Standard 5.2

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Community Health Improvement Plan (CHIP)

Uncas Health District Community Health Improvement Plan (CHIP)

June, 2017

UNCAS HEALTH DISTRICT

Health Resources in Action
Advancing Public Health and Medical Research

UNCAS HEALTH DISTRICT

Dear Colleagues and Residents:

The Uncas Health District (UHD) is pleased to present the 2017 Uncas Health District Community Health Improvement Plan (CHIP). The document will guide efforts to improve the health and wellness of residents within the District and surrounding areas. The collaborative effort put into the CHIP will result in strategies to address the highest priority health indicators for the region.

The Uncas Health District CHIP priorities have been established by the Uncas Health District 2016 Community Health Assessment. These two documents will be used to inform the Uncas Health District Strategic Plan and the work of the newly formed **Eastern Connecticut Health Collaborative**, which will be the lead entity for convening partners to implement the plan.

The three priority areas of concern identified in the CHIP are outlined below:

Priority 1: **Chronic Disease Prevention/Risk Factors**
Focus areas: 1) Food Access/Healthy Eating and 2) Tobacco/Cancer

Priority 2: **Substance Abuse**
Focus area: 1) Opioids

Priority 3: **Access to Care**
Focus area: 1) Transportation

The plan is guided by baseline targets and measures to monitor progress. Implementation of evidence-based strategies related to policy, advocacy, communication, partnership development and education will assure a healthier Uncas Health District regional community moving forward.

The Uncas Health District staff and Board of Directors would like to thank our many partners that contributed time and expertise to the process. We hope the plan serves as a useful resource for your personal and organizational strategy to improve the community's health and wellness.

Sincerely,

Patrick R. McCormack, MPH
Director of Health

401 W. Thames St., Ste. 106, Norwich, CT 06360
Telephone No. (860) 823-1189 FAX No. (860) 887-7898
E-Mail: doh@uncashd.org
Internet: www.uncashd.org

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EXECUTIVE SUMMARY

It is critical to understand the specific environmental factors in the communities served by the Uncas Health District -- where and how we live, learn, work, and play, and how they in turn influence our health -- in order to implement the best strategies for community health improvement. To accomplish this goal, Uncas Health District led a comprehensive community health planning effort to measurably improve the health of residents of the municipalities of Bozrah, Griswold, Lebanon, Lisbon, Montville, Norwich, Salem, Sprague, and Voluntown in New London County, Connecticut.

This effort included two major phases:

1. A community health assessment (CHA), conducted by Health Resources in Action, Inc., to identify the health related needs and strengths of the communities served, and

2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way to address these needs.

The CHA and CHIP are essential frameworks for guiding future services, programs, and policies for healthcare and public health-serving agencies in the communities served by Uncas Health District.

The 2017 Community Health Improvement Plan was developed over the period October 2016 - May, 2017, using the key findings from the CHA. The 2016 Uncas Health District Community Health Assessment is part of the health department's ongoing efforts to assess the health needs of the communities it serves. This effort included a review of existing secondary data from local, state, and national sources, conducting qualitative data collection with hospital and public health administrators and with focus group participants representing the firefighter/emergency responder and senior communities to understand their perceptions of community strengths and assets, priority health concerns, and suggestions for future programming and services to promote community health.

The 2016 CHA is accessible at:

http://www.uncashd.org/Uncas_FullCHA_Revised_10-16-2016.pdf

To develop a plan for improved community health, and help sustain implementation efforts, the community health assessment and planning process engaged community partners through different avenues. These partners included a cross-sector of community members such as health care, businesses, public safety, schools, emergency response services, holistic healthcare, planning and development, and transportation. The Uncas Community Health Improvement Coalition served as the guiding body for both CHA and CHIP development (see Section VIII for a list of Coalition members).

In October of 2016, Uncas Health District engaged Health Resources in Action, Inc. (HRiA), a non-profit public health organization located in Boston, MA, as a consultant partner to provide strategic guidance and facilitation of the CHA-CHIP process, to review and provide feedback on draft documents and output, and to develop the resulting plan to aid in their pursuit of Public Health Accreditation Board (PHAB) accreditation.

The Uncas Health District Community Health Improvement Coalition met at a kick-off meeting on June 8, 2016 to receive an overview of the CHIP planning process, review data outcomes from the CHA, and review the proposed process and timeline for engaging community members.

Health Priorities

Uncas Health District leadership and Board representatives identified a short list of potential priorities from the CHA based on evidence of burden, impact, and feasibility. Where possible, priorities were aligned with those of Ledge Light Health District's CHIP and Healthy Connecticut 2020, the Connecticut State Health Improvement Plan (SHIP).

The Coalition met for an all-day planning session on November 18, 2016 to develop the core elements of the CHIP. These draft priorities and rationale were presented by HRiA consultants, who facilitated discussion and consensus.

The three key priorities selected for CHIP planning are outlined in the table below:

Priority Area	Goal Statement
Priority 1: Chronic Disease Prevention/ Risk Factors With a focus on: ▪ Food Access/Healthy Eating ▪ Tobacco/Cancer	**Goal 1:** Reduce the impact of chronic disease in our communities
Priority 2: Substance Abuse With a focus on: ▪ Opioids	**Goal 2:** Achieve the lowest rates of opioid misuse, addiction, and death in Connecticut
Priority 3: Access to Care With a focus on ▪ Transportation	**Goal 3:** Ensure there is available, sufficient transportation to meet the healthcare needs of the Uncas Health District community

During the remainder of the planning session, participants developed goals, objectives, indicators and draft strategies for these three priorities. The output of this session follows below.

