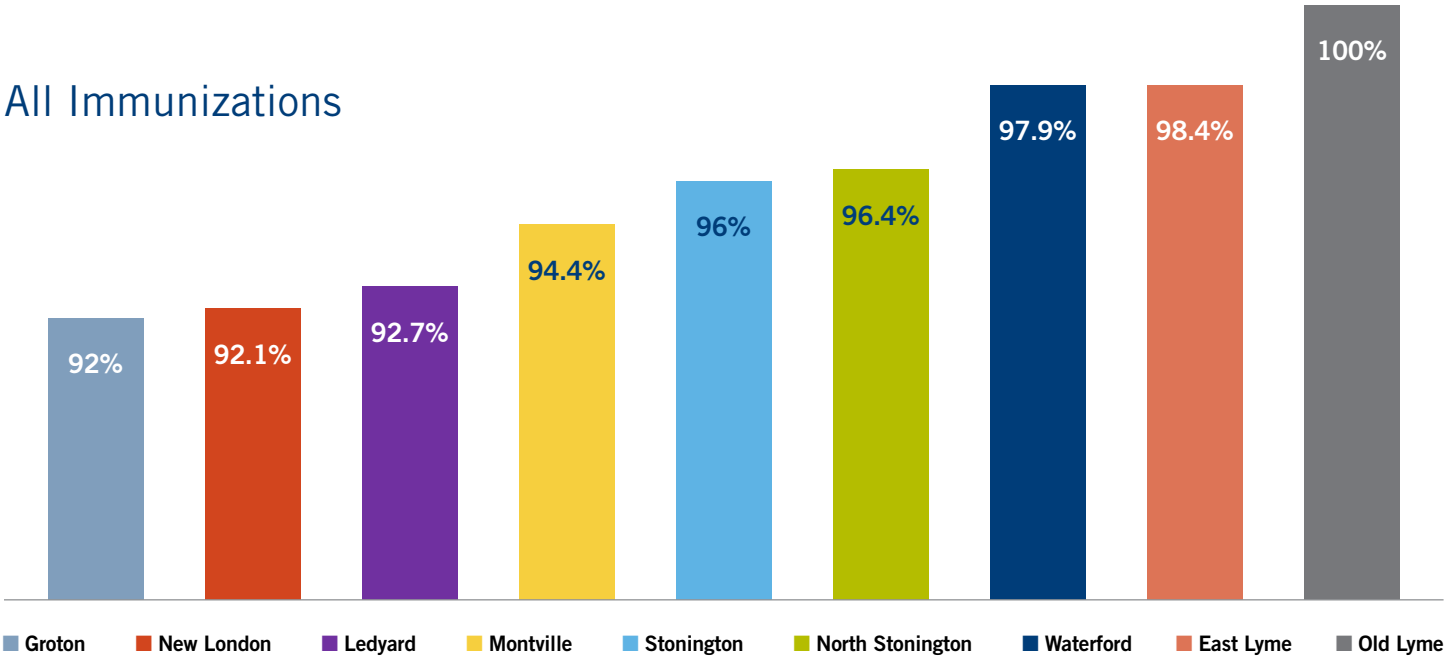
Immunization Rates for GNL Kindergarten Students, CT DPH 2018:

Some area communities fall below the recommended 95% immunization level recommended for school children. This places the school and wider community at risk for infectious diseases that otherwise have been eradicated or controlled by vaccination.

Measles, Mumps, and Rubella (MMR)



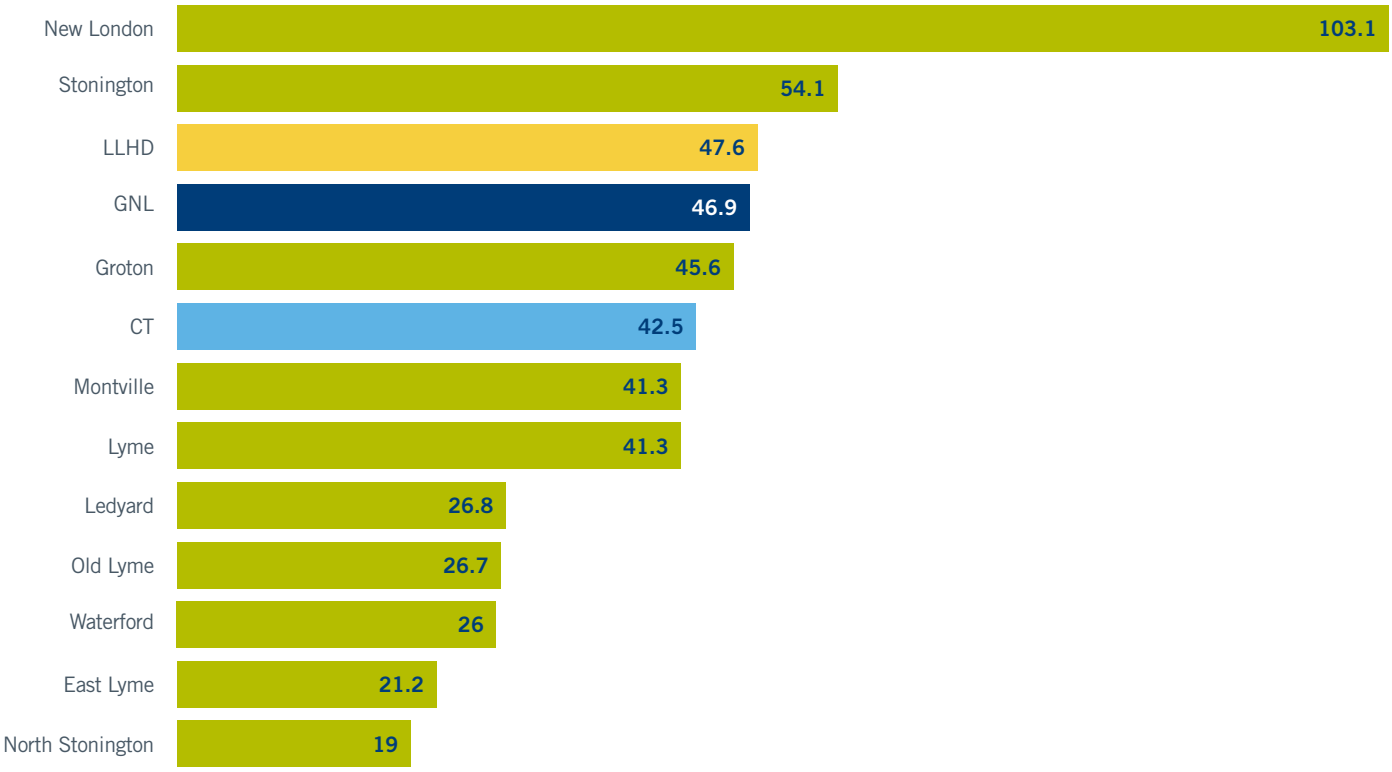
All Immunizations



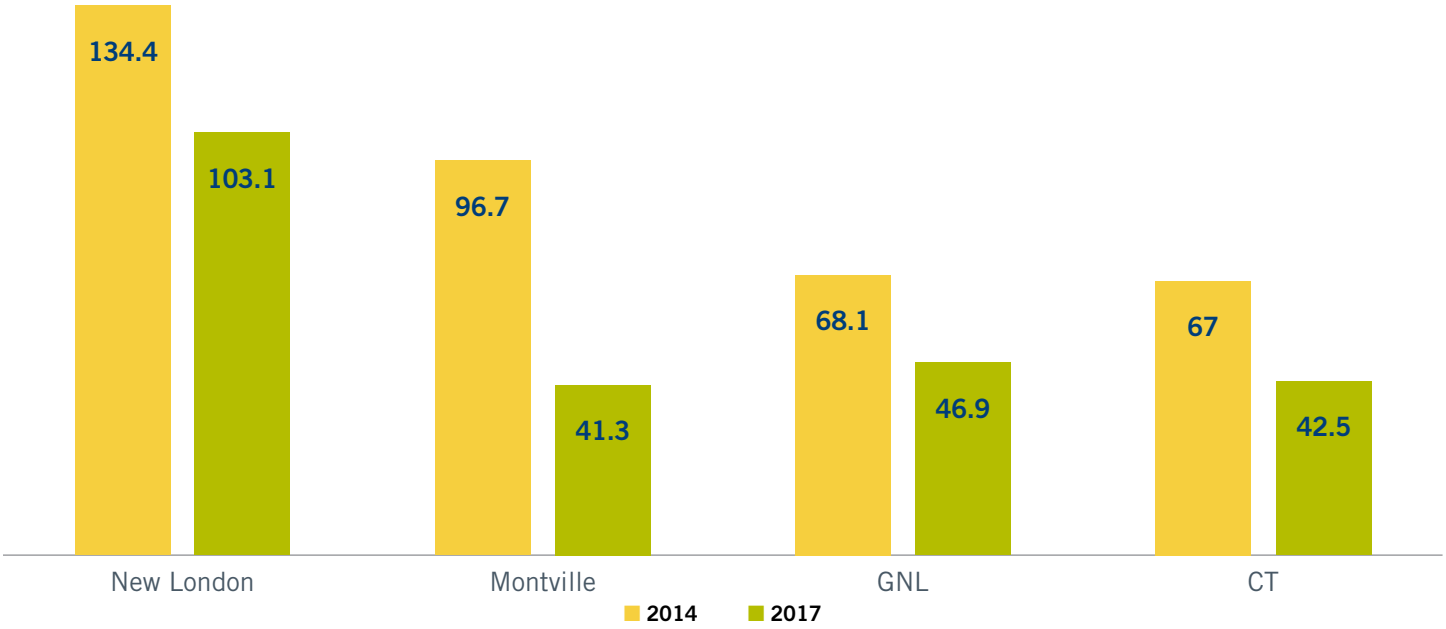
All immunizations include: DTaP, Polio, MMR, Varicella, HepB, & HepA.

