2019 Community Health Needs Assessment

Greater New Haven Community Forum

April 23, 2019

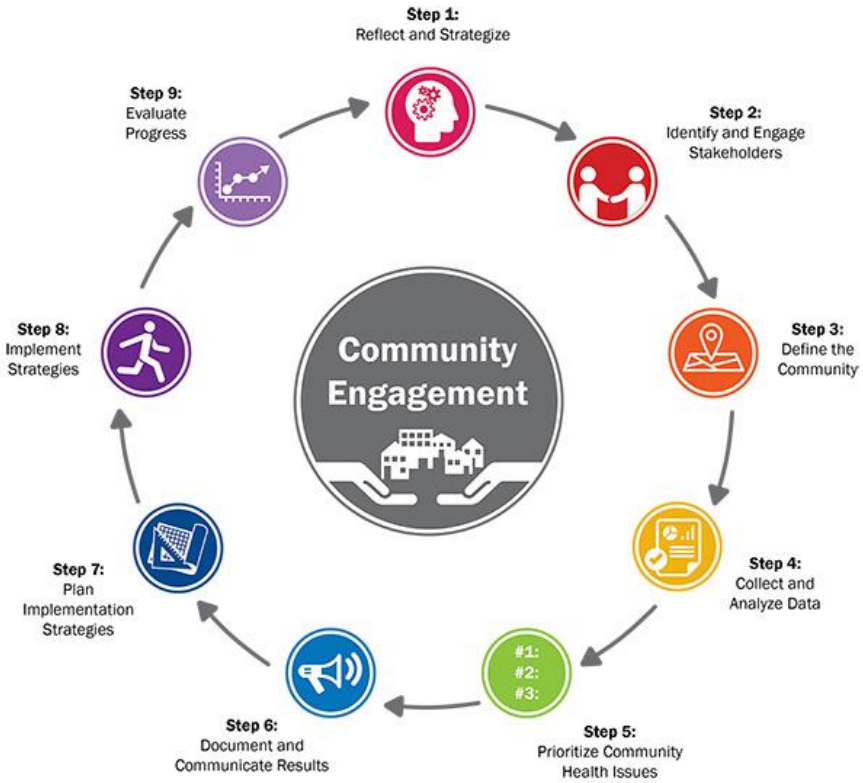
Agenda

- Overview of the Community Health Needs Assessment (CHNA) Process
- Summary of Data
  - Key Informant Survey
  - DataHaven Wellbeing Survey
  - Community Conversations
- 2019-2022 Health Priorities
- Community Health Improvement Plans (CHIP) & Implementation Strategies
- Discussion/Questions & Answers

Community Health Needs Assessment

- Health Care Reform Law, 2010
  - Internal Revenue Service
- Three-year cycle
  (e.g. 2016, 2019, 2022,….)
- Collaborative effort
  - Public Health (PHAB local/state, 5-year)
  - Broad interests of the community
- Two main elements:
  - Assessment
    - Quantitative
    - Qualitative
  - Implementation Strategy
    - Addressing significant health needs

Community Health Needs Assessment Process



Community Health Coalition

- Multi-stakeholder coalitions working with the community to improve health and well-being
- Healthcare Providers
  - Hospitals
  - Federally Qualified Health Centers
- Health Departments/Districts
- Academic Partners
- Social Service Agencies
- Non-profit Organizations

Community Health Improvement Plan Partners

Providers

- Clifford Beers Clinic
- Cornell Scott-Hill Health Center
- Fair Haven Community Health Care
- Milford Hospital
- Planned Parenthood of Southern New England
- Project Access-New Haven
- School-Based Health Centers
- Smilow Screening & Prevention
- Yale New Haven Health
- Yale New Haven Hospital

Businesses

- Greater New Haven Chamber of Commerce
- Hoodenpylegil
- Veyo

Health Departments

- East Shore District Health District
- Madison Health Department
- Milford Health Department
- New Haven Health Department
- Quinnipiack Valley Health District

Government

- Keefe Center/Town of Hamden
- New Haven Community Services Administration
- New Haven Parks, Recreation and Trees

Schools

- Southern CT State University
- Yale School of Medicine, Primary Care Residency Program
- Yale School of Medicine, Scholars Program
- Yale University – Yale School of Public Health
- Community Alliance for Research & Engagement at YSPH/SCSU

Community Health Improvement Plan Partners

Advocacy Groups & Coalitions

- American Heart Association
- Connecticut Hospital Association
- CT Academy of Nutrition and Dietetics
- Hispanic Health Council
- Milford Prevention Council
- New Haven Food Policy Council
- Special Olympics CT
- Tobacco-Free New Haven Coalition

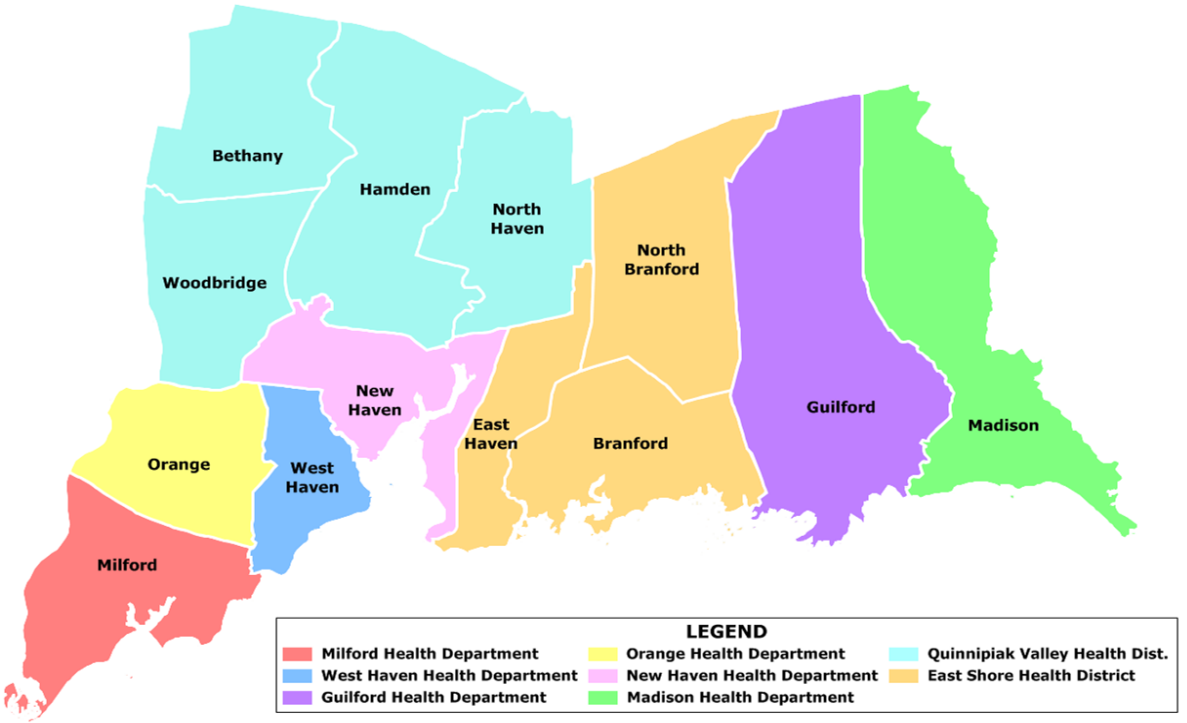
Community-Based Organizations

- Central CT Coast YMCA
- CT Food Bank
- DataHaven
- New Haven Healthy Start

Social Services

- Community Foundation for Greater New Haven
- United Way of Greater New Haven
- United Way of Milford

Greater New Haven
Community Health Planning Region

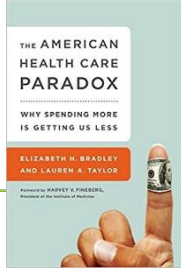


2018-19 CHNA & CHIP Timeline

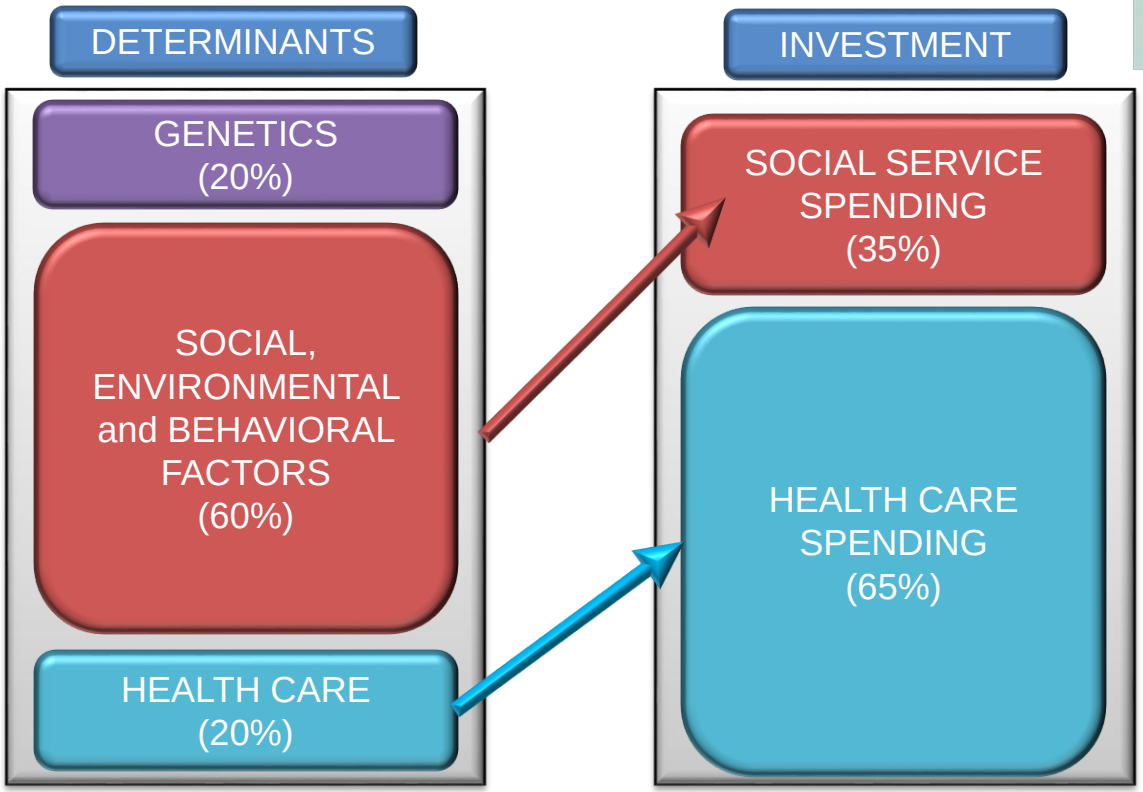
	WINTER 2018	SPRING 2018	SUMMER 2018	FALL 2018	WINTER 2019	SPRING 2019	SUMMER 2019
Key Informant Survey (YSPH Consulting Group)							
CT Well-Being Survey Conducted (DataHaven)							
Secondary Data Collection (CHIME/DataHaven)							
Primary & Secondary Data Findings Presented (DataHaven)							
Community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

Social Determinants of Health (SDoH)