UNCAS HEALTH DISTRICT
COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

I. BACKGROUND

It is critical to understand the specific environmental factors in the communities served by the Uncas Health District -- where and how we live, learn, work, and play, and how they in turn influence our health -- in order to implement the best strategies for community health improvement. To accomplish this goal, Uncas Health District led a comprehensive community health planning effort to measurably improve the health of residents of the municipalities of Bozrah, Griswold, Lebanon, Lisbon, Montville, Norwich, Salem, Sprague, and Voluntown in New London County, Connecticut.

This effort included two major phases:

1. A community health assessment (CHA), conducted by Health Resources in Action, Inc., to identify the health related needs and strengths of the communities served, and

2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way to address these needs.

The CHA and CHIP are essential frameworks for guiding future services, programs, and policies for healthcare and public health-serving agencies in the communities served by Uncas Health District.

II. OVERVIEW OF THE COMMUNITY HEALTH IMPROVEMENT PLAN

What Is a Community Health Improvement Plan?

A Community Health Improvement Plan, or CHIP, is a data-driven, collective, action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed, including strategies and measures, 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 unifying framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.[1]

Building upon the key findings and themes identified in the 2016 Community Health Assessment (CHA), the CHIP:

- Identifies priority issues for action to improve community health
- Outlines an annual implementation plan with performance measures for evaluating progress
- Guides future community decision-making related to community health improvement

[1] As defined by the Health Resources in Action, Strategic Planning Department, 2012

How To Use The 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, and citizens – can unite to improve the health and quality of life for all people who live, work, learn, and play in the communities served by Uncas Health District.

We encourage you to review the priorities and goals, reflect on the suggested strategies, and consider how you can participate in this effort, in whole or in part, as either an independent contributor or as a member of a health-focused agency, organization, or group. Consider: How do your current plans align with the CHIP? How can your future plans align with the CHIP?

Relationship Between the CHIP and Other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the public health in the communities served by Uncas Health District. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP planning process identified potential partners and resources already engaged in these efforts wherever possible, particularly with respect to Ledge Light Health District's CHIP and Connecticut's State Health Improvement Plan (SHIP).

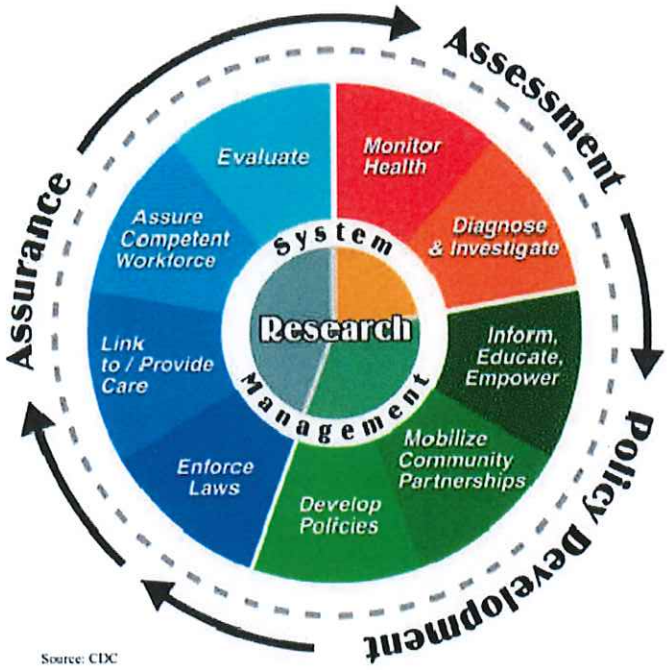
Methods

Following the guidelines of the National Association of County and City Health Officials (NACCHO), the community health improvement process was designed to integrate and enhance the activities of many organizations' contributions to community health improvement, building on current assets, enhancing existing programs and initiatives, and leveraging resources for greater efficiency and impact. Following these guidelines, Uncas Health District engaged influential leaders in healthcare, academia, mental health, local government, emergency management, local health, tribal leaders, community action councils, ambulance services, senior services, ministry, social services, members of the community, and other community based organizations to develop the CHIP.

The overall process, which includes assessment, planning, implementation, and evaluation, is a continuous cycle of improvement that seeks to show demonstrable improvement on key health priorities over the course of time. The cyclical nature of the Core Public Health Functions is illustrated in Figure 1.

The next phase of the CHIP will involve broad implementation of the strategies through an annual action plan developed from the CHIP, as well as monitoring and evaluation of the CHIP's short-term and long-term outcome indicators. These activities will be undertaken by the **Eastern Connecticut Health Collaborative**, the coalition that has been developed as a result of the CHA and CHIP processes.

Figure 1: The Cyclical Nature of the Core Public Health Functions



Source: Centers for Disease Control and Prevention (CDC), Ten Essential Public Health Services

III. CHIP PLANNING MODEL

Uncas Health District and key stakeholders developed this CHIP over the period October, 2016 - May, 2017 using the key findings from the CHA. The 2016 Uncas Health District Community Health Assessment is part of the district's ongoing efforts to assess the health needs of the communities it serves.

The 2016 CHA is accessible at

http://www.uncashd.org/Uncas_FullCHA_Revised_10-16-2016.pdf

The CHIP utilized a participatory, collaborative approach guided in part by elements of the Mobilization for Action through Planning and Partnerships (MAPP) process.[2] MAPP, a comprehensive, community-driven planning process for improving health, is a strategic framework that many community health coalitions across the country have employed to help direct their planning efforts. MAPP comprises rigorous assessment as the foundation for planning, and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP process allows for the periodic identification of new priorities and the realignment of activities and resources to address them.