Infectious Disease

Greater NL Prevalence of Hepatitis C by Town of Residence, DPH 2017:

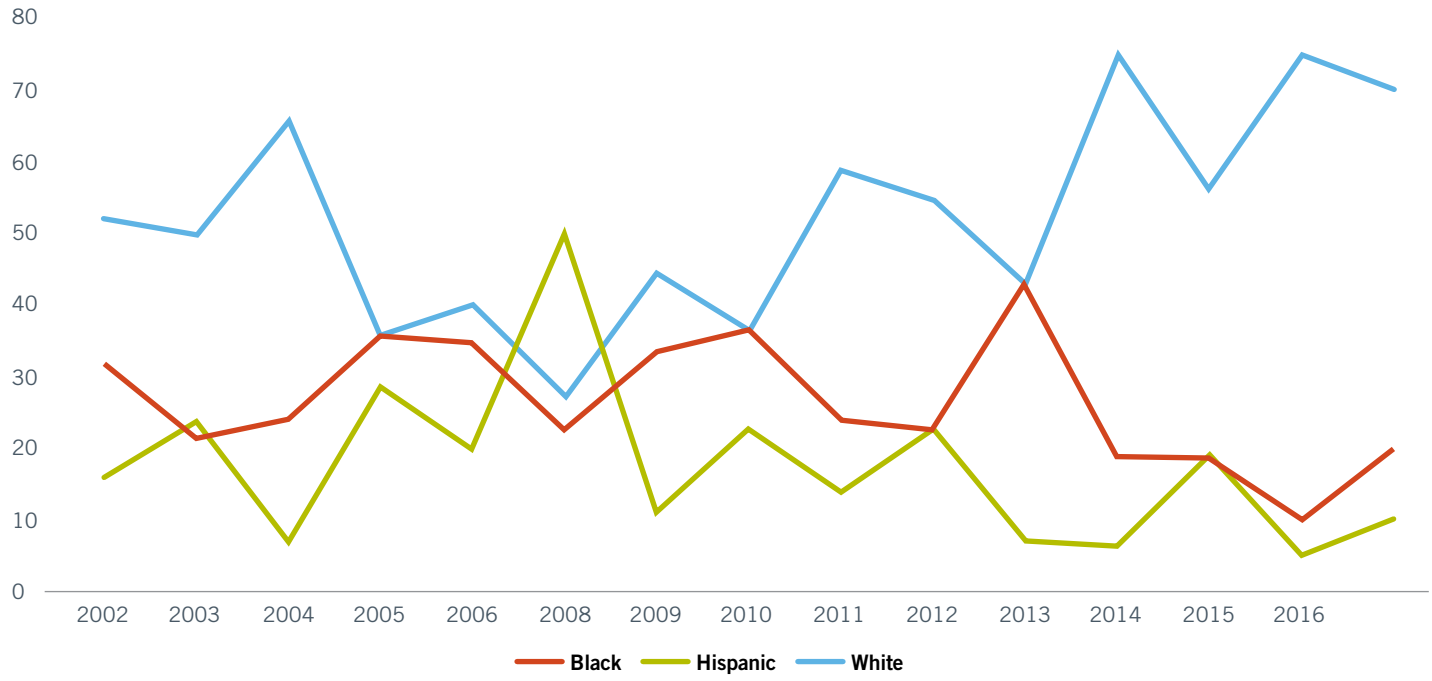


Prevalence of Hepatitis C, 2014 vs. 2017, DPH:

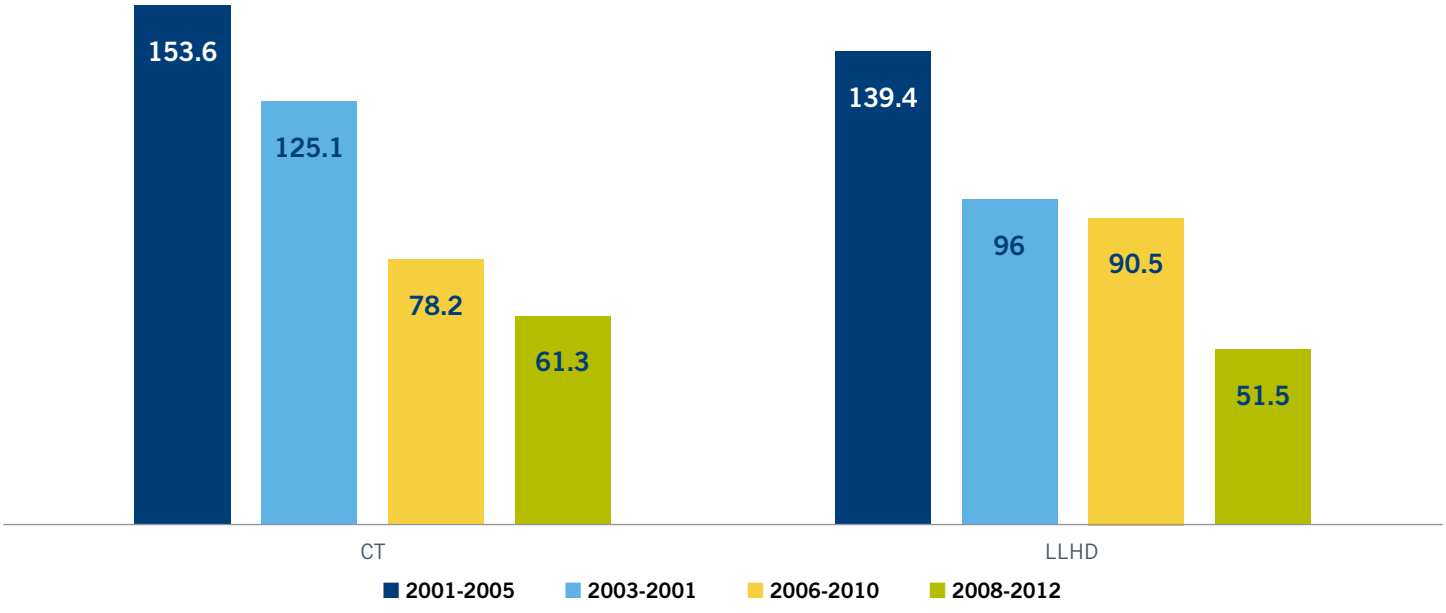


Infectious Disease

Percentage of HIV Cases by race/ethnicity and year of first diagnosis (2002-2016), New London County, DPH



HIV/AIDS mortality age adjusted years of potential life lost <75 per 100,000 people, 2001-2005 to 2008-2012, DPH:



APPENDIX A

Data Sources

The graphs and information included on the following pages reflect data from several sources:

- The 2018 DataHaven Wellbeing Survey (2018 Wellbeing Survey)
- The 2015 DataHaven Wellbeing Survey (2015 Wellbeing Survey)
- The American Community Survey (ACS), US Census
- Centers for Disease Control and Prevention (CDC)
- Connecticut Department of Public Health (CT DPH)
- Connecticut Department of Mental Health and Addiction Services (CT DMHAS)
- Connecticut Office of Chief Medical Examiner (CT OCME)
- Connecticut State Department of Education (CSDE)
- Connecticut Department of Transportation (DOT)
- Connecticut Hospital Association (CHA) – Chime Data
- Environmental Protection Agency (EPA)
- FBI Uniform Crime Reporting (UCR)
- Lawrence + Memorial Hospital (L+M)
- Ledge Light Health District (LLHD)
- Locally Conducted Focus Groups – Community Conversations by Health Equity Solutions
- Southeastern Regional Action Council (SERAC)
- The SEOW Prevention Data Portal by Center for Prevention and Evaluation Statistics (CPES)
- TVCCA
- National Survey on Drug Use and Health (NSDUH), from Substance Abuse and Mental Health Service Administration (SAMHSA)

APPENDIX B

Participating Organizations and Constituencies

NAME OF ORGANIZATION	NATURE AND EXTENT OF INPUT[1]	VULNERABLE POPULATION REPRESENTED[2]
Alliance for Living	AT, HIC, P, CC	People with HIV
American Heart Association	P	
The Arc of NL County	P	People with developmental disabilities
Child and Family Agency	HIC, P	MU, LI, POC
Church of the City	P, CC	LatinX, LI
Clergy Association (NL)	P, CC	MU, LI, POC
Community Foundation of Eastern CT	HIC, P	MU, LI, POC through funding priorities
CHN CT	P	MU, LI, POC
Connecticut Legal Services	HIC, P	LI, POC
Community Health Center, Inc	AT, HIC, P	MU, LI, POC
Connecticut College	L, HIC, P, CC	
CT Dept. of Mental Health and Addiction Services	AT, HIC, P	MU, LI, POC
The Connection, Inc.	AT, P	People with Substance Use Disorders
Town of East Lyme	P	MU, LI, POC through social services
Eastern CT AHEC	HIC	DataHaven
ECTC	HIC	POC
Fiddleheads Food Co-op	HIC	
FRESH New London	AT, HIC, P	
Groton Community Meals	CC	
Town of Groton	AT, HIC, P	MU, LI, POC through social services
Hispanic Alliance	AT, HIC, P, CC	LatinX
Homeless Hospitality Center	AT, HIC, P, CC	Homeless individuals
Lawrence and Memorial Hospital	L, AT, HIC, P	
Ledge Light Health District	L, AT, HIC, P, CC	

[1]**NATURE AND EXTENT OF INPUT:** **L** Leadership (participation in a steering committee or in chairing a subcommittee); **AT** Action Team (participation in a subcommittee); **HIC** Full Collaborative (participation in collaborative meetings); **P** Prioritization (participation in the CHNA data review and prioritization of issues); **CC** Community Conversation (participation in one of the community conversations)

[2]**VULNERABLE POPULATIONS REPRESENTED** include the medically underserved (**MU**) such as undocumented persons and LGBTQ persons; Low income (**LI**) include individuals with incomes $75K or below; People of Color (**POC**) include Blacks, African Americans, LatinX, People indicating 2 or more races/ethnicities, Native Americans, Asians, and Haitians.

NAME OF ORGANIZATION	NATURE AND EXTENT OF INPUT[1]	VULNERABLE POPULATION REPRESENTED[2]
Ledyard Visiting Nurses	P	MU, LI, POC
NAACP	L, AT, HIC, P	MU, LI, Black people
City of New London	AT, HIC, P	MU, LI, POC through social services
New London Public Library	P	
New London Public Schools	HIC, P	MU, LI, POC through school based health services and other supports
Office of U.S. Senator Chris Murphy	HIC	
Old Lyme VNA	P	
OUT CT	AT, HIC, P	LGBTQ individuals
People with involvement with the criminal justice system (individuals)	CC	MU, LI, POC
People impacted by substance use disorder (individuals)	CC	MU, LI, POC
Planned Parenthood of Southern New England	HIC, P	MU, LI, POC
Safe Futures	P	Survivors of domestic violence and sexual assault
SECT Council of Governments	AT, HIC, P	
SeCTer	AT, HIC	
SERAC	P	
Sound Community Services	AT, HIC, P	People with mental health challenges and substance use disorders
Southeastern Mental Health Authority	AT, HIC, P	MU, LI, POC
Town of Stonington	P	MU, LI, POC through social services
Thames Valley Council for Community Action	L, AT, HIC	MU, LI, POC
Three Rivers Community College	P	
UCONN Health Disparities Institute	HIC, P	MU, POC
United Action	AT, HIC, P	
United Community and Family Services	AT, HIC, P	MU, LI, POC
Uncas Health District	P	
United Way of SE CT	P	MU, LI, POC through funding priorities
U.S. Navy	P	
Veterans Coffee House (individuals)	CC	Veterans
VNA of SE CT	P	MU, LI, POC
Town of Waterford	P	MU, LI, POC through social services

[1]**NATURE AND EXTENT OF INPUT:** **L** Leadership (participation in a steering committee or in chairing a subcommittee); **AT** Action Team (participation in a subcommittee); **HIC** Full Collaborative (participation in collaborative meetings); **P** Prioritization (participation in the CHNA data review and prioritization of issues); **CC** Community Conversation (participation in one of the community conversations)

[2]**VULNERABLE POPULATIONS REPRESENTED** include the medically underserved (**MU**) such as undocumented persons and LGBTQ persons; Low income (**LI**) include individuals with incomes $75K or below; People of Color (**POC**) include Blacks, African Americans, LatinX, People indicating 2 or more races/ethnicities, Native Americans, Asians, and Haitians.

