2019 Greater Bridgeport Region Bridgeport Hospital and St. Vincent's Medical Center Collaborative Community Health Needs Assessment and Implementation Plan

By the

Health Improvement Alliance

This document is a special section of the **Fairfield County Community Wellbeing Index 2019**, a core program of DataHaven (ctdatahaven.org), in partnership with Fairfield County's Community Foundation and a **Community Health Needs Assessment** for the towns served by all Fairfield County hospitals including Bridgeport Hospital and St. Vincent's Medical Center

ABOUT THIS REPORT

This document is a special section of the ***Fairfield County Community Wellbeing Index 2019*** (Appendix A), a comprehensive report about Fairfield County and the towns within it. The *Community Index* was produced by DataHaven in partnership with Fairfield County's Community Foundation and many other regional partners, including the Health Improvement Alliance (HIA), a coalition serving towns in the Greater Bridgeport region.

This document serves as the **Community Health Needs Assessment** for the six towns in the HIA area (Bridgeport, Easton, Fairfield, Monroe, Stratford, and Trumbull).

The Community Health Needs Assessment documents the process that the HIA used to conduct the regional health assessment and health improvement activities. You may find the full *Community Wellbeing Index* attached to this section, or posted on the DataHaven, Fairfield County's Community Foundation, Bridgeport Hospital, St. Vincent's Medical Center, or any of the town health department websites. The Community Health Needs Assessment and Community Health Improvement Plan were approved by the Board of Trustees for St. Vincent's Medical Center in June 13, 2019 and the Board of Trustees for Bridgeport Hospital in July 9, 2019.

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

INTRODUCTION

Understanding the current health status of a community is a necessary first step towards identifying priorities for future planning and funding, existing strengths and assets on which to build, and areas for further collaboration and coordination across organizations, institutions, and community groups. To this end, the Health Improvement Alliance (HIA) comprised of Bridgeport Hospital, St. Vincent's Medical Center, local departments of public health, federally qualified health centers, and numerous community and non-profit organizations serving the Greater Bridgeport region, as fully set forth in Appendix B, are leading a comprehensive regional Community Health Needs Assessment (CHNA) effort. This effort is comprised of two main elements:

- Assessment – identifies the health-related needs in the Greater Bridgeport area using primary and secondary data.
- Implementation Plan– determines and prioritizes the significant health needs of the community identified through the CHNA, overarching goals, and specific strategies to implement across the service area resulting in a Community Health Improvement Plan (CHIP).

This report details the findings of the CHNA conducted from January 2018 – April 2019. During this process, the following goals were achieved: the current health status of the Greater Bridgeport region was examined and compared to state indicators and goals; current health priorities among residents and key stakeholders were explored; and community strengths, resources, and gaps were identified in order to assist HIA and community partners in establishing top health priorities as well as programming and implementation strategies to achieve these priorities.

METHODS

HIA adopted the Association for Community Health Improvement's (ACHI) Community Health Assessment Framework to guide the CHNA and to ensure that it meets the needs of the hospitals to comply with Internal Revenue Service regulations for charitable hospitals and those of the local health departments pursuing voluntary accreditation through the Public Health Accreditation Board. Specifically, the CHNA defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community's health – from lifestyle behaviors to clinical care to social and economic factors to the physical environment. This larger framework of the social determinants of health guided the overarching process.

Data Collection Methods

Quantitative and qualitative data were collected and reviewed throughout the CHNA process. Secondary data sources included, but were not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, State of Connecticut Department of Public Health, Connecticut Health Information Management Exchange (CHIME), as well as local organizations and agencies. Types of data included vital statistics based on birth and death records. In addition, HIA partnered with DataHaven and, in part, sponsored the 2018 DataHaven Community Wellbeing Survey, hired Health Equity Solutions to conduct community conversations in the Greater Bridgeport Region, worked with the Yale School of Public Health Student Consulting Group to conduct and later analyze Key Informant Surveys, and a student Practicum Team also from the Yale School of Public Health to identify community resources.

KEY FINDINGS

The following section provides a brief overview of the key findings from the community health needs assessment for the Greater Bridgeport Region. This includes overall demographics, social and physical environment, health outcomes and findings as they relate to the top health priorities that were selected for action planning at a regional level: **Healthy Lifestyles** (which includes Cardiac / Diabetes)**, Behavioral Health, and Access to Care**. These focus areas will be addressed through a **Social Determinants of Health** lens.

Demographics

Numerous factors are associated with the health of a community including what resources and services are available as well as who lives in the community. While individual characteristics such as age, gender, race, and ethnicity have an impact on people's health, the distribution of these characteristics across a community is also critically important and can affect the number and type of services and resources available.

- **Population**. The Greater Bridgeport Region has a population of about 330,000. Bridgeport, Connecticut's largest city, comprises 45% of the region's population.
- **Age Distribution.** The typical Bridgeport resident is 33 years old, but most towns in the region have a median age that is at least 10 years higher than that. The population of older adults is projected to grow significantly throughout the region over the next 20 years.
- **Racial, Ethnic, and Language Diversity**. The towns in the region vary dramatically in terms of their racial and ethnic composition. The communities of Easton, Fairfield, Monroe and Trumbull are over 80% White and Stratford is over two-thirds White. By contrast, close to 80% of Bridgeport's population is non-White; Hispanics and African-American's each comprise more than one third of Bridgeport's residents. Bridgeport benefits from high rates of immigration, but about 23 percent of its population struggles with low English proficiency, about twice the rate of Connecticut overall (8 percent).

Social and Physical Environment

Income and poverty are closely connected to health outcomes. A higher income makes it easier to live in a safe neighborhood with good schools and many recreational opportunities. Higher wage earners are better able to buy medical insurance and medical care, purchase nutritious foods, and obtain quality child care than those earning lower wages. Lower income communities have higher rates of asthma, diabetes, and heart disease. Those with lower incomes also generally experience lower life expectancies.

- **Income and Poverty.** There are wide gaps in Median Household income rates within the Greater Bridgeport Region. The towns of Easton, Fairfield, Monroe, and Trumbull are affluent with median incomes substantially higher than national and state averages. Stratford, which has a long history as an industrial town, was described by residents as blue collar and middle class. Bridgeport has a high poverty rate and a lower median income that both state and national averages, and certain neighborhoods such as the East End have rates of concentrated poverty and other conditions that rank them among the most economically-disadvantaged neighborhoods in the Northeast US.
- **Educational Attainment.** Only 18% of Bridgeport adults age 25 and over have a college degree or higher, less than half the rate for the state; Stratford also falls below the state rate with only 33% of the residents having a college degree or higher. The proportion of residents with a college degree or higher in Easton, Fairfield, Monroe and Trumbull is greater than that of the state, with Fairfield's adults having a college educational attainment rate of 63%.

Health Outcomes

Health outcomes and risk factors related to chronic disease, mental health and substance abuse, mortality and morbidity are covered in significant detail in the Fairfield County Community Wellbeing Index. These include:

- **Self-Reported Health Status.** Self-reported health status, which is a powerful predictor of future disability, hospitalization, and mortality, varies widely throughout the region by education and income level. Self-rated health and related indicators of personal well-being are lower in Bridgeport than in other towns, especially after adjusting for differences in age.
- **Neighborhood Environments.** Perceived quality of society, which relates to neighborhood trust, safety, child-friendliness, perceptions of government services, and many other factors, are studied in-depth in the Index. Once again, responses from Bridgeport residents were much less positive than those from the surrounding towns and responses are highly correlated to income levels with lower income households being less positive. For example, 49% of Bridgeport adults said that the availability of healthy, affordable food in their neighborhood was only fair or poor, compared to just 28% of Connecticut adults and 18% of Fairfield adults who said the same.
- **Financial Stress.** The 2015 CWS contains many markers of financial stress, all of which are directly correlated with income levels. Across the board, positive levels of markers of financial stability — food security, housing security, transportation access, and financial comfort — are significantly higher in wealthier areas.
- **Health Priorities.**
  - **Healthy Lifestyles.** Obesity rates are rising in Connecticut and Bridgeport with more than one out of four adults classified as obese. The findings indicate that the prevalence of obesity in Bridgeport (40%) and Stratford (37%) is higher than the Connecticut rate (29%). On the contrary, smoking prevalence rates in Connecticut have decreased since 2000 and were at 14% in 2018. Smoking rates in Bridgeport (21%) are considerably higher than the state rate, while rates in the other Greater Bridgeport towns are similar or much lower. A direct outcome of health behaviors such as lack of exercise, lack of access to healthy food and tobacco use are related medical conditions and complications from obesity including high blood pressure, high cholesterol, diabetes, heart disease or heart attack. Compared to Connecticut, there is higher incidence of diabetes and a much higher rate of hospital and emergency room encounters in Bridgeport for issues related to cardiovascular disease, hypertension, and diabetes.
  - **Behavioral Health.** The focus group findings, analysis of key informant surveys, and secondary data obtained from various sources including DataHaven's extensive analysis of the Connecticut Health Information Management Exchange (CHIME) data, a data repository for all hospital and emergency room encounters experienced by local residents, support the inclusion of this priority area. There is a significant need in the community for mental health services, as nationally twenty percent of people in a given year will need some type of mental health support, and there is a gap of available local services. Data from the 2018 DataHaven Community Wellbeing Survey find that a person's reported level of happiness and anxiety are directly correlated to income and education; adults who reported feeling somewhat or mostly happy ranged from a low of 82% in Bridgeport to a high of 94% in Fairfield, and these rates were directly correlated with income level. In addition, adults with limited income levels are about 2.5 times more likely to report feeling anxious than adults earning $75,000 per year or more.

- **Access to Care.** Financial stress and lower socioeconomic status also create challenges related to access to medical care. Approximately 11% of residents in the Greater Bridgeport region said they didn't get the medical care they needed last year, including 14% of Bridgeport residents. Although the majority of residents in the Greater Bridgeport region have health insurance and a single person or place that they consider to be their doctor, rates of these protective factors are lower among groups with either less educational achievement or lower earnings. In focus group discussions, it was determined that the type of insurance a person had was tied to issues around access to care and quality of care. Specifically, those with state insurance have limited providers, long wait times, and challenges with coverage for prescription medications, dental care and mental health services. Data from the 2018 DataHaven Community Wellbeing Survey on experiences of discrimination also show that some adults in the Bridgeport reason feel they are treated with less respect when seeking health care, often due to the type of health insurance they have.

Complete findings are covered in the *Fairfield County Community Wellbeing Index 2019* (Appendix A) and additional detailed data by town are available on the DataHaven website: ctdatahaven.org.

II. INTRODUCTION

A. OVERVIEW

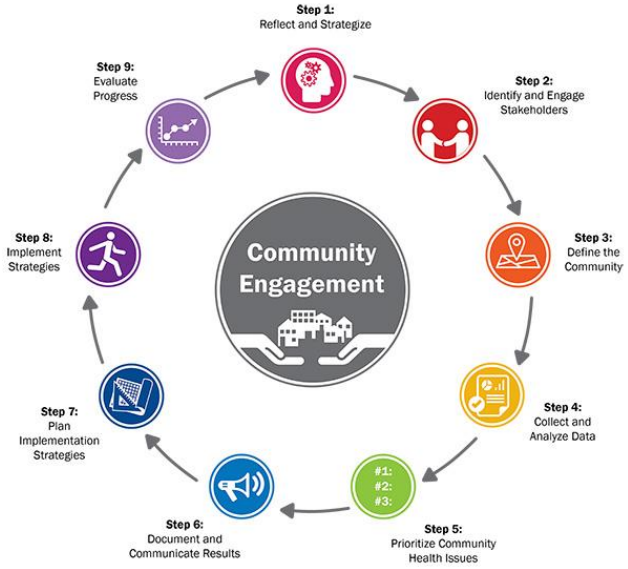
Improving the health of a community is critical to ensuring the quality of life of its residents and fostering sustainability and future prosperity. Health is intertwined with multiple facets of our lives; where we work, live, learn, and play all have an impact on our health. Understanding the current health status of a community – and the multitude of factors that influence health – is important in order to identify priorities for future planning and funding, the existing strengths and assets on which to build, and areas for further collaboration and coordination across organizations, institutions, and community groups.

To this end, the Health Improvement Alliance (HIA) – a coalition of two hospitals, five departments of public health, federally qualified health centers, and numerous community and non-profit organizations serving the Greater Bridgeport region of Connecticut – led a comprehensive regional Community Health Needs Assessment (CHNA) effort. This effort was comprised of two main elements:

- Assessment – identified the health-related needs in the Greater Bridgeport area using primary and secondary data.
- Implementation Plan – determined and prioritized the significant health needs of the community identified through the CHNA, overarching goals, and specific strategies to implement across the service area resulting in a Community Health Improvement Plan (CHIP).

This report details the findings of the Community Health Needs Assessment conducted from January 2018 – April 2019. The Health Improvement Alliance adopted the Association for Community Health Improvement's (ACHI) Community Health Assessment Framework (Figure 1) to guide the CHNA and to ensure that it fulfills the hospitals' Internal Revenue Service requirements and those of the local health departments pursuing voluntary accreditation through the Public Health Accreditation Board.

Figure 1: Association for Community Health Improvement Community Health Assessment Process



B. ADVISORY STRUCTURE AND PROCESS

The Community Health Needs Assessment was spearheaded, funded, and managed by the Health Improvement Alliance, which includes Bridgeport Hospital, St. Vincent's Medical Center, City of Bridgeport Department of Health and Social Services, Fairfield Health Department, Monroe Health Department, Trumbull Health Department, Stratford Health Department, Optimus Healthcare, Southwest Community Health Center, Americares Free Clinic of Bridgeport, LLC (see Appendix B for a full list of organizational members). The organizations are representative of those in the community who serve underserved, low-income, and hard to reach populations. Representatives from these organizations provide regular input as part of the Community Health Needs Assessment and Community Health Improvement Plan implementation process by routinely attending monthly coalition meetings, providing feedback and guidance at each stage of the CHNA process, identifying specific populations for community conversations, responding to key informant surveys, attending community forums and prioritization sessions, and by being valued community partners.

The Health Improvement Alliance formerly the Primary Care Action Group was founded in 2003 with the mission to improve the health of the community. HIA's vision is to work together as a coalition to identify, prioritize, and measurably improve the health of their community through health care prevention, education, and services. To develop a shared vision and plan for the community and help sustain lasting change, the PCAG assessment and planning process aimed to engage agencies, organizations, and residents in the area through participatory and collaborative approaches.

HIA reached out to the larger community through communications and meetings to discuss the importance of this planning process. Additionally, the comprehensive data collection effort of the Community Health Needs Assessment engaged the community in community conversations, key informant surveys, and the DataHaven Community Wellbeing Survey. Dissemination of the CHNA findings and subsequent CHIP priorities and strategies, in an effort to raise public awareness, will continue to be conducted via media coverage and public events.

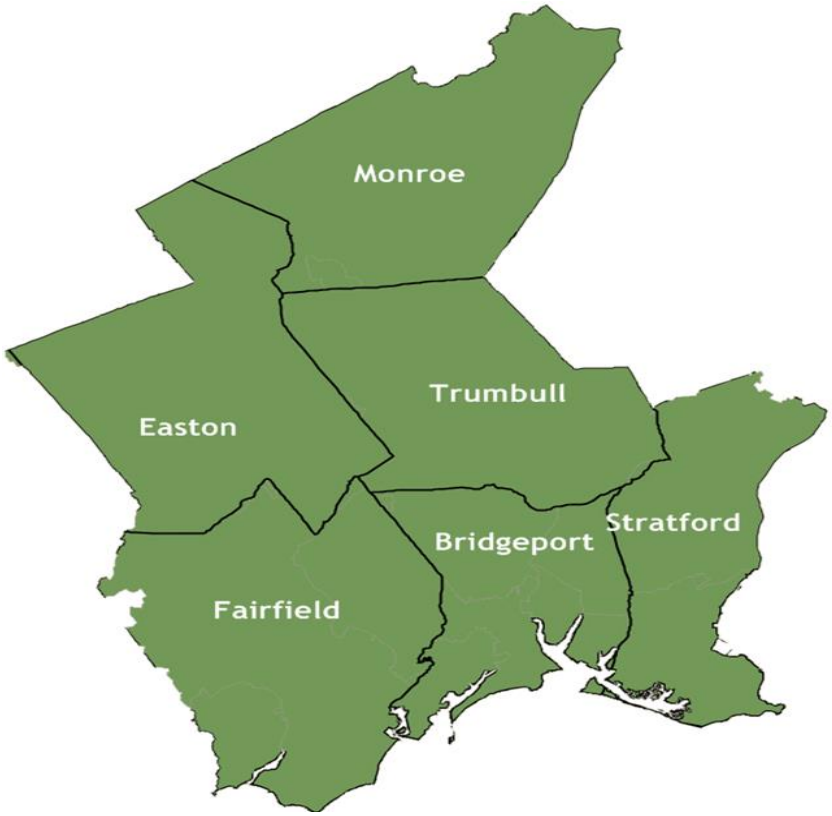
C. PURPOSE AND COMMUNITY SERVED

The Greater Bridgeport Community Health Needs Assessment was conducted to meet several overarching goals:

1. To examine the current health status of the Greater Bridgeport area (comprised of Bridgeport, Easton, Fairfield, Monroe, Stratford, and Trumbull)
2. To explore current health priorities – as well as emerging health concerns – among residents within the social context of their communities;
3. To meet the legal requirements, as stipulated by the Internal Revenue Service, of Bridgeport Hospital and St. Vincent's Medical Center to conduct a community health needs assessment at least once every three (3) years and to adopt a written implementation strategy to meet the needs identified through the community health needs assessment; and
4. To meet voluntary health department Public Health Accreditation Board requirements.

To define community for CHNA purposes, this Greater Bridgeport Community Health Needs Assessment uses a geographic approach focusing on six towns within Fairfield County, CT: Bridgeport, Easton, Fairfield, Monroe, Stratford, and Trumbull (Figure 2). These communities are served by both Bridgeport Hospital and St. Vincent's Medical Center representing at least 75% of total discharges and do not overlap with CHNA areas identified by other acute care hospitals and/or collaborations. Upon defining the geographic area and population served in Greater Bridgeport, HIA was diligent to ensure that no groups, especially minority, low-income or medically under-served, were excluded.