Source: Healthy People 2020



Investment Mismatch



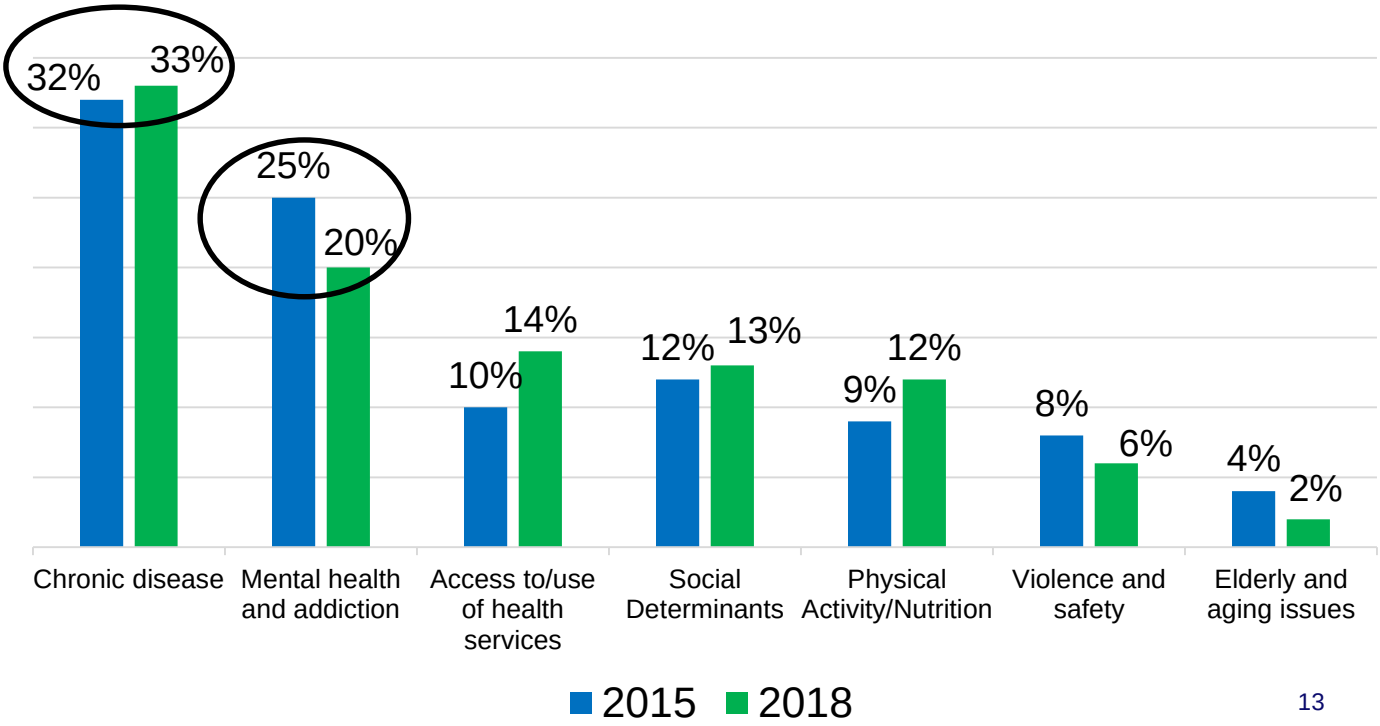
Source: The American Health Care Paradox, Elizabeth H. Bradley and Lauren A. Taylor, 2013

Key Informant Survey

- Key Informant Categories
  - Group 1: Health and Human Services (65% response rate)
    - Examples: hospital administrators, state and local health departments, physicians, nurses, social services
  - Group 2: Government and Community Leadership (35% response rate)
    - Examples: state and local elected officials, police and fire departments, library directors, clergy, other government agency heads
- Conducted throughout March 2018
- 172 surveys in Greater New Haven

Top 5 health issues of greatest concern

Chronic Disease and Mental health and addiction remain respondents' greatest concern



Issues that were of greatest negative impact for **adults** include economic and social barriers

Physical (23%)

- Obesity
- Poor nutrition
- Sedentary lifestyle

Social (35%)

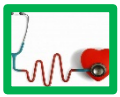
- Education (lack of technical skills)
- Community Safety
- Domestic Violence
- Lack of support for the elderly

Economic (41%)

- Access to primary and specialty care
- Access to mental heath resources
- Transportation
- Unemployment
- Unaffordable housing
- Lack of insurance

Issues that were of greatest negative impact for **children** include social and economic barriers

Physical (22%)



- Nutritional options in school and at home
- Lead
- Insufficient physical activity
- Obesity

Social (43%)

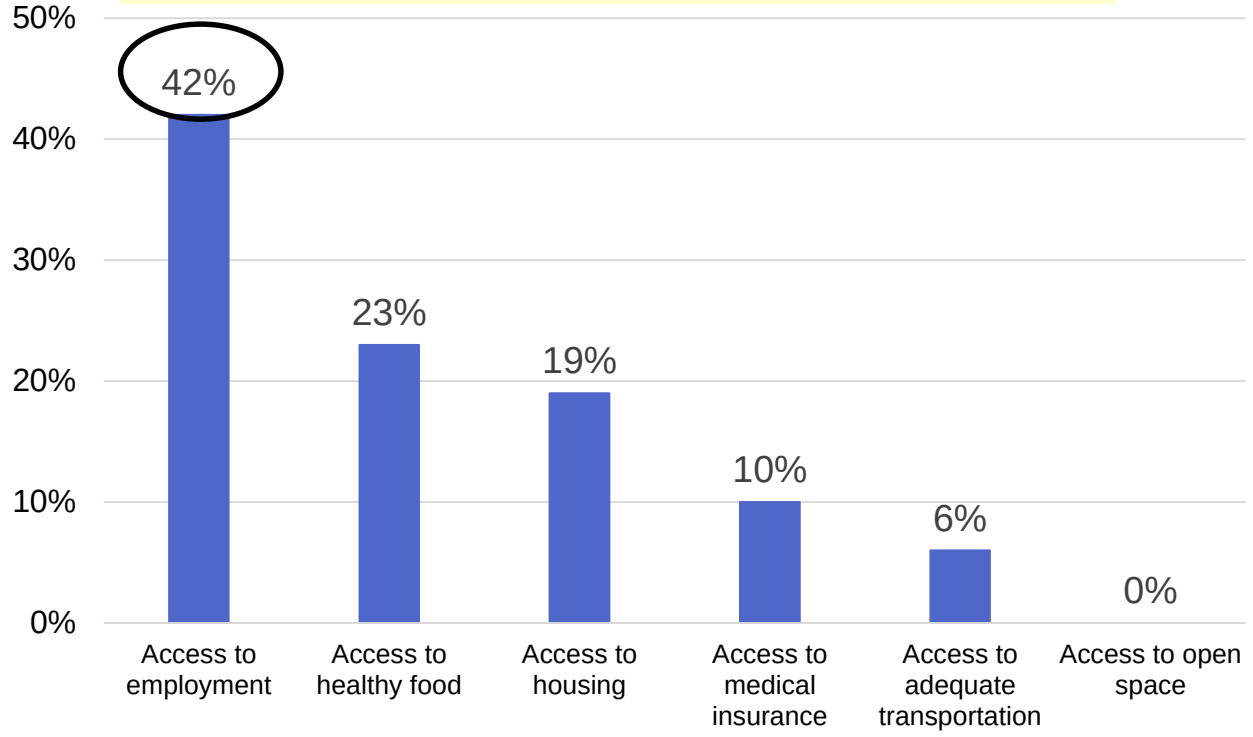
- Broken families
- Community safety
- Substance abuse (amongst caregivers)
- School Readiness

Economic (35%)

- Lack of recreational space
- Lack of access to a primary care physician
- Working parents unable to take children to appointments

Rank Socio-Economic barriers to good health*

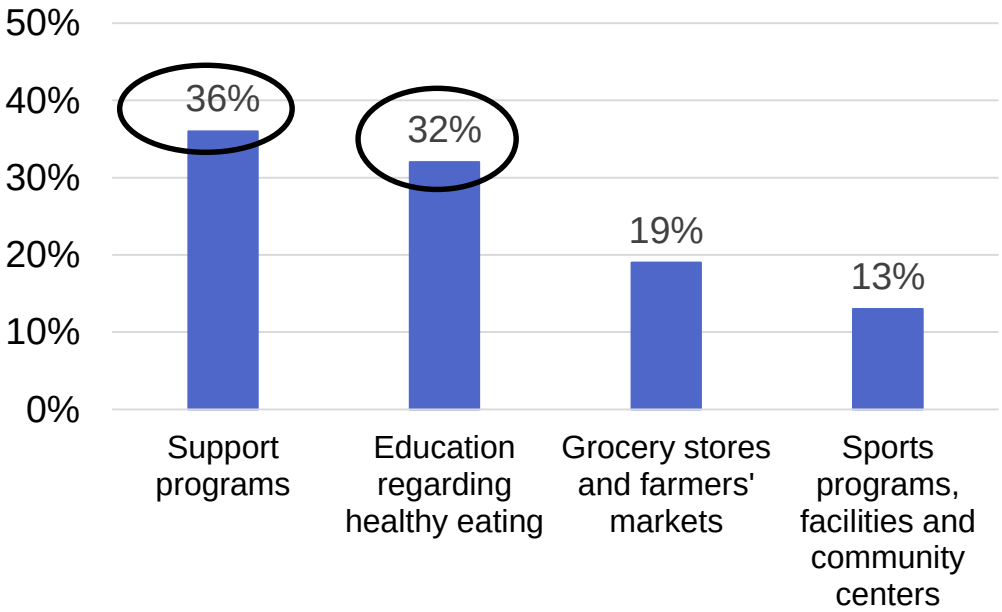
Access to employment was the most important factor



*Percentages were calculated using the responses ranked 1 or most important

Rank Environmental barriers to good health*

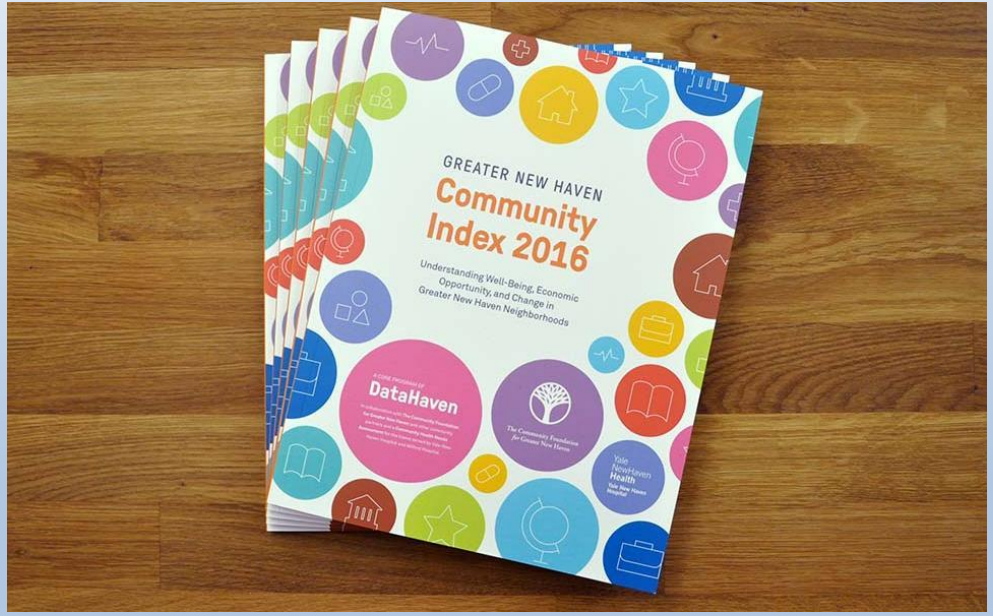
Lack of support programs and education regarding healthy eating



*Percentages were calculated using the responses ranked 1 or most important

Community Wellbeing Survey: 2018

DataHaven
The Twenty Fifth Year



Website: www.ctdatahaven.org

Survey Methodology

- In-depth interviews with nearly 16,043 Connecticut and New York residents in 2018
- Largest wellbeing survey in the US
- Topics covered: physical & mental health, economic opportunity, housing, transportation, and civic engagement.
- Conducted & weighted to be representative of adults in each area
- Randomly-selected landline & cell phone numbers (any area code) were called to ensure a representative sample
- Conducted in English & Spanish

2018 Connecticut Wellbeing Survey

- 16,043 Connecticut and New York
  - 2,367 Greater New Haven:
  - 663 Outer Ring*
  - 270 Milford
  - 145 East Haven
  - 292 Hamden
  - 266 West Haven
  - 1,001 New Haven

*Outer Ring includes the following nine towns Bethany, Branford, Guilford, Madison, Milford, North Branford, North Haven, Orange, and Woodbridge.