APPENDIX C

IRS Requirements Table

IRS FORM 990 SCHEDULE H	REPORT PAGE(S)
Part V Section B Line 3a A definition of the community served by the hospital facility.	**Page 7**
Part V Section B Line 3b Demographics of the community.	**Pages 10-12**
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community.	**Appendix D Pages 58-63**
Part V Section B Line 3d How data were obtained.	**Page 6 and Appendix A Page 55**
Part V Section B Line 3e The significant health needs of the community.	**Pages 31-54**
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups.	**Pages 35-54**
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs.	**Page 6, Appendix E Page 64, and Appendix F Pages 65-70**
Part V Section B Line 3h The process for consulting with persons representing the community's interests.	**Page 6 and Appendix B Pages 56-57**
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s).	**Appendix G Pages 71-73**

APPENDIX D

Community Assets

HEALTH SERVICES

AGENCY Location	Abortion Services	Aging and Disability Resource Centers	Community Clinics	Dental Care	Developmental Screening	Early Intervention for Children With Disabilities/ Delays	General Sexuality/ Reproductive Health Education	Health Care Referrals	Health Insurance Information/ Counseling	Health Screening/ Diagnostic Services	Home Health Care	Medical Expense Assistance	Medicare Information/ Counseling	Outpatient Health Facilities	Pediatrics	Prenatal Care	Prescription Expense Assistance	Weight Loss Assistance	Women's Health Centers
Alzheimer's Association - Connecticut Chapter - Eastern Regional Office, Norwich												X							
Careco Medical / Careco Shoreline, Waterford											X								
Community Health Center, Groton			X											X	X				
Community Health Center, New London			X	X										X	X				
Connecticut Community Care, Franklin		X																	
Easterseals - Birth to Three Program, Norwich						X													
Lawrence & Memorial Hospital - Yale New Haven Health, New London					X							X		X		X			
LEARN, Old Lyme						X													
Mashantucket Pequot Tribal Nation, Mashantucket								X		X				X	X				
Masonicare Home Health & Hospice, Mystic											X								
Overeaters Anonymous, West Mystic																		X	
Planned Parenthood of Southern New England, New London	X		X				X			X				X					X
Save the Kid Fund, Preston												X							
Senior Resources - Agency on Aging - Eastern Connecticut, Norwich									X				X				X		
Tri-Service Warrior Care Clinic, Groton										X									
Veterans Affairs, United States Department of - Connecticut Healthcare System, New London																	X		
Visiting Nurse Association of Southeastern Connecticut, Waterford										X	X					X			

MENTAL HEALTH SERVICES

AGENCY, Location	Counseling Services	Crisis Intervention	Faith Based Counseling	Inpatient Mental Health Facilities	Mental Health Evaluation	Outpatient Mental Health Facilities	Psychiatric Services	Residential Treatment Facilities	Supportive Therapies	Talklines/ Warmlines	Transitional Mental Health Services
Alliance For Living, New London										X	
Child & Family Agency of Southeastern Connecticut, New London	X				X		X				
Child & Family Agency of Southeastern Connecticut, Groton	X				X						
Community Health Center, New London	X				X						
Connection, The, Groton	X										
Connection, The, New London	X										
Creative Potential LLC, Uncasville							X				
Healing with Horses at Wildrose Horse Farm, Uncasville									X		
Reliance Health, Norwich	X										X
Safe Futures, New London	X	X	X								
Salvation Army - New London Corps Community Center, New London											
Sexual Assault Crisis Center of Eastern Connecticut Inc, New London	X	X									
Sound Community Services, New London	X						X	X			X
Substance Abuse Rehabilitation Program, Groton	X										
United Community and Family Services, New London	X				X		X				
Waterford Country School, Quaker Hill	X							X	X		
Wheeler Clinic, New London							X				

SUBSTANCE USE AND ADDICTION SERVICES

AGENCY, Location	Assessment for Substance Use Disorders	Counseling Services	Detoxification	DUI Offender Programs	Substance Use Disorder Education/ Prevention	Substance Use Disorder Treatment Programs	Supportive Substance Use Disorder Services	Transitional Residential Substance Use Disorder Services
A New Beginning Recovery Houses, New London								X
A-Cure LLC, New London								X
Alliance for Living, New London							X	
Catholic Charities - Diocese of Norwich, New London		X						
Community Health Center, New London						X		
Community Speaks Out, Groton					X		X	
Connection, The, Groton	X					X		
Hartford Dispensary, New London			X			X		
Healthy Lifestyles Recovery Living Centers, Waterford								X
Ledge Light Health District, New London					X		X	
Mashantucket Pequot Tribal Nation, Mashantucket					X	X		
Southeastern Council on Alcoholism and Drug Dependence (Scadd), New London	X		X			X		X
Stonington Institute, North Stonington			X			X		
Substance Abuse Rehabilitation Program, Groton	X					X		
Uncas Health District, Norwich						X		

HOUSING SERVICES

AGENCY, Location	Emergency Shelter			Homeless Permanent Supportive Housing	Housing Search and Information	Low Income/ Subsidized Rental Housing	Rent Payment Assistance	Transitional Housing/ Shelter
	Crisis Shelter	*Homeless Drop In Center*	*Homeless Shelter*					
Alliance for Living, New London			X					
Always Home, Mystic				X				
Carabetta Management, New London						X		
Covenant Shelter of New London, New London				X				
Demarco Management, New London			X					
Groton Housing Authority, Groton						X		
Ledyard Housing Authority / Kings Corner Manor, Gales Ferry						X		
Malta Transitional Living Center, Groton								X
Martin House, Norwich			X					
Montville Housing Authority, Uncasville						X		
Navy Fleet and Family Support Center, Groton					X			
New London Homeless Hospitality Center, New London		X		X				X
New London Housing Authority, New London						X		
Safe Futures, New London	X							X
Sound Community Services, New London			X					
Stonington Housing Authority, Pawcatuck						X		
Stonington, Town of, Pawcatuck							X	
Thames Valley Council For Community Action, New London				X	X	X	X	

UTILITIES ASSISTANCE

AGENCY	Location
Alliance for Living	New London
Care and Share of East Lyme	Niantic
Jewish Federation Senior and Community Services	New London
Operation Fuel	
Thames Valley Council for Community Action	New London
United Cerebral Palsy Association of Eastern Connecticut	Quaker Hill
United Way of Southeastern Connecticut	Gales Ferry

EMPLOYMENT AND INCOME

AGENCY, Location	Adult Education	Employment Documentation/ Verification	Job Finding Assistance	Personal Financial Counseling	Retirement Benefits	Tax Preparation Assistance	Training and Employment Programs	Vocational Education	Vocational Rehabilitation
American Job Centers, Uncasville		X	X						
Buckingham Community Services, New London							X		X
Centro De La Comunidad, New London	X	X	X						
Connecticut Indian Council, North Stonington		X	X				X		
Creative Potential LLC, Uncasville		X							
CW Resources, Gales Ferry							X		X
Disabilities Network of Eastern Connecticut, Norwich			X						
Education, State of Connecticut Department of - Ella T. Grasso Technical High School, Groton								X	
Education, State of Connecticut Department of - Norwich Technical High School, Norwich								X	
Navy Fleet and Family Support Center, Groton			X	X					
Navy-Marine Corps Relief Society, Groton				X					
New Beginnings for Life LLC, Salem			X						
New London, City of - Office of Youth Affairs, New London			X						
New London Public Schools, Adult and Continuing Education, New London	X								
Opportunities Industrialization Center of New London County (OIC), New London		X							
Pawcatuck Neighborhood Center, Pawcatuck		X							
Seabird Enterprises, Groton			X				X		X
Sea-Legs, New London		X							
Sound Community Services, New London							X		X
Thames Valley Council for Community Action, New London		X		X					
United Cerebral Palsy Association of Eastern Connecticut, Quaker Hill		X	X						
Veterans Affairs, United States Department of - Groton Submarine Base Itinerant Office									X
Viability, Inc., Gales Ferry							X		
VITA (Volunteer Income Tax Assistance) Sites - 2-1-1 Appointments, Mystic						X			
VITA (Volunteer Income Tax Assistance) Sites - 2-1-1 Appointments, New London						X			
VITA (Volunteer Income Tax Assistance) Sites - 2-1-1 Appointments, Pawcatuck						X			

FOOD ASSISTANCE

AGENCY, Location	Food Pantries	Meals-Congregate Meals / Nutrition Sites	Meals-Home Delivered Meals	Meals-Soup Kitchens
Adventist Community Services of Connecticut, Waterford	X			
Alliance for Living, New London	X			
Care and Share of East Lyme, Niantic	X			
Careco Medical / Careco Shoreline, Waterford				
Centro De La Comunidad, New London	X			
Church of fhe City of New London, New London				X
Groton Community Meals, Mystic				X
Jewish Federation Senior and Community, New London	X	X		
New London Area Food Pantry, New London	X			
New London Breakfast Program, New London				X
New London Community Meal Center, New London				X
New London Housing Authority, New London				
Niantic Community Church Food Pantry, Niantic	X			
Outreach for the Unreached Ministry, Gales Ferry	X			
Pawcatuck Neighborhood Center, Pawcatuck	X	X	X	X
Salvation Army, New London	X			
Shoreline Soup Kitchens and Pantries, Niantic	X			
Thames Valley Council for Community Action, New London		X	X	
United Way of Southeastern Connecticut, New London	X			

TRANSPORTATION

AGENCY, Location	Emergency Road Service	Local Bus Services	Non-Emergency Medical Transportation	Paratransit Programs
AAA - Hartford, Middlesex, New London, Tolland and Windham Counties, Waterford	X			
Curtin Transportation Group, Waterford			X	X
Eastern Connecticut Transportation Consortium, Uncasville		X	X	X
Groton, Town of - Senior Center, Groton			X	
New London, City of - Senior Center, New London			X	
Pawcatuck Neighborhood Center, Pawcatuck			X	X
Southeast Area Transit District, Preston		X		
Southeast Connecticut Community Center of the Blind, New London				X

APPENDIX E

Key Informant Survey Summary

The 2019 CHNA process was initiated in 2018 to include the collection of primary and secondary data elements. One primary data collection strategy included an online key informant survey administered and analyzed by the Yale School of Public Health Student Consulting Group. The online survey was distributed to community leaders and service providers in the Greater New London area using Qualtrics, an online survey tool. The survey design process was carried forward from the 2015 CHNA with technical assistance from DataHaven (qualitative / quantitative questions for trending purposes).