To develop a plan for improved community health, and help sustain implementation efforts, the community health assessment and planning process engaged community partners through different avenues. These partners included a cross-sector of community members

[2] Advanced by the National Association of County and City Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. More information on MAPP can be found at: http://www.naccho.org/topics/infrastructure/mapp/

such as health care, businesses, public safety, schools, emergency response services, holistic healthcare, planning and development, and transportation, tribal nations, senior services local government, mental health, members of the community.

In October of 2016, Uncas Health District engaged Health Resources in Action, Inc. (HRiA), a non-profit public health organization located in Boston, MA, as a consultant partner to provide strategic guidance and facilitation of the CHA-CHIP process, to review and provide feedback on draft documents and output, and to develop the resulting plan to aid in their pursuit of accreditation by the Public Health Accreditation Board (PHAB), a nonprofit agency that recognizes health districts who meet its standards of quality and performance.

Community Engagement

The Uncas Health District led the planning process and oversaw all aspects of CHIP development, including the establishment of CHIP workgroups and engagement of subject matter experts to refine details for identified health priorities. See Section VIII for workgroup participants and affiliations.

IV. Community Health Improvement Plan Components

Development of Data-Based, Community-Identified Health Priorities

In 2016, Health Resources in Action, Inc. conducted the 2016 Uncas Health District Community Health Assessment as part of the health department's ongoing efforts to assess the health needs of the communities it serves. This effort included a review of existing secondary data from local, state, and national sources, conducting qualitative data collection with hospital and public health administrators and with focus group participants representing the firefighter/emergency responder and senior communities to understand their perceptions of community strengths and assets, priority health concerns, and suggestions for future programming and services to promote community health. The results of the Community Health Assessment were not only used to inform the Community Health Improvement Plan (CHIP), but will also be used to inform the UHD Strategic Plan.

The Uncas Health District Community Health Improvement Coalition met at a kick-off meeting on June 8, 2016 to receive an overview of the CHIP planning process, review data outcomes from the CHA, and discuss the proposed process and timeline for engaging community members. Subsequent to this meeting, Uncas Health District leadership and Board representatives met with HRiA consultants to identify a short list of potential priorities from the CHA based on evidence of burden, impact, and feasibility, as defined below:

BURDEN *How Important Is It?*	- Magnitude and severity; economic cost; urgency of the problem - Community concern - Focus on equity and accessibility
IMPACT What will We Get Out of It?	- Effectiveness - Coverage - Builds on or enhances current work - Can move the needle and demonstrate measurable outcomes - Proven strategies to address multiple wins
FEASIBILITY Can We do It?	- Community capacity - Technical capacity - Economic capacity - Political capacity/will - Socio-cultural aspects - Ethical aspects - Can identify easy short-term wins

Where possible, priorities were aligned with those of Ledge Light Health District's CHIP and Healthy Connecticut 2020, the Connecticut State Health Improvement Plan (SHIP):

	Plans		
Focus Area/ Priority Area	**HCT2020:** CT State Health Improvement Plan (SHIP)	**SE CT Health Improvement Collaborative** (LLHD/L&M Hospital)	**Uncas Health District CHIP**
MICH Maternal and Child Health	✓	✓ with a focus on access for low-income individuals and maternal child health outcomes	
ENV Environment	✓		
CD Chronic Disease	✓	✓ with a focus on contributing factors to diabetes	✓ with a focus on Food Access/ Healthy Eating, Tobacco/ Cancer
ID Infectious Disease	✓		
IV Injury & Violence	✓		
MHSA Mental Health and Substance Abuse	✓	✓ with focus on opioid abuse and mental health Among Hispanics	✓ with a focus on Opioids
HS Health Systems	✓	✓ with a focus on access for low-income individuals and maternal child health outcomes	✓ with a focus on Transportation

The Community Health Improvement Coalition met for an all-day planning session on November 18, 2016 to develop the core elements of the CHIP. The short list of draft priorities and rationale were presented by HRiA consultants, who facilitated discussion and consensus-building.

The three key priorities selected for CHIP planning are outlined below.

Priorities Identified for the Uncas Health District CHIP

Priority 1: Chronic Disease Prevention/Risk Factors

With a focus on:

- Food Access/Healthy Eating
- Tobacco/Cancer

Priority 2: Substance Abuse

With a focus on:

- Opioids

Priority 3: Access to Care

With a focus on

- Transportation

CHIP Strategic Framework

During the planning session, following the prioritization discussion, participants self-selected into HRiA-facilitated, priority area working groups to develop goals, objectives, indicators and draft strategies for each of the three priority areas. Using structured, interactive exercises, all participants were provided the opportunity to draft plan components, comment on each other's work, and refine their components based on group feedback.

CHIP working group participants were also provided sample evidence-based strategies from a variety of resources including The Community Guide to Preventive Services, Healthy People 2020, and the National Prevention Strategy. Indicators for each objective were identified based on data available from the CHA, using whenever possible, targets outlined in Healthy People 2020 (HP2020).[3]

The draft CHIP was completed and disseminated to working group members for electronic review and feedback. The draft CHIP was also shared with subject matter experts for input on data indicators and targets. This feedback was incorporated into the final version of the CHIP, which will be used to develop annual implementation plans.

V. 2016 Community Health Improvement Plan

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of the desired future, and a clear evaluation of whether efforts are making a difference. Outcome indicators tell the story about where a community is in relation to its vision, as articulated by its related goals, objectives, and strategies. Targets for identified outcome indicators have been established using baseline data provided in the Community Health Assessment, wherever possible. Where no data were readily available, objectives were noted as "Developmental" and a primary strategy will be to collect and analyze data and determine a baseline for successive annual comparisons.

