Community Report Card for Western Connecticut

Community Health Improvement Action Plan

Summary Report – January 2014

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Health Improvement Action Plan Development – The Process

Effective strategies to improve community health involve active collaboration and commitment among health providers, public and community health agencies, educators, worksites, community and faith-based organizations and groups, and the public they serve. Developing a plan for health improvement in the region involves collective action by and sharing of expertise and resources across agencies and organizations in both the public and private sectors. The process builds on best practices and effective programs and services underway in the community. Fortunately, there are many model programs and services in the ten-municipality Housatonic Valley Region (HVR)[1] that provided a strong foundation for action planning.

In response to the key findings and recommendations from the most recent Community Report Card for Western Connecticut[2] (CRC), the CRC Steering Committee, including leads from the City of Danbury Department of Health and Human Services, Western CT Health Network/Danbury Hospital-New Milford Hospital, United Way of Western Connecticut, New Milford Health Department, and the Regional YMCA of Western CT, convened two Community Health Conversations with key community stakeholders in October 2012. These initial Community Health Conversations were held in two locations (Danbury and New Milford, CT) to ensure accessibility by key stakeholders throughout the region. During the Conversations, the need for collective commitment and responsibility in the prioritization of health issues and development of an action plan for health improvement were emphasized. Attendees included a total of 52 representatives from hospitals; community health centers; school-based health centers; Visiting Nurse Associations/Services; municipal health, education, social service, senior centers and fire departments; non-profit organizations; and a legislator's office. Geographically, all 10 HVR municipalities were represented either directly or through regional agencies and organizations.

Prior to the conversations, Mary Bevan, M.P.H., and Mhora Lorentson, Ph.D., from *EDUCATION CONNECTION's Center for Healthy Schools & Communities* met with the Community Report Card Steering Committee to review the objectives and desired outcomes for these facilitated discussions. Dr. Lorentson led the overview of key findings from the Community Report Card for Western CT and, with the assistance of the CRC Steering Committee members, facilitated the workgroup discussions to prioritize health issues. Key findings were presented for each of the Report Card indicators, including: community population and demographic data, economic stability, education, health status, health and lifestyle behaviors and risk factors, chronic and communicable diseases, and older adult health survey and focus group findings. Additional data from the CT Association of Directors of Health's Health Equity Index related to social determinants of health and health outcomes and United Way of CT's Infoline 2-1-1 database of health-related programs and services was included.

The objectives of the Community Health Conversations were to: 1) obtain input and insight from a diverse group of stakeholders, 2) reach consensus on priority health issues in the region, 3) identify community assets and challenges related to the priority issues, and 4) begin the process of forming workgroups to identify action steps for improvement. Following the presentation of CRC findings, participants were asked the following two questions:

Based on what you have learned today, <u>and</u> your own experience, what community needs stand out for you?
What do you believe are the priority health issues in our community?

Participants in Community Health Conversations universally agreed that the Priority Health Issues (PHI) most representative of needs in the region were: 1) disparities in health care access and outcomes;[3] 2) prevention/reduction of most prevalent chronic diseases/health conditions (specifically obesity,

[1] *The ten municipalities in the HVR include: Bethel, Brookfield, Bridgewater, Danbury, New Fairfield, New Milford, Newtown, Redding, Ridgefield, and Sherman.*
[2] *The Community Report Card can be accessed at: http://www.danburyhospital.org/en/About-Us/Publications/Community-Report-Card.*
[3] *Ultimately, PHI workgroups determined that disparities in health care access and outcomes were cross-cutting issues, and this PHI was integrated into the other 4 Action Plans as a result.*

hypertension, and type II diabetes), by addressing underlying risk factors; 3) substance use/abuse and co-related mental health issues; 4) older adult health, housing and social support needs; and 5) improved awareness and utilization of existing health and social programs and services. Upon reaching consensus on the priority health issues to address, participants self-selected a workgroup to join based on their interests and expertise. Each workgroup focused on their selected PHI, and responded to the following questions:

- What assessment information presented today did you find most relevant and important to your PHI?
- What are the key community strengths or assets related to your health issue?
- What are the key needs or challenges to address?
- Develop at least three recommended actions the community should consider to address these needs/challenges over the next two years.