Key informant interviews are in-depth interviews of a select (nonrandom) group of experts who are most knowledgeable of the organization or issue. The key informant is a proxy for her or his associates at the organization or group. Participating in our key informant survey were two categories of individuals: 1. Health and Human Services (51% response rate; examples include hospital administrators, state and local health departments, physicians, nurses, and social services); and 2. Government and Community Leadership (49% response rate; examples include state and local elected officials, police and fire departments, library directors, clergy, and other government agency heads).

In total, there were 112 surveys administered in Greater New London throughout the month of March 2018 with an overall 37% response rate. Significant observations from the survey include:

- A majority of the respondents (83%) were aware of the CHNA.
- 34% of respondents were aware of new health related community initiatives since 2015.
- The top 3 health issues of greatest concern cited were: mental health and addiction, access to health services, and chronic disease.
- Social determinants of health (SDOH) was issue #4 and respondents cited many SDOH as the greatest potential negative impact on adults and children in the region.
- Lack of access to medical insurance and availability of support programs were overwhelmingly identified as major barriers to health.
- Respondents believe there is limited access to mental/behavioral health care despite rising concerns as a top health issue.
- Many respondents were uncertain regarding enough / adequate providers (Medicaid, Bilingual) and transportation.
- Respondent perception is uncertain relative to whether others are treated equally.

APPENDIX F

Qualitative Data

Community Conversations

Between March and June 2019, seven community conversations engaging a total of 94 individuals were conducted by Health Equity Solutions in the Greater New London Region. The goals of the community conversations were to determine perceptions of health strengths and needs in the Greater New London Region; to identify gaps, challenges and opportunities for addressing community needs more effectively; and to explore how these issues can be addressed in the future. Working with HICSC, groups having a disproportionate burden of health issues were identified as a priority to include in the community conversations. HICSC members identified specific groups and/or organizations that fulfilled these criteria, and the consultant organized and facilitated the following groups: veterans, the homeless, people affected by substance abuse disorder, people affected by the criminal justice system, faith community leaders, the Tribal community and Latinxs.

In addition, the consultant maintained efforts to include a geographical sample of residents from the towns and cities that make up the Greater New London CHNA region (Town of Montville in addition to the Ledge Light Health District service area, which includes East Lyme, Lyme, Old Lyme, Waterford, New London, Groton, Ledyard, Stonington, and North Stonington.)

Regional Community Conversations

Community conversations, similar to focus groups, are meant to provide the perspective of community members, particularly the underserved and/or specific populations, as part of the community health needs assessment process. HES and HIA worked collaboratively to identify the target underserved population and to identify host organizations for each community conversation. A total of 94 individuals participated in six community conversations between the end of March through the end of June 2019. The goals of the conversations were to determine perceptions of the community, health and health care in the Greater New London region, including the vision for a healthy community, ways to achieve the vision, community health challenges, mental health and substance abuse issues and factors contributing to health issues in specific populations, e.g. cardiovascular disease/hypertension/diabetes in African Americans, anxiety and depression in Latinx.

The final set of participants yield a diverse cross-section of community members across various demographic variables: gender, age, race, ethnicity, income level, employment status, and geography. Overall, the participants self-identified as female (56%) and 53% were white; 11% were American Indian and 8% black. Due to space constraints on the demographic survey tool, only one ethnicity was listed and 28% of participants identified their ethnicity as Hispanic. 31 percent of the participants were single38% were married or in a domestic partnership, 6% were widowed and 25% divorced or separated. 39 percent of the participants were currently employed, 22% were retired, 8% were unable to work, and 11% were homemakers. Table 1 illustrates the overall demographics of the community conversation participants.

APPENDIX F

Qualitative Data

Table 1: Greater New London Community Conversation Demographics

Gender	
Female	56%
Male	44%
Age	
18-26	14%
27-34	8%
35-44	20%
45-54	22%
55-64	8%
65-74	14%
75+	14%
Race/Ethnicity	
American Indian/Alaska Native	11%
Asian/Pacific Islander	0%
Black/African American	8%
Hispanic	28%
White	53%
Marital Status	
Single, never married	31%
Married or domestic partnership	38%
Widowed	6%
Divorced/Separated	25%

Employment	
Employed for wages	39%
Self-employed	3%
Out of work	14%
A homemaker	11%
A student	3%
Military	0%
Retired	22%
Unable to work	8%
Place of Residence	
New London	41%
Oakdale	3%
Norwich	8%
Pawcatuck	8%
Mystic	6%
Groton	8%
North Stonington	11%
Westerly, RI	3%
Mashantucket	6%
Ledyard	3%
Canterbury	3%

A semi-structured protocol was used during the community conversation sessions to ensure consistency in the topics covered. Questions posed to each group are included in the Appendix. Each of the groups was led by an experienced facilitator. Each session was audio recorded to ensure that all information was captured. Questions explored during the community conversations focused on the overall vision for a healthy community and what is needed to achieve the vision, health issues, the impact of mental health and substance abuse issues on wellbeing in the community, and underlying factors affecting specific populations in the region. Two of the conversations also included graphic recording during the meeting which captured key thoughts and themes (Figures 1 and 2).

APPENDIX F

Qualitative Data

Figure 1

Community Health Needs Assessment | Yale New Haven Hospital
Community Conversation, Hispanic Alliance, New London, CT | 04.11.19
Facilitated by HEALTH EQUITY SOLUTIONS

Figure 2

Community Health Needs Assessment | Yale New Haven Hospital
Community Conversation, Hispanic Alliance, New London, CT | 05.15.19
Facilitated by HEALTH EQUITY SOLUTIONS

APPENDIX F

Qualitative Data

One of the groups was co-facilitated by a Spanish-speaking facilitator. On average, the focus groups lasted 60 to 90 minutes with an average group size of 14 participants. Transcriptions of all sessions were analyzed and categorized by themes.

Key Themes

An analysis of themes that emerged during the conversations was organized around the Social Determinants of Health (SDoH). SDoH are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

Figure 3
Source: HealthyPeople 2020

The five determinants in the diagram above align with the core determinants of health as described in Figure 2: Social Determinants of Health Framework in section III: Methods under the subheading, Social Determinants of Health Framework.

The following are the SDoH domains that surfaced most often and the key themes in each domain from the Greater New London region:

Neighborhood and Built Environment
- Transportation
- Food/Water
- Recreation
- Safety

Social and Community Context
- Sense of Community
- Mental Health
- Substance Use Disorder

Health and Health Care
- Health Coverage/Insurance/Cost
- Prevention/Education
- Language Barriers
- Provider Bias
- Access

Key themes from the conversations included transportation, food, recreation, safety, clean water, mental health access, substance abuse, and health insurance coverage. A more detailed summary follows:

Neighborhood and Built Environment

Transportation
The most discussed social determinant of health issue related to the neighborhood and built environment category, specifically transportation. Transportation related issues were discussed in all of the conversations. Subthemes include timing, availability of public transportation, public transportation routes, challenges of sharing a single vehicle in a family and cost of transportation. Participants were also concerned medical transportation delays causing providers to terminate services.

Food and Water
The second most highlighted social determinant was food. Specific themes related to food affordability, inadequate access to grocery stores and the expense of buying healthy food. Participants also voiced the need more education on how to make healthier choices and the relationship between unhealthy eating and cardiovascular disease, hypertension and diabetes. Participants also mentioned the importance of access to clean drinking water.

Recreation
Recreational activities, physical activity and availability of resources were also identified as themes. Participants noted that there is no YMCA or bowling alley in New London and that more access to recreational facilities is needed for families, low-income individuals, youth and seniors.

Safety
Participants express the need for increased availability of hand sanitizers in public places including buses. Concerns over germs in public places were discussed.

APPENDIX F

Qualitative Data

Housing

Affordable housing was identified as a need in all the community conversations in the region. The lack of affordable housing was noted as a contributing factor to homelessness, including homelessness among veterans.

Social and Community Context

Sense of Community

A common theme across conversations in the region was the importance of creating a sense of community through a variety of means including people having a positive attitude, the need for role models, community gardens and the dream of a multi-faceted community center. Several groups mentioned the importance of working together in partnership despite differences. One group raised the idea of having a truth and reconciliation center. People helping each other, partnerships, volunteer drivers, street outreach teams and community gatherings were also mentioned as ways to help build a sense of community and foster health and wellbeing.

Mental Health

Mental health related issues were often mentioned. Subthemes included the lack of available services and the impact of stress, depression, and anxiety. Isolation and loneliness were also mentioned in several conversations. The need for trauma services in the community was also identified as need. Many participants mentioned the relationship between physical and mental health. One group emphasized the need for more bilingual psychiatrists to serve the Hispanic community. Another concern was the inconvenience of the hours for mental health appointments. In one conversation the need for more support groups for mothers was mentioned. In the Tribal community, mental health issues are a major concern. Tribal members are unprepared to address mental health issues and crises among family and community members and those who seek to help or intervene are often stigmatized. Tribal members indicated an interest in Mental Health First Aid to help address mental health issues in the community.

Substance Use

Substance use was another concern and many participants expressed the need for services to address dual diagnosis of mental health issues and substance abuse. Opioids were specifically mentioned in the context of addressing pain management and stress. The need for education and prevention was mentioned in several of the conversations along with the need for self-supporting 12-step fellowships. More enforcement against drug dealing was also recommended.

Health and Health Care

Insurance/Coverage/Cost

Access to health care and insurance was identified as a need in the region. When exploring the vision for a healthy community, participants often mentioned health care needs being met regardless of income and affordable health care for all. The high cost of health care and insurance was identified as a major barrier. The high cost of specialty dental care and diabetic supplies was also noted.

Prevention and Education

A theme that emerged in most of the conversations was the need to emphasize prevention and education, especially for the younger generations. Participants recommended that people need more access to tools to maintain health. Tribal members expressed concerns about the high incidence of diabetes and hypertension. Prevention and education efforts are implemented on a regular basis, but unfortunately, the same, small group of members attend these sessions.

Language Barriers

Language barriers were also identified as an area of concern. Participants noted that it is difficult to understand services, insurance terminology and medical terms. More access to communication supports is needed. Several participants felt that here are too few medical interpreters.

Provider Bias

Another concern affecting health and health care is provider bias. Participants noted that some providers make assumptions based on race. Tribal members

Qualitative Data

mentioned that providers are often dismissive during an initial encounter but order additional tests and services when they learn that the member has coverage under the Tribal health plan.