Figure 2: Map of Community Served - Greater Bridgeport Area, Connecticut



III. METHODS

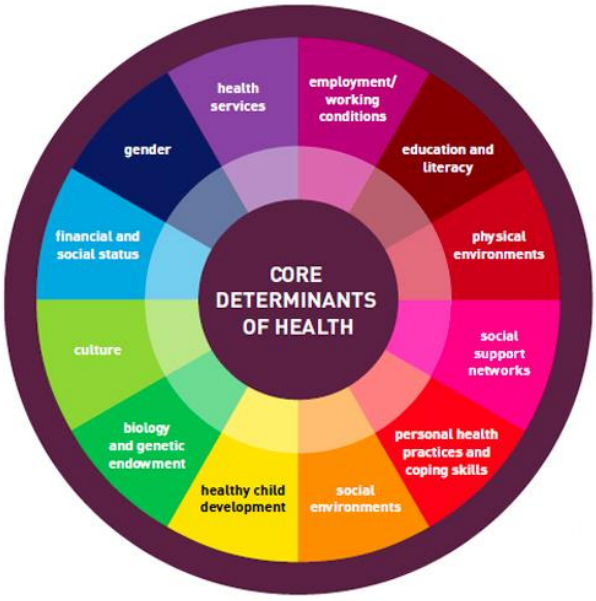
The following section describes the process and methods used to conduct the Community Health Needs Assessment, including the qualitative and quantitative data was compiled and how it was analyzed, as well as a description of the broader lens used to guide the process. Specifically, the Community Health Needs Assessment defines health in the broadest sense and recognizes that numerous factors at multiple levels impact a community's health – from lifestyle behaviors to clinical care to social and economic factors to the physical environment. The beginning of this section discusses the larger social determinants of health framework which helped guide this overarching process.

A. SOCIAL DETERMINANTS OF HEALTH FRAMEWORK

It is important to recognize that multiple factors have an impact on health and that there is a dynamic relationship between real people and their lived environments. Where we are born, grow, live, work, and age – from the environment in the womb to our community environment later in life – and the interconnections among these factors are critical to consider when examining health status. That is to say, health outcomes are influenced by more than just an individual's genetic code and, in fact, zip code is more predictive as it is associated with lifestyle behaviors and upstream factors such as income, education, employment, and quality of housing stock. The social determinants framework addresses the distribution of wellness and illness among a population, by examining factors not traditionally considered in medicine's relatively narrow view of health.

The following diagram provides a visual representation of this relationship, demonstrating how individual lifestyle factors, which are most proximate to health outcomes, are influenced by more upstream factors such as education, literacy, and physical environments (Figure 3). This report, as well as the *Fairfield County Community Wellbeing Index 2019* (Appendix A) provides information on many of these factors, and reviews key health outcomes.

Figure 3: Social Determinants of Health Framework



B. DATA COLLECTION METHODS – COMMUNITY INPUT

1. QUANTITATIVE DATA

a) Reviewing existing secondary data

The Greater Bridgeport Community Health Needs Assessment was built off of previous efforts in the Greater Bridgeport region, including the 2016 Community Health Needs Assessment and resulting Community Health Improvement Plan which has guided the Health Improvement Alliance over the past three years. In addition, the Community Health Needs Assessment utilized secondary data from sources including, but not limited to, the U.S. Census, U.S. Bureau of Labor Statistics, Centers for Disease Control and Prevention, State of Connecticut Department of Public Health, Connecticut Health Information Management Exchange (CHIME), as well as local organizations and agencies. Types of data include vital statistics based on birth and death records. Analysis of these extensive health data sources are compiled in DataHaven's *Fairfield County Community Wellbeing Index 2019*, which is appended to this document.

b) 2018 DataHaven Community Wellbeing Survey

The Health Improvement Alliance partnered with DataHaven, whose mission is to improve quality of life by collecting, interpreting, and sharing public data for effective decision-making, on the 2018 Community Wellbeing Survey. The Community Wellbeing Survey team assisted the Health Improvement Alliance to gather quantitative primary data that were not provided by secondary sources and to understand public perceptions around health, including social determinants, and other issues. The Wellbeing Survey was conducted from March to November 2018 by the Siena College Research Institute. The Survey was administered to randomly-selected landlines and cell phones and resulted in in-depth interviews with 16,043 adults statewide including 1,715 adults living in Bridgeport, Easton, Fairfield, Monroe, Stratford and Trumbull. The survey was designed by DataHaven and the Siena College Research Institute, in consultation with local, state, and national experts including members of HIA. Interviews were weighted to be statistically representative of adults in each city, town or geographic region. Surveys were administered in both English and Spanish and zip codes were targeted to supplement samples of hard-to-reach populations.

The survey has created information that was previously unavailable at a local level from any other source and cross-sector analysis provides information on neighborhood quality, happiness, housing, transportation, health, economic security, workforce development, and other topics. Findings from the Community Wellbeing Survey are primarily covered within the *Fairfield County Community Wellbeing Index 2019*. Detailed data by town are available in the survey crosstabs on the DataHaven website (https://ctdatahaven.org/reports/datahaven-community-wellbeing-survey).

2. QUALITATIVE DATA

a) Community Conversations

In February and March 2019, seven community conversations engaging a total of 114 individuals were conducted by Health Equity Solutions (HES) in the Greater Bridgeport region. The goals of the community conversations were to determine residents' perceptions of health strengths and needs in the Greater Bridgeport 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 the Health Improvement Alliance (HIA), groups having a disproportionate burden of health issues were identified (i.e., lower-income adults, uninsured residents, individuals with limited English proficiency or Latino adults) as a priority to include in the community conversations. HIA members identified specific groups and/or organizations that fulfilled these criteria, and Health Equity Solutions organized and facilitated the following groups: uninsured residents from an urban free health clinic; a mixed group of community residents; residents affiliated with a Hispanic church; parish nurses; seniors from two urban/suburban senior centers; and community members of an urban/suburban community center.

In addition, the consultant maintained efforts to include a geographical sample of residents from the six towns and cities that make up the Greater Bridgeport CHNA region.

b) Key Informant Surveys

The Community Health Needs Assessment was initiated in 2018 with the online key informant survey administered and analyzed by the Yale School of Public Health Student Consulting Group. The online survey was administered to two groups consisting of community leaders and health and human service providers, in the Greater Bridgeport area using Qualtrics, an online survey tool. Members of HIA identified 101 key informants between the two groups and had a 36% response rate. The Health and Human Services group included hospital administrators, state and local health department staff, physicians, nurses, and social service agency leaders. The Government and Community Leaders group included state and local elected officials, members of local police and fire departments, library directors, clergy, and other government agency heads. Surveys were designed to better understand the health needs of the Greater Bridgeport region and included qualitative and quantitative questions on community health initiatives, health related problems, barriers to good health, health services, and current outlooks.

3. ANALYSES

The secondary data and primary data from the 2018 Community Wellbeing Survey, community conversations, and key informant surveys were synthesized and integrated into this report.

4. LIMITATIONS

As with all research efforts, there are several limitations related to the assessment's research methods that should be acknowledged. Data based on self-reports should be interpreted with some caution. In some instances, respondents may over or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias – that is, they may attempt to answer accurately but remember incorrectly. In some surveys recalling and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys, particularly those using random sampling methods, benefit from large sample sizes and repeated administrations, enabling comparison overtime.

While community conversations and key informant surveys conducted for this assessment provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. It is also important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

IV. FINDINGS

A. 2019 FAIRFIELD COUNTY COMMUNITY WELLBEING INDEX

Overall Quality of Life and Economic Measures

From the DataHaven Community Index, which consists of a blend of indicators that illustrate the physical and social environments in which people live, overall findings include:

- Fairfield County scores well against US metros—among the top 20 percent nationally—but outcomes vary widely by race and ethnicity.
- Fairfield County ranks 19 out of 107 large US metropolitan areas, with a score of 621 out of 1,000. But the County is also home to the highest and lowest scoring geographic areas in our analysis, emphasizing its polarization on measures of well-being. For example, the towns of Greenwich and Fairfield score 724 and 698 on the Index, respectively, placing them above the best-performing metropolitan area in the nation (Madison, Wisconsin). However, the central and East End neighborhoods of Bridgeport have a score of just 320, which is lower than that of the lowest-performing US metro area (McAllen, Texas). These differences are largely related to income levels. The poverty rate among young children in the East End neighborhood of Bridgeport is more than 20 times greater than that of the wealthier towns.
- Asian and white residents are generally more advantaged than Black and Latino residents. The indicator with the highest degree of racial inequality is also young children in poverty. More than 1 in 4 Black children in Fairfield County live in poverty, compared to just 1 in 25 white children.
- The Community Index score predicts neighborhood-level life expectancy with a very high degree of accuracy. There is a 19-year difference in life expectancy between some neighborhoods in Fairfield County, including a 6-year difference between the East End of Bridgeport (76 years) and the countywide average as a whole (82 years).

Financial security measures also vary across the county, as shown in the table below.

Financial Insecurity Varies across Fairfield County

2018 DataHaven Community Wellbeing Survey, Percent of All Adults Age 18+

	Just getting by or finding it difficult to get by financially	Less than 2 months savings	Underwater financially (feel they have negative net worth)	Food Insecure	Threatened with utility shut off at home	Transport Insecure	No bank account
Connecticut	33%	33%	17%	13%	10%	12%	9%
Fairfield County	30%	29%	13%	11%	10%	11%	9%
By Demographic within Fairfield County							
M	28%	26%	12%	10%	8%	10%	9%
F	32%	31%	14%	13%	11%	12%	9%
18-34	39%	43%	16%	19%	14%	21%	14%
35-49	32%	32%	15%	13%	11%	9%	8%
50-64	30%	22%	11%	9%	9%	7%	7%
65+	17%	19%	7%	3%	4%	7%	4%
White	26%	23%	10%	7%	6%	6%	4%
Black/Afr Amer	47%	40%	22%	24%	21%	23%	19%
Hispanic	39%	48%	24%	25%	21%	22%	19%
By Geography							
Bridgeport	52%	45%	30%	28%	23%	23%	21%
Stamford	25%	29%	13%	9%	7%	10%	10%
Norwalk	31%	21%	9%	8%	7%	10%	9%
Danbury	31%	32%	14%	11%	5%	8%	8%
Greenwich	20%	23%	7%	7%	6%	9%	6%
Fairfield	24%	23%	15%	6%	5%	9%	4%
Stratford	40%	34%	15%	20%	20%	14%	9%
CT Wealthiest Towns	20%	18%	5%	5%	5%	7%	4%
CT Urban Core Cities	47%	47%	30%	25%	19%	23%	20%
By Income within Fairfield County							
<$15K	66%	61%	31%	37%	23%	34%	32%
$15K-$30K	60%	61%	32%	29%	20%	26%	18%
$30K-$50K	46%	37%	18%	19%	10%	16%	8%
$50K-$75K	37%	34%	16%	12%	13%	8%	8%
$75K-100K	24%	33%	9%	7%	8%	8%	6%
$100K-$200K	18%	18%	5%	5%	6%	5%	2%
$200K+	6%	8%	2%	1%	2%	3%	2%

All components of the DataHaven Community Index are shown in the table below, for areas for which it is calculated. The results show significant differences between Fairfield, Stratford, and areas within Bridgeport. In this Index, Easton, Monroe, and Trumbull fall within the "Other towns" category.

Data Table: Community Index Components

	Opportunity Youth	Poverty	High school graduates	Young child poverty	Health insurance	Preschool enrollment	Unemployment	Life expectancy	Severe housing cost burden	Young adults in labor force	Workers with short commute	Median household income
United States	7%	15%	87%	22%	90%	48%	7%	79	15%	26%	63%	58k
Connecticut	5%	10%	90%	15%	94%	64%	7%	80	17%	24%	65%	74k
Fairfield County	5%	9%	89%	13%	90%	69%	8%	82	20%	24%	60%	90k
Fairfield	3%	5%	95%	4%	96%	74%	6%	82	17%	19%	53%	128k
Greenwich	3%	7%	95%	5%	95%	84%	6%	84	19%	21%	61%	139k
Stratford town	5%	8%	90%	11%	95%	73%	7%	80	20%	24%	61%	73k
6 wealthiest towns	2%	3%	98%	2%	97%	82%	5%	84	15%	17%	51%	181k
Other towns	5%	10%	88%	14%	89%	66%	8%	81	20%	25%	61%	88k
Bridgeport, central	14%	24%	73%	43%	82%	61%	15%	77	31%	30%	62%	40k
Bridgeport, East End	13%	26%	70%	34%	84%	63%	17%	76	34%	31%	62%	36k
Bridgeport, north / Black Rock	1%	11%	83%	21%	86%	77%	10%	80	23%	29%	56%	67k
Danbury, central	5%	18%	68%	26%	70%	39%	9%	79	24%	34%	67%	50k
Danbury, outer	3%	7%	91%	13%	92%	45%	6%	83	15%	26%	61%	86k
Norwalk, south/ central	6%	18%	77%	32%	70%	74%	11%	79	25%	33%	66%	61k
Norwalk, north	9%	6%	91%	4%	85%	76%	7%	83	20%	26%	64%	96k
Stamford, central	4%	15%	81%	17%	79%	56%	8%	80	24%	38%	67%	63k
Stamford, north	3%	5%	94%	3%	92%	69%	7%	83	20%	27%	67%	118k

Additional demographic and economic findings for the general area include:

- Since 2000, Fairfield County's population has increased faster than that of Connecticut overall. Stamford has led the state in population growth from 117,083 residents in 2000 to 128,851 residents in 2017—just over a 10 percent increase.
- As of 2017, 63 percent of Fairfield County residents are white, 10 percent are Black, 19 percent are Latino, 5 percent are Asian, and 3 percent identify as another race/ethnicity. But the region is becoming more diverse: only half of young children and young adults (age 18-34) identify as non-Hispanic white.

- Fairfield County's middle class neighborhoods have progressively shrunk in size between 1980 and 2017. While 46 percent of Fairfield County residents lived in middle-income neighborhoods in 1980, only 28 percent did in 2017.
- Between 1990 and 2017, the six wealthiest towns in the county saw over a 15 percent increase in inflation-adjusted median household income from $156,850 to $181,155. County-wide, however, inflation-adjusted median household income was stagnant during this period, decreasing by around 1 percent to $89,773 - a reflection of the wider statewide trend.
- Wages in Fairfield County overall are among the highest in the nation. However, even as average wages rose a modest one percent between 2000 and 2017 in the state as a whole, in Fairfield County they fell 4 percent. Wages for the fastest growing sectors in the region are well below the county average and have hardly grown since 2000: Health Care ($55,425 per year, +$775 since 2000), Education ($59,708, -$580) and Accommodation/Food Services ($25,184, -$1,961). While not a rapidly growing sector, retail is the second largest industry in the region with about 49,000 jobs and has an average wage of $40,180 - down from $60,267 in 2000.
- There is a shortage in early care options in the county as coverage only expands to about 15 percent of infants and toddlers.
- Special education students and students eligible for free or reduced-prices meals were more than twice as likely as classmates outside of these high-needs designations to miss ten percent of school days during the 2017-18 school year.
- In Fairfield County public schools, black students are disciplined at a rate 5 times greater than white students, and special education students are disciplined almost three times as much as students who are not in special education.

Health outcomes

Prominent findings related to health outcomes in the region include:

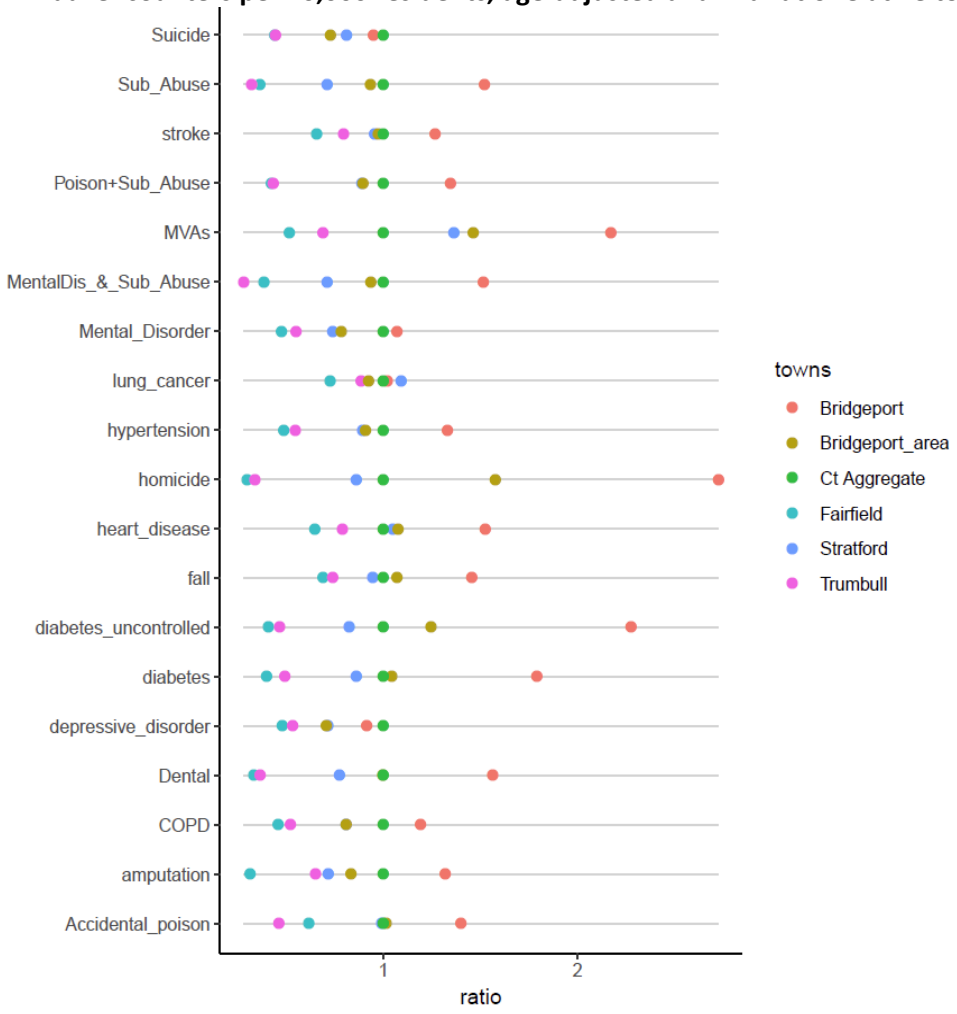
- Overall, Fairfield County is very healthy by national and state standards. However, 76 percent of adults earning $100,000 or more per year report being in good health, compared to just 41 percent of adults who earn less than $30,000 per year.
- While Fairfield County's average life expectancy of 81.6 years is very high, it masks a dramatic difference in life expectancy within the region. In some neighborhoods life expectancy is as low as 70.4 years—nearly 19 years lower than that of the neighborhood with the highest life expectancy (89.1 years). Town-wide averages range from a maximum of 86.5 years in Weston to a minimum of 77.6 years in Bridgeport, a difference of nine years.
- Geographic discrepancies in the rates at which Fairfield County residents visit hospitals and emergency rooms appear to be growing. This is especially true for issues related to chronic diseases such as heart disease, diabetes, and lung disease, as well as for falls, depression, and substance use disorders.
- Variations in life expectancy may be explained by differences in the rates of premature death within the population. In Fairfield County, cancers, fetal and infant mortality, cardiovascular diseases, opioid use disorders, suicides, motor vehicle crashes, and homicides are most prominent among the causes of premature death as measured by YPLL-75. There are large differences in premature mortality by town and neighborhood. For instance:
    - "For every 100,000 residents under the age of 75, a total of 6,928 years of potential life were lost due to all premature deaths in Bridgeport each year from 2010 to 2014, compared to 2,667 in Greenwich. Heart disease, one of the leading causes of premature death, contributed 1,056 years of life lost in Bridgeport (based on 100 premature deaths each year, with an average age at death of 60) and 293 in Greenwich (16 premature

deaths each year, with an average at death of 65). Homicides, a cause of premature death with some of the greatest disparities by place, race, and gender, led to the loss of 526 years of life (17 premature deaths from homicide each year, with an average age at death of 31) in Bridgeport, and nearly zero in Greenwich (fewer than one death per year)."