The following pages outline the Goals, Objectives, Strategies, Outcome Indicators, and Potential Partners/Resources for the three health priority areas outlined in the CHIP. See Appendix B for a glossary of terms used in the CHIP.

[3] HP2020 is the federal government's prevention agenda for building a healthier nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

Priority Area 1: Chronic Disease Prevention/Risk Factors

Focus Areas:

1. Food Access/Healthy Eating
2. Tobacco/Cancer

The prevalence of chronic conditions and their risk factors in the United States have been rising steadily, whereas many other diseases and conditions are declining. The CDC has designated reductions in smoking and obesity and improvements in nutrition and physical activity, as "Winnable Battles" in efforts to improve the health of Americans and reduce the prevalence and severity of chronic diseases.[4]
In Connecticut, chronic diseases account for 6 out of 10 of the leading causes of death. Addressing modifiable risk factors for chronic disease, such as smoking, nutrition, physical activity, obesity, and the early detection of disease, could save thousands of lives and reduce the future economic impact of chronic disease.[5]

Food Access/Healthy Eating

In 2012-2014, the food environment index score in New London County (7.8) was similar to that for Connecticut (7.9), indicating a moderately favorable context of access to healthy food for residents of New London County. This index measures several aspects of the healthy food environment:

- Food Access, operationalized as the proportion of the population who did not have access to a reliable source of food during the past year, and
- Food Security, defined as the percent of the low-income population who does not live close to a grocery store

Approximately one-quarter of New London County (27.0%) adults reported that they were obese, similar to the prevalence of self-reported obesity for Connecticut residents (25.0%) in 2012. In 2012 approximately one in five New London County (22.0%) adults reported not engaging in any leisure time physical activity, similar to the prevalence of physical inactivity reported by adults across Connecticut (22.0%).

Tobacco/Cancer

Cancer, heart disease, and chronic lower respiratory disease are the leading causes of death across the Uncas Health District towns and these conditions are all exacerbated by smoking. In 2014, 14.0% of New London County adults reported smoking, a prevalence that was similar to that for the State (15.0%). Tobacco use and abuse of alcohol was a concern that some focus group participants and key informants expressed, and one that they described as being a longstanding health issue in the region.

The towns of Sprague (253.5 per 100,000 population), Voluntown (230.1 per 100,000 population), and Norwich (201.2 per 100,000 population) had the highest rate of deaths attributed to cancer.

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[4] US Department of Health and Human Services. Winnable Battles. Centers for Disease Control and Prevention. Centers for Disease Control and Prevention. [Online] [Cited September 30, 2013] http://www.cdc.gov/winnablebattles/

[5] The Center for Public Health and Health Policy. *The Economic Impact of Prevention*. 2008. University of Connecticut.

The rate of deaths due to heart disease was highest in the towns of Sprague (239.6 per 100,000 population), Griswold (237.0 per 100,000 population), and Bozrah (210.3 per 100,000 population).

The chronic lower respiratory disease mortality rate ranged from a low of 40.6 per 100,000 population in Montville to a high of 47.5 per 100,000 population in Norwich.

Goal 1: Reduce the impact of chronic disease in our communities.

Objectives

1.1: By 2020, increase by 3% the number of adults meeting the CDC recommendation for fruit and vegetable consumption.

Outcome Indicators	Baseline	2020 Target	Data Source
Number of adults reporting consuming fruits and vegetables five or more times per day	27%		*CT BRFSS – state data (Crude – 2009)*
Adult fruit consumption – less than one serving/day (2013)	34%	0.93 cup eq./1000 calories	*CT BRFSS – state data (2013)*
Adult fruit consumption – 1 or 2 servings/day	51%		*CT BRFSS – state data (2013)*
Adult vegetable consumption – less than one serving/day (2013)	22%	1.16 cup eq./1000 calories	*CT BRFSS – state data (2013)*
Adult vegetable consumption – 1 or 2 servings/day	62%		*CT BRFSS – state data (2013)*
Households with food insecurity in the past 12 months	13%	6%	*Healthy People 2020*
Cholesterol/lipid levels	TBD	TBD post fruit and vegetable consumption	*Developmental*

Strategies

1.1.1: Support and implement vouchers for fruits & vegetables at farmer's markets and grocery stores.

1.1.2: Identify high need areas and work with local partners to expand the reach of mobile food pantries to these areas as well as to food deserts.

1.1.3: Support outreach to help families plant a home garden or establish a community garden.

- Identify locations where a community garden or greenhouse could be established, like empty warehouse facilities, old buildings, or lots that could be transformed to green space or a farm processing facility

1.1.4: Promote and support FRESH New London, UConn Extension programs, UConn College of Ag, Master Gardeners, Food CORP, Boy Scouts of America, AmeriCorps Service Members, College students with internships graduating with a degree in Horticulture. Make contacts with more hands on deck people who may need community service (legal system).

1.1.5: Partner with local providers to connect with senior centers and communities regarding healthy eating and active living strategies for this population.

1.1.6: Increase the volume of fruits and vegetables donated to food pantries by:

- Assessing current volume at Lutheran Church in Norwich
- Setting a target goal
- Determining if farm gleaning programs are a viable option
- Establishing/expanding partnerships with grocery stores to donate produce and goods close to the date of expiration
- Establish a grocery store in New London country like the Daily Table in Boston, where food is sold at reduced prices, because it has been rejected by the produce department of a supermarket or is close to date.
- Identifying current government regulations and barriers to donations and how to develop/ensure legal and safe methods for donating perishable items

1.1.7: Outreach to zoning and business community to address the number of fast food restaurants in communities.