2015-2018 Social Trends in Greater New Haven

Economic Stability

- Improved perception of job opportunity
- Rising financial stress: ex. adults with <2 months of savings increased (Region: 30% to 31% New Haven: 31% to 37%)

Neighborhood and Physical Environment

- Increased feelings of personal safety in city but not in suburban areas
- Bikeability perceptions improved (66% of region and 69%)

Community and Social Context

- Slightly lower levels of life satisfaction and happiness, higher reported anxiety
- Confidence in ability to influence local government rose from 59% to 71%

2015-2018 Health Trends in Greater New Haven

BMI (from height/weight)

- Obesity rates fairly stable:
  - From 29% to 30% in Greater New Haven
  - From 29% to 31% in New Haven

Tobacco

- Possible increase in smoking in Greater New Haven (from 14% to 16%)
- Rise in vaping (21% of adults having tried e-cigs)
- Adults using e-cigarettes in past 30 days:
  - 10% of Greater New Haven adults
  - 13% of city adults
  - 8% statewide

Mental Health

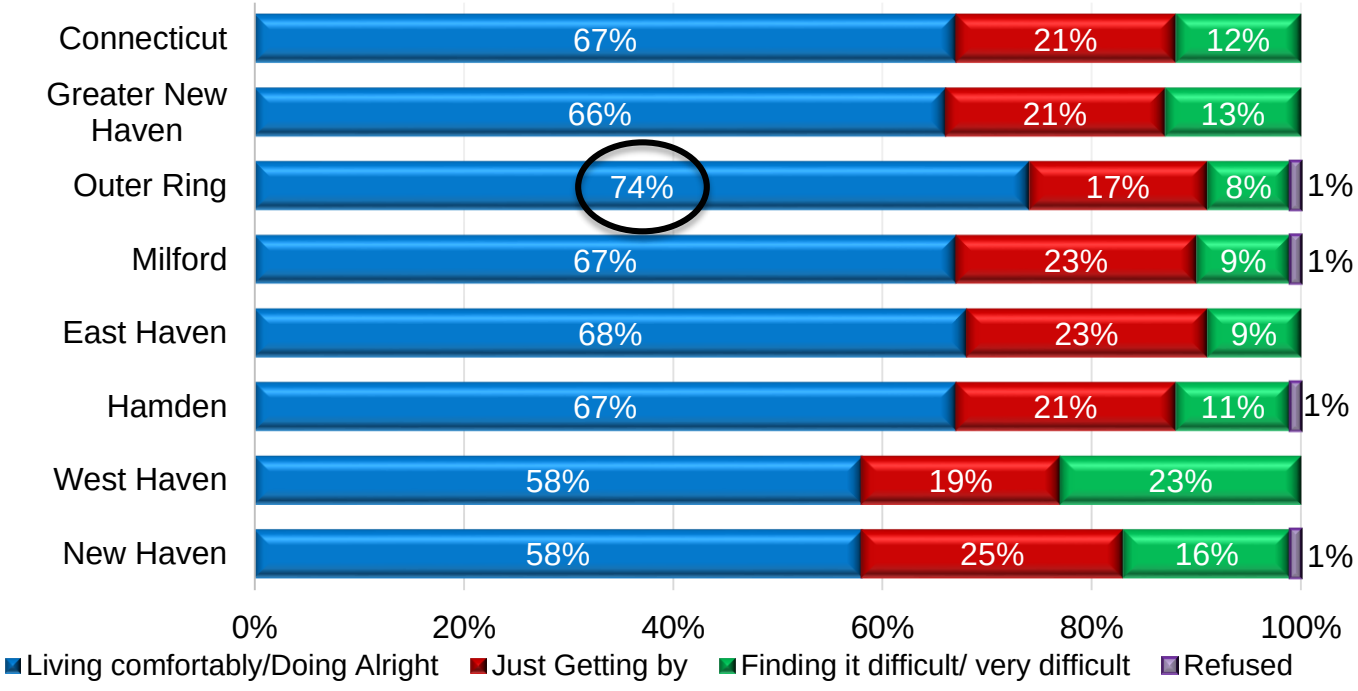
- Higher reported anxiety in the city & region
- Slightly lower levels of life satisfaction and happiness

2015-2018 Health Trends in Greater New Haven

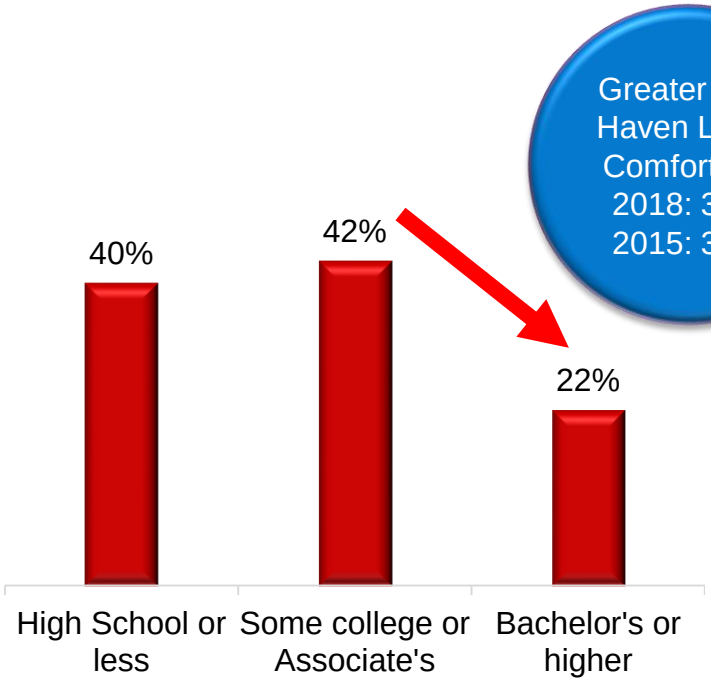
Health Care Access

- Adult health insurance coverage rate stable
- Dental visit in the past year declined
  - 72% of adults in region down from 75% in 2015
- Adults not getting the medical care they need increased
  - 8% to 9% in region
- Adults who postponed care rose from 20% to 22% in region
- Low-income adults (17%) and Latinos (18%) are twice as likely to say they didn't get the medical care they needed in the past year

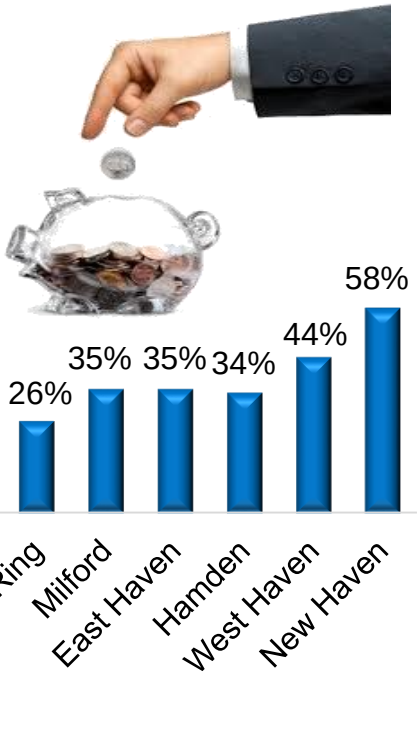
How well would you say you are managing financially these days? Would you say you are…



Ability to last 1 month but less than 2 without all current sources of income: Education Level / Town (n 31%)

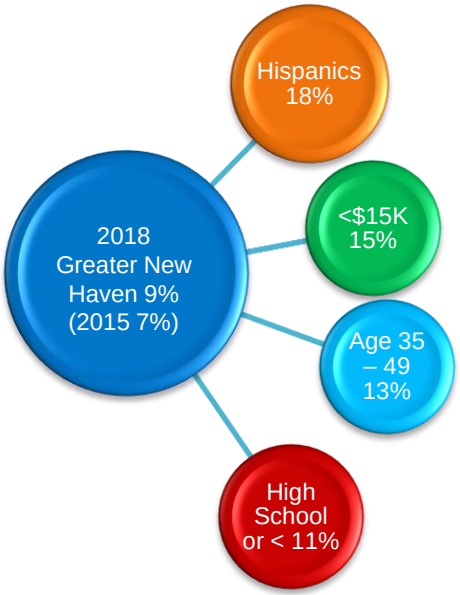


Greater New Haven Living Comfortably
2018: 31%
2015: 33%



Source: 2018 State of CT Wellbeing Survey, DataHaven

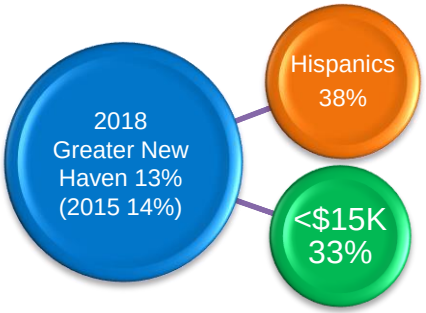
Housing Insecurity Respondent Demographics



Source: 2018 State of CT Wellbeing Survey, DataHaven

Food Insecurity Respondent Demographics

Food
Insecure

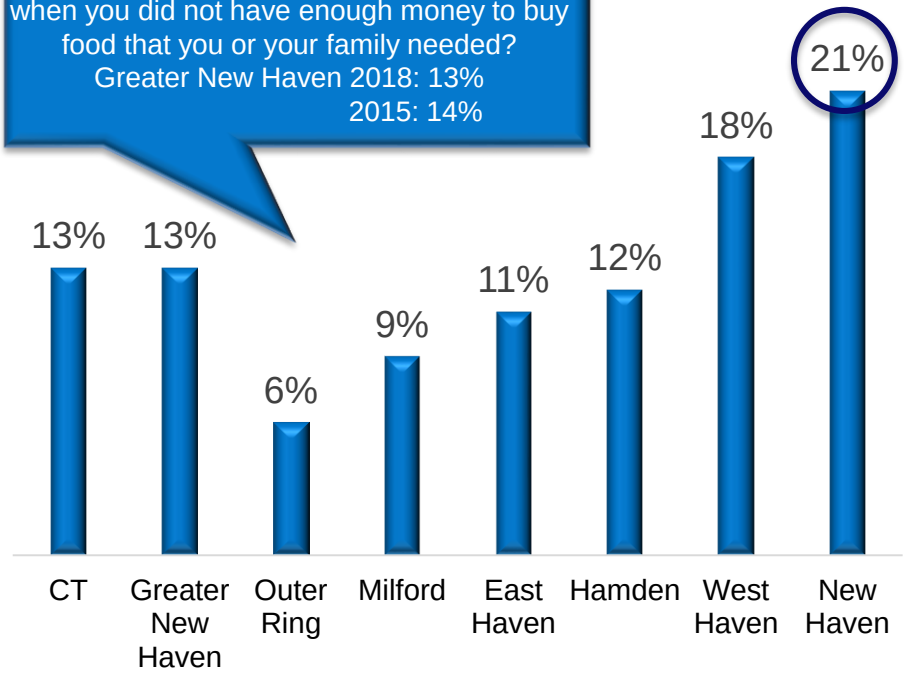


For the 13%, occurs nearly every month for 29% of respondents

Source: 2018 State of CT Wellbeing Survey, DataHaven

Food Insecurity:
Town

Have there been times in the past 12 months when you did not have enough money to buy food that you or your family needed?
Greater New Haven 2018: 13%
2015: 14%