Access

Participants also expressed concerns about inconvenient hours for medical and mental health appointments and suggested expanded hours on evenings and weekends. Another concern was the difficulty in retaining physicians in rural areas.

Survey

Participants attending the community conversations completed a short survey during each session. On the survey, participants were asked to provide demographic information, perceptions about access to health care and health care experiences, top health care issues and top barriers for the community. Survey data indicated dissatisfaction with access to healthy foods, access to Medicaid providers, access to open space and parks and access to sports programs. Of the 94 participants in all sessions, 38 individuals completed the survey—a 40% response rate.

Prioritization of Health Issues

HICSC met for a prioritization process for the Greater New London region in May 2019. Following the review of data from the DataHaven Community Wellbeing Survey, hospital CHIME data, and community conversations, the collaborative ranked the priorities for the Social Determinants of Health, physical chronic conditions, health and health care utilization, mental/ behavioral chronic conditions, health risk factors.

APPENDIX G

Outcomes of 2016 CHIP Implementation

PROGRESS ON IDENTIFIED PRIORITIES 2015–2018

The Health Improvement Collaborative of Southeastern Connecticut (HIC) met for the first time in May 2015 to provide input on the joint Community Health Assessment (CHA) being planned by L+M Hospital (L+M) and Ledge Light Health District (LLHD). The group continued on to support the development of the Community Health Improvement Plan (CHIP). The CHIP defines our commitment to using a collective impact model to affect change, states common values, and identifies clear goals and objectives for each of the prioritized areas.

Following a review of the data included in the CHA, a multi-stage prioritization process identified Mental Well-being and Substance Abuse (Opioid Use Disorder and Latinx Mental Health); Healthy Lifestyles (with attention to risk factors for diabetes among Black residents); and Access to Care (Access to Care for Low Income Populations and Prenatal Care) as priority areas. A focused "Action Team" of community partners and residents was established around each of these priority areas.

Each Action Team is working on evidence-based activities related to the needs identified in our community. The Action Teams have been successful in obtaining funding to support their work including the Opioid Action Team which collaborated on a successful application to the University of Baltimore; the Access to Care Team on one to the Community Foundation of Eastern CT; and the Healthy Lifestyles Team on the strategic implementation of health department programs funded by the federal government.

From September 2015 through June 2017, the full HIC met monthly. By the Spring of 2017, the HIC had fully developed four focused Action Teams.The Action Teams hold regular monthly meetings and work on additional data collection, strategies and tactics to address the prioritized health outcomes/ social determinants. The HIC also has a Coordinating Team, which includes representation from each Action Team and meets weekly to discuss strategies related to more broadly addressing the Social Determinants of Health, cross-pollinate ideas and activities between Action Teams, review potential funding opportunities, and develop agenda items and presentations for the full HIC. Given these frequent meetings of the Teams, the HIC now meets quarterly.

The HIC distribution group includes representation from over 100 community agencies. Approximately 32 of these agencies regularly participate in the quarterly meetings of the full HIC, one or more monthly meetings of Action Teams, or both. LLHD has served as the primary fiduciary for the HIC, handling the finances associated with the CHA, CHIP and other activities.

The HIC has a defined vision statement ("Southeastern Connecticut is a community healthy in body and mind that promotes access, health equity, social justice, inclusiveness and opportunities for all!") that was developed by HIC members over several months of discussion. In addition, the HIC developed branding materials in English and Spanish. From the beginning, the HIC has centered our discussions, work and actions to address local health disparities and root cause prevention. The opening section of the 2016 CHA is a comprehensive discussion of the social determinants of health and disparities related to race and ethnicity, gender and income.

The sections focused on specific health outcomes and health status in the region draw on local data to highlight related disparities. Each Action Team is charged with addressing disparities related to the specific health outcome they are addressing; three of the four Action Teams are centered on specific populations bearing inequitable burdens (Healthy Lifestyles-Black residents, Mental Health-Latinx residents, and Access to Care-low income residents). The HIC hosted a training by Health Equity Solutions, Inc. that primed the local conversation about the Social Determinants of Health, systemic racism,

and health equity. HIC members were joined by community residents as well as medical providers for this session. The HIC is also collaborating with a local community group to host movie screenings and panel discussions to elevate the conversation among policy makers and residents about health equity and necessary policy change.

ACCESS TO CARE ACTION TEAM OUTCOMES

The Access to Care Team has developed a coordinated effort to include entry points to multiple services (insurance literacy and enrollment, SNAP information and enrollment, case management and health screenings as examples) at mobile food pantry distributions. This work is supported by the efforts of a Community Health Worker. Accomplishments include:

- Funding received to support a part-time community health worker (CHW) for health insurance and health literacy support, social determinant screening, and referral
- Over 500 people screened for social determinants of health at food pantry sites
- More than 10% directly referred to partners for case management services and/or primary care services; 8% provided with transportation support
- 30 Thames Valley Council for Community Action case managers completed CHW training

HEALTHY LIFESTYLES ACTION TEAM OUTCOMES

The Healthy Lifestyles Team is organizing Diabetes risk factor and blood pressure screenings at community events including youth basketball games and the New London Community Meal Center, and supports Diabetes Self-Management Education (DSME) classes.

- Three DSME classes in English hosted by Ledge Light Health District in New London, Stonington, and Waterford. 50% of NL participants were people of color.
- Training of Spanish speaking educators from L+M conducted to allow for DSME in Spanish in 2019 for the first time in this region.
- One Healthy Cooking classes session was hosted by Ledge Light Health District with 30 registered.
- Strategies to promote the Park Rx program, a collaboration between health providers and Parks and Recreation, were developed for launch in 2019.
- The New London Mayor's Youth Challenge was supported by joint marketing through the HIC

LATINX MENTAL HEALTH ACTION TEAM OUTCOMES

The LatinX Mental Health Group is developing a network of bilingual behavioral health service providers as the basis for a system of coordinated access and referrals to mental health services.

- Adopted the name Hispanic Alliance Mental Health Network and conducted strategic planning
- Formed and convened the network which Includes 19 provider members including 1 private practitioner and 9 community partners.
- Developed a database of providers and local resources for distribution among the group; this will be hosted on the Hispanic Alliance website.
- Members including Child and Family Agency are actively engaged in recruiting and hiring bilingual/ bicultural providers.

OPIOID ACTION TEAM OUTCOMES

The Opioid Action Team has developed a work plan focused on Naloxone Saturation, Coordinated Access to Treatment and Recovery Support Services, Stigma Reduction and Insurance Education and Advocacy. Evidence-based activities in place include a process for certifying sober homes, a coordinated access network for medication based treatment, and promotion, education and distribution of naloxone.

- One of 13 funding awards in the nation to implement community based initiatives with a strong collaboration between public health and law enforcement.
- Funding for continuation and expansion of effort received from the University of Baltimore.
- Collaboration with Community Speaks Out, the City of New London, and L+M Hospital to support the sober house certification program
- The City of New London adopted a local ordinance giving access to regulatory officials to assure

safe conditions in recovery housing; successful advocacy on state legislation to establish a definition of what a sober living home is and a voluntary registration process

- Half of action team attendees self-identified as having lived experience with substance use disorder.
- 30 clinicians from a range of disciplines including dental, law enforcement and LCSW have participated in educational activities
- A minimum of 500 people have been impacted through: seminars with Dr. Heimer from Yale School of Medicine, Electric Boat employee event, Event in the park NL, legislative breakfast, harm reduction training, Editorial Board of The Day resulting in an editorial promoting Medication Assisted Treatment (MAT), regular features in the media promoting facts about substance use disorder
- Naloxone distribution to area first responders and residents; over 300 kits distributed
- Ads on SEAT busses ran for 2 months
- Systems in place to begin MAT initiation in the L+M Hospital Emergency Department (ED) in spring 2019
- Three action team coordinated peer recovery navigators in place; engaged with 112 individuals with 61 beginning treatment
- Navigator phone line initiated
- Coordination with ED-based CT Community for Addiction Recovery (CCAR) recovery coaches
- New community-based MAT access sites established (United Community and Family Services) and in planning (New London Homeless Hospitality Center)

The Coordinating Team has been tireless in efforts to align and coordinate with other local initiatives. This includes participation in a local group informally called "the collaborative of the collaboratives." On a quarterly basis representatives from the HIC Coordinating Team join representatives from the New London Partnership for Student Success, the Regional Human Services Collaborative, the Thames River Innovation Places Collaborative and the Regional Philanthropic Collaborative to share updates and information, coordinate data collection efforts, and identified shared visions and goals so that regional resources can be deployed as effectively efficiently as possible.

Through the Coordinating Team, the Action Teams align efforts to address root causes. For example, transportation has consistently been identified as a barrier in our region and the CHA highlights disparities related to access to reliable transportation. Members of the Coordinating Team have initiated a Regional Workgroup of transportation providers and others who are currently working on asset mapping, organizing advocacy efforts concerning proposed state budget cuts, and planning an Eastern CT Transportation Summit where providers, agencies and end users lcan come together to strategize and plan.

Yale NewHaven Health
Lawrence + Memorial Hospital

Fiscal Years (FY) 2019-22 Community Health Needs Assessment

Community Health Improvement Plan

August 26, 2019

FY 2019-22 Healthy Lifestyles
Asthma
Community Health Improvement Plan

Breathe Well – Respira Bien Program

In Southeastern CT region:

Indicator: Percentage of people with asthma who visit the ED three or more times in a year for asthma (10% in 2018)

Indicator: Percentage of overall population diagnosed with asthma (15% in 2018, CT DPH)

Indicator: Percentage of African Americans diagnosed with asthma (35.9% in 2018, CT DPH)

Indicator: Percentage of LatinX diagnosed with asthma (31.9% in 2018, CT DPH)

Indicator: Percentage of people who smoke daily (27% overall and 30% earning <$30K in 2015; 33% overall and 43% earning <$30K in 2018, Wellbeing Survey)

Indicator: Relative risk of hospital encounter for COPD compared to CT (1.75X for the overall pop.; 2.25X for New London residents, CT DPH)

Indicator: Relative risk of hospital encounter for COPD for New London residents age 45 – 64 (3.3 X the state resident risk, CT DPH)

Goal: Reduce the number of ED visits by 10% for asthma in the Latinx population by July 2022.