1.2 By 2020, increase by 5% the number of pre-school programs in our health district who have implemented an evidence-based healthy eating/active living curriculum.

Outcome Indicators	Baseline	2020 Target	Data Source
Number of programs in Uncas Health District towns	13	Not available	CT State Dept. Education – Office of Early Childhood http://www.ct.gov/oec/site/default.asp
States with food and beverage nutrition standards for pre-school children in child care	24	34	*Healthy People 2020*
Physical activity indicators	13	Not available	*CT Office of Early childhood*

Strategies

1.2.1: Develop inventory of preschools that provide meals and snacks.

1.2.2: Survey programs to establish whether they have a healthy preschool certification, a nutrition curriculum, and a physical activity curriculum and/or are interested in a program; and barriers to implementation.

1.2.3: Identify evidence-based programs to promote, such as USDA My Plate, American Academy of Pediatrics healthychildren.org, Rudd Center, precise portions, etc.

1.2.4: Promote identified program and implementation practices such as healthy preschool certification; offer staff training conducted by health care professionals; connect preschools to certification, consulting RDs that would review and approve menus, etc.

1.3 By 2020, decrease the % of youth who report smoking using cigarettes, tobacco, or e-cigarettes within the past 30 days.

Outcome Indicators	Baseline (Percent)	2020 Target (Percent)	Data Source
% high school students who currently smoked cigarettes on at least one day last month	10.3 (CT 2015)	16	*CT Youth Health Survey*
% high school students who currently smoked cigarettes on at least one day in the last month	10.8	16	*National Youth Risk Behavior Survey (2015)*
% high school students who used cigarettes in the past 30 days in Southeastern CT towns	4.1 Range: 2.2 - 7.1	16	*SERAC Youth Survey Regional Summary 2014-1015 (average)*
% high school students who used electronic *cigarettes in the past 30 days in Southeastern CT towns*	4.2 Range: 2.7 – 6.1	NOT AVAILABLE	*SERAC Youth Survey Regional Summary 2014-2015 (average)*
% high school students who used tobacco products in the last 30 days in Southeastern CT towns	2.9	21	*SERAC Youth Survey Regional Summary 2014-2015*

Strategies

1.3.1: Partner with youth prevention coalitions to support educational outreach and compliance checks.

1.3.2: Advocate for outreach to youth groups, athletic coaches, and after school/activity leaders through CIAC on the risks associated with tobacco use (including chew & alternatives to cigarettes).

1.3.3: Advocate for smoke-free outdoor spaces in our communities.

1.4 By 2020, increase the number of adults who are using lung cancer screening programs (DEVELOPMENTAL).

Outcome Indicators	Baseline	2020 Target	Data Source
TBD	TBD	TBD	*TBD*

Strategies

1.4.1: Increase outreach and education to primary care providers.

1.4.2: Develop community awareness campaign.

1.4.3: Establish partnership with local hospitals to increase lung cancer screenings.

1.4.4: Partner with Chamber of Commerce to educate employers on disseminating information.

1.5 By 2020, decrease the number of adults who smoke cigarettes or use tobacco products.

Outcome Indicators	Baseline	2020 Target	Data Source
Adult cigarette smoking- percent of adults 18+ years	22%	12%	*Behavioral Risk Factor Surveillance System 2011-2014. Uncas towns*

Adult cigarette smoking % of adults 18+ years	16%	12%	*BFRSS (state)*

Strategies

1.5.1: Increase access to community-based smoking cessation programs.

1.5.2: Establish culturally and linguistically appropriate cessation classes.

1.5.3: Promote the Quit Line.

1.5.4: Advocate for increased availability of Nicotine Replacement Therapy and other smoking cessation aids.

Potential Partners and Resources for Chronic Disease Prevention

- CT Department of Public Health
- Eastern CT Community Gardens
- FRESH New London
- Hartford Healthcare
- Health Improvement Collaborative of SE CT
- High School Service Clubs
- Large employers (1.4)
- New London County Food Policy Council
- Private Providers (doctors, dentists)
- Thames Valley Regional Action Council (TVCCA)
- The Eastern Connecticut Health Collaborative
- United Community and Family Services (UCFS)
- United Way-Gemma Moran Food Center

Priority Area 2: Substance Abuse

Focus Area:

1. Opioids

Substance abuse affects individuals, families, and communities and exacts substantial social, physical, and mental costs.[6]

Several focus group participants and key informants noted rising misuse and abuse of opioids in the region across age groups. Perceptions varied regarding the geographic distribution of opioid issues in the Uncas Health District. Though a couple of informants characterized opioid use as a greater concern in particular regions, such as along the coast, several residents characterized this as an issue that affected the region "regardless of geography or town" and one that was particularly acute in New London County. Reports of opioid misuse and abuse included prescription opioids and heroin. Residents attributed substance use to stress and untreated mental health issues.

As with mental health services, residents had varied perceptions of the availability of substance use services, with descriptions of substance use treatment availability ranging from "plenty" to "there are not enough providers." Several key informants cited inadequate substance use treatment as an issue affecting the health care system across the State. Several focus group participants and key informants observed that accessing substance use treatment was a challenge for more vulnerable populations. While perceptions of the availability of longer-term substance use treatment services varied, one key informant noted that emergency responders were equipped with Narcan to respond to opioid overdoses.

From 2009 to 2014, the number of unintentional opioid-related deaths increased across Connecticut.

In the five-year period of 2009-2014, each town in the Uncas Health District experienced at least one opioid-related death.