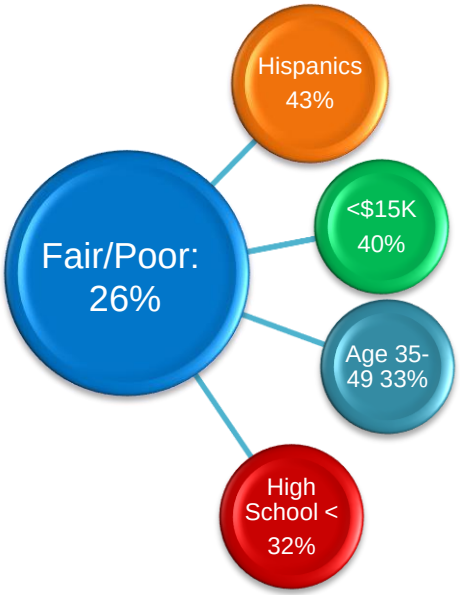
How often did you not have enough money to buy food that you and your family needed?

New Haven

69% did not have enough money either every month or some months

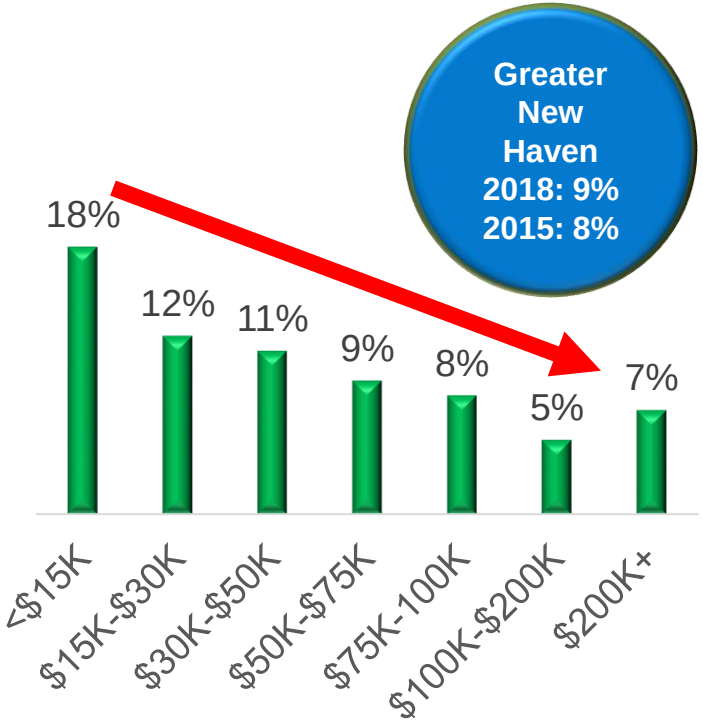
Source: 2015 & 2018 CT Wellbeing Surveys, Data Haven

Access to Affordable Fruit & Vegetables



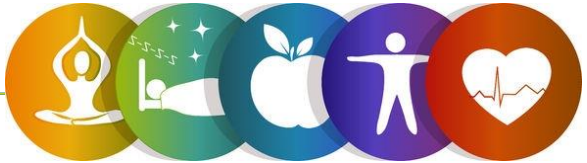
Source: 2018 State of CT Wellbeing Survey, DataHaven

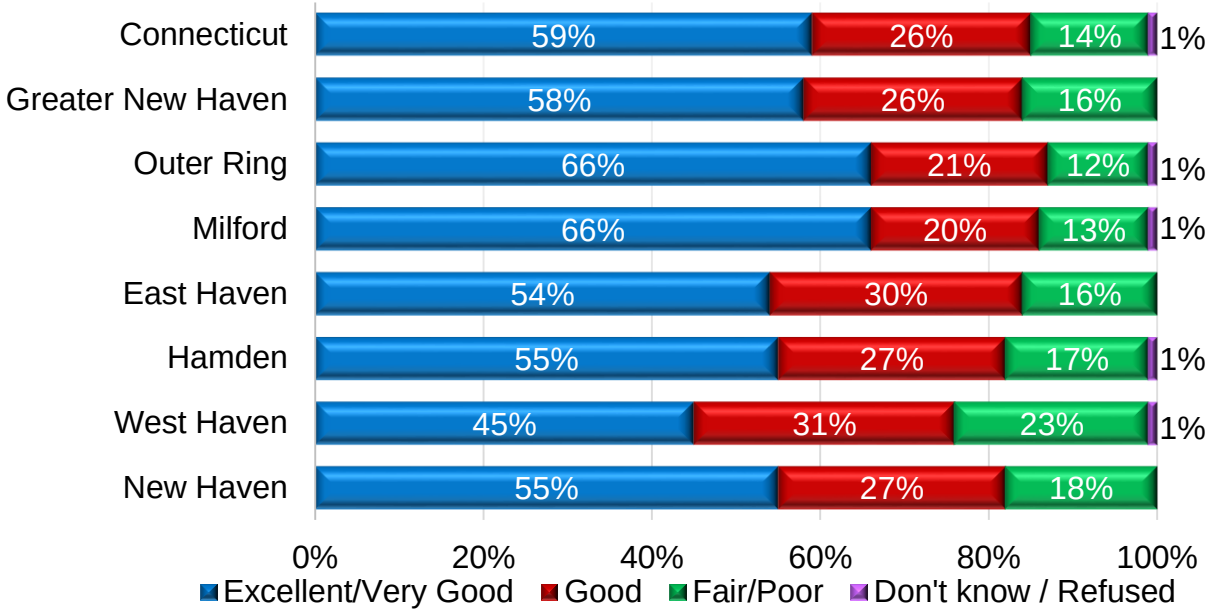
Unable to afford prescription medication due to cost:
Income



Source: 2018 State of CT Wellbeing Survey, DataHaven

Self Reported Health Status

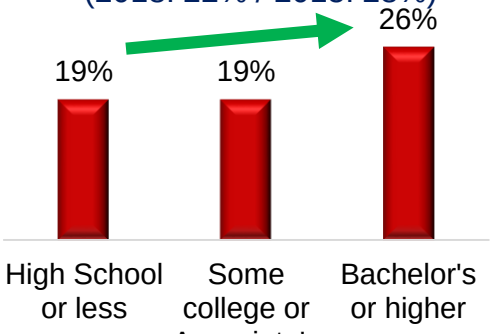


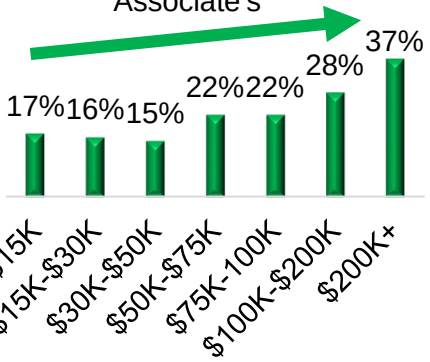


Source: 2018 State of CT Wellbeing Survey, DataHaven

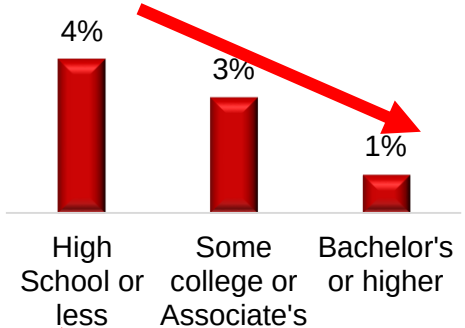
Self Reported Health Status:
Educational Attainment/Income

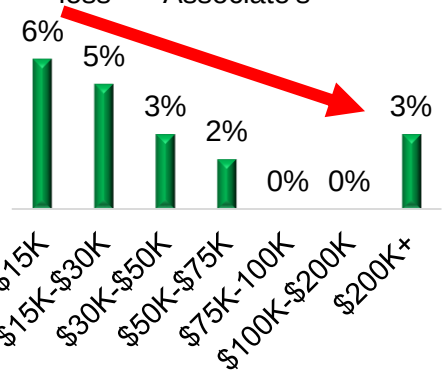
Excellent Health
(2018: 22% / 2015: 28%)





Poor Health
(2018: 3% / 2015: 4%)





Source: 2018 State of CT Wellbeing Survey, DataHaven, self reported excellent

Medical Conditions
(as diagnosed by a doctor or health professional)

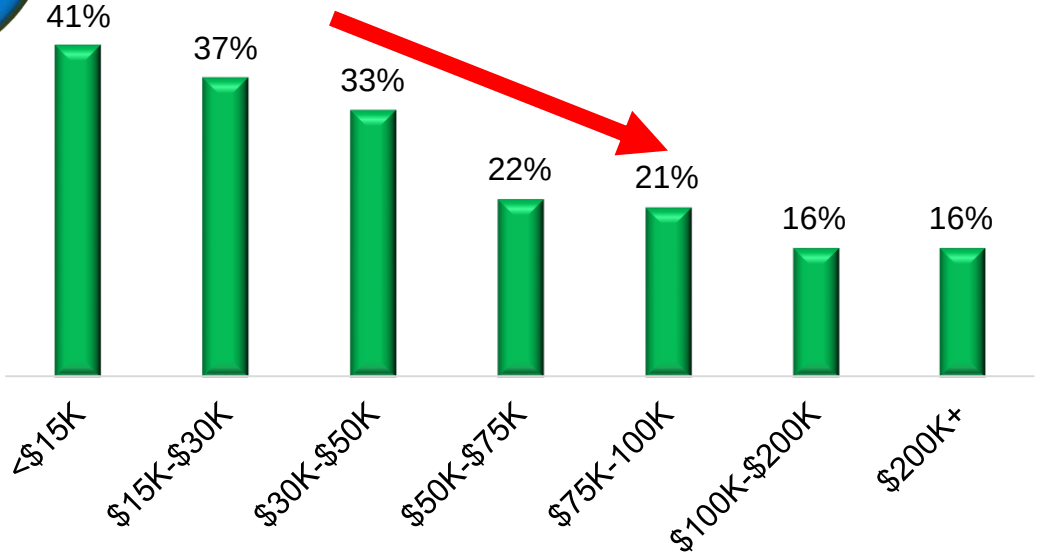
	CT	Greater New Haven	Outer Ring	Milford	East Haven	Hamden	West Haven	New Haven
High blood pressure/ Hypertension	30% (28%)	29% (27%)	28% (27%)	29% (25%)	35%	26% (27%)	35% (33%)	31% (24%)
Diabetes	10% (9%)	9% (9%)	9% (5%)	10% (7%)	13%	10% (13%)	14% (11%)	10% (10%)
Heart disease/ Heart attack	6% (5%)	6% (6%)	6% (5%)	6% (5%)	5%	6% (5%)	7% (9%)	5% (5%)
Asthma	15% (13%)	15% (13%)	14% (10%)	15% (14%)	9%	14% (6%)	15% (14%)	20% (17%)