Each workgroup identified an individual to summarize results on printed worksheets and report out to the larger group. Additionally, one member of the CRC Steering Committee participated in each workgroup discussion and further documented key observations and discussion points. Worksheets and recorded data were provided to EDUCATION CONNECTION for summary and analysis.

Finally, after sharing the results of the PHI workgroups, the following questions were addressed by the entire group.

- In what ways did the CRC assessment information we reviewed today help to better define community health needs?
- What additional information would be helpful to developing recommendations and action steps for your PHI?
- How is each of our organizations already contributing and how can we collaborate and leverage our resources to move towards creating a healthier future together?

Overall, data obtained from the Community Health Conversations provided high quality information needed to begin the community health improvement action planning process in the region. A broad diversity of community stakeholders attended both sessions, conversations were dynamic, and stakeholders were actively engaged in the process and expressed commitment to working together in the future to address the identified priority health issues.

The overarching goal of health improvement action planning is to increase a community's cohesiveness, efficiency, and productivity in working together to positively affect health conditions and outcomes that are identified as priorities in the community. Creating change requires commitment, perseverance, shared leadership, and ongoing collaboration among diverse community partners who unite to form a community health improvement team. This collaborative team works to identify, implement, and evaluate programs, services, policies, systems, and practices to enhance each community's capacity to be a healthy environment in which to live, work, learn, and play.

An action plan outlines what should happen to achieve the vision for a healthy community. Desirable changes and proposed activities (action steps), timelines, and assignment of accountability provide a detailed road map for community teams to follow.

An action plan, while a significant investment of time and energy, is an effective way to ground health improvement teams with a common purpose. Developing an action plan is a critical first step toward success in achieving objectives. An action plan assures that:

- ☑ Details are not overlooked;
- ☑ Proposed action steps are feasible and/or realistic;

- ☑ Teams follow through with their commitments; and
- ☑ Measurable activities are documented and evaluated.

Each community in the HVR has unique strengths and challenges related to improving health conditions for its residents. Action planning provides the roadmap for the change process within the context of a community's priority health needs. During the planning process, community perspectives and ideas were first distilled into a common *vision and mission*. Next, the priority needs or issues were refined into *objectives with corresponding strategies and actions*.

Vision Statement: Healthy People Living in Healthy Communities

A partnership of diverse individuals who, through a commitment to creativity and innovation, collaborative leadership, cultural responsiveness, and the development of evidence-based solutions for priority health issues, strives to create a community of the healthiest people in Connecticut.

Mission Statement: Promote Overall Physical, Social, Emotional, and Mental Health

Through collaborative and sustained action and commitment to excellence, we strive to promote and maintain the health of our community residents through prevention, education, evidence-based interventions, and the assurance of access to quality health care.

Throughout 2013, the CRC Steering Committee and PHI workgroups continued to meet to further develop and refine the four PHI Health Improvement Action Plans. Technical consultation and workgroup facilitation were provided by *EDUCATION CONNECTION's Center for Healthy Schools & Communities*. In addition, the City of Danbury Health & Human Services Department recruited public health interns from Kaplan University, New York Medical College, Western CT State University, and Yale University to provide support to each PHI workgroup. Three additional workgroup action planning sessions were co-facilitated by Dr. Lorentson with the active participation of the CRC Steering Committee and PHI Workgroup Leads, including:

Community Health Improvement Team Leadership

Sally Herlihy, Andrea Rynn, Deborah Weymouth, Judy Becker, & Jean Huntington, *Western CT Health Network*

Scott LeRoy & LisaMichelle King-Riley, *City of Danbury Department of Health & Human Services*

Kim Morgan & Elizabeth Goehring, *United Way of Western CT*

Michael Crespan, *New Milford Department of Health*

Marie Miszewski & Maureen Farrell, *Regional YMCA of Western CT*

Melanie Bonjour, *CIFC Community Health Center of Greater Danbury*

Allison Fulton, *Housatonic Valley Coalition Against Substance Abuse*

Caroline LaFleur, *Danbury's Promise for Children Partnership*

Michael Gold, *Geron Nursing and Respite Care, Inc.*

Consistent with the Community Health Improvement Team's vision and mission, and informed by the Community Report Card and Community Health Conversation findings, the draft Community Health Improvement Action Plan for Western CT by PHI follows. It is important to note that Action Plans are dynamic documents and are influenced by emerging needs. With this in mind, the workgroups will continue to meet at least quarterly to expand upon, modify, and refine their PHI objectives, strategies, and action steps and to collectively evaluate progress towards achieving health improvement in the region.