The rate of deaths due to opioids was highest in Norwich, Salem, and Sprague.

The rate of heroin overdose deaths has increased across the State in recent years.

In 2011-2013, the rate of heroin overdose deaths was highest in New London County (6.21-7.50 deaths per 100,000 population), an increase over the rate for 2008-2010 (2.31-3.60 deaths per 100,000 population).

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[6] US Department of Health and Human Services. *Mental Health and Mental Disorders*. Healthy People 2020. [Online] [Cited October 6, 2013]. http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=28

Goal 2: Achieve the lowest rates of opioid misuse, addiction, and death in Connecticut.

Objectives

2.1: Reduce the number of active opioid dependent individuals by 5% and the number who misuse by 10% by 2020.

Outcome Indicators	Baseline	2020 Target	Data Source
Percent of District residents who are opioid dependent	TBD	TBD	*Backus Hospital*
Percent of ED visits that are overdose related	TBD	TBD	*Backus Hospital*
Number of emergency room visits related to opioid abuse	TBD	TBD	*Backus Hospital*
Number of Suboxone prescriptions	TBD	TBD	*Backus Hospital*
Number of individuals with opioid dependence disorder	TBD	TBD	*Backus Hospital*
Number of people receiving Methadone	TBD	TBD	*Backus Hospital*

Strategies

2.1.1: Conduct Public Education campaigns on the hazards of opioids and the avenues to dependence.

2.1.2: Advocate for sufficient and accessible treatment, resources, and facilities. (See 2.3.1)

2.1.3: Conduct science-based, evaluated programming in schools targeting opioid abuse (peer leadership, experiential learning, influence/resistance/social skills).

2.2: Reduce the rate of opioid deaths by 10% by 2019.

Outcome Indicators	NL County	Connecticut	Data Source
Number of opioid deaths (2012)		357	*Office of the Chief Medical examiner*
Number of opioid Deaths (2013)		495	*Office of the Chief Medical examiner*
Number of opioid related deaths In New London County (2014)	45	568	*Office of the Chief Medical examiner*
Number of opioid related deaths in New London county (2015)	61	729	*Office of the Chief Medical examiner*
Number opioid deaths (2016 projected)	85	832	*Office of the Chief Medical examiner*

In 2015 the following towns in Region 4 were in the top 25th percentile for overdose deaths: Griswold, Groton, Norwich, New London and Putnam Windham.

Strategies

2.2.1 Increase access to Narcan by public education on acquisition and use.

2.2.2: Advocate for treatment of opioid dependent individuals over criminalization.

2.2.3: Conduct training for opioid users by standards on overdose signs and symptoms.

2.2.4: Conduct training for opioid users admitted for treatment on how to reduce overdose risk.

2.3: Increase the percent of people who have adequate addiction treatment coverage and can access and utilize inpatient and outpatient addiction services by 5% by 2020.

Outcome Indicators	NL County	Connecticut	Data Source
Number of registered licensed SA treatment centers (2/2015)	50+		*CT DPH Licensed SA Treatment Programs in New London County + Willimantic + Putnam*
Number of registered addiction providers for suboxone and vivitrol	9		*DMHAS New London County and Willimantic*
Referral networks			

Strategies

2.3.1: Advocate for more comprehensive coverage and funding/appropriate reimbursement for addiction services.

2.3.2: Provide the business case for increasing the number of beds/providers able to take new patients.

2.3.3: Promote job development and job training as key strategies for effective treatment, recovery, and sobriety.

2.3.4: Advocate for better transition support system for patients post-recovery.

2.4: Reduce the number of children who score greater than 4 on Adverse Childhood Experiences Survey (ACES – assessment) (DEVELOPMENTAL).

Outcome Indicators	Baseline	2020 Target	Data Source
Number of children ages 0-5 with ACES score greater than or equal to 4	TBD	TBD	TBD

Strategies

2.4.1 Identify potential data partners and resources.

2.4.2 Develop data collection system.

2.4.3 Identify who can screen young children 0-5 and train them.

2.4.4: Provide education and support to at-risk families through universal home visiting.

2.4.5: Increase trauma-focused treatment and care for kids 0-5 (FBR-Family based recovery).

- Nurturing Families screens all birth parents at Backus Hospital plus first-time parents at L&M Hospital

2.5: Increase provider adherence to opioid prescribing guidelines to 100% by 2020.

Outcome Indicators	Baseline	2020 Target	Data Source
Physicians utilizing the CT Prescription Monitoring Program (PMP)	All prescribers	n/a	*Public Act 16-43 (effective 7/1/2016); Department of consumer Protection*
Licensure			*Department of Consumer Protection*

Strategies

2.5.1: See State plan and adopt strategies.

2.5.2: Explore EPIC program as potential provider training source (Child Health Development Institute offers this free).

2.5.3: Encourage peer review of prescription practice.

Potential Partners and Resources for Substance Abuse: Opioids

- Alliance for Living
- American Ambulance/EMT
- Griswold Pride
- Hartford Dispensary – methadone clinic
- Health Improvement Collaborative of SE CT
- Municipal officials/Parks and Recreation
- Norwich Human Services
- Police
- SERAC
- Southeast Mental Health Authority (SMHA)
- The Eastern Connecticut Health Collaborative
- The William W. Backus Hospital
- United Community and Family Services – school-based health clinics
- Youth/Family Services

Priority Area 3: Access to Care

Focus Area:

1. Transportation

The majority of residents across towns served by Uncas Health District drive alone or carpool to work.

Griswold (90.2%) had the highest proportion of residents who drove alone to work, while Norwich (76.2%) and Voluntown (78.3%) had the smallest percent. The towns of Voluntown (15.5%) and Norwich (14.3%) had the largest percent of residents who carpooled to work.