- The opioid overdose crisis has accelerated in recent years, with a doubling in the rate of overdose deaths in Fairfield County, peaking at 18 per 100,000 residents in 2018. The average age at death is around 40, indicating a massive loss of human potential. This crisis has hit Bridgeport particularly hard.

Hospital encounters show concerns related to access to care, cardiovascular disease, substance use
As shown in the graphic below, rates of hospital and emergency room encounters in the Greater Bridgeport region appear to significantly exceed CT (aggregate) for motor vehicle-related injury, homicide or assault, and uncontrolled diabetes. Encounter rates are highest for Bridgeport residents, especially for the conditions listed above but also for encounters related to substance abuse, hypertension, heart disease, falls, diabetes, and preventable dental emergencies. In terms of volume, cardiovascular-related, mental health, substance abuse, COPD, fall-related injuries are among most the common encounter conditions.

Annual encounters per 10,000 residents, age-adjusted and in a ratio relative to state, 2015-2017



Chronic disease risk factors vary within the region

The chart below illustrates how risk factors for chronic diseases may vary widely by age, race/ethnicity, income level, and geography. Relatively speaking, greater needs are generally observed Bridgeport and Stratford. For example, smoking rates are 21% in Bridgeport and 14% in Stratford, versus just 7% in Fairfield and Greenwich.

Health Risk Factors Vary across Fairfield County

2018 DataHaven Community Wellbeing Survey, Percent of All Adults Age 18+

	Feel that the Local Availability/Affordability of Healthy Food is Not Good	Obesity Rate	Exercise <3 days per week	Smoking Rate
Connecticut	28%	29%	42%	14%
Fairfield County	28%	27%	40%	12%
By Demographic within Fairfield County				
M	27%	27%	38%	13%
F	28%	26%	44%	10%
18-34	37%	23%	46%	15%
35-49	31%	31%	45%	12%
50-64	23%	30%	37%	12%
65+	18%	23%	34%	8%
White	22%	24%	37%	10%
Black/Afr Amer	47%	36%	49%	19%
Hispanic	43%	35%	49%	14%
By Geography				
Bridgeport	49%	40%	48%	21%
Stamford	25%	23%	38%	9%
Norwalk	27%	24%	45%	9%
Danbury	28%	27%	37%	15%
Greenwich	19%	14%	34%	7%
Fairfield	18%	26%	41%	7%
Stratford	36%	37%	44%	14%
CT Wealthiest Towns	22%	17%	31%	6%
CT Urban Core Cities	46%	37%	48%	21%
By Income within Fairfield County				
<$15K	44%	43%	58%	21%
$15K-$30K	39%	41%	47%	23%
$30K-$50K	36%	33%	50%	20%
$50K-$75K	29%	30%	41%	11%
$75K-100K	26%	24%	39%	10%
$100K-$200K	22%	23%	40%	8%
$200K+	16%	16%	31%	6%

Barriers in accessing care vary within the region

The chart below illustrates how barriers to accessing health care also may vary widely by age, race/ethnicity, income level, and geography. Barriers to accessing health care are generally reported to be highest in Bridgeport. Many young adults (25%) lack a medical home and have not visited a dentist in the past year (30%).

Barriers to Health Care Access Vary across Fairfield County

2018 DataHaven Community Wellbeing Survey, Percent of All Adults Age 18+

	Didn't get care when needed in past 12 months	Postponed care when needed in past 12 months	Did not visit a dentist in the past 12 months	Do not have any medical home
Connecticut	9%	23%	25%	11%
Fairfield County	9%	22%	23%	13%
By Demographic within Fairfield County				
M	9%	19%	24%	13%
F	9%	25%	21%	11%
18-34	12%	30%	30%	25%
35-49	9%	26%	23%	16%
50-64	8%	22%	18%	7%
65+	5%	10%	21%	2%
White	7%	21%	18%	10%
Black/Afr Amer	11%	21%	36%	17%
Hispanic	14%	28%	29%	20%
By Geography				
Bridgeport	14%	25%	38%	19%
Stamford	8%	21%	20%	9%
Norwalk	10%	20%	24%	16%
Danbury	10%	22%	23%	13%
Greenwich	8%	19%	13%	8%
Fairfield	7%	22%	20%	12%
Stratford	9%	25%	27%	9%
CT Wealthiest Towns	7%	20%	17%	12%
CT Urban Core Cities	14%	26%	35%	17%
By Income within Fairfield County				
<$15K	19%	26%	41%	19%
$15K-$30K	15%	27%	37%	19%
$30K-$50K	12%	29%	32%	20%
$50K-$75K	10%	21%	28%	17%
$75K-100K	8%	23%	19%	11%
$100K-$200K	7%	24%	17%	9%
$200K+	2%	16%	7%	8%

B. REGIONAL COMMUNITY CONVERSATIONS

Community conversations, similar to focus groups, are meant to provide the perspective of specific populations of important and otherwise potentially hard to reach community members, including the underserved, as part of the community health needs assessment process. Health Equity Solutions (HES) and HIA worked collaboratively to identify the target underserved population and to identify host organizations for each community conversation. A total of 114 individuals participated in seven community conversations over a two-month period in February and March 2019. The goals of the conversations were to determine perceptions of the community, health, and health care in the Greater Bridgeport region, including community strengths, concerns, health services and service gaps, perceptions about discrimination, and health improvement priorities.

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, most participants self-identified as female (80%) and 68% were white; 6% were Asian/Pacific Islander and 5% black. Due to space constraints on the demographic survey tool, only one ethnicity was listed and 18% of participants identified their ethnicity as Hispanic. Fifteen percent of the participants were single, 52% were married or in a domestic partnership, 18% were widowed and 15% divorced or separated. Thirty-seven percent of the participants were currently employed, 46% were retired, 1% were unable to work, and 7% were homemakers. Table 1 illustrates the overall demographics of the focus group participants.

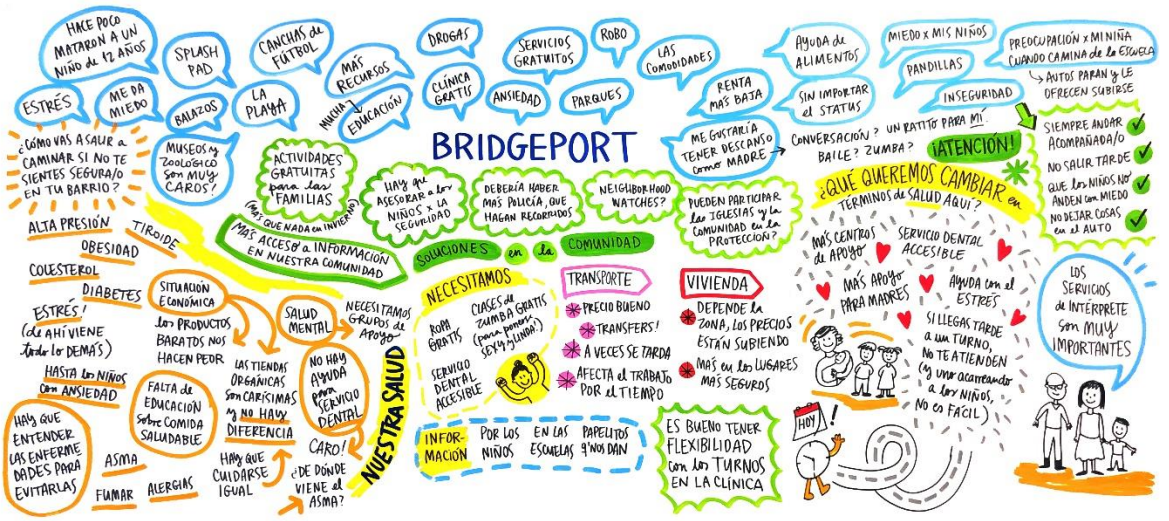
Table 1: Greater Bridgeport Community Conversation Demographics

Gender	
Female	80%
Male	20%
Age	
18-26	1%
27-34	0%
35-44	6%
45-54	16%
55-64	16%
65-74	18%
75+	43%
Race/Ethnicity	
American Indian/Alaska Native	0%
Asian/Pacific Islander	6%
Black/African American	5%
Hispanic	18%
White	68%
Other	3%

Marital Status	
Single, never married	15%
Married or domestic partnership	52%
Widowed	18%
Divorced/Separated	15%
Employment	
Employed for wages	37%
Self-employed	3%
Out of work and looking for work	3%
A homemaker	7%
A student	1%
Military	0%
Retired	46%
Unable to work	1%
Place of Residence	
Bridgeport	22%
Easton	0%
Fairfield	20%
Monroe	13%
Stratford	27%
Trumbull	13%
Other	5%

Topics explored during the community conversations focused on the overall strengths and concerns about the community, health issues, perceptions of health care services, gaps in services, the impact of discrimination, and recommended priorities to address over the next three years. All community conversations were recorded and transcribed to accurately assess emerging themes from the conversation. Two community conversations included graphic recording during the meeting which captured key thoughts and themes in word artform (Figure 4).

Figure 4: Graphic Recordings, Community Conversations



Community Health Needs Assessment | Yale New Haven Hospital
Community Conversation, Americares Free Clinic, Bridgeport CT | 03.15.19
Facilitated by HEALTH EQUITY SOLUTIONS

Community Health Needs Assessment | Yale New Haven Hospital
Community Conversation, La Senda Antigua Church, Bridgeport CT | 03.16.19
Facilitated by HEALTH EQUITY SOLUTIONS

An analysis of themes that emerged during the conversations was organized around the Social Determinants of Health (SDOH). SDOH are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. The following are the categories from the Greater Bridgeport region: Key themes from the conversations included transportation, food, recreation, safety, air pollution, mental health access, opioid use 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, and cost of transportation.

- **Food**

The second most highlighted social determinant was food. Specific themes related to food affordability, including the high cost of farmers market produce and the expense of buying healthy food. Participants also voiced that in addition to the need for increased access to healthy foods, people need more education on how to make healthier choices and how to evaluate food options. Another barrier to accessing healthy foods is lack of transportation.

- **Recreation**

Recreational activities, physical activity and availability of resources were also identified as themes. Seniors appreciate the senior centers in their areas and have some suggestions to make them better but truly enjoy the resource. The need for low cost/affordable options for exercise came up in conversations. Youth activities for teenagers are needed. The need for more options for physical activity and recreation for both seniors and teenagers was also discussed.

- **Safety**

Walkability surfaced in one area and specifically ideas were offered around improving street lighting, adding pedestrian walkways, paths, etc. to increase safety of walking (there is an inequity noted due to residential variability within towns regarding sidewalks, lighting, etc.).

In at least three conversations, air pollutants surfaced as a key safety concern. Subthemes included asthma incidence increasing related to increased air pollution, increased traffic, car use, and increased people resulting in increased air pollution. Participants expressed concerns about significant environmental hazards that required hazmat suits to protect workers, but residents were not protected.

Social and Community Context

- **Mental Health**

Mental health related issues were often mentioned. Subthemes included the lack of available services, stigma related to services, stress, depression, and anxiety (related to a variety of issues). Stigma about mental health was also mentioned as a frequent concern. The need for trauma services in the community was also identified as an issue.

Substance Use

Substance use was another concern. Opioids and marijuana were specifically mentioned. There were concerns that not enough attention is being paid to this in the more affluent and suburban towns (Stratford, Trumbull, Monroe). Service issues included shorter stays in treatment facilities and a lack of group homes and supportive housing.

Health and Health Care

- **Insurance/Coverage**

Insurance issues related to Medicare were often mentioned. Subthemes include difficulty with plan choice, doctors not accepting Medicare and/or new patients, no dental coverage, no coverage for hearing aid devices, vision care and the need for more oral health services and health supports for formerly incarcerated people. Participants also expressed a need for more help with navigating Medicare.

Additional themes that were mentioned included the following:

- Lack of focus on primary care and overemphasis on specialty care
- Cost of health care - insurance costs, out of pocket costs (dental and otherwise)
- Hope Dispensary is helpful but does not cover all medications

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 114 participants in all sessions, 100 individuals completed the survey—an 88% response rate.

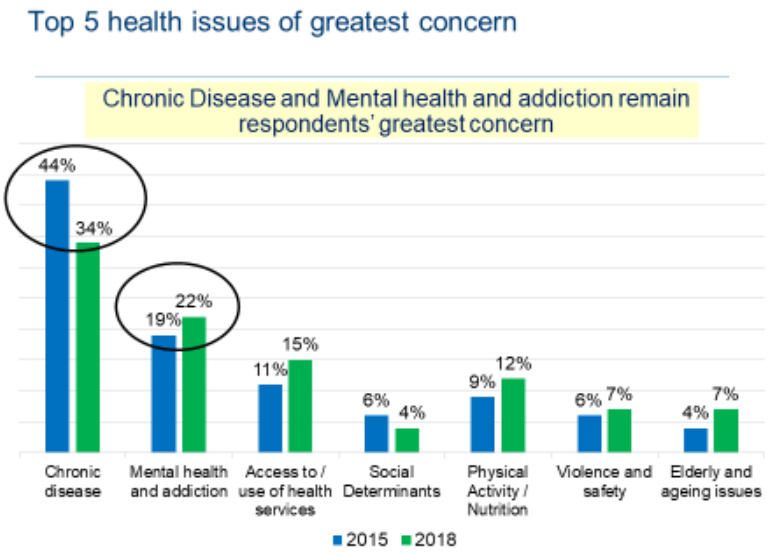
C. KEY INFORMANT SURVEYS

CHNA-related efforts were initiated in 2018 with a combination of primary data components, including an online key informant survey that was administered and analyzed by the Yale School of Public Health Student Consulting Group. The online survey was developed using Qualtrics, an online survey tool, and was designed to be completed by two groups, Health and Human Services providers, and Government and Community Leaders in the Greater Bridgeport area. Members of HIA identified 101 key informants between the two groups and achieved a 36% response rate. The Health and Human Services group included hospital administrators, state and local health department staff, physicians, nurses and social service agency leaders. The Government and Community Leaders group included state and local elected officials, members of local police and fire departments, library directors, clergy, and other government agency heads. Within the context of survey research, key informant refers to a person with whom an interview about a particular organization, social program, problem, or interest group is conducted. In a sense, the key informant is a proxy for her or his associates at the organization or group. Key informant interviews are in-depth interviews of a select (nonrandom) group of experts who are most knowledgeable about the organization or issues. Often used as part of program evaluations and needs assessments, these targets interviews allowed us to explore and understand the current health status of the community, identify strengths upon which to build, and prioritize efforts for the future.

Surveys included qualitative and quantitative questions about community health initiatives, common health-related problems, and barriers to good health, health services, and current outlooks. The key informant online surveys, indicated that 56% of respondents knew about the 2016 Community Health Needs Assessment and Community Health Improvement Plan compared to 83% of respondents who had known about the 2013 CHNA when a similar survey was conducted in 2015. Nearly 40% of respondents in 2018 were aware of new health initiatives in the area, including expansion of open space trails, including a dog park, extended free flu clinics, more programs about the opiate crisis, food policy council and a bike share program.

Across survey responses, recurring themes identified the top five health issues of greatest concern to respondents as: chronic disease; mental health and addiction; access to and use of health services; physical activity / nutrition and violence and safety, and elderly and aging issues (Figure **5**). The top health issues identified by the key informants align with the health priorities confirmed through the CHNA process in 2015 / 2016 and again in 2018 / 2019 (Healthy Lifestyles, Access to Care, and Behavioral Health).