Community Health Improvement Action Plan – The Results

Priority Health Issue (PHI) #1

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
PHI #1 - Prevention/ reduction of most prevalent chronic diseases and health conditions	• **To reduce the incidence and prevalence of obesity, diabetes, and hypertension for all individuals within our community.** • **To promote access to and utilization of related preventive health education, screenings, and diagnostic and treatment services for medically underserved groups within our community, including low SES and Latino or Hispanic groups.**	• By December 2015, stabilize or reduce the obesity prevalence rate in HVR adults from baseline county rates as reported in the 2013 County Health Rankings: 18% in Fairfield County (FC); 20% in Litchfield County (LC). • By December 2015, stabilize or reduce the diabetes prevalence rate in HVR adults from baseline county rates as reported by CDC: FC (7.1); LC (7.7). • By December 2015, stabilize or reduce the percentage of HVR adults reporting that they have hypertension (HTN). CT county baseline (2007-2009) BRFSS data compiled by DPH: 23.1% FC; 25.6% LC.	• Promote and strengthen a universal healthy lifestyle message by building on the 5,2,1,0 message across all sectors (Schools, Worksites, CBOs, FBOs, Healthcare, Health Depts. & Districts). • Collaborate with Coalition for Healthy Kids on 5,2,1,0 messaging with families. • Increase opportunities for residents to participate in no cost/low cost physical activity such as walking and biking. • Increase availability of healthy eating options across all age groups. • Collaborate with Regional YMCA for application to obtain Y Diabetes Prevention Program	**0-6 Month Milestones**: • By February 2014, engage parish nurses and senior center directors to promote 5,2,1,0 messages and healthy food options at church and senior events. • By February 2014, create a unified "Know Your Numbers Campaign" screening tool based on sub-committee input to share with collaborating organizations. • By March 2014, identify 3-5 key organizations and worksites to implement the "5,2,1,0 Let's Go" Strategies. • By April 2014, include resources on stakeholder websites with existing recreational programs such as the CT Trails Day, Walkct.org, local walking trails, parks, schools and mall walking promotions. • By May 2014, launch Diabetes Awareness Campaign in the HVR. **6-12 Month Milestones:** • By July 2014, identify one site to pilot the Y Diabetes Prevention Program based on diabetes prevalence and	• Create opportunities for healthy cooking/recipe programs in local parishes and where families convene. • 5 key local employers in addition to the hospitals will adopt Worksite Wellness policies around healthy food options and increasing physical activity. • Collaborate on at least 1 annual physical activity event for each HVR municipality and include chronic disease prevention messaging. • Meet Y-USA goal for participants in the Y Diabetes Prevention Program (YDPP). • Expand YDPP to all towns in Y service area with tracking	*County level prevalence data:* BRFSS and County Health Rankings: www.countyhealthrankings.org CDC County Diabetes Reports: www.cdc.gov/diabetes/atlas/countydata/atlas.html Child Health Data State Obesity Reports: http://childhealthdata.org *Local level screening and prevalence data*: CHC Uniform Data System Patient Services Reports *Local level measures:* • # of parishes and senior centers engaged in 5,2,1,0 messaging • # of Healthy Kids Coalition families reached with 5,2,1,0 messaging • # of CBOs and worksites implementing 5,2,1,0 Let's Go Strategies • # of stakeholder websites listing recreational programs and # of hits • # of new options for physical activity created in community, school, and	**Parish Nurses** United Way Leads, Coalition for Healthy Kids **Worksite Wellness** United Way Leads with collaborating partners **Active Living** Each town takes lead but to include collaborating partners **Screening Tool** Health Department(s) Leads **Diabetes Awareness Pilot** YMCA Leads **Y Diabetes Prevention** YMCA leads with collaborating partners including WCHN DSME **"Know Your Numbers"** Health Department(s) Leads with collaborating partners