Lebanon (9.8%), Norwich (9.5%), and Lisbon (9.0%) had the largest proportion of residents who used another mode of transportation to work, such as public transportation, walking, taking a cab or cycling, or working from home.

A couple of participants observed public transportation in towns outside of the Uncas Health District, while few noted alternative transportation options in the towns served by the Uncas Health District, particularly for vulnerable populations such as senior and low-income residents.

There is limited public transportation across communities and for vulnerable populations, as exemplified by the quote below:

"[The] elderly who are part of the senior center and live in Norwich have access to transportation, but it's specific to elderly and they have to live in Norwich. What about those in other communities?" – Key informant

Goal 3: Ensure there is available, sufficient transportation to meet the healthcare needs of the Uncas Health District community.

Objectives

3.1: Reduce transportation barriers to health care for residents of the Uncas Health District (DEVELOPMENTAL).

Outcome Indicators	Baseline	2020 Target	Data Source
Ridership on SEAT buses	TBD	n/a	
No show rates at Community Health Centers & other providers	TBD	n/a	
School-based health centers	TBD	n/a	
Expansion of outpatient care centers	TBD	n/a	
Ridership on SEAT buses	TBD	n/a	

Strategies

3.1.1: Conduct a transportation needs assessment to identify barriers to access.

- Create a Transportation Task Force (include: existing transportation providers, community members, Council of Governments (COG), Eastern CT Transportation Consortium (ECTC), Nonprofits, healthcare providers, senior centers, social services, etc.).

- Select a subcommittee of the Task Force to collect additional data and conduct a gap analysis.

3.1.2: Present data to full Task Force with recommendations for top/high areas of need.

3.1.3: Establish baselines for other objectives in this Priority Area.

3.1.4: Once State Transportation Plan is complete, align strategies for this priority with that plan.

3.2: By 2020, increase by 5% the awareness of existing transportation options (DEVELOPMENTAL).

Outcome Indicators	Baseline	2020 Target	Data Source
Increased awareness levels	TBD	TBD	*Survey*
Web activity/hits	TBD	TBD	

Strategies

3.2.1: Establish a subcommittee of the Transportation Task Force.

3.2.2: Identify the message & methods of distribution (e.g., social media, app's, LATV, newsletters (town, church, utility), senior centers, social services, resource guide, etc.).

3.2.3: Determine how we will measure awareness (existing or new survey?).

3.2.4: Identify and address perceptions/barriers to not utilizing transportation.

3.2.5: Identify funding to implement strategies for improvement.

3.3: By 2020, increase public transit routes to underserved areas (DEVELOPMENTAL).

Outcome Indicators	Baseline	2020 Target	Data Source
Ridership data (SEAT)	TBD	n/a	*SEAT Study*
Number of expanded routes	TBD	n/a	
ECTC Transportation Survey	TBD	n/a	

Strategies

3.3.1: Establish subcommittee of Task Force.

3.3.2: Identify underserved areas and towns not covered in study and expand study coverage.

3.3.3: Partner with other transit districts to potentially link to the SEAT System.

3.3.4: Prioritize based on biggest impact.

3.3.5: Identify potential funding sources to implement new routes.

3.4: By 2020, expand existing alternative transportation options to underserved areas (DEVELOPMENTAL).

Outcome Indicators	Baseline	2020 Target	Data Source
Number of routes	TBD	n/a	*ECTC*
Number transports/riders	TBD	n/a	*ECTC*
Coverage area	TBD	n/a	*ECTC*

Strategies

3.4.1: Establish a subcommittee of the Task Force.

3.4.2: Pull in other volunteers/organizations not involved in Task Force.

3.4.3: Identify alternative options available, including exploring partnerships with existing transportation service providers that are not used 24x7, like school buses.

3.4.4: Identify barriers (funding restrictions, liability, qualified drivers, school buses).

3.4.5: Prioritize and develop strategies to address barriers.

3.4.6: Establish baseline and way to monitor progress.

3.5: By 2020, increase the options for bringing care to the patient (DEVELOPMENTAL).

Outcome Indicators	Baseline	2020 Target	Data Source
TBD (measure mobile vans, home health care and telemedicine)	TBD	n/a	*TBD*

Strategies

3.5.1: Convene a group of providers, hospitals, VNA, first responders, social services, etc.

3.5.2: Identify services that are currently being done.

3.5.3: Identify what could be done (screening, care (PCP, dental)).

3.5.4: Identify gaps and determine what is most needed.

3.5.5: Prioritize which services to offer and where.

3.5.6: Identify funding.

Potential Partners and Resources for Access to Healthcare

- Churches
- Council of Governments
- Eastern Connecticut Health Collaborative
- Eastern CT Transportation Coalition (ECTC)
- Emergency Medical Services (EMS)
- Hospitals
- Housing Authority
- Human Services
- Local Health Departments
- Private Transportation Providers
- Regional Human Services Coordinating Committee
- Senior Center Vans
- Senior Housing
- Seniors Helping Seniors
- South Eastern Area Transit (SEAT)
- United Community and Family Services (UCFS)/Sheltering Arms
- Veterans Centers
- Visiting Nurses Association (VNA)
- Yellow cab/Curtin cab

VI. NEXT STEPS

The components included in this report represent the strategic framework for a data-driven, Community Health Improvement Plan. Uncas Health District, CHIP workgroups, partners, stakeholders, and community residents, will continue finalizing, implementing, and tracking CHIP progress over the coming year. A progress report will illustrate performance and will guide subsequent annual implementation planning.