Strategy	Action Steps	Outcomes
Provide Breathe Well – Respira Bien community based asthma intervention to improve asthma management particularly in LatinX populations where there is higher prevalence of asthma	• Secure core funds to support CHW position to supplement grant funding • Continue and build collaboration Respira Bien with pulmonary clinic • Support the expansion of providers in the pulmonary clinic • Provide in-kind support for the program	Improve asthma management among participants Increase referrals to the pulmonary clinic for culturally competent asthma care
Collaborate with respiratory therapists on COPD intervention	• Support community-based efforts to improve disease management and reduce hospitalizations	Improve COPD management with reduced readmissions

FY 2019-22 Healthy Lifestyles
Hypertension
Community Health Improvement Plan

In Southeastern CT Region:

Indicator: Percentage of people who have been diagnosed with hypertension (2015 – 29% overall; 2018 – 32.3% overall, Wellbeing Survey)

Indicator: Relative risk as compared to CT for a hospital encounter due to hypertension (2018 overall 1.25X, for New London residents 2X, CT DPH)

Goal: Reduce the number of ED visits by 10% for uncontrolled hypertension in African American men by July 2022.

Strategy	Action Steps	Outcomes
Provide Barbers Trimming Blood Pressure program	• Recruit and train NL barbers with largely African American clientele to check blood pressures • Support community health worker to assist in referrals of hypertensive men to primary care • Provide in-kind support for the program • Track ROI where applicable	Blood pressure control among participating men Increase PCP utilization among participating men

FY 2019-22 Healthy Lifestyles
Maternal Child Health
Community Health Improvement Plan

In Southeastern CT Region:

Indicator: Infant death rate per 1,000 live births (4.9 in the region, 6 in CT, 2015 CT DPH)

Indicator: Number of infants diagnosed with NAS per year (35 in FY 2018, L+M Hospital)

Goal: Increase the number of mothers/parents participating in available Maternal Child Health Programs by 10% by July 2022.

Strategy	Action Steps	Outcomes
Continue to support efforts to improve birth outcomes, healthy children, and healthy parenting.	• Offer Home Visiting Program: Parenting education and support for first and second time parents to reduce incidences of abuse and neglect; includes home visiting and group activities • Provide other Maternal Child Health programs: Caring for Your Baby, Preparing for Birth, Relaxation Station, Community Baby Shower, World Breastfeeding Week, Lactation support, Pediatric school visits • Offer Read to Grow	Increase knowledge of resources, opportunities and increased parenting efficacy of participating families Reduce number of babies born prematurely Increase number of mothers choosing to breastfeed
Offer Family Support Network	• Provide in-kind resources to program	Increase knowledge among participants of community resources for children with developmental disabilities

FY 2019-22 Healthy Lifestyles
Maternal Child Health (cont.)
Community Health Improvement Plan

Strategy	Action Steps	Outcomes
Provide Maternal Education of Newborn Care	• Continue to provide education and resources to improve maternal knowledge of newborn care after well-baby nursery discharge	Reduce number of babies brought to the ER for preventable injuries
Provide Pediatric Asthma Care in the ED	• Continue reducing time to steroid administration by using RN-initiated protocols based on initial ED assessment	Increase proportion of children with assessment of severity of asthma exacerbation at ED triage by 90% Increase proportion of eligible children who receive systemic corticosteroids within 60 minutes of ED arrival to more than 80% Decrease proportion of children with chest radiography ordered to less than 30%
Do Intervention in NAS	• Simplify infant assessments • Provide support for non-pharmacologic care • Improve weights and caloric intake • Increase team and parent communication • Improve supportive care for infants of incarcerated mothers	Decrease length of stay by 50% from 17 days to less than 8 days

FY 2019-22 Healthy Lifestyles
Cancer
Community Health Improvement Plan

Indicator: Percentage in region reporting they are overweight or obese (Overall -61% in 2015, 66% in 2018, Wellbeing Survey)
Indicator: Percentage of adolescents 13-17 years old completing the HPV vaccine series (58.0% in 2017 in CT, CT DPH)
Indicator: Incidence of Cervical Cancer (7.4 per 100,000 from 2011 – 2015 in New London County, IHME 2018)
Indicator: Incidence of Oral Cavity (Head) and Pharynx (Neck) Cancer (12.1 per 100,000 from 2011 – 2015 in New London County, IHME 2018)
Indicator: Incidence of Melanoma (22.7 per 100,000 from 2011 – 2015 in New London County, IHME 2018)
Indicator: Incidence of Colon Cancer (36.4 per 100,000 from 2011 – 2015 in New London County, IHME 2018)
Indicator: Incidence of Lung Cancer (64.8 per 100,000 from 2011 – 2015 in New London County, IHME 2018)
Indicator: Rates of E-cigarette use in high school age individuals (2015 - 7.2%; 2017 - 14.7% in CT, CT DPH)
Goal: Increase the number of individuals provided education, screening, and early detection programs in Greater New London.

Strategy	Action Steps	Outcomes
Provide education focused on obesity awareness and its relationship to hormonally generated cancers.	• Offer nutrition program, "My Body, My Health", for middle and high school students identifying tangible changes that can impact lifelong health improvements.	Reduce rates of adult obesity by 7-18% by 2022.
Offer prevention and screening programs identified as risk areas for growth in cancer disease sites: Melanoma	• Offer melanoma beach program, providing sunscreen and sunglasses on area beaches. Education tables with information on sun exposure and prevention of melanoma. • Provide kin protection programs in high schools during prom season promoting self-tanners in place of tanning booths. Self-tanners provided as incentive. • Conduct melanoma screenings at Smilow Cancer Hospital in collaboration with YSM Prevention/Screening program	3,000 sunscreen and sunglasses distributed on area beaches. At least 3 spray tan events conducted for high schools during prom season.
Offer prevention and screening programs identified by tumor registry as risk areas for growth in cancer disease sites: HPV	• Offer community education by Gyn Oncology and Head & Neck Oncology to raise awareness of the importance of Gardasil vaccination and the long-term implications of not vaccinating. • Offer head & Neck screening program in collaboration with YSM. Provide full oral exam and information on oral health.	Rate of a completed vaccination series in adolescents increased by 10% by 2022. Gardasil vaccination plan with pediatricians to target 9 – 13 year olds developed. Plan with area dentists to supplement YSM work on oral health developed.

FY 2019-22 Healthy Lifestyles
Cancer (cont.)
Community Health Improvement Plan

Strategy	Action Steps	Outcomes
Offer prevention and screening programs identified by tumor registry as risk areas for growth in cancer disease sites: Colon Cancer	• In collaboration with the VNASC provide information and EZ Detect kits for home occult blood testing. Follow-up provided by VNASC nurses under the direction of fellowship trained GI.	Rate of colonoscopy referrals increased by 10%.
Provide smoking cessation program	• In collaboration with YSM, provide smoking cessation education through the New London school system.	Rate of high school age individuals using E-cigarettes reduced by 10%.
Increase low dose CT lung screening to our SSA.	• In collaboration with radiology, provide education sessions with PCPs to reinforce the referral process and criteria for screening. • Provide behavioral and pharmaceutical counseling for individuals screened for lung cancer.	Survival rates for lung cancer increased by 10%.
Offer Psychosocial services	• Continue to provide psychosocial services for cancer patients at Smilow	Continued holistic approach
Participate in CEDPP	• Continue to provide in-kind resources for CT Early Detection and Prevention Program(CEDPP) • Track ROI where applicable	Increase availability of program services for low-income and uninsured women.
Re-integrate chaplaincy services at Smilow Cancer Center	• Core funds to support chaplain	Funding secured for new staff resource
Partner with Yale Medicine Urologists	• Host a prostate cancer screening event in November	At least 10 men participate in screening

FY 2019-22 Access to Care
Community Health Improvement Plan

A2C Action Team

In the Southeastern CT region (source DataHaven Wellbeing Survey):

Indicator: Percentage earning less than $30K that did not receive the medical care they needed (27% in 2015, 21% in 2018)

Indicator: Percentage of adults without 1 person/place considered primary care provider (31% earning <$30K, 40% of Blacks, 33% of LatinX 2018)

Indicator: Percentage earning less $30K per year who could not receive Rx medications due to cost (15.5% in 2015, 15% in 2018)

Indicator: Percentage earning less than $30K per year who delay necessary healthcare (32% in 2015, 40% in 2018)

Indicator: Percentage earning less than $30K per year who used the ED for any condition 3 or more times per year (11.5% in 2015, 15% in 2018)

Indicator: Percentage earning less than $30K per year who have not seen a dentist in more than 2 years (33% in 2015, 27% in 2018)

Goal: Increase Access to equitable and quality healthcare for low income residents

Strategy	Action Steps	Outcomes
Participate in and provide support for the Health Improvement Collaborative of SE CT (HIC SECT)	• Support leadership position and associate participation • Provide in-kind and financial support	Continue active engagement in HIC SECT activities with at least one L+M representative on each action team.
Provide in-kind resources for the HIC SECT	• Provide in-kind and financial resources to organizations to promote healthy lifestyles	$ community benefit
Improve Healthcare options education	• Support CHW for consumer engagement and education and reductions of barriers to care	At least 4 events held annually
Support efforts to strengthen the regional transportation system	• Provide transportation support for patients including taxi vouchers, bus tickets and Lyft/Uber options • Advocate on behalf of consumers with Veyo services	Reduce number of “no-shows” for appointments
Pursue opportunities to expand integrated care teams/specialty care	• Advocate with DSS for Medicaid billing of CHW services • Track ROI where applicable	Increase participation in CHW services

FY 2019-22 Access to Care (cont.)
Community Health Improvement Plan

Strategy	Action Steps	Outcomes
Expand the Primary Care Provider network	• Collaborate with NEMG and FQHCs to increase recruiting for primary care/family practice MDs, APRNs, and PAs	Decrease number of ED visits for primary care services
Improve cultural humility among providers	• Collaborate with YNHHS Chief Diversity Officer and local committee • Add cultural humility component to continuing education • Include persons with lived experience as co-speakers	Increase number of CLAS standards met by providers Increased number of providers meeting any standards
Continue partnerships with FQHCs	• ED scheduling for PCP appointments • Lease agreements for specialists to FQHCs • Track ROI where applicable	Decrease ED visits for primary care services.
Improve care options for underserved members of the community	• Continue to support the Homeless Hospitality Center with LMH operating funds	$ community benefit

FY 2019-22 Access to Care
Diabetes
Community Health Improvement Plan

In Southeastern CT Region:

Indicator: Percentage reporting having Diabetes (Overall population – 9% in 2015, 25% in 2018, Wellbeing Survey)

Indicator: Relative risk as compared to CT for a hospital encounter due to diabetes (in 2018 overall 1.25X; for New London residents 2.25X, CT DPH)

Goal: Reduce the number of ED visits by 10% for diabetes complications in the LatinX population by July 2022.