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
		• By December 2015, stabilize obesity rates in HVR children and adolescents from CT baseline prevalence rates as reported by Child Health Data.org of: <u>Children 2 to 5 years</u> - 15% <u>Children 10-17 years</u> - White: 24.7% Hispanic: 48.3% Black: 43.6%	funding. • Identify funding sources for chronic disease prevention work in the community focused on awareness and screening.	availability of town locations. • By July 2014, increase opportunities for free "Know Your Numbers" screenings by incorporating into all existing and identified health education activities and adding opportunities in towns that need additional screenings. • By September 2014, Promote/Collaborate "Know your Numbers" Campaign with at least 2 local worksites. • By October 2014, develop a resource brochure for individuals identified in screening for secondary prevention programs including the WCHN Diabetes Self- Management Education Program (DSME), YMCA Diabetes Prevention Program, and local Community Health Centers.	system. • Track the number of residents in all HVR municipalities participating in Know Your Numbers Campaigns.	worksite locations • # of new opportunities for healthy eating created in community, school and worksite locations, including school and community gardens • Development of "Know Your Numbers" screening tool and # of sites implementing • # of worksite wellness policies developed and # adopted • # of sites and participants in YDPP	**<u>Partner Sub-Committee</u>** Resource guide for primary and secondary prevention health services

<u>Action Step Progress:</u>
YDDP grant awarded – start date 1/14.

Priority Health Issue (PHI) #2

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
PHI #2– Improve access to and utilization of quality prevention, counseling, and treatment services for substance use and abuse and co-related mental health issues	• To decrease the incidence and prevalence of substance use and abuse and co-related mental health issues for all individuals within our community, with an emphasis on adolescents and underserved individuals.	• Conduct ongoing advocacy in Western Connecticut to ensure accessibility to a continuum of high quality prevention, counseling, and treatment services. • By July 2014 collaborate with Regional Action Council, LPCs and other partners to create a prevention plan using SAMHSA's Strategic Prevention Framework (SPF).	• Map current assets and identify gaps in services and accessibility. • Communicate and engage key stakeholders to collaborate on system of care redesign. • Identify enhancement opportunities. • Increase awareness and provide education. • Promote efforts of local prevention councils (LPCs). • Increase involvement of youth in LPCs. • Conduct needs assessments as indicated. • Increase communication and awareness regarding existing programs. • Provide parent/adult education. • Engage local officials support and	<u>6-12 Month Milestones:</u> • By July 2014, increase awareness by key stakeholders of existing services, opportunities to improve, and additional resources needed. • By July 2014, map current services, programs, funders, and geopolitical relationships to identify gaps in services, support, and accessibility. • By July 2014, identify service enhancement opportunities by process and participation including providers, agencies and funders. • By July 2014, increase the number of youth and underserved groups engaged in local prevention councils by 20%. • By September 2014, provide education to providers including strategies for stigma reduction and engage providers in supporting regulation or legislation. • By October 2014, disseminate substance use/abuse prevention information to parents and guardians of students in all HVR K-12 public and private schools By November 2014, research legislative activities	• Continue provider education and awareness campaign to reduce stigma/ discrimination. • Advocate for appropriate insurance coverage/ reimbursement. • Collect and use assessment data to inform planning and leverage funding. • Plan and coordinate regional prevention conferences every two years with RAC staff. • Coordinate legislative advocacy activities through statewide/ regional prevention networks. • Establish a Youth Prevention Council. • A minimum of once every 2 years, administer student	• Asset map created • Advocacy Campaign created • # of stakeholder meetings • Summary document of System of Care Redesign produced • # of prevention planning meetings, attendance rates, and priorities identified • # and % of youth and members of underserved groups serving on local prevention councils, tracked over time • # and types of enhancement opportunities identified • 2-1-1 , DMHAS, and local provider data on service utilization with comparisons over time • CHC Uniform Data Reports on related ambulatory care services • CHIME ED visit and hospitalization data • # and types of provider educational sessions tracked • # and types of providers engaged in legislative advocacy tracked • # funding opportunities	**<u>Stakeholder Meeting Coordination</u>** WCHN Steering Committee Sponsor will assign lead to coordinate initial meetings with mental health specialists. Specific responsibilities will then be assigned. **<u>Action Plan Coordination</u>** HVCASA will coordinate all action plan steps in partnership with LPCs via existing roles and partnerships, i.e., HVCASA is the designated Suicide Prevention Coordinator for Region 5, a Drug Endangered Child Alliance Coordinator, attends statewide meetings of the CT Prevention Network, and serves on the DMHAS State Advisory Board. These partnerships