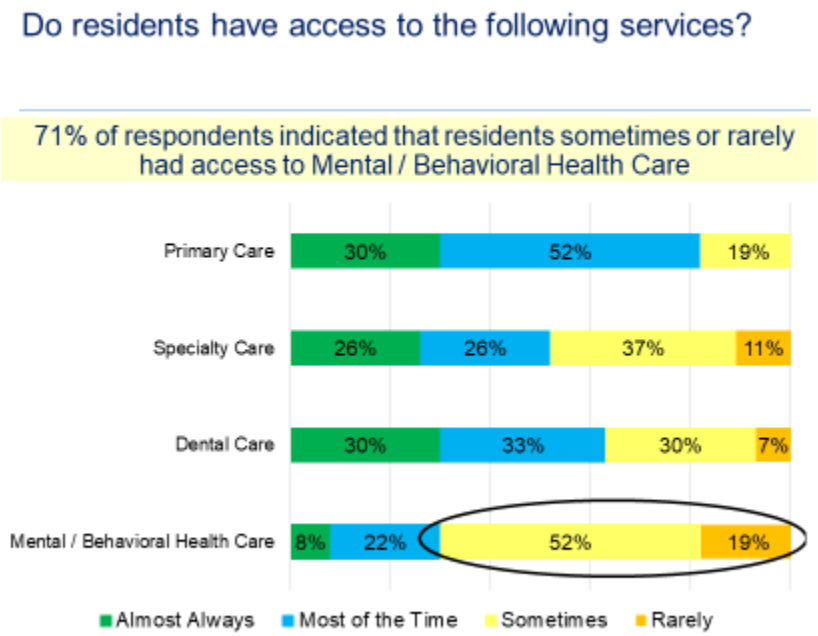
Figure 5: Key Informant Survey Top Five Health Issues



When asked to identify the most significant challenge(s) to improved health, 43 percent of respondents pointed to economic barriers, which they indicated impacted adults including lack of transportation and health insurance coverage. This was similar to the 60% of respondents who indicated that social barriers such as social isolation, technology, safe housing and education, were the most significant challenge(s) for children. The top three socio-economic barriers to good health that were identified by respondents were 1) access to health food, 2) access to medical insurance, and 3) access to employment.

Respondents perceive limited access to mental health care, which may be contributing to rising concerns about mental health and addiction as a top health issue in the region (Figure 6). Respondent perception is shifting to uncertainty or questioning relative to whether others are treated equally compared to 2015.

Figure 6: Key Informant Survey Access to Services



Lastly, respondents felt that the top three issues for policy makers to address included: 1) reducing opioid overdoses, 2) reducing tobacco use, and 3) ensuring community safety.

V. COMMUNITY ENGAGEMENT

In April 2019, an overview of the CHNA process and specific findings were disseminated at a community forum held at St. Vincent's Medical Center on behalf of the Health Improvement Alliance. On Thursday, April 4, 2019, 25 people attended the community forum. At this session the group received an overview of the community health needs assessment including a review of the purpose and scope, the 2019 primary and secondary data findings, and the 2019 focus area goals and strategies within each of the three priority areas (Healthy Lifestyles, Access to Care, and Behavioral Health). Participants were then given an opportunity to provide feedback on the 2019 priorities, draft implementation strategies.

In addition, a copy of the 2016 Community Health Needs Assessment and Implementation Plan prepared for HIA, Bridgeport Hospital, and St. Vincent's Medical Center, was made available for public comment for a period of time throughout the 2019 assessment process. Bridgeport Hospital placed a public notice in the Connecticut Post newspaper and created a dedicated email address for the receipt of written comments. No written comments were received.

This Community Health Needs Assessment document combined with the attached *Fairfield County Community Wellbeing Index 2019*, prepared by DataHaven, serves as the CHNA document for Bridgeport Hospital and St. Vincent's Medical Center along with the City of Bridgeport Health & Human Service Administration, Fairfield Health Department, Monroe Health Department, Stratford Health Department, Trumbull Health Department, and other members of HIA. The Community Health Needs Assessment will be made widely available through individual members' websites.

VI. PRIORITIZATION OF HEALTH ISSUES

A. 2016 COMMUNITY HEALTH IMPROVEMENT PLAN PROGRESS-TO-DATE

In 2016, the Primary Care Action Group (comprised of representation from Bridgeport Hospital, St. Vincent's Medical Center, local health departments, community agencies, faith-based organizations, community health centers, universities, town and city agencies and residents) from Bridgeport, Easton, Fairfield, Monroe, Stratford, and Trumbull, completed a CHNA and prioritization process to identify priority health issues. From this work, the coalition selected four areas of focus including: Cardiovascular Disease and Diabetes, Obesity (Healthy Lifestyles), Behavioral Health and Access to Care. Each focus area was assigned an individual task force that was comprised of partners from the Greater Bridgeport region.

The group then developed a Community Health Improvement Plan (CHIP) for each of the four identified focus areas. Each CHIP affirms our commitment to using a collective impact model to affect change, states common values, and identifies clear goals and objectives for the relevant individual focus areas

Since completing its last CHNA in 2016, the partnership has taken multiple steps to further enhance its focus in order to better serve our community. Those steps include:

- In 2017, HIA conduced an internal survey to allow all members the opportunity to help guide the direction of the group by providing valuable feedback, including identifying new potential partners and determining monthly meeting schedules and locations.
- In summer 2018, the Cardiovascular Disease and Diabetes Task Force and Obesity (Healthy Lifestyles) Task Force combined into one group under the name Healthy Lifestyles. The new combined group continues to meet monthly and work on all identified strategies and action steps from the 2016 CHNA. This new streamlined approach to these focus areas allowed for less duplication and more concentrated effort.
- The PCAG partnership officially changed its name in early 2019 to the Health Improvement Alliance (HIA). This new name was chosen to more accurately reflect the current work being done by the group to improve the health of the surrounding community.
- Along with the name change came the development of a new tagline, *Partnering to build healthier communities since 2003*. What was once a group that came together to connect people to primary care has become a partnership working to improve health through multiple strategies and focus areas.
- In 2017, a Tracking and Evaluation Subcommittee was formed and has since developed standardized forms, processes and semiannual dashboards to track progress towards goals for all of the task forces to utilize.
- In 2018, a Communications Subcommittee was formed that helped with the development of the new partnership name, communications plan and website development (to be completed by summer 2019). This was all done in an effort to better communicate our work to the general public.

HIA consists of about 75 individuals that represent different community agencies from around the six town region. Approximately 50 different agencies regularly participate in the monthly meetings of the full HIA, one or more monthly meetings of task forces, or both. Both Bridgeport Hospital and St. Vincent's Medical Center together have served in the lead role for the full HIA partnership and representatives from each hospital co-chair the monthly HIA meeting.

The HIA steering committee meets monthly and a portion of the meeting agenda is focused on report outs from all of the task forces to ensure specific community health improvement plan (CHIP) goals are met and progress is tracked. Each monthly meeting also includes time for partner organization announcements, sharing of news and upcoming events, as well as guest speaker presentations related to the different focus to help ensure that partners are fully informed of resources and initiatives in the service area and state. One meeting each quarter is used as an open discussion of topics of interest to the group that fall outside of the identified focus areas. These in-depth conversations between organizations in neighboring towns has shown to be a valuable way to identify needs and share information on best practices.

The three task forces each hold regular monthly meetings and work on their individual CHIP goals. These meetings include planning for additional data collection, strategies and tactics to address their prioritized health outcomes/social determinants and monitoring of results. Each task force has two or three co-chairs and these individuals represent a variety of community organizations and towns from within the region.

In addition to hosting monthly meetings and overseeing the work of all three task forces, HIA also seeks opportunities to advance the partnerships work towards improved health in the region. One example occurred in the summer of 2018, when HIA hosted a regional symposium on Culturally and Linguistically Appropriate Services (CLAS). This day-long symposium was offered to partners of HIA and the community and was attended by 30 individuals from around the region.

From 2016-2019, task forces have made significant progress towards their CHIP goals in the greater Bridgeport region including:

Access to Care Task Force Accomplishments

Since 2016, the Access to Care Task Force has worked on a variety of issues that impact patients receiving and seeking appropriate medical care. The have focused their main strategies on patient transportation issues, availability of specialty care, seeking appropriate care in the appropriate setting and asthma.

- Developed and implemented a magnet and 1-page informational sheet for providers to distribute to patients. This magnet serves as a way for patients to easily identify the appropriate healthcare providers needed in certain medical situations, with a goal of decreased non-emergency trips to a hospital ED.
- Created a specialty care database and identify gaps and needs in the region.
- Created a dental referral form to pilot at Weisman AmeriCares Free Clinic of Bridgeport in order for their providers to refer patients with dental needs to local clinics. This pilot is still underway and the group is now planning on rolling this process out to other providers.
- Developed a system and communicated it to local providers to help assist patients with setting up a dental appointment.
- As one of the initial accomplishments of the partnership in its early years, the Dispensary of Hope Greater Bridgeport, which is a free pharmacy, served over 4,500 patients in 2017 and has saved patients roughing $1.2 million in medication costs.
- Continues to work closely with Veyo, the Medicaid and Medicare non-emergency medical transportation provider for the state, to identify and troubleshoot issues with non-emergency medical transportation experienced by providers and their patients.
- Worked to build upon the work of the CLAS symposium hosted by HIA in summer 2018, by hosting CLAS learning sessions during three monthly meetings in 2018. This group plans to continue these learning sessions in order to identify current CLAS standards being met by HIA partners and gaps to address.

- The Stratford Health Department has been leading the regional work for Putting on AIRS. They have incorporated a Community Health Worker (CHW) onto the program team. Asthma patients now receive three education visits from Certified Asthma Educators, two visits from the CHW (phone call follow-ups) and one visit from an Environmentalists about housing issues. Since 2017, they have focused on indoor air quality and resolution of in home environmental triggers as well as the Social Determinants of Health that impact a patient's/family's ability to self-manage their asthma. First quarter analysis indicated an improvement in program completion.
- Worked with Bridgeport Hospital to present dental health information at a grand rounds, which was completed in 2018.

Behavioral Health Task Force Accomplishments

Since 2016, the Behavioral Health task force has worked to develop and implement a screening tool for mental health and substance abuse that could be integrated into different types of organizations. After development of the tool, potential sites to implement this new screener were identified, and staff at each site were trained to use the tool. In addition to this work, this group continues to oversee the work of the Community Care Team (CCT). The purpose of the CCT is to increase access to services by improving the coordination of care for frequent users of ED in local hospitals with behavioral health needs.

- Held weekly meetings of the CCT and in February of 2018, the CCT process was refined under the direction of a new facilitator.
- Developed a tool to integrate mental health and substance abuse screenings into urgent care and municipal settings. The tool has been utilized at municipal human services departments.
- Supported public awareness campaigns to de-stigmatize issues around mental health and provide training to providers and support to patients and their families.

Healthy Lifestyles Task Force Accomplishments

In summer of 2018, the Cardiovascular Disease and Diabetes task force and Obesity (Healthy Lifestyles) task force combined into one group under the name Healthy Lifestyles. This combined task force has worked towards preventing chronic diseases, particularly cardiovascular disease and diabetes, through promoting healthy lifestyle choices. Know Your Numbers (KYN), a community-based health screening program for food pantries and other venues, that was developed by the Cardiovascular Disease and Diabetes Task Force in 2014, continued and was expanded upon by the Healthy Lifestyles Task Force.

- Hosted an annual free family fitness event in Stratford 2016-2018 and Bridgeport in 2019. These events all included physical activity demonstrations and classes, information on local resources and activities for families to encourage movement and healthy lifestyle choices.
- Developed the Get Healthy Walk 'n Talk program in 2016. The walks are way to bring local healthcare professionals and community residents together for physical activity. Since then, 32 total Get Healthy Walk 'n Talks have taken place throughout the region in Bridgeport, Stratford, Fairfield and Trumbull. Also created a Get Healthy Walk 'n Talk Toolkit which allows other towns outside of the greater Bridgeport region to replicate the program. Successful walks have taken place in multiple towns beyond the region.
- Offered six smoking cessation programs throughout Fairfield, Stratford and Trumbull.
- Evaluated implementation of a regional bike share program to greater Bridgeport. A subgroup of the task force identified potential partners, worked with town officials to receive approvals and conducted surveys with residents and employees that live and work in all six towns. Planning continues today and each town involved is invested in moving this program forward.

- Promoted healthy worksites through the creation of a Get Healthy Pledge. The pledge form contains three different types of initiatives that organizations could commit to. These included building a culture of health by integrating existing Get Healthy CT resources into the workplace, improving healthy eating options within the organization and increasing physical activity opportunities for employees. To date, 17 local organizations have signed the pledge to implement healthy eating and/or physical activity initiatives in their organization.
- In 2019, the City of Bridgeport passed a local Tobacco21 ordinance.
- From 2016-2019, 1,316 individual KYN screenings were conducted in food pantries in the region. This combined with screenings offered by partner organizations in other venues for approximately 3,000 individual screenings completed since the program began in 2014.
- Since 2016, several enhancements were implemented into the KYN screening program. Those include:
    - Offered a Nutrition 101 program for food pantry managers and volunteers. 37 people total attended trainings and scores on the post-test increased an average of 26%.
    - Worked with three pantries to implement Supporting Wellness At food Pantries (SWAP), a nutritional ranking system developed by the UConn Rudd Center and Saint Joseph's University.
    - In 2017, received funding through the Bridgeport Rotary Foundation to expand SWAP in three additional food pantries.
    - In 2019, added the hemoglobin A1c screening to KYN to identify those with pre-diabetes and uncontrolled diabetes.
    - In 2019, distributed automated blood pressure cuffs to all those who were screened with elevated blood pressure, in total 59% of all those who were screened.
- In 2018, the KYN team partnered with community health workers from Southwestern Area Health Education Center (SWAHEC) to provide screening participants connections to local resources. From February 2018-March 2019, 156 KYN participants were seen by CHWs to be referred to community resources. CHWs provided the most referrals to primary care for screening follow-up, followed by referrals for clothing needs, energy assistance programs, and diaper banks.
- 15 different sites in the region joined the American Heart Association Check It! Connecticut challenge, a four-month long evidence based program that provides health education while encouraging individuals to self-monitor their blood pressure numbers. These sites received stroke awareness and education materials, impacting approximately 2,500 people.
- Optimus Health Care in Bridgeport, a federally qualified health center, hired two community health workers who conducted blood pressure screenings in community locations. They also identified community pharmacists to provide Medication Therapy Management (MTM) and created a workflow between the pharmacy and those suffering from high blood pressure.

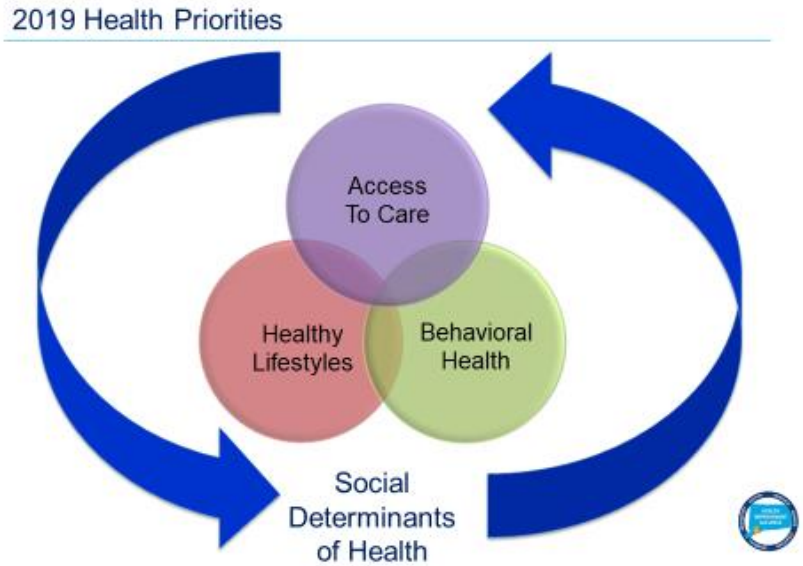
B. 2019 PRIORITIZATION OF HEALTH ISSUES

As part of the CHNA engagement process, Health Equity Solutions (HES) worked with HIA to develop a process to prioritize health issues for the Greater Bridgeport region. Following data collection from the 2018 DataHaven Community Wellbeing Survey, key informant interviews, and community conversations, each of the three HIA Task Forces met with Health Equity Solutions to prioritize health issues, develop measurable goals, set indicators, and identify strategies and actions for each priority.

As background, HIA's work is structured around Task Forces that reflect the four health priority areas identified during the 2013 planning cycles: Cardiac / Diabetes, Healthy Lifestyles, Behavioral Health and Access to Care. The same priorities were confirmed during the 2016 planning process. In 2019, concurrent with the Community Health Needs Assessment and Community Health Improvement Plan process, HIA restructured the Task Forces to focus on three priority areas: Healthy Lifestyles (combines the Healthy Lifestyles and Cardiac / Diabetes Task Forces), Behavioral Health and Access to Care (Figure 7). Based on the feedback from the prioritization sessions, community health improvement plans (CHIPs) were developed for each of the three priority areas. These focus areas will be addressed through a Social Determinants of Health lens.

Health Equity Solutions facilitated three, 1.5-hour prioritization sessions covering each of the Task Forces in February 2019. At each session, participants generated and refined goal statements and identified tracking indicators and potential strategies for each goal, then ranked each. A total of 38 HIA members attended the prioritization sessions. Priorities defined by the Task Forces served as the basis for Community Health Improvement Plans (CHIP) addressing each priority area for the Greater Bridgeport region over the next three years (2019-2022). The resulting CHIP was presented to the full HIA collaborative on March 26, 2019 to finalize priorities. In attendance were 22 HIA members. Finally, the community health improvement plans (CHIP) and data from the 2019 DataHaven Community Wellbeing Survey, key informant survey and the community conversations were presented at a public forum on April 4, 2019 and 25 people attended. Following the presentation of the data, participants were given the opportunity to provide feedback on the data and plans.

Figure 7: Primary Care Action Group Priority Health Areas



VII. COMMUNITY HEALTH IMPROVEMENT PLAN

In addition to guiding future services, programs and policies for the Health Improvement Alliance members and the overall area, the Community Health Needs Assessment and Community Health Improvement Plan are also prerequisites for health departments to earn voluntary accreditation, and for hospitals to maintain their tax-exempt status.

The 2019 Community Health Improvement Plan was developed over the period of January 2018 through April 2019, using the key findings from the Community Health Needs Assessment, which included primary data from the 2018 Community Wellbeing Survey, community conversations, and key informant surveys that were conducted locally, as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas.

As was the case in 2013 and in 2016, the Health Improvement Alliance was responsible for overseeing the Community Health Needs Assessment, identifying health priorities, and overseeing the development of the Community Health Improvement Plans. A core coordinating committee was responsible for the overall management of the process, and Community Health Improvement Plan Task Forces, which represented broad and diverse sectors of the community, were continued in each health priority area. The CHIP Task Forces developed goals, objectives, strategies, and action steps for their respective components of the Health Improvement Plan.