Strategy	Action Steps	Outcomes
Offer community –based diabetes self-management classes in Spanish	• Support community health workers in implementation • Secure core funding to supplement grant for CHW position • Partner with TVCCA • Provide in-kind support for the program • Develop Spanish-language diabetes self management classes • Provide participants with vouchers to pharmacies for diabetes testing supplies • Track ROI where applicable	Improve diabetes management among participants Funding secured for new staff resource At least 25 participants in bilingual classes At least 25 pharmacy vouchers distributed

FY 2019-22 Access to Care
Health Disparities
Community Health Improvement Plan

Black Health Collective

In Southeastern CT Region (DataHaven Wellbeing Survey):

Indicator: Percentage reporting having Diabetes (African Americans – 13% in 2015, 25% in 2018)

Indicator: Percentage reporting having hypertension (African Americans – 40% in 2015, 37.5% in 2018)

Indicator: Percentage of low income residents reporting never exercising in an average week (21% in 2015, 28% in 2018)

Indicator: Percentage reporting they are overweight or obese (African Americans – 74% in 2015, 60% in 2018)

Indicator: Percentage reporting fair or poor access to affordable, high quality fruits and vegetables (29% of people earning <$30K per year, 33% of people earning $30K - $75K per year in 2018)

Indicator: Percentage of Black people statewide reporting depression (32% vs. 26% Whites in CT 2018)

Goal: To improve the overall health and wellbeing of the region's Black residents

Goal: By March 2021, increase physical activity and health food consumption to reduce the incidence of diabetes and hypertension

Goal: By January 2020, develop a plan and implement activities to raise awareness of healthy lifestyles

Goal: By January 2020, create a more welcoming culture for Health Improvement Collaborative and Action Team meetings in order to engage residents in HIC work that is focused on community strategies to improve health.

Strategy	Action Steps	Outcomes
Engage residents in the work that is neighborhood and place based	• Develop collaborations with target neighborhood community organizations, residents, and appropriate public sector partners	Efforts implemented in at least one neighborhood with disparate social determinant challenges
Implement "pop-up" prototypes of healthy lifestyle events	• Continue partnership with the United Way mobile food pantry and other pantries in the region	Programs implemented in at least 5 sites throughout the region

FY 2019-22 Access to Care
Social Determinants of Health
Community Health Improvement Plan

In Southeastern CT Region:

Indicator: Disparity in life expectancy based on census tract (range of average 77.2 New London, average 83.9 Stonington)

Indicator: Poverty rates among Black and LatinX disproportionate (Blacks 5.3 % of population, 20.2 % of the poor; LatinX 11.75 of population, 27.6% of the poor)

Indicator: Percent of residents paying over 30% of income for housing costs (31% of residents in Greater New London 2018)

Indicator: Food insecurity disproportionately impacts certain populations (33% of those earning $30K - $75K, 42% of age 18-34, 52% of Blacks)

Goal: Impact social determinants of health to reduce the burden and improve health outcomes

Strategy	Action Steps	Outcomes
Partner with other community organizations to address physical improvements and housing needs through financial and in-kind support	• Provide community involvement and financial support for partner organizations. Includes support for transitional and shelter housing, sober house certification training, air conditioners for vulnerable residents, and other. • Support linens to HHC/Respite program support/dedicated social worker	$ community benefit
Partner with other community organizations to address economic development needs through financial and in-kind support Economic Development	• Provide community involvement and financial support for partner organizations including a regional infrastructure with sufficient employment opportunities providing a living wage, healthcare, retirement and other benefits. • Remain active in the NL Public Schools' Partnership for Student Success	$ community benefit
Partner with other community organizations to address community support needs through financial and in-kind support	• Provide community involvement and support for partner organizations. Includes support for education, youth development and neighborhood development strategies in distressed New London neighborhoods. • Hold food drives • Ensure transportation support including vouchers • Ensure distribution to vulnerable cancer patients • Have patient assistance fund for vulnerable patients • Provide High Hopes Therapeutic Riding in-kind support	Number of community outreach events Maintain or increase funding for patient assistance fund
Partner with other community organizations to workforce development needs through financial and in-kind support	• Collaborate with community partners including local school districts and the Eastern Workforce Investment board to support pathways to healthcare careers • Offer scholarship support to various community organizations	Participate in at least 1 job fair Secure funding for scholarships

FY 2019-22 Access to Care
Injury Prevention
Community Health Improvement Plan

In Southeastern CT Region:

Indicator: Number of car seats checked at LMH (206 seats checked 8.1.18 – 3.31.19)

Goal: Increase the number of car seat inspections at LMH by 10% by July 2022.

Strategy	Action Steps	Outcomes
Support an ongoing on-site car seat inspection service at LMH	• Identify sources of funding to continue a weekly inspection station schedule. • Partner with community organizations to promote the service and the importance of proper child restraint in vehicles. • Partner with companies to provide car seat vouchers	Funding secured for program continuation Increase the number of African American and LatinX children using the appropriate car seat by 10%.
Provide financial support for staff who train nurses on car seat safety	• Identify sources of funding	Funding secured for training of staff in basic information

FY 2019-22 Access to Care
Subsidized Health Services
Community Health Improvement Plan

In Southeastern CT Region:

Indicator: Number of patients accessing clinical services that are subsidized (est. 5800 in fy2018)

Indicator: Percentage of funding used to support subsidized services (3.5% of total community benefit expenses fy2018)

Goal: To continue to provide high quality clinical services that are needed by the community, but are not fully supported by off-setting revenue

Strategy	Action Steps	Outcomes
Ensure a robust emergency services network in the region.	• Continue to support services that meet identified community needs.	Ensure acute care safety net remains robust.
Support outpatient psychiatric services in primary care and cancer center settings	• Continue psychosocial services for patients at Smilow Cancer Center • Continue mental health services at NEMG outpatient primary care settings	Cancer Center patients supported in psychosocial needs Track access to outpatient mental health services
Continue patient support services at Smilow Cancer Center	• Nutritional supplement distribution program for vulnerable and economically patients	Cancer Center patients supported in nutritional needs
Maintain commitment to maternal child health services	• See maternal child section of CHIP	See maternal child section of CHIP

FY 2019-22 Access to Care
Health Professions Education
Community Health Improvement Plan

In Southeastern CT Region:

Indicator: Number of students with rotations in a year (659 in FY2018)

Goal: Provide diverse opportunities for student rotations including nursing, medical, allied health, chaplaincy and other health professions.

Strategy	Action Steps	Outcomes
Provide opportunities for students pursuing healthcare careers to learn on-site as part of their formal education.	• Offer student rotations and internships for health professions education including nursing, physicians, and allied health students: physicians/medical students, nurses/nursing students, other health professions education, internships, career days + other • Provide classroom training for CNA/PCA local programs • Plan for family practice residency	Reduce number of vacancies for positions with educational programs Plan to expand offerings to include family practice residency underway Increase number of hires from programs for which the hospital provides support
Offer Clinical Pastoral Education (CPE) program	• Develop a plan to expand CPE program opportunities	Increase spiritual support availability for patients

FY 2019-22 Behavioral Health
LatinX Mental Health
Community Health Improvement Plan

Hispanic Alliance Mental Health Network

In the Southeastern CT region (DataHaven Wellbeing Survey):
Indicator: Percentage of overall population reporting depression/hopelessness several days or more in the last 2 weeks (30% in 2018)
Indicator: Percentage of LatinX reporting depression/hopelessness several days or more in the last 2 weeks (42.5% in 2018 vs. 28% Whites)
Indicator: Percentage of overall population feeling mostly or completely anxious yesterday (12% in 2018)
Indicator: Percentage of LatinX feeling mostly or completely anxious yesterday (20.8% in 2018)
Goal: Ensure systems are in place to support mental health and emotional wellbeing in our community
Goal: Improve access to quality culturally responsive mental health services for the LatinX population

Strategy	Action Steps	Outcomes
Participate in and provide support for the Health Improvement Collaborative of SE CT (HIC SECT)	• Support leadership position and associate participation • Provide in-kind and financial support • Co-host collaborative health/wellness events with community partners	Continued active engagement in HIC SECT activities with at least one L+M representative on each action team.
Provide in-kind resources for the HIC SECT	• Provide in-kind and financial resources to organizations to promote healthy lifestyles	$ community benefit
Hire a bicultural/bilingual mental health provider	• Identify funding for a mental health provider • Create an Intensive Outpatient Program for Spanish speaking individuals	Funding secured for new staff resource New bilingual/bicultural service offerings established

FY 2019-22 Behavioral Health
Opioids
Community Health Improvement Plan

In the Southeastern CT region (CT Department of Public Health):
Indicator: Percentage of opioids involved in drug overdose deaths (85% in 2017)
Indicator: Percentage of Fentanyl-related drug overdose deaths (53% in 2017)
Goal: Ensure systems are in place to support mental health and emotional wellbeing in our community
Goal: Expand harm-reduction services and improve access to equitable and quality services for people living with substance use disorder.

Strategy	Action Steps	Outcomes
Reduce Stigma	• Support staff training in non-stigmatizing language	At least one training for staff completed
Increase Naloxone saturation in the community	• Provide Narcan to area first responders • Increase provision of Narcan to patients upon ED discharge	Reduce number of ED visits for opioid overdose
Coordinate access to treatment	• Medication assisted treatment (MAT) initiatedd in the ED • Support PCPs in accessing training in MAT • Partner with NEMG to increase the number of PCPs with MAT training • Project ASSERT in the ED	Reduce number of ED visits for opioid overdose
Support public policy change	• Support advocacy efforts of the Opioid Action Team	Partner with the Opioid Action Team on at least 1 advocacy effort

FY 2019-22 Behavioral Health
Opioids (cont.)
Community Health Improvement Plan

Strategy	Action Steps	Outcomes
Partner with Yale Addiction Medicine Consult Service (YAMCS)	• Assess and engage patients around their substance use treatment needs • Offer medication and brief behavioral treatments for opioid use • Advise on pain management in patients with substance use disorders • Identify discharge options and linkages to addiction care after hospitalization in which agonist medication-based treatment can continue • Meet patients' other social work needs	Improve care of patients with co-morbid opioid use disorder through inpatient consulting to surgery and infectious disease specialties

Fiscal Years (FY) 2019-22
Community Health Needs Assessment
Community Health Improvement Plan

July 11, 2019

FY 2019-22 Access to Care
Community Health Improvement Plan
A2C Action Team

In the Southeastern CT region (source DataHaven Wellbeing Survey):

Indicator: Percentage earning less than $30K that did not receive the medical care they needed (27% in 2015, 21% in 2018)

Indicator: Percentage of adults without 1 person/place considered primary care provider (31% earning <$30K, 40% of Blacks, 33% of LatinX 2018)

Indicator: Percentage earning less $30K per year who could not receive Rx medications due to cost (15.5% in 2015, 15% in 2018)

Indicator: Percentage earning less than $30K per year who delay necessary healthcare (32% in 2015, 40% in 2018)

Indicator: Percentage earning less than $30K per year who used the ED for any condition 3 or more times per year (11.5% in 2015, 15% in 2018)

Indicator: Percentage earning less than $30K per year who have not seen a dentist in more than 2 years (33% in 2015, 27% in 2018)

Vision: Respectful care that I want, understand, and can afford. Care that I can easily get.