			advocacy. • Promote the use of SAMHSA's Strategic Prevention Framework in all communities via the Local Prevention Councils as designated by Local Officials.	to identify advocacy opportunities for next year. • By December, 2014, develop and administer student surveys in participating schools. • By December 2014, conduct at least 12 stakeholder focus groups. • By December 2014, conduct a total of two prevention planning meetings to identify priorities.	surveys in participating schools.	identified, # proposals submitted, amount of funding secured • Changes in policy, legislation and insurance coverage • Legislative breakfast held • Advocacy opportunities identified, summarized and appropriately distributed • # of student surveys designed, administered and analyzed; results disseminated in summary report with recommendations • Survey repeated every two years and results compared over time • # and type of schools where prevention education materials distributed and # students enrolled	will advance PHI #2 action steps as will the following local and regional networks: 12 LPC chairs (meet quarterly) Drug-Free Schools Committee (meets monthly throughout school year) Recovery Committee (meets quarterly) Youth Advisory Board/Teen Council (meets quarterly)

Action Step Progress:

Priority Health Issue (PHI) #3

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
PHI #3 – Improved assessment and service planning to address older adult health, housing and social support needs	• **To improve the physical, emotional, and mental health of older adults within our community.** • **To increase the accessibility and availability of social supports for older adults within our community, with an emphasis on at-risk seniors.**	• Improve the physical, emotional, and mental health of older adults within our community. • Increase public awareness of changing demographics and its impact on our communities. • Increase access to and utilization of existing community support resources and housing options for the elderly.	• Identify, recruit, and convene a Task Force of providers from the HVR region. • Educate providers from the region on goals and strategies of the Health Improvement Action Plan for PHI#3. • Utilizing the results of the Community Report Card for Western CT (CRC) and Aging in Place (AIP) IRB-approved survey, disseminate best practices to the entire HVR. • Explore funding opportunities.	**<u>0-6 Month Milestones</u>:** • By March 2014, analyze Danbury-focused AIP survey results and align strategies, goals, and objectives with PHI#3 Action Plan. • By May 2014, recruit and convene providers and advocates for the Task Force including the following possible resources: law enforcement, faith-based and community organizations, older adult service providers, and physicians. • By June 2014, begin an audit of available resources for seniors in the region and complete gap analysis between results and the AIP survey and relevant CRC findings. **<u>6-12 Month Milestones:</u>** • By August 2014, compare the survey findings to the audit of services. • By November 2014, finalize plans to expand goals and objectives to region. • By December 2014, explore funding opportunities.	• Develop an online regional guide to services through local coordinators, and possibly in print, e.g., periodic newsletters etc. (2-1-1 included). • Assess the availability and utilization of services and measure changes as evidence for future funding opportunities. • Expand the scope of existing service providers as community needs indicate. • Continue to explore funding to communicate and educate both the elderly and their adult children.	• Representativeness of Task Force members • Consistency of meetings held, attendance rates, and action items generated and completed • Summary report of audit and gap analysis results produced and evidence of dissemination • Regional guide to services produced and evidence of dissemination • 3 year survey of key housing and social service providers developed; analysis of utilization data and service growth over time. Results summarized and disseminated • # of funding sources identified, proposals submitted, and funding secured	**<u>Task Force Recruitment</u>** Steering Committee PHI WCHN sponsor and co-lead will contact possible recruits for Task Force and schedule an initial meeting. **<u>AIP Coordination</u>** WCHN PHI co-lead will provide Danbury AIP survey results for analysis.
<u>Action Step Progress:</u>							