Health Improvement Alliance members outlined compelling and inspirational vision and mission statements to support the planning process and the CHIP.

Vision: To work together as a coalition to identify, prioritize, and measurably improve the health of our community, through healthcare prevention, education, and services

Mission: To improve the health of the community

A. OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PROCESS

- **What is a Community Health Improvement Plan?**
  A Community Health Improvement Plan or CHIP is an action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed, including strategies and indicators for measurement, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.

- **How to use a CHIP**
  A CHIP is designed to be a broad strategic framework for community health and should be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives so that all community groups and sectors – private and nonprofit organizations, government agencies, academic institutions, community – and faith-based organizations can participate in the effort and unite to improve the health and quality of life for all people who live, work, and play in a certain region, in this case, Greater Bridgeport.

- **Methods**
  Building upon the key findings identified in the Community Health Needs Assessment, the CHIP aims to:
  - Identify priority issues for action to improve community health
  - Develop and implement an improvement plan with performance measures for evaluation
  - Guide future community decision-making related to community health improvement

In addition to guiding future services, programs, and policies for participating agencies and the area overall, the Community Health Improvement Plan fulfills the prerequisites for a hospital to submit to the IRS as proof of its community benefit and for a health department to earn voluntary accreditation, which indicates that the agency is meeting national standards.

To develop the Community Health Needs Assessment and the Community Health Improvement Plan, the Health Improvement Alliance (which includes representatives from local public health entities) was the convening organization that brought together community residents and the area's influential leaders in healthcare, community organizations, and other key sectors, including mental health, local government, and social services. Using the guidelines of the Association for Community Health Improvement (ACHI) an improvement process was designed to incorporate the following steps:

1) Reflect and strategize;
2) Identify and Engage Stakeholders;
3) Define the Community;
4) Collect and Analyze Data
5) Prioritize Community Health Issues;
6) Document and Communicate Results;
7) Plan Implementation Strategies;
8) Implement Strategies;
9) Evaluate Progress

B. DEVELOPMENT OF THE 2019 CHIP STRATEGIC COMPONENTS

The three HIA task force groups (Access to Care, Healthy Lifestyles, and Behavioral Health) convened regularly from February to March 2019 and actively used the CHNA findings to review goals, objectives, and strategies to pursue for the next three-year cycle. From these meetings, groups developed a 2019 Community Health Improvement Plan document that is organized by the priority areas and includes specific goals, measurable indicators (short and long-term), strategies, action steps, and partners. These meetings were in part facilitated by Health Equity Solutions and members of the Health Improvement Alliance.

C. PLANNING FOR ACTION AND MONITORING PROGRESS

Progress will be monitored at routine monthly task force meetings and monthly HIA meetings using a monitoring tool developed to track the specific goals, objectives, and strategies identified in each area. If gaps in resources are identified, HIA will extend collaborative efforts to other organizations and programs that are currently providing those services as a means to foster relationships and efficiently meet the needs of the community members.

The *Fairfield County Community Wellbeing Index 2019*, hospital data and other resources identified in the CHIP provide common measurement indicators to monitor and evaluate progress on the implementation strategies.

D. COMMUNITY HEALTH IMPROVEMENT PLAN

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of where the Health Improvement Alliance would like to be, and clear evaluation of whether the collaborative efforts are making a difference. There are also a companion plans detailing implementation strategies to be addressed by Bridgeport Hospital and by St. Vincent's Medical Center. The following pages outline the goals, strategies, action steps, and indicators for the four health priority areas outlined in the Community Health Improvement Plan for the Coalition as well as Bridgeport Hospital and St. Vincent's Medical Center.

1. COMMUNITY HEALTH IMPROVEMENT PLAN: HEALTH IMPROVEMENT ALLICANCE

2019-22 Community Health Needs

Community Health Improvement Plan

Priority Area: Healthy Lifestyles

Indicator: % of people in Greater Bridgeport who have been told that they have high blood pressure [2015- 28%, 2018-30%], diabetes [2015- 9%, 2018- 11%] or heart disease [2015- 5%, 2018-5%]

Indicator: Current smoking [2015-15%, 2018- 15%] and vaping rates [2015-N/A, 2018- 10%] for Greater Bridgeport

Indicator: % of people in Greater Bridgeport who agree that there are safe places to walk [2015- 66%, 2018- 67%] or bike [2015- 55%, 2018-55%] in or near their neighborhood

Indicator: % of people in Greater Bridgeport who indicate that their neighborhood has either excellent or good access to affordable, high quality fruits and vegetables [2015- N/A 2018-65%]

**Source- DataHaven Community Wellbeing Survey 2015 and 2018*

Goal: By February 2022, promote healthy lifestyles in the Greater Bridgeport region to reduce diagnosed hypertension and diabetes in adults by 3%.

Strategy	Action Steps	Outcomes
Continue Know Your Numbers program in the Greater Bridgeport region	• Utilize American Heart Association's Life's Simple 7 • Design a KYN campaign targeted to adults ages 18-49 • Determine effectiveness of KYN screenings in their current sites and work with task force partners to make adjustments as needed based on data available • Continue to partner with community health workers to link KYN participants to follow-up care • Determine effectiveness of expanding KYN to include hA1c screenings and practice providing automated BP cuffs for ongoing BP monitoring and expand where feasible	# of people screened through KYN # of KYN participants connected to follow-up health care
Increase number of days per week of exercise among adults in Greater Bridgeport	• Determine barriers related to access to available free and low-cost fitness opportunities and develop ways to address these • Continue to work towards regional Bike Share programs and promote/support safe biking/walking in neighborhoods through complete streets policies, partnerships with police/law enforcement, planning and zoning, and other city/town officials	Track implementation of regional bike shares # of people who utilize the available bike shares

Priority Area: Healthy Lifestyles , continued

Strategy	Action Steps	Outcomes
Decrease rates of residents who report use of tobacco and e-cigarettes/vaping products	• Develop an educational campaign around e-cigarettes/vaping • Identify local youth prevention coalitions and collaborate to track vaping usage in youth • Promote Tobacco 21 ordinance roll out in the City of Bridgeport and support the passage of local ordinances or state laws around Tobacco 21 • Promote local tobacco cessation resources	Track vaping usage among youth # of local Tobacco 21 ordinances/track the passage of a state law # of participants referred to tobacco cessation resources
Increase access to healthy food and address other social determinants of health (SDOH) in the Greater Bridgeport region	• Evaluate implementing prescription to fruit and vegetable programs • Determine national best practices for addressing SDOH as related to healthy lifestyles and decreasing hypertension and diabetes • Start to build partnerships to work towards addressing SDOH, potential areas include Adverse Childhood Experiences (ACES), advocacy around increasing the minimum wage, WIC and SNAP acceptance in more venues	TBD as local initiatives are developed

Partner Organizations

Bridgeport Hospital, St. Vincent's Medical Center, Bridgeport Health Department, Stratford Health Department, Trumbull Health Department, Fairfield Health Department, Monroe Health Department, American Heart Association, Hispanic Health Council, St. Vincent's Medical Center Parish Nurses, American Diabetes Association, Central Connecticut Coast YMCA, Bridgeport Regional Business Council, Bridgeport Food Policy Council, Council of Churches of Greater Bridgeport, local feeding programs, Sacred Heart University, Fairfield University, Bridgeport Farmers' Market Collaborative, Wakeman Boys and Girls Club, local businesses and non-profits, local municipalities

Priority Area: Access to Care

Indicator: Percentage of people in Greater Bridgeport that indicate that they do not have a medical home [2015- N/A, 2018-14%]
Indicator: Percentage of people in Greater Bridgeport that have indicate that they have been to the dentist in the last year [2015- 74%, 2018-71%]
Indicator: Percentage of people in Greater Bridgeport who report missing a doctor's appointment or a visit to a health care provider because they did not have access to reliable transportation [2015- N/A, 2018-40%]
Indicator: Percentage of people in Greater Bridgeport who indicate being treated with less respect or received services that were not as good while seeking health care [2015- N/A, 2018-11%]
**Source- DataHaven Community Wellbeing Survey 2015 and 2018*

Goal: By February 2022, only 13% of adults in Greater Bridgeport will report not having a medical home and 74% will report visiting a dentist at least once in the past year

Strategy	Action Steps	Outcomes
Promote available medical services in the Greater Bridgeport region to positively impact the number of individuals who have a medical home	• Determine how to best educate the community about the importance of having a medical home, particularly in the young adult population and implement strategies as appropriate • Promote available medical services in the region • Collaborate to increase referrals from partner organizations to primary care providers	# of referrals
Promote available dental services in the Greater Bridgeport region to positively impact the number of individuals who see a dental provider at least once a year	• Produce and distribute educational materials on the importance of dental care • Promote available dental services in the region • Continue to improve and expand the dental referral system between partner organizations • Advocate for improved dental insurance coverage	# of CHWs in GBT region who have successfully completed a dental training workshop # of referrals % change in dental service utilization

Priority Area: Access to Care, continued

Strategy	Action Steps	Outcomes
Increase access to specialty care providers	• Identify gaps in specialty care access for Medicaid and uninsured patients and investigate ways to increase availability and access • Collaborate with specialty care providers to increase the number of providers who accept Medicaid and uninsured patients • Continue to work on asthma initiatives	# of focus groups with specialty care providers # of new providers accepting Medicaid and uninsured patients Annual update of specialty care database
Continue to work with partners to improve access to reliable medical transportation	• Continue to be involved in the state medical transportation efforts and share local experiences at the state level • Continue communications with Veyo and invite them to task force meetings for quarterly updates and communicate those updates with partners organizations • Determine accessibility of additional medical transportation options, including public transportation and medical ride programs and develop strategies based on this assessment	# of task force meetings attended by Veyo Track initiatives and local outcomes with Veyo
Increase implementation of Culturally and Linguistically Appropriate Services (CLAS) standards by health care organizations in the Greater Bridgeport region	• Complete a CLAS assessment with local partner organizations to determine current gaps and implement CLAS strategies as needed • Collect CLAS implementation tools and disseminate within partner organizations within Access to Care and throughout PCAG organizations	# of organization assessments completed

Partner Organizations

Bridgeport Hospital, St. Vincent's Medical Center, Optimus Healthcare, Southwest Community Health Center, University of Bridgeport, Visiting Nurses Association of Connecticut, Americares, Connecticut Oral Health Initiative, CT Dental Health Partnership, Southwestern AHEC, Bridgeport Health Department, Stratford Health Department, Trumbull Health Department, Fairfield Health Department, Monroe Health Department

Priority Area : Behavioral Health

Indicator: Percentage of people in the Greater Bridgeport region who indicate that they receive the social and emotional support they need **[DHWS, 2018 Baseline: 66% Always/Usually]**

Indicator: Percentage of people in the Greater Bridgeport region who indicate how satisfied they are with their lives **[DHWS, 2018 Baseline: 36% Not all to somewhat satisfied]**

Indicator: Percentage of people in the Greater Bridgeport region who indicate that they felt down, depressed or hopeless in the past two weeks **[DHWS,2018 Baseline: 65% Not all]**

**Source- DataHaven Community Wellbeing Survey 2015 and 2018*

Goal: By February 2022, the Health Improvement Alliance's (HIA) efforts will result in a 2% increase in social and emotional support for adults in the Greater Bridgeport area.

Strategy	Action Steps	Outcomes
Increase access to mobile and community-based services and supports for behavioral health in the Greater Bridgeport area	• Align resources and build collaboration between organizations to increase access and awareness to community health workers and peer support specialists • Participate in funding opportunities such as BUILD Health • Develop strategies to link clinical and non-clinical services • Establish or expand mobile or community based resource in the greater Bridgeport area	# of initiatives to increase access/awareness for community health workers and peer support specialists # of funding opportunities with participation of members # of strategies to link clinical and non-clinical services # of initiatives to establish or expand mobile or community based resources
Develop targeted messaging around behavioral health in the Greater Bridgeport area to increase awareness of available resources	• Educate providers on resources (physicians, hospitals, others) • Develop strategy to educate the general community on available resources for non-crisis services • Develop strategy to educate the general community on available resources for crisis services • Develop strategies to reach selected communities (youth, young adult, elderly, etc)	# provider education initiatives # educational strategies for non-crisis services # educational strategies for crisis services # strategies to reach selected communities

Priority Area : Behavioral Health, continued

Strategy	Action Steps	Outcomes
Improve the coordination of care for frequent users of ED in local hospitals	• Refine Bridgeport Community Care Team (CCT) • Improve attendance at meetings and involvement of organizations • Establish a dedicated patient navigator for CCT • Improve information sharing across organizations • Track outcomes and share results on a quarterly basis • Evaluate state and local best practices for improvement of CCT including re-establishing participation in Health and Housing stability work group	# organizations actively involved from current to end of CHIP Establishment of patient navigator Tracking/results sharing improvement
Partner Organizations		
Operation Hope, CCAR, Supportive Housing Works, Town of Monroe, St. Vincent's Medical Center, DMHAS SWCMHS, City of Fairfield, Bridgeport Hospital, YNHHS, Town of Trumbull, Optimus, RNP, SWCHC, Beacon Health Options, Town of Stratford, The Hub, Town of Easton, SWAHEC		

2. COMMUNITY HEALTH IMPROVEMENT PLAN: BRIDGEPORT HOSPITAL

Yale NewHaven Health Bridgeport Hospital

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

Community Health Improvement Plan

May 23, 2019

Priority Area: Healthy Lifestyles

Indicator: % of people in Greater Bridgeport who have been told that they have high blood pressure [2015- 28%, 2018-30%], diabetes [2015- 9%, 2018- 11%] or heart disease [2015- 5%, 2018-5%]

Indicator: Current smoking [2015-15%, 2018- 15%] and vaping rates [2015-N/A, 2018- 10%] for Greater Bridgeport

Indicator: % of people in Greater Bridgeport who agree that there are safe places to walk [2015- 66%, 2018- 67%] or bike [2015- 55%, 2018-55%] in or near their neighborhood

Indicator: % of people in Greater Bridgeport who indicate that their neighborhood has either excellent or good access to affordable, high quality fruits and vegetables [2015- N/A 2018-65%]

Goal: By February 2022, promote healthy lifestyles in the Greater Bridgeport region to reduce diagnosed hypertension and diabetes in adults by 3%.

Strategy	Action Steps	Outcomes
Participate in and provide support for Health Improvement Alliance (HIA)	• Provide in-kind and financial support for Get Healthy CT • Co-host collaborative health/wellness events with community partners	# of health/wellness events
Provide in-kind and financial support to area organizations	• Provide in-kind and financial resources to organizations to promote healthy lifestyles	$ community benefit
Provide programs to support the healthy lifestyles of our patients	• Offer healthy lifestyles education to patients, such as the monthly breast feeding class at the PCC, nutrition counseling in diabetes clinic and others • Conduct educational programs and lectures in the community on topics such as falls prevention, nutrition and others and promote to patients • Evaluate opportunities for initiatives to enhance healthy lifestyle of patients • Pursue funding for initiatives through grants or philanthropy • Track ROI where applicable	# of programs for patients/# of participants # of community programs # of initiatives $ funding secured ROI

Priority Area: Healthy Lifestyles, continued

Strategy	Action Steps	Outcomes
Provide programs to improve the health of employees	• Encourage employee involvement in personal health through the Know Your Numbers program for employees • Enhance health coaching and other services and programs to employees through *livingwellcares* program • Develop programs relating to chronic disease and smoking/vaping cessation for employees • Promote opportunities for employees to be physically active • Pursue funding for initiatives through grants or philanthropy • Track ROI where applicable	% of employees screened # of employee participants # of programs/# of participants $ funding secured ROI
Support healthy lifestyles in the community	• Lead Get Healthy CT and enhance its services and program • Support community programs that promote healthy lifestyles such as helping to staff the community based Know Your Numbers Screenings, Get Healthy Walk 'n Talks and health fairs • Provide speakers for community presentations on different healthy living topics • Conduct annual Community Baby Shower • Identify resource gaps in the community and work with partners to develop approaches to fill the gaps	# of events # of presentations # of social media posts # of participants at annual event

Yale NewHaven Health Bridgeport Hospital

Priority Area: Healthy Lifestyles, continued

Strategy	Action Steps	Outcomes
Increase access to healthy food options	• Implement new initiatives to help offer healthy food options within the hospital facilities to patients, staff and visitors • Ensure access to fresh fruits and vegetables for patients, staff and visitors through programs such as farmers markets and CSAs offered on-site • Work with partners to expand access to free, fresh fruits and vegetables to the community through programs such as the Connecticut Food Bank Mobile Food Pantry • Utilize Get Healthy CT social media to disseminate healthy eating information • Pursue funding for initiatives through grants or philanthropy • Track ROI where applicable	# of healthy food initiatives # of programs/# of people served # of programs/# of people served $ funding secured ROI
Participate in healthy lifestyle opportunities for the Milford local community	• Review information for the Milford local community from 2019 Community Health Needs Assessment (CHNA) for Milford Hospital and the Healthier Greater New Haven Partnership • Participate in community focused efforts related to healthy lifestyles as indicated in the CHNA	# program/# of people served

Priority Area: Access to Care

Indicator: Percentage of people in Greater Bridgeport that indicate that they do not have a medical home [2015- N/A, 2018-14%]
Indicator: Percentage of people in Greater Bridgeport that have indicate that they have been to the dentist in the last year [2015- 74%, 2018-71%]
Indicator: Percentage of people in Greater Bridgeport who report missing a doctor's appointment or a visit to a health care provider because they did not have access to reliable transportation [2015- N/A, 2018-40%]
Indicator: Percentage of people in Greater Bridgeport who indicate being treated with less respect or received services that were not as good while seeking health care [2015- N/A, 2018-11%]

Goal: By February 2022, only 13% of adults in Greater Bridgeport will report not having a medical home and 74% will report visiting a dentist at least once in the past year

Strategy	Action Steps	Outcomes
Participate in and provide support for Health Improvement Alliance (HIA)	• Provide in-kind and financial support for access to care initiatives • Co-host collaborative events with community partners to ensure access to care	# of events related to access
Provide in-kind and financial support to area organizations	• Provide in-kind and financial resources to organizations to ensure access to care	$ community benefit