Source: 2015 & 2018 State of CT Wellbeing Survey, DataHaven

Emergency Department Use: Town / Income

Greater New Haven
2018: 26%
2015: 28%

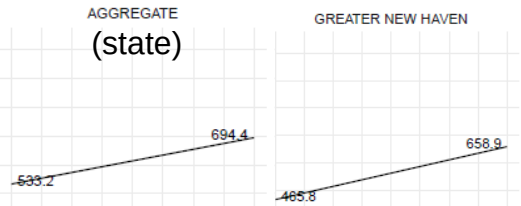
1 or more visits to the Emergency Room in the past 12 months



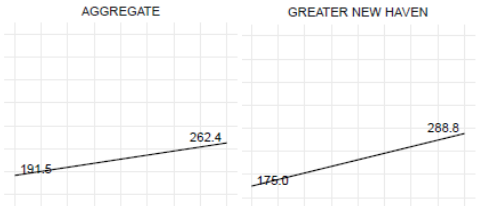
Source: 2015 & 2018 State of CT Wellbeing Surveys, DataHaven; ED 1 or more times by income

New Data: CHIME data on all Hospital Encounters

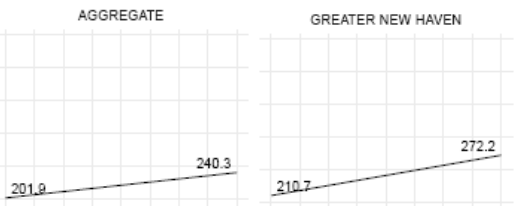
Rising rate of Greater New Haven resident visits for mental disorders, COPD, heart disease, and diabetes, in line with statewide trends



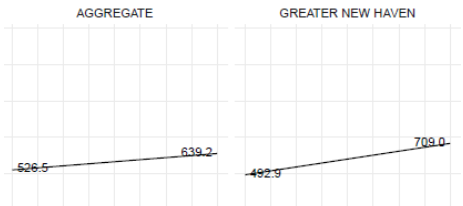
Mental Disorders Encounter Rate Trend, 2012-14 versus 2015-17



COPD Encounter Rate Trend, 2012-14 versus 2015-17

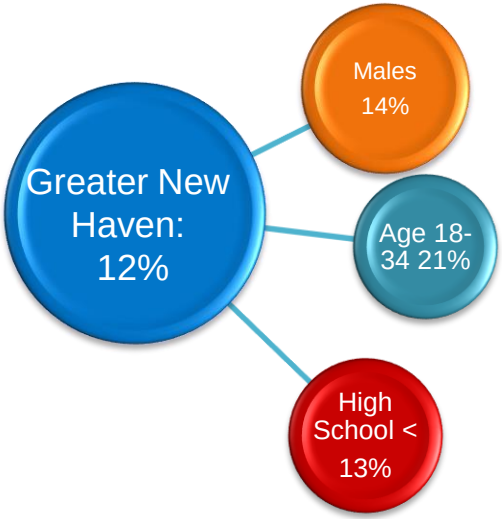


Heart Disease Encounter Rate Trend, 2012-14 versus 2015-17



Diabetes Encounter Rate Trend, 2012-14 versus 2015-17

No Medical Home Rate

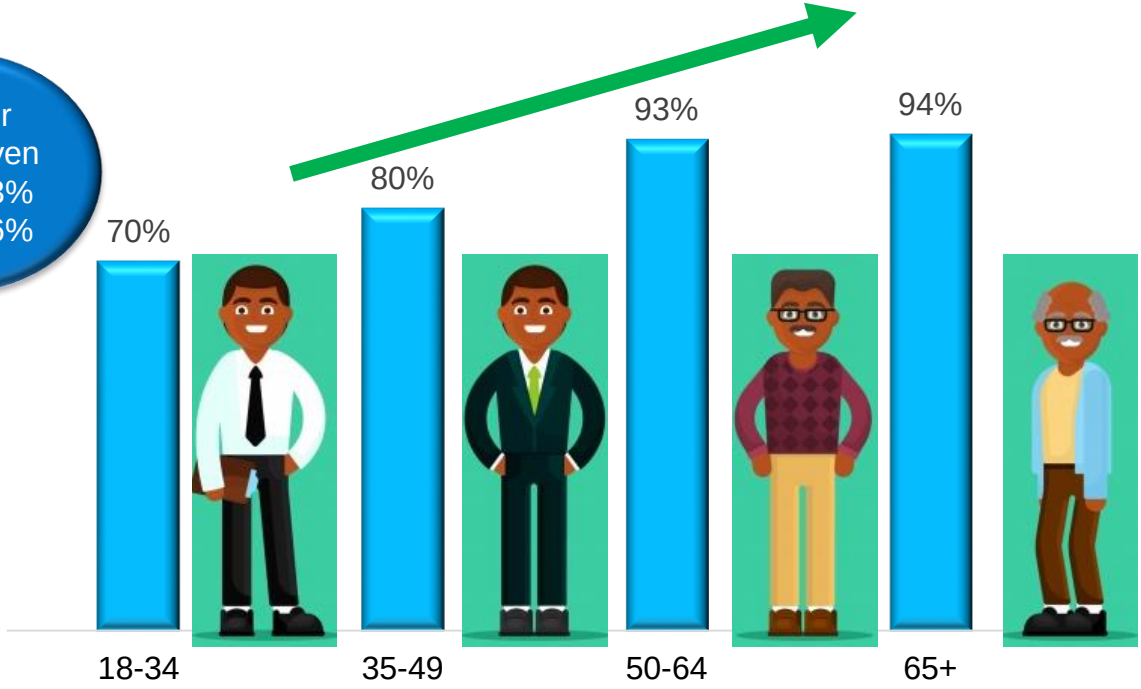


CT	Outer Ring	Milford	East Haven	Hamden	West Haven	New Haven
11%	8%	11%	13%	10%	7%	18%

Source: 2018 State of CT Wellbeing Surveys, DataHaven

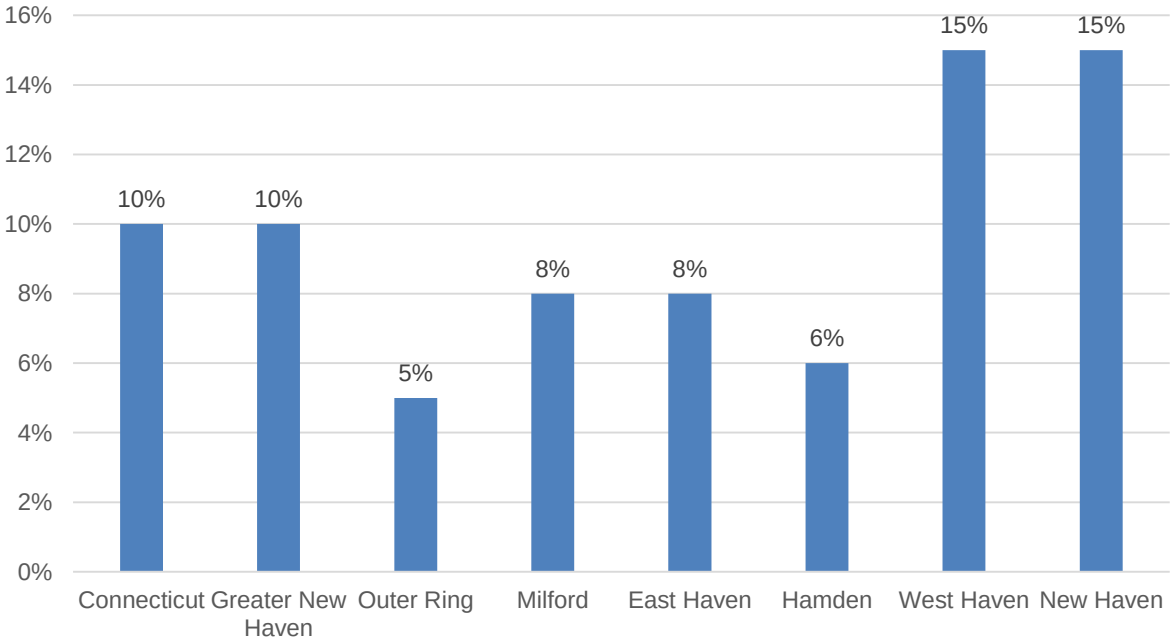
Personal doctor or health care provider:
Age/Gender

Greater New Haven
2018: 83%
2015: 86%



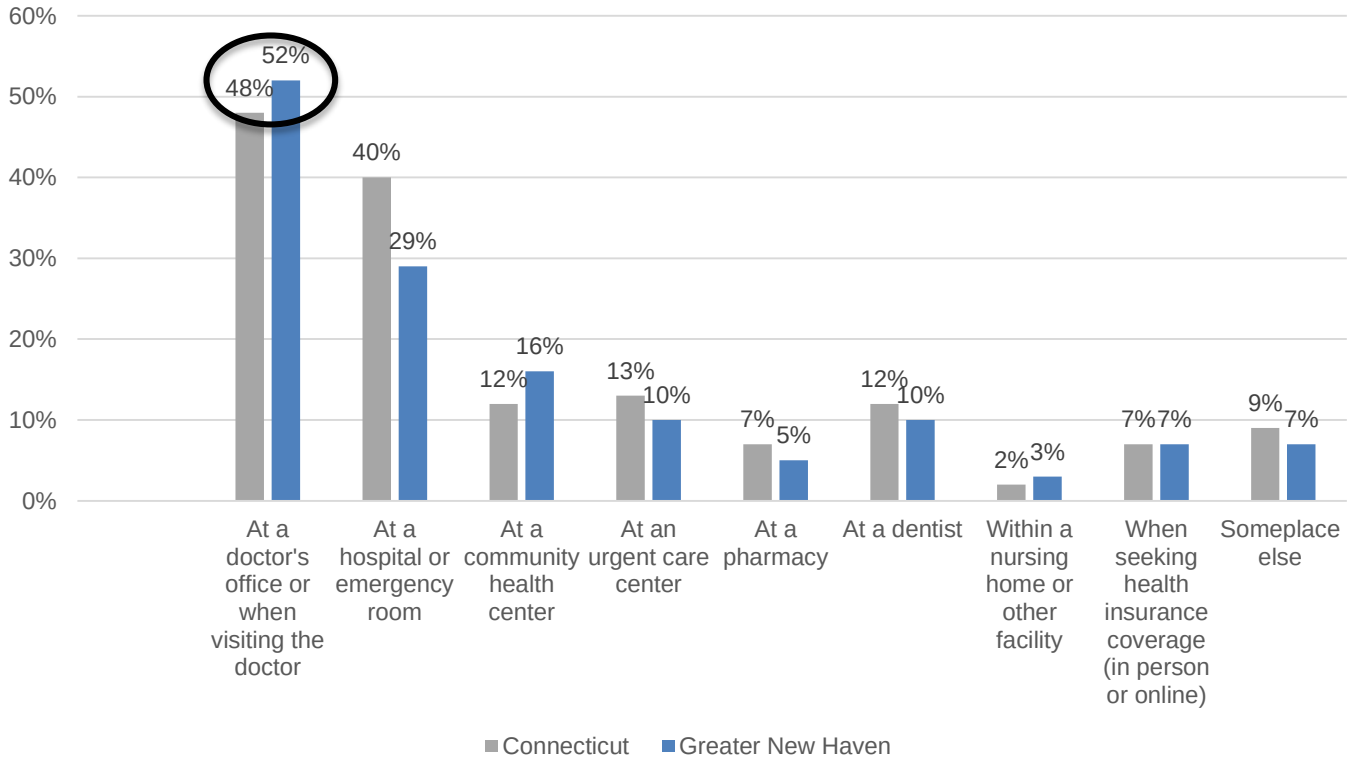
Source: 2015 & 2018 State of CT Wellbeing Surveys, DataHaven