VII. SUSTAINABILITY

Uncas Health District, CHIP workgroups, partners, stakeholders, and community residents, will continue the process by refining the specific annual action steps, assign lead agencies and personnel, and identify resources for each priority area.

Uncas Health District will provide executive oversight for the improvement plan, progress, and process, identifying additional partners that are integral to success of the plan. Community dialogue sessions and forums will occur through the Eastern CT Health Improvement Collaborative in order to engage residents in the implementation where appropriate, share progress, solicit feedback, and strengthen the CHIP. Regular communication through presentations, meetings and via the health district's website to community members and stakeholders will occur throughout the implementation. New and creative ways to feasibly engage all parties will be explored at the aforementioned engagement opportunities.

VIII. ACKNOWLEDGEMENTS

The dedication, expertise, and leadership of the following agencies and people made the 2017 Uncas Health District CHIP a collaborative, engaging, and substantive plan that will guide our community in improving the health and wellness for the residents of our communities.

Special thanks go out to the following:

WORKING GROUP MEMBERS FOR PRIORITY 1: CHRONIC DISEASE PREVENTION/RISK FACTORS, FOCUS ON FOOD ACCESS/HEALTHY LIVING AND TOBACCO/CANCER	
Name	**Email**
Susan Beeman	susan.beeman@gmail.com
Stephen Mansfield	smansfield@llhd.org
Russell Melmed	rmelmed@llhd.org
Robin Sargent	robinsargent@moheganmail.com
Dr. Peter Shea	peter.h.shea@gmail.com
Mary Lou Underwood	munderwood@tvcca.org
Dr. Setu Vora	setu.vora@hhchealth.org
Chris Watkins	Christopher.watkins@hhchealth.org
Brenda Viens	Bviens@tvcca.org

WORKING GROUP MEMBERS FOR PRIORITY 2: SUBSTANCE ABUSE, FOCUS ON OPIOIDS	
Name	**Email**
Denise Boras	denise.boras@CT.gov
Nancy Gentes	ngentes@madonnaplace.org
Allyson Schulz	aschulz@qualityperspectives.com
Kevin Skulczyck	firstselectman@griswold-ct.org

WORKING GROUP MEMBERS FOR PRIORITY AREA 3: ACCESS TO CARE, FOCUS ON TRANSPORTATION	
Name	**Email**
Damian Rickard	drichard@americanamb.com
Jeanne Kurasz	jeannekurasa@npumail.com
Ronald McDaniel	rmcdaniel@montville-ct.gov
Melinda Wilson	mwilson@ucfs.org
Gene Arters	garters@cityofnorich.org

Consultant Advisors

Health Resources in Action, Inc.
95 Berkeley Street, Suite 208
Boston, MA 02116
617.451.0049
Fax 617.451.0062
TTY: 617.451.0007
www.hria.org

APPENDIX B: ACRONYMS

ACEs: Adverse Childhood Experiences Survey
BRFSS: Behavioral Risk Factor Surveillance System
CDC: Centers for Disease Control and Prevention
CHA: Community Health Assessment
CHIP: Community Health Improvement Plan
CIAC: Connecticut Interscholastic Athletic Conference
COG: Council of Governments
ECTC: Eastern Connecticut Transportation Consortium
CT: Connecticut
CT PMP: Connecticut Prescription Monitoring Program
DMHAS: Department of Mental Health and Addiction Services
ECTC: Easter Connecticut Transportation Consortium
ED: Emergency Department
EMS: Emergency Medical Services
EMT: Emergency Medical Technician
EPIC: Educating Practices in the Community
FBR: Family Based Recovery
HCT2020: Health Connecticut 2020; the State Health Improvement Plan (see also SHIP)
LATV: Latino Alternative Television
MA: Massachusetts
MAPP: Mobilization for Action through Planning and Partnerships
NACCHO: National Association of County and City Health Officials
NRT: Nicotine Replacement Therapy
PCP: Primary Care Provider
PHAB: Public Health Accreditation Board
PMP: Prescription Monitoring Program
RD's: Registered Dieticians
SA: Substance Abuse
SEAT: Southeast Area Transit District
SE CT: Southeastern Connecticut
SERAC: Southeastern Regional Action Council
SHIP: State Health Improvement Plan
SMHA: Southeast Mental Health Authority
TBD: To be determined
UConn Ag: University of CT School of Agriculture
UDH: Uncas Health District
UCFS: United Community and Family Services
USDA: United States Department of Agriculture
VNA: Visiting Nurses Association

APPENDIX C: GLOSSARY OF TERMS

Community Health Improvement Plan (CHIP): Action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed.

Developmental Objectives: Objectives for which we do not currently collect data. The first strategy for each of these objectives will need to be around developing a way to gather data in order to establish baseline and monitor ongoing progress.

Evidence-based Method: Strategy for explicitly linking public health or clinical practice recommendations to scientific evidence of the effectiveness and/or other characteristics of such practices.

Goals: Identify in broad terms how the efforts will change things to solve identified problems

Health Equity/Social Justice: When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstances.

Health Literacy: Degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.

Narcan: Naloxone HCl

Objectives: Measurable statements of change that specify an expected result and timeline, objectives build toward achieving the goals.

Outcome Indicators: Indicators are ways to track progress for each of the objectives. They describe the baseline and target values for each objective based on data that are relevant and available.

Percentages: All percentages are relative; absolute change as a percentage of the baseline value

Performance Measures: Changes that occur at the community level as a result of completion of the strategies and actions taken

Priority Areas: Broad issues that pose problems for the community

Strategies: Action-oriented phrases to describe how the objectives will be approached