Provide access to care for underserved populations	• Provide free care and Medicaid services
	• Operate outpatient primary and specialty care clinics for eligible individuals
	• Offer financial assistance information and other information in English and Spanish
	• Identify barriers or gaps in care and develop strategies to increase access
	• Pursue funding for initiatives through grants or philanthropy
	• Track ROI where applicable
		$ free care
		$ Medicaid under reimbursement
		# enrolled primary clinic patients
		# specialty clinic patients
		$ funding secured
		ROI

Yale NewHaven Health Bridgeport Hospital

Priority Area: Access to Care, continued

Strategy	Action Steps	Outcomes
Promote diversity & inclusion to reduce discrimination and improve access to care.	• Conduct Diversity and Inclusion Council initiatives within Bridgeport Hospital • Conduct Diversity and Inclusion Council initiatives in the Bridgeport Hospital community	# of D&I initiatives
Participate in community meetings and events to understand the needs of community residents	• Increase involvement in community events such as staff serving as guest speakers and staffing health screenings as appropriate • Lead the efforts of HIA • Actively involve staff in local groups such as the Nursing Professional Governance Councils, HIA, Neighborhood Revitalization Zone (NRZ) meetings, Bridgeport City Council and others to ensure medical needs of the community are being met	# of events # of HIA meetings # of groups participating in/# of staff on committees
Offer a variety of services that meet the needs of patients	• Promote hospital services through community outreach events, such as health fairs, community presentations and others • Connect ED patients to hospital primary care services, through initiatives such as implementation of next day appointment times made available for ED discharges at the PCC • Ensure convenience of patient services for example extended evening hours at the Primary Care Center and other initiatives • Refer patients to medication resource initiatives such as the Dispensary of Hope and medication management programs • Offer additional services that meet non-medical needs of patients, such as maintaining the Care Closet, hat/scarf drives, toy drives and others as appropriate • Pursue funding for initiatives through grants or philanthropy • Track ROI where applicable	# of community outreach events # ED patients enrolled at PCC # patients utilizing extended hours # referrals to medication resource programs $ funding secured ROI

Yale NewHaven Health Bridgeport Hospital

Priority Area: Access to Care, continued

Strategy	Action Steps	Outcomes
Increase utilization of available community resources to meet non-medical and SDOH needs	• Screen for social determinants of health (SDOH) and connect patients with available resources through means such as social workers, Community Advocates, care coordination program and others • Establish resources for patients such as the Care Closet, employee giving campaign • Connect employees and their families with needed care through the Employee/Family Resources program • Provide access to funds such as the Fay Fund for non-medical needs	# of referrals through Community Advocates Program # of referrals for employees/families $ funds dispersed through Fay Fund # people served through resource programs
Increase access to reliable non-emergency medical transportation	• Partner with the state to improve the non-emergency medical transportation system though efforts with Veyo and sharing local experiences at the state level • Provide alternative medical transportation options to patients, like Uber Health and others through the transportation assistance fund	Track communication/progress with Veyo # rides via Uber Health Patient satisfaction with Uber Health $ funds dispersed through transportation assistance fund
Participate in access to care opportunities for the Milford local community	• Review information for the Milford local community from 2019 Community Health Needs Assessment (CHNA) for Milford Hospital and the Healthier Greater New Haven Partnership • Participate in community focused efforts related to access to care as indicated in the CHNA	# program/# of people served

Priority Area : Behavioral Health

Indicator: Percentage of people in the Greater Bridgeport region who indicate that they receive the social and emotional support they need [DHWS, 2018 Baseline: 66% Always/Usually]

Indicator: Percentage of people in the Greater Bridgeport region who indicate how satisfied they are with their lives [DHWS, 2018 Baseline: 36% Not all to somewhat satisfied]

Indicator: Percentage of people in the Greater Bridgeport region who indicate that they felt down, depressed or hopeless in the past two weeks [DHWS,2018 Baseline: 65% Not at all]

Goal: By February 2022, the Health Improvement Alliance's (HIA) efforts will result in a 2% increase in social and emotional support for adults in the Greater Bridgeport area.

Strategy	Action Steps	Outcomes
Participate in and provide support for Health Improvement Alliance (HIA)	• Co-host collaborative behavioral health events with community partners	# of behavioral health events
Provide in-kind and financial support to area organizations	• Provide in-kind and financial resources to organizations to promote behavioral health programs and services	$ community benefit
Provide services to support the behavioral health needs of the community	• Through REACH, provide intake assessments, medication management, group therapy, case management and after care planning for children, adolescents and adults • Explore opportunities to provide addiction services, such as an addiction interventionist, in additional locations beyond the ED • Refer geriatric patients to community programs to help with feelings of isolation and depression, such as adult daycares, assisted living programs, exercise programs and senior centers	# of patients in programs # of programs offered/# patients assisted # of patients referred to services # of presentations # of people referred to programs # of violence prevention initiatives

Yale NewHaven Health Bridgeport Hospital

Priority Area : Behavioral Health, continued

Strategy	Action Steps	Outcomes
Provide services to support the behavioral health needs of the community (cont)	• Provide speakers for mental health presentations in the community as requested • Refer families to support programs such as the Adjust to Diagnosis program • Partner with community leaders on violence prevention efforts in the community • Seek opportunities to partner with community based organizations on new programs to address unmet need • Pursue funding for initiatives through grants or philanthropy • Track ROI where applicable	$ funding secured ROI
Provide mental health resources for employees and their families	• Offer resources and programs related to stress management and other mental health issues to employees and their families	# of programs offered # of employees participating in programs
Improve the coordination of care for frequent users of ED	• Participate in the Community Care Team (CCT) to determine needs of high ED utilizers and refer them to appropriate care • Refer patients to services through the addiction specialist, addiction interventionist, care coordinators and others to help meet the needs of patients • Pursue funding for initiatives through grants or philanthropy • Track ROI where applicable	Track results of CCT Track referrals to services $ funding secured ROI
Provide referrals to services to support behavioral health needs of patients	• Utilize social workers to identify patient needs and connect them to available resources in the community such as Child First, REACH and others • Identify additional community resources for patients	# of referrals to programs

Yale NewHaven Health Bridgeport Hospital

Priority Area : Behavioral Health, continued

Strategy	Action Steps	Outcomes
Participate in access to behavioral health opportunities for the Milford local community	• Review information for the Milford local community from 2019 Community Health Needs Assessment (CHNA) for Milford Hospital and the Healthier Greater New Haven Partnership • Participate in community focused efforts related to behavioral health as indicated in the CHNA	# program/# of people served

Health Areas that will be addressed with existing Bridgeport Hospital resources

The Bridgeport Hospital Community Health Improvement Plan / Implementation Strategies are comprehensive to address the three areas prioritized through the Community Health Needs Assessment Process. Other areas identified through the Community Health Needs Assessment process will not be specifically addressed as part of this effort by Bridgeport Hospital due to resource constraints but are already being addressed through existing services and initiatives, as outlined below.

Health Issue	Sample Listing of Existing Programs and Resources
Cancer	Outreach and screening activities including: Fairfield County Health and Wellness Fair participation with Colon Cancer educational table and Breast Cancer educational table; Colon Cancer educational table in Bridgeport Hospital; Head & Neck Screening at Park Avenue Medical Center (PAMC); Cancer Survivors Day at PAMC; Skin Screening at PAMC; Prostate Screening at Bridgeport Hospital; High Risk Breast Cancer CME program for providers; Pink Pledge walk; Multiple events using mammography van; and DPH grant for screening and services for low income women for breast and cervical cancer
Injury Mortality	Eight week training course held with various local organizations on falls prevention primarily focused on seniors; Geriatric assessments for older adults to assess for safety and health concerns; Geriatric home visits bring care to home bound adults as well as assesses their safety within the home; AARP Senior Driving Safety Program offered monthly at the hospital; Programs to test hearing and treats dizziness; Medication management for seniors ; Conservatorships if needed; Geriatric Emergency Medical Service – have staff in ED to look at 65+ patients immediately when they come into the ED; and Evaluations for cognitive impairment to ensure patients can manage themselves. Offer services through the Geriatric Injury Institute.
Healthy Birth Outcomes	Child birth education classes; Infant CPR; Breast feeding classes and one on one sessions; Hearing screens on all newborns; All nurses receive training in lactation and breast feeding support to offer assistance to mothers both pre and post birth; car seat safety information; Postnatal follow up program/wellness check program will begin and has been funded though philanthropy; education on pregnancy diet, exercise, encourages walking, and other topics to maintain the health of the mother and unborn child in the Primary Care Clinic along with free breast feeding class at 28 weeks; and On-going education at prenatal visits

3. COMMUNITY HEALTH IMPROVEMENT PLAN: ST. VINCENT'S MEDICAL CENTER

2019 Community Health Improvement Plan
Implementation Strategies

2019 Community Health Improvement Plan

Implementation Strategies

Priority Area: Healthy lifestyles		
Indicator: % of people in Greater Bridgeport who have been told that they have high blood pressure **[2015- 28%, 2018-30%],** diabetes **[2015- 9%, 201.8-11%]** or heart disease **[2015- 5%, 2018-5%]** **Indicator:** Current smoking **[2015-15%, 2018-15%]** and vaping rates **[2015-N/A, 2018- 10%] for** Greater Bridgeport **Indicator:** % of people in Greater Bridgeport who agree that there are safe places to walk **[2015- 66%, 2018- 67%]** or bike **[2015- 55%, 2018-55%]** in or near their neighborhood **Indicator:** % of people in Greater Bridgeport who indicate that their neighborhood has either excellent or good access to affordable, high quality fruits and vegetables **[2015- N/ A 2018-65%]** *" Source—DataHaven Community Wellbeing Survey 2015 and 2018*		
Goal: By February 2022, promote healthy lifestyles in the Greater Bridgeport region to reduce diagnosed hypertension and diabetes in adults by 3%.		
Strategy	**Action Steps**	**Outcomes**
Continue Know Your Numbers program in the Greater Bridgeport region	• Utilize American Heart Association's Life's Simple 7 • Design a KYN campaign targeted to adults ages 18-49 • Determine effectiveness of KYN screenings in their current sites • and work with task force partners to make adjustments as needed based on data available • Continue to partner with community health workers to link KYN participants to follow-up care • Determine effectiveness of expanding KYN to include hAlc screenings and practice providing automated BP cuffs for ongoing • BP monitoring and expand where feasible • St. Vincent's will enhance the existing blood pressures screenings in the lobby to provide free automated blood pressure cuffs with education on usage and tracking guides to those people who screen >135 systolic or >85 diastolic.	# of people screened through KYN # of KYN participants connected to follow-up health care # of free automated blood pressure cuffs provided in the lobby at St. Vincent's.

Priority Area: Healthy lifestyles, continued		
Strategy	**Action Steps**	**Outcomes**
Increase number of days per week of exercise among adults in Greater Bridgeport	• Determine barriers related to access to available free and low-cost fitness opportunities and develop ways to address these • Continue to work towards regional Bike Share programs and promote/support safe biking/walking in neighborhoods through complete streets policies, partnerships with police/law enforcement, planning and zoning, and other city/town officials	Track implementation of regional bike shares # of people who utilize the available bike shares
Strategy	**Action Steps**	**Outcomes**
Decrease rates of residents who report use of tobacco and e-cigarettes / vaping products	• Develop an educational campaign around e-cigarettes/vaping • Identify local youth prevention coalitions and collaborate to track vaping usage in youth • Promote Tobacco 21 ordinance roll out in the City of Bridgeport and support the passage of local ordinances or state laws around Tobacco 21 • • Promote local tobacco cessation resources	Track vaping usage among youth # of local Tobacco 21 ordinances/track the passage of a state law # of participants referred to tobacco cessation resources
Strategy	**Action Steps**	**Outcomes**
Increase access to healthy food and address other social determinants of health (SDOH) in the Greater Bridgeport region	• Evaluate implementing prescription to fruit and vegetable programs • Invite the CT Food Bank Mobile Pantry to distribute free food from the St. Vincent's parking lot once monthly. • Determine national best practices for addressing social determinants of health as related to healthy lifestyles and • decreasing hypertension and diabetes • Start to build partnerships to work towards addressing SDOH, potential areas include Adverse Childhood Experiences (ACES), advocacy around increasing the minimum wage, WIC and SNAP acceptance in more venues.	TBD as local initiatives are developed # of people served by the CT Food Bank Mobile Pantry at St. Vincent's.

Priority Area: Access to Care		
Indicator: Percentage of people in Greater Bridgeport that indicate that they do not have a medical home **[2015- N/ A, 2018-14%)** **Indicator:** Percentage of people in Greater Bridgeport that have indicate that they have been to the dentist in the last year **[2015- 74%, 2018-71%)** **Indicator:** Percentage of people in Greater Bridgeport who report missing a doctor's appointment or a visit to a health care provider because they did not have access to reliable transportation **[2015- N/A, 2018-40%)** **Indicator:** Percentage of people in Greater Bridgeport who indicate being treated with less respect or received services that were not as good while seeking health care **[2015- N/A, 2018-11%)** **Source- DataHaven Community Wellbeing Survey 2015 and 2018*		
Goal: By February 2022, only 13% of adults in Greater Bridgeport will report not having a medical home and 74% will report visiting a dentist at least once in the past year		
Strategy	**Action Steps**	**Outcomes**
Promote available medical services in the Greater Bridgeport region to positively impact the number of individuals who have a medical home	• Determine how to best educate the community about the importance of having a medical home, particularly in the young adult population and implement strategies as appropriate • Promote available medical services in the region • Collaborate to increase referrals from partner organizations to primary care providers	# of referrals Improved capacity to provide on-going continuity of care in primary care.

St.Vincent's Medical Center | ASCENSION	Priority Area: Access to Care, continued	
Strategy	**Action Steps**	**Outcomes**
Create a model that promotes continuity of care for patients with a specific assignment to a primary care Resident physician.	• In collaboration with Southwest Community Health Center, (formerly St. Vincent's Family Health Center), we conduct primary care clinics which are staffed by our Internal Medicine Residents, as a major component to their education. This is located on Lindley Street in Bridgeport. In this model of care, patient are assigned to a specific Resident, who acts as the PCP in collaboration with Boarded Physician Educators who lead this program. This promotes continuity of care for the patient and therefore enhances the quality of that care, as they identify with whom they establish an ongoing and trusted rapport.	This system allows for tracking patient compliance with their scheduled appointments. It also establishes a setting in which an empowered patient can interact with an engaged physician provider.
	• We at SVMC, through our Foundation, provide an annual venue that we call our Medical Mission at Home. This is held in Bridgeport at a local school. We have multiple volunteers who provide healthcare t many levels. There is biometric testing, nursing and physician evaluation and exams, vaccinations, pharmacy, distribution of needed items:(reading glasses, winter coats, shoes and sox, toiletries) pastoral care support, and lunch. It is open to the community without a scheduled appointment. Last year, we embraced just about 400 patients. The community benefit to population management is that both SVMC and SWCHC are on-site to refer patients to PCP services at both entities. We are working to establish an on-going rapport with a PCP for their healthcare delivery. We have videos that we could share with you.	We have records of all encounters and can track the number of patients who are referred for follow-up of their findings and chronic issues.
	• St. Vincent's Medical Center has established a central call center to improve ease of scheduling an appointment at any of our SVMC/ MSG sites.	We can promote access to healthcare in our community and facilitate scheduling which we will track.

Priority Area: Access to Care, continued		
Strategy	**Action Steps**	**Outcomes**
Promote available dental services in the Greater Bridgeport region to positively impact the number of individuals who see a dental provider at least once a year	• Produce and distribute educational materials on the importance of dental care • Promote available dental services in the region • Continue to improve and expand the dental referral system between partner organizations • Advocate for improved dental insurance coverage • Because of the collaborative efforts between SVMC and SWCHC, patients now have access to Dental services through SWCHC. There has been an enhanced emphasis on dental health and hygiene for our community as a result this collaboration.	# of CHWs in GBT region who have successfully completed a dental training workshop # of referrals % change in dental service utilization We now can track the numbers of patients in need of dental services in our system and we can continue to track dental referrals from SWCHC.
Strategy	**Action Steps**	**Outcomes**
Increase access to specialty care providers	• Identify gaps in specialty care access for Medicaid and uninsured patients and investigate ways to increase availability and access • Collaborate with specialty care providers to increase the number of providers who accept Medicaid and uninsured patients • By transferring the Family Health Center to SWCHS, an FQHC site, we were able to re-purpose our financial resources to create, grow and better staff specialty clinics which are offered at 2979 Main Street in Bridgeport. We have increased the number of hours and days, as well as, introduced new services such as Orthopedics (3 full days per week), Plastic Reconstructive Surgery, Infectious Disease, G.I. and Nephrology. This has been a tremendous addition to population health management.	# of focus groups with specialty care providers # of new providers accepting Medicaid and uninsured patients Significant expansion in specialty and sub-specialty care. Enhances access and availability of services al update of specialty care database. We have also significantly reduced the wait times for scheduling specialty and sub-specialty appointments.

St.Vincent's Medical Center | ASCENSION	Priority Area: Access to Care, continued	
Strategy	**Action Steps**	**Outcomes**
Continue to work with partners to improve access to reliable medical transportation	• Continue to be involved in the state medical transportation efforts and share local experiences at the state level • Continue communications with Veyo and invite them to task force meetings for quarterly updates and communicate those updates with partners organizations • Determine accessibility of additional medical transportation options, including public transportation and medical ride programs and develop strategies based on this assessment • Both the SWCHC facility and the St. Vincent's Family Health Center Specialty Clinic are located on major bus routes. This provides for greater ease of access to both primary and specialty care clinics.	# of task force meetings attended by Veyo Track initiatives and local outcomes with Veyo Monitor the number of visits and query patients about challenges in transportation to and from the facilities. Work to provide resource assistance in securing transportation.
Strategy	**Action Steps**	**Outcomes**
Increase implementation of Culturally and Linguistically Appropriate Services (CLAS) standards by health care organizations in the Greater Bridgeport region	• Complete a CLAS assessment with local partner organizations to determine current gaps and implement CLAS strategies as needed • Collect CLAS implementation tools and disseminate within partner organizations within Access to Care and throughout PCAG organizations • Continue to grow CLAS to meet the specific needs of the patients in our area and satisfy population health management resources.	Continue to track growth relative to CLAS initiative.