Discrimination When Receiving Health Services



Source: 2018 State of CT Wellbeing Survey, DataHaven

Discrimination in Doctor's Office



Source: 2018 State of CT Wellbeing Survey, DataHaven

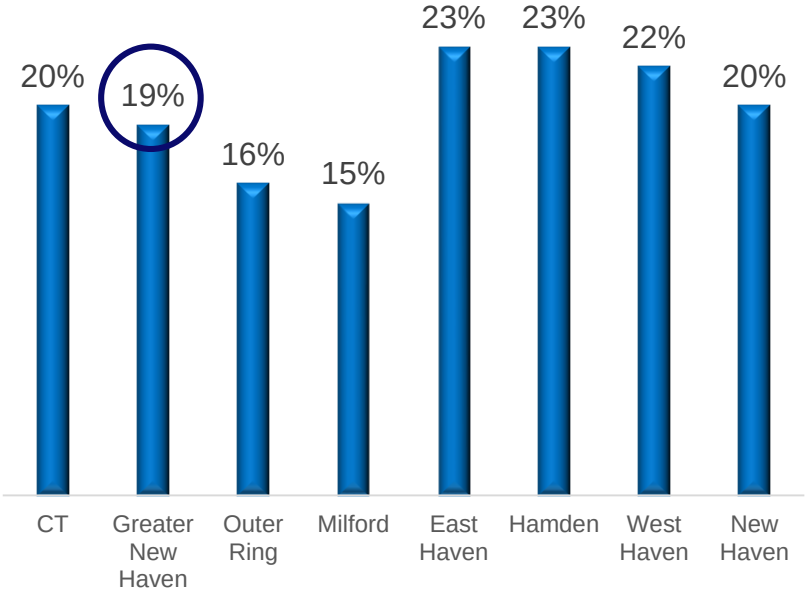
Reason for Discrimination

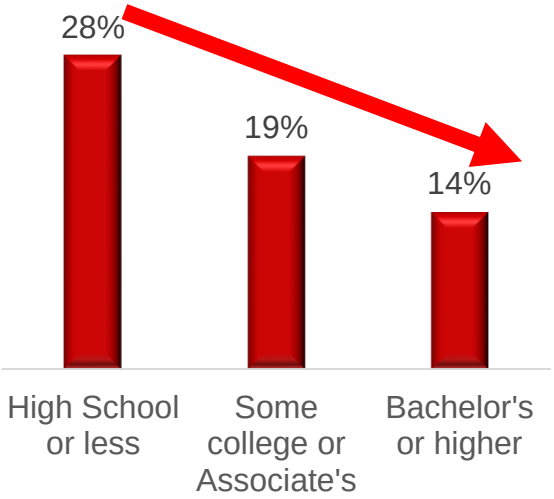
Responses	CT	Greater New Haven	New Haven
Ancestry/origin	7%	7%	4%
Gender	12%	10%	11%
Race	17%	17%	19%
Age	12%	8%	8%
Religion	3%	5%	7%
Height	1%	2%	1%
Weight	8%	8%	5%
Other aspect of appearance	11%	9%	9%
Sexual orientation	4%	15%	5%
Education or income level	13%	10%	8%
A physical disability	6%	4%	4%
Health insurance status	26%	31%	33%
Don't know / Refused	24%	30%	22%

How many days per week do you exercise:
Town / Educational Attainment

American Heart Association recommends 150 minutes per week of moderate-intensity aerobic activity or 75 minutes per week of vigorous aerobic activity, or a combination of both

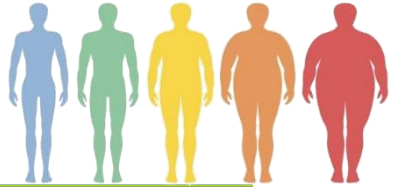
19% Greater New Haven (2018) respondents did not exercise compared to 16% in 2015



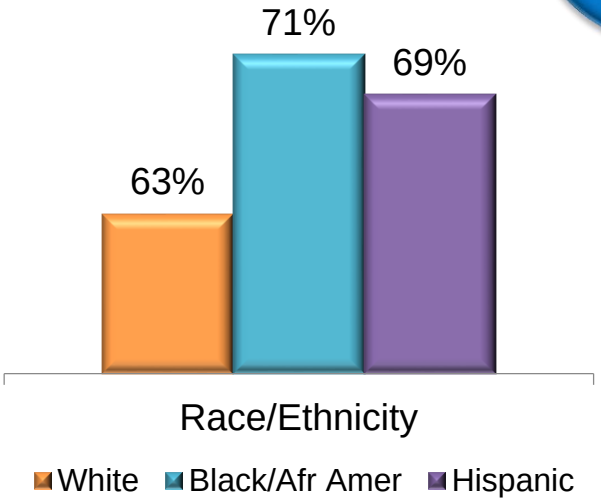


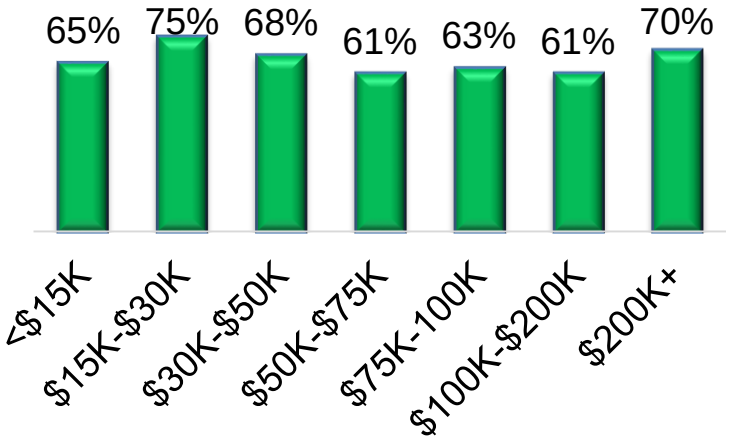
Source: 2018 State of CT Wellbeing Survey, DataHaven

Self Reported BMI Overweight & Obese:
Race / Income



Greater New Haven
2018: 65%
2015: 63%

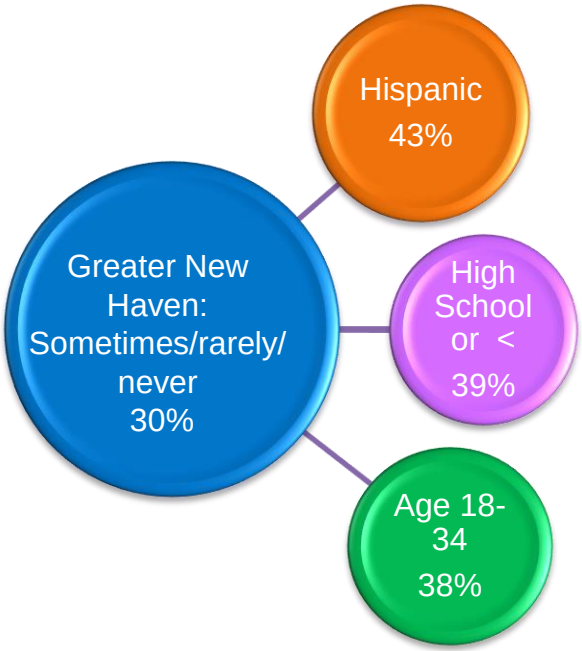




Source: 2018 State of CT Wellbeing Survey, DataHaven

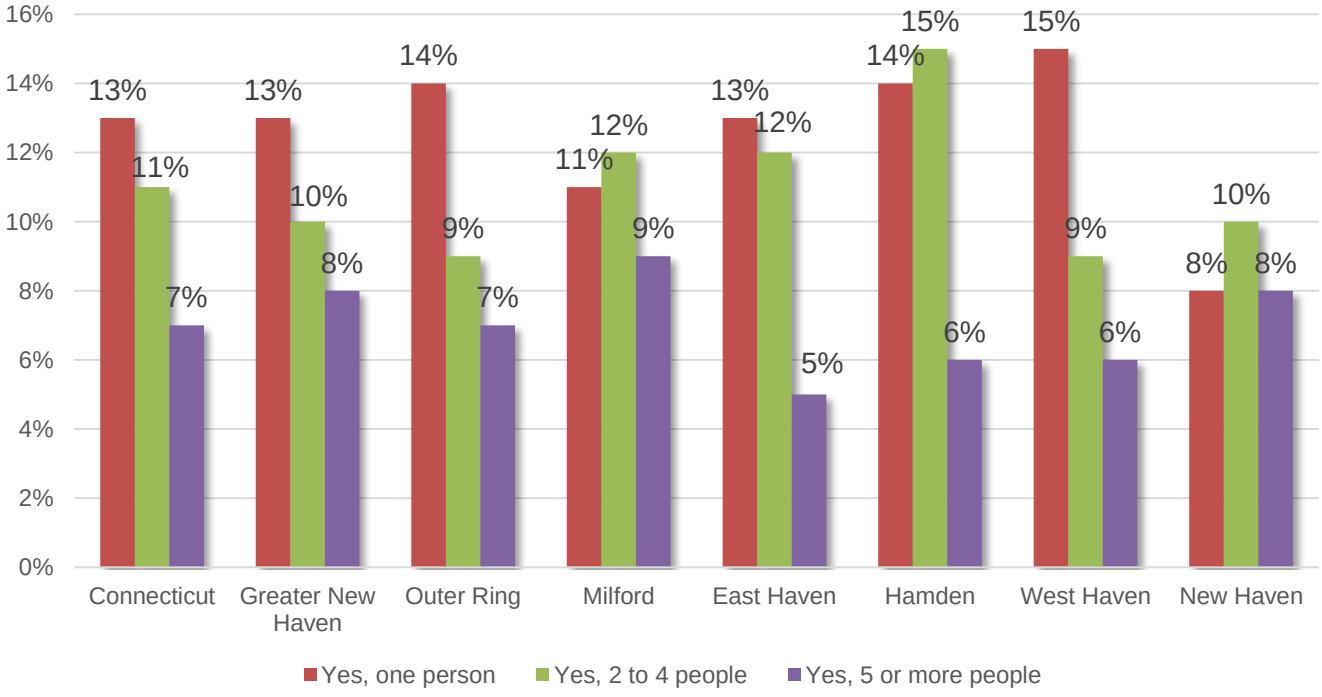
Social & Emotional Support

30% say they sometimes/rarely, or never get the social and emotional support they need