Goal: Increase Access to equitable and quality healthcare for low income residents

Strategy	Action Steps	Outcomes
Improve health education and community resource awareness	• Continue partnership with the United Way Mobile Food pantry and other pantries as an outreach and education opportunity	Activity at minimally 5 sites reaching at least 500 people
Promote connection to primary care providers and the expansion of specialty care services in the region	• Continue outreach efforts to support primary care access • Survey area providers on their experience in referring to specialty care and identify gaps • Develop strategies to address primary and specialty care gaps	Improvement in people reporting having a primary care provider (PCP)
Support efforts to strengthen the regional transportation system	• Participate in the regional transportation action group • Advocate on behalf of consumers with Veyo services • Advocate for medical providers to consider bus access in siting decisions	Improve transportation options for the most vulnerable populations
Pursue opportunities to expand integrated care teams/specialty care	• Advocate with CT Dept. of Social Services for Medicaid billing of community health worker (CHW) services	CHWs integrated into at least 25% of area primary care provider practices

FY 2019-22 Access to Care
Community Health Improvement Plan
A2C Action Team (cont.)

Strategy	Action Steps	Outcomes
Improve cultural humility among providers	• Collaborate with Yale New Haven Health System (YNHHS) Chief Diversity Officer and local committee • Add cultural humility component to continuing education • Include persons with lived experience as co-speakers	Increase number of Culturally and Linguistically Appropriate Services (CLAS) standards met by providers Increase number of providers meeting any standard
Partners Thames Valley Council for Community Action, United Community and Family Services, L+M Hospital, Community Health Center, United Action, residents, United Way, CT Legal Services, Southeastern CT Enterprise Region, Southeastern CT Council of Governments, YNHHS, Eastern Area Health Education Center		

FY 2019-22 Access to Care
Health Disparities
Community Health Improvement Plan
Black Health Collective

In Southeastern CT Region (DataHaven Wellbeing Survey):

Indicator: Percentage reporting having Diabetes (African Americans – 13% in 2015, 25% in 2018)

Indicator: Percentage reporting having hypertension (African Americans – 40% in 2015, 37.5% in 2018)

Indicator: Percentage of low income residents reporting never exercising in an average week (21% in 2015, 28% in 2018)

Indicator: Percentage reporting they are overweight or obese (African Americans – 74% in 2015, 60% in 2018)

Indicator: Percentage reporting fair or poor access to affordable, high quality fruits and vegetables (29% of people earning <$30K per year, 33% of people earning $30K - $75K per year in 2018)

Indicator: Percentage of Black people statewide reporting depression (32% vs. 26% Whites in CT 2018)

Goal: To improve the overall health and wellbeing of the region's Black residents by

Goal: By March 2021, increase physical activity and health food consumption to reduce the incidence of diabetes and hypertension

Goal: By January 2020, develop a plan and implement activities to raise awareness of healthy lifestyles

Goal: By January 2020, create a more welcoming culture for Health Improvement Collaborative and Action Team meetings in order to engage residents in HIC work that is focused on community strategies to improve health.

Strategy	Action Steps	Outcomes
Strengthen community capacity through meaningful engagement to amplify resident voice with a focus that is neighborhood and place based	• Secure and monitor progress of a cohort of interested people from the target population • Determine baseline data regarding health factors • Secure resources for incentives	Cohort participants report improvements on biometrics from baseline measures
Provide/support implementation of evidence-based, culturally-respectful and responsive, high-quality health programs/activities	• Implement "pop-up" prototypes of healthy lifestyle events • Engage with residents to take an active role in neighborhood improvement efforts • Partner with anchor institutions in neighborhoods with lower incomes and greater social determinant and health burden	At least 2 pop up events implemented Increased participation from at-risk populations

FY 2019-22 Access to Care
Health Disparities
Community Health Improvement Plan
Black Health Collective (cont.)

Strategy	Action Steps	Outcomes
Strive to improve systems, policies and practices that influence participation, social conditions, and health outcomes	• Utilize virtual public engagement tools • Engage civic, ecumenical, and neighborhood groups in order to have the people impacted involved in design of the efforts • Ensure that the community and its residents are defining what matters to them and determining course of action • Adjust collaborative and action team meeting times to be more accessible to resident participation • Secure resources in order to offer food and childcare as appropriate	• Increase resident involvement
Focus on outreach, education, prevention and advocacy to raise awareness around health issues in the Black community	• Develop strategic, targeted messaging to increase awareness of health issues that impact Black residents in the region. • Combat the narrative that healthy eating is unaffordable • Identify community and healthcare champions • Connect interested residents to resources to assist them with organizing and participating • Employ electronic and digital communications, utilizing best practices in social media • Increase opportunities for community partners to share information.	• Increase awareness and knowledge among those impacted by the activities • At least 5 community champions engaged • Multi-modal communications used consistently

Partners: SECT Ministerial Alliance, New London Branch NAACP Health Committee, Community Alliance for Health Equity, Community Health Center (Groton and NL), Parks and Recreation (Groton and NL), OIC of New London, FRESH New London, Ledge Light Health District, L+M Hospital

FY 2019-22 Behavioral Health
LatinX Mental Health
Community Health Improvement Plan
Hispanic Alliance Mental Health Network

In the Southeastern CT region (DataHaven Wellbeing Survey):

Indicator: Percentage of overall population reporting depression/hopelessness several days or more in the last 2 weeks (30% in 2018)

Indicator: Percentage of LatinX reporting depression/hopelessness several days or more in the last 2 weeks (42.5% in 2018 vs. 28% Whites)

Indicator: Percentage of overall population feeling mostly or completely anxious yesterday (12% in 2018)

Indicator: Percentage of LatinX feeling mostly or completely anxious yesterday (20.8% in 2018)

Goal: Ensure systems are in place to support mental health and emotional wellbeing in our community

Goal: Improve access to quality culturally responsive mental health services for the LatinX population

Strategy	Action Steps	Outcomes
Increase bicultural and bilingual mental health providers in the region	• Partner with Chris Soto from the Governor's office and legislative delegation on opportunities for policy change	Advocacy opportunities identified
Create an online resource for area providers	• Create a website platform, section of Hispanic Alliance website, for the resource list	Website platform created to host resource list
Focus on outreach, education, prevention and advocacy to raise awareness/reduce stigma around BeH issues in the LatinX community	• Focus groups among providers not currently part of group, agency directors, and consumers Summer 2019	Three focus groups with at least 10 providers and 10 agency directors and 25 consumers held
Improve cultural humility among providers	• Collaborate with Yale New Haven Health System (YNHHS) Chief Diversity Officer and local committee • Add cultural humility component to continuing education • Include persons with lived experience as co-speakers	Increase number of Culturally and Linguistically Appropriate Services (CLAS) standards met by providers Increase number of providers meeting any standard
Partners: Hispanic Alliance, Connecticut College, L+M Hospital, community behavioral health providers, African American Health Council, United Community and Family Services, Child and Family Agency, New London Public Schools, Community Health Center, Sound Community Services, Church of the City, Eastern Area Health Education Center		

FY 2019-22 Behavioral Health
Opioids
Community Health Improvement Plan
Opioid Action Team

In the Southeastern CT region (CT Department of Public Health):

Indicator: Percentage of opioids involved in drug overdose deaths (85% in 2017)

Indicator: Percentage of Fentanyl-related drug overdose deaths (53% in 2017)

Goal: Ensure systems are in place to support mental health and emotional wellbeing in our community

Goal: Expand harm-reduction services and improve access to equitable and quality services for people living with substance use disorder.

Strategy	Action Steps	Outcomes
Reduce Stigma	• Promote "language matters" • Continue community conversations and education about SUD	Features in local and state media outlets reducing the use of dehumanizing and stigmatizing language Offer at least 2 session per year on biology of Substance Use Disorder for various audiences
Increase Naloxone saturation in the community	• Promote awareness of availability of naloxone at pharmacy • Distribute naloxone kits to individuals for whom there is a barrier to access at the pharmacy	At least 100 kits to be distributed
Coordinate access to evidence-based treatment and remission support services	• Continue and enhance recovery navigator program • Continue and expand community-based clinical services for people living with SUD including mobile access program • Recruit, train and support new Suboxone prescribers	Current level of service maintained and expanded with available funding
Advocate for public policy change	• Continue to advocate for public policy to be rooted in harm reduction, equity and an understanding of SUD as a chronic disease	Expand low threshold access to evidence-based treatment for SUD
Partners: Alliance for Living, Ledge Light Health District, Community Health Center, Sound Community Services, CT Department of Mental Health and Addiction Services, Southeast Mental Health Authority, L+M Hospital, people with lived experience, City of New London, local substance use disorder treatment providers		

FY 2019-22 Community Health Improvement Plan
Racism as a Public Health Issue
Health Improvement Collaborative

In Southeastern CT Region (DataHaven Wellbeing Survey):

Indicator: Percentage reporting being unfairly stopped, searched, questioned, physically threatened, or abused by police (18% of people of color vs. 9% of Whites, 2018)

Indicator: Percentage reporting that their neighborhood Is safe to walk at night (65% people of color vs. 78% Whites, 2018)

Indicator: Percentage of survey respondents reporting that race is their main perceived reason for being unfairly treated by police (30%, 2018)

Indicator: Percentage of survey respondents reporting being unfairly treated when seeking healthcare (28% people of color vs. 10% Whites, 2018)

Indicator: Percentage of survey respondents reporting being unemployed and wanting to work (9% people of color vs. 5% Whites, 2018)

Goal: A reduction in racial and ethnic health disparities resulting from the community addressing:

-Institutional racism that drives systemic inequities in the social determinants of health, and

-Implicit bias, discrimination, and micro-aggressions to reduce racism related chronic stress and resulting health outcomes for people of color

Strategy	Action Steps	Outcomes
Create opportunities for learning about/intervention on implicit bias, discrimination & micro-aggressions & their impact on health and on historical/current systems & policies that perpetrate structural racism and how to disrupt those structures	• Consider locally available assets to guide conversations with organizations and residents • Build capacity at the HIC level, in particular increasing knowledge	Demonstrate awareness, knowledge, and skills that lead to personal, institutional/structural and cultural change.
Support local organizations in assessing internal policies & on working to create inclusive organizations with specific activities to increase diversity	• Engage partner organizations in creating a process for assessment • Research best practices to increase diversity	Assessment complete in at least 3 organizations Compendium of best practices developed
Advocate for policies that improve health in communities of color	• Partner with advocacy organizations to join their efforts	At least one new public policy enacted
Partners: Full membership of the Health Improvement Collaborative, municipalities, employers, healthcare providers		

Yale NewHaven Health
L+M Healthcare

Health Improvement Collaborative
Southeastern Connecticut