Priority Area: Behavioral Health		
Indicator: Percentage of people in the Greater Bridgeport region who indicate that they receive the social and emotional support they need **[DHWS, 2018 Baseline: 66% Always/Usually]** **Indicator:** Percentage of people in the Greater Bridgeport region who indicate how satisfied they are with their lives **[DHWS, 2018 Baseline: 36% Not all to somewhat satisfied]** **Indicator:** Percentage of people in the Greater Bridgeport region who indicate that they felt down, depressed or hopeless in the past two weeks **[DHWS, 2018 Baseline: 65% Not all]** **Source- DataHaven Community Wellbeing Survey 2015 and 2018*		
Goal: By February 2022, the Primary Care Action Group's (PCAG) efforts will result in a 2% increase in social and emotional support for adults in the Greater Bridgeport area.		
Strategy	**Action Steps**	**Outcomes**
Increase access to mobile and community-based services and supports for behavioral health in the Greater Bridgeport area	• Align resources and build collaboration between organizations to increase access and awareness to community health workers and peer support specialists • Participate in funding opportunities such as BUILD Health • Develop strategies to link clinical and non-clinical services • Establish or expand mobile or community based resource in the greater Bridgeport area	# of initiatives to increase access/awareness for community health workers and peer support specialists # of funding opportunities with participation of members # of strategies to link clinical and non-clinical services # of initiatives to establish or expand mobile or community based resources
Strategy	**Action Steps**	**Outcomes**
Develop targeted messaging around behavioral health in the Greater Bridgeport area to increase awareness of available resources	• Educate providers on resources (physicians, hospitals, others) • Develop strategy to educate the general community on available resources for non-crisis services • Develop strategy to educate the general community on available resources for crisis services • Develop strategies to reach selected communities (youth, young adult, elderly, etc.)	# provider education initiatives # educational strategies for non-crisis services # educational strategies for crisis services # strategies to reach selected communities

Behavioral Health, continued

Strategy	Action Steps	Outcomes
Improve the coordination of care for frequent users of ED in local hospitals	• Refine Bridgeport Care Coordination Team (CCT) • Improve attendance at meetings and involvement of organizations • Establish a dedicated patient navigator for CCT • Improve information sharing across organizations • Track outcomes and share results on a quarterly basis • Evaluate state and local best practices for improvement of CCT including re-establishing participation in Health and Housing stability work group	# organizations actively involved from current to end of CHIP Establishment of patient navigator Tracking/results sharing improvement
Strategy	**Action Steps**	**Outcomes**
Continue to organize, coordinate and host the Behavioral Health Task Force meeting at St. Vincent's	• Ensure smooth operation and timeliness of meetings of the Task Force.	Monthly meetings held.

Health areas that will be addressed with existing St. Vincent's Medical Center resources	
The St. Vincent's Medical Center Community Health Improvement Plan / Implementation Strategies are comprehensive to address the three areas prioritized through the Community Health Needs Assessment process. Other areas identified through the Community Health Needs Assessment process will be specifically addressed as part of this effort by St. Vincent's Medical Center due to resource constraints but are already being addressed through existing services and initiatives, as outlined below:	
Health Issue	**Sample Listing of Existing Programs and Resources**
Cancer	Smoke-stoppers program offered at schools throughout the state free of charge to reduce teen smoking. Educational programs held throughout the year on early detection of various cancers. Swim Across the Sound offers oncology support services including: yoga, meditation, qigong, music & art therapy, massage therapy, acupuncture, and support groups. Mobile mammography van utilized to encourage early detection of breast cancer.
Food Insecurity	St. Vincent's annually hosts a Farmers Market that offers healthy food choices at affordable prices and works with the Council of Churches to offer a doubling of SNAP coupons. St. Vincent ' s also offers patients in our primary care clinics and cardiology programs coupons to purchase healthy food at the Farmers Market. St. Vincent's annually conducts a food drive collaboratively with the Aquarian Water company that raises almost 7 tons of food.
Specialty Care Access	St. Vincent's continues to expand the offerings of specialty care clinics designed to provide access to patients in need regardless of ability to pay. This effort is a continuation of our collaboration with Southwest Community Health Clinic, a FQHC that assumed responsibility for primary care services in our surrounding community. Clinics opened to date include: Orthopedics, Cardiology, Infectious Disease, Neurology, Gastroenterology Podiatry, Pulmonology, and Reconstructive Plastic Surgery.

VIII. COMMUNITY RESOURCES

One goal of the Community Health Needs Assessment is to understand the needs of a particular community and the overall challenges they face, to plan for future policies. Community-level challenges can resonate through the needs of the individual, the organization, the neighborhood, or more broadly part of the larger city. Within communities, there exist various resources, including organizations, people, policies, and physical spaces, among other things, that elevate the quality of life of a community. As each person has unique needs within their community, what is a resource to one may not be for another. Homeless shelters, food pantries, day clinics, financial assistance programs, and recreational centers, are all examples of community resources that may be used by different community members. Identifying the resources that are available in the community actively uses is one important factor of the community needs assessment, as it can help ensure public awareness of available resources and demonstrate what models work well within that community and what can be done to fill in the existing gaps.

One method to find these assets is by utilizing the 2-1-1 program by United Way of Connecticut, which is supported by the State of Connecticut and other Connecticut-based United Ways. United Way 2-1-1 is an organization that aims to provide a state-wide resource to educate and connect its residents to services. Dialing 2-1-1 connects you to a specialist who will help you locate local services including utility assistance, food, housing, child care, after school programs, elder care, and crisis intervention among others. Entrance to certain housing shelters for example, can be facilitated by referral from 2-1-1. 2-1-1 also has a continually updated, comprehensive, and searchable online database of 4,100 agencies providing over 40,000 programs. 2-1-1 began as Infoline in 1976 and Connecticut became the first state to use 2-1-1 statewide in 1999. In 2018, a total of 248,890 calls and a total 322,166 requests were made in Connecticut. 2-1-1 is available 24 hours a day every day of the year, with multilingual assistance available.

The following pages include a sample of community health assets found by navigating the 2-1-1 website. In this example, health resources are organized into six health topics: access to care, food insecurity, healthy lifestyle, housing, mental health, and substance abuse for the Greater Bridgeport region.

Here are ways to access 2-1-1 CT. A more detailed description of how to access the services may be found in Appendix C.

Dialing from Connecticut: 2-1-1
Dialing from outside of Connecticut: 1-800-203-1234
Website: https://www.211ct.org

Community Resources

Access to Care

- Cancer Detection
- Community Clinics
- Dental Care
- Disability Related Transportation
- English as a Second Language
- Eye Screening
- Health Screening/Diagnostic Services
- Health Insurance Counseling
- Local Bus Services
- Local Rail Services
- Medicaid
- Medical Appointments Transportation
- Medical Expense Assistance
- Medicare
- Senior Ride Programs
- Specialized Treatment Programs
- Veterans

Food Insecurity

- Community Action Agencies
- Commodity Supplemental Food Program
- Congregate Meals/Nutrition Sites
- Food Pantries
- Food Stamps/SNAP
- Home Delivered Meals
- Local Officials Offices
- Soup Kitchens
- WIC

Healthy Lifestyles

- General Clothing Provision
- Nature Centers/Walks
- Recreational Activities/Sports
- Wellness Programs
- Youth Enrichment Programs

Housing

- Domestic Violence Shelters
- Ex-Offender Halfway Houses
- Housing Authorities
- Homeless Drop-In Centers
- Housing Search and Information
- Homeless Shelter
- Runaway/Youth Shelters
- Single Room Occupancy Housing
- Transitional Housing/Shelter

Mental Health

- Adolescent/Youth Counseling
- Child Guidance
- Domestic Violence Hotlines
- General Counseling Services
- Home Based Mental Health Services
- Mental Health Evaluation
- Mental Health Related Support Groups
- Psychiatric Disorder Counseling
- Psychiatric Mobile Response Teams
- Suicide Prevention Hotlines
- Talklines/Warmlines
- Therapy Referrals
- Youth Issues Hotlines

Substance Abuse

- Alcohol Dependency Support Groups
- Drug Use Disorder Support Groups
- Central Intake/Assessment for Substance Abuse
- General Assessment for Substance Use Disorder
- Inpatient Drug Detoxification
- Inpatient Medically Assisted Alcohol Detoxification
- Medication Assisted Maintenance Treatment for Substance Use Disorders
- Medication Assisted Maintenance Treatment for Opioid Use Disorders
- Methadone Maintenance
- Opioid Antidote Distribution Programs
- Outpatient Drug Detoxification
- Outpatient Medically Assisted Alcohol Detoxification
- Sober Living Homes
- Substance Abuse Walk in Assessment Center
- Substance Use Disorder Counseling
- Substance Use Disorder Day Treatment

Cancer Detection

Bridgeport Hospital - Norma F. Pfriem Breast Care Center
111 Beach Road
Fairfield, CT 06824
(203) 254-2381

The Witness Project Of Connecticut
2470 Fairfield Avenue
Bridgeport, CT 06605
(203) 367-4432

Community Clinics

Americares Free Clinics
115 Highland Avenue
Bridgeport, CT 06604
(203) 333-9175

Eye Screening

Onesight - Lenscrafters - Trumbull
5065 Main Street
Trumbull, CT 06611
(203) 374-1744

Onesight - Pearle Vision - Fairfield
1901 Black Rock Turnpike
Fairfield, CT 06825
(203) 334-7722

Health Screening/ Diagnostics

Bridgeport Hospital
267 Grant Street
Bridgeport, CT 06610
(203) 814-9410

Optimus Health Care - Hollow Community Health Center
82 George Street
Bridgeport, CT 06604
(203) 576-3881

Senior Ride Programs

Bridgeport Aging Department
3710 Main Street
Bridgeport, CT 06604
(203) 576-7993

Trumbull, Town Of - Senior Center
23 Priscilla Place
Trumbull, CT 06611
(2034525137)

2-1-1 United Way Connecticut data is current as of March 12, 2019

Congregate Meals/ Nutrition Sites

Dwight D. Eisenhower Senior Center
307 Golden Hill Street
Bridgeport, CT 06604
(203) 335-6175

Soup Kitchens

Bridgeport Rescue Mission
1088 Fairfield Avenue
Bridgeport, CT 06605
(203) 333-4087

Lord's Kitchen
2000 Main Street
Stratford, CT 06615
(203) 375-4447

Nourish Bridgeport
1062 Fairfield Avenue
Bridgeport, CT 06605
(203) 335-3107

Russell Temple
555 Connecticut Avenue
Bridgeport, CT 06607
(203) 333-9061

Food Pantries

Bethel Shiloh Apostolic Church Food Pantry
1621 Iranistan Avenue
Bridgeport, CT 06604
(203) 333-9388

First Haitian Evangelical
1192 Stratford Avenue
Stratford, CT 06615
(203) 274-1088

Town of Monroe – Food Pantry
980 Monroe Turnpike

Operation Hope
636 Old Post Road
Fairfield, CT 06824
(203) 293-5588

Refuge Temple Food Pantry
3050 Main Street
Bridgeport, CT 06606
(203) 373-0622

Tabernacle of God Food Pantry
1562 Stratford Avenue
Bridgeport, CT 06607
(203) 290-9992

Home Delivered Meals

Bridgeport Nutrition Program
215 Warren Street
Bridgeport, CT 06604
(203) 335-3107

2-1-1 United Way Connecticut data is current as of March 12, 2019

Nature Centers/Walks

Audubon Connecticut
2425 Burr Street
Fairfield, CT -6824
(203) 259-6305

Town of Stratford – Stratford
468 Birdseye Street
Stratford, CT 06615
(203) 385-4052

Recreational Activities/ Sports

Disability Resource Network
340 Capitol Avenue
Bridgeport Ave, CT 06604
(203) 873-0743

Jerome Orcutt Boys Club and Girls Club of Bridgeport
102 Park Street
Bridgeport, CT 06608
(203) 368-4644

Sterling House Community Center
2283 Main Street
Stratford, CT 06615
(203) 378-2606

Wellness Programs

Town of Fairfield – Health Department
725 Old Post Road
Fairfield, Ct 06824
(203) 256-3150

Kindred at Home
99 Hawley Lane
Stratford, CT 06614
(203) 377-5117

Saint Vincent's Medical Center
2800 Main Street
Bridgeport, CT 06604
(203) 576-5716

Youth Enrichment Programs

Barnum/Waltersville Family Resource Center
495 Waterview Avenue
Bridgeport, CT 06608
(203) 275-2371

Bridgeport Caribe Youth Leaders
1067 Park Avenue
Bridgeport, CT 06604
(203) 913-0073

Hall Neighborhood House
52 George E. Pipkin's Way
Bridgeport, CT 06608
(203) 345-2000

YMCA
20 Trefoil Drive
Trumbull, CT 06611
(203) 445-9633

2-1-1 United Way Connecticut data is current as of March 12, 2019

Domestic Violence Shelters

Center for Family Justice
341 Clinton Avenue
Bridgeport, CT 06604
(203) 384-9559

Ex-Offender Halfway Homes

Connecticut Renaissance
575 Maple Street
Bridgeport, CT 06608
(203) 335-8867

Isaiah House
112 Clinton Avenue
Bridgeport, CT 06605
(203) 367-9440

Homeless Shelter

Bridgeport Rescue Mission
1088 Fairfield Avenue
Bridgeport, CT 06605
(203) 333-4087

Recovery Network of Programs
392 Prospect Street
Bridgeport, CT
(203) 367-5830

Housing

Clifford House
1450 Main Street
Bridgeport, CT 06604
(203) 367-0808

Homes for the Brave
655 Park Avenue
Bridgeport, CT 06604
(203) 359-6940

Scattered Site Housing Program
238 Jewett Avenue
Bridgeport, CT 06606
(203) 416-1456

Sober Living Homes

Cassie's Cottage
Address upon inquiry
Easton, CT 06612
(203) 224-8818

Gorham Fellowship Sober Living Home
1108 Fairfield Avenue
Bridgeport, CT 06605
(203) 908-4487

Transitional Housing/ Shelter

Emerge, Inc
PO Box 1190
Stratford, CT 06615
(203) 375-8610

YMCA – Alpha Community Services
387 Clinton Avenue
Bridgeport, CT 06604
(203) 366-2809

2-1-1 United Way Connecticut data is current as of March 12, 2019

General Counseling Services

Family Re-Entry
75 Washington Avenue
Bridgeport, CT 06604
(203) 394-6529

Optimus Health Care
982-988 East Main Street
Bridgeport, CT 06608
(203 696-3260

Mental and Behavioral Health Services

Bridgeport Hospital
1470 Barnum Avenue
Bridgeport, CT 06610
(203) 384-3298

Southwest Community Health Center
968 Fairfield Avenue
Bridgeport, CT 06605
(203) 330-6000

Mental Health Evaluation

Child and Family Guidance Center
1073 North Benson Road
Fairfield, CT 06468
(203) 255-2631

Lifebridge Community Services
125 Penfield Road
Fairfield, CT 06824
(203) 255-4777

Psychiatric Disorder Counseling

Boys & Girls Village
170 Bennett Street
Bridgeport, CT 06605
(203) 330-6790

Diocese of Bridgeport
238 Jewett Avenue
Bridgeport, CT 06606
(203) 362-3900

Jewish Family Service
325 Reef Road
Fairfield, CT 06824
(203) 366-6438

Support Groups

Greater Bridgeport Area Prevention Program
1470 Barnum Avenue Ste 301
Bridgeport, CT 06610
(203) 366-8355

2-1-1 United Way Connecticut data is current as of March 12, 2019

Alcohol Use Disorder Support Groups

Connecticut Community for Addiction Recovery
49 Cannon Street
Bridgeport, CT 06604
(203) 583-4702

Double Trouble in Recovery
1635 Central Avenue
Bridgeport, CT 06610
Dial 2-1-1

Opioid Antidote Distribution Programs

CVS Pharmacy
930 White Plains Road
Trumbull, CT 06611
(203) 261-3541

Stop & Shop
200 East Main Street
Stratford, CT 06614
(203) 383-7741

Walgreens
275 Monroe Turnpike
Monroe, CT 06468
(203) 268-1216

Substance Use Disorder Counseling/Treatment

Connecticut Renaissance – Bridgeport Outpatient Program
1 Lafayette Circle
Bridgeport, CT 06604
(203) 331-1503

Liberation Programs
399 Mill Hill Avenue
Bridgeport, CT 06610
(203) 851-2077

New Era Rehabilitation Center
3851 Main Street
Bridgeport, CT 06606
(203) 372-3333

Saint Vincent's Behavioral Health Services
2400 Main Street
Bridgeport, CT 06606
(203) 352-3900

2-1-1 United Way Connecticut data is current as of March 12, 2019

IX. APPENDICES

APPENDIX A: FAIRFIELD COUNTY COMMUNITY WELLBEING INDEX 2019

[SEE ATTACHED PDF]

APPENDIX B: HEALTH IMPROVEMENT ALLIANCE MEMBERS

Providers

Bridgeport Hospital/YNHHS
St. Vincent's Medical Center
Optimus Healthcare
Southwest Community Health Center
Americares Free Clinic of Bridgeport
Greater Bridgeport Medical Assoc.
Northeast Medical Group
Pediatric Healthcare Associates
Visiting Nurse Services of CT

Health Departments

City of Bridgeport Department of Health and Social Services
Fairfield Health Department
Monroe Health Department
Trumbull Health Department
Stratford Health Department
Easton Health Department

Government

City of Bridgeport/City Council
Town of Stratford/City Council
Town of Fairfield
Town of Trumbull
Town of Monroe

Schools

Bridgeport Public School System
Bridgeport Hospital School of Nursing
Fairfield University School of Nursing
Sacred Heart University School of Nursing
St. Vincent's College Nursing Program
Southern CT State University
Housatonic Community College
University of Bridgeport

Faith Based

Greater Bridgeport Council of Churches
Catholic Charities

Social Service Agencies

Bridgeport Rescue Mission
Council of Churches Hunger Outreach Network (HON)
United Way of Coastal Fairfield County
Wholesome Wave
Central CT Coast YMCA
YMCA Kolbe Daycare Center
Green Village Initiative