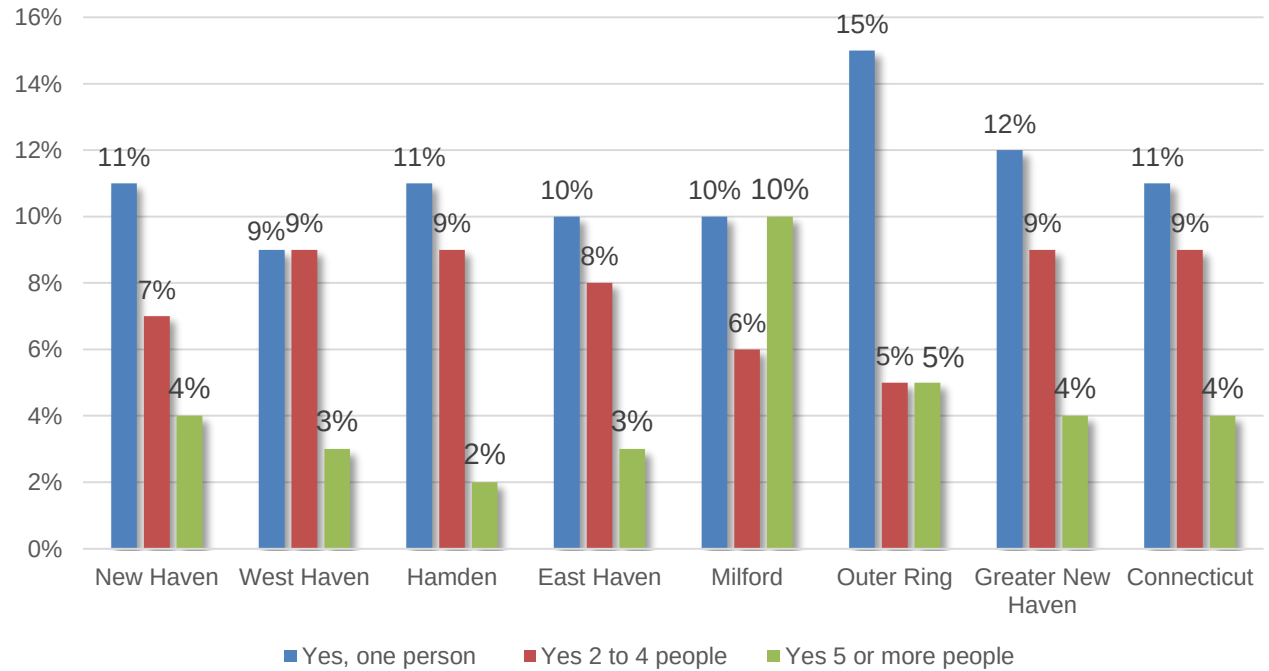
Source: 2018 State of CT Wellbeing Survey, DataHaven

Personal Knowledge of Someone Misusing Opioids



Source: 2018 State of CT Wellbeing Survey, DataHaven

Personal Knowledge of Someone Dying from Opioid Overdose

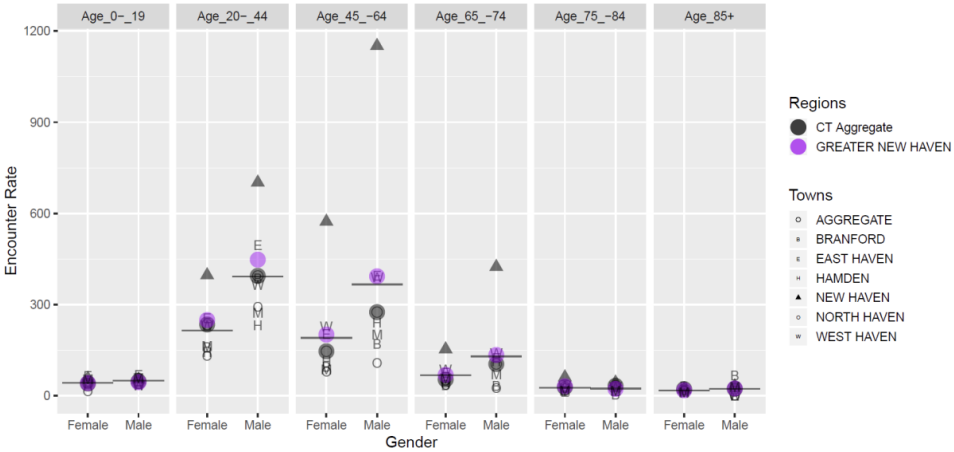


Source: 2018 State of CT Wellbeing Survey, DataHaven

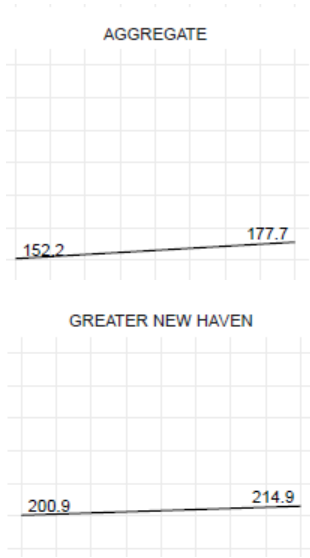
DataHaven
The Twenty Fifth Year

New Data: CHIME data on all Hospital Encounters

Rising rates of substance misuse encounters, similar to state



Higher rates among men, age 20-74 across residents of all towns, especially New Haven, East Haven, West Haven



Substance Misuse Encounter Rate Trend, 2012-14 versus 2015-17

Community Conversations

We Want To Hear From You!

Your Voice Matters

Tell us about community health needs and concerns.

What:
Community Conversation about healthcare

Where:
Keefe Center
11 Pine Street,
Hamden, CT 06514

When:
Thursday,
March 21, 2019

6:00 p.m. to 7:30 p.m.

Dinner will be served. Be the first 20 to arrive and receive a gift card!

Join the conversation

Healthier Greater New Haven Partnership

HEALTH EQUITY SOLUTIONS

Greater New Haven Community Conversations

Location & Audience

Target Population	Location	Date	Number Attending
Behavioral Health	New Haven Public Library	2/28/19	24
Seniors	Madison Senior Center	3/11/19	7
Mixed group	East Shore Health District	3/11/19	11
Mixed group	Keefe Center	3/21/19	12
Mixed group	Milford Hospital	3/27/19	5
Health Leaders	Southern Connecticut State University	4/18/19	13
Uninsured	TBD	TBD	TBD
TOTAL			72

Social Determinants of Health (SDoH)

Source: Healthy People 2020

Community Conversation Themes
Key Themes by SDoH Domains

Health & Health Care System
- Health
- Health Coverage/Insurance

Neighborhood & Built Environment
- Housing
- Neighborhood
- Safety
- Transportation

Social & Community Context
- Community
- Mental Health
- Substance Use

Community Conversation Themes

Health

- Diabetes
- Heart Disease
- Obesity

Health Coverage/Insurance

- Lack of affordable health insurance options
- Lack of urgent care facilities or hours of operation do not meet need
- Medication is not affordable

Community Conversation Themes

Housing

- Lack of affordable housing/gentrification
- High rates of homelessness

Neighborhood

- Variability in what's available based on zip code/neighborhood
- Variability of services based on zip code/neighborhood

Safety

- Walkability & safety limited due to lack of street lighting

Transportation

- Limitations of public transportation to get around

Community Conversation Themes

Community

- Need to come together more as a community (New Haven & Hamden)

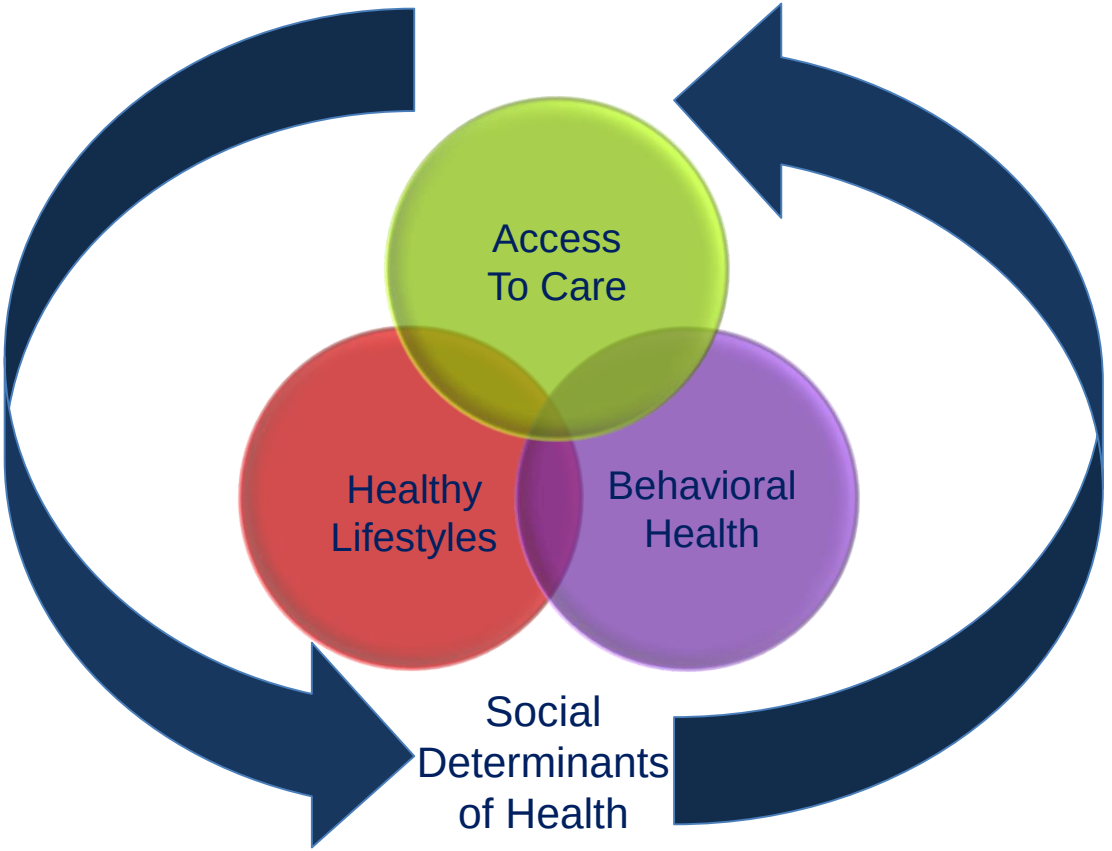
Mental Health

- Stress, depression, trauma, & anxiety (related to a variety of issues)
- Limited availability of services; more services needed

Substance Use

- Alcoholism and drug addiction (specifically opioids)

Implementation Strategy Focus Areas



2019-2022 Community Health Improvement Plan: Access to Care

By February 2022, the rate of adults without a medical home will reduce by 2%.

Strategies:

- Promote available primary and specialty medical services in the Greater New Haven region to impact the number of individuals who have a medical home
- Increase implementation of Culturally and Linguistically Appropriate Services(CLAS) standards throughout the Greater New Haven region as a way to address discrimination in the health care setting
- Address access issues such as clinic times and appointment availability
- Support efforts to increase economic security of individuals living in the region

2019-22 Access To Care
Community Health Improvement Plan

Indicator: Percentage of people reporting they do not have one person or place you think of as your personal doctor or health care provider **[2015- 13%, 2018-17%]**

Indicator: Percentage of people reporting they experienced discrimination at the doctor's office **[2015- N/A ;2018-52%]**

Indicator: Percentage of people in Greater New Haven that indicate they do not have a medical home **[2015- N/A;2018-12%]**

**Source:* *CT Well-Being Survey 2015 and 2018*

Goal: By February 2022, the rate of adults without a medical home will reduce by 2%.