Priority Health Issue (PHI) #4

Priority Health Issue	Goal	Objective(s)	Key Strategies/ Opportunities for Action	Short Term Action Steps (1 year) 1/1/14-12/31/14	Long Term Action Steps (2-3 years)	Potential Evaluation Measures & Metrics	Responsible Lead(s)
PHI #4 – Improved awareness and utilization of existing health and social programs and services	• **To increase awareness and utilization of existing health and social service programs and services within the community with an emphasis on reaching vulnerable residents, including low-income, non-English speaking, and undocumented individuals and families.**	• Increase awareness around the Affordable Care Act (ACA) coverage provisions and access to health insurance. • Increase and promote Infoline 2-1-1 awareness. • Increase awareness of affordable health care services and medication programs such as prescription discount programs. • Develop a coordinated system for ongoing dissemination of key information on programs and services to health providers and agencies serving vulnerable populations.	• Collaborate with Access Health CT to inform and promote awareness (work with local Assisters to promote awareness and identify target populations covered by each site - identify vulnerable subgroups). • Work with United Way to identify target populations for outreach and to avoid overlap. • Identify effective methods to provide information to patients, physicians, pharmacists and the community. • Ensure information is widely available regarding options for generic drugs, FamilyWize Discount Cards,	**0-6 Month Milestones:** • By January 2014 and ongoing, promote awareness of the 5 Assistor Sites in Danbury. • By January 2014 and ongoing, broadly distribute information at community events about 2-1-1, Familywize, and affordable health service providers, using existing resources, such as the Directory of Services for Danbury Families. • By February 2014, create a link from community websites, including United Way and Danbury's Promise for Children Partnership websites, to connect consumers with information on signing up for insurance. • By March 2014, promote awareness of the need for providers to update 2-1-1 listings. • By May 2014, convene a meeting with Access Health CT representatives and assistor sites to obtain information regarding their publicity and coordination efforts.	• By 2015, explore holding a Danbury Community Health Fair. • By 2016, promote collaboration between local Public Health Directors and Public Schools to distribute information about public health initiatives (immunizations, etc.). • By 2015, co-develop a Health Ambassador Program with United Way to disseminate key information to local providers and agencies serving vulnerable populations. • By 2015, co-develop a 1-2 page fact sheet with PHI #3 leads containing key contact information for health and human services for older adults, i.e., 2-1-1; 3-1-1, Senior Center Call Centers.	• Access Health CT Assistor utilization and enrollment data • # of events attended • Survey developed and results recorded and summarized • Meeting held with Access Health CT, attendees and action items developed • Website links created and operational • # of providers in the region who have connected with 2-1-1 to update their listings • 2-1-1 utilization data • # of contacts with local media and # PSAs developed and aired, # feature articles • # and location of 2-1-1	**Access Health CT, Assistor Site, and Discount Prescription Program Promotion** Danbury's Promise for Children Partnership and United Way will promote awareness about the Assistor sites through their networks. Danbury's Promise for Children Partnership and United Way and other workgroup members will distribute print materials, and related information within the community, through community partnerships and other outreach efforts. Danbury's Promise for Children Partnership and United Way to provide links on websites. Workgroup members develop publicity plan to promote information through local media sources. Workgroup members to develop 1-2 page descriptions of health providers serving low-income persons and prescription discount programs. **Provider Survey** In collaboration with workgroup leads, PHI #4

			and other prescription discount programs, including those offered by retailers, etc. • Collaborate with the CRC Steering Committee to develop a Community Health Ambassador Program to systematically disseminate information on key programs and services to local health providers. • Collaborate with PHI#3 to develop a 1-2 page fact sheet for use by home care providers, etc. with key contact information on services for older adults (i.e., 2-1-1, 3-1-1, Senior Center Call Center).	• By May 2014 and ongoing, contact local media/e-newsletters about publicizing 2-1-1. • By June 2014, survey health providers and social service agency directors about their challenges in getting information to potential clients about their services. • By June 2014, create a 1-2 page description of health providers who provide care to vulnerable individuals and families (i.e., CHCs) and a 1-2 page description of most accessible prescription discount programs for distribution by nonprofits, other providers, and at community events. Create materials in multiple languages. **6-12 Month Milestones:** • By October 2014, explore the need to conduct additional public presentations about 2-1-1, the 2-1-1 Navigator, etc. Target underserved groups for presentations and offer presentations in multiple languages.		presentations • # of Health Ambassadors recruited and trained • Older Adult Fact Sheet co-developed with PHI#3 leads; # printed and disseminated	Intern will develop survey of health care and social service providers. **2-1-1 Promotion** United Way will promote awareness of 2-1-1 online verification process and timeline and others distribute through networks. Danbury's Promise for Children Partnership and United Way and other workgroup members will plan public presentations on 2-1-1 and the 2-1-1 Navigator. **Health Ambassador Program Development** United Way's Volunteer Center and Danbury's Promise for Children Partnership will collaborate to develop the program and recruit and train Health Ambassador volunteers. **Older Adult Fact Sheet** PHI #3 and PHI # 4 co-leads will co-develop Fact Sheet.
Action Step Progress:							