Businesses

Bridgeport Regional Business Council

Housing

Supportive Housing Works

Mental Health Providers

Recovery Network of Programs
The Connection
Continuum of Care
Liberation Programs

Payers

Community Health Network
Access Health CT
Value Options

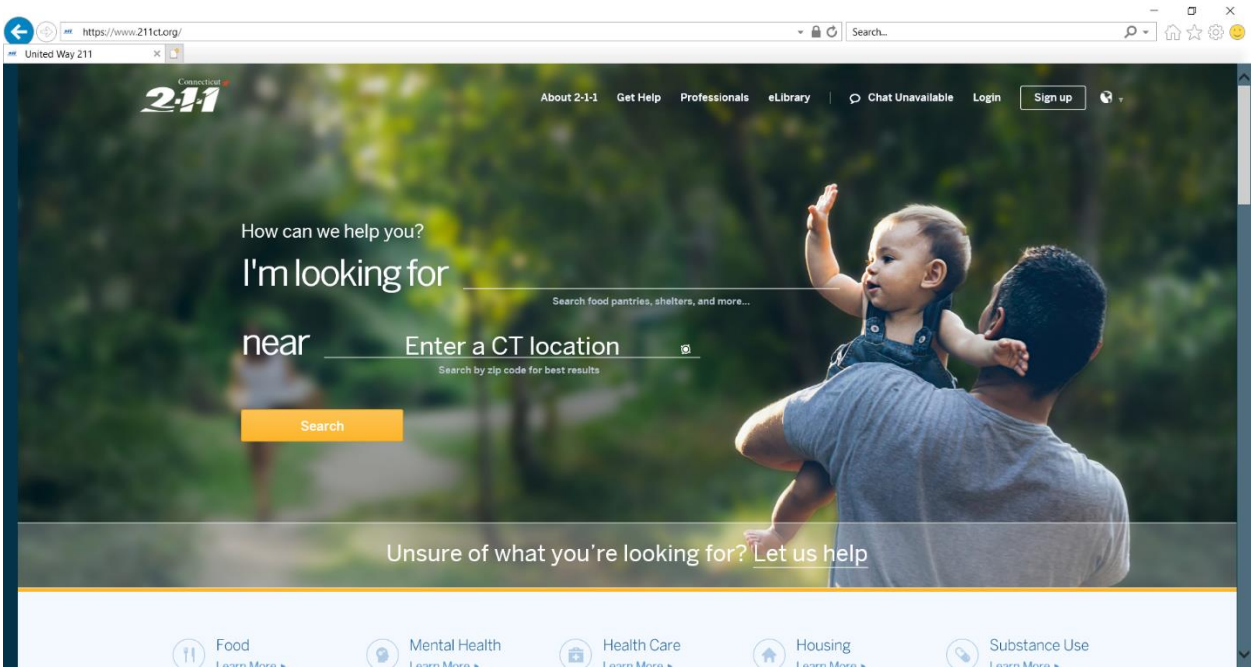
Advocacy Groups

American Diabetes Association
American Heart & Stroke Association
Bridgeport Alliance for Young Children Bridgeport Child Advocacy Coalition
Bridgeport Food Policy Council
Southwestern Area Health Education Center
DataHaven
Hispanic Health Council

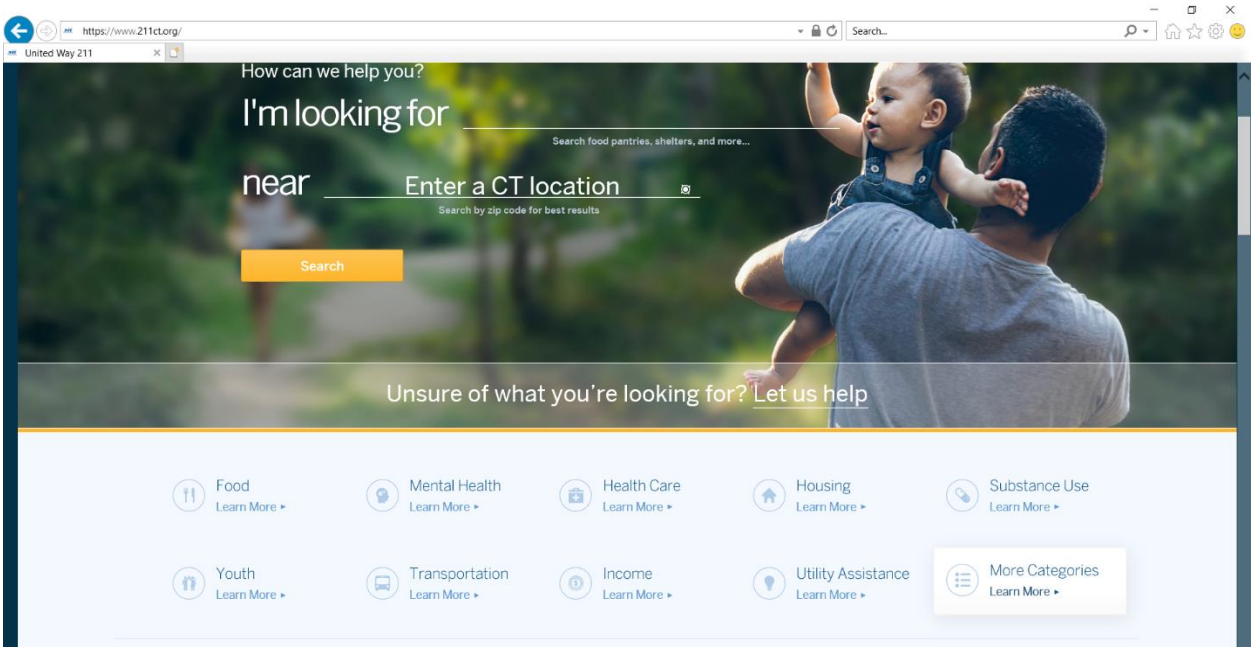
State Agencies

CT Department of Mental Health & Addiction Services/Greater Bridgeport Mental Health Services
CT Department of Public Health
CT Department of Social Services
Southwest CT Mental Health Board

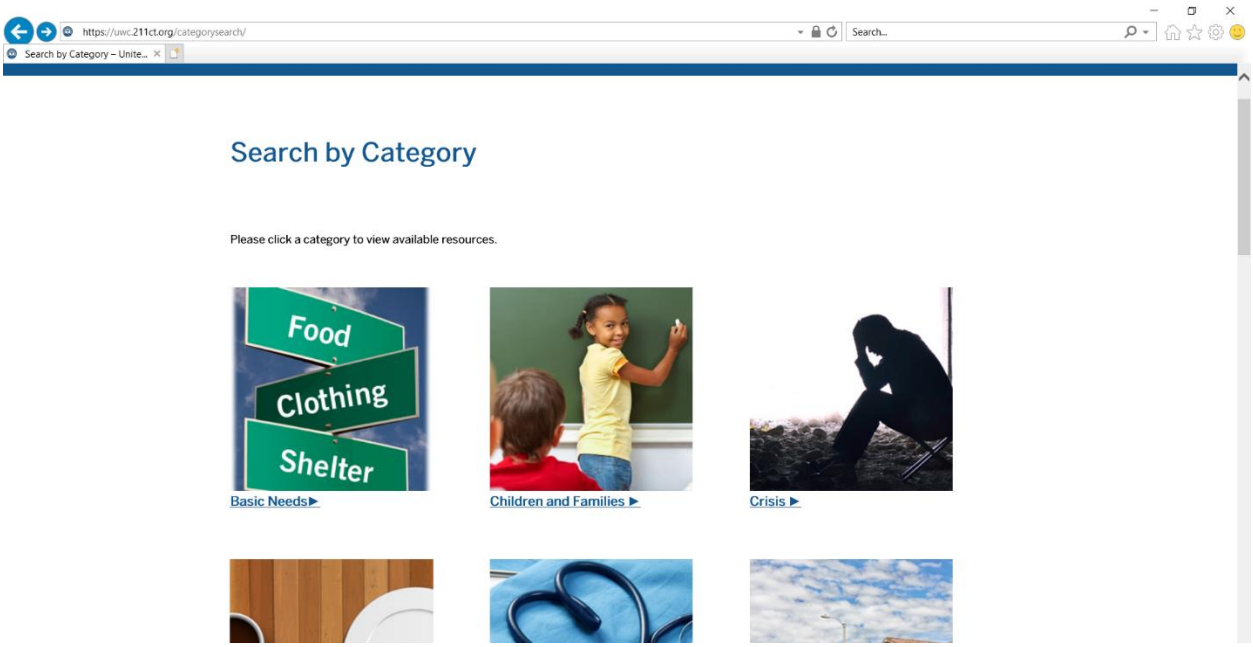
APPENDIX C: HOW TO SEARCH FOR A SERVICE USING THE 2-1-1 DATABASE



1. Visit https://www.211ct.org/ if you are looking for a particular service, and want to be connected.
2. If you know the particular service you are looking for, type in the service or need (e.g. "food", "clothing", "financial assistance") in the search box. A variety of items will auto-suggest for you to choose from if you want.



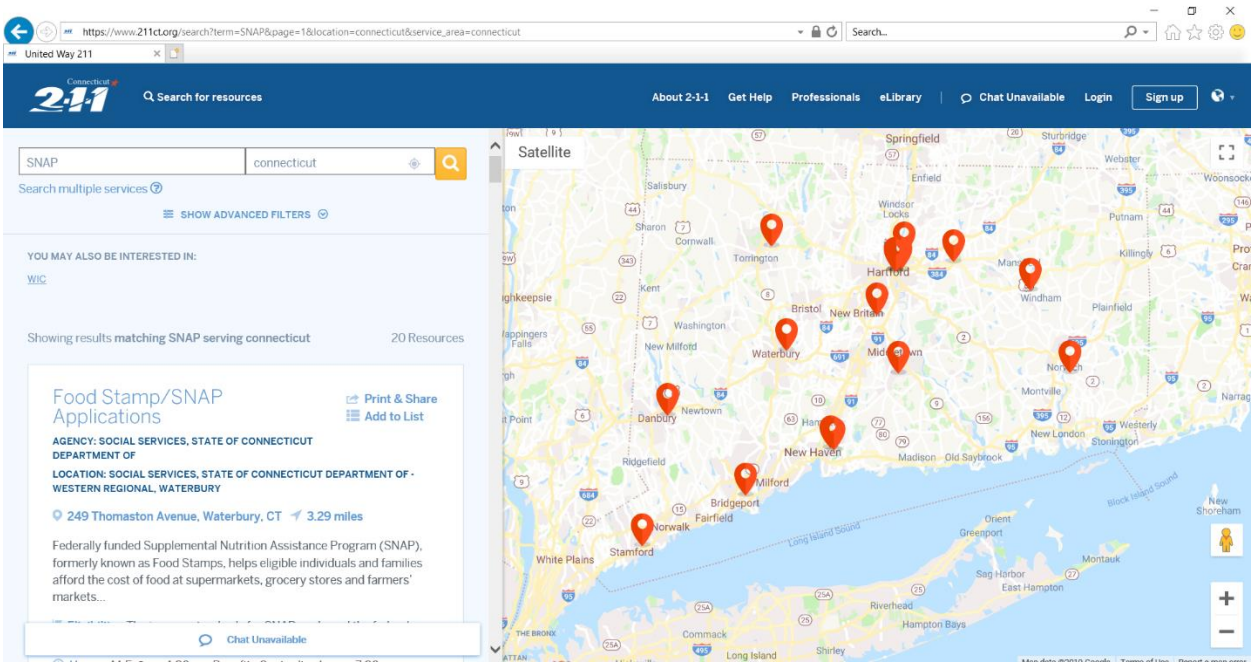
3. If you are unsure of what you are looking for, there is a selection of menus you can choose from, to narrow down what services you might want.



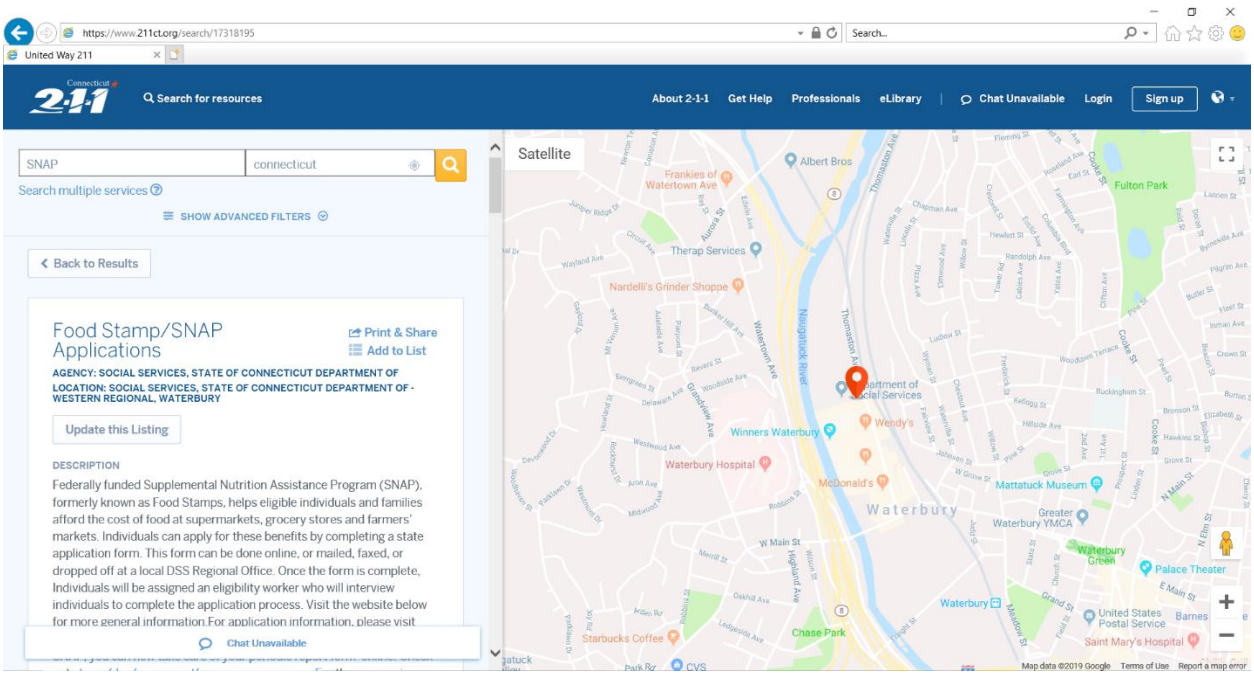
4. Click a category based on your specific need.

Listed Categories: Basic Needs, Children and Families, Crisis, Food, Health Care, Housing, Income, Legal Assistance, Mental Health, Older Adults, Re-Entry, Substance Use Disorder, Transportation, Utility Assistance, Volunteer, Youth

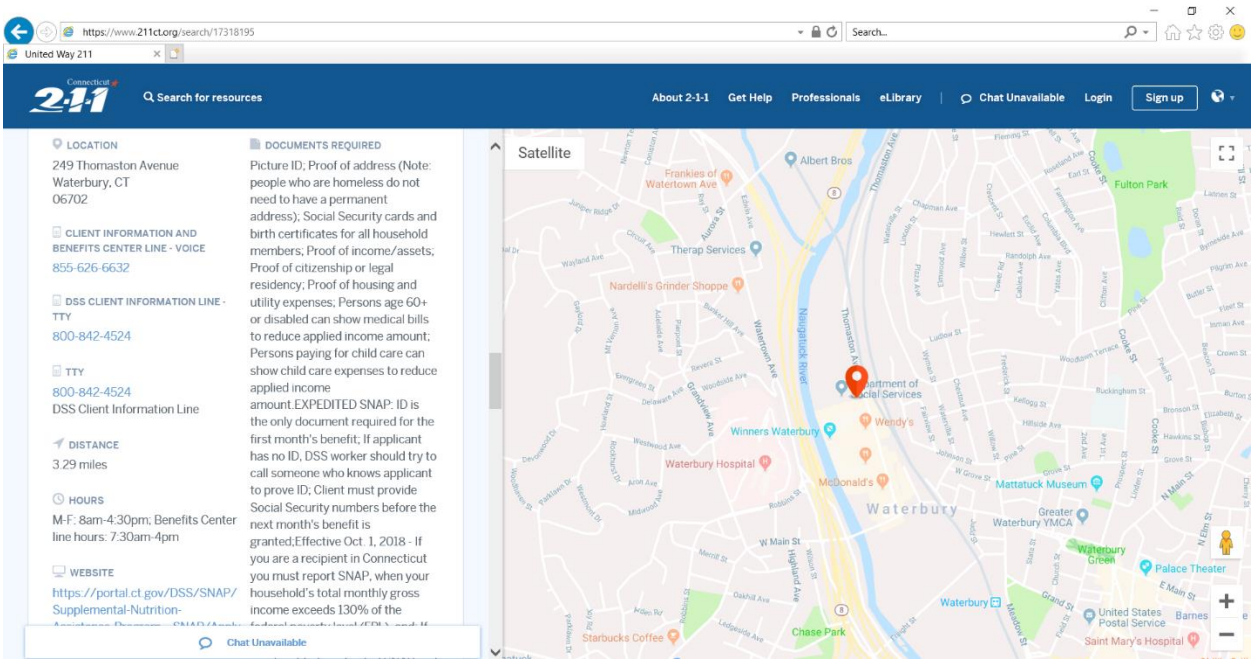
5. Example: Children and Families category. You can click on a sub-category best fitting your needs. We will select “SNAP” under the Child Nutrition Programs for this example.



6. This is the results list that shows up once clicking “SNAP”, under the Child Nutritions Program subcategory. Relevant organizations are listed as red flags on the map. You can use the “Show Advanced Filters” option to narrow down an organization closest or most relevant to you.



7. Once you have found a service of your liking, you can click on the program name or on the More Details button from any of the resource cards on the left-hand side to view its location and description.



8. Scroll down for detailed information on the service such as contact, location, documents required, and more.
9. You can call 2-1-1 during the search process to be connected with a specialist who can guide you to find the service fitted to your needs.

How to Access the Services by Phone

To access 2-1-1's telephone-based services, you can dial 2-1-1 within Connecticut, or 1-800-203-1234 outside Connecticut, 24/7. A Contact Specialist will try to connect you to a service fitted to your needs.