Strategy	Action Steps	Outcomes
Promote available primary and specialty medical services in the greater new haven region to impact the number of individuals who have a medical home	• Continue to work with the Primary Care Consortium • 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 • Promote the importance of having a regular source of care (medical home) • Leverage Patient Centered Medical Home (PCMH) and Person Centered Medical Home + (PCMH+), CMMI Accountable Health Communities (AHC) and CDC Racial and Ethnic Approaches to Community Health (REACH) grants to improve referrals and patient navigation between partner organizations and providers (primary and specialty, including mental health) • Leverage CARE Health Leaders program • Improve / evaluate access to Community Health Workers (CHWs)	# of gaps identified # of collaborations with specialty care providers accepting uninsured and Medicaid patients # of communications regarding medical homes # of referrals

Note: Indicators and goal are from the DataHaven 2015 and 2018 Wellbeing Survey

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

Strategy	Action Steps	Outcomes
Increase implementation of culturally and linguistically appropriate services(**CLAS)** standards throughout the greater new haven region as a way to address discrimination in the health care setting	• Complete a CLAS assessment with local partner organizations to determine current gaps and implement CLAS strategies as needed • Collect CLAS implementation tools and disseminate (ensure awareness of race, ethnicity, gender and LGBTQ issues) • Engage patients, public health departments, hospital association and other groups to conduct events promoting and/or training on CLAS (New England Public Health Training Center (NEPHTC), Connecticut Public Health Association (CPHA), Health & Equity, LLC, others)	# of organization assessments completed # of events promoting CLAS
Strategy	**Action Steps**	**Outcomes**
Address access issues such as clinic times and appointment availability	• Asset mapping and gap analysis focused on hours of operation for clinical and community based care options, to include urgent care, Federally Qualified Health Centers (FQHCs), FQHC look-alike, and other community health centers • Create a report of the findings and share broadly with the provider community and the community	Completion of mapping and analysis Completion of report # of educational sessions using the report # of providers using the report to drive change
Strategy	**Action Steps**	**Outcomes**
Support efforts to increase economic security of individuals living in the region	• Identify areas of focus each legislative session. 2019 examples include paid family medical leave, affordable housing, and living wage)	# of letters of support # of issues supported

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

Partner Organizations
Community Alliance for Research and Engagement (CARE), Cornell Scott Hill Health Center, East Shore District Health Department, Fair Haven Community Health Care, Milford Hospital, Project Access-New Haven, Quinnipiak Valley Health District, Yale New Haven Health, Yale New Haven Hospital, Yale School of Medicine Primary Care Residency Program

2019-2022 Community Health Improvement Plan: Healthy Lifestyles

By February 2022, promote healthy lifestyles and access to healthy food in the Greater New Haven region to reduce the combined percentage of adults who are obese or overweight to 62%.

Strategies:

- Promote proper nutrition
- Increase access to healthy food and affordable fruits and vegetables
- Promote free and low cost physical activity opportunities
- Increase utilization and access to health screenings
- Support partner organizations in activities related to healthy lifestyles

2019-22 Healthy Lifestyles Community Health Improvement Plan

Indicator: Percentage of people in Greater New Haven that indicate availability of affordable, high-quality fruits & vegetables where they live **[2015 – N/A, 2018-70%]**

Indicator: Percentage of people in Greater New Haven that indicate they have enough money to buy food for themselves & their family **[2015-14%, 2018-13%]**

Indicator: Percentage of people in Greater New Haven that are overweight or obese **[2015-63%, 2018-65%]** and percentage of people maintaining a normal weight **[2015-35%, 2018-33%]**

**Source- CT Well-Being Survey 2015 and 2018*

Goal: By February 2022, promote healthy lifestyles and access to healthy food in the Greater New Haven region to reduce the combined percentage of adults who are obese or overweight to 62%.

Strategy	Action Steps	Outcomes
Promote proper nutrition in the greater new haven region	• Review current data and collect additional data (as needed) to gain a deeper understanding of issues that impact proper nutrition and develop a plan to address the needs and gaps • Partner with Quinnipiak Valley Health District to gather baseline data on healthy eating habits and issues impacting proper nutrition and explore expansion to other areas in the region • Conduct culturally appropriate and culturally relevant nutritional education sessions throughout the region • Support the expansion of the Supporting Wellness at Pantries (SWAP) in local food pantries • Align work with current local activities (New Haven Food Policy Council, others) • Continue and expand current social media and community outreach efforts that promote proper nutrition techniques	Review of available data Baseline data collection and analysis Track new data collected # of people reached through community nutrition education sessions # of community nutrition education sessions offered # of food pantries utilizing SWAP Track social media and community outreach efforts on proper nutrition

Note: Indicators and goal are from the DataHaven 2015 and 2018 Wellbeing Survey

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

Strategy	Action Steps	Outcomes
Increase access to healthy food and affordable fruits and vegetables in the greater new haven region	• Increase access to healthier food in food pantries by promoting healthy food donations, utilizing health screening data to inform food choices in pantries • Support healthy food drives throughout the region • Promote programs that provide access to free or low cost fruits and vegetables throughout the region (CT Food Bank Mobile Food Pantries, farmers markets, community supported agriculture, etc.) and explore opportunities to partner to expand these options.	# of healthy food drives conducted in the region # of new programs developed to expand access to free or low cost fruits and vegetables
Strategy	**Action Steps**	**Outcomes**
Promote free and low cost physical activity opportunities in the greater new haven region	• Work with partners, including local parks and recreation departments, to identify available programs and determine how to better promote them in the community • Continue to provide the Get Healthy Walk 'n Talks and expand to other areas and towns as appropriate	Develop program promotion strategies # of Get Healthy Walk 'n Talks hosted # of Get Healthy Walk 'n Talk participants
Strategy	**Action Steps**	**Outcomes**
Increase utilization and access to health screenings	• Educate the community on importance of knowing health numbers (body mass index, blood pressure, diabetes risk, etc.) through initiatives including the Know Your Numbers (KYN) screening program in food pantries and expand to include additional partners and sites as appropriate • Include nutrition education and connection to follow-up care during community KYN screenings	# of KYN screenings # of new KYN sites # of KYN screening participants # of KYN screening participants referred to follow-up care # of KYN screening participants referred to nutrition education

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

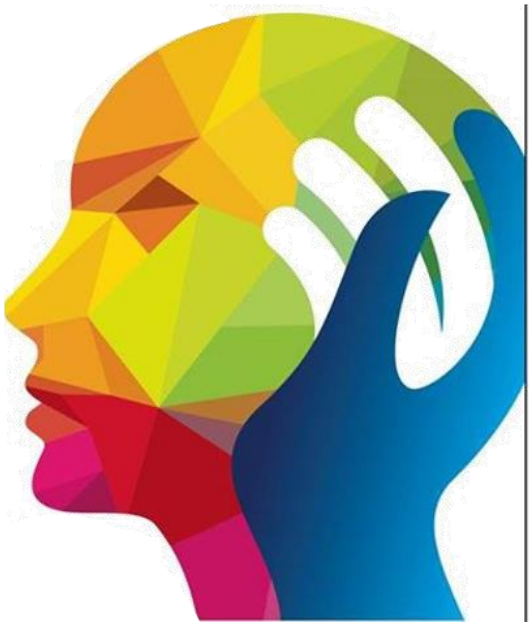
Strategy	Action Steps	Outcomes
Support partner organizations in activities related to healthy lifestyles in the greater new haven region	• Utilize monthly meetings to share and promote activities related to improving healthy lifestyles in the Greater New Haven Region • Identify new partners and continuously work to expand the reach of the Healthy Lifestyles Workgroup • Align work with Community Alliance for Research and Engagement (CARE) to support REACH grant activities in New Haven and determine opportunities to replicate initiatives in other communities as appropriate • Support local healthy lifestyles CHIP work of area health departments/districts (East Shore District Health Department, Quinnipiak Valley Health District and others) and provide opportunities for sharing updates/best practices among other regional partners	# of workgroup meetings that include opportunities to share and promote partners events/activities # of new partner organizations involved in Healthy Lifestyles Workgroup Track outcomes of CARE REACH grant # of monthly workgroup meetings with updates from partners on their local CHIPs
Partner Organizations		
Yale New Haven Hospital, Milford Hospital, New Haven Health Department, East Shore District Health Department, Quinnipiak Valley Health District, Madison Health Department, Milford Health Department, Cornell Scott-Hill Health Center, Central Connecticut Coast YMCA, Hispanic Health Council, NH Food Policy Council, School-Based Health Centers, CT Food Bank, Southern Connecticut State University, Community Alliance for Research and Engagement, CT Academy of Nutrition and Dietetics, local food pantries, CT Food Bank, Fair Haven Community Health Center, Hispanic Health Council, New Haven Parks and Recreation, Project Access New Haven, Yale University- Yale School of Public Health, Special Olympics CT, Smilow Screening and Prevention, local municipalities		

2019-2022 Community Health Improvement Plan: Behavioral Health

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

Strategies:

- Support substance use education and prevention efforts in the community aimed at reducing the stigma of getting mental health treatment
- Support suicide prevention activities aimed at reducing the stigma associated with suicide



2019-22 Behavioral Health Community Health Improvement Plan

Indicator: Percentage of people in the Greater New Haven region who indicate they receive the emotional and social support they need. **[2015-N/A; 2018-Greater New Haven always-usually 68%]**

Indicator: Percentage of people in the Greater New Haven region who indicate they know anyone who has struggled with misuse or addiction to heroin or other opiates such as prescription painkillers at any point during the last three years. **[2015-N/A; 2018-Greater New Haven-one or more people 31%]**

Indicator: Percentage of people in the Greater New Haven region who indicate that they personally know someone who has died from an opioid overdose**. [2015-N/A; 2018-Greater New Haven-one or more people 25%]**

**Source: CT Well-Being Survey 2015 and 2018*

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

Strategy	Action Steps	Outcomes
Support substance use education and prevention efforts in the community aimed at reducing the stigma of getting mental health treatment	• Administer surveys related to drug use, sharing and storage, utilize and communicate results • Increase awareness of opioid use with prescribing physicians, dentists, veterinarians, funeral directors, and real estate agents • Support efforts of Local Prevention Councils across the region • Advocate for medication take back protocols at area pharmacies • Where possible identify best practices throughout the region related to educational and prevention and expand effort as feasible to other communities • Continue to identify grant opportunities to support prevention efforts in area communities	# of surveys administered # of discussions # of provider training activities # of prevention activities conducted # of letters of support written

Note: Indicators and goal are from the DataHaven 2015 and 2018 Wellbeing Survey

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

Strategy	Action Steps	Outcomes
Support suicide prevention activities aimed at reducing the stigma associated with suicide	• Develop collaborative suicide prevention education trainings / community conversations to reduce stigma • Work with providers to identify and administer screenings for suicidal thoughts	# of prevention education trainings / community conversations # of provider education screenings
Partner Organizations		
East Shore District Health Department, Milford Health Department, Quinnipiak Valley Health District, Yale New Haven Hospital		

Discussion Exercise

- Break into groups

- Discuss the presentation (30 mins)
  - What did you hear today were the key issues? What stood out?
  - What specific feedback do you have related to what you heard today?

Questions? Comments?